This product was developed by the Robert Wood Johnson Foundation Diabetes Initiative. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

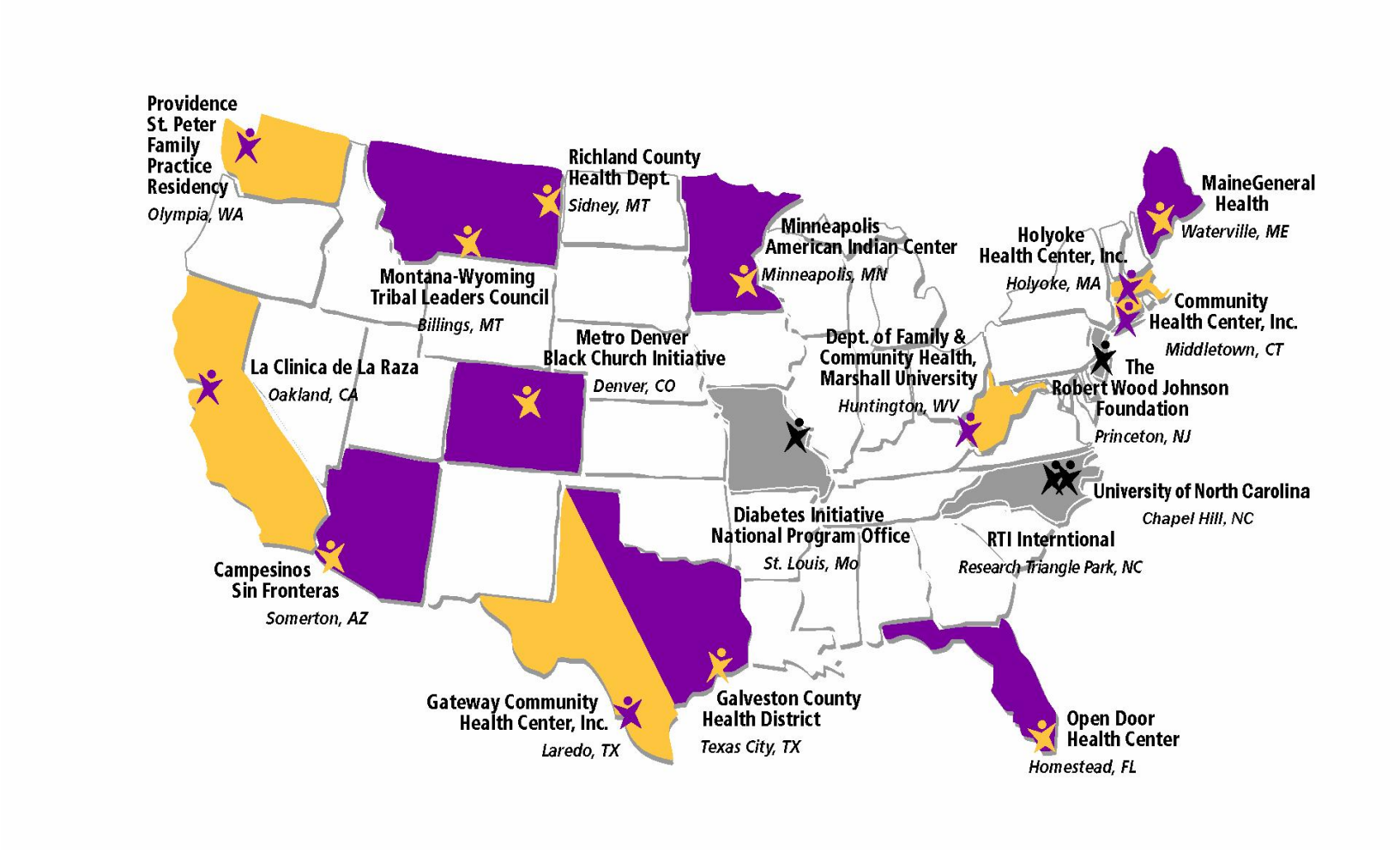
DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Ongoing Follow Up and Support in Diabetes Self Management

