Healthy Together

Transform Diabetes Prevention and Care

A step-by-step guide to implement the Centers for Disease Control and Prevention's National Diabetes Prevention Program curriculum using patient self-care tools in a virtual setting and applying a whole-person focus.

NATIONAL ASSOCIATION OF Community Health Centers®

Healthy Together

Congratulations your health center is one of only a handful of health centers to receive education, training, and support as part of NACHC's ***Healthy Together*** program to implement the Center for Disease Control and Prevention's (CDC) lifestyle curriculum for individuals at risk for diabetes as well as those with type 2 diabetes!

Healthy Together brings national and state/regional partners together with health centers to offer an innovative and robust lifestyle change program for health center patients. The program combines a number of effective diabetes prevention and control strategies together into one robust program:

- CDC's National Diabetes Prevention Program (National DPP) lifestyle change curriculum
- Enhancements to CDC's lifestyle change curriculum to focus on social support and health equity
- National expertise in diabetes prevention and control education and training
- State/regional coaching and support by health center membership organizations
- Lifestyle Coach training for health center staff by a CDC-recognized entity
- Patient self-care tools to improve health and prevent or manage diabetes
- Participation of individuals with diabetes as well as patients at-risk for type 2 diabetes

This brief Guide provides instructions and details for a successful program launch! It provides critical start-up information and implementation guidance and offers an overview of our journey together during the next twelve months. This Guide should be used with companion materials, including instructions for the Patient Care Kit tools, patient education and training materials, and the online platform that will record and track patient progress.

Quality Center

The Quality Center team looks forward to supporting you in this exciting journey. If you have any questions, do not hesitate to email us individually or at qualitycenter@nachc.org.

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TRANSFORM DIABETES PREVENTION AND CARE
Action Guide

WHAT
is Healthy Together?

Healthy Together is a lifestyle change program that enables health centers to increase the impact of diabetes prevention and control efforts. The whole-person approach of *Healthy Together* encourages the support and engagement of patients' family and significant others and attention to cultural needs and language preferences. The program offers participating patients one year of virtual group sessions supplemented with in-person connection. The enhanced CDC National DPP curriculum is delivered by a national diabetes expert with local support and application by trained health center Lifestyle Coaches. *Healthy Together* also provides participants with self-care tools that support valuable lifestyle changes and build self-management skills. These self-care tools, called "Patient Care Kits", used in combination with a virtual diabetes prevention and support program, offer a groundbreaking strategy to advance a health center's diabetes care model.

HOW
to Transform Diabetes Prevention and Control?

The National Association of Community Health Centers, Inc. (NACHC) designed the *Healthy Together* program as part of a systems and whole-person approach to diabetes prevention and control. NACHC uses a conceptual model called the Value Transformation Framework to guide this work. This model uses evidence-based approaches to guide health center improvement toward the Quintuple Aim goals of: improved health outcomes, improved patient experience, improved staff experience, reduced costs, and improved equity.

WHY
take a Whole-Person Approach to Diabetes Prevention and Control?

Studies show that the CDC's National DPP curriculum, delivered in-person or virtually, can help patients lose weight, improve healthy behaviors, and cut their risk of developing diabetes. These results can help prevent type 2 diabetes among at-risk individuals while also helping control diabetes in individuals with type 2 diabetes. Additionally, if delivered virtually, patients who may not otherwise have access to a local diabetes prevention program can participate. Providing participants with a set of self-care tools to assist with building self-management skills for healthy living and diabetes control and prevention can amplify the impacts of the DPP curriculum. Furthermore, education and training that includes attention to health equity and social support can help participants achieve and sustain important outcomes.

WHAT
is a Patient Care Kit?

A 'Patient Care Kit' is a toolbox of patient self-care tools with instructions and educational materials. Used as part of diabetes care in a virtual environment, these Kits can be an effective strategy to advance diabetes prevention and control efforts.

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This Guide provides instructions for health center staff to successfully launch the *Healthy Together* program. It is organized into four parts to support a step-by-step approach to health center implementation of a virtual diabetes lifestyle change program, with in-person support at critical junctures of the project.

LAY THE GROUNDWORK

STEP 1 Register for Online Access to the *Healthy Together* Platform.

NACHC's Quality Center launched a private online community for health centers participating in this program. There you will find information and tools to support your health center's success – including this Guide! It will also be the place to communicate with NACHC and other pilot health centers about receipt of supplies, identifying the target cohort, enrolling patients…and other steps along your journey. The project's partner Primary Care Associations (PCA) and Health Center Controlled Networks (HCCN), referred to as 'Hubs' in this program, also access and use this platform and its portfolio of tools. This community is located within NACHC's Value Transformation Framework (VTF) platform.

Action Step: Register for access to the *Healthy Together* private community on NACHC's Value Transformation Framework platform.

STEP 2 Communicate Healthy Together to Health Center Staff.

Successful initiatives start with communication! Inform health center staff about the organization's planned efforts and explain the role and impact it will have on staff and patients. Emphasize the groundbreaking nature of this work and how exciting it is for your health center to bring this innovative program to your patients. Be sure to name the individuals selected to serve as Lifestyle Coaches leading the program and recognize that other staff (members of the care team, IT, and others) will be needed to support project activities. Communicate the timeframe of the program – beginning with the preparation that took place in the fall, current activities to identify eligible patients, planned *Start Up Visits* in March, and launch of the group lifestyle change sessions in April.

Appendix A provides a sample email template that can be used by leadership to communicate the initiative to health center staff. In addition to communicating the initiative to staff, it can be helpful to share your health center's innovative new approach with the community via a press release. A sample press release template can be found in Appendix B.

Action Step: Health center CEO/CMO/leadership and project leads communicate with staff, patients, and the community about the new *Healthy Together* program.

STEP 3 Register for Elevate 2022; Complete Baseline Assessment.

In addition to registering for the *Healthy Together* private community, your health center is encouraged to register for NACHC's Elevate learning community to gain access to the Quality Center's full portfolio of tools and resources supporting health center systems change – above and beyond the tools and resources available in the *Healthy Together* community. Registration is free and open to all health centers nationally. Once registered for Elevate, it is beneficial to complete the brief 15-question Value Transformation Framework (VTF) Assessment tool to gain insight into areas of systems improvement your health center may choose to focus on during *Healthy Together* implementation. Additionally, completion of the VTF Assessment provides access to professional development opportunities, including scholarships to the Institute for Healthcare Improvement (IHI) online courses, and more. The value of the VTF Assessment tool is maximized when multiple staff across the organization complete the assessment, with results shared and discussed so teams can gain insight from multiple vantage points. The Assessment can be completed at the start and close of *Healthy Together* to evaluate changes that may result from this new way to deliver care. Get started with your assessment by clicking this link.

Action Step: To access the full portfolio of transformation resources offered by NACHC's Quality Center, register for Elevate 2022 and the VTF platform. Complete the Value Transformation Framework (VTF) Assessment to identify areas of systems change your health center may choose to focus on during the *Healthy Together* program year.

STEP 4 Designate a Place and Process to Receive, Store, and Assemble Patient Care Kits.

One person from the health center should be identified to receive, store, and assemble Kit materials. If the designated point person is not available to receive Kit shipments, they should notify other staff in the health center of expected shipments and provide instructions on how and where supplies should be stored.

Tools will arrive in separate shipments over the course of the program year, beginning at the end of February 2022. Accountability for the receipt and proper, safe storage of the tools is essential! Once tools have been received, it is recommended that staff install batteries, where needed, and test the devices. This will help streamline the distribution process to patients and will alert you to any malfunctioning tools that require immediate follow-up with the manufacturer or vendor.

Once the program gets underway, if a patient decides to no longer participate or if they miss more than 3 sessions, they are expected to return the tools to the health center. Health centers need to designate space to store and sanitize tools collected from patients no longer participating in the project, in addition to creating a place to store and manage incoming new tools.

The Patient Care Kits provided through this program offer a unique opportunity to place self-care tools into the hands of patients. With proper support and training, these Kits have the potential to improve care and health outcomes. Because the Kit will offer a variety of tools over time, this allows you to address multiple areas of health simultaneously in your target cohort. Each Kit should also include patient instructions and educational materials.
The tools are to be distributed to program participants throughout the course of the program year rather than all at once. This method encourages and motivates participants

to remain engaged. The proposed distribution schedule for the tools is outlined below, although the NACHC team is open to feedback from health center Lifestyle Coaches on any recommended changes as the year progresses. Health center Lifestyle Coaches should follow the below distribution schedule unless otherwise instruction by the NACHC team.

Patient Care Kit tool distribution schedule:

- *Start Up Visit:* Scale, measuring tape
  For patients with diabetes, blood sugar testing supplies
- Week of April 11: MyPlate, food journal, pill organizer
- Week of June 13 Thermometer
- Month of August: Pulse oximeter
- Month of October: Blood pressure monitor
- Month of December: TBD based on Lifestyle Coach input
- Month of March, 2023: Close Out Visit: TBD item to celebrate patient's success!

Action Step: Identify a staff lead to oversee the receipt, storage, and assembly of Patient Care Kit tools and supplies. Establish a process to handle returned tools. Once initial Kit shipment has been received and assembled, log completion in the *Healthy Together* platform. Upload a picture of your *Start Up Visit* Kit to share with the program.

