Optimizing Referral Systems to the Diabetes Prevention Program

Panel Discussion Presented for Evidenced-based Solutions for Prediabetes and Hypertension: Shifting the Practice Paradigm
Friday June 12, 2015
Facilitator

Sarah Piper, MPH, CDE
Diabetes Training and Technical Assistance Center (DTTAC), Emory University, Rollins School of Public Health
Introduction of Panelists:

Natalie Ritchie, Ph.D
Denver Health and Hospital Authority

Dr. Rocio Pereira
Director, CREAndo Bienestar Diabetes Prevention Program
University of Colorado Anschutz Health and Wellness Center
The Diabetes Prevention Program (DPP) Research Study

**Goal:** to find out whether losing modest amounts of weight through improving diet and increasing physical activity, or taking the diabetes drug metformin, could prevent or delay type 2 diabetes in people at high risk for developing the disease.

- **Major multicenter clinical research study**
  - 3,234 participants
  - 27 clinical centers in U.S.
  - Funded primarily by NIH
What Were the DPP Study Findings?

- Lifestyle intervention sharply reduced the chances of developing type 2 diabetes (58%)
  - 71% for aged 60+
- Metformin group reduced their risk but not as much as the lifestyle intervention group (31%)

New England Journal of Medicine, 2002
Program Goals and Structure

Program Goals

- Weight Loss: 5-7% of starting body weight
- Increasing physical activity to 150 minutes

Program Structure

- 16 weekly sessions delivered once a week during months 1-6
- Monthly or bi-monthly sessions during months 7-12
Panelist Presentations

Natalie Ritchie, Ph.D
Denver Health and Hospital Authority
Process

- **National Diabetes Prevention Program (DPP)** is an evidence-based resource promoting **5% weight loss** in a yearlong group class.

- We demonstrated a real-world translation in a **safety net healthcare system**.
  - Created a **registry of >10,000 at-risk patients** from medical record databases.
  - Established an internal **provider-referral network**.
  - **Community Health Workers** trained to deliver the DPP in English and Spanish.
  - **Over-enrolled classes** to prepare for attrition and maximize access.
Process cont’d.

- **Successes:**
  - **Over 1,900 patients enrolled** since March 2013.
  - Enrollees were of **diverse and underserved** backgrounds:
    - 60% Latino (47% Spanish-speaking), 18% Black, 18% White
    - 80% low-income
  - **Average of 11 of 16 intensive sessions** attended by participants who came to 4+ sessions (goal is 9).
  - **5% mean weight loss at 12-months** (goal is 5%).
    - Individuals lost up to 60 pounds!
- **Limitations:**
  - 3% mean weight loss at 6-months (goal is 5%)
  - Mean of 2 of 6 maintenance sessions attended (goal is 3).
Implementation

• **Providers** are essential partners.
  – 50% of patients referred by a provider enrolled (vs. 10% of non-referred patients).
  – We encouraged provider referrals with:
    • In-clinic presentations
    • **Emails** notifying providers of new classes, including **how to easily refer patients** using an electronic referral system.
    • Individualized emails **prompting providers to refer** by sending a list of their eligible patients (as needed to fill classes).
    • Regular **communication** regarding patient progress.
Implementation cont’d.

• **Clinics** are an essential partner.
  – We offered the DPP in Denver Health’s **community-based primary care clinics**.
    • **Convenient** for patients.
    • Same neighborhood location as their **medical home**.
    • Need to **negotiate class schedule** and other resources with clinics.
    • Need to support clinics by **demonstrating reach and successful outcomes** with their patients.
Resources

• **Data analyst** creates/updates patient registries.
• CDC freely publishes the **DPP curriculum** in both English and Spanish.
• CDPHE offers **TA** and hosts **work groups** to learn from other partners.
• **Funding** from (1) Amendment 35 awards through CDPHE, (2) grant from the CDC and America’s Health Insurance Plans, (3) Denver Health support.
Panelist Presentations

Rocio I. Pereira, MD
Director, CREAndo Bienestar Diabetes Prevention Program
University of Colorado Anschutz Health and Wellness Center

Assistant Professor of Medicine
University of Colorado School of Medicine, Division of Endocrinology, Diabetes & Metabolism
Prediabetes Panel

Rocio I. Pereira, MD
Director, CREAndo Bienestar Diabetes Prevention Program
University of Colorado Anschutz Health and Wellness Center

Assistant Professor of Medicine
University of Colorado School of Medicine, Division of Endocrinology, Diabetes & Metabolism
CREAndo Bienestar
Diabetes Prevention Program
PROCESS

CREAndo Bienestar Diabetes Prevention Program-
• **Community-based**, led by Promotoras
• **Targets** **Latinos**
• **Multi-intervention** program- NDPP, exercise program, cooking/shopping classes, referral to care
• **Collaborative**
  
  Recruitment- **CREA Results**, 9Health Fair, Colorado Prevention Center, community centers (churches, schools, recreation centers), clinics (DH, MCPN), UC Denver
  
