Promising Innovations to Address Diabetes in Vulnerable Populations: Local Solutions With National Implications

Thursday, November 6, 2014
12:00 – 1:00 PM ET

Sponsored by Merck Foundation
Co-hosted by the Society for Public Health Education

www.alliancefordiabetes.org
• Today’s session has been approved for **1.0** Category I continuing education contact hours (CECHs) for Certified Health Education Specialists (CHES) and Master Health Education Specialists (MCHES). The Society for Public Health Education (SOPHE), including its chapters, is a designated multiple event provider of CECHs by the National Commission for Health Education Credentialing, Inc. (NCHEC).

• This session also has been approved for **1.0** CPH Renewal Credits by the National Board of Public Health Examiners.

• Create a free account on SOPHE’s Center for Online Resources and Education (CORE)
  - [www.sophe.org/education.cfm](http://www.sophe.org/education.cfm)
  - Webinar CECH/CPH Fees:
    • **$12.00** for National SOPHE members
    • **$24.00** for non-members
Agenda

- Welcome and Introductions
- Integration of Health System and Community Approaches
- Implementing System and Policy Change to Ensure Sustainability of Promising Strategies
- Did the Multi-Level Alliance Effort Make a Difference?
- Panel Discussion
- Audience Q&A
- Closing Remarks
Welcome and Introductions

Leonard Jack, Jr., PhD, MSc
Director, Division of Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention
Co-editor of Health Promotion Practice supplement issue

Monica Peek, MD, MPH
Assistant Professor, Section of General Internal Medicine; Associate Director, Chicago Center for Diabetes Translation Research, University of Chicago

Martha Quinn, MPH
Senior Policy Research Specialist, Center for Managing Chronic Disease, University of Michigan

Megan Lewis, PhD
Director, Patient & Family Engagement Research Program Center for Communication Science, RTI International
The Alliance to Reduce Disparities in Diabetes is helping to decrease diabetes disparities and enhancing the quality of health care by improving prevention and management services.

- National program founded and supported by the Merck Foundation.
- Launched in 2009.
- Implementing comprehensive, evidence-based diabetes programs that are:
  - Applying proven, community-based and collaborative approaches
  - Enhancing patient and HCP communications
  - Mobilizing community partners
  - Disseminating important findings
  - Increasing policy maker awareness at all levels of changes to reduce health care disparities in diabetes
  - Promoting collaboration and information exchange
Integration of Health System and Community Approaches

Monica E. Peek, MD, MPH
University of Chicago
Alliance to Reduce Disparities in Diabetes Webinar
November 6, 2014
Diabetes Mortality in Chicago

Average annual adjusted diabetes-related mortality rate by Chicago community area, 2004 - 2008

Per 100,000:
- 26 - 59
- 60 - 79
- 80 - 99
- 100 - 122

Nationally, 73.1 diabetes-related deaths per 100,000 occurred in 2007. The Healthy People 2020 target is 65.6.
South Side of Chicago

• **Challenges:**
  – Poverty
  – Social challenges
  – Food deserts
  – Unsafe recreation
  – Mistrust of healthcare
  – Weakened hospital safety net

• **Strengths**
  – Historical social, political and cultural traditions
  – Community resources and institutions
  – Healthcare institutions
Conceptual Model

Community Partnerships

Quality Improvement

The Chronic Care Model

Community Health Systems

Patient Activation

Provider Training

Patient

Practice Team

Productive Interactions
Sustainable Community Partnerships

Food pantries  Chicago Park District  Walgreens
Pharmacy discounts  ADA & AHA  YMCA
Farmers’ markets  Grocery store tours  Local chefs
Fitness instructors  Churches  Community Centers

Greater Chicago Food Depository distribution day at KLEO Community Center
Lessons Learned from Efforts at Health System/Community Integration

• Start small and expand later
Prescriptions for Food & Exercise

- Chicago Park District
- Walgreens
- Farmers’ Market
- Food Depository
Health part of your treatment plan

Use this sheet to help you follow your doctor's guidance for a healthful eating plan. Read the nutrition labels on all your food products to learn more about what you're putting in your body.

What are **Low-Carb** Foods?

