PREVENTION FORWARD HEALTH SYSTEM QUARTERLY PROGRESS REPORT

INTRODUCTION

The California Department of Public Health (CDPH) is distributing this survey in an effort to assess the health system quarterly progress report regarding the activities performed under the Prevention Forward (1815) program. The activity includes the implementation of core measures in promoting the program's objectives for the management and treatment of patients with prediabetes, diabetes, cardiovascular disease, hypertension, and high blood cholesterol. Your participation in completing this survey will help CDPH identify and create local and statewide resources that will support health systems/clinics' capability to improve the quality of life of patients with pre diabetes, diabetes, cardiovascular disease, hypertension, and high blood cholesterol.

This survey has 92 questions and it will take approximately 43 minutes to complete. Please plan to complete the survey in one sitting, as responses may not be saved if you exit the survey before completion. Survey responses will be compiled into a state-level report to describe the Prevention Forward progress and challenges. No identifiable information will be shared in this report or any future publication using this survey. Your responses will inform and guide CDPH's work on chronic disease management, control, prevention, and treatment. If you are interested in this progress report result, resources regarding the implementation approaches of the Prevention Forward program, and/or have any further questions or feedback, please contact Ndukaku Omelu at Ndukaku.Omelu@cdph.ca.gov or at (916) 552-9033.

SECTION I. PREVENTION FORWARD QUARTERLY REPORT SURVEY GOAL

This survey will be administered to the clinic partners quarterly. The survey is a data collection tool that will be used to gather specific information about Prevention Forward performance measures from partnering health centers or clinics. The survey results will be analyzed by the evaluation team and the program staff to advance meaningful technical assistance to partnering health centers or clinics. The data analysis *will provide information about each partner clinics' unique organizational capacity needs to help prevent and manage chronic conditions, increase monitoring and reporting of chronic conditions, and increase referrals to and participation in lifestyle change programs (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food and Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], Curve Complete, National Diabetes Prevention Program [National DPP], and Diabetes Self-Management Education and Support [DSMES]).*

SECTION II. ORGANIZATIONAL INFORMATION

Health System/Center/Organization Name: click here to enter the organization Name

Participating Clinic Name: click here to enter the clinic Name

Clinic Address or Zip Code: click here to enter the clinics address

Program or clinic contact Person: click here to enter the program or clinic contact person

Progress Reporting Period (check one): Year 2

- ☐ Q1 = 07/01/19 - 09/30/19
- ☐ Q2 = 10/01/19 – 12/31/19

- ☐ Q3 = 01/01/20 – 03/31/20
- ☐ Q4 = 04/01/20 – 06/30/20

SECTION III. PATIENT POPULATION CHARACTERISTICS ENROLLED IN THE PREVENTION FORWARD PARTICIPATING CLINIC(S)/HOPITAL(S):

A. This section assesses the characteristics of the unit of analysis ENROLLED in the Prevention Forward participating clinic(s)/hospital(s).

1. **Total number of patients enrolled in the Prevention Forward Program by partner clinic/hospital**
   - Click here to enter number of patients

2. **Number of patients, ages 18-85 enrolled in the Prevention Forward Program by partner clinic/hospital**
   - Click here to enter number of patients

3. **Number of patients, ages 18-85 with prediabetes enrolled in the Prevention Forward Program by partner clinic/hospital (A4)**
   - Click here to enter number of patients

4. **Number of patients, ages 18-85 with diabetes enrolled in the Prevention Forward Program by partner clinic/hospital**
   - Click here to enter number of patients

5. **Number of patients, ages 18-85 with high blood pressure (ICD-10-CM:I10) enrolled in the Prevention Forward Program by partner clinic/hospital**
   - Click here to enter number of patients

6. **Number of patients, ages 18-85 with cardiovascular disease enrolled in the Prevention Forward Program by partner clinic/hospital**
   - Click here to enter number of patients

7. **Number of patients, ages 18-85 with stroke enrolled in the Prevention Forward Program by partner clinic/hospital**
   - Click here to enter number of patients

8. **Number of patients, ages 18-85 with high cholesterol enrolled in the Prevention Forward Program by partner clinic/hospital**
   - Click here to enter number of patients

9. **Number of uninsured patients, ages 18-85 enrolled in the Prevention Forward Program by partner clinic/hospital**
   - Click here to enter number of patients

10. **Number of patients, ages 18-85 covered by Medicaid/Medi-Cal enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

11. **Number of Hispanics, ages 18-85 enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

12. **Number of Whites, ages 18-85 enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

