

Utah Diabetes Prevention Strategic Plan

October 2015 to September 2020

*We aim to scale and sustain the
National Diabetes Prevention Program and
increase awareness of prediabetes in Utah.*



UTAH DEPARTMENT OF
HEALTH

Healthy Living Through Environment
Policy and Improved Clinical Care (EPICC)

For more information visit:
www.choosehealth.utah.gov



Acknowledgments

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Letter of Support

To whom it may concern,

On behalf of the Bureau of Health Promotion, I write to offer my support for the Utah Diabetes Prevention Strategic Plan. The purpose of the plan is to scale and expand the National Diabetes Prevention Program (National DPP) in Utah. The National Diabetes Prevention Program is an evidence-based lifestyle change program designed to prevent type 2 Diabetes. The program has demonstrated effectiveness in helping people at high risk lose a moderate amount of weight (5% to 7% of their current body weight) and increase their physical activity to 150 minutes per week. The result of these two lifestyle changes has been proven to prevent or delay the onset of type 2 Diabetes by nearly 60%.

Diabetes is a significant, costly disease that is often under-diagnosed. Between 2009-2014, approximately 5.8% of adult Utahns reported they were told by a healthcare provider that they have prediabetes. In the same time period approximately 7.6% of adult Utahns reported they have diabetes. Direct medical costs in Utah in 2012 were estimated at approximately \$864 million for diagnosed diabetes, \$139 million for undiagnosed diabetes, \$272 million for prediabetes, and \$8 million for gestational diabetes (Dall et al, 2014). Total cost (direct and indirect) of all forms of diabetes in Utah was estimated at approximately \$1.7 billion (Dall et al, 2014).

The Utah Department of Health (UDOH), Bureau of Health Promotion (BHP) is committed to working with statewide partners to implement this plan. The BHP's programs will coordinate partner activities and provide support to all partners as they work to implement the plan. Support will include activities such as convening meetings; providing surveillance, epidemiology and evaluation expertise; providing networking opportunities for partners, identifying evidence-based interventions; providing technical resources; and communicating progress on actionable objectives.

Respectfully,

Heather R. Borski, MPH, MCHES
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Nationally, approximately one of every three adults aged 20 and older has prediabetes. Unfortunately, a large majority of people with the condition are unaware that they have it. In Utah, more than seven percent (7.4%) of adults age 20 and over have been told by a healthcare provider that they have prediabetes, close to 113,000 individuals (BRFSS 2013-2015). However, the actual number with this condition is likely closer to 590,000. Prediabetes can be costly. In 2012, the estimated direct medical costs was approximately \$272 million (Dall et al., 2014).

We know that prediabetes, if identified and addressed by lifestyle changes, can lead to a delay or prevention of progression to diabetes. One of the Utah Diabetes Prevention Strategic Plan's goals is to increase the awareness of prediabetes in Utah. Achieving this goal will enable individuals with prediabetes to better manage their condition and possibly prevent their disease from progressing to diabetes. This could save the state millions of dollars in future direct medical costs.

The *Utah Diabetes Prevention Strategic Plan* was created with input from a variety of partners representing government, community-based organizations, business/industry, healthcare organizations, and private organizations. The plan was developed with funding from the Centers for Disease Control and Prevention (CDC) in order to unify statewide efforts to address prediabetes in Utah. The plan identifies goals and objectives which, if implemented, could prevent and manage prediabetes while increasing individual healthful behaviors. The intent of this plan is to present a common set of goals and objectives that align statewide partner activities for optimal results.

The plan identifies four important strategic planning areas:

1. *Healthcare systems and referrals*
2. *Reimbursement*
3. *Increasing awareness of prediabetes*
4. *Support for new programs*

Activities within these four strategic areas will be targeted to the following three settings:

1. *Healthcare*
2. *Community*
3. *Worksites*

The **Utah Department of Health (UDOH), Bureau of Health Promotion (BHP)** is committed to working with statewide partners to implement this plan. The BHP will coordinate partner activities and provide support to all partners as they work to implement the plan. Support will include activities such as convening meetings; providing surveillance; epidemiology and evaluation expertise; providing networking opportunities for partners; identifying evidence-based interventions; providing technical resources; and communicating progress on actionable objectives.

This plan is a living document and, as such, will be evaluated periodically and modified as needed. It will provide direction for diabetes prevention efforts in Utah. Implementation of the changes identified in this plan will lead to healthier individuals and a healthier state.

This plan is available to partners and the general public on the Healthy Living Through Environment, Policy and Improved Clinical Care (EPICC) Program's website at www.choosehealth.utah.gov.

Introduction



“Send your patients for this program, have flyers all over your office. Tell your staff to tell every single patient. Print a list of everybody that has prediabetes. If 30% or 40% of those people attend this program, it's going to change their life.”

Testimonial from a physician, CDC website, www.cdc.gov/diabetes/prevention/lifestyle-program/deliverers/testimonials.html

In July 2013, the Utah Department of Health (UDOH), *Healthy Living Through Environment, Policy and Improved Clinical Care (EPICC) Program*, was awarded the Center for Disease Control and Prevention (CDC) 1305 grant entitled, “**State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity, and Associated Risk Factors and Promote School Health.**” The purpose of CDC 1305 funding is to address health risk behaviors, environments, and systems associated with diabetes, heart disease, obesity, and school health.

In September 2014, the EPICC Program was one of 17 states to receive additional funding through the CDC 1422 grant entitled, “**Diabetes Prevention - State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke.**” The purpose of CDC 1422 funding is to support the implementation of population-wide and priority population approaches to prevent obesity, diabetes, heart disease, and stroke that mutually reinforce each other and reduce health disparities in these areas among adults.

In August 2015, the EPICC Program collaborated with the *National Association of Chronic Disease Directors (NACDD) Programmatic State Technical Assistance Team (PSTAT)* to host the **Utah National Diabetes Prevention Program State Engagement Meeting**. The two-day meeting was attended by more than 75 stakeholders that included local health departments (LHDs), healthcare and health plan providers, the state Medicaid and Medicaid Managed Care Organizations (Molina, HealthyU, SelectHealth, and Health Choice Utah/IASIS), WISEWOMAN, HealthInsight, and Salt Lake County Active Aging and national speakers. The goal of this meeting was to increase awareness of prediabetes, to encourage collaboration, and to sustain the National Diabetes Prevention Program (National DPP) in Utah.

As a follow-up to the Utah State Engagement meeting, four strategic planning groups were formed. One of the goals of the strategic planning groups was to help develop a diabetes prevention strategic plan. Two staff members of LHDs (funded by the CDC 1422 grant) were co-chairpersons of each strategic planning group. Additional stakeholders were invited to participate as needed.

The **four strategic planning groups** were focused on:

1. *healthcare systems and referrals;*
2. *reimbursement;*
3. *increasing awareness of prediabetes; and*
4. *support for new programs.*

From November 2015 through March 2016, the strategic planning groups met monthly to build on their previous work and to develop goals and objectives for the plan. The planning groups are targeting healthcare, communities, and worksites.

The diabetes prevention strategic plan is written for public, private, non-profit partners, and the general public. The plan includes a description of the burden of prediabetes in Utah, vision and mission statements, an action plan that includes actionable short term (1-2 years) and intermediate term (3-5 years) objectives, and a logic model.

The plan is designed to help target statewide efforts to effectively manage and guide activities around prediabetes. The plan will facilitate the creation of new partnerships and strengthen current partnerships. It will help Utah health professionals and others become more efficient and effective in delivering prevention, education, and management of prediabetes.



“My kids have never seen me run. And I can now. And I love it.”

Testimonial from a program participant, CDC website, www.cdc.gov/diabetes/prevention/real-people-stories/index.html

What is Prediabetes?

Prediabetes is a condition in which blood sugar is higher than normal but not high enough for a diagnosis of diabetes. People with prediabetes are at increased risk of developing type 2 diabetes. Over time, high blood sugar from prediabetes damages nerves and blood vessels leading to complications such as heart disease, stroke, blindness, kidney failure, and lower-limb amputations. Without lifestyle changes that can reduce the risk, 15% to 30% of people with prediabetes will develop diabetes within five to ten years.

There are three tests that can confirm a diagnosis of prediabetes (Table 1).

Table 1: Prediabetes/Diabetes Confirmatory Tests

Classification	Fasting Blood Sugar Test	Hemoglobin A1C Test	Oral Glucose Tolerance Test At two-hour blood draw
Normal	<100 mg/dL	4-5.6%	<140 mg/dL
Prediabetes	100-125 mg/dL	5.7-6.4%	140-199 mg/dL
Diabetes	≥126 mg/dL	>6.5%	>199 mg/dL

Source: American Diabetes Association, Clinical Practice Recommendations, 2014.

The American Diabetes Association (ADA) recommends that testing to detect prediabetes be considered in adults who are overweight or obese and have one or more additional risk factors for diabetes. Risk factors for prediabetes include the following:

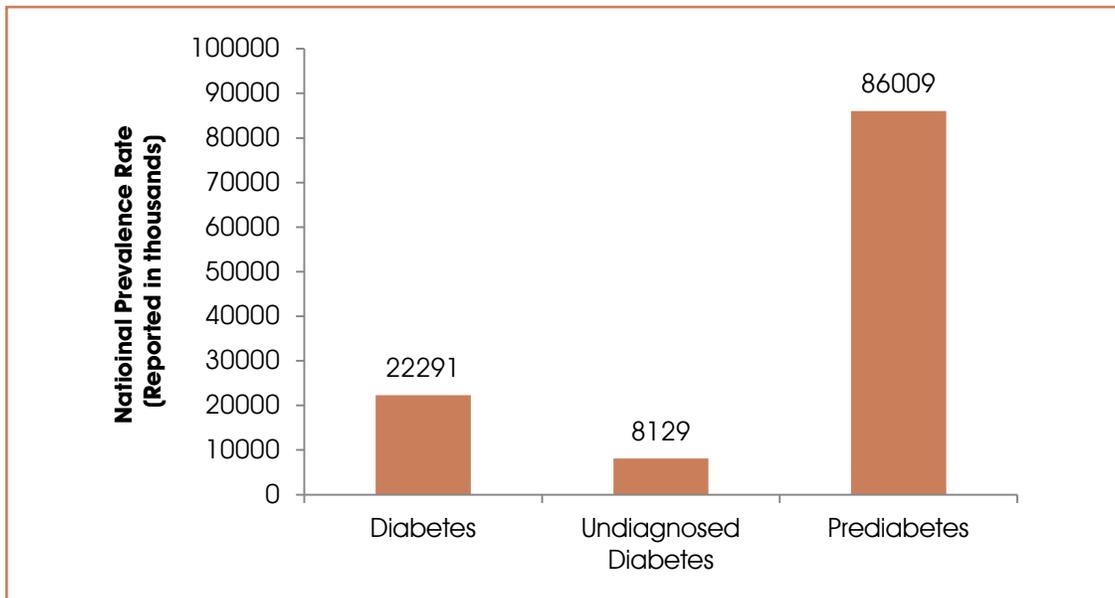
- Being over age 45
- Being overweight or obese
- Being physically inactive
- Having a parent or sibling with diabetes
- Having a family background that is African American, Alaska Native, American Indian, Asian American, Hispanic/Latino, or Pacific Islander American
- High blood sugar during pregnancy or giving birth to a baby weighing more than nine pounds
- History of gestational diabetes
- Having high blood pressure—140/90 mmHg or above—or being treated for high blood pressure

- HDL cholesterol level below 35 mg/dL or a triglyceride level above 250 mg/dL
- Having polycystic ovary syndrome (PCOS)
- Impaired fasting glucose (IFG) or impaired glucose tolerance (IGT) on an earlier testing
- Having other conditions associated with insulin resistance, such as acanthosis nigricans (dark patches in skins folds)
- Having cardiovascular disease

National Burden of Prediabetes

Nationally, in 2012, an estimated 22.3 million adults had diabetes. An additional 8.1 million adults had undiagnosed diabetes and 86 million adults had prediabetes (Figure 1) (Dall et al, 2014). This represents a 51% increase in the national burden of prediabetes since 2007, when 57 million adults were estimated to have prediabetes (Zhang, et al, 2009).

