# Investing in Prevention: Fueling Patient Education

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Wyoming Department of Health | PUBLIC HEALTH DIVISION | CHRONIC DISEASE PREVENTION PROGRAM

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**Notice of Requirements for Successful Completion:**

Learners must participate in the full activity and complete the evaluation in order to claim continuing education credit/hours.

**Presenter(s) Conflicts of Interest/Financial Relationships Disclosures:**

**Amber Nolte, MPH, CPM - None**
**Kacie Hutton, MPH - None**

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# OBJECTIVES

- ✓ **Identify and briefly describe at least three key evidence-based prevention programs, such as the Diabetes Prevention Program (DPP), and the American Heart Association's Heart Health Ambassador Program (HHA) and the Diabetes Self-Management Program (DSMP)**
- ✓ **Identify at least two potential funding sources for patient education programs related to health prevention and patient education in 2025**

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# MEET the TEAM


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## Diabetes Prevention Program

- Online DPP available
- 3 in-person DPPs operating in the state
- $25,434.00 of value-based payments paid to Wyoming DPPs
- 2 startup grants available!

NATIONAL DIABETES PREVENTION PROGRAM

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## Bringing Health to YOU - Online DPP

The Chronic Disease Prevention Program has partnered with Intertribal Wellness to provide a 100% virtual Diabetes Prevention Program that is available at no cost to any eligible Wyoming resident over the age of 18 who is at risk for developing type 2 diabetes.

- 26 out of 40 seats filled
- Continuous enrollment
- How to refer a patient


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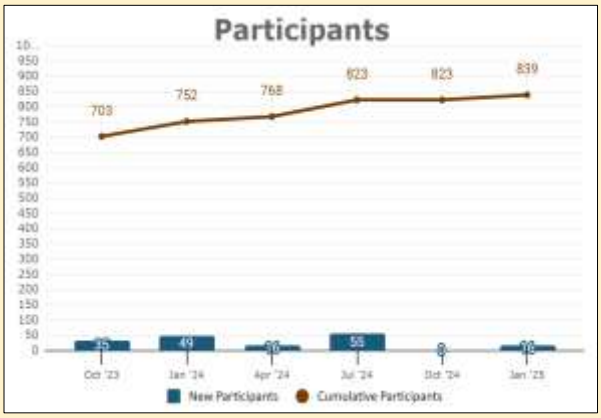
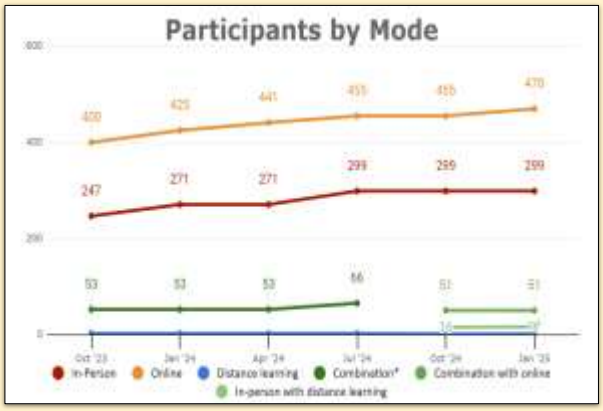
# DPP Dashboard

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## Cost-Effectiveness of the National Diabetes Prevention Program: A Real-World, 2-Year Prospective Study

Shihchen Kuo, Wen Ye, Di Wang, Laura N. McEwen, Claudia Villatoro Santos, and William H. Herman

*Diabetes Care* 2025;48(00):1–9 | https://doi.org/10.2337/dc24-1110

**In a real-world population with prediabetes, enrollment in the National Diabetes Prevention Program (NDPP) is likely to save money**

RESULTS: Comparing enrollees to non-enrollees:

- Cost savings of about $4,600 per person over 2 years (Figure)
- 2.6 percentage-point absolute risk reduction of developing diabetes over 2 years
- No difference in quality-adjusted life years (QALYs) over 2 years

Cost savings primarily related to lower costs for hospitalizations, outpatient visits, and emergency room visits among NDPP enrollees versus non-enrollees (Figure)

CONCLUSIONS:

Compared to non-enrollment, enrollment in the NDPP had:

- an 88% probability of being cost-saving

and resulted in:

- approximately $160,000 saved per case of diabetes prevented
- approximately $4.6 million saved per QALY-lost (incrementally cost-effective)
- a net monetary benefit of approximately $4,500 at a willingness-to-pay threshold of $100,000 per QALY gained

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## Healthy Heart Ambassador Blood Pressure Self Monitoring

- 73 facilitators trained, at least 1 facilitator in every county
- Startup funds and value-based payments are available
- Can be done concurrent with a DPP cohort

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## Family Healthy Weight Program


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# MEND: Mind Exercise Nutrition Do It!

