WYOMING MEDICARE RURAL HOSPITAL FLEXIBILITY (FLEX) PROGRAM

WY Quality Improvement Roundtable

January 11, 2018

Facilitated By: Rochelle Schultz Spinarski, Rural Health Solutions

AGENDA

MBQIP: Reporting Changes and Reminders

QHi: Reminders, Reporting, and Next Steps

Diabetes Prevention Program – Updates and Changes

Flex Program Updates

Upcoming Meetings and Reminders

FLEX PROGRAM: QI

MBQIP & QHi

MBQIP: MEDICARE BENEFICIARY QI PROJECT

National Flex Program initiative that encourages and supports CAHs participation in CMS' Hospital Compare along with other areas of rural relevant QI.

2018 MBQIP MEASURES

*Immunizations

- **HCP/OP-27**: Influenza vaccination coverage among healthcare personnel
- **IMM-2**: Influenza Immunization

*HCAHPS:

- Communication about Nurses
- Communication about Doctors
- Responsiveness of Staff
- Pain Management
- Communication about Meds
- Cleanliness of Hospital
- Quietness of Hospital
- Discharge Information
- Care Transitions
- Overall Rating
- Willingness to Recommend

Antibiotic stewardship program established

*EDTC:

- EDTC-1: Administrative Communication (2 data elements)
- EDTC-2: Patient Information (6 data elements)
- EDTC-3: Vital Signs (6 data elements)
- EDTC-4: Medication Information (3 data elements)
- EDTC-5: Physician or Practitioner Generated Information (2 data elements)
- EDTC-6: Nurse Generated Information (6 data elements)
- EDTC-7: Procedures and Tests (2 data elements)
- All Data Elements

*Outpatient:

- **OP-1:** Median time to Fibrinolysis
- **OP-2:** Fibrinolytic Therapy Received within 30 minutes
- **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention
- **OP-4:** Aspirin @ arrival
- **OP-5:** Median time to ECG
- **OP-18:** Median time ED to discharge
- **OP-20:** Door to diagnostic evaluation by a qualified medical professional
- **OP-21:** Median time to pain management for long bone fracture
- **OP-22:** Patient left without being seen

*ED:

- ED-1: Median Time from ED Arrival to ED Departure for Admitted ED Patients
- ED-2: Admit Decision Time to ED Departure Time for Admitted Patients

Note: CAHs should continue to collect these measures through Q1 2018 encounters (due 8/1/2018).

MBQIP ANTIBIOTIC STEWARDSHIP AND INPATIENT ED-1- AND ED-2 REPORTING FOR FISCAL YEAR 2018.

Inpatient ED-1 and ED-2: The first quarter of required reporting is 3Q 2017 (submission deadline February 1, 2018). Video training for reporting: https://www.youtube.com/watch?v=HEISUJ7AZGQ&list=PLrX6m5cvp8hAEJXD3Z1NeP_o1AxyTJw5w&index=8

Antibiotic Stewardship: CAHs should submit the 2017 NHSN Annual Facility Survey: https://www.cdc.gov/nhsn/forms/57.103_pshospsurv_blank.pdf. CDC encourages all CAHs to complete the survey by March 1, 2018.

- **Upcoming webinar:** FORHP/CDC webinar for CAHs on **January 23, 2018 1:00-2:00PM CST** focusing on completion of the Annual Facility Survey and to answer questions you have about the survey. Register here: **https://cc.readytalk.com/registration/#/?meeting=uwh6mhxlpx6a&campaign=6u5vm83tbs31**

MBQIP: UPCOMING REPORTING REMINDERS

January 31, 2018

Emergency Department Transfer Communication (EDTC):

Patients seen Q4 2017 (October, November, December)

Submitted to Kyle Cameron or entered into QHi

February 1, 2018

CMS Population and Sampling (optional)*

Patients seen Q3 2017 (July, August, September)

Inpatient and outpatient

Entered via the Secure Portal on QualityNet

Contact Shanelle Van Dyke or Kyle Cameron for more information

February 1, 2018

CMS Outpatient Measures:

Patients seen Q3 2017 (July, August, September)

CMS Hospital Outpatient Reporting Specifications Manual version 10.0a

Submitted to the QualityNet warehouse via CART or by vendor

CART version – 1.15

February 15, 2018

ED-1, ED-2, and IMM-2:

Patients seen Q3 2017 (July, August, September)

Submitted to the QualityNet warehouse via Inpatient CART or by vendor

March 1, 2018

NHSN Facility Survey

MBQIP QUESTIONS?

Measures:

- Quality
- Financial and Operations
  - Department Level
- Patient Satisfaction

Paid for By the Wyoming Flex Program for all CAHs to Use

https://www.qualityhealthindicators.org/

QHI PARTICIPATING HOSPITALS

Data At/Near Current

Crook County

North Big Horn Hospital

Powell Valley Healthcare

South Lincoln Medical Center

Weston County Health Services

Data Entry Needed

Star Valley Medical Center

Platte County Memorial Hospital

Torrington Community Hospital

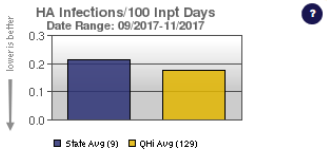
All Others: Consider using QHi for quality and financial benchmarking. Contact Rochelle for more information/ sign-up.

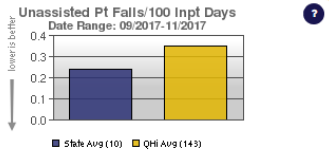
https://www.qualityhealthindicators.org/

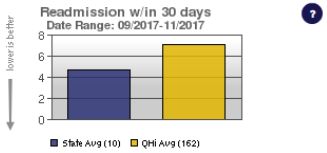
Rochelle Spinarski
Mode: State
Provider Kind: Hospital
(Switch Modes)

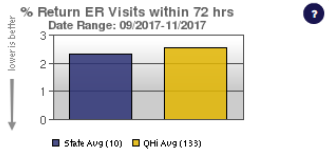
- Home
- Data Submissions
- Imports
- Reports
- Dashboards
- My Profile
- Administration
- Logout
- Help

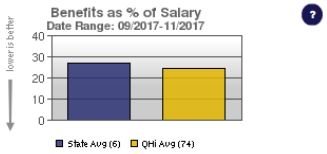
Core Measures Dashboard

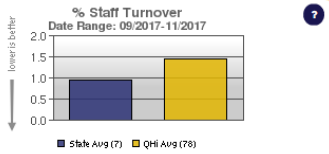


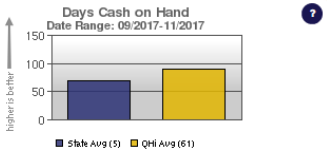


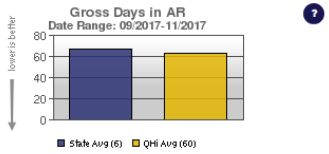












Change start month:

Default month selection

Note: Provider specific data will not display on quality measure graphs for providers with no occurrences during the reporting period.

Share Your Story

Success Stories from the Kansas Healthcare Collaborative HIIN

The Kansas Healthcare Collaborative supports 117 Kansas hospitals with patient safety improvement efforts as one of 32 state partners with the Health Research and Educational Trust (HRET) of the American Hospital Association.Since 2012, QHi is proud to have served as the data... Read more...

What's New?

Kansas HIIN NHSN to QHi Transfer a Success

KHC HIIN hospitals that submit HAI (hospital-acquired infection) data to NHSN can now see their monthly aggregated NHSN data in QHi. KHC and the QHi team at the Kansas Hospital Association completed development of the new process to transfer HAI data submitted to NHSN to the Quality Health... Read more...

New Hospital and RHC Measures in QHi

Ten new hospital measures: four new CMS ED measures, three Swing Bed measures, three CMS OP-18 measures and one CMS SEP-1 measure and **ten new RHC measures**: five Pediatric Oral Health measures and five Adults with Diabetes Oral Health Measures. Read more...

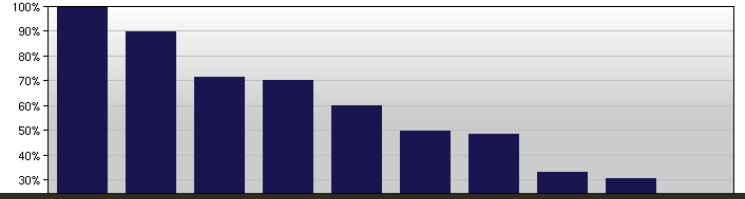
Training and Education

November QHi Training Recording Available

Thank you to those that joined our November QHi Back to Basics session. The recording is available here. Read more...

Submission Activity by State

09/2017 - 11/2017



Rochelle Spinarski
Mode: Provider
Provider Kind: Hospital

(Switch Modes)

- Home
- Data Submissions
- Imports
- Reports
- Dashboards
- My Profile
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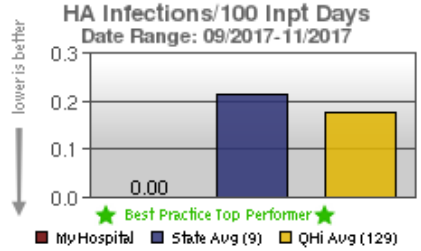
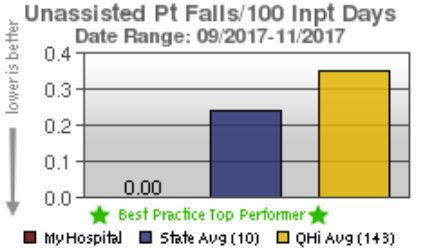
- Help

Core Measures Dashboard

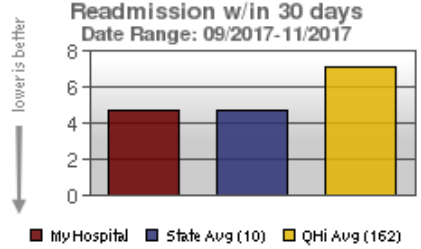
HA Infections/100 Inpt Days
Date Range: 09/2017-11/2017



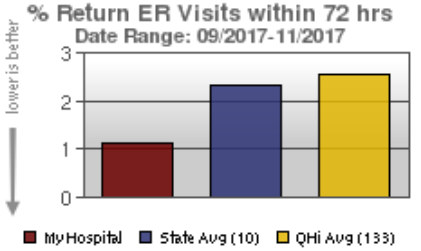
Unassisted Pt Falls/100 Inpt Days
Date Range: 09/2017-11/2017



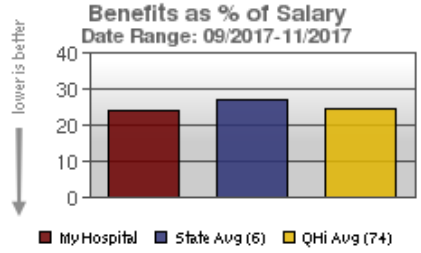
Readmission w/in 30 days
Date Range: 09/2017-11/2017



