



# **THE DIABETES INITIATIVE**

*A National Program of the Robert Wood Johnson Foundation*

*“Individuals with diabetes need a good doctor with whom to work out a plan for managing the disease. That takes about 2 – 3 hours a year. They then need self management programs to help them execute that plan the other 8,764! The research shows it can be done. Resources and Supports for Self Management clarify what must be done. And the grantees’ stories show how it can be done.”*

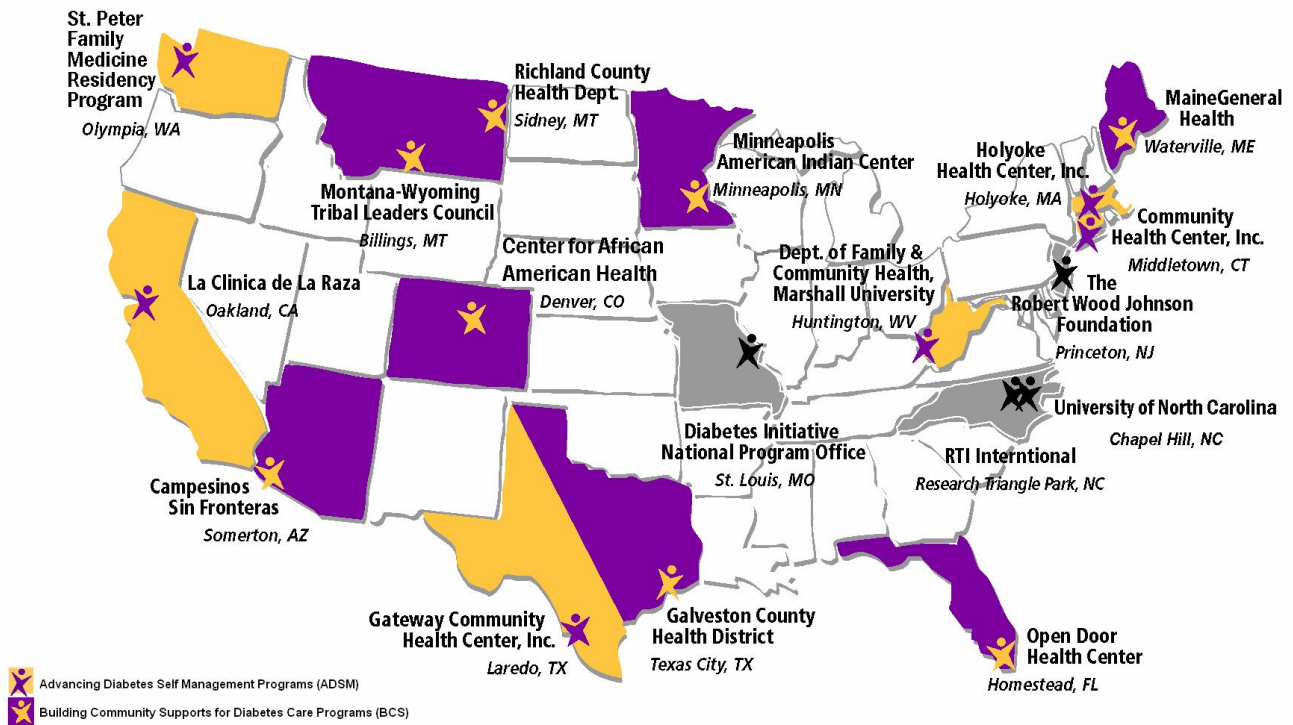
Ed Fisher, Director  
Diabetes Initiative National Program Office

# TABLE OF CONTENTS

|   |           |
|---|-----------|
| <b>MAP AND CONTACT INFORMATION</b> .....                                  | <b>i</b>  |
| <b>FOREWORD</b> .....   | <b>ii</b> |
| <b>CAMPESINOS SIN FRONTERAS</b> .....                                     | <b>1</b>  |
| <b>CENTER FOR AFRICAN AMERICAN HEALTH</b> .....                           | <b>3</b>  |
| <b>COMMUNITY HEALTH CENTER, INC</b> .....                                 | <b>5</b>  |
| <b>DEPT OF FAMILY &amp; COMMUNITY HEALTH AT MARSHALL UNIVERSITY</b> ..... | <b>7</b>  |
| <b>GALVESTON COUNTY HEALTH DISTRICT</b> .....                             | <b>9</b>  |
| <b>GATEWAY COMMUNITY HEALTH CENTER, INC</b> .....                         | <b>11</b> |
| <b>HOLYOKE HEALTH CENTER, INC</b> .....                                   | <b>13</b> |
| <b>LA CLINICA DE LA RAZA</b> .....  | <b>15</b> |
| <b>MAINEGENERAL HEALTH</b> .....  | <b>17</b> |
| <b>MINNEAPOLIS AMERICAN INDIAN CENTER</b> .....                           | <b>19</b> |
| <b>MONTANA-WYOMING TRIBAL LEADERS COUNCIL</b> .....                       | <b>21</b> |
| <b>OPEN DOOR HEALTH CENTER</b> .....                                      | <b>23</b> |
| <b>RICHLAND COUNTY HEALTH DEPARTMENT</b> .....                            | <b>25</b> |
| <b>ST. PETER FAMILY MEDICINE RESIDENCY</b> .....                          | <b>27</b> |
| <b>KEY LESSONS LEARNED</b> .....  | <b>29</b> |

# MAP AND CONTACT INFORMATION

## DIABETES INITIATIVE



### Contact Information

**Diabetes Initiative National Program Office  
Washington University School of Medicine  
in St. Louis  
Division of Health Behavior Research  
4444 Forest Park Avenue, Suite 6700  
St. Louis, Missouri 63108-2212  
Phone: 314-286-1900  
E-mail: [diabetes@im.wustl.edu](mailto:diabetes@im.wustl.edu)  
Website: [www.diabetesinitiative.org](http://www.diabetesinitiative.org)**

## FOREWORD

Managing diabetes is a “24/7” job for the rest of one’s life. Practice guidelines recommend 3-4 medical appointments per year—about 2 hours for the average patient. For the remaining 8,764 hours per year, an individual with diabetes is responsible for managing their disease – taking medicines as prescribed, measuring blood sugar and adjusting medications accordingly, eating a healthy diet, getting regular physical activity, and avoiding or managing stress and negative emotions. All of this needs to be incorporated into the complex routines of family, workplace, and daily life.

The *Diabetes Initiative* of The Robert Wood Johnson Foundation demonstrates that feasible, sustainable diabetes self management programs can be implemented in real-world settings. Grantees in the two arms of the program, *Advancing Diabetes Self Management* and *Building Community Supports for Diabetes Care*, have developed innovative ways to provide resources and supports for self management in primary care settings and through community-clinic partnerships.

The Initiative developed an ecologically-based model of “Resources and Supports for Self Management” (RSSM) that addresses diabetes self management from the perspective of the person with diabetes. RSSM includes:

- Continuity of quality clinical care
- Individualized assessment
- Collaborative goal setting
- Key skills both for disease management and healthy behaviors such as healthy eating, physical activity, and healthy coping
- Ongoing follow-up and support to help people adjust their plans as problems arise, stay motivated, and get back in to see their providers when they need to
- Community resources, e.g., for purchasing healthy foods or getting physical activity in safe, attractive environments

The fourteen grantees of the *Diabetes Initiative* have been remarkably creative in applying RSSM to their settings. Sites operationalized RSSM using a variety of intervention strategies, each tailored to the needs of the target audience with particular attention paid to local resources and culture. Representing rural, frontier and Indian Country settings; serving Latino, African American, American Indian, and White populations, the fourteen grantees here tell their stories of how they took the self management models of the research settings and made them grow in the clinics, communities, and relationships among patients, families, professionals, and volunteers.

*Diabetes Initiative National Program Office*

## Promotoras Make an Impact

**Promotoras provide diabetes support and education for farm workers and their families in border communities**

*“If my family does not care, why should I?”*  
-- Maria\*

Feelings of hopelessness and despair are just two of the many emotions that people with diabetes sometimes face, including Maria, a 42-year-old Yuma County woman.

Maria was struggling to manage several health conditions including diabetes, lupus, high blood pressure and cholesterol, as well as tuberculosis and depression. Without health insurance, access to regular care was difficult, adding to her stress. Coupled with the daily challenges of caring for a husband, two children and four grandchildren, plus several other family issues including spousal infidelity, emotional abuse and alcoholism, it's easy to see how Maria became overwhelmed. Taking care of her diabetes was a very low priority.

After attending a community health fair, Maria was referred to the Campesinos Diabetes Management Program (CDMP) offered by Campesinos Sin Fronteras (CSF). This nonprofit community-based organization promotes health, social and economic stability and empowerment among farm workers, new immigrants and their families in Yuma County, AZ.

CSF's diabetes program is designed to serve as a bridge between medical providers and community resources to advance diabetes care and self management. It uses a family-based diabetes education curriculum as well as the vital hands-on work of *promotoras*, or community health workers, to provide advocacy, support and diabetes education to community members with diabetes. *Promotoras* conduct home visits and outreach in the community.

A CDMP *promotora* reached out to Maria and encouraged her to participate in the program. Maria knew she needed some help, but explained that her responsibilities at home would make it hard to travel to support groups in the community. As a compromise, Maria agreed to have diabetes education home visits, which allowed her to get the support she desperately needed while keeping up with family demands.



*Farm workers receive help managing their diabetes from the Campesinos Diabetes Management Program*

The *promotora* and Maria talked about her health, her diabetes and personal life stressors that made it difficult to manage her condition. Through this interaction, the *promotora* became Maria's companion for emotional support and a resource for diabetes education. She helped Maria deal with and reduce overwhelming feelings of self-blame for family problems, and also helped her connect to other resources in her community for help.

Maria's *promotora* regularly visits with her, both at home and by phone. She teaches Maria problem solving skills for dealing with complex emotional and social issues, and helps her stay motivated to keep going. With her *promotora*'s help, Maria is on the road to improved diabetes self management and she's coping better with emotional health issues.

Maria's success story resembles that of many CDMP participants whom *promotoras* have helped. "Because they are part of the fabric of a community, *promotoras* are in the perfect position to provide coaching and support," says a CSF staff member. "The compassion and attention they can provide go a long way to helping people become more engaged with their health."

\* All program participant names have been changed to protect confidentiality



### Intervention Strategies

- *Promotora* outreach to the farm worker community offering:
  - ◊ Animadora-led support groups
  - ◊ Case management and client follow-up
  - ◊ Home visits/family education
  - ◊ Diabetes education classes
  - ◊ Community workshops and forums
- Collaboration with an extensive network of community agencies

### Key Accomplishments

- Significantly strengthened the partnership with Sunset Clinic, achieving reciprocal referrals, program space and shared staff
- Developed a family curriculum for diabetes education in the home
- *Promotoras* developed an 11-module curriculum that addresses diabetes follow-up and support, coping skills and the importance of mental health

The *promotoras* have proven to be a credible and effective resource of health information and advocacy for their community. Their primary purpose is to provide advocacy, support and education for people with diabetes and help them manage their condition. *Promotoras* recruit new participants for the program throughout the community in schools, churches, faith based organizations, stores, neighborhood events and health fairs, where Maria first learned about the CSF program.

*Promotoras* check on participants at least once a week, either at groups, in the person's home, or by phone. They remind participants to attend their weekly support groups and/or cooking classes. They inform them about community resources and refer them to other services they may need. *Promotoras* also help participants order supplies for their glucometers and translate letters they receive from their medical providers or insurers. They call and visit participants who are sick or in the hospital and celebrate their birthdays too.

To aid the *promotoras*, CDMP has implemented the "Animadora" model through which long-term program participants can be trained to help *promotoras* conduct the support groups. But most important are the "little things" *promotoras* give to participants--attention, care, kindness, compassion, understanding, confidentiality and respect.



