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.

Richland County Community Diabetes Project

Richland Health Network

Sidney, MT

Kristin Lawrence

- B.S. Health Education
- MSU-Northern
- Diabetes Program Specialist
- Wibaux, MT
- Taught and Coached in MT & ND
- Diabetes runs in the family

Tanya Rudicil

- BS in Human Services, minor in Public Administration
- Upper Iowa, Dawson
- Diabetes Project Director
- Chronic Disease Management Director
- Havre & Sidney, MT
- Public Health, Developmental Disabilities
- Family members with diabetes

Richland Health Network

- Sidney Health Center, Richland County Public Health, Richland County Commission on Aging
- 1999- 3 year Rural Health Outreach Grant – to reduce preventable hospitalizations in 55+ through RN, SW, Outreach Coordinator team

Growing good eggs

- RSVP
- Fire & Fall Prevention
- CERT
- Citizen Corp
- Diabetes Project
- Chronic Disease Management
- Senior Companion Volunteer Workstation
- Limited home visiting/ MOW assessments
- Senior Coalition

From strictly seniors to 18+
From 3 people in one room to our own offices on Central Ave!

Robert Wood Johnson Foundation

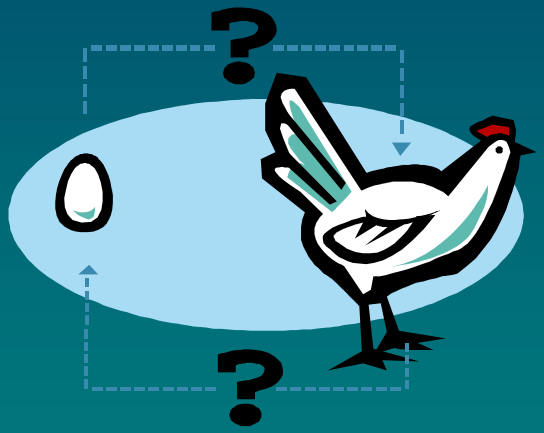
- Building Community Supports for Diabetes Self-Management
- 1-yr planning grant with pilot projects
- Wagner Chronic Care Model
- Self management using the Ecological Perspective

Ecological Perspective

- Approaches utilizing peers for communication, education, advocacy or support
- Innovative community outreach & awareness
- Community and environmental supports
- Systems or procedures
- Linking or coordinating community based health care services
- Use of community based information to guide improvements
- Advocacy and policy activities

The Chicken or the egg

- Develop an Advisory Board
- Original plan for projects
  - ADA program
  - Diabetes Ambassadors
  - Workplaces
  - Schools
  - Parish Nurses
  - Diabetes Care Quality Monitoring System



Diabetes

- “Eggcellent” Participation

National Statistics

- Age 20+ 18 million have Diabetes, or 8.7%
- Age 60+ 8.6 million or 18.3% have diabetes
- Total cost of Diabetes in the U.S. in 2002=$132 billion
- Direct medical cost=$92 billion
- Indirect costs=$40 billion (disability, work loss, premature mortality)

Montana Statistics

- Age 18 and over—

  5% have Diabetes
- 30% have Metabolic Syndrome or Diabetes
- Source: MT Department of Health & Human Services

Richland County Statistics

- Estimated number is 457 are diagnosed with Diabetes (9,967 total population)
- In 2002 18% of patients (18+) were hospitalized with a diagnosis of Diabetes

- Source: MT Dept. of Health and Human Services; Sidney Health Center

Focus Group Highlights

- Diabetic is the ultimate control person – the one who is responsible to take charge
- We need education on diabetes
- We need an organized diabetes ed program
- We want places to walk and exercise that are free or low cost
- We want someone to hold us accountable

Focus Groups continued..

- Parish Nurses/churches do enough already, the can get information out and help out, but we don't want anything else
- We want to know how to eat!
- We need incentives
- Restaurants and grocery stores could offer better choices, be more healthy-eating friendly.

Health Care Provider Focus Group

- We are already providing what patients need (education)
- Education/Support group is a good idea
- Walking group is good idea
- More healthy food choices in stores and restaurants
- People lack motivation; the either do it or they don’t
- Churches do enough already, but they are a good place for outreach

Projects

Each Participant

- Fills out participation questionnaire
- Keeps track of their progress
- Sets goals
- Provide us with test results (A1C)
- End of 3 months-questionnaire on progress and set new goals
- Will get their goals sent to their health care provider

Resources and Supports for Self-management

- Individualized assessment that includes attention to cultural and social factors.
- Collaborative goal setting
- Instruction in key skills for managing diabetes
- On-going follow-up and support for self-management
- Access to resources for healthy diet and physical activity
- Linkages/coordination among pertinent community organizations and services
- Access to high quality clinical care

Diabetes Walking Club

- Get a free pedometer
- Keep track of steps daily
- Turn in results after 3 months
- Walking available at schools, churches, fitness center, home or outside
- Improvements: meet more often to help set goals, find more places to walk, label the distances

Diabetes Watchers

- Weigh-in every Thursday
- Receive new handouts on safe weight loss and diabetes
- Improvements: Take measurements, and sit down to set goals with each individual, BMI machine

Diabetes Resources

- Check out Diabetes books from the Sidney Public Library
- Richland County Resource Book
- Improvements: Get a list of local and state mental health resources as well as expand other resources

Diabetes Education & Awareness Group

- Meets 2nd Monday of every month Sept.-May
- Local professionals donate their knowledge, talents and time
- Supported by the Sidney Lions Club
- Improvements: Meet year around, luncheons, expand list of speakers

Project Results

- Diabetic Walking Club—68
- Diabetes Watchers—26
- Diabetes Resources—19
- Diabetes Education Group—40
- 58 Diabetics
- 30 Non-Diabetics (family, friends)

Other Activities

- Tasty Fork—Richland County Nutrition Coalition
- Diabetes Conference
- Bike ‘N Trike
- Diabetes Walk-American Diabetes Association
- Local Fun Walks

Community Support

- RSVP
- Sidney Herald
- Roundup
- Radio Stations
- T.V. Stations
- Sidney Lions Club
- Jaycees
- Chamber of Commerce

Evaluation

- A1c's
- Self-Management behaviors
  - Measured by post-survey, clinical data, questionnaires
- RTI – Research Triangle Institute
- Evaluating Partnerships

Phase II

- ADA
- Walkable Community/Walking Club
- Diabetes Watchers
- Diabetes Ambassadors
- Education Group
- Resources
- Policy – Workplaces, insurance
- Linking services – TISA, Migrant, Literacy
- Tasty Fork
- Clinical Information Systems
- Goal setting/ behavior change using the Transtheoretical Model

Building supports for Chronic Disease Self-Management

The activities and behaviors essential for diabetes self-management are basically the same as those all persons, with our without a chronic disease, should be engaged in.

Physical Activity
Nutrition
Social Support
Medication compliance
Recommended Health Care visits

Likewise, the community supports essential for diabetes self-management are the same as for any disease.

Supports for healthy behaviors
Environmental supports
Community involvement
Policy Development

What did you learn?

- BINGO

Question & Answer

- Need more information on these projects?
  - Call, write, e-mail. We are happy to help other communities!