Robert Parker joined SCL Virtual Health in January, 2001. He's responsible for 24/7 support of all aspects of the network infrastructure and employee support to include configuration, upgrades, trouble tickets and documentation.

Joanna Carver DiBenedetto is the Director of Prevention at the American Association of Diabetes Educators where she has been working with AADE's Diabetes Prevention Program since its inception in 2012.

At the conclusion of the presentations we'll have about 15 minutes to answer questions. So you can be typing in questions in the chat box throughout the presentations and also we'll have lines open up for your questions at the end.

This program provides 1.5 CEUs of Continuing Education Credit through the Commission on Dietetic Registration. A Certificate of Completion verifying completion of the activity is available on request.

Included on this slide are a couple definitions, uh-oh, I went the wrong way, sorry. There we go. Included are a couple definitions so that we're all on the same page. DPP or the Diabetes Prevention Program is a year-long program promoting 5% to 7% weight loss through increased physical activity and improved nutrition.

Programs are registered by the CDC which verifies they are providing quality diabetes prevention that maintains senility to the evidenced-based program. Organizations are denoted as pending recognition or fully recognized.

Telehealth is the delivery of health related services and information via a variety of telecommunications technology. For example telephone, email, text messages, online systems, etcetera.

Today we're going to focus on underserved populations in rural or frontier areas and we'll feature those five expert speakers that I just introduced.

After participating in this webinar you'll be able to meet the following objectives. Appreciate that the cost of preventing diabetes is typically much less than the cost of managing Type 2 Diabetes, describe what the academic literature says regarding the clinical efficacy of using telehealth to deliver DPP, review key considerations at the originating and remote telehealth sites to ensure successful DPP sessions, identify the basic technology and equipment needed to connect those providing DPP to their patients, and name the key provisions of Medicare's new DPP benefit.

So the speakers today have notice closures. Handouts may be downloaded from the box in the lower side of your screen. It might be on the lower right or it might just be across the bottom of your screen.

Please note that this webinar is being recorded for future use. The link to the recording will be available within two days.

And now I'll hand it over to Rachel for an overview of the National DPP. Rachel.

Rachel Blacher: Thank you M.R. Good morning everyone. My name is Rachel Blacher. And I am a Project Officer in the Program Implementation Branch in the Division of Diabetes Translation here at CDC.

I'm going to spend the next few minutes providing a high level overview of the National Diabetes Prevention Program also known as the National DPP and then share some information regarding the economic impact and cost effectiveness of the program.

First, I'm going to assume that most of you on the webinar today are familiar with the National DPP. However in case you are not or if you need a refresher I'd like to start by explaining how the program came to be.

The National DPP is based on the Diabetes Prevention Program Research Study that found that Type 2 Diabetes can be prevented in those who are at high risk through lifestyle change including changes in diet, physical activity and other behaviors.

The initial study design had three arms. One group was assigned the lifestyle change intervention which included counseling on diet, physical activity and behavior modification. One group took Metformin twice daily. And the third group took placebo pills twice daily and received information about diet and exercise but did not have intensive counseling.

The participants who were in the lifestyle change arm reduced their risk of developing Type 2 Diabetes by 58% compared to a 31% reduction in the Metformin group. Only 5% of the participants in the lifestyle change group developed diabetes compared to 11% in the placebo group. Those participants in the lifestyle change group were 60 or older reduced their risk by 71%.

Additionally the DPP showed that this was a lasting benefit. Ten years on those who were in the lifestyle change program group were still 33% less likely to develop diabetes.

Since then there have been numerous studies translating the research. And based on those translation studies there have been guideline updates that embrace the evidence. In 2012 the U.S. Preventive Services Task Force or

USPSTF recommended that physicians screen their patients for obesity and to refer obese patients to intensive behavioral intervention.

In July, 2014 the Community Preventive Services Community Guide recommended that people at risk for Type 2 Diabetes engage in a combined diet and physical activity behavior change programs to prevent diabetes. This guideline also included DPP findings to support the recommendation.

Later on that year the USPSTF recommended that people who are overweight or obese and have cardiovascular disease risk factors be referred to intensive behavior interventions involving diet modification and behavior change and even mentioned the DPP Study as a particularly successful intervention.

Finally in October, 2015 the USPSTF issued a recommendation on diabetes screening in asymptomatic adults. The new recommendation supports screening for abnormal blood glucose as a part of a cardiovascular risk assessment in adults, age 40 to 70 who are overweight or obese.

It also requires clinicians to offer or refer patients with abnormal glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. This could include a CDC recognized lifestyle change program for individuals with glucose levels in the pre-diabetes range or diabetes self-management education for those diagnosed with Type 2 Diabetes.

In this recommendation the USPSTF defines behavioral counseling interventions as prevention services that are designed to help persons engage in healthy behaviors and limit unhealthy ones. The DPP is one of the two mentioned in the guidelines that could feasibly be adapted and delivered in the primary care setting or by local community providers.

And finally we do have a late breaker edition to add to this slide. In September the Community Preventive Services Task Force recommended that community health workers be a part of the effort to implement intensive behavioral diabetes prevention activities such as the DPP. So it's fair to say that the evidence summary is substantial and continues to grow.

In 2009 Congress authorized the CDC to establish the National Diabetes Prevention Program. The National DPP is a year-long community-based lifestyle change program that uses a trained lifestyle coach and a CDC approved curriculum to deliver the class in a group setting.

In order to successfully implement and grow the National DPP relies on public/private partnerships including employers, insurers, communities, faith organizations, healthcare systems and government agencies. Together these organizations build the workforce including training lifestyle coaches that can implement the program, insure program quality and standardized reporting through CDC Recognitions Program, to deliver the program nationwide and to promote the uptick of the program through healthcare provider referrals and marketing.

So we're all aware that the cost of living with Type 2 Diabetes can be costly. However what is the cost of preventing Type 2 Diabetes and is this program cost effective?

The American Medical Association estimates that when someone develops diabetes there is an average increase in costs related to diabetes treatment of $8,000 over a three year period. On the other hand the average cost of the National DPP lifestyle intervention is $500 per participant.

Additionally the Centers for Medicare and Medicaid Services determined that over the course of 15 months Medicare eligible individuals who participated in the YMCA's DPP Class avoided an average of $2,650 health costs.

My colleague Joanna DiBenedetto will be speaking in greater detail about the Medicare DPP later on in this webinar.

Finally while little data exists around the cost associated with providing the National DPP via telehealth one study compared the cost associated with providing an onsite National DPP Class and a Telehealth Class.

In their 2010 paper, Vadheim, et al. found that the average onsite cost was $560 per participant and the average cost for taking the class via telehealth was $470 per participant. This is very encouraging. However more data around telehealth and the National DPP needs to be collected to determine if this method of program delivery is consistently less costly than in person.

In 2015 CDC economist Dr. Ray Lee and coauthors published a study that asks whether or not lifestyle change programs were cost effective. Dr. Lee and colleagues performed an economic review of 28 studies from January, 1985 through April, 2015 and showed that combined diet and physical activity promotion programs for people who are at an increased risk for Type 2 Diabetes are in fact cost effective.

This graph presents the scatter plot of 16 studies the cost for Quality-Adjusted Life Year or QALY saved in health systems perspective. The X axis shows dollars per QALY in the thousands.

