

INTRODUCTION TO THE PROMISING PRACTICES COMPILATION

Each year, the American Diabetes Association (ADA) convenes its Annual Disparities Partnership Forum. The overall goal of the partnership forum is to explore collaborative methods for decreasing type 2 diabetes and obesity in high-risk populations.

A key feature of the 2009 forum, entitled *Overcoming Disparities: Building Successful Diabetes and Obesity Programs*, was the presentation of promising practices that can be applied to community efforts aimed at reducing the risk of type 2 diabetes and obesity in high-risk populations, including youth and adults. It is our pleasure to offer abstracts of the presentations as well as all submitted practices that met our selection criteria. Of the 35 promising practices submissions received, 34 were chosen to be included in this compilation.

We hope these examples of successful programs helps to inform your efforts in your communities.

18 INDIAN HEALTH BEST PRACTICES FOR DIABETES

Goal

To improve diabetes treatment and prevention efforts in Indian communities across the United States.

Target Population

All American Indians and Alaskan Natives with diabetes and those at risk for diabetes.

Method

IHS defines a Best Practice as a process, technique or approach that is universally recognized as a standard of excellence within a defined group or population. The defined group for the Indian health system is the Indian Health Service (IHS), Tribes and Tribal organizations, and urban Indian organizations (i.e., the I/T/U system).

Outcome Measures

Each IHS best practice has 2-3 process and/or outcome measures appropriate to the topic. Each site that implements the best practice is expected to collect the data.

Evaluation Results

To assess the use of the Diabetes Best Practice Models for AIAN communities, the Chief Medical Officers and Area Diabetes Consultants in each of the 12 IHS administrative regions of the country review each SDPI grant application and then submit data on each grantees' use of one or more Diabetes Best Practices. Results from the most recent evaluation are shown below, illustrating the percent of grant programs that used some or all of that particular best practice guidance:

Basic Care and Education-63%; Cardiovascular Disease & Diabetes-17%; Community Advocacy-40%; Dental Care for People w/Diabetes – 25%; Care for People w/Diabetes-35%; Foot Care for People w/Diabetes-57%; Kidney Disease-18%.

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ADVANCING HEALTH EQUITY THROUGH CHANGES IN PUBLIC HEALTH PRACTICE

Goal

Public health professionals will gain competencies and tools to advance health equity through public health practice.

Target Population

Public health professionals working in chronic disease prevention and control programs.

Method

To implement this training within public health agencies the following are recommended:

1. Required new staff orientation in health equity, the social determinants of health and cultural competency, along with ongoing advanced training for all staff.
2. Champions and support at the senior management level.
3. External political support.
4. Dedicated staff to plan and implement training.
5. Opportunity to spread concepts and initiatives to communities.

Outcome Measures

1. Participants will be able to articulate an understanding of health equity, the social determinants of health and cultural competency.
2. Participants will know how to apply this knowledge to improve current public health practice.
3. Participants will be able to select health indicators to measure progress in advancing health equity.

Evaluation Results

At the end of the session, 75% of participants will indicate a level of confidence in applying what they have learned at the conference to their public health practice and 90% of the participants will commit to take one action in applying what they have learned to their public health practice.

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BUILDING COALITIONS TO REACH UNDERSERVED POPULATIONS

Goal

To organize effective coalitions that will help disseminate diabetes information to underserved populations.

Target Population

Limited-resource audiences.

Method

County Extension agents recruited participants to serve on the Diabetes Education Awareness Prevention (DEAP) coalitions. A coalition chair and recorder were elected. The coalitions met regularly to assist the agent with disseminating information and planning activities. Several successful events were conducted, including diabetes classes and food demonstrations, walk-a-thons, fitness challenges and health fairs. Dates and locations of meetings are determined four to six months in advance. Tenure on the coalition is limited to three to five years to allow for different leaders to emerge. Support from administration is provided, making it possible to include work in staff's action plans.

Outcome Measures/Evaluation Results

Pre and post test evaluation of diabetes classes showed positive changes in behavior.

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CHURCH HEALTH CENTER AND HOPE AND HEALING

Goal

1) to serve the underserved by disseminating up-to-date, easy to understand health education in a warm, welcoming manner and 2) to provide individuals in the community with diabetes access to quality self-management education at no cost.

Target Population

1) residents of the area of low-socioeconomic status with limited access to health resources and 2) patients of the Church Health Center whose providers there have referred them for weight loss, diabetes education, smoking cessation, or a nutrition consultation with a registered dietitian

Method

The Church Health Center follows its own Model for Health Living, a practice application that establishes the patient as the center of their treatment plan. Faith life, physical activity, work life, emotional health, social connectivity, and eating habits are all discussed with a health coach when individuals establish themselves as patients. Patients' stage of change is determined and motivational interviewing is used to assist patients in setting goals for health-related behavior change. Respecting individuals' stage for readiness to change and meeting them where they are is an important part of the framework of the organization.

Outcome Measures

In accordance with the American Academy of Diabetes Educators, behavior change to reflect 7 self-care behaviors (health eating, being active, monitoring, taking medication, problem solving, and healthy coping) are measured post completion of our 4-class diabetes education program. A pre- and post-class survey asks participants how often they are performing an action in each self-care behavior area.

Evaluation Results

Of those participants who complete our program, 75% or more of program graduates report: Checking their feet multiples times per week or daily; Often or always monitoring their blood glucose as directed by their doctor; Following a meal plan/counting carbohydrates often or at every meal; Taking medication as directed by their doctor; Feeling capable of preventing low blood sugar. Post-completion, almost or half of program participants: Exercise 3 or more days per week; Feel capable or very capable to prevent health complications from diabetes; Report coping "very well" with their diabetes.

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CLEVELAND CLINIC OBESITY PREVENTION PROGRAM

Goal

Increase physical activity levels and number of family dinners and improve eating habits using the 5 to GO! framework. As a result, students will show a significant decrease in BMI.

Target Population

School-age youth and families in Northeast Ohio.

Method

1. Assessment (BMI Study) – Cleveland Clinic coordinates the school-based study, supplying volunteers to measure BMI. Students complete self-assessments on nutrition and physical activity. BMI results are sent home with recommendations for physician follow-up and resources if necessary. Data are analyzed for relationships between BMI and academic performance (Ohio Proficiency Test scores) and BMI and poverty (school lunch program enrollment).
2. School-based Interventions – Age-specific curricula is available (Pre-K/Kindergarten and 4th-6th grade) as well as school-wide interventions targeting nutrition, physical activity and mental health.
3. Community Interventions – The program supports safe bike routes and routes to school and walking school buses. We also offer a local Farmers' Market and programming in area supermarkets promoting nutrition education and Go! Foods. Age-specific curriculum is available through area museums and libraries.

