My Healthy Vermont's

Self-Management Programs

Operations Manual

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Self-Management Programs Overview

My Healthy VT is a series of free health education workshops to help Vermonters prevent and manage chronic conditions like high blood pressure and type 2 diabetes. Each workshop is backed by science and led by facilitators who understand, often firsthand, the needs and struggles of Vermonters living with these conditions.

Workshops are online, simple to join, and designed to help participants make small changes to their day-to-day lives. People who complete these workshops have seen major improvements to their health and wellbeing—from preventing or reversing prediabetes to better managing high blood pressure and type 2 diabetes to just feeling better overall.

The Blueprint for Health and the Vermont Department of Health (VDH), partner together on this comprehensive approach to prevent chronic disease through the statewide delivery of these evidence-based self-management programs.

There are currently 6 self-management programs being offered through My Healthy Vermont:

- Diabetes Prevention Program
- Diabetes Self-Management
- Blood Pressure Management
- Tobacco Cessation
- Chronic Disease Self-Management
- Chronic Pain Self-Management

History: Blueprint obligation and general landscape

Statutory Requirements for Blueprint provision of Self-Management Programming:

- Title 18, Chapter 13, Section 702 c: The Blueprint shall be developed and implemented to further the following principles:
    - (6) Interventions designed to prevent chronic disease and improve outcomes for persons with chronic disease should be maximized, should target specific chronic disease risk factors, and should address changes in individual behavior; the physical, mental, and social environment; and health care policies and systems.
- Title 18, Chapter 13, Section 703 d: The model for care coordination and management shall include the following components:
    - (4) Education for patients on how to manage conditions or diseases, including prevention of disease; programs to modify a patient's behavior; and a method of ensuring compliance of the patient with the recommended behavioral change.

Background:

The Blueprint for Health has offered workshops that help people learn skills to better manage chronic conditions since 2008. Topics have included healthy living with diabetes, diabetes prevention, tobacco cessation, mental health, and emotional well-being, and living with chronic pain. Consistent with its goals, many participants have gained a better understanding of their health

condition, explored their motivations, identified their strengths, and developed plans for achieving their health goals, all with the help and support of coaches and peers. Workshops run from four weeks to 12 months and were all held in person until Covid-19 forced rapid adoption of online offerings.

- Prior to October 1, 2021, the Blueprint grant agreements with the Health Service Areas (HSAs) included funding for a Regional Coordinator (approximately .5 FTE) and program costs (to cover leader stipends, materials, etc.). The Blueprint has previously contracted with outside organizations such as the Community Health Improvement Division of UVMMC and the YMCA to act as statewide administrator of the programs. The Vermont Department of Health has provided further resources to support the programs through marketing, evaluation, and other efforts.

SMP Workshops 101

Diabetes Self-Management Program (DSMP)

This Diabetes Self-Management program was developed by Stanford and adapted by the Self-Management Resource Center (SMRC) for people with Diabetes and focuses on techniques to deal with the symptoms of diabetes as well as the emotional consequences, exercise, nutrition, and working more effectively with health care providers. Healthier Living – Diabetes is a workshop given over two and a half hours, once a week for six weeks (seven weeks with a session zero). Two trained facilitators are required to run this workshop. This workshop can be offered in-person, online, or both.

Facilitator

Facilitators are authorized to lead Self-Management Workshops in Vermont. To become a facilitator, one must attend and pass a specific training and must facilitate at least one workshop within 6 months after training. Regional Coordinators are encouraged to review the "Facilitator Responsibilities" with all potential facilitators to clarify expectations. In addition:

- Facilitator trainings are 4 full days, provided by local Master Trainers. It is recommended, but not required, that facilitators first be trained in Chronic Disease before they may take a cross-training for Diabetes Self-Management.
- Facilitators must be audited by master trainer or peer facilitator in the first year and attend a refresher every two years.
- Recommended facilitator remuneration amount of $475/facilitator for 7 sessions (6 training sessions plus one introductory session "session 0" to assist with technical support and set expectations for the workshop). 2 facilitators required.
- Recommended auditor remuneration amount of $70/session audited.
- Clearance of background check for criminal activity

Facilitator Materials

Regional Coordinators will supply facilitators the following materials, as needed, to use during workshops (I=in-person, R=remote):

- Name tags/tents (I)
- Pens/Markers (I)
- Flip Chart Paper with Sticky Edge (I)
- Clipboard (I)
- Facilitator guide (I/R)
- Folders, participant books and handouts (I/R)
- Extra registration form (I)
- Attendance sheets (I)
- Check with facilitators about preparing homework handouts, etc. (I/R)
- Zoom link and any tech needs for virtual (I/R)

