

2016-2018 Santa Clara County  
Diabetes Prevention Initiative  
Strategic Plan

WE CAN PREVENT  
TOGETHER  
DIABETES



Santa Clara County  
**PUBLIC  
HEALTH**

# 2016-2018 Santa Clara County Diabetes Prevention Initiative Strategic Plan

*"The Diabetes Prevention Initiative (DPI) ensures that people with prediabetes are identified and connected to prevention, thereby increasing a healthy lifespan and decreasing the burden of illness. The DPI exemplifies the County's commitment to Better Health for All, promoting prediabetes awareness and action, particularly among Santa Clara County's high risk, low income, and diverse ethnic populations."*

Supervisor Ken Yeager  
Santa Clara County Board of Supervisors

Prepared by  
Santa Clara County Public Health Department  
July 2016

# 2016-2018 Santa Clara County Diabetes Prevention Initiative Strategic Plan

## Executive Summary

In early 2015, as directed by the Santa Clara County Board of Supervisors, the Public Health Department launched the **Diabetes Prevention Initiative (DPI)** to increase diabetes prevention awareness, screening and resources in Santa Clara County. The **DPI** supports better health for all by ensuring that people with prediabetes are identified and connected to prevention education and community healthy eating, active living resources, increasing a healthy lifespan and decreasing the burden of illness. The overarching goal of the **DPI** is to prevent individuals at the highest risk for type 2 diabetes, especially those identified with prediabetes, from progressing to a type 2 diabetes diagnosis.

The **DPI** takes a health equity approach, aiming to catalyze societal efforts to prevent diabetes inequities by creating necessary conditions for health for all people, particularly for those who have experienced socioeconomic disadvantage or historical injustices, including the large Medi-Cal population in Santa Clara County.

The **DPI** is in the second year of its four-year timeline. In 2015, the **DPI** implemented a media campaign to raise County resident awareness about preventing diabetes, conducted two outreach events to screen and test for diabetes risk, and reviewed evidence-based diabetes prevention practices and programs. These actions led to recommendations to develop a plan to guide diabetes prevention activities in the County, roll out new components of the County's awareness campaign, and expand community diabetes prevention resources.

In response to these recommendations, during Spring 2016, the Santa Clara County Public Health Department convened a countywide diabetes prevention stakeholder group to complete a multi-year diabetes prevention strategic plan. Facilitated by Ad Lucem Consulting, the strategic planning process identified action steps to increase diabetes prevention awareness, screening, and referral, and enhance and expand access to diabetes prevention resources.

The resulting three year **DPI** Strategic Plan leverages existing resources and initiatives including the Public Health Department, and identifies activities, recommended roles, outcomes, and timelines for the following focus areas crucial to diabetes prevention:

- Raise Prediabetes Awareness
- Establish Screening and Referral Protocols
- Increase Coverage for and Access to Evidence Based Diabetes Prevention Programs

Through the **DPI** Strategic Plan, the County will build on past experience to deepen and scale prediabetes and diabetes prevention, particularly for the communities at highest risk for developing type 2 diabetes.

# Santa Clara County Diabetes Prevention Initiative

## Background

In January 2015, the Santa Clara County Board of Supervisors recognized the importance of preventing diabetes and directed the Public Health Department to work with Supervisor Yeager on a countywide plan to improve access to diabetes screening and diabetes prevention education. Throughout 2015, three workgroups, led by the Santa Clara County Public Health Department, took action on the following:

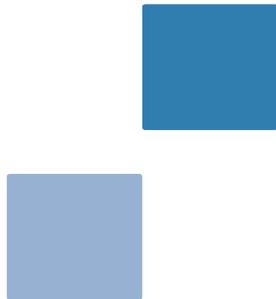
- Diabetes Prevention Awareness – Created the ***It's in our hands. Together we can prevent diabetes*** media campaign to raise County resident awareness and knowledge of preventing diabetes. The campaign, conducted in English, Spanish & Vietnamese, reaches out to the County's diverse ethnic and low income communities. The campaign promotes the multilingual Public Health website which explains prediabetes and diabetes risk factors, encourages those at risk to get screened by a health care provider, and provides resources to help prevent or manage diabetes.
- Prediabetes/Diabetes Screening – Conducted two large outreach events that included diabetes risk testing and blood glucose testing. Outreach events increased access to screening for diverse low income communities at high risk for prediabetes/diabetes and linked County residents identified as prediabetic/diabetic with community resources.
- Diabetes Prevention Community Resources – Reviewed evidence based practices to support diabetes prevention behavior change in diverse populations; inventoried evidence-based diabetes prevention programs in the County, such as the Indian Health Center and YMCA Diabetes Prevention Program; and recommended strategies to expand/improve access to diabetes prevention resources.

Recommendations to continue and enhance County diabetes prevention in 2016 and beyond included:

- Convene a broad stakeholder group to develop a multi-year diabetes prevention initiative for the County.
- Develop and deliver the second (***Know Your Risk***) and third (***Get Connected to Services***) components of the Diabetes Prevention Awareness Campaign to reach additional diverse, low income County residents.
- Implement recommendations to expand evidence-based, community diabetes prevention resources in partnership with community organizations and agencies.

The Strategic Plan presented in this report addresses the above recommendations and was developed by diverse diabetes prevention stakeholders participating in the Santa Clara County **Diabetes Prevention Initiative (DPI)**.

# The Case for Prevention in Santa Clara County



## ***Impact of Diabetes in Santa Clara County:***

- 46% of Santa Clara County adults are estimated to have prediabetes or undiagnosed diabetes. (1)
- Diabetes was the 6th leading cause of death in Santa Clara County in 2013. (2)
- From 2012-2014, the age-adjusted death rate for diabetes in Santa Clara County was 21.9 (per 100,000 people), slightly higher than the overall California diabetes death rate. (3)
- 8% of Santa Clara County adults say they have been diagnosed with diabetes. (4)
- A higher percentage of Latino (11%), African American (10%), and Vietnamese (10%) adults in Santa Clara County report being diagnosed with diabetes than White adults (8%). (4)

## ***Diabetes Costs in California:***

- The total cost of diabetes was estimated at over \$27 billion. (5)
  - \$19 billion on direct medical care
  - \$8 billion on other indirect costs
- Undiagnosed diabetes medical care costs California another \$2.8 billion and prediabetes adds another \$5.3 billion in medical care costs. (5)

# Santa Clara County Health Equity Approach

*"The definitive factors in determining whether someone is in good health extend significantly beyond access to care and include the conditions in their life and the conditions of their neighborhoods and communities."*

*John Auerbach  
Centers for Disease Control and  
Prevention*

Diverse ethnic and low income communities in Santa Clara County continue to be impacted by inequality and poor health outcomes, including a disproportionately higher rate of diabetes among Latinos, African Americans, and Vietnamese American residents. Diabetes is often an underlying contributor to heart conditions, other disabling diseases, disabilities and death.

