

Division of Diabetes Treatment and Prevention

FY2016 SDPI Community-Directed Best Practices Webinar

Ann Bullock, MD

Dr. Ann Bullock:

Thank you, Kelli. Welcome everyone! This is the third in our ongoing series about the FY 2016 Community-Directed Application process and everything associated with that. So we welcome you today. We appreciate you taking time out of your busy schedules to join us here. We hope and believe that the information we're going to provide you today will find useful as you start thinking about, and then very soon, have to start writing about your activities that you'll want to do, should you be a successful applicant for 2016 SDPI funds. So the Diabetes Best Practices are definitely a big part of that. So we'll be going over those at length today.

Before we start on that, I want to just give you a quick update on the Funding Opportunity Announcement, the FOA. At this point, it has gone on to the Federal Register, but it has not been published there. By the time it gets delivered there, it takes several days usually before it is posted, published in the Federal Register. So we are thinking that we will see the FOA possibly as soon as the beginning or middle of next week, but certainly would expect and hope that it will be available by the end of next week. As we've been telling you all, we will let you know when that is published as long as you have given us your email in one form or another including by signing in to these sessions, as many of you are doing now. You will receive an email from us when that is published and available and you all can start, because the 60-day clock will have started.

Okay. With that, let's talk about Best Practices. So you all are used to Best Practices. You've been doing them for a while. If you've been involved with SDPI in the last, say, almost 15 years now, you're familiar with them. We started them long ago, because Congress directed that SDPI funds be used to implement the Best Practice approach for diabetes prevention and treatment. They wanted us to use evidence-based approaches that are based not only in diabetes science but in the cultural values and wisdom of our communities. So, all of these are Best Practices that we implement for diabetes.

So we started this back in about 2001, we were remembering that, gosh, we've been writing these now for quite some time, so that it would be part of the grant program. Those of you who have been around for a while know we've done several versions of these over the years. They continue to evolve, and now we're unveiling Best Practices - the next generation.

Okay. For those of you who aren't Star Trek fans, just think of it as the next version of this. Why are the Best Practices changing for 2016? Well, a couple of important reasons. First is those of you who are using the current ones, you all know that these documents are very long. They are, in many cases, multiple tens of pages. Not only is that often not fun to read through, but we don't have the staff to keep up such long documents for so many Best Practices. Science changes too quickly for us to be able to keep up such long documents and keep them accurate.

The other thing is that many of you already know much of this. Diabetes science has been out there for quite some time now. It's not like it was in 1998 when many of us weren't familiar with these things. So, for many of us, reading through a long document is time consuming and not always helpful. So, for all of those reasons, they are much shorter now. And a very, very important reason for us changing the Best Practices is because we need data to demonstrate the effectiveness of SDPI.

Many of you know that we've required you to submit Required Key Measure data on your chosen Best Practice, but actually that data has not been combinable with other sites across the country using the same Best Practice. It's really important that we have data for the first time to demonstrate the effectiveness of SDPI Community-Directed dollars so that we can tell Congress and other stakeholders just how critically important SDPI is in our communities. So a key focus of the new Best Practices will be data collection.

And, we're expanding the scope of Best Practice work. Rather than us telling you how to improve your Required Key Measure, with what kind of population to work with, some of the old ones were like school-based or working with pregnant patients, or whatever. You can still work with those populations, but you will not have to select the Best Practice, which includes that group in the title. When you all select your Target Group, you will tell us what groups you're going to work with, where they might be found, whether in a school or in a worksites or in a senior center or wherever you wish to work with them. You'll also tell us what type of activities you want to implement in order to move the needle on, or improve, your Required Key Measure for your selected Best Practice.

So we're actually opening things up, so that the wonderful creativity, enthusiasm, and just so much talent that's out there. You all are going to be set free a little bit more actually to be able to determine what kind of work you're going to do in your communities.

So SDPI Best Practices, sort of a definition for us is that they're simply focused areas for improvement. Something you all want to look at that you've seen in your Audit or in some other form where you go, "Gosh, we really need to do a little bit better job on whatever that is, improving blood pressures in our patients with diabetes, or making sure our patients who are at risk for diabetes have gotten nutrition or physical activity education" whatever it is. Some Area that you all realize needs improving and that you have the capability and interest to put efforts toward improving and that with SDPI dollars, you would be able to actually improve them.

So, for 2016, there are 18 SDPI Diabetes Best Practices. Every single current Best Practice aligns with one of the new Best Practices with one exception, that is, to the old Community Advocacy Best Practice. Very few of you have selected that as your only Best Practice. So that should affect almost none of you, I think there may have been three for 2015. Now, you all can still do community advocacy efforts, you'll just need to do them as part of other activities that aren't your Best Practice, so everyone can promote those or ask to do those activities in your application. It just won't be part of your Best Practice work.

The reason for this one not having a new one is because it's really tough to measure this, "how do you measure policy changes in the communities" and things like that. So since there's not a good measure for it, this is the only one of the current Best Practices that will not have, one that it lines up for with the new Best Practices.

These new Best Practices have some different emphases as you will see. Some of them are about screening for things. Some of them are about education. Particularly the three main areas will be nutrition, physical activity, and other diabetes-related education. Some of them will be about clinical services, such as making sure that people who need to be on statins are on them, making sure that people who need immunizations who have diabetes are getting them. And some of these will be about clinical outcomes, like making sure that you're getting good results on blood pressures and glucose control.

Each of these is short as we've been saying, they're only one webpage each. This is much, much shorter, much easier to read, and we hope something that will be more straightforward for you all to use.

Each Best Practice, as you will see shortly -- this will walk you through a couple of them that are already on the website, includes four parts. One is a short Importance Statement. And the parts you really want to pay attention to are the next few. It is the Required Key Measure for that Best

Practice and then the guidance on how to select your Target Group for that particular Best Practice. Many Best Practices will have similar overall Target Group guidance, but there are some key differences that you will have to take into consideration as you select your Target Group. They're pretty broad, so you still have lots of opportunity for telling us which group of patients or participants you want to work with.

Finally, we have a section on resources. Now, we don't pretend this is an exhaustive list of resources about each of these Best Practice topics, but more precisely that we know that since we're not providing you 40 to 60 pages worth of information about the topic, that many of you may want to read more about the topic, or check on current guidelines related to that topic, or get some patient information handouts related to it. So these resources, that are at the end of each Best Practice, will link you to some that we think are particularly good.

So, you all need to select one of the new Best Practices for your application. Each applicant must select one. Now, some of you, you over achievers out there have been doing more than one Best Practice this year, and we will not be able to have you do more than one in 2016. The reason has to do with the new data collection system that we're developing. But as we have been talking about, you can still do different types of work. You just will need to put them in your "other activities" part of your application. So those of you who want to work on both eye care and foot care, for example, you don't have to pick two Best Practices to do it. Pick a Best Practice topic that relates to one of them and for the other one, include that in your "other activities and services" section of your application.

So this is not hamstringing you all in any way. You all can still do the multiple types of services that many of you are doing. Our Best Practices encompass both clinical and community types of activities and services. Yes, most of the titles listed there look pretty clinical and they are, but you folks doing community-based work are not handicapped in any way. You will be able to do many of the same types of services you're doing, and some new ones too, using most likely the nutrition education or physical activity education Best Practices.

As we're saying, emphasis is on providing data to show that improvements are being made. So we can show everybody, from Congress to our Tribal leaders, to our communities most importantly that all of these dollars, all of our efforts, are making a difference in health in our communities.

Our Required Key Measures are tied to the Diabetes Audit. In fact, those of you who know the Audit will look at these and go, "Gosh, that's pretty much all of the elements of the Audit." Well, we're not going to go into details about data collection. We're going to use the Diabetes Audit, which is really a program - it's a patch in RPMS which allows us to collect data from electronic records. One of the ways you're going to be able to get data on your Required Key Measure relates to using the Audit as simply a data collection tool. So indeed, the Required Key Measures are very much tied to the Diabetes Audit, but there will be several ways you all can collect the information that's needed. But the way we're going to collect it, those of you who picked the same Best Practice, we're going to be able to combine your information.

So if a program selects blood pressure control in the Nashville Area, then the improvements in their Target Group will be combinable with a program from Alaska that may select the Best Practice for example. So we're going to be able to show Congress through these different Best Practices how improvements are happening across the country.

Don't worry about getting any Required Key Measure data for the 2016 application. You will not need to do it. You wouldn't be able to do it, in fact, because the data system isn't available. So we'll mention this point several times today, because it's such an important one. We don't want anyone worrying about getting RKM data now or for the application. All you're going to need to do is select your Best Practice and related things that you will be working on if you're funded in 2016.

So applicants, as we said over and over, may propose using some of their funds for things outside their Best Practice. You've been doing it for a long time, you still can do that. We'll have you do it -- actually describe it to us better on the new Project Narrative that we showed you all on Tuesday's session. It will be easier for you to tell us about those different activities.

A reminder to grantees who are current grantees in cycle three and four, your end of your project period will overlap with the new 2016 single budget period. So you will need to be sure - for cycle three, you'll have three-month overlap - for current cycle four, you'll have a six-month overlap. You need to make sure that whatever you've committed to for your 2015 application and Best Practice work that you do indeed continue that through the end of that project period. So three months for cycle three and four for cycle four. So you'll have to be working on two basically at the same time, which many of you may select a very similar project so it shouldn't be difficult.

So, for selecting your Best Practice, so if you're a current grantee, you can propose to keep doing the same thing you're doing if you want to by selecting one of the new Best Practices that is aligned with your current Best Practice. We'll be showing you a Comparison Table here shortly. Or, if you don't want to continue, if you'd like to make a change, that's fine too. Then you can simply select a different Best Practice with a different focus. It's totally up to you. Of course, if you're not a current grantee, if you're a new applicant, you'll need to select one -- just simply select one of the Best Practices that you'd like to work on.

Okay. So with that, that's a quick introduction to the Best Practices overall concepts. So, before we go any further with talking about them, we want to show them to you. Melanie?

Melanie Knight:

Thank you, Dr. Bullock. I'm going to go ahead and switch out the layout here and start sharing my screen. So what you see in front of you -- wait for it to load, at least on our end. What you should see in front of you is the Division of Diabetes Treatment and Prevention homepage, which you can access anytime if you're on the www.ihs.gov website. You can look for the A to Z index, click on D, and then look for our full title, and that will take you to our homepage. Additionally, you could just type into your browser, www.diabetes.ihs.gov and that will take you to our homepage as well. I do recommend that once you get to our homepage, you save it as one of your favorites or bookmark it, whatever your browser decides and visit it often as we are updating it constantly, especially in terms of the FY 2016 application process.

