

# Move More Diabetes Project

- Lay Health Educator Findings
- New and Active Program Enrollees

## Final Report August 2006

### Prepared for:

MaineGeneral Health  
Greater Waterville PATCH  
Kennebec Valley Diabetes Care Initiative  
32 College Avenue, Suite 202  
Waterville, Maine 04901  
207-872-8130

### Prepared by:

Amy N. Black, Ph.D.  
Research Associate  
Maine Center for Public Health  
12 Church Street  
Augusta, ME 04330  
207-629-9272  
207-629-9277 (fax)  
[www.mcph.org](http://www.mcph.org)

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# Overview

## Background

MaineGeneral Medical Center contracted with the Maine Center for Public Health (MCPH) to assist with local evaluation efforts related to the Move More Diabetes Project. MCPH was responsible for working with program staff to evaluate the Lay Health Educator component of the program through the use of new and existing tracking systems. Funding for this initiative was provided by the Robert Wood Johnson Foundation (RWJF).

## Format of the Report

The report provides an overview of the Move More Diabetes Project and a description of the program components included in this process evaluation. Information in this report is intended to inform program staff and others about the collective efforts of Lay Health Educators, given their role in this initiative.

## Move More Diabetes Project

The Move More Diabetes Project is part of the Kennebec Valley Diabetes Care Initiative aimed at reducing diabetes incidence and mortality. The target population for this project is adults aged 30-70 living in the Kennebec Valley region with type 2 diabetes or pre-diabetes and who are currently “somewhat physically active,” but who do not routinely exercise 150 minutes per week. Lay Health Educators (LHEs) are a vital component of this project and their role involves providing referrals and support to program participants.

### Project Goals and Objectives

The program has three overarching goals identified below.

1. Increase enrollment in existing diabetes self-management education.
2. Increase the number of Lay Health Educators linked to sustainable settings.
3. Expand the use of social marketing to facilitate behavior change.

The project also has three objectives. They include:

1. Increase the number of medical providers, certified diabetes educators, and registered dietitians referring patients to the project.
2. Increase the number of patients with type 2 diabetes utilizing Diabetes Self- Management Education (DSME) options (e.g. support groups).
3. Increase the number of Lay Health Educators providing outreach to patients in community settings.

### Timeframe

The Move More Diabetes Project is a three year initiative. This evaluation report provides a snapshot approach. Data included in this report are based on a 12-month period from May 2005 through April

2006. This evaluation report also provides a comparison of a similar evaluation completed August 2005 for the 12-month period from May 2004 through April 2005.

# Evaluation Efforts

## Roles and Responsibilities

The Robert Wood Johnson Foundation contracted with Research Triangle Institute (RTI) to lead a multi-site evaluation of the 14 grantees delivering diabetes self-management programs in both community and practice-based settings. To date, their efforts have included site visits, telephone surveys, interviews and clinical data collection. The emphasis of their evaluation is on outcome data and includes clinical indicators.

Unlike RTI's efforts, the local evaluation was designed to collect process evaluation data. MCPH was responsible for the local evaluation efforts specifically related to the Lay Health Educators. As part of this initiative, LHEs were recruited and trained to:

1. Enroll participants in the Move More Diabetes initiative
2. Provide referrals for current and emerging diabetes self-management services
3. Offer ongoing support and encouragement to program participants regarding their physical activity goals.

## Local Evaluation Activities

In an effort to assess the three areas listed above, a tracking system was developed. Program staff was responsible for entering the data into a spreadsheet and LHEs were responsible for collecting and providing this information on a monthly basis. The components listed in the tracking system include:

- Location/setting of Lay Health Educator
- Town where Lay Health Educator is located
- Report period (both month and date)
- Number of contacts made with potential and existing program participants
- Type and number of contacts made
- Type and number of referrals made
- Number of new enrollees
- Number of active enrollees
- Comments

In addition, a separate spreadsheet was developed to track program enrollee information including:

- Enrollee code
- Identification of how they were referred to, or heard about, the program
- Services they used (e.g. support groups, nutritional therapy, case management)

