

*3rd Annual Disparities Partnership Forum: Overcoming Disparities
Building Successful Obesity and Diabetes Programs*
SUMMARY

Purpose of Summary

The purpose of this summary is to:

- Review the key points of the 2009 forum.
- Identify actions that could be taken in communities over the next year to reduce the risk of obesity and type 2 diabetes.

How to Use This Summary

We encourage all who read this summary to share it with their colleagues. It is our hope that it will inspire national and community leaders to take action to (1) prevent overweight/obesity and type 2 diabetes in high-risk populations and (2) lessen the effects of obesity and diabetes, particularly in communities at high risk for developing the disease. The presentations, promising practices, and actions described in this summary can be used in several ways, including to:

- Develop community activities and programs.
- Tailor existing successful interventions to communities.
- Create educational materials on obesity and diabetes.
- Engage new partners in collaborative efforts.
- Influence local and national policy and legislation that impacts diabetes.
- Inform colleagues and nontraditional partners about the 2010 annual partnership forum and encourage them to attend.

Overview of 2009 Forum¹

Each year, the American Diabetes Association (ADA), the nation's leading voluntary health organization in the fight against diabetes, 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.

On November 18 and 19, 2009, the ADA brought together a diverse group of community leaders and health care professionals from around the country for a two-day meeting in Arlington, Virginia. The meeting focused on the major challenges faced by at-risk minority and underserved populations regarding the prevention, detection, and management of obesity and type 2 diabetes. The forum included:

- An opening keynote address by Garth Graham, MD, MPH, Deputy Assistant Secretary, Office of Minority Health.
- Presentations of innovative interventions in various settings.

¹ To view the forum agenda, please click [here](#)

- Interactive, idea exchanges.
- A closing keynote address by Kyu Rhee ,MD, MPP, FAAP, FACP, Chief Public Health Officer, Office of the Administrator, Health Resources and Services Administration.

The forum focused on community solutions and action. It was highly interactive and offered multiple opportunities for the exchange of ideas among attendees, The practical application of the didactic presentations was emphasized and collaborations among stakeholders and thought leaders were fostered.

Goals of 2009 Forum

The goals of the 2009 forum were to:

- Highlight promising practices that address type 2 diabetes and obesity in high-risk populations.
- Identify key elements of coalition-building to eliminate disparities in health care at the community level.

Attendees accomplished these goals by:

- Hearing about what non-profit organizations, for-profit companies, and community-based organizations are doing in high-risk communities to reduce the incidence of obesity and type 2 diabetes.
- Participating in small-group discussions designed to
 - Explore how to use promising practices in their community/work settings.
 - Identify solutions and actions that will eliminate disparities in health care at the community level.
- Networking with others and learning about new approaches to stopping diabetes in their communities.

Speakers

Diabetes Statistics

Multiple speakers painted a statistical picture of diabetes in the United States:

- Every minute, three people are diagnosed with diabetes.
- Currently, there are 24 million children and adults who have diabetes, and nearly 5.7 million in this group are not aware that they have the disease.
- Another 57 million people have pre-diabetes, putting them at high risk for developing the disease.
- The risk of developing diabetes is disproportionately greater for minority communities.
- Latino-Americans are 1.8 times more likely to have diabetes than non-Latino whites, and African Americans are 1.6 more likely than whites.
- Every day, nearly 200 people with diabetes undergo amputation, 120 enter end-stage kidney disease programs, and 55 go blind.
- Diabetes kills more Americans each year than breast cancer and HIV/AIDS combined.
- The total estimated direct and indirect cost of diabetes annually is about \$174 billion.

- One in 6 people do not seek health care because of cost.
- In 2007, the annual health care cost for a person with diabetes was \$11,500.
- Eighty percent of people remain uninsured after having lost coverage due to a transition such as a job change or layoff.
- Fifty percent of those who are uninsured are from racial or ethnic minorities.

- If, in 2004, all states had improved diabetes control to the level of the top four best-performing states, 39,000 fewer patients would have been admitted to health care facilities for uncontrolled diabetes, potentially saving \$217 per patient per year.
- Although the United States spends more on health care than any other industrialized nation, it ranks much lower in terms of positive health care outcomes.

Larry Hausner, Chief Executive Officer, ADA

Mr. Hausner kicked off the forum by announcing that the organization is taking a bolder, more audacious approach by launching *Stop Diabetes*, a national movement to help people from all walks of life confront, fight, and most importantly, stop the disease. He stressed that diabetes is misunderstood and not taken seriously by the general public:

- Diabetes is perceived by the public as a condition, not a disease.
- Many Americans refuse to face the truth that diabetes is just as serious as other diseases and can lead to other deadly diseases and complications.
- One out of three children born today will face a future with diabetes if we don't do something right away to start changing things,.

