

Bristol-Myers Squibb Foundation

Together Diabetes

Communities Uniting to Meet America's Diabetes Challenge



DIABETES

AFFECTS 25.8 million people
8.3% of the U.S. population

DIAGNOSED 18.8 million people

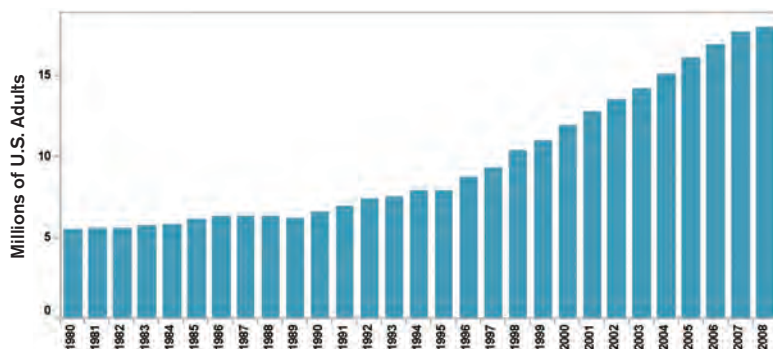
UNDIAGNOSED 7.0 million people

PREDIABETES 79 million people

IN 2050 as many as 1 in 3 adults
could have diabetes.

Centers for Disease Control and Prevention. National Diabetes Fact Sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

How Many Adults Had Diabetes in the U.S. From 1980 to 2008?



Data Source: Centers for Disease Control and Prevention



Together on Innovation, Healthier Communities and Healthier People

A Message from the President

The United States is fast becoming a diabetic nation. The number of Americans diagnosed with diabetes more than tripled since 1980, and the U.S. Centers for Disease Control and Prevention estimates that one in three adults could have diabetes by 2050 if current trends continue.

The cost of diabetes, estimated at \$174 billion in 2007, is projected to triple over the next 25 years, and then there's the cost in human suffering: heart disease, blindness, kidney disease and amputations.

Sadly, this situation reminds me how HIV/AIDS statistics in the developing world climbed sharply in the 1990s before a growing sense of urgency prompted a stepped up and coordinated global response. As with HIV/AIDS, I believe we can turn the tide of diabetes, together, but we must not lose any more time.

Following in the footsteps of *SECURE THE FUTURE*[®], the Bristol-Myers Squibb Foundation's landmark initiative to fight HIV/AIDS in Africa, *Together on Diabetes: Communities Uniting to Meet America's Diabetes Challenge*[®] confronts this growing problem. Funded at \$100 million over five years, it is the largest corporate philanthropic commitment ever made to address type 2 diabetes in the United States.

This first annual report introduces our initial partners. Since *Together on Diabetes* was launched on World Diabetes Day 2010, the Foundation has committed \$30.3 million in support of 15 grantees, each with diverse teams of government, academic and community partners. These creative projects are challenging and expanding current thinking and laying important groundwork for more comprehensive and impactful diabetes control efforts going forward.

The report also provides a window into our philosophy and grant-making approach. Consistent with the Foundation's mission, *Together on Diabetes* seeks to help reduce health disparities. That means focusing on communities and populations disproportionately affected by type 2 diabetes, especially the poor, the elderly and minorities. The goal of *Together on Diabetes* is to creatively strengthen and expand patient self-management and community support services, and serve as a catalyst for broad-based community mobilization.

The title, *Together on Innovation, Healthier Communities and Healthier People*, reflects the major grant-making categories where we focused our efforts, each of which is described in its own section. The section "Together on Innovation" highlights innovations in the delivery of evidence-based programs. "Together on Healthier Communities" focuses on efforts to bend the curve of the diabetes burden in targeted areas, while "Together on Healthier People" describes grants that seek to address the heavy disease burden found in certain high risk groups like racial and ethnic minorities and seniors.

Whether fighting HIV/AIDS in Africa, hepatitis in Asia, cancer in Central and Eastern Europe, or promoting mental health and well-being in the United States, the efforts of the Bristol-Myers Squibb Foundation have made a positive difference in the face of some of the world's toughest health challenges.

While the burden of this particular disease is indeed heavy, experience has taught us time and again that amazing things can happen when people and communities stand together.



