Population Health Management: Improving Health Where We Live, Work, and Play

The findings and conclusions in this webinar are those of the presenters and do not necessarily represent the official position of Centers for Disease Control and Prevention.
Welcome and Introductions

Pam Allweiss, M.D., M.P.H.
Medical Officer
CDC Division of Diabetes Translation
Today’s Presenters

Ron Loeppke, M.D., M.P.H., FACOEM, FACP
Vice Chairman
U.S. Preventive Medicine

Jeanette May, Ph.D., M.P.H.
Principal Investigator
Robert Wood Johnson Foundation Grant
Why Are We Here?

Hot off the press from CDC researchers:

• We have an epidemic of diabetes AND in the past two decades, managing diabetes has become more expensive, mostly due to the higher spending on drugs.
• CDC researchers also asked whether costs were higher because people used health services more or because the price of the service had risen.
  – The answer? Both.
  – Patients now use more medication, and the costs of the drugs have also risen.

Goals

• Learn about the benefits of population health management where people live, work, and play.
• Learn strategies for collaboration between worksites and communities to improve health.
• Learn about resources in the public domain that can be used to improve health management in worksites and communities with an emphasis on the launch of the new *Diabetes at Work* website.
What Is the National Diabetes Education Program (NDEP)?

• Established in 1997 as an initiative of the U.S. Department of Health and Human Services to:
  – Promote early diagnosis.
  – Improve diabetes management and outcomes.
  – Prevent/delay the onset of type 2 diabetes in the United States and its territories.
• Jointly sponsored by CDC and National Institutes of Health (NIH).
• Involves 200+ federal, state, and private sector agency partners.
What Is the NDEP Business Health Strategies Stakeholder Group?

• Public and private partners such as:
  – Business coalitions
  – Occupational health providers such as the American College of Occupational and Environmental Medicine (ACOEM) and the Association of Occupational Health Nurses (AOHN)
  – Population Health Alliance
  – Health plans
  – State health departments
Making the Community an Integral Part of Your Care Team

- Better health, better health care, and better value
Population Health Management

Ron Loeppke, M.D., M.P.H., FACOEM, FACPM
Population Health Management: Overview of Presentation

• **WHY?**
  Delineate the converging trends that are advancing the value of health and the power of prevention in population health management.

• **WHAT?**
  Discuss the solid business case for why employers should be interested in population health management.

• **HOW?**
  Examine the attributes and results of successful workplace-oriented population health management initiatives.
Converging Trends Driving the Need for Population Health Management

- Epidemiological trends
- Political trends
- Cultural trends
- Financial trends
  - The problem
    - The cost crisis due in large part to the health crisis
  - The bigger problem
    - Total cost impact of poor health to employers
  - The solution
    - Evidence-based population health management
Converging Trends Driving the Need for Population Health Management

Epidemiological Trends

- The global burden of health risk and chronic illness
- The age wave—silver tsunami about to hit the health care system
- The compression of morbidity
The Challenge—The Epidemic of Non-Communicable Diseases (NCDs)

- Global drivers of mortality due to unhealthy lifestyle behaviors:
  
  ➢ **Five lifestyle behaviors**
    - Physical inactivity
    - Poor nutrition
    - Smoking
    - Alcohol
    - Medicine non-adherence

  ➢ **Five chronic conditions**
    - Diabetes
    - Heart disease
    - Lung disease
    - Cancer
    - Mental illness

  Seventy-five percent of deaths worldwide
When the Age Wave Hits the Shore: Implications for Caring for Aging Baby Boomers
Health Care Costs: Which Matters More, Age or Health Risk?

