



NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS

Promoting Health. Preventing Disease.

2014

**STATE DIABETES
PREVENTION PROJECT**
Stories of Success



The NACDD State Diabetes Project State Stories of Success were written by the project's independent evaluator, the Great Lakes Center for Health Innovations, a Division of the National Kidney Foundation of Michigan. The authors thank each of the participating State Health Departments for sharing their experiences and providing their guidance for creation of this document.

September 2014

PROJECT HIGHLIGHTS

For complete results, see tables for each strategic focus area. These tables are found on pages 7, 27, 49, and 63.

4.3 million adults with prediabetes potentially reached through **10** awareness campaigns

805 healthcare providers educated about prediabetes and the evidence-based lifestyle change program, serving **208,011** adult patients

Nearly **1,000** adult patients were referred by their healthcare provider to the lifestyle change program

3.4 million adults with prediabetes live in geographic areas now covered by a diabetes prevention referral system

3 states added the lifestyle change program as a health benefit covering **86,944** state employees

685,217 employees working for public and private employers considering covering the lifestyle change program as a health benefit

TABLE OF CONTENTS

Project Background..... 3

Strategic Focus Areas..... 4

Participating States..... 5

 Strategy A..... 6

Colorado, Minnesota, New Mexico, New York, Washington

 Strategy B..... 18

Kentucky, Minnesota, New York, West Virginia

 Strategy C..... 26

Michigan, Minnesota, New York, Washington, West Virginia

 Strategy D..... 38

Colorado, Michigan, New Mexico, Washington, West Virginia

 Strategy E..... 48

Colorado, Kentucky, New Mexico, West Virginia

 Strategy F..... 58

Colorado, Kentucky

 Strategy G..... 62

Michigan, New Mexico

Common Threads..... 68

PROJECT BACKGROUND

The National Association of Chronic Disease Directors (NACDD), in collaboration with the CDC Division of Diabetes Translation (DDT), created the State Diabetes Prevention Project. The goal of this project was to engage eight state health departments in statewide or regional efforts to promote increased use of the National Diabetes Prevention Program's (National DPP) evidence-based lifestyle change program.

To select the participating states, NACDD applied criteria to identify states that were well-positioned and had high capacity to work in diabetes prevention. This would allow the funded states to draw upon their established strengths as they implemented their new diabetes prevention projects. The selection criteria reflected their:

- Current diabetes focused resources
- Recent experience with diabetes prevention
- Established connections with prevention partners
- Existing number of programs that had applied for CDC recognition
- Experience with health communications and marketing
- Experience working with health systems and providers
- Experience in policy work and documenting impact
- Employer or business coalition connections and partnerships
- Experience demonstrating and documenting intervention impact.

Each funded state selected three to four strategic focus areas to increase awareness, referrals, and access to the evidence-based lifestyle change program. These focus areas are listed on page 4; the map on page 5 notes those selected by each state.

Throughout this project, NACDD supported the states' diabetes prevention activities, assisted them in developing a plan for scaling these activities, and documented their unique contributions in promoting diabetes prevention efforts. In addition, the states received technical assistance and training from NACDD and its national partners: the National Business Coalition on Health (NBCH), the Directors of Health Promotion Education (DHPE), and the Centers for Disease Control and Prevention, Division of Diabetes Translation.

The NACDD State Diabetes Prevention website has additional information on the eight states and their projects. The website features a description of each project, contact information, and access to materials the State Health Departments developed or used for this project.

www.HaltDiabetes.org

STRATEGIC FOCUS AREAS

Strategic Focus Area A

Strategic use of health communication and marketing tools to raise awareness of prediabetes risk factors for people at risk, the location of sites offering the evidence-based lifestyle change program, and how to enroll in this program

Strategic Focus Area B

Strategies for raising awareness among healthcare providers of how to recognize and treat prediabetes

Strategic Focus Area C

Strategies for working with healthcare providers to increase referrals to the evidence-based lifestyle change program

Strategic Focus Area D

Strategies for developing and implementing systems for referral of people with prediabetes or at high risk for type 2 diabetes to sites offering the evidence-based lifestyle change program

Strategic Focus Area E

Strategies for partnering with state and local government agencies to recommend that the evidence-based lifestyle change program be offered as a covered health benefit for public employees

Strategic Focus Area F

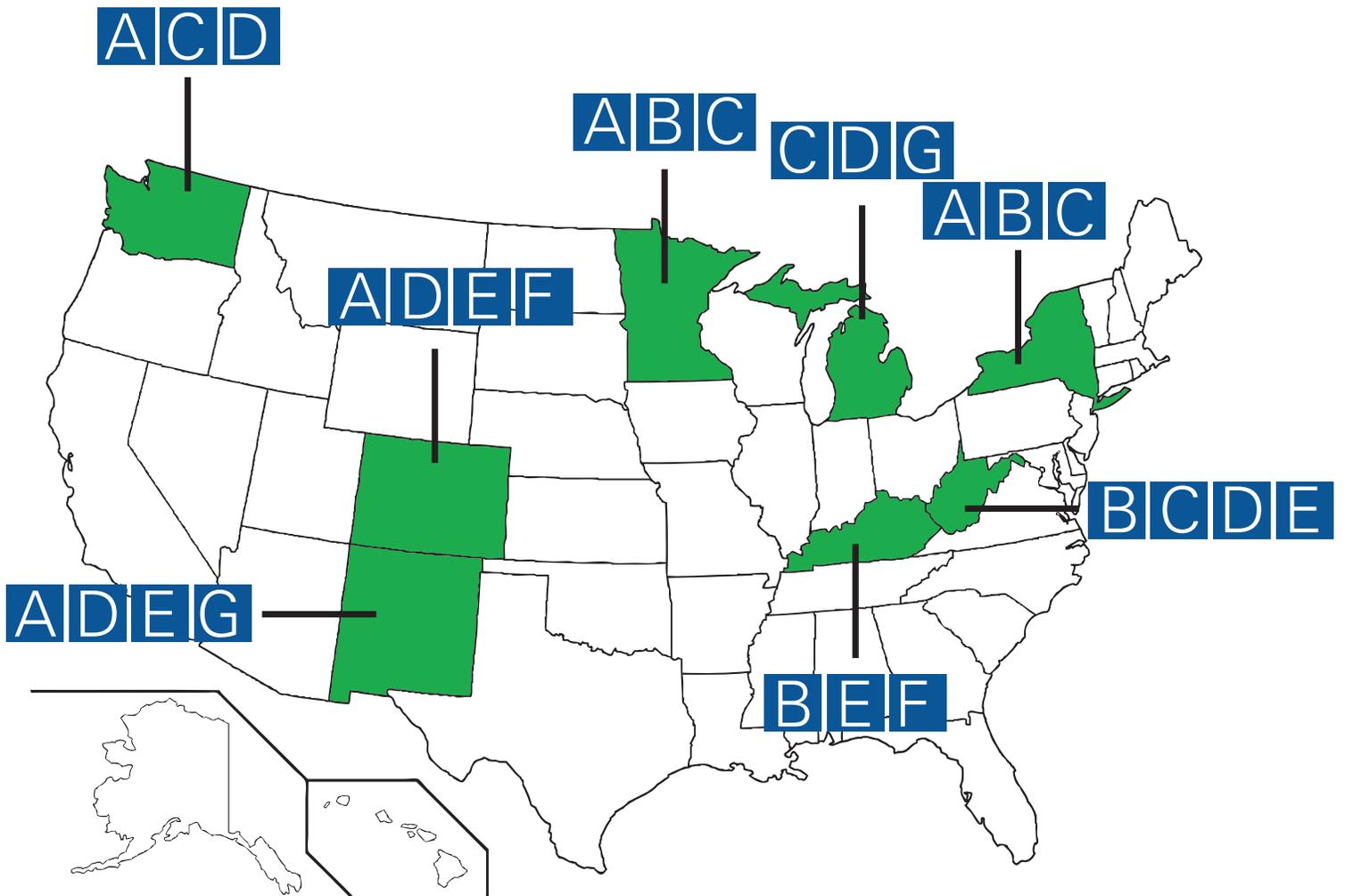
Strategies for partnering with organizations such as business coalitions to increase support for the evidence-based lifestyle change program as a covered health benefit by insurance providers and companies that are self-insured

Strategic Focus Area G

Strategies for ensuring that efforts to increase awareness and promote the evidence-based lifestyle change program are aligned and coordinated with organizations in the state that is delivering this program

PARTICIPATING STATES

Below are the participating State Health Departments and their selected Strategic Focus Areas.



STRATEGIC FOCUS AREAS



Promoting Prediabetes Awareness

As we evaluated the project, it became apparent that there were themes with organizational or implementation tactics that facilitated the states' work in these two strategic focus areas. We called these "facilitating factors." Similarly, there were themes with barriers to success the states encountered. The following is a brief overview of some of the most common facilitating factors and barriers.

- **Strategic Focus Area A**

Strategic use of health communication and marketing tools to raise awareness of prediabetes risk factors for people at risk, the location of sites offering the evidence-based lifestyle change program, and how to enroll in this program

- **Strategic Focus Area B**

Strategies for raising awareness among healthcare providers of how to recognize and treat prediabetes

Facilitating Factors

- NACDD funds
- Engaged community and stakeholders early and throughout campaign
- Partnered with organizations and contractors to create awareness campaign, utilize existing infrastructure, and expand reach
- Engaged internal and external champions by asking them to make presentations
- Used or adapted existing materials from CDC, NACDD, or other State Health Departments
- Utilized expertise and support from other state health department programs

Barriers

- Not enough time to:
 - Develop relationships
 - Identify the “right” partners and contractors
 - Complete state contract process
 - Identify, obtain, or create materials
- Need to tailor materials for appropriateness to target audience

Results

Strategic Focus Area A: Prediabetes Awareness	
Indicator	Total
Number of marketing campaigns ¹	10
Potential reach of awareness strategies (adults with prediabetes)	4,267,063
Strategic Focus Area B: Healthcare Provider Awareness	
Indicator	Total
Number of healthcare system partners (overall system)	25
Number of healthcare delivery sites within the system partners (e.g. clinic/practice)	244
Number of primary care health providers (physicians, PA, and NP) in participating delivery sites	805
Number of adult patients served by participating devlivery sites	208,011

¹New Mexico has one campaign planned reaching approximately 220,000 people

COLORADO



How did you raise awareness of prediabetes and diabetes prevention?

Approximately 35% of adults have prediabetes, yet only 6% of Coloradan adults know they have it. To close this gap, the Colorado Department of Public Health and Environment (CDPHE) developed a media campaign to raise prediabetes awareness in Denver, Colorado Springs, Grand Junction, and surrounding areas. The campaign included :15 and :30 second TV spots, social media postings, and a prediabetes landing page on the CBS4 Denver website (<http://denver.cbslocal.com/prediabetes/>). The campaign helped Coloradans recognize if they were at risk for prediabetes, offered the evidence-based lifestyle change program as a solution, and prompted them to call the American Diabetes Association (ADA) hotline (1-800-DIABETES) to learn more. While aimed at the general public, the campaign was expected to facilitate conversations among healthcare providers, health plans, and employers about prediabetes, the lifestyle change program, and the need to have this covered as a health benefit.

What was the State Health Department role?

- Utilized a fair and impartial process to select a qualified vendor
- Contracted with CBS4 (KCNC) as the vendor to develop and launch the campaign
- Linked CBS4 to existing marketing materials and resources they could use or adapt for the campaign
- Provided content expertise and technical assistance to CBS4 as they created the television and digital advertisements
- Prepared ADA hotline to refer consumers to the evidence-based lifestyle change program in response to the media campaign call to action

“As a company committed to the health and wellness of our community, CBS4 was proud to partner with the Colorado Department of Public Health and Environment to raise awareness about prediabetes. We have been working closely with the American Diabetes Association over the years to create awareness about diabetes so the prediabetes campaign was a natural extension of our ongoing efforts around the issue. Through a multi-faceted campaign we were able to reach 1.3 million adults.”

Elaine D. Torres, CBS4

What positioned you for success?

- Dedicated Funding: \$112,000
- Access to state health department communication staff with experience reaching audiences across multiple communication channels
- Existing diabetes prevention communication plan
- Ability to execute contracts with partners

Achievements

1 Media campaign

15,837,300 Media impressions

1,561,026 Online impressions

5,432 Visits to website

1.3 million Adults with prediabetes potentially reached through campaign

7-9% Increase in CBS4 viewers’ awareness of prediabetes and the evidence-based lifestyle change program (see next page for results)



COLORADO

How did you develop a prediabetes awareness campaign?

CDPHE released a Request for Proposal to identify its media partner for the awareness campaign. CDPHE selected KCNC, the Denver CBS television affiliate. CBS4 provided in-kind services that included development of the creative for the campaign. An initial step in campaign development was to review existing prediabetes awareness campaigns and materials. CDPHE and CBS4 chose the National Association of Chronic Disease Directors (NACDD) H.A.L.T. Diabetes campaign as a starting point. CBS4 built on the H.A.L.T. Diabetes message by adding information about prediabetes risk factors and the evidence-based lifestyle change program. The ADA hotline was included as the call to action, driving viewers to call and learn more about the program. The campaign ran from October to December, 2013. Television advertisements were placed based on target audience and media channel demographics. CDPHE and CBS4 created a webpage with educational information and links to prediabetes resources. Over the course of the campaign, the number of media spots exceeded what was planned. A quiz was conducted among CBS4 viewers pre- and post-campaign to determine campaign effectiveness. Post assessment showed 7-9% increases in the number of respondents who:

- correctly answered that 1 in 3 Coloradan adults have prediabetes (+8%);
- reported seeing advertising messages about diabetes prevention very or somewhat frequently (+9%); and
- selected "Call 1-800-DIABETES" as the best way to connect to a lifestyle change program (+7%).

Simultaneously, a communication kit was developed and posted online to support partner-driven awareness efforts (<https://sites.google.com/site/diabetespreventionprogram/home/communication-kit>).

Partners

- CBS4
- American Diabetes Association
- State health department communication staff

For More Information

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See *Colorado Story D* for more information on the ADA hotline referral system

Challenges and Solutions

- Needed to revise their plan to use CDC prediabetes marketing materials in the media campaign

Identified other media campaigns and marketing materials, including NACDD's national H.A.L.T. Diabetes campaign.

- Lack of a consistent name and brand made the lifestyle change program difficult to market through one awareness campaign.

The campaign used "Diabetes Prevention Program" as the generic name for the program, and the ADA hotline staff provided the specific name of the program provider at the time of referral.

- One year was insufficient time to identify and contract with a campaign vendor and allow the vendor to have enough time to create and implement the campaign.

State staff and the media contractor worked quickly to deliver the campaign in a three-month timeframe.

- Information to increase prediabetes awareness and encourage enrollment in the evidence-based lifestyle change program was a lot to include in brief media messages.

The messages were simplified and focused on:

- Am I at risk?
- What can I do?

What were the factors for success?

- Leveraged existing H.A.L.T. Diabetes materials developed by NACDD and CBS Health Solutions
- Partnered with local television station CBS4
- Planned to use new grant funding to continue and expand the campaign

MINNESOTA A B C

How did you raise awareness of prediabetes and diabetes prevention in diverse communities?

The MN Department of Health (MDH) developed the *Prediabetes and National Diabetes Prevention Program Awareness Campaign* for implementation in the 7-county Twin City Metropolitan Area. This included an overarching campaign for general use and components designed to reach the African American, American Indian, Latino, Asian/Hmong, and Somali communities. The media campaigns included radio, public service announcements, posters, social/electronic media, and bus shelter ads. In addition, “human media” was fostered to carry the messages and stories through person-to-person contact at community events and success stories of evidence-based lifestyle change program participants, a media strategy identified as being important to the five partner communities.

What was the State Health Department role?

- Dedicated funding to support formative evaluation necessary to design culturally-specific awareness campaigns
- Involved the community from inception to ensure buy-in
- Utilized an existing relationship with a community leader experienced with traditional and social media campaigns and respected across all cultural communities
- Engaged this community leader to identify trained facilitators who invited participants and led five culturally-specific Community Conversations
- Partnered with five facilitators to plan and implement a Collective Conversation, including designing a combined group process that embraced and celebrated each community’s cultural norms
- Provided scientific background and knowledge of diabetes prevention to inform the development of the campaign
- Contracted with communication vendors to refine campaign messages and create materials
- Linked the campaign to other state efforts aimed at recruiting participants to the evidence-based lifestyle change program
- Worked with health clinics to identify and recruit successful participants from the Hmong, Latino and Somali communities to share their experience in the evidence-based lifestyle program for success story videos and posters

Achievements

7 Community Conversations with **244** participants

7 Marketing campaigns

875,000 Adults with prediabetes living in the geographic area covered by these campaigns

4 Evidence-based lifestyle change program participant success story videos: Hmong, Latino, Somali, American Indian

Patient and provider materials about prediabetes and the lifestyle change program

Consumer prediabetes website with sections for each community

(<http://preventeddiabetesmn.org/>)

“To enroll multicultural communities in diabetes prevention, take the time to engage the community and listen. Help people take ownership of preventing diabetes for themselves, their families and community. All communities told us they want to hear stories and be in diabetes prevention groups with people who look and sound like them. They listen from their hearts to people who come from the world they live in. Their hearts, not their heads, will motivate them to make lifestyle changes.”

Rita Mays

What positioned you for success?

- Dedicated Funding: \$127,297
- Trust and interest from the five communities
- Experience with the evidence-based lifestyle change program
- Established connections with clinic and community organizations offering the program
- Awareness of cultural commonalities and differences
- Access to respected leaders in cultural communities willing to partner to address diabetes prevention

MINNESOTA

How did you reach five diverse communities in one Metropolitan area?

To guide the development of the culturally-specific campaigns, the MDH worked with community partners to implement five community conversations, one for each cultural community. Conversations were led by trained facilitators from the communities. Facilitators used either the World Café model or the Circle model. The MDH and the facilitators co-hosted a sixth conversation with representation from all 5 communities to continue the diabetes prevention discussion. The Collective Conversation produced the over-arching message for the general awareness campaign, revealed universal themes of the importance of family, and identified the need to convey messages through personal stories. MDH worked with the facilitators to identify respected communication agencies to develop and deliver the campaign messages. In 2014, a seventh conversation was held to show the original community participants the resulting outreach efforts and materials. These conversations created a sustainable community engagement process centered in the community's culture and built on trust.



What were the factors for success?

