

APPROACHES TO PROMOTING REFERRALS TO DIABETES SELF- MANAGEMENT EDUCATION AND CDC-RECOGNIZED DIABETES PREVENTION PROGRAM SITES

September, 2016



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Overview

Historically, the Centers for Disease Control and Prevention’s (CDC’s) National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has provided funding for state chronic disease programs for specific chronic conditions and risk factors, releasing separate funding opportunity announcements (FOAs) to address cardiovascular disease, diabetes, and obesity. However, chronic diseases have a high incidence of comorbidity, and the burden of these diseases has continued to rise.

In recognition of these issues, CDC has adopted a more integrated approach to chronic disease prevention and control, increasing opportunities for coordination across related diseases and risk factors. This approach allows public health programs to work together to be more efficient and achieve more significant and lasting outcomes. One recent FOA that embraces this approach is State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health (CDC-RFA-DP13-1305, hereafter referred to as 1305).

Because state health departments are on the front lines of coordinated chronic disease public health prevention efforts, 1305 grantees are exploring and testing innovative approaches that will provide critical insight and lessons learned. The goal of the *Emerging Practices in Diabetes* series is to summarize and share information on these practices to guide the work of other states working in these same areas.

This report describes the approaches of four states and one city that have done substantial work to increase referrals to diabetes self-management education (DSME) programs and CDC-

The Four Domains of Chronic Disease Prevention

To optimize public health’s efficiency and effectiveness, CDC recommends coordinating chronic disease prevention efforts in four key areas or domains:

1. Epidemiology and surveillance—to monitor trends and track progress.
2. Environmental approaches—to promote health and support healthy behaviors.
3. Health care system interventions—to improve the effective delivery and use of clinical and other high-value preventive services.
4. Community programs linked to clinical services—to improve and sustain management of chronic conditions.

The four domains help organize and focus the effective work the public health community has been doing for many years. At the same time, they help concentrate efforts to strengthen programs and build expertise to address gaps in services. Finally, they help government agencies, state and local grantees, and diverse public and private partners find new ways to work together and support each other’s efforts.

recognized diabetes prevention program sites operating under the framework of the National Diabetes Prevention Program (National DPP).

DSME and the National DPP

DSME

DSME is “the ongoing process of facilitating the knowledge, skill, and ability necessary for ... diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes ... and is guided by evidence-based standards. The overall objectives of DSME are to support informed decision making, self-care behaviors, problem solving, and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life” (p. 620)¹.

CDC statistics indicate that 29.1 million people in the United States have diabetes.² To address this public health need, it is vital that state health departments (SHDs) play a leadership role to increase referrals to and participation in DSME³ programs for people with diabetes.

National DPP

In 2010, Congress authorized CDC to establish the National DPP, a public-private partnership of community organizations, private insurers, health care organizations, employers, and government agencies. Together, these partners are working to establish, spread, and sustain an evidence-based, cost-effective lifestyle change program across the US to prevent type 2 diabetes. The lifestyle change program is founded on the science of the Diabetes Prevention Program (DPP) research study and several translation studies that followed. These studies showed that making modest behavior changes helped participants with prediabetes lose 5% to 7% of their body weight and reduce their risk of developing type 2 diabetes by 58% (71% for participants aged 60 or older).⁴

In this yearlong program, participants work with a lifestyle coach in an in-person group setting or through an online program to complete at least 16 sessions (usually conducted weekly during the first phase of the program) and at least six follow-up sessions (usually conducted monthly during the second phase). The goal is to increase healthy eating and physical activity and ultimately to achieve the 5% to 7% weight loss shown in the original DPP research study. The program is tailored specifically for those with prediabetes or at high risk of developing type 2 diabetes.

Through the National DPP, numerous partner organizations work to

- Deliver the lifestyle change program nationwide in a variety of settings.
- Ensure quality and adherence to proven standards.
- Increase referrals to and participation in the program.
- Increase coverage by employers and public and private insurers.

