Best Practices Guide

Recruiting, Enrolling, and Retaining Minnesotans with Greatest Need in the National Diabetes Prevention Program

DEPARTMENT OF HEALTH

Best Practices Guide: Recruiting, Enrolling, and Retaining Minnesotans with Greatest Need in the National Diabetes Prevention Program

Prepared for the Minnesota Department of Health

by the National Association of Chronic Disease Directors (NACDD) and Leavitt Partners, LLC.

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"Diabetes is a serious health concern for many Minnesotans, and those with lower incomes are particularly at risk. The roots of this problem go beyond the individual to include a host of community factors. That is why we all need to work together to improve the health and prosperity of our communities and ensure at-risk Minnesotans can access valuable support services like the National Diabetes Prevention Program."

Jan Malcolm, Minnesota Department of Health Commissioner

Introduction

Nationally, there has been a movement toward Medicaid coverage of the National Diabetes Prevention Program (National DPP) lifestyle change program, a year-long, evidence-based intervention developed by the Centers for Disease Control and Prevention (CDC). People with prediabetes who take part in this structured lifestyle change program can reduce their risk of developing type 2 diabetes by up to 58% (71% for people over 60 years old).[1] While there is substantial research available to support the evidence base for the program, it was determined that a collection of researched best practices, and examples of Medicaid member engagement, would help improve health outcomes among those participants with the highest need in Minnesota.

Diabetes and Prediabetes in Minnesota

In 2017, 7.8% of adult Minnesotans reported having been diagnosed with either type 1 or type 2 diabetes, and it is estimated that an additional 1 in 10 Minnesotans are not aware they have diabetes.[2]

While coverage for the National DPP lifestyle change program exists in Minnesota Medicaid, CDC-recognized organizations have had difficulty recruiting, enrolling, and retaining Medicaid eligible participants, despite this being one of the highest need populations.

Key Definitions:

Recruitment: The outreach conducted to eligible participants to educate them about the program, acquire their consent to participate in the program, and schedule them for a year-long series of sessions.

Enrollment: An eligible individual has attended his or her first session of a series (the "zero session" cannot be counted as the first session).

Retention: The process of encouraging participants to engage in and complete the required elements of the National DPP lifestyle change program.

On average, 95% of diabetes cases are type 2 diabetes, and type 2 diabetes may be prevented or delayed through lifestyle modification.[3]

The total direct and indirect costs of diabetes in Minnesota was estimated at $4.4 billion in 2012.[4] That same year, 8.4% of adult Minnesotans said their health care team told them they had prediabetes, but nationally it is estimated that one in three adults have prediabetes. At this rate, it is possible that 1.5 million Minnesotans are at a higher risk for developing type 2 diabetes, many of whom may be unaware of their risk.[5] Similarly, in Minnesota Medicaid, there are close to 600,000 adult members, potentially indicating close to 200,000 who are at higher risk for developing type 2 diabetes and who would be eligible for the National DPP lifestyle change program.[6, 7]

History of the National DPP Lifestyle Change Program Medicaid Benefit in Minnesota

In Minnesota, Medicaid is also known as Medical Assistance, and includes MinnesotaCare, and all other MN Health Care Programs. Minnesota was an early adopter of the National DPP lifestyle change program among state Medicaid agencies, offering the program as a covered benefit for Medicaid members beginning in January 2016.[8] Prior to the achievement of Medicaid coverage in the state, both the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) participated in the 2010 – 2015 Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grant administered by the Centers for Medicare and Medicaid Services Innovation Center (CMMI). Ten states (California, Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, New York, Texas, and Wisconsin) were awarded demonstration grants to implement chronic disease prevention approaches for their Medicaid beneficiaries to test the use of incentives to encourage behavior change. Four of the ten states—Minnesota, Montana, Nevada, and New York—used a subset of the grant dollars to fund incentives specifically for the National DPP lifestyle change program. Minnesota DHS and MDH co-led the "We Can Prevent Diabetes Minnesota" program with the following goals:

- To determine how financial incentives affect Medicaid beneficiaries' weight loss and attendance in the National DPP lifestyle change program
- Learn how to successfully recruit and retain Medicaid beneficiaries in the program

In 2012, Minnesota developed a collective impact approach to addressing type 2 diabetes within ten years, the Minnesota Diabetes Collective Impact Initiative, through a mandate from the state legislature. This led to a decision that coverage for the program should be achieved first for state and public employees and Medicaid members, paving the way for Minnesota's State Employee Group Insurance Program (SEGIP) to cover the program beginning spring of 2015 and Minnesota Medicaid coverage beginning January of 2016.

While coverage for the National DPP lifestyle change program exists in Minnesota Medicaid, CDC-recognized organizations have had difficulty recruiting, enrolling, and retaining Medicaid eligible participants, despite this being one of the highest need populations.

How to Use this Guide

This guide is intended for National DPP lifestyle coaches and program coordinators who serve low-income, Medicaid-eligible participants and individuals with the greatest need for the National DPP lifestyle change program. The collection of best practices contained in this guide can assist you with recruiting, enrolling, and retaining Minnesotans with the greatest need in the National DPP lifestyle change program by identifying and addressing common barriers to entry and program completion.

Creating an inclusive environment for National DPP lifestyle change program participants and addressing health disparities are also important parts of the recruitment, enrollment, and retention processes. The best practices outlined in this guide may help program administrators, lifestyle coaches, and other key stakeholders address the health equity gap in Minnesota through better engagement of eligible Medicaid members in the program. While the focus of this guide is those enrolled in Medicaid, the principles and practices discussed herein apply broadly and may benefit recruitment, enrollment, and retention efforts for all eligible participants.

Best Practices

Unless otherwise noted, the best practices and quotes below are based on findings in the MDH report entitled "Medicaid Members and the National DPP: Key Findings and Recommendations from Interviews with National DPP Providers in Minnesota"[10] or supplemental experience from the National Association of Chronic Disease Directors (NACDD) and Leavitt Partners.

Best Practices

Recruitment & Enrollment

Identify Priority Populations

Description: Identify which populations have the greatest need for the National DPP lifestyle change program in your area, which could include identifying underserved populations based on gender, age, race, income, Medicaid eligibility, cultural community, and geography (e.g., rural locations, locations with limited access to the program, etc.).

Rationale: Currently, National DPP lifestyle change program participants in Minnesota are commonly older, white, and female. However, there are individuals from all demographics who are at high risk for development of type 2 diabetes and would benefit from participating in the National DPP lifestyle change program. Lifestyle coaches and program coordinators interested in extending the reach of the National DPP lifestyle change program can identify priority populations and focus outreach, enrollment, and retention efforts on reaching those populations.

