Toolkit: Innovative Strategies for Effective and Equitable Prediabetes Care

ACPM

Building Health Care Provider Capacity to Screen, Test, and Refer Black and Hispanic Women with Prediabetes into the National Diabetes Prevention Program

Project Background

With funding from the CDC's Division of Diabetes Translation, the American College of Preventive Medicine (ACPM), in partnership with the American Medical Association (AMA) and the Black Women's Health Imperative (BWHI), participated in a multi-year initiative to support the implementation of innovative health systems and community-based approaches to address and improve diabetes prevention in disproportionately affected populations. This project focused on enhancing identification, testing, referral, enrollment, and retention of Black and Hispanic women with prediabetes within the CDC-recognized National Diabetes Prevention Program (National DPP). A fundamental component of the National DPP is the Lifestyle Change Program (LCP), which can decrease an individual's risk of developing type 2 diabetes by 50%. Furthermore, the year-long structured, lifestyle change program focuses on healthy eating and physical activity, that can prevent or delay the onset of type 2 diabetes through evidence-based practices and promote less than or equal to 5% weight loss over one year.[1]

In order to ensure consistent quality care, the CDC partners with organizations that practice high standards and effective delivery.[1] Three grantees were selected through a request for proposal process and provided with ongoing technical assistance throughout this funding period including: Northeast Valley Health Corporation, University of Texas Southwestern Medical Center/Parkland Health and Hospital System with support from Baylor Scott and White Health and Wellness Center, and University of Washington Valley Medical Center.

Toolkit Outline

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Introduction

Diabetes is a chronic disease that impacts the body's ability to create or properly use insulin, resulting in negative health outcomes. The primary diabetes diagnoses include Type 1, Type 2 and gestational diabetes. Type 1 diabetes is caused by low insulin levels in the body, whereas Type 2 diabetes is caused by insulin resistance in the body.[2]

According to the CDC's National Diabetes Statistics Report, 97.6 million Americans over the age of 18 have prediabetes, 48.8% of whom are adults 65 and older.[3] The same report cites 38.4 million Americans have diabetes, yet only 29 million have been formally diagnosed; 8.7 million remain undiagnosed and unaware of their disease status.[3] Hispanic or Latino individuals are over 50% more likely to develop type 2 diabetes compared to the US adult population (overall relative risk: 40%).[4] Americans spend approximately $413 billion a year on diabetes-related medical expenses, including lost work and wages.[5] It is imperative to address chronic disease in adulthood related to cardiovascular health and other obesity-related morbidity, including type 2 diabetes.[6] Risk factors for US adults 18 years or older that can lead to diabetes-related complications include: smoking, overweight and obesity, physical inactivity, high A1C levels, high blood pressure, and high cholesterol.[3] Therefore, special considerations and action steps need be taken to address health equity issues among disproportionately affected populations in order to obtain support for prediabetes care.

This toolkit provides guidance for preventive medicine physicians, healthcare professionals and health team leaders who develop and lead programs in healthcare setting(s) to address prediabetes with support of community resources. This toolkit can be used to inform initiatives and implement evidence-based strategies within diverse practice settings to equitably address diabetes prevention.

The recommendations in this toolkit can be implemented more effectively when a champion leader is identified and the health care team is engaged with specific roles to conduct the tasks, regardless of whether an internal National DPP is set up. Clinics that refer out to the National DPP will need clear role identification among their team (i.e., staff lead and additional team members) to set up and execute screenings and referrals in their specific setting.

PATHWAYS
to Effective and Equitable Prediabetes Care: Key Findings/Takeaways

All health care settings need to integrate steps for prediabetes intervention in coordination with community resources at three distinct levels including the: individual level (interactions between the health provider and the participant), interpersonal level (interactions between the health provider and the care team), and community level (interactions between the organizations). This framework aligns with the socio-ecological model that has been found to be useful in community engagement of health programs in underserved areas and groups, and represents the foundational framework of this toolkit.[7]

INDIVIDUAL LEVEL - For health providers working in clinical care settings

This level focuses on tools and resources that support the interactions between the health provider and the participant to screen, refer and motivate positive behavior modification practices for overall lifestyle change in areas known to impact risk for diabetes (i.e., weight management, exercise, etc.). Health team members who lead and manage the program need to plan for and determine how to implement these recommended steps, tools and resources. Supports need to be set up for the health provider and other health care professionals to effectively conduct screenings, increase referrals and guide behavior modification, regardless of whether the clinic conducts its own DPP LCP or refers out to and coordinates with an external program(s).

Screening, Testing & Referrals

Referral to the National DPP LCP

- Answer questions about prediabetes and referral options while building participant trust to follow through with enrollment.[8]
- Conduct readiness assessments to understand participant's willingness and ability to engage in the program.
- Build trust with participant and be transparent about how staff will use information to support participant.
- Reassure participant that the program staff will only use personal information to better support them in their needs and that providing the information will not jeopardize their immigration status.

Communicating with Participants

- Connect with participants who were referred by their physicians, educate them about prediabetes and the National DPP LCP, and answer their questions individually or through group information sessions.[8]
- Reframe "wellness" to focus on the participant's unique interests related to health, nutrition and physical activity.
- Communicate the effects of prediabetes on participant's health and inquire about their motivations for making lifestyle changes based on their healthcare provider's recommendation.
- Be clear and transparent about the program requirements so that prospective participants feel more informed and confident when making the decision to enroll.

INDIVIDUAL LEVEL - For health providers working in clinical care settings

Sharing Resources

Share informational flyers with participant during the clinical encounter (see Appendix 1).

- Ask participant if they have seen posters in the waiting room about actions to prevent diabetes. This can be used as an opportunity to discuss the participant's condition and recommended action steps, such as referral to the National DPP LCP.

Program Enrollment and Engagement

According to the CDC, 71.7% of participants do not achieve the anticipated annual weight loss of less than or equal to 5%, and women on average lose half as much weight as their male counterparts.[9] One of the greatest challenges in assisting Black and Hispanic women in addressing their prediabetes condition is enrolling them into the National DPP LCP.[8,9]

Potential barriers to enrollment that the provider should assess with participant include:

- Knowledge, attitude, and beliefs about prediabetes and diabetes
- Language preference
- Accessibility
  - Transportation
  - Dependent child/adult care
  - Work and/or other scheduling conflicts
- Mistrust
- Lack of social support
- Life challenges and emotional difficulties

Tips for the provider to work through these barriers:

- Provide individual support to understand barriers and promote engagement in lifestyle changes, offer strategies to overcome barriers to participation, and discuss progress toward goals.
- Engage through motivational interviewing and active listening strategies, and pay attention to participant's body language to help build trust.
- Use a nonjudgmental and supportive approach.
- Apply communication strategies with participant that abide by the CDCs Health Equity Guiding Principles for Inclusive Communication[10] and person-centered language
  - This can include using the phrase "persons with prediabetes" and avoiding words with negative connotations (like "vulnerable", "marginalized", and "high-risk"), as well as words with violent connotations (like "fighting diabetes").

Assessing and Addressing Social Needs

Social Needs Assessment Tools:

- Modified version of the Protocols for Responding to and Assessing Patients Assets, Risks, and Experience (PRAPARE) Screener
- The American Academy of Family Physicians' Social Needs Screening
- Screening tools administered via Electronic Health Records (EHR)
- Screening tool forms for participants to fill out (see Appendix 2)

Social needs tools should assess factors such as education, food insecurity, housing insecurity, social isolation, transportation, safety, mental health, insurance, tobacco use, and access to childcare.

INTERPERSONAL LEVEL - For members of the care team working in health systems, community-based organizations, etc.

This level focuses on the interaction between the provider and the care team members within the health system and organizations. As with the tools suggested for the individual level (participant-provider interactions), the tools and resources that support effective interactions between the provider and the care team can be implemented by those who lead/manage the program. The care team can use this toolkit to plan how to implement these recommended steps, tools and resources which are needed for both health systems that run a National DPP, as well as those screening, testing and then referring to an external National DPP LCP.

Screening, Testing and Referrals

Screening and Testing for Prediabetes (see Appendix 3)

- Use clinical decision supports such as screening algorithms and order sets in EHR to alert providers of participants with prediabetes and/or disproportionately affected individuals.
- Implement clinical care pathways to guide providers through workflows for screening and testing.

Referral to the National DPP LCP (see Appendix 3)

- Integrate clinical support tools like Smartphrases: these are pre-populated messages in the EHR to promote consistent messaging and support physicians and the care team in educating participants about prediabetes as they refer them to the National DPP LCP. A helpful resource can be found **here.**
- Answer questions about prediabetes and referrals while building enthusiasm and buy-in to encourage follow through with enrollment.
- If your organization refers participants to a different health system or to a community-based organization, communicate the role of the other health system or community-based organization in delivering the program.
- Have the program provider organization be present at the clinical site to build familiarity.

Increase Success with Referrals:

Staffing

- Identify healthcare staff, program coordinators, coaches, and health educators who can reach out to prospective participants to share information about the program and enroll participants.
- Ensure staff are from similar cultural or linguistic backgrounds to build rapport and address participants' questions during information sessions and classes.

Marketing

- Educate prospective program participants via letters, text messages, emails, calls, and flyers; ask past participants to share their experiences with the program.
- Post information through paper flyers in healthcare settings and community centers or in newsletters.
  - Include a QR code on the flyers to allow participants to select their preferred language and to translate the flyer into other languages.
- Translate participant education materials into Spanish and other languages, by using other tools such as Google Translate (see Appendix 2).
- Use images and messaging on marketing materials that are reflective of focus communities.

INTERPERSONAL LEVEL - For members of the care team working in health systems, community-based organizations, etc.

Screening, Testing and Referrals (CONT.)

Online Resources

The National DPP[11] offers several online resources to guide prediabetes testing and inform potential participants about the program. Clinics can incorporate these links and informational materials into their websites.

- Prediabetes Risk Test – Take the Test - Prediabetes | Diabetes | CDC
- CDC Path 2 Prevention – https://diabetespath2prevention.cdc.gov

Website and Sample Informational Flyers About National DPP

- Website with details about the program: CDC National DPP - About the Lifestyle Change Program
- Information to develop flyers about the program: CDC National DPP - Resources for Referring Patient to the LCP

Sample clinic website content about National DPP

- Program website examples
  - September-2023-Health-Ed-Calendar.pdf (nevhc.org)
  - National Diabetes Prevention Program | University of Utah Health
  - Diabetes Prevention Programs - The Brancati Center
- Additional programs can be found here: National Registry of Recognized Diabetes Prevention Programs

Program Enrollment and Engagement

Engagement and Activities in the National DPP LCP

A number of recommendations from the report *Advancing equity in diabetes prevention for Black or Hispanic women: Lessons learned and action steps*[8] provide guidance for successfully engaging Black and Hispanic women in lifestyle classes and overcoming barriers to making lifestyle changes. Many of these recommendations apply to participation in the program, as well as individual lifestyle change action plans.

- Tailor lessons or lifestyle change action plans to align with culturally relevant examples, such as traditional foods, herbs and supplements.
- Recommend or refer to safe spaces to exercise including:
  - Participating in fitness classes,
  - Walking with friends in your neighborhood,
  - Building small increments of exercise in between caregiving and professional responsibilities,
  - Utilizing online exercise videos at home, and/or
  - Redefining daily activities (like vacuuming) as exercise.
- Use periodic text messages, emails, or other messages to remind participants about upcoming classes or individual action plans.

INTERPERSONAL LEVEL - For members of the care team working in health systems, community-based organizations, etc.

Program Enrollment and Engagement (CONT.)

Recommendations for Approaching LCP Classes

- Offer financial resources/incentives for participants to complete the programs via grants or other funding sources including:
  - Exercise equipment,
  - Food preparation materials, and
  - Other giveaways (i.e., stress balls and measuring cups).
- Invite participants to share successes and challenges.
  - Create group chats over platforms (i.e., WhatsApp) to share progress and send motivational messages.
  - Share YouTube videos, social media, and apps for tracking food to help engage participants.
- Offer multiple class modalities (i.e., virtual, hybrid or in-person) for participants to choose based on preference and experience using technology.
  - Train lifestyle coaches to provide technical support to participants about platforms like Zoom and Teams, and creating email accounts.
  - Offer a tablet loaner program for people to access the class or help participants find access to the internet through local libraries.
  - Allow flexibility to share food logs via paper form or phone if participants prefer.
- Offer individualized support outside of group classes.
- Do periodic check-ins, convene support groups, and/or provide follow-up exercise videos to help participants sustain lifestyle changes.