To ensure high quality, CDC’s Diabetes Prevention Recognition Program recognizes those lifestyle change programs that meet national standards and show they can achieve results.

This document features the work of four states (Delaware, Kentucky, Maine, and New York) and one city (New York City Department of Health and Mental Hygiene) to increase referrals to DSME programs and/or to CDC-recognized diabetes prevention programs. Their stories are shared below, so that other state and local health departments can gain insights from their successful approaches, including challenges faced and overcome.

Delaware

Background

The Delaware Division of Public Health’s (DDPH’s) Diabetes and Heart Disease Prevention and Control program is focused on using electronic health record (EHR) data to identify individuals with prediabetes or diabetes. By extracting this information from the EHR, DDPH can increase referrals to CDC-recognized diabetes prevention programs, DSME programs, or diabetes self-management programs using the Stanford curriculum (Stanford DSMP). (The Stanford DSMP is typically delivered to people with type 2 diabetes in community settings [e.g., churches, community centers] over a period of 6 weeks via 2.5-hour weekly workshops. Trained lay leaders facilitate the workshops using a curriculum based on a detailed manual. DDPH recognizes that, although the Stanford DSMP is an evidence-based diabetes education/support curriculum, the organizations using this curriculum in Delaware have not achieved recognition from ADA or accreditation from AADE. Therefore, people with diabetes are encouraged to receive additional self-management education by attending DSME classes as well.)

DDPH decided to use EHRs to increase referrals for three reasons: (1) use of EHRs aligns with the 1305 strategies aimed at increasing quality improvement in health systems, increasing access to DSME, and increasing referrals to CDC-recognized diabetes prevention programs; (2) EHRs provide a means for direct action with data already available; and (3) only 50% of individuals with diabetes in Delaware report taking a class or course in how to manage their diabetes, and electronic referral through the EHR provides an opportunity to reach more individuals with diabetes.

Partners

Productive long-term partnerships have helped make DDPH’s program successful. Through the state’s collaboration with Quality Insights of Delaware (QID)—the state’s Quality Improvement Organization—and funding from CDC, DDPH has been able to expand its previous work in clinical settings through the promotion of referrals to the Stanford DSMP or hospital-based accredited/recognized DSME programs for people with diabetes, and YMCA-based diabetes prevention programs (Y-DPP) for people with prediabetes. QID has played an important role in increasing referrals, as they work with clinical providers to gain access to high-risk patients; to facilitate connections to Stanford DSMP workshops, accredited/recognized DSME programs, and CDC-recognized diabetes prevention programs; and to encourage health care providers to

host programs onsite at their practices. This work has resulted in workflow modification and increased patient access to self-management education as physicians' offices move toward incorporating referrals into their EHR systems. In addition, QID has developed monthly webinars and training modules that feature state and national statistics; national calls to action such as Prevent Diabetes STAT (Screen, Test, Act—Today); and tools and resources addressing self-management, patient engagement, workflow modification, and clinical decision support.

Another important partner in increasing referrals has been Nanticoke Memorial Hospital. The hospital redesigned its EHR to help identify, and ultimately enroll, individuals with diabetes in Stanford DSMP workshops and individuals with prediabetes in CDC-recognized diabetes prevention programs. The EHR is designed with clinical decision support functions, such as pop-up messages when a patient has a diagnosis of diabetes or qualifies for participation in a diabetes prevention program. The pop-up reminds staff of the patient's potential eligibility; once a patient has been referred to a class, the pop-up no longer appears. DDPH also worked with Nanticoke Memorial Hospital to generate EHR queries for patients with diabetes or prediabetes, which resulted in patient lists for a referral campaign. Patients eligible for the Stanford DSMP received a referral letter from the practice; as of summer 2016, DDPH and partners are also identifying and sending referral letters to patients eligible to participate in a CDC-recognized diabetes prevention program. QID trained community health workers (CHWs) to conduct follow-up calls with patients to encourage them to enroll in a program. During these calls, CHWs emphasize the importance and urgency of enrolling in a class and help address any patient-identified barriers. Most patients appreciated receiving a personalized follow-up call, and Spanish-speaking patients appreciated the opportunity to speak with a bilingual CHW. Enrollment in programs varied by program site; some sites handled it internally, and others preferred that either DDPH or a partner organization handle registration. In all cases, patients were also able to self-enroll.

