The National Diabetes Prevention Program & Community Health Centers

A Resource Guide for Implementation and Sustainability

Prepared for ADCES by

Disclaimers

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Introduction

According to the National Diabetes Statistics Report, 2020 from the Centers for Disease Control and Prevention (CDC), approximately one in three American adults have prediabetes. Patients with prediabetes have a higher risk of multiple health conditions, including heart disease, stroke, and type 2 diabetes, when compared to the general population. Fortunately, patients are oftentimes able to delay or prevent health concerns resulting from a prediabetes diagnosis with interventions targeting the specific causes and risk factors associated with prediabetes.

One such intervention is the CDC's National Diabetes Prevention Program (National DPP). The National DPP relies on CDC-recognized organizations to offer the National DPP lifestyle change program, a structured, evidence-based, year-long lifestyle change program to prevent or delay the onset of type 2 diabetes in adults with prediabetes or at risk of developing type 2 diabetes. The program is group-based, facilitated by a trained Lifestyle Coach, and uses a CDC-approved curriculum. The curriculum supports regular interaction between the Lifestyle Coach and participants; builds peer support; and focuses on behavioral modification through healthy eating, increasing physical activity, and managing stress. The National DPP lifestyle change program is founded on the science of the Diabetes Prevention Program research study, and subsequent translation studies, which showed that making realistic behavior changes helped people with prediabetes lose 5% to 7% of their body weight and reduce their risk of developing type 2 diabetes by 58% (71% for people over 60 years old).

In 2012, the Association of Diabetes Care & Education Specialists (ADCES) began working to support providers and communities across the country with implementing the National DPP lifestyle change program through a Cooperative Agreement with the CDC. ADCES helped implement the program in over 60 locations during its first five years. In 2017, the CDC awarded ADCES a second Cooperative Agreement to support the implementation of the National DPP lifestyle change program in communities with little or no access to CDC-recognized programs. Through this second agreement, ADCES has begun focusing specific training and technical assistance efforts towards Community Health Centers.

The Community Health Center Program, which includes both Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes, works to bring community-based and patient-directed care to underserved and vulnerable populations. Additionally, Community Health Centers are serving an increasing number of patients with prediabetes, at risk of developing type 2 diabetes, or with type 2 diabetes. The high prevalence of prediabetes and type 2 diabetes risk among Community Health Center patients make FQHCs and FQHC Look-Alikes ideal partners for implementing the National DPP lifestyle change program.

However, Community Health Centers are a unique provider type that must adhere to multiple federal regulations, operate myriad federal health programs, and ensure no patient is turned away from receiving care. Community Health Centers must also follow strict guidelines on how they can use their financial resources. These factors may pose challenges for Community Health Centers in effectively and sustainably implementing the National DPP lifestyle change program.

This resource was developed in recognition of the potential challenges faced by Community Health Centers with implementing the National DPP lifestyle change program. The intent of this resource is to offer Community Health Centers a framework through which they can understand the various benefits providing the National DPP lifestyle change program may have for their patients and their health center overall.

In general, this resource:

- Contextualizes the National DPP and the National DPP lifestyle change program into a larger diabetes-related clinical framework
- Identifies a comprehensive suite of services Community Health Centers can make available to patients participating in the National DPP lifestyle change program, including both during and after the program has concluded
- Highlights the opportunities Community Health Centers may have to realize increased reimbursements and additional incentive payments across payers by implementing the National DPP lifestyle change program

This resource is intended to offer Community Health Centers a strategic and programmatic framework through which to understand how the National DPP and the National DPP lifestyle change program can benefit both patients and the health center overall. This resource **is not** intended to provide clinical guidance. Additionally, Community Health Centers should always reference their contracts, operational manuals, and other official guidance prior to implementing recommendations provided in this resource.

How to use this resource

ADCES identified four areas Community Health Centers may need support in when deciding whether and how to implement the National DPP lifestyle change program: (1) culture readiness; (2) population health management; (3) optimizing billable services associated with the National DPP; and (4) identifying opportunities to achieve incentive payments and awards. The four primary sections of this resource correlate with these areas of support as follows:

1. *Community Health Centers & the National Diabetes Prevention Program* offers a broad and high-level overview of how the National DPP can provide financial benefits to the health center and improved clinical outcomes for its patients, concluding with action steps a Community Health Center can take prior to beginning the process to apply to be a CDC-recognized organization offering the National DPP lifestyle change program (culture readiness).
2. *Operational Considerations for the National Diabetes Prevention Program* offers a framework through which they can implement the National DPP lifestyle change program within the context of a population health approach to diabetes prevention, treatment, and maintenance (population health management).
3. *Diabetes-related Services and Codes* offers a list of billable services available to Community Health Centers within a population health management model for diabetes prevention, treatment, and maintenance (optimizing billable services associated with the National DPP).
4. *The National DPP and Quality Measures: Connections to Payer Payments* offers an approach to prioritizing prediabetes- and diabetes-related services to optimize incentive payments and awards associated Clinical Quality Measures across payer contracts (identifying opportunities to achieve incentive payments and awards).

