Starting a Diabetes Self-Management Program in a Free Clinic Setting

By:

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WHY ?

- ✓High Number of uninsured living with Diabetes & its complications
- ✓High cost of caring for people with Diabetes
- ✓Problem affects us all

AN ALTERNATIVE:

Prescription for Health
DIABETES PROJECT

DIABETES INITIATIVE

A National Program of The Robert Wood Johnson Foundation

The Prescription For Health Diabetes Project is a grantee of the Robert Wood Johnson Foundation Diabetes Initiative's Building Community Supports for Diabetes Care Program

GOAL

"To illustrate how free clinics could impact the health of people living with diabetes Type 2 and their community"

Open Door Health Center

- ✓A free clinic for the uninsured poor
- ✓Multiple awards & recognitions
- ✓ >60,000 visits
- ✓> 200 free surgeries
- ✓ >200 volunteers
- ✓ >300 students trained

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Tel: (305) 246-2400
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Clinic Model

Baptist Health South FL.

Volunteers

Miami-Dade AHEC

RWJ Foundation

ODHC

HFSF

Fl. DOH

UM University

Barry University

Open House Ministries

MISSION:

To provide free primary healthcare, diagnostic and educational services for adults, children and teens in a caring, compassionate teaching environment through collaboration

Step One: Measure knowledge, understanding and existing support.

65 organizations were surveyed including :

- ✓ 15 **health care providers**
- ✓ 17 **churches**
- ✓ 13 popular **restaurants**
- ✓ 20 **CBO's**

Step Two: Strengthen collaborations with other community agencies.

- ✓ **Share leadership -(Diabetes Management Action Team (DMAT)** & **Steering Committee**
- ✓ **Diabetes Resource Guide**
- ✓ **Increase access to resources** (i.e. at food closets, community gatherings, etc.)

Step Three: Increase involvement of target population

- ✓ **Patient Council** created and activated
- ✓ **Community Health Worker** component implemented

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Step Four: Develop culturally appropriate Interventions

- ✓ Cooking Classes
- ✓ Supermarket Tours
- ✓ Support/Group Appointments

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Step Five: Use culturally appropriate education methods

- ✓Popular Education (simple, fun, participatory)
- ✓Address "perceived barriers" – PSA's, appointments, presentations, role modeling
- ✓Use "target audience" sensitive communication methods and tools.

Step Six: Organize system of care

- ✓ Pre-planned scheduling system
- ✓ Ensure access to consultants
- ✓ Develop DM patient roster
- ✓ Organize medical records
- ✓ Implement case management system
- ✓ Collect and share appropriate data
- ✓ Make changes as needed

ODHC SYSTEM OF CARE

- ✓ Allows to focus on quality comprehensive health care
- ✓ AADE7™ Self-Care Behaviors - basis for self management goals
- ✓ All program group activities are free and open to the public
- ✓ Family and friends encouraged to participate

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Program Community Activities

- ✓ **Diabetes Presentations**
  - Churches & Places of Worship
  - Collaborative Agencies
  - Homework Clubs
  - Schools
  - Professional Organizations & Conferences
- ✓ **Health fairs**
- ✓ **Media Outreach**
  - Radio stations and other media outlets

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OUR PRESENT PROGRAM MODEL

Local Radio Stations

We Care

Local CBO's

Churches

After School Programs

Open Door Health Center

Support Group/Group Appt.

Cooking Classes

Supermarket Tours

"Diabetes 101"

Adult Fitness

Diabetes Presentations

Community

ODHC Patient Family

Adults with DM Type 2

Baptist Health South FL

Miami-Dade AHEC

BU/FIU UM

HFSF

RWJF Susan G. Komen

ODHC: Clinic as platform for community program

From Layperson to CHW/OW: A Process

Step One: Define CHW/OW Selection Criteria

Roles & Responsibilities:

- ✓ Bridging/Cultural Mediation
- ✓ Assist in providing culturally appropriate diabetes education
- ✓ Facilitate social/peer support
- ✓ Build Individual & Community Capacity
- ✓ Assist with patient recruitment

