IMPACTING COMMUNITY CHANGE FOR OLDER ADULTS WITH TYPE 2 DIABETES

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WORKSHOP OBJECTIVES

- Learn the components and strategies of the Community Organizer Model

- Describe the methods used to engage community members with type 2 diabetes, including those who are hard to reach and underserved

- Understand various interventions that can be effectively implemented in rural communities and impact behavioral change and community change

- Learn about data-driven outcomes from this initiative
• Health Promotion and Disease Prevention Programs and Services
  • Chronic Disease Self Management
  • Matter of Balance
  • Arthritis Foundation Fall Prevention
  • Health Rhythms
  • Medication Management

• Information, Assistance, and Education Services
• In-Home Care, Case Management & Assessment
• Congregate and Home Delivered Meals
• Transportation

• Skills in developing logic models
• Community engagement
• Need assessments
• Program Implementation and Evaluation
• Strong working history with KIPDA
WHAT GUIDES US?

Socio-Ecological Model

PUBLIC POLICY
national, state, local laws

COMMUNITY
relationships among organizations

ORGANIZATIONAL
organizations, social institutions

INTERPERSONAL
family, friends, social networks

INDIVIDUAL
knowledge, attitudes, skills
MAJOR ACTIVITIES OF THE FIVE YEAR GRANT

1. Convene and mobilize a coalition
2. Conduct a comprehensive needs assessment
3. Develop a strategic plan
4. Implement interventions
5. Evaluate process and outcomes
COMMUNITY ENGAGEMENT
From CDC’s *Principles of Community Engagement*

BEFORE STARTING A COMMUNITY ENGAGEMENT EFFORT . . .

1. Purposes and goals of effort? Populations/communities to engage?

2. Get to know the community – economic conditions, politics, norms, values, demographics, history, previous history of engagement efforts, perceptions of organizing entity
GOALS OF GRANT

TAKE SMALL STEPS
- Eat more fruit and vegetables
- Maintain a healthy weight
- Reduce smoking
- Exercise more

TAKE CHARGE
- Increase monitoring of daily glucose levels
- Take medications as prescribed
- Get recommended care from doctors (A1C test, cholesterol test, eye exam, foot exam, flu vaccine)

GET BIG REWARDS
- A1C levels below 7
- Blood pressure below 130/80
- Cholesterol levels below 100 (LDL)
GET TO KNOW OUR COMMUNITIES...

- Bullitt County: 12.4% diabetes, 34.2% obese
- Shelby County: 11.4% diabetes, 33% obese
- Henry County: 11.5% diabetes, 35.3% obese

Source: 2010 BRFSS data

- Dearth of diabetes education and support
  - No diabetes education classes except 1 or 2/year in Bullitt
  - No support groups except Bullitt
  - No diabetes educators
  - Few smoking cessation classes
- Food deserts
- Lack of public transportation
- Limited exercise opportunities
COMMUNITY ENGAGEMENT
From CDC’s *Principles of Community Engagement*

FOR ENGAGEMENT TO OCCUR, IT IS NECESSARY TO . . .

3. Go into the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.

4. Remember and accept that community self-determination is the responsibility and right of all people who comprise a community. No external entity should assume it can bestow on a community the power to act in its own self-interest.
BUILDING TRUST, LEARNING FROM COMMUNITY

World Cafés

Photovoice

Hire Community Organizers – from the Community
COMMUNITY ENGAGEMENT

From CDC’s *Principles of Community Engagement*

**FOR ENGAGEMENT TO SUCCEED . . .**

5. Partnering with the community is necessary to create change and improve health.

6. All aspects of community engagement must recognize and respect community diversity. Awareness of the various cultures of a community and other factors of diversity must be paramount in designing and implementing community engagement approaches.

7. Community engagement can only be sustained by identifying and mobilizing community assets, and by developing capacities and resources for community health decisions and action.

8. An engaging organization or individual change agent must be prepared to release control of actions or interventions to the community, and be flexible enough to meet the changing needs of the community.

9. Community collaboration requires long-term commitment by the engaging organization and its partners.
KIPDA Rural Diabetes Coalition
Diabetes has no boundaries

In collaboration with the University of Louisville
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OUR COALITION
COMMUNITY HEALTH WORKERS

Community Health Workers are **frontline public health workers** who are **trusted** members of and/or have an unusually close **understanding of the community** served. This trusting relationship enables CHWs to serve as a liaison, link, or intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

Source: Community Health Workers Section, American Public Health Association. Available at: [www.apha.org/membergroups/primary/aphaspigwebsites/chw](http://www.apha.org/membergroups/primary/aphaspigwebsites/chw)
OUR CHWs

- FROM the community
- Know resources, community local partners, social networks
- Community trust & cultural competence
- Up to 4 years experience
- Lay CHWs are efficient use of resources
- Peer-level support/education adds credibility and effectiveness

CHW model has given us...
→ Higher recruitment numbers
→ Tap into more resources to avoid duplication of efforts
→ Word of mouth spreads more quickly
OUR MODEL
Coalition/Community Health Worker Model
OUR MODEL
Coalition/Community Health Worker Model