Figure 1: National Prevalence of Diabetes, Undiagnosed Diabetes, and Prediabetes (2012)



Data are reported in thousands.

Source: Dall et al., 2014

Burden Statement

Nationally, in 2012, direct medical costs were estimated at approximately \$175.8 billion for diagnosed diabetes, \$23.4 billion for undiagnosed diabetes, and \$1.3 billion for gestational diabetes. Indirect costs for diagnosed diabetes and undiagnosed diabetes were estimated to be approximately \$69 billion and \$9 billion, respectively. Indirect costs include reduced employment and reduced productivity while at work, increased absenteeism, reduced productivity for those not in the workforce, and early mortality. The 2012 national estimated total cost (direct and indirect) of all forms of diabetes was estimated at approximately \$322 billion. Even prediabetes presents a substantial economic burden, with direct medical costs estimated to be \$43.9 billion in 2012 (Dall et al, 2014).

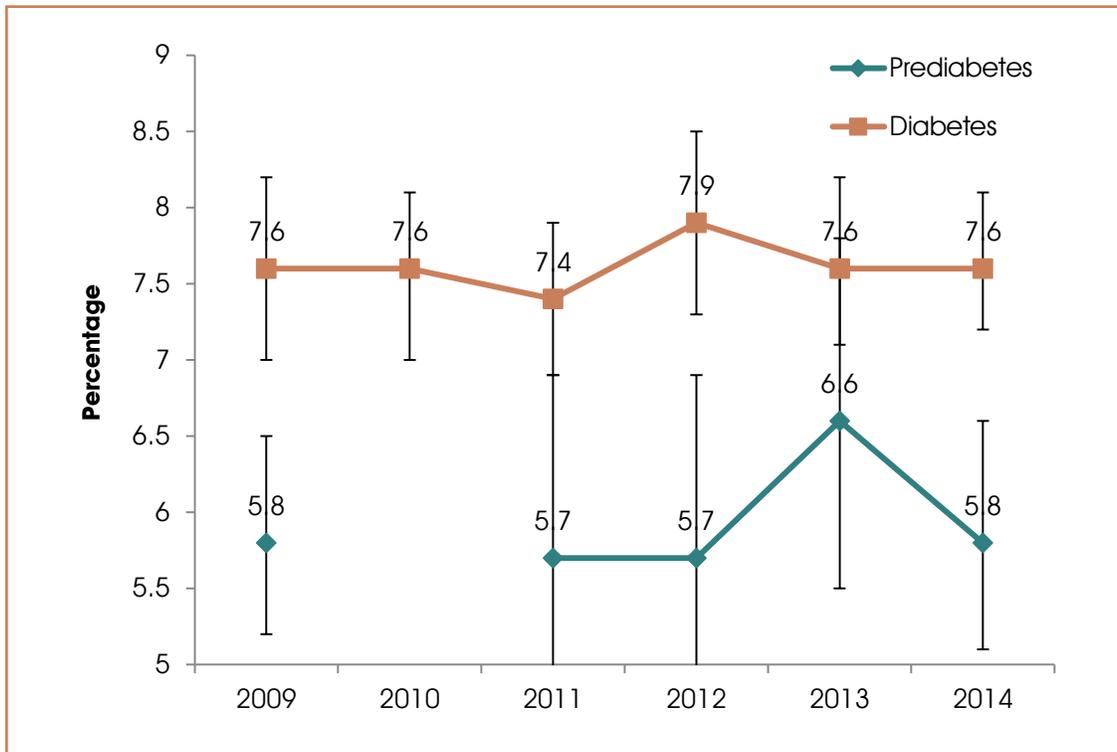
The National Health and Nutrition Examination Survey (NHANES) combines interview data with actual physical exams to assess prevalence of prediabetes in the U.S. A substantial proportion of adults who report they have never been told by a healthcare provider that they have prediabetes actually meet the criteria for it when tested (MMRW 2013). NHANES uses these results to estimate the prevalence of undiagnosed prediabetes in the U.S. population. If the NHANES estimates were applied to the Utah population, approximately 590,000 adults actually have prediabetes. This would mean that about 477,000 Utahns have undiagnosed prediabetes.

The following section uses data from the Utah Behavioral Risk Factor Surveillance System (BRFSS) to show the burden of diagnosed prediabetes in the state. Please note that the prevalence of prediabetes for BRFSS data is limited to people who have actually been diagnosed, so the rates shown are likely to be underreported. BRFSS reports data for Utah adults ages 18 and over.

Utah Burden of Prediabetes

In Utah, the prevalence of diabetes and prediabetes has remained fairly stable. Between 2009 and 2014 approximately 5.8% of adult Utahns reported they were told by a healthcare provider that they had prediabetes. In the same time period approximately 7.6% of adult Utahns reported they have diabetes (Figure 2).

Please note: All graphs and data using BRFSS data include the population of adults aged 18 and over, unless otherwise specified.

Figure 2: Utah Prevalence of Diabetes and Prediabetes Over time (2009-2014)

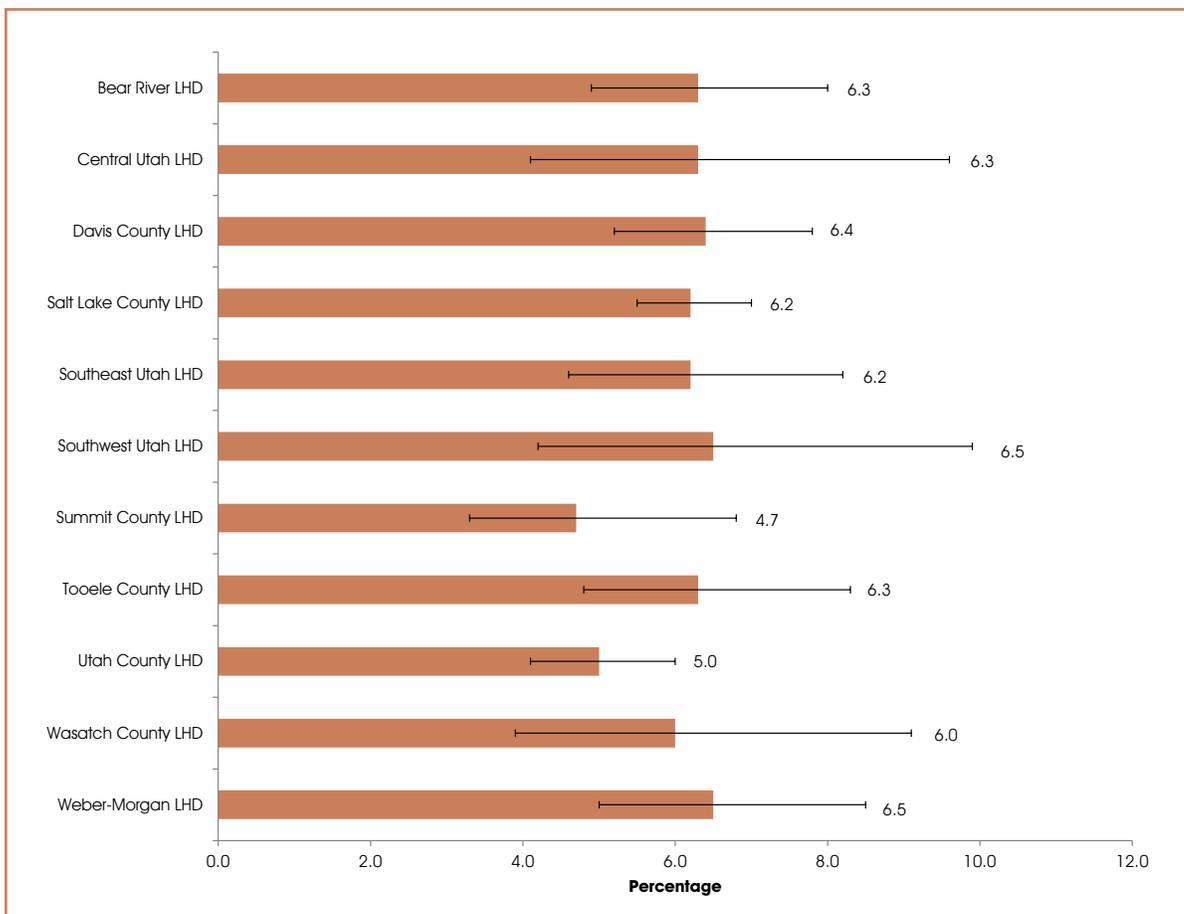
Source: Utah Behavioral Risk Factor Surveillance System Age-adjusted to the US 2000 standard population. Note: No data are available for prediabetes for 2010.

The latest estimates from the Behavioral Risk Factor Surveillance System (BRFSS) indicate that approximately 145,000 Utah adults have been diagnosed with diabetes and another 113,000 have been diagnosed with prediabetes (BRFSS 2013-2015).

Prediabetes by Local Health Department (LHD)

The percentage of Utah adults who reported having prediabetes is not different across LHDs (Figure 3). The estimates ranged from 4.7% in Summit County LHD to 6.5% in Weber-Morgan LHD. Note: Data are not reported for TriCounty LHD because the estimate is unreliable. Data for San Juan County LHD are not yet available.

Figure 3: Percentage of Utah Adults Who Report Having Prediabetes by LHD

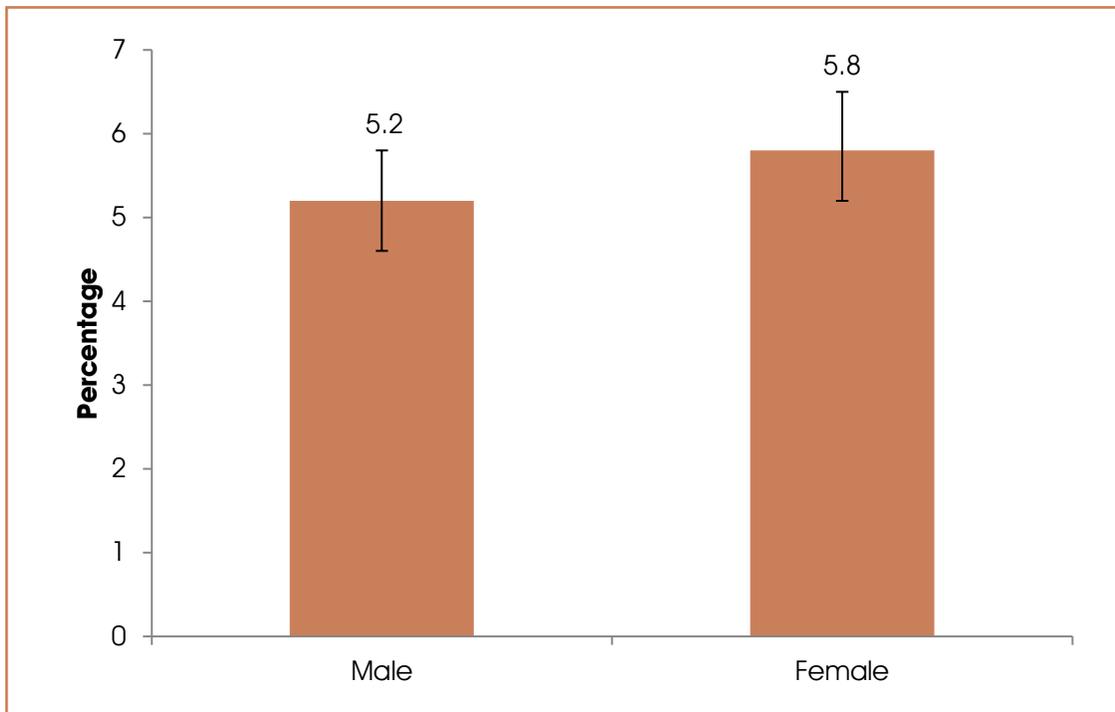


Source: Utah Behavioral Risk Factor Surveillance System age-adjusted, 2009-2014 Combined. Note: No data are available for 2010 and the estimate for TriCounty LHD is unstable and is not reported.

