2013 Diabetes Patient Tele-Education Programs
Targeting High Diabetes Risk Areas of Virginia

FINAL REPORT

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Virginia Center for Diabetes Professional Education
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Charlottesville, VA
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Acknowledgements

The 2013 Diabetes Tele-education program represents a team effort by several organizations and individuals. In almost all cases these partners have participated in expanding and improving the program over the course of several years, so their effort has been consistent and cumulative in terms of program evolution. We want to acknowledge these efforts and sincerely thank the following organizations or individuals for their many contributions.

- **Virginia Department of Health, Office of Minority Health and Health Equity.** Funding from VDH in the form of annual contracts has made this program possible in 2013. The Office of Minority Health and Health Equity possesses a strong vision of the educational potential of telemedicine technology and through consistent funding, has made it possible for the program to expand and to more effectively address statewide disparities in the availability of diabetes patient education.

- **University of Virginia Office of Telemedicine.** The diabetes tele-educational program depends upon a statewide teleconferencing network and technical expertise in order to bring interactive education classes to sites across Virginia. All programs are broadcast from the Office of Telemedicine’s conference room and are actively monitored and supported by a technician from that office. This high level of support is essential to creating an educational experience that is free from technical problems and has the feel of a face-to-face class.

- **Virginia Information Technology Agency (VITA).** VITA has made a substantial contribution to our tele-education efforts over the years by providing us with additional connectivity to health department sites across the state. They enable us to reach virtually the entire health department teleconferencing system through a single UVA connection.

- **University of Virginia Diabetes Education and Management Program.** Two of the educators from the Diabetes Education and Management Program, Shirley Fleishman, R.N., C.D.E. and Viola Holmes, M.S., R.D., C.D.E. teach all of the classes in the tele-education program. They each can draw on years of experience in working with diabetes patients and in-depth knowledge of diabetes management in presenting information understandably and answering participants’ questions. They invariably and deservedly receive extremely high ratings and expressions of thanks from program participants.

- **Jennifer Johnson, Certified Wellness Coach, Harry L. Coomes Recreation Center, Abingdon, VA.** Over the past few years, we have puzzled over how best to teach the physical activity aspect of diabetes self-management. In the course of implementing a diabetes prevention effort in southwestern Virginia, we met and partnered with Jennifer Johnson. Discussions about tele-education ensued and Jennifer volunteered to broadcast two segments on physical activity live from her home base at Coomes. Two Coomes members, Ellen Lee and Rhonda Goble, volunteered with Jennifer to demonstrate the use of the resistance bands, which we provided free of charge to all participants. These segments were upbeat, high energy, and accessible for beginners. The ability to bring in an instructor from Abingdon to teach a segment of a larger program being broadcast from Charlottesville is a demonstration of the powerful and flexible educational potential of teleconferencing.
Executive Summary for 2013 Diabetes Tele-education Program

Facilitator Training

- 2 facilitator trainings offered in Richmond and Abingdon, VA on January 16 and 30 with 21 facilitators being trained from 6 health districts, 4 community health centers, and 1 critical access hospital.
- The purpose of the training was to inform them about our plans for 2013, to discuss the technology used and how to troubleshoot and solve problems with connectivity, and to provide an opportunity for networking, discussion, and brainstorming of ideas.

Participants and Sites for 2013

- We had a total of 162 individuals attend the diabetes tele-education program. Many individuals attended one or more of the four different classes, resulting in a total of 335 class participants attending the programs offered from February through July.
- The highest levels of class attendance was in the middle months of March, April, and May, averaging 33.5 participants per class.
- 14 sites participated in the programs for 2013.
- Our new sites participating this year, Highland County Medical Center and Tri-Area Community Health Center (which has 3 locations in Ferrum, Floyd, and Laurel Fork) had the most participants per site, with 38, 64, 35, and 47 participants respectively.

Class Offerings for 2013

- The names of the four classes were changed to simplify the titles and to differentiate between the basic and the more in-depth classes.
- The basic classes, “Nuts and Bolts of Diabetes” and “Now I Have Diabetes, What Can I Eat?” were changed to “Self-Management Basics” and “Nutrition Basics”.
- The in-depth classes, “Diabetes Medications and Glucose Numbers” and “Eat Smart, Get Active” were changed to “Improve Your Control, Activity, and Stress” and “Eat Smart, Change Your Lifestyle”.
- A total of 10 classes were offered this year; the basic classes were each offered in February, April and June (a total of 6 classes) and the in-depth classes were offered in March and May (a total of 4 classes).