Though interconnected in concepts, each section of this resource is intended to be a standalone reference for Community Health Centers that they can leverage depending on their readiness for and maturity in implementing the National DPP lifestyle change program.

Contents

Community Health Centers & the National Diabetes Prevention Program

The National Diabetes Prevention Program (National DPP) and its structured, evidence-based, year-long lifestyle change program is an intervention Community Health Centers can implement to prevent or delay the onset of type 2 diabetes in adults with prediabetes or at risk of development type 2 diabetes. Successfully implementing the National DPP lifestyle change program provides benefits to both Community Health Centers and Community Health Center patients.

Benefits for Community Health Centers

1. **Increased Revenue:** Provide more billable services through enhanced care coordination and care management infrastructures.
2. **Workforce Development:** Expand the Lifestyle Coach role and support staff in working at the top of their license.
3. **Access to Value-Based Payments:** Receive incentive payments across payers by improving performance on up to 11 Clinical Quality Measures (CQMs).

Benefits for Community Health Center patients

1. **More Coordinated Care:** Access to an expanded care team, increasing support to effectively navigate and access primary care services.
2. **Earlier Treatment:** Early detection and treatment of comorbid conditions associated with prediabetes.
3. **Reduced risk of type 2 diabetes:** Participation in an evidence-based intervention to lose weight and reduce risk of developing type 2 diabetes.

Becoming a CDC-recognized organization that offers the National DPP lifestyle change program takes a lot of work and the Association of Diabetes Care & Education Specialists (ADCES) has resources to help through that process.

Before beginning the work of becoming a CDC-recognized organization, Community Health Centers should:

Improve data	•Build capacity to track and report on diabetes-related CQMs
Partner with Payers	•Identify payers that will reimburse or provide incentive payments for diabetes-related CQMs
Streamline patient screening	•Learn how to screen patients for prediabetes, type 2 diabetes risk, and diabetes-related comorbid conditions
Create a diabetes framework	•Develop a diabetes clinical services framework across the full spectrum of care: Prevention, Treatment, and Maintenance

Operational Considerations for the National Diabetes Prevention Program

Introduction

A key component of the National Diabetes Prevention Program (National DPP) is a structured, evidence-based, year-long lifestyle change program to prevent or delay the onset of type 2 diabetes in adults with prediabetes or at risk of developing type 2 diabetes. Implementing the National DPP lifestyle change program within a Community Health Center is a proven way to help patients of the Community Health Center with prediabetes or at risk of developing type 2 diabetes reduce their risk of developing type 2 diabetes by 58%. This reduction in risk of developing type 2 diabetes is associated with new behaviors learned through the National DPP lifestyle change program aimed at helping participants eat healthier, increase their physical activity, and more effectively manage their stress.

The National DPP lifestyle change program is an intervention for Community Health Centers to use to address one component of a comprehensive diabetes spectrum of care: Prevention. However, Community Health Centers must also think about how to support patients across the entire diabetes spectrum of care, including not only Prevention, but also Treatment and Maintenance. The *Operational Considerations for the National Diabetes Prevention Program* resource from the Association of Diabetes Care & Education Specialists (ADCES) is intended to help Community Health Centers consider how implementing the National DPP lifestyle change program can form the foundation of, or otherwise support a comprehensive diabetes spectrum of care framework for its patient population.

The uniqueness of Community Health Centers

While there are a lot of similarities among and between Community Health Centers, they by nature each operate in unique ways in order to meet the specific needs of the communities they serve. The geographic location and size of a Community Health Center influences what staff they hire and what services they provide. This means that how one Community Health Center operationalizes the National DPP lifestyle change program may not work the exact same way for another Community Health Center.[1]

There are two main factors that may determine how a Community Health Center may operationalize the National DPP lifestyle change program. The first is the Community Health Center's overall Diabetes Management Program. This program integrates services across the full spectrum of diabetes care into one comprehensive clinical framework which is used to support all Community Health Center patients with their diabetes management, including prevention and treatment of diabetes. The second is the staffing pattern of the Community Health Center, which will inform what services the Community Health Center is able to bill for across payers.

A Diabetes Management Program

Community Health Centers have experienced an estimated 30% growth in the number of their patients that have Diabetes[2], indicating an increased need to improve prevention and treatment services associated with prediabetes and diabetes. Addressing this need is so important that HRSA required all Community Health Centers to have a Diabetes Action Plan put in place between

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[1] It is important to keep in mind that while there may be some differences, Community Health Centers must all follow federal Medicare and state Medicaid guidance on implementing the National DPP and National DPP lifestyle change program.

