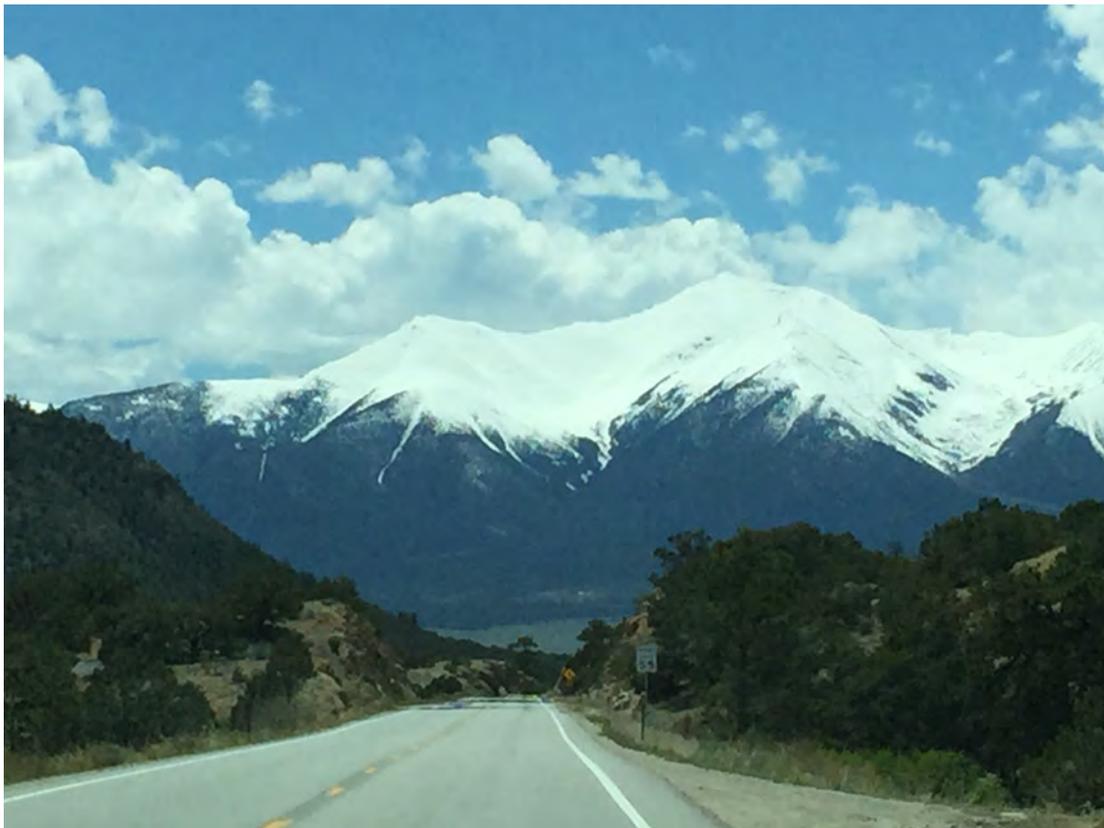


Pathways to Diabetes Prevention

How Colorado Organizations are Creating

Healthcare Referral Systems

that *Work*



Introduction

It is estimated that 35% of Colorado adults and half of all adults aged 65 years and older have prediabetes. People with prediabetes have an increased risk of developing type 2 diabetes, which can lead to serious and costly health problems such as vision loss, lower limb amputations, and kidney disease. Early detection and treatment through increased physical activity and weight control can prevent most cases, save healthcare costs, and improve quality of life for those afflicted.

58%
risk reduction for
type 2 diabetes
observed among
DPP participants

The Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program for preventing type 2 diabetes being delivered by over 625 organizations nationally¹. With the support of a trained Lifestyle Coach

through the yearlong program, people with prediabetes and/or at risk for type 2 diabetes make achievable and realistic lifestyle changes and cut their risk of developing type 2 diabetes by 58 percent.



It will require the combined efforts of community-based groups, organizations delivering the DPP, health systems, and healthcare providers throughout the state to prevent the health and

economic burden of diabetes from growing. Recognizing the unique contributions of these stakeholders, these case studies outline takeaway messages for each audience to help prevent type 2 diabetes. ■

The following case studies showcase how organizations are creating referral systems to help Coloradans at the greatest risk for type 2 diabetes access evidence-based prevention programs in their communities.