Community Outreach & Collaboration

In addition to provider and clinic referrals for screening and testing by the care team, community outreach is essential. This approach leverages community engagement that is essential in improving the health of Black and Hispanic women who are disproportionately affected by prediabetes. Care teams that do not typically conduct projects with the community may consider contacting their local health department for a list of community-based organizations that support the health of disadvantaged populations.

Examples of community outreach methods (some of which are used by National DPP delivery organizations or clinics providing the National DPP LCP) include[8]:

1. Identify significant organizations in your community

- *What connections do your care team members have with community organizations?*
- Forge partnerships with community organizations that also serve the populations being served. These organizations can represent a variety of services, not necessarily tied to health including:
  - Faith-based groups,
  - Soup kitchens,
  - Charity organizations,
  - Cultural organizations, and/or
  - Organizations or companies that the individuals being served use (i.e., hairdressers; other various stores).
- Provide information at community events and gatherings.

INTERPERSONAL LEVEL - For members of the care team working in health systems, community-based organizations, etc.

Community Outreach & Collaboration (CONT.)

2. Identify community leaders

- *Who does your staff know in the community?*
- Encourage care team members to build relationships with community leaders.
- Hire community members as liaisons and educators.
  - Below are characteristics and experiences that can be helpful when recruiting individuals to serve as liaisons. Most importantly, they need to reflect the socioeconomical and cultural background of the community.
  - Look for:
    - Higher level of education (preferred), but training can help.
    - Strong verbal and written communication skills.
    - Interpersonal skills with ability to create and maintain relationships.
      - Identify individuals in the practice who have connections with and/or are close to the community being served.
- Engage volunteers.
- Involve community participation in developing needs assessments, so the community drives the program.

3. Build relationships with participants.

- Participants interact with team members the most and can help identify needs.
  - For example:
    - Front Desk Staff
      - See how the participant gets in (i.e., are they alone or with someone; did they come in in their own vehicle or did they use public transportation?).
      - Perceive the participant's initial well-being (i.e., is the participant anxious, shy, scared?).
      - Observe and note significant interactions.
    - Medical Assistants:
      - Before the visit - taking vitals is the perfect moment to ask general questions about wellbeing and note them in the chart.
      - After the visit - reinforce what the doctor told the participant and discuss it in plain language.

Your staff can help determine realistic expectations to develop the following capacity building activities.[12,13]

- Fundraising: Raising funds to keep nonprofits operating is always a challenge. Capacity building activities that focus on fundraising lead to improved sustainability; this may include training/fundraising techniques, fiscal management, or development skills. The clinic may consider fundraising to support their efforts in screening, enrolling and referring to an existing DPP LCP program, rather than starting a new DPP LCP program.
- Hiring new people or seeking volunteers with expertise: Recruiting (and retaining) staff or volunteers with relevant knowledge and expertise means transference of knowledge to the rest of the organization. Focusing on staffing, through both selection and development, can promote organizational stability.
- Forging partnerships with other organizations: Which other organizations are working in your field? Could a partnership complement your mission? In many cases, collaboration makes sense, both in terms of avoiding duplication of services and optimizing the work both groups perform.

What is going to work for your community?

Community Needs Assessment Workbook: https://www.cdc.gov/globalhealth/healthprotection/fetp/training_modules/15/community-needs_pw_final_9252013.pdf

Nurse's Role: https://www.ncbi.nlm.nih.gov/books/NBK590038/

Evaluators: https://ctb.ku.edu/en/table-of-contents/evaluate/evaluation/choose-evaluators/main

INTERPERSONAL LEVEL - For members of the care team working in health systems, community-based organizations, etc.

Sharing Resources

- Training of clinic staff: One-on-one or group training, whether face-to-face or online, can increase personal knowledge and skills surrounding an issue. Individuals receive the tools needed to make meaningful actions and advocate/educate others in the organization, community, or personal sphere.
- Mentorships with staff of other clinics that conduct the National DPP LCP: Mentoring provides intensive, personalized guidance and builds knowledge and skills. By learning from those with expertise and experiences, mentees can gain confidence and build personal and professional networks.

Resources to develop specific programs below.

CDC National DPP - PreventT2 Curriculum and Handouts

National Diabetes Prevention Programs | DoIHavePrediabetes.org

Diabetes Prevention Programs - YMCA

Assessing and Addressing Social Needs

Program Engagement and Potential Solutions to Barriers[8]

Engaging women in the program to follow through with classes and activities is also a major challenge.[9,14,15]

For Black and Hispanic women with barriers to care, assessing and addressing social needs is foundational to success.

At the outset of the program, the physician champion and others at the clinic leading the diabetes prevention activities can identify team members to develop a list of local resources, contact the health department and community organizations and develop partnerships for assistance. The role of various partner organizations needs to be communicated to the entire care team, as well as program participants.

- Discuss how participation in the program may help participants achieve their goals (i.e., making lifestyle changes can help you feel better and have more energy).
- Use translation services; if not immediately available, seek informal assistance from family members.
- Use travel vouchers (for public or other transportation services) to attend sessions; hold virtual sessions if digital equipment is available; if computer is not available, but the participant has a cell phone, consider participating via phone.
- Engage community health workers from the population of focus who can build trust.
- Engage other participants who represent the population of focus to share positive experiences.
- Engage church or other community volunteers to assist with babysitting/caregiving; identify areas at the clinic or class for children to play.
- Identify a future and/or better time to participate in classes.
- Engage close family members to support program participation by sharing information and answering questions.
- Identify how the classes may help with goals other than health, such as social connection.
- Identify other community and social work resources that can help address social needs.
- Seek counseling for emotional challenges at the clinic or other low-cost community programs.
- Refer to peer support programs for specific issues, such as Alcoholics Anonymous.

INTERPERSONAL LEVEL - For members of the care team working in health systems, community-based organizations, etc.

Assessing and Addressing Social Needs (CONT.)

Health care practices may consider partnering with community-based organizations/programs to implement these solutions. Local health departments which work with these types of community-based organizations may be able to help identify those working in the local community or virtual programs.

Social Needs Assessments

- Wait for participants to open up and share when they are comfortable, rather than asking specific questions right away about social needs.
- Conduct individual check-ins to discuss social needs with participants to build trust and follow-up with them about whether their needs have been met.
- Gather information about social needs informally as participants raise them during National DPP LCP classes or clinic visits.
- Offer social needs screening in different languages and modalities to align with cultural and personal preferences.
- Conduct social needs screening during clinic visits; or have lifestyle coaches fill out the social needs survey during the class sessions.
- Make sure program coordinators and lifestyle coaches can access the EHR to enter social needs information to inform the care team.
- Use interpreters or lifestyle coaches who speak participants' language to walk through the social needs screening tool with participants.
- Offer diverse ways to complete social needs screening tools, such as text messages, paper surveys, or include the tool in the Zoom registration link for the National DPP LCP class.

If the clinic is offering the DPP LCP program, the clinic may consider providing program incentives to help increase enrollment. If the clinic is partnering with external programs, the clinic leaders can explore various enrollment incentives with partners. Examples of program incentives that can be offered to participants include:

- Gift cards,
- Food vouchers; farmers market vouchers,
- Vouchers for physical activity programs in the community,
- Discounts to community services,
- Certificates of completion,
- Showcase participants as role models/champions (if desired), and/or
- Healthy recipe books.

To address social needs, clinics can maintain resource lists and use community resource platforms by:

- Provide education about available resources and services, such as handouts about local food banks, community garden resources, and newsletters with relevant events.
- Use community resource platforms to identify relevant resources, share them with participants, and track referrals. Examples:
  - One Degree transmits referral information via email, text, and paper printout, and allows staff to know if participants have used the resources.
  - FindHelp
  - Unite Us is your partner for social care
- Offer mental and emotional health support, share resources and referrals to behavioral health resources, and connect participants with pastoral care to support their emotional health.
- Get feedback from participants about social services to update their resource lists.

INTERPERSONAL LEVEL - For members of the care team working in health systems, community-based organizations, etc.

Assessing and Addressing Social Needs (CONT.)

Social Needs Questionnaires:

https://prapare.org/

https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

Additional Resources:

AHA | Screening for Social Needs: Guiding Care Teams to Engage Patients

AHRQ | Identifying and Addressing Social Needs in Primary Care Settings

Community Catalyst: Screening for Social Needs

Health Leads | The Health Leads Screening Toolkit

AAFP: Assessment and Action

COMMUNITY LEVEL - For leaders of the care team working in health systems, community-based organizations, etc.

This level focuses on the interaction within the community and the relationships between organizations to facilitate systems-based outreach, communication and change to improve population health overall. This section is exceptionally applicable to organizations delivering an internal National DPP LCP. However, clinics referring to external programs will be more successful in serving their community by incorporating these recommendations.[8]

Screening, Testing & Referrals

Provide social needs questionnaires to the organizations:

https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/assessment.html

Provide National DPP questionnaires to the organizations:

https://www.cdc.gov/prediabetes/takethetest/

CDC National DPP - Additional Resources for Program Providers

COMMUNITY LEVEL - For leaders of the care team working in health systems, community-based organizations, etc.

Community Outreach and Collaboration

Working with the community is essential for developing successful programs that reach the focus community. The clinic team leading this program may need to consider contacting external community-based organizations which are actively engaged in public programs that support the participant communities.

Engage with the Community

- Engage in community outreach through partnerships with trusted community-based organizations, public health agencies, and other health systems.
- Facilitate trainings about the importance of improving equity in prediabetes referrals for the focus communities.
- Hire and train community health workers, community champions, or participant navigators to support community outreach and enrollment.
  - Engage staff to support outreach, such as posting flyers or giving presentations at community centers, places of worship, libraries, and bus stations.
    - Host conferences in partnership with a local church, combining health education and screenings with church services as a way of building community among participants and addressing their emotional and spiritual needs.
  - Host information sessions or health fairs at the clinic or community centers to answer prospective participants' questions about the program in both English and Spanish.
- Host events within the neighborhoods prospective participants live in to share information about the National DPP and lifestyle programs.
  - Work with churches to educate Black and Hispanic women.
  - Conduct outreach at community events (i.e., Juneteenth observance).
- Use TV ads and social media content featuring Black women participating in lifestyle changes.
- Feature testimonies of past participants in information sessions to communicate the value of the program and answer prospective participants' questions.
  - Seek support from past participants from similar cultural backgrounds.
- Identify new community resources with capacity to serve participants that are culturally and linguistically responsive.
  - Ensure that community resources have Spanish-speaking staff before referring Hispanic participants.
- Build stronger partnerships with community-based organizations, public health agencies, and other healthcare organizations for sustainability, by involving institutional leadership, getting leadership buy-in, and addressing privacy and legal considerations (see Appendix 5).
- Consider developing specific partnership letterheads and templates for communication with other service providers and prospective participants.

COMMUNITY LEVEL - For leaders of the care team working in health systems, community-based organizations, etc.

Community Outreach and Collaboration (CONT.)

Connecting with Health Professionals

When connecting with health professionals in the community to discuss the National DPP or lifestyle programs, include:

- Overview of program,
- How the program works,
- Eligibility,
- Screening and referral,
- Examples of successful programs,
- Health team roles that can serve as champions; how physicians can leverage the team, and
- Key lessons from the ACPM-CDC grant.

Helpful resources to develop using key information:

- CDC National DPP: About the Lifestyle Change Program
- https://coveragetoolkit.org

The clinic team leading the program needs to discuss with health professionals ***at other health care settings in the community*** the details of the program, the process for referring, and the specific role of the physicians and health team (see Appendix 5). Below are sample discussion questions:

- What are you currently doing routinely in your clinical setting to screen for prediabetes?
- What recommendations do you make to participants with prediabetes?
- To what programs do you currently refer participants with prediabetes?
- What National DPP programs are available in or near your clinical setting?
- Would you consider developing an internal National DPP at your clinical setting?
- What senior leaders can you engage for to develope a systematic plan for identifying participants with prediabetes, and referring and enrolling them in the National DPP LCP?
- Which health team members in your healthcare setting could serve as champions for the National DPP?
- Which members of your health team have roles that can be adjusted to promote a National DPP program that is either internal or external to your organization?