- Carbohydrates (or carbs) include fruits, sweets and starches.
- The good news is that you don't have to cut them out. Eating the right portion is important.
- **AIM for 15 grams or less of carbohydrates per serving, and 45-60 grams or less per meal.**

<table>
<thead>
<tr>
<th>Low-Carb Foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tomatoes</td>
</tr>
<tr>
<td>Onions</td>
</tr>
<tr>
<td>Carrots</td>
</tr>
<tr>
<td>Mushrooms</td>
</tr>
<tr>
<td>Tea and Coffee</td>
</tr>
<tr>
<td>Yogurt</td>
</tr>
<tr>
<td>Cottage cheese</td>
</tr>
<tr>
<td>Green, leafy vegetables</td>
</tr>
<tr>
<td>Green, yellow, red peppers</td>
</tr>
<tr>
<td>Eggs</td>
</tr>
<tr>
<td>Tofu</td>
</tr>
<tr>
<td>Fish</td>
</tr>
<tr>
<td>Chicken</td>
</tr>
<tr>
<td>Lean cuts of meat</td>
</tr>
<tr>
<td>Peanut butter</td>
</tr>
</tbody>
</table>

What are **Low-Fat** Foods?

- Go for foods that are reduced or low-fat: these will have at least 25% less fat per serving as compared to the traditional version of the food item.

<table>
<thead>
<tr>
<th>Low-Fat Foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olive Oil</td>
</tr>
<tr>
<td>Avocado</td>
</tr>
<tr>
<td>Fruits</td>
</tr>
<tr>
<td>Vegetables</td>
</tr>
<tr>
<td>Walnuts</td>
</tr>
<tr>
<td>Flaxseeds</td>
</tr>
<tr>
<td>Salmon</td>
</tr>
<tr>
<td>Trout</td>
</tr>
<tr>
<td>Tuna</td>
</tr>
<tr>
<td>Whole wheat bread</td>
</tr>
<tr>
<td>Oatmeal</td>
</tr>
<tr>
<td>Grains</td>
</tr>
</tbody>
</table>

**Just what the Doctor Ordered!**

**What are High-Fiber Foods?**

The best sources of fiber have: 5 grams of fiber or more per serving. Food that is a good source of fiber has 2.5 to 4.9 grams of fiber per serving.

<table>
<thead>
<tr>
<th>High-Fiber Foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prunes</td>
</tr>
<tr>
<td>Dates</td>
</tr>
<tr>
<td>Beans</td>
</tr>
<tr>
<td>Oatmeal</td>
</tr>
<tr>
<td>Avocados</td>
</tr>
<tr>
<td>Raspberries</td>
</tr>
<tr>
<td>Figs (dried)</td>
</tr>
<tr>
<td>Apricots (dried)</td>
</tr>
<tr>
<td>Coconut (dried)</td>
</tr>
<tr>
<td>Fortified cereals</td>
</tr>
<tr>
<td>Bran cereals</td>
</tr>
<tr>
<td>Toasted wheat germ</td>
</tr>
</tbody>
</table>

**What are Low-Sodium Foods?**

Look for foods with less than 140 milligrams of sodium per serving—that's about 1/16 of a teaspoon.

**Careful!** “No salt added” means no salt added during processing; it does not necessarily mean sodium free!

<table>
<thead>
<tr>
<th>Low-Sodium Foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk</td>
</tr>
<tr>
<td>Eggs</td>
</tr>
<tr>
<td>Sherbert</td>
</tr>
<tr>
<td>Pastas</td>
</tr>
<tr>
<td>Rice</td>
</tr>
<tr>
<td>Fresh fish</td>
</tr>
<tr>
<td>Fresh poultry</td>
</tr>
<tr>
<td>Tabasco</td>
</tr>
<tr>
<td>Vinegar</td>
</tr>
<tr>
<td>Nuts (unsalted)</td>
</tr>
<tr>
<td>Peanut Butter</td>
</tr>
<tr>
<td>Tuna (low sodium)</td>
</tr>
<tr>
<td>Fresh fruit</td>
</tr>
<tr>
<td>Fresh vegetables</td>
</tr>
<tr>
<td>Sour cream</td>
</tr>
<tr>
<td>Frozen fruit (no sauce)</td>
</tr>
<tr>
<td>Frozen vegetables (no sauce)</td>
</tr>
<tr>
<td>Whole grain breads</td>
</tr>
<tr>
<td>Horseradish, mustard</td>
</tr>
<tr>
<td>Cream (half an tablespoon)</td>
</tr>
<tr>
<td>Non-dairy creamer</td>
</tr>
<tr>
<td>Spices</td>
</tr>
<tr>
<td>Herbs</td>
</tr>
<tr>
<td>Cream cheese</td>
</tr>
<tr>
<td>Low-salt Cheeses</td>
</tr>
<tr>
<td>Low-salt Crackers (2 tablespoons)</td>
</tr>
<tr>
<td>Popcorn (unsalted)</td>
</tr>
</tbody>
</table>

For more information

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**Improving Diabetes Care on the South Side of Chicago**
Food Rx: Incorporation into EMR

- EPIC Rx

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**Food Rx**

*Welcome to the Food Rx program!* Your doctor has ordered you a Food Rx, or “food prescription”, because eating healthy is an important part of taking care of yourself and your diabetes.

