Toolkit for Partnering with Community to Reduce the Burden of Kidney Disease Among Latinos with Diabetes

CLINICAL SCHOLARS

A Robert Wood Johnson Foundation program

Toolkit for Partnering with Community to Reduce the Burden of Kidney Disease Among Latinos with Diabetes

AUTHORS

- **Ro Pereira**, MD, Denver Health
- **Kayce Sol**, RN, Denver Health
- **Adrian Boka**, PharmD, Denver Health
- **Lilia Cervantes**, MD, University of Colorado
- **Natalie Ritchie**, PhD, Denver for Health
- **Diana Pineda**, Vuela for Health

ABOUT

This toolkit provides tools and resources to be utilized by other healthcare teams to partner with community-based organizations to advance health equity. Our team's efforts are focused on reducing the burden of kidney disease among Latinos with Diabetes. The lessons can be applied to other clinical areas with other populations.

CONTACT

For more information:

rocio.pereira@dhha.org

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Executive Summary

In the U.S., Latinos, particularly those who are undocumented immigrants, are less likely to have healthcare insurance compared to other race and ethnic groups. This is important because Latinos (i.e., Hispanics) across the country are disproportionately burdened by diabetes. In Colorado, Latinos represent 21% or 1.3 million of the state's total 5.8 million residents. An estimated 10.7% of Colorado's Latinos have diabetes compared to 6.2% of non-Latino Whites. Latinos with diabetes are at increased risk for chronic kidney disease and the progression of chronic kidney disease to kidney failure is twice that of non-Latino Whites. In interviews of Latinos with kidney disease, many report:

- **They were not informed of their risk for kidney disease.**
- **There is a lack of culturally & language concordant diabetes & kidney disease education.**
- **They did not know they had kidney disease until they were diagnosed with kidney failure in the hospital, at which point, they were started on hemodialysis.**

Vuela for Health, a non-profit community-based organization in Denver, provides health education, screening, leadership training, and social-emotional support to Colorado Latinos through its community health worker (CHW) workforce. They have provided CDC accredited diabetes prevention education to Latinos through classes led by culturally and language concordant CHWs for more than 10 years. Through their work with the community, the Vuela team identified a need for educational services for individuals with diabetes, focused on diabetes management and prevention of kidney disease. This identified need led to the development of our Clinical Scholars project and our partnership with Vuela. We collaborated to build a culturally and language concordant Diabetes Self-Management Education and Support (DSMES) curriculum focused on diabetic kidney disease prevention and designed to be delivered by CHWs to groups of Spanish-speaking Latinos with diabetes. We also partnered on a community-based screening for early detection of kidney disease.

The root cause of the higher prevalence of diabetes and diabetic kidney disease among Latinos is structural racism. Compared to non-Latino Whites, Latinos are more likely to attend under-resourced schools, less likely to attend college and graduate, more likely to be obese, and more likely to live in a neighborhood without healthy food options or the opportunities to spend time outdoors. These social factors are all associated with higher rates of diabetes and more rapid development and progression of diabetes complications, including diabetic kidney disease. Latinos are also less likely to have health insurance, have an established primary care provider, or receive preventative care services. In many states in the US, Latinos with kidney failure do not have access to outpatient dialysis services and they rely on weekly emergency dialysis in a hospital setting.

Our team has addressed structural racism head-on by engaging in advocacy work at various levels. At the individual level, we developed a culturally and language concordant curriculum for CHWs and expanded screening access. At the organizational level, we work at a safety-net healthcare organization that provides access to care to all individuals regardless of insurance status or ability to pay, and we consistently work to identify and address disparities in care and clinical outcomes. At a structural level, our team members are engaged in policy development and these efforts have led to successfully passing state policy that expands access to full-scope Medicaid and expands access to low premium private insurance plans to undocumented immigrants. State-wide efforts supported a policy that in 2022 for the first time allowed 10,000 undocumented immigrants to enroll in private health insurance off the marketplace at no cost. Policy to create a reimbursement mechanism for CHW services in Colorado has also now passed and will be implemented in the coming years.

Planning

Our approach to decreasing diabetic kidney disease among low-income Latino adults was developed in 2019 and evolved since that time. Some changes in our approach were due to rising needs and barriers as we addressed the COVID-19 pandemic starting in March 2020. Other changes resulted from our team's experiences and learnings as we implemented the project, and new opportunities that became available. The approach was built upon an existing partnership between Denver Health and the Vuela for Health community organization.

We aimed to strengthen this partnership by expanding an existing community-based diabetes prevention program for Latinos to include:

- Additional community-based screening services to identify early kidney disease.
- A community-based diabetes self-management education (DSMES) program.
- Increased awareness of diabetic kidney disease among low-income Latino adults.

We leveraged our clinic-community partnership and emerging leadership skills to:

- Support our community partner to identify mental health needs arising during COVID-19.
- Start a qualitative exploration on the family effects of a diabetes prevention program.
- Inform statewide legislation related to health care services for undocumented immigrants and community health worker reimbursement.
- Take on leadership roles to continue to advance local and national health equity efforts.

Key Skill Sets

The interdisciplinary Clinical Scholars team was assembled by the team lead and included clinical professionals with expertise in diabetes management and education, quality improvement, medical management of chronic disease, program implementation and dissemination, program evaluation, patient-centered/health services research, community-based participatory research, health care advocacy and policy, and health equity best practices.

Project Team

Ro Pereira, MD: Project Lead; Director of the Office of Health Equity and Chief of Endocrinology Section; Denver Health

Adrian Boka, PharmD: Supervisor of Ambulatory Clinical Pharmacy; Denver Health

Lilia Cervantes, MD: Hospitalist and Health Equity Researcher; University of Colorado

Natalie Ritchie, PhD: Psychologist and Senior Researcher

Kayce Sol, RN: Certified Diabetes Care and Education Specialist; Denver Health

Dian Pineda: Community organization Executive Director; Vuela for Health

Jayna DeRoeck: Project Coordinator; Denver Health

Karen Uvina: Research Assistant; Denver Health

Funding

Funding for this project came from the UNC Clinical Scholars program. Each team member was also supported by our respective employers to spend time on developing our leadership skills and on completing project tasks. In addition to protecting each team member's time, funds were used to pay for community health worker time, administrative and research assistant efforts, screening materials and supplies, and educational materials.

Community Partnerships

Community partnerships are essential for health equity work. The development and implementation of the project were done in collaboration with our primary partner Vuela for Health. Our CS project was informed by a pre-existing longstanding collaboration between the CS team lead and the Vuela team, and it was developed to address a community need identified by the Vuela CHW team as they delivered diabetes prevention services. Vuela for Health is a Latina-led and Latino-serving community-based organization providing outreach, health education, leadership training, and self-care services to Latino immigrant communities in Denver and surrounding areas. Vuela's community health workers and Executive Director Diana Pineda have worked together for over 15 years and are themselves Latina immigrants living in the communities they serve. The unique opportunity in partnering with Vuela for Health was that they are trusted by the Latino community, they are deeply invested in improving the well-being of the community, and they were already providing culturally and language concordant education on pre-diabetes to the Latino community. We also partnered with the local chapter of the National Kidney Foundation to train the CHW team to perform kidney screening tests, and to support implementation of community-based screening services.

Our community partners were involved at every step of the project, from development to implementation. Close communication between the CS team and the Vuela team allowed us to remain responsive to community needs throughout the project. The CS project lead, project coordinator, and research assistant communicated with the Vuela team regularly as they implemented a parallel diabetes prevention program. Communication was particularly important when the COVID-19 pandemic begun just as we were about to start implementation of our project. As our teams pivoted to providing services through virtual platforms, trying to keep up with rapidly changing social distancing recommendations, we continued to work together and support each other. Our collaborative approach and strong partnership with the Vuela team allowed us to identify additional opportunities to serve the community, including supporting the Vuela team in developing the tools and workflows to identify mental health needs among community members and to refer people to resources and care. Our partnership with Vuela has led to additional funding to continue the screening workflows and educational programing we developed, and to other opportunities for collaboration beyond the scope of our CS project.

Key Considerations: What community partnerships do you need to foster to address root problems? What are the unique opportunities that arise to keep us moving forward? How do we use a culturally informed process to drive the final product?

Project Work

Our project focused on decreasing the progression of diabetic kidney disease among Latinos. We had identified major reasons for high progression of diabetic kidney disease in low-income Latino communities, including lack of access to preventive screening services, barriers to accessing services in the healthcare setting, and lack of cultural and language concordant materials for diabetes self-management education.

To decrease the progression of Diabetic Kidney Disease in the Latino community, we focused on:

1. **Strengthening community resources**
2. **Increasing community-based screening for diabetes and asymptomatic kidney disease**
3. **Development of a culturally and language concordant DSMES curriculum**

Project Timeline

Year One	■ Established MOA between Vuela for Health (Vuela) and National Kidney Foundation (NKF) to use the kidney screening equipment ■ Procured supplies and materials for kidney screening ■ Trained 4 Vuela CHWs to conduct kidney screening tests ■ Developed the workflows for kidney screening tests ■ Requested additional funding for Paving the Way Mental Health Screening Project
Year Two	■ Implemented mental health screening tool with Vuela ■ Developed culturally congruent DSMES Curriculum ■ Started participant enrollment for DSMES classes ■ Conducted community health fairs with Kidney and blood pressure screenings added
Year Three	■ Provided training to Community Partner to deliver the DSMES group classes. ■ Screened 224 adults for kidney disease since project started ■ Piloted DSMES classes to 10 participants and their family or peer support person ■ Made curriculum modifications based on participant/CHW's feedback ■ Delivered DSMES classes to 117 participants with updated curriculum ■ Secured additional funding for program continuation

Strengthening Community Resources and Community Health System Ties

In 2021, a unique opportunity came about to address mental health screening as additional funding was secured through RWJF to reduce mental health disparities. Vuela for Health community health workers (CHWs) had been administering the PHQ-9 and GAD-7 to participants of some Vuela programs. However, CHWs reported concern that the screening tests were not accurately identifying individuals with symptoms of depression or anxiety. An analysis of past PHQ-9 and GAD-7 responses showed participants were most likely to report having "no symptoms" or "symptoms several days per

week", which indicated much lower rates of mental health distress than expected and did not match verbal reports of depression and anxiety symptoms. We found that variability in effectiveness of these tools may be due to the many ways that participants interpret the questions, prompting us to focus our project on how to better train CHWs to implement the screenings. We created a script and presentation slide deck to train CHWs to educate participants about mental health and the screenings. The presentation was refined using feedback from the CHWs and spurred the creation of a mental health resource list to help CHWs refer participants based on screening scores.

Increasing Kidney Screenings

Health screening for kidney disease is crucial in providing early detection and diagnosis. We identified increasing screening in the Latino population as a hallmark to this project. In order to increase access to screening, we partnered with the National Kidney Foundation (NKF) and Vuela for Health to offer community health screenings for kidney disease and high blood pressure. Vuela routinely provides health screenings events, we leveraged this workflow and added a urine protein test to identify individuals with kidney disease. To execute this, first, we set up an MOA with Vuela and NKF to allow for the utilization of a urine screening machine. Secondly, we facilitated the training on the machine with CHW's and held a virtual educational session on kidney disease. Additionally, once DSMES classes were initiated, those who were enrolled in class received both pre-post screenings.

Developing Curriculum

To embed a DSMES program into Vuela's programs, it was essential to utilize delivery models that were already successful within their other programs. Through meetings and collaboration, it was decided that the classes would be held either virtually or in-person and would be delivered by CHWs. The next step was to identify a curriculum that was culturally relevant and promoted kidney health with diabetes self-management. It was not the original intent to create a diabetes education curriculum. This change happened after we evaluated existing DSMES curricula and identified the many barriers preventing us from using these existing materials. Problems included that they had been designed for healthcare centers and not delivery in community settings, there was a cost to utilize the curriculum, some were copyrighted and did not permit alterations, essential topics for our community were missing, and Spanish versions had words and foods that were not culturally congruent. Our goal was to include a focused kidney health component to address that Latinos with diabetes are at increased risk for chronic kidney disease compared to non-Latino Whites. It became apparent that designing a curriculum to meet the community needs was necessary.

Promotora Providing the DSMES Curriculum:

"My opinion is that this DSMES class has a lot of very useful information for the participant. In these 5 classes, everything that a participant should know is covered, it has helped them a lot to understand what diabetes is, that it is a chronic disease that cannot be removed because many people believe otherwise, and that if you do not take care of yourself it can affect your health. For me, the program is very complete and very well explained in a way that the participants understand. From what I have heard from them they finish the classes very happy and very grateful for all the information because some of them have not been given much importance about their health and end up with a different mentality. Also, something that they liked a lot is that Dr. Rocio Pereira has been attending the last class for questions."

Key points from the Vuela DSMES curriculum design process included:

- Make it bi-directional: The creation was an interactive process with Vuela who provided culturally relevant changes and recommendations to address the needs of the target audience.
- Leverage existing standards: We utilized frameworks from the American Diabetes Association (ADA) and Association of Diabetes Care & Educational Specialists (ADCES) to design and create educational content ensuring that the information aligns with current guidelines.
- Foster relationship building: Our kidney module built on the work of ***Riñones, Tesoros Education Program for Community Health workers—developed by the NIH, NKDEP***. With their permission we expanded their concept and engaged in focused collaboration with our community partner Vuela for cultural adaptation and workflow implementation.

DSMES Curriculum Outline

Class	Topics
Class 1: Introduction	What is Type 2 Diabetes? How common is diabetes? How can we live well with diabetes?
Class 2: Diabetes Management & Prevention of Complications	How does diabetes impact the body? How do you manage and monitor glucose levels? How does medication prevent complications with diabetes?
Class 3: Nutrition	What are macronutrients? How do you read nutrition labels and what does it mean? What are strategies to achieve balanced nutrition?
Class 4: Stress Management, Depression & Physical Activity	How do you manage stress? What is depression and anxiety and how can it relate to diabetes? How does physical activity impact diabetes and overall health?
Class 5: Prevention of Kidney Disease	How can I keep my kidneys healthy with diabetes? How is diabetes related to kidney disease? What is the treatment for kidney disease?

For more detailed information on the curriculum or interest in collaboration, email: Admin@vuelaforhealth.com

Evaluation and Dissemination

In development of our evaluation plan, we considered what different stakeholder groups would most want to know about our work and which outcomes would be feasible to collect and report. See Appendix A for team publications.

Clinical Outcomes

Our experience is that healthcare providers are primarily interested in clinical outcomes including A1C improvement after intervention. Specifically, A1C is a key indicator of diabetes control, and well-controlled diabetes can prevent progression to kidney disease. By partnering with the Latino immigrant-serving organization Vuela for Health and the National Kidney Foundation we were able to conduct community-based screenings for diabetic kidney disease, measurement of A1c and blood pressure screenings for community adults with or without diabetes. We measured:

- **Frequency of positive screenings** (for pre-diabetes, diabetes, kidney disease and hypertension)
- **Change in A1c over 3 months** (standard measure of diabetes control for DSMES participants)

Patient-Reported Outcomes

Our team member has found that participants are most interested in seeing the change in levels of diabetes distress after intervention, which is the outcome of greatest personal importance and familial importance. We assessed:

- **Change in diabetes-related distress among DSMES participants** (measured at first/last sessions attended with the Diabetes Distress Scale)
- **Care provider visit after abnormal screening test**
- **Change in medication adherence among DSMES participants** (measured at first/last sessions attended with the Morisky Medication Adherence Scale)

Qualitative Data	Examples
Participant	The content was very good, very enjoyable and motivated.
Participant	I am more aware of how to take care of myself, exercise, and what I should not eat
Participant	The material was very good for me, the promoters did it very well, very understandable

Process Measures

We utilized process measures to monitor the quality, efficiency, and effectiveness of our community-based screenings and DSMES classes. Additionally, these facilitated identification of our successes and barriers that affect the delivery and outcomes of our intervention.

- **Number of individuals screened**
- **Number of Vuela CHW's trained**
- **Number of DSMES classes held**
- **Number of DSMES participants**
- **Average number of DSMES sessions attended**
- **Patient panels convened**

We recognized that funders would be interested in hearing how successful our project was compared to our initial plan. Finally, we considered how healthcare payers (e.g., insurers) would especially be interested in data on the return on investment (ROI) of interventions, including the associated costs and savings (e.g., reduced healthcare utilization) over a given timeframe. Although evaluating ROI is beyond the scope of this project, it is an important factor to assess prior to wider implementation.

Dissemination

The workflows and processes we developed in partnership with the Vuela team will be disseminated in several ways. The Vuela team will be working with other CHW teams to teach them and provide support as they develop their own workflows for participant outreach, screening events, and group education sessions. This toolkit will be posted online and available to other teams doing similar work. Our dissemination activities have also included advocacy to spread the message about the wicked problem of diabetic kidney disease in Latino adults and potential solutions, as well as formal publications and presentations (see Appendix A).

We have secured funding to continue providing services to the community for the next 3-5 years. Additionally, the State bill that allows for CHW reimbursement has passed and this law will be implemented soon. Our goal will be to continue to advocate for policy change that will ensure all individuals in the US have access to preventive and healthcare services regardless of their income, insurance status, or documentation status.

Lessons Learned

Embarking on this project during the COVID-19 pandemic brought on many challenges for our team, partner organizations, and community. All involved had competing demands during this time. Our Clinical Scholars team experienced: increased demand of caring for COVID-19 patients and a shortage of healthcare workers/staffing. Vuela for Health experienced increased demands from the Latino community; Vuela for Health pivoted their work to provide culturally and language concordant education about COVID-19 and vaccination. Recognizing these competing demands, we kept in constant communication with each other and aligned our work with the overall goal of improving the health of our Latino community. We had to continuously pivot to move this work forward. We were flexible and adaptable to the rapidly changing environment and timeline of our work. Vuela listened to what the Latino community needed and prioritized the health of the community by focusing on:

- **COVID-19 testing and vaccine administration.**
- **Mental health evaluations and referral to resources.**
- **Enrollment in low-premium health insurance to expand care for undocumented immigrants in Colorado.**

Therefore, the work of this project, appropriately, was not always the priority and our timeline shifted to best serve the Latino community. We were patient yet persistent in our efforts and focused on other efforts to dismantle discrimination, racism, and bias so our Latino community can thrive.

Successes

This project was successful in increasing access to community health screenings and referral for chronic kidney disease, diabetes and hypertension, facilitating early diagnosis and treatment. Prevention is better than cure for any chronic disease state including kidney disease. Our team developed the first culturally concordant DSMES curriculum that focuses on kidney health. Community health screenings and the DSMES curriculum were developed for the community, by the community and in the community. Our team addressed structural racism head-on by engaging in advocacy work at various levels. Members of our team worked to successfully pass policy that expands access to full-scope Medicaid for undocumented immigrants, policy that builds sustainability for CHWs by providing reimbursement for CHW services, and policy which makes it possible for undocumented immigrants to enroll into private health insurance. Ultimately, this increase in access is fundamental for our overall sustainability plan to improve the health of the Latino community.

Shifts in Thinking

We wanted to address the health disparity that exists among Latinos regarding the prevalence of chronic kidney disease and the progression of kidney disease to kidney failure. As our work progressed, our team shifted and prioritized improving the overall health of our Latino community. This shift helped anchor our team. It allowed us to maneuver through challenges and what we thought were setbacks at the time, as we had to delay the roll out of our DSMES curriculum, due to competing demands. In retrospect, by delaying our DSMES curriculum roll out, this allowed our community organization to prioritize enrolling our Latino community into health insurance. This increase in access will help mitigate existing health disparities for the Latino community, decrease the potential for future health disparities, and ultimately improve health equity.

Initially, our team was not planning on developing and building our own DSMES curriculum. We thought we could refine and tailor existing curriculum to meet the needs of our Latino community. We discovered multiple barriers to this approach that would limit the effectiveness. It did not align with our goals of being culturally and language concordant while meeting the specific needs of the population and jeopardized the sustainability of this work. Creating our own DSMES was time consuming for our team and pushed back our curriculum roll out which decreased the number of participants we could enroll within our designated timeline. Our focus on sustainability helped us navigate this challenge and many others. Developing and making freely available our own cultural and language concordant kidney health DSMES curriculum was the right thing to raise awareness and educate our Latino community and increase our reach by delivering it in the community by CHWs.

COVID-19 forced a shift in the way we deliver care. We rapidly shifted to provide remote care for our patients and community in response to the pandemic. This shift to the digital/telehealth healthcare delivery model proved to be remarkably successful in meeting the needs of our community when we were not able to provide the traditional form of care, in-person. These digital healthcare delivery systems are now an integral part of our daily lives, as the world's population has never been more interconnected. Innovation, particularly in the digital healthcare sphere, is happening at an unprecedented rate. Even so, its application to improve the health of our communities has largely remained untapped, and there is immense scope for use of digital health solutions. Patients have become accustomed to this digital model of care and now demand these services. One barrier of this care delivery model is the lack of reimbursement by payors. For sustainability of digital healthcare delivery models, one of the next shifts in healthcare needs to be in how we reimburse them.

Recommendations

Getting Started

Partnering with community is not always straightforward or easy but it is essential for health equity efforts. When thinking about how to begin, we recommend the community partner should be included early during the project development phase to ensure a trusted/authentic partnership. The community voice is sometimes included as an afterthought or only when the grant funding has already been awarded. This practice creates mistrust from the beginning and should be avoided. Another pitfall to avoid is assuming that health disparities are due to lack of knowledge/awareness or "unhealthy" behaviors and that education and counseling for community members is enough to close disparity gaps. Social determinants of health and racism are primary barriers to health, particularly for individuals from minoritized communities.

We recommend that teams discuss and agree on a communication and work plan at the very beginning of project development so that all stakeholders remain engaged and informed throughout the project. When developing a project, think about sustainability from the beginning and throughout your work/partnership. The goal is to start a partnership that will continue, even if the specific project ends after the funding ends. Ideally, the project will also continue in one way or another if there is enough thought to sustainability at the beginning.

An essential determinant of sustainability is evaluation. Without evaluation that demonstrates the project was worthwhile, it will be difficult to secure funding to continue. Plan to collect data on outcomes that will be important to key groups of interested parties (e.g., cost, clinical outcomes, participant satisfaction). Consider what data is feasible to collect and how you will evaluate the data that comes in.

As you begin a project and engage stakeholders, it is important to understand how much of your time will be required. Be sure to avoid overcommitting yourself, your team, or your partners to more work than is realistic to do. Consider your resources carefully and remember that it is okay to take small steps toward your "bigger picture" goal. Common advice is also to avoid "scope creep", which is when a project morphs into something unwieldy.

Best Practices

- **Expand the circle of influence:** To change the culture of health we must expand the concept of who is involved in providing and creating healthcare services. Creating sustainable solutions, requires mimicking nature: this involved engaging diverse opinions, experiences, and voices to drive effective care and prevention.
- **Start with a plan for sustainability:** How will the work continue after the project ends?
- **Understand the challenges and solutions from the community's perspective:** Community must lead in developing solutions and healthcare policy change because they are the ones affected by the health or advocacy challenge.
- **Aim to publish your work if possible:** Decision-makers are often expected to use published papers to inform their decisions. Either way, be sure to share the word about your learnings and successes!
- **Change takes time:** Everything takes longer than you think. Being adaptable and flexible while focusing on your goals will help guide you and your team partners. Remember to celebrate your victories along the way.

Appendix

Appendix A: Team Publications

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Appendix B: Morisky Scale

On the next two pages.

NOMBRE______________________________ MRN_____________________________
FECHA____________________

Sus Sentimientos sobre la Diabetes

Por favor díganos a qué grado cada uno de los siguientes problemas le complicarón la vida **durante el mes pasado**.

EMOCIONES

	¿Qué tan grave o molesto es para usted…	No es un Problema	Es un Problema Pequeño	Es un Problema Moderado	Es un Problema Algo grave	Es un Problema Grave	Es un Problema Muy Grave
		1	2	3	4	5	6
1	Sentir que la diabetes diariamente consume mucho de su energía mental y física	☐	☐	☐	☐	☐	☐
2	Sentir enojo, miedo, o depresión cuando piensa en tener que vivir con la diabetes	☐	☐	☐	☐	☐	☐
3	Sentir que la diabetes controla su vida	☐	☐	☐	☐	☐	☐
4	Sentir que haga lo que haga, tendrá complicaciones serias con efectos a largo plazo	☐	☐	☐	☐	☐	☐
5	Sentirse abrumado(a) por el cuidado que requiere vivir con diabetes	☐	☐	☐	☐	☐	☐

Para la oficina: puntuación para las emociones_____

DOCTORES

	¿Qué tan grave o molesto es para usted…	No es un Problema	Es un Problema Pequeño	Es un Problema Moderado	Es un Problema Algo grave	Es un Problema Grave	Es un Problema Muy Grave
		1	2	3	4	5	6
1	Sentir que su doctor no sabe lo suficiente acerca de la diabetes, así como del cuidado de la diabetes	☐	☐	☐	☐	☐	☐
2	Sentir que su doctor no le explica claramente cómo controlar su diabetes	☐	☐	☐	☐	☐	☐
3	Sentir que su doctor no toma en serio sus preocupaciones sobre su(s) enfermedad(des)	☐	☐	☐	☐	☐	☐
4	Sentir que no tiene un doctor que pueda ver con suficiente frecuencia para atender su diabetes	☐	☐	☐	☐	☐	☐

Para la oficina: puntuación para los doctores_____

Pacientes: Por favor NO anote ningún puntaje. Los educadores de salud los anotarán después de que termine la sesión.

NOMBRE______________________________ MRN______________________________
FECHA____________________

CUIDAR DE SÍ MISMO							
¿Qué tan grave o molesto es para usted…		No es un Problema	Es un Problema Pequeño	Es un Problema Moderado	Es un Problema Algo grave	Es un Problema Grave	Es un Problema Muy Grave
		1	2	3	4	5	6
1	Sentir que no se está midiendo el azúcar en la sangre con la frecuencia adecuada	☐	☐	☐	☐	☐	☐
2	Sentir que a menudo fracasa con su rutina de cuidados de la diabetes	☐	☐	☐	☐	☐	☐
3	No sentir confianza en su capacidad para manejar su diabetes día a día	☐	☐	☐	☐	☐	☐
4	Sentir que no está cumpliendo con una alimentación saludable	☐	☐	☐	☐	☐	☐
5	Sentir que no tiene la motivación necesaria para controlar su diabetes	☐	☐	☐	☐	☐	☐

Para la oficina: puntuación para Cuidar de sí Mismo_____

ASUNTOS INTERPERSONALES							
¿Qué tan grave o molesto es para usted…		No es un Problema	Es un Problema Pequeño	Es un Problema Moderado	Es un Problema Algo grave	Es un Problema Grave	Es un Problema Muy Grave
		1	2	3	4	5	6
1	Sentir que ni sus amigos, ni su familia apoyan sus esfuerzos para cuidarse (planean actividades que dificultan sus horarios, lo(a) motivan a comer comidas inapropiadas)	☐	☐	☐	☐	☐	☐
2	Sentir que ni sus amigos, ni su familia reconocen lo difícil que es vivir con la diabetes	☐	☐	☐	☐	☐	☐
3	Sentir que ni sus amigos, ni su familia le dan el apoyo emocional que le gustaría tener	☐	☐	☐	☐	☐	☐

Para la oficina: puntuación para los Asuntos Interpersonales:_____

Puntuación para todo “Sentimientos sobre la Diabetes”:____

Pacientes: Por favor NO anote ningún puntaje. Los educadores de salud los anotarán después de que termine la sesión.