Diabetes Prevention and Management in Maryland

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Prevention and Health Promotion Administration

Center for Chronic Disease Prevention and Control

December 6, 2018

MARYLAND Department of Health

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

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Prevalence of Diabetes and Prediabetes

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

Centers for Disease Control and Prevention. *Diabetes Report Card 2017*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2018.

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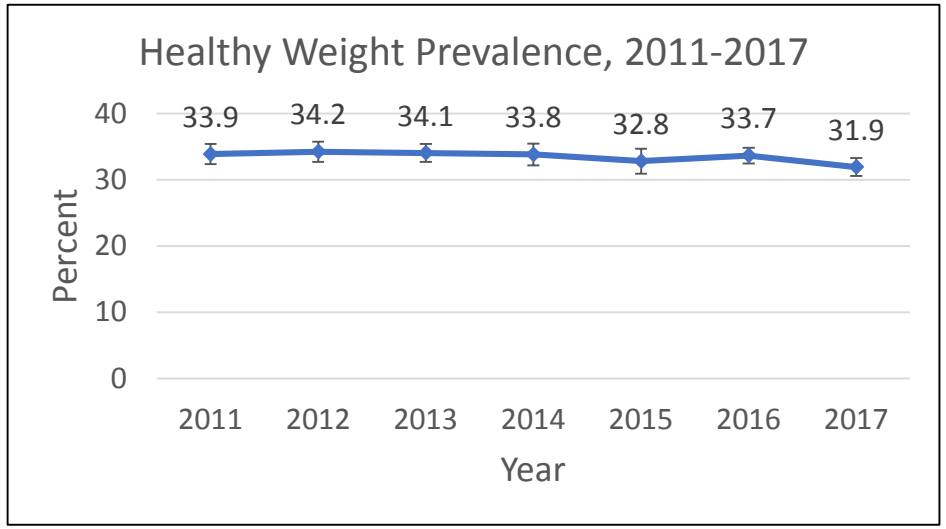
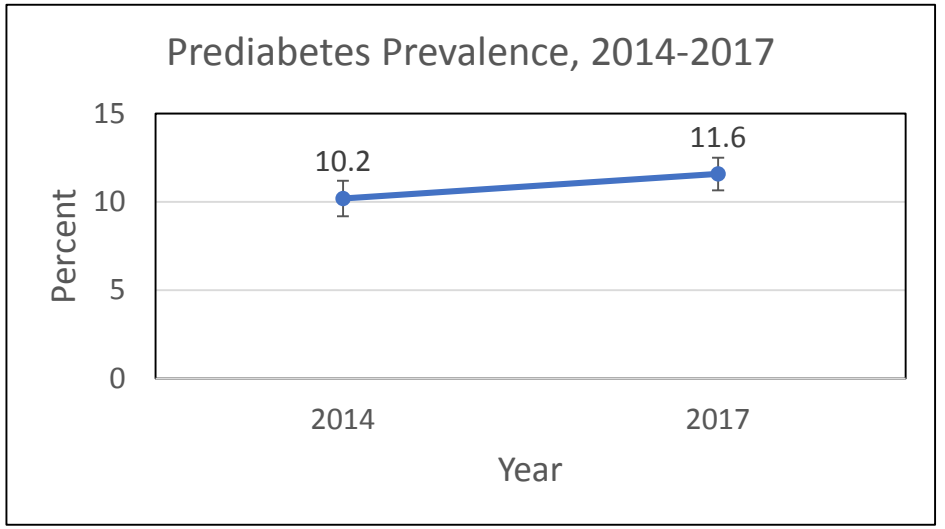
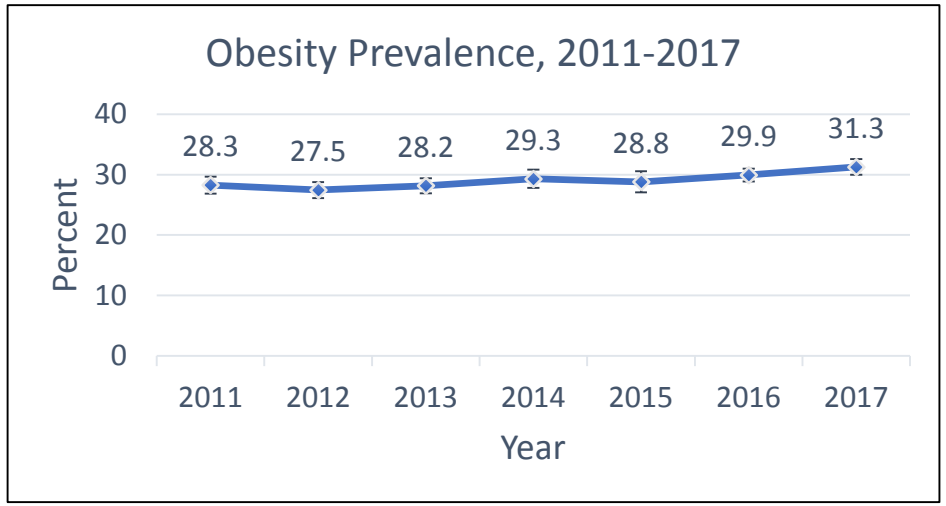
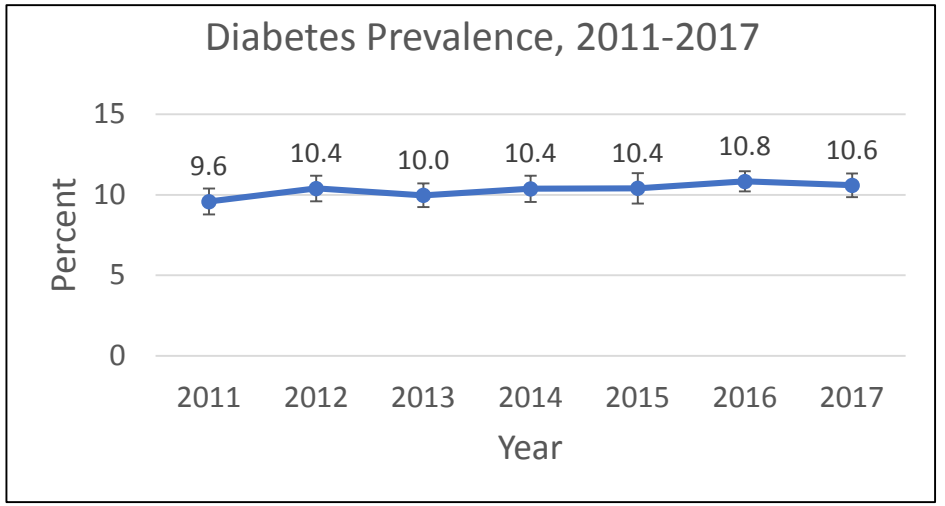
Healthy Weight and Obesity Trends









