

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.





National Diabetes Education Program

A program of the National Institutes of Health and the Centers for Disease Control and Prevention

Welcome and Introductions



Pam Allweiss, M.D., M.P.H.

Medical Officer

CDC Division of Diabetes Translation



National Diabetes Education Program

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Today's Presenters



**Ron Loeppke, M.D., M.P.H., FACOEM,
FACPM**

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

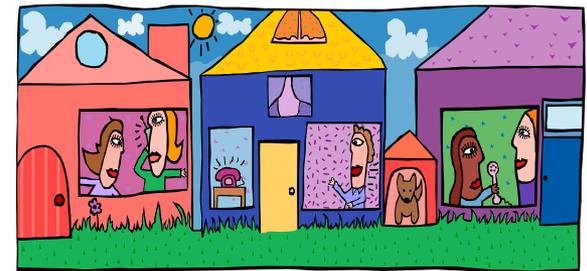
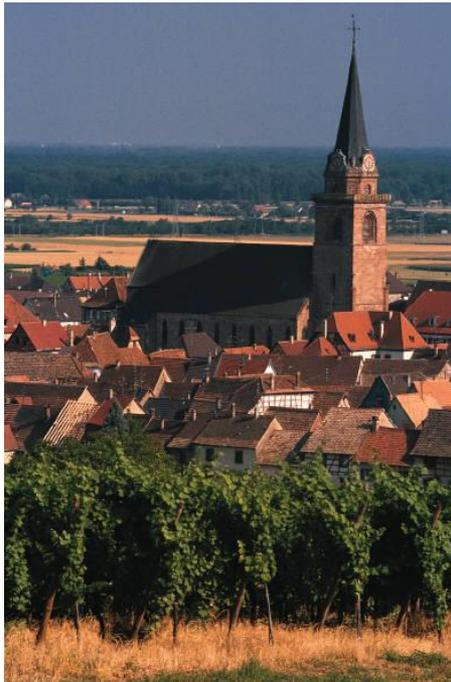


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Making the Community an Integral Part of Your Care Team

- Better health, better health care, and better value





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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

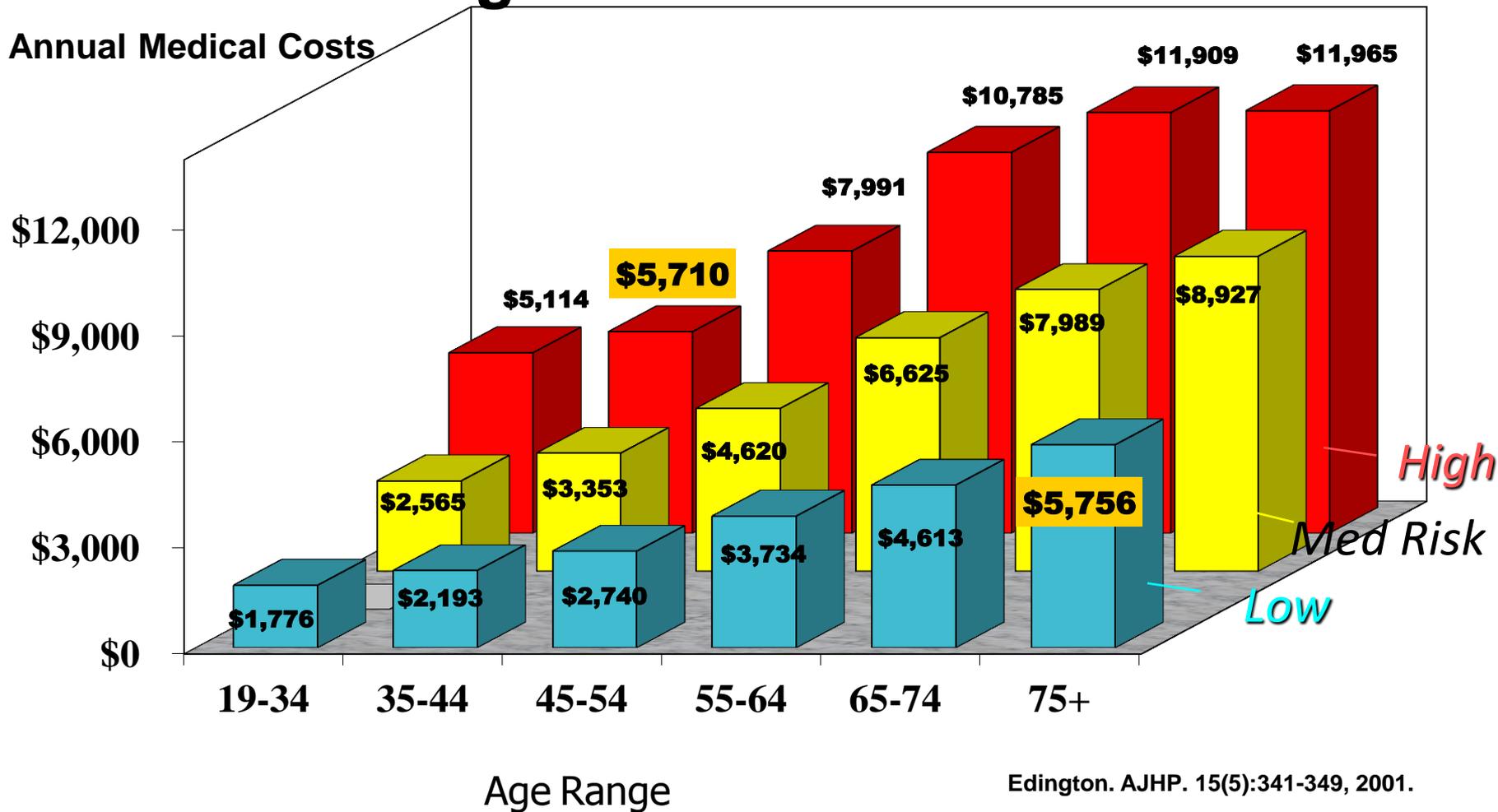
Seventy-five percent of deaths worldwide



**When the Age Wave Hits the Shore:
Implications for Caring for Aging Baby
Boomers**



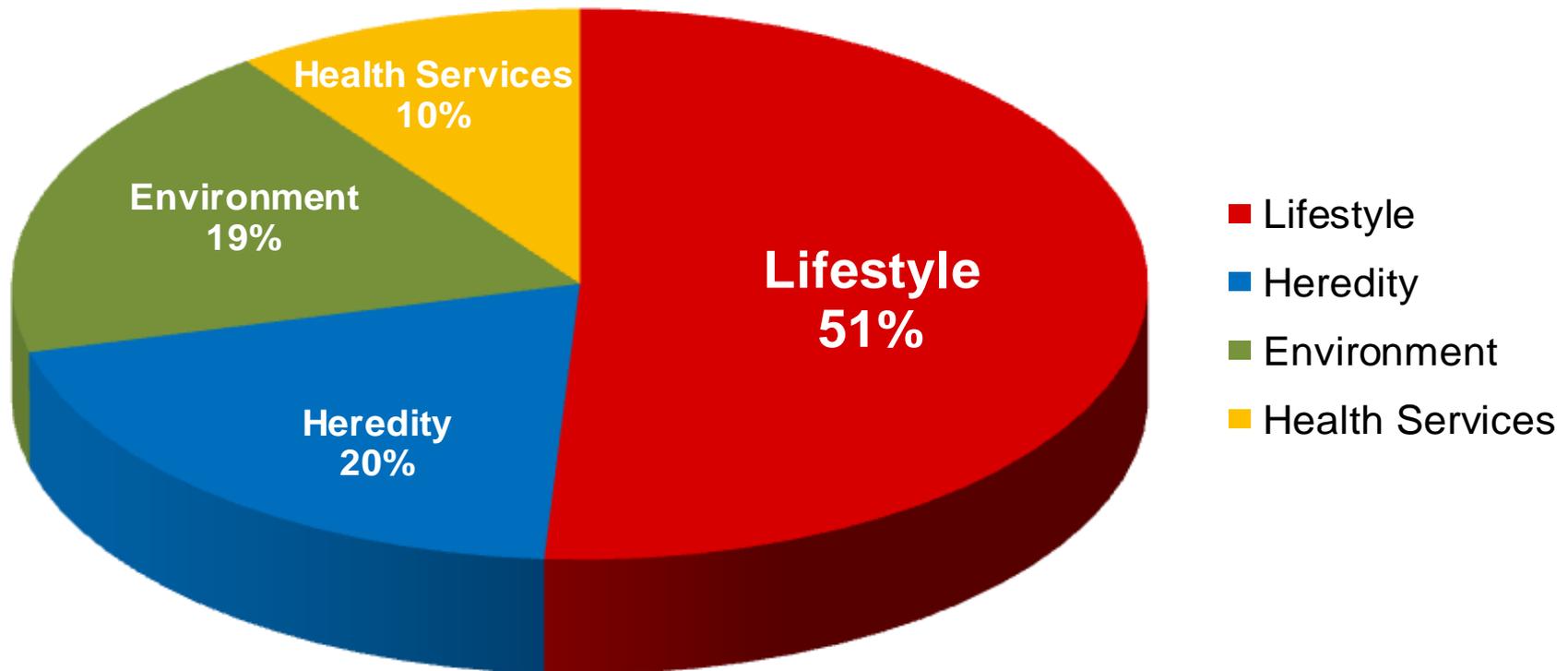
Health Care Costs: Which Matters More, Age or Health Risk?



