Men & Diabetes Webinar

July 24, 2019

Slide 1: Welcome

Operator: Excuse me, everyone; we now have all of our speakers in conference. Please be aware that each of your lines is in a listen-only mode. At this time, I would like to turn the conference over to Mr. Wayne Millington. Please go ahead, sir.

Slide 2: Wayne Millington's Bio

Wayne: Good afternoon, good morning, to viewers on the West Coast, Alaska, and Hawaii. Welcome to our webinar, Health Is a Team Sport: A Playbook for Engaging Men in Diabetes Prevention and Management. My name is Wayne Millington and I'm Senior Public Health Advisor in the Division of Diabetes Translation of the Centers for Disease Control and Prevention. I'm responsible for providing strategic direction on public health policy, programs, and practice.

Slide 3: Adobe Chat Box

I will be your moderator for today. Throughout the webinar, please feel free to submit questions via the chat box. We will do our best to respond to chat questions during the webinar and will follow up after the event as well. Presenters may also ask you to type answers in the chat box; you will see it at the upper right hand of your screen.

Slide 4: Edit My Info… To Include Affiliation

If you haven't included your affiliation after your name, please do so by selecting Edit My Info from the top right-hand corner of the attendees' box. You will then see a popup allowing you to edit your information. Making this change will help connect participants and let us know where you are joining from today.

Slide 5: Objectives for Today

Today's objectives are to recognize the challenges men face in preventing type 2 diabetes and/or living with diabetes, identify barriers for men's participation and retention in type 2 diabetes prevention and [diabetes] management programs, and to identify strategies to increase men's participation in type 2 diabetes prevention programs or diabetes self-management education and support [DSMES] programs/services.

Slide 6: Health Is a Team Sport: A Playbook for Engaging Men in Diabetes Prevention and Management

And now, let's get started with today's webinar. We've got fantastic guests today. Peter Simpson, Dr. Sal Giorgianni, Aaron Perry, and Darryl Davidson.

Slide 7: Input

Before I introduce our first presenter, we want to hear from you. What is the biggest challenge you face in engaging men in type 2 diabetes prevention or [diabetes] management? Please enter your thoughts in the chat box. Thank you for sharing. We hope to learn today about strategies that will help you with some of these concerns and barriers.

Slide 8: Peter Simpson's Bio

I would now like to introduce our first presenter. Peter has over 49 years of business experience in medical research in the health care arena. His client experience includes Johnson & Johnson, Boston Scientific, Medtronic, Pfizer, Roswell Park Cancer Institute, ConAgra, the American Medical Association, the Centers for Disease Control and Prevention, and many more companies and organizations. Peter's skills include strategic planning processes, branding issues, market segmentation, and health care marketing, and innovative marketing research. In over two decades of consulting with the health care industry, he

has conducted numerous research projects. In particular, he has worked on developing psychology-based based methodologies for medical market research.

Slide 9: Current Landscape: Men and Diabetes

Now I'd like to turn it over to Peter.

Peter: Thank you, Wayne. And my greetings to everyone today. Thank you for being here. This is going to be in two sections. The first is going to be a look at epidemiological and demographic information. And then, we're going to look at psychological information. And as we do those two things, we're going to kind of build a picture of risk and issues, as it relates to men of particular demographic backgrounds.

Slide 10: 30.3 Million People…

So let's start right away. What is the size of the problem? I think we all are aware that about 30 million people are thought to have type 2 diabetes in this country, of whom about one-fourth are unaware of the fact. And this adds up to about 12 to 12.2% of the total adult population.

Slide 11: Diagnosed Diabetes by Race/Ethnicity

In most cases, men and women—when we look at prevalence numbers—are not that different between the two genders. Not within statistical significance, as we can see here. So we actually need to build a picture of men, and men's other demographic and psychological features, which puts them at a greater risk. We will certainly see that education is a strong marker.

Slide 12: Is Diabetes a Male and Ethnic Issue?

And in fact, if we look at this slide, the left-hand panel demonstrates that we have nearly double the incidence amongst people with lower level of education, less than high school, than those people with more than high school. And across a lot of research projects that we conducted at xsperient, we found this to be

very consistent. Looking at the middle panel, there isn't a great deal of difference between men and women in terms of diagnosed levels, but there seems to be a higher difference in terms of the estimated undiagnosed amount. And on the right-hand panel we can see that outside of the white Caucasian and Asian populations, different ethnicities have between 50 and 100% greater level of incidence of type 2 diabetes.

Slide 13: Participation in a National Diabetes Prevention Program Lifestyle Change Program by Gender

And of course, I think again we are mostly all aware of this, that in the National Diabetes Prevention Program [National DPP] only one-fourth of those who enter the program or persist in the program are male. And there are probably a lot of different reasons for this. As we build up our picture of men, let's try to kind of think about that.

Slide 14: Prediabetes is the Gateway to Type 2 Diabetes

So when it gets to prediabetes, we have to recognize that there are many more people who are not aware of their situation. In fact, of the estimated 84 million people with prediabetes, we think only 10% have an awareness of that. But awareness is much lower among men than women. And we'll start to see some of the reasons why that is.

Slide 15: Diabetes, Obesity, and Food Deserts Largely Overlap

And finally, in the demographics—these are heat maps from the CDC; they're at the county level. The left-hand one shows the incidence of clinically diagnosed obesity. Actually, I should say the prevalence. The center one shows the prevalence of type 2 diabetes. And the right-hand one shows food deserts. And food desert as we know is not a place. A food desert is a person who lives [an area where a person lives] more than a mile from a grocery store and does not have some form of personal transportation. And it's

reasonable to suppose that the prediabetes maps out the same way. So not only are gender, ethnicity, and education risk factors, [but] location and income are risk factors as well.

Slide 16: Prediabetes: The Journey

So as we build up this picture, we can see that, as well as being male is not particularly [a] bad thing, but being an older male, being a poorer male, being a male in certain locations, and being a male of color—these are highly cumulative risk factors as I'm sure other panelists will agree and speak to. This flow map is from my company's prediabetes study from last year. And I'd like to start and just focus at the top middle, where it says diagnosed with little explanation. And what we find is that when primary care physicians are advising patients with prediabetes and diabetes, in the most cases and with some honorable exceptions, they make a very poor job of it. The conversation immediately becomes one of obesity; it leaves patients feeling criminalized and victimized, feeling that they are being told—and maybe they are being told—that they lack self-control and self-respect. They can't keep their promises. And so the dotted wavy line shows a very small number [who], with PCP [primary care provider] and other practice staff support, find their way to a dietitian, to a program, to be prescribed with metformin, to compliance with these things and leading to a maintenance or reduction of A1C. And there were certainly quite a lot of cases where people back[ed] out of prediabetes in this way and I can attest to this, because I'm one of them. However, most people move to the top right, they get a wake-up call, they get brief levels of motivation. They try different things [and] usually fail. And they enter into a vicious circle of failure and depression with sometimes tangible impact on their mental health.