Source: Maryland 2017 Behavioral Risk Factor Surveillance Survey

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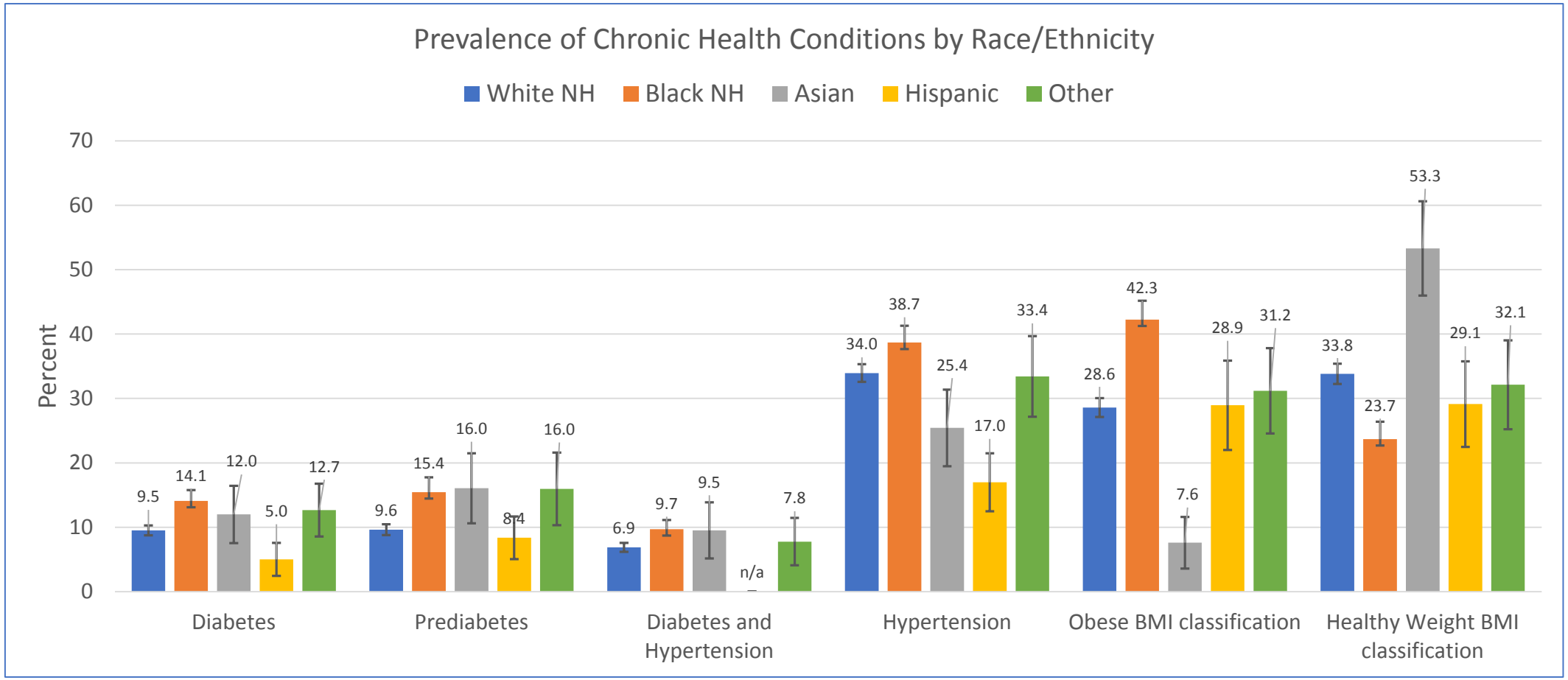
Diabetes Disparities

Prevalence of Health Conditions by Race and Ethnicity



Source: Maryland 2017 Behavioral Risk Factor Surveillance Survey

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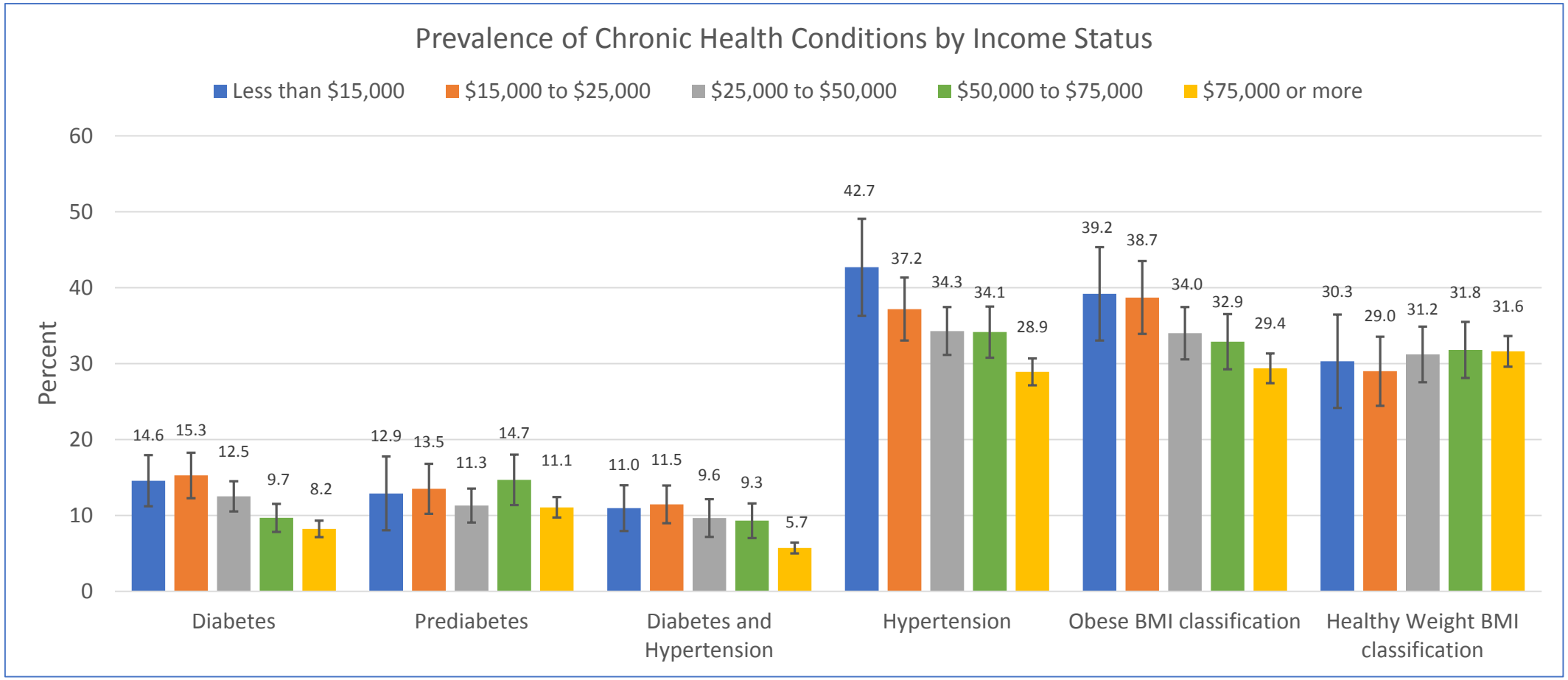
Prevalence of Health Conditions by Income