- **Health inequities** are differences in health that are avoidable, unfair, and unjust. Health inequities experienced by County residents are largely shaped by education, income, race, and discrimination.
- **Health disparities** are differences in health outcomes among groups of people.

The Public Health Department's equity approach to diabetes prevention includes diverse partnerships and deep community relationships. The Department aims to reduce diabetes inequities by establishing and advocating for policies, programs, and services that provide every individual with the opportunity for optimal health. This begins with working toward all County residents having equal access to places for physical activity, affordable healthy foods and beverages, tobacco-free environments, and high quality preventive health care. (6, 7)

The **Diabetes Prevention Initiative** supports *Better Health for All* by assuring that diverse County residents have access to prediabetes screening and prevention resources.



# Diabetes Prevention Initiative Strategic Plan Guiding Principles



## ***Build on the County's experience and capacity to address prediabetes***

The **DPI** Strategic Plan leverages stakeholder commitment and experience, existing partnerships and resources to document and disseminate best practices and bring effective pilots to scale across the County. The **DPI** Strategic Plan increases community organization and health care system capacity to prevent prediabetes and diabetes.



## ***Prioritize the populations at highest risk***

The **DPI** Strategic Plan emphasizes and tailors activities to best meet the cultural, language, socioeconomic and lifestyle needs of County residents of all ages at high risk for diabetes. Diverse ethnic and low-income communities bear the greatest diabetes burden, and Medi-Cal recipients have limited covered services for diabetes prevention. Type 2 diabetes is increasing in children and adolescents and diabetes prevention services for this age group are rare.



## ***Integrate with County primary care redesign efforts***

The federal Affordable Care Act (ACA) provides opportunities and incentives to integrate diabetes prevention screening, referral and coverage into Santa Clara County primary care. County stakeholders engaged in redesigning primary care to lower costs, increase customer engagement, and improve health outcomes are important partners to engage in implementing the **DPI** Strategic Plan.



## ***Leverage and enhance collaborations among health plans, CBOs and clinic networks***

There is a long history of collaboration among health plans, hospitals, clinics and community-based organizations (CBOs) in the County. The **DPI** Strategic Plan leverages and enhances established collaborations to increase awareness and utilization of diabetes prevention resources; scale successful pilot programs to increase reach; and engage County leaders to increase County capacity to identify residents at high risk for diabetes and connect them to and cover prevention resources.



## ***Link to California Department of Public Health (CADPH) and Centers for Disease Control and Prevention (CDC) prediabetes/Diabetes Prevention Program efforts***

Representatives from the County participate in California's statewide diabetes prevention planning process. The **DPI** Strategic Plan builds on learnings from the statewide planning process and integrates the gold-standard tools available from the CDC, including: 1) the Diabetes Prevention Program (DPP), an evidence-based lifestyle modification diabetes prevention program; and 2) the American Medical Association (AMA)/CDC Prevent Diabetes STAT (Screen, Test, Act, Today) toolkit, a set of resources for health care teams.

# Diabetes Prevention Initiative Strategic Plan Overview

## Focus Areas

The **DPI** Strategic Plan, rooted in the guiding principles (page 5), presents a comprehensive diabetes prevention approach encompassing a continuum of diabetes prevention strategies including prediabetes awareness, prediabetes screening and referral to prevention resources, and access to diabetes prevention programs.

### Focus Area 1 - Raise Prediabetes Awareness

#### Goal

Increase awareness/knowledge among County residents, community organizations and health care providers about risk factors for prediabetes and actions to take to prevent diabetes.

#### Activities

- Add culturally, linguistically and youth appropriate elements and implement the existing County prediabetes awareness media campaign to reach specific priority populations.
- Engage providers/clinics in disseminating diabetes awareness media campaign materials to promote prediabetes awareness, screening, and referral.
- Engage community organizations to use social/electronic media to disseminate County/CDC diabetes prevention media campaign materials to reach priority populations.

### Focus Area 2 - Establish Screening and Referral Protocols

#### Goal

Increase access to screening (risk testing and blood glucose testing) and referrals to health care providers, prevention programs and community resources for those at risk for prediabetes and diabetes in the County.

#### Activities

- Engage community organizations as prediabetes risk testing sites to identify individuals at risk for diabetes and refer to health care providers.
- Package and promote evidence based prediabetes screening/referral clinical models to safety net clinics.
- Promote lessons learned from ongoing prediabetes screening/referral safety net clinic pilots and programs.
- Routinize prediabetes screening/referral in safety net clinics.
- Develop mechanisms to refer individuals screened at greater risk for prediabetes to community based healthy eating, physical activity, and tobacco cessation resources.

## Focus Area 3 - Increase Coverage for and Access to Evidence Based Diabetes Prevention Programs

### Goal

Increase coverage for, supply of and participation in evidence-based, feasible and cost effective diabetes prevention programs in the County.

### Activities

- Develop and implement a strategy to increase health plan and employer coverage of DPPs with a focus on Medi-Cal recipients.
- Research/promote practices that motivate participation/completion of the DPP among people with prediabetes.
- Develop a plan for scaling the DPP to assure residents throughout the County have access.
- Identify and promote feasible and cost effective evidence based DPP alternatives that require a reduced time commitment from participants.

## Refine and Evaluate the DPI Strategic Plan

### Goal

Evaluate **DPI** progress towards achieving outcomes and expand membership to inform strategic plan refinements to maximize **DPI** impact.

### Activities

- Recruit additional members to the **DPI**.
- Review the **DPI** Strategic Plan periodically to assess progress and make modifications as needed.
- Monitor progress to achieving strategic plan outcomes.

# Santa Clara County Diabetes Prevention Initiative Strategic Plan

The **DPI** Strategic Plan identifies the actions needed over the next 3 years to make progress on diabetes prevention. The **DPI** Strategic Plan describes how the Santa Clara County Public Health Department (SCCPHD), health plans, health systems, provider champions, community leaders, and coalitions of community organization partners can play a role in implementing and scaling diabetes prevention best practices. For each focus area, the **DPI** Strategic Plan lists activities to accomplish goals, recommends organizations to engage, identifies outcomes that will result from the activities, and sets a timeline for implementation. Activities in the three focus areas will be addressed simultaneously, and a few activities within each focus area identified as “high priority” (marked with a red asterisk) will be addressed first. The **DPI** Strategic Plan is intended to be a living document that will be reviewed to assess progress and refined periodically to reflect additional collaborators and emerging opportunities.

