Community Care Hubs (CCHs) and the National DPP Lifestyle Change Program: CCH Spotlights

The National Diabetes Prevention Program (National DPP) lifestyle change program played a significant role in the development of CCHs. In 2014, the Center for Medicare and Medicaid Innovation (CMMI) funded a demonstration for the National DPP lifestyle change program in which the YMCA of the USA served as a lead organization to a delivery system of local YMCAs across the country that delivered the program. The outcome showed increased effectiveness of individual community-based organizations (CBOs) organized as a network under a single managing organization, improved health outcomes, and reduced costs.

As a result of the demonstration, Medicare established coverage for the Medicare Diabetes Prevention Program (MDPP), allowing CBOs to deliver the program as a new Medicare benefit. The history and evidence demonstrating the effectiveness of the National DPP lifestyle change program makes it a promising starting place for CCHs.

There are many examples across the country of organizations that use the CCH model to support a network of CBOs. Western New York Integrated Care Collaborative (WNYICC) is an example of a CCH that supports providers in offering the National DPP lifestyle change program among other evidence-based programs.

Western New York Integrated Care Collaborative (WNYICC)

Background and description

WNYICC is a community care hub serving the communities of western and central New York. WNYICC includes a network of more than 70 CBOs, nine county Area Agencies on Aging (AAA), two county Departments of Health, and a Center for Independent Living (CIL) with 15 affiliate offices throughout the region.

In 2017, WNYICC received funding from the Health Foundation of Western and Central New York to develop the hub's infrastructure and grow its network. WNYICC used this funding to hire a full-time Director of Business Development who operationalized the program by developing a network of CBOs, acquiring contracts, establishing referral pathways, and building a training academy for network partners.

From 2016-2019, WNYICC operated solely through grant funding. By early 2024, approximately 25% of WNYICC's budget was funded through grants and the remaining 75% through contracts (55% are contracts with payers and 45% are consulting and technical assistance contracts). WNYICC primarily contracts with Medicare Advantage (MA) plans. Other payer contracts include Medicaid managed care organizations (MCOs), Medicaid long-term care plans, and commercial health insurance plans.

Service delivery model

WNYICC subcontracts service delivery to a network of CBOs. They use Welld Health, a centralized documentation system, to record services and bill health plans via submitted claims. CBO staff document services for their assigned clients using this system.

WNYICC's menu of service offerings has expanded over time to include Healthy IDEAS (a social isolation intervention), post-discharge meals delivery, medical nutrition therapy, a community health coaching program (CHC), a caregiver support program, and other evidence-based programs (i.e., National DPP lifestyle change program, Diabetes Self-Management Education and Support (DSMES), and Falls Prevention).

WNYICC uses a coaching model to provide CHC, Falls Prevention, and caregiver support services. When an individual is referred to WNYICC, a WNYICC-trained health coach is assigned to the member and conducts a social determinants of health (SDOH) screening. WNYICC coaches work with members for up to 12 months to address needs identified through the screening process and assist members in setting goals, linking to health-related social needs (HRSN) services (i.e., food, housing, transportation, community supports, SNAP), and coordinating their health care. The health coach then helps the member enroll in evidence-based community programs such as the National DPP lifestyle change program, Chronic Disease Self-Management Program, Matter of Balance, Tai Chi, Enhance Fitness, Walk with Ease, Powerful Tools for Caregivers, and Exhale Caregiver Respite Programs.

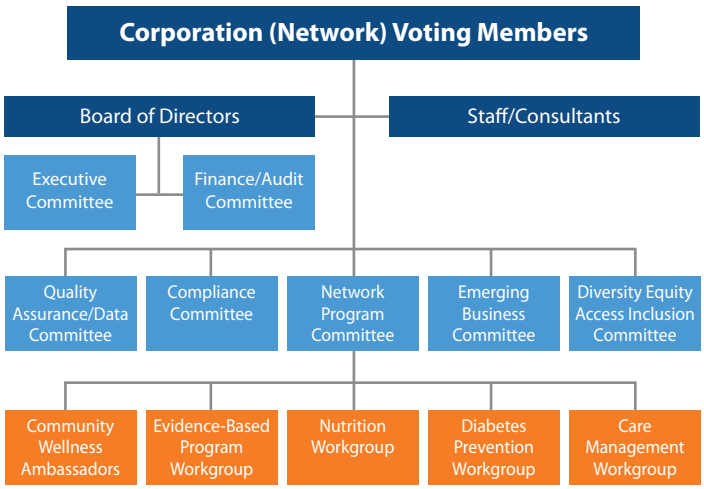
Governance model

WNYICC's governance model consists of a Board of Directors and six committees (Figure 1). The board includes 11 members from the hub's network partners (CBOs) serving 3-year terms and acting as committee chairs. The six committees focus on (1) finance and audits; (2) network programs; (3) compliance; (4) quality assurance and data; (5) diversity, equity, and inclusion (DEI); and (6) emerging business. The committees and Board of Directors guide the development and operations of the hub.

Role of National DPP lifestyle change program

The National DPP lifestyle change program created new contract opportunities for WNYICC. As a CDC-Plus Recognized National DPP program, all network partners deliver the National DPP lifestyle change program under WNYICC's Diabetes Prevention Recognition Program (DPRP) code. CMS' requirement that Medicare Advantage (MA) plans provide the National DPP lifestyle change program (or MDPP) created a pathway for WNYICC to expand its contract portfolio. WNYICC serves as a centralized hub for MA plans, allowing them to contract with multiple MDPP suppliers. This created additional opportunities for WYNICC to work with these MA plans to promote coverage for other evidence-based programs.

Figure 1: WNYICC Organizational Chart



It is important to note that the MDPP and National DPP lifestyle change program do not alone support the financial sustainability of CCHs, requiring hubs like WNYICC to develop a diversified menu of service offerings to build financial sustainability. To support sustainability and promote the hub's offerings, WNYICC educates providers on the hub's programs and encourages referrals.