Source: Maryland 2017 Behavioral Risk Factor Surveillance Survey

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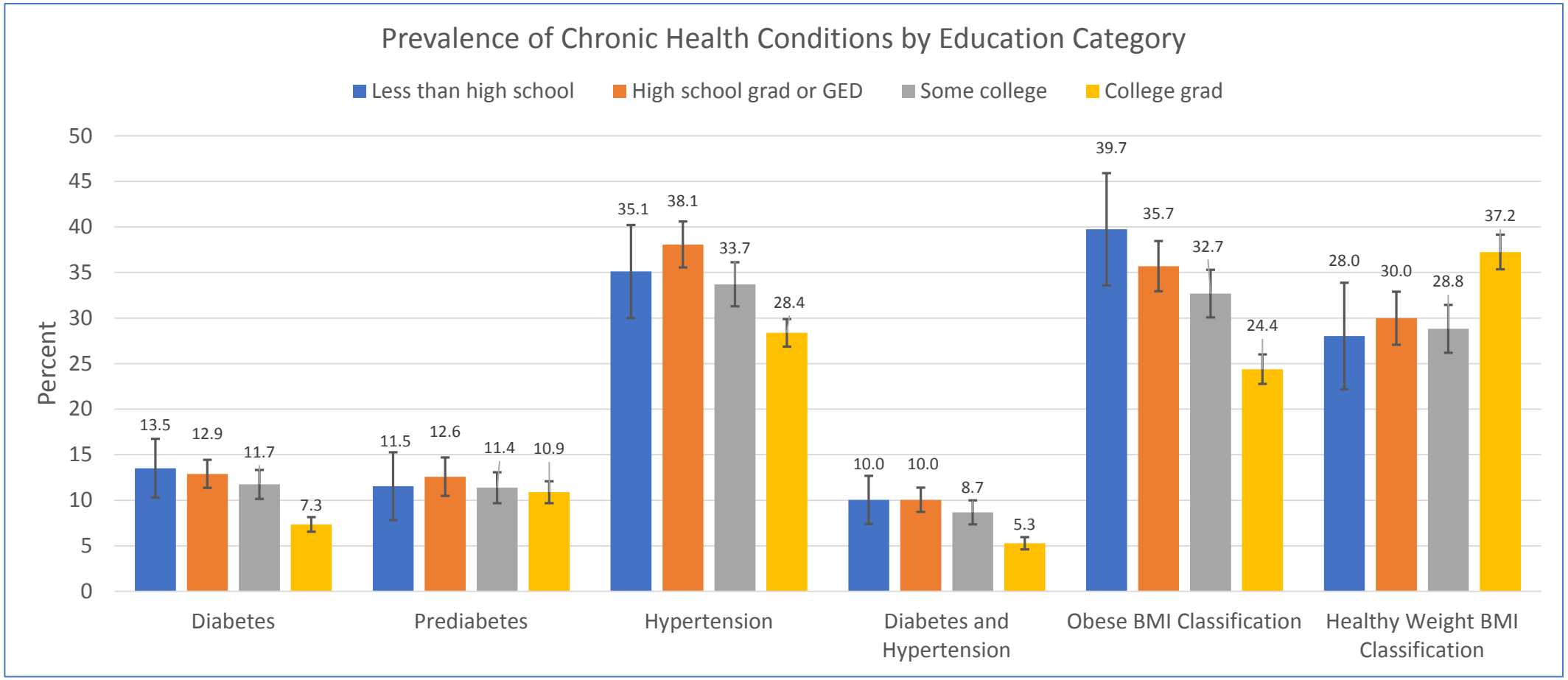
Prevalence of Health Conditions by Education



Source: Maryland 2017 Behavioral Risk Factor Surveillance Survey

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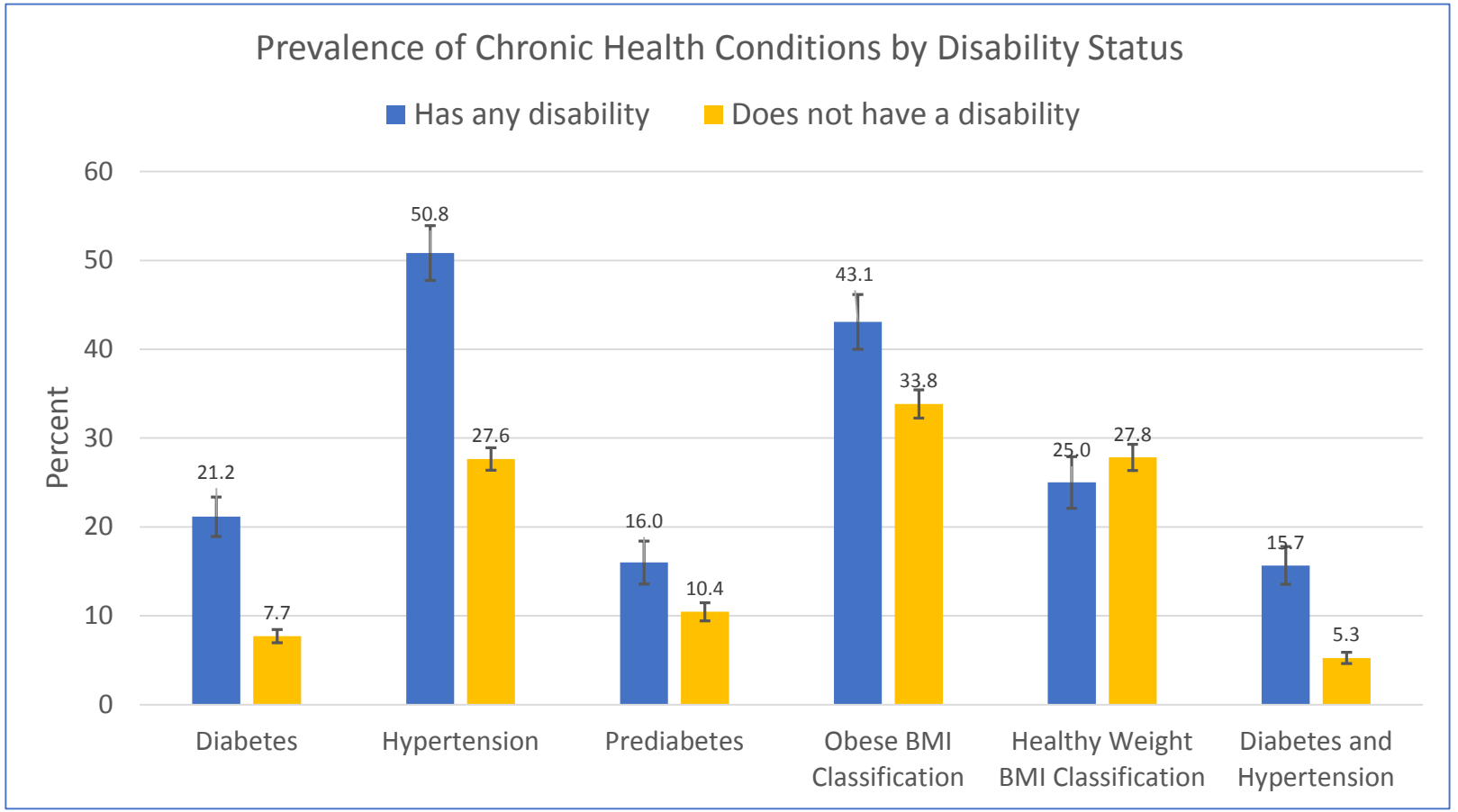
Prevalence of Chronic Health Conditions by Disability Status



