Abstract Summary – Collaborating for Wellness

The Fresno County Department of Public Health's Collaborating for Wellness project will contribute to the improved prevention and management of diabetes, heart disease, and stroke through clinic-based strategies and community clinical linkages.

Building upon a previous pilot project funded by CDC's Partnerships to Improve Community Health (PICH), as well as current work as a sub-awardee of the 1422 Lifetime of Wellness funds, FCDPH will revitalize the Rx for Health program to include improved identification and referral process to CDC-recognized lifestyle change programs. Fresno County will increase preventive interventions through provider referrals to approved diabetes prevention and management classes, chronic disease self-management sessions, nutrition education classes, free/low-cost physical activity opportunities, breastfeeding education, and/or tobacco cessation resources. Sub-contracts will be available to Federally Qualified Health Centers (FQHCs) to establish the referral system.

Some of the key projects will include:

- Engaging and aligning community partners to determine current program availability.
- Coordinating partners to ensure maximum reach of programs, especially to the target population.
- Increasing availability of programs through new trainings and assisting with recognition/accreditation of those programs.
- Improving capacity of current coaches/facilitators through advanced training opportunities.
- Engaging non-physician team members through advanced training to assist with engagement of patients.
- Adjusting clinic workflow to improve identifying patients at risk for diabetes and cardiovascular disease.
- Establishing a Rx for Health referral system utilizing EHRs to refer patients to CDC-recognized lifestyle change programs.
- Working with clinics and FCDPH media vendor to develop targeted messaging for the target population.
- Working with pharmacists and pharmacy students to improve hypertension self-management and incorporate MTM.

Project Narrative – Collaborating for Wellness

A. Background

Fresno County Department of Public Health (FCDPH) is the health authority for the County, and its fifteen incorporated cities, under the leadership of David Pomaville, Director, and Ken Bird, MD, MPH, Health Officer. The mission of FCDPH is the promotion, preservation and protection of the community's health. We accomplish this through identifying community health needs, assuring the availability of quality health services and providing effective leadership in developing public health policies. We are committed to working in partnership with our communities to eliminate health disparities.

The Fresno proposal addresses the following Healthy People 2020 goals: 1) Reduce coronary heart disease and stroke deaths; 2) Increase the proportion of adults with hypertension whose blood pressure is under control; 3) Increase prevention behaviors in persons at high risk for diabetes with prediabetes; and 4) Increase the proportion of persons at high risk for diabetes with prediabetes who report increasing their levels of physical activity, trying to lose weight, and reduce the amount of fat or calories in their diet. The proposal also aligns with national health objectives aimed at creating social and physical environments that promote good health for all by encouraging collaboration across sectors, implementing evidence-based strategies, and measuring the effects of prevention and management activities.

At 6,000 square miles, Fresno County is the sixth largest county by land mass and tenth largest county by population in California. Having one of the fastest growing and most diverse populations, the County has been growing at a rate nearly twice that of California. In 2017, its estimated population was 989,255 (US Census). More than half of Fresno County residents live in a single metropolitan area (nearly 60%) and the rest (approximately 40%) live within rural communities and in unincorporated areas. Fresno County is a minority majority County with more than 50% of the population being Latino, 11% Asian, 5.8%, African American, 3.0% American Indian/Alaska Native, and 0.3% Native Hawaiian and other Pacific Islander in 2017. 29.5% were White (non-Hispanic). Nearly 44.6% of the County population speaks a primary language other than English at home. Compared to the state, 73.8% of County residents versus 82.1% of Californians age 25 or older are high school graduates; only 19.7% of County residents versus 32.0% of Californians age 25 or older hold a bachelor's degree. In 2012, the agricultural industry provided an estimated 48,900 jobs, making up 14.7 percent of all classified industry jobs. The County continues to be one of the top agriculture producing regions in California and the nation.

As of May 2018, Fresno's unemployment rate was 6.9% compared to California at 3.7% and the US at 3.6%. The 2016 median household income was estimated at $45,963 compared to $63,783 for California and $55,322 nationally. More than 25% of the County's population lives below the poverty line compared to 12.7% nationally.

Even though Fresno County is one of the nation's food baskets, the 2016 California Health

Interview Survey (CHIS) estimated that 52.3% of Fresno County adults were not able to afford enough food versus 44.4% for California. A substantial number of County residents were either in or near USDA designated food deserts. Limited access to grocery stores results in fewer choices to quality food and restricts purchase of fresh fruits and vegetables. With few food options, families often depend on fast food or corner stores to feed their children, a diet that is rich in calories but offers little nutritional benefit. Consequently, obesity rates and chronic diseases, such as prediabetes, type 2 diabetes, and high blood pressure, are often higher in areas with high poverty and low access to quality food.

The disproportionate rates of chronic disease among low-income residents are a primary focus for FCDPH. The 2016 CHIS found that Fresno County percentages of overweight and obese adults were 40.2% and 32.4% respectively. These are above the Healthy People 2020 target of 30.6%. The 2018 California County Health Status Profiles indicated that Fresno County's age-adjusted deaths rate from coronary heart disease was 108.1 compared to HP 2020's National target at 103.4 per 100,000 population. The 2016 CHIS found 6.4% of Fresno County adults have been diagnosed with heart disease, as compared to 5.9% of the State. Fresno County ranked 48 out of 58 California counties for deaths attributed to heart disease. The age-adjusted death rate due to stroke was 44.7, higher than the HP2020 target of 34.8 per 100,000 population. The 2016 CHIS found 7.6% of Fresno County adults have ever been diagnosed with diabetes. The age-adjusted death rate due to diabetes in Fresno County was 26.4%, higher than the California rate of 20.7%. Additionally, according to a 2016 study by the University of California, Los Angeles (UCLA), 49% of Fresno County adults are prediabetic or undiagnosed diabetic. Fresno County is designated as a Health Professional Shortage Area in primary care. The 2016 CHIS Health Profile indicated that 53.2% of Fresno County residents received Medi-cal coverage compared to 33.0% of people in California.

Previous countywide assessments highlight the concern of community members, health care providers, academic experts, and community leaders for health challenges attributed to the region's socioeconomic and environmental conditions. All attest to the concentrated poverty in the county and its impact on community health. The marked poor health in Fresno County in comparison to California and the nation is the result of multifaceted issues that demand aligned intervention priorities and strategies from multi-sector partners. Many of the multiple community health challenges in Fresno County can be attributed to the region's socioeconomic and environmental conditions. Fresno, one of the poorest counties in California, is sometimes referred to as "the Appalachia of the West." Social determinants impact health care and health status and manifest as health inequities. The health challenges are far beyond what any one organization can address. The process of focusing priorities will allow for expanded opportunities to align limited resources and target strategies in communities where change is needed and people are primed for action.

B. Approach

i. Purpose

In the Collaborating for Wellness project, FCDPH will partner with local healthcare systems, including hospitals, federally qualified healthcare centers, local managed care plans, mobile health units, and other health community based organizations to implement, expand, and sustain diabetes and cardiovascular disease prevention and management activities. This will be achieved through strategies that include training to expand and improve CDC-recognized lifestyle change programs, removing barriers to care, improving care coordination and continuity of care, and greater utilization of non-physician team members.

ii. Outcomes

FCDPH's strategies align with CDC's outcomes. As outlined in the logic model and the work plan, outcomes will include:

Category A: Diabetes Management and Type 2 Diabetes Prevention

Type 2 Diabetes Prevention

Short –term outcomes:

- Increased access to the National DPP lifestyle change program in underserved areas for people at-risk for diabetes
- Increased community clinical links that support bi-directional referrals to assist in enrolling and retaining participants in the National DPP lifestyle change program

Intermediate outcomes:

- Increased enrollment and retention in CDC-recognized organization delivering the National DP lifestyle change program

Long-term outcomes:

- Increased number of people with prediabetes enrolled in a CDC-recognized lifestyle change program who have achieved 5-7% weight loss

Diabetes Management

Short-term outcomes:

- Increased adoption and use of people with diabetes served by healthcare systems actively using clinical systems and care practices to improve diabetes-related health outcomes.

