Bending the Trend: Kaiser Permanente's Approach to Diabetes Prevention

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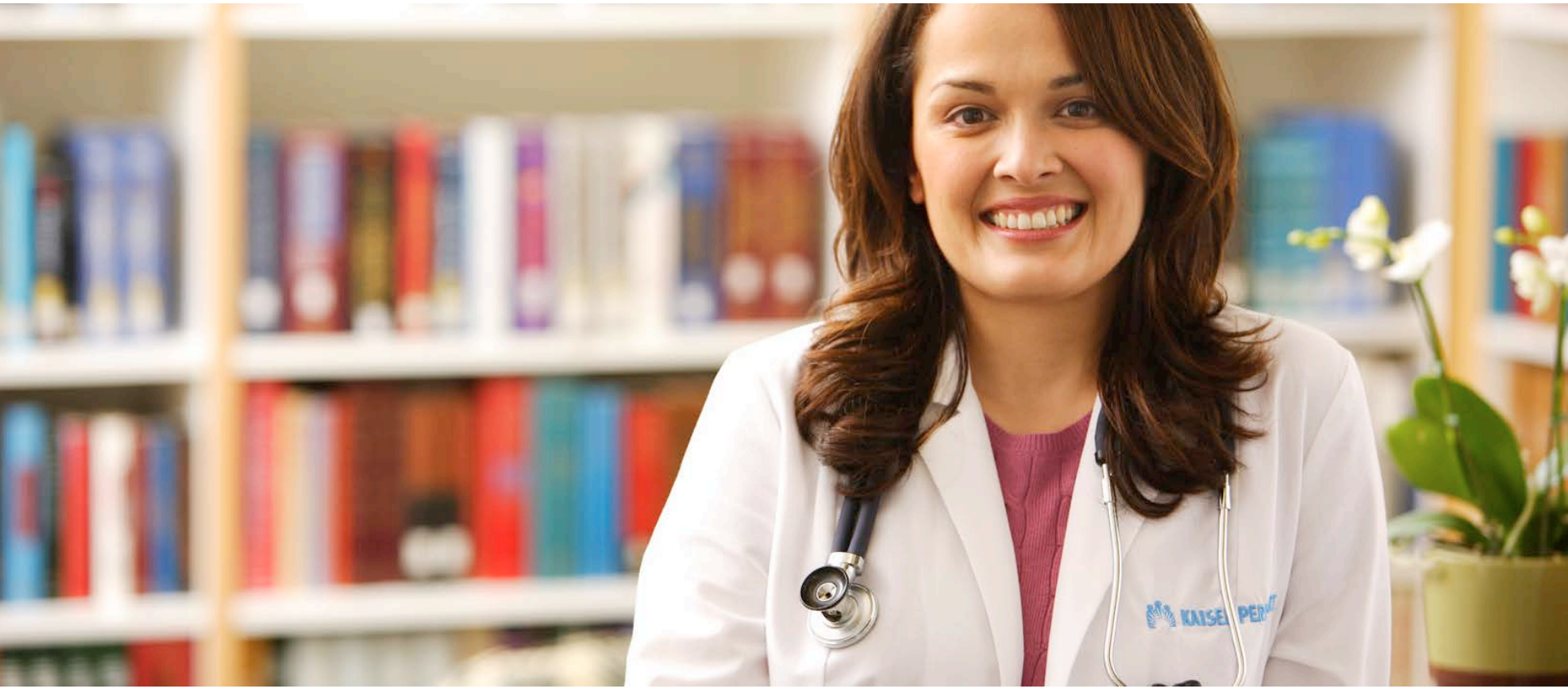
NCHICA: Navigating the Transition to Value
March 16, 2016