Prediabetes and Health Disparities

Prediabetes by Sex

The percentage of Utah adults who reported having prediabetes was similar for males and females (Figure 4). While females had a slightly higher rate than males, the difference was not statistically significant.

Figure 4: Percentage of Utah Adults Who Report Having Prediabetes by Sex

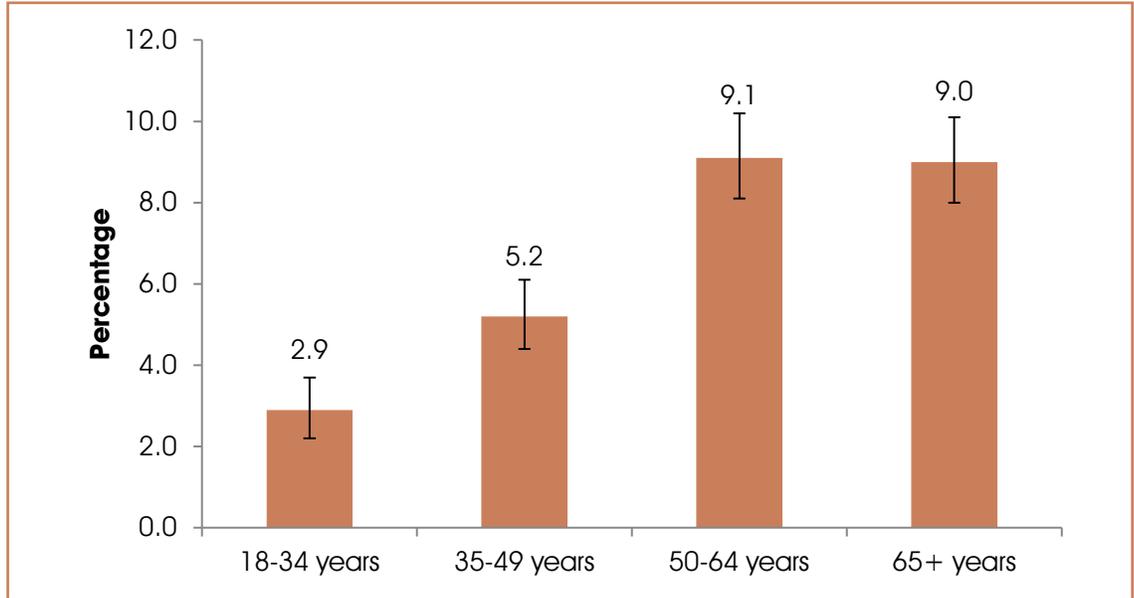
Source: Utah Behavioral Risk Factor Surveillance System 2009-2014 Combined. Crude rates.
Note: No data are available for 2010.

Prediabetes by Age

The percentage of Utah adults reporting they have prediabetes increases with age. Among adults aged 18 to 34 years of age, 2.9% reported they had prediabetes (BRFSS 2009-2014). This percentage increased to 5.2% among adults aged 35 to 49 years. Among adults aged 50 to 64, 9.1% reported they had prediabetes; and among adults aged 65 and older, 9.0% reported they had prediabetes (Figure 5).

There was little difference in the rate of prediabetes between adults aged 50-64 and 65 and older. However, differences between these two age groups and the two younger age groups were statistically significant.

Figure 5: Percentage of Utah Adults Who Report Having Prediabetes by Age

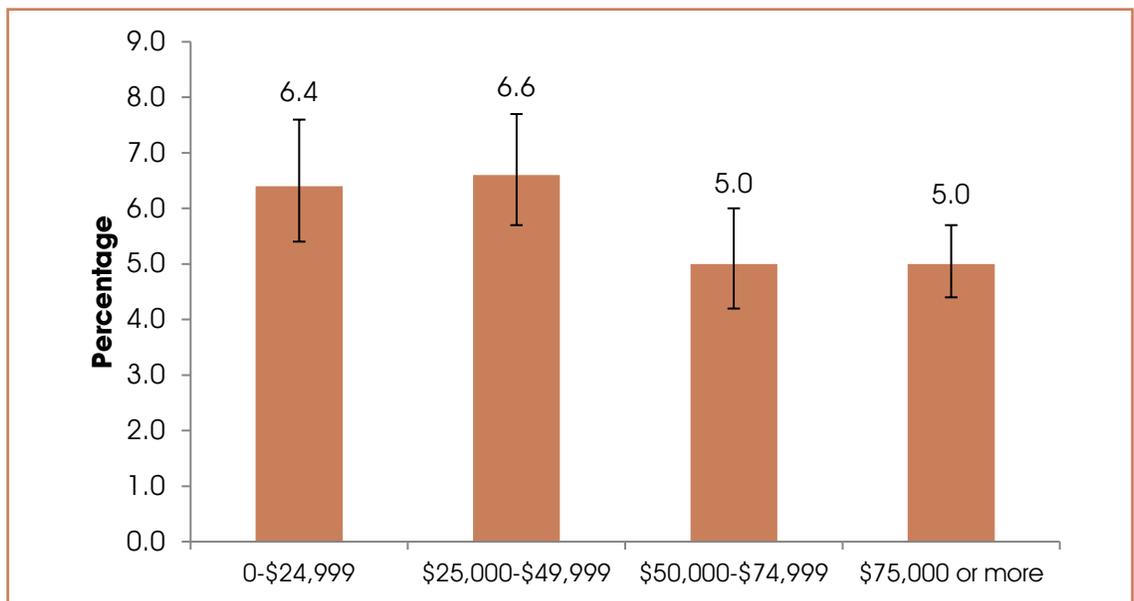


Source: Utah Behavioral Risk Factor Surveillance System 2009-2014 Combined. Crude rates
 Note: No data are available for 2010.

Prediabetes by Income

Differences in prediabetes rates by household income were not statistically significant (Figure 6). However, there is a marked difference between rates of prediabetes for adults living in households with less than \$50,000 annual incomes and households with incomes of \$50,000 and over.

Figure 6: Percentage of Utah Adults Who Report Having Prediabetes by Income

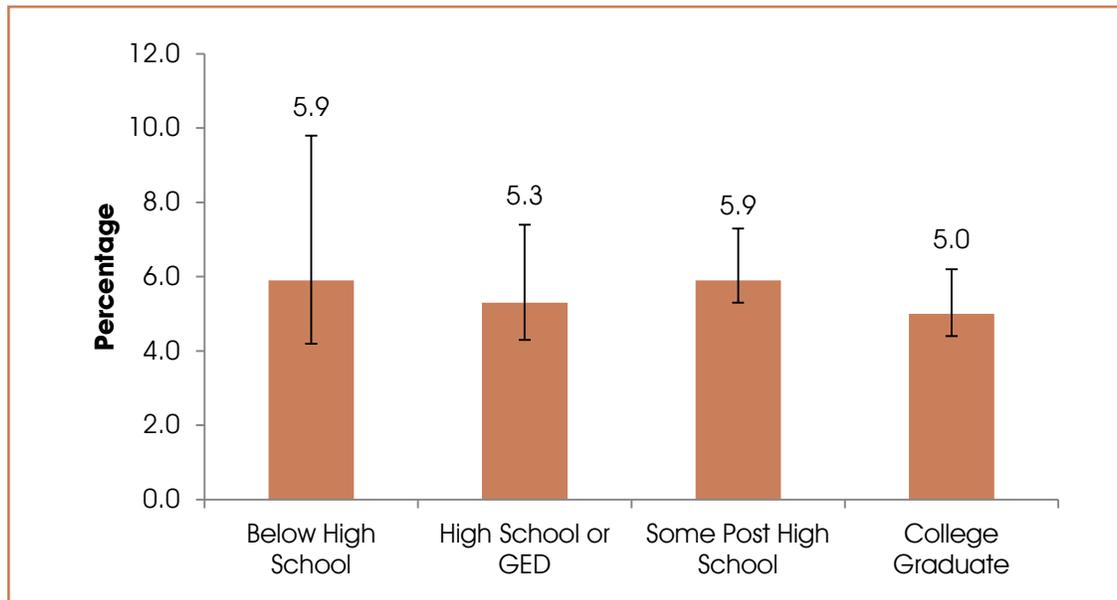


Source: Utah Behavioral Risk Factor Surveillance System 2009-2014 Combined. Crude rates
 Note: No data are available for 2010.

Prediabetes by Education

The percentage of Utah adults who reported having prediabetes was not different by highest educational attainment (Figure 7). No clear pattern emerged for prediabetes prevalence by education.

Figure 7: Percentage of Utah Adults Who Report Having Prediabetes by Education



Source: Utah Behavioral Risk Factor Surveillance System 2009-2014 Combined. Crude rates.

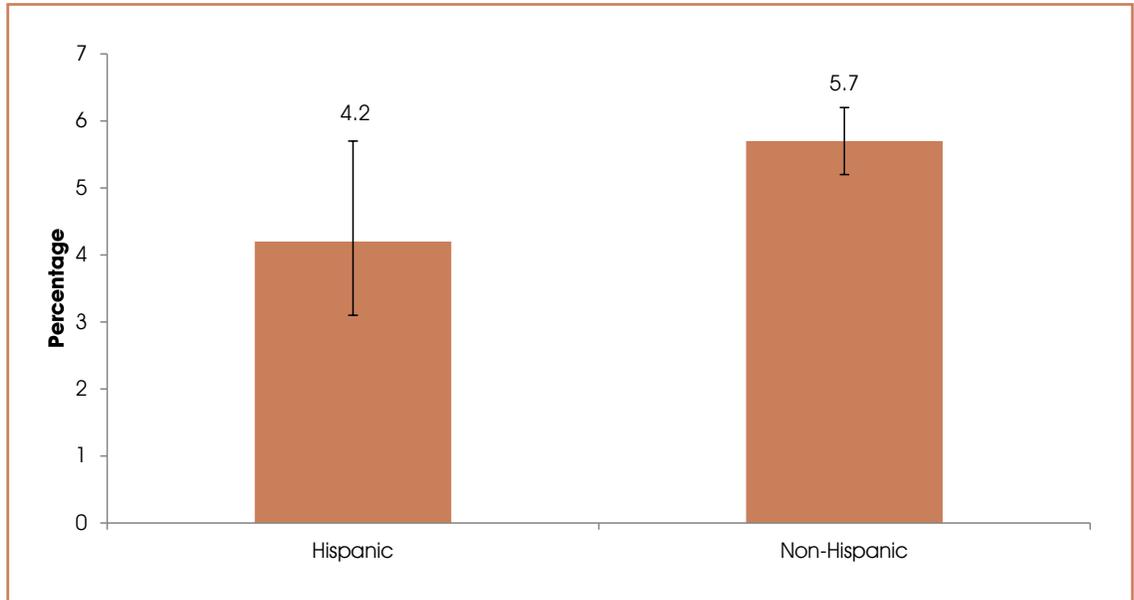
Note: No data are available for 2010.

