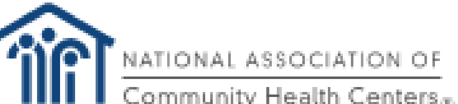
National Diabetes Prevention Program

Basics for Health Centers

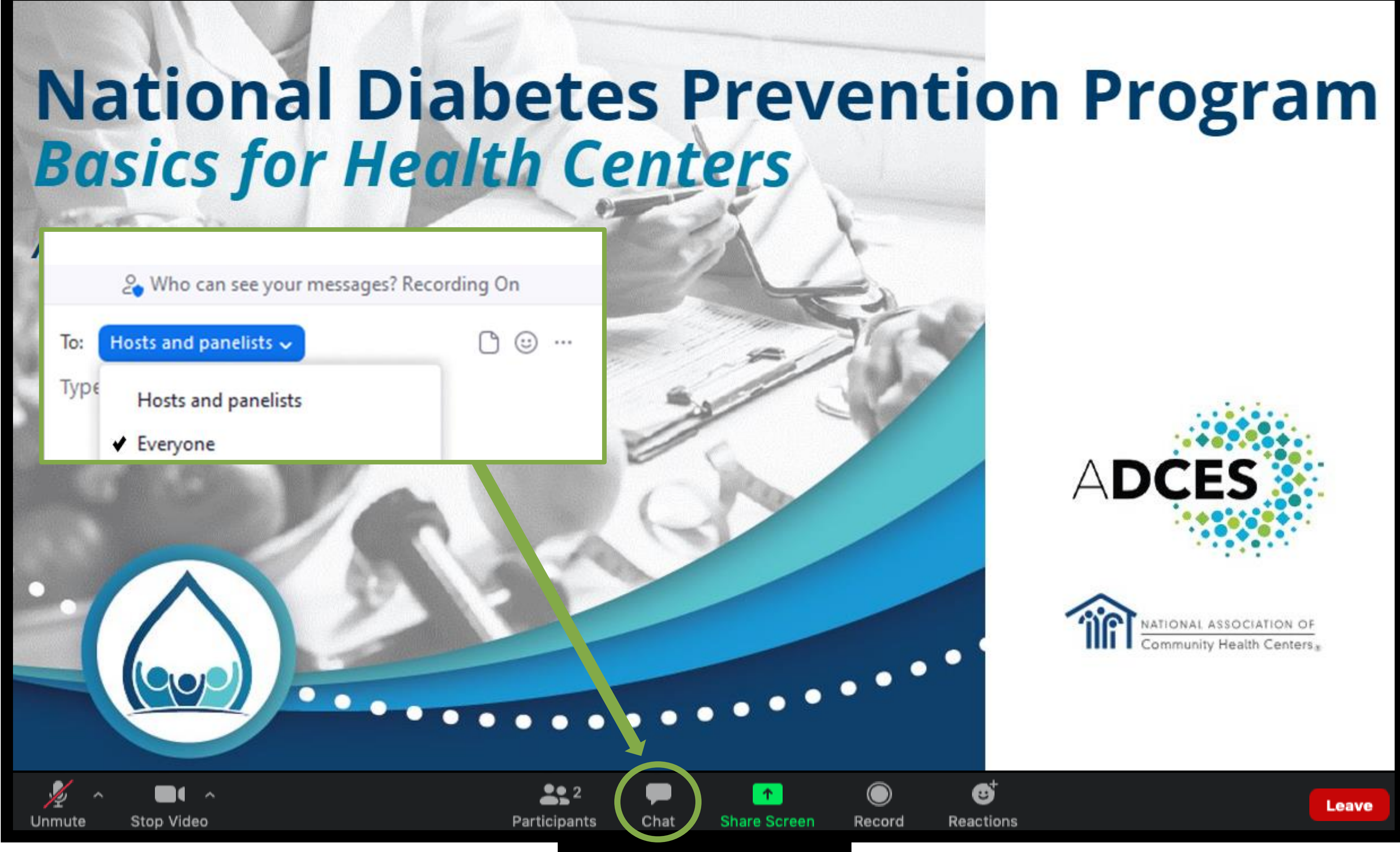
April 6, 2023



THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.



During today's session:

- **Questions:** Throughout the webinar, type your questions in the chat feature. Be sure to select "Everyone"! There will be Q&A and discussion at the end.
- **Resources:** If you have a tool or resource to share, let us know in the chat!

Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

Cheryl Modica

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Today's Agenda:

- **National Diabetes Prevention Program (NDPP) Overview**

  The What? Why? How? for health centers

- **Findings from NACHC's Healthy Together Pilot Project**

- **The Health Center & PCA/HCCN Experience**

Angela M. Forfia, MA

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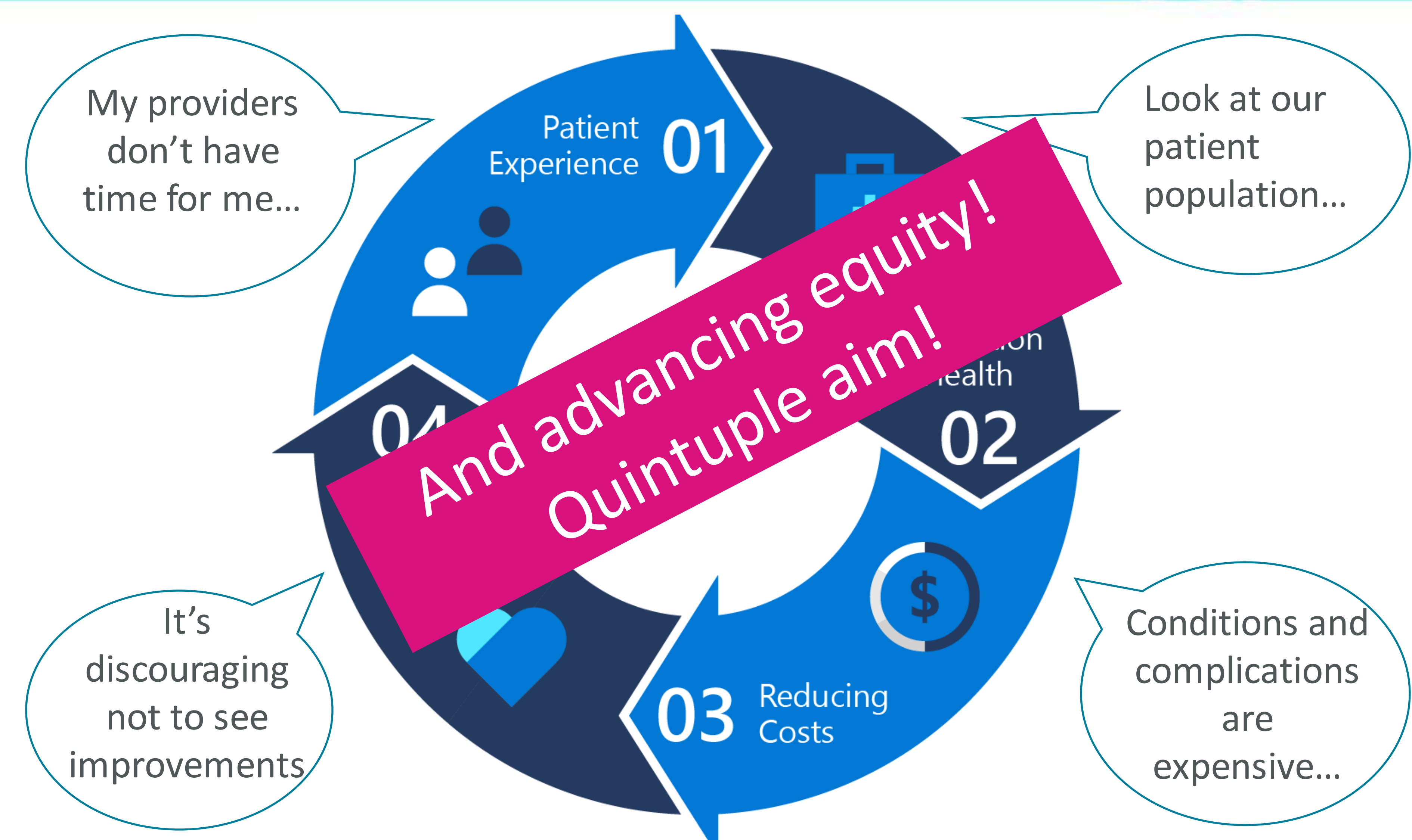
National Diabetes Prevention Programs: Basics for Health Centers

6 April 2023

Why This Work Matters

The quadruple aim



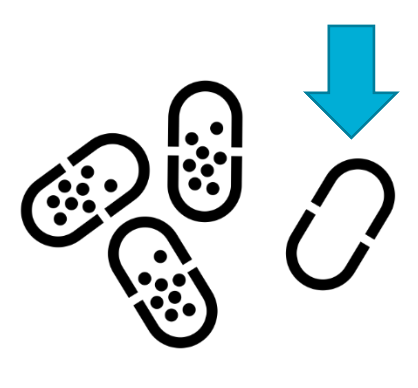
Good news…

- You’re seeing people with diabetes, prediabetes, and other cardiometabolic conditions (obesity, CVD)
- You’re already screening and/or testing many adults in line with current guidance
- You know how to have person-centered conversations about risks and treatments
- You have a commitment to preventive medicine and chronic disease self-management
- You understand the community context of health and well-being
- You understand how to coordinate care—medical home to medical neighborhood

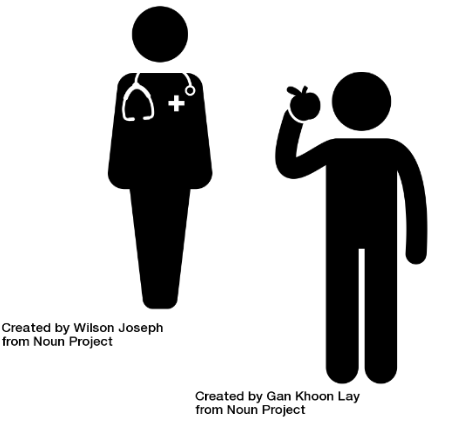
…even better news

Diabetes Prevention Program (DPP) Study

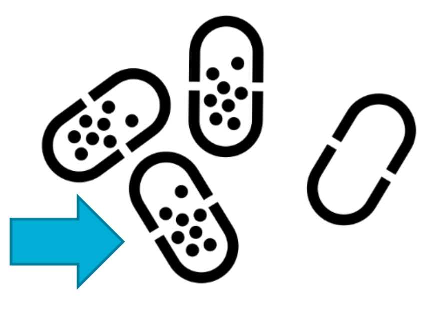
Participants were randomly divided into one of three treatment groups:



Placebo with brief lifestyle counseling

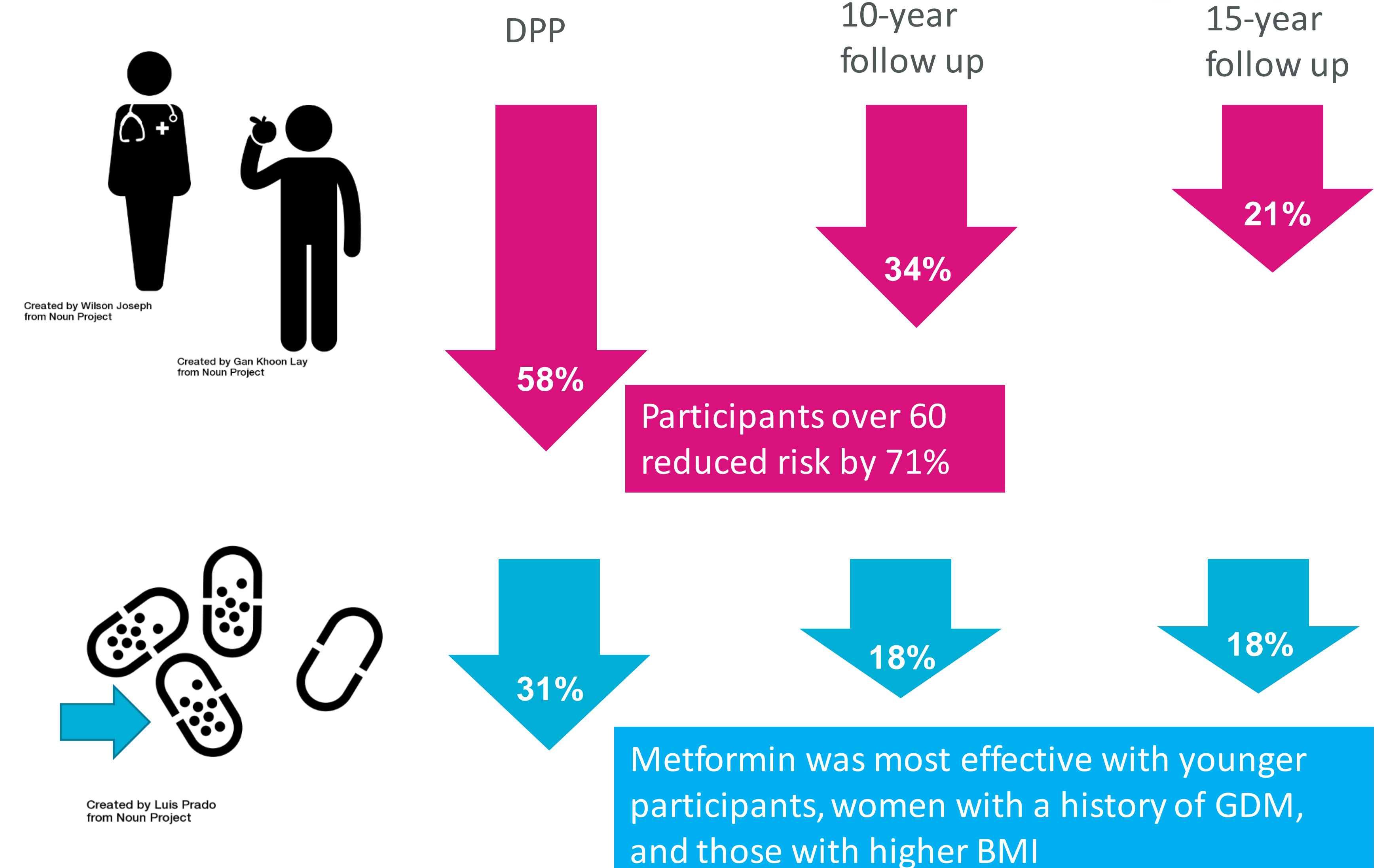


Intensive one-on-one lifestyle modification program



Medication (metformin 850 mg/twice daily)

What we learned



Translating research into practice

- DPP in **community settings** were as successful as interventions in clinical settings
- DPP in **small group formats** were as successful as one-on-one coaching
- **Trained lifestyle coaches** did not need to be physicians, nurses, pharmacists, RDs, or diabetes care & education specialists
- DPP can be offered **online or through distance learning** (tele-health)
- Group format + community settings + diversity of lifestyle coaches + different modalities= **Less than 1/3 cost of the DPP Study!**

What that looks like today…

- Led by a trained lifestyle coach, on-site or remote
- Happens in small group settings, all in one place or calling in from home
- Can use video or phone only for “distance learning sessions”
- Focused on small steps to eat healthy, move more, manage stress, and

Program design and health outcomes

- **Program Duration**
  - At least 12 months
- **Program Intensity**
  - A CORE series of at least 16 weekly to bi-weekly one-hour sessions delivered in months 1-6
  - A CORE MAINTENANCE series of at least 6 one-hour sessions delivered at least monthly in months 7-12
- **Reduction in diabetes risk:**
  - 5% weight loss
  - 4% weight loss PLUS 150 minutes/week of physical activity
  - .2% reduction in HbA1c

