
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®

August 2023

# TRANSFORM DIABETES PREVENTION AND CARE
## *Action Guide*

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

Studies show that the CDC's National Diabetes Prevention Program (National DPP) curriculum, delivered in-person or virtually, can help patients lose weight, improve healthy behaviors, and reduce their risk of developing type 2 diabetes. This curriculum can also help to control diabetes in individuals diagnosed 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 National 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 *Healthy Together*?

***Healthy Together*** is a lifestyle change program that enables health centers to increase the impact of diabetes prevention and control efforts, by combining several effective diabetes prevention and control strategies into one robust program:

- CDC's National DPP lifestyle change curriculum
- Enhancements to the lifestyle change curriculum to focus on social support and health equity
- Access to national expertise in diabetes prevention and control education and training
- The option to couple the program with patient self-care tools to improve health and prevent or manage diabetes
- The option to extend participation to include individuals diagnosed with type 2 diabetes or other chronic conditions in addition to National DPP qualifying individuals at-risk for type 2 diabetes
- The option to leverage virtual delivery of the lifestyle change curriculum
- The option to centralize administrative and data reporting components of the model within a Primary Care Association (PCA) or Health Center Controlled Network (HCCN) 'Hub'

The whole-person approach of *Healthy Together* encourages the support and engagement of patients' families and significant others and attention to cultural needs and language preferences. The enhanced lifestyle change curriculum can be delivered by a national diabetes expert with local support and application by trained health center Lifestyle Coaches. *Healthy Together* also provides the option to connect participants with self-care tools that support valuable lifestyle changes and build self-management skills. These self-care tools, called "Patient Care Kits", combined with a diabetes prevention and support program, offer a groundbreaking strategy to advance a health center's diabetes care model. A 'Patient Care Kit' is a toolbox of patient self-care tools with instructions and educational materials. When coupled with remote support from health center staff, these Kits can be an effective strategy to advance diabetes prevention and control efforts.

 

# TRANSFORM DIABETES PREVENTION AND CARE
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# 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 experiences, improved staff experiences, reduced costs, and equity.

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 diabetes prevention and control lifestyle change program.

 

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LAY THE GROUNDWORK

## STEP 1 Access *Healthy Together* and National DPP Resources

NACHC conducted a pilot of this *Healthy Together* program, concluding in the Summer of 2023, with a group of health centers from across the country along with their state/regional PCA/HCCN, referred to as 'Hubs'. Through this pilot program, a national model for health centers to implement the *Healthy Together* program has been developed.

Log in to the Elevate Online Platform to access information and tools to support health centers implementing the *Healthy Together* lifestyle change program. Elevate is a national community of health centers and partners coming together to transform systems and enhance value. The Elevate Online Platform can be accessed here. Available resources include:

- This *Healthy Together* Action Guide with appendices
- Recorded webinar on 'National DPP Basics for Health Centers'
- Library of recorded National DPP curriculum sessions delivered by a national diabetes education expert and Lifestyle Coach (coming soon)
- A summary of findings from the *Healthy Together* pilot project (coming soon)

Additionally, if your health center is interested in gaining recognition through the CDC Diabetes Prevention Recognition Program (DPRP), it is important to build an understanding of the DPRP standards. CDC offers an e Organizational Capacity Assessment for DPRP to determine readiness in applying for CDC recognition. See also the DPRP Application. Additional resources available on the CDC's National DPP website include curricula and handouts, FAQs, and more.

**Action Step:** Log in to the Elevate Online Platform to access *Healthy Together* Resources and review National DPP resources available from the CDC.

## STEP 2 Plan initiative

The national model for *Healthy Together* can be customized to meet your health center's needs. After reviewing available *Healthy Together* and National DPP resources, plan how the initiative will be implemented at your health center.

Work with your PCA or HCCN to determine if they will serve in a Hub role to provide centralized administrative and data reporting support. The Hub model works best if there are multiple health centers under a PCA/HCCN who are offering the *Healthy Together* program. For example, the Hub may provide support to participating health centers for:

- Completing the DPRP Application
- Submitting DPRP data
- Organizing Lifestyle Coach training opportunities
- Identifying eligible patients through risk stratification
- Providing program technical assistance to health centers

Determine whether a lifestyle coaching program aligns with existing organizational priorities for diabetes prevention and management or population health. If yes, assess for opportunities to coordinate efforts. For example, while the CDC's National DPP model is focused only on patients with pre-diabetes, the *Healthy Together* model discussed in this Action Guide combines patients with diabetes and patients with pre-diabetes into a single cohort for lifestyle change. Health centers could also consider whether to extend participation to patients with another chronic condition, such as hypertension, who could similarly benefit from lifestyle coaching.

Determine whether Patient Care Kits will be provided to participating patients. Patient Care Kits 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. Each Kit should include patient instructions and educational materials. If Kits are used, it is recommended to distribute the tools in the Kit to program participants throughout the course of the program year rather than all at once. This method encourages and motivates participants to remain engaged. Examples of Kits tools that health centers may consider include, scales, measuring tapes, thermometers, portion- sized meal containers, water bottles, exercise supplies (such as yoga mats and resistance bands), self- blood pressure monitors, and pulse oximeters.

Determine whether the program will be provided in-person, virtually (e.g., via Zoom or another telehealth system), or a combination of in-person and virtually. Also consider how the library of recorded National DPP curriculum sessions delivered by a national diabetes education expert and Lifestyle Coach will be utilized. Some health center Lifestyle Coaches may prefer to teach the curriculum content themselves and use the videos as a tool to aid in preparation of the session, while others may prefer to share the videos with the participants.

**Action Step:** Plan the *Healthy Together* program to meet your health center's needs; consider Hub support, the initiative's population of focus, Patient Care Kits, and program delivery method.

## STEP 3 Communicate Initiative to Health Center Staff

Successful initiatives start with communication! Inform health center staff about the organization's planned efforts and explain its role and impact 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 program activities. Communicate the timeframe of the program – beginning with Laying the Groundwork activities, the Launch of the initiative, and the Implementation of the curriculum sessions.

Appendix A provides a sample email template that leadership can use to communicate the initiative to health center staff. In addition to communicating the initiative to staff, sharing your health center's innovative new approach with the community can be helpful 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 4 Set Goals and Define Success for Your Health Center

It is important for health centers to define success for the *Healthy Together* program 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. Use the S.M.A.R.T. goals methodology to help focus your efforts and set effective and achievable goals. The goals you select should be: Specific, Measurable, Achievable, Relevant, and Time-bound. Program goals could, for example, focus on patient outcomes, staff outcomes, or processes. Consider what data elements are needed to achieve your stated goals. See Appendix C for the list of data elements that may 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 atend all Lifestyle Coach training sessions.
- Improve staff experience by 25% from baseline.

