

Karen Scherr, MD, PhD

INCREASING UTILIZATION OF THE DIABETES PREVENTION PROGRAM

OVERALL AIM

To improve the care of patients with prediabetes at Duke Family Medicine through increased utilization of the Diabetes Prevention Program



PROJECT PHASES

- Phase I: Preparation
 - Gathering background knowledge
 - Stakeholder identification and cultivating relationships
 - Baseline survey of clinic providers
- Phase II: Pilot
 - Identifying eligible patients
 - Creating the electronic referral
 - Retrospective referral of our own patients
- Phase III: Roll out
 - Education campaign for clinic providers
 - Providers prospectively refer their own patients
 - Post-intervention survey of clinic providers
- Phase IV: Next steps
 - Further refinement of referral
 - Roll out to other clinics
 - Development of a “Best Practice Advisory” (BPA)

PHASE I: PREPARATION

Gathering background knowledge

Stakeholder identification and
cultivating relationships

Baseline survey of clinic
providers

HEALTH CONCERNS IN DURHAM

Table 2.01(a) Top Responses from the Full County Sample

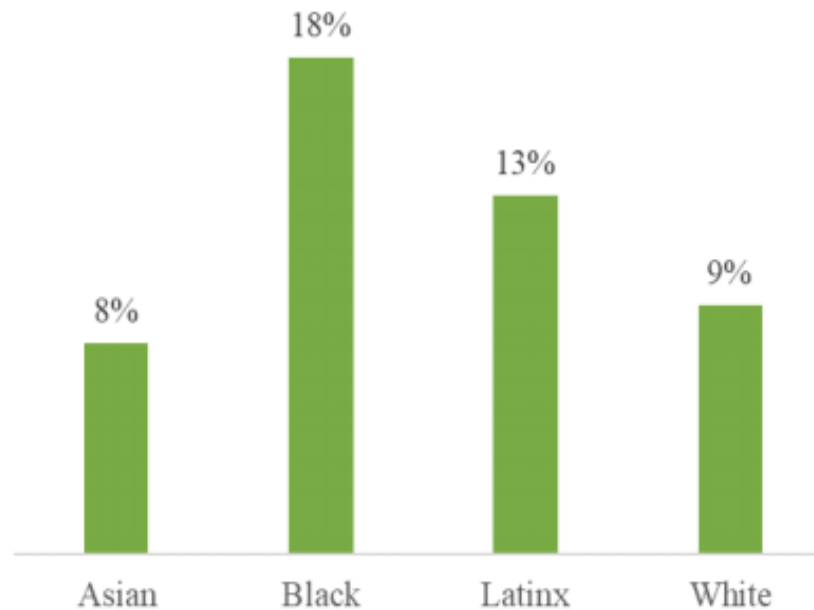
Community Issues	Health Problems	Services Needing Improvement
1. Violent Crime	1. Diabetes	1. Public transportation improvements
2. Affordable housing	2. Mental health	2. Safer community-more police and crime reduction
3. Gentrification	3. Drug use	3. Physical activity infrastructure

Table 2.01(b) Top Responses from the Hispanic or Latino Neighborhood Sample

Community Issues	Health Problems	Services Needing Improvement
1. Theft	1. Diabetes	1. Increased police response to crime
2. Violent Crime	2. Obesity or overweight	2. Access to care
3. Other	3. Cold, flu and cough	3. More health programming and health education

DISPARITIES IN DIABETES IN DURHAM

Type 2 Diabetes Prevalence among Duke Patients by Race and Ethnicity, 2017¹⁷



THE DPP: BARRIERS TO UTILIZATION

~~Cost~~

Difficulty identifying eligible patients

Cumbersome faxed referral process

Low provider and patient awareness and buy-in

Carroll J, Winters P, Fiscella K, Williams G, Bauch J, Clark L, et al. Process evaluation of practice-based Diabetes Prevention Programs: what are the implementation challenges? *Diabetes Educ* 2015;41(3):271–9.



NEWS RELEASE

For Immediate Release: February 18, 2019

Blue Cross NC Invests \$5 Million to Combat Diabetes Epidemic in NC

Investment in Diabetes Free NC to cut diagnosis of Type 2 diabetes by expanding free access to diabetes prevention programs for all North Carolinians.

<https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/news-and-information/news/News%20Release%20Diabetes%20Free%20NC.pdf>

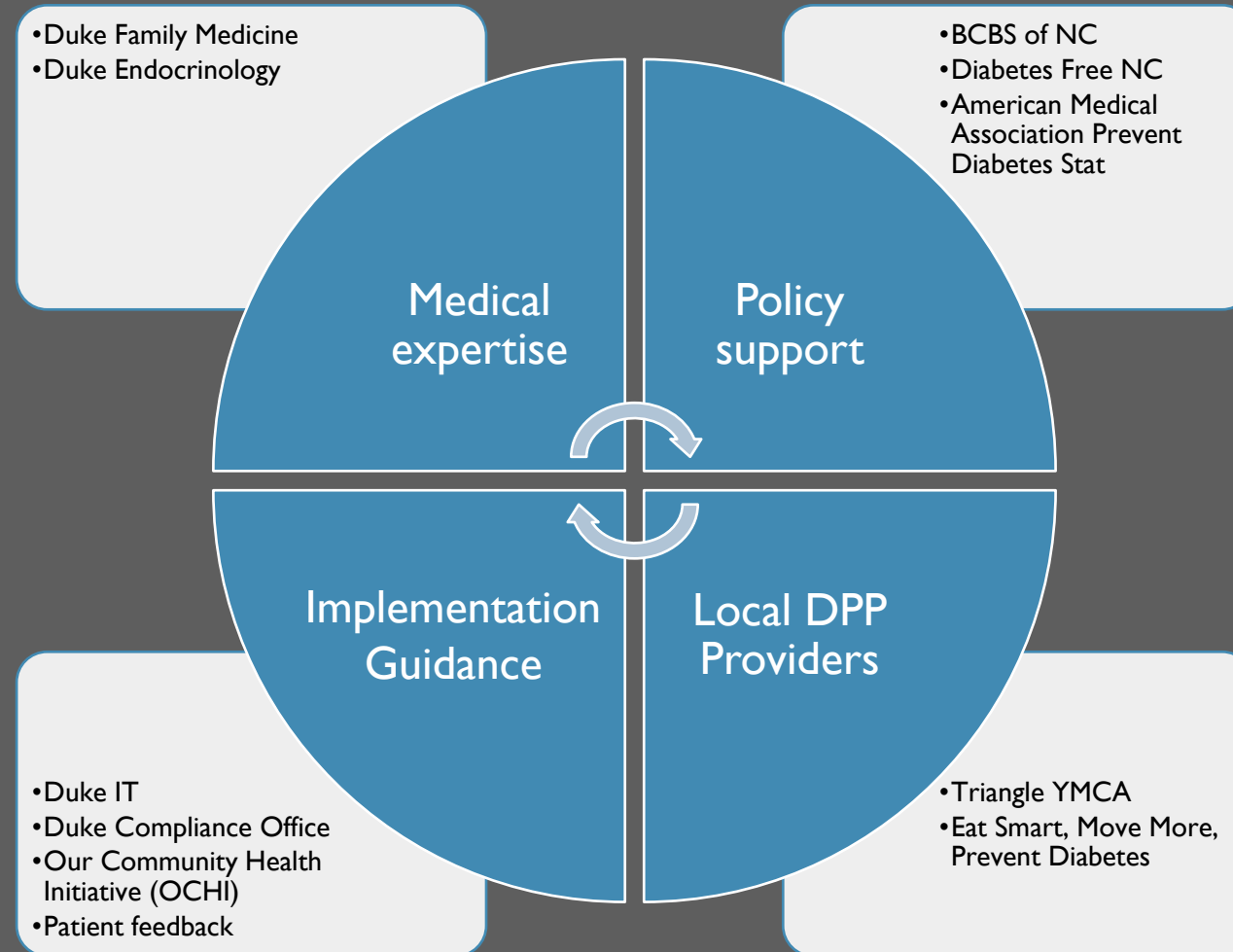
PHASE I: PREPARATION

Gathering background knowledge

Stakeholder identification and
cultivating relationships

Baseline survey of clinic
providers

STAKEHOLDERS



Duke University



Community Partners



Duke Family Medicine & Community Health
Division of Community Health

Duke Family Medicine & Community Health

FAMILY MEDICINE LEADS
EMERGING LEADER INSTITUTE
American Academy of Family Physicians Foundation

the Y
YMCA of the Triangle



Duke OIT



Department of Medicine
Duke University School of Medicine
Endocrinology, Metabolism, and Nutrition

