THIRD WAY

REPORT *Published March 5, 2015 • 15 minute read*

Prevent Diabetes

David Kendall
Senior Fellow for Health and Fiscal Policy
@DavidBKendall

Elizabeth Quill
Former Policy Advisor, Economic Program

David went to his physician in the Minneapolis area for a check-up and found out he was at risk for getting Type 2 diabetes. His physician found his blood sugar in the prediabetic range, and explained to David that he has prediabetes and how that condition could affect his life. David was alarmed because he had seen his mother-in-law and friends struggling to deal with diabetes. He enrolled with a local diabetes prevention program at the Y which helped him realize how poorly he was eating and showed him how to lose weight—drastically decreasing his chance of getting diabetes. The physician got David's commitment to the program, which was covered by David's health plan, and he learned healthy diet and exercise tips that he incorporated into his daily life. After a year, David has lost a significant amount of weight and greatly reduced his risk of developing diabetes. [1]

David's story is how our health care system should operate. But, currently there are too many obstacles to adequate diabetes screenings and getting patients into effective prevention programs. By changing the way we diagnose and treat diabetes, patients will live a longer, healthier life and

the federal government could save as much as $8.1 billion over 10 years.

This idea brief is one of a series of Third Way proposals that cuts waste in health care by removing obstacles to quality patient care. This approach directly improves the patient experience—when patients stay healthy, or get better quicker, they need less care. Our proposals come from innovative ideas pioneered by health care professionals and organizations, and show how to scale successful pilots from red and blue states. Together, they make cutting waste a policy agenda instead of a mere slogan.

What is Stopping Patients from Getting Quality Prediabetes Care?

How would you react to the diagnosis of "impaired fasting glucose level?" Probably with some confusion. The health care system treats 29 million Americans with diabetes every year but does very little to prevent it. [2] Researchers from the Centers for Disease Control and Prevention (CDC) have estimated that 40% of Americans born between 2000 and 2011 will develop diabetes. [3] It has grown like an epidemic with the number of people with diabetes doubling between 1990 and 2005.

The cost of diabetes is staggering. In 2012, the total cost of diabetes in the United States was estimated at $245 billion. [4] One of every 10 health care dollars goes to treating it. For adults with diabetes, overall medical costs are more than twice as high as those without it, and costs tend to increase with time as complications develop.

The nation is failing to prevent diabetes for two main reasons: **inadequate screenings** and a **lack of effective prevention programs**.

> *"People with prediabetes have blood glucose levels that are above the normal levels but aren't high enough to*

> *indicate diabetes.* [5] *Roughly 33% of adults in the U.S. have prediabetes, and the vast majority (more than 90%) of those individuals are unaware of their condition.* [6]

Providers often do not screen for diabetes, which means patients have no chance to learn they can prevent the disease. Diabetes screening typically catches prediabetes because most of the symptoms are similar, but diabetes screening has significant gaps. The U.S. Preventive Services Task Force (USPSTF) only recommends and covers diabetes screenings for patients with high blood pressure. [7] These USPSTF screening guidelines do not currently include other risk factors for diabetes including a high body mass index (BMI), a sedentary lifestyle, and a familial history of Type 2 diabetes—all critical factors which, when missed, fail to catch individuals with diabetes. [8] However, the USPSTF released a draft recommendation in October, 2014 that recommends adding additional risk factors. If these draft recommendations are accepted, screening would be covered for individuals with these risk factors. [9]

Also contributing to inadequate screenings is that patients who are screened today may not take negative results seriously. All too often, providers tell patients that they have an "impaired glucose tolerance" or an "impaired fasting glucose level." With little more than medical jargon to inform them, patients may not be concerned enough to act or may not understand they need to act to prevent the progression to diabetes. [10] Many people simply don't understand how important it is to change their habits during this early stage even though they have not been diagnosed with diabetes. Yet, they still have a blood sugar level that is abnormally high and some of the damage to their body caused by diabetes may already be underway. [11]