Intensity and Duration: Core and Core Maintenance

<table>
<tr><th colspan="2">Core (Months 1-6; 16 sessions)
sometimes called Phase 1</th><th>Core Maintenance (Months 6-12, 10 sessions)
sometimes called Phase 2</th></tr>
<tr><td>Skill building, self-monitoring, and physical activity</td><td>Psychosocial aspects of lifestyle change</td><td>Maintaining lifestyle changes</td></tr>
<tr><td>• Introduction
• Get Active to PreventT2
• Track Your Activity
• Eat Well to PreventT2
• Track Your Food
• Get More Active
• Burn More Calories Than You Take In
• Shop and Cook to PreventT2</td><td>• Manage Stress
• Find Time for Fitness
• Cope with Triggers
• Keep Your Heart Healthy
• Take Charge of Your Thoughts
• Get Support
• Eat Well Away From Home
• Stay Motivated to PreventT2</td><td>• When Weight Loss Stalls
• Take a Fitness Break
• Stay Active to PreventT2
• Stay Active Away From Home
• More About T2
• More About Carbs
• Have Healthy Food You Enjoy
• Get Enough Sleep
• Get Back on Track
• PreventT2—for Life!</td></tr>
</table>

How you can activate prevention in your health centers!

Providing the right care

- SCREEN/TEST patients for prediabetes and increase the identification of people with prediabetes in your system
- Reduce or reframe fatalistic or fixed mindset understandings of type 2 diabetes
- Support people as they activate lifestyle change advice
- Refer people with prediabetes or significant risk factors for type 2 diabetes to CDC-recognized lifestyle change programs…or start your own!
- Support individuals as they participate in those intensive programs to eat healthy, be active, manage stress, and develop healthy sleep routines

If you want to refer…

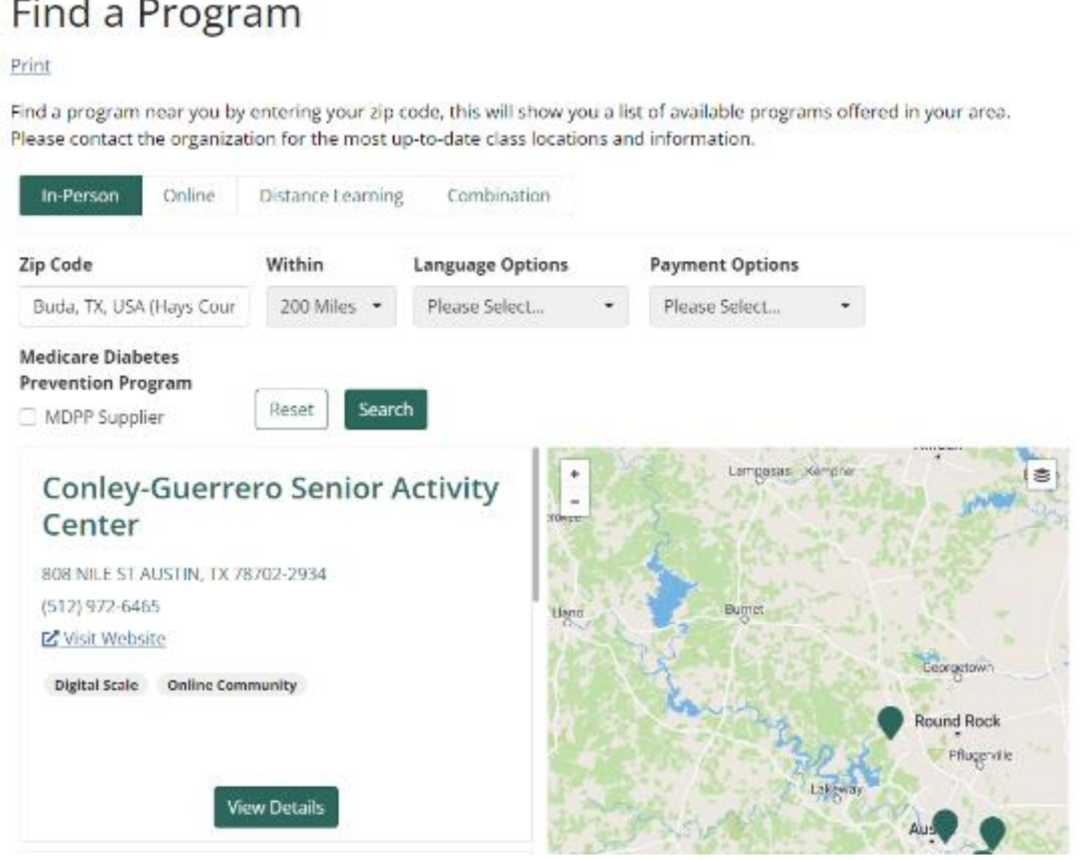
Why your referral matters

- Community health care center care teams play an important role in diabetes prevention
- You identify individuals with prediabetes, may have the first conversation with them about their risk, and your guidance matters
- Research shows that people referred by their healthcare provider are more likely to enroll, get engaged, and achieve health outcomes
- **A paper referral is not needed, but your quality referral is critical**

Why your referral matters

- Lifestyle change cannot happen within a single visit to your health center
- People with prediabetes need ongoing support to develop healthy eating patterns, get more active, manage stress, and form healthy habits—often facing barriers to those changes
- Your health care providers may need to provide pharmacotherapy or referrals to specialty care (e.g. depression, sleep apnea, obesity treatment) outside the scope of the CDC lifestyle change program

There are programs in your area NOW



https://www.cdc.gov/diabetes/prevention/find-a-program.html

If you want to start a program...

