



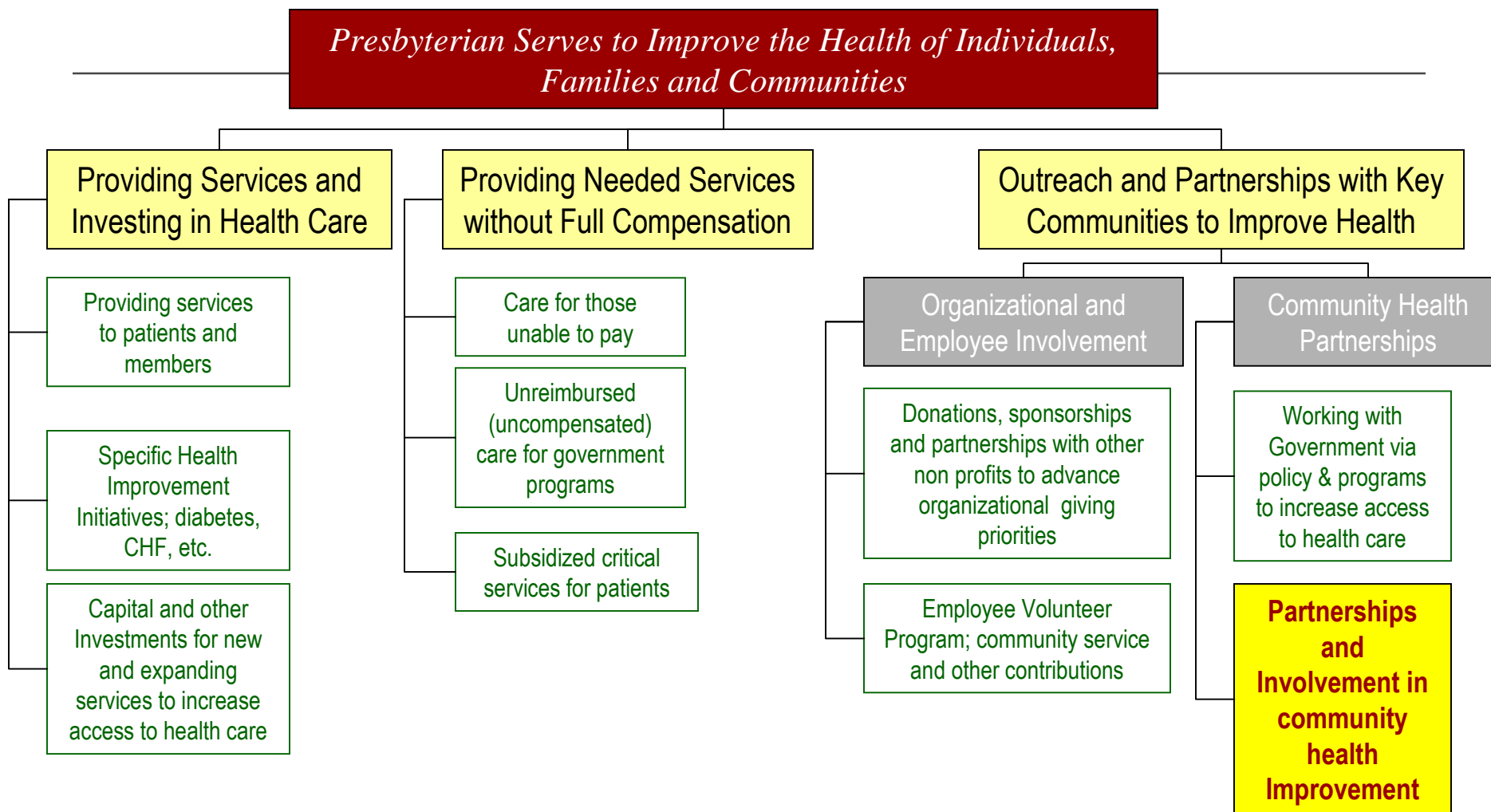
# Diabetes Community Gift Report to Diabetes Advisory Council

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March 6, 2009

Michelle Campbell and Patsy Nelson

# As part of our charitable purpose, Presbyterian seeks to benefit the community in every decision and action.



08/06

# Diabetes Community Gift

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- What is it?
  - As part of our charitable purpose and commitment to improving the health of individuals, families and communities, Presbyterian seeks to partner with local community health organizations to bring proven diabetes care to uninsured and underinsured adults.

# Diabetes Community Gift

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- Purpose:
  - By using the proven chronic care model, Presbyterian seeks to create improved disease management in uninsured and underinsured adults with diabetes in order to reduce long-term complications from the disease such as dialysis, amputation or blindness beginning first in the five counties with Presbyterian hospitals and moving throughout the state in subsequent years.

