Oregon Health Authority

OREGON DIABETES PREVENTION PROGRAM EVALUATION

07/2021

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Oregon Health Authority

Acknowledgments

The Rede Group produced this report on behalf of the Oregon Health Authority, Health Promotion and Chronic Disease Prevention Section. We want to acknowledge the many people who contributed to this evaluation, including the many NDPP stakeholders, including CCOs, providers, and referring providers, who participated in this evaluation through interviews and surveys.

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ACRONYMS + DEFINITIONS

Acronyms

ACO	Accountable Care Organization
APAC	All Payers All Claims
CBO	Community-Based Organization
CCO	Coordinated Care Organization
CDC	Centers for Disease Control and Prevention
DMAP	Division of Medical Assistance Programs
DPRP	Diabetes Prevention Recognition Program
EHR	Electronic Health Record
HERC	Health Evidence Review Committee
HPCDP	Health Promotion and Chronic Disease Prevention
HSD	Oregon Health Authority, Health Systems Division
LCP	Lifestyle Change Program
MCO	Managed Care Organization
NACDD	National Association of Chronic Disease Directors
NDPP	National Diabetes Prevention Program
NPAIHB	Northwest Portland Area Indian Health Board
ODC	Oregon Data Collaborative
OMA	Oregon Medical Association
OHA	Oregon Health Authority
PCP	Primary Care Provider
PHD	Oregon Health Authority, Public Health Division
SMA	State Medical Agency
SDPI	Special Diabetes Program for Indians
QI	Quality Improvement

Definitions

CARE MANAGER:
Supervise a clinical team and are responsible for the direction of patient care. They protect the health and safety of the patient and advocate to improve patient outcomes.

CLOSED-LOOP REFERRALS:
Referrals that, in addition to linking the referred individual to a given self-management intervention as described below, also provide the referring provider with timely follow-up information pertinent to the individual's continuing care.

LIFESTYLE CHANGE PROGRAM:
A CDC-recognized lifestyle change program is an evidence-based solution that can reduce a person's risk of developing type 2 diabetes by 58% (71% in individuals aged 65 and older).

NDPP PROVIDERS:
Entities offering the NDPP lifestyle change program such as hospitals, clinics, CBOs, and CCOs.

NDPP REFERRING PHYSICIANS:
Health care professionals who identify and refer eligible beneficiaries into the NDPP lifestyle change program.

NDPP DELIVERY METHODS:[1]
In-person: A yearlong National DPP LCP delivered 100% in-person for all participants by trained Lifestyle Coaches. Participants are physically present in a classroom or classroom-like setting. Organizations that conduct make-up sessions via a delivery mode other than in-person are still considered to be delivering the program in-person.

notes
1. Centers for Disease Control and Prevention.. National Diabetes Prevention Program. Delivering the lifestyle change program. FAQ Delivery Mode. 2021

Online: A yearlong National DPP LCP delivered 100% online for all participants. Participants log into course sessions via a computer, laptop, tablet, or smart phone. The organization must be able to track the participants' progress through online course sessions. CDC recommends requiring user IDs and passwords for course access. Live Lifestyle Coach interaction is required and should be offered to each participant no less than once per week during the first six months and once per month during the second six months. E-mails and text messages can count toward the requirement for live coach interaction as long as there is bi-directional communication (i.e., organizations do not simply send out an announcement via text or e-mail and count that as live coach interaction; the participant must have the ability to respond to and get support from the live coach).

Distance learning: A yearlong National DPP LCP delivered 100% by trained Lifestyle Coaches via remote classroom or telehealth. The Lifestyle Coach provides live delivery of session content in one location and participants call-in or video-conference from another location. Organizations that conduct make-up sessions via a delivery mode other than distance learning are still considered to be delivering the program by distance learning.

Combination: A yearlong National DPP LCP delivered as a combination of any of the previously defined delivery modes for each individual participant by trained Lifestyle Coaches.

NDPP MEDICAID BENEFIT ROLL-OUT:
Initial introduction of the NDPP Medicaid benefit, generally considered the period before implementation occurs.

NDPP MEDICAID BENEFIT IMPLEMENTATION:
Execution of the NDPP Medicaid benefit and all associated processes.

Program Description

The National Diabetes Prevention Program (NDPP) is a CDC-recognized lifestyle change program developed for individuals with prediabetes to lower their risk of developing diabetes through physical activity and healthy eating. The NDPP is an evidence-based one to two-year program focusing on long-term changes among participants, emphasizing self-monitoring, self-efficacy, and problem solving skills. Long-term behavioral changes include increasing physical activity, decreasing fat consumption, and achieving a five to seven percent weight loss. The impact of the NDPP can be seen in other health outcomes as well, including improvements in comorbidities associated with diabetes (e.g., cardiovascular disease, renal disease, high blood pressure). The NDPP is offered in community settings as well as online. Community-based organizations (CBOs), such as the YMCA and health care clinics, typically offer the NDPP. Importantly, the NDPP is a well-established cost-effective program that can yield cost savings via reductions in health care spending. The Institute for Clinical and Economic Review has estimated cost savings between $1,146 to $1,565 per NDPP participant at five years for in-person and virtual NDPP programs, respectively.[2]

Adult members of the Oregon Health Plan (OHP) are disproportionately affected by diabetes compared to adults with employer-provided health insurance. Almost 19% of OHP members (approximately 38,000 OHP members) have been diagnosed with diabetes; 7% of adults with employer-provided health insurance have been diagnosed with diabetes. Diabetes risk factors (e.g., obesity, cigarette smoking, high blood pressure, and high cholesterol) are more prevalent among OHP members, putting OHP members at a higher risk of developing diabetes and associated complications.[3]

Figure 1: Demonstration Project participants

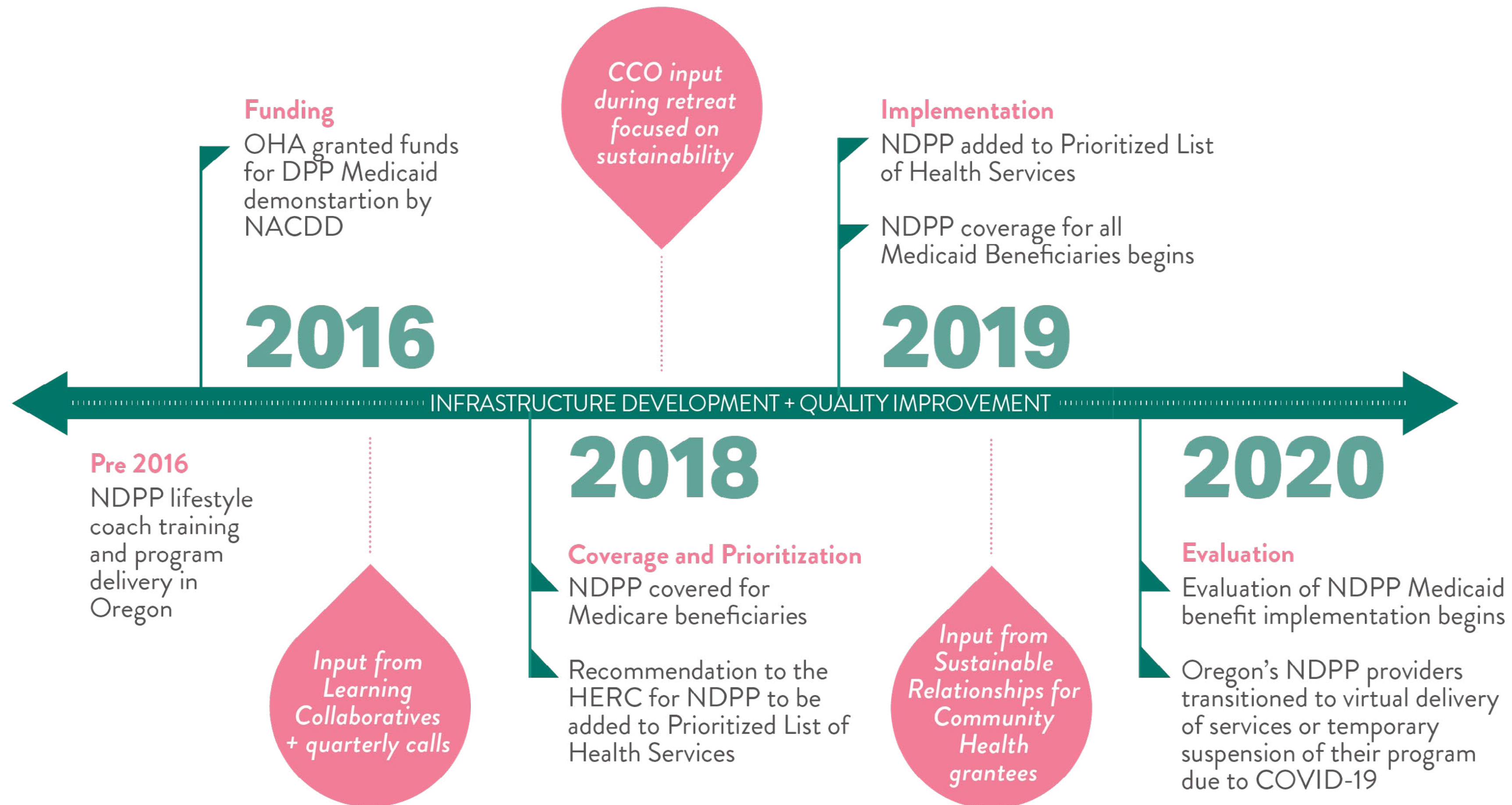
From 2016 to 2019, the OHA, PHD took part in a National Association of Chronic Disease Directors DPP Medicaid Demonstration Project (see Figure 2) to pilot the provision of the NDPP as a covered benefit for Medicaid beneficiaries by State Medicaid Agencies (SMAs). This included the implementation of delivery models for the NDPP through managed care organizations (MCOs) or accountable care organizations (ACOs). See Figure 1 for Oregon Demonstration Project participants. Eventually, NDPP would be added to the Prioritized List of Health Services for Oregon's Coordinated Care Organizations (CCOs). Coverage of the NDPP for all Oregon Medicaid beneficiaries began on January 1, 2019.

notes

2. *Oregon Health Authority. Implementing Comprehensive Diabetes Prevention Programs: A Guide for CCOs.*
3. *Oregon Health Authority. Oregon Diabetes Report. 2015*

Figure 2: Oregon NDPP Medicaid benefit implementation timeline

Acronyms:
HERC: Health Evidence Review Commission
NDPP: National Diabetes Prevention Program
NACDD: National Association of Chronic Disease Directors



**The Medicaid Coverage for the NDPP Demonstration Project was a multi-year project carried out in two states, Maryland and Oregon, and designed to work through and develop solutions for the real-world challenges of Medicaid coverage for the NDPP lifestyle change program. The Demonstration advanced understanding of the processes and systems-building needed to achieve sustainable coverage of the NDPP lifestyle change program for Medicaid beneficiaries.*

Diabetes Prevention Recognition Program

An important aspect of the NDPP is the Diabetes Prevention Recognition Program (DPRP), the quality assurance arm managed by the CDC. The DPRP awards CDC recognition to NDPP providers that have demonstrated effectiveness in both delivery of the NDPP and achieving improvements in health outcomes.

As of April 2020 (when the evaluation began), 23 organizations in Oregon held preliminary or full DPRP CDC recognition[4] (see Figure 4). All of these programs agreed to use a CDC-approved curriculum that meets the duration, intensity, and reporting requirements described in the DPRP Standards.[5] Of the 23 organizations, 15 had achieved full CDC recognition. Full recognition means that a program demonstrated effectiveness by achieving all of the performance criteria detailed in the DPRP Standards. An additional eight organizations held preliminary CDC recognition, meaning that they met several standards outlined by the CDC, including submitting an application to the DPRP, utilizing the CDC-approved curriculum, administering at least 22 sessions over the course of one year, and achieving a minimum amount of participation.

Obtaining CDC DPRP recognition can be a lengthy process. During this evaluation (April 2020 and June 2021), three NDPP providers who had preliminary recognition established full recognition (Crook County Health Department, Legacy Health, and Sky Lakes Medical Center).

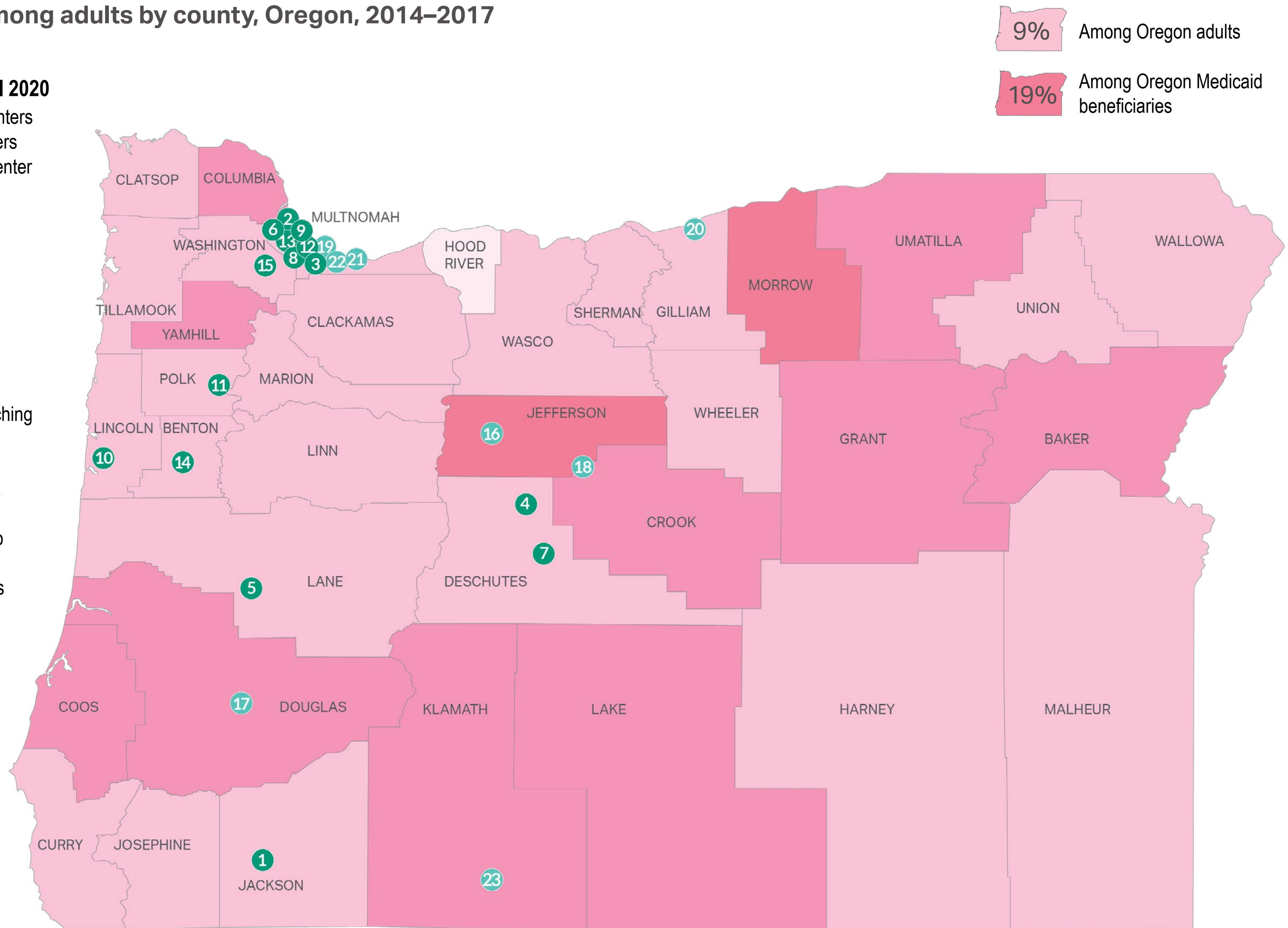
notes

4. *Centers for Disease Control and Prevention. The National Registry of Recognized Diabetes Prevention Programs.*
5. *Centers for Disease Control and Prevention. Diabetes Prevention Recognition Program. Standards and Operating Procedures. May 2021.*
6. *Oregon Health Authority, PHD. National Diabetes Prevention Program Contacts – Oregon.*

Figure 3: Diabetes among adults by county, Oregon, 2014–2017

NDPP Providers: April 2020

1. Asante Diabetes Care Centers & Asante Physician Partners
2. Asian Health & Service Center
3. BordlandFree Clinic
4. Deschutes County Health Services
5. Eugene Family YMCA
6. Harold Schnitzer Diabetes Health Center at OHSU
7. La Pine Community Health Center
8. Lifestyle Medicine Group
9. Lifeweighs Wellness Coaching
10. The Newport 60+ Activity Center
11. Oregon Wellness Network
12. Providence Health Plan
13. Providence Medical Group Oregon Prevent DPP
14. Samaritan Health Services
15. Yamhill Community Care Organization
16. Confederated Tribes of Warm Springs
17. Cow Creek Health and Wellness Center
18. Crook County Health Department
19. Legacy Health
20. MidColumbia Medical Center
21. The Miracles Club
22. Native American Rehabilitation Association
23. Sky Lakes Medical Center



Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS)
Notes: Adults = age 18+. Number of respondents (N) is unweighted; percentages are weighted. Age-Adjusted to standard U.S. 2000 population - 3 groups (18-34, 35-54, 55+). Includes respondents who answered "Yes" to the question: "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes?" Excludes females told only during pregnancy, pre-diabetes, and borderline diabetes.

Purpose

The purpose of this project was to evaluate the NDPP Medicaid benefit implementation in Oregon, including the processes involved in implementation and associated implementation-related outcomes. The primary focus of this evaluation was to understand the barriers and facilitators to NDPP Medicaid benefit implementation across the following key stakeholder groups:

A. CCOs;
B. NDPP providers; and
C. NDPP referring physicians.

Rede also aimed to assess the outcomes of implementation of the NDPP Medicaid benefit in Oregon, including:

A. NDPP referral;
B. NDPP enrollment;
C. claims; and
D. diabetes-related outcomes.

Results of this evaluation will inform Medicaid coverage of chronic disease lifestyle change programs (LCPs) in Oregon and nationally.

Key Evaluation Questions

#	Question	Method
1	WHAT FACTORS SUPPORT SUSTAINABILITY AND EFFECTIVENESS OF IMPLEMENTATION OF THE NDPP MEDICAID BENEFIT IN OREGON?	Key informant interviews and implementation survey
2	WHAT FACTORS HINDER IMPLEMENTATION OF THE NDPP MEDICAID BENEFIT IN OREGON?	Key informant interviews and implementation survey
3	WHAT ARE PROMISING PRACTICES FOR RECRUITMENT, ENROLLMENT, AND RETENTION IN THE NDPP?	Literature review, key informant interviews, and implementation survey
4	WHAT IS SATISFACTION WITH THE IMPLEMENTATION OF THE NDPP MEDICAID BENEFIT AMONG KEY STAKEHOLDERS?	Key informant interviews and implementation survey
5	WHAT ARE THE OUTCOMES OF THE NDPP MEDICAID BENEFIT IN OREGON? INCLUDING, BUT NOT LIMITED TO: ADOPTION, REFERRAL, ENROLLMENT, CLAIMS, AND PAYMENTS.	Implementation survey

Literature Search

At the onset of this evaluation, Rede conducted a literature search to assess the extent to which facilitators and barriers of the NDPP, specifically relating to the Medicaid benefit, have been examined. The search covered the following peer-reviewed databases, using keywords and controlled vocabulary: PubMed, Medline, Health Source, Web of Science, and Google Scholar. Rede used combinations of nine different search terms, including "DPP," "Medicaid," and "implementation." To yield the most relevant results within each database, Rede used search terms in an array of combinations. See Appendix A for a complete list of search terms. Rede then screened articles for relevance. In total, Rede found 15 relevant studies which were included in the literature review.

Rede extracted data from each relevant study, including key findings and recommendations for future work, and entered it into a literature search table (see Appendix B). Rede utilized findings from the literature review to inform qualitative data collection instrument development, resulting in comprehensive key informant interview guides for each of the three key NDPP stakeholder groups for this evaluation.

Situational and Program Review

Rede conducted a situational analysis, beginning with a document review. After gathering a wide variety of background documents that were provided by HPCDP and via web searches, Rede organized 31 documents into a catalogue of resources. This catalogue was used to gain historical knowledge of the NDPP as well as contextual information specific to the NDPP Medicaid benefit in Oregon. Examples of documents included a list and map of Oregon CCOs, DPRP recognition requirements, and timelines of NDPP milestones. Following the document review, Rede convened and facilitated meetings with HPCDP staff and other stakeholders. The full list of stakeholders who informed the situational analysis is found in Appendix C. Via this situational analysis, Rede sought to thoroughly understand the context of this evaluation, through asking the following questions:[7]

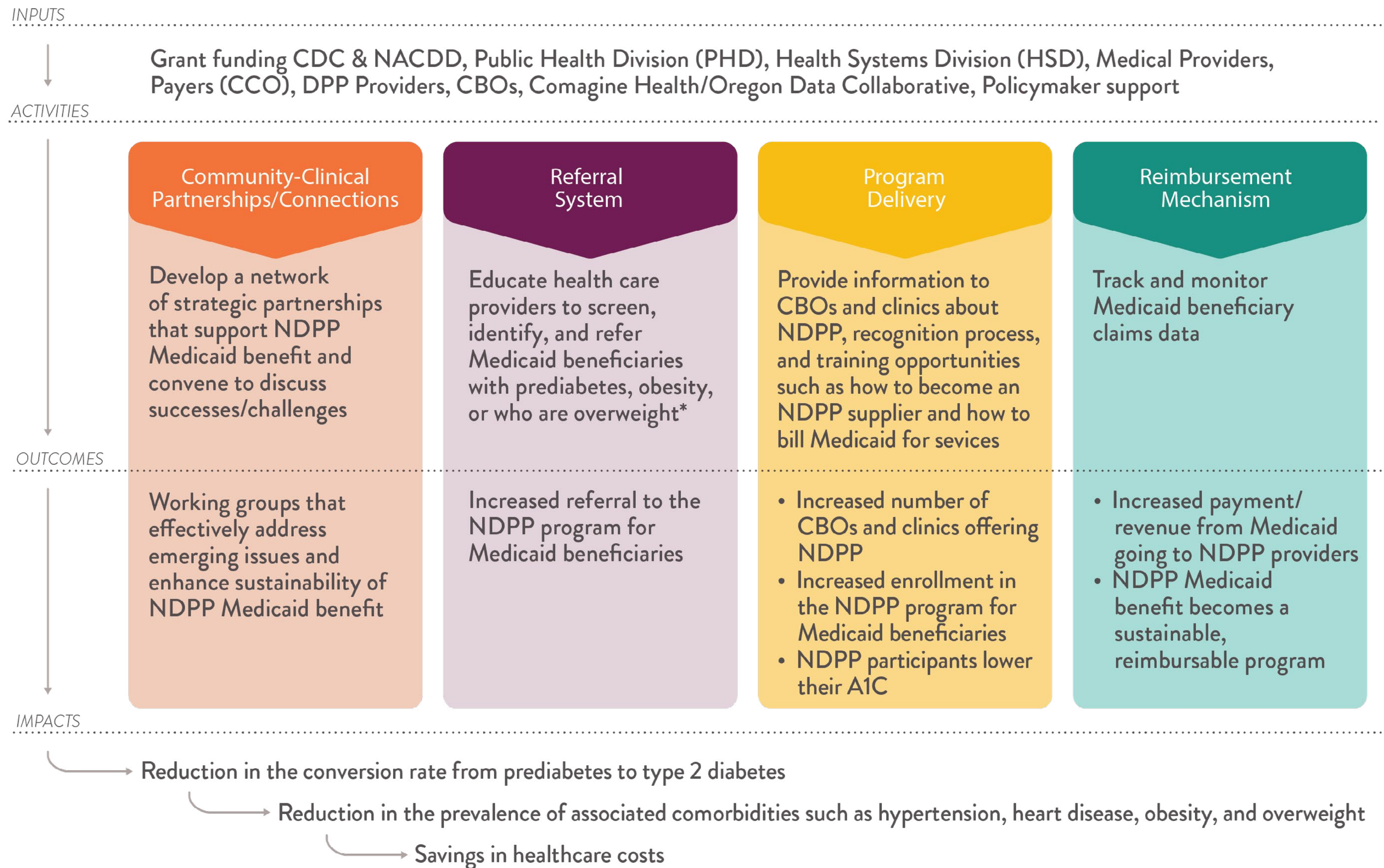
- What is the NDPP's history? What situation gave rise to the program?
- What are the NDPP's primary goals?
- What are the strategies to obtain these goals?
- Who are the intended beneficiaries of the NDPP, and what are their characteristics?
- Where do stakeholders' interests align, and where do they conflict?