Outcome Measures

All program components include outcomes measures. Curricula are IRB-approved, utilizing BMI measurements and pre- and post-survey responses regarding personal behavior (eating habits, number of family dinners, physical activity, etc) as evaluation components.

Evaluation Results

This study demonstrated a relationship (not a cause) among poverty, BMI scores, and academic achievement. Specifically, a child living in poverty was far more likely to have a high BMI score and low academic achievement. These results demonstrate a dire need for programming to prevent childhood obesity.

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CONNECTING FAMILIES TO PROMOTE HEALTH

Goal

1) to raise awareness about kidney disease and the key risk factors causing the disease, 2) to teach prevention strategies and promote better lifestyle choices and 3) to encourage families to share their family health histories.

Target Population

It is documented that African Americans have higher instances of type 2 diabetes and hypertension, which are the leading risk factors for chronic kidney disease.

Method

The program provides families with information about the risk factors of diabetes, its connection to chronic kidney disease and the importance of managing the disease. Providing individuals with information and tools for making better lifestyle choices, which includes changing eating habits and adding physical activity can make a significant impact on long-term health outcomes. Effective outreach programs for any ethnic group should be culturally sensitive so that the uniqueness of the community is addressed. When the informational materials provided reflect the community that you are trying to reach, they are more readily accepted by members of the group. Messages must be culturally appropriate and in language where applicable. An important consideration for the success of any minority outreach program is that employees working with the program or making presentations are aware of the cultural differences of the ethnic groups they work with and the circle of influences within those groups which is key.

Outcome Measures

By providing information about the increased health risk factors of Diabetes, High Blood Pressure and Chronic Kidney Disease:

- Individuals will take on responsibility of managing their health care
- Individuals are empowered to make better eating and lifestyle choices
- Individuals will be motivated to take preventive health measures

Evaluation Results

Individuals whose level of awareness about increased risk for Diabetes, High Blood Pressure and Chronic Kidney disease will be more pro-active with their health management:

- Number of individuals that have received an information brochure and bookmark
- Number of individuals that have participated in a Prevention Education Workshop
- Number of individuals that complete the Kidney Early Evaluation Program (KEEP)

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DIABETES PREVENTION USING COMMUNITY HEALTH WORKERS FOR AFRICAN AMERICAN AND HISPANIC/LATINO POPULATIONS

Goal

To reduce obesity and type 2 diabetes through Community Health Workers by using the Road to Health toolkit and providing ongoing support.

Target Population

African Americans and Hispanic/Latin Americans

Method

The Road to Health toolkit is an adaptation of the lifestyle intervention that was shown to be effective in the Diabetes Prevention Program study. The toolkit also incorporates principles of the Health Belief Model including perceived susceptibility, perceived benefits and self efficacy; Social Learning Theory including social support, behavioral capability, observational learning and positive reinforcement; and social marketing including audience research and segmentation. Culture Care Diversity is the theoretical model used to support the concept of CHWs delivering health messages to the community. Having an individual who knows and understands the culture improves the acceptance of the education messages. This model was developed by Madeline Leininger and suggests that individuals of culturally diverse backgrounds respond best when their unique cultures are honored.

Outcome Measures

Weight /BMI; Blood pressure control; lipids; goals met.

Evaluation Results

We do need to evaluate more effectively. We have some outcome data that is not statistically significant though it is clinically significant to the participants involved. Patients in the faith setting where data is captured from screenings indicate decreased cholesterol, decreased blood pressure toward normal, and through CHW follow up, decreased weight/BMI and effectiveness in meeting goals set at the start of the program.

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DINING WITH DIABETES/ON THE ROAD TO LIVING WELL WITH DIABETES: BUILDING PARTNERSHIPS

Goal

The goals of the Dining with Diabetes/On the Road to Living Well with Diabetes program are to enable individuals with diabetes to "know their numbers" and to increase their self-management skills in an effort to reduce the risk of complications; to increase their in-take of healthy foods and to encourage increased physical activity.

Target Population

Persons with diabetes, especially those without access to more traditional diabetes education programs.

Method

The Dining with Diabetes/On the Road to Living Well with Diabetes program is a program for persons with diabetes and family members. Classes run for four weeks, 2.5 hours per week with a follow-up class three months later. Pre and post questionnaires are used with A1c and blood pressure testing at the first and follow-up class.

Outcome Measures

The overall outcome that we are hoping to achieve is that individuals with diabetes who participate in our program are better able to manage their diabetes through knowledge of appropriate clinical tests, improvement of self-management skills, better nutrition and increased physical activity. To date 466 classes have been held with an average of 23 persons in each class.

Evaluation Results

Sample results from the pre/post questionnaires show a statistically significant increase in nutrition knowledge and behavior change. In clinical measurements 55% of participants reported having an annual dilated eye exam; 25% reduced their A1c and 25% of participants with blood pressure over 130/80 reduced their blood pressure.

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DMH NET – MISSOURI’S ANSWER TO HEALTH PROMOTION AMONG INDIVIDUALS WITH SEVERE MENTAL ILLNESS

Goal

To improve the overall health outcomes of individuals with SMI in Missouri through integrated care coordination in hopes of improving their quality of life while simultaneously conserving healthcare dollars through prevention-focused interventions.

Target Population

Medicaid adult individuals with SMI in the State of Missouri with identified co-morbid conditions, including an intensive focus on diabetes and pre-diabetes.

Method

These interventions are based in the evidence that shows that consumers with serious mental illness have a life span that is shortened, on average, by 25 years, compared to a non SMI population (Parks, et. al. 2006). Life expectancy for this disparate health group is shortened due to death by preventable medical conditions. The National Association of State Mental Health Program Directors are advocating for the SMI population to be formally designated as a health disparity population due to these facts. By improving care access and coordination for the SMI population through dissemination of clinical services information and best practice guidance, improved healthcare quality and increased life expectancy is the goal.

Outcome Measures

Number of patients having a psychiatric and physical health treatment home; Change in number of psychiatric and medical inpatient and ER admissions; Number of patients identified with diabetes or a pre-diabetic condition and provided with intervention; Number of diabetic or prediabetic patients receiving educational materials or counseling through the CMHC; Number of mental health case managers provided with medical education and referral resources; Number of medical case managers provided with mental health education and referral resources.

