



NATIONAL ASSOCIATION OF  
**CHRONIC DISEASE DIRECTORS**

Promoting Health. Preventing Disease.

## MEDICARE DIABETES PREVENTION PROGRAM

# Sustainable Pathways for Accelerating Referrals of Quality (MDPP SPARQ) Project

MDPP Beneficiary Referral to Enrollment Case Studies



October 2024

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## Project Background

Through funding from the Centers of Disease Control and Prevention (CDC), the National Association of Chronic Disease Directors (NACDD), partnered with Medicare Diabetes Prevention Program (MDPP) suppliers to continue to learn how programs can increase Medicare beneficiary enrollment into the MDPP through the MDPP Sustainable Pathways for Accelerating Referrals of Quality (SPARQ) project. MDPP SPARQ was launched in September 2023 and is based on cumulative learnings from the NACDD’s MDPP Enrollment Project (2020-2023).

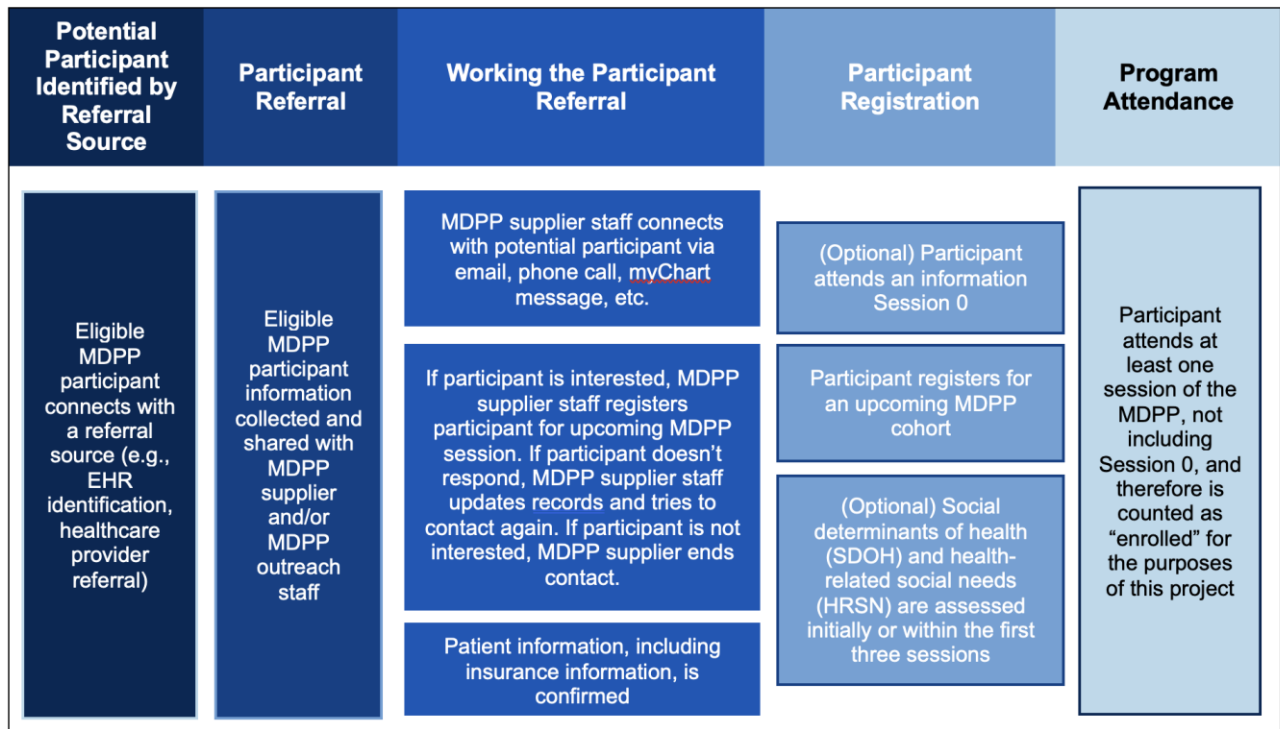
The MDPP SPARQ project seeks to better understand the processes that lead to successful Medicare beneficiary referral to enrollment conversions by analyzing data collected from three MDPP suppliers on beneficiary referral sources and MDPP supplier workflows. MDPP SPARQ also examines the technical aspects of the MDPP referral and billing processes including work with electronic health records (EHRs).

MDPP SPARQ worked with three MDPP suppliers that had high rates of referrals and enrollment based on data reported through the MDPP Enrollment Project and existing relationships with referring healthcare providers including two healthcare organizations: Henry Ford Health (Michigan) and Trinity Health (Maryland and New York) and one community-based organization: YMCA of Greater Seattle (Washington state).

## Enrollment Workflow Process

Participant engagement in the MDPP consists of several stages. For this project, NACDD examined the referral to enrollment process, from the point of initial referral eligible participants through the participant’s attendance in the first session of the program, at which point they were considered “enrolled” (Figure 1). While MDPP supplier methods, technology platforms, staff and approaches vary across programs, case studies in the report follow the steps of the example workflow (Figure 1).

**Figure 1.** Example Referral to Enrollment Workflow



## About This Resource

Through funding from the Centers of Disease Control and Prevention (CDC), the National Association of Chronic Disease Directors (NACDD), partnered with Medicare Diabetes Prevention Program (MDPP) suppliers to continue to learn how programs can increase Medicare beneficiary enrollment into the MDPP through the MDPP Sustainable Pathways for Accelerating Referrals of Quality (SPARQ) project. MDPP SPARQ was launched in September 2023 and is based on cumulative learnings from the NACDD's MDPP Enrollment Project (2020-2023). This report reports key learnings around factors that contribute to quality referrals based on data gathered from three MDPP SPARQ supplier grantees, representing two healthcare organizations and one community-based organization (CBO).

MDPP referral data were collected between October 2023 and July 2024 to better understand the processes that lead to successful participant enrollment. Additionally, between February and March 2024, interviews were conducted with all MDPP SPARQ grantee staff to gather data for organizational case studies. The case studies in this report provide information on the grantees' organizational background, outreach and referral processes, and enrollment of Medicare beneficiaries into the MDPP.

When reviewing this document, begin by reviewing the [Key Takeaways from the MDPP Supplier Interviews](#) section, which provides a high-level, aggregate summary of the interview themes. Use the organizational description of grantees on the following page to identify the most relevant case study for your work based on organization type, staffing, or workflow processes. Click on the organization's logo to jump to its case study.



## MDPP SPARQ Grantees



**Henry Ford Health:** Henry Ford Health is one of the nation’s leading comprehensive, integrated health systems, providing a full continuum of services – from primary and preventative care, to complex and specialty care, health insurance, a full suite of home health offerings, virtual care, pharmacy, eye care and other healthcare retail. With six hospitals, dozens of medical centers, and over 30,000 employees, they are committed to improving the health and wellness of the diverse Michigan community. HFH has been providing the MDPP since 2020



**Trinity Health:** Trinity Health is one of the largest not-for-profit, faith-based healthcare systems in the nation. It is a family of 121,000 colleagues and nearly 36,500 physicians and clinicians caring for diverse communities across 27 states. Nationally recognized for care and experience, the Trinity Health system includes 101 hospitals, 126 continuing care locations, the second largest PACE program in the country, 136 urgent care locations and many other health and well-being services. In fiscal year 2023, the Livonia, Michigan-based health system invested \$1.5 billion in its communities in the form of charity care and other community benefit programs.



