# Shared Learnings for Integrating the National DPP into Hospitals and Health Systems[1]

Background and Purpose

The National Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program proven to delay or prevent the onset of type 2 diabetes among people at high risk by 58 percent (71 percent for individuals over 60 years old).[2][3] Implementing this structured lifestyle change program can improve health outcomes, reduce healthcare costs, result in fewer hospital admissions, and in Maryland align with the goals of the All-Payer Model. A recent study conducted by the YMCA of the USA on Medicare participants enrolled in the National DPP found that during the first three years of the intervention period there was an overall savings of $5,048,449 for the 3,319 participants. Additionally, the total decreases in inpatient admissions and emergency department (ED) visits were significant, with nine fewer inpatient stays and nine fewer ED visits per 1,000 participants per quarter.[4]

This document provides shared learnings for integrating the National DPP into hospitals and health systems, which are organized into the following key categories:

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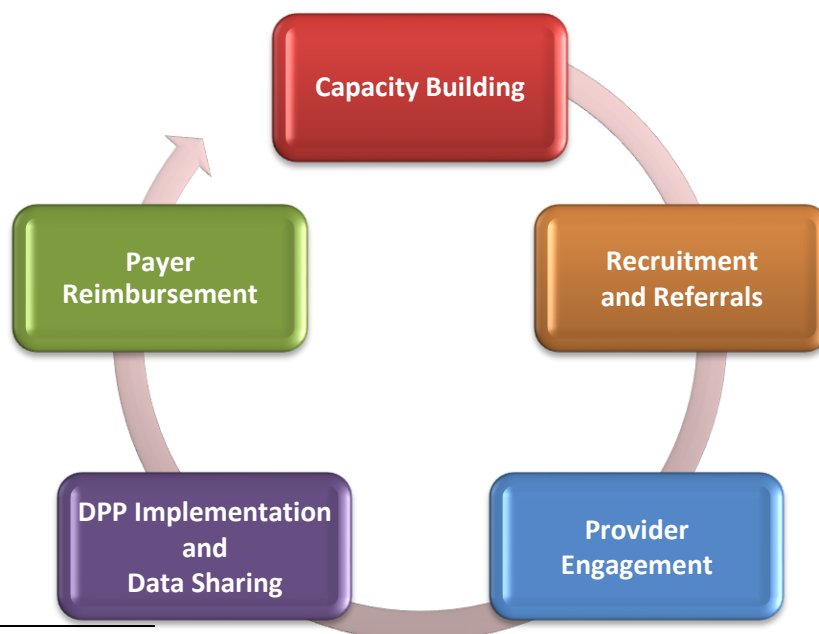
[1] This document was created in 2018 as part of Maryland's 6|18 work and it may not include the most updated information.

[2] US Preventive Services Task Force. (2014). Final Recommendation Statement. Retrieved from https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd

[3] American Medical Association and Centers for Disease Control and Prevention. (2015). Preventing Type 2 Diabetes: A guide to refer your patients with prediabetes to an evidence-based diabetes prevention program. Retrieved from https://www.cdc.gov/diabetes/prevention/pdf/stat_toolkit.pdf

[4] Iva, Maria Liliana. (2017). Impact of the YMCA of the USA Diabetes Prevention Program on Medicare spending and utilization. Health Affairs 36. 10.1377/hlthaff.2016.1307.

Capacity Building

Hospitals and health systems, through their patient registries, have the ability to offer or facilitate connection with preventive services to patients, who are developing life threatening, and often expensive, chronic illness, including prediabetes. This positions them well to contribute to state and/or local capacity-building efforts to scale and sustain the National DPP.

Hospitals and health systems can help to build the National DPP infrastructure and increase patient engagement by taking any of the following actions:

- **Become a Centers for Disease Control and Prevention (CDC)-Recognized Organization or Medicare DPP (MDPP)**[5] **Supplier** and offer classes taught by hospital-employed Lifestyle Coaches at the hospital / affiliated sites.[6]
    - Hospitals often already offer Diabetes Self-Management Education (DSME) classes and may cross-train registered Nurses, Dietitians, Nutritionists, health educators, or lay health workers to be DPP lifestyle coaches and offer the program.
    - [Information on how to become a DPP Supplier;](#)
- **Contract with a CDC-Recognized Lifestyle Change Program or MDPP Supplier** and host classes taught by the DPP Supplier's Lifestyle Coaches at the hospital / affiliated sites.[6]
    - [List of CDC Recognized DPP Suppliers in your area](#)
- **Act as a referral hub** in the hospital's community and refer patients to available CDC-Recognized Lifestyle Change Programs.