Program Enrollment and Engagement

Lifestyle Changes

Health professionals referring to the program and offering prediabetes counseling can be encouraged to learn, not only from the National DPP, but also leaders in lifestyle medicine to gain knowledge and skills in helping participants make lifestyle changes. A key leading organization in this field is the American College of Lifestyle Medicine, which offers a number of resources such as the Lifestyle Medicine Core Competencies curriculum, as well as a program on diabetes.

The Lifestyle Medicine Core Competencies Program offers 10 unique modules that focus on different aspects of Lifestyle Medicine with an opportunity to earn 32 CME credits: Lifestyle Medicine Core Competencies Program | ACPM.

Additional Information

Sample scripts for community health workers (see Appendix 4).

Sample of information to keep in the clinic about food assessment and food programs in the community (see Appendix 4).

PATHWAYS

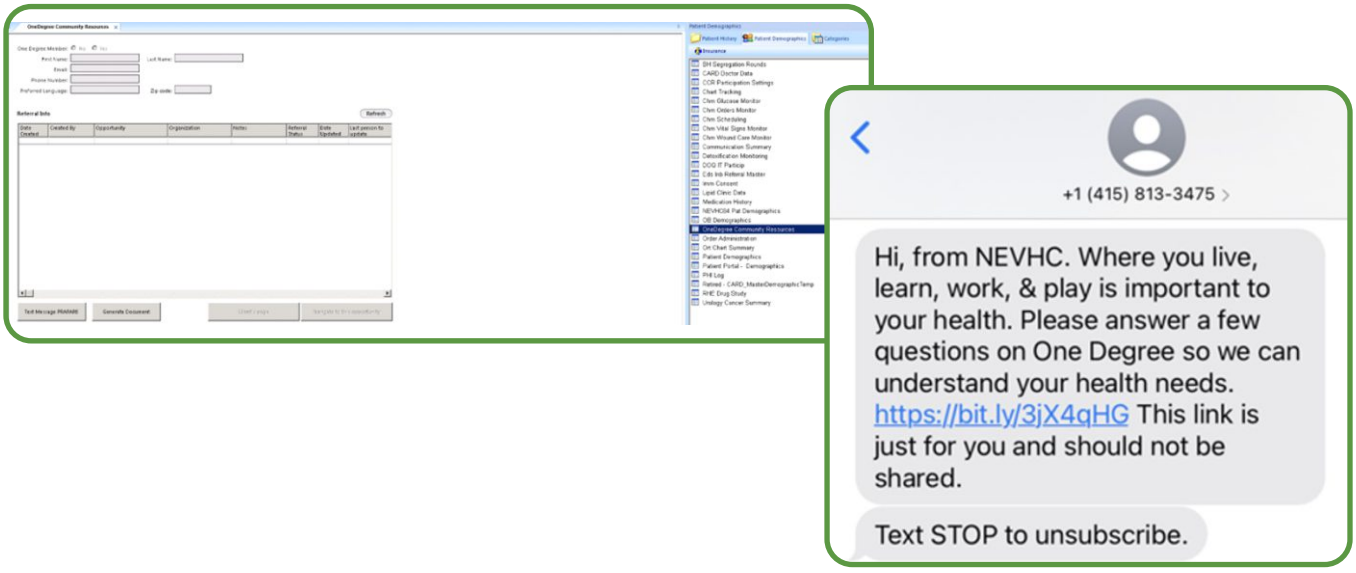
to Effective and Equitable Prediabetes Care: Key Findings/Takeaways from Three CDC-Funded Demonstration Sites

Referral to an Internal National DPP

Northeast Valley Health Corporation (NEVHC) is a federally qualified health center in Los Angeles County, CA serving a population that is more than 84% Hispanic and referring participants to an internal National DPP.

1. Implemented system changes and effective intervention strategies to engage providers/care teams; identified participants with prediabetes; increased referrals; increased conversion rates; and increased National DPP LCP completion rates.

- Created an alert on the clinical decision support tool to identify participants who needed to be screened.
- Implemented Adult Standing Orders – added a lab panel to screen at risk participants for diabetes and prediabetes.
- Developed an algorithm for providers with instructions on when to diagnose, counsel, and refer participants.
- Tracked referral rates, conversion to enrollment, and completion rates to identify opportunities to improve.
- Pivoted to a virtual modality for the National DPP program during COVID-19.
- Implemented assessment of SDOH using the PRAPARE tool and One-Degree for social service referrals.
  - Send PRAPARE link via SMS to participant from EHR.



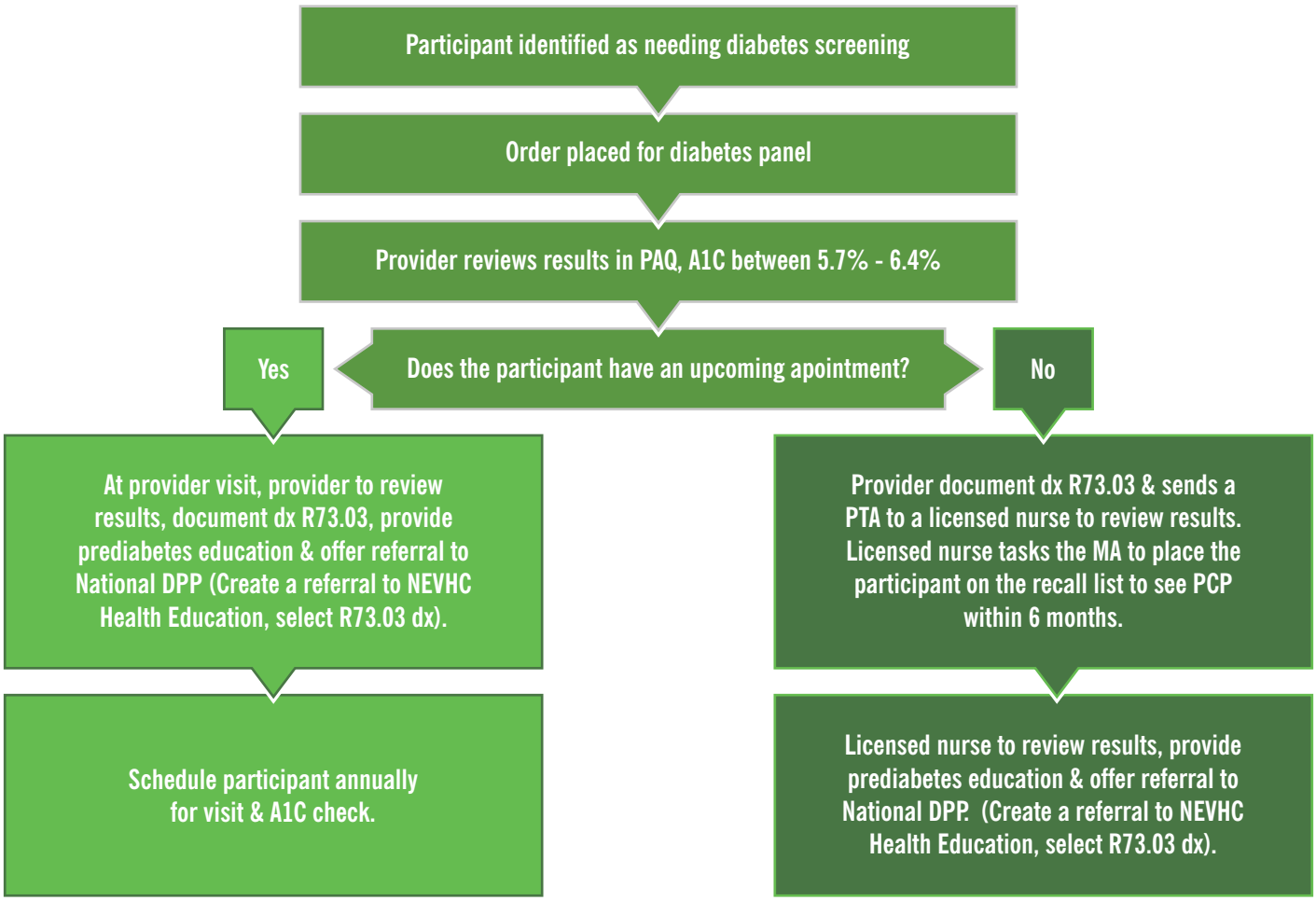
Community Outreach and Collaboration (CONT.)

2. Continued to implement the National DPP LCP.

- B.S. Level Certified Lifestyle Coaches.
- Program Participants – mostly participants/internal referrals, Spanish speaking, females.
- Logistics – Virtual modality, weekdays, mid-afternoon/early evening, preparing to also offer the in-person option.
- Recruitment – provider and care team referrals, registries, text messages, word of mouth.
- Data collection 1st session – prediabetes risk assessment and PRAPARE.
- Engagement – incentives, rapport, connecting to non-medical services (PRAPARE).

3. Identified key takeaways from project funding period.

- Training is important, but periodic reminders are essential for sustained change.
- The National DPP is a lifestyle program that will prevent diabetes regardless of how you deliver the program.
- Need to utilize innovative strategies to engage participants to continue engagement in the program.
- Participants need support to make changes - acknowledging increased social needs enables you to better address barriers.
- One Degree is an effective digital social service referral platform.
- Developing low-touch processes will help spread the solution.

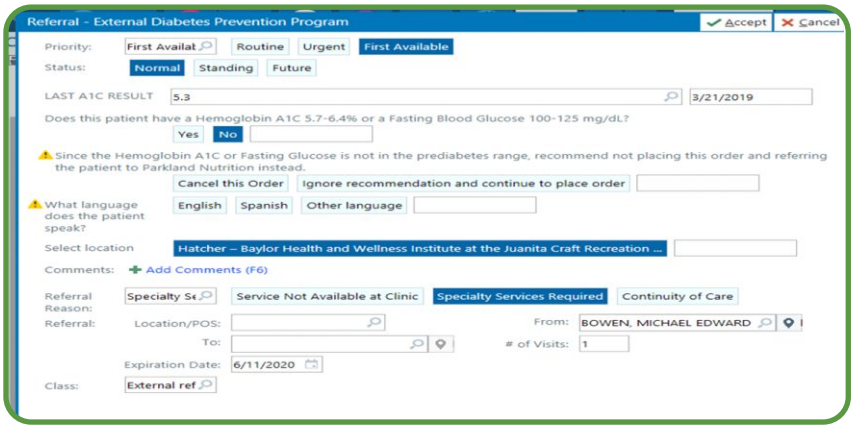


Referrals Between Two Health Systems

Parkland Health and Hospital System is an integrated safety net system in Dallas County, TX referring participants to an external National DPP LCP at **Baylor Scott & White Health and Wellness Center**.

1. Implemented population health-based screening and trained clinicians to refer participants.

- Target Users
  - Providers – place referral during visits
  - Nutritionists – pend referral for providers during visits
  - Medical Assistants – pend orders for providers from Provider Data Management (PDM) Registry
- Referral Transmission
  - Capture referrals on Epic Reporting Workbench, extract and sent to Baylor DPP Program for outreach and enrollment.
- Lessons Learned
  - Referrals based on diagnosis/program eligibility alone seems to have lower conversion rates in population.
    - Participant initiated 'self-referrals' or navigation by the medical assistant seems to have higher conversion/engagement rates.
  - Need to identify 'activated' participants within health systems without placing additional burdens on already over-burdened clinical staff.



- Baylor DPP Team has periodic information table in clinic lobby.
- Healthcare systems are reluctant to activate the Epic CareEverywhere platform to support electronic referrals and data exchange.

2. Optimized referral workflows from Parkland to Baylor during COVID-19.

- Improved referral transmission workflows from Parkland to Baylor with bi-weekly emails of referred participants.
- Contacted participants by a Baylor National DPP facilitator to enroll in upcoming classes.
  - Received approval to send informational letters to participants about their prediabetes status and provide information/contact information to the participant for the National DPP program at Baylor.
- Conducted participant outreach to assess interest and technological capability to participate in virtual vs. in person classes
- Pivoted from in-person classes to telehealth classes using Microsoft Teams Platforms.

3. Addressed social determinants of health to increase food access in the community (see Appendix 4).

- Integrated farm stand voucher education into the National DPP classes to address food insecurity.

Referral to an External Community-Based National DPP

University of Washington Valley Medical Center is a public hospital in King County, WA referring participants to a community-based National DPP at the **YMCA of Greater Seattle**.

