The Importance of Utilizing Diabetes Prevention Programs

Webinar Transcript

Krista Davis: Good afternoon everyone, and welcome to today's QIN-QIO Regional Supporting Sharing Call: The Importance of Utilizing Diabetes Prevention Programs. My name is Krista Davis and I'm a Communications Specialist at Quality Insights and your host for today's presentation. We'll get started in just a few moments, but first a few housekeeping items.

All participants entered today's webinar in a listen only mode. Should you have a question or a comment during today's call, we ask that you please type it into either the chat or the Q&A box that you'll find on the right side of your screen. To activate your chat box, click on the word "chat" with the speech bubble in the bottom right corner of your screen.

The slides you see today have been posted on our website on the webinars page. The link to download them will be posted in the chat box momentarily.

At the end of today's program you'll be directed to a meeting evaluation. We thank you in advance for your completion of that evaluation, as it helps tell us how we did and what educational topics are of most interest to you for future sharing calls.

We have a lot of excellent information to deliver today. So, without further ado I'd like to introduce our five guest speakers.

Dr. Mitchell Kaminski is a family physician who has combined clinical practice and teaching with a career in healthcare leadership that has included private groups, hospital systems and academic institutions. Since joining the Jefferson College of Population Health in August 2018, Dr. Kaminski led enhancement of the college curriculum, to include a greater emphasis on value based care, population health management, and an increasing focus on the social determinants of health.

Dr. Wade Brosius is a Medical Director for Pots Town Medical Specialist Inc., or PMSI, a virtually integrated, multi-specialty group in suburban Philadelphia. He has held this position for the past 10 years. He is also a family physician at Spring-Ford Family Practice, a division of PMSI, located in Royersford, Pennsylvania and Medical Director for Accurate Coding and Education for Tandigm Health in Conshohocken, Pennsylvania.

Debbie Zlomek is a Registered Nurse and Certified Diabetes Educator. She's also board certified in advanced diabetes management and holds a Master's Degree in Clinical Systems Management. Debbie has worked at PMSI since 2008 as its Education Coordinator. She developed and is responsible for operating its fully recognized CDC Diabetes Prevention Program and its accredited DSME Program.

Dr. Samantha Shawley-Brzoska is a Research Assistant Professor with the West Virginia University Department of Social and Behavioral Sciences, and The Office of Health Service's research in the School of Public Health. Her work focused on chronic disease programming and database management for primary care and community partners. She serves as a Co-Investigator on numerous grant funded efforts to improve population health outcomes, in particular a very valuable partnership with the West Virginia Bureau for Public Health Division of Health Promotion and Chronic Disease, which focuses on statewide efforts to address chronic disease prevention and control.

Dr. Adam Baus is Director of the West Virginia University Office of Health Services Research and a Research Assistant Professor with Social and Behavioral Sciences with an expertise in Health Informatics, quality of care improvement, and health services research.

It is my great pleasure to turn the program over to Dr. Mitchell Kaminski to start things off. Dr. Kaminski, the floor is yours.

Dr. Mitchell Kaminski: Thank you for those introductions Krista. And, thank you everybody for logging in to participate in our Sharing Call today. I'm pleased to talk to you about efforts that we've been implementing in the Philadelphia region. I'm happy also that Deb and Dr. Brosius have joined us. We see them as kind of a role model for a group of private primary care practices that have successfully integrated, not only diabetes education and care into their practices, but prevention of diabetes through the DPP Program.

We are just over a year into a Philadelphia Diabetes Prevention Collaborative. This is a collaboration with The American Medical Association, and indirectly with the CDC. We are attempting to promote DPP classes and DPP enrollment in our five county metropolitan region.

You can see these five counties are located in Southeastern Pennsylvania, clustered about Philadelphia. The red dots on this chart show you where we already have nationally recognized DPP providers. Both throughout the state, and in our region.

Our goal in late 2019 was to enroll an additional 2,000 of our patients into DPP programs in 2020. And, like the rest of our country, and really the rest of the world, we had an unexpected pandemic, which forced us to modify our goals, but also to modify our operations, and we'll talk a little bit about that this

afternoon as well. But, you can see on this slide, we've partnered with the AMA. We also have on our board representatives from the American Diabetes Association, and we've been working indirectly with the American Heart Association.

And this pandemic underscored the importance of preventing diabetes. Looking at COVID and at confirmed hospitalized cases, you can see that in the top five underlying medical conditions were obesity and diabetes. Both addressed through the DPP.

The pandemic has also highlighted racial disparities in comorbidities. You can see in this graph, the green bar graph represents Black, not Hispanic population. The blue bar graph represents Hispanic. The brown representing White and the purple representing Asian, not Hispanic. And you can see in three of our most common comorbidities, hypertension, obesity and diabetes, that the Black population is affected much more, followed close behind by the Hispanic population. So, these racial disparities can be addressed through the DPP Program as well.