The **DPI** Strategic Plan refers to diabetes screening activities, which include risk testing (a paper or online diabetes risk assessment questionnaire) and blood glucose testing, such as the hemoglobin A1C test. Visit the Public Health Department diabetes website at [www.SCCPreventDiabetes.org](http://www.SCCPreventDiabetes.org) to download or take the online diabetes risk test.

**DPI** stakeholders will meet quarterly to share progress, maintain momentum, and refine and evaluate the Strategic Plan. Individual focus area workgroups will support the implementation of their specific activities and will meet at quarterly **DPI** meetings and as needed between meetings.

Focus Area 1 - Raise Prediabetes Awareness			
Activities	Recommended Roles	Outcomes	Timeline
<p><b>1. Develop and implement a plan to add additional culturally, linguistically and youth appropriate elements to the County’s existing paid media campaign to reach specific priority populations with prediabetes awareness messages</b></p> <ul style="list-style-type: none"> <li>Determine the potential for adding images/translations to the paid campaign                             <ul style="list-style-type: none"> <li>Explore feasibility of convening a community member advisory group for input when future campaign images are created</li> </ul> </li> <li>Identify priority populations to reach, including youth, seniors, men, and African American, Latino, Vietnamese, Chinese, Taiwanese, Filipino, Korean, Asian Pacific Islander (e.g., Tongan, Samoan, Hawaiian), Asian Indian, and Russian populations</li> <li>Develop and apply criteria for prioritizing the high risk populations to target</li> <li>Phase in visuals tailored for additional priority populations*</li> </ul>	<ul style="list-style-type: none"> <li>SCCPHD tailors paid media campaign</li> <li>Diabetes Prevention Awareness Workgroup (DPA) provides input (e.g., feedback on culturally appropriate images)</li> <li>SCCPHD places paid media</li> </ul>	<ul style="list-style-type: none"> <li>Increased awareness of prediabetes prevention among priority populations</li> <li>Increased awareness of steps to take to prevent diabetes</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Develop plan/images, including community input</li> <li>Use new images in the 11/2016 paid media ad campaign to support American Diabetes Month*</li> <li>Phase in 4 new ad visuals to provide total of 8 ads</li> <li>Leverage CDC/CA Media</li> </ul> <p>Year 2:</p> <ul style="list-style-type: none"> <li>Explore additional language translation</li> <li>Explore funding (e.g., leverage PICH funding) for additional tailoring</li> <li>Disseminate new ad visuals and continue leveraging CDC/CA Media</li> </ul> <p>Year 3:</p> <ul style="list-style-type: none"> <li>Conduct focus groups to test images/messages</li> </ul>

## Focus Area 1 - Raise Prediabetes Awareness

Activities	Recommended Roles	Outcomes	Timeline
<ul style="list-style-type: none"> <li>Link to/leverage the CDC/CA media campaigns and timing</li> <li>Implement paid media campaign, including placements in digital and social media, utilizing new and existing images</li> </ul>			
<p><b>2. Engage providers/clinics in disseminating media campaign materials to enhance awareness of the need for, and resources to address prediabetes screening and referral</b></p> <ul style="list-style-type: none"> <li>Identify clinics to participate in disseminating the County/CDC media campaign materials*               <ul style="list-style-type: none"> <li>Focus on safety net clinics</li> </ul> </li> <li>Engage clinics in disseminating tailored media campaign materials to meet cultural/linguistic needs</li> </ul>	<ul style="list-style-type: none"> <li>SCCPHD and DPA workgroup engage providers/clinics</li> </ul>	<ul style="list-style-type: none"> <li>Clinics/providers engaged in raising prediabetes awareness</li> <li>Increased awareness of individual prediabetes risk among priority populations</li> </ul>	<p>Years 1 and 2:</p> <ul style="list-style-type: none"> <li>Identify/meet with providers/ clinics</li> </ul> <p>Years 2 and 3:</p> <ul style="list-style-type: none"> <li>Disseminate materials</li> </ul>
<p><b>3. Engage organizations to disseminate County/CDC campaign materials through social/electronic media to reach priority populations with prediabetes prevention messages</b></p> <ul style="list-style-type: none"> <li>Identify, understand capacity of and outreach to community organizations serving priority populations including schools, the faith community and youth-serving and social service organizations.*</li> <li>Develop a toolkit to guide organizations in disseminating prediabetes owned media campaigns:*               <ul style="list-style-type: none"> <li>Identify opportunities to cross promote SCCPHD/CBO resources and events</li> <li>Develop communications materials to disseminate through partners' owned media channels, integrating materials developed for County paid media campaign</li> <li>Train organizations to use the toolkit and refer people to online resources</li> <li>Tailor messages/images to ensure cultural and linguistic competence</li> <li>Develop a timeline for piloting/implementing coordinated owned media campaigns</li> </ul> </li> <li>Link owned and paid media campaigns</li> </ul>	<ul style="list-style-type: none"> <li>SCCPHD Diabetes Prevention Coordinator inventories and engages CBOs</li> <li>SCCPHD Communications Lead creates media toolkit and develops/delivers training</li> <li>DPA Workgroup provides input and introductions to organizations</li> </ul>	<ul style="list-style-type: none"> <li>Community organizations engaged in increasing awareness of prediabetes risk to priority populations</li> <li>Increased awareness of prediabetes risk among priority populations</li> <li>Increased awareness of diabetes prevention events</li> <li>Increased awareness of steps to take to prevent diabetes</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Identify organizations*</li> <li>Develop toolkit*</li> <li>Develop/deliver training</li> <li>Initiate distribution of toolkit</li> </ul> <p>Year 2:</p> <ul style="list-style-type: none"> <li>Expand use of toolkit</li> <li>Meet with organizations/identify opportunities</li> </ul> <p>Year 3:</p> <ul style="list-style-type: none"> <li>Implement coordinated owned media campaigns</li> <li>Ongoing dissemination of toolkit</li> </ul>