Slide 17: The Health Care System is Largely Ineffective

So as we move forward and see what doctors actually recommend, from the studies that we have conducted, two-thirds of patients who have prediabetes are simply told to lose weight, without any specificity to that recommendation. Nearly 40% are given information to take home and read. About a quarter are

asked to test their blood sugar, and further research has shown that's where they're at or below [above] their normal or their ideal weight, which of course causes the physician to be clinically much more concerned about them. And a quarter are asked to see a nutritionist, but again with normally no specificity as to which nutritionist to see. And so on, down the line. Less than a half say that their physician discusses their prediabetes with them on every visit. And a quarter say their physician discusses very rarely. And when we talk to physicians about this, it's clear that they feel unequipped, untrained, they don't have the time, or even that it's not their job to bring about behavioral change. And that's why so many patients fall into this depressive vicious circle. And we find that diagnosis doesn't drive better behavior.

Slide 18: Diagnosis Does Not Drive Better Behavior

So on this bar chart, on the left of each cluster, we see people with type 2 diabetes; in the middle, with diagnosed prediabetes; [and] on the right, a balanced sample of consumers who have neither, as far as they know. And you see that there is a marginal but distinct tendency for those with type 2 diabetes and prediabetes still to favor a high level of carb intake into their diet. And in fact, when you get granular about things like added sugar, you find that actually is an increasing tendency for that to be the case.

Slide 19: Men and Women are Different

So as we think about men and women, men are, from our studies, less likely to go for an annual checkup with their primary [health care provider]. Less likely to visit with some illness or concern. Less likely to use a walk-in clinic, although certainly they favor walk-in clinics for reasons we'll come to at the end. And they spend less time researching their physicians. And as we move to the bottom bullet, they have a lower regard for the US health care system by quite a large level. The only positive thing we can say is they are more comfortable in taking medications than women are. So they're less concerned about their health, or at least that manifests itself less in proactivity.

Slide 20: Men and Women's Prediabetes Experience is Different

Women's prediabetes experience too is different. Women are much more likely to report having received a diagnosis of obesity and the diagnosis of anxiety. Women are much more likely to report attendance, as we know, to a prevention program [or] in our studies too, other forms of help, such as using in-grocery-store dietitians. Men are more likely to know their numbers. They're more likely to know their A1C score. Women are more likely to know the directionality of that score, whether it's getting better or worse, or what the significance of that score might be.

Slide 21: Quote

So this is one of our company heroes, Sir William Osler, the great Canadian teaching physician. He was one of the founders of Johns Hopkins Hospital in Baltimore. And he taught—120 years ago—that it's more important to know what kind of patient has a disease than what kind of disease the patient has.

Slide 22: Input

And that is what we're going to focus [on] for the rest of my input. So at this point we're just going to pause and ask you to answer a question. What percentage of individuals with prediabetes say that their physician discusses it with them on every visit? Can you make some input to that? Okay, so I think it's interesting and very meaningful that 50% of you voted for 18%; the number that I showed in my studies was actually 44. But I think it's very characteristic of what you consider the problem to be. And your focus is in the right direction, you're erring in the right direction.

Slide 23: PersonaSmart™ Personality Based Health Care Engagement Model

So let's move along. I want to talk about personality. This is our PersonaSmart™ Personality-Based Health Care Engagement Model. It's based on a globally validated personality assessment model. And what it tells us is that about 10% of the population (on the left-hand side there, the Proactives) are people who face up

to a diagnosis. They work on a disease. They have internal locus of control. They use their physician as a resource. The next group, about 25%, want to be good patients, but they want to live most of the time as if everything was normal. That's why we call them Seeks Normality. They will give themselves drug holidays. They will take time off from seeing their doctor or getting their labs. They will be episodically engaged with any disease. And that, of course, includes diabetes. The Hopefuls, about 35%, just are fatalistic. They just hope things will turn out okay. They'll rely on their doctor, they'll rely on God, they'll rely on their family. They think of themselves as being normal people; it's just their body is sick. And finally, about 30% are absolute Avoiders. They just do not want to deal with this at any notion. So we start to see that the combination of being male, poor, ethnic, and to the right-hand side of this scale, which is essentially one of self-efficacy—that's a very bad place to be. That's accumulated risk factor[s]. And we can use these types through any kind of behavior model we want.

Slide 24: Transtheoretical Model of Health Care Behavioral Change

This is the old Transtheoretical Model of [Health Care Behavioral] Change. It dates back 50 or 60 years. I think it's still a good one. And it shows how people go through a process in changing their behavior, also with relapses and restarts. And it's very important to know two things when you're designing a program: one is what kind of person you are dealing with, and the other one is what stage are they at in their behavioral change process.

Slide 25: Summary

So let me summarize. These are stereotypes. These are buckets, all right? There are 7.7 billion people on earth, and we try to squeeze them into four buckets. There's a high level of generalization. Do the math, right? So we know these things, and they may not apply to every individual. But when we're looking to engage men on health care, we need to know where they stand in terms of their engagement overall, and their level of self-efficacy. We need to remember that men look after their cars like women look after their

bodies, and women look after their cars like men look after their bodies. And it's very sexist, but my excuse is that a doctor told me that. Men tend to deny conditions and think of obesity and diabetes as being normal. Not even an illness necessarily. Certainly obesity. And they want to seek convenient solutions. So health hubs—in-store clinics—are most popular among men between 25 and 50 years old who could park easily, get seen quickly, and probably by a woman who will sympathize with them. So in and out. So we need to think about that and remember that men are going to seek convenience. And this is maybe one of the reasons why they don't want to attend the [National] DPP. They may just actually want something that's much simpler. So that's a summary of what I've had to say, and I'm happy now to hand back to Wayne.

Slide 26: Barriers: Men and Diabetes

Wayne: Thank you, Peter. We will now discuss the barriers to engaging men in type 2 diabetes prevention and diabetes management. But before we move forward, I would just like to recap the first question we had and some of the challenges that we face. And thanks for your input. We have a number of really great insights into some of the challenges we face. We had one talk about how do we access the readiness to change and [the] want to change. We also have one regarding never wanting to ask or upset a system. Marketing and referrals—how do we deal with that? Also recognizing the problem and willingness to participate. And getting there. How do we get men to join a class that's full of women? I think that was one of the most interesting ones. But we will get into that a little bit later on.

