

- This product was developed by the Richland County Community Diabetes Project at the Richland County Health Department in Sidney, MT. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

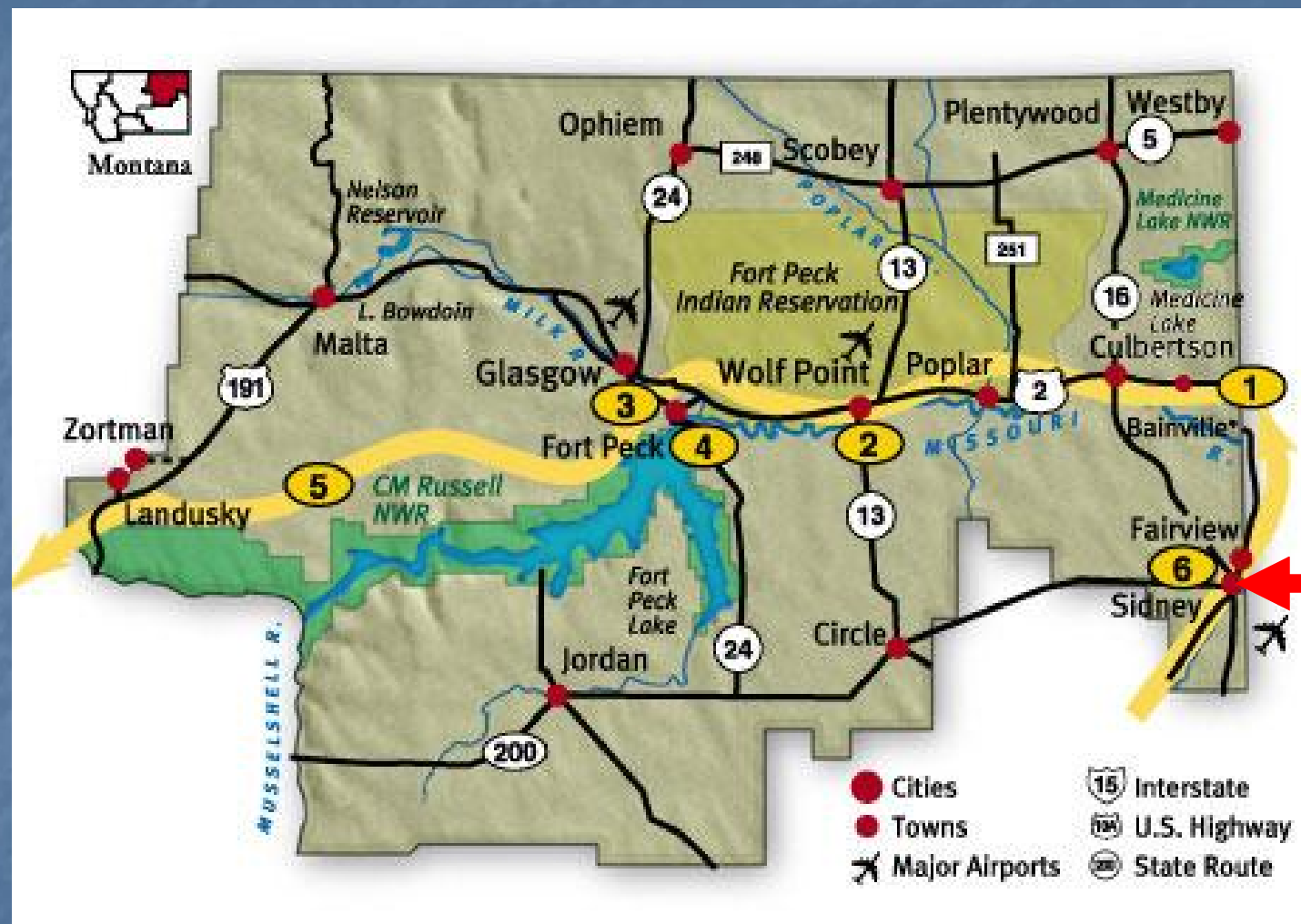
Richland County Community Diabetes Project



Richland County, Montana

Presented by: Tanya Rudicil, Program Director

Eastern Montana





Community Profile

- Frontier, aging community on the border between North Dakota & Montana
- Sidney, Fairview, Savage, Lambert, Crane
- Population: 9,155 (4.6 persons per sq. mile)
- Farming (beets), ranching, oil, small business
- 1/3 older adults
- Median household income (1999) is 32K