Evaluation Results

For the diabetes prevention component, 50,097 consumers through out the state of MO were identified as having a pre-diabetic condition of these 26,918 were receiving services at a Federally Qualified Health Center +/-or a Community Mental Health Center (CMHC). Screening tools in all CMHC sites have been distributed to track basic care aspects such as: HbA1C testing, lipid panel testing, evidence of eye exam 6,717 consumers were identified as having Type 1 and Type 2 diabetes across the state. Connection to self management training will be tracked in the 2nd year for this group of diabetic patients. 1,190 mental health case managers have been provided with additional education regarding comorbid medical conditions and adherence issues.

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FAMILIES ACTIVELY IMPROVING THEIR HEALTH WORKS

Goal

The goal of this program is 7% weight loss and 150 minutes a week exercise in adults, maintaining body mass index below 85% with 60 minutes of exercise most days of week for children and developing family environment that promotes healthy behaviors. There were three study aims: 1) development of complementary curriculum for adults and children 6-11 years old, 2) evaluate feasibility of implementing six-session program, and 3) assess effect of six sessions on body mass index, fasting glucose, self-reported exercise and dietary habits, and a family environment survey. Additionally, we measured participants' attendance to the sessions and their evaluation of the content and delivery of the sessions and the group process.

Target Population

This faith based lifestyle intervention program, implemented in the church, utilizes community based participatory research model to reduce risk of diabetes in African American(AA) children 6-11 years old and their overweight or obese parent(s).

Method

This six week complementary concurrent sessions for children and adults with individual and family goal setting, was developed utilizing integrated concepts of National Institute of Health's Diabetes Prevention Program, Coordinated Approach To Child Health, and Epstein's Stoplight Diet .

Outcome Measures

The first aim of this study was the development of a complementary curriculum for adults and children 6-11 years old. The second aim was to evaluate the feasibility of implementing the six-session program. The third aim was to assess the effect of the six sessions on body mass index, self-reported exercise and dietary habits, and a family environment survey. Additionally, we measured participants' attendance to the sessions and their evaluation of the content and delivery of the sessions and the group process.

Evaluation Results

The pilot study had six families participate six adults (four women, two men) and eight children (five boys, and three girls). Each session lasted 60 minutes and had an exercise component. The sessions were enjoyed by parents and children. The information was described as useful and practical. The church group environment was identified as a plus for assistance with behavior change and group support.

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FOCUS ON DIABETES: A COMMUNITY APPROACH TO ADDRESS HEALTH DISPARITIES IN DIABETES SELF-MANAGEMENT EDUCATION

Goal

The goal of Focus on Diabetes include providing African Americans with the knowledge, skills and support to manage their diabetes so that their health-related quality of live is improved; Identifying the undiagnosed and connecting them with health care and community support; and reducing the risk of diabetes by increased physical activity and improved nutrition.

Target Population

The geographic area served by the Center for African American Health is greater metropolitan Denver. Denver has a population of about 2.5 million people with approximately 120,000 of them African American. Denver County is the home to over half of the African American Community which represents 11% of the total population of the Denver metro community. The goal of the Center is to provide health education and screening to over 15,000 of our constituents utilizing our strong history with the black church, predominately African-American media outlets, sororities, fraternities and neighborhood health clinics and hospitals each year.

Method

The two-hour education sessions are highly interactive, focusing on building skills, sharing experiences, and providing support. Medical professionals from the University of Colorado School of Pharmacy and Dentistry, Kaiser Permanente, the Association of Black Psychologists, certified diabetes educators, and certified personal trainers serve as volunteer faculty. Each session includes a healthy dinner and 15 minutes of physical activity.

Outcome Measures

After participants finish the program, the Center utilizes Motivational Interviewing as its follow-up telephone support in order to track goal-setting outcomes for diet and nutrition, medical adherence and physical activity.

Evaluation Results

Upon enrollment (pre-test) in the diabetes self-management class: In the pre-test 38.9% rated their understanding of ways to cope with stress as poor or very poor and 12% rated their understanding poor or very poor in the post-test; In the pre-test 44.3% rated their understanding of overall diabetes care as poor or very poor; in the post-test only 4.8 rated their understanding poor or very poor; In the pre-test 59% rated their understanding of their meal plan as a means for blood sugar control as poor or very poor; in the post-test only 12% rated their understanding poor or very poor.

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HEALTHIER FOOD CHOICES IN NON-PROFIT COMMUNITY SETTINGS

Goal

Reduce obesity and diabetes rates in Prince Georges County, MD by increasing opportunities for people to have healthy food options in their social settings.

Target Population

Food service managers of non-profit organizations were offered an opportunity to attend a nutrition session prior to their required county certification course. They represented a variety of groups including private schools, churches, fraternal organizations, senior nutrition sites, and boys and girls clubs, thus providing service to a broad range of our ethnically diverse (68% African American; 11% Latino) county population. Some offer free meals to low income populations.

Method

Attendees were educated about healthy, practical food choices vs. some of the foods commonly served when providing meals in community settings. MyPyramid was used as their guide. Educators included an RD and 2 RN CDE's. Visuals were used to display sodium, sugar, and fat content in frequently served foods. Healthier alternatives were suggested. Portion control was discussed using the plate method and food models. Participants received a packet of sample menus.

Outcome Measures

Food service managers are required to attend training every three years. New clients will be seen for at least the next two years. Additional resources will be offered and changes will be tracked and documented as needed.

Evaluation Results

During the course of 17 months 286 people were educated, representing 75 different food service sites.

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HEALTHY LIFESTYLES PROGRAM

Goal

The Healthy Lifestyle Program (HeLP) takes evidenced based information and translates it into behavior change for providers and members to prevent and treat child obesity.

Target Population

The Healthy Lifestyles Program (HeLP) is part of the disease management arm of Children's Mercy Family Health Partners, a not-for-profit safety net health plan. We serve medicaid and SCHIP members in Kansas and Missouri.

Method

A standardized curriculum is provided for all staff and clinicians at each participating clinic. Once a clinic completes the didactic component of HeLP a treatment code is activated allowing additional reimbursement for healthy lifestyles education. Certified Health coaches offer a high-touch service to members, providing coaching telephonically or in person at a member's home or community location. Coaches employ a diverse array of assessment, psychological, and behavior change tools to empower members to take charge, connect with personal motivators to grow and change. They communicate with providers regularly on member's progress, supporting the partnership between the provider, member and health plan.