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:** Set goals that are patient-focused, staff-focused, and process focused; Define program success for your health center.

## STEP 5 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 staff 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 sample workflows designed by health centers for *Healthy Together*. Determine how and where patient data will be documented and tracked within each workflow.

If your health center provides Patient Care Kits, one person from the health center should be identified to receive, store, and assemble Kit materials. Suppose the designated point person is not available to receive Kit shipments. In that case, they should notify other staff in the health center of expected shipments and provide storage instructions. Staff should install batteries and perform device tests to streamline the distribution process and address any potential tool malfunctions requiring immediate follow-up with the manufacturer or vendor. Once the program gets underway, if a patient decides to participate no longer, they are expected to return the tools to the health center. Health centers must designate space to store and sanitize tools collected from patients no longer participating in the project and create a place to store and manage incoming new tools. See Appendix E for a sample Care Kit Tool Tracking Sheet that can be used to track the distribution of tools to *Healthy Together* participants.

**Action Step:** Document your health center's *Healthy Together* workflows.

## STEP 6 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.

First, leverage EHR/population health management system reporting functionality to identify patients based on clinical diagnosis criteria. For example, if you follow the *Healthy Together* model, identify patients diagnosed with type 2 diabetes and patients at risk for type 2 diabetes who meet program eligibility. Refer to Appendix F, "Checklist for Running and Analyzing Patient Lists to Identify Eligible Patients".

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 potential patients. The recommended number of patients per group is 12-15. Starting with a list of eligible patients that is two-three times the number of target patients (e.g., 40-50 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 if this will be part of your program model. 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 7 Train Health Center Lead(s) for Project Role

Health center staff selected to serve as Lifestyle Coaches must complete training to serve in this role. The Association for Diabetes Care and Education Specialists (ADCES), nationally recognized experts in diabetes prevention and control, offer Lifestyle Coach training courses – more information can be found on the ADCES website.

Additionally, health center staff who work with patients engaged in *Healthy Together* should be provided education and training on the project workflows. Your project leads can set up a virtual or in-person training for all staff involved. Proper program knowledge 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 use all Patient Care Kit tools properly and can educate and train patients in proper use. Document how staff will be trained in the *Healthy Together* workflows 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:** Train Lifestyle Coaches; Educate and train staff on *Healthy Together* workflows. Ensure staff have the information, knowledge, and skills to properly support participating patients in proper use of tools.

## STEP 8 Schedule Group Lifestyle Change Curriculum Sessions

Health centers may set their curriculum session schedules to best meet the needs of the participants and the Lifestyle Coaches. Plan out the day(s) and time(s) your *Healthy Together* group lifestyle curriculum sessions will take place throughout the year. It is best to keep the day and time consistent to make sure the schedule is clear.

After patients are identified to participate in the program (see Step 9), schedule these sessions in the patient's EHR so all health center staff and care team members have access to the information and know when they will take place.

Sample instructions for setting your *Healthy Together* program schedule are found in Appendix G.

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

## STEP 9 Invite Patients to Participate in *Healthy Together*

Using the list of eligible patients identified through risk stratification (Step 6), 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 12-15 total participants in the program.

Patients can be invited using outreach methods determined by your team (e.g., provider visit, warm hand-off, phone call). While various care team members can effectively deliver the invitation to patients, it is important to communicate to patients that their provider recommends that they participate.

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, the day and time of the curriculum sessions (see Appendix H, Patient Handout Curriculum Schedule, and the kinds of follow-up and communication they can expect. The Patient Information Sheet, Appendix I, 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 (Appendix J). 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. 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 participation ability, explain program expectations and requirements. Obtain signed Patient Participation Agreement.

LAUNCH

STEP 10

## Complete Individual Patient Start-Up Visits

Schedule each participating patient for an individual, in-person Start Up Visit. When participants have family members or significant others participating in the program, they can complete the Start-Up Visit together. The Start-Up Visit includes:

- Sign Patient Participation Agreement. It is recommended that health centers require each patient to sign a Patient Participation Agreement to participate in the program.
- Complete the patient questionnaire. It can be helpful to gather baseline data regarding the patient's clinical and social needs. Support patient with completion of the pre-program questionnaire (See Appendix K). If feasible, capture relevant data within the EHR.
- Distribute the Patient Care Kit & instruct the patient in using the tools. Distribute Kit tools during the Start-Up Visit and train participants on the proper use of each item. Have patients demonstrate the correct use of each tool back to you and provide patients with take-home instructions.

  See Appendix L for Sample Patient Instructions: Patient Care Kit Tools. The tools for distribution at the Start-Up Visit may include:
  - Scale
  - Measuring Tape
  - Healthy Together Wellness Tracker (see Appendix M)
  - Glucometer Kits (only for patients diagnosed with diabetes)
  - Glucose Test Strips (only for patients diagnosed with diabetes)
  - Lancets (only for patients diagnosed with diabetes)
- Distribute an initial set of participant materials, including the first portion of the NDPP curriculum (see Step 11)
- Complete baseline measurements. Ensure ALL patients participating in *Healthy Together* have a baseline Hemoglobin A1c test (tests completed within the 3 months before the start of group lifestyle sessions are recommended). Record the participant's height and weight. Data collected during the Start-Up Visit is essential for evaluating the overall impact of this enhanced DPP curriculum. Health centers are also encouraged to capture data in the EHR as part of their documentation process.

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

STEP 11

## 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.

As described in this Action Guide, 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 the program curriculum:

| National DPP Group Session Topics | | |
|---|---|---|
| **Core (16 Sessions)** | | **Core Maintenance (10 sessions)** |
| Skill Building, Self-monitoring, and Physical 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! |

NACHC's *Healthy Together* program is designed as a combination lifestyle change program, meaning both virtual and in-person touchpoints are part of the design. Patients should be scheduled to receive Patient Care Kit tools in person, including education and training in the use of the tools.