[2] National Association of Community Health Centers. (2021). Community Health Center Chartbook 2021. Retrieved from https://www.nachc.org/research-and-data/research-fact-sheets-and-infographics/2021-community-health-center-chartbook.

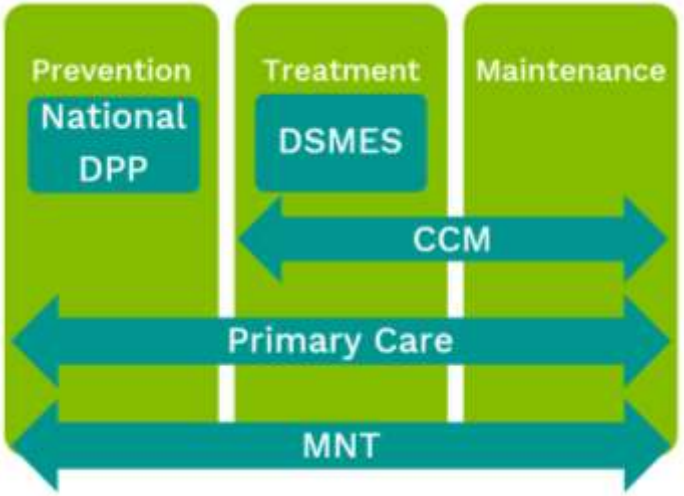
2018-2020.[3] Though no longer a HRSA requirement, continuing development and implementation of a Diabetes Action Plan can play a critical role in helping Community Health Centers address the clinical needs of their patients who have diabetes as well as continue to support patients with prediabetes or at risk for diabetes from having an onset of type 2 diabetes.

It is important to understand the critical role the National DPP lifestyle change program can have in a Community Health Center's Diabetes Action Plan. Enrolling a patient into the National DPP lifestyle change program requires that the patient's primary care provider (PCP) complete a health screen to determine whether or not the patient has prediabetes or is at high risk for prediabetes (and therefore type 2 diabetes). In that same screening, the PCP may also identify other comorbid and/or chronic conditions the patient needs help addressing.

As discussed in the *Diabetes-related Services and Codes* ADCES reference document, Lifestyle Coaches can play an important role in helping patients participating in the National DPP lifestyle change program access other clinically appropriate preventive and treatment services within the Community Health Center. This support may be provided while the patient is actively participating in the National DPP lifestyle change program, as well as serving as a transition into primary care after the patient's participation in the National DPP lifestyle change program has concluded. In facilitating these connections, Lifestyle Coaches may also help Community Health Centers improve their performance on measures associated with financial awards or quality incentive payments as discussed in the *National DPP and Quality Measures* ADCES reference document from ADCES.

While the National DPP lifestyle change program curriculum may focus on lifestyle changes specific to patients with prediabetes, Community Health Centers have the opportunity to more fully utilize a Lifestyle Coach position to further support patients along the full continuum of their diabetes care. Figure 1 demonstrates the positioning of the National DPP, and other services related to diabetes and comorbid conditions, along the diabetes spectrum of care.

Figure 1. Services, including the National DPP, along the diabetes spectrum of care.



Staffing matters

In addition to understanding what services can most effectively support patients within the diabetes spectrum of care, Community Health Centers must also know what staff are able to and/or required in order to bill for certain services. Table 1 provides a general overview of staff requirements associated with four priority types of services within the diabetes spectrum of care: the National Diabetes Prevention Program, Diabetes Self-Management Education Services (DSMES), Medical Nutrition Therapy (MNT), and Chronic Care Management (CCM).

[3] Health Resources & Services Administration. (March 2021). Diabetes and Health Centers. Retrieved from https://bphc.hrsa.gov/qualityimprovement/clinicalquality/diabetes.html.

Table 1. Staff requirements for four Diabetes-related services for five select Medicaid programs and Medicare.

Program	Medicaid					Medicare
	AK	IL	NJ	TX	WA	All States
National DPP	CDC Trained Lifestyle Coach	CDC Trained Lifestyle Coach	CDC Trained Lifestyle Coach	CDC Trained Lifestyle Coach	CDC Trained Lifestyle Coach	CDC Trained Lifestyle Coach
DSMES	Licensed Professional with knowledge in Diabetes	Certified Diabetes Care & Education Specialist	Clinical Nurse Specialist Clinical Social Worker Nurse Practitioner Physician Physician Assistant Psychologist, Clinical Registered Dietitian/Nutrition Professional	Clinical Nurse Specialist Clinical Social Worker Nurse Practitioner Physician Physician Assistant Psychologist, Clinical Registered Dietitian/Nutrition Professional	Clinical Nurse Specialist Clinical Social Worker Nurse Practitioner Physician Physician Assistant Psychologist, Clinical Registered Dietitian/Nutrition Professional	Clinical Nurse Specialist Clinical Social Worker Nurse Practitioner Physician Physician Assistant Psychologist, Clinical Registered Dietitian/Nutrition Professional
MNT	Registered Dietitian	Registered Dietitian	Registered Dietitian Certified Nutritionist	Registered Dietitian	Registered Dietitian	Registered Dietitian Registered Dietitian Nutritionist
CCM						Any staff under the supervision of a Medical Provider (MD, DO, PA, NP)