Outcome Measures

We measure individual clinical practice change through a pre-program and semi-annual chart review process. We have observed practice change varies with each group; however, there is an increase in obesity risk factor screening and education post program.

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HEALTHY SCHOOLS PARTNERSHIP

Goal

- Motivate students to attain and maintain a healthy body weight through an Energy Balance approach
- Improve students' nutrition knowledge and attitude about healthy foods and physical activity
- Improve students' consumption of nutrient-dense foods at school and away from school
- Create a culture of wellness in schools through policy and environment change
- Develop community relationships and partnerships to improve the health and wellness of the citizens and families in each community HSP has a presence and to create program sustainability

Target Population

High minority, low-income, students in grades 2-8

Method

Fourteen week nutrition curriculum by Registered Dietitians (RD) during PE class that includes integrated nutrition and physical activity games and one-on-one nutrition coaching. Contact with students also in the cafeteria with surround-sound messaging throughout the school.

Outcome Measures

Nutrition knowledge; eating behavior changes

Evaluation Results

Significantly improved nutrition knowledge; increased reported and actual consumption of fruits and vegetables

Applicability Type 2 Diabetes

Establishing healthy eating and physical activity patterns during childhood plays a critical role in preventing obesity and Type 2 diabetes. HSP is a uniquely intense Energy Balance program that provides nutrition experts to students to deliver the program, including one-on-one nutrition coaching, which helps them apply the information in an individualized manner. Implementing 'calories in' messaging in PE class while kids are engaged in 'calories out' activities and reinforcing the messages throughout the school is a unique and effective model for knowledge and behavior change

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HELPING “PEOPLE LIKE ME”: ENGAGING AFRICAN AMERICAN AND HISPANIC MEMBERS IN BETTER SELF-CARE THROUGH CULTURALLY AND LINGUISTICALLY APPROPRIATE MESSAGING

Goal

Our overarching study question is: How do culturally relevant strategies for African Americans and Hispanics with diabetes impact member engagement and health outcomes -- proximal, intermediate and long term?

Target Population

African American and Hispanic adults with diabetes

Method

1) Identify behavioral, psychological, and environmental drivers that motivate highly adherent self-care behavior; 2) Identify activities to enhance existing efforts, including the identification/stratification of target populations, our proactive outreach and engagement strategies, and communication materials and other interventions based on themes that emerged from our research of culturally relevant motivational drivers; 3) Launch randomized control pilot to test the new activities; 4) Evaluate quantitative/qualitative metrics, including response to newly developed culturally and linguistically appropriate materials for relevance and perceived value; and 5) Identify iterative process change opportunities.

Outcome Measures

Proximal/intermediate/long-term evaluation of randomized control pilot based on claims analysis and qualitative study performed by independent market researchers. Metrics include engagement, claims-based clinical indicators (e.g. presence/absence of labs/screens/tests), and claims-based acute utilization patterns.

Evaluation Results

Focus group findings include barriers to self care, variables potentially affecting adherence, and preferred communication channels and health-education content. Proximal metrics evaluation of the randomized pilot seems to indicate that culturally relevant strategies for African Americans and Hispanics with diabetes have a positive impact on member engagement.

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KIDNEY EARLY EVALUATION PROGRAM (KEEP)

Goal

Identify individuals with and at increased risk for kidney disease in the community to improve awareness of kidney disease and kidney disease risk factors and ultimately improve outcomes.

Target Population

Individuals 18 years or older with a history of diabetes or hypertension, or who have a family history of these conditions or kidney disease. Patients treated with dialysis or kidney transplantation are excluded.

Method

An approximately 45 minute free community-based screening offered nationwide. Informed consent is required. Health questionnaire evaluates personal and family history. On site tests include blood pressure, body mass index, waist circumference, urinary albumin-creatinine ratio and glucose. Central laboratory tests are estimated glomerular filtration rate, hemoglobin A1C, lipid panel and hemoglobin. The detection program concludes with a clinician consultation. Results reports are mailed to all, and their physicians with consent. A call center provides additional follow up by phone and mail. Annual repeat assessments began 6/15/08.

Outcome Measures

The ability to identify the target groups and measure changes in the population over time. Results: Comparing nearly 90,000 individuals screened in 49 US states in KEEP 2000 to 2007 to NHANES 1999-2006 revealed 29.4 vs. 6.9% diabetes, 69.4 vs. 26.9% hypertension, 35.6 vs. 26.5% obese, 33 vs. 11.3% Black, and 26.2 vs. 15.3% chronic kidney disease. The high prevalence of diabetes, obesity, Black race and kidney disease demonstrate that KEEP is able to identify individuals with and at risk for kidney disease in the community.

Evaluation Results

Data is in the process of being analyzed and preliminary results will be available later this year. These will include changes in diabetes awareness (accurate self-reporting), diabetes treatment (oral agents and insulin) and diabetes control (glucose and glycosylated hemoglobin). In addition changes in kidney disease and BMI over time. Lastly, hard outcomes will be evaluated 1) kidney failure through the United States Renal Data System, 2) Death via the National Death Index and 3) Potentially a rich source of administrative data for morbidity through a pending Medicare merge (requested).

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MEDICARE DIABETES SCREENING PROJECT

Goal

Increase usage of Medicare's benefits for diabetes screening among Medicare beneficiaries ages 65 and older by increasing awareness of these benefits among target populations, and motivating and enabling target population members to take appropriate actions.

Target Population

Seniors ages 65 and older who are at-risk for type 2 diabetes, and healthcare providers that can administer the Medicare-covered blood glucose tests in clinical-care settings.

Method

Awareness and communication campaign using community-based organizing and identification of community influentials to lead local outreach efforts, special events such as health fairs and senior programs, faith-based outreach and media tactics.

Outcome Measures

CMS/Medicare claims database analysis of utilization of the screening benefits in Columbus, Georgia, we have collected baseline measures (in 2007) of awareness and self-reported behavior in terms of getting screened for diabetes, and thus can measure changes after a 3-year interval. We have created a process of community organizing, based on experience in Columbus, Georgia, and the state of New Hampshire that can be replicated in other communities.

Evaluation Results

CMS data for 2007 and 2008 are not yet available.

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Mi SALUD – Mi VIDA

Goal

To facilitate self-management of diabetes type 2 among Hispanics/Latinos in Waukesha County, WI.

