

This product was developed by the Richland County Community Diabetes Project at the Richland County Health Department in Sidney, MT. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

**"Mixing Oil and Water: a successful hospital and local public health partnership supports diabetes self-management"**



**The Richland County Community Diabetes Project**

**Richland County, Montana**

**Judy Lapan, MS, MBA, Department Administrator**

**Tanya Rudicil, BS, Chronic Disease Team Leader**

**Lisa Aisenbrey, RD, Diabetes Project Director**



# Community Profile



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

# Climate & location challenges

- Cold winters, hot & humid summers
- 250+ miles to nearest major hospital & specialists

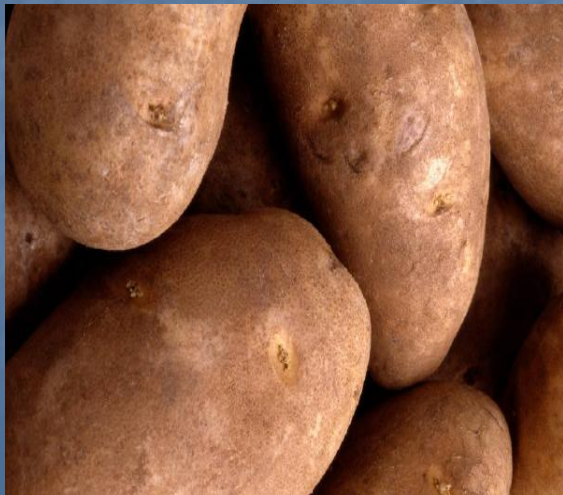


# Culture



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

# Nutrition in Eastern Montana



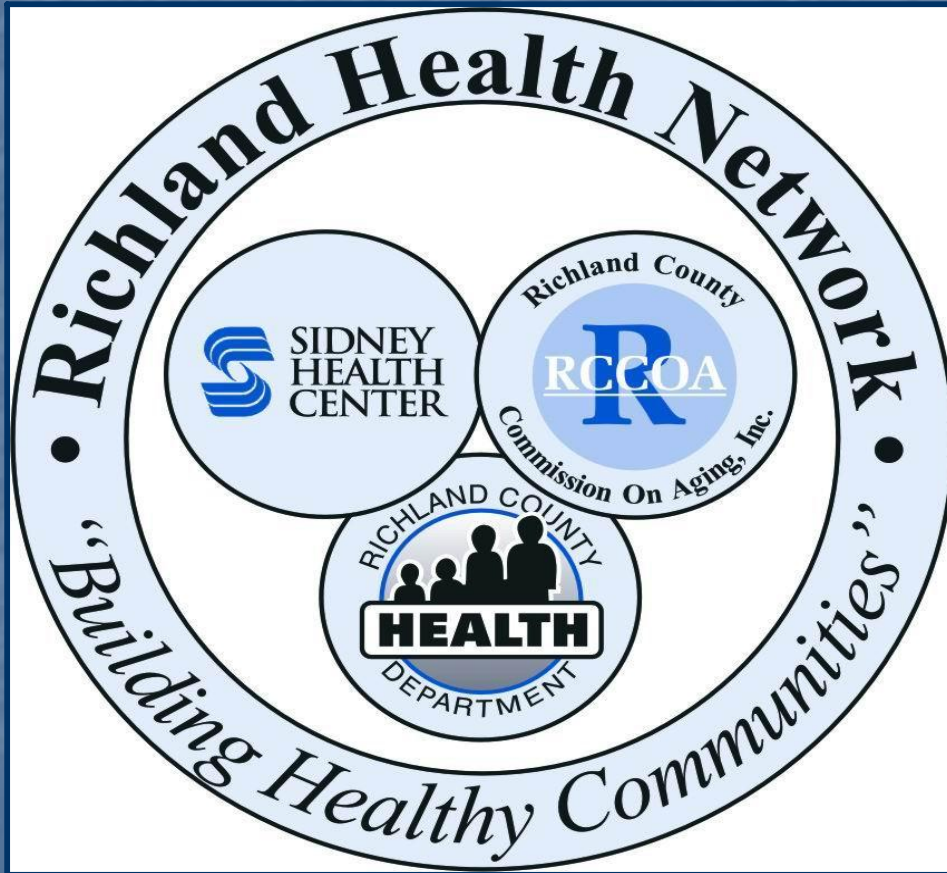




# Physical Activity in Eastern Montana



# Richland Health Network



Richland County  
Commission On Aging

Richland County Health  
Department

Sidney Health Center  
(hospital, clinic, pharmacy,  
extended care, fitness  
center, assisted living)

# DIABETES INITIATIVE

A National Program of The Robert Wood Johnson Foundation





**Advancing  
Diabetes  
Self Management**

Promoting self management of diabetes through primary care settings



**Building  
Community Supports  
for Diabetes Care**

Community collaborations to support self management of diabetes and diabetes care

# Building Community Supports for Diabetes Care

- Demonstrate models of comprehensive community support for diabetes self-management that improve health outcomes and quality of life
- Demonstrate role of community support for self management as part of quality diabetes care and promoting access to it
- Emphasize building collaborations in 12-month planning phase
