Expanding Diabetes Prevention & Management Programs: The Role of Local Health Departments

May 17, 2017

Illinois Public Health Institute
Welcome & Introductions

Janna Simon, MPH
Program Manager, Center for Policy & Partnership Initiatives
Illinois Public Health Institute
We’d like to thank the following funder for support of this initiative:

- University of Wisconsin Population Health Institute’s *County Health Rankings and Roadmaps*

*Webinar co-planned by the Illinois Department of Public Health, Illinois Association of Public Health Administrators, Illinois Alliance to Prevent Obesity members, and local health department leaders in Illinois*
Bridging to Preventive Care: Medicaid Coverage of Community-Based Chronic Disease Prevention & Management

Goal:
Leverage new CMS rules on Medicaid payment of community-based providers to expand diabetes prevention and management services to Medicaid clients

Task
Develop a Roadmap; launch a pilot; expand capacity; scale
Poll

Where are you located?
1. Northern Illinois
2. Central Illinois
3. Southern Illinois
4. Oregon
5. Other
Poll

Which program(s) are you most interested in supporting/providing at your local health department?

1) National Diabetes Prevention Program (DPP)
2) Diabetes Self-Management Education (DSME)
3) Stanford model Diabetes Self-Management Program (“Take Charge of Your Health”; DSMP)
4) I’d like to provide something but am still learning the differences
5) None at this time
Illinois Diabetes State Plan

Paula Jimenez, RN
Assistant Division Chief
Division of Chronic Disease
Illinois Department of Public Health

May 17, 2017
Agenda

• ASTHO grant Overview
• Mission and Goal of the State Diabetes Plan
• Priority Areas for the Diabetes Plan
• Completed Activities
• Next Steps
ASTHO Grant Overview

ASTHO
- Association of State and Territorial Health Officials

November 2016
- ASTHO requested bids to participate in demonstration project to align state diabetes plans

December 2016
- Illinois one of two states awarded
To partner across sectors including clinical, community, and public health partners to align state diabetes plans and address gaps to improve diabetes management and associated outcomes.
Priority Areas for Diabetes State Plan

- Community/Clinical linkages
- Data and Health Information Technology (IT)
- Finance and reimbursement mechanisms
Completed Activities

December
- Identified stakeholders
- Disseminate stakeholder survey

January
- Convene stakeholder meeting
- Identify workgroup team leads
- Finalize agendas and meeting dates

February – May
- Convene work groups monthly
- Initial framework for Diabetes Action Plan presented across workgroups
Next Steps

- **Late May**
  - Share final drafts of Diabetes Action Plan
  - Attend ASTHO virtual learning session

- **June**
  - Develop additional context / framework around developed goals/objectives

- **July**
  - All Stakeholders meeting July 20th
  - 2nd ASTHO virtual learning session (date TBD)

- **August**
  - Submit and publish final version of Diabetes State Plan to ASTHO

IDPH
What does the future hold?

- Chronic Disease and School Health Grant
- New Partners in FY 18
- Innovative Approaches
THANK YOU

Paula.Jimenez@Illinois.gov
Preparing for DSME Accreditation

JODI LAVIN-TOMPKINS, RN, MSN, CDE, BC-ADM
DIRECTOR OF ACCREDITATION
Who is AADE?

• Multi-disciplinary professional membership organization dedicated to improving diabetes care through innovative education, management and support – Our membership is at 14,500 and growing.

• National Accrediting Organization (NAO) for Medicare. Our Diabetes Education Accreditation Program (DEAP) certifies Diabetes Self-Management Education and Support (DSMES) programs in order for them to be eligible to bill Medicare.

• A leader in the field of the National Diabetes Prevention Program, with one of the largest in-person DPP network (AADE DPP), scaling the National DPP through a cooperative agreement with CDC since 2012.
Diabetes Self-Management Education and Support

- The ongoing process of facilitating the knowledge, skill, and ability necessary for prediabetes and diabetes self-care.

- This process incorporates the needs, goals, and life experiences of the person with diabetes or prediabetes and is guided by evidence-based standards.

