GPBCH
Greater Philadelphia
Business Coalition on Health
DRIVING INNOVATION AND VALUE IN HEALTHCARE

Diabetes Vendor Resource Guide

An Overview of Diabetes Management Vendors and Other Resources for Diabetes Prevention and Management

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2024 GPBCH Diabetes Vendor and Resource Guide

Diabetes is a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. Insulin is a hormone that regulates blood glucose.

Prediabetes means you have a higher than normal blood sugar level. It's not high enough to be considered type 2 diabetes yet. However without lifestyle changes, adults and children with prediabetes are at high risk of developing type 2 diabetes.

Diabetes is prevalent and costly, and improving diabetes management is a priority for employers.

Diabetes and its related complications account for $413 billion in total (direct and indirect) medical costs and lost work and wages in the United States. According to the Centers for Disease Control and Prevention (CDC), 14.7% of U.S. adults have type 2 diabetes, more than 38% percent have prediabetes, and 33.6% percent have obesity.

To assist employers in improving diabetes prevention and management for the workforce and families, the Greater Philadelphia Business Coalition on Health has developed this guide featuring a range of service vendors and other resources.

GPBCH identified service vendors and other organizations that currently offer tools, information, and management programs to help employers in their diabetes prevention and management efforts. Not all invitees chose to respond to the request for information, and there may be other organizations that were not identified that offer information and services of value.

GPBCH requested the following information from these organizations:

1. **Organization Name**
2. **Contact information**
3. **Description of diabetes-related services:**
   a. Diabetes Prevention (include if you are a CDC approved provider for the National Diabetes Prevention Lifestyle Change Program (NDPP))
   b. Diabetes Management (also advise if you are a CDC approved provider for Diabetes for About the Diabetes Self-Management Education and Support (DSMES) Toolkit | Diabetes Self-Management Education and Support (DSMES) Toolkit | CDC
4. **Experience**: One paragraph summarizing number of clients and/or lives; outcomes data if available
5. **Pricing of services:** Provide a price or range; if you are not able to provide a price please describe the pricing model (e.g. pepy, pmpm, per referred case, etc.)
6. **Website:** for additional information
7. **Advancing Health Equity:** Briefly describe how you engage the population equitably, and address social determinants of health, including capacity to deliver services in languages other than English.

The information in this guide includes service vendor descriptions and an appendix with other useful resources, including links to national directories for diabetes prevention and management vendors.

For additional information please visit the American Diabetes Association, Tools and Resources at https://diabetes.org/tools-resources

We welcome feedback about this resource guide. Please let us know of any vendors or services not listed here that you would like to see included in a future edition.

*The **National Diabetes Prevention Program** (**NDPP)** addresses the increasing burden of prediabetes and type 2 diabetes in the United States. This national effort created partnerships between public and private organizations to offer evidence-based, cost-effective ways to help prevent type 2 diabetes.

***Diabetes Self-Management Education and Support (DSMES)** is a program for people with diabetes to gain the knowledge and skills to make behavior changes and better control their diabetes and related conditions. This evidence-based practice accounts for the needs, goals and life experiences of the participant.

TABLE OF CONTENTS

Abbott	3
Accessible Pharmacy Services	4
Cappa Health	5
Ciba Health	6
Health Advocate	8
Noom, Inc	10
Novo Nordisk	12
Omada Health	13
Pack Health (Quest Diagnostics)	15
Personify Health	17
Ramp Health	18
Teladoc Health, Inc. (Livongo)	19
Tria Health	20
Twin Health	22
University of Delaware	24
Vida Health, Inc.	26
Viora Health	28
Welldoc	30
WellSpark Health	31
Wellworks For You	33
YMCA of Delaware	34
YMCA New Jersey YMCA State Alliance (NJYSA)	35

Abbott

Organization Name: Abbott

At Abbott, we believe people with diabetes should have the freedom to enjoy vigorous, active lives. Our systems help people with diabetes manage their health more effectively and comfortably with easy-to-use products that provide accurate data to drive better informed decisions.

- **Abbott Diabetes Representatives:** Adrienne Coe; adrienne.foster@abbott.com, Stan Ferrell; stan.ferrell@abbott.com

- The FreeStyle Libre 3 system is a real-time continuous glucose monitoring (CGM) device with real-time alarms* indicated for use in people living with diabetes ages 4 and older.

Website for healthcare providers: FreeStyleProvider.Abbott

- Support for Providers
- How to Prescribe
- Practice Resources

Website for patients: FreeStyle.Abbott

- Support for Members
- Patient Stories
- Getting Started and MyFreeStyle Program

The FreeStyle Libre 3 system is indicated for use in people with diabetes age 4 and older.

The FreeStyle Libre 3 Plus system is indicated for use in people with diabetes age 2 and older.

***** Notifications will only be received when alarms are turned on and the sensor is within 33 feet unobstructed of the reading device. You must enable the appropriate settings on your smartphone to receive alarms and alerts, see the FreeStyle Libre 3 User's Manual for more information.

Accessible Pharmacy Services

Organization name: Accessible Pharmacy Services

Description of Services:
Diabetes Prevention
We are a provider of the Diabetes Prevention Program (DPP). We have two certified Diabetes Lifestyle Coaches who are blind running cohorts with the blind and low vision community. The program works to prevent the onset of type 2 diabetes amongst pre-diabetic populations through peer-to-peer, mindfulness conversations and lessons. We also have a Diabetes Prevention Program cohort taught by an American Sign Language instructor for individuals in the deaf community.

Diabetes Management
We are in the process of training our staff to become certified Diabetes Self-Management Education and Support coaches. 53% of our patients have diabetes and we have immense experience helping individuals living with prediabetes, type 1, and type 2 diabetes. We help our patients with insulin, medications, drug interactions, and diabetic devices on a daily basis. We have developed several educational programs for the blind and low vision community on diabetes topics with expert presenters from University of Pennsylvania Diabetes Education Center, Virginia Rehabilitation Center for the Blind and Vision Impaired, University of Pittsburgh Medical Center, and more.

Experience: We currently operate in 29 states and serve thousands of individuals throughout the country.

Pricing of Services: Our accessibility services including accessible packaging, labeling, home delivery, webinars, and online events, are all free of charge to the patient.

Advancing Health Equity: The majority of patients we serve are patients with disabilities. We understand our patient base comes from many different backgrounds, income statuses, education levels, insurance programs, and support networks. We work with each of our patients individually to find a pathway to optimize their health. They are able to choose between a plethora of accessible packaging, and accessible labeling to find what prescription, vitamin, and supplement packaging will improve their health outcomes. These packaging options include organizers, easy-open lids, large bottles, and pill packets. Labeling options include grade 1 and contracted braille, audio labels, contrasted background labels, large font, and labels in over 200 different languages. Our patients also help us learn about additional services we can provide to assist more community members.

Websites:
www.accessiblepharmacy.com
Diabetes Services: https://accessiblepharmacy.com/diabetes/
Diabetes Prevention Program (DPP): https://accessiblepharmacy.com/diabetes-prevention-program/
Blindness and Diabetes Webinar: https://accessiblepharmacy.com/blindness-and-diabetes-webinar/
Blindness and Diabetes: Continuous Glucose Monitoring Devices Webinar: https://accessiblepharmacy.com/blindness-diabetes-webinar-dexcom-vs-freestyle-libre/

Contact Information:
Andy Burstein, CEO
Alexandra Luzier, Vice President of Business Development and Communications
Accessible Pharmacy Services
8 Neshaminy Interplex Dr. Suite 102, Feasterville-Trevose, PA 19053
info@AccessiblePharmacy.com
1-888-633-7007

CAPPA Health, Inc

Organization name: CAPPA Health, Inc

Description of Services: CAPPA Health is an online program delivery platform that any CDC- recognized organization can utilize to provide the National Diabetes Prevention Program (National DPP Lifestyle Change Program virtually). The platform is custom-branded and includes a CDC-approved video-based curriculum, participant and coaching dashboards, mobile apps, photo food-logging and CDC-data collection and reporting functionality. It provides asynchronous access to the weekly curriculum via its state-of-the-art technology but also includes access to a live coach from their community or state. The CAPPA platform allows lifestyle change coaches to offer the National DPP LCP remotely across their entire state – in English, Spanish and adapted Native American. The platform also serves additional online programming for Hypertension, DSMES, Smoking Cessation, Weight Management, Anxiety, etc.

Evidence Base/Background: CAPPA Health is a mobile health platform leading the delivery for intense behavioral counseling in weight management and chronic disease prevention programs. The CAPPA programs are high-touch, scalable and cost-effective online behavior change programs designed to address the growing epidemic of weight management and obesity related chronic disease ailments. CAPPA Health was the 3rd overall online provider to be Fully Recognized by the CDC for the delivery of the National Diabetes Prevention Program. CAPPA's online programs are results-based to help people reduce the risk factors that contribute to chronic disease and Type2 Diabetes. CAPPA platforms engage participants with an updated evidence-based online and video curriculum (CDC approved), the guidance of a "Lifestyle Coach", a supportive social network, and digital tracking tools that include a mobile app. CAPPA Health has partnered with the ProVention Health Foundation to enable health departments and their affiliates with an online platform, content and interactive coaching capabilities to deliver high-touch programs to all communities throughout the U.S. and reduce racial disparities in population health outcomes.

Experience & Pricing: CAPPA's history of implementing, serving and enabling the online delivery of the National DPP includes collaborating with the CDC in 2016 to update the National DPP curriculum (T2). In 2018, CAPPA Health was the third overall provider to achieve Full Recognition by the CDC for delivering the online National Diabetes Prevention Program. Today, CAPPA is partnering with over 17 Health Departments (enabling over 100 providers to serve the online DPP), healthcare providers (Medicaid, Trinity Health, Sun Health), Indigenous and Tribal communities (Great Plains Tribal Leader Health Board, MHA Nation, Haskell, Washoe) Employers and non-profit organizations (National Kidney Foundation, Provention Health Foundation) to serve online programs.