If you have a 61st Street Farmers Market Food Rx, you can take it to the South Side Diabetes project booth at the market (61st and Dorchester) Saturdays from 9:30am-1:30pm and get $9 worth of fresh produce!

The South Side Diabetes Team also has free Farmers’ Market tours every Saturday at 10:30am, and we would love to see you there! To register: 773-702-2939.

Your Food Rx will look like EITHER of the two pictures below. BOTH versions work just the same.

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**Picture of printed Rx here**

---

Questions? 773-702-2939 [www.southsidediabetes.org](http://www.southsidediabetes.org)

For more information: [www.southsidediabetes.org](http://www.southsidediabetes.org) 773-702-2939
Food Rx: Market Tours & Health Education
Lessons Learned from Collaborative Efforts

• Start small and expand later
• Identify champions
• Find projects of mutual benefit
KLEO Food Pantry
Patient Activation & Community Partnerships

Patient empowerment classes

Resources
Reinforcement
Sustainability

Pantry partnership
- Free food
- Health information
- Cooking demonstrations
- Exercise lessons

K.L.E.O. Community Family Life Center

Education
Resources
Screening
Lessons Learned from Collaborative Efforts

- Start small and expand later
- Identify champions
- Find projects of mutual benefit
- Align with organizational strategic priorities
• Urban Health Initiative
• UCM collaborations
  – Faculty at partner FQHCs
  – South Side Health Collaborative
• CommunityRx/HealtheRx
Chicago Public Health Department
Lessons Learned from Collaborative Efforts

• Start small and expand later
• Identify champions
• Find projects of mutual benefit
• Align with organizational strategic priorities
• Utilize principles of CBPR/Community Engaged Research
Working with Community Organizations

• Remember it’s about people
• Start with your friends and/or like-minded organizations
• Build relationships before organizations
• Give before you get
• Nurture equal relationships
• Understand historical, policy, and economic contexts
• Be committed to the cause, not the grant
• Do good work and good people will find you….
Project Team

- Marshall Chin
- Monica Peek
- Tonya Roberson
- Anna Goddu
- Molly Ferguson
- Nora Geary
- Deb Maltby
- Yolanda O’Neal
- Kristine Bordenave
- Michael Quinn
- Doriane Miller
- Lisa Vinci
- Andrew Davis
- Elbert Huang
- Nyahne Bergeron
- Jonathan Dick
- Shantanu Nundy
- Seo Young Park
- Neha Setha
- Emily Lu
- Robert Sanchez
- Deborah Burnet
- Karen Kim
- Dawnavan Davis
- Sheila Harmon
- Daniel Rowell
- Yue Gao
- Sang Mee Lee
- Julie Whyte
- Chef Brian Alston
- Shelley Scott
- Mickey Eder
- Peggy Hasenauer
- Louis Philipson
- Marla Soloman
- Hui Tang
- Robert Nocon
- Katie Raffel
- Ndang Azang-Njaah
- Gwen Burrows
- Braunda Anderson
- Melishia Bansa
Thank you!

- Merck Foundation
- NIDDK R18 DK083946
- NIDDK P30 DK092949
- NIDDK K23 DK075006
- NIDDK K24 DK071933
- University of Chicago CTSA Pilot and Collaborative Translational and Clinical Studies Award
Implementing System and Policy Change to Ensure Sustainability of Promising Strategies

Martha Quinn, MPH
Senior Policy Research Specialist

Center for Managing Chronic Disease, November 2014
The Alliance aims to help decrease diabetes disparities and enhance the quality of health care by improving prevention and management services. The Alliance is working with national, regional and community partners to develop and implement comprehensive, evidence-based diabetes programs.
The Alliance has two interrelated efforts:

**Demonstration of community level improvements in quality and coordination of care.**

**Assisting efforts of national partners and furthering consideration of care enhancing policies informed by experience at the community level.**
Approach and Methods