Starting a diabetes prevention program

- Get leadership support
- Consider how you can use your existing programs and staff to support prevention services
- Think about your patients and community members who would qualify
- Complete a CDC capacity assessment to see if you're ready
- Develop a plan that is the right size for your organization
- **Learn about Healthy Together TODAY!**

Administrative Steps

- Read the standards: https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf
- Get lifestyle coaches trained: https://nationaldppcsc.cdc.gov/s/article/Training-for-your-Lifestyle-Coaches
- Complete a 5-minute application process—no really! https://dprp.cdc.gov/
- Start your program!

Administrative Steps

- Collect data: https://nationaldppcsc.cdc.gov/s/article/Data-Entry-Spreadsheet-Template
- Submit data every 6 months: https://dprpdataportal.cdc.gov/samsinfo
- Explore Medicaid reimbursement opportunities in your state
- Explore Medicare reimbursement opportunities when you reach preliminary recognition

CDC Standards focus on quality assurance

A. Participant eligibility
B. Safety of participants and participant data
C. Location
D. Delivery mode
E. Staffing
F. Training
G. Change of ownership
H. Required curriculum content
I. Make-up sessions
J. Umbrella arrangements
K. Requirements for recognition status (Pending, Preliminary, Full, and Full Plus)
L. Recognition extensions and exceptions

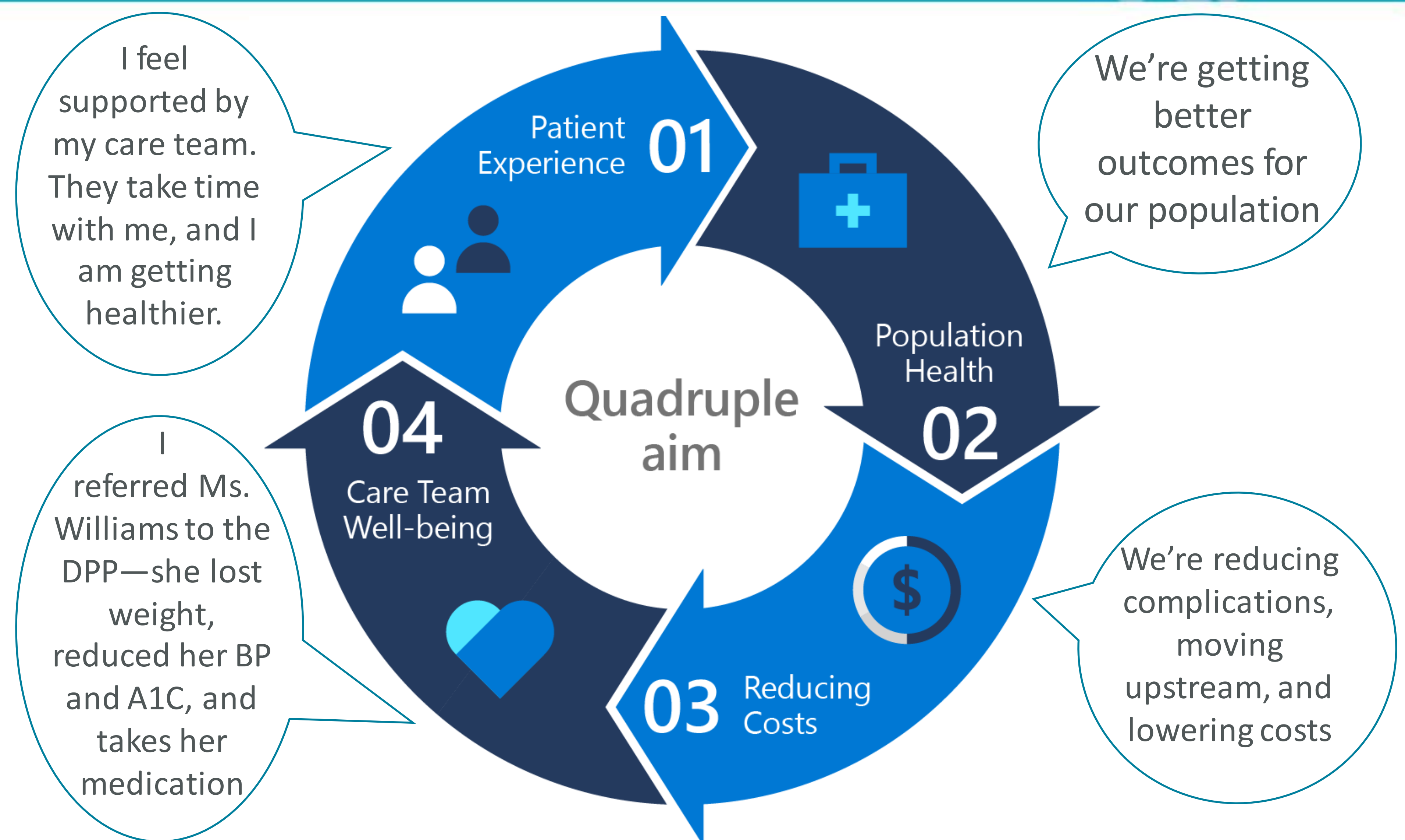
CDC Recognition Status

Pending	Preliminary	Full	Full Plus
Intensity	All pending	All pending All preliminary	All pending All preliminary All full
Duration	Enrollment (1 core session)	35% blood-based values (A1c, FPG, OGTT, or past GDM)	Retention metrics 50%>4 months 40%>7 months 30%>10 months
	Attendance (8 core sessions)	60% of completers reduce T2DM risk (.2% A1c reduction, 5% weight loss, 4% + 150 minutes PA average)	
	Retention through 9 months (Core maintenance activity after 9 months)		

What can coaches focus on?

