Type 2 Diabetes (T2D) LHIP Workgroup Logic Model

(07/01/2022)

Vision Statement: Frederick County is a healthy community that provides access to healthy lifestyles for all residents and supports all people living with or at risk for diabetes.

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The future prosperity of our community depends on having healthy residents. Data is not available on the prevalence of prediabetes or diabetes in youth. Many residents find it difficult to maintain a healthy lifestyle including healthy food choices, physical activity, & stress management. Screening and referrals of high risk residents to primary care providers for diabetes evaluation & diagnosis then allows for tx/ mgmt of condition to prevents or slow disease progression.	Direct: Frederick County residents overall and Priority populations: Seniors -African Am./Black, -Hispanic/Latinos -Asian Americans -Youth/ adolescents -Other disparity groups -Census tracts with high social vulnerability index -Zip codes identified as	Community and agency champions (i.e., partners orgs, FBOs, CHWs, Bridges Lay Leaders, Trusted community leaders)	**A-Hold listening sessions for community members** in priority populations– what does community say would be help them prevent & better manage diabetes? What are the SDOH barriers & possible solutions?	# listening sessions and report on feedback gathered	Increased linkages with community partners that build leadership, support referrals, and help design interventions Increase public awareness and understanding of T2D risk factors & severity of complications if undiagnosed/ untreated Increase understanding of importance of healthy blood glucose management Increase # of people who engage in risk assessments and/or are screened (with follow-up) for	Increase # people who maintain/reduce unhealthy BMI through healthy food and physical activity environments (primary prevention) Increase # of people diagnosed with prediabetes/diabetes who are being effectively managed (as evidenced by a decrease in # of ED/hospital visits) to help prevent complications and burden (intervention) Increase % of seniors connected to diabetes lifestyle mgmt programs who improve health outcomes
		Strong community partnerships, such as FCPS, FCHD, FCPS, FCPL, YMCA, Dept Senior Services, FCHCC, Diabetes LHIP Workgroup	**A-Brief partner organizations** that serve priority populations on Workgroup goals & **gather feedback** on how to best design promotions & programs and connect with the community.	# briefings for CBOs and report on feedback gathered		
		Educational/ promotional materials (culturally/ language	**A-Provide public with education** on risk factors for diabetes & prediabetes and how to decrease risk; include how COVID increases risk for developing diabetes &	# events # flyers distributed		

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Some residents do not have a primary care provider. Some providers are not adequately screening patients for prediabetes. Providers often lack the knowledge/tools/time/ capacity to refer patients with prediabetes/diabetes to local lifestyle change programs & other local supports. SDOH barriers must be identified and solutions wrapped into programs in order to improve health outcomes. Residents with untreated depression will find it more	diabetes hotspots -ALICE/low income <u>Indirect:</u> -Primary care providers -CHWs -CBOs -Faith-based orgs -Major Employers	appropriate & utilize health literacy best practices) ADA, CDC, and FH educational materials	increases risk of complications in those with diabetes		prediabetes & T2D to support early detection Increase % seniors and caregivers that know their risk for diabetes. Increase % of families and high risk individuals connected to primary care providers (regardless of insurance status) Increase % people with prediabetes connected to lifestyle change programs (regardless of insurance status). Increased # of healthy food options	Increase % FCPS students reporting healthy food choices (YRBS-next reporting cycle) Increase % FCPS students reporting higher levels of physical activity (YRBS-next reporting cycle) All residents have access to transportation for PCP visits, pharmacy, healthy grocery store All residents get 150 minutes of physical activity per week.
		Medical diabetes management for uninsured/ underinsured: -FH Center for Diabetes & Nutrition -Mission of Mercy -City FQHC -FH CARE Clinic	**A-Connect with provider practices** to provide educational materials & info on referrals to lifestyle changes programs	# of providers trained/given info on local lifestyle change programs/ resources		
		Community partners Alignment with partnership grant for low income senior	**A/P-Host or participate in community events** to conduct screening & education/resource navigation (i.e., fall health fair, joint event with ADA) A/P-Conduct diabetes risk test & A1c screenings in high priority groups	# of community events and # attendees # of people screened with risk test (including # in priority populations, # screened in languages other than English)		