**YMCA of Greater Seattle:** The YMCA of Greater Seattle is Seattle’s founding nonprofit organization, offering health, hope, and opportunity. The Y provides crucial programs and services to more than 232,000 people every year, including housing for vulnerable youth, health meals to food-insecure families, and more than \$12.2 million in financial assistance to ensure everyone has a chance to succeed and belong at the Y. The Y’s suite of chronic disease prevention and management programs helps to extend the goals and values of clinical care into community settings through strong partnerships with healthcare systems. The YMCA of Greater Seattle has been providing the MDPP since 2018.



## Key Takeaways from MDPP Supplier Interviews

Several themes emerged from the MDPP Supplier Interviews. Interviewees<sup>1</sup> discussed processes related to MDPP participant preferences eligibility, outreach and provider education, patient education and readiness, and data and technology.

### MDPP Participants

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**Outreach method:** There is variation in how comfortable MDPP potential participants are with using technology to respond to outreach. Interviewees noted the use of multiple methods of outreach to potential MDPP enrollees, including providing response options (e.g., email, text, phone, patient portal). ***When conducting phone calls, interviewees noted that potential MDPP enrollees were more likely to answer the phone and spend more time talking to staff than potential participants who were not Medicare beneficiaries.*** Phone calls also provided staff with the opportunity to state early on that the MDPP is a covered benefit for Medicare beneficiaries.

**Medicare beneficiary readiness:** In general, interviewees agreed that potential MDPP enrollees were concerned about their overall health, particularly when health concerns were first flagged by their healthcare provider. Potential MDPP enrollees were also receptive to participating in non-pharmacologic interventions and could prevent them from being prescribed more medication (i.e. “not another pill”).

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*“[The Medicare] population almost seems to be more concerned about their health than the younger people who still think they're invincible. The Medicare population doesn't want to take one more pill. They don't want to have one more diagnosis on their chart. They want to take control.”*

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**Preferred participation modality:** There is variation in how familiar and comfortable MDPP participants are with using technology to attend MDPP sessions. Multiple delivery modalities are offered to account for participant preferences. Two interviewees shared that potential MDPP participants are more likely to request to enroll in in-person MDPP sessions during onboarding.

**Verification of eligibility:** MDPP and/or National Diabetes Prevention Program (National DPP) lifestyle change program eligibility verification for potential participants occurred prior to sending outreach or referring patients when conducting bulk outreach and point of care referrals. When receiving referrals from other sources, including non-electronic health record (EHR) healthcare provider referrals, participant self-referrals, and community event sign ups, insurance verification and program eligibility is determined when conducting initial outreach and/or prior to participant enrollment.

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<sup>1</sup> Throughout this report, NACDD's MDPP SPARQ grantee staff who were interviewed are referred to as interviewees.



## Outreach Strategies and Provider Education

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**Referral sources:** Healthcare provider/point-of-care referrals and bulk communications were the most frequently used source of referral (for two of the grantees, these categories made up 85% of all MDPP referrals). Following initial outreach, most communication is conducted by staff via phone call, email, text, or patient portal messaging. Staff members conducting outreach were typically health educators, community health workers (CHWs), or Lifestyle Coaches.

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*“From a value perspective, the cost is very minimal for bulk outreach and point of care [referrals] and the results are high.”*

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**Outreach staff:** When performing outreach via phone call, interviewees emphasized that it is critical that the caller is able to talk with the eligible participant. This helps to engage the participant and build the trust necessary to screen, educate, and enroll participants. Staff making the calls should be champions at connecting with people. Training staff in motivational interviewing, developing scripts/outlines with key talking points, and shadowing staff members with more experience can help to prepare staff to better engage potential participants.

**Outreach timing:** Following initial referral or interest from the potential participant (e.g., response to a bulk communications or marketing campaign), two interviewees noted they will attempt to contact potential participants up to three times before moving them to a non-responsive list. For bulk referrals, non-responsive participants will continue to remain on bulk outreach lists until they are no longer deemed eligible, or they request to be removed from the list. Timing for outreach varies depending on location and resources of the organization.

**Phone call outreach:** Overall, interviewees noted that cold calling participants from eligibility lists is challenging and often results in hang ups or no answer. Interviewees agreed that ensuring the hospital or healthcare provider’s name appears in the caller identification results in a higher rate of responses. This can be done by calling from a phone line with hospital information in the caller identification, if possible.

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*“Make sure to get them comfortable with you by letting them know you're calling from their health system... [if you have permission to do so]. You want to build that trust a little within the first minute or so of a conversation. Nowadays people get so many spam calls, if you get a chance to get someone on the phone, grab their attention and build that relationship immediately.”*

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**Healthcare provider connections:** It is important to obtain permission to use a healthcare provider name when implementing any outreach method, if possible. This can have a positive impact on responsiveness and engagement from potential participants. Provide healthcare providers with education and advanced notice when their names are included in patient outreach materials. This prepares the healthcare provider to answer questions or concerns their patient may have about the MDPP and helps facilitate and reinforce future healthcare provider referrals. One grantee noted that engaging a healthcare provider champion can help to recruit and engage additional healthcare providers in referring their patients to the MDPP. Additionally, two grantees



are implementing bi-directional referral processes to provide information on their patients' enrollment, milestones, and completion of the program, including EHR messages and quarterly enrollment lists.

## Patient Education and Readiness

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**Participant screening:** MDPP SPARQ grantees are implementing processes around determining participant program readiness. Unmet social needs often drive negative health outcomes and make it difficult for individuals to focus on long-term goals or proactive prevention. Timing for health-related social needs (HRSN) screening varied among the grantees, with some conducting screenings for every individual as part of standard organizational process and others conducting the screening once the patient is enrolled in MDPP. Screening workflow examples included using Lifestyle Coaches or CHWs to conduct HRSN screening following patient enrollment in MDPP, HRSN screening conducted at Session 0, and patients completing HRSN assessments via the patient portal. One interviewee noted that addressing HRSN screening and referral resources upfront positively affects program enrollment and retention outcomes. Of note, one organization estimated that only about 10% of those screened and identified as having HRSN wanted help or referrals to HRSN resources.

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[Learn more about and compare existing Health-Related Social Needs \(HRSN\) screening tools on the National DPP Coverage Toolkit's Health Equity Initiatives resource page and review the crosswalk of the three most used HRSN screening tools.](#)

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**Session 0:** While the grantees have implemented a [Session 0](#) (information session prior to the program start that introduces the National DPP lifestyle change program to potential participants-not reimbursable by Medicare), the objective and timing of the session 0 varied among interviewees. Some sites automatically included a Session 0 for participants who were already enrolled in the program as a program kick-off, while others kept Session 0 as an informal opportunity for anyone to learn more about the National DPP lifestyle change program. Some organizations use phone calls to onboard individuals and review information that would occur during a Session 0. Because of the variation in processes, no key themes were identified as to whether Session 0 increased enrollment among the cohort (*statement not inclusive of grantee data analysis*).

## Data and Technology

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**Technology platform:** Using one singular data/technology platform for participant identification, referral, outreach, enrollment, and data collection would streamline and allow for better evaluation of processes. Incorporation or communication of the platform with the EHR would be the most effective. Currently, several of the grantee sites are using separate platforms for different stages of the workflow and/or from different referral sites, including a mix of EHR, billing/technology platforms, and other internal data collection methods. This can lead to slower or less efficient outreach and enrollment and therefore continuous quality improvement of data platforms is critical to ensuring efficient systems are in place.