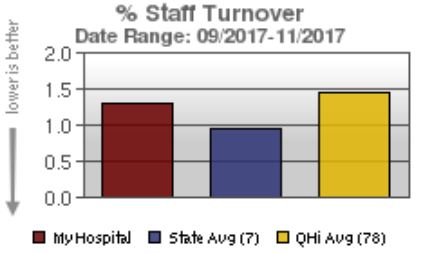
% Return ER Visits within 72 hrs
Date Range: 09/2017-11/2017



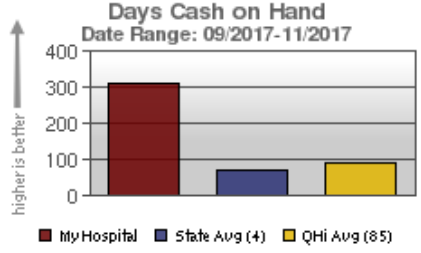
Benefits as % of Salary
Date Range: 09/2017-11/2017



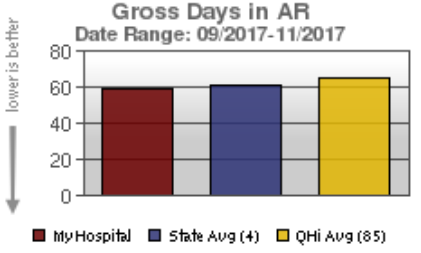
% Staff Turnover
Date Range: 09/2017-11/2017

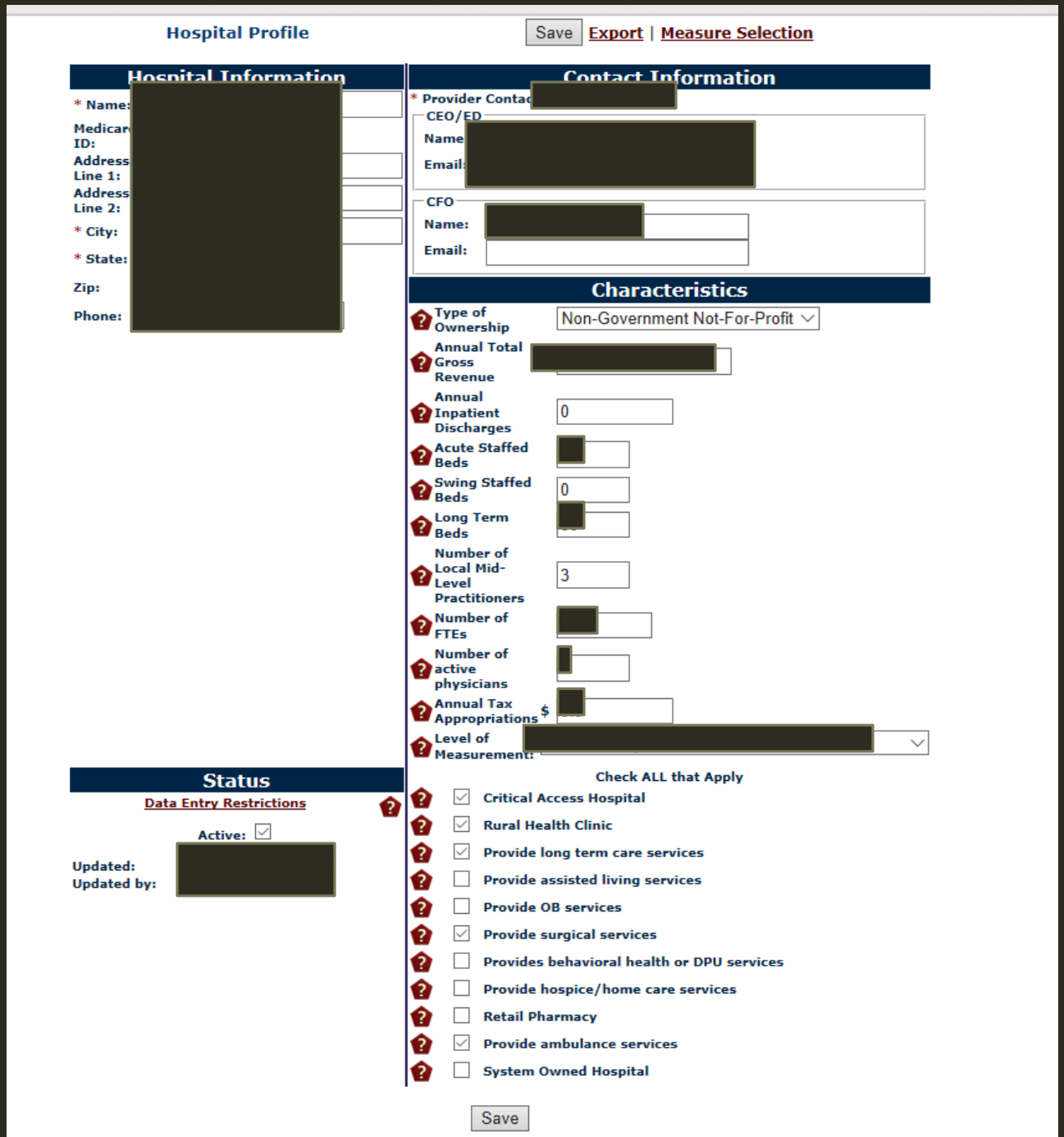


Days Cash on Hand
Date Range: 09/2017-11/2017

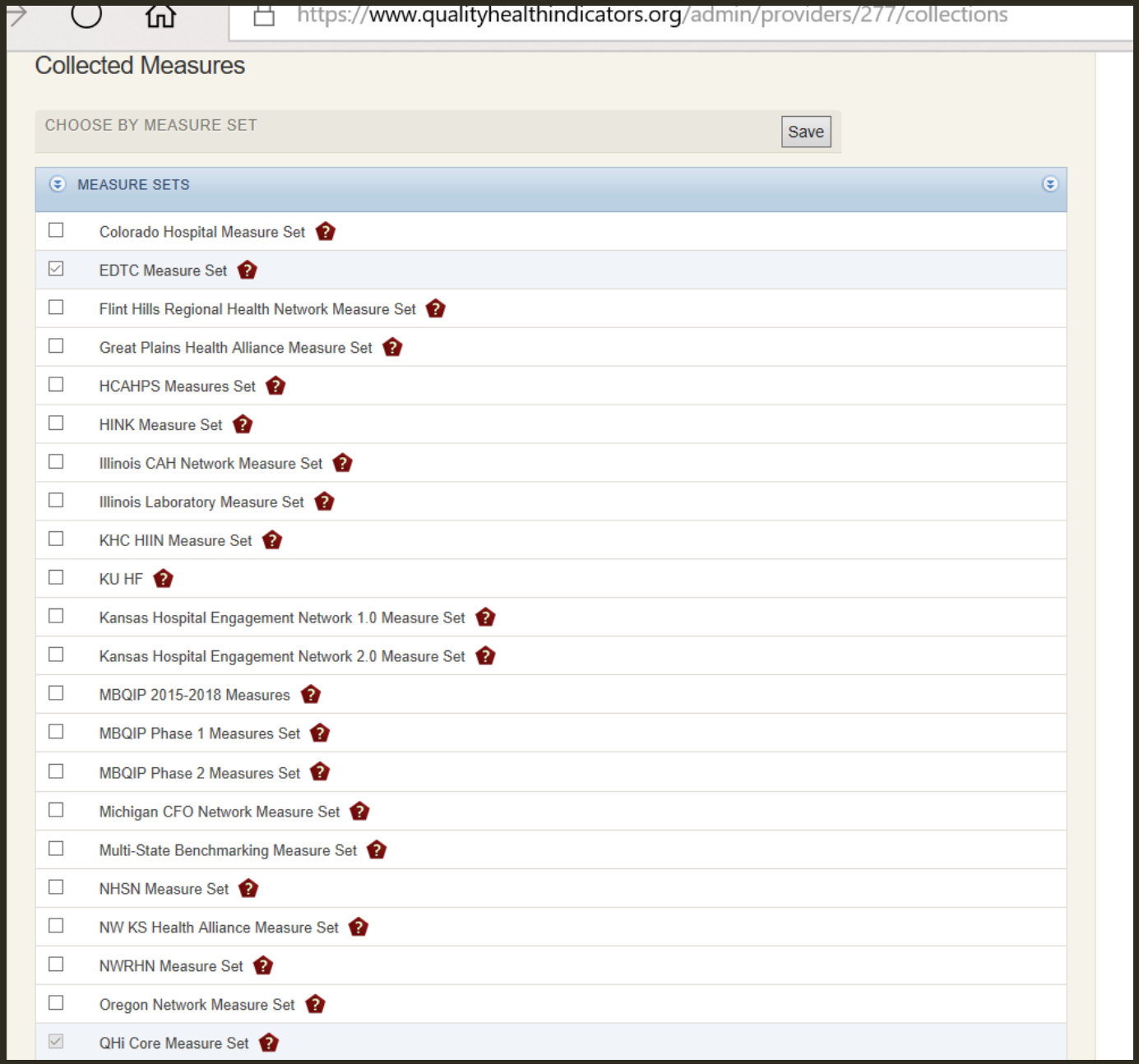


Gross Days in AR
Date Range: 09/2017-11/2017





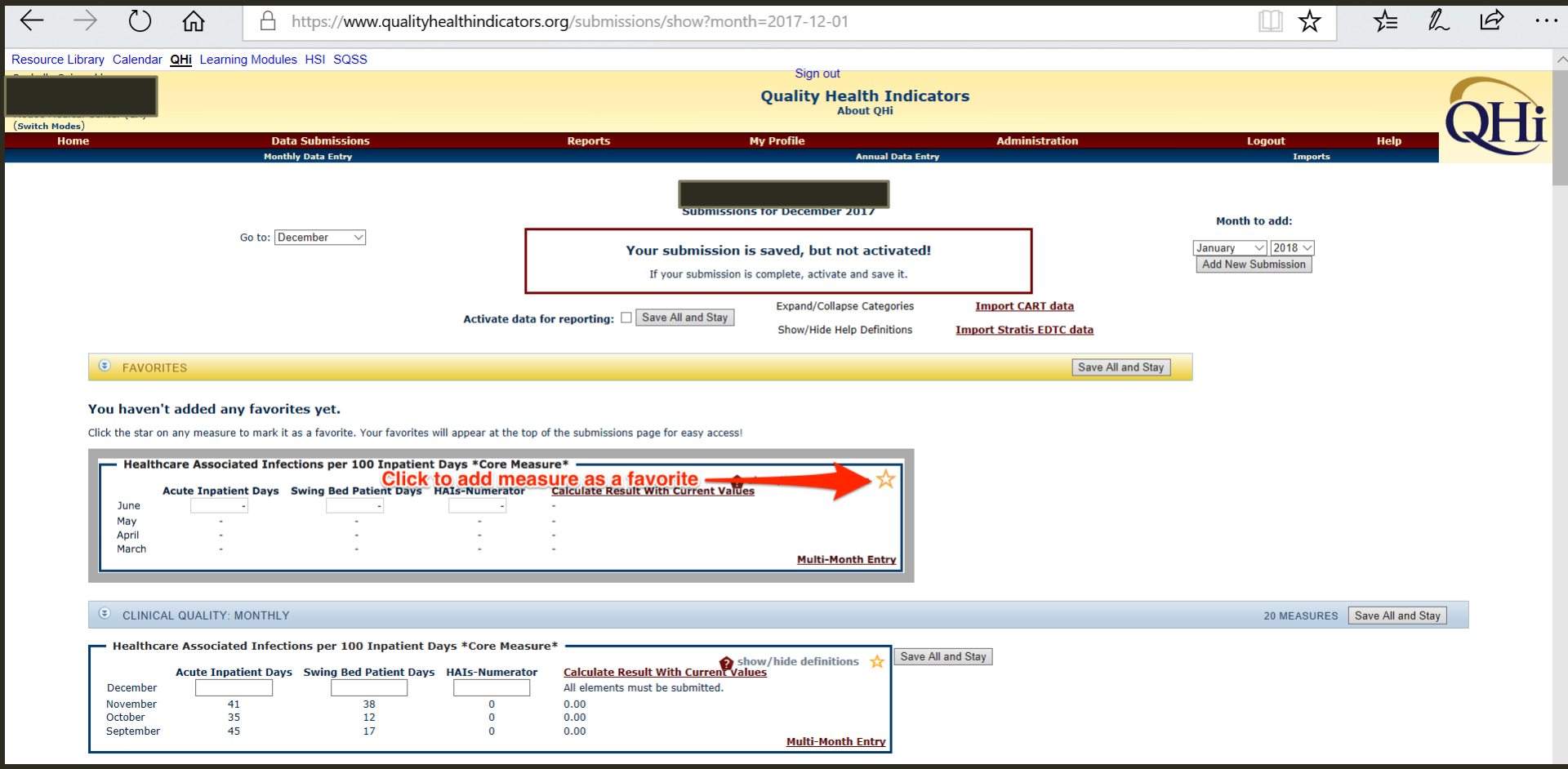
All Users: Please update your Hospital Profile Page. This is used to create cohorts for benchmarking.