Platform pricing options include private platform branding for clients or an option to license CAPPA's main platform for a reduced fee. CAPPA is flexible with pricing models and the average cost to deliver the DPP to participants is <$100 for providers.

Advancing Health Equity: CAPPA's unique approach of enabling employers, health departments, Indigenous communities, faith-based organizations, priority specific populations not only will provide these populations with an online platform and content they would not be available to these specific communities and organizations. This enablement also provides the ability for local community members, fellow colleagues and proper cultural representation the ability for participants to be served by providers and coaches that understand their culture and challenges.

Website: https://cappahealth.com

Contact Information:

Cappa Health, Inc. 8525 E Pinnacle Peak Rd., Scottsdale AZ, 85255
Ray Lyons, Ray@CappaHealth.com, 602-570-5833

Ciba Health

Organization name: Ciba Health

Diabetes Prevention: Ciba Health provides a CDC recognized NDPP program with some additional resources, including a dietician and a Continuous Glucose Monitor. Additionally, we implement an approach that is truly patient-centric. Our nutritional approach isn't prescriptive, instead using advanced lab testing to target specific modifications to their diet. Combined with patient preferences and restrictions, this allows our clinical team to tailor each patient's experience to achieve optimal results. Similarly, our physical activity approach takes into consideration preferences, limitations, and goals to create an initial plan, with multiple built-in feedback loops to adjust, motivate, and improve based on patient experience and results. This program can be administered in the traditional DPP cohort style, or on an individual basis.

Diabetes Management: Ciba Health's Type 2 Diabetes Reversal is based on a root-cause approach powered by advanced lab testing, a multidisciplinary care team, personalized supplements, and remote patient monitoring. Each of these aspects plays an important role in Ciba's proven results.

- **Advanced Lab Testing**, using up to 300 biomarkers, provides a level of insight into each patient's unique biochemistry. This gives our care team a depth of insight not found in traditional chronic disease management.
- A physician-led **Multidisciplinary Care Team**, also including a dietician, health coach, and mental health specialist (when needed), stays consistent throughout a patient's journey. Each care team member has multiple hour-long appointments with the patient and collaborate behind the scenes to deliver optimal care. This care includes dietary and physical activity modifications, stress reduction and sleep improvement methods, and other therapies that are recommended based on the patient's stated goals.
- **Personalized Supplements** give our care teams another tool to address the specific imbalances discovered by our Advanced Lab Testing. Additionally, we recognize that what might be a "normal" value for something like Vitamin D for one person might not be optimal for another. This level of understanding allows us to optimize, not simply manage, a patient's health.
- **Remote Patient Monitoring** allows Ciba's care team to track their patient's progress. Additionally, they can translate all the data collected to instruct patients on how certain foods or activities positively or negatively impact their health and goals. Using RPM as a feedback methodology versus the primary driver of change is key to Ciba's success.

Experience to date: Since 2020, Ciba Health has treated over 20,000 Patients in the US, China, the United Arab Emirates, and Canada. Our patients have seen remarkable outcomes, and here are some key data points demonstrating that:

- Average sleep score improvement: 1.1-1.6 points ($p < 0.01$)
- 95% of patients reduced their HbA1C level, with an average reduction of 3 points or greater per patient
- 75% of T2DM patients reduced their medication usage, with an average reduction of 1.3 medications per patient
- 75% program completion rate
- 50% enrollment of eligible population
- 79 NPS score (patient satisfaction)

Pricing: All of the elements of the Ciba Health care delivery model are bundled under one price, inclusive of all elements listed above. Our standard billing is based on a per engaged member per month format, with alternative models available, such as value-based pricing or milestone-based pricing. The cost is $2,499 for one member to complete the 12-month program, with up to 100% of fees at-risk based on the achievement of critical milestones.

Health Equity: Internally, we are committed to equity, which enhances our capacity to do the same for our patients. From care team members to executives, we can relate to many different backgrounds: race, class, sexual orientation, ability, gender, religion, etc.. By using virtual care via desktop or mobile device, we reduce barriers to access. We also partner key vendors to offer in-home labs, language translation, and free healthy food delivery with Instacart. Lastly, our patient-centric methodology acknowledges that no two patients are the same nor should they be treated the same. We work in tandem with our patients to help them reach their individualized goals based on their unique biochemistry. The ultimate in health equity.

Contact information: Michael Tomback, SVP of Sales | mtomback@cibahealth.com | 312.246.9555 | https://cibahealth.com/

Health Advocate

Organization name: Health Advocate

Description of Services: Health Advocate provides comprehensive and personalized clinical support across a broad range of health conditions. Condition management for diabetes is a key component of our whole-person Population Health solution. We leverage advanced, AI enabled data analytics based on multiple data sources, including the record of interactions with our team of Personal Health Advocates, medical and pharmacy claims data, biometric screening results, and health risk assessment responses to identify and risk stratify members, and engage them in personalized coaching with our team of Nurse Personal Health Advocates. Utilizing a multi-channel approach to engaging members, our goal is to provide personalized support to close gaps in care and improve health outcomes.

Health Advocate's Diabetes Condition Management coaches are Registered Nurses with additional training as Certified Diabetes Educators. Outreach to identified members is made utilizing multiple modalities, including telephone, direct mail, email, secure SMS, web messaging and push notifications across our Member Engagement App, with the goal of engaging with and enrolling participants in our coaching program to help them better manage their condition.

Our Population Health Program is NCQA accredited and follows national guidelines and standards, including those from the Centers for Disease Control, as well as specialty organizations such as the American Diabetes Association.

In our diabetes coaching program, a nurse performs an initial screening assessment to qualify the member for the program. This is followed by a detailed clinical assessment to understand the member's medical history, dietary preferences, physical activity level, current treatment plan, medication adherence, self-management skills, and relationship with a treating physician. The nurse coach utilizes motivational interviewing and positive psychology to assesses readiness to change and collaborates with the member to establish an action plan based on short-term and SMART goals, as well as a long-term action plan. The nurse coach and member will schedule coaching sessions at regular intervals (usually weekly to start) and the nurse will facilitate communication with the member's physician(s). In addition, education, advocacy, and navigational support is provided, and the member is connected to available outside resources and support. Our goal is to educate the member to better manage their condition, close gaps in care, find specialists when needed, assist with pharmacy issues, address benefit questions, and improve treatment compliance.

Experience: Health Advocate has been providing condition management support and addressing gaps in care for a broad range of chronic conditions including diabetes for more than 20 years. Our typical client recognizes a significant improvement in compliance with recommended care, improved medication adherence, and reduced costs associated with diabetes as the result of fewer and shorter hospital admissions and decreased use of the emergency department.

Health Advocate's chronic condition solution, which includes our diabetes and prediabetes program, is currently provided to 174 employer groups covering more than 500,000 employees. We measure outcomes by comparing the clinical performance of the diabetic population that has engaged with us to the performance of the group of diabetics that did not engage, recognizing that even those who did not engage may have nevertheless, received outbound messaging that motivated them to take actions. While individual experience varies across these employers, the typical client will see a significant (5% to 25%) annual improvement in compliance with recommended diabetic care. Aggregated across all of our clinical care programs, among 26,024 members who received outreach because of an existing Gap-In-Care or other medical need, 45% engaged with Health Advocate, leading to a 7.6% decrease in medical costs year over year. Among the 100 highest cost members in our program, there was a 10.3% decrease in costs year over year.

Pricing of Services: Our diabetes condition management program is a component of our whole-person Population Health Solution which is priced on a PEPM basis. The program is presented as a "whole," encompassing all of the conditions we focus on, however, any of our programs addressing a single condition are available individually. Pricing varies with the size of the client and the number of conditions covered.

Advancing Health Equity: Health Advocate is fully committed to advancing health equity, removing obstacles to access to care, and reducing health disparities. A key goal is to empower the member to make informed decisions about their care. In our Population Health Solution, support includes exploring social, cultural, economic, and environmental

factors impacting the individual's health. Performing a comprehensive needs assessment, including the identification of any barriers to care, is an important component of our clinical intake process. Through advocacy support, the nurse coach will attempt to help the member overcome barriers to care and identify community resources which may be available. We provide culturally competent care, understanding every member's unique needs and circumstances.

Health Advocate is a wholly owned subsidiary of Teleperformance. Through our sister company, Language Line, we have the added ability to interact with our members in more than 250 languages. Teleperformance has been named one of 2023's top 5 World's Best Workplaces by Fortune Magazine and Great Places to Work® and has **achieved Enterprise-Wide Corporate Social Responsibility Certification from Verego for the 10th Consecutive Year**.

Website: https://www.healthadvocate.com

Contact Information:
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Health Advocate
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sstarker@healthadvocate.com

Noom, Inc.

Organization Name: Noom, Inc.

Noom for Work was founded in 2008 and has offered an enterprise employer program since 2019. Noom's mission is to help everyone lead healthier lives through behavior change.

Programs:
Noom Weight offers long-term weight management, including maintenance support for individuals looking to sustain weight loss vs those looking to lose weight.
Noom's Diabetes Prevention (DPP) program was the first digital DPP fully recognized by the CDC- a measure of quality outcomes and adherence to CDC requirements.

Noom Diabetes Program augments existing programs to deliver tailored behavior and lifestyle change, including enhanced content, coaching, and community support, for members with type 2 diabetes.

Noom Med integrates clinical care with Noom's award-winning behavior change program to help patients with obesity optimize weight loss with their underlying biology and maintain that weight loss with lasting lifestyle changes that reduce long-term medication use.