Rede and the HPCDP NDPP evaluation team then collaboratively developed an Oregon NDPP Medicaid Benefit Implementation Logic Model (Figure 5), and two system maps (Figure 6 and 7). The logic model details inputs, activities, and outcomes of the NDPP Medicaid benefit implementation in Oregon. Additionally, the logic model informed the development of primary data collection instruments. The system maps found on pages 14-15 provide an overall picture of the components that make up the system, and how they interact with one another to facilitate the successful implementation of the NDPP Medicaid benefit. Figure 5 flows from left to right, and demonstrates how different entities interact to advise/regulate, reimburse, and deliver NDPP to all patients in Oregon. Figure 6 flows from the outside inward, and focuses specifically on delivering NDPP to Medicaid beneficiaries.

notes

7. *Patton, M. Q. (2012). Essentials of utilization-focused evaluation. Los Angeles, Calif: SAGE*

Figure 4: Oregon NDPP Medicaid benefit implementation logic model



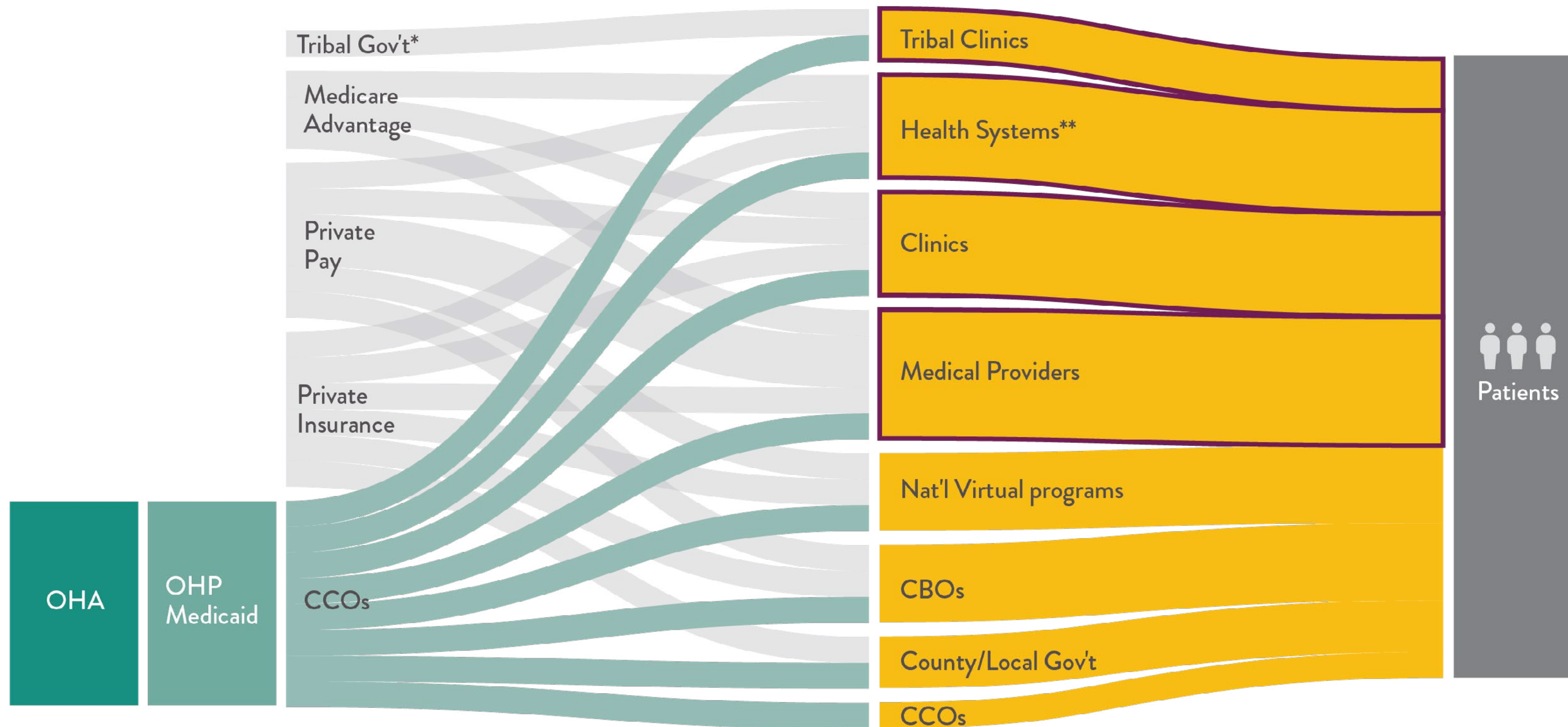
This is an Oregon specific activity

Figure 5: Oregon DPP: a systems overview

The NDPP is an evidence-based lifestyle change program for preventing type 2 diabetes. This system map provides an overview of the entities involved and their role in delivering NDPP in Oregon with a focus on the delivery of NDPP to Medicaid beneficiaries through OHP (Medicaid).

Acronyms:
CBO: Community Based Organization
CCO: Coordinated Care Organization
NDPP: National Diabetes Prevention Program
OHA: Oregon Health Authority
OHP: Oregon Health Plan

Relationships
- Advisory/regulatory
- Medicaid reimbursement mechanism
- Other reimbursement mechanisms
- NDPP program delivery
- Referring entities



*Some tribes in Oregon have their own health insurance plans
**Health systems such as Providence Medical Group

Figure 6: Oregon DPP Medicaid benefit implementation: a systems overview

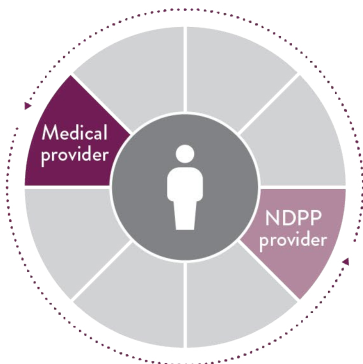
The NDPP is an evidence-based lifestyle change program for preventing type 2 diabetes. In 2019, NDPP became a covered program for Medicaid beneficiaries. This system map provides an overview of the entities involved and their role in delivering NDPP to Medicaid beneficiaries in Oregon.

Legend:
- Advisor/regulator
- Payer
- Coordinating organizations
- Referring entities
- NDPP providers
- Closed-loop referrals
- Supports, wrap-around TA, consultants

Acronyms:
CBO: Community Based Organization
CCO: Coordinated Care Organization
NDPP: National Diabetes Prevention Program
OHA: Oregon Health Authority
OHP: Oregon Health Plan

*Health systems such as Providence Medical Group

Closed-loop referrals:
Closed-loop referrals are coordinated, reciporical relationships between medical providers, Medicaid beneficiaries, and NDPP providers. Medicaid beneficiaries can also refer themselves to NDPP providers.



National Diabetes Prevention Programs in Oregon's Federally Recognized Tribes

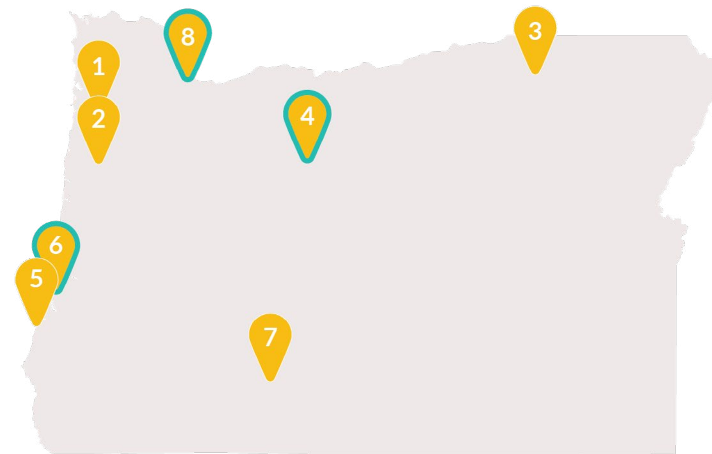
Oregon's nine federally recognized tribes have been engaged in diabetes prevention lifestyle change programs since the U.S. Congress established the Special Diabetes Program for Indians (SDPI) in the Balanced Budget Act of 1997 to provide for prevention and treatment services to address the growing problem of diabetes in Indian Country. The SDPI provides a comprehensive source of grant-based funding to address diabetes in tribal communities.

In 2019, all tribal SDPI diabetes coordinators and tribal programs from Oregon were contacted with information on NDPP Lifestyle Coach trainings, including information on sponsorship of the trainings, reimbursement, and logistics. Under a grant from the CDC, the Northwest Portland Area Indian Health Board (NPAIHB), trained 27 DPP staff across eight tribes or tribal support organizations including: Confederated Tribes of Grand Ronde, Confederated Tribes of Siletz, Confederated Tribes of Umatilla Reservation, Confederate Tribes of Warm Springs, Coquille Indian Tribe, Cow Creek Band of Umpqua Indians, Klamath Tribes, and Native American Rehabilitation Association (NARA).

Implementation of the Medicaid benefit in tribal NDPP programs is outside the scope of this evaluation because the NPAIHB is conducting a concurrent evaluation which will be available in winter of 2022. As seen in the systems maps, tribal NDPP programs represent a critical element of the overall system and, ideally, the two evaluations would have been synchronized; however, the extraordinary toll of COVID-19 on tribal health organizations caused delays in completing the formal evaluation.

Figure 7: NDPP training in Oregon tribes

The Northwest Portland Area Indian Health Board (NPAIHB), trained 27 DPP staff across the following tribes or tribal support organizations:



1. Confederated Tribes of Grand Ronde
2. Confederated Tribes of Siletz
3. Confederated Tribes of Umatilla Reservation
4. Confederate Tribes of Warm Springs
5. Coquille Indian Tribe
6. Cow Creek Band of Umpqua Indians
7. Klamath Tribes
8. Native American Rehabilitation Association (NARA)

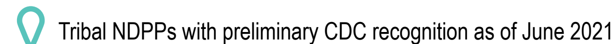


Figure 8: Components of data collection

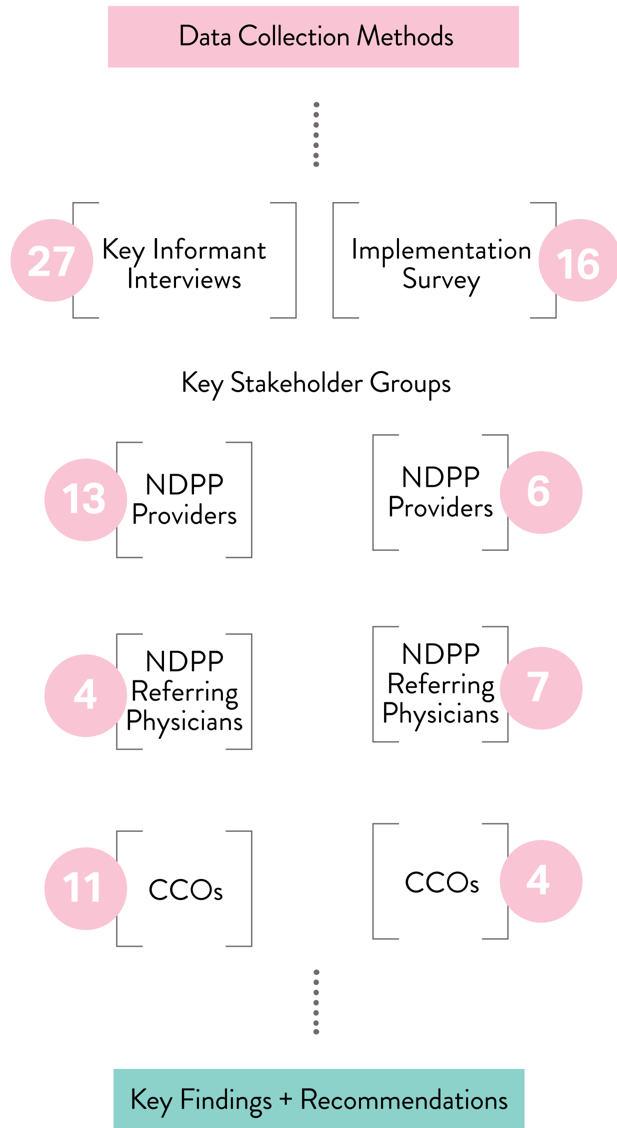
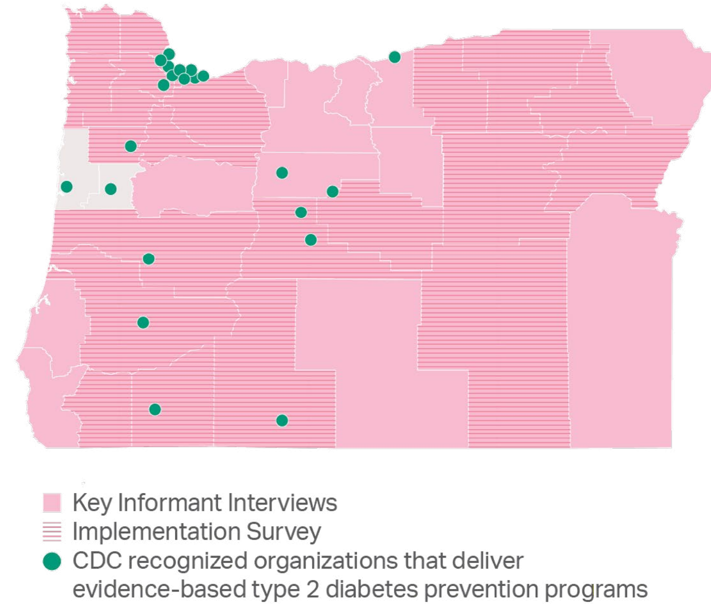


Figure 9: Counties represented in data collection



Key Informant Interviews

METHODS:

To gather information about barriers and facilitators to the NDPP Medicaid benefit implementation, we conducted interviews with individuals and organizations involved in one or more aspects of delivering the program. Using insights gleaned from the initial literature review, Rede drafted unique and comprehensive interview guides for NDPP providers, NDPP referring physicians, and CCOs in collaboration with HPCDP staff and the Quality Improvement Director at OHA. Interview questions focused on NDPP Medicaid benefit awareness, roll-out and implementation, recruitment and retention of Medicaid beneficiaries, impact of the COVID-19 pandemic on implementation, additional resources needed, and overall satisfaction with the NDPP Medicaid benefit implementation.

See Appendices D, E, and F for interview guides for NDPP providers, NDPP referring physicians, and CCOs respectively.

RECRUITMENT AND RESPONSE:

Rede utilized a non-probability convenience sampling design to recruit key informants across each stakeholder group for interviews. For recruitment of NDPP referring physicians, Rede utilized snowball sampling.

NDPP providers: Rede created a list of all NDPP providers in Oregon, subgrouping NDPP providers based on area(s) served, organization type, and CDC recognition status. Rede then recruited NDPP providers to take part in interviews via email. The initial target for NDPP Provider interviews was 15-20. Between November 2020 and January 2021, Rede conducted 13 key informant interviews with NDPP providers via Zoom, lasting between 15 and 50 minutes. Interviewees represented a variety of organization types, including health care clinics, County Health Departments, CCOs, culturally-specific CBOs, and online delivery programs. Interviewees were also representative of the different recognition levels of the DPRP, including NDPP providers with both full and preliminary CDC recognition status.

NDPP referring physicians: For the recruitment of NDPP referring physicians, Rede asked each CCO and NDPP provider for a contact list of NDPP referring physicians in their service area. Recruitment of this key stakeholder group was the most challenging, which was unsuprising given the COVID-19 pandemic and subsequent vaccinations. Therefore, Rede utilized OHA partners such as Comagine Health, Oregon Medical Association, Oregon Primary Care Association, and Oregon Wellness Network to recruit Oregon medical providers to participate in interviews. The initial target for NDPP referring physician interviews was 10-15. Between February 2021 and April 2021, Rede conducted four key informant interviews via Zoom (one provider responded in writing) with NDPP referring physicians, ranging in duration from 10 to 15 minutes. Additionally, three key informant interviews were conducted via Zoom with providers who were thought to be NDPP referring physicians, but during the interview, Rede learned these providers were not yet referring to a NDPP.

CCOs: To obtain an exhaustive list of potential interviewees in each of the three stakeholder groups, OHA provided Rede with contact information for Oregon CCOs. Rede then emailed potential key CCOs; response rates were 83%. The initial target for CCO interviews was 5-10. Between December 2020 and February 2021, Rede conducted 11 key informant interviews with CCOs via Zoom, lasting between 20 and 65 minutes.

ANALYSIS:

Rede recorded all key informant interviews for accuracy, with participants' permission, then transcribed the audio recordings and uploaded them into Dedoose[8] software for qualitative analysis. Rede developed and pilot tested coding trees for each set of interviews (NDPP providers, NDPP referring physicians, and CCOs) before establishing inter-rater reliability using one transcript for each stakeholder group. Rede coded each transcript based on emerging themes, analyzing key themes and important narratives across all transcripts.

notes:

8. Dedoose web application for managing, analyzing, and presenting qualitative and mixed method research data (2021). Los Angeles, CA: SocioCultural Research Consultants, LLC

Implementation Survey

METHODS:

Based on the literature search, evaluation questions, and results of the interviews with key stakeholders, Rede developed a brief online implementation survey. The survey contained demographic questions of key stakeholders (e.g., geographic region, panel size, CDC recognition status), as well as questions on the NDPP Medicaid benefit implementation, including barriers to implementation, beneficial resources, additional resources needed to be successful in implementation, the impact of COVID-19 on implementation, and overall satisfaction with NDPP, including payment and claims-related processes. The survey included advanced skip logic, which advanced different stakeholder groups to a series of tailored questions based on their responses to previous choices. For example, NDPP referring physicians received questions relating to identification of eligible Medicaid beneficiaries and the referral process, while NDPP providers received questions relating to program enrollment and retention. See Appendices G and H for the complete surveys.

Figure 10: Demographic characteristics of NDPP providers who took the survey (N=6)

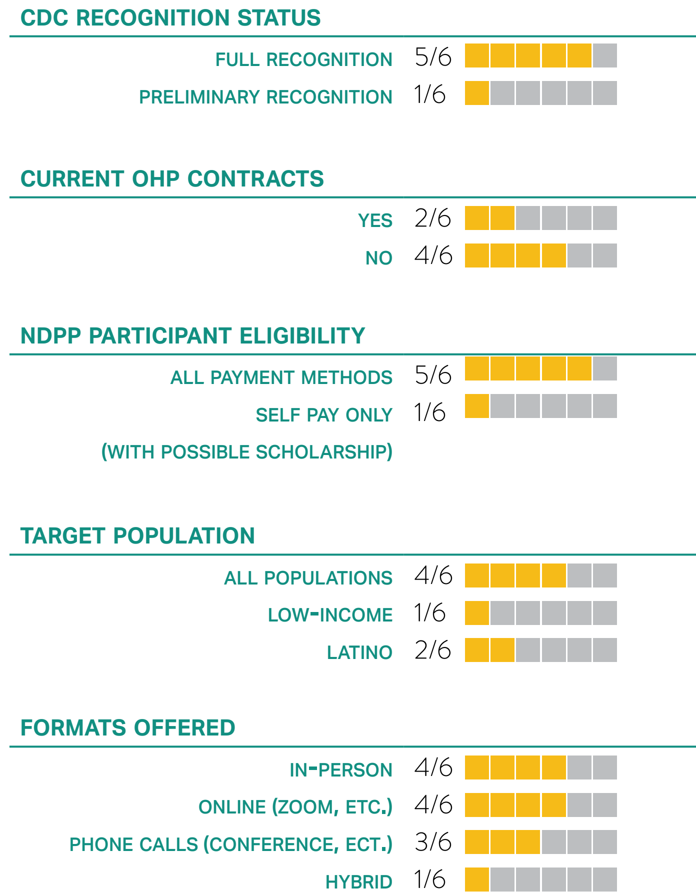


Figure 11: Demographic characteristics of referring physicians who took the survey (N=7)

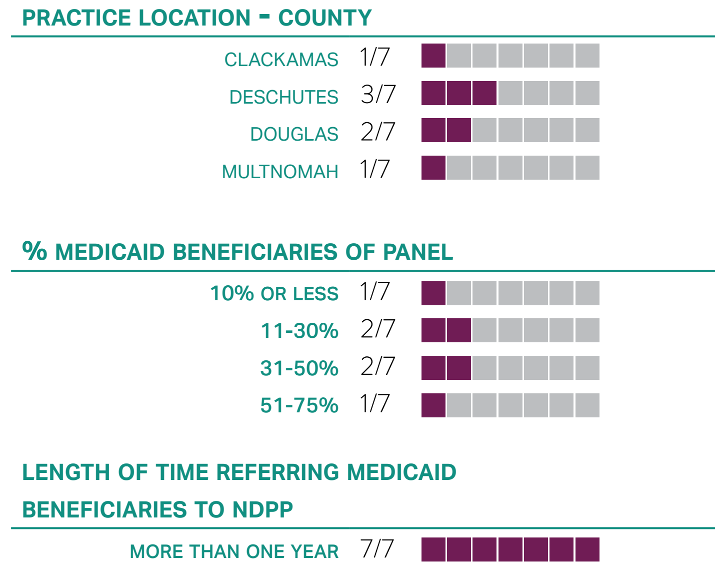
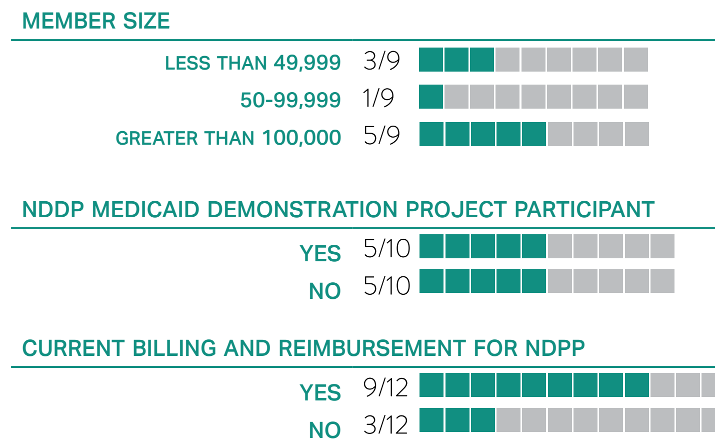


Figure 12: Demographic characteristics of CCOs who took the survey (N=12)



RECRUITMENT AND RESPONSE:

Rede administered the survey between April 2021 and May 2021 among three key stakeholder groups: NDPP providers, NDPP referring physicians, and CCOs.