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difficult to prevent or manage their diabetes. Resources are lacking (print, electronic, etc) that meet the needs of the population from a health literacy and/or cultural competent perspective. Price transparency is not readily available for services, medications, etc. There is a knowledge gap regarding available financial supports for individuals with financial barriers. Scheduling a new patient appointment with an endocrinologist may take weeks or months.		service coordination	A/P – Connect residents without PCP to a primary care provider	# of positive screens #screened for depression # referred to primary care/medical provider # referred to lifestyle change program	for FCPS school meals Increase % FCPS students reporting healthy food choices (YRBS-next release) Increase % FCPS students reporting higher levels of physical activity (YRBS-next release) Increased % FC residents who have access to transportation for PCP visits, pharmacy, healthy grocery store Reduction in care gaps associated with diabetes in targeted populations.	All FC residents have access to green spaces and exercise opportunities
		Local lifestyle change programs (DPP, DSMT, DSMP, DWD)	P-Increase capacity of local lifestyle change programs (i.e., DPP, DSMP, DSMT?, and DWD) by recruiting and training more leaders/coaches and other program expansion activities.	# of new coaches trained # of new workshops offered		
			P-Increase recruitment and retention in lifestyle change programs (DPP, DSMP, DWD, DSMT?) by focusing on priority populations and SDOH screenings with wrap around services	# referred, # enrolled, # completed		
		FCPS School Health Council	A-Conduct **more promotions of 5210 healthy lifestyle campaign** in FCPS and for the general public	# promotions/ wellness challenges and # of participants		

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		5210 Program & LiveWell Frederick	A-Conduct **other healthy eating/physical activity challenges for youth** using social media/Instagram with prize incentives **I-Partner with FCPS** to advocate for healthier food choices for school meals	# meetings with policy makers?	Increased # people knowledgeable of healthy food prep Increase opportunities available for safe physical activity in the community (ie, beginner 5Ks with giveaways) % increase of residents that get at least 150 minutes physical activity per week. Increased % FC residents have access to green spaces and exercise opportunities	
		Ride United program (United Way) Ausherman Family Foundation local transportation committee	A-Awareness campaign to address **transportation barriers** to healthy lifestyle for residents without access to a vehicle (ie, transportation to doctors visits, grocery store, safe areas for physical activities)	# residents educated on low-cost transportation options		
			A-Develop central T2D information hub/website with resources for patients & providers (i.e., LiveWell Frederick website &/or new Coalition website); possibly develop an app for easy phone access.	Tracking analytics		
		Chamber of Commerce members	A-Conduct workshops/outreach to **local employers** to encourage them to provide	# employer workshops # employees screened		

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			incentives for employee screening & appropriate follow-up.			
			A-Conduct **training on motivational interviewing** for CHWs, healthcare providers, partners	# trained		
			A-Conduct training on depression screening and resource navigation (i.e., CHWs, lay health educators, counselors, pastors)	# trained on how to do depression screening # trained on resource navigation		
			P/I-Develop/implement a closed loop referral system for medical care and referrals to local diabetes programs & resources	TBD		
			P-Conduct lifestyle change programs (DPP, DSMP, and DWD) in the neighborhoods of priority populations/high risk areas	# workshops # participants		
		UME Grocery store tours	TI-Conduct **healthy cooking/ meal prep classes** for families, including kid-friendly recipes	# classes # participants		

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		Love for Lochlin healthy food prep program SHARE Food Network (thru FH): low cost healthy groceries Frederick Food Security Network (Hood); community gardens & food distribution)	TI-Provide **education on healthy eating and cooking on a budget** (how to modify common recipes; grocery store tours) **TI-Programs to increase availability & accessibility of healthy foods** in food deserts. (i.e., community gardens)			
		Dept Parks/Rec, YMCA Local gyms	TI-Conduct **events to promote physical activity**, including for those with disabilities (i.e., beginner 5Ks with giveaways, partner to create neighborhood walking clubs); collaborate with existing local programs; include those with disabilities	# physical activity focused events held # walking clubs created		
		Dept of Parks and Rec	TI-Increase access to green spaces and exercise opportunities.	# of FC residents with increased access to green		

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				spaces and exercise opportunities		

Evaluation/Survey Instruments/Indicators: Diabetes risk test; referral and health outcome/output data from CRISP, shared village, Frederick health patient data, DSMT/DPP/DSMP recruitment/retention/completion records. 2022 Frederick County CHNA Report. Claims data by payer. DPP enrollment status (state has Medicaid data.) Maryland Behavioral Risk Factor Surveillance System (BRFSS) (adults). Maryland Youth Risk Behavior Survey (YRBS) (middle & high school students). MD Vital Statistics (mortality data). Liveable Frederick county plan.

Note: Subgroup Abbreviations are A = awareness; P = prevention; TI = treatment/intervention

(Diabetes LHIP Logic Model-07.05.22)