While Table 1 provides a general overview of staff requirements, Community Health Centers should review their payer contracts, billing guidelines, and other related collateral to confirm staff requirements for the services listed. For example: most state Medicaid programs follow Medicare guidelines regarding the provision of DSMES and MNT services. Additionally, DSMES requires a billing sponsor who is a Medicare Part B supplier with a National Provider Identifier number (NPI #); while Community Health Centers, generally, already meet this requirement, this should be confirmed with health center leadership.

Next Steps and Resources

Community Health Centers may consider establishing a Diabetes Management Program that incorporates the full spectrum of diabetes care, including Prevention, Treatment, and Maintenance. The National DPP lifestyle change program can play a vital step in implementing such a program, as the screening process for participation provides opportunity for Community Health Centers to stratify patients by their diabetes status and ensure they receive clinically appropriate preventive or treatment services. Lifestyle Coaches can play a vital role in supporting patients participating in the National DPP lifestyle change program in accessing these clinically-appropriate services. Community Health Centers that are interested in implementing a Diabetes Management Program and building the capacity of Lifestyle Coaches to support the program can consider taking the following steps:

1. Collaborate with Clinical and Operational leadership to identify the full suite of Diabetes-related services the Community Health Center is interested in and capability of offering.

2. Establish clinical guidelines and decision support services to aid Community Health Center staff in effectively and appropriately navigating patients participating in the National DPP lifestyle change program through the Diabetes Management Program.

3. Train Lifestyle Coaches in care coordination practices so they are able to assist patients participating in the National DPP lifestyle change program with accessing clinically appropriate services.

Diabetes-related Services and Codes

Introduction

A primary objective of the National Diabetes Prevention Program (National DPP) lifestyle change program is to support patients with prediabetes with making lifestyle changes that may prevent or delay the onset of type 2 diabetes through the delivery of a curriculum approved by the Centers for Disease Control and Prevention (CDC). The curriculum focuses on behavior modification through healthy eating, increasing physical activity, and managing stress. Patients participating in the National DPP lifestyle change program may reduce their risk of developing Type 2 Diabetes by 58%[4] as a result of these behavior modifications.

In addition to lifestyle changes, patients with prediabetes can also prevent or delay the onset of type 2 diabetes by remaining regularly engaged in primary care and preventive services. These services can support patients in adhering to lifestyle changes learned through the National DPP lifestyle change program as well as help in managing other health conditions the patient may have. Engagement in primary care services is also essential should a patient progress to a diabetes diagnosis. Primary care can support patients in managing, and therefore reducing further health complications as a result of, a diabetes diagnosis. Community Health Centers who facilitate a National DPP lifestyle change program are uniquely positioned to help patients access primary care and preventive services to:

- prevent or delay the onset of type 2 diabetes
- identify and treat comorbid conditions
- manage health needs resulting from the progression to a diabetes diagnosis

The *Diabetes-related Services and Codes* resource from the Association of Diabetes Care & Education Specialists (ADCES) is intended to help Community Health Centers understand how to use the National DPP lifestyle change program to help patients access primary care and preventive services to effectively manage their health across the diabetes spectrum of care.

Prediabetes is complicated

A person with prediabetes has a blood sugar level higher than normal, but not yet high enough to be considered diabetes.[5] Patients with prediabetes may already be experiencing long-term damage to their bodies, especially to their heart, blood vessels, and kidney, that is associated with a diabetes diagnosis.[6] Community Health Centers that offer the National DPP lifestyle change program provide an opportunity for their patients to learn how to effectively make lifestyle changes that can prevent or delay the onset of type 2 diabetes; this, in turn, reduces the negative health outcomes a patient may experience as a result of having prediabetes.

Oftentimes, however, patients with prediabetes also have other health conditions (known as, “comorbid conditions”) that can create challenges to making and adhering to lifestyle changes learned through the National DPP lifestyle change program (see Figure 2). Unfortunately, patients are not always aware that they have a comorbid condition.

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[4] Centers for Disease Control and Prevention. (August 3, 2021). Research Behind the National DPP. Retrieved from https://www.cdc.gov/diabetes/prevention/research-behind-ndpp.htm.

[5] Centers for Disease Control and Prevention. (June 11, 2020). The Surprising Truth About Prediabetes. Retrieved from https://www.cdc.gov/diabetes/library/features/truth-about-prediabetes.html

[6] Mayo Clinic. (2021). Prediabetes. Retrieved from https://www.mayoclinic.org/diseases-conditions/prediabetes/symptoms-causes/syc-20355278

Figure 2. Examples of health conditions comorbid with prediabetes.

