Where are we with Diabetes Prevention in Virginia?

Annual Networking Meeting 2019

Viola Holmes, MS, RD, CDE
Virginia

PRELIMINARY
n = 6

Virginia

FULL
n = 10
Comparison of the types and number of sites 2018 to 2019

8 sites in January 2016 >> 46 sites in May 2018

<table>
<thead>
<tr>
<th>2018 Types</th>
<th>2019 Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 Health Systems</td>
<td>12 Health Systems</td>
</tr>
<tr>
<td>7 regional YMCA’s</td>
<td>5 regional YMCA’s</td>
</tr>
<tr>
<td>7 Free Clinics</td>
<td>4 Free Clinics</td>
</tr>
<tr>
<td>7 Physician and Nurse Practitioner-Based Practices</td>
<td>3 Physician and Nurse Practitioner-Based Practices</td>
</tr>
<tr>
<td>3 Fitness Center</td>
<td>1 Fitness Center</td>
</tr>
<tr>
<td>2 Federally Qualified Health Center (FQHC)</td>
<td>3 Federally Qualified Health Center (FQHC)</td>
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<tr>
<td></td>
<td>1 Virginia Cooperative Extension</td>
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<tr>
<td></td>
<td>2 Faith-Based Organizations</td>
</tr>
<tr>
<td></td>
<td>1 Hispanic non-profit Organization</td>
</tr>
<tr>
<td></td>
<td>1 Virginia Cooperative Extension</td>
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<tr>
<td></td>
<td>2 Military</td>
</tr>
<tr>
<td></td>
<td>1 Health Department (CVHD - Lynchburg)</td>
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</tbody>
</table>

Comparison CDC- NDPP Recognition Status

2018 Recognition Status:
- Full: 85%
- Preliminary: 6%
- Pending: 9%

2019 Recognition Status:
- Full: 54%
- Preliminary: 29%
- Pending: 17%
Findings for the decrease in the number of recognized sites:

▪ Organizational re-structuring
▪ Medicaid Expansion
▪ Coach Turnover
▪ Per data evaluation and recommendations from CDC
▪ Challenges with recruitment & retention
▪ Lack of funding & reimbursement to sustain the program
▪ Not a good fit for the organization

Summary

▪ Significant progress has been made in organizations obtaining preliminary and full CDC recognition
▪ Reimbursement and sustainability are still a challenge; the more we work together the more feasible it will be for organizations to achieve these goals.
▪ VCDPE to focus on supporting organizations in the areas of Virginia that have few to no NDPP programs.

Let’s keep moving forward and working together!
**Strategies to Sustain Weight Loss**

**Speaker:** Linda Delahanty, MS, RD  
Diabetes Prevention Program Research Trial  
Massachusetts General Hospital, Boston, MA

The slides from this presentation will be available via the webinar that Linda will be recording for us later this month. Once the recording and materials are available for viewing, we will send a message to the Networking group.

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**Break through Recruitment and Referral Barriers**

Tanya Henderson, PhD Balm in Gilead  
Lauren Palmer, RN  ACAC Health and Wellness  
Anne Wolf, MS,RD University of Virginia
National DPPs in Virginia, 2019

DPPs in Virginia Open to Public
DPPs in Virginia, Private (employer, Internal Clinic)

Virginia

Objectives

By the end of this session, participants will be able to

• Discuss Key marketing strategies when recruiting participants into the National DPP from the community and faith-based organizations.

• Learn strategies to overcome challenges and build healthy relationships with physician offices to increase your referral stream for the National DPP

• Identify at least three ways a clinic or hospital system can use their Electronic Health Record to identify, screen or refer patients to a National diabetes prevention program.
The Balm In Gilead, Inc.

• The Balm In Gilead, Inc. builds and strengthens the capacity of faith communities in the United States and in the United Republic of Tanzania (East Africa) to deliver programs and services that contribute to the elimination of health disparities.

• The organization develops educational and training programs specifically designed to establish sustainable, integrated systems of public health and faith principles, which helps to improve health outcomes of individuals living in urban, rural and remote communities.