STEP 5 Identify Prospective Patients Using Risk Stratification and Provider Champions.

Complete risk stratification to identify patients for participation in the *Healthy Together* program. While the health center staff that receive training as a Lifestyle Coaches are leads for this project, it will be necessary to work with other members of the health center team (e.g., data analysts, IT, etc.) for support at various points, including this step.

Refer to Appendix C, "Checklist for Running and Analyzing Patient Lists to Identify Eligible Patients". First, based on clinical diagnosis criteria, identify patients diagnosed with type 2 diabetes and patients at risk for type 2 diabetes who meet program eligibility. Sort your patient lists by primary care provider name and identify 2-3 providers who are interested in supporting their qualifying patients' participation in *Healthy Together*. We will refer to these providers as 'champions'. Provider champions should be enthusiastic about the project and have a sufficient number of assigned patients eligible to participate. Provider champions will help to recruit and engage participants, stay informed of patient progress throughout the program (along with patient care team/s), and follow up as needed.

Once provider champions have been identified, review the list of eligible patients, and stratify according to the steps in the Checklist to create a list of 40-50 patients for first invites. Starting with a list of eligible patients that is two-three times the number of target patients allows you to arrive at a desired number of participants after accounting for those who are not interested, available, or not an appropriate match.

It is important to consider whether potential participants can access/use audio and visual telehealth technology. Analyze your lists to identify where multiple members of the same family or household are eligible and can be invited to participate together.

Action Step: Use risk stratification and provider champions to identify prospective program participants.

STEP 6 Document *Healthy Together* Workflows.

Documenting a workflow is a great way to consider all the steps in a process and determine 'who' will be responsible for completing each step, 'how' each step will be completed, and 'where' the step will be completed or documented. Document your workflows using a diagram or flow chart format so that other health center and project partners can readily visualize the steps. Health center staff who have any role in the project should be involved in putting together, or reviewing, workflows. See Appendix D for a Workflow Template designed for *Healthy Together*. Work with your project team to fill in the template with details unique to your health center.

Action Step: Document your health center's *Healthy Together* workflows; modify sample project template, as needed. Upload to *Healthy Together* portal.

STEP 7 Inform and Train Health Center Staff on *Healthy Together* Workflows and Patient Care Kit Tools.

Health center staff who work with patients engaged in *Healthy Together* should be provided education and training on the workflow and Patient Care Kit tools. Your project leads can set up a virtual or in-person training for all staff involved. Proper knowledge of the program will be essential to providing patients with the appropriate support.

Consider creating a training video or recording that staff can view at their convenience. These permanent resources also help ensure sustainability in the event of staff turnover. Ensure staff have the information, knowledge, and skills to properly use all Patient Care Kit tools and tests and can educate and train patients in proper use.

Document how staff will be trained in the *Healthy Together* workflow and Kit tools. Key areas to address include processes and timelines for:

- Staff training (e.g., via recorded training, in-person, staff meeting).
- Process for updating work processes, policies, or protocols, if needed.
- Updates to the EHR to capture patient data (e.g., self-reported measurements, curriculum sessions).
- Updates to staff roles and responsibilities.
- How clinical issues or adverse events will be managed.
- Ways for staff to provide feedback and improvement to program implementation.

Action Step: Educate and train staff on *Healthy Together* workflows and Patient Care Kit tools and use. Ensure staff have the information, knowledge, and skills to properly support participating patients in proper use of tools.

Educate and train staff on Healthy Together workflows and Patient Care Kit contents and use.

STEP 8 Set Goals and Define Success for Your Health Center.

While NACHC's *Healthy Together* team has set overall program goals (below), it is important for your health center to define success locally. In addition to individual patient goals the Lifestyle Coach will develop together with each patient, take time to define a small set of organizational goals.

NACHC's *Healthy Together* goals include:

- Design and launch a national program to implement virtual delivery of CDC's National DPP curriculum within a cohort of health centers, in partnership with PCAs/HCCNs, using a whole-person focus, patient self-care tools, and attention to social factors and equity.
- Develop models and workflows for virtual delivery of the CDC National DPP curriculum complemented by patient self-care tools.
- Leverage the experience of a small cohort of health centers engaged in *Healthy Together* to identify best practices, lessons, and recommendations for future program design that will benefit health centers nationally.

Define the goals your health center would like to accomplish through the *Healthy Together* program. Review results of your VTF Assessment to help set goals. Establish goals that align with your focus areas and the Quintuple Aim: improved health outcomes, improved patient experience, improved staff experience, reduced costs, and improved equity.

To help focus your efforts and set effective and achievable goals, use the S.M.A.R.T. Goals methodology. The goals you set should be: **S**pecific, **M**easurable, **A**ttainable, **R**elevant, and **T**ime-bound. Program goals could, for example, focus on patient outcomes, staff outcomes, or processes. Consider what measurements must be gathered to achieve your stated goals. See Appendix E for the list of data elements that will be collected and measured for *Healthy Together*.

Sample *Healthy Together* S.M.A.R.T. Goals:

- Patient-focused:
  - Health centers will enroll 12-15 eligible patients by X date.
  - Health centers will retain at least 60% of enrolled patients in the program throughout the core curriculum sessions.
  - Participants will experience at least 5% weight loss 12 months after the cohort began.
  - Participants will log at least 150 minutes/week on average of physical activity 12 months after the cohort began.
  - Participants will reduce their A1c by an average of at least 0.2%.
- Staff-focused:
  - Health center staff identified to be trained as Lifestyle Coaches will attend 5 out of 5 of the Lifestyle Coach training sessions.
  - Improve staff experience by 25% from baseline to end of project.
- Process-focused:
  - A timeline will be developed to implement the initiative and evaluate achievements.
  - A functional workflow will be created that defines each staff member's role relative to *Healthy Together*, prior to launching the curriculum.
  - A workflow scalable to additional providers and locations by X date will be developed.

Action Step: Define S.M.A.R.T goals your health center aims to achieve through participation in the *Healthy Together* program.

STEP 9 Participate in Project Calls.

Beginning in the fall of 2021, NACHC's project team established a series of project calls designed to support your health center during the program's *'Lay the Foundation'* and *'Launch'* steps. Monthly *Healthy Together* project calls will continue for the duration of program year. These calls will take place on the 3rd Wednesday of every month from 1:00-2:00 pm ET. Project calls offer participating health centers and Lifestyle Coaches national partner support, connection with peers, and information sharing and/or training. Participation in these monthly calls helps ensure your health center's success.

Action Step: Participate in *Healthy Together* project calls the 3rd Wednesday of each month from 1-2 pm ET. Email clindholm@nachc.org if you need the call-in logistics. Recordings of these sessions are available on the *Healthy Together* online platform.

STEP 10 Train Health Center Lead(s) for Project Role (E.g., Lifestyle Coach, Wellocity Platform).

Health center staff selected to serve as Lifestyle Coaches will be trained by the Association for Diabetes Care and Education Specialists (ADCES), nationally recognized experts in diabetes prevention and control. Lifestyle Coach training will take place in a series of five, 90-minutes sessions, conducted once/week over a 5-week period. Attendance at all sessions is required for a health center staff person to receive a certificate from ADCES to serve in the role of a Lifestyle Coach.

The *Healthy Together* program collects CDC required data using an online platform that follows CDC's National DPP specifications. This platform, Wellocity, will be used throughout the program by participating patients and Lifestyle Coaches. Lifestyle Coaches will access the platform via a coach portal and be able to track and monitor participant self-reported data and engagement throughout the program. Wellocity will provide training to Lifestyle Coaches in how to access and navigate the coach portal.

Training will also be provided to the Lifestyle Coaches on the patient app/portal, to demonstrate the way patients will connect to the platform. Training will include: how to assist patients with completing the registration process, logging into the app/portal, completing program questionnaires, and entering patient data. See Appendix F for the *Start Up Visit* Wellocity workflow.

Action Step: Train selected health center staff as Lifestyle Coaches; Train Lifestyle Coaches on Wellocity's CDC DPP platform.

STEP 11 Invite Patients to Participate in *Healthy Together*.

Using the list of eligible patients identified through risk stratification (Step 5), supplemented by care team information and insights, extend invitations to patients to participate in the program until you reach your target number of patients. For a single cohort, target 12-16 total participants in the program. To add a second cohort you must have at least 12 patients. Roughly half of the patients in each cohort should be patients diagnosed with type 2 diabetes, and the other half should be patients at risk for type 2 diabetes. Your health center can decide whether you will offer 1 or 2 cohorts, based on capacity to hold 1 or 2 separate group sessions. Patients can be invited using outreach methods determined by your team (e.g., provider visit, warm hand off, phone call).

While a variety of care team members can effectively deliver the invitation to patients, it is important to communicate to patients that their provider recommends that they participate. ***Please note, for patients diagnosed with diabetes, the patient's primary care provider is required to sign off on their participation.***

As part of the invitation process, provide patients with information about the benefits of Lifestyle Coaching, information on the self-care tools, who to contact for more information, and the kinds of follow-up and communication they can expect. The Patient Information Sheet, Appendix G, can be used to guide conversations with patients, and for patients to take home and review.

Patients who agree to participate will need to sign a Patient Participation Agreement, ensuring they understand the requirements of the program. See Patient Participation Agreement in Appendix H. The signed Patient Participation Agreement should be scanned and saved in the patient's medical record.