Prediabetes by Race and Ethnicity

The percentage of Utah adults who report having prediabetes by race is difficult to estimate because of unstable estimates for races other than Whites. The prediabetes percentage for Whites is 5.6% which is no different from the state rate of 5.5%.

The percentage of Utah adults who reported having prediabetes was not statistically different for non-Hispanics and Hispanics (Figure 8). The rate of self-reported prediabetes was lower for Hispanic adults than for non-Hispanic adults, but the difference was not statistically significant.

Figure 8: Percentage of Utah Adults Who Report Having Prediabetes by Ethnicity

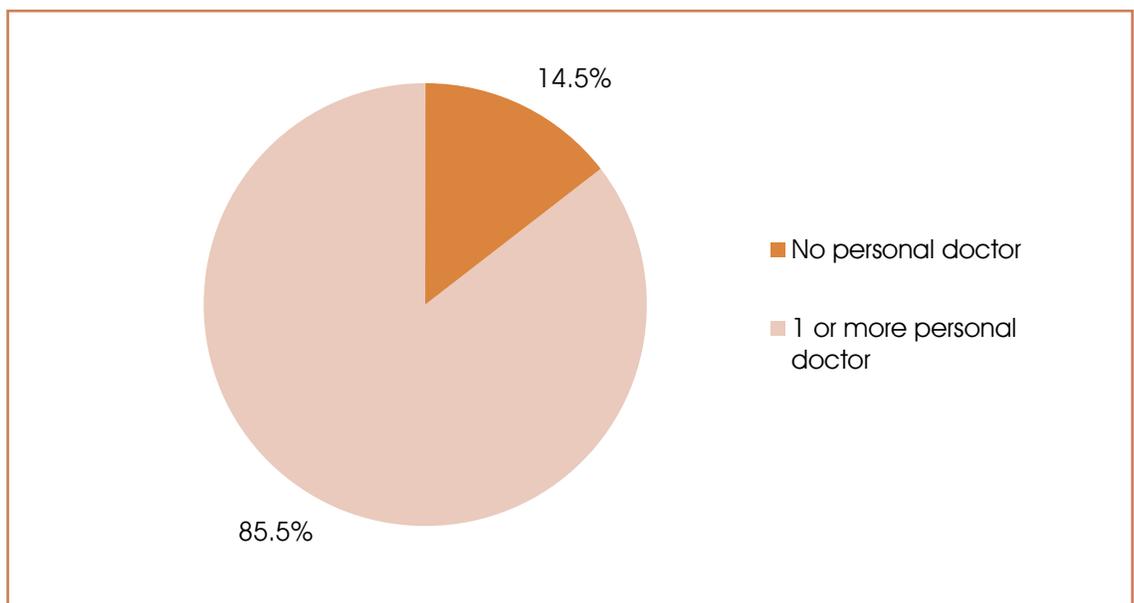


Source: Utah Behavioral Risk Factor Surveillance System 2009-2014 Combined. Crude rates. Note: No data are available for 2010.

Having a Healthcare Provider or Personal Doctor by Prediabetes

The percentage of Utah adults with prediabetes who do not have a healthcare provider or personal doctor among adults with prediabetes is 14.5% (Figure 9). This percentage is lower than for the general Utah population (31.0%).

Figure 9: Percentage of Utah Adults with Prediabetes Having a Healthcare Provider or Personal Doctor



Source: Utah Behavioral Risk Factor Surveillance System 2009-2014 Combined. Crude rates. Note: No data are available for 2010.

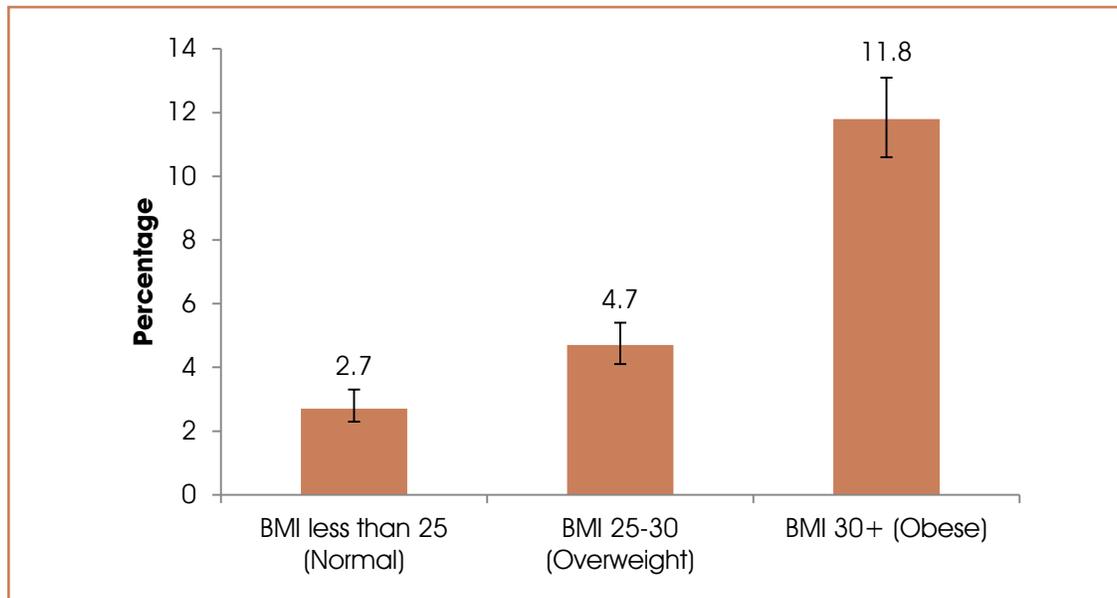
Prediabetes and Co-morbid Conditions

The following health conditions have been linked to prediabetes: obesity, cardiovascular disease, polycystic ovarian syndrome (PCOS), nonalcoholic fatty liver disease, and chronic kidney disease.

Prediabetes by Body Mass Index

The percentage of reported prediabetes in Utah adults increases with body mass index. The percentage of prediabetes for adults at a normal body mass index was 2.7% and 4.7% for adults who are categorized as overweight. The percentage of prediabetes is highest for adults in the obese category at 11.8% (Figure 10).

Figure 10: Percentage of Utah Adults Who Report Having Prediabetes by Body Mass Index



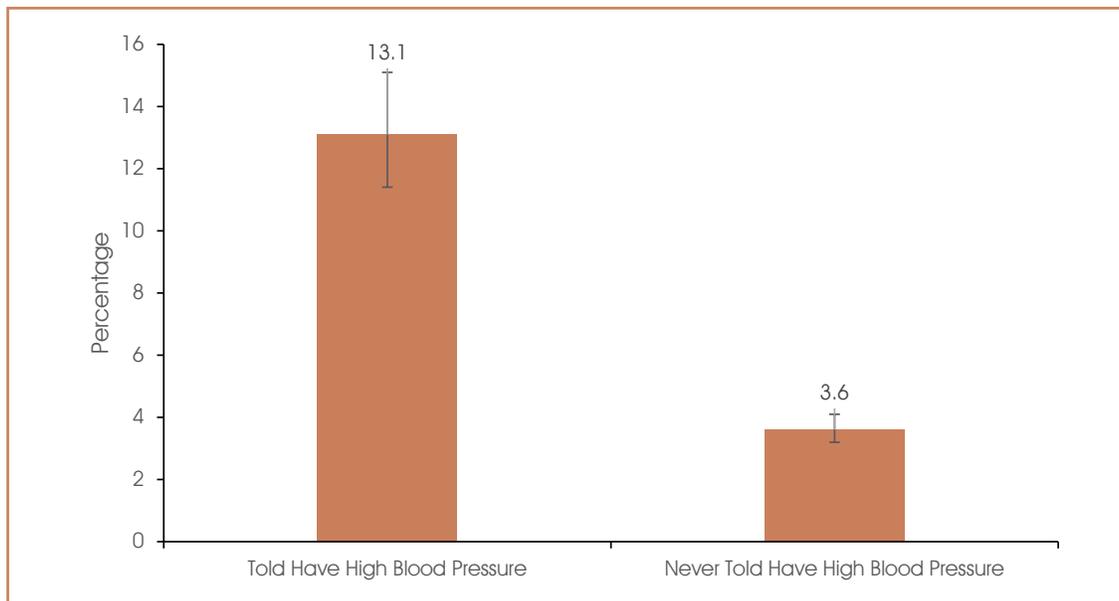
Source: Utah Behavioral Risk Factor Surveillance System 2009-2014 Combined. Crude rates.

Note: No data are available for 2010.

Prediabetes by Blood Pressure

High blood pressure is another risk factor for prediabetes. The prevalence of prediabetes is almost three times higher among Utah adults with high blood pressure than it is for adults who have never been told they have high blood pressure.

Figure 11: Percentage of Utah Adults With and Without High Blood Pressure Who Report Having Prediabetes



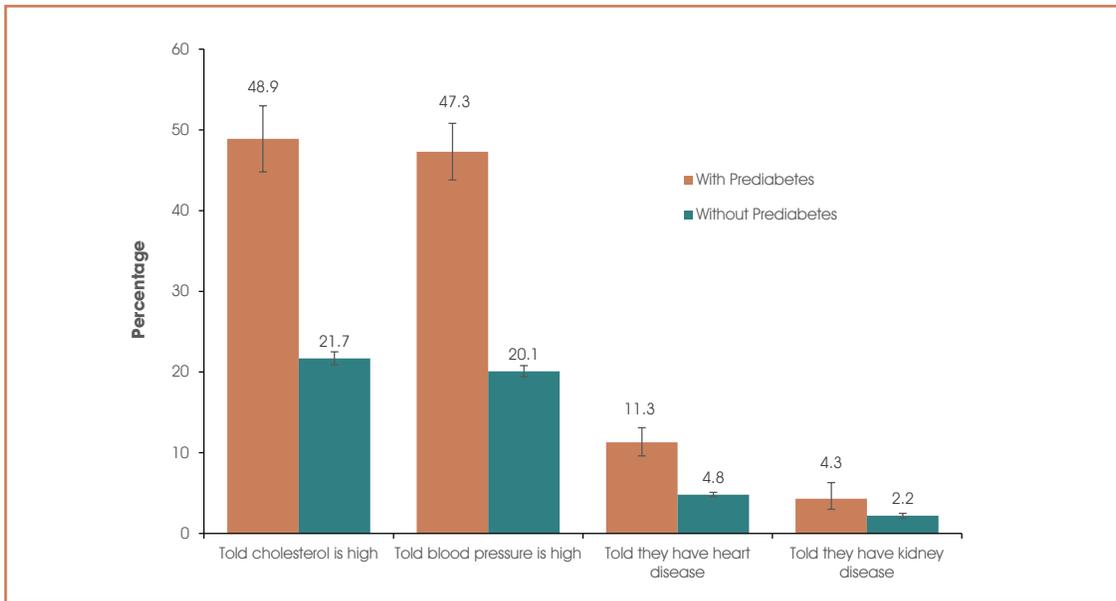
Utah Behavioral Risk Factor Surveillance System 2009-2014 Combined.