NACHC has assembled a library of recorded trainings of the NDPP curriculum conducted by a national diabetes prevention program expert from ADCES. Each NDPP module has a recording lasting approximately 30 minutes in length. These recordings are available for use by health center Lifestyle Coaches in a way best suited for your health center and participants. For example, this could include playing the recording for the group, pausing at designated intervals, and the Lifestyle Coach facilitating discussions, building on the content delivered by the ADCES expert with attention to the local needs (e.g., cultural and social support) of the participants. Alternatively, the Lifestyle Coach could watch the recording beforehand to help prepare for delivering the module curriculum themselves without playing the recording for the group. It is highly encouraged that Lifestyle Coaches watch the recording ahead of the session, regardless of if/how they plan to utilize the recording during the session. The health center lifestyle coaches will facilitate discussion in whichever language best serves the health center cohort.

It is essential that the Lifestyle Coaches take certain steps to prepare for each curriculum session. In addition to viewing the ADCES recording, Lifestyle Coaches should take time to familiarize themselves with the applicable module in both CDC's Coach Guide and Participant Guide. In addition to being prepared to cover the Coach material, it is best practice to understand what the participant will be seeing. Lifestyle Coaches may also wish to organize activities or discussion questions using resources

IMPLEMENT

made available by the CDC or other applicable sources. For in-person sessions, the Lifestyle Coach will need to ensure the meeting space is set up (e.g., chairs are available, light refreshments, etc.). The Coach and Participant Guides can be found here:

Lifestyle Coach Guide  Participant Guide — English | Spanish

Supplemental program resources from the CDC can be found here.

Participants who miss attending a regularly scheduled curriculum session are required to make that session up. Make-up sessions can be provided in person, via phone, or through a telehealth session and must be comparable to regularly scheduled sessions in content and length. The make-up session reviews a CDC-approved curriculum module which is generally about an hour. A single make-up session per participant may be held on the same date as a regularly scheduled session. A participant should have at most one make-up session in a single week. There must be at least five days between makeup sessions to maintain the intensity of the program.

Lastly, it is recommended that Lifestyle Coaches remind participants of upcoming sessions. Participant reminders can be provided through portal messages, phone calls, text messages, or a combination of these options. Be sure to tailor the reminders to the needs and preferences of the participants, whenever possible.

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

ASSESS AND EVALUATE

STEP 12

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

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

At the conclusion of the program year, Lifestyle Coaches will assist patients in repeating the program questionnaire.

**Action Step:** Establish processes to collect and review data, assess progress toward goals, and share lessons learned.

APPENDIX A

# APPENDIX A: *HEALTHY TOGETHER* LEADERSHIP EMAIL TEMPLATE

***Sample leadership communication announcing implementation of Healthy Together.***

Dear Colleagues,

*Healthy Together* is a program model that was developed 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), and [applicable PCA/HCCN name] and participant health centers.

*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 change curriculum, combined with patient self-care tools, and coaching by our trained health center Lifestyle Coaches. 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]

# APPENDIX B: *HEALTHY TOGETHER* SAMPLE PRESS RELEASE

## Health Centers Reimagine Diabetes Care and Prevention through Implementation of Lifestyle Change Program

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

Community health centers care for a large population of high-risk patients who are more likely to suffer from a disproportionate array of chronic conditions. 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 national model for a cutting-edge 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. It will offer training, education, and support in healthy eating, physical activity, and stress management. Health center family members are encouraged to participate and show support!

*"[Health center name] is excited to be offering 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."*

# APPENDIX C: *HEALTHY TOGETHER* DATA DICTIONARY

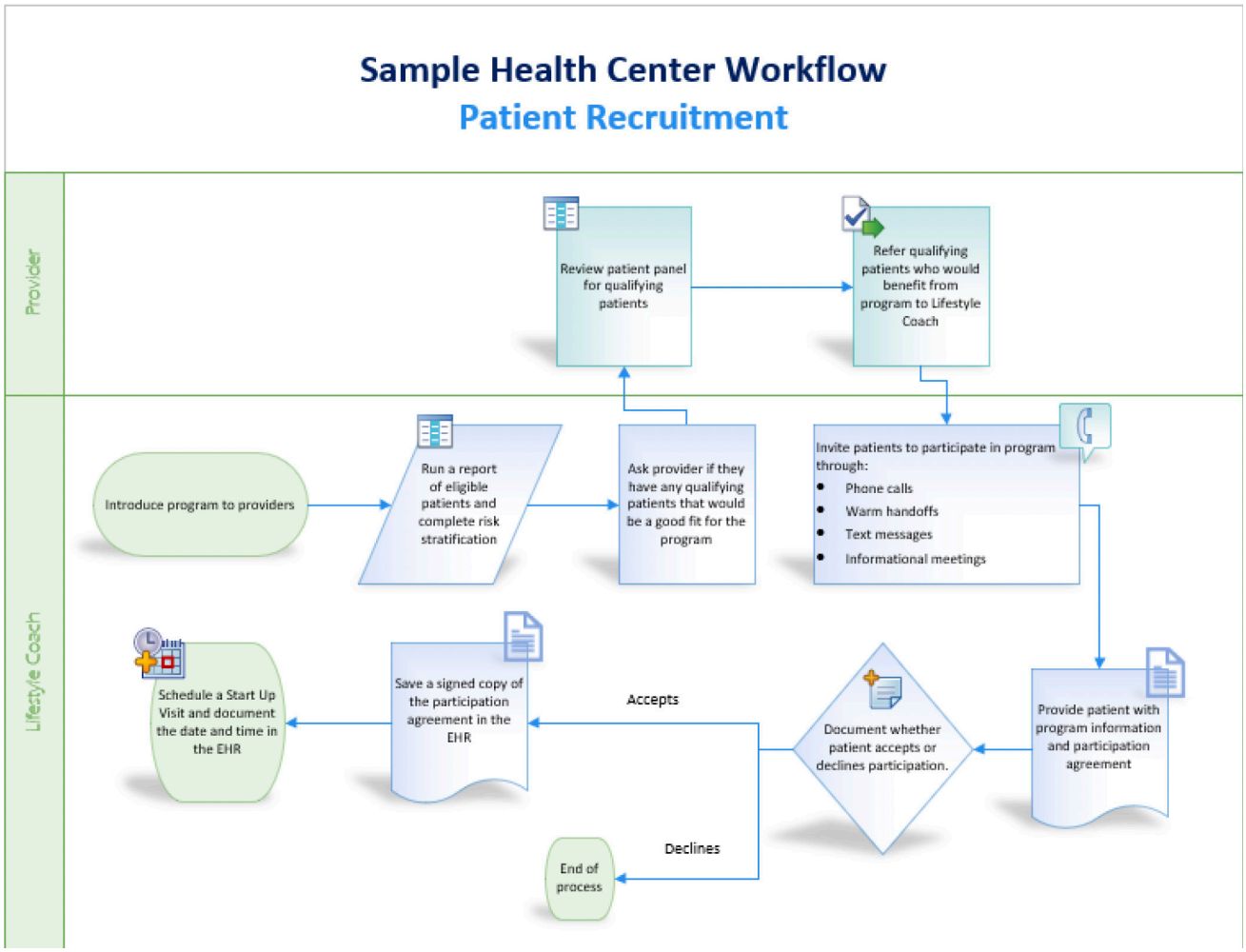
| Data Element | Description |
|---|---|
| Organization Code | Assigned by CDC |
| Participant ID | Assigned by Health Center |
| Cohort ID | Assigned by Health Center |
| Coach ID | Assigned by Health Center |
| Enrollment Motivation | 1. Health care professional<br>2. Blood test results<br>3. Prediabetes risk test (short survey)<br>4. Someone at a community-based organization (church, community center, fitness center)<br>5. Family or friends<br>6. Current or past participant in the National DPP LCP<br>7. Employer or employer's wellness plan<br>8. Health insurance plan<br>9. Media advertisements (social media, flyer, brochure, radio ad, billboard, etc.) |
| Enrollment Source | 1. Yes, a doctor/doctor's office<br>2. Yes, a pharmacist<br>3. Yes, other healthcare professional<br>4. No |
| Payer Source | 1. Medicare<br>2. Medicaid<br>3. Private Insurer<br>4. Self-pay<br>5. Dual Eligible (Medicare and Medicaid)<br>6. Grant funding<br>7. Employer<br>8. Free of charge<br>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<br>2. Prediabetes determined by clinical diagnosis of GDM during previous pregnancy<br>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<br>2. NOT Hispanic or Latino<br>9. Not reported (default) |
| Participant's Race | 1. American Indian or Alaska Native<br>2. Asian or Asian American<br>3. Black or African American<br>4. Native Hawaiian or Other Pacific Islander<br>5. White |
| Participant's Sex | 1. Male<br>2. Female<br>9. Not reported |
| Participant's Gender | 1. Male<br>2. Female<br>3. Transgender<br>9. Not reported |