So the focus is on finding the Best Practices. Without me even scrolling, you could see on this map that we do have a link to the Best Practices, and that might be the first place you click on, and that's okay if you do. Just note that it will take you to the 2011 Best Practices, which are not going to be our focus for the FY 2016 application. However, there is a note at the top of the Best Practices that leads you to the FY 2016 Application and Best Practices. So you could see, if click this link here, it will take you to the 2016 Best Practices and Application website.

So I'm going to briefly go back to our homepage now. I do want to show you another section that's available on our homepage and provides our latest updates, and that's here towards the bottom. This middle column here called the "SDPI Spotlight". So you could see here we have everything regarding SDPI including DP/HH and then the whole rest of the section is dedicated to Community-Directed. We have several ways in which you can access the Application website, or webpages as we call it, because they it consists of so much information and multiple webpages.

You can always click on this turquoise icon you can see here, and then we also have a link that takes you directly to the Best Practices, directly below the icon here. So I'm going to go ahead and click on the new SDPI Diabetes Best Practices, and we are taken right back to that page.

Before we go into details of this page though, I'm going to go ahead and just briefly highlight some of the other tabs that are available on this page. A lot of these tabs were covered in a previous

session as well, but again, just kind of giving you an idea what else is available on this webpage or webpage that consist of a lot of webpages. There's the introduction tab that basically provides the basic overview, some important dates and then some brief information about funding. We also have a link to our Kickoff webinar that was earlier this month, and then we also have links to the Dear Tribal Leader Letters that provided the decision on SDPI funding.

One thing that's common on the bottom of all of our webpages on this site is that we have a Questions box. So if you have any questions, this kind of gives you an idea of who you can contact based on your question. We also have the application page, and right now it's kind of under construction as we call it. It will be available as soon as that FOA becomes available on the Federal Register.

We also have our Planning Tools, Implementation Tools, and Evaluation Tools, or as we call it the "PIE" tab. Again, those are pretty much the same as the application right now. They will be pushed live when they become available, the information for each of them. And then we also have the Training tab that has again our Kickoff call, the recording, the slides and the transcript, and then we have our upcoming webinars and Q&As or focus sessions that are coming up in August.

Then, if you were on our last session on Tuesday, you can see that we have already pushed live the session that happened two days ago. So you could see you have the session recording, the slides, and then that checklist as well, and we will have a transcript coming soon.

So I'm going to go ahead and take it back to the Best Practices and let Dr. Bullock take over from here.

Dr. Ann Bullock:

Thanks, Melanie. So that was a quick tour of how to find the Best Practices now from our homepage, and then the quick review of those tabs. So right now the Intro, Best Practices and Training tabs have good information, and as Melanie said, the Application tab will have a lot more information pushed live once that Funding Opportunity Announcement is available.

So, the Best Practices have a quick overview, pretty much things we've just talked about. So I won't read that to you. Please do, I hope take some time to quickly look at this. So Melanie, if you will scroll down. For those of you, who haven't looked at the page yet. These are the Best Practice topics for 2016. Some of them look very familiar either the same name or similar name to what the ones we have been using for the last few years have. Some of the names have become more specific. For example, eye exam, it used to be called "eye care", but really what we've been tracking is retinopathy screening. So we are more precise about that. Same with foot exam, it used to be foot care, but really what's tracked is whether our patients are receiving foot exams.

So some of them are really the same kind of Best Practice simply a refinement of the name, so it more closely matches what the Required Key Measure actually is about. There are some new ones. You'll notice all of immunization ones in the upper right. For those of you who would like to work on improving the immunization coverage for your patients with diabetes, you are welcome to choose that as something you'd like to work on. That's brand-new. There was not anything for immunizations in the last version of Best Practices. You can see that the four immunizations that are considered to be related to diabetes more directly, I mean, there's always the general immunizations that all adult patients should have, but these four have particular relevance for people with diabetes, so Hepatitis B, Influenza, the Pneumococcal Vaccines and Tetanus Diphtheria.

You'll notice we're already getting questions in there (chat), "Gosh, where are all the things on prevention?" Well, we'll talk about that in just a minute. So each of these has their own webpage, and we're not going to click it in and out of 18 of them. We're going to show you two of them. Although, you are welcome to please do on your time, just take a look at each of these, but we think we'll show you a way that's even easier to take a look at them in a more concise way.

So we want to show you one clinical one. We'll start with that. And then one that's going to be the one chosen by most, probably, community programs as well as some clinical programs. So blood pressure control, this is the one we're going to start with looking at. You'll see, just as we talked about a minute ago, that there is an Importance Statement. It's pretty obvious why blood pressure control is important.

And then the two things you're really going to want to pay attention to are the Essential Elements. One is the Required Key Measures. So what you're going to do is you'll want to implement activities that will increase the number and percent of individuals in your self-selected Target Group, who have an average blood pressure of less than 140 over 90.

Now, we know that there are some patients who are older and sicker, who may not be able to achieve that tight a goal. We would suggest you do not put those in your Target Group and indeed let them have individualized targets as they need to. But for the vast majority of patients with diabetes, a blood pressure goal of less than 140 over 90 is very appropriate and will help reduce risks for things like cardiovascular and kidney disease. So the Required Key Measure is to improve, to increase the percent and number of individuals in your entire group whose blood pressures are controlled.

So you'll notice that underneath, that it says the notes. So what we defined improvement as, which is, in this case, is more people controlled. The timeframe is the budget period, which is for everyone now, will be January 1 to December 31, 2016, and then we'll be talking more about data collection a little bit today, but much more in the future.

So the second of the Essential Elements is your Target Group. So for this, we'll be looking at all adults with diabetes as the group you can select your Target Group from. Why do we not include youth? Well, many of you know that youth norms and targets for blood pressure are not necessarily the same as they are for adults, especially ones in the younger youth with diabetes. So rather than deal with that issue, for your Target Group, select it if you choose this Best Practice from your whole adult population that has diabetes.

If you don't have a very large group of people with diabetes, your Target Group could be all of them. But if you have a lot of people with diabetes and you want to focus, for example, on younger patients perhaps in their 20s and 30s and really work on their blood pressures, or you want to work -- you have a clinic that's in a particular community on your reservation, you might select that as your Target Group. Whatever as you see down below, in the Importance Statement about choosing your Target Group, you have to pick it based on the size and characteristics of the community or patient population that you want to work with, and also how intense are these activities and how many resources you had to do it.

We'll talk a lot more about Target Group selection on the call on August 11th. We'll go into much more detail about this. But right now, just start thinking about, "Can we serve everyone or do we need to pick a group? And if so, what group would we pick and why would we pick them?"

You'll notice also there's an asterisk that says, "To not include or exclude pregnant individuals." Why do we say that? Well, for blood pressure targets, pregnant women with diabetes have different blood pressure targets. They're even lower than they are for nonpregnant individuals. So, if you would like to work with pregnant individuals as part of your activities, that is fine, but you wouldn't want to pick this Best Practice because that less than 140 over 90 is not a generalizable target for pregnant women. So that's why we ask you to exclude pregnant individuals if you select this.

In scrolling down are those Resources and Tools. Since we're not giving you a long description of what all of these things are, here are some references and resources that you might find helpful whether it's to learn more about blood pressure control, learn about medications you might want to use for this, about the Million Hearts Initiative, which is focusing on reducing cardiovascular disease and they have some good patient information on things like blood pressure, the most recent

evidence-based guidelines, those sorts of things are going to be found in Resources and Tools. So that's all there is to each Best Practice.

We want to show you now just one more Best Practice, in terms of its own webpage, and then we'll show you some comparisons here in just a minute. So we want to show you also the one that many of you are going to select, and that is Nutrition Education. We thought and thought and thought, as have many people, how do you measure prevention activities? How do you measure it whether it's in people who have diabetes, like you're trying to help them prevent getting cardiovascular disease through diet and exercise as well as medications? How do we measure it in people with pre-diabetes or in youth at risk for diabetes? If you look at guidelines across the country or around the world, it's very tough to measure that. Some people might try to say, "Well, how many exercise minutes did someone do? Did they increase that?" But that's something that kind of goes up and down with time. It's tough to find something that really shows how well we're doing with prevention.

So for many, many of you, you're going to probably pick Nutrition Education as the Best Practice that will suit what you plan to do. Now, as you see here, it says it can be by a Registered Dietitian, but it does not have to be. It can be another health or wellness program staff member who has some background in nutrition. So community-based programs who do not have an RD, a Registered Dietitian, can still pick this one because all prevention activities when it comes to diabetes have some aspect of nutrition education as part of their activities. It's not the only part of what you do for prevention, but it is an essential element of it. So for those of you who want to work on diabetes prevention, this is going to be a good one for you to select, because you have already got nutrition education built into whatever program you're already doing or one you may be planning to do.

So, you will also include physical activity education and all kinds of other things that will -- stress reduction and other things that help your participants with their health or wellness goals and activities. But no doubt, nutrition education is one of those things. So what you will be working on is improving and increasing the number and percent of individuals in your Target Group who achieve this measure, who get nutrition education. Of course, we hope that with education that they're going to improve their diet habits, but again that's a tough thing to measure. So we're simply measuring whether or not we've gotten better at providing nutrition education as part of those prevention activities.

So the Target Group Guidance here is very huge, because who wouldn't benefit from nutrition education. So the Target Group you can select from are both adults and/or youth, and it can be people who have diabetes and/or people who are at risk for developing diabetes. Is that pretty much everyone in your community? Pretty close, isn't it? So you're not necessarily going to be able to provide nutrition education to everyone. So who would you like to provide it too? We'll show you an example in a few minutes to get you thinking more about how you can select this.

So we're going to have clinical programs, perhaps selecting nutrition education because they want to have a Registered Dietitian provide medical nutrition therapy for their patients with diabetes. We're also going to have community-based programs who don't have an RD, who have someone who can just provide some good nutrition basic education information either in group classes or one-on-one, it doesn't matter. You will tell us how you're going to do it.

And then, down below, we have Resources and Tools for this one just as we do for all of them. Again, not an exhaustive list but at least a few things that you may find useful as you implement this. So, we're just giving you an idea here of how this works. Those are two of the many Best Practices. We encourage you to look at the webpages.

Let's go now to the Summary Table because that's the easiest way that you're going to be able to look at all of these Best Practices pretty quickly. So you can see where Melanie is right now. She is showing you where that link is, right there in that little Quick Links box at the top of the Best Practices webpage. When you click on that, you'll come to this document. This is a list of all the Best Practices all together on just two pages and you will see the Importance Statement after the topic header on

the left, then the importance, then Required Key Measure, of course that's awfully important there, and then whatever the overall Target Group Guidance is for that Best Practice. Again, you can see it's often pretty broad that you are going to select your Best Practice Target Group from.