**Mixed cohorts:** Two interviewees conduct cohorts of participants with mixed insurance providers (e.g., Medicare, Medicaid, commercial payer, self-pay). One interviewee, representing a healthcare organization, holds cohorts of MDPP-only participants for billing purposes.



## Grantee Learnings from Data Collection and Tracking

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"This project supported the team in creating a safe space to really examine our data and internal processes of documenting data. Opportunities were recognized for adjusting our processes and improving the resulting data collection." -**Henry Ford Health**

"Standardization and automation of referral and data collection processes are essential to analyze, improve quality and facilitate collaboration among stakeholders. This process can accelerate our mission of improving the health of those we serve." -**Trinity Health**

"It's been really helpful to drill down on what types of outreach and provider engagement tactics work best in not only increasing number of referrals, but referrals for people who are most likely to "say yes" to joining the DPP. We want to concentrate our limited resources on those people - and we know there are a lot of them - who are ready to say yes to DPP and just need to hear the program is out there from a trusted source like their provider." -**Y of Greater Seattle**

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If you are interested in utilizing a tool to estimate Medicare beneficiary referral to enrollment conversion rates from specific referral sources, please visit [www.dppbusinessstools.org](http://www.dppbusinessstools.org). Through funding from the Center for Disease Control and Prevention (CDC), the National Association of Chronic Disease Directors (NACDD) worked with CreateApe, a digital product and website design company, to develop this website to support planning for successful National Diabetes Prevention Program (National DPP) and Medicare Diabetes Prevention Program (MDPP) implementation. The website features customizable, web-based DPP Business Tools, developed based on feedback and beta testing from over 50 MDPP suppliers.



# Case Study 1: Henry Ford Health

## Henry Ford Health and the National DPP/ MDPP

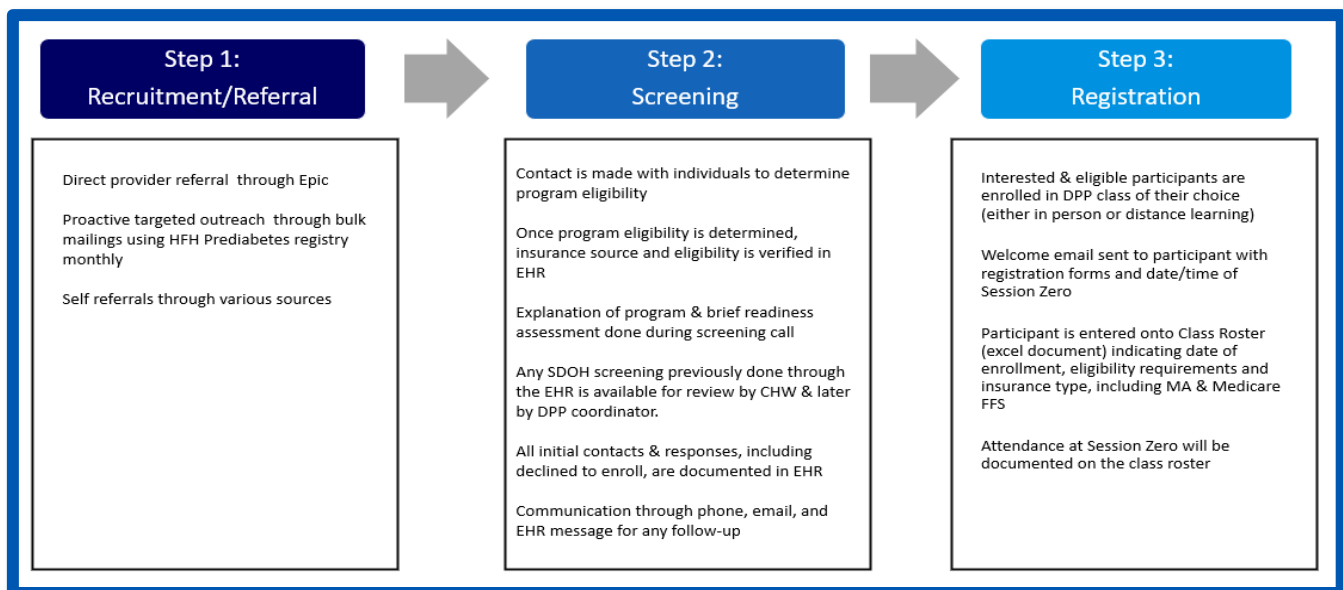
**Henry Ford Health** is one of the nation’s leading comprehensive, integrated health systems, providing a full continuum of services – from primary and preventative care to specialty care, health insurance, home health offerings, virtual care, pharmacy, eye care, and other healthcare retail. Henry Ford Health operates six hospitals, dozens of medical centers, and oversees 30,000 employees.

Located in Michigan, Henry Ford Health has been engaged with the National Diabetes Prevention Program (National DPP) lifestyle change program since 2015 and became a Medicare Diabetes Prevention Program (MDPP) supplier in 2020. They currently have four delivery sites and one administrative site which deliver the National DPP lifestyle change program through various modalities, including in-person and distance learning. Henry Ford Health operates mixed payer cohorts. For individuals who have payer coverage of the National DPP or MDPP, including through their Medicare Advantage (MA) contracts, they submit claims for reimbursement. For those who do not have coverage, Henry Ford Health currently covers the cost of the program.

To increase referrals, Henry Ford Health markets the program to individuals of all ages who are eligible for the National DPP. To reach MDPP eligible beneficiaries, they perform educational events through partnerships with senior centers, funeral homes, and health fairs. For example, a local funeral home, Dignity Memorial, arranges presentation opportunities (similar to Session 0) at a Township Senior Center to educate participants on the MDPP. Henry Ford Health’s partnership with Faith Community Nurses and Health Ministers bring awareness and information to local congregations and their recreation center partners also offer extensive senior programming, including promotion of MDPP.

Members of the Henry Ford Health outreach staff conduct informational sessions for potential participants to increase education and awareness of the National DPP lifestyle change program. They also hold promotional and educational classes with healthcare providers as a means of increasing referrals. When possible, the Henry Ford Health Diabetes Care team also promotes the program at community events.

**Figure 2.** Henry Ford Health Referral Workflow



While Henry Ford Health receives most referrals through their internal healthcare delivery systems, they also contract with CDC-recognized organizations to deliver the National DPP to eligible individuals who cannot attend an open Henry Ford Health class. Additional information on Henry Ford Health's referral methods are available in the [referral section](#) below.

According to their electronic health records (EHR), Henry Ford Health has roughly 65,000 patients

living with prediabetes. Through their current outreach processes, they are able to reach out to approximately 12,000 of those individuals per year, with an estimated 10% of those outreached converting into enrollment.

The sections below detail Henry Ford Health's processes to outreach and communicate to participants, obtain referrals, and enroll individuals in the program (Figure 2).

## Referral and Communication Pathways

Henry Ford Health obtains referrals through three unique pathways, which include:

- Responses from individuals who are identified as eligible via the EHR and receive outreach letters (approximately 15% of referrals)
- Individuals contacting Henry Ford Health or signing up at a community event (approximately 5% of referrals)
- Direct point of care (POC) referrals from providers via the EHR at point of contact (approximately 80% of referrals)

These referral methods are dependent solely on program eligibility and include individuals from all insurance types. Last year, Henry Ford Health obtained about 700 referrals to the National DPP through the EHR referral method.

