COMMUNITY INTERVENTIONS IN DIABETES CARE IN LOW INCOME POPULATIONS

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In compliance with the accrediting board policies, the American Diabetes Association requires the following disclosure to the participants:

Yvonne D. Greer, MPH, RD, CD

Consultant: Well Women, Wise Woman Program
Others: None
OBJECTIVES

- State four strategies that have been successful in promoting self-management in low income populations.

- Explore the barriers to achieving diabetes control.

- Review community interventions and resources that promote empowerment skills for diabetes care.
WHO ARE THE LOW-INCOME COMMUNITY?

- Some are young and working minimum wage jobs
- Some are unemployed, struggling to find a place to stay
- Some have their own businesses, trying to build income
- Some are retired individuals on a fixed income
Some are bound by geographic locations (the neighborhood; the Inner City; your service area)

Others are defined by a social/religious group (Zeta Phi Beta Sorority Community Outreach Area, Church of God in Christ Services to the Poor; the Ausar Auset Society Outreach)
CHARACTERISTICS OF THE LOW-INCOME POPULATION

- Lower literacy, health literacy, and numeracy levels
- Lower access to health care
- Lower priority for health maintenance; belief in fate!
- Lower educational attainment with lower income levels
- Limited access to the internet, although they do have access to smart phones
CHARACTERISTICS OF THE LOW-INCOME POPULATION

- Limited medical and nutrition knowledge; more use of home remedies;
- More susceptible to myths from word of mouth street folklore (I heard that...)
- Higher single parent households, primarily headed by women
- Large household unit with children or adult extended families or co-habitation
SOCIAL DETERMINANTS TO CONSIDER:

- Income/Job status
- Food Insecurity/Food Budget
- Housing/Rent
- Transportation
- Perceived Safety
SOCIAL CAPITAL/ SUPPORT SYSTEMS TO ASSESS:

- Marital status/significant other
- Children, younger ages, teens, or adults
- Other family support (aunts, cousins, adopted family)
- Friends or co-workers
- Types of support received
- Empowering the ask/do they ask for help, when needed
BARRIERS TO ACHIEVING DIABETES CONTROL:

- Overcoming the stigma of having diabetes, “I’m not claiming it.”
- Poor understanding of basic diabetes physiology
- Lack of cooking skills, equipment, or healthy food access
- Cultural norms, peers attitudes (larger meals; eating out)
- Busy lifestyle, “too busy to worry about my blood sugar”
BARRIERS TO ACHIEVING DIABETES CONTROL (CONT.):

- Functional health/mobility
- Limited follow-up post hospital
- Speed of the healthcare visit
- Guilt/Shaming by healthcare provider
- Diabetes programs locations (not in the community)
SUCCESSFUL STRATEGIES FOR PROMOTING DIABETES SELF-MANAGEMENT:

- Developing a shared vision of success, from the patient’s perspective.
- Incorporating Behavioral Change Theory into health planning:
  - Transtheoretical Model/Stages of Change (Individual/Group Approach)
  - Integral Model or Social Ecological Model (Systems Approach)
  - New: Health Literacy Instructional Model (View Diagram)
FIGURE 1: HEALTH LITERACY INSTRUCTIONAL MODEL

SUCCESSFUL STRATEGIES FOR PROMOTING DIABETES SELF-MANAGEMENT CONT.

- Church Based Initiatives (e.g., Branch Out Faith Based Initiative)
- Neighborhood Center Programs (e.g., Milwaukee County Partners Promoting Prevention, MCOPP)
  - 8 UNCOM Agencies
  - Health and Wellness Programming
  - Family Meal Programs
SELECTED COMMUNITY INTERVENTIONS

- WI Community Health Workers Programs -
  - Healthy Living with Diabetes (Food and Medication Management for Diabetes Control)
  - Living Well with Chronic Conditions (Generic, All Chronic Disease, Coping/Overcoming Obstacles)
  - Both are CDC Best Practice Models and Stanford Evidence Based Program with 6 month and 1 year follow-ups
WI COMMUNITY HEALTH WORKERS

PROGRAM CHARACTERISTICS

- Found in 45 WI Counties; free or low charge ($20 material rental)
- Six Week Course, 2.5 hours/session
- Word of Mouth Marketing or Partner with Providers for formal referrals
- Train the Trainer, 4 Day Training Workshop
- Course Leaders are Diabetic or Diabetic Caregivers
- Community Based – Church, School, etc.
PARTICIPANT FACILITATION

