



Lincoln - Lancaster County Community
Diabetes Prevention
 LONG-RANGE OUTCOMES * *Logic Model*

Purpose

Activities

Outcome

Improve the health and fitness levels of all within the City of Lincoln and in Lancaster County.

- Take *ActionNow!* to promote regular daily physical activity and optimal nutrition status.
- Take *ActionNow!* to change the local environment to one that encourages healthy eating and physical activity through policies, behaviors, social norms, habits, environmental characteristics, etc.

- Decrease in the number and proportion of people with pre-diabetes who go on to develop diabetes.
- Decrease in the costs of diabetes.

Improve the longevity and quality of life for all persons within the City of Lincoln and in Lancaster County with or without diabetes.

- Take *ActionNow!* to expedite diabetes prevention, especially among vulnerable and at-risk populations.
- Take *ActionNow!* to decrease the number, proportion, and severity of health consequences of diabetes for the entire population.

- Decrease in adverse health disparities between majority and minority populations' experiences with diabetes.
- Decrease in sentinel events, such as, premature death, amputations, heart surgeries, blindness, dialysis, and other morbidity and disability from diabetes.

Celebrate every community victory that shows that we are reducing the burden of diabetes within the City of Lincoln and in all of Lancaster County!

Live Long & Prosper!

Planning

Phase 1: Roll-out * Phase 2: Implementation

Evaluation

Situation
 Needs and Assets
 Assumptions
 External Factors
 Stakeholder Engagement

Priorities Considered:
 • Mission, Vision, Values
 • Mandates, Resources
 • Local Dynamics
 • Collaborators
 • Competitors

Intended Outcomes

INPUTS	ACTIVITIES	PARTICIPATION	OUTPUTS
What we invest	What we do	Who we reach	What we deliver
<ul style="list-style-type: none"> Partners Staff Volunteers Time Money In-kind resources Materials Equipment Technology Research base Data Work, Thought Energy 	<ul style="list-style-type: none"> Conduct meetings, workshops Deliver services Develop products, curriculum, resources Train Assess Facilitate Partner Work with media 	<ul style="list-style-type: none"> Citizens & citizen groups Key stakeholders Clients, customers, & patients of partners Decision-makers Agencies Community Centers Businesses/Worksites Hospitals/Medical Offices Schools Parent Groups Senior Centers Restaurants Grocery Stores Churches & Faith-based Organizations Health Clubs Insurance Companies Social Organizations Coalitions/Associations Local Entities Related to Health 	<ul style="list-style-type: none"> DIABETES PREVENTION Satisfaction of community needs Healthy choices Healthier communities Better policies and laws Reliable, consistent information Pamphlets, posters, & other tangibles

OUTCOMES

IMPACT

What the results are

Short-range LEARNING
 ○ Awareness
 ○ Knowledge, attitudes, beliefs
 ○ Opinions
 ○ Motivations

Medium-range ACTION
 ○ Behavioral change
 ○ Improve practices
 ○ Decision-making
 ○ Better life-styles
 ○ Policies
 ○ Social Action

Long-range CONDITIONS
 ○ Health
 ○ Social
 ○ Economic
 ○ Civic
 ○ Environmental

Evaluation
 Focus – Collect Data – Analyze and Interpret - Report

Phase 2: Implementation

What we deliver

- DIABETES PREVENTION
- Satisfaction of community needs
- Healthy choices
- Healthier communities
- Better policies and laws
- Reliable, consistent information
- Pamphlets, posters, & other tangibles

Evaluation

Focus – Collect Data – Analyze and Interpret – Report

What's been done – Sampling ONLY

1. Logo & Name: *ActionNow!*
2. “*Diabetes Prevention is as easy as 1 – 2– 3*” Icon
3. Major Messages:
 - a. *Eat Healthy!*
 - b. *Move More!*
 - c. *Know Your Numbers!*
 - d. *You can do it! We can help!*
4. Mayor’s Press Conference
5. Website: 123ActionNow.org

6. Posters
7. Theater ads, billboards
8. Training & Resource Manual
9. Newspaper articles
10. Risk Assessment Test
11. Community-wide Screening
12. Abstracts submitted for national conference

Evaluation

Focus – Collect Data – Analyze and Interpret – Report

What needs to be done – Sampling ONLY

1. Widen the circle of partners at the table including
2. Minority representation.
3. Make specific workplans for the work groups, as needed:
 - a. Outreach – (focus groups +)
 - b. Evaluation – (website +)
 - c. Fund Development
 - d. Steering
4. Create & disband *ad hoc* groups, as needed.
5. Assess & address gaps in strategies already in place.
6. All partners contribute to evaluation of the project.
7. Collect, analyze, & disseminate data/research findings & outcomes.
8. Upstream planning.
9. Phase 3: Create sustainability