Annual Medical Costs

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Low</th>
<th>Med Risk</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-34</td>
<td>$1,776</td>
<td>$2,193</td>
<td>$5,114</td>
</tr>
<tr>
<td>35-44</td>
<td>$2,193</td>
<td>$2,740</td>
<td>$5,710</td>
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<tr>
<td>45-54</td>
<td>$2,565</td>
<td>$3,353</td>
<td>$7,991</td>
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<tr>
<td>55-64</td>
<td>$3,734</td>
<td>$4,620</td>
<td>$10,785</td>
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<tr>
<td>65-74</td>
<td>$4,163</td>
<td>$5,756</td>
<td>$11,909</td>
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<tr>
<td>75+</td>
<td>$5,114</td>
<td>$7,989</td>
<td>$11,965</td>
</tr>
</tbody>
</table>

Personal Health Behaviors Are the Main Causes of Death

Health Behaviors: The Main Mortality Risk Factors in the United States

Live Healthier Longer and Die More Suddenly at Lower Cost

- The compression of morbidity relates to postponing the age of onset of morbidity, disability, and cumulative health costs—even though life expectancy is increased largely by reducing health risks.

Converging Trends
Driving the Need for Population Health Management

• Epidemiological Trends
  – Global burden of risk and illness
  – The age wave—silver tsunami about to hit the health care system
  – Compression of morbidity

• Political Trends
  – Affordable Care Act National Prevention Strategy
  – Aligning incentives among consumers, providers, and employers
  – Accountable care organizations (ACOs)/patient centered medical homes (PCMHs)
ACOs/PCMH Definitions

- **Accountable Care Organizations (ACOs)**
  - Care model that makes physicians and hospitals more accountable
  - Outcomes-oriented, performance-based with aligned incentives
  - Goal to improve value of health services, control costs, improve quality
  - ACOs sharing in a portion of any savings gained

- **Patient Centered Medical Homes (PCMHs)**
  - “Whole-person” and “whole-population” orientation
  - Integrated and coordinated care
  - More emphasis on quality, safety, better access to physicians
  - Aligned incentives for improving health as well as better clinical outcomes
Converging Trends Driving the Need for Population Health Management

- **Epidemiological Trends**
  - Global burden of risk and illness
  - The age wave—silver tsunami about to hit the health care system
  - Compression of morbidity

- **Political Trends**
  - Aligning incentives among consumers, providers, employers
  - ACOs/Pay for Performance/PCMH…Consumer-centered health at home

- **Cultural Trends**
  - Health as the new green: the ultimate sustainability strategy
  - Social networking/game theory innovations in health
  - Mobile/wireless tech transforming the health care industry
Mobile Technology: The World’s Most Ubiquitous Platform

- More people have access to cell phones than drinking water, electricity, or a toothbrush.

Transforming Health Care

By 2020, ~160 million Americans will be monitored and treated remotely for at least one chronic condition.

Prescription Apps—Wireless Engagement

- Poised to transform health care as we know it
- Effective channel to deliver behavior change interventions to large groups at lower costs (Noar & Harrington, 2012)
- Perpetual connectivity/communication
  - Information into knowledge
  - Reminders/notifications
  - Knowledge into action
  - Clinical and social support
  - Action into results
- Always with you, always on

Converging Trends Driving the Need for Population Health Management

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Cultural Trends
- Wellness as the new green: the ultimate personal sustainability
- Social networking/game theory innovations in wellness
- Mobile/wireless tech transforming the health care industry

Financial Trends
- The problem: the cost crisis largely due to the health crisis
Patients With Chronic Diseases Account for Seventy-Five Percent of U.S. Health Care Costs

Of the $3 trillion spent on U.S. health care

Of every dollar spent…

…75 cents went towards treating patients with one or more chronic diseases

In public programs, treatment of chronic diseases constitutes an even higher portion of spending:

More than **96 cents** in Medicare…

…and **83 cents** in Medicaid

“The United States cannot effectively address escalating health care costs without addressing the problem of chronic diseases.”