John Damonti

President, Bristol-Myers Squibb Foundation
Vice President, Corporate Philanthropy, Bristol-Myers Squibb

Together On Innovation

Necessity has been called the mother of invention. This is certainly true when it comes to meeting the challenge of diabetes. Diabetes is a dire problem in the United States, but the good news is that communities across the country are responding to the challenge with many creative, innovative and effective approaches.

An important aspect of the grant-making focus of *Together on Diabetes* this first year involved identifying and encouraging innovative initiatives that could be scaled up – often with the help of national organizations – to reach disparity populations.

As a member of the *Together on Diabetes* Expert Advisory Council, I have had the privilege of seeing how the Bristol-Myers Squibb Foundation looks to drive innovation from a variety of angles. Sometimes the innovation is in the service or intervention itself, as in New Jersey's Riverview Medical Center's project taking a self-management tool for depression and adapting it for use by people living with diabetes and depression, a common co-morbidity. Sometimes innovation comes from combining effective interventions in new ways, like Feeding America's plan to develop partnerships between food agencies and health clinics so people with diabetes who come through the doors of either have access to health care services, diabetes and nutrition education and healthy foods.

Innovation was also evident in strategies for scaling up essential disease self-management education services. Such is the program from the American Association of Diabetes Educators to expand the base of diabetes educators by creating multi-level teams ranging from advanced practice diabetes educators to community health workers, and matching the education need of the patient with the right type of educator.

No matter how bright the idea, however, all of our partners in the innovative grants described in this section know that their most important partners are the communities they serve. For ideas to work, they must reflect the realities of the local community, draw on community strengths and be shaped through the community's involvement.

When this happens, the results can be powerful, and provide lessons that can benefit communities across the country.

Kate Lorig, R.N., Dr.P.H.

Professor Emeritus
Director, Stanford Patient Education Research Center
Stanford University School of Medicine
Member, *Together on Diabetes* Expert Advisory Council

Pharmacists Help Make IMPACT on Diabetes

Managing diabetes is a collaborative effort and pharmacists are an important member of a patient's health care team. Project IMPACT (Improving America's Communities Together) is a national initiative that seeks to improve care for people with type 2 diabetes through community-based, interdisciplinary teams that include pharmacists.

The initiative builds upon the American Pharmacists Association (APhA) Foundation's successful Asheville Project and Diabetes Ten City Challenge, which presented the pharmacist coach model for privately insured patients in urban areas. The *Together on Diabetes* grant allows APhA to bring this intervention to publicly and privately insured patients in high-need communities.

In the months since receiving notification of the award, the APhA Foundation has been laying the groundwork for this large demonstration project, establishing a National Partner Advisory Committee, developing a web-based tool kit, collecting diabetes care best practices and selecting pharmacy and community partner organizations in 25 target communities.

These pharmacist leaders in turn are bringing together a diverse group that includes primary care providers, endocrinologists, nurses, diabetes educators, social workers, pharmacy benefit managers, insurance companies, government agencies, pharmacists and pharmacy chains to implement the Asheville Project model.

GRANT SUMMARY

Grantee: The American Pharmacists Association Foundation in partnership with American Pharmacists Association, Center for Health Value Innovation, Giant Food Stores, HHS Office of Women's Health, National Diabetes Education Program, U.S. Health Resource Services Administration - Pharmacy Services Support Center, and Walgreens.

Amount: \$4.4 million over four years
Purpose: To establish community-

based pharmacist "coaches" as extensions of the clinic-based team to support diabetes understanding, lifestyle changes, care access and medication management.

Areas of Focus: 25 communities in 16 states: Virginia, California, Kansas, Alabama, Ohio, Texas, South Carolina, Maryland, Tennessee, Arizona, New York, Kentucky, Oklahoma, West Virginia, North Carolina and New Jersey

“The national disaster of diabetes is especially pronounced among Latinos. *Together on Diabetes* provides a wonderful opportunity to demonstrate how the *promotora* tradition of the Latino communities can enhance diabetes care and management.”

– Delia Pompa, senior vice president, National Council of La Raza



Maria Milagros Aburto is a *promotora de salud*, or community health educator, in the Hispanic community in Washington, D.C. ▶

Exploring the Diabetes-Depression Connection

Studies show that people with diabetes are also at greater risk of depression. These findings are affirmed by health care providers at Riverview Medical Center (RMC) in Neptune, New Jersey, who report increasing numbers of type 2 diabetes patients who also suffer from depression, which can also be a barrier to making the lifestyle changes needed to control diabetes.