The YMCA has also been a critical partner. DDPH contracted with the YMCA of Delaware to partner with QID and hospital health information technologists to build referrals into the EHRs of health care practices and to send retrospective referral letters to patients. Thus far, the YMCA of Delaware has used the referral process to recruit 882 persons with prediabetes or qualifying risk factors to enroll in over 40 Y-DPP locations statewide.

Delaware Division of Public Health's Role

In addition to providing financial support and working closely with partners, additional DDPH efforts have helped facilitate program referral success. DDPH's Diabetes and Heart Disease Prevention and Control Program designed a comprehensive brochure promoting all DSME, Stanford DSMP, and CDC-recognized diabetes prevention programs. It also added links to all classes on its website (<https://www.healthyladelaware.org/>). Lastly, DDPH used geographic information system (GIS) mapping to help determine areas of need for diabetes self-management or prevention programs, which helps the department continue to focus its referral efforts.

Summary

The establishment of strong partnerships and the leadership of DDPH have increased electronic referrals to CDC-recognized diabetes prevention programs, Stanford DSMP workshops, and DSME programs statewide.

Kentucky

Background

One of the Kentucky Department for Public Health's (KDPH's) program objectives is to promote and systemize referrals to CDC-recognized diabetes prevention programs by working with insurers.

Previous CDC cooperative agreements and Kentucky legislation laid the groundwork for the current initiative. In 2011, the Kentucky legislature passed 211.752, requiring that in odd-numbered years, three agencies under the Cabinet for Health and Family Services—the Department for Public Health, the Department for Medicaid Services, and the Office of Health Policy—collaborate with the Personnel Cabinet to develop a report on the impact of diabetes in Kentucky and a proposed plan for addressing the epidemic. This process facilitated discussions between KDPH, the Kentucky Employees' Health Plan (KEHP) (which is part of the Personnel Cabinet), and Medicaid about the need for diabetes prevention coverage. In December 2012, KDPH received a grant from the National Association of Chronic Disease Directors (NACDD) using CDC funds, which allowed KDPH to expand its diabetes prevention work. Around this same time, AADE facilitated the establishment of additional CDC-recognized diabetes prevention program sites in Kentucky, one of which was used by KEHP as part of a diabetes prevention pilot program. KEHP and Medicaid were the main entities that KDPH worked with to obtain the program as a covered benefit for state employees. Coverage was ultimately achieved, and KEHP began implementation in January 2014.

Partners

Throughout this initiative, KDPH partnered with KEHP and its third-party administrator, Anthem. Both organizations have been critical partners in increasing referrals to CDC-recognized diabetes prevention programs, and Anthem has successfully engaged local program delivery organizations and referred KEHP members at risk for type 2 diabetes. Each month, KDPH provides Anthem with an updated list of CDC-recognized diabetes prevention programs in Kentucky. Anthem uses this list to ensure that all organizations seeking reimbursement are recognized by CDC and offers training on reimbursement policies and procedures for these organizations. Organizations that agree to participate in the program for KEHP members are contacted monthly to collect information on new class start dates so that their organizations can be included in Anthem's outreach and referral process.