Slide 27: Dr. Sal Giorgianni's Bio

I would now like to introduce Dr. Sal Giorgianni. Dr. Giorgianni received his bachelor's and Doctor of Pharmacy degrees from Columbia University. He has extensive experience in all aspects of [the] practice of pharmacy and has held faculty appointments at Columbia and Belmont University. Dr. Giorgianni is a licensed pharmacist in his home state of New York and in Florida. He holds both general and consultant

pharmacist licenses. Dr. Giorgianni's professional career includes 27 years at Pfizer Headquarters in New York City, where he held various responsibilities in the medical, regulatory affairs, corporate planning, and marketing groups. He currently is senior scientific advisor for their National Men's Health Network and cofounder and Chair Emeritus of the American Public Health Association section on men's health. He is author of over 70 publications and scientific presentations and is an editor/reviewer for the *American Journal of Men's Health*. He is a recognized expert on effects of culture, advertisement, socialization, and male perceptions of health and wellness and is a frequent speaker on this topic. He practiced clinical pharmacy with [an] emphasis on medication adherence, as part of a family medicine practice owned by his physician son in Florida. I will now turn it over to Dr. Giorgianni.

Slide 28: Men's Health Network

Dr. Giorgianni: Thank you for that lovely introduction. I appreciate it. I found some of the questions or issues that people face very important. Those of rapport, getting men to join groups, and go[ing] to get care. And getting physicians to refer men. So hopefully the next couple of minutes I'll spend giving you some of the background and some of the perspectives that I and my colleagues at Men's Health Network feel are at play here. A little bit about the Men's Health Network. We're celebrating about 25 years; I've been working with them for about 15 years. And Men's Health Network is the largest and oldest health advocacy organization that covers the spectrum of health care issues across the lifespan for boys and men, and across all sorts of medical conditions, as well as wellness. Men's Health Network likes to say their motto is to help men and boys become healthier where they live, work, play, and pray. Part of our expertise, and that's I guess why we're asked to present a little bit here, is engagement in health and wellness. We know how to do that. We've been very successful in developing programs, projects, practices, and helping other organizations engage boys and men in a meaningful way. So that's a little bit about the Men's Health Network.

Slide 29: Men and their Health

In the next slide, we'll talk about men and their health. One of the areas that I find very interesting—and I think it's a little bit of a byproduct from my work at Pfizer—is to view how the media shapes the opinions of boys and men, and of young women, girls, and women, about health and health care. At the same time, we look at how social structures in media can affect [people], and we can't ignore a couple million years of evolutionary history because men do and will always look at themselves as hunters and gatherers. Not so much as caregivers unless they go into a caregiving profession. But then when they come out and they're home, they still sort of take on the role of hunter gatherers. So we have to temper our view of what is realistic for men and how we provide information and incentivize men and make, develop that rapport with men there. When you look at some of the factors that men tell us in general, not just for diabetes, why they don't want to seek health care—it makes them look weak—whether that's in the work environment or social clubs. And it makes them look weak, and it doesn't advance any of their careers. Men are acculturated from a very young age to disregard wellness. You can see some of the phrases that are particularly prevalent. And that I think [these phrases] also help shape the view of boys, men, and young girls, when they hear these [phrases] being thrown at young boys.

Slide 30: Media and Male Perceptions of Role in Health

In the next slide, I present a little bit of the information on male perspectives. In the media, males are generally viewed in an action role. Men who care about health are often, unfortunately, portrayed as uncool. Men and boys do not read about health as often as women do. And much of the advertising that's directed to [the] American public is characterized in context of women, rather than men. This is a little study that I and some of my associates of Belmont University in Nashville did that looked at the health advertising [and] print advertising in magazines. And you can see the dominant themes and whether they be graphically, verbally, or otherwise were geared towards men, I mean, towards women. And that was my generalized experience at Pfizer as well. I found that most advertising executives within the corporation

(I was in a medical group much of my time there), view the drivers of health care decision-making as women. And so they geared much of what we did toward women. So when you're looking for reasons why maybe it's a little bit difficult to get through to the guys, or to try and understand women [health care] providers or even male health care providers, who consider [reaching men to help them manage their] health a very important part [of providing health care], an almost generalist in the health care provider market, it's a little difficult for us to understand when we see some of these issues and how men are barraged with these anti-wellness messages.

Slide 31: Health Care System is not "Men-Friendly"

In the next slide we talk a little bit about the health care system. Well, it's not friendly to men. That's something that Men's Health Network and I try to correct. I know in my son's practice, we try to be a little more male-friendly and try to adapt what we do to the men. It's not enough to really take a generalized program that has worked well with women and sort of make it blue and turn it on, so you've got to [create it for men from the start]. And we've learned that at Men's Health Network over years of experience in crafting messaging, programing, outreach efforts, and even policy. It's got to be done for the guys at the outset. It's [a] really important point for all of you who are looking to bring men into the programs. Men like their messages a little bit differently. You can't help the fact that men health care providers are gender-based acculturated themselves. So while they tend to look at health care very differently and wellness very differently than the general population, we all are subject to evolution and just social context. One of the areas Men's Health Network looks [at] from a policy perspective to change is [there are] few resources for men and boys out there. There's no federal office of men's health. There are very few state offices of men's health. Very few are funded, when you look—and I've done a series of surveys, along with some colleagues at Men's Health Network and others, that look at state public health department's ability or programs to reach men and boys. There's not an awful lot out there. There are no men's hospitals. And unfortunately, a lot of […]; there's not a funding source for

men-focused health research. And Men's Health Network is trying to change that vigorously. In the next [slide], one other point on this slide before we move [on], back, one slide back please.

We've done studies published with Demetrius Porche who was the dean at the medical school at LSU [Louisiana State University], a survey of programs that offer men's health-specific curricula. There are very, very few. In fact, one of our advisors has told us that on the family practice boards, there are two questions that are oriented to men's health specifically. Both of them have to deal with—guess what? Prostate cancer, rather than overall male-directed health issues. So here again, the training—we think that there is a lapse in training and there is no defined specialty for men's health, per se. And the next slide, ….