- Engaged stakeholders from the beginning and secured their buy-in
- Recognized communities as strong partners who understand the seriousness of diabetes
- Directed funding to engage the communities, resulting in culturally-acceptable campaigns
- Tailored approach to invite community members to provide input
- Listened to each community and acted upon their suggestions
- Recognized the importance of “human media” as a way to support traditional and social media
- Developed ways to sustain the campaign by increasing community capacity and assuring ownership

Challenges and Solutions

- State contracting procedures took longer than expected and impacted start up.
 - State staff, contractors, and community partners willing to complete the work in a shortened time period.
- The one-year project time-frame was short for full implementation of the campaigns.
 - Planned to use other funds to continue campaigns through 2014
- Identifying vendors within each community was often a challenge, as contact persons or information was not always accessible.
 - Used information at hand and built new relationships with vendors
- Vendors recommended social/electronic media to reach their communities, but the state's websites were not designed for community users.
 - Developed a consumer web page with separate, culturally unique pages for communities to post stories and information in their own languages

Partners

- Team of five community engagement facilitators
- I CAN Prevent Diabetes programs in Twin City metro area, e.g. Stairstep and LaClinica
- We Can Prevent Diabetes/Medicaid Incentives for Prevention of Chronic Disease project clinics, program participants and YMCA coaches
- Five communications vendors representing the communities
- Ampers, Diverse Public Radio for Minnesota

For More Information

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NEW MEXICO **A D E G**

How did you raise awareness of prediabetes and the evidence-based lifestyle change program?

To capture the attention of healthcare providers, the New Mexico Diabetes Prevention and Control Program (DPCP) contracted with a marketing firm to create a plan to develop, test, and implement an eye-catching awareness campaign. The campaign, which was based on CDC materials, included a brochure to raise awareness among providers and a poster for providers to display in their clinics. Along with the campaign, the DPCP planned to partner with New Mexico Health Care Takes on Diabetes (NMHCTOD) to educate the healthcare provider population about prediabetes during professional meetings.

What was the State Health Department role?

- Used data, including a state profile and maps that highlighted areas and populations of greatest risk, from the Directors of Health Promotion and Education to determine the geographic area covered by the awareness campaign
- Funded a contractor to create a marketing plan to increase healthcare provider awareness
- Identified and obtained feedback from relevant stakeholders (health plans, hospitals, and clinics) for use in developing campaign materials and messages
- Extended implementation of the campaign by linking with NMHCTOD

Achievements

1 Awareness campaign planned

Targeting healthcare providers in **2** counties: Bernalillo and Santa Fe

An estimated **220,854** adults with prediabetes living in the geographic area to be covered by this campaign

"The recommendation form will be a great way for healthcare providers to ensure their patients meet the eligibility criteria for the National Diabetes Prevention Program."

Susan Baum, MD, MPH

What positioned you for success?

- Dedicated Funding: \$88,144
- Experience delivering health communication and marketing campaigns
- Some prediabetes education tools in place to raise awareness among health professionals and the public



NEW MEXICO

How did you develop a healthcare provider awareness campaign?

The DPCP worked with a contractor to create a plan for raising awareness of prediabetes and the evidence-based lifestyle change program among healthcare providers. Prior to campaign development, the DPCP identified 12 key partners from health plans, hospitals, and clinics and arranged a brainstorming meeting to obtain their input. At this meeting, attendees defined strategies that would work best to increase provider awareness and willingness to refer patients. The contractor subsequently refined the campaign objective, target audience, and ways to reach them. Campaign materials were adapted from CDC materials. The final products included a provider brochure and a poster. Both were eye-catching, using bold, red font and color boxes to draw attention to important messages. On the front of the brochure was the message: "You'd jump in front of a bus for your patients. But what if that bus was diabetes?" The rest of the brochure contained information about the evidence-based lifestyle change program and patient criteria for enrollment. The poster was designed to look like an infographic, and the color and font matched that of the brochure. The poster used a question-and-answer format to raise awareness and provide information. The three questions were: "Am I at risk?", "Why do I care?", and "What should I do?" Additionally, the DPCP funded NMHTOD to continue healthcare provider awareness through planned education sessions.

Challenges and Solutions

- Contracting procedures took longer than expected which delayed the awareness campaign.

Divided the work between a referral system contractor and a marketing contractor in order to efficiently complete as much work possible in the short amount of time remaining in the project

Decided to focus solely on healthcare providers and put a hold on the consumer-focused campaign

Partners

- McKee Wallwork & Company
- Health plans, hospitals, and clinics
- New Mexico Health Care Takes on Diabetes
- Directors of Health Promotion and Education

What were the factors for success?

- Worked with a creative marketing team
- Committed set of stakeholders provided input that was instrumental in developing the campaign materials and messages
- Reviewed CDC materials as campaign materials and messages were developed
- Used state funding to extend implementation of the campaign through its contract with NMHTOD

For More Information

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See New Mexico Story D for more information on the referral system

NEW YORK



How did you raise awareness of prediabetes and diabetes prevention?

Working with the P² Collaborative of Western New York (P² Collaborative), a non-profit organization dedicated to health improvement, the New York Diabetes Prevention and Control Program (DPCP) created three diabetes prevention awareness toolkits. The toolkits were designed to increase awareness of prediabetes, introduce the evidence-based lifestyle change program, and promote referral to the lifestyle change program. Each toolkit was tailored to a unique audience: individuals at risk for prediabetes, community organizations, and healthcare providers. The toolkits were disseminated across Western New York and made available online (<http://www.p2wny.org/materials.html>). The P² Collaborative invited 150 partners to an event that launched the toolkits and presented information on recognizing prediabetes and referring to an evidence-based lifestyle change program. Additional components of the awareness campaign included: published articles in the Buffalo Healthy Living Magazine and partner newsletters, and distribution of flyers, brochures, and posters advertising the lifestyle change program.

What was the State Health Department role?

- Contracted with the P² Collaborative to create, pretest, distribute, and evaluate three diabetes prevention toolkits
- Convened key stakeholders via webinar to promote the campaign
- Educated community members and healthcare providers about prediabetes through publications and presentations

Achievements

1 Marketing campaign

423,162 Adults with prediabetes living in the geographic area covered by the campaign

3 Diabetes prevention toolkits



“Working in partnership, public health and health systems can create relevant awareness materials and messages that engage individuals at risk, community organizations, and healthcare providers to consider next steps toward diabetes prevention, including self- or provider-referral to an evidence-based lifestyle change program.”

Sue Millstein, NY DPCP

What positioned you for success?

- Dedicated Funding: \$40,000
- Experience developing and implementing health communication materials and marketing campaigns
- Partnership with the P² Collaborative
- Connections with health systems, health plans, and evidence-based lifestyle change program providers

NEW YORK

How did you develop tailored toolkits?

The DPCP partnered with the P² Collaborative to create a base toolkit that was modified for three audiences: individuals at risk for prediabetes, community organizations, and healthcare providers. In preparation for the toolkit creation, two P² Collaborative staff members attended a training provided by the National Resource Center for Academic Detailing. The P² Collaborative collected and reviewed other awareness campaign examples, communication routes, and referral systems used by its county, health plan, and other partners. Existing materials provided by the state diabetes programs from New York, Minnesota, and New Mexico were revised for use in the toolkits. The toolkits included information on prediabetes, benefits of diabetes prevention, and how to enroll in the evidence-based lifestyle change program. While the content was similar in all toolkits, tone, wording, and culturally acceptable images were adapted to each target audience. A graphic designer formatted the toolkits, and each kit was assigned a unique color. To pretest the toolkits, the P² Collaborative held focus groups with individuals of varying education levels, health plan and provider partners, and faith-based community members. Prior to distribution, organizations provided feedback on how they would like to receive and use their toolkits. The P² Collaborative posted the finalized toolkits on their website and distributed them to health systems, healthcare providers, community organizations, and employers.

What were the factors for success?

- Utilized a partner with awareness campaign experience and expertise
- Adopted existing materials that had a proven track record of success
- Solicited feedback from target audiences prior to toolkit publication
- Included information on statewide diabetes prevention registration and resources in the toolkits
- P² Collaborative staff were trained to conduct academic detailing
- Released toolkits at a prediabetes event that was attended by 150 partners from all 8 counties in Western New York

Challenges and Solutions

- Initially the consumer toolkit was written using language that did not engage the target audience.

Enlisted the help of several Medicaid practices and community outreach partners, and incorporated feedback by adjusting the reading level and using language that was encouraging and positive

- Subcontract with the P² Collaborative took longer than anticipated, which delayed development of the toolkits.

Continued to work internally and build partnerships that would be key in the development of the toolkits

Partners

- P² Collaborative of Western New York
- Health plans, healthcare providers, churches, and other community organizations

For More Information

Susan Millstein
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See New York Story B for more information on the provider toolkit and C for information on the referral system

WASHINGTON



How did you raise awareness of prediabetes and the evidence-based lifestyle change program?

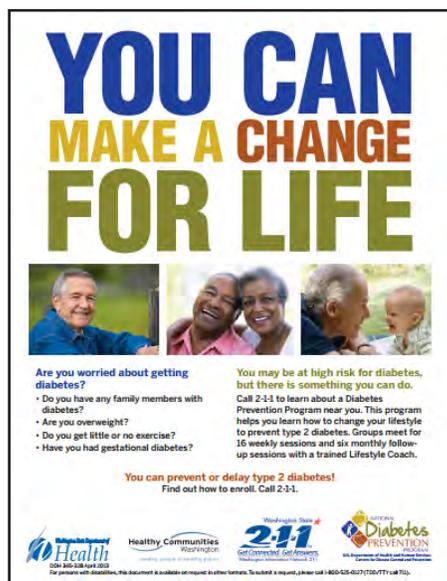
In partnership with the Washington State Diabetes Network, the Washington Diabetes Prevention and Control Program (DPCP) adapted a CDC suite of diabetes prevention promotional materials, including a consumer-focused poster and brochure. Awareness materials were translated into Spanish and tailored to reflect the audience’s age and ethnicity. Washington Information Network 211 (WIN211) branding was included in one version of the materials, and a second version was customizable. The DPCP, WIN211, and evidence-based lifestyle change program providers used these modified materials to promote the lifestyle change program at multiple venues. Additionally, these materials were given to healthcare providers to raise prediabetes awareness and refer patients to the evidence-based lifestyle change program.

What was the State Health Department role?

- Partnered with the Washington State Diabetes Network to modify existing promotional materials
- Contracted with WIN211 to distribute promotional materials for the evidence-based lifestyle change program at regional call centers and outreach events
- Promoted the evidence-based lifestyle change program to healthcare providers and employers at meetings and events
- Provided promotional materials to evidence-based lifestyle change program providers for use in participant recruitment
- Identified additional funding sources to expand promotion of the lifestyle change program

Achievements

- 1 Marketing campaign
 - 1,631,000 Adults with prediabetes living in the geographic area covered by this campaign
- 368 Outreach events attended by staff from WIN211 call centers
- 267 Consumer calls
- 429 Referrals to the evidence-based lifestyle change program and other diabetes services



What positioned you for success?

- Dedicated Funding: \$5,000
- Participation from the Washington Diabetes Network Leadership Team
- Access to Washington Department of Health staff with expertise in consumer-focused print and web-based media

English and Spanish versions of promotional posters aimed at older adults

WASHINGTON

How did you modify awareness materials and promote the evidence-based lifestyle change program?

The DPCP gathered input from the Washington State Diabetes Network Leadership Team and Communications Committee to edit a CDC-developed suite of promotional materials featuring the phrase, “You Can Make A Change For Life.” The Washington Department of Health’s Health Promotion staff, together with the DPCP, used this input to develop a consumer-focused poster and brochure. Two versions of the poster were created: one for all ages and one aimed at older adults. Posters and brochures were available in English and Spanish. For all materials, text and pictures were changed to reflect the age, gender, ethnicity, and literacy level of audiences. For example, the word “Usted” was used on the Spanish poster for older adults because it conveyed respect. Evidence-based lifestyle change program coaches assisted with testing materials with target audiences. Once finalized, posters and brochures were made available to download or order at the Washington State Diabetes Connection website and Health Education Resource Exchange.

Awareness materials were used by the DPCP and its partners to promote the evidence-based lifestyle change program. The DPCP and WIN211 distributed promotional materials during meetings and other events. The DPCP reached employers at the Healthy Worksite Summit and healthcare providers via the Washington Health Improvement Network project. In addition, evidence-based lifestyle change program providers used materials to recruit participants.

Partners

- Washington State Diabetes Network
 - Members
 - Leadership Team
 - Communications Committee
- Washington Information Network 211
- Washington Healthcare Improvement Network
- Evidence-based lifestyle change program providers

For More Information

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Washington Awareness Materials
<http://diabetes.doh.wa.gov/resources-for-health-professionals-2/patient-education-resources-1/patient-education-materials-1/you-can-make-a-change-for-life>

Challenges and Solutions

- Awareness materials were needed quickly due to the short, one-year project time-frame.
 - Adapted existing CDC materials
 - Washington Department of Health’s Health Promotion staff modified the materials quickly.
 - Stakeholders who provided input were focused on primary prevention and therefore gave input in a timely manner.
- Loss of some essential staff due to budget cuts caused setbacks in development and implementation.
 - Utilized project funding and other in-kind funding to support staff focused on this strategy
- The print material inventory was dependent on availability of funding.
 - Distributed materials on a first-come, first-served basis
 - Reprinting was based on demand
 - Materials were available in an electronic format for partners to print.

What were the factors for success?

- Developed Washington-specific campaign materials that were:
 - Adapted from existing CDC awareness materials
 - Tailored to be appropriate for the target audiences
 - Based on input from a variety of stakeholders
- Engaged evidence-based lifestyle change program providers and Washington State Diabetes Network members and Leadership Team during the material development phase, which ensured their future use of the materials

KENTUCKY



How did you raise healthcare provider awareness of the evidence-based lifestyle change program?

The Kentucky (KY) Diabetes Prevention and Control Program (DPCP) worked with the KY Prediabetes/Diabetes Prevention Program steering committee and other partners to develop prediabetes/National Diabetes Prevention Program (National DPP) toolkits and presentations.

- **Toolkits:** Two toolkits for diabetes educators and healthcare providers were developed and distributed statewide. The purpose of the toolkits was to: 1) increase educator and provider awareness, 2) increase referrals to the lifestyle change program, 3) provide tools to increase community and employer awareness, and 4) encourage educators/providers to consider becoming an evidence-based lifestyle change program provider.
- **Presentations:** Two presentations were developed targeting health professionals and the public. The presentation for professionals was given at three diabetes symposia and American Association of Diabetes Educators (AADE) Local Networking Group (LNG) meetings. A community presentation was included in the diabetes educator toolkit.

In addition, an online continuing medical education (CME) activity, an episode on a KY Educational Television (KET) show, and two news articles were released, all of which focused on prediabetes and the lifestyle change program.

What was the State Health Department role?

- Developed a prediabetes/ diabetes prevention community awareness presentation (for public) and KY-specific materials for diabetes educator toolkit
- Facilitated development of a state level “diabetes prevention champion”
- Presented information on prediabetes and the evidence-based lifestyle change program to diabetes educators and the Kentucky Medical Association (KMA)
- Partnered with an expert in academic detailing and a KMA physician member to help develop and promote the provider toolkit
- Distributed toolkits to diabetes educators, physicians, and other health professionals
- Collaborated with the New Mexico (NM) DPCP to utilize their free online prediabetes CME activity for healthcare providers
- Collaborated with the Minnesota (MN) DPCP to utilize their prediabetes algorithm in the provider toolkit

Achievements

- 7 State or regional presentations
- 204 Organizations where diabetes educators are employed or practice
- 154 Certified diabetes educators at participating organizations
- 4 Diabetes educator group partners
- 700 Diabetes educator toolkits distributed to diabetes educators/ health professionals
- 100 Physicians received provider toolkits
- 1 television segment completed through KET

“It’s all about relationships ---- connecting with key organizations and partners to use all available resources to make a difference for our people at risk for diabetes.”
Theresa Renn, KY DPCP

Diabetes Educator Toolkit for Prediabetes / Diabetes Prevention Program

What Diabetes Educators Can Do

Work within your own organization to become a CDC recognized diabetes prevention program site (or refer to DPP recognized sites).

Work with local healthcare providers to ensure they are screening patients for prediabetes and interventions are offered when screenings indicate prediabetes.

Excerpt above (partial list) taken from the diabetes educator toolkit

What positioned you for success?

- Dedicated Funding: \$35,000
- State health department leadership strongly supported the evidence-based lifestyle change program
- Existing relationships with AADE LNGs and local health departments
- Working relationships with other state DPCPs

KENTUCKY

How did you develop toolkits and presentations?

The Department for Public Health's (DPH) Deputy Commissioner of Clinical Affairs became a state champion for diabetes prevention and presented to nearly 600 attendees at three state or regional symposia. Keynote presentations included information about prediabetes, the National DPP, and suggestions for diabetes educator involvement. In addition, four AADE LNG presentations were given to approximately 100 diabetes educators.

The DPCP led the toolkit development with input and assistance from the KY Prediabetes/Diabetes Prevention Program steering committee. Separate toolkits were created for diabetes educators and healthcare providers. Both contained general and KY-specific information on diabetes prevention, the National DPP, and evidence-based lifestyle change program providers. Materials came from the National Diabetes Education Program (NDEP), the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), and the CDC. The diabetes educator toolkit included a CD with a community presentation adapted from the NDEP Road to Health Toolkit, which could be used for public promotion of prediabetes and the National DPP. The CD included enrollment options, if enrollment was applicable for the area. The provider toolkit included an algorithm adapted from the MN DPCP. Diabetes educator toolkits were distributed at educational events and through local health departments, while provider toolkits were distributed through physician visits and the KMA's Community and Rural Health Workgroup.

Simultaneously, the DPCP was involved in several other prediabetes awareness initiatives. The DPCP accessed and advertised a healthcare provider CME activity developed by the NM DPCP. To promote the CME, the DPCP mailed over 6,000 flyers. Two prediabetes articles, one for an academic journal and one for a state magazine, were written by expert authors. Furthermore, an episode of the TV show "Connections with Renee Shaw" featured discussion regarding diabetes prevention. The episode aired three times and is available online at <http://www.ket.org/connections/program.fwx?programid=CWRS0910>.

Partners

- Cabinet for Health and Family Services – Secretary's office
- Department for Public Health – Deputy Commissioner of Clinical Affairs
- Kentucky Prediabetes/Diabetes Prevention Program steering committee
- Kentucky Educational Television – Renee Shaw with University of Kentucky endocrinologist and Louisville YMCA
- Kentucky Medical Association – Community and Rural Health Workgroup
- University of Louisville – endocrinologist and CME director
- Diabetes Prevention and Control Programs – Minnesota and New Mexico
- Local Health Departments (Louisville Metro, Lexington, and Northern Kentucky)
- American Association of Diabetes Educators
- 4 Kentucky Local Networking Groups

Challenges and Solutions

- There was limited time to finalize and assemble a large number of toolkits.
 - Utilized volunteer and support staff to ensure the task was completed on time
- Publication of the articles was delayed because the expert authors were writing on volunteer time.
 - Revised the timeline to give authors more time to write
- Promotion of the CME to Kentucky providers was behind schedule because a process had to be determined with the CME provider to offer this to large numbers of out-of-state participants.
 - The KY and NM DPCP staff worked with the CME provider to obtain approval and develop a process to offer the CME in Kentucky.
- Distributing the provider toolkit through academic detailing was delayed due to time needed to finalize and print the toolkit.

Provider toolkits were distributed via limited physician visits in three areas of the state.