### Providing Valuable Diabetes Assistance through the Campesinos Diabetes Management Program

The Campesinos Diabetes Management Program (CDMP) is offered by Campesinos Sin Fronteras (CSF). The program assists medically underserved and poor migrant and seasonal farm workers and new immigrants who have diabetes and who live in the rural border communities of Somerton, Gadsden, San Luis, Wellton, Dateland, and "colonias" surrounding the City of Yuma in Yuma County, AZ.

The goal of CDMP is to build strong collaborations among medical providers and community resources to advance the care and self management of type 2 diabetes among the targeted population. CDMP has been instrumental in developing and providing community resources and self management education and support services for this population by creating strong partnerships among CSF, Sunset Community Health Center, the University of Arizona Cooperative Extension and the Arizona College of Public Health. The program has been effective because of the intimate knowledge that CSF staff have of the target population, which led to the main strength of the project: direct involvement in the target population through recruiting and hiring *Promotoras de Salud*, or community health workers.



Support group meeting

### Lessons Learned

- *Promotoras* play an important role in helping people with their diabetes self management at home and in the community
- Community *promotoras* help people with diabetes manage their negative emotions
- *Promotora*-led support groups help people with diabetes improve self management skills

**For More Information:**  
**Campsinos Sin Fronteras**  
**928-627-1060**

## Faith and Support Enhance Self Management Success

### ***Culturally appropriate education makes a measurable difference for African Americans with diabetes***

*"I thought the class was excellent, fun, informative and educational. It gave you information from A to Z on how to manage your diabetes."--A.T.*

*"In every session, we were taught new things that we don't get in the doctor's office."--B.C.*

*"The most important thing I learned was that you are the one responsible for your health, not your doctor, but you, knowing your body and telling your doctor about all your problems." --J.I.*

While Colorado as a whole is considered one of the healthiest states in America, that is not the case for its communities of color--in particular, the African American community. To improve the health and well being of African Americans in the Denver area, the Center for African American Health (CAAH) partners with major health education and delivery organizations to coordinate the provision of culturally appropriate education, screenings, disease management and the promotion of healthy lifestyles.

Specifically, the Focus on Diabetes project teaches people with, or at risk for, diabetes and those who care for them how to manage the disease. CAAH conducts a series of six classes every eight weeks. People come to CAAH from their churches or community organizations, and some are referred from partner health systems.

The fact that these classes are offered in the community in familiar surroundings accounts for much of the program's success. Classes are taught mainly by African American professionals with non-African American partner agencies acting as consultants. CAAH has gotten high grades from past participants who, in their class evaluation forms, wrote comments like these: "Information was presented very well. Presenters were well prepared." And, "The staff was excellent, giving vital information concerning our illness. All of the facilitators were most helpful and knowledgeable and dedicated to the cause. I received more than I expected."



*Participants enjoy themselves and learn healthy cooking techniques and recipes at the Center for African American Health's cooking classes.*

The key message of the classes is the importance of self management for diabetes. Diet, exercise, monitoring blood sugar, managing medications and understanding and recognizing depression are all aspects of diabetes that can be influenced by self management techniques. One participant wrote, "The class made me more aware of the foods that I can eat." Wrote another, "The changes I'm going to make are to continue to watch what I eat and how much I eat by measuring my food. I am going to try to cook more healthy foods and eat healthy even when dining out." Participants also enjoyed the in-class exercises. "I liked the various exercises we did, especially the chair exercises," a graduate wrote.

Above all, the Focus on Diabetes classes reinforce the fact that self management must become a part of participants' everyday lives, for the rest of their lives. The faculty use message repetition, demonstration, practice, modeling, faith and prayer to emphasize this important message. It's definitely getting through. As one participant wrote, "I learned that even though I have diabetes, if it is managed, I can still live a quality life." Another wrote, "I will use everything I learned from this class every day to help me with all the things I need to make my life better."

Perhaps one best summed up everyone's feelings about Focus on Diabetes: "OUTSTANDING!!!!!!!"



*Participants get physical activity during the class*



### Intervention Strategies

- Community diabetes education classes that incorporate physical activity and experiential learning about healthy eating
- Walking programs and outreach in African American churches
- Participation in community screenings and outreach activities
- Periodic stand-alone sessions such as seasonal cooking classes, dental screening, depression workshop and a summer cook-out

### Key Accomplishments

- Developed a culturally appropriate diabetes self management education curriculum
- Engaged African American health professionals, including a pharmacist and a dentist, to serve as faculty for self management classes
- Developed a video on the diabetes self management (DSM) program and services as a tool for community education and outreach efforts
- Received national coverage of the DSM program in Winter 2005 Better Homes and Gardens Special Interest Publication, *Diabetic Living*
- Developed a phone support model to maintain follow-up for DSM class graduates

Focus on Diabetes partners developed a program that addresses those needs through the following key activities:

*Diabetes self management (DSM) classes* held at the CAAH and taught by African American health professionals and others from partners agencies. Each class includes a nutritious dinner and an exercise component. One class is a hands-on cooking class that teaches portion control and demonstrates healthful ways to enjoy traditional foods. Flyers about the classes are distributed in churches and at various community sites and events by past program participants, the Outreach Coordinator and Diabetes Advisory Committee members.

*Walking programs at African American churches.* In addition to promoting walking through churches, a pilot project to help prevent obesity and lower risks for diabetes, called "Lighten Up," was conducted at one church. The program included participants from the DSM classes and focused on physical activity and healthy eating.

*Follow-up through support groups* and, more recently, via telephone, to support people living with diabetes once they complete the self management classes. This innovation, made possible through additional local funding, includes ongoing goal setting, periodic A1C testing, and quarterly face-to-face visits.

*Community awareness and education activities* include seasonal cooking demonstrations; Diabetes Awareness Sundays (information and screening) at black churches; and outreach at churches, beauty salons, barbershops and other community sites using an educational video with a healthy lifestyle message targeted at African Americans.

Focus on Diabetes reaches many people who have had no diabetes education in the past. By tailoring activities to the needs of the audience, Focus on Diabetes hopes to reduce the number of African Americans and their families whose lives are negatively affected by this disease.

### Lessons Learned

- Self management skills are best taught in an easy-to-understand format with time set aside for hands-on practice and periodic one-on-one consultation with participants
- Having culturally competent faculty from the African American community and offering classes in a community setting encourages participation and increases client satisfaction
- The black church continues to be one of the most successful venues for reaching African Americans—place matters
- Providing a meal with DSM classes serves as both an incentive and a teaching tool, especially on issues of portion size and identification of and counting carbohydrates



## Focusing on Diabetes Education and Self Management

The Building Community Supports for Diabetes Care project, Focus on Diabetes, is a partnership between the Center for African American Health (CAAH) and Eastside Health Center, a clinic site of Denver Health. The purpose of the project is to improve the health and health-related quality of life of African Americans with, or at risk for, diabetes in northeast Denver neighborhoods, through a culturally competent diabetes self management course and comprehensive self management services.

CAAH and Denver Health serve approximately 17,000 parishioners from 35 black churches, via the CAAH's Faith and Health Ministries Collaborative, and an estimated 2,300 individuals with diabetes and/or cardiovascular disease who are patients at Denver's federally-funded community health centers. Fifteen per cent of the parishioners responding to a 2001 CAAH survey reported having diabetes, and another 36 percent reported they have immediate family members with diabetes.

Focus groups conducted by CAAH revealed that African Americans with diabetes have difficulty accepting that they have the disease and changing lifelong habits. Participants said they need to know more about diabetes and its potential consequences, the importance of diet, exercise and blood glucose monitoring, how to prepare healthful foods and where to get guidance and support in managing diabetes.

**For More Information:** 303-355-3423  
Center for African American Health [www.caahealth.org](http://www.caahealth.org)

## A Model of Collaboration Helps People with Diabetes to Succeed

*By letting patients “lead the story,” the self management model gets results*

At the Community Health Center (CHC), collaboration among a psychologist, a physician and a Certified Diabetes Educator (CDE) is achieving outstanding results with patients who have diabetes. “It’s a wonderful model, with no territorial issues or turfism,” says the psychologist of the group, Dr. Robert Muro. “We’re all here to work together with the patient.”

The CDE, Hilda Cardona, takes care of the “nuts and bolts,” Muro says, like education regarding diet and exercise. “I come into the picture primarily to creatively address any depression that may be impeding the progress of self management.” The primary care provider (PCP) is the leader of the team, attending to all the patients medical needs, including acute care, preventive care, and chronic care needs. The PCP will assist in depression management by prescribing antidepressants when indicated. Day-to-day management of diabetes is coordinated by the PCP as well.

For example, Muro says, “We had a patient who weighed 262 pounds and was struggling to control her diabetes and lose weight. What we ended up doing was meeting her where she was at.” He explains that the patient was newly diagnosed with diabetes and “not really into talking about it.” Also, she had recently arrived from Puerto Rico and spoke only Spanish but wanted to learn English.



*At CHC’s annual cook-a-thons, the diabetes team prepares diabetic-friendly meals. After the tasting, patients vote for the best cook and receive a bilingual cookbook of the food creations.*

“We didn’t mention diabetes or complications,” Muro says. “We supported her goals to learn English and get a job.” She enrolled in a free English class one mile from her home. “She went religiously, and in the course of the class she made new friends and the walking helped her lose weight,” Muro notes. “We started seeing her in February and by May she had dropped 30 pounds, her numbers were improving and she was doing better psychologically,” Muro says. “Hilda, the PCP, and I were thrilled and the patient was too, because she was doing something—not necessarily what we would have chosen for her to work on, but it took her where she wanted to go with her life. That’s a key to collaboration. It’s not just the health professionals telling patients what’s in their best interest, but listening to what’s important to them, getting them to dream a little and follow through on it.”

Another patient the team has been working with is a woman who was newly separated from her husband. The last of her three children had moved out of the house. “She was very lonely and depressed and had uncontrolled diabetes,” Muro says. “But in addition to medical management by the physician, we ended up connecting her to a social group in her building and another in the community. She learned how to interact with people, how to keep a conversation going. She had to take a risk.” Today she is making some strides to lift her depression, Muro says. “She has severe asthma so her A1Cs are not really coming down, but we’ve kept her stable, so I count that as a positive. If she comes for another six months, Hilda, the physician and I will help her make even more progress.”



*Certified Diabetes Educator Hilda Cardona leads a grocery store tour.*

### Intervention Strategies

- One-on-one self management sessions with a Certified Diabetes Educator
- Referral options for healthy coping:
  - ◊ Stress reduction program (a nurse-led multi-week course to build coping skills such as relaxation and meditation)
  - ◊ Solution focused brief therapy with a psychologist or Licensed Clinical Social Worker
- Training of staff nurses in self management goal setting to increase organizational capacity for self management

### Key Accomplishments

- Initiated depression screening for all patients with diabetes
- Integrated behavioral health services into the diabetes self management program
- Expanded the role of staff nurses to review and facilitate self management goals
- Developed a tool to track self management goal setting and capture goal attainment on a scale of one to four



## Setting Goals For Self Management Success

The Community Health Center, Inc. (CHC) is a federally qualified health center with practice locations across Connecticut. The centers provide comprehensive primary care services including dental, mental health, women's health/OB, pediatrics, and adult medicine. Each practice site serves a population of predominantly indigent, uninsured or under-insured patients from ethnically diverse backgrounds. Eighty-nine percent of patients seen at CHC are at or below 200 percent of the federal poverty level and 29 percent are without any form of medical insurance.

The *Advancing Diabetes Self Management Program* at CHC targets adult patients with a diagnosis of type 2 diabetes who receive their primary care and diabetes care at the Community Health Centers of Meriden, New Britain and Middletown. These three sites have approximately 1,200 active patients with type 2 diabetes. Of these patients, nearly half are Hispanic, and 17 percent are African American. The prevalence of diabetes in each of the communities served by CHC is extremely high. Analysis of encounter data for all three sites demonstrates that diabetes is the most common diagnostic code other than routine health maintenance evaluation.