- 8 Sites: AZ, CO, FL, ME, MN, MT (2), TX

# Richland County Community Diabetes Project

- Adults with Type 2 Diabetes
- 18 member Advisory Board
- **Staff:**
  - Judy Lapan, Health Department Administrator
  - Tanya Rudicil, CDM Team Leader
  - Lisa Aisenbrey, RD Diabetes Project Director (Health Dept. & Sidney Health Center)
  - Idelle Badt, Diabetes Project Coordinator
  - Susan Dahl, SHC Nurse for Education Center
  - Rebecca Miller, Administrative Assistant



## Consultants:

- Mary Madison, CDE
- Phillip Weaver, MD, Medical Consultant
- June Lewis, RD

# Community Collaboration

- Communities in Action
- WIC, At-Risk home visiting
- Richland County Nutrition Coalition
- Sidney Health Center Community Health Improvement Committee
- Parish Nursing
- RSVP
- Literacy Volunteers of America
- LIONS Club
- American Diabetes Association – Montana
- Montana Migrant Council (on Advisory Board)
- McCone County Senior Center
- Montana Diabetes Project
- Sidney Public Library
- Eastern Montana Mental Health
- Health Fair Planning Committee at hospital
- Media
- And more...

# Original Main Projects

- Diabetes Walking Club
- Diabetes Watchers (weight loss support)
- Diabetes Ambassadors
- Chronic Disease Self-Management Class
- Diabetes Education & Support Group
- Diabetes Education Center
- Diabetes Resources

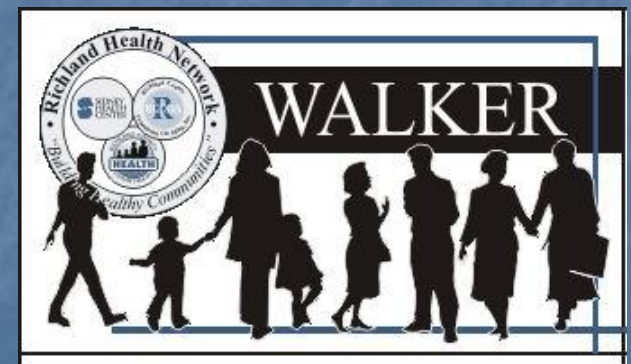


# Restructuring

- **Addressing the whole person**
  - **Physical activity**
  - **Healthy eating**
  - **Social support**
  - **Diabetes education**

# Physical Activity

- Strike Diabetes Out
- Walk NW North Dakota
  - Motivating short-term pushes, group & individual
- Indoor walking opps increased (community)
  - 8 free, 1 pay
  - Varied hours, day and night
  - Free pedometer
- Walking Rx





Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Exercise Prescription



Walk (or \_\_\_\_\_)  
\_\_\_\_\_ times per week  
for \_\_\_\_\_ minutes.