## *HEALTHY TOGETHER* DATA DICTIONARY continued

| | |
|---|---|
| Participant's Height | 30 to 98 (in inches) |
| Education | 1. Less than grade 12 (No high school diploma or GED)<br>2. Grade 12 or GED (High school graduate)<br>3. Some college or technical school<br>4. College or technical school graduate or higher<br>9. Not reported (default) |
| Delivery Mode | 1. In-person<br>2. Online<br>3. Distance learning |
| Session Type | C Core session<br>CM Core maintenance session<br>OM Ongoing maintenance sessions (for MDPP supplier organizations or other organizations that choose to offer ongoing maintenance sessions)<br>MU-C Make-up sessions in the Core phase<br>MU-CM Make-up sessions in the Core Maintenance phase<br>MU-OM Make-up sessions in the Ongoing Maintenance phase |
| Session Date | mm/dd/yyyy |
| Participant's Weight | 70 to 997 (in pounds)<br>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 |
| Participant's A1C | Participant's A1C |
| PHQ-2 Screening Results | 1. During the past two weeks, have you been bothered by little interest or pleasure in doing things? Yes/No<br>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?<br>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?<br>2. What is your current work situation?<br>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.<br>4. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.<br>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)<br>6. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?<br>7. Do you feel physically and emotionally safe where you currently live?<br>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?<br>2. Do you feel confident in your day-to-day ability to manage your blood sugar?<br>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 |