This innovative demonstration project seeks to adapt a behavioral health self-management tool known as Wellness Recovery Action Planning, or WRAP, to provide patients with the self-management education and support they need to improve their emotional and physical well-being.

The Diabetes WRAP pilot will allow patients to explore their levels of wellness in six dimensions: physical, emotional, social, vocational/educational, spiritual, and intellectual, and develop an action plan to increase wellness. RMC will evaluate participants' adherence to their diabetes treatment, changes in their self-management skills and mental wellness, and progress against a variety of clinical indicators, like HbA1c and cholesterol levels.

GRANT SUMMARY

Grantee: Riverview Medical Center Foundation

Amount: \$51,000

Purpose: To pilot a modified Wellness Recovery Action

Plan (WRAP) model for type 2 diabetes patients who also are suffering from or at risk of developing depression.

Area of Focus: New Jersey

Peer Supporters Help Strengthen Patients' Medical Homes

Type 2 diabetes management that spans from the clinic to the community and targeting Latino adults is the focus of this demonstration project that is led by the American Academy of Family Physicians in partnership with Peers for Progress, National Council of La Raza and the University of North Carolina's Gillings School of Global Public Health.

The project brings together two important trends in health care delivery: the Patient-Centered Medical Home (PCMH) and the integration of peer and *promotora* support and community outreach in the management of chronic disease.

PCMH describes a more team-oriented and proactive approach to primary care that is gaining currency as a model for the delivery of high-quality and better coordinated care. The program's sponsors are working to incorporate a comprehensive approach to diabetes management in the PCMH setting, one with a strong peer support and community outreach component, in an effort to improve outcomes for Latino diabetes patients.

The American Academy of Family Physicians and its partners recently selected Alivio Community Health Center in Chicago as the implementation site for this project, the outcome of which promises to provide valuable lessons for the provision of coordinated primary care services, self-management education and ongoing, real-world support.

GRANT SUMMARY

Grantee: American Academy of Family Physicians Foundation in partnership with Peers for Progress, National Council of La Raza, TransforMed, the University of North Carolina's Gillings School of Global Public Health and Alivio Community Health Center in Chicago

Amount: \$5.2 million over three years

Purpose: To incorporate patient self-management education, peer support and community outreach for low-income Hispanics and African Americans into the patient-centered medical home model.

Area of Focus: Chicago

Together On Innovation



▲ Seniors who have been diagnosed with type 2 diabetes or pre-diabetes discuss ways to increase understanding about the barriers to better diabetes management during a United Hospital Fund-led focus group at the ARC Senior Center in Washington Heights, New York City.

A Healthy Place to Grow Old

As the American population ages, the number of “naturally occurring retirement communities,” or NORCs, is increasing across the country, providing platforms for many innovative models of care and support for senior citizens.

Unlike planned retirement communities or age-restricted communities, NORCs are places that have evolved over time as homes to a significant proportion of older residents. New York City has identified approximately 40 such communities that range from single buildings to age-integrated neighborhoods.

The United Hospital Fund's Together on Diabetes: A Community Control Project for Seniors, undertaken in partnership with the New York City Department of Aging and New York City Department of Health and Mental Hygiene, seeks to build and test a new model to better support seniors with diabetes through a broad range of social and health care services.

The United Hospital Fund and its partners began by conducting a detailed evaluation of potential sites for this demonstration project leading to the selection of the Washington Heights/Inwood section of Manhattan, an area with a 26 percent diabetes rate among seniors.

The organizational groundwork is continuing with efforts to consult with and engage seniors living in the neighborhood and community partners toward the goal of linking clinical services and supportive neighborhood resources in a mutually reinforcing network of care.

GRANT SUMMARY

Grantee: United Hospital Fund in partnership with the New York City Department of Health and Mental Hygiene and the New York City Department for Aging

Amount: \$2.8 million over three years

Purpose: To test an integrated, community-based diabetes control strategy for seniors living in “naturally occurring retirement communities” (NORCs).

Area of Focus: New York City

“The challenge is to create a community-wide safety net woven so tight that no senior with diabetes can slip through – a net that connects seniors, their caregivers, their health care providers, community-based organizations, and the mix of business, civic and religious organizations in a community – all focused on improving the management of diabetes and the quality of life of affected seniors.”