Program Specific Workshops Supplies and Materials

- "Living a Healthy Life with Chronic Conditions – 4th Edition – Kate Lorig, RN, DrPH (and others)
- "Relaxation for Mind and Body" Catherine Regan, PhD and Rick Seidel, PhD

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Diabetes Prevention Program (DPP)

This workshop is based on research by the National Institute of Health and is part of the National Diabetes Prevention Program led by the Centers for Disease Control and Prevention. This workshop is for people at risk for developing type 2 diabetes and informs about the healthy eating and physical activity habits that have been proven to reduce the risk of developing the disease. Each workshop is 12-months and has 16 one-hour weekly sessions that then taper down to monthly sessions for a total of 24 sessions (25 with a session zero). This workshop is facilitated by a trained Lifestyle Coach. This workshop can be offered in-person, online, or both.

This workshop has strict registration criterion. The workshop has two specific goals: Participants lose 5-7% of their body weight and gradually increase their weekly physical activity minutes. People interested in participating in the workshop must be:

- 18 or over and not have been diagnosed with diabetes
- Have a BMI greater than 25
- At risk for or have been diagnosed with Prediabetes, defined as
    - Previous diagnosis of gestational diabetes
    - Fasting Plasma Glucose between 100-125mg/dL
    - 2-hour Plasma Glucose between 140-199mg/dL
    - A1c between 5.7%-6.4%

In absence of blood values, you may qualify participants by using the Risk Score Screening tool (found on program intake forms, on the website, and embedded in the tracking tool).

Anyone not meeting the above criteria may not attend the workshop but may attend as a support person for a registered participant. Interested people who already have a diagnosis of diabetes should be referred to your Diabetes Self-Management Program.

Facilitator

Facilitators (Lifestyle Coaches) are authorized to lead Self-Management Workshops in Vermont. To become a facilitator, one must attend and pass a specific training and must facilitate at least one workshop within 6 months after training. Regional Coordinators are encouraged to review the "Facilitator Responsibilities" with all potential facilitators to clarify expectations. In addition:

- Facilitators must first take online prerequisites and then are trained by attending a two-day (or 4 half day) training and preparing a mock facilitation session presented to the group and the Master Trainer.
- Facilitators must be audited by master trainer or peer facilitator in first year (recommended within the first 8 sessions). Attend a refresher every two years.
- Recommended facilitator remuneration amount of $985/facilitator for the 25 sessions (24 training sessions plus one introductory session "session 0" to assist with technical support and set expectations for the workshop.) 1 facilitator required.
- Recommended Auditor Remuneration Amount of $35/session audited.
- Clearance of background check for criminal activity

Facilitator Materials

- Regional Coordinators will supply facilitators the following materials, as needed, to use during workshops (I=in-person, R=remote):
  - Name tags/tents (I)
  - Pens/Markers (I)
  - Flip Chart Paper with Sticky Edge (I)
  - Clipboard (I)
  - Facilitator log (I/R)
  - Full participant guide (completely at session 0 or weekly) (I/R)
  - Scale (I)
  - Attendance sheets (I)
  - Meeting schedule (I/R)
  - Food and activity trackers (I/R)
  - Projector (if required by facilitator) (I)
  - Zoom link and any tech needs for virtual (I/R)

Program Specific Workshops Supplies and Materials

All participant handouts for core and maintenance session are available in PDF formation for you to print in either black and white or color. All manuals are available on the CDC Diabetes Prevention Program website and are also uploaded on the statewide Self-Management Program e-learning platform Vermont Health Learn.

Blood Pressure Management Workshop

This program is evidence based and follows the guidelines of the Joint National Committee 7 (JNC7). This program is for people 40 years of age or older, with a diagnosis of hypertension. Each workshop is an hour and a half over eight weeks (nine weeks with a session zero) and focuses on understanding hypertension, nutrition for hypertension, physical activity, and stress management. This workshop can be offered in-person, online, or both.

Facilitator

Facilitators are specifically trained as "health coaches." To become a facilitator, one must pass either a clinical or lay facilitator training. Regional Coordinators are encouraged to review the "Facilitator Responsibilities" with all potential facilitators to clarify expectations. In addition:

- Facilitators should be a member of community shared by targeted participants (peer led)
- Clearance of background check for criminal activity
- Demonstrated skill in implementing HCHC sessions
- Agreement to provide at least one workshop per year.
- Recommended facilitator remuneration amount of $475/facilitator for 9 sessions (8 training sessions plus one introductory session "session 0" to assist with technical support and set expectations for the workshop). 1 facilitator required.