NDPP providers: Rede distributed the survey to all non-tribal in-person NDPP providers in Oregon (22) and two online providers. HPCDP shared the contact information for all but one NDPP provider whose contact information was provided by a CCO interviewed. The NDPP provider survey received a 29.2% response rate (N=7). However, one NDPP provider did not complete the survey and was excluded from analysis. The remaining six NDPP providers included 5 providers with full CDC recognition and one provider with preliminary CDC recognition.

NDPP referring physicians: Rede distributed the survey to all NDPP referring physician contacts obtained via interviews with CCOs and NDPP providers. Additionally, Rede also collaborated with OHA partner organizations such as Oregon Wellness Network, Comagine Health, Oregon Medical Association, and Adventist Health to distribute the implementation survey to their provider networks. Ten referring physicians started the implementation survey. However, two providers did not provide responses after the first question and another referring physician did not currently refer to the NDPP. These three responses were excluded from final analysis, resulting in a sample of 7 referring physicians with complete responses.

CCOs: Rede distributed the survey to all CCO contacts provided by HPCDP. Initially, 12 CCOs started the implementation survey, with 9 CCOs reporting current billing for the NDPP. Three CCOs reported not yet billing for the NDPP, which resulted in survey closure. Five CCOs completed less than 10% of the implementation survey and were excluded from analysis. This resulted in a final sample size of 4 CCOs. Four CCOs representatives and seven NDPP referring physicians completed the implementation survey.

ANALYSIS:

Rede was limited by the low sample sizes for each stakeholder group. As such, data analysis for the implementation survey included exploration of the data via descriptive statistics, including measures of central tendency and measures of variability for each stakeholder group. We also performed simple stratified analyses, which enabled examination of how certain stakeholders characteristics (e.g., geographic location, organization size, CDC recognition status) were related to certain outcomes (e.g., barriers encountered, referrals, satisfaction). This type of simple analysis enabled us to answer our evaluation questions with clarity.

Limitations

This evaluation's chief limitation was the COVID-19 pandemic. As this evaluation was carried out, the spread of COVID-19 in Oregon and the United States significantly impacted all Americans, including key stakeholders in this evaluation, such as governmental public health, hospitals, CCOs, and CBOs. Because these entities' staff and resources were primarily directed toward COVID-19 response, their participation in this evaluation was at times limited.

Participation from NDPP referring physicians was particularly limited. This was in part due to COVID-19, and in part due to the absence of an existing list of NDPP referring physicians. As a result, recruitment of NDPP referring physicians depended on input from other sources, including CCOs, NDPP providers, and OHA partners such as Comagine Health. Though efforts were made to contact as many referring physicians as possible, only seven were ultimately available for key informant interviews.

A main limitation of the implementation survey was that it was intended to be brief, and therefore did not allow for great detail in responses. However, this limitation is mitigated by the detailed insights that were collected in key informant interviews. The descriptive nature of this evaluation, in combination with small sample sizes among stakeholder groups, did not lend itself to more advanced statistical analyses for the implementation survey. Additionally, the implementation survey was limited by its relatively small sample size (six NDPP providers, seven NDPP referring physicians, and four CCOs).

Rede intended to utilize Medicaid claims and DPRP registry data sets to answer key evaluation question 5 (What are the outcomes of the NDPP Medicaid benefit?) but were ultimately unable to use this information. OHA and their partners could not share Medicaid claims data with Rede due to the small number of claims meeting the criteria for data suppression. Data sharing agreements also excluded the use of DPRP data in this evaluation.

Key Informant Interviews & Surveys of Key Stakeholders

This section includes data collected through interviews and surveys of three key stakeholder groups: NDPP providers, NDPP referring physicians, and CCOs. Stakeholders reported being at various stages of NDPP Medicaid benefit implementation. Some entities were in the "roll-out" stages of program implementation, some were conducting NDPP programs but were not yet billing Medicaid, and others had fully implemented the benefit.

Benefit Awareness

NDPP PROVIDERS

NDPP providers surveyed reported becoming aware of the NDPP Medicaid benefit in several ways, including learning about it from:

- Comagine Health (42.9% surveyed, n=3 and 30.8% interviewed, n=4);
- the NDPP Demonstration Project (28.6% surveyed, n=2 and 15.4% interviewed, n=2);
- a CCO (14.3% surveyed, n=1 and 7.7% interviewed, n=1); and
- OHA NDPP workgroups (7.7% interviewed, n=1).

NDPP REFERRING PHYSICIANS

Referring physicians described learning about the benefit from:

- OHA (50.0% surveyed, n=3);
- via a physician or other healthcare professional (33.3% surveyed, n=2);
- a NDPP (50.0% interviewed, n=2); and
- through a staff meeting (25.0% interviewed, n=1).

CCOS

The primary means through which CCOs interviewed learned about the NDPP Medicaid benefit was OHA, with 54.5% (n=6) reporting becoming aware via OHA webinars, emails, and meetings. Several CCOs (18.2%, n=2) specified they learned about the Medicaid benefit through OHA's Quality and Health Outcomes Committee (QHOC). Additionally, 18.2% (n=2) of CCOs learned about the benefit through an NDPP provider, and 27.3% (n=3) of CCOs could not recall how their team first became aware of the benefit.

Promising practices for recruitment, enrollment, and retention in the NDPP

TARGETED RECRUITMENT OF MEDICAID BENEFICIARIES

Most NDPP providers surveyed (57.1%, n=4) and a few interviewed (23.1%, n=3) reported utilizing targeted recruitment strategies to enroll Medicaid beneficiaries. An array of methods were described by NDPP providers to specifically recruit Medicaid beneficiaries (see Figure 13 for survey responses). NDPP providers surveyed and interviewed reported similarly on recruitment strategies for Medicaid beneficiaries. In contrast to survey participants, the most common means of recruitment mentioned by interviewees was physician referral, with 46.2% (n=6) of interviewees referencing it. Three NDPP providers surveyed (42.9%) did not conduct targeted Medicaid beneficiary recruitment, and 30.8% (n=4) of interviewees reported the same recruitment strategies, regardless of the payee.

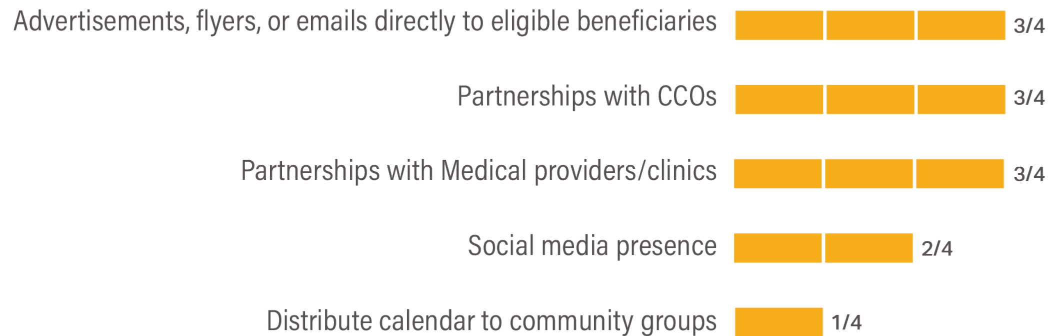
Rede asked CCOs (interviewed) how they recognize and promote NDPP delivery sites to Medicaid beneficiaries. Responses included:

- brochures delivered at primary care physicians' offices;
- CCO websites;
- informational materials handed out at special events; and
- mailings.

ENROLLMENT SOURCES AND STRATEGIES FOR MEDICAID BENEFICIARIES

The top three sources of NDPP enrollment (identified by survey participants) specific to Medicaid beneficiaries were physician referral (85.7%, n=6), other referrals (e.g., CCOs, FQHCs, health department, self-referral) (85.7%, n=6), and word of mouth (42.9%, n=3). Almost all NDPP providers (83.3%, n=6) said they were interested in partnering with other clinics, practices, and CCOs for NDPP referral, with only one NDPP provider stating they were "unsure" (16.7%).

Figure 13: Strategies utilized by NDPP providers using targeted recruitment to Medicaid beneficiaries (N=4)



"We're really relying on our primary care physicians to do the screening, to identify the people with prediabetes. The outreach has gone out to the prospective referrers."

—NDPP Provider

Only 15.4% (n=2) of CCOs surveyed reported using enrollment strategies to assist Medicaid beneficiaries in enrolling in the NDPP. Methods utilized by CCOs included partnerships with clinics or physicians to refer eligible Medicaid beneficiaries to the NDPP and utilizing internal staff that assists in enrolling Medicaid beneficiaries.

MEDICAID BENEFICIARY RETENTION

When Rede asked CCOs (interviewed) about strategies for retaining Medicaid beneficiaries/members, the most common interview response was incentives, with 27.3% (n=3) CCOs discussing them. These incentives included a Bluetooth scale, pedometer, measuring cups, and a family pool pass.

Conversely, one CCO cautioned against incentives, stating that internal motivation is a more sustainable route to long-term behavior change.

Other strategies CCOs reported for retaining Medicaid beneficiaries included:

- addressing cultural barriers;
- asking members to sign a letter of commitment;
- utilizing care managers; and
- holding a member-centric philosophy.

KEY QUOTES

"The virtual program comes with some internal incentives because someone gets this fairly expensive Bluetooth scale and, possibly, a fitness tracker."
—CCO

"If they came for the first four classes, maybe they'd get a pedometer, or the cohort of the Latino women wanted measuring cups. Then at the end of the whole session, we gave everybody a family pool pass. So [with] things like that, we were able to try to keep people engaged, but it's rough."
—CCO

You have to be really careful with incentivizing behavior change because you want it to come from within, or it doesn't keep."
—CCO

"If a care manager knew a member was in DPP, they would work with them to encourage them to stay in the program. If they had transportation issues around getting to the provider, they could assist with that. If they had challenges just understanding the material or instructions, they could help with that."
—CCO

Factors that hindered implementation of the NDPP medicaid benefit

NDPP PROVIDER IMPLEMENTATION BARRIERS

NDPP providers experienced many barriers associated with implementing the Medicaid benefit. Table 1 includes barriers reported by survey and interview respondents.

A leading barrier across survey and interview participants was a lack of patient awareness or engagement to the NDPP.

When asked to describe the greatest challenge relating to the implementation of the NDPP Medicaid benefit, three NDPP providers (surveyed) reported the following:

- "Getting CCOs to contract with us; at this time, many do not see it as a priority."
- "Finding ways to support people in the program so that they can/do stay. For Zoom sessions, two OHP members didn't have good devices to use, so I requested flex funds to purchase tablets which took a long time. And then I found out I ordered too inexpensive tablets which unfortunately don't allow gallery view."
- "Finalizing reimbursement structure"

Table 1: NDPP provider implementation barriers

	SURVEY RESPONSES (n (%))	INTERVIEW RESPONSES (n (%))
LACK OF PATIENT AWARENESS OR ENGAGEMENT (e.g., not answering calls or following up after referral)	4 (66.7%)	8 (61.5%)
LACK OF REFERRING PHYSICIAN AWARENESS OF BENEFIT OR REFERRAL	3 (50.0%)	2 (15.4%)
MEDICAID BENEFICIARY RETENTION	2 (33.3%)	3 (23.1%)
BILLING AND REIMBURSEMENT PROCESSES		9 (69.2%)
IDENTIFICATION OF ELIGIBLE MEDICAID BENEFICIARIES	3 (50.0%)	
LACK OF BUY-IN FROM REFERRING PHYSICIANS		3 (23.1%)
LIMITED PROMOTION BY PAYERS	1 (16.7%)	

The most commonly cited implementation barrier for interviewees was program billing and reimbursement processes, with 69.2% of NDPP providers (n=9) reporting this barrier. When describing challenges with billing and reimbursement, NDPP providers felt that this payment process was highly complex due to the array of codes and data involved in reporting to maintain CDC recognition status. In addition, several NDPP providers (30.8%, n=4) felt that these billing and reimbursement barriers were more prevalent for small organizations, which may not have had the necessary capacity or infrastructure. Notably, 100% of providers who reported billing barriers offered NDPP in-person or combination; those NDPP providers operating online-only NDPP programs did not identify this barrier.

Several NDPP providers reported a lack of awareness of the NDPP program posed a significant barrier to implementing the NDPP Medicaid benefit. In addition to a lack of awareness, three NDPP providers (interviewed) (23.1%) experienced apathy towards referring patients to the program among referring physicians. Two NDPP providers attributed a lack of buy-in from referring physicians to the program's preventative (as opposed to treatment) nature. Another NDPP provider described a belief that referral to NDPP is a waste of time because patients are unlikely to attend a year-long LCP.

KEY QUOTES

"It's not just one or two codes. It's several codes, depending on the scenario and where they are in their progress through the program. There's a difference between if they're doing it as a make-up in the first six months, in the second six months. It's just challenging all the way around, and maintaining, collecting all that data, and reporting it is hard, but it's also critical to maintaining our CDC recognition, and therefore our Medicare supplier status."

—NDPP provider

"If we were a community-based health organization that hadn't ever done billing, it would have been almost impossible. The fact that we have that capability already made it doable for us."

—NDPP provider

"The hardest part is it's a yearlong commitment for them [Medicaid beneficiaries]. They have to understand that it's not just about taking a workshop, but it's about changing lifestyle."

—NDPP provider

"Referring physicians don't recognize the value. Unless I go there and do a song and dance in their office, provide them lunch and say, 'This is the data, send us your patients,' then I don't get anybody. It's not part of their toolkit."

—NDPP provider

"I've run into some apathy around recruiting. Referring physicians feel like nobody's going to sign up for a year-long program. They don't feel like it's worth their time to help us recruit for a program that they don't see people being interested in."

—NDPP provider

RETENTION OF MEDICAID BENEFICIARIES

Contrary to interview responses, 66.7% (n=4) of NDPP providers stated that retention of Medicaid beneficiaries in the NDPP was not an issue in their organization. However, two NDPP providers (33.3%) reported retention of Medicaid beneficiaries was a challenge. Although most NDPP providers did not say that retention of Medicaid beneficiaries was a challenge for their organization, most NDPP providers surveyed reported they had, at some point, experienced retention challenges specific to this population, as seen by responses in Figure 14.

Figure 15 describes reported Medicaid beneficiary completion rates for the NDPP with 80% describing completion rates above 50%.

Figure 14: Medicaid beneficiaries retention barriers among NDPP providers surveyed

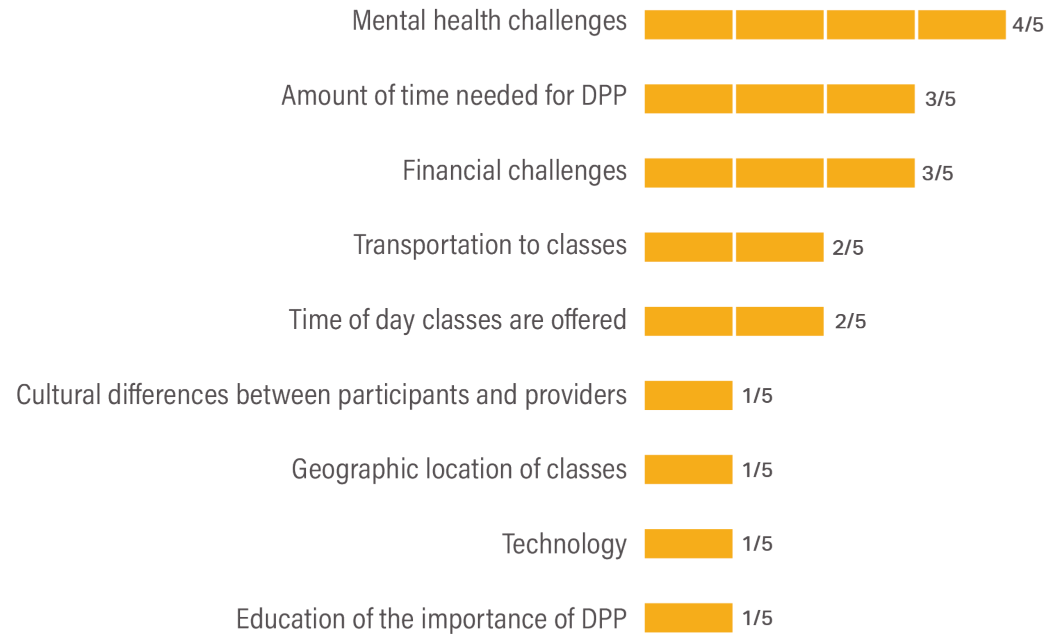
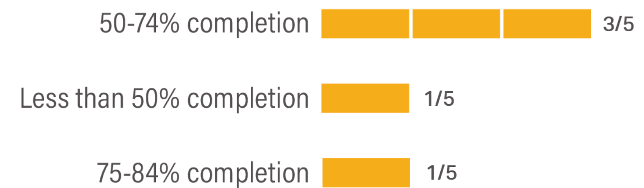


Figure 15: Completion rates reported by NDPP providers surveyed



REFERRING PHYSICIAN IMPLEMENTATION BARRIERS

Referring physicians reported numerous barriers to referring Medicaid beneficiaries to the NDPP. Table 2 shows the barriers reported in surveys and interviews.

Referring physicians (surveyed) reported the greatest challenges in referring Medicaid beneficiaries to the NDPP as patient resistance and hesitation toward the NDPP, lack of required lab work necessary to refer patients to the NDPP, and a lack of established referral workflow.

Almost all referring physicians surveyed (85.7%, n=6) noted there was not a standardized assessment tool for screening Medicaid beneficiaries for prediabetes, with only one referring physician (14.3%) reporting utilization of a standardized assessment tool.

Table 2: Refefing physician implementation barriers

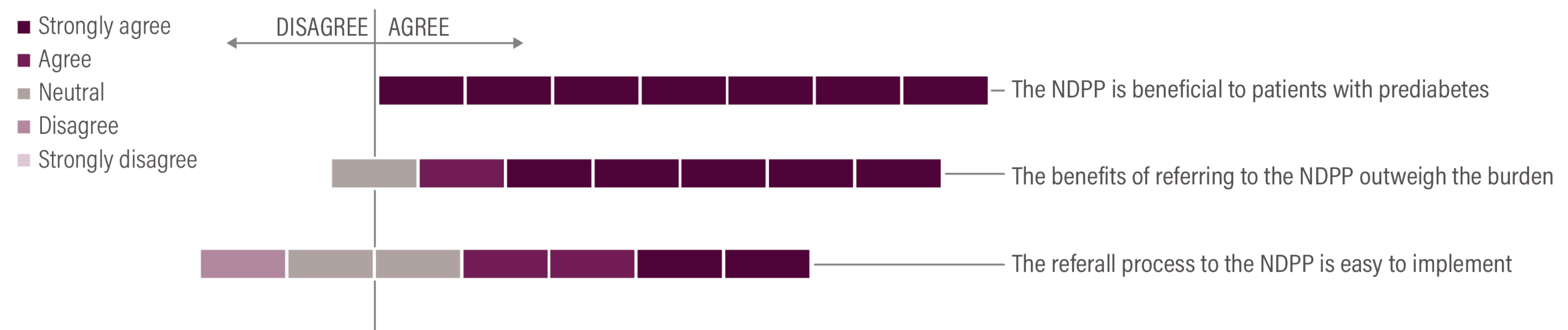
	SURVEY RESPONSES (n (%))	INTERVIEW RESPONSES (n (%))[9]
LACK OF PATIENT BUY-IN TO THE NDPP	5 (71.4%)	
LACK OF PATIENT ENGAGEMENT TO THE NDPP (e.g., not answering calls or following up after referral)	5 (71.4%)	1 (33.3%)
ELIGIBILITY REQUIREMENTS OF THE NDPP	3 (42.9%)	2 (66.7%)
MEDICAL PROVIDER BUY-IN TO THE NDPP	2 (28.6%)	1 (33.3%)
LANGUAGE BARRIERS	2 (28.6%)	2 (66.7%)
BENEFIT AWARENESS AMONG REFERRING PHYSICIANS	1 (14.3%)	6 (85.7%) [10]
REFERRING PATIENTS THROUGH AN EHR		2 (66.7%)

Notes:
9. Data includes physicians who had reported referring Medicaid beneficiaries to a NDPP (N=3) unless stated otherwise
10. Data includes all physicians interviewed (N=7)

Interestingly, many NDPP providers and CCOs interviewed discussed that lack of medical provider buy-in to the NDPP was a barrier to Medicaid beneficiary referral. However, when asked to rate perceived benefit of the NDPP to prediabetic patients on a scale from 1-10, the average score was 9.7, reflecting strong agreement that the NDPP program is "extremely beneficial" to patients diagnosed with prediabetes. Referring physicians also rated their agreement with a series of statements related to the benefit of the NDPP program; Figure 16 reports these results.

One of the most common barriers identified by interview participants was a lack of awareness of NDPP and its Medicaid benefit. In fact, three out of seven physicians interviewed were themselves not aware that NDPP was a program they could refer to. The four remaining providers reported that although they were aware of the NDPP Medicaid benefit, a lack of awareness is a common barrier among referring physicians. Lack of awareness among referring physicians proved to be a thematic barrier across key stakeholders, as mentioned by NDPP providers and CCOs in addition to referring physicians.

Figure 16: Buy-in among referring physicians surveyed (N=7)



Physicians provided insights as to why there may be such a lack of awareness among referring physicians. These included:

- absence of a comprehensive list of benefits available to patients;
- a focus on patients with more severe diabetes;
- high provider turnover; and
- information about NDPP not reaching health care providers.

Participant recruitment emerged as a barrier for one referring physician who reported a number of underlying reasons for this barrier, including:

- classes offered only at inconvenient times;
- a lack of participant incentive to enroll in the program;
- patients not answering their phones; and
- a preference for one-on-one programs.