- **Enrollment/Attendance**
  - Aim for 35%+ blood-based screening
  - Getting participants to attend 8 Core sessions
  - Holding make-up sessions to ensure 8 Core session attendance
  - Aiming for 50% retention at 4 months
- **Retention**
  - Strengthening connection to the program so that participants will continue to monthly sessions
  - Aiming for 40% retention at 7 months
  - Getting participants to attend at least 1 Core Maintenance session after 9 months in the program—also may require make-up sessions to prevent attrition
  - Aiming for 30% retention at 10 months
- **Diabetes risk reduction metrics**
  - Collect baseline A1c for all participants
  - Collect baseline weight and height (BMI)
  - Measure/collect weight weekly
  - Collect minutes of physical activity weekly (after Module 3)
  - Collect a final A1c in months 10-12

The quadruple aim



References/Resources

- National DPP Customer Service Center: https://nationaldppcsc.cdc.gov/s/
- National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the US https://www.cdc.gov/diabetes/data/statistics-report/index.html
- DoIHavePrediabetes.org (EN and ES)
- Imagine You Preventing Type 2: https://www.cdc.gov/diabetestv/imagine-you.html
- Find a DPP: https://www.cdc.gov/diabetes/prevention/find-a-program.html

THANK YOU!

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NACHC's Healthy Together
Pilot Program

Healthy Together is a lifestyle change program that blends

virtual care | **self-care tools** | **lifestyle coaching**

to increase the impact of **diabetes prevention and management** at health centers.

Guided by NACHC's Value Transformation Framework, which guides systems change in health center infrastructure, care delivery, and people to tackle issues such as diabetes.

Goal is to improve health outcomes, patient and staff experience, cost, and equity (Quintuple Aim).

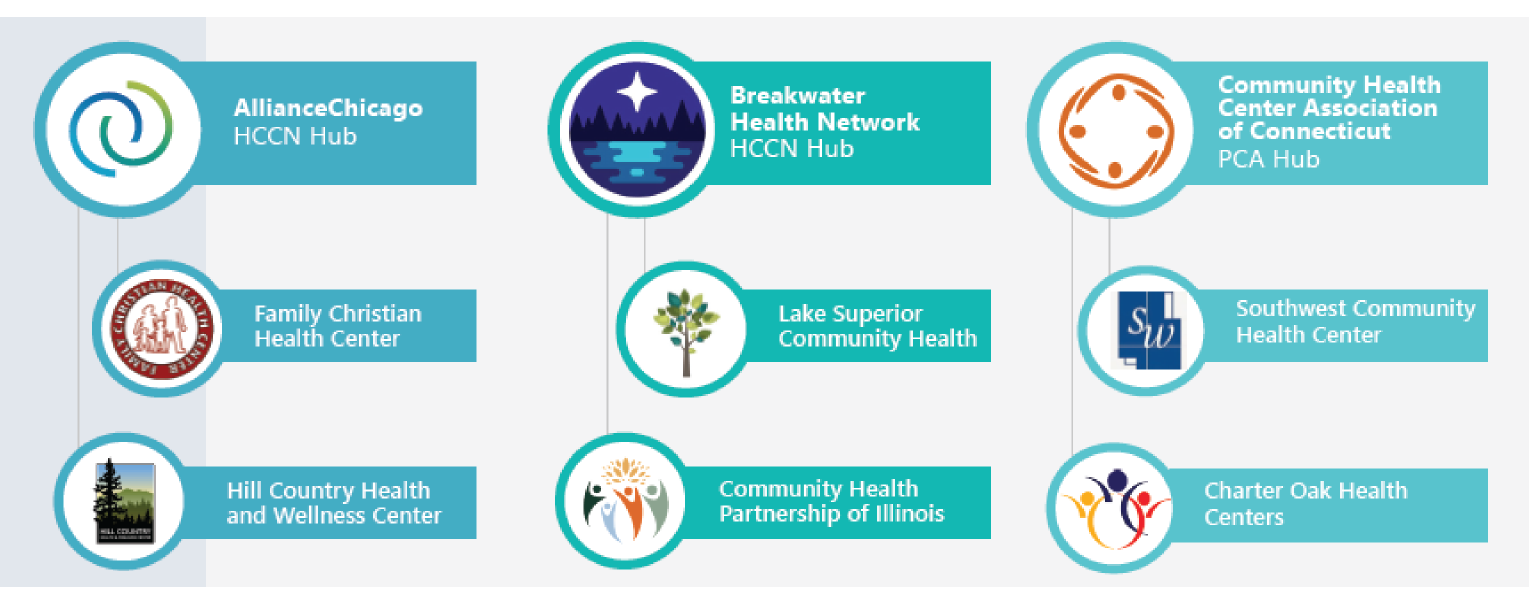
NACHC's Healthy Together *Pilot Program*

Healthy Together engages partnerships at the national, state/network, and local levels, including:

National Lifestyle Coach partner who provides health center staff with Lifestyle Coach training and assists the local level health center Lifestyle Coaches with curriculum content delivery.