I wanted to just review of some of the basics of pre-diabetes in the DPP Program. Starting with the fact that 88 million American adults have pre-diabetes.

The diabetes that we treat is actually only the tip of an iceberg. You can see on this graphic that in the US diabetes afflicts 34.2 million of our patients, or about 10.5% of the population. And one in five of them have diabetes, which has not yet been diagnosed. But beneath the surface, we have 88 million cases of pre-diabetes estimated or a little more than a third of the population with pre-diabetes. And nearly nine out of 10 of these patients are unaware that they have pre-diabetes.

So, the DPP Program, hold on here. I skipped ahead here. The DPP Program is supported by recommendations from the US Preventative Services Taskforce. They have a Grade B recommendation, which advocates for screening all adults ages 40 to 70 who have a BMI greater than or equal to 25. And you all know that 25 to 30 BMI represents overweight, and over 30 represents obese. And they recommend that screening either with a fasting glucose, a hemoglobin A1C determination, or less commonly used today, an oral glucose tolerance test. And their standard recommends screening all patients with overweight or obesity every three years for pre-diabetes and diabetes.

The National DPP Lifestyle Change Program is an evidence based program, studied over the past 15 to 20 years and shown to have significant impact to delay or avoid the development of diabetes in patients with pre-diabetes. In order to qualify for the program, a patient needs to have a hemoglobin A1C in the pre-diabetes range, listed here: 5.7 to 6.4% and to have a BMI greater than

or equal to 25. They can also qualify for the program by taking the pre-diabetes risk test. This is a test developed through the National Diabetes Prevention Program. It's available on the ADA website, and also available on the CDC website. So, any of these three qualifications allows a patient to enter into a DPP Program.

You can also consider testing adults who are lower age than 40, or below the BMI target of greater than 25 if other risk factors are present. That includes a family history of Type 2 Diabetes, when you're looking at the first degree relatives. A medical history of either Gestational Diabetes or Polycystic Ovary Syndrome, which we know causes insulin resistance and diabetes. And also consider screening for diabetes in racial and ethnic minorities listed here, since they are at higher risk for developing diabetes.

And if a patient does have an abnormal glucose screening, the recommendation is for an intensive behavioral counseling intervention, which promotes a health diet and promotes physical activity, which in fact is what the DPP Program provides.

This shows you the timeline of development of the DPP Program, beginning in the mid-1990s with the study comparing lifestyle change, Metformin therapy or placebo, no intervention, and the development of diabetes. They refined the program and discovered that the lifestyle change actually had the biggest impact at delaying or avoiding the development of diabetes. It, in fact, had more impact than beginning Metformin therapy alone.

The DPP Program itself is year-long. These are our length classes. In the first six months the classes are more frequent, at least 16 need to be offered, so two or three a month. For the second six months, at least six classes need to be offered. And makeup classes need to be offered as well. This program started out originally in-person, but is rapidly converting to virtual DPP classes for our patients. There's a requirement to track weight and activity minutes as part of the program, and the evidence based curriculum is provided to DPP coaches. But the structure, the group support, and the learning that patients get from being in the cohort are really the secret formula in the DPP Program. I personally, when I got involved with the DPP Program at our institution as part of this initiative, attended some classes and as a physician I was blown away by the success stories, and the energy that the participants had. And also, that they were successfully making lifestyle changes and reverting their hemoglobin A1C's back to normal. Really impressive.

So, the National DPP Program, which can be implemented in our communities, involve these main components. A trained lifestyle coach who does not necessarily need to be a medically trained person, but someone who can lead a group successfully. There is a CDC approved curriculum. There is an emphasis on prevention and empowerment through personal activities and quality assurance through the CDC dictates that programs have to report data about their

participant outcomes for the program. The CDC recognizes programs that can meet these criteria, usually, after 12 to 18 months of operation. And that allows for payment for offering these programs. Many programs begin through grants that were offered by the CDC to promote DPP.

So, with COVID-19 we've actually had a remarkable success story with converting our programs to virtual format through Zoom. And, during the pandemic, and hopefully as it subsides, this format will be approved by the CDC for continued payment. We found a better retention rate of our patients who enroll in the classes, and improved engagement. There are rich discussions through the remote technology equal to those that we experience when patients were meeting in person. There's obviously the benefit of no travel, no parking expenses, no concerns about the weather. We bring in guest speakers and the virtual format makes that even easier to arrange. And I think there's something additional through this support group, our patients are feeling more connected to the outside world while they're being forced to be less interactive with the world outside their homes.