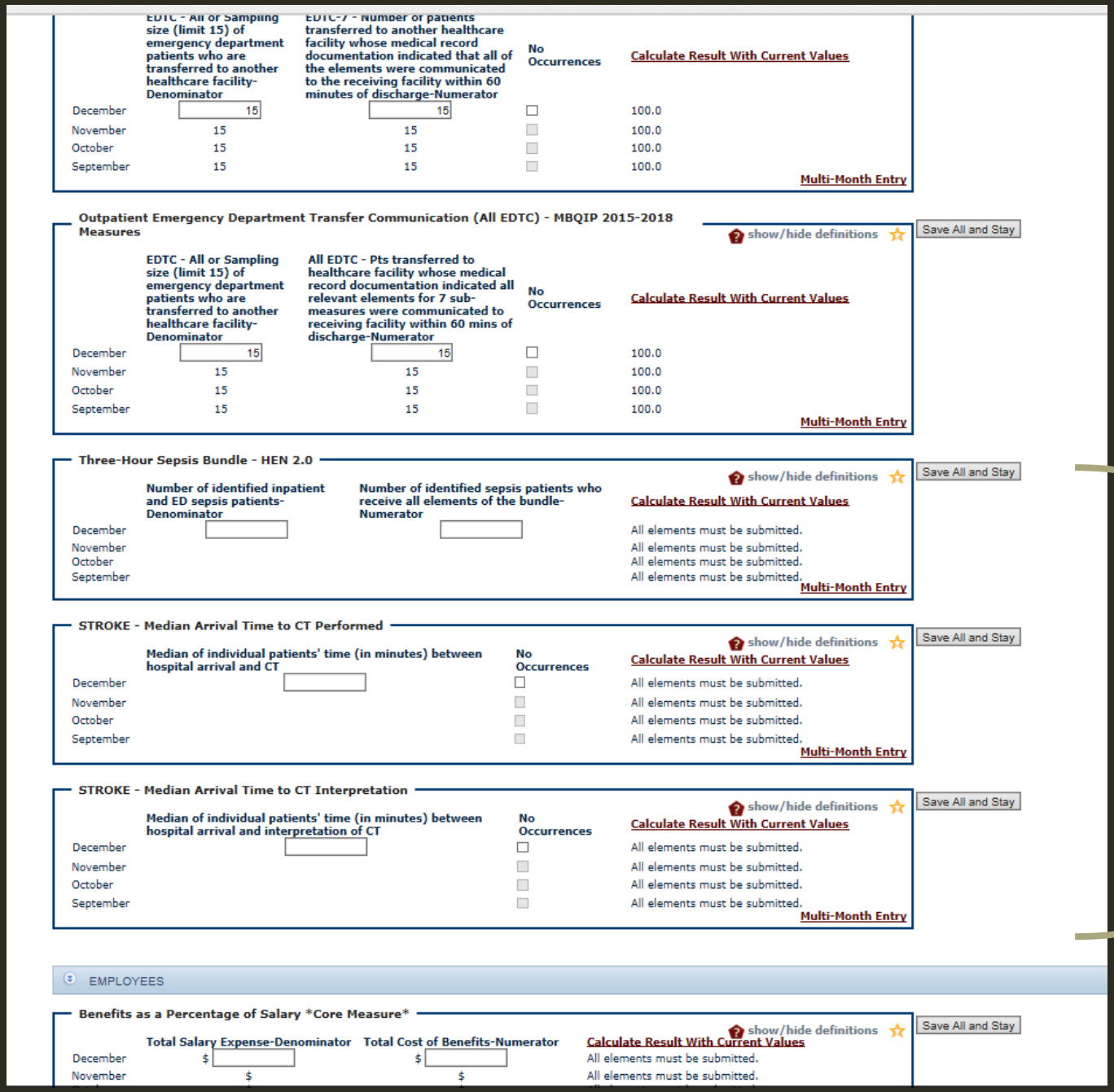


Measure Selection

All Users: Please update your Measure Selection Page. QHi Core Measures will always be selected but you can self-select all others. EDTC is a good set of measures to include. Look at others you want to work on.

This is the top of the data submission page





EDTC - All or Sampling size (limit 15) of emergency department patients who are transferred to another healthcare facility-Denominator

EDTC-7 - Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of discharge-Numerator

No Occurrences

Calculate Result With Current Values

December	15	15	☐	100.0
November	15	15	☐	100.0
October	15	15	☐	100.0
September	15	15	☐	100.0

Multi-Month Entry

Outpatient Emergency Department Transfer Communication (All EDTC) - MBQIP 2015-2018 Measures

show/hide definitions ☆ Save All and Stay

EDTC - All or Sampling size (limit 15) of emergency department patients who are transferred to another healthcare facility-Denominator

All EDTC - Pts transferred to healthcare facility whose medical record documentation indicated all relevant elements for 7 sub-measures were communicated to receiving facility within 60 mins of discharge-Numerator

No Occurrences

Calculate Result With Current Values

December	15	15	☐	100.0
November	15	15	☐	100.0
October	15	15	☐	100.0
September	15	15	☐	100.0

Multi-Month Entry

Three-Hour Sepsis Bundle - HEN 2.0

show/hide definitions ☆ Save All and Stay

Number of identified inpatient and ED sepsis patients-Denominator

Number of identified sepsis patients who receive all elements of the bundle-Numerator

Calculate Result With Current Values

December			All elements must be submitted.
November			All elements must be submitted.
October			All elements must be submitted.
September			All elements must be submitted.

Multi-Month Entry

STROKE - Median Arrival Time to CT Performed

show/hide definitions ☆ Save All and Stay

Median of individual patients' time (in minutes) between hospital arrival and CT

No Occurrences

Calculate Result With Current Values

December		☐	All elements must be submitted.
November		☐	All elements must be submitted.
October		☐	All elements must be submitted.
September		☐	All elements must be submitted.

Multi-Month Entry

STROKE - Median Arrival Time to CT Interpretation

show/hide definitions ☆ Save All and Stay

Median of individual patients' time (in minutes) between hospital arrival and interpretation of CT

No Occurrences

Calculate Result With Current Values

December		☐	All elements must be submitted.
November		☐	All elements must be submitted.
October		☐	All elements must be submitted.
September		☐	All elements must be submitted.

Multi-Month Entry

EMPLOYEES

Benefits as a Percentage of Salary *Core Measure*

show/hide definitions ☆ Save All and Stay

Total Salary Expense-Denominator

Total Cost of Benefits-Numerator

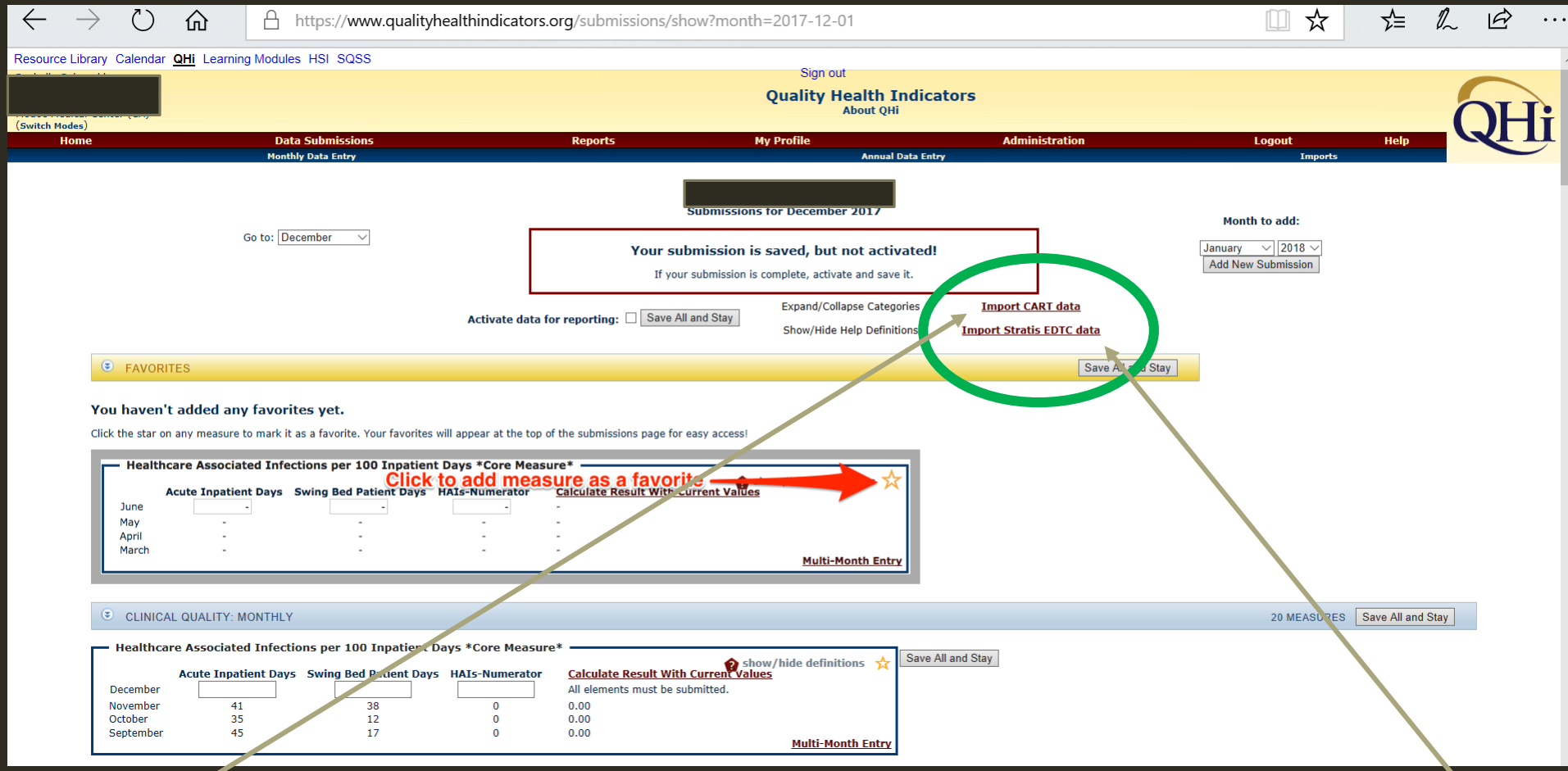
Calculate Result With Current Values

December	$	$	All elements must be submitted.
November	$	$	All elements must be submitted.