So as you scroll through, if you are a clinical program, there are a lot of clinically oriented things here because these are all important for diabetes care, they're on the Audit, and they are things that help us take better care of our patients with diabetes.

If you are a community-based program, you are most likely going to either want to do Diabetes-related Education or you may wish to do, as we've been talking about, either Nutrition Education or Physical Activity Education. Any of those will work for any of the programs that we've got going now, because all of you are doing one form or other of those types of education services for your participants, whether they have diabetes or they're at risk for diabetes, have pre-diabetes, whatever it is, you're incorporating those.

So, as you scroll through these pages, you can see where the -- you can look at them all. They're in alphabetical order. That's the ordering of them. It's simply alphabetical. So you may wish, for example, to do Tobacco Use Screening. Now, that could be either a clinic-based service or a community-based service.

So if you want to work on -- really, if there's one single thing that we could do to help improve the health of our patients whether they have diabetes or not, it's helping them with smoking cessation. The first step to that, of course, is finding out whether they are using non-ceremonial tobacco, whether it's oral or smoking, and screen for it, and then refer them for services. So what we will measure here is the screening for tobacco use. So again, whether you are a community-based program or you are a clinic-based program, you may select these.

I do want to mention, I've mentioned the Immunization was a new one, but another new one is Tuberculosis Screening. For those of you who got to hear the Advancements in Diabetes a couple of months ago that Dr. Jonathan Iralu, the IHS Chief Clinical Consultant for Infectious Disease gave, you know that Tuberculosis is still a problem in our communities and is especially so for people with diabetes. So you may wish, if you are in an area that has some issues with Tuberculosis still, and there are pockets of it around the Indian country, perhaps you'll want to work on Tuberculosis Screening and also making sure that people who have a positive TB test are referred for appropriate evaluation and treatment.

So as you look through this list, this will give you kind of a quick comparison or look at them all at one time. I said two pages, but actually this one runs on to a fourth page because it's lengthwise there. But you can see that these are all kinds of topics of things both clinical and community in some that absolutely are involved with -- it could be for either one.

Okay. So now you've looked at these and you're going, "Gosh, I don't see the one that I've been working on. I want to still do it. How do I figure out which one to pick?" Well then, you're going to go to a second link here, which you see as both in the text as Melanie is showing and it's also in the Quick Links box. You can go to what we call the Best Practice Comparison Table. So I'm doing something now, I want to keep doing, how do I keep doing it? So you'll come to this document when you click there. So Melanie, if you'll scroll down to the Comparison Table first off and then we'll come back up to these examples.

So this is the Comparison Table. So you can see there are just two columns. On the left are the Best Practices that you're all working with now, and on the right are the ones you will need to choose from for 2016. If you want to continue to do the same types of activities for your Best Practice work as you're doing now, then you will find the name of the current Best Practice in that column on the left, then you can look to the right to see which ones we recommend you consider using if you want to do the same types of activities. It may have a very different name in 2016, but that doesn't mean you can't do the same types of activities. So let's take the first one as an example.

So those of you who are doing the Adult Weight and Cardiometabolic Risk Management and Diabetes Guidelines one, gosh, that's a mouthful, isn't it? You can still do that work if you want as part of what you're doing to help people with either weight control or with reducing their cardiovascular disease risk is inevitably Nutrition Education and probably also Physical Activity Education. So you can continue to do those same services. So what you will track for your Required Key Measure is whichever of these two you pick. Either the Nutrition Education you provide them or the physical activity education you provide them if you choose either of those.

Breastfeeding Support is similar. If you wish to continue to work with pregnant and breastfeeding women to encourage breastfeeding, which is a wonderful intervention not only to hopefully reduce some obesity but also to increase bonding and all kinds of other important things between mom and baby, you can do that. You will probably want to pick the Nutrition Education one because inevitably when you talk to breastfeeding women about how important breastfeeding is, you are providing nutrition education. So the nutrition education you provide them would be on how good breastfeeding is.

Nutrition Education, of course is a very broad topic. You don't have to provide all nutrition education to document that you did some nutrition education. So that you can say, documenting that "I did nutrition education for breastfeeding moms, so they know how important breastfeeding is. I talk to them maybe about food insecurity and how important it is to get connected to the food resources in the community so that there's more nutrition for the baby through the breast milk." Whatever it is, there's some aspect of nutrition education you are providing them.

So the next one, Cardiovascular Health and Diabetes is -- you can choose amongst four of the more clinically oriented ones, making sure your patients who have cardiovascular disease are on aspirin or other antiplatelet therapy, making sure their blood pressures are controlled, that their lipids are being addressed through statin use, and also, of course, making sure that we're working with them on tobacco use screening and intervention.

So, you can work on all of these things but you'll just pick one Best Practice to report Required Key Measure data on. It's mentioned that community advocacy is the one from 2015 that there is not an equivalent for in 2016 and you can see that that's what we have in this Comparison Table, is that you'll need to pick something else to work on for your Best Practice work, but if you wish to continue your community advocacy work, that is fine. You'll just want to put it into the part of the Project Narrative Template which is titled "Activities and Services not related to a selected Best Practice" and you can still do community advocacy activities.

You can see as we go through this, that Community Diabetes Screening, again, it's usually if you're doing some screening in the community, you're going to provide -- we hope you are -- providing some education as part of it. It can be brief. But if you're going to screen someone for diabetes, then hopefully, you're also giving them some information on how they can either prevent it or control it.

For Depression Care, what we're following is the measure for whether or not we're screening for depression, and so on. So you all can take some time to look through here; the Diabetes and Pregnancy one is, again, you can keep working with pregnant women if you want to because the clinical targets for pregnant women are different than they are for non-pregnant people with diabetes. We don't have any of the clinical Required Key Measures and Best Practices here, but you inevitably again will be providing some form of diabetes-related or nutrition, or physical activity education as part of what you do for those pregnant women with diabetes.

Diabetes Prevention, many of you are working on that. Again, you can pick any of these forms of education. You can do the full Diabetes Prevention Program if you want, the full DPP, or some version of it as your resources allow. But you will report on whichever Required Key Measure goes with the

Best Practice you picked. This is not limiting you to not doing the full DPP, absolutely not. But what we will track for your RKM is whichever of these education Best Practices you select.

I hope this is becoming clearer as we're going through these. This is not limiting the types of activities you do; it's saying, "What can we actually measure? What can we pull out of these great activities that you're doing that is not too burdensome on you all to have to keep track of and report, and what can we then put together and show national data on?" Showing that we've improved nutrition education, the people who are at risk for diabetes, or who have diabetes, that's important. And Congress will be glad to know that, even though it's only maybe one aspect of the larger wonderful programs you're providing.

Diabetes Self-Management Education and Support, similarly. Self-Management Education and Support is something that everybody can use; if they have diabetes on how to manage it if they're at risk for diabetes, how they can prevent it. You can keep doing that work with this good tool. Pick some other aspect whether it's education or if you wish to incorporate it into Glycemic Control or one of the others, that's fine. You can keep doing that work.

If you'll scroll down a little bit further, Melanie?

Melanie Knight:

Dr. Bullock, I'm just going to have to re-share really quickly. I'm frozen. Just give me a moment.

Dr. Ann Bullock:

Oh dear! All right, so nothing like technology. I hope it's becoming more clear that the Best Practice and Required Key Measure is not intended to encompass everything that you are doing. Although it might. Some of you who are spending all of your dollars to refer your patients out for eye exams, you may pick Eye Care and that will be the entire thing that your dollars are spent on. That is fine. That's fine. Even though when they get sent out for eye care, they're going to be also getting tested for glaucoma and having their glasses, prescriptions done. That's all great. But what you'll be tracking with the retinopathy screening exams that are taking place.

Let's see, if you'll scroll down a little further, Pharmaceutical Care, most of these clinical topics, of course, have pharmacy involved and we want to have pharmacists continue to be involved and all pharmacists who do clinical care provide diabetes-related education when they work with their patients with diabetes, so they can continue to be the ones that can still focus on pharmaceutical care but what we'll track will be the diabetes-related education that those pharmacists provide to that Target Group of people that they're working with.

School Health, you can still work with kids in school, whether they have diabetes or they're at risk for diabetes. Again, if you're going to work with kids, you're going to provide some form of nutrition, physical activity, or other diabetes-related education as part of what you do.

Kidney Disease one is still pretty straightforward. That's, are we getting the right tests to screen and monitor kidney disease? Many of you have picked Systems of Care in the past. As you remember, the Required Key Measures around Systems of Care are glycemic control, blood pressure control, and lipids. So if you wish to pick one of those three, you can continue to do something that looks like your Systems of Care. In fact, this is less burdensome because instead of having to track measures on all those things, you can just track on whichever one of those you wish to focus on. It doesn't mean you don't work on the others; it just means that's what you're going to track.

And then Youth in Type 2, of course, as we've said, several times, with some of the others because they're similar. If you're going to work with kids to prevent or treat diabetes as part of what you do, you're going to do some form of education. You can keep working with youth. This is what you're

going to track. This is going to be better data that we can track as part of these wonderful services you're providing to youth.

And then the remainder ones here are the new ones; the Immunizations and also the Tuberculosis Screening. Except for the community advocacy one, we're not reducing you by any. We're actually giving you some new areas you can move into if you wish.

With that, let's go back to the slides and what I'll show you is an example, especially around the Nutrition Education. Thanks, Melanie. Here's a good example. For those who pick the same Best Practice, and here's the example we're giving, is Nutrition Education. So same Best Practice but very different activities and Target Groups are selected by these different SDPI programs. They all pick Nutrition Education. How can they do different things? Well, this is how.

Let's say program A picks it, and they want to work with breastfeeding women and pregnant women so that when they deliver, they will breastfeed. So they may select Nutrition Education, provide that support, and they're going to pick pregnant women ages, perhaps, this is just totally an example, ages 18 to 30 who all have or who are at risk for diabetes out of their local clinic population, maybe they work with their prenatal providers or whatever they want to do. That's Nutrition Education. Maybe site B says, "We want to do Nutrition Education but we're working on diabetes prevention in youth." They may say, "We're going to work with youth ages 8 to 15 who are at risk for obesity and diabetes and we're going to find them at the local Boys and Girls Club each afternoon."