Noom GLP-1 Companion is an adjunct diet and exercise program for members taking a GLP-1 for weight loss, designed to minimize side effects and optimize sustainable weight loss.

Noom Mood empowers and equips users to better manage their day-to-day experiences of stress and anxiety. Noom Mood offers a fun, friendly, and engaging way to develop emotional awareness, effective stress response mechanisms, and overall resilience.

Noom's Diabetes Prevention Program (DPP) is a personalized course that supports participants in reducing their risk of developing type 2 diabetes by focusing on healthy habits that create long-lasting lifestyle changes. Noom's DPP was the first digital DPP to become Fully Recognized by the CDC in 2017. Noom's DPP combines the latest diabetes prevention science with award-winning psychology-backed tools, an engaging curriculum, a team of skilled coaches, and peer support. In addition to achieving individualized goals, participants aim to achieve one of the three clinically significant outcomes that can demonstrate the prevention or delayed onset of type 2 diabetes:

- At least 5% weight loss
- At least 4% weight loss plus achieving 150 minutes of at least moderate physical activity - Reducing A1C by at least 0.2%

Noom has more than 40 peer-reviewed scientific articles. Amongst them, Noom's DPP demonstrated that it is an engaging and effective solution:

- 0.28% reduction in A1C at 12-months 1
- 66% of program completers lost at least 5% of their body weight at 65 weeks from baseline 3
- 84% of individuals completed a majority of lessons 2

Contact information:
Jackie Johnson, Enterprise Sales Executive
One Palmer Square, Suite 441, Princeton, NJ 08452
jackie.johnson@noom.com

Description of diabetes-related services:

a. Diabetes Prevention:

Noom's Diabetes Prevention (DPP) program was the first digital DPP to be Fully Recognized by the CDC in 2017- a measure of quality outcomes and adherence to CDC requirements. Our DPP addresses the CDC criteria for success, including weight loss %, A1C reduction, and physical activity minutes. Noom's psychology-based techniques and personalized curriculum focus on bite-sized lifestyle changes that create meaningful results.

- Techniques that teach people the why behind their habits and how to change them for

good.

- Daily lessons tailored to each person's goals.
- One-on-one support with coaches specially trained in diabetes to help improve outcomes.

b. Diabetes Management:

Noom's Diabetes program enhances existing solutions to provide a tailored care track for members with type 2 diabetes. Informed by the core principles of the Diabetes Self-Management Education (DSMES) and Support curriculum, our offering uses psychology to help members develop lasting habits to better manage their diabetes, including learning how to eat balanced meals, exercise safely, monitor blood sugar, reduce the risk of complications, and build healthy coping strategies. Key features of the program include:

- Enhanced coaching from coaches with specialized training on how to support members with diabetes
- Personalized content addressing common physical and emotional challenges of living with diabetes
- Coach-moderated, diabetes-specific peer group for a robust support system for members navigating their diabetes journey
- Blood glucose tracking and device integration enable out-of-range alerts and support
- Macro and carb tracking to help manage post-meal blood sugar spikes and learn the impact of food on blood glucose levels

Experience: In Noom's early-stage Diabetes programs, over 50% of users achieved a clinically significant reduction (≥0.5%) in HbA1c after 3 months, with users reducing by 1.03% on average.

While Noom is well-known for its direct-to-consumer products, it provides behavior-change solutions to millions of lives via 200+ employers and hundreds of plan sponsors through health partnerships, service PBMs, health systems, etc.

Pricing of services: Noom offers multiple pricing models. Please contact teams@noom.com to discuss the solution that works best for your population.

Website: https://www.noom.com/for-work

Contact Information:
Noom Enterprise Sales
teams@noom.com
Noom Diabetes Prevention Program
Diana Cartron Gallo: dpp@noom.com

Advancing Health Equity: Briefly describe how you engage the population equitably and address social determinants of health Noom's mission is to empower everyone, everywhere, to live a better, healthier life. Noom's

programs address social determinants of health through curriculum and coaching by addressing how to choose healthy food items at any income level, how to incorporate joyful movement regardless of location or access to fitness facilities, how to set up and maintain social support, and Noom's DPP curriculum meets CDC requirements for plain language standards.

Noom Weight is offered in English, Spanish, or German languages.

Novo Nordisk

Organization Name: Novo Nordisk

Cornerstones4Care is a support program that provides the information, tools, and resources you need to help manage your diabetes. Membership is FREE. And if you'd like to become a member, you may receive benefits like calls from a diabetes educator and educational emails. Check out the free resources below to learn more:

- Cornerstones4Care – Diabetes Medicines Booklet. The purpose of this booklet is to help you learn about the different types of medicines for treating diabetes. Be sure to discuss your personal diabetes care needs with your diabetes care team. https://www.cornerstones4care.com/content/dam/nni/cornerstones4care/pdf/content/medicine/DiabetesMedicines.pdf

- Cornerstones4Care – Glooko App. A Free diabetes management app that can track your blood sugar, activity, and meals all in one place. https://www.glooko.com/landing/c4c/

- Diabetes Education Program – Planning Healthy Meals. A visual guide to help with the fundamentals of planning healthy meals, including information on food labels and portions, and helpful food lists for making healthy choices when creating a balanced meal. https://www.novomedlink.com/content/dam/novonordisk/novomedlink/resources/generaldocuments/Planning_Healthy_Meals.pdf

- Our customizable Diabetes patient education center: Home (novomedlink.com)

Website: https://www.cornerstones4care.com

Omada Health

Organization Name: Omada Health

Contact Information:
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(630) 639-7333; sara.sheridan@omadahealth.com

Description of diabetes-related services:

With Omada, members can engage in multi-condition virtual care that accommodates their real-life circumstances. This is only possible through Omada's compassionate care, delivered by human care teams and powered by technology. Launched in 2011, Omada for Prevention focuses on pre-diabetes and weight management--two critical elements of preventing diabetes or heart conditions. Following guidelines and recommendations set by the U.S. Preventive Services Task Force and the CDC, and fully recognized by the CDC as a DPP provider, the goal of the program is to lose weight, maintain a healthy weight, and increase physical activity.

Key components:

- A fully dedicated care team of specially trained health coaches to support members throughout their entire care journey.
- Connected devices + intuitive mobile app to make communication and data sharing between members, their care team and in-person provider(s) easy. Integrated behavioral health tools within all programs at no additional cost to support members with stress, depression or anxiety related needs. Examples include holistic assessments, condition-specific care adjustments, protocols for high-risk members, stress management, sleep lessons, behavior change support, covered services navigation and self help-tools like guided meditations.
- Embedded GLP-1 care track that supports members before, during and after GLP-1 usage with personalized care plans, dedicated learning paths and flexible support for your coverage management to promote lifelong weight health.
- SDoH-informed interventions and resources such as access to local food sourcing and housing programs, budget-friendly recipes in English and Spanish, topic-based communities and more. Care teams receive 100+ hours of ongoing annual training on topics like identity & health equity, Social Drivers of Health (SDoH), behavioral health, clinical lectures and more.
- Plus, care teams are backed by Omada's Insights Lab, which learns from a database of over 1M lifetime members and 3B+ data points to identify what interventions work well within a population.

Omada for Diabetes supports and enables eligible members to achieve stable blood glucose levels and meet and maintain their A1C reduction goals based on treatment guidelines from the American Diabetes Association. Members are paired with a dedicated, DPP-certified health coach and Certified Diabetes Care and Education Specialist (CDCES). On-call CDCES' are also available 24/7 in the event of a dangerous glucose or blood pressure reading to provide in-depth consultation to the health coach.

Omada holds Association of Diabetes Care & Education Specialists (ADCES) accreditations--a DSMES provider accreditation, and a Diabetes Education Accreditation Program (DEAP) accreditation. We're also the first fully virtual healthcare provider to earn the NCQA Population Health Program Accreditation for our Diabetes and combined Diabetes+Hypertension programs.

The key components in our Diabetes Prevention program outlined above are also available in our Diabetes Management program.

Experience: Omada's customer base comprises 1,900+ customers (available to 19.2 million+ covered lives) including Fortune 500 and small to medium-sized employers, the world's leading health plans and health systems. Our clients span a wide range of industries, including healthcare, banking, insurance, retail, information technology, aerospace, manufacturing, government, and education. Our solutions have improved the lives of more than 1 million all-time enrolled participants.

With our Prevention program, our most recent Level 1 RCT demonstrated weight loss of 5.5% after 12 months. In our whitepaper in partnership with Express Scripts by Evernorth, our analysis showed that 82% of Omada members on a GLP-1 experienced amplified weight loss. These members were meaningfully engaged with Omada and experienced 1.7x the weight loss compared to the 18%with limited engagement. With our Diabetes program, our retrospective, observational study demonstrated that members who had a baseline A1C above 8% saw on average Hba1c reduction of -1.9% points at 6 months and a reduction of -2% points after 12 months.

Pricing of services: Omada pricing is designed with the success of members and customers in mind. Our cardiometabolic programs (Prevention, Hypertension, and Diabetes) use the activity-based billing (ABB) model, working to ensure that members are actively using the program and managing their health.

Website: www.omadahealth.com

Advancing Health Equity: Omada fosters health equity through several strategic initiatives:

● **Care team health equity training:** we empower our health coaches and specialists with training on the intersection of identity factors (like race, ethnicity, culture, class, gender identity, sexual orientation, age, disability, veteran status and immigration status) with health and healthcare perceptions. This ensures sensitive, personalized care that considers the diverse backgrounds of our members.

● **Tailored resources for SDOH:** we develop and provide resources specifically designed to address social drivers such as food insecurity, healthcare access, and unsafe environments. These resources help members overcome barriers to better health.