If the Incremental Cost Effectiveness Ratio or ICER is less than $50,000 per QALY gain which all studies except for 1R, the intervention is considered

effective. If the ICER is negative the intervention is considered cost savings. Two studies demonstrated a cost savings.

The takeaway point here is that diabetes prevention lifestyle change programs have been shown to be cost effective and can be cost savings depending on the target population. For example those people who are at the highest risk will be the most cost effective. Delivery format and personnel, for example paying healthcare professionals to serve as lifestyle coaches will be more costly than lay health workers and the time horizon which means looking beyond one year.

In addition to the evidence I presented you too will soon have the opportunity to determine if providing the National DPP is cost effective in specific populations of interest.

Coming early next year the CDC will be releasing the Diabetes Prevention Impact Toolkit which is an online calculator that can be used by state health departments, insurers or employers to develop estimates of program costs and cost effectiveness at five and ten years including total cost of delivering lifestyle change program, total health benefit obtained from the program measured by cases and years of diabetes prevented, life years gained, quality saved, the cost effectiveness of the program and return on investment of the lifestyle change program.

When users have specific data about their population of interest they will be allowed to input customized values.

Another resource coming from the Division of Diabetes Translation early in the New Year is the Diabetes Health and Economic Burden Toolkit Calculator.

This calculator is only for state health departments and other stakeholders to report state specific estimates on health and economic burden of data of diabetes including prevalence of diabetes by age and sex, aggregated diabetes, attributable cases of coronary heart disease, stroke, blindness, end state renal disease, lower extremity amputation, aggregated diabetes attributable deaths or cause specific death if feasible, aggregated health life years lost to diabetes, aggregate quality loss due to diabetes, aggregated diabetes attributed medical cost in total by service and by payment source and aggregated diabetes attributable, productivity loss including the cost of workday absence, reduced productivity, diabetes related disability and diabetes related premature death.

Similar to the impact toolkit the Diabetes Burden Toolkit will also allow users to input customized values when available.

In addition to these toolkit calculators the Division of Diabetes Translation has also released two emerging practice documents on our web site that describe coverage of the National DPP by public and private sectors. The first document describes the process undertaken by the states of Kentucky, Minnesota and Washington to achieve and implement coverage of the National DPP for all state employees.

The second document describes six private sector employers representing local, national and global industries and how they use different approaches to providing the National DPP to their employees.

Both documents are useful within the context of providing case studies around how they built the business case to work with key decision makers to cover the National DPP as a benefit for employees.

Back in 2010 when we first analyzed the data we already had a small sample size of about 14 participants in the telehealth group. We decided to repeat these analyses with a larger sample to validate previous findings.

Our study objective was to compare the outcomes of those participating in DPP onsite so in person with a lifestyle coach to outcomes of those participating in DPP remotely so via telehealth. We looked at the differences in attendance, self-monitoring intake, self-monitoring physical activity, differences in weight loss and differences in cardiovascular disease, birth factors between those two groups.

Now I will briefly describe the methods used for these analyses. Montana's DPP eligibility criteria is a little bit broader than the National DPP criteria. However Montana's criteria includes all of the National DPP's criteria plus few additional risk factors for cardiovascular disease.

In order to enroll in DPP one must be at least 18 years of age and overweight or obese plus have one or more of the following risk factors for cardiovascular disease or Type 2 Diabetes. The participant may be diagnosed with pre-diabetes, have an A1C between 5.7% and (6.4%), high blood pressure, elevated triglycerides, high cholesterol, history of gestation diabetes or delivered a baby greater than 9 pounds.

Prior to enrollment into the DPP participants must have a medical clearance from their healthcare provider.

This flow chart shows the population included in this study. Starting from the top from 2008 through spring, 2015 we had a total of 894 participants enrolled in the DPP who are exposed to this intervention. The participants were taught by a lifestyle coach from Holy Rosary Healthcare. Of the 894 participants

71% took the class in person with a lifestyle coach and 29% participated via telehealth.

This map illustrates DPP sties funded by the State of Montana. Currently Montana has 20 on sites, 16 telehealth sites and 2 satellite sites.

However in these analyses we compared participants' outcomes from one onsite so Holy Rosary Healthcare which is circled on this map in the Southeastern part of the state to participants' outcomes from seven telehealth sites also taught by lifestyle coaches from the Holy Rosary Healthcare. Those sites are indicated in the blue that's outlined in the rectangular shape.

For data analyses we run (unintelligible) statistics to obtain frequency means standard deviations for both study groups. We use high score test to compare categorical data. T-tests and Paired T-Tests were applied to analyze creatine was variable with statistical significance indicated by a P Value of less than 0.05.

We applied in patient to treat analysis to calculate mean weight loss at four and ten months and finally we conducted two logistic regression models to predict permeability for outcomes for 5% weight loss and 7% weight goal.

Now I will highlight some of the study results. So in this graph we're looking at attendance. The blue bar indicates telehealth group and the grey bar indicates the onsite group.

We found that the telehealth and the onsite participants had a similar attendance. On average of 12 weekly sessions and four monthly sessions were attended in both groups.

In this slide we can see a gender breakdown and a mean age for each study group. On the left side we are looking at the gender distribution for telehealth group in which 87% of the participants were female compared to 83% in the onsite group. The mean age was exactly the same for both groups of 52 years. There were no significant differences in gender and age between these study groups.

This graph illustrates the self-reported risk factors collected at intake. Participants from the telehealth group indicated by the blue bar significantly less also reported these risk factors than participants from the onsite group. While other half so 51% of the participants from the onsite group reported diagnosis of dyslipidemia which was the most commonly reported risk factors in both groups.

In this graph we are looking at the average weight at baseline four and ten months. The lifestyle coach weighted each participant at the beginning of each weekly and monthly session. Notice that at baseline participants from the onsite group indicated by the grey bars were heavier on average by 4 pounds than participants from the telehealth group, however both groups loss similar number of pounds over the course of this program.

To conclude we found no statistically significant differences in weight loss between the groups at baseline, four and ten months.

The two main goals of the DPP are the 150 minutes of physical activity per week and the 7% weight loss goal. At ten months just over 60% of participants from both groups achieved the goal of 150 minutes of physical activity per week. And a little bit over a third of participants in both groups achieved the 7% weight loss goal at ten months. We found no statistically

significant differences in physical activity and weight loss goal between the study groups.

On this slide we see a graph that illustrates the percentage of participants from the telehealth group with normal levels in blood pressure, cholesterol, triglycerides or fasting blood glucose at baseline and ten months. The light blue bars indicate baseline and the dark blue bars indicate ten months.

For example you can see on the bottom of this graph that at baseline 62% of participants from the telehealth group had fasting blood glucose with normal range and that the percentage significantly increased to 77% at ten months. That's a 15%age point positive change if you will.

Also this intervention significantly increased HDL levels and decreased LDL levels for participants in the telehealth group.

This slide shows the same measures as the previous slide. However those results are for participants from the onsite group. In the onsite group the percentage of participants with normal range in the fasting blood glucose significantly increased from 58% at baseline to 65% at ten months. The message here is that at ten months into this program participants from both the onsite and the telehealth group got healthier and significantly decreased their risk for cardiovascular disease and Type 2 Diabetes.