– Fredda Vladeck, director, Aging in Place Initiative, United Hospital Fund

Diabetes Educator Teams Expand Patient Education and Patient-Centered Care

Research has shown that people with type 2 diabetes who participate in diabetes education have lower average health costs and better overall quality of life than those who don't. People of low socioeconomic status and in underserved communities, however, often face barriers that prevent them from getting the education and support they need to fully implement the behavior changes related to healthy eating, exercise, glucose monitoring and medication compliance that are so critical to successful disease management.

The American Association of Diabetes Educators (AADE) and its partners in Tennessee, Florida, Oklahoma and Ohio are undertaking a demonstration project testing an operating model for multi-level diabetes education teams to provide coordinated and comprehensive patient education and patient-centered

care in partnership with primary care physicians. These teams include advanced practice nurses, certified diabetes educators, non-certified diabetes educators and clinicians, as well as community health workers who reflect the cultural diversity of patients.

GRANT SUMMARY

Grantee: American Association of Diabetes Educators

Amount: \$400,000

Purpose: To conduct a one-year pilot study of the effectiveness and sustainability of a flexible, multi-level diabetes education and support team that serves minority populations and uses professional and lay health workers.

Areas of Focus: Tennessee, Florida, Oklahoma and Ohio

“We anticipate this project will expand access to high-quality, coordinated care for patients in underserved populations, reduce emergency room and in-patient hospital stays, and improve clinical and behavioral outcomes.”

– Lana Vukovljak, CEO, American Association of Diabetes Educators

Fighting Diabetes – and Food Insecurity

People struggling against hunger are more vulnerable to a variety of illnesses, and that includes type 2 diabetes. A research study conducted by the University of California at San Francisco found adults living with the most severe levels of food insecurity had more than twice the risk of type 2 diabetes than adults who have ready access to healthy foods.

In this demonstration project, Feeding America, a national hunger relief charity, and three member food banks in Texas, Ohio and California will collaborate with area health care providers to help this at-risk population.

In addition to providing healthy and nutritious food through its food banks, Feeding America will connect people in need to nutrition and disease education, as well as diabetes screening and medical treatment. A rigorous evaluation component will track indicators such as adherence to treatment, improved self-care skills and clinical outcomes, laying the groundwork for potential expansion to other regions.

GRANT SUMMARY

Grantee: Feeding America

Amount: \$3.1 million over three years

Purpose: To improve the health outcomes of individuals who are food insecure or at risk for food insecurity and also affected by type 2 diabetes by connecting food bank and health center diabetic clients to diabetes self-management education, as well as access to healthy foods.

Areas of Focus: Texas, Ohio and California



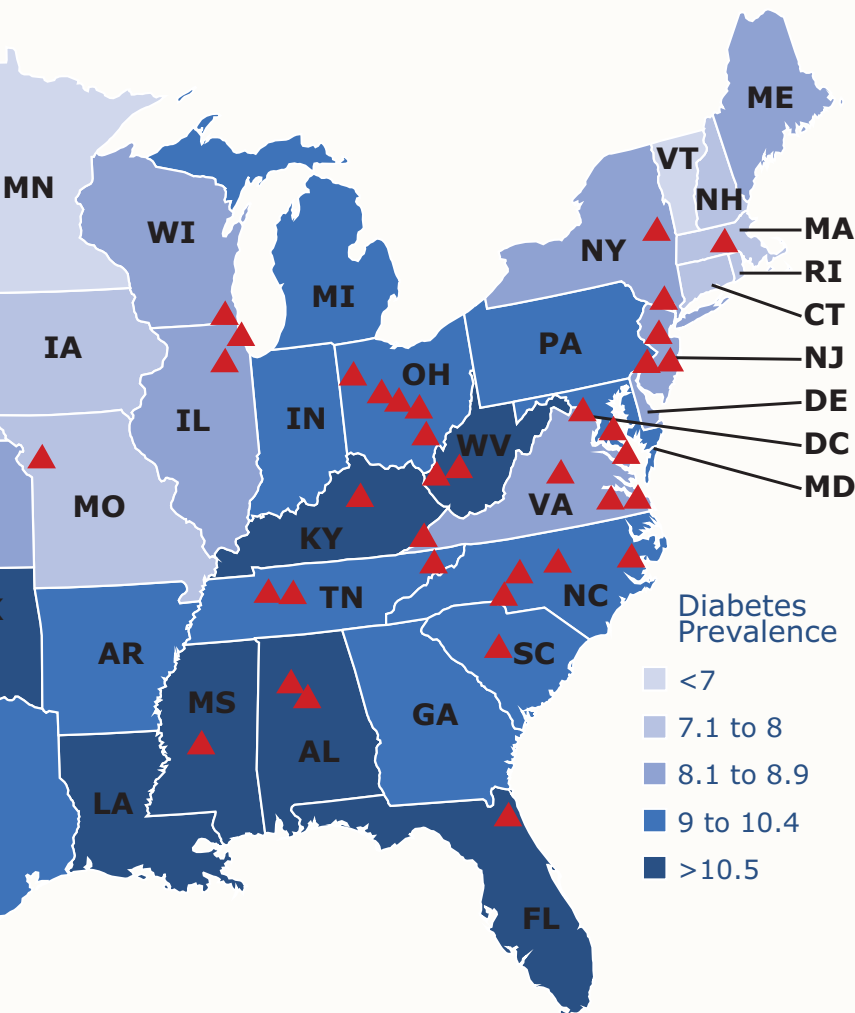
◀ Feeding America connects people in need to nutrition and disease education, as well as diabetes screening and medical care.