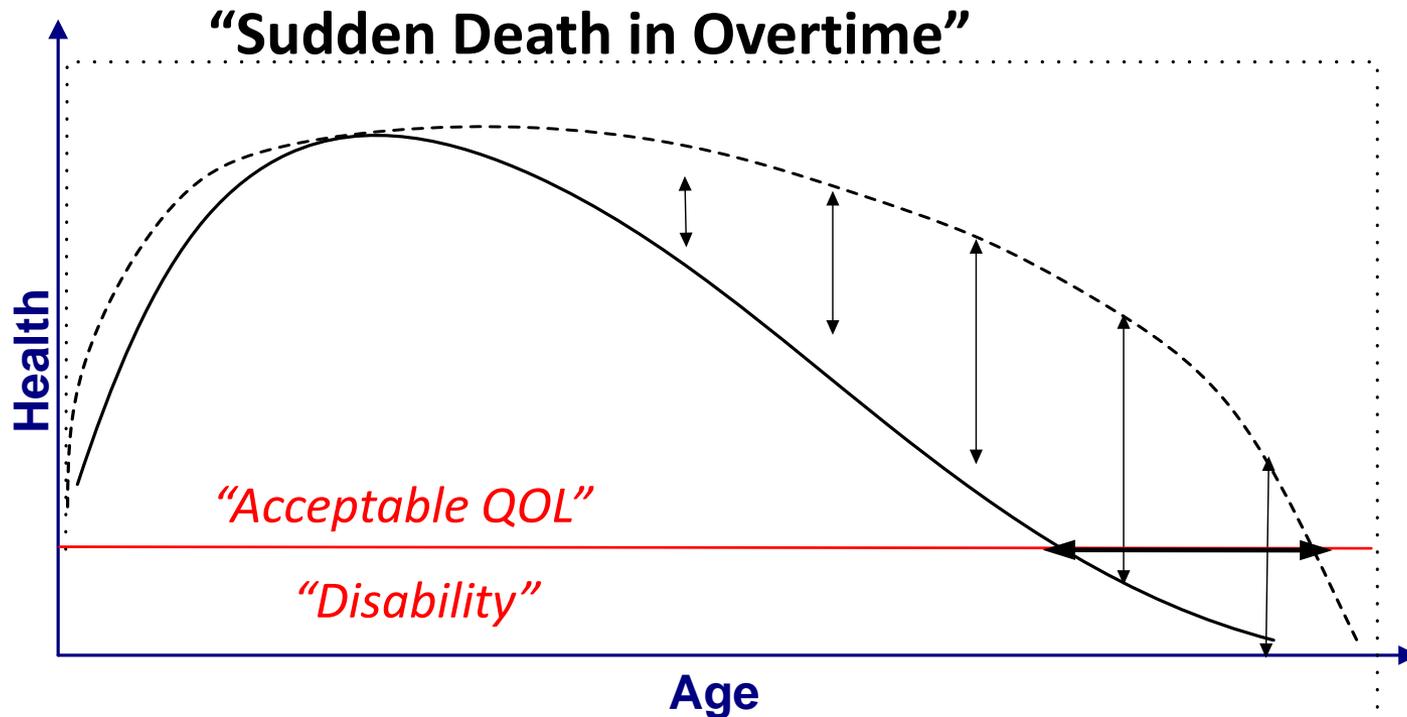


Personal Health Behaviors Are the Main Causes of Death

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

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- 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.





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Transforming Health Care

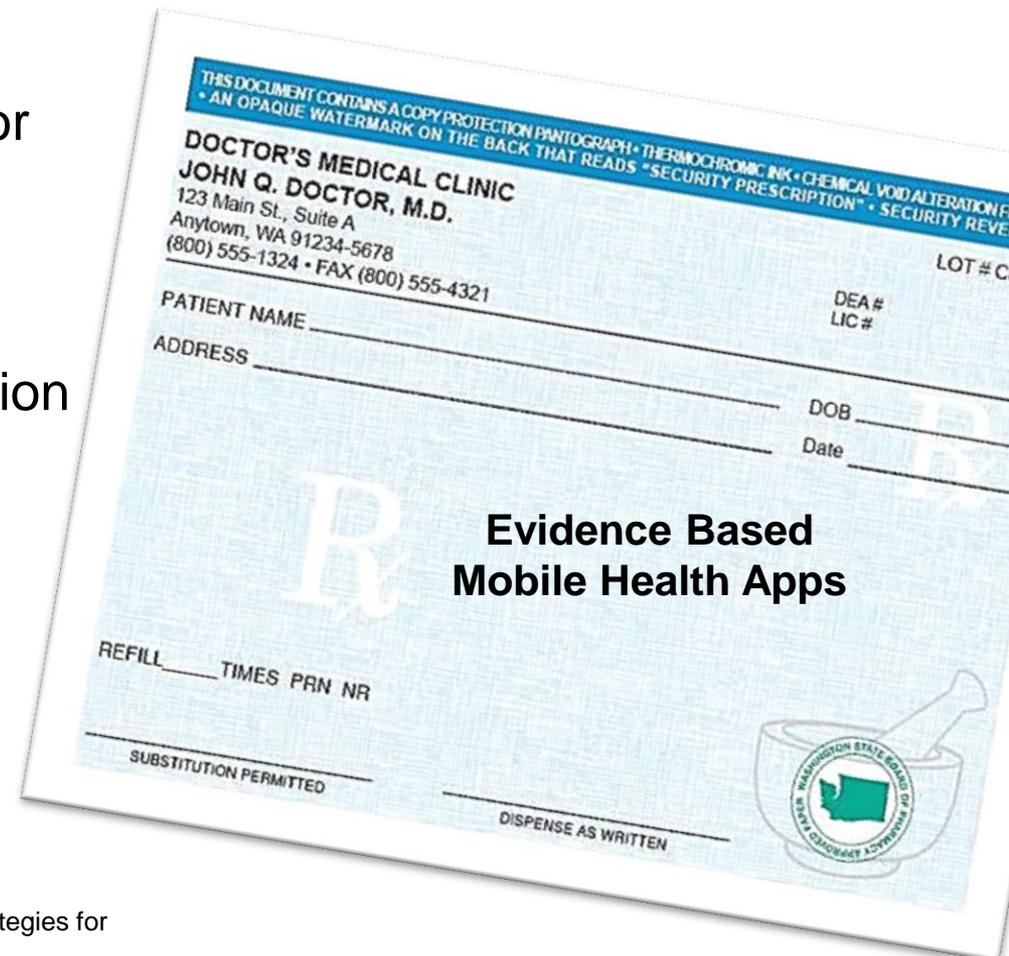
An elderly man with glasses is sitting on a couch in a dimly lit room, focused on assembling a large puzzle on a coffee table. A glowing blue and orange wavy line arches over the scene. A white remote control is connected to the puzzle by a thin white cord.

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





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- ACOs/PCMHs

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.”