This graph illustrates the percentage of participants in the telehealth and the onsite groups who self-monitored fat over the course of this program. Significantly higher percentage of participants from the telehealth group self-monitored fat up to 13 weeks. However the participants from the onsite group self-monitored fat for longer. Forty-eight percent of participants in the onsite

Liane Vadheim: I'm ready. So advance. Holy Rosary Healthcare is located in Miles City which is in Southeastern Montana. It's a critical access hospital as well as outpatient clinic and residential living facility.

The town of Miles City has about 9000 residents and is a medical hub and referral center for 10 counties all classified as rural or frontier. The next higher level of care and the nearest shopping mall is 140 miles away. Miles City is the yellow star on the map and the blue stars show the location of our telemedicine sites which are each between 50 and 100 miles away from us.

Health lifestyles is the name we use for our DPP Program. In 2008 we were one of 4 sites funded by the Montana Department of Health and Human Services to deliver the DPP. We are currently having monthly classes with the 16th cohort and weekly classes with the 17th. Each of these groups have 40 to 60 participants divided between two local classes and our remote sites. And our program has achieved full CDC recognition.

The staff started with myself and a cardiac rehab nurse, each halftime. I still do halftime and there's an athletic trainer who is about three force time. As part of our grant funding we offer exercise classes so that's an important part of what she does. And we also have data reporting requirements for our state grant that takes some of her time.

Flexibility of hours is important for us. Some weeks we have both weekly and monthly classes and are quite busy. And during the summer months we have only monthly classes so we spend less time.

Since we serve such a large geographic area we always have a few out of town participants who choose to drive into our classes. The greatest distance

has been about 80 miles each way for all 22 classes which is a total of 3520 miles. This prompted us to investigate the option of telehealth to reach participants who weren't able to drive those distances.

There are a lot of possible ways to deliver the program virtually. But I'll describe what we found works for us. We usually have two classes in Miles City plus one or two telehealth sites with each spring and fall start time. The photo here is a telehealth group. I'll be giving more details about challenges. But room arrangement can be one.

Here they're arranged this way because their room has risers and they all need to be able to see and hear the television monitor. The class size will be determined by the room they have and so ours has ranged from 3 to 25 with 8 to 12 being the most common number.

We partner with local health organizations such as a public health department, clinic or medical assistance facility to offer the program and enter into a Service Agreement with them to cover the legal aspects. They provide the facility, local equipment and the site coordinator. We provide the program materials and come in person to do pre and post visits with participants.

We pay the remote sites a small fee for their expenses. We use existing telemedicine network so there's no charge for that. The telemedicine connections are usually in a clinic, a medical assistance facility. But in one case it was a local high school. Another community did not have telemedicine at all so we used a webinar format.

You'll be hearing from Robert Parker on the actual technical descriptors of how the telemedicine worked. When I'm asked that question I just answer magic.

For the past eight years I'd come up with questions about what I would want and then I'd contact Robert and he makes it happen. So that meets the definition of magic.

The local site coordinator helps with logistics, room reservations and setup. For their end of the technology they need to know how to turn on their equipment, how to mute and unmute the microphone, adjust the volume and the camera and who to call with problems.

The local coordinators also weigh participants and distribute program materials. We mail the trackers back and forth each week. Online tracking is an option but some of our participants don't have good Internet or cell service.

The actual sessions are led by lifestyle coaches here in Miles City. Usually we have a live local class at the same time that we're connected to the remote site so the two groups have a chance to interact. The site coordinators are one of the keys of the success of the telehealth group.

They've come to us in a variety of ways. Some are people who've actually traveled to attend our group here and want to bring it back to their community. Others were previous participants in their own telehealth site and some are people we've (unintelligible) by networking with our Marketing Director and with site administrators.

The two ladies in the photo are from our very first telehealth group and are celebrating the finish of their first triathlon.

Physical activity, these communities often have limited options for organized or supervised exercise.

With each challenge comes the opportunity for some creativity. Distance and weather were the reasons we began outreach via telehealth and webinar. But many of our telehealth participants are still traveling several miles on rural roads to reach their site.

I'm a firm believer in the power of the group which is why I organized the remote sites to be groups and not collection of individuals. But for the first time this fall which didn't show up in (Deroto)'s study yet, Robert's staff is recording sessions for us. We still encourage coming to the group but when that's impossible we can forward them the link via email and they can watch the session as long as their Wi-Fi connection is adequate.

Limitations are opportunity for creativity. We're very intentional about how we plan our sessions to give the remote sites the feeling that they're both part of their own group as well as part of the combined group.

And as far as connectivity my best advice is know the IT Team. Both Robert and his staff who are 140 miles away from us and the three local IT technicians that are pictured there on the bottom have helped us out countless times.

And then backup plans are essential. At a minimum each site needs a troubleshooting cheat sheet including appropriate phone numbers. We also provide paper copies of PowerPoint slides to the remote sites and have occasionally had to resort to a conference call or even face time.

But the reliability of the technology has improved since we started. And I give total credit to the IT Team.

Community buy-in, my best advice is to learn the communication avenues in each community. Our marketing specialist who's picture is up on the top travels to various health fairs and community events. And she's a great public relations resource.

And then she's quick to volunteer us when she needs a community event speaker. But the payoff is that we become known as wellness and prevention resources.

Personal contact is a problem when they just see us on the television screen each week. So if you get to know the telemed participants, we make an in person visit at the beginning of the program and again at the end. In the meantime we exchange trackers with comments each week. We encourage them to unmute their microphones and ask questions and try to structure the sessions so that they have a chance to do their own group discussion then report back to our group.

Due to microphones and a slight time delay the conversations aren't perfect. So we encourage them to call or email us with individual questions.

And then questions or comments by our local class participants aren't always carried well on the microphone. So repeating key points so they can be heard and have participants on either end come closer to the microphone is important.

For cost we offer early burden enrollment discounts and scholarships to both local and telehealth participants. And our additional costs have been offset by our grants funding.

For physical activity we find ways to partner with the local facilities and individuals. We brainstorm with the participants to find out what's available in each community. Each one's different. It's ranged from providing exercise DVDs which a group did together in a church basement to finding a personal trainer who would do balance ball and stretch band class to partnerships with community rec centers.

All DPP programs have a huge impact. But we're really excited because in a small community that impact becomes very visible. Since we've been doing this for several years many people in town here have participated themselves or have family members participate or know someone who has. So we have new walking paths here in Miles City. We have a new story walk.

The gentleman in the upper right is the local pastor. The food at the church potlucks has changed. The gentleman with his wife, the other picture is the manager of the local grocery store and some of the foods available at that store has changed and may have produce specials that now include a bag that can be filled with fruits and vegetables for $10.

Partnerships are really essential. With the county extension service we offer healthy cooking classes. We partner with at local motel to have water aerobics classes because we don't have an indoor public pool. The gym at the local community college is another partner. The high school lets us use their consumer science room for cooking classes.

SCL Virtual Health was initially called PHTN, Partners in Health Telemedicine Network. You may see references to PHTN during my presentation.

The original idea was to connect our outlying clinic managers back to St. Vincent for Leadership Meetings. This was to prevent the clinic managers from having to travel hours into town. Those outlying clinics were located in Hardin, Red Lodge, Bridger and Ozark, Montana.