Maybe another site says, "We're going to do Nutrition Education and we're a clinical program. What we want to make sure is that we're getting good medical nutrition therapy done by a Registered Dietitian to help reduce cardiovascular disease risk in our patients with diabetes." So they may pick then a Target Group of adults with diabetes. They want to work on the younger ones for prevention so maybe they'd pick ages 18 to 45 of people with diabetes who don't have CVD yet but to hopefully help prevent them from getting CVD. So this is related to those of you who are doing the SDPI Healthy Heart Intervention. This is a similar thing to what the Healthy Heart folks have been doing.

So same Best Practice, very different activities, and very different Target Groups; that is all great. We want you all to be able to expand, do what you want to do that's needed in your community. You're going to tell us who you're going to work with and how you're going to move the needle on and improve that Required Key Measure for the Target Group that you select. Hopefully, that's helping to make some sense out of this, because Nutrition Education will be one that many of you will pick.

With your SDPI Best Practice, as you think about it, you're going to base it on the needs and resources that you will identify during your planning process, and then pick the Best Practice that makes the most sense based on the needs of your community, the resources available, both SDPI and others, what your community wants you to focus on, whatever is involved with how you make that decision. Then review the elements of that Best Practice that you selected because obviously, it's going to guide your planning of the activities and services that you're going to implement that will show improvement in a Required Key Measure. Again, the services don't only work on a Required Key Measure, but they should improve it.

Make sure that you're able to collect and report Required Key Measure data. So if you are a community-based program, you're probably not going to want to either pick or try to report on something that's more clinical. Just make sure it's something that you'll be able to collect data on and we'll get around to -- I'm already seeing the questions: What if we don't have RPMS, et cetera? Don't worry. This is not a problem. And what if we don't even have access to our electronic health record systems? Don't worry. We're going to tell you more about that in a little bit.

And then you're going to need to figure out your Target Group, which again we talked a little bit about on Tuesday when we looked at the Project Narrative, and we will talk a lot more about come August 11th's session, on how to pick your Target Group. And again, remember, not all of your SDPI

dollars have to be spent just on your Best Practice. It's one aspect. For many of you, it's one aspect of what you will be doing.

I want to just give a minute here to Karen Sheff who is our data guru at DDTP just to remind you a little bit more about the Required Key Measures. Karen?

Karen Sheff:

Thank you, Dr. Bullock. You've heard Dr. Bullock mention that key focus of SDPI 2016 is collecting data which is something that we want to make as easy as possible and still get good quality data, but as she mentioned also, it's not something you need to worry about just yet. I'm kind of covering a lot of things she's already mentioned but each Best Practice has one and only one Required Key Measure. They're all listed in the website and in the tables that you've seen today. So Required Key Measure data are intended to show if the activities and services that you're implementing for SDPI 2016 are making a difference. Are there improvements?

It's also to allow IHS to provide accountability to SDPI stakeholders as Dr. Bullock mentioned. So again, the RKM data for your one selected Best Practice does not have to be reported in your FY 2016 grant application. We know you have plenty of other stuff you need to get lined up and get ready for your application, and this is not one of the things you need to worry about right now. It does, however, have to be measured by you at the beginning and at the end of the budget period. That's how we're going to show improvement. So RKM data for your selected Best Practice will be reported to IHS using a web-based data system. It's not the Audit and it's not RPMS. It's going to be a new system that will be available close to the beginning of the budget period in December or January.

Again, you don't need to worry about this now, and there'll be a whole lot more information and training coming out when you need to worry about using that.

Dr. Ann Bullock:

Great! Thanks Karen! Karen is such a resource on lots of things about data and she'll be one of the main speakers on our Target Group discussion, so we have lots of resource people at Division of Diabetes to help with all these overall questions. As you consider things that aren't your Best Practice activities, if you have sufficient resources, you can propose to do others as we've said, based on your needs and your resources. Your Project Narrative as we saw on Tuesday's session has space for up to five types of activities and services that you'll provide in addition to your Best Practice work.

We've had the question, "Will an applicant lose points for not completing other activities?" No. Everybody has to do a Best Practice and talk about that in their application, but if you only do one focus to your SDPI dollars, I gave an example a few minutes ago of maybe a small site that refers out all of its patients and uses all of its dollars for referrals to their local optometrist or ophthalmologist, then they would not be completing the "other activities" sections. That's fine. But for those of you, and maybe you do, do more than one thing with your dollars, you'll have room to tell us about that.

So in the Project Narrative you can document up to five and you'll want to make sure that you are covering -- if you have more than five, that's fine but at least for those five, make sure you're doing the ones that use the most grant funding, take up most of your staff's time and are really addressing the big needs.

With that, you all have been planning, but if you haven't it's time to start. Because of the combination of the merging of SDPI, Diabetes Prevention and Healthy Heart dollars, the DP/HH funds are being merged with Community-Directed as you've heard about especially in the Kickoff discussions. We expect that everyone who currently receives a grant, who successfully applies for 2016 will receive at least as much funding as they are currently getting. Many of you will receive more. You won't know how much more, none of us will, until after you've written your applications because all of the

things, all the components that will have to go into determining that won't be known until probably the middle of December.

But be thinking that you're going to probably have, if you are a successful applicant, at least as much funding as you have in 2015, and if you're in a new applicant, we are going to have you apply for just a small amount, but many of you will likely receive some amount more than that, small, \$12,500 that we'll have you apply for. Be thinking about this: This is your chance; you know, with a new FOA, a new competitive process. We're not starting from scratch. SDPI is 18 years old. But, all that time, SDPI has had a vision. Collectively, and we at the national level, at the Area level, but at the local level, too, we've all had a vision for what we like our communities to be like, how we can reduce the burden of diabetes, to improve health and well-being, and happiness, and joy in our communities.

This is a chance to revisit that vision. Maybe get your staff together as you're thinking about your application and start with the big picture; what's your vision for your community? And how does your SDPI program's mission fit into that? If what you're doing already is what you want to keep doing, great! If you have additional dollars or if you want to switch what you're doing, what could you do? What could you add? What could you improve? What could you beef up a little? Or how could you get some new vision? Maybe it's based on some new science that's come out in the last few years. Maybe it's based on just some new needs you've become aware of.

We in diabetes have been pretty narrowly focused at times just on glucoses and blood pressures, and as important as those are, so many other things are important in the lives of our patients that affect their diabetes; whether they're depressed, whether they're abusing alcohol or other substances, the amount of trauma and pain, and poverty, and other problems in our communities. These all affect diabetes and diabetes affects them. So I really want to challenge us all to revisit our vision.

We've had a lot of chances over the last 18 years and it's easy for this to become kind of a rope thing so let's put some energy and imagination into it. So many of you do this still and it's just exciting to hear you all. Maybe you want to add behavioral health to your program. Maybe you'll have enough dollars to hire your own behavioral health person for your diabetes program, or maybe you'll partner with your Tribal or IHS or urban behavioral health program to make sure that your patients with diabetes are getting screened and treated for depression.

Screening for depression alone is not enough. We've got to treat it as well. Some of you are offering complementary therapies that have good evidence that they help with things like chronic pain. Massage and acupuncture are two of those. Patients often love those, and they're very welcome ways of getting people to come in for diabetes care because we're helping them overcome chronic pain with something other than medications.

Maybe you're moved by the significant evidence now that much risk for obesity and diabetes starts in the womb or actually even before, we now know. But in the womb and the first few years of life. And we now have evidence that home-visiting interventions such as the Family Spirit Intervention which we talked about on a recent Advancements in Diabetes seminar which you can find the recording on our website, that Family Spirit, which was developed and tested in our communities in the southwest actually reduces obesity-associated risk factors in both moms and children. This is exciting work.

We don't have to wait until they're 10 or 11 years old and try to only work on losing weight then. As important as that is, we can go even further upstream and you can use SDPI dollars to provide evidence-based home-visiting interventions like Family Spirit because we now know Family Spirit reduces obesity-associated risk factors. How exciting is that? Because not only does it reduce obesity-associated risk factors, it reduces -- the same risk factors are also there for substance abuse and other adverse outcomes that happen all too commonly in our communities. Wouldn't it be exciting if we, in the diabetes world, could be innovators in early life interventions that not only help

reduce stuff that's in our bailiwick, our wheelhouse of obesity and diabetes but these other things that hurt our communities at least as much. How exciting would that be?

Many of our communities are dealing with food insecurity. Shouldn't our dietitians be food advocates and help link people to food resources in their communities? So often the reason people don't eat healthy foods is because they don't have access to them. They can't afford them. How could we make a difference in that in our communities? How exciting would that be?

Some of you already do this. Can we find ways to connect with the spiritual and cultural hearts of our communities? Maybe we can partner with traditional healers so we can refer people who wish to see them, who may not know how to do it. Many people in our communities do, but many don't. How can we partner with them to bring traditional values and healing to be part of what we do for our people with diabetes or pre-diabetes? How can we connect with our Tribal cultural programs and languages? Many of you do this. How can we do it even more?

Case management has been one of the Best Practices for 2015, but really, it's something that we should be using with almost all of these. Not just case management in the clinic, but we need to roll up our sleeves and go into patient homes and worksites, especially patients who have difficulty getting into our clinics, whether it's because they have lack of transportation, how far out they live, or just because they have an abusive spouse that won't let them go out of the house. There are so many reasons why people don't come to us for care. Maybe it's time that we think even more about how to go to them.

So, how do you do these? Maybe you can think about adding yoga or tai chi or some other form of stress reduction or mindfulness classes. They've been very successful in many places. People find them to be fun and uplifting, and helped them feel better in their lives and helped them take care of their diabetes better as well.

As we've been talking about here, there are many social service needs for our patients and participants in our communities. We often want them to make improvements in their diets, in their physical activity, when really, they don't have enough good food or they live in substandard housing, and they don't have an education maybe and so they can't get a good job. And so, poverty is a cycle they can't break. Maybe they're an elder and they are alone most of the day. Maybe we can help connect them with services and other things at senior centers -- and then, we can go there and do our case management at the senior center, to help take care of them. Maybe our younger patients have a hard time getting out or getting a job because they don't know about day care options for their children, that are safe and good in their community. Or maybe they just don't have access to good, reliable transportation, and maybe we can help work with them with Tribal transit or some other systems that already exist in our communities to help them.

Let's think bigger and broader. Diabetes is awfully important but all of these things affect diabetes and diabetes affects all of these things, too. It's truly a part of a larger part of the lives of our patients and participants in our communities.

All right, Take-Home Messages. Well, we're coming to the end. We're here with just a few slides and we'll start answering all these questions. So, make sure after all this, what we want you to know is an applicant, you will have to select one Best Practice. You'll need to identify Target Group and you will need to, of course, propose activities and services that you think will improve the Required Key Measures in the Target Group for the Best Practice you've selected.