AMAX
AMERICAN MEDICAL ASSOCIATION

COMMUNITY HEALTH INITIATIVE

North Carolina Medical Society FOUNDATION
Opening Doors to Quality Health Care

BlueCross BlueShield of North Carolina

Prevent Diabetes

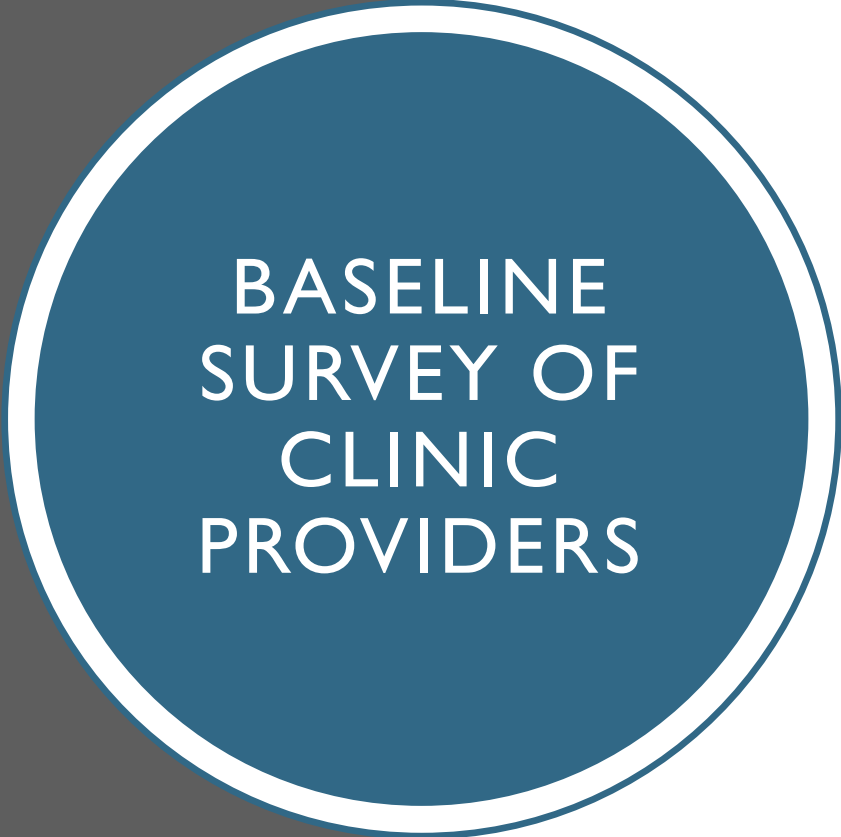
DIABETESFREE NC

PHASE I: PREPARATION

Gathering background knowledge

Stakeholder identification and
cultivating relationships

Baseline survey of clinic
providers

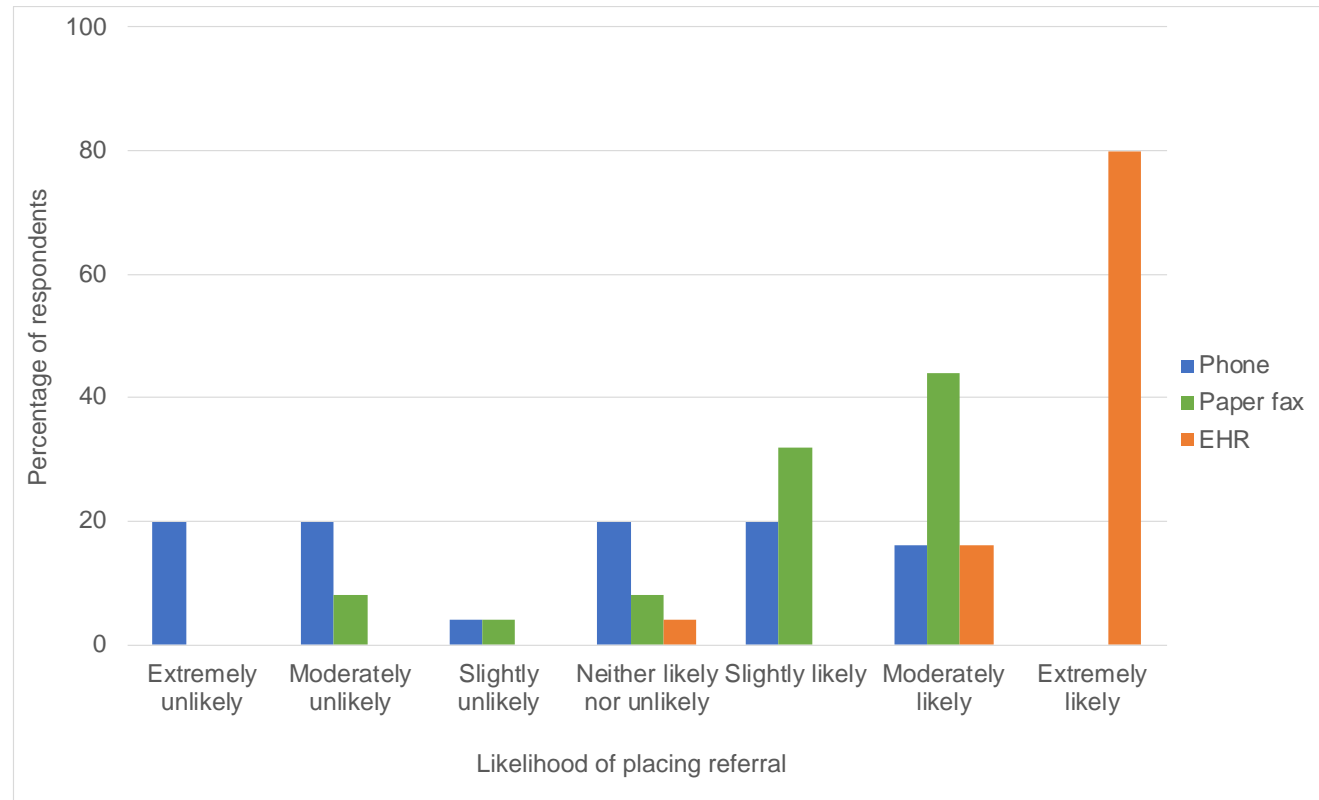


BASELINE SURVEY OF CLINIC PROVIDERS

- 25 providers responded
 - 14 residents (response rate = 88%)
 - 11 non-resident providers (response rate = 48%)
- Imperfect survey – some providers (especially residents) had already heard informally about this project. We attempted to separate the impact of that on their responses through explicit questions.

REFERRAL LIKELIHOOD

How likely would you be to place a referral to the DPP with each of the following referral methods?

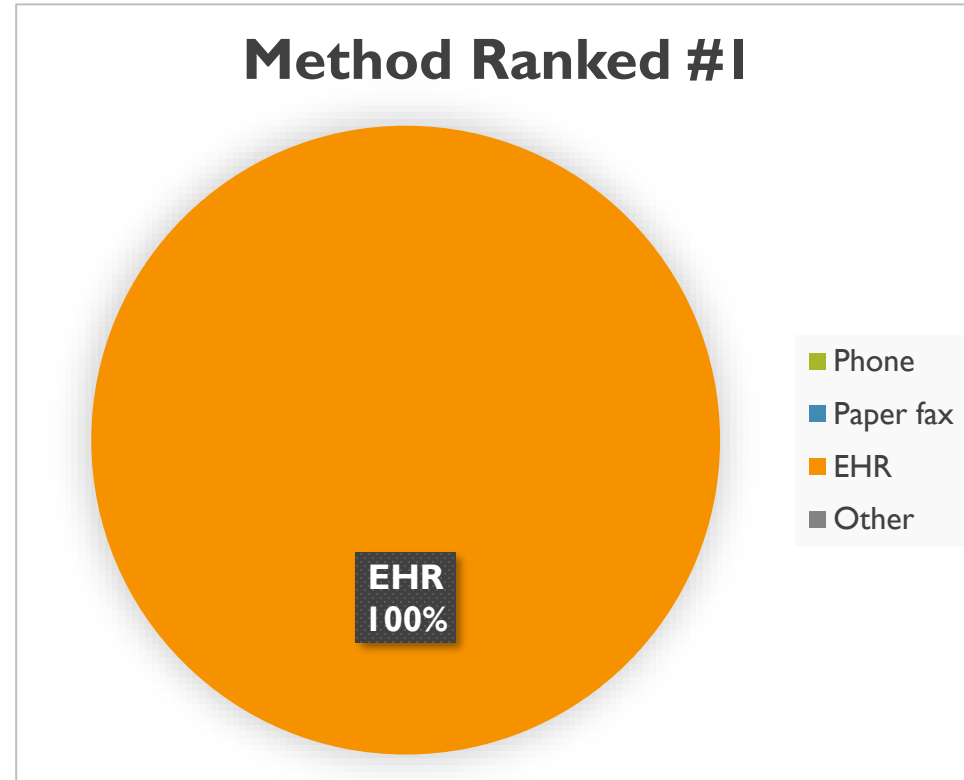


PREFERRED REFERRAL METHOD

Please rank the following referral methods in order of preference:

- EHR
- Phone
- Paper fax
- Other

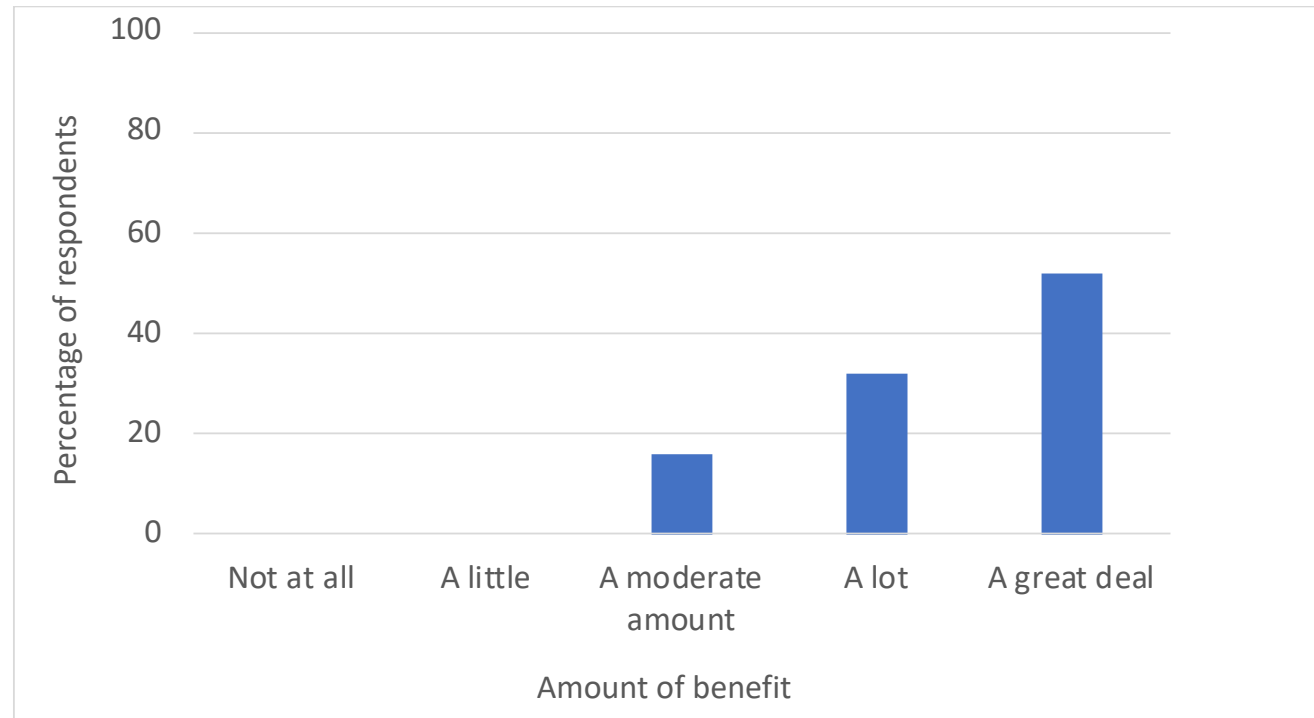
Method Ranked #1



PERCEIVED BENEFIT OF THE DPP

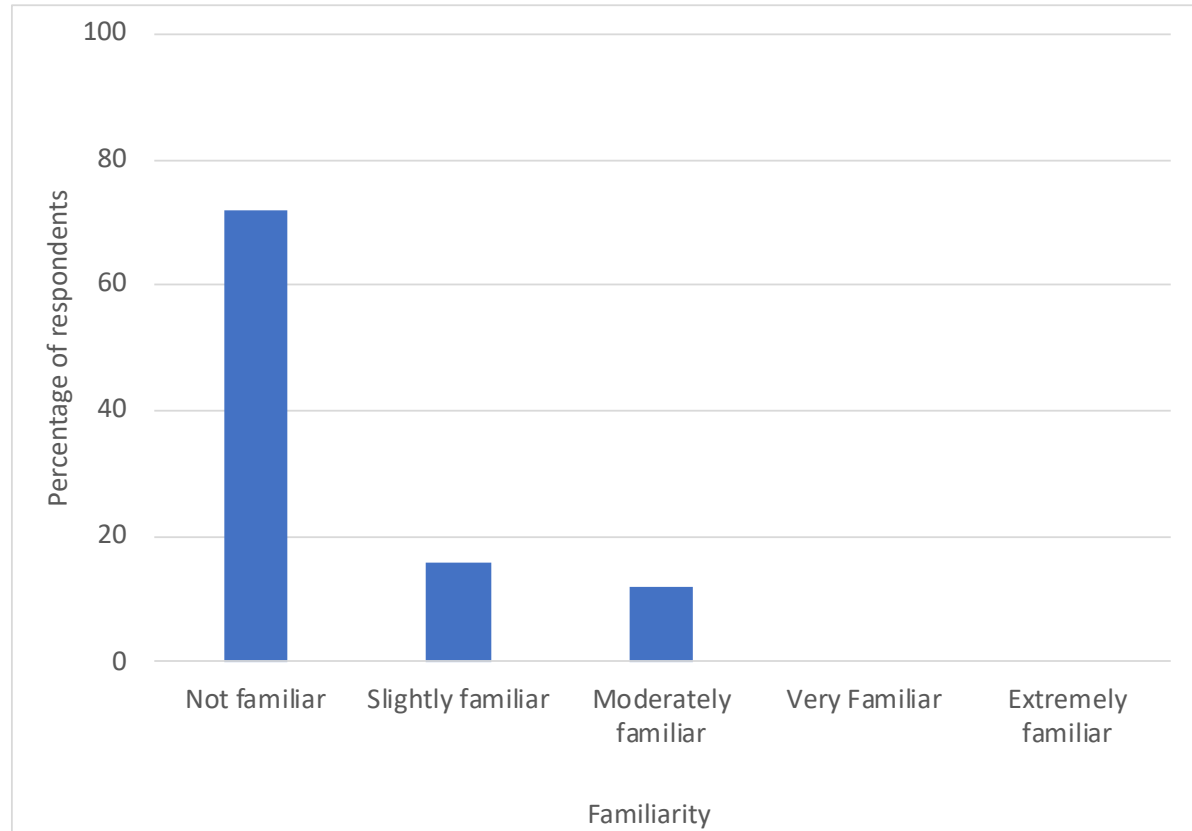
The Diabetes Prevention Program (DPP) is a formal evidence-based treatment for patients with prediabetes or at high risk for diabetes. It is a 12-month intervention that provides patients with education and support to achieve a healthier lifestyle in terms of nutrition, exercise, and stress management.

How much do you think patients at Pickens who have prediabetes or are at high risk for diabetes could benefit from the DPP?



FAMILIARITY WITH THE DPP

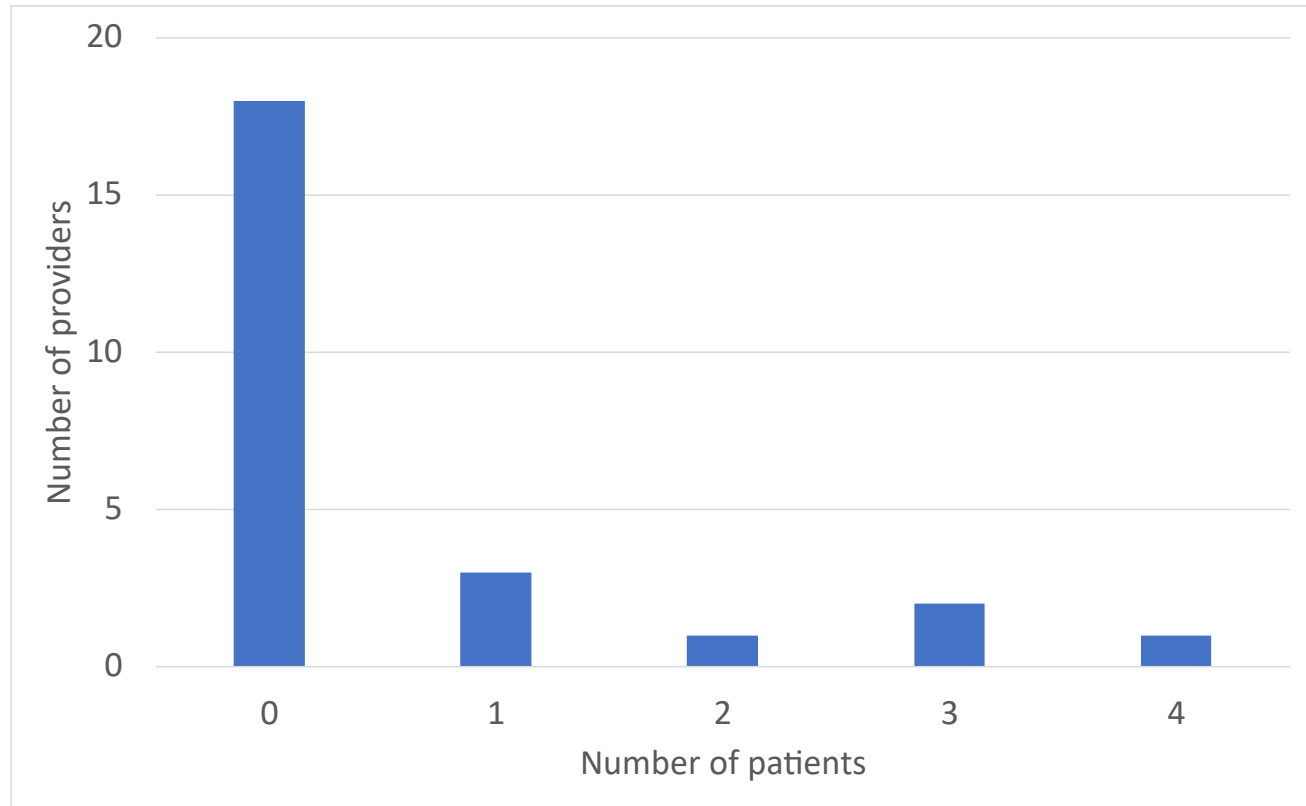
How familiar are you with the Diabetes Prevention Program treatment?