He encouraged attendees to join the movement to *Stop Diabetes* by visiting www.stopdiabetes.com or calling 1-800-DIABETES and to:

- Share. Tell personal stories that will encourage others to join the movement and visit www.stopdiabetes.com, [Facebook.com/AmericanDiabetesAssociation](https://www.facebook.com/AmericanDiabetesAssociation), and [Twitter.com/AmDiabetesAssn](https://twitter.com/AmDiabetesAssn).
- Act. Help build momentum for the *Stop Diabetes* movement in whatever way they can: run, walk, bike, become a diabetes advocate, or simply tell a friend.
- Learn. Refer people with or at risk for diabetes to the ADA website for medical, lifestyle, and motivational information to prevent diabetes from taking control of their lives and the lives of those around them.
- Give. Donate to or volunteer at any one of the hundreds of ADA offices in communities across the country that provide diabetes education and raise money for diabetes research as well as federal and state advocacy activities.

Yvette Roubideaux, MD, MPH, Director, Indian Health Service

Dr. Roubideaux spoke about diabetes in communities, in particular, American Indian communities:

- The Indian Health Service (IHS) established the National Diabetes Program in 1979 to address the growing epidemic of diabetes in American Indian communities.
- It is essential to work in partnership with communities to improve their health.
- There are many factors in communities that affect individuals' health, e.g., the economy; peoples' ability to buy prescription drugs; the availability of healthy foods, wellness programs, and safe places to exercise; local culture and traditions.
- Annual audits have shown that the IHS diabetes programs have resulted in quality care.

She also commented on the goals of health care reform:

- To ensure that all Americans have access to quality and affordable health care.
- To reduce health care costs.
- To ensure security and stability for those with health care insurance.

Dr. Roubideaux concluded her remarks by stressing the:

- Importance of evaluation of all IHS programs to make certain that they are effective and lead to the desired outcomes.
- Need to share best practices.

Garth Graham, MD, MPH, Deputy Assistant Secretary, Office of Minority Health

Dr. Graham's opening keynote presentation provided a perspective on the importance of health care reform, particularly as it relates to diabetes, prevention of disease, and the impact of partnerships and community and individual engagement to improve the health of our country:

- It is essential that everyone become engaged in the discussion of health care reform and understand the facts.
- Success occurs when one of two things happen: there is a burgeoning local community activity that spreads infectiously into a national wave of activity, or there is a federal activity that engages people at the grassroots level.
- Health insurance affects the incidence and prevalence of diabetes and reduces, but does not eliminate, health disparities.
- Three things need to happen before we see some real, concrete "numbers" in terms of eliminating health disparities:
 - The system needs to change.
 - Communities must become engaged and mobilized.
 - Individuals must make personal behavior changes.
- Much of what is currently being talked about in terms of health care reform includes community-based approaches and prevention strategies.
- The Mississippi Health First Initiative is an example of a state-based activity that brings together federal and non-federal representatives.
- The Common Community Measures for Obesity Prevention Project identified six recommendations that should permeate community strategies:
 - Promote the availability of affordable healthy food and beverages.
 - Support healthy food and beverage choices.
 - Encourage breastfeeding.
 - Encourage physical activity.
 - Create safe communities that support physical activity.
 - Encourage communities to organize for change.
- The National Partnerships for Action (www.minorityhealth.hhs.gov) is a multi-year initiative launched by the Office of Minority Health (OMH) that is concerned with creating partnerships that are interested in health care reform.
- A National Health Disparities Plan is being drafted.

Kyu Rhee, MD, MPP, FAAP, FACP, Chief Public Health Officer, Health Resources and Services Admin.

Dr. Rhee's closing keynote presentation provided a framework for public health and how chronic conditions like obesity and diabetes are the next great public health challenge. He reminded attendees that health is not just about behavior, disease, and genetics, but also about the broader determinants of health, i.e., housing; education; access; employment and salary; and geographic disparities (transportation); and other factors such as faith, culture, and language. He made the following key points:

- We need to integrate science, practice, and policy.
- Innovation involves three "T's":
 - Translation, i.e., integrating science, practice, and policy.
 - Transdisciplinary teams, i.e., recognizing that diverse teams breed creativity and require emotionally intelligent leadership.
 - Transformation, i.e., changing the way things are.
- Teams go through various stages of development: forming, storming, norming, performing, transforming, and mourning.
- Different leadership styles are necessary for different situations.
- Rather than labeling populations as high risk, viewing them as resilient is more assets-oriented than problem-centric.
- Self-management issues include: self-awareness, social awareness, being proactive, speaking up, being heard, listening, beginning with the end in mind, putting first things first, thinking win-win, renewing, and continuing to improve.
- Find your own voice and inspire others to find theirs.
- Use social networks to connect people and programs.