In February of 2020 we started a cohort. 32 were enrolled and interestingly, five who enrolled were graduates of 2019's program. They wanted to continue participating in the group. All 37 of them are still active, which was not something we would see in our in-person cohorts. There would usually be drop off, about a third to a half of the participants. 32 of the enrolled remain enrolled, and 27 attend regularly. In July 15th of 2020 we began a second cohort with 23 enrolled in our virtual programming.

So, this leads to telling you about PMSI, The Pots Town Medical Group. Dr. Brosius is going to talk, Deb may pipe in as well, as his practice manager. But they are part of our collaborative and we have learned from them, and they success that they have achieved through DPP Programming for their practices. So, Wade, please tell us.

Dr. Wade Brosius: Thank you very much Mitch. So, as Mitch said, my name is Wade Brosius. I'm the current Medical Director of Pots Town Medical Specialist, and with me on the call is Deb Zlomek, who is our CDE extraordinaire. I can tell [inaudible 00:17:37] that Deb is the one who deserves all the credit for our program. We've been very successful in starting this program many years, and have had great success enrolling. So, Mitch, if you would, hop on to the next slide, because people really don't want to see me.

All right, so on this slide you can see sort of the way that we've set up our referrals into the DPP Program. First of all, there are really four different ways to do so. But, you've already made the information that's necessary for the referral itself, and that is you setting up the cohort by defining the patient population that has a A1C between 5.7 and 6.4. [inaudible 00:18:21] is can we, in turn, besides running backend queries on monthly reports through our EMR system to define the cohort, besides that, can we also have opportunities to notify the

providers that they should refer automatically if they are reviewing labs for patients who have newfound labs that fall into the range between 5.7 and 6.4. On top of that, clearly there are times when you may not have those labs in front of you prior to the visit. But when the patients are there in front of you, either because they've recently had the labs done and you just got them today, or because they transferred into your practice, it clearly is appropriate to refer the patients into the program. Or, when you find out that they have the qualifications.

And then, lastly, one other opportunity is frequently we'll get referrals because we have support people that are bringing our patients to our full diabetic education classes, and quickly by word of mouth, the attendees with the patients who are attending the diabetic education classes will speak up and state that they are also qualifying, in which case we'll get referrals in that regard.

So, that's sort of how we do the cohort and the recruitment of our patients. If you would, move on to the next slide please, Mitch.

So, the way we have our cohort set up is they are done quarterly, also if need be. So, like most places, first of the year brings on an onset of patients because they are trying to become healthier, and also because they're getting their new labs for the beginning of the year. We set up the cohorts, like I said, quarterly, but sooner if need be. Why would we get set up sooner? Well, remember that the groups themselves are groups of 20, so if we have an interest level where we have greater than 20 people we'll open up a new class. And then, what happens is, in an effort to try to make sure that the classes themselves are run the right way and have great engagement by the patients, whether it be in-person or virtual, clearly just as Mitch said, because of the world we live in right now with COVID-19, our classes are, in fact, virtual. What we try and do is we try to make sure that the coaches contact the patients individually. This early contact by the coach is what allows for the buy-in and the early engagement. It's really done through individual outreach.

So, what happens is, the coaches will reach out to the patients and make sure that we get the information that's necessary. We'll make sure that we can grab the data, including their weight and their [inaudible 00:21:10] and we make sure that we actually have their preferred method of communication. Is it by email? Is it by phone? So, I would tell you that when setting up a program such as this, you want to make sure that there's that good engagement by both the coaches, as well as the patients.

As Mitch said, you don't need to have people that are medical to be coaches. However, in our classes our coaches are not only the Diabetic Education Department, but also nutritionist and certified [inaudible 00:21:43] in an effort to try and make sure that we have patients moving in the right direction. Next slide please.

So, as Mitch has also already said, really to maintain the CDC recognition, what you must do is you must be able to meet their guidelines. The CDC requires that report is sent every six months, and for PMSI Debs will make those out for us. We found that the ACDD has a database and its format is currently preferred by the CDC. So, there's no reason, quite honestly, to reinvent the wheel. What happens then is the coaches keep the data sheets with the weights and the exercise activity, and they're sent weekly to the Diabetic Education Department. When we're keeping the statistics, what we want to try and do is make sure, obviously, that we have as I mentioned the patient's contact information. And for the virtual programs, the coaches will contact all the members still, even though they're not in-person, to ensure that they're able to participate. And if they'll be able to obtain the information as necessary to meet the CDC requirements. Next slide.

So, for PMSI, the DPP timeline was that, for step one, we applied for a CDC recognition back in July of 2017. Please remember that it will take about 18 months to get full recognition status. So, once we achieved full recognition status, at that point we felt that it was really important for us to make sure that we got notification of being a Medicare supplier. The importance of this is, quite honestly, to make sure that the department itself is sustainable. Remember, as a Medicare supplier, you have preferred rates and this will allow us to make sure that we're able to keep the program.

