Helping Yourself to Health – Vermont’s Self-Management Programs

Regional Coordinator Operations Manual

Vermont Blueprint for Health, in collaboration with the Vermont Department of Health, and The University of Vermont Medical Center, is working to successfully implement evidence-based self-management programs in all Health Service Areas of Vermont in order to improve the overall health of Vermonters. These programs are the Self-Management Resource Center Self-Management Programs: Chronic Disease, workplace Chronic Disease, Chronic Pain and Diabetes; The Vermont Department of Health’s Fresh Start Program; American Lung Association's Not On Tobacco, the Copeland Center Wellness Recovery Action Planning (WRAP) and the CDC’s Prevent T2 Diabetes Prevention Program
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What are Self-Management Programs? An Overview

Self-Management Programs (SMPs)

Self-Management Programs (SMPs) are evidence-based programs that support individuals in learning how to manage and improve their own health by helping them to understand their central role in managing their illness, making informed decisions about care, and choosing to engage in healthy behaviors. Participants have many different health problems, but the peer learning environment lends itself to building a community and safe space for sharing common issues, barriers, and celebrating successes. In addition to the peer leader role-modelling, the group process is highly valued in the workshops, because it can facilitate social connections, reduces isolation, improve coping skills, and helps participants to improve their self-efficacy.

Each self-management workshop is meant to utilize the group process of a supportive peer environment to help participants learn ways to become more active and engaged in their own health. They are facilitated experiences, not taught experiences. With the exception of the Fresh Start program, which allows for a rolling admission process, each of the programs builds upon itself with each session, therefore has a defined start and end date. In addition, the formation of the group dynamic builds over time and the group learns to work together and trust each other by sharing their experiences and stories.

The research behind these evidence-based programs prove that the self-management behaviors gained have positive effects on quality of life and health-related outcomes, including the potential to reduce health care costs. They are congruent with the 3-4-50 campaign, Vermont’s call to action to reduce chronic disease in our state, and RiseVT, which aim to help individuals, employers, schools, childcare providers, and municipalities to provide opportunities to make the healthy choice the easy choice in Vermont.

The Blueprint for Health, Vermont Department of Health (VDH), and UVM Medical Center partner to provide a comprehensive approaching to prevent chronic disease through the statewide delivery of the evidence-based self-management programs. VDH provides subject matter expertise and supports the marketing and training to ensure the programs meet the needs of all Vermonters, no matter their abilities, age, or gender. The Blueprint for Health ensures that each Health Service Area has the funding, training, materials, and technical assistance to implement the evidence-based self-management programs. Together they work to improve and expand the self-management programs by partnering with other organizations (i.e. OneCare VT and SASH) and other Agency of Human Services departments.
Chronic Disease Self-Management (CDSMP) is a Self-Management Resource Center (SMRC) program that focuses 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 six weeks. Two trained facilitators are required to run this workshop.

Workplace Chronic Disease Self-Management (wCDSMP) program is a collaboration between Self-Management Resource Center (SMRC) and the University of Georgia adapted from the six week Chronic Disease Self-Management Program. In addition to focusing on problems common to individuals dealing with any chronic conditions such as pain management, nutrition, exercise, medication use and communicating with health care providers, there is an emphasis on work-life balance and stress management. According to an ongoing program evaluation, wCDSMP participants have reported significantly larger improvements in fatigue, physical activity, soda/sugary beverage consumption, and mental work limitations. Healthier Living – Workplace Chronic Disease workshop is given in one-hour sessions, twice a week, for six weeks. Two trained facilitators are required to run this workshop.

Chronic Pain Self-Management (CPSMP) is a Self-Management Resource Center (SMRC) program 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. Two trained facilitators are required to run this workshop.

Diabetes Self-Management (DSMP) is a Self-Management Resource Center (SMRC) program 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. Two trained facilitators are required to run this workshop.

Fresh Start is an American Cancer Society tobacco cessation program. Tobacco cessation programs focus on helping people quit or reduce tobacco use. These workshops are an hour once a week for either four weeks or six weeks—and can be offered on an ongoing basis, with rolling admission. Participants may join at any time, and, on average, attend four sessions. These workshops are led by a trained Tobacco Treatment Specialist (TTS).

Not-On-Tobacco (NOT) is the American Lung Association’s tobacco cessation program from adolescents, 14-19 years old. It is a 10-week program where for 50 minutes per week participants learn to identify their reasons for using tobacco products (including e-cigarettes and chew), learn healthy alternative to tobacco use, and meet people who will support them through their efforts to quit. These workshops are led by a trained Tobacco Treatment Specialist (TTS).
Wellness Recovery Action Planning (WRAP) was designed in Vermont at the Copeland Center with input from the Vermont Psychiatric Survivors and the Substance Abuse and Mental Health Services Administration. WRAP programs are for anyone who has mental health difficulties or is struggling to incorporate wellness tools and strategies into their lives. These workshops focus on developing action plans, skills for self-management and recovery. The workshop is composed of 24 hours of content, but may be offered in either four 6-hour sessions, six 4-hour sessions or eight 3-hour sessions. Each WRAP workshop is led by two facilitators, one or both of whom are peers in recovery. These workshops can be offered for adults, adolescents, and youth.

CDC’s Diabetes Prevention Program (Prevent T2) 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 program is for people at risk for developing type 2 diabetes and helps them learn about the healthy eating and physical activity habits that have been proven to reduce the risk of developing the disease. Each workshop is a 12-month program that has 16 one-hour weekly sessions tapering down to monthly sessions for a total of 24 sessions. This workshop facilitated by a trained Lifestyle Coach. Starting in the 2018/2019 HSA grant cycle we will be offering this program in-person, online, or both.
Regional Coordinator Responsibilities

The Blueprint Self-Management Regional Coordinator is responsible for:

1. Developing and monitoring an annual Strategic Plan around ensuring the community has access to SMPs. Including, but not limited to:
   - Meeting all grant requirements
   - Using data to inform the growth of self-management programs in their local Health Service Area
   - Building relationships with peer mentor organizations who may provide ongoing peer support groups for participants
   - Coordinating with other agencies to aid in the success of the programs
   - Connecting peer to peer programs for recovery with local health care providers and reform initiatives
   - Educating primary care offices, medical homes and workplaces
   - Engaging the support of Providers and Practices to increase referrals
   - Community outreach to develop strategic partnerships

2. Managing program logistics for all SMPs:
   - Scheduling workshops and requesting workshop IDs using the Wufoo link from the UVM Medical Center (link found on Basecamp)
   - Locating/securing and if necessary paying for the space
   - Facilitate and track participant screening processes
   - Providing supplies to the facilitators such as markers, paper, and course materials
   - Actively recruiting and registering participants, maintaining client records utilizing HIPAA standards
   - Collecting program evaluation materials and providing them to the state in the required format which may include data entry into an electronic system
   - Collecting attendance sheets and securely sending the completed sheets/workbooks to UVM Medical Center

3. Maintain and recruit workshop leaders/facilitators:
   - Ensuring all current facilitators continue to be active/maintain their leader status (by leading 1 workshop/year and participating in refreshers) including paying for travel expenses and tuition to attend leader trainings and refreshers
   - Ensuring that all workshops are led by active facilitators
   - Recruiting new facilitators as needed
   - Ensure facilitators receive necessary HIPAA training in agreement with parent organizations policies
   - Reviewing workshop evaluations with every facilitator or pair following each workshop
   - Arranging facilitator stipends and travel expenses paperwork
   - Coordinating local facilitator meetings
   - Audit local facilitators in workshop for program fidelity on yearly basis
Workshop Logistics and Timelines

A. Location

When you schedule the room it should comfortably fit the number of participants and be accessible for individuals who have a disability. If possible, it should have tables to put in a U-shape with comfortable chairs and contain enough wall space for flip chart paper.

Workshops may be held in various community locations (i.e. hospitals, primary care offices, specialty clinics, libraries, senior centers, etc…) with an emphasis on traveling to the participants—meeting them where it is most convenient for them is an overarching goal of our work.

Holding workshops at a workplace is a frequently-used and effective way to make the program more accessible to participants, and if approached by a worksite or partner organization, make sure it happens!

B. Participant and Leader Materials

Regional Coordinators will ensure that Facilitators have the all the materials they need to give to each participant (suggestion – bring extra copies in case an extra person shows up)

C. Leader Materials

Regional Coordinators will ensure the Facilitators are given the following materials to use to facilitate the workshops (suggestion – Facilitators and Regional Coordinators should communicate to see if they have additional facilitation materials are desired):

For **SMRC Workshops (CDSMP, wCDSMP, DSMP, and CPSMP)**
- Name tags/Name tents
- Pens
- Markers
- Flip Chart Paper with sticky edge to hang on wall (i.e. large Post-it flip chart paper)
- Folders, participant books
- Extra registration forms
- Clipboard
- Leader guide
- Attendance sheets
- Workshop-specific participant handouts:
  - Check with leaders about preparing homework handouts, etc.
  - Workshop specific books – (Living with a Chronic Condition or Living with Pain)

For **CDC Diabetes Prevention Program: Prevent T2:**
- Weekly handouts or full participant guide (some leaders prefer to hand out weekly)
- Program Meeting Schedule
- Food and Activity Trackers
- Scale
- Projector needed for some weeks (check with leader)
Workshop Logistics and Timelines

- Flip Chart Paper with sticky edge to hang on wall (i.e. large Post-it flip chart paper)
- Attendance Sheets
- Lifestyle Coach Log

For **FreshStart**:  
- FreshStart participant guides  
- LCD Projector  
- Pens  
- Markers  
- Flip Chart Paper with sticky edge to hang on wall (i.e. large Post-it flip chart paper)

For **Not On Tobacco**:  
- NOT participant guides  
- LCD Projector  
- Pens  
- Markers  
- Flip Chart Paper with sticky edge to hang on wall (i.e. large Post-it flip chart paper)

For **WRAP**:  
- Pens  
- Markers  
- Flip Chart Paper with sticky edge to hang on wall (i.e. large Post-it flip chart paper)  
- WRAP Book
Workshop Logistics and Timelines

Sample Timeline for planning and preparing a workshop:

<table>
<thead>
<tr>
<th>TO DO</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>1. Determine date</td>
<td>3-6 months prior</td>
</tr>
<tr>
<td>2. Determine location of workshop</td>
<td>3-6 months prior</td>
</tr>
<tr>
<td>3. Determine day of week and time</td>
<td>3-6 months prior</td>
</tr>
<tr>
<td>4. Secure leaders/facilitators</td>
<td>3-6 months prior</td>
</tr>
<tr>
<td>5. Schedule time for two leaders/facilitators to meet (if needed)</td>
<td>3-6 months prior</td>
</tr>
<tr>
<td>6. Begin to advertise workshop and/or panel management</td>
<td>At least 2-3 months prior</td>
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<tr>
<td>7. Be sure to collaborate with community partners for potential referrals (attending community meetings; informing CHT and clinicians of upcoming workshops, etc)</td>
<td>At least 2-3 months prior</td>
</tr>
<tr>
<td>8. Request workshop ID</td>
<td>At least 1 month prior</td>
</tr>
<tr>
<td>9. As registrants begin to sign up be sure to add their information to the most current attendance form/workbook; urge participants to share the workshop with family, friends, etc. ** (for Prevent T2 screening tool must be completed)</td>
<td>ongoing</td>
</tr>
<tr>
<td>10. Start organizing supplies needed and materials; including leader/facilitator supplies</td>
<td>At least 1 month prior</td>
</tr>
<tr>
<td>11. IF NEEDED complete a site visit to be sure room in equipped properly</td>
<td>1 month prior</td>
</tr>
<tr>
<td>12. Reminder calls to registered participants</td>
<td>At least 1 week prior</td>
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<tr>
<td>13. Schedule time to meet with leaders to provide them with attendance sheet &amp; supplies</td>
<td>Prior to beginning of workshop</td>
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Workshop Logistics and Timelines

Program Specific Workshop Supplies and Materials

- **Healthier Living Workshops** (CDSMP, wCDSMP, DSMP, CPSMP)
  Chronic Disease and Diabetes Self-Management Workshops both utilize *Living a Healthy Life with Chronic Conditions* (currently 4th edition) and *Relaxation for Mind and Body*, a relaxation CD.

  Chronic Pain workshops utilize *Living a Healthy Life with Chronic Pain* and *Relaxation for Mind and Body*, a relaxation CD.

- **Tobacco Cessation Workshops**
  These workshops all utilize the FreshStart Participant guide from American Cancer Society. The workshops are the in-person arm of 802Quits (802Quits also has phone and online) support known as Vermont Quit Partners. Clients set their own quit date and are eligible for free NRT when they attend a workshop. **Any NRT distributed to FreshStart Participants must be tracked in the NRT Tracking Tool as part of data collection.**

  - **Nicotine Replacement Therapy**, or NRT, can be an invaluable tool for workshop participants: Upon registration, clients should be given a description of all cessation medications available, which include 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 365-day period. Registrants may NOT receive a 2nd NRT shipment without attending a group session. On day 366, after the first order, the client becomes eligible to order additional NRT for a subsequent quit attempt. Those who have other 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.

  - **NRT Shipping**: In 3/18, a new online NRT order system was launched. Please note that all TTS’s ordering need to have a secure email in place to do so. We cannot set up individuals with gmail, hotmail, yahoo, etc. accounts. Shipments can take up to 10 business days to arrive. Although most deliveries will occur sooner than 10 days, using the 10-day timeframe is a good guideline to ensure that participants get their NRT on time.