## Focus Area 2 - Establish Screening and Referral Protocols

Activities	Recommended Roles	Outcomes	Timeline
<p><b>1. Engage community organizations as prediabetes risk testing/referral sites</b></p> <ul style="list-style-type: none"> <li>Identify/outreach to trusted community organizations that provide services in areas of food security, health education and exercise: <ul style="list-style-type: none"> <li>Cultivate organizational leadership as champions for prediabetes risk testing/referral <ul style="list-style-type: none"> <li>Frame diabetes prevention as integral to the organization’s mission serving constituents</li> <li>Identify the “value add” and incentives for organizations to conduct risk testing/referral</li> <li>Enlist community organizations in marketing the DPP/diabetes prevention resources</li> </ul> </li> </ul> </li> <li>Create and pilot standardized, flexible prediabetes risk testing/referral protocols for trusted community organizations and non-traditional venues (e.g., pharmacies, social services agencies, senior centers, faith community) <ul style="list-style-type: none"> <li>Adapt and pilot the American Diabetes Association’s (ADA) diabetes risk test and the American Medical Association (AMA)/Centers for Disease Control (CDC) Prevent Diabetes STAT toolkit for community settings as a standard risk testing/referral protocol* <ul style="list-style-type: none"> <li>Include guidance in toolkit to explain results/next steps and encourage blood glucose testing for people screened “at risk”</li> <li>Explore translation for languages beyond English/ Spanish</li> </ul> </li> </ul> </li> <li>Provide one-on-one TA and training to implement the protocols</li> <li>Gather lessons learned from pilots, develop best practice guide and disseminate</li> <li>Track number of people risk tested/referred by community organizations and report to SCCPHD</li> </ul>	<ul style="list-style-type: none"> <li>SCCPHD/Screening &amp; Referral (S/R) workgroup outreaches to organizations</li> <li>YMCA/ADA adapts and pilots the STAT toolkit</li> <li>SCCPHD adapts and pilots ADA diabetes risk test</li> <li>SCCPHD disseminates toolkit/screener</li> <li>Community settings screen clients with risk test for prediabetes</li> </ul>	<ul style="list-style-type: none"> <li>STAT toolkit/ADA diabetes risk test adapted as screening/referral protocol for community settings</li> <li>Prediabetes screening/referral protocols incorporated into community organization services and events</li> <li>Organizations track # risk tested, submit to SCCPHD</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Identify community organizations</li> <li>Develop outreach strategy</li> <li>Adapt STAT toolkit/ADA diabetes risk test*</li> <li>Pilot STAT toolkit/ADA diabetes risk test and gather lessons learned/best practices</li> </ul> <p>Year 2:</p> <ul style="list-style-type: none"> <li>Meet with and engage organizations</li> <li>Develop and deliver trainings on implementing STAT toolkit/ADA diabetes risk testing</li> </ul> <p>Year 3:</p> <ul style="list-style-type: none"> <li>Refine adapted STAT toolkit/ADA diabetes risk test</li> <li>Disseminate/implement adapted toolkit/risk test broadly</li> </ul>
<p><b>2. Package and promote evidence based prediabetes screening/referral clinical models</b></p> <ul style="list-style-type: none"> <li>Promote the STAT toolkit to clinics/pilots serving priority populations <ul style="list-style-type: none"> <li>Identify/outreach to clinics to pilot implementing</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>SCCPHD, Ambulatory Care &amp; CHP meet with clinics to promote STAT toolkit, develop group session</li> </ul>	<ul style="list-style-type: none"> <li>STAT toolkit/ADA diabetes risk test adopted as screening/referral protocol for clinics</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Identify and meet with clinic staff and leadership</li> <li>Assess clinic workflow</li> <li>Incorporate screening triggers for</li> </ul>

## Focus Area 2 - Establish Screening and Referral Protocols

Activities	Recommended Roles	Outcomes	Timeline
<p>modules of the STAT toolkit pilot and provide 1-to-1 TA and training to implement the toolkit, including clinic staff (nurses, medical assistants)</p> <ul style="list-style-type: none"> <li>• Obtain clinic leadership (CEO, others) buy in</li> <li>• Chart clinic work flow to integrate screening, referral and follow-up</li> <li>• Train clinic staff to implement the protocol and use motivational techniques</li> <li>• Gather lessons learned from pilots and develop best practices screening guide</li> <li>• Include guidance in toolkit to explain results/next steps and encourage blood glucose testing for people screened “at risk”</li> <li>• Explore translation for languages beyond English/ Spanish</li> <li>• Include screening triggers for priority populations (e.g., screen at lower BMI for Asian populations</li> <li>• Incorporate existing County prediabetes/diabetes resource list to assist with referrals</li> <li>• Identify and review group session models for prediabetes screening, education, and referral               <ul style="list-style-type: none"> <li>• Develop a group session protocol based on existing models                   <ul style="list-style-type: none"> <li>• Ensure individuals screened at high risk have access to blood glucose testing</li> <li>• Identify needed clinic infrastructure to support group session model</li> <li>• Assess clinic capacity to deliver group prediabetes sessions</li> <li>• Identify appropriate group session leader and train staff to conduct pilot group sessions</li> <li>• Implement pilot group sessions</li> <li>• Collect lessons learned and best practices from pilot group sessions</li> </ul> </li> <li>• Create a toolkit with guidelines for conducting group sessions</li> <li>• Disseminate the group session toolkit and train clinic staff</li> </ul> </li> </ul>	<p>protocol/toolkit, conduct outreach, training and TA, gather lessons learned and develop best practices screening guide</p> <ul style="list-style-type: none"> <li>• SCCPHD develops group session tool kit</li> <li>• S/R Workgroup disseminates toolkit</li> <li>• S/R Workgroup identifies EHR/EMR modules</li> </ul>	<ul style="list-style-type: none"> <li>• Best practice systems (group sessions, EHR modules) to facilitate screening/referral in clinic settings promoted</li> <li>• Increased prediabetes screening, education, and referral by clinics</li> </ul>	<ul style="list-style-type: none"> <li>• priority populations and County resources into STAT toolkit</li> <li>• Begin promoting STAT toolkit</li> </ul> <p>Year 2:</p> <ul style="list-style-type: none"> <li>• Develop group session protocol</li> <li>• Continue promoting STAT toolkit</li> </ul> <p>Year 3:</p> <ul style="list-style-type: none"> <li>• Pilot group session protocol</li> <li>• Develop toolkit based on group session best practices and disseminate</li> <li>• Research EHR/EMR systems</li> <li>• Explore funding for EHR/EMR modules</li> <li>• Educate clinic leadership on benefits of clinical models</li> <li>• Package clinical models in a toolkit</li> </ul>

