



NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS

STATE DIABETES
PREVENTION
PROJECT

2013

STORIES OF
SUCCESS

TABLE OF CONTENTS

Project Background.....	2
Strategic Focus Areas.....	3
Participating States.....	4
Minnesota.....	5
New York.....	7
West Virginia.....	9
Washington.....	11
Colorado.....	13
Kentucky.....	15
Michigan.....	17
New Mexico.....	19
Results.....	21
Common Threads.....	23

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.

February 2014

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 (S-DPP). 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 3; the map on page 4 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 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

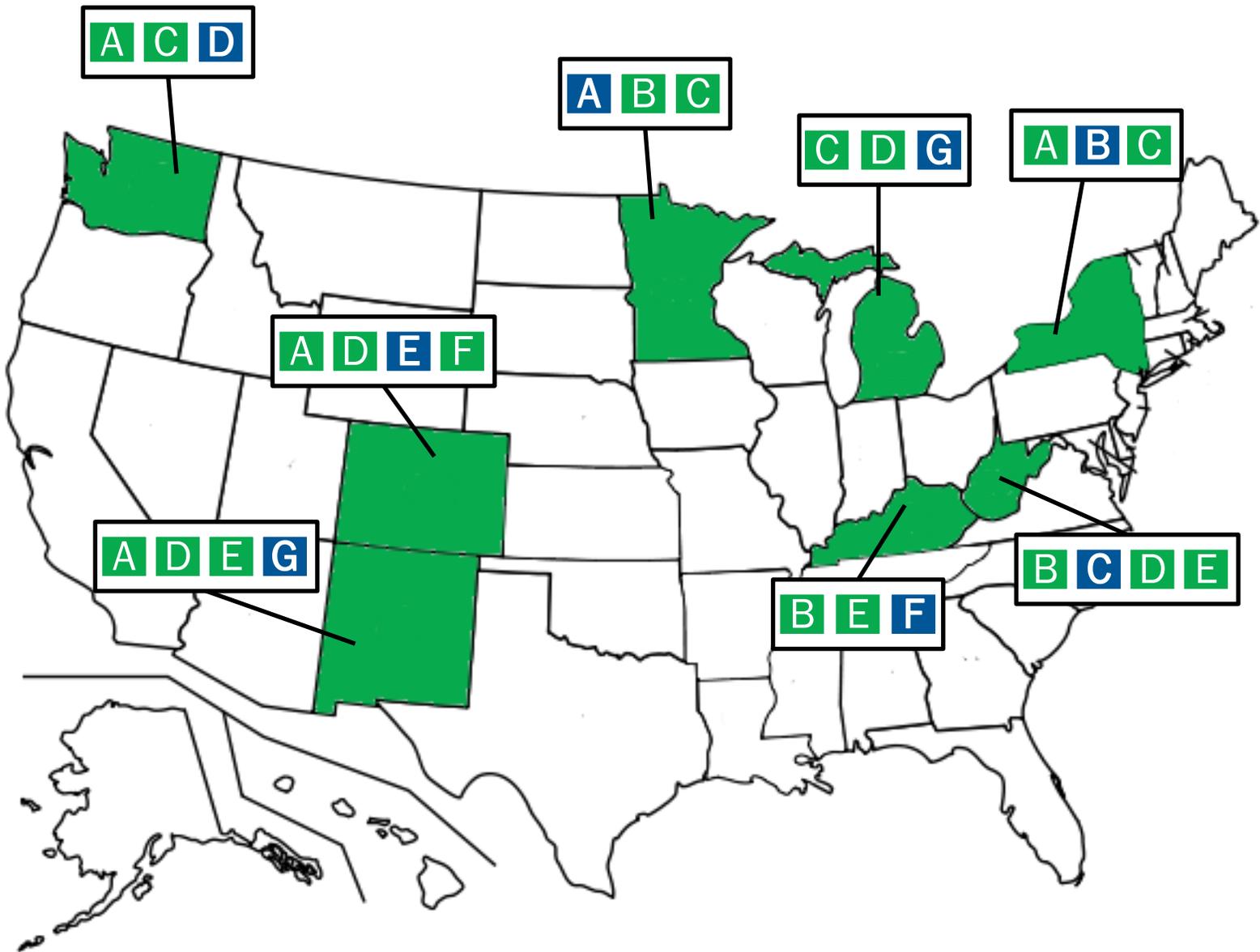
- **Strategic Focus Area G**

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 are delivering this program

PARTICIPATING STATES

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

Focus areas in **blue** are highlighted in the following pages



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

The MN Department of Health (MDH) developed the *Prediabetes and National DPP 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

Achievements

- 6 Community Conversations with 200 participants; 1 additional conversation planned
- 7 Marketing campaigns
 - 875,000 adults with prediabetes living in the geographic area covered by these campaigns
- 3 DPP Participant Success Story Videos: Hmong, Latino, Somali
- Patient and provider materials about prediabetes and the DPP
- Consumer prediabetes website with sections for each community

What positioned you for success?