“*Together on Diabetes* projects are challenging and expanding current thinking and laying important groundwork for more comprehensive and impactful diabetes control efforts going forward.”

–John Damonti, president, Bristol-Myers Squibb Foundation



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[Click here](#) to access an interactive version of this map for specific site and project details.

2012 Focus Population: Native Americans

In 2012, *Together on Diabetes* will seek to pioneer public health innovations designed to strengthen diabetes prevention, case management and quality of care for Native Americans, who suffer the highest rates of type 2 diabetes in the nation and are 2.2 times more likely to be diagnosed with diabetes than non-Hispanic whites. Studies indicate that more than half of the increase in the mortality rate for Native Americans over the past two decades is attributable to type 2 diabetes. The rapid increase is partially explained by significant shifts over the past three decades in dietary patterns from traditional foods, such as wild game, nuts, fruits and berries to processed, energy-dense convenience foods and from traditionally active lifestyles to more sedentary lifestyles associated with Westernization. Native American traditions support healthier patterns of diet and physical activity, and loss of culture and connections to these traditions have been associated with psychosocial outcomes – depression and hopelessness – which may be risk factors for diabetes and obesity. Family-centered and multi-generational approaches that draw heavily on Native American traditions and are integrated with clinical services will be a special focus of *Together on Diabetes* grant-making and partnership development in 2012.

Together On Healthier Communities

While access to well-trained health care professionals and effective medications are important parts of diabetes management, their beneficial impact on diabetes outcomes has not accrued equally to all segments of our diverse population. Effective diabetes care requires an effective partnership between the clinical team and the patient, in the context of family, community and culture.

Clinical practices may be especially challenged in meeting the needs of patients whose families speak another language, or who have non-majority cultural perspectives on health care or diabetes. Patients living in poor neighborhoods may have no market offering affordable healthy food and no safe park in which to exercise, but may also have great strengths in extended family relationships, faith communities and cultural resiliency. The vision of *Together on Diabetes* is to build effective clinician-patient partnerships and culturally relevant self-care strategies, combining the strengths of the clinical team with the strengths of the communities they serve, in order to achieve optimal and equitable health outcomes for all.

The grants described in this section outline a series of demonstration projects advocating holistic approaches that integrate public health, clinical care, and social determinants in communities bearing a disproportionate burden of disease.

No one size fits all. From the streets of a struggling New Jersey city to the small towns of the Mississippi Delta to the hollers of Kentucky, the local issues – and the community strengths and resources that can be leveraged – vary greatly, as do the approaches for confronting them. Common to the methodology

“Through collaboration with the Bristol Myers-Squibb Foundation, the Camden (NJ) Coalition of Healthcare Providers has a unique opportunity to enhance the cutting-edge chronic disease disparities work we have already been pursuing for the past seven years. Through this partnership, we will be able to take a much deeper dive into the primary care and community-based interventions already in place. This project will have a far-reaching impact in helping Camden residents live with diabetes and proactively manage their disease.”