There are multiple approaches to selecting a priority population, which could include consideration of the population's gender, age, race, income, Medicaid eligibility, cultural community, and geography. One approach is to target populations with a higher prevalence of prediabetes and/or type 2 diabetes. A recent report from the CDC states that more men have prediabetes than women and that communities of color and low-income populations have a higher risk for type 2 diabetes.[11, 12] Another approach is to target populations that currently have less access to the program or would benefit from cultural adaptations of the program. For example, there are many cultural communities in Minnesota, such as the Hmong, Somali, Spanish, Oromo, and Russian speaking communities, that would benefit from program enhancements to tailor the program to that group (more information about delivering the program using program enhancements can be found in the "Meet Unique Participant Needs" best practice in the "Retention" section of this guide). Another example would be focusing on a rural population

that currently does not have in-person access to the program due to the remote location (for information about online and distance learning options for populations unable to access the program in-person, see the "Expand Flexibility through Online and Distance Learning" best practice in the "Retention" section of this guide).

Tips for Action:

- Collaborate with MDH to better understand which populations in the area you serve have the greatest need for the National DPP lifestyle change program.
- Connect with your local hospital to learn about the findings of their most recent Community Health Needs Assessment.[13]
- Partner with other service organizations or nonprofit organizations in your area to help identify priority populations.
- Visit the CDC Diabetes State Burden Toolkit to learn more about the prevalence of diabetes in Minnesota, including the prevalence rates for men and women.[14]

Target Outreach to Priority Populations

Description: Target your outreach efforts to reach the priority populations you have identified, with the goal of increasing the number of individuals participating in and completing the program.

Rationale: By focusing outreach on underserved groups, you can help address health disparities and increase use of the National DPP lifestyle change program by individuals who need it the most.[15] A thoughtful outreach strategy should be developed with the target population in mind. For example, with cultures that highly value personal relationships, outreach through phone calls or written materials may have minimal effectiveness and in-person contact may be required.[16] The Medicaid Coverage for the National DPP Demonstration Project (Medicaid Demonstration Project) found that "…tailoring messages to be well received by the target population was critical to successful outreach. Tailoring could mean that they were customized with personal messages and cultural references, written at the appropriate literacy level, offered in languages in addition to English (i.e., Spanish, Vietnamese), or any combination of these."[17]

One way to tailor your outreach is to choose a program tag line that would appeal to your population of interest. Your program can be branded as something other than the "National Diabetes Prevention Program" and still be recognized by the CDC. Ideally, CDC-recognized organizations would work with MDH to use a consistent program name throughout the state to increase brand recognition, and tailor the program tag line to appeal to the target population.

Tips for Action:

- Look for partners who already interact with your priority population, such as community health centers, cultural brokers, and community health workers (CHWs).[15] These partners can be a source of referrals, provide insight about how to best reach out to the priority population, or provide a location where you can interact with your priority population face-to-face.
- Describe the National DPP lifestyle change program in a way that is likely to resonate with the values and motives of your priority population. This could include emphasizing the peer-to-peer support component of the program or the flexibility to focus on culturally traditional foods or practices.
- Use data points that are relevant to the priority population. For example, if you are trying to target middle-aged men, share the type 2 diabetes rates for men, not the general population, and share testimonials from men in that age category who have completed the program.
- Use written materials and visuals that have been tailored to your priority population. Visit the CDC Resources for Recruiting Participants website for promotional materials that have been adapted for various cultural communities.[18]
- Review the resources in the "Publications in Support of Specific Population Engagement with the National DPP Lifestyle Change Program" section of this guide. These resources are organized by population type, and some of them describe ways to tailor outreach to the population of interest.
- Present your written and verbal materials to a focus group made up of members of the priority population to receive feedback on the effectiveness of your approach.

Use Multiple Methods and Start Outreach Early

Description: Develop an overall outreach strategy that includes multiple methods to recruit participants to the program and plenty of time.

Rationale: A successful outreach strategy typically involves using multiple approaches employed simultaneously.[19] Your outreach strategy may include using participant champions, partnering with community-based organizations, and seeking referrals from health care providers, all of which are described in further detail in the subsequent best practices. Other outreach strategies could include word-of-mouth referrals from previous participants, direct mailings, phone calls, brochures in clinics or community centers, hosting a table at a community health fair, advertising through local media outlets (such as posters, radio, community newsletters), advertising through social media, and leveraging existing days and months of awareness (such as National Diabetes month).[20, 21]

Tips for Action:

- Start planning at least one to two months before you begin outreach, and begin outreach at least three months before the first class is to begin.[20]
- Maximize limited outreach resources and staff capacity by focusing on outreach methods that are more likely to be successful with your priority population. Consult cultural leaders to advise you.
- List your program on class registration platforms (e.g. Compass or Juniper) promoting the National DPP lifestyle change Program.[22]
- Leverage existing outreach materials, such as the video, radio, print, and digital materials produced by the Ad Council, including the Do I Have Prediabetes website, selecting items that would resonate with your priority population.[23, 24]

"Some strategies that I have used have [included] being present at different health fairs that the YMCA offers. For example, we have Healthy Aging week coming up, so I'll set up a table with different information on different programs that I offer including the Diabetes Prevention Program. And then I usually do some sort of smoothie demo or a healthy snack sample for members that are walking by to help engage them and come and chat with me about what programs we have going on. So that, I think, face-to-face has been the best way to recruit people rather than putting up different signs and flyers, which I think is helpful for increasing awareness, but really making that connection with members at the Y branch has been the most successful way for me to recruit people."

– Lifestyle coach, community organization in urban Minnesota

Identify Participant Champions

Description: Use past participants as program champions during recruitment.

Rationale: Individuals who have successfully completed the program can be powerful program ambassadors.

These individuals can be part of the recruitment process, either in a formal volunteer position or a paid position if funding is available.

Tips for Action:

- Encourage current and previous program participants to refer individuals to the program.[20]
- Collect success stories from participants that can be shared with future potential participants. The CDC Testimonials from Participants website[25] has video and written testimonials in English, and written testimonials in Spanish that you can share with potential program participants.

Partner with Community-Based Organizations

Description: Partner with community-based organizations to outreach to potential participants.

Rationale: One way to reach your priority population is to build relationships with community-based organizations that serve and are trusted by the population, such as hospitals, clinics, community health centers, employers, food shelves, the YMCA, affordable housing units, and faith-based organizations.[17,20] Local public health agencies can also be strong partners, and may be able to help you make connections with community-based organizations. Community-based organizations have existing relationships with potential participants, which can increase the likelihood of successful recruitment.[14] Partner organizations may be a source of a referrals, and/or a location where you can conduct outreach activities.

> *"We focus a lot on community partnerships for our programming. We have a lot of partners help us with recruiting. Those agencies that work with low-income populations...they know the clients; they know the people. They promote. Sometimes we'll come to a meeting and explain what the program is about either to the agency, or if they have a group sitting there, we can explain to the group."*
>
> *- Lifestyle coach, community organization in rural Minnesota*

When contacting potential community-based organizations, consider how the National DPP lifestyle change program aligns with that organization's values or mission. This can help you articulate what the community-based organization can gain from partnering with you.

Once a mutually beneficial relationship is established, it is helpful to have staff from the partner organization involved in referring potential participants, or program coordinators or lifestyle coaches go in-person to these sites to talk to staff and clients about the program.

