National Diabetes Prevention Program 101 for 1422 Grantees

June 4, 2015

Agenda

- **Introduction/Call Objectives**
- **The National DPP**
  - Four Elements
  - Lead and Supporting Roles for Various Organizations/Partners
- **Specific Roles for 1422 Grantees**
  - Guidance for Strategies 1.5-1.7, 2.5, 2.6, and 2.8
  - Short-term Performance Measures
  - Challenges and Lessons Learned
- **Q & A**

Introduction/Call Objectives

- **The National DPP has four elements**
  - Training: Develop the Workforce
  - Recognition Program: Assure Quality
  - Intervention Sites: Deliver Program
  - Health Marketing: Support Program Uptake
- **Many organizations are involved in lead and supporting roles for each element**
- **1422 Grantees are not funded to do all the work in each element – state and city work complements the work of other organizations also working in each element**

Some Key Organizations Involved in the National DPP

- **CDC Grantees**
  - FOA 1212 – Six national organizations (AADE, AHIP, BWHI, NACDD, Optum, and Y-USA)
  - FOA 1305 – All states/DC
  - FOA 1422 – 17 States and 4 large cities
- **AMA –** Prevent Diabetes STAT, Healthcare Provider Toolkit, State Partner Engagement Meetings
- **NACDD –** PSTAT (Partner Engagement Meetings)
- **NACCHO –** Training and TA for Local Health Departments
- **Contractors/Vendors/Training Entities**
- **CDC-Recognized Lifestyle Change Programs (LCPs)**
- **CDC DPRP Staff**

National DPP - Training

- **Six Training Entities**
  - MOUs with CDC – training offered in person and virtually
  - Have trained over 6500 coaches as of April 2015
- **Six National Organizations**
  - Training coaches for the CDC-recognized LCPs they are supporting
- **Curriculum Development**
  - New CDC Prevent T2 curriculum in English and Spanish (end of 2015)
  - Prevent T2 branded marketing materials
  - 5 DPRP approved curricula
- ***1422 Grantee Support***
  - Pay for training as part of start-up for new CDC-recognized LCPs serving priority populations
  - Pay for additional skills-based training (motivational interviewing)

National DPP
Diabetes Prevention Recognition Program (DPRP)

- **This is a CDC-only responsibility**
  - Assess organizational success in meeting the OMB approved recognition standards
  - Provide TA on standards and data submissions to organizations with pending status
  - Maintain the DPRP website
  - Conduct random quality audits to ensure validity of data submissions
  - Provide data on 600+ CDC-recognized LCPs
  - Provide state level data on enrollment for 1305/1422 Performance Measures
- ***1422 Grantees can help by:***
  - Working with any organization that will be starting a new CDC-recognized LCP with 1422 funds to ensure that they fully understand the DPRP recognition standards, including the metrics and benchmarks for recognition.

National DPP
Intervention Sites – Delivering the Program

- **Two parts – recruiting organizations and obtaining coverage**
- **Identifying potential organizations**
  - CDC – meeting with national organizations not currently funded by 1212 (i.e. Weight Watchers)
  - The 1212 grantees - continuing to identify additional sites
  - *The 1422 grantees and subawarded communities - identifying organizations willing to serve priority populations using a "decision tree" approach*

National DPP
Intervention Sites – Delivering the Program

- **Enabling Coverage and/or Reimbursement**
  - CDC
    - Meeting of Medicaid "Thought Leaders" – May 2015
    - Bi-partisan legislation to make the National DPP a covered benefit for Medicare – April 2015
  - The 1212 grantees
    - Coverage for more than 1.3 million persons in selected geographic areas
  - The 1305 grantees
    - Coverage for state employees (CO, KY, MN, WA, ME, OH, LA, and MS)
    - Coverage for Medicaid beneficiaries (MN, MT, NY, and TX)
    - Full or partial (by insurer, geographic area, etc.)
    - Emerging Practices Guide
  - *The 1422 grantees - working with private insurers and self-funded employers*