Your Project Narrative, which we reviewed on Tuesday, will be available for you to download as soon as the Funding Opportunity Announcement is out. When you write your Project Narrative, you should provide a complete picture of what you plan to do with your SDPI funds. The section on Best Practice that you select, and of course, also, other activities and services that are not related to Best Practice, if you have them. If you don't have them, that's fine. But many of you do.

We have given you a full good opportunity in the past to tell us about them. We're excited to see all the things you are doing, and of course there is our website there.

So with that, the last few slides -- Melanie is going to go over and then we'll get to the Q&A. So, thanks everyone for listening to all of that. Melanie?

Melanie Knight:

Thank you, Dr. Bullock. I want to give her just a minute to rest her voice before she starts shooting away at answering those questions. We have here on the slide, the upcoming training webinars. So, you could see the one on August 3rd on the Funding Opportunity Announcement. Again, we just don't know for sure if it'll be available by then. If it is available, on the Federal Register by August 3rd, we will definitely be presenting on that Funding Opportunity Announcement. However, if it is not available by then, we will just hold a regular Q&A, pretty much going over whatever is available on our web pages and answering questions.

We are hoping that by August 7th, that FOA will be available and we will provide a focus session on that then. The Project Narrative will be moved down. We already have it as a repeat topic on August 14th. If that feels a little late for you, fret now, we will have a recorded overview available on the Application tab.

We will make sure to have at least a recorded overview pretty much going over that Project Narrative Template available beforehand.

So again, just keep your eyes out on that Training tab. We will have more upcoming webinars throughout the remainder of August as well. We also want to make sure that you stay informed, so as always like I mentioned, visit the Division of Diabetes website, visit it often, bookmark it, save it as one of your favorites. Whatever you do to check it often. Again, look for this logo or icon and click on it often for it will take you straight to that application and those application webpages. And then also, check your email often. If you want to make sure you're on the email list, send us an email, you can click on this link here and it'll open up in the email and go to several of us and we will make sure that you're on the email list. If you're a current grantee, chances are you are already on this list. If you were on a previous session, chances are you're already on this list as well. Again, don't hesitate. If you're just not sure or you're not sure if you're receiving emails from us, go ahead and shoot us an email, and we'll make sure you're on that list.

Again, if you sign in today as well, you will be added to this email list for updates on the Fiscal Year 2016 application. And then again, if you have any questions, you can also use that same email as well to send us questions. So with that, I'm going to go ahead and move on next to the Q&A's and have Dr. Bullock take over again.

Dr. Ann Bullock:

Thanks, Melanie! So, I know that lots of questions have been coming in. I hope that as we went through this, some of them had been answered already, but we'll be sure and get through them.

All right, we have just a comment that, saying, "It's good to have a key measure report included with the Audit." Indeed, the Audit already includes some of the Required Key Measures as part of what's in there. So, that's great.

Okay, Paula Tsoodle said, "Tribal communities sometimes have trouble with accessing RPMS, any solutions?"

Don't worry about the data systems. If you are on RPMS, you will have an option for using the Audit, the collection tool, but you do not have to be on RPMS or even have an electronic medical record. There will be several options for collecting and reporting Required Key Measure data. We will tell

you much more about that later. You don't need to worry about this for the application. But everyone, whether you are on electronic record, RPMS, or otherwise or even if you do not have an electronic record available to you, maybe you're community-based program that's not connected to a clinic, we can still get your Required Key Measure data. We will tell you how to do it. So, no worries.

Sandra Hahn said, "Just a reminder that some tribes are in different computer system."

Okay. Same question, don't worry. You don't have to be on RPMS or even have electronic health record at your disposal.

"When will the project narrative template be available?" That was a question from Kerstin Powell.

The project narrative template and all of the application materials will be available as soon as the Funding Opportunity Announcement is posted on the Federal Register; we will send an email out to all of you who are on that email list that Melanie just talked about, as soon as that Funding Opportunity Announcement is available. I assume most of you are not looking at the Federal Register everyday of your life, no worries, we will tell you when it's available. But that's when the starting gun goes off, so to speak, is when it is posted in the Federal Register, and then it is official that it is a grant program of the Federal Government and all of the application materials in grants.gov and on our website will be available. We're hoping; fingers crossed that it will be next week.

I can't tell the name on this one. "In the past, we used nurse case management, nutrition case management, foot care, eye care nutrition. Can we do the case management?"

Absolutely! Case management is an excellent tool as opposed of it being its own Best Practice. We hope that you all are using case management for most if not all of the Best Practices. But it's not possible to really measure case management per se, but use it as a tool for doing something else, something that we can measure in the Audits. So, please do case management. That's completely fine. Just pick one of the Best Practices that you can watch your case management to focus on. So, if you want to keep focusing on nutrition, or foot or eye care as you have in your question, that's perfectly fine.

Bernita said, "Are we still able to utilize the Area nutritionist? We do not have a nutritionist available to provide services to our community and I am told our service Area has a nutritionist. I know now Phoenix Area has a nutritionist."

Okay, we are happy if you pick Nutrition Education. If you want to have a Registered Dietitian provide that, that's great. But if you don't have one and don't have access to one, you can still provide nutrition education. We're not requiring it to be an RD to do this. If you are a community-based program, you can use one of your staff members whose job is to be, know a little bit more about nutrition, then you can have that person provide the nutrition education. It does not have to be an RD. Although we'd love it if you have an RD to help inform your services, you don't have to.

Juli Kelly said, "If we want to track additional patient outcome measures, can we have more than one Required Key Measure."

Oh, gosh! There are those overachievers. Good for you, guys! The limitation here, and what was said in the discussion, is that our new data system, at least for this year, we may in the future be able to track more than one Required Key Measure for you all. But because for many of you, you will actually be tracking your data within our system, we're not going to be able to do more than one Required Key Measure in 2016. But that does not mean that you all cannot do your own work. We hope you will.

In fact, when you look at the "other activities and services" part of the Project Narrative, you will see that we're going to ask how you are going to assess what you're doing. Do you have a data collection

plan or some tool for figuring out if your other activities are also providing improvements. Certainly, you can do or track more than one outcome of what you're doing, but we won't be able to do it in the data system. It's simply a limitation of this brand new data system which our excellent web programmers are working on furiously right now to get ready in time for 2016.

Dr. Veazie, "If an applicant is in a position to commit to measurably changing A1C level through medical nutrition therapy, should they choose nutrition education or glycemic control?" Yes. Either one, whatever one you want to work on. If you want to pick Glycemic Control and measure that you have increased the number of people in your Target Group who achieve an A1C less than 8, then go ahead and pick Glycemic Control. If you wish to pick nutrition therapy and demonstrate that you provided Nutrition Education to people as part of that effort, that's fine, too. You can do the same activity. You can pick which of the Best Practices you select to do it.

The rest of this question is. "Should the Required Key Measure the site is willing to commit to changing be a primary criterion for which Best Practice to choose?"

Well, it really should. Your Required Key Measure is certainly at the central part of what you're going to be responsible for doing. Not only will you have to in your annual progress report tell us about how you're doing with the activities, but where the rubber really meets the road is of course the Required Key Measure. So yes, indeed, that would be a very essential part of your decision as to what Best Practice to pick. Of course, we also hope you'll factor in the needs of your community and what you're hearing from Tribal leaders and community members about what they'd like you to work on. But absolutely, the Required Key Measure is huge and should be an essential part of your decision process, making sure that whatever it is you work on, you'll be able to gather data for.

Jill J. says, "In regards to nutrition education or any of the other education aspects, are the reported numbers duplicate or unduplicated counts?"

I think if I'm understanding your question, you're referring to, if you would provide the same education for more than one person over a year and we hope that you often will, it's the number of people in your Target Group who receive it. So, if they receive it once or 10 times, that person would count as one. So, you would be trying to improve the number of people in your Target Group who receive nutrition education. So it would be, if I'm understanding your question correctly, it would be unduplicated counts.

Arlyn Pittler said, "How would you define pre-diabetes populations? Since most of our people are at-risk according to DPP Guidelines. The question is in regards to the nutrition education Best Practice."

Pre-diabetes has a very specific definition. Most people use the A1C definition of 5.7 or 6.4, but you don't have to take care of everybody with pre-diabetes nor do you even have to measure it if you do not want to restrict yourself to people with pre-diabetes. I completely agree we all do. That many people in our communities are at-risk for developing diabetes, maybe it's because of their glucoses are in a pre-diabetes range. Maybe it's because of obesity or acanthosis or some other type of thing that you know makes them at-risk for diabetes. So, we don't have an issue with who you do the nutrition education for.

If you wish, as a site, to do the full diabetes prevention program, you might wish to restrict yourself to patients who you know have pre-diabetes, but that would be your choice. That's not our selection in terms of who you pick for your Nutrition Education Best Practice. Again, you will tell us who you want to serve, and what direction you want your services to go.

Annie Edleman said, "Would it work better to do diabetes-related education for many of us who were doing school health, community activities and exercise promotions along with many of the nutrition education activities we are doing? Can we then add some of the more clinical things we're doing like foot exams or eye screenings or other activities?"

Yes, you very well may want to do that. Diabetes-related Education—if you'll all look in the health codes, for those of you who use RPMS, if you don't, don't worry. But if you look at the health codes, for diabetes education, it's pretty broad. It does include physical activity and nutrition topics. So you very well may want to, for the type of program you're describing, select Diabetes-related Education and then, you would be able to count any of those kinds. Exactly right.

Juli Kelly says, "If you have a combination of community and clinical services, can the Target Group be delineated by type of service somehow, because the Target Group for our youth services won't be the same Target Group for our clinical setting services with adult patients?"

Indeed. You're talking about probably two different types of services. So, you will pick one of those two groups to have for your Best Practice activities and you pick appropriate Best Practice that matches the activities and the group that you wish to serve there. And then for the other set of activities and Target Group, you will describe that for us in your "other activities and services" part of your Project Narrative. So, it's up to you which one you'd like to pick for your Best Practice work. Again, your choice.

Heather Garrow said, "Technically, diabetes-related education encompasses -- right."

So this question came in before we said that other one. Yes, indeed. You're quite right Diabetes-related Education does encompass nutrition education and physical activities. So, if you are providing a number of different kinds of education to your patients, you very well may wish to pick Diabetes-related Education. So you'll have the option of many types of education in that realm in order to document, to show improvement on that Required Key Measure.

Stefanie Stark asked, "If I select an immunization Best Practice and also use SDPI funds for community physical activity, could I still do this under other activities?"

Absolutely! You bet! If you want to improve immunizations, for example, for influenza, in your patients with diabetes and also wish to do education related to physical activity and have fun runs and other sorts of things in the community, just pick which one you want to have for your Best Practice and the other can be part of your other activities. Absolutely!