A KMA member distributed nearly 100 toolkits to local physicians.

What were the factors for success?

- Gained DPH senior leadership support (i.e., diabetes prevention champion)
- Used steering committee/local health department expertise to develop toolkit materials and the CD
- Accessed support staff to produce and distribute toolkits
- Ability to leverage work of other DPCPs and not have to "reinvent the wheel"
- Utilized existing relationships with AADE LNGs and local health departments for toolkit distribution

For More Information

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MINNESOTA A B C

How did you raise awareness of prediabetes and the evidence-based lifestyle change program among healthcare providers?

A prediabetes webinar, toolkit, and print ads were used to raise awareness among healthcare providers in Minnesota, with a focus on the 7-county Twin City Metropolitan Area. To develop and distribute prediabetes awareness materials, the Minnesota Department of Health (MDH) partnered with healthcare organizations and clinics involved in the We Can Prevent Diabetes (WCPD) Minnesota project. The MDH worked with contract partners and an endocrinologist to produce, promote, and deliver a healthcare provider webinar. It was initially presented during a live computer/phone event, after which it was made available online and through provider discussions held at WCPD clinics. Furthermore, the MDH updated an existing healthcare provider toolkit, which was stored online. Three unique print advertisements were published in the Minnesota Physician, a monthly newspaper that circulates to 17,000 physicians.

What was the State Health Department role?

- Partnered with WCPD healthcare organizations and clinics to develop and distribute healthcare provider awareness materials
- Partnered with the Institute for Clinical Systems Improvement (ICSI) and prediabetes and health system experts to create and deliver a healthcare provider webinar
- Provided funding, guidance, and content for the awareness campaign
- Updated the existing *Prediabetes Provider Toolkit*, including the prediabetes screening and treatment algorithm
- Contracted with a prediabetes clinical expert to provide on-site provider discussions about prediabetes to WCPD clinics

“The provider discussions brought members from the clinic team together to learn more about prediabetes and the National Diabetes Prevention Program, as well as to discuss patient identification and referral strategies.”

Sara Vine, WCPD Project Coordinator

What positioned you for success?

- Dedicated Funding: \$48,177
- Experience with communications and marketing activities aimed at preventing diabetes
- Partnership with the ICSI and WCPD to increase provider and public awareness of prediabetes
- Existing healthcare provider toolkit and prediabetes algorithm

Achievements

- 13** Healthcare system partners
- 24** Healthcare delivery sites
- 114** Primary care health providers
- 48,679** Adult patients served by these providers
- 227** Providers or clinic staff educated about prediabetes
 - 88** Attended a provider discussion
 - 78** Attended a live webinar
 - 61** Viewed the webinar online
- 51,000** Print media impressions reaching **17,000** providers

What can YOU do for PATIENTS WITH DIABETES?



- Refer them to a local National Diabetes Prevention Program [add link to list]
- Urge them to lose 10% of their body weight
- Prescribe 150 minutes/week of physical activity
- Ask them to eat more fruits and vegetables and less fat
- Refer them to a cessation program if they smoke

Diabetes CAN be prevented or delayed with simple lifestyle changes!



Learn more about prediabetes, the NDPP and sites in Minnesota at: www.icanpreventdiabetes.org



MINNESOTA

How did you create and distribute the healthcare provider webinar, toolkit, and print ads?

The MDH contracted with the ICSI, a reputable organization among clinics in Minnesota; Teresa Pearson, MS, RN, CDE, FAADE; and Michael Gonzalez-Campoy, MD, PhD, FACE to create a 45 minute webinar titled *Screen, Counsel, Refer, and Follow-up for Diabetes and Prediabetes*. The goal of the webinar was to raise awareness of prediabetes among healthcare providers and prompt referrals to the evidence-based lifestyle change program. The consultant and physician initially delivered the live webinar. Afterward, slides and a recording were made available online, and the consultant and MDH used the slides during in-person provider discussions at WCPD clinics.

In addition, the MDH updated an existing Prediabetes Provider Toolkit, which included a prediabetes screening and treatment algorithm, information about identification of people with prediabetes and referral to the evidence-based lifestyle change program, and a list of lifestyle change program providers in Minnesota. Previously developed awareness and referral materials were replaced with new CDC materials. The webinar and advertisements in three consecutive issues of the Minnesota Physician directed healthcare providers to the toolkit. The ads listed ways that physicians could help their patients prevent diabetes. Three half-page ads were created, two covering general risk factors and one focused on gestational diabetes.

What were the factors for success?

- Selected consultants who have experience with healthcare systems and knowledge of prediabetes and the evidence-based lifestyle change program
- Ads pre-purchased by the MDH allowed flexibility in placement following the webinar
- Worked with a physician who could address the physiology and diagnosis of prediabetes
- WCPD project provided the opportunity to work closely with healthcare systems and clinics
- Posted the webinar on the Insitute for Clinical Systems Improvement website, a credible source in the medical community, to generate more traffic
- Invited the clinic Medical Director to speak about the significance of prediabetes awareness, which was a useful peer-to-peer strategy to underscore the importance of the presentation and encourage attendance and participation in the discussion

Challenges and Solutions

- Limited availability of busy providers made scheduling awareness activities challenging.

To allow providers to select the option that would best fit their schedule, the MDH used a variety of formats and times of day to deliver the awareness activities. Formats and times included an early morning live webinar, an in-person provider "Lunch and Learn," and an online pre-recorded webinar.

- Keeping awareness of prediabetes and the evidence-based lifestyle change program on healthcare providers' radar over time

MDH staff have further reached providers with information from the webinar by using it in additional presentations at their professional meetings.

- Webinar registration was limited by a set number of phone lines.

To maximize participation, the MDH team lead encouraged webinar participants from the same organization to call-in on one phone line.

Partners

- Institute for Clinical Systems Improvement
- Contract consultant and endocrinologist
- Healthcare organizations and clinics participating in the We Can Prevent Diabetes Minnesota project
- Minnesota Physician Publishing, Inc.

For More Information

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Prediabetes Webinar: https://www.icsi.org/education_services/education_offerings/past_event_materials/

Prediabetes Healthcare Provider Toolkit
<http://icanpreventdiabetes.org/health-provider-toolkit/>

See Minnesota Story C for more information on healthcare provider discussions

NEW YORK

A

B

C

How did you create healthcare provider awareness of the evidence-based lifestyle change program in order to facilitate referrals?

The New York Diabetes Prevention and Control Program (DPCP) partnered with the P² Collaborative of Western New York (P² Collaborative) to create a New York State evidence-based lifestyle change program toolkit and a continuing medical education (CME) as part of their healthcare provider awareness campaign. Toolkit materials were reviewed by stakeholders, including 24 physician leaders from health systems and practice groups in Western New York. Once approved, materials were widely disseminated to Western New York health providers through an academic detailing model.

What was the State Health Department role?

- Convened key statewide stakeholders via webinar to promote the campaign
- Selected practices and providers to reach through academic detailing
- Developed and utilized new relationships with health system partners to build a foundation for diabetes prevention referral
- Connected with the New York State Quality & Technical Assistance Center (QTAC) (www.ceacw.org/qtac) to create an online portal to promote the evidence-based lifestyle change program and translate program participant data into CDC-approved data files
- Trained evidence-based lifestyle change program coaches to serve Safety Net practices
- Provided technical assistance to evidence-based lifestyle change program coaches and coordinators
- Worked with the P² Collaborative to facilitate referrals to the evidence-based lifestyle change program through 2-1-1, NY Connects, and the QTAC portal

What positioned you for success?

- Dedicated Funding: \$50,000
- Established relationships with health systems
- Partnership with the P² Collaborative

Achievements

- 3** Healthcare system partners
- 7** Healthcare delivery sites
- 500** Primary care providers
- 143,000** Adult patients served by these providers
- 48** Presentations of the toolkit through academic detailing
- 25** Healthcare practice sites

HEALTHY LIVING
WITH CHRONIC
CONDITIONS

PHYSICIAN TOOLKIT



NEW YORK

How did you create awareness for healthcare providers within multiple counties?

The toolkit included information about the 2-1-1 referral system, evidence-based lifestyle change program benefits, and how referral activity could assist providers in meeting the criteria for Patient Centered Medical Home (PCMH) and Centers for Medicare and Medicaid Services (CMS) Stage 2 Meaningful Use. A clinical algorithm for prediabetes and type 2 diabetes and FAQs were also in the toolkit. The materials were created by the DPCP and the P² Collaborative or adapted from other sources, such as the New York State Department of Health. Key staff attended the National Resource for Academic Detailing training prior to the toolkit dissemination in order to enhance provider presentation skills. Using the academic detailing, staff were able to reach over 45 providers. Additionally, they used the toolkit and the academic detailing model to increase awareness among 15 churches, 4 employers, and 4 large community based organizations. These presentations led to strategic partnerships which facilitated diabetes prevention referrals for at-risk patient populations.

Challenges and Solutions

- Subcontract with the P² Collaborative took longer than anticipated, which put work with external vendors on hold.
 - Continued to work internally and build partnerships that would be key in the execution of the campaign
- Lack of agreement regarding physician reimbursement method deterred referrals.
 - Met with health plans in the area which resulted in new health plans signing on and agreeing to a common payment structure
- Two regional health plans would not agree to reimbursement of the evidence-based lifestyle change program.
 - Assisted the health plans in enrolling their Medicaid population into the lifestyle change program

“Robust relationships with diverse local and regional partners remain the most critical success factor in realizing improvement in prediabetes awareness, diagnosis, referral, and participation in the evidence-based lifestyle change program.”

Sue Millstein, NY DPCP

What were the factors for success?

- Leveraged existing relationships with healthcare providers
- Selected a partner with experience and the know how to take an awareness campaign from development to dissemination
- Adopted existing materials that have a proven track record of success
- Built trust with key stakeholders by incorporating them in the process through formative evaluation
- Identified and highlighted advantages for stakeholder buy-in (e.g. PCMH)

Partners

- P² Collaborative of Western New York
- New York State Department of Health
- New York State Quality & Technical Assistance Center

For More Information

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WEST VIRGINIA



How did you raise healthcare provider awareness of diabetes prevention?

Increasing provider awareness about diabetes prevention is a priority for the West Virginia Diabetes Prevention and Control Program (DPCP). To educate healthcare providers about how to recognize and treat prediabetes, the DPCP presented on prediabetes and the evidence-based lifestyle change program. The DPCP gave PowerPoint and poster presentations at numerous conferences, meetings, and webinars. An article about using electronic health records (EHRs) to identify patients at risk for diabetes was published in the online journal Perspectives in Health Information Management. In addition, the DPCP created a media campaign, which included TV, radio, print, and billboard advertisements. While the campaign was targeted to individuals at risk for diabetes, the advertisements reinforced information healthcare providers learned through the DPCP presentations.

Link to the journal article: http://perspectives.ahima.org/registry-based-diabetes-risk-detection-schema-for-the-systematic-identification-of-patients-at-risk-for-diabetes-in-west-virginia-primary-care-centers/#.U-4xW_IdV1Y

What was the State Health Department role?

- Developed tools to educate healthcare providers, administrators, and other health center staff
- Delivered presentations to Federally Qualified Health Centers, Free Clinics, and other groups and organizations
- Distributed CDC marketing materials among community clinics and organizations
- Educated health center CEOs and COOs about the evidence-based lifestyle change program and associated payment models/strategies
- Collaborated with the state’s media contractor to develop and produce a diabetes prevention media campaign

Achievements

- 5 Healthcare system partners
- 9 Healthcare delivery sites
- 37 Primary care health providers
- 16,332 Adult patients served by these providers
- 4,340 Radio commercials
- 62 Radio stations
- 70 Spots per station
- 1 million People reached through radio campaign



“The efforts led by the WV DPCP not only helped to raise awareness of diabetes but importantly raised awareness of and facilitated linkages with local programs designed to support diabetes prevention.”
Adam Baus, WVU OHSR

What positioned you for success?

- Dedicated Funding: \$64,000
- Existing healthcare provider educational tools
- Previous experience with successful state diabetes and smoking awareness campaigns
- Partnerships with West Virginia University Office of Health Services Research (WVU OHSR) and health centers

Print advertisement created for the media campaign

WEST VIRGINIA

How did you present information on diabetes prevention to raise awareness?

The DPCP modified existing PowerPoint slides to create three slide decks for use at in-person presentations and webinars. The presentation format was largely discussion-based accompanied by slides. Posters, referral forms, and CDC-developed provider brochures were distributed to attendees. Most presentations focused on awareness of prediabetes, the evidence-based lifestyle change program, and healthcare provider referral. In addition, the DPCP created an academic poster and published an article. The poster, which was displayed at several conferences, showcased the results of a pilot lifestyle change program provided to West Virginia Bureau for Public Health staff. Of the 13 pilot program participants, 7 (53.8%) achieved at least 5% weight loss, 5 (38.5%) exceeded the 7% weight loss goal, and 3 (23%) achieved 150 minutes physical activity per week. The average percentage of body weight lost was 5.6%. The article demonstrated the viability of patient registry software for identification of individuals at risk for diabetes. Furthermore, the DPCP contracted with the West Virginia Primary Care Association (WV PCA) to develop and implement a healthcare provider webinar. Using a variety of formats, the DPCP was able to reach healthcare providers, insurers, employers, county health department staff, health and quality improvement professionals, and health center administrators and staff. Simultaneously, the media campaign increased awareness of risk factors and advertised the DPCP's website (<http://www.wvdiabetes.org>), which contained prediabetes information and evidence-based lifestyle change program listings. The printed advertisements used bright colors to draw attention to diabetes risk factors and listed the evidence-based lifestyle change program as a solution. Two versions were created, highlighting general and pregnancy-specific risk factors.

Challenges and Solutions

- Providers wanted to know the location of evidence-based lifestyle change program sites in their area. The DPCP did not have a coordinated way to collect or provide this information.

Evidence-based lifestyle change program providers were given the option to include their information on a Google Map created by a local health department and linked to the DPCP's website.

- Limited number of DPCP staff and lack of time among clinic staff/providers was a barrier to delivering presentations.

Meetings were scheduled as soon as both partners were able to meet.

- State contracting to develop a provider webinar was delayed.

Worked with WV PCA to discuss options for delivering provider education due to delays

What were the factors for success?

- Formed partnerships with health systems and health centers
- Utilized partnerships with organizations representing healthcare providers to expand reach
- Discussion-based format captured the audience's attention by making the presentation interactive and relevant
- Strengthened alliance with WV PCA to focus attention on prediabetes among health centers and providers and staff

Partners

- West Virginia University Office of Health Services Research
- West Virginia Primary Care Association
- Health centers
- Media contractor for West Virginia Department of Health and Human Resources

For More Information

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STRATEGIC FOCUS AREAS



Inreasing Referrals

As we evaluated the project, it became apparent that there were themes with organizational or implementation tactics that facilitated the states' work in these two strategic focus areas. We called these "facilitating factors." Similarly, there were themes with barriers to success the states encountered. The following is a brief overview of some of the most common facilitating factors and barriers.

- **Strategic Focus Area C**

Strategies for working with healthcare providers to increase referrals to the evidence-based lifestyle change program

- **Strategic Focus Area D**

Strategies for developing and implementing systems for referral of people with prediabetes or at high risk for type 2 diabetes to sites offering the evidence-based lifestyle change program

Facilitating Factors

- Provided funding to support referral process/system
- Established partnership with a known referral system
- Established relationships with health care clinics and providers
- Identified benefits from the provider's perspective
- Added new and diversified partnerships
- Frequently communicated with partners and contractors to tailor the effort and problem-solve

Barriers

- Project timeframe was too short to:
 - Contract
 - Establish relationships
 - Understand the clinic's structure
 - Develop referral processes and systems
 - Implement referral processes and systems
 - Collect referral data
- Challenges to get entre to healthcare providers/clinics
- Loss of resources
 - Staff
 - CDC funding

Results

Strategic Focus Area C: Healthcare Provider Referral	
Indicator	Total
Number of healthcare system partners/referral systems	51
Number of healthcare delivery sites within the system partners (e.g. clinic/practice)	187
Number of primary care health providers (physicians, PA, and NP) in participating delivery sites	1,374
Number of adult patients served by participating healthcare delivery sites	529,934
Optional indicator: Number of adult patients in participating healthcare delivery sites referred to an evidence-based lifestyle change program	947
Strategic Focus Area D: Referral System	
Indicator	Total
Number of system partners (overall system)	32
Number of adults with prediabetes living in geographic area covered by the referral system(s)	3,357,416
Optional indicator: Number of adults referred to an evidence-based lifestyle change program through the newly created referral system(s)	261

MICHIGAN



How did you work with healthcare providers to increase referrals to the evidence-based lifestyle change program?

The Michigan Diabetes Prevention and Control Program (DPCP) funded a small pilot project with six evidence-based lifestyle change program providers. The goal was to increase healthcare provider referrals to the lifestyle change program. These pilot partners worked with healthcare offices, practices, and organizations to institute strategies to support and sustain provider referrals. Three partners also worked with local health department programs through Maternal/Child Health and WIC clinics and WISEWOMAN programs. Their efforts increased healthcare provider identification and referral of patients who could benefit from the lifestyle change program.

What was the State Health Department role?

- Engaged six evidence-based lifestyle change program providers to implement pilot referral project
- Shared CDC and other healthcare focused materials with pilot partners
- Provided technical assistance to pilot partners as they established relationships with healthcare providers and implemented referral processes
- Linked pilot partners to a healthcare provider referral expert for training and follow-up technical support
- Identified and facilitated relationships with state health department programs equipped to institute referral processes
- Clarified definition of referral system and desired outcome of the pilot project

Achievements

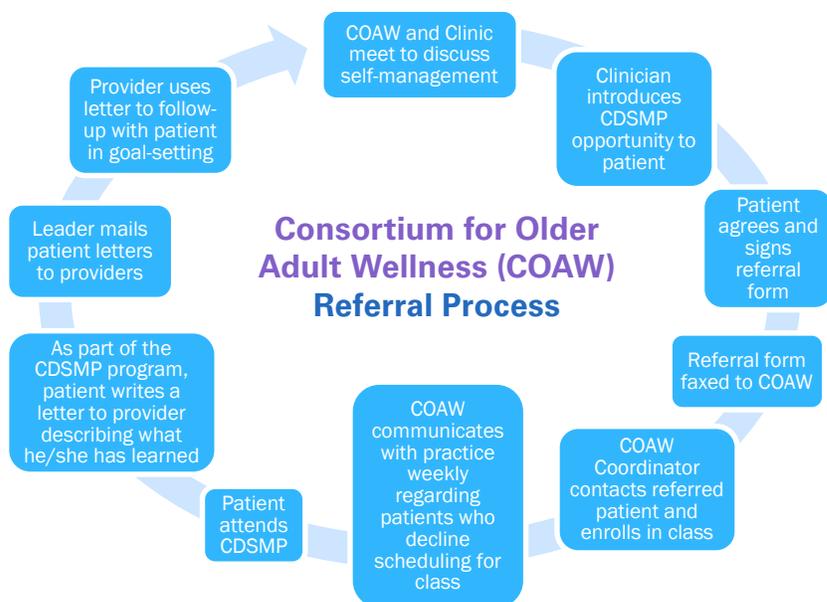
19 Healthcare system partners

88 Healthcare delivery sites

220 Primary care providers at participating sites

76,923 Adult patients served by participating healthcare delivery sites

126 Adult patients in participating healthcare delivery sites referred to evidence-based lifestyle change program



“Working with healthcare providers on referring their under-activated patients can change the mindset of the practice on the power of self-management support....not to mention transforming the life of the patient.”