¹Source: Centers for Disease Control and Prevention, National Diabetes Prevention Program <http://www.cdc.gov/diabetes/prevention/about.htm>

Tips for Establishing & Enhancing Referral Systems

Healthcare Providers and Health Systems Promoting the DPP can:

- **Talk with all eligible patients** to increase awareness of prediabetes.
- **Refer eligible patients.** Use your electronic medical record (EMR) and fax or email referral forms for convenience.
- **Develop formal referral policies or practices** to support consistent screening and referral within your clinic.
- **Track your patients' progress** using your EMR or feedback from the DPP, and support their healthy choices.
- **Make a difference** by educating your staff and other providers about the program!

Organizations Delivering the DPP can:

- **Identify a healthcare provider champion** and be clear on what you are asking them to do.
- **Establish community partnerships.** Gain visible support from organizations and stakeholders trusted and respected by potential participants.
- **Track how people enter your program.** Use this data to determine the most efficient ways to recruit eligible participants.
- **Create a closed loop referral process** and follow through with feedback to referring providers.
- **Create simple referral tools for providers.** A quick and easy way to refer patients to your program minimizes barriers to participation.
- **Be persistent!** Cultivate relationships with local healthcare providers to help keep the door open to conversations about the DPP.

Case study 1: Serving the Latino community through partnerships and referrals from a Federally Qualified Health Center

The University of Colorado Anschutz Health and Wellness Center, through funding from a local foundation, formed a strong partnership with **CREAndo Bienestar (CREA)**, a community-based organization affiliated with the University of Colorado, for the implementation of the DPP with Latino participants. CREA, whose name translates to “CREAting Wellness,” is a community organization that works with Latino communities throughout the Denver Metro area.



Rocio Pereira, MD, Director of the CREAndo Bienestar Diabetes Prevention Program at the Anschutz Health and Wellness Center, is a practicing endocrinologist with specialization in diabetes. She saw the need to bring the DPP out to the community in Denver and specifically to the Latino community. She has been instrumental in the success of the DPP as a champion for the program, particularly in her work to engage providers.

Recruitment and referral strategies

Since Anschutz and CREA launched the DPP approximately two years ago, about 500 participants have been enrolled. New groups of participants start the program three times throughout the year. The three primary mechanisms through which participants enroll in the lifestyle change program are:

- Referrals from healthcare providers at the Metro Community Provider Network (MCPN), a Federally Qualified Health Center.
- Referrals through a third party payer.
- Community outreach at health fairs and in schools and churches where programs are delivered.

Expanding reach through healthcare provider referrals

The MCPN is a Federally Qualified Health Center that has many clinics around the metro Denver area to provide healthcare to individuals who are underinsured.

Dr. Pereira approached clinicians at MCPN about developing a referral system for MCPN patients who are enrolled in WISEWOMAN, a CDC program targeted toward low income, underinsured women with chronic disease risk. In MCPN’s electronic medical record (EMR) system, a healthcare provider can automatically populate a referral form to easily refer participants to the

Key Messages for Healthcare Providers (HCP)

Easily refer eligible patients to the evidence-based Diabetes Prevention Program using your electronic medical record (EMR) and fax or email referral forms.

“Having it in the EMR has worked really well. We’re hoping to do that at other clinics as well.”

Consider developing other formal policies or practices within your clinic to consistently screen and refer patients to the DPP.

Make a difference by getting other providers involved. If you’ve seen benefits to your patients, serve as a champion of the program by educating providers and staff about prediabetes, the DPP, and the referral process.

lifestyle change program. The referral form includes the information CREA needs to submit to the CDC with additional information helpful for program delivery such as:

- Spanish or English language preference
- WISEWOMAN eligibility
- BMI
- Medical history - fasting blood glucose or A1C tests, gestational diabetes, etc.

The provider faxes the referral to Anschutz, and CREA staff contact the participants to set up the classes. Eventually, the referral form will include the DPP eligibility criteria so the providers can more easily see if a patient is eligible.

CREA does not currently provide information about DPP participants' progress toward their lifestyle change goals back to providers, but Anschutz is in the process of developing a system to do that for the MCPN providers.

Engaging other healthcare providers

Dr. Pereira actively reaches out to recruit primary care providers at area clinics outside of MCPN, and is working to set up more partnerships. She initially speaks with the providers to get their buy-in, then introduces them to the CREA staff, who provide logistical information about upcoming programs.