KEY QUOTES

"One barrier was just getting people to know that it existed."
—Referring physician

"I think it's a benefit that we just haven't heard that much about, and maybe it's because we're so focused on the people that are on the high end of the A1C scale. That's where all our diabetes focus is and it doesn't leave very much bandwidth."
—Referring physician

"I guess I don't know where there would have been a clearing house to let us know. We worked through our CCO and we have measures that we follow, but I'm not aware that they have provided us with a list of individual benefits for the patients."
—Referring physician

"So even though we told everybody about [the NDPP benefit] six months ago, we've had three new providers since then. Those three new providers probably don't know anything about it. So having to do it continuously is a lesson that we've had to learn."
—Referring physician

"It's more technical things regarding the way the order is structured within Epic or EHR. It's kind of buried within the diabetes center, and so that is confusing."
—Referring physician

CCO IMPLEMENTATION BARRIERS

Table 3 includes cited implementation barriers among CCOs with few common challenges among survey and interview participants. Among those CCOs surveyed reporting implementation barriers, most reported having challenges with providers referring beneficiaries to NDPP (75%, n=3); this is a thematic barrier also mentioned by NDPP providers and referring physicians.

When survey respondents were asked the open-ended question, "What has been your organization's greatest challenge related to implementing the National DPP Medicaid benefit?", CCOs (surveyed) reported that COVID disruption and resource investment were the biggest challenges. One CCO said that the leadership and resources required for the NDPP Medicaid benefit were the biggest challenges for them, as there are many different focus areas (e.g., quality metrics, utilization costs, etc.). Another CCO reported that COVID disruption was their greatest challenge.

Table 3: CCO implementation barriers

	SURVEY RESPONSES (n (%))	INTERVIEW RESPONSES (n (%))
IDENTIFYING ELIGIBLE MEMBERS	2 (50.0%)	4 (36.4%)
BILLING AND REIMBURSEMENT PROCESSES		7 (64.6%)
IDENTIFICATION OF NDPP PROVIDERS		5 (45.5%)
STAKEHOLDER TIME AND CAPACITY NEEDED TO START UP THE PROGRAM		4 (36.4%)
SUSTAINABLE PAYMENT ARRANGEMENTS WITH NDPP PROVIDERS	1 (25.05)	
PROVIDER WILLINGNESS TO REFER BENEFICIARIES TO NDPP	3 (75.0%)	
VIRTUAL FORMAT		3 (27.3%)
EXECUTION OF DATA-SHARING AGREEMENTS WITH NDPP PROVIDERS	1 (25.0%)	

The top-cited barrier by CCOs interviewed was billing and reimbursement processes (63.6%, n=7), due, in part, to the reimbursement structure dependency on CDC recognition status. Another notable barrier cited by 36.4% (n=4) of CCOs was recruiting and enrolling participants, which was challenging due to the intensity of the NDPP.

Other barriers mentioned by interviewees (not shown to be thematic) included:

- ensuring program modifications are culturally appropriate;
- a lack of benefit awareness among participants and providers;
- time-consuming to startup programs and lack of capacity for some local NDPP providers;
- participant transportation to classes;
- the time needed to manage NDPP provider relationships; and
- reporting in Compass.

KEY QUOTES

"We've heard from [health care] providers who have told us they're not really interested in us spending time trying to get NDPP available in the region, because it is really cumbersome in terms of the number of classes you need to attend, the length of them."

—CCO

"Being mindful that community-based organizations are usually working at a different capacity level and so the expectation of organizations to have a lot of infrastructure in terms of how clinical spaces or other health systems run is unrealistic and doesn't necessarily honor the ways in which those organizations already function."

—CCO

"Some of the barriers were in trying to find stakeholders that had time and capacity to participate, because being a CCO, we can provide the services and cover the services, but really at the point of care where the members are getting that diabetes prevention education that's on our medical providers."

—CCO

IMPACT OF COVID-19 ON IMPLEMENTATION

Nearly all stakeholders (NDPP providers, referring physicians, CCOs) identified ways COVID-19 impacted NDPP Medicaid benefit implementation. The government-imposed stay-at-home order forced NDPPs once held in-person to be paused or conducted via distance learning for several months of 2020. COVID-19 restrictions on in-person gatherings remained in place at varying levels by county through the end of the evaluation. A challenge of COVID-19 noted across all three stakeholder groups was the transition to virtual format for NDPP classes.

NDPP providers interviewed reported transitioning to a virtual format posed several barriers, with the most significant being a lack of Medicaid beneficiary access to technology (61.5%, n=8). One survey participant also mentioned a lack of technology within their organization and among Medicaid beneficiaries as a challenge. In response to this barrier, 30.1% (n=4) of NDPP providers interviewed reported seeking funding to spend on supplies such as laptops and tablets and internet access for Medicaid beneficiaries to continue in the NDPP.

KEY QUOTES

"Access to the internet and other technologies is a requirement to join now and can be a huge barrier for some people...We are under the 1705 grant with Comagine...They've been able to support and provide some funding for people to actually get data and internet to help them join the class."

—NDPP provider

"We've had to go virtual and we had to seek some support with that funding, so that we could offer those resources [laptops] for folks. So that we felt like we could successfully offer a virtual program to folks who had limited income."

—NDPP provider

"Even if there is some access, it's having the bandwidth necessary to be able to participate in, say, a Zoom meeting. We've had some folks who have phones, but not internet. We've had some folks without email, and so, communication and being able to participate in the group in the same way, for some folks, there's been a little bit of a challenge."

—NDPP provider

In addition to a lack of patient access to technology, NDPP providers discussed other challenges associated with the transition to a virtual format. These included:

- a lack of ability to weigh patients;
- a lack of patient engagement;
- a lack of personal connection;
- a lack of Medicaid beneficiary participation; and
- preference for in-person programs.

Given these substantial challenges, only 15.4% (n=2) of NDPP providers interviewed reported having a smooth transition from in-person to virtual programming.

In agreement with NDPP providers, referring physicians discussed a lack of access to technology among their patients as a barrier to transitioning to virtual programs.

27.3% (n=3) of CCOs interviewed discussed this transition in a negative light, explaining that virtual programming is not comparable to connecting with communities in person.

KEY QUOTES

"The programming has been very impacted, not just in terms of delivery mode. I think the program does really well with in-person meetings, where you can really build that relationship with participants, and that helps keep them coming back and willing to put a little effort out there on their own. Having to transition to virtual classes, that's a little bit harder to achieve."

—NDPP provider

"So you are a pre-diabetic in a space that really needs that wraparound approach. You can't wrap around when you're on a screen. It's just not the same."

—CCO

"Zoom is a really big barrier for a lot of my patients. A lot of my patients don't have smartphones, and if they do have smartphones, they have some weird limit that they can't do video streaming because of their minutes. Then they don't have WiFi."

—Referring physician

Two NDPP providers (15.4%) and one referring physician (33.3%) interviewed discussed potential lasting benefits to a virtual format, given its potential to overcome barriers prevalent in the Medicaid population, such as transportation and childcare. Though most CCOs who discussed virtual programming focused on its drawbacks, one CCO (9.1%) emphasized its benefits, citing that virtual delivery may allow catering to various learning styles. Additionally, though a lack of access to technology was commonly discussed as a barrier by NDPP providers and referring physicians, one CCO did not share this concern, stating that Medicaid beneficiaries are likely to own a smartphone.

KEY QUOTES

"We're hoping that [a virtual platform] is going to be helpful with sustainability and with getting people to be a part of the program. We're trying to see it as an opportunity, and a model that we can use post-COVID."

—NDPP provider

"Virtual programming actually provides more opportunity for people to participate. Certainly, someone might not have a computer or a smartphone, but I think a lot of the research lately shows that people on Medicaid are likely to have a smartphone.

—CCO

"When the pandemic hit, we shifted to a virtual delivery. We've been able to engage participants and continue to offer the program."

—NDPP provider

"It'd be great if we could have a live NDPP on every corner, and then people would be able to easily get to them. But that's not realistic. Transportation can be a major issue. So having this online, virtual experience is really the answer to that."

—NDPP provider

"I think the digital program allows different levels of engagement that you really can't get through a brick and mortar solution. We can be more accessible and honestly more interesting to a broader group of individuals who need support."

—NDPP provider

In addition to barriers related to the virtual format, referring physicians also noted the following ways the COVID-19 pandemic impeded benefit implementation:

- confusion around when the classes were being held;
- lack of in-person provider meetings, making it difficult to begin new initiatives;
- organizations closed, resulting in no current NDPP program;
- patients general tendency toward delaying care;
- patients feeling overwhelmed
- providers feeling overwhelmed
- smaller cohort sizes when returning to in person; and
- vaccine clinics consuming clinical resources.

CCOs cited that the pandemic resulted in a "limited focus" and reduced provider bandwidth to add new workflows or processes in. When asked how COVID-19 impacted NDPP Medicaid benefit implementation, the most common theme discussed by CCOs was prioritization. Specifically, 45.5% (n=5) of CCOs interviewed explained that attention was shifted to COVID-19-related priorities, leaving less bandwidth for NDPP.

KEY QUOTES

"In general, people are just leery of healthcare. I think they want to wait, even with discussions available online, people are just delaying lots of care. I'm a primary care doctor, I see it about all sorts of things, not just prediabetes."

—Referring physician

"It's been kind of all hands on deck for COVID, and unfortunately DPP is not even part of the conversation."

—CCO

"There's been little to no discussion on anything other than COVID testing and vaccine, and PPE. I think the big barrier has been no bandwidth to talk about things like DPP."

—CCO

"A lot of our work on NDPP has taken a back seat. We have been focused on trying to respond to the needs of our communities and support our provider networks. We have been experiencing a pretty horrific mental health crisis and substance use disorder crisis on top of the pandemic, as a result of some of the regulations and closures. We've been distracted in 2020, and haven't had the capacity to focus on NDPP."

—CCO

"We're just not able to get out into the community. We're not able to talk to members, talk to providers, talk to clinics, remind them about these programs and about these metrics, talk about their barriers and obstacles."

—CCO

BARRIERS TO SUSTAINABILITY

NDPP providers (surveyed) reported several barriers to the sustainability of the NDPP Medicaid benefit, which included the inability to recruit Medicaid beneficiaries (40.0%, n=2) and the current reimbursement structure (60.0%, n=3). Three other NDPP providers elaborated on these sustainability barriers:

- "Contracting with CCOs has been a challenge; taking more than a year in some cases; others don't return our call."
- "The benefit is working well enough, but we are dependent on grant funds to ensure that we can offer the program. Reimbursement doesn't cover program delivery costs (including OHP and Medicare)."
- "The billing process seems cumbersome. We don't currently have a contract in place with OHP."

It was evident that contracting with CCOs and OHP was a challenge for NDPP Providers. Even though they were enrolling Medicaid beneficiaries into the NDPP, only two providers (33.3%) reported submitting claims for Medicaid beneficiaries for the NDPP. Of the NDPP providers not yet billing for Medicaid beneficiaries, only a quarter (n=1) said they plan to begin billing Medicaid for the NDPP in the next 12 months.

KEY QUOTES

"If it generates a very small number of participants, and it has little future to generate more, meaning go to scale, it won't be sustainable."

—NDPP provider

"Especially when talking about chronic conditions and long-term behavior change, people can be somewhat erratic. You're trying to build habits that are not there now. We have to basically restart every time they don't do something for a month, that makes it really hard for us to, one, have a sustainable business model, but two, be able to push and re-engage that member."

—NDPP provider

When asked about barriers that prevent NDPP providers from billing, the top-cited reason was the reimbursement structure, which included a lack of financial viability of the current Medicaid reimbursement structure and hold-ups associated with the reimbursement structure due to the CDC recognition.

In agreement with NDPP providers surveyed, NDPP providers interviewed identified the NDPP reimbursement structure as a significant barrier to sustainability, with 31.0% (n=4) of NDPP providers interviewed mentioning it. Barriers around reimbursement structure were closely tied to challenges with participant recruitment and retention. One interviewee described that the NDPP Medicaid benefit is not financially viable without sufficient enrollment and associated billing.

Funding itself, however, as a barrier to sustainability, was not shown to be thematic. One provider (7.7%) discussed funding, stating that they required grant funding to supplement the funding provided for the Medicaid benefit.

Referring physicians provided barriers to the sustainability of the NDPP Medicaid benefit; one provider emphasized the importance of continued coverage. Another provider highlighted the referral process itself as a potential barrier to sustainability.

KEY QUOTES

"For us funding is always an issue, because we're grant funded. Sometimes it only lasts for a year. So, that's always a challenge to sustainability. The dollars that we're looking at getting from the Medicaid benefit aren't going to be enough to cover other costs of running the program."

—NDPP provider

"Without a streamlined and efficient process, regular referrals are unlikely to be sustained."

—Referring physician

"I think that a lot of people benefit from the NDPP program. It's been great. We've seen a lot of really good successes from participants, but they are able to do it because it is a covered benefit for them or it's free to them via grant or insurance or something. And if it is not, then we would have a lot less people present."

—Referring physician

Rede explicitly asked CCOs what barriers they faced in sustaining relationships with clinical providers. Roughly half of CCOs (45.5%, n=5) did not report any barriers in maintaining relationships with clinic providers. Nevertheless, some barriers to sustaining relationships with clinic providers were identified, with 18.2% (n=2) of CCOs citing high demand on clinics, leaving little bandwidth for NDPP. These CCOs suggested that although some clinics may have had initial bandwidth for relationships with CCOs, it is not sustainable. A unique factor placing demand on clinic providers was COVID-19, which 18.2% (n=2) of CCOs identified as a barrier to sustaining relationships with clinic providers.

Less than half of referring physicians reported having a NDPP champion at their clinic or practice (42.7%, n=3).

Although all referring physicians who took the survey had been referring Medicaid beneficiaries to the NDPP for over one year, only 42.9% (n=3) of referring physicians reported current partnerships with NDPP providers. Of those partnering with NDPP programs, referring physicians said their NDPP provider partners distributed educational materials about the NDPP for Medicaid beneficiaries, provided updates on the progress of Medicaid beneficiaries in the NDPP, and provided direct service to their patients. Notably, most referring physicians reported that they did not have any existing partnerships with NDPP providers (57.1%, n=4).

KEY QUOTES

"I think that they're really excited about having somewhere to refer their patients to take care of their diabetes prevention."

—CCO

"You go in, you talk to a provider or a clinic about a benefit or a program, you'll see an influx of referrals, and you'll get three or four new referrals from a clinic after you've reminded them. But then two months down the road, they forgot about us because I'm not the only person trying to tout my program."

—CCO

"Just balancing the demand of things that our clinic partners are trying to do. And with a pretty skinny staff model, and lots of turnover, and trying to meet all these different demands and metrics and everything."

—CCO

NDPP QUALITY IMPROVEMENT & METRICS FOR SUCCESS

A vast majority (75.0%, n=3 surveyed and 63.6%, n=7 interviewed) of CCOs reported that the NDPP Medicaid benefit was not yet integrated into their Quality Improvement (QI) plan, with only three CCOs (one surveyed and two interviewed) reporting integration of the NDPP Medicaid benefit into their organization's QI plan. Among CCOs (interviewed) who did discuss quality improvement methods, one explained that quality improvement centered around communication with members and with care managers.

Of CCOs surveyed, few reported using metrics of success for the NDPP Medicaid benefit (50.0%, n=2). The participant retention rate in the NDPP and the number of beneficiaries with closed-loop referrals were the only two metrics reported. Not a single CCO reported recognizing referring physicians for referral of Medicaid beneficiaries to the NDPP.

Of CCOs surveyed, 85.7% (n=6) reported not having any performance metrics or incentives for NDPP providers that are specific to Medicaid beneficiaries; only one CCO (14.3%) reported having an incentive for DPP providers specific to Medicaid beneficiaries, which involved setting higher rates than DMAP to incorporate incentives for enrolled members.

When asked about their metrics of success for the NDPP Medicaid benefit, some CCOs interviewed (36.4%, n=4) reported a lack of specific metrics of success.

However, other CCOs (36.4%, n=4) reported utilizing metrics of success, including:

- development of diabetes;
- number of certified NDPP educators;
- participant engagement;
- participant graduation rates from the NDPP; and
- 5% weight loss rates.

KEY QUOTES

"So we see them usually tie to weight loss at the end if they stay engaged. But we know that even if for some reason they don't engage for the entire time period, that they do end up having some positive health outcomes even just from some engagement."

—CCO

"We talked about it, we're tracking it. We are circling around and having specific followup with our members around those issues. And we are asking the care managers to look back and as they're working with the member, is this work being done? What do we need to do differently?"

—CCO

Factors supporting sustainability and effectiveness of NDPP Medicaid benefit implementation in Oregon

IMPLEMENTATION RESOURCES: NDPP PROVIDERS

NDPP providers interviewed received implementation assistance from several different sources. For example:

- 53.8% (n=7) of NDPP providers cited collaborative groups, including the Healthy Living Coalition NDPP subgroup, and the Central Oregon Diabetes Prevention Collaborative.
- 53.8% (n=7) of NDPP providers cited specific documents or presentations, such as OHA webinars, OHA's one-pager on billing, the Medicaid Companion Guide, and materials from the CDC.
- 38.5% (n=5) of NDPP providers cited specific individuals at the Oregon Medical Association (OMA), OHSU, and OHA who were instrumental in their implementation process.
- 30.8% (n=4) of NDPP providers cited grant funding, through sources such as Comagine or the OHA SRCH grant. Funding was mentioned to be highly valued and especially crucial for programs that have yet to receive CDC recognition.
- 15.4% (n=2) of NDPP providers cited relationships with CCOs.

KEY QUOTES

"[Grant funding] has been very, very, very helpful, because the low reimbursement rates from Medicare, Medicaid, and our CCO make it very difficult to get a program up and off the ground. You essentially have to be offering this program for free for at least the first year to 18 months until you get preliminary recognition status."

—NDPP provider

IMPLEMENTATION RESOURCES: NDPP REFERRING PHYSICIANS

Most referring physicians surveyed cited having support resources from the OHA (50.0%, n=3) and CDC (33.3%, n=2). One referring physician reported having to seek out their own resources related to the NDPP Medicaid benefit. Another provided reported not being aware of any support resources during benefit roll-out. We asked referring physicians what additional support or resources would have been beneficial in referring Medicaid beneficiaries to the NDPP (see Figure 17). In contrast to qualitative findings, not a single referring physician reported they wanted additional information on the benefits of the NDPP program to Medicaid beneficiaries.

Referring physicians (interviewed) identified useful implementation resources for the NDPP Medicaid benefit to be a diabetes educator providing information and updates about the benefit, support from a dietician involved with diabetes, and a table showing different options for different lines of insurance.

Notably, in spite of the resources listed by referring physicians, one referring physician interviewed stated that they had not received any resources specific to the NDPP Medicaid benefit. Additionally, another referring physician identified absent resources that would have been useful, including a clear summary of participant eligibility criteria (in agreement with survey respondents).

Figure 17: Additional supports or resources wanted by referring physicians surveyed

"Once I learned what the eligibility criteria were, it became pretty simple, but just getting a good grasp on that eligibility criteria was a little bit of a handful. Having someone in an organization who can concisely explain it in a way that people will listen and then remember the key thing.

—Referring physician

IMPLEMENTATION RESOURCES: CCOS

Of CCOs surveyed, the most cited beneficial resource during the NDPP roll-out was OHA's 2-pager, "Requirements for DPP reimbursement", with 75.0% (n=3) of CCOs reporting this resource as beneficial. Surprisingly, only one CCO (25.0%) reported OHA's Diabetes Prevention Program Guide for CCOs as helpful, with no organizations reporting the National DPP Coverage Toolkit or resources from the CDC as beneficial to benefit roll-out.

CCOs interviewed identified several facilitators and support resources that were useful during roll-out, which included:

- assistance from specific individuals at Oregon Health Sciences University (OHSU) and Oregon Wellness Network;
- a financial quality incentive program;
- funding/grants, such as the SRCH grant;
- learning collaboratives with similar health systems, including a group facilitated by Comagine;
- resources from the CDC, such as an approved NDPP providers list; and
- resources from OHA, including:
  - feedback on progress toward quality reimbursement metrics;
  - NDPP specific meetings, such as the QHOC;
  - resource guide;
  - technical assistance; and
  - webinars.

KEY QUOTES

"In terms of resources or support, it would probably be Comagine, in terms of coming together with other stakeholders who are also trying to roll out the benefit or have rolled out the benefit."

—CCO

"We had resources from the CDC in terms of capacity building, support, and training. We also had webinars that we had access to. We had some different templates of various interventions that other programs had used as part of DPP programming. So we had access to a lot of information."

—CCO

"We had several learning collaboratives for the organizations who were providing the DPP implementation to come together and share best practices and lessons. It was really helpful to hear across various communities of color what it looked like to be able to engage communities; what was important to folks who participated in the program."

—CCO

IMPLEMENTATION FACILITATORS: NDPP PROVIDERS

A majority of NDPP providers interviewed (53.8%, n=7) had prior experience in the delivery of the NDPP (46.2%, n=6) or a similar lifestyle change program (7.7%, n=1). For these NDPP providers, their prior experience appeared to facilitate the roll-out of the Medicaid benefit. Two NDPP providers (15.4%) had the existing infrastructure for processing Medicaid claims that supported a smooth implementation of the benefit.

Current NDPP providers (surveyed) reported that Medicaid beneficiaries could find information about their NDPP via an array of channels, including through their health care provider (71.4%, n=5), CCO (28.6%, n=2), and local AAA and ADRCs (14.3%, n=1). All NDPP providers surveyed reported having information specific to their program on their website. One NDPP provider mentioned targeted outreach to OHP members to enroll a Medicaid-specific cohort.

Two NDPP Providers elaborated on their greatest success regarding implementation of the NDPP Medicaid benefit:

- "Negotiated and completed one contract with a parent organization representing 4 CCOs."
- "Support from local Medicaid office staff."

Surprisingly, only 2 NDPP providers surveyed reported that they offered the NDPP in a language other than English; both of these providers reported Spanish.

KEY QUOTES

"We began delivering the national DPP in 2013. So we had a legacy of delivering the program, and it was essentially just letting prospective referrers know that the program is available to Medicaid beneficiaries and encourage them to make those referrals."

—NDPP provider

"It's kind of just [a] very natural roll out because we already do a DPP group, and we have a community health program that provide a lot of health educations, health classes. And so besides from the diabetes prevention program, we also do chronic disease management, things like that. I just add on the DPP into those available education classes when we do promotion with community, or when we go out to do outreach activity."

—NDPP provider

IMPLEMENTATION FACILITATORS: REFERRING PHYSICIANS

Referring physicians (surveyed) discussed their greatest facilitators for implementing the NDPP Medicaid benefit, which included physician direction, having registered dietitians on site, Registered Nurse Care Coordinators, and offering the NDPP in-house.

When it came to operationalizing the NDPP Medicaid benefit, referring physicians (interviewed) reported that EHRs were a large facilitator for implementation. All three providers who had referred Medicaid beneficiaries reported utilization of EHRs to refer into the NDPP. One provider described utilization of EHRs as, "Easy. Really easy. Importantly, not all referring physicians reported EHR referral to the NDPP as equally simplistic; one provider described this process as "Confusing."

IMPLEMENTATION FACILITATORS: CCOS

Only one CCO (surveyed) elaborated on facilitators for implementing the NDPP Medicaid benefit, who stated that their organization's greatest facilitator was "partnering with local agencies and partners delivering the program."