Climate & location

- Cold winters, hot & humid summers
- 250+ miles to nearest major hospital & specialists



Culture



- Scandinavian, German homesteaders, ranchers
- Seasonal migrant farmworkers (Hispanic, Native American)
- Near 2 Native American Reservations, one Indian Service area
- Small percentage Native American, Hispanic, Black American, Asian.
- Hardy, independent, stoic, resistant to change, wary of outsiders, private, loyal to neighbors and friends. Resistance to change and territoriality Spills over into health care environment as well.

Richland Health Network



Formal Partners since 1999, to meet the health and social needs of an aging community.

- Richland County Commission On Aging
- Richland County Health Department
- Sidney Health Center

Partners

Richland County Public Health

17+ employees, everything from breastfeeding coalitions to RSVP.

Richland Co. Commission on Aging

Older adult programs

Sidney Health Center

Hospital, Clinic, Extended Care, Assisted Living, Fitness Center, Pharmacy

Collaboration



- Richland County Nutrition Coalition
- Sidney Health Center Community Health Improvement Committee
- Parish Nursing
- RSVP
- Literacy Volunteers of America
- LIONS Club
- American Diabetes Association – Montana
- Montana Migrant Council (on Advisory Board)
- McCone County Senior Center
- Montana Diabetes Project
- Sidney Public Library
- Eastern Montana Mental Health
- Media
- And more...

From case management to diabetes...

- Large number of case management clients had diabetes or other chronic illness
- Lack of supports for chronic illness management in the county
- Estimated 457 are diagnosed with diabetes or metabolic syndrome
- In 2002 18% of patients at Sidney Health Center (18+) were hospitalized with a diagnosis of Diabetes

Building Community Supports for Diabetes Self Management Grant

- The Robert Wood Johnson Foundation
- NPO: Washington University, St. Louis
- 1 year pilot
- Additional funding awarded for 2 ½ years for implementation
- Staff: Director, Program Specialist, Administrative Assistant, Nursing Supervisor
- Consultants: M.D., R.D., C.D.E.

Resources and Supports for Self Management (RSSM)

- Individualized assessment (w/ attention to cultural and social factors)
- Collaborative Goal Setting
- Instruction in key skills
- Ongoing follow-up and support (family, friends, lay health workers, health care providers, etc)
- Access to Resources (for healthy diet and physical activity)
- Linkages /coordination (among pertinent community organizations and services)
- Access to high quality clinical care

Year One

- Developed an 18 member Advisory Board (health care providers, pharmacy, Parish Nurses, diabetics, business persons, LIONS club, Nurses, CDE, aging services staff, etc.)
- Conducted community focus groups
- Piloted 4 community based Projects, in addition to other activities over 4 months

Focus Group results

■ Community

- 57 attended
- Accountability, low cost exercise opps, support group, education other than brochures, info on what to eat, formal comprehensive education program

■ Health Care Providers

- 11 attended
- Support group helpful, education is already provided (most felt) but additional education would be helpful

Walking Club

- Arranged free indoor walking at schools & a church.
- Free pedometers, tracking form
- 42 participants
- Continued in Phase 2

Diabetes Watchers

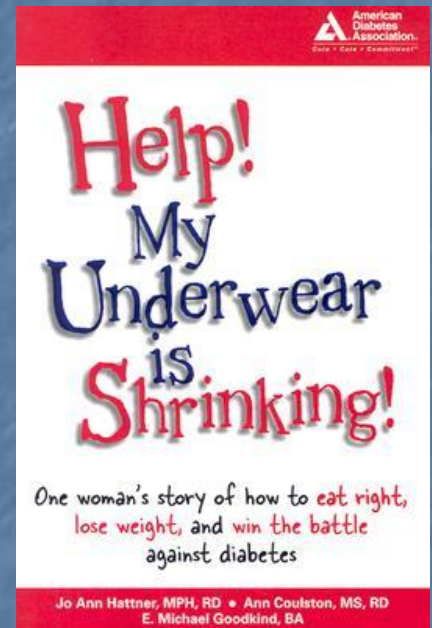
- Weighed in once weekly at office
- Goal setting forms
- Information on safe weight loss, recipes
- 20 participants
- Continued in Phase 2

