Diabetes Prevention: Your Role as a Healthcare Professional (July 15, 2020)

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Welcome

• Webinar is being recorded and shared
• Please keep yourself on mute
• Enter questions in chat box
Welcome and Introductions

American Medical Association
Neha Sachdev, MD, Director of Health Systems Relationships

Health Promotion Council of Southeastern Pennsylvania
Gina Trignani, MS, RD, LDN, Director, Training and Capacity Building
Susanne Trexler, CHES, Program Manager, Training and Capacity Building

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Alexis Skoufalos, EdD, Associate Dean, College of Population Health
Mitch Kaminski, MD, MBA, Program Director, Population Health, College of Population Health
Neva White, DNP, CRNP, CDE, Senior Health Educator, Center for Urban Health
Agenda

8:00 am   Philadelphia Diabetes Prevention Collaborative
          AMA Overview and Background on Philadelphia Focus
          Prediabetes Screening, Testing, and Referring
          Testimonial from a local Master Lifestyle Coach
          DPP Landscape in Southeastern PA
          Questions & Answers

9:00 am   Closing
Objectives

1. State the prevalence of prediabetes in SEPA to understand the public health urgency.

2. State the risk for type 2 diabetes.

3. Describe the guidelines for screening and testing of patients for prediabetes.

4. Discuss the history of the development of the National DPP and the evidence behind the program.

5. Identify and make appropriate referrals to National DPP lifestyle change programs.
Philadelphia Diabetes Prevention Collaborative

Alexis Skoufalos, EdD
The DPP Philadelphia Concept City project was officially initiated in July 2019

Multi-stakeholder collaborative to prevent diabetes by identifying and referring those with prediabetes to a CDC-recognized Diabetes Prevention Program

www.Jefferson.edu/PreventDiabetesPHL
Philadelphia Diabetes Prevention Collaborative

Our goal: 2000 in 2020

Half from physician referral

National Partners
Local Stakeholder Collaborators

Greater Philadelphia Business Coalition On Health
“Building Bridges to Better Healthcare”

HealthShare Exchange of Southeastern Pennsylvania, Inc.

City of Philadelphia

Health Promotion Council a PHMC affiliate

Temple Health

Aetna

Health Partners Plans

Keystone First

PMSI

OAK STREET HEALTH

The Health Federation of Philadelphia

The Philadelphia County Medical Society

The Health Care Improvement Foundation

Building Partnerships for Better Health Care
Prioritizing Diabetes Prevention
Type 2 diabetes affects millions of Americans — and thousands of Philadelphians

Nationally.... 13.0% of all US adults aged 18 years or older had diabetes

Locally.... In annual surveys, an estimated 11.4% of adults in Philadelphia had diabetes


Diagnosed diabetes is associated with a significant cost burden

Estimated economic cost of diabetes - 2017

$327 BILLION

$237B in direct medical costs
$90B in reduced productivity

Estimated individual cost of diabetes

$9,600/yr. avg. medical expenses attributed to diabetes
2.3X higher expenses than those w/o diabetes

Diabetes and COVID-19

- Current evidence suggests that diabetes is a risk factor for more severe COVID-19
- Uncertainty remains
- Effects of COVID-19 include changes to health care and daily lives


AMA mission: Improve the health of the nation

1. Representing physicians with a unified voice
2. Driving the future of medicine
3. Removing obstacles that interfere with patient care
4. Leading the charge to confront public health crises

Physicians’ powerful ally in patient care
Improving Health Outcomes

1. No new preventable cases of type 2 diabetes

2. Everyone with hypertension has their blood pressure at goal
88 MILLION AMERICAN ADULTS HAVE PREDIABETES

Physicians, care teams and health care organizations play an essential role in diabetes prevention.