-- Centers for Disease Control and Prevention
Population Health Management:  
**Good Health is Good Business**

- As health risks go, so go health costs
- Dr. Dee Edington
  – *Zero Trends*
Learning From the Past

An Ounce of Prevention is Worth a Pound of Cure

- Benjamin Franklin -
Converging Trends Driving the Need for Population Health Management

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Financial Trends
– The problem: the cost crisis largely due to the health crisis
– The bigger problem: the total cost impact of poor health to employers
The Bigger Problem: The Full Cost of Poor Health

Medical Care
- Pharmaceutical costs

Productivity Costs

Absenteeism
- Short-term disability
- Long-term disability

Presenteeism
- Overtime
- Turnover
- Temporary staffing
- Administrative costs
- Replacement training
- Offsite travel for care
- Customer dissatisfaction
- Variable product quality

Top 10 Health Conditions by Med + Rx Costs
Per 1,000 Full Time Employees (FTEs) for Employers

Top 10 Health Conditions by Full Costs for Employers
(Med + RX + Absenteeism + Presenteeism) Costs/1,000 FTEs

The Business Value of Better Health and Productivity

- Market cap value impact from regaining one day of productivity per year per FTE
- 58,000 employees, current 8 days per FTE of health-related productivity loss

1 day per FTE of regained productivity = $18.8M Earning Before Interest, Taxes, Depreciation and Amortization

13x (EBITDA Multiple)

$244.4M estimated market cap increase

÷ 292M shares

$0.84 in additional per share value

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**Financial Trends**
- The problem: the cost crisis largely due to the health crisis
- The bigger problem: total cost impact of poor health to employers
- **The solution:** evidence-based population health management
Evidence-Based Preventive Medicine a Key Component

• CDC has found that:
  – Eighty percent of heart disease and type 2 diabetes and forty percent of cancer are *preventable* if people just:
    o Stopped smoking.
    o Ate healthy.
    o Exercised.
Whole Population Health Management

**PRIMARY PREVENTION**
Wellness/Health Promotion

**SECONDARY PREVENTION**
Screening/Early Detection

**TERTIARY PREVENTION**
Early Intervention/Care Mgmt

Total Population

Low Risk
Medium Risk
High Risk

Better Health, Better Healthcare and Better Value

Need for Better Diabetes Population Health Management

- **86 million** Americans have PRE-DIABETES
- **29 million** Americans have DIABETES
- **21 million** of those are DIAGNOSED
- **17 million** of those are TREATED
- **8.5 million** have their disease CONTROLLED
- **20.5 million** have Diabetes that is NOT CONTROLLED
- **77 million** are UNAWARE
- **8 million** are UNDIAGNOSED
- **4 million** are diagnosed but NOT TREATED
- **8.5 million** are treated but NOT SUCCESSFULLY CONTROLLED

**Goal:**
- Reduce or Eliminate Risk Factors and Avert Disease
- Find and Treat Disease in Its Earliest Stages to Stop Its Progression
- Manage Disease to Avoid Complications and Disease Progression
- Manage Disease to Avoid Complications and Disease Progression
- Avert Onset of Diabetes or Costs Due to Untreated or Uncontrolled Disease

Sources: NIH, CDC, American Diabetes Association
The Association of Technology in a Workplace Wellness Program With Health Risk Factor Reduction

Ron Loepke, MD, MPH, Dee Edington, PhD, Joel Bender, MD, MPH, MSPH, and Ashley Reynolds, MSN, RN

Objective: Determine whether there is a relationship between level of engagement in workplace wellness programs and population-individual health risk reductions. Methods: A total of 794 employees from 15 employers completed health risk appraisal and laboratory testing at baseline and again after 2 years of participating in their personalization prevention plan. Population and individual health risk transitions were analyzed across the population, as well as by stage of engagement. Results: Of those individuals who started in a high risk category at baseline, 46% moved down to medium risk and 19% moved down to low risk category after 2 years on their prevention plan. In the group that only engaged through the Web-based technology, 26% reduced their health risk(s) (P < .0001). Conclusions: Engaging technology and interactive Web-based tools can engage individuals to be more proactive about their health and reduce their health risks.