National DPP
Health Marketing/Supporting Uptake

- **Three parts**
  - Health Communication – Raise Awareness
  - Promote Screening and Referrals
  - Translation and Evaluation Projects
- **Health Communication Initiatives as part of the National DPP**
  - CDC/AMA - Prevent Diabetes STAT (Call to Action), Healthcare Provider Toolkit, State Partner Engagement Meetings
  - CDC - National media campaign and TV advertising this summer/fall
  - CDC - National DPP website Redesign (Consumer section – fall 2015)
  - *1422 grantees - developing statewide/citywide marketing plans (including leveraging these national initiatives)*

National DPP
Health Marketing/Supporting Uptake

- **Promote Screening and Referrals**
  - AMA/CDC - Healthcare Provider Toolkit on Referrals
  - The 1305 grantees - working with health care systems to implement referral policies and practices, including promotion of the AMA/CDC Healthcare Provider Toolkit
  - *The 1422 grantees - working with health systems on EHR screening protocols and bi-directional referral systems*
- **Translation and Evaluation Projects to Increase Enrollment**
  - CDC/RTI - developing an on-line customizable ROI calculator (2016)
  - CDC/ENROLL workgroup (Behavioral Economics and Incentives) – developing best practices on engagement strategies/incentives
  - *The 1422 grantees – making the business case to employers using ROI toolkits and implementing recommended engagement strategies*

1422 Strategies and Performance Measures Scaling and Sustaining the National DPP

- **General Comments:**
  - 1422 Build Support for Lifestyle Change = Scale and Sustain the National DPP
  - 1305 Strategies related to the National DPP should be fully in place
  - Dual Approach and Mutually Reinforcing Strategies
    - 1422 Community of Practice – June 25th at 2:00
  - Focus today is on 1422 strategies and short-term PMs specific to the National DPP
  - The intermediate performance measure for all DDT supported strategies: # of people enrolled in a CDC-recognized LCP

Strategy 1.5 – Plan and Execute Data-Driven Actions Through a Network of Partners and Local Organizations

- **A statewide network and a state strategic plan are required**
  - Large cities must be part of the state network; may have their own network
  - Collective Impact Model and Shared Measurement Systems
  - Key network partners – those who can influence one of more of the National DPP drivers (programs, physician referrals, payment, and participants)
  - The strategic plan must be actionable and measurable
  - Existing networks/plans may be expanded or modified
  - Assessment of the current environment is a critical first step in plan development

Strategy 1.5 – Plan and Execute Data-Driven Actions Through a Network of Partners and Local Organizations

- **PSTAT Partner Engagement Meetings (*AMA)**
  - 6 states completed (KS, MI*, NC, MS, CO, WV)
  - 5 states scheduled in 2015 (CA*, SC*, UT, MA, and MD)
  - 2 states scheduled in 2016 (OH*, TX*)
  - Contracting with NACDD for a webinar and additional PSTAT meetings/TA
- ***Key Point: State Networks and State Plans must be substantially in place before funds can be used to support new CDC-recognized LCPs as part of Strategy 1.6***
  - It is critical that new CDC-recognized LCPs started with 1422 funds to serve priority populations are successful over the long term.
  - They must be supported by a strong and comprehensive statewide infrastructure, including a network of partners committed to their success.

Strategy 1.5/PM 9 – Number of Unique Sectors Represented in the Network

- **Need a variety of sectors to scale and sustain the National DPP**
  - Goal is strategic (not numeric) participation
  - Need a wide range of organizations to influence all the drivers
  - Existing regional networks are allowed if state provides overall leadership and aggregates data for the PM
- **Unique Sectors in the Network**
  - Business
  - Health Systems
  - Organizations involved in implementing the National DPP
  - Government
  - Community
  - Education/Academia
  - Philanthropy
  - Others

Strategy 1.5/PM 10 – Participation Rate of Network Partners in Self-Assessments based on Shared Measurement

