

Aggregated Questions from Participants in ODPHP Webinar:

**“Promoting Diabetes Prevention Programs and New Payment Options:
A Healthy People 2020 Spotlight on Health Webinar” held on June 13, 2018**

Final, September 10, 2018

CDC – General Questions

1. National data suggest an average weight loss of 4.2% (Diabetes Care, 2017). Will the DPRP consider lowering the threshold for recognition since many suppliers have not been able to meet this benchmark?

The Centers for Disease Control and Prevention’s (CDC’s) first report of findings from the National Diabetes Prevention Program (National DPP), entitled “A National Effort to Prevent Type 2 Diabetes: Participant-Level Evaluation of CDC’s National Diabetes Prevention Program 2017” (Diabetes Care, 2017), is an initial, preliminary report of data from the first few years of program implementation and data collection only. The report describes the experience of 14,747 adults enrolled in the year-long type 2 diabetes prevention programs from **February 2012 through January 2016**; primarily from the in-person, only, programs. As of July 2018, the National DPP has grown exponentially and has more than 1,780 organizations, and of those that have submitted data, there were more than 124,000 participants. Current average weight loss across all evaluated participants via all delivery modalities is over 5.0%, and the current average weight loss across all evaluated participants in in-person, only, programs is 6.2%.

Evidence continues to show that participants can achieve the 5.0% weight loss, even exceed it, when program duration and intensity are met. The CDC published its new 2018 Standards in March 2018 and introduced new methods that have allowed organizations to better achieve success towards weight loss.

2. Can teens and young adults enroll in the program? Are the eligibility rules different?

All of a program’s participants must be 18 years of age or older and not pregnant at time of enrollment. These programs are intended for adults at high risk for developing type 2 diabetes. (See Diabetes Prevention Recognition Program [Standards and Operating Procedures](#) document, page 3.)

3. Is the CDC’s National DPP an ongoing program for the foreseeable future, or is there an end date for it?

The CDC’s National DPP is an ongoing program with no fixed end date. Costs of delivering the National DPP lifestyle change program are increasingly covered by both public and private payers and employers. For example, as of April 1, 2018, Medicare Part B covers the lifestyle

change program for Medicare beneficiaries. The Program does, however, depend upon continued Congressional funding to maintain the Diabetes Prevention Recognition Program, the quality assurance arm of the National DPP, and to continue efforts to scale up the program nationwide.

4. What is the difference between preliminary and pending recognition?

Pending recognition means that an organization has successfully submitted an application for CDC recognition and has been issued an effective date by CDC. Preliminary recognition was introduced in the 2018 DPRP Standards. To obtain preliminary recognition, an organization must meet the requirements for pending recognition and some additional requirements regarding the intensity and duration of sessions (at least 60% of participants attended at least 9 sessions in months 1-6, and at least 60% attended at least 3 sessions in months 7-12) but do not have to meet the full recognition requirements regarding weight loss and documentation of physical activity minutes.

Once an organization submits a full 12 months' worth of data (meaning that 365 days will have lapsed from a participant's first session date), CDC will evaluate the organization for preliminary and full recognition. This evaluation may occur at 12 months if the organization started offering classes immediately upon approval (and before its effective date.) Otherwise, the evaluation will occur at the 18-month point.

To obtain preliminary recognition, an organization must meet the requirements for pending recognition and some additional requirements regarding the intensity and duration of sessions (at least 60% of participants attended at least 9 sessions in months 1-6, and at least 60% attended at least 3 sessions in months 7-12) but do not have to meet the full recognition requirements regarding weight loss and documentation of physical activity minutes.

For more information on pending, preliminary and full recognition, please see pages 9-16 of the Diabetes Prevention Recognition Program [Standards and Operating Procedures](#) document.

5. Are there any National DPP curricula that are designed to prevent gestational diabetes (GDM)?

Since the original DPP clinical trial (2002) did not include prevention of gestational diabetes as a trial objective, the evidence does not support a type 2 diabetes prevention curriculum's use specifically to prevent gestational diabetes. However, all CDC-approved curricula meet the 2018 DPRP Standards which allow women with a history of GDM to enroll in a lifestyle change program as women with GDM are at high risk for type 2 diabetes. Also, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) offers [information](#) on prevention of gestational diabetes. See also a [study in Diabetes Care](#) (January 2016) entitled Gestational Diabetes Mellitus Can Be Prevented by Lifestyle Intervention: The Finnish Gestational Diabetes Prevention Study (RADIEL).