www.diabetesinitiative.org

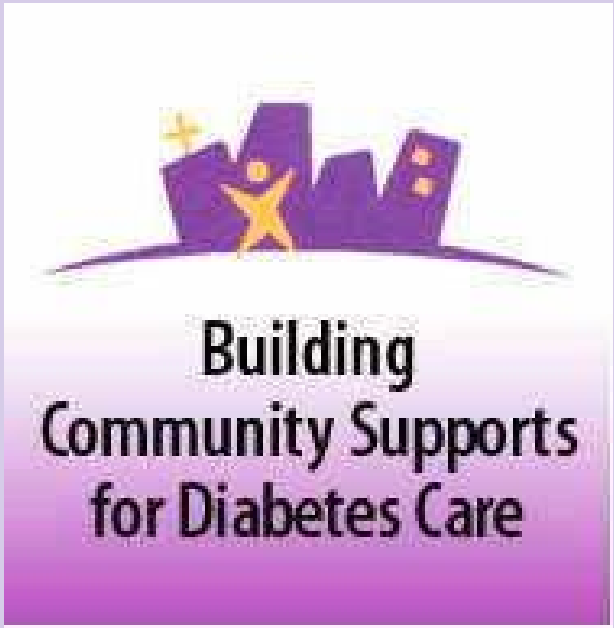
CDC Diabetes Translation Conference
Atlanta, May, 2007

The 14 Sites of the Diabetes Initiative



Diabetes Initiative of the Robert Wood Johnson Foundation

Real world demonstration of self management as part of high quality diabetes care in primary care and community settings



Resources & Supports for Self Management

- Individualized Assessment
- Collaborative Goal Setting
- Instruction in Skills
- *Ongoing Follow Up and Support*
- Community Resources
- Continuity of Quality Clinical Care

Importance of Ongoing Follow Up and Support

- Review of programs to enhance diabetes self management (Norris et al., *Diabetes Care* 2001 24: 561-587.):
  - "Interventions with regular reinforcement are more effective than one-time or short-term education"

- Review of effects of self management on metabolic control (Glycosolated hemoglobin) (Norris et al., *Diabetes Care* 2002 25: 1159-1171.)
  - Only predictor of success: ***Length of time over which contact was maintained***

Not just in diabetes – Duration and Variety of Smoking Cessation Interventions

- Meta-analysis of Kottke et al. (*JAMA* 1988 259: 2882-2889) "Success was **not associated with novel or unusual interventions**. It was the product of **personalized smoking cessation advice and assistance**, **repeated** in **different forms** by **several sources** over the **longest feasible period**."

- AHRQ meta-analysis: Greater likelihood of smoking cessation with greater length of intervention (Fiore et al. *Treating tobacco use and dependence.* USDHHS, 2000).

- Those who receive 2 or more interventions 1.48 times more likely to quit than those who receive 1 (Baillie et al. 1994)

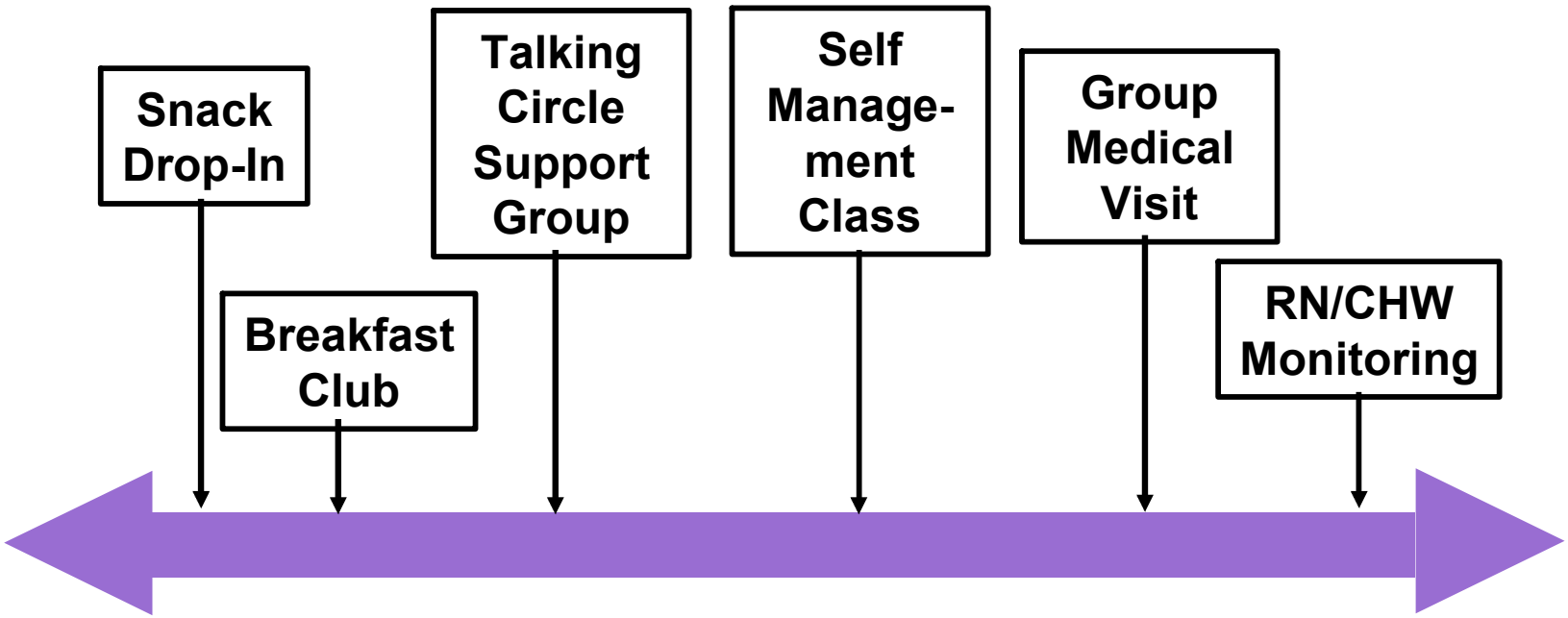
Key Features of Ongoing Follow Up and Support