Anthem's analytics team uses claims data to identify at-risk KEHP members who are likely to meet CDC-recognized diabetes prevention program eligibility requirements. They identify approximately 150 at-risk members to be recruited for each new class. The team then matches the members' ZIP codes to upcoming class locations, and Anthem's outreach team makes four attempts to contact

and inform these members of available classes. Anthem’s Personal Health Consultants (nurses) educate and refer interested KEHP members to specific classes in their community. Even though a KEHP member may be referred to a class, the ultimate decision on who is eligible for enrollment is made by the CDC-recognized organization. These referral mechanisms provide participating organizations with more opportunities to fill their classes compared to organizations that have elected not to be part of the referral program for KEHP members.

In addition to their work with Anthem, KEHP has been an important partner in other ways. KEHP offers biometric screenings for its members. The biometric screenings are completed by a variety of organizations across the state—some of which are CDC-recognized diabetes prevention program providers—which facilitates the process of identifying and referring individuals with prediabetes to programs. KDPH is continuing to work with KEHP to improve education and referral processes.

Kentucky Department for Public Health’s Role

KDPH is also working to obtain Medicaid coverage for the National DPP’s lifestyle change program. KDPH held meetings with Medicaid and its contracted managed care organizations’ (MCO’s) chief medical officers. These meetings were important not only to educate the MCOs about the program, but also because MCOs have discretionary funds from the state that could potentially be used to cover these services. The Director of the Division of Diabetes Translation at CDC presented to this group by phone and met with them in person to discuss the National DPP and the role of CDC-recognized diabetes prevention programs. Recently, a Medicaid 1115 waiver (Kentucky HEALTH) was submitted to the Centers for Medicare & Medicaid Services that includes the governor’s encouragement for MCOs to include the National DPP as a covered benefit for Medicaid beneficiaries with prediabetes. KDPH is hopeful that the Department for Medicaid Services will begin covering the program in the near future. Some of the referral processes developed in KDPH’s work with Anthem and KEHP could be used in work with Medicaid, including identification of members at risk and direct contacts with members by disease management staff. However, many processes may need a more automated approach that would work on a larger scale, including the identification of CDC-recognized diabetes prevention program providers and class details across the state.

In addition to building strong partnerships, KDPH has created, and maintains, the Kentucky Diabetes Resource Directory (KDRD), which has facilitated self-referrals to CDC-recognized diabetes prevention programs. The KDRD is a web-based directory that includes all CDC-recognized diabetes prevention program providers in the state (<https://prd.chfs.ky.gov/KYDiabetesResources/>). The directory can be searched by county and includes detailed information on where and when classes are being held and which sites are for state employees only. This resource is available to all Kentucky residents, enabling them to identify and contact local CDC-recognized diabetes prevention programs.

Challenges & Lessons Learned

KDPH has encountered several challenges as it works to increase referrals to CDC-recognized diabetes prevention programs. First, keeping medical providers aware of program locations and class offerings can be difficult. Second, engaging providers to make referrals can be challenging due to the limited number of in-person programs available in some areas of the state. KDPH has also observed that CDC-recognized diabetes prevention programs with established referral networks (such as those connected to hospitals) face fewer challenges in filling classes compared to programs with fewer established relationships within the health care system. KDPH has also had success with employer-based programs offered at workplaces for KEHP members. This may be a result of convenience (i.e., easy to get to) or social support (i.e., coworkers encourage attendance).

Summary

Close partnerships with KEHP, Anthem, and CDC-recognized diabetes prevention program providers have facilitated KDPH's ability to reach those at risk for type 2 diabetes and to continue to improve referrals to CDC-recognized diabetes prevention programs.

Maine

Background

The Maine Department of Health and Human Services, Maine Center for Disease Control and Prevention—Diabetes Unit (Maine CDC—Diabetes) is increasing referrals to CDC-recognized diabetes prevention programs through the use of an algorithm designed to identify and refer individuals with prediabetes.