Comorbidity

Patients with prediabetes and at risk for diabetes oftentimes have other comorbid conditions, such as:

- High blood pressure
- Kidney dysfunction
- Behavioral Health conditions (e.g., Anxiety, Depression)
- Obesity

The health issues that arise from having prediabetes, along with those associated with comorbid conditions, make prediabetes a complicated health condition to manage for patients. Sometimes the behavior changes patients learn about through the National DPP lifestyle change program are not enough to help them effectively address the health concerns associated with having prediabetes. For some patients, they also need ongoing primary care services to help address and manage their health conditions.

Primary care services are also important for those patients who participate in the National DPP lifestyle change program and eventually progress to a diabetes diagnosis. For patients who do have an onset of type 2 diabetes, engagement in primary care is imperative to help ensure they receive the full suite of care and services necessary to manage the health issues associated with type 2 diabetes (see Figure 3).

Figure 3. Examples of primary care services necessary to treat patients with diabetes.

Diabetes progression

Some patients, despite participation in the National DPP lifestyle change program, progress to a diabetes diagnosis. This may be the result of biological factors or Social Determinants of Health[7] that impact a patient's ability to make lifestyle changes. A progression to a Diabetes diagnosis may result in a patient's need for:

- Diabetes Self-Management Education and Support
- Diabetic Foot, Diabetic Eye, or Diabetic Dental exams
- Routine Hemoglobin A1c and Microalbumin testing

[7] Centers for Disease Control and Prevention. (March 10, 2021). Social Determinants of Health: Know What Affects Health. Retrieved from https://www.cdc.gov/socialdeterminants/about.html

The National DPP can support the full spectrum of diabetes care

Because of the health issues associated with prediabetes, the varying comorbid conditions that may accompany a prediabetes diagnosis, and the health issues that may result from the onset of type 2 diabetes, patients who participate in a Community Health Center's National DPP lifestyle change program can receive significant benefit from being supported by Lifestyle Coaches in being connected to and remaining engaged in primary care services. The National DPP lifestyle change program is a tool Community Health Centers can use in providing support to patients participating in the National DPP lifestyle change program in enhancing their utilization of primary care services (see Figure 4).

Figure 4. Sample list of potential primary care services across the spectrum of care for patients participating in a National DPP lifestyle change program.

Prediabetes	•**Potential services**: Blood glucose testing, Blood pressure and cholesterol checks, nutrition counseling, behavioral counseling for obesity
Comorbid Conditions	•**Potential services**: Medical Nutrition Therapy, Blood pressure and cholesterol checks, behavioral health services
Progression to type 2 diabetes	•**Potential services**: Diabetic-related exams (e.g., Foot, Eye, Dental), Diabetes Self-Management Education, Microalbumin testing

Expanding the number and type of services received by patients who participate in the National DPP lifestyle change program:

- identifies emerging health conditions for the patient
- allows for earlier intervention to reduce the risk of disease or condition progression
- supports patients in managing chronic conditions

Additionally, providing a more comprehensive suite of clinically appropriate services to patients allows for Community Health Centers to increase the amount of money they receive from payers. First, patients with chronic health conditions who are regularly engaged in primary care are likely to increase the number of times they are seen by and the number of services they receive from a Community Health Center. As a result, the Community Health Center is able to increase the number of Encounters it is able to bill for, and therefore receive more reimbursements from payers. Second, by helping patients better manage their health, Community Health Centers are more likely to be eligible for different financial incentives and awards provided by payers, including Medicaid, Medicare, and HRSA. (For more information on how the National DPP connects to payer payments, please see *The National DPP and Quality Measures: Connections to Payer Payments* resource from ADCES.)

How could this work?

Lifestyle Coaches running the National DPP lifestyle change program in Community Health Centers can have a critical role in ensuring their patients are successfully linked to clinically appropriate services.[8]

Prediabetes

A provider will have already diagnosed patients participating in a National DPP lifestyle change program with prediabetes. As part of their and facilitation of the National DPP lifestyle change program, Lifestyle Coaches may consider:

- Completing a chart review for each patient to identify which prediabetes-related service is needed and encouraging patients to schedule appointments for said services during reminder calls for National DPP lifestyle change program sessions
- Participating in clinical Huddles to identify which patient(s) are in need of prediabetes-related services
- Reviewing in each National DPP lifestyle change program session the list of prediabetes-related services patients should be receiving and offering to support them in scheduling appointments

Comorbid Conditions

Patients are not always aware of their health status as they may not be able to regularly engage in preventive and/or primary care services. As part of their role in supporting patients participating in the National DPP lifestyle change program with accessing clinically appropriate primary care services, Lifestyle Coaches may consider:

- Participating in clinical Huddles to identify which patients have comorbid conditions and are in need of preventive or primary care services
- Facilitating monthly Case Conference sessions about patients with the patients' primary care provider(s)
- Encouraging patients to schedule needed preventive and primary care services during reminder calls for National DPP lifestyle change program sessions

Diabetes

Some patients will progress to a diabetes diagnosis, and will need additional treatment services to reduce negative health outcomes associated with type 2 diabetes. As part of their role in facilitating transitions to diabetes treatment services for patients who progress to a diabetes diagnosis, Lifestyle Coaches may consider:

- Creating a care transition plan to diabetes treatment services
- Facilitating a warm handoff to a Community Health Center Care Manager
- Helping to enroll patients in Chronic Care Management services

[8] All decisions regarding services made available to patients participating in a National DPP lifestyle change program need to be made in consultation with and under the direction of clinically-trained Community Health Center staff who are informed and involved with the patient's health.

Next Steps and Resources

Community Health Centers are uniquely positioned to offer patients participating in the National DPP lifestyle change program early detection, preventive, and treatment services associated with prediabetes, comorbid conditions, and diabetes. Lifestyle Coaches can play a vital role in supporting patients in accessing clinically appropriate services. Community Health Centers that are interested in building capacity of Lifestyle Coaches to support the comprehensive care of patients participating in the National DPP lifestyle change program can consider taking the following steps:

1. Train Lifestyle Coaches to become familiar with the conditions and services associated with the full spectrum of diabetes care (see Table 2 and Table 3).

2. Support primary care providers with integrating Lifestyle Coaches into Huddles, Case Conferences, and other patient review opportunities.

3. Create clinical workflows that support Lifestyle Coaches in transitioning patients participating in the National DPP lifestyle change program between members of their care team, including primary care providers, behavioral health specialists and care managers.

4. Train Lifestyle Coaches to identify and enroll eligible patients who are participating in the National DPP lifestyle change program into Chronic Care Management services (see Table 4).

Table 2. Sample services, diagnosis codes, required staff and procedure codes for prediabetes services.

Prediabetes Services						
Clinical Service	**Medical Nutrition Therapy (MNT)**	**Hemoglobin A1c Testing**	**Cholesterol Check**	**Blood Pressure Check**	**Eye Exam**	**Intensive Behavioral Health Counseling for Obesity**
Diagnosis Codes	E66- (Obesity) R73.10 (Pre-Diabetes)	R73.09 (Pre-Diabetes)	R73.10 (Pre-Diabetes)	I10-I16 (Hypertension) R73.10 (Pre-Diabetes)	Z01.00 (Encounter for examination of eyes and vision without abnormal findings)	E66- (Obesity)
Required Staff	Registered Dietitian	Nurse, Medical Office Assistance (Provider Evaluation)	Nurse, Medical Office Assistance (Provider Evaluation)	Nurse, Medical Office Assistance (Provider Evaluation)	Nurse, Medical Office Assistance (Provider Evaluation)	Behaviorist (i.e. LCSW)
CPT Codes	97802 (Individual Initial) 97803 (Individual Subsequent) 97804 (Group)	83036	82465	99211 (Nurse Visit)	99202 to 99205 (New Pt) 99212 to 99215 (Established Pt)	98032 (Psychotherapy 30 Min with Pt) 98034 (Psychotherapy 45 Min with Pt) 98037 (Psychotherapy 60 Min with Pt)

Table 3. Sample services, diagnosis codes, required staff and procedure codes for diabetes services.

Diabetes Services						
Clinical Service	**Dental Exam**	**Diabetes Self-Management and Education Services**	**Diabetic Retinal Eye Exam**	**Diabetic Foot Exam**	**Hemoglobin A1c Testing**	**Microalbumin Testing**
Diagnosis Codes	E11.630 (Type 2 Diabetes with Periodontal Disease)	E08-E13 (Diabetes Type 2)	E08-E13 (Diabetes Type 2) E11.319 (Type 2 Diabetes with unspecified diabetic retinopathy w/o macular edema)	E08-E13 (Diabetes Type 2)	E08-E13 (Diabetes Type 2)	E11.22 (Diabetes 2 with Kidney Complications)
Required Staff	Dentist	Clinical Nurse Specialist Clinical Social Worker Nurse Practitioner Physician Physician Assistant Psychologist, Clinical Registered Dietitian/Nutrition Professional	Ophthalmologist	Medical Doctor, Doctor of Osteopathy, Advanced Practice Provider	Nurse, Medical Office Assistance (Provider Evaluation)	Nurse, Medical Office Assistance

CPT Codes	D0150 (Comprehensive Oral Eval)	G0108 (Individual) G0109 (Group)	2022F (Dilated Retinal Eye Exam)	G0245 (Initial) G0246 (Subsequent) G0247 (Routine Care)	83036	82043 82570

Table 4. Diagnosis codes, required staff and procedure codes for Medicare Chronic Care Management services.