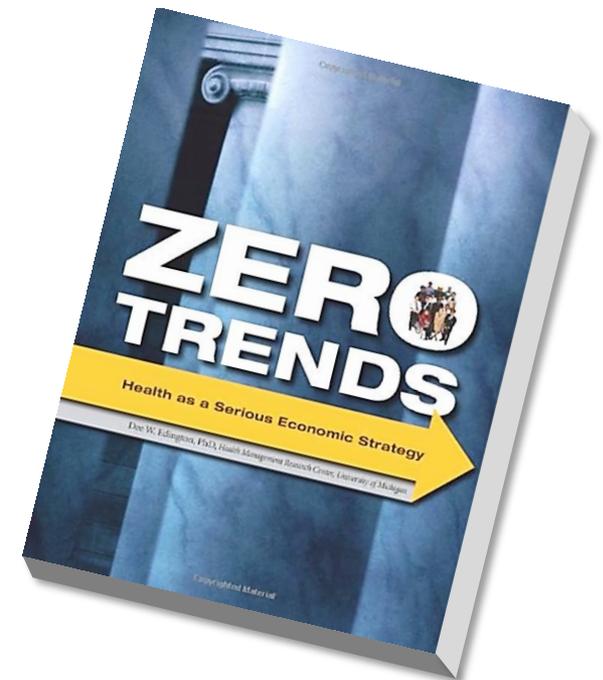


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Population Health Management: *Good Health is Good Business*

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

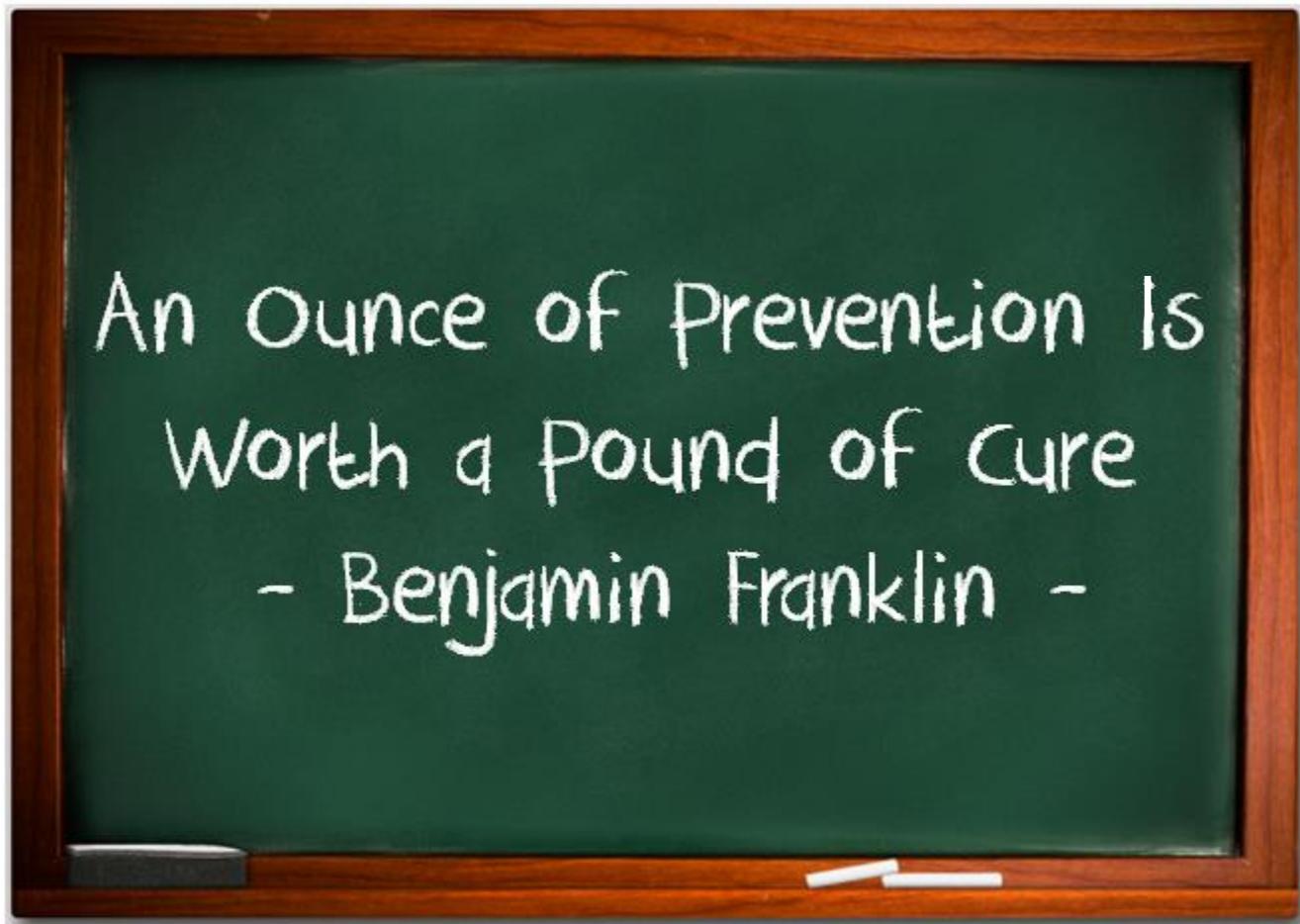




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Learning From the Past





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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