"I really think the participants would benefit from having their provider engaged," Dr. Pereira says.

Healthcare providers can encourage participation in the program, monitor progress from a clinical standpoint and reinforce to the participant the importance of lifestyle change for risk reduction.

Community outreach

CREA delivers the yearlong DPP with *promotoras*, who have been trained as Lifestyle Coaches. A promotora is a lay Hispanic/Latino community member who receives specialized training to provide basic health education in the community. The promotoras do a lot of health promotion in the communities, especially at the locations where the program will be delivered. This has helped build trusting relationships with the people they serve, and their community presence has been extremely fruitful for recruiting and retaining participants in the program. ■

Key Messages for Organizations Delivering the DPP

Identify a healthcare provider who has been supportive and invite them to serve as a champion. Healthcare providers may be more receptive to hearing from their peers about the program, so aligning with a healthcare provider will open doors.

"It's easier to get into a clinic setting as an MD than it is as a community member. I feel that that's really my role, to open those doors and set up those relationships."

Establish community partnerships with organizations and stakeholders that are known and trusted among the people you are trying to reach.

"Participation has a lot to do with knowing someone who recommends the program as well as the location. And it helps for them to be familiar with the site."



Case study 2: Face time with physicians: Establishing and maintaining relationships between healthcare providers, community organizations, and patients in rural Colorado

San Luis Valley Health (SLVH) is a regional health provider that operates hospitals and health clinics serving the rural southwest part of Colorado.

Valerie Hagedorn is the Program Coordinator for PRO-Fit, a program at SLVH that provides a variety of education classes on topics such as diabetes self-management and smoking cessation. She is a certified personal trainer and Lifestyle Coach. In addition, a major part of Valerie's role is to visit partners on a regular basis, marketing the program to providers in the SLVH hospital system and in community-based practices.

The PRO-Fit lifestyle change program is based on the DPP and funded by grants from the state, serving a diverse, rural community spanning 12 counties. SLVH was a DPP pioneer, having started their program 8 years ago with research materials, before CDC adopted the curriculum.



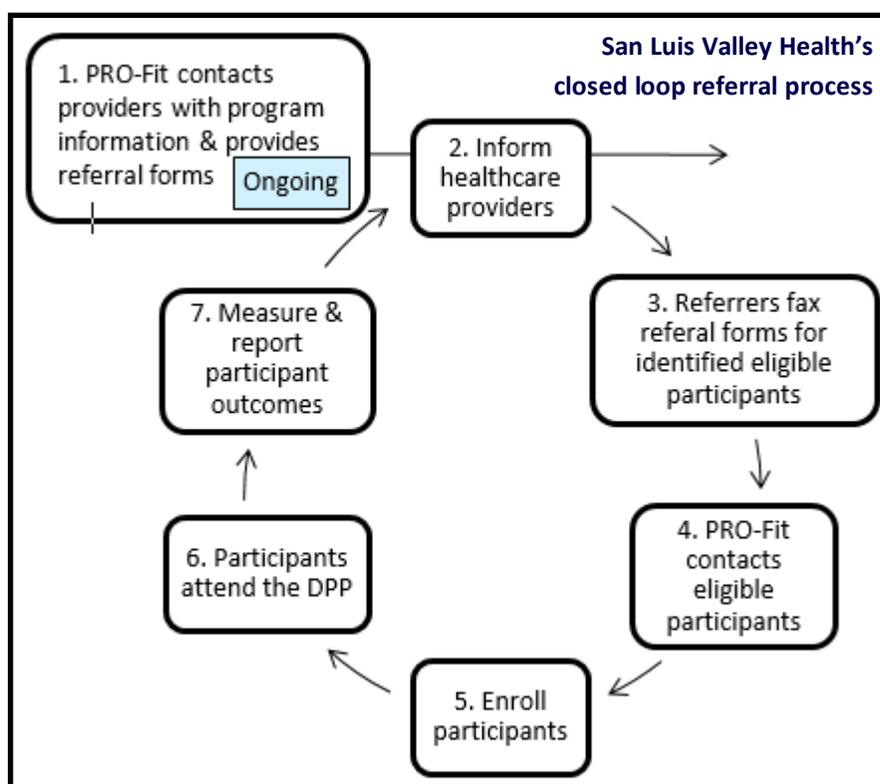
Making referrals simple

Participants must have a referral to join the PRO-Fit program, whether it's from public health, diabetes educators, or their provider.