Lynzy McIntosh, COAW

What positioned you for success?

- Dedicated Funding: \$32,500
- Established network of committed partners that included evidenced-based lifestyle change program providers, Michigan Department of Community Health programs, and state and national organizations interested in working on diabetes prevention efforts
- Experience working with healthcare providers to increase referrals to the Stanford Chronic Disease Self-Management Program

This Chronic Disease Self-Management Program (CDSMP) referral process was shared by the healthcare provider referral expert. Pilot partners could adapt this process for the evidence-based lifestyle change program.

Source: Consortium for Older Adult Wellness

MICHIGAN

How did you establish referral processes at healthcare provider practices?

The DPCP partnered with six evidence-based lifestyle change program providers to pilot test referral processes. The primary intent of the pilot project was to establish local relationships with healthcare organizations and practices and to build sustainable systems to drive referrals to the evidence-based lifestyle change program. First, the pilot partners identified healthcare providers that were likely to be receptive to diabetes prevention programming. The partners contacted practices through phone calls, e-mail, and in-person meetings and presentations. Targeted educational/awareness materials, including the CDC provider brochure, were utilized. Once they had buy-in, the pilot partners worked with practice staff to identify and implement referral processes or tools. Methods varied across practices. Many began to use referral forms/logs and display consumer-focused marketing materials in exam rooms.

Throughout the project, the DPCP helped troubleshoot and assure movement toward institution of referral processes. The DPCP provided technical assistance mainly through phone calls, including a formal review call two months after contract initiation. In addition, the DPCP arranged for a referral system expert, Lynnzy McIntosh, to consult with pilot partners. Ms. McIntosh explained that before healthcare providers will refer, they must have an understanding of the program, trust in its evidence and credibility, trust in the relationships with the program provider, and receive regular updates on their referred patients. This advice greatly influenced the pilot partners' work. For example, one developed a feedback loop in which healthcare providers referring to the lifestyle change program received four letters about their patients' progress. A registration letter informing the referring provider of patient enrollment, 8- and 16-week updates, and an overall evaluation at program end were sent.

What were the factors for success?

- Built or expanded relationships with healthcare provider offices, practices, and organizations
- Four pilot partners worked with their existing healthcare partners
- Utilized messages and materials that were relevant to healthcare providers
- Achieved healthcare provider understanding of and trust in the evidence-based lifestyle change program
- Expert provided practical applications of key concepts and follow-up technical assistance as pilot partners worked with this project
- Created referral processes that were sustainable

Challenges and Solutions

- Evidence-based lifestyle change program providers needed a clear definition of a referral system and what constitutes a successful outcome.

The DPCP provided additional education and technical assistance to assure lifestyle change program providers understood definitions, outcomes, and processes needed to achieve sustainable relationships with provider practices.

- Project timeline allowed for implementation of provider referral processes but was too short to demonstrate long-term outcomes.

While the data shown here reflects the project time period, the referral processes are in place and will continue.

- Pilot partners were unsure of all the steps in the referral process and what was needed for ongoing capacity and sustainability.

These pilot partners were encouraged to be prepared with actionable next steps and adapt established referral processes to fit the lifestyle change program.

Partners

- Pilot partner organizations
 - District Health Department #10
 - Hurley Medical Center
 - MedNetOne Health Solutions
 - Michigan State University Extension
 - University Pharmacy
 - YMCA of Marquette County
- Healthcare provider offices, practices, and organizations

For More Information

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See Michigan Story G for more information on the Michigan Diabetes Prevention Network

MINNESOTA



How did you increase healthcare provider referrals to the evidence-based lifestyle change program?

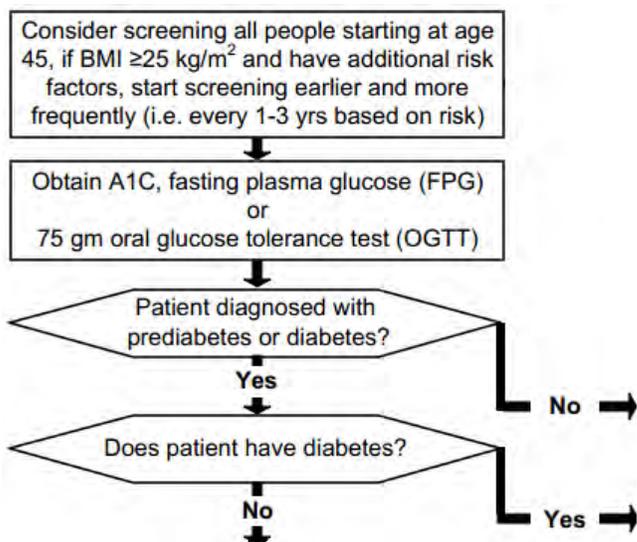
The Minnesota Department of Health (MDH) worked with healthcare providers and staff at 24 clinics involved in the We Can Prevent Diabetes (WCPD) Minnesota project. This Centers for Medicare and Medicaid Services (CMS)-funded project uses the YMCA Diabetes Prevention Program (Y-DPP) as its evidence-based lifestyle change program and tests the effects of incentives on attendance and weight loss among Medicaid enrollees in the Y-DPP. Through existing partnerships, the MDH worked synergistically with WCPD clinics to increase provider awareness and incorporate community feedback to support enrollment in the Y-DPP. The MDH used CMS funds to provide clinic trainings as part of the WCPD project. State Diabetes Prevention Project funds were used to support healthcare provider discussions about identification of patients with prediabetes, referral to the Y-DPP, and how to tailor recruitment strategies for diverse communities.

What was the State Health Department role?

- Formed strategic partnerships with and provided guidance to WCPD healthcare organizations and their clinics to increase referrals to the evidence-based lifestyle change program
- Contracted with an experienced consultant to facilitate healthcare provider discussions at WCPD clinics
- Provided current information to the WCPD clinics, including an updated prediabetes treatment and referral algorithm, provider referral card, and a list of evidence-based lifestyle change program providers
- Invited WCPD clinics to attend community conversations with African American, American Indian, Latino, Asian/Hmong, and Somali groups
- Worked with WCPD clinics to plan and conduct community health and resource fairs aimed at increasing referrals to the evidence-based lifestyle change program

Achievements

- 13** Healthcare system partners
- 24** Healthcare delivery sites
- 114** Primary care health providers
- 48,679** Adult patients served by these providers
- 560** Adult patients referred to evidence-based lifestyle change program
- 7** Provider discussions
- 88** Healthcare providers attended discussions



Excerpt from the Minnesota prediabetes screening and algorithm (see link on following page for complete algorithm)

“Each participating clinic receives funds for a support staff position responsible for recruitment and enrollment in the WCPD study. This person works with providers and other clinic staff to develop policies and systems for referral to the Y-DPP. This position is important for success.”

Gretchen Taylor, MDH

What positioned you for success?

- Dedicated Funding: \$42,656
- Centers for Medicare & Medicaid Services grant funding for the WCPD project
- Connections to healthcare systems and clinics participating in the WCPD project
- Experience with the evidence-based lifestyle change program
- Awareness of cultural commonalities and differences

MINNESOTA

How did you implement healthcare provider discussions?

To generate healthcare provider referrals at WCPD clinics, the MDH held provider discussions facilitated by a contract consultant who is a well-known Certified Diabetes Educator. Slides used during discussions were adapted from a healthcare provider webinar, which highlighted a healthcare provider toolkit and a recently updated prediabetes screening and treatment algorithm (<http://icanpreventdiabetes.org/health-provider-toolkit/>). The discussions provided a forum to explore barriers as well as policy or practice changes for referring patients to the evidence-based lifestyle change program. Policy or system changes varied and included use of:

- Electronic medical records to flag patients at risk for prediabetes based on an algorithm
- Standing orders for labs so that patients at risk for prediabetes could be screened immediately
- Risk assessment screening tools
- Clinic flow sheets outlining steps from identification to enrollment in the lifestyle change program
- WCPD clinic coordinators to explain the program to patients at risk for prediabetes
- Positive language to describe the program

Several tools were developed as a result of the discussions, including a 3 x 5 inch provider pocket card, patient handouts translated into three languages, and risk assessment pads. In addition, new insights obtained from conversations with five ethnic communities were shared during provider discussions. With respect for providers' knowledge of their patient populations, these insights were used to strategize ways to recruit patients from diverse communities. The MDH also invited WCPD clinics to attend the community conversations to learn about culturally acceptable recruitment, enrollment, and implementation of evidence-based lifestyle change programs. Clinics added value to the discussion by sharing their perspective about the patient populations they serve. Furthermore, the WCPD clinic coordinators formed a partnership to increase referrals within and across each of their clinics. The MDH hosted partnership meetings, which was helpful for scheduling provider discussions and moving forward with policy and practice changes.

What were the factors for success?

- Facilitated learning opportunities between WCPD clinics, providers, and coordinators across systems and sites
- MDH WCPD Project Coordinator established and strengthened relationships with WCPD clinics
- Accessed WCPD clinic coordinator partnership to schedule provider discussions and strengthen referral processes
- WCPD clinic coordinators passionately promoted the evidence-based lifestyle change program and diabetes prevention
- Utilized insight from community conversations to strategize for program recruitment and implementation

Challenges and Solutions

- Not all WCPD clinics had a robust referral system.
 - As a result of the provider discussions, six clinics developed and implemented prediabetes identification and referral processes that included referral to the evidence-based lifestyle change program.
- WCPD clinics working to promote and refer patients to the lifestyle change program reported challenges engaging patients in a year-long program.
 - WCPD Project Coordinator coached individual clinic staff responsible for recruiting about how to reframe the program as "a year of support."
 - Role playing and a brief tutorial on motivational interviewing were used to teach clinic staff how to highlight the positive aspects of the program.
- WCPD clinic coordinators expressed difficulty generating referrals among certain communities due to a lack of diverse coaches, cultural beliefs, and timing of religious practices.

MDH used feedback from community conversations to tailor their approach to recruitment; examples include: seeking out representatives from communities to be trained as coaches, scheduling classes around holidays, and focusing on provider referral to increase enrollment

Partners

- We Can Prevent Diabetes/ Medicaid Incentives for Prevention of Chronic Disease project clinics and clinic coordinators
- Contract consultant

For More Information

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See *Minnesota Story A* for more information on the community conversations

See *Minnesota Story B* for more information on healthcare provider awareness of prediabetes and the evidence-based lifestyle change program

NEW YORK



How did you work with healthcare providers to increase referrals to the evidence-based lifestyle change program?

To facilitate healthcare provider referral, the New York Diabetes Prevention and Control Program (DPCP) identified multiple pathways for referral. The New York State (NYS) Quality & Technical Assistance Center (QTAC) included the evidence-based lifestyle change program in a newly developed consumer portal. In addition, the DPCP and the P² Collaborative of Western New York (P² Collaborative) provided information and resources on diabetes prevention to two information and referral lines: 2-1-1 Western New York (WNY) and NY Connects. Both added the evidence-based lifestyle change program to their referral databases and were connected to the QTAC portal. Through academic detailing and a healthcare provider toolkit, the P² Collaborative engaged medical practices to consistently use these new referral systems.

What was the State Health Department role?

- Contracted with the P² Collaborative and QTAC to facilitate healthcare provider referrals through information and referral centers
- Assisted QTAC in building an online portal to promote the evidence-based lifestyle change program
- Solicited evidence-based lifestyle change program providers to join the QTAC portal
- Encouraged evidence-based lifestyle change program providers to submit program information to 2-1-1 WNY and NY Connects
- Facilitated strategic meetings and trainings with providers, health care system groups, and community organizations
- Built linkages with hospitals, health plans, provider groups, and community organizations through the Community Health Improvement Planning Process in all eight WNY counties
- Utilized new relationships with large health system partners to develop a foundation for diabetes prevention referral processes
- Acted as a neutral convener between all partners promoting the evidence-based lifestyle change program

Links to Referral Systems

2-1-1 WNY: <http://www.211wny.org/>
 NY Connects: <https://ny.getcare.com/>
 QTAC: <https://www.ceacw.org/find-a-workshop>

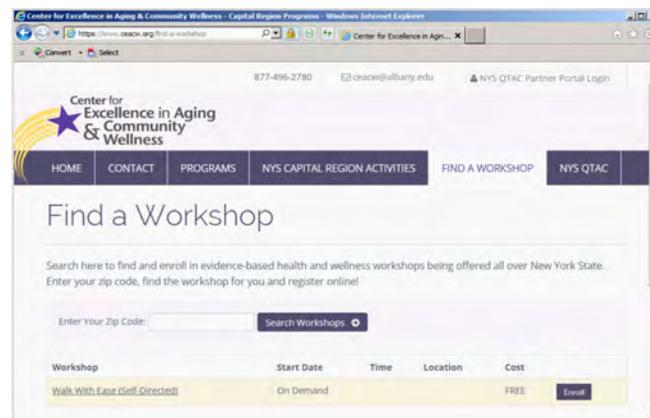
Achievements

- 15** Healthcare system partners
- 22** Healthcare delivery sites
- 700** Primary care providers
- 143,000** Adult patients served by participating healthcare delivery sites

Screenshot of the QTAC portal for referral and enrollment

What positioned you for success?

- Dedicated Funding: \$25,000
- Contract with QTAC to build capacity, establish infrastructure, and increase access
- Existing NYS clinical prediabetes algorithm
- Partnership with the P² Collaborative



NEW YORK

How did you create a healthcare provider referral system to cover all eight Western New York counties?

The DPCP created a fully functional healthcare provider referral system in three steps. First, the DPCP contracted with QTAC and the P² Collaborative to develop referral systems. To connect people to the evidence-based lifestyle change program, QTAC used an online portal and the P² Collaborative added the lifestyle change program to two existing information and referral systems: 2-1-1 WNY and NY Connects. 2-1-1 WNY is a confidential phone number that connects people to free or low-cost services in Western New York. NY Connects provides information and assistance on long term care so that people of all ages can remain independent. Both information and referral systems were set up to connect to the QTAC portal. The P² Collaborative trained call center representatives from both organizations. Second, the DPCP linked healthcare systems and providers to the QTAC portal, 2-1-1 WNY, and NY Connects. All three were advertised in the healthcare provider toolkit, and the toolkits were disseminated to practices across Western New York. A kickoff event was held to introduce 150 health plan staff and healthcare providers to the referral systems. Third, the DPCP worked with community organizations to ensure lifestyle change program availability in all communities, including those at greatest risk. This gave healthcare providers confidence that their referrals would indeed connect patients to a lifestyle change program that was easily accessible to them. Through these three steps, the DPCP facilitated healthcare provider referral by providing multiple points of entry for referrals.

Challenges and Solutions

- Some healthcare providers were reluctant to use the referral system if there were geographic gaps in evidence-based lifestyle change program availability or if their patients were unable to afford the program.

Worked with two county Offices for the Aging and other community organizations to develop the capacity to implement the evidence-based lifestyle change program in these areas

Met with health plans to explore reimbursement options and other ways to financially support implementation of the evidence-based lifestyle change program

“Public health and community partners must work together to increase prediabetes awareness and create demand for the lifestyle change program to tip the scales against the type 2 diabetes epidemic.”

Sue Millstein, NY DPCP

What were the factors for success?

- Made county-level connections through the Community Health Improvement Planning Process
- Formed strong partnerships with healthcare providers across Western New York
- Expanded reach from two counties to eight due to the P² Collaborative’s strong infrastructure
- Built community capacity to reach high risk communities in response to NYS Medicaid mandate that health plans provide programs to a certain percentage of their members
- Identified benefits from a provider’s perspective

Partners

- New York State Quality & Technical Assistance Center
- P² Collaborative of Western New York
- 2-1-1 Western New York
- NY Connects
- County Offices of the Aging

For More Information

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See *New York Stories A and B* for more information on the toolkits

WASHINGTON



How did you increase healthcare provider referrals to the evidence-based lifestyle change program?

The Washington Healthcare Improvement Network (WHIN) offers training and improvement coaching to support primary care providers and practices in behavioral health/medical home development. Provider referral to evidence-based community programs is a part of the behavioral health/medical home model. The Washington Diabetes Prevention and Control Program (DPCP) and WHIN staff worked with providers enrolled in the WHIN project to increase referrals to the evidence-based lifestyle change program. Their work was focused on raising provider awareness and developing referral processes. The DPCP also helped Washington State University (WSU) Extension align its diabetes prevention efforts with the WHIN project. With the DPCP's support, WSU Extension trained lifestyle coaches to serve counties with WHIN primary care practices. WHIN practices were encouraged to refer to the evidence-based lifestyle change program sessions provided by these newly trained coaches.

What was the State Health Department role?

- Collaborated with the WHIN staff to integrate prediabetes awareness and referral into the WHIN project
- Developed a provider brochure to increase prediabetes awareness
- Provided consultation and consumer-focused materials to the WHIN primary care practices
- Encouraged WSU Extension to align their diabetes prevention efforts with the WHIN project
- Facilitated connections between evidence-based lifestyle change program providers, WHIN primary care practices, and other referral sources/community providers

Achievements

- 1 Healthcare system partner
- 45 Healthcare delivery sites
- 308 Primary care health providers
- 250,000+ Adult patients served by these providers
- 5 Counties with primary care teams enrolled in the WHIN project
- 38% of Washington counties offered the lifestyle change program



Washington Healthcare Improvement Network

A Statewide Pathway for Patient-Centered Medical Health/Medical Home Development

Washington State Department of Health coordinates the Washington Health Improvement Network (WHIN) partnership with multiple organizations. The WHIN Institute offers self-paced training and support for primary care and behavioral health medical/health home development.

For more information on WHIN, visit: <http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/ProfessionalResources/WashingtonHealthcareImprovementNetwork>

What positioned you for success?

- Dedicated Funding: \$20,000
- Extensive experience and a strong reputation for working with healthcare providers to improve quality of care
- Access to Washington Department of Health's WHIN project
- Long-standing, statewide network of organizations supporting the DPCP and its work
- Partnership with WSU Extension

WASHINGTON

How did you promote referrals among WHIN primary care practices?

The DPCP partnered with the WHIN project to promote prediabetes awareness and provider referrals. The DPCP and WHIN's efforts were aimed at primary care providers, case managers, and office systems managers. WHIN primary care practices were encouraged to embed processes for referral to the evidence-based lifestyle change program into their clinical decision systems. This could assist healthcare practices in achieving Patient Centered Medical Home (PCMH) recognition from the National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) Stage 2 Meaningful Use. Referral to and participation in the lifestyle change program satisfies PCMH criteria, including: providing educational resources or assisting in self-management, using EHR to identify patient-specific education resources, and developing and documenting self-management goals in collaboration with patients.