Chronic illness and health care costs are advancing at a staggering rate worldwide. The World Economic Forum, in its Global Risk 2010 report, indicated that the impact on developing countries as well as advanced economies from the "silent pandemic" of chronic illness (like diabetes, heart disease, and cancer) is a critical global risk that is not adequately acknowledged by individuals as well as nations and that the only sustainable solution is a greater emphasis on prevention. These dramatic increases are largely attributable to lifestyle- or behavior-related causes such as suboptimal eating habits, smoking, or sedentary lifestyle. Given the converging epidemiological, political, cultural, and financial trends, delivering accountable care organizations and patient-centered medical home initiatives are the need for better health at lower cost. This requires a sustainable prevention strategy in concert with effective health management systems. Therefore, employers intervene to address the growing burden of health risks leading to the expanding burden of chronic illness as not only a fiscal imperative but also a clinical and moral imperative.1-3

The current risk model in the United States is not designed to meet the real health and wellness needs of people. Therefore, employers fund the majority of the economic burden of this broken system, because they pay for the ever increasing costs of medical care while our system spends less than $0.05 of every health care $1.00 on prevention to help promote a healthier, safer, more productive workforce. A large percentage of 137 million employees in the United States receive some health benefits today. Therefore, employers have a unique opportunity to play a stronger role because lifestyle risks and medical conditions directly influence productivity. Workplace health and wellness initiatives now reach millions of workers, with occupational health professionals designing and delivering wellness and prevention services typically impacting employees many hours per month compared with the minutes spent in a primary care physician’s office each year. Occupational health providers are a critical medical resource for the nation’s workers and their dependents. With its emphasis on prevention, the relevance of occupational health and its sphere of influence on population health management are a great resource of medical support for patient-centered medical homes and accountable care organizations. By embracing a prevention and health promotion strategy, employers have the capability and expertise to meet the challenges of creating a more resilient, healthier workforce and improving their bottom line.

US Preventive Medicine, Inc (Boston, TN), has created an innovative information technology solution for a personalized prevention solution, the Prevention Plan. The Prevention Plan leverages social cognitive concepts such as efficacy building and self-regulatory mechanisms like goal setting and self-monitoring, which facilitate health behavior change.1 The Web-based prevention plan allows individual users to complete a health risk appraisal (HRA), biometric reporting, and laboratory testing to develop a customized prevention plan. The plan provides users with knowledge of their health risks as well as suggestions to reduce those risks. In addition, each user is provided a suite of support tools, recommended risk-reduction activities, and information that allows them to translate knowledge into action.

Users were able to complete an HRA, virtual coaching, live coaching, or social challenges to reduce their risks and were able to determine for themselves what level of engagement they preferred. All coaching programs were structured using risk-profiling educational modules. Live coaches completed these modules telephonically, while virtual coaching was completed using the same content, through self-directed online programs. Both coaching interventions used recommended action plans related to the risks identified from the risk appraisal, laboratory testing, and biometric screening. They were based on identification of barriers, goal setting, and self-monitoring activities aimed at increasing self-efficacy. Live coaches used motivational interviewing as a method of engagement for engaging members in the coaching process, which was the only significant difference from the virtual coaching intervention.

NATURAL FLOW OF HEALTH RISK

The tool used to initiate awareness of health, determine health risk status of populations, and raise consciousness about health is the HRA. The health risks and cutoff points used in the HRA have been described previously.4 The most commonly used risk stratification is low-risk status (zero to two risk factors), medium-risk status (three to four risk factors), and high-risk status (five or more risk factors). The first HRA provides baseline information to individuals with future HRAs indicating the direction individuals are moving on a continuum of health.5 The transition of individuals or percentage of individuals moving from one risk status to another when individuals are not engaged in wellness programs has been described by Dr Dee Edington as the natural flow of health risks. The transitions are measured using Marovian chain analysis, a mathematical technique used to examine longitudinal data from the same individuals, which is described in our previous work.6 The risk transitions for the population studied in this article were also analyzed using this same type of Markov chain analysis. It becomes obvious from the diagrams used to display the risk transitions that slowing upward migration into
Significant Overall Health Risk Reduction of Population Participating in a Personalized Preventive Plan for 2 Years

Net Movement of Health Risk Levels in Cohort Baseline vs Year 2 on Preventive Plan

N = 7,804

Population Health Risk Transitions in Markov Chain Analysis After 2 Years on a Personalized Preventive Plan