## Focus Area 2 - Establish Screening and Referral Protocols

Activities	Recommended Roles	Outcomes	Timeline
<ul style="list-style-type: none"> <li>Recommend Electronic Health/Medical Record (EHR/EMR) modules to automate prediabetes screening/referral                             <ul style="list-style-type: none"> <li>Identify EHR/EMR system with highest utilization in safety net clinics</li> <li>Support seeking funding to create new EHR/EMR modules</li> </ul> </li> <li>Utilize STAT toolkit and package best practice clinical models to:                             <ul style="list-style-type: none"> <li>Educate clinic leadership on benefits of the STAT, EHR/EMR enhancements, and group prediabetes sessions</li> <li>Provide evidence that these models reduce staff workload and enhance service delivery</li> </ul> </li> </ul>			
<p><b>3. Promote lessons learned from ongoing prediabetes programs and pilots</b></p> <ul style="list-style-type: none"> <li>Support and engage 1-3 prediabetes clinical pilot sites:                             <ul style="list-style-type: none"> <li>Facilitate sharing of lessons learned</li> <li>Document and disseminate lessons learned and best practices</li> </ul> </li> <li>Collaborate to develop and implement a shared evaluation strategy and methods</li> </ul>	<ul style="list-style-type: none"> <li>SCCPHD facilitates sharing of lessons learned among clinic pilots sites</li> <li>IHS, VHP and CHP develop/disseminate best practice guidelines based on pilots</li> <li>SCCPHD leads development of shared evaluation strategy</li> </ul>	<ul style="list-style-type: none"> <li>Lessons learned from pilots/programs enhance prediabetes screening/referral practice</li> <li>Pilots and programs utilize shared evaluation strategy</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Develop shared evaluation strategy and methods</li> <li>Gather lessons learned/best practices</li> </ul> <p>Year 2:</p> <ul style="list-style-type: none"> <li>Implement shared evaluation strategy</li> <li>Gather lessons learned/best practices</li> </ul> <p>Year 3:</p> <ul style="list-style-type: none"> <li>Implement shared evaluation strategy</li> <li>Package and disseminate lessons learned/best practices</li> </ul>
<p><b>4. Routinize prediabetes screening (diabetes risk test and blood glucose tests)/referral in clinics</b></p> <ul style="list-style-type: none"> <li>Assess current clinic prediabetes screening/referral practices</li> <li>Engage local ACA primary care redesign efforts to integrate screening/referral protocols (e.g., SCVHHS PRIME Ambulatory Care Redesign, Whole Person Care Leadership Group, American Heart Association's Million Hearts Campaign)</li> <li>Cultivate clinic leadership as champions for prediabetes screening/referral                             <ul style="list-style-type: none"> <li>Explore how prediabetes screening can be profitable for clinics</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>SCCPHD, Health Plans, CHP, and Ambulatory Care Services use pilot experience to develop strategy to integrate screening/referral into clinic workflow</li> <li>SCCPHD, CHP and Ambulatory Care Services cultivate champions and provide TA</li> </ul>	<ul style="list-style-type: none"> <li>Other campaigns integrate prediabetes screening/referral</li> <li>Feedback/referral process in place to facilitate communication between clinics and diabetes prevention services</li> <li>Increased prediabetes screening, education, and referral by clinics</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Develop outreach strategy</li> <li>Assess current clinic practices</li> <li>Identify and meet with health system key stakeholders</li> <li>Develop best practice guidelines around CBO/clinic referral feedback loops</li> </ul> <p>Year 2:</p> <ul style="list-style-type: none"> <li>Integrate prediabetes screening/referral into other campaigns</li> <li>Continue to cultivate prediabetes champions</li> </ul>

## Focus Area 2 - Establish Screening and Referral Protocols

Activities	Recommended Roles	Outcomes	Timeline
<ul style="list-style-type: none"> <li>Identify screening/referral incentives and disincentives</li> <li>Support/provide TA to implement referral/feedback loops between CBOs (e.g., YMCA) and clinics for participants in screening and DPPs               <ul style="list-style-type: none"> <li>Build on pilot project work to create a referral/feedback loop                   <ul style="list-style-type: none"> <li>Assess CBO and clinic needs, including the additional time and cost to administer the referral/feedback process</li> <li>Identify best practices for implementing referral/feedback loop</li> <li>Develop and disseminate guidelines for referral/feedback process</li> <li>Explore a train-the-trainer model for clinic staff</li> </ul> </li> </ul> </li> <li>Engage clinic leadership in promoting/implementing a scaled countywide strategy to address prediabetes</li> </ul>			<ul style="list-style-type: none"> <li>Provide TA to clinics</li> <li>Disseminate feedback loop best practice guidelines</li> </ul> <p>Year 3:</p> <ul style="list-style-type: none"> <li>Document and summarize lessons learned and implementation opportunities for scaling screening &amp; referral</li> <li>Engage clinic leadership in promoting/implementing the scaled strategy</li> </ul>
<p><b>5. Develop mechanisms to refer individuals screened at greater risk for prediabetes to community healthy eating, physical activity and tobacco prevention resources</b></p> <ul style="list-style-type: none"> <li>Referral protocols include resources promoting healthy weight, healthy foods and beverages, physical activity, and smoking cessation:               <ul style="list-style-type: none"> <li>Access to healthy foods/beverages such as farmers markets, school meals, community gardens, Rethink Your Drink, water/hydration stations</li> <li>Access to physical activity such as walk and bike to work/school programs, parks and trails, active transportation</li> <li>Tobacco use prevention such as tobacco campaign materials, tobacco cessation classes, Tobacco Helpline 1-800-662-8887</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>SCCPHD adds community resources to screening/referral protocols</li> <li>Community organizations distribute community resource marketing materials to clients/residents</li> </ul>	<ul style="list-style-type: none"> <li>Increased referrals to diabetes prevention resources</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Create library of community resource marketing materials</li> <li>Initiate marketing materials dissemination</li> </ul> <p>Years 2 and 3:</p> <ul style="list-style-type: none"> <li>Disseminate marketing materials</li> </ul>