The Power of Prayer

Celebrating the 25th Anniversary of the Week of Prayer for the Healing of AIDS
The Balm In Gilead, Inc.

• The Southeast Diabetes Faith Initiative, The National Brain Health Center for African Americans and The Healthy Churches 2020 National Campaign are three unique national programs of The Balm In Gilead, which deliver science-based, health awareness, understanding and interventions through the tenets of cultural competence to a broad spectrum of African Americans across the United States.

The Southeast Diabetes Faith Initiative (SDFI) is a national program of The Balm In Gilead.

It is a 5-state faith-based project designed to expand access and utilization of the Centers of Disease Control (CDC)’s PREVENT T2 Program.

In partnership with local faith partners, SDFI supports and encourages communities and individuals to live healthier in mind, body and spirit.
SDFI Virginia Sites

City of Colonial Heights
Bethesda Baptist Church
15800 Woods Edge Road
Colonial Heights, VA 23834
Rev. Bernice Harrison, Pastor

Fairfax County
First Baptist Church of Vienna
450 Orchard Street, NW
Vienna, VA 22180
Rev. Vernon C. Walton, Pastor

City of Hampton
Sixth Mount Zion Baptist Temple/Six House Inc.
2003 Kecoughtan Road
Hampton, VA 23661
Rev. Jerome Barber, Pastor

City of Hopewell
Friendship Baptist Church
1305 Arlington Road
Hopewell, VA 23860
Rev. Dr. Norwood Carson, Pastor

Sussex County
Mars Hill AME Zion Church
401 Main Street
Wakefield, VA 23888
Rev. Willie Dixon, Pastor

Virginia Staff

Program Coordinator
Sharon Napper

Colonial Heights
Shirl Isley
Jackie Briggs

Fairfax County
Robin Williams
Dale Wallace

Hampton
Michelle McRae
Phyllis Richardson

Hopewell
Lawana Simpson

Sussex County
Claressa Strawn
For more information about SDFI

Contact ME!!!

Tanya Bender Henderson, PhD
Virginia State Manager
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202.277.5872

Establishing a reliable stream of medical referrals

Lauren Palmer, RN
acac Fitness and Wellness Centers
Using the P.R.E.P. Model

What is P.R.E.P?

Key P.R.E.P. team members

- Director, Nurse, Medical Fitness Team Member
- Physician Liaison
  - Builds and sustains business relationships with physicians and their teams
  - Distributes info about P.R.E.P. and educates physicians about the program
  - Organizes physician dinners or other events
  - Lunches, breakfasts, other appointments and office visits
- Corporate outreach

First...A Faulty Assumption:

- P.R.E.P. medical outreach would have an easy time adding DPP message to their usual routine
What Can DPP Steal (ahem...learn) From P.R.E.P.? 

- Craft a message that conveys the value of our program to physicians...and their patients
- Build strong relationships with physicians and their staff
- Effective communication and follow up is key
National Diabetes Prevention Program

National Diabetes Prevention Program is a 16-week intervention program with bi-monthly follow-up utilizing the CDC-approved PreventT2 curriculum. Participants meet in small groups with trained Lifestyle coaches who empower them to develop the skills needed to lose weight, be more active, manage stress and achieve their goals.

Proven to reduce the incidence of diabetes by 58%*

Patient Information

Provider Information

[Form fields]

* Do NOT refer to person.
Patient is NOT insured for exercise.

[Form fields]
Build strong relationships

- **Consistency is key**
  - Might take many visits to an office to achieve any progress
    - Always have something to drop off!
  
- **Target your efforts**
  - Start with physicians who already have a good relationship with your organization, or are leaders in the community
  - Give more attention to physicians with a record of being good referral sources
  - Be mindful of physician’s patient population
    - Prefer PCP offices, but don’t rule out specialty practices

- **Have a clear message**
  - Physician time is limited...know your elevator pitch!
Communicate and Follow Up

Opportunities to reach out to physicians:

- Physician refers a patient
  - Patient enrolls
  - Patient decides NOT to enroll
- Patient self-refers to DPP
  - Opportunity to inform physician of patient’s enrollment AND provide information about the program
- Obtain lab results to establish patient eligibility
- Progress reports

Your patient has elected to enroll in the National Diabetes Prevention Program at acac Fitness & Wellness Centers. The NDPP is an evidence-based program recognized by the CDC, which provides lifestyle and wellness coaching in a small group setting over the course of one year. Participants who enroll in our program are seeking to improve their health through modest weight loss and increased physical activity.