We believe **everyone** with prediabetes should be aware of the condition and be able to take action to reduce their risk of developing diabetes.
Prediabetes Screening, Testing, and Referring

Mitch A. Kaminski, MD, MBA
U.S. Preventive Services Task Force (USPSTF) abnormal glucose recommendation

Grade B recommendation

- Screen all adults ages 40-70 AND who have a BMI ≥ 25
- Screen with a fasting glucose, hemoglobin A1C or oral glucose tolerance test

USPSTF standards suggest testing patients every 3 years

Consider testing adults of a lower age or BMI if risk factors are present

**Family history**
Family history of type 2 diabetes includes first-degree relatives (a person’s parent, sibling or child)

**Medical history**
- Gestational diabetes
- Polycystic ovary syndrome

**Racial & ethnic minorities**
- African Americans
- American Indians
- Alaskan Natives
- Asian Americans
- Hispanics or Latinos
- Native Hawaiians or Pacific Islanders

Offer or refer patients with abnormal glucose to intensive behavioral counseling interventions to help promote a healthy diet and physical activity.

Historical starting point: DPP study

DPP & DPPOS Timeline

1996: DPP
2001: Modified DPP Lifestyle Change Program
2002: Modified DPP Lifestyle Change Program and Self-Management Classes
2002: Modified DPP Lifestyle Change Program and Metformin
Present: Modified DPP Lifestyle Change Program

2010: National DPP created
2018: CMS covers participation
The DPP Program

- Year-long hour-length classes
  - months 1-6: at least 16 classes offered
  - months 7-12: at least 6 classes offered
  - make-up classes offered
- In-person, virtual, distance learning, or combination
- Weight, activity minutes tracked

The structure, group support and learning are the “secret formula” in the DPP program...
Understanding the National DPP Lifestyle Change Program

- Trained lifestyle coaches teach group classes
- Programs deliver a CDC-approved curriculum
- Emphasis on prevention and empowerment through a personal action plan
- Quality assurance through the Centers for Disease Control and Prevention (CDC); programs are required to submit data on participant outcomes

*Key standard for CDC recognition: Average participant body weight loss of 5%. 
Who qualifies for the National DPP Lifestyle Change Program?

5.7%-6.4% HbA1c

≥ 25 BMI
Enrolling in the National DPP Lifestyle Change Program

Participants must meet ALL the following:

- Be 18 years or older
- Overweight or obese
- Not diagnosed with diabetes
- Not pregnant

And ONE of the following:

- Blood test within the past year:
- Previous diagnosis of gestational diabetes
- An elevated score on a prediabetes risk test/questionnaire

Standards and Operating Procedures. Centers for Disease Control and Prevention Diabetes Prevention Recognition Program [www.cdc.gov/diabetes/prevention/recognition](http://www.cdc.gov/diabetes/prevention/recognition), March 1, 2018
The AMA can help you prevent type 2 diabetes

Approximately one in three adults has prediabetes, and 90 percent of people with prediabetes are unaware.

The American Medical Association offers a comprehensive assessment and guided process to support your health care organization with implementing a diabetes prevention strategy, including access to an evidence-based diabetes prevention lifestyle change program.

Get started today.

Take the first step toward developing a free customized diabetes prevention strategy.

Your Name

Your Email

By signing up you agree to the terms of service.

Get started
JOIN IN THIS NATIONAL EFFORT

Everyone can play a part in preventing type 2 diabetes

RAISE AWARENESS of prediabetes

SHARE INFORMATION about the National DPP

ENCourage PARTICIPATION in a local lifestyle change program

PROMOTE the National DPP as a covered health benefit

Find out how to get involved with the National Diabetes Prevention Program

www.cdc.gov/diabetes/prevention
Lose Weight and Prevent Diabetes

Center for Urban Health
Diabetes Prevention Program Local Master Lifestyle Coach

Neva White DNP, CRNP, CDE
Virtual Lifestyle Coach Training

• The Diabetes Prevention Programs are led by certified Lifestyle Coaches, trained by CDC approved training entities

• Two Day – 8 hour training
Virtual Diabetes Prevention Program
Lose weight and Prevent Diabetes

Centers for Disease Control National Diabetes Prevention Program
Full Recognition Program
Prevent T2 curriculum

PREVENT T2
A PROVEN PROGRAM TO PREVENT OR DELAY TYPE 2 DIABETES
## Prevent T2 Curriculum