Facilitator Materials

- Regional Coordinators will supply facilitators the following materials, as needed, to use during workshops (I=in-person, R=remote):
  - Name tags/tents (I)
  - Pens/Markers (I)
  - Flip Chart Paper with Sticky Edge (I)
  - Clipboard (I)
  - Facilitator manual (I/R)
  - Full participant guide (completely at session 0 or weekly) (I/R)
  - Attendance sheets (I)
  - Meeting schedule (I/R)
  - Blood Pressure Monitors to loan (I/R)
  - Projector (if required by facilitator) (I)
  - Zoom link and any tech needs for virtual (I/R)

Program Specific Workshops Supplies and Materials

All participant handouts for core and maintenance session are available in PDF formation for you to print in either black and white or color. All manuals are available to Regional Coordinators on Vermont Health Learn.

Quit Smoking Workshops

Tobacco cessation programs focus on helping people quit or reduce tobacco use. These workshops are an hour once a week for four to eight weeks (or five to nine weeks with a session zero). These workshops are led by a trained Tobacco Treatment Specialist. This workshop can be offered in-person, online, or both.

These workshops are the in-person arm of 802Quits which also has phone and online support known as Vermont Quit Partners. Clients set their own quit date and are eligible for free Nicotine Replacement Therapy (NRT) when they attend a workshop. Any NRT distributed to Tobacco Cessation Workshop Participants must be tracked in the NRT Tracking Tool as part of the data collection.

- All registered participants should be given a description of cessation medications available, including nicotine replacement gum, patches, and lozenges. Prescription medication like Chantix must be prescribed by a physician. Registrants are eligible for 8 weeks of dual NRT or 16 weeks of single NRT per 6-month period. Registrants may not receive a 2nd NRT shipment without attending a group session. Six months after the first NRT order, the participant is eligible to order additional NRT for a subsequent quit attempt. Those with NRT medical contraindications (active peptic ulcer, myocardial infarction within 2 weeks, serious arrhythmia, serious angina pectoris), or depression will be advised to gain consent to use NRT from their clinical provider. Please note that all TTS's ordering needs to have a secure e-mail in place. Shipments can take up to 10 business days to arrive.

Facilitator

Facilitators are authorized to lead Self-Management Workshops in Vermont. To become a facilitator, one must attend and pass a specific training and must facilitate at least one workshop within 6 months after training. Regional Coordinators are encouraged to review the "Facilitator Responsibilities" with all potential facilitators to clarify expectations. In addition:

- Facilitators must successfully complete a tobacco treatment specialist (TTS) training certified by the Council for Tobacco Treatment Training Programs (Http://ctttp.org/accredited-programs/)
- It is recommended that newly trained facilitators audit other Tobacco Cessation Workshops, as a training exercise.
- Facilitators must be audited by a Master Trainer or peer facilitator every 2 years
- Clearance of background check for criminal activity
- Recommended facilitator remuneration amount of $250/facilitator for each 4-session workshop. 1 facilitator required.
- Recommended Auditor Remuneration Amount of $35/session audited.

Facilitator Materials

- Regional Coordinators will supply facilitators the following materials, as needed, to use during workshops (I=in-person, R=remote):
  - Participant guides (I/R)
  - LCD projector (I)
  - Pens(I)
  - Markers (I)
  - Flip chart paper with sticky edge to hang on wall (I)
  - Zoom links and any tech needs for virtual (R)

Program Specific Workshops Supplies and Materials

The PDF link to the updated Participation Guide can be found on Vermont Health Learn, Resource Hub.

Chronic Disease Self-Management (CDSMP)

This Chronic Disease Self-Management Program was developed by Stanford and adapted by the Self-Management Resource Center (SMRC) focusing on problems that are common to individuals dealing with any chronic condition such as pain management, nutrition, exercise, medication use, emotions, and communicating with health care providers. Healthier Living-Chronic Disease is a workshop given over two and a half hours, once a week for 6 weeks (seven weeks with a session zero). Two trained facilitators are required to run this workshop. This workshop can be offered in-person, online, or both.