Slide 32: Health Care System is not "Men-Friendly"

There we go. I won't reiterate the information that Peter so aptly presented before, but just to reinforce that the men really don't engage [in] the health care system as frequently as women do. They can't identify a regular physician. And very importantly, that 1, 2, 3, 4, 5th point down there—men wait much longer to see physicians when symptoms occur, and that often complicates treatment. And then there are several studies (I'm sure you can all look them up and get lots of staggering strategic statistics), which show that men do not come to diabetes care until much later on than do women. And I think that's also reflected and embedded in some of the information that was previously presented to you in the initial diabetes study. So I think the issue is the underdiagnosed, or the untreated guy. Next slide.

Slide 33: Stigma of Disease…

The stigma of disease is a very important and difficult issue for men. I talked a little bit about how men who have medical conditions or who have to go into the men's room to take an insulin shot, or who can't engage in a full diet, you know, if they're a hard-charging business executive at any major corporation in the world. Or even smaller corporations. You know they really have a very difficult time dealing with some

of the restrictions that they have because of the stigma of looking weak. And I think that is a very difficult, sociologic, sociocultural context for health care providers to overcome. We see this in women in some conditions, but in conditions such as diabetes, metabolic conditions, I don't think it is as prevalent as it is in many given men [men who are working in executive or leadership positions]. Now, I don't know that there's been a study looking at career women to see if this issue with stigma is as prominent [as it is] in boys and men. But it certainly would be an intriguing kind of study for someone to do. Next one.

Slide 34: The Uncomfortable Truth About Boys and Men and Health…

The uncomfortable truth about boys and men and health is that … in the next slide.

Slide 35: "We have Met the Enemy and He is Us"

We have met the enemy, and it's the guys. When I speak to groups out there, I often talk about the fact that men really need to take a page out of the women's health playbook from the 1960s and '70s, and they have to make their health care their issue. And the next slide, there's a couple of suggestions.

Slide 36: Age Adjusted Death Rate in US for Diabetes

Oh, yeah, I'm sorry this got plopped in there. It probably looks a little bit out [of] order, my mistake. As Peter spoke a little bit about how there's some, there's non-differences in men and women in diabetes, but when you look at the bottom line, the adjusted death rate for diabetes [of] all types from CDC data is significantly higher in men than in women; the ratio of 1.54, men greater than women. So whatever is going on, when the cause of death is attributable, the age-adjusted death rate to men for diabetes is much higher. And that, I think, reflects on the number of men who come into treatment and then leave it, or never come in at all. Next slide.

Slide 37: Prevention and Awareness at Early Age Can Help to Counterbalance Anti-Health Acculturation

What can you do? There are lots of opportunities to engage men and boys in health care practices. I think if we had a male, boys', or men's health specialty, it would be a lot easier. We in Men's Health Network, and I in particular, feel that family physicians are uniquely in a position to be able to provide that kind of information and that kind of life across the lifespan and across all of medical conditions […] health of boys and men. But yet they're not recognized, and they don't have many men, many physicians in the men's health practice. Using sports physicals is one technique that family physicians who focus on guys use to get boys engaged in health care early on. Multi-system screening programs. You know we all talk about treating all of the conditions at one point and not just focusing on one thing at a time. Guys like that sort of physician. Once you get them engaged in their health, you've got to try to help them fix everything. Careful approach to discussion of prediabetes. There was an interesting discussion before. I think Peter used the words that when men get a diagnosis of prediabetes or some other conditions, they feel criminalized. They can't, they are stigmatized, that they can't control themselves. And guys hate being out of control. So one caution to all the clinicians out there, and we tried this in my practice, is carefully approach the way you talk about prediabetes. So you don't want to drive the guys away; you want to engage them in becoming engaged in their care. Not scaring them or making them, you know, try to minimize the stigma issue. Use educational tools, I covered this before, designed for boys and men. You just can't take something that's worked for women and just, you know, put a little different picture on it. You've got to think about how to approach boys and men from the onset. Boys and men like a little bit of humor with their health care. And they really like to engage in their health care as guys. Many of the people—I think our next speaker will talk a little bit about that—like to have their health care [as] "just guy" sessions. Try guy sessions rather than sessions for women and men. Just like, you know, [the] very popular women's only exercise facilities. I think we can see some very popular programs just for men.

Slide 38: Linking Treatment…

And the last slide, the most influential tool of all is to try to make covenants with patients. We all know the strong links between diabetes and other metabolic conditions—with erectile dysfunction, testosterone levels, and other conditions that the guys traditionally care a lot about. So if you can try to make a linkage between treating what's important to the guy—and certainly ED is important to many, especially [men] over their 50s, I think you'll have a lot more success in treating the guys.

Slide 39: Become Involved At The Community/Workplace Arena

And that's it.

Slide 40: Input

Yeah, we'll just leave that slide up there if any questions come up. I think I covered all the material there. And my time's up.

Wayne: Great. Thank you Dr. Giorgianni. Before I introduce our last presenter, we have another opportunity for you to share your input. What is the top marketing strategy you have found to be helpful to reach men about programs and services for diabetes? Thank you. One interesting idea was [through] the advertisement of food.

Slide 41: Aaron Perry's Bio

So as we move forward, I would now like to introduce our last two presenters. Aaron is the president of Rebalanced-Life Wellness Association, whose goal is ensuring that African American males who live in underrepresented communities live fuller and healthier lives. Aaron is a former police officer and a current member of [the] Dane County Gang Response Intervention Team. Aaron was diagnosed with type 1 diabetes at age 29 and since then has become a leading health advocate focusing on preventing chronic health condition[s] in black men and boys. At the age of 44, Aaron became the world's first insulin-dependent person with type 1 diabetes to ever complete the Ironman Triathlon. In 2016, Aaron

opened the nation's first Men's Health and Education Center located inside the City of Madison's largest black barbershop. And in 2018, he was selected as one of *Time* magazine's "The Health Care 50 – Thinking Outside the Hospital."

Slide 42: Darryl Davidson's Bio

Presenting with Aaron will be Darryl Davidson. Darryl is the Men's Health Manager at the City of Milwaukee's Health Department. He oversees programs, preventative education, and outreach activities related to teen males and men. He achieved one of his public health career goals when he helped establish a men's health center as the entry point to address various issues that affect male health. He values client-centered approaches when solving problems when it concerns clinical disease, and family and community health. Darryl attributes his past work in sexual health, HIV education, adolescent health, and domestic violence prevention as the glue that allows success in his present activities. He's a member of the National Men's Health Network and the Wisconsin Public Health Association and a founding member of the American Public Health Association Men's Health Caucus. He's also a program co-chair with the Milwaukee Fatherhood Initiative Annual Fatherhood Summit.

Slide 43: Example Program: Men and Diabetes

Now, I will turn things over to Aaron and Darryl.