This program has been highly successful, as we'll show you in a few slides, in making sure that we're able to get the benefits for the patient. And we've been really happy with the results. Next slide, please.

So, the CDC funds the Health Promotion Council. The Health Promotion Council is able to give financial support that goes directly to the funding of the salaries only for our providers. And so, as I mentioned, one of the big things is to try and make sure you can afford a Diabetes Prevention Program. We donned just getting financial support from the Health Promotion Council, also have been able to successfully run an annual Diabetes Health Fair. This is held in November, and in fact, we just had ours. And, it's quite a huge success.

And I'm sure you're wondering, "Well, how can you do that in a time of COVID and with social distancing?" But we actually did a drive-by health fair this year. One of the great things for the health fair is that we're able to get financial support from pharma companies, as well as other diabetic suppliers. And by doing that, we're able to have talks, promote the DPP Program itself, invite the patients to show up, obviously, at the fair. Plus, also bring others, because quite honestly, word of mouth is one of the other sources of recruitment for our DPP Program.

The proceeds of the program help to pay for documents and other supporting things that are given to the patients, including things such as binders, activity trackers, glucose log books, et cetera. So, the fundraiser itself is [inaudible

00:25:18] the fair itself is really a tremendous fundraiser, but it's also, as I mentioned, an external referral source into the program itself.

One of the problems with DPP right now is that Medicare is covering it. However, one of the problems that we find is that some patients are very happy to be there because they have no out of pocket expense, but yet, we're not getting universal coverage by all insurance carriers. And obviously this is still not one of the main agenda items for other insurance programs. So, really, it can be a problem where one patient is thrilled to be there because it's free, where yet another patient is somewhat disgruntled because they're finding this out, finding out that they're paying out of pocket.

So, we hopefully anticipate future sustainability because we believe that with the success we're showing, regionally as well as nationally with DPP, that insurance carriers will be much more likely to fund this moving forward. Next slide, please.

Here you'll see some of the information that we have regarding our program. As you can see, starting in 2019 we've been able to successfully enroll 134 participants. And currently, there are 106 [inaudible 00:26:40] based on reporting requirements. Obviously, having some fall off due to difficulties with the cohorts. We already had 14 cohorts, and there are three more that are still in progress. As you can see that we've been able to have really great job with the patients to achieve their weight loss, and again, as you can see the average number of core sessions attended were really close to that 14 number. So, we've been able to find that this is a very successful program for PMSI.

And, just to go one step further, I think for those who are on the call that are familiar with this, please remember that there's been a lot of information right now about diabetics that are going into diabetes with remission, right? So, this was originally founded by UK Studies. And, how was that done? Well, again, it was done with significant improvement in lifestyle changes, including dramatic weight loss and improved physical activity. Obviously getting in front of the tidal wave to try and make sure that we stop the downhill slide towards all these patients that are becoming diabetic is really a wiser idea, both financially as well as towards their overall health.

So, I thank you very much for the opportunity to speak on behalf of PMSI, and will be happy to take questions at the end. Thank you.

Dr. Mitchell Kaminski: Thank you very much, Wade. Krista, I'll turn the virtual podium back over to you.

Krista Davis: Thank you very much, Dr. Kaminski and I'd like to turn the program over to our two guest speakers from the West Virginia University starting with Dr. Adam Baus. Adam, the floor is yours.

Dr. Adam Baus: All right, thank you so much Krista. Samantha and I wanted to start by saying thank you to Quality Science for convening everybody here today. It's a really special important opportunity and we're glad to be part of this, and to share our West Virginia story. So, looking forward to this very much.

I've really enjoyed the other panelist as well, and I absolutely love the better retention and improved rate of engagement that the Philadelphia Diabetes Prevention Collaborative is demonstrating. I think it's very encouraging. And, also I want to say thank you to all of the participants for being here and for persevering with diabetes prevention in light of our pandemic. So, hats off to you all. So, very happy to be here, and I'll go ahead and start us out. Then, Samantha and I will go back and forth on these slides. And we'll just be sharing some good news from West Virginia.

Okay, so we start by saying thank you also to the funders and supporters of West Virginia Health Connection and the overall chronic disease prevention and control efforts that are happening here in West Virginia. So, first and foremost, the West Virginia Bureau for Public Health, Division of Health Promotion and Chronic Disease. They have been [inaudible 00:30:10] leaders in our state in terms of building and sustaining a really solid chronic disease programming across our counties. So, a world of thank you to the Bureau. And also, we're working with the [inaudible 00:30:27] Foundation, which is a local foundation supporting this work. And also the informatics group that CTIS has, in the past, supported this work as well.