  - **Not-On-Tobacco**
    These workshops utilize the N-O-T Participant workbook from the American Lung Association. Individuals who attend will not only focus on quitting smoking cigarettes (and other products, such as e-cigarettes) but develop communication, problem solving, and stress-management skills in order to reduce usage. Participant workbooks, evaluation forms, and flyers can be printed from PDF.

- **WRAP Workshops**
  WRAP workshops are facilitated by peers who are committed to developing and using their own personal action plan developed in the WRAP course they attended. Participants use the Copeland Center specialized WRAP workbook: either traditional
Workshop Logistics and Timelines

WRAP; adolescent; youth; co-occurring mental health and substance abuse, or Veterans. Workbook ordering information is found in the logistics tab of this binder.

- **CDC’s Diabetes Prevention Program – Prevent T2**
  This program is facilitated by peer Lifestyle Coaches and has strict registration criterion. The Prevent T2 Program 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 program must be:
    - Over 18 and not have been diagnosed with diabetes
    - Have a BMI greater or equal to 25
    - At risk for or have been diagnosed with Prediabetes, defined as
      - Previous diagnosis of gestational diabetes
      - Fasting Plasma Glucose between 100 – 125 mg/dL
      - 2-hour (75 gm glucola) Plasma Glucose between 140 - 199 mg/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 register in the program, 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.** Binders/books are needed for each participant. Participant material information is in the Books and Supplies of this binder.
Book/Supply ordering info

CDSMP & Diabetes

“Living a Healthy Life with Chronic Conditions” - 4th Edition - Kate Lorig, RN, DrPH (and others)

Chronic Pain

“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:

Bull Publishing
www.bullpub.com
800-676-2855

Emily Sewell
Emily@bullpub.com
303-545-6354-fax
Workshop Logistics and Timelines

**WRAP**
Say you’re with Blueprint to get further savings. Workbooks available as well. Order Info: [http://wrapandrecoverybooks.com/store/](http://wrapandrecoverybooks.com/store/)

Quantity Pricing for WRAP books
1 - 9 copies: $10.00 each
10 - 99 copies: $8.00 each
100+ copies: $7.00 each
1000+ copies: $6.00 each

**Diabetes Prevention Program: Prevent T2**
All participant handouts for core and maintenance sessions are available in PDF formation for you to print in either black & white or color. All manuals are available on the CDC Prevent T2 website and are also uploaded on the Statewide Self-Management Program Basecamp site: [https://vthealth.basecamphq.com/projects/11837360-vt-blueprint-self-management-regional-coordinators/posts](https://vthealth.basecamphq.com/projects/11837360-vt-blueprint-self-management-regional-coordinators/posts)

**Tobacco Cessation Workshops**
FreshStart Participant Guides can be ordered from American Cancer Society website. We can also request tobacco materials and quit tools from Vermont’s Tobacco Control Group by emailing [tobaccovt@vermont.gov](mailto:tobaccovt@vermont.gov)

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**Request Support Materials**

To request any of the support materials below, please email: tobaccovt@vermont.gov

- Provider Poster
- Patient Poster
- Brochure
- Rack Card
- Rack Card
- Sticker
- Brief Intervention Tool
SMP Faculty Definitions, Trainings and Stipends

Self-Management Program facilitators are committed to providing support and resources to participants working toward making and sustaining positive lifestyle changes. Facilitators should have experience in Motivational Interviewing and demonstrate an understanding of the issues and challenges participants face when trying to make lifestyle changes. All facilitators work in pairs, except for in the Fresh Start, N-O-T and CDC’s Diabetes Prevention Programs which require only one facilitator. Self-Management Resource Center Program facilitators are known as Leaders; all others are referred to as facilitators. If the facilitator or leader is not employed by the sub recipient of the HSA agreement, then the sub recipient will need to complete the subcontractor compliance form with facilitator/leader. Please see the subcontractor form example included in the Appendix for how the form should be completed.

In order to remain certified, ALL Leaders/Facilitators must facilitate at least one workshop every 12 months from date of original training. Any facilitator deemed in need of mentoring must participate in an ongoing mentoring by an Advanced Level Facilitator. (See also: Training and Refreshers section of this binder.)

Leader/Facilitator Responsibilities

- Entering required attendance information into database/attendance sheet
- Maintaining program fidelity
- Providing a welcoming environment for participants to learn and work on self-management skills
- Facilitation the group to set goals, develop actions plans, assign homework, and hold participants to program targets

Prerequisites for Leaders

**Tobacco Treatment Specialist who is a Group Cessation Facilitator:**
Requires attending tobacco treatment specialist (TTS) training certified by the Council for Tobacco Treatment Training Programs ([http://ctttp.org/accredited-programs/](http://ctttp.org/accredited-programs/)). The details and price of the course varies.

**WRAP:**
Introduction to WRAP through a workshop; Copeland Center Correspondence Course or 3-day WRAP seminar 1 Course.

**CDCs Diabetes Prevention Program (Prevent T2):**
Requires 3 online e-learnings and a pre-reading assignment prior to being able to register leader training.

Leader/Facilitation Levels

**A. Ambassador**
Ambassadors help to promote the Self-Management Program Workshops by sharing their experience using the workshops to enhance their own wellness. Ambassadors have an understanding of the program and identify as a peer or a ‘graduate’ of a self-management
SMP Faculty Definitions, Trainings and Stipends

program. Ambassadors do not facilitate workshops.

**B. Facilitator or Leader**
Facilitators or Leaders are authorized to lead Self-Management Workshops in Vermont. In order to become a leader, one must pass a Leader Training and must facilitate at least one workshop within 6 months after training. Regional Coordinators are encouraged to review a job description with all potential Facilitators or Leaders in order to clarify any expectations. An example of a Summary of Responsibilities for Facilitators is included in the Appendix. In addition:

- **Self-Management Resource Center Program** Leaders are trained by local master trainers by attending and successfully completing four full day training sessions. Leaders must first be trained in Chronic Disease before they may take a cross-training for Diabetes or Chronic Pain.

- **CDC’s Diabetes Prevention Program (Prevent T2)** facilitators must first take online prerequisites and then are trained by attending a two day training and preparing a mock facilitation session presented to the group and the Master Trainer.

- **WRAP** facilitators must first attend either a WRAP workshop, the Copeland Center Correspondence Course, or the 3 day intensive Seminar in order to attend the WRAP facilitator training. WRAP Facilitator Training is a 5-day long course.

- **FreshStart & N-O-T** facilitators must take a tobacco treatment specialist (TTS) training certified by the Council for Tobacco Treatment Training Programs (http://ctttp.org/accredited-programs/). After successfully completing TTS training you are qualified to take the FreshStart, only after which you may begin leading tobacco cessation workshops.

**C. WRAP Facilitator Training:**

- **Requirements for certification:** Completion of 5 Practice Elements during the 5 day training. Participation in all group activities and discussions. Attendance for at least 80% of the training. All absences must be communicated to the workshop leaders, if at all possible in advance. At the conclusion of the Facilitator Training, all participants will develop and submit an individual mentoring plan. Instructions for this process will be discussed on Friday afternoon of the training. Participants will be given 6 weeks to develop and submit this mentoring plan. Participant can decide with whom they want to share this mentoring plan. It is highly encouraged that new facilitators co-facilitate with an experienced facilitator who can mentor them during their first WRAP workshop. This facilitator should be current with Refreshers as well.

- Regional Coordinators can ask new facilitators if they would be willing to share their mentoring plan, especially with their co-facilitator. The advanced level Facilitators can act as a resource to help Regional Coordinators decide how to deploy new leaders and meet with new facilitator and co-facilitator to talk about mentoring and mentoring plans to ensure a successful workshop.
SMP Faculty Definitions, Trainings and Stipends

Partnerships (Health Service Areas)
Regional Coordinators are encouraged to partner with neighboring Health Service Areas in order to implement workshops throughout their communities. Regional Coordinators should devise a work plan in order to ensure equal division of resources and workload. It is expected Regional Coordinators will determine which party will submit the workshop ID request form, attendance data and/or workbook data entry to the UVMMC CHI Team in order to prevent duplication. It is expected Facilitators will be aware their contact information will be shared amongst both Regional Coordinators.

Master Trainers
Vermont Master Trainers are authorized to facilitate Self-Management Workshops. In addition, they are authorized to train Leaders and teach refresher in how to facilitate Self-Management Workshops. They are also able to perform leader audits to ensure program fidelity.

Please note that some H.S.A.’s have a master trainer budget line item. The sub recipients of the HSA agreements can use this budget line item to cover the costs of Master Trainers they employ and will not invoice the UVMMC, Community Health Improvement team. H.S.A.’s that do not have a master trainer budget line item will be able to invoice the UVMMC, Community Health Improvement team. Master Trainers that are not employed by the sub recipients of the HSA agreement will be subcontracted as a vendor by the UVMMC, Community Health Improvement team.

Trainings Length for Leaders
Self-Management Resource Programs (CDSMP, DSMP, CPSMP)
  
  - 4 full days. *Please note that once a leader is trained in CDSMP, they may take the 2 day cross training in DSMP or CPSMP. However, you don’t have to begin with CDSMP.*

Tobacco Treatment Specialist Group Cessation Facilitator
  
  - 1 full day FreshStart Training. (TTS overview attached).
  - Attend full N-O-T Facilitator Training

WRAP
  
  - 5 full days (WRAP trainings are only held each April in Vermont.)

CDC’s Diabetes Prevention Program (Prevent T2)
  
  - 2 full days

Refreshers for Leaders
Self-Management Resource Programs (CDSMP, wCDSMP, DSMP, CPSMP)
  
  - Audit by master trainer or peer leader in first year. Attend a refresher every two years.

Tobacco Treatment Specialist Group Cessation Facilitator
  
  - Audit by a master trainer or peer leader every 2 years and attend a FreshStart
SMP Faculty Definitions, Trainings and Stipends

refresher every 2 years.

WRAP
  o Attend a WRAP Facilitator Refresher every 2 years. In rare cases, facilitating
    a workshop with an Advanced Level Facilitator may be substituted for a
    refresher.

CDC’s Diabetes Prevention Program (Prevent T2)
  o Audit by master trainer or peer leader in first year. Attend a refresher every
    two years.

Recommended Leader/Facilitator Stipend Amounts
  o CDSMP, wCDSMP, DSMP, CPSMP – 6 sessions, $400/leader
  o Fresh Start - 5 sessions, $250/leader
  o N-O-T – 10 sessions, $500/leader
  o DPP/T2 – 24 sessions, $985/leader
  o WRAP – 24 hours, $650/leader

Recommended Master Trainer Stipend Amount
  o $200/day (Master Trainers are provided an extra half day for preparation)

Auditing
In order to ensure the on-going fidelity of the self-management programs, all Facilitators must be
audited on a yearly basis. Regional Coordinators are responsible for scheduling audits for their
facilitators. These audits are conducted by either a Master Trainer (for CDSMP, wCDSMP,
DSMP or CPSMP) or a facilitator with at least two years’ experience in the area of specialty not
before the third session of a workshop series. We highly encourage Regional Coordinators
correspond with a Master Trainer to audit any Leaders who are in need of mentorship. The
Auditor will observe facilitators for the entirety of the session utilizing evaluation forms included
within the Appendix. Any questions or concerns should be reported directly to Regional
Coordinators and the UVMMC CHI Team.

Recommended Auditor Stipend Amounts
  o CDSMP, wCDSMP, DSMP, CPSMP – $65 per session
  o Fresh Start - $30 per session
  o N-O-T – $30 per session
  o DPP/T2 – $30 per session
Self-Management Grant Definitions per Blueprint Contracts

To ensure the self-management programs are accountable to goals of the programs we have developed measures that track how much was done (quantity), how well it was done (quality), and if anyone is better off (impact). This follows the Program Accountability Framework from Results-Based Accountability.