Facilitator

- Facilitators are authorized to lead Self-Management Workshops in Vermont. To become a facilitator, one must attend and pass a specific training and must facilitate at least one workshop within 6 months after training. Regional Coordinators are encouraged to review the "Facilitator Responsibilities" with all potential facilitators to clarify expectations. In addition:
  - Facilitators are trained over 4 full days by local master trainers.
  - Facilitators must be audited by Master Trainer in the first year and attend a refresher every two years.
  - Clearance of background check for criminal activity
  - Recommended facilitator remuneration amount of $475/facilitator for 7 sessions (6 training sessions plus one introductory session "session 0" to assist with technical support and set expectations for the workshop). 2 facilitators required.
  - Recommended auditor remuneration amount of $70/session audited.

Facilitator Materials

- Regional Coordinators will supply facilitators the following materials, as needed, to use during workshops (I=in-person, R=remote):
  - Name tags/tents (I)
  - Pens/Markers (I)
  - Flip Chart Paper with Sticky Edge (I)
  - Clipboard (I)
  - Facilitator guide (I/R)
  - Folders, participant books and handouts (I/R)
  - Extra registration form (I)
  - Attendance sheets (I)
  - Check with facilitators about preparing homework handouts, etc. (I/R)
  - Zoom link and any tech needs for virtual (R)

Program Specific Workshops Supplies and Materials

- "Living a Healthy Life with Chronic Conditions – 4th Edition – Kate Lorig, RN, DrPH (and others)
- "Relaxation for Mind and Body" Catherine Regan, PhD and Rick Seidel, PhD

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Chronic Pain Self-Management (CPSMP)

This Chronic Pain Self-Management Program was developed by Stanford and adapted by the Self-Management Resource Center (SMRC) for people who have either a primary or secondary diagnosis of chronic pain (as defined as lasting for longer than three to six months or lasting longer than the normal healing time of an injury) and focuses on problem solving, appropriate usage of medications and exercise, nutrition, emotions and communicating with health care providers. Healthier Living _ Chronic Pain is a workshop given over two and a half hours, once a week for six weeks (seven weeks with a session 0). Two trained facilitators are required to run this workshop.

Facilitator

- Facilitators are authorized to lead Self-Management Workshops in Vermont. To become a facilitator, one must attend and pass a specific training and must facilitate at least one workshop within 6 months after training. Regional Coordinators are encouraged to review the "Facilitator Responsibilities" with all potential facilitators to clarify expectations. In addition:
    - Facilitators are trained over 4 full days by local master trainers. It is recommended, but not required, that Facilitators first be trained in Chronic Disease before they may take a cross-training for Chronic Pain Self-Management.
    - Facilitators must be audited by Master Trainer in the first year and attend a refresher every two years.
    - Clearance of background check for criminal activity
    - Recommended facilitator remuneration amount of $475/facilitator for 7 sessions (6 training sessions plus one introductory session "session 0" to assist with technical support and set expectations for the workshop). 2 facilitators required.
    - Recommended auditor remuneration amount of $70/session audited.

Facilitator Materials

- Regional Coordinators will supply facilitators the following materials, as needed, to use during workshops (I=in-person, R=remote):
    - Name tags/tents (I)
    - Pens/Markers (I)
    - Flip Chart Paper with Sticky Edge (I)
    - Clipboard (I)
    - Facilitator guide (I/R)
    - Folders, participant books and handouts (I/R)
    - Extra registration form (I)
    - Attendance sheets (I/R)
    - Check with facilitators about preparing homework handouts, etc. (I/R)
    - Zoom link and any tech needs for virtual (R)

Program Specific Workshops Supplies and Materials

- "Living a Healthy Life with Chronic Pain" – Sandra LeFort, MN, PhD (and others)
    - They offer quantity discounts for orders, ideally plan for how many workshops you will be holding, plan on 15 participants per workshop, and order accordingly. Order info:
- "Relaxation for Mind and Body" Catherine Regan, PhD and Rick Seidel, PhD

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Regional Coordinators Responsibilities