Evaluation

Focus – Collect Data – Analyze and Interpret – Report

What we won't do – Sampling ONLY

1. Give up! We're in this for the long-term, to sustain gains.
2. Beat our heads against the wall – by short-term failures/OFI's (called *Opportunities for Improvement*). We will learn & move on.
3. Re-invent the wheel! We'll honorably adopt whenever & wherever we can.
4. Get offended if someone tries to help us! We'll thank them.
5. Stop for fear of failure. We'll relentlessly plan, prepare, & take action.
6. Concentrate all our efforts on “clean-up.” Our focus will be prevention, proactive planning, & action.
7. Get lost in the trees and forget that there is a forest to nurture. We'll work together for the good of our entire community.

Evaluation

Focus – Collect Data – Analyze and Interpret – Report



Lincoln - Lancaster County Community
Diabetes Prevention
*Project Development * SPECIFIC * Logic Model*

Purpose	Activities						Outcome
1. Assess & Address Diabetes Burden	1.1 Identify critical areas of burden and high-risk populations.	1.2 Organize partnerships around areas of interest.	1.3 Assess and address gaps in strategies already in place.	1.4 Create and prioritize measurable objectives.	1.5 Identify and prioritize intervention strategies.	1.6 Identify how and who will implement strategies.	<ul style="list-style-type: none"> • High need areas for diabetes prevention and control selected and prioritized.
2. Build Partnerships	2.1 Identify and convene potential partners.	<div style="border: 2px solid #000; padding: 5px; width: fit-content; margin: auto;"> 2.2 Create work groups. </div>	2.3 Establish partnership leadership.	2.4 Agree on vision, mission, and decision-making processes.	2.5 Assess and increase partner interest and capacity to contribute.	2.6 Develop ways for non-members to join or provide input to partners.	<ul style="list-style-type: none"> • Members stay engaged in diabetes prevention and new members join. • Meetings held and attended.
3. Utilize Data & Research	3.1 Identify available data/research – local, state, national.	3.2 Review data/research basis for action and adjust strategies accordingly.	3.3 Assess and address data/research gaps.	3.4 Identify or create communication links among partners for data sharing.	3.5 Identify or collect baseline data against which to measure outcomes.	3.6 Collect, analyze, and disseminate data/research findings and outcomes.	<ul style="list-style-type: none"> • Ongoing data/research review utilized for strategic development. • Data/research gaps addressed.
4. Mobilize Support	4.1 Assess and address current level of support.	4.2 Re-assess partnership representation and implementation coverage.	4.3 Develop approaches for funding and other resources.	4.4 Build support among the public and private sectors.	4.5 Secure funds and in-kind resources.	4.6 Publicize efforts of the partnership and results of taking ActionNow!	<ul style="list-style-type: none"> • Partnership priorities set for allocation of resources • Objectives reached.
5. Create Sustainability	5.1 Assess needs and capacity for sustaining and increasing gains.	5.2 Gain and increase the support of community leaders.	5.3 Develop work plan that addresses how to continue progress.	5.4 Create core groups, processes, and supports needed for sustainability.	5.5 Establish coordination and monitoring of community diabetes prevention.	5.6 Establish accountability.	<ul style="list-style-type: none"> • Processes and structures to prevent diabetes developed, documented, and implemented.
6. Conduct Evaluation	6.1 Identify resources and persons to plan and do evaluation.	6.2 Create and implement plans for evaluation.	6.3 Provide training on evaluation to partners as needed.	6.4 All partners contribute to evaluation of the project.	6.5 Identify and address challenges, solutions, and outcomes.	6.6 Publish/disseminate findings.	<ul style="list-style-type: none"> • Strategies for assessment, measurement, and reporting of outcomes in place.