When asked about how CCOs adapted internal infrastructure to assist with implementing the NDPP Medicaid benefit, 63.6% (n=7) of CCOs interviewed reported infrastructure adaptation, with payment-related adaptations being the most common (36.4%, n=4). Other infrastructure adaptations reported by CCOs included identifying and training involved staff and shifting from internal delivery of the NDPP to outsourcing to provide the benefit.

KEY QUOTES

"That is a process that we really nailed down, I'd say three years ago, for our referrals in general. I think that the benefit of an electronic health record is that it has automatic reminders, and things go into workflows, and they go into queues, and they stay in the queue until they're done."

—Referring physician

"So down here, we're pretty rural. Very rural. And so we have a lot of providers who are practicing the same way now that they did when they graduated medical school 20 or 30 years ago, and are very reluctant to change because, why should I? This has always worked for me. And so having the financial quality incentive programs in place can really, at the very least, get their attention so we can provide them some of that evidence or they can learn some of those new practices."

—CCO

CCO AND REFERRING PHYSICIAN PARTNERSHIPS

CCO interviewees described a number of strategies for introducing and promoting NDPP to their clinic partners. These included:

- allowing clinics to initiate conversations;
- bringing up the NDPP to a clinical advisory panel and/or community advisory council;
- emphasizing evidence-based practice;
- emphasizing the potential for positive member outcomes of the NDPP;
- partnering with Health and Human Services; and
- prioritizing engagement with clinics serving a high number of CCO members.

When asked how CCOs support clinic partners in referring Medicaid beneficiaries to the NDPP, CCOs (interviewed) described a variety of strategies. One CCO emphasized the importance of taking a flexible approach, in which CCO support is tailored to the needs of clinic partners. Other CCOs echoed the sentiment that supporting clinic partners in referring Medicaid beneficiaries to NDPP can take several different forms. These included:

- acting as a central hub to receive referrals;
- directly contacting referring physicians;
- planning trainings;
- providing data support;
- providing funding;
- regularly promoting/marketing NDPP classes; and
- simplifying health plan offerings.

KEY QUOTES

"We are selling it as an evidence-based practice recommendation rather than a requirement. If you follow it, of course you get the quality reward. But the reason we have this proverbial carrot hanging out there is because the evidence supports it as a best practice."

—CCO

"What one clinic needed was the evidence. Other folks wanted to know how it is going to benefit the patient? Much like what we want our physicians to practice, we needed to be flexible with meeting the individual needs of each provider and/or clinic."

—CCO

"We've got a member provider portal that can send over any referrals, both to care management for assistance with care coordination, as well as any pre-approvals that need to happen."

—CCO

"We're going to reach out to providers to have them consider referring patients into the program. We'll communicate to providers that we have identified these patients in your practice who have the diagnosis of prediabetes, and are at high risk for developing diabetes and its complications and there's a program that has been shown to reverse this development."

—CCO

Clinic champions also emerged as a key facilitator to Medicaid benefit implementation, with 27.3% (n=3) of CCOs reporting clinic champions as integral to implementation. Other CCOs (18.2%, n=2) mentioned that, although they did not have a clinic champion, they had specific medical providers or NDPP providers who had served as a champion of sorts. Interestingly, CCOs reported that the identification of clinic champions did not occur via a formal process. Instead, clinic champions developed organically.

CCO AND NDPP PROVIDER PARTNERSHIPS

CCOs interviewed also mentioned several routes to partnering with NDPP providers for implementation of the NDPP Medicaid benefit. These included:

- building upon existing partnerships;
- emails and newsletters;
- individual outreach;
- a survey of local clinics, hospitals, and community organizations to get a list of current NDPP providers;
- Traditional Health Worker liaisons; and
- word of mouth.

The Oregon Wellness Network played a significant role in facilitating partnerships with NDPP providers, with 36.4% (n=4) of CCOs mentioning it.

54.5% of CCOs discussed having a formal agreement with their NDPP providers, though the interviewees themselves were not aware of the details of these agreements. In contrast, 27.3% (n=3) of CCOs stated that they do not have any formal agreements with NDPP providers.

KEY QUOTES

"I think in every organization or every area, there's one or two early adopter clinics who are just a little easier to work with, who are a little more motivated, and have a lot more initiative. We have just partnered with them and utilized them and said, 'Hey, we've got this. This is coming out. Is this something you're interested in?'"

—CCO

"We asked and the ones who had the capacity said 'pick me.'"

—CCO

"We have been having conversations regarding potential future partnerships in collaboration with the Oregon Wellness Network. They serve as the hub and oversee and support various NDPP providers in our region. We've largely just been having exploratory conversations with the Oregon Wellness Network around what a partnership could look like."

—CCO

"We have a specific contract department that creates and approves those. I see the finished product, but as far as, 'what's the negotiations? What are the benchmarks?' I'm not involved in that process."

—CCO

CLOSED-LOOP REFERRAL PROCESSES

A majority of NDPP providers surveyed (66.7%, n=4) reported ensuring a closed-loop referral process for Medicaid beneficiaries to the NDPP. Only one NDPP provider said they did not ensure a closed-loop referral process for Medicaid beneficiaries (16.7%), and one NDPP provider was unsure (16.7%). Almost all (85.7%, n=6) of referring physicians surveyed reported they did not or were unsure if their practice ensured a closed-loop referral process for Medicaid beneficiaries to the NDPP. Only one referring physician reported ensuring a closed-loop referral process for Medicaid beneficiaries (14.3%). A majority of referring physicians (57.1%, n=4) did not have the NDPP referral process for Medicaid beneficiaries integrated into their EHR; three providers reported having NDPP referral processes integrated into their EHR.

Two (66.7%) referring physicians interviewed reported having an existing closed-loop referral process. Among those with a closed-loop referral process, opinions on the process were mixed. One referring physician described their process positively, with one citing EHRs as critical to success. In contrast, one referring physician described the process as needing improvements. For the one referring provider without a closed-loop referral process, they identified this absence as a significant barrier to referring patients in their clinic.

A majority of CCOs surveyed (71.4%, n=5) did not report supporting a closed-loop referral process for Medicaid beneficiaries. Two CCOs (28.6%) reported supporting closed-loop referrals for Medicaid beneficiaries via the following strategies: identifying eligible members, and assisting in referral of Medicaid beneficiaries to NDPP. Only one CCO reported offering assistance to the NDPP provider to identify and eliminate any barriers for Medicaid members. This same CCO also reported maintaining member engagement in the NDPP and providing the referral source with timely follow-up information about the member's success.

KEY QUOTES

"They put a lot of the onus under the physician by saying, "Patient didn't reply. We're done now, it's back on you". So they just close it out if the patient doesn't answer phone calls. They call the patient at really inopportune times. They call them during work hours. My most recent patient that I referred was super interested, the first one in a long time. And they were offering the program at 1:00 PM on a weekday. That's the only time they were offering it. She's like "I work, I can't really do that"

—Referring physician

Satisfaction with the implementation of the NDPP Medicaid benefit among key stakeholders

SATISFACTION ACROSS STAKEHOLDER GROUPS

Stakeholder groups, level of satisfaction with the NDPP Medicaid benefit varied. On the whole, NDPP providers and NDPP referring physicians tended to have higher satisfaction rates than CCOs, with the majority of NDPP providers interviewed, and the majority of referring physicians surveyed reported that they were satisfied. In contrast, less than half of interviewed CCOs were satisfied, and both CCOs surveyed were neutral.

A common theme contributing to lower satisfaction was difficulty finding information about the benefit, as both NDPP providers and CCOs discussed this. Another common theme was a lack of promotion of the NDPP program. NDPP providers cited this lack of promotion as lowering their satisfaction while referring physicians, and CCOs stated that increased program promotion would improve their satisfaction.

Figure 18: Level of overall satisfaction with NDPP implementation by data collection method across all stakeholder groups

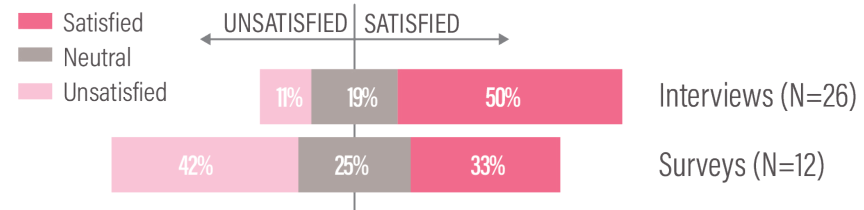
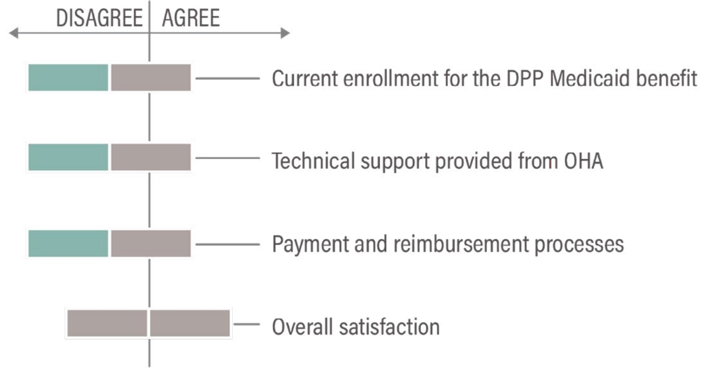


Figure 19: Satisfaction with components of NDPP implementation among survey participants

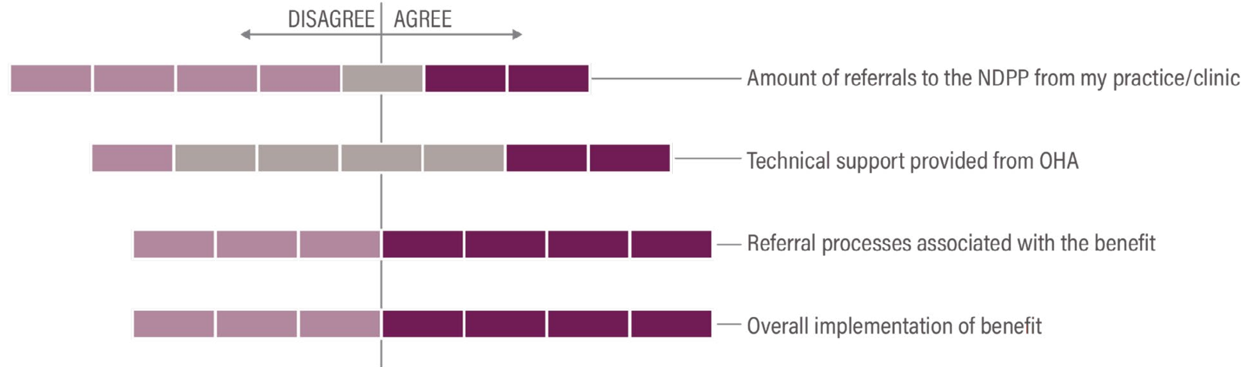
CCOs (n=2)

- Agree
- Neutral
- Disagree



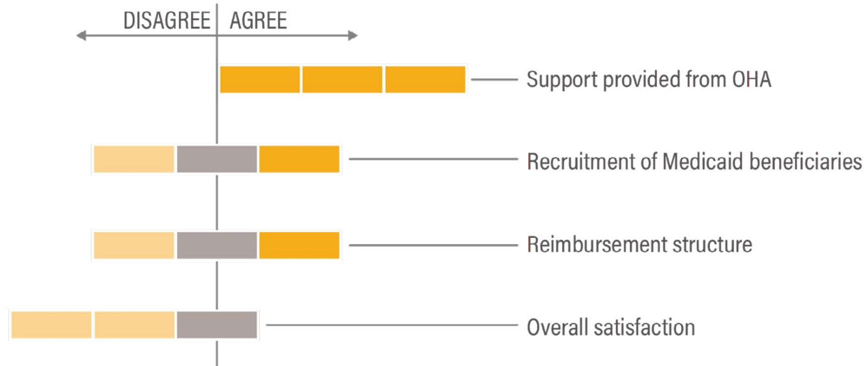
NDPP referring physicians (n=7)

- Agree
- Neutral
- Disagree



NDPP providers (n=3)

- Agree
- Neutral
- Disagree



NDPP PROVIDER SATISFACTION

Satisfaction with NDPP Medicaid benefit implementation among NDPP providers interviewed was largely positive. Eight providers (61.5%) reporting primarily positive responses, three providers stated that they felt unqualified to answer at this point (23.1%), and one provider (7.7%) reporting dissatisfaction with the NDPP Medicaid benefit.

Factors contributing to satisfaction with the benefit implementation included:

- billing options for Medicaid that aligns with models for other payers;
- detailed communication from OHA;
- inclusive eligibility criteria beyond prediabetes criteria;
- OHA's responsiveness to feedback; and
- reasonable reimbursement amounts, relative to Medicare.

NDPP Providers reported the following were contributing factors to lower satisfaction with the benefit implementation:

- lack of program promotion;
- reimbursement methodology that was not conducive to online-only programs;
- slow contracting process; and
- timeliness/slow release of information about the benefit.

As opposed to NDPP providers interviewed, those surveyed had low overall satisfaction rates, with 66.7% (n=2) unsatisfied (see Figure 19). In agreement with providers interviewed, all providers surveyed were satisfied with the support provided by OHA. When asked what could improve overall satisfaction with the NDPP Medicaid benefit, NDPP providers reported the following:

- "A concerted effort to get the CCOs to contract with us to provide DPP and encourage providers to make referrals and for members to participate."
- "We are implementing the Distance Learning module (Zoom connection) with Spanish speakers only, which should increase participation. Many of these populations do not have access to health care/insurance. We do need a source of funding besides the future Medicaid source."
- "Clear reimbursement/billing strategy. Currently waiting on a signed contract for reimbursement."
- "The [local] YMCA does not accept the DPP Medicaid benefit because it requires more person-hours and operational expenses than it covers. For a non-profit, this is unsustainable."

KEY QUOTES

"We found great information. We thought the state was very communicative and shared a lot of specific details."

—NDPP provider

"I'm very satisfied. I appreciate the fact that the implementation has been thoughtful and that OHA has listened to organizations across the state. Because of their experience with Medicare, they've designed the benefit to be more turnkey."

—NDPP provider

"As far as implementation, I think they've just done very little in terms of really trying to drive the program at all. I'm not satisfied with that part, it could be a lot better."

—NDPP provider

NDPP REFERRING PHYSICIAN SATISFACTION

Rede shortened the interview guide in an effort to recruit additional referring providers to participate in interviews resulting in only two referring physicians reporting on the level of satisfaction with the Medicaid benefit. Of the two referring physicians, one reported a high level of satisfaction, and the other felt neutral. Referring physicians surveyed also had mixed satisfaction with the overall benefit implementation, with a little more than half (57.2%, n=4) satisfied.

When asked what could improve overall satisfaction with the NDPP Medicaid benefit, there were an array of responses, which included the following write-in responses:

- "Continued access to phone/virtual visit coverage"
- "Medicaid encouragement [of the benefit]"
- "Regular times of classes so don't have to wait for each flyer to come out, often getting to me after the class has started"
- "More patient education materials"
- "I believe more outreach could be done to primary care providers to sell the benefits of the DPP to their patients, eligibility and encourage routine screening for prediabetes. I am a registered dietitian and see the power of prevention in my own patients, but I don't always see that from primary care providers."

KEY QUOTES

"Very satisfied. I think [the NDPP] has done a great job for the people who have been able to participate."
—Referring physician

CCO SATISFACTION

Satisfaction with the NDPP Medicaid benefit among interviewed CCOs was mixed, with four CCOs (36.4%) reporting primarily positive responses, four CCOs (36.4%) reporting mixed responses, two CCOs (18.2%) reporting mainly negative responses, and one CCO (9.1%) reporting an inability to answer at present.

One factor influencing CCO satisfaction, identified by two CCOs, was difficulty collecting information. One CCO emphasized that it was complicated to piece together the information coming from various sources, while another CCO compared it to a "wild goose chase." Other barriers that CCOs identified as directly contributing to their satisfaction with Medicaid benefit implementation were (each identified by one CCO):

- the amount of time it took to get CDC approval (for a CCO who was also an NDPP provider);
- COVID-19;
- dissatisfaction with the OHA preferred vendor; and
- a lack of local NDPP providers.

When asked what would improve their satisfaction with Medicaid benefit implementation, CCOs (interviewed) provided an array of responses. These included (each identified by one CCO):

- better alignment with CDC requirements and Medicare implementation;
- improved member access to internet and devices;
- funding for member incentives;
- more awareness around the program;
- enhanced guidance on best practices; and
- program expansion to individuals with a diabetes diagnosis.

Interestingly, not a single CCO surveyed reported being satisfied with the implementation of the NDPP Medicaid benefit (see Figure 20).

When asked what could improve overall satisfaction with the NDPP Medicaid benefit, only one CCO surveyed gave a response, which was, "paying a community-based organization who is a DPP provider is complicated. People say to use HRS, but that isn't always a sustainable funding method. Still seems like a hard area without much guidance."

KEY QUOTES

"I think the biggest challenge is the availability of national providers in the area. I think a lot of that's due to the challenges of those organizations, especially if they're non-provider organizations, which a good portion of them are. Being able to financially support the Medicaid program through the current financial structure and the current interest."

—CCO

Stakeholder Recommendations for Medicaid Benefit Implementation

NDPP Providers described an array of recommendations for improving the NDPP Medicaid benefit implementation. The greatest number of NDPP providers (38.5%, n=5) recommended OHA offer additional and more timely information about the benefit, including:

- the reimbursement process;
- restrictions for makeup classes;
- credentialing and enrolling a provider that could bill for the service;
- enhanced availability of promotional resources for marketing the NDPP to Medicaid beneficiaries;
- a simple one or two-page overview of the benefit and eligibility criteria (in addition to the Medicaid Companion Guide);
- guidance on how to deliver the program virtually; and
- a tool to communicate about NDPP with referring physicians.

About one quarter of NDPP providers interviewed (23.1%, n=3) recommended improving existing digital infrastructure to support efficient and effective implementation of the NDPP Medicaid benefit. Specific recommendations included improvements to enhance many implementation-related processes associated with the NDPP Medicaid benefit (e.g., recruitment, retention, delivery, billing, etc.):

- an Oregon-specific billing app designed for Medicaid beneficiaries, lifestyle coaches, and the billing team;
- pre-built and easily modifiable modules within the electronic health record system to enable billing;
- a simplified digital interface for facilitating NDPP classes (even simpler than Zoom); and
- a tool for NDPP providers to easily communicate with NDPP referring physicians.

KEY QUOTES

"Now that we're virtual, we would love to be able to have some app, rather than tell people to take a picture of your tracker and send it to me, have some way of communicating and sharing that information."

—NDPP provider

"Provide us with some virtual tools that we can make available to connect with our participants outside of class and streamline our data collection and billing."

—NDPP provider

Other recommendations (not identified as thematic) included:

- increase awareness and encourage utility of the benefit;
- increased flexibility around billing to allow make-up and a regular session on the same day;
- expand eligibility requirements so that people with lower diabetes risk have access to the program as well;
- a more holistic treatment approach that includes providing a description of all the services available for patients with prediabetes;
- a system for receiving funding for fitness tracking devices or Bluetooth scale;
- align NDPP Medicaid requirements such as makeup classes and eligibility with other payers;
- a designated liaison for NDPP providers at each CCO who is knowledgeable about the NDPP Medicaid benefit;
- incentivize the program through CCO metrics or quality improvement measures; and
- NDPP recruitment through organizations that have established trust in the community.

Online providers identified recommendations specific to their format of program delivery to be:

- identical reporting for all CCOs;
- a standard contract for CCOs;
- continue and increase opportunities for online programs;
- a liaison at OHA to provide guidance on CCO readiness and who would be the best fit to contract with;
- more extended time periods to prove activity in the program to accomodate life events that impact participation;
- provide fitness tracking devices for participants without one;
- distribute NDPP resources and surveys designed with online providers in mind;
- gather Medicaid beneficiary email addresses for recruitment and to ensure the participant has technological capabilities to complete the program; and
- better embrace the value of online programs rather than treating them as secondary to in-person programs.

KEY QUOTES

"Most of the time when I see something sent out, it has not really been customized for digital providers. It doesn't take into account that we're not in-person."

—NDPP provider

"I would ask that the focus on digital programs continue to grow. Allow for digital programs to flourish and embrace their value."

—NDPP provider

"I would recommend that OHA evaluate the option of having a longer window for members to essentially prove activity. I'm not sure what the technical language would be, I don't want to use our in-house language; but the monthly billing eligibility.

—NDPP provider

NDPP referring physicians offered a few recommendations to improve the implementation of the NDPP Medicaid benefit. Two providers' recommendations centered around reducing provider burden, which included shifting the responsibility of determining Medicaid beneficiary eligibility for the NDPP. One provider suggested that CCOs could provide clinics with a list of potentially eligible patients so that there is less uncertainty on the part of referring physicians. Another provider highlighted the role a wellness center could play in reducing providing burden, stating that their own wellness center assisted with eligibility.

Other recommendations from referring physicians included:

- ensuring long-standing insurance coverage for Medicaid beneficiaries;
- providing a health advocate for high risk patients; and
- simplifying EHR referral processes.

KEY QUOTES

"I think that our wellness center does a great job, and it's a really easy kind of wraparound and solve everything. We do the work for you, kind of solution. I think at other places where providers who are doing the referring have to figure out eligibility and approval, then it gets more difficult and that would be a way to improve it."

—Referring physician

"I just don't think patients would participate if they had to pay for it."

—Referring physician

"I think the answer is always to have some sort of health advocate for patients who are high risk; someone to hold their hand through things like scheduling their COVID vaccine and picking up their diabetic supplies. That's a huge phone call I get all the time."

—Referring physician

CCOs mentioned several ways that OHA could further support their NDPP implementation. These included providing:

- billing support, as well as talking points for conversations with NDPP providers about billing;
- continued flexibility in meeting metrics and due dates for deliverables given the COVID-19 pandemic;
- a designated OHA liaison for each CCO to work with;
- distributing information to increase awareness of the benefit among referring physicians and Medicaid beneficiaries;
- A platform for connecting with other CCOs, NDPP providers, referring physicians, and NDPP participants, for sharing best practices and lessons learned;
- an up-to-date list of Oregon NDPP providers in their service area;
- Medicaid beneficiary recruitment strategies, including culturally specific engagement strategies;
- advanced notice of benefit implementation, and additional communication about the benefit and timeline for implementation;
- state-sponsored trainings on NDPP; and
- a template for contracting with NDPP providers.

KEY QUOTES

"I think it would be helpful to have a [health care] provider education component because providers see the members more frequently. They're completing the testing associated with identification of a member meeting the criteria for a program, and then coaching the member into participating into the program."

—CCO

"It would be helpful to have a collaborative of some sort to chat through some of the barriers that other CCOs are experiencing, or learn from best practices that some of the more successful CCOs have already implemented."

—CCO

"More planning, more communication, more advanced notice that this is coming."