Promising Practices Presentations

A key feature of the 2009 forum 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 youth and/or adults, particularly in high-risk populations (e.g., racial and ethnic minorities, under-insured or uninsured populations, the elderly, and geographically isolated populations).

Promising practice submissions were required to have measurable outcomes and be capable of being replicated and sustained. The selection process was as follows:

- A call for promising practices aimed at reducing obesity and the risk of type 2 diabetes, particularly in underserved populations, was sent to over 1500 individuals/organizations.
- Thirty-five submissions were received.
- The submissions went through a formal internal and external review process and were scored.
- Six submissions were selected for presentation, and 34 were included in a published compilation.

The six practices chosen for presentation are summarized below. [Click to view presentations](#)

The Healthy Schools Partnership - (Presented by Katie Brown, EdD, RD, LD of the American Dietetic Association Foundation.)

The key features of the Healthy Schools Partnership are:

- Registered dietitians, rather than classroom teachers, deliver the program.
- Students are taught to apply key concepts to his/her own eating style and behavior.
- Energy balance is emphasized.
- Healthy food choices are identified by a “power pick” logo.
- Messages are distributed throughout the school, including posters hung in hallways, daily announcements made by the principal or student, wellness articles in family newsletters, cafeteria signage identifying “power foods.”
- Prior to implementing the program, relationships are built with community programs and services that students and families can use.

The Kidney Early Evaluation Program (KEEP) - (Presented by Joseph Vassalotti, MD of the National Kidney Foundation.)

The key features of KEEP are:

- Free, one-hour screenings are provided in community facilities (e.g., community centers, churches).
- The screenings are targeted to individuals who are 18 and older and who have the following risk factors:
 - Personal history of diabetes or hypertension.
 - Family history of diabetes, hypertension, or chronic kidney disease.
- The screenings are organized around a set of six tables:
 - Registration.
 - Screening questionnaire.
 - Physical measurements.
 - Blood and urine collection for laboratory testing.
 - Consultation with a physician, nurse practitioner, or physician assistant.
 - Screening review.
- The screenings are staffed by volunteers drawn from the community and include
 - Community leaders.
 - People who are multilingual.
 - Individuals with knowledge of medicine (e.g., nurses, physicians, physician assistants, nursing and pharmacy school students, dietitians, and social workers).
- The only paid staff is a phlebotomist.
- Results are mailed to participants and their physicians.
- A comprehensive education program is offered.
- Follow-up is provided and includes
 - Mailed results.
 - Phone calls.
 - Repeat screening invitation, one year later.

- Connections to community resources for individuals without health insurance (e.g., free clinics, social workers).
- Participants have access to a call center.

The Medicare Diabetes Screening Project - (Presented by Jay Hedlund, BS of the Medicare Diabetes Screening Project.)

The key features of the Medicare Diabetes Screening Project are:

- This national coalition was established to promote the utilization of the Medicare diabetes screening benefit that came into effect in 2005.
- The coalition comprises providers, government agencies, organizations that serve seniors, the ADA, the Healthcare Leadership Council, and Novo Nordisk.
- The goals of the project are to:
 - Increase usage of the benefit (less than 10% of Medicare beneficiaries are using this benefit).
 - Encourage federal, state, and local government agencies and private organizations to make diabetes screening a priority.
 - Develop models, messages, and grassroots outreach efforts that can be replicated elsewhere.
 - Deliver the message that people should talk to their providers about this free benefit.
- This benefit allows annual diabetes screening for beneficiaries with the following risk factors: high blood pressure, high cholesterol, overweight, or family history, or history of gestational diabetes. An individual with pre-diabetes can be rescreened every 6 months.
- There is no co-pay or deductible required.
- The screening must be done in a medical context, either by a physician, a physician assistant, or other recognized provider.
- A joint effort with the National Council on Aging has enabled trainings with individuals who work with seniors. They are provided with toolkits and go back to their communities to educate and inform seniors and their caregivers about the benefit.
- Mini-grants of \$2500 are given to community-based organizations to encourage them to promote the benefit. These organizations include area agencies on aging, churches, health systems, and pharmacy services.
- The approach is to “organize the organized”: partner with networks that work with seniors and give them the tools to reach their constituencies (e.g., seniors, fire departments, business leaders, diabetes organizations). They are encouraged to develop a local council so that the effort can be sustained at the community level.
- Educational materials (including a church bulletin insert, risk assessment checklist, and consumer brochure) and templates for community organizing are available for communities, along with technical assistance.