– Jeffrey Brenner, M.D., founder and executive director, Camden Coalition of Healthcare Providers

of each approach, however, is a thorough, inclusive process for setting goals, integrating programs and resources and measuring results. This is about more than data collection. Clinicians, patients and communities working together on shared objectives can build long-term relationships and shared ownership of successful programs and outcomes.

George Rust, M.D., M.P.H.

Professor of Family Medicine
Director, National Center for Primary Care
Morehouse School of Medicine
Member, *Together on Diabetes* Expert Advisory Council

Durham County, North Carolina

The toll of diabetes is heavy in Durham County, North Carolina. About 9.3 percent of county residents have type 2 diabetes and another 2.2 percent have type 2 diabetes but are undiagnosed, according to state estimates. Other troubling indicators from recent studies: 85 percent of diabetes patients in the county are overweight or obese, 69 percent don't exercise and almost half had not attended any diabetes education classes.

Duke University and the Durham County Department of Health and Human Services are working toward a healthier Durham County with an ambitious, multi-stage project that seeks to improve patient self-management, clinical outcomes and quality of life at the population level.

Initial efforts include reaching out to community partners and building a geo-spatial map that provides a deep picture of the diabetes challenge in Durham County and can track diabetes-related activities across the clinic and community, permitting real-time monitoring of patients and populations.

Duke University, the county and their partners in the local communities will then develop and implement a series of targeted, community-based, population-level interventions, with monitoring and evaluation to track changes in health outcomes and health service usage, as well as costs and projected savings.

GRANT SUMMARY

Grantee: Duke University in partnership with Durham County Department of Health and Human Services

Amount: \$6.2 million over five years

Purpose: To develop, pilot and implement a coordinated response to bend the diabetes burden and cost curves at the population level.



Appalachia

The prevalence of type 2 diabetes in the vast expanse of the Appalachian Mountains is higher than for the nation as a whole, and especially high – above 13 percent – in the counties classified as distressed by the Appalachian Regional Commission (ARC). This grant seeks to encourage efforts to address the needs of diabetes patients beyond the clinics and doctors' offices by building the capacity of local diabetes coalitions that have been established in rural, low-income counties through a partnership of the Marshall University Center for Rural Health, ARC and the U.S. Centers for Disease Control and Prevention.

The project partners will work with 10 diabetes coalitions to implement evidence-based programs that support long-term behavior change and control of type 2 diabetes and other chronic conditions.

GRANT SUMMARY

Grantee: Marshall University Center for Rural Health in partnership with the Appalachian Regional Commission and the U.S. Centers for Disease Control and Prevention

Amount: \$2.6 million over five years

Purpose: To intensify the efforts of local community diabetes coalitions.

The Mississippi Delta

Mississippi has the third-highest prevalence of diabetes in the nation. The disease burden is especially heavy in the counties of the Mississippi Delta, a burden exacerbated by high rates of poverty as well as a serious shortage of physicians and other health care professionals.

The Mississippi Public Health Institute and its partners are developing a coordinated, evidence-based plan and community-based approach for addressing the higher disease burden in 18 Delta counties.

The plan includes integrating existing medical and non-medical systems of care for patients with type 2 diabetes based on best practices adapted to local needs. Working with public health physician practices, Federally Qualified Health Centers, Rural Health Clinics and community partners, the initiative will seek to identify the most effective methods for making locally adapted, sustainable best practices like Community Health Workers an integral part of ongoing efforts to create patient-centered medical homes. The partners will also work with communities to identify specific policies that can drive healthy lifestyles, such as making fresh foods more readily available through community gardens or incentives to local grocers.

GRANT SUMMARY

Grantee: Mississippi Public Health Institute in partnership with the Mississippi Department of Health, University of Mississippi Medical Center and the Mississippi Division of Medicaid

Amount: \$484,000

Purpose: To develop a comprehensive plan to lower the incidence and burden of diabetes in the Delta.

Camden, New Jersey

The prevalence of type 2 diabetes among adults in Camden, New Jersey, is 12.8 percent – nearly 50 percent higher than the state average. The Camden Coalition of Healthcare Providers (CCHP) is working to ease that burden by improving care at the patient, practice and community level.

Major goals for the initiative include improving patient self-management, education and support; enhancing behavioral health and community engagement; and expanding access to healthy, nutritious food and physical activity programs.