6. Is the Stanford model Diabetes Self-Management Program (DSMP) a CDC-approved program?

Diabetes self-management education and support (DSMES) services are designed for people with diabetes to help them manage their condition and prevent serious complications, whereas the National DPP lifestyle change program is designed to help people with prediabetes or at high risk for type 2 diabetes significantly reduce their risk for type 2 diabetes. The American Diabetes Association and the American Association of Diabetes Educators administer recognition and accreditation programs for DSMES services.

7. The biggest issue we have is our patients participating and staying in the program consistently for 1 year. Can this program be modified?

The CDC describes the standards for the National DPP lifestyle change program, including whether the program can be modified, in the Diabetes Prevention Recognition Program (DPRP) [Standards and Operating Procedures](#) (see pages 6-9). The program's length is based on the original Diabetes Prevention Program (DPP) trial and follow-up efficacy studies, all showing that one year continues to be the appropriate intervention length for prevention or delay of type 2 diabetes. Systematic reviews, like that conducted by the Community Guide (www.thecommunityguide.org), and CDC analysis of DPRP data also show that one year is the appropriate program length in order to reach the 5% weight loss goal. CDC has no plans to modify the length of the lifestyle change program at this time. It is important that work by stakeholders focus on testing strategies for program engagement and retention. CDC does provide tips on helping participants stay in the program (<https://www.cdc.gov/diabetes/prevention/lifestyle-program/keys-to-success/tip-sheets.html>) and continues to do work in this critical area.

8. For those National DPP providers out selling the program to other employer groups, do you have any suggestions on what areas or topics to focus to convince other employers of the benefits of the program?

The CDC has a variety of resources available to help you work with employers at the new National DPP Customer Service Center (NationalDPPCSC@cdc.gov).

CDC – Coaching-Related Questions

9. How do people become Lifestyle Coaches? Where does one obtain training for coaching, or to become a Master Trainer?

The eligibility criteria, skills, knowledge, qualities, and training required of Lifestyle Coaches and Diabetes Prevention Program Coordinators (Program Coordinators) are described in the CDC Diabetes Prevention Recognition Program's [Standards and Operating Procedures](#) document (March 1, 2018) in the guidance section (Appendix C: there is information under Guidelines for Staff Eligibility, Roles, Responsibilities, and Sample Job Descriptions).

CDC-recognized organizations are responsible for ensuring that an adequate and well-trained workforce is available prior to launching the first class of their type 2 diabetes prevention lifestyle change programs. People who are eligible to be Lifestyle Coaches must have been formally trained to a CDC-approved curriculum for a minimum of 12 hours, or approximately two days, by one of the following: 1) a training entity listed on the CDC website, 2) a private organization with a national network of CDC-recognized program sites, 3) a CDC-recognized virtual organization with national reach, or 4) a Master Trainer, as designated by the CDC-recognized program, who has delivered the lifestyle change program for at least one year and has completed a Master Trainer program offered by a training entity on the CDC website. Additional training on group facilitation, motivational interviewing, and data collection and interpretation are also essential to effectively carry out Lifestyle Coach responsibilities. While Lifestyle Coaches may have credentials (e.g., RD, RN), credentials are not required. Community Health Workers and lay people can be effective coaches as well.

Recognized organizations are responsible for the ongoing support and continued training of Lifestyle Coaches. Organizations should provide new Lifestyle Coaches with an opportunity to attend CDC-sponsored webinar trainings on specialized topics such as program delivery and data submission. Additional refresher or new skill training for experienced Coaches is not required but is highly recommended and has been shown to have a positive impact on participant outcomes.

If your organization needs training for your lifestyle coaches, the organizations listed below can help. (This content and additional information are available [here](#) on the CDC's Web site.) They have signed a memorandum of understanding (MOU) with CDC to provide training. Some of them can also provide training for Master Trainers, who can, in turn, train lifestyle coaches in their own and partner organizations. There are thousands of trained lifestyle coaches nationwide.