- Successful Workshops Defined as: Maintaining a minimum of 6 attendees per session for CDSMP, wCDSMP, DSMP, CPSMP, WRAP, and Prevent T2. Maintaining a minimum of 3 attendees per session for FreshStart and N-O-T.
  - We heavily suggest starting workshops with a minimum of 10 participants to adjust for the average 40% attrition rate. However, it is not a grant requirement.
- Completer defined as:
  - HLW completer is someone who completes 4 out of the 6 sessions.
  - FreshStart completer is someone who completes 3 sessions.
  - N-O-T completer is someone who completes 7 out of the 10 sessions.
  - Diabetes Prevention Program completer is someone who completes 9 of the 16 core sessions.
  - WRAP completer is someone who completes 18 of the 24 required hours.
- Participant defined as:
  - Anyone who registers for the workshop and attends at least one class.
## Implementation Guidelines and Performance Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Operational Definition</th>
<th>Source</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Total number of workshops</td>
<td>Noted in Health Service Agreement</td>
<td>Number of successful workshops. See definition by workshop above.</td>
<td>Reported by State or State's designee (based on data sent from Regional Coordinator)</td>
<td>Quantity</td>
</tr>
<tr>
<td>2 Average wait time from registration to workshop attendance</td>
<td>Tobacco: 2 weeks For all other programs, establish benchmark</td>
<td>Average of elapsed time from date of registration to date of attendance at first workshop session for all workshop registrants</td>
<td>Reported by State or State's designee (based on data sent from Regional Coordinator)</td>
<td>Quality</td>
</tr>
<tr>
<td>3 Workshop cancellation rate</td>
<td>20%</td>
<td>Number of workshops cancelled/number of hosted workshops *100%</td>
<td>Reported by State or State's designee (based on data sent from Regional Coordinator)</td>
<td>Quality</td>
</tr>
<tr>
<td>4 No show rate</td>
<td>10%</td>
<td>Total number of registrants who attended 0 sessions/Total number of individuals * 100 registered</td>
<td>Reported by State or State's designee (based on data sent from Regional Coordinator)</td>
<td>Quality</td>
</tr>
<tr>
<td>5 Number of Completers</td>
<td>Target should be based on each HSA’s previous year’s total number of completers.</td>
<td>Participants that have attended the minimum number of session per workshop: 3 for tobacco, 6 for HLW, 9 for DPP, and 18hrs of WRAP.</td>
<td>Reported by State or State's designee (based on data sent from Regional Coordinator)</td>
<td>Quantity and Quality</td>
</tr>
<tr>
<td>6 Percent of participants who complete</td>
<td>Target is 5% increase from last year’s completer rate.</td>
<td>Total number of participants who complete/total number of participants * 100%</td>
<td>Reported by State or State's designee (based on data sent from Regional Coordinator)</td>
<td>Quality</td>
</tr>
</tbody>
</table>
## Implementation Guidelines and Performance Measures

<table>
<thead>
<tr>
<th></th>
<th>DPP Average Participant Weight Loss at 12 months</th>
<th>Goal of greater than or equal to 5.0%</th>
<th>Total percent weight lost/total number of participants</th>
<th>Reported by State or State's designee (based on data sent from Regional Coordinator)</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>DPP Percent of physical activity minutes documented</td>
<td>Establish benchmark This grant cycle.</td>
<td>Total number of participants who had physical activity minute documented/Total number of participants</td>
<td>Reported by State or State's designee (based on data sent from Regional Coordinator)</td>
<td>Impact</td>
</tr>
<tr>
<td>8</td>
<td>DPP Percent of completed food trackers</td>
<td>Establish Benchmark this grant cycle.</td>
<td>Total completed food trackers/total number of participants * 100%</td>
<td>Reported by State or State’s designee (based on data sent from Regional Coordinator)</td>
<td>Impact</td>
</tr>
<tr>
<td>9</td>
<td>Tobacco Cessation Percent quit at end of workshop</td>
<td>Establish Benchmark this grant cycle.</td>
<td>Number of tobacco-free individuals at end of workshop/Total number of participants</td>
<td>Reported by State or State’s designee (based on data sent from Regional Coordinator)</td>
<td>Impact</td>
</tr>
<tr>
<td>10</td>
<td>Tobacco Cessation Percent quit at 6-month follow-up</td>
<td>Establish benchmark</td>
<td>Number of tobacco-free individuals at 6-month call back/Total number of workshop participants</td>
<td>Reported by State or State's designee (based on data sent from Regional Coordinator)</td>
<td>Impact</td>
</tr>
<tr>
<td>11</td>
<td>Tobacco Cessation Percent quit at 12-month follow-up</td>
<td>Establish benchmark</td>
<td>Number of tobacco-free individuals at 12-month call back/Total number workshop participants</td>
<td>Reported by State or State’s designee (based on data sent from Regional Coordinator)</td>
<td>Impact</td>
</tr>
</tbody>
</table>
Data Collection

A. Scheduling form

When a workshop is scheduled, a Workshop ID request is completed on Wufoo at:

https://workshopids.wufoo.com/forms/z1abx6c20eimtc8/

Once a workshop ID has been assigned, the UVMMC Team will update the MyHealthyVT workshop calendar to showcase most recent events. If the workshop is cancelled or changes, the Regional Coordinator should email the UVMMC Team with changes or reason for cancellation as soon as possible.

B. Registration and Attendance

When speaking with someone who is interested in attending or is registering for a program please use the Screening & Intake form found in the Appendix or another approved screening and intake form. If you have another intake form that you prefer to use please send it to the Statewide Program Coordinator for approval.

The “Self-Management Workshop Attendance Sheet” is used for tracking registration, facilitators, partners and attendance at workshops. Information is captured for each individual who registers for the program regardless of whether they attend. It is vital that the registrant, date of birth, their contact information and their referral source is included on this sheet. The form is then forwarded onto the leaders to complete for attendance during the sessions. This will ensure that the leaders have an accurate list of potential attendees. If a registrant does not attend or subsequently drop out of the workshop, the Regional Coordinator will contact them to try find out why, and indicate their response on the attendance sheet.

Attached are examples of the attendance sheets used for the following workshops:
- Healthy Living Workshops (CDSMP, DSMP, CPSMP)
- WRAP (Wellness Recovery Action Planning)

To track attendance and participant outcome data for FreshStart, N-O-T, and Prevent T2 data, contact the UVMMC Team for H.S.A specific workbooks.

To find the most up-to-date attendance sheets, please login to basecamp.

C. Data Entry

Regional Coordinators or group facilitators are responsible for collecting data from facilitators and entering the info on the most up-to-date data collection form. The University of Vermont Medical Center team oversees data collection and entry to ensure completion.
Data Collection

D. Data Submission

A copy of the “Self-Management Workshop Attendance Sheet” is sent to the UVMMC team within seven business days of the last sessions of the workshop. FreshStart, N-O-T and Prevent T2 participant data is submitted on a monthly basis to the UVMMC Team. Workbooks must be emailed to the Data Quality and Training Coordinator by the 15th of each month.

E. Workshop Evaluation

At the last session of the Workshop a workshop evaluation is completed by all participants. The Regional Coordinator should send the evaluations with the final attendance sheet. If someone drops out of the program, the Regional Coordinator should call the participant and fill out the form over the phone. The form helps to identify barriers and any improvements that can be made to enhance participation. The results of the workshop evaluations should be aggregated and shared with the workshop Facilitators.

- Results of WRAP workshops will be shared with the advanced level Facilitators (Jane Winterling and Katie Wilson in Vermont) to include in the mentoring plans.

CDC’s Diabetes Prevention Program: Prevent T2 participants complete a survey evaluation at week 16 and the final session. Those evaluations are to be administered from the Regional Coordinators to the Lifestyle Coaches during weeks 15 and 22 of the program, and after completion are entered in a survey monkey or other data collection platform.
Included are the following:

- Regional Coordinator Outreach Toolkit
- Diabetes Prevention Provider’s Toolkit
Regional Coordinator Outreach Toolkit

April 2018
Helping Yourself to Health
Partner Toolkit

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Helping Yourself to Health
Partner Toolkit

Introduction

Purpose

Helping Yourself to Health is a one-stop resource for Vermont’s six self-management programs run by the Vermont Blueprint for Health. Having these classes on one website, MyHealthyVT.org, allows Vermonters easy access to information and support, and elevates the value and visibility of all programs. This is especially important considering many eligible participants have one or more chronic conditions.

More Vermonters die each year from chronic disease than any other cause of death, but chronic disease is not anyone’s fate. By changing three behaviors—lack of physical activity, poor diet, and tobacco use—we can reduce the rate of four chronic diseases—cancer, heart disease, type 2 diabetes, and lung disease—that are the cause of more than 50 percent of deaths in Vermont each year.

This Helping Yourself to Health toolkit can help you in your work to build awareness of the self-management programs, connect potential participants with Regional Coordinators, increase enrollment in your workshops, and start participants on the road to better health.

Your Role

Think of yourself as a Brand Champion for Helping Yourself to Health. Being a Brand Champion means that you recognize the importance of the self-management programs and know that being consistent with how you talk about and represent the programs matters when establishing trust and continuity. This toolkit will align your recruitment efforts and health messages with those of your fellow Regional Coordinators throughout the state—helping eligible Vermonters, regardless of where they live, to see the self-management programs as valuable, professional and supportive.
Helping Yourself to Health
Partner Toolkit

Using the Toolkit

The following toolkit provides tips and tools to connect your programs to potential participants. We’ve designed most of these promotional materials to be customizable and flexible so they can fit into your current work and can also be easily shared with key partners and community organizations. We encourage you to also share these tools—such as the social media posts, newspaper ads and Front Porch Forum post—with your own communications departments.

We also have included a dedicated section to help providers counsel and refer patients with prediabetes to the Diabetes Prevention Program. Thank you for sharing this resource with the providers and practices you work with—your relationships build providers’ trust in referring their patients to these self-management programs.

Questions?

Statewide Self-Management Program Coordinator

University of Vermont Medical Center

selfmanagement@uvmhealth.org

802-847-5468
# Toolkit Materials at a Glance

Below is an overview of the materials included in this toolkit, including who they are for, how to use and where to find them. Toolkit materials with a file name are saved in the accompanying **Toolkit Materials** folder.

<table>
<thead>
<tr>
<th>TYPE</th>
<th>TARGET AUDIENCES</th>
<th>HOW TO USE</th>
<th>FORMAT</th>
<th>ACCESS INFO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Programs Overview &amp; Talking Points</strong>&lt;br&gt;Purpose: To quickly and consistently describe the programs, their benefits, expectations, and to answer questions.</td>
<td><strong>Potential participants and influencers</strong> (family members, friends, etc.)&lt;br&gt;<strong>Participant gatekeepers / channels</strong> (provider offices, social service programs, community-based orgs, etc.)&lt;br&gt;<strong>Communication partners / media</strong> (internal communication dept., media outlets, journalists, legislators, etc.)</td>
<td>Use these in everyday communication or with the media.&lt;br&gt;You can edit or build on these key points as you get to know the topics and questions most important to your audiences.&lt;br&gt;Consider keeping a running list of frequently asked questions and answers specific to your own program(s).</td>
<td>✔️&lt;br&gt;CUSTOMIZABLE</td>
<td>Programs Overview / Page 10&lt;br&gt;Talking Points / Page 11&lt;br&gt;2018_HYTH_overview-points.docx</td>
</tr>
<tr>
<td><strong>Printed Rack Card &amp; Poster</strong>&lt;br&gt;Purpose: Promote all six self-management programs and the website, <a href="http://www.myhealthyvt.org">myhealthyvt.org</a>.</td>
<td><strong>Potential participants and influencers</strong> (family members, friends, etc.)&lt;br&gt;<strong>Participant gatekeepers / channels</strong> (provider offices, social service programs, community-based orgs, etc.)</td>
<td>Attach the PDF files of the poster or rack card in emails promoting the collection of Helping Yourself to Health classes.&lt;br&gt;Please request pre-printed materials to hand out or hang in visible locations and events.&lt;br&gt;There is free space at the bottom of the poster and on the back of the rack card to customize with your contact email or phone number.</td>
<td>✔️&lt;br&gt;SEND DIGITALLY&lt;br&gt;✔️&lt;br&gt;FOR ORDER&lt;br&gt;✔️&lt;br&gt;CUSTOMIZABLE</td>
<td>2018_HYTH_rackcard.pdf&lt;br&gt;2018_HYTH_poster.pdf</td>
</tr>
</tbody>
</table>

To ensure quality, do not print these materials. To order materials, contact: [amanda.biggs@uvmhealth.org](mailto:amanda.biggs@uvmhealth.org)
<table>
<thead>
<tr>
<th>TYPE</th>
<th>TARGET AUDIENCES</th>
<th>HOW TO USE</th>
<th>FORMAT</th>
<th>ACCESS INFO</th>
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</thead>
<tbody>
<tr>
<td>Customizable Handout / Poster</td>
<td><strong>Potential participants and influencers</strong> (family members, friends, etc.)</td>
<td>Input your information, including your contact details, logo, and class information, and share electronically as a PDF by email or as printed copies at events, partner locations or places most likely to be frequented by potential participants—e.g. doctor’s offices, schools, grocery stores, etc. Keep a list of where you hung up the posters and be sure to remove and recycle the materials once they are outdated.</td>
<td>SEND DIGITALLY</td>
<td>2018_HYTH_customhandout.docx</td>
</tr>
<tr>
<td></td>
<td><strong>Participant gatekeepers / channels</strong> (provider offices, social service programs, community-based orgs, etc.)</td>
<td></td>
<td>PRINTABLE</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>CUSTOMIZABLE</td>
<td></td>
</tr>
<tr>
<td>Customizable Tear Sheet</td>
<td><strong>Potential participants and influencers</strong> (family members, friends, etc.)</td>
<td>Input your information, including your contact details, logo, and class information. Then print out, cut the contact information tabs and hang them in locations frequented by potential participants. Don’t forget to replace these materials if all the tabs are gone or the information is outdated.</td>
<td>PRINTABLE</td>
<td>2018_HYTH_customtearsheet.docx</td>
</tr>
<tr>
<td></td>
<td><strong>Participant gatekeepers / channels</strong> (provider offices, social service programs, community-based orgs, etc.)</td>
<td></td>
<td>CUSTOMIZABLE</td>
<td></td>
</tr>
<tr>
<td>TYPE</td>
<td>TARGET AUDIENCES</td>
<td>HOW TO USE</td>
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<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Customizable One-Sheets</td>
<td>Potential participants and influencers (family members, friends, etc.)</td>
<td>Program-specific one-sheets provide an overview of the program’s purpose, its benefits, what’s covered and the specific logistics, such as location, time and how-to sign-up. These are customizable and can be shared digitally as PDFs or can be printed and distributed to locations frequented by potential participants.</td>
<td>SEND DIGITALLY</td>
<td>2018_HYTH_onesheet_CD.docx/jpg</td>
</tr>
<tr>
<td></td>
<td>Participant gatekeepers / channels (provider offices, social service programs, community-based orgs, etc.)</td>
<td></td>
<td>PRINTABLE</td>
<td>2018_HYTH_onesheet_CP.docx/jpg</td>
</tr>
<tr>
<td></td>
<td>Communication partners / media (internal communication dept., media outlets, journalists, legislators, etc.)</td>
<td></td>
<td>CUSTOMIZABLE</td>
<td>2018_HYTH_onesheet_DM.docx/jpg</td>
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<td>2018_HYTH_onesheet_DP.docx/jpg</td>
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<td>2018_HYTH_onesheet_QS.docx/jpg</td>
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<td></td>
<td></td>
<td>2018_HYTH_onesheet.WRAP.docx/jpg</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2018_HYTH_onesheet_ProgramsOverview.pdf</td>
</tr>
<tr>
<td>Save the Date Postcard Template</td>
<td>Potential participants and influencers (family members, friends, etc.)</td>
<td>The template can be customized and printed, and then mailed to list of recipients, or handed out, as necessary. The template is set up to print with Avery Postcard templates (tall, 4 per sheet), which is compatible with Avery Products 3256, 3263, 33380, 3377, 3380, 3381, 5689, 8383, 8387, 8577.</td>
<td>PRINTABLE</td>
<td>2018_HYTH_postcard.docx</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CUSTOMIZABLE</td>
<td></td>
</tr>
<tr>
<td>TYPE</td>
<td>TARGET AUDIENCES</td>
<td>HOW TO USE</td>
<td>FORMAT</td>
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</tr>
<tr>
<td><strong>Certificate of Completion</strong></td>
<td>Participants who Complete Program/s</td>
<td>Customize this template with the participant’s name, workshop and completion date, then print, as needed.</td>
<td>PRINTABLE</td>
<td>2018_HYTH_certificate.docx/png</td>
</tr>
<tr>
<td><strong>Purpose:</strong> Recognize the achievements of those who complete the self-management classes.</td>
<td></td>
<td></td>
<td>CUSTOMIZABLE</td>
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</tr>
</tbody>
</table>