One CDC-recognized organization in Minnesota that offers the program to people who have limited mobility partnered with a nonprofit organization that provides services and housing for people with disabilities. The staff from this CDC-recognized organization host informational meetings at apartment complexes and engage personal care workers to refer their clients to the program. This CDC-recognized organization also partnered with the local public health agency, which developed a health prescription sheet for residents at a local health system to give to their patients at-risk for diabetes as a referral.

Tips for Action:

- Hold outreach activities at organizations or locations frequented by your priority population.
- Participate in screening events sponsored by local communities, employers, insurers, and large retailers to identify potential program participants.[20]
- Develop an effective way to communicate your program data, such as the success and impact of the program, to potential partners. For example, you could consider creating a one-page fact sheet to share.
- Maintain relationships and build trust with partners, such as by sending updates to leadership (e.g., CEO, director, pastor, etc.) or holding regularly scheduled meetings together.[25, 26]

Seek Referrals from Health Care Providers

Description: Develop relationships with health care providers and educate them about the National DPP lifestyle change program to encourage referrals to the program of eligible patients seen by the health care provider.

Rationale: Health care provider referrals can be one of the most effective outreach methods for the National DPP lifestyle change program. For example, Denver Health, a safety-net health system, found that individuals were five times more likely to enroll in the program if they learned that their physician recommended their participation in the program. Instead of 1 in 10 at-risk individuals committing to participate in the program when contacted by phone by a lifestyle coach, nearly 1 in 2 individuals would commit to participate if the lifestyle coach shared that the individual had been referred by their health care provider.[21]

When developing a relationship with a health care provider, it is important to educate them about the National DPP lifestyle change program. This can be done through provider influencers, such as association education, association newsletters, or peer-reviewed publications; health system or clinical approaches, such as provider protocols and workflows, and co-locating with the health system or clinic; or through contacting providers directly through provider education, provider engagement in patient referrals, and updating providers on patient participation.[21]

> *"My director talked with the CEO of our medical center, because he is supportive of [referring to the National DPP], yet it's not really the standard practice for them to refer. There's this administrative support but when it comes down to in that office, the [health care] provider/patient conversation, it's not always happening. Mainly, we're told, due to time restriction. They don't have that much time and they may not even think of it when they're in a rush for time with their patients."*
>
> *- Program coordinator and lifestyle coach, rural Minnesota*

Health care providers often have many competing priorities for their time, so it is important to make the referral process as easy as possible. Integrating referrals into health care providers' electronic health record (EHR) system and providing health provider education has been shown to increase provider referrals. EHRs can be set up so that the health care provider can both fill out the referral form within the EHR, and transmit the referral to the CDC-recognized organization through the EHR. However, transmitting the referral through the EHR can be complicated to set up, so autofax or manual fax are also an alternative.[21] The EHR can also be used to create reminders for providers to refer to the program when a patient is identified as eligible.[19]

Health care provider EHRs can often be queried as a method to find potential participants. When partnering with a health care provider, engaging their medical records administrator in a conversation may be a good method for getting a discussion started around querying records. Resources are available on the Screening and Identification page of the National DPP Coverage Toolkit that can help health care providers set up queries specific to National DPP lifestyle change program eligibility.[28]

Tips for Action:

- Read the Recruitment and Referral page of the National DPP Coverage Toolkit to learn more about increasing referrals from health care providers.[21]
- Develop an effective way to communicate your program data, such as the success and impact of the program, to health care providers. For example, you could consider creating a one-page fact sheet to share and using the AMA Physicians and Care Team Engagement Presentation Tips to help prepare your presentation.
- Identify a health care provider champion who is committed to referring patients to the program and is willing to encourage others to do the same.[20]
- Focus on a few health care provider groups to obtain referrals from rather than sending materials to a large number of health care providers.[17]
- Consider developing a "warm hand-off" protocol so individuals referred by a health care provider can be easily introduced to a National DPP lifestyle change program's coordinator or lifestyle coach.[27]
- Plan on making multiple attempts to reach individuals once they have been referred by their health care provider. For example, it may take as many as 6-10 attempts before you reach a referred individual on the phone.[30]
- Contact the Local Public Health Statewide Health Improvement Partnership (SHIP) coordinators in your region to see if they can provide technical assistance and support with local partnerships and EHR integration to support referrals to the National DPP lifestyle change program.

Establish a Bi-Directional Referral System

Bi-Directional Referral System:

A referral system where the healthcare provider receives information back from the CDC-recognized organization regarding the status of any referrals.

Description: Establish a bi-directional referral system with referring health care providers, meaning a referral system where the health care provider receives information back from the CDC-recognized organization regarding the status of any referrals.

Rationale: A key way to encourage health care providers to continue to refer individuals to the National DPP lifestyle change program is to create a bi-directional referral system. By doing this, CDC-recognized organizations can build a relationship of trust with the health care provider, and health care providers can see first-hand the impact of the National DPP lifestyle change program on their patients. In a study where presentations and reminders to health care providers had limited success in generating referrals, some health care providers indicated frequent updates about the patients' progress would have motivated more referrals.[31]

Health care providers and CDC-recognized organizations should work together when developing a bi-directional referral system to determine the desired frequency of contact and the level of detail to include. Some content that could be in the progress reports includes:

- Whether a referred individual was successfully contacted;
- Whether the referred individual enrolled in the program; and
- The referred individual's progress in the program, such as program attendance, progress in achieving weight loss and physical activity goals, and any other notable successes.

CDC-recognized organizations should also discuss with health care providers the desired frequency of these progress reports.[21] It may be necessary for program participants to provide written consent prior to the CDC-recognized organization sharing information back with the health care provider.

When a bi-directional referral system is in place, health care providers can encourage their patients to enroll in the National DPP lifestyle change program, and to stick with it. For example, if a health care provider receives a progress report indicating that their patient has missed several classes recently, they could contact the patient to encourage them to continue attending the program.[21]

Tips for Action:

- Read the Recruitment and Referral page of the National DPP Coverage Toolkit to learn more about developing a bi-directional referral system.[21]
- Involve health care providers and any other stakeholders in the design and implementation of the bi-directional referral system.
- Use project management principles to approach the development of a bi-directional referral system and pick an appropriate project team to support the work.[21]
- Identify a health care provider champion who is passionate about diabetes prevention, can co-lead the project, and can help educate fellow clinicians and leadership.[21]
- Take a phased approach. Leverage technology where possible, but if you need to get going, start with the low-tech version.[21]

Assess Readiness

Description: Use readiness assessments and/or a "session zero" (see explanation below) to educate potential participants about the program and encourage participation.

Rationale: Participants who are ready to change and understand the program are more likely to complete and be successful. Many CDC-recognized organizations use a readiness assessment and/or hold a "session zero" to help a potential participant self-evaluate their commitment to change and get a clear understanding of the program prior to enrollment.

The readiness assessment is usually a written formal questionnaire. A "session zero" is typically a group based or one-on-one exchange between the potential participant and the lifestyle coach or program coordinator either in-person or over the phone to discuss program expectations.