Source: Maryland 2017 Behavioral Risk Factor Surveillance Survey

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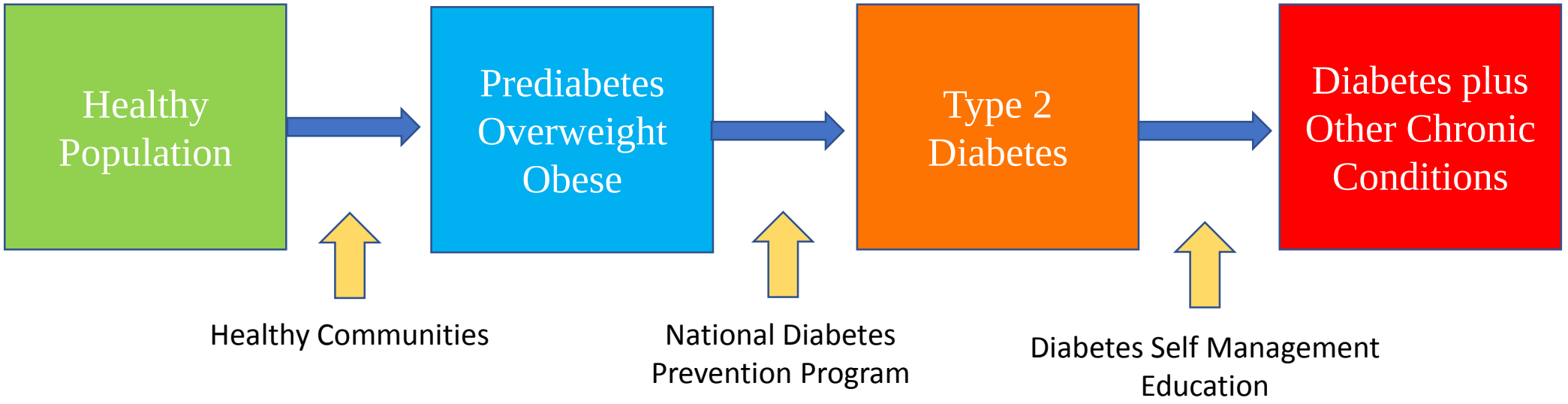
Population Health and Diabetes

Systems Model – Diabetes



Focus on intervention/leverage points to impact population health

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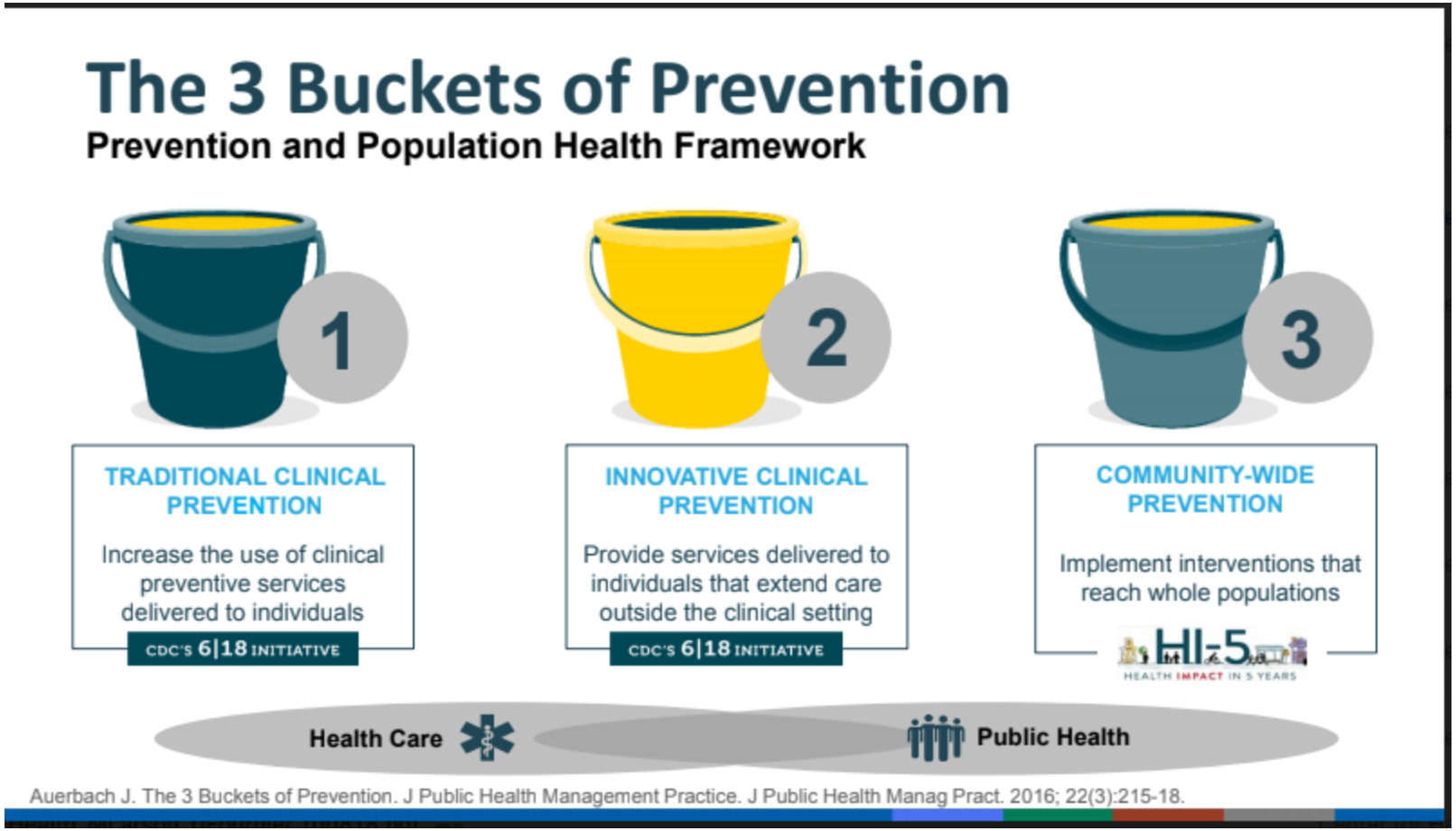
Prevention and Population Health Framework