- **Personal connections is critical**
  - Based in an ongoing relationship with the source or provider
- **Both On-Demand and Staff-Initiated:**
  - Available on demand and as needed by the recipient
  - Staff-Initiated to keep tabs through low-demand contact initiated by provider on a regular basis (e.g., every 2 to 3 months)
- **Variety – Range of "good practices" rather than single "best practice"**
  - Use varied channels – telephone, drop-in groups, scheduled groups

Key Features of Ongoing Follow Up and Support, cont.

- **Motivational**
  - Generally Nondirective rather than Directive Support
- **Core common language and concepts,**
  - e.g., "HbA1" vs. "blood sugars"; "Action Plan" vs. "Problem Solving"
- **Not limited to diabetes**
  - Address a variety of concerns or challenges the recipient faces
- **Monitors needs/promotes access**
  - e.g., refers to other components of Resources and Supports for Self-Management (e.g., classes to enhance skills, continuity of quality clinical care)
- **Extend to community resources – "broaden the team"**

On-Demand -- Staff Initiated
A Critical Continuum



On-demand, Varied Contacts to Suit Individual Preferences

Staff-Initiated Contacts to Maintain Contact and Prompt Engagement

Culture Shift??

- Personal connection with staff
- On demand (as well as staff initiated)
- Variety of alternatives for individual preferences
- Motivational
- Common language and concepts
- Not limited to diabetes – person-centered
- Monitors needs and promotes access
- Extends to community, neighborhood, family

Program culture that makes central the role, needs, and preferences of the individual in self management

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Laura R. Bazyler
Dawn Heffernan
Sally Hurst

www.diabetesinitiative.org

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Ongoing Follow-Up & Support in a Free Clinic

CDC – Division of Diabetes Translation Conference

Laura R. Bazyler
Open Door Health Center
Homestead, FL
May 2, 2007
lbazyler@opendoorhc.org

Open Door Health Center

- Free clinic for the uninsured poor; 501c3
- Adult, Women's Health & Pediatric Care
  - 2,200 patients
  - 45,000 patient visits
  - 160 free surgeries
  - 150 volunteers
  - 200 students trained on-site
- $1.5 million in free services provided annually

Homestead, Florida

www.opendoorhc.org

Our Patients

- Mainly farmworkers in fields and packing houses
- Highest % uninsured in Dade County
- Demographics:
  - 72% Hispanic/Latino
  - 11% African American
  - 9% Haitian
  - 8% Other

Before "Prescription for Health"

Traditional Patient Care:

- Monthly Provider Visits
- Diagnostic Tests
- Podiatric Care
- Limited DSME from Providers
- Med Pickup
- Volunteer Nutritionist

With…

- *Limited DSME*
- *No exercise opportunities*
- *No "hands-on" education*
- *No peer support*
- *Limited family involvement*
- *Community not involved*
- *No variety*

Boring!

- Like having Black Beans without White Rice!

"It's a Cuban thing!"