Recruitment and Referrals

Hospitals and health systems have access to patient information through electronic health records which facilitates taking a targeted approach for DPP recruitment. The hospital or health system's DPP implementation leaders can work with their IT and/or data analytics departments to create a report of patients with prediabetes or at risk for type 2 diabetes who appear to meet eligibility criteria for the DPP. This may be done using an algorithm (see Attachment A) that mirrors the necessary health criteria for DPP participation. All patients can and should be included in the prediabetes eligibility report; data can be sorted and manipulated to align with hospital and health system recruitment priorities (i.e. payer reimbursement, target populations etc.)

Using the prediabetes eligibility report, the following strategies may be deployed depending on the hospital or health system's communication culture:

- **Targeted mailers** to pre-identified patients directing them to either call, go online, or visit a DPP location for an informational session, to register for a DPP (depending on the model). Including the patient's health care provider's name with their contact information often results in more

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[5] Medicare Diabetes Prevention Program Suppliers will be able to be reimbursed for payment starting April 1, 2018. To be an MDPP Supplier, organizations must have achieved at least preliminary or interim recognition from the CDC.

[6] Payment for regulated space may depend on payer.

enrollments. The mailers provide an initial contact with the potentially eligible patients but have been most successful when followed up with a call (live or automated).

- **Personal calls** to patients. Similar to the targeted mailers, mentioning the patient's health care provider's name during personal calls has often resulted in more enrollments.
- **Automated calls to patients**, connecting them instantly to a member service representative. Calls are staggered to prevent overburdening of the member services representatives receiving the calls and to limit the number of call-backs needed.
- **Text messages** to patients with a link to the prediabetes risk assessment, informational session invitation, or the online registration portal (if a virtual model is selected). This strategy has been most effective among organizations that communicate via text regularly.
- **Health communications:** Hospitals and health systems can use their social media accounts and other electronic messaging systems to send educational messages that inform the public about prediabetes and promote the availability of DPPs.
- **Employee wellness:** Hospitals and health systems that are self-insured or offer employee wellness programs may offer the DPP for free to employees who meet eligibility criteria.

Provider Engagement

Hospitals and health systems can engage their provider networks to emphasize and/or prioritize a preventive approach to healthcare through screening, testing, and referring patients to the DPP. Providers may be incentivized to participate by taking a prediabetes course with available CME credits, meeting quality metric measures, or billing for services.

The following efforts can be made to involve providers:

- **Engage** your provider networks around diabetes prevention, the risk in their population, and potential referral pathways to eligible CDC-Recognized Lifestyle Change Programs, or other choices of intervention for their at-risk population.
  - o Outreach efforts have included primary care providers, and also specialists such as Endocrinologists, Dentists, and Ob-Gyns; some organizations have engaged other types of clinical and non-clinical health workers such as Community Health Workers, Case Managers, Dieticians, Nutritionists, and Naturopaths.
  - o Other integrated healthcare systems have engaged providers by forming or leveraging existing advisory boards that review evidence-based programs, such as DPP, to make recommendations for provider referrals and process, as well as establish quality metrics or integration with existing chronic disease programs.

The following are examples of strategies used to engage providers:

- **Educate** providers and their office staff about prediabetes as an emerging health risk and emphasize the importance of referring eligible patients to CDC-Recognized Lifestyle Change Programs as soon as possible.
  - o **Notify** your network providers about the availability of the American Medical Association's (AMA) CME credits for prediabetes, and consider requiring them to obtain these CME credits.

- o **Inform** your network providers about the [AMA's Prevent Diabetes STAT Toolkit](), which assists providers with integrating diabetes prevention in their practices.
  - o **Share** the [National Diabetes Prevention Program Coverage Toolkit]() as a resource for further information.
- **Provide** a list of pre-identified patients to your providers via secure email or a provider portal to facilitate the referral process (algorithm found in Attachment A).
- **Work** with providers and their office staff to establish workflow processes for identification of coverage and eligibility prior to visit and for making referrals (please refer to the AMA Prevent Diabetes STAT Toolkit).
- **Outreach** directly to provider offices via in-person meetings or electronically and offer providers and office staff information and tools that educate patients and facilitate referrals. If time and infrastructure permits a staff member could meet with the patient following a visit to describe the program, answer questions, and make a referral. Some have found motivational interviewing to be an effective tool when making referrals. Alternatively, a provider can share DPP information and make a referral via the patient portal, if available, post-visit.[7] Some tools and resources include:
  - o In-clinic presentations to providers, staff, and patients;
  - o Prescription pad for lifestyle change programs;
  - o One-page handout or postcard describing the DPP program, location(s), and how to register;
  - o A locally developed community resource guide that supplements or supports DPP success (e.g., smoking cessation, nutrition counseling, physical activity, etc.), and includes information on cost;
  - o CDC-Recognized Lifestyle Change Programs can offer providers and/or office staff a poster-sized diabetes risk test, in English and Spanish, and encourage them to hang it in the waiting room with the following questions: *Are you at risk for diabetes (based on your test score)? Are you 18 and over? Ask your doctor if you qualify for the National DPP program.*
- **Offer** multiple pathways for referral based on your patient needs.
  - o One integrated delivery system developed both a Prediabetes 101 online module and an in-person class offering in order to give their providers and patients choices for follow-up that are most appropriate for each individual.

