CDC/National Diabetes Education Program
Community Collaboration to Prevent and Manage Diabetes
May 25, 2017

<u>TRANSCRIPT</u>

SLIDE 1: Opening Slide

SLIDE 2: Welcome

Pam Allweiss: Hi, everybody. This is Pam Allweiss with the Division of Diabetes Translation at the CDC. I want to welcome all of you to our current webinar called Community Collaboration to Prevent and Manage Diabetes. We are very excited about today's program. We have over 1,000 registrations for today's webinar, so we are very pleased about the interest in today's topic. We wanted to highlight some different aspects of community collaboration in the real world. Today's program will be recorded, and later it will be posted on the CDC/NDEP website, where all participants will be able to access the PowerPoint, the recording, and the transcripts.

SLIDE 3: Continuing Education

Continuing education credits will be provided through the CDC Training and Continuing Online Education System. The presenters have no conflicts of interest to disclose. A handout will be provided once we close this webinar with specific instructions on how to obtain CEUs.

SLIDE 4: Today's Presenters

I'm briefly going to tell you about our presenters and then we'll have more bios later. We have Lisa Carr, a senior adviser with the Centers for Medicare and Medicaid Services in Washington, DC. We have Gretchen Piatt, who's with the University of Michigan; Morgan Smith, with Feeding America; and Barbara Gordon, with the Kentuckiana Regional Planning and Development Agency, KIPDA for short, in Louisville, Kentucky. So first we're going to start with Lisa. Take it away, Lisa.

SLIDE 5: Introduction

Lisa Carr: Thank you so much, Pam, and we're so glad that all of you are with us today. All the participant lines are

going to be muted, so we'll be answering questions through the chat box. You can see that on the lower

left corner of your screen. We invite you to submit questions during the webinar, and we will be answering

them during the question and answer portion of the program at the end of our webinar.

Let me review the learning objectives for you.

SLIDE 6: Learning Objectives

We'll just go to the next slide here. And you can see we have a couple of learning objectives. We're going

to analyze the challenges and opportunities unique to their setting. We're going to identify potential

diabetes prevention or management education partners within their setting. We'll articulate the basic steps

in planning for collaboration. We'll name at least two strategies to fund diabetes prevention and

management education. We'll share strategies used by other organizations to evaluate the impact of

community collaboration to achieve diabetes and prevention and management educational goals.

SLIDE 7: Dr. Gretchen Piatt, Challenges and Pitfalls to Diabetes Self-Management in Low Resource Settings

Now, I'd like to introduce our next speaker. Dr Gretchen Piatt is an assistant professor of Learning Health

Sciences and Health Behavior and Health Education at the University of Michigan Medical School and School

of Public Health. Her broad background is in chronic disease epidemiology, with specific training and

expertise in implementing, designing, and evaluating efforts aimed at improving health systems and health

care delivery for people with, and at risk for, diabetes. Additionally, Gretchen has extensive training and

expertise in understanding the behavioral and psychological aspects of diabetes self-management and

support and developing and implementing diabetes prevention and self-management interventions in the

community and primary care settings. She has contributed to and led research teams that designed and

evaluated interventions in primary and secondary prevention of diabetes and its complications, including

the translation of the Diabetes Prevention Program; implementation of the Chronic Care Model; and

implementation and evaluation of peer-navigator, self-management support innovations in underserved communities, federally qualified health centers, and primary care. Welcome, Dr. Piatt.

Gretchen Piatt: Thank you, Lisa, and hello to everyone who's chosen to participate in the webinar today. And I would also like to thank the National Diabetes Education Program for inviting me to share my research and ideas with all of you. So, as you can see by the title of my presentation (SLIDE 7: Challenges and Pitfalls to Diabetes Self-Management in Low Resource Settings), it's not your normal positive spin on the issues of reaching underserved populations. Instead, I'm going to focus largely today on the challenges of reaching the underserved and what we know doesn't work.

SLIDE 8: Objectives

So the objectives of my talk today are to, one, highlight issues that are often not considered when planning interventions in diabetes care for underserved populations, and, two, provide some examples of effective interventions in underserved populations that considered the prior implementation of them.

SLIDE 9: Despite Everyone's Best Efforts…

So despite everyone's best efforts, disparities still exist in the quality of diabetes care in racial and ethnic minority populations in the United States. But why is this? And I believe there are two major assumptions that can be quite dangerous. So the first one being the danger of the blaming aspect. So if the implementation of an intervention fails, it's really easy to blame that on the population. For example, you know, we couldn't recruit them; it was hard to retain them. But instead, we really need to be focusing in on the intervention or the implementation process. So we need to think more deeply on what we are implementing. How and to whom are we implementing these interventions? And then the second dangerous assumption that we tend to make is that adaptations are usually not documented and consequently not tested. So it's really difficult then to replicate these interventions when it's time to.

SLIDE 10: Mrs. Pierce

So here we have Mrs. Pierce and Mrs. Pierce is a typical person who we see in our research studies in metro Detroit. She's about 63 years old. She has type 2 diabetes, high blood pressure, and she has hypothyroidism. Her latest A1C was high—9.8. She also works full time, and she's married. She has a husband with heart disease and COPD. She also has an adult daughter who lost her job and moved into her home with her two school-aged children. Mrs. Pierce prepares meals that the grandchildren like to eat. She sees her primary care provider about twice a year, and she attends church regularly.

SLIDE 11: How Do We Help Mrs. Pierce?

So how do we help Mrs. Pierce? In order to truly understand how to help her, we really need to think about what it is we're currently doing with our diabetes self-management education programs (DSME), and participants who go to DSME, and whether it's working or not. We know that in the African-American community, the church plays a very central role in community life and may indeed serve as a powerful channel to deliver health-promotion types of programs, including DSME.

SLIDE 12: Didactic Teaching Style

So, in my very optimistic view of diabetes self-management education, I truly believe that didactic teaching is on its way out. However, the realist in me knows that this method is still happening regardless of all the evidence that empowerment has shown us. And when the content is presented didactically, the lectures are used to convey information. They're passive. People choose to teach in this way because it's easy. People are only able to pay attention for about 15 minutes, and there is really not any effective or type of social or behavior change support that's provided. Yet this is still happening. And unfortunately it's happening in a lot of places.

SLIDE 13: Behavior Change

I think all of us probably work with Homer Simpson in some capacity. So, these are your colleagues whose philosophy to diabetes goes something like: You have diabetes; you should test your blood sugar. But what

if this person doesn't want to check their blood sugar, you know? What if checking their blood sugar isn't important to them that day because they're dealing with family issues or problems with their kids? This is the reality when we work in communities, and especially low-resource communities. So "you should really" does need to be replaced with "what would you like to talk about?" or "what's important to you?"

SLIDE 14: Lack of Attention to Health Literacy and Numeracy

The lack of attention to health literacy and numeracy is also a challenge that we face in diabetes self-management education programs. And, you know, as diabetes educators and as clinicians and nurse practitioners, and physician's assistants—the whole gamut, you know—do you ever wonder why it takes your participants so long to fill out that intake form or that survey that you hand to them? I mean, it's something that I don't think a lot of attention is paid to. However, 90 million people in the United States have difficulty understanding and using health information. And it's actually a stronger predictor of a person's health than age, income, employment status, education level, and race. So, the next time you hand one of your patients an algorithm for adjusting their insulin, for example, think about, you know, what they're actually doing with that algorithm and whether they're actually able to use it effectively.

SLIDE 15: No Cultural Tailoring

Another barrier or challenge that we have is the lack of cultural tailoring. And there's a growing recognition that lack of cultural tailoring may significantly reduce the uptake or effectiveness of these types of interventions. And a key recommendation in diabetes translational research has been the incorporation of patient perspectives and adapting interventions to the resources and culture and needs of the population. So for those of you who are knowledgeable about PCORI—the Patient-Centered Outcomes Institute—this is a major focus of PCORI and the studies that they go on to fund. They must incorporate that patient perspective along with the culture perspective and adapting things to the needs of the population. Yet, relatively few interventions are tailored for these groups. So it really makes it a difficult situation when you go into a low-resource community with an intervention that has been developed in a non-low-resource community.

SLIDE 16: Paternalistic Care

So, when I was a graduate student over 10 years ago, the concept of patient-centered care was just gaining popularity, largely because of the Institute of Medicine Report called *Crossing the Quality Chasm*. And while this concept has improved with time, unfortunately there are still providers out there that absolutely do not focus on their interaction with the patients. They want to define their patient's care because they think they know everything about their patient's care. But in order to keep the momentum moving more and more toward patient-centered care, the question of "what's the matter?" which is what most providers will say, really needs to become "what matters?"

SLIDE 17: Short-Sighted Outcomes

In the same vein, I think in diabetes we're so largely stuck on focusing on A1C as a measure of effectiveness and improvement. And while this is largely due to reimbursement, we absolutely need to include additional outcomes in our evaluations. We don't get to improvements in A1C without improvements in behavior and psychosocial issues first. So measuring things like diabetes distress, self-efficacy, quality of life, [and] self-care behavior is absolutely critical.

SLIDE 18: Lack of Social Support

So, the concept of social support has been around for a long time, but it's actually just beginning to gain a lot of momentum in diabetes care. We know that social support affects mental and physical health through its influence on emotions, cognition, and behavior. And it does play a role in the risk for, and progression of, physical illness.

SLIDE 19: Lack of Infrastructure Focus

And, similarly, we really need to start focusing on what's already there in the community and not trying to continually reinvent the wheel. So, you know, we know that the current system is not designed to support long-term self-management for diabetes. And because of that, efforts have shifted towards community resources. So I think in order to get the best bang for your buck, the focus really needs to be on low-cost

interventions that build on available resources, for instance, like a church, and existing infrastructures, again, like the church.

SLIDE 20: No Sustainability Plan

And finally, we really should be focusing on sustainability because once these programs and grants that we get, and that we use to intervene by implementing programs, once they go away, there really needs to be a sustainability plan in place. Right now there remains a huge deficit of research on approaches to sustained gains from diabetes self-management education and the infrastructure needed to foster sustainability of the improved outcomes. And this research is especially important in underserved communities who are often served by health care systems that lack the resources and personnel for providing long-term diabetes self-management support in-between clinic visits.

SLIDE 21: Diabetes Self-Management Education (DSME)

So I'm preaching to the choir a bit when I talk about the DSME, but we know that DSME is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes care. We know that it's a covered benefit of the health system. We also know that the research shows us that it is effective at improving outcomes in the short-term. Most times, diabetes education is provided by a certified diabetes educator in a hospital setting. We know that the outcomes are not sustainable without continued follow-up support. And the biggest message that I want to get across is that diabetes self-management education is absolutely essential, but it is certainly not sufficient to sustain outcomes in the long-term.

SLIDE 22: Diabetes Self-Management Support

So that's why it's so important to pay attention to diabetes self-management support services. These are activities that help a patient implement and sustain ongoing behaviors needed to manage their diabetes. They could be behavioral; they could be educational; they could be psychosocial. But they really are activities that focus on feelings, decision making, roles and responsibilities, and costs and benefits.

What the problem is in the current diabetes world is that there is lack of sound evidence about diabetes self-management support.

SLIDE 23: Who Should Provide Self-Management Support?

You know, we don't necessarily know who should provide the support.

SLIDE 24: Where to Provide Self-Management Support?

Where to provide self-management support? You know, do we provide it in the primary care office? Do we provide it via an app on a phone? Do we provide it at a community organization? We simply don't know.

SLIDE 25: When to Provide Self-Management Support?

We also don't know when to provide it. What is the opportune time to provide self-management support services?

SLIDE 26: How to Provide Self-Management Support

We don't necessarily know how to provide self-management support. Is it with peer leaders? Is it with diabetes educators? Is it on the phone? Is it, you know, in person?

SLIDE 27: What Do These Questions Mean?

So what do these questions mean? They mean that there's a lack of evidence, and about diabetes self-management support and there's limited access and availability of these programs, particularly in low-resource communities. So there's a critical need to develop, evaluate, and understand effective DSMS [diabetes self-management support] models that are ongoing, that are patient-driven, and that are embedded in the community.

SLIDE 28: Are Peer Support Models the Answer?

So one of the questions that I have to ask myself is that, Are peer-support models the answer? And there's four key functions of a peer leader: assisting in self-management, providing emotional and social support, linking to clinical care, and providing ongoing support. And we know from the literature that peer support helps to lower problematic health behaviors, improve depression, and improve diabetes self-management behaviors. Peers may effectively and economically fill the need for the patient support in maintaining lifestyle changes that all patients seem to really be wanting.

SLIDE 29: Who Are Peer Leaders?

So who are the peer leaders? Peer leaders are people who live, work, and study in their communities. They often have diabetes. They're respected members of the organization that they work in or they volunteer in. They're usually very empathetic and I think, very importantly, they are not necessarily the diabetes superstar. They are the people who struggled, and that usually is what makes them a really good peer leader. They understand the struggle that it takes to manage their diabetes.

SLIDE 30: Praise Study and Praise 2

So with that, I'd like to transition into talking a bit about two studies that I have that are ongoing that incorporate peer leaders and parish nurses as part of a diabetes self-management support program, focused on churches in metro Detroit. And the first study was called the Praise study and the follow-up study is called Praise 2.

SLIDE 31: Praise Study- Diabetes Self-Management Support in Church-Based Settings

So the Praise study, like I said, is a diabetes self-management support study that takes place in churches.

SLIDE 32: Project Goals and Summary

The goal of Praise was to determine the relative effectiveness of parish nurse plus peer leader diabetes self-management support versus peer leader only diabetes self-management support, compared to a usual care

group. And then to implement diabetes self-management support in a feasible, scalable, and sustainable manner.

SLIDE 33: Methods; Community Partner

So this was a 15-month cluster randomized practical behavioral trial. We intervened in nine African-American churches in metro Detroit in those three study groups, like I mentioned. The unit of randomization in this study was the church. So we did not randomize participants, we randomized the church. The community partner who we worked with in this particular study was Detroit Parish Nurse Network. And they were able to assist us greatly in recruitment of the parish nurses. The support that they provided [included] support staff and assisted in the development of project materials. They were the ones who oversaw the coordination of peer support with the parish nurses, and they assisted with dissemination and sustainability efforts as well.

SLIDE 34: No Title

So this particular slide is very busy, but I thought it was the best way to lay out what Praise was all about. So, if you start at the top, you see that we identified and recruited nine churches. The churches had to be African-American churches. They all had to have a membership greater than 100 people, because what we find is that churches that are really small don't usually have the capacity to do education and support programming. Each church had a peer leader. Each peer leader was African American, and they had type 2 diabetes for at least a year. They were adults. They at least had an 8th grade education. Most importantly, they were willing to be trained to be peer leaders. The parish nurses were all registered nurses in Michigan. They were identified as a parish nurse in the church, and they were willing to serve in that capacity. We trained all of the peer leaders and parish nurses with the University of Michigan Diabetes Self-Management Support Curriculum that we have available. It's a 30-hour training program facilitated by the research staff, and it focuses on empowerment, autonomy, support, patient-centered communication, goal setting, and to a lesser extent, diabetes concerns. When we train our peer leaders and our parish nurses, the goal is to

train them to facilitate groups and be able to problem-solve with patients, and to a lesser extent, training them about the physical aspects of diabetes.

So you could see there that we had the three groups—the parish nurse and peer leader support group, the peer leader group, and enhanced usual care. We collected anthropometric measures and laboratory measures, and survey data at each time point. So for example, if people came in for a baseline assessment, they then received 10 hours of DSME (Diabetes Self-Management Education) provided by CDEs (certified diabetes educators). They then transitioned into six monthly diabetes self-management workgroups that were led by the peer leaders with oversight by the parish nurses. And then they transitioned into a period where (actually I think is the most interesting) where we gave the church the toolkit and all of the tools they needed to carry this out without us and we told them, "Okay, we're going to back off during this time period and it's up to you to continue to do this in your churches." So people, they chose continuing with the groups, or they chose to do walking clubs, or they chose to do grocery store tours—anything that was meaningful to them. And at the end of the study we then assessed all of the same values again.

SLIDE 35: Qualitative Results

So we have all of our qualitative data analyzed, and we saw three key processes for diabetes self-management support come out of that qualitative data. Patients identified goal-setting, problem-solving, and sharing experiences and information in the context of mutual support, camaraderie, and a sense of safety as being the most important. The group processes were also linked to improvements in motivation and self-management goals.

SLIDE 36: Qualitative Results (Continued)

Additionally, participants found that discussion of non-evidence-based treatments was beneficial. And this may be a cultural aspect that we see in the African-American churches, but there does seem to be a desire for non-traditional diabetes treatments to be discussed. So if the patients bring it up and ask about it, we will certainly discuss it with them.

The challenges that the peer leaders and the parish nurses found was in using open-ended questions. And they also found it very difficult to motivate attendance. However, you know, to summarize, peer-led, self-management support efforts in these churches can motivate self-management behaviors in part via positive group dynamics that are facilitated by the safe community setting.

And if any of you are attending the upcoming American Diabetes Association meeting, that study will actually be presented in an oral presentation there. And we can give you more information about it.

SLIDE 37: Praise 2- Fostering Sustainability of Diabetes Self-Management Support in Church-Based Settings

So the follow-up study to that study is called Praise 2. And Praise 2 was a 5-year study that was funded by NIH (National Institutes of Health). We just completed year one of it.

SLIDE 38: Project Goals and Summary

But the goals of Praise 2 are to examine the relative effectiveness of three approaches to address support, compared to enhanced usual care within the church-based setting. It's a 33-month cluster randomized practical behavioral trial with three different support approaches. So one group is parish nurse plus peer leader, one group is parish nurse, and one group is peer leader. And this is actually, to my knowledge, the longest diabetes self-management education and support trial that has been done.

SLIDE 39: Study Design

So here we could see the study design and you could see that, you know, we carried out over 33 months. We measure the same measures at each time period.

SLIDE 40: No Title

And we're in 21 African-American churches in Detroit, Flint, and Toledo. Because we have 21 churches, we have 14 parish nurses who are volunteers and 28 peer leaders who are involved in delivering diabetes self-management support.

SLIDE 41: Church Recruitment

We used a bunch of different methods to recruit the churches, including Internet searches, referrals from other churches, and individuals. But the most important thing was really developing relationships with the churches and doing pulpit announcement[s] in church, and making sure that our flyers were in the churches. So that's what helped us recruit.

SLIDE 42: Church Recruitment (continued)

So we recruited all of the churches that were needed. The goal was 21. We recruited all 21. You could see there on the map that, in relation to Ann Arbor, which is denoted by the M, we have nine churches in Detroit, we have six churches in Flint, and we have six churches in Toledo. And they are all various denominations.

SLIDE 43: Sustainability Strategies

There are a bunch of sustainability strategies built into Praise 2, and that is the main focus of Praise 2. We really want to be able to disseminate the findings and tools, not only to, you know, academics and people in public health, but also to African-American churches and community organizations, especially the American Nursing Association. I mean, I think it would be fantastic to be able to talk with the American Nursing Association about how to include our training for parish nurses into their faith-community nurse-training certificate that they offer. We also provide a toolkit to all of the churches including our curriculum and manuals all of our data collection instruments, so that they're able to do this after we're finished with the study.

SLIDE 44: Sustainability Strategies (Continued)

It's also really important to think about integration into other health care systems. So currently, the Detroit Parish Nurse Network is tied to four large health systems in southeast Michigan. So hopefully I would like there to be work done and research done on how we take the data that we collect in these community-based studies and get that data populated into the EHRs (Electronic Health Records) of these different

community health systems that are out there, so that care could be integrated across the community and health system.

And finally. I would just like to say that I would love to see this type of work be recognized by ADA or by AADE.

SLIDE 45: Pitfalls; Successes

So, just to summarize, we have a bunch of pitfalls that I talked about, but we also have a bunch of successes. So the next time you're thinking about didactic education, think about focusing on the patient's wants and needs; turning "you should" into "what would work for you?" Turning adherence and compliance into empowerment, focusing on health literacy and numeracy, making sure your programs and interventions are culturally tailored, moving away from that paternalistic care, including peer leaders or buddies or community health workers or navigators or family members, as the social support that's needed, and leveraging the existing infrastructures that are already in place in the community to figure out how to achieve sustainability. And with that, I thank you, and I am going to turn it over to our next speaker, who is Morgan Smith.

Lisa Carr: Great. And thank you, Gretchen. This is Lisa. Just wanted to thank you for your presentation. We so appreciate this.

SLIDE 46: Morgan Smith, Addressing Diabetes in the Context of Food Insecurity

Let me introduce our next speaker, Morgan Smith. Morgan Smith is the Interventions for Health Manager on the Community Health and Nutrition team at Feeding America. He joined Feeding America in 2015 and currently oversees Feeding America's diabetes research trial, which is called Faith–DM and other health promotion programming. Morgan previously held diabetes wellness programs at the Redwood Empire Food Bank in Northern California, and he managed the Healthy Traditions diabetes program at the Sonoma

County Indian Health Project. He has worked in clinical settings in community health programming for over 12 years. Take it away, Morgan.

Morgan Smith: Hi, everybody. Thank you for the introduction, and thank you to NDEP and our co-presenters today. I'm excited to be speaking with you. My goals for the next 15 to 20 minutes are to briefly describe food insecurity in the United States, highlight the work that Feeding America is doing and that food banks are doing in addressing diabetes management and diabetes prevention, and hopefully leave you with some steps that you could take to expand your own diabetes programming in your community to address both diabetes management and prevention in the context of food insecurity.

SLIDE 47: What Is Food Security?

So to start with, a few definitions. The USDA defines food security as "access by all people in a household, at all times, to enough food for an active and healthy life." And conversely, food insecurity is "the household-level condition of limited or uncertain access to adequate food supplies." And hunger, on the other hand, is the individual physiological sensation, so it's the sensation people have after going without food for a period of time and not eating.

SLIDE 48: The Numbers

The USDA further breaks down food security into two different categories—low food security and very low food security. Overall, about 12.7% of households in the United States were food insecure in 2015—the most previous year that the study was conducted and that we have data for. And again, 7.7% of those households were identified as low food secure, where they have impacts on their diet quality, but not necessarily the quantity of food. And very low food security are about 5% of those food insecure households, where household members experienced disrupted eating patterns, so they're missing meals and have an overall reduction in both quality and quantity of food. That 12.7% of households represents nearly 16 million homes and over 42 million people who experienced food insecurity in the previous year. And the USDA also reports on a number of populations that experience significantly higher rates of food

insecurity. For example, households with children experience food insecurity at a rate of 16.6%; black, non-Hispanic households experience food insecurity at a rate of 21.5%; and over 30% of households with children headed by a single woman experienced food insecurity at some point in the previous year.

SLIDE 49: Prevalence of Food Insecurity and Diabetes in the United. States

Food insecurity exists in every county in the United States. But as you see there are areas that have much higher coverage rates of food insecurity. And some of the most impacted areas are in the south and southeastern parts of the United States. And there is considerable overlap between areas that are both impacted by food insecurity and nutritionally related chronic diseases like diabetes.

SLIDE 50: Coping Strategies to Avoid Hunger

So, we define food insecurity as a household level indicator. But we know that people living in food insecure homes will often modify or change their behavior to prevent individual instances of hunger. So these coping strategies—like eating low-cost foods, which often include fewer fruits and vegetables might be higher in fat and carbohydrate content, and foods that are very filling. These are very effective coping strategies for someone in a food-insecure home to prevent that individual sensation of hunger. But the problem is, over time, as people cycle in and out of food insecurity and adopt these strategies, the risk is increased for developing chronic diseases like prediabetes, obesity, and type 2 diabetes. And for people who already have one of those diagnoses, if they become food insecure, their capacity to self-manage that disease with these coping strategies is very challenging.

SLIDE 51: The Cycle of Food Insecurity and Diet-Sensitive Chronic Disease

This cycle is our framework for thinking about [how] food insecurity impacts health in chronic disease. So, when a household experiences food insecurity, they might adopt some of those coping strategies that we discussed, which results in an overall decrease in dietary quality, which can again either increase someone's risk for developing prediabetes or diabetes or, for someone with a diagnosis, makes it much more challenging to self-manage, which increases the risk for both acute and long-term complications, putting

people either in a hospital or back in the clinic office, which can increase their health care expenditures and impact their ability for employment, which impacts the household resources that they have. So there may be increasing trade-offs between paying for medical supplies or diabetes-testing supplies and medications, making those trade-offs for food instead, which drives those competing demands to be a little bit worse and further exacerbates that condition of food insecurity in the home.

SLIDE 52: Food Insecurity and Diabetes

And we see that diabetes prevalence rates are also affected by food-security status. So this chart shows data from NHANES (National Health and Nutrition Examination Survey) and looks at rates of diabetes among low-income adults by food security status. And rates are significantly higher in adults who've faced food insecurity. So at 10.2%, again looking at the low-income population, people who are food insecure have higher diabetes prevalence rates than the food secure population, looking at this NHANES data.

We also know that food-insecure adults with diabetes have additional challenges for diabetes self-management. And to echo some of what Gretchen was talking about in terms of capacity for self-management, we know that food insecurity also impacts people living with diabetes in their self-efficacy. Food insecurity results in higher rates of diabetes-related distress. And all these can again impair self-management capacity and really increase their risk for adverse-health outcomes and diabetes-related complications.

SLIDE 53: Food Insecure Adults with Diabetes Have Higher Average Blood Sugars

We see this play out in long-term blood glucose control as indicated by hemoglobin A1C levels. To compare to food-secure counterparts, food-insecure diabetes patients are less likely to have A1C levels at target, and they're more likely to have elevated A1C levels well above goal, putting them at increased risk for acute and long-term diabetes complications.

SLIDE 54: Hunger in America 2014

We also have a lot of information about families who access food through the nation's charitable feeding system, where people receive assistance at food pantries, meal sites, and other food programs in their communities. And these data are from the Feeding America Hunger in America 2014 study, which is the sixth study of its kind. It's the largest, most comprehensive study of hunger ever conducted in the United States. For this study in 2014, we surveyed 192 food banks, 32,000 agencies, visited over 12,000 feeding programs, and conducted interviews with 60,000 clients queuing for food distributions at pantries. And the 2014 survey was the first time that we included questions about health and wellness, and the results were quite shocking. So, we had 58% of households reporting that they had at least one member living with a diagnosis of hypertension, and a third of all households reported that they had at least one member living with a diagnosis of diabetes.

SLIDE 55: Difficult Choices

So, what's the effect of food insecurity? It means that over 42 million Americans are making difficult choices each month. These data are also from the Hunger in America 2014 study. We saw that approximately one third of households had reported making difficult choices like these every single month. So, 66% of households, for example, had to choose between paying for medical care and food. And we know if you're choosing between health care, between diabetes supplies, between your medications, and food, those trade-offs are really going to impact a person's ability to effectively manage their diabetes.

SLIDE 56: Feeding America Network

So, I work on the Community Health and Nutrition team here at Feeding America. If you're not aware about Feeding America, Feeding America is the nation's largest domestic hunger relief organization. We reach every community in the United States, serving one in seven Americans each year, and distributing a total of over 4 billion meals annually. We're made up of a national office and 200 regional food banks. These food banks provide food resources and infrastructure to approximately 58,000 community agencies and food

pantries. And it's these food pantries that ultimately provide food directly to clients in need in their communities.

We also collaborate with other organizations to support clients in achieving stability overall. And beyond working to source and distribute food directly through our network, we advocate for government programs like SNAP [Supplemental Nutrition Assistance Program] and WIC [Women, Infants, and Children]. We engage the public to address hunger and most recently, we've been building partnerships and programs that address the intersections of hunger and health. So, we've been developing collaborations and programs nationally and locally and partnering with health care organizations to implement them at the community level.

SLIDE 57: Diabetes Interventions

A real strength of the Feeding America network and local food banks is that we meet people where they are in their community. So, food pantries are embedded within communities, much like the churches that Gretchen was speaking about in her presentation. And they have the trust of community members, potentially making them a really effective and novel place to engage high-risk vulnerable populations with health-promotion activities. Food banks and pantries are also skilled and have staff that have expertise in tailoring education and self-management support to account for the realities that their clients are facing; so addressing issues like low literacy or numeracy skills, limited food access or transportation barriers.

I'd like to highlight a couple of main diabetes programs that we've developed and evaluated over the last couple of years. Our first diabetes pilot project ran from 2011 to 2014. It was funded by the Bristol-Myers Squibb Together with diabetes initiative and involved three food banks. And we are currently nearing the end of a 2-year randomized controlled trial. That's the Faith–DM study, with three different food banks located in Michigan, Texas, and California. And while the study design for both of those were a little bit different, the main intervention components were very similar. So, for both projects, we focused on delivering or providing blood glucose and A1C testing at community food pantries. So, as people were queueing for distributions at their community pantry, they were offered free blood, glucose, and A1C

testing. And we also worked with local health care organizations and clinics to have clinicians screen their diabetes patients for food insecurity, and ultimately refer those patients directly to food bank programs for services. Clients who were in these programs received distributions of healthy foods one to two times per month, meant to cover about 20% to 25% of their household's food needs. Food bank and pantry staff delivered diabetes self-management education and tailored those messages to address food insecurity. And referrals to primary care providers and partner clinics were made for clients who identified as not having a doctor when they enrolled in the programs.

At all these sites we saw that clinical testing uptake was very high, so people were interested in receiving blood sugar testing at a food pantry. We learned that a majority of clients had never received formal diabetes self-management education. So the messages and education that they received through these food bank programs, they reported as being valuable. We also identified that while most clients had identified either [a] clinic or a doctor that they had been to in the past for their diabetes care, a great majority of them were quite disconnected from care and had not seen a provider for months, or in many cases, years, to have any sort of preventative or diabetes-specific care. So, we've seen that food bank diabetes programs can help and nudge these patients back into clinical care. And a growing number of our food banks across the network are building on lessons learned from these two projects; specifically, to develop diabetes programming in their own communities, and working very closely with health care partners, oftentimes supporting clinics and providers in screening their patients and referring their diabetes patients who are food insecure to the food bank for additional support.

SLIDE 58: Tailoring DSME for Food Insecurity

Many food banks have robust nutrition education programs and staff, and significant expertise in promoting good nutrition with families who are food insecure and who receive food from their distributions. And we've learned a lot from our diabetes work about adapting educational programming to address diabetes specifically in the context of food insecurity. So, we're very excited to see in 2016 that the American Diabetes Association, for the very first time, included in their clinical recommendations guidance on

working with food insecure diabetes patients. And some of the areas that the ADA touched on, food bank diabetes programs have been addressing as well. And they are listed here—so, things around literacy and numeracy, making sure that programs are culturally relevant, working to connect patients to additional resources outside the food bank or outside the clinic, addressing issues around food affordability and their educational messages. For the diabetes educators out there, you've probably spent a lot of time with your patients talking about "what to do on your sick days." But for clients who don't have food, who might be taking diabetes medications, talking about no-food days can be a very important component of those programs when working with food insecure populations.

SLIDE 59: Diabetes Prevention Work

The Feeding America network has been building on our diabetes programming to also address diabetes prevention. So, at the national level, we're currently kicking off two different diabetes prevention initiatives, including a collaborative effort with Americares to support free clinic patients enrolled in diabetes prevention programs with supplemental healthy food from their local food pantries. And we're also launching our own 2-year pilot project to identify effective strategies for screening adults, again using food pantries to identify people at risk for prediabetes and referring them to community-based providers of diabetes prevention programs and supporting those clients with healthy supplemental food. So our food banks work with community partners like the YMCA and other organizations to support Diabetes Prevention Program clients who are food insecure with accessing proper nutrition.

SLIDE 60: Health Care Partnership Work

Our work to address diabetes and prediabetes really depends on effective health care partnerships. And one of the things a lot of our food banks and our energies are around are supporting clinics in developing food insecurity screening and referral programs. Screening is obviously important. You certainly can't tell if you're in a clinic which of your patients might be facing food insecurity. So, this is a two-question screener that is validated and is being implemented in clinics and health care systems across the country to help identify food insecurity systematically in patient populations. And it's something that's being embedded as

well in electronic medical record systems to really be a part of the clinic flow. And the goal for many organizations is to universally screen their patients for food insecurity and then connect that to the very important referral piece to get their patients access to food bank programs, to SNAP (Supplemental Nutrition Assistance Program) or WIC (Women, Infants, and Children Program), or to other food assistance programs, to do something actionable once they identify someone who's at risk for food insecurity.

SLIDE 61: Health Care Partnership Work (Continued)

So the success of the food bank diabetes management and prevention programs, again, really hinges on strong partnerships with community organizations, many of which are listed here on this slide. Perhaps the biggest lesson learned from this process is to make collaborations and partnerships effective, is finding a champion in that organization that you're wanting to partner with who can really spearhead efforts internally to support that work. So, for food banks, it's finding one clinician, a nurse, a provider at a clinic to really focus on food insecurity within that clinic. If you're working in a clinic or diabetes education program, it might be reaching out to a food bank or food pantry to find someone who's interested in diabetes and can support diabetes programming in the food bank, whether it be additional self-management support or the provision of diabetes-appropriate food through that food pantry that your clinic patients can access.

SLIDE 62: Challenges and Opportunities

We certainly identified a number of challenges and opportunities in our diabetes and our diabetes prevention work. Previously, food banks have probably not been turned to first for public health promotion and health education activities. But through this work and through our activities, we are really demonstrating that our network has some unique strengths and capacity to be strong partners in health promotion. So, working with health care providers and having that conversation has been a very productive part of our work over the last several years. Funding is always top of mind for food banks and food pantries—how to support their ongoing work. So, in addition to providing grants and fundraising activities, we're working our way to partner and sustain this work over the long-term and translate the work that we do at our community level with our pilot sites to our entire network of 200 food banks. Again, we reach

over 40 million Americans each year. A great many of them are at increased risk for chronic diseases like prediabetes and diabetes. So, this is potentially a really effective way to get out to a large population at risk.

SLIDE 63: Evaluation and Outcomes

We do have a lot of evaluation and outcomes data, especially from our diabetes pilot project that finished in 2014, the results of which were published in Health Affairs at the end of 2015. And for that project, we saw a lot of significant—statistically significant—improvements for people who went to that program and received healthy food through their food banks. So, we saw a decrease in A1C levels, significant increases in fruit and vegetable intake, decreases in diabetes-related stress, decrease in trade-offs, and increases in self-efficacy. And we're looking at a lot of those same outcomes and some additional ones around health care utilization in our current Faith–DM study. And we have a lot of rigorous evaluation components as well for our diabetes prevention work, again to learn about how effective these interventions can be, potentially, and how we can roll them out to our network.

SLIDE 64: Next Steps and Vision

So, we'll continue to try and build the evidence base to demonstrate individual outcome effectiveness and potential population health impacts for these types of interventions. As an organization, Feeding America also works on addressing the root causes of poverty and food insecurity to help people exit the cycle of food insecurity if they are facing it now and hopefully prevent families and households from becoming food insecure in the future. We're constantly working on sourcing and distributing foods that are high nutritional content across our entire network of 200 food banks. Developing partnerships with health care organizations, both nationally and at the local level, continue to be a really important part of our work.

SLIDE 65: What YOU Can Do

So, from where you sit as working in diabetes self-management education programs, as clinicians, as delivering care directly to patients with diagnosis of diabetes or prediabetes, there are certainly steps that

you can walk away and start with today. The first one is connecting with your local food banks. So, this is a link on the Feeding America website where you can identify the food banks that serve your community. Hunger and Health is also a Feeding America website that is a public site designed for anti-hunger professionals and health care workers. So there's a lot of good information on there to learn about food insecurity and resources that you can use with your patient population. There's resources specifically on that site about food insecurity screening. So, you can learn about screening and referral programs and how to connect your patients with prediabetes or diabetes to resources in the community and to feeding programs to make sure that they get the proper nutrition as a part of the way for them to manage their disease. And you can also learn about, on that website, and through some of the work that we've been doing, how to tailor some of your diabetes self-management education programming and messages to specifically address food insecurity in your patient population.

So thank you very much for your time and your work to address diabetes and prediabetes and consider food insecurity in that context. I'll turn over to the next speaker.

Lisa Carr: Thank you so much, Morgan. We so appreciate your remarks.

SLIDE 66: Barbara Gordon, Impacting Community Change for Older Adults with Type 2 Diabetes: The Journey

Our next speaker is Barbara Gordon. She is director of Social Services at KIPDA, which also serves as the area agency for aging for a seven-county region, including the largest metropolitan area in Kentucky. Ms. Gordon has worked in the field of social services for more than 38 years, including significant work with grassroots advocacy, community coalitions, and health equity. She serves on several boards, including the N4A Board, and is current president for the Southeast Association for Area Agencies on Aging. Ms. Gordon will focus her remarks on how diabetes prevention and management is being addressed through community collaboration in rural communities, particularly in working with older adults. Welcome, Barbara.

Barbara Gordon: Thank you, and thanks for everyone who is joining in this webinar. I'm excited to share with you just some information about our journey working with older adults in rural communities in Kentucky, helping them to hopefully improve their success with their diabetes, as well as with other chronic conditions. I'm just going to take you on a journey for a few minutes to share with you the things that we have been able to accomplish with this initiative.

SLIDE 67: Facilitating and Impacting Change: It is a Facilitated Journey

Let me just share with you a little bit about how we got started and who's involved in this particular initiative. It requires a lot of partnership and collaboration to impact change in communities. And that was our focus from the beginning, is impacting change in the communities—because we believe that that is really the only way to eliminate health disparities that many of our rural older adults were experiencing, particularly as it related to chronic conditions that they had, and especially diabetes. So, in 2010, we were able to access a grant from the Centers for Disease Control and Prevention, whose focus was primarily on eliminating health disparities for vulnerable populations who were experiencing type 2 diabetes. And we were successful in accessing that grant, and our target was rural communities, for older adults—people aged 55 years and older. So, that is our community. That's the community that we targeted, that we wanted to focus on. And in Kentucky, many of you may or may not know, we have a significant health care issue, and are often in the top five as it relates to chronic conditions, including diabetes. So it was really important for us to try to target and focus on the needs and issues in this particular space.

We, KIPDA—if you are familiar with Area Agencies on Aging—we may have some partners and colleagues in that space or on the call. We are an entity that works with older adults, persons with disabilities, and caregivers across the spectrum. And we serve planning service areas primarily, so we have geographic areas that we serve. And in the introduction, you heard that our region does include the largest metropolitan area in Kentucky. But Kentucky's a very rural state, so much of our geographic area that we serve is also rural. And in our purview, we provide a lot of programs and services. But we also focus in the area of disease

prevention and health promotion and provide several evidence-based interventions, including diabetes self-management as well as chronic disease self-management programs.

And then the University of Louisville is the other major partner on this journey and had a very, very significant role in facilitating the work done in the rural communities that we targeted. And primarily we worked with the Kent School of Social Work at the University of Louisville but also, later in our journey, the Institute for Sustainable Health and Optimal Aging.

SLIDE 68: Every Journey Requires a Guide

On this journey, our focus, our guide is the socio-economic, ecological model that you see in the slide now. We know that, and my co-presenters have indicated in their presentations, that often we look at the individual and their behavior or their response to interventions, etc. as the culprit for failure. But we know, and you all know, that that's not necessarily so. Obviously, it plays a part in success, but it is not the full picture of success. So we really wanted to come at the work that we did in these communities from a socio-ecological model, identifying all the layers that are critical to successfully helping individuals to manage and take care of themselves, especially when they have chronic conditions. Obviously, looking at public policy, community, organizational aspects, interpersonal, and individual, is the premise for this model. And the role that we took utilized strategies in each of these categories. And we'll identify and talk about some of those through the presentation.

SLIDE 69: Travelers on This Journey: The Community

Older adults with type 2 diabetes, again, were our primary target, living in rural communities. And we wanted to come towards this initiative from a coalition perspective, from the ground up, from the community up, utilizing coalition work to facilitate and impact the change that is necessary in communities, and particularly rural communities.

SLIDE 70: Our Coalition

The focus of our work, utilizing coalition work, took on several aspects, including convening and mobilizing a coalition. And if you've done any coalition work you know that that is very, very challenging. In order to be able to do that in these communities, we knew that we had to understand the communities. And basically, the work that we do as an area agency on aging—we have a lot of knowledge, a lot of involvement, a lot of participation in the community—but there were several things that we needed to understand about our communities, including its geography, but also the resources—what's available in those communities? And what are the critical issues that our citizens experience that interfere with them being able to have access to health care, access to the things that they need to manage their diabetes, the things that they need to be successful in taking care of themselves?

So we looked at this from a number of perspectives, and it included several things, with a comprehensive needs assessment. This needs assessment was multi-levelled, utilizing strategies to assess our community and the resources available, but also to assess our health care system, and to assess the availability of health care management and the corporations and providers and manufacturers and employers within the community; and, last but not least, and most important, assessing the individuals who were participating in the coalition, who had diabetes, as well as those that we were targeting to engage in the project.

Our goal was also to develop a strategic plan and a sustainable plan. We know that coalition work is challenging and often grants come and grants go. What happens to that community after the grant has ended? So, our focus in strategic planning had a sustainability aspect. The other aspect of this project was to implement interventions—and we'll talk a little bit about the different type of interventions we used in a few minutes—and to evaluate the process and the outcomes.

So our coalition started with many, many partners. I'll identify some of those partners in another slide. But, the focus was to make sure that we had community member involvement, and we utilized community organizers who live in those communities and who know those communities. Our recruitment efforts to

find those individuals to engage in the project were challenged by a number of things, but we were able to find and identify community organizers for the three counties that we originally started with. And those individuals were very instrumental in helping us to recruit and engage community members in the coalition work. Our coalition also included health care providers. It includes payers, insurance companies, managed care organizations, as well as our health department, public health department, and other health care providers in the community. It includes some churches and some school systems. And they were all instrumental in helping us to move forward with our project and our plan.

The coalition started off with being just one large coalition for the three rural communities that we began to target. And we found out very quickly in our initiative that we needed to make sure that each community was represented individually. And those communities decided to create local groups to represent their county within the larger coalition. So, we often call this our three-legged stool. We had a large coalition that focused on the overall initiative and then three local groups that made sure that their county and their communities were reflected in the decision-making and work that we did.

SLIDE 71: Our Model

Our model included a number of strategies. I talked about some of those strategies already but want to emphasize some of the other focus that we utilized. Personal level interventions was one focus. So, we used Stanford diabetes self-management programs, NDEP's New Beginnings Program, the ADA's Live Empowered program, [and] the Kentucky DPCP's Diabetes 101 Class. We also even included Cooper Clayton Method to Stop Smoking, [inaudible] Cooking Matters program, Biggest Loser competitions, the University of Kentucky's Taking Ownership of Your Diabetes program, KRDC Peer Mentoring program, which I'll give a little description of later, as well as diabetes support groups in every county. The classes listed were either implemented by paid community organizers or in-kind contributions of time provided by partners. So we had a number of partners who actually were able to help support these interventions, including KIPDA, who had trained interventionists in many of those particular strategies.

Also, from an organizational standpoint, we did some creative things as well to try to help diversify the strategies that we used with individuals with diabetes in these communities. In working with health care professionals, we had some primary care offices within the three counties who agreed to work with us. And in working with them, we helped them to reach individuals or their patients with diabetes by creating patient packets for these health care professionals, as well as a prescription tablet that they could use to help refer their patients to the diabetes resources that were available in their communities.

For example, if their particular primary care physician felt that this individual could benefit from a diabetes self-management course, then they would identify that particular item on the prescription pad, along with the contact information, so that their patient can access that service. We engaged ourselves in health ministry programs in the churches, and we also worked with local restaurants, particularly around National Diabetes Day, to work with us in changing their menu to include healthy food choices, as a result of Diabetes Education Day, so that the community could know that these restaurants were working with the coalition to make change within the community.

We also worked with farm-to-food-bank programs, local advocacy initiatives, including through our Kentucky Diabetes Network, again, with the goal of making change, permanent change, within the communities. We offered education at workplaces, in churches, and to community groups, coordination of diabetes education opportunities in many locations including health fairs and county fairs. One of the initiatives that we created during the early parts of this coalition continues even today, several of them. But one that continues today is County Walk Competition that brings out individuals in the community, including their families, to walk in a competitive way for steps for a travelling award.

So our coalition was very, very diverse in the different strategies that it utilized to help affect change in the community. And as you can see, some of these strategies are traditional, and many of them are very non-traditional. Some of these strategies are evidence-based interventions; others are not evidence-based interventions. One in particular that we utilized and created a training and a model for, is a peer-mentoring

program. During one of our coalition meetings, we had individuals who have type 2 diabetes to participate in a talk show format, sharing with us their experiences with diabetes. And during their presentation, one of the individuals, one of the coalition members talked about what they needed to be successful. This particular member identified the need for a peer mentor for someone who would help them, who would walk with them, not daily obviously, but occasionally; come to their home, look in their food pantry, help them to identify and know what foods are good to keep in the pantry [and] what foods should be thrown out; go to the grocery store with them occasionally and help them to learn how to buy the appropriate foods and to shop, to cook healthy meals; [and] help them in terms of just learning the different things that they need to do to stay healthy and to manage their diabetes.

And out of that conversation, over a couple of years' span, we learned and decided to create a peer mentor program. And that program basically trained lay leaders or peer mentors who experienced type 2 diabetes themselves, who are also in the same demographic of our older adults—55 years or older—and willing to serve as a peer mentor to a group of individuals who needed that extra help—that extra step to be successful in managing their diabetes. And with that particular project, we were able to engage seven peer mentors who successfully worked with a group of 20 individuals. And in that work, we were able to evaluate and identify reduction in several areas that indicated improvement in diabetes management: reducing fasting blood glucose levels, hemoglobin A1C levels, systolic blood pressure, body weight, as well as improvement in knowledge of their disease, reduction in the need of medication, etc. It was a successful project, and we still attempt to implement that particular project in our community today. We still have some peer mentors. We don't have funding to support it at the level that we desire to, but we are continuing to engage peer mentors and individuals who are readily interested in participating.

SLIDE 72: Coalition Partners

This slide, I'm not going to harbor on it too long, but it includes a listing and identification of the many partners that participated with this coalition work, and it requires every single partner identified. The

coalition partners is a good example of a win-win in terms of working towards improving the community itself for individuals who want to be successful in managing their diabetes.

SLIDE 73: Travelers on This Journey: The Community

Just another slide of some other partners that joined us later in our project and our process of this coalition work.

SLIDE 74: The Many Challenges and Opportunities along This Journey

So with this journey, obviously, we have engaged in many things, but have been met with many challenges, but also many opportunities. And quickly, just some of the challenges, and some of these were identified earlier with my co-presenters, is—establishing a strategic focus. That was probably one of the major challenges earlier on because communities do not often receive entities in their communities who come in saying, you know, that they have a grant and they're going to do good work, because they need a level of trust. And, in order to gain that level of trust, we all had, together, to establish a strategic focus—a focus that we could all agree on. Fostering or anchoring collaboration. This is hard work. Coalition work, especially coalition work that is impacting community change, is hard work, and you have to have partners in this work. And fostering and anchoring those partners—those collaborators—is not always easy. It was a challenge. Developing and implementing our strategic plan is an ongoing process. We're continuing to do that even now in the work that we do with our coalition. Dealing with conflict and emotions is real, you know, we are all human and we all have them. And being able to manage that amongst the community members and the partners involved in the coalition was definitely a challenge. And then sustaining the movement. And I'll talk to you a little bit more in just a minute about how we've been able to do that.

But more importantly, this initiative has met many opportunities. Basically, we have been able to engage and mobilize community members. And even today—and it's seven years later since the beginning of this initiative—many of those community members are still engaged in the coalition and in the work of the coalition, especially in their local communities. The work with many community partners towards common

goals has been very, very effective and have opened up opportunities for even other partnership plans and strategies. Assist communities to learn about health care, health systems and more. This work has actually led us into different rural communities in my region, but also in other regions, with work in terms of improving health care systems and the access to these systems to our community members. And to impact change in policy systems and the community for health [inaudible] is a big opportunity.

SLIDE 75: Partner Engagement is a Journey

Partner engagement on this journey was definitely necessary in the five boxes that I have listed here, within this particular circle. It's a continuous circle—is where it begins and ends and begins again—finding common ground, identifying those key representatives. People do make the difference. And when you're able to identify in the community champions—I hate to call them that but that is exactly what they are. Our community organizers were critical and key in terms of making differences within those communities, but also other key representatives, including local officials who we engaged significantly and continue to engage in the work. Identifying roles, communicate effectively and often, and evaluate partner engagement.

SLIDE 76: Mobilizing for Change: The Journey

Mobilizing for change requires these four quadrants: advocacy, education, services, and interventions. And we made sure that we tried to bring all four of these quadrants together and utilize them effectively to impact community change. An example of advocacy at the local level, I will share with you. It had to do with training our community members, our coalition members, on how to do advocacy—individual advocacy,[1] local community advocacy, as well as state and federal advocacy as it relates to policies and legislation. One of our coalition members identified a sidewalk in their community that was in disrepair and really inhibited individuals, especially those with disabilities and older adults, from being able to cross the street in their downtown area. They advocated with their local officials and it took some time, but eventually that sidewalk was repaired. And that's just an example of some of the coalition work that has been done out of this coalition that again, impact community change, that helps individuals to access health care, to become more physically active, to access fresh fruits and vegetables.

SLIDE 77: Continuing the Journey

We're continuing this journey through the coalition work that we started as the KIPDA Rural Diabetes Coalition. It has now transitioned to be the Kentucky Coalition for Healthy Communities.

SLIDE 78: KCHC

In this slide you can see its mission and its vision. Bottom line—optimal health for all of Kentucky. This transition occurred as a result of just continuing to work with the communities at a coalition level, as well as other grant initiatives and opportunities that we were able to access.

SLIDE 79: Journeying for Change: Healthy Communities

And in those particular grant opportunities, we moved, not necessarily from diabetes—diabetes is still a focus and a target—but to overall health. And the coalition members were very, very instrumental in helping us to understand and see, and identify that health in general will be especially critical and important for even individuals with diabetes because they all experience so many other chronic conditions. And their mantra is, "Diabetes is personal, diabetes is about family, diabetes is about community, and so is health." It's personal, it's about family, and it's about community. And impacting community change with coalition work, making sure that the people that live and exist in those communities are able to access the things that they need to manage their health and to improve their condition, is very, very important. Thank you.

SLIDE 80: Presenters' Information

Lisa Carr: Thank you so much, Barbara. Your presentation was so helpful. You can see on the screen the presenters' information with their contact info. Please make note of this. It may be helpful as you want to follow up on some of the questions that you've presented.

SLIDE 81: Q&A

So we'll start off with a question for Gretchen. Gretchen, we know that there's some common strategies to address diabetes prevention and management. And one of the things that we've heard a lot through our questions that have come in today are what are some of the suggestions that you all have on what to do with non-compliant clients?

Gretchen Piatt: Thank you for that question. And I think that's something that comes up quite a bit. I would say it's really not an issue of non-compliance. It's an issue of understanding what barriers that patient is facing to not being able to manage their diabetes well, and then focusing on those barriers before you start focusing on the diabetes part. And I think that's something that we heard through all of the presentations today— that there are so many outside factors that influence how a person manages their diabetes or how they attempt to prevent developing diabetes. And those things should all be addressed in some logical way.

Lisa Carr: Great, thank you so much. And Morgan, a question that we've received for you—how did food banks motivate people to stay for DSME, either before or after they've picked up food?

Morgan Smith: Thank you. That is a great question. And I think again one of the strengths of our food bank network and our pantries is that they're providing food directly to clients in need. And that can be a very big motivator for people to participate in classes. So, they try to make any educational component attached to a distribution, so people aren't going to a different location at a different time for education; it's part of the food distribution. Food pantry staff are also trained in delivering shorter, individual-specific, self-management support and educational messages with people while they might be waiting in line for a distribution. So it's an opportunity to do some less formal education and support as well.

Lisa Carr: Thank you. And for Barbara, how do you handle elderly patients in their 70s and 80s with out-of-control health issues and poorly controlled diabetes who are happy with the way things are; they do not mind going

to the hospital? And it's really the providers and the family that are trying to encourage them to change but that's not happening. Do you have any thoughts for this person?

Barbara Gordon: Yes, definitely. We encounter that quite a bit. And as I indicated in one of my final slides, you know, health, diabetes is about the individual, obviously, but it's also about family and community. And one of the strategies that we've used is actually just engaging the entire family in the conversation. With our coalition, we actually had some, many of our coalition members were family members. But in the instance of just actual interventions and targeting particular people with health care issues, we try to utilize, even with our diabetes self-management classes, asking the individual family member to attend the diabetes self-management with their family member. And opening up that line of communication is the critical piece—making sure that the older adult understands and agrees with opening up that line of communication and allowing their family member to participate.

But even after all of that—and you do have some successes in that area—but you know, sometimes you just work with the family and if the individual[s] themselves are resistant to making any changes. You just work with the family and help them to educate themselves and to prepare themselves, because behavior change requires the individual.

SLIDE 82: Visit CDC NDEP Website

Lisa Carr: Great. Thank you so much. Thank you to all of our excellent speakers today and thank you for the answers to our questions. We do invite everyone to visit the NDEP website and also to check out our many resources that we have to help you with diabetes prevention and management programming.

SLIDE 83: Continuing Education

SLIDE 84: Thank You!

I would like to thank today's presenters for their time and for answering the questions. This does conclude

our webinar today.

SLIDE 85: Disclosure Statement

SLIDE 86: Disclaimer

The information, views, and opinions contained on this presentation are those of the presenters and do

not necessarily reflect the views and opinions of the Centers for Disease Control and Prevention, the

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