1. Implemented clinical support tools for ordering referrals & participant education.

- Created Ambulatory Care Pathway to define Evidence Based Standard Workflow.
- Integrated tools for ordering and participant education.
- Coordinated referrals for the National DPP to be automatically faxed to YMCA.
- Developed Smartphrases for providers to educate participants on new diagnosis of prediabetes.
- Imbedded education handouts in EHR and made attachable to After Visit Summaries.

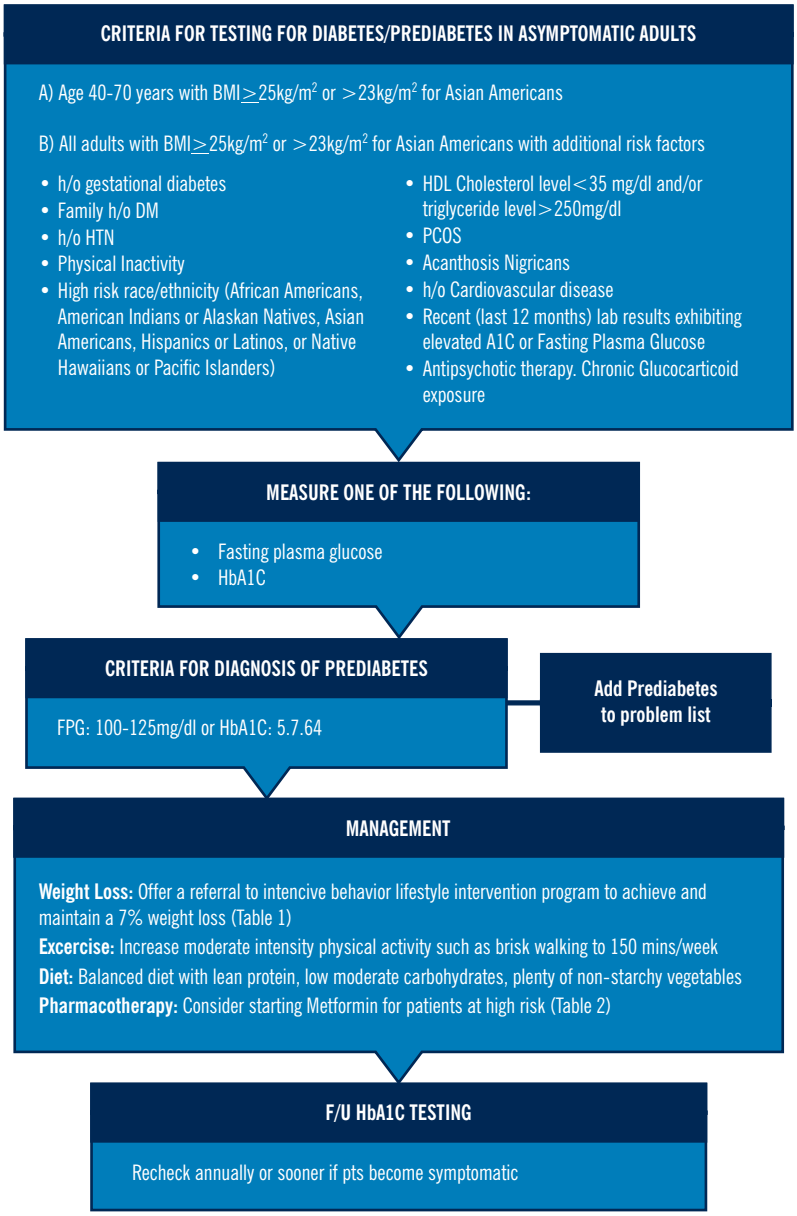


TABLE 1 REFERRAL CRITERIA

1. CDC Recognized DPP program:
- Be at least 18 years old and be overweight or obese (BMI≥25; ≥23 if Asian) and
- Have a blood test in the prediabetes range within the past year
  - HbA1C: 5.7-6.4%
  - FPG: 100-125mg/dl
  - 2 hr PPG: 140-199 mg/dl OR
- Be previously diagnosed with GDM and
- Have no previous dx of diabetes

2. Lifestyle Medicine:
- No specific requirement for enrollment; depending on coverage and patient preference for individualized education

3. RN Care Manager/Health Facilitator:
- If patient needs other form of social assistance

4. Endocrinology:
- Suspected Type 1 Diabetes

TABLE 2 INDICATIONS FOR STARTING METFORMIN

BMI≥35kg/m²
- Worsening glycernia
- No improvement within 3-6 months of initiating lifestyle modification and worsening A1C
- h/o CVD
- h/o GDM

Referral to an External Community-Based National DPP (CONT.)

2. Evaluated barriers to enrollment among participants referred to the YMCA.

- Conducted a qualitative study to help understand barriers for individuals with prediabetes from enrolling in the YMCA's National DPP.
  - Conducted semi-structured interviews with participants who declined enrollment to National DPP.
  - Designed questionnaires with VMC providers and YMCA staff.
- Project Purpose:
  - Identify barriers to enrollment in National DPP from the perspectives of:
    - Referred participant who did not enroll
    - YMCA staff who facilitate the program
    - Providers who make the referral
- Identified Barriers:
  - Cost
  - Time Constraints
  - Adequate Knowledge
  - Gap in Communication
  - Program Format

3. Educated providers and participants through informational videos, meetings and materials.

Staff Education

- Enlisted help from provider champions during piloting stages.
- Held in-person presentations at multiple committee meetings.
  - Primary Care Providers
  - MA Coordinators
  - RN Care Managers
  - Clinic Managers
- Published articles in VMC Newsletters for ongoing education and updates.
- Collaborated with VMC's Marketing team to develop educational video for staff.

Participant Education and Awareness

- Cobranded materials to reflect systematic partnership and reassure participants/providers.
- Shared posters/social media posts about risk and prediabetes awareness.
- Held YMCA National DPP Information Sessions.
- Published prediabetes "Doc Talk" in community newsletter.

4. Expanded the project to all primary care clinics and implemented Plan-Do-Study-Act cycle on prediabetes care pathway.

Established Community Partnerships

- Developed processes for open lines of communication.
- Facilitated quarterly steering committee meetings held with leadership and key shareholders from both organizations.
- Facilitated monthly workgroups with project leaders from both organizations to brainstorm, discuss progress, and identify/solve issues.
- Participated in joint trainings hosted by BWHI.
- Shared documents including workplans, referral tracking, and cohort outcomes.
- Collaborated through cobranding of participant resources.

Small Tests of Change

- All Primary Care Clinics participate in Quality Improvement Committee Projects (PDSA – Plan Do Study Act)
- **Purpose:** Improve implementation of the Prediabetes Ambulatory Care Pathway
- **Aim: Improve by 5%**
  1. The percentage of participants screened for prediabetes.
  2. The percentage of participants with Prediabetes added to their problem list.
  3. The percentage of participants with referral to the Diabetes Prevention Program.
- Results: The percentage of participants screened/diagnosed increased by 7.5% (average per clinic). The number of referrals to National DPP per month more than doubled.
- Successful Strategies: Reviewing results and project goals at morning huddles, adding notes to the visit to remind providers of participants due for screening, MAs pending orders for labs, adding A1c and BMI columns to provider schedules, outreach for overdue participants.

REFERENCES

1. What is the National DPP? National Diabetes Prevention Program. Published May 15, 2024. https://www.cdc.gov/diabetes-prevention/programs/what-is-the-national-dpp.html#cdc_generic_section_3-key-component-the-lifestyle-change-program

2. About Type 2 diabetes. Diabetes. Published May 15, 2024. https://www.cdc.gov/diabetes/about/about-type-2-diabetes.html

3. National Diabetes Statistics Report | Diabetes | CDC. https://www.cdc.gov/diabetes/php/data-research/?CDC_AAref_Val=https://www.cdc.gov/diabetes/data/statistics-report/index.html

4. Hispanic/Latino Americans and type 2 diabetes. Centers for Disease Control and Prevention. Published June 20, 2022. https://www.cdc.gov/diabetes/communication-resources/hispanic-and-asian-subgroups-are-at-higher-risk-for-diabetes.html?CDC_AAref_Val=https://www.cdc.gov/diabetes/library/features/hispanic-diabetes.html

5. A report card: Diabetes in the United States. Diabetes. Published May 15, 2024. https://www.cdc.gov/diabetes/communication-resources/diabetes-statistics.html?CDC_AAref_Val=https://www.cdc.gov/diabetes/library/socialmedia/infographics/diabetes.html

6. Obesity in Children and Adolescents: screening. Published June 20, 2017. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/obesity-in-children-and-adolescents-screening

7. Caperon L, Saville F, Ahern SM. Developing a socio-ecological model for community engagement in a health programme in an underserved urban area. PLOS ONE. 2022;17(9):e0275092. doi:10.1371/journal.pone.0275092

8. American College of Preventive Medicine, American Medical Association, Black Women's Health Imperative. Advancing equity in diabetes prevention for Black or Hispanic women: Lessons learned and action steps.; 2024. https://www.acpm.org/getattachment/f1afb09a-2fba-4be2-b2e3-2d963754a63a/Narrative-Report_June2024_Final.pdf.aspx?lang=en-US

9. Ritchie ND, Baucom KJW, Sauder KA. Current Perspectives on the Impact of the National Diabetes Prevention Program: Building on Successes and Overcoming Challenges. Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy. 2020;Volume 13:2949-2957. doi:10.2147/dmso.s218334

10. Calanan R, Bonds ME, Bedrosian S, Laird S, Satter DE, Penman-Aguilar A. CDC's guiding principles to promote an Equity-Centered Approach to Public Health Communication. Preventing Chronic Disease. 2023;20. doi:10.5888/pcd20.230061

11. National Diabetes Prevention Program. CDC. Accessed March 12, 2024. https://www.cdc.gov/diabetes-prevention/?CDC_AAref_Val=https://www.cdc.gov/diabetes/prevention/index.html

12. Li K. 8 Examples of capacity building activities for health service organizations - Capacity 4 Health. Capacity 4 Health. Published April 2, 2019. https://capacity4health.org/examples-of-capacity-building-activities/

13. Whitfield J, Northrop Grumman Health Solutions. Successful Strategies for Recruiting, Training, and Utilizing Volunteers: A Guide for Faith- and Community-Based Service Providers. Substance Abuse and Mental Health Services Administration; 2005. https://www.samhsa.gov/sites/default/files/volunteer_handbook.pdf

14. Baucom KJW, Pershing ML, Dwenger K, Karasawa M, Cohan JN, Ozanne EM. Barriers and Facilitators to enrollment and retention in the National Diabetes Prevention Program: Perspectives of women and Clinicians within a Health system. Women's Health Reports. 2021;2(1):133-141. doi:10.1089/whr.2020.0102

15. Ritchie ND, Phimphasone-Brady P, Sauder KA, Amura CR. Perceived barriers and potential solutions to engagement in the National Diabetes Prevention Program. ADCES in Practice. 2021;9(1):16-20. doi:10.1177/2633559x20966275

16. YMCA of Greater Seattle, UW Medicine Valley Medical Center. Building Provider Capacity to Screen, Identify, and Refer Disparate Populations with Prediabetes.

