Prevent at risk individuals from converting to type 2 diabetes

Help individuals with type 2 diabetes stay in control
Why DPCA?

The Onset of Type 2 Diabetes

- Follows natural progression with individuals first developing prediabetes (obesity and age)
- Type 1 is caused by acute health problems (B-cell destruction leading to insulin deficiency); Type 2 is a silent problem and may remain undetected for many years
- In our current system the average diabetic goes 4 to 7 years without diagnosis and over 90% of prediabetics and 27% of diabetics have no diagnosis
- Undiagnosed individuals are at high risk for heart disease, stroke, kidney damage, blindness and other complications

Why the Current System Isn’t Optimized

- The primary focus of the current medical system is medical management of the complications of diabetes.
- Because this disease has a distinct clinical progression, the late stage focus misses significant opportunities to both prevent the disease and it’s complications through well established guidelines.
- Effective early intervention in the disease life-cycle can have a material effect on costs and outcomes
What is DPCA?

**Diabetes Prevention Program (DPP)**
- **UnitedHealth Group**
- **the Y**
- **79 million prediabetic US adults (35% of US population)**

**Definition:**
Blood glucose levels are higher than normal, but not irreversible

**Major cost driver:**
Obesity & inactivity

**Goals:**
Modify participant behavior and affect lifestyle change to help participants lose weight

**Ideal outcome:**
Reduce or eliminate diabetes conversion

**Diabetes Control Program (DCP)**
- **Amerisource**
- **Walgreens**
- **27 million diabetic US adults (11.5% of US population)**

**Definition:**
The body can’t process glucose (a type of blood sugar) normally

**Major cost driver:**
Lack of control for BP, LDL and glucose

**Goals:**
Monitor diabetes medications & blood pressure, cholesterol, HbA1c control, increase ADA compliance

**Ideal outcome:**
Avoid debilitating, costly complications resulting from non-compliance
Diabetes Prevention Program (DPP)
People with Prediabetes
DPP at a Glance

Identification
Synthesize employer’s medical claims, demographics and other indicators to identify individuals who match prediabetic profiles.

Outreach
Host testing events to screen those at risk; contact eligible participants via multiple channels – telephonically, direct marketing, and e-campaigns.

Enrollment
Enroll participants in the 16 session lifestyle change program delivered over 20 weeks.

Maintenance
Participants have option for 12 months of “monthly maintenance” to sustain results.

Engagement
The comprehensive program covers weight loss, healthy eating habits, prediabetes reduction and risk-factor reduction.

OUTCOME
Better Clinical and Financial Results
- Increased physical activity
- Healthier eating habits
- Improved nutrition
- 5% weight loss reduces diabetes conversion by 58%

5% weight loss reduces diabetes conversion by 58%
Outcomes We Can Scale

- Programs in 46 markets, 23 states + DC
  - 529 Lifestyle Coaches
  - 509 total class locations = 509

- Enrolled and/or graduated 3,773 individuals
  - Mean DPCA participant weight loss = 5.2%
  - Average sessions attended (out of 16) = 13.5
  - Only 11.5% didn’t make it to at least 4 sessions
DPCA Operations And Technology
Health Information Technology (HIT) & Scalable Business Practices

Advanced analytics / Large scale management work flow / Call center and participant engagement tracking / Connections among providers of care across different care settings / Outcomes tracking and administration of complex, incentive based payment structures
Why Is This Different than Traditional DM?

It’s Health Reform

1. Bringing in CBOs to extend Primary Care (lifestyle coaches)
2. Expanding roles of underutilized resources (pharmacists)
3. Filing claims for related services:
   - Requesting new diagnosis code
   - Focus on presentation / 1st dollar coverage
4. Performance-based / FFS reimbursement
5. Created technology and infrastructure to expand to other programs:
   - Online DPP
   - Comcast VOD
   - JOIN for Me
   - Maintenance Program
6. It works – RTCs, observational studies and our own experience
### Critical Points for Policy Makers

#### Top 10 DPP Facts

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<th>Many are overweight or obese but losing just 10-15 lbs. cuts the chances of diabetes in more than half. Many think the goal is to lose 50-100lbs or something unachievable at scale.</th>
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<td>Yes, we have broad public health initiatives promoting diet and exercise but hundreds of studies show that even modest weight change requires intensive support via structured programming and follow-up.</td>
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<td>Intensive lifestyle interventions require more resources – this is a challenge due to the large number of people that qualify.</td>
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<td>Short-term studies (including our own experience) show that this added investment is sustainable when the resources are directed toward those with pre-diabetes.</td>
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<td>Costs can be recovered via fewer treated cases of type 2 diabetes and lower Rx and health care needs for High Blood Pressure and High Cholesterol.</td>
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<td>6</td>
<td>While most who have it don’t know – pre-diabetes is easy to identify – it requires a simple blood test already performed routinely in patients with diabetes. The health care system just isn’t doing this testing.</td>
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<td>Cost of offering the Diabetes Prevention Program (DPP) in the community are only 10-20% of the costs to offer the same program, one on one, in the health care system.</td>
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<td>8</td>
<td>Weight loss and overall effectiveness of community and health care delivery models for the DPP are similar</td>
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<td>9</td>
<td>Primary care settings do not currently have the facilities or skills to offer DPP interventions to 1 in 3 American adults, so the community approach is more immediately scalable.</td>
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<td>10</td>
<td>DPP showed that lifestyle interventions work for all age, gender, race and BMI groups (overweight as well as obese), but adults over 60 were more likely to attend persistently and to have even larger decreases in the development of diabetes.</td>
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1. Amend CMS coverage policies for diabetes screening tests to incorporate recent changes to ADA recommendations: A1c testing should be added to list of options for high risk. Add CPT code 83036 to current list that includes: 82947, 82950, 82951. Current policy language should be updated to reflect definition of “diabetes” as A1c >6.4% and “pre-diabetes” as A1c 5.7% - 6.4%.

2. Direct CDC’s National Center for Health Stats (NCHS) and CMS to modify current ICD-10-CM classification to include a new code for “Abnormal Glucose Metabolism, Elevated A1c” (propose 790.23) to facilitate more wide scale use of testing and diagnosis of pre-diabetes. Current codes (ICD 790.21(IFG), 790.22 (IGT)) are increasingly uncommon diagnoses due to impracticality of these tests.

3. Diabetes prevention services such as DPP should be defined as “medical services” and such services should be encouraged and extended broadly to the general public including beneficiaries of Medicare and Medicaid.

4. Encourage CMS to review data for the use of its diabetes screening test recommendation in clinical practice over past 2 years (e.g. use of the V77.1 code) to understand its use and consider ways to encourage providers to perform the recommendation more routinely.

5. Encourage AHRQ and USPSTF to revisit its current recommendation that intensive lifestyle interventions (i.e. the DPP) should be offered only to obese adults. Many individuals with pre-diabetes and metabolic risk are not obese but overweight.

6. Community based providers such as YMCAs, faith-based organizations and others that emerge should be permitted to provide lifestyle services for Medicare and Medicaid as providers. Multiple translations have proven effectiveness is bringing these resources in to extend primary care for diabetes prevention.

7. Consider ways to manage quality and administration of these services through intermediaries that can manage networks of resources on behalf of payers, ensure quality, report and measure results (IPA type model).