Long-term outcomes:

- Decreased proportion of people with diabetes with an A1C > 9

Category B: Cardiovascular Disease Prevention and Management

Short-term outcomes:

- Increased reporting, monitoring, and tracking of clinical data for improved identification, management, and treatment of patients with high blood pressure and high blood cholesterol
- Increased use of and adherence to evidence-based guidelines and policies related to team-based care for patients with high blood pressure and high blood cholesterol
- Increased community clinical links that support bi-directional referrals, self-management, and lifestyle change for patient with high blood pressure, high blood cholesterol, and/or who have had a cardiac event

Intermediate outcomes:

- Increased medication adherence among patients with high blood pressure and high blood cholesterol
- Increased engagement in self-management among patients with high blood pressure and high blood cholesterol
- Increased participation in evidence-based lifestyle interventions among patients with high blood pressure and high blood cholesterol

Long-term outcomes:

- Increased control among adults with known high blood pressure
- Increased cholesterol management among patients at high risk of cardiovascular events

iii. Strategies and Activities

Both research and experience have shown that making policy, systems and environment (PSE) changes to scale and sustain lifestyle change programs and community clinical links where people live, learn, work, and play contributes to improvements in short- and long-term health outcomes. The collaborative foundation of this project will allow for greater reach for underserved populations in Fresno County. Collaborating for Health will also build upon the activities completed from two previous awards. Through the CDC-funded Partners to Improve Community Health (PICH) funding in 2014, FCDPH staff completed a Rx for Health pilot project with a one local federally qualified health center (FQHC). This program will be updated and expanded to address identification and referrals of patients with or at-risk for diabetes or cardiovascular disease (CVD). Additionally, as a sub-awardee of the California Department of Public Health (CDPH) 1422 Lifetime of Wellness award, some work has already been completed in the areas of collaboration and diabetes CVD prevention and self-management. FCDPH will work to scale and expand those programs to serve additional communities within Fresno County.

1. Collaborations
    a. FCDPH will collaborate with the CDC for technical assistance and continued quality improvement in regards to national best practices and

evidence based programs for diabetes and cardiovascular disease. FCDPH will also continue to collaborate with the CDPH who has provided excellent leadership and technical assistance with 1422 funding for the past 4 years. For example, they established the Statewide PDSTAT (Prevent Diabetes Stop Test Act Today) workgroup. Through this workgroup, FCDPH has supported the statewide and local implementation and coverage of diabetes prevention programs. They also established the Healthy Hearts California workgroup, which provides resources to improve the heart health of all Californians. The CDPH does an excellent job of coordinating efforts throughout the State to ensure consistent messaging and leveraging of resources where possible.

b. Additionally, FCDPH has several established community relationships that would be significant for this program. These collaborations include working with the local health systems, such as local managed care plans, hospitals, and federally qualified health centers. These health systems will be the venue to reach the priority populations through their clinical settings. They will identify and refer patients to relevant programs and in some cases provide the actual intervention programs on site. One of the local hospitals has the only ADA accredited DSMES program in Fresno County. FCDPH would work with this hospital system to remove barriers to participation while working with our clinics to implement prevention and self-management programs.

   Other collaborations include community-based organizations (CBOs) who could also assist with outreach and program implementation. One local CBO has almost achieved 'recognized' status for the Diabetes Prevention Program (DPP) and will also be the only Medicare Diabetes Prevention Program (MDPP) in Fresno County. FCDPH will work with them to expand their program in order to serve additional patients.

   Other non-traditional collaborations include the Fresno Diabetes Collaborative, a local quality improvement organization and a local pharmacy school. As a part of the Fresno Community Health Improvement Partnership (FCHIP), the Fresno Diabetes Collaborative will act as a hub to coordinate activities and promote programs to the community. Health Services Advisory Group (HSAG) is a quality improvement organization that will assist with training local facilitators for diabetes management classes and will help to coordinate all instructors in the area to reach the priority populations. The local pharmacy school already works with some of the health systems to provide a blood pressure self-management program. The pharmacy students also assist with medication therapy management, which would be up-scaled through this program to address CVD management.

2. Target Populations

FCDPH serves the entire jurisdiction of Fresno County. However, one of the primary targets for this program will be the Hispanic community. Hispanics make up over half of the population of Fresno County and are disproportionately affected by cardiovascular disease and diabetes. From 2012-2016, heart disease and diabetes were the number two and four causes of death for Hispanics respectively. By targeting adults (18+) in this ethnic group to address prevention and management, FCDPH would inherently be reaching most of the population of Fresno County. The Hispanic community faces several challenges. They typically have a lower socio-economic status and make up more than half of the County's Medicaid recipients. Many speak only Spanish, which creates language barriers that also affect their understanding and trust of medical providers, and prevention and treatment options. Additionally, many residents of this population live in rural Fresno County. These areas tend to have very limited access to care, and limited healthy food and nutrition options. FCDPH would decrease health disparities by increasing screenings in hard to reach communities through mobile clinics, improving clinical community linkages to CDC-recognized lifestyle change programs and other support services, improving team-based care and engaging non-physician team members to identify and refer patients, and ensuring that all program interventions in available in Spanish to increase access and utilization of these programs.

Other target populations will include urban and rural low-income, Medicaid/Medi-cal recipients, immigrant populations, and the medically underserved.

C. <u>Applicant Evaluation and Performance Measure Plan</u>

Through a review for proposals (RFP) process, FCDPH will select an Evaluation contractor that will plan, implement, and report on a comprehensive performance management and evaluation for the Collaborating for Wellness project. With guidance from program staff, and key stakeholders and partners, the Evaluation contractor will, as directed by CDC, participate in implementing the National Evaluation Plan and act on recommendations from CDC and contractors on how best to implement evaluation directives. The Evaluation contractor will assist Fresno County in all required reporting on program evaluation actions and findings as well as overall program activities, performance, and outcomes on a quarterly and annual basis.

The proposed approach includes both process and outcome evaluation activities, collection of key annual performance measures and other indicators of short-term outcomes and program reach for all proposed interventions and calculation of overall performance expressed as reach to individuals using intervention settings. The following sections describe partner roles, evaluation overview, key questions, performance measures, data sources, use of evaluation findings, potential contribution of the innovative strategy, and links to other site and national evaluations.

Program Partners' Roles in Evaluation and Performing Measurement Planning:
Throughout the planning of evaluation and performance management activities, and for the subsequent tracking and reporting of evaluation implementation and preliminary findings, FCDPH and the Evaluation contractor will work in close partnership. At least bi-weekly planned meetings between FCDPH and the Evaluation Contractor will support and ensure the continuity of this partnership. The approaches described here will be further articulated and reviewed at program steering committee/stakeholder meetings, which will include the healthcare systems sub-contractors. Throughout the five-year project period, there will be regular reporting to community partners and stakeholders on evaluation implementation and process/outcome evaluation findings. Their guidance will be sought on potential improvements or supplements to evaluation activities based on this ongoing consultation.

Overview of the Process and Outcome Evaluation: FCDPH proposes to conduct and report on a comprehensive process and outcome evaluation, including documentation of proposed activities and collection of performance measures for all strategies and activities. FCDPH will select strategies A3, A5, B4 and B5 for more rigorous evaluation.

Evaluation Component	Activities/Tools/Deliverables
Process Evaluation: Activity Tracking	Activity logs, event summaries, document review, interviews
Supplemental Process Evaluation • Increased engagement of non-physician team members • Advanced training for non-physician team members to increase patient engagement and referrals	Interviews with FQHC clinicians, community providers, community partners on referrals/outcomes
Performance Measure: • # of clinic sites using the Rx for Health Program • # of enrollments into CDC-recognized lifestyle change programs • # organizations offering a CDC-recognized lifestyle change program • % improved health outcomes as a result of intervention programs	EHR reports/queries and patient health indicators (de-identified)
Supplemental Impact Measures: % of patients with changes in PA/self-care behavior and behavioral intention	Sample of participating patient pre-post health behavior and stages of change survey

Key Evaluation Questions: Evaluation questions will be further refined through consultations with community partners and the CDC. The evaluation will address some basic questions across each of three program initiatives:
1) Did Fresno County implement the proposed program activities and achieve milestones?