Data Submission

If you have measures on your data submission page that you are no longer using remove them from your measure selection page.

EDTC and Outpatient Measure Reporting and Tracking

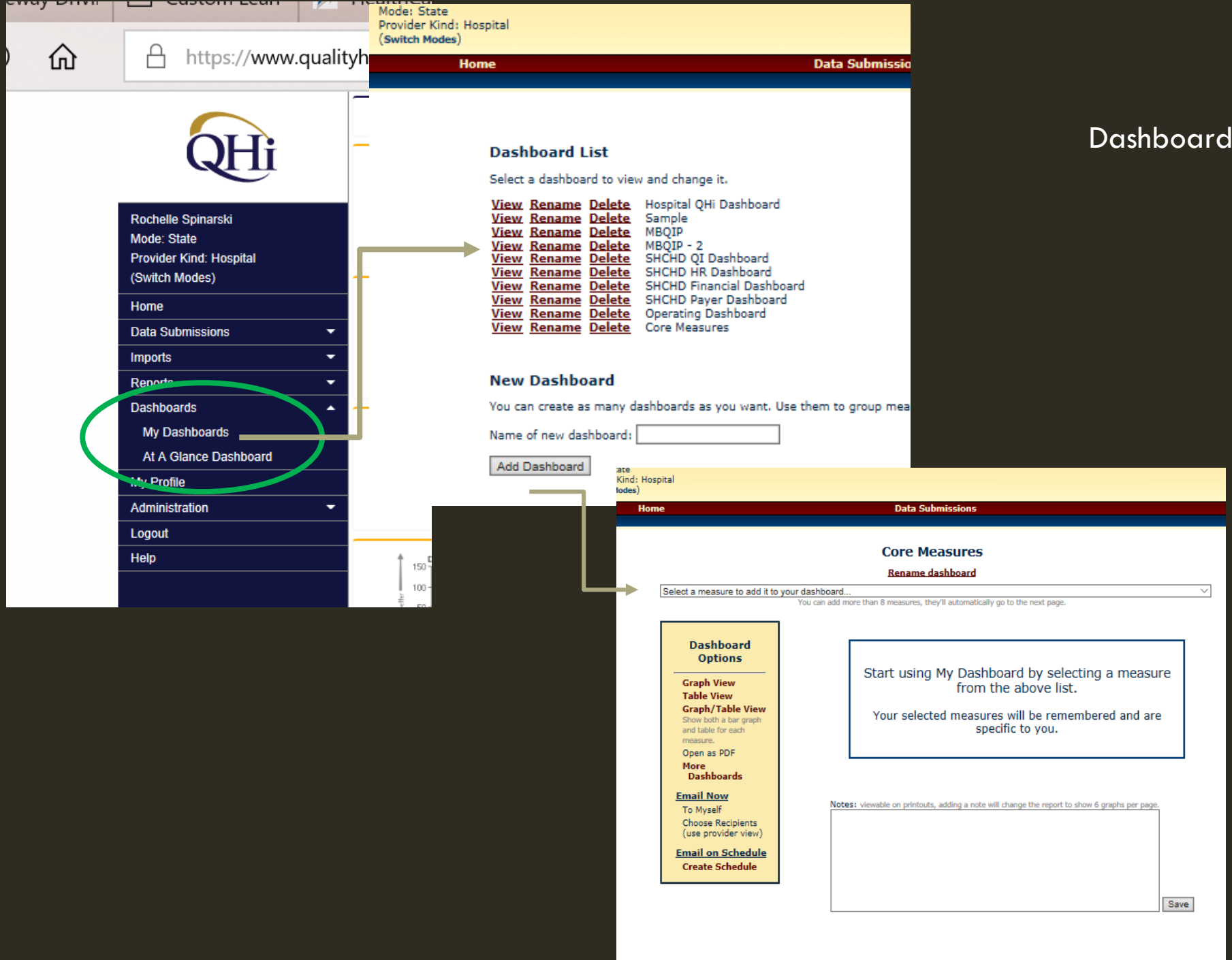


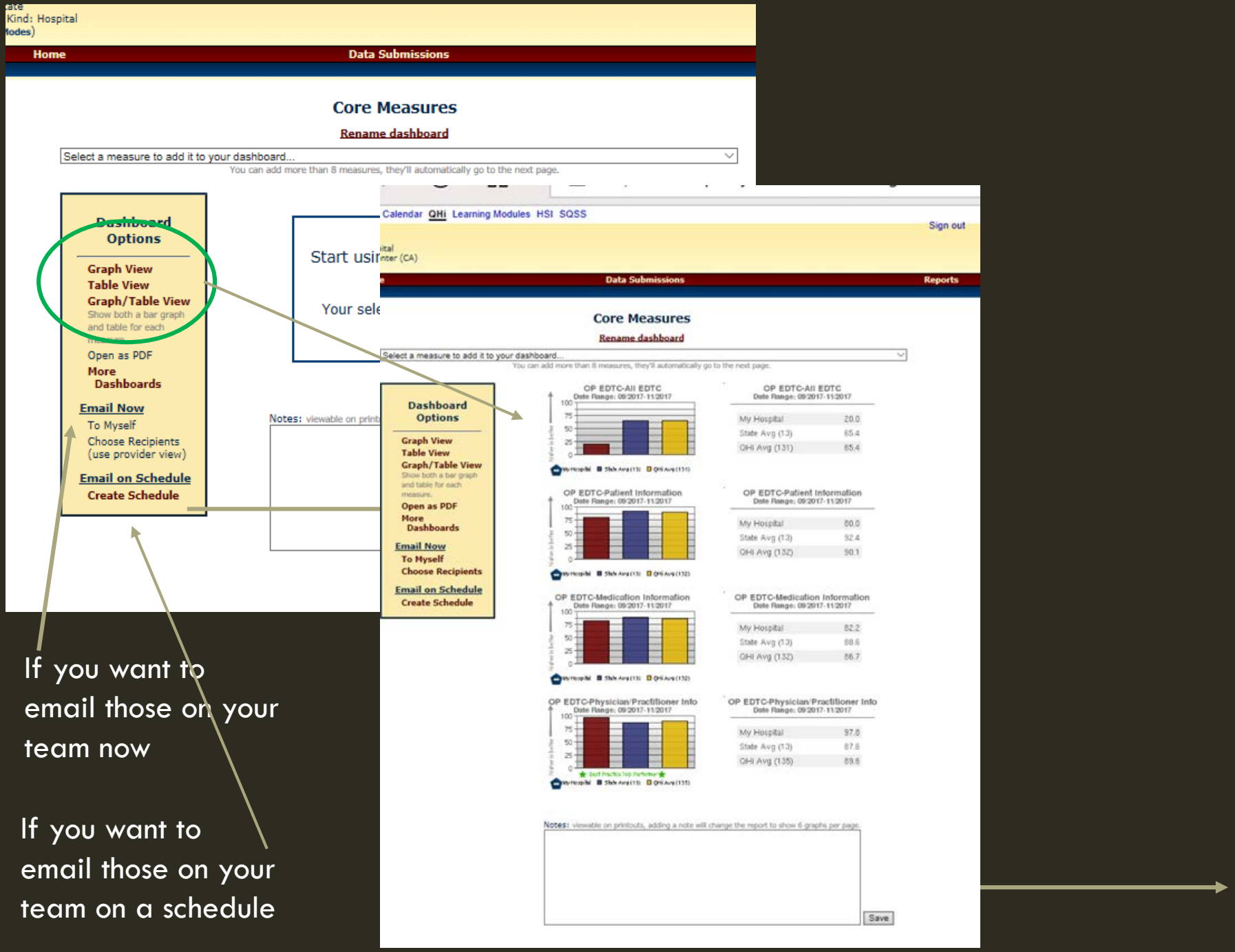
Find the EDTC reporting tool, upload feature and instructions for uploading data.

Find the instructions and where to upload inpatient and outpatient measures from CART (CMS)

Any measures for upload MUST be selected on data selection page to populate into tool.