<p>| <strong>SHARE THIS SECTION WITH INTERNAL COMMUNICATIONS OR OUTREACH DEPARTMENTS</strong> | | | | |
| Newsletter or Front Porch Forum Post Template | Potential participants and influencers (family members, friends, etc.) | Share your class on online community outlets like Front Porch Forum and online community or school newsletters or local papers. | SHARE DIGITALLY | 2018_HYTH_newsletter.docx |
| Purpose: Pre-written, customizable post for print and e-newsletters and newspapers, Front Porch Forum, and other local channels. | Communication partners / media (internal - communication dept., media outlets, journalists, legislators, etc.) | In the included post, input contact details and class information. If possible, post an announcement a month before the start date and post weekly reminders, as information on these channels gets outdated quickly. | CUSTOMIZABLE | |
| Social Media Posts Preview | Potential participants and influencers (family members, friends, etc.) | Includes pre-designed posts and customizable areas to promote your classes. | SHARE DIGITALLY | Social Media Posts Preview / Page 12 2018_HYTH_Social_Templates.pptx |
| Purpose: Easy to use, pre-designed and customizable posts promoting the self-management programs and upcoming classes. | Communication partners / media (internal - communication dept., media outlets, journalists, legislators, etc.) | Share this section of the toolkit with internal communications or outreach departments so that they can promote your classes on their own networks. | CUSTOMIZABLE | |</p>
<table>
<thead>
<tr>
<th>TYPE</th>
<th>TARGET AUDIENCES</th>
<th>HOW TO USE</th>
<th>FORMAT</th>
<th>ACCESS INFO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newspaper Ad Templates</td>
<td>Potential participants and influencers (family members, friends, etc.)</td>
<td>Customize pre-designed template with your name and contact info to promote workshops in your local area.</td>
<td>✓ CUSTOMIZABLE</td>
<td>2018_HYTH_newspaper.docx</td>
</tr>
<tr>
<td></td>
<td>Communication partners / media (internal - communication dept., media outlets, journalists, legislators, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Features of MyHealthyVT.org</td>
<td>Communication partners / media (internal - communication dept., media outlets, journalists, legislators, etc.)</td>
<td>A brief overview of the offerings MyHealthyVT.org has for communication partners. Share this section of the toolkit with internal communications or outreach departments so they have an understanding of the features of the MyHealthyVT.org site.</td>
<td>✓ SEND DIGITALLY ✓ PRINTABLE</td>
<td>Features of MyHealthyVT.org / Pages 19 - 21</td>
</tr>
</tbody>
</table>
### Programs Overview

1. **Diabetes Prevention**

For people at risk for developing type 2 diabetes. Attendees learn how to decrease their risk of developing diabetes through healthy eating, getting more physical activity, managing stress, and creating action plans that work for them. **Program length: One year, 16 weekly core sessions plus monthly maintenance sessions**

2. **Diabetes Management**

For people diagnosed with type 2 diabetes. Attendees get the support they need from specially-trained professionals, at least one of whom has diabetes, to eat better, exercise, problem solve, manage stress, handle sick days and monitor blood sugar to lower the risk of serious health problems related to diabetes. **Program length: 6 sessions**

3. **Quitting Smoking**

For current smokers or tobacco users looking to quit. Attendees get the support and motivation they need to quit tobacco in a small group of other people trying to quit too. Attendees can also get free patches and gum or lozenges to help them quit. **Program length: Self-designed**

4. **Emotional Wellness**

For people who are struggling with mental health challenges and their supporters and caregivers. The Wellness Recovery Action Plan (or WRAP®) is a self-designed prevention and wellness process that anyone can use to get well, stay well, and make life the way they want it to be. Attendees get support, tips, and advice from people who are also working toward emotional well-being. **Program length: Self-designed**

5. **Chronic Disease Management**

For people living with a chronic disease such as arthritis, diabetes, cancer, obesity or heart disease. Attendees learn how to make choices to live healthier with chronic disease and lower the risk of related health problems. **Program length: 6 sessions**

6. **Chronic Pain Management**

For people living with chronic pain for more than 3 to 6 months. Attendees learn ways to reduce pain, deal with related issues like having trouble sleeping, and more. **Program length: 6 sessions**
Helping Yourself to Health
Partner Toolkit

Talking Points

Self-Management Programs

- Chronic disease is not our fate, we have the power to influence it.
- There are many small steps we can take to improve our health over time.
- Vermont has FREE programs to help people get started and provide the support they need to keep going.
- Learn how to make practical lifestyle changes with the support of a trained facilitator and a small group of other people looking to make a change too.
- People who complete the program say they see big improvements, like eating better, feeling less depressed, and having better relationships with their doctors.
- To learn about programs, find a program location, and hear stories from other Vermonters, visit the Helping Yourself to Health website, MyHealthyVT.org

MyHealthyVT.org

Helping Yourself to Health and the website, MyHealthyVT.org, are the result of a partnership among the following Vermont organizations dedicated to helping Vermonters get the support they need to take control of their health. These partners created MyHealthyVT.org, an online hub connecting Vermonters to six self-management programs and contacts available in their communities.

- **Vermont Department of Health**, helping Vermonters live fuller, healthier lives from birth through old age—with a focus on prevention. healthvermont.gov
- **Vermont Blueprint for Health**, bringing together health-care providers, accountable-care organizations, social services, and more to incentivize research-based advanced primary care, and connect more Vermonters to its benefits. blueprintforhealth.vermont.gov
- **University of Vermont Medical Center**, committed to providing the highest quality of care for patients throughout the Burlington, Vermont region. https://www.uvmhealth.org/medcenter/
Helping Yourself to Health Partner Toolkit

Social Media Posts Preview

Use the pre-designed posts and recommended text in this chart for self-management program classes starting soon in your area. Keep track of what posts you’ve used by entering the date in this chart when it goes live on your social media.

<table>
<thead>
<tr>
<th>Posted Date</th>
<th>Topic</th>
<th>Social Media Post</th>
<th>Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>There are many small steps you can take to improve your health, like quitting smoking, making better eating choices, and learning to manage stress. Helping Yourself to Health’s free workshops offered throughout VT can help.</td>
<td>HYTH_2018_smallsteps.jpg</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.myhealthyvt.org">http://www.myhealthyvt.org</a></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>Helping Yourself to Health offers free local classes in your area. Learn more and take charge of your health today.</td>
<td>HYTH_2018_help.jpg</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.myhealthyvt.org">http://www.myhealthyvt.org</a></td>
<td></td>
</tr>
<tr>
<td>Posted Date</td>
<td>Topic</td>
<td>Social Media Post</td>
<td>Files</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
</tbody>
</table>
| General     | General     | There’s a lot you can do to help improve your health. Small steps like adding more fruits and vegetables into your diet or being more active can change your life. Our programs can help you get started – and provide support to keep going.  
http://www.myhealthyvt.org                                                                                                                                                                                            | HYTH_2018_bigjourneys.jpg                  |
| General     | General     | Improving your health can be easier than you think. With a few small steps, you can gain control over your health. Learn about our programs designed to help.  
http://www.myhealthyvt.org                                                                                                                                                                                                 | HYTH_2018_initiative.jpg                   |
<table>
<thead>
<tr>
<th>Posted Date</th>
<th>Topic</th>
<th>Social Media Post</th>
<th>Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programs</td>
<td>It’s important to take steps to reduce your risk and prevent diabetes. Our program can help you adopt healthier habits that can lead to weight loss and reduce the chance of developing diabetes. <a href="http://myhealthyvt.org/diabetes-prevention">http://myhealthyvt.org/diabetes-prevention</a></td>
<td>HYTH_2018_program_diabetesprev.jpg</td>
<td></td>
</tr>
<tr>
<td>Programs</td>
<td>Our program can help you get the support you need to quit tobacco in a small group of other people trying to quit too. You can also get free patches and gum or lozenges. <a href="https://myhealthyvt.org/quit-tobacco">https://myhealthyvt.org/quit-tobacco</a></td>
<td>HYTH_2018_program_smoking.jpg</td>
<td></td>
</tr>
</tbody>
</table>
# FACEBOOK

<table>
<thead>
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<th>Posted Date</th>
<th>Topic</th>
<th>Social Media Post</th>
<th>Files</th>
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</thead>
<tbody>
<tr>
<td>Programs</td>
<td>There are a lot of small steps you can take to manage chronic disease and prevent health-related problems. Our program can help you take charge by building the skills to manage your condition. <a href="https://myhealthyvt.org/chronic-disease">https://myhealthyvt.org/chronic-disease</a></td>
<td>HYTH_2018_program_chronic.jpg</td>
<td></td>
</tr>
<tr>
<td>Programs</td>
<td>If you’re struggling with a mental health challenge—such as depression or anxiety—you’re not alone. More than 80% of American adults are living with some form of mental health issues. See if our Wellness Recovery Action Plan is right for you and take charge of your health today. <a href="https://myhealthyvt.org/emotional-wellness/">https://myhealthyvt.org/emotional-wellness/</a></td>
<td>HYTH_2018_program_emotional.jpg</td>
<td></td>
</tr>
</tbody>
</table>
# Helping Yourself to Health Partner Toolkit

## FACEBOOK

<table>
<thead>
<tr>
<th>Posted Date</th>
<th>Topic</th>
<th>Social Media Post</th>
<th>Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programs</td>
<td>If you suffer from long-lasting (chronic) pain from an injury, surgery, or health condition, you’re not alone. About 100 million Americans are living with chronic pain. See if our Healthier Living Workshop for Chronic Pain can help you take charge of your health today. <a href="https://myhealthyvt.org/chronic-pain/">https://myhealthyvt.org/chronic-pain/</a></td>
<td>HYTH_2018_program_managechronic.jpg</td>
<td></td>
</tr>
<tr>
<td>Program</td>
<td>Diabetes can be difficult to manage on your own. Our program can help you learn how to manage stress, problem solve, eat healthy, exercise, and even handle sick days. <a href="https://myhealthyvt.org/diabetes-management/">https://myhealthyvt.org/diabetes-management/</a></td>
<td>HYTH_2018_program_diabetesmanage.jpg</td>
<td></td>
</tr>
</tbody>
</table>
# Helping Yourself to Health Partner Toolkit

<table>
<thead>
<tr>
<th>FACEBOOK</th>
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</thead>
<tbody>
<tr>
<td><strong>Posted Date</strong></td>
</tr>
<tr>
<td>Videos</td>
</tr>
<tr>
<td>Video</td>
</tr>
<tr>
<td>Video</td>
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Helping Yourself to Health Partner Toolkit

### FACEBOOK

<table>
<thead>
<tr>
<th>Posted Date</th>
<th>Topic</th>
<th>Social Media Post</th>
<th>Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video</td>
<td>Making a lifestyle change can be hard. Bryan, and many others like him, started with small steps to help them get back on the path to healthy living.</td>
<td>Link to: <a href="http://bit.ly/2pFHfEz">http://bit.ly/2pFHfEz</a></td>
<td></td>
</tr>
</tbody>
</table>

### TWITTER

<table>
<thead>
<tr>
<th>Posted Date</th>
<th>Topic</th>
<th>Social Media Post</th>
<th>Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video</td>
<td>Cynthia from #VT describes why she decided to make small lifestyle changes to take control of her health.</td>
<td><a href="http://bit.ly/2pxYcSQ">http://bit.ly/2pxYcSQ</a></td>
<td>HYTH_2018_control.jpg</td>
</tr>
<tr>
<td>Video</td>
<td>Shawn from #VT shares his story of how simple changes to his diet have put him on the path toward a healthier future.</td>
<td><a href="http://bit.ly/2oYrTxF">http://bit.ly/2oYrTxF</a></td>
<td>HYTH_2018_initiative.jpg</td>
</tr>
</tbody>
</table>
# Helping Yourself to Health

**Partner Toolkit**

<table>
<thead>
<tr>
<th>Posted Date</th>
<th>Topic</th>
<th>Social Media Post</th>
<th>Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video</td>
<td>These #VTer’s changed their diet by making simple changes. <a href="http://bit.ly/2p6qS1U">http://bit.ly/2p6qS1U</a></td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Video</td>
<td>These #VT’ers became more active by starting with small steps. <a href="http://bit.ly/2oYiLJn">http://bit.ly/2oYiLJn</a></td>
<td>n/a</td>
<td></td>
</tr>
</tbody>
</table>
Helping Yourself to Health Partner Toolkit

Features of MyHealthyVT.org

MyHealthyVT.org
See the collection of free self-management programs available in Vermont at http://myhealthyvt.org

Diabetes Prevention
Explore the Diabetes Prevention page to find details about the FREE Diabetes Prevention Program, what it offers and who it’s for, as well as upcoming workshops, success stories and resources.

http://myhealthyvt.org/diabetes-prevention
Helping Yourself to Health Partner Toolkit

Find Nearest Location

Locate the Regional Coordinator closest to you by using the statewide interactive map or scroll through the list.

http://myhealthyvt.org/find-nearest-location

Free Workshops

Locate workshops using the interactive calendar.

http://myhealthyvt.org/workshops
Helping Yourself to Health
Partner Toolkit

Real Stories

Hear how real Vermonters found the motivation and support they needed to help themselves to a healthier life.

http://myhealthyvt.org/real-stories/
HELPING
YOURSELF
TO HEALTH
—
SMALL STEPS ARE THE START.