Maine CDC-Diabetes has a strong history of working with partners in diabetes prevention. Early adopters of CDC-recognized diabetes prevention programs in Maine were successful in adapting their intake processes to identify individuals at high risk for type 2 diabetes and enroll them. Maine CDC—Diabetes assisted these organizations in developing intake forms and electronic referral systems using EHRs. While program staff were successful in implementing prevention efforts, it became clear that a more systematic way to identify individuals at risk for type 2 diabetes was needed. Therefore, Maine CDC-Diabetes piloted the use of a prediabetes algorithm to identify at-risk individuals and refer them to CDC-recognized diabetes prevention programs. Health care providers found the algorithm useful as a reminder to screen for prediabetes and of the appropriate criteria to use for diagnosis. Some provider offices also integrated the algorithm into pre-visit planning; office staff flagged patients with 2 or more risk factors so that providers were reminded to test for prediabetes. Regardless of how the algorithm was used, the intervention for people at risk was the same: identify readiness for lifestyle/behavior change, and refer patients indicating readiness to a CDC-recognized diabetes prevention program.

Maine CDC–Diabetes’ Role

In addition to its work on the prediabetes algorithm, Maine CDC–Diabetes developed a website (<http://rethinkdiabetes.org>) which was launched in 2014 and serves as the portal to Maine’s diabetes prevention efforts. It is directed at four sectors: (1) employers, (2) payers, (3) health systems, and (4) consumers. All information is available to the public. The website does not function as a referral portal, but does provide information on upcoming CDC-recognized diabetes prevention program classes offered throughout the state. For the website, Maine CDC–Diabetes culled content from the CDC, the American Medical Association (AMA), ADA, and AADE. The website also contains information on Maine’s prediabetes algorithm.

Challenges & Lessons Learned

Maine CDC–Diabetes encountered a variety of challenges as it worked to promote referrals. First, it found that CDC-recognized diabetes program providers did not have adequate knowledge of health plans and other payers. Lack of payment created a barrier to increasing class offerings, in turn limiting referrals to classes. Maine CDC–Diabetes has worked to address this challenge by speaking directly with payers and health plans to educate them on how CDC-recognized diabetes prevention programs can be integrated into benefit designs. As a result, one self-insured employer has included the program as a covered benefit. A second challenge Maine CDC–Diabetes encountered was that health care professionals also serving as lifestyle coaches often did not have enough time in their work schedules to provide classes to eligible individuals. To address this challenge, Maine CDC–Diabetes provides technical assistance to health care organizations on how to allocate resources and time so that CDC-recognized diabetes prevention program classes can become part of the regular roles and responsibilities of health care professionals who are also trained lifestyle coaches.

Summary

Maine CDC–Diabetes has made substantial headway toward its diabetes prevention referral goals. The development of a prediabetes algorithm and a website to promote CDC-recognized diabetes prevention programs and referrals to programs, along with efforts to increase coverage, have facilitated program success.

New York State and New York City

Background

The New York State Department of Health (NYSDOH) and the New York City Department of Health and Mental Hygiene (DOHMH) are committed to establishing electronic referral systems for improved efficiency in getting people with prediabetes referred to and enrolled in CDC-recognized diabetes prevention programs. Strong communication and strategic collaboration between state and local health departments, and the development of referral systems based on local knowledge and context, have been keys to success.

New York State Department of Health’s Role and Partners

NYSDOH partners with 62 local health departments representing every county in New York State. Local health departments are responsible for promoting awareness of and referrals to existing CDC-recognized diabetes prevention programs. In areas with limited access, several local health departments have also taken responsibility for the delivery of CDC-recognized diabetes prevention programs to vulnerable populations.

Other key NYSDOH partners are Federally Qualified Health Centers, community- and faith-based organizations, public and private payers, and health information exchanges. However, even with these partnerships, NYSDOH found that the infrastructure supporting diabetes prevention programs in the state was fractured. To effectively reach and refer a greater proportion of patients at high risk for type 2 diabetes, including racial and ethnic minorities and uninsured or underinsured patients, NYSDOH sought out a statewide partner for centralized training, technical assistance, and data collection.