GLOSSARY

ACPM - American College of Preventive Medicine

AMA - American Medical Association

BWHI - Black Women's Health Imperative

CDC - Centers for Disease Control and Prevention

DX - Diagnosis

EHR - Electronic Health Record

H/O - History Of

HHS - U.S. Department of Health and Human Services

LCP - Lifestyle Change Program

National DPP - National Diabetes Prevention Program

PRAPARE - Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

SDOH - Social Determinants of Health

TX - Texas

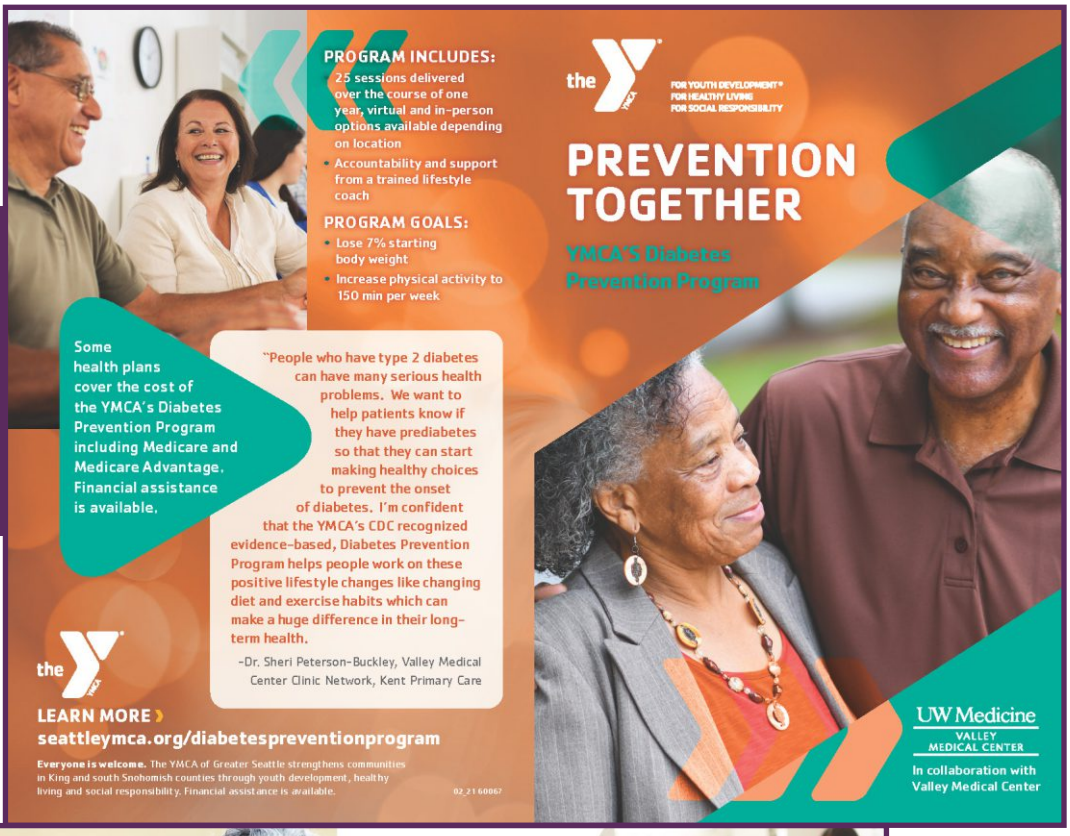
UW - University of Washington

WA - Washington

Appendix 1: Sharing and Disseminating National DPP Resources

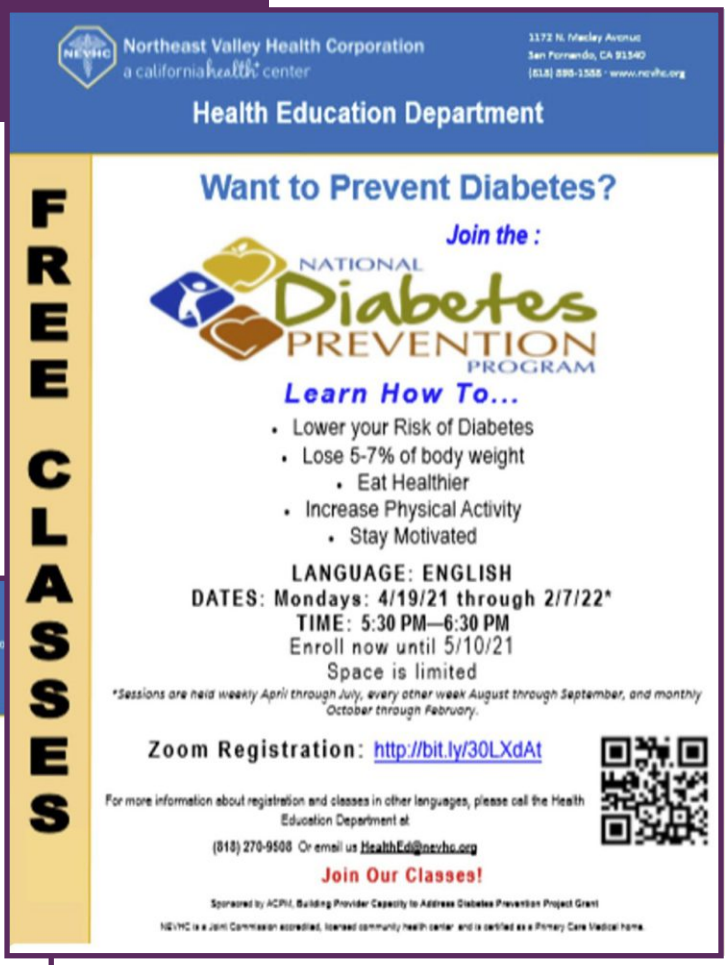
Sample informational flyers that can be shared with the participant during the clinical encounter below.

Developed by UW Medicine Valley Medical Center and YMCA of Greater Seattle with funding from the CDC.



Appendix 1: Sharing and Disseminating National DPP Resources

Developed by Northeast Valley Health Corporation with funding from the CDC.



Appendix 2: Assessing and Addressing Social Needs

Sample screening tool forms for participants to fill out, participant education materials, session information and outreach in Spanish to reflect specific attributes of the population below.

Provided by the Northeast Valley Health Corporation with funding from the CDC.

PRAPARE Assessment

Important
Highlights in grey indicate that we do not ask this question as it is not scored.
Highlights in yellow indicate that these questions are NOT included in the Digital PRAPARE

English	Spanish
Where you live, learn, work and play are important to your health. Northeast Valley Health Corporation wants to make sure you have access to resources, so we are asking our patients these questions.	En donde usted vive, aprende, trabaja y juega es importante para su salud. Northeast Valley Health Corporation quiere asegurarse que usted tenga acceso a estos recursos, es por eso que hacemos estas preguntas a nuestros pacientes.
1. Have you been discharged from the armed forces of the United States? ☐ Yes ☐ No ☐ I choose not to answer this question	1. ¿Ha servido en las fuerzas armadas de los Estados Unidos? ☐ Si ☐ No ☐ Prefiero no responder a esta pregunta
2. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income? ☐ Yes ☐ No ☐ I choose not to answer this question	2. En algún momento de los últimos 2 años, ¿ha sido el trabajo agrícola el ingreso principal de su familia? ☐ Si ☐ No ☐ Prefiero no responder a esta pregunta
Do Not Ask 3. How many family members, including yourself do you currently live with? ☐ _____ ☐ I choose not to answer this question	***Do Not Ask*** 3. Incluyendo usted mismo, ¿cuántos miembros de su familia viven con usted? ☐ _____ ☐ Prefiero no responder a esta pregunta
4. What is your housing situation today? ☐ I have housing ☐ I do not have housing ○ Domestic Violence Center ○ Doubling up ○ Hotel/motel ○ Shelter ○ Single room occupancy ○ Street ○ Transitional living ○ Unsafe or unheated building ○ Vehicle ☐ I choose not to answer this question	4. ¿Cuál es su situación actual de vivienda? ☐ Tengo vivienda ☐ No tengo vivienda ○ Centro para víctimas de violencia doméstica ○ Con otras personas/familiares ○ Hotel o motel ○ En un albergue ○ Habitación individual ○ En la calle ○ En alojamiento temporal ○ En edificio inseguro o sin calefacción ○ Automóvil ☐ Prefiero no responder a esta pregunta

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PRAPARE Assessment

5. Are you worried about losing your housing? ☐ Yes ☐ No ☐ I choose not to answer this question	5. ¿Le preocupa poder perder su vivienda? ☐ Si ☐ No ☐ Prefiero no responder a esta pregunta
Do Not Ask 6. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits. ☐ _____ ☐ I choose not to answer this question	***Do Not Ask*** 6. Durante el año pasado, ¿cuál fue el ingreso total combinado para usted y los miembros de su familia con quienes vive? Esta información nos ayudará a determinar si usted es elegible para recibir algún beneficio. ☐ _____ ☐ Prefiero no responder a esta pregunta
(Format entry will auto populate from 6A) 7. Federal Poverty Level (%FPL) ☐ 100% or below ☐ 101-150% ☐ 151-200% ☐ 200% or more ☐ Unknown	*(Formato entrada se llenará automáticamente desde 6A)* 7. Nivel federal de pobreza (%NFP) ☐ 100% o menos ☐ 101-150% ☐ 151-200% ☐ 200% o mas ☐ Desconozco
8. What's the highest level of education that you have finished? ☐ None ☐ Elementary school ☐ Intermediate Middle School ☐ High school diploma or GED ☐ College/Trade school ☐ I choose not to answer this question	8. ¿Cuál es el nivel de escuela más alto que ha completado? ☐ Ninguna/o ☐ Escuela primaria ☐ Escuela media intermedia ☐ Escuela secundaria O examen general equivalente a diploma secundario ☐ Colegio o Universidad / Escuela vocacional ☐ Prefiero no responder a esta pregunta
9. What is your current work situation? ☐ Unemployed ☐ Part-time or temporary work ☐ Full-time work ☐ Student ☐ Medical leave or absence ☐ Retired due to disability ☐ Retired due to age/preference ☐ I choose not to answer this question ☐ Question not administered ☐ Skipped question	9. ¿Cuál es su situación de trabajo? ☐ Desempleada/o ☐ Trabajo de tiempo parcial o temporal ☐ Trabajo de tiempo completo ☐ Estudiante ☐ Incapacitada/o por enfermedad o ausencia medica ☐ Retirada/o por discapacidad ☐ Retirada/o por edad/preferencia ☐ Prefiero no responder a esta pregunta ☐ Question not administered ☐ Skipped question

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PRAPARE Assessment

10. In the past 30 days, have you or your family members you live with been unable to get any of the following when it was really needed? (Check all that apply) ☐ Utilities ☐ Medicine or any health care ○ Medical ○ Dental ○ Mental Health ○ Vision ☐ Phone ☐ Clothing ☐ Rent or Mortgage payment ☐ Child care ☐ Other _____ ☐ I choose not to answer this question	10. En los últimos 30 días, ¿usted o algún miembro de su familia tuvieron que negarse de comprar o pagar por algo que realmente se necesitaba? (Marque todas las que corresponden) ☐ Servicios públicos ☐ Medicina o cualquier cuidado de salud ○ Medica ○ Dental ○ Salud mental ○ Visión ☐ Teléfono ☐ Ropa ☐ Pago de alquiler o hipoteca ☐ Cuidado infantil ☐ Otro _____ ☐ Prefiero no responder a esta pregunta
11. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? ☐ Yes, it has kept me from medical appointments or from getting my medications ☐ Yes, it has kept me from non-medical meetings, appointments, work or from getting things that I need ☐ No ☐ I choose not to answer this question	11. ¿Le ha impedido la falta de transporte acudir a consultas médicas, asistir a reuniones, poder ir al trabajo o conseguir cosas necesarias para la vida diaria? ☐ Si, me ha impedido acudir a consultas médicas o a recoger mis medicamentos ☐ Si, me ha impedido ir a reuniones o citas no médicas, al trabajo o conseguir cosas que necesito ☐ No ☐ Prefiero no responder a esta pregunta
12. Have you stayed in the hospital overnight two or more times in the past 30 days? ☐ Yes ☐ No ☐ I choose not to answer this question	12. En los último 30 días ¿Ha pasado más de 2 o más noches seguidas en una en el hospital? ☐ Si ☐ No ☐ Prefiero no responder a esta pregunta
13. *(0-11yo and 18yo+)* Within the last 12 months, we (I) worried whether our food would run out before we got money to buy more: *(12-17yo)* I worried about not having enough to eat. ☐ Often true ☐ Sometimes true ☐ Never true	13. *(0-11yo and 18yo+)* En los últimos 12 meses, estuvimos (estuve) preocupado (s) de que los alimentos se acabaran antes de obtener dinero para comprar más: *(12-17yo)* Me preocupe por no tener suficiente para comer. ☐ Frecuentemente ☐ A veces ☐ Nunca