CHC found that traditional diabetes education and self management programs often fail to consider the unique needs of patients from different ethnic and socioeconomic backgrounds. In response, CHC developed an effective, culturally-sensitive diabetes education program. In this program, self management goal setting is closely linked to a flexible, comprehensive diabetes education intervention that is provided in both group and individual settings. Woven throughout the process is a consistent emphasis on the process of goal setting. The interventions are designed to be adaptable to individual circumstances and needs.

Certified Diabetes Educators (CDEs) enroll patients into the program on a referral basis. Primary care providers and other staff refer all interested diabetic patients to them for an intake evaluation. During the intake, CDEs collect baseline information, review HIPPA and informed consent forms, perform an individualized assessment focusing on diabetes knowledge, psychosocial, cultural and social factors, and administer a depression screening questionnaire. Patients with coexistent depression are referred for a collaborative behavioral health intervention with a therapist. Baseline clinical data is also collected, and, if not already entered, this information is added to the computerized diabetes registry.

Patients may then elect to take part in any of the following activities: individual education sessions, group sessions, physical activity sessions, and cooking clubs. For people who are experiencing negative emotions or clinical depression, a referral is made to a psychologist or Licensed Clinical Social Worker for Solution Focused Brief Therapy. In addition, patients in Meriden may elect to participate in an eight-week stress reduction program that is open to anyone interested. Together with system changes to improve clinical care, the diabetes programs and services at CHC are improving self management and quality of life for people with diabetes.

### Lessons Learned

- Self management needs to be tailored to patients' specific needs, provided in different formats and integrated into primary care
- Optimal diabetes self management includes depression screening and options for addressing a range of negative emotions
- The concept of self management goal setting represents a paradigm shift that requires ongoing training and support for both providers and patients

**For More Information:**  
**Community Health Center, Inc.**  
**860-347-6971**



## Training the Trainers

***Trainers who learn how to teach self management techniques can changes lives, including their own***

*"I feel like I'm a used car and I'm trying to find the best way of making me work."--Sandra\*, Help Yourself graduate*

*"The Help Yourself program has changed my career and has become the basis of how I see the delivery of health care to our aging patients." --Linda Stein, Chronic Disease Coordinator, New River Health Association*

Quality training leads to confident teachers who motivate students to understand and put into action what they are taught. All of these ingredients came together at Marshall University's Center for Rural Health, where 79 individuals have been trained in the Chronic Disease Self Management Program to work with regional residents who have diabetes. These trainers came from area clinics, healthcare facilities and community organizations. Locally the diabetes self management program is known as *Help Yourself*.

When asked about *Help Yourself*, participants cited many aspects of the program that helped them begin to manage their diabetes. They learned valuable techniques to apply in all areas of their lives. One participant, Mary, explained, "The program gave me tools to set goals, learn to relax, communicate better and handle my frustration and anger. I know what I can do to develop and keep a positive attitude."

Participants also developed new attitudes toward nutrition and exercise. Sandra noted, "I learned how to make meals work for me, not against me." Nora added, "I had it in my mind that I hated vegetables. Now I am *enjoying* two to six servings of fruits and vegetables daily and have lost 10 pounds since the classes began." Lori commented, "I learned how to eat right and exercise and walk regularly. I was walking with a cane when I first started this program and ... finally I'm able to walk up to two miles twice a week. That helped strengthen me and find muscles I didn't know I had."

*Participants learn together in the Help Yourself class*



\*All persons named in this story have provided permission to use their names.



*Exercise classes are part of the Help Yourself program.*

Those coping with pain discovered new management strategies. Gilberta said, "When I first began the class I thought I was doing all I could to control the pain, but what I found out was that the pain was really controlling me. Talking and listening to others as a group was inspiring, and I really learned a lot."

Nora spoke for many participants when she said, "I plan to use many of the things I've learned to manage my mental and physical health in a more positive and constructive way. Learning about the symptom cycle, and that it can affect everyone, and ways you can break that cycle were very eye-opening."

But it's not just the participants who have benefited from *Help Yourself*. Trainers, too, say teaching the course has encouraged them to make changes, both in the way they approach health care and their own health. Linda Stein, Chronic Disease Coordinator at New River Health Association, commented, "The *Help Yourself* program has changed my career and has become the basis of how I see the delivery of health care to our aging patients. It has provided me with a vast new view on how I approach patients and the way I interact with them in medical group visits, during one-on-one patient encounters and in other group settings. I am more able to help them look at their behaviors and determine what action they may be ready to take."

She added, "*Help Yourself* has also helped me change my thinking about my own health and allowed me to accept my chronic condition and move from guilt to action...It not only helped me to take action but to normalize what I was feeling and realize that it's nothing to be ashamed about. I can share this with patients and they understand that I've been struggling, too, and that I found this program helpful."

### Intervention Strategies

- *Help Yourself* Chronic Disease Self Management workshops and leader trainings in multiple community settings
- *Are you ready?* materials to assess patients readiness to change and help them make action plans
- Medical Group Visits (MGVs) to enhance education and collaborative learning among patients and the patient care team
- Collaboration with local Partnership of African American Churches for outreach activities
- Nurse case management to improve care coordination
- Diabetes Support Groups that incorporate self management skill building

### Key Accomplishments

- Successfully spread the *Help Yourself* course through training of leaders in clinics, health departments and community organizations to offer classes throughout Appalachia
- Developed, tested and disseminated a theory-based set of materials—*Balance Your Plate, Chose To Move, and Kick the Habit*—to support healthy self management behaviors
- Expanded the MGV model to eight teams who are providing monthly group visits

information that enables patients to make action plans for behavior change. The materials are being marketed to three key audiences: 1) primary care centers, especially those that are new members of a Health Disparities Collaborative; 2) community organizations such as support groups and diabetes coalitions; and 3) the Partnership of African American Churches.

Medical group visits (MGVs) take place in a supportive group setting and include the same services that are delivered during routine individual office visits. However, they provide several advantages over traditional patient visits: improved follow-up; more time for self management education and problem solving; more time for patients and their care team to interact and build collaborative partnerships; opportunity for patients to learn from and support each other; greater patient and provider satisfaction; and fewer urgent care visits.

To facilitate the spread the MGV model, a Group Visit Resource Manual was developed, and New River Health Association has hosted over a dozen visits from other West Virginia community health centers. Experienced MGV staff are available to do demonstration presentations and provide support for the teams from other health care organizations.

The scenic, but isolated environment of Southern West Virginia coupled with the somewhat fatalistic culture of the rural Appalachian people presents a considerable challenge to improving access to health care and resources that support healthy lifestyles. However, the ADSM project has helped diabetes health care professionals in the area to become advocates, not only for individual patients, but also for the system changes needed to provide the resources and support people need for healthy self management.



*Help Yourself participants gather for a group walk*



### Teaching Self Management Techniques at a Rural Health Center

The *Advancing Diabetes Self Management Program* (ADSM) is a partnership of rural health centers and churches in Rural West Virginia working to promote innovative ways to help people experience the benefit of taking control of their diabetes. The lead organization for this project is the Department of Family and Community Health (FCH) at Marshall University's School of Medicine. Its goals have been to: 1) Equip and support partner agencies to lead ongoing *Help Yourself* self management workshops; 2) Disseminate self management communication materials using social marketing strategies; 3) Integrate changes into health care systems that facilitate self management education and support; and 4) Promote expansion of medical group visits through mentoring and consultation.

The six-week *Help Yourself* Chronic Disease Self Management Course, co-taught by clinic staff and lay leaders, is designed to teach people how to deal with the symptoms and frustrations of living with diabetes and other chronic conditions. The program is skills-based and centers on goal setting and problem solving. Sessions are highly interactive, where mutual support and success builds participants' skills and confidence to self manage.

Self management health communication materials were developed using the stages of change constructs of the Transtheoretical Model. They focus on three messages: *Balance Your Plate, Choose to Move* and *Kick the Habit*, and they provide

**For More Information:**  
**Department of Family and Community Health, Marshall University**  
**304-691-1198**

### Lessons Learned

- The *Help Yourself* course and health communication materials are strategic tools for successful diabetes self management.
- Overcoming barriers to self management requires system changes in primary care practices
- Medical group visits have a positive impact on self management and clinical outcomes



## Community Health Coaches Volunteer to Help People with Diabetes

### *Health coaches help others with diabetes manage the disease successfully*

*"I wanted to help other people who have the same problem [diabetes] as I have." – Rosie\**

*"I like to interact with people and help others who still have old ideas about diabetes." – Willie\**

Rosie\* and Willie\* are community health coaches with the Galveston County Health District (GCHD) Community Health Coach Program. They both have diabetes and manage it well—and they help others with diabetes to successfully manage the disease, too.

When Rosie was diagnosed with diabetes 10 years ago, her doctor advised her to go to diabetes classes. Rosie says she cried during the first class that she attended because she knew nothing about managing diabetes. But after attending more classes and learning about diabetes self management, Rosie has been able to manage her diabetes and keep her blood sugar levels under control.

Rosie gained a lot from the classes. In fact, she believes they saved her life. To show her appreciation, she decided to become a community health coach herself. "I wanted to help other people who have the same problem as I have," she says.

Rosie has been a health coach with the Galveston program for three years. She has taught diabetes classes at many locations in her community including a senior center and a nursing home. She also teaches at community food fairs targeted to low-income families. Altogether, Rosie estimates that she drives about 300 miles a month to teach diabetes classes and lead diabetes support groups.

"I enjoy helping people to understand their diabetes better," Rosie says. "Seeing their faces as they begin to understand their diabetes and to realize they can make a difference gives me a lot of satisfaction."

Willie also shares Rosie's passion for and commitment to being a health coach. Since he also has diabetes and is managing it well, he finds that he is better able to relate to people in his classes and understand their struggles with diabetes management in daily life.

What he most enjoys about teaching diabetes classes, he says, is "seeing the facial expression when a person begins to get it. It's like a light comes on. I get a lot of satisfaction out of seeing people realize they can do things to make their lives better."



*A GCHD Community Health Coach leads participants on a grocery store tour.*

Sandra, another health coach, talks about the difference the classes made in one participant's life. In Sandra's classes, she helps people maintain a "diabetes workbook" to record all of their recent lab results and blood sugar levels. When one of her class participants was hospitalized for chest pain while on vacation, he brought his diabetes workbook to the hospital and showed it to the doctor, who praised it for the valuable information it contained about the patient's lab work and blood sugar. That inspired the patient to write to the GCHD staff to tell them how important the coach program had proven to be in his time of crisis.

Clearly, the Galveston Community Health Coach Program is helping people learn to manage diabetes successfully through positive reinforcement and sharing. "It's so nice to have a relaxed class where we can ask questions," says one class participant. Says another, "I like that we can try out new things here to help manage diabetes."

\* Rosie and Willie gave permission to use their names in this story

### Intervention Strategies

- Coach-led *Take Action* diabetes education classes in community settings
- Diabetes support groups
- *Whisking Your Way to Health* cooking classes in community settings

### Key Accomplishments

- Developed a diabetes self management curriculum and coach training materials
- Successfully recruited and trained more than 50 community health coaches
- Achieved widespread reach of *Take Action* classes through the network of coaches



## Changing Lives through Coaching

The Galveston County Health District (GCHD) is the administrative agency for the Building Community Supports for Diabetes program in Galveston County. GCHD is a unique governmental entity that manages a variety of community programs, administers a federally qualified community health center—the Galveston County Coordinated Community Clinic known as the “4 C’s”—and also serves as the local health department. Clinical partners are the University of Texas Medical Branch (UTMB) and Mainland Medical Center. All are members of the local Community Access Program (CAP) coalition. Through this coalition, the partners have adopted a shared formulary and clinical practice guidelines that are available to all partners via the CAP website.

Based on 2000 census data, the race/ethnicity of Galveston County’s 250,000 residents is 66 percent non-Hispanic white, 18 percent Hispanic and 16 percent African American. Using current prevalence estimates for diabetes suggests that there are more than 19,000 people in Galveston County with diabetes. According to the Texas Department of Health, about 25 percent of this group lack any form of health insurance. Most go untreated or rely entirely on episodic free and low-cost services or on emergency room care. It is this population—the low-income medically uninsured or under-insured adults with type 2 diabetes who receive (or are eligible to receive) health care at the 4 C’s Clinic—that GCHD set out to serve with their diabetes project.

GCHD and its community partners developed, implemented and continue to support *Take Action* self management classes, *Whisking your Way to Health* cooking/nutrition classes, and diabetes support groups. The classes and support groups are held at federally qualified community health centers, a university hospital clinic, a work site program, senior citizen centers, low-income housing projects, community centers, faith-based

**For More Information:**  
**Galveston County Health District**  
**409-938-2401**  
**[www.gchd.org](http://www.gchd.org)**

institutions, pharmacy waiting rooms, Friday Food Fairs, a family home, and a hurricane evacuation shelter.

The success of these programs is due to the many volunteer coaches who teach these courses in community settings. To date, more than 50 coaches have been trained to teach the *Take Action* diabetes self-management course. They lead the classes in their own communities, enabling reach into many areas of the county previously unserved by educational programming for people with diabetes.

Coaches come from both lay and professional backgrounds. They include former class participants, interested community members, community and parish nurses, health education center staff, local pharmacists and medical or nursing students. The interest in becoming a community health coach has been overwhelming; there continues to be a waiting list of people wanting training to become a coach.



*Friday Food Fair*

GCHD staff conduct the training and provide ongoing follow up and support to the network of community health coaches. Training materials include a coach’s manual, an accompanying Power Point presentation, and a tool box with hands-on learning materials. Coaches are guided and supported by GCHD staff who maintain monthly phone contact and help set up classes, deliver supplies and certificates, plan quarterly coach luncheons and publish a quarterly newsletter.

*Take Action* programs all focus on increasing community supports and self management activities among persons with diabetes. Using volunteer coaches, GCHD is spreading education to those most at need in Galveston County.

### Lessons Learned

- A network of volunteer coaches can provide widespread availability of diabetes self management education
- Maintaining an extensive network of partnerships results in successes, such as reach into the community, but also requires effort to sustain the collaboration

## A Promotora is Promoted

### **Becky Vela's accomplishments as a diabetes educator led to a job promotion and personal satisfaction**

*"The experience gained while working with the RWJF program has helped me become one of the best promotoras in the clinic."  
 --Becky Vela\**

Becky Vela became a *promotora* at Gateway Community Health Center (GCHC) in March 2003. "During this time, I had the good fortune to help participants make lifestyle changes, not only to improve their health but also to improve their emotional well being and self esteem," Becky says. "My desire and passion to help participants manage their diabetes and their health has also helped me become a much better person."

The Laredo native estimates she has helped hundreds of people with diabetes. "What affects me most is seeing them make changes and feel better and look better," Becky says. "My goal is not to make everyone change, but at least if I can help them make a couple of changes so when they grow older they won't be so sick, that's super cool for me!"

She recalls working with a man who was very angry when he was diagnosed with diabetes. "I remember I saw him in the first class, and then he started losing weight and his skin tone turned grayish. This was happening because he was so out of control. It's not always good to lose weight," she says. But he completed the course "and had a much better view of the whole picture." A couple of years later, Becky saw the man's wife who told her he was doing fine.



*A promotora and participant work together*

Another man who joined her class was being prepped to begin dialysis, she says. "This was two years ago and he still has not gone to dialysis because he still applies his lifestyle changes to his everyday living."

*\*Becky Vela has provided permission to use her name in this story.*



*Participants learn about teamwork while getting some physical activity*

And then there are the ladies. "We have had some who told us years had gone by and they never wore makeup or styled their hair," Becky says. "After a couple of weeks in class, they show up and we ask, Who is this? They're wearing makeup and their hair looks nice." Another lady always dressed in black, she recalls. "Now she wears pink and fuchsia because she feels better about herself," Becky says. Sometimes all anyone needs is someone to listen and not pass judgment."

Becky herself was diagnosed with diabetes 12 years ago. "If I knew then what I know now, maybe I wouldn't have diabetes," she says. "But my doctor back then never explained the benefits of eating right and losing weight." Becky says she got scared and did some research—and found a new doctor. "From then on, I got on medication and began to make changes." Now she says when she tells patients she has diabetes, they find it hard to believe. "I tell them, I didn't let diabetes control me," she says.

Becky says she frequently sees or hears from people who have taken her diabetes education classes. "I love when the participants tell me that something that I taught them has had a positive effect on them and has helped them better their health," she says.

Becky has now moved on to become a project coordinator, but she still works directly with patients. "I wouldn't change that for anything," she says. "I want to do this kind of work for a long time." The key to her success, she believes, is "having a passion for helping people," she says. "It has to come from the heart."



### Intervention Strategies

- 10-week *promotora*-led diabetes self management course that includes depression screening, referral and follow-up *promotora*-led support groups
- Standard protocols for *promotora* follow-up and support, including weekly phone calls to participants for problem solving and support

### Key Accomplishments

- Integrated *promotora*-led self management interventions into clinic protocols and usual systems of care for people with chronic conditions
- Developed a culturally competent diabetes self management education curriculum that also addresses cardiovascular disease and depression
- Became certified by the State of Texas Health Department as a Certified Center for Health Promoters; developed curricula and increased spread of training workshops for *promotoras*

interventions include a 10-week diabetes self management course tailored for the target audience, a subsequent 10-week support group that meets on a bi-weekly basis, and weekly phone follow-up and support. Knowledge and skills related to blood glucose monitoring, medication management, physical activity, healthy eating and healthy coping are taught by *promotoras* in the self management course. Goal setting and problem solving are practiced at each class and during the support groups that follow. Weekly telephone calls from the *promotoras* reinforce problem-solving strategies and help keep participants motivated.

The program infrastructure supports and reinforces these interventions. There are appropriate job descriptions, extensive competency and skills training, performance monitoring and supervision for *promotoras*. Policies and procedures ensure coordination of patient care, and monthly *promotoras*-provider conferences include discussion of patient self management issues. Assessment of patient behavior, collaborative goal setting, goal follow up, goal revision, and problem solving to overcome barriers occur during all patient interactions (physician, *promotora*, and certified diabetes educator visits). Finally, the Patient Electronic Care System is used to collect and manage self management processes and outcomes.

By incorporating patient feedback and striving for quality, the Advancing Diabetes Self management program is helping GCHC achieve its mission: *“To improve the health status of the people in Webb County and surrounding areas by providing high quality medical and dental care, health promotion and disease prevention services in a professional, personal, and cost effective manner.”*



## Integrating *Promotoras* Into Diabetes Self Management

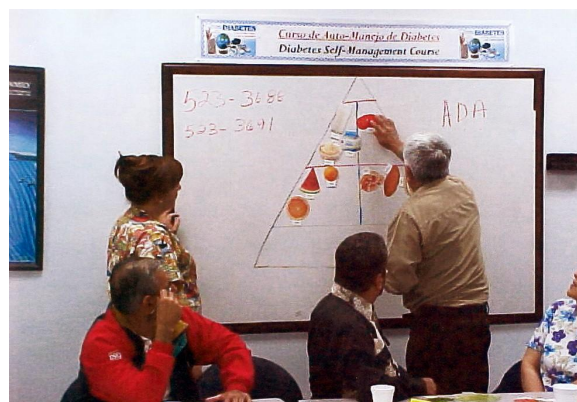
Gateway Community Health Center (GCHC) is a federally qualified health center located on the U.S.-Mexico border in Laredo, TX, that serves residents of Webb County. More than 95 percent of the county’s residents are Hispanic, and more than one-third fall below the federal poverty level. Among patients served by GCHC, nearly two-thirds are uninsured and 23 percent qualify for Medicaid. Approximately 16 percent of the adult patients at GCHC have diabetes.

Patients served by GGHC who have type 2 diabetes are the target population for the *Advancing Diabetes Self Management* project. The project goal was to build an infrastructure and methodology to assist patients with diabetes in controlling their blood sugar levels over an extended period of time by implementing and integrating diabetes self management programs and services in a culturally sensitive manner.

As a result of ongoing quality improvement efforts, GCHC found several components to be integral to their diabetes self management system of care: provider use of self management principles; an infrastructure that supports patient input yet provides some choices regarding care; a system of referral, follow-up, feedback, and documentation that produces integrated and consistently high quality self management clinical practice; a system that recognizes and manages chronic illness-related depression; and a community-based, culturally sensitive approach.

A critical component of GCHC’s comprehensive approach involves the integration of *promotoras* (community health workers) into the care of patients with diabetes. *Promotora*-led

**For More Information:**  
**Gateway Community Health Center**  
**956-795-8140**



*Participants in the self management class learn about food groups*

### Lessons Learned

- A comprehensive system of care and a team approach are essential for successful program outcomes
- Integrating a self management program into a primary care system results in high quality diabetes care
- Integrating *promotoras* into a healthcare delivery system results in more comprehensive services and better outcomes

## Damaris: A Promotora's Story

### *A promotora helps herself while she helps others learn to manage their diabetes*

Damaris\* has been a *promotora* at Holyoke Health Center (HHC) for three years. Here she talks about what she enjoys about the job and how it has changed her life.

#### *How did you become a promotora?*

I was first a patient at Holyoke Health Center. I had just arrived from New York and I had to find a doctor here. I was overweight and my A1C scores were high. My first doctor was very helpful. She directed me to members of the diabetes care team. They told me that they were going to open a diabetes self management program, and asked if I would be interested in applying for a *promotora* position. I didn't have a job at the time and I thought the position sounded very interesting. It would give me the chance to interact with and motivate other people. I realized I could help other patients and, at the same time, I'd be helping myself.

#### *What do you do as a promotora?*

As a *promotora*, I work closely with providers and other diabetes program staff. We have a list of patients who have not been seen by their doctors in three to four months. The doctors send them letters about coming in to the clinic, and if they don't come, my job as a *promotora* is to go out and find them to try and schedule their appointments. I'm a friend to them. I can relate to them because I have diabetes. I know what they're going through and I know what their ups and downs are. It's a lot of hard work, but it's very gratifying; I love it.



*Promotoras on the diabetes team at Holyoke Health Center*

#### *What impact has being a promotora had on your life personally?*

Personally, it's had a great impact on my life. It's made me think about how to take better care of myself, what to do and what not to do. I think of myself as a beautiful person now. Before this, I was very negative. I had a lot of issues, and that was all based on having diabetes, because diabetes affects people in many ways. But now I feel like I'm a conqueror. I can do anything if I'm willing to set my mind to it. I'm helping myself, I'm helping my body, and I'm helping others. I love my life now.

#### *How has being a promotora impacted your diabetes?*

I'm doing what I'm teaching. It wasn't always this way. First, I had to change my way of doing things, especially the way I was eating, so I could teach others. I want to be a good role model for the other patients. So when I'm working with the doctors and the nurses, I'm learning from them that I have to take my meds, I have to check my blood sugar, and I have to take it seriously if I want to keep living a healthy life. And then I am able to teach other patients about the importance of taking their medications and controlling their blood sugar, blood pressure and cholesterol. Other patients tend to listen to me when I tell them they need to take this seriously because they know I am in the same position. Being a *promotora* has opened all new doors for me. Before, I used to eat anything, and now I won't bring anything into my house that isn't part of my eating plan. I don't buy things that aren't good for my diabetes.

#### *What do you like best about being a promotora?*

Just being here with everybody and the love and affection the patients show me and that I show them. It's a family. They encourage you and talk to you. I used to weigh 260 pounds, almost 270, and now I'm down to 204 and still working at it. My goal is to get into the 100's--140 and I'll be happy! If I can get the word out there to the people, and if I can make one person happy and change his or her lifestyle, I think I will have accomplished a lot.

**For More Information:**  
**Holyoke Health Center, Inc.**  
**413-420-2200**

\*Damaris has provided permission to us her name in this story.



### Intervention Strategies

- Multiple activities that focus on developing and maintaining self management skills and that offer choice to patients:  
Breakfast Club, supermarket tours, diabetes education classes, weekly Snack Club, exercise classes, individual consultation with the nurse educator and nutritionist and chronic disease self management classes
- Use of *promotoras* to assist, teach, and empower patients to navigate Holyoke Health Center services and community resources, teach self management skills and provide on-going follow-up and support

### Key Accomplishments

- Improved organizational capacity for self management support through staff and program development
- Developed a *promotora* program to implement self management interventions
- Developed a menu of self management program options to maximize patient access to intervention activities
- Improved staff knowledge in relation to self management strategies and techniques
- Increased awareness of the impact of health literacy on patients' ability to manage their disease

*Bilingual diabetes education classes* are designed to meet the health literacy needs of patients. Many low literacy teaching techniques and tools are utilized in the classroom setting. *Individual counseling* sessions with a diabetes nurse educator or nutritionist emphasize strategies based on the readiness of each patient to change behavior. Patients who have completed Breakfast Club or diabetes education classes participate in a field trip to local supermarkets to apply what they have learned about healthy foods. *Chronic Disease Self Management Classes* based on the Stanford model are generally offered to patients after they have completed either the diabetes education class or the Breakfast Club. Patients learn problem solving skills, practice goal setting and action planning and learn new relaxation techniques.

*Promotoras* are a critical link between clinical staff and patients. *Promotoras* identify, engage, and motivate patients with type 2 diabetes who have not seen their primary care provider for routine care in the past four months. The *promotoras* reach out to these patients to reconnect them with primary care. Additionally, *promotoras* receive referrals from primary care providers and follow up with patients at the health center, by phone or in patients' homes, to provide social and emotional support and education on a variety of diabetes self management topics. *Promotoras* are trained in goal setting, problem solving, action planning, communication techniques, health literacy and general knowledge about diabetes. They are mentors, teachers and advocates for patients with type 2 diabetes.



### Providing Diabetes Education and Emotional Support

Holyoke Health Center, Inc. (HHC) is a state-licensed 501(c)(3) organization established in 1970. It is also a federally qualified community health center and JCAHO-accredited. The HHC catchment area encompasses the downtown district of Holyoke that is designated as a Medically Underserved Area and a Health Professional Shortage Area; it is also the poorest area of the city.

The city of Holyoke has the highest rate of diabetes mortality in the Commonwealth of Massachusetts. HHC patients share the burden of this disease and suffer disproportionately. The diabetes project, *Proyecto Vida Saludable*, focuses on patients in HHC's current registry of patients with type 2 diabetes. These patients are 89 percent Latino /Puerto Rican and 100 percent live at or below the poverty level.

The diabetes project at HHC gives patients with type 2 diabetes an opportunity to choose from a wide range of programmatic interventions that have been shown to be effective for Latino patients. The *Snack Club* provides nutritious, easy-to-prepare snacks and offers an opportunity for patients to get acquainted with HHC programs and staff. Patients who have had success managing their diabetes are often invited to the Snack Club to provide testimonials to inspire and motivate newly diagnosed patients or those whose diabetes is still not well controlled. The *Breakfast Club* fulfills a need for social and emotional support, and is a venue for effective, hands-on education. Patients benefit from joining together to eat a nutritious breakfast in a supportive and educational environment, and they begin to establish a breakfast routine during the eleven-week session.



*Participants of the diabetes project getting some physical activity*

HHC's organizational philosophy has led to a culture that recognizes the importance of a collaborative relationship among the patient, provider and support staff in order to achieve successful chronic disease self management. HHC anticipates that this culture will result in long-term, positive outcomes for patients with diabetes.

### Lessons Learned

- Individual choice of intervention activities is key to helping patients stay engaged in self management
- Resources and Supports for Self Management (RSSM) is a useful framework to guide self management program development

## First a Patient, Now a *Promotora*

***A patient helped by promotoras is empowered by the experience--and becomes a promotora herself***

*"The support of the promotoras makes a difference. They know what you're going through. They make you feel comfortable, happier and healthier."*

*-- Patty\* - a patient-turned-promotora*

For years, Patty struggled to control her diabetes. Although she received diabetes education and good clinical care, her blood sugar levels remained high. As a result, she was referred to the *Advancing Diabetes Self Management (ADSM)* program at La Clinica de La Raza.

In the program, Patty began working one-on-one with a peer health worker, or *promotora*, to help her manage her diabetes. Through this interaction, her *promotora* learned that Patty regularly took her medications and insulin and that she had no problem measuring her blood sugar levels. However, she was not regularly exercising and did not follow a meal plan.

Using La Clinica's programmatic approach (based on the Transtheoretical Model), Patty's *promotora* discovered that she had been thinking about exercising more and eating better, but had not developed an action plan. Together they set a goal for Patty to get more exercise. She participated in La Clinica's walking club and was given a six-month pass to a local gym. After a lot of hard work, Patty was exercising 30-60 minutes

almost every day. She also set a goal to eat smaller, healthy meals. Patty's efforts paid off. She lost weight, her A1c level fell from 9.2 to 6.9, and her depression improved.

Patty did not stop there. She became involved in the care of other patients around her. For example, she helped lead the walking club and teach patients to use their glucose meters. By this time, because she was so successful and understood the difficulties of managing diabetes, other *promotoras* recommended that Patty become one herself.

Now Patty helps run the program that helped her so much. She works with patients to assess where they are with their diabetes self management and helps them develop their own action plans for making healthy lifestyle changes. "The support of the *promotoras* makes a difference. They know what you're going through. They make you feel comfortable, happier and healthier," Patty says. "I am happy to be a part of this experience."

\*All program participant names have been changed to protect confidentiality



*Promotoras and project staff at La Clinica de La Raza*

### Key Interventions

- Diabetes education classes
- Groups for people with different needs:
  - ◊ “Circle of Friends” support group
  - ◊ Meditation/ stress reduction group
  - ◊ Cognitive behavioral therapy group for people with depression and diabetes
- Walking club
- Family home visits
- One-on-one interaction with *promotoras*
- Patient-centered staging and counseling based on the Transtheoretical Model of Change
- Quarterly *promotora*-provider case conferences

### Key Accomplishments

- Implemented a theoretically framed program and intervention activities
- Developed materials for providers that aid in assessing patients’ readiness to change
- Trained and successfully integrated *promotoras* into the primary care team
- Trained *promotoras* to work with patients on self management plans



## Using the Transtheoretical Model to Advance Diabetes Self Management

The *Advancing Diabetes Self management* (ADSM) program at La Clinica de La Raza targets Spanish-speaking adults with type 2 diabetes who reside in Oakland, CA, and are patients at La Clinica’s Fruitvale and San Antonio clinics. Eighty-five percent of the patient population have family incomes at or below 150 percent of the federal poverty level, and the majority are either uninsured or enrolled in Medi-Cal. These patients often have difficulties gaining and maintaining control over their diabetes through the traditional health care system, so innovative approaches are required.

The goal of the ADSM project is to improve health outcomes for patients with diabetes by helping them successfully manage their condition. The project uses a multi-faceted approach to improve diabetes self management based on the Transtheoretical Model of Change (TTM), a theoretical model of behavior change. It incorporates two elements missing from the standard medical model of care: involvement of the patient’s community through peer support and patient-centered counseling. Providers at La Clinica are trained in TTM principles and use them in their clinical practices.

Patients are referred to the project by their primary care provider. They then attend an orientation meeting facilitated by a *promotora*, who provides support throughout the patient’s involvement in the project. In addition, patients are invited to

**For more information:**  
**La Clinica de La Raza Fruitvale Health Project, Inc.**  
**510-535-4000**  
**[www.laclinica.org](http://www.laclinica.org)**

classes and groups designed to teach self management skills. Patients who are also diagnosed with depression may attend special support groups that are facilitated by a mental health professional and tailored for people who have both depression and diabetes.



*La Clinica’s Fruitvale clinic*

Despite a variety of challenges, the Fruitvale and San Antonio neighborhoods are vibrant, lively communities where residents are actively involved in improving their surroundings and their lives. Through its use of TTM and empathetic *promotoras*, La Clinica’s ADSM program builds on this spirit and empowers its patients to effectively manage their diabetes – one patient at a time.

### Key Lessons Learned

- Providers can gain greater understanding of patients’ needs and barriers to treatment adherence though working as a team with *promotoras*
- *Promotoras* can successfully stage patients using the TTM and use their patient’s stage to intervene appropriately
- Working with *promotoras* in a patient-centered program improves patient outcomes when compared with care as usual
- *Promotoras* can be trained to recognize and triage depression and to participate in mental health interventions



## Journey to Becoming a Lay Health Educator

### *Friendly support from a Lay Health Educator led one woman to become one herself*

*"Being a lay health educator has allowed me to help others, and it has helped me better manage my diabetes. My day-to-day diabetes management has improved greatly by learning to make goals and break them down into action plans small enough to be successful at them, but large enough to manage my diabetes better and work towards my goals." --Jackie\**

Jackie is a Lay Health Educator (LHE) with the *Move More* program at MaineGeneral Health in Waterville, Maine. She has a family history of diabetes, and was diagnosed with the disease when she was a teenager. Now in her mid-20s, she is successfully managing her diabetes with the help of her husband and her diabetes care team.

Jackie enrolled in *Move More* after she heard a presentation by a LHE at a diabetes support group. The help the LHE gave her--which she describes as "friendly support"--was important in her own journey to becoming a LHE. It was just what she needed to help make lifestyle changes that could positively affect her health.

Jackie liked the non-directive peer support her LHE provided. Her LHE was "gently encouraging" as she learned ways to fit physical activity into her lifestyle. She also learned new self management and stress management skills as a result of being enrolled in the program.

A year later, Jackie became a LHE herself. The experience has been more rewarding than she ever imagined. She provides friendly support to people she meets every day. For example, Jackie describes a situation at her local beauty salon, where the hair stylists were talking about wanting to lose weight but not doing anything to meet that goal. Jackie joined the conversation and explained what had worked for her. She told them about developing an action plan, setting goals, and recording progress. She also told them about pedometers to help track how much they were walking.

As a LHE, Jackie likes meeting new people and being a problem-solver. She describes the *Move More* program to people in her community and tells them about small changes that have made a large, positive impact on her own health. She lets people know that they don't have to commit to a strenuous, time-consuming exercise regimen, and that small changes like walking a little at lunch or parking farther from the store when shopping are good ways to start working toward better health. She teaches people about making action plans and setting goals for improvement.



*Jackie and her husband enjoy a different sort of "date night" now that they incorporate more physical activity into their lives.*

Jackie says that being a LHE has had a very significant impact on the quality of her health care and on her self management skills. She is more proactive when interacting with her health care provider team and takes part in decision-making about her care. She has learned skills to reduce stress in her life as well as self management skills that carry over into her family interactions.

Jackie adds that being a LHE also has had a positive impact on her husband. "It has affected us a lot," she says. "Date night now is a bike ride or something like that." And when others in her family want fast food, she suggests they all get together for a walk in the park beforehand.

In addition to affecting her personal life, being a LHE has been important in Jackie's professional life. She recently made a career transition from engineering to health education so she can continue to help people make positive changes in their lives.

\* Jackie provided permission to use her name and photograph in this story.



*MaineGeneral Health's Move More program encourages people to add physical activity into their everyday routines.*

### Intervention Strategies

- Lay Health Educators to encourage physical activity
- Walking maps, pedometers and physical activity logs
- Referrals to diabetes self management resources
- Different social marketing message for target audience segments and delivery settings
- Chronic disease self management education classes
- Weekly motivational e-mail
- Web site [www.movemore.org](http://www.movemore.org)

### Key Accomplishments

- Used social marketing to develop intervention activities and promote behavior change
- Established a network of 40 volunteer Lay Health Educators and support for them (e.g., monthly trainings, resources, web page)

An integral component of *Move More* is the use of Lay Health Educators (LHEs) to implement social marketing strategies. LHEs are peer volunteers from the community, many of whom have type 2 diabetes themselves. LHEs “look like” the enrollees. They understand the challenges of exercising with diabetes.

LHEs go through an initial one-hour training class led by project staff in which they learn the basics about physical activity and nutrition as well as how to provide non-directive support. They are taught strategies for motivating participants, answering participant questions, and making referrals to other chronic disease self management resources in the Kennebec Valley area. For example, LHEs provide participants with physical activity resources such as walking maps, pedometers and physical activity log sheets. Ongoing, optional monthly training sessions for LHEs address various topics related to healthy lifestyle behaviors and offer LHEs an opportunity to network with each other.



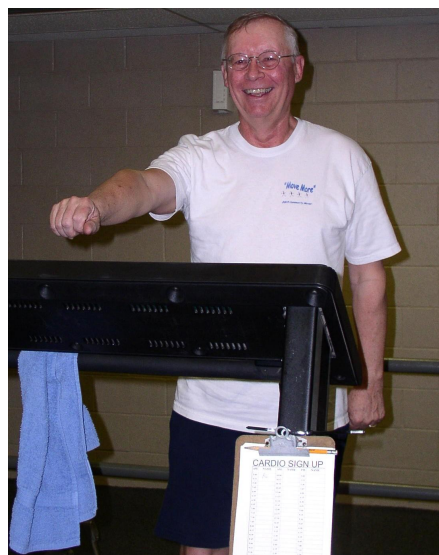
### Providing Positive Support for Lifestyle Changes—the Move More Project

MaineGeneral Health, a health care system in central Maine, is the lead agency for *Move More*, a project of the *Building Community Supports for Diabetes Care* program. The Kennebec Valley Diabetes Care Initiative Advisory Group, an inter-organizational collaborative in rural Maine, serves as a resource and in an advisory capacity to *Move More*.

*Move More* targets adults 30-70 years of age with type 2 diabetes or pre-diabetes who are currently somewhat physically active, but who do not consistently meet CDC recommendations for 150 minutes of moderate intensity physical activity per week. The primary goal of the project is to increase physical activity in the target population. To achieve this goal, *Move More* aims to increase enrollment in diabetes self management skill development programs and to facilitate achievement of physical activity and other diabetes self management goals.

The *Move More* project is based on the 5 P model of social marketing. The *places* targeted to deliver messages to potential participants are work sites, healthcare settings, faith and community settings and local newspapers. The *price* is the cost to participants, not only in dollars, but also in time and effort needed to change behavior. The *product* is the accumulation of 150 minutes of physical activity per week. *Promotion* consists of strategies to make physical activity an attractive option for participants. *Move More* addresses *policy* by working with community partners to create and promote physical activity opportunities, and to promote other types of environmental change. Using this framework, *Move More* is designed to become a model that can be replicated in many other rural communities.

**For More Information:**  
**MaineGeneral Health**  
**207-872-1000**  
**[www.movemore.org](http://www.movemore.org)**



*A Lay Health Educator enjoying his physical activity!*

One of the strengths of the *Move More* project is that LHEs are given the latitude to decide how to stay in contact with individual participants. Some LHEs opt to be trained as leaders in the Chronic Disease Self Management Program and conduct classes in work sites, faith communities, and health care sites. Others use e-mail, incidental contact in work site or community settings, and/or phone follow-up. Through it all, “friendly support” is the hallmark of a good LHE.

### Lessons Learned

- Long-standing collaborative relationships provide a strong foundation for expanding or developing new programs
- A social marketing strategy can be used to address the Community Resources and Policy component of the Chronic Care Model
- The use of volunteer Lay Health Educators is an effective approach to promote and increase rates of physical activity in targeted audiences in the community



## A Community Council Empowers People with Diabetes

***The Diabetes Community Council is a powerful group that is spreading the word about diabetes self management and prevention in Indian country***

*“Growing up on the reservation, my people never knew what diabetes was ...It’s difficult to see my father suffer with diabetes...It’s difficult to look for support for diabetes...” --Carol\*, Council member*

Too often, these are the testimonies from people with diabetes and their loved ones who live in Minnesota’s Indian country. However, the *Full Circle Diabetes Program* is working to change this. The program is a collaboration among the Minneapolis American Indian Center Ginew/Golden Eagle Program, the Native American Community Clinic and the Diabetes Community Council, whose members help spread the word about diabetes awareness, self management and prevention in the Indian community.

Carol, an influential Council member, has struggled with diabetes for years. After being diagnosed at age 25, Carol remembers that no one really talked about the disease, not even her doctors. She felt fine, so she ignored her diabetes for eight years, until that became impossible. By then, irreversible damage had been done and diabetes-related complications had set in. As a result, today she can no longer walk.

Despite the daily struggles, Carol is managing her diabetes better. She tests her blood sugar regularly and takes her medications. “You can’t turn back the clock,” she says. “If I could, I would start all over and eat the proper foods and take medicine on a regular basis and exercise regularly.” But she can help her loved ones avoid diabetes. She says, “I do not want this



*Talking Circles help participants learn from and support one another.*

[diabetes] for my daughter, grandchild, or my nieces and nephews. Not when it can be prevented or delayed.” As a member of the Diabetes Community Council, Carol helps her family, her neighbors and her community maintain healthy lifestyles so they can live long, healthy lives with diabetes or prevent it altogether.

The Council works with its partners to design community activities for people with diabetes and their families. It also provides avenues to help people with diabetes cope with the struggles of self management and to access additional resources. The best way to fully appreciate the impact of the Council’s work is through the words of those whom it has affected:

*“Talking Circles helped me to understand that education is important and to become more aware of diabetes.”*

*“I gained strength from the group activities.”*

*“It has given people a sense of value and accomplishment.”*

*“A strength of the program is helping us to realize that we are not alone.”*

*“The program helped people feel comfortable to open up about their own challenges and receive the healing benefit of sharing.”*



*Full Circle participants come together to walk for diabetes awareness*

\* Carol has provided permission to use her name in this story.

### Intervention Strategies

- Participatory program planning through a Diabetes Community Council
- Use of a Circle Model of community organizing for designing diabetes self management activities
- Case management for enrollees of the *Full Circle Diabetes Program*
- *Living in Balance* chronic disease self management workshops led by trained members of the Diabetes Community Council

### Key Accomplishments

- Effectively engaged the community to support and participate in diabetes self management activities
- Developed a fully integrated community-clinic diabetes self management program



### The Full Circle Approach to Building Community Supports for Diabetes Care

According to the 2000 census, the seven-county Twin Cities metropolitan area is home to approximately 34,000 Native Americans—just under half of the state’s 81,000 American Indian population. Not only is the community large, it also is the poorest of all ethnic groups in the Minneapolis area.

In order to provide this community with increased physical, mental, emotional and spiritual supports for diabetes care, the Minneapolis American Indian Center (MAIC) formed a strong community-clinical partnership to develop the *Full Circle Diabetes Program*. MAIC’s Ginew/Golden Eagle Program serves as the lead agency in its partnership with the Native American Community Clinic (NACC), a primary health care clinic. Recruits to the program come from the Phillips neighborhood of south Minneapolis, where both organizations are located, but services extend to the entire metropolitan area.

The MAIC recruited and engaged Native American community members living with or concerned about diabetes to form the Diabetes Community Council. This Council provides invaluable insight into the barriers of diabetes self management and the availability and accessibility of current resources. With support and participation of project staff, the Council designed community-based activities to complement and expand resources to meet these needs.

The NACC actively supported the planning process by attending all of the Council meetings and providing expertise and consultation on diabetes care. Collectively, the partners designed and coordinated the activities of the Full Circle Diabetes Program. The symbolic Circle Model of community organizing

**For More Information:**  
**Minneapolis American Indian Center**  
**612-879-1708**  
**[www.maicnet.org](http://www.maicnet.org)**

reflects Native American culture and values, recognizing that all people contribute to the survival and vitality of a community through their individual contributions.

The *Full Circle Diabetes Program* focuses on providing resources and supports for diabetes self management to promote physical, mental, emotional and spiritual wellness.

\* *Physical* supports include options for physical activity, regular medical care, case management, and access to medical supplies.

\* *Mental* supports—educational supports for the mind—include diabetes classes and medical case management services. A key component is goal setting, which is promoted in the program’s five-week small group education sessions. Participants also receive educational boosters at the clinic’s monthly Diabetes Breakfast.

\* *Emotional* supports include a supportive Talking Circle as well as Council-led intergenerational events.

\* *Spiritual* supports focus on the attention to culture throughout all of the activities, with an emphasis on respecting and listening to the teachings of one’s ancestors to live well.



*Program participants enjoy breakfast together while learning about healthy eating*

The *Full Circle Diabetes Program’s* group activities enhance and reinforce the individualized attention provided in the clinic. The program’s resources and supports for diabetes care reinforce the Native American cultural belief that wellness results from balance of the body, mind, emotions and spirit. The Diabetes Community Council, supported by the partnership of the MAIC and the NACC, has provided Carol and other Native Americans in the Twin Cities area a voice and a forum to help others living with diabetes.

### Lessons Learned

- A Circle Model promotes holistic diabetes self management programming and enhances community capacity among Native Americans in an urban setting
- *Living in Balance* chronic disease self management classes for people with diabetes been accepted and are successful in an urban American Indian population



## Education Is Key to Diabetes Control

### ***American Indians with diabetes testify that self management and specialized classes make a difference***

In early August 2006, United States Senator Max Baucus of Montana was the special guest at a meeting of the Diabetes Roundtable, sponsored by the Fort Peck Indian Reservation. He wanted to find out first-hand about the extent of diabetes among American Indians and what was being done to help those with the disease.

The Roundtable was sponsored by the Montana-Wyoming Tribal Leaders Council and the Fort Peck Tribal Diabetes Program. Speakers included five people with diabetes who attended self management education classes at the reservation.

Susan Cheek, an elder, testified that she “never really listened” to how diabetes affected her body. She was depressed and didn’t take her medications as prescribed. But attending the classes ultimately helped her understand the diabetes disease process. She started taking her medications and monitoring her blood sugar.

At the other end of the age spectrum, Leslie Moran, in her 30s, testified that although she was very recently diagnosed with type 2 diabetes, no one educated her about the disease. So, when she saw the ads for the diabetes classes, she immediately signed up. In the classes she learned how to take care of her diabetes—how to monitor her blood sugar, walk more and watch her diet. Leslie’s husband attended the classes with her to offer support and to learn how to help her manage her diabetes.



*A class participant practices what she learned about healthy eating*

A young man, Thomas Jerome, in his late 20s, also testified that he was diagnosed with type 2 diabetes and did not receive any education about it. He said he “didn’t understand” how he got diabetes, since he is very active and not overweight. To find out more, he attended the diabetes self management education classes and learned that he can control his diabetes through diet and keeping his appointments with his health care team.

Another resident, Myra Pipe, testified that several family members are affected by diabetes. She said she’s very thankful education is available in each reservation community. And Arlyn Headdress of the Fort Peck Tribal Executive Board reinforced the importance of addressing diabetes on the reservation. He has diabetes himself.

Senator Baucus also heard about features of the diabetes project that participants thought made it special—and successful. One was that certain classes were taught by a fifth grade teacher, who took into consideration the reading level of participants. Another mentioned a time when there happened to be many deaths on the reservation and many class participants were grieving. To help them through this difficult time, Indian Health Service mental health staff participated in the Talking Circle support group. “Many of the participants thanked us for this,” said Verbenia Savior, Diabetes Program Director.



*Program staff gather to prepare for an education session*

Participants provided permission to use their names and photographs in this story.