## Focus Area 3 - Increase Coverage for and Access to Evidence Based Diabetes Prevention Programs

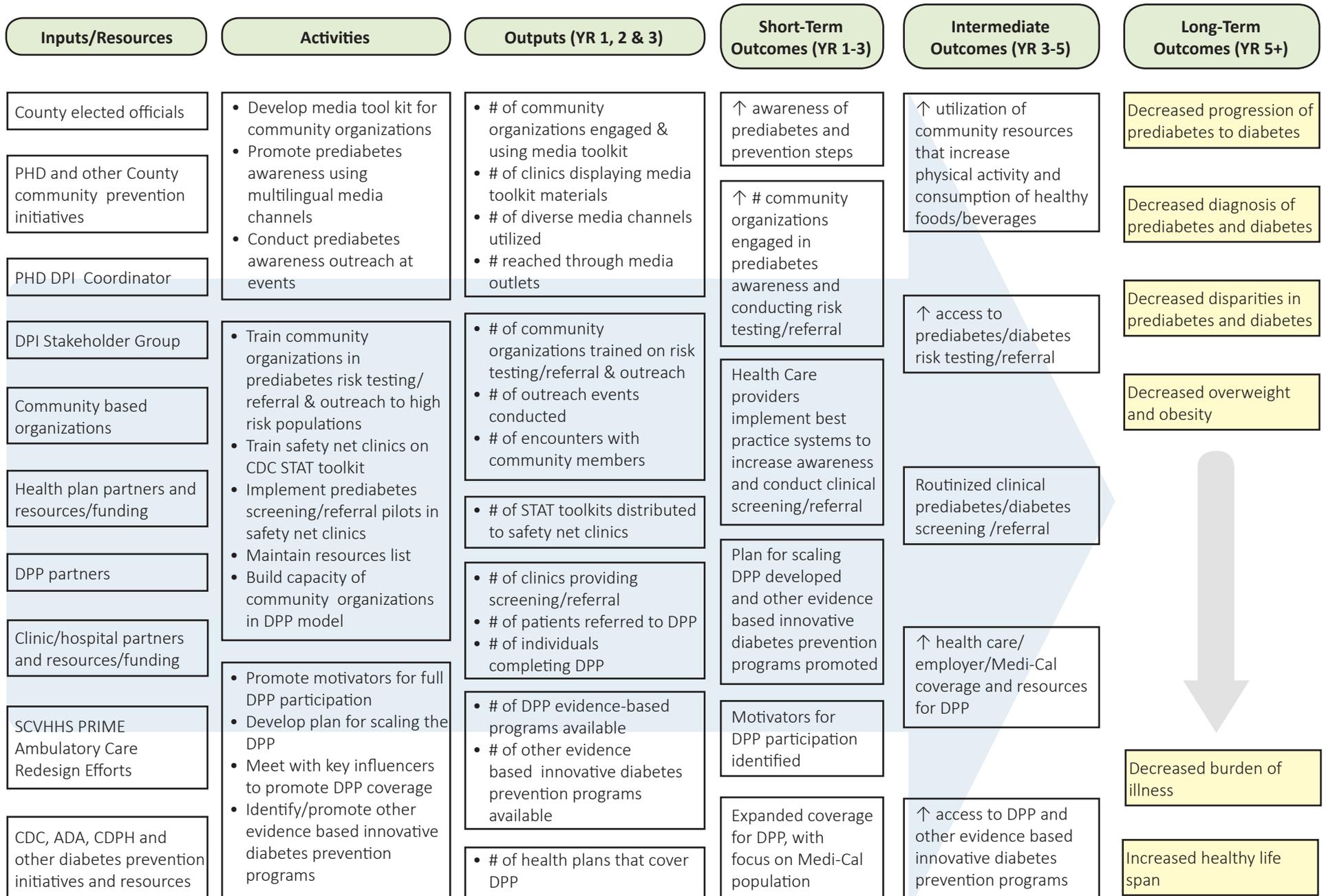
Activities	Recommended Roles	Outcomes	Timeline
<p><b>1. Develop and implement a strategy to increase health plan and employer coverage of the DPP with a focus on Medi-Cal recipients</b></p> <ul style="list-style-type: none"> <li>Identify current health system coverage practices and readiness to cover prevention*</li> <li>Stay apprised of CA Department of Public Health (CDPH) diabetes prevention strategic planning activities and CDC funded DPP practices to inform local DPP coverage expansion efforts</li> <li>Include coverage options/lessons from other health systems</li> <li>Meet with health plan leadership to explore potential coverage mechanisms                             <ul style="list-style-type: none"> <li>Define the “ask” for health plans (e.g., which programs/populations to cover)</li> <li>Engage Santa Clara Family Health Plan &amp; Blue Cross Medi-Cal Health Plan leadership to explore coverage options for Medi-Cal Managed Care populations                                     <ul style="list-style-type: none"> <li>Present and discuss diabetes prevention research and Return on Investment (ROI) with health plan leadership that best supports providing same day visits and diabetes prevention</li> </ul> </li> <li>Develop coverage recommendations                                     <ul style="list-style-type: none"> <li>Engage Healthcare Reform Stakeholders Group in promoting/implementing the recommendations</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>SCCPHD/DPI updates DPI on CDPH activities and DPI members utilize resources</li> <li>Coverage workgroup identifies coverage practices</li> <li>SCFHP, SCVHHS Ambulatory Care, VHP, Blue Cross &amp; CHP to share current coverage practices</li> <li>Coverage workgroup develops coverage recommendations and presents to Healthcare Reform Stakeholders Group</li> </ul>	<ul style="list-style-type: none"> <li>Mechanisms in place for learning from and leveraging CDPH work</li> <li>Health plan leadership engaged in strategizing about DPP coverage</li> <li>DPP coverage strategy developed</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Identify current practices in other health systems*</li> <li>Document opportunities/strategies for MediCal/health plan/employee coverage, including lessons learned from pilots</li> </ul> <p>Year 2:</p> <ul style="list-style-type: none"> <li>Meet with health plan leadership</li> <li>Develop coverage recommendations</li> <li>Conduct initial Healthcare Reform Stakeholders Group meeting</li> </ul> <p>Year 3:</p> <ul style="list-style-type: none"> <li>Engage Healthcare Reform Stakeholder Group in implementing coverage recommendations</li> </ul>
<p><b>2. Research/promote practices that motivate participation/completion of the DPP among people with prediabetes</b></p> <ul style="list-style-type: none"> <li>Test motivational techniques in DPP pilots                             <ul style="list-style-type: none"> <li>Develop and test culturally, socioeconomically, and age appropriate motivators for full DPP participation (e.g., social support, DPP facilitator ability to motivate)*</li> <li>Include diverse populations, including Medi-Cal populations</li> <li>Test motivational messages in the YMCA DPP and with other key stakeholders</li> <li>Gather lessons learned from motivator testing to develop best practice guide</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>YMCA proposes motivators to build into VHP/YMCA DPP</li> <li>Motivator workgroup reviews motivators/ provides input</li> <li>Gardner Family Health Network/IHS share lessons learned from obtaining participant commitment to DPP</li> <li>Catholic Charities and Fresh Approach share lessons learned</li> </ul>	<ul style="list-style-type: none"> <li>Motivators for full DPP participation identified for priority populations</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Identify motivators for enhancing commitment to full DPP participation*</li> </ul> <p>Year 2:</p> <ul style="list-style-type: none"> <li>Partners test and document efficacy of DPP motivators</li> </ul> <p>Year 3:</p> <ul style="list-style-type: none"> <li>Develop/disseminate DPP motivators best practices</li> </ul>