Lifestyle Coach and Master Training Organizations:

- [American Association of Diabetes Educators, Diabetes Prevention Program](#)
- [Black Women's Health Imperative](#)
- [Center for Excellence in Aging & Community Wellness/Quality and Technical Assistance Center \(QTAC\)](#)
- [Diabetes Training and Technical Assistance Center, The Emory Centers for Training and Technical Assistance at Emory University](#)
- [Magnolia Medical Foundation](#)
- [Solera Health Inc](#)
- [State of Wellness](#)
- [Innovative Wellness Solutions™](#)
- [Virginia Center for Diabetes Prevention & Education](#)

MDPP – Questions related to becoming or being a supplier

Question #10 (The questions, below, were grouped due to similarity of subject matter.)

- Can a Medicare supplier be a local health department? If so, what are the required credentialing for staff to provide the services?
- Can a pharmacy become an MDPP supplier? And how can a pharmacy become involved in this program?
- Can a federally qualified health care center be an MDPP provider?
- What other organizations can get certified to provide DPP programs other than YMCAs?
- I am with an FQHC and we have trained lifestyle coaches. What would be the next step to become recognized and move towards being able to bill Medicare?
- What infrastructure does an MDPP supplier need to have to be able to submit a Medicare claim?

Any organization that has the capacity to deliver an approved type 2 diabetes prevention lifestyle change program may apply to the CDC's Diabetes Prevention Recognition Program (DPRP) for recognition. It is strongly recommended that potential applicants thoroughly read the [DPRP Standards](#) and conduct a capacity assessment (see Appendix guidance titled Organizational Capacity Assessment) before submitting an [application for recognition](#).

An MDPP supplier must have and maintain preliminary or full Center for Disease Prevention and Control (CDC) Diabetes Prevention Recognition Program (DPRP) recognition. Please see page 2 of the [Medicare Enrollment Application for Medicare Diabetes Prevention Program Suppliers](#) for a list of MDPP Supplier Standards.

Prospective MDPP suppliers can use [this checklist](#) to gather the specific information and documentation needed to enroll as an MDPP supplier. Additional information generally required to enroll as a Medicare provider can be found at:

<https://pecos.cms.hhs.gov/pecos/help-main/prvdrsplrchecklist.jsp>.

Coaches who provide training are not required to have clinical experience. CMS does not stipulate requirements around coach training but relies on the CDC's Diabetes Prevention Recognition Program (DPRP) standards. To find Lifestyle Coach Training Programs, please visit the [staffing and training page](#) of the CDC DPRP website.

11. For those organizations that are thinking about becoming an MDPP Supplier or may be hesitant, what would you tell them are the key benefits of becoming an MDPP Supplier?

If your organization becomes an MDPP supplier, you would be able to provide diabetes prevention services to a population in great need of such services, as [approximately 23 million adults aged 65+ have prediabetes](#). Also, the CDC offers general information on [why an organization should consider offering a diabetes prevention program](#).

MDPP – Reimbursement-related questions

12. Are online or virtual diabetes prevention programs now reimbursed by CMS?

Diabetes prevention programs delivered 100% through virtual/online platforms are not eligible for CMS reimbursement for Medicare patients at this time. CMS recognizes the need for a virtual program but the path toward reimbursement is not clear and there is no timeline. A limited number of virtual make-up sessions are allowed to be reimbursed by CMS.

13. Are providers reimbursed for MDPP in year one, or do they have to get through year 2 with the weight loss requirement to get reimbursed?

MDPP suppliers can submit claims as soon as beneficiaries meet performance goals, which are based on attendance and weight loss within the program. Please see the [MDPP Quick Reference Guide to Payment and Billing](#) for information on reimbursement.

14. Can programs that are offered by hospital-based providers, or by non-healthcare providers (employers, community-based organizations, etc.), bill for the MDPP?

Yes. But In order to enroll in Medicare as an MDPP supplier and be reimbursed, the enrolling organization must meet recognition criteria. Please see the [CDC Diabetes Prevention Recognition Program \(DPRP\) standards](#) or contact CMS's partners at CDC at dprpAsk@cdc.gov for questions related specifically to recognition.

15. Is payment cumulative?

Payments are made in three-month intervals. Payment schedules are explained in the [MDPP Quick Reference Guide to Payment and Billing](#).