- **Purpose - measure the commitment of partners to working collaboratively to demonstrate progress toward the collective goals in the strategic plan**
- **Shared measurement includes agreement about:**
    - How success will be measured and reported
    - A short list of common indicators
    - How date will be utilized in meaningful ways
- **Contributing data to a shared measurement system is optimal**
- **As measurement systems are being developed, other activities such as surveys or focus groups can be counted**

Strategy 1.6 – Scale and Sustain the National DPP
Implement evidence-based engagement strategies to build support for lifestyle change

- **Goal is to recruit and enroll priority populations, including Medicaid beneficiaries, in CDC-recognized LCPs**
- **Two ways to do this:**
  - Enroll priority populations in existing CDC-recognized LCPs (recommended)
  - Start new CDC-recognized LCPs (where there are no viable alternatives)
- ***Minimum Expectation for Year 1:*** *At least one cohort must be enrolled in either an existing or new CDC-recognized LCP in each of the subawarded communities (for large cities, a minimum of 4 cohorts must be enrolled in year 1).*
- *Either the state or the subawardee must budget for this intervention or otherwise show how they will meet it (i.e. CDC-recognized LCPs provided at no cost by partners)*

Strategy 1.6 – Scale and Sustain the National DPP

Enroll priority populations in existing CDC-recognized LCPs

- **What organizations are eligible?**
  - Any organization offering a CDC-recognized LCP (in person or virtual)
- **Which organizations should be prioritized?**
  - First, CDC-recognized LCPs that have support from a 1212 national organization (Y-USA, AADE, BWHI, or Optum)
  - Second, CDC-recognized LCPs that have made at least one data submission to the DPRP
- **Are all Y organizations eligible?**
  - Only some Y programs are CDC-recognized LCPs
  - The Y-USA has a unique onboarding process, but it may be expedited to allow local Ys to work with 1422 grantees

Strategy 1.6 – Scale and Sustain the National DPP

Negotiating Payment Rates with CDC-recognized LCPs

- **CDC will not specify payment rates**
  - Average costs for the year long program are about $500
  - Ask about volume discounts or sliding scale fees
  - Consider a pay for performance model (pay at intervals based on continued participation)
- **Data requirements associated with payment**
  - At a minimum, include data on aggregate enrollment for participants enrolled with 1422 grants funds as part of the negotiation
  - The DPRP cannot report participation by payment source
  - May include other aggregate data as part of the negotiation (i.e. completion data needed for a pay for performance model)

Strategy 1.6 – Scale and Sustain the National DPP

Billing and Payment

- **Grantees will need to develop a billing or payment mechanism to cover the enrollment costs of priority populations in CDC-recognized LCPs**
  - Can be at the state or local level
  - Arrangements may vary by CDC-recognized LCP
  - Simple vouchers may be acceptable
  - Can include contracting with a Third Party Administrator, but this is not required

Strategy 1.6 – Scale and Sustain the National DPP

Starting New CDC-recognized LCPs

- ***This option should only be used if there is no existing capacity to serve priority populations in a subawarded community***
- **Use "*Decision Tree*" Approach:**
  1. The1212 national organizations that have indicated to CDC their interest in expanding to a subawarded community
  2. Other CDC-recognized LCPs in the state with an interest in expanding to a subawarded community
  3. Organizations with an existing infrastructure/experience (i.e. DSME programs, health care systems, managed care organizations, cooperative extension agencies, etc.)
     - ADA/AADE DSME programs interested in developing a strategic business plan for offering a CDC-recognized LCP (1305 funds allowed)
  4. Local health departments that have developed a plan demonstrating how they will achieve long-term financial viability (NACCHO webinar for LHDs on June 24)

Strategy 1.6 – Scale and Sustain the National DPP
Start-up Costs for New CDC-recognized LCPs