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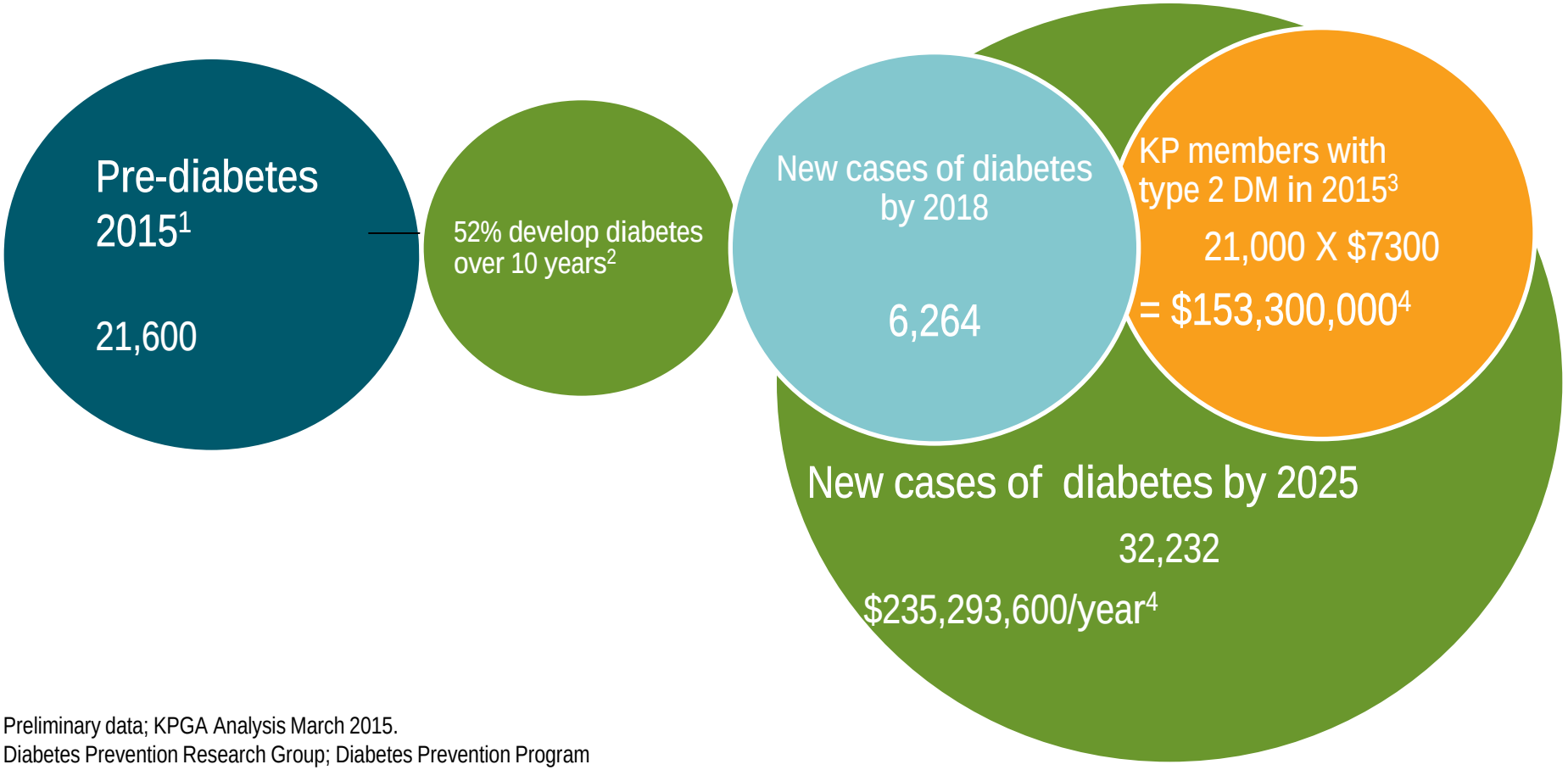
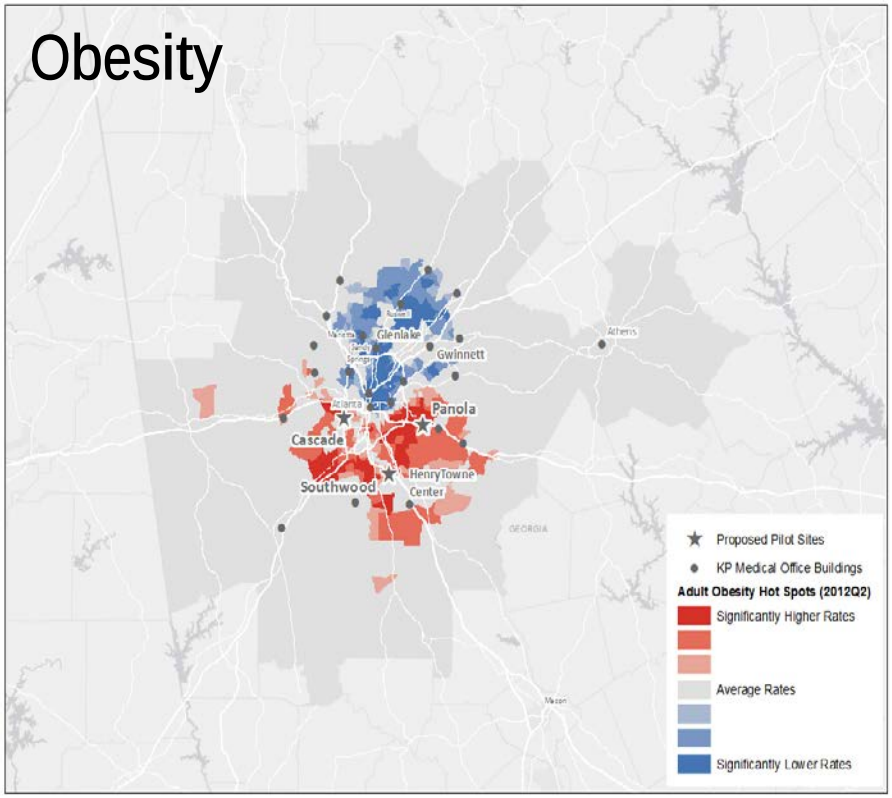
KP Diabetes Burden to Surge Over Time