We're getting a lot of questions that are similar, so we'll try -- can I do this and this kinds of questions?

Dr. Shumway asked, "It seems like if we all pick a different Target Group, the data won't aggregated as easily."

Well, you're right about that. But what we're trying to do is look at the number of people across Target Groups that are selected for sites that select the same Best Practice. Even if they're doing adult or youth, or they're doing different types of activities which we expect you will, we can still say the number of people who, in the nutrition one for example. I'm totally making up numbers here. We can say across the country, 100 programs selected Nutrition Education. They targeted those activities at 10,000 patients and they went from 3,000 to 6,000 patients who had nutrition education provided to them. That's an improvement and that is a meaningful improvement. It's the kind of things our stakeholders like to hear.

Similarly, if you want to pick different groups of people to focus on - blood pressure, some of you may want to focus on the younger folks. Some of you may want to focus on patients with diabetes who have cardiovascular disease. We still can say of the number of patients who have blood pressure was addressed in that there was an improvement in the number of patients of that total Target Group who had improvement, controlled blood pressures. So, you're right indeed. The data will come from different Target Groups. But that's okay. It will still give us meaningful data across the country on improvements.

It was a similar question from Arlyn Pittler, hopefully we just covered that.

Hualapai says, "If you select physical activity education, could you identify a large Target Group -- such as everyone over three?"

Does that mean over the age of three? I'm not sure.

"In work, in schools, fitness centers, and senior centers?"

Absolutely! If you want to go and do classes, this is where Target Group selection is really key and well applied. You're really great for this question to bring that out. So if you want to do education in group classes and you want to work in some of the places that you described, schools, fitness centers, senior centers, you may pick a large Target Group to work with and then show improvement by showing how many of those people receive Physical Activity Education at the end of the year compared at the beginning of your project year. Absolutely.

The more you do screening or things that can be done quickly or education that may be done in groups, you may wish you should pick larger Target Groups. If you want to do something that is very staff intensive like a full Diabetes Prevention Program or a very intensive clinical program for patients who have advanced kidney disease and heart disease, you're going to pick smaller groups because the amount of time and resources it will take to take care of those different kinds of populations will be different.

Marie Rumsey asked, "Will nutrition by RD under diabetes-related education still be in on the next Audit or will that be changing?"

We will continue to ask that question on the Audit, but we will be looking at both. Karen, did I say that right?

Karen Sheff:

Yes, that's correct. The item will still be on the Audit.

Dr. Ann Bullock:

Right, good. Thanks. Juli Kelly asked, "Will the services and activities we identify in the other activities section have an option for identifying outcome measures we will track that activity?"

Absolutely! Now we won't be able to -- we won't have a data system where we can collect all the data we hope you guys will generate from your other activities, but we will be asking you how indeed you will be assessing whether or not these other activities have been effective. And you very well may tell us that you're going to be measuring that through some very concrete data measures. We would love that, for where that is possible.

Bernita asked, "Our obesity rates among women is high and we know it will eventually turn into diabetes without some type of intervention. I wonder if any program has done their Best Practice on obesity rates or if there is one? I need some examples and ideas."

Gosh, that is a huge problem, and in Indian country we're not the only ones dealing with that. It is very tough to measure weight loss across large groups in a meaningful way and it's tough to achieve meaningful weight loss as well. So you're noticing that we don't have BMI as a Required Key Measure. So if you wish to work on obesity prevention or reduction or management, most likely programs doing that will pick Nutrition Education or Physical Activity Education or Diabetes-related Education as you've been hearing as they work on those larger issues.

Juli Kelly said, "So breast feeding is linked with nutrition education Best Practice in the comparison table, but can't it also fit under diabetes-related education Best Practice too?" You betcha, absolutely.

Bernita asked, "Is there any other curricula out there besides balancing your food choices addressing the obesity dilemma?"

I think Monica put something in the chat about linking to the DPP. As we all know, nobody has really simple, easy answers on any of these things. None of these programs work magic. DPP does indeed reduce some of the risk factors and has been shown in clinical trials to reduce incidence of diabetes, at least to slow it down, it's not prevent it. But this is tough. So there are curricula out there but indeed, we want to encourage you all to work on that if that's what you and your community would like to do, because helping connect people to healthy food is a really good thing. But it means you're going to have work on food insecurity because a lot of our people don't have consistent access to enough food of sufficient quality to be able to feed themselves and their families in a healthy way.

Kathy Canclini asked, "We do both Adult Weight and Diabetes Self-Management Education now, so is it okay to do self-management education as our new Best Practice since nutrition and physical activity and rest of diabetes topics are all in the scope?"

You certainly can continue to do Diabetes Self-Management Education. We hope that many of you will use that as a tool for improving your Required Key Measures. Which focus you use for that DSME is up to you if you want to do nutrition or physical activity or any of the others including some of the clinical topics, you are welcome to do that. If you want to do Diabetes Self-Management for people as part of improving blood pressures or glucoses or anything else, that's all fine. It's a good tool for helping with whichever Best Practice you select.

Bernita asked, "We don't have to use the provided Audit but start with our own data?"

Right. This Audit that you guys do, we all do every year that looks at that hopefully everybody in our communities that comes to our clinics for services related to diabetes. The Audit will probably not be the place that you will be getting your data out of to show progress and Required Key Measure. Why do I say that? Well first of all, the Audit only looks at people who have diabetes. So if you're going to work with the populations that don't yet have diabetes, they won't be in the Audit.

The other issue is that the Audit hopefully is capturing a lot of people in your community and you may not select a Target Group that large. So the Audit itself is a great data tool to show you how overall things are going in your communities and help you as you plan your activities and select your Best Practice to know where things could use some improving. But we will indeed be looking at other ways of getting data besides the Annual Audit Report you all get in terms of reporting on your Required Key Measures. So we will be telling you more about that and indeed you will, as Bernita says, be starting with your own data which will come some different ways.

So Jamie Sweet asked, "Subpopulations outside of the diabetes registry will not be captured in the Audit?"

Okay, we just talked about that. So indeed, one option will be to have -- if you have RPMS or an electronic records system that has the option for a registry, you can have a registry of people in your Target Group but that is not the only way to do it. You'll be able to do it directly through our web-based data system that will be, as Karen said, available in December or January, so no worries.

Maggie Miller asked, "Is there any work happening with Centers for Disease Control under DPP certification program for the IHS DPP version being an accepted curriculum? Any new buzz about reexamining DPP as new dietary guidelines are coming out?"

Right. Many of you who are aware about the Diabetes Prevention Program know that the DPP curriculum itself and the Native Lifestyle Balance Curriculum that is based on that for our population,

is a little out-of-date or becoming out-of-date. The University of Pittsburgh actually has the copyright on the DPP and I understand they are indeed updating that curriculum to include new dietary guidelines. So, some of the Native Lifestyle Balance and old DPP curricula are a little out-of-date, especially on nutrition. You're quite right about that, but understand that that is being worked on at least from the DPP angle and hopefully someone will adapt that to Native Lifestyle Balance.

The question on the CDC – CDC does now have a certifying process for diabetes prevention intervention at sites. We're not working directly with them, except to help get the word out about that. We have met with CDC with Dr. Ann Albright who is the head of the CDC's diabetes, Division of Diabetes Translation, and they're very glad that a number of our sites are indeed pursuing their certification program for providing diabetes prevention services. Those of you who wish to do a full DPP, we certainly encourage you to go to the CDC website and if you're not aware about their certification program to consider pursuing it. The advantage if you are certified is that some forms of health insurance, including Medicare and others, will reimburse for those interventions. Not all health insurances will do that, but many will. So I encourage you to take a look at that.

We're just about at the hour and a half mark. As Kelli said at the beginning, we're happy to stay on for another -- up to a half an hour to keep answering questions. Those of you who will have to drop off, we understand. We'll just keep going with questions until either five o'clock eastern or until we run out of questions. But we'll keep going with those in the meantime.

As you heard earlier, this session, like the others is being recorded and will be available on our website within a week probably within just a few days.

Okay. So next question, Janet Crutcher asked about recommendations for a new Best Practice instead of case management. Well, case management is a great tool for lots of different -- pretty much all actually Best Practices.

So if you have a particular focus of your case management, or even if you don't, just pick a Best Practice that you would like to use case management as a tool to improve. You have lots of choices there. And even if you work on case management with more than just the one single Best Practice you select, which you probably will, you'll just have to report on the Required Key Measure for one. But case management is an excellent tool.

In fact we will have short, we're calling them, "primers" on these two excellent tools we hope you all will use in your efforts. One is self-management education and support and the other is case management. So those will be available on our resources tab. I'm not sure just which one, but hopefully in the next couple of months as you all try to start implementing your Best Practices, we'll actually have some several page documents to help those of you who are maybe not as familiar with those two really important tools.

Kathy asked, "Can we still use physical activity for our Best Practice and still contract a pharmacist?"

Absolutely. Physical activity, I assume you'll do -- I'm guessing the pharmacist isn't the one providing it so I'm guessing you're talking about two different activities, but again, you can continue the same activities, you may need to describe them, one is your Best Practice and one is your other--one of your other activities, but you can certainly continue to do both.

Beth Moody asked, "With nutrition education, can you have more than one target population identified?"

In a sense, the answer is yes. If you want to work with several different groups of people, but you're only going to measure them all together. You're only going to follow them together. So for example, if you want to work on Nutrition Education for students in the elementary school and also patients in your clinic, you can work with both, just define your Target Group as being those two groups of people. And in terms of the Required Key Measure, you'll report on them together. But if you wish

to have kind of two different groups that are combined for one Target Group, you can do that. If you want to just follow your success for them separately, we wouldn't be able to do that in our data system, but I'm guessing that you all probably could.

Amy Ward said, "Can we have two Target Groups in one Best Practice?" A similar question. "For example, glycemic control: improving blood glucose in both patients with diabetes and those with pre-diabetes."

Well glycemic control is only for people with diabetes. So there are examples of two Target Groups that you might use or combine into one Target Group, but for Glycemic Control, you would be focusing just on improving blood sugar in patients with diabetes. But if you wish to work with patients who have pre-diabetes, there are other choices for Best Practices.

Beth Nichols asked, "If we are on cycle four and have a six month overlap of funds, do you have any suggestions about what we can use those overlapping funds for?"