N = 7,804 Participants

Individual Health Risk Reductions After Participating in Their Personalized Preventive Plan for 2 Years (Total N = 7,804)

<table>
<thead>
<tr>
<th>Individual Risks</th>
<th># people and % of overall population (7,804) with high risk in baseline year</th>
<th># people and % of the baseline high risk group remaining high risk after year 2</th>
<th># people and % of the baseline high risk group reducing risk out of high risk after year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>923 (12%) (M=142/90)</td>
<td>179 (19%) (M=143/90)</td>
<td>744 (81%) (M=123/77)</td>
</tr>
<tr>
<td>HDL</td>
<td>328 (4%) (M=31)</td>
<td>134 (41%) (M=30)</td>
<td>194 (59%) (M=41)</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>836 (11%) (M=263)</td>
<td>353 (42%) (M=265)</td>
<td>483 (58%) (M=208)</td>
</tr>
<tr>
<td>Fasting Blood Glucose</td>
<td>1616 (21%) (M=116 mg/dL)</td>
<td>926 (57%) (M=123 mg/dL)</td>
<td>690 (43%) (M=92 mg/dL)</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td>3338 (43%) (M=33)</td>
<td>2937 (82%) (M=34)</td>
<td>401 (12%) (M=26)</td>
</tr>
</tbody>
</table>

Total Medical and Pharmacy Claims Costs for One Actual Employer Over 1 year

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Claims Paid Between 6/1/2012 and 5/31/2013</td>
<td></td>
</tr>
<tr>
<td>Medical Paid</td>
<td>$ 94,318,172.00</td>
</tr>
<tr>
<td>Rx Paid</td>
<td>$ 30,836,368.78</td>
</tr>
<tr>
<td>Total Paid</td>
<td>$125,154,540.78</td>
</tr>
</tbody>
</table>
## Example of Data Analysis for Evidence-Based CARE GAPS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Care Guide</th>
<th>Care Guide Total</th>
<th>Condition Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Patients with asthma related ER visit</td>
<td>161</td>
<td>4680</td>
</tr>
<tr>
<td>Asthma</td>
<td>Patients with asthma related hospitalization</td>
<td>138</td>
<td>4680</td>
</tr>
<tr>
<td>Asthma</td>
<td>Patients without inhaled corticosteroids or leukotriene inhibitors</td>
<td>2785</td>
<td>4680</td>
</tr>
<tr>
<td>Asthma</td>
<td>Patients without office visit</td>
<td>643</td>
<td>4680</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients with CHF or pulmonary edema related ER visit</td>
<td>98</td>
<td>722</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients with CHF or pulmonary edema related hospitalization</td>
<td>262</td>
<td>722</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients without ACE inhibitors or ARBs (HED18)</td>
<td>328</td>
<td>722</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients without beta-blocker drugs (HED18)</td>
<td>271</td>
<td>722</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients without LDL-C or lipid profile test in the last 12 months</td>
<td>611</td>
<td>722</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Patients without office visit in the last 12 months</td>
<td>311</td>
<td>722</td>
</tr>
<tr>
<td>Depression</td>
<td>Patients taking SSRI and bupropion</td>
<td>236</td>
<td>3342</td>
</tr>
<tr>
<td>Depression</td>
<td>Patients with depression related ER visit</td>
<td>121</td>
<td>3342</td>
</tr>
<tr>
<td>Depression</td>
<td>Patients with depression related hospitalization</td>
<td>261</td>
<td>3342</td>
</tr>
<tr>
<td>Depression</td>
<td>Patients without office visit in the last 12 months</td>
<td>2168</td>
<td>3342</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Patients with antiplatelet agent (HED18)</td>
<td>328</td>
<td>1638</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Patients without Hba1c test in the last 12 months</td>
<td>525</td>
<td>1638</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Patients without lipid profile test in the last 12 months</td>
<td>647</td>
<td>1638</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Patients without nephropathy screening in the last 12 months</td>
<td>1033</td>
<td>1638</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Patients without retinal eye exam in the last 12 months</td>
<td>103</td>
<td>1638</td>
</tr>
</tbody>
</table>
Employer Case Study of Diabetes Care Management:
*Total Costs Per Person with Diabetes Per Month across 3 Years in Program

