MISSION AND VISION

MISSION
The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

VISION
The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.
Objectives

Attendees will

• Understand the burden of prediabetes and diabetes in Maryland
• Recognize disparities among different population groups
• Learn statewide priorities for diabetes prevention and management
• Name three diabetes prevention and management programs available in Maryland
Diabetes Burden in Maryland
Prevalence of Diabetes and Prediabetes

- 30 Million with diabetes
- 84 Million with prediabetes
- 9 of 10 people do not know they have prediabetes

Healthy Weight and Obesity Trends

Source: Maryland 2017 Behavioral Risk Factor Surveillance Survey
Diabetes Disparities
Prevalence of Chronic Health Conditions by Race/Ethnicity

Source: Maryland 2017 Behavioral Risk Factor Surveillance Survey
Prevalence of Health Conditions by Income

**Source:** Maryland 2017 Behavioral Risk Factor Surveillance Survey

### Prevalence of Chronic Health Conditions by Income Status

- **Less than $15,000**
- **$15,000 to $25,000**
- **$25,000 to $50,000**
- **$50,000 to $75,000**
- **$75,000 or more**

#### Diabetes
- Fewer than $15,000: 15.3%
- $15,000 to $25,000: 12.5%
- $25,000 to $50,000: 11.1%
- $50,000 to $75,000: 9.6%
- $75,000 or more: 8.2%

#### Prediabetes
- Fewer than $15,000: 14.7%
- $15,000 to $25,000: 13.5%
- $25,000 to $50,000: 11.5%
- $50,000 to $75,000: 9.3%
- $75,000 or more: 5.7%

#### Diabetes and Hypertension
- Fewer than $15,000: 42.7%
- $15,000 to $25,000: 37.2%
- $25,000 to $50,000: 34.1%
- $50,000 to $75,000: 28.9%
- $75,000 or more: 34.0%

#### Hypertension
- Fewer than $15,000: 39.2%
- $15,000 to $25,000: 38.7%
- $25,000 to $50,000: 32.9%
- $50,000 to $75,000: 29.4%
- $75,000 or more: 30.3%

#### Obese BMI classification
- Fewer than $15,000: 29.0%
- $15,000 to $25,000: 31.2%
- $25,000 to $50,000: 31.0%
- $50,000 to $75,000: 31.8%
- $75,000 or more: 31.6%

#### Healthy Weight BMI classification
- Fewer than $15,000: 34.3%
- $15,000 to $25,000: 34.0%
- $25,000 to $50,000: 31.2%
- $50,000 to $75,000: 31.2%
- $75,000 or more: 31.6%

**Source:** Maryland 2017 Behavioral Risk Factor Surveillance Survey
Prevalence of Health Conditions by Education

Source: Maryland 2017 Behavioral Risk Factor Surveillance Survey
Prevalence of Chronic Health Conditions by Disability Status

Source: Maryland 2017 Behavioral Risk Factor Surveillance Survey
Focus on intervention/leverage points to impact population health
Prevention and Population Health Framework

The 3 Buckets of Prevention
Prevention and Population Health Framework

1. Traditional Clinical Prevention
   Increase the use of clinical preventive services delivered to individuals
   CDC's 6|18 Initiative

2. Innovative Clinical Prevention
   Provide services delivered to individuals that extend care outside the clinical setting
   CDC's 6|18 Initiative

3. Community-Wide Prevention
   Implement interventions that reach whole populations

MDH Priorities

- Healthy Lifestyles
- Diabetes Prevention
- Diabetes Management
- Cardiovascular Disease Management

Bucket 3
Community-Wide Prevention

- Improve population health
- Evidence-based approaches
- Health impact and good value

PUBLIC HEALTH

MARYLAND Department of Health
Encourage system-level change

• Local Health Department (LHD)/health systems quality improvement (QI)
• Cross-disciplinary work
  • Oral health
  • Pharmacy
  • Early Childhood Education and school nutrition
  • Breastfeeding
  • National DPP/DSMES/CDSMP/DSMP
Opportunity to Reduce Diabetes Burden

Multi-faceted implementation strategy to prevent or delay onset of diabetes

- Broad penetration of diabetes prevention programs (National DPP) for all payer populations
- Close partnerships between prevention groups and health care providers
- Rapid scaling up of prevention programs in every Maryland community
- Outreach and education of residents
- Data sharing with providers, CRISP, and the State
Diabetes Prevention and Control in the Community
Evidence-Based Programs to Address Diabetes and Diabetes Prevention

- National Diabetes Prevention Program (National DPP)

- Diabetes Self-Management Education and Supports (DSMES)

- Stanford Chronic Disease or Diabetes Self-Management Programs (DSMP/CDSMP)
Community- Clinical Linkages

• Evidence-based programs

• Screening, referrals, and wellness with internal and external partners

• Focus on vulnerable populations
Reinforce Community-Clinical Bridges

- Underserved communities
- Healthiest Maryland Businesses
- Walking initiatives/interventions
- National Diabetes Prevention Program (National DPP)
  - Strong partnership with Medicaid
  - Tobacco cessation and diabetes prevention
- Disease self-management programs (CDSMP/DSMP/DSMES)
  - Strong partnership with Department of Aging
- Disabilities inclusion
- Statewide Councils: Health and Wellness, Alzheimer’s and Related Diseases
National Diabetes Prevention Program
Inclusion and Reach