● **Multi-language accessibility:** If a client opts to make our Spanish program available, their enrolled members can choose to be partnered with a Spanish-speaking care team and a Spanish-speaking peer group, and they receive resources translated into Spanish in addition to the standard program curriculum, which remains in English. We also offer telephonic translation, via appointment, in more than 200 languages, for communicating with our health coaches or our Member Support agents.

● **Institute for Health Improvement:** a core Omada team engages with the Institute for Health Improvement Leadership Alliance and Pursuing Equity Learning Network programs to continuously learn and apply the best practices in promoting health equity.

Pack Health, a Quest Diagnostics Company

Organization Name: Pack Health, a Quest Diagnostics Company

Description of Services: Pack Health is a digital patient engagement platform that provides structured, compassionate, person to person health coaching to foster behavioral changes and overcome social determinant of health (SDoH) barriers. We meet members where they are in their health journey and transform health behavior through a whole person approach to poly-chronic condition management for up to 30 conditions, including diabetes prevention and Type 2 Diabetes Mellitus (T2DM) management.

Now a Quest Diagnostics company, Pack Health offers stand-alone coaching, in addition to biometric-screen-driven coaching, empowering employees to couple biometric insight with behavioral support and providing employers with even greater service and value. Pack Health coaching, alone, has shown:

- A significant ROI for employers, nearly 5:1, through an independent analysis of paid claims data
- Successful engagement of cardiometabolic members, improvement of health outcomes, and reduction in barriers to health for employees (view a sample employer report)
- Our program is especially effective for high-risk members with T2DM, as referenced in this HBA1C case study
- Our focus on satisfaction (member and client), cost avoidance, and Return on Investment (ROI) demonstrates program value

Pack Health is a CDC fully accredited National Diabetes Prevention Program Provider. Through our multi-channel member engagement platform we conduct an adaptation of the CDC Diabetes Prevention Program (DPP), combining the DPP curriculum with our evidence-based approach. Pack Health's DPP is a year-long curriculum focused on establishing healthy behaviors, such as eating a nutritious diet, and increasing physical activity. Each member is matched with one of Pack Health's in-house Health Advisors who will guide them through 16 condition-specific modules within their first six months. The following ten modules are carried out over the course of the next six months where members will learn how to maintain behaviors.

Experience to Date: Pack Health was the first fully digital T2DM self-management program in the American Diabetes Association's (ADA) Diabetes Support Directory and has achieved NCQA (National Committee for Quality Assurance) accreditation, currently active through 2026, for our T2DM program, the first fully digital program to do so. Pack Health has presented clinically significant results on the impact of our type 2 diabetes program at the last five ADA Scientific Sessions, as well as having our research published in JMIR Diabetes. Pack Health's T2DM Program has weekly, one-on-one engagement with a dedicated health advisor for 12 weeks, with engagement tapering in a similar fashion to our DPP program for maintenance up to one year (dependent on billing models).

Pack Health has 550,000+ lives contracted within the self-funded employer and health plan space. We also work within the life sciences to engage ~20,000 members with diabetes and obesity in our live and digital coaching per year, handling 80,000+ inbound calls per year. Hear from Coca Cola Bottling Company United CEO Hafiz Chandiwala on how Pack Health builds long-lasting relationships with our employer clients through our personalized client approach and proven programming.

Addressing Health Equity: Addressing health equity and SDoH are core to Pack Health programs. SDoH issues are often uncovered through engagement organically. Our Health Advisors build trust with members by asking specific questions about anticipated barriers to healthy behavior change and empathetically listening. Establishing this trust allows members to be transparent about challenges they are facing. As these barriers are uncovered, we use platforms like Aunt Bertha or findhelp.org to directly connect members with local resources, while also empowering members with appreciative inquiry to take advantage of resources available to them locally. At the 82nd (2022) Scientific Sessions, Pack Health was selected as an ADA Health Disparities Committee Top 10 Recommended Abstract for our focus on health care disparities and inequities in diabetes outcomes for our oral presentation on our combined food support + Type 2 Diabetes program. Pack Health currently offers our traditional programming in English. We have language support services available for members, which facilitate a live interpreter to conduct the coaching call in the members preferred language, covering 190 languages.*

Pricing: Per Engaged Member Per Month (PEMPM) rate is $83 per engaged member per month, coming out to an average $465 per member per year. Alternatively, we can do Claims Billing (CPT) with each session billed through medical claims: $149 for initial session, $45 for sessions 2-13, $19.50 for sessions 14-25. Pack Health's minimum eligible member threshold is 1,000** (10,000 for biometric screening service integration).

*Interpretation service is deployed for the coaching only; content is not translated into over 190 different languages
**Valid contact information- email and phone- must be available for all 1,000 eligible members

Contact Information:

Pack Health, 110 12th St. N, Birmingham, AL 35203
Lindsey Jackson, Manager, Commercial & Marketing Operations
(770) 634-0731, Laura.L.Jackson@questdiagnostics.com
Additional information at www.packhealth.com

Personify Health

Organization Name: Personify Health

Contact information:
A.J. Cosenza
alan.cosenza@personifyhealth.com

Diabetes-Related Services: Diabetes prevention and management is one of our health, wellbeing and lifestyle channels addressed on the Personify Health platform. Specific services include:

Transform, Diabetes Prevention Program: Our certified diabetes prevention program guides those at risk for developing type 2 diabetes to live healthier lives and meaningfully reduce their risk. Transform Prediabetes is recognized by the CDC as a top performing program. The program includes health coaching via chat and phone, weight tracking via connected scale, physical activity tracking, food tracking with uploaded photos, and structured lessons.

Multimodal (telephonic, messaging) Coaching: High-touch support is provided by our NCQA-Certified Personify Health coaching team. Coaches address the topic of diabetes within the broader context of the participant's overall wellbeing. Coaching is integrated into our personalized health platform and coaches leverage the depth & breadth of topics and engagement modalities to help people more deeply engage in their health. Our coaching staff includes certified diabetes educators, nutritionists, RNs, and pharmacists.

Experience to Date: Personify Health's Transform for Diabetes Prevention has been recognized by the CDC as a top performing program for 12 years since it launched in 2012. After 4 months participants on average achieve a 6.5% weight loss while increasing their physical activity by 1.7 days per week. Across our book of business 52% of participants met or surpassed the 5% weight loss goal compared to an industry standard of 35% per the American Diabetes Association. Additionally, participants who achieve programs goals cut their risk of developing type 2 diabetes by 58%.

JMIR Diabetes - *A 12-Month Follow-Up of the Effects of a Digital Diabetes Prevention Program (VP Transform for Prediabetes) on Weight and Physical Activity Among Adults With Prediabetes: Secondary Analysis* - https://diabetes.jmir.org/2022/1/e23243

Pricing of Services: Pricing options based on services provided and can include PEPY, PEPM, PPPY, or Milestone. Please contact Personify Health for specific pricing details.

Additional Information: Prediabetes prevention program - science-backed interventions (personifyhealth.com)

Health Equity: Personify Health understands the importance of addressing social determinants of health and creating a solution that supports all members in any stage of their health journey. The health risk assessment addresses social determinants of health both directly and indirectly. Questions address challenges and status related to finances, work, housing costs, personal safety, job stability, anxiety, depression, and are inclusive of diverse occupations, work styles & hours. Our live coaches are trained on SDOH and work with members for their unique place to address challenges of healthcare access, quality, education, social & community, economic, and neighborhood environment.

Ramp Health

Organization Name: Ramp Health

Ramp Health offers a comprehensive approach to diabetes prevention, management, and treatment, including:

1. **Group Programming for Prediabetes**: Our Diabetes Prevention Program targets individuals at risk of Type 2 Diabetes. It includes risk stratification, diagnosis confirmation, and a year-long program led by Certified Diabetes Care and Education Specialists (CDCES), focusing on lifestyle interventions like healthy eating, physical activity, and weight loss.

2. **One-on-One Care for Diabetes**: Our Diabetes Self-Management Education and Support (DSMES) program provides 14 personalized visits with a CDCES, covering key aspects of diabetes care, including understanding the disease, self-care behaviors, navigating the healthcare system, and self-advocacy.

3. **Personalized Nutrition Counseling**: For those not eligible for the DPP or DSMES, we offer one-on-one sessions with a Registered Dietitian to help individuals make informed dietary choices, crucial for preventing diabetes.

Digital Health Platform: Our HIPAA-compliant platform enhances engagement through easy onboarding, on-demand access to the care team, personalized content, and data analytics, providing insights into population health trends and outcomes.

Experience and Equity: With 22 years in business, Ramp Health has grown into a leading provider of clinical, chronic condition management, and digital health solutions. We are committed to health equity by offering culturally competent care, addressing social determinants of health, and providing multilingual services.

Pricing: Pricing is dependent on eligible population size and dedicated service hours. Some services may be eligible to be billed through your Health Plan.

Contact information:
John Rickards, VP of Client Strategy
215-431-8980; Jrickards@ramphealth.com

Nicole Putnam, VP of Client Strategy
215-694-0908; Nputnam@ramphealth.com

Website: www.ramphealth.com

Teladoc Health, Inc.

Organization Name: Teladoc Health, Inc.