Demographics of Participants

- Most participants are in the 50-70 years of age category representing 63% of total participants; this comports with CDC data which reports 55 as the average age of persons with type 2 diabetes.
- Most of our class participants were female (73%); BRFSS data shows no difference with respect to gender in participation in diabetes education classes.
- The majority of participants were Caucasian (82%) followed by African-Americans (15%).
- Most participants have type 2 diabetes (63%) and take oral medications (63%); 15% of participants with type 2 diabetes reported that they take both oral medication and insulin.
Class Usefulness

- Participants responded very favorably to the usefulness of all the class sessions with an average usefulness rating of 4.38 on a 1-5 scale.

Self-Management Behaviors of Participants

- The vast majority of participants consistently see a need to improve their nutrition-related self-management behaviors;
- Blood glucose testing, physical activity, and stress management are also commonly seen by participants as areas where their self-management needs to be improved.

Community Engagement

- Participants are most likely to share information gained in class and to receive diabetes support with and from spouses or partners, children, and friends.

Future Plans

Future challenges facing the tele-education program are the level and schedule of funding, collection of more accurate demographics and more meaningful behavioral outcome data, new site recruitment, site retention, and increased patient attendance at our low participating sites. We will continue to try to recruit new sites in the Southside area of Virginia where the rates of pre-diabetes and diabetes continue to be high. The challenges in this area continue to be access to functional teleconferencing equipment and adequate staff and leadership to market and coordinate these programs. We will also work on targeting new sites in Central and Southside Virginia where the population of African Americans is higher. In addition, we will work to increase the number of African Americans participating in all our programs throughout the state.
Facilitator Training

We began the diabetes tele-education program in 2013 by providing two regional trainings for site facilitators – January 16 in Richmond, VA and January 30 in Abingdon, VA. We had 9 site facilitators attend the training in Richmond representing 3 Health Districts (Three Rivers, Crater, and Prince Edward) and 3 Community Health Centers (Blue Ridge Medical Center, Onley Community Health Center, and Highland County Medical Center). In Abingdon, we had 12 site facilitators representing 3 Health Districts (Cumberland-Plateau, Mt. Rogers, and LENOWISCO), 1 Community Health Center (Tri Area Community Health Center), 1 Critical Access Hospital (Dickenson Community Hospital) and 1 Diabetes Care Center (Mountain States Johnston Memorial Hospital-Abingdon, VA).

The purposes of the training were to:

• make a personal connection with site facilitators and provide an opportunity to network with each other;
• inform participants about past accomplishments and plans for 2013;
• gather input from facilitators to improve and expand the tele-education program throughout the state;
• disseminate marketing resources and brainstorm ideas to interest participants in attending local classes;
• provide information about the technology used in tele-education and discuss how to troubleshoot and prevent problems with connectivity;
• discuss ideas and techniques for group facilitation and improving interaction; additional evaluation measures; long-term support and follow-up to promote improved diabetes self-management behaviors; and community engagement concepts and possible use of Community Health Ambassadors.

The results of the evaluation summary indicate that the site facilitators felt the training was “very useful” with an average usefulness rating of 4.8 on a 1-5 scale. The specific aspects of the training that they felt were the most useful included:

• learning new strategies and ideas for marketing the program;
• communicating and discussing needs with the program faculty and other site facilitators; networking and sharing of ideas with other facilitators;
• reviewing the VCDPE tele-education program website;
• becoming familiar with the program components and educational resources.
Participants and Sites for 2013

In 2013, a total of 335 class participants attended our diabetes tele-education programs offered from February through July. A total of 14 sites participated in the educational programs, including five new sites: Highland County Medical Center in Monterey, Shore Memorial Hospital on the Eastern Shore, and the Tri-Area Community Health Centers in Ferrum, Floyd, and Laurel Fork. As is often the case, these sites attracted above average total numbers of participants. Six health departments and six community health centers participated (see Chart 1 below). Bath Community Hospital was the only Critical Access Hospital that participated this year. Table 1 summarizes this information by site and class date (see next page).