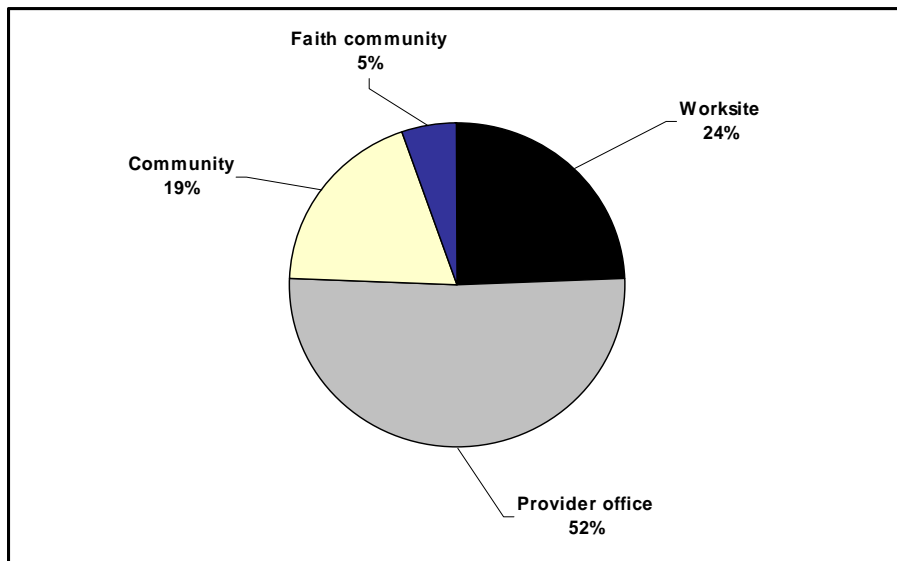
LHEs' monthly reporting of their referrals of enrollees to self-management services did not contain sufficient detail to use in this evaluation report.

# Evaluation Results

## Lay Health Educators

There were a total of 37 Lay Health Educators (LHE) who participated in the Move More Diabetes initiative between April 2005 and May 2006. A total of 19 LHEs began on or before May 1, 2005. The remaining 18 LHEs began between May 1, 2005 and September 30, 2005. Chart 1 depicts the various settings for LHEs.

Chart 1. Percent of Lay Health Educators in Each Setting May 2006



Lay Health Educators were located in the settings identified above throughout the Kennebec Valley area. Table 1 provides a synopsis of the municipalities where all LHEs were located. The table also provides the total number of new enrollees by each listed location, and the location of LHEs by setting.

Table 1. Lay Health Educator Location by Municipality

Town*	Lay Health Educator (LHE) Location				
	Health Care Office	Faith Community	Worksite	General Community	Other
Albion	1				
Augusta		1	1		
Benton	1				
Bowdoinham	1				
Chelsea			1		
China			1		
Fairfield	3			3	
Farmingdale			1		
Gardiner	1				

Hartford	1				
Leeds	3				
Lewiston	1				
Livermore Falls	2				
Oakland		1		1	
Readfield	1			1	
Rome			1		
Turner	2				
Waterville			1	1	
Whitefield			1		
Windsor			1		
Winslow			1		
Winthrop	1			1	
<b>Total</b>	<b>19</b>	<b>2</b>	<b>9</b>	<b>7</b>	

\* Note: Town is based on the location(s) of each Lay Health Educator  
NA = Enrollee data not available