CCHP will measure the impact of its interventions against a variety of indicators including clinical outcomes, patient behavior and the demand for and cost of health care services in an effort to identify the savings that can be gained through a coordinated continuum of clinical care and chronic disease management.

GRANT SUMMARY

Grantee: Camden Coalition of Healthcare Providers

Amount: \$3 million over five years

Purpose: To support the self-management and community support and mobilization components of a coordinated effort to bend the diabetes burden and cost curves in Camden, New Jersey.

Other CCHP Funders and Partners:

The Merck Company Foundation, Cooper University Hospital, The Nicholson Foundation, U.S. Office of the National Coordinator, HEREIU Fund, Institution for Medication Access and Compliance (IMAAC), Virtua Health, Our Lady of Lourdes Health System, Underwood Hospital, Campbell's Soup Company, Health Research and Education Trust (HRET)

Together On Healthier People

Racial and ethnic minority communities bear a heavy burden of diabetes and its devastating complications. African Americans, Hispanic/Latino Americans, Native Americans, and some Asian Americans and Native Hawaiians or other Pacific Islanders are at particularly high risk of developing type 2 diabetes and its complications.

Investing in promising programs dedicated to addressing the disease burden in high-risk populations has been a key aspect of the grant strategy of *Together on Diabetes*. Over the past year, *Together on Diabetes* awarded grants to five organizations focusing on African American women, one of the country's highest risk groups.

The goal of these grants is to provide funding support for empowerment of African American women living with

type 2 diabetes. The purpose is for African American women to better manage their disease, while leveraging their roles as leaders in their families and communities to improve health behaviors of people in their environment across generations. Promoting health equity by reducing type 2 diabetes health disparities in high-risk communities is imperative and the expected outcome of our programs.

In the coming year, *Together on Diabetes* will expand this special focus to another high-risk population, Native Americans living in the Southwest.

Cheryl Taylor, Ph.D., R.N.

Director, Office of Research
Southern University School of Nursing, Baton Rouge, Louisiana
Expert Grant Reviewer, *Together on Diabetes*

University of Virginia

The prevalence of type 2 diabetes among African Americans is 14.4 percent in Virginia and estimated to be as high as 30 percent among African American women living in rural counties in the central region of the state.

The University of Virginia's Division of General Medicine, Geriatrics and Palliative Care and the Charlottesville-Albemarle Community Obesity Task Force will evaluate whether Call to Health, a comprehensive clinic- and community-based self-management support program, can improve the outcomes for rural and underserved African American women with type 2 diabetes.

Call to Health will seek to help underserved African American women manage their diabetes through various supportive services and techniques. These include daily personalized text messages based on disease management and behavior change goals; pairing with a female friend or "buddy" and other peer support; educational retreats; monthly group visits in clinic and community-based settings; and community resource referral and mobilization for greater access to healthy foods and physical activity.

GRANT SUMMARY

Grantee: University of Virginia in partnership with the Charlottesville-Albemarle Community Obesity Task Force, University Medical Associates, UVA Center for Appreciative Practice, Health Decision Technologies and Division Research Task Force

Amount: \$300,000 over two years

Purpose: To study the Call to Health model, which uses text messages, buddy support and other techniques to help African American women manage type 2 diabetes.

Area of Focus: Charlottesville, Virginia

East Carolina University

The prevalence of diabetes among North Carolina adults has more than doubled from 4.5 percent in 1995 to 9.6 percent in 2009. Diabetes prevalence was highest among African Americans at 15.6 percent, according to the North Carolina State Center for Health Statistics.

Working with a range of partners, East Carolina University in Greenville, North Carolina, has begun a demonstration project focusing on African American women with uncontrolled type 2 diabetes in four eastern counties.

The initiative focuses on helping patients make steady, sustainable improvements in diet, physical activity and self-management under the guidance of supervised lay health ambassadors and patient navigators drawn from the local community.

GRANT SUMMARY

Grantee: East Carolina University Health Disparities Center in partnership with Peers for Progress, North Carolina Office of Minority Health, North Carolina Department of Health & Human Services, Diabetes Control Program, Success Dynamics, Community Development Corp., Cornerstone Ministries, Lucille Gorham Intergenerational Center, Tillery Community Health Center, Greene County Health Care, University Health Systems of Eastern Carolina and local health departments in four counties

Amount: \$300,000 over two years

Purpose: To implement a behaviorally centered "small changes" approach and care navigation delivered by lay health worker teams in four rural counties.