Diabetes Prevention Program (DPP)
7/1/14 - 10/31/18

All Minority: 47%
White/Caucasian: 63%

National Diabetes Prevention Program
7/1/14 - 10/31/18

- Other Minority: 1%
- Asian/Asian American: 1%
- Hispanic/Latino: 4%
- Black/African American: 32%
- White/Caucasian: 63%
- All Minority: 47%
Chronic Disease and Diabetes Self-Management Programs Inclusion and Reach

**Chronic Disease Self-Management Program (CDSMP) 7/1/13 - 6/30/18**

- White/Caucasian: 48%
- Black/African American: 41%
- Hispanic/Latino: 2%
- Asian/Asian American: 2%
- Other Minority: 2%

**Diabetes Self-Management Program (DSMP) 7/1/13 - 6/30/18**

- White/Caucasian: 50%
- Black/African American: 40%
- Hispanic/Latino: 4%
- Asian/Asian American: 3%
- Other Minority: 2%
How to Access Evidence-Based Programs
BeHealthyMaryland.org
Contacts

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Maryland Department of Health
Prevention and Health Promotion Administration

https://phpa.health.maryland.gov
The Inclusion of Community Health Workers in Diabetes Prevention and Self Management Programs
Objectives:

- To define the rural community, its demographics and the Health Needs

- To demonstrate community engagement strategies for the inclusion of CHWs in Diabetes Prevention and Self-management Programs

- To address the benefits of the Community Health Worker influence on DPP and DSM education

- To review the challenges surrounding successful inclusion of CHW’s rural community Health Programs
Dorchester County is extremely rural with a population density (People/Square mile) of 54.32 within a land mass of 540.76 square miles. This often lends to accessibility obstacles for the residents.

- Limited Transportation Network
- Food Availability
- Health Disparities
9.2% of the Dorchester County Population is officially unemployed, which decreased from our pre-recession state of 10.2%

The population demographics reflect 27.6% African American, 3.4% Latino, 1.6% Asian/Pacific Islanders, .9% Native American and 66.5% classified as non-minority
In Dorchester County, 22.4% of the total population households are below 185% of the Federal Poverty Level and the median household income differs across racial lines.

- African Americans – $26,321
- White Americans – $46,683

*This shows a median income which is 56% higher*
The Need in our Community
WHAT DID WE DO?
Diabetes

Hypertension
Community Health Workers

• Trained, non-clinical, trusted community members to focus on connecting our community to the DPP (Diabetes Prevention Program) and Self-management.

• Met our community members where they lived, worked, prayed or played
Community Health Workers on the move!

The CHWs serve communities and provide direct intervention to the residents through the Diabetes Prevention, Self-management and DSM Follow-up Programs at little to often NO COST.
Cost associated with the year long DPP program
  CHW’s
  Programmatic - Materials
Maintaining interest and continuing effective engagement with enrolled participants
  • Having participants value the benefit of participating
Hospital Discharge referrals for high risk individuals diagnosed with Diabetes or those with higher recidivism rates
CHWs & Diabetes Programming - BENEFITS

- Care Coordination between Community Members, CHW’s and Health Care Providers along with an effective Bi-directional referral system
- Emergency Room utilization reduced for preventable Chronic Disease issues specifically Diabetes
- A restored sense of TRUST among program participants within the community
- CHW’s more inclusive as a part of the overall health care team
- LITTLE TO NO COST to program participants for Diabetes Education and Training Program services
Community Health Workers and Health Equity

TRANSACTIONAL & TRANSFORMATIVE CHANGE

- **TRANSACTIONAL**: Interventions that help individuals negotiate existing structures and challenges

- **TRANSFORMATIVE**: Solutions that re-frame issues from a focus on “problem individuals” or “problem groups of people” to the acknowledgement of how people are historically “differently placed”;
  - A solutions-oriented focus on making systems and structures equitable.
Effective Solutions for CHW Interventions

- Diabetes Prevention & Self Management Programs
- Communities Engaged in longer term Prevention & Self-Management Behaviors
- CHW providing services for the community within the Community
- Support Team – Participant, CHW, PCP, Resources and Service Agencies
- Cost-Sharing among Provider and Community Stakeholders for Vulnerable Populations
Resources

DHMH - Maryland Health Equity Data
http://dhmh.maryland.gov/mhhd/Pages/Health-Equity-Data

Maryland Chartbook of Minority Health And Minority Health Disparities Data
Selected Statewide and Dorchester County Data

Chronic Disease SHIP Metrics: Mid-Shore
THANK YOU!

Ashyrra C. Dotson
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410 – 221 – 0795
History

1983
Volunteer-run clinic launched in response to first Salvadorian immigrant wave (war, natural disasters, violence) to the DC Metropolitan area

1995
Incorporated as an independent, non-profit 501(c)(3) agency

2007
Federally Qualified Health Center (FQHC) status
To build a healthy Latino community through culturally appropriate health services, focusing on those most in need.