<table>
<thead>
<tr>
<th>Module Topic</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get Active to Prevent T2 Track Your Activity</td>
<td>Skill</td>
</tr>
<tr>
<td>Eat Well to Prevent T2</td>
<td></td>
</tr>
<tr>
<td>Get Support Take Charge of Your Thoughts to</td>
<td>Emotions</td>
</tr>
<tr>
<td>Prevent T2</td>
<td></td>
</tr>
<tr>
<td>Shop and Cook to Prevent T2 Eat Well Away from</td>
<td>Environment</td>
</tr>
<tr>
<td>Home</td>
<td></td>
</tr>
<tr>
<td>Keep Your Heart Healthy</td>
<td>Health and Wellness</td>
</tr>
</tbody>
</table>

The lifestyle change program curriculum emphasizes self-monitoring, self-efficacy, and problem-solving; provides for coach feedback; includes participant materials to support program goals; and calls for participant weigh-ins to track progress.
Virtual Program Delivery in the Time of Covid-19

• Facilitated Program: the virtual program is consistent with the in-person CDC recognized curriculum
• Better retention rate and improved engagement
• Rich discussions
• No Travel
• No concerns about the weather
• Easier to secure Guest Speakers
• A way to stay connected to the outside world!
Distance Learning Using Zoom
Closing the Digital Divide

• Selecting a Platform
  • Zoom (Jefferson Approved)

• Training
  • (One on One Zoom Training for each participants new to zoom)

• Regular Email/ Phone Reminders
## Distance Learning Using Zoom
### 2018-2019 Pilot Outcomes
(Jefferson data)

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>A total of enrolled 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPP Retention</td>
<td>84% (n=21) of individuals enrolled, attended at least 5 core sessions (month 1-6; 16 sessions)</td>
</tr>
<tr>
<td></td>
<td>65% (n=15) completed at least 5 core sessions and 5 post core (month 7-12; 6-12 sessions)</td>
</tr>
</tbody>
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Of the 15 individuals who completed the program:

<table>
<thead>
<tr>
<th>Weight Loss</th>
<th>87% (n=13) lost at least 5% of their starting body weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Activity</td>
<td>87% (n= 13) achieved over 150 minutes per week of physical activity</td>
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Distance Learning Using Zoom
Closing the Digital Divide

• Current Program
• Started February 2020
• 32 enrolled
• 5 alumni enrolled
• Currently 97% participation
• 100% alumni still active
How to Refer to National Diabetes Prevention Programs in Southeastern Pennsylvania

Gina Trignani, MS, RD, LDN, Director
Susanne Trexler, CHES, Program Manager
Training and Capacity Building
About Health Promotion Council

HPC is a non-profit organization whose mission is to promote health, prevent and manage chronic diseases, especially among vulnerable populations through community-based outreach, education, and advocacy.

A subsidiary of Public Health Management Corporation (PHMC), a Public Health Institute in Pennsylvania.

HPC has been working to build capacity of the National DPP delivery in Pennsylvania since 2014 in partnership with the Pennsylvania Department of Health.

Our work focuses on the four pillars for National DPP sustainability

<table>
<thead>
<tr>
<th>Availability</th>
<th>Awareness</th>
<th>Referrals</th>
<th>Coverage</th>
</tr>
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</table>
Where is DPP being delivered?

- Anywhere a group of eligible participants can convene – typically 10-20 participants
- Currently, due to COVID19, all programs are virtual
- Delivery sites and partners are continually evolving
- Programs are initiated when sufficient registration is achieved
National DPP in Southeastern Pennsylvania – Recognized Program Providers

Philadelphia Diabetes Prevention Collaborative
Focuses on 5 Counties of SEPA Region
- Bucks
- Chester
- Delaware
- Montgomery
- Philadelphia

http://www.health.state.pa.us/diabetesmap/dpp-map.aspx
Standard Referral Process

A primary goal is to make the referral and enrollment process as simple and seamless as possible for the healthcare provider, patient, and DPP provider/supplier.

**Healthcare Provider (HCP)**
- Screen, Test, Refer
- Counsel patient on reason for referral – *very important*
- Provider or patient identifies a program location

**DPP Provider / Supplier**
- Receives referral from HCP by mail, fax, secure email or EHR or secure FTP
- Contacts patient to enroll
- Tracks weight and attendance
- Ideally, notifies HCP of enrollment

**Patient completes one-year program**
- Ideally, DPP provider communicates completion to HCP provider
- Patient shares experience with HCP
Assumption for Referrals to DPP Lifestyle Change Programs

1. If you have existing successful referral pathways – continue to use them.
2. Best practices for referrals to lifestyle change programs are evolving.
3. One size does not fit all – a variety of programs are needed to serve diverse populations.
4. Social determinants play a significant role in successful enrollment and retention in, and completion of DPP.
5. COVID-19 has created a significant shift in program delivery.

