Community Educator Impact: The Role of Community Health Workers in Diabetes Self-Management Education

An Everyone with Diabetes Counts (EDC) Webinar

Transcript
February 23, 2017

Mitzi Vince: Welcome to today's webinar, “The Community Educator Impact: The Role of the Community Health Worker in Diabetes Self-Management Education." We will get started with today's program in just a few minutes, but first I just wanted to mention a few housekeeping items. First, all participants entered today's webinar in listen-only mode. Should you have a question during the presentation, we just ask that you type it into either the chat or the Q&A box to the right of your screen, and then we will also answer as many questions as we can at the end of the program. Also we will be recording today's presentation. The recording and the slide deck will be posted on My Quality Insights, the online learning platform in the Everyone With Diabetes Counts community. These resources should be posted within the next few days, so just keep a lookout for those.

Today's speakers will include staff from our Everyone With Diabetes Counts program and some of the community health workers that have been working tirelessly that make this program a success in the community. At this time I'm going to hand the presentation over to today's first speaker, and her name is Natalie Tappe. She's our network task lead for the Everyone with Diabetes Counts Program. At this point, Natalie, I'm going to turn it over to you.

Natalie Tappe: Thank you, Mitzi. Good afternoon and welcome to the Quality Insights Community Health Worker Webinar. As Mitzi said, my name is Natalie Tappe, and I'm the network task lead for the Everyone with Diabetes Counts program in Delaware, Louisiana, New Jersey, Pennsylvania, and West Virginia. Our other speaker, Karen Ziecker, is a quality improvement specialist with EQ Health Solutions from Louisiana. She will also join us today as the community health worker facilitator. Our objective today: What is Everyone With Diabetes Counts, what is the current definition of a community health worker, what is diabetes self-management, what is the AADE's position on community health workers teaching diabetes self-management education, what are the merits and opportunities of a community health worker, and why do we need community health workers in teaching Everyone With Diabetes Counts.

What are the next steps for those community health workers that help us teach Everyone With Diabetes Counts. Then lastly, our interview with the community health workers who are actually in the field. What is Everyone With Diabetes Counts? To begin with, I'd like to tell you a little bit about it. This is a five-year program from the Centers for Medicare and Medicaid to address the national diabetes epidemic. As I'm sure you know, 29.1 million people in the US have

diabetes. One out of four don't know they have it. We spend approximately 245 billion in total medical costs and lost work and wages for people who are diagnosed with diabetes. People who have diabetes are at a higher risk of serious health complications such as blindness, kidney failure, heart disease, stroke, amputation.

Currently at least one out of three people will develop diabetes in their lifetime. What's even more frightening is actually that young people are becoming Type Two diabetics at a much younger age. CMS wanted to try and help reduce these disparities by trying to improve health literacy and quality of care. They wanted to decrease the disparity of diabetes in our minority populations by improving the frequency of testing for hemoglobin A1C, eye exam, lipid profiles, foot exams, and improve clinical outcomes of people with diabetes so that they don't develop complications. If they do have complication, we can prevent further worsening of their complications.

When we teach Everyone with Diabetes Counts, what is their target audience? For us, it happens to be the physician practices, people with Medicare and Medicaid who are dual eligible, and people with Medicare Advantage. We do have national partnerships with the ADA, the AADE, and the American Medical Association. Locally we have partners all over our communities. The local area agencies on aging, faith-based communities, senior centers, federally-qualified health centers, rural health initiatives, departments of health, hospitals, libraries, et cetera. We develop partnerships with a lot of entities around our community. In speaking of community health workers, I wanted to make sure that everybody was on the same page and to provide the current definition according to the American Public Health Association.

A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community they serve. They serve as a liaison, a link, an intermediary between healthcare, social services, and the community. They also facilitate access to services and improved quality and cultural competency of service delivery. They build individual and community capacity by increasing health knowledge and self-sufficiency. They play a very vital role in improving the health and well-being of people in their own communities. We see a lot of community health workers that are actually embedded within their own communities. They speak the language, they walk the walk, they talk the talk. It's very difficult at times to be an outsider and to come into these communities to make or deliver healthcare change.