[Patient] attended an Intake and Health Assessment appointment on 3/11/19. At this appointment we discussed her goals for the program, previous weight loss efforts, and determined how best to support her over the next year.

We also reviewed her medical history, current medical status, and current medications. Her elevated A1c lab result qualifies her for complete coverage of this program through her Medicare insurance policy.

[Patient] is a lovely woman, and I am so pleased she is participating in the National DPP. She will be joining a group already in progress which began meeting in February, and will receive make-up sessions from her coach for any content they have already covered. I look forward to apprising you of changes in her biometric data and progress toward her goals following routine periodic assessments. In the meantime, if you have any questions please feel free to reach out to me.
Thank you so much for recommending [patient] for the National Diabetes Prevention Program at acac Fitness & Wellness Centers. She has elected to enroll in the program as of today, and will be joining my Tuesday 11:45 cohort effective next week.

I had a chance to talk at length with [patient] this morning. We briefly reviewed her medical history and current medical status. Based on the results of her A1C lab result, she will qualify for complete coverage of this program through her Medicare insurance policy.

[Patient] is a delightful woman, and I am so pleased she will be joining my group. Both she and her husband are also enrolling in our P.R.E.P program. I look forward to apprising you of changes in her biometric data and progress toward her goals following routine periodic assessments. In the meantime, if you have any questions please feel free to reach out to me.

Last summer your patient elected to enroll in acac Fitness & Wellness Center’s National Diabetes Prevention Program, a year-long lifestyle change program providing nutrition, exercise and wellness counselling. At this time, I am pleased to provide you with an update on her progress.

Upon enrollment in the National DPP, each patient is provided with an InBody analysis, which gives a complete assessment of body composition. This data, along with weight, hip and waist measurements, allows us to track participants as they progress toward their goals. Within the program, our goal for every patient is to reduce his/her initial weight by 5-10% and establish a habit of 150 minutes of moderate exercise each week.

Below you will find intake data for [patient] as well as data collected today at her 6 month follow up. As you can see, she has already exceeded the program goal of 10% weight loss, with corresponding decrease in her BMI, body fat percentage, and waist and hip circumference.

<table>
<thead>
<tr>
<th>Intake (6/18/18)</th>
<th>6-Month F/U (2/7/19) Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>163.7</td>
<td>144.4</td>
</tr>
<tr>
<td>BMI 24.8</td>
<td>BMI 28.1</td>
</tr>
<tr>
<td>Waist 35”</td>
<td>Hip 43”</td>
</tr>
<tr>
<td>Hip 39”</td>
<td>% Body Fat 42.3</td>
</tr>
<tr>
<td>% Body Fat</td>
<td>36.8</td>
</tr>
</tbody>
</table>

[Patient] clearly takes great pride in the progress she has made. My next formal follow up to reassess her biometric data will occur at the 12-month mark. In the meantime, if you have any questions or would like to learn more about our program, please feel free to reach out to me. We would appreciate the opportunity to assist more of your patients in developing a healthier lifestyle!
In summary....

- Develop a clear message about how NDPP is good for physicians’ patients
- Build strong relationships
- Regular communication and follow up is key

BREAKING THROUGH RECRUITMENT AND REFERRAL BARRIERS USING THE EHR

ANNE WOLF, MS,RD
VIRGINIA CENTER FOR DIABETES PREVENTION AND EDUCATION
Focus

Hospitals + Clinics

QUESTION

Please stand if your facility

• Uses an Electronic Health Record (EHR)?
• Uses the EHR to identify people with prediabetes?
  • Uses a patient registry to identify prediabetes
  • Uses Best Practice Alerts to id and screen high risk people
• Uses the EHR to provide information about prediabetes
• Uses the EHR to refer to your program
Challenges faced by practicing physicians and care teams