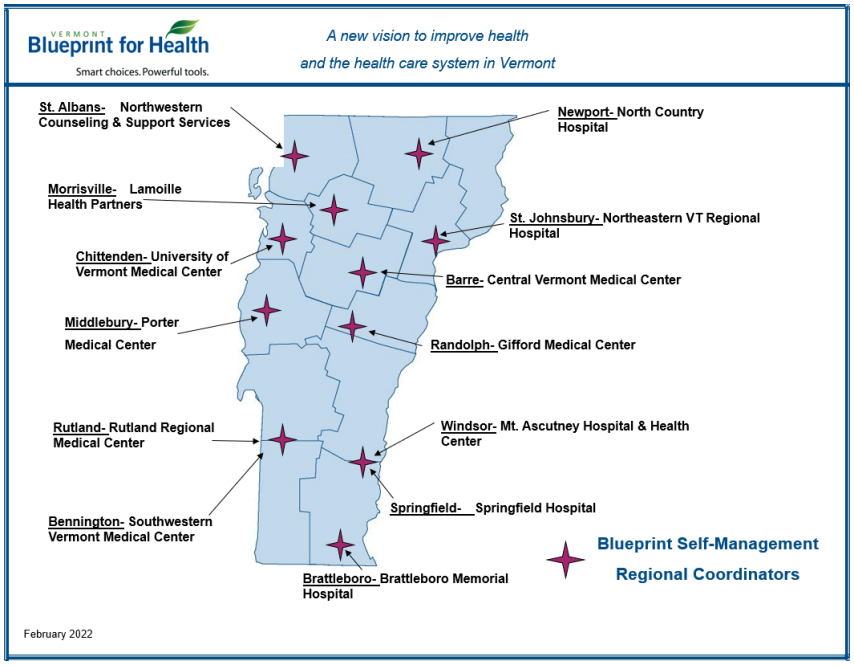
Statewide Landscape/Regional Coordinator Map

There are 13 health services areas in Vermont that are covered by 10 self-management regional coordinators. The Vermont Department of Health provides program administration and oversite.

We know in Vermont that 3 behaviors; low physical activity, poor diet, and tobacco use lead to 4 diseases; cancer, heart disease and stroke, type 2 diabetes, and lung disease which result in 50% of Vermont Deaths. As a result, the Agency of Human Services has provided funds to the State of Vermont Blueprint for Health, which in turn funds the Regional Coordinators positions. The Blueprint for Health's mission is connecting Vermonters with whole-person care that is evidence-based, patient- and family-centered, and cost-effective. Regional Coordinators focus their work of addressing chronic disease through the implementation of My Healthy VT self-management programs with administrative oversite from the Vermont Department of Health.

Regional coordinators help address these chronic conditions by:

- Fostering connections with local providers and community organizations to raise awareness of Self-Management Programs
- Utilizing Electronic Health Record or provider partnerships to target outreach to at-risk individuals
- Recruiting and tracking workshop facilitators and ensuring training benchmarks are met
- Scheduling, promoting, and managing logistics for successful workshop implementation
- Collecting registration, participation, demographic, and biometric data and working with the Health Data Administrator at VDH to ensure correct and timely entry into the data repository
- Marketing by acting as brand and program ambassadors for My Healthy Vermont



Regional Coordinator Job Description Template

Job Title: Regional Coordinator

Position Summary: It is the role of the regional coordinator to address chronic disease prevention and management through the implementation of My Healthy VT self-management programs. The Regional Coordinator will conduct program outreach, expand program availability, and participate in progress and data reporting.

Pay Scale: To align with organization's standards for similar education, experience, and responsibilities.

Essential Functions:

- The Regional Coordinator will submit data and grant reports to the State quarterly.
- The Regional Coordinator will attend monthly meetings hosted by the state, 2 per-quarter virtually, and 1 per quarter in-person as circumstances allow. The Regional Coordinator will participate in these monthly meetings by contributing to discussion, and the development of the agenda, as appropriate.
- The Regional Coordinator will establish a current list of active self-management program trained facilitators covering the HSA(s) and maintain the list by updating as changes occur through the training of new facilitators or the separation of current facilitators. The Regional Coordinator will report these changes to the State quarterly. The Regional Coordinator will work with their agency to obtain criminal background checks for all Facilitators.
- The Regional Coordinator will conduct community outreach, including outreach to healthcare providers (e.g. physicians, physician's assistants, nurse practitioners, pharmacists, etc.), extended care providers (e.g. nurses, technicians, community health workers, etc.), and patients to increase visibility of and referral to My Healthy VT self-management programs, as well as generally support the My Healthy VT brand.
- The Regional Coordinator must participate in at least one of three MHVT Diabetes Coalition workgroups.
- The Regional Coordinator will offer a continuous schedule of the My Healthy VT Diabetes Prevention Program, Diabetes Self-Management Program, Blood Pressure Management Program, and Group Tobacco Cessation Program.
- A set number workshops, to be determined by each HSA grant, will be scheduled annually. In addition, the Regional Coordinator may offer other available My Healthy VT programs (such as Healthier Living with Chronic Conditions, and Healthier Living with Chronic Pain) as demand and availability allow. Implementation must be done in alignment with the Self-Management Operating Manual. Implementation includes:
    - Scheduling
    - Recruitment of trainer and participants
    - Assisting with registration
    - Data collection (registration/demographic/programmatic/outcome) and submission
    - Utilization of platforms and modalities (Vermont Health Learn/in-person/hybrid) to meet participant demand
    - Supply learning materials and host programs
- The Regional Coordinator will participate in State-led evaluation efforts, including quarterly (maximum) interviews, conducted by Professional Data Analysis (PDA) and inform continuous quality improvement efforts by reporting on selected performance measures.