It's very important that these community health workers are out within the communities that they live in. They can also decrease healthcare costs such as visits to the emergency room, increased hospitalizations. If a community health worker is able to stop a worsening condition or is able to refer a beneficiary back to their physician or back to the clinic that they need to go to, they definitely can help decrease healthcare costs and prevent visits to the emergency room. They also can help patients and communities better

understand what they do and what their healthcare options are as well. Now I say community health worker, but as you can see from this slide, there are a variety of names.

These include and not limited to, believe me, because there's other ones that I probably haven't thought of, but the one is the standard community health care worker, community health adviser, outreach worker, community health representative, promotore de salud, health promoter, patient navigator, navigator promotores, peer counselor, lay health adviser, peer health adviser, peer supporters, peer leader, peer educator, and lastly CHERP, which is a community health education resource person. You can see all of these names mean community health worker in one way or another. I wanted to introduce you to other names so that you would know this list is not all encompassing, but the general title is community health worker.

Speaker 3: [inaudible 00:08:38].

Natalie Tappe: In order to talk about community health workers, we know that they teach many other disciplines which incorporate chronic disease states such as arthritis, cancer, stress, HIV, et cetera. The need for diabetes self-management education seems to be growing daily, so for a quick review, I wanted to talk about what is diabetes self-management education. This happens to be according to the American Association of Diabetes Educators. DSME is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. We want to make sure that the individual is able to understand diabetes and what they can do improve their healthcare, to be empowered to be able to go to their healthcare team and say, "This is what I want done. This is how I envision my care. What can you do to help me get there?"

It also incorporates, as I said, the needs, the goals, and life experience of the person not only with diabetes but also with pre-diabetes. As we know, there is a large number of people with pre-diabetes along with people who don't know they have diabetes. If we could theoretically catch people that have pre-diabetes before they reach diabetes, we have in effect reduced the footprint of diabetes complications. All of the diabetes self-management education is always evidence-based. The objective, as I said earlier, also to support informed decision making, help those people or individuals make the decisions involving their own care, promote self-care behaviors, problem solving, "How do I make a change in my healthcare? What do I do to improve my health." Lastly, as I said, improve quality of life for those that we are teaching.

While I'm talking about the AADE, along with the ADA, which is the American Diabetes Association, they have long recognized community health workers. Since they're a national organization of diabetes educators along with the American Diabetes Association, they do have a position statement about community health workers and what is their role in diabetes education. The AADE and the 2012 National Standards for Diabetes Self-Management

Education and Support have acknowledged community health workers role in delivering DSME to specific populations and then connecting the more than 100 million Americans with diabetes and those at risk for development of diabetes. That's a pretty powerful statement. They also believe that we should support community health workers as they continue to serve as a bridge between the healthcare community and people with diabetes.

We want to support the community health worker in the role of priMary Keller and secondary prevention. They should also receive training from an evidence-based program such as I mentioned before the American Diabetes Association or the AADE, which is the American Association of Diabetes Educators. There's also other evidence-based programs such as Diabetes Education Empowerment Program or DEEP or the Stanford Diabetes Self-Management Program. All of these are ways that the community health worker can become certified in teaching diabetes self-management education. There should be reciprocal exchange and support between community health workers and the healthcare team to provide the best outcome for the beneficiary.

We want to do what's right for the individual to make them feel that they are participating in their healthcare also to recognize that community health workers are valid and they do help in the community to promote healthcare. We want to make sure that we also support continued research that evaluates the roles, contributions, and effectiveness of community health workers. There's a lot of community health worker organizations around the country. There's a lot of community health worker associations where community health workers are actually employed by practices or health departments. Some states don't have community health worker associations. Some community health workers, or most actually, community health workers that are embedded in the communities do this out of the goodness of their heart. They want to effect change.

They volunteer their time and their effort in teaching people about diabetes self-management education. In order to get compensation for community health workers, legislation within each state would have to be passed in order to recognize those community health workers as employees of an institution or a practice. Why is it important to have community health workers, and what opportunities are in the community? What can they do to help beneficiaries or patients or their community change how they see their healthcare? Since most rural and ethnically diverse communities are highly concentrated, it seems as though community health workers have a greater opportunity to develop these relationships. They can definitely act as the liaison between the provider and the consumer of the healthcare.

They also can gain support from organizations serving the community. Your area agencies on aging, your Department of Health. A lot of those individuals work with these entities to be able to bring if it's not diabetes self-management education, it may be chronic disease self-management education as I had mentioned before. It's imperative that other organizations recognize the need

for community health workers and support them as well. The merits of being a community health worker is to connect the consumers with needed healthcare and social support services. A lot of times in particularly despaired areas, there's a lack of transportation, there's a lack of money to be able to first of all visit your provider or get to the provider because of the transportation issue.