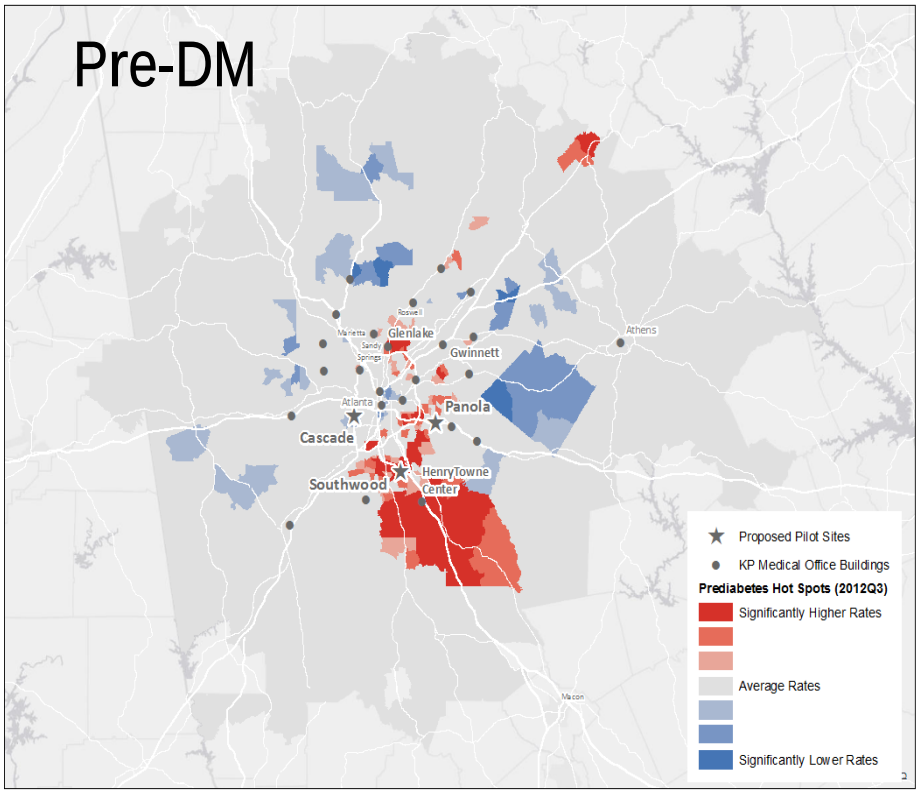


1 – Preliminary data; KPGA Analysis March 2015.
2 – Diabetes Prevention Research Group; Diabetes Prevention Program
3 – Preliminary data; CMI Analysis, as of Dec 31 2013. CORE KP HEDIS Diabetes cohort, minus expected 10% of Type 1 diabetes per CDC national prevalence
4 – Based on average annual medical expenditure estimates, Vojta et al, Hlth Aff, Jan 2012. Effective Interventions for Stemming Diabetes and Pre-Diabetes (513,375 x $7300)