Each referral method is tracked in the Henry Ford Health EHR, and once recorded, it is autopopulated into a report which is reviewed by two community health workers (CHWs) at Henry Ford Health. The staff then contact the individuals in the report.

During initial calls, outreach staff verify eligibility and insurance coverage status. Outreach staff also conduct an initial readiness screening to assess patient interest in the program. In doing so, they provide a description of the program and the eligibility criteria which led to their referral. The goal of the outreach staff is to develop a relationship with the individual on the other end of the phone (or alternate communication style) in order to educate them on the value of participating in the program.

Outreach staff have noted that by framing the participation as one hour per week, they are able to make the year-long program feel less daunting during initial discussions.

If an individual expresses interest in the program, the outreach staff will then review the class list by patient zip code to identify a time and location that fits the participant's schedule, either in-person or virtual. If no classes are available that fit the participant's schedule, they may then be referred to a contracted community partner to identify class times and locations that fit better.



During initial discussions, Henry Ford Health has found that the most critical aspects are **making the potential participants feel comfortable** and ensuring that they **begin by letting them know they are calling on behalf of their provider**. This allows the potential participant to feel comfortable communicating about their health and feel they are doing so with a trusted source of information.



Calls can take anywhere from 3 to 45 minutes, depending on the preference and communication styles of the potential participant. While staff's communication points and techniques are consistent across age groups, Henry Ford Health has noted that conversations with older adults can be longer, particularly with those who have limited familiarity with the technology associated with enrollment and participation in the National DPP. In order to train new staff in the best practices of engaging potential participants, they are provided with a call script and spend time shadowing more experienced staff members.

Henry Ford Health attributes their enrollment success to the abilities of the outreach staff to connect and engage with potential participants.

At the end of each call, potential participants are placed in the appropriate category:

- **Enrolled:** Signed up to participate in the National DPP lifestyle change program.
- **Waitlisted:** Interested in participating in the program but no cohorts are available which meet participant needs.
- **Pending additional communication:** Requires additional verification or requested to discuss the program at another time.
- **Ineligible:** Does not meet National DPP eligibility criteria.
- **Declined:** Eligible but not interested in participating in the program.

All outreach attempts, including the date outreach occurred, who made the call, and the information that was received from the potential participant are documented in the EHR. Once a referral populates into the EHR report, it will remain active for one year as the outreach staff continues to work with the potential participant.

Following a category assignment, the EHR automatically notifies the referring provider that their patient has been enrolled, waitlisted, declined to participate, or does not meet the eligibility criteria

for participation. Additionally, Henry Ford Health follows up with the referring providers who are interested in feedback to provide progress reports for individuals who have enrolled in the program 3-4 times throughout the course of the program.

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*“We start [the call] with the physician information because most people already have an established relationship with their doctor. That’s one of the advantages that we do have, that the referral is coming directly from their physician.”*

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## Staffing and Training

At Henry Ford Health, training for referral management also includes health system Epic training for scheduling, registering, and documenting. These trainings are one to two hours. Henry Ford Health uses the “train the trainer” model, with the National DPP Coordinator being an onsite trainer and support person. The Referral Manager staff are also CHWs and learning support coordinators. This model ensures availability of staff to screen participants and serve as subject matter experts for the delivery of the program.

The training includes additional training, coaching, and observation for staff who will be contacting referrals by phone. The goal is to have enough trained staff make contact with the referral quickly and have a support system within Henry Ford Health. Henry Ford Health aims to have a team member working the referral queue five days per week. Currently two part-time team members are conducting referrals at approximately 60% FTE total, with hopes of expanding to the equivalent of 100% FTE in the future.

## Participant Information Sessions and Enrollment

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Individuals who have agreed to participate in the National DPP lifestyle change program are first asked to attend an introductory [Session 0](#). At Henry Ford Health, Session 0 occurs one week before the first National DPP class and includes only enrolled participants. Session 0 takes place at the time and location the future classes will occur, including virtual. During Session 0, participants receive an information packet, registration forms, and links to CDC-developed marketing videos, located in the [CDC Customer Service Center](#), which describe the program. For in-person classes, Session 0 also includes manual completion of the registration



packet. For virtual sessions, participants are asked to complete the registration packet on their own and send them back via email, fax, or postal mail.

Since Session 0 is meant for participants who have already committed to enrollment, rather than an open information session for all interested individuals, the rate of attendance in Session 1 after attending Session 0 is very high (estimated 75-80%). While they would not decline participants who were simply interested in learning more, this is not the purpose of Session 0 at Henry Ford Health. Additionally, while initial conversations with participants include some discussion of their readiness to participate, in-depth conversations around motivation and readiness assessments occur during Session 0 information classes.

Individuals who attend Session 0 or subsequent classes but stop attending are added to a follow-up report. They begin by sending an email to the participant after the first missed class and will continue to follow up to the extent possible if additional sessions are missed.

Currently, all processes up to class enrollment are documented in the Henry Ford Health EHR. Following enrollment, documentation occurs on an internal system which tracks attendance, weight, and other participant metrics. Henry Ford Health is working to incorporate all documentation into the EHR to help streamline enrollment and communication processes. They are also exploring platforms to incorporate and conduct social determinants of health (SDOH) screenings and health-related social need (HRSN) referrals.

Henry Ford Health attempts to begin one to two classes each month, with evening, weekday classes being the most requested class time. They estimate an equal number of requests for in-person and virtual classes, however, among Medicare eligible participants this is dependent on their level of comfort with technology. From October 1, 2023 through July 31<sup>st</sup>, 2024, Henry Ford Health received 169 MDPP referrals and enrolled 28 individuals in their MDPP lifestyle change program.

## Epic Build Out

During the MDPP SPARQ grant year, Henry Ford Health was conducting a build out of their EHR system, Epic, to include additional pathways for MDPP/National DPP referral, enrollment, and feedback. Key learnings from this process include:

1. Assign a project manager to the process to bring teams to the table, keep workflow moving, and follow through on action items.
2. Identify a champion to bridge the gap between the community work and the IT/Epic team members. They speak a different language and there is a steep

learning curve from both sides. The National DPP coordinator had Epic support background and was instrumental in this role.

3. Remember that you are representing the needs of the community you serve. Automation of this work is necessary but find a balance when seeking ways to engage and serve the community, keeping the needs of the community at the forefront.

## Key Learnings

### Henry Ford Health attributes their enrollment success to two factors:

1. Personable and professional outreach coordinators who are able to connect with potential participants.
2. Direct connection to referring providers as trusted support for the program.



## Case Study 2: Trinity Health

### Trinity Health and the National DPP

**Trinity Health** is one of the nation's largest not-for-profit, faith-based healthcare systems, serving 1.6 million attributed lives. Two of Trinity Health's regional systems, in Maryland and New York, are participating in the MDPP SPARQ Project.

Trinity Health's System Office serves as the technical lead for the nine CDC-recognized organizations offering the National Diabetes Prevention Program (National DPP) lifestyle change program for the system. While Trinity Health's active engagement with the National DPP lifestyle change program began during their participation as a CDC [DP17-1705](#) recipient in 2017 and the CDC [CP23-2320](#) award in 2023, some of their delivery sites have been offering the program for much longer. Trinity Health's first site to become a Medicare Diabetes Prevention Program (MDPP) supplier occurred in 2021, with four more sites achieving MDPP supplier status since that time.