Sometimes community health workers are able to facilitate those people in need. They also facilitate improvements in health status and quality of life as I was mentioning in particularly rural and ethically-diverse communities. They work daily to combat ethnic and racial disparities. That's really an important part of why community health workers are so important. Why should someone want to be a community health worker. As I said before, if the community health workers are embedded within their communities, they can effect change much more than a stranger coming from outside of their own community. They can also help them support people with chronic disease, get them the access that they need, work with healthcare providers for behavior changes, support people as they make these changes.

A lot of community health workers tend to they're the ones that are out in the community. They're the ones that have the diabetic support groups. They're the ones that call the patients to come to class. They're the ones that call the provider if somebody's blood sugar is 500 or they can make sure that the beneficiary calls the provider immediately. They obviously don't offer medical advice, but they can help the patient make sure that they have contacted their healthcare team, and as I said develop community coalitions to meet the needs of specific populations. Why does EDC, why does Everyone With Diabetes Counts need community health workers? It's imperative because they help with sustainability of the program. They help us with the reach into the community.

Since they're recognized as a level-one diabetes educator by the AADE, we can use community health workers in identifying cultural differences, cultural barriers to self-care or promote behavioral change. Sometimes the cultural barriers or challenges are what prevent those people from seeking healthcare in the first place. Again, we need them to help us with providers and make the referrals if they're out in the community to our classes around the areas. Let the physicians or the practices know that we're out there. Where are the classes? What diabetes health management education class can they refer them to. Also, they can help provide us with culturally specific health information. Certain nuances that we may not know about, community health workers that embedded in the community are able to do that for us.

They can also help us convey self-management information to the healthcare provider for the people that have diabetes. A lot of our community health workers that we utilize, they help us with the program. What works about the program? What doesn't work? They give us guidance. They tell us, you know, "Maybe this is too much verbiage. We need more visuals. We need more help developing a plan of action, or our action plans aren't working. What else can we do?" They're able to help us evaluate our program so that we know what

we're doing and is it helpful for the beneficiary or the patients. One of the other things that also is extremely important is the community health worker may be able to help a practice, a hospital, a department of health, a federally qualified health center become ABA recognized or ADA accredited in diabetes self-management education.

This is a long process, so with the help of the community health worker, they may be able to recognize that there's a need and that this organization wants to become AADE recognized or AADE accredited. If that occurs the community health worker can assist in that process be able to be the liaison between the organizations and help them develop a plan of action to become certified. Also we need them for obvious reasons because they provide the DSME in areas we can't reach or areas that are most despaired. We live in large states, so we might not be able to get three hours away. We may not able to drive three hours to teach a class. If we have community health workers within the communities, they can actually hold their own class because they're right there. They're able to do that. They're able to get within the community and hold their classes.

They also can help us, like I said before, develop and implement new strategies. Well, how can we get beneficiary participation and retention? What can we do differently, and again use their own community to recruit beneficiary participation. What are the next steps for community health workers that teach EDC? One of the things is to continue teaching DSME. Stay certified in the respected curriculums, be up to date, be able to, if this program, Everyone With Diabetes Counts program goes away at the end of five years in 2019, be able to continue to teach DSME within your communities. Make this resource available to those who need it most, help us recruit, find people within your community who want to become community health workers, peer educators, promotores, whatever you want to call them.

As I said before, obviously community health workers do not have to be in the medical field. They're peer educators, peer teaching peer. Help us with trainings, facilitate community health worker trainings, tell us that you have people who are interested. We have a space to hold a training. Let's provide it to the community. Provide us with best practices. What works in your area? What's the best way to get the teaching across, the diabetes self-management? What works in your area? What doesn't work? What success stories have you had? Serve as a mentor. Be able to be there when they need help.

One of the things that we have done as a [inaudible 00:24:30] is for our community health workers, the West Virginia program coordinator developed a guide, a community health worker guide for each of the modules that we teach for diabetes health management education that has immensely helped with the mentoring process for new community health workers, if there's something else that's new or different out there, be able to share with all of us. With that being said, I now would like to turn the presentation over to Karen Ziecker who as I mentioned before is a quality improvement specialist with EQ Health Solutions

in Louisiana. We have four community health workers who I'd like to introduce to you. We have SueAnn Taylor from the …I can't pronounce it.