The DPCP also helped providers become more comfortable with referring to the evidence-based lifestyle change program and talking about the program in positive and realistic ways. Washington Information Network 211 (WIN211) was available for patients and providers to find a nearby lifestyle change program. In areas without evidence-based lifestyle change program providers, the DPCP worked with WSU Extension to train coaches and offer the lifestyle change program. The DPCP connected these newly trained lifestyle coaches to primary care practices enrolled in the WHIN project.

Furthermore, the DPCP used various methods to encourage WHIN primary care practices to focus on prediabetes. They attended the WHIN kickoff meeting, displayed materials, and made initial contacts. The DPCP also presented a webinar to WHIN practice providers and worked with WHIN staff to create an online learning system to reach providers statewide.

What were the factors for success?

- Collaborated with the Washington Department of Health WHIN project
- Utilized a stepwise set of strategies to engage WHIN primary care practices
- Attended the WHIN kickoff meeting and made initial contacts
- Created/presented a webinar to WHIN teams
- WHIN partners invested in an online learning system to educate healthcare providers statewide
- Linked WHIN primary care providers to an established mechanism for referrals (WIN211)
- Partnered with WSU Extension to assure the evidence-based lifestyle change program was offered in all WHIN counties

Challenges and Solutions

- Loss of essential staff increased the workload for remaining staff.
 - Remained committed to this project and sought alternative resources
- DPCP was not able to meet with practices prior to their enrollment in the WHIN project.
 - Met with WHIN colleagues to discuss ways to reach practices and next steps
- Initially the WHIN project focused on small community health practices, which do not have a large reach.
 - As the healthcare landscape becomes more stable, WHIN will consider working with larger health systems to serve more people.

Partners

- Washington Healthcare Improvement Network
- State staff
- Primary care practices and providers
- Washington State University Extension

For More Information

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WEST VIRGINIA



How did you generate healthcare provider referrals to the evidence-based lifestyle change program?

The West Virginia Diabetes Prevention and Control Program (DPCP) worked with three health centers to pilot test a diabetes prevention referral system. The aim was to embed referral processes, including prediabetes identification and evidence-based lifestyle change program referral, into the delivery systems currently used by healthcare providers. These processes helped providers engage in conversations with patients about prediabetes risk and inform them about how they might benefit from the evidence-based lifestyle change program.

What was the State Health Department role?

- Selected three pilot sites to test the referral system
- Provided CDC risk assessment, marketing materials, and talking points to health centers and evidence-based lifestyle change program providers
- Identified metrics of interest for health centers, such as how referrals fulfill the goals of Centers for Medicare and Medicaid Services Stage 2 Meaningful Use and Patient Centered Medical Home (PCMH) models
- Encouraged the development of formalized and clear policies, procedures, and partner roles for each referral system
- Convened meeting of trained coaches and other diabetes prevention partners to address barriers and solutions learned in implementing the evidence-based lifestyle change program
- Maintained ongoing communication with health centers to discuss issues and successes of the referral process
- Assessed the utilization of diabetes prevention referral processes within pilot sites

Achievements

- 3** Healthcare system partners
- 8** Healthcare delivery sites
- 32** Primary care health providers
- 11,332** Adult patients served by these providers
- 2,270** Adult patients identified as at-risk for prediabetes
- 261** Adult patients referred to evidence-based lifestyle change program



"We have more energy! We feel a lot better! We are both in the Group Life-Style Balance Program at work and have each lost 34 pounds! We love it!"
 Lisa & Robert Adams

"Most of the health centers did not have to change their current referral system to incorporate referrals to the lifestyle change program. This effort promises to be very sustainable."

Jessica Wright, WV DPCP

What positioned you for success?

- Dedicated Funding: \$109,000
- Partnerships with health centers
- Partnerships with evidence-based lifestyle change program providers
- Access to health center electronic health records via the West Virginia University Office of Health Services Research (WVU OHSR)

WEST VIRGINIA

How did you individualize referral processes for health centers?

The DPCP partnered with three health centers to pilot the referral system. At project onset, the DPCP met with health center leadership to discuss how to address prediabetes in their patient population. Two factors facilitated health center buy-in: 1) better understanding of prediabetes and its impact on their patients, and 2) recognition that referral processes could help them achieve PCMH status or Meaningful Use goals. In order to accommodate the unique needs of each health center, the DPCP worked with them independently and suggested modifications to their current referral processes. While these varied, the overall system sought to first select start dates for the evidence-based lifestyle change program then refer eligible patients. The DPCP and WVU OHSR also applied an algorithm to mine electronic health record (EHR) data in order to help identify at-risk patients. The referral processes were evaluated throughout the project and revised as needed. A key revision was closing the “feedback loop.” The DPCP helped establish center-specific procedures to provide feedback to referring healthcare providers, including the type of information and frequency of feedback. Part of this process was the creation of a referral form that obtained patient consent to release information about their progress back to their referring provider. This change helped to sustain the referral processes by letting health centers and providers see the successes of the patients and the program.

What were the factors for success?

- Achieved necessary buy-in from pilot partners
- Tailored modifications to the health centers’ current referral processes to allow for often minimal changes palatable to their healthcare providers
- Provided individual support to meet each health center’s unique needs
- Evaluated and adapted processes continuously to adjust for challenges
- Recognized how provider referrals can meet PCMH standards, achieve Meaningful Use goals, and fit Affordable Care Act provisions
- Developed feedback protocol that aided in closing the “feedback loop”
- Facilitated the addition of the evidence-based lifestyle change program to the list of referrals within EHRs in order to create referrals electronically
- Developed a process whereby EHR data was exported to a patient registry and analyzed to identify patients at risk for prediabetes/diabetes

Challenges and Solutions

- Participant progress was not relayed back to their providers.

[Worked with the evidence-based lifestyle change program partners to close the feedback loop and supply patient information to the referring healthcare provider](#)

- Some health centers voiced difficulty in recruiting patients who would commit to the program.
- Providers wanted to know the location of evidence-based lifestyle change program sites in their area. The DPCP did not have a coordinated way to collect or provide this information.

[Evidence-based lifestyle change program providers were given the option to include their information on a Google Map created by a local health department and linked to the DPCP’s website.](#)

Partners

- West Virginia University Office of Health Services Research
- Community Health Centers and Free Clinics

For More Information

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See West Virginia Story D for more information on referral system development

COLORADO



How did you create referral systems for the evidence-based lifestyle change program?

To increase referrals to the evidence-based lifestyle change program, the Colorado Department of Public Health and Environment (CDPHE) established two referral systems.

- Self-referral: The American Diabetes Association (ADA) agreed to incorporate the evidence-based lifestyle change program in their hotline (1-800-DIABETES) and refer Colorado callers to the program.
- Healthcare Provider Referral: CDPHE partnered with HealthTeamWorks, a quality improvement organization, to offer health centers “Rapid Improvement Activities (RIAs)” to educate the health center staff about prediabetes and the evidence-based lifestyle change program and to establish a provider-initiated referral system. RIAs are similar to academic detailing.

What was the State Health Department role?

- Coordinated efforts to add the evidence-based lifestyle change program to the ADA consumer hotline
- Adapted marketing materials to include the ADA hotline
- Supported ADA hotline staff through training and providing up-to-date information on Colorado organizations offering the evidence-based lifestyle change program
- Acted as a liaison between HealthTeamWorks, health centers participating in RIAs, and evidence-based lifestyle change program providers
- Established tracking mechanisms to evaluate use of the referral systems
- Hosted an evaluation workshop and provided technical assistance on tracking referrals to the evidence-based lifestyle change program providers

Achievements

2 Referral system partners

1.3 million Adults with prediabetes living in the geographic area covered by the referral systems

100% Of the evidence-based lifestyle change programs with “pending recognition” status were listed on the ADA hotline

11 Health centers completed Rapid Improvement Activities

“The American Diabetes Association is pleased to partner with CDPHE to promote and enroll patients in the National Diabetes Prevention Program through our 1-800-Diabetes hotline. The partnership aligns with one of the Association’s strategic priorities to improve outcomes for people with prediabetes.”

Sue Glass, ADA



What positioned you for success?

- Dedicated Funding: \$35,000
- Partnerships with ADA and evidence-based lifestyle change program providers
- Existing contract with HealthTeamWorks to execute RIAs

COLORADO

How did you implement each referral system?

Self-referral: CDPHE's relationship with the ADA Colorado office helped them establish a partnership with the ADA hotline to add the evidence-based lifestyle change program to their national hotline database. CDPHE trained hotline staff at ADA's Center for Information and Community Support (CICS) to refer callers from Colorado seeking information on the lifestyle change program to a program near them. CDPHE contacted the Senior Manager at CICS monthly to share information about new organizations offering the evidence-based lifestyle change program, evaluate the number of callers asking about prediabetes, and troubleshoot the referral process.

Healthcare provider referral: CDPHE contracted with a quality improvement organization, HealthTeamWorks, to develop and implement Rapid Improvement Activities in health centers. The RIAs focused on increasing healthcare provider awareness of the importance of screening for prediabetes and referrals to the evidence-based lifestyle change program. Each RIA included facilitation of a one-hour, onsite training provided by a quality improvement coach from HealthTeamWorks. The coach provided monthly follow-up to assess progress on implementation and offer ongoing technical assistance. In addition, CDPHE hosted an evaluation workshop and webinar for evidence-based lifestyle change program providers. At these events, program providers were encouraged to continue communication with health centers and establish a "feedback loop" for referring healthcare providers to receive information on their patients' progress in the lifestyle change program. Establishment of a "feedback loop" allows providers to see their patients' success in the program and can help sustain the referral system.

Challenges and Solutions

- Scheduling RIAs with clinics was difficult because the quality improvement organization wanted the evidence-based lifestyle change program provider to make the first introduction to the clinic.

Despite state communication to evidence-based lifestyle change program providers about the value of the RIAs, program providers did not schedule RIAs until one provider that completed an RIA confirmed its value to others.

- Needed a formal mechanism to evaluate the impact of the healthcare provider referral system
 - Held an evaluation workshop to help evidence-based lifestyle change program providers track and report referrals*
- Media campaign for ADA hotline did not start until late into the project.
 - Planned to continue and expand the media campaign using new federal funds*

What were the factors for success?

- Used relationship with Colorado ADA office to initiate partnership with the national ADA hotline
- Maintained regular communication between CDPHE and ADA hotline
- Advertised the ADA hotline throughout the media campaign
- Trained evidence-based lifestyle change program providers on establishing a "feedback loop" with referring healthcare providers

Partners

- American Diabetes Association, Colorado
- HealthTeamWorks
- Evidence-based lifestyle change program providers
- Health centers participating in RIAs

For More Information

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See Colorado Story A for more information on the media campaign

MICHIGAN



How did you work to establish referral systems to the evidence-based lifestyle change program?

Two evidence-based lifestyle change program providers, YMCA of Marquette County and the National Kidney Foundation of Michigan, strived to establish referral systems in large health systems. Both provider agencies were awarded small subcontracts by the Michigan Diabetes Prevention and Control Program (DPCP) to develop at least one referral process in a healthcare system, linking healthcare providers to the lifestyle change program. The provider agencies used the six-month contract period to develop and enhance relationships with key decision makers in health systems and health plans. Although the timeframe was too short to fully integrate referral in large systems, the DPCP and both provider agencies continue to work toward this goal.

What was the State Health Department role?

- Identified and engaged two evidence-based lifestyle change program providers to establish referral systems with their health system partners
- Linked provider agencies to an expert in healthcare provider referrals for training and follow-up technical support
- Provided additional resources and technical assistance, which enabled provider agencies to focus staff time on building relationships with their health system partners

Achievements

- 6 Healthcare system partners
- 163,695 Adults with prediabetes living in the geographic area covered by the referral system

“Meetings with high level decision makers were made possible through the credibility and trust gained through the experience of delivering other evidence-based programming in the community.”

Richard Wimberley, MI DPCP



YMCA'S HEALTH INNOVATIONS PROGRAMS

I have diagnosed: _____
(please print)

WITH PREDIABETES BASED ON ONE OF THE FOLLOWING CRITERIA:

- A1c: 5.7-6.4%
- Fasting Plasma Glucose: 100-125 mg/dL
- 2-hr (75 gm glucola) Plasma Glucose: 140-199 mg/dL
- BMI = _____ (≥ 25) *Asian individuals BMI ≥ 22

OTHER RECOMMENDATIONS

- YMCA Diabetes Prevention Program
- LIVESTRONG at the YMCA LIVELISE
- Freedom From Smoking Nutrition Specialist
- Exercise Specialist Other

Print Name of Medical Professional _____ Signature _____

Participant Signature _____ Phone Number _____

What positioned you for success?

- Dedicated Funding: \$12,500
- Established network of partners that included evidence-based lifestyle change program providers, Michigan Department of Community Health programs, and state and national partners interested in working on diabetes prevention efforts
- Provider agencies had experience establishing relationships with health systems and credibility in their communities
- Michigan Quality Improvement Consortium had existing guidelines for diabetes prevention under Adult Preventive Services which reinforced referrals

Referral prescription pads given to health systems and plans by one evidence-based lifestyle change program provider

MICHIGAN

How did you work toward integrating referral systems?

The DPCP partnered with two evidence-based lifestyle change program providers to establish systems for referral to the lifestyle change program. Because they had established relationships with large health systems and credibility in delivering the lifestyle change program, the provider agencies gained access to decision makers at health systems and plans. When possible, the evidence-based lifestyle change program providers used key leaders within the health system or plan to broker meetings with decision makers. During meetings, the providers and decision makers discussed diabetes prevention and worked together to explore opportunities for developing a referral system. Both provider agencies encouraged their partners to add the evidence-based lifestyle change program as a covered health benefit for employees and individuals insured by health plans. While time did not allow this to occur during the grant period, evidence-based lifestyle change program providers and their partners identified tangible next steps for reaching this goal. For example, one provider offered to deliver the evidence-based lifestyle change program to health plan employees in order to get a foot in the door and demonstrate program benefits. The other provider gave its referral prescription pads to a Medicaid health plan and is working toward achieving a 100% referral rate. By project end, provider agencies had met with a total of five health systems and four health plans. They are moving forward in partnerships with three health systems and three health plans, optimistically looking toward full integration of referral systems in 2014.

In addition to providing funding, the DPCP provided technical assistance through phone calls, including one formal review call two months after contract initiation. Toward the beginning of the contract period, the DPCP arranged for a healthcare referral expert to speak with lifestyle change program providers and provide follow-up support. While the DPCP focused its work in this strategic focus area on health system and plans, they also saw an opportunity to facilitate self-referral. The DPCP provided Michigan Diabetes Prevention Network partners with information on establishing referral systems in 2-1-1 resource centers. Two of the Network's evidence-based lifestyle change program providers capitalized on this opportunity. As a result, the evidence-based lifestyle change program was included in 2-1-1 resource centers covering twelve Michigan counties.

For More Information

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See Michigan Story G for more information on the Michigan Diabetes Prevention Network

Challenges and Solutions

- Due to short time frame, establishing a complete, integrated referral system was not possible.

Both provider agencies worked smartly and diligently to build long-lasting relationships with health system partners, allowing them to continue work on this project.

- Health system partners were at different stages of readiness to adopt a referral system.

The two evidence-based lifestyle change program providers tailored information to each partner and continued to focus on relationship building.

What were the factors for success?

- Lifestyle change program provider agencies used their relationships and experience to gain entry to decision makers
- Both provider agencies utilized key leaders within health systems when conducting outreach
- Worked to build long-lasting relationships with health systems and health plans
- Provided regular follow-up with health systems

Partners

- Health systems and plans
- Michigan Diabetes Prevention Network
- National Kidney Foundation of Michigan
- YMCA of Marquette County

NEW MEXICO **A D E G**

How did you create a referral system for the evidence-based lifestyle change program?

To link people with prediabetes to evidence-based lifestyle change program providers, the New Mexico Diabetes Prevention and Control Program (DPCP) developed a dedicated website with referral information (<http://nmhealth.org/about/phd/cdb/dpcp/ndpp/>). The DPCP worked with the New Mexico Department of Health Information Technology (NM DOH IT) and a referral contractor to design the website, which features an interactive map and contact information for lifestyle change program providers. The website also contains information and resources for healthcare providers, including a prediabetes screening and treatment algorithm, a prediabetes screening test, and marketing and referral materials for the evidence-based lifestyle change program.

What was the State Health Department role?

- Contracted with the marketing agency to seek input from relevant stakeholders and research existing models in developing a referral system
- Worked with NM DOH IT and the contractor to design a website dedicated to prediabetes and the evidence-based lifestyle change program
- Coordinated efforts among key partners to establish a referral system for evidence-based programs, including the lifestyle change program
- Linked with New Mexico Health Care Takes On Diabetes to provide education and information for providers to refer patients

Achievements

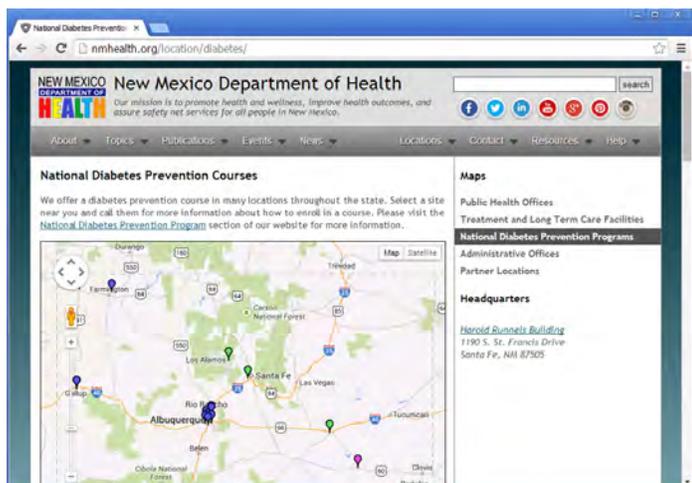
1 Online referral system covering **2** counties

An estimated **220,854** adults with prediabetes living in the area covered by the referral system (Bernalillo and Santa Fe Counties)

18 Evidence-based lifestyle change program sites listed on the referral system

“The planned integrated referral process within New Mexico will allow participants to seamlessly move from one evidence-based program to another, e.g. the lifestyle change program or chronic disease self-management programs. Referring providers can encourage their patients to enter this self-care system to access any of these programs. Participants are encouraged to enroll to support their ongoing prevention and/or self-management goals.”

Catherine A. Offutt, National DPP Lifestyle Coach and Manage Your Chronic Disease (MyCD) Program Director



Screenshot of the interactive map on the DPCP's website

What positioned you for success?

- Dedicated Funding: \$49,969
- Experience working with a contractor and NM DOH IT to design a state website
- Past collaboration with the New Mexico Primary Care Association and health center organizations on a health systems intervention

NEW MEXICO

How did you create an online referral system?

