Michigan Diabetes Promising Practices and Outcome-Based Programs

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Diabetes affects nearly 1 million Michigan citizens. Diabetes is common, costly and serious; but can often be prevented and managed when diagnosed. As the number of people with diabetes continues to increase, health care providers and others continue to look for the best ways to prevent or manage this disease. People who make healthy lifestyle changes can often prevent type 2 diabetes. (95% of people with diabetes have type 2 diabetes.) People with type 1 or type 2 diabetes can learn to self-manage their diabetes to feel better, stay healthier and reduce complications. Throughout 2011, the Diabetes Partners in Action Coalition (DPAC) Policy and Advocacy Workgroup has been active in compiling promising and outcomes-based diabetes programs in Michigan. For more information about any of these programs, please visit their websites or make a call to the contact person that is listed for each program.

Name of Program:	**CDC-YMCA United Health Care Diabetes Prevention Program**
Located:	National YMCA and CDC – Sites in Michigan to be determined
Program Summary:	Federal legislation passed in 2010 created the National Diabetes Prevention Program (NDPP) based on the outcomes from the Diabetes Prevention Program (DPP). The DPP showed that prevention works – modest weight loss and regular physical activity were proven effective in preventing type 2 diabetes. The NDPP is a lifestyle change program consisting of 16 weekly core sessions, followed by 6 monthly post-core sessions. Michigan is not included in the National YMCA pilot sites, however many Michigan YMCA branches have either applied or in the application process to implement the NDPP in their branch.
Evidence Base:	The DPP research study showed those who participated in the DPP reduced their risk of developing type 2 diabetes 58% by: losing 5% to 7% of body weight and being physically active at least 150 minutes per week.
Website	CDC: www.cdc.gov/diabetes/prevention/index.htm. National YMCA: http://ymca.net/diabetes-prevention
Contact Person/Information:	Kristi Pier- Michigan Diabetes Prevention and Control Program; 517-335-6937 PierK@michigan.gov

Name of Program:	**Group Visits for Diabetes Patients**
Located:	Statewide & Nationwide
Program Summary:	Most patients with diabetes receive their care from a primary care provider. Medical appointments are often brief and diabetes self-management education and discussion of lifestyle improvements are almost impossible to address in such short appointments. A new model of care called a “group visit” has been introduced. The group visit is led by a team consisting of a physician, nurse or diabetes educator and often a pharmacist. The group visit provides a cost effective medical appointment that improves the patient-provider relationship, provides more culturally competent care and improves patient outcomes. Group visits often blend clinical exams (such as eye, foot, etc.) as well as an educational, interactive component that can aid in increase in the understanding of diabetes and potentially improve self-management. A literature review has shown improved glycemic control of diabetes group visit participants.
Evidence Base:	http://clinical.diabetesjournals.org/content/26/2/58.full#sec-2
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Contact Person/Information:	Kathy Moran, DNP, CDE - My Self-Management Team, Inc. kathyjmoran@aol.com Greater Flint Health Coalition (has a Diabetes Group Visit Manual) http://www.gfhc.org/cp_diabetes_group_visit.html 810- 232-2228

Name of Program:	**Value-Based Insurance Design (V-BID)**
Located:	Nationwide
Program Summary:	Diabetes is a leading area for V-BID. The premise of value-based insurance design is removing barriers to essential high-value health services. V-BID strives to align patients' out-of-pocket costs, such as co-pays and premiums, with the value of high-value health services. By reducing barriers to high-value treatments (through lower costs to patients) and discouraging low-value treatments (through higher costs to patients) V-BID plans achieve improved health outcomes by increasing patient compliance with recommended treatments. For example, Caterpillar Inc.'s diabetes V-BID program resulted in, reduction of HbA1c levels from 8.7 to 7.2 in 50% of enrollees over the course of one year, measurement of HbA1c levels in 96% of enrollees and attainment of recommended activity levels by the Surgeon General in 72% of enrollees. Other examples show similar results. UnitedHealthcare, a consumer-oriented health plan, anticipates that their V-BID Diabetes Health Plan will result in savings of $500 per member per year. V-BID concepts and data have been lead by the University of Michigan.
Evidence Base:	http://www.sph.umich.edu/vbidcenter/publications/index.html Diabetes Outcomes: http://www.sph.umich.edu/vbidcenter/publications/case_studies/UnitedHealthcare_CaseStudy.pdf http://www.sph.umich.edu/vbidcenter/publications/case_studies/MBGH_CaseStudy.pdf http://www.sph.umich.edu/vbidcenter/publications/case_studies/CityofSpringfield_CaseStudy.pdf http://www.sph.umich.edu/vbidcenter/publications/case_studies/Caterpillar_CaseStudy.pdf
Website	http://www.sph.umich.edu/vbidcenter/