The referral form includes the patient's name, BMI, weight, phone number, date of birth, and a statement saying "I understand that my patient would like to participate in this class. I am releasing them to be able to exercise." Providers simply sign and fax the form to SLVH, and PRO-Fit staff continue the rest of the process. The referral template is very simple for providers to fill out, and as a result, SLVH has not experienced any significant barriers to referrals.

Prior to beginning a cohort, program staff physically visit every single clinic in the San Luis Valley. During the visits PRO-Fit staff give the providers brochures, and make sure they know how to fill out a fax referral form. These regular and ongoing face-to-face site visits have been vital to establish relationships, keep the program at the top of providers' minds, and generate a reliable stream of referrals.

When a fax referral is sent to SLVH, the provider lets their patient know to expect a call. After receiving the



referral, SLVH calls the participant, collects any additional information needed for enrollment, and sets them up for class.

Meeting participants where they are

PRO-Fit classes are offered for free in a variety of facilities such as local rec centers, schools, and community centers. There are two Lifestyle Coaches who run the weekly classes, which average about 12 participants. Classes start as early as 6:30 in the morning, and as late as 6:30 at night, with a variety of different times throughout the day. Classes are scheduled Monday through Thursday; experience shows that participants do not like to attend classes on Fridays. One day is dedicated for administrative time to enter data and return phone calls.

The DPP has been offered in several locations within SLVH's 12-county service area; right now, classes are being delivered in Alamosa and Rio Grande counties. Participants and Lifestyle Coaches drive to one of those counties in order to attend classes, which can be a big barrier.

The population served is mostly Caucasian and Hispanic. Classes are delivered in English, so monolingual Spanish speaking participants receive the materials in Spanish, and a translator often comes into class with them.

Feedback to providers

SLVH maintains very good relationships with the providers from the first day patients enroll to the very end of the program. Referring providers receive a note thanking them for the referral and letting them know the participant is set up for class. At the end, another letter is sent to the provider with a progress report, keeping the provider in the loop the entire time.



About half of the participants come from the SLVH and half are from providers outside the system. If the participants are in the San Luis Valley Health system, their progress is electronically documented in the participant's record so the provider can see it immediately. If they're not in the SLVH system, a letter template is customized for each participant and manually mailed to each provider at the end of the program. ■

Key Messages for Healthcare Providers (HCP)

Use your EMR or other feedback from the DPP to track your patients' progress and support the healthy lifestyle choices they are making. Lifestyle coaches can be valuable partners in your patients' care.

Key Messages for Organizations Delivering the DPP

Create simple tools for providers to quickly and easily refer patients to your program and make it clear what they need to do.

"I've made it simple as possible for providers, so I really haven't had any barriers to referrals."

Be persistent! Create and maintain ongoing relationships with the providers in your area, making connections in person when possible.

"When I go into their offices they remember me. The only barrier is when I don't visit my referring providers, they tend to forget about me, so I have to remember to keep showing my face."

Keep referring providers in the loop about their patients throughout your program.

"We have very good relationships with the providers from the very first day to the very end. Because of that, our providers are constantly referring back to us."

Case study 3: “Closing the loop” with healthcare providers to coordinate and celebrate diabetes prevention successes in a Metro Denver health system



Denver Health is an integrated organization providing comprehensive care for all, regardless of ability to pay. It is composed of a hospital, multiple primary care offices, and specialty clinics. Twenty-five percent of all Denver residents, or approximately 150,000 individuals, receive their healthcare at Denver Health, and there are about 400 new cases of prediabetes in Denver Health every month.

Denver Health has been delivering the DPP since March 2013, and to date 1,800 people have enrolled.

Natalie Ritchie, PhD, Project Director for Denver Health’s Diabetes Prevention Program, is responsible for funding proposals, hiring, and training Lifestyle Coaches. She manages area operations, program evaluation, and works toward sustainability goals.



Proactive recruitment through referrals

The Denver Health DPP primarily uses a proactive approach to identifying people at risk for diabetes; however, they learned that cold calls from the registry don’t work well, resulting in only about 1 out of 10 people signing up. Instead, a referral is requested for all participants – this happens in one of two ways: healthcare providers can use an internal email account to refer to the program, or program staff use the registry to identify additional participants.