13. **Number of Blacks or African Americans, ages 18-85 enrolled in the Prevention Forward Program within the partner clinic/hospital**
    - Click here to enter number of patients

14. **Number of Asians, ages 18-85 enrolled in the Prevention Forward Program within the partner clinic/hospital**
    - Click here to enter number of patients

15. **Number of Native Hawaiian or other Pacific Islanders, ages 18-85 enrolled in the Prevention Forward Program within the partner clinic/hospital**
    - Click here to enter number of patients

16. **Number of American Indians or Alaska Natives, ages 18-85 enrolled in the Prevention Forward Program within the partner clinic/hospital**
    - Click here to enter number of patients

17. **Number of bi- or multi-racial patients, ages 18-85 enrolled in the Prevention Forward Program within the partner clinic/hospital**
    - Click here to enter number of patients

SECTION IV. EVALUATION OF PREVENTION FORWARD OBJECTIVES

A. **Prevention Forward Objective 1: Objective 1 addresses and assesses the use of health care reporting system to identify, report standard clinical quality measures, and/or refer patients with chronic conditions to nationally recognized lifestyle change programs (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food AND Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], Curve Complete, National DPP, and DSMES).**

18. **Does your health organization have a health care reporting system [e.g., Electronic Health Record, Health Information Exchange, Health Information Technology]**
    - ☐ Yes
    - ☐ Available, but do not currently used (skip to question 3)
    - ☐ No (skip to question 4)

19. **Does your organization have a health care reporting system [e.g., Electronic Health Record, Health Information Exchange, Health Information Technology] to identify patients/clients with prediabetes for referral to Centers for Disease Control (CDC)-recognized lifestyle change programs (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food AND Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], Curve Complete, National DPP, and DSMES) (A4)**?
    - ☐ Yes
    - ☐ Available, but do not currently used (skip to question 3)
    - ☐ No (skip to question 4)

20. **Type of health care reporting system your organization uses, or is developing to identify and/or refer patients/clients with chronic conditions to national CDC-recognized lifestyle change programs (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food and Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], Curve Complete, National DPP, and DSMES), if not applicable, enter NA (A4).**

➢ Click here to enter the type of reporting system(s)

21. **If your health center/hospital/clinic does not have a health care reporting system [e.g., Electronic Health Record, Health Information Exchange, Health Information Technology] to identify patients/clients with prediabetes for referral to national CDC-recognized lifestyle change programs (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food and Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], Curve Complete, National DPP, and DSMES), do you plan to develop or adopt a system that can do this (A4)?**
    - ☐ Yes
    - ☐ No

22. **What is the total number of patients (18-85 years old) within the entire health system (B3a)?**

➢ Click here to enter number of patients

23. **What is the total number of patients (18-85 years old) within the clinic (B3a)?**

➢ Click here to enter number of patients

24. **What is the total number of patients 18-85 years old served within the clinic for the following conditions (A and B)?**

Chronic Diseases or Conditions	Total number of patients 18-85 years old with a documented diagnosis or at least a measurement of the following health conditions	Total number of patients 18-85 years old with at least one measurement of the following health conditions who received at least one "Referral" to an approved evidence-based lifestyle change program (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food and Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], Curve Complete, National DPP, and DSMES)	Total number Enrolled in an approved evidence-based lifestyle change program (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food and Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], Curve Complete, National DPP, and DSMES)
Diabetes (A4) (Type II)			
Prediabetes (A4)			
Cardiovascular Disease			
Hypertension (ICD-10: I10-15)			
High Blood Cholesterol			
Stroke			

25. Which of the following diseases/conditions were reported in the past quarter as Standard Clinical Quality Measures (for example to the National Committee for Quality Assurance [NCQA] or other standard reporting organization) (select all that apply)?

☐ Diabetes (Type II)

- ☐ Prediabetes
- ☐ Cardiovascular Disease
- ☐ Hypertension (ICD-10: I10-15)
- ☐ High Blood Pressure (ICD-10-CM:I10)
- ☐ Stroke

26. Does your health center/hospital/clinic implement strategies to increase enrollment in the CDC-recognized lifestyle change programs (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food and Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], Curve Complete, National DPP, and DSMES) (A6)?

- ☐ Yes
- ☐ No

27. At your clinic/hospital, what is the total number of patients with diabetes (Type II) ages 18-85 years old referred to Diabetes Self-Management Education and Support (DSMES) within this reporting period?

- ➢ Click here to enter number of patients

28. At your clinic/hospital, what is the total number of patients with prediabetes ages 18-85 years old referred to the National DPP for diabetes (Type II) prevention within this reporting period?