16. If a patient is both Medicaid and Medicare eligible, who gets billed first?

Dual eligible beneficiaries will be treated no differently for MDPP services than for other covered services. MDPP rules lay out the codes for billing of Medicare, through the MACs. Please see the [MDPP Quick Reference Guide to Payment and Billing](#) for more information on HCPCS codes for MDPP services.

MDPP – Blood Tests

Question 17 (Two questions are paired here.)

- Is Medicare considering reducing or eliminating the blood test requirement for participation? This has been a big barrier to enrollment. How do we submit blood tests for MDPP? Is this self-report or do we need a copy of lab reports?
- Why is the FBG requirement at 110 and not at 100 for MDPP eligibility?

Use of blood tests for determining eligibility for the Medicare Diabetes Prevention Program (MDPP) is different from eligibility for National Diabetes Prevention Program (NDPP) recognition. If a recognized organization is also a Medicare DPP supplier, all Medicare participants must be eligible based on a blood test indicating prediabetes.

For MDPP suppliers, participants are required to have a recent blood test (within the past year), and blood test results cannot be self-reported (i.e., MDPP suppliers need a copy of lab test results). The blood test must meet **one of the following three** specifications:

- A hemoglobin A1c test with a value between 5.7 and 6.4%, or
- Fasting glucose of 110 to 125 mg/dl (Note: CDC eligibility requirement for NDPP suppliers is 100 to 125 mg/dl); or
- A 2-hours plasma glucose of 140 to 199 mg/dl (oral glucose tolerance test)

The evidence used to make the MDPP expanded model actuarial certification indicated that individuals who fall into the 100-110mg/dL range for fasting plasma glucose and those with BMIs of 24 kg/m² (22 kg/m² for Asians) or less have lower risk for developing type 2 diabetes. CMS has chosen to focus on the highest risk population, and the Chief Actuary's analysis for certification focused on this population.

From 2017 PFS final rule: We believe the requirement to obtain blood test results is important for maintaining program integrity and use of risk questionnaires presents opportunities for invalid and unreliable data reporting. The DPP model test required blood test results as part of its eligibility criteria to show a beneficiary has pre-diabetes, and therefore we are requiring blood tests for MDPP eligibility. In considering how to expand the DPP model test, we relied on eligibility criteria that was either tested in the initial DPP model test and/or set forth by the American Diabetes Association or World Health Organization, and we do not intend to include additional eligibility criteria at this time.

Please see the [MDPP Expanded Model Fact Sheet](#) for a summary of MDPP participant eligibility requirements.

Please see page 3 of the CDC's Diabetes Prevention Recognition Program's [Standards and Operating Procedures](#) document for a summary of NDPP and MDPP participant eligibility standards.

18. If an in-range HbA1c is an acceptable qualifying test for NDPP eligibility determination, will CMS/Medicare be allowing it as a covered diabetes screening test soon?

From 2017 PFS: CDC standards for eligibility, which align with the American Diabetes Association definition for pre-diabetes, include an option for demonstrating eligibility using an HgA1c test and we proposed to adopt these eligibility standards for the MDPP expanded model. However, the blood tests that are permitted to be used to demonstrate MDPP eligibility are not covered as part of the MDPP services and occur before the start of the beneficiary's participation in MDPP. We did not propose to cover HgA1C tests for purposes of screening for pre-diabetes, but we note that the other blood tests that can be used to demonstrate eligibility for MDPP services, the oral glucose tolerance test and fasting plasma glucose test, are covered for pre-diabetes screening under Medicare. To cover HgA1C tests for purposes of screening for pre-diabetes, we would first need to make a separate coverage determination.

MDPP – General Questions

19. Why does the MDPP have 2 years of sessions - this seems a departure from NDPP and makes the program more challenging for payors. What is the evidence for including year 2?

CMS provides the following information in a [Fact Sheet](#) entitled Final Policies for the Medicare Diabetes Prevention Program Expanded Model in the Calendar Year 2018 Physician Fee Schedule Final Rule:

Ongoing Maintenance Sessions: We have finalized a one-year limit on ongoing maintenance sessions (assuming attendance and weight loss performance goals are met), which makes the total MDPP services period two years, consisting of one year of core and core maintenance sessions followed by up to one year of ongoing maintenance sessions, depending on eligibility, as described below. We finalized that MDPP beneficiaries must attend at least two out of three monthly ongoing maintenance sessions and maintain 5% weight loss at least once in the previous ongoing maintenance session interval to be eligible for additional intervals after the first.