SueAnn Taylor: It's Nacogdoches.

Natalie Tappe: Nacogdoches, thank you, Regional Medical Center in Louisiana. We have Carol Matheny from the Hospice Care Palliative Care Center in West Virginia. We have Mary Keller from the Coushatta Health Department in Louisiana, and we have Crystal Hawkins from Cabin Creek Health System, a federally qualified health center in West Virginia. Karen Ziecker, if you'd like to take over, that would be great. Thank you, everyone.

Karen Ziecker: Thanks, Natalie Tappe, just great information. It is so good to hear others listening and learning more about the community health worker program. We do know that the patient who receive diabetes self-management education seem to really have improved use of their primary care and prevention services. They're more likely to take their medication as prescribed. They have better control of their glucose and blood pressure and LDL cholesterol. We are looking at trying to lower those healthcare costs as much as we can, so we're very appreciative for our community health workers and peer educators that are in the field with us now. It is my pleasure to have this discussion with the four that you see in front of you now.

I want to start with the first question. This is going to be a little panel discussion of their experiences. We want to start with the first question of being what made you decide to become a community health worker or a peer educator? If I could I'd like to maybe start off with SueAnn Taylor from Nacogdoches, and then we'll just go through the four and answer that question first.

SueAnn Taylor: Sure. In 2015 our CEO here at the hospital came to me and asked me to try and get a well-spot designation through the Department of Health and Hospitals here in our state. I found out that one of the benchmarks to achieve that is having a DSME at your hospital. I really had no idea what DSME stood for. I knew there were diabetes classes out there, but this was a new term to me. A couple of months after I started trying to get this designation, AADE was having their yearly conference in New Orleans. It's probably about four hours from us, and I decided to take my mother who was 69 at the time. She'd been diabetic for probably about 15 years and had been on insulin probably about seven. She came to some of the seminars with me, and she really enjoyed going through the expo.

One of the days that she stayed in the hotel I brought back, it was a product called Tartoos. It was a temporary tattoo that you could put on your skin, and it would help you remember where you put your injections, your insulin injections, so you could rotate your sites. My mom had been taking insulin for seven years, and I brought it back to show her how awesome this was. She couldn't understand the concept of it, and she couldn't understand why it was important. I asked her I said, "You know, you know to rotate your injection

sites." She said, "No." She had been giving herself insulin in the same spot for seven years. She has an RN for a daughter, and she goes to an endocrinologist. I thought that all these things were taught to her in that office, and my mother is an intelligent person.

That was one of the things that gave me a passion and a drive to not just get this designation for our hospital but to be a part of the education for these patients who don't know. It was important to me, too, to stop so casually using the term "noncompliant," because a lot of our patients would be more compliant if they had more education and more tools.

Karen Ziecker: Yes, so-

SueAnn Taylor: That's what made me decide to get involved with this. It's helping people like my mother have more power to change the outcomes of their health.

Karen Ziecker: Absolutely. That's a great story and testimony of what we do see on a daily basis sometimes and other families and things. Well, Carol Matheny, could you please share with us what brought you to become a community health worker, peer educator?

Carol Matheny: First of all, my boss saw the ad that Natalie Tappe had put in the paper for community health workers. We said it would be a good avenue for a recourse to find out what it was about. I have been diabetic for eleven years. I'm still diet controlled, and I learned so much in that class. As a nurse, you would think, "Oh, she knows everything," but there were things brought out in the class that if I knew, I had forgotten. I agree with SueAnn Taylor. People go to the doctor and they think their doctor tells them everything that they need to know, but they truly don't. There are things that you don't think to ask when you're seeing them about your diabetes or how you should control it, or they just assume that you know it.

Karen Ziecker: That's right so it is an eye opener to be able to see that that opportunity is there for education in so many ways. Thank you, Carol Matheny. Let's move to Crystal Hawkins. Crystal Hawkins, if you could share with us how you decided to become a community health worker peer educator.

Crystal Hawkins: Well, one of my main reasons for me becoming is we're in a rural area, and our patients can't necessarily travel further out to get nutrition education or see a specialist. That was a big part of why we wanted to get involved is so that our patients could better understand what their limits are and how to actually take care of themselves versus just letting them learning it by a 15-minute conversation from a provider.