EDUCATING ABOUT DPP

In the last three months, how many patients have you educated/told about the DPP?

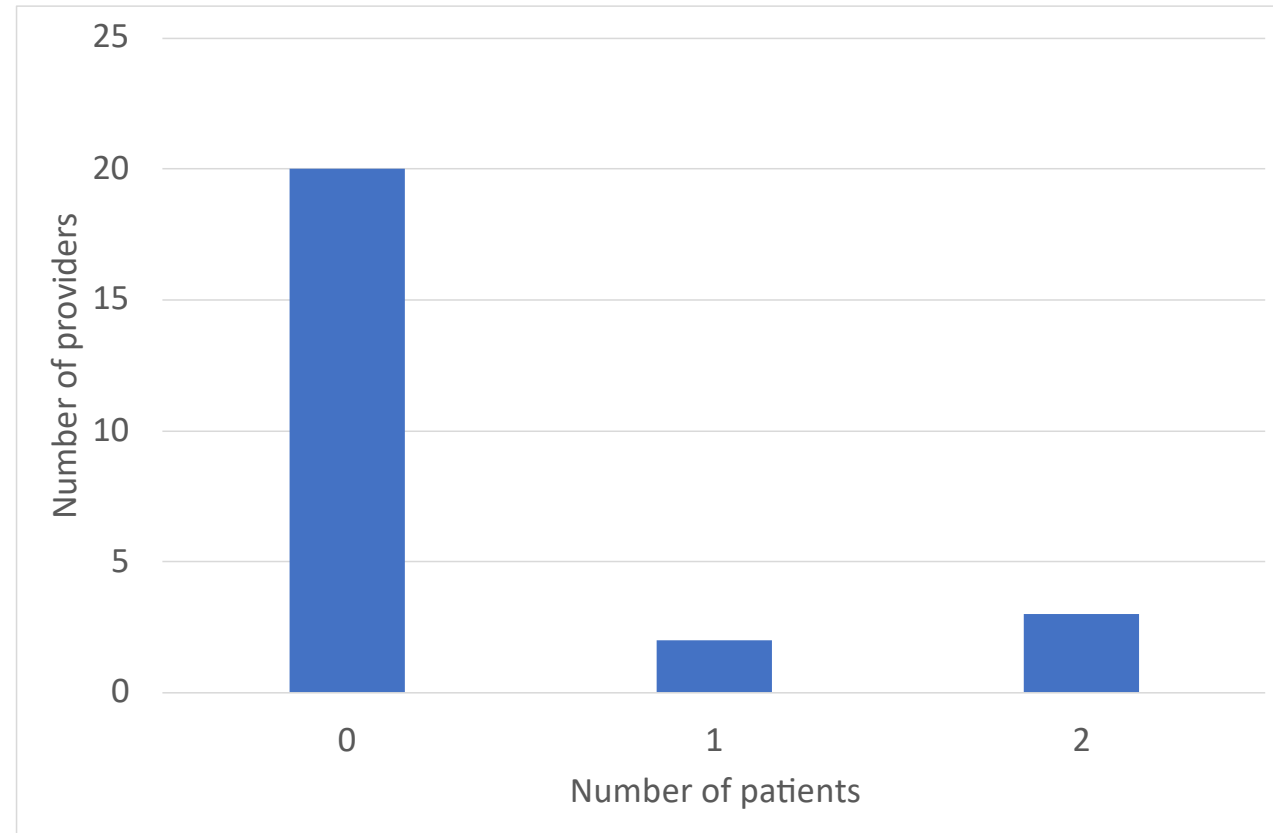
Of the 7 providers who told patients about the DPP, 6 were residents who specifically attributed their behavior to informally hearing about the program from this project.



REFERRALS TO DPP

In the last three months, how many patients have you referred to the DPP?

Of the 5 providers who referred patients to the DPP, all 5 were residents who specifically attributed their behavior to informally hearing about the program from this project.



PHASE I: SUMMARY

- The landscape is complex and just identifying the people to involve was time intensive.
- Providers thought patients could benefit from the DPP, but they were not very familiar with the program and baseline utilization was low.

PHASE II: PILOT

Identifying eligible patients

Creating the electronic referral

Retrospective referral of our
own patients

IDENTIFYING ELIGIBLE PATIENTS

Addition of “diabetes screening” to health maintenance recommendations in the EHR

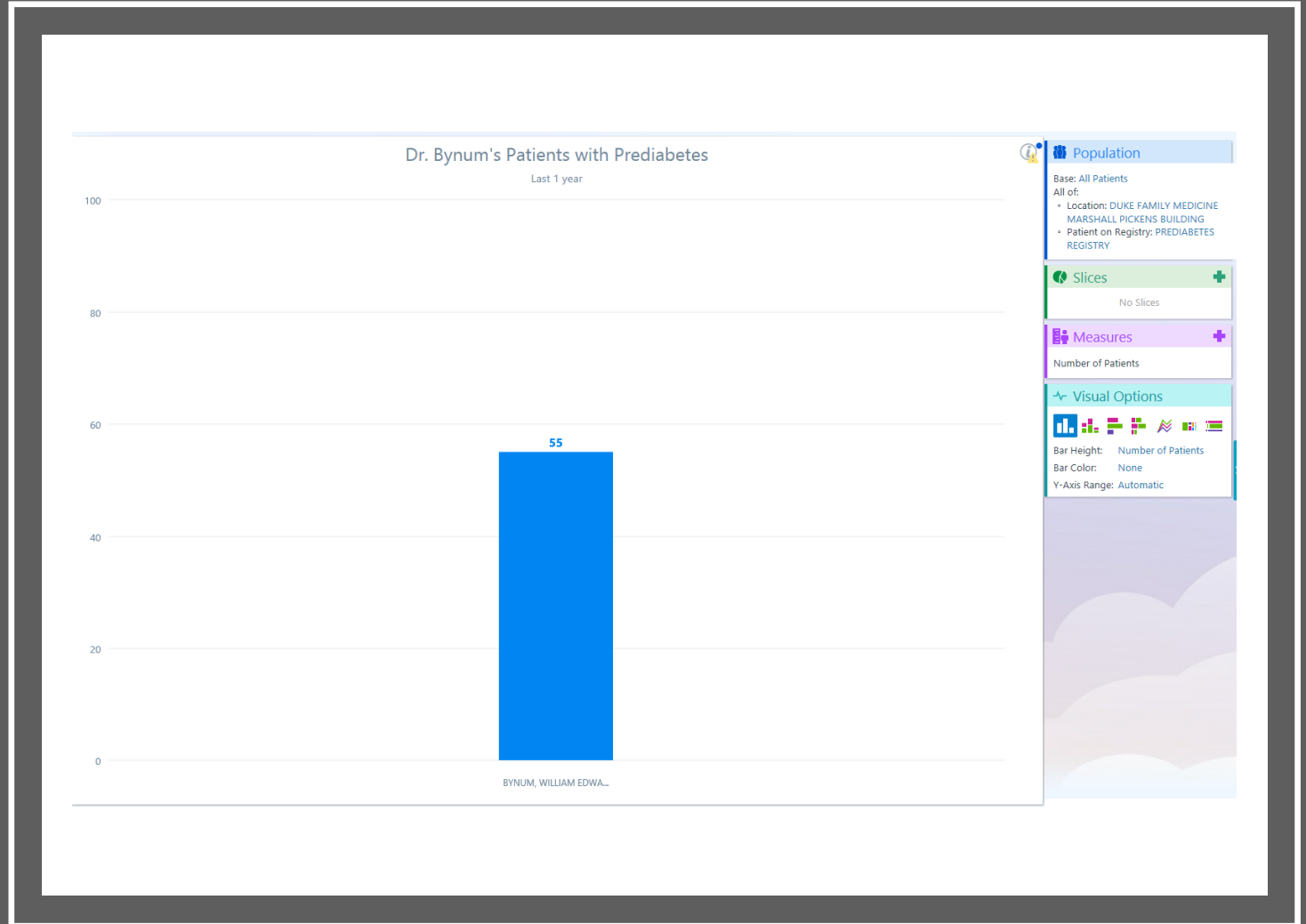
Health Maintenance

[+](#) Address Topic [✕](#) Remove Override [📄](#) Document Past Immunization | [✎](#) Edit Modifiers [📄](#) Report [🔄](#) Update HM | [ℹ](#) Guidelines

Topic	Due Date	Frequency	Date Completed
Upcoming			
Influenza Vaccine (Season Ended)	Next due on 9/1/2020	Imm Details	📅 1/1/2019
Adult Tetanus (Td And Tdap)	Next due on 11/8/2022	10 year(s)	11/8/2012 (N/S)
Diabetes Screening	Next due on 1/30/2023	3 year(s)	1/30/2020
Completed or No Longer Recommended			
HIV Screen	Completed	Once	9/9/2015
HPV Vaccines	Aged Out	Imm Details	