- NPO assessment team formed
- Collect data
  - Document review (annual reports, site visit reports, presentations)
  - Telephone Interviews
  - Discussions at grantee meetings
- Verification
## Camden

<table>
<thead>
<tr>
<th>Description of Effort</th>
<th>Level of Change</th>
<th>Stage</th>
<th>Formal Documentation</th>
<th>Impact Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountable Care Organization (ACO) legislation</strong> (led by Camden Coalition) was enacted and signed by New Jersey Governor creating a 3-year demonstration project.</td>
<td>Statewide</td>
<td>3</td>
<td>Bill drafted and signed</td>
<td>25,000 (Medicaid population in Camden after expansion)</td>
</tr>
<tr>
<td><strong>Regulations for implementing ACO legislation</strong> were written by the Camden Coalition of Healthcare Providers (CCHP), published for public comment and received final approval in May 2014.</td>
<td>Statewide</td>
<td>3</td>
<td>Regulations drafted and reviewed by state and FTC</td>
<td></td>
</tr>
<tr>
<td><strong>Citywide Camden Health Information Exchange (CHIE)</strong> created which allows hospitals, PCPs and specialists to access lab results, radiology reports and discharge summaries. CHIE is primarily used to target high-utilizers of hospital services.</td>
<td>Citywide</td>
<td>3</td>
<td>Written Business Agreements; Workflows; Protocols</td>
<td>79,000 (Camden population — almost all are in the HIE)</td>
</tr>
</tbody>
</table>
## System & Policy Change Efforts Common Across Alliance Sites

<table>
<thead>
<tr>
<th>Common System and Policy Changes</th>
<th>Camden</th>
<th>Chicago</th>
<th>Dallas</th>
<th>Memphis</th>
<th>Wind River</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health workers (CHWs)/Patient navigators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure reimbursement or funding for services provided by CHWs</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Establish community health worker roles and responsibilities</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrate work of CHWs into clinical care team</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive health information systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-risk patient tracking systems</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Diabetes registries</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes self-management education (DSME)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhance and institutionalize content and process for DSME</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Clinic redesign and provider training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create tools to help patients manage their disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other efforts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish ACOs or other provider networks that coordinate care and share in cost savings</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinic-community partnerships</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Table includes system and policy change efforts common across at least 3 Alliance sites.
Total S&P Efforts (n=53)

**Stage of Accomplishment**
- Beginning: 3
- Adoption: 10
- Implementation: 31
- Maintenance: 9

**Scope of Change**
- Organizational: 2
- Multi-Organizational: 28
- Citywide: 5
- Statewide: 13
- National: 5
Institutionalize role of CHWs within Baylor Scott and White Health System

System & Policy Changes:
- Established job codes
- Secured funding: Medicaid Waiver 1115
- Embedded CHW role in clinical team

Key Strategies:
- Started small and then scaled up
- Found a champion
- Identified a funding stream
Established Camden Health Information Exchange

System & Policy Changes:
- Written business agreements with local health systems
- Developed diabetes registries
- Implemented EHRs in clinics

Key Strategies:
- Built relationships/trust with local health systems
- Started small, scaled up to regional
- Securing funding
Implemented and Expanded DSME

System & Policy Changes:
• Secured reimbursement for DSME
• Standardized process for DSME referral
• Written agreements between IHS and Tribal Health to share data and DSME staff

Key Strategies:
• Established Wind River Diabetes Coalition
• Benefits of coordination: shared resources & cost savings
Essential Elements of System and Policy Change Across Alliance Sites

- Start small & scale up
- Build trusting relationships
- Secure champions
- Use data/evidence to support change
- Identify common goals/mutual benefits
- Allow adequate time
- Document change
- Funding and resources are needed
Did the Multi-Level Alliance Effort Make a Difference?

Megan Lewis, PhD
Director, Patient & Family Engagement Research Program
Center for Communication Science
RTI International
RTI’s Role

- Cross-site evaluation of the Merck Foundation Alliance to Reduce Disparities in Diabetes over 5 years
  - Quantitative data collection and analysis
    - Clinical measures
    - Patient-reported outcomes
  - Qualitative data collection and analysis
    - Review of existing documents
    - Grantee site visits
  - Cost-effectiveness modeling
Chronic Care Model: Extension and Contribution

- Empower patients and providers to engage in proactive, planned and coordinated care for chronic illnesses (Coleman, Austin, Brach & Wagner, 2009)
- Programs based on CCM have typically used a set implementation strategy (Institute for Healthcare Improvement, 2004)
Diabetes Alliance Model
Bringing the Chronic Care Model to Life