Target Population

Hispanic/Latino adults with, or at high risk for, type 2 diabetes. Program provides linguistically and culturally appropriate education and support. Targeted for Spanish-speaking individuals who are uninsured or underinsured and, therefore, typically have few resources for this type of education.

Method

Assessment of community needs, stakeholder input, literature review of best practices, curriculum development, health promoter training, lesson planning, material preparation, delivery of program.

Outcome Measures

Pre and post testing of knowledge
Pre and post testing of attitudes/behaviors
Height/weight measures
Open-ended comments, written and verbal

Evaluation Results

Knowledge pre test average 42%; post test 84%. 46 questions were answered "I don't know" in the pretest; 2 questions were answered "I don't know" in the posttest. 100% said they would strongly recommend the program to others. 75% of participants lost 1 to 4 pounds during the program.

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MOVE, BABY MOVE!

Goal

Move Baby, Move! is designed to increase the physical activity of diabetics who need to become active, but do not know how, or where to start.

Target Population

To provide older adults, particularly older diabetics, a fun, non-threatening, full-body workout while seated.

Method

In study after study, regular workouts have been proven to insulate us from heart disease, cancer, Alzheimer's, stroke, osteoporosis and diabetes. Our doctors are always telling us to do it...So why are we not exercising? Perhaps because it involves too much work and too little fun! Well, you owe it to yourself to experience the holistic chair exercise program that utilizes music and evidence-based movements to deliver a truly unique experience in older adult wellness: Move Baby, Move!

Outcome Measures

The effectiveness of the Move Baby, Move! program has primarily been measured by the increase of our participant's ability to perform their Activities of Daily Living (ADL's) and from the reports (Hemoglobin A1c) of their physicians when they have their check-ups. Move Baby, Move! provides a unique, quantitative older adult exercise program. The program includes initial/baseline and post-assessments of the participant's abilities to perform a basic test battery and answer an Activities of Daily Living Questionnaire. These serve as a measure of their functional health status and their ability to perform ADL's.

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ON THE ROAD – DIABETES AND LIFESTYLE PROGRAM

Goal

There are two overarching goals of the On the Road (OTR) Program: (1) Awareness of basic diabetes tests to promote self-management; and (2) engagement or re-engagement with the healthcare system.

Target Population

This program was originally designed for delivery by county agents of the USDA Extension Services. These agents have the distinct advantage of being embedded in the communities they serve. They have established track records in delivering nutrition and food safety information to their local communities especially medically underserved and low income populations.

Method

The OTR began as a diabetes pre-education program targeting information to a less educated population that was not regularly accessing healthcare. Programs are delivered in a local community setting by any level of educator: from lay health workers with only basic knowledge about diabetes; to educators using OTR to supplement a more comprehensive diabetes education program. OTR Living Well with Diabetes, the base program, uses point-of-care testing with results immediately provided to participants and their families, so that they have their individual results available during the discussion of the tests. Additional OTR programs are focused on nutrition and physical activity, including a DVD that can be used by people with limited motility. Together these programs meet the requirements for ADA recognition.

Outcome Measures

Awareness of the 5 diabetes tests (A1C, BP, Cholesterol, microalbumin, and the eye exam) including: knowledge of test, recall of test value, and interpretation of test value. Engagement or re-engagement with a healthcare provider. Improved intermediate outcomes (A1C, cholesterol, BP, and micro albumin). Improved level of physical activity (# days >20 minutes physical activity, MET-min/day)

Evaluation Results

The OTR base program showed a mean A1C improvement of 0.32%, $p < 0.0005$ in paired participants with diabetes ($n=604$), and a mean improvement of 1.20%, $p < .0005$ in participants whose baseline A1C $\geq 8.0\%$. There was improvement in systolic blood pressure (1.87 mmHg [0.21, 3.52], $p < 0.027$) and other biomarkers, as well as self-care behaviors and healthcare beliefs.

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PARENT EFFICACY TRAINING FOR THE PREVENTION OF PRE-SCHOOL OBESITY IN THE HEAD START POPULATION

Goal

The purpose of this study is to examine the feasibility of a parenting/nutritional intervention program designed to prevent childhood obesity in an urban, lower SES population. The intervention combines two well recognized curriculums: 1) knowledge of nutrition/activity (WE CAN!) and 2) parent skills training (*The Incredible Years*).

Target Population

The need for well-designed studies to assess the feasibility of obesity prevention programs in the pre-school population has been identified. Current evidence suggests that diet and exercise interventions alone that focus only on changing child behavior are not effective in preventing childhood weight gain. Parenting behavior is now being addressed as a treatment component for children with obesity. The target population are primary caregivers of children ages 3-5 years.

Method

It will be a non-randomized that will recruit 60 primary care providers whose children attend an urban Head Start program. The caregivers will be offered the combined curriculum intervention (We Can! and *The Incredible Years*). Once a week, for 6 consecutive weeks, enrolled caregivers will drop their child off at the Head Start classroom and then attend the educational session at an on-site classroom. Childcare for younger siblings of the participants will be provided at an on-site classroom.

Outcome Measures

Because of the limited scope of this pilot proposal, we will assess short term immediate outcomes 6 months post intervention, including changes in family eating, family physical activity, and parenting efficacy. In addition, we will assess change in child BMI.

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PARTNERSHIP FOR A HEALTH TEXAS: A COMMUNITY COALITION WITH A SIGNIFICANT IMPACT ON OBESITY PREVENTION LEGISLATION IN TEXAS

Goal

Develop policy recommendations and get them passed via legislation or regulation.

Target Population

N/A

Method

Although state-level policy can be an effective tool for population-based obesity prevention, few states have developed good approaches for identifying, developing and supporting policies that have a significant impact on obesity rates. The purpose of this presentation is to describe the background, goals, strategies, and successful outcomes of the Partnership for a Healthy Texas, a coalition of 47 organizations devoted “to develop and promote policies that prevent and reduce obesity in Texas.”

A Steering Committee was established to govern the partnership. THI facilitated the Partnership and provided administrative and technical support. As a result of an obesity forum, the Partnership met and identified six priorities for the 80th legislative session (2007): codifying the Texas School Nutrition policy into Texas law; requiring physical education for grades K-12; funding to implement coordinated school health; strengthening and improving accountability for current legislation; a comprehensive nutrition and physical activity public awareness campaign; and promoting worksite wellness programs. Two events sponsored by the Partnership were subsequently held at the Capitol to bring targeted information on the obesity epidemic to the attention of legislators. The Partnership then collaborated with both the House and the Senate to turn five of these six bills into law. Progress was made toward the objectives on the sixth priority (codifying the Texas School Nutrition policy) through meetings with staff from the Texas Department of Agriculture.