So, basic goal and the learning objectives, we want to just take a few minutes and describe the West Virginia Health Connection Initiative, and focus on the impact of this initiative on statewide diabetes prevention programming on health and quality of life indicators and on those program participants. We have some really positive, encouraging results to share. And, for those of you out there thinking about doing National DPP, or are already involved in that, hopefully this is encouraging and something to help keep [inaudible 00:31:17].

So, we'll step through Health Connection as a resource for what we're approaching with our partners at The Bureau for Public Health as a statewide effort in helping to ramp up and seeing diabetes prevention and control. We'll take a look at trends and improved health outcomes across National DP Programming and the [inaudible 00:31:39] and its impact of this improvement is on overall quality of life and healthcare savings. And we'll take a look at what we view as a central component to implementing these programs in our state, and hopefully, we pass along something that is applicable to you wherever you are and wherever your community happens to be.

So, a quick blurb about Samantha and I. We are in the Office of Health Services and Research at The School of Public Health. Super fortunate to get to do the kind of work that we do. Our office has been up and running for over 40 years in [inaudible 00:32:21] communities and health systems around the state in as far

as learning about what the needs are. And then, just listening and being quiet, and we've seen what we can do to contribute to those needs.

So, we do a lot of hands-on technical support and training, and applied research. And overall, we try to help empower our partners to be more comfortable in working with data, and feel good about the data that they have and that they [inaudible 00:32:52] quality data to act on, and to do something with. And, pertinent to today, Samantha in particular is going to be talking about the clinical community [inaudible 00:33:04] piece of what we do with health promotion and chronic disease on the state.

Much of what we're describing takes place within context of a current grant through CDC, 1815, and again, The Bureau for Public Health, Division of Health Promotion and Chronic Disease is the lead on that grant. And they have convened a very wide array of synergy partners around the state. Our office is one of a variety of these partners. So, we get to share the good news today, but we are certainly not the only ones out there and engaged in the work. We have a large number of health systems involved and local health departments who [inaudible 00:33:53] these organizations. It takes a lot of people, or a lot of groups, to solve complex problems. And, I think that that's one of the exciting things about public health is that you have opportunity to connect with groups with a shared mission and shared values, but complimentary skillsets. That's exciting about the work that we do.

But, overall we're looking to help prevent, delay or manage onset of Type 2, and also prevent and manage cardio vascular disease in our state. We have at least 85% comorbidity among our state population, in terms of folks that are experiencing diabetes and have high blood pressure. So, the two populations really go hand in hand, and we're doing all that we can to address those. Also, incorporate blood pressure tracking and monitoring within the DPP metrics, which is, I think, something Samantha will be talking about as well.

Those of you who've heard me talk before know that this is my absolute favorite slide in all of the world. It's from the Institute for Healthcare Improvement. When I was saying earlier that to solve a complex public health problem it takes a lot of people, and this slide really represents that. So, it's called one verses 8,765. If you've seen this before, you'll know that that one orange dot in the sea of blue dots represent the one hour out of all of the hours in the year that generally speaking a patient has the opportunity to spend with a specialist. This is a patient, sorry, of someone who has Parkinson's, but when you think about one hour per year for someone with, or at risk for, diabetes, ideally they're coming in to see their primary care provider maybe each quarter, hopefully. And those office visits are complex and relatively short in time, and generally speaking, probably amounts to possibly an hour per year. And I think this speaks quite well to diabetes prevention as well.

All of those other hours of the year, the patient is not with the healthcare provider. So, it's important to figure out how to best support them, and impact their health outcomes wherever they happen to be in their lives [inaudible 00:36:30] of public health and the clinic [inaudible 00:36:32], while that is so very important to what we do.

This is the model that we're following. It comes from the [inaudible 00:36:41]. It's a framework to integrate community and clinical systems for prevention and management, whether it be obesity and other chronic diseases. What we're going to share with you today with West Virginia Health Connection is really the linkage piece. Like how do we engage and connect primary care and local [inaudible 00:37:04] health community based organizations so that they have a better opportunity and a better system, really, for engaging around a person in their family.

So, that's exciting for us. Health Connection plays that linkage piece within this model, and I'll go ahead and turn it over to Samantha here to tell us more about Health Connection.

Dr. Samantha Shawley: Thanks Adam for giving an overview our state and the overall efforts involved with 1815 and some of the things that our office is doing. And I think to start out, just introducing you to this topic. It's West Virginia Health Connection. The focus is clinic and community linkages, how Adam has mentioned. And you can go ahead to the next slide if you don't mind, Adam.

So, with all of that said, there has been some long standing challenges, like Adam was mentioning, in our state and like the others have mentioned earlier, with integrating and mobilizing across these clinical and community settings. We are currently able to directly facilitate between these two sectors, and basically knowing where the programs are, and how to refer and then, helping with the data tracking piece. That could be tracking within a clinical setting, or community setting. And then, initiating communication among those groups are a big piece for making this work.