> *"So, we do what's called a session zero, so it's not part of the curriculum, but it's just basically getting participants or possible future participants together and talking about what the program entails, the commitment, etc. I'm going to have one coming up in June here, and I'm going to invite past participants who've been successful with the program to come and talk personally at that session zero to say, 'Hey, this really is a good thing. Don't be scared. It goes by really fast, you'll enjoy the support from one another,' stuff like that."*
>
> *– Program coordinator and lifestyle coach, health care organization in Minnesota*

A readiness assessment or a "session zero" should not be used as a barrier to participation. Everyone who is eligible should be invited and encouraged to participate in the program. Rather, these tools are opportunities for lifestyle coaches to understand the barriers to participation a potential participant is facing and use motivational interviewing techniques to address the barriers in a non-threatening way. Tips for increasing a potential participant's confidence and conviction to participate in the program can be found in the Los Angles National Diabetes Prevention Program Implementation Toolkit (pages 42-43).[32]

It may be that using both a readiness assessment and a "session zero" is the most comprehensive approach to be transparent about the components and expectations of the program with potential participants. This conversation provides participants with the opportunity to ask questions and share concerns. Using a comprehensive approach to assess the readiness of potential participants will improve participants' understanding of the expectations of the program and may improve participant retention.

Tips for Action:

- Access examples of readiness assessments, readiness questions, and "session zeros" in the following locations:

  Living Well Utah:
  - Readiness for Change: Guided Questions[33]
  - Readiness Assessment[34]
  - "Session Zero" Tips Webinar (video)[35]

  Diabetes Training and Technical Assistance Center (DTTAC) Common Ground:
  - Holding a Session Zero[36]

  Los Angeles National DPP Implementation Toolkit:[32]
  - Readiness to Change Assessment – pg. 40
  - Readiness to Change Questions – pg. 41
  - Session Zero Tips – pg. 47
- Consider creating a nonbinding statement of commitment with participants as this may help them acknowledge and commit to the program's requirements. This contract could include the details about the weekly and monthly class schedule as well as the participant's goal for joining the program.[26] An example statement of commitment can be found on the Living Well Utah's website.[37]

Meet Unique Participant Needs

Description: Enhance the National DPP lifestyle change program to meet the needs of specific populations.

Rationale: Lifestyle coaches and program coordinators can increase retention by ensuring they are meeting the unique needs of the individuals in their classes. Lifestyle coaches and coordinators may need to consider the cultural community, gender, age, literacy level, disabilities, income level, and location (e.g., rural vs. urban) of participants when preparing for each program session.

An organization can enhance its National DPP lifestyle change program curriculum to increase its effectiveness with a specific cultural community or translate the curriculum into another language by notifying CDC at DPRPAsk@cdc.gov and following the steps provided by CDC for submission and review (review can take four to six weeks).[38] The use of supplementary materials and handouts that do not change the curriculum content do not require CDC review and approval prior to use.[26] Enhancements might include incorporating recipes and diet/nutrition tips that align with culturally traditional foods, and adaptations to the curriculum to define and explain key concepts that underpin the program. One lifestyle coach in Minnesota found that the concept of "prevention" had to be explained to a class of Somali participants, because the term is not well-understood in the Somali community. In the Medicaid Demonstration Project, CDC-recognized organizations made the curriculum more sensitive to economic insecurity by incorporating low-budget recipe suggestions.[19] In Montana, staff revised the diabetes prevention program to include audio instead of written food diaries for blind participants and provided classes at a slower pace for cognitively impaired participants.

Tips for Action:

- Review the list of already completed translations of CDC's PreventT2 National DPP curriculum to other languages on the National Diabetes Prevention Program Coverage Toolkit.[39]
- Review the resources in the "Publications in Support of Specific Population Engagement with the National DPP Lifestyle Change Program" section at the end of this guide. These resources, organized by population type, describe how others have enhanced the National DPP lifestyle change program for various populations.
- Hire bilingual lifestyle coaches, or lifestyle coaches who have previously worked with the priority population.[15, 26] Work with cultural brokers, formal or informal community leaders, or CHWs to identify ways to tailor the curriculum to meet the needs of the communities being served. Ideally, this should be done as part of the planning process, before recruiting or enrolling participants.

Use Low-Literacy Materials

Description: Incorporate the use of additional low-literacy materials, such as visuals and materials written at a 6th grade level or below.

Rationale: Low-income populations are likely to have a higher proportion of the population with limited literacy.[17, 40] The US National Institutes of Health recommends aiming for a 6th grade reading level or below when developing health materials.[40, 41] Currently, the PreventT2 curriculum, used by many National DPP lifestyle change program coaches, is written at a 5th grade reading level. CDC-recognized organizations in the Medicaid Demonstration Project chose to adapt literacy materials to below a 4th or 5th grade level and found it helpful to use many visuals, such as pictures, props, and drawings on a dry erase board.[19] Visual tools can also make the curriculum more concrete and hands on, such as showing how much fat is in one French fry, and how much sugar and salt you should eat per day.[12]

Tips for Action:

- Look for opportunities to incorporate more visuals into your sessions. Take care to ensure they are culturally appropriate.
- Be sensitive to the reading level of program participants and provide additional one-on-one support as needed.
- Provide simplified food journaling options as needed.[42]

Address Barriers to Participation

Description: Find creative solutions to address the common barriers that prevent participants from enrolling and/or continuing in the program.

Rationale: Addressing barriers to participation can be a powerful way to increase retention. Interviews with CDC-recognized organizations who were part of the Medicaid Demonstration Project suggested that addressing barriers to participation was even more effective at facilitating retention than offering monetary incentives.

A small sample of participants who did not complete the National DPP lifestyle change program during the Medicaid Demonstration Project gave the following reasons for discontinuing: general availability (including issues of schedule and timing), not being able to get away from work, language preferences, specific family commitments, and lack of childcare.[17] Other barriers to participation include illness, injury, transportation, cultural barriers, life instability (e.g., lack of housing), food insecurity, a lack of positive results (e.g., weight loss), a lack of readiness to change, and intimidation in committing to a year-long program. For programs that are not available for free, cost may also be a barrier. The type of barriers experienced by participants will vary by the population served.

For example, organizations serving low-income participants and younger participants who have children at home may be more likely to run into transportation and childcare concerns. You can support the success of program participants by looking for creative ways to overcome barriers to their success. For example, some CDC-recognized organizations in the Medicaid Demonstration Project allowed participants to bring their children to class.[17]

> *"Folks that are low-income are struggling from day-to-day. They can't think a year out. They've got to figure one day at a time in a sense. Forward thinking is not really…they're not accustomed to that. It's challenging. It's very challenging. I'll get a lot of people saying, 'yeah, I can do this', and then life happens."*
>
> *– Program coordinator and lifestyle coach, rural Minnesota*

You can also make it easier to catch up on missed sessions. For example, you can meet participants at a convenient location for makeup sessions, allow makeup sessions over the phone, and create an atmosphere of no shame for missing a session. One CDC-recognized organization worked with a local college to develop 15-minute YouTube presentations for each National DPP session. If a participant misses a session, they are emailed the link to the video, the handout for that week, and the lifestyle coach reaches out to them to see how they are doing. The participant is then asked to self-report their weight and activities to the lifestyle coach. The CDC approved this as an acceptable alternative to attending the class in person.