Karen Ziecker: Thank you. Let's move to Mary Keller. Mary, if you could share with us your thoughts?

Mary Keller: Well, I found out about the program when you called because you were reaching out to Native American Tribes in Louisiana, which I work for a federally recognized tribe here. As most people know, Native Americans have a way higher chance of diabetes than the general population. We are always trying to look for things to spike their interest to learn about the disease that they have and how they can manage it. I'm a certified diabetes educator, but that class was amazing. It brought a new perspective and a perspective that it was understandable. It wasn't based on medical terminology. It was based on layman terminology. The classes that we've taught, the people have been so excited because they enjoy them, they're fun. That's how I came to know about it.

Karen Ziecker: Thank you, Mary. I appreciate that. Yes, as Natalie was explaining, we are trying to reach into the multiple populations and either the despaired populations, rural, our Native Indians, our African-Americans, and those that are most at high risk. Each one of you are helping so much to penetrate those areas, so that we can reach to those that just didn't have access before maybe. I'm going to do the round robin again, and let's do the goals. We've touched on it a little bit with the goals you'd like to achieve by becoming a community health worker. Let's get a little bit deeper into that, the goals that you would like to achieve in your particular organization, are you reaching them, or just what the status is on that. Let's start with SueAnn. I guess we'll go ahead and start with SueAnn.

SueAnn Taylor: Well, my main goal was to help people and to give people the education to improve their overall health. One of my CNAs attended the first diabetes class that we had here at the hospital. She's a young, 31-year-old mother of four, and she works a lot. She was having trouble controlling her blood sugars, and the doctor had already put her on insulin even though she was just diagnosed a few years ago. After coming to the class, her hemoglobin A1C she told me a couple of months after the class it had gone down by two points. Another thing that I get to see on a daily basis whenever I work with her whenever she was in the class and we were talking about drinking water, avoiding high-sugar drinks, she said, "Well, I hate water. I have to drink juice." She said, "But I quit drinking Cokes." She didn't realize, you know, there was a lot of sugar in these bottled juices.

She comes up to me and said, "I'm still drinking my water." She said, "I don't like it." She said, "But I like my eye sight. I like keeping my limbs." She said, "I know that those are complications that can arise with poor control of my blood sugar." She said, "So, um, I'm only drinking water." I was like, "Wow, you know, those are both wins." Her hemoglobin A1C and realizing that she has power to change just by even changing what she drinks.

Karen Ziecker: That's right. Well, Crystal, let's go to you. What goals have you been setting for your area or things that you maybe have met, goals you have maybe met?

Crystal Hawkins: One of the things we target in our area is what we call a 9Ds which is A1C above 9. We encourage all of our diabetic patient to take the class. However, the

providers will refer to me, which helps me reach a more higher number of them what I would do on my own. They'll listen to their providers when they won't listen to me sometimes. It helps me reach more patients with their support, so that's a big part of our program of just trying to get the providers involved with us in order to help the patients. We work together.

Karen Ziecker: Very good, yes. It is important that we have our providers, that we're all working together towards the same goals. In as much as we can support our providers we certainly want to because they are on the frontline many times. They are an excellent referral source when it comes to being able when we're starting to design our class and make arrangements and schedules for our class. Let's see. Let's go to Mary, if you don't mind to maybe share some of your goals in your area.

Mary Keller: Our goal, and what I have been looking for a long time, was something that I could put in place that would be available like certain number of times of year if you missed a class, you could make it up the next time. That kind of a thing that would be ongoing. We've done things off and off, like, we'll have a diabetes day here or whatever. This gave me an option to start teaching the classes. What our goal is, and we've done one already, and I have one scheduled in March, so March is diabetes alert month. November is diabetes month, so I try to schedule my classes in March and November so that it also brings awareness about what month it is as far as health promotion.

It's also the same constant thing. I've really been looking for that for a long time. Our goal was to always find this constant thing, and we've done that with this program. We'll continue to do that those two times of the year, so that people will know that it'll be available.

Karen Ziecker: Yes, that flexibility sometimes, and I have found that also with the DEEP Program and what is mainly what I teach as well. I do find that that flexibility helps so much whenever we're working with many organizations and things, so I'm glad you mentioned that. That's a good point. Carol, I believe you're up next.