Managing patient expectations from the beginning and providing appropriate follow-up throughout the course of the program, will increase the likelihood of patient success in *Healthy Together*. It is also important to acknowledge the likelihood that some patients may drop out of the program while it is in progress. This could be for a number of reasons including sickness, hospitalization, or difficulty with technology. Develop plans to manage patient attrition.

Patients who agree to participate should be scheduled to come to the health center in-person for an individual *Start Up Visit* (Step 12). In cases where invited participants are family members/significant others, they may complete their *Start Up Visit* together.

Action Step: Contact patients identified through risk stratification, and informed by care team input, for participation in *Healthy Together*. To confirm patients' interest and ability to participate, explain program expectations and requirements to participate. Obtain signed Patient Participation Agreement.

STEP 12 Complete Individual Patient *'Start Up Visits'*.

Schedule each participating patient for an individual in-person *'Start Up Visit'*. In instances where participants are family members/significant others, their *Start Up Visit* can be completed together. The *Start Up Visit* includes:

- **Sign Patient Participation Agreement.** If not already completed, each patient MUST sign a Patient Participation Agreement to participate.
- **Assist patient with logging in to app/portal.** Guide patient with login to the Wellocity app/portal and orient patient to the tool.
- **Complete pre-program questionnaires.** Support patient with navigation and completion of the pre-program questionnaire within Wellocity. Wherever possible, capture relevant data within the EHR.
- **Distribute Patient Care Kit & instruct patient in use of the tools.** Distribute Kit tools that have been designated for distribution during the *Start Up Visit* and train participants on proper use of each item. Have patients demonstrate correct use of each tool back to you and provide patients with take-home instructions. See Appendix I for Sample Patient Instructions: Patient Care Kit Tools. The tools for distribution at the *Start Up Visit* include:
  - Scale
  - Measuring Tape
  - *Healthy Together* Wellness Tracker
  - Glucometer Kits (only for patients diagnosed with diabetes)
  - Glucose Test Strips (only for patients diagnosed with diabetes)
- **Complete baseline measurements.** Ensure ALL patients participating in *Healthy Together* have a baseline A1c test (tests completed within the 3 months prior to the start of April group lifestyle sessions are acceptable). Record the participants height and weight. Assist patients in completing the pre-program questionnaire on the Wellocity DPP platform. Data collected as part of the *Start Up Visit* is essential for evaluating the overall impact of this enhanced DPP curriculum. It is imperative for CDC requirements that Lifestyle Coaches ensure patient data is entered in the Wellocity platform. Health centers are also encouraged to ensure the data is captured as part of EHR documentation processes.

See *Start Up Visit* Wellocity Workflow (Appendix F). The Patient Checklist tool (Appendix K) can be used to track steps that have been completed for individual patients.

Action Step: Complete an individual *'Start Up Visit'* for each *Healthy Together* participating patient.

STEP 13 Schedule Group Lifestyle Change Curriculum Sessions.

Confirm the day(s) and time(s) for your *Healthy Together* group lifestyle curriculum sessions. Confirm that all patients who have signed a Patient Participation Agreement are aware of the day/time of the session in which they will participate and have information to connect to the first session. Schedule these sessions in the patient's EHR so all health center staff and care team members have access to the information.

Action Step: Schedule group lifestyle change curriculum sessions. Communicate information and logistics for these group sessions to all participating patients.

STEP 14 Conduct Group Curriculum Sessions.

This exciting phase of the program is when group sessions of CDC's NDPP curriculum begin! *Healthy Together* follows the CDC NDPP requirement that the program run for one year.

The program is designed as a virtual lifestyle curriculum, enhanced with in-person support at critical junctures throughout the year. CDC divides the year-long curriculum into two phases: Core Phase and Core Maintenance Phase.

Below is a high-level overview of the content that will be covered during the two phases of program curriculum:

NDPP Group Session Topics		
Core (16 Sessions)		**Core Maintenance (10 sessions)**
Skill Building, Self-monitoring, and Physician Activity	Physiological Aspects of Lifestyle Change	Maintaining Lifestyle Change
Introduction	Manage Stress	When Weight Loss Stalls
Get Active to Prevent T2	Find Time for Fitness	Take a Fitness Break
Track Your Activity	Cope with Triggers	Stay Active to Prevent T2
Eat Well to Prevent T2	Keep Your Heart Healthy	Stay Active Away From Home
Track Your Food	Take Charge of Your Thoughts	More About T2
Get More Active	Get Support	More About Carbs
Burn More Calories Than You Take In	Eat Well Away From Home	Have Healthy Food You Enjoy
Shop and Cook to Prevent T2	Stay Motivated to Prevent T2	Get Enough Sleep
		Get Back on Track
		Prevent T2- For Life!

Instructions for setting your *Healthy Together* program schedule are found in Appendix L.

While NACHC's *Healthy Together* program is designed as a virtual lifestyle program, several in-person group touchpoints are part of the design. Patients should be scheduled to receive Patient Care Kit tools in person, including education and training in use of the tools. These in-person group sessions are a supplement to virtual group sessions held throughout the year. If COVID conditions prevent a full cohort from meeting in-person together at these minimum touchpoints (e.g., gathering a group of approximately 12 patients together at one time), the Lifestyle Coach could consider staggering patient arrivals/departures for this in-person session or breaking up into smaller groups.

For each lifestyle change session, there will be approximately 30-minutes of pre-recorded training by a national diabetes prevention program expert at ADCES. These recordings will be available for both the health center Lifestyle Coach and patient to view at, or in advance of, the health center group session. Then, during health center group session(s), the Lifestyle Coach and participating patients discuss and apply this content. Each Lifestyle Coach session will build on the content delivered by the ADCES expert with attention to the local needs (e.g., cultural and social support) of participating health center patients. The health center lifestyle coaches will facilitate discussion in whichever language best serves the health center cohort.

Action Step: Deliver curriculum sessions enhanced with recordings from a National DPP content expert.

ASSESS AND EVALUATE

STEP 15

Collect, Monitor, Evaluate and Report: Patient and Health Center Progress Toward Goals.

Establish an ongoing process for Lifestyle Coaches to review patient data, engagement in group sessions, and progress in meeting lifestyle change goals. Lifestyle Coaches should also monitor health center progress toward program goals (Step 8). Document and update program workflows as changes arise.

At the conclusion of the program year, Lifestyle Coaches will assist patients in completing the post-program questionnaire on the Wellocity platform. The health center is encouraged to repeat NACHC's VTF Assessment tool to measure any systems changes since the start of the program.

Action Step: Establish processes to collect and review data, assess progress toward goals, and share lessons learned. Share documentation, feedback, and workflows with your program Hub and national partners to inform future *Healthy Together* planning and spread to other health centers.

APPENDIX A: *HEALTHY TOGETHER* LEADERSHIP EMAIL TEMPLATE

Sample leadership communication announcing implementation of Healthy Together.

Dear Colleagues,

I am pleased to announce that [Health center name] has been selected to be one of only several health centers across the nation chosen to pilot *Healthy Together*, a truly exciting lifestyle change program for patients with, or at-risk for, diabetes.

Healthy Together is offered through a unique partnership between The National Association of Community Health Centers (NACHC), the Association of Diabetes Care & Education Specialists (ADCES), Wellocity (a National Diabetes Prevention Program platform that follows CDC specifications), [applicable PCA/HCCN name], and participating health centers such as [health center name].

Healthy Together is designed to improve the impact of diabetes prevention and control efforts using the Centers for Disease Control and Prevention's (CDC) lifestyle curriculum, combined with patient self-care tools, and coaching by our trained health center lifestyle coaches. The lifestyle coaches will provide patients with education and support in healthy eating, physical activity, and stress management. Patients at-risk for diabetes and patients with diabetes will be invited to participate, together with supportive family or significant others.

[Health center name] is proud to announce the two staff individuals selected to serve as Lifestyle Coaches for this program!

- [Staff name], [Credential]-[Job Title]
- [Staff name], [Credential]-[Job Title]

Successful implementation of this program will be a team effort, so other staff (members of the care team, IT, and others) will also support project activities.

We are excited to launch this new initiative and welcome your input and suggestions in the process. In the meantime, please feel free to reach out to the team [contact info] if you have any questions.

Sincerely,

[Name]

LEADERSHIP EMAIL TEMPLATE

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APPENDIX B: PRESS RELEASE TEMPLATE

Sample press release that can be shared with local media to announce health center's use of Patient Care Kits as part of diabetes prevention and control.

Health Centers Reimagine Diabetes Care and Prevention with an Exciting Lifestyle Change Program

[Clinic Name] was chosen as one of a select group of health centers participating in a national pilot

A large population of high-risk patients who are more likely to suffer from a disproportionate array of chronic conditions are cared for by community health centers. Approximately 35.6% of all Community Health Center patients struggle with diabetes and many more are at risk for developing diabetes. The National Association of Community Health Centers (NACHC) developed a cutting-edge pilot project with several select health centers in a lifestyle change program called *Healthy Together*.

Healthy Together is designed to improve the impact of diabetes prevention and control efforts using the Centers for Disease Control and Prevention's (CDC) lifestyle curriculum, combined with patient self-care tools and supportive coaching by trained health center lifestyle coaches. The program is open to health center patients at-risk for diabetes as well as those with diabetes and will offer training, education, and support in healthy eating, physical activity, and stress management. Health center family members are encouraged to participate and offer support!