Outcome Measures

Number of policy prioritized successfully covered by legislation.

Applicability Type 2 Diabetes

The Partnership for a Healthy Texas is focusing on obesity, but the strategy can be used for diabetes and other health priorities.

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PHARMACIST DIRECTED DIABETES EDUCATION AND MANAGEMENT FOR THE UNINSURED

Goal

1. To improve patient outcomes through self-management education
2. To improve patient access to medications and supplies related to the care of diabetes
3. To improve quality performance measures for diabetes
4. To improve medication adherence rates
5. To provide education of health care professionals to manage diabetes

Target Population

Uninsured, low income adults under the age of 65.

Method

The first step was to develop a relationship with a center providing free health care and its volunteer medical providers. Established system for referrals and a curriculum for DSME. Self-assessment of program's effectiveness and success at achieving goals which led to revisions in the program's curriculum.

Outcome Measures

Hemoglobin A1c, LDL and HDL, Blood pressure, foot exam, fundoscopic eye exam, dental exam, immunizations, microalbumin/creatinine, education on lifestyle change.

Evaluation Results

Pending

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PREVENTING OVERWEIGHT AND OBESITY IN CHILD CARE SETTINGS (SCOOP): IMPLEMENTING “I AM MOVING, I AM LEARNING” THROUGH THE CULTURAL MUSIC SERIES “MY LITTLE WORLD”

Goal

The goal is to effectively disseminate training and education to the teaching staff, children and families affiliated with early care and education centers and home care facilities. This program is designed to achieve three main goals; 1) Increase the quantity of time that children spend achieving moderate to vigorous physical activity (MVPA), 2) Improve the quality of daily structured movement experiences, and 3) Improve healthy nutrition choices for children every day.

Target Population

Given the amount of time that children are present in early care and education environments, child care centers and home care facilities identified in Wards 1, 5, 7 and 8 were selected to receive educational materials and training.

Method

This program utilizes the culturally based music series “My Little World”- Vol. 1 – A Day In Pre-School, to direct child care providers in the implementation of the techniques of nationally recognized, “I Am Moving, I Am Learning”(IMIL). A proactive approach is provided to address childhood obesity through physical activity and nutrition services improvement.

Outcome Measures

Trained to incorporate SCOOP into the daily curriculum, the percentage of participating centers achieving 60 or more minutes of MVPA increased from 39% prior to SCOOP training to 74% following the training. The percentage of participating centers achieving 60 minutes of MVPA on a daily basis increased from 45% to 72%

Evaluation Results

Exercise plays a major role in preventing the complications of diabetes, SCOOP is a successful program that has provided over 3000 children and child care providers in the District of Columbia with opportunities for daily healthy movement and improvement in nutrition services.

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REACH CHARLESTON AND GEORGETOWN DIABETES COALITION: DECREASING AMPUTATION IN AFRICAN AMERICAN MALES

Goal

To focus on reducing disparities for African Americans with diabetes. During the initial planning year (1999) amputations in African Americans were identified as one of our major community concerns. After examining the epidemiological data showing high rates of amputations in African American men, our goal was to decrease amputations in this group by 5% each year.

Target Population

African Americans (males)

Method

The plan and implementation included 1) community education related to the problem and ways to decrease the problem of amputations; 2) health systems education and improvement related to foot care; 3) community clinics to provide foot care demonstrations; and 4) surveillance and community feedback related to progress.

Outcome Measures

Changes in (1) lay and professional educators; (2) community skill-building and improved screening in neighborhood clinics; (3) health professional training; (4) amputations (by race and gender) over time.

Evaluation Results

All plans were implemented with excellent community response and ownership. Amputations in African American males in Charleston County decreased by more than 50% from 1999 to 2003 and this decrease has been maintained through 2007. Community practices have been institutionalized in 5 health care systems with foot exams increasing from 64.1% in 1999 to 97% for those visiting their health provider. Community education is integrated into faith-based and other sites within community. Media and community volunteers have supported our efforts in decreasing disparities, as we united to improve outcomes.

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SMALL STEPS. BIG REWARDS. PREVENT TYPE 2 DIABETES MULTICULTURAL CAMPAIGN

Goal

NDEP's goal is to address health disparities through translating the latest science and spreading the word that diabetes is serious, common, and costly, yet controllable and for type 2 diabetes preventable.

Target Population

Materials have been adapted to reach audiences at highest risk for developing diabetes. These adaptations address cultural issues like food choices. Target audiences include African Americans and people of African ancestry, Hispanics/Latinos, Asian Americans, Pacific Islanders, American Indians, Alaska Natives, Older adults and Women with a history of gestational diabetes.

Method

NDEP has recently revised its print public service announcements (PSAs) to lead with the "family history" angle and to help people understand that they are at risk for diabetes. In response to the findings of NDEP's public opinion survey to learn the risk factors that resonated among our target population, NDEP is taking steps to ensure that all campaign elements such as feature articles, website promotions, and products aimed at high-risk populations reflect this new angle. Steps in implementation include a plan for dissemination through various channels such as exhibiting at conferences, professional presentations, and print, online, radio and television promotions. Annually, NDEP develops a promotion plan and updates/revises materials, as necessary, to ensure dissemination to the target populations. Partners also promote campaign messages and materials. Our primary resource for disseminating and highlighting materials and information is the NDEP website. In June, NDEP unveiled a redesigned website to better meet the needs of our various audiences. The new site is more streamlined and user-friendly and allows consumers, health care professionals, and partners to easily access the information that is most appropriate for them. The site also features Spanish-language content for people with diabetes and those at risk.

Outcome Measures

NDEP completed a Public Survey in 2006 and 2008, which provided information on knowledge, awareness, attitudes, and beliefs of diabetes and pre-diabetes. NDEP monitors other research (i.e. HNIS, NHANES, and BRFSS) to track awareness of diabetes prevention and control. For example, when NDEP was initiated in 1997, only 8 percent of Americans believed that diabetes was serious. By 2006, 89 percent of Americans believed that diabetes was a serious disease. NDEP also completes a Partner Activity Survey and Progress Report annually. In these reports, partner activities, initiatives across communities, identified media hits, and the number of publications distributed are highlighted.