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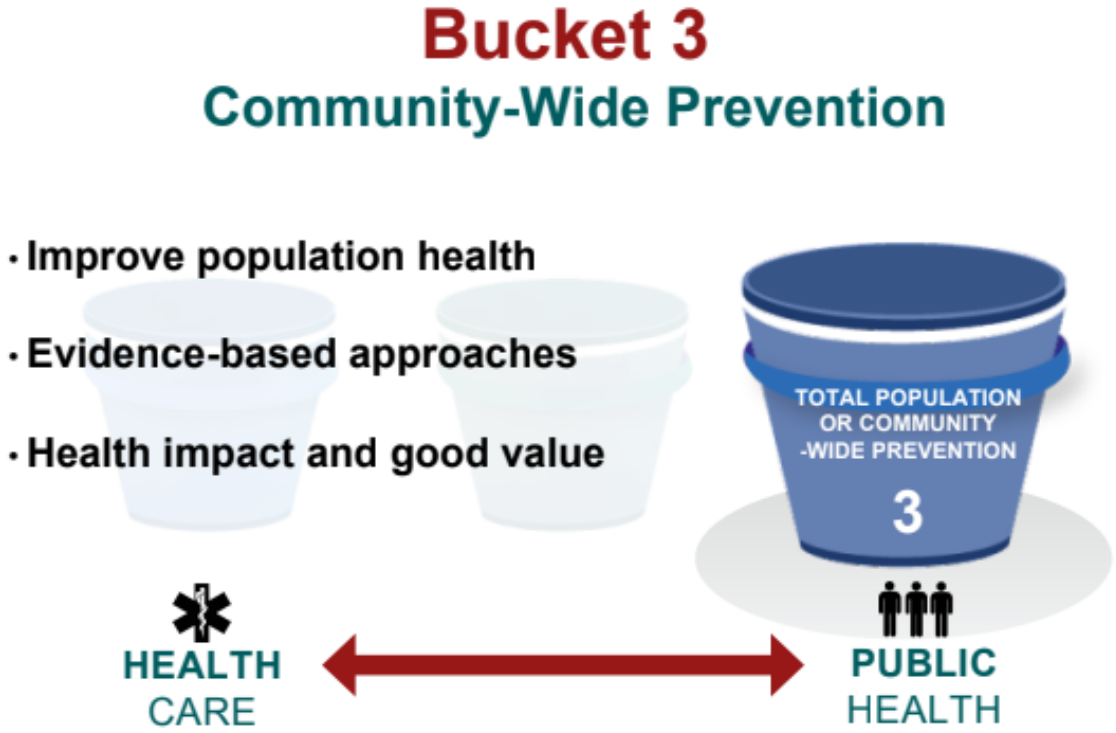
MDH Priorities

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



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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

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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

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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)

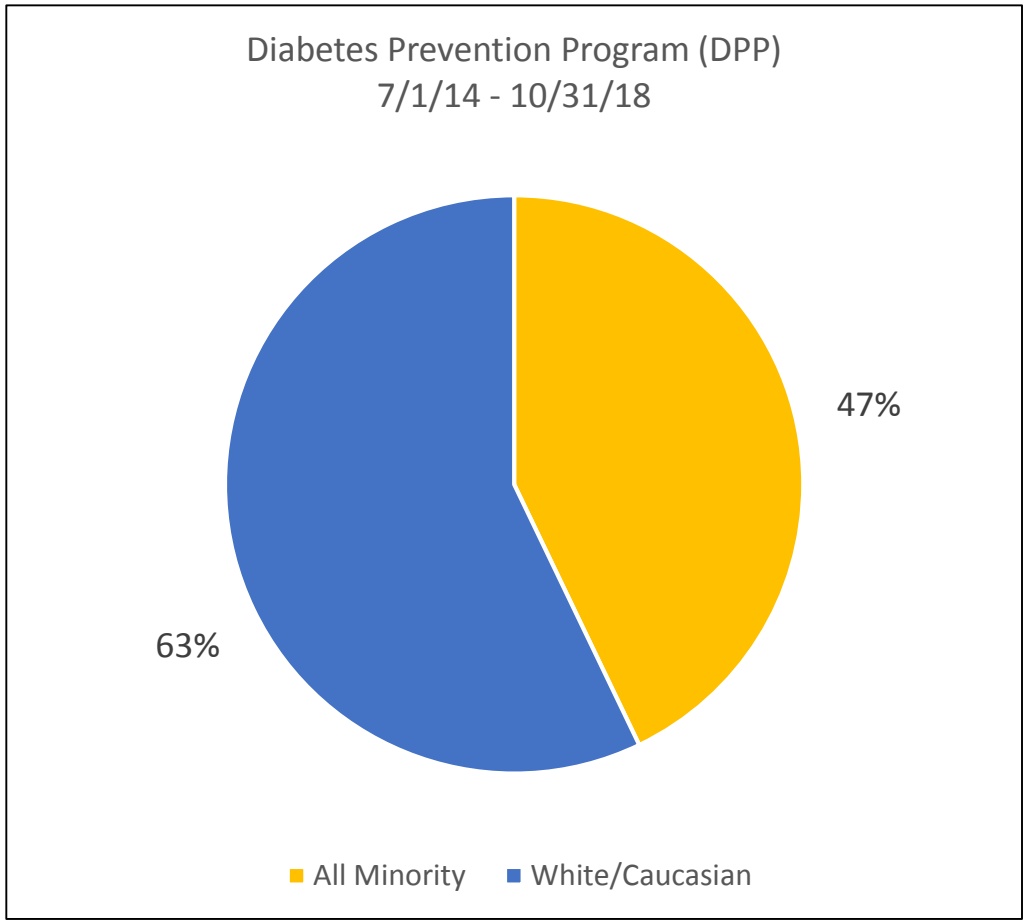
Community- Clinical Linkages

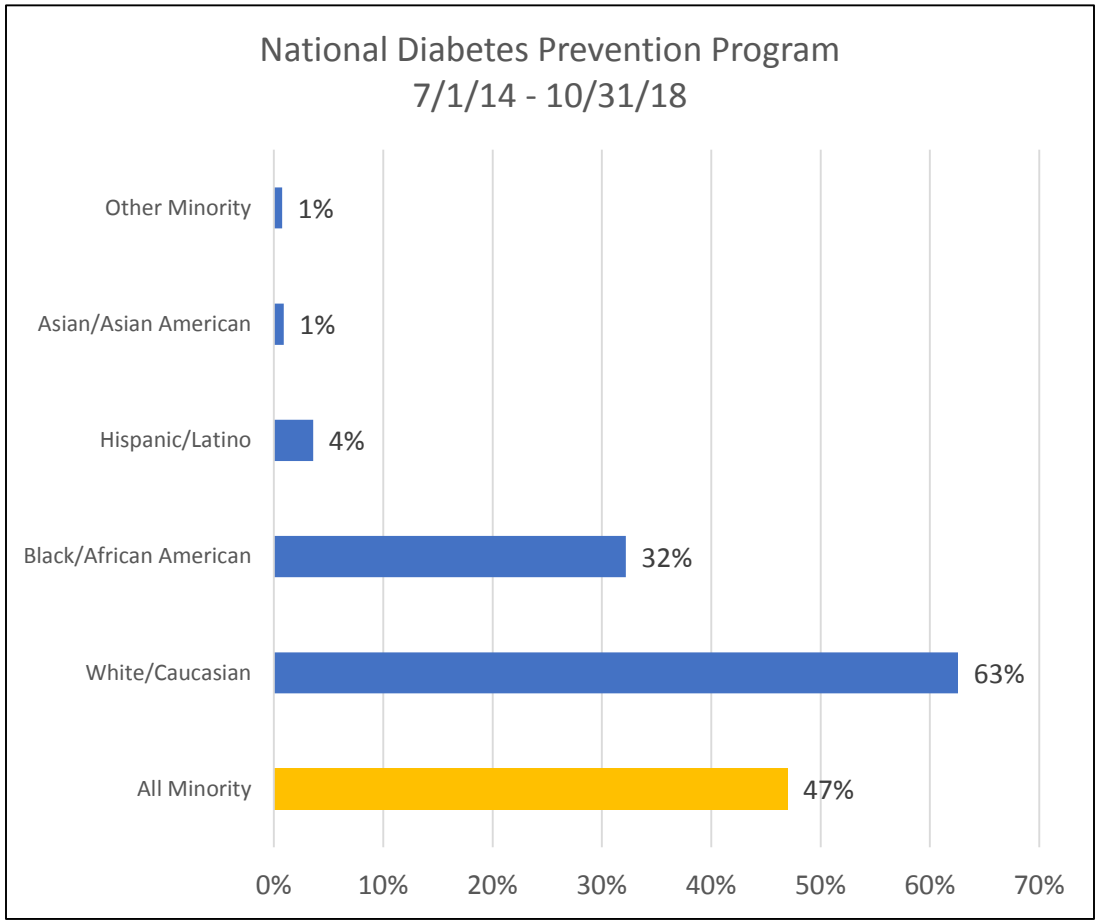
- Evidence-based programs
- Screening, referrals, and wellness with internal and external partners
- Focus on vulnerable populations