20. For the ongoing maintenance sessions, do we have to offer separate sessions for each cohort or can we combine cohorts for these ongoing maintenance sessions?

Cohorts that are receiving ongoing maintenance sessions can be combined with cohorts receiving core maintenance sessions, but not with cohorts that are receiving core sessions. The

reason for this distinction is that the curriculum topics that are covered in core sessions focus on learning material for the first time, while the curriculum topics covered in maintenance sessions focus on reinforcing this material. The curriculum topics that are covered during ongoing maintenance sessions can repeat topics that were covered during core maintenance sessions. Click [here](#) for a set of frequently asked questions about the MDPP, available on the CMS Web site.

Medicaid

21. Will Medicaid eventually provide reimbursement as well? Any idea on when Medicaid coverage might be available?

The CDC has a resource entitled [Working with Medicaid Beneficiaries Guide for CDC-Recognized Organizations](#). It offers information on recruiting and enrolling Medicaid beneficiaries for diabetes prevention programs. Medicaid models vary from one state to another. Specific [information about each state's Medicaid program](#) is available on the Medicaid Web site. Visit this [site](#) to verify the current coverage types and levels offered in your state.

In addition, the National Association of Chronic Disease Directors (NACDD) and the CDC have a Medicaid Coverage for the National DPP Demonstration Project that is wrapping up soon and data from this project should be available in fall 2018. NACDD provided funding to state Medicaid agencies in **Maryland** and **Oregon** for a two-year demonstration (July 1, 2016 – June 30, 2018) to determine how to implement and deliver a sustainable coverage model for the National DPP lifestyle change program to Medicaid beneficiaries with prediabetes through managed care organizations (MCO) and accountable care organizations (ACO). More information is available [here](#).

Also, NACDD and CDC have prepared a [National Diabetes Prevention Program Coverage Toolkit](#) to provide information about the mechanics of covering the National DPP lifestyle change program. The [“Delivery” section of the “Medicaid Agencies” tab](#) outlines steps for implementing the National DPP lifestyle change program. It also discusses practices that have been implemented in Medicaid and other contexts to enhance delivery of the National DPP lifestyle change program. Additional content related to program delivery can be found at the [CDC National Diabetes Prevention Program website](#).

Uninsured and Low-Income Patients/Culturally Tailored Programs

22. Are there any efforts to address diabetes prevention for patients who do not have health insurance?

In April 2017, CDC issued [RFA DP17-1705](#), Scaling the National Diabetes Prevention Program in Underserved Areas to promote scaling and sustaining the National Diabetes Prevention Program (National DPP). The closing date for applications was June 12, 2017.

The intent of this five-year cooperative agreement is to further build out the National DPP infrastructure in underserved areas of the U.S. to ensure that all adults with prediabetes or at high risk for type 2 diabetes have the opportunity to enroll in a CDC-recognized lifestyle change program. Applicants were judged on these criteria:

- Be a national or U.S. regional organization with affiliate sites in **at least three states**.
- Have experience offering either the National DPP lifestyle change program or another evidence-based behavior change program offered in a group setting.
- Have the **capacity to enroll at least 1000 participants** from both general and priority populations in underserved areas in year 1 - with continued growth of sites and participants in years 2-5.
- Have experience either directly or through established partnerships working with **priority populations including Medicare beneficiaries and at least one of the following:** Men, visually and physically disabled, African Americans, Asian Americans, Hispanics, American Indians, Alaska Natives, and Pacific Islanders.

Organizations awarded grants under RFA DP17-1705 were:

- Association of Asian Pacific Community Health Organizations
- American Association of Diabetes Educators
- American Diabetes Association
- American Pharmacists Association Foundation
- Balm in Gilead
- Black Women's Health Imperative
- HealthInsight
- National Association of Chronic Disease Directors
- National Alliance for Hispanic Health
- Trinity Health

Other examples:

[Americares](#) is working to address prediabetes among those served by free and charitable clinics to increase the identification of prediabetes, reduce health disparities and improve health-related outcomes for a highly vulnerable population. Through its free and charitable clinic partners, Americares is working to promote and support the implementation of the Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program (NDPP), an evidence-based lifestyle change intervention. Descriptions of Americares NDPP-focused initiatives can be found [here](#). A Fact Sheet entitled "Transforming Prediabetes Care through the Diabetes Prevention Program (DPP): A National Demonstration for Free and Charitable Clinics," is available [here](#).