In 2012, NYSDOH partnered with the Quality & Technical Assistance Center (QTAC) at the University at Albany School of Social Welfare to support the development of a workshop and data management portal for CDC-recognized diabetes prevention programs. QTAC had already created an infrastructure to support chronic disease self-management programs and was very interested in expanding to support CDC-recognized diabetes prevention programs. The data management system that evolved, known as COMPASS (<https://compass.qtacny.org/>), offers information on CDC-recognized diabetes prevention program locations and class schedules, connects lifestyle coaches with available technical assistance and training, and helps delivery organizations collect and transmit data to CDC for recognition.

New York City Department of Health and Mental Hygiene’s Role and Partners

In 2012, NYC DOHMH partnered with eight small, clinical practices in the South Bronx, the borough with the highest diabetes prevalence rate. The intention of this partnership was to increase referrals to CDC-recognized diabetes prevention programs sponsored by the local YMCA. Once the demand for the classes was substantiated, NYC DOHMH partnered with the YMCA to establish more classes.

At first, physicians faxed paper-based referral forms, but this presented a number of challenges. Physicians found the process burdensome, and CDC-recognized diabetes prevention program sites had difficulty reading physicians’ handwriting. Additionally, because physicians were unable to confirm whether the information was received, they sometimes felt like they were referring patients into a “black hole.”

To overcome these challenges and improve community-clinical linkages, NYC DOHMH contracted with QTAC to enhance the workshop management portal developed with NYSDOH with the goal of creating a centralized, streamlined clinical referral and enrollment system. These enhancements were made within a newly created QTAC physician portal. The portal

provides physicians with a ZIP code–based directory of nearby CDC-recognized diabetes prevention programs delivered by a variety of organizations. It also generates periodic, automated e-fax receipts for physicians and provides updates on patients’ class attendance, weight loss, and physical activity.

Beyond their efforts with the physician portal, as of July 2016, NYC DOHMH has partnered with approximately 59 clinical organizations that refer community members to a variety of evidence-based interventions, including CDC-recognized diabetes prevention programs. NYC DOHMH also provides technical assistance and capacity building opportunities to a diverse group of CDC-recognized program providers, including hospitals, community health centers, small health care practices, community- and faith-based organizations, and chronic disease-focused CHW programs across New York City.

Challenges & Lessons Learned

As scale-up and sustainability of CDC-recognized diabetes prevention programming is assessed, the cost of technology consultants and referral software needs to be considered. The direct costs associated with developing the physician portal included building and maintaining the portal, staffing a public-facing call center, and providing training and technical assistance for partners using the software. Other costs included the time NYC DOHMH staff spent partnering with QTAC on testing the portal and working to refine the interface for effective use by clinical providers. CDC-recognized program providers paid a one-time lifestyle coach training fee to QTAC to cover the cost of accessing the portal and related technical assistance. In an effort to address these costs, NYC DOHMH has worked closely with QTAC to develop a more flexible and sustainable pricing model that accommodates the range of preferences and needs of program delivery organizations (e.g., allowing payment for use of the software only if coaches are already trained via another mechanism). Future efforts should include an assessment of the legal and technological landscape to develop guidelines for the strategic and cost-effective implementation of physician referral portals.

Summary

NYSDOH and NYC DOHMH have made substantial progress in increasing referrals to CDC-recognized diabetes prevention programs. Strong relationships and communication with partners enabled technological solutions to be well-attuned to the challenges faced by the communities. The implementation of the physician portal required dedicated resources, including staff, training, and technical assistance materials.

Additional Resources

1. AADE DSME and CDC-recognized diabetes prevention program referral resources: <https://www.diabeteseducator.org/practice/provider-resources>
2. AMA's Prevent Diabetes STAT toolkit: <http://www.ama-assn.org/sub/prevent-diabetes-stat/toolkit.html>

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