Eventually we engaged our sister facilities in Holy Rosary in Miles City and St. James in Butte. Once we got that up and running we realized that since we already have the equipment in these locations why not use them just to provide continuing education to docs and nurses.

So we started partnering with outside facilities such as Children's Colorado, University of Utah, even Seattle Children's to bring in some grand rounds that we could rebroadcast out to our sites.

These classes were very topic driven and anything that came across with diabetes in a title just filled every seat we could provide. At this point we were feeling pretty good about ourselves. We were busy. We were providing a service to these communities. But we still weren't doing telemedicine, if you could see my finger quotes which I know you can't.

Well we partnered with the Mental Health Center that was near the hospital. And we approached them with the option of providing - them providing services to the four communities that we had established. You know mental health services being a low-hanging fruit for telehealth it's basically two talking heads. No need for peripherals, electronic stethoscopes, otoscopes, that kind of thing.

The Mental Health Center came back and requested that we install equipment in the communities where their patients live. So we're more than happy to do that. After all we're trying to enter the world of telemedicine.

So here we are. It's 2001. We're doing administrative meetings, continuing education, support groups and telemedicine. So we're kind of moving and we felt like we were a little bit ahead of the curve.

Fast forward to 2016 you can see that telemedicine is now number 1. Our specialties have grown exponentially. Diabetes remains the top user of telehealth services. Patients can see their provider and diabetes educator without having to travel, right. The definition of telehealth is the remote diagnosis and treatment of patients by means of telecommunications technology.

If we take a look at our map here, I know it's a little bit hard to see but for many of us in Montana drive times can be several hours to see a provider. Montana being the fourth largest state, 46 of Montana's 56 counties are considered frontier counties. That's an average population of six or less people per square mile. That's literally more cattle than people.

That combined with the inclement weather can make traveling very hazardous and possibly deadly. These are the communities throughout Montana where we currently have telehealth equipment being used.

If we take a broader look here Montana is over 700 miles across. Here we can see that if we were to be able to pick up the State of Montana and move it over to the Midwest it would actually range from Washington, D.C. to Chicago.

This is the top of driving that Montanans don't even think twice about. We just get in our car and go. And well that's where telehealth steps in.

So we begin to look at some of the traditional technology. The hub and spoke model is where we started. And it sounds exactly like what it is. All the spoke sites are connected to the hub via direct connection. Although spoke sites can dial each other directly or by simply passing through hub similar to think of it like a bicycle tire.

We currently have 98 video units throughout the state. Fortunately most of the major manufacturers do talk to each other. But web-based protocols such as WebEx and GoToMeeting and that kind of stuff talk to traditional IP-based videoconferencing. We must at this time bring in third party software, kind of an interpreter.

We do use appliance-based infrastructure. So our infrastructure provides a number of services. We have a video bridge that allows us to connect up to 85 high definition participants simultaneously. Have a border proxy. It allows calls to come in and out through the firewall. We have a gatekeeper that controls calls and end point management such as (unintelligible) and such.

We do apply quality of service. All the traffic on the network is configured to prioritized video traffic as most important since unlike an email which can take several attempts and different paths to its destination. Video traffic must arrive on time and in order to provide an acceptable experience.

We move forward here. So if we kind of look at our traditional types of equipment we currently use a multitude of technologies. First and foremost our stable hardware unit has been in the past a portable cart. We set it up to be wireless so it's mobile, anywhere throughout the rural facility. We can attach

peripherals such as stethoscopes, exam cameras, otoscopes. Really this guy is built for longevity, got relatively small footprint which is a plus for storage in rural communities with space challenges. You can see some of the other features listed here.\

These are typically with the outlying sites used to participate in Liane's Healthy Lifestyle Class.

On the physician side the docs really like the desktop unit they can keep in their office. You know this allows them to access patient's medical record during the videoconference. The doctor can share files such as X-rays and scans with the patient as well.

We start to look at peripherals. These are just some - a sample of some of the devices it uses. There are many others that work wonderful as well but exam cameras. We use them for burn and wound care. Just push the button, power, zoom up to 50 times. It's got an auto focus, built-in light. It's washable, very reliable. There's also many types available. Like I said this is not the one and only.

The Bluetooth stethoscopes, they amplify heart and vascular sounds that normal hearing may miss. It's powered with AA batteries. And it uses Bluetooth wireless so it maintains a high level of security. And it connects to a laptop with heart and lung visualization software and it can be shared.

And we're also using some otoscopes that offer white balance and windowing. They include an anti-moiré filter. Visual cameras struggle with pattern moiré or aliasing which is caused by interference between repeating patterns such as denim or tweed so it makes it - some of these filters make it difficult for the camera to have a consistent light intensity.

So we start to look at some of the newer technologies. You know mobile devices. Unlike traditional IP videoconferencing we no longer have to book a room and then go to that room to join a video meeting. Software Kodak downloads like Cisco and Skype and Vidyo are available to App stores. These are particularly useful for clinicians that are on call. The ability to dial in from home or elsewhere makes productivity seamless.

The cloud and server-based systems, a lot of their folks have their heels sunk in very deep in infrastructure. Us included. Newer cloud and server-based services allow us to provide video services from the cloud.

In case that term still confuses you, the cloud is really just a fancy way of saying the Internet. Cloud-based services are live on the Internet and are available when needed. The downside is that no one owns or controls the Internet so you're susceptible to (lawful) quality. On the other hand coding and decoding devices have matured to a point where sending and receiving video over the Internet has developed into an everyday occurrence.

SVC, Scalable Video Coding, coding and decoding describes how bits of audio and video are transformed into ones and zeros that become packets that can be sent over the Internet. In traditional IP videoconferencing if one or more of those packets gets lost or destroyed you're going to see frozen images because the packet isn't there.

Well with SVC the standard has changed to proactively look at the network availability and dynamically scale the bandwidth and resources on your computer used so it performs at optimum efficiency.

Again my name is Joanna Craver DiBenedetto. And I'm the Director of Prevention at the American Association of Diabetes Educators.

So for those of you who may not be aware AADE or the American Association of Diabetes Educators, we're both membership organization. We have about 14,000 members nationwide who are made up of RDs, RNs, certified Diabetes Educators, pharmacists, physicians, etcetera, basically the people who are working with the people with diabetes.

But we also are an accreditor. We have an accrediting arm for Medicare for diabetes education or diabetes self-management education. What we refer to as DSME.

We have our accrediting body which accredits about 800 organizations nationwide which we call the (Ap) program. ADA is the other accrediting body and they accredit organizations and they call them ERP program but both programs are then able to bill Medicare for diabetes education services.

So a question that was brought up more often in the past, less often recently but why did AADE get involved in diabetes prevention. Well in 2012 and again in 2015, we had a national practice survey going out to all our members and we found that about 80% of them responded to already be working with people with pre-diabetes and I think that was even surprising to us. We didn't realize that so many of our members were working with people with pre-diabetes and the same went for the actual program. About 80% of those programs also reported to be working with people with pre-diabetes and doing some sort of prevention programming.

So not necessarily the national diabetes prevention programming but they were implementing some sort of educational services for people who were

interested in preventing or delaying type 2 diabetes. And at the bottom there is the really important caveat that only 0.4 of those respondents reported receiving reimbursement for preventative services.