Aaron: Thank you, Wayne. And thank you to everybody that's participating. Today, Darryl and I will share our experiences with successfully engaging men in diabetes care. For me at age 29, actually I was diagnosed with type 2 diabetes and I lived with that diagnosis for two years. [I] definitely was not getting better. My health care, and what was being prescribed, was not working. However, at age 31, I was properly diagnosed with type 1 diabetes. And I share that with you because I had to become an advocate for my own health. And when you receive pushback from patients—please, please, you know, keep in mind that sometimes what is being prescribed is not working. And so that pushback is from the patient

because we know that something is not right. I became a health advocate representing the diabetes community throughout the state of Wisconsin and narrowed my focus to black boys and men specific to Madison, Wisconsin, Dane County. This was the first and most important thing that I did. I was engaged with the Madison Dane County Public Health Department to commission a report titled "The Social and Health Conditions of Black Males." The 2018 census places [the] Dane County population at about 542,000 residents. However, what was helpful to us is to understand that black males in Dane County accounted for 6% of the male population. There are 15,600 of us. And I share that because that, again, knowing what you're working with in terms of the number of people that are in the community was very important.

Slide 44: Understanding Diabetes

So education, income, and where we live—if you go to the next slide—where we live are as important to our health as our behavior, health care, and genetics combined. In Wisconsin, black males' life expectancy is 7 years shorter than white males. In addition, African Americans in Dane County suffer higher rates of cancer, obesity, and diabetes, as compared to whites. Helping us to navigate barriers, if you want to go to the next slide.

Slide 45: Barriers

Helping us navigate barriers such as fear, shame, lack of trust. We also engage with community partners here in Madison, Wisconsin. FSM Health and the Wisconsin Partnership Program, which is part of the University of Wisconsin School of Medicine and Public Health, as health advocates, we all combine together to understand the data from community partners, and then we coordinated a series of listening sessions with black men and boys from a location that they're comfortable, that they trust. And this led us to the city of Madison's largest black barbershop. If you want to go to the next slide.

Slide 46: Photos

Here, more than 1,700 black men expressed a very strong desire to us to be educated about their health outside of the health care facilities. And we listened to that very important 1,700. So in 2016, we opened the nation's first Men's Health and Education Center inside of Madison's largest barbershop. And in this location, we are able to do a lot of preventative health screening. We have also pinpointed a significant number of men living with diabetes in our community. And this is by understanding what the zip codes are in our area. And more importantly, just listening to our men. We are 100% clientele-centered. That is the approach that we take. The majority of what we do is about listening to what our men state they need. But in this Men's Health and Education Center, we can do daily blood pressure screening, diabetes testing, oral health care, (free oral health care), [and] flu shots. We do insurance enrollment and we recently added a mental health counselor, as well as a substance abuse counselor. We do [a] yoga class for men, adult men. And we also do yoga classes for middle school boys. Diabetes patients with depression have poor adherence to self-management behaviors compared to those without depression. And so, these are some of the areas that we are going to continue to push forward in terms of engaging and breaking through the many barriers that we see that are present with our men's health. Go to the next slide please. Thank you.

Slide 47: The Diabetes Project: Milwaukee, Wisconsin

Darryl: In Milwaukee, Wisconsin, we have what's called our Men's Health Center which is located in three different parts of the city. And each one of them is a one-stop shop for Milwaukee men. It has availability of health education in groups [and] health education for individual sessions. We're also doing health insurance enrollment, and we're tailoring the services to meet their needs based on assessment. One of the needs that came out of the assessments was the need for getting trained educators in the Healthy Living with Diabetes curriculum. The Healthy Living with Diabetes curriculum is a model self-management program developed by Stanford University. And it was designed for individuals with type 1 diabetes, type 2, as well as prediabetes or for those who live with or care for individuals with diabetes.

We're doing this activity in partnership with the Wisconsin Institute for Healthy Aging and the Milwaukee Housing Authority. These classes are 2.5 hours once a week for six weeks, with a seventh session. And keeping the philosophy of what the Men's Health Network has [done], we're trying to reach men where they live, work, play, and pray. So we're scheduling these sessions around lunch. We're scheduling the sessions around dinner. Whenever the men are available. We've set it up with the housing authority so that the men who live in those facilities can come downstairs and listen to us. We have pre-sessions in case they don't, [if] their schedules don't match our sessions. And we also have make-up session[s] for them.

Slide 48: The Diabetes Project: Milwaukee, Wisconsin

The other activity that we're very proud of is sustained eye screening using mobile teleophthalmology. And the Men's Health Program here in Milwaukee is a team member of the TeleEye Health Collaborative, which includes the Medical College of Wisconsin, our community organization titled the United Community Center on the south side of Milwaukee, our City of Milwaukee Well Woman's Program, Carroll University, and Marquette University. And so all of these project partners are available to assist each other in implementing a new sustainable eye disease screening system using a mobile unit. It's a device that can detect early signs of diabetes and prediabetes. It's a noninvasive camera. It's just like going to the optometrist's [or] ophthalmologist's office and they take a picture. That picture is sent to the ophthalmologist who is working on our team. And then there is a diagnosis made mobiley [via sharing on a mobile device] based on what the image is saying. And when we receive the image again, we're able to let the individual know if they need to come back for another recommendation.

Slide 49: The Diabetes Project: Milwaukee, Wisconsin

We have the ophthalmologists who are at the Medical College of Wisconsin, and a local hospital who assists us with any type of information that might be of great concern to the people who participate in this

program. Now our diabetic retinopathy project has provided over 800 screenings and identified early stages of diabetes using this as an entry point to address other preventive health concerns. Because just as we can see what type of influence diabetes has had on the retina, or any of the other elements in the eye, it can also discern if a person has high cholesterol. It can tell if someone has other types of damages. And this can be done at an early level. So, we have a men's health nurse, men's health educator, and they're trained to do a screening as well as do the A1C screening. The A1C is a blood test that reflects your average blood glucose levels over the past three months. They are available at our Men's Health Centers. And we make a conscious effort to identify men in every community, but we have a special focus on our African American males because diabetes is one of the leading causes of blindness, heart disease, and stroke in our community. So, we are trying to close the gaps required by meeting people where they are and by working through relationships that they've already established. So those could be social relationships, church relationships, or even family relationships.

Slide 50: Health Care Disparities are Impacted by Social Determinants of Health…

So the health care disparities—they exist. Racial health disparities. Educational levels make a difference. Employment, housing, income levels. Access to community resources. We see a variety of those health care disparities coming from numerous social determinants of health. And so we're trying to address them in as many ways as we can. And even when we're doing publicity around our events and outreach, we always make sure to have male images or at the very least in the locations where we have these events, we try to bring images of positive male health and men in activities related to health so that people can make that the standard.

