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 Health Network
Sidney, MT
Kristin Lawrence

- B.S. Health Education
- MSU-Northern
- Diabetes Program Specialist
- Wibaux, MT
- Taught and Coached in MT & ND
- Diabetes runs in the family
Tanya Rudicil

- BS in Human Services, minor in Public Administration
- Upper Iowa, Dawson
- Diabetes Project Director
- Chronic Disease Management Director
- Havre & Sidney, MT
- Public Health, Developmental Disabilities
- Family members with diabetes
Richland Health Network

- Sidney Health Center, Richland County
  Public Health, Richland County
  Commission on Aging

- 1999-3 year Rural Health Outreach Grant – to reduce preventable hospitalizations in 55+ through RN, SW, Outreach Coordinator team
Growing good eggs

- RSVP
- Fire & Fall Prevention
- CERT
- Citizen Corp
- Diabetes Project
- Chronic Disease Management
- Senior Companion Volunteer Workstation
- Limited home visiting/ MOW assessments
- Senior Coalition

From strictly seniors to 18+
From 3 people in one room to our own offices on Central Ave!
Building Community Supports for Diabetes Self-Management

1-yr planning grant with pilot projects

Wagner Chronic Care Model

Self management using the Ecological Perspective
Ecological Perspective

- Approaches utilizing peers for communication, education, advocacy or support
- Innovative community outreach & awareness
- Community and environmental supports
- Systems or procedures
- Linking or coordinating community based health care services
- Use of community based information to guide improvements
- Advocacy and policy activities
The Chicken or the egg

- Develop an Advisory Board
- Original plan for projects
  - ADA program
  - Diabetes Ambassadors
  - Workplaces
  - Schools
  - Parish Nurses
  - Diabetes Care Quality Monitoring System
Diabetes

“Eggcellent” Participation
National Statistics

- Age 20+ 18 million have Diabetes, or 8.7%
- Age 60+ 8.6 million or 18.3% have diabetes
- Total cost of Diabetes in the U.S. in 2002=$132 billion
- Direct medical cost=$92 billion
- Indirect costs=$40 billion (disability, work loss, premature mortality)
Montana Statistics

- Age 18 and over—5% have Diabetes
- 30% have Metabolic Syndrome or Diabetes

Source: MT Department of Health & Human Services
Richland County Statistics

- Estimated number is 457 are diagnosed with Diabetes (9,967 total population)
- In 2002 18% of patients (18+) were hospitalized with a diagnosis of Diabetes

Source: MT Dept. of Health and Human Services; Sidney Health Center
Focus Group Highlights

- Diabetic is the ultimate control person – the one who is responsible to take charge
- We need education on diabetes
- We need an organized diabetes ed program
- We want places to walk and exercise that are free or low cost
- We want someone to hold us accountable
Parish Nurses/churches do enough already, the can get information out and help out, but we don’t want anything else.

We want to know how to eat!

We need incentives.

Restaurants and grocery stores could offer better choices, be more healthy-eating friendly.
We are already providing what patients need (education)

Education/Support group is a good idea

Walking group is a good idea

More healthy food choices in stores and restaurants

People lack motivation; the either do it or they don’t

Churches do enough already, but they are a good place for outreach
Projects
Each Participant

- Fills out participation questionnaire
- Keeps track of their progress
- Sets goals
- Provide us with test results (A1C)
- End of 3 months-questionnaire on progress and set new goals
- Will get their goals sent to their health care provider
Resources and Supports for Self-management

- Individualized assessment that includes attention to cultural and social factors.
- Collaborative goal setting
- Instruction in key skills for managing diabetes
- On-going follow-up and support for self-management
- Access to resources for healthy diet and physical activity
- Linkages/coordination among pertinent community organizations and services
- Access to high quality clinical care
Diabetes Walking Club

- Get a free pedometer
- Keep track of steps daily
- Turn in results after 3 months
- Walking available at schools, churches, fitness center, home or outside
- Improvements: meet more often to help set goals, find more places to walk, label the distances
Diabetes Watchers

- Weigh-in every Thursday
- Receive new handouts on safe weight loss and diabetes
- Improvements: Take measurements, and sit down to set goals with each individual, BMI machine
Check out Diabetes books from the Sidney Public Library

Richland County Resource Book

Improvements: Get a list of local and state mental health resources as well as expand other resources
Diabetes Education & Awareness Group

- Meets 2nd Monday of every month Sept.-May
- Local professionals donate their knowledge, talents and time
- Supported by the Sidney Lions Club
- Improvements: Meet year around, luncheons, expand list of speakers
Project Results

- Diabetic Walking Club—68
- Diabetes Watchers—26
- Diabetes Resources—19
- Diabetes Education Group—40
- 58 Diabetics
- 30 Non-Diabetics (family, friends)
Other Activities

- Tasty Fork—Richland County Nutrition Coalition
- Diabetes Conference
- Bike ‘N Trike
- Diabetes Walk-American Diabetes Association
- Local Fun Walks
Community Support

- RSVP
- Sidney Herald
- Roundup
- Radio Stations
- T.V. Stations
- Sidney Lions Club
- Jaycees
- Chamber of Commerce
Evaluation

- A1c’s
- Self-Management behaviors
  - Measured by post-survey, clinical data, questionnaires
- RTI – Research Triangle Institute
- Evaluating Partnerships
Phase II

- ADA
- Walkable Community/Walking Club
- Diabetes Watchers
- Diabetes Ambassadors
- Education Group
- Resources
- Policy – Workplaces, insurance
- Linking services – TISA, Migrant, Literacy
- Tasty Fork
- Clinical Information Systems
- Goal setting/ behavior change using the Transtheoretical Model
Building supports for Chronic Disease Self-Management

The activities and behaviors essential for diabetes self-management are basically the same as those all persons, with or without a chronic disease, should be engaged in.

- Physical Activity
- Nutrition
- Social Support
- Medication compliance
- Recommended Health Care visits

Likewise, the community supports essential for diabetes self-management are the same as for any disease.

- Supports for healthy behaviors
- Environmental supports
- Community involvement
- Policy Development
What did you learn?

BINGO
Need more information on these projects?
- Call, write, e-mail. We are happy to help other communities!