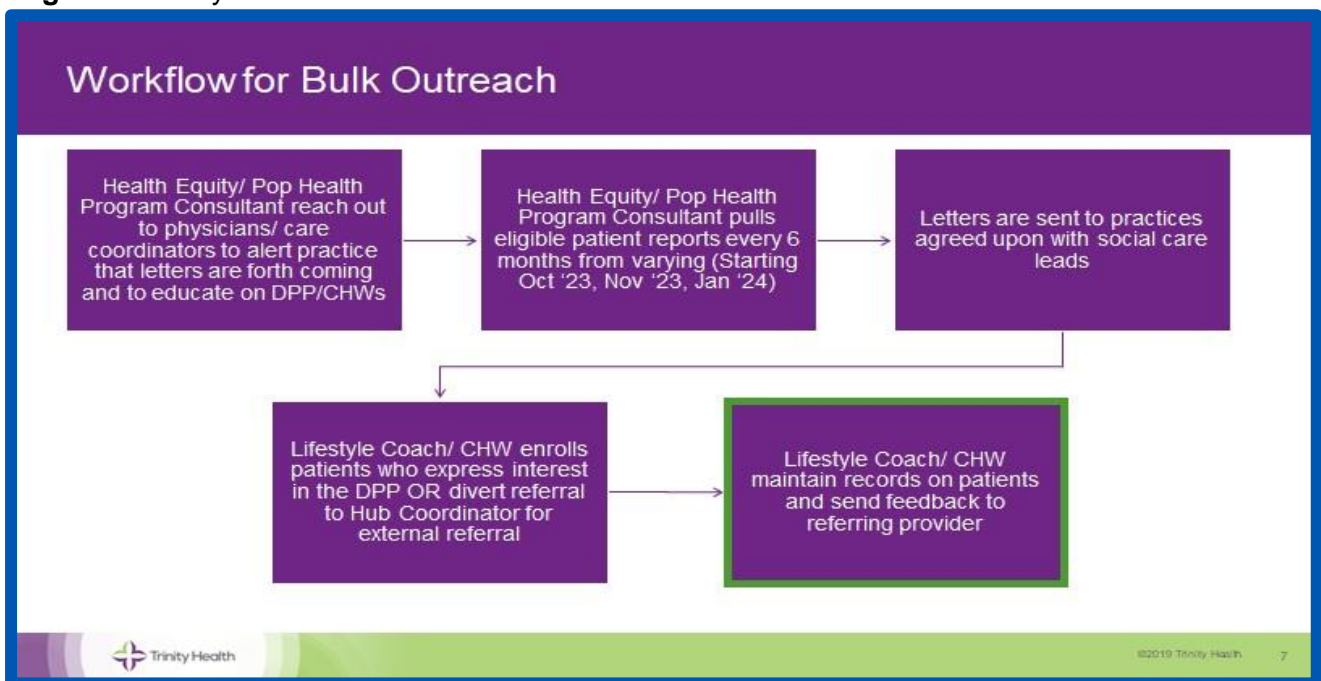
Trinity Health operates in-person, virtual, and distance learning cohorts separated by payer type

(Medicare versus non-Medicare patients). This is done to help separate their billing and reimbursement processes for grant-related compliance purposes. Processes are being developed to allow mixed-payer cohorts in the future.

To increase awareness and referrals into the program, Trinity Health holds provider education sessions with the assistance of healthcare provider champions at each site. Additionally, Trinity Health conducts local campaigns. The majority of Trinity Health's referrals come from within the Trinity Health system.

Bulk communication outreach (e.g., mass communication outreach that is delivered by email, physically mailed letters, and/or the patient portal) is the most cost-effective method for identifying and enrolling individuals in the National DPP lifestyle change program, accounting for their highest volume of referrals and connections with potential participants. **Trinity Health sends roughly 32,000 communications a year to individuals who are**

**Figure 3.** Trinity Health Bulk Referral Workflow



**deemed at risk of prediabetes through their electronic health record (EHR) system, with about 7,200 of those being MDPP eligible participants.** Following bulk referrals, primary care providers also provide a significant number of point of care referrals through the EHR. Finally, a number of point of care referrals come to Trinity Health from direct provider referrals and community-based organizations. Trinity Health

hopes to increase community-based referrals over the next five years through additional partnerships. The bulk referral workflow and the additional referral method workflows are shown (Figures 3-5). Additional workflows are also described in the [Referrals Pathways section](#), followed by additional information on Trinity Health’s communication and enrollment processes.

## Referral Pathways

Trinity Health uses three primary referral workflows: social needs referrals, point of care referrals, and bulk communication referral outreach.

### Social Needs Referrals

When Trinity Health patients attend a primary care appointment, they receive a health-related social needs (HRSN) screening (Figure 4). Patients who indicate HRSN are referred to the Social Care Lead, the head of the community health worker (CHW) program at Trinity Health. After discussing screening results and addressing the patients’ identified HRSN, if desired, the CHW will determine if the patient is eligible for other programs or services, including the National DPP lifestyle change program<sup>2</sup>.

Training protocols and certification requirements for CHWs, provided by an external provider, ensure that they are empowered to have sensitive

conversations with the patient and help to address their needs as appropriate. Additionally, a CHW will continue to work with a MDPP participant who completes the program until social needs are addressed, and continually seeking to remove barriers to program participation.

### Point of Care Referrals

During point of care referrals, patients are referred to the National DPP lifestyle change program when they are deemed eligible by their treatment provider during a healthcare visit. Following the referral, a CHW and/or Lifestyle Coach reviews the referral to confirm eligibility, conducts a social needs screening and then completes program enrollment after addressing HRSN, similar to the social needs referral workflow.

Trinity Health understands that unaddressed **HRSN may impact an individual’s ability to participate in the National DPP lifestyle change program**, and therefore social needs are always addressed prior to discussing any further programs to eliminate barriers to participation.



<sup>2</sup> Trinity Health estimated **9%** of patients with identified HRSN (all Trinity Health patients are screened for HRSN) indicate they would like assistance and connection to resources to address those needs.



## Bulk Outreach (via emails, physically mailed letters, or patient portal messages)

The entire Trinity Health system has selected diabetes prevention for a national communication campaign focus from between June 2024 through June 2028. This campaign uses tools in the HER system to encourage eligible patients at risk for type 2 diabetes to enroll in the evidence-based lifestyle change program to prevent or delay the onset of type 2 diabetes. This campaign will recur monthly throughout the next 4 years. Each month, a new intended population, meeting the campaign criteria, will be determined and informed about the intervention. Five to 10% of the eligible system-wide patient population will be notified monthly about their potential eligibility in the National DPP lifestyle change program. Patients are eligible for inclusion in a campaign once each year.

