Diabetes Prevention Program (DPP) – Increasing Referrals
Community of Practice: Session 5
Groups 1 and 2: May 26, 2015
Group 4, May 27, 2015
NOTES

Topic: A conversation with CDC about the National Diabetes Prevention Program (National DPP) and the Diabetes Prevention Recognition Program (DPRP)

CDC Attendees: Pat Schumacher, Pat Shea, and David Dennison

A note about terms:

- The National Diabetes Prevention Program is abbreviated as the National DPP. The National DPP is the umbrella term used to include four levers: training, the Diabetes Prevention Recognition Program, intervention sites, and health marketing.
- Terms for organizations or programs using the 1-year long evidence-based diabetes prevention curriculum are:
    - Organizations offering a CDC-recognized lifestyle change program or
    - CDC-recognized lifestyle change programs (abbreviated CDC-recognized LCPs.

Questions for CDC Regarding National DPP and DPRP and CDC Responses

1) **The price of attending a CDC-recognized lifestyle change programs (CDC-recognized LCP) is too high for many patients. States are concerned about the cost barrier for participants and providers see this as a barrier to refer to a CDC-recognized LCP. Can you recommend any strategies/activities to address the cost until reimbursement becomes a reality?**

CDC Response

- A comment to note for employers and payers: The average cost of the National DPP is $500, which is a value considering the average health care costs for a person with diabetes is over $13,000 per year (reference: American Diabetes Association). CDC is also working on an economic tool that will help make the case for an employer. The tool is in development and should be ready in the near future. The American Medical Association (AMA) is also working on a tool to help make the business case.
- CDC is working through various channels and cooperative agreements to increase the number of organizations with reimbursement and health

insurance coverage for CDC-recognized LCPs.

- There is a lot of movement on coverage across the nation. Some progress to date:
    - *State employee coverage.* Eight states have coverage for CDC-recognized LCPs for state employees: six states (CO, KY, ME, MI, MN, and WA) have full coverage and two states have limited coverage (OH state employees insured by United and LA state employees insured by BCBS)
    - *Medicaid coverage.* Four states (MN, MT, NY, and TX) have at least some coverage in the state for Medicaid participants through innovation projects, state amendment and/or waiver programs. CDC and NACDD had a meeting last week with about 25 partners and thought leaders to address Medicaid coverage.
    - *Medicare.* Congress introduced bipartisan legislation April 29, 2015, for CDC-recognized LCPs coverage for Medicare participants.
    - CDC funds six national organizations and part of their work is focused on increasing coverage for the National DPP
        - American's Health Insurance Plans (4 plans are covering it FL, NM, NY, and TX)
    - CDC continues to learn about payers and employers who are covering the CDC-recognized LCPs. CDC does not have a full list of all health plans that offer coverage and at this time they do not have a way to track coverage. States should let their project officers know about employers and health plans that begin covering CDC-recognized LCPs in their states.
- CDC recognizes that some health care providers will not refer their patients to a CDC-recognized LCP until there is coverage. It's important to bring the right partners to the table as you are working to increase referrals to CDC-recognized LCPs.
- For 1422 states: Grant funds can be used to cover the enrollment costs. Each state has to negotiate separately with each organization (Y or otherwise) that provides CDC-recognized LCPs on the costs.
- Y–costs and sliding scale fees: CDC's understanding is that the cost of providing the CDC-recognized LCP at the Y is a local decision that the local Y makes. States need to work with the Y or other organizations offering a CDC-recognized LCP to address cost for participants.

Questions 2 and 3 address organizations offering an evidence-based lifestyle change program who choose not to become CDC recognized by the DPRP

2) Do you have any recommendations/strategies for states to address/influence large employers who offer an evidence-based lifestyle

change program, but choose not to become CDC-recognized?