<table>
<thead>
<tr>
<th>Chart 1: Total Number of Participants by Site</th>
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<tbody>
<tr>
<td>Wise Co HD</td>
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<tr>
<td>Tri-Area Community Health Center - Laurel...</td>
</tr>
<tr>
<td>Tri-Area Community Health Center - Floyd</td>
</tr>
<tr>
<td>Tri-Area Community Health Center - Ferrum</td>
</tr>
<tr>
<td>Riverside Shore Memorial Hospital Board...</td>
</tr>
<tr>
<td>Richmond Co HD (Warsaw)</td>
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<tr>
<td>Petersburg HD - Crater</td>
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<tr>
<td>Onley Community Health Center</td>
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<tr>
<td>Lee Co HD</td>
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<tr>
<td>Highland Medical Center</td>
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<tr>
<td>Farmville HD (Prince Edward Co.)</td>
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<tr>
<td>Buchanan Co HD</td>
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<tr>
<td>Blue Ridge Medical Center</td>
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<tr>
<td>Bath Community Hospital</td>
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</tbody>
</table>

Chart 2 (below) is derived from Table 1 and highlights some findings important for discussion. First, the highest levels of class attendance over the five-month period that classes were offered (February – June) was in the middle months of March, April, and May, averaging 33.5 participants per class. We think the initially slow build up (from February – March) was due to the additional time needed to market classes and winter weather conditions. We believe the drop in class attendance seen from May to June was due to winding down and summer schedules.

Site participation, also captured in Chart 2, ranged from a high of 11 on April 23 to a low of 3 on June 25. Buchanan County and Lee County Health Departments took advantage of the most class offerings, participating in 9 and 8 classes respectively, from February through June of 2013. On average, about 7.6 sites participated in each broadcast. The explanatory comments offered previously about patient participation in February and June classes would also apply to site participation.
<table>
<thead>
<tr>
<th>Week</th>
<th>7.7</th>
<th>7.6</th>
<th>Total Participants</th>
<th>Total Participants per Class</th>
<th>Average Participants per Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>3</td>
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<tr>
<td>2</td>
<td>0</td>
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<td>5</td>
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<td>7</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: The table is a representation of data collected from 2013 Diabetes Education Programs.
Map 1 (below) shows the geographic dispersion of sites throughout the state, with recipients located primarily in the southwestern, Southside, and Northern Neck areas of Virginia. Providing regional trainings for site facilitators as well as strong local leadership helped to produce the large number of patients participating in the southwestern area (particularly the Tri-Area Community Health Centers) and the Eastern Shore (Onley Community Health Center whose liaison also assisted in getting Shore Memorial Hospital, a small rural hospital, involved).
Health Districts and Number of Patients Per Site
Map 1: Sites Participating in 2013
Revision of Class Offerings for 2013

The schedule and number of classes was changed in 2013 in line with funding and contractual adjustments (see Table 2, below). We also changed the names of our four classes this year, primarily to simplify the titles and to differentiate between the basic and the more in-depth classes. The basic classes, “Nuts and Bolts of Diabetes” and “I Have Diabetes, Now What Do I Eat?” were changed to “Self-Management Basics” and “Nutrition Basics” and the in-depth classes, “Diabetes Medications and Glucose Numbers” and “Eat Smart, Get Active” were changed to “Improve Your Control, Activity, and Stress” and “Eat Smart, Change Your Lifestyle”. The basic classes were each offered in February, April and June (a total of 6 classes) and the in-depth classes were offered in March and May (a total of 4 classes).