"[Health center name] is excited and extremely honored to be chosen for this timely initiative," says XX, [title] of [health center name]. "The care team support, self-care tools, and whole-person focus will provide patients with the support and information they need to make healthy changes in their lifestyle and will make a tremendous difference in their lives."

The pilot is funded by Health Resources and Services Administration. It officially began this week.

NACHC's Quality Center is excited to launch this initiative. *"This pandemic has shown us how community health center partners continue to step-up and transform our local healthcare systems and lead us into the future with new blended care delivery models that include at-home self-care integrated with virtual care. These steps have the potential to critically improve the way diabetes is managed and prevented."*

PRESS RELEASE TEMPLATE

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APPENDIX C: CHECKLIST FOR RUNNING AND ANALYZING PATIENT LISTS TO IDENTIFY ELIGIBLE PATIENTS

List A:
Patients with a diagnosis of Diabetes

- ☐ Patient identifying information:
  - ☐ First name
  - ☐ Last name
  - ☐ Date of birth
  - ☐ Medical record number
  - ☐ Address
  - ☐ Primary language
  - ☐ Primary care provider
  - ☐ Health center site name
- ☐ 18 years of age and older
- ☐ Diagnosis of type II diabetes
- ☐ Most recent A1c result
- ☐ One additional chronic condition diagnosis: obesity, hypertension, depression
- ☐ Exclude patients who are currently pregnant
- ☐ Date of upcoming medical appointment
- ☐ Date of last telehealth (audio and visual) appt
- ☐ Date of last no show

List B:
Patients at risk for Diabetes

- ☐ Patient identifying information:
  - ☐ First name
  - ☐ Last name
  - ☐ Date of birth
  - ☐ Medical record number
  - ☐ Address
  - ☐ Primary language
  - ☐ Primary care provider
  - ☐ Health center site name
- ☐ 18 years of age and older
- ☐ NOT diagnosed with type II diabetes
- ☐ Two or more of the following chronic condition diagnoses: obesity, HTN, depression
- ☐ **ONE OR MORE** of the following:
  - ☐ BMI >25 kg/m2 (or >23 kg/m2, if Asian American)
  - ☐ Fasting glucose 100-125 mg/dl
  - ☐ Plasma glucose 140-199 mg/dl 2 hrs after a 75 mg glucose load
  - ☐ A1c of 5.7-6.4
  - ☐ Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy (may be self-reported)
  - ☐ Positive screen for prediabetes based on CDC Prediabetes Risk Assessment (optional- include if data is available)
- ☐ Exclude patients who are currently pregnant
- ☐ Date of upcoming medical appointment
- ☐ Date of last telehealth (audio and visual) appt
- ☐ Date of last no show

GO BACK TO STEP 5

APPENDIX C

CHECKLIST FOR ANALYZING PATIENT LISTS TO IDENTIFY PATIENTS ELIGIBLE FOR HEALTHY TOGETHER

Identify Provider Champions

- ☐ Combine Lists A & B.
- ☐ Sort by health center site and primary care provider.
- ☐ Identify 2-3 provider champions. Consider the following:
  - Number of eligible patients.
  - Commitment to the project.
  - Providers within the same site or "pod".
  - Ensure the provider has agreed to participate before moving forward with the analysis.

Identify 40-50 Patients for First Invites

- ☐ Filter your combined list to only display patients of the selected provider champions.

Identify Multiple Family Members on One/Both Lists or Significant Others (e.g., same address)

- ☐ Sort by patient last name. Consider the following:
  - Are there any family members on this list? (Note, patients having the same last name does not necessarily mean the patients are related. If unsure, consult with other members of the care team who may know (e.g., provider, nurse, MA, CHW, care manager, etc.).
  - Mark patients to consider for first invites (e.g., add a spreadsheet column and place an X in the patient's row).
- ☐ Sort by address. Consider the following:
  - Are there any patients who have the same household address?
  - Mark patients to consider for first invites.

Identify Patient's Technological Capabilities

- ☐ Filter to display patients who have had at least one telehealth visit (audio and visual) since June 2020.
  - Mark patients to consider for first invites.

Other Consideration Criteria

- ☐ Filter to display patients who have not had any no shows since June 2020.
  - Mark patients to consider for first invites.
- ☐ For patients diagnosed with diabetes, sort by A1c value.
  - Mark patients with A1C > 9 to consider for first invites.
- ☐ Sort by upcoming appointment date.
  - Patients with an appointment coming up soon may be a good opportunity to invite to participate via a warm handoff process.
  - Mark patients to consider for first invites.

CHECKLIST FOR ANALYZING PATIENT LISTS TO IDENTIFY PATIENTS ELIGIBLE FOR HEALTHY TOGETHER continued

Consult with members of the care team (e.g., provider, nurse, MA, CHW, care manager, etc.)

☐ Review patients marked through the steps above:

- Are these patients likely to participate?
- Will these patients be able to meet the technological requirements?
- Are these patients able to understand enough spoken English to benefit from the national expert lifestyle coaching?

Finalize your list

☐ Increase or decrease the number of patients marked for first invites until you have between 40 and 50.

- Goal of 20-30 total participants (10-15 patients with diabetes and 10-15 patients at risk for diabetes).

APPENDIX D: HEALTH CENTER WORKFLOW TEMPLATE

Health Center Name: _____

Names of Staff Completing this Template _____

_____

Repeat as needed for each shipment received

Patient Care Kit tools received by _____(staff name).

_____ (staff name) takes a photo of the received tools, uploads the photo and confirms receipt of correct inventory on Docebo.

_____(staff name) tests tools and installs batteries if needed.

_____(staff name) secures supplies separate from regular inventory/supplies by _____ (e.g. labels tools as being for Healthy Together, etc.).

Equipment is stored at _____(location) until it is needed.

_____(staff name) runs reports of eligible patients using _____(EHR/PHM system) and completes risk stratification.

_____(staff name) identifies prospective provider champions.

_____(staff name) talks with prospective provider champions to confirm support for patient participation.

Using risk stratification criteria, _____(staff name) identifies patients for first invites- working off a patient list of 2-3 provider champions.

_____(staff name) invites patients by _____ (phone call, warm hand off, etc.).

May provide patient with Patient Info Sheet and Patient Agreement Form for patient signature at this time.

If Patient Agreement Form is signed, _____ (staff name) scans and saves it in _____ (location in patient's medical record).

_____ (staff name) documents in _____ (location- EHR, spreadsheet, etc.) whether the patient accepts or declines participation.

_____ (staff name) schedules the patient an appointment (phone call or in person) for Healthy Together Start-Up Visit..

This Start-Up Visit will be distinguished in the EHR by _____(visit type, reason for visit, etc.)

HEALTH CENTER WORKFLOW TEMPLATE

GO BACK TO STEP 6

APPENDIX D

APPENDIX E: *HEALTHY TOGETHER* DATA DICTIONARY

Data Element	Description
Organization Code	Assigned by CDC
Participant ID	Assigned by Wellocity
Cohort ID	Assigned by Wellocity
Coach ID	Assigned by Wellocity
Enrollment Motivation	1. Health care professional 2. Blood test results 3. Prediabetes risk test (short survey) 4. Someone at a community-based organization (church, community center, fitness center) 5. Family or friends 6. Current or past participant in the National DPP LCP 7. Employer or employer's wellness plan 8. Health insurance plan 9. Media advertisements (social media, flyer, brochure, radio ad, billboard, etc.)
Enrollment Source	1. Yes, a doctor/doctor's office 2. Yes, a pharmacist 3. Yes, other healthcare professional 4. No
Payer Source	1. Medicare 2. Medicaid 3. Private Insurer 4. Self-pay 5. Dual Eligible (Medicare and Medicaid) 6. Grant funding 7. Employer 8. Free of charge 9. Other
Participant State	Two-letter abbreviation for the U.S. state or territory in which the participant resides.
Participant's Prediabetes Determination	1. Prediabetes diagnosed by blood glucose test 2. Prediabetes determined by clinical diagnosis of GDM during previous pregnancy 3. Prediabetes determined by risk test
Participant's reported HbA1c value	2.5 to 18
Participant's Age	18 to 125
Participant's Ethnicity	1. Hispanic or Latino 2. NOT Hispanic or Latino 9. Not reported (default)
Participant's Race	1. American Indian or Alaska Native 2. Asian or Asian American 3. Black or African American 4. Native Hawaiian or Other Pacific Islander 5. White
Participant's Sex	1. Male 2. Female 9. Not reported
Participant's Gender	1. Male 2. Female 3. Transgender 9. Not reported
Participant's Height	30 to 98 (in inches)