Diabetes Education & Support Group

- Monthly meetings
- Health care providers, other professionals speak on a variety of topics
- Lunch meetings added – potlucks and recipe swaps
- 35 participants

Diabetes Resources

- CDE reviewed educational materials at Public Library
- Ordered new books, videos, cookbooks for Library and for health care providers
- Developed a Local Diabetes Resources & Prevention Guide
- 17 participants
- Discontinued as a main project, but kept as an activity



Other activities

- Bike & Trike Ride for Diabetes
- Diabetes Conference
- American Diabetes Walk
- Tasty Fork – (Richland County Nutrition Coalition)
 - 6 local restaurants offered dietitian approved healthy entrees on their menus for one month. Items were judged for taste and appearance by the community. The winner received a “Tasty Fork” inscribed glass plate to display at their business. Six of the 7 restaurants kept the “Tasty Fork” item on their menu.

Evaluation

-Pre/post participation survey

Diabetes Project Participation Questionnaire

All of this information will be kept **CONFIDENTIAL**.

PID# _____ (office use only)

Name _____

DOB _____ Sex: M F

Address _____

City _____ State _____

Zip _____

Phone(s) _____

Best time to call? M T W TH F

AM

PM

Evening

E-mail _____

Insurance Provider _____

Primary Health Care Provider _____

Provider

For how long? _____

Emergency contact person _____ Phone(s) _____

Education Level: Elementary

High School

Bachelor's

Master's

Doctorate

Race: Caucasian

Hispanic

Native American

Latino

Spanish

When were you diagnosed with Diabetes? _____

Has a doctor ever told you that you have high cholesterol? YES

NO

Has a doctor ever told you that you have high blood pressure?

YES

NO

Are you a smoker? YES NO

Height _____

Weight _____ Date _____

Weight _____ Date _____

Blood Pressure _____ Date _____

Blood Pressure _____ Date _____

Fat %/BMI _____ Date _____

Fat %/BMI _____ Date _____

Please **circle** the correct answer.

- | | | | | | | |
|-----|--|---------------|----|---------|------------------|---|
| 1. | I am diabetic. | YES | NO | Type? | 1 | 2 |
| 2. | If not diabetic: I am family/friend to a diabetic. | YES | NO | | | |
| 3. | I am employed. | YES | NO | RETIRED | | |
| 4. | I have had my clinical foot examination within the past year. | YES | NO | | | |
| 5. | I have had an eye exam within the past year. | YES | NO | | | |
| 6. | I have been tested for microalbuminuria (urine) test within the past year. | YES | NO | | | |
| 7. | I have received my flu shot within the past year. | YES | NO | | | |
| 8. | I have received a pneumonia shot. | YES | NO | | | |
| 9. | I receive my HbA1C (average blood sugar) test regularly. | YES | NO | | | |
| 10. | I have NOT received the above tests because | TOO EXPENSIVE | | | NO INSURANCE | |
| | | | | | I'M NOT DIABETIC | |

OTHER _____

- | | | | | | |
|-----|---|---------------|-------------|---------|-------------|
| 11. | My <u>main</u> support is from | DOCTOR | FAMILY | FRIENDS | OTHER _____ |
| 12. | Number of work days missed in the last year because of diabetes. | 0 | 1-10 | 11-25 | 26+ |
| 13. | I perceive my health status as | EXCELLENT | GOOD | FAIR | POOR |
| 14. | Would you be willing to share your health test (i.e. HbA1c) scores with us?
If YES, please sign form. Thank you. | YES | NO | | |
| 15. | I feel my knowledge on diabetes is | EXCELLENT | GOOD | FAIR | POOR |
| 16. | I exercise | 1-3X/WEEK | 4-7X/WEEK | NONE | |
| 17. | How did you hear about our projects? | RADIO | NEWSPAPER | MAILING | T.V |
| | DOCTOR | FRIEND/FAMILY | OTHER _____ | | |

PROJECTS PARTICIPATING IN:

_____ DIABETES WALKING CLUB
_____ DIABETES EDUCATION GROUP
_____ OTHER ACTIVITIES _____

_____ DIABETES WATCHERS
_____ DIABETES EDUCATION CENTER

Evaluation continued...