Tri-county coalition: Regional resources & partners – coordination & partnership
Coalition county chapters: Local partners & community members with diabetes
OUR MODEL
Coalition/Community Health Worker Model

Community Organizers: Experts in local diabetes/health resources. Connect patients, providers, & other agencies to diabetes resources.
OUR MODEL
Coalition/Community Health Worker Model

**Community Organizers:** Facilitate and coordinate non-clinical diabetes self-management education classes, support groups, coalition chapters, resources
OUR MODEL
Coalition/Community Health Worker Model

Coalition members: Advocating for healthy changes in local communities
OUR MODEL
Coalition/Community Health Worker Model

Peer Mentors: Experts in motivating patients. Provide one-on-one support & connect to resources & support network.
OUR MODEL
Coalition/Community Health Worker Model
INTERVENTIONS

Personal level interventions:
- Stanford Diabetes Self-Management Program
- NDEP New Beginnings Program
- ADA’s Live Empowered Program
- Kentucky DPCP’s Diabetes 101 class
- Cooper-Clayton Method to Stop Smoking
- Share our Strength’s Cooking Matters Program
- Biggest Loser Competitions
- University of Kentucky’s Taking Ownership of Your Diabetes Program
- KRDC Peer Mentoring Program (in-person one-on-one mentoring to reach self-management goals)
- Diabetes support groups in every county
INTERVENTIONS

Organizational, community, and societal interventions:

- Patient Packets for health care professionals
- Continuing medical education opportunities for health care professionals
- Statewide advocacy efforts to support diabetes programs
- Local restaurant menu improvements
- Health ministry programs in churches
- Farm to food bank programs
- Local advocacy for infrastructure improvement (i.e. sidewalks)
- Offer education at workplaces, in churches, to community groups, etc.
- Coordination of diabetes education opportunities, filling of gaps, establishment of new services (i.e. support groups) through pulling partners together
- Annual tri-county walk
THE RESEARCH: OUTCOMES

Diabetes self-management education (DSME) has been proven effective when used as a supplement to traditional medical care and shown to:

- Reduce fasting blood glucose levels
- Reduce hemoglobin A1c levels
- Reduce systolic blood pressure levels
- Reduce body weight
- Improve glycated hemoglobin (GHb) levels
- Improve knowledge of disease
- Reduce need for medication

Source: American Association of Diabetes Educators
THE RESEARCH: OUTCOMES

Education Outcomes

• Diabetes Self-Management Education associated with improved cognitive (knowledge) scores increased in the education group – not A1C

• Study results demonstrate that education alone has modest effect if does not affect attitude and motivation


Comparative Effectiveness of Peer Leaders and Community Health Workers in Diabetes Self-Management Support (DSMS)

• Peer Led and CHW groups both showed reduction in HbA1c, but Peer Led groups maintained reduced A1c, and reduced blood pressure after 18 months.

• Both groups maintained improvements in waist circumference, diabetes support, and diabetes distress

OUR OUTCOMES

Our interventions have already shown immediate positive impacts on participants’ health behaviors that are in line with recommended diabetes self-management behaviors:

- Increased consumption of fruits and vegetables (pre: avg of 3.8 days/wk, post: 4.95 days/wk, p=0.001)
- Increased frequency of exercise (pre: avg of 2.7 days/wk, post: 2.9 days/wk, p=0.001)
- Increased blood sugar monitoring (pre: 3.95 days/wk, post: 5.01 days/wk, p=0.001)
- Maintained high adherence to medication (pre: 6.4 days/wk, post: 6.7 days/wk, ns)
- Increased self-efficacy to manage diabetes (pre: avg of 6.3, post: 7.8, p=0.001)
OUR OUTCOMES

“I went to the doctor and I got my A1C down, and my weight’s coming down, and he asked me what I was doing. I told him I belong to the Henry County coalition and he said, keep doing what you’re doing!”

“I’ve learned that there are a lot of other people like me. I felt alone, and it helped to be with them, and learn together.”

“It gives you an incentive to work a little harder.”

“What I liked best was meeting with other people with the same problem. That helped me a lot.”

“You’re the only one that cares about my diabetes.”
MAJOR SUCCESSES

• Connect members to immediate and community-based resources and social support to help them implement changes

• More efficient use of resources, increased effectiveness due to peer leader advantage

• Anticipate reduced clinical measures, prevented complications, reduced number of preventable hospitalizations, readmissions, overuse of ER, etc.
OUR HOPES FOR THE FUTURE

Hospitals & Physician Groups
Insurance Companies & Health Plans
Foundation & Government Grants
Government funding
Community Donations

Diabetes is a **PERSONAL** diagnosis
Diabetes is a **FAMILY** diagnosis
Diabetes is a **COMMUNITY** diagnosis...

**TOGETHER**, we can win the battle!
QUESTIONS?

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For more info on our project visit: www.krdcoalition.com