Table 2: Class Offerings for 2013

<table>
<thead>
<tr>
<th>Name of Class</th>
<th>Instructor</th>
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<tbody>
<tr>
<td><strong>Self-Management Basics</strong></td>
<td>Shirley Fleishman, RN, CDE</td>
</tr>
<tr>
<td>This class covers areas identified by the American Diabetes Association as essential to successfully manage diabetes. Topics include definition, diagnosis, and types of diabetes, target glucose goals, oral and injectable medications for type 1 and type 2 diabetes, treatment of hypoglycemia, sick day guidelines, foot care, and diabetes complications. An in-depth discussion of insulin is covered in the Glucose Control, Activity, and Stress class.</td>
<td>2 hours 3 per year</td>
</tr>
<tr>
<td><strong>Nutrition Basics</strong></td>
<td>Viola Holmes, RD, MS, CDE</td>
</tr>
<tr>
<td>This class provides up-to-date, helpful information that participants can readily use to plan meals that will improve their blood glucose control and are heart healthy. Topics include nutrient effects on blood glucose, healthy food choices, serving sizes, reading food labels, use of non-nutritive sweeteners, use of alcohol, recommendations for fats and fiber, and healthy snack choices.</td>
<td>2 hours 3 per year</td>
</tr>
<tr>
<td><strong>Improve your Control, Activity, and Stress</strong></td>
<td>Shirley Fleishman, RN, CDE and Jennifer Johnson, BS, Certified Wellness Coach</td>
</tr>
<tr>
<td>This class focuses on blood glucose control. Topics include an in-depth discussion of insulin management, case studies to understand and interpret daily glucose patterns, and a discussion of how eating, activity, and medication can be adjusted to improve glucose. The focus will then shift to interactive sessions on physical activity and managing stress. Activities include 20 minutes of stretching using resistance bands, provided free to participants, and practice with deep breathing and relaxation.</td>
<td>2 hours 2 per year</td>
</tr>
<tr>
<td><strong>Eat Smart, Change Your Lifestyle</strong></td>
<td>Viola Holmes, RD, MS, CDE</td>
</tr>
<tr>
<td>This class focuses on the “how to” aspects of changing what you eat. Topics include tips about shopping for healthy meals, portion sizes, easy ways to cut calories, avoiding common eating traps, tips on how to eat healthier. The class will end with a discussion of how to set personal goals for improving your lifestyle.</td>
<td>2 hours 2 per year</td>
</tr>
</tbody>
</table>
Participants, Completion of Evaluations, and Class Attendance

In 2013, 335 participants attended our diabetes tele-education classes. Of these, 235 (70.5%) completed evaluation forms in part or in full. Partially completed evaluations contributed to varying sample sizes for the data presented in this report (see, for example, the discussion of age, gender, and ethnicity in the next section). The 335 participants are comprised of 162 individuals who, on average, attended about 2 classes. Specifically, as Chart 3 (below) indicates, 21 individuals (13%) attended all four of the diabetes education classes, 28 (17%) attended three classes, 33 (20%) attended two classes, and 75 (46%) attended one class. Four individuals attended five or more classes (which means they repeated one class) and 1 individual attended six classes (repeating two classes). All those who attended all four classes received a certificate of completion and a congratulatory letter from the program directors.

![Chart 3: Number of Classes Taken by Individuals (n=162)](chart3.png)

- 1 class (n=75)
- 2 classes (n=33)
- 3 classes (n=28)
- 4 classes (n=21)
- 5 classes (n=4)
- 6 classes (n=1)
Age, Gender, and Ethnicity of our Participants

In order to capture additional demographics of our participants this year, we are including summative data for age, gender, and race/ethnicity (N = 156, 162, and 286, respectively). The information on age and gender was obtained from the attendance sheet which was required for all participants to complete—however, 6 people did not record their birthdate. The information on race/ethnicity was reported on anonymous evaluation forms which were completed each time participants attended classes and therefore, recorded more than once in some cases. A solution for this problem will be incorporated in future programs, possibly by asking participants to complete a one-time registration form.

Of the 156 individuals reporting age, most of our participants are in the 50-69 years of age category, representing 63% of our total participants (ages 50-59, 24%; 60-69, 39%) (see Chart 4). Twenty six percent (26%) of our individuals were under 50 years old, while 21% were 70 or older. Our youngest individual was 19, while our oldest was 95.

Most of the class participants this year were female. Of the total number of participants, 73% (N=118) were female and 27% (N=44) were male (see Chart 5). This does not comport with Virginia BRFSS data from 2007-2009 which shows that there is no difference with respect to gender in participation in diabetes education classes (56.9% male and 57.5% female). However, a study published in Family Medicine in 2009 reported that female gender, insulin use, and a higher degree of obesity was positively associated with education program attendance.
It is important to know whether the program is reaching a diverse racial/ethnic group of people with diabetes. Of the 286 participants who reported race/ethnicity data, 82% (n=233) were Caucasian, 15% (n=42) were African-American, 2.7% (n=7) were Native American, and only 1 was Asian. About 1% (n=3) reported that they were Hispanic/Latino (see Chart 6, below). Thus, there was racial/ethnic diversity among participants in the tele-education program.

