Diabetes 360

An Evaluation of the Collaboration Potential of Diabetes Programs in New Haven, Conn.

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Community Health Program Planning 2010 Field Action Report

Background and Overview

In the United States, the rising prevalence of Type 2 Diabetes is a huge public health concern. Type 2 Diabetes is a condition in which the body does not produce enough insulin and does not use insulin effectively (1). Currently, 7.8% of American adults and 7.6% of adults in New Haven County have Diabetes, and most have Type 2 Diabetes (1,5). If inadequately treated, diabetes can lead to debilitating, yet preventable, complications such as kidney disease, blindness, and amputations (1).

Minority groups are disproportionately affected by Type 2 Diabetes. In Connecticut, age-adjusted diabetes prevalence estimates show that both African American and Hispanic adults have higher age-adjusted diabetes prevalence rates compared to white adults, 15.9%, 10.5%, and 5.5%, respectively (2). This disparity must be addressed.

In New Haven, there are several diabetes initiatives that provide valuable support services, above and beyond medical services, for adults living with Type 2 diabetes.

Goals and Objectives

The overall goal of the Diabetes 360° team was to improve the care of those with Type 2 Diabetes in the Greater New Haven community. The more specific objectives of this project were to perform an informal evaluation of the current diabetes initiatives in New Haven and to make recommendations about next steps based upon the results of the evaluation.

Methods

Five interviews were performed with diabetes initiative program directors to evaluate the similarities and differences between the programs and to investigate the potential for collaboration between diabetes care programs in the New Haven area.

An interview guide with 14 questions was created in collaboration with Yale New Haven Hospital. The questionnaire contained questions about the program's vision, the population it serves, barriers to providing services, and other questions designed to gauge the potential for collaboration amongst the programs.

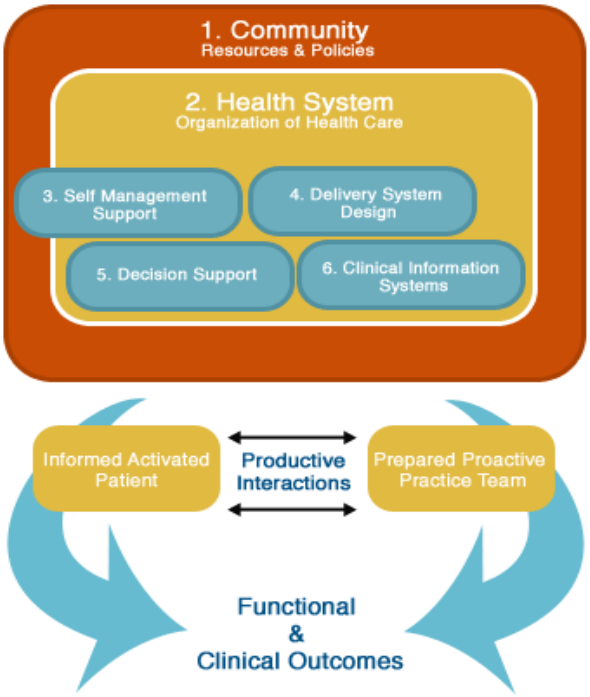
The interview guide was approved by the Yale Human Research and Protection Program. The interview guide was implemented uniformly throughout all interviews and each interview lasted one hour. Three interviews were performed in-person and two interviews were conducted over the phone.

The team followed-up with program sites to collect any available quantitative data, such as patient data, program fact sheets, and annual reports.

The qualitative data was analyzed using standard qualitative data analysis methods (3). Each team member developed an organic code structure and then worked as a team to finalize the code structure. The data was then coded using the finalized code structure. Attention was especially paid to the potential for opportunities for the programs to collaborate. This process allowed for the cataloguing of key concepts and to match these concepts to the workings of the Chronic Care Model (see Figure 1).

The Chronic Care Model presents the components of a successful community infrastructure to provide quality, comprehensive care for patients with chronic diseases. The team used this model as a framework to assess the findings from each program.

Figure 1. Chronic Care Model (4)



Key Findings

From the program director interviews the following themes were elucidated:

1. Many of the programs take the approach of fostering self-sufficiency and promoting a positive attitude toward diabetes management.

2. Some programs work hard to improve service provisions and communication with patients in order to reduce health disparities.

3. There is minimal communication between the different diabetes initiatives in the New Haven area and they know little about each other.

4. Some health outreach and education programs had low participation rates, especially among men.

5. The different programs use a variety of information technology systems and outcome measures. Measures of program success range from evaluating patient's HbA1c levels to more subjective outcomes such as well being and self-education.

6. Some program directors identified the existence of cross-cultural barriers between the clients and the providers.

7. Some program directors were concerned that coordinating care across programs could erode a program's identity, limit its ability to serve their unique patient populations, and cause turf issues.

8. Some program directors identified being able to serve more people, eliminating duplication of services, and meeting economies of scale for cost savings as being the benefits of having collaboration among initiatives.

Recommendations

The preliminary findings of this report support the following recommendations:

1. The lack of communication between diabetes programs in New Haven may be affecting the overall quality of diabetes care and services available. Yale New Haven Hospital could encourage organizations to become acquainted with one another through semi-regular meetings.

2. Yale New Haven Hospital could offer information technology, marketing, and cultural sensitivity learning opportunities for staff from the different diabetes programs in the Greater New Haven area.

Lessons Learned and Conclusions

Throughout this project, the team learned to: 1) make connections between theoretical concepts and practice, 2) conduct respectful, yet informative interviews, and 3) collect and analyze qualitative data.

Overall, New Haven residents with Type 2 Diabetes stand to benefit from more attention being given to diabetes care and support services in New Haven. As presented in the Chronic Care Model, positive functional and clinical outcomes are dependent on a patient's ability to access quality medical and support services. Ultimately, because the consequences of poor diabetes control are so great, patients, providers, and hospital stand to benefit from having healthier patients. The diabetes initiatives in New Haven play an important role in helping patients successfully take control of their disease. The recommendations set forth in this report present ways in which initiatives could be strengthened to provide even greater benefits to the clients they serve.

References

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Resources

Yale New Haven Hospital http://www.ynhh.org/
New Haven Health Department
http://www.cityofnewhaven.com/Health/
American Diabetes Association http://www.diabetes.org/

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