IDENTIFYING ELIGIBLE PATIENTS

Creation of a new searchable "prediabetes registry"



PHASE II: PILOT

Identifying eligible patients

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AMB REF DIAB

[Browse](#)[Preference List](#)[Facility List](#)[Database](#)[Panels](#) (No results found)[Medications](#) (No results found)[Procedures](#)

	Name	Type	Code	Pref List	Cost to Org
	Amb Referral to Poet/Periop Diabetes	REF	REF479	AMB FACILITY REFERRALS DUHS	
	Ambulatory Referral to Adult Diabetes Education	REF	REF20	AMB FACILITY REFERRALS DUHS	
	Ambulatory Referral to Diabetes Prevention Program	REF	REF519	AMB FACILITY REFERRALS DUHS	

THE NEW ELECTRONIC REFERRAL

Class: External Re: External Referral ← Auto-populates

Referral: Override restrictions
To provider: [Search] [Location]

Priority: Routine Routine STAT ASAP

Process Inst.: Note about PRIORITY:
STAT Appointment within 24 hours
ASAP Appointment within 7 days
Routine Appointment in more than 7 days

Referral to program: Triangle YMCA Online Eat Smart Move More Other

Last A1C Result: 5.7 ← Auto-populates

Last BMI: 24.21

Comments: [Rich text editor toolbar] [Insert SmartText] [Rich text editor area]

Auto-populates, info for schedulers

Sched Inst.: [Rich text editor toolbar] [Insert SmartText] [Rich text editor area]

Scheduling Note:
If referring to the YMCA program, the referral has been automatically routed and the YMCA will contact the patient.
If referring to the Eat Smart Move More program, the patient has been given a printed referral and will self-enroll; no further action is needed.

THE NEW ELECTRONIC REFERRAL

Class: External Re: External Referral

Referral: Override restrictions

To provider:

Priority: Routine Routine STAT ASAP

Process Inst.: Note about PRIORITY:

STAT Appointment within 24 hours
 ASAP Appointment within 7 days
 Routine Appointment in more than 7 days

Referral to program: Triangle YMCA Online Eat Smart Move More Other ← Select "Triangle YMCA"

Last A1C Result: 5.7

Last BMI: 24.21

Comments:

Sched Inst.:

Scheduling Note:
 If referring to the YMCA program, the referral has been automatically routed and the YMCA will contact the patient.
 If referring to the Eat Smart Move More program, the patient has been given a printed referral and will self-enroll; no further action is needed.

THE NEW ELECTRONIC REFERRAL: YMCA

Class: External Referral

Referral: Override restrictions
To provide

Priority: Routine

Process Inst.: Note about
STAT
ASAP
Routine

Referral to program:

You have selected
Triangle YMCA:

Last A1C Result:

Last BMI:

Comments: Type ".dppymcareferral" here

Sched Inst.: Scheduling Note:
If referring to the YMCA program, the referral has been scheduled.
If referring to the Eat Smart Move More program, the referral has been scheduled.
If referring to the Eat Smart Move More program, the referral has been scheduled.
action is needed.

Patient information
Age: @AGE@
@LASTBMI(1)@
@RESUFAST(HGBA1C:1)@
Phone: @PHONE@
Address: @ADDCAP@

Referring provider information:
PCP: @PCP@
@ADDRESSDEPTENC@

Patient information
Age: 49 y.o.
BMI Readings from Last 1 Encounters:
03/04/21 : 24.21 kg/m²

Lab Results

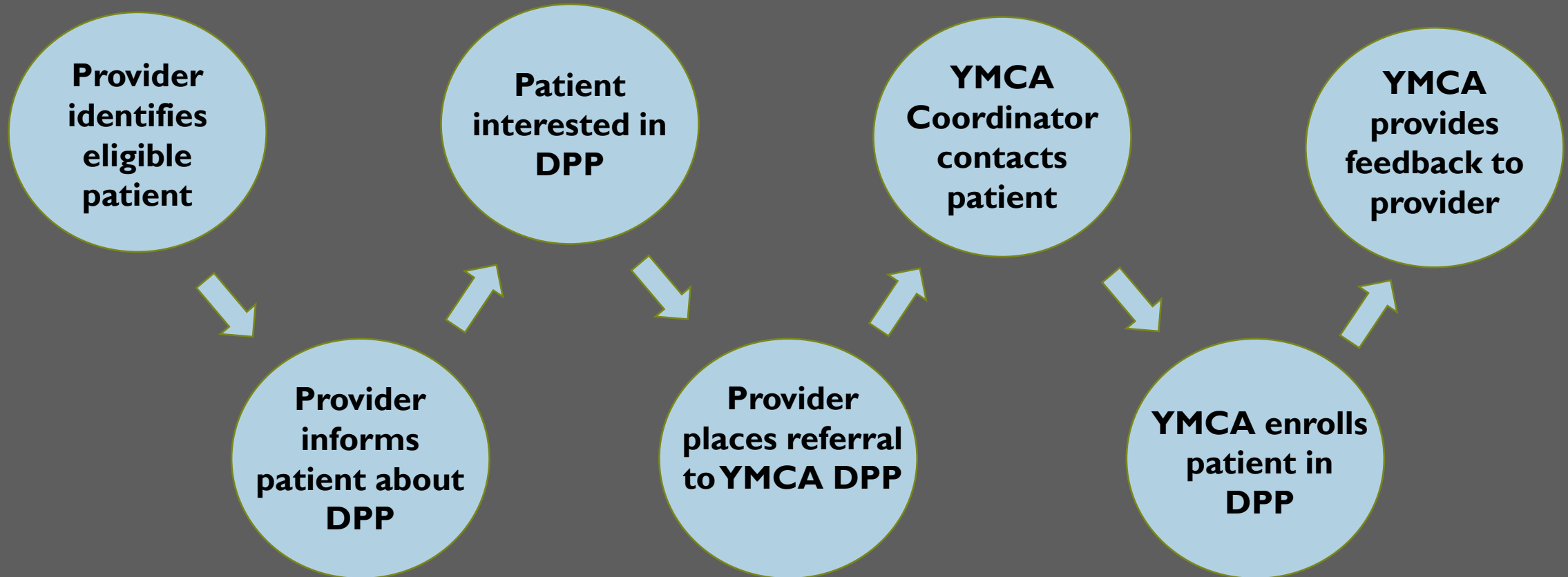
Component	Value	Date
HGBA1C	5.7	01/23/2019

Phone: 919-222-2222
Address: 137 ABC STREET
DURHAM NC 27713-7188

Referring provider information:
PCP: Scherr, Karen Amanda, MD
DUKE FAMILY MEDICINE MARSHALL PICKENS BUILDING
DUKE FAMILY MEDICINE CENTER
2100 ERWIN ROAD
MARSHALL I PICKENS BUILDING
DURHAM NC 27705-3941
Dept: 919-684-6721
Dept Fax: 919-681-7085
Loc: 919-684-6721

THE NEW ELECTRONIC REFERRAL: YMCA

REFERRAL FLOW FOR THE YMCA



Class: **External Referral**

Referral: Override restrictions

To provider:

Priority: **Routine** STAT ASAP

Process Inst.: Note about PRIORITY:

STAT Appointment within 24 hours
 ASAP Appointment within 7 days
 Routine Appointment in more than 7 days

Referral to program: **Online Eat Smart Move More** Other ← Select "Online Eat Smart Move more"

Last A1C Result:

Last BMI:

Comments:

Sched Inst.:

Scheduling Note:
 If referring to the YMCA program, the referral has been automatically routed and the YMCA will contact the patient.
 If referring to the Eat Smart Move More program, the patient has been given a printed referral and will self-enroll; no further action is needed.

**THE NEW ELECTRONIC REFERRAL:
 EAT SMART MOVE MORE PREVENT DIABETES**

Class: External Referral External Referral

Referral: Override restrictions
To provider:

Priority: Routine Routine STAT ASAP

Process Inst.: Note about PR

STAT	Appo
ASAP	Appo
Routine	Appo

Referral to program: Triar

You have selected Eat Smart Move More Add

Last A1C Result: 5.7

Last BMI: 24.21

Comments: Type ".dpp"

Component	Value	Date
HGBA1C	5.7	01/23/2019

Sched Inst.: Scheduling Note:
If referring to the YMCA program, the referral has been automatically routed and the YMCA will contact the patient.
If referring to the Eat Smart Move More program, the patient has been given a printed referral and will self-enroll; no further action is needed.