Job Requirements:

- Ability to demonstrate cultural competence through mutual respect, understanding and effective communication with people across cultures, races and ethnicities, ranges of ability, and gender identities, while honoring their lived experiences and perspectives.
- Proven experience with health promotion, health education, health administration, nutrition, or self-management or other health management programs.
- Proven ability to work with individuals and groups
- Demonstrate thorough understanding of social determinants of health, and a commitment to social justice, diversity, equity, inclusion, and accessibility.
- Ability to work independently and meet stated goals
- Be a role model for excellent and culturally responsive customer service and communication
- Adhere to ethical and professional standards of [insert employer agency here]
- Adhere to HIPAA confidentiality regulations
- Perform with tact, diplomacy, and professionalism at all times, while leading with humility and cultural sensitivity during interactions with participants, providers, and Community Health Team members
- This position includes in-person visitation to various locations within the region, means of private transportation is preferred

Education:

- High School diploma (required)
- Some college education/ Associate Degree (preferred)

Experience:

- Experience with Coordination of self-management programs (preferred)
- Administrative experience
- At least two years working in a related healthcare and/or wellness position
- Communications/Marketing experience (preferred)

Knowledge, Skills, and Abilities:

- Strong written and verbal communication skills
- Strong sense of organizational commitment, customer orientation, performance focus, and self-management
- Proficiency in Microsoft Office applications such as Outlook, Excel, and Word required
- Proficiency in Web meeting platforms such as Zoom, Microsoft Teams, Skype, Google Meets, etc.

Physical Demands:

- Ability to travel to multiple community sites in one day
- Ability to enter information into a computer understanding the task will require sitting for extended periods of time. Sedentary work with occasional walking or standing
- Repetitive motions of the wrist, hand, and/or fingertips
- Stooping, kneeling, reaching, pushing, pulling, and lifting up to 10 pounds

Facilitator Responsibilities

Role of the facilitator: facilitators implement MyHealthyVT.org workshops utilizing approved evidence-based curriculum designed for effective lifestyle change and provide support and guidance to participants in the workshop.

Responsibilities of the facilitator:

- Delivering the MyHealthyVT.org workshops and adhering to the approved curriculum with the required intensity and duration, to workshop participants in an effective, meaningful, compelling, and respectful way.

- Encouraging group or individual participation and interaction using open-ended questions and facilitating commitment to activities for effective lifestyle change

- Motivating participants and creating a friendly and interactive environment for group discussion or interactive learning, whether in-person or online

- Making learning a shared objective and encouraging peer-to-peer learning

- Preparing for each workshop by reviewing the lesson plan and workshop content, reviewing data, making reminder calls, or sending messages to participants, and reviewing participants' food and activity trackers when applicable

- Being accessible to participants both before and after sessions to answer questions

- Recording, entering, and submitting session data elements for each participant as required

- As able or requested, make-up sessions can be provided before or after workshop, or via phone/webinar for any missed sessions

- Supporting and encouraging goal setting and problem solving

- Collaborating with the Regional Coordinator and others involved in data preparation to regularly monitor participant progress and address any issues to improve participant outcomes

- Complying with all applicable laws and regulations, including those governing participant privacy and data security (e.g., the Health Insurance Portability and Accountability Act [HIPAA])

- Completing the required organizational trainings, refresher, or new skills trainings

- Participating in workshop audits as required.

HIPAA Compliance

It is the responsibility of each HSA grantee to ensure that their Regional Coordinator has received adequate HIPAA training. It is the responsibility of each Regional Coordinator to ensure that all trained facilitators have also received adequate HIPAA training. The following is provided as a basic overview but does not constitute adequate training.

General Overview:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. (https://www.cdc.gov/phlp/publications/topic/hipaa.html)

The HIPAA Privacy Rule

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other individually identifiable health information (collectively defined as "protected health information") and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of protected health information and sets limits and conditions on the uses and disclosures that may be made of such information without an individual's authorization. The Rule also gives individuals rights over their protected health information, including rights to examine and obtain a copy of their health records, to direct a covered entity to transmit to a third party an electronic copy of their protected health information in an electronic health record, and to request corrections.