N = 299

*Total Costs Include Medical/Rx Claims Costs as well as the Costs of the Diabetes Care Management Program

- Pre-Program: $1,262.15
- Year 1: $849.17 (33%)
- Year 2: $691.85 (45%)
- Year 3: $667.20 (47%)
Employer Case Study of Diabetes Care Management:
*Total Annual Costs for 299 Individuals with Diabetes across 3 Years in Program

N = 299

*Total Cost Savings After Subtracting the Costs of the Diabetes Care Management Program

3 Year Cumulative Cost Savings
$5,662,689
($18,938 Savings per Person)
Population Health and Public/Private Partnerships

Jeanette May, M.P.H., Ph.D.
Efforts to Enhance Public–Private Partnerships

Healthy Workplaces, Healthy Communities
- HERO Environmental Scan
- HERO Executive Convening
- Dissemination

- Clinton Health Matters
- Robert Wood Johnson Foundation Culture of Health
- Institute of Medicine Population Health Roundtable
- Employer Roundtable—Building the Business Case
- Healthy Workplaces, Healthy Communities Website
- Bluezones Prevention Partners, etc.
**Business Case Development and Evolution**

- **Compliance-Driven**
  - (e.g., meeting minimal regulatory standards for worker safety)

- **Charitable**
  - (e.g., corporate giving campaigns that enhance company brand, image)

- **Strategic**
  - (e.g., core business and management systems deployed to generate health and business value)

- **Systemic**
  - (e.g., systemic solutions designed to intentionally generate population health and business value, and to address social determinants of health)

Adapted from: Visser W. J Bus Systems, 2010; A New CSR Frontier. BSR, 2013; HERO: Role of Corporate America in Community Health, 2014
Resources in the Public Domain: No Copyright

Diabetes at Work website
• www.diabetesatwork.org
• Ten-year anniversary
• Completely updated by an NDEP Task Group chaired by Dr. Loeppke

General NDEP materials
• http://www.cdc.gov/diabetes/ndep

Primary Prevention of Diabetes
• http://www.cdc.gov/diabetes/prevention
Diabetes accounts for 15 million work days absent and 120 million work days with reduced performance.

Let's prevent and manage diabetes. It's good for employees and good for business.

Spotlight On...

Diabetes is a Common Disease

Diabetes is a common disease, yet every individual needs unique care. We encourage people with diabetes...

More success stories

What's New

Use wellness programs to help obese workers, attorneys say

Featured Resources

- GAME PLAN Fat and Calorie...
- Diabetes Snapshot

Quick Links

- Lesson Plans
- Depression CE
www.diabetesatwork.org

- **Featured Resources**
  - GAME PLAN Fat and Calorie Counter
  - Diabetes Snapshot

- **Quick Links**
  - Lesson plans
  - Depression (Continuing Education given)
  - Fact sheets

- **Ask the Expert**
  - Find answers to your questions from experts in diabetes and worksite wellness.
• **Diabetes Basics**
  - What is diabetes
  - Diabetes and the workplace
  - Employees with diabetes
  - Diabetes prevention
  - Diabetes management
  - Emotional health
  - Healthy lifestyles
  - Diabetes and pregnancy
www.diabetesatwork.org

• Plan
  – Understand your environment.
  – Conduct a health risk assessment.
  – Make the business case.
  – Set goals, timeline, budget.
  – Work with third-party providers.
• Build
  – Developing a culture of wellness
  – Program activities
  – Lesson plans
  – The health care team
  – In the community
National Diabetes Education Program
A program of the National Institutes of Health and the Centers for Disease Control and Prevention

For more information, call 1-800-CDC-INFO (800-232-4636).
TTY 1-888-232-6348 or visit www.cdc.gov/info.
To order resources, visit www.cdc.gov/diabetes/ndep.

Or contact:
Pam Allweiss M.D., M.P.H.
Medical Officer
Centers for Disease Control and Prevention
Division of Diabetes Translation
pca8@cdc.gov