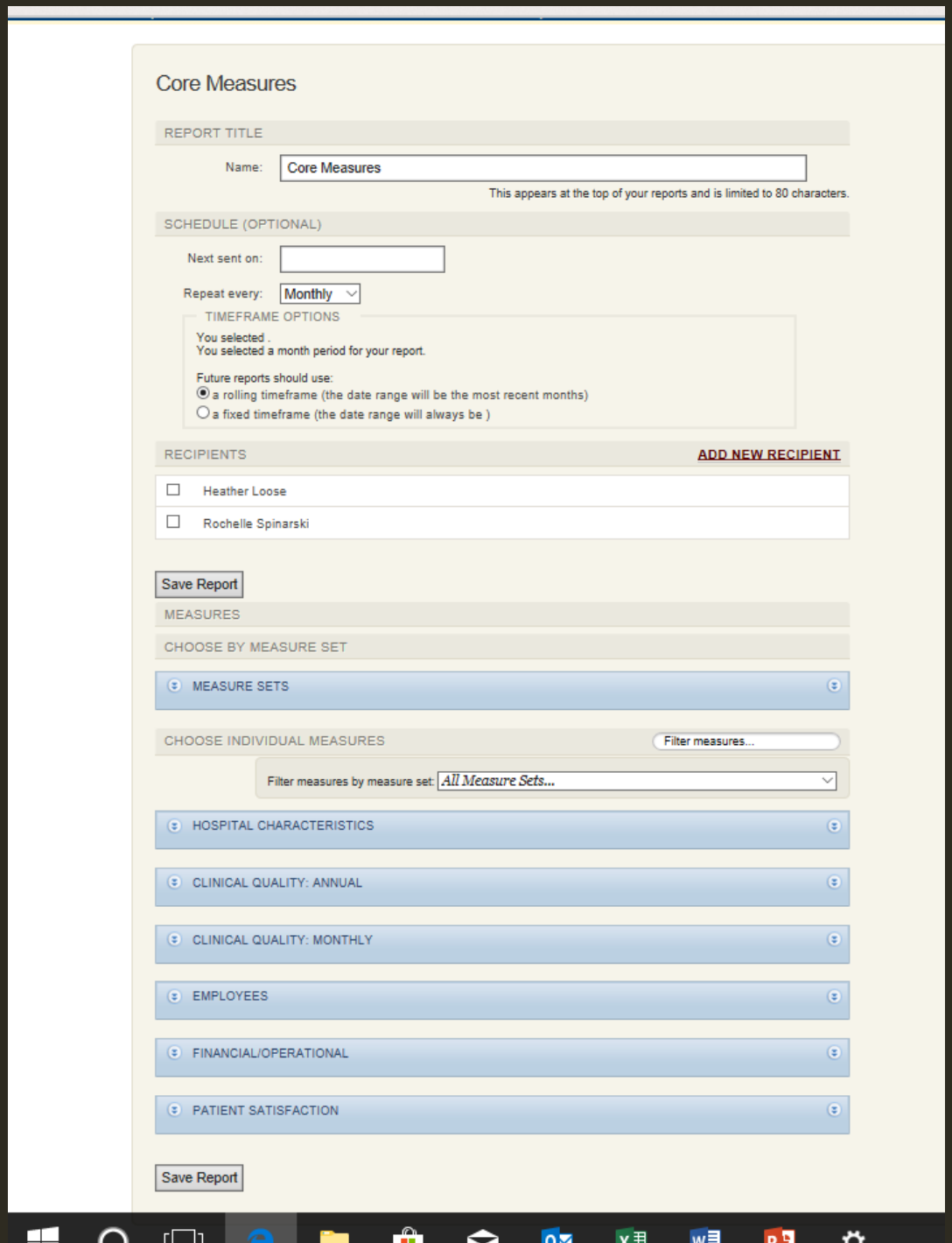
Dashboards


https://www.qualityh
QHi
Rochelle Spinarski
Mode: State
Provider Kind: Hospital
(Switch Modes)
Home
Data Submissions
Imports
Reports
Dashboards
My Dashboards
At A Glance Dashboard
My Profile
Administration
Logout
Help
Mode: State
Provider Kind: Hospital
(Switch Modes)
Home
Data Submissio
Dashboard List
Select a dashboard to view and change it.
View Rename Delete Hospital QHi Dashboard
View Rename Delete Sample
View Rename Delete MBQIP
View Rename Delete MBQIP - 2
View Rename Delete SHCHD QI Dashboard
View Rename Delete SHCHD HR Dashboard
View Rename Delete SHCHD Financial Dashboard
View Rename Delete SHCHD Payer Dashboard
View Rename Delete Operating Dashboard
View Rename Delete Core Measures
New Dashboard
You can create as many dashboards as you want. Use them to group mea
Name of new dashboard:
Add Dashboard
Home
Data Submissions
Core Measures
Rename dashboard
Select a measure to add it to your dashboard...
You can add more than 8 measures, they'll automatically go to the next page.
Dashboard Options
Graph View
Table View
Graph/Table View
Show both a bar graph and table for each measure.
Open as PDF
More Dashboards
Email Now
To Myself
Choose Recipients (use provider view)
Email on Schedule
Create Schedule
Start using My Dashboard by selecting a measure from the above list.
Your selected measures will be remembered and are specific to you.
Notes: viewable on printouts, adding a note will change the report to show 6 graphs per page.
Save



If you want to email those on your team now

If you want to email those on your team on a schedule



To Create a Schedule

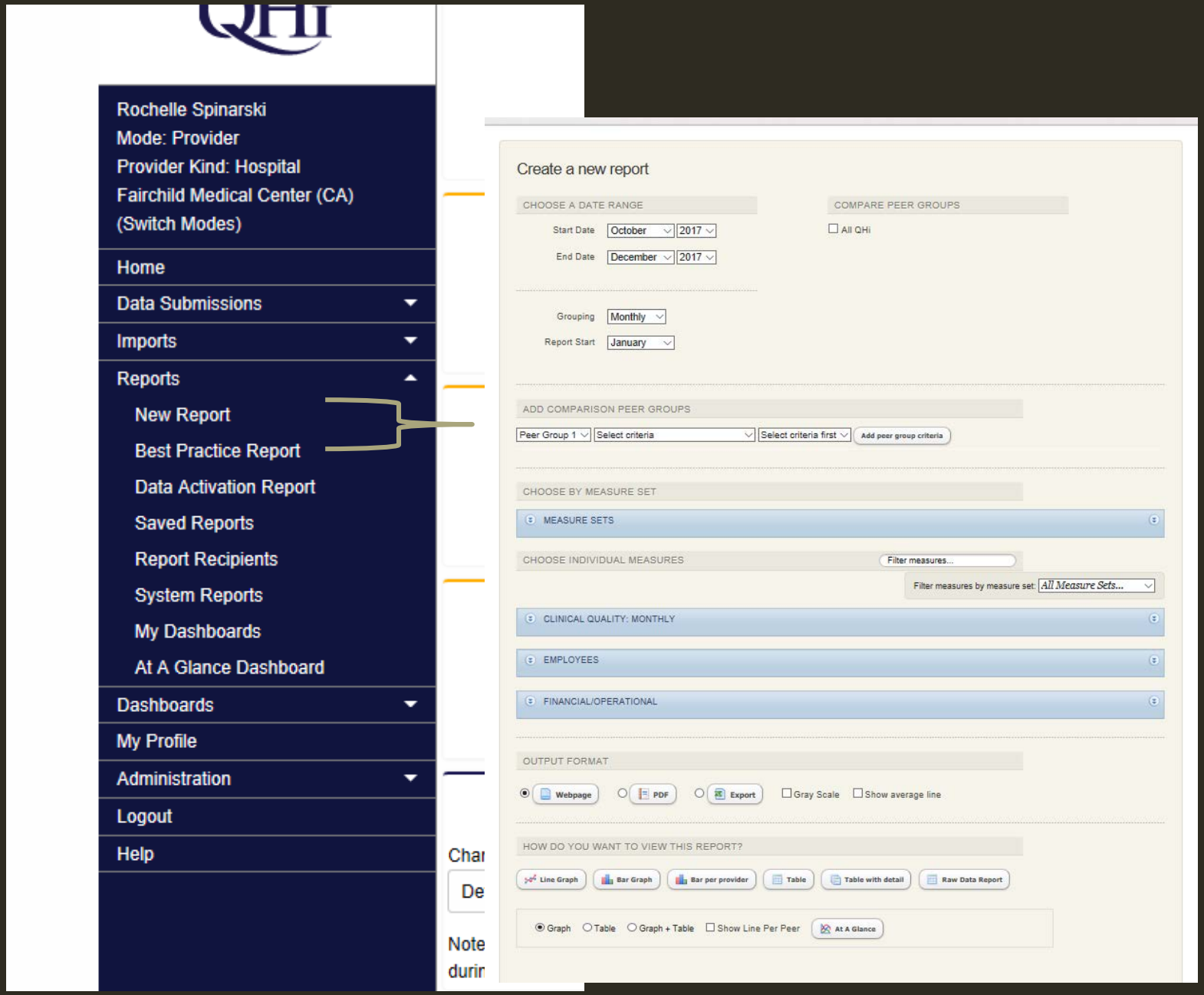
1) Select schedule dates.

2) Select recipients. Note: They do not need to be QHi users.

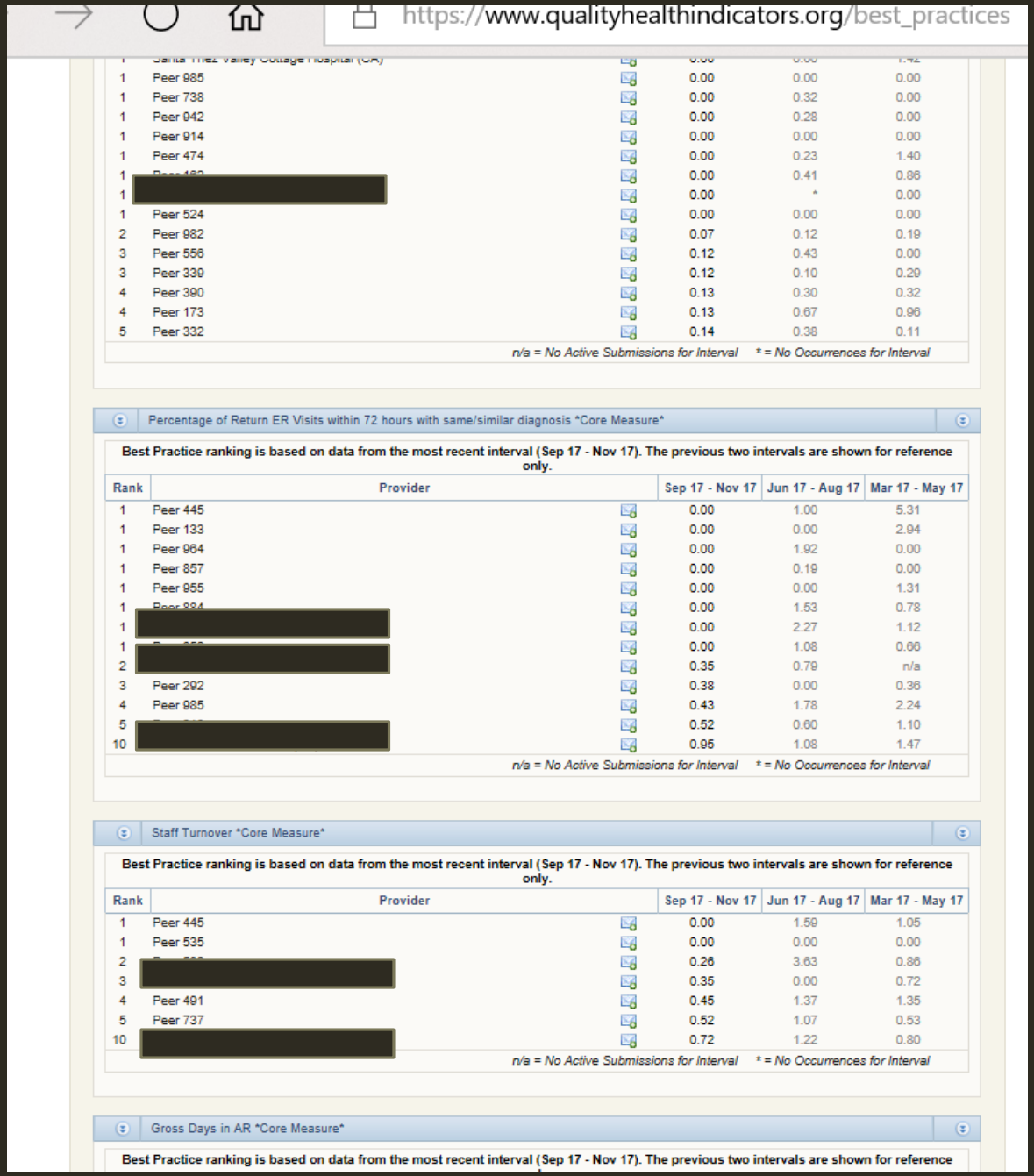
3) Select Measures (if not done on last page)

4) Save Report

For all CAHs using QHi – I will set up a schedule report for QHi core measures and EDTC. If you do not want to get a monthly dashboard emailed to you, contact Rochelle



All Other Reports



https://www.qualityhealthindicators.org/best_practices

1	Peer 985	0.00	0.00	0.00
1	Peer 738	0.00	0.32	0.00
1	Peer 942	0.00	0.28	0.00
1	Peer 914	0.00	0.00	0.00
1	Peer 474	0.00	0.23	1.40
1	[redacted]	0.00	0.41	0.86
1	[redacted]	0.00	*	0.00
1	Peer 524	0.00	0.00	0.00
2	Peer 982	0.07	0.12	0.19
3	Peer 556	0.12	0.43	0.00
3	Peer 339	0.12	0.10	0.29
4	Peer 390	0.13	0.30	0.32
4	Peer 173	0.13	0.67	0.96
5	Peer 332	0.14	0.38	0.11

n/a = No Active Submissions for Interval ** = No Occurrences for Interval*

Percentage of Return ER Visits within 72 hours with same/similar diagnosis *Core Measure*

Best Practice ranking is based on data from the most recent interval (Sep 17 - Nov 17). The previous two intervals are shown for reference only.