Clinical Service	**Medicare Chronic Care Management**
Diagnosis Code	Eligible ICD from CMS approved list of Chronic Conditions[9]
Required Staff	Licensed or Unlicensed Staff under the Supervision of the Medical Provider (MD, DO, PA, NP)
CPT Code(s)	G0511

Table 2, Table 3 and Table 4 explore varying services associated with prediabetes and diabetes care, along with the diagnosis codes, and required staff and procedure codes associated with each service. This list is not exhaustive of all services than can be rendered. The implementation of any clinical guidelines and pathways should be approved by the Community Health Center's appropriate governance and/or clinical structure(s).

[9] Chronic Conditions Data Warehouse. (2021). Condition Categories. Retrieved from https://www2.ccwdata.org/web/guest/condition-categories

The National DPP and Quality Measures: Connections to Payer Payments

Introduction

Most conversations about the National Diabetes Prevention Program (National DPP) focus on the benefits received by patients who participate in the National DPP lifestyle change program. After all, patients who participate in a National DPP lifestyle change program may reduce their risk of developing type 2 diabetes by 58%.[10] These benefits are important to remember: patient care is at the heart of the work of Community Health Centers.

In addition to the improving clinical outcomes for patients, a National DPP can also provide financial benefits for Community Health Centers. By leveraging the infrastructure of a National DPP lifestyle change program, Community Health Centers can work to improve their performance on Clinical Quality Measures (CQMs). For many payers (including Medicaid, Medicare, and HRSA), improving performance on CQMs make Community Health Centers eligible for financial incentives such as quality payments, quality improvement awards and increased reimbursement rates. *The National DPP and Quality Measures: Connections to Payer Payments* resource from the Association of Diabetes Care & Education Specialists (ADCES) is intended to help Community Health Centers understand how implementing a National DPP lifestyle change program can support them in improving their financial health through achieving a higher quality of care.

The financial benefit of the National DPP

Implementing the National DPP lifestyle change program can benefit a Community Health Center by providing an infrastructure through which patients can receive comprehensive preventive and primary care services.[11] Offering clinically appropriate services to patients who participate in a National DPP lifestyle change program can, in turn, help Community Health Centers improve their performance on CQMs, such as those identified by the Healthcare Effectiveness Data and Information Set (HEDIS). HRSA tracks many HEDIS measures, and offers Quality Awards[12] for Community Health Centers that show improvement on their performance for some CQMs. As a result, using the National DPP to provide more comprehensive care for patients can result in a Community Health Center receiving a financial award (see Figure 5).

Figure 5. Relationship between patient care and quality awards.

[10] Centers for Disease Control and Prevention. (August 3, 2021). Research Behind the National DPP. Retrieved from https://www.cdc.gov/diabetes/prevention/research-behind-ndpp.htm.

[11] For more information on how a DPP can help to provide more comprehensive preventive and primary care services to patients, please see the ADCES reference document: *Diabetes-related Services and Codes*.

[12] Health Resources & Services Administration. (September 2020). Quality Improvement Awards. Retrieved from https://bphc.hrsa.gov/program-opportunities/quality

Look at Other Payers

Looking at financial awards provided by HRSA related to CQMs is a good first step for Community Health Centers. After all, a lot of what Community Health Centers do is guided or directed by HRSA. But other payers also provide opportunities for Community Health Centers to receive financial (usually called "incentive") payments for meeting certain CQMs:

Medicaid

Almost one-half (48.52%[13]) of patients seen at Community Health Centers are covered by Medicaid, making Medicaid an important payer. Most state Medicaid programs offer incentive payments to providers, including Community Health Centers, for meeting benchmarks set for CQMs. State Medicaid programs may also use performance on CQMs to determine any shared savings the Community Health Center is eligible for under shared savings contracts.

To best understand what CQM-related incentive payments are available through their state Medicaid program, Community Health Centers can:

- Look at their Medicaid contract, either with the state administrator or a Medicaid Managed Care plan
- Review their state Medicaid Quality Plan

Most state Medicaid programs use a similar set of CQMs, including those related to diabetes prevention and treatment. A sample list of common Medicaid CQMs is provided in Table 1.

Medicare

Community Health Centers saw a 61% growth[14] in the number of Medicare-eligible patients seen between 2013 and 2018. This makes individuals eligible for Medicare the fastest growing population among Community Health Center patients.

There are two primary ways in which Community Health Centers can receive incentive payments through Medicare:

1. Medicare Shared Savings ACOs: Many Community Health Centers are joining Medicare Shared Savings ACOs, where incentive payments are based partly on how well the ACO performs on certain CQMs.
2. Medicare Advantage Plans: Medicare Advantage (MA) plans cover Medicare-related services and are offered by Commercial plans. Incentives are provided for meeting CQMs individually, and some Community Health Centers may receive higher overall reimbursement rates for performing well on CQMs generally.