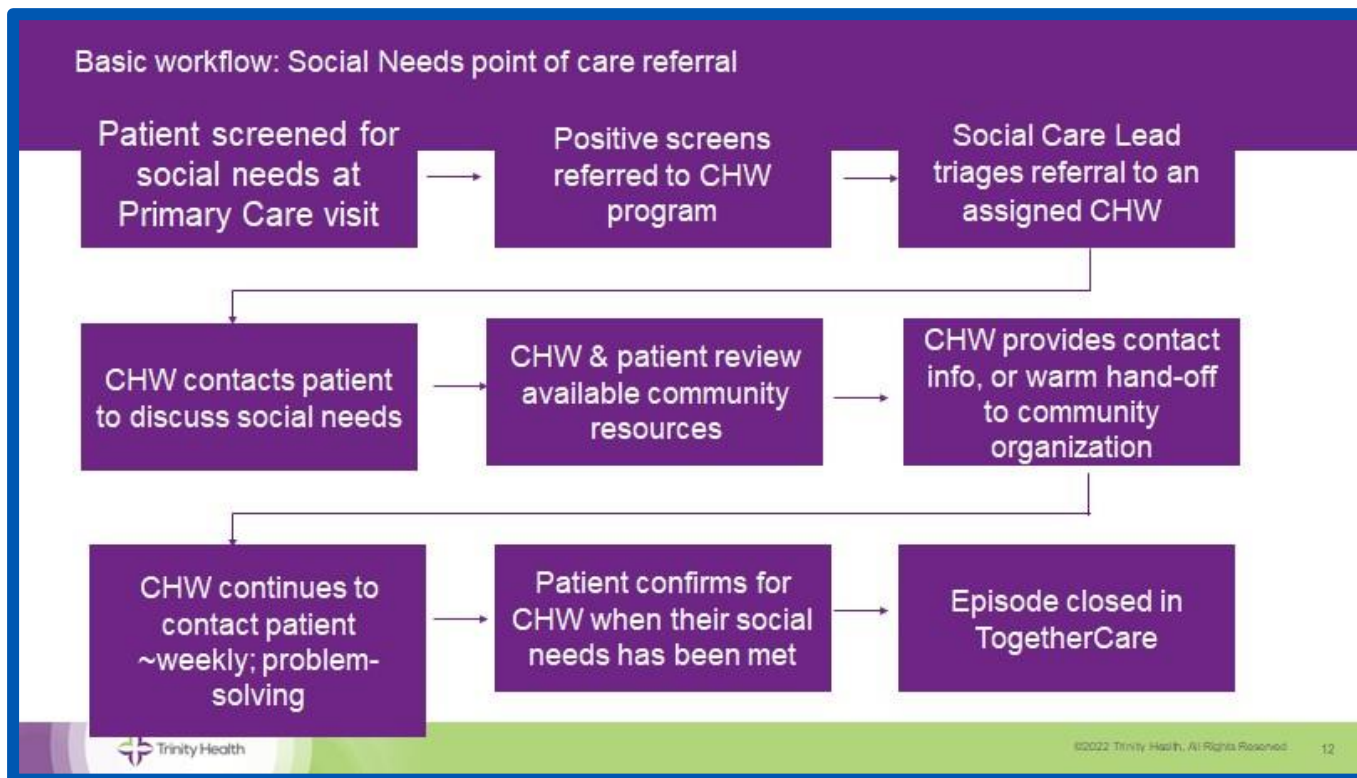
In the previous 4 years, Trinity Health conducted bulk communication process on a practice level. A month before initiating bulk outreach processes, the system office colleague(s) reach out to Trinity Health physicians and care coordinators to inform them that bulk outreach will be sent to patients who are identified as having prediabetes. Trinity Health has found that notifying providers in advance is a critical step in the process to have their support.

Providers who do not want their name included in the bulk letter outreach are given the option to opt out during the outreach period, and eligible patients who see these providers instead receive letters signed by the medical care team at Trinity Health. For Medicare eligible participants, bulk outreach also includes notice that the MDPP is a covered benefit.

After bulk outreach is conducted, eligible patients are asked to respond either through the patient portal, email, or by calling Trinity Health. Through all contact methods, CHWs, Lifestyle Coaches, and social care leads respond to potential participants to let them know which National DPP sessions are available for enrollment.

Bulk referrals occur about twice per year for Trinity Health clinics/departments, with more than 50,000 communications sent per year. However, the number of classes offered is dependent on the capacity of the delivery sites to offer the program. Letters are only sent to patients when there are cohorts available. Most responses to bulk outreach are received within one to two days of the letters being sent, although this may be longer for physical mailers, and therefore attempt to send outreach two to three weeks prior to the cohort start date. In the past, Trinity Health's bulk communication process

Figure 4. Trinity Health Social Needs Referral Workflow



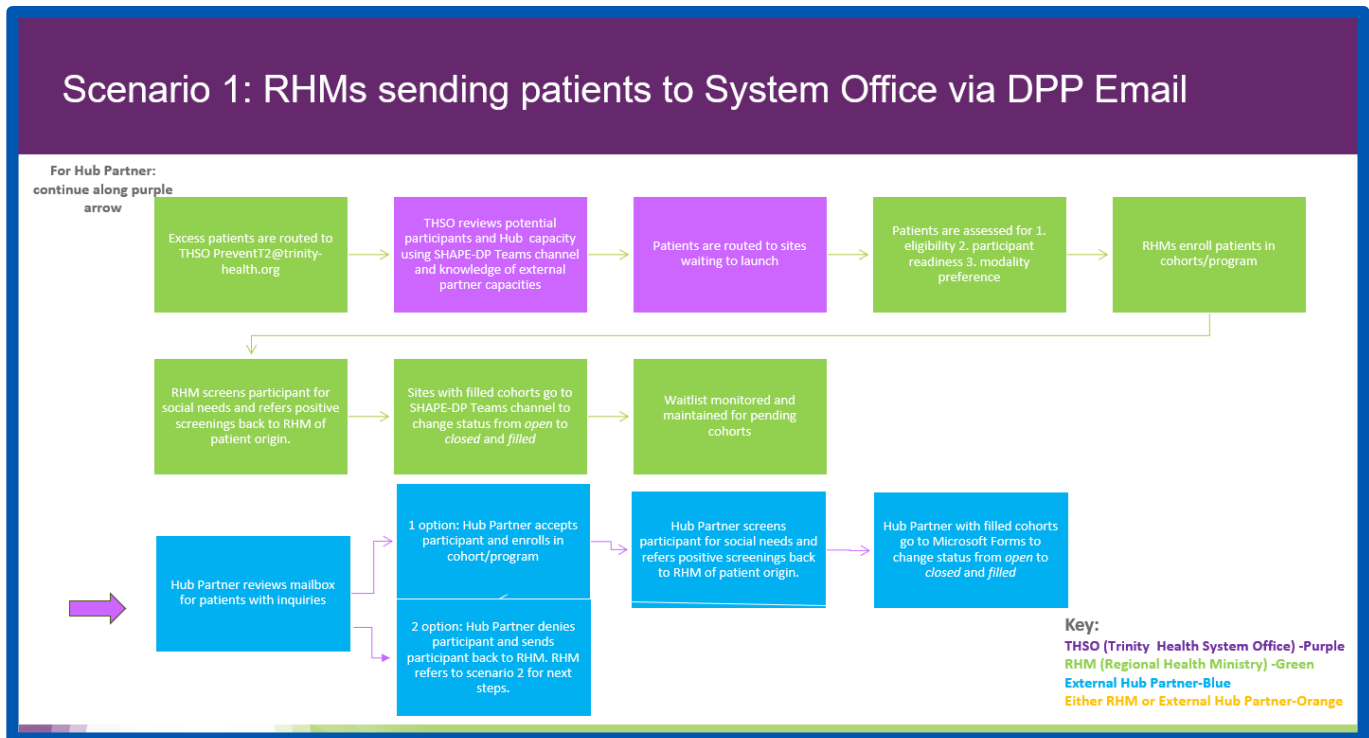
was dependent on local capacity. Due to the scale and spread of the Lifestyle Change Program model throughout the system, Trinity Health is able to place eligible participants in local, distance, and virtual programs throughout the health system and with contracted delivery partners, including community-based organizations (Figure 5).