Adult Obesity & Pre-diabetes in KP Georgia

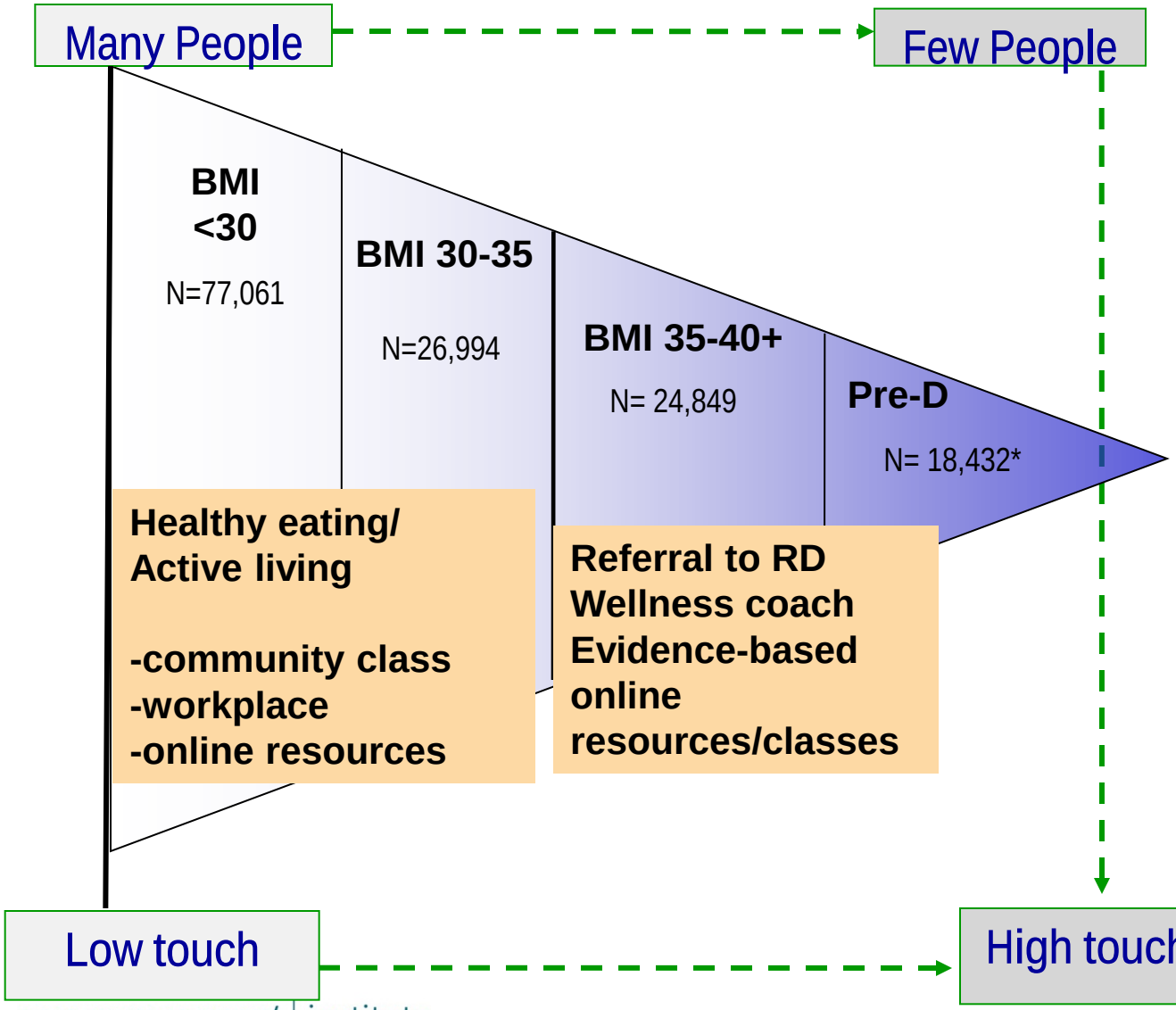


Obesity
Blue zone: 21-23%
Red Zone: 45-50%



Pre-diabetes
Blue zone: 3-4.5%
Red Zone: 6-7%

"The Science" – KP Georgia Disease Burden Targeted Programming Based on Risk and Modality