So I normally bring this up in a lot of conversations such to show that really it's not sustainable model if our programs and our members are providing the service and they are not receiving reimbursement for it. So AADE start work with CDC in a cooperative agreement called DP 1212, if anyone's heard of that grant funding opportunity. We started working with them in 2012. In order to increase the national DPP within our network of diabetes educators and with - in all DS program, so both ADA accredited or recognized and AADE accredited programs.

So working within those DSME programs comes a lot of initial foundational requirements for DPP. So working with these programs there was always a large pool or eligible participants that could be easily identified and enrolled. All of our programs follow HIPAA compliance. There is a diabetes educator at all of these programs so when we work with them we require that our program coordinator be a diabetes educator.

We also required all of our program coordinators and anyone teaching the program to be trained as lifestyle coaches no matter what their background or education already was. We felt like it was very important to be trained in the actual national DPP curriculum but we did allow those who were not diabetes educators or community health workers, paraprofessional and lay healthcare workers to be also trained as lifestyle coaches as part of our network.

All of our programs already have an NPI number for their organization. We link it with local primary care providers for referral change and then linkage for DSME for people with type 2 diabetes. There was notification that in

many of the national DPP programs people who are enrolled throughout that year program actually realized that they had type 2 diabetes through a visit to their doctor and we felt that our programs were able to handle that and ensure that the patient got the appropriate education for their new diagnosis.

In that work, we also published our results for a three year period for 2013, ‘14 and ‘15. You can read this publication in the diabetes educator but we presented the results of these programs that we were working with, about 25 over the course of three, four years and compared their results to the CDC, recognition requirement results. And this is an infographic that should be available to everyone on the webinar to be able to download and zoom in a little bit but in this work, we have shown some good results and had some good feedback. I’ll just highlight that out of our 45 programs that we’ve been working with throughout the country, again some in Montana, but our results on average is a 6.1% weight loss for the year long program and over an 80% retention rate.

So, again, just utilizing the DSE programs to deliver the national DPP has proven really effective and I’ll just make a comment that we are providing cost-effective data later in 2017 but our costs were very similar and very comparable to any other in-person delivery network.

So I think (Rachel) went over these in an earlier slide. Again this is just the four components of the CBC’s national diabetes prevention program. What I want to highly is that CBC oversees the DPRP, the Diabetes Prevention and Recognition Program or the CDC Recognition Program. This is all available for free on their website. It’s free to apply and they also provide the CDC approved curriculum and CDC approved training entity on their website as well as a list of registered programs in the registry both the pending

recognized programs and then the fully recognized programs are listed on their websites.

They also do many other things but I just wanted to highlight the CDC Recognition Program as I will refer to that in later slides.

So the question has bene on everyone's mind, I think, recently the Medicare coverage of prediabetes. So I will go a little bit more into that right now. Most of you have probably were aware or have read the CMS demonstration project, the CMMI demonstration projected implemented through the YUSA. In March 2016, CMS certified the project and presented the results and concluded that the national DPP based on that study both increased health quality and reduced healthcare costs, so it did pass the CMS inspection qualifications and the big news is that Medicare will begin to reimburse for the national DPP for eligible patients at eligible Medicare DPP supplier organizations as of January 1, 2018. And I think everyone is very excited and very thankful that (unintelligible) was able to demonstrate the results to the national DPP.

So this is the overview of the timeline of the coverage. Again it was this past March that the demonstration results were announced. In July 2016 the physician fee schedule from CMS released a proposed coverage of DPP and was open for public comments. I'm sure many of you probably submitted comments of your own during that time. In November 2016, CMS's 2017 final rule was released and it outlined the initial coverage proposal of the DPP and in 2017we are assuming it will be similar timeline but at some point in 2017 again the physician fee schedule will be released for public comment and then again in about fall of 2017. The 2018 final rule will come out and it will address many of the questions that we still have for the future rulemaking of DPP.

So in this final rule that was just released in November, CMS released the key provisions for DPP including the benefits, eligibility requirements. The benefits will need to enroll in Medicare Part B and will need to have a BMI of greater than 25 or greater than 23 for Asian Americans. They need to present one of three blood glucose tests within 12 months of the start of the 1st session. This includes a hemoglobin A1c fast or a fasting plasma blood glucose of 110 to 125 or a 2-hour post glucose of 140 to 199.

They also need to ensure that no previous diagnosis of type 1 or type 2 or end stage renal disease. Gestational diabetes mellitus is okay but it not an eligibility on its own. You will need to have a blood-based glucose test. And I just wanted to star that no physician referral is required. So that is something that is different from DSME services, that there is a physician referral required but you do need to have a blood-based test ensuring that the person qualified for pre-diabetes.

Moving on the in CMS ruling, the key provision for DP for an organization to apply to become an MDPP or Medicare DPP supplier, they use the term supplier versus provider here. The proposed entity must have full CDC recognition to enroll as the Medicare supplier with the caveat that there will be a definition of preliminary recognition entered in the new DPP standards coming out in effect - will be put in effect in 2018 and this preliminary recognition will likely be defined as a program showing outcomes of delivering the DPP for at least one year.

All MDPP suppliers will need to enroll in Medicare even if they are an existing Medicare provider. They will need to do a separate application to become a Medicare DPP suppliers and take the screening for a high categorical risk defined. They will also need to submit a roster of all their DPP

coaches within 30 days and they will need to include individual and PMI numbers for each coach.

Again, this is different from DSME. They will need to actually apply and ensure that each coach has their own individual MPI number and they're going to be more explanation than there is already is, a link provided by CMS of how to obtain an MBI number for individuals.

The Medicare DPP supplier requirement for process of claims, they will be required to submit claims to Medicare using the standard claim forms and procedures. They will need to maintain a crosswalk between their CBC data submission and their Medicare billing data. They will also need to maintain records that contain the details of the documents of services and our eligibility requirements as well as the blood-based test and they will need to, of course, maintain HIPAA compliance.

So I wanted to highlight some of the things outlined in the CMS ruling that vary from if you - any of you are familiar with the 2015 DPRP standards or CDC standards for CDC recognition. Again the CDC standards will be open for public comment at some point in 2017 for their updated 2018 standards and just so everyone's aware, CDC and CMS are communicating just I think hopefully coordinate so that the standard makes sense along with the - the reimbursement. But as of now, there are differences between the CDC standards and eligibility requirements.

Again that BMI is going to be slightly different. Preliminary recognition still needs to be defined. Ongoing maintenance sessions for the CMS ruling. They consider the core program to be the 12 months of the program and then they are also including ongoing maintenance sessions which CDC's DPRP

currently does not collect data on any ongoing maintenance sessions beyond the 12 month program.

There will also need to be discussions on makeup session on the telehealth implementation and coverage and on virtual implementation and coverage. Currently CMS has instructor that the telehealth and virtual will be discussed for future rulemaking so as just heard many great things about telehealth implantation and studies done. I encourage everyone to provide CMS with some comments on their future position fee schedule that explain the benefits of including telehealth in the Medicare ruling.

As far as private payers, I just want to mention that there are private payers covering DPP at this point. The coverage depends on the payer including the cost amounts. You will need to negotiate or you have the potential to negotiate payment structures and amounts. As Medicare covers DPP, experts have seen it happen in other realms of coverage so we expect to see many more private payers cover DPP as Medicare (unintelligible) is implemented.