Purpose	Activities / Outputs						Outcome
<p>Create & prioritize measurable objectives.</p>	<p>Objective #1 – EAT HEALTHY * MOVE MORE</p> <p>EAT HEALTHY. Proportion of the population that eats 2 cups of fruit and 3 cups of vegetables daily will increase by 15% within 3 years of program start.</p> <p>MOVE MORE. Proportion of the population that routinely engages in 30 – 60 minutes, 5 or more days a week, of physical activity will increase by 15% within 3 years of program start.</p>		<p>Objective #2 – KNOW YOUR NUMBERS</p> <p>KNOW YOUR NUMBERS. Proportion of the population that knows at least some of their diabetes prevention-related numbers, such as, weight, body mass index, blood sugar, and cholesterol will increase by 5% within 3 years of program start.</p>				<ul style="list-style-type: none"> • High need areas for diabetes prevention selected and prioritized.
<p>Identify & prioritize intervention strategies.</p>	<ol style="list-style-type: none"> 1. Do analysis of diabetes prevention and control services and activities, such as promoting healthy weight through physical activity and healthy eating and what numbers are important to know and improve on for diabetes prevention. 2. Advocate for policy and environmental changes that address community gaps in diabetes prevention and control. 3. Launch and sustain a multi-pronged media campaign that appeals to everyone to take ActionNow! to prevent or control diabetes. 						<ul style="list-style-type: none"> • Interventions for diabetes prevention selected and prioritized.
<p>Assess Situation</p>	<p>3.1 Assess & address current situation, using SWOT, gap analysis, etc.</p>	<p>3.2 Document assumptions, external factors, and stakeholder engagement.</p>	<p>3.3 Assess partnership representation and implementation coverage.</p>	<p>3.4 Prioritize “audiences,” & determine how best to reach them.</p>	<p>3.5 Document the LEARNING & ACTION outcomes needed & plan interventions.</p>	<p>3.6 Publicize efforts of the partnership and results of taking ActionNow!</p>	<ul style="list-style-type: none"> • Analyses available to support decision-making & intervention planning for all groups.
<p>Advocate for Change</p>	<p>4.1 Discover and remove barriers to physical activity and healthy eating.</p>	<p>4.2 Advocate for policy & environmental changes.</p>	<p>4.3 Promote continued practice of health-promoting behaviors.</p>	<p>4.4 Increase access to, and choices available for, healthy eating and physical activity.</p>	<p>4.5 Teach motivational interviewing to help encourage behavior change.</p>	<p>4.6 Publicize community resources that encourage healthy eating & physical activity.</p>	<ul style="list-style-type: none"> • Processes and structures to prevent diabetes developed, documented, and implemented.
<p>Media Campaign</p>	<p>5.1 Keep messages simple, consistent, current, and reliable.</p>	<p>5.2 Coordinate ActionNow! development of a community identity to prevent diabetes.</p>	<p>5.3 Develop and roll-out messages, using multiple avenues.</p>	<p>5.4 Assure consistent diabetes messages delivered to constituency.</p>	<p>5.5 Build support among both public and private sectors.</p>	<p>5.6 Develop and use multiple means to publish prevention messages.</p>	<ul style="list-style-type: none"> • Deliverables well utilized, such as, website, video, Rx pad, stairwells, parking lot signs, bike paths, etc.

Risk Assessment & Referral

Purpose	Activities / Outputs						Outcome
<p>Create & prioritize measurable <u>objectives</u>.</p>	<p>Objective #3 - <u>MORE ASSESSMENTS</u></p> <p>3,000 Diabetes Risk Assessments completed during the first 3 years of ActionNow! with referrals made as needed.</p>			<p>Objective #4 - <u>APPROPRIATE REFERRALS</u></p> <p>Referral base appropriate to meet community need. Those screened for diabetes are referred appropriately.</p>			<ul style="list-style-type: none"> Population is systematically assessed. Appropriate referrals made that meet community need.
<p>Identify & prioritize <u>intervention strategies</u>.</p>	<ol style="list-style-type: none"> Develop and implement a systematic community-wide risk assessment process. Assure availability of mechanisms to refer for appropriate services, information, and resources. Create and continually improve on and update a Training & Resource Manual to serve as a dissemination tool for information about how to take ActionNow! to prevent or control diabetes. Assure its continued use and usefulness. 						<ul style="list-style-type: none"> Interventions for secondary prevention of diabetes selected and prioritized.
<p>Community Risk Assessment</p>	<p>3.1 Develop and implement a community-wide risk assessment process.</p>	<p>3.2 Create a standardized method of Risk Assessment that is widely used.</p>	<p>3.3 Assure that Risk Assessment data can be aggregated & reported.</p>	<p>3.4 Increase availability of risk assessment opportunities.</p>	<p>3.5 Create incentives for those participating in Risk Assessment.</p>	<p>3.6 Partner with Prevention Group to promote risk assessment.</p>	<ul style="list-style-type: none"> Planned approach to Risk Assessment and Referral is implemented.
<p>Appropriate Referrals</p>	<p>4.1 Assess and assure availability and access to appropriate referral services, information, & resources.</p>	<p>4.2a Create and publicize a standard referral and follow-up approach.</p>	<p>4.2b Include follow-up approaches appropriate to various situations:</p>	<p>4.2c (1) risk detected, (2) moderate risk detected, and (3) no risk detected,</p>	<p>4.2d including next steps to be taken by assessed individuals.</p>	<p>4.3 Create and publish a partners' information and referral list.</p>	<ul style="list-style-type: none"> More people with pre-diabetes reverse progression to diabetes.
<p>Training & Resource Manual</p>	<p>5.1 Construct a Training & Resource Manual (TRM).</p>	<p>5.2 Use manual as one tool to disseminate information.</p>	<p>5.3 Support behavior change with talk outlines, handouts, & activities.</p>	<p>5.4 Provide sections about how to reduce risks, <i>i.e.</i>, healthy eating and exercise.</p>	<p>5.5 Conduct training sessions to groups who will use the TRM.</p>	<p>5.6 Post TRM info on the website.</p>	<ul style="list-style-type: none"> All diabetes work groups are well-supported with accurate, clear, current, and consistent information.