For patient navigation interaction use only

PRAPARE Assessment

14. *(0-11yo and 18yo+)* Within the last 12 months, the food we (I) bought just didn't last and we didn't have money to get more: *(12-17yo)* I tried not to eat so that our food would last. ☐ Often true ☐ Sometimes true ☐ Never true	14. En los últimos 12 meses, los alimentos que compramos (compre) no duraron y no hubo dinero para comprar mas: ☐ *(12-17yo)* Intenté no comer para que nuestra comida durara. ☐ Frecuentemente ☐ A veces ☐ Nunca
15. How often do you see or talk to people you care about and feel close to? (For example: Talking to friends on the phone, visiting friends or family, going to church or club meetings) ☐ Less than once a week ☐ 1 or 2 times a week ☐ 3 or 5 times a week ☐ I choose not to answer this question ☐ Question not administered ☐ Skipped question	15. ¿Con qué frecuencia convive o conversa con personas cercanas o por las que se preocupa? (Por ejemplo: conversar con amigos por teléfono, visitar a amigos o familiares, asistir a la iglesia o a reuniones de club) ☐ Menos de una vez por semana ☐ 1 o 2 veces por semana ☐ 3 o 5 veces por semana ☐ 5 o más veces por semana ☐ Prefiero no responder a esta pregunta ☐ Question not administered ☐ Skipped question
16. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you? ☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much ☐ I choose not to answer this question	16. Estrés es cuando alguien se siente tenso, nervioso, ansioso o no puede dormir a la noche porque su mente está preocupada. ¿Qué tan estresado se encuentra? ☐ Para nada ☐ Un poquito ☐ Algunas veces ☐ Bastante ☐ Mucho ☐ Prefiero no responder a esta pregunta
17. Do you feel physically and emotionally safe where you currently live? ☐ Yes ☐ No ☐ I choose not to answer this question	17. ¿Se siente física o emocionalmente seguro en su lugar de residencia? ☐ Si ☐ No ☐ Prefiero no responder a esta pregunta
18. In the past year, have you been afraid of your partner or ex -partner? ☐ Yes ☐ No ☐ I have not had a partner in the past year ☐ I choose not to answer this question	18. Durante el último año, ¿tuvo miedo de su pareja o expareja? ☐ Si ☐ No ☐ No he tenido pareja en el año pasado ☐ Prefiero no responder esta pregunta

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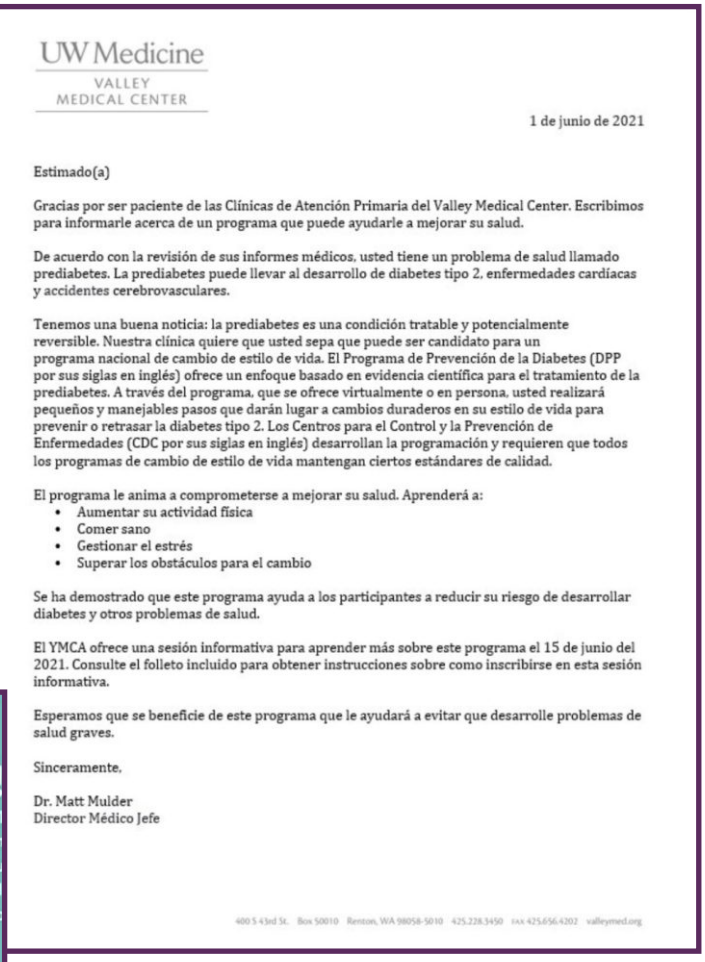
Appendix 2: Assessing and Addressing Social Needs

Developed by UW Medicine Valley Medical Center and YMCA of Greater Seattle with funding from the CDC.



UW Medicine
VALLEY MEDICAL CENTER

1 de junio de 2021

Estimado(a)

Gracias por ser paciente de las Clínicas de Atención Primaria del Valley Medical Center. Escribimos para informarle acerca de un programa que puede ayudarle a mejorar su salud.

De acuerdo con la revisión de sus informes médicos, usted tiene un problema de salud llamado prediabetes. La prediabetes puede llevar al desarrollo de diabetes tipo 2, enfermedades cardíacas y accidentes cerebrovasculares.

Tenemos una buena noticia: la prediabetes es una condición tratable y potencialmente reversible. Nuestra clínica quiere que usted sepa que puede ser candidato para un programa nacional de cambio de estilo de vida. El Programa de Prevención de la Diabetes (DPP por sus siglas en inglés) ofrece un enfoque basado en evidencia científica para el tratamiento de la prediabetes. A través del programa, que se ofrece virtualmente o en persona, usted realizará pequeños y manejables pasos que darán lugar a cambios duraderos en su estilo de vida para prevenir o retrasar la diabetes tipo 2. Los Centros para el Control y la Prevención de Enfermedades (CDC por sus siglas en inglés) desarrollan la programación y requieren que todos los programas de cambio de estilo de vida mantengan ciertos estándares de calidad.

El programa le anima a comprometerse a mejorar su salud. Aprenderá a:

- Aumentar su actividad física
- Comer sano
- Gestionar el estrés
- Superar los obstáculos para el cambio

Se ha demostrado que este programa ayuda a los participantes a reducir su riesgo de desarrollar diabetes y otros problemas de salud.

El YMCA ofrece una sesión informativa para aprender más sobre este programa el 15 de junio del 2021. Consulte el folleto incluido para obtener instrucciones sobre como inscribirse en esta sesión informativa.

Esperamos que se beneficie de este programa que le ayudará a evitar que desarrolle problemas de salud graves.

Sinceramente,

Dr. Matt Mulder
Director Médico Jefe

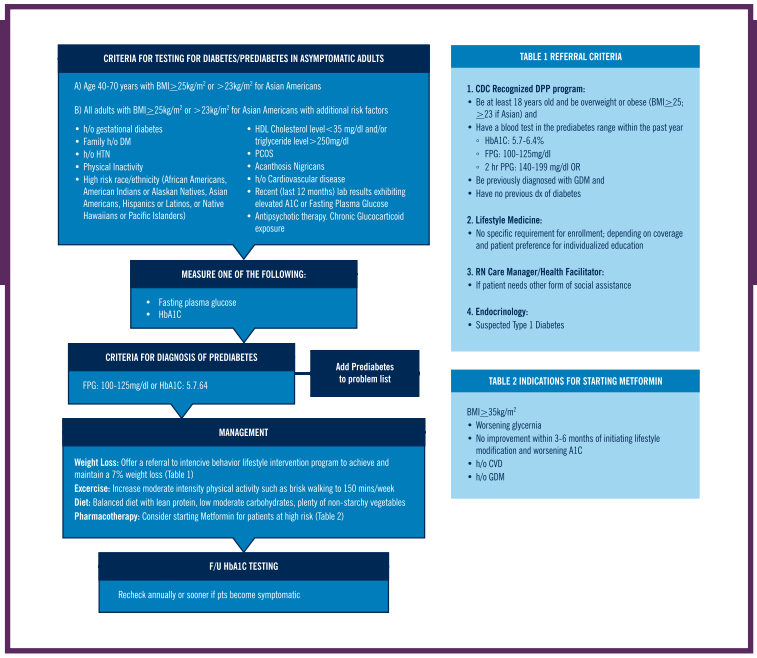
400 S 43rd St. Box 50010 Renton, WA 98058-5010 425.228.3450 FAX 425.656.4202 valleymed.org

Provided by UW Medicine Valley Medical Center and YMCA of Greater Seattle with funding from the CDC.

Appendix 3: Sharing National DPP Resources

Clinical support tools like the Ambulatory Care Pathway below can be used to define evidence-based standard workflows within a health system.

Developed by UW Medicine Valley Medical Center and YMCA of Greater Seattle with funding from the CDC.



CRITERIA FOR TESTING FOR DIABETES/PREDIABETES IN ASYMPTOMATIC ADULTS

A) Age 40-70 years with BMI≥25kg/m² or >23kg/m² for Asian Americans

B) All adults with BMI≥25kg/m² or >23kg/m² for Asian Americans with additional risk factors

- h/o gestational diabetes
- Family h/o DM
- h/o HTN
- Physical Inactivity
- High risk race/ethnicity (African Americans, American Indians or Alaskan Natives, Asian Americans, Hispanics or Latinos, or Native Hawaiians or Pacific Islanders)
- HDL Cholesterol level <35 mg/dl and/or triglyceride level >250mg/dl
- PCOS
- Acanthosis Nigricans
- h/o Cardiovascular disease
- Recent (last 12 months) lab results exhibiting elevated A1C or Fasting Plasma Glucose
- Antipsychotic therapy, Chronic Glucocarticoid exposure

MEASURE ONE OF THE FOLLOWING:

- Fasting plasma glucose
- HbA1C

CRITERIA FOR DIAGNOSIS OF PREDIABETES

FPG: 100-125mg/dl or HbA1C: 5.7-64

Add Prediabetes to problem list

MANAGEMENT

Weight Loss: Offer a referral to intencive behavior lifestyle intervention program to achieve and maintain a 7% weight loss (Table 1)
Excercise: Increase moderate intensity physical activity such as brisk walking to 150 mins/week
Diet: Balanced diet with lean protein, low moderate carbohydrates, plenty of non-starchy vegetables
Pharmacotherapy: Consider starting Metformin for patients at high risk (Table 2)

F/U HbA1C TESTING

Recheck annually or sooner if pts become symptomatic

TABLE 1 REFERRAL CRITERIA

1. CDC Recognized DPP program:
- Be at least 18 years old and be overweight or obese (BMI≥25; ≥23 if Asian) and
- Have a blood test in the prediabetes range within the past year
  - HbA1C: 5.7-6.4%
  - FPG: 100-125mg/dl
  - 2 hr PPG: 140-199 mg/dl OR
- Be previously diagnosed with GDM and
- Have no previous dx of diabetes

2. Lifestyle Medicine:
- No specific requirement for enrollment; depending on coverage and patient preference for individualized education

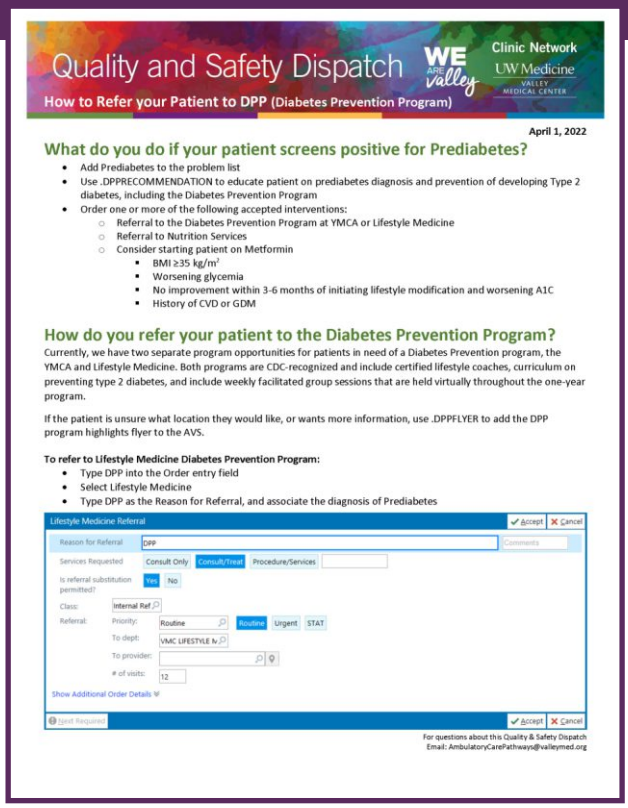
3. RN Care Manager/Health Facilitator:
- If patient needs other form of social assistance

4. Endocrinology:
- Suspected Type 1 Diabetes

TABLE 2 INDICATIONS FOR STARTING METFORMIN

BMI≥35kg/m²
- Worsening glycernia
- No improvement within 3-6 months of initiating lifestyle modification and worsening A1C
- h/o CVD
- h/o GDM

Developed by UW Medicine Valley Medical Center with funding from the CDC.



Quality and Safety Dispatch — WE ARE Valley — Clinic Network — UW Medicine Valley Medical Center

How to Refer your Patient to DPP (Diabetes Prevention Program)

April 1, 2022

What do you do if your patient screens positive for Prediabetes?