So what can you all do now to prepare? You need to begin to promote the physician referral system and any feedback loops or referral chain systems that you can embed as far as referring to DPP. Even though Medicare does not require a DPP referral or a physician referral for DPP, it still doesn't hurt to have one especially as you will likely need to have the blood-based test potentially performed by a physician and also the indication that physician referral helps support the participant to take the program seriously and succeed. There are some indications of that as well.

You as a param will need to decide your database system for collecting data. In order to complete a crosswalk with your CDC data and Medicare, you might want to consider some other levels of data collection and also to reduce

time and reduction and error. There will be a pretty data intensive set for this program.

Of course applying and maintaining CDC recognition will be pivotal to being reimbursed for Medicare. They've indicated that if a program loses CDC recognition, they would also lose their eligibility for Medicare so it's very important to read and understand the standards and be aware that they will be updated in the next year for 2018 and be able to adjust to those new standards. Again look for the physician fee schedule and DPRP standards when they're available for public comment and also attend any quality workshops, trainings and webinars such as this one that review and prepare your program for successful and sustainable DPP implementation.

There are many various groups who are working with CDC to ensure that proper information is being delegated and there are many groups working with CMS to help scale this program on a national basis. And as far as AADE, we are committed to diabetes prevention and playing a role in diabetes prevention and scaling the national DPP. We hope to be able to prepare DSME programs to become MDPP suppliers. Again we're looking to prepare a cost analysis of our model so people are aware of what this program should potentially cost and what they can potentially charge for the program.

Guidance to CDC recognition and reimbursement. We currently have about 15 programs in our network that are CDC fully recognized and there are over 30 to 40 DSE programs that are fully recognized with CDC right now. We are also creating a database system to help again compute and analyze the DPP data. We're working exploring technology implementation for implication for the DPP space including augmented services, apps and tracking devices.

We're working with the state health departments to increase referrals and the structure and support for DSME and DPP and we're looking to expand our workshops which help provide programs with the tools and resources needed to build their program as well as we have offered lifestyle coach trainings to prepare coaches to implement the program. The coach training and the workshops are open to any and all and to expand our DPP network so our model of DSE programs, both ADA and AAPE recognized programs who deliver the national DPP.

Our launching of that network services to any and all will be coming in 2017. And that is all I have so I think Marci, I will let you take it from here.

Marci: Fabulous . Thank you so much. I so appreciate all the speakers. We have a ton of questions coming in. I'm (Marci Butcher). I am the diabetes education coordinator for the Montana Diabetes Program and I am happy to sort of coordinate the Q&A session and I hope to get most of your questions answered here from our wonderful speakers.

I'm just sort of going to sort of back up and go from the beginning and questions probably are directed at (Dorota) at this point. (Dorota) is with the Montana Diabetes Program and there is some questions regarding our telehealth study for the DPP and probably Liane as well. The first one was did you use the same provider for Telehealth as the on-site DPP?

(Liane) This is (Liane). By provider if you mean me, yes.

Marci: I believe that's what was meant.

(Liane): Okay. Yes.

Marci: So the same educator, the same lifestyle coach provided the on-site service as well as the telehealth site.

(Liane): Right and that - the way we had it set up is we actually had simultaneous classes. We had our local class was meeting at the same exact time so that they heard the same thing our local class did.

Marci: Right. So you were in front of a class in a room and you also had a screen with another class sitting in a distance community and so you were teaching both classes simultaneously and being able to see and hear them at the same time.

(Liane): Right.

Marci: Okay. Super. One question was asking about incentives. Did you use incentives for any of your participants, either on site or at your telehealth sites?

(Liane): A little bit because Montana was part of a Medicaid incentive study, which is a whole other conversation. I think and (Dorota) can answer it more. I think it turned out that the incentives really didn't make much difference. They were only for our Medicaid participants which was a pretty minor part of this telehealth thing. So otherwise other than the occasional, hey, you won the door prize of stretch bands, no we didn't use incentives.

Marci: Great. Thank you. And this is probably more for (Dorota). What do you believe attributed the differences to be on the 14 week self-monitoring of weight? I believe I am asking that one correctly but maybe not ...

Joanna Carver DiBenedetto: Yes and Marci. This is (Joanna). As a CEC approved training entity, I just wanted to chime in that there's no educational prerequisites or requirements to become a lifestyle coach. AAED's model we allow community health workers and lay health workers as a part of our model, absolutely and in general to become a CDC recognized program, the only requirement is that they need to be trained as a lifestyle coach and a lifestyle curriculum by a CDC approved training entity.

Marci: Exactly and that's exactly what I was after. I think - I think there are different models throughout the country but you really need to take a look at the CDC guidelines as the training on the curriculum and that sort of thing is much - much emphasized. So take a look at the CDC guidelines and AEDE's website. It really outlines that very well.

Somebody was asking about if we provide - if DPP is provided in different languages. I'm not sure who to ask about that. Montana is pretty ...

Woman: Currently the prevent T2 curriculum is provided in Spanish on the CDC website and it was really nice because there was not a direct translation. It was actually translated by native Spanish-speaking people, so the translation adhered to cultural differences and it's also at a fifth grade reading level.

Marci: Awesome. Thank you. So the next bunch of questions get into sort of the - the definition of telehealth and what does that entail and how does that translate in different states. For our purposes, for this particular webinar it meant providing real time communication, two-way communication between two parties via audio and video conferencing. So it's real time going both ways.

There are many definitions out there. Does anybody, maybe Robert want to address that sort of definition and what does that have in terms of implications across states.

Robert Parker: Well, I can tell you that telehealth is really a broad term that covers multiple ways of communication. Telemedicine, right, is dealing with the diagnosis and treatment of patients using telecommunications technology. Kind of a subgenre of telehealth that incorporates a broader scope. As far as I know from state to state to state the definitions are the same. It's just that telehealth goes to include other forms of communication, even as far as telephone conversation, texting, emailing photos. Anything that uses the technology, telecommunications technology can be defined as telehealth.

Marci: Right but in the context of providing these classes, clearly real time audio and video is probably really preferred. What about HIPAA kinds of issues?

Robert Parker: So with - in our state, we are sure to encrypt all of our - all of our connections. When we start talking about using other providers such as maybe WebEx or GoToMeeting and those types of things, you have to remember that you're using servers, out of state servers owned by those entities and the HIPAA compliance cannot be guaranteed on other people's servers.

Marci: So the recommendations for entities that like to do this, do they need to explore HIPAA approved versions of these kind - this kind of technology?

Robert Parker: Any of these folks that you speak to our going to tell you that they are HIPAA compliant and, you know, as the HIPAA rule goes, you make an effort to protect patient confidentiality but at the same time I've heard that, you know, the FBI is unable to crack skype and I know they've got some really smart people at the FBI so, you know, there's arguments from both sides. People

will tell you all the time that, you know, I will not do video consultations, clinical consultations over skype because it's not HIPAA compliant but yet the FBI can't crack it.

Marci: So are there state organizations or regional organizations that can help facilities walk through these questions and figure out the answers?

Robert Parker: Absolutely and that's where the TRCs come in.

Marci: Please elaborate a little bit on that.