The DPCP worked with NM DOH IT and a contracted marketing agency to design a website to facilitate healthcare provider referral to the evidence-based lifestyle change program. Prior to the contract, the DPCP organized a marketing retreat and asked stakeholders to discuss healthcare provider referral. The DPCP also attended a webinar series on Patient Centered Medical Home presented by the National Association of Chronic Disease Directors (NACDD) and the Consortium of Older Adult Wellness (COAW). This resulted in the DPCP contacting the New Mexico Primary Care Association (NMPCA) for advice about increasing referrals. Following the NMPCA's advice, the DPCP plans to work with Federally Qualified Health Centers (FQHCs) as a primary referral source and will continue to work with NMPCA to connect with the FQHCs. In addition, the DPCP followed up with COAW to explore technical assistance/consultation about building a referral system in health center organizations.

The website was created as a referral system for healthcare providers and individuals at risk for diabetes. The website has five sections: 1) Understanding Prediabetes, 2) Identifying People at Risk, 3) Referring Your Patients, 4) Enrolling in the Program, and 5) Learning More. The enrollment section features an interactive map with contact information for current lifestyle change program providers in New Mexico. Along with the map, the DPCP produced several informational documents about prediabetes and the evidence-based lifestyle change program, which are available in the "Understanding Diabetes" section of the website. A prediabetes screening and treatment algorithm developed by the Minnesota Department of Health as well as marketing materials and a prediabetes screening test from the CDC are also posted on the website. The DPCP plans to promote the website in areas where there are existing evidence-based lifestyle change program providers, particularly in Bernalillo and Santa Fe counties.

What were the factors for success?

- Secured support from NM DOH IT to facilitate contract approval
- Contractor designed the DPCP's original website and was familiar with their program goals
- Stakeholders who attended the marketing retreat discussed best ways to elicit referrals from healthcare providers
- The NACDD/COAW webinar provided valuable information and ideas on how to develop and promote the referral system

Challenges and Solutions

- Contracting procedures took longer than expected which delayed referral system development.
 - **Divided the work between a referral system contractor and a marketing contractor in order to efficiently complete as much work as possible in the short amount of time remaining in the project**
- NM DOH IT had a change in priorities which delayed work on the website.
 - **Secured support from within the NM DOH to escalate the referral system as a priority**

Partners

- Cooney, Watson & Associates
- New Mexico Department of Health – Information Technology
- Evidence-based lifestyle change program providers
- New Mexico Primary Care Association

For More Information

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WASHINGTON



How did you create a statewide referral system that consumers will use?

The Washington Diabetes Prevention and Control Program (DPCP), as part of the state Heart, Stroke and Diabetes Program, partnered with Washington Information Network 211 (WIN211), a statewide referral system, to add the evidence-based lifestyle change program and other health education programs to the 211 database. The State linked the evidence-based lifestyle change program providers to WIN211 and helped them provide their program information to this statewide referral system. Partnering with WIN211 was a logical choice given its strong reputation within Washington. Washington residents can go to their website (www.win211.org) or call 2-1-1 to speak to live phone specialists who will provide information on diabetes prevention and the availability of an evidence-based lifestyle change program in their area.

What was the State Health Department role?

- Managed the WIN211 contract and served as the state point of contact for their staff
- Coordinated efforts to add the evidence-based lifestyle change program to WIN211 listings
- Promoted WIN211 as a referral system to other evidence-based providers and programs
- Communicated weekly with WIN211 management and staff to provide technical assistance and troubleshoot
- Encouraged new evidence-based lifestyle change program providers to provide program information to WIN211
- Adapted CDC marketing materials to include the WIN211 initiative
- Provided promotional materials for public outreach events
- Recognized the necessity to provide a bridge to diabetes self-management education (DSME) and diabetes prevention

Achievements

18 System partners

1.6 million Adults with prediabetes living in the area covered by the referral system

20 Evidence-based lifestyle change program listings on WIN211

33 DSME listings on WIN211

386 Outreach events

9,142 Promotional materials distributed by WIN211 staff

“With strong partnerships at the local and national level, we were able to develop a sustainable referral system for the evidence-based lifestyle change program in Washington. It wasn’t always easy, but having a shared vision, endurance, and funding made it work.”

Jeanne Harmon and Sara Eve Sarliker, WA DPCP

What positioned you for success?

- Dedicated Funding: \$110,000
- An existing statewide referral system, such as WIN211
- Ability to execute state contracts with partners

WASHINGTON

How did you leverage an existing referral system?

WIN211 is a statewide telephone system connecting residents with regional call centers for health and human services information. The State Health Department chose to partner with WIN211 because of its endorsement from the state legislature and its ability to reach residents statewide. Through work with the State, WIN211 added health education programs to their menu of resources. These included evidence-based programs (EBPs) such as the evidence-based lifestyle change program, DSME, and the Stanford Chronic Disease Self-Management Program. Information was added to the WIN211 website and provided through their telephone hotline. Because WIN211 was well-developed and well-known within the state, adding the health education content was simple and cost-effective. In order to promote the evidence-based lifestyle change program and the WIN211 referral system, the State Health Department modified CDC diabetes prevention awareness materials to include a "Call WIN211 logo" and message. These materials were then distributed by WIN211 call center staff at outreach events and by request.

What were the factors for success?

- Utilized a well-known and reputable referral system that was endorsed by the state legislature as the official state referral system
- Tailored existing CDC awareness materials for the audience and used them to promote diabetes prevention awareness and the WIN211 system
- Maintained close contact with WIN211 management and staff to troubleshoot any issues
- Washington Diabetes Network Leadership Team supported the project

For More Information

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Challenges and Solutions

- Organizations were unsure of the value of being included in WIN211 listings.
 - Helped organizations without prior experience with WIN211 see the value; soon others followed
- Loss of some essential staff due to CDC budget cuts caused setbacks in promotion.
 - Incorporating efforts to promote other EBPs opened new funding avenues
- The submission of new programs to the WIN211 listings was slow.
 - WIN211 staff initiated calls to invite EBP providers to add their program information to the WIN211 database.

Partners

- Washington Information Network 211
- Evidence-based lifestyle change program providers
- Other evidence-based program partners and providers
- Washington State Diabetes Network

**YOU CAN
MAKE A CHANGE
FOR LIFE**



WEST VIRGINIA



How did you create a system of referral to the evidence-based lifestyle change program?

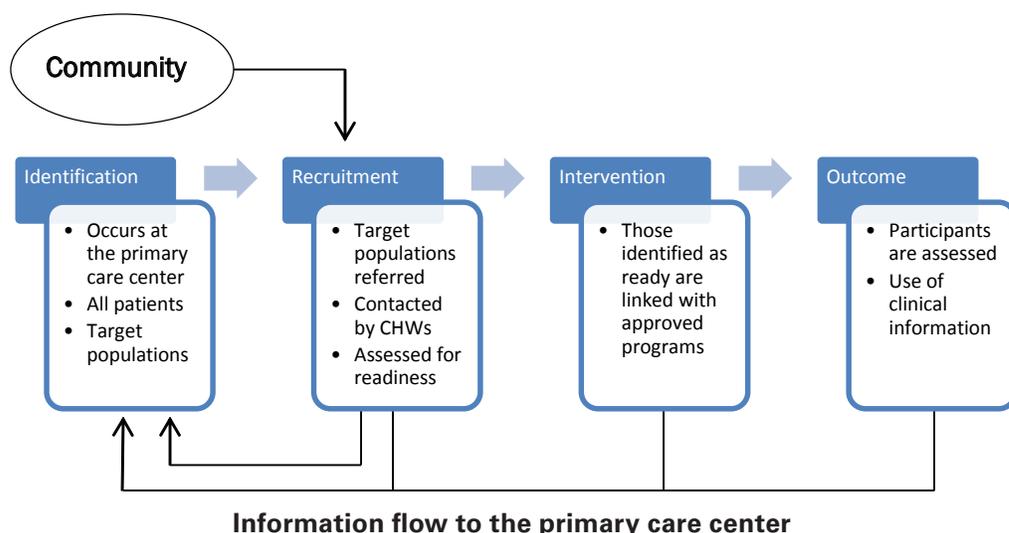
An effective diabetes prevention referral system helps ensure optimal care for individuals at risk by connecting them to an evidence-based lifestyle change program provider. To develop such a referral system, the West Virginia Diabetes Prevention and Control Program (DPCP) partnered with West Virginia University Office of Health Services Research (WVU OHSR). The system they developed included an algorithm for identification of patients at risk for diabetes and intervention through the evidence-based lifestyle change program. It was pilot tested in three health centers. In addition, the DPCP worked with WVU Extension Service (WVU Extension) and local health departments in Community Transformation Grant (CTG) communities to link health centers to the lifestyle change program providers.

What was the State Health Department role?

- Contracted with WVU OHSR to create a diabetes prevention referral system
- Developed a screening/referral algorithm for prediabetes diagnosis and referral
- Partnered with WVU Extension and local health departments to connect health centers with evidence-based lifestyle change programs and trained lifestyle change coaches
- Facilitated meetings between health centers and evidence-based lifestyle change program providers in order to establish a formalized referral process
- Drafted a service agreement between health centers and evidence-based lifestyle change program providers

Achievements

- 5** Healthcare system partners
- 3,966** Adults with prediabetes living in the area covered by the referral system
- 261** Adults referred to the evidence-based lifestyle change program through the newly created referral system



Source: West Virginia University School of Public Health
Office of Health Services Research

What positioned you for success?

- Dedicated Funding: \$80,000
- Partnerships with health centers and evidence-based lifestyle change program providers
- 10-year history of quality improvement partnerships with WVU OHSR and health clinics

WEST VIRGINIA

How did you create the referral system and algorithm?

The DPCP partnered with WVU OHSR to develop a referral system and algorithm for use in health centers. The referral system worked as follows: 1) at-risk patients identified through electronic health record (EHR) data or individual screening, 2) patients informed of their risk and the evidence-based lifestyle change program by the health center or lifestyle change program provider, 3) referral forms returned to lifestyle change program providers and patients provided a copy of the referral, and 4) patients enrolled in program. The DPCP expected these elements to remain relatively uniform across health centers, with slight differences in process and methods of communication used. The algorithm listed procedures for identification of patients at risk for diabetes and referral to the evidence-based lifestyle change program. The algorithm also provided two sets of instructions for follow-up with referred patients who either: a) participated in the program, or b) did not participate or were “no shows.” These follow-up instructions were aimed at both healthcare and lifestyle change program providers (i.e. community health workers) to ensure a closed loop referral and/or intervention. Following development, the referral system and algorithm were pilot tested at three health centers. To ensure there were sufficient lifestyle change program providers for pilot centers to refer patients, the DPCP partnered with WVU Extension. Staff from WVU Extension had community-level experience and pre-existing relationships with health centers, which helped connect centers to evidence-based lifestyle change program providers. In addition, a service agreement outlined a partnership between the health center, WVU OHSR, and the evidence-based lifestyle change program provider. The responsibilities of each partner were outlined, with the goal being for at-risk patients to receive the care they need and have that information funnel back to the health center. Forms were created for referral and quarterly review of indicators.

Challenges and Solutions

- Health centers and evidence-based lifestyle change program providers were not always located in the same area.

The DPCP helped link health centers and evidence-based lifestyle change program providers.

- Not all patients referred to the program were previously informed of their prediabetes risk.

Recognized the importance of determining the process for patient contact and education, including the readiness assessment, recruitment, and referral roles

“Helping to identify at-risk patients was only the first step. Helping to build a system whereby those patients could be referred for appropriate care, and that the results and progress of those patients are shared back to the referring physician, was key.”
Adam Baus, WVU OHSR

What were the factors for success?

- Linked Federally Qualified Health Centers and evidence-based lifestyle change program providers
- Formed partnerships with WVU Extension Service and local health departments
- Connected with partners (WVU Extension and CTG local health departments) whose staff had been trained as lifestyle coaches and had pre-existing relationships with their local health centers
- Incorporated referral to the evidence-based lifestyle change program into health centers’ existing delivery systems

Partners

- West Virginia University Office of Health Services Research
- Community Health Centers and Free Clinics
- West Virginia University Extension Service
- Community Transformation Grant Local Health Departments

For More Information

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See *West Virginia Story C* for more information on the pilot test of the referral system

STRATEGIC FOCUS AREAS



Increasing/Expanding Reimbursement

As we evaluated the project, it became apparent that there were themes with organizational or implementation tactics that facilitated the states' work in these two strategic focus areas. We called these "facilitating factors." Similarly, there were themes with barriers to success the states encountered. The following is a brief overview of some of the most common facilitating factors and barriers.

- **Strategic Focus Area E**

Strategies for partnering with state and local government agencies to recommend that the evidence-based lifestyle change program be offered as a covered health benefit for public employees

- **Strategic Focus Area F**

Strategies for partnering with organizations such as business coalitions to increase support for the evidence-based lifestyle change program as a covered health benefit by insurance providers and companies that are self-insured

Facilitating Factors

- Worked with partners with expertise in employee health and health benefits
 - Learned from them
 - Used their tools
 - Had them advocate and educate on the states' behalf
- Used demonstration program to show how the program works in their environment
- Highlighted how diabetes prevention was aligned with government priorities
- Shared materials and lessons learned from other states
- Capitalized on planned and unplanned opportunities to educate decision-makers

Barriers

- Health benefit cycle typically is longer than one year
- Is this the right time?

Government, employers, and payers have competing priorities and are making multiple changes in the face of a great deal of uncertainty

Results

Strategic Focus Area E: Public Employee Covered Health Benefit	
Indicator	Total
Number of presentations/meetings with government employees	13
Number of state/local government employers educated about the evidence-based lifestyle change program and the value of offering this as a covered benefit	14
Number of state/local government employees working in these state/local governments	151,944
Optional indicator: Number of state/local government employees referred to the evidence-based lifestyle change program	67
Optional indicator: Number of state/local government employees participating in a lifestyle change program	64
Strategic Focus Area F: Employer/Insurer Covered Health Benefit	
Indicator	Total
Number of business coalition events attended to educate employers about the evidence-based lifestyle change program and the value of offering this as a covered benefit	12
Number of employers at the coalition events	242
Number of businesses educated about the evidence-based lifestyle change program and the value of offering this as a covered benefit	239
Number of employees working for these businesses	620,217

COLORADO



How did you advocate for diabetes prevention to be a covered benefit for public employees?

The Colorado Department of Public Health and Environment (CDPHE) advocated for the evidence-based lifestyle change program to be added as a covered health benefit for local and state government employees. To do this, CDPHE partnered with internal and external program champions, including the state wellness coordinator and health plans. CDPHE used these relationships to offer a demonstration evidence-based lifestyle change program at the state health department. This helped policy makers see the effectiveness and understand the value of this program. The evidence-based lifestyle change program became a covered health benefit for public employees with fully insured United Healthcare plans on March 1, 2013 and for all state employees on September 1, 2013.

What was the State Health Department role?

- Advocated for diabetes prevention coverage at local and state levels
- Created a presentation and talking points to educate state and local government employers
- Formed strategic partnerships with internal champions and external organizations who helped to influence decisions
- Organized a demonstration of the evidence-based lifestyle change program for state employees
- Presented to key government decision makers on how diabetes prevention fits into the goals of chronic disease prevention in their workforce
- Represented the evidence-based lifestyle change program at state government events, such as the State Employee Wellness Fair
- Used existing relationships with organizations, such as the Colorado Business Group on Health and the Colorado Prevention Alliance, to gain access to key health plan and large employer group decision makers
- Continued to promote the evidence-based lifestyle change program to other government agencies

Achievements

- 3** Meetings/presentations with government employers
- 10** State/local government employers educated about the evidence-based lifestyle change program and the value of offering it as a covered benefit
- 34,321** State employees now have the evidence-based lifestyle change program as a covered benefit
- 42** State employees participated in the evidence-based lifestyle change program; of these **23** completed the demonstration program
 - For those who completed the demonstration program by attending at least 9 core sessions:
 - Average % body weight lost: **3.2%**
 - Average body weight lost: **6.7 lbs**
 - 47%** Increase in average weekly exercise



Photo: Shannon Barbare | CDPHE

Dr. Larry Wolk (above), Executive Director and Chief Medical Officer of the Colorado Department of Public Health and Environment participates in a state employee prediabetes screening event in September, 2013

What positioned you for success?

- Dedicated Funding: \$15,000
- Relationships with internal and external champions
- Connections made through the Colorado Business Group on Health and other business related organizations

COLORADO

How did you persuade government leaders to see the value in diabetes prevention?

CDPHE leveraged relationships and the expertise of others to facilitate a demonstration class of the evidence-based lifestyle change program to show its value. CDPHE worked with their worksite wellness coordinator and personnel from the Kaiser Permanente health plan to offer a demonstration of the evidence-based lifestyle change program at CDPHE. The program was marketed and promoted with flyers and posters designed by CDPHE's communications department. Additionally, CDPHE gained leadership and management support to ensure staff attended the program. The promotion efforts worked, and 23 employees participated. The success of the demonstration class helped to generate new support for diabetes prevention, which increased the momentum. In addition to the demonstration class, CDPHE continually advocated for the evidence-based lifestyle change program whenever the opportunity arose to speak to key decision makers both within the government and from health plans.

"A consistent message delivered with persistence can be a powerful tool for persuasion."

Kelly McCracken, CDPHE

What were the factors for success?

- Demonstrated the success and efficacy of the program by offering the evidence-based lifestyle change program at a government worksite
- Delivered a consistent message about diabetes prevention to influence key decision makers
- Leveraged the expertise and relationships of leaders
- Capitalized on any opportunity to speak with key leadership about the evidence-based lifestyle change program
- Promoted diabetes prevention at presentations or events for public and state employees
- Built strategic relationships with the Colorado Business Group on Health and the Colorado Prevention Alliance to make inroads with leadership from health plans

Challenges and Solutions

- The Department of Personnel Administration would not consider adding the evidence-based lifestyle change program as a covered benefit unless both state health plans offered it.

Secured agreement with both health plans to add the evidence-based lifestyle change program as a covered health benefit for their members

- Initially, local health departments were not sure of their role in scaling the evidence-based lifestyle change program in Colorado.

Presented specific evidence-based lifestyle change program strategies for local public health departments, providing them with information and resources for any future efforts

Partners

- CDPHE Worksite Wellness Coordinator
- United Healthcare
- Kaiser Permanente
- CDPHE Obesity Staff
- CDPHE Office of Planning and Partnership (local public health liaison)
- Colorado Prevention Alliance
- Colorado Business Group on Health
- National Business Coalition on Health
- Department of Personnel Administration
- Governor's Office

For More Information

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KENTUCKY



How did the State consider offering the evidence-based lifestyle change program as a covered health benefit to state employees and Medicaid members?