2) How were diverse community partners, organizations, and perspectives integrated into implementation of the program? How have other factors influenced implementation of activities and achievement of milestones?
3) Did Fresno County achieve the performance objective?

In addition, for the outcomes evaluation of the program and associated effort to increase accessibility of prevention and management community options, two additional questions will be explored:

1) What were the effects of the Rx for Health initiative on physical activity/self-care program participation, health care utilization, and health status?
2) How did the organization of FQHCs, physician engagement, community organization structures, and community recreation resources influence the implementation and outcomes of Rx for Health?

Performance Measures: The performance measures are aligned with CDC's logic model and are outlined in the work plan. FCDPH assumes that overall performance measures/reach will be determined in partnership with CDC. Annual measures include the proportion of the population (and FQHC patient population) with access to CDC-recognized lifestyle change programs. The evaluation will also examine supplemental performance measures the number of organizations offering programs to the target population and the number of persons actually referred to and participating in intervention programming. Outcome measures included in the Rx for Health innovative program evaluation include improved health outcomes such as lowered A1C, reduced weight, and lowered blood pressure.

Data Sources and Data Collection (data management plan): FCDPH and evaluators will track the completion of program activities and achievement of milestones through activity logs, event summaries, and document reviews. These data and qualitative interviews will be collected along with tracking data to address barriers and facilitators of milestone achievement. Data on the number of (FQHC and other) patients receiving care in a setting with Rx for Health infrastructure and referral partners will be collected from the healthcare system sub-contractors using queries to ensure integration of the EHR systems. All data will be de-identified. Also tracked will be the number of sites and events available for low / no-cost PA and access to food services that are linked to FQHC and other Rx for Health initiatives. FCDPH staff will work with the Evaluation contractor to determine standards to be used for the collected or generated data and to establish a means to store, access, and archive the data.

Using Evaluation Findings for Continuous Program and Quality Improvement: Based on relationships established through prior collaborations, the Evaluation contractor will be in frequent and regular contact with the FCDPH about implementation and early findings from the evaluation. On a quarterly basis, the Evaluation contractor will review activity completion and milestone achievement documentation to observe opportunities for adjustments to program activities and quality improvement. Preliminary findings on performance measurement and other indicators will be shared and reviewed for possible program improvements as they become available.

D. Organizational Capacity

Fresno County is a "large county" with a mix of big city challenges and a small town atmosphere. The Department specifically prioritizes health equity, system change, and policy-level work to address a broad spectrum of local health challenges, including chronic disease prevention, maternal, child and adolescent health, and communicable disease prevention. Capacity building activities will take place in urban and rural areas across Fresno County, will concentrate in areas with identified health disparities, and will engage subpopulations including low-income Hispanic, Southeast Asian and African American families, farmers and farmworkers, and the medically underserved. The Department serves the entire jurisdiction of Fresno County.

FCDPH's commitment to lead the community in the prevention of heart disease, stroke diabetes, and obesity is described by the Health Officer, Dr. Ken Bird, in his May 20, 2014 Fresno Bee op-ed titled *Diabetes Team Up to Beat Diabetes*, "We have the information and resources to prevent and control the illness. We must, as a society, apply all of our resources to the effort. We cannot afford to let this epidemic go unchecked." In the op-ed, Dr. Bird also called upon the *Eight Pillars of a Healthy Fresno County* to engage in chronic disease prevention:

1. Individuals: Learn about, and adopt, regular physical activity and healthy eating habits.
2. Families: Ensure the safe, loving, and supportive environment that fosters personal growth.
3. Employers: Adopt and emphasize wellness in the workplace.
4. Retailers: Assure our community has ready access to healthful products and services with limited marketing of unhealthy products and services.
5. Medical and Mental Health Providers: Offer our patients every preventive intervention available.
6. Educators: Assure that each student fully understands the meaning and value of health.
7. Community and Spiritual Leaders: Enhance partnerships to assess the health needs of our community and implement actions proven to be effective.
8. Public Officials: Assure that every decision and policy reflects a careful consideration of its public health impact.

The Fresno Bee op-ed was followed by a detailed call to action in Dr. Bird's regular letters to the community at www.fcdph.org/toyourhealth in a series called *Chronic is Prolific*.

FCDPH has a long history of engaging community, local, regional and statewide agencies to identify and develop environmental, policy and systems change strategies to address obesity, tobacco use, and related chronic conditions. Through new, unique and existing partnerships, FCDPH continues to build capacity to address chronic diseases "upstream" and reduce the burden of obesity, diabetes, CVD, and other related chronic diseases utilizing Health in all Policies and the socio ecological models.

FCDPH has been actively working to address social determinants of health, health equity, planning and built environment, health in all policies, and similar environmental and system change work for at least the past two decades. FCDPH's Office of Health Policy and Wellness is dedicated to chronic disease prevention program planning and development of strategies for reducing health disparities in Fresno County through evidence and practice-based population-based policy/systems change. Through the Fresno Fresh Program, the SNAP-Ed Nutrition Education and Obesity Prevention Program (NEOP), Tobacco Prevention Program, the Lifetime of Wellness program, and the Partners to Improve Community Health (PICH) program, staff have successfully implemented policy level/systems changes including increasing access to healthy foods, reducing exposure to unhealthy options, increasing physical activity opportunities, increasing access to smoke-free and tobacco-free environments, increasing access and coverage of diabetes and hypertension prevention programs, and improving clinical community linkages. Our role has included leadership and facilitation of county stakeholders in strategic planning, resource allocation, implementation of key strategies, evaluation, and reporting outcomes, and communicating formally and informally about the work being done. While many strides have been made, there are still many significant challenges to overcome to fully address Fresno's health equity disparities and to "make the healthy choice, the easy choice" for all Fresno County residents.

FCDPH is uniquely positioned and ready to lead and coordinate the proposed implementation. As a sub-awardee of the CDPH 1422 funding, FCDPH program staff have been working on diabetes and cardiovascular disease prevention efforts since 2014. FCDPH worked with the CDPH to plan and implement scope of work activities to address diabetes and cardiovascular disease prevention locally. In this role, FCDPH also sub-contracted with a local federally qualified health center to implement several of the clinical activities. FCDPH provided technical assistance to incorporate workflow changes to address diabetes and hypertension prevention efforts. This foundation will lead to seamless work to incorporate additional activities regarding management of these illnesses. Program staff also collected data to share with the statewide evaluator to determine best practices and program effectiveness. Additionally, FCDPH anticipates completing a local community needs assessment this fiscal year, which will inform our local strategic planning process. Through this assessment, FCDPH will be able to determine additional barriers or challenges to access care and services for those with or at-risk for diabetes and/or cardiovascular disease.

Through FCHIP, several agencies and organizations in the County are currently engaged in very creative work to improve the health status of the community. As a member of the Fresno Diabetes Collaborative, which is a workgroup of FCHIP, FCDPH is well versed in what current resources are available and where gaps exist. Members of the Fresno Diabetes Collaborative include: Community Regional Medical Centers, Valley Children's Hospital, Dairy Council of California, United Health Centers of the San Joaquin Valley, Valley Health Team, Centro la Familia, Anthem Blue Cross, CalViva Health Net, the California Health Collaborative, the Central California Asthma Collaborative, and St. Agnes Medical Center.

FCDPH staff leads the sub-committee to address the diabetes prevention program. In this role, FCDPH monitors and evaluates activities, and provides technical assistance to other local agencies to apply for recognition status through the Diabetes Prevention Recognition Program (DPRP), to implement the program in both clinical and community settings, and to coordinate recruitment activities throughout the County. This collaborative group will continue to support, inform, and assist with coordinating resources and performing outreach to the community.

FCDPH has access to expertise and resources through active partnerships with several statewide organizations: California Department of Public Health (CDPH), California Conference of Local Health Officers, California Center for Public Health Advocacy, California PDSTAT, Healthy Hearts California, and the Local Government Commission. FCDPH is also a member of NACCHO's Big Cities Chronic Disease Community of Practice.

