Family Health Coaches
Addressing the Burden of Type 2 Diabetes among American Indian Youth

Johns Hopkins Center for American Indian Health
Together on Diabetes Program

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Bristol-Myers Squibb Foundation
Together ON Diabetes
Communities Uniting to Meet America’s Diabetes Challenge
Presenters

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THE TEAM!
Johns Hopkins Center for American Indian Health

- Center founded in 1991 within JHSPH International Health
  - Based on a decade of infectious disease research with tribal communities
  - 1991 - Behavioral and mental health programs launched
  - 2000 - Training program launched
- Public health interventions with global application/dissemination
Center Mission

To work in partnership with American Indian and Alaska Native communities to raise AI/AN health status, self-sufficiency and health leadership to the highest possible level.
Johns Hopkins Together on Diabetes (TOD) Sites

Navajo Nation
- Chinle, AZ
- Shiprock, NM
- Tuba City, AZ

- White Mountain Apache
  - Whiteriver, AZ

Location of Program Sites

Navajo Nation: 3 sites
White Mountain Apache
TOD Program Goals

1) Identify gaps and assets in diabetes prevention and care for adolescents and their families in the participating communities.

2) Identify and adapt an Evidence Based Intervention for youth and families that is appropriate for the communities’ needs and resources.

3) Enroll 250 youth and families, implement and evaluate the pilot intervention, share and disseminate best practices across sites and to other tribal communities.
TOD Target Population

- Primary Target Population: Youth (ages 10 - 19)
- Secondary Target Population: Support Person (>18 years)
TOD Inclusion Criteria

1) American Indian youth aged 10-19 years old at study enrollment.

2) Reside within ~ 1-hour transportation range of health facilities in Chinle, Shiprock, Tuba City, or Whiteriver.

3) Referral from a hospital provider indicating a diagnosis of pre-diabetes or type 2 diabetes by qualifying lab test OR considered at-risk for type 2 diabetes based on BMI ≥ 85\textsuperscript{th} percentile and qualifying lab test.
TOD Intervention Overview

- Home-based intervention
- Delivered by Native paraprofessionals: “Family Health Coach”
- Youth Sessions
  - Intervention Phase:
    - 12 Biweekly lessons (0-6 months)
      Integration of youth-made videos and “Khan Academy” learning strategy
  - Maintenance Phase:
    - 6 Monthly lessons (7-12 months)
  - Assisted Provider visits
- Support Person Sessions
  - 4 Lessons (0-12 months)
- Community Wide Activities
  - Community Advisory Boards
  - Partnership with community programs/events – sports, gardening, farmers markets, outdoor adventure
Community Based Participatory Research Methods in TOD Program

- Hiring and training of local staff, including local youth assistants

- In-depth interviews and roundtable discussions with youth and parents to guide program development

- Community Advisory Boards and Cross-Site Steering Committee – with regular feedback surveys

- Ongoing collaboration with community partners on intervention and evaluation design, data interpretation and next directions

- Participate in and develop community events
The Role of the Family Health Coach

- **Who:**
  - Trained paraprofessionals from the local community

- **Key Activities:**
  - Deliver TOD intervention to youth and family
  - Connect youth and families to services through facilitated referrals
  - Attend youth provider visits
  - Communicate with providers to improve quality and consistency of care
  - Support community healthy living programs
  - Coordinate Community Advisory Board Meetings
  - Build relationships with community programs and organizations
Family Health Coach Training

- **Knowledge**
  - Diabetes prevention and management
  - Nutrition
  - Physical activity
  - Mental health promotion

- **Skill Development**
  - Data collection (interviews, surveys, physiological measures)
  - Motivational Interviewing
  - Curriculum facilitation
  - Special topics (e.g. addressing bullying)

- **Professional Development**
  - Stress management
  - Public speaking
Significance of Family Health Coach Model

- Ensures program is grounded in the local cultural and social context
- Increases program impact through knowledge and understanding of the unique cultural and social environment surrounding type 2 diabetes in Native communities
- Builds on local knowledge and expertise
- Optimizes local resources
- Builds local workforce and capacity of resource-stressed communities
- Family Health Coaches are compensated as full-time JHU employees with benefits
Owen Laluk, Family Health Coach

- Background
- Education / Training
- Role in TOD Program
Participant Case Story

- **Participant 4004**
  - 14 year old boy
  - Living with type 2 diabetes
    - Taking medication and insulin
  - In 8th grade and active in school sports
  - Father is enrolled “Support Person”
    - Father very engaged and concerned about son
  - Participant’s primary goal in TOD program: eat healthier
  - Progress since joining TOD: meal planning, reading nutrition labels, monitoring blood sugar, more active at home
    - Doctor noted significant improvement after participant joined TOD program and began working with Family Health Coach
  - Current challenge: family stressors and participant is hard to reach
Stacie Tsingine, Family Health Coach

- Background
- Education / Training
- Role in TOD Program
Participant Case Story

- **Participant 3021**
  - 14 year old boy
  - Diagnosis of pre-diabetes
  - Mother is enrolled as “Support Person”
    - Engaged with all TOD events (physical fitness activities and food demos)
  - Participant’s primary goal in TOD program: lose weight
  - Progress since joining TOD: lost 6 lbs so far; joined a school sport; staying away from soda; no more Hot Cheetos; encourages brother to be healthier; overall greater concern about his health
    - He is focusing on small steps toward big goals
Sustainability Plans

- Family Health Coach criteria built to match Community Health Representative (CHR)s and Health Techs within Public Health Nursing (PHN) programs – congressionally funded through Indian Health Service (IHS)

- Working to disseminate through regional and national service units via pre-existing MOU between Johns Hopkins and IHS

- Launching cost effectiveness study to assist with advocacy efforts

- Plans to expand curriculum to encompass obesity prevention and other risk and protective factors to prevent diabetes
THANK YOU!

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