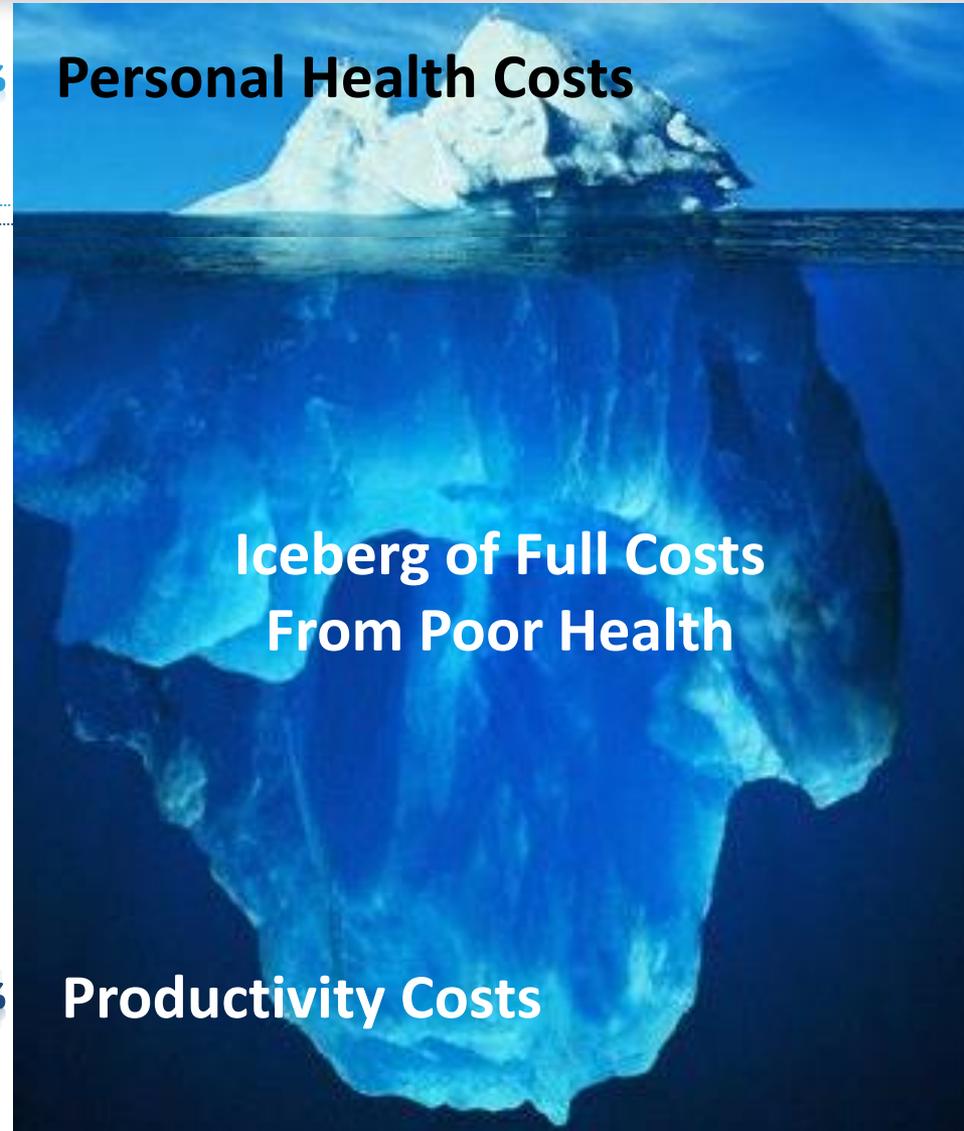
30%

Personal Health Costs

Iceberg of Full Costs
From Poor Health

70%

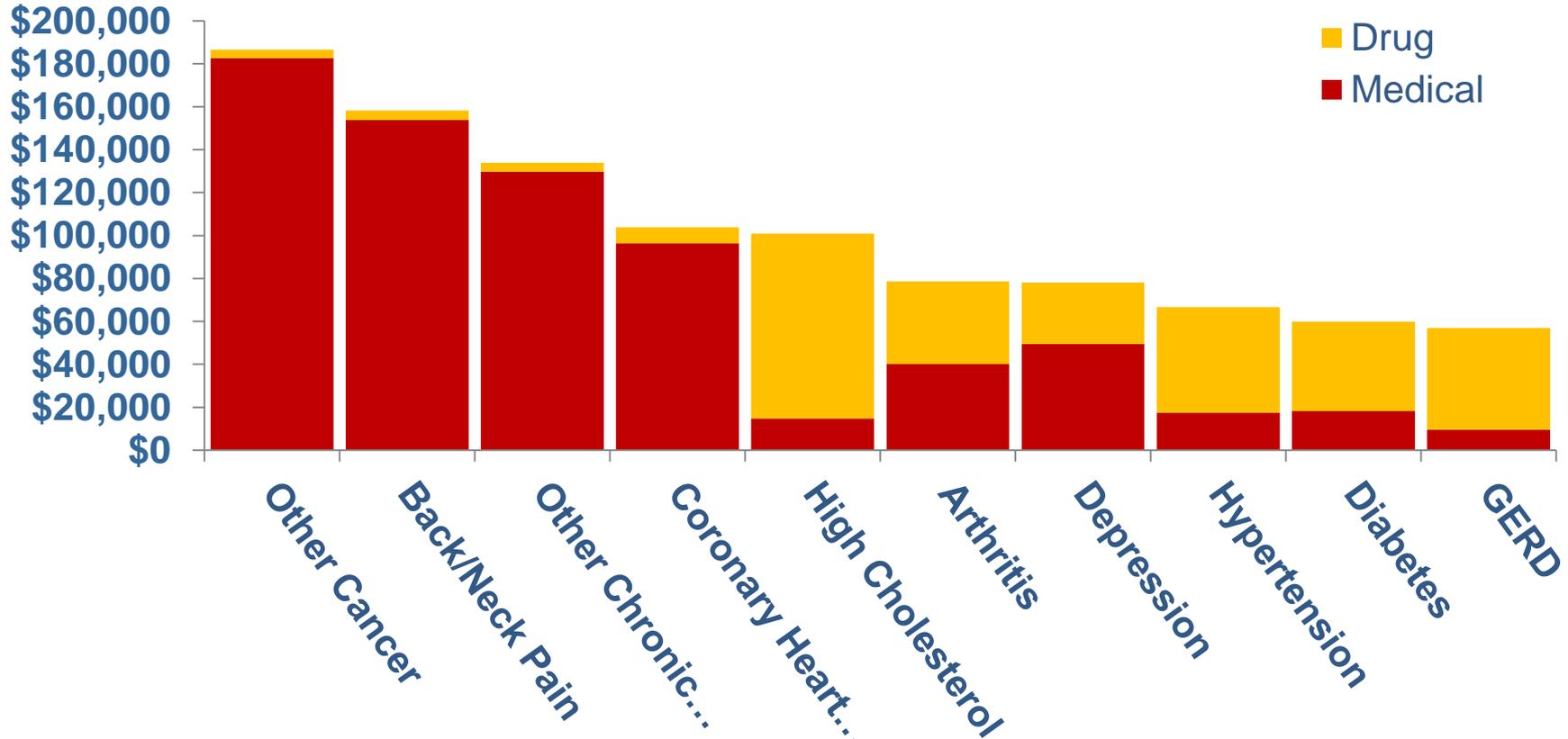
Productivity Costs





Top 10 Health Conditions by Med + Rx Costs

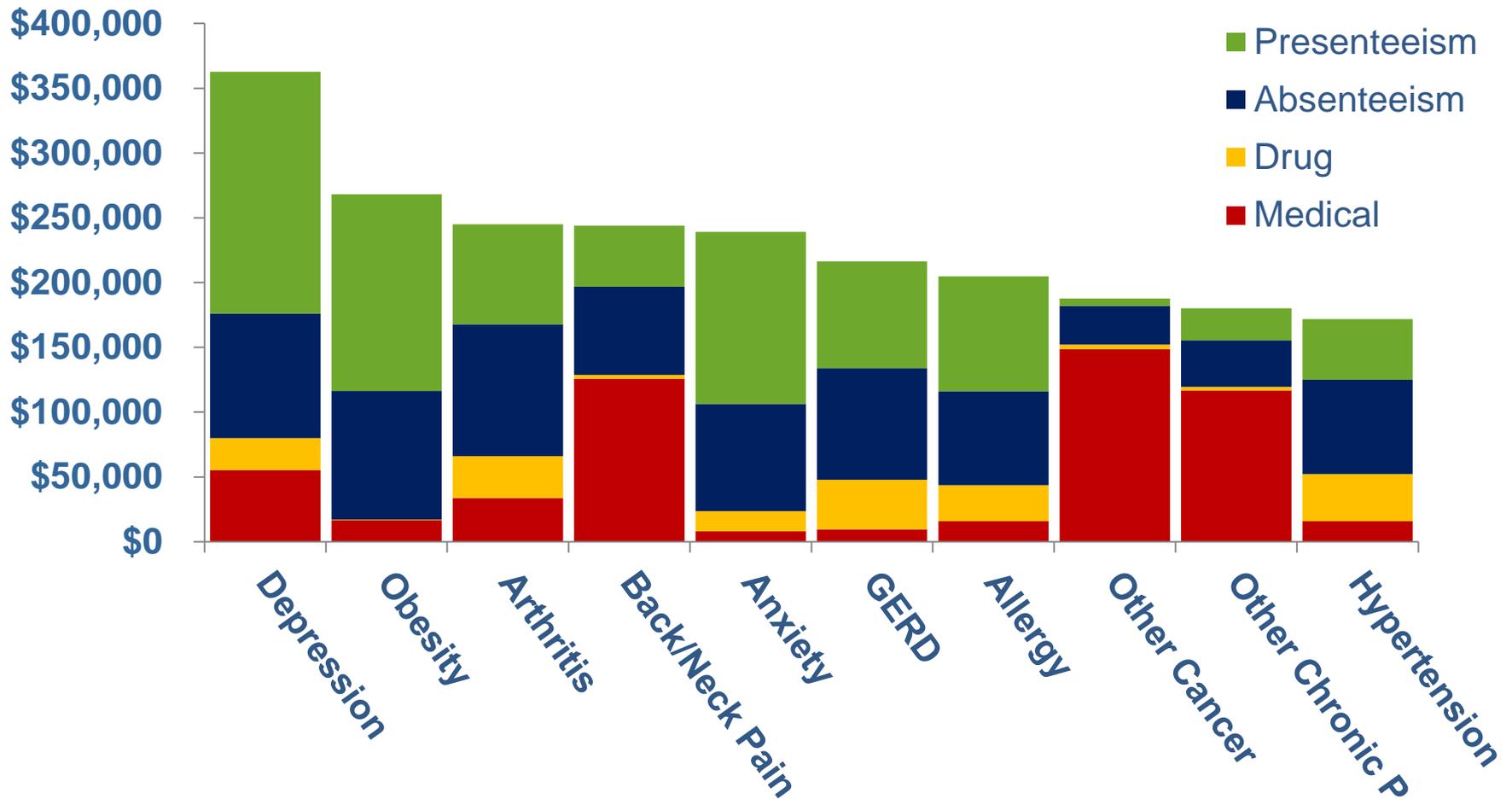
Per 1,000 Full Time Employees (FTEs) for Employers





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

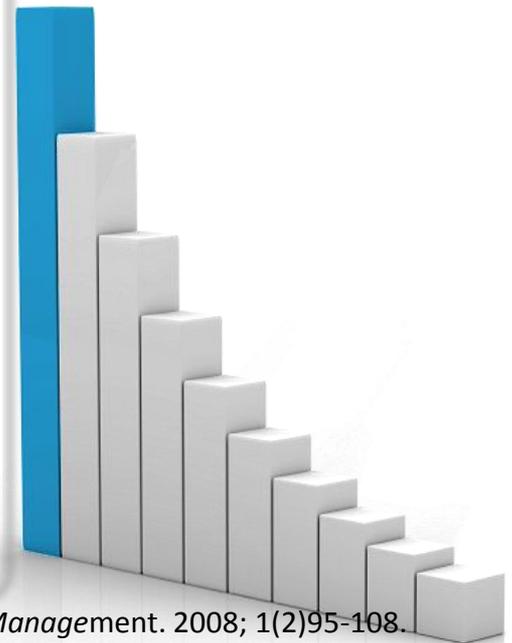
1 day per FTE of regained productivity =
**\$18.8M Earning Before Interest, Taxes,
Depreciation and Amortization**

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:
 - Stopped smoking.
 - Ate healthy.
 - Exercised.