They have used the EMR to create a registry of patients eligible for the DPP. The registry is refreshed quarterly one to two months before new classes begin. The registry has identified about 9,000 eligible participants based on strict criteria. DPP staff filter the registry for eligible patients and then filter by provider to request referrals.

Provider involvement makes a difference at Denver Health

Providers are informed when their patients are eligible to participate. Some providers say it is OK to contact all of their patients, while others prefer to select which patients receive a recruitment call.



Provider buy-in makes DPP outreach more effective, as participants are more likely to listen if DPP staff can say the call was made on their doctor’s order. Denver Health has found that 1 in 2 prospective participants signed up if the caller mentioned their provider had asked them to call.

Key Messages for Healthcare Providers (HCP)

Talk with all eligible patients to increase awareness of prediabetes and what to do about it, even if they are not ready to enroll in a Lifestyle Change program right away.

“Studies regarding readiness to change indicate that only 10% of the population is ready. We didn’t want to impair the other 80% from getting the initial message. We believe Session 1 may have an impact, in terms of helping them move their readiness. Or at least increasing their awareness of prediabetes.”

Denver Health even requests a provider referral if a patient learns about the program through word of mouth or from marketing in the clinics, although they have found that those who self-refer from these sources are 7 times more likely to participate than those who were cold-called. To facilitate provider involvement, emails are sent to all providers prior to each new class series, and program staff provide outreach and education about the DPP and prediabetes at clinic meetings.

Staffed to serve all high-risk patients



Denver Health currently has two Lifestyle Coaches, each with a high school education and prior experience in healthcare related positions. Both are bilingual, which is significant since 60% of their participants are Latino. They

began with three coaches, and then a resignation created the opportunity to fund the following:

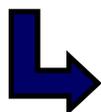
- Text message reminders to participants to facilitate ongoing engagement with the program
- Salary increases for the two remaining Lifestyle Coaches

A new class is begun every 3-4 months, when about 70 participants enroll with a verbal commitment to attend at least one class. Generally,

50% of those contacted enroll (70)



50% of those enrolled come (35);



50% of those who come become regular attendees (17);



...and 50% of those complete the program (9).

The Lifestyle Coaches co-teach because initial classes are quite large. Once the class gets to about 7-10 participants, they use one coach.



Key Messages for Organizations Delivering the DPP

Find a physician champion at the outset to gain momentum and support from other healthcare providers.

“Initially, we worked side by side with one of the providers and then it became word of mouth.”

Track how people enter the program. This is important to determine how to most efficiently recruit eligible participants. For example, Denver Health learned not to waste time on cold calls when their data showed it led to low enrollment in classes.

Create a closed loop process for referral and feedback. Work with your partner providers when developing your referral process, and include feedback to the referring provider. This could mean a note in the EMR from the Lifestyle Coach at specific intervals, a summary note in the EMR, or a template letter for the provider upon program completion.

Follow through with feedback to referring providers on their patients’ progress and outcomes (with permission from participants, if appropriate) and information about upcoming DPP classes to maintain awareness of and support for your program.

“The program works! No one at Denver Health questions the need.”

Denver Health has had 28 classes to date, and begins new classes in various locations, with a Spanish class every cohort. Denver Health pays for the program, so it is free of charge, but open only to their patients. Denver Health also waives the participants' parking fees, which has helped to reduce transportation as a barrier.

Denver Health has a **“closed loop” referral process**, meaning that after a participant enrolls in the DPP, referring providers are notified about their patients' progress.

Sharing successes with healthcare providers

Prior to class starting, an email is sent to the provider with a list of their patients who have enrolled and how to find information in their medical records to track their ongoing participation and outcomes. Progress during the classes is documented in the EMR including attendance history and their weight, at 1-month, 6-month, and 12-month weigh-ins. The coaches can add relevant notes if appropriate.

Providers are informed about their patients' success stories. Natalie does the data entry and if she sees someone that has lost a lot of weight or something remarkable she will let the coaches know and encourage them to write a personal email about the patients' success. Sometimes the DPP staff get emails from providers saying that the patients have gone back in and they were blown away by the patients' success. ■



These case studies were compiled by the Diabetes Training and Technical Assistance Center (DTTAC) at Emory University with funding from the Colorado Department of Public Health and Environment (CDPHE). To learn more about the DPP in Colorado, please visit <https://www.colorado.gov/cdphe/diabetes-prevention-program>.



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