DATA DICTONARY - PDF | DATA DICTONARY - EXCEL

GO BACK TO STEP 8

HEALTHY TOGETHER DATA DICTIONARY continued

Education	1. Less than grade 12 (No high school diploma or GED) 2. Grade 12 or GED (High school graduate) 3. Some college or technical school 4. College or technical school graduate or higher 9. Not reported (default)
Delivery Mode	1. In-person 2. Online 3. Distance learning
Session Type	C Core session CM Core maintenance session OM Ongoing maintenance sessions (for MDPP supplier organizations or other organizations that choose to offer ongoing maintenance sessions) MU-C Make-up sessions in the Core phase MU-CM Make-up sessions in the Core Maintenance phase MU-OM Make-up sessions in the Ongoing Maintenance phase
Session Date	mm/dd/yyyy
Participant's Weight	70 to 997 (in pounds) 999 If weight cannot be reported
Participant's Physical Activity Minutes	0 to (in minutes) of moderate or brisk physical activity competed during the proceeding week
Participant's Food Intake	Participant's Food Intake
Participant's Blood Pressure	Participant's Blood Pressure
Number of interactions with local Lifestyle Coach since last session	Number of interactions with local Lifestyle Coach since last session
Hospitalizations	Number of hospitalizations since last session
ED visits	Number of ED visits since last session
Primary language	Primary language
PHQ-2 Screening Results	1. During the past two weeks, have you been bothered by little interest or pleasure in doing things? Yes/No 2. During the past two weeks, have you been bothered by feeling down, depressed, or hopeless? Yes/No
SBIRT Screening Results	1. Men: How many times in the past year have you had 5 or more drinks in a day? Women: How many times in the past year have you had 4 or more drinks in a day? 2. How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?
PRAPARE Screening Results	1. What is the highest level of school that you have finished? 2. What is your current work situation? 3. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply. 4. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply. 5. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings) 6. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you? 7. Do you feel physically and emotionally safe where you currently live? 8. In the past year, have you been afraid of your partner or ex-partner?
Patient Experience Screening Results	1. In general, how would you rate your overall health? 2. Do you feel confident in your day-to-day ability to manage your blood sugar? 3. How likely are you to recommend [health center name] to your family and friends?
Staff Experience Screening Results	Staff Experience Screening Results
Lifestyle Coach Training Attendance	Lifestyle Coach Training Attendance

APPENDIX F: *START UP VISIT* WELLOCITY WORKFLOW

OVERVIEW

Participating patients come to the health center for their 'Start-Up Visit' where the following steps are completed:

1. **Sign the Patient Agreement**
2. **Sign Up for *Healthy Together* in Wellocity**
3. **Complete Wellocity Training**
4. **Receive & Learn How to Use Patient Care Kit Tools**
5. **Complete Baseline Measurements (Including A1c, Height, & Weight)**

Use the Patient Checklist as a guide to make sure all Start-Up Visit steps are completed.

CONTENTS

This 'Start-Up Visit' Guide to Wellocity Sign Up walks through the following steps on the pages listed below:

Patients should complete these steps with the assistance of the Lifestyle Coach as part of the *Healthy Together* 'Start Up Visit'.

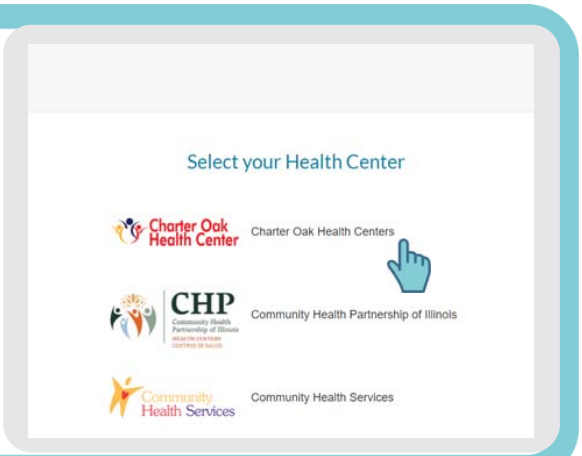
GO BACK TO STEP 10

START UP VISIT WELLOCITY WORKFLOW continued

STEP ONE

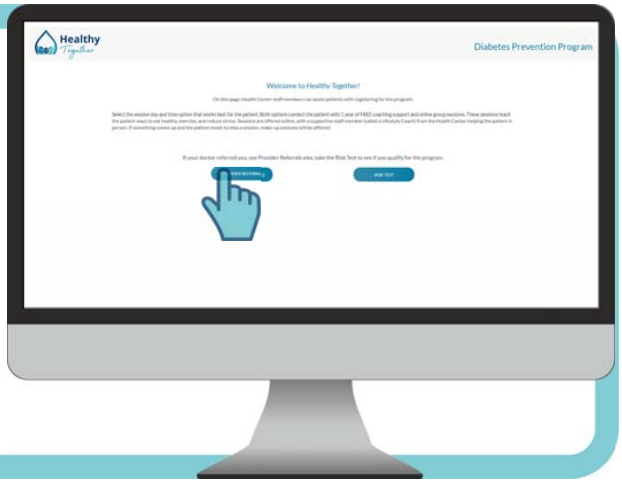
Visit the *Healthy Together* portal.

Scroll through the list to find and select your health center's name, and the session day/time you will join.



STEP TWO

Click on 'Provider Referrals'

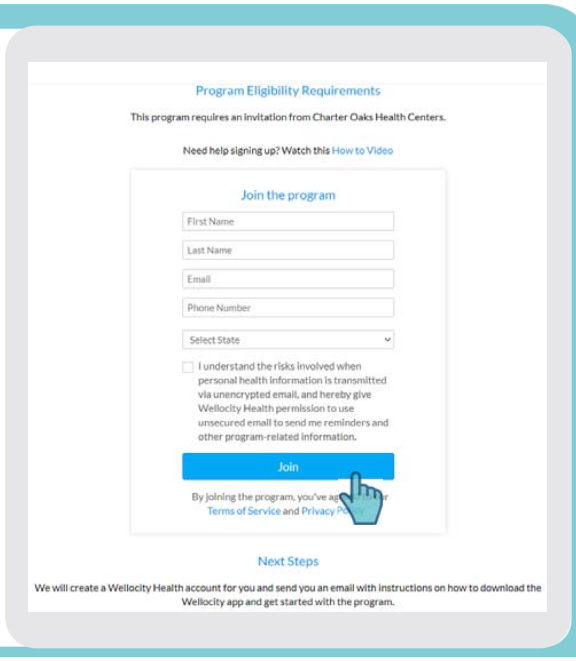


STEP THREE

Fill in your name, email address, phone number and select your state.

Check the box to give Wellocity permission to email you.

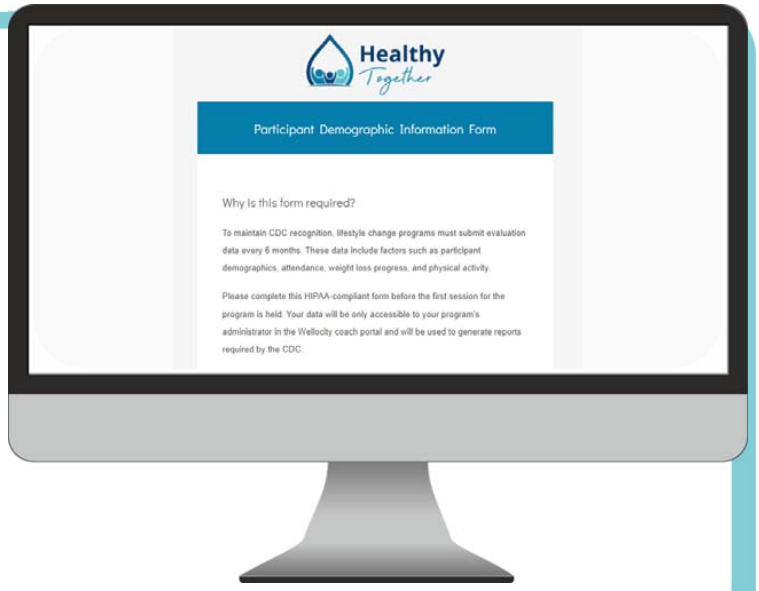
Click "Join".



START UP VISIT WELLOCITY WORKFLOW continued

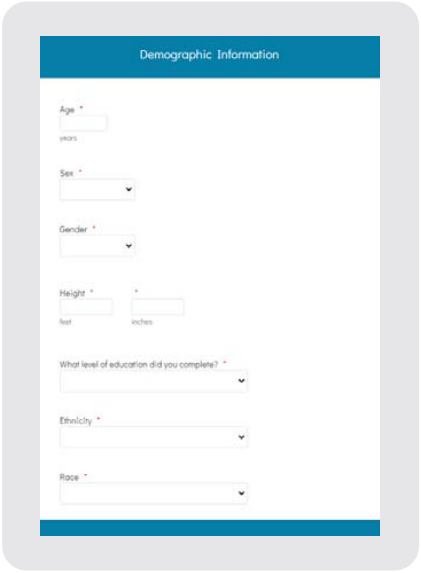
STEP FOUR

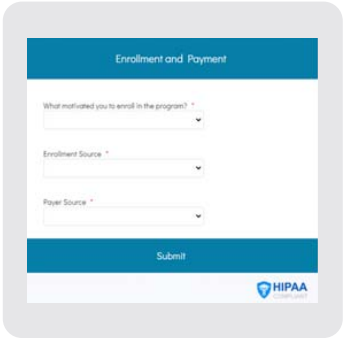
Fill in Participant Demographic Information Form.



a) Fill in your name, email, and select your state.

b) Fill in your age, sex, gender, height, level of education, ethnicity, and race.