Required by legislation, four state agencies in the Kentucky (KY) Cabinet for Health and Family Services created a biennial KY Diabetes Report. The Kentucky Diabetes Prevention and Control Program (KY DPCP) led this effort. Three outcomes resulting from the production of this report generated state momentum to support health benefit coverage. First, critical relationships between the state entities were established as they wrote the report. Second, the report, presented to the legislature in 2013, included coverage of diabetes prevention as a key recommendation. Third, the KY DPCP formed a Prediabetes/Diabetes Prevention Program (DPP) steering committee including staff from the Personnel Cabinet, Office of the Secretary, and the Department for Public Health. Committee members met with crucial stakeholders to increase their prediabetes awareness, inform them about current diabetes prevention work in KY, and share ideas about demonstration programs regarding DPP coverage through Medicaid and state employee health plans. In 2013, diabetes prevention was integrated into the state employee health plan, and as of January 1, 2014, became a covered benefit.

What was the State Health Department role?

- Educated and established ongoing communications with key government officials about the evidence-based lifestyle change program and its potential to reverse KY diabetes trends
- Recommended diabetes prevention initiatives be included in the 2013 KY Diabetes Report to the legislature
- Led the formation of a state DPP steering committee that helped to connect staff from key state entities with KY providers of the evidence-based lifestyle change program
- Provided prediabetes content expertise and resources for government leaders and decision makers
- Shared experiences and materials from other states that had achieved success in securing diabetes prevention coverage for state employees or Medicaid members
- Created diabetes prevention educational and awareness materials
- Facilitated meeting with KY Medicaid Managed Care Organization (MCO) Medical Directors to present the evidence-based lifestyle change program

What positioned you for success?

- Dedicated Funding: \$13,600
- Experienced DPCP staff
- Diabetes prevention prioritized by the State
- Strong relationships with key government leaders
- Other state experiences with similar initiatives
- Access to diabetes prevention experts and trained lifestyle coaches

Achievements

Coverage of the evidence-based lifestyle change program for state employees began in 2014

48,000 State employees now have the evidence-based lifestyle change program as a covered benefit

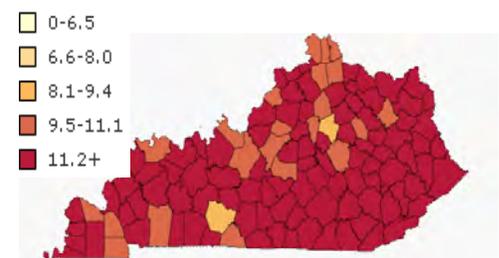
Participation in the evidence-based lifestyle change program included as part of the state employee incentive points program in 2013

2 Payers/Government Employers educated about the evidence-based lifestyle change program and its value [Medicaid and the State Department of Employee Insurance]

6 Meetings with government employers and insurers

Kentucky Needs You To Help Reverse Diabetes Trends

2010 Diagnosed Diabetes Percentages in Kentucky
(Retrieved August 20, 2013 - CDC Diabetes Atlas)



<http://www.cdc.gov/diabetes/atlas/countydata/atlas.html>

This message and graphic was used as a header in documents to government leaders and other stakeholders

KENTUCKY

How did you advocate with government leaders to cover diabetes prevention?

The KY DPCP capitalized on an opportunity to educate key officials by connecting discussions about the evidence-based lifestyle change program to the diabetes prevention recommendation in the KY diabetes legislative report. The DPCP also garnered support from the Department for Public Health's Deputy Commissioner of Clinical Affairs by arranging for her to be a state diabetes prevention spokesperson, presenting at numerous conferences. This relationship resulted in the state DPCP attending high level meetings focused on Medicaid and state employee coverage. The DPCP came to these meetings fully prepared to share content expertise and examples of other states' experiences. They contacted Montana, where the evidence-based lifestyle program is covered by Medicaid, to gain a better understanding of their processes and protocols. The DPCP also spoke with Washington staff about coverage for state employees. Additionally, the DPCP used CDC leadership, Dr. Ann Albright, to conduct a presentation by phone followed by a face-to-face open dialogue meeting with the KY Medicaid MCOs.

*"Passion.... Perseverance.... AND Patience ----
Three needed virtues for DPCP staff."*

Janice Haile, KY DPCP

What were the factors for success?

- Acted as a neutral convener of a state steering committee that included all KY evidence-based lifestyle change program providers
- Built strong relationships with government leaders who ultimately became strong program supporters
- Utilized knowledge of other state experience in this area
- Identified a program champion in the Department for Public Health's Deputy Commissioner of Clinical Affairs

For More Information

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Challenges and Solutions

- The Medicaid program lacks funding to support the evidence-based lifestyle change program.
 - Medicaid MCOs have engaged in active discussions regarding DPP coverage. Department for Medicaid Services CMO has agreed to work with the MCO medical directors to develop alternative support and funding model options.
- Due to timing issues, coverage for diabetes prevention programs as part of the state employee health plan was not possible for 2013.
 - Piloted processes to identify and refer high risk state employees to a CDC recognized diabetes prevention program which led to full coverage in 2014
- KY DPCP staff needed a better understanding of how the evidence-based lifestyle change program could be a covered health benefit.
 - Used relationships with other state and national experts who have been leading the way in diabetes prevention coverage to learn from their experience

Partners

- Cabinet for Health and Family Services -- Secretary and Senior Policy Advisor
- Department for Public Health -- Commissioner and Deputy Commissioner of Clinical Affairs
- Personnel Cabinet – Commissioner, Department of Employee Insurance Staff, and third party administrator – Humana
- Medicaid – Commissioner, Chief Medical Officer (CMO), and staff
- Medicaid Managed Care Organizations
- YMCA (Louisville, Lexington, Northern Kentucky)
- AADE funded evidence-based lifestyle change program providers (Louisville, Lexington, Ashland)
- Local Health Departments (Louisville, Lexington, Northern KY)

NEW MEXICO **A D E G**

How did you promote the evidence-based lifestyle change program as a covered health benefit for state employees?

The New Mexico Diabetes Prevention and Control Program (DPCP) formed a strategic partnership with the New Mexico Risk Management Division Employee Benefits Bureau (EBB) and leadership from the Public Health Division and Department of Health (DOH) to explore offering the evidence-based lifestyle change program as a covered health benefit for state employees. To inform this process, the DPCP had conversations with other states that provided this as a covered health benefit for their employees. Following these conversations, the DPCP decided to offer a demonstration session of the lifestyle change program to DOH staff. Before the demonstration could begin, EBB agreed to offer the lifestyle change program as a covered health benefit for eligible state employees.

What was the State Health Department role?

- Utilized technical assistance from the National Business Coalition on Health (NBCH) to build a business case for diabetes prevention in New Mexico
- Communicated with other states about achieving coverage of the evidence-based lifestyle change program as a health benefit for state employees
- Presented to EBB about prediabetes and the value of the evidence-based lifestyle change program
- Organized a demonstration session of the evidence-based lifestyle change program for DOH staff
- Currently providing ongoing consultation to EBB as they consider how to operationalize this health benefit

The DPCP submitted an implementation plan to EBB proposing how to build infrastructure for and pilot the program in the two counties where the majority of state employees work: Bernalillo and Santa Fe.

Achievements

2 Meetings/presentations with government employer

1 State government employer educated about the evidence-based lifestyle change program and the value of offering it as a covered benefit

An estimated **4,623** state government employees living in Bernalillo and Santa Fe counties

20 State government employees self-referred to the evidence-based lifestyle change program; of these, **17** participated in the demonstration program

Of those who attended >50% of sessions:

Average % body weight lost: **7%**

Average body weight lost: **13.5 lbs**

Average physical activity: **213 mins**



State government employees participating in the demonstration program

What positioned you for success?

- Dedicated Funding: \$0
- Dedicated staff resources
- Existing relationship with EBB staff
- EBB staff had an understanding of diabetes prevention

NEW MEXICO

How did you encourage your state benefits bureau to cover diabetes prevention?

At project onset, the DPCP met with EBB staff to discuss incorporating the evidence-based lifestyle change program into the state employee benefits package. Meanwhile, the DPCP had conversations with Colorado and Washington about their experience obtaining state employee health benefit coverage for the evidence-based lifestyle change program. Based on advice from Colorado, the DPCP planned a demonstration of the evidence-based lifestyle change program in order to catalyze movement toward the policy change. Before the demonstration could begin, EBB informed the DPCP that they planned to offer the evidence-based lifestyle change program as a health benefit for eligible employees. The demonstration was subsequently offered in 2014 with 17 DOH employees participating. Over the course of the project, the NBCH provided the DPCP with technical assistance in the form of ideas and talking points to build a case for the evidence-based lifestyle change program when approaching the state benefits department. In addition, the DPCP submitted an implementation plan to EBB proposing how to build infrastructure for and pilot the program in the two counties where the majority of state employees work: Bernalillo and Santa Fe. There are an estimated 4,623 employees with prediabetes in these locations.

"I am eating more vegetables and fruits than I ever have. I exercise now, and I never did. I eat smaller portions. I still have times that I fall off... but the tools this class has given me help me pick myself up and continue to try...I am so grateful for this class and my team members and coaches."

Jeryl Vigil, NM State Employee

What were the factors for success?

- Learned from the experiences of states that were successful in getting the evidence-based lifestyle change program covered as a health benefit for their employees
- Leveraged the expertise and relationships of state government leaders, including the Secretary of Health and an EBB staff member who was a previous bureau chief in the Public Health Division
- Accessed experts from NBCH to expand skill and knowledge base

Challenges and Solutions

- Implementation of the policy was delayed because EBB staff were focused on employee re-enrollment for health benefits.

[Continued to check in with EBB and offered support by providing program and cost information as needed](#)

- Building the infrastructure to offer the evidence-based lifestyle change program as a covered health benefit and implementing the policy at the same time can be challenging.

[DPCP decided to pilot the lifestyle change program in two counties before implementing statewide.](#)

Partners

- New Mexico Risk Management Division Employee Benefits Bureau
- National Business Coalition on Health
- New Mexico Department of Health leadership

For More Information

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WEST VIRGINIA

B

C

D

E

How did you advocate for diabetes prevention to be a covered benefit for public employees?

The state's public employee insurer, West Virginia Public Employees Insurance Agency (WV PEIA), had expressed interest in the evidence-based lifestyle change program and engaged the West Virginia Diabetes Prevention and Control Program (DPCP) in conversations prior to this project. Early in the project, the DPCP organized meetings and facilitated expert consultation to support WV PEIA's exploration to offer the lifestyle change program as a covered health benefit.

What was the State Health Department role?

- Advocated for diabetes prevention coverage at the state level
- Organized meetings and engaged key insurance stakeholders to discuss prediabetes and the benefits of the evidence-based lifestyle change program
- Created educational materials to distribute at meetings with insurers
- Facilitated expert consultation and provided technical assistance to insurers to examine ways to overcome barriers to reimbursement

Achievements

1 State government employer educated about the evidence-based lifestyle change program and the value of offering it as a covered benefit

2 Meetings/presentations with government employer

65,000 State government employees working in this state government



“Funding is the largest barrier to implementing the National Diabetes Prevention Program (National DPP). Offering the National DPP as a covered health benefit will facilitate implementation of the evidence-based lifestyle change program.”

Denise Ryan, Berkley County Health Department

What positioned you for success?

- Dedicated Funding: \$15,000
- Engaged in conversations about the evidence-based lifestyle change program with WV PEIA for two years
- Many insurers attended a Diabetes Prevention Roundtable Meeting to discuss provisions under the Affordable Care Act

WEST VIRGINIA

How did you build a relationship with the state insurer?

Given that the state insurer had expressed interest in the evidence-based lifestyle change program, the DPCP organized a meeting of insurers to discuss prediabetes and the benefits of the lifestyle change program. The DPCP distributed a diabetes prevention fact sheet and the CDC risk assessment tool. Following this meeting, additional quarterly meetings were scheduled. Early in the project, WV PEIA participated in the Department of Health and Human Resources Secretary's wellness committee, which drafted a wellness program proposal for the agency. While the state insurer identified many barriers to covering the program under both benefit design and wellness programs, they seemed willing to work with the DPCP to overcome those barriers. WV PEIA entered into a Memorandum of Understanding with an evidence-based lifestyle change program provider to conduct a pilot program. Throughout the project, the DPCP acted as a resource to WV PEIA by sharing information and determining answers to questions related to barriers. The National Association of Chronic Disease Directors (NACDD) and MedWorks USA also provided direct support in this effort, including brokering conversations between the DPCP and insurers.

What were the factors for success?

- Key state government leaders supported diabetes prevention initiatives
- NACDD and MedWorks USA brokered conversations between the DPCP and insurers

For More Information

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Challenges and Solutions

- The DPCP lacked experience working with insurers prior to the project, and it was difficult to gather insurers for a meeting about the evidence-based lifestyle change program.

[The West Virginia Bureau for Public Health Commissioner issued the invitation to the meeting, which gave credibility.](#)

[Representatives from NACDD and MedWorks USA assisted the DPCP in conversations with WV PEIA and other insurers.](#)

- WV PEIA did not see the benefits of the evidence-based lifestyle change program as superior to the benefits of lifestyle change programs that were already reimbursable.
- Senior state leaders with decision making power or influence who had supported diabetes prevention initiatives left their positions during the project time frame.

[The DPCP had to take time to establish relationships with new leaders.](#)

- At the present time in West Virginia, medical claims cannot be used to pay for the evidence-based lifestyle change program as there are no codes to cover services implemented by lay providers.

Partners

- Department of Health and Human Resources
- West Virginia Offices of the Insurance Commissioner
- West Virginia Bureau for Public Health Commissioner
- West Virginia Public Employees Insurance Agency
- National Association of Chronic Disease Directors
- MedWorks USA

COLORADO



How did the State create movement toward employee health coverage of the evidence-based lifestyle change program?

The Colorado Department of Public Health and Environment (CDPHE) advocated for inclusion of the evidence-based lifestyle change program in employee health benefit plans. To do this, CDPHE partnered with the Colorado Business Group on Health (CBGH) and other business coalitions to raise awareness of prediabetes and diabetes prevention among employers. CDPHE educated employers about the value of the evidence-based lifestyle change program and its potential impact on reducing health care costs. Increasing awareness was instrumental to engaging employers in discussions about including the lifestyle change program in their employee health benefit packages.

What was the State Health Department role?

- Partnered with the Colorado Business Group on Health (CBGH) and other business coalitions and groups
- Served as a prediabetes content expert and created business-focused educational materials and tools
- Raised awareness of prediabetes and the evidence-based lifestyle change program among employers through presentations at business events
- Conducted pre- and post-surveys among attendees at business events to look for changes in level of awareness
- Capitalized on new opportunities to educate employers individually in response to interest generated by business coalition events

Achievements

4 Business coalition events

150 Employers educated about the evidence-based lifestyle change program and its value as a covered health benefit

45,217 Employees work for these employers

What positioned you for success?

- Dedicated Funding: \$15,000
- Business coalition was an active member of the Diabetes Prevention Program Advisory Group
- Partnerships with health plans and other employer groups

Take Steps to Prevent Diabetes at Work

Employees are eligible for this program if they are overweight (BMI ≥ 24) and have a history of gestational diabetes, have been diagnosed with prediabetes, or **score 9 or higher on the following risk test:**

are you **9**

+1	Had a baby weighing more than 9 pounds?
+1	Have a sister or brother with diabetes?
+1	Have a parent with diabetes?
+5	Are you overweight (BMI ≥ 24)?
+5	Are you younger than 65 and do little or no exercise in a typical day?
+5	Are you between 45 and 64?
+9	Are you older than 65?

Role for employers:

- Have employees call 1-800-DIABETES to find a Diabetes Prevention Program in their area
- Use pre-existing communication channels to educate employees about their risk for prediabetes and the National Diabetes Prevention Program
- Negotiate with your health plan to include the National Diabetes Prevention Program as a covered benefit

Excerpt from flyers aimed at raising awareness among employers

COLORADO

How did your partnerships with business coalitions raise awareness among employers?

As part of this project, CDPHE was asked to present at several business coalition events. These events included Colorado Business Group on Health (CBGH) member meetings, CBGH's annual conference, and a Denver Metro Chamber of Commerce Healthcare Committee meeting. For each of these events, CDPHE developed PowerPoint presentations, talking points, and flyers. The National Business Coalition on Health (NBCH) assisted with creation of a presentation for employers and provided action briefs to distribute at meetings. Meeting attendees were surveyed to determine the effectiveness of the presentation. At one meeting, 24 of 34 (70%) respondents indicated increased awareness of prediabetes and the evidence-based lifestyle change program. At another meeting, 19 of 21 (90%) respondents indicated increased awareness of prediabetes, and 16 of 19 (84%) indicated they would negotiate with their health plan for the evidence-based lifestyle change program. In addition, CDPHE wrote an article about the evidence-based lifestyle change program for CBGH's Colorado Health Matters Quality Reports, an annual publication distributed to consumers, employers, and physicians. The article discussed the impact of prediabetes and provided an overview of the evidence-based lifestyle change program.

Challenges and Solutions

- Lack of knowledge among CDPHE staff about employers' purchasing power with health plans
 - Met with the executive director of CBGH to learn more about this process
- Need for additional materials and talking points tailored to employers for use in presentations
 - Sought employer-specific materials and talking points from CDC and NBCH

"The Colorado Business Group on Health values the long-standing relationship we have had with the Colorado Department of Public Health & Environment, and we are pleased to help contribute to the success of promoting awareness and action among Colorado employers. We know that it takes many helping hands to attain a healthier community."

Donna Marshall, CBGH

What were the factors for success?

- Partnership with CBGH created valuable connections to other employers and business groups
- Used the business expertise of the State Health Department's Worksite Wellness Manager
- Accessed business-related resources from National Association of Chronic Disease Directors and NBCH

Partners

- Colorado Business Group on Health
- National Business Coalition on Health
- Denver Metro Chamber of Commerce Healthcare Committee

For More Information

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KENTUCKY



How did you increase employer support for diabetes prevention in the workplace?

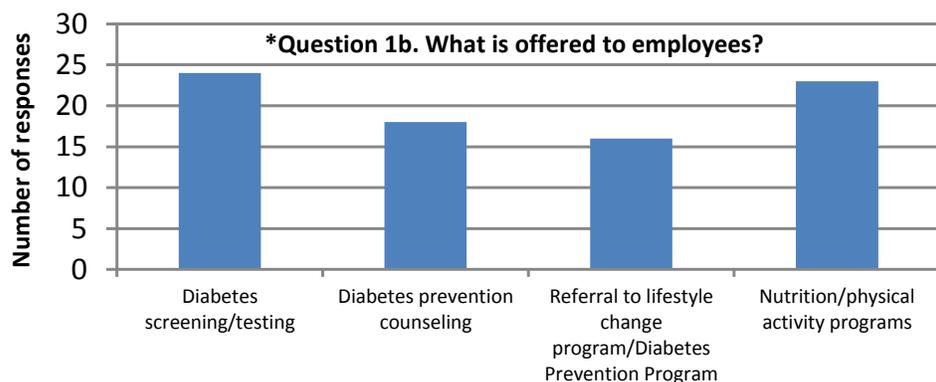
To identify businesses interested in diabetes prevention and coverage of the evidence-based lifestyle change program as a health benefit, the Kentucky Diabetes Prevention and Control Program (KY DPCP) worked with the Department for Public Health’s Worksite Wellness Coordinator to administer two surveys. A brief survey was conducted among attendees at the 2013 KY Chamber Worksite Wellness Conference and a larger, more comprehensive survey was conducted in 2014. For the 2014 KY Chamber Worksite Wellness Conference, the DPCP arranged for diabetes prevention to be a keynote topic and for Dr. Ann Albright, the CDC Division of Diabetes Translation Director, to be the presenter. In addition, the DPCP worked to develop a return on investment (ROI) fact sheet, which was placed in a toolkit along with the National Business Coalition on Health’s (NBCH) Prediabetes Action Brief. This business toolkit was utilized when interacting with employers. Furthermore, the DPCP facilitated Kentucky’s involvement as a member of the NBCH by establishing a linkage between the Kentuckiana Health Collaborative (KHC) and NBCH.