Tips for Action:

- Identify the major barriers preventing program participants in your sessions from being successful and preventing potential participants from joining.
- Identify available funding streams as needed to support transportation and childcare for participants. Medicaid beneficiaries may be able to use the Medicaid's non-emergency medical transportation benefit. It will be important to make Medicaid beneficiaries aware of this and encourage them to use this Medicaid benefit.
- Develop partnerships with other organizations to help address barriers to participation, such as with local food shelfs and non-profit organizations.
- Encourage family members to provide support to program participants, such as through providing transportation, participating in exercise and healthy eating activities, or joining the program.[42]
- Add additional class locations to meet the needs of participants, such as having a class at a church because members of that church are already familiar with the location and meet there regularly.[19]

Expand Flexibility through Online and Distance Learning

Description: Increase access to the National DPP lifestyle change program by offering a combination of in-person, online, and/or distance learning delivery of the program.

Rationale: Offering classes through online and distance learning (also known as telehealth), as well as in-person, can increase access to the program to rural locations and to individuals where work schedules, limited transportation, or limited childcare are barriers to participation.

A recent study captured the successful recruitment, enrollment, and engagement of a low-income population to an online National DPP lifestyle change program. However, the study found that while the majority of participants had access to a computer or a mobile device, many needed help to enroll in the program, particularly Spanish-speaking participants.[31] Checking in regularly with participants enrolled in online programs can help catch technology issues early on.[17] Evidence supports the long-term feasibility of online delivery of the National DPP lifestyle change program among the general population, however, additional research is needed to evaluate the effectiveness with the Medicaid population. The Medicaid Demonstration Project found that online participants attended fewer sessions on average, but achieved greater weight loss.[17]

Montana conducted a study on telehealth delivery of the National DPP lifestyle change program to rural communities, which found no statistical differences in the number of sessions attended or weight loss between the telehealth and the onsite groups.[44] While the study was not Medicaid specific, Montana is currently using telehealth to deliver the National DPP lifestyle change program to Medicaid enrollees. More information about how Montana delivers the program through telehealth can be found in the case study on the National DPP Coverage Toolkit website.[45]

Tips for Action:

- Ask potential program participants for feedback on the availability of your current session offerings, including time, location, and type of delivery.

Encourage Social Connections

Description: Facilitate social connections between program participants.

Rationale: A primary reason participants stay in the program is the social connections that are formed between participants over the course of the program. The rapport between the lifestyle coach and participants is also an important factor for participant engagement and retention.

As the lifestyle coach, you can encourage the creation of social connections. For example, one lifestyle coach gave their group a list of walking trails in the area so that participants

could walk together if they desired. Another made t-shirts for participants to unify the group and help further develop a team mentality. Consider culturally appropriate ways to encourage group cohesion. For example, one CDC-recognized organization providing the program to a group of Hmong participants extended the session time from 60 minutes to 90 minutes to allow for socialization before the start of the session. This change was warmly received by the participants.

> *"One of the things that I find is that a group that becomes good friends and is really bonded as a group, they all do a lot better and they attend better. Your retention is a lot better. I guess I don't know how to say this exactly, but [a retention strategy might include] ways to make them be friends with each other. Help them bond as a group because then that improves success and improves retention for the year."*
>
> *– Program coordinator, rural Minnesota*

Celebrating participant progress can be another way to strengthen relationships in a group of participants. Seeing the results of their work in the program can be motivating and gratifying for participants and is likely a significant contributor to program retention. Find engaging ways to track and celebrate participant progress individually and as a group.

Tips for Action:

- Set up a private social media group for the class to facilitate communication with and among participants, and to allow for activities such as sharing recipes and discussing personal strategies, experiences, and tips.[26]
- Share contact information of group participants (if given permission) and encourage members to get together outside of the program to engage in physical activity, food shopping, meal preparation, etc.
- If possible, group similar participants together in the same cohort to further facilitate social cohesion due to similarities (i.e., older adults, youth, mothers, etc.).
- Offer supplementary experiences that build group cohesion (see the following best practice for additional ideas).

Offer Supplementary Experiences

Description: Add variety and interest by offering unique supplementary experiences to participants.

Rationale: Adding supplementary experiences to the programming makes the sessions more interactive, builds social connections, and increases retention, particularly during months 7 through 12 of the program.[26] For example, a grocery store tour can build participant confidence in selecting healthier options and

> *"Within that class, we do a grocery store tour. The food bank provides up to $10 per person for a grocery store challenge. Participants come up with a meal for under $10 that's healthy."*
>
> *– Lifestyle coach, rural Minnesota*

reading food labels.[12] Food tastings or cooking demonstrations can be helpful for individuals who may not want to spend money on items they have not tried before.

You can also use supplementary experiences to address food insecurity. One CDC-recognized organization in Minnesota partnered with a local food shelf to offer food bags at each session. A CDC-recognized organization could also partner with service organizations and programs like Market Bucks offered throughout Minnesota, an incentive program that encourages EBT customers to use their benefits at participating farmer's markets.

> *"We've added [grocery store tours] this year. We work with our local grocery store, one of our bigger chains, Coborn's, and they have dietitians on staff. So, they provided handouts on portion sizes for me. They've given me at least eight weeks of menus and handouts of a healthy eating menu for people who are maybe struggling. And they gave me three or four different handouts that I'm able to provide for all of our participants. And then I set up grocery store tours, outside of the times of our workshops."*
>
> *– Program coordinator, Community-based program in Minnesota*

Tips for Action:

- Incorporate indoor and outdoor physical activities into or in conjunction with the sessions, such as scheduling group walks before or after the session.[12]
- Host engaging guest speakers, such as inviting past participants who can speak about their struggles, achievements, and lessons learned.[26]
- Look for opportunities to partner with community organizations to contribute to the sup-

Tailor Communications to Participants

Description: Contact program participants frequently to encourage retention.

Rationale: By frequently contacting program participants, you can receive feedback from participants about what they enjoyed, receive early indicators about barriers, build rapport, and provide motivation and support to participants who are struggling to stay engaged. You can communicate with participants using a variety of modes, including phone calls, emails, Facebook groups, and text messages. In the Medicaid Demonstration Project, lifestyle coaches found staying in touch with participants between classes through telephone, text messages, and email helped increase retention.[17] It may be particularly important to increase communication during the transition at six months from weekly to monthly sessions, as this is a time when there is often a significant drop off in participation.

Tips for Action:

- Tailor the mode of communication based on the preferences of the group.
- Contact participants who are struggling to help them feel supported and stay motivated to continue in the program. Motivational interviewing skills can play a key role in these conversations.
- Reach out when a participant has missed a session to check in and explore make-up options.

Use Incentives

Description: Provide incentives related to healthy living.

