# 1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health, CDC-RFA-DP13-1305

## Strategies and Performance Measures Related to Community Programs Linked to Clinical Services Link to Resources (View hyperlink below each strategy for online resources)

| 1305 Basic | |
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| **Strategy** | **Performance Measures** |
| **Strategy 6:** Promote awareness of prediabetes among people at high risk for type 2 diabetes<br><br>Diabetes Prevention Resources | [B.6.01] Prevalence (%) of people with self-reported prediabetes |
| **Strategy 7:** Promote participation in ADA-recognized, AADE-accredited, state-accredited/certified, and/or Stanford licensed diabetes self-management education (DSME) programs<br><br>Self-Management Resources and Bi-Directional Referral Systems | [B.7.01] Proportion of people with diabetes in targeted settings who have at least one encounter at an ADA recognized, AADE accredited, state accredited/certified, and/or Stanford licensed DSME program |

| 1305 Enhanced | | | |
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| **Strategy** | **Performance Measures** | | |
| | **Short-term** | **Intermediate** | **Long-term** |
| **Strategy 1:** Increase use of diabetes self-management programs in community settings | [4.1.01] Number of ADA recognized, AADE accredited, or state accredited/certified DSME programs during the funding year<br><br>[4.1.02] Number of Stanford DSMP workshops offered during the funding | [4.1.06] Proportion of people with diabetes in targeted settings who have at least one encounter at an ADA recognized, AADE accredited, state accredited/certified, and/or Stanford licensed DSME program during the funding year | [4.1.07] Decreased proportion of people with diabetes with A1C >9<br><br>[4.1.08] Age-adjusted hospital discharge rate for diabetes as any-listed diagnosis per 1,000 |

| **1305 Enhanced** | | | |
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| **Strategy** | **Performance Measures** | | |
| | **Short-term** | **Intermediate** | **Long-term** |
| Strategy 1 continued<br><br>Self-Management Resources<br>and<br>Bi-Directional Referral Systems | year<br><br>[4.1.03] Proportion of counties with ADA recognized, AADE accredited, or state accredited/certified DSME programs<br><br>[4.1.04] Proportion of counties with Stanford DSMP workshops<br><br>[4.1.05] Number of Medicaid recipients with diabetes who have DSME as a covered Medicaid benefit | | persons with diabetes |
| **Strategy 2:**<br>Increase use of lifestyle intervention programs in community settings for the primary prevention of type 2 diabetes<br>**Intervention:**<br>*Increase referrals to, use of, and reimbursement for CDC recognized lifestyle change programs for the prevention of type 2 diabetes*<br><br>Diabetes Prevention Resources<br>and<br>Bi-Directional Referral Systems | [4.2.01] Proportion of health care systems with policies or practices to refer persons with prediabetes or at high risk for type 2 diabetes to a CDC-recognized lifestyle change program<br><br>[4.2.02] Proportion of participants in CDC-recognized lifestyle change programs who were referred by a health care provider<br><br>[4.2.03] Number of Medicaid recipients or state/local public employees with prediabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle change programs as a covered benefit | [4.2.04] Number of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program | [4.2.05] Percent of participants in CDC-recognized lifestyle change programs achieving 5-7% weight loss (as reported by the CDC Diabetes Prevention Recognition Program) |