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[13] Kaiser Family Foundation. (2021). Community Health Center Patients by Payer Source. Retrieved from https://www.kff.org/other/state-indicator/chc-patients-by-payer-source/

[14] National Association of Community Health Centers. (2020). Community Health Center Chartbook 2020. Retrieved from https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf

What about commercial payers?

It is not common for commercial (or "private") insurance providers to offer incentive payments for CQMs. This may change, however. Over time, commercial payers tend to offer incentives to providers in alignment with HRSA and CMS. As such, Community Health Centers should pay attention to any changes in their commercial payer contracts to identify new and emerging opportunities to receive incentive payments based on CQM performance.

Community Health Centers should continue to focus on providing clinically appropriate services across the full spectrum of diabetes care for their patients with commercial insurance, however, as doing so may increase the number of billable services or Encounters (see the ADCES reference document: *Diabetes-related Services and Codes* for more information).

Next Steps and Resources

Implementing a National DPP lifestyle change program within a Community Health Center provides many benefits for both the Community Health Center and its patients. One important way to recognize these benefits is by focusing Community Health Center efforts on ensuring patients who participate in a National DPP lifestyle change program receive preventive and treatment primary care services associated with payer incentive programs. Community Health Centers that are interested in building capacity to address performance on CQMs can consider taking the following steps:

1. Incorporate CQMs associated with the full spectrum of Diabetes care across all payers (see Table 1) into the Community Health Center's Quality Improvement/Quality Assurance Plan.

2. Train Lifestyle Coaches on tracking Community Health Center performance against priority CQMs.

3. Continue to implement a HRSA Diabetes Action Plan[15] and include tracking of Diabetes-related CQMs as a primary action step.

4. Consider joining local, regional, or national networks of Community Health Centers that may bolster the Community Health Center's ability to collect and analyze clinical data. Such networks include Health Center Controlled Networks, Independent Practice Associations, and Accountable Care Organizations.

[15] Health Resources & Services Administration. (March 2021). Diabetes and Health Centers. Retrieved from https://bphc.hrsa.gov/qualityimprovement/clinicalquality/diabetes.html

Table 5. Crosswalk of quality metrics, by payer, associated with the full spectrum of Diabetes care.

Quality Metric	Payer	Medicare / MA	Medicaid	HRSA	Measure Steward	NQF	CMS/HEDIS	NCQA
Comprehensive Diabetes Care: Blood Pressure Control		x	x			x	x	x
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed		x	x			x	x	x
Comprehensive Diabetes Care: Hemoglobin A1C (HbA1c) Poor Control (>9.0%)		x	x	x		x	x	x
Comprehensive Diabetes Care: Medical Attention for Nephropathy		x	x			x	x	x
Controlling High Blood Pressure: <140/90 (non-Diabetic specific)		x	x	x		x	x	x
Diabetes Short-Term Complications Admission Rate			x					
Hemoglobin A1c (HbA1c) testing		x	x				x	
HbA1c Control: <7.0% for Selected Population		x	x				x	x
HbA1c Control: <8.0%		x	x				x	x
Persistence of Beta-Blocker Treatment After a Heart Attack		x	x					
Statin Therapy for patients with Diabetes		x	x	x			x	x

This table explores CQMs commonly incentivized by various payers, including HRSA, Medicare, and Medicaid. The table includes the specific measure, the payer type(s) that often include the measure in incentive programs, and the measure steward. This list is not exhaustive of all measures, and Community Health Centers should review their payment contracts to identify which specific measures are part of any incentive program(s). The implementation of any clinical guidelines and pathways associated with the above CQMs should be approved by the Community Health Center's appropriate governance and/or clinical structure(s).

About the National Diabetes Prevention Program

The National Diabetes Prevention Program (National DPP) is a partnership of public and private organizations working together to build a nationwide delivery system for a lifestyle change program proven to prevent or delay onset of type 2 diabetes in adults with prediabetes. The National DPP provides a framework for type 2 diabetes prevention efforts in the U.S. founded on four key pillars: 1) a trained workforce of Lifestyle Coaches; 2) national quality standards supported by the CDC Diabetes Prevention Recognition Program; 3) a network of program delivery organizations sustained through coverage; and 4) participant referral and engagement. These pillars link closely to the CDC's strategy goals for the National DPP: increase the supply of quality programs; increase demand for the program among people at risk; increase referrals from health care providers; and increase coverage among public and private payers.

About the Association of Diabetes Care & Education Specialists

The Association of Diabetes Care & Education Specialists (ADCES) is an interdisciplinary professional membership organization at the forefront for better care. A community of collaborators, advisors and supporters, the organization translates evidence-based research into accessible resources so members can stay on top of best practices and propel the specialty forward. With a shared purpose and a singular focus, ADCES features an integrated care team that lowers the cost of care, improves experiences and helps its members lead so better outcomes follow.