Evaluation Results

N/A

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STEP-DC: STOP EMERGENCY DEPARTMENT VISITS FOR HYPERGLYCEMIA PROJECT – DC

Goal

Reduce ED visits for uncontrolled hyperglycemia by incorporating: 1) a diabetes medication algorithm for use by the physician, 2) health system navigation, and 3) concise diabetes self-management survival skills education. Provide secondary prevention from complications for patients with diabetes through improved outcomes.

Target Population

Patients presenting to the WHC ED with a blood sugar over 200 who were otherwise stable for discharge home. This included patients with a history of type 2 diabetes or patients diagnosed in the ED at the time of the visit.

Method

- Patients would receive intervention regardless of insurance status/ability to pay
- The ED at WHC is used by a high percentage of minorities and patients with limited access to diabetes education
- Patients would be assisted in finding a primary care provider or "medical home" for future care once the involvement in this project ended after 4 weeks

Outcome Measures

- Average blood sugar, and A1C at baseline (week 1) and at the end of project (4 weeks)
- Safety as measured by rates of day 1 hypoglycemia and rates of hypoglycemia throughout the study.
- Rates of program completion
- Decrease in return ED visits for patients who participated in the Step-DC intervention
- Compliance with prescribed DM medications

Evaluation Results

There were statistically significant decreases in A1C and BG from baseline, where mean A1C dropped by 0.4 (p= 0.048) and mean BG dropped by 173.5g/dL (p<0.001). The drop in A1C was measured over a 2 week period, and the drop in BG over a 4 week period; Out of 86 patients enrolled in the study, 60% completed all 4 study visits, 21% completed 2 or 3 study visits, and 19% did not come in for any follow up visit after initial contact in the ED; There was a drop in ED visits/hospitalizations for hypo/hyperglycemia for patients enrolled in the study; however the subset of patients involved was too small to achieve statistical significance; Medication compliance was highest with basal insulin and with metformin (95%); The top two self-reported reasons for presenting to the ED with hypo/hyperglycemia were no MD appointment (41.67%) and no PCP (14.58%); Insurance breakdown was: Private 48%, Medicaid 29%, Medicare 8%, none/private pay: 15%; Demographic information: Black or African-American 92.7%, Hispanic or Latino 4.8%, female/male participation evenly split.

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TACKLING OBESITY THROUGH POLICY DEVELOPMENT: AN EXCERPT INTO THE NEXT GENERATION OF PACIFIC ISLANDERS

Goal

(1) To articulate the procedure for assessing obesity prevention in relation to the surrounding environment of significantly populated Pacific Islander communities; (2) To explain the need for addressing culturally competent community collaborations through the understanding of Pacific Islander cultural values; (3) To discuss policy change towards the design and/or maintenance of recreational parks and possible open/free space; and (4) To describe procedural issues relating to the history and formation of the CAG including community assessments, current implementations, and presentations.

Target Population

Pacific Islander and other underserved populations in affected areas

Method

The Pacific Islander Obesity Community Action Group, through the Asian & Pacific Islander Obesity Prevention Alliance, uses various methods to address obesity prevention amongst Pacific Islanders in Southern California. Although, there has been minimal research regarding Pacific Islanders and obesity, anecdotal evidence indicates that cardiovascular disease, diabetes, and cancer are the top three health disparities among these groups, indicating that obesity prevention is a much needed service. Building on the fundamental Pacific Islander cultural values of family, faith, and respect, this program is working to bring together Micronesians, Melanesians, and Polynesians to address obesity prevention through policy change at local, city, and state government levels.

Outcome Measures

- 1) extend lighting on affected parks
- 2) clean sidewalks free of graffiti
- 3) more park presence/security during park hours
- 4) more park activities/programs during extended hours
- 5) more families, community individuals/organizations utilizing park

Evaluation Results

Follow through with expansion plans, apply programming to selected parks agreed upon, search for more funding and partnerships to address the top health disparity in the Pacific Islander community and other underserved populations.

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THE ALLIANCE TO REDUCE DISPARITIES IN DIABETES

Goal

The Alliance to Reduce Disparities in Diabetes is comprised of a National Program Office and five community grantees serving large numbers of vulnerable adults with diabetes. Over 5 years (2009-2014) they will evaluate comprehensive evidence-based programs and work with community, regional, and national partners toward reducing diabetes disparities and enhancing the quality of health care through:

(1) Applying proven, community-based and collaborative approaches for assisting adults in low-income communities; (2) Enhancing patient and health care provider communication, mobilizing community partners and enhancing health care organizations; (3) Disseminating important findings and increasing public awareness of health care disparities and diabetes; (4) Promoting collaboration and information exchange to strengthen the efforts of interested stakeholders and organizations that share the vision of the Alliance

Target Population

The focus will be on national and local efforts targeting adults with type 2 diabetes in five vulnerable communities as follows: Camden, New Jersey; South Side of Chicago; Dallas County, Texas; Wind River Indian Reservation, Fort Washakie, WY; and Memphis, TN.

Method/Outcome Measures

Quantitative and qualitative data will be collected from patients, providers, health care systems, and community stakeholders to assess the effectiveness of the interventions and the processes by which the interventions were implemented. Specific planned measures include: clinical outcomes, patient knowledge and behavioral outcomes, patient health care utilization and costs, patient satisfaction with care, clinician participation in education and training, community resources used and partnerships developed.

Evaluation Results

Ongoing monitoring is identifying processes of collaboration and implementation. For further information visit: www.alliancefordiabetes.org.

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THE HRSA PATIENT SAFETY AND CLINICAL PHARMACY SERVICES COLLABORATIVE WITH A FOCUS ON DIABETES AND OBESITY

Goal

To integrate the healthcare delivery system across multiple providers, producing improvements in health outcomes and patient safety using a patient-centered, primary health home model.

Target Population

Each PSPC team identifies and targets their high-risk, high-cost patient population. Nearly half of the target populations identified by teams – spanning urban, rural, hospital and health center settings – include patients with diabetes and/or obesity.

Method

Using the Institute for Healthcare Improvement (IHI) Breakthrough Series model, safety-net communities select multidisciplinary teams of healthcare providers to participate in intensive series of Learning Sessions and Action Periods. Drawing from the leading practices of high performing organizations, teams work together to rapidly learn, test, implement and track their patient care to achieve established collaborative goals.

Outcome Measures

Teams share results on their target populations and demonstrate improvements in health outcomes and patient safety through the integration of clinical pharmacy services. The health outcomes measures that address patients with diabetes and obesity include: A1C, blood pressure control and BMI screening. Teams also track and share results in the identification of potential Adverse Drug Events (ADEs) and ADEs.