## Healthy Together Program Option

| | |
|---|---|
| Who is it for? | Kids aged 6-13 with a BMI >85% and their parents |
| Number of families per cohort | 6+ |
| Duration | 10 weeks: 2x/week 60 -120 minute sessions |
| Delivery Mode | Online, in-person or hybrid |
| Staff Model | 1 coach |
| Typical Setting | Clinical or Community-based |

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# Marketing Case Study

**Community-Led Marketing in Frontier Communities**

Focus on marketing for DSMES and/or DPP programs in 2 communities

Project goals:

- Increase awareness and enrollment in the diabetes programs located in the selected communities.
- Document marketing processes and placement in frontier areas.
- Document what type of community engagement was done.
- Document differences in marketing strategy between selected communities

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HEALTHY U

**HealthyU workshops are available to anyone with a chronic health condition, such as diabetes, arthritis, high blood pressure, heart disease, pain, anxiety, or depression. It is also available to anyone who cares for someone with a chronic health condition or who simply wants to learn more about improving their health.**

## Chronic Disease Self-Management Program

| Activities | Improvements in: |
|---|---|
| • Action planning | • General health, disability |
| • Decision making | • Exercise habits |
| • Communication | • Communication w/ physicians |
| • Problem solving | • Social & activity limitations |
| • Medication management | • Fewer days in the hospital |

## Diabetes Self-Management Program

| Activities | Improvements in: |
|---|---|
| • Monitoring A1C & blood sugar | • Depression |
| • Menu Planning | • Symptoms of hypoglycemia |
| • Dealing with Stress | • Healthy eating |
| • Preventing or Delaying Complications | • Adherence to diabetes medication & testing |
| • Foot Care | • HbA1C levels |

## Cancer: Thriving and Surviving

| Activities | Improvements in: |
|---|---|
| • Fear of recurrence | • Depression |
| • Body image changes | • Provider communication |
| • Appropriate exercise | • Energy |
| • Making decisions: treatment & complementary therapies | • Sleep |
| • Dealing with negative emotions | • Stress-related problems |

## Healthy U Structure (All Workshops)

- (1) 2.5 hour class weekly for 6 weeks
- Facilitated by a pair of trained Leaders
- Leaders are community members with a strong connection to the topics
- 8-18 participants attend each workshop
- Includes homework, reading, etc.
- In-person and virtual delivery options

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HEALTHY U
FOR DIABETES

| | | Started | Completed |
|---|---|---|---|
| Riverton Honor Farm | 12/20/23-01/24/24 | 10 | 10 |
| Riverton Honor Farm | 02/07/24-03/13/24 | 10 | 9 |
| Riverton Honor Farm | 05/15/24-06/19/24 | 15 | 10 |
| Goshen County Senior Center | 11/01/24-12/20/24 | 8 | 7 |

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# GOAL

## Increase Access to DSMES

**"DSMES is highly effective in improving health and diabetes management skills, but less than 7% of eligible patients participate within the first year of diagnosis."**

CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

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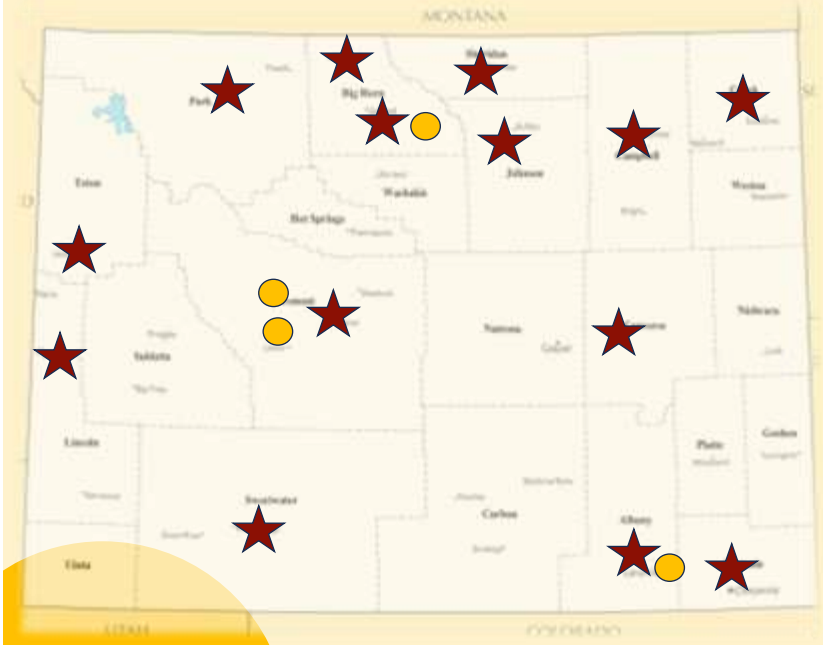