Rank	Provider	Sep 17 - Nov 17	Jun 17 - Aug 17	Mar 17 - May 17
1	Peer 445	0.00	1.00	5.31
1	Peer 133	0.00	0.00	2.94
1	Peer 964	0.00	1.92	0.00
1	Peer 857	0.00	0.19	0.00
1	Peer 955	0.00	0.00	1.31
1	[redacted]	0.00	1.53	0.78
1	[redacted]	0.00	2.27	1.12
1	[redacted]	0.00	1.08	0.66
2	[redacted]	0.35	0.79	n/a
3	Peer 292	0.38	0.00	0.36
4	Peer 985	0.43	1.78	2.24
5	[redacted]	0.52	0.60	1.10
10	[redacted]	0.95	1.08	1.47

n/a = No Active Submissions for Interval ** = No Occurrences for Interval*

Staff Turnover *Core Measure*

Best Practice ranking is based on data from the most recent interval (Sep 17 - Nov 17). The previous two intervals are shown for reference only.

Rank	Provider	Sep 17 - Nov 17	Jun 17 - Aug 17	Mar 17 - May 17
1	Peer 445	0.00	1.59	1.05
1	Peer 535	0.00	0.00	0.00
2	[redacted]	0.26	3.63	0.86
3	[redacted]	0.35	0.00	0.72
4	Peer 491	0.45	1.37	1.35
5	Peer 737	0.52	1.07	0.53
10	[redacted]	0.72	1.22	0.80

n/a = No Active Submissions for Interval ** = No Occurrences for Interval*

Gross Days in AR *Core Measure*

Best Practice ranking is based on data from the most recent interval (Sep 17 - Nov 17). The previous two intervals are shown for reference

Best Practices Report

FYI - NEXT STEPS – FINANCIAL AND OPERATIONAL BENCHMARKING

Focused on QI today but making steps for additional participation in financial and operational measures

Meeting on 1/16 with CAH financial teams and CEOs

Discuss department level measures and reporting

All CAHs are encouraged to have staff participate

Dial-in info:

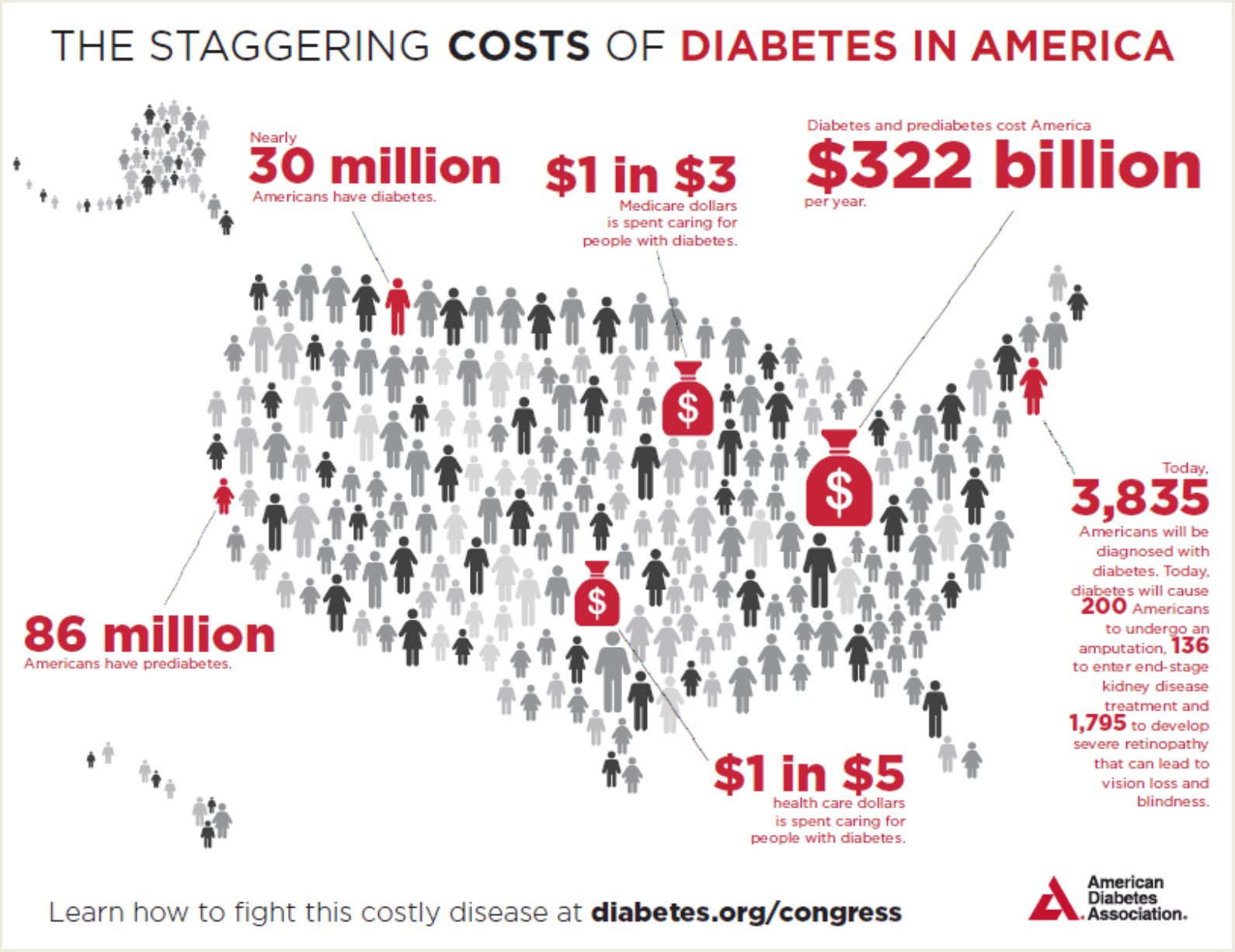
U.S. Toll: 303.248.0285
Access Code: 7315211

https://cc.readytalk.com/r/dimur07t84cd&eom

QUESTIONS ABOUT QHI?

THE NATIONAL DIABETES PREVENTION PROGRAM

Hannah Herold, MPH, MA, CHES
Wyoming Department of Health – Chronic Disease Prevention Program



American Diabetes Association (n.d.) The staggering costs of diabetes in America. Retrieved from http://www.diabetes.org/diabetes-basics/statistics/infographics/adv-staggering-cost-of-diabetes.html

ESTIMATED COST OF DIABETES IN WYOMING

Total Inpatient Costs:

$232,825,610

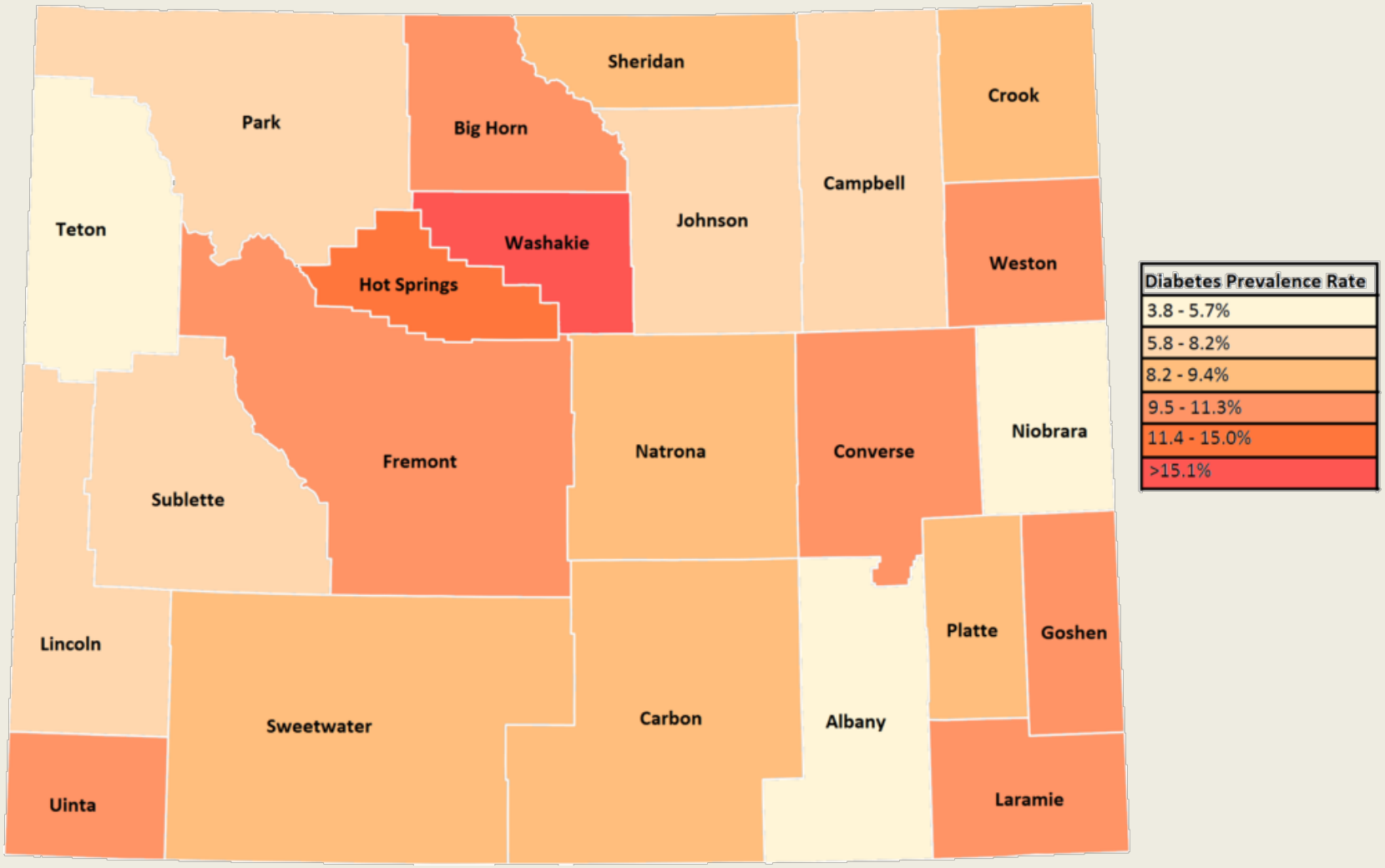
People with diabetes incur an average of

$7,900

in medical costs per year.