- The overall objectives of DSME are to support informed decision-making, self-care behaviors, problem solving, and active collaboration with the health care team, and to improve clinical outcomes, health status, and quality of life.
Who can provide DSMT “AND” get reimbursed by Medicare

- **Settings, once accredited**
  - Hospitals
  - Pharmacies
  - FQHC’s
  - Health Departments
  - Outpatient offices
  - Areas on Aging

- **Professions**
  - RDs
  - Physicians (MDs and DOs)
  - Physician assistants, Nurse practitioners, Clinical nurse specialists
AADE Accreditation requires programs to adhere to the National Standards for Diabetes Self-Management Education and Support. These are reviewed and updated every 3-5 years.

The newly updated standards will be published in October 2017. New Interpretive guidance will follow.
Review of the National Standards...

- Originally published in 2000
- There are 10 National Standards divided into:
  - *Structure*
  - *Process*
  - *Outcomes*
- *They are the blue print to your program*
- Simply stated:
  - WHO - People (Staff & Clients)
  - WHERE - Space
  - WHAT - curriculum, assessment, measurement
  - HOW – formalization of your program
10 National Standards

**Structure Standards**
- Standard One – Internal Structure
- Standard Two – External Input
- Standard Three – Access
- Standard Four – Program Coordination

**Process Standards**
- Standard Five – Instructional Staff
- Standard Six – Curriculum
- Standard Seven – Individualization
- Standard Eight – Ongoing Support

**Outcome Standards**
- Standard Nine – Patient Progress
- Standard Ten – Quality Improvement
How do I apply?

Our website Will be helpful during the application process.
DEAP Program Resources

https://www.diabeteseducator.org/practice/diabetes-education-accreditation-program-(deap)

DEAP Contact Information:
Tel: (800) 338-3633
Email: deap@aadenet.org

DSME Program Management Certificate Program

https://www.diabeteseducator.org/education-career/online-courses/dsme-program-management-certificate-program
Why is AADE in Diabetes Prevention?

Prevention is within our organization’s vision: *Optimal health and quality of life for persons with, affected by or at risk for diabetes and related chronic conditions* and is one of our organizational Strategic Initiatives.

- AADE’s National Practice Survey (2015) found that 80.5% of respondents reported to be working with people with prediabetes
- Our accredited DSMES program survey found 80% of DEAP programs work with people with prediabetes
  - Only 0.4% reported receiving reimbursement for prevention services

We have found value in Diabetes Education Programs delivering the National DPP
CDC and the National DPP

CDC’s National DPP:

- Approved Lifestyle Change Program Curriculum and Trainings
- Diabetes Prevention and Recognition Program (DPRP)
- Both in-person and online delivery methods
- Marketing/Awareness Campaigns

http://www.cdc.gov/diabetes/prevention
dprpask@cdc.gov
Since 2012, AADE has worked with CDC to scale the National DPP

“AADE DPP” model- National DPP offered through DSMES (DEAP/ERP) programs:

- Large pool of eligible participants through EMR’s
- HIPAA compliant/accustomed to proper data collection and entry
- Program Coordinator is a Diabetes Educator (HCP)
- Educated DPP Lifestyle Coaches (Can be CHW’S)
- Already billing capabilities and NPI number
- Already providing service for payers- Insurers and Employers (DSME and Screenings)
- Linkage with local primary care providers (referral required for DSMT)
- Experience with telehealth delivery and other types of telemedicine
- Transition of care for people found to have type 2 diabetes
### AADE DPP Site Stats:

<table>
<thead>
<tr>
<th>AADE DPP SITES as of 2016:</th>
<th>CDC DPRP Guidelines to Achieve Full Recognition:</th>
<th>AADE DPP Sites’ Aggregated data from DPRP Progress Reports:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of AADE DPP Sites</td>
<td>44 Proportion of participants program eligibility determined by a blood based test</td>
<td>≥ 50 % 75.40%</td>
</tr>
<tr>
<td>Number of Classes</td>
<td>&gt; 230 Minimum Average number of sessions attended during months 1-6 for participants attending ≥ 4 sessions</td>
<td>≥ 9 14.5</td>
</tr>
<tr>
<td>Number of Participants</td>
<td>&gt; 2200 Minimum Average weight loss achieved at 6 months</td>
<td>≥ 5-7 5.20%</td>
</tr>
<tr>
<td>Number of Lifestyle Coaches at AADE DPP Sites</td>
<td>228 Minimum Average number of sessions attended during month 7-12 for participants attending ≥ 4 sessions</td>
<td>≥ 3 3.62</td>
</tr>
<tr>
<td></td>
<td>Average weight loss achieved at 12 months</td>
<td>≥ 5-7 % 6.00%</td>
</tr>
</tbody>
</table>
In September 2016, The Diabetes Educator published a manuscript demonstrating the AADE DPP model over three years within 25 programs.

“Achievement of Weight Loss and Other Requirements of the Diabetes Prevention and Recognition Program: A National Diabetes Prevention Program Network Based on Nationally Certified Diabetes Self-management Education Programs”
As of January 2017, CDC’s DPRP Registry:

1222 - Total number of CDC Recognized Programs

- 268 - Total number of DPRP programs that are also Certified Medicare DSMES Programs (DEAP/ERP)
- 88 - Total number of Fully Recognized programs
  - 41 - Almost half of all Fully Recognized programs are DSMES

Source: CDC DPRP Registry: https://nccd.cdc.gov/DDT_DPRP/Programs.aspx, January 2016
Medicare Coverage of Prediabetes

CMS concluded the National DPP:
- Increases health quality
- Reduces health care costs

- In mid-2017, 2018 PFS released for public comment
- In late-2017, 2018 CMS Final Rule will be released
- January 1 2018- Medicare will cover DPP for eligible participants at eligible Medicare DPP Suppliers
What can programs do now to prepare to be a MDPP Supplier/ DPP Provider?

- Decide system for data collection and support network
- Develop Budget, business case, pricing, cost and ROI to launch your DPP
- Apply and maintain CDC Recognition and attend webinars
- Begin to promote Physician Referrals, especially for Medicare covered lives, set up a provider referral loop
- Look for 2018 PFS and 2018 DPRP standards and comment when available (likely in Summer 2017)
- Attend workshops, trainings, webinars and research Networks that offer services to prepare and support your program for successful and sustainable DPP implementation
DSMES in Illinois- Potential to Scale the AADE DPP model (National DPP)

Number of DSMES (DEAP/ERP) in IL: 142

Each one of these DSMES programs may be able to serve the National DPP in multiple geographic locations

There are currently a total of 34 CDC Recognized DPP programs in IL

Source: https://www.diabeteseducator.org/patient-resources/find-a-diabetes-educator, March 2017
DPP Services from AADE

- **Lifestyle Coach Trainings**- Public and Private trainings provided around the country- AADE is listed on CDC website as a LSC training entity (*June* 21-22, Chicago IL).

- **2017 AADE Workshops**- Designed to help program coordinators build internal business case to become a successful CDC Recognized DPP and MDPP Supplier (*June 23*rd in Chicago).

- **AADE Prevention Network**- Any DPP program can subscribe to the AADE Prevention Network to gain access to ongoing education, tools, payment, coverage information and access to a cloud-based participant data base analytics system (DAPS) to ensure quality and sustainability. Any CDC Pending of Fully Recognized DPRP may apply!

- **“Best Practices in the National DPP” Precon AADE17**- Attend this meeting to hear from experts in the field, CDC, YMCA, BWHI, AADE DPP and others about best practices in delivery of the National DPP to various populations in various delivery models (*August 3*rd, 2017, Indianapolis)

[www.diabeteseducator.org/preventionsimplified](http://www.diabeteseducator.org/preventionsimplified)

Email [dpp@aadenet.org](mailto:dpp@aadenet.org) to receive email updates.
More on the AADE Prevention Network:

A subscription to AADE Prevention Network will provide DPP orgs an opportunity for a one-stop-shop for all tools and resources to be a successful and reimbursed DPP program:

- Physician Referrals tools, templates and best practices
- Business Case and ROI information
- Best Practices on DPP implementation
- Discussion Forum with Coordinators and Coaches
- Payer Tracking- Updates regarding reimbursement, policy coverage information and coding
- Guidance on Medicare and Medicaid Requirements
- Access to DAPS™- online participant data base system
Questions?