Sure. Most likely, what most of you will do is one of two things. You can either use those six months of funds where you have both 2015 and 2016 funds if you're a current cycle four. This will only happen once, once we get every one on one budget cycle. This won't happen every year, just once. If you have a way of augmenting your current services, that's fine to do. Many of you may select to use those funds for one-time purchases, like diabetes medications, or orthotics for your diabetic shoe clinic, or other kinds of things that you use for one-time allowable costs. So most likely, cycle three for their three-month overlap and cycle four for their six-month overlap. We'll see a number of you proposing to use your 2016 funds during that overlap period possibly on some one-time allowable cost. So, lots of choices on that one.

Nevada Urban said, "When we choose up to five activities in addition to the chosen Best Practice, can we include several items per activity, e.g. monitoring blood pressure glucose and lipids?"

Absolutely! You don't have to talk about individual clinical indicators where we'd assume that really what you'd be reporting on would be clinical activity or clinical care for people with diabetes which includes those three things. And if you're going to focus your measurements for your "other activities" on blood pressure, glucose and lipids, then that would be part of that. So you don't have to separate them, you can just talk about the clinical care that you'll provide with some of your SDPI funds, that will work.

"Would any of these components have to be a separate activity?"

Right. Probably you would pick one Best Practice activity and then clinical care or something else for the others.

Kathy Canclini asked, "Are we providing numbers in our specific Target Group?"

Yes, you'll have it. You're going to be telling us on the Project Narrative what you estimate the total group of people is that you could pull your Target Group from and then you will tell us what the Target Group is that you select. Both describe it and give us an estimate of the numbers that will be in your Target Group.

T. Aguilar asked, "If programs continue with their current Best Practices, do we still have to report on our old key measures in addition to our new Best Practice?"

Yes. As we said in the presentation, if you're a cycle one or two grantee, you will finish your 2015 activities before you must start 2016. The current cycles three and four will have overlap. Three months for cycle three. Six months for cycle four. You have already promised to do certain Best Practice and other activities for 2015 so you need to be sure that you are fulfilling whatever you've promised to do in your application for 2015 funds. So with 2016 funds, you will do, like I said,

perhaps some one-time purchases during that overlap time whatever you wish to do, but you will need to report out on 2015 just as you always have.

Jamie Sweet asked, "Will you be covering how to write a SMART objective without a baseline percentage for improving the Required Key Measures/objective?"

SMART objectives, of course, relate to being very specific and whatever. I think, Jamie, once you see what we have for the Target Group kind of things that will come pretty close. We won't have exact baseline numbers on what the RKM will be, but there will be some estimates. And so, in this first year, of course going forward, once we are done with 2016, and we're moving to 2017, you will have baseline numbers to start with for 2017, because it will be your end point for 2016 if you continue the same Best Practice. So, it will be pretty close, Jamie. We'll be able to do some estimates in the application without having people having to measure Required Key Measure data now. That would be pretty additionally burdensome to process where there's already a big process for an application.

Amber Garcia asked, "Will the annual Diabetes Audit be replaced with the new Required Key Measure webpage? Will the Audit still be required?"

The Audit will still be required. Karen, you want to take this question? This is a good Audit question.

Karen Sheff:

Sure, absolutely. So the Audit will continue as it always has. The web Audit will still be there for people to use. We'll still have the Annual Audit tools available early in the year and we'll still have the interim Audits in the web Audit for people to use. None of that will change. The new web-based system will have a new name. For people who use the WebAudit, it will look similar in some ways, but you do not have access. You have to have access to the WebAudit to use the new system. And as I said, we'll be providing folks with lots of training and resources when they need to start using that system.

Dr. Ann Bullock:

Great. Another question, sort of related from Heather Garrow. "We don't report in the application but do report at the beginning and end of the budget period. Can we expand on that?"

So for the Required Key Measure, you will need to, through these data systems we're going to tell you more about, if you are a successful applicant and become a grantee for 2016, then you will need to measure whatever your Best Practice is, whatever key measure goes along with that, you're going to need to see in your Target Group where you're starting from. What number of patients already have control blood pressure in your Target Group versus the number of patients overall that you are -- versus the number of patients that are in your Target Group? I said that badly.

So if you're doing blood pressure control, the beginning in January, you'll see -- just find your Target Group. Let's say it's 200 people, and let's say 70 of them in January 2016 have controlled blood pressure less than 140 over 90, then you will then measure it again in that same group of people in your Target Group in December 2016, and hopefully that number has gone from 70 to, let's say, 150 of those 200 people now have controlled blood pressure. So, we'll be telling you a lot more about how you report on all of that, but you're going to show that from the beginning of the budget period to the end of the budget period that things got better in your Required Key Measure. At least that's what we all hope we will all show.

Dede Lavezzo asked, "Would we combine -- we have DPP and community-directed -- the two grants for the funding total?"

DP and HH have taught us a lot and shown us a lot since 2004, but they are a separate grant program from the Community-Directed grant. So when you apply for 2016 community-directed funding, you will be applying for the same amount of Community-Directed funding that you received in 2015. You will not be adding in any funding you may have received for DP or HH, just Community-Directed. There will no -- not be any 2016 dollars going through either DP or HH, as a separate grant program, just Community-Directed.

Joaquin Marchand asked, "Is the funding amount the same as both the grants?" Same question. No, simply it is Community-Directed funding that you have received in 2015.

Bernita asked, "Would we be able to utilize the funding to get a doctor to provide services to our diabetes clinic at least one time a month?"

Yes. If you want to use your funds to provide physician services, that's fine. We would think that having a physician where you didn't have one before, you would see some improvements. You can take whichever Best Practice you want to measure data on and show improvement in that Required Key Measure, because you provided the doctor one time a month. That would be great.

Her question goes on to say, "I know it's IHS' responsibility, but there is no continuity of services for Area, but the service members rotate every two weeks."

Right. If you wish to provide clinical care through your SDPI funds, whether it's through a contracted physician that comes to your clinic or that you send your patients to, if that's something that's appropriate for where you are, that is fine. That has been okay in SDPI. It will continue to be okay.

Jessie Hecocta asked, "And so if you choose DPP to keep our current program going as is, would other Best Practice that we would like to focus on be considered other activities or vice versa? Would we choose a Best Practice like oral care and then state DPP is another activity?"

Again, this is your choice. Whichever one you would like to collect Required Key Measure data on is the one I'd suggest you pick for your Best Practice and your RKM. So if you want to do DPP, you can use that as your Best Practice if you wish to and pick one of those, probably one those education Best Practices we talked about, and then have your oral care, your dental exam Best Practice, be one of your "other activities." Or if you would prefer to do the reverse, that's fine too. It's up to you.

Kathy Canclini asked, "Can you elaborate on the levels of intensity, low, medium, high intensity?"

Okay. When Melanie showed the Project Narrative on Tuesday and when you get the Project Narrative when the FOA is released, you'll see it again. We were showing that there are different intensities in activities you might select to do. We were giving them, and when you get a chance to look at it more in depth, you'll see that this was simply an example of -- if you're going to do an intense activity like a full Diabetes Prevention Program intervention, then you will not be able to probably work with hundreds of people because it's a very intensive activity that takes a lot of staff, time and resources. Whereas, if you want to do a screening one, such as perhaps depression screening in your clinic, you could probably select a much larger Target Group because of the less intensive activity.

So the "low", "medium", "high" intensity activities, the thing that you saw in the Project Narrative is simply helping you all as you consider what your Target Group should be to figure out whether you should be picking a lot of people, because you have lots of resources and you're doing a low intensity intervention like screening - or if you are doing a higher intensity activity that you would probably want to pick a smaller Target Group for working with. So no worries, you'll see that. It's just simply a way of helping you all think about your Target Group selection.

Another question from Kathy, "In the narrative, we need to choose Audit items for improvement. We would like to choose an item which was new for 2015 which is statins through age 40 to 75 as recommended by ACC/AHA. Is this okay, or are we limited to the "Yes" for all ages?"

The new lipid Best Practice reflects the ACC/AHA guidelines, but because it's very difficult to measure the different groups within it, though the new statin Best Practice or lipid Best Practice is about increasing the number of patients in your Target Group, and that Target Group is only patients with diabetes and cardiovascular disease who are on a statin. So you are welcomed and encouraged to also put people on statins who have diabetes who are aged 40 to 75 even if they don't yet have CVD.

That would be above and beyond what your Target Group would be for the Best Practice because it's a lot easier to measure people who have CVD because it's clear that they should all be on that. So the Best Practice really just looks at that group, but we encourage you to use statins for all age groups that are appropriate in people who have diabetes.

Karen Sheff:

And Ann, this is Karen. I just wanted to add. The Audit report for 2016, so remember we changed the Audit report with the Annual Audit every year. So the Annual Audit report for 2016, which I know you guys won't have until late next year, actually has the statins report for several different groups including different ages and those with CVD.

Dr. Ann Bullock:

Great, thanks. So right, the Audit will show some of that for sure. The Best Practice focuses on people with CVD, but we certainly don't want you all to only put people on statins who have CVD. We want you to put all the right people with diabetes on statins. But the Best Practice will focus on those with CVD and that's really a data collection issue.

Hualapai, "Do we have to direct most of the funding to the Best Practice? Could we spend a significant amount of funds on the other activities?" That's up to you. You should spend enough of your SDPI dollars on your Best Practice activities that it takes to do what you need to do.

So, in terms of the reviewers, when they look at the applications, they will want to see that your Best Practice activities are adequately funded and that other activities you suggest are also adequately funded for what you proposed. But there's no recommendation that most of your dollars go to Best Practice versus the other. That is totally up to you guys as you decide how you like to spend your dollars.

Miriam Fematt asked, "Will the Best Practice require an evaluation piece or is the evaluation piece the RKM?"

Yes, the main evaluation piece is the RKM. That's exactly right. The Required Key Measure is the main evaluation piece. Now having said that, when you all -- who are successful applicants become grantees at the end of the year, not only will we need Required Key Measure data, but you'll be doing a year-end report where you'll tell us about how you've done with your different activities, more in a narrative or text way. But right, the RKM is otherwise the main kind of thing.

A comment from Sandra Hahn, it's a compliment. Oh my gosh, we love those. "Thanks for the more reasonable Required Key Measure, very relieved compared to the previous ones, excellent." Thank you, that was indeed one of our goals here was that the Required Key Measures would not only get us good data, but they'd be more straightforward and easier to collect so that it will be less burdensome on you all. So glad that you all are seeing that that is the way it's going to be. Once the data system where you'll put that in will require a little bit of effort, but we're going to get better data not only for you, but to combine across the country. So that's great.

United American Indian said, "What data do we use for baseline?"

The baseline will be not your Annual Audit. As Karen just said, it will be looking at your Target Group and measuring -- don't worry about that now. You don't have to do it for your application. We'll be telling you a lot more about that in the months to come. But you'll be evaluating your Target Group at baseline, then again after you've had a year to move the needle on that Required Key Measure, make an improvement.