### Staffing and Training

Trinity Health staff, Lifestyle Coaches and CHWs, are trained on presenting the program benefits and highlights, how to accept and redirect referrals to Coaches who have capacity in upcoming cohorts, and how to document the referral process. Training occurs at various points throughout the year: at

system-wide meetings, at Lifestyle Coach/CHW communities of practice, and individually on an as-needed basis. All delivery staff have a basic understanding of the National DPP, the eligibility requirements, and how to send a referral to the correct department. Converting potential participants from referrals to enrollees takes about 10 to 20% of staff time, ensuring all calls and emails are answered within 48 hours. All referrals are routed to one location, dependent on method received (e.g. Point of care referrals are monitored in the EHR, emailed referrals are in a shared mailbox, and phone referrals are routed to one phone number). This process creates standardization of the referral system.

**Figure 5.** Trinity Health CHEERS Bulk Referral Campaign Workflow



## Participant Enrollment and Education

When enrolling patients, Trinity Health is able to provide flexibility in class time and modality due to the extensive delivery network they have developed.

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*“If within a particular region, a [National DPP class] time does not work out for that potential participant, we are able to accommodate other options because of our interconnectivity as a system.”*

---

For some of the Trinity Health delivery sites, enrollment in the National DPP includes participation in a [Session 0](#), however, not all delivery sites have implemented this preliminary session. During Session 0, participants learn about the program and relevant logistical information is provided. For participants who do not attend a Session 0, preliminary information is obtained through the patient portal, emails, or through phone calls although this method is used as sparingly as it is a high administrative burden on staff to collect patient information over the phone.

During Session 1, when participants are officially considered enrolled in the program, they receive their participant identification. Participants are asked to complete the HRSN within the first three classes.

Trinity Health uses their EHR, Epic, for referral and enrollment processes across most of their delivery sites and aims to have all sites incorporated in Epic by 2026. For sites that use Epic, Trinity Health uses an external cloud-based data system. There are also some instances where they are still receiving referrals via fax machine from community partners, though these were noted as rare.

Patients who were responsive to initial outreach methods but did not enroll immediately receive additional outreach by Trinity Health. Staff attempt to contact patients three times before they are removed from the current list, though they may be contacted again during the next round of bulk outreach if they are still deemed eligible and have not asked to be removed from the outreach list.

Once a patient is successfully enrolled in the program, their treatment provider will receive a notification through the EHR. Treatment providers will also receive a midpoint and endpoint status update, including weight loss. They will also be notified in the event their patient drops from the program.

Overall, Trinity Health attributes much of their success to the high value and low burden of bulk outreach methods. Between October 1<sup>st</sup> 2023 to July 31<sup>st</sup> 2024, 331 Medicare beneficiaries contacted Trinity Health for more information about MDPP after they were notified that they were eligible, and 40 enrolled in Trinity’s MDPP.

## Key Learnings

### Trinity Health attributes their enrollment success to:

- Low cost and high value of bulk outreach
- Use of CHWs communicating with potential participants
- Extensive network of delivery sites that provide flexibility to potential participants



## Case Study 3: The YMCA of Greater Seattle

### YMCA of Greater Seattle and the National DPP

The [YMCA of Greater Seattle](#) is Seattle's founding nonprofit organization, which provides crucial programs and services to more than 232,000 people every year. With support from their national organization, Y-USA, the YMCA of Greater Seattle became a CDC-recognized supplier to deliver the National Diabetes Prevention Program (National DPP) lifestyle change program and as a Medicare Diabetes Prevention Program (MDPP) supplier.

The YMCA of Greater Seattle conducts virtual information sessions bi-monthly, where staff provide an overview of the program and have a successful past participant share their experience. They also hold provider education campaigns to create provider champions, maintain relationships with partners, and encourage additional provider referrals.

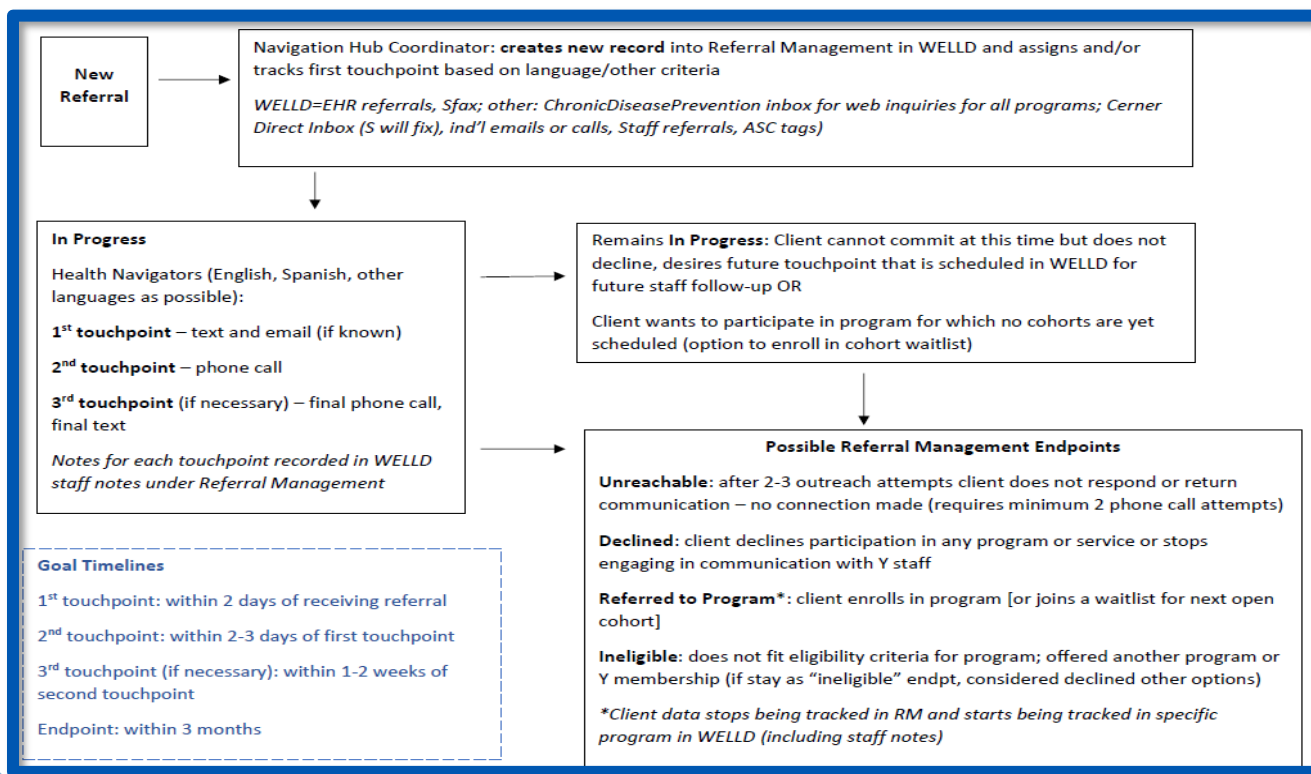
The YMCA of Greater Seattle receives over 900 National DPP referrals per year, with around 600 coming from clinical sources. The majority of clinical referrals are received from the same few

health systems in the area with whom they have developed strong, lasting partnerships with over many years. In 2023, about 24% of clinical referrals were for Medicare eligible individuals and a majority of the remaining were self-pay.

