This product was developed by the University of Missouri-Columbia Department of Family and Community Medicine as part of the Better Self Management of Diabetes Program, with grant support from the Missouri Foundation for Health.
Better Self-Care of Diabetes Project

Tami Day, RN, BSN
Project Manager
Department of Family and Community Medicine
when researchers make all the decisions …nicknamed Helicopter Research…

“outside research teams swooped down from the skies, swarmed all over town, asked nosey questions that were none of their business and then disappeared never to be heard of again”

Dr Louis T. Montour
1987

From Ann McCauley, MD, MPH
Presentation, March, 2007
Participatory Research (PR)

✓ systematic inquiry
✓ with the collaboration of those affected by the issue being studied (individuals, organization or community)
✓ for the purpose of education and taking action or effecting social change.”

Undertake the research within the partnership to make a difference

Definition used by Institute of Medicine, CDC and Royal Society of Canada

PR guidelines available at http://lgreen.net/guidelines.html

From Ann McCauley, MD, MPH
Presentation, March, 2007
More….

- Research **with** community, not ‘in’ or ‘about’ community

Is the purpose of the research to facilitate the empowerment of individuals, organizations or community?

Will the project help participants to deal with factors that influence their health?
Researchers bring their expertise - as opposed to being the experts - working as equal partners with participants to undertake research which incorporates both scientific rigor and meaningful outcomes.

From Ann McCauley, MD, MPH
Presentation, March, 2007
**Overall Program Goal**

To demonstrate that collaborative, multi-component, self-care diabetes programs can be delivered in a variety of health care and community settings.

**Better Self-Management of Diabetes: Cross-Site Logic Model**

**Educational & Skills for Patients**
- Provide individual DM education and case management to patients in partner clinics.
- Provide free group DM education services to people in community.

**Training Programs for Providers and Care Teams**
- Offer healthcare providers training in soliciting behavioral changes in their patients.
  - Provide healthcare providers update in-services regarding latest DM information.

**Collaboration with Community Partners**
- Develop strong partnerships with local businesses and organizations who can help support the project in the future.
- Work with local Advisory Boards to develop plan for sustainability after grant.

**Follow-Up Care, Support, & Communication**
- Organize local support groups.
- Provide nurses to communicate between project, clinic and community.
- Report results at end of project.

**Key Program Inputs**

**Shorter-term Outcomes**

**Process Improvements**
- Improve patient’s confidence in their ability to self-manage DM.
- Improve provider’s ability to help patient with self-care skills.
- Improve patient satisfaction with care.
- Improve patient and community understanding of the importance of self-care.

**Program Effectiveness**
- Improved retention rates in self-care management.
- Increased use of self-care resources and tools.
- Improved ability to monitor patient outcomes.
- Improved processes of care related to DM patients in practices.

**Engage in Clinical Feedback and Quality Improvement Efforts**

**Longer-term Outcomes**

**Patient Outcomes**
- Improved patient clinical measures (e.g., A1c, BP, BMI)
- Improved health and quality of life.

**Program Outcomes**
- Self-care skills integrated into routine care
- Continued training of care providers around the provision of self-care.
- Community-based strategic alliances
- Program sustainability

**Organizational Outcomes**
- Improvements in data management and patient monitoring.
- Shifts in clinical, administrative, and cultural practices and policy changes related to self-care
- Integration of self-care into quality improvement processes

**System Wide Spread**
- Spread of self-care tools and resources to other target populations
- Buy-in from other care providers
- Support from senior level management
- Show evidence that self-care management is cost-effective.
CLINICAL MEASUREMENTS

- A1C’s (goal is <7%)
- Blood Pressure (goal is <130/85)
- % of patients getting annual dilated eye exams
- % of patients getting annual foot exams
- % of patients on daily ASA
- % of patients on statins
- # of patients getting individual DM education
- # of patients attending DM nurse-led classes
- # of patients attending CDSM support groups
LESSONS LEARNED SO FAR...

- In the 1 ½ years of the project we have learned:
  - There is a great need of nutrition education at all levels.
  - Motivating patients to change behaviors is possibly the most challenging issue facing healthcare today.
  - Selling the community on ownership of the project is tough.
SELF-CARE

- Nutrition Information
- Physical Activity
- Follow-up with Physician
- Education/Information regarding diabetes.
- Accountability
- Learning how to make and follow an action plan.
PLATE METHOD

½ Plate of Color (Fruits and vegetables)

¼ Plate STARCH (potato or beans) or GRAIN (rice, bread or pasta) or DESSERT

¼ Plate PROTEIN (lean meat, eggs, nuts)

Plate method developed by Scottie Rawlings, RD
Meal Plan Tips
Simple guidelines to help you feel better, reduce your waistline and eat healthy.

- Strive to eat SOMETHING before 9:30 a.m.
- Strive NOT to eat after 8:00 p.m.
- Decrease and/or avoid sugary drinks.
- Use the PLATE METHOD when choosing meals.
- PLAN your meals and snacks.
- MONITOR your blood sugar levels and share information with your healthcare provider.
- Strive to eat at REGULAR times each day and about the SAME AMOUNT with each meal.

Developed by Scottie Rawlings, RD
COMMUNITY INVOLVEMENT

- Educating community about project.
- Enlisting motivated individuals to become actively involved.
- Convincing community of project relevance.
- Enlisting support from community businesses, organizations and volunteers to build a sustainable project.
COLLABORATIONS

- School of Journalism Capstone Project
  - Senior students researched and developed community specific PR campaign.

- School of Nursing Community Health Class Preceptor
  - 3 nursing students from this class helped survey the townships within in counties to help determine where help is needed most.

- PhD Student Internship
  - Registered Dietician, Masters in Public Health and working on Doctorate in Healthcare Literacy is doing internship with our project.

- MD Research Fellow
  - Medical student at UMC did a two month rotation in research on our project. Helped do patient interviews and literature reviews.

- UMC Extension Office
  - Collaborating with us to develop nutrition information and establish a toll-free call in number for nutrition and project information.
Accomplishments So Far

- Hired and trained nurse case-managers in each of the 6 clinic partner sites.
- Established Community Advisory Boards in each county.
- Recruited and trained 10 support group leaders in each county.
- Data shows improved patient A1Cs, foot & eye exams, blood pressures, etc., in all clinics.
- Providers see benefits of nurse dedicated to providing this service in their practice.
- Patients report increased ability in self-care.
QUESTIONS?????