FCDPH provides core public health, environmental health, and emergency response programs. With more than 50 years of successful administration of agreements, contracts, and budgets, FCDPH currently administers more than 250 local, state and federal revenue agreements and contracts for services. FCDPH places a high priority on contracting for services through local vendors. FCDPH routinely works with local policy makers, agency representatives, community-based organizations, and resident groups as well as state and nationally recognized public health leaders.

The Collaborating for Wellness project will be housed in the Office of Health Policy and Wellness. This office administers chronic disease prevention programs, which focus on policy, systems and environmental change. Staff assigned to work on this project will include:

Principal Investigator: Melanie Ruvalcaba, MPH (25%) – Ms. Ruvalcaba will be the PI. As the Manager of the Office of Health Policy and Wellness, she has ultimate oversight for all program activities.

Project Manager: Ana Cruz, MPH (60%) – Ms. Cruz will be responsible for all aspects of completing the work plan, including tracking timelines, maintaining documentation, compiling reports and supervising staff.

Health Education Specialists: Vacant (100%) – This position will require a Bachelor's degree in community health or a related field. The HES will work with the project lead and project coordinator to ensure completion of all work plan activities.

Two additional administrative support staff positions include a Staff Analyst, to assist in contracts, tracking invoices, and other administrative approval processes, and an Office Assistant, to assist in all projects related clerical processes.

The Office of Budget and Finance handles all aspects of budget development and

monitoring, accounts payable, and accounts receivable for FCDPH's over $83 million budget. Fresno County's financial management system is PeopleSoft, an integrated financial software package that provides a wide variety of business applications and reports. Each application, Financials, Customer Relationship Management, and Human Resources, interacts to offer an effective and efficient means of processing and reporting. Data derived from PeopleSoft queries will be utilized to fulfill grant requirements. FCDPH has in place a mechanism to track leveraged funds from additional sources.

Work Plan – Collaborating for Wellness

Category A: Diabetes Management and Type 2 Diabetes Prevention

Strategy Description A.1 Implement systems to facilitate bi-directional e-referral between healthcare systems and CDC-recognized lifestyle change programs for type 2 diabetes prevention.					
Activity Description	**Lead Personnel Assigned**	**Contributing Partners**	**Key Contracts & Consultants**	**Start Quarter**	**End Quarter**
Activity A.1.1 Contractor will convene and coordinate local CDC-recognized lifestyle change programs to gather current information: availability, location, language, cost, capacity, current referral process, and additional support (childcare, transportation, etc.). Update information on the Fresno Diabetes Collaborative web site (www.fresnodiabetes.org). Also update site with additional support systems: physical activity programs, food systems/pantries, smoking cessation, etc.	Health Educator (HE), Health Education Specialist (HES)	Fresno Diabetes Collaborative	Healthcare System Sub-Contractors (HSS 1-3)	Year 1, Quarter 1 (Y1Q1)	Y5Q4
Activity A.1.2 Contractor will work with partner programs and subcontractors, which may include the Fresno Diabetes Collaborative, Fresno County 211, and local healthcare systems, to create a coordinated electronic Rx for Health program to address current diabetes prevention and management programs, as well as other support programs such as physical activity, smoking cessation, and access to food through local food pantries.	HE, HES	Fresno Diabetes Collaborative	HSS 1-3	Y1Q2	Y2Q1
Activity A.1.3 Contractor will develop education, program, and marketing materials for healthcare staff, providers, and community partners on the Rx for Health program. Program staff will	HE, HES	Fresno Diabetes Collaborative	HSS 1-3	Y1Q4	Y5Q4

perform outreach to local healthcare systems and providers to inform them of the new program and how to participate.					
Activity A.1.4 Contractor will identify and participate in national and state meetings, webinars, and conferences as appropriate to increase local knowledge and capacity on Rx for Health or similar e-referral programs to increase knowledge and capacity.	HE, HES			Y1Q1	Y5Q4
Activity A.1.5 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		Evaluation Contractor (EC)	Y1Q1	Y5Q4

Short Term Outcomes(s)	**Short Term Measures**
Increased community clinical links that support bi-directional referrals to assist in enrolling and retaining participants in the National DPP lifestyle change program.	Measure: Number of organizations using the Rx for Health program to refer participants to CDC-recognized lifestyle change programs for type 2 diabetes prevention. -Baseline: 0 -Year 1 Target: 1 -Data Source: Healthcare systems and/or lifestyle change program self-reporting, EHR queries
Increased referrals to CDC-recognized lifestyle change programs.	Measure: Number of referrals made to CDC-recognized program through the Rx for Health program. -Baseline: 0 Year 1 Target: 50 -Data Source: EHR queries
Setting	Healthcare systems, hospitals, FQHCs, community based organizations offering lifestyle change programs
Population of focus	General

Strategy Description A.2

Support organizations in increasing enrollment in existing CDC-recognized lifestyle change programs or establishing and sustaining new CDC recognized lifestyle change programs in underserved areas.					
Activity Description	**Lead Personnel Assigned**	**Contributing Partners**	**Key Contracts & Consultants**	**Start Quarter**	**End Quarter**
Activity A.2.1 Contractor will work through the Fresno Diabetes Collaborative and partners to determine any organizations that would like to establish a new CDC recognized lifestyle change program. Contractor will conduct capacity/readiness assessment utilizing the Diabetes Prevention Recognition Program (DPRP) tool. Contractor will provide technical assistance (TA) to new organizations to establish programs.	HE, HES	Fresno Diabetes Collaborative	HSS 1-3	Y1Q1	Y1Q4
Activity A.2.2 Contractor will continue to lead the Diabetes Prevention Program Advisory Committee through the Fresno Diabetes Collaborative, to coordinate recruitment and retention activities for all local organizations that are offering lifestyle change programs to prevent diabetes.	HE	Fresno Diabetes Collaborative		Y1Q1	Y5Q4
Activity A.2.3 Contractor will work with established programs to evaluate current recruitment and enrollment methods. Contractor will provide TA to increase enrollment. Contractor may use materials developed from Activity A.1.3 to assist with recruitment efforts.	HE, HES		HSS 1-3	Y1Q1	Y5Q4
Activity A.2.4 Contractor will evaluate data from local community needs assessment to determine any new barriers to participation or access to resources for diabetes prevention. Contractor will work with partner agencies to remove barriers.	HE, HES		EC	Y1Q2	Y2Q2
Activity A.2.5	HE, HES			Y1Q1	Y5Q4

Contractor will identify and participate in national, state, and local meetings, webinars and conferences as appropriate to increase knowledge and capacity on increasing enrollment into lifestyle change programs for diabetes prevention.					
Activity A.2.6 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		EC	Y1Q1	Y5Q4

Short Term Outcomes(s)	**Short Term Measures**
Increased access to the National DPP lifestyle change program in underserved areas for people at risk for diabetes.	Measure: Number of organizations offering a CDC-recognized lifestyle change programs for type 2 diabetes prevention. -Baseline: 2 -Year 1 Target: 3 -Data Source: DPRP data, local DPP self-reporting
Increase enrollment of participants into CDC-recognized lifestyle change programs.	Measure: Number of enrollments into a CDC-recognized lifestyle change program for type 2 diabetes prevention. -Baseline: 15 -Year 1 Target: 40 -Data Source: local DPP self-reporting, EHR queries
Setting	Healthcare systems, hospitals, FQHCs, community based organizations offering lifestyle change programs
Population of focus	Hispanic adults Low socioeconomic status adults Urban and rural areas

Strategy Description A.3
Implement tailored communication/messaging to reach underserved populations at greatest risk for type 2 diabetes to increase awareness of prediabetes and the National DPP.