The Privacy Rule is located at 45 CFR Part 160 and Subparts A and E of Part 164.

The Security Rule

The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

The Security Rule is located at 45 CFR Part 160 and Subparts A and C of Part 164.

Best Practices

- Keep all HIPAA protected health information, like that found on the SMP registration forms, in a locked filing cabinet, or secured network folder.
- If there is participant specific information, such as name, address, e-mail, workshop registration etc. that needs to be shared between RC and Facilitator only send via secure encrypted e-mail.

Performance Measures, Reporting, and Administrative Structure

The Agency of Human Services Central Office Blueprint for Health Team, through an MOU, is now collaborating with the Vermont Department of Health (VDH) in offering statewide Self-Management Programs. VDH will provide administrative oversite of Self-Management Programs (SMPs) while the Blueprint will provide consultation including sharing subject matter expertise regarding health care systems and policies. VDH is granting funding to HSAs to address chronic disease prevention and management through the implementation of My Healthy Vermont SMPs. The regional HSA grantees will conduct program outreach, expand program availability, and participate in data pathways to ensure a continuous flow of data needed to execute and inform program offerings.

Performance Measures, Reporting, and Grant Guidance

Performance Measures: This section is directly drawn from the Self-Management Program Grant language and will be updated with each annual grant renewal.

The work conducted under this agreement will help decrease the burden of diabetes, heart disease and stroke, and related risk factors with the following strategies in mind:

- Implement systems to facilitate systemic referral of adults with hypertension and/or high blood cholesterol to community programs/resources
- Improve access to and participation in ADA-recognized/AADE-accredited DSMES programs in underserved areas
- Assist health care organizations in implementing systems to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs for Type 2 diabetes prevention
- Implement strategies to increase enrollment in CDC-recognized lifestyle change programs

Performance Measures- first step- update data to establish baseline, second step- establish goals

- # of Vermonters with diabetes who complete a Diabetes Management Workshop
- # of Vermonters at risk for diabetes who complete the Diabetes Prevention Program
- # of Health Service Areas that offer Diabetes Prevention Program workshops
- # of Vermonters with hypertension who complete a blood pressure self-management workshop
- # of Vermonters who participate in Tobacco Cessation

The adequacy of performance measures will be continuously evaluated, in-part, using the Vermont Department of Health, Heart Disease and Diabetes Program indicators:

- Indicators
    - % of adults with diagnosed diabetes who had diabetes education
    - % of adults with diagnosed prediabetes meeting aerobic physical activity guidelines
    - % of adults with hypertension
    - Stroke death rate per 100,000 Vermonters
    - Coronary Heart Disease death rate per 100,000 Vermonters

- Maintaining or decreasing the CVD death rate per 100,000 Vermonters as outlined in Healthy Vermonters 2020 (current rate 114.5/100,000)
- Maintaining or decreasing the stroke death rate per 100,000 Vermonters as outlined in Healthy People 2020 (current rate 31.3/100,000)
- Maintaining or decreasing the incidence of End Stage Renal Disease incidence (ESRD) as outlined in Healthy Vermonters 2020 (current incidence 178.8/million).

Data Sources include:

- MyHealthyVT Performance Dashboard › Overview (google.com)
- https://www.healthvermont.gov/sites/default/files/documents/pdf/HS_1305_Data_Pages_081816.pdf
- Diabetes & Chronic Kidney Disease (clearimpact.com)
- Heart Disease & Stroke (clearimpact.com)

Reporting Guidance

Deliverable	Required submissions
Deliverable 1: Financial Reports	Financial Report – must include: • Subtotals for each category (template provided to use or just for reference) • No more than 10% (**of direct costs**) in indirect costs per quarter • Copies of invoices for any subcontract work or payments to external workshop facilitators • Signature and date Invoice – must include: • grantee name • grant number • invoice date • reporting period • total • deliverables listed • template provided for use or reference
Deliverable 2: Monthly Regional Coordinator Meeting Report	This is now fully embedded in the Grant Deliverables Reporting Form
Deliverable 3: Facilitator/Facilitator Data Report	Please make sure to add both new trained facilitators and remove those who are no longer active or able to lead new workshops. Many HSAs list people who have changed roles and are no longer be able or willing to lead. Please ask RCs to connect with any facilitator whose status is unclear.
Deliverable 4: My Healthy VT Program Outreach and Promotion Report	Submit a sample/screenshot of outreach that was used during the reporting period such as Facebook or Front Porch Forum posts, fliers, posters, etc. If no examples were used, please submit a paragraph describing alternative efforts.
Deliverable 5: Program Implementation and Data Report	Submit data on any MyHealthyVT workshops in your HSA with sessions falling within the previous quarter, including participant data/completers/etc. Please feel free to send that data in any format, or direct questions to Elizabeth.lang@vermont.gov.
Deliverable 6: Ongoing Evaluation Report	This is to report time spent working with the evaluators from PDA, there will most likely be nothing to report for Q2.