Three PCAs/HCCNs, referred to as 'Hubs', who provide their participating health centers with programmatic guidance, technical assistance, and data collection support.

A cohort of health centers participating in the Healthy Together program.



NACHC's Healthy Together *Pilot Program*

- ✓ Extends the CDC NDPP curriculum to include patients diagnosed with type 2 diabetes in addition patients at-risk for type 2 diabetes.
- ✓ Builds patient self-management skills in healthy eating, physical activity, and stress management through lifestyle coaching within a group setting.
- ✓ Leverages technology to provide virtual care to patients in their homes.
- ✓ Culturally inclusive and applies a whole-person, family centered approach by encouraging members of the same family/household to participate together.
- ✓ Empowers participants by providing them with self-care tools and the knowledge to implement healthy lifestyle changes that may last a lifetime.
- ✓ Expands the skillset of health center staff through professional development training in Lifestyle Coaching.

NACHC's Healthy Together *Pilot Program*

- Assemble health center project teams
- Identify qualifying patients through risk stratification
- Document workflows
- Develop processes to manage patient self-care tools
- Set goals
- Train Lifestyle Coaches
- Set curriculum schedules

Conduct 'Start Up' Visits for patients to:

- Sign participation agreements
- Learn how to navigate the virtual platform
- Complete pre-program questionnaire
- Receive initial self-care tools

Hold group curriculum sessions:

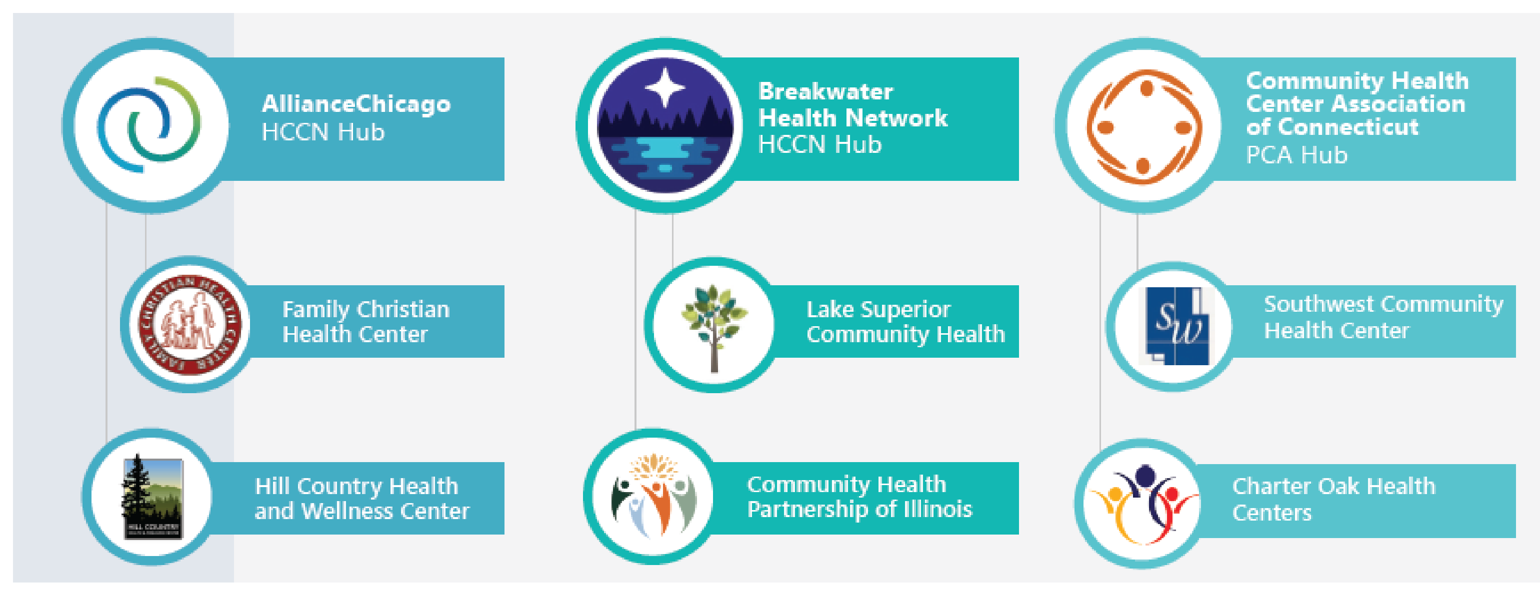
- Health center Lifestyle Coaches deliver curriculum content with attention to local and cultural needs, while the ADCES expert provides supporting content accessible via a recorded video.
- Health centers vary in their use of the ADCES videos; some prefer to teach the curriculum content themselves and use the videos as a tool to aid in preparation of the session, others prefer to share the videos with the participants.