—CCO

"If there were some state sponsored trainings on DPP program to create awareness of it, and they were specific for CCOs, that would be great. I'm not really hearing anything from the OHA on this benefit. If there's any bandwidth, maybe there could be some virtual meetings, conferences, lectures, education on the program."

—CCO

Additional CCO recommendations included:

- availability of NDPP in multiple languages;
- a community liaison or practice facilitator to support partnerships between CCOs, NDPP referring physicians, and NDPP to implement the benefit;
- expanding NDPP eligibility criteria to those with a diabetes diagnosis;
- offering additional healthy lifestyle supports to participants;
- offering incentives for participation in NDPP such as childcare, exercise tracking technology, and Double Up Food Bucks at local farmers markets;
- providing internet and technology for virtual participation; and
- recruitment led by referring physicians rather than the CCO.

KEY QUOTES

"A practice facilitator embedded in the community that understands the culture and the context in the area. Someone that can understand what's needed to implement and work with the providers who are like, 'Hey, we just don't have time, this isn't going to work', etc. I'm thinking about how to integrate it more into the model of care in the community and partnering with CBOs. I think that having a regionally-based practice facilitator network would be a huge help."

—CCO

"I attended a virtual demo of 'WELLD' and it has cool features, including a way for coaches to know what participants are working on and send tailored messages. I think that would streamline things and just keep people feeling connected."

—NDPP provider

"Making sure that there was support outside of the facilitators who were implementing the program, so considering community health workers, or other community folks to provide support, like grocery shopping or supporting folks in finding joyful movement. So there were different ways that the learning collaborative provided information for folks to figure out how to expand what the program could look like beyond the initial requirements of the CDC listed implementation. So it was about modifying it to fit."

-—CCO

Outcomes of the NDPP Medicaid Benefit in Oregon

IMPLEMENTATION SURVEY FINDINGS

NDPP providers: Unfortunately, NDPP providers were unable to give exact numbers regarding Medicaid beneficiary participation in their NDPP for a number of reasons, including lack of specific Medicaid-beneficiary only cohorts, lack of current billing for Medicaid, and staff turnover.

Referring physicians: Six referring physicians gave exact numbers for the amount of Medicaid beneficiaries referred to the NDPP since the start of the NDPP Medicaid benefit in Oregon, which ranged from 5 to 30. These same referring physicians reported, on average, that of referrals, 4.8 Medicaid beneficiaries completed the NDPP since benefit start, with a mode of 5, and a range of 1 to 8.

CCOs: CCOs were unsure of the number of Medicaid beneficiary NDPP claims received since the start of the benefit. Only a single CCO was able to report on the number of Medicaid beneficiaries that had enrolled in the NDPP since the start of the benefit (36 beneficiaries). Not a single CCO was able to provide information on Medicaid member completion of the NDPP.

Based on evaluation findings, Rede created a set of recommendations to improve implementation of the NDPP Medicaid benefit in Oregon. The preliminary recommendations are presented in Appendix I. As part of the process of finalizing recommendations, Rede, along with HPCDP, conveneed a group of key NDPP partners to assist with prioritizing and refining recommendations. This group included representatives from OHA (PHD, HPCDP, HSD, Transformation Center, Health Evidence Review Committee (HERC)), and NACDD. Small groups were conducted to facilitate meaningful discussion around recommendation prioritization, feasibility of recommendation, and responsibility for implementing recommendations. Based on discussions and feedback from these critical NDPP partners, recommendations were refined and prioritized. Table 4 presents current challenges with implementation of the NDPP Medicaid benefit and solutions to address these challenges.

Table 4: Current challenges and possible solutions for NDPP Medicaid benefit implementation

	CURRENT CHALLENGES	POSSIBLE SOLUTIONS
AWARENESS	» Many key stakeholders unaware of the NDPP Medicaid benefit	» Targeted outreach to different stakeholder groups
ROLL-OUT	» NDPP resources, processes, and requirements difficult to navigate	» Creation of an Oregon-specific NDPP platform* » Enhanced billing and reimbursement supports*
SUSTAINABILITY	» Poor retention of Medicaid beneficiaries in the NDPP » Fee for service (FFS) rates are below costs	» Reduce barriers for Medicaid beneficiaries » Increase NDPP rates » Expand incentive metric technical assistance to include NDPP-related metrics » Increase NDPP partner networking and engagement
REACH	» Limited reach to Medicaid beneficiaries; uptake of the benefit » Lack of targeted recruitment to Medicaid beneficiaries	» Improve health care system referrals and associated protocols* » Utilize existing resources to expand reach to Medicaid beneficiaries
EFFECTIVENESS	» Limited data on NDPP Medicaid benefit in Oregon and associated data systems	» Creation of target metrics specific to the NDPP Medicaid benefit* » Ongoing evaluation of the NDPP Medicaid benefit

*Indicates the recommendations is a priority area

notes

11. National Diabetes Statistics Report 2020, Estimates of Diabetes and its Burden in the United States. Centers for Disease Control and Prevention.

Prioritized Recommendations
Based on discussions with key NDPP partners, Rede has identified six priority recommendations to improve implementation of the NDPP Medicaid benefit:

- Expand awareness and reach
- Create an Oregon-specific NDPP platform;
- Enhance billing and reimbursement supports;
- Improve health care system referrals and associated protocols;
- Conduct ongoing evaluation of the benefit; and
- Create target metrics specific to the benefit.

Awareness

Stakeholders identified awareness of the NDPP Medicaid benefit as an area with substantial challenges and much room for improvement. Many stakeholder groups reported not being aware of the NDPP Medicaid benefit and expressed an interest in learning more about the benefit. In alignment with our evaluation findings, Rede recommends targeted outreach to different stakeholder groups to increase awareness of the NDPP Medicaid benefit. Collaboration among offices in the OHA's HSD and PHD will be integral in achieving increased awareness of the NDPP Medicaid benefit.

OHA, along with other key NDPP partners, should create targeted outreach initiatives to inform key stakeholder groups about the NDPP Medicaid benefit. To increase overall awareness of the NDPP, mass-reach public health campaigns could be used, which could also help beneficiaries to be proactive about referral to the NDPP. One key NDPP partner mentioned the "1-800-QUIT-NOW" smoking cessation campaign, which is a great example of a successful mass-reach public health campaign.

A similar effort could increase overall awareness about diabetes as well as NDPP participation. However, it was also discussed that these types of mass-reach public health campaigns require significant public health resources for success and this type of internal infrastructure is not yet built for the NDPP in Oregon. For referring physicians and other referring partners, awareness could be improved by enhanced promotion via existing professional organizations, such as the OMA and the American Medical Association (AMA), to name a few. Engagement with regional and community-specific chapters or divisions could also enhance reach. Specifically, OHA could create targeted promotional resources for these partners to use, including social media campaigns/tweets/posts as well as slide decks about the benefit which could be presented at annual conferences.

Benefit Roll-out

CREATION OF AN OREGON-SPECIFIC NDPP PLATFORM

Stakeholder groups faced numerous barriers during the initial roll-out phase of the NDPP Medicaid benefit. Many stakeholders reported either struggling to get through these barriers or an inability to get past them altogether. In an effort to reduce barriers associated with initial roll-out of the benefit and increase uptake, Rede recommends developing an Oregon-specific NDPP web-based platform to increase accessibility of key implementation resources. Currently, NDPP resources are housed across a series of websites, including the CDC's, OHA's, AMA's, and OMA's websites, to name a few. With a centralized location for Oregon NDPP resources, key partners will be able to easily access the compendium's existing materials. Additionally, creation of an Oregon-specific NDPP platform could be used to centralize NDPP data collection,

which would not only assist in streamlining the data collection process, but could reduce burden on NDPP providers if integrated or coordinated with the Compass. Finally, many NDPP stakeholders wanted a platform for networking with other NDPP stakeholders; an NDPP platform could be designed to serve as this platform. Although this recommendation is one with substantial initial lift and continued maintenance, this recommendation is also one with substantial ongoing potential to improve benefit roll-out and implementation. Based on evaluation findings, the NDPP digital platform should house the following specific items:

- Recorded training modules for different stakeholder groups to introduce and guide them through benefit roll-out
- NDPP providers and staff (e.g., lifestyle coaches, billing team, etc.)
- Referring physicians and other sources of referrals
- CCOs
- Promotional resources for marketing the NDPP to different target populations (e.g., Medicaid beneficiaries);
- Enhanced billing and reimbursement supports; and
- An up-to-date list of NDPP providers in each CCO service area

ENHANCED BILLING AND REIMBURSEMENT SUPPORTS

Both NDPP providers and CCOs reported that the billing and reimbursement process was difficult to navigate, with much uncertainty about many billing and payment processes. Thus, this is a key recommendation area to ensure success of the benefit roll-out as well as sustainability. If the above recommendation of an Oregon-specific NDPP platform is accepted, it could house a repository of training modules and associated FAQs on billing and reimbursement processes associated with the NDPP. Additionally, Rede recommends enhanced support via technical assistance to NDPP providers and CCOs in which technical assistance would be frontloaded during benefit roll-out and reduced over time. This technical assistance could be provided via a direct point of contact for stakeholders related to billing and payment processes. Evaluation findings suggest that individualized technical assistance would be most beneficial for those NDPP providers who have not yet established billing infrastructure, as well as those CCOs that have yet to contract with a CBO. Although this type of billing and reimbursement support seems burdensome, it could greatly enhance uptake of the NDPP Medicaid benefit.

Another key recommendation to improve billing and reimbursement support for the NDPP involves enhancements to EHRs. Specifically, many NDPP providers wanted to see pre-built, modifiable modules within EHRs to allow for streamlined billing.

Additional EHR-related recommendations are discussed below in the “improvement health care system referrals and associated protocols”.

Sustainability

REDUCE BARRIERS OF NDPP UPTAKE FOR MEDICAID BENEFICIARIES

Although this evaluation did not directly interview Medicaid beneficiaries, barriers for the target population were brought up during interviews with all three key stakeholder groups. Specifically, Medicaid beneficiary retention was brought up as a barrier to sustainability. Medicaid beneficiaries are

a unique population and themselves have unique barriers to uptake of and continuation in the NDPP. These barriers include geographic, language, and format offerings of NDPP classes, to name a few. Potential solutions to these challenges include improving geographic accessibility of in-person NDPP classes, increasing the number of NDPP offerings in languages other than English, and increasing the number and quality of virtual classes.

One potential solution is to create additional funding for NDPP providers to acquire necessary participant equipment for participation in the NDPP (e.g., internet access). Further, increasing DMAP FFS rates for NDPP could allow NDPP providers to address other challenges to Medicaid beneficiary continuation in the NDPP, such as childcare. It is critical that stakeholders work together to find innovative ways to find solutions to poor uptake of and retention in the NDPP among Medicaid beneficiaries.

INCREASE NDPP FFS RATES

NDPP providers reported that current FFS rates for Medicaid are below costs associated with delivery of the NDPP and thus, not a financially viable option for their organizations. This is especially true for initial adoption for CBOs without existing billing infrastructure. Additionally, increased costs associated with launching virtual NDPP classes necessitates a need for increased FFS rates. Although this may not be an immediately feasible recommendation, this is something NDPP partners should consider for sustainability of the NDPP Medicaid benefit.

INCREASE NDPP PARTNER NETWORKING AND ENGAGEMENT

The NDPP is a LCP that requires partner collaboration and communication. As such, an overarching recommendation is to increase NDPP partner networking and engagement. NDPP collaborative groups were identified as a useful resource by NDPP providers. Creation of CCO-specific collaborative groups were recommendations from CCOs. Many stakeholders wanted to see a digital platform in which best practices and lessons learned could be shared. An Oregon-specific NDPP platform would be ideal for this type of partner networking and engagement. Importantly, OHA should continue to engage with Oregon's federally recognized tribes and the Northwest Portland Area Indian Health Board through integrated networking, collaborating, practice communities, and collective action to improve NDPP outcomes. High-level discussions about Tribal and non-Tribal NDPP programs should not be siloed but rather integrated to encompass the richness in diversity of Oregon's entire health system, while staying attuned to the unique perspectives and knowledge of tribal partners. Naturally, changes to the Medicaid benefit program or implementation must be considered in consultation with the tribal organizations and the NPAIHB.

Reach

IMPROVE HEALTH CARE SYSTEM REFERRALS AND ASSOCIATED PROTOCOLS

Identification of eligible Medicaid beneficiaries is imperative to sustainability of the NDPP Medicaid benefit. This can occur through improved screening and referral at point-of-care, including PCPs. A critical aspect of Medicaid beneficiary identification and subsequent NDPP referral is efficient PCP workflows, which do not currently exist. Given the absence of this key piece to improve reach, Rede recommends the development of workflows for PCPs to identify and refer eligible Medicaid beneficiaries to the NDPP. This workflow

should be developed in partnership with referring physicians and include pre-diabetes screenings, NDPP referral via EHR, and closed-loop referrals. Identification of eligible Medicaid beneficiaries can also occur through CCOs and NDPP providers. Another way to enhance the identification and referral process is to perform regular queries of EHRs to identify eligible beneficiaries and link to NDPP via automatic referral process.

Also, improving reach to Medicaid beneficiaries by expansion of team-based approaches in the NDPP referral process will improve referral outcomes. Increased involvement of non-physicians (e.g., pharmacists, THW, registered dieticians) in the referral process could substantially improve reach. In fact, the CDC recently launched a new initiative that aims to increase the role of pharmacists in the NDPP.[12] Additionally, there is increased opportunity for integration of preventive health centers in identification and referral of Medicaid beneficiaries to the NDPP.

Effectiveness of the NDPP Medicaid benefit in Oregon

CREATION OF TARGET METRICS SPECIFIC TO THE NDPP MEDICAID BENEFIT AND EVALUATION OUTCOME MEASURES

Currently, the NDPP Medicaid benefit is absent of both metrics of success and evaluation measures. Although the benefit is in its' infancy, creation of metrics specific to the NDPP Medicaid benefit are critical for both initial and ongoing evaluation. Thus, Rede recommends that OHA work with key partners to create metrics of success for the NDPP Medicaid benefit in Oregon. These may include, but are not limited, to the following outcome variables:

- Referral, enrollment, and completion (by phase)
- Number of claims per annum or claims per beneficiary
- Conversion rate from prediabetes to diabetes
- Weight-related outcomes
- Cost-effectiveness

INCREASED EVALUATION OF THE NDPP MEDICAID BENEFIT

This evaluation is the first to examine implementation of the NDPP Medicaid benefit in Oregon. There are many strengths of this evaluation, but there are also limitations. Many of these limitations are directly related to the COVID-19 pandemic and its direct impact on stakeholder availability and engagement in this evaluation. However, additional limitations of this evaluation are directly related to a lack of existing data systems and measures for the NDPP in Oregon. Given challenges with primary and secondary data sources, Rede recommends focused, ongoing evaluation efforts of the NDPP Medicaid benefit in Oregon. The first step in this is to create data systems around the NDPP, including specific measures relating to Medicaid beneficiaries and the NDPP Medicaid benefit as described above. Additionally, evaluation of CCO's utilization of health-related services funds to pay for NDPP for Medicaid beneficiaries is an urgent need that was beyond the scope of this evaluation. Continued formative and summative evaluation is imperative to refine and improve the benefit to achieve the long-term health outcomes of the NDPP for Medicaid beneficiaries.

notes

12. Centers for Disease Control and Prevention. Rx for the National Diabetes Prevention Program: Action Guide for Community Pharmacists. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2019.

APPENDIX

A. Literature search terms
B. Literature search table
C. Situation and program review informants
D. NDPP provider interview guide
E. NDPP referring physician interview guide
F. CCO interview guide
G. NDPP provider and CCO implementation survey
H. NDPP referring physician implementation survey
I. Preliminary NDPP Medicaid benefit implementation recommendations

NDPP Evaluation Literature Search Terms

"DPP" AND "evaluation"
"Diabetes Prevention Program" AND "evaluation"
"DPP" AND "implementation"
"Diabetes Prevention Program" AND "implementation"
"DPP" AND "Medicaid"
"Diabetes Prevention Program" AND "Medicaid"
"DPP" AND "evaluation"
"Diabetes Prevention Program" AND "evaluation"
"DPP" AND "implementation"
"Diabetes Prevention Program" AND "implementation"
"DPP" AND "Medicaid"
"Diabetes Prevention Program" AND "Medicaid"

It may also be helpful to include following terms, with an AND or adding onto the string:
"CDC"
"Coordinate care organization"
"Community-based organization"
"Provider"

Literature Search Table

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
(1) **Perceived Benefits and Barriers to the Diabetes Prevention Program/** *L. Nicole Johnson, DrPH, MPH, MA, Stephanie T. Melton, PhD, MPH, MA/ 2016/* DOI: http://dx.doi.org/10.17125/plaid.2016.65	Healthcare providers and people with diabetes who have participated in the DPP programs in Florida	Perceived benefits and barriers to the DPP	The goal of this project is to understand the factors that motivate and deter people with prediabetes from utilizing evidence-based education programs, such as the DPP	Mixed methods -(Qualitative) Semi-structured interviews (total of 97 interviews with 5 focus groups), -(Quantitative) survey data through the use of Survey Monkey	The DPP is successful in helping individuals with pre-diabetes make positive lifestyle changes. However, lack of knowledge about the program is a deterrent for utilization. Barriers to program utilization include cost of the program and significant time commitments.	While time required and cost of program are barriers at the macro-level, the largest barrier present, lack of knowledge about the program, is something that can be addressed and would create a significant impact. Creation of a social marketing campaign designed to increase health care providers referrals to the DPP is recommended.
(2) **Evaluation of the Medicaid Coverage for the National Diabetes Prevention Program**	Medicaid Demonstration Project recipients (applicable Maryland and Oregon MCOs and CCOs)	Final report on the results of the Medicaid Demonstration Project	To learn about both successes and challenges, to engage stakeholders, and to advance understanding of how to achieve sustainable coverage of the DPP	Mixed Methods - Program interviews regarding outcomes of recruitment, weight loss, and variation in cost	Lessons learned for serving Medicaid population: National DPP lifestyle change program can be implemented through Medicaid managed care to engage, enroll, and retain Medicaid beneficiaries	Recommendations for serving Medicaid population: Many specific recommendations for tailoring of program curriculum and delivery emerged

1

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
Demonstration Project Executive Summary/*Deborah Porterfield, MD, MPH et al., 2018,* https://coveragetoolkit.org/wp-content/uploads/2019/04/Medicaid-Demonstration-Project-Final-Report_Executive-Summary.pdf			program from Medicaid beneficiaries.	-Program surveys, cost surveys, participant outcome data	with prediabetes. Online delivery is feasible but may have unique considerations. Lessons learned for replicability Identified promising practices for efficient participant identification and recruitment, which can be replicated in other states where the MCOs/CCOs will have an active role in recruitment.	from this project, including paying attention to the literacy level of materials; recognizing the high prevalence of barriers to participation; providing program supports to facilitate attendance; and using tailored, frequent contact by trained lifestyle coaches to encourage retention Recommendations for replicability Key considerations for replication include having a 6-month period for project planning, ensuring sufficient staff time and reimbursement systems in place at the MCO/CCO level, and identifying resources to cover start-up costs.

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
(3) **Integrating data from an online diabetes prevention program into an electronic health record and clinical workflow, a design phase usability study/** *Mishuris, R.G., Yoder, J., Wilson, D. et al., 2016,* https://doi.org/10.1186/s12911-016-0328-x	Primary care providers from Boston University School of Medicine	Integrating data from an online diabetes prevention program into an EHR and clinical workflow	This study aims to characterize the preferences of providers concerning the integration of externally generated lifestyle modification data (DPP data) into a primary care EHR workflow.	Used qualitative data through semi-structured interviews to understand clinical workflow	The integration of external health-related data into the EHR must be embedded into the provider workflow in order to be useful to the provider and beneficial for the patient. Accomplishing this requires evaluation of that clinical workflow during software design.	Time constraints during a patient-provider visit may limit the utility of the new data to the provider. Practices may do well to think of additional roles, outside of the primary care provider, which might be better suited to using this data in patient interactions, leveraging the evolving team approach to patient care and population health.
(4) **A Coordinated National Model for Diabetes Prevention** *Vojta, D. MD, et al. 2013,*	Participants of the YMCA's DPP in 46 communities across 23 states	The main outcome measures were infrastructure (communities involved and personnel trained);	A 2002 Diabetes Prevention Program research study proved the effectiveness of the original 2002 DPP. However, cost per participant was high,	Participant outcome data,	In less than 2 years, the YMCA's DPP was effectively scaled to 46 communities in 23 states. More than 500 YMCA Lifestyle Coaches were trained. The program enrolled 2369 participants,	Large-scale prevention efforts can be scalable and sustainable with collaboration, health information technology, community-based

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
https://doi.org/10.1016/j.amepre.2012.12.018		engagement (screening and enrollment of people with prediabetes); program outcomes (attendance and weight loss); and service delivery cost of the intervention	complicating efforts to scale up the program. UnitedHealth Group (UHG) and the YMCA, in collaboration with the CDC, sought to develop the infrastructure and business case to scale the congressionally authorized National DPP nationwide at a lower cost per patient		and 1723 participants completed the core program at an average service-delivery cost of about $400 each. For those individuals completing the program, average weight loss was about 5%. UHG anticipates that within 3 years, savings from reduced medical spending will outweigh initial costs.	delivery of evidence-based interventions, and novel payment structures that incentivize efficiency and outcomes linked to better health and lower future costs.
(5) **Early Results of States' Efforts to Support, Scale, and Sustain the National Diabetes Prevention Program** *Mensa-Wilmot Y, 2017* 10.5888/pcd14.170478	CDC DPP funded states	This article describes activities, barriers, and facilitators reported by funded states during the first 3 years (2013–2015) of a 5-year funding cycle.	Present preliminary findings from a collaborative effort between CDC and state health departments designed to scale and sustain the National DPP. Findings from the first 3 years are described with the goal of providing an in-depth understanding of types of activities implemented along with barriers and facilitators	(Qualitative) data from grantee annual performance reports	Barriers included: complicated CDC recognition process, limited program resources, lack of standardized reimbursement availability, minimal referrals obtained, participant cost, lack of data, lack of awareness Facilitators included: Strong program curriculum, referral policies were strong (when implemented)	-utilize partners to increase availability of program - Integration of prediabetes clinical measures into EHRs and providing prediabetes resources in patient waiting areas contributed to referral success - Lack of insurance coverage for the National DPP was reported as a significant barrier State health

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
			experienced.			departments reported that availability of culturally and linguistically aligned lifestyle coaches was a major facilitator for identification and enrollment of people with prediabetes or at high risk for type 2 diabetes
(6) **Using a RE-AIM framework to identify promising practices in National Diabetes Prevention Program implementation** *Nhim, K, et al 2019* http://dx.doi.org.ezproxy.proxy.library.oregonstate.edu/10.1186/s13012	165 CDC-recognized organizations		This study aims to describe reach, adoption, and maintenance during the 4-year funding period and to assess associations between site-level factors and program effectiveness regarding participant attendance and participation duration.	Descriptive analyses include program data from evaluations, progress reports, data from participants. Multi-level analyses includes national DPP sites, and participants.	Recruitment strategies, and delivery adaptations influence retention and successful implementation	There were challenges in reaching some population groups such as males, African-Americans, Asian-Americans, Hispanics, American Indians, Alaska Natives, Pacific Islanders, and people with disabilities. As a result, these groups have been identified as populations of focus for the future.