Whole Population Health Management

PRIMARY PREVENTION

Wellness/Health Promotion

SECONDARY PREVENTION

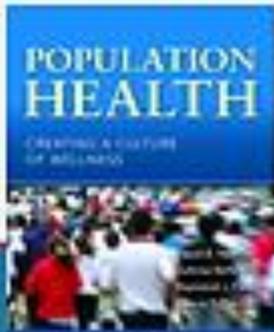
Screening/Early Detection

TERTIARY PREVENTION

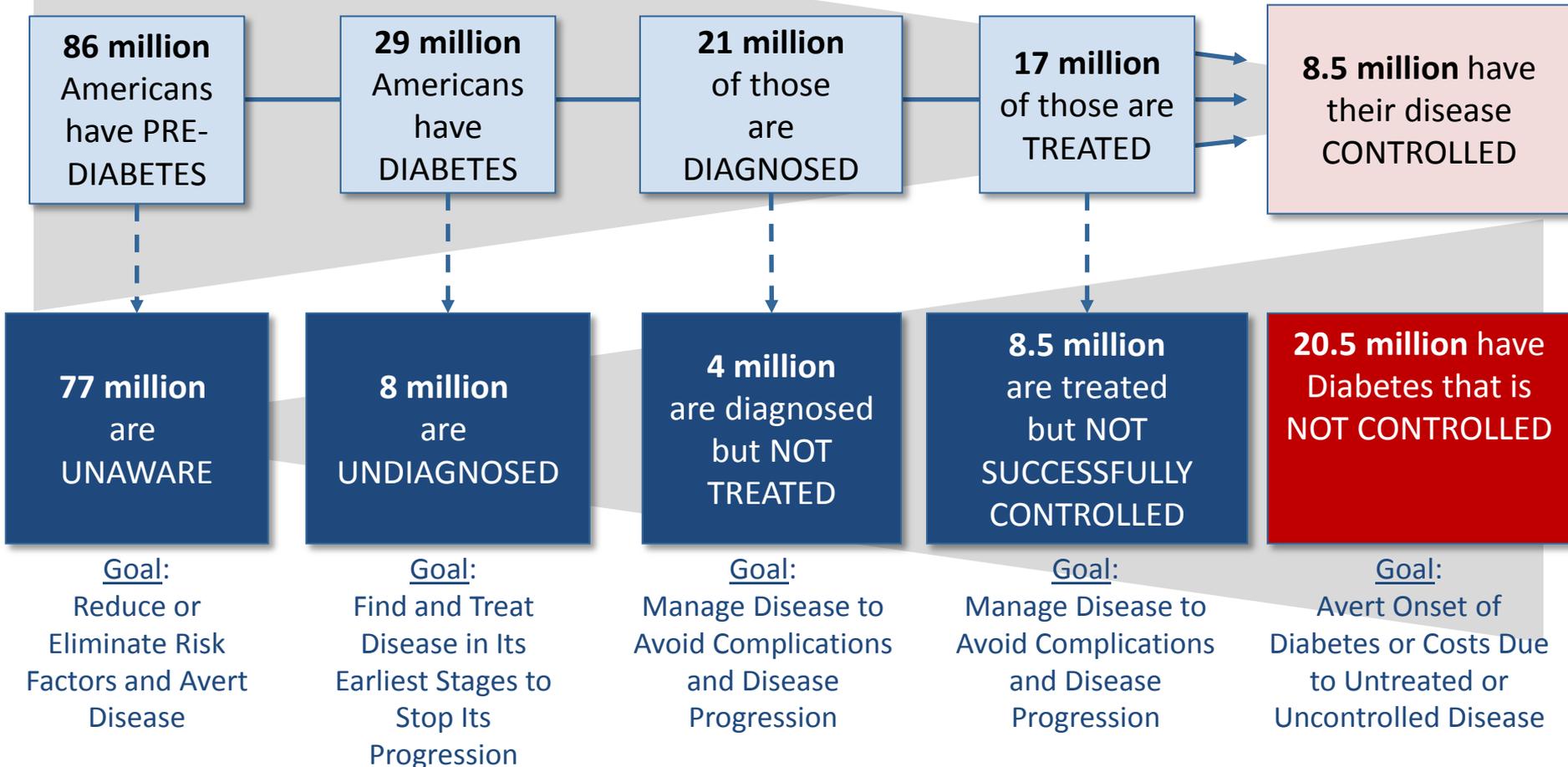
Early Intervention/Care Mgmt



Better Health, Better Healthcare and Better Value



Need for Better Diabetes Population Health Management



www.foem.org

JOEM

Journal of
Occupational and
Environmental MedicineAMERICAN COLLEGE OF
OCCUPATIONAL AND
ENVIRONMENTAL MEDICINE

- New-onset Asthma and Occupational Exposures
- Rheumatoid Arthritis Impact on Annual Incremental Health Benefit Costs and Absenteeism
- Modifiable Health Risks and Illness Absence from Work
- Patient-reported Depression Severity Measured by the PHQ-9 and Impact on Work Productivity

Fast Track Article

- Association of Technology in a Workplace Wellness Program with Health Risk Factor Reduction

Wolters Kluwer Health
Lippincott
Williams & Wilkins

The Association of Technology in a Workplace Wellness Program With Health Risk Factor Reduction

Ron Loeppke, MD, MPH, Dee Edington, PhD, Joel Bender, MD, PhD, 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 7804 employees from 15 employers completed health risk appraisal and laboratory testing at baseline and again after 2 years of participating in their personalized 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, 24% reduced their health risks ($P < 0.0001$). **Conclusions:** Engaging technology and interactive Web-based tools can empower 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 illnesses (like diabetes, heart disease, and cancer) is a critical global risk that is destructive and debilitating to 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 unhealthy eating habits, smoking, or sedentary lifestyles. Given the converging epidemiological, political, cultural, and financial trends, driving accountable care organizations and patient-centered medical home initiatives is the need for better health at lower cost. This requires a sustainable prevention strategy in concert with effective population health management interventions to reduce 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 sick care 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 health benefits at work; 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 em-

ployees 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 (Brentwood, 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.⁴ This 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-based 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 programs related to the risks identified from the risk appraisal, laboratory testing, and biometric screening. They were focused on identification of barriers, goal setting, and self-monitoring activities aimed at increasing self-efficacy. Live coaches used motivational interviewing as a method 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.⁵ 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.⁶ 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 Markov chain analyses, a mathematical technique used to examine longitudinal data from the same individuals, which is described in our previous work.⁷ The risk transitions for the population studied in this article were also analyzed using this same type of Markov chain analyses. It becomes obvious from the diagrams used to display the risk transitions that slowing upward migration into

From US Preventive Medicine, Inc (Dr Loeppke and Bender and Mr Reynolds), Brentwood, Tenn; and Health Management Research Center (Dr Edington), University of Michigan, Ann Arbor.

The authors declare no conflict of interest. No funding was received. Dr Ron Loeppke, Dr Joel Bender, and Mr Ashley Reynolds are employees of US Preventive Medicine, Inc, and Dr Dee Edington is a consultant and member of the US Preventive Medicine International Advisory Board.