### Focus Area 3 - Increase Coverage for and Access to Evidence Based Diabetes Prevention Programs

Activities	Recommended Roles	Outcomes	Timeline
<p><b>3. Develop a plan for scaling the DPP to assure residents throughout the County have access</b></p> <ul style="list-style-type: none"> <li>Plan elements include: <ul style="list-style-type: none"> <li>Identifying lessons learned from existing County DPPs</li> <li>Expanding the network of CDC recognized DPP providers and CBOs offering the DPP</li> <li>Engaging employers/health plans/Medi-Cal/CBOs in understanding and promoting DPP</li> <li>Identifying funding sources for DPP program retention and expansion</li> <li>Continue to explore multiple models of DPP delivery</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Coverage workgroup develops plan</li> </ul>	<ul style="list-style-type: none"> <li>County plan for scaling DPP in place to guide implementation</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Learn from existing County DPPs</li> <li>Engage DPP providers/CBOs and employers</li> </ul> <p>Year 2:</p> <ul style="list-style-type: none"> <li>Continue engaging DPP providers/CBOs and employers</li> <li>Identify funding sources</li> </ul> <p>Year 3:</p> <ul style="list-style-type: none"> <li>Disseminate findings and scale DPP</li> </ul>
<p><b>4. Identify and promote feasible and cost effective evidence based DPP alternatives that require a reduced time commitment from participants</b></p> <ul style="list-style-type: none"> <li>Review analyses of effective diabetes prevention programs, including CDC studies/reports*</li> <li>Conduct a scan of County diabetes prevention programs*</li> <li>Identify criteria for assessing feasible, high quality, innovative and evidence based programs</li> <li>Apply criteria to identify quality programs that meet the needs of priority populations</li> <li>Market identified programs as referral resources</li> </ul>	<ul style="list-style-type: none"> <li>The Health Trust/ SCCPHD conducts review of effective programs</li> <li>Coverage Workgroup conducts scan</li> <li>Coverage Workgroup identifies and applies criteria</li> <li>SCCPHD &amp; CHP share referral resources with their networks</li> </ul>	<ul style="list-style-type: none"> <li>Criteria for assessing diabetes prevention program quality</li> <li>Expanded list of alternative diabetes prevention programs</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Conduct review and scan*</li> </ul> <p>Year 2:</p> <ul style="list-style-type: none"> <li>Identify/apply criteria to diabetes prevention programs</li> </ul> <p>Year 3:</p> <ul style="list-style-type: none"> <li>Disseminate list of high quality diabetes prevention programs</li> </ul>

Refine and Evaluate the DPI Strategic Plan			
Activities	Recommended Roles	Outcomes	Timeline
<p><b>1. Recruit additional members to the DPI</b></p> <ul style="list-style-type: none"> <li>Establish goals for <b>DPI</b> composition (e.g., #/type of organizations)</li> <li>Identify and outreach to potential members</li> </ul>	<ul style="list-style-type: none"> <li><b>DPI</b>/ Workgroups identify organizations</li> <li>SCCPHD Diabetes Prevention Coordinator conducts outreach</li> </ul>	<ul style="list-style-type: none"> <li>Larger, more representative <b>DPI</b></li> <li>Enhanced engagement of key County sectors and organizations</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Establish composition goals</li> <li>Identify and outreach to potential members</li> </ul> <p>Years 2-3:</p> <ul style="list-style-type: none"> <li>Continually review membership and recruit additional members</li> </ul>
<p><b>2. Review the DPI Strategic Plan periodically to assess progress and make modifications as needed</b></p> <ul style="list-style-type: none"> <li>Include Strategic Plan review and revision on <b>DPI</b> meeting agendas <ul style="list-style-type: none"> <li>Report workgroup progress on activities and outcomes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>SCCPHD Diabetes Prevention Coordinator creates agenda</li> <li>Workgroups present progress</li> </ul>	<ul style="list-style-type: none"> <li>Strategic Plan revised as needed</li> </ul>	<p>Year 1, 2, and 3:</p> <ul style="list-style-type: none"> <li>Include Strategic Plan review and revision on <b>DPI</b> meeting agendas</li> </ul>
<p><b>3. Monitor progress to achieving Strategic Plan outcomes</b></p> <ul style="list-style-type: none"> <li>Develop an evaluation plan to track progress on <b>DPI</b> Strategic Plan</li> <li>Track progress towards outcomes</li> <li>Disseminate <b>DPI</b> achievements</li> </ul>	<ul style="list-style-type: none"> <li><b>DPI</b> members share evaluation approaches</li> <li>SCCPHD develops evaluation plan including shared approaches</li> <li>SCCPHD develops report and presents to County Board of Supervisors</li> <li><b>DPI</b> members disseminate progress report to additional stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>Strategic Plan progress tracked</li> <li>Achievements and lessons learned disseminated</li> </ul>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>Develop evaluation plan</li> <li>Track progress</li> </ul> <p>Year 2:</p> <ul style="list-style-type: none"> <li>Continue tracking progress</li> </ul> <p>Year 3:</p> <ul style="list-style-type: none"> <li>Develop a report on progress</li> <li>Disseminate report to County leadership and other key stakeholders</li> </ul>

# Diabetes Prevention Initiative (DPI) Logic Model for Implementation (July 2016-June 2019)



# Diabetes Prevention Initiative Evaluation Plan

The **DPI** uses the **RE-AIM** evaluation framework to assess impact. RE-AIM defines **DPI** indicators and research questions, and measures **DPI** intervention success for individual behavior, community organization, clinical practice, systems and environmental changes. The **DPI** evaluation will collect and analyze data from multiple sources. RE-AIM findings will inform **DPI** program refinements and guide scaling diabetes prevention efforts.