Segment population to focus on most at risk for disease and disability

Partner with employers and community benefit

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* Projected end 2014

The Team

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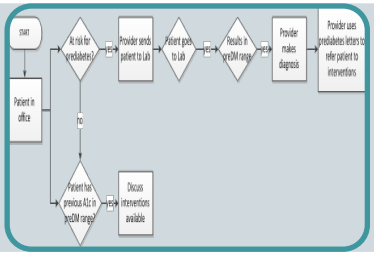
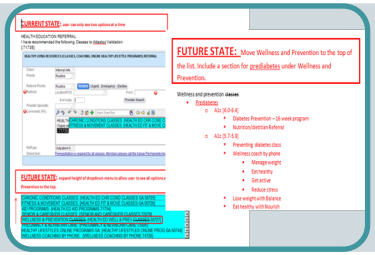
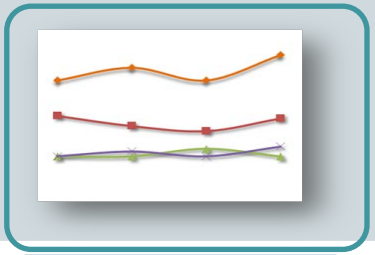
Where we started: KP-GA demonstration aims

Aim	Primary Drivers	Secondary Drivers	Initiatives
Improve health outcomes in pre-diabetes and obesity and increase levels of physical activity in adult members and KP employees.	**1) Person with obesity with co-morbidities (HTN, diabetes, degenerative joint disease (BMI> 35): Manage to live healthier with chronic conditions**	**Medical Weight Management** • Increase screening rate for members at risk for DM • Provide multiple pre-DM intervention modalities • Increase access to program modalities for 8-20% of pre-DM members • Scale pre-DM intervention modalities from 4 demonstration MOBs to region	Group Appt for Obesity • Medications & Obesity Clinic • VLCDs/LCDs (Optifast) • Bariatric Surgery
	2) Pre-Condition/At risk for Diabetes: Bend the trend for DM in KP GA by addressing pre-diabetes and reducing **the conversion to diabetes**		• In person DPP (KP, community, workplace) • In person single session pre-DM class • Online Omada Prevent (DPP) • Telephonic Wellness Coach • Care Delivery: RD visit
	3) High Risk Members: Slow or halt the progression to chronic disease by addressing those with BMI > 35 (high touch)	• Increase referrals to KP and community weight mgmt and PA programs • Increase referrals to wellness coaching	• KP Healthy Workforce Programs • KPGA Weight Mgmt Classes • GA Community Weight Mgmt Classes • KPGA Physical Activity Classes
	4) Moderate and Lower Risk Members: Slow or halt the progression to higher BMI by addressing those with BMI 30-35. "Maintain don't gain" for members BMI < 30	• Design and leverage "know your risk" poster to increase engagement in healthy behaviors • Increased referrals to Maintain Don't Gain (year-round messaging) starting with employees and moving to members • Leverage community, online engagement	• KP Healthy Living Classes • Balance Online Program • Everybody Walk • YMCA programs, Weight Watchers, Community

KP-GA has been building the infrastructure and capacity for Pre-DM screening, referral, and intervention







Step 1: Established and invested in DPP capacity

Step 2: Used PI and systems design to build and test CQI pathway. Implemented POE Screening Decision support & scaled outreach

Step 3: Build KPHC Referrals to Pre-DM Resources (2016)

Test & Deploy DPP resources (online and in-person)

Step 4: Develop tracking system to monitor and learn from outcomes (2016)

Performance to Goal

Screening

POE care gap goal: 80%
Current: 47.5% for screening
43% for rescreening (Nov)

Referrals

Goal: 90-100%
Current: 68% for efforts at Panola, Cascade, HTC, SW

Interventions

Goal: 8 - 20%
Current: DPP: 332 enrolled
Omada: 452 participants have completed or in process since 11/13. Coaches: June –Dec: 33 referrals (40% uptake)

Evaluation

Goal: 5-7% weight loss
Current: In-person DPP 39% (93) achieved goal by wk 16; Omada: 45% (141) achieved goal by wk 16 and 43% at wk 52

Prediabetes POE Screening Criteria

Group 1: Screening

- Those at-risk with normal lab value at last lab test (A1c<5.7) and that lab test was >3 years ago **or** those at-risk who have never been tested. Exclude anyone w/ DX of DM, prediabetes, and current pregnancy.
  - If age >45: test; if normal results, retest every 3 years
  - If age 18-45, last BMI >30 and has one of the risk factors below: test; if normal results, retest every 3 years
    - Risk factors
      - Physical Inactivity: <150 min
      - First-degree relative with diabetes
      - Member of a high-risk ethnic group: Black/African American, Latino, Native American, Asian American, Pacific Islander
      - Diagnosis of gestational diabetes, polycystic ovarian syndrome (PCOS), Metabolic Syndrome, HTN, HF, CAD, or CKD.
      - Last HDL cholesterol level < 35 mg/dl (0.90 mmol/l) and/or a triglyceride level > 250 mg/dl (2.82 mmol/l)
      - Other clinical conditions associated with insulin resistance (e.g., severe obesity [defined as BMI ≥ 40], acanthosis nigricans, adhesive capsulitis, hyperinsulinemia)