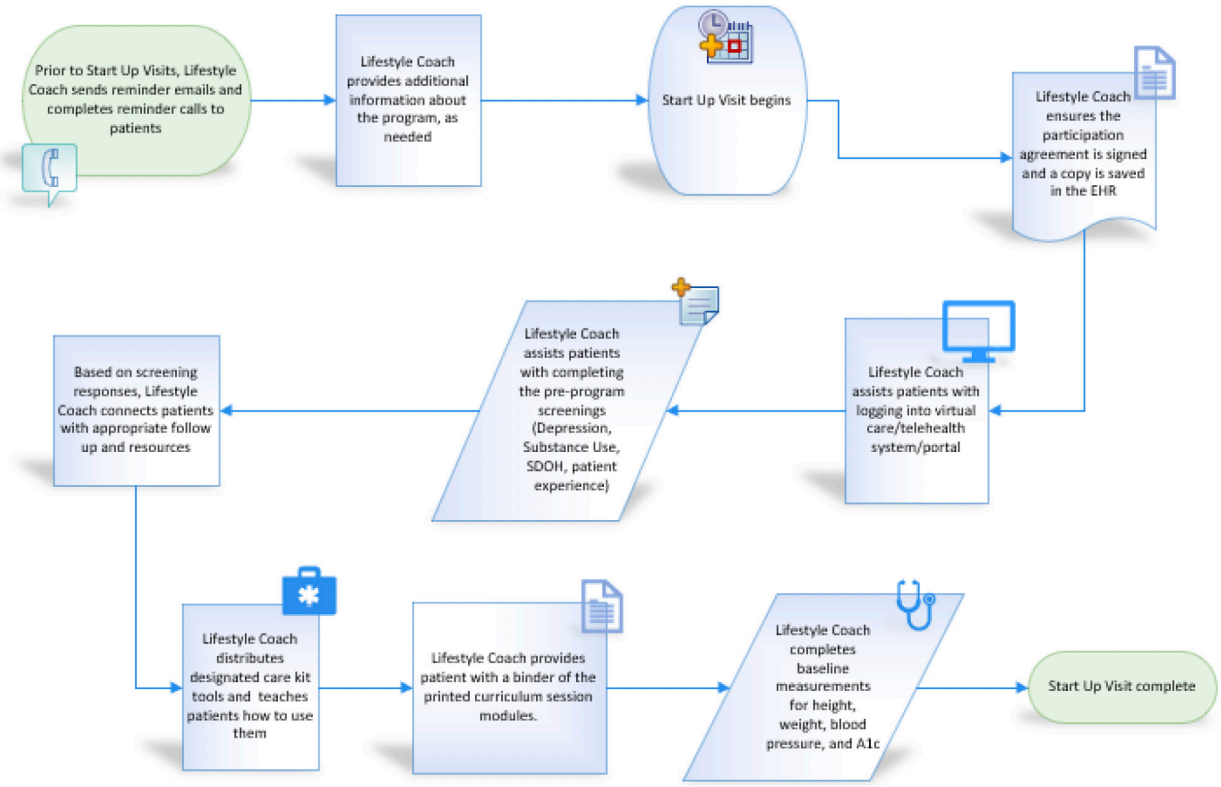
APPENDIX D

# APPENDIX D: *HEALTHY TOGETHER* SAMPLE WORKFLOWS



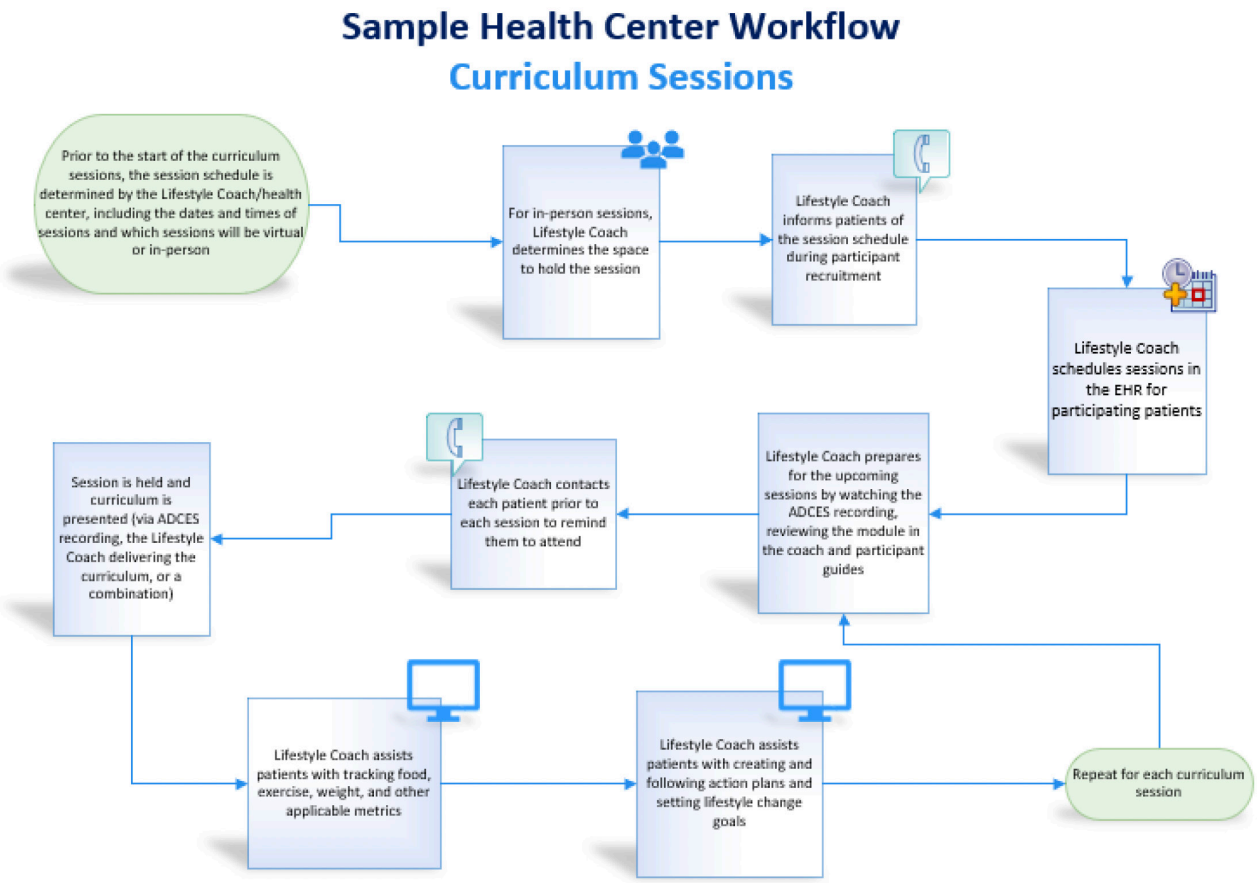
## *HEALTHY TOGETHER* SAMPLE WORKFLOWS continued