- The current and growing volume of chronic disease
- Lack of time to effectively deliver the intensive counseling needed for lifestyle changes
- Social determinants of health often fall outside our scope of influence
- Lack of adequate information about community-based resources for diabetes prevention

**QUESTION**

Please stand if your facility’s EHR is:

- EPIC
- Cerner
- EClinicalWorks
- Allscripts
- Other
Approaches for Patient Referral in EHR

- **Care Management**  IDs patients who meet criteria for prediabetes and are eligible for referral
  - ID patients at risk
  - Prediabetes Registry
  - Batch referrals
  - Batch Education and communication through patient portal

- **Point of Care**  Uses patient routine office visit to id, screen and refer

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**EHR Patient Identification**

Query in EHR, Registry

- BMI* > 25 (> 23 kg/m² for Asian Americans), and
- Blood glucose/HbA1C levels in prediabetes range, or
- History of Gestational Diabetes
- No history of Diabetes

Point of Care Management with EHR

**Patient ID**
- Embed CDC/ADA questionnaire into EHR

**Alert Provider of Risk**
- EHR Best Practice Alert (BPA) → Cues to order HbA1c lab test

**Alert Provider of Prediabetes lab value**
- EHR BPA → Cues provider to take action

**Patient Management**
- Prediabetes Registry – Puts people with prediabetes in one dataset. Easy ID
- Prediabetes SmartSet - One order set for patient management (labs, education, fu)
- Refer to your National DPP
EHR Patient Identification
Best Practice Alerts

• BPA fires if patient is
  • > 45 years and
  • BMI ≥ 25 (≥ 23 if Asian)
  Or
  • Has history of GDM, + Family Hx
• Use with caution

RMH Sentara EHR Referral
CVHS Prediabetes Identification, Screening and Treatment Workflow

PATIENT WORKFLOW
- Completes paper screener
  - Lab Test
  - Places HbA1c order for patient

NURSE/CARE COORDINATOR/HE WORKFLOW
- Reviews paper screener score
  - Identifies high risk as score > 5
  - Global Alert: + Prediabetes Screen
    - Adds global alert to EHR
    - Places HbA1c order for patient
    - Adds patient to prediabetes registry when HbA1c 5.7 - 6.4

PHYSICIAN/ NP WORKFLOW
- Reviews patient’s lab results
  - GLOBAL ALERT: PREDIABETES
  - Puts Prediabetes on Problem list
  - Uses Prediabetes Order Set
- Treatment Options
  - Referral to DPP
  - Referral for MNT
  - Education onsite
  - Metformin
  - Pt not interested in treatment

GLOBAL ALERT
- PREDIABETES
- NeedPDScreen

EclinicalWorks Prediabetes Order set – CVHS

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength</th>
<th>Take</th>
<th>Freq</th>
<th>Duration</th>
<th>Refill</th>
<th>Route</th>
<th>Formulation</th>
<th>Dispense</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin HCl</td>
<td>500 MG</td>
<td>1 tablet with a meal</td>
<td>Once a day</td>
<td>30 day(s)</td>
<td>Orale</td>
<td>Tablet</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Diagnostic Imaging

Procedures

Communications

Therapeutic Interventions

Appointments

Physician Education

- Prediabetes_PrePdlbleRiskTest(English).pdf
- Prediabetes English.pdf
CVHS Order set: Educational Material

Bidirectional Referral: Closing Feedback Loop

- National DPPs can close loop in referral process and provide feedback to provider
- Information to provider: Patient enrollment, attendance, % weight loss
  - Internal DPP/Access to EHR
    - Progress documented
    - Patient enrollment & progress at 1-, 6-, & 12-month
  - External NDPP to health system/clinic/Non access to EHR
    - Patient enrollment and progress at 12 months
Summary
If you have an EHR, use it to...

• Screen your population automatically
• Alert providers to order blood test
• Provide standardized educational material
• Refer to your program

• In any new process, important to develop a workflow for your clinic and health system

Q & A
THANK YOU
ON BEHALF OF
VCDPE, VDH, & VDC

https://med.virginia.edu/vcdpe/