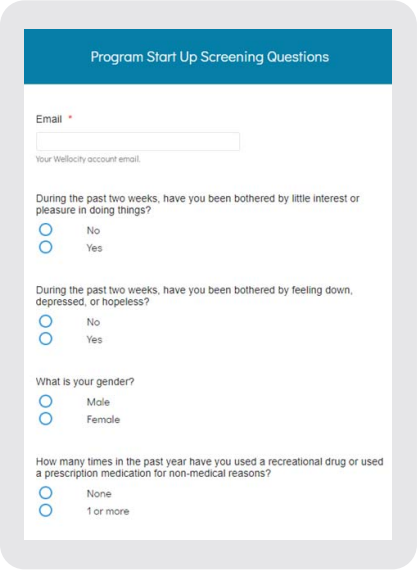
c) Select your motivation for joining the program, Enrollment Source, and Payer Source.

START UP VISIT WELLOCITY WORKFLOW continued

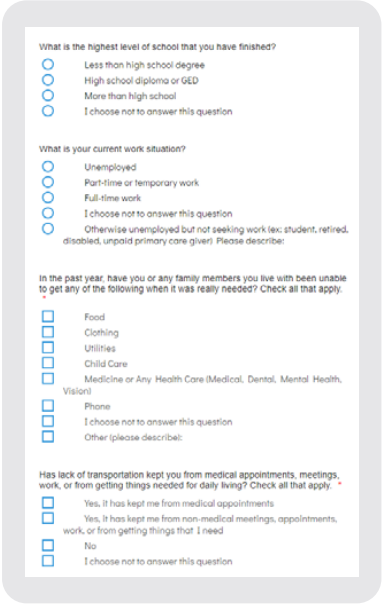
STEP FIVE

Complete the 'Program Start-Up Screening Questions'.

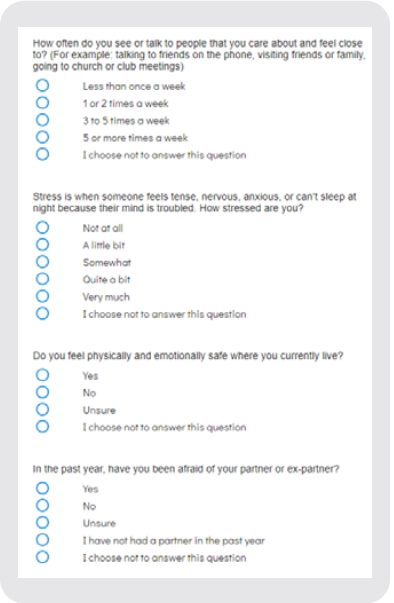
a) Answer the questions about your recent mood, your gender, and drug use.



b) Answer the questions about your education, work, income, and transportation.

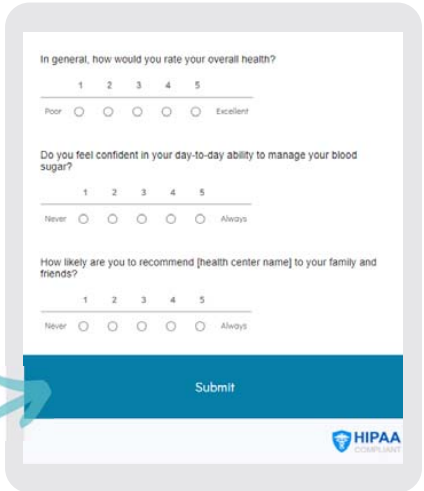


c) Answer the questions about your social life, stress level, and safety.



CLICK **'SUBMIT'**

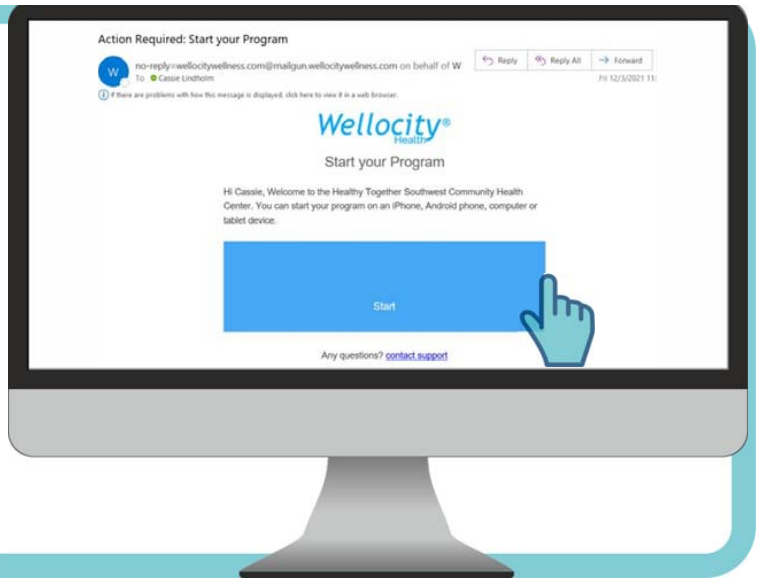
d) Rank your feelings about your overall health, ability to manage your blood sugar, and your opinion of the health center.



START UP VISIT WELLOCITY WORKFLOW continued

STEP SIX

Log into your email account, open the email from Wellocity, and click 'Start'.



STEP SEVEN

Create a password for Wellocity.

A great password should have:

- At least eight characters
- Letters, uppercase and lowercase
- Numbers
- At least one special character

Save your password.

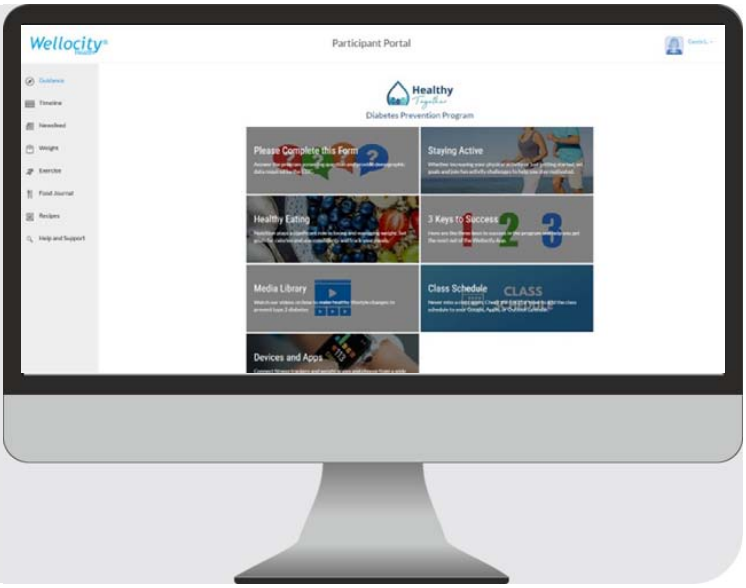
STEP EIGHT

Log into the Wellocity Portal using your email address and the password you created in **Step Seven**.

START UP VISIT WELLOCITY WORKFLOW continued

SUCCESS!

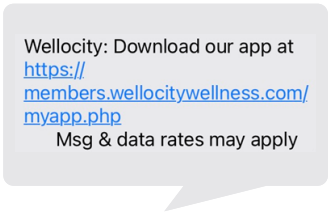
You have created an account and logged into the online portal!



STEP NINE

Go to the App Store and search for "Wellocity Health" or follow the link sent to you via text message.

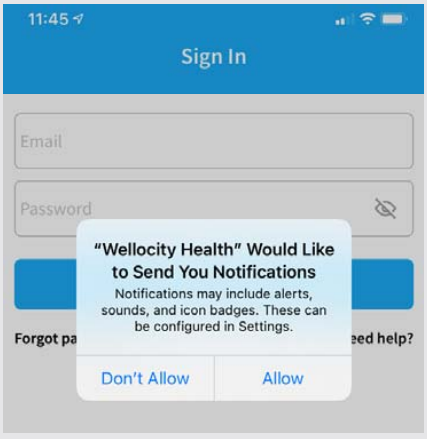
Download the App.



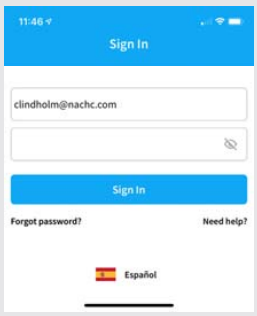
STEP TEN

Open the Wellocity app. Click 'Allow' to allow the app to send notifications.

Notifications will include important reminders for logging your data and attending sessions.



START UP VISIT WELLOCITY WORKFLOW continued



STEP ELEVEN

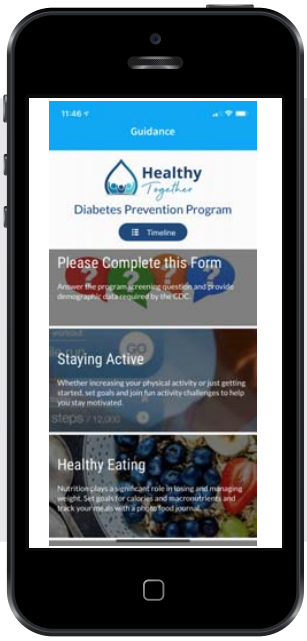
Log into the app.

Your username is your email address and the password is the one you created in **Step Seven**.

SUCCESS!

You have successfully downloaded and signed into the Wellocity mobile app!

Tip: Bookmark the portal for quicker access in the future!