However, in the interest of understanding whether we are adequately reaching these groups, we also made an effort to compare these percentages with the racial/ethnic makeup of the geographic areas in which participating sites are located. Since county estimates of diabetes prevalence by race/ethnicity are not readily available, 2012 census estimates were obtained for the racial/ethnic composition of each of the 14 participating counties. These population estimates were then multiplied by either the 2010 Virginia BRFSS prevalence estimates for Caucasians (8.5%) and African Americans (13.7%), or the national BRFSS prevalence estimates for Asian-Americans (12.6%) and Hispanics (11.8%). An exception was made in the case of the 8
Appalachian counties that participated in the program (Bath, Buchanan, Carroll, Floyd, Franklin, Highland, Lee, and Wise), where the Caucasian population is ≥90%. Because of the documented higher prevalence of diabetes among Caucasians in Virginia’s Appalachian counties, the overall county rates for diabetes were used instead. Native Americans were not broken out separately in the county census figures, hence are not included in this analysis.

Chart 7 (below) compares the estimated percentages of the 14-county diabetic population that fall in each of four racial/ethnic categories with the percentages of these groups that participated in the tele-education programs.

Since the Asian/Asian-American and Hispanic groups were very small, the results of the comparison is only meaningful in the Caucasian and African-American groups. Caucasian participants were overrepresented in the tele-education program by about 16% of the estimated county prevalence, while African-American participants were underrepresented by about 37%. Underrepresentation of African-Americans in health care programs is recognized as a major national problem and we will work to increase the percentage of African-Americans who participate in our future programs.
Most Participants have Type 2 Diabetes and Take Oral Medication

Also included in the summative data for 2013 was differentiating the type of diabetes of class participants. We asked the participants what type of diabetes they had, including a response for pre-diabetes, don’t know, and don’t have. Also, we were interested in knowing if and what type of diabetes medication was used by participants with diabetes.

As would be expected, many more participants had type 2 than type 1 diabetes (63% vs. 7%, respectively). Seven percent (7%) of participants also reported having pre-diabetes (7%), which parallels national findings of pre-diabetes awareness. A substantial portion of the participants (20%) reported having ‘no diabetes’. This figure represents a mixture of family members, support persons, and staff or other health care professionals who attended the class sessions. Also, 3% reported that they ‘didn’t know’ what type of diabetes they had. Chart 8 (below) summarizes these results.

![Chart 8: Self-report of Type of Diabetes (n=309)](chart8.png)
The majority of participants (63%) stated that they took oral medication for management of their type 2 diabetes while 15% stated they took both oral medication and insulin. There was a 12% response rate for those who took only insulin to manage their diabetes but this represents both those with type 1 and type 2 diabetes. A total of 27% of the class participants indicated that they take insulin which justifies the time we spend talking about insulin and glucose pattern analysis. This year, we were also able to analyze data for participants with type 2 diabetes who took no medication (3%) and those with pre-diabetes who took no medication (7%). Chart 9 (below) summarizes these results, which are generally comparable to results of the National Health Interview Survey (2007-2009).
Class Sessions Are Rated as Being Very Useful

Participants again this year responded very favorably to the usefulness of all the class sessions with an average usefulness rating of 4.38 on a 1-5 scale (see Chart 10, below). In the written comments sections of the evaluation form, the following information was reported as specifically useful:

- information about diabetes medication and insulin (how they effect blood glucose, the different kinds, and how to take them)
- all aspects of food and what to eat, but particularly information about carbohydrate
- better understanding of numbers (glucose patterns, hemoglobin A1c)
- showing examples of portion sizes, how to read food labels, and how to plan meals using simple foods that we routinely eat
- emphasis on exercise (and showing us how to use the resistance bands) and the relaxation exercise for stress management
- all the handouts (particularly the slide handouts)
- case studies were very helpful to put information into practice
Effectiveness of Tele-education Technology

Participants rated the effectiveness of tele-education technology 4.19 on a 1-5 scale. This rating confirms that program participants have a positive view of teleconferencing as a means for providing diabetes education. The primary technical problems we had this year were because of outdated equipment at a couple of participating sites, specifically community health center locations. The UVA Office of Telemedicine, in conjunction with VITA, was very helpful with troubleshooting and solving any technical problems that arose during the live broadcasting.