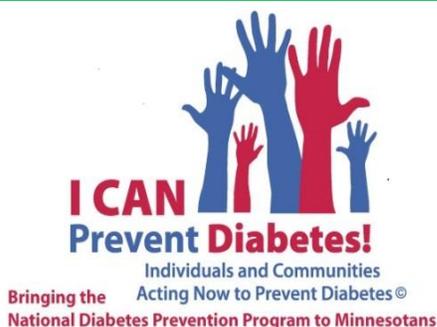
- Dedicated Funding: \$218,130
- Trust and interest from the five communities
- Experience with the evidence-based lifestyle change program
- Established connections with clinic and community organizations offering the program
- Awareness of cultural commonalities and differences
- Access to respected leaders in cultural communities willing to partner to address diabetes prevention

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

How did you reach 5 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. The facilitators requested that a seventh conversation be 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 study 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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How did you create 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 P² Collaborative of Western NY to create a New York State Diabetes Prevention Program provider 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 target for academic detailing
- Developed and utilized new relationships with health system partners to build a foundation for diabetes prevention referrals
- Connected with Quality & Technical Assistance Center (QTAC) (www.ceacw.org/qtac) to create an online portal to promote local evidence-based lifestyle change programs and to translate DPRP (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 P² to facilitate referrals to the evidence-based lifestyle change program through 211, NY Connects, and the QTAC Portal

Achievements

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

HEALTHY LIVING
WITH CHRONIC
CONDITIONS

PHYSICIAN TOOLKIT



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 evidence-based diabetes prevention programs.

Sue Millstein

What positioned you for success?

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

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

The toolkit included information about the 211 referral system, evidence-based lifestyle change program benefits, and how referral activity could assist providers in meeting the criteria for Patient Centered Medical Home 2011 and 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 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.

What are 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)

Challenges and Solutions

- Subcontract with 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 locally run diabetes prevention programs

Partners

- P² Collaborative of Western New York
- New York State Department of Health
- NYS Quality & Technical Assistance Center
- County Office of the Aging Departments

For More Information

Susan Millstein (slm11@health.ny.gov)

How did you implement an evidence-based lifestyle change program referral system with providers?

The West Virginia Diabetes Prevention and Control Program (DPCP) worked with four pilot sites to test the development and implementation of a diabetes prevention referral system. The aim was to embed the referral system, including prediabetes identification and evidence-based lifestyle change program referral, into the delivery systems currently used by healthcare providers. The system 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. Additionally, the DPCP worked with the West Virginia University Office of Health Services Research (WVU OHSR) to develop a screening/referral algorithm.

What was the State Health Department role?

- Selected pilot sites to test the development and implementation of the referral system
- Facilitated meetings between health centers and evidence-based lifestyle change program providers in order to establish a formalized referral process
- Maintained ongoing communication with health centers to discuss issues and successes of the referral process
- Developed a screening/referral algorithm to direct diagnosis and referral of at-risk patients
- Identified metrics of interest for health centers, such as how referrals fulfill the goals of 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

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

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



"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

What positioned you for success?

- Dedicated Funding: \$109,000
- Partnerships with health centers
- Partnerships with community organizations offering the evidence-based lifestyle change program
- Access to health center electronic health records via the WVU Office of Health Services Research

How did you implement a referral system with health centers that have individualized needs?

The DPCP partnered with four health centers to pilot the referral system. In order to accommodate unique needs, the DPCP worked with each center 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 data in order to help identify at-risk patients. The referral system was 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 system by letting health centers and providers see the successes of the patients and the program.

What were the factors for success?

- 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 ACA 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
- Connected with partners* whose staff had been trained as lifestyle coaches and had pre-existing relationships with their local health centers

Challenges and Solutions

- Participant progress communication 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
- 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
- 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

Partners

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

For More Information

Jessica Wright
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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 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 211 was a logical choice given its strong reputation within Washington. Washington residents can go to their website (www.win211.org) or call WIN211 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.

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

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

What positioned you for success?

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

With strong partnerships at the local and national level, we were able to develop a sustainable referral system for DPP in Washington. It wasn't always easy, but having a shared vision, endurance, and funding made it work.

*Jeanne Harmon and
Sara Eve Sarliker*

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, Diabetes Self-Management Education (DSME), and the Stanford Chronic Disease Self-Management Program (CDSMP). 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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Sara Eve Sarliker
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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

- WIN 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**



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 24 participated in the demonstration program



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

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 24 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

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 (DPA) 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

Kelly McCracken
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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

Achievements

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

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

Janice Haile

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

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.