Area of Focus: Eastern North Carolina



▲ The University of Virginia is using texting to help African American women connect to diabetes "buddies" and disease management information.

United Neighborhood Health Services

In Nashville, Tennessee, and surrounding areas, the prevalence of type 2 diabetes is growing fastest among older African American women. Poverty, lack of access to health care resources and limited education are barriers to care and disease management for these women, who may also face emotional challenges such as the stress of living in poverty, the burden of being caregivers and depression.

In response to these challenges, United Neighborhood Health Services and its partners are working to implement the East Community Women's Diabetes Control Initiative, a comprehensive diabetes program that includes clinical care, case management, nutrition counseling, fitness instruction and counseling, structured physical activity, social supports, and stress and behavioral counseling. The project's focus on physical activity also includes the integration of a fitness expert into the clinical team to support patient goal-setting and access to area resources for recreation and exercise.

GRANT SUMMARY

Grantee: United Neighborhood Health Services in partnership with Meharry-Vanderbilt Alliance, Metro Nashville Public Health Department and Tennessee State University

Amount: \$300,000 over two years

Purpose: To implement a comprehensive diabetes self-management program that includes a robust physical activity component.

Area of Focus: Nashville, Tennessee

Whittier Street Health Center

Public housing residents of Boston's Roxbury section are three times more likely to suffer from type 2 diabetes than other city residents, according to a Kresge Foundation-funded needs assessment.

Whittier Street Health Center and its partners will implement a Diabetes Care Coordination Program to connect 150 African American women living in public housing in Roxbury with comprehensive diabetes management services, including health education by a certified diabetes educator, nutritional counseling by dietitians and custom programs of physical activity.

The initiative also includes outreach by community health workers/ambassadors who are African American women with well-managed diabetes. The program will focus both on African American women who know their type 2 diabetes status but are not engaged in comprehensive chronic care management, as well as newly diagnosed women identified through community outreach, education and screening.

GRANT SUMMARY

Grantee: Whittier Street Health Center in partnership with Boston Housing Authority, Boston YMCA and Kresge Foundation-Health Safety Net Social Health Coordinators

Amount: \$300,000 over two years

Purpose: To connect African American women living in public housing in Boston's Roxbury neighborhood to comprehensive diabetes management and support services.

Area of Focus: Roxbury, Massachusetts

The Black Women's Health Imperative

The Black Women's Health Imperative, working in coalition with clinical, community and faith-based partners, is implementing a comprehensive self-management, social support and empowerment program for African American women age 40 and older living with uncontrolled diabetes in three wards of Washington, D.C.

After consultations with the communities, the partners will screen and diagnose African American women with type 2 diabetes in health center, community and faith-based settings and help connect them to clinical care. The partners will also provide six-week classes in diabetes self-management, develop support networks by training Health Wise Women leaders, and implement a "Sister Circle" model to provide psychosocial support and reinforce healthy behaviors and education.

GRANT SUMMARY

Grantee: Black Women's Health Imperative in partnership with Greater Mt. Calvary Holy Church, Union Temple Baptist Church, Georgia Avenue Rock Creek East Family Strengthening Collaborative, Matthews Memorial Baptist Church, Unity Health Care, Washington Hospital Center's diabetes management

program and the Howard University Hospital Diabetes Treatment Center

Amount: \$300,000 over two years

Purpose: To implement a comprehensive self-management, social support and empowerment program for African American women.

Area of Focus: Washington, D.C.

Our Grants and Partnerships

Applying for Grants

Funding is awarded to nonprofit organizations primarily through invited requests for proposals. An open request for letters of interest will be issued in January 2012 and be available on the program website: www.togetherondiabetes.com.

Partnership with other funders, corporate social responsibility initiatives, and government programs and agencies

The Bristol-Myers Squibb Foundation and *Together on Diabetes* welcome and seek opportunities to join forces and resources with other foundations and charities, corporate social responsibility initiatives from diverse industries, and government programs and agencies. Please submit partnership inquiries to togetherondiabetes@bms.com.

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Additional information and updates about the Bristol-Myers Squibb Foundation are available online at www.bms.com/foundation.



The mission of the Bristol-Myers Squibb Foundation is to help reduce health disparities by strengthening community-based health care worker capacity, integrating medical care and community-based supportive services, and mobilizing communities in the fight against disease.



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