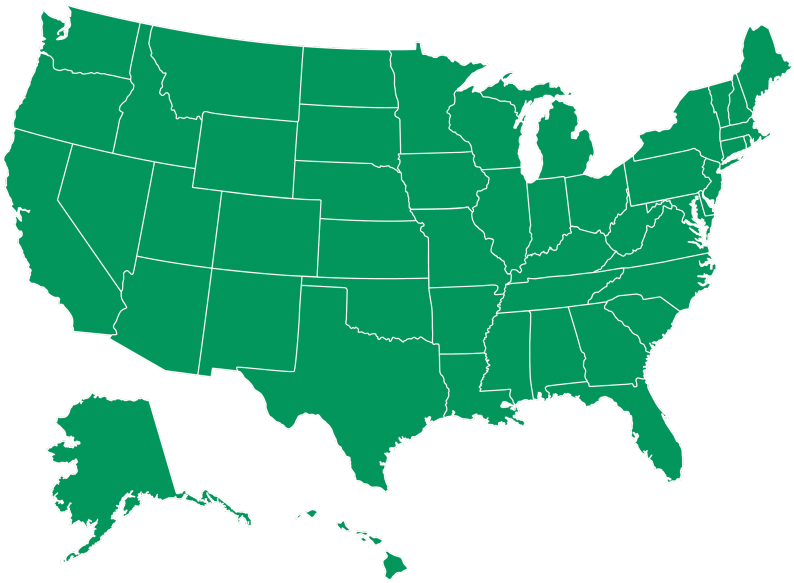
Finally, when providers don't have programs to which they can refer patients when testing reveals prediabetes, screenings are far less effective. And other doctors may feel it

is not their job to deal with prediabetes because weight loss is the patient's responsibility.

Where are Innovations Happening?

Type 2 diabetes is largely preventable. [12] There are many examples of successful programs that help people at risk for diabetes change their lifestyle. These programs focus on improving people's lives and reducing their risk of diabetes. With some changes to behavior, millions of people at risk for Type 2 diabetes can delay or avoid developing it by losing weight through regular physical activity and a low fat diet. [13] Weight loss helps reduce blood pressure and allows the body to use insulin more effectively. Exercise promotes weight loss, helps lower blood sugar levels, lowers risk for heart disease and stroke, and helps reduce "bad" LDL cholesterol and raise "good" HDL cholesterol. [14]

The National Diabetes Prevention Program (NDPP) is an "evidence-based lifestyle change program" aimed at preventing Type 2 diabetes. [15] It has programs in all 50 states.



The CDC launched the NDPP and partnered with the YMCA of the USA (Y-USA) and UnitedHealthGroup to offer these intervention programs. Diabetes prevention research has found that if people at risk for the disease lose 5 to 7% of

their body weight and exercise moderately, they can reduce their risk of developing diabetes by up to 58%. [16]

Pioneered at Y-USA locations in Indiana, Kentucky, and Minnesota, the Y's Diabetes Prevention Program, which uses one of 6 NDPP approved curricula, teaches people with high blood sugar levels about the benefits of healthy eating and increasing their physical activity levels. [17] The program now has more than 1,000 locations in over 40 states. The goals are simple and clear: lose 7% of your body weight and gradually increase physical activity to 150 minutes a week. [18] Six additional groups have received grants from the CDC to operate diabetes prevention programs, including America's Health Insurance Plans (AHIP). [19]

At least three major insurers—UnitedHealth Group, Optum, and Health Medica—are paying for clients to participate in a year-long program that includes 16 weekly small-group sessions followed by monthly maintenance sessions led by a trained lifestyle coach. [20] These programs provide motivational support to keep patients on track with healthy eating, exercise, and behavior modifications. [21] Large employers like Albertson's, Cub Pharmacy, Kroger, Rite Aid, Safeway, Shop'n Save, and Winn-Dixie have jumped on the bandwagon to offer similar programs.

The original Diabetes Prevention Program produced significant results. The number of participants who developed diabetes dropped by 50%; among people over 60, the decline was 71%. Within two years, the reduced cost of treating diabetes and its complications more than paid for the cost of the training. [22]

Another NDPP initiative is underway in Florida, New Mexico, New York, and Texas. The CDC and AHIP have teamed up with four health insurers—Aetna, EmblemHealth, Florida Blue, and Molina Healthcare—to operate a program similar to the Y's over the next four years. [23] It will focus on reaching groups with a disproportionately higher risk of developing diabetes, including African Americans, Hispanics, and women who begin their pregnancy with prediabetes or develop

diabetes during pregnancy. The data and experience from this initiative will help promote its adoption among employers and other health plans. [24] The initiative is part of a series of diabetes prevention programs under the NDPP that have been authorized through the *Affordable Care Act*.