Slide 51: Engaging Black Men in Activities - Building Social Cohesion

Aaron: And to piggyback off of what Darryl is indicating, closing the gap requires meeting people where they are and establishing relationships. And by having our Men's Health and Education Center located in the

barbershop, we've engaged our barbers, we've trained them on how to do blood pressure screening. We've brought in health care professionals and physicians from the community that help train them on certain signs to look for in terms of lines on the back of the neck. Zeroing in when the clientele talks about certain concerns that they have. And so a lot of these things have been very effective as we focus on engaging our men—particularly from a place that they trust, respect, and feel welcomed. The other activities that we do with our Black Men Run group, we build social cohesion, which we find is very important in our area. Right now, we have, we do daily runs. We do runs on the weekend where we have about 81 men that have successfully joined our running group. Of that 81 men, 27 are living their daily life with type 1 and type 2 diabetes. But we often have those discussions as we're running. But we focus on the chronic health condition, and also—what we're learning in this process is not only are men dealing with the diabetes type 1, type 2 diabetes. But they are also dealing with a significant number of other chronic health conditions. And so that's why we know that building that social cohesion and encouraging our men to talk about their health challenges really makes a significant difference. But we've seen some, you know, significant success with our Men's Health and Education Center as well as our community activities that we do with our African American men and boys in this area. Thank you.

Slide 52: Questions?

Wayne: Great, thank you. We shared some great information here today. Thank you, all of our presenters. I would like to invite all of our presenters back. Now I would ask if there's anything to add or to answer any of your questions. Please submit questions using the chat box on the right side of your screen. Great, looks like we have some questions. For Dr. Giorgianni or anyone who would like to share: I have a question. Are there any programs and practices that employ CHWs (community health workers) to work on diabetes and other men's health issues?

Dr. Giorgianni: That's a fabulous question. I think you just saw a great example of that from the two wonderful gentlemen in Milwaukee. Men's Health Network has actually developed [a] community health educators' program specifically designed for men. It goes into some of the sociocultural presentation styles and ways to do, as they've done in Milwaukee, create these programs in the context that's comfortable for the guys. So yeah, that is a program. I don't know of too many places where it's being done, quite frankly. We've done a few of these programs. They've been very well received where it's been done. And we are always willing to do more. And maybe Darryl or [his] colleague[s] can have a comment or two about that.

Darryl: Yes, as a matter of fact in Milwaukee we are using community health workers [CHWs] specifically with men's health for the areas of heart disease prevention and education, as well as for our smoking cessation project. We have classes here at our area health education centers. So, in the fall of 2019, they're going to be offering them from October to November. So if anyone is in the Midwest, I'd be happy to give that information to them. And we have two community health workers [CHWs] who are working with us on projects right now. We will be moving them into diabetes in the near future.

Wayne: Great, we've got another question. Do you know anyone currently that is delivering the [National] DPP successfully to men? And this is for anyone who may want to take a shot at this.

Dr. Giorgianni: Sorry, I can't comment on this, this is Dr. Giorgianni, sorry.

Wayne: Well, we will get back with you through our website on this particular question. We have another one: How responsive are men towards a female educator versus a male educator? Do they respond differently? How do men respond to female[s] versus men?

Dr. Giorgianni: This is Dr. Giorgianni. I'll take a first swipe at that. There's been some studies done on male to female communication in health care. Generally, they're equivocal and they don't show a huge difference. I will say though that men are not a homogeneous group; it's just it's very different. And I

think a lot of it is the approach that's taken. We have found in some work that I was engaged in at Pfizer that women providers are able to develop better rapport with men in some conditions, particularly in sexual health conditions. And usually the middle-aged female provider as opposed to a younger female provider. But I think that the context in which the information is delivered for most men is much more important than the gender identity and the gender of the person delivering that information. It will be interesting to hear what others have to comment on that.

Darryl: So go ahead.

Aaron: Yeah, what I can add is here in the barbershop with our Men's Health and Education Center we have partnered with the Edgewood College Nursing program and so we have about eight female nursing interns that come in. We also have three UW [University of Wisconsin] medical students—females—that come in and do a rotating schedule. What we found is that the environment that these men are in plays a critical part of that, because they are in a location—the barbershop—where they trust and respect. We do not see any concerns. And we've been doing this for three years and [have] yet to observe any concerns having our female students helping us out here. So I think more of it has to do with the environment and the location of where your program is at.

Dr. Giogianni: Great point. Yes, absolutely.

Darryl: So [in] the example that I was going to give… the lead educators in Milwaukee are all male and for the most part, they're African American male because we're primarily working with African American audiences. But there will be points in most of our long-term sessions when we will have a female instructor or subject matter expert who will come in. So independently we haven't really seen what type of effect they have on the audience, but I can say that they have been a wonderful addition to the information that we've shared with the audiences so far, and we're not noticing any type of negative reaction when we're getting our surveys back. I also want to address what came up before which was

related to some of the outcomes that we've experienced here. But we have seen improvements in A1C levels, [and] we've seen individuals improve self-identified health outcomes related to diabetes. We noticed that there's reduced distress around talking about the subject matter, and there's also a higher level of compliance after they've completed the Healthy Living with Diabetes workshops.

Wayne: We have another question for Dr. Giorgianni I believe. Do you have more [information on] types of education that works best on each of the four behavioral levels?

Dr. Giorgianni: I don't have anything specific. I do think I will totally agree that getting men actively involved in activities in places where they feel comfortable with are a key to success in any medical condition, getting them engaged. So I'm not an expert on behavioral levels. I would leave that pretty much for Peter to answer. I'd be interested in the answer myself.

Peter: I think that, as indicated in my remarks, that what's important is to understand that there are different personality types with different levels of self-efficacy. So it's important to think about men and boys. It's important to think about African American men and boys. But within those groups, we're getting to find different levels of ability to deal with things based on those individual personalities. So the only contribution I can make to this is to suggest that where possible, build in some very basic psycho profiling into the programs, so the programs can be modified, and interactions can be modified accordingly. It's not actually a difficult thing to do.

Dr. Giorgianni: That's a great kind of question for the folks at PCORI [Patient Centered Outcomes Research Institute] [of the] MHN [Men's Health Network] Village. We do work a lot with PCORI. That might be a fertile area for research for us, or anyone.

Wayne: Another question we have in the box is what are the best ways to address EDS [erectile dysfunction]?

Dr. Giorgianni: EDS? I'm sorry that acronym is for? I always tend to think of ED, as erectile dysfunction. EDS?