Email: dpp@aadenet.org

www.diabeteseducator.org/dpp
Implementation of the National Diabetes Prevention Program in Oregon

Nancy Goff
Health Systems Policy Specialist
Health Promotion and Chronic Disease Prevention Section
Public Health Division
Oregon Health Authority
Oregon’s Health Promotion and Chronic Disease Prevention Program

- Tobacco, physical activity, nutrition & alcohol use

- Policy, systems, environmental change
  - State policy
  - Local grants (Tobacco Prevention & Education; Healthy Communities)

- Health systems
  - State and federal policy
  - Grants to local public health and CCO teams (SRCH)
Sustainable Relationships for Community Health

- Grant program for CCOs, LPHAs, Clinics & Community Partners
- Starting third year this fall
- Teams participate in three facilitated institutes to build **closed-loop referral systems** for chronic disease self-management programs
- Includes tobacco quit line, diabetes prevention & cancer screening
- **Grantees:**
  - Clackamas County & FamilyCare
  - The Public Health Foundation of Columbia County & Columbia Pacific CCO
  - InterCommunity Health Network & Lincoln County
  - Klamath County & Cascade Health Alliance
  - Lane County & Trillium Community Health Plan
  - Deschutes County & PacificSource
  - AllCare Health Plan & Josephine County
National Diabetes Prevention Program

- National Association of Chronic Disease Directors (NACDD) grant
  - Implementation through SRCH
  - Three CCOs enrolling 100 participants each

- Building statewide delivery site infrastructure
  - Oregon Health and Sciences University
  - Community-based organizations
  - Building new partnerships

- State Medicaid policy
  - Coverage and reimbursement strategies through CCOs
Expanding the Diabetes Prevention Program through Community Clinical Linkages in Clackamas County

Apryl Herron, MPH
Public Health Program Coordinator
Clackamas County Public Health Division
Developing Community-Clinical Linkages

CCPHD Community Health Improvement Plan (CHIP) Priorities:
- Reduce the medical and financial burden of chronic disease by improving screening rates, referral processes, and the reimbursement of programs that support patients to make healthier lifestyle changes.

Community Collaboration:
- Coordination of work with partners whose works aligns with ours.
- Collectively influence population health through improved access to chronic disease self-management programs (CDSMP).
- Increase capacity for program offerings in Clackamas County.
Building Partnerships and Establishing Roles

- **Clackamas County Public Health** – Lead efforts to build and improve linkages; establish and maintain partnerships, support Health Centers.

- **Clackamas County Community Health Centers (FQHC)** – pilot site providing comprehensive health care services to the uninsured, low income and racial/ethnic minority population. Screen, identify and refer patients into Diabetes Prevention Programs.

- **FamilyCare & Health Share CCO’s** – develop sustainable funding mechanism identify target population, data analysis

- **Community-based Programs providing DPP** – YMCA, Lifestyle Medicine Group and Clackamas Volunteers in Medicine

- **ORCHWA** – Community Health Worker support
Processes and Activities:

- Mapping the current and future state to identify gaps in screening, workflow and referral processes
- Use of EPIC to implement workflow changes to initiate referral and close the loop
- Medical Director and Provider engagement to increase referral of patients with prediabetes
- Developed a new policy and procedure for referrals
- Identified patients eligible for DPP- provide outreach and referral
- Establish and track performance measures
Our impact:

What we hope to achieve:

- Build capacity for DPP
- Expand clinical linkages to community-based providers
- Seamless closed-loop referral pathway
- Retention of program participants
- Demonstrate a return on investment through improved health outcomes and reduced health care costs
Thank you!