- Average Ages – 50 years/ In Communities of Color, Average 20-30 years
- 10-15 per Session; Promotes Buddy System
- Group Brainstorming for Problem Solving
- Review Food Logs; BS Monitoring; Medication Management
- Redirected to MD; Assist with communication
- Promotes Provider as Partner
- Optional Week 7; Diabetes Educator Guest Speakers
PARTICIPANT SURVEY OUTCOMES

- Patient stated that they don’t feel so alone; social support
- They feel more in control
- Energized
- Able to advocate for themselves
- Trusting relationships with CHWs
- Sessions builds confidence
Ascension Community Outreach Programs – *Under 8 Initiative*

- Collaboration with Feeding America & Ebenezer C.O.G.I.C. Resource Center
- Participants are provided a food box and health education each week for 15 weeks with a goal of achieving an A1C under 8 (or improvements to baseline).
- **Appointments:** From week 1 to week 15, only 6 appointments were missed out of 150 appointments. One participant was dropped from the program due to missed appointments. **Program Dates: April – July 2016**
# Table 1

**Under 8 Program Results – Participant Healthy Improvements**

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<th>Age/Gender</th>
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<th>A1c WK 10</th>
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COMMUNITY INTERVENTIONS (CONT.):

- WI Well Woman, Wise Women Program, Health Coaches
- TOPS (Take Off Pounds Sensibly) – Weight Loss Support Groups (Local Meetings or On-line only)
- YMCA Diabetes Prevention Program/Personal Trainers
- School Evening Recreation Program (e.g., Spiritual Fitness; Healthy Cooking Classes)
COMMUNITY INTERVENTIONS RESOURCES

- Diabetes CDs (e.g., the Lions Programs)
- MCNPAC Role Modeling Action Guide
- Back to the Kitchen: Healthy Cooking Series
- CDC Diabetes Self-Education Modules
- Diabetes Forecast Magazine
COMMUNITY INTERVENTION RESOURCES (CONT.):

- American Diabetes Association Resources/Books
- National Diabetes Education Program
- WI Chronic Disease Prevention and Health Promotion Program Resources
- WI Diabetes Advisory Group Resources
COMMUNITY INTERVENTION RESOURCES (CONT.):

- **Oldways Health Through Heritage Resources**
  www.oldwayspt.org/resources
  - African Heritage Diet
  - Latin American Diet
  - Asian Diet
  - Mediterranean Diet
  - Vegetarian and Vegan Diet

- **MyPlate, MyWins**
  www.ChooseMyPlate.org
  - Choose MyPlate in 20 Languages
  - MyPlate Checklists
  - SuperTracker Group Challenges

- **Fruits and Veggies, More Matters**
  www.FruitsandVeggiesmorematters.org
  - Healthy Cooking Videos
  - Nutrition Information
PRACTICAL TIPS/LESSONS LEARNED:

- Enlist the Help of **Community Champions**
  - Aids in building trust in a non-judgmental way
  - Establish a **shared vision** from the client’s perspective

- Assess their knowledge of their condition and **understanding of recommendations given**
  - “Do you know what the HgbA1c tells you?”
  - Using the Talk Back Method, “Can you tell me…?”
PRACTICAL TIPS/LESSONS LEARNED (CONT.):

- Understand **Your Own Cultural Competence**
  - Cross Cultural Communications
  - Showing Cultural Respect
  - Incorporate Cultural Context into messaging

- Understanding the **Time Factors** related to their lifestyle
  - Job duties/shifts, and if there are break times
  - Sleeping patterns
  - Partying habits
PRACTICAL TIPS/LESSONS LEARNED (CONT.):

- **Short, Easy to Follow Recommendations:**
  - Eating Real Food First…
  - Feeding Your Body Nutrients…
  - Practicing Mindful Eating…

- **Promote Use of Liquid Diabetic Nutritional Supplements:**
  - For those that have problems with skipping meals
  - Can put in coffee cup before going into long business meeting
“IT IS MORE IMPORTANT TO KNOW WHAT KIND OF PERSON HAS THE DISEASE THAN TO KNOW WHAT DISEASE THE PERSON HAS”

BY: UNKNOWN
REFERENCES