Name of Program:	**Diabetes PATH (Personal Action Toward Health)** (patterned after the Stanford Diabetes Self-Management Program developed by Kate Lorig, R.N. Dr. P.H, Director of the Stanford Patient Education Research Center and Professor of Medicine in the Stanford School of Medicine.)
Located:	Statewide and nationally
Program Summary:	Developed at Stanford University, the Diabetes Self Management Program (called Diabetes PATH in Michigan) is designed specifically to enhance patient confidence in their ability to manage their disease – diabetes in this case- and to work more effectively with their health care providers. The six week program

	has several components: • skills mastery (participants complete weekly action plans and report results), • modeling (peer leaders who have diabetes or care for someone with diabetes facilitate the workshops and demonstrate or "model" the skills), and • action planning with social support (group members systematically share their successes and solutions). The effectiveness of Diabetes PATH lies in the use of lay language, especially when providing diabetes specific information, in tandem with a process that engages the patient to take action toward a healthy lifestyle.
Evidence Base:	The original diabetes self-management program was developed in Spanish. After successful outcomes were found with that program, the Stanford Patient Education Research Center began the randomized, controlled study to test the workshop's effectiveness for English-speakers. The study was completed in 2008 and data is now being analyzed. Results from the Spanish program, however, showed that the program participants, as compared with usual-care control subjects, demonstrated improved health status, health behavior, and self-efficacy, as well as fewer emergency room visits at four months. At one year, the improvements were maintained and remained significantly different from baseline condition.
Website	http://mihealthyprograms.org/ http://patienteducation.stanford.edu/programs/diabeteseng.html
Contact Person/Information:	Karen McCloskey, Michigan Arthritis Program 517-335-1236 McCloskeyK@michigan.gov

Name of Program:	Racial and Ethnic Approaches to Community Health **(REACH) Detroit Partnership,** a community project of Community Health and Social Services (CHASS) Center, Inc.
Located:	Detroit, MI
Program Summary:	The CHASS/REACH Partnership focuses on diabetes care. REACH works in several African American and Hispanic communities in the city of Detroit. The CHASS/ REACH program seeks to educate and empower families, communities, and healthcare providers to prevent or better manage diabetes through support groups, and community-wide healthy lifestyle activities.
Evidence Base:	In randomized control trails, participants of the CHASS/REACH programs in Detroit showed an increase in their ability to care for their diabetes and decreases in A1C levels and LDL levels. http://healthylifestyles.ssw.umich.edu/publications/pubindex.html
Website	http://www.reachdetroit.org/
Contact Person/Information:	Gloria Palmisano, Project Manager REACH Detroit Partnership c/o CHASS 5635 W. Fort St. Detroit, Michigan 48209 313-849-3920 Fax: 313-849-0824 gpalmisano@chasscenter.org

Name of Program:	**West Michigan Glycemic Collaborative (WMGC)**
Located:	West Michigan and reaching out to entire state of Michigan
Program Summary:	The WMGC came together initially to measure, redesign and improve treatment and glycemic (blood sugar) control in hospital patients with diabetes. This resulted in the development of a set of "best practices for inpatient diabetes care." Three acute care hospital systems collaborated to improve patient care in diabetes and acute hyperglycemia to improve hospital outcomes and contribute to the improved health status of the West Michigan community. Systematically, the WMCG is improving hospital admission and discharge processes as well as improving a patient's transitions back to their primary care physician. They have demonstrated that individual hospital implementations of evidence-based treatments via a collaborative model can improve the health status of a community. Additionally they are improving and researching patient follow-up processes proven to reduce downstream complications and costs. The WMGC, which started as a hospital collaborative, is now a health-system collaborative focusing on diabetes education, research, system process changes, outcomes, leadership and patient advocacy.
Evidence Base:	Program results were verified upon publication of West Michigan glycemic control measure rates, compared to state and national averages. Information upon request.
Website	None available at this time
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Name of Program:	**Diabetes Self-Management Education**
Located:	Statewide in Michigan
Program Summary:	Diabetes Self-Management Education (DSME) is an interactive, collaborative, ongoing process involving individuals who have diabetes or are at risk of developing the disease and diabetes educators. This process includes: • Assessment of individual needs • Identification of specific diabetes preventive or self-management goals • Education and behavioral intervention designed to help individuals achieve identified self-management/prevention goals • Evaluation and support of self-management efforts and future needs Diabetes self-management education is a critical part of the medical plan for people with diabetes or who are at risk for development of the disease.
Evidence Base:	Diabetes education is effective for improving clinical outcomes and quality of life, at least in the short-term (1-7) (below) . 1. Brown SA: Interventions to promote diabetes self-management: state of the science. *Diabetes Educ* 25 (6 Suppl.):52– 61, 1999 2. Norris SL, Engelgau MM, Naranyan KMV: Effectiveness of self-management training in type 2 diabetes: a systematic review of randomized controlled trials. *Diabetes Care* 24:561–587, 2001 3. Norris SL, Lau J, Smith SJ, Schmid CH, Engelgau MM: Self-management education for adults with type 2 diabetes: a meta-analysis on the effect on

	glycemic control. *Diabetes Care* 25:1159–1171, 2002 4. Norris SL: Self-management education in type 2 diabetes. *Practical Diabetology* 22:713, 2003 5. Gary TL, Genkinger JM, Guallar E, Peyrot M, Brancati FL: Meta-analysis of randomized educational and behavioral interventions in type 2 diabetes. *Diabetes* *Educ* 29:488 –501, 2003 6. Deakin T, McShane CE, Cade JE, et al. Review: group based education in self management strategies improves outcomes in type 2 diabetes mellitus. *Cochrane Database Syst Rev* (2): CD003417, 2005 7. Renders CM, Valk GD, Griffin SJ, Wagner EH, Eijk van JThM, Assendelft WJJ: Interventions to improve the management of diabetes in primary care, outpatient, and community settings: a systematic review. *Diabetes Care* 24: 1821–1833, 2001
Website	http://www.michigan.gov/mdch/0,1607,7-132-2940_2955_2980-13791--,00.html
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