High Cholesterol, High Blood Pressure, Heart Disease, or Kidney Disease among Adults with Prediabetes

Adults with prediabetes have much greater prevalence of some conditions than adults who do not. Among all Utah adults reporting they have prediabetes, 48.9% reported they had high cholesterol, compared to 21.7% of adults without prediabetes (See Figure 12). About forty-seven percent (47.3%) of adults with prediabetes reported they had high blood pressure, while only 20.1% of adults without prediabetes reported they did. About 11% (11.3%) of adults with prediabetes reported they had some form of heart disease (stroke, angina, coronary heart disease, or heart attack), compared to 4.8% of adults without prediabetes. More than four percent (4.3%) of adults with prediabetes report they had kidney disease, compared to about two percent (2.2%) of adults without prediabetes.

In the overall population, 19.7% of adults report having high cholesterol; 25.2% of report having high blood pressure, 6.7% report having some form of heart disease, and 2.9% report having kidney disease (not shown in chart).

Figure 12: Percentage of Utah Adults with and without Prediabetes Who Report Having High Cholesterol, High Blood Pressure, Heart Disease, or Kidney Disease



Source: Utah Behavioral Risk Factor Surveillance System 2009-2014 Combined. Crude rates. Note: No data are available for 2010. Cholesterol data does not include 2014. Kidney disease data does not include 2009 or 2010.

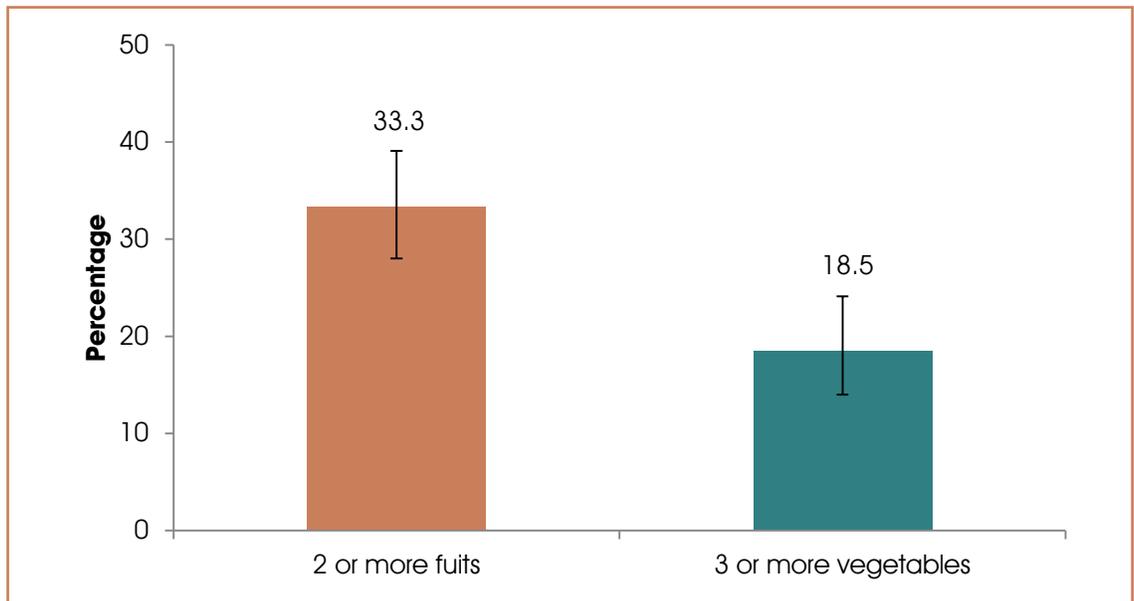
Fruit and Vegetable Consumption Among Adults with Prediabetes

Having a healthy diet, such as eating more fruits and vegetables, can help prevent prediabetes from progressing to type 2 diabetes. Only one-third (33.3%) of adults with prediabetes report consuming two or more servings of fruit daily and even fewer, 18.5%, report consuming three or more vegetables daily (Figure 13). These percentages are similar to the general population. Less than one-third (31.0%) of Utah adults overall report consuming two or more fruits daily and 17.5% report consuming three or more vegetables daily.

Modifiable Risk Factors Among Adults with Prediabetes

For adults with prediabetes, research shows that doing just two things can help prevent or delay type 2 diabetes: losing 5% to 7% of their body weight, which would be 10 to 14 pounds for a 200-pound person and getting at least 150 minutes of physical activity each week, such as brisk walking (Diabetes Prevention Research Group, 2002).

Figure 13: Percentage of Utah Adults with Prediabetes Who Report Consumption of 2+ Fruits or 3+ Vegetables Daily

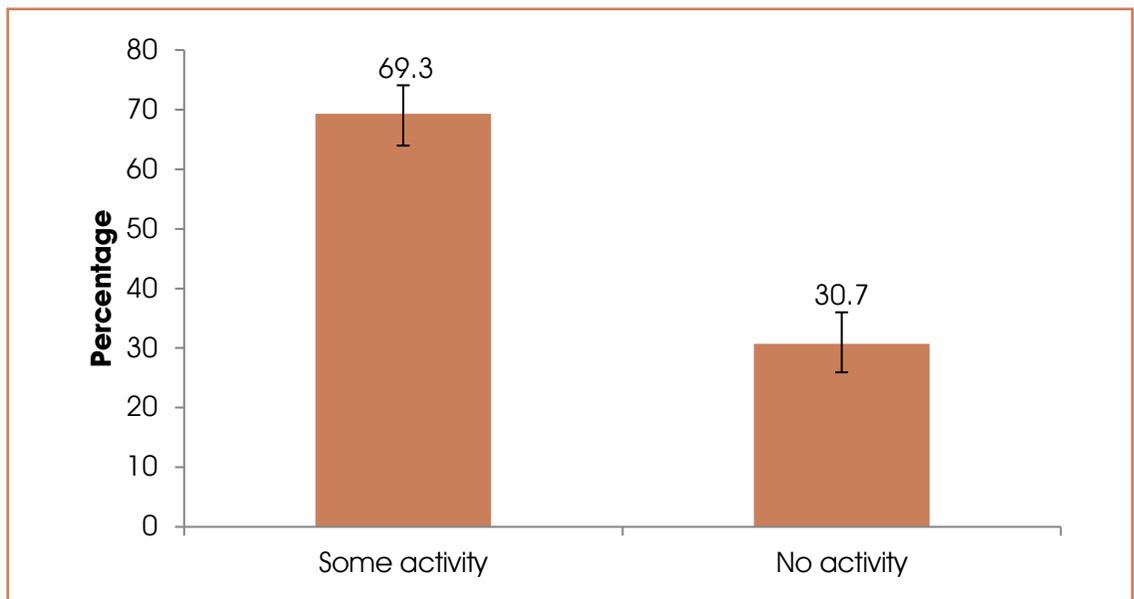


Source: Utah Behavioral Risk Factor Surveillance System 2011-2013 Combined. Crude rates.

Leisure Time Physical Activity Level Among Adults with Prediabetes

The percentage of Utah adults with prediabetes who report no leisure time physical activity was 30.7% (Figure 14). This percentage is higher than the general population (18.7%).

Figure 14: Percentage of Adults with Prediabetes Who Report Having Some or No Leisure Time Activity



Source: Utah Behavioral Risk Factor Surveillance System 2011-2013 Combined. Crude rates.

Summary

About 113,000 Utah adults have been diagnosed with prediabetes but the true prevalence is likely closer to 590,000. The prevalence of prediabetes increases with age. Certain co-morbid conditions, such as high blood pressure, are also associated with an increased risk. In Utah, the prevalence of prediabetes is three times higher among adults with high blood pressure compared to those without prediabetes.

Utah data also shows that individuals at lower income levels have higher prevalence of prediabetes than those with higher incomes. While differences for Utah adults by the income level may not be statistically significant, the data clearly show a striking disparity between adults living in households with annual incomes less than \$50,000 and those in households with annual incomes of \$50,000 and above.

Utah data clearly show that the prevalence of prediabetes is associated with higher body mass index and physical inactivity. Simple lifestyle changes, such as **increasing physical activity and losing weight**, can help individuals with prediabetes prevent or delay progression to diabetes.

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“Most times we think we have to shoulder all of the work and the resources around taking care of our patients and making sure they stay healthy, but this partnership with the community... really does expand our care team.”

Testimonial from a physician, CDC website, www.cdc.gov/diabetes/prevention/lifestyle-program/deliverers/testimonials.html

EPICC Program Vision

Healthy Utahns in Healthy Communities Supported by Healthy Systems.

Domain 1, Epidemiology and Surveillance Mission:

Use information to assess EPICC program and partner efforts, collaboration, and synergy to ensure efficiency and effectiveness of strategies and monitor progress on objectives.

Domain 2, Environmental Approaches Mission:

Supporting communities to develop policies and environments that improve healthful eating and active living throughout the lifespan.

Domain 3, Healthcare Systems Intervention Mission:

Improving clinical care by supporting Utah health systems in using data for quality improvement and expanding the role of non-physician team members to help patients manage hypertension and diabetes.

Domain 4, Community-Clinical Linkages Mission:

Empower Utahns to improve quality of life through self-management of chronic conditions and connect them to resources.

EPICC Program Goals

Healthier people living in healthier communities. Improved prevention and control of diabetes, heart disease, and obesity. Promotion of health in schools.

Utah's Diabetes Prevention Goal

Scale and sustain the National Diabetes Prevention Program and increase awareness of prediabetes in Utah.

The following strategic plan goals are grouped by four strategic planning areas:

1. *health systems and referrals,*
2. *reimbursement,*
3. *increasing awareness of prediabetes, and*
4. *support for new programs.*



Within each of those four strategic areas three settings are targeted:

- *healthcare,*
- *community, and*
- *worksites.*

Strategic Plan Goals

1. Healthcare Systems and Referrals

HEALTHCARE SETTING

GOAL: *Develop a value-driven network of stakeholders to facilitate screening, testing, and referrals.*

Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
1. Short Term: By June 30, 2016, identify and invite key stakeholder(s) who represent healthcare to the Utah Diabetes Coalition. (physician, nurse practitioner, pharmacist, etc.)	UDOH EPICC Program LHDs	Number of new attendees at coalition Number of unique sectors represented	Active coalition Support and a reason for new partners to attend Actionable items for attendees
2. Short Term: By June 30, 2017, provide at least two trainings and TA to four LHDs and network partners for making bi-directional referrals using the Compass portal.	UDOH EPICC Program UDOH Arthritis Program LHDs Lifestyle coaches HealthInsight	Number of bi-directional referral policies implemented	Access and orientation to Compass portal Training (online & in-person) Access to Compass portal
3. Short Term: By June 30, 2017, 10 healthcare providers will have developed a way to identify priority populations with high rates of prediabetes.	HealthInsight LHDs Evaluators	Number of providers have implemented ways to identify priority populations with high rates of prediabetes	Willing healthcare providers AMA/CDC STAT toolkit Trainings
4. Short Term: By June 30, 2017, at least three health systems have Electronic Medical Records (EMR) that have the capacity to flag patients at high risk for prediabetes for blood glucose testing.	HealthInsight Medical assistants and physicians LHDs	Number of prediabetes blood tests performed. Number of policies developed/implemented to flag people with prediabetes	Trainings Policy development Flow chart Willing healthcare provider staff or champion CPT code awareness
5. Intermediate Term: By June 30, 2018, LHDs maintain a check-in plan with providers to evaluate the flow process and referrals.	LHDs and Providers Medical assistants HealthInsight	Number of referrals	Trust Time Availability

