CDC, Division of Diabetes Translation
Community Collaboration to Prevent and Manage Diabetes
Quick Learn

TRANSCRIPT

Welcome

Pam Allweiss: Hi, everybody. This is Pam Allweiss with the Division of Diabetes Translation at the CDC. 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.

Gretchen Piatt: 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.

Who Are Peer Leaders?

So who are the peer leaders? Peer leaders are people who live and work in the study 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.

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.

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.

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.

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.

Morgan Smith: Food Insecurity and Diabetes

We see that diabetes prevalence rates are also impacted by food-security status. So this chart shows data from NHANES 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.

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.

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.

Barbara Gordon: 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.

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?

Journeying for Change: Healthy Communities

And their mantra is, “Diabetes is personal, diabetes is about family, diabetes is about community, and so is health.” It is 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.