We envision a diverse, inclusive, healthy, safe, and happy community, free from violence and discrimination, where individuals have access to health care and are well-informed and empowered to care for themselves and their families. **Continually advocating for healthcare as a human right**, we also envision our community united and organized to end health inequities based on immigration status, language, gender, sexual identity, and race.

Health Equity
Community
Quality Care
Perseverance
Enthusiasm
Collaboration
Programs and Services

Primary Care

Language Access

Mental Health & Substance Use

Community Health Action

EMPODERATE
Health and Gender Program

ENTRE AMIGAS
LGBTQ Health Program

MI REFUGIO
School-Based Program

VOLVIENDO AVIVIR
Substance Use Program

LA CLINICA EN SU VECINDARIO
School-Based Program
Locations

DC Clinical Site
2831 15th St. NW
Washington, DC 20009

Hyattsville/MD Clinical Site
2970 Belcrest Center Dr,
Hyattsville, MD 20782

La Casa
3166 Mt Pleasant St NW,
Washington, DC 20010

Mi Refugio
7000 Adelphi Rd,
Hyattsville, MD 20782

Empodérate MD
7411 Riggs Rd,
Hyattsville, MD 20782
Core elements

• High quality, culturally sensitive, patient-centered and trauma-informed care to uninsured and underinsured patients

• Integrated and co-located services

• Coordinated primary and mental health care, social services and peer-based health education

• Community Health Action – health promotion and safe spaces for especial populations
Community Health Action Touchpoints

Community Health Action Department - Participants Touchpoints:

According to the Patient Experience Consulting Group “TOWER”, positively transforming the patient experience is complex, requires collaboration and an integrated approach across all touchpoints, and come from having a patient-centered approach to care; actively engaging the participants in the care delivery process and building trusting relationships. Also, requires engagement of the participants, family, social networks, health educators, healthcare professionals and the organization to leverage technology and build upon what is working today – processes, systems, knowledge, resources, and relationships - to re-define the experience (2012).

The touchpoints are all the different ways the participants experience a product or service, from when they first become aware of it, until they make use and/or benefit from the product or service. “These are a trusted source for insight, strategy, and resources needed to precisely navigate a rapidly changing and highly complex healthcare environment” (2017).

CHA Indicators Using to Determine the Department Reach Through Touchpoints:

- HIV CTR Sessions
- STI CTR Sessions
- Navigation Sessions Performed
- Unique Clients Received Individual Health Education (by month)
- Unique Clients Received Group Health Education (by month)
- Unique Clients Attending Support Groups (by month)
- Street-Outreach Encounter (people reached / fairs, flyers distribution, community forums, etc.)
- Participants Reached Through Educational or Stage-Based Interventions
- Health Promoters Trained and attending to Retraining Sessions (by month)

References:


Tu Salud en Tus Manos:
Peer-based obesity, diabetes, and cardiovascular disease prevention program for low-income, immigrant Latinos in Prince George’s County.
Community Awareness

Year 1 - 37 culturally competent small group workshops reaching 416 community members.

Year 2 - 14 culturally competent small group workshops reaching 211 community members

Year 2 - Festival and Health Fair 72 people attended and 62 received health screenings (BMI, nutrition counselling and blood pressure measurements).
Behavior change intervention

- Intervention based on the CDC’s Road to Health curriculum.
- Weekly sessions are delivered by a trained LCDP staff member and 2 CHW.
- 6 weeks with two follow-up sessions taking place at one month intervals afterwards.
- The sessions include a variety of educational and physical activities as well as visit to a grocery store.
- Each participant establishes their own written lifestyle goals for chronic disease prevention (e.g. reducing sugary drink consumption).
- The group format helps participants stay accountable and engaged.
Results
<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enrolled 22 participants in the behavior change program.</td>
<td>• Enrolled 17 participants in the behavior change program.</td>
</tr>
<tr>
<td>• 19 participants attended at least four sessions.</td>
<td>• 17 participants attended at least four sessions</td>
</tr>
<tr>
<td>• 19 established lifestyle change goals.</td>
<td>• 15 established lifestyle change goals.</td>
</tr>
<tr>
<td>• The total weight lost was 134.2lbs.</td>
<td>• The total weight lost was 110.6lbs.</td>
</tr>
<tr>
<td>• Average of 7.1 lbs. per participant.</td>
<td>• Average of 6.5lbs per participant.</td>
</tr>
<tr>
<td>• 5 individuals lost at least 10lbs.</td>
<td>• 3 individuals lost at least 10lbs.</td>
</tr>
<tr>
<td>• 1 participant lost a total of 17lbs over the course of the intervention.</td>
<td>• 1 individual lost a total of 20lbs over the course of the intervention.</td>
</tr>
</tbody>
</table>
Lessons learned

- Recognition of the social determinants of health *singular* to the Latino immigrant community.
- Policy solutions to address *large, structural issues* such as universal access to health care, food security and fair work conditions and education.
- Health intervention programming designed to meet the *culturally specific needs* of the Latinos immigrant community.