1. Healthcare Systems and Referrals (continued)

<i>COMMUNITY SETTING</i>			
GOAL: <i>Develop a value-driven network of stakeholders to facilitate screening, testing, and referrals.</i>			
Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
1. Short Term: By June 30, 2016, identify target population and most effective ways to reach it to increase awareness of prediabetes and availability of National DPP.	Evaluators LHDs UDOH EPICC Program	Priority populations are identified Priority populations and best ways to reach them are identified	Data available for priority populations Identify barriers and facilitators to reaching priority populations
2. Short Term: By June 30, 2016, identify and invite a National DPP graduate/ champion to the Living Well Coalition.	National DPP provider LHDs	Number of champions identified or attending coalition meetings regularly	Time Willing National DPP graduate Recommendations for 1-2 champions from lifestyle coaches or coordinators
3. Short Term: By June 30, 2017, conduct outreach and recruitment at a minimum of 11 sites including community events, food pantries, etc. Join partners at health screening events where possible to disseminate information about prediabetes and National DPP classes.	LHDs National DPP providers Other community or referral partners	Number of sites where outreach was conducted	Contacts Calendar of events Partners that conduct screening Time and location of appropriate community events

Strategic Plan Goals

1. Healthcare Systems and Referrals (continued)

<i>WORKSITE SETTING</i>			
GOAL: <i>Develop a value-driven network of stakeholders to facilitate screening, testing, and referrals.</i>			
Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
1. Short Term: By June 30, 2016, two worksite wellness councils are represented in the newly formed National DPP support group (Living Well).	UDOH EPICC Program LHDs Wellness Council National DPP Providers	Increased number of representatives on National DPP support group or coalition	Time Invitation Release time from work Reason to attend group
2. Short Term: By June 30, 2017, 10 worksites are presented to on the importance of knowing about prediabetes and National DPP. (Beginning with worksites that already have wellness programs)	LHDs National DPP providers UDOH EPICC Program Worksite Wellness coordinator	Presentation at Worksite Wellness conference	Invitation to present Increase in the number of worksite wellness programs Contacts with wellness council committees Invitation to National DPP providers to present
3. Short Term: By June 30, 2017, appropriately modified marketing materials will be distributed to 20 worksites.	Worksite Wellness coordinators	Increased number of prediabetes materials produced at worksites Prediabetes materials that reflect worksite culture are produced at 20 worksite	Information about National DPP Time to develop materials Buy-in from executive management
4. Intermediate Term: By June 30, 2018, prediabetes testing and marketing materials are integrated into wellness council business practices for 20 worksites	Wellness Council coordinators Lifestyle coaches	Increase in worksites that have business policies which accommodate prediabetes testing	Buy-in from executive management to allow for testing Training Covering costs for equipment

2. Reimbursement for the National Diabetes Prevention Program

HEALTHCARE SETTING

GOAL: *Increase and expand reimbursement for the CDC recognized National DPP.*

Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
1. Short Term: By December 31, 2016, National DPP awareness is promoted to providers and healthcare professionals through assistance with or attendance at least two medical conferences.	LHDs National DPP partners	Number of conferences assisted with or attended Number of presentations or facilitated briefings Number of National DPP pamphlets distributed	National DPP pamphlets or presentation materials that will be presented at this conference
2. Short Term: By December 31, 2016, physician education is conducted through 1:1 contact or systems communications.	UDOH EPICC Program Partner organizations	Number of physicians who increased awareness of prediabetes	Program advertisement (CDC) Identification of CME provider
3. Short Term: By December 31, 2016, at least six providers have a system in place to refer at-risk patients to the National DPP.	UDOH EPICC Program, LHDs, Community Partners National DPP Providers	Number of referrals into a National DPP from physicians	Identify or develop best-practices referral process
4. Short Term: By June 30, 2017, avenues will be available for individuals on Medicare to enroll in National DPP, including options for reimbursement.	UDOH EPICC Program	Enrollment options into National DPP are available, including options for reimbursement	Collaboration with Medicare
5. Short Term: By January 30, 2018, an application will be filed for a Policy Brief, a waiver [1115, 1915 (b), 1915 (c)], a State Plan Amendment or Alternative Benefit Plan through Medicaid.	UDOH EPICC Program	An approved waiver, amendment, or alternative benefit plan within Medicaid is available	Collaboration with Medicaid
6. Intermediate Term: By January 30, 2018, a Utah General Statue will be added that requires reimbursement for National DPP which covers private insurance, Medicaid, and the State Health Plan.	UDOH EPICC Program	At least one private insurer, Medicaid, or state health plan covers National DPP as a reimbursable benefit	Collaboration with the largest private health insurer in Utah, Medicaid, and the State Health Plan

2. Reimbursement for the National Diabetes Prevention Program (cont.)

<i>COMMUNITY SETTING</i>			
GOAL: Increase and expand reimbursement for the CDC recognized National DPP.			
Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
1. Short Term: By July 30, 2016, at least one organization will be contacted regarding sponsorship (e.g., Larry H Miller).	UDOH EPICC Program or community partner	A sponsor is on-board and supports residents of underserved/underinsured communities who meet the National DPP criteria to enroll in National DPP	Finances from the sponsor
2. Short Term: By September 30, 2016, at least two community outreach events have been held that focus on diabetes prevention awareness and the National DPP.	LHDs Community partners (e.g., YMCA)	Number of community outreach events Number of people who received information regarding a National DPP educational pamphlet	National DPP documents or presentation materials
3. Short Term: By July 30, 2017, at least one champion with a success story (e.g., participant, program coordinator, physician who have referred patients) is willing to help advocate for insurance coverage of National DPP.	LHDs National DPP providers and coordinators Family Medicine Internal Medicine Community champions	At least one champion/success story from each health district that describes the personal benefit obtained from the National DPP	Willing people to share their personal stories

2. Reimbursement for the National Diabetes Prevention Program (cont.)

<i>WORKSITE SETTING</i>			
GOAL: Increase and expand reimbursement for the CDC recognized National DPP.			
Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
1. Short Term: By February 28, 2016, a business case for employers to include National DPP as a covered health benefit is available for use.	LHDs	A completed National DPP business case for employers	Time to develop a business case
2. Short Term: By September 30, 2016, LHDs have contacted companies/businesses regarding worksite wellness, including holding a meeting to assist with worksite wellness initiatives (e.g., National DPP).	LHDs	Number of contacts made at companies/businesses within the LHD Number of health risk appraisals completed by employees at companies/businesses	Contact list of companies or businesses with worksite wellness programs
3. Intermediate Term: By January 30, 2017, at least two employers offer National DPP as a covered benefit.	LHDs	At least two employers offer National DPP as a covered benefit in each LHD	Partnerships with two or more employers interested in offering the National DPP

Strategic Plan Goals

3. Increasing Awareness of Prediabetes

HEALTHCARE SETTING

GOAL: *Use a variety of methods to distribute information to Utah healthcare workers in order to educate them and promote the issue of prediabetes with the intent of reaching more people at risk for diabetes.*

Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
<p>1. Short Term: By October 30, 2016, the media has been contacted at least twice to generate publicity for National DPP programs offered in Utah and all major health plans include prediabetes information in patient mailings.</p>	<p>UDOH EPICC Program (use CDC social media tool kit to create messages) Spokesperson designated by various DPP programs may also be a resource</p>	<p>Prediabetes information routinely in news media and healthcare communications such as newsletters and social media Track where interested people get their National DPP information from and see a consistent increase from each source</p>	<p>TV interviews are free publicity Spokesperson Need a lot of partnerships and communication between groups Toolkit, social media packet, and other CDC resources</p>
<p>2. Short Term: By November 30, 2016, a bulleted list about the risk factors for prediabetes is available for providers to use in their practice. The document will include contact information for local programs.</p>	<p>UDOH EPICC Program (will review and finalize bullet points and contact information)</p>	<p>Providers and healthcare educators are routinely including a prediabetes discussion with people at risk or diagnosed with prediabetes</p>	<p>LHDs track which providers refer patients and offer public thanks to all of referring providers Brightly colored paper and a laminator. Partnerships with healthcare practices, educators, etc.</p>
<p>3. Short Term: By June 30, 2017, resources designed to educate patients about prediabetes have been developed and distributed to providers to give to patients.</p>	<p>UDOH EPICC Program (prepares resource packets for healthcare practices using the AMA/CDC STAT toolkit to create a resource for those at risk and for those diagnosed)</p>	<p>Resource packets are being distributed to HCPs and other health professionals at their conferences or through individual clinic visits Resource packets to all at risk patients at visits and through EMRs</p>	<p>Utah Diabetes and Living Well Coalition and connections to different professional groups</p>

3. Increasing Awareness of Prediabetes (continued)

HEALTHCARE SETTING (continued)

GOAL: *Use a variety of methods to distribute information to Utah healthcare workers in order to educate them and promote the issue of prediabetes with the intent of reaching more people at risk for diabetes.*

Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
<p>4. Short Term: By November 30, 2016, the Diabetes and Living Well Coalitions provide support and resources to healthcare settings.</p>	<p>UDOH EPPIC Program Living Well Coalition members Diabetes Coalition members</p>	<p>Active discussions and support among members of the Diabetes and Living Well Coalition</p>	<p>Good will</p>
<p>5. Short Term: By September 30, 2017, healthcare-related trainers have information about prediabetes that can be included in their training programs.</p>	<p>UDOH EPICC Program and partners</p>	<p>All new graduates (MA, CNA, LPN, RN, RD, PT, PTA, RPh, PharmD, pharmacy support staff, CHES, and health promotion and education staff) understand, to the degree appropriate for their profession, the basic causes and risks of prediabetes, methods to prevent it, and local resources to address it Healthcare professionals share this information with their clients</p>	<p>Partnerships</p>
<p>6. Short Term: By January 30, 2018, successes have been analyzed and follow-up strategies have been developed.</p>	<p>UDOH EPICC Program</p>	<p>Successes and follow-up plans are documented</p>	<p>Good will</p>

Strategic Plan Goals

3. Increasing Awareness of Prediabetes (continued)

COMMUNITY SETTING

GOAL: *Use media, community events, existing organizations, and promotions to educate the public about the problem and prevalence of prediabetes and raise awareness about the availability of diabetes prevention resources.*

Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
<p>1. Short Term: By December 30, 2016, an ongoing mass media social campaign using Ad Council materials has been initiated.</p>	<p>UDOH EPICC Program Media Coordinator</p>	<p>Statewide social media shared by LHDs and providers Data collected on those who enroll in a National DPP class after hearing or seeing the media campaign materials</p>	<p>Ideas from UDOH EPICC Program and partners</p>
<p>2. Short Term: By December 30, 2016, National DPP participants are identified as champions and have been selected to speak at public meetings and other events.</p>	<p>National DPP participants Coaches should be on the look-out for champions that would be willing to speak out (this needs to be done individually and privately)</p>	<p>Number of new participants who join because of referral by friend or family</p>	<p>Participants who have great success and are excited to spread the word</p>
<p>3. Short Term: By September 30, 2017, information about prediabetes is made available through at least one community event (e.g., information booth; seminar).</p>	<p>LHDs Local clinic volunteers Community members</p>	<p>Residents attended community events and inquired about prediabetes. Referrals to National DPP or other local diabetes prevention program</p>	<p>Partnerships</p>

3. Increasing Awareness of Prediabetes (continued)

COMMUNITY SETTING (continued)

GOAL: *Use media, community events, existing organizations, and promotions to educate the public about the problem and prevalence of prediabetes and raise awareness about the availability of diabetes prevention resources.*

Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
4. Short Term: By January 30, 2017, champions of local National DPP programs are available to help with information and awareness efforts.	Leaders of local National DPP programs find champions within their programs	Champions will be featured on billboards, radio, newspaper, social media, etc.	Partnerships Free air time Social media such as Facebook, Instagram, etc.
5. Short Term: By August 30, 2017, successes have been analyzed and follow-up strategies have been developed.	UDOH EPICC Program Partners	Successes and follow-up plans are documented	Time
6. Short Term: By September 30, 2017, Ad Council PSAs have been distributed to radio, TV, and newspaper outlets.	UDOH EPICC Program Media Specialists LHDs for local media	Broadcasts seen and heard on local TV and radio stations as well as read in the local newspapers	Air time
7. Short Term: By November 30, 2017, all healthcare organizations and laboratory companies include prediabetes ranges as standard practice when reporting blood sugar or A1C.	Living Well Coalition Diabetes Coalition Partners	Fasting blood sugar values of 100-125 mg/dL and A1Cs of 5.7-6.4% are universally recognized by healthcare providers as prediabetes	Partnerships

3. Increasing Awareness of Prediabetes (continued)

WORKSITE SETTING

GOAL: *Locate employers in the state of Utah willing to incorporate diabetes prevention into employee wellness efforts and facilitate the implementation of such programs at several worksites.*

Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
<p>1. Short Term: By June 30, 2107, prediabetes information and guidelines (including test result interpretation) are provided to employees of businesses that provide classes or release time to attend classes.</p>	<p>LHDs will provide information to Human Resources Departments of selected businesses</p>	<p>Businesses are engaged throughout the state A questionnaire is sent out to determine effectiveness Several of the models are shared throughout the state to Chambers of Commerce</p>	<p>Use employee intranets to distribute information Business owner's time Local trainers, presenters County government EMTs at some businesses who could be trained</p>
<p>2. Intermediate Term: By January 30, 2018, at least 2 of the smaller funded LHDs have diabetes prevention programs as part of their employee wellness program.</p>	<p>LHDs National DPP providers</p>	<p>At least 1-2 contacts have been made with employers in each health district Plans have been made with each receptive business</p>	<p>Time of employees Wellness plans Use Wellness Councils to provide awareness of local diabetes prevention classes/ programs Approach Human Resources Departments and ask them to include diabetes prevention programs as part of their employee wellness incentives</p>
<p>3. Intermediate Term: By October 30, 2019, successes have been analyzed and follow-up plans have been developed.</p>	<p>UDOH EPICC Program and partners</p>	<p>Successes and follow-up plans are documented</p>	<p>Time</p>

4. Support for New National Diabetes Prevention Programs

HEALTHCARE SETTING

GOAL: *Increase affordability, accessibility, and sustainability of CDC-recognized diabetes prevention lifestyle change programs so participants can enroll when they are ready.*

Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
<p>1. Short Term: By September 30, 2017, a National DPP program has been established in each of the funded local areas.</p> <ul style="list-style-type: none"> Partners who may be service providers of the National DPP program are identified. Assistance is provided to partners applying for CDC recognition status. Partners are connected with appropriate National DPP training. When a partner is not available, LHDs fulfill the role of assurance and becomes a National DPP provider. 	<p>UDOH EPICC Program LHDs Other identified partners</p>	<p>Increased number of National DPP providers</p>	<p>Partnerships with agencies</p>
<p>2. Intermediate Term: By September 30, 2018, a minimum of 10 eligible patients are referred to the National DPP program.</p> <ul style="list-style-type: none"> By September 30, 2017, primary healthcare providers who are interested in referring patients to the National DPP program are identified. By September 30, 2018, a referral process exists for participating healthcare providers to link patients to National DPP. 	<p>LHDs Local healthcare providers</p>	<p>Establishment of a referral process Healthcare providers use identified referral options</p>	<p>Compass online data management tool Referral link in the healthcare provider's electronic health record</p>

4. Support for New National Diabetes Prevention Programs (continued)

HEALTHCARE SETTING (continued)

GOAL: Increase affordability, accessibility, and sustainability of CDC-recognized diabetes prevention lifestyle change programs so participants can enroll when they are ready.

Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
<p>3. Intermediate Term: By September 30, 2018, Compass portal is used for bi-directional referrals to provide feedback to healthcare providers.</p> <ul style="list-style-type: none"> By September 30, 2018, 100% of referring healthcare providers are trained on how to use the portal. 	<p>LHDs UDOH EPICC Program Healthcare providers</p>	<p>Utilization of Compass online data management tool</p>	<p>Compass portal Bi-directional referral process development</p>
<p>4. Intermediate Term: By September 30, 2018, National DPP is a covered benefit for Medicaid and Federally Qualified Health Centers (FQHC) patients.</p> <ul style="list-style-type: none"> By September 30, 2018, Medicaid ACOs and FQHCs have been presented the business case regarding National DPP reimbursement. By September 30, 2018, healthcare providers have been educated on the prediabetes diagnostic codes and CPT codes. 	<p>UDOH EPICC Program LHDs Medicaid ACOs (Molina, HealthyU, Health Choice Utah, & SelectHealth), FQHCs Healthcare provider champions</p>	<p>National DPP is a covered benefit</p>	<p>Advocacy champions within payer system to approve National DPP as a covered benefit</p>
<p>5. Intermediate Term: By September 30, 2018, partnering pharmacies have written policies to refer patients to National DPP.</p>	<p>UDOH EPICC Program LHDs Partnering pharmacies</p>	<p>Referral policy established with pharmacies</p>	<p>Make existing sample policies available (Birch Family Pharmacies and Olive Pharmacy)</p>

4. Support for New National Diabetes Prevention Programs (continued)

COMMUNITY SETTING

GOAL: Increase affordability, accessibility, and sustainability of CDC-recognized diabetes prevention lifestyle change programs so participants can enroll when they are ready.

Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
<p>1. Short Term: By June 30, 2017, a community assessment has identified prediabetes and diabetes services in the health district.</p>	<p>LHD conducts the assessment</p> <p>UDOH EPICC Program helps with analysis of the assessment</p>	<p>Completed assessment</p>	<p>Time dedicated to assessment</p>
<p>2. Short Term: By June 30, 2017, the National DPP has been promoted using the national media campaign.</p> <ul style="list-style-type: none"> · By September 30, 2017, LHDs and associated partners have promoted the National DPP using social media, · By September 30, 2017, local news media has received campaign materials including press releases, letters to the editor, and PSAs. · By September 30, 2017, a kick-off media event has been held for National Diabetes Day, Diabetes Alert Day, or other national health observances. 	<p>UDOH EPICC Program</p> <p>LHDs</p> <p>Local and state media partners</p>	<p>Number of advertisements placed</p> <p>Number of estimated viewers</p> <p>Number of media channels used</p> <p>Community awareness of the campaign</p>	<p>AdCouncil media campaign materials</p> <p>Donated time and space for national campaign materials</p>
<p>3. Intermediate Term: By June 30, 2018, the use of the CDC prediabetes paper screen tool has been used at community venues, such as health fairs, community walks, church bulletins, etc.</p>	<p>LHDs</p>	<p>Number of people completing risk assessment tool</p> <p>Number of people enrolling in National DPP program</p>	<p>Community venues</p> <p>Local religious sites</p> <p>Health fairs</p>
<p>4. Intermediate Term: By June 30, 2018, partner organizations (ADA, AADE, or other advocacy organizations) have educated legislators on including National DPP as a covered benefit on insurance plans.</p>	<p>UDOH EPICC Program</p> <p>LHDs</p> <p>Advocacy teams</p>	<p>National DPP is included as a covered benefit in insurance plans</p>	<p>Time with legislators</p> <p>ADA and AADE support</p>

4. Support for New National Diabetes Prevention Programs (continued)

WORKSITE SETTING

GOAL: Increase affordability, accessibility, and sustainability of CDC-recognized diabetes prevention lifestyle change programs so participants can enroll when they are ready.

Actionable Short Term (1-2 years) and Intermediate objectives (3-5 years)	Who will do the work?	Indicators of success	What non-financial resources are needed for this step?
<p>1. Short Term: By June 30, 2017, the Utah Wellness Council includes the National DPP in its awards program.</p> <ul style="list-style-type: none"> By September 30, 2017, the Utah Wellness Council's award program has been marketed to local worksites. 	<p>UDOH EPICC Program LHDs Utah Worksite Wellness Council</p>	<p>National DPP included as a requirement for recognition</p>	<p>Coordination with Wellness Council's awards program</p>
<p>2. Intermediate Term: By June 30, 2018, two or more large employers have National DPP as a covered benefit or they allow work time to attend the National DPP classes.</p> <ul style="list-style-type: none"> By June 30, 2016, the cost calculator supports the business case for offering National DPP classes during work time. 	<p>UDOH EPICC Program LHDs Employers</p>	<p>Number of partnering worksites Number of private insurance companies that cover National DPP as a benefit</p>	<p>Identification and partnership with large employer groups Development of work release policy to attend classes</p>
<p>3. Intermediate Term: By June 30, 2018, local worksite wellness programs have access to technical assistance from LHDs.</p> <ul style="list-style-type: none"> By June 30, 2017, prediabetes screening events are encouraged at worksites. By June 30, 2017, swiss cheese articles about prediabetes awareness are provided by LHDs for employee newsletters. By June 30, 2017, local worksites conduct National DPP classes at their facilities. 	<p>LHDs Worksites</p>	<p>Number of partnering worksites. Number of screening events. Number of articles in employee newsletters. Number of National DPP programs offered</p>	<p>Worksite health fairs or screenings Ready-to-use newsletter articles from AdCouncil's national campaign</p>

**86 MILLION
AMERICANS
MAYBE EVEN YOU,
HAVE PREDIABETES.
PERSON-ABOUT-TO-
FACT-CHECK-THIS-FACT.**

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**National Association of Chronic Disease Directors (NACDD)
Programmatic State Technical Assistance Team (PSTAT)
Utah National Diabetes Prevention Program State Engagement Meeting
*August 11th & 12th, 2015***

Purpose of the Meeting

This meeting provided an opportunity for LHD 1422 sub-grantees implementing the National DPP to meet to learn, share, and network with one another on defining their role in state National DPP initiatives and address related challenges. Attendees participated in facilitated discussions, which led to the development of action steps for carrying out National DPP efforts using state and local mutually reinforcing approaches.