Prescription for Health
DIABETES PROJECT

Project Staff:

Medical Director

Podiatrist – part-time

Program Coordinator, Nutritionist & Lifestyle Coach

Case Manager

5 Community Health Workers:

- **3 women, 2 men**
- **2 Mexican, 1 African American, 1 Haitian, & 1 Jamaican**

“Re-energized” Patient Care

“Personal Connection”

- Weekly Diabetes Support/Group Appointments
- Quarterly Diabetes Classes
- Staff exercise with patients
- Plus, ongoing medical care
- Community Health Workers

Services "On Demand"

- *Patients can "walk-in" to any program activity*
- *Patients have access to variety of "team" members*

- *"Team" can schedule patients for additional visits as needed*

"Monitors Needs & Promotes Access"

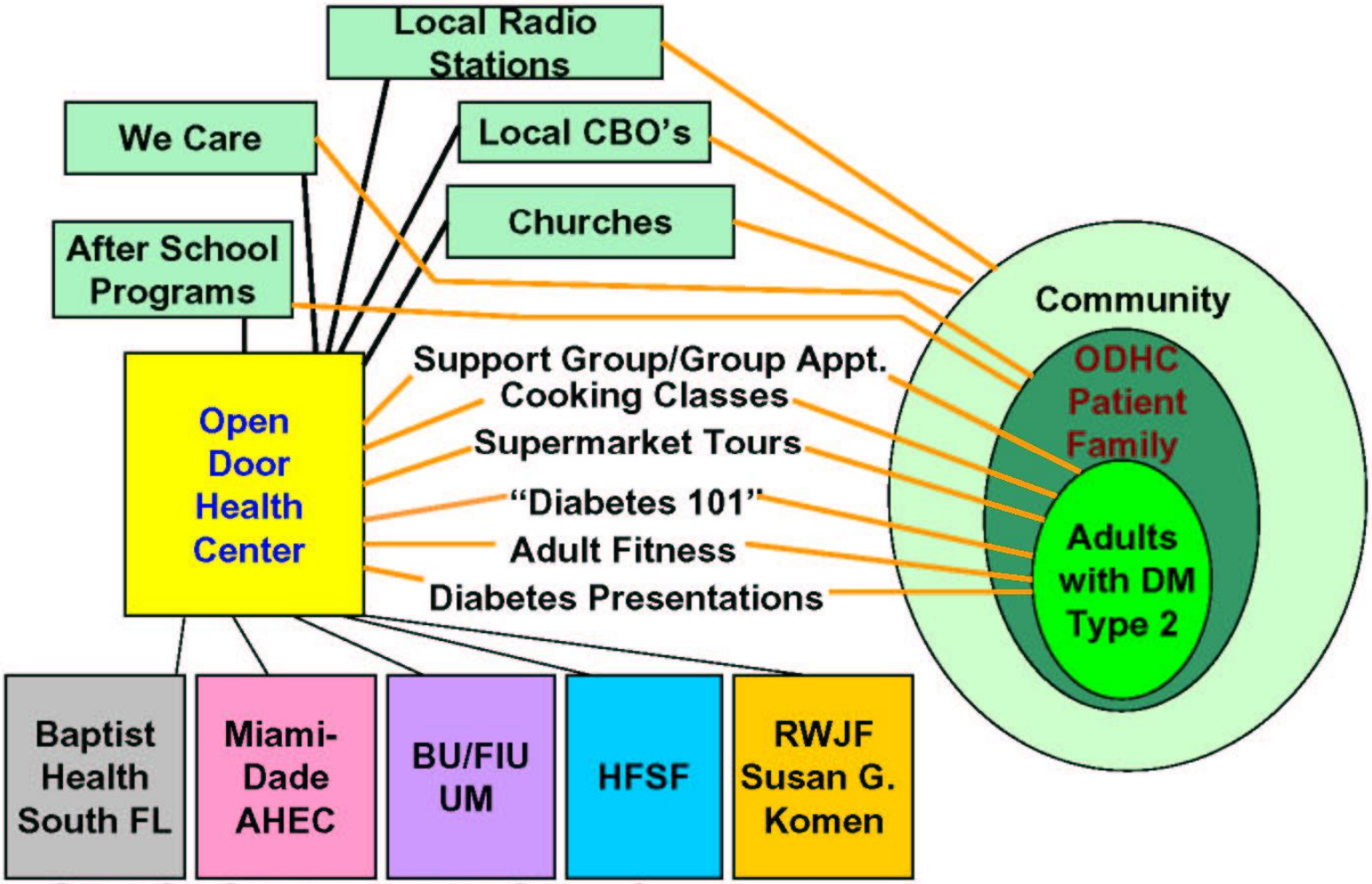
- Quality primary & secondary medical care
  - General medical
  - Podiatry
  - Woman's health
  - Nutrition
- Varied project activities to reinforce diabetes self-mgt.