Rationale: Although incentives are not widely used by lifestyle change coaches in Minnesota, the literature suggests that this may be an effective retention strategy.[15, 46] For example, the MIPCD study, which Minnesota participated in, found that participants receiving incentives had significantly higher attendance (attended 1–2 more National DPP lifestyle change classes) than control groups without incentives.[15] Incentives could also be used to recruit and enroll participants in the program. However, it is important to note that the use of incentives cannot be covered by Medicaid and other funding sources need to be used.

Incentives are often provided when participants achieve attendance and weight loss goals, and are typically items related to healthy living.[26] Examples of incentives currently used by CDC-recognized organizations in Minnesota include a free bag of groceries for participants at each session, a free 3-month YMCA membership, free personal training sessions, and material items such as t-shirts and cups. The MIPCD study discussed the important of ensuring the appropriateness of an incentive. For example, several programs indicated that they had provided program participants with gym memberships, but later found that the participants weren't using them because some people did not know how to use a gym, were overweight and uncomfortable wearing exercise clothes in the gym, or were from a culture that did not approve of co-ed gyms.[47]

Tips for Action:

- Provide incentives at key transitions, such as when transitioning from weekly to monthly sessions.[15]
- Provide the incentive immediately after the goal is reached, so there is a clear connection between the achievement and the reward.[15]
- Partner with other organizations to provide deals, prizes, and other incentives when funding for incentives is not available.[46]
- Read the Enrollment, Incentives, and Retention page of the National DPP Coverage Toolkit for additional incentive examples.[46]

Provide Lifestyle Coach Training

Description: Provide opportunities for continuing lifestyle coach education.

Rationale: The quality of the lifestyle coaches can be one of the most important aspects of retaining participants. Having a highly skilled lifestyle coach who is personable, friendly, and motivational can be a key factor to increasing the level of participant engagement.

Lifestyle coaches can continue to learn to improve their ability to help the participants in their programs.

Lifestyle coaches in Minnesota said they would like additional training on motivational interviewing, group style learning, facilitation skills, physical activity for people with mobility or health issues, working with participants with mental health issues (e.g., depression, emotional eating), and adaptations for specific populations.

> *"…developing the rapport and the relationship with the lifestyle coaches is a big part of it. I think when you've got engaging coaches, people are going to stay involved and keep coming back."*
>
> *– Program coordinator, health care organization in Minnesota*

Training opportunities used during the Medicaid Demonstration Project included using master trainers, the Y-USA, and the Diabetes Training and Technical Assistance Center (DTTAC). Additional training interests included nutrition, HIPAA training or certification; cultural competency/awareness; motivational interviewing; group facilitation; disability awareness; lesbian, gay, bisexual, transgender, and questioning (LGBTQ) awareness; and training on logistical procedures (such as weigh-ins). Additionally, some lifestyle coaches suggested they would have benefited from having access to an online community where they could share resources, challenges, and lessons learned with other lifestyle coaches.[19]

Tips for Action:

- Use a program coordinator or more experienced lifestyle coach to mentor lifestyle coaches to build their capacity and skills.[26]
- Utilize CDC's National DPP Customer Service Center, a one-stop location where you can access webinars and trainings, request technical assistance, and connect with others to share tips and best practices.[48]
- Join the DTTAC online learning community for lifestyle coaches called Common Ground, where you can access resources, and ask questions to Master Trainers and other lifestyle coaches.[49]
- Review CDC's resources on Staffing your Lifestyle Change Program and Training Your Lifestyle Coaches.[50]

Best Practices Development

MDH worked with a broad team to collect best practices from both state and national partners implementing the National DPP lifestyle change program with Medicaid members. Below is a description of the contributors and their role in developing this guide.

Wilder Research is a nationally respected nonprofit research and evaluation group. Wilder Research works with nonprofits, community leaders, government agencies, foundations, and policymakers throughout Minnesota and the country to gather and interpret facts and trends, help uncover and understand issues affecting communities and how best to address them, and make data-informed decisions that improve lives and communities.

The research team at Wilder Research conducted interviews with 29 lifestyle coaches and program coordinators from 23 CDC-recognized organizations in Minnesota to identify barriers and innovative practices to recruit, enroll, and retain participants. Through their research they also uncovered additional training and supports needed for lifestyle coaches to better administer the program. The results of this primary research are contained in the Best Practices section of this guide. To learn more about this research or to request a copy of the report please contact health.diabetes@state.mn.us.

The National Association of Chronic Disease Directors (NACDD) is a nonprofit, public health organization for chronic disease program directors of each state and U.S. territory. Founded in 1988, NACDD connects more than 7,000 members to advocate for preventive policies and programs, encourage knowledge sharing, and develop partnerships for health promotion. Since its founding, NACDD has been a national leader in mobilizing efforts to reduce chronic diseases and their associated risk factors through state and community-based prevention strategies.

Leavitt Partners is a health intelligence firm founded by former Health and Human Services Secretary Mike Leavitt. Headquartered in Salt Lake City, Utah, Leavitt Partners helps clients navigate the value economy in health care by providing strategy insights, health care industry intelligence, and convening learning communities to advance health care in the United States.

Through funding from the CDC, NACDD and Leavitt Partners have been working together for the past several years with state Medicaid agencies, managed care organizations (MCOs), State Health Departments, and other stakeholders to establish best practices for covering and implementing the National DPP lifestyle change program in Medicaid.
Through funding from the CDC, NACDD implemented the Medicaid Demonstration Project, a multi-year project (2015 – 2019) designed to work through and develop solutions for the real-world challenges of Medicaid coverage for the National DPP lifestyle change program. These partnerships continue to provide insight and a collaborative community to help states successfully cover and implement the National DPP lifestyle change program in Medicaid. One of the resources that came from this work is the National DPP Coverage Toolkit website (www.coveragetoolkit.org), a national resource for state Medicaid agencies, MCOs, commercial health plans, employers, national stakeholders, and CDC-recognized organizations.

The Coverage Toolkit is a repository of the latest information on and examples of attaining coverage for the National DPP lifestyle change program as well as

program implementation, such as engaging, enrolling, and retaining eligible participants in the program. NACDD and Leavitt Partners used this extensive experience to supplement and support the Best Practices section of this guide.

Additional MDH Efforts to Support National DPP Lifestyle Change Program Reach and Access

This guide, targeted toward lifestyle coaches and program coordinators, is one of a variety of efforts MDH and their partners are engaged in to support and enhance Minnesota stakeholder engagement with the Medicaid benefit of the National DPP lifestyle change program. Supporting the ability of CDC-recognized organizations to achieve Medicaid reimbursement for the program as well as supporting additional modalities of program delivery are both important ways to increase access and uptake of the National DPP lifestyle change program for Minnesotans most at need. These two efforts are highlighted below.

Payment Workgroup

MDH, in partnership with CHW Solutions (information below), has established a Payment Workgroup to find collaborative opportunities with CDC-recognized organizations, MCOs, and Medicaid enrolled providers to increase access and uptake of the Medicaid benefit.