Carol Matheny: Well, our goals are probably a little bit different, but overall it's about quality of life. With hospice you usually see patients within the last six months. If they've learned how to control their diabetes early on, they have less complications with any disease process that is going on be it cancer, congestive heart failure, COPD. It's teaching them to manage that chronic illness so that they don't have extra complications along with what they're already going through. It seems to help ease that burden for not only the patient but also for the caregiver.

Karen Ziecker: It does whenever they can have that education and the sharing of education. Sometimes if they can attend classes together and things, it does seem to be a special time together to be able to learn. Let me ask this. Did your diabetes self-management education training program, whether it's DEEP or Stanford, prepare you for the interaction with your participants? Let's start with Mary on that.

Mary Keller: Yes, it definitely did. It gave a perspective to teach in a way that was different than I had been taught as a medical professional. The teachers at the DEEP class were one on one with you almost because it was a small group but brought innovative ideas of how to show someone what happens to your kidneys if you don't take care of your diabetes by simply giving a strainer, some beads, and some colored water. It got the point across. The follow-up that y'all have with us is amazing, come and helping with the first class, always making sure we have everything we need, if there's anything new out, like those new handouts that she was just talking about, that help support the educators, like a script almost to help them through the class. All of those just add up to being a great program, and the training was amazing.

Karen Ziecker: Thank you, Mary. I'm going to go back to Carol.

Carol Matheny: I agree with Mary. The training was hands-on, and you were excited to take it out and share it with others. They get that same excitement from you that you learn from the instructors that taught us. Natalie was my instructor, and she did an excellent job in teaching the things that, as Mary said, you normally don't learn in nursing school when teaching other people. It was really good.

Karen Ziecker: Thanks. Well, let's hear from SueAnn, and then we'll hear from Crystal.

SueAnn Taylor: I agree. I felt like it really prepared us all well. In fact, there was some people in our class that were nervous from the first day. They knew that on the last day we were going to have an opportunity to get up and teach a topic. They were just nervous about having to get up because they said that they weren't a good public speaker. We were able to encourage them, and they encouraged us. It also prepared us by hearing questions that were going to pop up. We were able to role-play and be the classroom and be the teachers. That was one thing that I liked, and I know that the person in our class that was nervous to begin with, that gave her some peace of mind knowing that she could do it. She actually did a good job whenever she got up there.

Karen Ziecker: Yes, that confidence building is real helpful in that trial period so that you can work through those questions and answers and potential items and things. Yes, I find that it does help. It helped me whenever I went through that process. Crystal Hawkins?

Crystal Hawkins: Yes?

Karen Ziecker: Did you want to respond to that answer?

Crystal Hawkins: Sorry, my phone-

Karen Ziecker: [crosstalk 00:43:10]

Crystal Hawkins: ... is messing on me here a minute.

Karen Ziecker: That's okay. Are you there? I can move-

Crystal Hawkins: Are you there?

Karen Ziecker: Are you in? How did the education curriculum either DEEP or Stanford prepare you for interaction with the class participants? Do you feel like it helped you?

Crystal Hawkins: I absolutely felt like it helped. I believe that it helped me think about not everyone knows medical terms, not everyone is medically trained. It brings it down to a level that anybody can understand. It makes them in your class feel like you're teaching them at their level, you're not going above their head. You're focusing on how they're going to be able to learn. You have their best interest at mind whenever you're trying your hardest to get them to understand with our displays that we have and our flow charts, our boards, all of our demonstration products. I think a lot of people learn better that way.

Karen Ziecker: Well, thank you. We're going to move onto the next question because our time is getting shorter. I know that I would love to share inspiration that I have received from some of my classes. I really want to hear from you what inspired you most during your classes and maybe a short success story. We've already heard a couple of little short success stories, but maybe the thing that just inspired you the most whenever you began your work in doing this education. Let's start Crystal Hawkins, I'm going to go ahead and start with you again, please.

Crystal Hawkins: One of my success stories is we had a patient come in. She had taken her classes, and she comes back a little while later. She's like, "Hey, guess what? I've, I've lost, like, nine pounds already." And we go, "How are you doing it?" She's like, "I'm not really not eating what I want to eat, but I'm eating less of it." That was a big, you know, at least I knew she was catching on and learning what I was trying to get across to her. That makes you feel better.

Karen Ziecker: Excellent. Yes, indeed, it does. Carol Matheny?

Carol Matheny: Hello?