- ➢ Click here to enter number of patients

29. At your clinic/hospital, what is the total number of patients ages 18-85 years old referred to the CDC-lifestyle change program (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food and Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], or Curve Complete) for cholesterol or high blood pressure (ICD-10-CM: I10) management within this reporting period?

- ➢ Click here to enter number of patients

30. At your clinics, what is the total number of people with prediabetes participating in the CDC-recognized lifestyle change programs [such as the National DPP] who have achieved 5-7% weight loss (*long-term measure*) (A11)?

- ➢ Click here to enter number of eligible patients who achieved 5-7% weight loss

31. Does your health center/hospital/clinic have systems to report standardized clinical quality measures (e.g., National Quality Forum [NQF0018]) for identification, management, and treatment of patients with hypertension (ICD-10: I10-15) (B1)?

- ☐ Yes
- ☐ Available, but do not currently used
- ☐ No

32. **What is the total number of patients (18-85 years old) in your health center/system/clinic/hospital (B1).**

- Click here to enter number of eligible patients

33. **Does your health center/hospital/clinic have policies or systems to encourage self-measured blood pressure monitoring (SMBP) with clinical support for patients with hypertension (ICD-10: I10-15) (B6)?**

- ☐ Yes
- ☐ No (skip to question 18)

34. **If yes, does your health center/hospital/clinic encourage self-measured blood pressure monitoring for blood pressure control (B6)?**

- ☐ Yes
- ☐ No
- ☐ Not Applicable

35. **If your health center/hospital/clinic does not have policies or system(s) to encourage self-measured blood pressure monitoring for blood pressure control, does the health center/hospital/clinic plan to develop policies or system(s) (B6)?**

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

36. **State the type of policies or system(s) your health center/hospital/clinic uses, or are developing to encourage self-measured blood pressure monitoring for blood pressure control, if not applicable, enter 'Not applicable' (B6).**

- Click here to enter the type of reporting system(s)

37. **If your health center/hospital/clinic has policies or systems to encourage self-measured blood pressure monitoring for blood pressure control, enter cumulative number of eligible patients (18-85 years old) in your clinic (B6).**

- Click here to enter number of eligible patients

38. **Briefly describe the successes and challenges for using the health care reporting system(s) to identify and refer patients or clients with chronic conditions**.

- Click here to describe the successes and challenges

39. **Briefly describe the barriers to develop or acquire a reporting system to identify and refer patients or clients with chronic conditions**.

- Click here to describe the barriers

40. **Briefly describe the Next Steps to improve health care reporting system to identify patients with diabetes (Type II), high blood pressure (ICD-10-CM: I10), high cholesterol, and cardiovascular disease to treat and refer patients to lifestyle change programs (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food and Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], or Curve Complete)**:

- Click here to describe the next steps to improve the organization policies or reporting systems

41. **Briefly describe the Technical Assistance the health center/hospital/clinic would like to receive on health care reporting system**:

- Click here to describe or identify the technical assistance your organization would like to receive

B. Prevention Forward Objective 2: Objective 2 identify policies and procedures used within the clinic to identity, manage, and prevent chronic conditions within their target population.

42. **Does your health center/hospital/clinic have American Diabetes Association (ADA)-recognized Diabetes Self-Management Education and Support (DSMES) programs (A1)?**
    - ☐ Yes
    - ☐ No

43. **If no, is the health center/hospital/clinic interested in becoming American Diabetes Association-recognized Diabetes Self-Management Education and Support programs (A1)?**
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Not Applicable

44. **Does the Prevention Forward clinic/hospital promote the use of Medi-Cal DPP benefits as means of payment among eligible patients for CDC-recognized lifestyle change programs such as the National Diabetes Prevention Programs [National DPP]?**
    - ☐ Yes
    - ☐ No

45. **Does your health center/hospital/clinic have American Association of Diabetes Educators (AADE)-accredited Diabetes Self-Management Education and Support programs (A1)?**
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Not Applicable

46. **If no, is the health center/hospital/clinic interested in becoming an American Association of Diabetes Educator–accredited Diabetes Self-Management Education and Support programs (A1)?**
    - ☐ Yes

- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

47. What is the total number of patients 18-85 years old with diabetes (Type II) with at least one encounter at an ADA-recognized/AADE-accredited DSMES program <u>(an intermediate goal) (A8)?</u>

- ➢ Click here to enter number of eligible patients (18-85 years old)

48. What is the total number of people 18-75 years old with Diabetes (Type II) with a medical visit during this quarter or reporting period (*long-term measure*) (A10).