Financial Reporting Template

APPENDIX II

FINANCIAL REPORT TEMPLATE

Grantee Name: _____ Grant #: _____

Report for period beginning: _____ and ending: _____

Expense	Budget	Less: Period 1 Expenses	Less: Period 2 Expenses	Less: Period 3 Expenses	Less: Period 4 Expenses	Remaining Balance
Personnel						
Salaries	0.00	0.00	0.00	0.00	0.00	0.00
Fringe	0.00	0.00	0.00	0.00	0.00	0.00
Total Personnel Costs	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Non Personnel						
Contracts/Sub-Awards	0.00	0.00	0.00	0.00	0.00	0.00
Advertising	0.00	0.00	0.00	0.00	0.00	0.00
Education/Training	0.00	0.00	0.00	0.00	0.00	0.00
Equipment	0.00	0.00	0.00	0.00	0.00	0.00
Incentives/Promotional	0.00	0.00	0.00	0.00	0.00	0.00
Postage	0.00	0.00	0.00	0.00	0.00	0.00
Printing	0.00	0.00	0.00	0.00	0.00	0.00
Supplies/Materials	0.00	0.00	0.00	0.00	0.00	0.00
Travel	0.00	0.00	0.00	0.00	0.00	0.00
Total Non-Personnel Costs	0.00	0.00	0.00	0.00	0.00	0.00
Total Direct Costs (Total Personnel + Total Non-Personnel)	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Indirect Costs (@ 10% direct costs)	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL BUDGET	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Authorized Signature: _____ **Date:** _____

Invoice Template

Organization Name:

Street Address (PO box):

City, State, Zip:

Date:

Grant #:

Bill to:
Vermont Department of Health
Division of Health Promotion and Disease Prevention
108 Cherry Street
PO Box 70
Burlington, VT 05402

Melissa.Southwick@vermont.gov

Payment	Reporting Period	Deliverable (s) Due	Due Date	Payment
		Deliverable 1: Financial Reports		
		Deliverable 2: Monthly Regional Coordinator Meeting Report		
		Deliverable 3: Leader/Facilitator Data Report		
		Deliverable 4: My HealthyVT Program Outreach and Promotion Report		
		Deliverable 5: Program Implementation and Data Report		
		Deliverable 6: Ongoing Evaluation Report		
Total				

Signature

Date

Administrative Structure

Vermont Department of Health Contacts:

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Melissa Southwick
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Elizabeth Lang
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Anika Bachofen
Training Coordinator, Support and Services at Home (SASH)
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Diabetes Prevention Coalition

The Diabetes Prevention Coalition was developed in March of 2020 as the StEM (Statewide Engagement group). The purpose of this engagement group was to engage and expand a network of key stakeholders to develop and implement an action plan that builds on the state's strengths and identifies opportunities for scaling and sustaining the National Diabetes Prevention Program. The objective was for stakeholders to have the foundational components of a short-term action plan for one or more of the following: Awareness, Screen/Test/Refer, Coverage, and Availability. The approach was to identify strengths, gaps, and opportunities to engage existing and new partners to coordinate actions to sustain and scale the National Diabetes Prevention Program.

This group of dedicated Vermont Department of Health Staff, Regional Coordinators, providers, and community partners continued to meet bimonthly for the last 2 years. In May of 2022 the group was renamed the Diabetes Prevention Coalition and three new workgroups were developed.

Provider Engagement Workgroup: focusing on increasing provider awareness of, referrals to, and engagement with the Diabetes Prevention Program.

Facilitator Engagement and Education workgroup: focusing on providing support and education to the trained Diabetes Prevention Program facilitators.

Participant Engagement workgroup: focused on improving the participant experiences, from referral to completion of the Diabetes Prevention Program.

Each Regional Coordinator is encouraged to attend the larger bi-monthly Diabetes Prevention Coalition and/or at least one of the workgroups. Regional Coordinators should reach out to the My Healthy Vermont Program Manager to arrange their participation.