If you have any questions about navigating and using the Wellocity app, please contact your Lifestyle Coach.

WELLOCITY WORKFLOW

APPENDIX G: PATIENT INFORMATION SHEET

You are Invited to join *Healthy Together*!

Dear _____ (patient name),

_____ (PCP name) is inviting you to join a new **FREE** program called ***Healthy Together*** offered by _____ (health center name). The program is to help you eat healthy, exercise, and deal with stress to help you lower blood sugar and live healthier! If you have a family member or support person who also has high blood sugar – you can participate together!

How does the program work?

By joining ***Healthy Together***, you get access to:

1. 1 year of FREE 'Lifestyle Coaching' and group sessions. A Lifestyle Coach from your health center together with an online Lifestyle Coach from the Association of Diabetes Care and Education Specialists will teach you ways to eat healthy, exercise, and reduce stress. These sessions are group sessions and will include other patients from your health center who also are looking for ways to eat healthier, exercise more, and reduce stress. Sessions will be virtual (phone or video), with in-person check-ins at key points during the year. The sessions will follow this schedule:

    - April 1 – July 31, 2022: weekly group call (60-75 mins); no session 4th of July week
        - In-person connection at weeks 2 & 10 to receive additional tools
    - August 1– March 31, 2023: monthly group call (60-75 mins)
        - In-person connections in August, October, December, and March to receive additional tools.

2. **FREE** tools to help you eat healthy, exercise, and reduce stress. Tools* are provided at various points during the program year:

    - Start Up Visit: Scale, measuring tape, Healthy Together wellness tracker
      For patients with diabetes: blood sugar testing supplies
    - Week 2: MyPlate, Pill Organizer
    - Week 10: Thermometer
    - August: Pulse oximeter
    - October: Blood pressure monitor
    - December: Food or exercise related tool to support healthy lifestyle
    - March: Close Out Visit: Item to celebrate your success!

    **Tools listed are subject to change based on availability*

GO BACK TO STEP 11

PATIENT INFORMATION SHEET continued

Do I get to keep the tools?

YES! But only if you attend the sessions and record your weight, exercise, and food weekly. If you do not attend sessions or record your progress, you will be required to return the tools.

What if I miss a session?

Make-up sessions (scheduled in the same week) are offered! If you miss a regularly scheduled session, you are required to attend a make-up session. You are allowed to make up no more than 3 sessions. If you miss more than 3 regularly scheduled sessions, you may be removed from the program.

What do I need to do to join?

- Talk with your provider and health center staff to decide if this program is right for you. If you have diabetes, your provider must approve your participation in the program.
- Confirm that you have access to a phone for the group session calls. Let your health center Lifestyle Coach know if you have internet and/or cellular service or a smart phone (iPhone, Windows phone, Android, Amazon Fire Phone), tablet, or computer for other options.
- Sign a Patient Participation Agreement.

Participating in Healthy Together is a fantastic opportunity to access free tools and benefit from the support of Lifestyle Coaches as they guide you through healthy eating, exercise, and dealing with stress to help you lower blood sugar and live healthier. We are very excited to invite you to join this program, and we hope you will consider participating!

_____ (health center provider/care team member name)

_____ (health center name)

PATIENT INFORMATION SHEET - UNFORMATTED | PATIENT INFORMATION SHEET - FORMATTED

APPENDIX H: PATIENT AGREEMENT

I agree to participate in the Healthy Together program until March 31, 2023.

During that time, I will:

- Attend group sessions with other patients from my health center who also are looking for ways to eat healthier, exercise more, and reduce stress. Sessions will be virtual (phone or video), with in-person check-ins at key points during the year. The sessions will follow this schedule:
  - April 1 – July 31, 2022: weekly group call (60-75 mins); no session 4th of July week.
    - In-person connection at weeks 2 & 10 to receive additional tools.
  - August 1– March 31, 2023: monthly group call (60-75 mins).
    - In-person connection in August, October, December, and March to receive additional tools.
- Attend make up sessions (scheduled in the same week) if I am not able to attend a regular session.
  - I am allowed to make up no more than 3 sessions. If more than 3 regularly scheduled sessions are missed, I may be removed from the program.
- Track and share my progress:

What do I track?	How often?	When?	Where do I track
The food I eat	Every day	After eating or end of day	The program app/online portal or the Healthy Together wellness tracker
The number of minutes I exercise	Every day	After exercise or end of day	The program app/online portal or the Healthy Together wellness tracker
Weight	Once weekly	On session days; before joining session	The program app/online portal
Oxygen Level	Instructions will follow		
Blood Pressure	Instructions will follow		

I will contact my provider's office if:

- My temperature reading is more than_____.
- My blood pressure reading is more than _____.
- My oxygen level reading is less than _____.
- For patients with diabetes, my blood sugar reading is more than _____.

If I have any questions, I will call _____ at (phone)_____.

I agree to use the tools provided and track my results as outlined above. If I decide to no longer participate in the program (or if I miss more than 3 sessions), I understand that I am required to return the tools to the health center.

GO BACK TO STEP 11

PATIENT AGREEMENT continued

- ☐ I understand that the sessions will be group visits with other patients.
- ☐ I understand that discussions may occur regarding individually identifiable health information during a group visit.
- ☐ It is possible that the information that is used or disclosed in a group visit may be redisclosed by other participants in the group visit.
- ☐ I agree to keep all information regarding other patients attending group visits private and confidential.

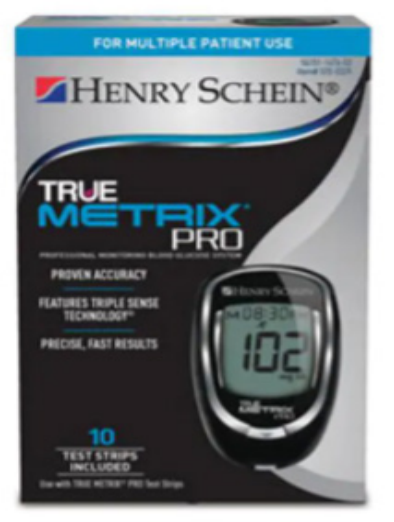
Patient Name (print):	
Patient Signature:	
Date:	

For patients with diabetes:

Provider Name (print):	
Provider Signature:	

PATIENT AGREEMENT

APPENDIX I: DIABETES CONTROL: BLOOD GLUCOSE METER KIT



Why is it Important to Follow My Blood Sugar?

Many health problems happen when blood sugar levels are too high. Blood sugar testing provides useful information for diabetes management. It can help you:

- Monitor the effect of diabetes medications on blood sugar levels.
- Identify blood sugar levels that are high or low.
- Track your progress in reaching your overall treatment goals.
- Learn how diet and exercise affect blood sugar levels.
- Understand how other factors, such as illness or stress, affect blood sugar levels.

Patient Care Kit Item

Your Kit includes one (1) Henry Schein True Metrix Pro Blood Glucose Meter Kit. It has enough supplies for many blood tests to be done.

Your Henry Schein True Metrix Pro box includes:

- Instruction Sheet
- Meter: the small black device
- Test strips
- Lancet (needle)

GO BACK TO STEP 12

DIABETES CONTROL: BLOOD GLUCOSE METER KIT continued

Instructions

- ✔ Wash and dry your hands well. (Food and other substances can give you an inaccurate reading.)
- ✔ Insert a test strip into your meter.
- ✔ Prick the side of your fingertip with the needle (lancet) provided with your test kit.
- ✔ Touch and hold the edge of the test strip to the drop of blood.
- ✔ The meter will display your blood sugar level on a screen after a few seconds.

Blood sugar meters need to be used and maintained properly. Follow these tips to ensure proper usage:

- Check the user's guide for your device for instructions
- Use a blood sample size as directed in the user's guide.
- Use only test strips designed for your meter.
- Store test strips as directed.
- Don't use expired test strips.
- Clean the device and run quality-control checks as directed.
- Bring the meter to your health care provider's appointments to address any questions and to show how you use your meter.

GO BACK TO STEP 12

APPENDIX I: TEMPERATURE MONITORING: HENRY SCHEIN DIGITAL THERMOMETER

Why is it Important to Check My Temperature?

A fever is a temperature higher than 100.4ºF. It is a symptom that can happen with mild to severe illness, including COVID-19. You should check your temperature when you think you have a fever.

Instructions

- To turn the thermometer on, press and release the round button (the button on top, below the display window).
- Place new probe cover onto the thermometer tip.
- With your mouth open, place the covered thermometer tip under your tongue.
- Close your lips gently around the thermometer.
- Keep the thermometer under your tongue until the digital thermometer beeps.
- Read the numbers in the display window, this is your temperature.
- Remove and dispose the used probe cover.

Here are a few tips to get a good reading:

- Try not to move your body or the thermometer while it is reading.
- Wait at least 30 minutes after exercise or hot/cold drinks!
- Wait at least 6 hours after taking pills like acetaminophen, ibuprofen, or aspirin. These can lower your body temperature.

Patient Care Kit Item

Your Kit includes one (1) Henry Schein Thermometer.

GO BACK TO STEP 12

APPENDIX I: HEALTHOMETER MECHANICAL FLOOR SCALE AND MEASURING TAPE

Patient Care Kit Item

Your Kit includes one (1) Healthometer Mechanical Floor Scale and one (1) TECHMED measuring tape.