What was the State Health Department role?

- Assessed workplace diabetes prevention wellness or health benefit status
- Identified employers interested in additional information on the evidence-based lifestyle change program
- Developed or identified educational tools demonstrating the value of diabetes prevention from the employer’s point of view
- Facilitated Kentucky’s first representation in NBCH
- Secured national expert Ann Albright, PhD, RD as a keynote speaker for the 2014 KY Chamber Worksite Wellness Conference

Results from 2013 Worksite Wellness Conference Survey

Question	Yes	No
1. Do you have a wellness program at your worksite?	41 (80%)	10 (20%)
<ul style="list-style-type: none"> • 1a. If yes, is “diabetes prevention” part of the wellness program offered to employees? • 1b. If yes, circle what is offered to employees?* 	27 (67.5%)	13 (32.5%)
2. Is “diabetes prevention” part of the health insurance coverage offered to employees?	25 (62.5%)	15 (37.5%)
3. Would you like more information about diabetes prevention programs for the workplace?	32 (67%)	16 (33%)



Achievements

2 Kentucky Business coalition events (KY Chamber of Commerce)

87 Employers educated about the evidence-based lifestyle change program

575,000 Employees work for these employers

2 Worksite diabetes prevention surveys

52 Employers surveyed about diabetes prevention in 2013

365 Employers participated in a 2014 worksite wellness assessment

First Kentucky Membership in NBCH

What positioned you for success?

- Dedicated Funding: \$25,000
- Experienced DPCP and Worksite Wellness staff with the KY Department for Public Health (DPH)
- Large employers and insurers expressed interest in incorporating the evidence-based lifestyle change program as a covered health benefit
- DPCP’s relationship with KHC
- KY DPH Worksite Wellness Coordinator worked closely with the KY Chamber of Commerce

KENTUCKY

How did you engage employers in diabetes prevention?

The DPCP, via DPH Worksite Wellness staff, surveyed 2013 KY Chamber Worksite Wellness Conference attendees representing private business, non-profit organizations, and other employers. The 2013 survey asked business attendees if diabetes prevention was included in their employee worksite wellness program or health benefits. More than half responded “yes” to one or both questions, and two-thirds of respondents said they wanted more information about worksite diabetes prevention programming. The DPCP and DPH Worksite Wellness staff used the survey to identify businesses interested in diabetes prevention. This list was used to plan follow-up face-to-face visits.

In 2014, the DPH administered a worksite wellness assessment based upon the CDC Worksite Health ScoreCard. Of the 365 respondents: 32% reported providing free or subsidized self-assessment for prediabetes and diabetes; 18% reported providing educational opportunities for preventing or treating diabetes; and 25% reported offering one-on-one or group lifestyle counseling and follow-up monitoring for elevated blood glucose levels. For the 2014 KY Chamber Worksite Wellness Conference, the DPCP submitted a proposal to provide a keynote speaker. The proposal was accepted, and Ann Albright, PhD, RD agreed to speak.

The DPCP identified the need for KY-specific educational tools for employers. With support from the CDC and NBCH, they created a diabetes prevention ROI fact sheet. This fact sheet and NBCH’s Prediabetes Action Brief were part of a business toolkit that was reviewed by the Prediabetes/Diabetes Prevention Program Steering Committee. Toolkits were first distributed to employers by Louisville YMCA staff at a Worksite Wellness Committee event, along with a short presentation about the evidence-based lifestyle change program. To explore Kentucky membership in NBCH, the DPCP linked KHC and NBCH. This connection led to KHC leadership joining NBCH.

“Employers are becoming increasingly aware of the need to know more and do more to help prevent diabetes in the working population.”

Teresa Lovely, KY DPH Worksite Wellness Coordinator

What were the factors for success?

- Employers indicated interest in diabetes prevention and the evidence-based lifestyle change program
- Created business toolkit to give to employers
- KY DPH Worksite Wellness Coordinator:
 - Facilitated access to state’s largest business association, the KY Chamber of Commerce
 - Planned the worksite wellness assessment
- DPCP connected KHC with the NBCH

Challenges and Solutions

- The DPCP could not identify an existing ROI document relevant to KY employers.
 - [DPCP created an ROI fact sheet with expert guidance from NBCH and CDC.](#)
- The DPCP was unable to conduct face-to-face visits with selected businesses as previously planned.
 - [Prediabetes and diabetes prevention resources were provided via e-mail to those businesses that had requested more information.](#)
- KHC leadership was unaware their organization met the criteria for membership in the NBCH.
 - [DPCP educated KHC about the benefits of NBCH membership and provided follow-up and linkages between the two organizations.](#)

Partners

- Kentucky Department for Public Health Worksite Wellness staff
- Kentucky Chamber of Commerce
- Kentuckiana Health Collaborative
- National Business Coalition on Health
- YMCA – Louisville
- Prediabetes/Diabetes Prevention Program Steering Committee

For More Information

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KY ROI Fact Sheet:

http://c.ymcdn.com/sites/www.chronicdisease.org/resource/resmgr/NDPP_KY_/Final_KY_PREDIABETES_ROI__FA.pdf

NBCH Prediabetes Action Brief:

http://www.nbch.org/nbch/files/ccLibraryFiles/Filename/000000003046/NBCH_AB_PREDIABETES_UPDATED%2010.16.13.pdf

STRATEGIC FOCUS AREA



Alignment and Coordination

As we evaluated the project, it became apparent that there were themes with organizational or implementation tactics that facilitated the states' work in these two strategic focus areas. We called these "facilitating factors." Similarly, there were themes with barriers to success the states encountered. The following is a brief overview of some of the most common facilitating factors and barriers.

- **Strategic Focus Area G**

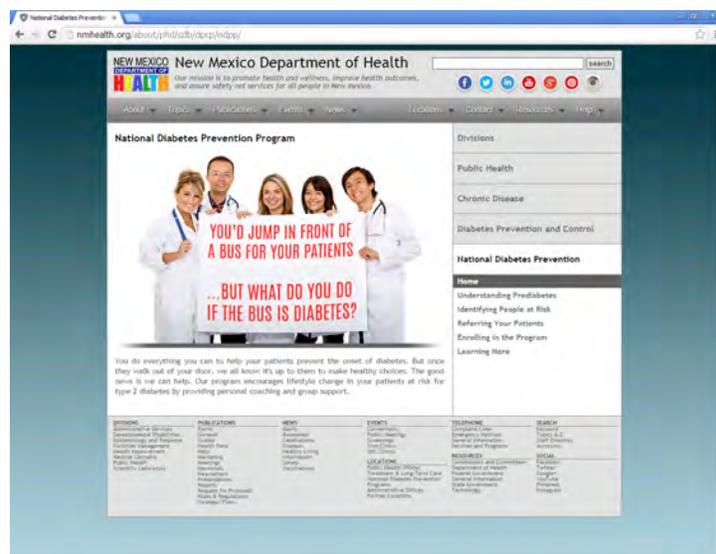
Strategies for ensuring that efforts to increase awareness and promote the evidence-based lifestyle change program are aligned and coordinated with organizations in the state that is delivering this program

Facilitating Factors

- Strong foundation of relationships with existing lifestyle change program providers and other interested partners
- Access to resources and experts that could support the lifestyle change program provider
- Learned from and coordinated with other state chronic disease programs
- Used technology to support coordination and sharing lessons and resources

Results

Strategic Focus Area G: State Coordination and Alignment	
Indicator	Total
Number of partners	46
Number of meetings with partners	7
Average number of partners participating in each meeting	35
Average proportion (%) of evidence-based lifestyle change program providers in the state participating in each meeting	85%



Screenshots of websites used by New Mexico and Michigan for coordination of their diabetes prevention efforts

MICHIGAN



How did you align state diabetes prevention experiences and resources?

The Michigan Diabetes Prevention and Control Program (DPCP) tackled alignment and coordination of the evidence-based lifestyle change program by creating a statewide network, the Michigan Diabetes Prevention Network. This network was created to support and engage partners, serve as a vehicle to share information and resources, and leverage existing state and local resources. Network partners include Michigan evidence-based lifestyle change program providers, Michigan Department of Community Health programs, and national partners such as the American Association of Diabetes Educators and the Directors of Health Promotion and Education. Additionally, a website was created to house Network resources.

What was the State Health Department role?

- Assessed needs of diabetes prevention partners
- Planned, coordinated, and executed the full-day Michigan Diabetes Prevention Conference
- Convened state partners for quarterly meetings
- Wrote and distributed network newsletters
- Provided technical assistance to partners, as needed
- Disseminated resources to network partners
- Designed and maintained a webpage for partners with resources and tools for implementing and sustaining local evidence-based lifestyle change program sites
- Created relationships with new partners and engaged new organizations to offer the evidence-based lifestyle change program
- Leveraged network partners to establish local referral systems

Achievements

26 Partners

1 Statewide Diabetes Prevention Conference

193 Attendees

4 Partner Meetings

Average of **23** partners participating per meeting

85% of evidence lifestyle change program providers in the state participated in each meeting

6 Partners established referral systems at **88** healthcare sites with **220** healthcare providers

“By building a statewide Diabetes Prevention Network, we can do more collectively than any one organization can do alone or even working side by side. The Network is a great vehicle to help partners work together, learn from each other, and tap into much needed resources.”

Kristi Pier, MI DPCP

What positioned you for success?

- Dedicated Funding: \$121,000
- Strong partner relationships
- Ability to share resources through in-person meetings, conference calls, and the website www.midiabetesprevention.org



David Marrero, keynote speaker, Making the Case -- the Michigan Diabetes Prevention Conference (Ann Arbor, October 22, 2013)

MICHIGAN

How did you create a statewide network that will work for its partners?

The Michigan DPCP modeled its statewide network, including resource sharing, on the successes of those created by other chronic disease programs. The network leveraged existing relationships with organizations and cultivated new relationships. The DPCP convened the network for conference calls, in-person meetings, and an all-day diabetes prevention conference. The DPCP selected topics based on the needs of the network partners and used input from partner organizations. They maintained contact with partners through distribution of regular newsletters and announcements, which featured resources, information, and upcoming events. Additionally, the DPCP created a website to house resources for easy accessibility to network partners. The website includes a search page allowing providers to seek information on upcoming evidence-based lifestyle change programs.

Partners

- American Association of Diabetes Educators
- Ann Arbor YMCA
- Botsford Hospital
- Center for Health and Social Services (CHASS)
- Directors of Health Promotion and Education
- District Health Department #10
- Garden City Hospital
- Holland Hospital
- Hurley Medical Center
- MedNet One Health Solutions
- Metro Health
- Michigan State University Extension Services
- National Kidney Foundation of Michigan
- Public Health, Delta & Menominee Counties
- Spectrum Health Gerber Memorial
- Spectrum Health Reed City
- University Pharmacy
- YMCA of Greater Grand Rapids
- YMCA of Marquette County

Challenges and Solutions

- Limited funding
 - Worked efficiently within the funding constraints, including using the network to ensure resources were not duplicated*
- Many partners voiced challenges around the expansiveness of the evidence-based lifestyle change program structure.
 - Provided individualized support by helping partners strategize and problem-solve; also provided tools, including a free database to document and report outcomes*
- The direct communication loop between CDC and the evidence-based lifestyle change program providers impacted the role DPCP had established with its long-term partners.
- Competition among network partners could reduce resource sharing and collaboration.
 - Provided information and resources with fairness and inclusiveness*

What were the factors for success?

- Upfront planning for a statewide network to assure sustainability of collaboration long after this grant had ended
- Leveraged internal models of networking and resource sharing
- Created and maintained partnerships to maximize resources
- Accessed experts within and outside the state to expand skill and knowledge base
- Involved partners in planning of meetings, conferences, and website to ensure applicability to the specific target audience
- Developed a website to allow programs to promote activities and search for resources

For More Information

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NEW MEXICO **A D E G**

How did you create a statewide infrastructure to support diabetes prevention?

The New Mexico Diabetes Prevention and Control Program (DPCP) created a statewide infrastructure to support implementation, maintenance and sustainability of the evidence-based lifestyle change program. The infrastructure aims to support site coordinators, health plans, worksites, clinics and tribes in delivering and sustaining the evidence-based lifestyle change program. New Mexico created this network by assessing the capacity of sites to deliver the evidence-based lifestyle change program and by providing technical assistance on many aspects of the program. The DPCP held several meetings and trainings with the network of partners in order to continue to build and sustain the infrastructure.

What was the State Health Department role?

- Created a robust statewide network of diabetes prevention and management partners
- Convened statewide partners for meetings, trainings, and technical assistance
- Provided training for lifestyle coaches in order to ensure a solid foundation
- Developed a dedicated website with educational and promotional materials and an online referral system with an interactive map and contact information for evidence-based lifestyle change program coordinators
- Coordinated efforts between the program providers to create a more integrated and extensive statewide network
- Engaged health plan and state government benefits leadership to encourage adoption of the evidence-based lifestyle change program as a covered health benefit
- Organized a demonstration of the evidence-based lifestyle change program to be delivered to state employees in 2014

Achievements

20 Partners

3 Health Plan Partner Meetings

Average of 12 partners participating per meeting

40+ Trained lifestyle coaches

A marketing plan for healthcare providers

An evidence-based lifestyle change program website (www.stopdiabetesnm.org)

Discussions with the State about adoption of the evidence-based lifestyle change program as a covered health benefit

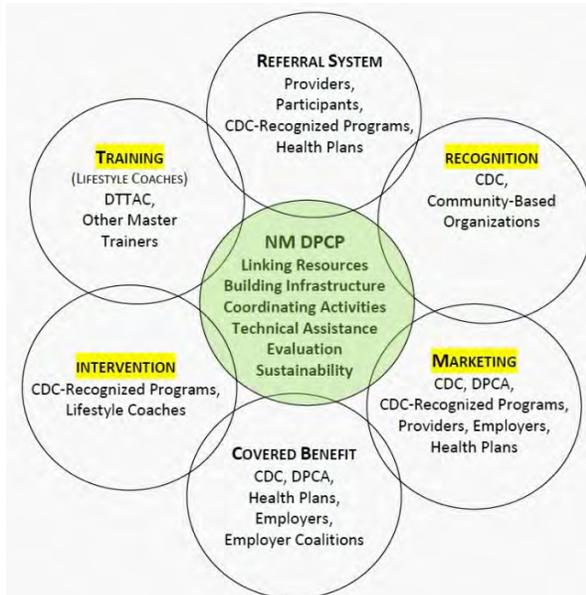
“Working with NACDD and the other funded states on the S-DPP project has given the expansion of the NDPP in New Mexico a real boost. It has also confirmed that DPCPs have a critical role to play in this endeavor.”

Judith Gabriele, NM DPCP

What positioned you for success?

- Dedicated Funding: \$137,300
- Strong foundation of existing statewide evidence-based lifestyle change program and partners

NM DPCP Roles in Diabetes Prevention



NEW MEXICO

How did you create an infrastructure that will support diabetes prevention?

The NM DPCP collaborated with existing partners to create a statewide network. Once the network was established, partners met with health plan and state government risk management leadership to discuss the possibility of adopting the evidence-based lifestyle change program as a covered health benefit. Starting in January 2014, the DPCP offered the program to state employees in a “demonstration” format. Using state funding, the DPCP has trained over 40 lifestyle coaches to continue to expand the network and reinforce infrastructure for scaling the program statewide. The DPCP is partnering with a referral system contractor to help develop strategies for referrals to the evidence-based lifestyle change program. Likewise, a marketing contractor is creating a campaign objective, target audience, and effective approach for increasing prediabetes awareness and promoting the evidence-based lifestyle change program to healthcare providers across the state.

What were the factors for success?

- State funding enabled the DPCP to focus on training and other critical components of the system infrastructure
- Capitalized on a strong, existing foundation of evidence-based lifestyle change program sites
- Applied lessons learned from “early adopters,” which allowed for more effective technical assistance to subsequent participating organizations
- Increased healthcare provider awareness through messaging and a referral system

For More Information

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Challenges and Solutions

- The state procurement process delayed the development of marketing and referral system contracts.
Worked hard to complete as much work as they could in a short period of time
- Health plan decision makers were not brought to the table for network meeting.
Reached out to health plans and brought in the right players (Medical Directors) for later meetings, resulting in productive discussions that garnered support for the evidence-based lifestyle change program
- Changing priorities within Department of Health (DOH) Information Technology (IT) delayed dedicated website development.
Continued to work with the DOH IT staff to keep the website on their radar, with persistence paying off
- NM DPCP did not receive CDC Enhanced Funding.
Continued building the evidence-based lifestyle change program infrastructure using state funds

Despite all of the above setbacks, the DPCP persevered with the support of NACDD to move the program forward.

Partners

- Evidence-based lifestyle change program coordinators
- Blue Cross Blue Shield NM
- Molina Health Care NM
- Presbyterian Health Care
- United Healthcare
- Present and future diabetes prevention programs
- State of NM Risk Management
- Department of Health Information Technology

COMMON THREADS

As we evaluated the project, it became apparent that there were themes with organizational or implementation tactics that facilitated the states' work in their strategic focus areas. We called these "facilitating factors." Similarly, there were themes with barriers to success the states encountered. The following is a brief overview of some of the most common facilitating factors and barriers that crossed all strategic focus areas.

Facilitating Factors

- Used funding and other resources to supplement the NACDD funding
- Prepared to respond to unanticipated opportunities to promote the evidence-based lifestyle change program
- Established credibility as content experts and neutral conveners
- Engaged stakeholders early in the process
- Considered the stakeholder perspective when illustrating the benefits of the evidence-based lifestyle change program
- Leveraged internal and external partners with expertise, credibility and connections
- Cultivated high level support including identification of champions
- Utilized existing network and relationships with evidence-based lifestyle change program providers
- Used and adopted existing materials and resources, or developed new where gaps existed
- Integrated other evidence based programs with their diabetes prevention work
- Linked with the CDC-funded National Diabetes Prevention Program grantees

Barriers

- Limited funding, staffing, and other resources
- Programmatic delays caused by working through the state contract system
- Insufficient system to identify and remain current on the evidence-based lifestyle change program providers, especially upcoming program dates and locations
- Lacked experience, expertise and existing partnerships for their work with insurers and employers
- Overly optimistic project timeframe for implementation and sustainability of strategies

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CHRONIC DISEASE DIRECTORS

Promoting Health. Preventing Disease.