Evaluation Results

Teams have demonstrated improved health outcomes and patient safety in high-risk, high-cost, complex patients. Among patients with diabetes and/or obesity, teams in the PSPC over a 12 month period, have dramatically improved A1Cs. PSPC teams were also able to document and avert nearly 3000 potential ADEs and use that data to implement system improvements.

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THE POWER OF PARTNERSHIP... PREVENTING CHILDHOOD OBESITY IN DC

Goal

The Collaborative seeks to help build, accelerate and sustain a grassroots healthy living movement that halts and reverses childhood obesity trends and promotes healthy living in Ward 8.

Target Population

African American low income adults and youth, youth serving organizations, residents of the Ward 8 community in DC.

Method

Implementation steps include: conducting several focus groups and surveys with residents, professionals and organizations in Ward 8, attending community meetings with local church and clergy groups, offering resources to agencies working to combat obesity, inviting non-traditional stakeholders to learn about and join the Collaborative and consulting with members of the Ward 8 community to prioritize programs, policies, and strategies to prevent childhood obesity.

Outcome Measures

The primary outcome measure for the Collaborative is to increase the number of residents engaged in a healthy living movement to decrease rates of childhood obesity.

Evaluation Results

Thirty-five Teen Health Educators were trained to be peer educators and advocates in healthy eating and active living principles. Successfully conducted community consultations to solicit policy recommendations that will be submitted to the DC State Obesity Plan. Successfully became one of nine Leading Sites for the Healthy Kids, Healthy Communities Program of the Robert Wood Johnson Foundation to implement healthy eating and active living policies for residents in Wards 7 and 8. Through a series of community consultations, conducted two town hall meetings, focus groups, community surveys and key informant interviews.

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THE SCHOOL'S ROLE IN REVERSING TRENDS OF CHILDHOOD OBESITY

Goal

To identify the school nurse role in the assessment, treatment and prevention of overweight and obesity in children at school and the results of school nurse interventions in three large, culturally diverse school districts.

Target Population

School nurses, overweight and obese children and their families.

Method

1. Identify a leader school nurse in the school district, known as the Diabetes Resource Nurses (DRN), a professional school nurse with expertise in diabetes management and prevention (risk reduction) who provides training, coaching, consultation and resources for school nurses; 2. Empower school nurses, who have been educated, to assess, identify and refer children at risk for diabetes and other chronic health problems association with overweight, to primary health providers for follow up; provide resources and education to students and families and collaborate with health care providers and community resources for children and families at risk; 3. Provide for follow-up with children, families, health care providers and schools; 4. Collaborate with community partners.

Outcome Measures

Numbers of school nurses utilizing models and tools in the care of overweight and obese children; numbers of children who have been screened and referred to health care providers and community resources; number of policies implemented in schools to promote healthy eating and physical activity; number of collaborations and coalitions schools nurse are involved in related to lowering the risk for diabetes in school children and promoting healthy behaviors in schools and for parents.

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TRANSLATING THE DIABETES PREVENTION PROGRAM INTO THE COMMUNITY IN MONTANA

Goal

The purpose of this study was to evaluate the feasibility of translating the Diabetes Prevention Program (DPP) lifestyle intervention into practice in the general community.

Target Population

Adults aged 18 years or older at high risk for diabetes or cardiovascular disease.

Method

In 2008, the Montana Diabetes Control Program working collaboratively with four health care facilities implemented an adapted group-based DPP lifestyle intervention. Participants set targets to reduce fat intake and increase physical activity (>150 minutes per week) in order to achieve 7% weight loss goal.

Outcome Measures

Sites enrolled 355 participants and 83% (n = 295) of participants completed the 16 session program. Seventy percent of participants achieved the physical activity goal of >150 minutes/week. There was a significant decrease among participants weight from baseline (mean 99.3 ± SD 19.7 kg) to week 16 (mean 92.6 ± SD 18.8 kg, mean difference 6.7 ± 4.0 kg, p < 0.001). Forty-five percent of the participants achieved the 7% weight loss goal and 67% achieved at least 5% weight loss. Participants who were 60 years of age and older, had a diagnosis of hypertension, met their physical activity goal of >150 minutes per week, and those more frequently monitoring their fat intake were more likely to meet the 7% weight loss goal compared to participants without these characteristics.

Evaluation Results

Our findings suggest that it is feasible to recruit and retain high-risk participants and achieve weight loss and physical goals in a group setting that are comparable to those achieved in the DPP.

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WARD 5 DIABETES – OBESITY/OVERWEIGHT AND/OR CARDIOVASCULAR (DOC) PREVENTION AND CONTROL PROGRAM

Goal

Goal 1: Implement evidence-based, replicable and sustainable community based Diabetes, Obesity and Cardiovascular disease prevention and control program in Ward 5, with a focus on increasing physical activity and improving nutrition intake. This program will be collaboration between the MedStar Diabetes Institute at Washington Hospital Center and an integrated community network-- Woodridge Neighborhood Library, Turkey Thicket Recreation Center and other community-based programs/organizations; Goal 2: Increase awareness and referrals for treatment of new cases of suspected diabetes, and hypertension; Goal 3: Provide the DOC prevention and control interventions-- Lifestyle Balance, and Diabetes and Heart Health for Life to those at risk for or who have Diabetes, Obesity/overweight or Cardiovascular disease.

Target Population

African American Adults with diabetes or at risk for diabetes, obesity and cardiovascular disease.

Method

This project brings the primary and secondary prevention program into the community in order to increase access to education.

Outcome Measures

Clinical Outcomes at Baseline and at 3 Months: Number and percent of patients who meet American Diabetes Association goals of A1C<7, and BP<130/80; Mean A1C; Mean BP; Mean BMI; Number and percent of diabetes related ED visits and hospitalizations; Process Outcomes at Baseline and at 3 Months; Number and dose of diabetes medications; Number and percent of participants receiving navigation services.

Evaluation Results

Initial diabetes self-management education program was placed in the central library in DC from 2002 to 2009. Outcomes collected on 263 of the 2000 participants included increase fund of knowledge, 1/3 decrease in Emergency Department visits, and a .5% absolute decrease in A1C 6 months post program. Outcomes measures of the 300 participants who entered the primary (Lifestyle Balance Program) and secondary (Controlling Your Diabetes for Life) prevention program at the recreation center will be available in the Fall of 2009 at the completion of the program.

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