### Intervention Strategies

- Training tribal diabetes program staff, tribal health department staff and Community Health Representatives (CHRs) on all aspects of diabetes, diabetes self management and motivational interviewing techniques
- Culturally appropriate diabetes self management education classes and follow-up
- Talking Circles/support groups
- Use of tribal diabetes program staff and CHRs to provide follow-up, motivation and goal-setting

### Key Accomplishments

- Designed and implemented a tribally tailored curriculum for diabetes self management
- Built a successful partnership with Billings Area Office of the Indian Health Service to develop procedures and processes to obtain pre/post clinical data on program participants



## Building Community Supports for American Indian People with Diabetes

The Montana-Wyoming Tribal Leaders Council (TLC), the Billings Area Indian Health Service (IHS) and Black Hills State University have collaborated to build community supports for people with type 2 diabetes who live on large land-based federal Indian reservations in Montana and Wyoming. Two American Indian tribes/reservations are involved in the project, *Building Community Supports (BCS) for American Indian People with Diabetes*. They are the Eastern Shoshone Tribe on the Wind River Reservation in Wyoming and the Fort Peck Reservation in Montana. Each of the sites is located in a frontier area, with harsh winters, high unemployment rates and high rates of poverty. Most health care available to members of these tribes is provided by the Indian Health Service, which is chronically under-funded.

The TLC represents nine federally recognized tribes and one non-federally recognized tribe in Montana and Wyoming. The TLC is responsible for health policy and guidance, tribal health directors, and tribal community health representatives. The Billings Area IHS provides health services to over 72,000 American Indians residing on seven reservations in Montana and Wyoming. Facilities include three hospitals, six health centers and three health stations, all operating in highly rural and frontier areas. The TLC-IHS partnership extends to the local sites, with tribal health departments and tribal diabetes programs collaborating with local IHS diabetes program staff to develop and implement BCS programs.

The BCS project has two primary goals: 1) To provide effective, community-based and culturally appropriate self management programs to Indian people with diabetes, and 2) To offer community-based support and follow-up services that

**For More Information:**  
**Montana-Wyoming Tribal Leaders Council**  
**406-252-2550**  
**[www.mtwytlc.com](http://www.mtwytlc.com)**

encourage and assist program participants to make changes to improve their management of diabetes. In addition, the program aims to encourage more Indian people with diabetes, who are informed about the effectiveness of diabetes self management, to control their condition, make and keep medical appointments and receive annual foot, eye and dental exams and appropriate lab tests. The program also evaluates and documents the interventions in order to provide tools and methodologies that other tribes can adapt and replicate.

Training for the BCS program at each site has been extensive. The project has provided training on diabetes, the Diabetes Self management Education (DSME) curriculum, motivational interviewing and follow-up support to all tribal health staff, diabetes staff, and Community Health Representatives (CHRs). Tribal-specific DSME programs have been offered for both tribes/reservations. CHRs meet with DSME participants at least once a month for follow-up, motivation and goal-setting.

The Fort Peck BCS program provides follow-up sessions as part of a Diabetes Breakfast Program, as well as by telephone and in-person contacts. In addition, people with diabetes have been informed of and encouraged to participate in weekly Talking Circles that provide support for self management through sharing and problem solving.

Using this comprehensive collaborative approach, BCS is improving the quality of life for American Indian people with diabetes.



*Program staff on the Wind River Indian Reservation*

### Lessons Learned

- A participatory approach is necessary for tribal programs to be successful; *i.e.*, community members must be actively involved from design through implementation and evaluation
- Community leaders and participants must perceive the program as providing both direct (*e.g.*, improved health outcomes) and indirect (*e.g.*, training and skills-building) benefits for community members

## Ongoing Support for Self Management Works

***Ongoing reinforcement beyond traditional medical care helps people with diabetes successfully manage their disease every day for the rest of their lives***

*"I've never gone to a place where they've [health center staff] helped you and they actually care, and it makes you feel so good inside." -- Sharon\**

Sharon is a poor, uninsured woman whose diabetes was not well controlled. She could not afford to take appropriate medications, and she suffered from many diabetes-related complications. When she arrived at the Open Door Health Center (ODHC), a free clinic in Homestead, Sharon said she felt so overwhelmed by her health situation that she prayed she would die.

But, through the *Prescription for Health Diabetes Project* at ODHC, Sharon found the support she needed to manage her diabetes in the context of her everyday life. First, Sharon received a clinical evaluation by her team of providers. They also encouraged her to attend ODHC's weekly diabetes support groups and group support appointments.



*ODHC's weekly diabetes support groups teach skills for diabetes self management in a supportive environment.*

In these activities, Sharon learned more about diabetes and acquired essential skills for managing it successfully. For example, cooking and nutrition classes helped her discover how to prepare easy, low-cost and nutritious meals, control portions and make healthy substitutions. Sharon attended exercise classes where she learned how to incorporate physical activity into her daily routine. She also attended stress management classes and learned about self management and goal setting.

\* Sharon has provided permission to use her name and photograph in this story



*Sharon is feeling great now that her diabetes is well controlled*

As Sharon made progress and continued to attend support group activities, she became more equipped to follow her treatment plan. She began taking her medications regularly and lost weight. Her blood sugar levels became controlled.

Today Sharon continues to attend support group activities and to control her diabetes. Above all, she no longer prays to die. Instead, Sharon is grateful that she has found support for diabetes management. "I've never gone to a place where they've helped you and they actually care, and it makes you feel so good inside," she says.

Sharon's case is an example of how community-based support for diabetes self management can be successful. Although she could not afford clinical care through insurance, Sharon was able to receive affordable high quality diabetes care from ODHC. With many volunteers and partners, including the local faith community, grocery stores and universities, ODHC is a focal point in the community--a place that provides support for people with diabetes to gain the skills and reinforcement they need to manage their disease every day for the rest of their lives.



*A member of the ODHC staff teaches a patient how to check her blood glucose levels.*



### Intervention Strategies

- Community health workers to support patients and assist project staff
- Weekly diabetes group support appointments with an exercise component
- Case management
- Lifestyle activities such as three-times-a-week exercise, quarterly supermarket tours and bi-monthly cooking classes
- Quarterly “Diabetes 101” classes
- Community outreach and awareness activities

### Key Accomplishments

- Expanded pharmaceutical program use
- Partnered with “Healthier Groceries” on-site
- Improved patients’ knowledge of diabetes through classes and peer educators
- Used the Popular Education method to help patients apply diabetes information

diabetes self management in the target population, *Prescription for Health* developed the following approaches:

*Multicultural Community Health Workers (CHWs)* recruited from the patient population. CHWs provide peer support and culturally and linguistically appropriate diabetes education to other clinic patients. They also serve as liaisons with the community.

*Group support appointments*, which encourage peer support and help patients understand self management tools better. Group appointments also allow project staff to witness patient interactions and identify potential CHW candidates. Family members, friends and local community residents are encouraged to attend.

*Linkages with local social service agencies*, community-based organizations, churches, after school programs, media and more, which help address cultural myths and misperceptions related to diabetes. A Directory of Community Service Providers has been developed and has improved self management by increasing access to and coordination of services for the target population.



### Providing Community-Based Support for People with Diabetes

Open Door Health Center (ODHC) is a free clinic that provides primary health care, diagnostic and education service for the uninsured poor in the Homestead/Florida City area. Almost half the population of this rural community is Hispanic and primarily from Mexico. Other immigrant groups include Haitians, people from the English-speaking Caribbean, and indigenous peoples from Mexico and Guatemala. African Americans comprise another quarter of the local population.

A large proportion of local residents are farm workers, both seasonal and year-round residents, who do not have medical insurance and generally do not qualify for Medicaid. The conditions of poverty and demands of survival contribute to poor preventive health practices and the high incidence of hypertension, diabetes, substance abuse, mental illness, and other health problems.

The *Prescription for Health Diabetes Project* is a demonstration of collaboration among academia, the faith community, a local foundation, a private hospital, volunteers, and community-based organizations. In addition to providing good medical care with the help of its clinical partners, ODHC has established linkages with multiple community resources. Through its membership in WeCare of South Dade, a coalition of social service providers, ODHC has connections to more than 70 different agencies representing every area of social services.

ODHC’s approach gives credence to the saying, “*Medicine for the poor doesn’t have to be poor medicine.*” To positively affect

**For More Information:**  
**Open Door Health Center**  
**305-246-2400**  
**www.opendoorhc.org**



*ODHC’s grocery store tours are a popular program that helps participants build on what they already know about the foods*

*The Popular Education Method*, a highly participatory learning process that starts with what a person knows and builds upon it. Popular Education views the individual as the one who is capable of identifying and solving his/her own problems. Sessions focus on identifying participants’ needs and interests as they relate to diabetes and include brainstorming sessions where participants can suggest ideas for personal application.

### Lessons Learned

- Improved diabetes self management in a multi-ethnic community is possible through innovative collaboration and cultural competence
- A successful system of care for diabetes that includes self management can be created through partnerships and group support visits
- Participatory and Popular Education methods are important when working with populations with varied literacy levels, cultural/ethnic backgrounds and languages in a primary care outpatient setting



## The Tasty Fork: A Win-Win Approach

***A competition between local restaurants brings healthy menu options to the table and helps people reach nutrition goals***

Each year in Richland County, Montana, the Tasty Fork contest encourages area restaurants to introduce healthy low-fat options to their menus. Participating restaurants receive free publicity and compete for the best tasting healthy menu item.

The Tasty Fork contest was developed by the Richland County Nutrition Coalition, made up of agencies and programs including the Richland County Community Diabetes Project. The contest is part of a larger effort to increase awareness of proper nutrition and promote healthy eating community-wide. Since the contest started in 2003, the number of participating restaurants has tripled.

In 2005, the T & C Diner, a small café in Fairview, Montana, won the contest for its *Tuna Salsa Wrap*. The entrée was created specifically for the Tasty Fork contest, but, due to high customer demand, it remains a regular option on the menu today.


reduced fat, reduced sugar muffins. Some restaurants have begun using their menu's "healthy fare" as an advertising strategy, providing an alternative to "all you can eat" promotions they used prior to the contest.

The success of the Tasty Fork contest is a tribute to the ability of the Richland County Nutrition Coalition and Richland County Community Diabetes Project to engage the community in project activities. In fact, the Coalition was honored to be recognized by the governor of Montana for collaborating with local restaurants to help reduce disease burden in Richland County. Community collaboration will continue to be central to future project activities.

**T & C Diner**  
 Winner of the 2005 Tasty Fork Award

Tuna Salsa Wrap  
 6 oz. glass of orange juice  
 350 calories

**Tuna Salsa Wrap**  
 One 6-8 oz can of water packed tuna, drained  
 ¼ cup salsa  
 2 Tbs. low fat mayo  
 ½ tsp. mustard  
 1 cup lettuce  
 2 Tbs. shredded cheese



Mix the tuna, salsa, mayo and mustard together and spread on a 10 inch whole wheat/low carbohydrate tortilla. Top with lettuce and cheese and roll the tortilla up like a burrito. Serve with taco sauce.



*T & C Diner's Tasty Fork creation, the Tuna Salsa Wrap has become a regular menu item due to its popularity.*



*A tasty Fork contest entry, Baker Boy bakery's reduced fat, reduced sugar muffins are now a hot commodity in Sidney.*

Overall, the contest has been a fun and engaging activity for the entire community. Tasty Fork contest participation certificates and awards hang prominently on the walls of competing restaurants. The contest is exciting for the participants, and it also yields tasty results. About 89 percent of customers rate Tasty Fork entrées as "good" or "very good." And many restaurants have used the contest as a unique way to add more nutritious options to their menus, like offering more nutrient-dense vegetables and serving fats like salad dressing and butter on the side. As a result, establishments like Baker Boy bakery in Sidney have a "good problem" of keeping up with demand for its

### Intervention Strategies

- Monthly Diabetes Education and Support Group
- *Live Your Best Life* chronic disease self management class
- Walking programs, supported by physicians using exercise prescription pads and the development of free indoor walking options
- Participant newsletter
- Public awareness campaigns
- Enhanced community resources including diabetes education materials in the library, the Tasty Fork program to increase public awareness of healthy restaurant options, community walkability assessments, Thin-2-Win weight loss contest, and worksite wellness campaigns

### Key Accomplishments

- Developed a multi-level program using an ecological framework
- Expanded and strengthened the continuum of diabetes care through greater collaboration among key clinic and community partners

To address this need, RCCDP created the Diabetes Education and Support Group. At the monthly meetings, participants learn and talk about topics related to diabetes. These meetings are free and open to the public. The RCCDP also developed an ADA-recognized Diabetes Education Center. Housed at the Sidney Health Center and coordinated by the Richland County Health Department, the center helps strengthen the clinical-community partnership. Other interventions that bring diabetes self management into the everyday lives of the community include a walking club, weight-loss program, worksite wellness activities and, of course, the Tasty Fork contest.



*Baker Boy bakery in Sidney, a participant in the Tasty Fork Contest, is helping to promote diabetes self-management in the community with its healthier baked goods.*

Prior to the creation of the RCCDP, few resources existed outside the clinic setting. Community agencies and clinical providers seldom talked together about diabetes self management. RCCDP has changed all that by linking clinical and community care models to strengthen the continuum of care throughout the area's health care system. The project has brought these groups together for regular discussion, and as a result, several diabetes self management, health education and health promotion interventions have been implemented.

The key to each of these interventions has been the involvement of the larger community in the project and coming together around the goal of bettering residents' health. Collaboration has greatly increased since RCCDP demonstrated how a frontier community with limited resources can successfully build community supports for diabetes self management.

### Lessons Learned

- An ecological approach provides a comprehensive model to initiate and sustain diabetes self management
- The unique partnership between the hospital and the health department promotes synergy through sharing and streamlining of key diabetes services



### Developing Creative Community Strategies for Diabetes Care

The Richland County Community Diabetes Project (RCCDP) was developed by the Richland Health Network, a unique partnership among the Richland County Health Department, the Sidney Health Center and the Richland County Commission on Aging. This network provides a variety of services to frontier agricultural communities in Richland and McCone counties in eastern MT, several hours drive from any major towns or cities. Severe winters further isolate these communities and limit opportunities for physical activity. Change typically comes slowly here.



*Participants gather for an educational session on healthy eating*

The RCCDP is dedicated to building a community environment that supports diabetes self management. Focus groups conducted during the project's planning phase identified a desire in the community for more information about diabetes. Although health care providers were reported as the most important source of information for managing their care, the participants wanted practical, understandable information that they could apply in their daily lives.

**For More Information:**  
**Richland County Health Department**  
**406-433-2207**  
**[www.richland.org/health](http://www.richland.org/health)**



## Patient-Driven Care: An Effective Approach

***Encouraging patients to set self management goals and get involved in their own care can make a real difference***

The St. Peter Family Medicine (SPFM) residency offers patients a choice in the format in which they see their primary care provider (PCP). They can choose between a traditional medical visit and a mini-group medical visit. Prior to either type of PCP visit, the patient attends a planned visit with a medical assistant (MA). Open office group visits provide another opportunity for patients to interact with their medical care team. Polly\* found a combination that worked for her and set off on a self management journey filled with great accomplishments, difficult struggles and family support.

Polly first became a patient at SPFM at age 24. Pregnant with her second child, her pregnancy was complicated by gestational diabetes and a number of other health issues. After delivering a healthy baby, Polly was told she had type 2 diabetes. Young Polly went from having no significant health concerns to having three chronic diseases, all of which would significantly impact her life and require her to make healthy lifestyle decisions every day.

Initially Polly did fairly well under the traditional, provider-driven primary care model of six to ten 15-minute appointments a year at SPFM, with appropriate referrals to specialists and educators. She attended a few diabetes classes, took her medications most of the time, and kept most medical appointments. Still, her blood sugar level stayed above 9.5.

Due to enormous family stress, Polly's life grew even more complicated. She withdrew and became depressed. She began to smoke and gain weight. She stopped taking medications and waited longer between doctor visits. As a result, Polly's diabetes became even more poorly controlled and she was hospitalized for a severe blot clot.

SPFM was determined to find better ways to meet Polly's primary care needs. The staff implemented diabetes self management system improvements, including a program to assess a patient's readiness to make lifestyle changes, collaborative goal setting, and patient-specific support for problem solving. SPFM also developed a more comprehensive curriculum for resident physicians on chronic disease management and patient self management support. These changes led to the development of the MA planned visit, in which the MA meets with patients separately from the doctor, follows standing orders and discusses goal setting with patients. Another



*Polly and her father, Allen*

innovation was the mini-group medical visit, in which groups of patients meet with their provider team together rather than one-on-one as in traditional medical visits. The new primary care collaborative team now includes the MA, the physician, other providers, the patient, his or her family and other patients.

For about a year, Polly attended a few MA planned visits and group visits. Initially, she remained quite passive. Then she began to talk openly with her providers. Her depression management improved with counseling and medication. She began problem solving and goal setting at each visit. Her PHQ-9 (depression screening and monitoring questionnaire) scores returned to the normal range and her blood sugar levels dropped from 12.5 to 8.8.

During this time Polly's father also was diagnosed with diabetes. After her father's own commitment to self management, they both agreed to try the mini-group medical visit at SPFM, during which the provider meets with two or three patients simultaneously for about one hour following individual planned visits with the MA. Patients receive the same medical care they would with an individual 15-minute traditional visit, but they also benefit from meeting others with diabetes who have similar frustrations and challenges.

During the mini-group medical visit Polly shared her story with the other patients. Everyone expressed feeling inspired and pledged to return for another mini-group medical visit in three to four months.

\* Polly and Allen provided permission to use their names and photographs in this story.



### Intervention Strategies

- Medical assistant (MA) planned visits with phone follow up
- Mini-group medical visits
- Open office drop-in clinic
- Walking club
- Project newsletter

### Key Accomplishments

- Redesigned diabetes care to offer patient choices for their clinic visits: mini-group medical visit, traditional office visit and/or open office visit
- Developed a curriculum for an enhanced role for MAs that includes planned visits with patients prior to their clinic visit
- Served as a training site for primary care settings working toward improved chronic illness care

Following a planned visit, a patient can choose the format of his or her PCP clinical visit. One option is a one-on-one PCP visit that will include medical management and self management goal coaching. A second option is a mini-group medical visit in which two or three patients meet with their PCP-MA team for a one-hour group medical/ self management goal setting session. Patients in the mini-group medical visit consent to share their medical information with the group so that medical management can occur openly with input not only from the provider team, but also from the other patients. The patients explore barriers and successes with lifestyle change and review self management goals. They set new goals and, if patients are willing, they also exchange contact information. After each visit, the same set of patients is offered a scheduled mini-group medical visit every three to four months.



## Customizing Diabetes Self Management in Primary Care

The St. Peter Family Medicine (SPFM) residency is one of 14 family medicine residency programs affiliated with the University of Washington. The hospital serves 300,000 residents in Thurston County and four adjacent counties in western Washington. The residency program emphasizes physician training for small town and rural practice, with special attention to the poor and vulnerable.

The *Advancing Diabetes Self Management* project at SPFM is centered on expanding the training of the provider-medical assistant (MA) team and engaging patients in their care. The goal of the project is to create a primary care system that supports healthy self management for people with chronic conditions.

A “Self Management Goal Cycle” model is used to redefine medical team-patient interaction. This model expands the role of the MA, allowing the primary care provider (PCP) to spend more quality time with each patient. Prior to a PCP visit, the MA conducts a “planned visit” with each patient in which vital signs, labs, referrals, and immunizations are completed under standing physician orders. The concepts of patient self management goal setting are introduced and, if appropriate, the patient sets a goal. The MA follows up with a phone call to the patient two weeks later to offer support and reinforcement and review and update goals. The MA repeats the process three to four months later.



*Medical assistant and patient meet during a planned visit.*

**For More Information:**  
**St. Peter Family Medicine Residency Program**  
**360-493-7230**



*An open office group visit at St. Peter Family Medicine*

Open office group visits offer an open forum for further discussion among the provider team and patients. Seven to 12 patients attend each session staffed by a faculty preceptor and a resident physician. The agenda is unstructured with the provider team coordinating the discussion, providing medical expertise when appropriate, and taking notes on each patient. The stress and distress of suffering from a chronic illness is a frequent topic of discussion. Patients support and encourage each other while the providers facilitate discussion of stress management and healthy coping strategies. The open office visits are supplemental to the traditional individual or mini-group medical visits.

As a result of offering choices to patients for their care, SPFM has improved provider and patient satisfaction as well as the quality of care for people with chronic conditions.

### Lessons Learned

- Group and mini-group medical visits are promising alternatives for delivering quality diabetes care in primary care settings
- The medical assistant plays a critical role in providing comprehensive diabetes self management services in a family medicine practice
- Collaborative goal setting in a primary care setting improves diabetes self management

Projects of the Diabetes Initiative have contributed to the health and well being of people with diabetes in their targeted communities in unique and creative ways. Importantly, they also worked together with the National Program Office, partners and consultants to glean lessons learned from their experiences to be shared with the broader diabetes community. These lessons include:

### **SELF MANAGEMENT IS CENTRAL TO DIABETES MANAGEMENT**

It is well recognized that managing diabetes is a life-long task and that good medical care is not enough to maintain health and quality of life. Self management programs and services help individuals develop and carry out their management plans during the 8,764 hours a year they are not in a doctor's office. An individual who receives only updated medications and tests from a physician a few times a year is receiving care that is far less than state-of-the-art.

### **INFRASTRUCTURE NEEDS TO SUPPORT SELF MANAGEMENT**

Organizational factors and system features need to facilitate consistent and high quality provision of self management services. The Diabetes Initiative has developed a tool, *Assessment of Primary Care Resources and Supports for Chronic Diseases Self Management*, that can be used by teams wishing to improve self management supports in their settings.

### **ONGOING FOLLOW UP AND SUPPORT IS ESSENTIAL**

Patients need convenient access to talk to someone when they need, or to get a question about their diabetes answered. At the same time, they need to be contacted periodically to see how they are doing even if they haven't checked in with their diabetes team. Thus, both routine contacts by the health care team as well as "as needed" options for patients are essential to sustained self management. Choice is key!

### **ATTENTION TO STRESS, DEPRESSION, AND HEALTHY COPING ARE KEY PARTS OF SELF MANAGEMENT**

Managing negative emotions is important in diabetes management. A range of strategies to address these include support groups, self management classes, supportive community health workers, counselors on the diabetes care team, medication and as-needed referral care. Healthy coping isn't just for a few; all individuals can benefit from improving their coping skills.

### **MANY GOOD PRACTICES MAY BE BETTER THAN A FEW BEST PRACTICES**

Resources & Supports for Self Management (RSSM) can be implemented in ways that fit individual settings and populations – through clinical settings, group education classes, community health workers, interactive e-health interventions, or community organizations and partnerships. Regardless of specifics, those to be served are better able to engage in healthy self management practices if they are able to choose among a variety of appealing, easily available options for learning the skills they need to manage their diabetes.

### **COMMUNITY HEALTH WORKERS (CHWS) CAN PLAY A CENTRAL ROLE**

Called by a number of names ("promotora," "coach," "lay health educator," etc.), CHWs play a variety of roles in diabetes care. These include instruction in key skills for self management and problem solving, emotional support and encouragement, and facilitation of effective communication among patients and their health care teams. They offer unique services and functions not provided by traditional health care teams. To date, CHWs are used primarily in programs that serve underserved populations. Their contributions to high quality diabetes would be beneficial to all adults with diabetes.

### **CLINIC-COMMUNITY PARTNERSHIPS IMPROVE ACCESS TO RESOURCES**

Clinics, community organizations, and other groups can develop partnerships to extend the range and variety of opportunities and supports for self management. These reflect the reality that diabetes management takes place in daily life, not in clinics. The Initiative has identified key characteristics of effective partnerships and tools for assessing their benefits.

Diabetes is widely recognized as a model of chronic disease. Almost any topic of pertinence in chronic disease management is present in diabetes management. Thus, the lessons learned from the Diabetes Initiative can be applied more broadly as chronic diseases become an ever greater focus of attention in health and health care.

Take advantage of additional resources offered by the Robert Wood Johnson Foundation Diabetes Initiative. Please visit [www.diabetesinitiative.org](http://www.diabetesinitiative.org) to learn more about the Diabetes Initiative and find out about our customizable tools and models for self management programs that are available to download.