**Accredited Diabetes Self-Management Programs (DSME)**

- ✓ Ivinson Memorial Hospital - Laramie
- ✓ Big Horn Nutrition - Greybull
- ✓ North Big Horn Hospital - Lovell
- ✓ Hoskinson Health and Wellness Clinic - Gillette
- ✓ Memorial Hospital of Converse County - Douglas
- ✓ Crook County Hospital (PENDING)
- ✓ Fremont Wellness Education Center
- ✓ Johnson County Healthcare Center
- ✓ Cheyenne Regional Medical Clinic
- ✓ Star Valley Health
- ✓ Billings Clinic – Cody
- ✓ Sheridan Memorial Hospital
- ✓ Memorial Hospital of Sweetwater County
- ✓ St. John's Health

**Diabetes Prevention Programs (DPP)**

- ✓ Big Horn Nutrition
- ✓ Eastern Shoshone Tribal Health
- ✓ Intertribal Wellness (In Person & Virtual)
- ✓ UW College of Health Sciences -Laramie

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# HOW

**"To increase enrollment, the CDPP and contracted partners plan to tailor recruitment and referral strategies for the state by developing a centralized referral system for diabetes care. This system will allow for a single point of entry (e.g., a dedicated phone line, online portal) where individuals diagnosed with diabetes can contact for assistance and *(Provider)* referral."**

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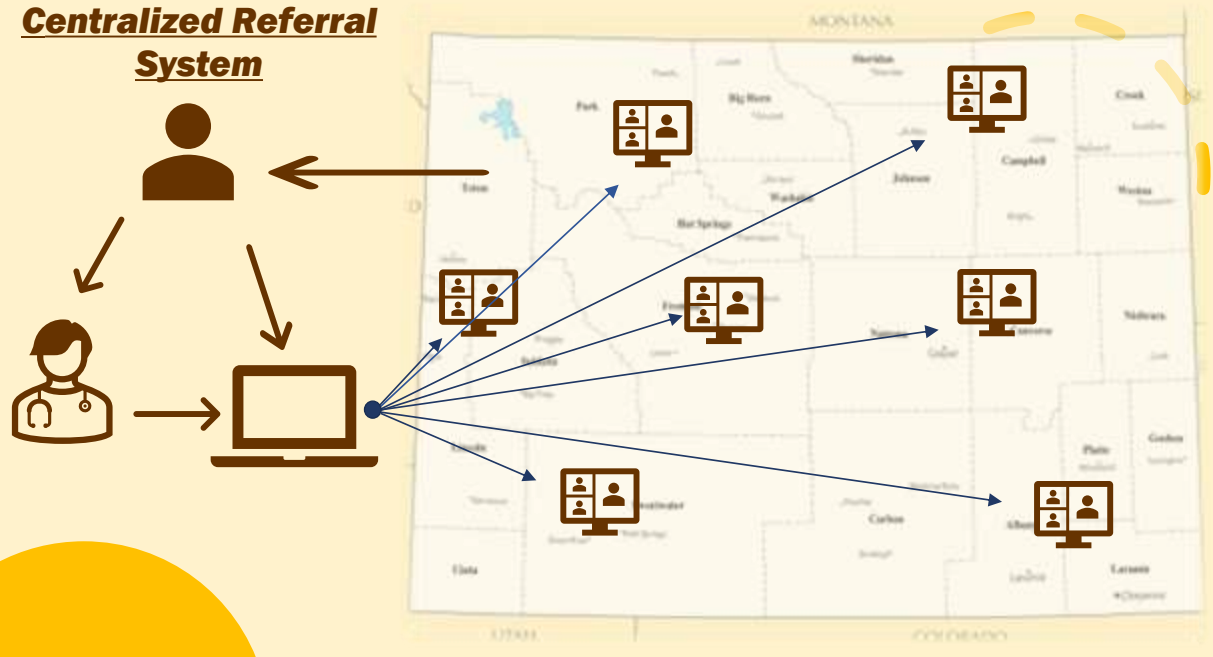
## ***Centralized Referral System***

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# Peer Learning Network

- Half-day Virtual Conference in October
- Annual Conference in Spring 2026

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# Community Diabetes Symposiums

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## We Want to Know

- **What's going well with your diabetes program?**
- **How satisfied are you with the technical assistance (if any) you have received from CDPP or its contractors (e.g. WyCOA, MPQH etc.)?**
- **How could CDPP allocate funds toward diabetes self-management projects to support your program?**
- **How could CDPP allocate funds toward diabetes prevention projects to support your program?**

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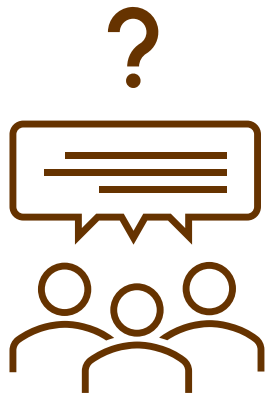

# Thank you !

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