Description of Services: Teladoc Health, Inc. is a CDC approved provider for the National Diabetes Prevention Lifestyle Change Program (NDPP) and for Diabetes Self-Management Education and Support (DSMES). Diabetes Care Complete offers personalized support to help members understand their blood sugar, develop healthy lifestyle habits that improve their glycemic control, support comorbidities (hypertension, weight management, mental health) and, if in poor clinical control, connect with a Teladoc Health provider. It includes:

- Connected technology: cellularly connected blood glucose meter and unlimited test strips and lancets
- Data science powered engagement for behavior change including: Real-time insights, health nudges on the connected blood glucose meter, an action plan, medication adherence support, remote monitoring and outreach, activity tracking, and food logging and feedback
- Expert coaching: unlimited 24/7/365 1:1 personal coaching and proactively reach out to members during low/high blood sure events
- Provider-based care: members in poor clinical control are invited to connect with a provider and care team for dedicated support to prescribe and optimize medication, prescribe CGMs and order labs to better support members

Experience to Date: Teladoc Health covers 42M lives via its 24/7 on-demand care service. Our scale enables us to serve 1M+ active chronic condition management members. We have a comprehensive body of statistical evidence in reducing medical and pharmacy claims up to as much as $180 PPPM using an actuarially sound and Milliman-reviewed methodology for isolating the impact of our programs. We consistently improve clinical outcomes, including 2.1% sustained reduction in A1c for uncontrolled members over five years for members starting A1c ≥ 8% at three months, 13mmHg average systolic blood pressure reduction for members starting in Stage 2 at one-year member tenure, and 6% average weight loss.

Pricing of Services: Diabetes management programs are priced Per Participant Per Month. We offer multiple contracting paths through direct contracts, health plans and other partnerships.

Advancing Health Equity: Health equity is foundational to the pursuit of our mission to empower all people everywhere to live their healthiest lives. Our commitment to health equity within our suite of Diabetes Management solutions is evident in the people we hire and the products and experiences we create. Our diabetes solution is designed with accessibility in mind for all members regardless of their resources and available in both English and Spanish. Outreach to potential members uses multiple means of communication, such as telephone, SMS texting, direct mail, email and care managers. For members who use 1:1 coaching, during the first session, the coach will assess for social determinants of health (SDOH). We also offer a robust content library that includes educational resources in English and Spanish, meal plans and resources developed to support a variety of ethnic cuisines, budget-friendly meal planning tips and menus, along with food insecurity resources (information about WIC or food pantries throughout the nation).

Website: https://www.teladochealth.com

Contact Information:
Teledoc Health, Inc.
2 Manhattanville Road, Suite 203, Purchase, NY 10577 (p: 203-635-2002 | f: 203-621-3098)
Stacey Anger, Regional Vice President, Stacey.anger@teladochealth.com, (484) 515-3919

Tria Health

Organization Name: Tria Health

Contact information:
Vince McLaughlin, Vice President, Sales
1729 Grand Blvd, Suite #21 Kansas City, MO 64108
Phone: 610-761-2899 | Email: vmclaughlin@triahealth.com

Description of diabetes-related services:

a. **Diabetes Prevention** (include if you are a CDC approved provider for the **National Diabetes Prevention Lifestyle Change Program** **(NDPP))**
At Tria Health, we are dedicated to preventing diabetes and other chronic conditions through our comprehensive weight loss management program, Choose to Lose. Recognizing that obesity is a precursor to several chronic conditions, including diabetes, our program pairs participants with a dedicated health coach, provides a Wi-Fi enabled scale, and offers a convenient app for food tracking. The health coach helps create a personalized plan tailored to each individual's unique needs, offering ongoing guidance and support to ensure success. For those opting for or having access to anti-obesity medications, Tria Health also provides consultations with expert pharmacists to ensure clinical oversight and optimal management of these costly medications. We empower individuals to take control of their health and prevent diabetes through effective weight management and comprehensive support.

b. **Diabetes Management** (also advise if you are a CDC approved provider for Diabetes for **Diabetes Self-Management Education and Support** **(DSMES))**
Our diabetes management approach centers around Tria Health's Pharmacy Advocate Program. Tria Health improves health outcomes by focusing on the entire patient, not just a specific disease state. Most people with chronic conditions have multiple conditions, so a whole-person approach is needed and most effective. The process kicks off with a comprehensive medication and lifestyle review with one of our pharmacists, who takes the time to understand each patient's unique needs. Tria's pharmacists help patients improve health literacy, close care gaps, and resolve drug therapy problems. From there, we tailor our approach, offering additional tools like remote monitoring, pharmacogenomics (PGx) or personalized weight loss support (Choose to Lose) based on what will benefit each individual the most. This ensures a customized path to health, specifically designed to manage diabetes.

Experience to date: Tria Health has approximately 320 clients managing over 700,000 lives. Tria Health recommends a minimum of 500 employees to ensure the best results. On average, Tria Health identifies approximately 20% of members and engages between 15-20% of those members into the program.

Based on Tria Health's 2023 book of business, Tria Health:

- Saves $2,432 per engaged member.
- Reduces A1C by 1.7 for those with uncontrolled diabetes.
- Prevents 5 adverse drug events (PGx).
- Helps 72% of Choose to Lose participants lose weight.
- Assists 25% of hypertensive cuff users achieve a 10mmHg reduction in blood pressure.

Tria Health will conduct a free claims analysis using six months of pharmacy claims to provide an estimated annual savings for clients prior to engaging with Tria Health.

Pricing of services: Tria Health's services are available for a fee of $4.25 per employee per month (PEPM) with no additional implementation fees.

- Diabetes Monitoring: $35 PPPM
- Blood Pressure Monitoring: $30 PPPM
- Choose to Lose – Weight Loss: $65 PPPM
- Pharmacogenomics (PGx): $550 per participant

Minimum revenue threshold of $20,000 on the administrative fee.

Websites:

- **Chronic Condition Management | Tria Health**
- **Knowledge Center | Tria Health**
- **Overview Video**
- **Validation Institute**

Advancing Health Equity: At Tria Health, we focus on providing equitable care and addressing social determinants of health (SDOH) to improve patient outcomes. We start by analyzing claims to identify patients with chronic conditions, multiple medications, or those needing specialty medications. Advanced algorithms assign a risk score to each patient, helping us prioritize those most in need for one-on-one consultations with our pharmacists.

Our pharmacists work closely with patients to identify and overcome barriers to their health goals, including SDOH. They may suggest alternative medications or find coupons to help patients adhere to their treatment plans.

To ensure we reach a diverse patient population, Tria Health offers services in both English and Spanish. This allows us to communicate effectively with more patients and provide the support they need in their preferred language.

Twin Health

Organization Name: Twin Health

Diabetes Prevention and Management: At Twin Health, we empower individuals to overcome chronic metabolic diseases and lead healthier, happier lives. Our groundbreaking Whole Body Digital Twin™ technology revolutionizes metabolic health management by creating personalized digital replicas of each person's metabolism. This approach addresses the root causes of conditions like Type 2 Diabetes, Prediabetes, and Obesity. We move beyond traditional symptom management to enable sustainable health improvements—from medication reduction and A1c improvement to significant weight loss and disease reversal. Our compassionate care team provides ongoing support, ensuring personalized and empathetic guidance throughout each member's journey. Our goal is to partner with organizations ready to challenge the status quo in healthcare, delivering superior outcomes, happier members, and meaningful cost savings.

Unparalleled Personalization with AI and Machine Learning: At Twin Health, personalized care transforms lives. Our technology goes beyond managing symptoms to address the root cause of metabolic diseases by creating a precise digital replica—or "Twin"—of each person's metabolism. Using proprietary predictive models and over 3,000 daily data points from wearable trackers, care team interactions, and personal preferences, we pinpoint metabolic dysfunction and develop tailored lifestyle modifications across nutrition, sleep, activity, stress management, and relevant medications like GLP-1s. Our compassionate care team, including health coaches, RNs, and specialists, provides empathetic support and guidance throughout each member's journey. They ensure every recommendation fits the individual's unique needs and preferences. Twin's intervention is unique to each member and evolves over time. This empathetic, data-driven approach leads to unmatched rates of weight loss, medication reduction, A1c improvement, and disease reversal, helping members achieve lasting metabolic health.

Superior Health Outcomes while Reducing and Eliminating Expensive Medications: We believe everyone deserves to live a healthy life free from medications, wherever possible and clinically appropriate. Our mission is to heal our members' metabolism, normalizing their clinical values so they no longer need medication for the conditions we treat. When it's clinically appropriate, we wean members off their medications, often eliminating (deprescribing) them entirely. We are particularly proud of our success in quickly and safely eliminating GLP-1 medications. While other vendors may prescribe GLP-1s for 12-18 months before attempting to reduce them, our members typically eliminate them within 90-120 days. Our compassionate care team continues to support members' weight loss goals after medication elimination, ensuring sustainable progress. Our members experience significant weight loss when they join the Twin program. Remarkably, they see an average additional 5% weight loss after GLP-1 elimination, compared to usual care where weight regain is common upon stopping the drug. This approach not only improves health outcomes but also reduces the financial burden of expensive medications.

Twin Care Team: At Twin Health, we combine validated clinical science with compassionate, hands-on support from our dedicated team of health coaches, registered nurses, and specialists. This ensures that each member receives personalized care throughout their unique health journey, fostering a supportive environment for sustainable health improvements.

Experience to Date: Twin Health serves thousands of members across millions of lives, partnering with large health plans, jumbo employers, and small/medium businesses. Our partners span the diverse American economy, including truck drivers, healthcare workers, financial services professionals, and manufacturing teams, among others. We deliver exceptional clinical outcomes. Recognized by peer-reviewed studies and the American Diabetes Association (ADA), our remission rates are the highest on record. Our members consistently achieve substantial and sustainable improvements in key health metrics such as weight, HbA1c levels, blood pressure, cholesterol, BMI, and liver fat scores, underscoring the effectiveness of our solution. Visit twinhealth.com/impact to explore our latest clinical outcomes, publications, and inspiring member testimonials.

Pricing of Services: Our Performance-Based Earned Fee Model ensures the highest level of accountability and mutual alignment with our partners. We do not use traditional per employee per month (PEPM) fees, opting instead for a model where our fees are entirely contingent on delivering real, measurable outcomes. This aligns our success directly

with the health improvements, satisfaction, and cost savings experienced by our partners and members, ensuring that we are fully invested in their success.