Wayne: Yes, I believe it is erectile dysfunction.

Dr. Giorgianni: Oh, okay. Straight out, I think that one of the conditions that men are always looking for a comfortable place to talk about ED is a practitioner who asks are you having any problems of this kind? Are you having erectile dysfunction? Or sometimes men with diabetes experience erectile dysfunction. So we have done a series of vignettes to help clinicians engage in that discussion in a 3-minute time period, which is usually a time that they feel comfortable dedicating to that condition. But, in general, men with that condition like to approach it head on. And I am very direct with them about it. And I think, again, studies we have done at Pfizer show that women [are] inquiring also. They get good, straight, and direct results—you know, responses. It is a trigger point for men to change their behavior. And I think, that is, you know, something just if you'll get yourself comfortable with asking that kind of a question. Practice with your colleagues asking—you know, are you noticing any erectile dysfunction? Sometimes it's a little uncomfortable for clinicians to do that, who are just not generally trained that way. But I do think it's something you can address.

Peter: And I would add, this is Peter Simpson, that studies that we've done in this area for pharmaceutical companies, where a patient doesn't bring the issue up in the middle of a meeting or during an appointment, it becomes an “oh, by the way” complaint. So the physician has put the pad in his pocket, has folded up his iPad, he's got his hand on the handle of the door, he's ready to leave. And “oh, by the way, doc. I'm having a problem.” And what happens then is almost inevitably a sample of Viagra is given. There's no actual discussion about the sexual experience that the man might want to have in distinguishing between Viagra and Cialis, in particular. It's important to understand that the pattern of sexual activity that the man is having difficulty with [or] is desiring and to get the right medication. And very often that doesn't happen for just that reason.

Dr. Giorgianni: That’s such a great point, and it was our experience as well. The second Viagra was launched, physicians couldn't wait to get out of the office quickly (some of them anyway). Because they weren't used to having that conversation. And what you say is so important. Because it's not just the right medication but setting the appropriate expectations for the patient and his partner about “how do we engage in sexual activity” if they've lost intimacy for several years. You may not be able to just—pardon the pun—jump right into it. You've got to sort of re-engage over a period of time. So that's another topic we can discuss another time, but I think it goes to the point of educating the patient [that] has to come with all of these disease conditions.

Wayne: So [does] leveraging technology—for example phone apps for engagement in [type 2] diabetes prevention or diabetes management programs—work?

Peter: This is Peter, I'd like to kick that one off if I may. According to IMS [IMS Institute for Healthcare Informatics], there are over 200,000 English language (actually a quarter of a million English language) health and wellness apps available in the US, and about half are intended for consumers and half for professionals. Twelve percent of them account for 90% of the downloads, and the average use time is between 3 and 5 weeks. And we've done a lot of testing for pharma and device companies and for health plans and hospital groups and this kind of thing. And one of the things that we find is that people don't want and won't use an app that deals with just one aspect of a condition. So they don't want an app that helps them measure their carbs or their calorie intake or their sugar intake, and another one that helps them manage their insulin, or another one that reminds them to take their metformin, or whatever it might be. There's a tremendous demand for convenient apps that not only would deal with most aspects of one condition, but actually will cover their comorbidities as well. And there's lots of commercial companies out there working on [and] trying to develop that kind of modular software which we believe will be very much more successful than single use apps today.

Dr. Giorgianni: And I tend to agree with that as well. As I mentioned during the presentation, try to integrate care across all disease conditions. My view is that the issue on telehealth—the assessment of the outcomes for telehealth—the jury's still out, it's a pretty new technology. I don't think it's just apps alone. I think the extension of that are telehealth programs, telephonic chronic care management programs, which we do in my son's practice, [and] home health care visits, which also we do in my son's practice. So I think that you know there are lots of other modalities to reach out to patients outside the traditional office. The kinds of programs that are being done in Milwaukee. Those are all things where there's a huge need for outcomes work on both men and women to see whether these things work or not. But in telehealth in general, I think there's a bright future, but a lot of things, particularly reimbursement, that have to be addressed before we really can reach its potential.

Darryl: And in order to at least address the cultural shift, what we're starting to do is ask questions related to what type of technology that a person might be familiar with and that they might be comfortable using in during the assessment practice [process]. So during their initial visit, we're making it a part of our initial questions. And if they are using a patient-generated app, we'd like to at least have an idea of what type of data is coming from it and how often they're using it. We're in the very early stages. We did something like this related to another chronic illness about two years ago. So we're just creating a version of it that's going to be related to its use with the condition of diabetes.

Wayne: And then, one of the things we're seeing here is that we're seeing more men enrolling online, and I think that's a very good sign. So the technology is there; it's there for our use. And I think as long as we can embrace it and help it work for us, then we're going to see more men using technology in the future. I have another question. Can you provide an example of how you address the stigma associated with diabetes?

Aaron: Well, I can take that. I've been living with diabetes for most of my—half of my life. And what I found is when we're in social settings, I start to talk about it. And believe it or not, once I start sharing, it's like I give permission for other men to start talking about it. We have found that men in our community have been living with diabetes. I've known [these men] for well over 20 years, and [I] never knew that they had diabetes until I started to talk about it. And then they just disclosed. So just being comfortable having people living with the condition. Involve them in that conversation. I found that that's been very effective.

Darryl: For us, it is a part of the Healthy Living with Diabetes curriculum, and the characteristics of the stigma do include people having negative feelings or blaming themselves because of how other people uncharacteristically may perceive them. Or, issues around control. So we let them know that they have not only the ability to manage their own health through self-management as well as an active lifestyle, but we also let them know that this is not an environment where they're supposed to blame themselves. We create buddy systems, and we have other activities where they can talk out some of the things that are bothering them the most related to living with the condition, and what are the most challenging things. And we even have them set goals. And they identify how likely they are to either maintain or to exceed that goal that they've already predicted, and then we give them a time limit—basically by this [time] next week or in the next few days, where will you be with your goal? So that's been really encouraging, and we've been able to see some improvements in how people feel about themselves related to controlling some of the things that are going on in their lives.