### Sample Health Center Workflow
### Start Up Visits

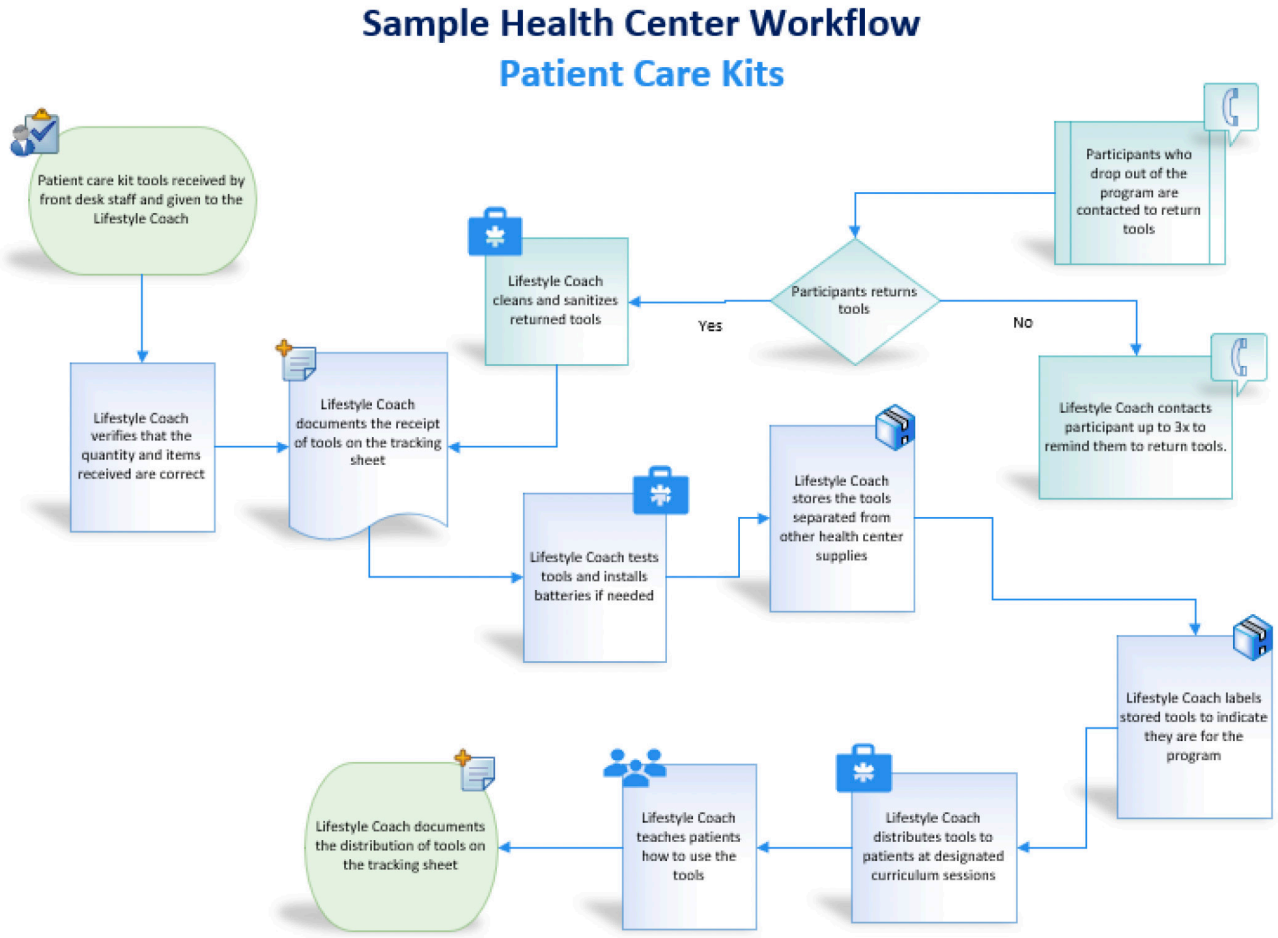


APPENDIX D

## *HEALTHY TOGETHER* SAMPLE WORKFLOWS continued



## *HEALTHY TOGETHER* SAMPLE WORKFLOWS continued



APPENDIX E

# APPENDIX E: PATIENT CARE KIT TOOL TRACKING SHEET

### Instructions

1. Fill in your health center name.
2. Fill in the name of the Lifestyle Coach who is tracking the care kit tools.
3. Fill in the **Total # of *Healthy Together* participants** who initially started the program, the total # currently in the program, and the total # who dropped out.
4. Fill in the **Total # of *Healthy Together* participants with Diabetes** who initially started the program, the total # currently in the program, and the total # who dropped out.
5. Fill in the **Total # of *Healthy Together* participants at-risk for Diabetes** who initially started the program, the total # currently in the program, and the total # who dropped out.
6. Fill in the **# Received** for each care kit tool.
7. Fill in the **# Distributed to Participants** as the tools are provided to *Healthy Together* Participant.
8. Fill in the **# Returned from Participants who Dropped out** as tools are collected from former participants.
9. Calculate the **# Remaining**.

| | |
|---|---|
| **Health Center Name** | |
| **Name of Lifestyle Coach Tracking Tools** | |

| | # Started the Program | # Currently in the Program | # Dropped Out |
|---|---|---|---|
| Total # *Healthy Together* Participants | | | |
| Total # *Healthy Together* Participants with Diabetes | | | |
| Total # *Healthy Together* Participants At-Risk for Diabetes | | | |

| Patient Care Kit Tool | # Received | # Distributed to Participants | # Returned from Participants who Dropped out | # Remaining |
|---|---|---|---|---|
| Participant Binder | | | | |
| Scale | | | | |
| Measuring Tape | | | | |
| Pill Organizer | | | | |
| MyPlate | | | | |
| Thermometer | | | | |
| Tote Bag | | | | |
| Bento Box | | | | |
| Water Bottle | | | | |
| Pulse Oximeter | | | | |
| Blood Pressure Monitor | | | | |
| Yoga Mat | | | | |
| Glucometer Kit* | | | | |
| Test Strips* | | | | |
| Lancet* | | | | |

**Tools to be distributed ONLY to patients with Diabetes*

# APPENDIX F: *HEALTHY TOGETHER* 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
- ☐ BMI >25 kg/m² (or >23 kg/m², if Asian American)
- ☐ **ONE OR MORE** of the following:
  - ☐ 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

APPENDIX F

# 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 agrees to participate before proceeding 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 care team members 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 the Patient's Technological Capabilities

- ☐ Filter to display patients with a 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 an excellent opportunity to invite to participate via a warm handoff process.
  - Mark patients to consider for first invites.

### Consult with Care Team Members (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?

APPENDIX F

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

### Finalize your list

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

☐ Goal of 12-15 patients for each *Healthy Together* cohort. Roughly half of the patients in each cohort should be diagnosed with type 2 diabetes; the other half should be at risk for type 2 diabetes.

# APPENDIX G: SAMPLE INSTRUCTIONS FOR SETTING YOUR *HEALTHY TOGETHER* PROGRAM SCHEDULE

1. Determine the total number of patient cohorts.
   - Consider your total number of participating patients:
     - 12-15 patients = 1 cohort
     - 24-30 patients = 2 cohorts
   - No cohort should start with fewer than 12 participants

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, plus about 15 minutes of pre-session activity (weigh-in, checking food and activity logs).
     - For example, for one cohort: Monday at 3-4:15 pm
     - For example, for two cohorts: Monday at 3-4:15 pm and Thursday at 2-3:15 pm
   - Curriculum group sessions will be held weekly (month, year) through (month, year), and monthly (month, year) through (month, year).
   - For monthly curriculum group sessions, your health center can determine which week of the month session(s) will occur. (e.g., the first Monday of the month).
   - Ensure the Lifestyle Coach blocks session days/times on their calendar.
   - Health centers may individually set their curriculum session schedules to best meet the needs of the participants and the Lifestyle Coaches. The schedule must include both in-person and virtual sessions that follow a predictable pattern).
     - For example, sessions alternate each week between in-person and virtual.
     - For example, sessions are mostly virtual, with an in-person session one week out of the month.
   - Curriculum group sessions will be held virtually e.g., via Zoom.
   - In-person sessions offer an opportunity for patients to receive instruction in the use of the tools, and accompanying education, as well as to connecting with other patients in the cohort.
   - The Lifestyle Coach should consider staggering patient arrivals and departures (i.e., breaking up the cohort into smaller groups) if COVID-19 conditions prevent a full cohort from meeting in person together.