Treatment & Management

Purpose	Activities / Outputs						Outcome		
<p>Create & prioritize measurable objectives.</p>	<p>Objective #5 – STANDARDS REVIEW Proportion of medical practices that participate in a review of medical community standards of care for diabetes will increase by 30% within 3 years of start.</p>		<p>Objective #6 – DIABETES EDUCATION Proportion of population with diabetes that receives diabetes education referrals will increase by 15% within 3 years of program start.</p>		<p>Objective #7 – DIABETES SUPPLIES The maximum possible proportion of the population with diabetes will obtain no cost or low cost supplies from ActionNow! within 3 years of program start.</p>		<p>Objective #8 – DATABASES ActionNow! will identify or create sources of aggregate information related to diabetes prevention and control in our community within 3 years of start.</p>		<ul style="list-style-type: none"> • High need areas for tertiary prevention of diabetes selected and prioritized.
<p>Identify & prioritize intervention strategies.</p>	<ol style="list-style-type: none"> 1. Identify or develop and implement regular standards review opportunities for healthcare providers and others interested in practicing community-acceptable, medical standards of diabetes care . 2. Promote diabetes education referrals, opportunities, and utilization. 3. Address gaps in need and ability to obtain supplies for adequate management of diabetes. 4. Identify or create sources of aggregate information related to diabetes prevention and control. 						<ul style="list-style-type: none"> • Interventions for tertiary prevention of diabetes selected and prioritized. 		
<p>Standards Review</p>	<p>3.1 Educate providers & office staff on benefits of performance evaluation.</p>	<p>3.2 Assess performance. Need people to gather/ analyze data & a database.</p>	<p>3.3 Interventions. Implement tools and strategies for practices to improve.</p>	<p>3.4 Create Quick Sheets of criteria and documentation needed for diabetes education and other expenses to be paid by 3rd party payers to provide healthcare providers.</p>	<p>3.5 Reassess. Look for changes after intervention/s.</p>	<p>3.6 Share results with the practice and others.</p>	<ul style="list-style-type: none"> • Increased adherence to standards of care. • Increase health of diabetics. 		
<p>Diabetes Education</p>	<p>4.1 Educate patients on value of diabetic education (DE).</p>	<p>4.2 Educate clinicians on value of DE & where offered.</p>	<p>4.3 Reminders to patients and providers.</p>	<p>4.4 Make education affordable.</p>	<p>4.5 Discover and reduce other barriers to receiving education.</p>	<p>4.6 Reassess level of DE within the community.</p>	<ul style="list-style-type: none"> • Better educated patients. • Healthier patients. 		
<p>Diabetes Supplies</p>	<p>5.1 Find funding sources.</p>	<p>5.2 Develop a centralized access point for supplies.</p>	<p>5.3 Educate patients and providers on how to access supplies.</p>	<p>5.4 Secure perpetual funding and manage inventory.</p>	<p>5.5 Assess utilization compared to community need.</p>	<p>5.6 Reassess and report.</p>	<ul style="list-style-type: none"> • Have supplies to manage DM regardless of income, insurance, etc. 		
<p>Community Information</p>	<p>6.1 Identify key information to be gathered & disseminated.</p>	<p>6.2 Develop consistent messages & best info</p>	<p>6.3 Disseminate info to providers, patients, and general population.</p>	<ul style="list-style-type: none"> • Healthier people already diagnosed with diabetes. 	<ul style="list-style-type: none"> • Fewer persons with diabetes than would be expected if current trends continue. 	<ul style="list-style-type: none"> • Healthier Nebraskans overall – with or without diabetes. 			



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