DPP Implementation and Data Sharing

Hospitals and health systems may have data sharing infrastructure in place to support and enhance the implementation of a DPP. Data sharing between a DPP and a provider can help to improve the overall health of patients and in bridging medical care and public health initiatives.

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[7]Smith, T. (2017). Physicians praise online diabetes prevention program: "Finally." Retrieved on 01/26/2018 from: https://wire.ama-assn.org/delivering-care/physicians-praise-online-diabetes-prevention-program-finally

Data can be utilized to support DPP implementation in the following ways:
- The verification of a prediabetes diagnosis by a lifestyle coach for hospital or health system patients through electronic health records (EHRs).
- Participant outcome data may be shared via the EHR throughout the year (e.g. monthly or quarterly) to providers to inform them about their patient's health status since participating in the DPP.
    - This feedback may prompt the provider to give positive feedback and reinforce the importance of DPP with the patient, which in return may help lifestyle coaches retain their participants.
    - One integrated delivery network developed a workflow that has the lifestyle coach outreaching to the provider initially, to indicate enrollment acceptance or denial, at six months and again at 12 months to report health status.

Payer Reimbursement

Currently, approximately 65 commercial health plans nationwide provide partial or full coverage for the DPP,and Medicare reimbursement will begin April 1, 2018.[8] Maryland Medicaid has committed to evaluate the diabetes prevention program through its demonstration[9] (through January 31, 2019), and pathways to sustained coverage are being explored.
- Before offering DPP to patients, coverage for DPP should be verified by your billing department.
- Medicare will implement a pay-for-performance model that reimburses for DPP services at benchmarks that have been shown to improve retention and health outcomes.[10]
- Currently, CDC-recognized National DPP Programs can use a variety of billing methods to obtain reimbursement, including:
    - Invoice an employer or insurer who has a contract to pay for services rendered;
    - Self-pay by participant; or
    - Submit claims to insurers or designated benefit administrators using existing Current Procedural Terminology (CPT) codes.[11]

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[8] National Association of Chronic Disease Directors (NACDD). (2017). National Diabetes Prevention Program (National DPP) coverage toolkit. Retrieved from: http://www.chronicdisease.org/page/DiabetesToolkit/National-Diabetes-Prevention-Program-Coverage-Toolkit.htm

[9] Demonstration funded by NACDD.

[10] Centers for Medicare and Medicaid Services (CMS). (2017). Fact sheet: Final policies for the Medicare Diabetes Prevention Program Expanded Model in the calendar year 2018 physician fee schedule final rule. Retrieved from: https://innovation.cms.gov/Files/fact-sheet/mdpp-cy2018fr-fs.pdf

[11] American Medical Association (AMA). (2016) New 2016 National Diabetes Prevention Program CPT code: Background, description, and frequently asked questions. Retrieved from: https://assets.ama-assn.org/sub/prevent-diabetes-stat/downloads/cpt-code-brief.pdf

ATTACHMENT A

MCO Data Mining Using ICD-10 Codes to Identify Eligible Beneficiaries

Overview

During this demonstration,[12] participating Managed Care Organizations (MCOs) will follow the Center for Disease Control and Prevention's (CDC) Diabetes Prevention Recognition Program (DPRP) criteria to determine eligible beneficiaries for participation in the National Diabetes Prevention Program (National DPP). At the start of the demonstration, Maryland Medicaid provided an initial claims analysis to MCOs, who have since updated and refined this data in preparation for actual enrollment. Throughout the demonstration, MCOs will use claims and/or lab analyses to identify potentially eligible beneficiaries who meet the standard criteria related to blood sugar levels. This document outlines the logic and specific ICD-10 codes that MCOs can use to identify potentially eligible beneficiaries for referral to their subcontracted DPP suppliers.