PREVENTING
TYPE 2 DIABETES

Provider Toolkit

A guide to refer your patients with prediabetes to an evidence-based Diabetes Prevention Program

To find resources for your patients, visit: MYHEALTHYVT.ORG
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Helping Yourself to Health
Provider Toolkit for Prediabetes

Introduction
This toolkit helps primary care office staff prevent type 2 diabetes by identifying patients with prediabetes and connecting them to free, evidence-based diabetes prevention programs available throughout Vermont.

Type 2 diabetes is one of four chronic diseases that is the cause of more than 50 percent of deaths in Vermont each year. More Vermonters die each year from chronic disease than any other cause of death, but chronic disease is not anyone's fate. By changing three behaviors—lack of physical activity, poor diet and tobacco use—Vermonters can improve their quality of life and reduce their likelihood of having a chronic disease. To learn more about the statewide movement to reduce the rate of chronic disease, visit healthvermont.gov/3-4-50.

Prediabetes can lead to type 2 diabetes
Prediabetes is a health condition characterized by blood glucose levels that are higher than normal, but not high enough to be diagnosed as diabetes. Left untreated, up to one-third of people with prediabetes will progress to diabetes within five years. Prediabetes also increases the risk for type 2 diabetes, heart disease and stroke.

Prediabetes is treatable, but only about 10 percent of people who have it are aware that they do. A diagnosis of prediabetes from a provider can be the catalyst to your patients making lifestyle changes.

Free self-management programs for your patients
Helping Yourself to Health is a one-stop resource for Vermont's six self-management programs run by the Vermont Blueprint for Health, in collaboration with the Health Department and the University of Vermont Medical Center. Having these classes on one website, MyHealthyVT.org, allows Vermonters easy access to information and support, and elevates the value and visibility of all programs. This is especially important considering many eligible participants have one or more chronic conditions.

MyHealthyVT.org connects your patients to free, local self-management programs addressing:

- Diabetes prevention
- Diabetes management
- Quitting smoking
- Emotional wellness
- Chronic disease management
- Chronic pain management
How Does a Diabetes Prevention Program Work?

National Diabetes Prevention Programs use lifestyle-change interventions to improve nutrition, increase physical activity, and achieve moderate weight loss. Among those with prediabetes, the diabetes prevention program has shown a reduction in high blood pressure, a 58 percent reduction in the number of new cases of diabetes overall, and a 71 percent reduction in new cases for those over age 60. To learn more about NIDDK-sponsored Diabetes Prevention Programs, visit their website.

The goal for each participant is to lose 5-7% of body weight by:

- Progressively reducing dietary intake of calories and fat through improved food choices
- Increasing moderate physical activity (e.g., brisk walking) to ≥150 minutes per week
- Developing behavioral problem-solving and coping skills

**Diabetes Prevention Program features:**

- Empower participants with the tools and information needed to improve their health and well-being.
- Meet in groups with a trained lifestyle coach for one year (16 weekly sessions) and gradually tapering to monthly sessions for the last six months of the program.
- Learn ways to eat healthier, increase moderate physical activity, make action-plans/ solve problems, and incorporate stress-reduction and coping skills into their daily lives.
- Provide feedback to referring clinicians after the eighth and 16th group sessions, as well as periodic participant self-evaluations that can be requested directly from patients. All patient information adheres to the rules of protected health information (PHI).

**Who is eligible for referral to a diabetes prevention program?**

To be eligible for referral, patients must:

- Be at least 18 years old and overweight (Body-Mass Index [BMI] ≥25; ≥23 if Asian) and
- Score 9 or higher on CDC’s prediabetes risk test (see page 19) or
- Have a blood test result in the prediabetes range within the past year:
  - Hemoglobin A1C: 5.7–6.4% or
  - Fasting plasma glucose: 100–125 mg/dL or
  - Two-hour plasma glucose (after a 75gm glucose load): 140–199 mg/dL or
- Be previously diagnosed with gestational diabetes and
- Have no previous diagnosis of type 2 diabetes

**How can patients find a diabetes prevention program near them?**

Visit MyHealthyVT.org to learn more, locate a program, and connect with a regional coordinator.

---

1. 58% reduction in the number of new cases of diabetes overall, and a 71% reduction in new cases for those over age 60, represent a three-year reduction rate.
2. [https://www.niddk.nih.gov/health-information/conditions-diseases/heart-disease/what-is-a-familial-disorder](https://www.niddk.nih.gov/health-information/conditions-diseases/heart-disease/what-is-a-familial-disorder)
Sample Talking Points for Providers

What is prediabetes?

• Prediabetes means your blood glucose (sugar) level is higher than normal, but not high enough to be diagnosed as diabetes. This condition raises your risk of type 2 diabetes, stroke and heart disease.
• If left untreated, many people with prediabetes will develop type 2 diabetes within five years.
• Type 2 diabetes is a serious condition that can lead to health issues such as heart attack, stroke, blindness, kidney failure, or loss of toes, feet or legs.

What can you do about it?

• The good news is that there’s a free program that can help you. Visit MyHealthyVT.org to find a Diabetes Prevention Program in your area.
• The National Diabetes Prevention Program, led by the Centers for Disease Control and Prevention (CDC), is proven to prevent or delay type 2 diabetes.
• Vermont offers this program FREE of charge to any qualifying participant all over the state.
• By improving food choices and increasing physical activity, your goal will be to lose 5 to 7 percent of your body weight—that is 10 to 14 pounds for a person weighing 200 pounds.
• These lifestyle changes can cut your risk of developing type 2 diabetes by more than half.

How does the program work?

• As part of a group, you will work with a trained diabetes prevention coach and other participants to learn the skills you need to make lasting lifestyle changes.
• You will learn to eat healthy, add physical activity to your life, manage stress, stay motivated, and solve problems that can get in the way of healthy changes.
• By going through the program with others who have prediabetes, you can celebrate each other’s successes and work together to overcome challenges.
• The program lasts one year, with 16 sessions taking place about once a week and six to eight more sessions meeting every other week or once a month (24 sessions total).
• This program—which costs $429 in other states—is free for Vermonters.
Point of Care Prediabetes Identification

METHOD 1:

**MEASURE**

If patient is age ≥18 and does not have diabetes, provide CDC’s Prediabetes Screening Test (page 19). If test reveals risk, proceed to next step. A score of 9 or higher qualifies patient for Diabetes Prevention Program

Review medical record to determine if BMI ≥25 (≥23 if Asian) or history of GDM*

- **NO**
  - Patient does not currently meet program eligibility requirements

**Determine if a HbA1C, FPG or OGTT was performed in the past 12 months**

- **NO**
  - **Order one of the tests below:**
    - Hemoglobin A1C (HbA1C)
    - Fasting plasma glucose (FPG)
    - Oral glucose tolerance test (OGTT)

**RESULTS**

<table>
<thead>
<tr>
<th>Diagnostic test</th>
<th>Normal</th>
<th>Prediabetes</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1C(%)</td>
<td>&lt;5.7</td>
<td>5.7–6.4</td>
<td>≥6.5</td>
</tr>
<tr>
<td>Fasting plasma glucose (mg/dl)</td>
<td>&lt;100</td>
<td>100–125</td>
<td>≥126</td>
</tr>
<tr>
<td>Oral glucose tolerance test (mg/dl)</td>
<td>&lt;140</td>
<td>140–199</td>
<td>≥200</td>
</tr>
</tbody>
</table>

**ACT**

- **Normal**
  - Encourage patient to maintain a healthy lifestyle.
  - Continue with exam/consult.
  - Retest within three years of last negative test.

- **Prediabetes**
  - Refer to diabetes prevention program, MyHealthyVT.org
  - Consider retesting annually to check for diabetes onset.

- **Diabetes**
  - Confirm diagnosis retest if necessary.
  - Counsel patient re: diagnosis.
  - Initiate therapy. Refer to MyHealthyVT.org for Healthier Living Workshop for Diabetes.

**PARTNER**

Communicate with your local diabetes program.

- Contact patient and troubleshoot issues with enrollment or participation.
- At next visit, ask patient about progress and encourage continued participation in the program.

* Gestational diabetes mellitus

Point of Care Referral to a Diabetes Prevention Program

METHOD 1:

| Point-of-care identification and referral |
| Download and display the patient handout |
| Print the practice and patient resources included in this guide in advance of patient visits, so your office can have them available in the waiting room or during consult. |

Measure

Step 1 — During check-in: If age ≥18 and patient does not have diabetes, give him/her the CDC Prediabetes Screening Test included on page 19 of this toolkit. After patient completes the test and returns it, insert completed test in the paper chart or note risk score in the electronic medical record (EMR). Screening test can also be mailed to patient along with other pre-visit materials.

Step 2 — During rooming/vitals: Calculate the patient's body-mass index. Most EMRs can calculate BMI automatically. Review the patient's diabetes risk score and, if elevated (9 or higher), flag for possible referral.

Step 3 — During exam/consult: Follow the point-of-care prediabetes identification algorithm on page 7 to determine if patient has prediabetes.

If the blood test results do not indicate prediabetes, encourage the patient to maintain healthy lifestyle choices.

If blood test results do indicate prediabetes, please continue to the next page to the ACT and PARTNER steps.
Point of Care Referral to a Diabetes Prevention Program (Cont’d)

Act

A. If the patient screens positive for prediabetes and has BMI <25 (<23 if Asian):
   • Introduce the topic of prediabetes by briefly explaining what it is and its relation to diabetes (see Sample Talking Points on page 5). Review the patient’s own risk factors.
   • Emphasize the importance of prevention, including healthy eating, increased physical activity, and the elimination of risky drinking and tobacco use.

B. If the patient screens positive for prediabetes and has BMI ≥25 (≥23 if Asian):
   • Return to “A” above, discuss the value of participating in a diabetes prevention program, and determine the patient’s willingness to let you refer him/her to a program.
   • If the patient agrees, notify the Health Service Area’s Regional Coordinator or call the Statewide Self-Management Coordinator at (802) 847-5468.
   • If patient declines, offer him/her a program handout with the website MyHealthyVT.org and reevaluate risk factors at next clinic visit.

Step 4 — Referral to diabetes prevention program: Most diabetes prevention programs are configured to receive referrals via conventional fax (over a phone line) or secure email. If a patient agrees to a referral, complete the referral form (page 11) and submit to a program as follows:

Secure Fax: 802-847-6545
Secure Email: selfmanagement@uvmhealth.org

A. If using a paper referral form, as available in this toolkit, send via fax (over a phone line) or scan and securely email.

B. If the referral form is embedded in your EMR, either fax (over a phone line) or email using the EMR.

Physicians and other health care providers should also use their clinical judgment when referring to a diabetes prevention program.

Partner

Step 5 — Follow-up with patient: After referring, contact patient and troubleshoot issues with enrollment or participation.

At the next visit, ask patient about progress and encourage continued participation in the program.
Retrospective Prediabetes Identification

METHOD 2:

**MEASURE**

Query Electronic Health Records or patient database every 6–12 months using the following criteria:

A. Inclusion criteria:
   - Age ≥18 years and
   - Most recent BMI ≥25 (≥23 if Asian) and
   - A positive lab test result within previous 12 months:
     - HbA1C 5.7–6.4% (LOINC* code 4548-4) or
     - FPG 100–125 mg/dl (LOINC code 1558-6) or
     - OGTT 140–199 mg/dl (LOIN code 62856-0) or
   - History of gestational diabetes (ICD-10: Z86.32)

B. Exclusion criteria:
   - Current diagnosis of type 2 diabetes (ICD-10: E11) or
   - Current insulin use
   - Current pregnancy

**ACT**

Use the patient list to:

A. Contact patients to inform of risk status, explain prediabetes, and share info on diabetes prevention programs, and/or

B. Send patient contact info to Diabetes Prevention Program’s Regional Coordinator (found at MyHealthyVT.org). The Regional Coordinator will contact the patient directly, and

C. Flag medical record for patient’s next office visit

**PARTNER**

Discuss program participation at next visit

* Logical Observation Identifiers Names and Codes

Retrospective Referral to a Diabetes Prevention Program

METHOD 2:

Retrospective identification and referral

Measure

Step 1 — Query EMR or patient database
Query your EMR or patient database every 6–12 months using the following criteria:

A. INCLUSION CRITERIA
   • Age ≥18 years and
   • BMI ≥25 (≥23 if Asian) and
   • A positive test result for prediabetes within the preceding 12 months:
     » HbA1C 5.7–6.4% or
     » Fasting plasma glucose 100–125 mg/dL or
     » OGTT 140–199 mg/dL

OR

• Clinically diagnosed gestational diabetes during a previous pregnancy

B. EXCLUSION CRITERIA
   • Current diagnosis of diabetes

Step 2 — Generate a list of patient names and other information required to make referrals:
   • Gender and birth date
   • Email address
   • Mailing address
   • Phone number

Act

Step 3 — Referral to diabetes prevention program

A. Contact patients via phone, email, letter, or postcard to explain their prediabetes status and let them know about the diabetes prevention program. For sample outreach language, see pages 14-15.

