Innovative Strategies for Rural Diabetic Care:

*Diabetes Self Management and Peer Support in Rural Communities*

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Overview

• Introduce the critical importance of self management support for improving and maintaining health

• Illustrate the application of support and related improvements in outcomes via two rural demonstration projects as part of the RWJF’s Diabetes Initiative

• Frame current peer support work in rural contexts, both domestic and global, via AAFPF’s Peers for Progress Evaluation Grants

• Share preliminary reflections about connecting support interventions with local physician providers and thoughts about sustainability
“Well how is this different than just good clinical care?” J. Shapiro, NPR

8,766 = 24 X 365.25

6 hours a year in the doctor’s office or with dietitian or other health professional.

8,760 hours on your own

– Healthy diet
– Physical activity
– Monitor blood sugar
– Take medications, insulin
– Manage sick days
– Manage stress – Healthy Coping
Protectively, social relationships may be as important as the negative effects of established risk factors such as smoking, obesity, and high blood pressure. Conversely, the risk associated with social isolation is stronger than that between cigarette smoking and mortality.

*House, Landis & Umberson, Science, 1988 241: 543*

Duration of contact, not necessarily novelty of intervention, is critical to sustained behavior change and managing health.

*Norris et al., Diabetes Care 2002 25: 1159-1171*
*Kottke et al., JAMA 1988 259: 2882-2889*
*Wadden et al. Obesity 2009 17: 713-722*
What the individual needs

• Help figuring out what might work in her/his daily life
• Skills to do it
• Ongoing encouragement and support – it’s every day for the rest of your life (and help when things change)
• Community linkages and resources
• Tying it all together with good clinical care
Diabetes Initiative of the Robert Wood Johnson Foundation

Demonstrating feasible, sustainable self management programs as part of high quality diabetes care in primary care and community settings

Advancing Diabetes Self Management

Building Community Supports for Diabetes Care
The 14 Sites of the Diabetes Initiative

DIABETES INITIATIVE

- St. Peter Family Medicine Residency Program
  - Olympia, WA
- Montana-Wyoming Tribal Leaders Council
  - Billings, MT
- La Clinica de La Raza
  - Oakland, CA
- Campesinos Sin Fronteras
  - Somerton, AZ
- Gateway Community Health Center, Inc.
  - Laredo, TX
- Galveston County Health District
  - Texas City, TX
- Richland County Health Dept.
  - Sidney, MT
- Minneapolis American Indian Center
  - Minneapolis, MN
- Holyoke Health Center, Inc.
  - Holyoke, MA
- Robert Wood Johnson Foundation
  - Princeton, NJ
- University of North Carolina
  - Chapel Hill, NC
- RTI International
  - Research Triangle Park, NC
- Open Door Health Center
  - Homestead, FL

Advancing Diabetes Self Management Programs (ADSM)
Building Community Supports for Diabetes Care Programs (BCS)
"An Unlikely Recipe for Success: hospital and local public health partnership supports diabetes self-management"

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

- Scandinavian, German homesteaders, ranchers
- Seasonal migrant farmworkers (Hispanic, Native American)
- Near 2 Native American Reservations, one Indian Service area
- Small percentage Native American, Hispanic, Black American, Asian.
- Hardy, independent, stoic, resistant to change, wary of outsiders, private, loyal to neighbors and friends.
Richland Health Network

Community Collaboration

- Communities in Action
- WIC, At-Risk home visiting
- Richland County Nutrition Coalition
- Sidney Health Center Community Health Improvement Committee
- Parish Nursing
- RSVP
- Literacy Volunteers of America
- LIONS Club
- American Diabetes Association – MT
- Montana Migrant Council
- McCoine County Senior Center
- Montana Diabetes Project
- Sidney Public Library
- Eastern Montana Mental Health
- Health Fair Planning Committee at hospital
- Media
- And more...
Social Support & Continuing Education

- Diabetes Education Group
- Goal Setting
- Newsletter
- Resources at Public Library
- Community Resource Book
- Chronic Disease Self-Management Class
- Ambassadors (lay health workers)
Diabetes Education Center

- Formal group and individual diabetes self management education in medical setting
  - Housed at Sidney Health Center
  - Staff: RD, RN, Coordinator
- Physician referral required
- Coordinated by Public Health
  - Linked with community projects
  - Strong source of referrals
- Diabetes Quality Care Monitoring System
- Achieved ADA recognition!!
Campesinos Sin Fronteras, Somerton, Arizona
“Campesinos Diabetes Management Program” (CDMP)

A collaborative between
Campesinos Sin Fronteras, Sunset Community
Health Center,
University of Arizona College of Public Health
and Yuma County Cooperative Extension

By

Floribella Redondo, Program Manager
Maria Retiz, Promotora de Salud

Project Funded by The Robert Wood Johnson, Building Community Support for Diabetes Care
Selecting CDMP’s Target Population

Farmworkers and their Families
Needs of Target Population

Hispanic/Mexican farmworkers are greatly affected by diabetes due to:

- Limited access to health care services
- Working poor
- Lack of health insurance
- Lack of transportation
- Lack of knowledge and education on disease
Promotora Model