## Curriculum Session and Patient Care Kit Tool Distribution Schedule:

| Session | |
|---|---|
| 0 | **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 |
| 1 | **Week of April 4:** Patient attends virtual group curriculum session |
| 2 | **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 |
| 3 | **Week of April 18:** Patient attends virtual group curriculum session |
| 4 | **Week of April 25:** Patient attends virtual group curriculum session |
| 5 | **Week of May 2:** Patient attends virtual group curriculum session |
| 6 | **Week of May 9:** Patient attends virtual group curriculum session |

APPENDIX G

## SAMPLE INSTRUCTIONS FOR SETTING YOUR *HEALTHY TOGETHER* PROGRAM SCHEDULE continued

| | |
|---|---|
| 7 | **Week of May 16**: Patient attends virtual group curriculum session |
| 8 | **Week of May 23:** Patient attends virtual group curriculum session |
| 9 | **Week of May 30:** Patient attends virtual group curriculum session |
| 10 | **Week of June 6:** Patient attends in-person group curriculum session |
| | Patient is provided with Patient Care Kit tools and accompanying instruction sheets: **thermometer**, **water bottle**, **bento box**, and is trained to use them |
| 11 | **Week of June 13:** Patient attends virtual group curriculum session |
| 12 | **Week of June 20:** Patient attends virtual group curriculum session |
| 13 | **Week of June 27:** Patient attends virtual group curriculum session |
| 14 | **Week of July 11:** Patient attends virtual group curriculum session |
| | **Week of July 4:** No session the week of July 4th |
| 15 | **Week of July 18:** Patient attends virtual group curriculum session |
| 16 | **Week of July 25:** 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 |
| 17 | **Month of August:** Patient attends virtual group curriculum session |
| 18 | **Month of September:** 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 |
| 19 | **Month of October:** Patient attends virtual group curriculum session |
| 20 | **Month of November:** Patient attends in-person group curriculum session |
| | Patient is provided with Patient Care Kit tools and accompanying instruction sheets: **yoga mat**, and is trained to use them |
| 21 | **Month of December:** Patient attends virtual group curriculum session |
| 22 | **Month of January:** Patient attends virtual group curriculum session |
| 23 | **Month of February:** Patient attends virtual group curriculum session |
| 24 | **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: **exercise bands**, and is trained to use them |

# APPENDIX H: PATIENT HANDOUT CURRICULUM SCHEDULE

## My *Healthy Together* Session Schedule

My Lifestyle Coach's name is: _____

I can contact my Lifestyle Coach at: _____

Sessions will take place on _____ at _____

day of the week time

Some sessions are held virtually via Zoom, and some are in-person. In person sessions will be held at:

_____

location

| | Session # | Topic | Date | Virtual or In-Person |
|---|---|---|---|---|
| **Weekly** | 1 | Introduction to the Program | | |
| | 2 | Get Active to Prevent T2 | | |
| | 3 | Track Your Activity | | |
| | 4 | Eat Well to Prevent T2 | | |
| | 5 | Track Your Food | | |
| | 6 | Get More Active | | |
| | 7 | Energy In, Energy Out | | |
| | 8 | Eating to Support Your Health Goals | | |
| | 9 | Manage Stress | | |
| | 10 | Eat Well Away from Home | | |
| | 11 | Managing Triggers | | |
| | 12 | Stay Active to Prevent T2 | | |
| | 13 | Take Charge of Your Thoughts | | |
| | 14 | Get Back on Track | | |
| | 15 | Get Support | | |
| | 16 | Stay Motivated to Prevent T2 | | |
| **Monthly** | 17 | When Weight Loss Stalls | | |
| | 18 | Take a Movement Break | | |
| | 19 | Keep Your Heart Healthy | | |
| | 20 | Shop and Cook to Prevent T2 | | |
| | 21 | Find Time for Physical Activity | | |
| | 22 | Get Enough Sleep | | |
| | 23 | Stay Active Away from Home | | |
| | 24 | Prevent T2 for Life! | | |

# APPENDIX I: 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 make healthy lifestyle changes, including healthy eating, exercise, dealing with stress, and lowering your blood sugar! 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. One 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 looking for ways to eat healthier, exercise more, and reduce stress. Sessions will be both virtual and in-person, following the schedule provided. Sessions will occur once a week from (month, year) through (month, year) and then once a month from (month, year) through (month, year).
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, water bottle, bento box
    - August: Pulse oximeter
    - October: Blood pressure monitor
    - December: Food or exercise related tools to support a healthy lifestyle
    - March: Close Out Visit: Item to celebrate your success!

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

### 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.

### 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 join the virtual sessions by phone OR by internet. Access to a device, including a smartphone, tablet, or computer, may be helpful but is not required.
- Sign a Patient Participation Agreement.

## PATIENT INFORMATION SHEET continued

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)

# APPENDIX J: PATIENT PARTICIPATION AGREEMENT

I agree to participate in the *Healthy Together* program until (month, year).

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 both in-person and virtual, following the schedule provided. Sessions will occur once a week from (month, year) through (month, year) and then once a month from (month, year) through (month, year).
- Attend make-up sessions (scheduled in the same week) if I cannot attend a regular session.
- 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 or the *Healthy Together* wellness tracker |
| 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 _____.
- 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, I understand that I am required to return the tools to the health center.

- ☐ 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 PARTICIPATION AGREEMENT continued

| | |
|---|---|
| Patient Name (print): | |
| Patient Signature: | |
| Date: | |

For patients with diabetes:

| | |
|---|---|
| Provider Signature: | |
| Date: | |

# APPENDIX K: PARTICIPANT QUESTIONNAIRE

| | |
|---|---|
| Health Center Name: | |
| Wellocity Patient ID Number: | |

**Participant to Complete: (Lifestyle Coach may assist)**

1. During the past two weeks, have you been bothered by litle 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

3. (Men only, women may skip to next question) How many times in the past year have you had 5 or more drinks in a day?

- ☐ None
- ☐ 1 or more

4. (Women only, men may skip to next question) How many times in the past year have you had 4 or more drinks in a day?

- ☐ None
- ☐ 1 or more

5. How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?

- ☐ None
- ☐ 1 or more

6. What is the highest level of school that you have finished?

- ☐ Less than high school degree
- ☐ High school diploma or GED
- ☐ More than high school
- ☐ I choose not to answer this question

## PARTICIPANT QUESTIONNAIRE continued

7. What is your current work situation?

- ☐ Unemployed
- ☐ Part-time or temporary work
- ☐ Full-time work
- ☐ Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver)

  Please describe: _____

- ☐ I choose not to answer this question

8. 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.

- ☐ Food
- ☐ Clothing
- ☐ Utilities
- ☐ Childcare
- ☐ Medicine or any other health care (medical, dental, mental health, vision)
- ☐ Phone
- ☐ Other (please describe) _____
- ☐ I choose not to answer this question

9. 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.

- ☐ Yes, it has kept me from medical appointments
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- ☐ No
- ☐ I choose not to answer this question

10. 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).