<b>REACH</b>	
Participation and representativeness of the target population for the intervention	<ul style="list-style-type: none"> <li>• How many people were reached with diabetes prevention awareness information?</li> <li>• How many people received prediabetes risk testing through community organizations, with a focus on high risk communities?*</li> <li>• How many community organizations engaged in prediabetes awareness campaigns, with a focus on high risk communities?*</li> <li>• How many safety net clinics integrated the STAT toolkit into clinic settings?</li> <li>• How many people reached with prediabetes screening and referrals through safety net clinic pilots?</li> </ul>
<b>EFFECTIVENESS</b>	
Effectiveness of the intervention to achieve intended outcomes	<ul style="list-style-type: none"> <li>• What are the facilitators and barriers to prediabetes risk testing/referral in community organizations?</li> <li>• What are the facilitators and barriers to prediabetes clinical screening and referral in safety net clinic pilots?</li> <li>• How many safety net clinic patients referred to the DPP from clinic pilots?</li> <li>• What are safety net clinic pilot site patients' facilitators and barriers to accessing the DPP?</li> <li>• What is the average weight loss per participant completing the DPP or other evidence based innovative diabetes prevention programs?</li> </ul>
<b>ADOPTION</b>	
Intervention adoption by target organizations	<ul style="list-style-type: none"> <li>• How many and what types of community organizations establish prediabetes risk testing/referral systems?</li> <li>• How many safety net clinics establish prediabetes clinical screening and referral systems?</li> <li>• How many safety net clinics refer patients to DPP?</li> <li>• What are the policy, systems, and environmental change facilitators and barriers to DPP enrollment and completion?</li> </ul>
<b>IMPLEMENTATION</b>	
Implementation consistency, costs & adaptations	<ul style="list-style-type: none"> <li>• How many DPPs exist in Santa Clara County and which populations do they serve?</li> <li>• How many other evidence based innovative diabetes prevention programs exist in the County and which populations do they serve?</li> </ul>
<b>MAINTENANCE</b>	
Sustainability of interventions over time.	<ul style="list-style-type: none"> <li>• How many health plans cover DPP and which populations do they serve?</li> <li>• How many prediabetes screening and referral processes in safety net clinics have been integrated into clinic Electronic Medical Record and Quality Improvement systems?</li> <li>• How many community organizations have integrated prediabetes risk testing/referral into organizational practices?</li> <li>• How have County diabetes and obesity rates changed?</li> <li>• How have County diabetes and obesity disparities changed?</li> </ul>

\* Priority populations in high risk communities include: youth, seniors, men, and African American, Latino, Vietnamese, Chinese, Taiwanese, Filipino, Korean, Asian Pacific Islander (e.g., Tongan, Samoan, Hawaiian), Asian Indian and Russian populations.

# Diabetes Prevention Initiative Communications Framework

## Overarching Strategies

- Utilize the Santa Clara County **It's in your hands. Together we can prevent diabetes** media campaign as well as national diabetes prevention (CDC/Ad Council Campaigns) materials for the prediabetes communications messaging
- Update and maintain the Diabetes Prevention webpages on the Public Health Department website
- Create a communications toolkit for promoting campaign materials via partner websites, social media, e-newsletters, and events
- Create and disseminate quarterly and annual progress reports to key stakeholders

### Target: General Public at Risk for Prediabetes

#### Strategies:

- Use multiple media channels to disseminate **It's in your hands. Together we can prevent diabetes** campaign to increase the general population's prediabetes awareness
- Use owned media channels to promote national CDC diabetes prevention ad
- Increase general population's knowledge about the benefits of eating healthy, being active and modest weight loss for diabetes prevention
- Create culturally and linguistically appropriate materials to inform community members of County DPP and other prevention resources
- Update Diabetes Prevention webpages to include all new/ updated campaign images and outreach materials

### Target: Healthcare Providers

#### Strategies:

- Utilize the AMA/CDC Prevent Diabetes STAT Toolkit and other resources to engage providers
- Distribute **It's in your hands. Together we can prevent diabetes** campaign materials to clinics
- Create a network of provider peer champions to share lessons learned from ongoing prediabetes programs and pilots
- Document and disseminate lessons learned and best practices to share with providers
- Add additional provider resources and links on the current Diabetes Prevention webpage

### Target: Community Partners

#### Strategies:

- Develop communication toolkit (including County and CDC media campaign materials) for community partners to utilize in owned media channels and at events
- Disseminate toolkit and train community partners to include diabetes prevention messaging on owned media and at events
- Create a network for community partners to share lessons learned from ongoing diabetes prevention efforts

### Target: Health Plans and Employers

#### Strategies:

- Create materials and messaging for Health Plans and employers demonstrating a business case for covering the DPP
- Participate in State conferences and meetings with Health Plans to present County data supporting the business case for DPP programs and coverage
- Share the AMA/CDC Prevent Diabetes STAT Toolkit and other resources to engage Health Plans
- Leverage CA Dept of Public Health Prevent Diabetes STAT efforts to engage Health Plans and employers

# Diabetes Prevention Initiative Acknowledgments

## **Santa Clara County Leadership**

Supervisor David Cortese, President, Board of Supervisors

Supervisor Ken Yeager, Board of Supervisors

Sara H. Cody, MD, Public Health Department

## **DPI Stakeholder Organizations**

A.J. Robinson Foundation & Lions Club  
International

Ambulatory Care, SCVHHS

American Diabetes Association

Asian Americans for Community Involvement

Behavioral Health Services, Santa Clara County

Black Leadership Kitchen Cabinet Of Silicon Valley

Catholic Charities of Santa Clara County

Community Health Partnership

Community Services Agency

El Camino Hospital

Foothill Community Health Center

Fresh Approach

Gardner Family Health Network

Healthier Kids Foundation

Indian Health Center

Kaiser Permanente

Office of Cultural Competency, Santa Clara County

Office of Supervisor Cortese, Board of Supervisors

Office of Supervisor Yeager, Board of Supervisors

Onlok, Inc.

Palo Alto Medical Foundation

Pediatric Healthy Lifestyles Center, SCVHHS

Public Health Department

Roots Community Health Center

Sacred Heart Community Services

Santa Clara County Medical Association

Santa Clara Family Health Plan

Santa Clara Valley Medical Center, SCVHHS

Social Services Agency, Santa Clara County

Somos Mayfair

Sourcewise

South County Collaborative

Stanford Medicine

The Health Trust

Timpany Center, San Jose State University

Ujima Adult & Family Services

Valley Health Plan

Working Partnerships, USA

YMCA of Silicon Valley

## **Community Efforts Supporting Diabetes Prevention**

Chronic Disease/Healthy Eating & Active Living  
Assessment Workgroup Members of Community  
Health Improvement Plan (CHIP) and Mobilizing  
Action through Planning & Partnership (MAPP)

## **Consultants**

Ad Lucem Consulting



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