B. Send relevant patient information to your Regional Coordinator who will contact the patient directly.

C. Flag patient’s medical records for the next office visit.

Physicians and other health care providers should also use their clinical judgment when referring to a diabetes prevention program.

Partner

During the next office visit, discuss diabetes prevention program participation:

• If the patient is participating, discuss program experience and encourage continued participation.

• If the patient has declined to participate, stress the importance of lifestyle change and continue to encourage participation.
# Referral Form for the Diabetes Prevention Program

Secure Fax: 802-847-6545 | Secure Email: selfmanagement@uvmhealth.org

## Patient Information

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td></td>
</tr>
<tr>
<td>Birth Date:</td>
<td>City:</td>
</tr>
<tr>
<td>Gender:</td>
<td>State / ZIP code:</td>
</tr>
<tr>
<td>Email:</td>
<td>Phone number:</td>
</tr>
</tbody>
</table>

By providing your information above, you authorize your health care practitioner to provide this information to the Diabetes Prevention Program provider, who will use this information to communicate with you regarding enrollment in the program.

## Practitioner Information

<table>
<thead>
<tr>
<th>Provider:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice contact:</td>
<td>City:</td>
</tr>
<tr>
<td>Phone:</td>
<td>State:</td>
</tr>
<tr>
<td>Fax:</td>
<td>ZIP code:</td>
</tr>
</tbody>
</table>

## Screening Information

Body-Mass Index (BMI) eligibility ≥25, ≥23 if Asian

<table>
<thead>
<tr>
<th>Blood test (check one)</th>
<th>Eligible range</th>
<th>Test result</th>
<th>Date of test</th>
</tr>
</thead>
<tbody>
<tr>
<td>__ Hemoglobin A1c</td>
<td>5.7–6.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Fasting Plasma Glucose</td>
<td>100–125 mg/dL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ 2-hour plasma glucose (75 gm OGTT)</td>
<td>140–199 mg/dL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Gestational Diabetes (in a prior pregnancy)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

By signing this form, I authorize my practitioner to disclose my diabetes screening results to the Diabetes Prevention Program for the sole purpose of determining my eligibility for the diabetes prevention program.

I understand that I am not obligated to participate, and that this authorization is voluntary. I understand that I may revoke this authorization by notifying my provider in writing. Any revocation will not influence actions taken before my provider received said revocation.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
# ICD-10 Codes for Prediabetes and Diabetes Screening

<table>
<thead>
<tr>
<th>ICD-10 code</th>
<th>ICD-10 code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z13.1</td>
<td>Encounter for screening for diabetes mellitus</td>
</tr>
<tr>
<td>R73.09</td>
<td>Prediabetes or other abnormal glucose</td>
</tr>
<tr>
<td>R73.01</td>
<td>Impaired fasting glucose</td>
</tr>
<tr>
<td>R73.02</td>
<td>Impaired glucose tolerance (oral)</td>
</tr>
<tr>
<td>R73.9</td>
<td>Hyperglycemia, unspecified</td>
</tr>
<tr>
<td>Z86.32</td>
<td>Personal history of gestational diabetes</td>
</tr>
<tr>
<td>E66.01</td>
<td>Morbid obesity due to excess calories</td>
</tr>
<tr>
<td>E66.09</td>
<td>Other obesity due to excess calories</td>
</tr>
<tr>
<td>E66.8</td>
<td>Other obesity</td>
</tr>
<tr>
<td>E66.9</td>
<td>Obesity, unspecified</td>
</tr>
<tr>
<td>E66.3</td>
<td>Overweight</td>
</tr>
<tr>
<td>Z68.3X</td>
<td>Body mass indexes 30.0-39.9 (adult)</td>
</tr>
<tr>
<td>Z68.4X</td>
<td>Body mass indexes ≥ 40.0 (adult)</td>
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</tbody>
</table>
CPT Codes for Diabetes Screening Tests

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPT E/M codes for prevention-related office visits</strong></td>
</tr>
<tr>
<td>Preventative visit New Patient, Commercial/Medicaid</td>
</tr>
<tr>
<td>Preventative visit Established Patient Commercial/Medicaid</td>
</tr>
<tr>
<td>Annual Wellness Visit Initial Medicare</td>
</tr>
<tr>
<td>Annual Wellness Visit Subsequent enrolled &gt; 1-year Medicare</td>
</tr>
<tr>
<td>Individual Preventative Counseling* Commercial/Medicaid</td>
</tr>
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<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Face-to-Face Obesity</td>
</tr>
<tr>
<td>Counseling for Obesity:† Medicare</td>
</tr>
</tbody>
</table>

These codes may be useful to report services/tests performed to screen for prediabetes and diabetes.

* Preventatives codes 99381-99397 include counseling and cannot be combined with additional counseling codes. If significant risk factor reduction and/or behavior change counseling is provided during a problem-oriented encounter, additional preventative counseling may be billed. In this case, modifier 25 code may allow for payment for both services, although this may vary by payer. Reimbursement for this code is not guaranteed.

† Must be billed with an ICD code indicating a BMI of 30 or greater. Medicare does not allow billing for another service provided on the same day.
Outreach Letter Template

Use or adapt these templates to conduct efficient follow-up and referral with patients who have been identified as having prediabetes.

<<YOUR LETTERHEAD>>
<<ADDRESS>>
<<PHONE NUMBER>>
<<DATE>>
<<PATIENT NAME>>
<<PATIENT ADDRESS>>

Dr./Mr./Mrs. <<PATIENT LAST NAME>>,  
Your health team at <<PRACTICE NAME HERE>> wants to tell you about a free service to help make your health better.

In reviewing our records, you have been identified as a patient who has one or more risk factors for type 2 diabetes. To help keep you on a healthy path and minimize your risk of developing diabetes, our office wants you to know that you may be eligible for a FREE diabetes prevention program run by our partner, Blueprint for Health. They offer diabetes prevention programs in diverse locations throughout the state that are proven to reduce your risk of developing diabetes and other health problems.

We have sent a referral to <<NAME OF Regional Coordinator>>, the self-management regional coordinator, and someone will call you to discuss the program, answer any questions you may have, and, if you are interested, enroll you in the program.

Please feel free to give <<NAME OF Regional Coordinator>> a call at <<PHONE NUMBER>>.

—OR—

We have sent a referral to the Regional Coordinator’s office for this program, and we urge you to call the phone number available at MyHealthyVT.org to find the nearest location, learn more about the program, and enroll. On the MyHealthyVT.org, select “Learn More” under Diabetes Prevention, and then select “Ready to get Started? Find a Program Near You.” Click on the “Green Balloon” in your area for the Regional Coordinator’s contact information.

We hope you will take advantage of this program, which can help prevent you from developing serious health problems.

Sincerely,
Dr. <<PHYSICIAN LAST NAME>>
Hello <<PATIENT NAME>>.

• I am calling from <<PRACTICE NAME HERE>>.

• I'm calling to tell you about a program we'd like you to consider, to help you prevent some serious health problems.

• Based on our review of your medical chart, you have been identified as a patient who has one or more risk factors for type 2 diabetes. This means your blood sugar is higher than normal, which makes you more likely to develop serious health problems including type 2 diabetes, stroke and heart disease.

• We have some good news, too.

• You may be eligible for a free diabetes prevention program run by our partners, Blueprint for Health.

• Their Diabetes Prevention Program is based on research proven to reduce one’s risk of developing diabetes and other health problems. These programs are offered in many locations statewide.

Option A

• We have sent a referral to <<NAME OF REGIONAL COORDINATOR >> and someone will call you to discuss the program, answer any questions you may have, and, if you are interested, enroll you in the program.

• Please feel free to give <<NAME OF REGIONAL COORDINATOR>> a call at <<PHONE NUMBER—see map linked to FIND A PROGRAM NEAR YOU>>.

• Do you have any questions for me?

• Thank you for your time.

Option B

• We have sent a referral to <<NAME OF REGIONAL COORDINATOR>> and we urge you to call <<PHONE NUMBER>> to learn more about the program and enroll.

• We hope you will take advantage of this program, which can help prevent you from developing serious health problems.

• Do you have any questions for me?

• Thank you for your time.
Features of MyHealthyVT.org

MyHealthyVT.org
See the collection of free self-management programs available in Vermont at myhealthyvt.org

Diabetes Prevention
Explore the Diabetes Prevention page to find details about the FREE Diabetes Prevention Program, what it offers and who it's for, as well as upcoming workshops, success stories and resources.

myhealthyvt.org/diabetes-prevention

Find Nearest Location
Locate the Regional Coordinator closest to you by using the statewide interactive map or scroll through the list.

myhealthyvt.org/find-nearest-location
Features of MyHealthyVT.org

**Free Workshops**
Locate workshops using the interactive calendar.

[myhealthyvt.org/workshops](http://myhealthyvt.org/workshops)

**Real Stories**
Hear how real Vermonters found the motivation and support they needed to help themselves to a healthier life.

[myhealthyvt.org/real-stories](http://myhealthyvt.org/real-stories)
PREDIABETES
SCREENING TEST

COULD YOU HAVE PREDIABETES?
Prediabetes means your blood glucose (sugar) is higher than normal, but not yet diabetes. Diabetes is a serious disease that can cause heart attack, stroke, blindness, kidney failure, or loss of feet or legs. Type 2 diabetes can be delayed or prevented in people with prediabetes through effective lifestyle programs. Take the first step. Find out your risk for prediabetes.

TAKE THE TEST—KNOW YOUR SCORE!
Answer these seven simple questions. For each “Yes” answer, add the number of points listed. All “No” answers are 0 points.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
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<td></td>
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<td>9</td>
<td>0</td>
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</tbody>
</table>

Add your score and check below to see what it means.

IF YOUR SCORE IS 3 TO 8 POINTS
Your risk is probably low for having prediabetes now. Keep your risk low by being active, not using tobacco, and eating low-fat meals with fruits, vegetables, and whole-grain foods. If you have high cholesterol or high blood pressure, talk to your health care provider.

IF YOUR SCORE IS 9 OR MORE POINTS
Your risk is high for having prediabetes now. Schedule an appointment with your health care provider soon.

Adapted from the CDC Prediabetes Screening Test.
Diabetes Prevention

A Self-Management Program to help you get more active, lose weight, and decrease your risk of getting diabetes.

It’s important to take steps to reduce your risk and prevent diabetes. This is because diabetes can lead to serious health problems. You have a greater risk of getting diabetes if you:

- Are overweight or obese
- Don’t get enough exercise
- Have high blood pressure
- Have abnormal cholesterol
- Have a parent, brother, or sister with diabetes

The good news is there’s a lot you can do to help prevent diabetes—and we can help. Get started today by joining a Nationally Recognized Diabetes Prevention Program near you.

The Program

The Diabetes Prevention Program

WHAT THE PROGRAM OFFERS
Education and support to help you adopt healthier eating and exercise habits that can lead to weight loss and reduce your risk of getting diabetes.

TIMING
Participants meet once a week for the first 16 weeks, and then meet every other week, and then monthly for a total of 25 sessions over a year.

WHO IT’S FOR
People at risk for developing type 2 diabetes.

To take the next step, visit: MYHEALTHYVT.ORG
Take small steps today
TO IMPROVE YOUR HEALTH.

Our **FREE** programs can help you get started and provide the support you need to keep going. We are ready to help you today with:

**DIABETES PREVENTION & MANAGEMENT**

Learn ways to help you get more active, lose weight, and decrease your risk of getting diabetes. And, get the support you need to eat better and exercise to lower your risk of serious health problems related to diabetes.

**QUITTING SMOKING**

Get the support you need to quit tobacco in a small group of other people trying to quit too.

**EMOTIONAL WELLNESS**

A self-designed prevention and wellness process that anyone can use to get well, stay well, and make life the way you want it to be.

**CHRONIC DISEASE MANAGEMENT**

Learn how to make choices to live healthier with chronic disease and lower your risk of related health problems.

**CHRONIC PAIN MANAGEMENT**

Learn ways to reduce pain, deal with related issues like trouble sleeping, and more.

To take the next step, visit: **MYHEALTHYVT.ORG**
CONTACT

Vermont Statewide Self-Management Coordinator
selfmanagement@uvmhealth.org  | (802) 847-5468

This guide is available for download at
www.healthvermont.gov/wellness/diabetes

Adapted from a guide of the same name created by the American Medical Association and the Centers for Disease Control and Prevention.
Revised July 2018.