Reasons listed for not becoming recognized:

- **Half of their participants needed to have a qualifying lab to participate. They want to offer this program to people with risk factors; but, not necessarily testing in the pre-diabetes range yet.**
- **The time factor beyond the first 16 sessions was also an issue, all participants wanting to participate in the post core phase are currently pooled into one big class to attend as long as they wish.**
- **Too much reporting involved and too many parameters to report, reporting to CDC twice a year was too much.**

CDC Response

- The DPRP is a voluntary program and CDC can't require organizations to become recognized. Some employers and insurers are making CDC recognition mandatory in order to receive reimbursement. This is a standard CDC highly encourages.
- If current proposed Medicare legislation passes, it would require the program providers to be CDC-recognized.
- 1422 funds can only be used for CDC-recognized LCPs. Some organizations may not fully understand the benefit of becoming recognized. Recognition allows organizations to have high quality programs, assure fidelity to program standards, and allow a third-party objective review of their program and data.
- CDC is learning from organizations about barriers to recognition. These include:
    - *The requirement that at least 50% of participants must have a blood test*
        - CDC clarified that blood values are not needed; participants are only asked *if* they had a blood test.
        - Data is analyzed at 12 months and it is for the entire number of participants for year 1. It is not analyzed by class/cohort. So over the course of the year, at least 50% of all participants must have a blood test. CDC noted that nearly all programs meet this criteria and often its 60-70% of participants with a blood test.
        - People who come to the program on the basis of a blood test generally have better outcomes.
    - *Program length of time.* The CDC-recognized LCP is a 12-month intervention based on the evidence and science and this is a lifestyle-change program, which means it takes time and intensive interaction for behavior change to occur. CDC sets a minimum number of sessions (22); 16 weekly sessions in first 6 months and 6 monthly sessions in

last 6 months.

- CDC DPRP recommends the organizations do more than the minimum standards. Organizations that do more than the minimum standards generally do better with meeting recognition program requirements.
- *Question/Comment:* The new standards (January 2015) use new terms, but CDC materials/website do not use the new terms. *CDC Response:* We are not using the terms "core" and "post core" and instead we are using the terms "first 6 months" and "second six months." This is to ensure that both parts of the year-long program are seen as equally important. CDC is updating their website to make the language consistent with these new terms.

- *Reporting requirements.* There is a time and energy factor for organizations to submit data. CDC has streamlined reporting requirements. CDC reduced time interval for reporting (organizations now only need to report every 12 months) and they reduced the number of data elements per participant in the most recent update (January 2015) to the DPRP standards.

Additional questions from state staff:

Question: How is data that is shared with states showing the number of participants calculated at state level?
Response: CDC provides the 1305 and 1422 grantees with an annual report for use with the 1305/1422 performance measures. For purposes of this report, enrollment is defined as attendance at a minimum of one session. This is because the performance measures are designed to assess state efforts at increasing referrals to CDC-recognized LCPs and are not designed to assess retention. The report provides cumulative data (all data reported by all programs since the time they made application for recognition.) The programs included in the state reports are all programs with a record of address in the state. Thus, enrollment may be slightly overstated for State X and slightly understated for State Y when, for example, residents from State Y cross a state line to participate in a program located in State X. Under the previous DPRP standards, the DPRP did not collect data on a participant's residence. With the new standards, and the addition of virtual programs, in 2016, the method for developing the state enrollment report will change to report enrollment by the state residence of the participants, rather than the location of the CDC-recognized lifestyle change program.

Question: When do people get counted in the numbers that are reported back to states?

Response: Response is provided above.

Question: Can you comment about third party data administrators? It seems like these will be useful for program providers to collect data.
Response: There are many sizes of organizations participating in DPRP. Some are very small and serving less than 20 people annually and there are some that serve 1,000 or more people. Organizations offering either large or small class sizes can be successful in meeting the recognition standards. Different organizations have different challenges; class size is only one factor that can influence results.

There are pros and cons to having a third party data administrator. Regardless of whether organizations collect their own data or contract with a third party administrator, CDC recommends that they monitor their data routinely to help identify any potential problems that might require mid-stream corrective action. Organizations that conduct routine monitoring generally achieve better results.

Question: How many sites have applied and achieved recognition?
Response: CDC is tracking how many have applied and achieved full recognition. There are about 18 organizations that have achieved full recognition and these are noted in the DPRP Registry. CDC is expecting more organizations to receive full recognition in the near future.