Dr. Giorgianni: Destigmatizing a medical condition, whether it's anxiety, depression, sleep deprivation, diabetes, even for some guys, hypertension can be misperceived. Ironically now, I mean we did it with ED by making it a medical condition. You know, it's not something for many men that they have intentionally done. It's not a sign of weakness. So I think the approach always has to be one of gentle coaching and counseling. You have to build that rapport with the patient, so that they can tell you why in their

experience they feel it's stigmatizing. It's probably going to be different for the young athlete, the college athlete, or a high school kid. I think it's going to be very different for a business executive versus a retired gentleman. So I think what the folks' clinicians need to do, which is very difficult when there's some reimbursement about spend time talking with the patient. The diabetes educators—I think that they are extremely well suited for doing that. I worked on a program between the American Pharmacists Association, and the Diabetes Educators' Association (American Association of Diabetes Educators) to help pharmacists counsel their patients on this. So I think it's the dialogue. And it's not an instant fix. You just don't throw some Glucotrol tablets at them, or insulin with injection and not talk with them. You have to help them understand that this is manageable. And give guys the notion that they can manage it, they can lick it—that empowers them. So giving them that sense, and that takes time and a lot of discussion.

Wayne: Great. So another question that popped up was: Do you use incentives in your program? Incentives that will attract [the] male population and will increase the likelihood of enrolling in a diabetes education program?

Dr. Giorgianni: I have a little bit of experience with incentives as far as when we did work with the ADA [American Diabetes Association] to create some diabetes incentive programs where people accumulate points and then, you know, cash them in for premiums and things like that. They work for a while. They're not for a condition like diabetes. I think you have a secondary issue. How long can the incentives last? So unless you're changing from the patients'—the guys'—fundamental view of the condition and then the fundamental view that this is a lifelong thing they have to deal with, giving short incentives which [we] can only keep up with for a finite period of time I think really may not be creating a long-lasting result for diabetes health care or all self-care. I think better is to work on them in the environment as we saw in the Milwaukee programs. And we've seen some fantastic programs in California as well, where the men are engaged with groups. I think the incentive is a sense of self-

empowerment. That's a lifelong kind of incentive you can build in. And the incentive is I'm healthier and better able to live better for my family.

Darryl: So as I was just saying, in Milwaukee, we are not using what we traditionally would use with other conditions. We've had incentives like gift cards and things of that nature. But with this one we have healthy eating. So we're bringing in food. And we're showing people how to cook. We're showing people how to create a list of healthy fruits and vegetables and proteins to shop for. And we did receive money from a grant through the Milwaukee County Department of Aging, but the incentives have not been the traditional type. It's primarily been related to grocery shopping and food and exercise, but nothing that we've directly given to any of the people who are in the program.

Peter: Health plans have extensively tried all kinds of motivational tricks, from reducing premiums, to paying for vegetables, to giving gym subscriptions. And I think the general conclusion is that you can incent somebody to join a program, but you can't incent them to stay in it successfully. That the program has to be—has to do more than give information. Beyond information, you have to give inspiration and aspiration. And maybe that's part of the issue with classes is that is every feature, every leader of a class [must be] aspirational or inspirational. Because the information by itself [or] an incentive by itself just won't hold most people in.

Dr. Giorgianni: One of the beautiful things about the program that was described in Milwaukee is that they are social programs where men learn how to talk about their health conditions in the comfort of […]. You know you look at; you know we often tease in Men's Health Network that women will gather around the water cooler if you will and talk about their health issues. And no one thinks too much of it. It's what they do. They have a social network. It's socially acceptable to talk about things that are troubling them—physically, emotionally troubling them. Men are culturally not [inclined] to do that. So one of the beautiful things that I see in the programs that are in barbershops and social networks and runs and

clubs and groups is that it teaches [us] also that men can talk with peers in a comfortable, safe environment about their health conditions, just like the gals do. And that, I think, is incentive plenty. I can finally talk to somebody about what's really bothering me. And I think that's a huge incentive for guys.

Aaron: One of the activities that we've done, we host a father-son night out event. It's an incentive-based activity, but we invite fathers to bring their sons. We typically host the event at the movie theatre, where we pay for the movie. We have dinner together. And then one of the activities with this is . . . we brought in a diabetes educator that talked about diabetes. And therefore you start to see these conversations that these fathers are having with their sons and involving them in it. And so it's another way of doing kind of an incentive-based activity. And then from that, we actually developed a committee of fathers that wanted to continue to have those conversations long after the activity ended. So it's an incentive base, but we've seen a lot of progress with that.

Wayne: Can we incorporate more messaging and programing around men's preference for action roles and the self-perception as hunters and gatherers and all that in prevention and management programs?

Dr. Giorgianni: Sure, I think that you can be very creative. One of the great folks we work with that we know has very successful programs down in Oklahoma—and there's other question about bringing family and friends, and stuff. They do prostate screening—"prostate and pancakes." Runs [running or races], that is you know, something, it's not just exclusively for the guys, but certainly a guy-oriented run [running] program I think works well. Anything you can do in an area of baseball programs. Men's Health Network has worked with minor league and major league baseball for programs. Some football groups. It's difficult though, for organizations to fund programs for men. I will say that. So if you can find a champion within your sports network, your community network who wants to engage with the guys, that's great. One of the best things you can do is look to where men gravitate. It's not always sports. But

it could be a celebrity chef in your area. Or the best chef in your area to do programs such as fine cooking programs. So there are lots of ways to engage guys in a social way that they find acceptable. And again, go back to the very important point that men are not homogeneous. So not everybody relates to a sports figure. So look for other thing that guys relate to in your community. Not everybody relates to mechanical things. It could be an arts group. So there are lots of ways to find the interests in men, as diverse as they are, and then tag health messages or health programs around them.

Wayne: Great. Do any of our presenters have anything additional to add?

Darryl: I will add that at the end of our sessions, we will have a graduation. We give out certificates, and that's the time when perhaps partners, family, and friends can attend the final session. The final session is also used as a method to recruit people to future classes.

Aaron: If I could share a quick story. Back when I was in high school and applying for colleges, there was a time in our community where every kid in the community that filled out a college application, the entire community gathered together and walked with that kid to the mailbox to mail that college application. What we're trying to do is emulate those old things that we used to do when we were kids. We're trying to bring them back and utilize them in places like the barbershop and the movie theaters to engage people and to build that community again. And so that's what we are attempting to do with our organization, and our community partners have been phenomenal in supporting these out-of-the-box thinking activities.

Wayne: That's great. That's really, truly bringing the community [in] to support these types of activities. Again, I want to thank everyone in the audience for some great questions today. If you have additional questions please send them to the Division of Diabetes Translation mailbox, noted here on your screen. We will follow up with you after all.

Slide 53: Claim Your Continuing Education Credit Today

Be sure to get your continuing education credit. Instructions are listed here and will be emailed to you. As a reminder, a recording of this webinar and the slides will be shared in the near future.

Slide 54: Thank you

Again, thank you for joining us today. And take care.