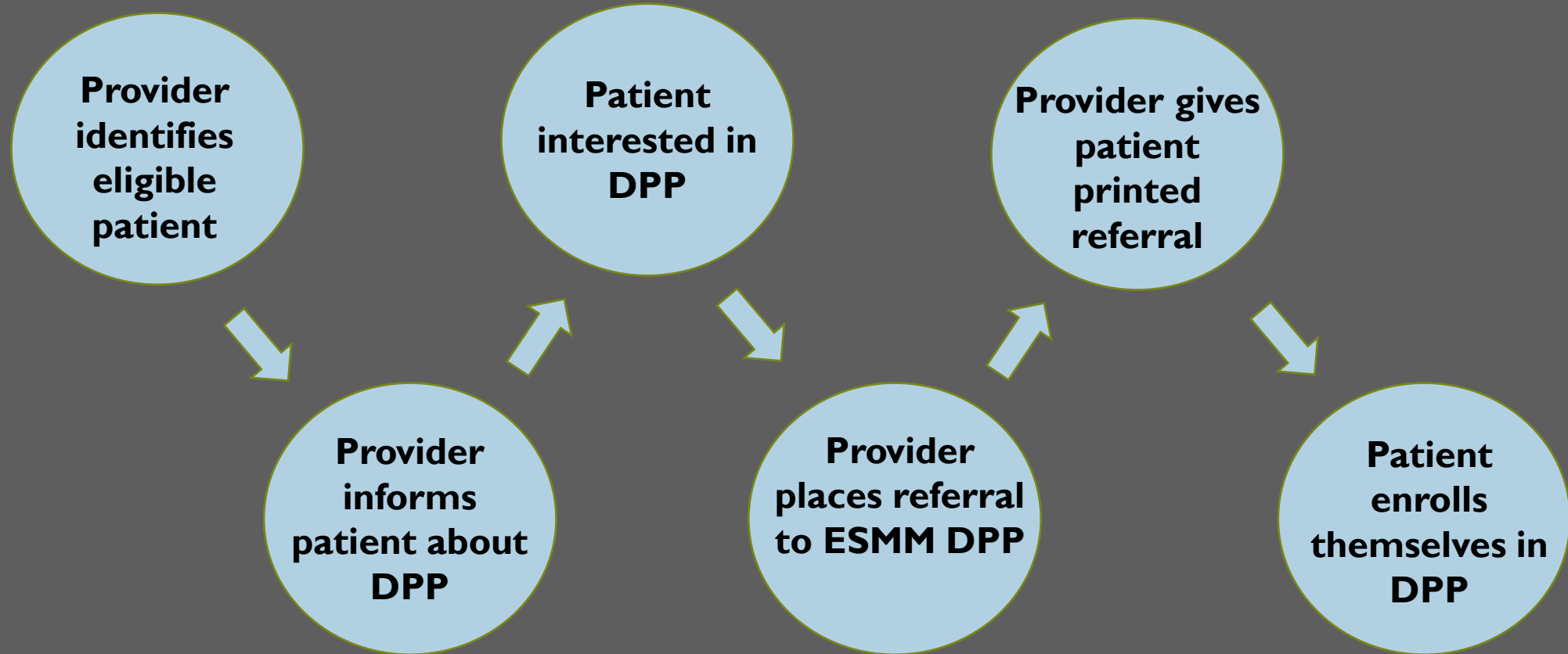
You are being referred to the online "Eat Smart, Move More, Prevent Diabetes Program." This is a CDC-approved, evidence-based 12 month program to help you eat healthier, increase your physical activity, better deal with stress, and lose weight. It has been shown to cut your risk in half of progressing from prediabetes to diabetes.

To sign up or learn more, please visit the website: <https://esmmpreventdiabetes.com> and click "enroll" on the top of the screen. When you fill out the enrollment form, make sure to click "yes" that you were referred by a physician or health professional and include the name of your PCP (Scherr, Karen Amanda, MD) in the box. You will need to enter your last A1c, which is Lab Results

Please contact our office at Dept: 919-684-6721 or send a MyChart message to your PCP if you have any issues completing this referral process.

**THE NEW ELECTRONIC REFERRAL:
EAT SMART MOVE MORE PREVENT DIABETES**

REFERRAL FLOW FOR EAT SMART, MOVE MORE, PREVENT DIABETES



PHASE II: PILOT

Identifying eligible patients

Creating the electronic referral

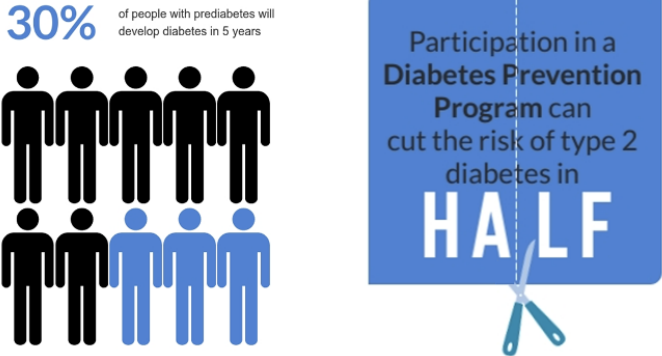
Retrospective referral of our
own patients

PROCESS FOR RETROSPECTIVE REFERRALS

Dear @M@ @FNAME@ @LNAME@,

Thank you for being a patient of Duke Family Medicine! We are writing to let you know about a free program to help improve your health.

Our records show that you have a condition that we call “prediabetes.” This means your blood glucose (sugar) level is not in the diabetes range, but it is higher than normal, which increases your risk of developing serious health problems including type 2 diabetes, heart disease, and stroke.



We have some good news — the Diabetes Prevention Program (DPP) can cut your risk of getting Type 2 diabetes in half, and we think you would benefit from the program. The DPP is a 12-month program led by a trained lifestyle coach that helps you learn to eat healthier, get more physical activity, better deal with stress, and lose weight.

DPPs usually cost about \$430, but right now it’s free to all North Carolina residents regardless of your insurance! The YMCA of the Triangle currently offers an excellent virtual online program. When COVID-19 restrictions are lifted, they will restart their in-person DPPs at several locations, and offer transportation, child-care, and a discounted medical membership to people who qualify.

The YCMA will be calling you in the next few weeks to tell you more about this program and can help you sign up if you are interested. We are here to support you in your journey to health. If you would like to talk more about your prediabetes, please call our office at 919-684-6721 to schedule an appointment.

Sincerely,
Duke Family Medicine, on behalf of your PCP @PCP@



OUTCOMES OF RETROSPECTIVE REFERRALS

Referred
(n = 52)

- Only 37% of patients were successfully contacted. The most common outcome was voicemail (44% of referrals).
- However, of the patients who were successfully contacted, 50% were enrolled and 16% were interested.

PHASE II: SUMMARY

- The creation of a new prediabetes registry allowed us to easily identify patients who could potentially benefit from the DPP (n = 5,723 at our clinic).
- Referral of our own patients allowed us to identify and fix issues with the new electronic referral process.

PHASE III: ROLL OUT

Education campaign for clinic providers

Providers prospectively refer their own patients

Post-intervention survey

GRAND ROUNDS

FMCH Grand Rounds is open to all members of the Duke Family Medicine & Community Health community, including faculty, staff, trainees, students, alumni, and friends of the department.



"Transdisciplinary Vertical Research Teams in Family Medicine and Community Health"

Speakers:

Teah Bayless, DO, assistant professor
Emily D'Agostino, DrPH, MEd, MA, assistant professor
Ashley Price, PhD, MPH, senior research program leader
Karen Scherr, MD, PhD, co-chief resident, family medicine
Julien Xie, MS4
Hanzhang Xu, PhD, assistant professor

Tuesday, November 10, 2020, 12-1 pm

PRESENTATION AT
DEPARTMENT GRAND ROUNDS

PRESENTATION AT CLINIC
PROVIDER MEETING

INCREASING UTILIZATION OF THE
DIABETES PREVENTION PROGRAM

Matthew Geisz, MD
Karen Scherr, MD, PhD
DFM All Provider Meeting
January 5, 2021

INFORMATION IN CLINIC NEWSLETTER

The Diabetes Prevention Program (DPP) see attachment is a CDC recognized, evidenced-based program focused on achieving weight loss. The DPP has been shown to decrease the risk of developing diabetes by 50% for patients with prediabetes. This program is free of cost to the patient! There is now a referral within Epic, "Ambulatory Referral to Diabetes Prevention Program", to two local DPP providers:

1) YMCA of the Triangle: Online and In-person classes available. Multiple locations throughout the Triangle. Patients may also be eligible for discounted membership to YMCA, although a membership is NOT required to participate in the DPP. Karen and Matt would encourage use of the YMCA DPP as we are partnering for the YMCA to provide feedback to providers on patient outcomes.


2) Eat Smart Move More: Online only. \$30 enrollment fee that is reimbursed following completion of the course.

Please consider referring your patients at risk of diabetes. Further information on eligibility and step-by-step referral instructions are attached. Contact Matt Geisz or Karen Scherr with questions.