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





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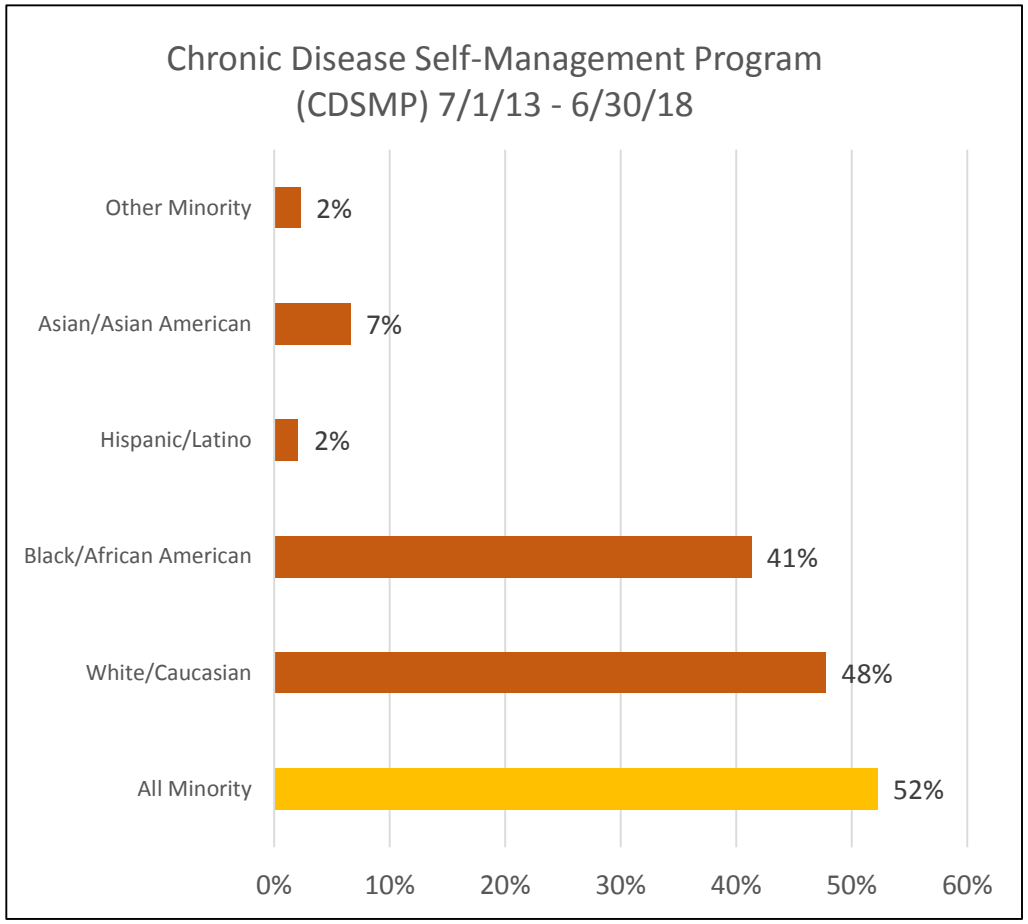
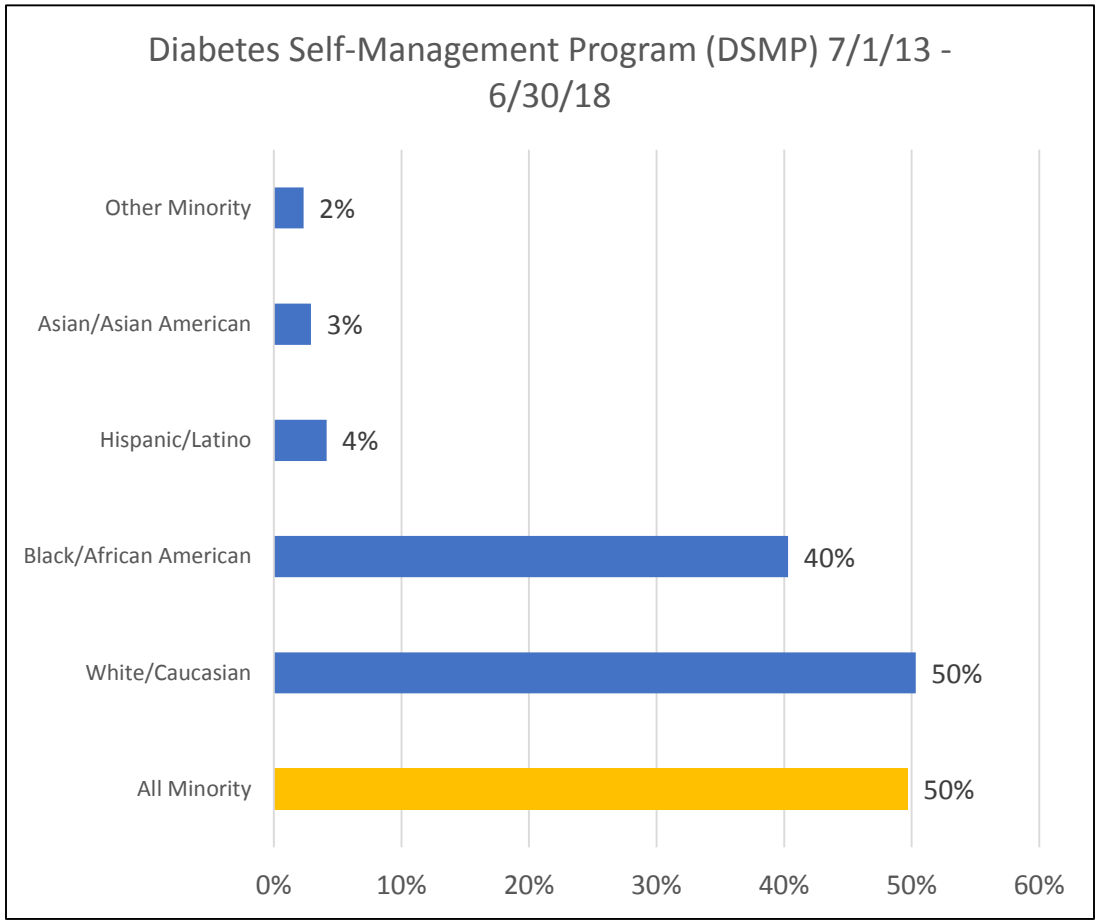
Chronic Disease and Diabetes Self-Management Programs Inclusion and Reach