The REACH Charleston and Georgetown Diabetes Coalition: Decreasing Amputation in African American Males - (Presented by Carolyn Jenkins, DrPH of the Medical University of South Carolina).

The key features of the REACH Charleston and Georgetown Diabetes Coalition initiative are:

- Two of the goals of this program are to improve foot care for African Americans with diabetes and to eliminate the disparities in amputations for African American men.

- Implementation of the program was preceded by one year of community assessment and planning.
- The community-based participatory research process was used.
- Community actions were organized around three areas:
 - Community-driven educational activities and the creation of healthy learning environments where people live, work, worship, play, and seek health care.
 - Evidence-based health system change with continuous quality improvement.
 - Building the power of the coalition.
- The health professionals and scientists help determine the evidence base and bring it to the community. The community determines what, when, where, and how to apply that evidence.
- The following interventions, developed in collaboration with the community, were used:
 - Grassroots efforts at community skill building.
 - Training lay people, community health workers, and professionals from the community to do outreach.
 - Development of a lesson plan entitled “Check Yourself to Protect Yourself: Taking Care of Our Feet.”
 - Creation of a television series on diabetes.
 - Participation in radio talk shows.
 - Promoting messages about diabetes on buses.
 - Offering clinics with foot checks and foot care demonstrations.
 - Providing ongoing diabetes self-management classes at community sites.
 - Marketing special shoe and medication assistance programs.
 - Creation of a book on diabetes care and management, “My Guide to Sugar Diabetes.”
 - Establishing neighborhood walk and talk groups.
 - Teaching people how to use computers to search for information on diabetes.

The On the Road Diabetes and Lifestyle Program - (Presented by Richard Jackson, MD of the Joslin Diabetes Center.)

The key features of the On the Road Diabetes and Lifestyle Program are:

- The key partner is the US Department of Agriculture (USDA) Extension Service.
- The extension service is well established and is present in every county in the country and already has programs they are delivering successfully (e.g., food stamp nutrition programs, programs for women, children, and infants).
- The goals of the program are to identify people with diabetes, provide them with information, and increase the use of local resources.
- Point of care testing, nutrition education, exercise, and hopeful messages about diabetes are provided.
- The approach is personalized to an individual’s physical measures (e.g., blood pressure, A1C) and abilities.
- The program is available in English, Spanish, Chinese, and Russian.
- Local partnerships are fostered, e.g., with local high schools, medical schools, hospitals.

The Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) With a Focus on the Diabetes and Obesity Teams - (Presented by Krista Pedley, PharmD, MS and Dennis Wagner, MPA of the Health Resources and Services Administration.)

The key features of the PSPC are:

- One hundred ten teams from communities across the country provide the clinical pharmacy services necessary to properly manage complex, high-risk patients who have chronic conditions (e.g., hypertension, diabetes, HIV/AIDS, obesity) and are taking a large number of medications.
- Community-based systems of care are established and use a patient-centered approach, with the health home at the center.
- Services include medication reconciliation (counseling of patients when they get their medications to ensure that they are taking them properly), chart review, and tracking of adverse drug events.
- Teams include health care professionals from community pharmacies, health centers, and hospitals and schools of pharmacy.
- The collaborative is made up of four learning sessions.
- The teams rapidly replicate proven clinical pharmacy practices that generate safety and health improvements.
- Nurses and physicians report increased productivity and the ability to better focus on acute-care patients because pharmacy services are focusing on education and counseling of complex patients.
- In addition to community partners, the collaborative engages national partners such as the Agency for Health Care Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration (FDA), National Institutes of Health (NIH), and Indian Health Service (IHS).

Idea Exchanges

The idea exchanges took place during three concurrent sessions. Attendees engaged in lively dialogues in which they were invited to think together about how they could put into practice some of the ideas they had heard in the presentations preceding the idea exchange. They were asked to characterize:

- The key points of the preceding presentation.
- The challenges they might face in implementing some of the ideas they heard.
- Ways they might overcome these challenges.

At the conclusion of each idea exchange, attendees identified actions they could implement in their work and community settings. [Click to view exchange ideas](#)

How You Can Remain Involved

- Send suggestions for individuals or organizations that should be engaged in this effort and notified of the forum to Monique Lindsay at mlindsay@diabetes.org. Please include email and other contact information for the individuals or organizations that you suggest.
- Respond to future surveys from ADA on ways in which you are implementing some of the actions identified at the 2009 forum.