Activity Description	Lead Personnel Assigned	Contributing Partners	Key Contracts & Consultants	Start Quarter	End Quarter
Activity A.3.1 Contractor will collect and evaluate current communication/messaging data regarding current diabetes prevention programs to determine effectiveness and identify existing gaps. Current communication may include national campaigns (doihaveprediabetes.org), statewide campaigns (testyourbloodsugar.org), and/or local campaigns (Fresno Diabetes Collaborative).	HE, HES	Fresno Diabetes Collaborative FCDPH media vendor	EC	Y1Q1	Y2Q1
Activity A.3.2 Contractor will work with local partners to create updated messaging to reach underserved populations and to increase awareness of prediabetes and the National DPP. If possible, contractor will utilize the CDPH Chronic Disease Prevention Messaging toolkit to develop culturally and linguistically appropriate campaign messages. Develop and implement updated communication strategy.	HE, HES	FCDPH media vendor		Y1Q1	Y1Q4
Activity A.3.3 Contractor will identify and participate in national, state, and local meetings, webinars and conferences as appropriate to increase local knowledge and capacity regarding communication/messaging for lifestyle change programs for diabetes prevention.	HE, HES			Y1Q1	Y5Q4
Activity A.3.4 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		EC	Y1Q1	Y5Q4
Short Term Outcomes(s)	**Short Term Measures**				

Increased awareness and promotion of prediabetes and available lifestyle change programs to prevent type 2 diabetes.	Measure: Number of media impressions and click throughs with new and/or updated messaging to increase awareness of prediabetes and the National DPP. -Baseline: 132,962 -Year 1 Target: 250,000 -Data Source: Media and partner sources Measure: Number of people reached by tailored communication/messaging to increase awareness of prediabetes and the National DPP. -Baseline: 0 Year 1 Target: 250,000 -Data Source: Media and partner sources
Setting	Healthcare systems, hospitals, FQHCs, community based organizations, local media markets
Population of focus	Hispanic adults Low socioeconomic status adults Urban and rural areas

Strategy Description A.4
Support advanced training for lifestyle coaches working at CDC-recognized lifestyle change programs to strengthen skills needed to engage and retain participants.

Activity Description	Lead Personnel Assigned	Contributing Partners	Key Contracts & Consultants	Start Quarter	End Quarter
Activity A.4.1 Contractor will work with current lifestyle coaches to conduct a needs assessment of what types of training would strengthen skills to engage and retain participants.	HE, HES	Local DPPs	HSS 1-3, EC	Y1Q1	Y1Q4
Activity A.4.2	HE, HES	CDC, CDPH, Fresno		Y1Q1	Y4Q1

Contractor will work with national, state, and local partners to determine availability of advanced training opportunities and develop a schedule that is flexible to maximize attendance.		Diabetes Collaborative			
Activity A.4.3 Contractor will work with Evaluation Contractor to conduct follow up with participants to determine effectiveness of advanced training opportunities.	HE, HES		EC	Y1Q1	Y5Q4
Activity A.4.4 Contractor will identify and participate in national, state, and local meetings, webinars and conferences as appropriate to increase local knowledge and capacity of advanced training opportunities.	HE, HES			Y1Q1	Y5Q4
Activity A.4.5 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		EC	Y1Q1	Y5Q4
Short Term Outcomes(s)		**Short Term Measures**			
Increased capacity and skills of current lifestyle coaches.	Measure: Number of lifestyle coaches that attended advanced training to engage and retain participants. -Baseline: 0 -Year 1 Target: 20 -Data Source: Healthcare systems and/or lifestyle change coach self-reporting				
Setting	Healthcare systems, hospitals, FQHCs, community based organizations offering lifestyle change programs				
Population of focus	General				

Strategy Description A.5

Explore and test innovative ways to eliminate barriers to participation and retention in CDC-recognized lifestyle change programs for type 2 diabetes prevention and/or ADA-recognized/AADE-accredited diabetes self-management education and support (DSMES) programs for diabetes management among high burden populations.					
Activity Description	**Lead Personnel Assigned**	**Contributing Partners**	**Key Contracts & Consultants**	**Start Quarter**	**End Quarter**
Activity A.5.1 Contractor will work with local partners, including local ADA-recognized programs, to determine barriers and challenges to participation in current CDC-recognized lifestyle change programs.	HE, HES	Community Regional Medical Centers (CRMC), Saint Agnes Medical Centers (SAMC)	EC, HSS 1-3	Y1Q1	Y5Q4
Activity A.5.2 Contractor will work with local partners to document current diabetes management programs available in the community. Contractor will work with the Fresno Diabetes Collaborative to act as a hub to identify information regarding active local programs.	HE, HES	Fresno Diabetes Collaborative	HSS 1-3	Y1Q1	Y5Q4
Activity A.5.3 Contractor will work with local partners to collaborate and coordinate with all local facilitators to ensure that hard to serve populations are being reached.	HE, HES	CRMC, SAMC, Health Services Advisory Group (HSAG)	HSS 1-3	Y1Q1	Y5Q4
Activity A.5.4	HE, HES	HSAG		Y1Q2	Y3Q1

Contractor will work with a local quality improvement organization to assist programs with their accreditation to facilitate billing for services to increase sustainability.					
Activity A.5.5 Contractor will identify and participate in national, state, and local meetings, webinars and conferences as appropriate to increase local knowledge and capacity of ADA recognized/AADE-accredited DSMES programs.	HE, HES			Y1Q1	Y5Q4
Activity A.5.6 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		EC	Y1Q1	Y5Q4

Short Term Outcomes(s)	**Short Term Measures**
Minimize barriers to enrollment and participation in current DSMES or other recognized programs.	Measure: Number of new patients enrolled in DSMES or other recognized program -Baseline: 0 -Year 1 Target: 50 -Data Source: Healthcare systems and/or lifestyle change program self-reporting, EHR queries
Setting	Healthcare systems, hospitals, FQHCs, community based organizations offering lifestyle change programs
Population of focus	Hispanic adults Low socioeconomic status adults Urban and rural areas

Strategy Description A7
Increase adoption and use of clinical systems and care practices to improve health outcomes for people with diabetes (e.g., HIT/EHRs, clinical decision support tools, learning collaboratives to improve quality of care).

Activity Description	Lead Personnel Assigned	Contributing Partners	Key Contracts & Consultants	Start Quarter	End Quarter
Activity A.7.1 Contractor will conduct a scan of local healthcare systems to determine what clinical systems are currently in place to improve health outcomes for people with diabetes. Identify gaps or areas for improvement.	HE, HES		EC, HSS 1-3	Y1Q1	Y2Q1
Activity A.7.2 Contractor will work with local, state and national partners to determine available and/or improved clinical systems to improve quality of care. Evaluate which programs would be most feasible for local healthcare systems.	HE, HES	HSAG	EC, HSS 1-3	Y1Q1	Y3Q1
Activity A.7.3 Contractor will work with healthcare systems to identify key clinical staff (case managers, health educators, etc.) and provide advanced training and/or participate in learning collaboratives to improve care practices to improve health outcomes for people with diabetes.	HE, HES		EC, HSS 1-3	Y1Q1	Y5Q1
Activity A.7.4 Contractor will identify and participate in national, state, and local meetings, webinars and conferences as appropriate to increase local knowledge and capacity of clinical systems and care practices to improve health outcomes.	HE, HES			Y1Q1	Y5Q4
Activity A.7.5 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		EC	Y1Q1	Y5Q4
Short Term Outcomes(s)	**Short Term Measures**				

Local healthcare systems will adopt a plan to increase adoption and use of clinical systems and care practices.	Measure: Number of healthcare systems actively using clinical systems and care practices to improve health outcomes for people with diabetes. -Baseline: 0 -Year 1 Target: 2 -Data Source: Healthcare systems self-reporting
Setting	Healthcare systems, hospitals, FQHCs
Population of focus	General

Category B: Cardiovascular Disease Prevention and Management

Strategy Description B.1 Increase identification of patients with undiagnosed hypertension using EHRs/HIT.					
Activity Description	**Lead Personnel Assigned**	**Contributing Partners**	**Key Contracts & Consultants**	**Start Quarter**	**End Quarter**
Activity B.1.1 Contractor will work with local partners and healthcare systems to determine if and how EHR systems are being used to identify patients with undiagnosed hypertension.	HE, HES		HSS 1-3, EC	Y1Q1	Y1Q4
Activity B.1.2 Contractor will work with local partners, healthcare systems, and/or consultants to determine best practices, improved algorithms, workflows, etc. that could be implemented to improve identification of patients with undiagnosed hypertension.	HE, HES	CDC, CDPH	HSS 1-3	Y1Q2	Y2Q1
Activity B.1.3 Contractor will identify and participate in national, state, and local meetings, webinars and conferences as appropriate to increase local knowledge and capacity of identifying patients with undiagnosed hypertension.	HE, HES			Y1Q1	Y5Q4

Activity B.1.4 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		EC	Y1Q1	Y5Q4

Short Term Outcomes(s)	**Short Term Measures**
Increased identification of patients at-risk for hypertension and screened for potential referral to intervention programs.	Measure: Increased number of patients identified for screening for hypertension. -Baseline: 0 -Year 1 Target: 50 -Data Source: EHR queries
Setting	Healthcare systems, hospitals, FQHCs
Population of focus	Hispanic adults African American adults Low socioeconomic status adults Urban and rural areas

Strategy Description B.3
Explore and test innovative ways to engage non-physician team members (e.g., nurses, nurse practitioners, pharmacist, nutritionists, physical therapists, social workers) in hypertension and cholesterol management in clinical settings.