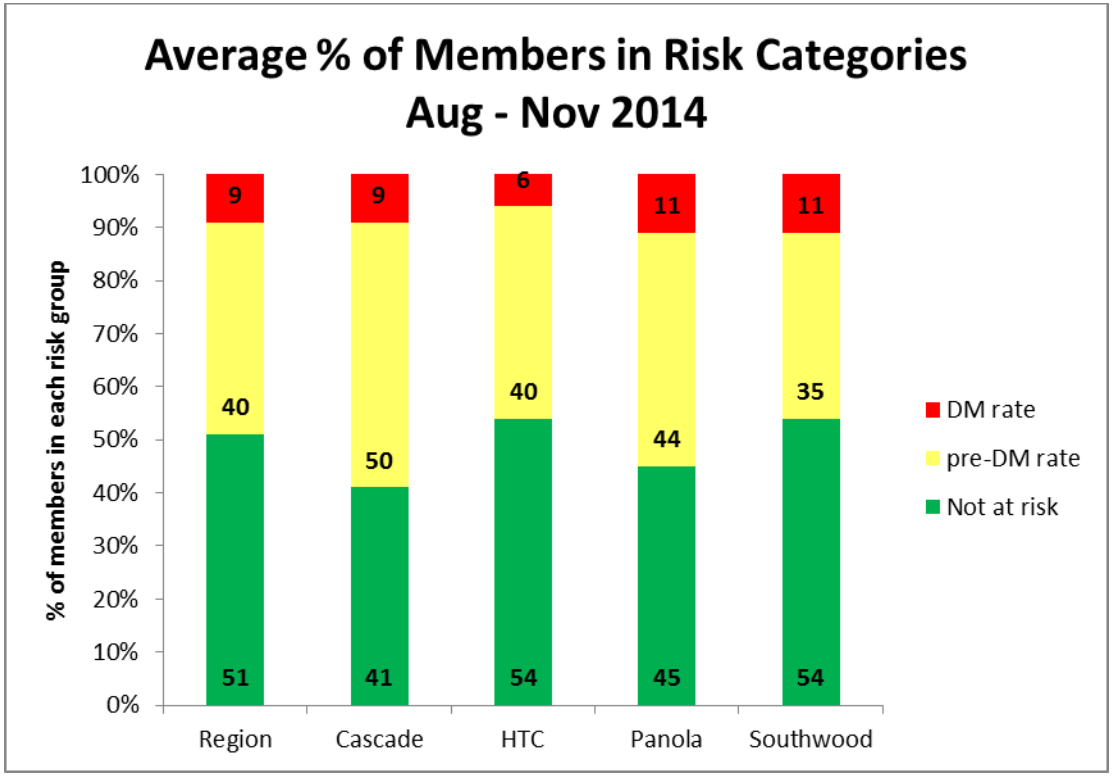
Group 2: Retesting

- Those with past pre-DM lab value (A1C ≥ 5.7%). Exclude anyone with diagnosis of diabetes and current pregnancy.
- Screening frequency according to risk
  - Red: every 1 year
  - Yellow: every 2 years
  - Green: every 3 years

BMI / A1c	Missing	<25	25-29	30-34	35+
5.7-5.8	0.0%	0.1%	0.1%	0.1%	0.4%
5.9-6.0	0.5%	0.4%	0.4%	0.9%	1.4%
6.1-6.2	1.8%	0.8%	1.9%	3.2%	4.3%
6.3-6.4	6.4%	6.7%	12.6%	12.5%	15.7%

- Estimated 1 year incidence of DM by BMI and A1c category

About 50% of those screened are Pre-DM (42%) or DM (9%)