Challenges and Solutions

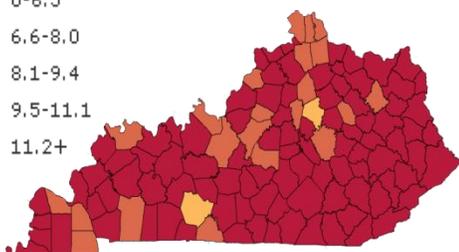
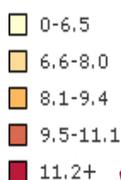
- The Medicaid program lacks funding to support the evidence-based lifestyle change program
 - Medicaid MCOs have engaged in active discussions regarding DPP coverage. Department for Medicaid Services CMO has agreed to work with the MCO medical directors to develop alternative support and funding model 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

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

Kentucky Needs You To Help Reverse Diabetes Trends

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



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

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

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)

For More Information

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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 diabetes prevention 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 DPP 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

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)

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

Kristi Pier (PierK@michigan.gov)

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 their evidence-based lifestyle change programs. 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, available Spring 2014)
- Discussions with the State about adoption of the evidence-based lifestyle change program as a covered health benefit

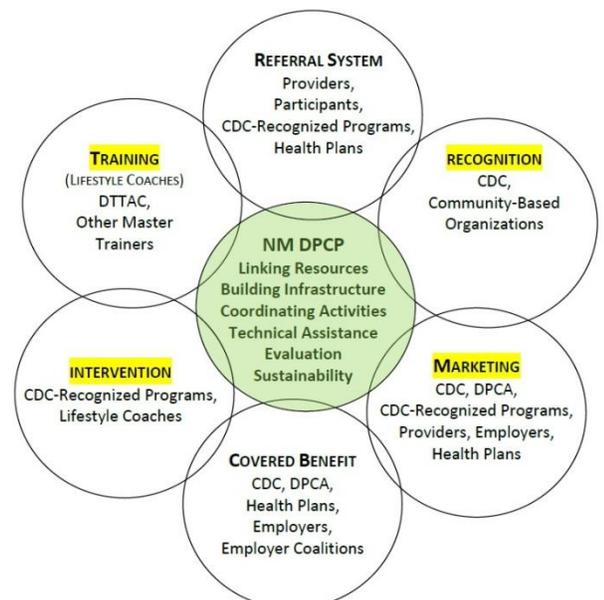
Working with NACDD and the other funded states on the S-DPP project has given the expansion of the NDPP in New Mexico a real boost. It has also confirmed that DPCPs have a critical role to play in this endeavor.

Judith Gabriele

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



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

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

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.*

For More Information

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RESULTS

The Results Tables display the aggregate results of the State Diabetes Prevention Project. Indicators were predetermined and measured for the states working in a selected Strategic Focus Area.

Strategic Focus Area A: Prediabetes Awareness	
Indicator	Total
Number of marketing campaigns	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)	248
Number of primary care health providers (physicians, PA, and NP) in participating delivery sites	805
Number of adult patients served by participating healthcare delivery sites	241,732
Strategic Focus Area C: Healthcare Provider Referral	
Indicator	Total
Number of healthcare system partners (overall system)	51
Number of healthcare delivery sites within the system partners (e.g. clinic/practice)	146
Number of primary care health providers (physicians, PA, and NP) in participating delivery sites	1,066
Number of adult patients served by participating healthcare delivery sites	313,655
Optional indicator: Number of adult patients in participating healthcare delivery sites referred to an evidence-based lifestyle change program	678
Strategic Focus Area D: Referral System	
Indicator	Total
Number of system partners (overall system)	31
Number of adults with prediabetes living in geographic area covered by the referral system(s)	3,136,562
Optional indicator: Number of adults referred to an evidence-based lifestyle change program through the newly created referral system(s)	261

RESULTS

Strategic Focus Area E: Public Employee Covered Health Benefit

Indicator	Total
Number of presentations/meetings with government employees	10
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	147,511
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

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%



COMMON THREADS

As we evaluated the project, it became apparent that there were themes with organizational or implementation tactics that facilitated the state's work in their strategic focus area. 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.

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

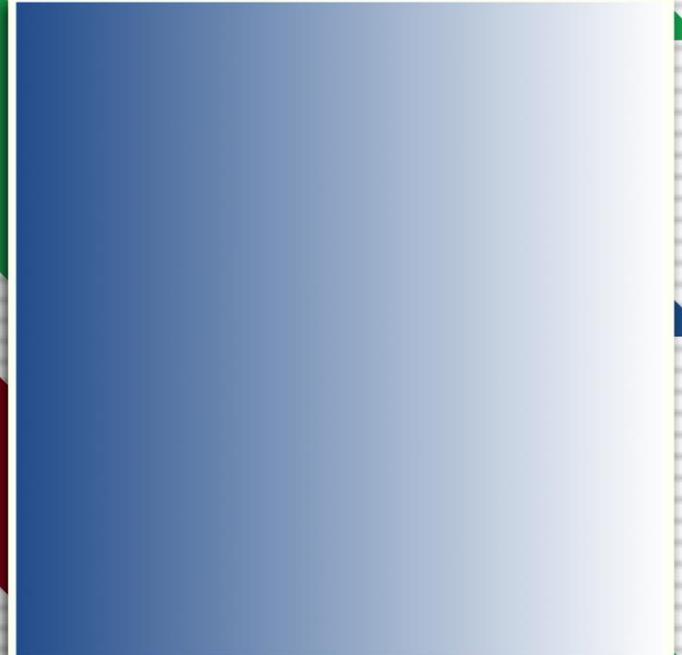
Barriers

- 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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