Another example comes from a [news article](#) (March 2018) from West Chester, Pennsylvania. This article states that “the CVS Health Foundation – a private charitable organization created by CVS Health – in partnership with the National Association of Free & Charitable Clinics (NAFC) has awarded a \$20,000 grant to the [Community Volunteers in Medicine](#) (CVIM), an organization in West Chester focusing on expanding patient access to the Centers for Disease Control and Prevention’s (CDC) National Diabetes Prevention Program and Diabetes Self-Management and Support Program. The clinic’s goal is to make a significant impact on the health of the community through education. The [CVS Health Foundation](#) recently extended its commitment to the NAFC with \$1 million in new grants. The West Chester clinic is one of 49 free clinics across the country receiving funding as part of the foundation’s ongoing effort to make quality health care convenient and affordable for more Americans.”

23. Are there any examples of evidence that the DPP can reach low-income patients at scale?

There are a number of projects and resources that provide information on how the National Diabetes Prevention Program could be delivered to low-income patients with Medicaid. (Please see Question #21.)

Here is one peer-reviewed article that may be helpful, of a study of a YMCA diabetes prevention program in the Bronx, New York: “Factors in Placement and Enrollment of Primary Care Patients in YMCA’s Diabetes Prevention Program, Bronx, New York, 2010–2015,” and an abstract is available [here](#).

24. Is there a location where we can learn about tailoring details that other organizations have implemented? (Specifically, culturally tailored programs)

We found one peer-reviewed article in the *American Journal of Preventive Medicine* that may be helpful, entitled “Diabetes Prevention in U.S. Hispanic Adults: A Systematic Review of Culturally Tailored Interventions” and an article abstract is available [here](#). Another peer-reviewed article that may be helpful is from the *Diabetes Educator* (February 2017): “Culturally Targeted Strategies for Diabetes Prevention in Minority Populations: A Systematic Review and Framework” and an abstract is available [here](#).

Also, the CDC’s National Diabetes Education Program (NDEP) has [information and materials](#) designed specifically for people of Hispanic and Latino ancestry. These resources can be used by community health workers, diabetes educators, and health care providers to meet the needs of this audience. The NDEP also has diabetes prevention and management resources designed specifically for African Americans and people of African ancestry, available [here](#); for Asian Americans, Pacific Islanders, and Native Hawaiians, available [here](#); for American Indians and Alaska Natives, available [here](#); and for rural populations, available [here](#).

Questions for Dow Chemical

25. Can you provide some more detail about Dow’s diabetes prevention program?

- What percentage of all employees who started the program then achieved 9+ lessons?
 - Our most recent reports indicate 59% of Dow participants are completing 9+ lessons.
- What have you found were successful retention strategies?
 - The engagement capacity of the Lifestyle Coach is #1 in retaining participants and leaving them seeking more.
- Did you use incentives?
 - Small trinkets were used along the way such as: resistance training tubing or bands, guides to healthier eating at fast food restaurants, etc.
- Was the diabetes prevention program at Dow offered on work time?
 - Because Dow's workplace culture supports flexible options, where appropriate, given the location and employee's role, our DPP classes were offered at a variety of times during work hours and outside of traditional work hours. In addition, our virtual offering is a self-paced platform where participants can access online lessons and engagement opportunities at times convenient for them.
- How many of the lifestyle change programs are delivered to individuals via small groups versus individualized delivery?
 - We do have some individual programs that our Wellness coaches provide. The majority of our DPP classes are delivered in small group, or virtual group formats.