FLYERS POSTED
IN CLINIC:
SIDE 1

PREVENT TYPE 2 DIABETES

TALKING TO YOUR
PATIENTS ABOUT
LIFESTYLE CHANGES

88 MILLION  88 million American adults — more than 1 in 3 — have prediabetes

MORE THAN 8 IN 10 adults with prediabetes don't know they have it

If your patients have prediabetes, losing weight by:

  &  **EATING HEALTHY** & **BEING MORE ACTIVE**

can cut their risk of getting type 2 diabetes in

HALF

Prediabetes increases the risk of:



TYPE 2 DIABETES **HEART DISEASE** **STROKE**


LIFESTYLE CHANGE PROGRAM



The lifestyle change program that is part of the CDC-led National Diabetes Prevention Program is proven to help prevent or delay type 2 diabetes. It is based on research that showed:

 **58%**

Weight loss of 5 to 7% of body weight achieved by reducing calories and increasing physical activity to at least 150 minutes per week resulted in a 58% lower incidence of type 2 diabetes

 **71%**

For people 60 and older, the program reduced the incidence of type 2 diabetes by 71%

 **27%**

After 15 years, lifestyle change program participants had a 27% lower incidence of type 2 diabetes

The lifestyle change program provides:



A trained lifestyle coach



CDC-approved curriculum



Group support



A full year of in-person or online meetings

Your patients will learn to make achievable and realistic lifestyle changes



Eat healthy



Incorporate physical activity into their daily routine



Manage stress



Solve problems that get in the way of healthy changes

PATIENT ELIGIBILITY



18 YEARS OR OLDER

AND



OVERWEIGHT

AND



DIAGNOSED WITH PREDIABETES

OR



DIABETES RISK SCORE ≥ 5

OR



PREVIOUSLY DIAGNOSED WITH GESTATIONAL DIABETES

FLYERS POSTED IN CLINIC: SIDE 2

HOW TO REFER PATIENTS TO THE DIABETES PREVENTION PROGRAM

PLACE THE REFERRAL ORDER IN EPIC

TRIANGLE YMCA

- 1** Search for the order by typing in **"amb ref diab"**
 - The full name of the order is the "Ambulatory referral to diabetes prevention program" (REF 519)
- 2** Select **"Triangle YMCA"** for the "referral to program"
- 3** **Follow the instructions** that pop up, which state the following:
 1. In the "To Provider" box, select **"Triangle YMCA"**
 2. In the "Comments" box, type **".dppymcareferral"**
- 4** Sign the order
- 5** The referral is routed
 - The referral will be automatically routed electronically to the YMCA's EHR
- 6** The YCMA contacts your patient
 - Staff will confirm eligibility, explain more about the program, explore barriers to enrollment/attendance, and help patients enroll in the program

EAT SMART MOVE MORE

- 1** Search for the order by typing in **"amb ref diab"**
 - The full name of the order is the "Ambulatory referral to diabetes prevention program" (REF 519)
- 2** Select **"Online Eat Smart Move More"** for the "referral to program"
- 3** **Follow the instructions** that pop up, which state the following:
 1. In the "Comments" box, type **".dpeatsmartmovemorereferral"**
- 4** Hand the printed referral to patient and encourage patient to self-enroll
 - Once signed, the referral will automatically print
 - The dotphrase "dpeatsmartmovemorereferral" that was placed in the comments will be included in the printed referral and instructs patients on how to enroll

PHASE III: ROLL OUT

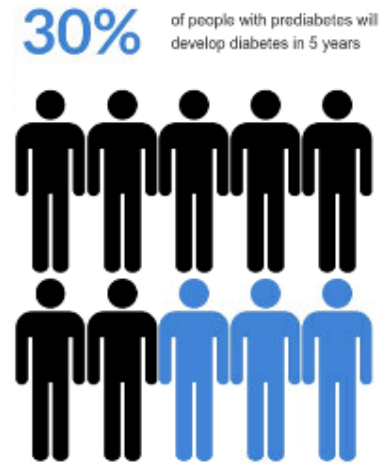
Education campaign for clinic providers

Providers prospectively refer their own patients

Post-intervention survey

PROSPECTIVE REFERRALS

As we've discussed before, you have prediabetes. This means your blood glucose (sugar) level is higher than normal, which increases your risk of developing serious health problems including type 2 diabetes, heart disease, and stroke.

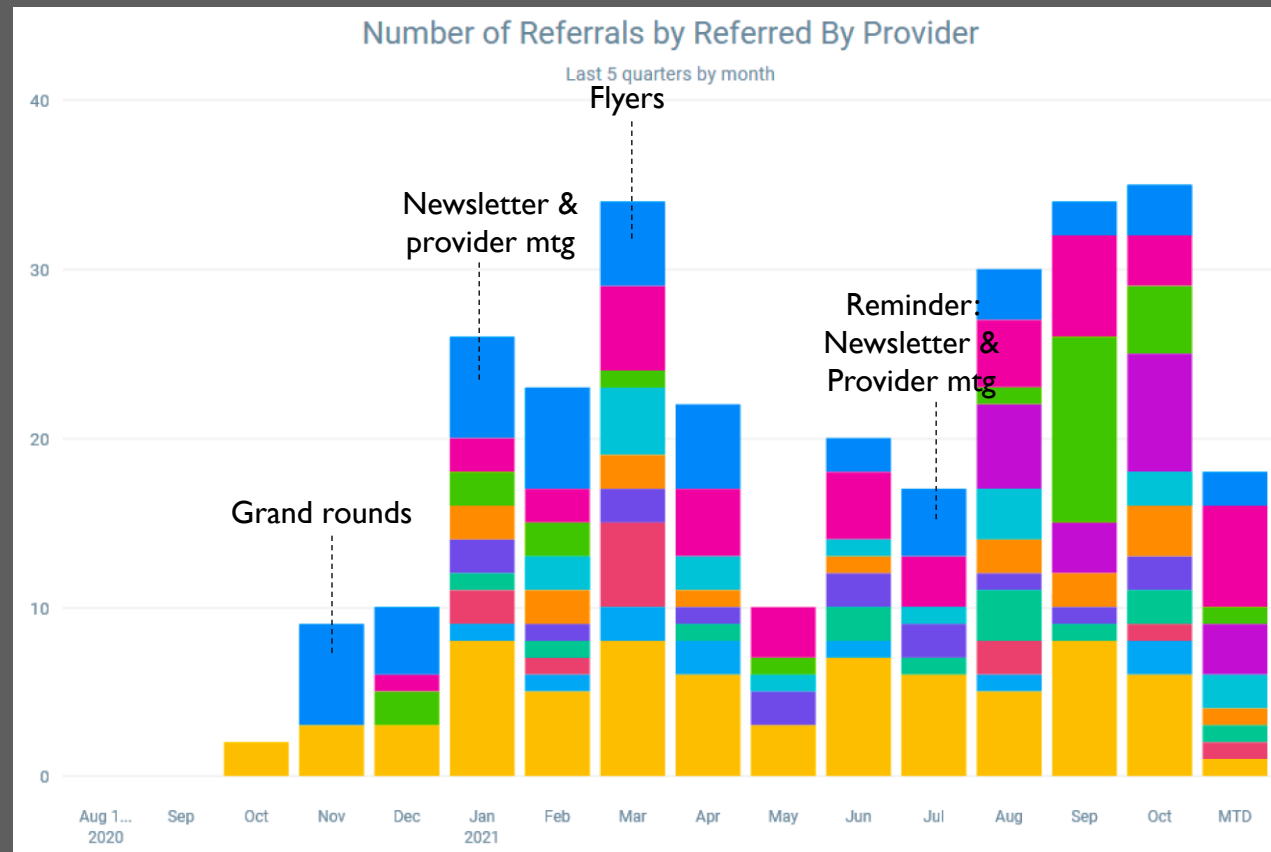


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DPPs usually cost about \$430, but right now it's free to all North Carolina residents regardless of your insurance! The YMCA of the Triangle currently offers an excellent virtual online program. When COVID-19 restrictions are lifted, they will restart their in-person DPPs at several locations, and offer transportation, child-care, and a discounted medical membership to people who qualify. There is also an online DPP through "Eat Smart, Move More, Prevent Diabetes" (you do have to pay \$30 at the beginning of this program, but it is given back to you later as long as you complete the program).

Please let me know if you are interested in a referral to a DPP by sending a MyChart message or calling 919-684-6721 and leaving a message stating you would like a referral. If you want to discuss your case more or have specific questions, please call 919-684-6721 to schedule an appointment with any Duke Family Medicine provider.

REFERRALS



PHASE III: ROLL OUT

Education campaign for clinic providers

Providers prospectively refer their own patients

Post-intervention survey

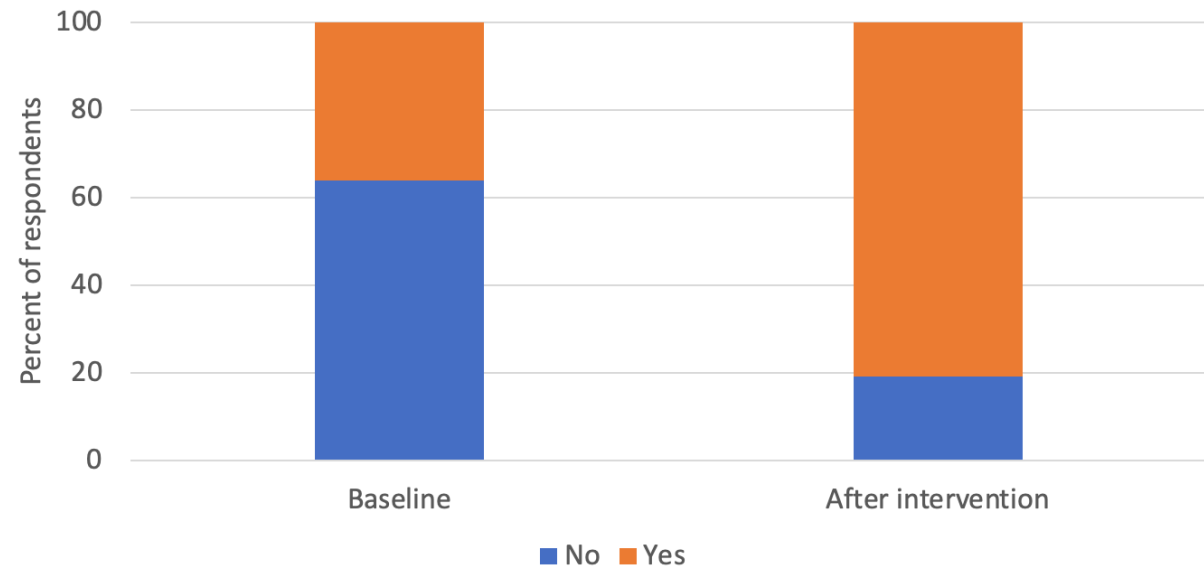


POST-
INTERVENTION
SURVEY

- 27 providers responded
 - 9 residents (75% response rate), did not include PGY-Is
 - 18 attendings (80% response rate)
- Imperfect pre/post survey
 - Provider turnover
 - Missing unique identifiers

AWARENESS

Are you aware that DPPs are currently available for free to all North Carolina residents at high risk for diabetes, regardless of insurance?