Karen Ziecker: Do you want to share with us?

Carol Matheny: Well, I think what is interesting to watch as you go through the class, and you bring the hands-on stuff like showing how the kidneys function and the different organs. People look at you and say, "I didn't realize it affected all that."

Karen Ziecker: Yes.

Carol Matheny: You know, "I didn't think it was a big deal," and just watching the light bulbs go off. Then they're coming to class with recipes and their blood sugar logs and just really excited about it.

Karen Ziecker: I've experienced some of those same thoughts. It does seem to inspire many of us that are on this phone call today when we can see progress like that. SueAnn, please, if you could respond?

SueAnn Taylor: It's inspiring to me whenever they just get excited about what they're learning. You can see is click. Whenever they come in, a lot them think, well, you know, they have a sentence. Whatever happened to their brother or their mother who had it, whatever complications they had, that that's what they're in for. It's like an inheritance that they're going to get. It's so exciting to see that they know that that's not the case by the time they leave the class that they can change their outcomes.

Karen Ziecker: Yes, that's right. They can change their outcomes. We want to bring the message of health and hope, and the management of their chronic diseases. It's just as important as ever for us to be able to help bring that hope and timely education and treatment and proper self-management. Mary, I want to give you an opportunity to respond.

Mary Keller: Like what some of the others said, what inspires me the most and to keep on is when it clicks. Their grandmas lost their leg or this one can't see, and they think, "Well, that's just going to happen to me." Then when you teach them that there are ways you can prevent that or put it off, it's like, "Oh, wow, I didn't know that could happen." That to me you know you're being successful at showing them something that they can use in their life. Simple things that we just take for granted because we work in the field they don't really know. When that happens that aha moment happens, then you know you've made a difference in someone's life. That's what inspires me to keep on.

Karen Ziecker: Thank you. Well, let's shift gears a little bit. You know, we've been talking about reaching into the rural, reaching into certain populations. Let's just real quickly go around and identify the primary targeting folks that you're working with in your region. I believe most of you are successful in reaching that population, but what are the challenges that you may be run up against, if you could share that. SueAnn, if we could start with you, please?

SueAnn Taylor: We're new here with our classes. Our first class had a diversity of people in it and age groups and social groups. One of the challenges I'm having is getting people in the class is because our classes are between the hours of 8:00 and 4:30. We're having trouble reaching those people that work, so our plan for later on the year is to offer some classes in the evenings.

Karen Ziecker: Good point. I know whenever Natalie was going through some of those identifying us getting into certain areas, and it was hard for us to get to. That is so important when we have the regional community health workers and peer educators where they are. Afternoon classes or perhaps night classes, if it works better for certain people, that that could be an opportunity where we reach folks. A lot of it is done during the day hours, and we certainly potentially could reach more at different times. Carol?

Carol Matheny: The biggest issue is changing the culture that, "Well, I've got diabetes. Grandma had diabetes. Mom had diabetes. There's nothing I can do, and the doctor tells me everything that I can." Once you get them in there and you start telling them, they see that there are things that they can do. That's the biggest thing, whenever I've had a class. Sometimes I'll do it in the elderly high-rises, and I'll have people say, "Well, my doctor tells me everything I need to know." Then their friends will come out after the class and start telling them. Then the next class, those people will show up because they didn't know something that I had taught during the class, so they wanted to hear more.

Karen Ziecker: Good deal. Mary, if you could share with us your feelings or things that you've come across?

Mary Keller: Well, of course, my population is limited because we do just reach the Native Americans in our area. I've found that it's hard to get people to come or to convince them come. Once they get here, they're excited because I don't know what they expect. Maybe they expected it's going to be this long drawn out, boring, listening to this person talk for four hours or two hours or whatever. My problem, I guess, is just getting it out there to them and letting them realize that it's a good thing. It's not a boring thing. It's an exciting thing. We just keep putting out the signs and sending out the mail-outs to try to get people interested in coming also word of mouth to try to get that to happen.

Karen Ziecker: Yes and I appreciate that, Mary. Mary has also been such a good resource for me for reaching other tribes in our state as well. I do appreciate when we do have those communications so that we continue to reach as many as we can. Who have I got left? Is that Carol or Crystal?

Mary Keller: Crystal.

Crystal Hawkins: Crystal.