And I see here our graphic doesn't quite show fully on the display but we'll be hopeful to get that out to you in another version. But as you can see here, there's two different pieces there. We have a HIPPA compliant software that allows for the data tracking, and then, a public facing website that has more arrogate or summary level information that's helpful for our partners. You can go ahead, Adam.

So, Adam had mentioned a lot of partners being involved with the overall effort with 1815. That particular grant effort. However, there is some direct partners within our State of West Virginia. This list is growing daily, and weekly by the needs of our partners. We really focus on the clinical community's settings, but we really have got more partners in the state. So, local and community

coalitions, local health departments, pharmacies, other groups like that, that really facilitate this work going forward.

Some of the programs that we focus on today is National DPP, but there is some other programs that we wanted to let you guys know that we cover with West Virginia Health Connection. There's things around chronic disease or the Stanford programs that are out there. There's things around physical activity, wellness programs, and then food access programs in our state.

These are some of the health conditions or social conditions that we focus on. Adam had mentioned pre-diabetes, diabetes hypertension. We do also focus on chronic pain, physical activity and nutrition opportunities, and more recently getting involved with including cancer efforts in our state within West Virginia Health Connection.

This is the data management structure that we work with. We work with PAC Software Incorporated through workshop focus for one of the softwares that we use. This is the structure that we use, so you have a local health system that can also be the organization offering that program with a physical location for that class to happen at. And then, the curriculum for this case would be DPP. The workshop is actually that particular cohort that's going forward. It was mentioned earlier once you have 20 folks that's considered a class. That would be that particular day and time that it's happening at. Then, we're able to go ahead and track particular participant outcomes. Then, over on the right you see that there is referrals being fed into our data structure.

So, on this page, this is some of the data that we collect for the particular cohort or class that's happening. So, you see the date and time. Something important to mention is what health system that's happening at. And then, if there's any survey data that's being collected. Sometimes there's pre and post metrics outside of what CDC is requiring to collect. We're able to attach that to the same database. And then, we're also able to have a contact person, so if anybody ever wants to reach out, then they have somebody to contact, even if they're in their local community, to join.

For participants, it was mentioned earlier, some of the eligibility criteria and what's required. This is just a snapshot of those demographics being collected in our system. We are able to, if it is a health system partner, we are able to directly import this information in here so that it isn't double entry for our partners. And we're also able to, if it's on the community end, help them be able to collect this in a system that's a statewide infrastructure for West Virginia. We're bringing more and more partners on board for this effort, and we hope to have standardized data collection throughout the state eventually.

This is really what our referral systems look like in a simple sense. So, we have clinic based risk pools that can be identified by those criteria mentioned earlier

through the EHR. We also have community based referrals coming in. Really, the focus is on treatment around self-management programming. So, allowing individuals to seek care outside of their regular clinic appointments, like Adam was mentioning. And then, allowing for outcomes to be [inaudible 00:42:54] back to that provider. So, letting that provider know if their participant lost weight over time, or was able to complete the program so that they can have the best care for that patient as possible.

We allow for self-referrals, as been mentioned, for some of the community based programming, so that they can get on a wait list. We have a direct register button on our website that allows for them to sign up for these classes that are more available publicly. As you can see there, there are some measures that we normally check and allow for them to ask if we are okay with sharing with their provider or if they would rather not. So, that allows to get a consent directly from that individual as they sign up.

Some technical assistance that we provide, overall, for this program is logistics of setting up the program, connecting local partners with others who are offering the same program in our state. Brainstorming on those virtual sessions, just like the group had mentioned earlier. We have a lot of folks that have moved their platform to online. And we've had great success. We've also created some data tracking tools to capture those weight and physical activity minutes in an online database that allows them to send out a link. They can record their weight, and physical activity minutes for the week. And then, that comes back and is imported into our system on an immediate basis. So, that's really exciting.

We also have the ability to help groups register for CDC and complete the application. And then, follow those standards that are necessary to become a recognized organization.

This is some additional TA. I won't go through all of these, but really, we focus on outcomes. So, outcomes at the clinical setting, outcomes at the community setting. And allowing for feedback across those groups or even internally. Another thing that we focus on is return on investment, and reimbursement efforts. And, I'm going to toss that back over to Adam.

Dr. Adam Baus: All right, thanks Samantha. And I will keep my eye on the time as well. I won't spend too much time on these slides. It's important to take a pause and see how you are doing, right? So, we wanted to look across the board at all of the DPP effort, National DPP efforts happening around the state and see how are things working.