Robert Parker: Well as you know, hopefully, most - the TRCs for ten years now provided the nation with comprehensive unbiased information in education related telehealth. They are nonprofit organizations. They facilitate the expansion of telehealth and availability of healthcare to rural and underserved populations but they're most knowledgeable, they're knowledgeable experts - the most knowledgeable experts as far as support, getting started, education, questions, HIPAA compliance, reimbursement, anything that you can - question about telehealth can be addressed through the TRCs.

Marci: Great. And just remind everybody what TRC stands for.

Robert Parker: It's the telehealth resource center.

Marci: Perfect. And so hopefully we'll be able to enter a link for the telehealth resource centers and I see you're pulling up a slide right now. Thank you, folks. Thank you Robert. I think that's much appreciated.

Questions on fees. What is charged for DPP on site via telehealth and is there a difference and how have you handled the fees (Liane) now in Montana.

(Liane): Okay. Well, because we have grant funding, we have the luxury of not having to charge our participants what it actually costs us. So since 2008, our - both local and telemed participant fee has been $150. The early bird special is $100 because there's enough paperwork to get the labs and the physician referrals in ahead of time that it really is nice to have that early bird special.

We offer scholarships which are just - it's - there's not a certain number of scholarships. They are need based, based on the hospital's charity care guidelines and those can either fund all or a percentage of that hundred or $150 fee plus Medicaid people automatically - if the qualify for Medicaid they automatically qualify for our charity care and can take the program free. But again that's all because we have wonderful grant funding from the state of Montana.

Marci: Right and also we have Medicaid funding for the DPP as well through a grant but moving forward, we're hopefully going to continue that Medicaid funding after the grant because they've seen the value of this program. The other thing is I think, you know, many states are working on payers. We're really excited to see Medicare going to be reimbursing for the DPP. One of the questions was specifically about the YMCA and will the YMCA be able to build Metcare services. (Joanna), you want to tackle that one?

Joanna Carver DiBenedetto: Absolutely, yes.

Marci: I think we sort of answered it. Maybe you can lay it out there.

Joanna Carver DiBenedetto: The YMCAs along with any other organization, will be able to apply as they can apply now to be a CEC recognized program as long as it's an organization and then as long as they have CEC recognition requirements

and all those other requirements I listed to become a Medicaid eligible DPP supplier, then they can become eligible. So yes. It's including nontraditional providers or suppliers in this case that the Medicare will allow to - to apply.

Now the caveat is that you need to have the CDC requirements of recognition first before you will be eligible to apply and that can also take at this time it takes at least two years to become fully recognized. Again in the next ruling they should define preliminary recognition which we've heard will be one year of providing DPP in order to become CDC preliminary recognized program and then you could apply to become an MDPP supplier in that case. So I think it's really important whether you're a YMCA community center or a local health group, a DSME program to ensure that you're on track to apply for and maintain CDC recognition in order to become - to be able to apply to become an MDPP supplier.

Marci: Thank you. Well, we're after 11 o'clock. So there's been a ton of questions. Much more in the capbox. We're going to be asked to wrap up and the Webinar will end but if you need to stay on the phone for a little bit longer, we can continue conversations. Those questions will not be on the recorded webinar. I just wanted to thank all of our speakers and thank participants for joining us. This webinar will be available on the Montana and Florida diabetes program websites and we are thankful that you joined us today. Thanks. Hang out with us on the phone, however.

All right. I'm hoping that the have wrapped up the Webinar recording but we can continue to talk. I think there's some questions coming in about, of course, CMS reimbursement and I think that is still a somewhat unknown entity but there is one question by Linda that if asking if participants don't reach their 5% weight loss, CMS won't pay us at a certain point. Are these

participants dropped from the program and I'm wondering if (Joanna) is still available to answer that?

(Joann): Yes, Marci. So when you look at the CMS ruling, they have a proposed payment schedule and that again needs to be confirmed in the next ruling so I would say that will be confirmed in future rulemaking but as it stands right now, they would allow a participant to continue in the 12 month program even if they have not achieved that 5% weight loss but in the ongoing maintenance questions after the 12 month program, that participant would need to continue to maintain that 5% weight loss in order to be reimbursed for those ongoing maintenance sessions.

Again that is the way the rule is laid out at this point but there - it will be open for public comments so there could be some changes made to that.

Marci: (Joanna) do you know when that public comment period will commence?

Joanna Carver DiBenedetto: Oh, you think I have a crystal ball?

Marci: I'm wondering.

Joanna Carver DiBenedetto: Yes. I would assume and there's a lot of indication that it would be similar to this - the timing that it was in 2017 where it comes out normally midsummer. It's not a specific date that they release it but it's normally he end of June or early July that that physician fee schedule will come out and then they normally give 60 days to submit public comments and then it's normally about another 60 days for them to review and make any changes and then release the final ruling.

Marci: Well, I appreciate that. I guess I wanted to throw that out there to get you all thinking about this, keep your eyes open for that public comment period and please - please provide that comment back to CMS because I think those of us doing the DPP in communities and to our participants are really valuable to this process.

Joanna Carver DiBenedetto: It's so valuable and so important and Marci I can also send you - there is a link to CMS's website where you can be on their email list so they can directly notify you when things like that come out.

Marci: Perfect. I think we'll try to include that when we post our Webinar. Have that on our Websites as well. Thank you.

Question says will Medicare require the program coordinator to be a CDE in order for reimbursement.

Joanna Carver DiBenedetto: No. There won't be any requirements for the program coordinator to be a CDE. This is something that AADE for our model, we don't necessarily require our programs to be - coordinators to be CDEs. We require them to be diabetes educators and there is a difference but according to Medicare, there's eligibility requirements that I listed. That's what you would need to become an MDPP supplier. For CDC recognition, you simply have to designate a program coordinator but there is again no requirements for educational background for a program coordinator or lifestyle coach for CDEC or for Medicare.

Marci: Great. Thank you. I have just been - lost my slides. I'm not sure if everybody else has.

Woman: Yes. Adobe just ended, Marci.

Marci: Okay. Thank you. Is there an option for calling in?

Coordinator: Thank you. At this time for questions from the phone lines press Star 1. Please record your name to be introduced. Again for questions or comments from the phone lines press Star 1.

Marci: And I'm saying we'll have - take another five or six minutes, five, six, seven minutes to stay on the phone for any questions.

Coordinator: And it looks like we have a couple questions in queue. Thank you. One moment please. Okay. We have our first question from (Novina Gocho). Your line is open and please state your organization.

(Novina Gocho): Northwest Senior and Disability Services.

Marci: Go ahead and ask your question.

(Novina Gocho): I had asked whether - where we can get the DPP master training so that we can train our own lifestyle coaches.

Marci: Good question. Either (Joanna) can answer that or (Liane) who is a master trainer can answer that.

(Liane): DTTAC, two T's is under contract from CDC and provides master training programs so you can look at their website. (Joanna) do you know if other trainees for the master trainer program? I know you train lifestyle coaches, but I don't know about master trainers.

Joanna Carver DiBenedetto: Yes, sure. I know that there's about five or six, possibly seven CBC approved training entities and those are listed on CDCs websites and that include DTTAC and AADE. Some of them may offer master coach training. I know that DTTAC in the past has offered master coach lifestyle training. They do nave their requirements and everything listed on their website and AAED currently does not offer a master lifestyle coach training but it's something that we're thinking about potentially offering in the future.

Marci: Thank you. Next question.