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| **Strategy** | **Performance Measures** | | |
| | **Short-term** | **Intermediate** | **Long-term** |
| **Strategy 3:**<br>Increase use of health-care extenders in the community in support of self-management of high blood pressure and diabetes<br><br>***Interventions:***<br>▪ *Increase engagement of community health workers (CHWs) in the provision of self-management programs and on-going support for adults with diabetes*<br>▪ *Increase engagement of CHWs to promote linkages between health systems and community resources for adults with high blood pressure*<br>▪ *Increase engagement of community pharmacists in the provision of medication/self-management for adults with high blood pressure and adults with diabetes*<br>Health Care Extenders Resources<br>and<br>Health Systems Resource Guide | [4.3.01] Proportion of recognized/accredited DSME programs in targeted settings using CHWs in the delivery of education/services<br><br>[4.3.02] Proportion of health care systems that engage CHWs to link adult patients with high blood pressure to community resources that promote self-management<br><br>[4.3.03] Proportion of community pharmacists that promote medication-/self-management for adults with high blood pressure<br><br>[4.3.04] Proportion of community pharmacists that promote medication-/self-management for adults with diabetes | [4.3.05] Proportion of patients with high blood pressure in adherence to medication regimens<br><br>[4.3.06] Proportion of patients with diabetes in adherence to medication regimens<br><br>[4.3.07] Number of participants in recognized/accredited DSME programs* using CHWs in the delivery of education/services<br><br>[4.3.08] Proportion of patients with high blood pressure that have a self-management plan (including medication adherence, self-monitoring of blood pressure levels, increased consumption of nutritious food and beverages, increased physical activity, maintaining medical appointments) | [4.3.09] Decreased proportion of people with diabetes with A1C >9<br><br>[4.3.10] Proportion of adults with known high blood pressure who have achieved high blood pressure control |

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| **Strategy** | **Performance Measures** | | |
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| **Strategy 4:**<br>Increase use of chronic disease self-management programs in community settings<br><br>***Intervention:***<br>▪ *Increase access to and use of Chronic Disease Self-Management (CDSM) programs (Note: States selecting this strategy must already be engaged in this work at a state level and/or be currently funded for by the CDC Arthritis Program to support work in CDSMP.)*<br><br>Self-Management Resources | [4.4.01] Number of CDSM workshops offered during the funding year<br><br>[4.4.02] Proportion of counties with CDSM workshops | [4.4.03] Number of CDSM program participants who self-report having diabetes and complete at least 4 out of 6 workshop sessions, as a proportion of the total number of people with diabetes in the state | [4.4.04] Age-adjusted hospital discharge rate for diabetes as any-listed diagnosis per 1,000 persons with diabetes |

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| **Strategy** | **Performance Measures** | | |
| | **Short-term** | **Intermediate** | **Long-term** |
| **Strategy 5:**<br>Implement policies, processes, and protocols in schools to meet the management and care needs of students with chronic conditions<br><br>***Intervention:***<br>▪ *Identifying and tracking students with chronic conditions that may require daily or emergency management, e.g. asthma and food allergies*<br><br>School Health Resources | [4.5.01] Number of local education agencies that receive professional development and technical assistance on meeting the daily management and emergency care needs of students with chronic conditions<br><br>[4.5.02] Percent of schools that identify and track students with chronic conditions that may require daily or emergency management, e.g. asthma and food allergies<br><br>[4.5.03] Number of local education agencies that receive professional development and technical assistance on meeting the daily management and emergency care needs of students with chronic conditions<br><br>[4.5.04] Number of students identified with chronic conditions in local education agencies with staff that received professional development and technical assistance on meeting the daily management and emergency care needs of students with chronic conditions<br><br>[4.5.05] Percent of schools that have protocols that ensure students identified with a chronic condition that may require daily or emergency management are enrolled into private, | [4.5.09] Reduced absences for students identified with chronic conditions (in the local education agencies targeted by FOA funding) | [4.5.10] Percentage of students identified with chronic conditions who have a medical home (i.e., a medical home with skilled and knowledgeable health care professionals who, acting as a team, continuously monitor the child's health status over time and manage the medications (not merely episodic management of attacks) (in the local education agencies targeted by FOA funding) |

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| **Strategy** | **Performance Measures** | | |
| | **Short-term** | **Intermediate** | **Long-term** |
| Strategy 5 continued | state, or federally funded insurance programs if eligible<br><br>[4.5.06] Number of local education agencies that receive professional development and technical assistance on assessment, counseling, and referrals to community-based medical care providers for students on activity, diet, and weight-related chronic conditions<br><br>[4.5.07] Number of students identified with chronic conditions in local education agencies with staff that received professional development and technical assistance on assessment, counseling, and referrals to community-based medical care providers for students on activity, diet, and weight-related chronic conditions<br><br>[4.5.08] Percent of schools that provide students with referral to community-based medical care providers for students identified with chronic conditions or at risk for activity, diet, and weight-related chronic conditions | | |