- **Organizations must receive pending recognition from the DPRP before start-up costs can be paid**
- **Funds cannot be used for start-up costs for organizations that had pending recognition prior to 1422**
- **Organizations using 1422 funds to cover start-up/operational costs must have a written plan showing how they will achieve financial sustainability after the initial 2 year period of grant funding ends**
  - *1422 grantees are responsible for reviewing and approving these plans*
- **Organizations receiving start-up/operating costs for up to 2 years must agree to serve priority populations at no additional cost while they are receiving this assistance**
  - They are not limited to serving priority populations
  - They are encouraged to serve other populations and charge prevailing rates

Strategy 1.6 – Scale and Sustain the National DPP

Allowable Start-up Costs for New CDC-recognized LCPs

- **Allowable start-up costs include:**
  - Training lifestyle coaches
  - Hiring and paying staff
  - Space rental
  - Marketing and advertising to recruit and enroll participants
  - Training materials and supplies
- **Note: please check with your Project Officer on any costs not listed here**
- ***1422 Grantees must document these costs; it is not sufficient to award a lump sum for start-up costs.***

Strategy 1.6 – Scale and Sustain the National DPP Allowable Participant Incentives – Year 1

- **Very limited options for year 1**
- **Removing barriers to participation for priority populations**
  - Childcare or transportation vouchers may be covered
- **Teaching tools and class materials**
  - Items such as scales, plates, measuring cups, etc., may be purchased as teaching tools but cannot be purchased for individual program participants
- **Cash incentives or bonuses are not allowed with grant funds**
- **Non cash incentives – work with community partners**
  - Network or community partners may provide items such as pedometers, Calorie King books, or discount vouchers for footwear

Strategy 1.6 – Scale and Sustain the National DPP
Engagement Strategies and a Marketing Plan – Year 1

- **For year 1, evidence-based engagement strategies are limited to marketing and communication efforts**
  - 1422 State grantees – take the lead for developing a statewide marketing plan
  - Subawarded communities - tailor the marketing plan for priority populations
- **Plan Development**
  - Focus groups (FGs) – may pay FG participants a reasonable amount
    - $10-$75
  - CDC-recognized LCPs may brand their programs
    - Must acknowledge the National DPP and CDC
    - May use the National DPP logo
    - Policy on using the Prevent Diabetes STAT logo will be out shortly

Strategy 1.6 – Scale and Sustain the National DPP
Engagement Strategies – Years 2-4

- **The ENROLL Workgroup (Engage, Nudge, Recruit – Opportunities to Leverage Lifestyle change)**
  - Developing recommendations regarding behaviorally-based engagement strategies appropriate to increasing enrollment in CDC-recognized LCPs
  - Conducting interviews with successful CDC-recognized LCPs to identify promising practices (recommendations in the fall)
  - Convening an Expert Panel in the fall to help design a rigorous evaluation of engagement strategies

Strategy 1.6/PM 11 – Number of people reached through evidence-based engagement strategies (state-level)

- **For year 1, this means people reached through multi-channel, community-wide communication activities designed to promote enrollment of priority populations in CDC-recognized LCPs**
  - The operationalized profile includes evidence-based recommendations from the Community Preventive Services Task Force on using communications to increase behavior change
  - Efforts should link, as possible, with the Prevent Diabetes STAT Call to Action initiative and CDC sponsored national media campaigns
  - Goal is to balance the broadest reach with the highest effectiveness
  - For purposes of the measure, the following can be counted:
    - Materials distributed, attendance at promotional events, newsletters/emails, print media, TV and radio monitoring, media impressions, web site metrics, and social media analytics

Strategy 1.6 – Scale and Sustain the National DPP

Working with the DPRP

- Working with the DPRP
  - 1422 grantees should send questions to their Project Officer and not to the DPRPAsk mailbox
  - The DPRP will now be providing aggregate state level enrollment data on a quarterly basis
    - Reports are currently based on the location of the CDC-recognized LCP
    - In 2016, reports will be based on the residence of participants (will include state enrollment in virtual programs)
  - The DPRP cannot respond to other requests for data (by county, by individual, by referral source, etc.)
  - CDC-recognized LCPs may volunteer to give grantees information, but they are not required to do so except for providing aggregate data for participants enrolled with 1422 grant funds