- Add Prediabetes to the problem list
- Use .DPPRECOMMENDATION to educate patient on prediabetes diagnosis and prevention of developing Type 2 diabetes, including the Diabetes Prevention Program
- Order one or more of the following accepted interventions:
  - Referral to the Diabetes Prevention Program at YMCA or Lifestyle Medicine
  - Referral to Nutrition Services
  - Consider starting patient on Metformin
    - BMI ≥35 kg/m²
    - Worsening glycemia
    - No improvement within 3-6 months of initiating lifestyle modification and worsening A1C
    - History of CVD or GDM

How do you refer your patient to the Diabetes Prevention Program?

Currently, we have two separate program opportunities for patients in need of a Diabetes Prevention program, the YMCA and Lifestyle Medicine. Both programs are CDC-recognized and include certified lifestyle coaches, curriculum on preventing type 2 diabetes, and include weekly facilitated group sessions that are held virtually throughout the one-year program.

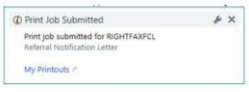
If the patient is unsure what location they would like, or wants more information, use .DPPFLYER to add the DPP program highlights flyer to the AVS.

To refer to Lifestyle Medicine Diabetes Prevention Program:
- Type DPP into the Order entry field
- Select Lifestyle Medicine
- Type DPP as the Reason for Referral, and associate the diagnosis of Prediabetes

For questions about this Quality & Safety Dispatch
Email: AmbulatoryCarePathways@valleymed.org

To refer to YMCA Diabetes Prevention Program:
- Type DPP into the Order entry field
- Select Diabetes Prevention Program YMCA

The information in the referral will auto populate. The provider will then enter Prediabetes as the associated diagnosis. Once signed, the order automatically faxes to the YMCA. The YMCA will work with the patient on determining the best location for services.



Add .DPPREFERRALYMCA to the AVS:

The YMCA's Diabetes Prevention Program can help reduce your chance of developing diabetes by taking steps that will improve your overall health and well-being. The program consists of 25 sessions over one year. Sessions are 1 hour and meet weekly for the first 4 months, typically on weekday evenings. Goals are to reduce body weight by 5-7% and increase physical activity to 150 minutes/week.

The YMCA staff will try to contact you over the next few weeks to discuss the program. For more information or to enroll, you can visit seattleymca.org/diabetespreventionprogram, contact ChronicDiseasePrevention@seattleymca.org, or call (206) 432-8904.

For more information about which patients should be screened, and how to screen patients, see the Prediabetes Ambulatory Care Pathway.

For questions about this Quality & Safety Dispatch
Email: AmbulatoryCarePathways@valleymed.org

Appendix 4: Program Enrollment and Engagement

Strategies to improve enrollment and engagement below including sample scripts for community health workers, and examples for food assessment and food programs.

Developed by UW Medicine Valley Medical Center and YMCA of Greater Seattle with funding from the CDC.

1

Enrollment Process and Sample Script:

1. **Phone Call Overview:** During our call today, we'll discuss your health concerns, details about the program, answer any questions and if you'd like, enroll you in an upcoming class.
2. **Introduction (Interest in Program):** Tell me about your health concerns or health goals and what interested you in the Diabetes Prevention Program?
3. **Introduction (Knowledge of Program):** What do you know so far about the Diabetes Prevention Program?
4. **Program Overview:** Diabetes prevention program is for folks that are in the prediabetic range to learn about healthy lifestyle changes in a supportive group led by a trained lifestyle coach. It's 26 sessions over the course of a year. The first 4 months are once a week for one-hour sessions, followed by biweekly and monthly classes for the second half of the program. Your lifestyle coach will give you a schedule of classes to save the dates. We follow a curriculum approved by the CDC discussing different health-related topics such as healthier eating habits, getting physical activity, stress management, improving sleep, and setting individual health goals. Currently we have virtual options and in-person classes at a few locations. There are a few things we require in the program: food journaling, tracking physical activity minutes, doing a weekly weigh-in, virtual or in-person attendance.
5. **Member Status:** Are you a current Y member? (If yes, what location? If no, identify which location is nearest.)
    a. **If no membership:** With this program, we can provide a 4-month promotional membership to your local YMCA of Greater Seattle branch. With the membership, all members must pass a sex offender screening before being extended membership. We need you to visit a branch with your ID to get your photo taken and complete your screening prior to facility usage.
6. **Motivation:** What's motivating you to get health support at this time?
7. **Previous Health Interventions:** Have you ever done a weight loss program or health related program before? Have you ever participated in food tracking or food journaling?
8. **Eligibility:** There are some eligibility criteria for the Diabetes Prevention Program. Have you had a recent blood screening done that listed A1c or Glucose? (If no, take the diabetes risk test and qualify with a 5 or higher)
    a. **A1c:** *A1c must be between 5.7-6.4. Must be taken within 1 year of the cohort start date. For Medicare coverage, it should be within 6 months of the cohort start date.*
    b. **GLU:** *Fasting Plasma Glucose must be between 100-125 for CDC Eligibility. For Medicare coverage, it must be between 110-125.*
    c. **Ineligibility:** *Participants are ineligible if participant has had a Type 1 or Type 2 diagnosis.*
9. **Height and Weight:** In our program, we ask participants to do a weekly weigh-in to track progress. What is your current height and weight? Do you have any concerns about reporting a weekly weigh-in?
    a. *If there are any concerns, note them in WELLD touchpoints and tell the participant to discuss concerns with their coach during the Welcome Call.*
    b. *Determine if qualified based on BMI (25+)*
10. **Emergency Contact:** Can you please provide a good emergency contact for yourself?
    a. *Name, relationship, phone number*

2

11. **Cohort Selection:** We offer virtual and in-person options. Do you prefer a daytime or evening class? Virtual or in-person? What works best for your schedule?
12. **Commitment Check:** Confirm program start date and time works for participant's schedule. Do you see any challenges with committing to a year-long program and attending weekly, bi-weekly, and monthly sessions?
13. **User Information:** We need to collect some basic information from you to finalize enrollment. Can you please provide the following information?
14. **Demographics:** We like to know a little about the participants in our program. I'm going to ask you a few basic demographic questions. You can feel free to decline to answer any of the questions if you don't feel comfortable.
15. **Payment:**
    a. *For YMCA Members:* The total cost of the program for YMCA members is $500. This includes a $50 non-refundable enrollment fee that must be paid today to hold your spot in the cohort you are interested in. We do offer financial assistance on an income-based sliding scale as well as payment plans. How would you like to proceed with payment for this program?
    b. *For Community Members:* The total cost of the program for community members is $850. This includes a $50 non-refundable enrollment fee that must be paid today to hold your spot in the cohort you are interested in. We do offer financial assistance on an income-based sliding scale as well as payment plans. How would you like to proceed with payment for this program?
    c. *Payment Plan:* We are able to allow payment plans of up to three months for the remaining cost of the program [Y members: $450, community members: $800] after the $50 non-refundable enrollment fee. This enrollment fee must be paid today in order to hold your spot in the class. Four monthly payments would come out to [Y members: $112.50 per month for 4 months, community members: $200 per month for 4 months] and the first payment can be run as late as the start day of your cohort.
    d. *Financial Assistance:* We'll fill out the Financial Assistance: Affordable for All form together on our website. You should hear back via email regarding your awarded financial assistance in 1-2 weeks. Let's schedule you an appointment with our Enrollment Team to further discuss financial assistance and finalize your enrollment.
        i. *If a price is quoted to the participant, make a note of the quoted price in WELLD touchpoints.*
    e. *Insurance coverage:* There are some insurances that cover the Diabetes Prevention Program. What type of insurance do you have?
        i. *Medicare or Medicare Advantage Plan:* Most Medicare or Medicare Advantage plans cover the Diabetes Prevention Program. To verify insurance coverage, we'd need the participant to send us a photo of the front and back of their insurance card. The Diabetes Prevention Program is a one-time Medicare benefit. This means, if you start the program and withdraw, you would have exhausted that one-time benefit.
        ii. *Molina Apple Health Medicaid:* The YMCA is currently offering the Diabetes Prevention Program to Molina Apple Health Medicaid beneficiaries at no cost to the participants. To verify insurance coverage, we'd need the participant to send us a photo of the front and back of their insurance card.
            1. *Other incentives for Molina Medicaid participants:* We can provide you with a 6-month family membership to a YMCA in Washington. We will collect this information from you (who you'd want on this membership) at the beginning of your program.
    f. *Refund Policy:* Participants are responsible for the sessions they attend (pro-rated refunds), they wouldn't get their $50 enrollment fee since that's non-refundable, no refunds after first 4 months have been completed
16. **DPP Eligibility Form:**
    a. Do you have a previous diagnosis of type 1 or type 2 diabetes (Gestational Diabetes (GDM) not included)?
    b. Have you been diagnosed with end-stage renal disease?
    c. BMI: Input previously collected height and weight
    d. Blood value/diagnosis qualification sets:
        i. Option 1- Blood test result in the prediabetes range within the past year
            1. Hemoglobin A1c
            2. Fasting plasma glucose
            3. Two-hour plasma glucose (after a 75gm glucose load)
        ii. Option 2- Previous diagnosis for gestational diabetes
            1. Prediabetes determined by clinical diagnosis of Gestational Diabetes (GDM)
        iii. Option 3- Qualified by risk test (CDC only)
            1. Qualified by risk test (CDC only)
        iv. Option 4- None of the above
            1. Applying as a self-pay, non Medicare or CDC ineligible participant
17. **DPP Enrollment Source & Motivation:**
    a. How did you hear about us?
        i. Who or what motivated you the most to sign up for this program; what was the most influential factor?
        ii. Did a healthcare professional ask you to join this program?
18. **Welcome Call Scheduling:** The next steps from here are to schedule your Welcome Phone Call to connect with your Wellness Coach
19. **Additional Questions:** Do you have any other questions about the program?

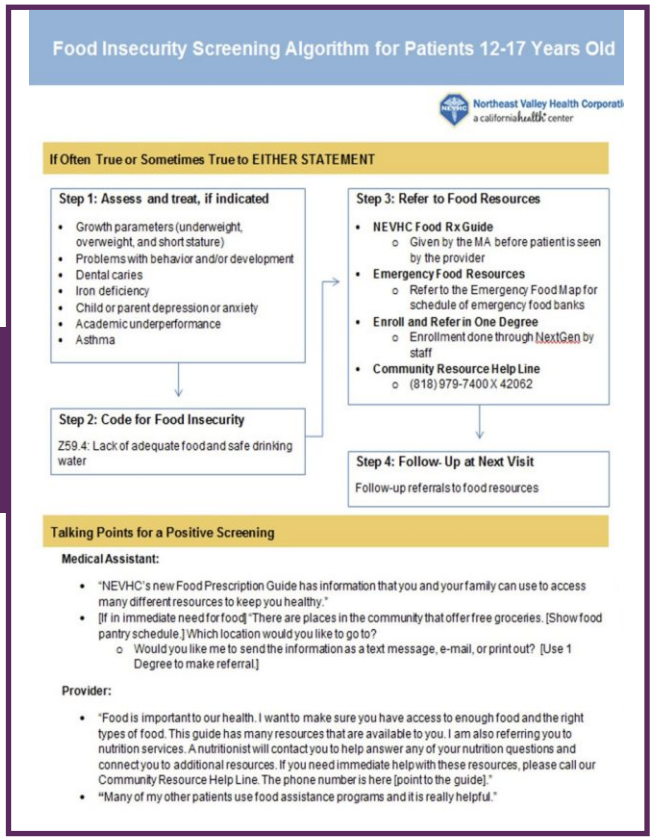
Voicemail Script:

Hi, ***[interested participant or referral's name]*** my name is ***[insert name]***, and I am calling you in regard to the YMCA healthy living programs. We received your interest inquiry [or "We received a referral from your DR"] for support with your health and wellness goals. We offer programs at the Y that support weight management, diabetes prevention, nutrition support as well as a variety of fitness classes and more. Please give us a call back at your earliest convenience to further discuss how the Y can support your health journey. We can be reached at ***[insert phone number]*** again, that's ***[insert phone number]***. We look forward to hearing from you and supporting your health goals! Thank you and have a wonderful day.

Appendix 4: Program Enrollment and Engagement (cont.)

Strategies to improve enrollment and engagement below including sample scripts for community health workers, and examples for food assessment and food programs.