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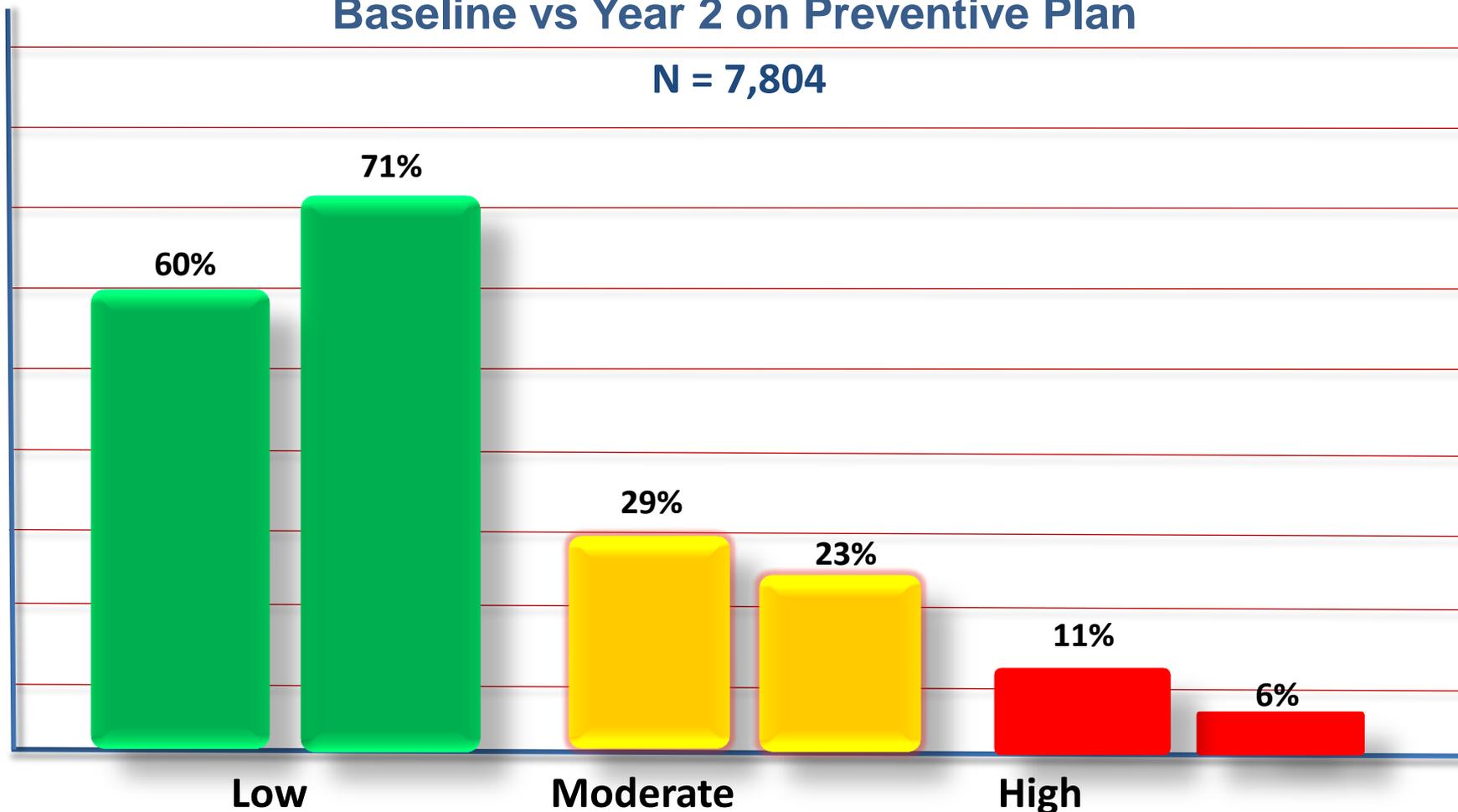
Copyright © 2013 by American College of Occupational and Environmental Medicine

DOI: 10.1097/JOM.0b013e3182896639

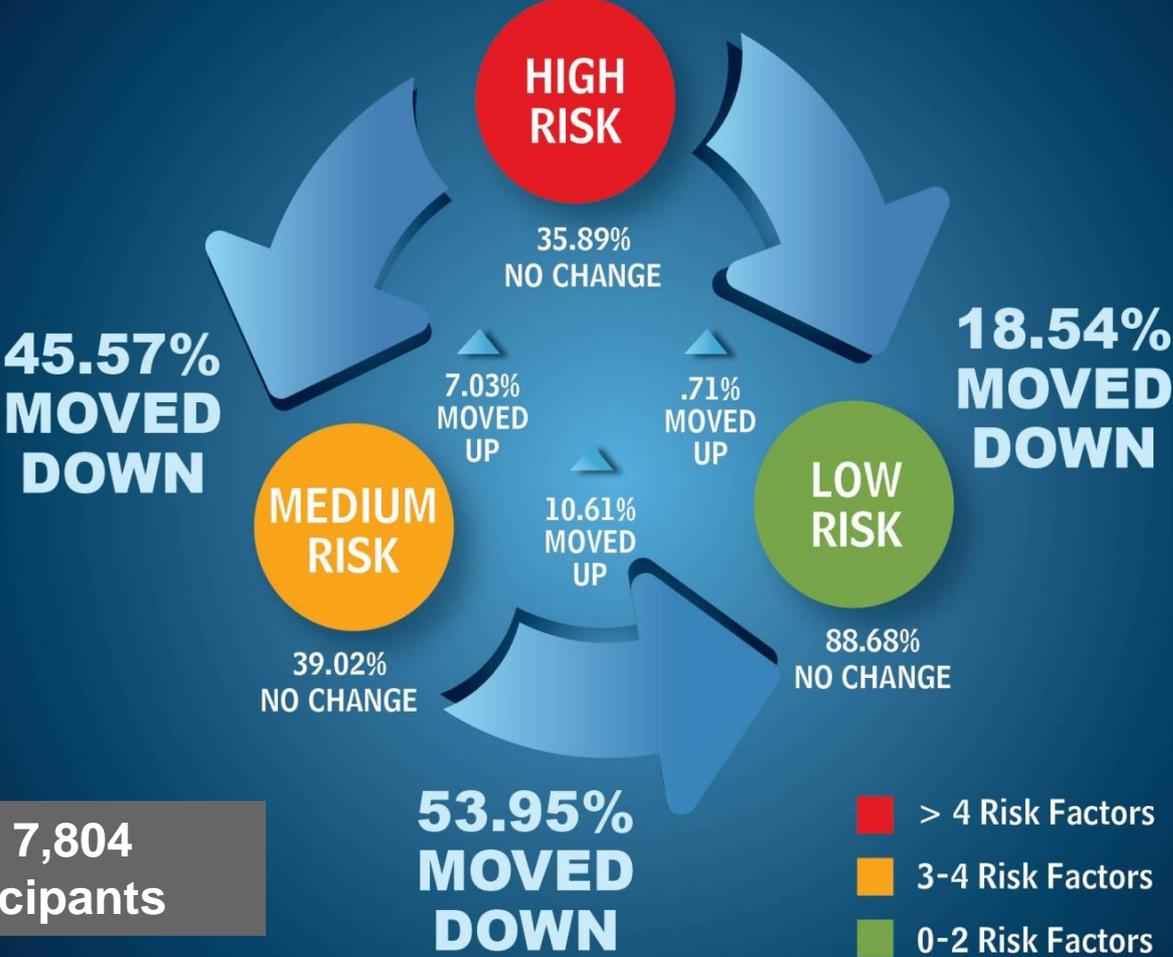
Significant Overall Health Risk Reduction of Population Participating in a Personalized Preventive Plan for 2 Years

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



Loeppke R, Edington D, Bender J, Reynolds A. The association of technology in a workplace wellness program with health risk factor reduction. *Journal of Occupational and Environmental Medicine*: March, 2013; Volume 55, Number 3: pp 259–264.

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

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

Loeppke R, Edington D, Bender J, Reynolds A. The association of technology in a workplace wellness program with health risk factor reduction. *Journal of Occupational and Environmental Medicine*: March, 2013; Volume 55, Number 3: pp 259–264.

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

Total Claims Paid Between 6/1/2012 and 5/31/2013

Medical Paid	\$ 94,318,172.00
Rx Paid	\$ 30,836,368.78
Total Paid	\$125,154,540.78

Example of Data Analysis for Evidence-Based CARE GAPS

GAPS in EVIDENCE BASED CARE			
Condition	Care Guide	Care Guide Total	Condition Total
Asthma	Patients with asthma related ER visit	161	4680
Asthma	Patients with asthma related hospitalization	138	4680
Asthma	Patients without inhaled corticosteroids or leukotriene inhibitors	2788	4680
Asthma	Patients without office visit	643	4680
Congestive Heart Failure	Patients with CHF or pulmonary edema related ER visit	98	722
Congestive Heart Failure	Patients with CHF or pulmonary edema related hospitalization	262	722
Congestive Heart Failure	Patients without ACE inhibitors or ARBs (HEDIS)	328	722
Congestive Heart Failure	Patients without beta-blocker drugs (HEDIS)	271	722
Congestive Heart Failure	Patients without LDL-C or lipid profile test in the last 12 months	611	722
Congestive Heart Failure	Patients without office visit	311	722
Congestive Heart Failure	Patients without office visit in the last 12 months	677	722
Depression	Patients taking SSRI and bupropion	286	3842
Depression	Patients with depression related ER visit	121	3842
Depression	Patients with depression related hospitalization	261	3842
Depression	Patients without office visit in the last 12 months	2168	3842
Diabetes	Patients with antiplatelet agent (HEDIS)	328	1638
Diabetes	Patients without HbA1c test in the last 12 months	525	1638
Diabetes	Patients without lipid profile test in the last 12 months	647	1638
Diabetes	Patients without nephropathy screening in the last 12 months	1033	1638
Diabetes	Patients without retinal eye exam in the last 12 months	103	1638