Table 2. Lay Health Educators New Enrollees by Setting and Setting Location

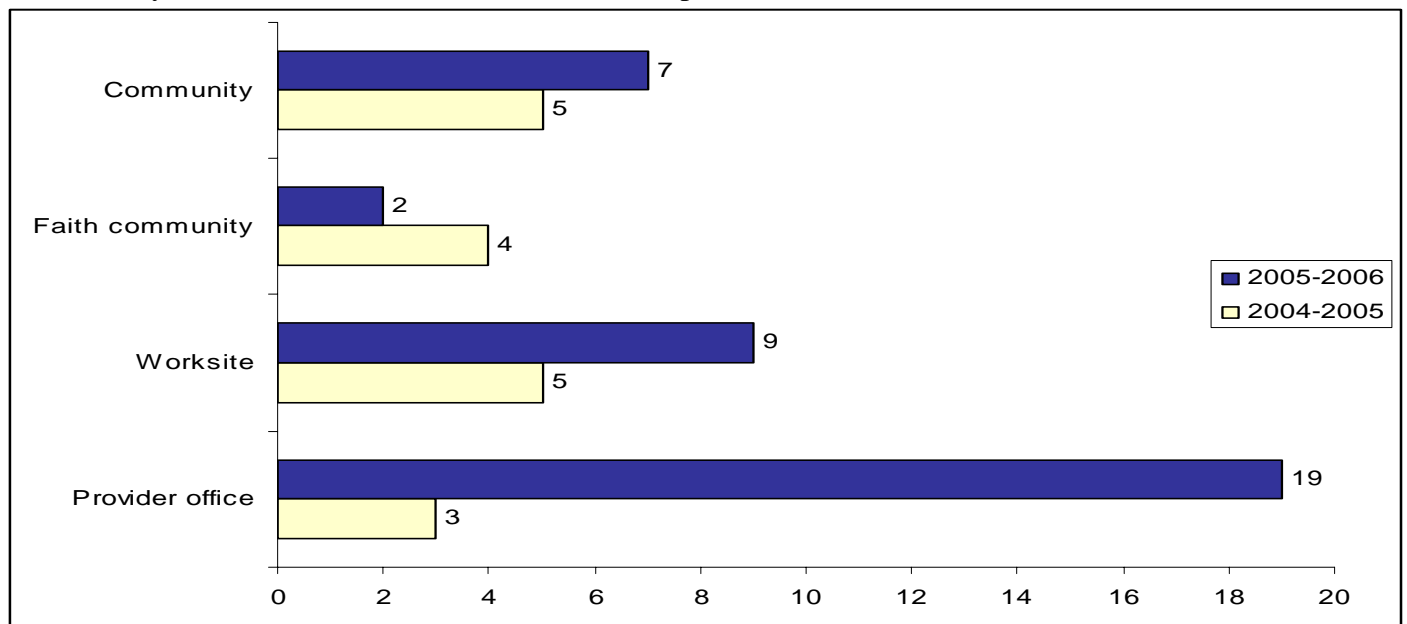
Town*	New Enrollees	Lay Health Educator (LHE) Location				
		Health Care Office	Faith Community	Worksite	General Community	Other
Augusta	3		1	4		
Benton	3			1		
China	NA			1		
Fairfield	22			1	3	
Monmouth	20	12				
Oakland	4		1		1	
Readfield	0				1	
Richmond	NA	2				
Waterville	23	5		2	1	
Winthrop	NA				1	
<b>Total</b>	<b>75</b>	<b>19</b>	<b>2</b>	<b>9</b>	<b>7</b>	

May 2004 – April 2006 Overview: Lay Health Educators

In comparison with data from the May 2004 – April 2005 cycle, the total number of LHEs increased from 20 to 37 during the current cycle.

As shown in Chart 2, the number of LHEs from a health care provider’s office drastically increased, due large in part to 12 located in one setting (Monmouth). In addition, the number of LHEs from worksites almost doubled while the number of LHE’s from faith communities decreased by half.