In a separate effort, the CareMore Health System, an Anthem subsidiary, focuses on screenings to ensure members are aware of their health condition early. Patients are screened for diabetes during an initial meeting with an advance practice clinician (e.g., nurse practitioner and physician assistant). Those identified as prediabetic then receive diet and exercise programs according to practice guidelines developed by the American Diabetes Association. [25]

The American Medical Association (AMA) has teamed up with Y-USA in an effort to encourage physicians to both diagnose prediabetes and refer patients to diabetes prevention programs. [26] Patients like David in the Minneapolis area, mentioned at the beginning of this idea brief, should not have to rely on good luck in hearing about effective diabetes prevention programs. The AMA is giving physicians the information they to need to refer people with prediabetes into proven, local programs. [27]

How Can We Bring Solutions to Scale?

These successful experiments are ready to be scaled up nationwide. Public policy should ensure that these diabetes prevention programs are widely available to the patients who can benefit from them through the following steps:

1. Medicare should pay for prediabetes programs so providers can help patients prevent diabetes through screenings and referrals.

Medicare (and all other health plans) should cover the cost of diabetes prevention programs like the Y's for people who have prediabetes. Based on the AMA's referral program, such

coverage will allow physicians and other providers to conduct regular screening for prediabetes and give patients a "prescription" for prevention programs when they have prediabetes. [28]

Here's how effective programs should work. Providers should use the moment of delivering negative screening results as a "teachable moment." First, providers should tell patients they have "prediabetes," explain they are already exhibiting signs of the disease, and detail the specific negative consequences they face (e.g., amputations). After getting the patient's full attention, providers then should ask patients to commit to prevention programs that will teach them healthy lifestyle tips and reduce their risk of developing diabetes. Positive messages about the benefits of taking action—called gain-framed messages—have successfully been employed to encourage individuals to adopt and maintain preventive behavior. [29]

Effective prevention programs, like the one offered at the Y, help patients overcome their projection bias that can stop them from following through on an initial commitment. Projection bias explains that people often make decisions by projecting their current preferences that are different from the decisions they would make if they could set their current preferences aside. [30] These programs work to help individuals focus on how their current unhealthy habits will affect them in the long-term, which effectively battles projection bias. Such programs have proven to be an effective way to educate people with prediabetes about how to change their lifestyles and help maintain the healthy changes. [31]

Bipartisan legislation introduced in 2013 by Senators Al Franken (D-MN), Jay Rockefeller (D-WV) and Susan Collins (R-ME), the Medicare Diabetes Prevention Act of 2013 (S.452), is a step in the right direction. It would provide Medicare coverage for diabetes preventive programs under standards set by the NDPP. The House version of this bill was introduced by Susan Davis (D-CA). [32]

In order for people to get into these programs and have quick scalability, it is necessary to expand the list of approved programs. Organizations like Weight Watchers and Omada Health have very similar programs that have proven to be very effective. [33] Allowing programs like these to offer diabetes prevention programs to the Medicare population would help begin to address the scalability issue. These programs are also offered virtually, which would appeal to many potential patients. One study found that offering the program through cable television is also an effective way to reach a broader audience and can achieve similar results to the live programs. [34] These programs are also significantly cheaper to offer and would substantially increase cost savings.

2. Medicare and all other health plans—public and private—should also measure and report success with diabetes prevention.

Health plans are in a good position to measure and report success in preventing diabetes because they have data to determine diabetes screening rates and reductions the number of patients at risk for diabetes. Such data generally comes from insurance claims paid by health plans.

Collecting the data on diabetes prevention would build off existing health plan reporting on prevention like breast cancer screenings, colorectal cancer screenings, and influenza immunizations. The plan's performance receives scores using the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a set of performance measures governed by the National Committee for Quality Assurance (NCQA) that are utilized by more than 90% of health plans in the U.S. to measure aspects of health care performance and service. [35] In fact, health plans compete in part over how many of their members get preventive services.

HEDIS has been successful in improving prevention like colorectal cancer screenings. A study in Pennsylvania determined that the implementation of HEDIS measures for

colorectal cancer resulted in increased screening rates and an improvement in awareness of the importance of early screening for the cancer. [36] HEDIS measures implemented for diabetes could get similar results, increasing the number of people screened and detected, and increasing awareness of diabetes as a significant public health issue.

Along with other health care quality measures, diabetes prevention should be part of the National Health Care Quality report published by the Agency for Healthcare Research and Quality. This report tracks progress in health care quality at the national and state levels. [37]

The ultimate goal of reporting on diabetes prevention is to reduce the number of new cases of diabetes. Requiring this reporting will cause health plans to compete over the success of their diabetes prevention as they often have done with other disease prevention programs. Their success would be captured in Medicare's five star ratings of health plans, which are based on HEDIS measures. The star ratings have proven effective in guiding consumers to choose higher quality plans. [38] This would supplement the current CDC reporting program where recognized diabetes prevention programs submit reports every six months on the progress of their participants. [39] The CDC keeps a registry of recognized diabetes prevention programs and frequently makes sure these programs are meeting the standards of the CDC curriculum and getting results.