INCLUDE:

1. 18 years or older;

AND

2. Overweight or obese (have a BMI of ≥ 25kg/m^2 (≥ 23kg/m^2, if Asian)[13]

AND EITHER

3. Elevated blood glucose level

   OR

4. History of gestational diabetes

   NOT

5. Diagnosed with type I or type II diabetes (exclude anyone with any of the E10.x, E11.x, or E13.x ICD-10 diabetes codes);

   NOR

6. Currently pregnant[14]

Another way to depict this logic is shown in the table below. If 1 + 2 + 3 then Eligible for DPP:

1	+2	+3	= ELIGIBLE FOR DPP
ARE:	AT LEAST ONE (may be both)	ARE NOT:	
✔ ≥ 18 years old ✔ Overweight or	✔ Elevated Blood Glucose ✔ History Gestational Diabetes	≠ Type 1 or Type 2 diabetic ≠ Currently Pregnant^2	MCOS may refer to demonstration DPPs

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[12] Funded by National Association of Chronic Disease Directors (NACDD), 6/2016-6/2017

[13] BMI requirement updated to reflect eligibility requirements per the 2018 Diabetes Prevention Recognition Program requirements. Information retrieved from:
https://www.eiseverywhere.com/file_uploads/f4deceaeed225e785f4761a94e4fb95f_ELY_Day2_115pm.pdf

[14] Participant should be at least eight weeks post-partum with post-partum blood work completed.

Obese			

For data mining, MCOs may use select ICD-10 codes for overweight and obesity, abnormal or elevated glucose, gestational diabetes, and BMI to identify potentially eligible beneficiaries for this demonstration (see Tables 1 – 3).

ICD-10 Diagnoses Codes and Descriptions

Table 1. *Overweight and Obesity ICD-10 Codes*

ICD-10 Code	Description
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug-induced obesity
E66.2	Morbid (severe) obesity with alveolar hypoventilation
E66.3	Overweight
E66.8	Other obesity
E66.9	Obesity, unspecified
O99.21	Obesity complicating pregnancy, childbirth and the puerperium
O99.210	Obesity complicating pregnancy, unspecified trimester
O99.211	Obesity complicating pregnancy, first trimester
O99.212	Obesity complicating pregnancy, second trimester
O99.213	Obesity complicating pregnancy, third trimester
O99.214	Obesity complicating childbirth
O99.215	Obesity complicating the puerperium

Table 2. *Elevated Blood Glucose Level and Gestational Diabetes ICD-10 Codes*

ICD-10 Code	Description – Elevated Blood Glucose Level	ICD-10 Code	Description - Gestational Diabetes
R73.01	Impaired fasting glucose	Z86.32[15]	Personal history of gestational diabetes
R73.02	Impaired glucose tolerance - Oral	O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
R73.03	Prediabetes	O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled

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[15] DPP suppliers should include Z86.32 as primary code for all individuals indicating history of gestational diabetes after confirming not currently pregnant.

ICD-10 Code	Description – Elevated Blood Glucose Level	ICD-10 Code	Description - Gestational Diabetes
R73.09[16]	Other abnormal glucose	O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
		O24.420	Gestational diabetes mellitus in childbirth, diet controlled
		O24.424	Gestational diabetes mellitus in childbirth, insulin controlled
		O24.429	Gestational diabetes mellitus in childbirth, unspecified control
		O24.430	Gestational diabetes mellitus in the puerperium, diet controlled
		O24.434	Gestational diabetes mellitus in the puerperium, insulin controlled
		O24.439	Gestational diabetes mellitus in the puerperium, unspecified control

Table 3. *BMI ICD-10 Codes for BMI 22.0 and greater*[17]

ICD-10 Code	Description – Body Mass Index	ICD-10 Code	Description – Body Mass Index
Z68.22	Body mass index (BMI) 22.0-22.9, adult	Z68.34	Body mass index (BMI) 34.0-34.9, adult
Z68.23	Body mass index (BMI) 23.0-23.9, adult	Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.24	Body mass index (BMI) 24.0-24.9, adult	Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.25	Body mass index (BMI) 25.0-25.9, adult	Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.26	Body mass index (BMI) 26.0-26.9, adult	Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.27	Body mass index (BMI) 27.0-27.9, adult	Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.28	Body mass index (BMI) 28.0-28.9, adult	Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.29	Body mass index (BMI) 29.0-29.9, adult	Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.30	Body mass index (BMI) 30.0-30.9, adult	Z68.43	Body mass index (BMI) 50-59.9, adult
Z68.31	Body mass index (BMI) 31.0-31.9, adult	Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.32	Body mass index (BMI) 32.0-32.9, adult	Z68.45	Body mass index (BMI) ≥ 70, adult
Z68.33	Body mass index (BMI) 33.0-33.9, adult		

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[16] For beneficiaries that do not have an ICD-10 diagnosis of elevated blood glucose/ gestational diabetes to confirm prediabetes, a DPP supplier may assign R73.09. In these cases, a risk test is given, and the DPP supplier assigns the R73.09 code (primary), along with BMI (secondary; see Scenario 2, in Chapter 4: Eligibility, Billing, and Coding Procedures for Participating National Diabetes Prevention Program (DPP) Suppliers).

[17] For data mining, use ICD-10 codes for BMI of 25 or greater.