2015

# Getting Real About Food: "Fed Up" & Nutrition Education

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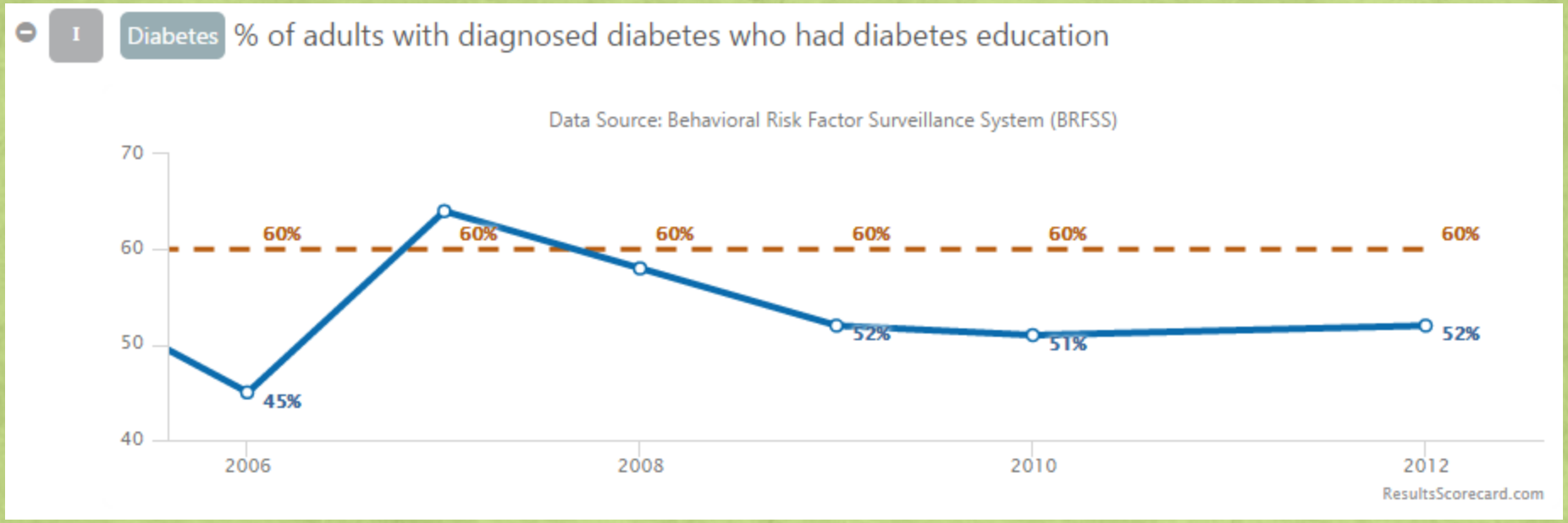
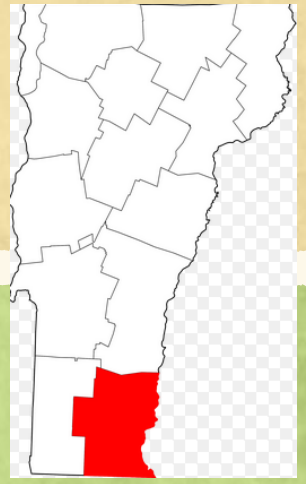
# 2A: Problem Identification
# Diabetes and Obesity Prevalence in VT

- 25% of Vermonter adults age 20 and older are obese
- Nearly 1 in 10 Vermont adults (8%) have diagnosed diabetes; it is the 7th leading cause of death in Vermont
- Vermont identified gap between patients with diagnosed diabetes receiving education (52%) and current target (60%)



# 2B: Community Need
# Townshend, Windham County



- In 2013, Windham County's diabetes prevalence rate was 9%
- Grace Cottage Family Practice serves patients from all across Windham County, approximately 9,000 patient annually
  - 638 patients with a diagnosis of diabetes
  - 187 patients (age 30+) with HbA1c ≥ 9 *without* a HbA1c in the last 6 months
- Grace Cottage 2015 Community Needs Assessment Report Priorities
  - High priority: Diabetes
  - Medium priority: Obesity, Overweight, Physical Fitness