Coordinator: Thank you. Next question is (Julia Glade). Your line is open and please state your organization.

(Julia Glade): Okay. This is (Julia Glade) with the Salt Lake County Health Department. My question is just, you know, with turn - we just noticed turnover in Utah with lifestyle coaches. How do you - how do you as an organization handle that when you do the telehelp?

Marci: (Liane) do you have some insight into that?

(Liane): Well, as far as turnover with the coaches since the coach is here, not out at the Telemed site, the only turnover is going to be when I finally decide to retire but we do have turnover in our site coordinators and that the site coordinator is not trained as a coach because they're not presenting the program. They're just turning on the TV and - but they really have an important job force because they're the liaison and we have had some turnover there and that - when I was doing my presentation, I said that's the most important part and that's also the most challenging part because the key person there just in terms of organization and being there and being on time and being approachable and

enthusiastic has - is really important and that is an ongoing challenge because sometimes they just move away or something happens.

So I didn't really answer it but as far as the actual coaches because we're here, we haven't really turned over.

Marci: And I'm wondering (Joanna) have you seen any turnover in - amongst AADEs coaches, life coaches? My thought is it's probably a pretty consistent bunch because most of them are diabetes educators.

Joanna Carver DiBenedetto: Yes as far as the program coordinators and diabetes educators or lifestyle coach staff, it seems to be somewhat consistent although we know what DSME programs this is of course another issue is, you know, keeping track of staff turnover and ensuring that the contacts that CDC has or their accreditation has are the correct ones to ensure Medicare compliance knowing that Medicare is going to require MPI numbers for all lifestyle coaches. Again that's going to be something else that the programs are going to need to maintain and report on a consistent basis and with staff turnover that can be, you know, a challenge.

So that's why you know, with some of our programs that have full-time staff or staff that are in those organizations that do other jobs and then lifestyle coaching is part of their role of that organization we think tends to be a better model. Of course as the program scales and they're going out into communities and are utilizing community health workers and they are going to various locations that you would want someone in a remote location who might not be a full-time staff.

So again these are all, you know, challenges and things to think about. There's no perfect solution but it's definitely something to think about as you're building your program.

Marci: Excellent. Thank you. Anybody have another question on the phone?

Coordinator: Thank you. Our next question is from (Joanne Kish). Your line is now open and please state your organization.

(Joanne Kish): Hi. This is (Joanne Kish) from Baycare Health System in Florida. My question is for (Joanna) and you may have already answered this (Joanna) but you were talking about the NPI numbers and know that there are a lot of RN CDEs who are providing DSNE and NDPP and RNs cannot have NPI numbers unless they're nurse practitioners, so the question is the language that is in the requirements from Medicare are they saying that RNs will be eligible to apply for NPI numbers now?

Joanna Carver DiBenedetto: Yes.

(Joanne Kish): Oh.

Joanna Carver DiBenedetto: So everyone, well not for DSME ...

(Joanne Kish): No, no, no, no.

Joanna Carver DiBenedetto: Everyone can now apply according to what we've seen with the NPI application. It's simply a person's name, address, phone number, Social Security, things like that to have them on record. There's - there's no requirements or restrictions for an individual to get an NPI number for MDPP services. They are actually going to require that any coach that's delivering

the DPP has that NPI number and that NPI number is provided to Medicare but for DSME again it's different. The organization needs to have an NPI number.

(Joanne Kish): Well, and - and that's absolutely wonderful news actually that nurses will be eligible to have NPI numbers but for - but that does open the door for DSME because RDs can apply because they do MNT with an NPI number, they can apply to be primary providers for DSME without being part of a larger organization, so it's I think that - I think for DSME you have to have an NPI number for something other than DSME to - to apply for billing for DSME. You have to have your NPI number for something else, so that actually opens the door for us if we're doing MDPP and having an NPI number that means eventually down the road we'll be looking at DSME as nurses.

Well, anyway my question was about nurses and having NPI numbers and thank you. You answered that. I appreciate that information. I'm going to go celebrate now.

Marci: Absolutely. If you have questions - this is (Marci Butcher) and if you have questions about reimbursement for DSME, there is a previous webinar that is recorded. I'm not sure if it's continued to be on the Florida website but I know it's on the Montana Diabetes Program website. (Mara) is it on the Florida one?

(Mara): Yes, I should have mentioned this. We're actually having a reimbursement webinar tomorrow at (unintelligible).

Marci: Hey, awesome.

(Mara): So it should be updated as of tomorrow.

Marci: Great. So that will be via AADE, the American Association of Diabetes Educators website.

(Mara): Yes, it's a live webinar tomorrow.

Marci: (Unintelligible) was there, diabetes educator. Org.

(Mara): (Unintelligible). Mm-hmm.

Marci: And I'm thinking we better be wrapping up. Is there one final question?

Coordinator: We do have our final questions from (Michelle Foster). Your line is open and please state your organization. Okay. It looks like she took herself out of the queue. So our last question is (Angela Gonzalez). Your line is open and please state your organization.

(Angela Gonzalez): Thank you. It's (unintelligible) Latino of Arlington County and just would like to - I'm located here in New Jersey, Mulholland, New Jersey. I just would like to know where I can get more information about how to actually become a master trainer as you mentioned. I am calling the master training to run the program here, this CDSMP and I would like to see how our agency is able to assess telehealth and I just want to educate more of the community in reference to this.

So at the beginning I had some issues trying to connecting with - and I couldn't - I don't know if I missed some things and I apologize if I did. I just want to make sure that - kind of go back into the A, B, C of it or the whole thing if I may ask.

Marci: So this is Marci again. So what - this whole webinar will be available on the Montana Diabetes Program website as well as the Florida website, and so you can go back and catch the whole thing, particularly the beginning of the webinar at your convenience.

The one thing I wanted to say in terms of telehealth reimbursement of the DPP is it's not in the current Medicare rulings but hopefully down the road it will be. We've had so many requests for - to share how we've done telehealth DPP here in Montana because people are wanting to provide that as a - just a service to their communities. In order to become a master trainer, you can go to the CDC diabetes prevention website and there is a ton of information there. Another great resource is the American Association of Diabetes Educators, Diabetes Prevention program.

Anybody else want to jump in in terms of final resources?

(Liane): Well, this is (Liane) and the only thing I would say is that you certainly need training to do your local DPP program in whatever format you're doing it but I don't think any of the trainings will necessarily address how you do it by telemed which is why we kind of did this is you get to know your IT people because each situation will be different on what resources you have available and how you might present it. So I'm not sure exactly about your question but my advice would be present your local program first and then explore the options for expanding that virtually based on what you have available for resources.

(Angela Gonzalez): Well, thank you so much. I will certainly check the entire webinar again.

Marci: Oh, fabulous. Well thank you for your participation. Great questions by everyone and great presentations. Please again we'll have these posted on the

Montana Diabetes Program website and the Florida Diabetes Program website. You have in the webinar was the ability to download the entire slide deck and hopefully we'll have a lot of information posted in addition to the slide deck for you in terms of resources.

So thank you. Thank you to all of our presenters. (Rachel), (Dorota), (Liane), Robert and (Joanna) and thank you to our participants. Keep doing a great job in your communities everyone. Thank you. Have a good day.

Coordinator: Thank you for your participation. That does conclude today's conference. You may disconnect at this time.

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