- Pre/post participation survey
 - Improvements noted in self reported knowledge of diabetes, perceived health status, clinical foot exams, regularity of A1c testes, pneumonia vaccinations, > days per week of exercise, < days of work missed due to diabetes and microalbuminuria tests.
- Hemoglobin A1c's (consent from hospital lab)
 - 4 participants lowered A1c's during the 4 months
- Weight loss records – nearly 50 pounds lost

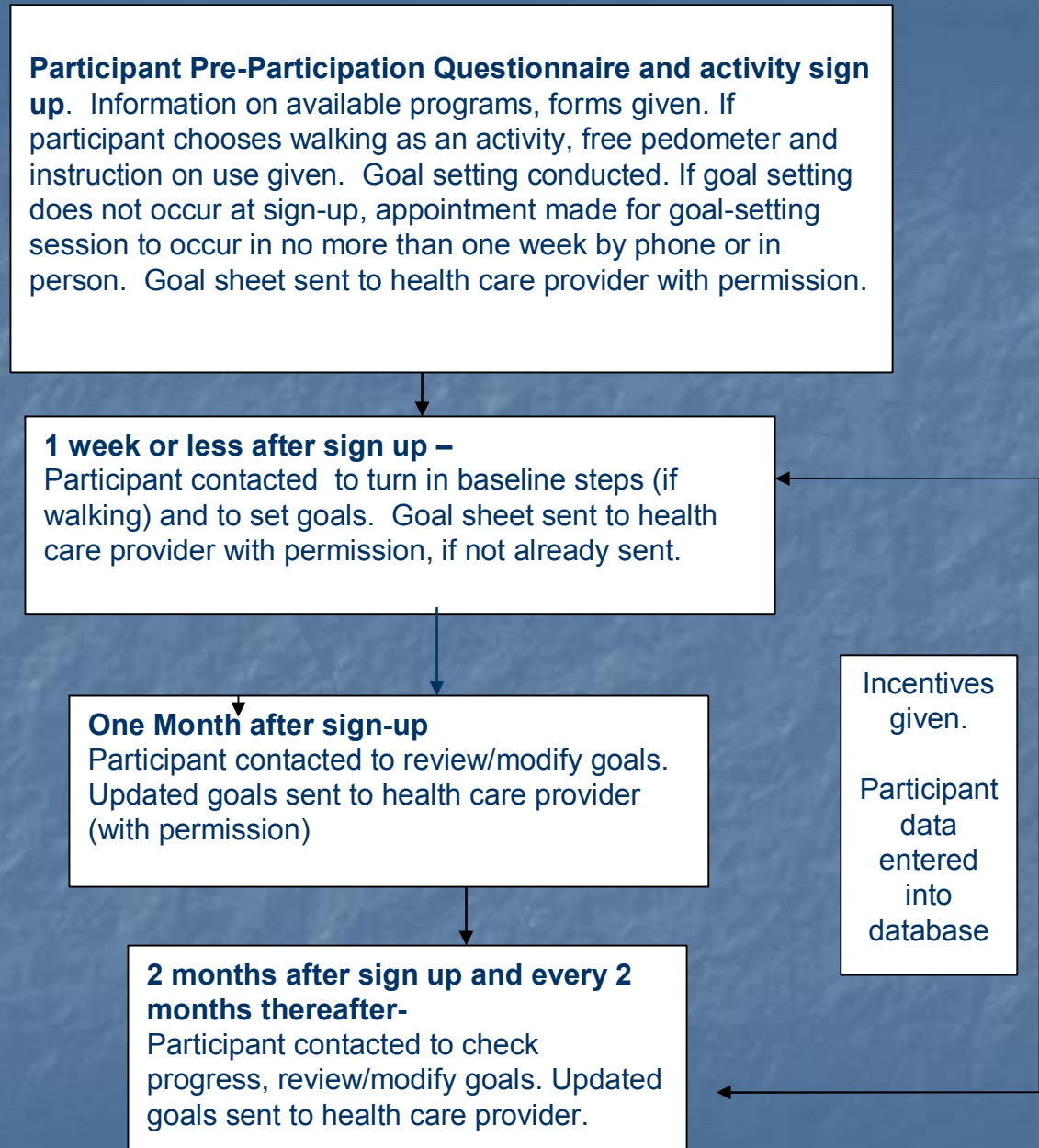
Phase 2

(May '04 to Oct. '06)

- Diabetes Watchers, Walking Club, Education & Support group continued with improvements.
- Additional activities added or begun.