Judy Reuter asked, "Will there be specific definitions or criteria for what counts as education?"

Most of you who look at health codes, education codes know that there's a fairly wide variation in this and that is okay. So again, nutrition education can be done by an RD or by someone who provides nutrition education to groups who maybe isn't an RD or to individuals as part of like a DPP intervention or something similar. Same with physical activity, you can have a physical activity specialist who has a certification or you can have a member of your community-based wellness program provide basic physical activity education. It's a pretty wide net that is cast to in terms of what counts as education for things like nutrition and physical activity. We want to not exclude anybody because they don't have a particular type of professional on their staff.

SYTHC, "Will there be a midyear and annual progress report required for FY '16?"

Yes, those are grants requirements.

Jessie Hecocta, "Can we open our DPP requirements up from 18 plus years to all patients including less than 18 who have pre-diabetes?"

Again, you're getting at kind of a distinction here about whether you want to do the DPP as it is published out in the general world, what the randomized controlled trials done by NIH did, in which case it would just be adults and those who have pre-diabetes. That is not our issue. That is your decision. We don't have evidence in youth that the DPP reduces progression to diabetes and youth with pre-diabetes, but there certainly is some indication that it very well may be true.

So, if you wish to do the full DPP on some older teenagers who don't yet meet the 18 and over requirements, that's not our concern. You can tell us that that's what you plan to do. So you're not getting medications or something to youth that are contraindicated, you're providing an intensive lifestyle intervention. So if they wish to participate and you wish to open it up to older youth, that is not going to be a problem as far as SDPI is concerned. Whether you want to say you're doing the full DPP or not, will also sort of depend on what you want to be able to talk to your community about. But we leave those kinds of issues more to you all in terms of that.

Many sites are doing a DPP or DPP-like intervention with younger people as part of their Community-Directed activities and we don't have a problem with that. That is fine.

Sandra Hahn said, "Appreciating the inspirational message regarding looking for big picture in community vision." Great! Love it! That's what we want, that excitement, that energy that enervates SDPI to be very much here for 2016. She goes on to say, "It's exciting to approach diabetes and realize the link between diabetes risk and risk for lots of other things including substance abuse, unemployment, poor outlook for employment, heart disease, depression, et cetera, et cetera."

Wonderful, exactly, the bigger picture of what's happening in our communities. Diabetes is a big problem in our communities but it is not the only one. And it doesn't surprise us, we've done this work for many years, that the risk factors for so many of the problems in our communities are very similar. They have their same roots in stress, in trauma and poor nutrition and adequate nutrition in the in utero periods and early life. How neat would it be that we could make a difference in so many of those things including educational outcomes. And if we can work on brain development and good ways with teaching parents how to read to kids and appropriately discipline them and help

them not develop a lot of the problems that we see so often so young in our communities. So yes, let's think outside the box, let's think the bigger picture. Glad to hear you make those comments.

Lora and Deb, "If you have been successful in your past Best Practice and met your goals and have high numbers, wouldn't it be better to pick another practice so you can show improvement?"

We would love to see you do that. Right, let's hope that over the years your Best Practice work is paid off. Absolutely! We hope you will pick a new Best Practice. If you've done a great job with your last one and you want to work on something else that needs improving, we certainly encourage that. It's going to be easier to show improvement on something you're not as good at, than something that you are doing well. So, shifting your focus a little could be a good thing and of course, we all hope we don't lose the good stuff we've been doing while we shift our focus. But we encourage you all to pick another one.

Sherry Taylor comments, "I've only been in the position for a year. I'm excited with the changes and all the work all tribes are doing to try to do to educate and enhance the lives of people we serve." Yes, that's right. "We appreciate all the help we are getting through all these webinars and thank you for the help and guidance." Wonderful! Glad these are beneficial. That's certainly our goal.

And I know we got about six minutes to the top of the hour and we'll get through as many of the remainder as we can. We may miss the last few but we'll do our best here.

Juli Kelly says, "Just to clarify. You can only have one Target Group for the Best Practice. So if we've got four types of services that would fit under the diabetes-related education, that different Target Groups, one goes in the Best Practice and the other Target Groups in the other category?"

That's your choice. If you're going to pick -- you're mentioning Diabetes-related Education. If you're going to do Diabetes-related Education with people in your clinic who have diabetes and you want to also focus on people, kids in the schools and maybe also pregnant women about Diabetes-related Education, you can put them together as -- just tell us that that is the combination of people that are going to be in your Target Group. That is okay with us. We expect that will happen a number of times. So, if you wish to put them all into one single Target Group and you will measure on all of them together, that's great. If you're doing different kinds of education as they don't really all fit together, then you might wish to put some of that into the "other" category, but we leave that to your good judgment.

Donald Dever says, "For those in 2015 cycle four who continue with grant activities and budget for six months and wish to apply for funding in 2016 at the same rate as currently funded -- if we wish to continue with one of the 2015 Best Practices in 2016, identify additional activities to account for maintaining our funding level in 2015 with the funding level in 2016?"

I'm not sure I'm quite catching the drift to your question but I think you're saying with the overlap for cycle four just account for what you're going to do for that six-month of overlap. That's right. That's all we ask in your application, is just account for it. We talked about possibly one-time allowable purchases, that would be great.

Juli Kelly, "If we have overlap, do we have to put in the other category, the activities we're doing to continue the work of 2015?"

No, you've already accounted for 2015. It's not that we don't want you to mention it at all in your 2016 application, but you might just say how that you're going to work with that overlap. But you already have things you're promising to report on for your 2015 so you don't have to talk about the accounting for 2015. Really, it's just how you're going to work with that six-month of overlap if you're a current cycle four.

Stefanie Stark, "Our tribe is also part of the CDC Good Health and Wellness grant. We're looking at partnering SDPI with that regarding healthy food and physical activities. Should that go under other activities?"

That's your choice, Ms. Stark. If you wish to put that into your Best Practice work, you're welcomed to. If you're doing the full CDC thing, that's the DPP, then you absolutely have three kinds of education that will count here. You're doing nutrition education. You're doing physical activity education and you're doing diabetes related education. If you want to use that as your Best Practice work, I would pick one of those three and report on that aspect of what you're doing as providing a full DPP. If you wish to pick another one for your Best Practice and put that under others, that is okay too.

Kathy Canclini, "When I say Diabetes Self-Management Education, I really mean diabetes-related education. Okay, operating short sessions in the clinic and one-on-one, can I include all these in diabetes education Best Practice?"

Yes, yes, whether you do one-on-one sessions or you do it in the office or you do it -- as you say in the gym or wherever it is, if you're providing diabetes-related education, you're going to tell us to whom you're going to do it and in what settings you're going to do it. We encourage you to get out of the clinic and do these things in other places. How great is that? Absolutely, please do.

She asked another question, "So project narrative estimate on target population numbers, but in 2016, we give the exact baseline?"

Well, you'll see more of this when the FOA is out and we can talk more about this in depth. You'll see that your Required Key Measure data and Target Group population, you'll make an estimate on it for your application, but then once you've really nailed down your Target Group and it's time to start getting baseline data, then you'll have a more exact number. So I think the answer to your question is, yes it may be a bit of an estimate in your application, but you'll definitely have it defined when you start doing baseline measurements for Required Key Measures.

This will be the last one because we're just at the top of the hour. Elizabeth Hester, "If you are choosing a Best Practice that focuses on a yearly screening, example, for foot exam or eye exam, would your data for the start of the year would be zero?" That's a really good question. If you're doing something that starts at the beginning of the year, you can elect to if you -- to start with zero in that group and then show that you -- I mean because they won't have had it for that year, but you can also do it for the next year. Karen, do you want to answer more on that?

Karen Sheff:

Yeah. So hopefully for most folks, they'll be able to get some estimate of what the baseline would have been in the previous year. So as Ann has mentioned as well, we haven't really got into depth today, but we will in the future, that the Audit is a tool that can be outside of the Annual Audit and RPMS and the WebAudit as well. And so, it doesn't encompass folks who can't use that but we're going to do the best we can to help folks get a baseline that's not just a zero for the previous year.

Dr. Ann Bullock:

Right. We'll talk more about that. But you're right that some of these things start over.

Just one last question. We're at the top of the hour, but we're going to catch it because some of you may have some confusion.

Elena Cox asked, "In past grants, my score was lower because I was told I need to add foot care since we're paying for a podiatrist. If I don't choose foot care as our Best Practice, will my 2016 grant score be lowered if we still choose to cover the cost for our visiting podiatrist?"

This is exactly why we now have in "other activities" section where you very clearly will spell out your different activities and how you will evaluate it.

So the answer to your question is no, you will not be lower on that, because you are not going to be able to put everything into your Best Practice. If you want to have foot care as your Best Practice and then say you're going to pay for a podiatrist et cetera, that's fine. If you want to pick something else for your Best Practice and put your podiatry care into your "other activities," because podiatrists do a lot more than just foot exams of course, then you will put it into your "other activities." The thing we think is -- one of the many improvements on this year's Project Narrative is that you're going to be able to tell us very clearly what is your Best Practice work, where you're going to track a Required Key Measure. But in a sense, it's not uniquely differently from the "other activities" except for the fact that you have to be more precise about your Target Group and Required Key Measure.

Your "other activities," for many of you, will be very important. Some of them perhaps in terms of the number of dollars you spend on them and staff time will be even more important, perhaps. That's okay. So the answer is you will not be dinged on anything here as long as you put into your activities that you're going to do foot care with the podiatrist. It can be a Best Practice or it can be an "other". Just tell us how you're going to spend your money and what type of activities.

I think with that, because we're at the top of the hour, a little beyond many of you have stayed with us. We appreciate that. There's about three or four questions we didn't get to. We'll try to make sure that we -- if there's anything in those questions that we can start with next week, we'll do that. Otherwise, if those people with those questions want to join our next session, that's great. As Melanie said, on Monday, is our next session. If the FOA is out on Monday, that's what the topic will be. It may not be out on Monday, so we will do a general Q&A there, so any of these questions that are unanswered today will be -- feel free to bring them back to us on Monday. We're pretty darn sure nothing is final until it's final that we'll see in FOA by next Friday, August 7th. So as Mel said, we will do the FOA on that August 7th session if it's out by then.

We wish you all the very best with all of this. We are excited for 2016. Your energy and enthusiasm over these years just inspires and humbles us. We want to do our very best to support you all. We would love it if every single applicant that's eligible for SDPI has a fundable score. That's our goal and we really want to make sure that we're doing everything we can to support you all in that.

So with that, we thank you for joining us today and we look forward to talking with you again on Monday. Thank you all.