- Effective to reach minority and underserved populations - at their work site, their homes, churches and community
- Have trust and respect from their community members
- Have gained medical providers’ appreciation for their contribution to improving the health of their families and community members
- Represent the cultural, linguistic, socio/economic, educational characteristics of the population served
- Most Promotores are members of a farmworker family or are ex-farmworkers
Community Support Services

**Offered by CDMP**

- Diabetes Self-Management Education Classes
- Promotora Advocacy and Referral
- Home Visits
- Diabetes Support Groups
- Family and couple support
- Physical Activity

**Offered by Promotoras**

- *Patient Diabetes Education*
  Through educational sessions participants learn about diabetes and how to manage it

- *Family Diabetes Prevention*
  Through home visits, participant and family members are provided the tools to control and prevent diabetes.

- *Healthy Cooking Classes*
  Through classes and home visits participants and family members learn about proper food portions and healthy food
Health Care Services Offered by CDMP Collaborator

Sunset Community Health Center

- Patient’s Medical Care
- Patient Case Management
- Monitor Patient’s Medical Compliance
- Patient Diabetes Education Program
- Monitor Patient Medicine Intake
- Patient & Physician Communication
Follow-up & Results


- **Patient Support**
  Promotoras help the participants to monitor and control their diabetes through advocacy, home visits and phone calls

- **Diabetes Portable Record**
  Participants use this document to keep a record of their doctor’s office visits in the U.S and Mexico

- Over 12 months, mean decrease of glycated hemoglobin of 0.58 percentage point

- Among those who began ≥ 7%, mean decrease of 1.0 percentage point

- Decreases in glycated hemoglobin correlated with
  - Attendance at support groups \((r = -0.343) \ (p = 0.004)\)
  - Instrumental support or advocacy \((r = -0.410) \ (p = 0.001)\)
Peers for Progress
Peer Support Around the World

“Go to” Source on Peer Support

- Reliable, Up-to-Date Information on Peer Support
- Program Models, Materials for Program Development
- Regional Networks for Collaboration, Advocacy
- Global Networking and Website for QI, Knowledge Sharing
- Tools for Program Monitoring, Quality Improvement

Enhanced Quality and Availability of Peer Support Worldwide
Peers for Progress

Key Functions of Peer Support

1. Assistance, consultation in applying management plan in daily life
2. Ongoing social and emotional support
3. Linkage to/assistance in gaining access to and utilizing clinical care
4. Ongoing availability of support; proactive contact
### Peers for Progress

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<th>Australia</th>
<th>Gambia</th>
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1. **Key functions are global**
2. *How they are addressed needs to be worked out within each setting*
Peers for Progress Grantees (N=14)

5 US-Based Evaluation Grants:
- Ayala – San Diego
- Bodenheimer – San Francisco
- Knox – Texas
- Safford – Alabama
- Tang, Heisler – Michigan

YELLOW BOXES = Evaluation Grants (N=8)

AQUA BOXES = Demonstration Grants (N=6)

Simmons: [England]

Chan [Hong Kong]

Sanguanprasit [Thailand]

Mbuya [Cameroon]

Awah [Cameroon]

Gagliardino [Argentina]

Rotheram-Borus [South Africa]

Oldenburg [Australia]
Peer support in “real-world” clinics and communities (Tang & Heisler, MI)

With African-American adults in community-based setting and Latino adults in a clinic-based setting

All receive 3 mos DSME; Peer support receives 12 mos ongoing, peer-led diabetes self-management support (DSMS)

- Peer-led weekly group sessions – empowerment, focus on participants’ diabetes-related priorities, questions, concerns
- Follow-up telephone calls from peer leader to provide emotional support and follow-up on participant-identified goals

Participants encouraged to call peer leaders

Participants matched with one ‘peer buddy’ for ongoing reciprocal support; encourage at least weekly contact
Buddy System among South African Women (Rotheram-Borus)

Through Women’s Wellness Fairs and clinics in Mfuleni Township in Cape Town, recruit women with diabetes

Diabetes Buddies
- drop-in events
- support meetings
- other 1:1 contacts, along with text messaging
- ongoing, reciprocal support among women
Issues/Challenges

• Practical - Commuting/”Getting-There” (e.g., road closures, public transportation)
• Lack of electricity, especially its impact on charging cell phones
• Costs of medications
• Cultural roles in relationship to core functions of peer support (e.g., assertiveness of women, relationships with health care providers, lack of physician buy-in regarding need for active patient participation in ongoing management)
• Organizational partnerships (e.g., logistics among multiple organizations, capacities among others)
Some Early Reflections

- “Cultural” tailoring and vetting – setting and populations
- Innovative technologies (e.g., clinician-guided texting, other mobile phone supports)
  - Documentation!
- Partnerships – pairing among people and collaborations among organizations
  - Demonstrate and then pitch success in terms of need for, convenience, and suitability of ongoing support
- Mobilizing organizations and resources – existing and new arrangements
- Staying healthy in the midst of great need is feasible and achievable with support!
Contacts

diabetesinitiative.org and peersforprogress.org

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