# 3A: Public Health & Cost Considerations

- **American Diabetes Association 2013 Report estimates the total annual cost of diabetes in 2010 in Vermont as $370 million**
- The Unites States economic burden associated with diagnosed diabetes (all ages) and undiagnosed diabetes, gestational diabetes, and prediabetes (adults) exceeded $322 billion in 2012
  - $244 billion in excess medical costs
  - $78 billion in reduced productivity
  - Combined, this amounts to an economic burden exceeding $1,000 for each American in 2012

# 3B: Public Health & Cost Considerations

- **Community Health Teams introduced through Vermont Blueprint for Health**
  - Local multi-disciplinary teams, funded through Blueprint payment reforms, hired at the local level with flexibility in terms of team composition
  - Expands capacity of primary care practices by providing patients with access to a range of services with more individualized follow up
  - Minimizes barriers to care since there is no charge
- **Blueprint for Health cost savings**
  - Analysis of the first pilot program found significant year-over-year decreases in hospital admissions and emergency department visits, and their related per person per month costs.
  - Once rolled out statewide, the initiative is projected to save 28.7 percent in incremental health spending in the state by its fifth year.

# 4A: Community Perspective
# Local Environment and Challenges

- **Elizabeth Harrison, CCN, Community Health Team**
  - "[The goal of the Community Health Team is…] to help people reduce their medical need and costs – helping people eat right and take care of themselves."
  - "There are gaps in communication in terms of what resources are available"
  - "Food industry has trained the public that it costs more to buy farm food."
- **Daniel Riley, Patient**
  - "The challenge is knowing what to do. I didn't know what to eat. I ate healthy my whole life, but would tend to overindulge and my weight climbed."
- **Crystal Harrison, Director Wellness and Rehabilitation**
  - "Poor diet and poor food choice prevail in the West River Valley…it comes back to education about how to prepare healthier foods, how to grown and glean foods. How do we shift perspectives?"
  - "Process food are an issue. If you shop at the grocery store, convenience foods are everywhere."
  - "We are working on a survey looking at Wellness programs. I don't know what I don't know….if I offered X, would you come?"
- **Houghton Smith, RN, Certified Diabetes Educator**
  - "Patients don't want to face what to do. A lot of patients know that they've done things over their lives that have created problems, but they don't know how to fix it, or they can't."
  - "We have a good team approach that we are advocating for at this point to identify people who need help."
- **Jim Scott, Patient**
  - "Primary challenge is health insurance. Many residents simply don't have it. Secondary is education – particularly the parents of children. They aren't getting proper education about diet, dental care, dangers of drugs, and so forth."
  - "I think people don't realize the dangers of processed food. That they eat too much fatty food, maybe red meats—the consequence of poor education."

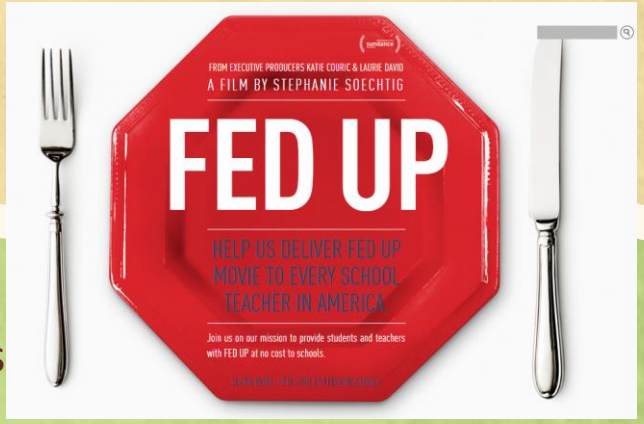
# 4B: Community Perspective
# Strengths and Educational Opportunities