Chart 2. Lay Health Educator Location, 2-Year Comparison, N = 37



## Monthly Contacts & Program Enrollees

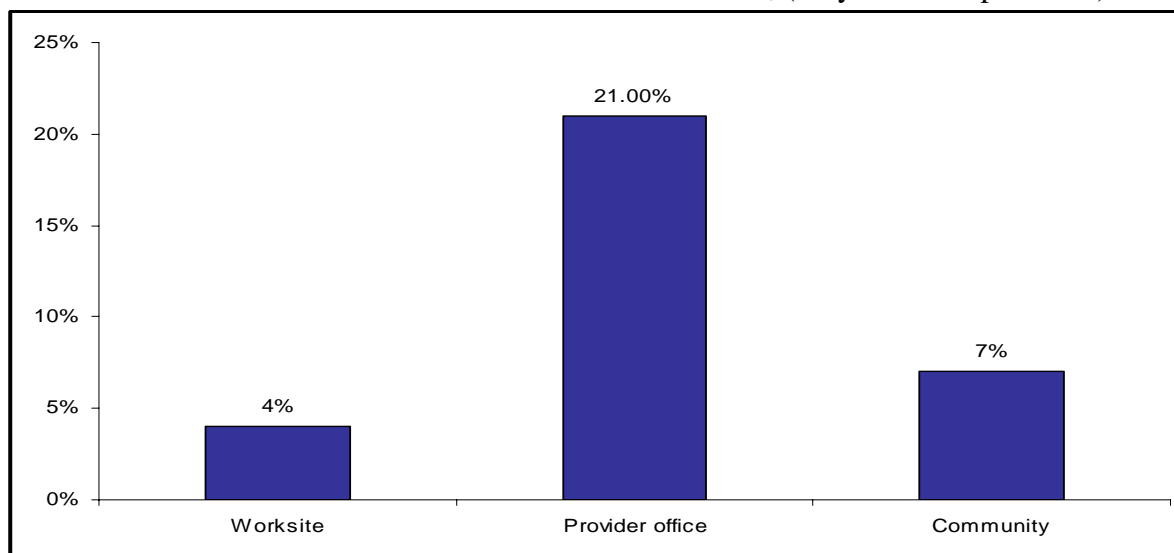
Lay Health Educators were asked to record the number and type of contacts they made with program participants on a monthly basis. As seen in Table 2, LHEs in the worksite and community recorded the highest number of contacts. The overall number of contacts per month remained relatively stable with the exception of October, December of 2005 and January, February and March of 2006. In all, there were 792 contacts made during the 12 month period.

Table 3. Monthly Contacts and Enrollee Data by LHE Setting

LHE Setting	Monthly Contacts & Enrollee Data												Total
	2005						2006						
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
Health care office	22	18	18	4	24	9	18	14	11	20	11	27	196
<i>New Enrollees</i>	1	1	0	0	6	1	12	6	1	4	2	7	41
<i>Active Enrollees</i>	11	10	6	4	11	5	6	4	10	5	5	18	95 Avg. = 3
Worksite	35	35	28	16	24	30	31	4	17	12	17	23	272
<i>New Enrollees</i>	3	0	0	3	0	4	0	0	1	0	0	0	11
<i>Active Enrollees</i>	16	11	12	9	6	20	13	7	18	7	15	15	147 Avg. = 5
General community	37	30	24	56	55	9	54	35	--	2	9	13	324
<i>New Enrollees</i>	2	3	0	1	7	0	8	0	2	0	0	0	23
<i>Active Enrollees</i>	3	11	4	29	27	0	20	33	--	0	2	2	313 Avg. = 6
<b>Total Contacts</b>	<b>94</b>	<b>83</b>	<b>70</b>	<b>76</b>	<b>103</b>	<b>48</b>	<b>103</b>	<b>53</b>	<b>28</b>	<b>34</b>	<b>37</b>	<b>63</b>	<b>792</b>

The following chart depicts the percent of new enrollees based on the total contacts made by all LHEs in a particular setting during May 2005 to April 2006. The results suggest that LHEs in the health care provider office were the most successful at enrolling new participants. These results are consistent with the fact that LHEs were specifically recruited in health care settings during those months. A total of 16 of the 18 LHEs who were trained between May 1, 2005 and September 30 were located in health care settings. In addition, LHEs leading chronic disease self-management classes at health care provider offices enrolled some new enrollees from class participants.