YMCA of Greater Seattle operates mixed payer cohorts, and offers in-person and distance learning classes. They attempt to launch approximately two cohorts per month, with a focus on the beginning of the year when people are more motivated to improve health and excluding July, November, and December. Fourteen cohorts were held in 2023. While Medicare-eligible participants account for about 25% of referrals, that population accounts for roughly 45% of enrollment. The YMCA estimates this may be a result of less cost and time barriers than those faced by non-MDPP participants.

The YMCA of Greater Seattle's referral workflow is outlined in Figure 6. Additional details on the referral, communication, outreach, and enrollment workflow, are provided in the sections below.

**Figure 6.** YMCA of Greater Seattle Referral Workflow



## Referral Pathways and Enrollment Process

The YMCA of Greater Seattle has developed processes to embed referral methods to the National DPP directly into partner organization electronic health records (EHR), which helps to ease burden on providers and streamline referral processes. Once the YMCA receives a referral from one of their referral partners, a YMCA Health Navigation Coordinator (trained in patient communication, public health coaching, and motivational interviewing) enters the referral into the referral management portal in [Welld Health](#), the data and technology platform they use to collect participant data and submit claims. The YMCA noted that this process can be time consuming, as referrals from healthcare providers can sometimes come in the form of continuity of care documents, which contain a lot of information about the patient's medical history which the Health Navigation Coordinator needs to scan through to confirm eligibility.

Within one day of completing the profile, the Health Navigation Coordinator sends a text to the

individual informing them that their provider has referred them to the National DPP lifestyle change program. Due to Washington text messaging restriction laws, the information is limited to a request to call or email for more information about the program. An example of an outreach message is shown (Figure 7). They hope to transition the text message process from manual to automated for more efficient outreach following referral.

Outreach sometimes contains a “bookings” link where individuals can click to schedule a call with YMCA staff. They have found that potential participants who enter via this action item are often more involved in the conversation than those who receive cold calls from the organization, ultimately leading to higher enrollment rates. Additionally, individuals can sign up for the information sessions to learn more about the program in a flexible setting.

### Figure 7: Sample MyChart Message

“Hi [Preferred Name]

This is Dr. [INSERT], and I work with [INSERT]. I'm reaching out to you because it looks like you've had an a1c (the 3-month average blood sugar) between 5.7-6.5 this year. Your doctor or care team may have talked to you about this, but this is the range for prediabetes.

I'm excited to share with you a new partnership with the YMCA for a program called the Diabetes Prevention Program. If you have Medicare insurance, it's free of charge as it's covered by insurance. See below for all the details.

Would this be of interest to you? If so, let me know and I can put in the referral. Classes start January.

If this is not the right program for you in your life situation, please feel free to ignore this message.”

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*“Being able to automate and have templates and texts and ways for the participant to be actively engaged helps us connect more because it's on [the participant's] time. They're the ones opting in for the appointment and wanting to learn more.”*

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Within one week after the initial touchpoint, staff will conduct a second outreach attempt via phone call. A third and final outreach attempt, either through a phone call or text message, is conducted within a few weeks of the first outreach, and all referrals are closed within 3 months post-referral date. Email is used throughout this process, when known, reducing the need for cold calls. All information regarding outreach attempts or communication is recorded in staff notes in Welld. Potential participants who don't respond are still eligible for future emails blasts sent by YMCA of Greater Seattle about the National DPP.

Individuals who are interested in enrolling in the program engage in a motivational interviewing conversation with YMCA staff where they receive an overview of the program. YMCA staff estimated this conversation typically takes between 20 and 30 minutes to ensure they cover the enrollment discussion checklist. Preliminary conversations also assess motivation for participating in the program,



participant health goals or support requests, current physical activity regimen, family history of diabetes, individual physical or mental limitations, and experience with evidence-based programs. For non-Medicare participants, they also review cost information for the class during this time. YMCA of Greater Seattle sends an email to each participant detailing:

- Year-long class schedule
- WellD Health information
- National DPP and YMCA health-related resources
- National DPP required health data (e.g., weight, exercise)
- Zoom information (virtual classes only)

In the event that an individual is interested in enrolling in the National DPP lifestyle change program or MDPP, but a class is not available that meets their needs, they can be added to the waitlist for priority enrollment in the next class that becomes available.

After registering for an available class, participants receive a Welcome Call from their Lifestyle Coach, who reviews any notes in WellD about the participant provided by the coordinator prior to the call. The Lifestyle Coach informs them about the [Session 0](#) information session, which is built into the program for all YMCA National DPP participants.

## Staffing and Training

Three people work on generating and managing National DPP referrals. The Program Executive for Health Integration (50% FTE) builds partnerships with leaders and referring providers in partner healthcare systems to generate e-referral pathways in their EHR and integrate Y programs into relevant clinical care pathways and workflows. The Health Navigation Coordinator completes data entry for all new referrals from all referral sources and creates a profile for the potential participant in WellD. The Health Navigation Coordinator (33% FTE) is responsible for sending the initial text and email outreach with links that allow the participant to schedule a call directly with the lead Health Navigation Supervisor. Both the Coordinator and Supervisor engage in ongoing outreach via phone/voicemail, email, and text. The Health Navigation Supervisor (75% FTE) completes more National DPP enrollments. The Health Navigation Supervisor is a trained Health & Wellness Coach and both the Coordinator and Supervisor have completed YMCA motivational interviewing (Listen First) and National DPP trainings.



## Participant Communication

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YMCA of Greater Seattle noted that the goal of the initial conversations is to build trust. While this includes discussion of readiness to participate in MDPP, it is not the only conversation topic covered during the preliminary conversations. If MDPP is not the right fit for someone's life circumstances or readiness level at the time, they are provided other program options to connect to at the YMCA. Although a uniform social determinant of health (SDOH) screening is not currently used, they hope to implement one in the future depending on WellD system capabilities. In cases where Referral Coordinators or Lifestyle Coaches identify health-related social needs (HRSN), they can refer participants to the YMCA social worker, as needed.

Medicare beneficiaries, compared to non-Medicare participants, are often more responsive to recruitment messages because there is no cost to participate in the program. Medicare beneficiaries also frequently mention a desire for peer connection and a desire to invest in their health, particularly when encouraged by their healthcare provider. Medicare-eligible participants traditionally preferred in-person classes, however since the COVID-19 pandemic, they are open to both in-person and virtual options depending on their technology literacy. As needed, YMCA staff will talk participants through the technology requirements of the National DPP lifestyle change program and guide them in using Zoom.

To obtain an understanding of program success and barriers, YMCA of Greater Seattle has implemented processes to send each National DPP participant a pre- and post-program survey to obtain feedback on their experience. Most participants who complete the survey have expressed tremendous gratitude for their Lifestyle Coaches and their experience in the National DPP lifestyle change program. YMCA of Greater Seattle also encourages participants to maintain communication with their referring provider about their enrollment and participation in the program.

From October 1<sup>st</sup> 2023 to July 31<sup>st</sup> 2024, YMCA of Greater Seattle received 180 MDPP referrals and enrolled 62 individuals in their MDPP.

## Key Learnings

### YMCA of Greater Seattle attributes their enrollment success to:

- Ability to recruit MDPP-eligible participants on the message that the program is a covered benefit
- Vast evidence-based research showing the benefit of the program leading to trust from referring providers
- System of electronic referral pathways
- Strong relationships with referral partners
- Connections to provider champions
- Passionate outreach staff who are able to connect with empathy with referred individuals



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For more information on the MDPP, visit the National Diabetes Prevention Program Coverage Toolkit [MDPP](#) pages.

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