A high performing plan will likely use the flexibility it and employers have under current law to provide financial incentives to encourage people with prediabetes to lose weight and participate in diabetes prevention programs. The best way to encourage the cost-effective use of such strategies is for public and private health plans to measure and report on their results.

Potential Savings?

The Y-USA estimates its program can reduce the risk of developing Type 2 diabetes by as much as 58% and as high as

71% among adults 60+ based on results from the original diabetes prevention program clinical trial funded by the National Institutes for Health. Nationally, implementing community-based diabetes intervention programs could save the United States $191 billion over the next 10 years, with 75% of the savings ($142.9 billion) realized by Medicare and Medicaid. [40] A report released by the ADA, the Y-USA, and the AMA estimated that the Medicare Diabetes Prevention Act would reduce federal spending by $1.3 billion between 2015 and 2024 by reducing the incidence of diabetes among seniors. [41]

Using the lower price of prevention programs offered through cable, websites, and other similar programs, Third Way estimates that these programs would decrease federal spending by $8.2 billion over the 2015-2024 federal budget window. It would decrease spending among states, employers, and individuals by $14.3 billion for total of $22.5 billion in savings over ten years. As the chart below shows, for the first few years of implementation, the savings are negative, meaning that diabetes prevention costs money as an upfront investment to achieve the cost-savings in the long run.

Savings from Diabetes Prevention

(in $billions)	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	10 years
Medicare	-0.2	-0.3	-0.4	-0.3	-0.2	0.1	0.5	1.2	2.1	3.3	5.8
Medicaid-federal	-0.1	-0.2	-0.2	-0.2	-0.1	0.0	0.2	0.6	0.9	1.4	2.5
Total federal	**-0.3**	**-0.5**	**-0.6**	**-0.5**	**-0.3**	**0.2**	**0.7**	**1.8**	**3.0**	**4.7**	**8.2**
Medicaid-state	-0.1	-0.1	-0.1	-0.1	-0.1	0.0	0.2	0.4	0.6	1.0	1.7
Private health insurance	-0.5	-0.7	-0.9	-0.6	-0.4	0.2	1.0	2.3	3.8	5.9	10.2
Out of pocket spending	-0.1	-0.2	-0.2	-0.1	-0.1	0.0	0.2	0.5	0.9	1.4	2.4
Total-all sources	**-0.9**	**-1.4**	**-1.8**	**-1.4**	**-0.9**	**0.4**	**2.2**	**5.1**	**8.3**	**13.0**	**22.5**

Source: Avalere: 2014, and Actuarial Research Corporation: 2014.

Questions and Responses

Do physicians really have time to refer patients to these programs?

Medical home models can enable physicians to help more with prevention. A medical home gives patients 24x7 support for their basic care needs. Primary care physicians receive a lump sum payment for care coordination, which would include making sure patients are appropriately screened for

diabetes. They also receive an additional payment when their patients achieved healthy results like a reduction in their risk for developing Type 2 diabetes. [42] Beyond the financial payments for medical homes, health plans can support them with data that health plans have from lab results to identify and reach out to prediabetes patients.

What is the role of the pharmacy in diabetes prevention?

The medication therapy management (MTM) model, similar to a medical home, permits pharmacists to counsel at-risk patients on reducing their risk of developing type 2 diabetes. [43] Both the medical home model and the MTM model would allow health care providers and pharmacists to identify and screen those high risk individuals who are already being treated for other conditions or picking up their medications. The federal government could increase access to screenings for Medicare beneficiaries by allowing other capable providers, such as pharmacists, to perform these services. Pharmacists would be capable of providing these services and expanding screening efforts if they were recognized as eligible providers under Medicare. The government must grant pharmacists provider status for services already recognized by Medicare as allowed by state scope of practice laws.

What about employers? What can they do to help their employees to prevent diabetes?

Health plans and employers should work together to identify employees in the prediabetes range and assist them with placement in lifestyle intervention programs. As of 2010, it was estimated that employers spent an average of $4,413 more annually for employees with diabetes. [44] Employers can utilize worksite health fairs to identify at-risk employees and provide the employees with information on how to access intervention programs nearby.

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