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
-019-0928-9						
(7) Evaluation of a digital diabetes prevention program adapted for the Medicaid population: Study design and methods for a non-randomized, controlled trial *Kim, S.E. et al, 2018* *https://doi.org/10.1016/j.contc.2018.05.007*	3 health care facilities serving Medicaid-insured, safety net insured, or uninsured individuals. (1) FQHC located in Southern California (2) an outpatient clinic located within a large public teaching hospital in Southern Cali, and (3) a clinic serving large numbers of Medicaid patients operating within a large, not-for-profit, integrated healthcare network in the state of	(1)Experience of patients utilizing the digital DPP to evaluate clinical outcomes and (2) to better understand the clinic implementation of the program in facilities serving low-income populations.	The purpose of this study is to evaluate a digitally-delivered version of the DPP that was specially adapted for lower-income populations	The trial is a non-randomized, controlled trial with historical, matched controls serving as the comparison group. Analyses of patient outcomes, program engagement and qualitative interviews.	Found that it is feasible to recruit a safety net population unfamiliar with online or digital health programs to participate in a digitally-delivered diabetes prevention program. Initial assessment of the trial also showed that there were various challenges and barriers at different phases of the intervention related to referrals, enrollment, and data collection.	

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
	Washington.					
(8) Identifying Motivators and Barriers for Wellness Programs to Inform Recruitment and Retention of Diabetes Prevention Programs (DPPs)/ *Kamran, B., Beatty, K., Hurst, L., & Slawson, D. (2018).* https://dc.etsu.edu/cgi/viewcontent.cgi?article=1187&context=asrf	7 staff members from East Tennessee University's administration building	Measuring barriers and motivators to enrollment and participation in national DPP	Researchers wanted to address low overall recruitment/beneficiary interest in national DPP	Qualitative interviews	1. an emphasis on improving wellness rather than preventing diabetes is key when advertising or sharing about this program 2. appealing to individualized interests and concerns will encourage individuals to take more ownership of their health. 3. support from families and coworkers plays a huge role in retention.	(1) For program implementation, it's important to note how to frame these programs so it is more appealing and encouraging for all individuals to join. (2) encourage further, larger scale research in communities facing similar recruitment and retention issues.
(9) Prediabetes Identification and Diabetes Prevention Program	For patients who met inclusion criteria (>18 years old, lab values in prediabetes	measuring the rate of prediabetes diagnosis against the rate of those who join DPP.	The purpose of this project was to implement and evaluate a quality improvement project incorporating	Data were collected throughout implementation process and analyzed according to three categories	Overall, office staff was willing to learn how to identify prediabetic patients and refer them to a DPP. Patients identified with prediabetes and notified of the DPP were	Limitations of implementation were identified and if altered could improve the volume of patients referred to a DPP.

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
Referral/ *Hansen, S.C. (2019)* https://archive.hshsl.umaryland.edu/bitstream/handle/10713/9522/Hansen_PrediabetesReferral_2019.pdf?sequence=1	range, and no previous diabetes diagnosis.)		prediabetes identification and referral to a DPP at the primary care clinic	(1) number of patients seen during the specified timeframe; (2) number of patients with abnormal diagnostic testing for prediabetes (HbA1c) without a diabetes diagnosis; and (3) number of DPP referrals made for the patients identified with prediabetes.	willing to be referred.	Sustaining the prediabetes identification and referral process at this clinic could help to detect additional patients with prediabetes and help to prevent or prolong a diabetes diagnosis
(10) Implementation findings from a hybrid III implementation-effectiveness trial of the Diabetes Prevention Program (DPP) in the Veterans Health	This clinical demonstration was conducted in three geographically diverse medical centers. Candidate participants included patients with prediabetes who lived within 60 min	Identify barriers and facilitators in Reach, Adoption, Implementation, Effectiveness and Maintenance for DPP in VA population.	The aim of this study was to evaluate implementation of DPP via assessment of a clinical demonstration in the Veterans Health Administration (VHA).	A 12-month pragmatic clinical trial compared weight outcomes between the Veterans Affairs Diabetes Prevention Program (VA-DPP) and the usual care MOVE!® weight management program (MOVE!).	Several barriers and facilitators to Reach, Adoption, Implementation, Effectiveness and Maintenance were identified; barriers related to Reach were the largest challenge encountered by site teams. Fidelity was higher for VA-DPP delivery compared to MOVE! for five of seven domains assessed. Participant satisfaction was high in	Multi-faceted strategies are needed to reach targeted participants and successfully implement DPP. Costs for assessing patients for eligibility need to be carefully considered while still maximizing reach to the targeted population.

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
Administration (VHA)/ *Damschroder, L.J., et al, (2017)* https://doi.org/10.1186/s13012-017-0619-3	of a demonstration site, were obese overweight with diagnosis of an obesity-related condition, and attended a MOVE! orientation session.				both programs, but higher in VA-DPP for most items.	
(11) Increasing Referrals to a YMCA-Based Diabetes Prevention Program: Effects of Electronic Referral System Modification and Provider Education in Federally Qualified Health Centers *Chambers, E.C., et al 2015*	6 FQHC in Bronx, NY	Barriers/facilitators to provider referrals to DPP	The aim of this study is to evaluate how modifying the EHR system for ease of patient referral combined with a provider education intervention to increase and sustain clinic-based YDPP referrals over time in federally qualified health centers (FQHCs) in the Bronx, New York affects referral rates.	Referral data from April 2012 through November 2014 were analyzed using segmented regression analysis.	Study shows that the trend in referrals before the electronic referral lead-in and the change in levels of referrals around the point of the electronic referral system lead-in were not significant. However, there was a significant increasing trend of referrals after the EHR lead-in period. At the beginning of the provider education intervention there was a significant drop in referrals. There was also a significant positive trend in referrals after the provider education intervention	Based on medical directors' feedback, researchers are exploring strategies to develop a "warm hand-off" protocol with a more personalized referral, so the patients feel they have been introduced to YMCA staff that will provide the YDDP program.

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
https://www.cdc.gov/pcd/issues/2015/15_0294.htm					compared with before the intervention took place..	
(12) Prevalence and Correlates of Diabetes Prevention Program Referral and Participation *Venkataramani, M., 2019* https://doi.org/10.1016/j.amepre.2018.10.005	study population consisted of respondents aged ≥18 years without a self-reported diagnosis of diabetes and who would likely be eligible for diabetes prevention programming based on program eligibility criteria: (1) meeting National DPP 2015 BMI criteria and (2) a self-reported diagnosis of prediabetes or self-reported history of	Prevalence of self-reported referral and participation was determined, and sociodemographic correlates of referral, participation, and interest were characterized through multivariable logistic regression analyses.	Using nationally representative data, this study identifies how frequently at-risk adults are being referred to and participating in diabetes prevention programming, and explores correlates of referral, participation, and interest.	Data from the 2016 National Health Interview Survey (NHIS) were used in the analyses. Qualitative surveys were administered. Descriptive statistics were used to characterize the prevalence of self-reported referral, participation, and interest. Pearson chi-square analyses were used to compare characteristics of those who reported referral, participation, and interest versus those who did not. Sociodemographic correlates of referral, participation, and interest were	Although more than one quarter of adults likely eligible for diabetes prevention programming express interest in participating, few are being referred and fewer still have participated. This underscores the need for efforts to enhance program referral and access.	Low rates of referral and participation suggest that efforts to enhance identification, recruitment, and retention of high-risk adults from clinical and community-based settings will be essential to realizing the potential of lifestyle interventions for diabetes prevention

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
	gestational diabetes.			characterized by using separate multivariable logistic regression analyses.		
(13) Establishing an Effective Primary Care Provider Referral Network for the National Diabetes Prevention Program *Ritchie, N.D. & Swigert, T.J. 2016* https://doi-org.ezproxy.proxy.library.oregonstate.edu/10.1177/2325160316647707	NDPP participants and providers in an urban safety-net healthcare system (Denver Health).	self- and provider referrals meeting NDPP eligibility criteria	This study highlights the advantages of a provider referral network for the National DPP.	Assessed the effectiveness of various recruitment methods by examining the number of respective patients identified and likelihood of subsequent enrollment, along with odds ratios from logistic regression analyses. Examined descriptive results from the provider surveys.	Benefits of generating provider referrals included: -cost-effective and efficient recruitment -helping patients engage in risk-reduction activities -supporting PCPs in their management of patient needs -furthering an integrated care culture.	email recruitment may be another low-cost recruitment strategy to be considered in the future. Additional work is also needed to identify best practices for increasing long-term engagement in the NDPP.
(14) Women Veterans' Experience With a Web-Based Diabetes	Women veterans with prediabetes from the Midwest VA Women's Health Clinic	attitudes towards online program (advantages and disadvantages), and measure engagement	Primary objective was to qualitatively explore women veterans' early experiences with a Web-based DPP intervention.	Used an exploratory mixed-methods study design. Collected qualitative data through in-person semistructured	A Web-based DPP intervention appears to be a promising means of translating the DPP for women veterans with prediabetes in the VA. Early qualitative findings	Studies with larger and more diverse cohorts/settings, non-completers, and long-term follow-up are needed to provide a more

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
Prevention Program: A Qualitative Study to Inform Future Practice *Moinn, T., et al. 2015* https://www.jmir.org/2015/5/e127	who had enrolled in Prevent by January 19, 2014		Secondary objective was to estimate weight loss, participation, and engagement to provide context for our qualitative findings.	interviews conducted in a private room by one investigator	provide a deeper understanding of participants' early experiences and reveal how the convenience, fit, and integration of the program into daily life, and feelings of accountability contributed to participation and engagement.	definitive evidence base for Web-based DPP interventions.
(15) A systematic review of real-world diabetes prevention programs: learnings from the last 15 years *Aziz, Z., et al. 2015* https://doi.org/10.1186/s13012-015-0354-6	all published studies in the last 15 years (i.e. 2001–2015) that reported on the evaluation of a lifestyle-focused program aimed at individuals at moderate or high risk of diabetes (e.g. impaired glucose tolerance (IGT), elevated haemoglobin A1c (HbA1c), high body mass	critical success factors for implementing diabetes prevention programs in real-world settings	Findings from a systematic review that focuses on identifying the factors (positive and negative) in implementing DPP	A comprehensive search was carried out using PubMed, Web of Science, MEDLINE, CENTRAL, and EMBASE (February 2014). Search terms were 'diabetes' AND 'prevention' AND ('program' OR 'intervention') AND (implementation' OR 'translation'). The search was repeated using PubMed to include relevant articles from February 2014 to March	Programs that have high uptake—both in terms of good coverage of invitees and their willingness to accept the invitation—can still have considerable impact in lowering diabetes risk in a population, even with a low intensity intervention that only leads to low or moderate weight loss. From a public health perspective, this is an important finding, especially for resource constrained settings.	Key elements of the PIPE Impact Metric are not routinely reported in many published implementation trials of diabetes prevention which therefore reduces their utility for information resource allocation and 'real-world' implementation. More rigorous evaluation methods are required to better understand the factors that influence the likely success of such

Title/Author/Year/link	Population/ Location	Constructs/Factors Examined	Project Aim/Purpose of Project/Evaluation	Methodology	Findings	Recommendations by authors for future work/research
	index (BMI) or overweight).			2015. Developed a two step coding system to score data.		interventions in the future.

Situation and Program Review Informants

1. Katrina Seipp, Comagine Health
2. Tori Scholl, Comagine Health
3. Tracy Carver, Comagine Health
4. Kerri Lopez, Northwest Portland Area Indian Health Board
5. Anne Celovsky, OHA, HPCDP
6. Kaityn Lyle, OHA, HPCDP
7. Rachel Burdon, OHA, HPCDP
8. Steven Fiala, OHA, HPCDP
9. Don Kain, OHSU
10. Rika Martini, Oregon Medical Association
11. Lavinia Goto, Oregon Wellness Network

DPP Evaluation Interview Guide for DPP Providers

Introduction:
The Rede Group, at the request of the Oregon Health Authority, Health Promotion and Chronic Disease Prevention Section, is conducting an evaluation of the Diabetes Prevention Program Medicaid benefit implementation in Oregon. In 2019, DPP became a covered benefit for Medicaid beneficiaries in Oregon. This interview is a part of a project to understand barriers and facilitators to DPP Medicaid benefit implementation and inform OHA efforts to support accelerated implementation. The interviews are across three key stakeholder groups: DPP providers, DPP referring entities, and CCOs. We will be asking questions regarding the roll-out, implementation, and satisfaction with the Medicaid benefit implementation.

This interview will take approximately 45 minutes. We will be taking notes and recording the interview so that we can analyze the information which will inform OHA's efforts to support the implementation of the Medicaid benefit. The recording will not be shared with anyone outside of the Rede Group and will only be used as a reference to verify information in our notes and for the accuracy of reporting. The final report will be made available to you. Your comments today will not be attributed to you in the report, nor will they be shared with the OHA. We will not attribute any information to you in the report, and will only include your name as a person interviewed if we receive your permission to do so.

Do you mind if we record the interview?

Do you have any questions before we begin?

To start out could you please state your name, position, and organization for the interview transcript.

The first few questions will be about the roll-out of the Medicaid benefit...

<u>Roll-out of Medicaid benefit</u>:

1) How did your organization become aware of the DPP Medicaid benefit?
2) What support resources were available to you prior to, and during the initial roll-out of the DPP Medicaid benefit?
    a) Prompt for resources available from OHA, CDC, etc.
3) What were barriers for your organization in starting the Medicaid benefit roll-out?
4) How has your organization recruited and retained Medicaid beneficiaries in the DPP?
5) Looking back at the initial roll-out of the DPP Medicaid benefit in your organization, what additional resources would have been beneficial?

Now, we will ask some questions about the Medicaid benefit implementation...

<u>Implementation</u>:

6) How is the DPP Medicaid benefit put into use or implemented in your organization?

7) How is the delivery of the DPP Medicaid benefit supported in your organization?
    a) Tell me about how the DPP Medicaid benefit has been going since roll-out?
        i) Prompt for internal and external, if they do not mention
8) What are the biggest challenges to the delivery of the DPP Medicaid benefit for your organization?
    a) Prompt to ensure other barriers, aside from COVID-19, if that is all that is mentioned.
9) What do you see as the biggest challenges to keeping the Medicaid benefit going in your organization?
10) What are some things, specific to your organization, that help make the DPP Medicaid benefit available for the population you serve?
    a) What resources (online, in-person, etc.) have been the most helpful for the effective implementation of the DPP Medicaid benefit?
    b) What resources help support the sustainability of the DPP Medicaid benefit for your organization?

The next couple of questions will be about the impact of COVID-19 on DPP Medicaid benefit implementation...

COVID-19:

11) How has the implementation of the DPP Medicaid benefit been impacted by the COVID-19 pandemic?
    a) What new barriers have arisen during adaptation to the current environment?
    b) What additional resources, if any, do you need to ensure you are able to implement the DPP Medicaid benefit given the current environment?
12) Reflecting on changes to the delivery of the DPP for Medicaid beneficiaries in response to COVID-19, how do you think the delivery of the DPP, particularly for Medicaid beneficiaries, will be impacted?

The last set of questions will address your satisfaction with implementation...

Satisfaction:

13) How satisfied are you with the implementation of the DPP Medicaid benefit?
    a) Prompt for recruitment/enrollment, claims, etc.
14) What, if anything, would improve your satisfaction with implementing the DPP Medicaid benefit in Oregon?

List of DPP referring providers

We will be interviewing DPP referring providers as part of this evaluation but have found it challenging to obtain a list of providers referring to DPP.

15) Would you be able to provide us with contact information for your top 1-3 providers referring to your DPP program or a comprehensive list of providers to your DPP program?

Thank you for your time and attention today. Your input in the evaluation is extremely valuable. If you have any additional questions about this interview or the evaluation you can reach out to me or Rachel Burdon at OHA.

Thanks again.

If requested: Rachel.E.Burdon@dhsoha.state.or.us

DPP Evaluation Interview Questions for Referring Providers

Introduction:
The Rede Group, at the request of the Oregon Health Authority, Health Promotion and Chronic Disease Prevention Section, is conducting an evaluation of the Diabetes Prevention Program Medicaid benefit implementation in Oregon. This interview is a part of a project to understand barriers and facilitators to DPP Medicaid benefit implementation and inform OHA efforts to support accelerated implementation. The interviews are across three key stakeholder groups: DPP providers, DPP referring entities, and CCOs. We will be asking questions regarding the roll-out, implementation, and satisfaction with the Medicaid benefit implementation.

This interview will take approximately 20 minutes. We will be taking notes and recording the interview so that we can analyze the information which will inform OHA's efforts to support the implementation of the Medicaid benefit. The recording will not be shared with anyone outside of the Rede Group and will only be used as a reference to verify information in our notes and for the accuracy of reporting. The final report will be made available to you. Your comments today will not be attributed to you in the report, nor will they be shared with the OHA. We will not attribute any information to you in the report, and will only include your name as a person interviewed if we receive your permission to do so. Do you mind if we record the interview?

Do you have any questions before we begin?

To start out could you please state your name, position, and organization for the interview transcript.

The first few questions will be about the roll-out of the Medicaid benefit...

Roll-out of Medicaid benefit:

1) How did you become aware of the DPP Medicaid benefit?
2) What support resources were available to you prior to, and during the initial roll-out of the DPP Medicaid benefit?
    a) Prompt for resources available from OHA, CDC, CCOs, DPP providers, etc.
3) What were barriers to starting referral of Medicaid beneficiaries to the DPP?*
4) Looking back at the initial roll-out of the DPP Medicaid benefit (Jan. 2019), what additional resources would have been beneficial in assisting you with understanding the benefit and referral process?

Now, we will ask some questions about the Medicaid benefit implementation...

Implementation:

5) What does the referral process for Medicaid beneficiaries to the DPP look like in your practice/clinic?
    a) Prompt for how specific partnerships with DPP providers and CCOs are formed

    b) How does your practice/clinic support a closed-loop referral process for the DPP for Medicaid beneficiaries? When we say closed-loop referral, we are referring to the bi-directional flow of patient information between clinic/referring entity and CBOs that implement the DPP.

6) How are referral-related functions to the DPP Medicaid benefit supported in your practice/clinic?*
    a) Prompt for internal and external, if they do not mention
7) What are the current barriers to referring Medicaid beneficiaries to the DPP for your practice/clinic?
    a) What do you see as barriers to the sustainability of the DPP referral process for Medicaid beneficiaries?
    b) Prompt to ensure other barriers, aside from COVID-19, if that is all that is mentioned.
8) What are facilitators for the referral of Medicaid beneficiaries to the DPP for your practice/clinic?
    a) What resources (online, in-person, etc.) have been the most helpful for understanding the benefits of, and the referral process for the DPP for Medicaid beneficiaries?
    b) What resources help support the sustainability of the DPP referral process for Medicaid beneficiaries?

<u>COVID-19</u>:

9) How has the referral of Medicaid beneficiaries to the DPP been impacted by the COVID-19 pandemic?
    a) What new barriers have arisen during adaptation to the current environment?
    b) What additional resources, if any, do you need to ensure you are able to continue referring Medicaid beneficiaries to the DPP given the current environment?

The last set of questions will address your satisfaction with implementation...

<u>Satisfaction</u>:

10) How satisfied are you with the implementation of the DPP Medicaid benefit?
    a) Prompt for recruitment/enrollment, claims, etc.
11) What, if anything, would improve your satisfaction with referring Medicaid beneficiaries to the DPP Medicaid benefit in Oregon?

Thank you for your time and attention today. Your input in the evaluation is extremely valuable. If you have any additional questions about this interview or the evaluation you can reach out to me or Rachel Burdon at OHA.

DPP Evaluation Interview Guide for CCOs

Introduction:
The Rede Group, at the request of the Oregon Health Authority, Health Promotion and Chronic Disease Prevention Section, is conducting an evaluation of the Diabetes Prevention Program Medicaid benefit implementation in Oregon. This interview is a part of a project to understand barriers and facilitators to DPP Medicaid benefit implementation and inform OHA efforts to support accelerated implementation. The interviews are across three key stakeholder groups: DPP providers, DPP referring entities, and CCOs. We will be asking questions regarding the roll-out, implementation, and satisfaction with the Medicaid benefit implementation.

This interview will take approximately 45 minutes. We will be taking notes and recording the interview so that we can analyze the information which will inform OHA's efforts to support the implementation of the Medicaid benefit. The recording will not be shared with anyone outside of the Rede Group and will only be used as a reference to verify information in our notes and for the accuracy of reporting. The final report will be made available to you. Your comments today will not be attributed to you in the report, nor will they be shared with the OHA. We will not attribute any information to you in the report, and will only include your name as a person interviewed if we receive your permission to do so. Do you mind if we record the interview?

Do you have any questions before we begin?

To start out could you please state your name, position, and organization for the interview transcript.

The first few questions will be about the roll-out of the Medicaid benefit...

Roll-out of Medicaid benefit:

1) How did your organization become aware of the DPP Medicaid benefit?
2) What support resources were available to you prior to, and during the initial roll-out of the DPP Medicaid benefit?
    a) Prompt for resources available from OHA, OHP, CDC, etc.
3) What were barriers in starting the Medicaid benefit roll-out?
4) Looking back at the initial roll-out of the DPP Medicaid benefit, what additional resources would have been beneficial for your organization?

******ONLY ask if CCO is also a CDC-recognized DPP Provider (Yamhill Only) ******

5) What were barriers for your organization in becoming a CDC-recognized DPP Provider?

Now, we will ask some questions about the Medicaid benefit implementation...

Implementation:

6) How has your organization adapted internal infrastructure to assist with implementing the DPP Medicaid benefit?

7) How did your organization determine the costs of providing access to and coverage of the DPP Medicaid benefit?
8) Describe the payment and reimbursement methodology for your organization.
    a) How did your organization establish these?
9) What are metrics of success for the DPP Medicaid benefit for your organization?
10) What quality improvement methods are utilized for the DPP Medicaid benefit?

<u>Implementation with key partners</u>:

DPP Providers

11) How did your organization partner with DPP providers for the Medicaid benefit?
    a) Prompt for how organization identifies partners with new DPP providers to expand the reach of the Medicaid benefit?
12) What formal agreements are made when developing contracts with DPP providers?
    a) Prompt for data use agreements, OHP provisions, description of services covered, the term of the contract, reimbursement schedule, data confidentiality, etc.
13) How does your organization partner with DPP providers to support program delivery for Medicaid beneficiaries?
14) How does your organization recognize and promote DPP delivery sites?
    a) Prompt for, payment incentives, success stories, etc.
15) What are barriers to partnering with DPP providers for the implementation of the Medicaid benefit?
16) What are facilitators for the implementation of the DPP Medicaid benefit for your organization?
    a) What resources (online, in-person, etc.) have been the most helpful for the effective implementation of the DPP Medicaid benefit?
    b) What resources help support the sustainability of the DPP Medicaid benefit for your organization?