To find resources for your patients, visit: MYHEALTHYVT.ORG
Appendix (Resources)

Attached are the following resources:

1) Regional Coordinator Map
2) Sub-Contractor Compliance Form
   a) Example of completed form
   b) Invoicing for Leaders FAQs
3) Sample of Leader Job Description/Responsibilities
4) Sample Screening and Intake Forms
5) Sample Attendance Sheets
   a) Healthy Living Workshop (CDSMP, wCDSMP, CPSMP, DSMP)
   b) WRAP
6) Prevent T2 eTool Guide
7) NRT Eligibility Guidelines
8) NRT Ordering Portal FAQs
9) Workshop Evaluation Forms (to be attached)
10) Auditor and Evaluation Forms
11) Literature Review (to be attached)
A new vision to improve health
and the health care system in Vermont

July 2018
Subcontractor Compliance Forms:
Subcontractor Compliance forms must be submitted on within each grant cycle and at least annually to the State of Vermont. If the facilitator or leader is certified to lead multiple specialties (ex. CDSMP and DSMP Master Trainer certified) then please list all appropriate specialties. Also, in the subcontractor form please note timeframe in which you will be working with the facilitator or leader (no more than 12 months or the end of the grant cycle). If the facilitator or leader is leading more than one workshop throughout the grant cycle please have the timeframe set to the end of the grant cycle. Please see the subcontractor form example for how the form should be completed. Once completed, please email to the following parties:

Julie Ho, Data Quality and Training Coordinator - Julie.Ho@uvmhealth.org
Alexandra Frey, Blueprint Project Administrator - Alexandra.Frey@vermont.gov
Rachel Green, Grants Management Specialist - Rachel.Green@vermont.gov
Invoicing for Leaders/Facilitators FAQs

Step 1 - Subcontractor Agreement Forms

The Blueprint needs a copy of the subcontractor compliance form for every subcontractor in each H.S.A. The subcontractor form should be submitted as soon as Regional Coordinators are aware a subcontractor will be delivering services under the grant requirement. The subcontractor compliance form (which needs to be signed by the subcontractor and Regional Coordinator) must be submitted to the Grant Managements Specialist at Department of Vermont Health Access (DVHA). Please refer to the Self-Management Programs Operations Manual or contact the Blueprint Project Administrator directly for contact information. The grant requires the subcontractor forms to be completed and submitted prior to signing any agreement with a third party.

The form requires Regional Coordinators set out the scope of subcontracted services. If the subcontractor is facilitating workshops, then please provide a brief description e.g. [Name of subcontractor] will act as a facilitator for Healthy Living Workshops for Diabetes and Chronic Pain beginning October 1, 2018 through September 30, 2019. If individual will be facilitating workshops under multiple specialties, please ensure this is noted in the subcontractor form. The following are not required to be disclosed on the subcontractor compliance form, but should be agreed upon between the subcontractor and the Regional Coordinator: specific workshop dates or payment arrangements. Each sub recipient has their own budget requirements, and it is up to the sub recipient to operate within their budget to achieve their deliverables.

Step 2 – Invoicing

Leaders/facilitators who are subcontractors with the H.S.A will invoice per parent organization’s requirements. Please provide a copy of the subcontractor’s invoice when seeking reimbursement through the Blueprint HSA grant.

Step 3 – Reimbursement

Regional Coordinator will invoice Department of Vermont Health Access for reimbursement.
Active Leader Status Summary

To become an Active Leader:
- Successfully complete the 4-day Leader’s Training

To remain an Active Leader:
- Facilitate at least one 6-week workshop per year
- If unable to facilitate during a given year, take refresher training
- Cannot take refresher training 2 years in a row

To become an Active Leader in more than one program:
- Attend a training or a cross-training for the new program

To remain an Active Leader in more than one program:
- Facilitate at least one 6-week workshop per year in either program
- If unable to facilitate any program during a given year, take refresher training
- Cannot take refresher training 2 years in a row
- Facilitate at least one workshop in each program every 2 years

Leader MUST DOs
- Leaders should be persons who have the condition that is targeted in the workshop or live with a person with the condition. In the case of Building Better Caregivers, the Leaders should have family caregiver experience. It is highly recommended that both Leaders meet this criterion, but at least one of them must.
- Leaders should come from the same communities you want to serve (think about ethnicity, culture, race, socio-economic status, etc.).
- Leaders must be willing to facilitate in the communities that you wish to serve.
- Leaders must be comfortable speaking in front of groups.
- Leaders must read, write and speak fluently the language of the workshop participants.
- Leaders must be literate in the language in which they are going to facilitate (this means that they must read well at about a 10th grade level). They must read fluently the Leader’s Manual.
• Leaders must be willing to facilitate workshop in “off hours” (Saturday, evenings, etc.). (Please note, if your program does not deliver the program off hours, then this does not apply, and exceptions may be made for extenuating circumstances).

• Leaders must have or be willing to arrange transportation to get to the site of workshops.

• Leaders must be able to or willing to find help to transport training materials and light equipment (an easel for example).

• Leaders must be a model for participants (i.e., working on maintaining healthy behaviors).

• Leaders must commit to facilitating at least one 6-week workshop (all 6 sessions) every 12 months from the date first achieves Leader status to remain active as Leader.

• Leaders must be willing to attend (if available locally) a refresher course if they become inactive.

• Leaders must be willing to be re-trained if they become inactive and the option of a refresher course is not available.
Position Description - Lifestyle Coach

Role of the Lifestyle Coach: Lifestyle Coaches implement a CDC-approved curriculum designed for effective lifestyle change for preventing or delaying type 2 diabetes, and provide support and guidance to participants in the program.

Responsibilities of the Lifestyle Coach:  

a. Delivering the lifestyle change program and adhering to a CDC-approved curriculum with the required intensity and duration (per the Diabetes Prevention Recognition Program Standards and Operating Procedures, i.e., DPRP Standards) to class participants in an effective, meaningful, and compelling way.

b. Encouraging group or individual participation and interaction through the use of open-ended questions and facilitating commitment to activities for effective lifestyle change.

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

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

e. Preparing for each class by reviewing the lesson plan and class content, reviewing data, making reminder calls or sending text messages to participants, and reviewing participants’ food and activity trackers.

f. Being accessible to participants both before and after sessions to answer questions.

g. In collaboration with the Program Coordinator and/or Data Preparer, recording, entering, and submitting session data elements for each participant as noted in Table 2 within the DPRP Standards (i.e., attendance, body weight, total weekly minutes of physical activity, etc.).

h. When make-up sessions are needed, following up with participants outside of class if they were unable to attend a session that week (during months 1-6) or month (during months 7-12) to offer a make-up session (make-up sessions should consist of a one hour, in-person discussion or can be delivered via phone, video conference, or virtual session).

i. Supporting and encouraging goal setting and problem solving.

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

k. 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]).

l. Completing the required organizational trainings, refresher or new skills trainings, and trainings offered by CDC, such as DPRP-related webinars.

Adapted from 2018 CDC Diabetes Prevention Recognition Program – Standards and Operating Procedures.
### National Diabetes Prevention Program Intake Form

**Step 1: Participant Details**

<table>
<thead>
<tr>
<th>Field</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:*</td>
<td></td>
</tr>
<tr>
<td>Last Name:*</td>
<td></td>
</tr>
<tr>
<td>Gender:*</td>
<td>□ American Indian or □ Hispanic/Latino</td>
</tr>
<tr>
<td></td>
<td>□ Alaska Native □ Not Hispanic/Latino</td>
</tr>
<tr>
<td></td>
<td>□ Asian</td>
</tr>
<tr>
<td></td>
<td>□ Black or African American</td>
</tr>
<tr>
<td></td>
<td>□ White</td>
</tr>
<tr>
<td>Date of Birth:*</td>
<td>□ Native Hawaiian or another Pacific Islander</td>
</tr>
</tbody>
</table>

**Step 2: BMI & Qualification Criteria** *(Must meet BMI requirements AND either 1 or 2 below)*

<table>
<thead>
<tr>
<th>Field</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height (ft):*</td>
<td></td>
</tr>
<tr>
<td>Height (in):*</td>
<td></td>
</tr>
<tr>
<td>Weight (lbs):*</td>
<td></td>
</tr>
</tbody>
</table>

For program participation, BMI $\geq 25$. If identify as Asian BMI $\geq 23$

1. **Blood Value Diagnosis Qualification**: (one self-reported value must fall within () range)

   - □ A1C: ______ (5.7%-6.4%)
   - □ Glucose tolerance test with 75g load: ______ (140-199mg/dl)
   - □ Fasting blood sugar: ______ (100-125mg/dl)
   - □ Any previous diagnosis of Gestational Diabetes (GDM)

2. **At-Risk Qualification**: (Score must be $\geq 9$ to qualify for enrollment in this category)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes – Points</th>
<th>No – Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the candidate birthed a baby weighing more than 9 pounds?</td>
<td>□ 1</td>
<td>□ 0</td>
</tr>
<tr>
<td>Does the candidate have a brother or sister with diabetes?</td>
<td>□ 1</td>
<td>□ 0</td>
</tr>
<tr>
<td>Does the candidate have a parent with diabetes?</td>
<td>□ 1</td>
<td>□ 0</td>
</tr>
<tr>
<td>Does the candidate weigh as much or more than the weight listed for their height?</td>
<td>□ 5</td>
<td>□ 0</td>
</tr>
<tr>
<td>Is the candidate younger than 65 years of age and gets little or no activity in a typical day?</td>
<td>□ 5</td>
<td>□ 0</td>
</tr>
<tr>
<td>Is the candidate between 45 and 65 years of age?</td>
<td>□ 5</td>
<td>□ 0</td>
</tr>
<tr>
<td>Is the candidate 65 years of age or older?</td>
<td>□ 9</td>
<td>□ 0</td>
</tr>
</tbody>
</table>

Total Risk Score:__________

**If eligible, please fill out the section below:**

### Step 3: Contact Information and Referral Source

**Email address:**

**Street Name:** *

**Street Name 2:**

**City:** *

**State:** *

**Postal Code:** *

**Preferred phone number:**

**Participant Insurance Type:**

**Referral Method:**

- □ Non-primary care health professional
- □ Primary care provider/office
- □ Community-based organization
- □ Self
- □ Family/friends
- □ An employer or employer’s wellness program
- □ Insurance Company
- □ Media
- □ Other: ____________________________
- □ Website: ____________________________

**Provider’s Office:**

**Highest education attained:**

**Number of people in household:**

**Annual household income:** □ < $20,000 □ $20,000-$30,000 □ $30,000-$40,000 □ $40,000-$50,000 □ $50,000-$75,000 □ $75,000

*Required information to complete enrollment*
# Self-Management Attendance Sheet

**HLW**

<table>
<thead>
<tr>
<th>Workshop ID</th>
<th>Workshop Type</th>
<th>Chronic Pain</th>
<th>Average Wait Time (Weeks)</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Coordinator</td>
<td>Workshop Start Date</td>
<td>Workshop End Date</td>
<td>% Completers (Part. to Comp)</td>
<td>0.00%</td>
</tr>
<tr>
<td>HSA</td>
<td>Day of the Week</td>
<td>Avg. Number of Attendees/Session</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Town Where</td>
<td>New Registrants</td>
<td>Participants</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Workshop Held</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workshop Location</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitator 1</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitator 2</td>
<td>0</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Phone</th>
<th>Zip Code</th>
<th>Date Registered</th>
<th>DOB</th>
<th>Referral Source</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
<th>6th</th>
<th>Total Attended</th>
<th>Reason for dropping out or no show</th>
<th>Address</th>
</tr>
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<tbody>
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**Workshop Notes**

**Note These Notes:**
### Self-Management Attendance Sheet

**Workshop ID**

**Workshop Type**

**WRAP**

**How many sessions?**

**Average Wait Time (Weeks)**

**No Show % (New Registrants)**

**% Complete (Part. to Comp)**

**Avg. Number of Attendees/Session**

**Total Hours Attended**

**Reason for dropping out or no show**

**Address**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Phone</th>
<th>Zip Code</th>
<th>Date Registered</th>
<th>DOB</th>
<th>Referral Source</th>
<th>Primary Care Physician</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
<th>6th</th>
<th>7th</th>
<th>8th</th>
<th>9th</th>
<th>10th</th>
<th>Total Hours Attended</th>
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**Workshop Notes**

**Workshop Notes**
PREVENT T2 WORKBOOK ETOOL GUIDE

Directions:
1) Open up Prevent T2 Workbook eTool excel spreadsheet.
2) On the “Homepage” tab, select cell with text “Your assigned workshop ID: (type here)” and enter workshop ID number.
3) Enter H.S.A name
4) Enter Facilitator name
5) All fields in Step 1: Participant Details, Step 2: BMI & Qualification Criteria and personal contact information is required in order to enroll in Prevent T2 program. Please refer to the PDF/hardcopy National Diabetes Prevention Program Intake Form for required fields, as marked by an asterisk (*).