2011-2013 Wyoming BRFSS, retrieved from https://health.wyo.gov/publichealth/prevention/chronicdisease/data/

PREVALENCE OF DIABETES IN WYOMING



Source: 2011-2015 Wyoming BRFSS, retrieved from https://health.wyo.gov/publichealth/prevention/chronicdisease/data/

NDPPS IN WYOMING

St. John's Medical Center Jackson, WY

Northern Arapaho Tribal Health Wind River Indian Reservation

YMCA Sheridan, WY

YMCA Cheyenne, WY

NATIONAL DIABETES PREVENTION PROGRAM

(NDPP)

NDPP OVERVIEW

- A **lifestyle change program** following an evidence-based, CDC-approved curriculum
- Designed for people who **have prediabetes** or **are at risk for type 2 diabetes**
- Consists of 16 weeks of **intervention** followed by 6 months of **maintenance and follow-up**
- Focuses on **healthy habits**

https://www.cdc.gov/diabetes/prevention/prediabetes-type2/preventing.html

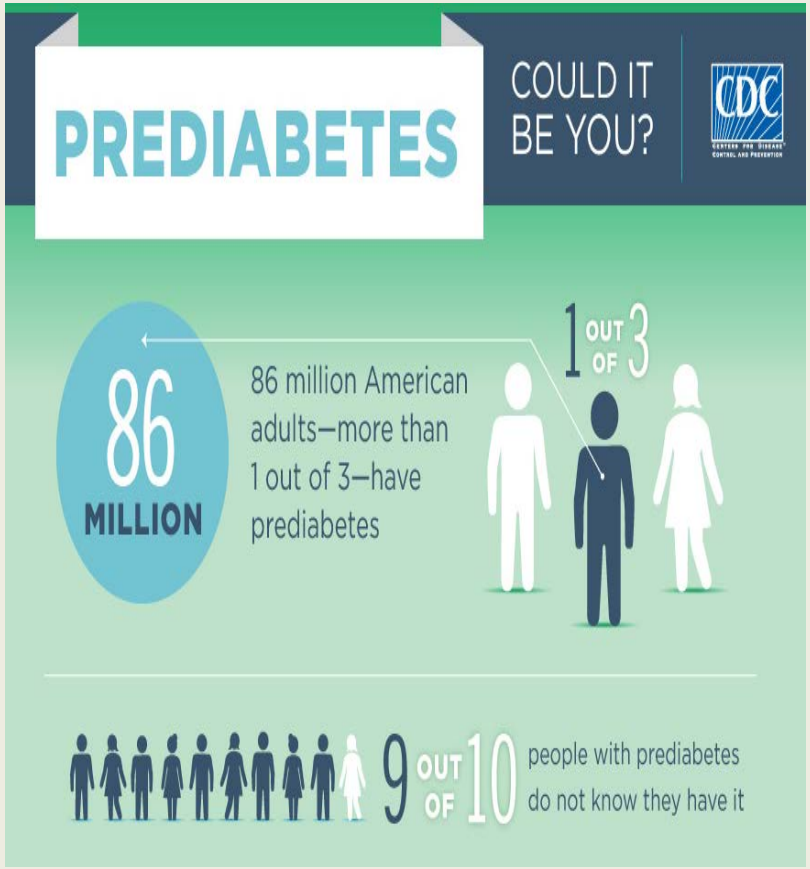
WHAT IS PREDIABETES?

A **reversible** cardiometabolic risk factor

- Plasma glucose levels are above normal, but not high enough for diagnosis of type 2 diabetes
- A1c between 5.7 - 6.4
- No prior diabetes diagnosis

Risks factors for Prediabetes include:

- Overweight/Obesity
- Lack of physical activity
- Age (risk increases with age)
- Race/Ethnicity
- Low birth weight



Centers for Disease Control and Prevention. National diabetes statistics report: estimates of diabetes and its burden in the United States, 2014. Atlanta, GA: US HHS, CDC,2014.
American Diabetes Association. "Standards of medical care in diabetes—2013." Diabetes Care (2013); 36:Suppl 1:S11.
James C, Bullard KM, Rolka DB, et al. "Implications of alternative definitions of prediabetes for prevalence in US adults." Diabetes Care 2011; 34(2):387-391.

STANDARD NDPP CURRICULUM

First 6 Months - Modules	Last 6 Months - Modules
Program Overview/Introduction	When Weight Loss Stalls
Get Active to Prevent T2	Take a Fitness Break
Track Your Activity	Stay Active to Prevent T2
Eat Well to Prevent T2	Stay Active Away from Home
Track Your Food	More About T2
Get More Active	More About Carbs
Burn More Calories Than You Take In	Have Healthy Food You Enjoy
Shop and Cook to Prevent T2	Get Enough Sleep
Manage Stress	Get Back on Track
Find Time for Fitness	Prevent T2 – For Life!
Cope with Triggers	
Keep Your Heart Healthy	
Take Charge of Your Thoughts	
Get Support	
Eat Well Away from Home	
Stay Motivated to Prevent T2	

https://www.cdc.gov/diabetes/prevention/lifestyle-program/curriculum.html

NDPP OUTCOMES

NDPP is a result of a major clinical research study designed to test whether lifestyle changes (diet and physical activity) could prevent or delay onset of type 2 diabetes.

National Institute of Health (NIH)-funded 3-arm Randomized Control Trial		
Control Group	Intervention Group 1	Intervention Group 2
Placebo	Metformin	Intensive Lifestyle Coaching*

*Individual counseling and motivational support on effective diet, exercise, and behavior modification

Outcome – 3 years

Intervention Group 2

A **5-7% body weight loss** reduced the risk of developing type 2 diabetes by **58%** in those with prediabetes (**71%** in those 60+ years).

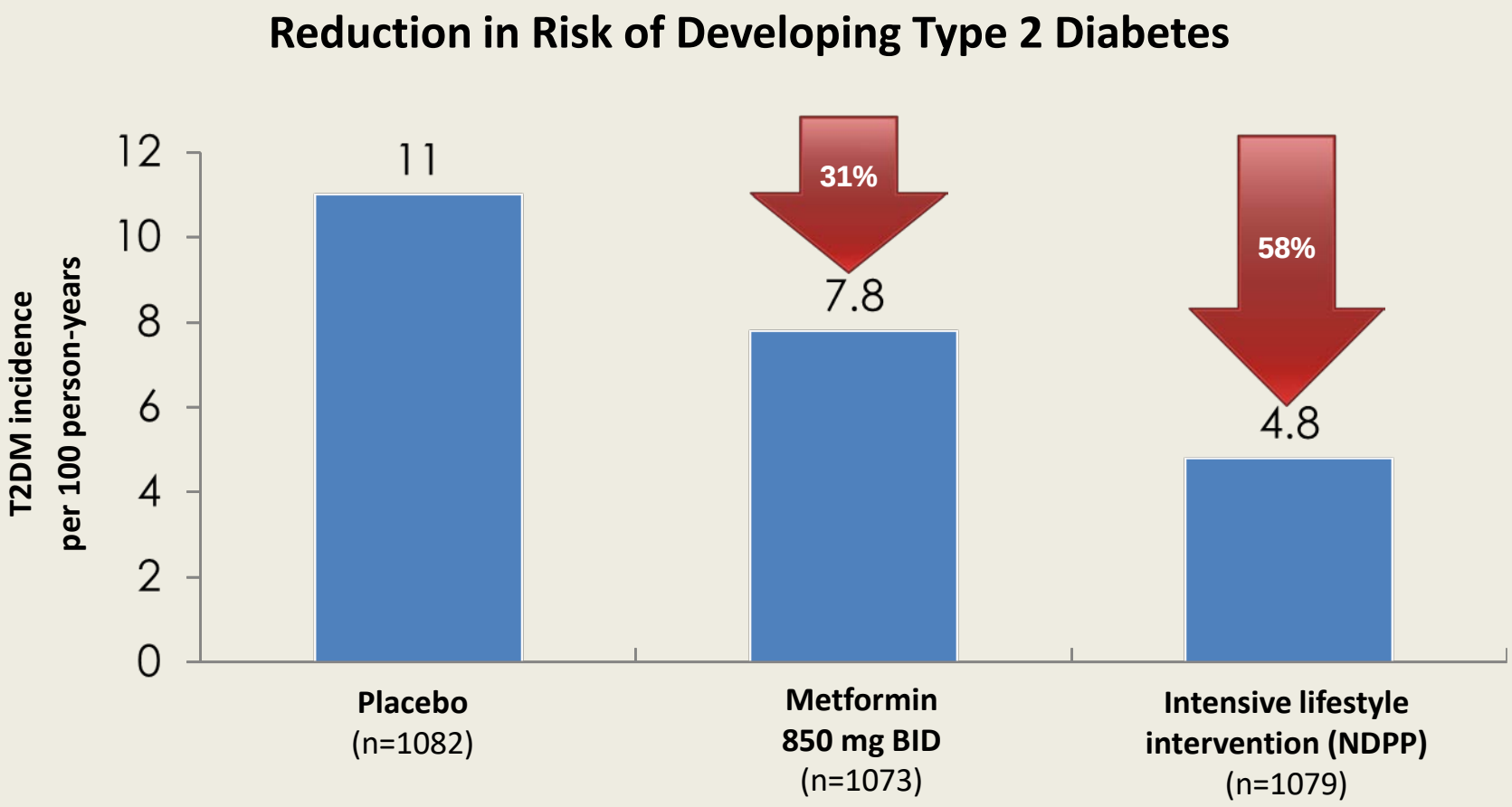
Outcome – 10 years

Intervention Group 2

34% decrease in prevalence of type 2 diabetes.

http://www.cdc.gov/diabetes/prevention/
Knowler WC, Barrett-Connor E, Fowler SE, et al. Diabetes Prevention Program Research Group. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med. 2002;346(6):393-403.

NDPP OUTCOMES



Diabetes Prevention Program Research Group (2002). Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. The New England Journal of Medicine, 346, 393-403. DOI: 10.1056/NEJMoa012512

WHAT IS THE IMPORTANCE OF AN NDPP?

1 in 5 adults could have type 2 diabetes by **2025**

In 2013, diabetes as a primary or secondary diagnosis cost the state of Wyoming **$232,825,610** in inpatient costs alone

Participation in an NDPP resulted in Medicare cost savings of **$2,650 per patient** compared to control beneficiaries

Boyle JP, Thompson TJ, Gregg EW, Barker LE, Williamson DF. (2010) Projection of the year 2050 burden of diabetes in the US adult population: dynamic modeling of incidence, mortality, and prediabetes prevalence. Population Health Metrics. 2010;8:29, 2010.
State of Wyoming Hospital Discharge Data, 2013.
YMCA & CDC, 2016.