# Three-Phase Project Approach

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- Obtain input from internal and external diabetes and public health experts
- Perform community needs assessments to identify specific barriers affecting the health of adults with diabetes and locally available resources
- Based on that assessment and considering PHS strengths, work with communities to develop interventions to improve the health of uninsured New Mexicans with diabetes

# Input from External Experts

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- Stakeholder input was key
  - Determined that focus should be county (or bigger) rather than just town where hospital was located
  - Helped shape need for more community voice and interest in partnering during implementation
  - Helped identify method to determine number of uninsured with diabetes

## Step 1 - Profile of Diabetes by Counties

	Number of People with Diabetes (Avg. Estimate)	Number of Uninsured with Diabetes (Estimate @ 21% uninsured)
Curry	2,524	530
Lincoln	1,260	265
Quay (est.)	886	186
Rio Arriba	3,018	634
Socorro	2,655	558
<b>Total</b>	<b>10,456</b>	<b>2,196</b>

Source: New Mexico Department of Health, Diabetes Prevention and Control Program. "Estimated Diabetes Prevalence Among New Mexico Adults, 2004-2006." <http://www.diabetesnm.org/facts.htm>

## Step 2 – Conduct Community Assessment

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Combination of:

- Online survey or paper survey
- Face-to-face interviews of key community leaders and providers
- Interviews of community members living with diabetes conducted at community locations such as WalMarts, grocery stores and parades



## Step 3 - Follow-up Meetings with Communities

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- Held meetings in each county
  - Community leaders and providers
  - People with diabetes
- Purpose - Present findings and get feedback to confirm or challenge findings and revise recommendations, if necessary
  - Reviewed assets/strengths and barriers/challenges
  - Prioritized recommendations



	<b>People with Diabetes</b>	<b>Community Leaders/ Providers</b>	<b>Combined Ranking</b>
Curry	#1 – Cost of Care #2 – Delivery of Care #3 – Affordable Food/ Education/Prevention/ Partnerships (all tied)	#1 – Healthy Eating #2 – Prevention and Delivery of Care (tied) #3 –Cost of Care	#1 – Healthy Eating #2 – Cost of Care #3 –Prevention and Education (tied)
Lincoln	#1 – Education #2 – Delivery of Care #3 – Cost of Care	#1 – Education #2 – Delivery of Care #3 – Cost of Care	#1 – Education #2 – Delivery of Care #3 – Cost of Care
Quay	#1 – Healthy Eating #2 – Rural Communities (#1 and #2 tied) #3 – Delivery of Care	#1 – Education #2 – Delivery of Care #3 –Cost of Care	#1 – Healthy Eating #2 – Cost of Care #3 –Prevention and Education (tied)
Rio Arriba	#1 – Education #2 – Prevention and Healthy Eating #3 – Delivery of Care	#1 – Delivery of Care #2 – Cost of Care #3 – Prevention and Risk Reduction	#1 – Delivery of Care #2 – Prevention/Risk Reduction #3 Education
Socorro	#1 – Education #2 – Rural Communities #3 – Cost of Care	#1 – Education #2 – Cost of Care #3 – Delivery of Care (#2 and #3 tied)	#1 – Education #2 – Rural Communities #3 – Cost of Care (#2 and #3 tied) #4 - Delivery of Care

## Step 4 – Prioritize and Define Recommendations in 3 Areas

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### Delivery of Care

- Ensure implementation of all components of the Chronic Care Model in the community.
- Increase the employment and use of certified diabetes educators (CDE) and promotoras/community health workers (CHW) in each county.
- Advocate for a policy change to CDE reimbursement that will provide payment for any CDE, not just a dietitian.
- Consider offering a Diabetes Clinic.

# Prioritized Recommendations

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## Cost of Care

- Promote patient access to free/reduced cost services
  - Presbyterian Charity Care Policy,
  - FQHC,
  - enrollment in Medicaid SCI, and
  - other community options.
- Increase the availability of free/low-cost testing supplies (especially strips) to all patients.

# Prioritized Recommendations

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## Education:

- Raise the awareness of diabetes in the community through broad community education efforts.
- Provide one-on-one or peer-to-peer education or support groups.

## Step 5 - Implementation

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- Work with PHS Regional hospital staff and communities to identify strategies specific to counties
- Develop Diabetes Teams in each County
- Integrate with/develop Diabetes Coalitions in each County

# Questions?

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## Contact Information

- Michelle Campbell
  - 923-6347
- Patsy Nelson, BSN, MA
  - 505-228-5087
  - patsyncnelson@msn.com

# THANK YOU!!!

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