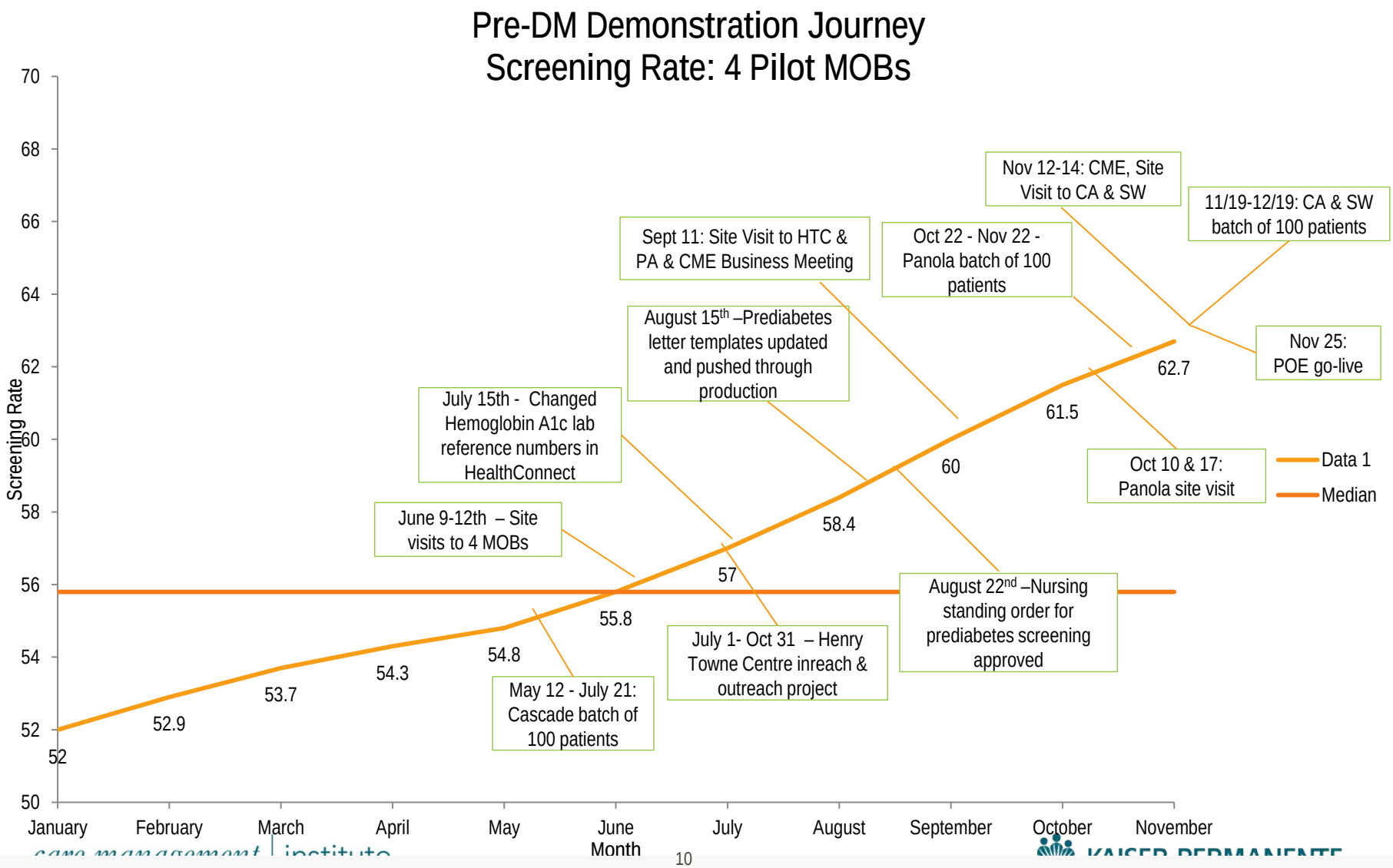


On average, 663 members per month tested in pre-DM range and 147 members per month tested in DM range in the region between Aug – Nov 2014.

At current screening levels, KP-GA would expect to identify about 8,230 pre-diabetic members (of the total 27K predicted pre-DM members) in 2015.

Assuming 10-20% uptake, demand for pre-diabetic interventions to total 800-1600 in 2015.

We have seen screening rates rise at the 4 MOBs….