- **Crystal Harrison, Director Wellness and Rehabilitation**
  - "There's something special about this state: it is fiercely independent in a lot of ways. Pride can also get in the way. Asking for help is hard for people to do."
  - "People want a takeaway, they want to know how they might be able to make a difference – and they can decide if it's possible for them."
  - "It is not only about access, but preparation. We are working on learning kitchen collaboratives with the local schools, working on a combined community garden. Kids are where the change starts."
- **Jim Scott, Patient**
  - "We have to get more into adult education, especially seniors. Maybe have some innovative approaches. Maybe ask Fire Departments to host evenings about these topics. These are people who are well-respected and they might have a greater impact because they are part of the community."
  - "I've attended a Wellness course and really enjoyed it. I didn't think I was going to. I am a stick in the mud…it's a hidden treasure that not too many people know about."
- **Elizabeth Harrison, CCN, Community Health Team**
  - "If you can educate people about what is going on, they can make better choice."
  - "Everyone has been amazed [by the film, *Fed Up*] and has taken charge of something in their lives. It is the 'cornerstone', the 'hey, wake up – and here's why! It is simple…this meets the need…"
- **Daniel Riley, Patient**
  - "Money is tight. Getting educated to have two vegetables and a meat, not a starch, has made the biggest change."
  - "In the diabetes groups, I've learned some tricks…how to pick yourself up and how to get back on track."
- **Houghton Smith, RN, Certified Diabetes Educator**
  - "Clinicians try to give the same messages and try not to be confusing. Not everyone is literate so keep the education basic."

# Slide 5A: Methodology

- **Identify current Wellness initiatives and new opportunities**
  - Wellness Center offers community exercise programs, "Eat Better, Move More" nutrition and walking class, yoga, ballroom dancing, meditation group
  - Expanding into schools, teaching afterschool yoga program
  - Currently expanding program to address: chronic disease, prevention, and wellness initiatives in the community
  - "How do we keep patient more well?" – Crystal Mansfield, Director of Wellness & Rehab
  - Community needs assessment in progress for the Wellness Center
- **Introduce "*Fed Up*" education to the Grace Cottage community**
  - Provide educational materials to expose patients and employees to information about nutrition and the food industry through monthly weight support groups and community lunch & learns using 2014 documentary, "*Fed Up*"
  - Facilitate discussion and support patients to identify a "takeaway" or next step after watching and discussing part of the film
  - Increase community education through town newspaper, bulletin boards, word of mouth
  - Encourage continued collaboration between the Community Health Team and Wellness Center in outreach efforts

# Slide 5B: Intervention

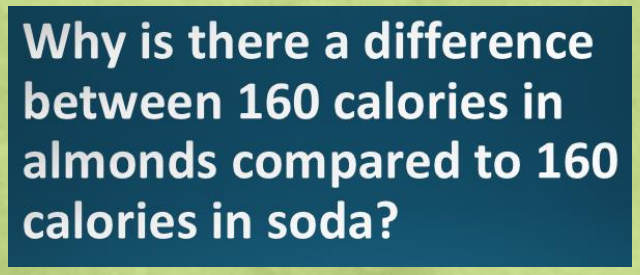



- **Venues for "*Fed Up*" viewing and discussion**
  - Community and Employee 1-hour Lunch & Learn sessions
  - Leland and Gray High School
  - Townshend Community Hope and Action coalition community dinners
  - Local Fire Department – hosting or invite as special guests of facilitators
- **Recruitment**
  - Local newspaper, bulletin boards, newsletters (hospital and school)
  - Personalized invitations to all CHT patients
  - Reconnect by phone and/or mail with the 187 patients (age 30+) with HbA1c ≥ 9 *without* a HbA1c in the last 6 months
- **Adapting Content and Format**
  - Highlight specific scenes (15-20 minutes if time is limited to 1 hour)
  - Utilize slideshow with quotes and statistics as interactive tool (20-30 minutes, including flexible time for questions)
- **Takeaways**
  - Ask participants to write down one thing they plan to change as the result of the session and ask folks to share (or facilitator can read, depending on group comfort)

# 6A: Results

- **Adapting format and content of "*Fed Up*"**
  - A total of 2 full screenings and 1 abbreviated review were completed to identify key messages for discussion
  - Powerpoint slides were developed to assist with facilitation and to highlight key messages such that the film could be shown in abbreviated forms, depending on the audience