BENEFITS OF OFFERING NDPP

HOW DOES OFFERING A NDPP BENEFIT YOU?

Provides increased visibility to your organization.

- CDC lists all recognized lifestyle change programs on it's website

Provides increased credibility to your organization.

- The science behind the program and its association with the CDC brings added credibility.

https://www.cdc.gov/diabetes/prevention/lifestyle-program/why_offer.html

HOW DOES OFFERING A NDPP BENEFIT YOU?

Complements your current work.

- A DPP works to improve the health and well-being of individuals in your community – just like much of the other work you already do.

Expands reach in your community.

- Expanding your scope of services will expand the population you see and/or treat. This may translate to additional clients for services beyond the DPP.

https://www.cdc.gov/diabetes/prevention/lifestyle-program/why_offer.html

HOW DOES OFFERING A NDPP BENEFIT YOU?

Improves quality metrics.

- **MIPS Quality Measures:**
  - Preventive Care and Screening: BMI Screening and Follow-Up Plan
- **NCQA Wellness & Health Promotion Performance Measures:**
  - Percentage of adults who had at least one of the three core risk factors (obesity, cigarette smoking, or physical inactivity), as defined by a baseline HA and who reduced their risk, as identified by a follow-up HA
  - Percentage of adults who were obese and had at least one interactive contact specific to weight loss, and who have maintained their BMI or reduced their BMI by at least one point

HOW DOES OFFERING A NDPP BENEFIT YOU?

Increases income.

- Potential to increase incentive payments
- In January 2018, NDPP became a covered benefit of Medicare
- NDPP may soon become a covered benefit of Wyoming Medicaid
- Covered by some private insurance companies:
  - GEHA
  - Humana
  - Kaiser Permanente
  - UnitedHealthcare
- Covered by some employers

HOW DOES OFFERING A NDPP BENEFIT YOU?

Your employees may see <u>greater job satisfaction</u>:

"It's the most beautiful transformation to witness, and to be a part of, and to say that you contributed to someone regaining their mobility. You contributed to someone getting their blood pressure management reduced. You contributed to them giving up the unhealthy choices and substituting those for now-healthy choices... that has been such a gift I have witnessed and experienced in this program."

- DPP Facilitator

Johnson, N., & Melton, S. (2016). *Perceived Benefits and Barriers to the Diabetes Prevention Program.* PLAID: People Living with And Inspired by Diabetes, 2(1). doi:10.17125/plaid.2016.65

REMEMBER – WYOMING HAS A NEED FOR MORE NDPP!

St. John's Medical Center Jackson, WY

Northern Arapaho Tribal Health Wind River Indian Reservation

YMCA Sheridan, WY

YMCA Cheyenne, WY

NDPP OPPORTUNITIES

IN-PERSON OR TELEHEALTH

NDPP VIA TELEHEALTH

What? High-quality lifestyle interventions with frequent provider interaction delivered to patients in remote locations

Why? Reduce cost burden to health systems and disease burden to Wyoming

How?

Provide:

- Facilities
- Facilitator
- Referrals and recruitment
- Video conferencing technology

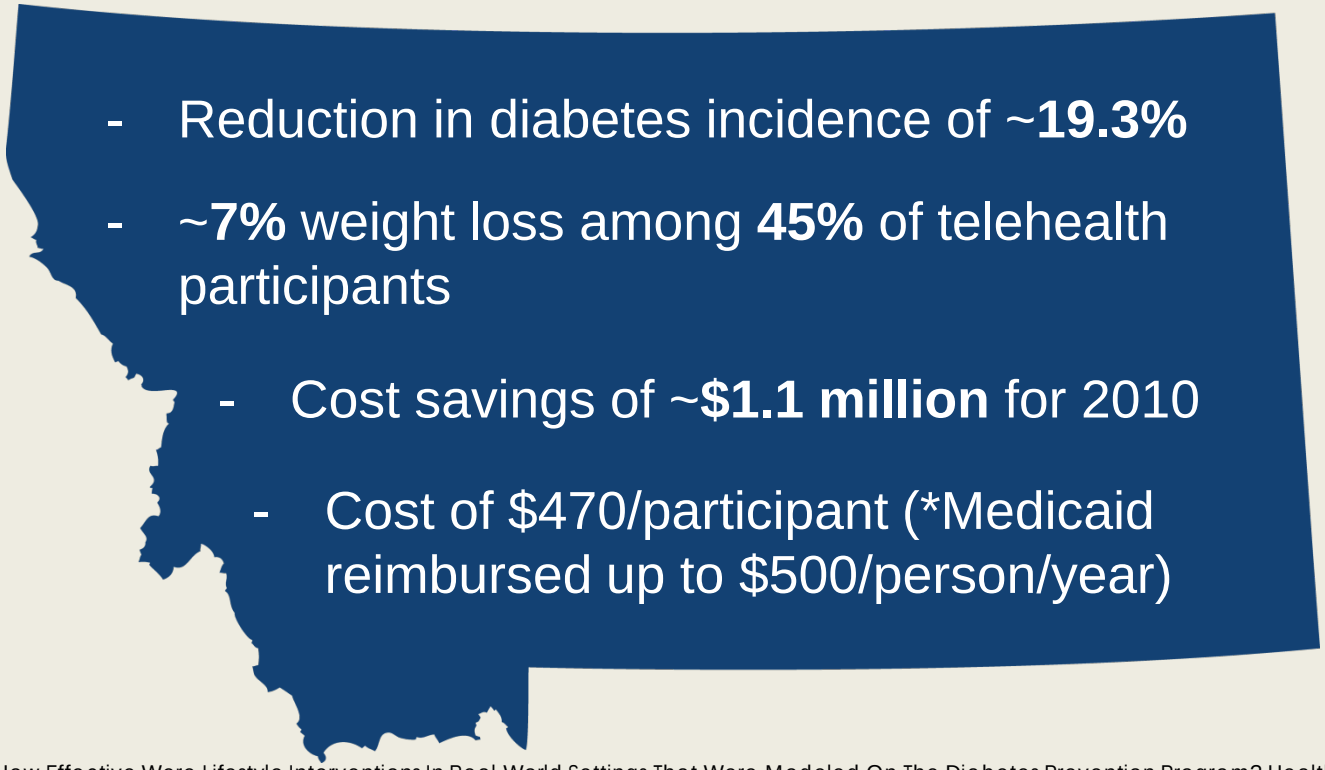
Receive:

- CDC-recognized NDPP
- Trained Lifestyle Coach
- Cost savings
- Innovative program

NDPP VIA TELEHEALTH

Can a Telehealth NDPP be successful? Yes!

In Montana, a Telehealth NDPP resulted in:



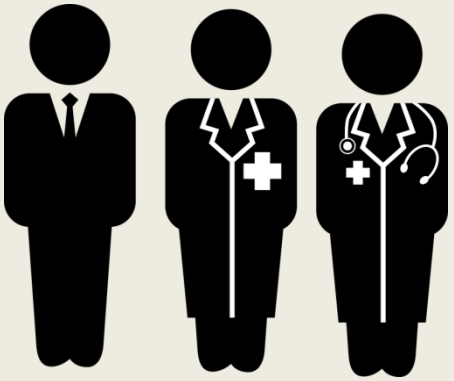
- Reduction in diabetes incidence of ~**19.3%**
- ~**7%** weight loss among **45%** of telehealth participants
- Cost savings of ~**$1.1 million** for 2010
- Cost of $470/participant (*Medicaid reimbursed up to $500/person/year)

Ali, MK et al. (2012). How Effective Were Lifestyle Interventions In Real-World Settings That Were Modeled On The Diabetes Prevention Program? Health Affairs, vol. 31 no. 1 67-75.
Vadheim, LM, et al. (2010). Adapted diabetes prevention program lifestyle intervention can be effectively delivered through telehealth. The Diabetes Educator, Jul-Aug;36(4):651-6.

NDPP VIA TELEHEALTH

Can a Telehealth NDPP be successful? Yes!

In a meta-analysis of 28 NDPPs nationally, virtual programs had equivalent rates of **participant retention** and **weight loss** to in-person interventions.



Ali, MK et al. (2012). How Effective Were Lifestyle Interventions In Real-World Settings That Were Modeled On The Diabetes Prevention Program? Health Affairs, vol. 31 no. 1 67-75.
Vadheim, LM, et al. (2010). Adapted diabetes prevention program lifestyle intervention can be effectively delivered through telehealth. The Diabetes Educator, Jul-Aug;36(4):651-6.

LOOKING FORWARD…

ORGANIZATIONAL CAPACITY ASSESSMENT

The CDC provides an organization capacity assessment that will help you identify areas that may need enhanced prior to applying for CDC recognition.

We recommend you start reviewing this now – it will help in the process!

Capacity assessment can be found here:

https://www.cdc.gov/diabetes/prevention/pdf/capacity-assessment.pdf

*(*CDC has not yet updated website to reflect the 2018 capacity assessment)*

BECOMING A RECOGNIZED DPP

Centers for Disease Control and Prevention (CDC)

- Diabetes Prevention Recognition Program (DPRP)
- https://www.cdc.gov/diabetes/prevention/lifestyle-program/requirements.html
  *(*CDC has not yet updated website to reflect the 2018 standards)*
- Standards for CDC recognition include:
  - CDC-approved curriculum
  - Ability to begin offering program <6 months from CDC approval
  - Capacity and commitment to deliver program for >1 year
  - Ability to record and submit data on participant progress
  - Trained lifestyle coaches
  - Designated DPP Coordinator(s)

Support from Chronic Disease Prevention Program at the Wyoming Department of Health and Independent Contractors

UPCOMING LIFESTYLE COACH TRAINING

- Lifestyle Coach training hosted by Wyoming Association of Diabetes Educators and supported by the Wyoming Department of Health.
- Travel stipends available through Wyoming FLEX program.

March 15 & 16, 2018

Casper, WY

Registration:
http://www.myaadenetwork.org/e/in/eid=1124

WYOMING DEPARTMENT OF HEALTH – CHRONIC DISEASE PREVENTION PROGRAM

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Chronic Disease Prevention Program Manager
hannah.herold@wyo.gov
307.777.3579

https://health.wyo.gov/publichealth/prevention/chronicdisease

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QUESTIONS?

Thank you for participating!

The Power of Rural

Meeting the Needs of Rural and Frontier Communities through Evidence, Partnership and Quality

The Wyoming Primary Care Association, Wyoming Department of Health and the Wyoming Association of Diabetes Educators are pleased to invite you to this statewide learning and networking opportunity. If your rural surroundings impact how you deliver health care to the community, this is the conference for you. *CEUs available

May 16 - 17 2018

Ramkota Hotel - Casper, WY

WYPCA

Wyoming Department of Health

Next QI Roundtable:
March 15, 10:00 am – 11:00am
FORHP/CDC webinar for CAHs on **January 23, 2018 1:00-2:00PM CST, Register Here:**
https://cc.readytalk.com/registration/#/?meeting=uwh6mhxlpx6a&campaign=6u5vm83tbs31

Roundtable will focus on HCAHPS, including lessons learned from the Healthcare Service Excellence Conference

FLEX & OTHER CONTACTS

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