Chart 3. Percent of New Enrollees Based on Total Contacts, (May 2005 – April 2006)

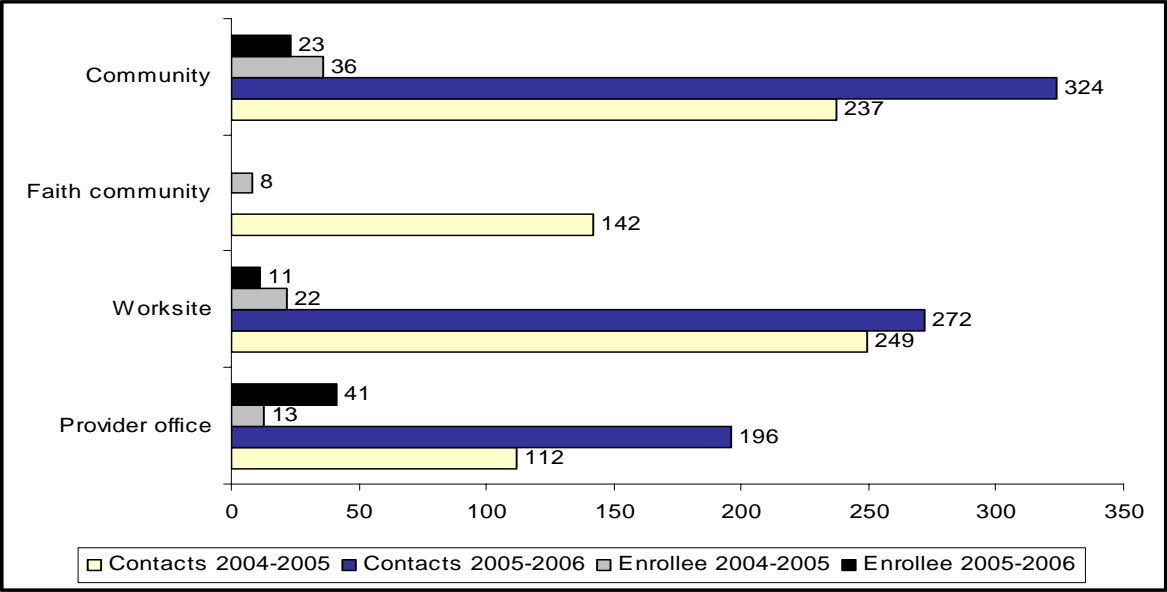


#### May 2004 – April 2006 Overview: Contacts and Program Enrollees

In comparison to the previous cycle the number of contacts increased slightly (750 to 792) while the number of new enrollees decreased slightly (81 to 75). The average number of active enrollees per month has remained stable over the past two years (*range* = 2 – 6). Over two years, LHEs have made 1,592 contacts and enrolled 156 new participants.

Chart 4 provides an overview of the number of contacts and new program enrollees by setting over the 2 year period. As shown in this chart, the number of new enrollees from the health care setting more than doubled. The number of new enrollees from the general community settings decreased slightly but was relatively consistent. Finally, LHEs from worksites had half the number of new enrollees than the previous cycle. There is no data this cycle from LHEs from the two faith settings. The variation in new enrollees from the various settings is most likely due to the increase of LHEs from the health care settings.

Chart 4. New Enrollee and Contacts, 2-Year Comparison



## Type of Contacts and Referrals

Table 4 highlights the type and number of contacts made by all LHEs in each setting over the course of the report period. Overall, the most frequent methods of communication were mail and e-mail. The mailed format appeared to be the most favorable for those in the community setting, while email was the most frequently recorded type of communication for those in health care offices and the worksite.

Table 4. Type and Number of Contacts Made by Lay Health Educator Setting

LHE Setting	Type and Number of Contacts Made							*Total
	Mail	E-Mail	Phone	Walking	Support Group	Other Face-to-Face	Other	
Health care office	40	107	7	0	0	28	5	187
Worksite	24	152	30	12	0	31	3	252
General community	186	45	27	10	0	37	9	314
<b>Total</b>	<b>210</b>	<b>304</b>	<b>64</b>	<b>22</b>	<b>0</b>	<b>96</b>	<b>17</b>	<b>753</b>

\* Note: Discrepancies in this table and Table 2 are due to contacts not captured by type or contacts made by multiple methods of communication

The table below details all of the reported referrals made by the Lay Health Educators in each setting. In all, a total of 100 referrals for diabetes self-management services were made. Three-quarters of all referrals were reported as “other” and approximately 10% of referrals were to a Diabetes Nutrition Center. Nutrition Therapy and ADEF were less frequently referred. No specific information about what is included in the “other” category is available.