So, we did a cohort analysis of all of the programs that are engaged in Health Connection. We took a look at the personal level summaries, their sessions attended, weekly physical activity, weight loss, and [inaudible 00:45:52] and

look at the quality of the data. Across the board we looked at... Our cohort was made up of, in the end, 320 individuals who had completed their National DPP workshops. So, you can see the break down there is very non-remarkable for our state. Generally speaking, folks were middle aged. We have over half were age 40 to 64, predominately female. Predominately white, and of course the obesity rate and the overweight rates were quite high naturally. So, 80.3% with a BMI greater or equal to 30, and 19.4% with a BMI of overweight at the time of implementation.

So, looking at these 320 folks over time, very encouraging. We're seeing an average weight loss of 13.6 pounds per person. So, that's 6.3% and that's within the CDC goal of 5% to 7% weight loss. So, we're really excited. Obesity among this cohort decreased from that 80.3% down to 68.4. Still a long way to go, a lot of profess left to make, but it's very encouraging that staying with these programs, of course, makes sense for the person and pays off. That 6.3% average weight loss on this scatter plot is the red line that you see going across, and the green line is the weight loss over time on average.

And what I wanted to mention about that line is the slope. The slope is significant. So, over time there is a significant amount of weight loss as participants continue to engage in the program. And that's exactly what we hope to see, and what we wanted to see, and then, we are finding that.

Samantha, back to you.

Dr. Samantha Shawley: Yeah, thank you so much. I think to follow-up there, we had some of the programs in our state included in that analysis that was relevant at the time, or that we had data available for the timeframe. Currently, we're working with 10 different groups throughout the state. Some of those health systems, some of those local agencies to collect data together. And I think that's really an important point to make, and we also have a new project that's going to be going on with The Bureau for Public Health to get more rural hospitals in our state involved with this effort.

Currently, for reimbursement we have Medicare, of course, reimbursing. We've been providing a lot of TA around that as well in our state. There has been pilot projects going on with some of the [inaudible 00:49:02] and also presentations with our state insurance agency. As well as some conversations with our insurance commissioner and Medicaid director. We have been learning a lot from local states nearby, like Maryland Department of Health, and others. And I think that it's really important going forward to keep in mind the partnerships that we have for this effort.

Our future goals and next steps for us, for West Virginia Health Connection, is to expand our support, resources and programming in the state, strengthen these partnerships through a network and allow for things to be disseminated widely,

allowing for a statewide data infrastructure for these programs and resources. Then, overall, what we've been saying the whole entire presentation is just changing the state's culture of health around these current conditions. And thank you so much.

Dr. Adam Baus: All right, thank you.

Krista Davis: Thank you to all of our presenters and we are going to now move into the Q&A portion of today's program. So, we invite you to please type any questions that you may have for any of our guest speakers into either the chat box or the Q&A box on the right side of your screen. We'll read questions in the order that they came, and we do have a few that we have all ready to go.

So, guest speakers, I will invite you to go ahead and just unmute yourself if you care to answer the question. The first question that we have could really be for anybody, and it is: how do you combat technology disparities in regards to the virtual DPP classes?

Do we have any speaker that wants to take on that one?

Dr. Mitchell Kaminski: Hi, this is Mitch, can you hear me?

Krista Davis: Yep.

Dr. Mitchell Kaminski: Yeah. So, I wanted to comment that our program is in Inner City Philadelphia, and although there is broadband, unlike some rural areas, there is sometimes limited technology. When a patient enrolls in the class, our coach reaches out to them and makes sure that they are connected. Some patients don't even have email, and we teach them how to open an email account up. Then, we actually practice Zoom before the classes with them. Show them how to get Zoom up. Hopefully they do have an iPad or a computer, although you could do it on your phone as well.

And so, that's how we try to overcome the technology barrier.

Dr. Samantha Shawley: And for in West Virginia, I can speak to that if you want, Krista. I think generally the partners are using Zoom or Facebook, in terms of providing content. A secure Facebook piece of it, of course. But, I think if they cannot join the online sessions in a live sense, they've been able to do makeup sessions or just be able to call in instead of having the full technology of a full video going and audio. And that's been really helpful for the participants to have some diversity in terms of logging in.

Dr. Adam Baus: Mm-hmm (affirmative). Yeah. And this is Adam, just to add to what Mitch had just said. Mitch, I really like your comment about helping people to get introduced to the technology and, to try it out and to feel more comfortable

with it. I think we're seeing [inaudible 00:53:11] the same theme when it comes to the electronic patient portal into EHR. Same concept, where you have to maneuver [inaudible 00:53:25] worthwhile technology that [inaudible 00:53:29] still might just not be accustomed to. And helping them see the value in trying it, is important.

And our state being very rural, we do still have bandwidth challenges in certain parts of our state as well, which is certainly something to keep in mind. The virtual options won't always help everyone, but while they can help a lot of other people, so it seems like you always need multiple ways in which to reach everyone. But virtually is one of those big ways that I think we can reach a lot of people.