- ➢ Click here to enter number of eligible patients (18-75 years old)

49. During the quarter or reporting period, what is the total number of patients 18-75 years old with an A1C greater than 9 (>9) (*long-term measure*) (A10)?

- ➢ Click here to enter number of eligible patients (18-75 years old)

50. Is your health center/hospital/clinic implementing new or enhanced team-based approaches or policies to address blood pressure control (B3a)?

- ☐ Yes
- ☐ No
- ☐ Don't Know

51. If yes, will your health center/hospital/clinic share the team-based approaches or policies with the California Department of Public Health (Prevention Forward Program) (B3a)?

- ☐ Yes
- ☐ No

52. If your health center/hospital/clinic does not have or has not implemented new or enhanced team-based approaches or policies to address blood pressure control, does your clinic plan to develop approaches or policies to address blood pressure control (B3a)?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

53. Does your health center/hospital/clinic use team-based care policies to encourage patients with blood pressure to manage or control the condition?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

54. Is your health center/hospital/clinic implementing new or enhanced team-based approaches or policies to address cholesterol management (B3b)?

- ☐ Yes
- ☐ No
- ☐ Don't Know

55. If yes, will your health center/hospital/clinic share the team-based approaches or policies (B3b)?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not applicable

56. If your health center/hospital/clinic does not have or have not implemented team-based approaches or policies to address cholesterol management, does your clinic plan to develop approaches or policies to address cholesterol management (B3b)?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

57. What are the type of policies or system(s) your health center/hospital/clinic uses, or are developing for team-based care to encourage patients/clients with high cholesterol to participate in the practice of management of high cholesterol, if not applicable enter 'Not Applicable'?

➢ Click here to enter the type of reporting system(s)

58. What is the number of patients 18-85 years old with known high blood pressure (ICD-10-CM: I10) within this quarter or reporting period who have achieved blood pressure control *[long-term]* (B8)?

➢ Click here to enter the number of patients

59. What is the total number of patients considered at high risk of cardiovascular events (patients with ASCVD or LDL-C>190mg/dL or patients with familial history or Hypercholesterolemia or patients with Type 1 or Type 2 diabetes with an LDL-C of 70-189mg/dL) who have their cholesterol managed with statin therapy *[long-term measure]* (B9).

➢ Click here to enter the number of patients

60. What is the total number of patients ≥21 years old who had LDL –C ≥ 190mg/dL [fasting or direct laboratory result] or diagnosed with familial or pure hypercholesterolemia?

➢ Click here to enter the number of patients

61. What is the number of adult patients ≥21 years old who received at least one order (prescription) for statin therapy at any point during this quarter or reporting period (B9 Numerator)

- Click here to enter the number of patients

62. **Briefly describe the successes and challenges for using the health care reporting system(s) or policies to identify, monitor, and refer patients or clients with chronic conditions**
- Click here to describe the successes, challenges or barriers

63. **Briefly describe the barriers to develop or acquire a reporting system to identify and refer patients or clients with chronic conditions**.
- Click here to describe the barriers

64. **Briefly describe the Next Steps to improve the reporting system (s) or policies to identify patients with diabetes (Type II), high blood pressure (ICD-10-CM: I10), high cholesterol, and cardiovascular disease to treat and refer patients to lifestyle change programs**.
- Click here to describe the next steps to improve the organization policies or reporting systems

65. **Briefly describe the Technical Assistance the health center/hospital/clinic would like to receive on reporting systems or policy improvement to identify patients with diabetes (Type II), high blood pressure (ICD-10-CM: I10), high cholesterol, and cardiovascular disease to treat and refer patients to lifestyle change programs (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food and Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], or Curve Complete)**.
- Click here to describe or identify the technical assistance your organization would like to receive

Prevention Forward Objective 3: Objective 3 assess the use of team-based models to manage, monitor, and refer patients with chronic conditions to nationally recognized lifestyle change programs (such as YMCA's blood pressure self –monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food and Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], Curve Complete, National DPP, and DSMES).