Developed by UW Medicine Valley Medical Center and YMCA of Greater Seattle with funding from the CDC.



Food Insecurity Screening Algorithm for Patients 12-17 Years Old

Northeast Valley Health Corporation
a californiahealth center

If Often True or Sometimes True to EITHER STATEMENT

Step 1: Assess and treat, if indicated

- Growth parameters (underweight, overweight, and short stature)
- Problems with behavior and/or development
- Dental caries
- Iron deficiency
- Child or parent depression or anxiety
- Academic underperformance
- Asthma

Step 2: Code for Food Insecurity

Z59.4: Lack of adequate food and safe drinking water

Step 3: Refer to Food Resources

- **NEVHC Food Rx Guide**
  - Given by the MA before patient is seen by the provider
- **Emergency Food Resources**
  - Refer to the Emergency Food Map for schedule of emergency food banks
- **Enroll and Refer in One Degree**
  - Enrollment done through NextGen by staff
- **Community Resource Help Line**
  - (818) 979-7400 X 42062

Step 4: Follow-Up at Next Visit

Follow-up referrals to food resources

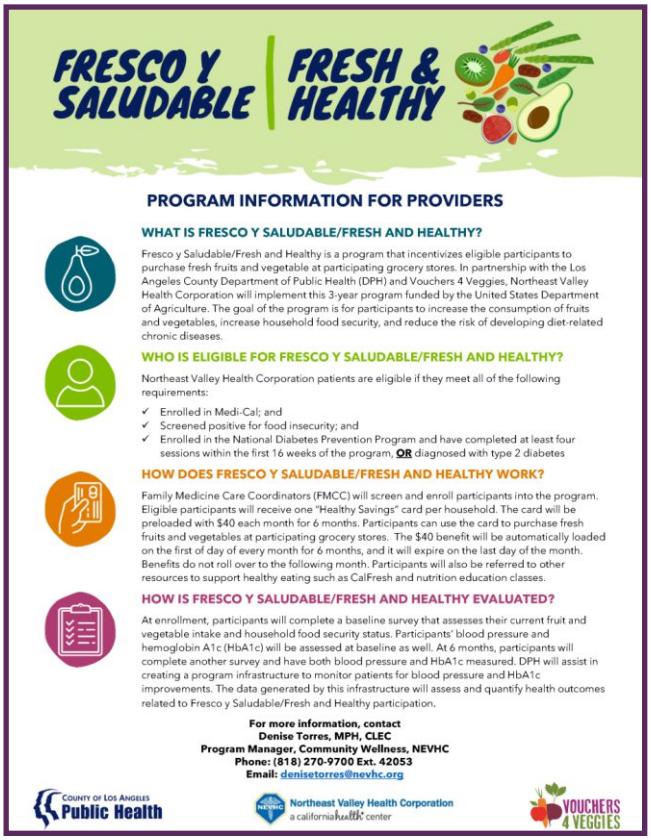
Talking Points for a Positive Screening

Medical Assistant:

- "NEVHC's new Food Prescription Guide has information that you and your family can use to access many different resources to keep you healthy."
- [If in immediate need for food] "There are places in the community that offer free groceries. [Show food pantry schedule.] Which location would you like to go to?
  - Would you like me to send the information as a text message, e-mail, or print out? [Use 1 Degree to make referral.]

Provider:

- "Food is important to our health. I want to make sure you have access to enough food and the right types of food. This guide has many resources that are available to you. I am also referring you to nutrition services. A nutritionist will contact you to help answer any of your nutrition questions and connect you to additional resources. If you need immediate help with these resources, please call our Community Resource Help Line. The phone number is here [point to the guide]."
- "Many of my other patients use food assistance programs and it is really helpful."



FRESCO Y SALUDABLE | FRESH & HEALTHY

PROGRAM INFORMATION FOR PROVIDERS

WHAT IS FRESCO Y SALUDABLE/FRESH AND HEALTHY?

Fresco y Saludable/Fresh and Healthy is a program that incentivizes eligible participants to purchase fresh fruits and vegetable at participating grocery stores. In partnership with the Los Angeles County Department of Public Health (DPH) and Vouchers 4 Veggies, Northeast Valley Health Corporation will implement this 3-year program funded by the United States Department of Agriculture. The goal of the program is for participants to increase the consumption of fruits and vegetables, increase household food security, and reduce the risk of developing diet-related chronic diseases.

WHO IS ELIGIBLE FOR FRESCO Y SALUDABLE/FRESH AND HEALTHY?

Northeast Valley Health Corporation patients are eligible if they meet all of the following requirements:

- ✓ Enrolled in Medi-Cal; and
- ✓ Screened positive for food insecurity; and
- ✓ Enrolled in the National Diabetes Prevention Program and have completed at least four sessions within the first 16 weeks of the program, **OR** diagnosed with type 2 diabetes

HOW DOES FRESCO Y SALUDABLE/FRESH AND HEALTHY WORK?

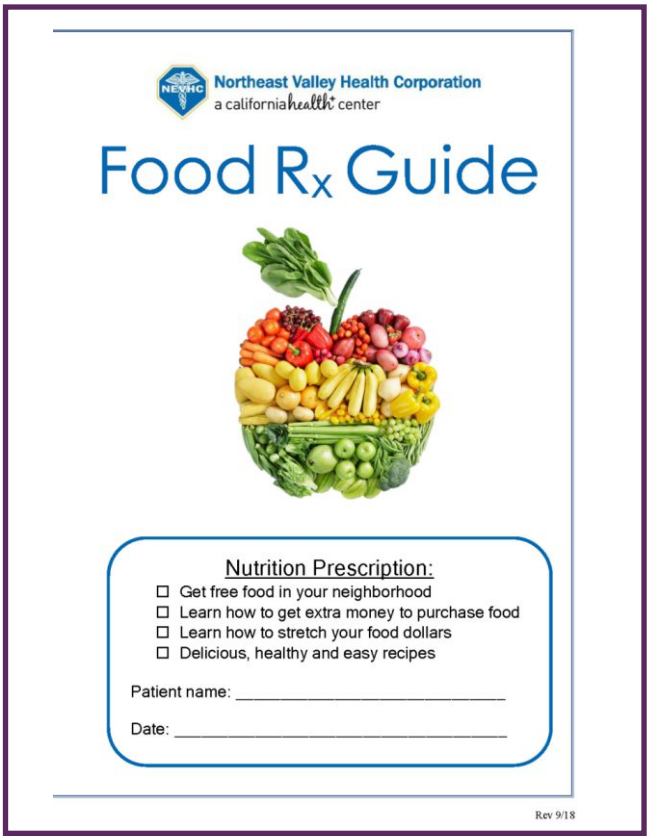
Family Medicine Care Coordinators (FMCC) will screen and enroll participants into the program. Eligible participants will receive one "Healthy Savings" card per household. The card will be preloaded with $40 each month for 6 months. Participants can use the card to purchase fresh fruits and vegetables at participating grocery stores. The $40 benefit will be automatically loaded on the first of day of every month for 6 months, and it will expire on the last day of the month. Benefits do not roll over to the following month. Participants will also be referred to other resources to support healthy eating such as CalFresh and nutrition education classes.

HOW IS FRESCO Y SALUDABLE/FRESH AND HEALTHY EVALUATED?

At enrollment, participants will complete a baseline survey that assesses their current fruit and vegetable intake and household food security status. Participants' blood pressure and hemoglobin A1c (HbA1c) will be assessed at baseline as well. At 6 months, participants will complete another survey and have both blood pressure and HbA1c measured. DPH will assist in creating a program infrastructure to monitor patients for blood pressure and HbA1c improvements. The data generated by this infrastructure will assess and quantify health outcomes related to Fresco y Saludable/Fresh and Healthy participation.

For more information, contact
Denise Torres, MPH, CLEC
Program Manager, Community Wellness, NEVHC
Phone: (818) 270-9700 Ext. 42053
Email: denisetorres@nevhc.org

County of Los Angeles Public Health | Northeast Valley Health Corporation a californiahealth center | VOUCHERS 4 VEGGIES



Northeast Valley Health Corporation
a californiahealth center

Food Rx Guide

Nutrition Prescription:

- ☐ Get free food in your neighborhood
- ☐ Learn how to get extra money to purchase food
- ☐ Learn how to stretch your food dollars
- ☐ Delicious, healthy and easy recipes

Patient name: _____

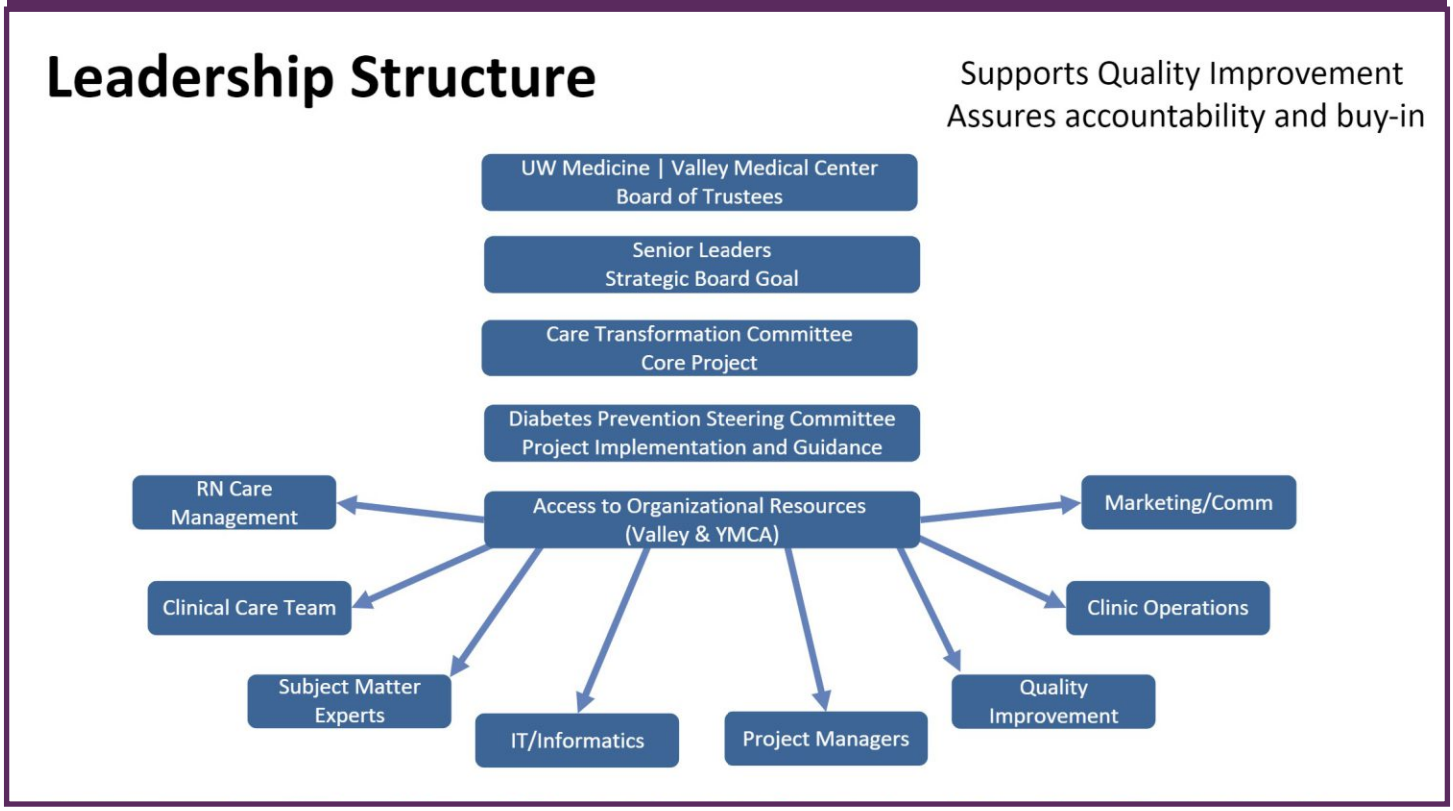
Date: _____

Rev 9/18

Appendix 5: Community Outreach and Collaboration

Highlighting the role of specific leaders, staff and the health team members offers clarity in developing an action plan for initiating and operating the program. See an example of leadership structure from one of the CDC grantees below.

Developed by UW Medicine Valley Medical Center and YMCA of Greater Seattle with funding from the CDC.




ACPM