How to enter Registrant information:
1) Go to “Screening & Intake” tab on excel workbook
2) Under “Submit your participant info clicking the button below” header, click the grey Screening & Intake Form button. This will open a new window with the e-form
3) If transcribing information from hardcopy, fill out all according fields. The e-form follows the same format as the National Diabetes Prevention Program Intake form (2.0)
4) In Step 1: Participant Details Section, enter DOB information in following format: MM/DD/YYYY. Example: 01/01/1990
5) In Gender field, please enter additional information provided by the individual. Otherwise, leave blank
6) Select one option for participant ethnicity. If individual did not answer this section, select “Prefer not to say”
7) Select checkboxes for reporting on participant ethnicity. If individual identifies multiple races, check boxes as needed
8) In Step 2: BMI & Qualification Criteria Section, enter participant height in feet and inches measurement. If individual has ½ inch measurement, round to the nearest inch.
9) In Weight (lbs) field, enter participant weight as whole numbers. If weight is less than .4lbs, round down to lowest pound. If weight is equal or greater than .5lbs, round up to the nearest pound.
   In order to qualify to participate in the Prevent T2 program, individuals must have a BMI of equal/greater than 25kg/m² (if Asian American, then equal/greater than 23kg/m²). You can follow the blue hyperlink in the e-form to open up a webpage to the CDC BMI calculator. ALSO one of the following qualifiers:
   - Blood Value Test diagnosis
   - Previous diagnosis of Gestational Diabetes (GDM)
   - If neither of the above apply, individual must take Risk Test
PREVENT T2 WORKBOOK ETOOL GUIDE

10) Individual must answer all questions. Check answers as Yes or No as reported. If individual is eligible, select Yes option. If not, select No option. If BMI is less than threshold above, then do not submit the registration form. Follow up with individual on eligibility requirements.

11) When checking off answers on Risk test, the Total Risk Score will calculate at the end of the section. Total Risk Score must be 9 or greater in order to qualify if no other blood tests done or no history of GDM. Example below:

12) If individual is eligible for Prevent T2 program, proceed to enter information in Step 3: Contact Information & Referral Source Section.

13) Enter “N/A” or “Not applicable” if individual does not provide personal information or field is not applicable to their status. For example, if individual does not have an email address or Primary Care Provider.

14) In the “If individual is eligible for program, please fill out the following fields:” section, select reported dropdown options. If individual leaves blank or there is no response, select “Prefer not to say” or “Not reported.”
15) All participants must have a unique ID number *not containing* PHI or personal identifiable factors (such as SSN digits, initials, DOB, etc.). Participant ID numbers must be unique to the individual and cannot be repeated *within* the same workshop. We strongly recommend creating a participant ID containing the workshop ID number provided and a corresponding number.

16) Once participant ID is entered, review all fields for participant information.

17) To submit and save registrant information, click the “Submit Form” button at end of e-form. A message will pop-up to confirm the data submission.

18) To clear the form and enter another individual’s information, click the “Clear Form” button. It will clear all data entry fields. Enter new information in fields as needed.

19) To close the form and view tables, click the “Close Form” button or click on X button on top right-hand window. See an example below:

20) After closing the form, review participant information entered in “Screening & Intake” table. If changes or notes need to be made, rows can be edited.
Submit your participant info clicking the button below:

Weekly Data Collection Directions:
1) Go to “Weekly Data Collection” tab on workbook
2) Under the “Submit weekly data collection here by clicking the button below:” header, click the grey Weekly Data Collection Form button
3) If transcribing information from PDF or hardcopy, please follow the same data entry format as shown in e-form. Only submit weekly data for individuals that attended the session. This will ensure only capture information of those who came to the class
4) For each participant who attended class session, select corresponding participant ID from dropdown menu. You will be brought back to the “Screening & Intake” tab Participant Registration Information table
5) In the Enter the following section, enter date in following format: MM/DD/YYYY
6) In session number, select which class session data is being entered for (ex. 5th class = session number 5)
7) In session type, select appropriate option from dropdown menu. Here is a breakdown of the options:
   - C – Core session → Individual attends class session within first 16 weeks (within months 1-6)
   - CM – Core maintenance → individual attends class session within months 7-12 (after core 16 weeks)
   - OM – Ongoing maintenance → *Not applicable currently*
   - MU – Make-up session → Individual make-up session. *participants are limited to 1 make-up session per week MAX. Make-up sessions can occur throughout program
8) In the Participant Details section, enter their weight using only whole numbers in Participant Weight field. If the individual becomes pregnant while attending the class, enter their weight as 998. If an individual attends a session but was unable to provide their weight, enter 999
9) Enter physical activity minutes for each participant. If participants did not track physical activity minutes, enter value 999 (as not reported). Enter number of minutes between 0 and 997 (if exceeding 997 minutes, only enter up to 997)
10) Enter food journal completion as applicable per participant
11) To submit and save weekly participant information, click the “Submit Form” button at end of e-form. A message will pop-up to confirm the data submission
12) To clear the form and enter another individual’s information, click the “Clear Form” button. It will clear all data entry fields. Enter new information in fields as needed.

13) To close the form and view tables, click the “Close Form” button or click on X button on top right-hand window. See an example below:

![Weekly Data Submission Form]

14) After closing the form, review participant information entered in “Weekly Data Collection” table. If changes or notes need to be made, rows can be edited.

Please contact the UVMMC CHI Team if you have any further questions. Thank you!
Nicotine Replacement Therapy FAQ for Vermont Quit Partners

- **Who provides NRT?**
  The Vermont Quit Partners can provide Freshstart class attendees with Nicotine Replacement Therapy (NRT) through a partnership with the Vermont Tobacco Control Program. The benefits available from the Vermont Tobacco Control Program (TCP) are subject to change and availability.

- **Can my clients get NRT from another source?**
  Clients may also have NRT and cessation medication benefits through their insurance. This is a good option to check on before a class, after a class, or if they need more than the amount provided through the Tobacco Control Program.

- **How do I order NRT?**
  VQPs can order NRT for their clients through the online platform [see ordering instructions](#). If you need to get access to this platform for a new facilitator that has undergone tobacco treatment specialist and Freshstart training, please send the facilitator’s information to Statewide Self-Management Program Coordinator. Please also alert Program Coordinator if a facilitator leaves.

- **What is the NRT benefit available through the Tobacco Control Program?**
  Freshstart class attendees can receive eight weeks of short AND long acting NRT in a 365 day period from their initial NRT order. This means a client can receive eight weeks of patches and gum or lozenges, available in two- or four-week increments. This is the most publicized option and dual therapy is highly recommended.

- **What is considered a “week” of NRT?**
  A “week” of NRT is defined as a set amount of NRT. Ex. 7 patches is one week of patches.

- **What is if my client needs a higher dosage?**
  If a client requires a higher dosage, such as more than one 21 mg patch per day or they go through a higher number of lozenges than is shipped for a two or four week benefit they would use up their allotted benefit before eight weeks of time elapsed.

- **Do I HAVE to supply my clients dual NRT?**
  VQPs that have completed the tobacco treatment specialist training are well suited to assess the amount and kind of NRT appropriate for the client. If there is a case where someone would do best on only gum or only lozenges or only patches they can receive 16 weeks of one NRT item. This means they deplete their annual benefit after 16 weeks and would not be eligible for eight weeks of dual NRT until 365 days from their first order.
Nicotine Replacement Therapy Order Portal
User Manual
Table of Contents:

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Overview

Welcome to the Nicotine Replacement Therapy Order Portal managed and supported by Arrowhead Promotion & Fulfillment. This training guide serves as a tutorial for the basic instructions to walk you through the order site capabilities. Depending on the privileges you are assigned, you will be able to:

- Create New Orders
- Look Up Orders
- Place Subsequent Orders
- View & Edit Settings
**Login:**

Arrowhead will assign one ‘Super User’ to each company. The Super User has the ability to add additional users and delete existing users at their discretion. Once your company’s Super User creates your user profile, you will be able to login as outlined below.

Access the order portal through your web browser at:

[https://apfco.com/secure/w1200/portal/](https://apfco.com/secure/w1200/portal/)

*Tip: Save the link as a shortcut on your desktop for future access.*

Once you access the site, the login page appears as below:

1. Enter your Login ID. Typically your email address.
2. Enter your Temporary Password. This will be assigned by your company’s Super User.
For Security reasons, the first attempt at logging in will prompt you to change your temporary password. You will use the new password to log in for all future attempts.

If you forget your password, please click on the “forgot password” link on the main login page and change password instructions will be e-mailed to you.

*Note:* Login ID and Password fields are case sensitive. If you are having trouble logging in, double check your caps lock button.
Creating a New Order:

To create an order for a new participant, there are two options:

1. Click on the ‘New Order’ button.
The ‘Participant Information’ page will appear as below:

- All fields with a *red asterisk are mandatory. If a mandatory field is left blank or the participant is under 18 years of age, an error message will appear.
- Adding your e-mail address is optional but recommended for tracking # information. Once the order ships from Arrowhead an order confirmation and tracking # hyperlink will be sent to your e-mail address.
- The Client ID is selected from a drop-down list and should be “502700 - 802Quits”
- The Participant ID is created by you and serves as an order number.*
- The Order Date is automatically populated with the current date.

Once all the information is populated, select ‘Continue’.

* NOTE : To order dual therapy for a client you must submit two orders and the participant ID must be different for each order. For example, to order patches for a client you may use the ID “02122018KSKa” and to order gum or lozenges on the same day you may use the ID “02122018KSKb”
The ‘Choose Treatment’ page will appear as below:

Note: This page will reflect Vermont’s current treatment protocol and product offering. It may not be identical to the screen shot below.

1. Select the ‘Product’ formulation i.e. Patch, Gum, or Lozenge.
2. Verify and select ‘Shipment #’, 1 or 2.
3. Depending on the product selected, you can filter on ‘Cigarettes per Day’ or ‘Time to First Cigarette’.
4. Additionally, you can filter on the milligram dose strength, ‘2mg’ or ‘4mg’ if gum or lozenge is selected as the product.
5. Once you have identified the appropriate participant treatment option, click ‘Select’.

Special Feature: To learn more about a specific product click on the ‘Product Image’ to be directed the product web site which includes updated FAQs.
An ‘Order Confirmation’ page will appear as below:

1. Review the Participant Information for accuracy.
2. Review the ‘Treatment Selected’ in lower right section of the screen.
3. If any of the information on the ‘Confirmation Page’ needs revised, you can select ‘Change Address’ and/or ‘Change Treatment’.
4. You also have the option to cancel the order by selecting ‘Cancel Order’.
5. If the information is accurate, select ‘Submit Order’.
After selecting ‘Submit Order’, the following screen will appear:

The order number is clearly displayed for your records.

Once the product has shipped, an email confirmation will be sent if an email address was provided. The confirmation will contain the ship date and tracking information.
**Lookup Orders:**

To lookup an order, there are two options:

1. Click on the ‘Lookup’ button.
The ‘Lookup’ page will appear as below:

A lookup search can be completed by completing just one field. The more fields completed the more advanced the search.

1. Complete at least one required field.
2. Click on ‘Search’.
The ‘Search Results’ will appear as below:

1. Click on ‘Expand’ to view order detail and status.
Order detail and status is displayed as below:

The following options are available:

1. If the order is still pending, you can request to cancel the order by selecting the ‘Cancel Order’ button.
2. Place another order by selecting ‘Place next order’.
3. Select the ‘Collapse’ hyperlink to minimize the order information and go back to the lookup screen.
4. Exit out of the screen by scrolling up to the tool bar and selecting the appropriate option.
Placing Subsequent Orders:

From the order portal main page you can place a subsequent order for an existing participant without re-entering the participant information.

You’ll need to first locate the existing participant in the portal by selecting ‘Lookup’.
1. Conduct a lookup search as previously instructed.
2. Once you have located the participant, ‘Expand’ the search results to view all the previous order information including the previous items ordered.
3. Select ‘Place next order’.

Note: Each participant ID is allowed only one order per day. If you try to order more than one per day, you will receive an error message.
Upon selecting ‘Place next order’, the portal will automatically populate the next item to order within your company’s existing treatment protocol.

1. You can change to another product formulation or re-order the first shipment if the situation arises.
2. Click ‘Select’ to choose the appropriate next shipment.
An Order Confirmation page, similar to a new order confirmation, will appear as below:

1. Confirm Participant Information and ‘Treatment Selected’ for accuracy.
2. Select ‘Submit Order’.
View & Edit Settings:

The ‘Settings’ tab on the portal main page toolbar allows users to change their profile information and password. Click on ‘Settings’.

1. Select ‘Update Profile Information’ or
2. Select ‘Update Password’
If you select, ‘Update Profile Information’, the page will appear as below:

1. Update accordingly.
2. Select ‘Continue’.
3. A notification will appear that the account has been successfully updated.
If you select, ‘Update Password’, the page will appear as below:

1. Enter your current password.
2. Enter a new password in the ‘Password’ box.
3. Re-enter the new password in the ‘Confirm Password’ box.
4. A notification will appear that the account has been successfully update
Contact Information:

For questions or concerns please email:

802NRT@vermont.gov
Leader Audit Form

Please evaluate the teaching session on the following by marking the appropriate number that best corresponds to your response:

Leader's Name: ___________________________ Workshop Location: ___________________________
Regional Coordinator: _____________________ Date of Audit: ___________________________
Master Trainer Name: _____________________ Session Number: ___________________________

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<tr>
<th>Leader Evaluation Checklist</th>
<th>(4) Excellent</th>
<th>(3) Good</th>
<th>(2) Fair</th>
<th>(1) Poor</th>
<th>N/A</th>
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<tr>
<td>Arrive on-time and prepared to teach session</td>
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<td>Followed the Leaders Manual content and process</td>
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<td>Modeled session activities appropriately</td>
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<td>Worked as a partner with co-leader</td>
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<td>Used brainstorming techniques correctly (ie. Repeated question, used silence, offers own response only at end of brainstorm)</td>
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<td>Used problem-solving (directed questions back to the group for a brainstorm)</td>
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<td>Encouraged group participation</td>
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<td>Modeled Action Planning appropriately</td>
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<td>Positively reinforced group members</td>
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<td>Handled problem people appropriately</td>
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Comments:

Recommend Leader?

☐ Yes

☐ Corrective action required and further review recommended:

☐ No, please explain: