NACCHO
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2017 Model Practices

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Model Practice Title

Please provide the name or title of your practice: *

Developing Community Connections to Prevent Diabetes

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select all the practice areas that apply.: *

- [x] Access to Care
- [ ] Advocacy and Policy Making
- [ ] Animal Control
- [x] Coalitions and Partnerships
- [ ] Communications/Public Relations
- [x] Community Involvement
- [x] Cultural Competence
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Food Safety
- [ ] Global Climate Change
- [x] Health Equity
- [ ] HIV/STI
- [ ] Immunization
- [ ] Infectious Disease
- [ ] Informatics
- [x] Information Technology
- [ ] Injury and Violence Prevention
- [x] Marketing and Promotion
- [ ] Maternal-Child and Adolescent Health
- [ ] Organizational Practices
- [x] Other Infrastructure and Systems
- [ ] Organizational Practices
- [x] Primary Care
- [x] Quality Improvement
- [ ] Research and Evaluation
- [ ] Tobacco
- [ ] Vector Control
- [ ] Water Quality
- [ ] Workforce
- [ ] Conference Theme: Bridging Clinical Medicine and Population Health

Other::

Chronic Disease Prevention

Is this practice evidence based, if so please explain. :

This practice utilizes the evidence-based National Diabetes Prevention Program[1] and enhances on the evidence-based use of community health workers (CHWS) to maintain engagement of participants in self-management of their health[2]. 1. Research-Based Prevention Program. (2016). Retrieved December 1, 2016, from http://www.cdc.gov/diabetes/prevention/prediabetes-type2/preventing.html 2. A POLICY BRIEF ON COMMUNITY HEALTH WORKERS - cdc.gov. (n.d.). Retrieved December 1, 2016, from http://www.cdc.gov/dhdsp/docs/chw_brief.pdf&p=DevEx,5083.1

Winnable Battles

To keep pace with emerging public health challenges and to address the leading causes of death and disability, CDC initiated an effort called Winnable Battles to achieve measurable impact quickly.Winnable Battles are public health priorities with large-scale impact on health and known effective strategies to address them. Does this practice address any CDC's seven Winnable Battles? If so, please choose from the following:: *

- ☐ Food Safety
- ☐ HIV in the U.S.
- ☑ Nutrition, Physical Activity, and Obesity
- ☐ Tobacco
- ☐ Healthcare-associated Infections
- ☐ Motor Vehicle Injuries
- ☐ Teen Pregnancy
- ☐ None

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community
- Describe public health issue
- Goals and objectives of the proposed practice
- How was the practice implemented/activities
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
  - Were all of the objectives met?
  - What specific factors led to the success of this practice?
- Public Health impact of practice
- Website for your program, or LHD.

750 Word Maximum

Please use this portion to respond to the questions in the overview section. : *

Albany County is located in eastern New York State, 136 miles north of New York City. The total County population is 305,279, including 245,557 adults. The County population is predominantly white (78.2%), and the largest minority groups include Black or African American (12.8%), Hispanic/Latino (5.2%) and Asian (5.1%) persons. The percentage of minorities in Albany County is substantially below the estimated percentages for New York State; however, minority populations are concentrated primarily in the urban areas. While the City of Albany is home to approximately 32% of the County population, 77% of the African American population and more than 53% of the Hispanic population reside within the City of Albany. The latest Behavioral Risk Factor Surveillance System (BRFSS) survey conducted in Albany County estimates that 21.7% of adults do not participate in leisure time physical activity, 10% of adults do not have adequate access to locations for physical activity, and an estimated 62.8% of adults are overweight or obese, a significant increase from the 2003 estimate of 54%. The 2014 National Diabetes Statistics Report indicated that 9.8% (22,790) of Albany County adult residents were diagnosed with diabetes. It is projected that 37% (86,043) of adult residents have prediabetes. Obesity is a significant risk factor for diabetes and other chronic diseases. Further analysis indicates that these chronic diseases and associated risk factors are disproportionately occurring in communities with limited access to resources, socio-economic hardship and minority health disparities. The Albany County Department of Health's (www.albanycounty.com/Government/Departments/DepartmentofHealth.aspx) goal is to build ongoing support for YMCA and National Diabetes Prevention Programs (Y/NDPPs) by producing a calendar of upcoming Y/NDPPS, increasing referrals into the programs, and utilizing community health workers (CHWs) to keep enrollees engaged in the programs. Specifically, our goal is to launch at least one new Y/NDPP serving our priority population (i.e. those residents in neighborhoods experiencing a high prevalence of diabetes and obesity as well as social determinants of health) for 10 out of the next 12 months. The objective for each program is to initially enroll 20-30 individuals of the priority populations and to achieve a 50% completion rate defined as attending 9 of the 16 core Y/NDPP classes. Through these efforts, 100 -150 individuals from our priority populations will reduce their risk for diabetes and lose 5-7% of their body weight. A multi-pronged approach was implemented to build support for Y/NDPPs. Focus groups were conducted to identify opportunities and challenges for keeping enrollees engaged in Y/NDPPs. These findings were utilized to guide the coordination of Y/NDPPs (time, site location, incentives). Partnerships were formed with healthcare providers to increase diagnosis and referral of residents living with prediabetes. Community Health Workers (CHWs) were trained as lifestyle coaches and partnered with Y/NDPPs to maintain enrollee engagement. As peer mentors, they encourage and help enrollees navigate challenges that affect their progress towards meeting their health goals. This initiative coordinated eight Y/NDPPs held over 10 months and is on pace to deliver 10 Y/NDPPs over a 12 month period. The programs were provided by three different agencies that are recognized by the Diabetes Provider Recognition Program (DPRP). Innovative program sites were selected in priority populations and included health clinics, grocery stores, and churches. Recruitment efforts highlight the no-cost for participation, weight loss as a benefit, and listed risk factors as suggested by the focus groups. CHWs call participants weekly to remind them of upcoming classes, offer relevant health coaching, and address challenges towards attendance and implementation of action plans. The three programs held to date have successfully enrolled 44 participants which meets 44% of our goal with 33% of our planned classes. One program had a 100% completion rate with its 13 enrollees and achieved a 2.86% average weight loss; two programs are ongoing and currently have a 75% attendance rate; recruitment is ongoing for the other five scheduled programs. Success for the program is attributed to the comprehensive approach used to address the health care challenges that make lifestyle changes difficult to implement and maintain. These include identifying the environmental challenges such as limited access to healthy food and safe walking areas that can hinder commitment to healthy action plans and implementing health system changes such as alerts and procedures that facilitate the diagnosis and follow up care for prediabetes. In conjunction with environmental and health systems strategies, these efforts are projected to reduce diabetes-related death and disability by 3% by 2018. 1. United States Census Bureau: State & County QuickFacts. Albany City: http://quickfacts.census.gov/qfd/states/36/3601000.html Albany County: http://quickfacts.census.gov/qfd/states/36/36001.html 2. New York State Expanded Behavioral Risk Factor Surveillance System, 2013-2014.

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be (1) **new to the field of public health (and not just new to your health department)** OR **(2) a creative use of an existing tool or practice**, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue
- What target population is affected by problem (please include relevant demographics)
    - What is the target population size?
    - What percentage did you reach?
- What has been done in the past to address the problem?
- Why is the current/proposed practice better?
- Is current practice innovative? How so/explain?
    - Is it new to the field of public health
      OR
    - Is it a creative use of existing tool or practice:
      What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)

- Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.)

2000 Word Maximum

Please state the Responsiveness and Innovation of your practice (2000 Word Maximum) : *

There is a significant disparity in distribution of obesity related disease within Albany County. In general, hospitalization rates for diabetes in the County are higher in urban areas (specifically Albany, Watervliet, Green Island, and Cohoes), than in areas considered suburban and rural. These urban areas also tend to have higher poverty rates than the County as a whole. The percent of persons living below the poverty level in the City of Albany is almost double the percent living below the poverty level in Albany County (25.2% vs. 13% respectively). There is no comparable summary of behavioral risk factors (i.e. nutrition, physical activity, and tobacco use) at these smaller geographic levels; however it is likely that these disparate disease rates are accompanied by a disparity in behavioral risk as well. Chronic diseases and related risk factors are the leading causes of death and disability in the United States. The Albany County priority population, which includes residents in the cities of Albany, Green Island, Watervliet, and Cohoes, has disproportionate risk for chronic conditions. The percentage of residents below the poverty level in the priority neighborhoods of the City of Albany are 28.2% in Arbor Hill, 38.9% in the West End and 31.3% in the South End. In Green Island, 15.9% of residents are below the poverty level; 15.4% of Watervliet residents are below the poverty level; and 14.3% of Cohoes residents are below the poverty level. The poverty rates in these target areas are all above the 13.6% average poverty rate for the County of Albany and 13.5% for the nation. Prevention Quality Indicator (PQI) data are used to describe the health disparities in certain neighborhoods of the target population. The West End, South End and West Hill neighborhoods all have observed rates for PQI Diabetes data that are three times as high as the Albany County rate. The anticipated adult population reach for the identified target area is approximately 104,405 adults, or 43%, of Albany County adult residents. Top Tier Neighborhoods are defined as those with residents who are super-utilizers (persons who are emergency room super-utilizers and/or had a 30 day readmission history), as well as those who have multiple chronic physical conditions include Arbor Hill, South End, West End, and West Hill. Neighborhoods like the South End in Albany have high proportions and numbers of these super-utilizers, as well as poverty rates that are almost double the regional average and a more diverse racial mix. Cohoes, Watervliet, and Green Island were also identified as Top Tier Neighborhoods. There are a number of existing resources and services to prevent chronic disease in the priority population. Access to free physical activity opportunities in the City of Albany include the Healthy Living Center located in the Hannaford Supermarket and free fitness classes, including Zumba and yoga, offered by the City of Albany Department of Recreation. The cities of Albany, Watervliet and Cohoes have public pools open to residents in the summer months. Each municipality also has community gyms, parks and trails. Ongoing work is being completed at both the county and city level to improve access to safe walking areas. This work includes developing and implementing transportation and community plan that promote walking and biking. The Albany County 2016-2018 Community Health Improvement Plan (CHIP) has a focus on diabetes prevention. CHIP activities that provide resources to the target population include the creation and subsequent distribution of a diabetes resource guide and the promotion of the National Diabetes Prevention Program (NDPP). NDPP is available through the Center for Excellence in Aging and Community Wellness, Capital Region YMCA and the Capital Region Diabetes & Endocrinology Center. The Center for Excellence in Aging and Community Wellness also provides other self-management classes to the community including the Chronic Disease Self-Management Program, the Diabetes Self-Management Program, as well as programs to increase physical activity. There are a number of primary care providers that are located within the target population communities. Whitney M. Young Health Center is a federally qualified health center located in the Arbor Hill neighborhood in the City of Albany and in Watervliet. Other primary care providers include St. Peter's Family Health Center and Koinonia Primary Care located in the South End and West Hill neighborhoods in Albany. St. Peter's Health Partners has a family practice in Cohoes and Watervliet. Healthy Capital District Initiative indicates that neighborhoods such as Arbor Hill, Cohoes, and Watervliet have fewer than the upstate average for primary care physicians. Gaps and barriers to accessing resources and services can have a profound effect on one's overall health and wellbeing. At a clinic-to-community listening forum sponsored by the Capital District YMCA, partner organizations and residents came together to discuss some of these barriers. It was determined existing barriers include lack of transportation, housing instability, and available hours of current healthcare providers. The current traditional system of care including scheduled appointments at existing clinics is not effective. There are perceived inequalities between service providers and community members. Racial, ethnic, language and cultural barriers exist that limit access to services. The use of community health workers (CHWs) that focus on chronic disease prevention and control would help to reduce or eliminate many identified barriers. Through the Albany County Department of Health's implementation of Local IMPACT (one of four subawardees for the NYSDOH CDC–funded State and Local Public Health Action 1422 Program), CHWs were trained in the areas of prediabetes, diabetes, hypertension, healthy eating and physical activity. In addition, they completed training and received certification as Lifestyle Coaches for the NDPP. They were then creatively placed with Y/NDPPs that predominately serve the priority populations in the county. Through this placement, CHWs assisted the Lifestyle Coach as a peer mentor and provided ongoing support to participants between classes. This ongoing support was done through weekly phone calls that were placed to remind participants about the next upcoming class and help them work through any challenges with attending the class. Additionally, the CHWs used motivational interviewing during these calls to help participants implement and/or maintain healthy behavior changes that support their health goals and established action plans from the previous class. CHWs have been used in clinical settings to form clinical-community linkages. The embedment of CHWs within the NDPP is an innovative approach to using CHWs to promote self-management of prediabetes. This model builds on evidence-based practices cited in the CDC's Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach, 2nd edition published in April 2015. In particular, CHWs cited in this publication have been utilized to perform community outreach, complete home visits to reinforce lifestyle change behaviors and assist with the navigation of health care systems. The Albany County Department of Health has used CHWs not only in these traditional roles but also placed them directly within NDPPs. In this capacity, they enhance the work of the lifestyle coaches by providing ongoing support to participants as needed.

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broad-based involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
    - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice
- Were other stakeholders involved? What was their role in the planning and implementation process?
    - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)
- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

5000 words maximum

Enter the LHD and Community Collaboration related to your practice (5000 words maximum): *

The Albany County Department of Health's goal is to scale and sustain the YMCA and National Diabetes Prevention Programs (Y/NDPPs). Initial steps to implementation include producing a calendar of upcoming Y/NDPPS, increasing referrals into the programs, and utilizing Community Health Workers (CHWs) to keep enrollees engaged. Specifically, our objectives include launching at least one new Y/NDPP serving our priority populations for 10 out of 12 months annually. Each program is to initially enroll 20-30 individuals representative of these priority populations with the intent to achieve a 50% completion rate defined as attending 9 of the 16 core Y/NDPP classes. Evidence has shown that completing 9 of the 16 core Y/NDPP classes reduces the risk for type 2 diabetes by 58% and promotes an average weight loss of 5-7% by promoting healthier eating and at least 150 minutes of physical activity weekly.[1] Through these efforts, 42 individuals from our priority populations were enrolled in Y/NDPPs and 32 (75%) completed 9 of the 16 core classes and are expected to have reduced their risk for type 2 diabetes by 58%. Before the Y/NDPPs were scheduled, three focus groups were coordinated by the Capital District YMCA with technical assistance from the Albany County Department of Health. The focus group objective was to identify barriers to enrolling in and completing Y/NDPPs. The groups represented the following populations: • Y/NDPP participants who completed 9 out of 16 core classes, • Y/NDPP participants who did not complete 9 out of 16 core classes, • Individuals who did not participat in a Y/NDPP. Findings from the focus group identified competing schedules, untimely life events, transportation, childcare and limited availability to healthy food as barriers or challenges to committing to the program. Programs that were low-cost or had built-in participation incentives, promoted group/peer support, were scheduled to coordinate with other activities (i.e. gym, church group, library, etc.), emphasized weight loss and tools for implementing healthy behaviors attract more participants. Additionally, it was noted that engaging primary care providers to refer participants to the program would positively impact enrollment and participation. These findings were used to structure how participants would be recruited, where and when programming would be held, as well as how incentives would be used. A multi-pronged approach was used to identify potential enrollees for the Y/NDPP. CHWs provided information on prediabetes and administered the Do I Have Prediabetes Risk Test from www.DoIHavePrediabetes.org. Once the test was completed, the CHWs identified those who scored in the at-risk category and determined if they had a primary care provider. Those that did have a primary care provider were given their risk test, contact information to reach the CHW, and instructions to contact their primary care provider in the next two business days to make a follow up appointment for further evaluation i.e. confirmatory bloodwork. Those who did not have a primary care provider were given a copy of their risk test, contact information to reach the CHW, a list of primary care providers in their neighborhood and instructions to schedule an appointment for further evaluation. A follow up procedure was implemented that included phone calls from the CHW to these residents to encourage and coordinate follow through as needed. The CHWs conducted this outreach at various community venues: worksites, church groups, health clinics, mobile vegetable stops, and other community events within the priority neighborhoods. The mobile vegetable stops were coordinated with Capital Roots, a community based organization that travels to inner-city neighborhoods to deliver a large variety of fresh, affordable and local produce to residents with limited access to fresh produce. These stops were located in the identified priority neighborhoods. The provision of NDPP classes was funded through the CDC 1422 cooperative agreement awarded to the New York State Department of Health. The Albany County Department of Health utilized funds from this award to contract with Y/NDPP provider agencies that are recognized by the Diabetes Provider Recognition Program (DPRP) to offer Y/NDPP classes at no-cost to participants. Agencies selected to provide services included the Capital District YMCA, Capital Region Diabetes & Endocrine Care (part of St. Peter's Heath Partners), and the Center for Excellence in Aging and Community Wellness. Each of these agencies was given a list of priority populations that have a high incidence of health disparity related to their low socio-economic status and /or high percentage of minority demographics. Each agency developed a strategy to recruit in these neighborhoods and to address the challenges identified in the focus groups. In particular, class locations were selected within the priority populations to minimize transportation issues. Classes were offered at varied times to increase the possibility of attendance among different groups i.e. retirees, unemployed, employed with various work schedules. A variety of incentives were offered that included tools for implementing healthy changes including workbooks to track nutritional intake and physical activity, tools for measuring and weighing food, and in some cases produce coupons to purchase fresh fruits and vegetables. Additionally, each contracted agency was paid $400 per participant that enrolled and attended at least one class in the program and another $100 per participant for those that completed 9 of the 16 core classes. Each agency providing a Y/NDPP

developed a flier promoting the upcoming Y/NDPP. CHWs disseminated the fliers at their outreach venues, to primary care providers serving the priority population and throughout the priority communities. The fliers highlighted that the program was free of charge to participants, identified risk factors for prediabetes, and promoted the benefits of being in the program i.e. learning how to eat healthier, stay physically active, lose weight, and achieving a reduced risk for type 2 diabetes. The Albany County Department of Health also informed key primary care providers in the priority neighborhoods about the Y/NDPPs to increase awareness about the programs and build capacity for the programs by facilitating increased diagnosis of prediabetes and referrals to the Y/NDPPs. Additionally, the Albany County Department of Health partnered with Whitney M. Young Jr. Health Center, a federally qualified health center. Through this partnership, the health department provided technical assistance with the New York State Department of Health to pilot health system changes through quality improvement methodologies to increase diagnosis of prediabetes and referral into NDPPs. Additionally, champions within the clinic (the registered dietitian and a physician assistant) provided prediabetes academic detailing to the other providers six weeks prior to the start date of the NDPP at this site. Through these efforts, 96 previously undiagnosed patients with prediabetes were identified. After previously undiagnosed patients with prediabetes were identified and informed of their diagnosis, the dietitian sent a letter to the potential enrollees inviting them to participate in the upcoming NDPP. Within a week after sending the letter, CHWs embedded in the NDPP contacted these patients and explained the program and immediately enrolled 20 interested patients. Capital Region Diabetes and Endocrine Care leveraged their ongoing relationship with Cohoes Family Care (a primary care provider that predominately serves the priority population in Cohoes) to identify patients with prediabetes. Two months before the start date of the NDPP located at this site, registered dietitians from the Capital Region Diabetes and Endocrine Care conducted academic detailing utilizing the Prediabetes: A healthcare provider's toolkit for action at www.prediatbetesNY.org. The providers then generated a list of qualified patients (those diagnosed with prediabetes) that was given to the dietitian at Capital Region Diabetes and Endocrine Care. The dietitian then contacted these patients and enrolled 11 patients into the program. CHWs contacted enrollees of each program one week before and again the day before the onset of the classes. Once the classes began, CHWs contacted participants two days before each class to remind them about the upcoming class, address any challenges with attending the class, reviewed progress on their action plan from the previous class, and utilized motivational interviewing to maintain implementation of their action plan. During the class, the CHWs served as peer mentors by assisting the lifestyle coach and developing relationships with the participants. They have maintained engagement by implementing the following strategies: • Addressing transportation issues through the provision of bus passes as needed. • Providing accountability through two contacts each week. One contact is the weekly phone call, where the CHWs use motivational interviewing to confirm or modify client-centered goals and develop appropriate, achievable action plans. The other is face to face during the weekly NDPP class over the course of the 16 week core sessions. These very individualized contacts give the CHW an additional opportunity to provide nutrition and physical activity information that is relevant to that participant and supplements the work of the class's group discussions. • Assisting with the navigation of challenges associated with implementing and maintaining healthy behavior changes. This includes addressing access to healthy food, encouraging physical activity by identifying places to walk and participate in no-cost or low-cost recreational activities, and helping them identify physical activity partners. • Helping them work through unplanned crisis by linking them to community resources as needed. This has included identifying resources for clothing for their family, mental health services for family members, housing, the provision of basic household goods (i.e. furniture, pots and pans, etc.), and childcare. As a result, our priority population, that historically is difficult to maintain engagement in Y/NDPPs, has maintained a 75% completion rate (defined as completing 9 of the 16 core NDPP classes) through this comprehensive approach. The NDPP completion rate for the general New York State population that is experiencing a lesser percentage of social determinants of health is 68.8% according to a catalog of NDPPs in New York State from 1/1/2015 to 6/30/2016 by the Quality and Technical Assistance Center of New York. 1. Research-Based Prevention Program. (2016). Retrieved December 01, 2016, from http://www.cdc.gov/diabetes/prevention/prediabetes-type2/preventing.html

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are **process** and **outcome**. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
    - List any primary data sources, who collected the data, and how (if applicable)
    - List any secondary data sources used (if applicable)
    - List performance measures used. Include process and outcome measures as appropriate.
    - Describe how results were analyzed
    - Were any modifications made to the practice as a result of the data findings?

2000 Words Maximum

Please enter the evaluation results of your practice (2000 Words Maximum): *

The Albany County Department of Health has tried various strategies for supporting Y/NDPPs over the past 3 years. Initial attempts resulted in one NDPP being held with 9 enrollees and achieving a 44.4% completion rate (completion is defined as attending 9 of the 16 core classes). Four other programs were scheduled but were cancelled due to low enrollment. In 2014, the health department conducted a “Living Healthy” program for 10 individuals at Whitney M. Young Jr. Health Center, a federally qualified health center. The program was promoted by primary care providers and to the community which led to an enrollment of 21 individuals and 10 (47.6%) completers. Successful strategies included promoting the program sufficiently in advance, involving key stakeholders (i.e. healthcare providers), and promoting the value of the program to participants. One of the key challenges identified through this effort was how life challenges interfered with participant’s ability to commit to the self-management program. In 2014, focus groups were held with residents and community partners to explore ways to redesign the implementation of the Y/NDPP to increase engagement of the priority population. The group identified the following challenges: more pressing issues than their health, lack of self-efficacy, and difficulty implementing and maintaining healthy behavior changes. Opportunities for improving enrollment and retention were identified as: provider referral / recommendation, innovative program measures that included incentives, and active engagement of community stakeholders (i.e. faith community). In May 2016, the Albany County Department of Health provided technical assistance and funding for the Capital District YMCA to conduct three focus groups with recent Y/NDPP completers, non-completers, and potential enrollees. The results from this group identified similar challenges as the previous focus group: competing schedules, untimely life events, transportation, childcare and limited availability to healthy food. Opportunities for increased enrollment and retention included: low-cost and/or built-in participation incentives, promotion of group / peer support, coordinating classes with other activities (i.e. gym, church group, library, etc.), emphasizing weight loss and tools for implementing healthy behavior. Additionally, it was noted that engaging primary care providers to refer participants to the program would positively impact enrollment and participation. The Albany County Department of Health coordinated 3 Y/NDPPs since June 2016. One program was implemented by the Capital District YMCA and was held at the Healthy Living Center which is located in a grocery retail store and offers a free gym facility. Engagement of CHWs was implemented late into the program and the group was not 100% representative of the priority population. This YDPP had 13 enrollees, a 100% completion rate, and an average weight loss of 2.86%. Another NDPP was held at the Whitney M. Young Jr. Health Center and implemented by the Center for Excellence in Aging and Wellness. CHWs were part of the enrollment with Whitney M. Young Jr. Health Center providers and assisted the lifestyle coaches with the NDPP classes throughout the program. The group had an enrollment of 20 residents who were 100% representative of the priority population. There are 11 (55%) actively engaged participants and 9 (45%) completers with 3 more classes scheduled before the 16 core classes are completed. This group is on track to have at least a 55% completion rate. The Capital Region Diabetes and Endocrine Care agency is providing an NDPP at the Cohoes Family Care. Dietitians worked with primary care providers from this program to enroll 11 residents who were 100% representative from the priority population. CHWs have assisted with each NDPP class since its inception. The class has 11 actively engaged members who have completed 9 of the core classes with 3 more classes scheduled before the 16 core classes are complete. This group has achieved a 100% completion rate. The objective for each program is to initially enroll 20-30 individuals from the priority populations and to achieve a 50% completion rate defined as attending 9 of the 16 core Y/NDPP classes. Enrollment for each program has varied (13, 20, and 11 enrollees) with 84% being from the priority population. The completion rate for each program varied with one achieving a 45% (this is likely to improve to 55% with only 3 more classes remaining) and two achieving a 100% completion rate. These rates are higher than previous efforts. The overall enrollment average for these three NDPPs is 15 participants and the average completion rate is 70.5% - 75%. Both measures are higher than previous efforts. Success can be attributed to the innovative location of NDPPs, involvement of key stakeholders in enrollment (e.g. primary care providers, community based organizations), embedment of CHWs in both recruitment and Y/NDPP classes, and advance promotion of classes.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (*NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation*.)

- Lessons learned in relation to practice
- Lessons learned in relation to partner collaboration (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
    - Describe sustainability plans

1500 Words Maximum

Please enter the sustainability of your practice (2000 Words Maximum): *

The Albany County Department of Health developed this practice around the “Four Pillars of National Diabetes Prevention Program (NDPP)” identified by the CDC as being essential for scaling and sustaining the NDPP: • Increasing awareness of prediabetes; • Increasing clinical screening, testing, and referral to CDC-recognized lifestyle change programs under the National DPP; • Increasing the availability of and enrollment in CDC-recognized lifestyle change programs; • Providing coverage and payment for the National Diabetes Prevention Program to all eligible populations. 1. Awareness Awareness of prediabetes was addressed at both the community and clinical level. Through its participation in the Albany County Strategic Alliance for Health, the Albany County Department of Health collaborated with health care practices and community based organizations to increase awareness of the prevalence of prediabetes and to identify strategies for reaching the priority population. Through this group, the health department developed and implemented action plans to make environmental changes that improve access to healthy food and promote physical activity within the priority population. Additionally, the health department is an active member of the Healthy Capital District Initiative (HCDI). HCDI is a group of public health leaders that discuss how the Capital Region of New York State (Albany, Columbia, Greene, Rensselaer, Saratoga and Schenectady counties) can be more effective in identifying and addressing public health problems. The Albany County Department of Health has guided the development of strategies to reduce type 2 diabetes through the region’s Community Health Improvement Plan. Community health workers (CHWs) of the health department have worked directly with the priority populations to increase general community awareness of prediabetes and to deliver prediabetes risk assessment tools to individuals. 2. Screening, Testing, and Referral The Albany County Department of Health has provided technical assistance and guidance to Y/NDPP providers and primary care practices that serve the priority population. Y/NDPP providers were encouraged to provide prediabetes academic detailing to the primary care practices that work with the priority populations. The development of these relationships has led to an increase in prediabetes diagnosis and subsequent referral to NDPPs and/or dietitians for lifestyle change self-management. The health systems change work completed with Whitney M. Young Jr. Health Center included piloting changes to more efficiently and consistently alert providers of patients with prediabetes and the development of a prediabetes registry that is used to more consistently refer patients to Y/NDPPs. 3. Availability and Enrollment The Albany County Department of Health has helped bridge partnerships between primary care providers serving the priority populations and Y/NDPP providers. This has led to additional Y/NDPPs being strategically placed and scheduled to serve the needs of these residents. Innovative locations include churches, retail sites, and primary care practices located in the neighborhoods of priority populations. This increase availability and referral by clinical providers has positively impacted the enrollment of these Y/NDPPs. 4. Coverage The current programing is being offered free of charge to participants through the Albany County Department of Health’s funding as a subawardee for the NYSDOH CDC–funded State and Local Public Health Action 1422 Program. The reimbursement structure to Y/NDPPs was staged to phase in the upcoming Medicare reimbursement pay structure. This first round of Y/NDPP classes paid subcontractors $400 per enrollee and another $100 per completer. The next phase will pay the subcontractors $250 per enrollee, $200 per completer and $50 per participant that achieves at least a 5% weight loss. These performance measures reflect the proposed reimbursement schedule for Medicare coverage in 2018. Y/NDPPs involved in piloting this reimbursement structure will have the opportunity to pilot program incentives and practices that will improve their ability to meet these performance measures. Results from these strategies will be shared with local health insurance companies and self-insured employers who have the ability to provide Y/NDPPs to their qualified members and employees. The health department is providing ongoing technical assistance to local health insurance companies and self-insured employers around the implementation and benefits of worksite Y/NDPPs. By addressing these four pillars of Y/NDPP through these collaborative and innovative approaches, the Albany County Department of Health is building a foundation to sustain the implementation of Y/NDPPs.

Additional Information

How did you hear about the Model Practices Program:: *

- ☐ I am a previous Model Practices applicant
- ☐ At a Conference
- ☐ NACCHO Website
- ☐ Public Health Dispatch
- ☐ Colleague in my LHD
- ☐ Model Practices brochure
- ☐ NACCHO Exhibit Booth
- ☑ NACCHO Connect
- ☐ Colleague from another public health agency
- ☐ E-Mail from NACCHO
- ☐ NACCHO Exchange