  Programing- CREA Results and Aurora Community Connection
  
  Funding and advocacy- Colorado Health Foundation, Colorado Department of Public Health and Environment, Viridian/Anthem
  
  Collaborators- ADA, YMCA, CAAH, DH
Program locations
PROCESS (continued)

Participants
• 521 individuals registered in 2014
• 98% Latino, 90% Spanish-speakers
• 45 +/- 12 years old, 85% female

Successes
• Goal **attendance** (9 sessions) during first 6 months was achieved by **80% of participants**. (Average 13 sessions)

Limitations
• Goal **5% weight loss** achieved by **27% of participants** and average weight loss at **6 months** was **3%**
• **81%** of registered participants met DPRP eligibility criteria
IMPLEMENTATION

Recruitment/ referrals
- Outreach- 43% (at community centers and events)
- Word of mouth- 37%
- Provider- 17%

Steps to referring to DPP programs
- Patient education
- Identify local programs and set up referral protocol
- Screen
- Refer
RESOURCES

• CREAndo Bienestar Diabetes Prevention Program
  • Director- Rocio (Ro) Pereira, MD; rocio.pereira@ucdenver.edu
  • Program Coordinator- Jimikaye Beck; jimikaye.beck@ucdenver.edu
• CDC prediabetes screening test:
Facilitated Discussion
Question for Panelist:

- Tell us more about what and who was involved with establishing an internal provider-referral network?

- Your program intentionally over enrolls participants as a strategy to manage expected attrition. What type of follow up if any is done with drop outs? Do providers get feedback if their referral dropped out?
Question for Panelist:

- The referral sources for CREAndo Bienestar Diabetes Prevention Program are diverse. Can you tell us more about how you established the referring relationship you described with MCPN in particular?
  - Do you see any difference in attendance or success between participants referred by providers vs. other sources?

- You mentioned that the program is a Multi-intervention program which includes NDPP, exercise program, cooking/shopping classes, referral to care-are these all in one, or separate distinct services?
Question for Panelist:

- If you had to identify one major “lesson learned” about establishing referrals with health care providers for the DPP, what would that be?
- What are you hopes and plans for growing the impact of your DPP program?
- What specifically are your next steps to further establish relationships with health care providers/clinics within or external to your organization?
Audience Q&A
Resources and Wrap Up
Next Steps to Consider

To Begin Referring Patients to DPP Programs

- Learn more about the DPP
- Identify organizations delivering the DPP in Colorado
- Contact organizations to discuss referring patients
- Work with orgs to set up a referral process
- Screen patients for prediabetes and refer to DPP

To Offer the DPP in Your Organization

- Review CDC DPP websites and program standards
- Talk to CDPHE about resources
- Apply for CDC recognition
- Develop a referral process
- Consider training lifestyle coaches
CDPHE Resources

- DPP Advisory Group
- Community-Based Organization Workgroup
- Case Studies

https://www.colorado.gov/cdphe/diabetes-prevention-program
CDC Resources

- Background information
- CDC DPRP Standards
- National registry of programs
- Curriculum
- Talking points for HCP’s
- Marketing materials

www.cdc.gov/diabetes/prevention/resources.htm
A guide to refer your patients with prediabetes to an evidence-based diabetes prevention program.

Provider’s Toolkit
Developed by AMA and CDC

www.preventdabetesstat.org
Sample processes and risk screening tools

**Point-of-care prediabetes identification**

**MEASURE**

If patient is age ≥18 and does not have diabetes, provide self-screening test (CDC Prediabetes Screening Test or ADA Diabetes Risk Test)

If self-screening test reveals risk, proceed to next step

Determine if HbA1c, FPG or OGTT was performed in the past 12 months

Order one of the tests below:
- Hemoglobin A1C (HbA1C)
- Fasting plasma glucose (FPG)
- Oral glucose tolerance test (OGTT)

**RESULTS**

Diagnostic test

<table>
<thead>
<tr>
<th>Normal</th>
<th>Prediabetes</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c (%)</td>
<td>&lt; 5.7</td>
<td>5.7---6.4</td>
</tr>
<tr>
<td>Fasting plasma glucose (mg/dL)</td>
<td>&lt; 100</td>
<td>100---125</td>
</tr>
<tr>
<td>Oral glucose tolerance test (mg/dL)</td>
<td>&lt; 140</td>
<td>140---199</td>
</tr>
</tbody>
</table>

**ACT**

- Refer to diabetes prevention program, provide brochure.
- Consider retesting annually to check for diabetes onset.
- Counsel patient re diagnosis.
- Initiate therapy.

**PARTNER**

Communicate with your local diabetes prevention program.

Contact patient and troubleshoot issues with enrollment or participation. At the next visit, ask patient about progress and encourage continued participation in the program.


*History of GDM = eligibility for diabetes prevention program
Thank You!