Krista Davis: Thank you all very much. And our next question is actually for Dr. Brosius, and this question is: does the National DPP at Pots Town Medical accept patient referrals from other local practices that are not affiliated with PMSI? And if so, what is the process for referrals?

Debbie Zlomek: And I can chime in on this. This is Debbie. Yes, we do accept referrals. We have a form that, if there is a provider outside of PMSI and they want to refer patients, they can just send us that referral form to include what their last labs were. We've had patients call us directly and we'll contact their provider with their permission to get the labs to make sure they meet the criteria for the program. But we're absolutely open to the community, and to non-PMSI patients.

Krista Davis: Thank you very much, Debbie. And our next question is, I guess, for any of our guest speakers. And that is: can any provider specialty participate along with you all in the Diabetes Prevention Programs that you have going on?

Debbie Zlomek: I can speak. This is Debbie again. We get a lot of referrals from our cardiology and nephrology departments for diabetes prevention. So, we encourage all specialties because they see pre-diabetics just as well as family practice. And they do refer to us.

Dr. Mitchell Kaminski: This is Mitch. I wanted to interject that during our classes we invite speakers, and that includes some specialty speakers, for example, a podiatrist may come and answer questions at one class. Or an endocrinologist may come. So, we do invite participation in that way from specialists as well.

Krista Davis: Thank you. And our next question is for Debbie, and that is: do any of the MA plans cover your DPP Program?

Debbie Zlomek: Right now, it's kind of sketchy. We really don't have a good coverage basis for who is covering what. I know that the AADE has been providing lists of what's covered, who covers what. It changes consistently. We're hoping now with COVID that maybe insurance companies are a little bit more receptive and

aware that preventative medicine can save them money in the long run. And they'll be more receptive to accepting DPP as another preventative form of healthcare.

And Wade, do you have any more information on the MA coverage?

Dr. Wade Brosius: So, two things. I'm always cautious about answer MA when it could be the Medicaid or Medicare Advantage because Medicare Advantage plans definitely do cover a lot of the services, but Medicaid plans generally do not.

Krista Davis: Thank you both. Our next question is, I guess, for those in Pennsylvania, our speakers in Pennsylvania, and that is: how will partners be solicited in the different Southeast areas that you're looking to roll out this program? And are you only looking for healthcare providers, or healthcare partners/hospitals?

Dr. Mitchell Kaminski: This is Mitch, I can answer that. So, we reached out to not only health systems in our region, but also to community organizations, different other collaboratives running classes. So, a wide variety. We also reached out to employers and private insurance companies and have had some participation with them as well.

Debbie Zlomek: And this is Debbie. We have some senior centers in the area, and we've encouraged them to participate in DPP.

Krista Davis: Thank you. And we have time for one more quick question, but luckily we have one more question in our Q&A. So, we'll answer this one, and then we'll wrap it up. So, this question is closely related to what we have been talking about, and that is: how are any of you promoting referrals from physician practices?

Dr. Mitchell Kaminski: This is Mitch. I can say that we've put a DPP show on the road. NEBA and I have given grand rounds to our internal medicine and family medicine departments. We've given webinars to physician organizations like our county medical societies. So, we're reaching out in any way we can to educate physicians and practices about preventing diabetes.

Dr. Wade Brosius: It's Wade, [inaudible 00:59:58] sadly in our region, many, many CT programs are shutting down because of finances associated with what's going on with COVID. As such, because we have been lucky enough to have Debbie really drive the bus, and make sure that we're having success, we're having a lot of referrals in for not just only our DPP Program but also our CT programs and they're sort of going hand in hand, where one is drawing up business for the other.

Dr. Samantha Shawley: And this is Samantha. I just wanted to add from West Virginia, what we're seeing for increasing referrals, is allowing for those presentations like was mentioned earlier, grand rounds. We're calling them an RSS informational sessions for allowing patients to come and learn about the program and

highlighting it as really a lifestyle change program. Maybe not focusing on the chronic condition as much, but allowing them to see the lifestyle changes they can make over time. We usually do a session zero for a patients to come and just learn about it before starting that session one that really gets to collecting baseline information and providing actual content for the curriculum. So, that's been really helpful.

Krista Davis: Thank you all for those answers to the questions, and it is now 3:01 PM Eastern. So, we have unfortunately run out of time, but I want to, on behalf of Quality Insights, extend our thanks to every one of our guest speakers for sharing your knowledge and information about diabetes prevention programs in both Pennsylvania and West Virginia with our providers. And for all of you all that were able to attend today's session, thank you for making the time for this education. The recording will soon be available on our website, so please refer any colleagues that were not able to make it. But until that time, I'm going to say thank you all, once again, for joining us. Have a happy holiday coming up, and stay safe everyone. Thank you.

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