- ☐ Less than once a week
- ☐ 1 or 2 times a week
- ☐ 3 to 5 times a week
- ☐ 5 or more times a week
- ☐ I choose not to answer this question

11. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

- ☐ Not at all
- ☐ A litle bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much
- ☐ I choose not to answer this question

## PARTICIPANT QUESTIONNAIRE continued

12. Do you feel physically and emotionally safe where you currently live?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I choose not to answer this question

13. In the past year, have you been afraid of your partner or ex-partner?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I choose not to answer this question

14. In general, how would you rate your overall health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

15. Do you feel confident in your day-to-day ability to manage your blood sugar?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

16. How likely are you to recommend this health center to your family and friends?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

**POST-PROGRAM ONLY:**

17. Did the Healthy Together program meet your expectations?

- ☐ Yes, about what I expected
- ☐ Yes, more than I expected
- ☐ No, not quite what I expected

## PARTICIPANT QUESTIONNAIRE continued

18. How confident do you feel about maintaining the skills you have learned during the *Healthy Together* program?

- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident

19. Would you recommend this *Healthy Together* program to your family or friends who could benefit from this type of lifestyle coaching?

- ☐ Yes
- ☐ No
- ☐ Unsure

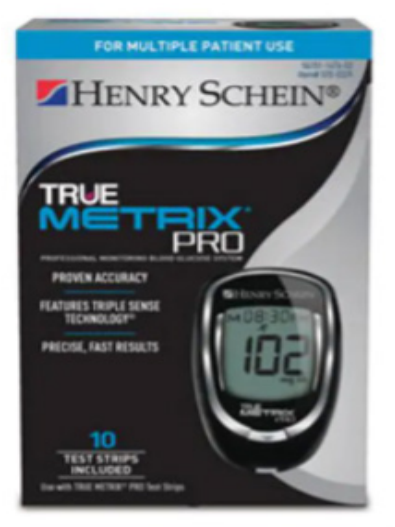
20. What was your favorite part of the *Healthy Together* program?

_____

20. If you could change one part of the *Healthy Together* program, what would it be?

_____

# APPENDIX L: 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)


BLOOD GLUCOSE METER PATIENT INSTRUCTIONS — ENGLISH | SPANISH

## 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.

APPENDIX L

# TEMPERATURE MONITORING: HENRY SCHEIN DIGITAL THERMOMETER


## Why is it Important to Check My Temperature?

A fever is a temperature higher than 100.4⁰F. 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.

## Patient Care Kit Item

Your Kit includes one (1) Henry Schein Thermometer.

## 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.

DIGITAL THERMOMETER PATIENT INSTRUCTIONS — ENGLISH | SPANISH

# BLOOD OXYGEN MONITORING: AMERICAN DIAGNOSTIC CORP. FINGERTIP PULSE OXIMETER

## Why is it Important to Check My Blood Oxygen Saturation?

Oxygen saturation gives information about the amount of oxygen carried in the blood without having to draw a blood sample.

When monitoring oxygen levels at home, pay attention to other signs or symptoms of low oxygen levels, such as:
- Bluish coloring in the face, lips, or nails
- Shortness of breath
- Difficulty breathing, or a cough that gets worse
- Restlessness and discomfort
- Chest pain or tightness
- Fast or racing pulse rate


## Patient Care Kit Item

Your Kit includes one (1) American Diagnostic Corp. Fingertip Pulse Oximeter with lanyard.

## Instructions

- ✔ Remove any fingernail polish on the finger that will be used.
- ✔ Place the oximeter on your finger; make sure your hand is at room temperature, relaxed, and held below the level of the heart.
- ✔ Place the oximeter on your finger, fingernail side up.
- ✔ Sit still and do not move the part of your body where the pulse oximeter is located.
- ✔ Wait a few seconds until the reading stops changing and displays one steady number.
- ✔ Write down your oxygen levels with the date and time of the reading so you can easily track changes and report these to your health care provider.

Understanding your reading:

Your pulse oximeter will show two numbers. The most important number, oxygen saturation level, is abbreviated SpO2, and is presented as a percentage. The pulse rate (similar to heart rate) is abbreviated PR. Oxygen saturation values are between 95% and 100% for most healthy individuals, but sometimes can be lower in people with lung problems.

**If you are concerned about the pulse oximeter reading, or if your symptoms are serious or getting worse, contact your health care provider.**

# 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.

WEIGHT MANAGEMENT PATIENT INSTRUCTIONS — ENGLISH | SPANISH

# 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.

# APPENDIX M: 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 |
| Weight ☐ pounds | Weight ☐ pounds | Weight ☐ pounds | Weight ☐ pounds | Weight ☐ pounds | Weight ☐ pounds | Weight ☐ pounds |
| 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** TIME: ITEM AMOUNT CAL | **BREAKFAST** TIME: ITEM AMOUNT CAL | **BREAKFAST** TIME: ITEM AMOUNT CAL | **BREAKFAST** TIME: ITEM AMOUNT CAL | **BREAKFAST** TIME: ITEM AMOUNT CAL | **BREAKFAST** TIME: ITEM AMOUNT CAL | **BREAKFAST** TIME: ITEM AMOUNT CAL |
| **LUNCH** TIME: ITEM AMOUNT CAL | **LUNCH** TIME: ITEM AMOUNT CAL | **LUNCH** TIME: ITEM AMOUNT CAL | **LUNCH** TIME: ITEM AMOUNT CAL | **LUNCH** TIME: ITEM AMOUNT CAL | **LUNCH** TIME: ITEM AMOUNT CAL | **LUNCH** TIME: ITEM AMOUNT CAL |
| **DINNER** TIME: ITEM AMOUNT CAL | **DINNER** TIME: ITEM AMOUNT CAL | **DINNER** TIME: ITEM AMOUNT CAL | **DINNER** TIME: ITEM AMOUNT CAL | **DINNER** TIME: ITEM AMOUNT CAL | **DINNER** TIME: ITEM AMOUNT CAL | **DINNER** TIME: ITEM AMOUNT CAL |
| **SNACK** TIME: ITEM AMOUNT CAL | **SNACK** TIME: ITEM AMOUNT CAL | **SNACK** TIME: ITEM AMOUNT CAL | **SNACK** TIME: ITEM AMOUNT CAL | **SNACK** TIME: ITEM AMOUNT CAL | **SNACK** TIME: ITEM AMOUNT CAL | **SNACK** TIME: ITEM AMOUNT CAL |

WEEKLY WELLNESS TRACKER — ENGLISH | SPANISH

# Healthy Together

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This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $6,625,000 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.