Advancing Health Equity: Twin Health is committed to equitable healthcare delivery. During enrollment, members self-report demographics, allowing us to monitor outcomes by age, gender, race, and ethnicity to identify and address health disparities. Our materials are written at a 6th-grade reading level, and our app includes accessible icons for vision impairment. We strive to match members with coaches fluent in their preferred language, such as Spanish. We recognize the cultural importance of food, asking about dietary restrictions and preferences during enrollment. Our technology suggests healthy recipes tailored to these preferences. Coaches also provide education on affordable and accessible food options. Our program's interventions are effective across all demographics, with personalized recommendations that consider cultural, ethnic, and social lifestyle factors to ensure sustainability and success.

Websites:
www.twinhealth.com
twinhealth.com/impact
https://usa.twinhealth.com/partner-with-twin
Bloomberg: Blackstone Is Using AI to Control Diabetes and Slash Spending on Drugs
Twin Perspective on GLP-1s

University of Delaware

Organization Name: University of Delaware

The University of Delaware's Health system (UD Health) is comprised of six ambulatory healthcare clinics located at the Science, Technology, and Advanced Research (STAR) Campus of the University of Delaware. Healthcare and disease prevention services are provided through the following healthcare clinics: Nurse Managed Primary Care, Physical Therapy, Speech Language Hearing, Nutrition, Health Coaching, and Exercise Counseling Clinics. UD Health Clinics are vital to our educational and research missions; in addition to providing healthcare services to the public, our clinics also serve as vital extensions of classroom learning and cutting-edge research.

The mission of the Nutrition Clinic is to provide evidenced-based nutrition services to individuals and the community, educate future Registered Dietitian Nutritionists (RDNs), and engage in research that advances the evidence base.

Clinic RDNs provide outpatient and telehealth medical nutrition therapy (MNT) counseling for individuals and group nutrition education classes to prevent chronic disease, and support optimal health and medical illness management for a wide range of health conditions including weight management, diabetes, cardiovascular disease, eating disorders, and many others. The Nutrition Clinic is also a CDC-recognized provider of the National Diabetes Prevention Program, a lifestyle behavior change program designed to prevent or delay onset of type 2 diabetes, improve overall health, and build healthy habits that last a lifetime.

The Nutrition Clinic is located at the UD STAR Campus. The facility is state-of-the-art, featuring counseling rooms equipped with built-in observation technology, research-grade nutrition and anthropometry assessment equipment, capabilities for online and telehealth formats, and group classroom space to support its National and Medicare Diabetes Prevention Programs. As part of the UD Health Clinic network, the Clinic benefits from ancillary billing, electronic medical records, and scheduling support. The Nutrition Clinic accepts most major private and federal health insurance plans and provides contracted MNT services to health care providers regionally.

Contact information:
Donna Paulhamus, MS, RDN, LDN; Nutrition Clinic Director UD Health Nutrition Clinic
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Phone: 1-302-831-1165
Fax: 1-302-309-9163
Email: Nutrition-clinic@udel.edu

Description of diabetes-related services: CDC-recognized provider of the Lifestyle Change Program for the National and Medicare Diabetes Prevention Programs.

Outpatient Medical Nutrition Therapy Counseling for prediabetes, diabetes, and many other health conditions by a Certified Diabetes Care and Education Specialist (CDCES) Registered Dietitian Nutritionist.

Experience to date: The University of Delaware's Nutrition Clinic founded its National Diabetes Prevention Program in 2019, achieved CDC recognition in 2021, and expanded to become a Medicare Diabetes Prevention Program supplier in 2023. To date, approximately 100 participants have completed our in-person program. With insurance-coverage of services starting in 2024, we have expanded the program to ongoing enrollment. This expansion increases our capacity to help more people prevent or delay type 2 diabetes, improve their overall health, and build healthy habits that last a lifetime.

Pricing of services: The Nutrition Clinic is in network with most major private and federal health insurance plans. If insurance does not cover the cost of services, UD Health offers a substantial self-pay discount for payment at the time of service. Please call the Clinic at 1-302-831-1165 for more information.

Website: https://www.udel.edu/academics/colleges/chs/departments/hbns/clinics/nutrition-clinic

Advancing Health Equity: UD Health provides equal access to care regardless of source of payment. If healthcare clients do not have health insurance, they are directed to visit www.healthcare.gov for information about obtaining

coverage. The UD Health Nurse Managed Primary Care Center, along with partners at Westside Family Healthcare, is a great resource for information regarding obtaining insurance coverage on Healthcare.gov. Their enrollment assisters (phone number: 302-472-8655) will even offer support with the enrollment process. Low self-pay rates are available for Nutrition Clinic clients who are not insured, or whose insurance does not cover service fees. Translators are available to provide outpatient and telehealth MNT services in multiple languages by Language Liaisons, and Spanish materials are available for Spanish-speaking participants enrolled in the National and Medicare Diabetes Prevention Programs.

Vida Health, Inc.

Organization Name: Vida Health, Inc.

Vida is a virtual cardiometabolic clinic, with personalized care delivered through a human-led team, addressing the cardiometabolic spectrum. Established in 2014, Vida is the premier cardiometabolic solution launched from the start to address physical and mental health together, along with the socioeconomic barriers to health. Vida addresses the full range of cardiometabolic acuities to achieve clinically significant outcomes — with up to 100% fees at risk. We bring together the power of human connection, expert coaching, motivational interviewing, cognitive behavioral principles, nutritional expertise, medication management, and clinical rigor to drive the long-term behaviors that support member health and help shift the course of cardiometabolic disease. Vida considers BMI, lab values, patient goals (e.g., lose weight, manage conditions), glucose data from devices when available with diagnosed diabetes, medical and weight loss history, current and failed medication regimen, PHQ/GAD, and social factor screeners to place members in the appropriate starting pathway for care which include:

- Preventive Care:
  - For members with Prediabetes; overweight (no diabetes)
  - Vida offers a CDC-recognized DPP track, with preliminary recognition.
  - Includes: 1:1 consults, unlimited asynchronous interactions with health experts (e.g., health coaches), group coaching, coach-moderated support groups, device tracking, the Vida app, and devices.

- Chronic Care:
  - For members with Diabetes type 1 or type 2, A1C <9, with particular monitoring of those presenting with A1C 8-9.
  - Our deep bench of clinical expertise includes Registered Dietitians, Board Certified Specialist in Obesity and Weight Management, Physicians, and Nurse Practitioners, Certified Diabetes Care and Education Specialists, NB-HWC Certified Health Coaches, MA Health Education/MPHs, PhDs, Licensed Therapists. Vida is not a CDC approved provider for Diabetes for Diabetes Self-Management Education and Support (DSMES)
  - Includes 1:1 consults, unlimited asynchronous interactions with health experts (e.g., health coaches, dietitians), group coaching, coach-moderated support groups, remote monitoring, device tracking, all features of the Vida app, and devices for users that meet clinical criteria. Care interventions may include: Medical Nutrition Therapy, prescribing (as clinically appropriate), remote patient monitoring for blood glucose, blood pressure, hyperlipidemia.

- Clinical Obesity Management+:
  - For members with Diabetes with co-occurring obesity as defined above and a desire to treat both; Diabetes with or without hypertension/hyperlipidemia: A1C ≥9
  - Includes: comprehensive assessment, RD-led 12 week behavior change coaching, 1:1 sessions with the RD, comprehensive nutrition assessment, individualized plan, prescriptive Medical Nutrition Therapy follow-up sessions provided in tandem with group support; self-directed CBT techniques to support behavior change, device tracking, all features of the Vida app, shared decision-making and evidence-based anti-obesity and/or cardiometabolic pharmacotherapy (e.g., anti-hypertensives, statins, insulin, bupropion/naltrexone, topamax, zonisamide, GLP-1s), side effect and medication adherence support, medical monitoring and labs as needed, synchronous and asynchronous physician or Nurse Practitioner access, reassessment.

Advancing Health Equity: Vida leverages a three-part framework to advance health equity.

1. Understanding and engaging members: stratification, screening, and assessment

   - Leverage area deprivation index, claims information, and member demographics to assess the burden of socioeconomic barriers and (i) design outreach strategies, (ii) inform content and design (e.g., WCAG 2.0 AA compliance; reading level; VoiceOver/TalkBack); (iii) train health guides (including Spanish-

speaking guides), (iv) tailor the member experience; and (v) engage Care Navigators for members with severe mental health needs, crisis triggers, food insecurity or other socioeconomic barriers.

2. Successful interventions: tailored for culture, socioeconomics, and individual barriers to health
    - We provide simple, pragmatic strategies across our programs to tailor the member journey, attune to cultural and demographic needs, and address health barriers, including SDOH, mental health, motivational, or any other type of barriers.
3. Measuring impact: subpopulation outcomes
    - Vida applies sophisticated stratification and predictive analytics for populations, enhancing our ability to understand and track against impact on subpopulations (see Experience to Date).

Experience to Date: Overall, Vida has 60 direct employer contracts in place in addition to channel partnerships that represent over 1800 clients. Vida sells direct-to-employer as well as through channel partners. With clients across multiple lines of business, we support 3M+ eligible lives — across industries and sectors, including health plans, health systems, PBMs, TPAs, and employers from retail, manufacturing, agriculture, technology, education, healthcare, and financial services. We also work closely with health plans in support of employer accounts and partner with health plans across all lines of business, including Medicare, Medicaid, Commercial Fully-Insured, ASO, and ACA Marketplace.