Karen Ziecker: Crystal. Okay, Crystal. The primary people that you're targeting in your region and how your success has been and what challenges you may have.

Crystal Hawkins: We mostly target our Medicare patients 65 and older. If we have someone that's interested otherwise, we will also take care of them as well. One of our challenges is getting people to come in during the hours that I'm available. Some people that work in our area drive an hour, 45 minutes or an hour to and from work. By the time they get off work and get here, it's already gone. That's a challenge for us, so that they don't have to miss work.

Karen Ziecker: Thank you, Crystal. One of the things that we are very concerned about, and I know many people on our phone call that sharing information, is how is the facilitation and sustainability of diabetes education within our states? We as Quality Insights are trying to facilitate that and work with other organizations so that we can make as bigger reach into the community as we can. Do you

envision this program sustaining itself for the future, and what are some of the ways that we could maintain sustainability? I know others that are on the phone and through the partner organizations are really concerned about it as well, so they're going to be listening socially. Let's start with Carol, if you don't mind.

Carol Matheny: This program has good sustainability. I have been trained in both this program and the Stanford Program. To me, this program by far offers more to the participant in learning about their diabetes. Personal opinions of [inaudible 00:54:38] my people have taken both, seem to enjoy this class better because of the hands on. It gets back to the C1 using all the senses to learn with. How to sustain it? Again, getting more of our health departments, possibly some of the larger family practices to buy in and help to spread the word, and to help teach the class would be helpful.

Karen Ziecker: Good ideas. Let's go with SueAnn.

SueAnn Taylor: It has sustainability for the simple fact that it's effective. Just in the little bit that I've been doing this, I've seen positive outcomes. That will help sustain it. The more that we teach, the more the word of mouth will get out from those participants that have participated. You know, diabetes being something that does run in the family, once one family member has some positive outcomes, they can tell others and bring more into it. One thing about it is, it's relatively low cost for us to do this. After the initial purchase of our teaching tools and the hands-on items that we use to teach certain concepts, really besides some printouts of the paper, it's low cost to maintain.

Karen Ziecker: That's right. We've got about one-

Natalie Tappe: Hey-

Karen Ziecker: ... more minute for questions left, so [inaudible 00:56:28] Mary and, oh, I'm sorry? Natalie, can I wrap it up, or do I need to wrap it up because I-

Natalie Tappe: Yeah, we need to need to wrap it up now just to see. We've got three minutes left just to see if there's any questions from the field or Mitzi if there's anything in Chat. I do want to thank our community health workers in the field because without them we couldn't get this done. We couldn't reach those populations. As Karen said, it's you in those communities helping us make this program successful. Mitzi, do we have any questions in the queue?

Mitzi Vince: Hi, Natalie. We just have one question asking if the community health workers would be okay with us forwarding their contact information to the attendees? Is that possible?

Natalie Tappe: Sure. That's fine with me.

Mitzi Vince: [inaudible 00:57:33].

Natalie Tappe: Okay.

Mitzi Vince: Sure. That's all the-

Natalie Tappe: Well, good.

Mitzi Vince: ... questions that we have in the Chat Box right now.

Natalie Tappe: Are there any questions from the field?

Mitzi Vince: I'm going to go ahead and mute all the phone lines right now, so if anybody has any questions on the telephone, go ahead and ask now.

Natalie Tappe: If we have any questions, the phone lines are muted. We have about two minutes, or if you'd like to ask one of the community health workers a question. Well, we will go ahead and wrap up. Again, thank you. If you could take a small survey at the end of our presentation to help us see if this was beneficial to you or not, we would certainly appreciate it. I'd like to again thank SueAnn, Carol, Mary, and Crystal for joining us. Your insight was most helpful. It was very inspiring to others. We hope that for those of you who are on the line we were able to explain the program, explain what we do, have a better understanding of what community health workers, peer educators, CHERPs, whatever they're called, it's a service to the community. As I said before, we thank you for that. As Mitzi said, the recording will be available as well as the slides.

Was there anything else, Karen? I would like to also thank Karen Ziecker for facilitating the community health worker portion. Excellent job. Mitzi, anything else, any other housekeeping before we sign off?

Mitzi Vince: No, I don't think so.

Natalie Tappe: Thank you everyone and have a great weekend.

Mitzi Vince: You too.

Natalie Tappe: Bye-bye.

SueAnn Taylor: Thank you.

Karen Ziecker: Thank you again.