Strategy 1.6 – Scale and Sustain the National DPP

Working with the DPRP

- **Please carefully review the recognition standards and metrics with any organizations receiving start-up funds**
- **Routine Data Monitoring is Critical**
  - Session attendance, documentation of weight and physical activity minutes, weight loss
- **Metrics are based on averages for all program participants who complete at least 4 sessions**
  - Average session attendance of 9 (out of 16) in months 1-6
  - Average session attendance of 3 (out of 6) in months 7-12
- **Physician referrals are a critical factor in success**
  - Eligibility on the basis of a blood test can be self-reported
- **The standards represent a minimum number of sessions**
  - Organizations offering more than the minimum generally have better outcomes
  - Special attention should be paid to the transition between weekly sessions in months 1-6 and monthly sessions in months 7-12

Strategy 1.7 – Work with Private Sector Employers and Insurers to Offer the National DPP as a Covered Benefit for Employees

- **Work with network partners on coverage should be documented in the state strategic plan and/or marketing plan**
  - Learning curve about the “insurance world”
  - Lessons learned from states and 1212 grantees
- **Activities may include:**
  - Participation in employer council or insurance broker events
  - Engaging group health care purchasing coalitions
  - Leveraging other grant activities involving worksites and employers
- **Making the Business Case**
  - CDC/RTI – developing an online customizable ROI calculator (2016)
  - AMA – developing a “business case” tool
  - Individual Grantees – have developed or contracted for tools

Strategy 1.7/PM 12 – Number of employees with prediabetes or at high risk for type 2 diabetes who have access to an evidence-based lifestyle change program as a covered benefit

- **Purpose is to assess grantee success in increasing private sector/non-government employee coverage for CDC-recognized LCPs**
  - Covered benefit/access means any level of payment or reimbursement for participation in a CDC-recognized LCP, including pilot reimbursement systems that are not part of an established benefit package
  - Public sector (state) employees are counted in the 1305 PM
  - This PM has been revised from the wording in the FOA to include all private sector/non-government employees, rather than just those with prediabetes or at high risk for type 2 diabetes

Strategy 2.5 – Implement Systems to Facilitate the Identification of People with Prediabetes

- **Goal is to increase the number of health systems that implement systems level screening protocols for prediabetes**
  - Work with partners to promote the use of the AMA/CDC Healthcare Provider Toolkit
  - The Toolkit addresses:
    - Point of care and retrospective methods for identifying people with prediabetes
    - ICD coding for prediabetes screening and counseling
    - Referrals to CDC-recognized LCPs
  - CDC is working with AMA to develop some turn-key materials to help grantees promote use of the Toolkit
  - EHR screening and referral systems are optimal and some EHR vendors are beginning to offer this option
    - Please let CDC know if you are aware of good examples of health care systems using EHRs for screening

Strategy 2.5 – Implement Systems to Facilitate the Identification of People with Prediabetes

- **A few key issues on screening and referrals**
  - Grant funds cannot be used to pay for referrals on a one-time basis
  - 1305 and 1422 funds may be awarded to help health systems develop an EHR screening and referral module if they promote the Toolkit
  - 1305 and 1422 funds may be awarded to CDC-recognized LCPs for systems-level work to increase referrals from health systems
    - These model referral systems should have broad applicability and be available to all CDC-recognized LCPs in the state
  - NACDD is facilitating Communities of Practice to address referral issues
    - State grantees should share lessons learned with subawardees

Strategy 2.5/PM 17B – Percentage of patients within health care systems with policies or systems to facilitate identification of people with prediabetes