66. **Does your health center/hospital/clinic have pharmacy locations/pharmacists (A3).**
    - ☐ Yes
    - ☐ No

67. **Does your health center/hospital/clinic's pharmacy locations or pharmacists use patient care processes to promote medication management (A3)?**
    - ☐ Yes
    - ☐ No

68. **Does your health center/hospital/clinic's pharmacy locations or pharmacists use patient care processes to promote enrollment of patient with diabetes (Type II) in the Diabetes Self-Management Education and Support (DSMES) (A3)?**
    - ☐ Yes
    - ☐ No

69. **Do your pharmacists engage in the practice of Medication Therapy Management (MTM) to promote medication self-management for high blood pressure (ICD-10-CM: I10)? (B4a)**
    - ☐ Yes
    - ☐ No

70. **Number of pharmacists who provide Medication Therapy Management (MTM) services to promote medication self-management and lifestyle modification for patients with high blood pressure (ICD-10-CM: I10) (B4a).**
    - ➢ Click here to enter number

71. **Do your pharmacists engage in the practice of Medication Therapy Management (MTM) to promote lifestyle modification for high blood cholesterol (B4b)?**
    - ☐ Yes
    - ☐ No

72. **Number of pharmacists who provide Medication Therapy Management (MTM) services to promote medication self-management for patients with high blood cholesterol (B4b).**
    - ➢ Click here to enter number

73. **Number of pharmacists who provide Medication Therapy Management (MTM) services to promote lifestyle modification for patients with high blood cholesterol (B4b).**
    - ➢ Click here to enter number

74. **Does the health center/hospital/clinic have Community Health Workers (CHWs) or promotores?**
    - ☐ Yes
    - ☐ No

75. **Does the health center/hospital/clinic use the Community Health Workers/promotores for health promotion (A7 & B5)?**
    - ☐ Yes
    - ☐ No

76. **Does the health center/hospital/clinic offer community health worker or promotores curricula or core competency training (A7 & B5)**?
    - ☐ Yes
    - ☐ No

77. **Did community health workers or promotores within the health center/hospital/clinic or those involved in the Prevention Forward Program receive core competency training (A7 & B5)?**
    - ☐ Yes

☐ No

78. **Did community health workers or promotores within the health center/hospital/clinic or those involved in the Prevention Forward Program receive CHW certification (A7 & B5)?**
    ☐ Yes
    ☐ No

79. **Are community health workers or promotores within the health center/hospital/clinic setting or those involved in the Prevention Forward Program paid through the clinic payment mechanisms (A7 & B5)?**
    ☐ Yes
    ☐ No

80. **Does the health center/hospital/clinic need any technical assistant or support on any of the community health workers or promotores' activities?**
    ☐ Yes
    ☐ No

81. **Does the health center/hospital/clinic promote and encourage professional development or provider education**?
    ☐ Yes
    ☐ No

82. **Does the health center/hospital/clinic use patient reminder systems to provide care**?
    ☐ Yes
    ☐ No

83. **Does the health center/hospital/clinic use provider reminder systems to provide care**?
    ☐ Yes
    ☐ No

84. **Briefly describe the successes and challenges of using team-based care to identify, monitor, and refer patients or clients with chronic conditions**.
    ➢ Click here to describe the successes, challenges or barriers

85. **Briefly describe the barriers to develop or acquire a reporting system or policies for team-based care to identify, monitor, and refer patients or clients with chronic conditions**.
    ➢ Click here to describe the barriers

86. **Briefly describe the Next Steps to improve the team-based care**:
    ➢ Click here to describe the next steps to improve the health care organization team-based care

87. **Briefly describe the technical assistance the health center/hospital/clinic would like to receive on team-based care**:

- Click here to describe or identify the technical assistance your organization would like to receive on team-based care

Additional Information:

88. **What is the health center/hospital/clinic status on becoming an ADA-Recognized or AADE-Accredited DSMES programs (A1)**
    - ☐ Started
    - ☐ Not started
    - ☐ Completed
    - ☐ Already Recognized/Accredited
    - ☐ Already Recognized
    - ☐ Already Accredited

89. **Briefly describe the successes and challenges on becoming an ADA-Recognized or AADE-Accredited DSMES programs**.

- Click here to describe the successes, challenges or barriers

90. **If your clinic is not recognized or accredited, briefly describe the Next Steps to becoming an ADA-Recognized or AADE-Accredited DSMES programs**:

- Click here to describe the next steps for recognition or accreditation

91. **Briefly describe the Technical Assistance the health center/hospital/clinic would like to receive on ADA-Recognition or AADE-Accreditation DSMES process**:

- Click here to describe or identify the technical assistance your organization would like to receive

92. **In the absence of the prevention forward funding, can your health systems/centers/hospitals/clinics sustain the activities of prevention forward mentioned above (Sustainability)**
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Too early to measure

Thank you for your participation in this quarterly survey. Your work with CDPH-Prevention Forward is highly appreciated!