Activity Description	Lead Personnel Assigned	Contributing Partners	Key Contracts & Consultants	Start Quarter	End Quarter
Activity B.3.1 Contractor will engage with current programs that use pharmacy students and pharmacists to identify and educate patients with high blood pressure to improve self-management. Contractor will work with the program to determine best practices to engage non-physician team members.	HE, HES	CDPH, California Health Sciences University (CHSU)	CRMC, EC	Y1Q1	Y5Q4

Activity B.3.2 Contractor will work with local healthcare systems to identify opportunities for non-physician team members (MAs, Health Educators, Community Health Workers, Pharmacists, Dieticians, etc.) to engage patients in hypertension and cholesterol management through activities such as the Rx for Health program. Coordinate training for advanced skills (i.e. health coach training, motivational interviewing, etc.) to improve engagement with patients.	HE, HES	CDPH, HSAG, Central Valley Health Network, (CVHN), University of California San Francisco (UCSF)	HSS 1-3	Y1Q1	Y5Q3
Activity B.3.3 Contractor will identify and participate in national, state, and local meetings, webinars and conferences as appropriate to increase local knowledge and capacity of engaging with non-physician team members.	HE, HES			Y1Q1	Y5Q4
Activity B.3.4 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		EC	Y1Q1	Y5Q4
Short Term Outcomes(s)	**Short Term Measures**				
Increased engagement of non-physician team members.	Measure: Number of non-physician team members trained in advanced skills to engage patients and provide referrals using the Rx for Health program. -Baseline: 0 -Year 1 Target: 25 -Data Source: Healthcare systems self-reporting				

Increased blood pressure control and management among patients using the Rx for Health program.	Measure: Percentage improvement in blood pressure control and cholesterol management among patient referred using the Rx for Health program. Baseline: 0 Year 1 Target: 10% Data Source: EHR BP queries
Setting	Healthcare systems, hospitals, FQHCs
Population of focus	Hispanic adults African American adults Low socioeconomic status adults Urban and rural areas

Strategy Description B.4
Promote the adoption of MTM between community pharmacists and physicians for the purpose of managing high blood pressure, high blood cholesterol, and lifestyle modification.

Activity Description	Lead Personnel Assigned	Contributing Partners	Key Contracts & Consultants	Start Quarter	End Quarter
Activity B.4.1 Contractor will engage with programs already in place that use pharmacy students and pharmacists to identify and educate patients with high blood pressure to improve self-management. Contractor will work with program staff to develop a strategic plan to promote the program with community pharmacists and physicians to expand to additional sites.	HE, HES	CRMC	HSS 1-3, EC	Y1Q1	Y2Q1
Activity B.4.2 Contractor will train local pharmacists and pharmacy students on how to use the Rx for Health program to refer	HE, HES		HSS 1-3	Y1Q1	Y5Q4

patients to additional CDC-recognized lifestyle change programs.					
Activity B.4.3 Contractor will establish relationships with local pharmacist groups to determine level of participation in the Rx for Health and blood pressure self-monitoring programs.	HE, HES	CRMC, CHSU		Y1Q1	Y1Q4
Activity B.4.4 Contractor will identify and participate in national, state, and local meetings, webinars and conferences as appropriate to increase local knowledge and capacity of MTM.	HE, HES			Y1Q1	Y5Q4
Activity B.4.5 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		EC	Y1Q1	Y5Q4

Short Term Outcomes(s)	**Short Term Measures**
Increased access to MTM programs in Fresno County for patients with or at-risk for hypertension.	Measure: Number of pharmacists and/or physicians implementing MTM to refer patients with or at-risk for hypertension. -Baseline: 0 -Year 1 Target: 5 -Data Source: Healthcare systems self-reporting, EHR queries
Setting	Healthcare systems, hospitals, FQHCs, pharmacies, community based organizations
Population of focus	General

Strategy Description B.5
Facilitate engagement of patient navigators/community health workers in hypertension and cholesterol management in clinical and community settings.

Activity Description	**Lead Personnel Assigned**	**Contributing Partners**	**Key Contracts & Consultants**	**Start Quarter**	**End Quarter**

Activity B.5.1 Contractor will work with local healthcare systems and community based organizations to identify opportunities for non-physician team members (MAs, Health Educators, Community Health Workers, Pharmacists, Dieticians, etc.) to engage patients in hypertension and cholesterol management through activities such as the Rx for Health program. Work with interested staff to coordinate training for advanced skills (i.e. health coach training, motivational interviewing, etc.) to improve engagement with patients.	HE, HES	CDPH, HSAG, CVHN, UCSF	HSS 1-3	Y1Q1	Y4Q3
Activity B.5.2 Engage with non-traditional partners to determine potential for screening and referrals to CDC-lifestyle change programs using Rx for Health. This may include local resident programs, mobile heath units, college students, social workers, etc. Train non-traditional programs on identification and referral processes to healthcare systems and community resources.	HE, HES	UCSF, California State University Fresno (CSUF)		Y1Q1	Y4Q3
Activity B.5.3 Contractor will identify and participate in national, state, and local meetings, webinars and conferences as appropriate to increase local knowledge and capacity of clinical community linkages.	HE, HES			Y1Q1	Y5Q4
Activity B.5.4 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		EC	Y1Q1	Y5Q4
Short Term Outcomes(s)	**Short Term Measures**				
Increased engagement of patient navigators/community health workers.	Measure: Number and percent of patients within healthcare systems that utilize community health workers or community navigators to link patients to community resources that promote				

	self-management of high blood pressure and high blood cholesterol and manage barriers that prevent patients from utilizing these resources. -Baseline: TBD -Year 1 Target: 25 -Data Source: EHR queries, healthcare systems self-reporting
Setting	Healthcare systems, hospitals, FQHCs,
Population of focus	Hispanic adults African American adults Low socioeconomic status adults Urban and rural areas

Strategy Description B.6
Implement systems to facilitate bi-directional referral between community programs/resources and healthcare systems (e.g. using EHRs, 800 numbers, 211 referral systems, etc.).