**Goal - streamline the steps required to make referrals to and enroll in DPP**
Making the Referral
DPP Network Referral Hub Pilot in Select Philadelphia Zip Codes

Pilot zip codes: (North Phila) 19140, 19120, 19124, 19134; (South Phila); 19145, 19148

Purpose of Referral Hub Pilot

• Test the efficacy of a single point of referral
• Streamlines the administrative burden of making multiple outreach attempts.
• Centralizes readiness assessment of participants and program matching.
• Centralizes communication of referral disposition to PCP.
• Facilitates identification and possible resolution of barriers to attendance due to social determinants.

Function of DPP Referral Hub

• PCP sends referral through HealthShare Exchange - Direct Secure Messaging platform
• HPC receives referral
• HPC trained team conducts patient interview
• Registers patient into program based upon patient needs and preferences
• HPC sends list of participants to each DPP Provider via secure communication channel.
• HPC sends HCP referral status report
Making the Referral – Health Promotion Council
DPP Referral Hub Pilot in Select Philadelphia Zip Codes

Pilot zip codes: (North Phila) 19140, 19120, 19124, 19134

Pilot zip codes: (South Phila) 19145, 19148
Philadelphia DPP Network Referral Hub Pilot

Healthcare Provider (HCP) transmits referral through direct secure email

Cultivates centralized calendar of programs
Provides connection to workforce training and ongoing networking for lifestyle coaches
Identify and address barriers

HPC DPP Network HUB

- Contacts referred patients
  - email, phone, text
- Identifies optimal DPP with patient
- Identifies and addresses barriers
- Potential disposition of outreach:
  1. Enroll in DPP
  2. Place on wait list
  3. Unable to reach
  4. Patient refuses program

HPC Securely sends participant registration to designated DPP Provider

DPP Provider

- Receives registration
- Collects DPP intake form
- Reminder calls, texts, email
- Conducts lifestyle change program sessions
- Collects data on attendance, weight, physical activity.
- Reports data to CDC for recognition
- Ideally send reports to referring providers

HPC reports referral disposition to HCP
How to Find and Refer to a DPP Lifestyle Change Program in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties

- DPP Network Referral Hub – Pilot zip codes only
- Direct to DPP provider referral – See Upcoming Class on HPC website

Also available are:
- PA DOH DPP website
- CDC-recognized DPP registry
DPP Lifestyle Change Programs in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties

• DPP providers will not start a program until they have a full roster of patients are registered for the series – ideally 15-20.

• Until the volume of referrals have a sustained increase – DPP providers are challenged with setting start dates.

• HPC is compiling DPP provider/supplier contact information to allow direct referral from HCP until referral hub can be expanded.
Making the Referral – Key considerations

- This is a sample referral from AMA – create a unique referral for your organization that includes your legal requirements
- Keep referral diagnostic criteria and data consistent
- If possible integrate referral into EHR workflow
- Ensure that HIPAA, legal, patient consents are in place
- Ensure the referral is transmitted securely to HPC and/or the DPP program provider/supplier
- Establish patient consent for sharing data for referral

https://amapreventdiabetes.org/sites/default/files/uploaded-files/amapreventdiabetes_Referral%20Form_0.pdf
Only Together Can We Prevent Type 2 Diabetes

It brings together:
- Employers
- Health Care Organizations
- Private Insurers
- Faith-Based Organizations
- Community Organizations
- Government Agencies

...to achieve a greater impact on reducing type 2 diabetes
Thank you

HPC's Training and Capacity Building Department
– Philadelphia Diabetes Prevention Collaborative Team

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Questions?
For more information & questions about:

Referring patients or local programs:
Contact Susanne Trexler

The Philadelphia Diabetes Prevention Collaborative
Contact Alexis Skoufalos or Vivian Castillo
or visit Jefferson.edu/PreventDiabetesPHL