Table 5. Type and Number of Referrals Made by Lay Health Educator Setting

LHE Setting	Type and Number of Specific Referrals* Made						Total
	Support Group	ADEF	Nutrition Therapy	Diabetes Nutrition Center	Case Mgmt.	Other	
Health care office	5	0	0	3	0	0	5
Worksite	0	1	1	7	3	33	45
General community	3	1	1	1	2	42	50
<b>Total</b>	<b>8</b>	<b>2</b>	<b>2</b>	<b>11</b>	<b>5</b>	<b>75</b>	<b>100</b>

\* Note: Referrals from July 2005-April 2006

### May 2004 – April 2006 Overview: Type of Contacts and Referrals

As delineated in the following table, the total number of contacts made has remained stable over the past two years. The number of email and mail contacts, however, has increased while the number of contacts made by walking, phone, support groups and other face-to-face contacts has decreased. In general, the most commonly used forms of communication have been email and mail.

Table 6. Type and Number of Contacts Made by Program Cycle Year

Cycle	Type and Number of Contacts Made							Total
	Mail	E-Mail	Phone	Walking	Support Group	Other Face-to-Face	Other	
May 2004 – April 2005	116	232	121	94	11	173	4	751
May 2005 – April 2006	210	304	64	22	0	96	17	753
<b>Total</b>	<b>326</b>	<b>536</b>	<b>185</b>	<b>116</b>	<b>11</b>	<b>269</b>	<b>21</b>	<b>1504</b>

As indicated in Table 7, the number of total referrals made has increased. The number of support group referrals, however, has decreased dramatically since last cycle. Referrals to Nutrition Therapy also dropped in the current cycle while “other” referrals notably increased. The number of referrals classified as “other” has remained the most common. Referrals to ADEF and case management remain two of the least common. Finally, referrals to the Diabetes Nutrition Center have remained consistent. In total, 176 referrals were made over the 2 year period.

Table 7. Type and Number of Referrals Made by Program Cycle Year

Cycle	Type and Number of Specific Referrals Made						Total
	Support Group	ADEF	Nutrition Therapy	Diabetes Nutrition Center	Case Mgmt.	Other	
May 2004 – April 2005	20	7	9	10	6	24	76
May 2005 – April 2006	8	2	2	11	5	75	100
<b>Total</b>	<b>28</b>	<b>9</b>	<b>11</b>	<b>21</b>	<b>11</b>	<b>99</b>	<b>176</b>

# Summary

The information in this report provides a snapshot of the Lay Health Educator component of the Move More Diabetes Project. A total of 37 LHEs were involved in the initiative and responsible for approximately 790 contacts and 100 referrals during the months of May 2005 through April 2006. Over the past two years, a total of 37 LHEs have been involved in the initiative and made over 1500 contacts and 176 referrals. Moreover, while there has been some fluctuation in the settings of the LHEs, number of new enrollees per setting and type of referrals, in general the implementation of the program has been consistent. Finally, it should be noted that the data reported does not represent every LHE's activities each month, as many did not turn in reports on a consistent monthly basis – particularly toward the end of the project cycle (i.e., February - April 2006). Nevertheless, data from this report should be beneficial to the planning and implementation of the project.

Due to the lack of outcome data (e.g. utilization of services, level of physical activity) among program enrollees, generalizations about this data and the effectiveness of LHEs should be made with caution. Continued efforts to track the frequency and type of contacts made as well as the number and type of referrals given to, and utilized by, program participants is recommended. Discussing potential methods for tracking enrollees with LHEs may be particularly useful for the implementation of this effort. In addition, program staff may want to consider opportunities for coordinating the local evaluation efforts with the outcome data collected by Research Triangle Institute in an effort to further evaluate the impact of the Lay Health Educator component of the initiative.