DPP Referrers

17) How did your organization initially partner with medical providers and/or clinics for implementation of the DPP Medicaid benefit?
    a) Prompt for membership of CCO, geographic region to DPP providers, claims data, etc.
18) How did your organization find a clinic champion within clinic partners?
19) What strategies were used for introducing and promoting DPP to clinic partners?
20) What support does your organization offer for clinic partners to make DPP referrals for Medicaid beneficiaries?
21) What are barriers to sustaining relationships with clinic partners relating to DPP Medicaid benefit implementation?

Medicaid beneficiaries

22) How does your organization support the recruitment of Medicaid beneficiaries in the DPP?

    a) Prompt for active recruitment from the CCO

23) How does your organization support a closed-loop referral process for the DPP for Medicaid beneficiaries?
    a) Prompt for identification and referral, communication with the referrer, etc

24) How does your organization encourage retention of the Medicaid beneficiaries in the DPP?

The next couple of questions will be about the impact of COVID-19 on DPP Medicaid benefit implementation...

<u>COVID-19</u>:

25) How has the implementation of the DPP Medicaid benefit been impacted by the COVID-19 pandemic?
    a) Prompt: What new barriers have arisen during adaptation to the current environment?
    b) Prompt: What additional resources, if any, do you need to ensure you are able to implement the DPP Medicaid benefit given the current environment?

The last set of questions will address your satisfaction with implementation...

<u>Satisfaction</u>:

26) How satisfied are you with the implementation of the DPP Medicaid benefit?
    a) Prompt for recruitment/enrollment, claims, etc.
27) What, if anything, would improve your satisfaction with implementing the DPP Medicaid benefit in Oregon?

<u>List of DPP referring providers</u>

We will be interviewing DPP referring providers as part of this evaluation but have found it challenging to obtain a list of providers referring to DPP.

28) Would you be able to provide us with contact information for your top 1-3 DPP referring providers or a comprehensive list of DPP referring providers in your service area?

Thank you for your time and attention today. Your input in the evaluation is extremely valuable. If you have any additional questions about this interview or the evaluation you can reach out to me or Rachel Burdon at OHA.

Thanks again.

If requested: Rachel.E.Burdon@dhsoha.state.or.us

DPP Medicaid Benefit Implementation Survey

The Rede Group, at the request of the Oregon Health Authority, Health Promotion and Chronic Disease Prevention Section, is conducting an evaluation of the Diabetes Prevention Program (DPP) Medicaid benefit implementation in Oregon. This survey is a part of a project to understand the barriers and facilitators to DPP Medicaid benefit implementation and inform OHA efforts to support accelerated implementation. This survey is for two key stakeholder groups: DPP providers and CCOs. We will be asking questions regarding the roll-out, implementation, outcomes, and satisfaction with the Medicaid benefit implementation. This survey does not include any personally identifying questions, so your responses will not be attributed to you.

If you have any questions about this survey or need any assistance, please contact: elisabeth.castillo@redegroup.co

This survey should take about 15-20 minutes to complete. Thank you for your time.

DPP Medicaid Benefit Implementation Survey

1. What is your current title?

* 2. What is your affiliation with the National Diabetes Prevention Program (National DPP)?

- [ ] Coordinated Care Organization (CCO)
- [ ] DPP Provider (Currently providing the DPP)
- [ ] Other (please specify)

DPP Medicaid Benefit Implementation Survey

DPP Provider

3. In which county(ies) does your organization provide the National DPP?

- [ ] Jackson
- [ ] Marion
- [ ] Multnomah
- [ ] Josephine
- [ ] Clatsop
- [ ] Clackamas
- [ ] Klamath
- [ ] Coos
- [ ] Washington
- [ ] Deschutes
- [ ] Malheur
- [ ] Lane
- [ ] Linn
- [ ] Umatilla
- [ ] Harney
- [ ] Wasco
- [ ] Yamhill
- [ ] Douglas
- [ ] Hood River
- [ ] Tillamook
- [ ] Columbia
- [ ] Baker
- [ ] Polk
- [ ] Wallowa
- [ ] Benton
- [ ] Morrow
- [ ] Curry

- [ ] Jefferson
- [ ] Union
- [ ] Lincoln
- [ ] Lake
- [ ] Gilliam
- [ ] Wheeler
- [ ] Grant
- [ ] Crook
- [ ] Sherman
- [ ] Clark
- [ ] Skamania
- [ ] Payette
- [ ] Klickitat

4. What is your organization's CDC recognition status?

- ○ Full recognition
- ○ Preliminary recognition
- ○ Pending recognition
- ○ Not currently recognized
- ○ Other (please specify)

5. Is your National DPP open to all eligible participants, regardless of payment method?

- ○ Yes
- ○ No, please list what payment methods your program accepts:

6. Does your National DPP focus on enrolling a specific population?

- ○ No
- ○ Yes, please list what specific populations(s):

7. In which language(s) does your organization provide the National DPP? (please select all that apply)

- [ ] Spanish
- [ ] English
- [ ] Other (please specify)

8. In which of the following formats is your National DPP implemented? (please select all that apply)

- [ ] In-person
- [ ] Online
- [ ] Conference calls
- [ ] Hybrid
- [ ] Other

9. How did your organization become aware of the National DPP Medicaid benefit?

- ○ DPP Demonstration Project
- ○ OHA DPP Work group
- ○ Comagine Health
- ○ Not aware of the Medicaid Benefit
- ○ Other (please specify)

10. Where can interested Medicaid beneficiaries find information about your National DPP? (please select all that apply)

- [ ] On our website
- [ ] Through their Medical Provider
- [ ] Through their CCO
- [ ] Other (please specify)

* 11. Does your organization promote the recruitment of Medicaid beneficiaries, specifically?

- ○ Yes
- ○ No

DPP Medicaid Benefit Implementation Survey

DPP Provider

12. Which of the following strategies does your organization use to recruit Medicaid beneficiaries, specifically? (please select all that apply)

- [ ] Partnerships with Medical Providers/Clinics
- [ ] Partnerships with CCOs
- [ ] Advertisements, flyers, or emails directly to eligible beneficiaries
- [ ] Social Media presence
- [ ] Other

* 13. Please choose the top 3 sources of enrollment for Medicaid beneficiaries in your National DPP?

- [ ] Physician referrals
- [ ] Health Department referrals
- [ ] CCOs
- [ ] FQHCs
- [ ] Word of mouth
- [ ] Other (please specify)

DPP Medicaid Benefit Implementation Survey

DPP Provider

14. Are you interested in partnering with other clinics and health care organizations to receive referrals for your National DPP?

- ◯ Yes
- ◯ No
- ◯ Unsure

15. Does your organization ensure a closed-loop referral process for all Medicaid beneficiaries?

- ◯ Yes
- ◯ No
- ◯ Unsure

DPP Medicaid Benefit Implementation Survey

DPP Provider

16. Which of the following barriers has your organization experienced when trying to recruit and enroll Medicaid beneficiaries in the National DPP? (please select all that apply)

- [ ] Lack of provider awareness or referral
- [ ] Lack of patient awareness
- [ ] Incorrect or poor usage of ICD-10 codes
- [ ] Identifying eligible Medicaid beneficiaries
- [ ] Other (please specify)

17. Please tell us about other barriers to Medicaid beneficiary recruitment in the DPP that your organization is facing.

18. Is retention of Medicaid beneficiaries in the DPP an issue for your organization?

- ( ) Yes
- ( ) No

19. For Medicaid beneficiaries, what is your completion rate for the DPP Program?

- ( ) Less than 50%
- ( ) 50%- 74%
- ( ) 75%- 84%
- ( ) 85%- 94%
- ( ) 95%-99%
- ( ) 100%

20. Which of the following Medicaid beneficiary-specific barriers has your organization experienced regarding retention in the National DPP? (please select all that apply)

- ☐ Geographic location of DPP classes
- ☐ Transportation to and from classes
- ☐ Time of day classes are offered
- ☐ Cultural differences between DPP participants
- ☐ Financial challenges
- ☐ Mental health challenges
- ☐ Amount of time needed for the DPP
- ☐ Languages that classes are offered in
- ☐ Other

21. What are barriers to the sustainability of the National DPP Medicaid benefit for your organization? (please select all that apply)

- ☐ Inability to recruit Medicaid beneficiaries
- ☐ Inability to retain Medicaid beneficiaries
- ☐ Reimbursement
- ☐ Other

22. Do you have contracts in place with OHP as a payor for the National DPP for Medicaid beneficiaries?

- ○ Yes
- ○ No

* 23. Do you currently submit claims and bill Medicaid beneficiaries for the National DPP?

- ○ Yes
- ○ No

DPP Medicaid Benefit Implementation Survey

DPP Provider

* 24. Do you plan to begin billing for Medicaid beneficiaries in the next 12 months?

- ◯ Yes
- ◯ No

DPP Medicaid Benefit Implementation Survey

DPP Provider

25. What are the reasons or barriers that prevent you from billing? (please select all that apply)

- ☐ Medicaid beneficiary enrollment
- ☐ Medicaid beneficiary retention
- ☐ Reimbursement structure
- ☐ Other

DPP Medicaid Benefit Implementation Survey

DPP Provider

26. How long has your program been accepting Medicaid beneficiaries?

27. How many National DPP cohorts have you started since January 1st, 2019?

28. In what counties were programs offered in? (Enter number)

29. How many National DPP cohorts do you plan to start in the next 6 months?

30. How many Medicaid beneficiaries has your organization enrolled in the National DPP?

31. How many Medicaid beneficiaries have completed the National DPP with your organization?

DPP Medicaid Benefit Implementation Survey

DPP Provider

32. What has been your greatest success related to the implementation of the National DPP Medicaid benefit?

33. What has been your greatest challenge related to the implementation of the National DPP Medicaid benefit?

34. Please tell us the extent to which you agree or disagree with the following statements:

Statement	Response
1. I am satisfied with the support provided from OHA for the DPP Medicaid benefit	
2. I am satisfied with recruitment of Medicaid beneficiaries for the DPP	
3. I am satisfied with the reimbursement structure of the DPP Medicaid benefit	
4. Overall, I am satisfied with the implementation of the DPP Medicaid benefit	

DPP Medicaid Benefit Implementation Survey

DPP Provider

35. Please tell us what, if anything, would improve your overall satisfaction with the implementation of the DPP Medicaid Benefit.

DPP Medicaid Benefit Implementation Survey

CCO

36. What is your organization's member size?

- ◯ <49,999 members
- ◯ 50,000-99,999 members
- ◯ 100,000 or more members

37. Did your CCO participate in the DPP Medicaid Demonstration project funded by NACDD?

- ◯ Yes
- ◯ No

* 38. Does your CCO currently support billing and reimbursement for the DPP?

- ◯ Yes
- ◯ No

DPP Medicaid Benefit Implementation Survey

CCO

39. How long has your CCO been implementing the DPP Medicaid benefit?

40. How many CDC Recognized DPP providers are within your coverage area?

- ○ 1
- ○ 2-4
- ○ 5-9
- ○ 10 or more

41. How many CDC-recognized DPP providers do you currently contract with to serve Medicaid beneficiaries?

- ○ 1
- ○ 2-4
- ○ 5-9
- ○ 10 or more

DPP Medicaid Benefit Implementation Survey

CCO

* 42. Do you have any performance metrics and/or incentives for DPP Providers that you contract with for Medicaid beneficiaries, specifically?

- Yes
- No

DPP Medicaid Benefit Implementation Survey

CCO

43. What are your performance metrics and/or incentives for DPP Providers for Medicaid beneficiaries?

DPP Medicaid Benefit Implementation Survey

CCO

* 44. Does your CCO support a closed-loop referral process for Medicaid beneficiaries in the DPP?

- Yes
- No

DPP Medicaid Benefit Implementation Survey

CCO

45. Which of the following does your organization do to support a closed-loop referral for Medicaid beneficiaries in the DPP? (please select all that apply)

- ☐ Identification of the eligible member
- ☐ Assistance in referral of the eligible member
- ☐ Maintain member engagement in the DPP
- ☐ Provide referral source with timely follow-up information (e.g., class attendance, weight loss)
- ☐ Offer assistance to DPP site to identify and eliminate barriers precluding a member's success
- ☐ None of the above
- ☐ Other (please specify)

DPP Medicaid Benefit Implementation Survey

CCO

46. Which of the following enrollment strategies does your CCO currently use to assist Medicaid beneficiaries in enrolling in the DPP? (please select all that apply)

- [ ] We partner with clinics or physicians to refer eligible Medicaid beneficiaries to the DPP
- [ ] We have internal staff (e.g., coordinated care staff) that assist in enrolling members into the DPP
- [ ] We do not use any DPP enrollment strategies specific to Medicaid beneficiaries
- [ ] Other (please specify)

47. Is the DPP Medicaid benefit integrated into your CCO's Quality Improvement?

- ( ) Yes
- ( ) No

48. Does your organization currently use any of the following as metrics of success for the DPP Medicaid benefit? (please select all that apply)

- [ ] Participant retention rate
- [ ] Number of DPP programs within your coverage area
- [ ] Number of trained lifestyle coaches
- [ ] Number of Medicaid beneficiaries referred by a HCP
- [ ] Number of Medicaid beneficiaries with closed-loop referrals
- [ ] Other (please specify)
- [ ] None of the above

49. Which of the following resources were beneficial for your organization in the roll-out of the DPP Medicaid benefit? (please select all that apply)

- ☐ National DPP Coverage Toolkit
- ☐ OHA's Diabetes Prevention Program Guide for CCOs
- ☐ OHA's 2-pager for Requirements for DPP reimbursement
- ☐ CDC's Covering a lifestyle change program as a health benefit
- ☐ Other (please specify)

50. Which of the following are barriers for your CCO in implementing the DPP Medicaid benefit? (please select all that apply)

- ☐ Provider willingness to refer beneficiaries to DPP
- ☐ Execution of data-sharing agreements with DPP Providers
- ☐ Identifying eligible members
- ☐ Other (please specify)

51. Does your CCO recognize participating clinics and medical providers for referring Medicaid beneficiaries to the DPP?

- ◯ No
- ◯ Yes, describe how:

52. How many DPP claims for Medicaid beneficiaries has your organization received since January 1st, 2019?

DPP Medicaid Benefit Implementation Survey

CCO

53. How many of your Medicaid members have enrolled in the DPP since January 1st 2019?

54. How many of your Medicaid members have completed the DPP since January 1st 2019?

55. What has been your organization's greatest facilitator for the implementation of the National DPP Medicaid benefit?

56. What has been your organization's greatest challenge related to the implementation of the National DPP Medicaid benefit?

57. Please tell us the extent to which you agree or disagree with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am satisfied with current enrollment for the DPP Medicaid benefit	○	○	○	○	○
I am satisfied with the technical support provided from OHA in implementing the DPP Medicaid benefit	○	○	○	○	○
I am satisfied with the payment and reimbursement processes associated with the DPP Medicaid benefit	○	○	○	○	○
Overall, I am satisfied with the implementation of the DPP Medicaid benefit	○	○	○	○	○

58. Please tell us what, if anything, would improve your overall satisfaction with the implementation of the DPP Medicaid Benefit.

59. Has the COVID-19 Pandemic impacted your CCO's ability to implement the DPP Medicaid benefit?

- No
- Yes, describe:

DPP Medicaid Benefit Implementation Survey (Healthcare Providers)

The Rede Group, at the request of the Oregon Health Authority, Health Promotion and Chronic Disease Prevention Section, is conducting an evaluation of the Diabetes Prevention Program (DPP) Medicaid benefit implementation in Oregon. This survey is a part of a project to understand the barriers and facilitators to DPP Medicaid benefit implementation and inform OHA efforts to support accelerated implementation. This survey is for DPP Referring Healthcare Providers. We will be asking questions regarding the roll-out, implementation, outcomes, and satisfaction with the Medicaid benefit implementation. This survey does not include any personally identifying questions, so your responses will not be attributed to you.

If you have any questions about this survey or need any assistance, please contact: elisabeth.castillo@redegroup.co

This survey should take about 10-15 minutes to complete. Thank you for your time.

DPP Medicaid Benefit Implementation Survey (Healthcare Providers)

* 1. Are you a Healthcare Provider that refers patients to the Diabetes Prevention Program?

- Yes
- No

DPP Medicaid Benefit Implementation Survey (Healthcare Providers)

2. In what county(ies) is your practice located? (please select all that apply)

- [ ] Jackson
- [ ] Clackamas
- [ ] Marion
- [ ] Multnomah
- [ ] Josephine
- [ ] Clatsop
- [ ] Klamath
- [ ] Coos
- [ ] Washington
- [ ] Deschutes
- [ ] Malheur
- [ ] Lane
- [ ] Linn
- [ ] Umatilla
- [ ] Harney
- [ ] Yamhill
- [ ] Wasco
- [ ] Douglas
- [ ] Hood River
- [ ] Tillamook
- [ ] Columbia
- [ ] Baker
- [ ] Polk
- [ ] Wallowa
- [ ] Benton
- [ ] Morrow
- [ ] Curry
- [ ] Jefferson

- [ ] Union
- [ ] Lincoln
- [ ] Lake
- [ ] Gilliam
- [ ] Wheeler
- [ ] Grant
- [ ] Crook
- [ ] Sherman
- [ ] Clark
- [ ] Skamania
- [ ] Payette
- [ ] Klickitat

3. What percentage of your panel is made up of Medicaid beneficiaries?

- ○ 10% or less
- ○ 11-30%
- ○ 31-50%
- ○ 51-75%
- ○ 76% or more

4. Thinking back, how did you first hear about the Medicaid benefit for the DPP?

- ○ Oregon Medical Association
- ○ Oregon Health Authority
- ○ Other state-affiliated workgroup
- ○ A physician or healthcare professional
- ○ Other (please specify)

5. What support resources were available to you prior to, and during the roll-out of the DPP Medicaid benefit? (please select all that apply)

- ☐ OHA provided resources
- ☐ CDC provided resources
- ☐ DPP provider resources
- ☐ I had to seek my own resources
- ☐ I was not aware of any resources
- ☐ Other (please specify)

6. What additional supports or resources would have been beneficial to you in referring patients to the DPP program? (please select all that apply)

- ☐ More information about the benefits of referring patients to the DPP
- ☐ More information about Medicaid beneficiaries' eligibility for the DPP
- ☐ More information about how to refer patients to the DPP
- ☐ Technical assistance
- ☐ None; I had all the resources I needed
- ☐ Other (please specify)

7. Does your practice/clinic currently have a DPP champion?

- ○ Yes
- ○ No

8. How long have you been referring Medicaid beneficiaries to the DPP?

- ○ 3 months or less
- ○ 4-6 months
- ○ 7-12 months
- ○ More than one year

9. Does your practice ensure a closed-loop referral process for Medicaid beneficiaries to the DPP?

- ○ Yes
- ○ No
- ○ Unsure

10. Is the DPP referral process for Medicaid beneficiaries integrated into your Electronic Health Records?

- Yes
- No

11. Which of the following are barriers for referring Medicaid beneficiaries to the DPP in your practice/clinic? (please select all that apply)

- Eligibility requirements of the DPP
- Language barriers
- Patients not engaging (e.g., not answering calls or following up after referral)
- Substantial increased workload for me
- Medical provider buy-in for the DPP program
- Patient buy-in for the DPP program
- No barriers
- Other (please specify)

12. On a scale of 1-10 with 1 being "not beneficial at all" and 10 being "extremely beneficial", how beneficial do you believe the DPP program is to your patients who are prediabetic?

0 10

13. Please tell us the extent to which you agree or disagree with the following statements:

	Strongly disagree	disagree	Neutral	Agree	Strongly agree
I believe the DPP is beneficial to my patients with prediabetes					
The benefits of referring Medicaid beneficiaries to the DPP outweigh the administrative burden					
The process for referring Medicaid beneficiaries to the DPP is easy to implement					

* 14. Do you currently use a standardized assessment tool to screen Medicaid beneficiaries for prediabetes?

- Yes
- No

DPP Medicaid Benefit Implementation Survey (Healthcare Providers)

15. Which standardized screener do you use?

DPP Medicaid Benefit Implementation Survey (Healthcare Providers)

* 16. Does your practice currently partner with any DPP providers?

- Yes
- No

DPP Medicaid Benefit Implementation Survey (Healthcare Providers)

17. In which of the following ways do you/your practice partner with DPP providers? (please select all that apply)

- [ ] DPP Providers provide us with educational materials about the DPP for Medicaid beneficiaries
- [ ] DPP Providers come into our practice to try to and increase referral for Medicaid beneficiaries
- [ ] DPP Providers provide Medicaid beneficiary progress to our practice
- [ ] Other (please specify)

DPP Medicaid Benefit Implementation Survey (Healthcare Providers)

18. What has been your organization's greatest facilitator for referring Medicaid beneficiaries to the DPP?

19. What has been your organization's greatest challenge in referring Medicaid beneficiaries to the DPP?

20. How many Medicaid beneficiaries have you referred to the DPP (please provide an exact number or your best estimate)?

21. Of your patients referred to the DPP, how many have successfully completed the DPP (please provide an exact number or your best estimate)?

22. Please tell us the extent to which you agree or disagree with the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I am satisfied with the amount of Medicaid beneficiary referrals to the DPP from my practice/clinic	○	○	○	○	○
I am satisfied with the technical support provided from OHA in implementing the DPP Medicaid benefit	○	○	○	○	○
I am satisfied with the referral processes associated with the DPP Medicaid benefit	○	○	○	○	○
Overall, I am satisfied with the implementation of the DPP Medicaid benefit	○	○	○	○	○

23. Please tell us what, if anything, would improve your overall satisfaction with the implementation of the DPP Medicaid Benefit in your practice/clinic.

24. Has the COVID-19 Pandemic impacted your ability to implement the DPP Medicaid benefit (e.g., screening or referring patients to the DPP)?

- No
- Yes, describe

Preliminary NDPP Medicaid Benefit Implementation Recommendations

	Current Challenges	**Possible Solutions**
Awareness	• Many key stakeholders unaware of the NDPP Medicaid benefit	• Targeted outreach to different stakeholder groups
Roll-out	• NDPP resources, processes, and requirements difficult to navigate	• Creation of an Oregon-specific NDPP platform • Enhanced billing and reimbursement supports
Sustainability	• Poor retention of Medicaid beneficiaries in the NDPP • FFS rates are below costs	• Reduce barriers for Medicaid beneficiaries • Increase NDPP rates • Expand incentive metric technical assistance to include NDPP-related metrics • Increase NDPP partner networking and engagement
Reach	• Limited reach of Medicaid beneficiaries; uptake of the benefit • Lack of targeted recruitment to Medicaid beneficiaries	• Improve health care system referrals and associated protocols • Utilize existing resources to expand reach
Effectiveness	• Limited data on NDPP Medicaid benefit in Oregon and associated data systems	• Ongoing evaluation of the NDPP Medicaid benefit • Creation of target metrics specific to the NDPP Medicaid benefit