Why is it Important to Track My Weight and Measure My Waist?

Your weight matters. When your weight is at a healthy level, it is easier to prevent or manage diabetes and prevent other health problems. You will also feel better and have more energy. Losing extra pounds may mean you will need less medicine. It can also reduce your risk for heart attack and stroke. The best ways to lose weight are to eat with your health in mind and to get more exercise.

Measuring the length around my waist, called "waist circumference" helps screen for possible health risks that come with excess weight. If most of your fat is around your waist rather than at your hips, you're at a higher risk for heart disease and type 2 diabetes.

GO BACK TO STEP 12

DIABETES CONTROL: HEALTHOMETER MECHANICAL FLOOR SCALE AND MEASURING TAPE continued

Weight Management: Healthometer Mechanical Floor Scale

Instructions

- To learn your weight, put the scale on a flat, hard floor. The scale will automatically turn on as soon as you step on the scale with both feet.
- You should weigh yourself at least once per week. It is best to weigh yourself on the same day and at about the same time each week (e.g., Saturday mornings). Be sure to weigh yourself on session days; before joining the session and record your weight in the Wellocity portal or app.

Weight Management: TECHMED Retractable Tape Measure

Instructions

- To learn your waist circumference, start at the top of your hip bone, then bring the tape measure all the way around your body, level with your belly button. Make sure it's not too tight and that it's straight, even at the back. Don't hold your breath while measuring. Check the number on the tape measure right after you exhale.
- You should measure your waist circumference at least once a week to measure your weight loss progress. This can be done the same day and time that you weigh yourself.

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APPENDIX J

APPENDIX J: WEEKLY WELLNESS TRACKER

Healthy Together

Weekly Wellness Tracker

week of: _____

SUN	MON	TUES	WED	THURS	FRI	SAT
☐ Medicine	☐ Medicine	☐ Medicine	☐ Medicine	☐ Medicine	☐ Medicine	☐ Medicine
Water	Water	Water	Water	Water	Water	Water
Exercise ☐ minutes	Exercise ☐ minutes	Exercise ☐ minutes	Exercise ☐ minutes	Exercise ☐ minutes	Exercise ☐ minutes	Exercise ☐ minutes
Personal Time	Personal Time	Personal Time	Personal Time	Personal Time	Personal Time	Personal Time
Sleep ☐ hours	Sleep ☐ hours	Sleep ☐ hours	Sleep ☐ hours	Sleep ☐ hours	Sleep ☐ hours	Sleep ☐ hours
Stress level 1 3 5 (low stress / high stress)	Stress level 1 3 5 (low stress / high stress)	Stress level 1 3 5 (low stress / high stress)	Stress level 1 3 5 (low stress / high stress)	Stress level 1 3 5 (low stress / high stress)	Stress level 1 3 5 (low stress / high stress)	Stress level 1 3 5 (low stress / high stress)

Healthy Together

Weekly Meal Tracker

week of: _____

SUN	MON	TUES	WED	THURS	FRI	SAT
BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST
TIME:	TIME:	TIME:	TIME:	TIME:	TIME:	TIME:
ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL
LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
TIME:	TIME:	TIME:	TIME:	TIME:	TIME:	TIME:
ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL
DINNER	DINNER	DINNER	DINNER	DINNER	DINNER	DINNER
TIME:	TIME:	TIME:	TIME:	TIME:	TIME:	TIME:
ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL
SNACK	SNACK	SNACK	SNACK	SNACK	SNACK	SNACK
TIME:	TIME:	TIME:	TIME:	TIME:	TIME:	TIME:
ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL	ITEM AMOUNT CAL

WEEKLY WELLNESS TRACKER GO BACK TO STEP 12

APPENDIX K: PATIENT CHECKLIST

Patient Name: _____

Patient DOB: _____

ACTION ITEMS
◯ **Patient meets eligibility criteria.** See Checklist for Running & Analyzing Patient Lists to Identify Eligible Patients. ◯ Patient has diagnosis of diabetes. ◯ Patient is at risk for diabetes.
◯ **Patient's primary care provider (PCP) approves patient participation.**
◯ **Patient invited to participate.**
◯ **Patient receives 'Patient Info Sheet' & 'Patient Agreement Form.'**
◯ **Patient accepts invitation to participate.**
◯ **Patient signs 'Patient Agreement Form.'**
◯ **Patient is scheduled for a *Healthy Together Start Up* Visit.**
◯ **Patient attends *Healthy Together* Start-Up Visit:** ◯ Patient signs 'Patient Agreement Form,' if not already done. ◯ Patient logs into Wellocity app/portal and is trained to navigate it. ◯ Patient is assisted with community resources, as needed. ◯ Patient is provided with Patient Care Kit tools. ◯ Patient is trained to use Patient Care Kit tools. ◯ Patient completes baseline measurements: ◯ Height ◯ Weight ◯ Blood Pressure ◯ A1c (within the past 3 months)

PATIENT CHECKLIST - PDF | PATIENT CHECKLIST - EXCEL

GO BACK TO STEP 12

APPENDIX L: INSTRUCTIONS FOR SETTING YOUR *HEALTHY TOGETHER* PROGRAM SCHEDULE

1. Determine how many cohorts of patients you have.

   - Consider your total number of participating patients::
     - 12-16 patients = 1 cohort
     - 24-30 patients = 2 cohorts

2. For each cohort, determine the day of the week and time of day the session will occur.
   - Each curriculum group session will be approximately 60-75 minutes in length. The curriculum sessions are about 60 minutes of coaching (including recorded coaching from ADCES and live coaching from the health center Lifestyle Coach), plus about 15 minutes of pre-session activity (weighing in, checking food and activity logs).
     - For example, for 1 cohort: Monday at 3:00-4:15 pm.
     - For example, for 2 cohorts: Monday at 3:00-4:25 pm and Thursday at 2-3:15pm.
   - Curriculum group sessions will be held weekly April-July, and monthly August-March.
   - For monthly curriculum group sessions, your health center can determine which week of the month session(s) will occur.
   - Ensure the Lifestyle Coach blocks session days/times on their calendar.
   - Virtual sessions will be supplemented by in-person connections at key points in the program to ensure engagement and provide patients with Patient Care Kit Tools (see below schedule). In-person group sessions offer an opportunity for patients to receive in-person instruction in use of the tools, and accompanying education, as well as to connect with other patients in the cohort. If COVID conditions prevent a full cohort from meeting in-person together at these minimum touchpoints (e.g., gathering a group of approximately 12 patients together at one time), the Lifestyle Coach could consider staggering patient arrivals/departures for this in-person session or breaking up into smaller groups.
   - Curriculum group sessions will be held virtually via audio-only. Health centers interested in exploring use of Zoom for audio and visual connection as the year progresses should contact their Hub and email clindholm@nachc.org.

Curriculum Session and Patient Care Kit Tool Distribution Schedule:

Month of March: Patient completes individual, in-person Start Up Visit
Patient is provided with Patient Care Kit tools and accompanying instruction sheets: **scale, measuring tape, glucometer kit and testing strips** (only patients diagnosed with Diabetes) and is trained to use them
Week of April 4: Patient attends virtual group curriculum session
Week of April 11: Patient attends (in-person) group curriculum session
Patient is provided with Patient Care Kit tools and accompanying instruction sheets: **MyPlate, pill organizer**, and is trained to use them
Week of April 18: Patient attends virtual group curriculum session
Week of May 2: Patient attends virtual group curriculum session
Week of May 9: Patient attends virtual group curriculum session
Week of May 16: Patient attends virtual group curriculum session
Week of May 23: Patient attends virtual group curriculum session
Week of May 30: Patient attends virtual group curriculum session

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INSTRUCTIONS FOR SETTING YOUR *HEALTHY TOGETHER* PROGRAM SCHEDULE continued

Week of June 6: Patient attends virtual group curriculum session
Week of June 13: Patient attends (in-person) group curriculum session
Patient is provided with Patient Care Kit tools and accompanying instruction sheets: **thermometer**, and is trained to use them
Week of June 20: Patient attends virtual group curriculum session
Week of June 27: Patient attends virtual group curriculum session
Week of July 11: Patient attends virtual group curriculum session
Week of July 18: Patient attends virtual group curriculum session
Week of July 25: Patient attends virtual group curriculum session
Month of August: Patient attends (in-person) group curriculum session
Patient is provided with Patient Care Kit tools and accompanying instruction sheets: **pulse oximeter**, and is trained to use them
Month of September: Patient attends virtual group curriculum session
Month of October: Patient attends (in-person) group curriculum session
Patient is provided with Patient Care Kit tools and accompanying instruction sheets: **blood pressure monitor**, and is trained to use them
Month of November: Patient attends virtual group curriculum session
Month of December: Patient attends (in-person) group curriculum session
Patient is provided with Patient Care Kit tools and accompanying instruction sheets: **TBD item based on Lifestyle Coach input**, and is trained to use them
Month of January: Patient attends virtual group curriculum session
Month of February: Patient attends virtual group curriculum session
Month of March: Patient attends (in-person) group curriculum session
Patient completes post-program screening questionnaire and is provided with Patient Care Kit tools and accompanying instruction sheets: **TBD item to celebrate patient's success**, and is trained to use them

INSTRUCTIONS FOR SETTING YOUR PROGRAM SCHEDULE

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