Activity Description	Lead Personnel Assigned	Contributing Partners	Key Contracts & Consultants	Start Quarter	End Quarter
Activity B.6.1 Contractor will convene and coordinate community organizations to gather current information regarding programs and resources: availability, location, language, cost, capacity, current referral process, additional support (childcare, transportation, etc.). Make the information available to local healthcare systems and organizations.	HE, HES	Fresno Diabetes Collaborative	HSS 1-3, EC	Y1Q1	Y5Q4
Activity B.6.2 Contractor will work with partner programs and subcontractors, including Fresno County 211, to coordinate implementation of the Rx for Health program to facilitate bi-directional referrals to community programs and healthcare systems.	HE, HES		HSS 1-3	Y1Q2	Y1Q4

Activity B.6.3 Contractor will develop education, program and marketing materials for healthcare staff, providers, and community partners on the Rx for Health program. Program staff will perform outreach to local healthcare systems and providers to inform them of the new program and how to participate.	HE, HES	Fresno Diabetes Collaborative	HSS 1-3	Y1Q4	Y5Q4
Activity B.6.4 Contractor will identify and participate in national and state meetings, webinars and conferences as appropriate to increase local knowledge and capacity on Rx for Health or similar referral bi-directional programs to increase knowledge and capacity.	HE, HES			Y1Q1	Y5Q4
Activity B.6.5 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		Evaluation Contractor (EC)	Y1Q1	Y5Q4

Short Term Outcomes(s)	**Short Term Measures**
Increased community clinical links that support bi-directional referrals and enrollment in evidence based lifestyle change programs for people with or at-risk for high blood pressure and/or cholesterol.	Measure: Number of organizations using the Rx for Health program to refer participants to evidence based programs for people with or at risk for high blood pressure and/or cholesterol. -Baseline: 1 -Year 1 Target: 2 -Data Source: Healthcare systems and/or lifestyle change program self-reporting
Increased referrals to evidence based programs for people with or at risk for high blood pressure and/or high cholesterol.	Measure: Number of referrals made to evidence based programs for people with or at risk for high blood pressure and/or cholesterol through the Rx for Health program. -Baseline: 0 Year 1 Target: 50 -Data Source: EHR queries

Setting	Healthcare systems, hospitals, FQHCs, community based organizations offering lifestyle change programs
Population of focus	General

Strategy Description B.8
Explore and test innovative ways to enhance referral, participation, and adherence in cardiac rehabilitation programs in traditional and community settings, including home-based settings.

Activity Description	Lead Personnel Assigned	Contributing Partners	Key Contracts & Consultants	Start Quarter	End Quarter
Activity B.8.1 Contractor will establish partnership with the single cardiac rehabilitation program in Fresno County. Contractor will evaluate and determine barriers to participation to increase referrals and participation through the Rx for Health program.	HE, HES	SAMC	EC	Y1Q1	Y2Q1
Activity B.8.2 Contractor will work with cardiac rehabilitation program to develop appropriate messaging to target priority populations. Contractor will work with community partners to provide outreach to patients, providers, and other community programs to promote the program and its benefits.	HE, HES	SAMC, FCDPH media vendor	HSS 1-3	Y1Q3	Y4Q1
Activity B.8.3 Contractor will work with partners to increase access to cardiac rehabilitation services. Contractor will work with cardiac rehabilitation partners, managed care plans, and community based organizations to determine feasibility of home-based cardiac rehabilitation settings.	HE, HES	SAMC	EC, HSS 1-3	Y1Q1	Y5Q1
Activity B.8.4	HE, HES			Y1Q1	Y5Q4

Contractor will identify and participate in national and state meetings, webinars and conferences as appropriate to increase local knowledge and capacity on referrals to and participation in cardiac rehabilitation programs.					
Activity B.8.5 Contractor will work with program evaluator to identify and collect data for required performance measures.	HE, HES		EC	Y1Q1	Y5Q4

Short Term Outcomes(s)	**Short Term Measures**
Increased awareness and utilization of cardiac rehabilitation program in Fresno County.	Measure: Number of referrals to the cardiac rehabilitation program using the Rx for Health program. -Baseline: 0 -Year 1 Target: 25 -Data Source: EHR queries
Setting	Healthcare systems, private practice, hospitals, FQHCs, community based organizations
Population of focus	Hispanic adults African American adults Low socioeconomic status adults Urban and rural areas

Categories A and B work Plan: Years 2-5

Program activities in years 2-5 for both Categories A and B would include:

- Upscaling current lifestyle change programs: Program staff will continue to assist current programs with recruitment and retention and ensure that the programs are available to target populations. Staff will also help to mediate any challenges and/or barriers to participation in these programs to achieve maximum participation. Program staff will provide TA to achieve 'recognized' and/or accredited status.

- Establishing new programs, where appropriate: Program staff will continue to provide TA to new organizations wishing to start new CDC-recognized lifestyle change programs for both diabetes and CVD prevention and management. Staff will work to ensure that programs are overlapping as little as possible to achieve maximum reach.
- Facilitate coordination and promotion of lifestyle change programs: Program staff will work with local partners to ensure that classes and program facilitators are being coordinated to have maximum reach and availability to the community, especially target populations. Staff will also provide TA to assist with billing options, where possible, to increase sustainability of the programs. Staff will engage with the FCDPH media vendor to develop tailored messages to target populations and hard to reach communities to facilitate and improve recruitment and retention.
- Continued refining of the referral system (mutually reinforcing): Program staff will continually work to refine and expand the Rx for Health program at local healthcare systems and community organizations. Staff will ensure referrals are made to both diabetes and CVD prevention and management programs. Support programs, such as smoking cessation, free or low-cost physical activity opportunities, and access to food programs will also be included as they affect both the prevention and management of diabetes and CVD. The referrals will be tracked and staff will follow up to review utilization of the system. Program staff will have regular meetings with partners and stakeholders to receive feedback on how to improve the program and to include new partners and/or programs where appropriate. Ideally, the Rx for Health program will live in EHR systems. Program staff will work with local healthcare systems to improve use of the EHR to identify, screen, refer, and track patients to improve health outcomes for diabetes and CVD.
- Engaging non-physician team members (mutually reinforcing): Program staff will work with local healthcare systems and partners to engage non-physician team members. Staff will coordinate trainings to increase skills of non-physician team members to improve engagement with patients. Staff will also work with healthcare systems and partners to develop opportunities for these team members to assist with diabetes and CVD prevention and management activities. Program staff will work to expand current innovative programs such as the local program that engages with pharmacy students to improve self-management of hypertension.

Budget Narrative – Collaborating for Wellness

A. Salaries and Wages

Name	Position	Salary	FTE	Months	Amount Requested
Melanie Ruvalcaba	Principal Investigator	$84,681	25%	12 Months	$21,170
Ana Cruz	Health Educator	$50,896	60%	12 Months	$30,537
Vacant	Health Education Specialist	$43,771	100%	12 Months	$43,771
Susanna Alvarez	Staff Analyst I	$47,468	20%	12 Months	$9,493
Leticia Renteria	Office Assistant III	$40,007	20%	12 Months	$8,001
					$112,974

Salaries and Wages Justification

Job Description: Principal Investigator - Melanie Ruvalcaba, MPH
This position acts as the project's Principal Investigator and works closely with the program staff to direct the overall operation and evaluation of the project. 25% of her time will be allotted to responsibilities for overseeing the implementation of project activities, supervision of project lead staff, coordination with other agencies and subcontractors; development of materials, development of communication and media activities, provisions of in-service training, conducting meetings; designs and directs the gathering, tabulating and interpreting of required data, responsible for assessment activities as well as overall program evaluation and for staff performance evaluation and subcontractor compliance; and is the responsible authority for ensuring necessary reports/documentation are submitted to CDC.

Job Description: Health Educator – Ana Cruz, MPH
This position serves as the Project Manager, coordinates the overall operation of the program. 60% of time will be allotted to the responsibilities for program oversight, development and monitoring of program budget, leading implementation of activities, supervision and evaluation of program staff, coordination with other agencies and subcontractors, coordination of assessment efforts, including provider outreach, training and technical assistance, development of materials, assisting coordination and implementation of health communication and media activities, subcontractor compliance, and is responsible for ensuring necessary reports/ documentation are submitted to CDC.

Job Description: Rx Health Education Specialist – (Vacant)
The Health Education Specialist (HES) position is a bachelor's prepared position in the health education classification track. The HES will work closely with the Health Educator to ensure the completion of all project activities to meet the goals and objectives. The HES will allot 100% of responsibilities for daily task completion related to program activities and related activities,

including assisting with coordination of activities, assisting with communication and media activities, daily task completion related to each project activity, including coordination with other agencies, including provider outreach, development of project materials, development and provisions of in service and training, and assistance in gathering data for the community assessment as well as data for overall program evaluation.

Job Description: Staff Analyst – Susanna Alvarez

The Staff Analyst position will allot 20% of time to assist program staff and County management by performing a wide variety of research, analysis, planning, evaluation, and administrative duties. This position is supervised by Principal Investigator. Administrative job duties and responsibilities include: preparing program related agreements, sub-contracts, leases, and MOUs and monitoring for contract compliance (maintaining records and files, and preparing reports and monitoring contract deliverables); assist with monitoring of budget and expenditures, preparing requests for proposals, requests for quotations, etc. to procure outside services and supplies for the department and program; preparing agenda items and presentations to go before the Board of Supervisors; representing the County at various meetings and before boards, commissions, and committees, as appropriate; conducting administrative studies in collaboration with Principal Investigator, Project Manager and program staff to determine needs, preparing reports, and recommending implementation procedures for a variety of special studies and projects; and assisting in the preparation of funding applications for local, state and federal funding opportunities.

