Experience, Partnership and Evidence:
Together on Diabetes™

Patricia Mae Doykos, PhD
Director, Bristol-Myers Squibb Foundation
Bristol-Myers Squibb Foundation: Mission

Promote health equity and improve the health outcomes of populations disproportionately affected by serious diseases and conditions
Bristol-Myers Squibb Foundation: Programs

United States
- Together ON Diabetes
  Communities Uniting to Meet America’s Diabetes Challenge
- Mental Health & Well-being
  Advancing Understanding, Care and Support

Central and Eastern Europe
- Bridging Cancer Care
  Community Awareness, Prevention and Care
- Secure the Future
  Care and support for communities affected by HIV/AIDS in Africa

Asia
- Delivering Hope
  Hepatitis Awareness, Prevention and Care
- Together ON Diabetes
  Communities Uniting to Meet the Challenge of Diabetes in China and India

Africa
- Bridging Cancer Care
  Community Awareness, Prevention and Care
Flagship philanthropic initiative to promote health equity and improve outcomes of adults living with type 2 diabetes — both diagnosed and undiagnosed — who are disproportionately affected in the United States

- National program
- Launched November 2010
- 26 grantees, 60 communities, $53 million committed
Focal points for funding and partnership:

- Strengthen patient self management education & support and care navigation

- Build and expand community supportive services and community mobilization efforts

- Foster a radical rethink and test new ideas about how diabetes prevention and control efforts are approached, designed, implemented and measured given the current and future scale of the epidemic and chronic nature of the disease
<table>
<thead>
<tr>
<th>Grantees</th>
<th>Evaluation &amp; Quality Improvement</th>
<th>Policy &amp; Advocacy</th>
<th>Dissemination &amp; Scaling of Successful Models &amp; Lessons Learned</th>
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<tbody>
<tr>
<td>American Pharmacist Association Foundation</td>
<td>University of Kansas Center for Community Development</td>
<td>Harvard Law School</td>
<td>Morehouse School of Medicine</td>
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<td>American Academy of Family Physicians Foundation/Peers for Progress</td>
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<td>Black Women's Health Imperative</td>
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<td>Camden Citywide Diabetes</td>
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<td>Feeding America</td>
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<td>Health Choice Network Florida</td>
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<td>United Neighborhood Health Services</td>
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<td>University of Michigan</td>
<td>Sixteenth Street Community Health Center</td>
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Purpose of evaluation work:
- explore and evolve new indicators to match the intervention approach, e.g. social correlates of health
- establish the evidence base of new interventions
- establish the evidence base of delivering EBPs to disparity communities
- detect failures quickly and course correct

Indicators:
- Equity – focus on disparity populations, access, outcomes
- Health outcomes, behavior change and quality of life
- Capacity built
- Community resources and engagement

Mobilizing Evidence:
- Sharing lessons learned with the community of practice
- Small “p” and big “P” policy advancement
- Improved standard of care
- Health system change
- Sustainability beyond just grant funding
Addressing Equity through Focus on Heavily Affected Populations and Regions
American Pharmacist Association Foundation: Project Impact Interim HbA1c Outcomes

**Patient Self-Management Credential – Knowledge Assessments (Interim Results)**

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<th></th>
<th>N</th>
<th>Baseline (SD)</th>
<th>Most Recent (SD)</th>
<th>Change to Date (SD)</th>
<th>P Value</th>
<th>Days Experience</th>
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<tr>
<td><strong>Beginner</strong> A1C</td>
<td>462</td>
<td>9.71 (1.99)</td>
<td>8.61 (1.94)</td>
<td>-1.10 (2.14)</td>
<td>&lt; 0.001</td>
<td>189 (94)</td>
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<td><strong>Proficient</strong> A1C</td>
<td>442</td>
<td>9.41 (1.84)</td>
<td>8.44 (1.67)</td>
<td>-0.97 (1.89)</td>
<td>&lt; 0.001</td>
<td>189 (88)</td>
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<tr>
<td><strong>Advanced</strong> A1C</td>
<td>160</td>
<td>9.16 (1.69)</td>
<td>8.31 (1.65)</td>
<td>-0.84 (1.76)</td>
<td>&lt; 0.001</td>
<td>177 (85)</td>
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African American Women Collaborative & Results

African Americans are 2x more likely to be diagnosed with T2DM as non-Hispanic whites and more likely to suffer complications (HHS/OMH)

- Target: 750 African American women living with uncontrolled diabetes
- Grantees: U Virginia, East Carolina University, Whittier Street Health Center, United Neighborhood Health Center, Black Women’s Health Imperative
- Interventions: ranging from rural community health worker teams and “small changes” approach to texting support to housing development based T2DM education

Results to date:
- 1,458 women living with diabetes enrolled in care and support programs
- 7.1%-10% HbA1c at baseline
- .5%-1% range of improvement in reported as average HbA1c reductions across projects
- High participation in diabetes self management education
- All projects incorporated social support in DSME
- 38 community health workers trained
United Hospital Fund:
Self-care Behaviors and Self-efficacy

Together on Diabetes—NYC: Impact to Date

- Rate their health as good or better: 60%, up from 47%
- Test blood sugar daily: 71%, up from 56%
- Check feet at least 4x/week: 84%, up from 64%
- Engage in recommended physical activity, 3+ days/week: 60%, up from 32%
- Confident they can control their diabetes: 94%, up from 74%
- Believe they have support necessary to manage diabetes: 94%, up from 72%

Notes: Based on the first 263 seniors to be reassessed as of December 9, 2013. Squares represent T1, circles represent T2.
Community Resources

Feeding America: Food Bank-Healthcare Partnerships
• 3 lead foodbanks: Redwood Food Bank, Corpus Christi Food Bank, Mid Ohio Foodbank
• 39 food pantries
• 14 clinical partners
• 1,500 clients enrolled to date

National Council on Aging: Community-based and online Stanford DSMP delivery pilot
• YMCA Atlanta / YMCA National
• OASIS Senior Centers – St. Louis and Indianapolis
• Wellpoint – Atlanta, St. Louis, Indianapolis
Hopkins Center for American Indian Health:
Local Community Mobilization

- Design, pilot and evaluate “Family Health Coach” intervention for AI youth ages 10-19 with or at risk for type 2 diabetes
- Youth enroll with adult Support Person
- 12 month home-based intervention
- “Family Health Coaches” are trained Native paraprofessionals from participating communities
- Data collection at 4 time points
- Engage with local providers to promote participant progress
- Consult with Traditional Healers about motivational content
- Guided by local Community Boards and a Cross-Site Steering Committee
Program Progress

• Disproportionately affected populations addressed through grant projects:
  – Medicare/Medicaid, uninsured, seniors, African American, Latino/Hispanic, American Indian, Appalachian people, rural and urban poor, homeless, food insecure

• 554 mobilized and collaborating partners from CBOs, FBOs, government, academia and business

• 83% of projects addressing access to healthy food

• 78% of projects addressing access to physical activity resources
Program Progress

• 292 lay health workers/147 professional health workers trained
• 83% of trained health workers mobilized to apply new and enhanced skills in the projects
• 24,500 people living with or at risk of diabetes reached with community engagement & community based self management education
• Up to 2.1% average reported change in Ha1c
Program Progress

- BMSF and TOD grantee presentations at key health meetings such as National Rural Health Association White House Forum, National Minority Quality Forum, AADE, ADA, ADA Disparities Forum, Joslin Diabetes Innovation Conference, APHA, Clinton Global Initiative, Global Business Coalition on Health
- 32 papers submitted to peer review publications
- $12.8 million in additional project funding from government and philanthropic sources
THANK YOU!

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