Regional: 43.4%	44.2%	45.0%	45.8%	46.3%	47.2%	48.1%	49.2%	50.3%	51.5%	52.4%

DPP and Omada have been well-received and effective

	In person DPP	Online DPP (Omada Prevent)
Start date	July 2014	Oct 2013
# of Enrollees	182 (156 attended ≥ 1 class)	465
Completed at least 4 classes	127 people (81%)	409 people (91%)
Completed at least 9 classes	97 people (62%)	354 people (87%)
Lost 5% of starting weight	52 people (54%)	185 people (41%)*

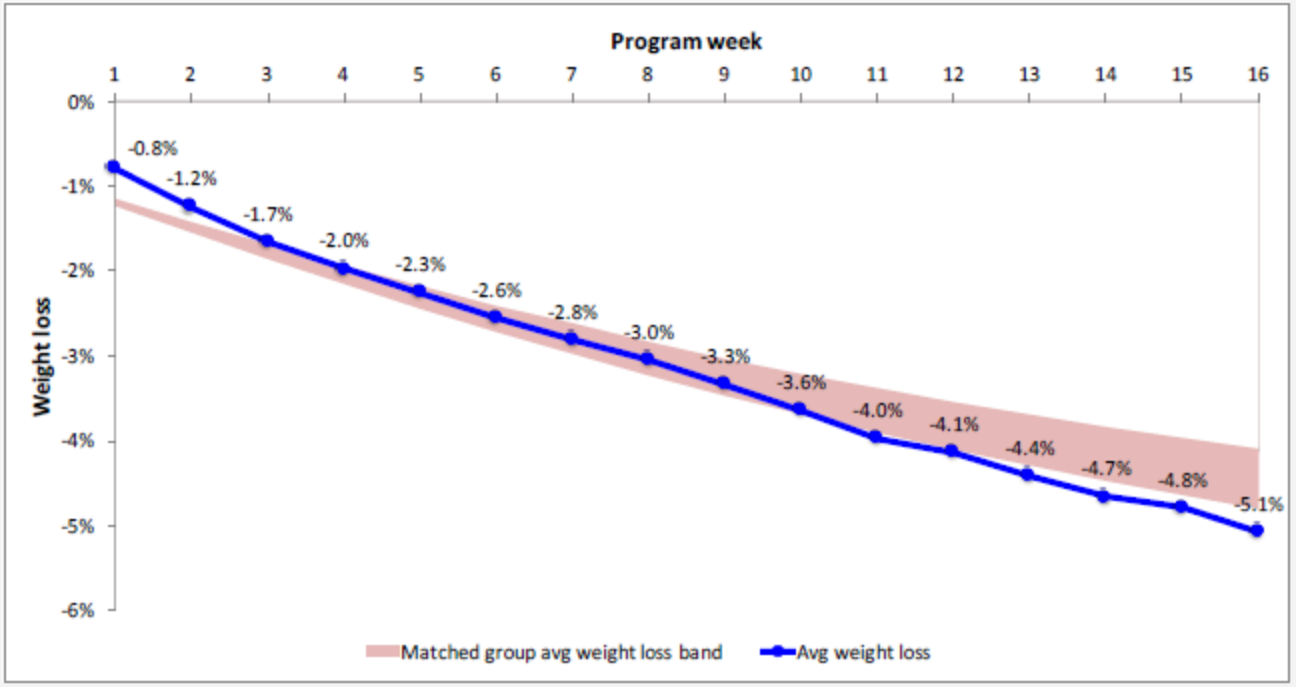
*Indicates people who completed at least 9 sessions and had their final weight at session 16

KPGA Prevent Participant Outcomes

Outcomes

Core Weight Loss Outcomes

- We see better than expected numbers, with KPGA outcomes exceeding matched cohort performance



- The blue trend line represents the average weight loss of all program starters that have weighed in during that current week
- The red shaded area represents the expected performance (95% confidence interval) of client participants when compared to a matched cohort group based on age, gender, and other key factors

KPGA Projected Risk Reduction

Outcomes

KPGA Projected Risk Reduction*

- Projected risk reduction by weight-loss range shows a significant impact at the individual participant level, with 40 participants reducing their risk for developing type 2 diabetes by 85%.

Weight-Loss Range	No. of Participants	Projected 3 year risk reduction[1]
0 - 3%	80	35%
3 - 5%	56	38%
5 - 7%	51	54%
7 - 10%	50	64%
10%+	40	85%

* Assumes week 16 results will stay constant out to week 26

1 - Maruther NM, Ma Y, Delahanty LM, et al. Early responses to preventative strategies in the diabetes prevention program. J Gen Intern Med. 2013;28(12):1629–36.

Lessons and Challenges

- Ensuring there are enough DPP classes across the region to meet demand
- Targeting works: we're reaching members with both pre-DM and DM
- Members like the resources that are offered to help them make behavior changes
- Members who utilize the pre-DM are losing weight!
- 80% of participants lost some weight and 52% lost 5% or more which reduces risk for conversion to diabetes

Questions?

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