We track clinical impact and provide rigorous performance reporting: on enrollment, engagement, member satisfaction, and outcomes. Our published results document the impact Vida has had on member outcomes:

- 1.9 point reduction in A1C
- 75% 1+ stage improvement for hypertension
- 55% reduction GAD anxiety measures and 61% reduction PHQ depression measures
- $4,056 PMPY savings for populations in food insecure geographies
- $1,128 PMPY savings for members in rural areas – those with a RUCA ≥7

Vida's own results show that 97% of members with prediabetes did not advance to a diagnosis of diabetes and 15% reduction in hospitalizations in the first 6 months. Across our spectrum of care, Vida's weight loss results range 7-15% — as much as 15% weight loss with AOMs for BMI 30+, 7% for BMI 25+. Beyond clinical measures, Vida's cohort results show up to $2,040 PMPY cost savings for high utilizers — based on a rigorous, case control and difference-in-difference assessment. We invite you to review Vida's published results at vida.com/research.

Pricing of services: Vida's cardiometabolic pathways including Preventive, Chronic, Clinical Obesity Management, and Clinical Obesity Management as well as our Mental Health Therapy program are priced on a Per Participant Per Month (PPPM) basis for clients with 1,500+ lives. Custom Per Employee Per Month (PEPM) pricing is available for clients with <1,500 total lives and based on the mix of clinical pathways.

Website: https://www.vida.com/

Contact information:
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(214) 250-4940
Jason.parrott@vida.com

Vida Health, Inc.
20500 Belshaw Ave, DPT# EXCA1377
Carson, CA 90746

Viora Health

Organization Name: Viora Health

Description of Services: The Viora Health mission is to advance health equity by promoting health and wellness of a diverse workforce at home by combining the power of technology and culturally relevant human-support.

Value to Employers
Improve your institution's rates of workforce health and employee satisfaction

- Reduce your costs due to improved participant health status and reduced absenteeism
- Demonstrate your commitment to your workforce diversity by offering a program that supports cultural relevancy
- Show your commitment to employee health by funding a program that fits their busy schedule

Problem
Digital and in-person healthcare programs are successful only for those who engage. But usage of employer offered programs is abysmal and >70% of minority populations disengage from lifestyle change programs even if they join. Racial and ethnic minorities face the highest health risks while also facing the highest barriers. While they will make up 50% of the U.S. population by 2050, African Americans (15x) and Hispanics(13x) do not believe they receive culturally competent care (versus Caucasians). Additionally, remote workforce is the new normal after Covid, but current prevention programs are not built with this flexibility in mind. This results in poor experience, poor outcomes, and high costs of care: $100B/year in ignored doctor' orders and $530B/year in absenteeism.

Viora Social and Lifestyle Change Program for Diabetes Prevention
As a CDC fully recognized provider, Viora Health offers Diabetes Prevention Programs with a mission driven by health equity. Viora Health's DPP is offered as a part of its technology-enabled personalized engagement platform to deliver social and behavioral change programs. Our platform is sophisticated in the backend (powered by data and behavioral science) with a simple user interface which can be accessed on any device without requiring download or behavior change. Viora secret sauce is a science-based design thinking approach iterated through direct community-based partnerships and learnings. Program features and bonus features are listed on the left.

Experience to Date: We have Full Recognition from the CDC as a DPP provider by exceeding performance metrics (reduced A1C, weight loss of >5% and >80% attendance). Our paid programs have shown a 2-3x improvement in retention for a diverse racial/ethnic minority population versus competition. Food insecurity, Social isolation, and Literacy gaps were resolved for 100% of all participants who faced these gaps. Additionally, the Net Promoter Sore (NPS) in our programs was 75% with a score of 8,9, and 10, demonstrating a high level of satisfaction reported by participants. An IRB approved human subject study funded by the NIH, further showed that technology and human-supported interactions with the Viora system improved participant buy-in and engagement. We have achieved multiple business milestones that validate the company's approach, technology, and product concept, including direct investments from top organizations: National Institutes of Health, American Heart Association and J&J and revenue contracts from others. Viora was also awarded the "Technical Company of 2022 in Philadelphia" by Technical.ly. Using the AMA published data, preventing or delaying type 2 Diabetes can result in cost savings $2671 per annum. Added to this, a reduction in SDOH can result in further savings, resulting in an ROI of 3-6x.

Pricing: Introductory pmpm rates are offered for first time customers. We offer 3 plans based on need: The basic plan offers program content, goal setting, on-app tracking, weekly peer discussions led by the certified health coach, automated text and email reminders and nudges, and on-app coach feedback. The intermediate plan offers 1-1 coach sessions via video conference for an additional fee. The advanced plan offers resources recommended by the Viora facilitator based on the participant needs assessment to mitigate social and lifestyle gaps. We take a phased approach to implementation with introductory pricing offered based on size and need. All 3 plans report aggregate stratification and performance data back to the customer to measure impact and ROI.

Advancing Health Equity: Viora programs are designed to meet participants where they are at, understand their needs, and offer culturally relevant advocacy and resources from a trained coach-facilitator to support people in their

own community. These additions are available as bonus features on the app. Once participants are onboarded, their social and lifestyle gaps (such as access to food or lack of social support) are screened via an onboarding quiz to assess individual needs. Based on this, personalization is incorporated into the program using AI to enhance the existing DPP program. The personalization includes additional content, strategies, tips, and community-based culturally relevant resource recommendations to mitigate gaps. In addition to system-based resources and content, additional advocacy and facilitation is available from a trained coach-facilitator to resolve gaps (such as a local food box delivery resource recommended to close a food gap). Not only do we identify individual gaps, but recommendations are reinforced and closing of gaps are tracked and reported back to the customer on their dashboard. This allows better tracking of demographic, SDOH and health status for participants in the program.

Contact Information:

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Welldoc

Organization Name: Welldoc

Welldoc's comprehensive chronic care platform provides multi-condition cardiometabolic support across diabetes, hypertension, heart failure, prediabetes, weight management, and also includes mental wellbeing support.

Through Artificial Intelligence (AI), our platform guides individuals through the complicated journey of living with diabetes by enabling them to self-manage their care while enhancing connections to their healthcare team. Members like having a "one stop shop" for all their chronic conditions so their care can be connected and coordinated. People living with diabetes get personized care by connecting to various devices, such as CGM's, blood glucose seters, weight scales and blood pressure monitors, to receive real-time care 24/7/365.

The Welldoc platform is device-agnostic and connects to 400+ devices. Welldoc has shown clinical rigor through earning: 11 FDA clearances, 45 patents, and 75+ publications.

Experience to date: Welldoc was founded in 2005 and been in business for 19 years with 350 Employees. We cover 12+ million lives spanning across Health Plans, Health Systems, Employers, and Channel Partnerships. Our largest clients include CVS Health, Paramount, Eli Lilly, MDLIVE and HealthFirst. Proven clinical results include A1c reduction, cost savings, weight loss, and blood pressure reduction.

Pricing of services: Welldoc will be about 1/6 the cost of other providers because we use AI rather than human coaches. Our fee structure is based on a Per Utilizer Per Month (PUPM) or Per Eligible Member Per Month (PMPM). Welldoc is part of the Optum and United Healthcare Hubs which offer reduced pricing.

Website: https://www.welldoc.com/ Testimonials: https://www.welldoc.com/insights/

Advancing Health Equity: Welldoc has incorporated cultural competency, social determinants of health and root cause factors into our holistic approach across product development, engagement and advancing our AI as described below.

Product development: The Welldoc food database is large and diverse, representing a diverse multicultural variety of cuisines/foods. The education curriculum and coaching are based on publicly available, evidence based clinical standards that focus on supporting a broad, diverse population. Language/communication in the app is written to a 4-6th grade level The app is available in a neutral US Spanish, with cultural changes made for the target audience We have an extensive human factors approach integrated into our product testing to ensure that our app is tested across a diverse population of individuals living with chronic conditions.

Engagement: Welldoc prides itself on partnering with our clients to develop an engagement approach that supports a client's diverse population. Engagement is based on segmenting the population in a way that ensures that individuals are receiving the right information at the right time in their journey. We can work with you to ensure that race, age, geography, and social determinants of health are incorporated into our engagement and communication strategies. Welldoc also supports Spanish language engagement and communications and customer care Welldoc has a market research and survey approach to continue understanding and obtaining feedback from the users of our product. This feedback is considered as we enhance our product offerings and capabilities.

Advanced AI: Welldoc continues to optimize our AI by integrating social determinants of health. This is an integral part in understanding how different segments of populations and ensuring our AI driven coaching continues to be personalized and supportive of an individual's journey. One example that showcases this is our partnership with the New York City Health and Hospital System. We are successfully integrating our solution, completely in Spanish, into their health ecosystem, which supports an extremely diverse population.

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WellSpark Health, Inc.

Organization Name: WellSpark Health, Inc.

Description of Services: Diabetes Prevention (include if you are a CDC approved provider for the NDPP)
WellSpark has achieved preliminary recognition1 by the CDC for our Diabetes Prevention Program (DPP) which follows the CDC's National DPP 12-month Prevent T2 curriculum. We have also been featured by the American Diabetes Association (ADA) in a publication2 on DPP. Our program infuses WellSpark's Life-Dimensional Approach where participants learn valuable tips and gain meaningful insights into how lifestyle behaviors impact their overall health. WellSpark's DPP – targeted to achieve full CDC recognition – focuses on individuals with prediabetes or those at high risk while ensuring health equity and equal access to resources. We work to ensure that even the hardest-to-reach workforces can participate in culturally relevant programming that recognizes the nuances of their type of work, such as the burdens placed on police officers and medical personnel. With a wide range of services – from in-person, group seminars and activities to individually paced online resources, programming, and coaching – we tailor every program to align with each unique population.
[1] Source: Diabetes Prevention Recognition Program Registry | CDC

[2] Source: American Diabetes Association (diabetesjournals.org)

Diabetes Management: WellSpark's Help 364 program provides year-round support to employees with diabetes and other chronic diseases to help participants improve their overall physical and mental health. WellSpark has achieved DSMES Association of Diabetes Care & Education Specialists (ADCES) accreditation. Our certified Nurse Wellness Coaches work with participants to best manage their condition through an emphasis on proper diet, exercise, and adherence to medications, with coaching provided that is culturally relevant to each participant. Support is provided individually and in group settings to help participants develop better behaviors to manage their condition and improve their lifestyle.