PROVIDER SELF-EFFICACY

How confident are you in your ability to identify which patients are eligible for the DPP?

IMPACT OF REFERRAL

When I treat a patient with prediabetes, I consider a referral to the DPP.

PROVIDERS' EVALUATION OF THE REFERRAL



A word cloud of terms used by providers to evaluate the referral process. The word 'easy' is the largest and most prominent, colored in a dark purple. Other words include 'convenient' (purple), 'streamlined' (red), 'helpful' (orange), 'auto-populates' (dark blue), 'electronic' (orange), 'workflow' (yellow-green), and 'simple' (dark blue).

streamlined
helpful
auto-populates
electronic
convenient
easy
workflow
simple

PHASE III: SUMMARY

- Providers were educated about the DPP through a variety of channels and are actively referring patients.
- 290 patients have been referred across the health system, mostly from Duke Family Medicine.

PHASE IV: NEXT STEPS

Further refinement of referral
Roll out to other clinics
Development of a “Best Practice
Advisory” (BPA)

SUMMARY

THE DPP: BARRIERS TO UTILIZATION

~~Cost~~

Difficulty identifying eligible patients

Cumbersome faxed referral process

Low provider and patient awareness and buy-in

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NEWS RELEASE

For Immediate Release: February 18, 2019

Blue Cross NC Invests \$5 Million to Combat Diabetes Epidemic in NC

Investment in Diabetes Free NC to cut diagnosis of Type 2 diabetes by expanding free access to diabetes prevention programs for all North Carolinians.

<https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/news-and-information/news/News%20Release%20Diabetes%20Free%20NC.pdf>

THE DPP: BARRIERS TO UTILIZATION

~~Cost~~

~~Difficulty identifying eligible patients~~

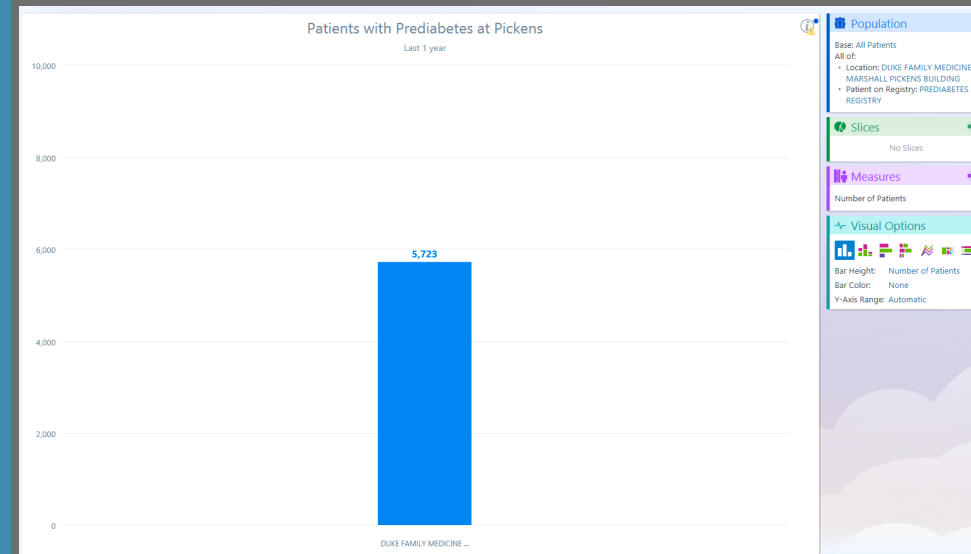
Cumbersome faxed referral process

Low provider and patient awareness and buy-in

Health Maintenance

[Address Topic](#) [Remove Override](#) [Document Past Immunization](#) [Edit Modifiers](#) [Report](#) [Update HM](#) [Guidelines](#)

Topic	Due Date	Frequency	Date Completed
Upcoming			
Influenza Vaccine (Season Ended)	Next due on 9/1/2020	Imm Details	1/1/2019
Adult Tetanus (Td And Tdap)	Next due on 11/8/2022	10 year(s)	11/8/2012 (N/S)
Diabetes Screening	Next due on 1/30/2023	3 year(s)	1/30/2020
Completed or No Longer Recommended			
HIV Screen	Completed	Once	9/9/2015
HPV Vaccines	Aged Out	Imm Details	



THE DPP: BARRIERS TO UTILIZATION

~~Cost~~

~~Difficulty identifying eligible patients~~

~~Cumbersome faxed referral process~~

Low provider and patient awareness and buy-in

Referral form to a diabetes prevention program

Send to: Fax: Email:

PATIENT INFORMATION	
First name	Address
Last name	
Health insurance	City
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	State
Birth date (mm/dd/yy)	ZIP code
Email	Phone

By providing your information above, you authorize your health care practitioner to provide this information to a diabetes prevention program provider, who may in turn use this information to communicate with you regarding its diabetes prevention program.

PRACTITIONER INFORMATION (COMPLETED BY HEALTH CARE PRACTITIONER)	
Physician/NP/PA	Address
Practice contact	City
Phone	State
Fax	ZIP code

SCREENING INFORMATION	
Body Mass Index (BMI)	Test result (one only)
Blood test (check one)	
<input type="checkbox"/> Hemoglobin A1C	
<input type="checkbox"/> Fasting Plasma Glucose	
<input type="checkbox"/> 2-hour plasma glucose (75 g OGTT) 140-199 mg/dL	
Date of blood test (mm/dd/yy):	

For Medicare requirements, I will retain this signed original document in the patient's medical record.

Date _____ Practitioner signature _____

OPTIONAL

By signing this form, I authorize you to use my diabetes screening results to the (insert program/organization name here) for the purpose of determining my eligibility for the diabetes prevention program and conducting other activities as permitted by law.

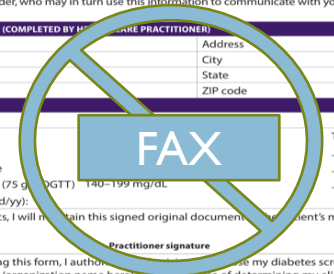
I understand that I am not obligated to participate in this diabetes screening program and that this authorization is voluntary.

I understand that I may revoke this authorization at any time by notifying my physician in writing. Any revocation will not have an effect on actions taken before my physician received my written revocation.

Date _____ Patient signature _____

IMPORTANT WARNING: The documents accompanying this transmission contain confidential health information protected from unauthorized use or disclosure except as permitted by law. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted to do so by law or regulation. If you are not the intended recipient and have received this information in error, please notify the sender immediately for the return or destruction of these documents. Rev. 05/30/14

* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥ 23 for Asian Americans and ≥ 25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.



AMB REF DIAB

🔍

📄 Panels (No results found)

🏠 Medications (No results found)

🏠 Procedures ⤴

Name
🏠 Amb Referral to Poet/Periop Diabetes
🏠 Ambulatory Referral to Adult Diabetes Education
🏠 Ambulatory Referral to Diabetes Prevention Program

Carroll J, Winters P, Fiscella K, Williams G, Bauch J, Clark L, et al. Process evaluation of practice-based Diabetes Prevention Programs: what are the implementation challenges? Diabetes Educ 2015;41(3):271-9.

THE DPP: BARRIERS TO UTILIZATION

~~Cost~~

~~Difficulty identifying eligible patients~~

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- Presentation at monthly provider meeting
- Information in weekly clinic newsletter
- Presentation at department Grand Rounds
- Laminated fliers posted in clinic
- Patient education via providers and information in After Visit Summaries

THANK YOU

- Sarah Sams, MD - Family Medicine Leads Emerging Leader Institute, American Academy of Family Physicians
- Anthony Viera, MD, MPH, Chair, Duke Department of Family Medicine and Community Health
- Susan Spratt, MD, Duke Endocrinology
- American Medical Association – Siga Vasaitis, Neha Sachdev, and Janet Williams
- The Triangle YMCA – Amy Ward, MA and Katherine Combs, MPH
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