# 6B: Results Cont'd

- **Patient identification**
  - Director of Information Technology and Family Practice Manager developed list of patients (de-identified for this project's purposes) with poorly controlled diabetes
- **Attendance and recruitment**
  - Liz Harrison, CCN, Community Health Team and Crystal Mansfield, Director of Wellness and Rehabilitation are currently managing the licensing to show the film and scheduling sessions for employees and patients

# 7A: Evaluation Framework

- **Measuring community reach and participation**
  - Total # of *Fed Up* educational sessions over 1 year
  - Total # of employees (providers and staff) who attended *Fed Up* educational session over 1 year
  - Total # of community members who attended *Fed Up* educational session over 1 years
  - Total # of students who attended *Fed Up* educational session at Leland and Gray High School over 1 year
  - % of patients with a diagnosis of diabetes who were sent a mailed invitation to attend *Fed Up* session
- **Assessing new knowledge**
  - Develop short (5 question) pre and post survey about key messages and statistics from *Fed Up* educational session
  - Collect participant takeaways (verbal or written) and analyze for qualitative themes to inform future Wellness Center and CHT programs
- **Long-term evaluation for Grace Cottage and Blueprint (over 5-10 years)**
  - Review patient population by weight classification and diabetes prevalence over time

# 7B: Evaluation Strengths and Limitations

## Strengths

- **Resources**: opportunity to integrate *Fed Up* messages into current infrastructure and programs that are already established
- **Leadership support:** strong collaboration among CHT, Wellness, and providers about providing consistent and simple messaging
- **Technology:** IT is working to utilize data systems to identify high risk patients which can help with reestablishing care and nutrition education

## Limitations

- **Time:** challenging to cover 1h32m of film and facilitate discussion, highlighting the importance of adapting the sessions to the audience
- **Assessing outcome:** difficult to assess the impact of film and educational session
- **Recruitment:** given challenges with communication, one challenge is how to get people to show up – especially some of the high-risk populations who have transportation limitations

# 8A: Recommendations

**1. Track attendance and response to sessions**

- Approach *Fed Up* educational sessions from a quality improvement perspective; consider small tests of change and work to adapt sessions to specific audiences
- Test approach with small group of employees (1-2 providers, 4-6 staff) and ask for their feedback – try this with monthly weight support group as well

**2. Utilize practice data to reconnect with high risk patients**

- Continue to collaborate with IT department to identify patients with poor diabetes control and follow up
- Consider data review for practice and Blueprint purposes given new ICD10 coding
  - Review patient population by weight status: underweight, normal, overweight, obese
  - Identify patients with diabetes based on HbA1c levels to assess level of control
- Compare IT department data with Wellness Center and CHT utilization
- Consider quarterly data review with key stakeholders
  - Explore opportunity to integrate community (patient) partners into the review process to provide balanced and diverse perspective

# 8B: Recommendations Cont'd

**3. Strength existing community connections and venues**

- Consider community opportunities for promotion and/or discussion of the issues: West River Valley Food Group (grassroots collaborative), Townshend Community Hope and Action dinners, Church groups

**4. Target and adapt to specific populations**

- High-schoolers at Leland and Gray: explore option of showing video with *Fed Up* interactive educational guide, designed specifically for this group (available online)
- Seniors: consider phone and/or mail invitations, work with Church groups to arrange transportation to screening, and develop a 1-page informational sheet specific to this population
  - Highlight resources available at Grace Cottage, including Strong Bones Exercise Class and Nutrition Series offered by Neighbor Hood Connections

**5. Collaborate with diverse community voices**

- Invite Community Leaders (firefighters, school principal, business leaders) to special screening of the film
- Request support and opportunity to participate in future sessions as facilitators

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# 10A: Interview Consent Form

Family Medicine Clerkship Community Project
Interviewee Consent Form

Thank you for agreeing to be interviewed.

This project is a requirement for the Family Medicine clerkship. It will be stored on the Dana Library ScholarWorks website. Your name will be attached to your interview and you may be cited directly or indirectly in subsequent unpublished or published work.

The interviewer affirms that he/she has explained the nature and purpose of this project. The interviewee affirms that he/she has consented to this interview. Yes _____ / No _____

If not consenting as above: please add the interviewee names here for the department of Family Medicine information only.

Name: _____