3) For organizations that offer an evidence-based lifestyle change program at no cost to participants, are there ways to encourage/motivate them to become CDC-recognized by the DPRP? These programs do not see a benefit to becoming CDC-recognized by the DPRP program. They are not charging for the program, so they are not interested in seeking reimbursement. These organizations are setting up referral systems with local hospitals.

CDC Response

- See response to question 2.
- Fidelity is a large part of the DPRP. If states are aware of programs that are stating that they are CDC-recognized, but are not, please let your CDC project officer know.
- CDC would also like to know about programs that provide a "National DPP-like" curriculum, but do not seek recognition so that they can assess reasons.
- States should only post/promote/support CDC-recognized LCPs.

4) NEWLY Pending CDC-recognized LCPs– Can you explain the process and why states can't be notified directly when new CDC-recognized LCPs in their state are added to the DPRP registry?

CDC Response

- The DPRP is a voluntary program so CDC cannot share information/data collected. The DPRP organizations can provide data directly to state, if they wish to do so.
- There is a process in place for the DPRP application review and posting DPRP information on the CDC DPRP website. Currently there are over 600 providers and one CDC staff person responsible to respond to their applications/questions. The DPRP website is updated every 8 hours. CDC recommends that state staff review the DPRP website weekly to find new programs in their states.
- After processing the application, a letter is sent to CDC-recognized LCP asking if they want to be linked with the State Health Department. If they respond positively, the State Health Department is notified.

5) Can you describe the Technical Assistance (TA) provided by DPRP to program providers? DPRP asks that all communication is sent via e-mail to DPRPask@cdc.gov, yet emails are not responded to in a timely manner (per states based on their communication with CDC-recognized LCPs in their state). Can you address the timeframe it takes to respond to e-mails?

CDC Response:

- The main mission of the DPRP is the recognition of programs and to ensure fidelity and quality control. The mission is not to provide TA, however, the DPRP often provides TA to organizations. When a provider organization submits data, the DPRP staff analyze it and make recommendations based on findings.
- The DPRPask@cdc.gov is for CDC-recognized LCP providers; State Health Department staff asking questions on behalf of programs should go through Project Officers. All questions sent to the DPRP from State Health Department staff are sent to the Program Implementation Branch to respond.
- CDC had a technical issue with e-mails sent to providers. A recent internal e-mail audit showed that 70 percent of e-mails were going to junk or spam folders of the receivers. State Health Department staff can ask programs that are not receiving responses to check their junk/spam folders.
- Since February 2015, most e-mails send to DPRPask@cdc.gov are responded to within 5 working days.
- *Question:* If state is working with a community partner who should ask the questions. *Response:* The preference is for the community partner to ask the question through the DPRPask@cdc.gov. If states are getting the same type of questions, states can submit to their project officers so that CDC can keep

track of common questions.

6) States are concerned that their smaller CDC-recognized LCPs will "fail" due to the smaller numbers of participants and that one or two people can impact if the acceptable weight loss is achieved. For programs that have many more participants such as the Y the weight loss is easier to achieve with the larger participant numbers. Can you address this concern?

CDC Response

- Class size can matter. DPRP uses averages so one person in a small class can impact results. Self-monitoring of the data is vital for program providers. Organizations should know their status/data at any given time and make plans for changes, if needed. However, there are programs with small class sizes that do well.
- CDC recognizes that the lifestyle coach is a critical person for success in the DPRP. CDC expanded 1305 activities to allow states to provide further training and support to lifestyle coaches. Refer to the 1305 and 1422 Side by Side (see attached) for activities.
- CDC will be preparing lessons learned about successful programs so that states can share with community-based organizations.
- DPRP analysis: At the 12-month reporting interval, all participants are analyzed (progress report). At 24 months, all participants who had their first session in year 1 (months 1-12) are evaluated (1st full recognition determination). At 36 months, all participants who had their first session in year 2 (months 13-24) are evaluated.

7) Can you provide an overview of the role of State Health Departments in working with DPP Providers?

- Refer to CDC 1305 and 1422 Side by Side chart (see attached). There have been some recent changes to this chart related to 1305 and expanded activities that states may address.
- For 1305, states are not being funded to work with programs to meet the DPRP standards.