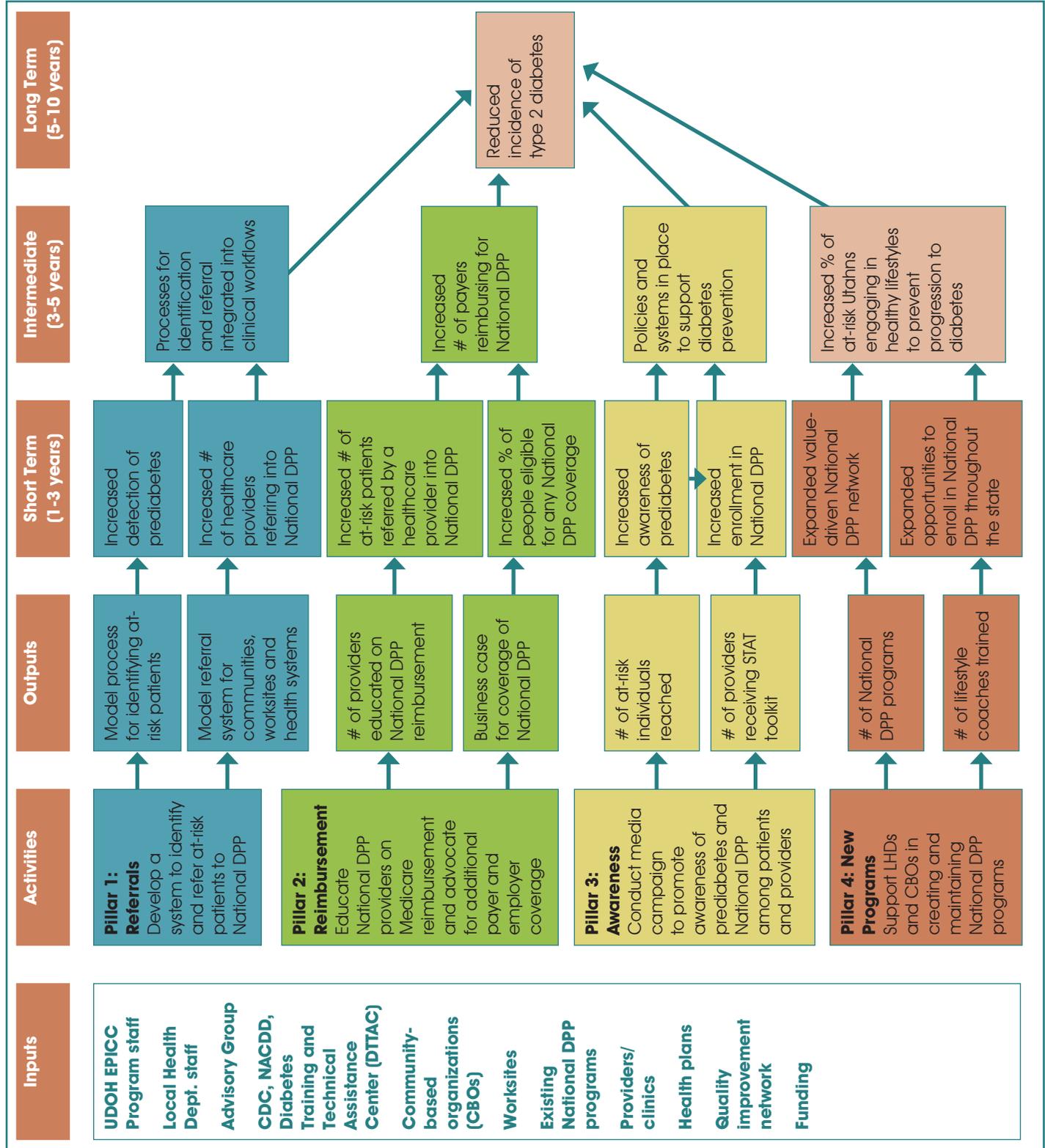
First Name	Last Name	Title	Organization
Travis	Ault	Business Operations Manager	University of Utah Health Plans
Ryan	Barfuss	Prevention Specialist	Utah State University
Beverly	Bartel	Program Manager	American Diabetes Association
Nicole	Bissonette	EPICC Program Manager	Utah Department of Health (UDOH)/EPICC Program
Lynda	Blades	Wellness Manager	PEHP
Celsa	Bowman	Health Program Specialist III	EPICC Program
SaRene	Brooks	Health Educator	Summit County Health Department
Brittany	Brown	Epidemiologist II	UDOH/EPICC Program
Dr. Kimberly	Brunisholz		Intermountain Healthcare
Holly	Budge	Public Health Resource Manager	Bear River Health Department
Anilee	Bundy	Health Educator	Southwest Public Health Department
Gloria	Bush	Director of Health Services	Health Choice Utah
Jesse	Bush	Health Educator	Weber-Morgan Health Department
Emily	Carrier	Health Educator	Davis County Health Department
Marianne	Christensen	Health Promotion Manager	Salt Lake County Aging and Adult Services
David	Cook	Director of Operations	HealthInsight
Joanna	Craver	DPP Manager	American Association of Diabetes Educators (AADE)
Pastor Francis	Davis	Pastor	Calvary Baptist Church
Eileen	DeLeeuw	Diabetes Consultant, CDE	Tooele County Health Department
Josette	Dorius	Director Clinical Operations	University of Utah Health Plans
Mckell	Drury	Coordinator	UDOH/EPICC Program
Alysia	Ducucara	SLIDH Program Coordinator	Salt Lake County Health Department
Linda	Emmett	Clinical Programs Manager	Association for Utah Community Health (AUCH)
Kalynn	Filion	WISEWOMAN Program Manager	Utah Department of Health

Appendix A (cont.)

First Name	Last Name	Title	Organization
Ann	Flinders	FNP	Exodus Healthcare Network, PLLC
Ann	Forburger	Diabetes Consultant	NACDD
Marie	Frankos	QI Specialist	Molina Healthcare
Eliza	Gibson	Director, Medicaid & Safety Net	Omada Health
Julia	Glade	Health Educator	Salt Lake County Health Department
Sunny	Hayes	Community Health Educator II	Weber-Morgan Health Department
Aubrie	Haymore	Associate Wellness Coordinator	USANA
Dustin	Jones	Training and Worksite Coordinator	UDOH/EPICC Program
Dr. Liz	Joy	Medical Director	Intermountain Healthcare
Carol	LaDamus		Regence BlueCross BlueShield
Morgan	Long	Public Health Nurse	Tooele County Health Department
Andrea	Lowry		Santaquin Pharmacy and Diabetes Center
Katherine	Luke	Health Program Specialist	Bear River Health Department
Robin	Marcus	Chief Wellness Officer	University of Utah
Julie	Metos	Chair, Nutrition University of Utah	University of Utah
Chad	Myler	Wellness Coordinator	USANA Health Sciences
Maralie	Nordfelt		Utah County Health Department
Stephanie	Norton-Bredl	OST Director YMCA of Northern Utah	YMCA of Northern Utah
Mike	Payne	Chief Commercial Officer and Head, Medical Affairs	Omada Health
Brenda	Ralls	Epidemiologist	UDOH/EPICC Program
Carol	Rasmussen	APRN, CDE	Exodus Healthcare Network, PLLC
Teresa	Rivera	President and CEO	Utah Health Information Network (UHIN)
Heather	Sarin	Local Health Department Liaison	UDOH/EPICC Program
Monica	Scrobotovicci	Clinical Support Coordinator	AUCH
Sheldon	Smith	Director, University of Utah, Diabetes Prevention Program	University of Utah
Janet	Tennison	Program Manager	HealthInsight
Vickie	Tilley	Diabetes Educator, RN, BSN, CDE	Intermountain, Logan Regional Hospital
James	Webster		Santaquin Pharmacy & Diabetes Center
Rich	West	CEO	YMCA of Northern Utah
Melissa	Zito, MS, RN	Indian Health Liaison/Health Policy Consultant	UDOH Office of American Indian/Alaska Native Health Affairs

Appendix B

Logic Model



Pending Utah National Diabetes Prevention Program Organizations

Name	Street Address	City	County	Network Category
Bear River Health Department	655 East 1300 North	Logan	Cache	Local Health Department
Birch Family Pharmacy	493 North Main Street	Tooele	Tooele	Pharmacy
Maliheh Free Clinic	415 East 3900 South	Salt Lake City	Salt Lake	Healthcare Clinic
National Tongan American Society (NTAS)	3007 S West Temple, Unit H	West Valley City	Salt Lake	Community Based Organization
Olive Pharmacy	2290 South Redwood Road	West Valley City	Salt Lake	Pharmacy
Salt Lake Community College	4600 South Redwood Road	Salt Lake City	Salt Lake	University
Santaquin Pharmacy and Diabetes Center	869 South Turf Farm Road	Payson	Utah	Pharmacy
Southwest Utah Public Health Department	620 South 400 East	St. George	Washington	Local Health Department
Summit County Health Department	650 Round Valley Drive	Park City	Summit	Local Health Department
University of Utah Diabetes Prevention Program	520 Wakara Way	Salt Lake City	Salt Lake	Health System
Utah Navajo Health System	P.O. Box 130, East Hwy 262	Montezuma Creek	San Juan	Health System
YMCA of Northern Utah (Y-DPP)	575 Lockwood Drive	Ogden	Weber/Morgan	Community Family Center

Last updated: 8/19/2016

Diabetes Prevention Recognition Site: https://nccd.cdc.gov/DDT_DPRP/Registry.aspx?STATE=UT

AMA/CDC Prevent Diabetes STAT Toolkit



PREVENTING
TYPE 2
DIABETES

A guide to refer your patients with prediabetes
to an evidence-based diabetes prevention program



Prevent Diabetes **STAT** | Screen / Test / Act Today™



www.preventdiabetesstat.org

List of Resources

1. AMA/CDC Prevent Diabetes STAT Toolkit, www.preventdiabetesstat.org
2. American Medical Association DPP Cost Saving Calculator, www.ama-roi-calculator.appspot.com
3. CDC National Diabetes Prevention Program, www.cdc.gov/diabetes/prevention
4. EPICC Program, www.choosehealth.utah.gov
5. National Diabetes Awareness Campaign, www.doihaveprediabetes.org
6. National Diabetes Prevention: Economic Assessment Tool (Colorado), www.colorado.gov/pacific/cdphe/ndpp-economic-tool
7. Utah's Living Well website, www.LivingWell.utah.gov

DO YOU HAVE PREDIABETES?

Prediabetes Risk Test

1 How old are you?
 Less than 40 years (0 points)
 40—49 years (1 point)
 50—59 years (2 points)
 60 years or older (3 points)

2 Are you a man or a woman?
 Man (1 point) Woman (0 points)

3 If you are a woman, have you ever been diagnosed with gestational diabetes?
 Yes (1 point) No (0 points)

4 Do you have a mother, father, sister, or brother with diabetes?
 Yes (1 point) No (0 points)

5 Have you ever been diagnosed with high blood pressure?
 Yes (1 point) No (0 points)

6 Are you physically active?
 Yes (0 points) No (1 point)

7 What is your weight status?
 (see chart at right)

Write your score in the box.

↓

Add up your score.

↓

If you scored 5 or higher:
 You're likely to have prediabetes and are at high risk for type 2 diabetes. However, only your doctor can tell for sure if you do have type 2 diabetes or prediabetes (a condition that precedes type 2 diabetes in which blood glucose levels are higher than normal). Talk to your doctor to see if additional testing is needed.

Type 2 diabetes is more common in African Americans, Hispanic/Latinos, American Indians, Asian Americans and Pacific Islanders.

Higher body weights increase diabetes risk for everyone. Asian Americans are at increased diabetes risk at lower body weights than the rest of the general public (about 15 pounds lower).

For more information, visit us at
DoIHavePrediabetes.org

Height	Weight (lbs.)		
4' 10"	119-142	143-190	191+
4' 11"	124-147	148-197	198+
5' 0"	128-152	153-203	204+
5' 1"	132-157	158-210	211+
5' 2"	136-163	164-217	218+
5' 3"	141-168	169-224	225+
5' 4"	145-173	174-231	232+
5' 5"	150-179	180-239	240+
5' 6"	155-185	186-246	247+
5' 7"	159-190	191-254	255+
5' 8"	164-196	197-261	262+
5' 9"	169-202	203-269	270+
5' 10"	174-208	209-277	278+
5' 11"	179-214	215-285	286+
6' 0"	184-220	221-293	294+
6' 1"	189-226	227-301	302+
6' 2"	194-232	233-310	311+
6' 3"	200-239	240-318	319+
6' 4"	205-245	246-327	328+
	(1 Point)	(2 Points)	(3 Points)

You weigh less than the amount in the left column (0 points)

Adapted from Bang et al., Ann Intern Med 151:775-783, 2009. Original algorithm was validated without gestational diabetes as part of the model.

LOWER YOUR RISK

Here's the good news: it is possible with small steps to reverse prediabetes - and these measures can help you live a longer and healthier life.

If you are at high risk, the best thing to do is contact your doctor to see if additional testing is needed.

Visit DoIHavePrediabetes.org for more information on how to make small lifestyle changes to help lower your risk.

Ad Council

American Diabetes Association

AMA

CDC

For more information visit:
www.choosehealth.utah.gov