Job Description: Office Assistant III – Leticia Renteria

The Office Assistant position will allot 20% of her time to provide office and administrative support to all program staff. This position will complete all required paper work for office supply purchases, requisitions, travels, mileage reimbursements, and make sure project staff completes required County forms for all appropriate activities. The Office Assistant will also provide audit file, data entry, and materials support for all related activities, answer phones and act as the front office staff, greeting and directing visitors.

B. Fringe Benefits

Position	Unemployment Insurance (0.0957% of Salary)	OASDI (7.65% of Salary)	Retirement (*% of Salary)	Tier	Health Insurance ($6,735 / FTE)	Management Life ($292 / FTE)	Benefits Admin ($110 / FTE)	Amount Requested
Principal Investigator	$34	$1,619	$10,278	5	$0	$41	$40	$12,012
Health Educator	$48	$2,336	$14,826	5	$4,752		$96	$22,059
Health Ed. Specialist	$70	$3,348	$21,250	5	$7,921		160	$32,750
Staff Analyst I	$15	$726	$5,923	5	$2,159	$32	$32	$8,888
OA III	$12	$612	$4,992	1	$2,159		$32	$7,808
								$83,517

Total Salaries: $112,974
Total Fringe: $83,517
Total Personnel: $196,491

C. Contractual Costs

Evaluation Subcontract: TBD - $200,000

Evaluation contractor will work closely with program staff, other subcontractors, and community partners to conduct all evaluation components of the program. The successful contractor will be required to work closely with program staff, key stakeholders, and healthcare systems subcontractors to complete scope of work activities including creating all evaluation tools, designing the program logic model to align with CDC's logic model, and to evaluate overall program outcomes to determine effectiveness.

Contractor requirements:

- Must have at least five years of experience evaluating large-scale community health programs.
- Must have at least three years of experience working with communities in Fresno County.
- Established healthcare and community partnerships in Fresno County
- Ability to hire or contract qualified staff within eight weeks of contract execution, including a Program Manager responsible for ensuring program and administrative scope of work deliverables are met. Program Manager must have a minimum of three years of experience managing large projects and working with a multi-disciplinary team.
- Administrative and fiscal capacity to implement grant requirements including directing and overseeing up to $225,000 in services.

Healthcare Systems Sub-Contractors – 3 awards at $350,000 each – Total $1,050,000

Healthcare systems sub-contractors will be responsible for implementing scope of work activities at their clinic sites. Activities may include: implementation of the Rx for Health referral program through clinic EHR systems; improvements to EHR systems to improve identification and screening of patients at-risk for diabetes and CVD; use of non-physician team members to engage with patients to improve self-management; training of staff to implement CDC-recognized programs and/or interventions; and increasing capacity of non-physician staff through advanced trainings and improved clinical workflow.

Contractor requirements:

- Established licensed healthcare system with at least three clinic sites in Fresno County that reach the target populations.
- Must demonstrate sufficient chronic disease community support that complements the program activities in the prevention and management of diabetes and CVD.
- Ability to identify and hire/contract qualified staff within eight weeks of the executed contract including a Program Manager with at least 3 years of experience managing

large projects that include a multi-disciplinary team.

- Administrative and fiscal capacity to implement grant requirements including contracting, directing and overseeing up to $1,452,318 in services.
- The philosophy, procedures, and staff training that shall allow limited or non-English speaking, culturally diverse and hard of hearing clients to be served effectively.

Total Contractual Costs: $1,250,000

D. Operating Expenses

Item	Type	Amount Requested
General Office Supplies	Office Supplies: pens, pencils, paper, toner, file folders, meeting folders, binders, paper clips, staples, and similar office supplies	$200
Printing	Cost of printing of materials and/or graphics for outreach and	$1,000
Meeting Room Rents	Cost of meeting room rentals for steering committees, collaboratives, etc.	500
Communications	Phones, computers, Fresno County technical support, internet access	$1,000
Facilities	Facilities, maintenance, security and utilities	$1,000
		$3,700

Justification: General supplies will be purchased under this category and will be used in completion of project activities, including supplies for meetings, outreach for primary and secondary data collection and daily office operations. Printing will be used for printing program materials for outreach and education purposes. Meeting room rentals will be for meetings that require larger spaces such as community collaboratives, etc. Communication costs include phones, computers, and networking for program staff. Facilities costs include janitorial services, building maintenance, security and utilities.

E. Travel

In State Travel: The Principal Investigator, Health Educator, and Health Education Specialist will travel an estimated 733 miles to attend multiple local collaborative meetings within Fresno County, to local outreach sites to monitor program implementation, and regional meetings throughout the central valley, as appropriate, to engage with partners conducting similar work. 734 miles x $0.545/mile = $400

Out of State Travel: FCDPH will budget $4,000 to send approximately 3 staff members to the required meeting/training to be held in Atlanta, GA in the first year of the period of performance.

Local Travel - $400

Conferences/Trainings - $4,000
Total Travel Requested - $4,400

F. Other Costs

Public Relations Services - $35,000
FCDPH will work with current contracted media vendor to conduct analysis of current media/communications campaigns available through the CDC, CDPH and locally. Media vendor will assist with developing tailored messaging and/or content to reach the priority populations. Medial vendor will work on both categories but will have more emphasis on Category A. The healthcare system sub-contractors, as well as other partners, will use these new messages to promote programs throughout the community.

Technical Assistance – TBD - $40,000
FCDPH will seek technical assistance in the following areas:

- EHR systems to assist with evaluation of current use of EHRs by healthcare system sub-contractors and how to implement an "add-on" which would act as the Rx for Health referral program.
- Provider outreach and education in the form of speakers and educational symposiums to promote program activities such as bi-directional referrals, lifestyle intervention programs, use of non-physician staff, improved clinical practices, etc.
- Assistance with coordinating some of the program activities to align with department accreditation standards.
- Mobile screening opportunities to increase reach and referral in hard to reach communities.

Meeting Supplies, interpretation, and child care - $400
Expenses for meeting supplies, interpretation, and/or child care for community meetings (NOT including lifestyle change classes).

Education/Training Materials - $20,000
FCDPH will plan and coordinate necessary training opportunities for CDC-recognized lifestyle change programs, assist with advanced training opportunities, and possible costs for application fees to achieve recognized/accredited status.

Total Other Costs: $95,400

Total Direct Costs: $1,550,078

H. Indirect Costs: $410,770
The current approved Fresno County indirect rate is 26.5% of direct costs. The indirect rate approval letter is attached to the application package.

Budget Summary

	Category A	Category B	
Personnel			
Salary	$56,488	$56,488	
Fringe	$41,801	$41,801	
	$98,289	**$98,289**	
Contractual Costs			
Evaluator	$100,000	$100,000	
Healthcare Systems Sub-contractor 1	$175,000	$175,000	
Healthcare systems Sub-contractor 2	$175,000	$175,000	
Healthcare systems Sub-contractor 3	$175,000	$175,000	
	$625,000	**$625,000**	
Operating Expenses			
Supplies	$100	$100	
Printing	$500	$500	
Meeting room rentals	$0	$500	
Communications	$500	$500	
Security, Utilities, and Facilities	$500	$500	
	$1,600	**$2,100**	
Travel			
Local Travel	$200	$200	
Conferences/Trainings	$2,000	$2,000	
	$2,200	**$2,200**	
Other			
Public Relations	$23,750	$11,250	
Technical Assistance	$19,000	$21,000	
Meeting supplies	$200	$200	
Education/Training Materials	$5,000	$15,000	
	$47,950	**$47,450**	
Direct Costs	$775,039	$775,039	
Indirect	$205,385	$205,385	
Total Budget	**$980,424**	**$980,424**	**$1,960,849**