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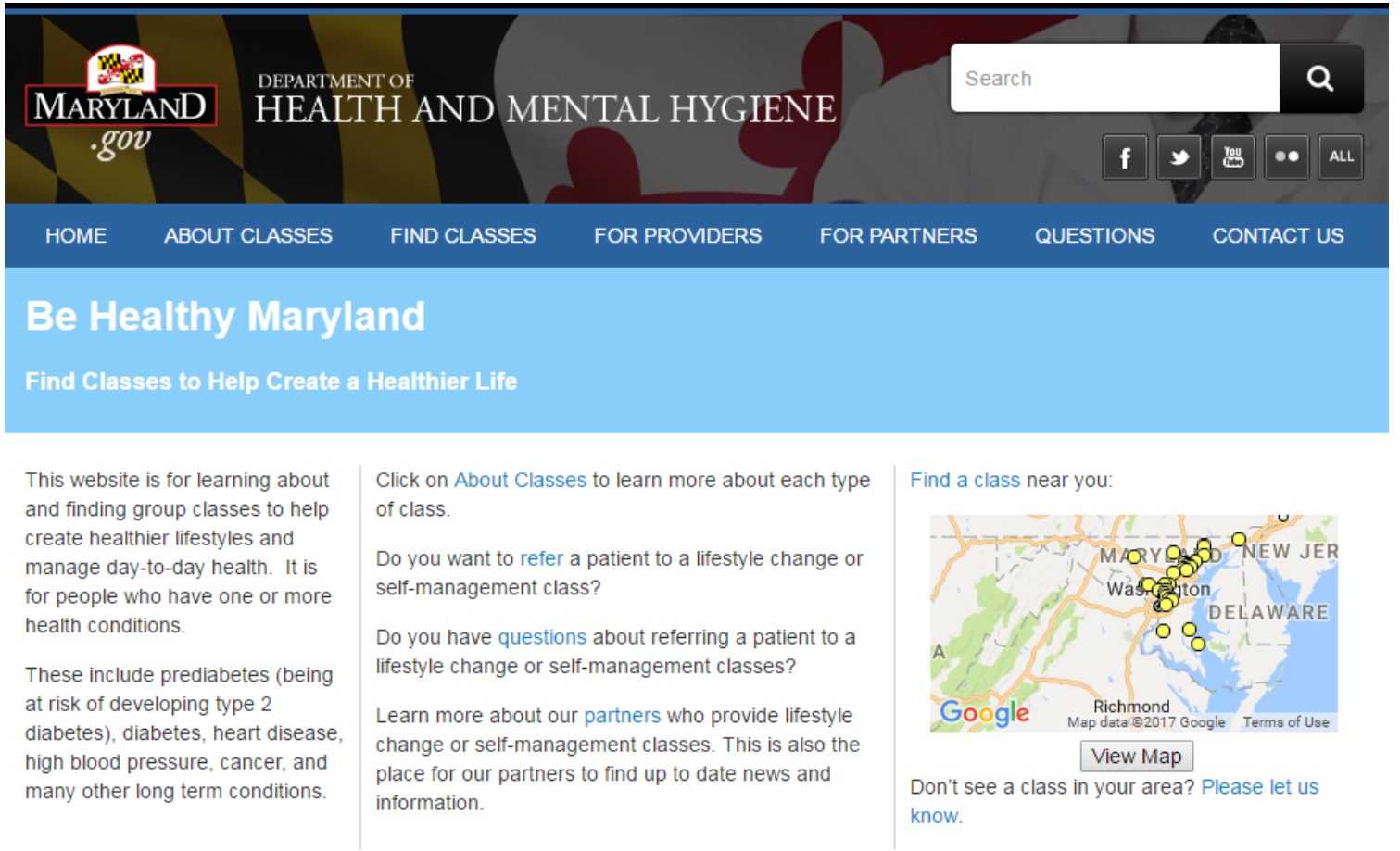
How to Access Evidence-Based Programs BeHealthyMaryland.org



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https://phpa.health.maryland.gov

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Eastern Shore
Wellness Solutions, Inc

The Inclusion of Community Health Workers in Diabetes Prevention and Self Management Programs

Ashyrra C. Dotson, President & CEO
Eastern Shore Wellness Solutions, Inc.

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Wellness Solutions, Inc

Objectives:

- To define the rural community, it's 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

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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

County Demographics

- 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

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County Demographics

- 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

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The Need in our Community

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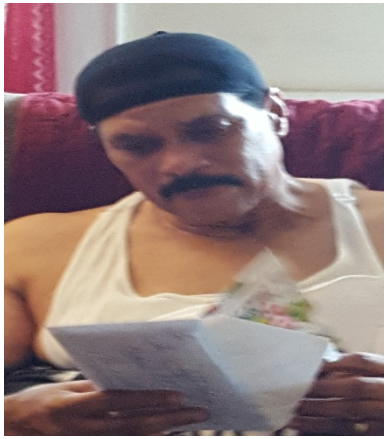
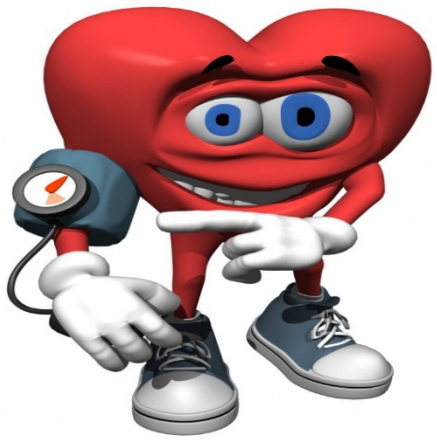


WHAT DID WE DO ?



Diabetes

Hypertension

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Community Health Workers

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- 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.

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CHW Integration– CHALLENGES

- 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

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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
- A 5.14% reduction in hospital recidivism for preventable Diabetes related issues between 2012 and 2017.

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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.

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Effective Solutions for CHW Interventions

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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
http://www.dhmh.maryland.gov/mhhd/Documents/MidShore%20Maryland%20Jurisdiction%20Level%20SHIP%20Disparity%20Charts%202012%2008%2016%20Final%20(1).pdf

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THANK YOU!