Additional Instructions:

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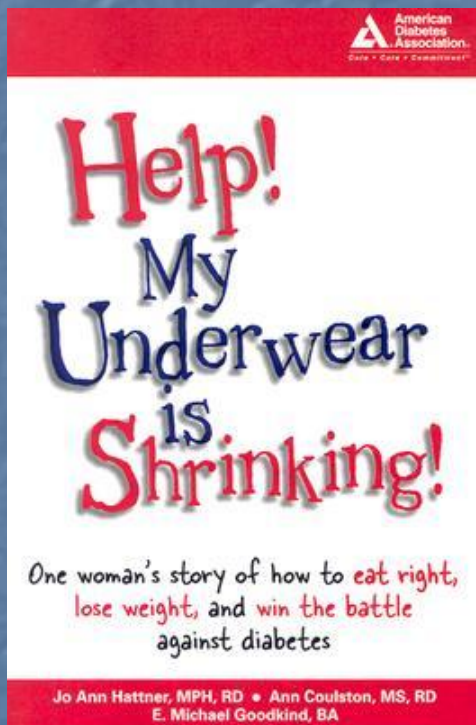
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# Healthy Eating

- Weight monitoring (Diabetes Watchers)
- Thin 2 Win
- Tasty Fork
- Nurtibase Software
- Recipe in newsletter
- Newspaper articles
- Health Fair booths
- Grocery Store Tours



# Social support & Continuing Education



- Diabetes Education Group
- Goal Setting
- Newsletter
- Resources at Public Library
- Community Resource Book
- Chronic Disease Class
- Ambassadors

# Diabetes Education Center

- Formal group and individual diabetes self management education in medical setting
  - Housed at Sidney Health Center
  - Staff: RD, RN, Coordinator
- Physician referral required
- Seeking ADA recognition
- Coordinated by Public Health
  - Linked with community projects
  - Strong source of referrals
- Diabetes Quality Care Monitoring System



# Other Activities



- Health literacy training
- Motivational interviewing training
- Provider education
- Local Worksite Wellness Programs

# Innovative Outreach

- Grocery Dividers
- Pharmacy Bags
- Bowling Alley Ad
- Bathroom Stall Advertising
- Planning a BIG campaign
  - Indirectly advertising project



# New Directions

- Insurance Summit
- Walkable Communities
- Exploring linkages
- Communities in Action
- Expansion to Circle, Fairview, etc.



# Results

- 88 Type 2 participants in database,
  - 6 Type 1, included in activities
  - 6 from McCone County
- 54 Active or consider themselves "Active"
- Average A1c is 7 (6.96)
  - Down from avg. 7.41 at beginning of RCCDP
  - Highest = 11.8, Lowest = 5.2 & 5.5
  - Sidney Health Center standard = 6

# Results, cont...

- 74% of surveyed participants report increase in physical activity (n=38)
- 50% of surveyed participants report weight loss (n=38)
- Watcher's Weight loss
  - 175 pounds from 12 people in last 12 months
  - 22 total in group, some maintaining

# The REAL Results

“RCCDP has kept me aware that diabetes is an every day thing that needs daily attention.”

“RCCDP has started me walking and helped me keep doing it”

“It’s fun and helpful to share with others.”



# Lessons learned

- Diabetes “label” not good for active program involvement.
- Working from community in, focusing on whole environment versus “strike diabetes out”
- Need for different phases of the program; new, maintenance, and apathetic
- Medical model – helps to get people interested
- Community model – available when they want it, adapt to their changing needs. “Drive thru” support.

- Involvement Perception Disconnection
- Some things people prefer to pay for – free does not always mean they will show up (Watchers vs Thin-2-Win)
- Culture – people want support – but on their terms, different for every person
  - – people prefer to do things on their own (steps). Just need a push.
- 77% of active participants surveyed (n=38) prefer to manage their diabetes on their own rather than with a friend or in a group