- Three core components of all site programs: patient change, clinician change, and system change
- Interventions tailored to local needs, resources, and strengths

Note: From Clark, Brenner, Johnson, et al, 2011. Copyright 2011 by the American Diabetes Association
Clinical Outcomes Improved

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>N</th>
<th>First Mean (SD)</th>
<th>Last Mean (SD)</th>
<th>Difference Mean (SD)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROGRAM PARTICIPANTS</strong>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Values</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c</td>
<td>1515</td>
<td>8.4 (2.2)</td>
<td>7.7 (1.9)</td>
<td>0.7 (1.9)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic</td>
<td>1573</td>
<td>129.2 (18.7)</td>
<td>128.2 (19.3)</td>
<td>1.1 (18.9)</td>
<td>0.025</td>
</tr>
<tr>
<td>Diastolic</td>
<td>1573</td>
<td>78.8 (11.4)</td>
<td>78.0 (11.8)</td>
<td>0.9 (12.5)</td>
<td>0.006</td>
</tr>
<tr>
<td>Lipids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>654</td>
<td>181.8 (42.9)</td>
<td>176.9 (41.4)</td>
<td>5.0 (41.3)</td>
<td>0.002</td>
</tr>
<tr>
<td>HDL</td>
<td>501</td>
<td>48.1 (14.5)</td>
<td>47.7 (13.6)</td>
<td>0.4 (10.3)</td>
<td>0.366</td>
</tr>
<tr>
<td>LDL</td>
<td>490</td>
<td>101.3 (35.7)</td>
<td>98.8 (33.2)</td>
<td>2.4 (32.0)</td>
<td>0.094</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>448</td>
<td>169.8 (117.0)</td>
<td>152.3 (110.0)</td>
<td>17.5 (107.5)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td><strong>COMPARISON GROUP</strong>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Values</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c</td>
<td>533</td>
<td>8.4 (2.4)</td>
<td>8.02 (2.14)</td>
<td>0.4 (2.15)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic</td>
<td>574</td>
<td>131.5 (20.5)</td>
<td>130.0 (19.0)</td>
<td>1.3 (21.7)</td>
<td>0.142</td>
</tr>
<tr>
<td>Diastolic</td>
<td>574</td>
<td>78.8 (13.1)</td>
<td>76.4 (12.4)</td>
<td>2.2 (14.9)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Lipids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>303</td>
<td>173.8 (42.6)</td>
<td>165.3 (44.2)</td>
<td>8.5 (41.9)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>HDL</td>
<td>58</td>
<td>49.1 (16.3)</td>
<td>50.0 (16.2)</td>
<td>0.9 (8.6)</td>
<td>0.421</td>
</tr>
<tr>
<td>LDL</td>
<td>200</td>
<td>102.1 (39.2)</td>
<td>99.3 (35.1)</td>
<td>2.8 (37.6)</td>
<td>0.300</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>58</td>
<td>160.7 (113.8)</td>
<td>155.9 (107.4)</td>
<td>4.8 (77.6)</td>
<td>0.640</td>
</tr>
</tbody>
</table>
Clinical Outcomes Improved More for Those Who Attended More Classes

[Graph showing the relationship between measurement and model-adjusted mean HbA1c for those who attended all classes and those who did not attend all classes.]
### Patient-reported Outcomes Improved

#### Engagement in Diabetes Self-Care Behaviors

<table>
<thead>
<tr>
<th>Self-Care Behavior</th>
<th>N</th>
<th>First Mean (SD)</th>
<th>Last Mean (SD)</th>
<th>Difference Mean (SD)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>General diet</td>
<td>546</td>
<td>3.72 (2.04)</td>
<td>4.74 (1.79)</td>
<td>1.02 (2.23)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Specific diet</td>
<td>550</td>
<td>4.04 (1.50)</td>
<td>4.57 (1.51)</td>
<td>0.53 (1.68)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Exercise</td>
<td>552</td>
<td>2.63 (2.11)</td>
<td>2.94 (2.16)</td>
<td>0.31 (2.48)</td>
<td>0.003</td>
</tr>
<tr>
<td>Glucose</td>
<td>552</td>
<td>4.11 (2.27)</td>
<td>5.02 (2.07)</td>
<td>0.90 (2.53)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Foot care</td>
<td>553</td>
<td>4.14 (2.50)</td>
<td>5.53 (2.02)</td>
<td>1.39 (2.56)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Smoking status N (%)</td>
<td>549</td>
<td>80 (15)</td>
<td>87 (16)</td>
<td>--</td>
<td>0.262</td>
</tr>
</tbody>
</table>
RTI International