Ongoing data collection:

- Patient engagement
- Progress toward lifestyle change goals
- Social risk
- Patient experience

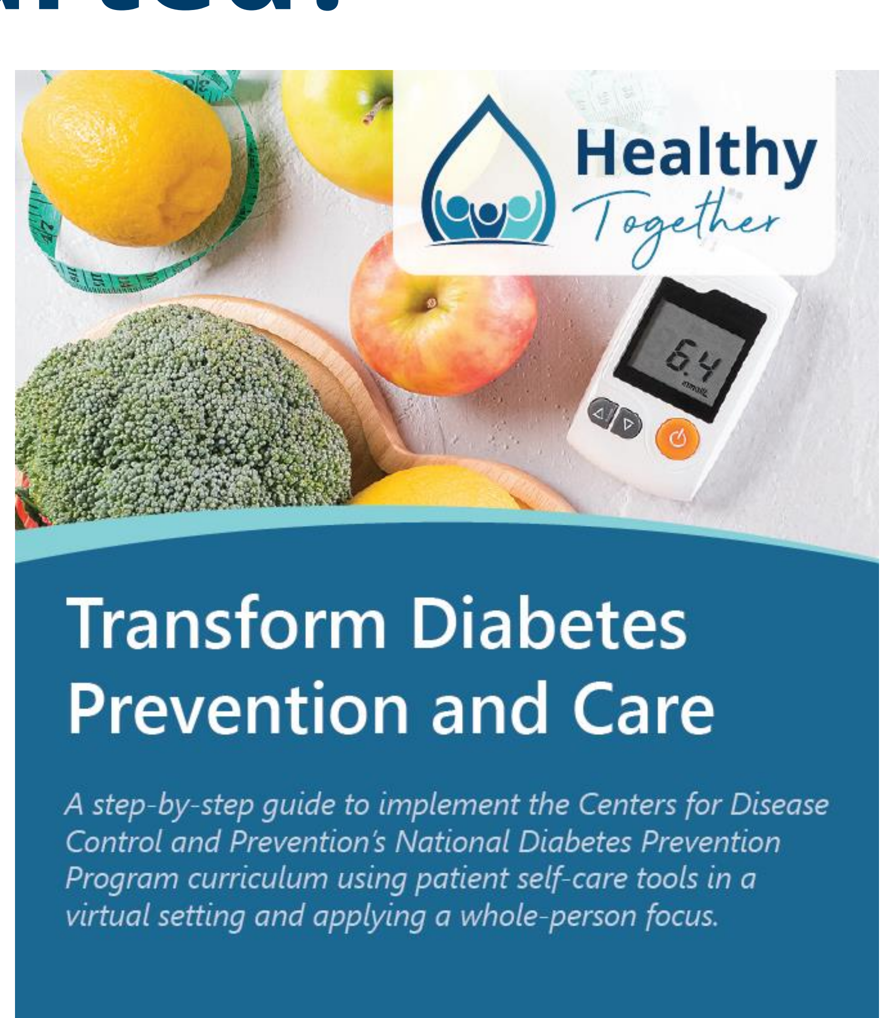
NACHC's Healthy Together *Pilot Program*

The Health Center and PCA/HCCN Experience



Interested in Getting Started?

- Register for Lifestyle Coach training (a limited number of **FREE** training slots are available!)
- Download NACHC's Healthy Together Action Guide ***(Coming Soon!)*** for step-by-step guidance on how to implement an NDPP following the Healthy Together model
- Access health center-tailored NDPP curriculum session video recordings
  - NACHC library of materials available this summer



Lifestyle Coach Training Opportunity!

NACHC is covering the cost for a limited number of health center staff to be trained by ADCES to become Lifestyle Coaches!

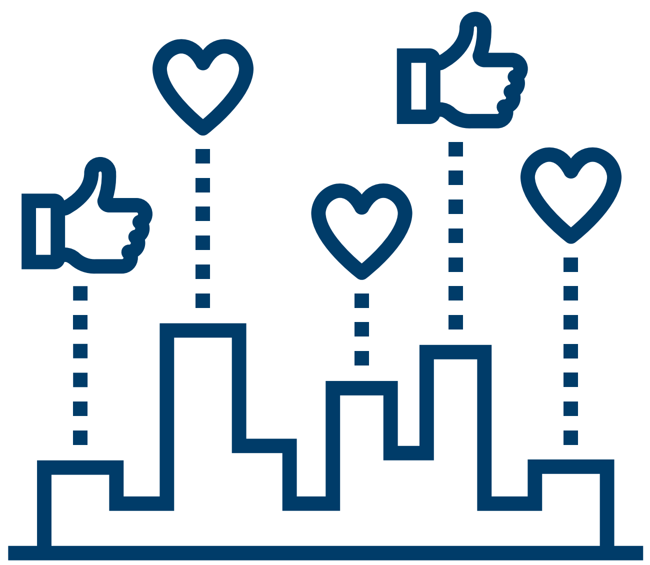
Participants of the training gain the knowledge and skills needed to facilitate a CDC-recognized lifestyle change program to prevent or delay type 2 diabetes.

By becoming a trained Lifestyle Coach, participants will enhance professional skills and help people with prediabetes eat healthy, move more, and manage stress.

- Virtual training sessions will occur **every Tuesday from May 16 – June 13 from 2-3pm ET**
- Sessions will also require 'homework' to be completed independently
- Makeup sessions are not available – attendees must plan to attend each session
- Upon successful completion of the training participants will be provided a certificate

If interested, complete this form by April 20th!

Discussion



Provide Us Feedback

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