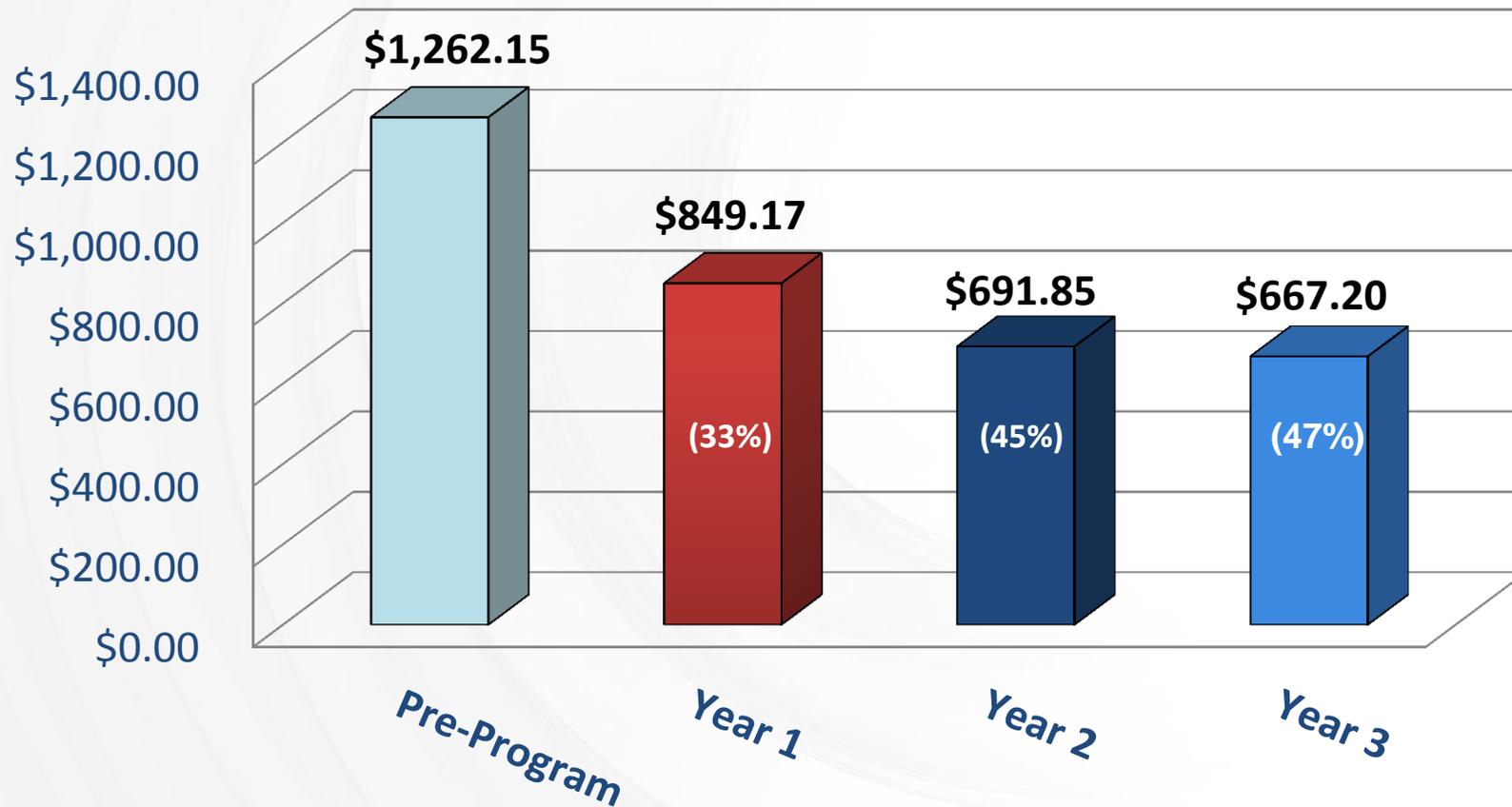


Employer Case Study of Diabetes Care Management:

*Total Costs Per Person with Diabetes Per Month across 3 Years in Program

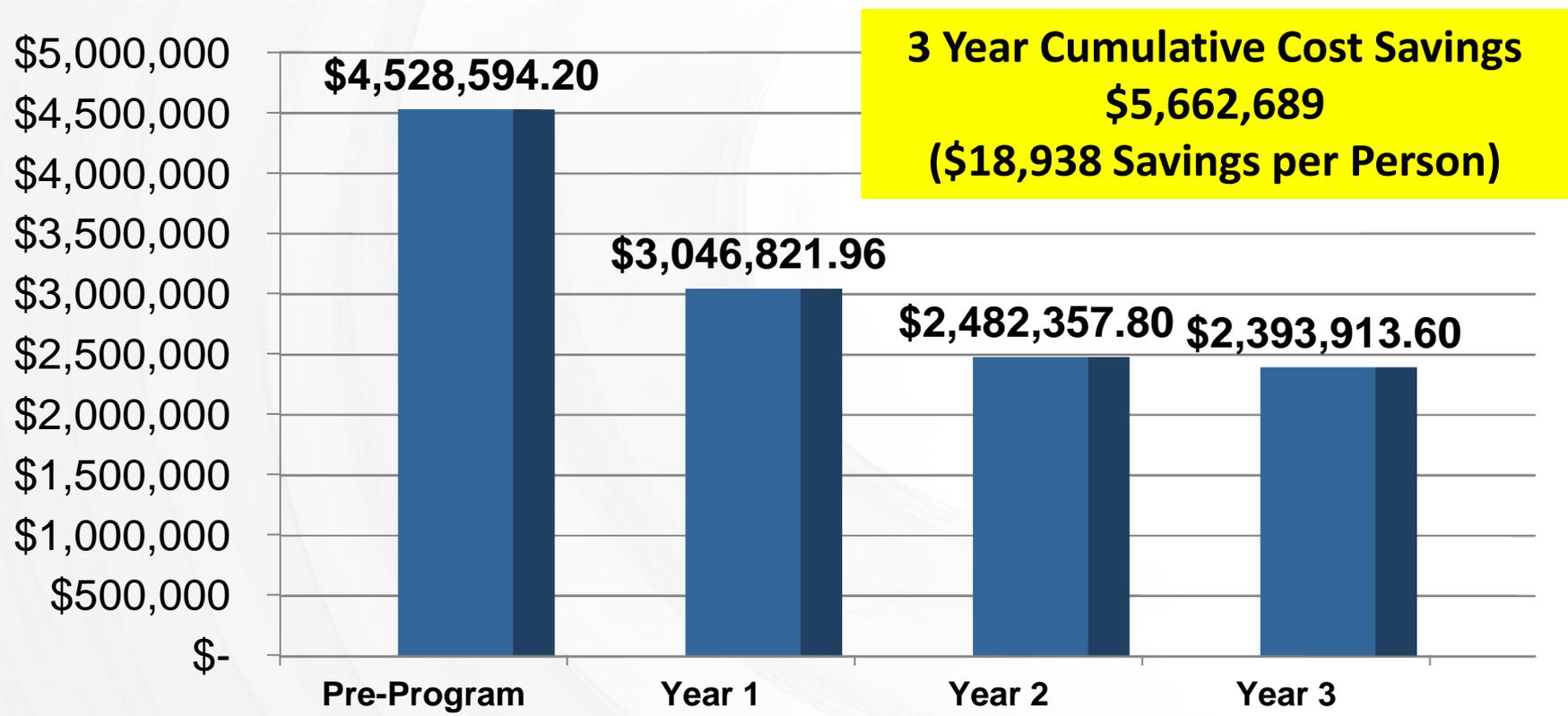
N = 299

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



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

N = 299





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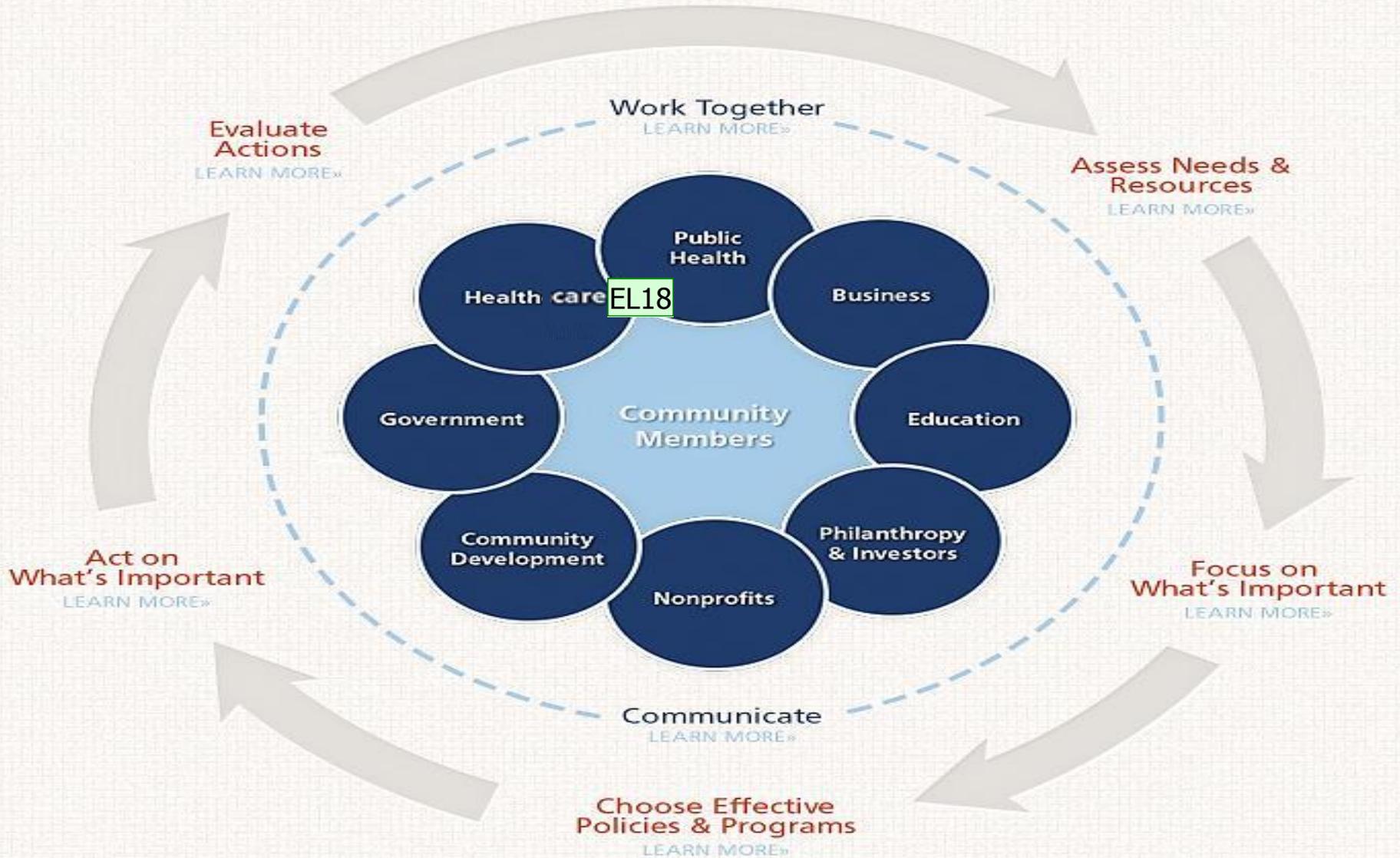
Population Health and Public/Private Partnerships

Jeanette May, M.P.H., Ph.D.



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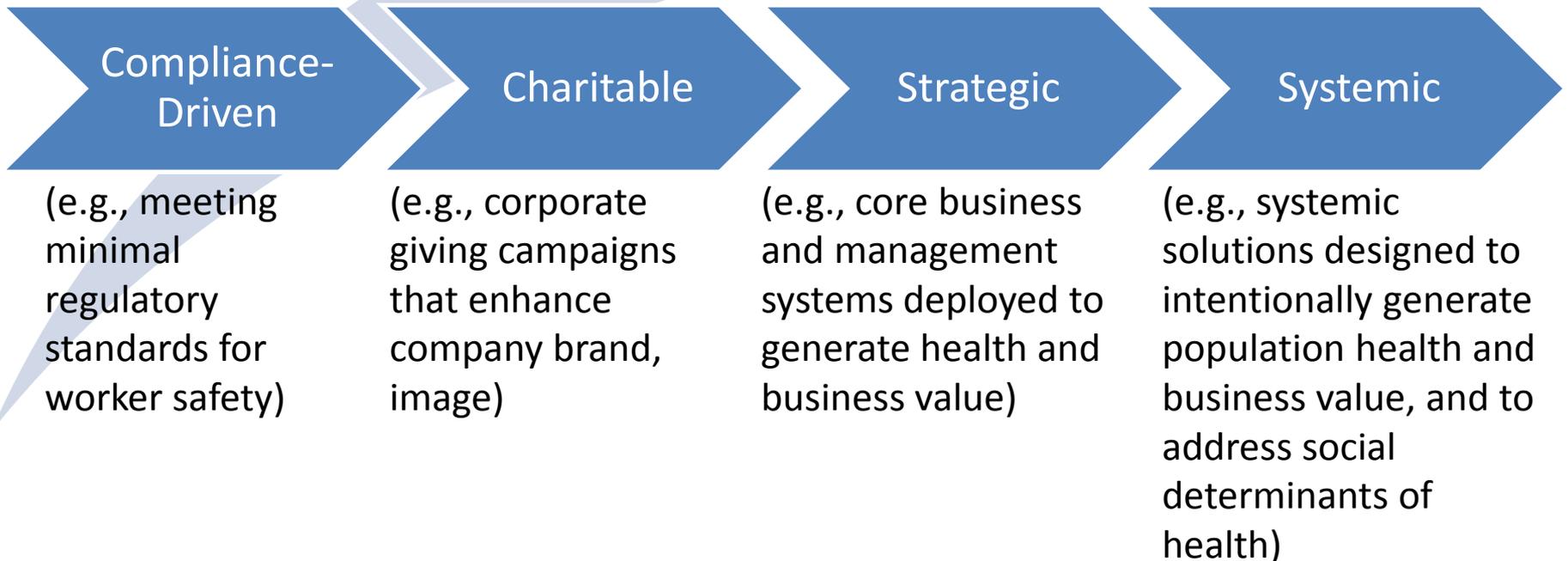


Efforts to Enhance Public–Private Partnerships





Business Case Development and Evolution





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[Why Invest In a Healthy Community](#)

[What To Do](#)

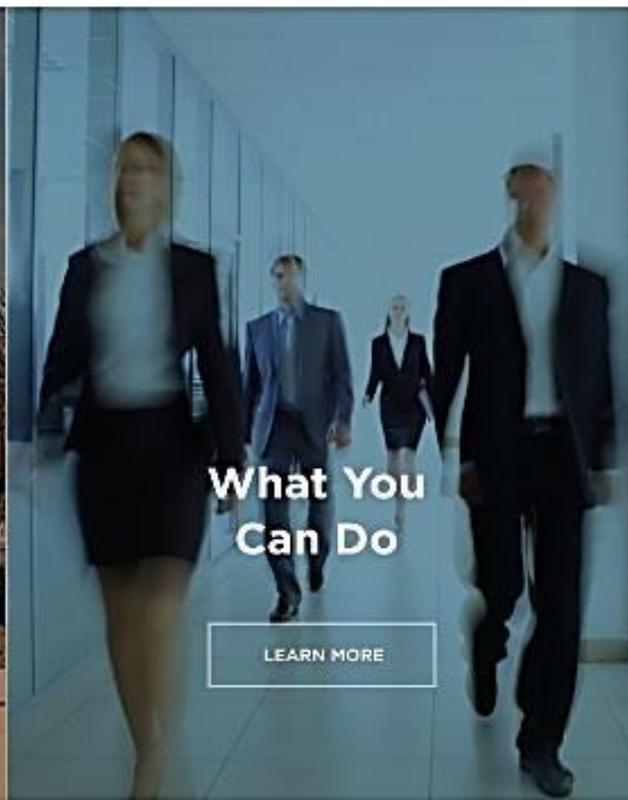
[How To Get Involved](#)

[Resources](#)



Why Invest in Community Health?

[LEARN MORE](#)



What You Can Do

[LEARN MORE](#)



How To Get Involved

[LEARN MORE](#)



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. Loepke

General NDEP materials

- <http://www.cdc.gov/diabetes/ndep>

Primary Prevention of Diabetes

- <http://www.cdc.gov/diabetes/prevention>

Diabetes at Work

A project of the National Diabetes Education Program

[Login](#)

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- [About](#)
- [Diabetes Basics](#)
- [Plan](#)
- [Build](#)
- [Promote](#)
- [Resources](#)

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.





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www.diabetesatwork.org

- **Diabetes Basics**
 - What is diabetes
 - Diabetes and the workplace
 - Employees with diabetes
 - Diabetes prevention
 - Diabetes management
 - Emotional health
 - Healthy lifestyles
 - Diabetes and pregnancy





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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.





National Diabetes Education Program

A program of the National Institutes of Health and the Centers for Disease Control and Prevention

www.diabetesatwork.org

- **Build**
 - Developing a culture of wellness
 - Program activities
 - Lesson plans
 - The health care team
 - In the community





NDEP 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:

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National Institutes
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