- **Purpose is to increase the number of health systems that implement a screening protocol for prediabetes**
  - Can count all patients in any health care system that has implemented a systems level screening protocol for prediabetes
  - This measure focuses on access, not uptake or utilization
  - Paper or web-based risk test may be used as a first level screening tool, but must be followed by a blood-based diagnostic test to count for the PM
  - Screening protocols should ideally be coupled with referral systems, but referral systems are not required for this PM

Strategy 2.6 – Increase the Engagement of CHWs to Promote Linkages between Health Systems and Community Resources for Adults with Prediabetes or at High Risk for Type 2 Diabetes

- **This intervention has two parts: foundational support and promotion of specific roles for CHWs in linking health systems to CDC-recognized LCPs**
- **Foundational Support includes:**
  - Facilitating the adoption of a core CHW training curriculum and delivery process (with Area Health Education Centers, community colleges, etc.)
  - Identifying a certification and credentialing process and mechanism (i.e., establishing a certifying entity and defining training and experience requirements)
  - Promoting the professional identify of CHWs through support for CHW Associations and networks
  - Ensuring that CHWs are invited to participate on the statewide network responsible for scaling/sustaining the National DPP
  - Promoting sustainable coverage options for the National DPP that include CHWs (i.e., 440.130 Medicaid rule)

Strategy 2.6 – Increase the Engagement of CHWs to Promote Linkages between Health Systems and Community Resources for Adults with Prediabetes or at High Risk for Type 2 Diabetes

- **Promotion of Specific Roles for CHWs includes working with health systems partners (FQHCS, Medicaid MCOs, etc.) to:**
  - Enable CHWs to follow up with people that have been screened and identified as having prediabetes
  - Enable CHWs to recruit and enroll priority populations in CDC-recognized LCPs in funded communities
  - Collaborate with State Medical Associations to encourage the engagement of CHWs in connecting people with prediabetes to CDC-recognized LCPs
  - Collaborate with community partners to engage CHWs in the implementation of bidirectional referral systems (e.g. EHRs, 800 or 211 numbers, etc.)

Strategy 2.6/PM 18B – Number of health care systems that engage CHWs to link patients to community resources that promote the prevention of type 2 diabetes

- **Goal is to assess health care system engagement in the prevention of type 2 diabetes via utilization of CHWs**
  - Assessing systems-level change
  - Count health systems that:
    - Develop and implement policies and practices to establish roles for CHWs in outreach, referrals, and patient support
    - Contribute significant foundational support (i.e. pay for CHWs to complete a training and/or credentialing program)

Strategy 2.8 – Implement Systems and Increase Partnerships to Facilitate Bi-Directional Referral between Health Systems and Community Resources, including CDC-recognized LCPs

- **Optimally, bi-directional referral systems include:**
  - Seamless integration of community referrals into EHR systems
  - A bi-directional component for health care providers
    - To evaluate information on patient participation/activation
    - To assess the effectiveness of community resources on population health

Strategy 2.8 – Implement Systems and Increase Partnerships to Facilitate Bi-Directional Referral between Health Systems and Community Resources, include CDC-recognized LCPs

- **Bi-directional e-referral systems are still in the early phases of development**
  - AHRQ Toolkit provides guidance for primary care providers on working with community partners, with a focus on patient activation
  - MA SIM project with CHCs and community programs including the Y-DPP
    - Data is provided to health care providers on number of referrals, number of services provided, and weight loss
- **In addition, grantees may partner with other organizations such as a 211 call center or 1-800 Helpline or Hotline**

Strategy 2.8/PM 20B – Number of health care systems with an implemented community referral system to CDC-recognized LCPs

- **Goal is to work with health care systems and CDC-recognized LCPs to develop and implement an optimal e-referral system, but other referral systems can be counted for the PM**
  - Paper-based, web-based, fax-based, or telephonic systems
  - Participation in a statewide referral system such as a 211 Call Center or 1-800 Helpline or Hotline
  - The bi-directional component may be phased in
- **Other community programs, such as food banks, should be included in bi-directional referral systems**

Questions