Step One continued...:

Desired Character Qualities:

Community member
Honest, respectful
Motivated, reliable
Flexible/persistent
Positive role model

Caring, empathetic
Committed
Creative/resourceful
Friendly/patient
Non-judgmental

Step One Continued...:

Skills Present or Potential:

- ✓ Multi-lingual literacy
- ✓ Confidentiality capacity
- ✓ Team player
- ✓ Good listener
- ✓ Time management
- ✓ Multi-cultural communication

- Plan and set goals
- Speak up for others
- Good leadership
- Broad community knowledge
- Basic diabetes knowledge

Step Two: Select /Create Curricula

- ✓ Conduct search to identify appropriate curricula
- ✓ Identify collaborators to assist with initial education
- ✓ Select Educator

Step Three: Recruit & Train

- ✓ Recruit and educate CHWs/OWs
- ✓ Adult Clinic patients if possible
- ✓ Representative of patient population
- ✓ Living with diabetes Type 2

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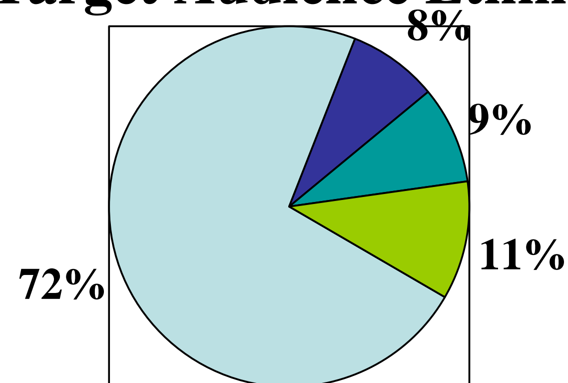
Step Four: Interview and Select Patients

Patients Interviewed:

- ✓ # of non-pregnant adults with diabetes Type 2 - 125
- ✓ # of patients interviewed – 9
- ✓ 4 Mexican, 2 African American, 2 Haitian, and 1 Jamaican



Patients Selected:

- ✓ 2 Mexican (1 ♂, 1 ♀), English & Spanish Speaking
- ✓ 1 African American ♀, English Speaking
- ✓ 1 Haitian ♂, English & Haitian Creole Speaking
- ✓ 1 Jamaican ♀, English Speaking

Step 5: Implement Curriculum

- ✓ 80 hours (8 hours/wk for 10 wks)
- ✓ Initial Education Topics:
  - Individual & community capacity
  - Diabetes Overview
  - Nutrition
  - Physical Activity
  - Psychosocial

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Step Six: Measure CHW Accomplishments

✓ **Assist with:**

- Diabetes Support/Gp. Appts.
- Multi-cultural Cooking Classes
- Supermarket Tours
- Diabetes Classes
- Exercise Classes

✓Diabetes Screening & Education

✓Patient Recruitment

✓Distribute brochures/flyers

✓Peer Support

Lessons Learned:

- ✓ Laypersons can be trained to be CHWs/OWs
- ✓ Selection which reflect the target audience builds credibility with the community they serve
- ✓ Education should include clarification of prevalent “myths” and misconceptions
- ✓ Modeling “non-directive support” is an ongoing process
- ✓ CHWs/OWs need ongoing education and encouragement

Implications for Practice:

*CHWs/Ows can be an asset to free clinics by:

- ✓ Extending the impact of the RD and/or CDE in DSME
- ✓ Helping to “bridge the gap” in diabetes health disparities
- ✓ Improving communication with “hard to reach” populations
- ✓ Increasing clinicians’ presence within the community

Important Outcomes

- ✓ Improved patient education
- ✓ Data collected show improved Hb A_1c correlated with improved clinical outcomes
- ✓ Increased access to resources
- ✓ Continued positive impact expected "down the road"

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“Creation of a successful system of care for patients with diabetes in a free clinic setting is possible through innovative collaboration and creative program design”

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Thank You!! *Gracias!!* Merci!!