Participants Need for Improvement with Self-Management Behaviors

This question was changed on the evaluation form this year to obtain improved reporting results. The question was revised as a two-part question; first, we asked participants how much they thought they needed to improve specific self-care behaviors using a 5-point Likert Scale and second, we asked them to select one behavior that they intended to improve and to tell us what they were going to do. We selected four specific self-care behaviors for them to report on for each class which are listed below:

- “Nutrition Basics”
  1. Eating a similar amount of carbohydrate
  2. Cutting down on portion sizes
  3. Eating more whole grains, fruits, and vegetables
  4. Eating less fat, sugar, and salt

- “Eat Smart, Change Your Lifestyle”
  1. Use smart grocery shopping strategies
  2. Make half my plate fruit and vegetables
  3. Include more whole grains in my meals
  4. Cut down on portion sizes

- “Self-Management Basics”
  1. Blood glucose testing
  2. Medication
  3. Foot care
  4. Treatment of low blood glucose

- “Improve Your Glucose Control, Activity, and Stress”
  1. Insulin therapy
  2. Glucose pattern management
  3. Physical activity
  4. Stress management

The vast majority of participants consistently see a need to improve their nutrition-related self-management behaviors. Across the four classes taught this year, participants rated the need to improve self-care behaviors associated with nutrition and eating most highly (see Charts 11 and 12, below). About 70% or more of the participants in both nutrition classes reported needing to improve their eating behaviors “a fair amount” or “a lot”.

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Chart 11: Nutrition Basics
"How much do you think you need to improve in each of the following areas?"

- Eating consistent amounts of carbohydrate: 42%
- Reducing portion sizes: 41%
- More grains, fruits, vegetables: 39%
- Less fat, sugar, salt: 38%

(A fair amount/A lot)
(Very little/Somewhat)
(Not at all/Not applicable)

Chart 12: Eat Smart, Change Your Lifestyle
"How much do you think you need to improve in each of the following areas?"

- Using smart shopping strategies: 50%
- Making half the plate fruit and vegetables: 56%
- More whole grains: 51%
- Reducing portion sizes: 52%

(A fair amount/A lot)
(Very little/Somewhat)
(Not at all/Not applicable)
Blood glucose testing, physical activity, and stress management are also commonly seen by participants as areas where their self-management needs to be improved. Other self-management behaviors perceived by large percentages of participants as needing “a fair amount” or “a lot” of improvement were blood glucose testing (46%), physical activity (55%), and stress management (43%; see Charts 13 and 14, below).
Community Engagement

This year, in order to promote the importance of engaging with others in the community to share the information they learned and also to receive support from other people to help them with their diabetes management, we involved Susan Triggs, PhD, from the VDH Office of Minority Health and Healthy Equity to do a short session at the end of the program on how participants can be more engaged in their communities.

We asked participants to report who they would most likely share learned information with from the community. We also asked them who in the community would help to support them in their efforts to better manage their diabetes.

Participants are most likely to share information gained in class with spouses or partners, children, and friends. The data also show that participants view their support relationships as being reciprocal, expecting to receive support as well as share information with their community networks (see Chart 15, below).

![Chart 15: Participants' Expectations About Giving and Receiving Information and Support](chart15.jpg)
Implications for Future Programs

Future challenges facing the tele-education program are the level and schedule of funding, collection of more accurate demographics and more meaningful behavioral outcome data, new site recruitment, site retention, and increased patient attendance at our low participating sites. We will continue to try to recruit new sites in the Southside area of Virginia where the rates of pre-diabetes and diabetes continue to be high. The challenges in this area continue to be access to functional teleconferencing equipment and adequate staff and leadership to market and coordinate these programs. We will also work on targeting new sites in Central and Southside Virginia where the population of African Americans is higher. In addition, we will work to increase the number of African Americans participating in all our programs throughout the state.

Plan for Restructuring Diabetes Tele-education Program for Fall of 2013 and 2014

- Program structure and frequency for the Fall of 2013 and 2014 will depend upon funding being present. Assuming adequate funding is in place, we plan to offer an 6-month schedule with classes in October and November of 2013, April-May and September-October of 2014.
  - October 2013, April and September 2014 – Self-Management Basics
  - October 2013, April and September 2014 – Nutrition Basics
  - November 2013, May and October 2014 – Improve Your Glucose Control, Activity and Stress
  - November 2013, May and October 2014 – Eat Smart, Change Your Lifestyle