Questions for YMCA of the USA

26. Can you provide some more detail about the Y's diabetes prevention program?

- Could you please share your experience related to referral? Do physicians refer patients to you?
 - We do receive referrals from physicians, but it does take work to set-up local referral networks. We recommend starting early (well before you launch your program) and continue to support the relationship management with your health care partners by sharing referral feedback data with all stakeholders.
- What challenges are you facing for billing? Are you getting reimbursed for what you are billing?
 - Typically, one of the biggest challenges around billing is determining if the potential participant has insurance coverage that includes the DPP. Additionally, organizations need to ensure they have the infrastructure to file claims, including knowledge of billing codes, NPIs, HIPAA, Compliance activities, and claims adjudication. Having both of these does not guarantee people will flock to your program. You will also need to have account managers to support participant recruitment and payor engagement.
- Do patients have to have insurance to utilize the program at the Y?

- No. The Y will serve individuals who are self-pay or have insurance coverage of the DPP. Ys also offer financial assistance.
- What is the Y's definition of a "completer?"
 - The Y uses CDC's definition from the Diabetes Prevention Recognition Program (DPRP). You can access a copy of the CDC's DPRP Standard Operating Procedures (March 1, 2018) [here](#).
- Where can we access a copy of your YMCA outreach mailings as examples?
 - A template of a generic letter is available [here](#).
- In addition to setting up an electronic medical record (EMR) within the Y network, do you also have lab testing available to determine eligibility for enrollment? Or did they get tested before coming to the Y to determine eligibility?
 - The Ys are not doing testing directly. The participant would bring their qualifying test information to the Y for enrollment.

27. How do the Y's outcomes vary, if at all, for low income participants? For those sites with the percentage of low-income participants, do you have any statistics on their average completion rate and weight loss percentage?

- We do look at our outcomes across our participant mix. We track participant demographics at or below the Federal Poverty Guidelines. We currently have 19% of our participants at or below the Federal poverty line. In this population, attendance is high, but weight loss tends to be ~1% less than participant above the Federal Poverty Guidelines.

Questions for the American Medical Association

28. When you say that physician referral increases engagement, does that mean that attrition in the NDPP is lower or that more people are enrolled in the program?

When physicians make a referral, a person is more likely to enroll in a diabetes prevention program, instead of someone reacting to a flyer in the physician's office or non-healthcare related location, or if they took part in a community screening event. Anecdotally, we know if the physician or a care team member contacts patients throughout the program to check in, patients are more likely to stay engaged and be more successful.

29. What incentives can we offer or talk about to encourage referral?

There are several things to do to increase or encourage prediabetes screening and referral. Activities can include letting physicians know the availability of CME/Maintenance of Certification activities available from the AMA for free. (www.stepsforward.org and www.ama-assn.org – search the Education Center.) Other ways to encourage clinical practice change is by operationalizing the process at the system level to make the process automatic and not place any added burden on a busy clinical practice. These system changes include:

- Running regular queries to identify patients at risk for prediabetes and then screening them with relevant blood tests;
- Creating a batch referral system to the DPP coordinator from these queries or registries; and
- Including prediabetes screening and referral rates on clinician reports/dashboards.

We also believe, and are looking at our engagement data to study, whether or when a feedback loop is created to the physician, can the physician also enhance participation by “nudging” patients – through encouragement, motivational interviewing, etc.?

30. Based on the AMA’s experience so far, how can we improve a referral system?

Physicians and teams are busy, and often with sicker patients so we need to make it as easy as possible for physicians and care teams and automate as much as possible.

- Create a registry through your EMR and automatically screen for prediabetes.
- Integrate the DPP as an intervention in a referral drop down menu on the EMR.
- Use the EMR to identify patients at risk for prediabetes prior to scheduled office visits and use the patient portal to do pre-office planning and send out the Prediabetes Risk Test from www.doihaveprediabetes.org.

31. Will the Henry Ford EPIC turbocharger be available to other health systems that use EPIC any time soon?

The Healthy Planet Prediabetes Turbocharger is available now to any systems with Epic 2015 version and higher. Henry Ford was the pilot site but does not own the Turbocharger. The AMA is planning to publish findings with Henry Ford in early 2019.

32. Is there any preference of curriculum found to be most successful with primary care physicians or large health systems? (i.e., Y-DPP or CDC Prevent T2: 2016 curriculum).

The AMA has not done any research on the curriculums to determine which is the best one being offered by health systems or primary care practices. The curriculums mentioned are all approved by CDC as they follow the basic principles for lifestyle change and are based on the intervention used in the original DPP study. Note, however, that only the YMCA’s can use the YMCA curriculum.