HbA1c Improved More for Those with Better Resources and Support for Self-Management

Note: Means adjusted for site, age, gender, measurement order, RSSM, and interaction between measurement order and RSSM. Changes in HbA1c values over time differed significantly for patients with different RSSM values (RSSM x measurement order: Wald $\chi^2(3)=12.80$, $p=0.005$).
Quality Indicators Improved for HbA1c and Blood Pressure

<table>
<thead>
<tr>
<th>Indicator</th>
<th>First Participants</th>
<th>Comparison Group</th>
<th>Last Participants</th>
<th>Comparison Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c</td>
<td>43</td>
<td>37</td>
<td>40</td>
<td>37***</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>39</td>
<td>40</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>LDL cholesterol</td>
<td>54</td>
<td>57</td>
<td>57</td>
<td>57</td>
</tr>
</tbody>
</table>

*** p < 0.001
Important Implementation Themes from Qualitative Analysis by Domain

**Patient Self-Management**
- Empowerment
- Access
- Support
- Addressing local needs and barriers
- Care coordination

**Implementing Multi-level, Multi-Component Programs**
- Communication
- Relationship building
- Aligning the program with larger organizational and community values and institutions

**Health Care Provider Training and Multidisciplinary Teams**
- Communication and cultural competency training for providers
- Providers became better at communicating and engaging with patients
- Care coordination improved because of multidisciplinary teams

**Sustainability**
- Care coordination and Multidisciplinary teams
- 3 strategies to achieve sustainability:
  - Clinic-Community collaborations
  - Community health workers
  - Sharing electronic data
Disparities Reduced

- The Alliance programs as a whole reduced health and health care disparities for underserved program participants
  - Programs were able to improve important clinical outcomes, and reduce the gap that is typically seen when comparisons are made with majority populations.
  - Patient outcomes indicative of better quality health care improved over time.
  - Important patient-reported outcomes related to diabetes management improved over time.

- Important implementation processes were identified that can help speed translation
Conclusion

- Longer evaluation needed to see significant improvements in some clinical outcomes
- Utilization not accounted for in cost-effectiveness analysis
- Essential components of the Alliance
  - Multilevel, multicomponent interventions target key determinants to change
  - Strong leaders and champions
  - Patient empowerment for self-management
  - Focus on enhancing patient-provider interactions
  - Adaptation to local needs, barriers, and strengths
  - Care coordination within health systems
  - Program alignment with larger organizational values and systems
  - Sustainability planning incorporated from beginning
Panel Discussion
Audience Q&A

To ask a question of the panel, please type your questions into the chat box that you find at the bottom of your screen and hit enter.

If your question isn’t answered during today’s broadcast, we will respond to you via email in the coming week.
Closing Remarks

Leonard Jack, Jr., PhD, MSc
Director, Division of Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention
Co-editor of Health Promotion Practice supplement issue
Health Promotion Practice

• All Alliance articles are available via open access at http://hpp.sagepub.com/content/15/2_suppl.toc

• Podcast interview with co-guest editor, Tawara Goode, Georgetown University, is also available at http://hpp.sagepub.com/content/15/2_suppl/6S/suppl/DC1
Continuing Education

• This session will be available on SOPHE’s Center for Online Resources & Education (CORE) within two weeks at: [http://www.sophe.org/education.cfm](http://www.sophe.org/education.cfm)

• CHES/MCHES CECH and CPH renewal credits are available through the SOPHE CORE:
  – 1.0 category I CECH
  – Fees: $12.00 national SOPHE members; $24.00 non-members
Save the Date!
SOPHE 66th Annual Meeting
Blazing a Trail for Health Education and Health Promotion
April 23 – 25, 2015
Portland, OR

www.sophe.org
The Alliance invites you to attend a policy briefing in Washington, D.C. on Thursday, Nov. 20, titled, “Uniting Policy, Practice, and System Change to Create Healthcare Systems That Work.”

The briefing will be held from noon to 2:15 p.m. ET at the National Press Club.

For more information or to RSVP, please contact Melissa Warren by emailing mwarren@ccapr.com
Promising Innovations to Address Diabetes in Vulnerable Populations: Local Solutions With National Implications

Thursday, November 6, 2014
12:00 – 1:00 PM ET

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Co-hosted by the Society for Public Health Education