Experience to Date: WellSpark's roots date back to 1981 when our wellness solutions were first offered through our affiliate, ConnectiCare, a leading regional health plan and part of the EmblemHealth family of companies. WellSpark was then officially established years later where we have continued to elevate and modernize our wellness technology, programs, and services for clients across the country, servicing 30,000+ individuals across hundreds of employer groups. Our DPP has been recognized as exceeding the national averages of traditional CDC programs. For example, in one group of over 600 participants, we saw a 21% trend reduction in HbA1c values, which is a key marker in measuring risk and improving diabetes.

Pricing of Services: Our pricing model is highly flexible and adaptable to meet the needs of each client. Typically, WellSpark charges for services by consumption instead of fixed, annual pricing or per member per month (PEPM). This ensures clients are only charged for actual services that are rendered, keeping WellSpark financially motivated to ensure participants remain highly engaged in our programming. Our bottom line? WellSpark strives to use this methodology to benefit both WellSpark and employers and employees alike as they improve their health and lifestyle.

Advancing Health Equity: WellSpark's mission is to create a wellness environment that is welcoming of all individuals, regardless of a member's gender, race, ethnicity, sexuality, etc. We administer wellness assessments to analyze the social determinants that impact each individual in order to provide the best resources. All member materials, communications, as well as our online technology are provided in multiple mediums and are translated into multiple languages. In addition, as members contact WellSpark for support, we have a Language Line support feature that establishes a three-way call between the agent, caller, and translator to provide live phone support. We also have Spanish-speaking and Chinese-speaking employees on staff.

Website: www.wellsparkhealth.com

Contact Information:
WellSpark Health, Inc.

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Wellworks For You

Organization Name: Wellworks For You

Contact Information:
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Description of diabetes-related services: We are not CDC approved at this time.
Our Big 8 Chronic Condition Management programs identify 8 lifestyle modifiable chronic conditions (Glucose Management, Hyperlipidemia, Hypertension, Obesity, Musculoskeletal Disorders, Respiratory Conditions, Sleep, and Stress) for the members to enroll in. The coaches assist the members with setting and meeting goals. Additionally, the members who participate in the wellness program will complete a biometric screening and answer a short questionnaire to receive the Know Your Number Risk Score Report. This report will detail the members risk of onset of 6 different disease states (Diabetes, Congestive Heart Failure, Coronary Heart Disease, Stroke, Lung Cancer, and COPD), what percentage of this is lifestyle modifiable, and what risk factors are contributing to onset. Our coaches review this information with the members and assist them with setting and meeting goals to prevent disease onset.

Our Diabetes Management Program combines data analytics, app-based technology, and personalized health coaching to achieve meaningful results. Our program partners the members with a Certified Diabetes Care and Education Specialist, who is also a registered nurse, to bridge the gap between provider visits and assist with day-to-day management of their diabetes.

Experience: There are 600 lives currently enrolled in our Diabetes Management Program. After 3 years of enrollment, our engaged participants are realizing, on average, a 29 mg/dL reduction in fasting blood glucose, a 0.8% reduction in HbA1C (0.5% is the FDA requirement for a medication to considered for approval), and an average weight loss of 9lbs.

Pricing of services: $30 per participant per year (50 person minimum)
Pricing can also be offered in a PEPM model

Website: https://www.wellworksforyou.com/solutions

Advancing Health Equity: At Wellworks, we are dedicated to advancing health equity by tailoring our coaching approach to meet the unique needs of each member. Our commitment to inclusivity begins with ensuring accessibility for all. Our portal, including both our website and app, is ADA compliant, ensuring that individuals with disabilities can easily access and utilize our digital offerings.

Understanding the diverse linguistic needs of our members, Wellworks digital resources are available in 104 languages. This multilingual capability enables us to reach and support a broader spectrum of individuals, breaking down language barriers that could otherwise hinder effective health engagement. Moreover, recognizing the importance of real-time communication in coaching, we offer telephonic translation services. This service allows our members to connect with coaches seamlessly in their preferred language, ensuring clarity and understanding during coaching sessions. Whether it's discussing personal health goals or navigating complex healthcare information, our telephonic translation service enhances accessibility and supports equitable engagement across all populations we serve.

YMCA – YMCA of Delaware

Organization Name: YMCA of Delaware

Description of Services: The YMCA of Delaware is a leading provider of the CDC-approved curriculum designed to reduce the risk of diabetes. Participants in the YMCA's Diabetes Prevention Program (YDPP), will take 25 classes over the course of a year surrounded by a group of supportive people with common goals. The evidence-based program is designed to help each participant reduce their risk for diabetes, reduce their body weight by 7%, and increase their physical activity by at least 150 minutes per week.

Participants will:

- Find a safe space where they feel comfortable sharing and learning in private
- Make new friends. Participants support each other as they trade old habits for healthier new ones.
- Work as a group. No one has to figure this out alone.
- Boost energy and confidence that comes with losing weight and reducing their risk for diabetes.
- Lose weight, reduce their risk for diabetes, and improve health for life!

Experience to Date: The YMCA program is based on the landmark Diabetes Prevention Program funded by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC). This program showed that by eating healthier, increasing physical activity and losing a small amount of weight, a person with prediabetes can prevent or delay the onset of type 2 diabetes by 58%. The YMCA of Delaware has offered YDPP for over 10 years. Last year alone, more than 400 people made the life-changing decision to register.

Pricing of Services: YDPP is currently available at no cost to qualified participants through their insurance providers, or through grants provided by the YMCA of Delaware to qualified participants. To help participants reach their goals, the YMCA of Delaware includes a four-month family membership, good at all the branches throughout Delaware.

Website: https://www.ymcade.org/preventdiabetes

Contact information:
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YMCA - New Jersey State Alliance (NJYSA)

Organization Name: NJYSA

NJYSA is a CDC approved provider for the National Diabetes Prevention Lifestyle Change Program.

Several NJ YMCAs offer the National Diabetes Prevention Program (DPP) for adults at high risk of developing type 2 diabetes.

Through this program, participants work with trained lifestyle coaches to make healthy lifestyle changes. These changes involve losing a modest amount of weight and increasing physical activity to 150 minutes per week, with the goal of reducing the risk of developing type 2 diabetes. The program comprises 25 sessions over one year. Participants attend weekly sessions during the first six months and monthly sessions for the remaining six months. Sessions are held at local YMCAs or community-based organizations and are available both in person and via Zoom.

Program Eligibility: To join the Diabetes Prevention Program, you must meet ALL 4 of these requirements:

1. 18 years or older.
2. Have a body mass index (BMI) of 25 or higher (23 or higher if you're Asian American).
3. Not previously diagnosed with type 1 or type 2 diabetes.
4. Not pregnant.

You'll also need to meet 1 of these requirements:

1. A blood test result in the prediabetes range within the past year
2. Previously diagnosed with gestational diabetes (diabetes during pregnancy)
3. Received a high-risk result (score of 5 or higher) on the Prediabetes Risk Test

Experience to Date: In Fall 2023, NJYSA supported five local YMCAs in their implementation of DPP across seven counties: Cumberland, Cape May, Atlantic, Bergen, Camden, Mercer, and Union. Several other NJ YMCAs also offered the year-long program.

As part of this effort, a New Jersey YMCA piloted a Spanish-language cohort to better serve community needs, while other YMCAs offering DPP launched a Simple Texting campaign to boost participant engagement. Evaluations revealed that 25% of DPP participants across NJ YMCAs achieved their weight loss goals from baseline weights. On average, participants lost 2.8% of their body weight and engaged in 128 minutes of physical activity per week.

Pricing for Services: Each local Y sets the costs for the DPP based on available funding. For more information, contact your preferred NJ YMCA for program costs.

Websites for Additional Information: Check your local YMCA's website to see if they offer the National Diabetes Prevention Program. YMCAs that have offered or are currently offering DPP include:

- Capital Area YMCA - Trenton, NJ
- Cumberland Cape Atlantic YMCA – Vineland, NJ
- Garfield YMCA - Garfield, NJ
- Gateway Family YMCA - Union, NJ
- Gloucester County YMCA (YMCA of the Pines) - Woodbury, NJ
- Greater Somerset County YMCA - Branches in Bridgewater, Franklin Twp., Hillsborough, Plainfield, Princeton, Somerset Hills, and Somerville.
- Hopewell Valley YMCA - Pennington, NJ

- Montclair YMCA - Montclair, NJ
- Summit Area YMCA - Multiple branches serving Berkeley Heights, Gillette, Millburn, New Providence, Short Hills, Springfield, Stirling and Summit.
- West Morris Area YMCA – Randolph, NJ

If you have trouble contacting your local YMCA, you can reach out to the NJ YMCA State Alliance for assistance.

Contact Information:
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The Greater Philadelphia Business Coalition on Health (GPBCH) seeks to increase the value of health benefit spending for the region's employers. We do this by improving workforce and community health, increasing healthcare quality and safety, and reducing healthcare costs. The Coalition represents employer interests in working with health plans, healthcare providers, benefits consultants, suppliers and other system stakeholders to address population health priorities and to ensure that when healthcare is needed it is accessible, affordable, equitable, high-quality, and safe.

Serving Southeastern Pennsylvania, Southern New Jersey and Delaware