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Clackamas County Public Health
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DPP IN CENTRAL OREGON
TRI-COUNTY COLLABORATION

SARAH WORTHINGTON MPH, RD
DESC RUTES COUNTY HEALTH SERVICES
Public Health and Behavioral Health
- Bend
- La Pine
- Redmond
- Sisters

Chronic Disease Prevention
- Self-management programs
- Diabetes Prevention Programs
- SRCH, Healthy Communities
CENTRAL OREGON DPP
First Program: Redmond, January 2016
Key Partners: Mosaic Medical, St. Charles Family Care
Coaches: DC HS Staff
Coordinator: DC HS Staff
La Pine*
La Pine Community Health Center
Prineville*
Crook County Health Department
Madras*
Mosaic Medical
Redmond
Council on Aging of Central Oregon
*CDC recognition
ROLE OF DPP COORDINATOR

- Arrange trainings
- Convene bi-monthly meetings of coaches
- Facilitate partnerships to offer DPP
- Substitute teach
- Marketing, outreach
- Procure supplies
- Lead cohorts as coach
HEALTH DEPARTMENT AS DELIVERY ENTITY: PROS

Good fit for facilitating partnerships among community agencies and clinics

Expertise in data collection and analysis

Big picture perspective of community needs and impact

Work with multiple clinical partners as “neutral” party offering a community-based resource that serves client/patient needs
HEALTH DEPARTMENT AS DELIVERY ENTITY: CONS

| Referrals easier to establish and maintain within clinical setting |
| Soft money/sustainability |
| Concurrent role of regional coordinator and Lifestyle Coach alongside other functions of PH work |
Funding for these programs provided by the Illinois Department of Public Health

State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity, and Associated Risk Factors and Promote School Health (CDC - DP13-130504PPHF17)
Helping Patients: Self-Measured Blood Pressure Monitoring and Million Hearts® Initiative Resources and Best Practices

Webinar: May 26 & 30, 10-11 a.m.

Learning Objectives:

• Describe the Million Hearts® design and priorities.
• Understand the contribution that SMBP has on improving blood pressure outcomes and how SMBP interventions can be implemented in a clinical setting.
• List community-based interventions that can be implemented to reduce sodium intake for a given population.

http://www.ihatoday.org/uploadDocs/1/millionhearts.pdf
Diabetes Self-Management Programs: Tips for Successful Recruitment and Retention

Webinar: June 14, 2-3 p.m.

Learning Objectives:

• Understand partnerships that have helped create successful programs.
• Review examples of successful national recruitment and retention strategies.
• Discuss Illinois-specific case studies surrounding diabetes recruitment and retention systems.
• Review tools that can be used by programs and clinicians to improve the recruitment and retention process.
Digging Deep into Diabetes –
2017 Prevention and Self-Management Symposium

June 29, 9:00 a.m.-3:45 p.m.
NIU Conference Center, Springfield, Southern Illinois

- Illinois Diabetes Strategic Plan
- American Diabetes Association Update
- American Association of Diabetes Educators Update
- Stanford Diabetes Self-Management Program Update
- Mechanics of Reimbursement
- Building System-Wide Capacity to Prevent Diabetes
- National Diabetes Prevention Program (DPP) –YMCA
- Exploring the Role of Community Health Workers
- Fix Your Diet, Fix Your Diabetes!
Diabetes Self-Management Program Training

Session I
June 22, 23, 26, 27
• 1048 LAKE STREET, SUITE 300
  OAK PARK, IL 60301-1102

Session II
July 19, 20, 26, 27
• 303 NW 11TH STREET
  FAIRFIELD, IL 62837

Session III
August 3, 4, 10, 11
• 700 SOUTH SECOND STREET
  SPRINGFIELD, IL 62704
Diabetes Self-Management Program Training

Session IV
September 18, 19, 25, 26
• SITE TBD, NORTHERN IL AREA

Session V
October 16, 17, 23, 24
• SITE TBD, LAKE COUNTY AREA

Session VI
October 19, 20, 26, 27
• 900 N. 2ND STREET
  ROCHELLE IL 61068
For more information contact:

Abby Radcliffe
aradcliffe@team-iha.org
217-541-1178
Questions?
Thank you!

For additional assistance or questions, contact Janna Simon at janna.simon@iphionline.org or 312-850-4744