The Payment Workgroup has focused some of its efforts on developing a Medicaid billing guide and training, with the ultimate goal of problem-solving known billing challenges by engaging MCOs, Medicaid enrolled providers, CHWs and CDC-recognized organizations and identifying and outlining processes for successful Medicaid reimbursement. The Medicaid billing guide will become available the summer of 2020. One opportunity the billing guide will describe is for CDC-recognized organizations to contract with Medicaid enrolled providers to administer Medicaid billing for the National DPP lifestyle change program. The Payment Workgroup will also recruit some CDC-recognized organizations to receive technical assistance on accessing Medicaid reimbursement.

CHW Solutions, LLC is a women-owned, Minnesota-based business dedicated to developing sustainable models for CHW services. Its mission is to connect CHWs with individuals at-risk for poor health outcomes to achieve better health. CHW Solutions supports organizations closest to the communities being served, such as community-based non-profits and local public health agencies, helping them develop their own sustainability mechanisms for service delivery. They offer consulting services, on-contract billing and clinical oversight, and evaluation assistance.

For more information about the Payment Workgroup, a planned "Medicaid reimbursement" survey, Medicaid billing guide development, and technical assistance opportunities, please contact Martha.Roberts@state.mn.us.

Telehealth

Telehealth, which can be defined as the delivery and facilitation of long-distance health related services including clinical health care, patient and provider health-related education, and health information services via telecommunications and digital communication technologies, is an important way to increase access to the National DPP lifestyle change program, especially for rural participants.

MDH is working toward supporting and expanding access to diabetes prevention and management services through telehealth delivery. For more information about this telehealth work please contact health.diabetes@state.mn.us.

Additional Contacts, Resources, and Publications

Contacts

The contacts below can help support your program through direct engagement with the National DPP work happening at state and national levels. MDH receives funding from the CDC to support CDC-recognized organizations in Minnesota through resources and skill building opportunities, and the CDC's Diabetes Prevention Recognition Program and Customer Service Center can help support your efforts toward achieving full recognition.

- Minnesota Department of Health: health.diabetes@state.mn.us
- Minnesota Department of Human Services Provider Center: 800-366-5411 or 651-431-2700
    - Minnesota Medicaid National DPP lifestyle change program benefit, Provider Manual

      https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_008926#dpp
    - Minnesota Medicaid CHW benefit, Provider Manual

      https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357
- CDC Contacts:
    - Diabetes Prevention Recognition Program:[38] DPRPAsk@cdc.gov ;

      https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf
    - National DPP Customer Service Center[47]

      https://nationaldppcsc.cdc.gov/s/

Additional Resources and Publications

The resources and publications below can provide further guidance on how to effectively recruit, enroll, and retain participants to the National DPP lifestyle change program. The CDC-developed resources contain translated curriculum, promotional materials, participant testimonials, and more. Also included is a collection of publications on program enhancements and how to tailor the program to engage with different populations. These resources are organized by target population, with some resources applicable to multiple populations.

CDC Resources

CDC National Diabetes Prevention Program Website: Tools and resources for lifestyle coaches, health care providers, employers, and potential participants.

> National Diabetes Prevention Program. (2018, August 10). Retrieved from Centers for Disease Control and Prevention website: https://www.cdc.gov/diabetes/prevention/index.html

Curriculum for the National DPP Lifestyle Change Program: Up-to-date access to language translations of the PreventT2 curriculum.

> Curriculum for the National DPP Lifestyle Change Program. (2019, January 30). Retrieved from National Diabetes Prevention Program Coverage Toolkit website: https://coveragetoolkit.org/national-dpp-curriculum/

National DPP Coverage Toolkit: A repository of the latest information on and examples of attaining coverage of the National DPP lifestyle change program and program implementation.

> National Diabetes Prevention Program Coverage Toolkit. (n.d.). Retrieved from National Diabetes Prevention Program Coverage Toolkit website: https://coveragetoolkit.org/

Resources for Recruiting Participants: Includes promotional materials such as brochures, posters, etc., many of which have been adapted for a variety of cultural communities.

> CDC-Recognized Lifestyle Change Program: Resources for Recruiting Participants. (2018, April 2). Retrieved from Centers for Disease Control and Prevention website: https://www.cdc.gov/diabetes/prevention/lifestyle-program/resources/participants.html

Testimonials from Participants: Video and written testimonials in English, and written testimonials in Spanish.

> CDC-Recognized Lifestyle Change Program: Testimonials From Participants. (2018, October 30). Retrieved from Centers for Disease Control and Prevention website: https://www.cdc.gov/diabetes/prevention/lifestyle-program/testimonials-participants.html

Diabetes State Burden Toolkit: Compares the health burden, economic burden, and mortality rates related to diabetes in different states, including the diabetes prevalence rates for men and women.

> Diabetes State Burden Toolkit. (n.d.). Retrieved from Centers for Disease Control and Prevention website: https://nccd.cdc.gov/Toolkit/DiabetesBurden/Home

Publications in Support of Specific Population Engagement with the National DPP Lifestyle Change Program

Age

Brokaw, S. M., Carpenedo, D., Campbell, P., Butcher, M. K., Furshong, G., Helgerson, S. D., & Harwell, T. S. (2015). Effectiveness of an Adapted Diabetes Prevention Program Lifestyle Intervention in Older and Younger Adults. Journal of the American Geriatrics Society, 63(6), 1067–1074. https://doi.org/10.1111/jgs.13428

National Center for Chronic Disease Prevention and Health Promotion. (n.d.). Communities in Action: Kentuckiana Regional Planning and Development Agency. Retrieved from https://www.cdc.gov/diabetes/pdfs/programs/kipda_cia_508.pdf

Gender

Farris, K. D., Bonner, T., Rutledge, G. E., & Smith, B. (2018). Assessing the Evaluability of Type 2 Diabetes Prevention and Diabetes Management Interventions Focusing on Underserved Populations. Diabetes, 67(Supplement 1), 696-P. https://doi.org/10.2337/db18-696-P

Race & Ethnicity

Farris, K. D., Bonner, T., Rutledge, G. E., & Smith, B. (2018). Assessing the Evaluability of Type 2 Diabetes Prevention and Diabetes Management Interventions Focusing on Underserved Populations. Diabetes, 67(Supplement 1), 696-P. https://doi.org/10.2337/db18-696-P

Gary-Webb, T. L., Walker, E. A., Realmuto, L., Kamler, A., Lukin, J., Tyson, W., … Weiss, L. (2018). Translation of the National Diabetes Prevention Program to engage men in disadvantaged neighborhoods in New York City: A description of Power Up for Health. American Journal of Men's Health, 12(4), 998–1006. https://doi.org/10.1177/1557988318758788

Lagisetty, P. A., Priyadarshini, S., Terrell, S., Hamati, M., Landgraf, J., Chopra, V., & Heisler, M. (2017). Culturally Targeted Strategies for Diabetes Prevention in Minority Population: A Systematic Review and Framework. The Diabetes Educator, 43(1), 54–77. https://doi.org/10.1177/0145721716683811