Project Flow Chart –

- Walkers
- Watchers
- Education
Group



Improvements

- Adding social activities
- Varying topics, adding physical activity into education group meetings

Other Activities



What physical activity means for men in Eastern Montana.....

Chronic Disease Self-Management Class

- Stanford University (Kate Lorig, RN, DrPH, Virginia Gonzalez, MPH, Diana Laurent, MPH)
- 6-week class -led by one health care professional and a lay person with a chronic disease
- <http://patienteducation.stanford.edu/programs/cdsmp.html>

Diabetes Education Center

- Coordinating the DEC, seeking ADA recognition.
- Office located at Sidney Health Center
- Instructional staff: R.D., R.N., employees of hospital
- Program Coordinator is also the Program Specialist for the Community Diabetes Project, employed by both hospital & health department

DEC continued...

- Patients referred to the DEC are also referred to Community Projects & vice versa
- Data shared between projects
- DEC using Diabetes Quality Care Monitoring Database System used by the state.

Diabetes Ambassadors

- Modeled after promotora, lay health worker model.
- Non-stipened -volunteers (through RSVP & Citizen Corps)
- Provided with training by a CDE
- Level 1 – provide social support and a listening ear, non-medical advice
- Level 2 – conduct Chronic Disease Self management class, assist with education group and activities.

Community Walking Promotion

- Partnered with Montana State University Extension Service, local office, and North Dakota Extension Service
- 1 - 9-week walking promotion, 1 8-week walking promotion
- Turned in steps on line or by mail
- Incentives to participate
- <http://www.walknd.com>

Workplace Wellness

- Piloted walking promotion at Health Department
- Gathering assessments & ideas
- Evaluate workplaces & encourage policy change ie,
 - Adequate breaks
 - Encourage physical activity
 - Encourage healthy snacks

Health Literacy

- Collaboration between Literacy Volunteers of America Representative, hospital quality assurance representative, and RCCDP.
- Conducted 2 trainings, one for health care providers and one for office staff, nurses, and social workers.
- One day after the training a referral made to literacy program for a diabetic whose first language is Spanish and can't read or write either Spanish or English.

Motivational Interviewing training

- Organized a 2-day workshop on MI in conjunction with Montana Gerontology Society Meeting
- Attended by approximately 50 professionals
- Separate lunch mini-training held for health care providers
- Arranged for follow-up via Telemedicine



Insurance

- Planning an “Insurance Summit”, to encourage insurance providers to provide discounts or incentives for people engaged in programs for chronic disease self-management.

Tasty Fork/Tasty Bites



- This year's Nutrition Coalition project:
 - To expand the contest to include side dishes, dressings, etc.

Exploring linkages

- Trenton Indian Service Area
- Montana Migrant Council
- ?

Resources/Training

- Nutrition analysis software for restaurants, public to use in analyzing their menus/favorite recipes
- Organizing meetings and trainings related to diabetes care as well as informing local providers and staff of educational opportunities
- Building a Diabetes Resource Library at Sidney Health Center

Evaluation

- Pre/post participation surveys
- A1c's & Lipid Panels
- Program database (designed by RTI) and DQCMS (from state) for Diabetes Ed. Center
- RTI Research Triangle – site evaluation & cross site evaluation

Shining Star

- Participant A:
 - Joined Walking Club, Education group, and Watchers
 - Lost 37 lbs in 5 months, < A1c
 - Won 2nd place in local Walk for Diabetes
 - “I just didn’t know I was so sick until I was well. Diabetes has changed my life completely.”

Sustainability

- To expand these programs to other chronic diseases
- Community ownership
- ADA program – limited funds
- Medical community support – collaboration (ie, ADA program)
- VISTA Project – will have one VISTA assigned to Chronic Disease Team

Web sites

- DIABETES INITIATIVE:
 - <http://diabetesnpo.im.wustl.edu/>
- RICHLAND HEALTH NETWORK: (being updated):
 - WWW.richland.org/rhn
- WASHINGTON STATE DEPARTMENT OF HEALTH:
 - http://www.doh.wa.gov/cfh/wsc/Model_Info/Self_Management_Support/SMSpage1.htm