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Building a collective

Road to Health

LA CLÍNICA DEL PUEBLO

Suyanna Linhales Barker, DrPH
Senior Director of Health Equity and Community Action
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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

LA CLÍNICA DEL PUEBLO

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

LA CLÍNICA DEL PUEBLO

Programs and Services

Primary Care

Language Access

Mental Health
& Substance Use

Community
Health Action

VOLVIENDO A VIVIR
SUBSTANCE USE PROGRAM

ENTRE♀AMIGAS
HEALTH AND GENDER PROGRAM

EMPODÉRATE
LGBTQ HEALTH PROGRAM

MI REFUGIO
SCHOOL BASED PROGRAM

LA CLÍNICA EN
SU VECINDARIO

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

LA CLÍNICA DEL PUEBLO

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

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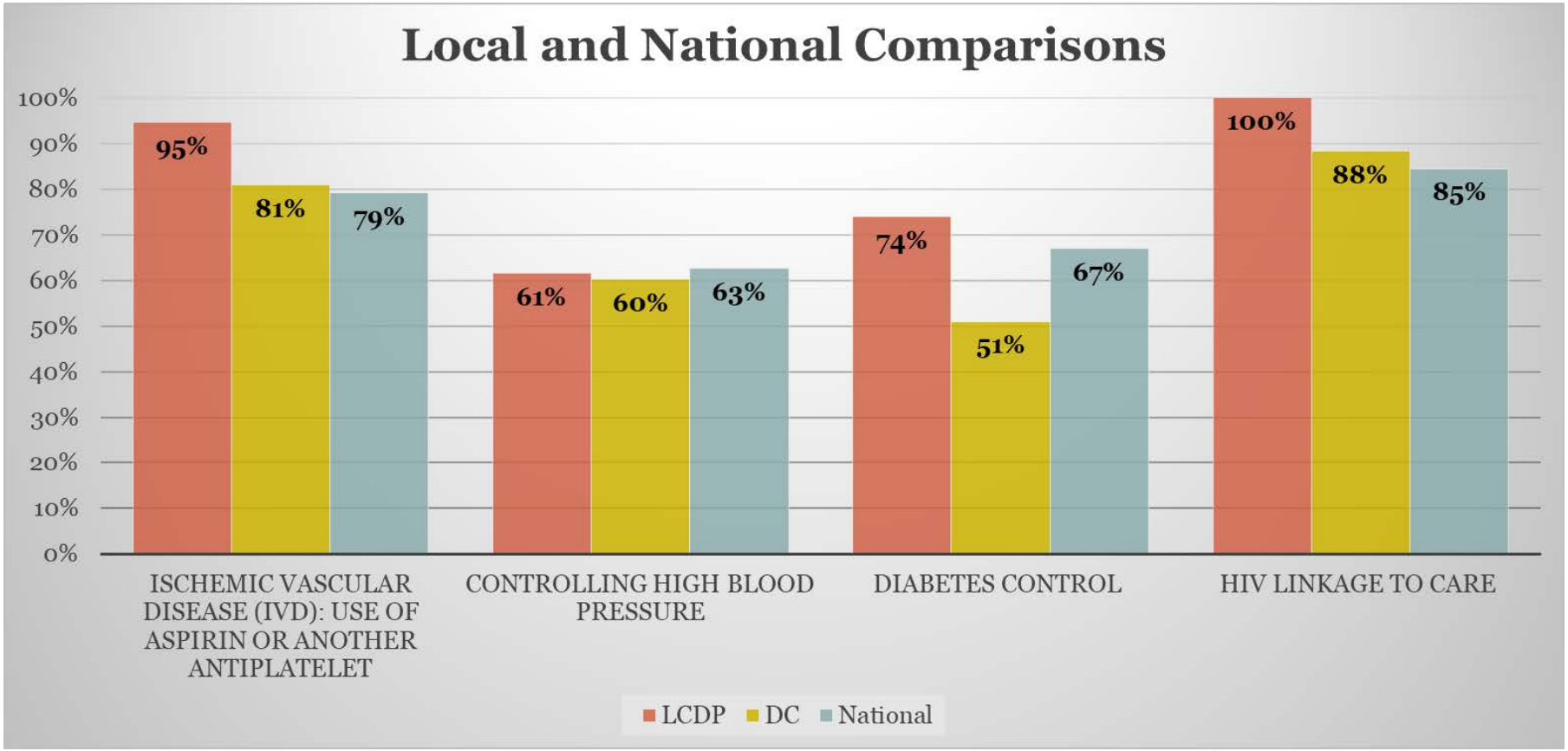
Results

Local and National Comparisons



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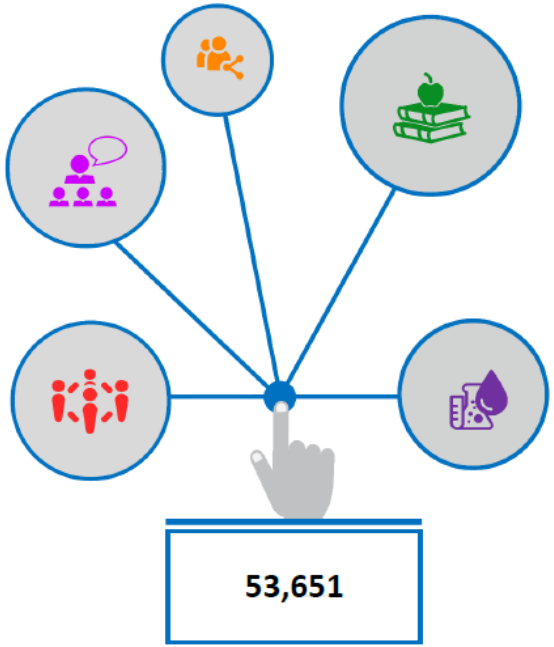
Community Health Action Touchpoints



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 TROUGH 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:

TOWER Patient Experience Consulting Group. (2012, April). Patient Engagement and Their Experience: The Virtual Touch Points [Whitepaper]. Retrieved from http://thielst.typepad.com/files/patient-engagement-and-their-experience-whitepaper-1.pdf

Healthcare Commercialization & Recruiting Solutions | Touchpoint. (2017). Retrieved from http://www.touchpointsolutions.com/

Tu Salud en Tus Manos:

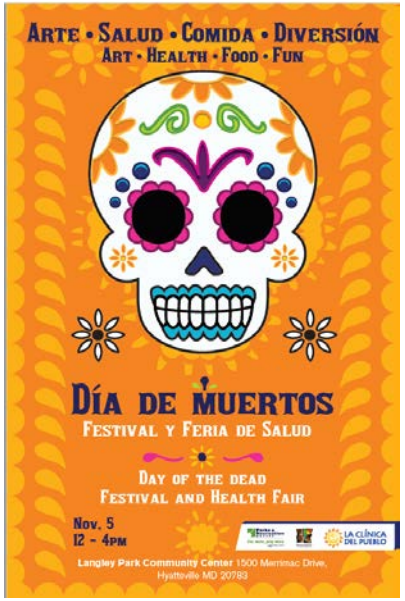
Peer-based obesity, diabetes, and cardiovascular disease prevention program for low-income, immigrant Latinos in Prince George's County.

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).



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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.

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Results

Year 1	Year 2
• Enrolled 22 participants in the behavior change program. • 19 participants attended at least four sessions. • 19 established lifestyle change goals. • The total weight lost was 134.2lbs. • Average of 7.1 lbs. per participant. • 5 individuals lost at least 10lbs. • 1 participant lost a total of 17lbs over the course of the intervention.	• Enrolled 17 participants in the behavior change program. • 17 participants attended at least four sessions • 15 established lifestyle change goals. • The total weight lost was 110.6lbs. • Average of 6.5lbs per participant. • 3 individuals lost at least 10lbs. • 1 individual lost a total of 20lbs over the course of the intervention.

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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.

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