Piper, S., Beatty, C., Blais, L., Ritchie, N. D., & Pereira, R. I. (2016). Pathways to Diabetes Prevention: Two Referral Models for the National Diabetes Prevention Program. AADE in Practice, 4(6), 32–36. https://doi.org/10.1177/2325160316668158

Ruggiero, L., Oros, S., & Choi, Y. K. (2011). Community-Based Translation of the Diabetes Prevention Program's Lifestyle Intervention in an Underserved Latino Population: The Diabetes Educator. https://doi.org/10.1177/0145721711411107

Language, Religion, & Culture

Fontil, V., McDermott, K., Tieu, L., Rios, C., Gibson, E., Sweet, C. C., … Lyles, C. R. (2016). Adaptation and feasibility study of a digital health program to prevent diabetes among low-income patients: Results from a partnership between a digital health company and an academic research team. Journal of Diabetes Research, 2016, 8472391. https://doi.org/10.1155/2016/8472391

Kim, S. E., Castro Sweet, C. M., Gibson, E., Madero, E. N., Rubino, B., Morrison, J., … Cousineau, M. R. (2018). Evaluation of a digital diabetes prevention program adapted for the Medicaid population: Study design and methods for a non-randomized, controlled trial. Contemporary Clinical Trials Communications, 10, 161–168. https://doi.org/10.1016/j.conctc.2018.05.007

Lagisetty, P. A., Priyadarshini, S., Terrell, S., Hamati, M., Landgraf, J., Chopra, V., & Heisler, M. (2017). Culturally Targeted Strategies for Diabetes Prevention in Minority Population: A Systematic Review and Framework. The Diabetes Educator, 43(1), 54–77. https://doi.org/10.1177/0145721716683811

Tabak, R. G., Sinclair, K. A., Baumann, A. A., Racette, S. B., Sebert Kuhlmann, A., Johnson-Jennings, M. D., & Brownson, R. C. (2015). A review of diabetes prevention program translations: Use of cultural adaptation and implementation research. Translational Behavioral Medicine, 5(4), 401–414. https://doi.org/10.1007/s13142-015-0341-0

Vincent, D., McEwen, M. M., Hepworth, J. T., & Stump, C. S. (2013). Challenges and Success of Recruiting and Retention for a Culturally Tailored Diabetes Prevention Program for Adults of Mexican Descent. The Diabetes Educator, 39(2), 222–230. https://doi.org/10.1177/0145721713475842

Rural Populations

National Center for Chronic Disease Prevention and Health Promotion. (n.d.). Communities in Action: Center for Appalachian Philanthropy. Retrieved from https://www.cdc.gov/diabetes/pdfs/programs/appaphil-_cia_508.pdf

National Center for Chronic Disease Prevention and Health Promotion. (n.d.). Communities in Action: Kentuckiana Regional Planning and Development Agency. Retrieved from https://www.cdc.gov/diabetes/pdfs/programs/kipda_cia_508.pdf

Reddy, P., Hernan, A. L., Vanderwood, K. K., Arave, D., Niebylski, M. L., Harwell, T. S., & Dunbar, J. A. (2011). Implementation of diabetes prevention programs in rural areas: Montana and south-eastern Australia compared. The Australian Journal of Rural Health, 19(3), 125–134. https://doi.org/10.1111/j.1440-1584.2011.01197.x

Rural Diabetes Prevention and Management Toolkit. (n.d.). Retrieved from Rural Health Information Hub website: https://www.ruralhealthinfo.org/toolkits/diabetes

Vadheim, L. M., Patch, K., Brokaw, S. M., Carpenedo, D., Butcher, M. K., Helgerson, S. D., & Harwell, T. S.(2017). Telehealth delivery of the diabetes prevention program to rural communities. Translational Behavioral Medicine, 7 (2), 286–291. https://doi.org/10.1007/s13142-017-0496-y

Low Income Populations

Carroll, J., Winters, P., Fiscella, K., Williams, G., Bauch, J., Clark, L., … Bennett, N. (2015). Process Evaluation of Practice-based Diabetes Prevention Programs: What Are the Implementation Challenges? The Diabetes Educator, 41(3), 271–279. https://doi.org/10.1177/0145721715572444

Fontil, V., McDermott, K., Tieu, L., Rios, C., Gibson, E., Sweet, C. C., … Lyles, C. R. (2016). Adaptation and feasibility study of a digital health program to prevent diabetes among low-income patients: Results from a partnership between a digital health company and an academic research team. Journal of Diabetes Research, 2016, 8472391. https://doi.org/10.1155/2016/8472391

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Medicaid Beneficiaries

Alva, M. L., Romaire, M., & Acquah, J. (2018). Impact of Financial Incentives on Diabetes Prevention Class Attendance and Program Completion: Evidence From Minnesota, Montana, and New York. American Journal of Health Promotion, 0890117118794087. https://www.ncbi.nlm.nih.gov/pubmed/30122055

Desai, J., Taylor, G., Vazquez-Benitez, G., Vine, S., Anderson, J., Garrett, J. E., … O'Connor, P. J. (2017). Financial incentives for diabetes prevention in a Medicaid population: Study design and baseline characteristics. Contemporary Clinical Trials, 53, 1–10. https://doi.org/10.1016/j.cct.2016.11.007

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RTI International. (2018). Evaluation of the Medicaid Coverage for the National Diabetes Prevention Program Demonstration Project [Executive Summary]. Retrieved from https://cdn.ymaws.com/www.chronicdisease.org/resource/resmgr/diabetes_dpp_materials/medicaid_demonstration_proje.pdf

The CDC Diabetes Prevention Recognition Program. (n.d.). Working with Medicaid Beneficiaries for CDC-Recognized Organizations. Retrieved from https://www.cdc.gov/diabetes/prevention/pdf/ta/Implementation-Guide-Medicaid.pdf

Populations with Disabilities

Carpenedo, D., Brokaw, S., Campbell, P., Butcher, M., Furshong, G., Helgerson, S., Harwell, T., Traci, M.A., & the Montana Cardiovascular Disease & Diabetes Prevention Program Workgroup. (n.d.). Are there Differences in Weight Loss Outcomes Among Participants with and without a Disability in an Adapted Version of the Diabetes Prevention Program (DPP)? Poster.

As described in the "Montana: Individuals with Disabilities" section of the National Diabetes Prevention Program Coverage Toolkit: https://coveragetoolkit.org/medicaid-agencies/medicaid-agencies-delivery/medicaid-agencies-retention/

Other Populations

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Sheon, A. R., Bolen, S. D., Callahan, B., Shick, S., & Perzynski, A. T. (2017). Addressing Disparities in Diabetes Management Through Novel Approaches to Encourage Technology Adoption and Use. JMIR Diabetes, 2(2), e16. https://doi.org/10.2196/diabetes.6751

Taradash, J., Kramer, M., Molenaar, D., Arena, V., Vanderwood, K., & Kriska, A. M. (2015). Recruitment for a Diabetes Prevention Program translation effort in a worksite setting. Contemporary Clinical Trials, 41, 204–210. https://doi.org/10.1016/j.cct.2015.01.010

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