"Not Limited to Diabetes"

- In-house clothing closet & food pantry
- Referrals to social service agencies
- In-house children's homework club & youth/teen outreach ministries
- Women's Health Program
- Referrals for "secondary & tertiary" healthcare

Nutrition Intern explaining the "Plate Method" to children from local Homework Club

OFUS on Three Levels



ODHC: Clinic as platform for community program

Prescription for Health
DIABETES PROJECT

Re-energized" Patient Care:

- Weekly Diabetes Support/ Group Appointments
- Bi-monthly Multi-Cultural Cooking Classes
- Quarterly Supermarket Tours
- Adult Fitness Classes 3/wk
- Diabetes 101 Classes
- Nutritionist/Nutrition Interns

With …

- **DSME reinforced in multiple ways**
- **Exercise opportunities 3x/week**
- **"Hands-on" education = FUN!"**
- **Peer support fostered & encouraged**
- **Family & Friends encouraged to participate**
- **Community outreach & education**
- **Variety of activities!!!**

Happy Patients & Staff!

"Now this is more like it!"

"Delicioso!!!"

Thank You!! *Gracias!!* **Merci!!**

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Maximizing Patient Choice: Self Management in a FQHC

CDC – Division of Diabetes Translation Conference

Dawn Heffernan
Holyoke Health Center
Holyoke, MA
May 2, 2007
Dawn.Heffernan@hhcinc.org

Holyoke Health Center

- **JCAHO accredited**
- **Federally Qualified CHC**
- **Western Massachusetts**
- **17,277 medical patients**
- **6,722 dental patients**
- **162 employees**
  - ✓ **25 medical providers**
  - ✓ **3 dentists**
  - ✓ **On-site retail pharmacy**
- **One of the highest diabetes mortality rates in Massachusetts**
- **Nearly 100% of our patients live at or below the poverty level**

Multiple Interventions provides ample opportunity for ongoing follow up and support

- Breakfast Club
- Chronic Disease Self-Management Classes
- Community Health Workers
- Diabetes Education Classes
- Exercise Classes
- Individual Appointments with the diabetes educator and the nutritionist
- Snack Club

Community Health Workers

- Bridge between the community and the health center
- Co-lead Programs
- Outreach
- Telephone Follow-Up
- Joint Visits with Providers
- Teaching
- Social Support
- Goal Setting/Problem Solving
- Collaboration with the nurses and providers in the clinic

Nurse and Community Health Worker Collaboration

- Follow up and support for patients not seen by their provider in the last 4 months
- Registry report generated every month
- Patients identified
- Nurses call patients, send letters and then refer to the community health workers
- Community health workers reattempt phone contact, letter and then provide a home visit to patients address

Community Mentors: Ongoing Support and Follow-Up

Community Mentors: Ongoing Support and Follow-Up

Exercise Class

Breakfast Club

- Eleven Sessions
- Nutritious Breakfast
- Correct Portion Sizes
- Balanced Meals
- Variety of Foods
- New food products introduced
- Label reading
- Hands on learning opportunities
- Incentives and raffles

Supermarket Tour

- Practice skills learned in class
- Patients with low literacy levels benefi
- Assess patient knowledge of produc and food selection
- Hands on learning

Drop In Snack Club

- Informal gatherings
- Meet Program Staff
- Diabetes Bingo
- Raffles with healthy prizes
- Goal Setting
- Problem Solving
- Referral to other programs

Interventions

- Variety of options
- Flexible
- Initiated by patients and providers
- Allow for repetition of programs
- Address multiple learning styles
- Low literacy teaching materials
- Social
- Fun
- Interactive
- Promote personal connection to patients

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Building Community Supports for Diabetes Care – Medical Group Visits: Much more than just a patient visit

CDC – Division of Diabetes Translation Conference

Sally Hurst

MARSHALL UNIVERSITY

Huntington, WV

May 2, 2007

Almost Heaven West Virginia

- Appalachian State
- Isolated rural communities
- System of rural primary care centers

Medical Group Visits at New River Health Association

May 2001 - Began

- One team - Doctor, Nurse and Facilitator

June 2006 – 8 MGV teams

- Mental health (2)
- Black lung (1)
- Chronic pain -GOLS (1)
- Chronic care teams (3)
- Workers comp (1)

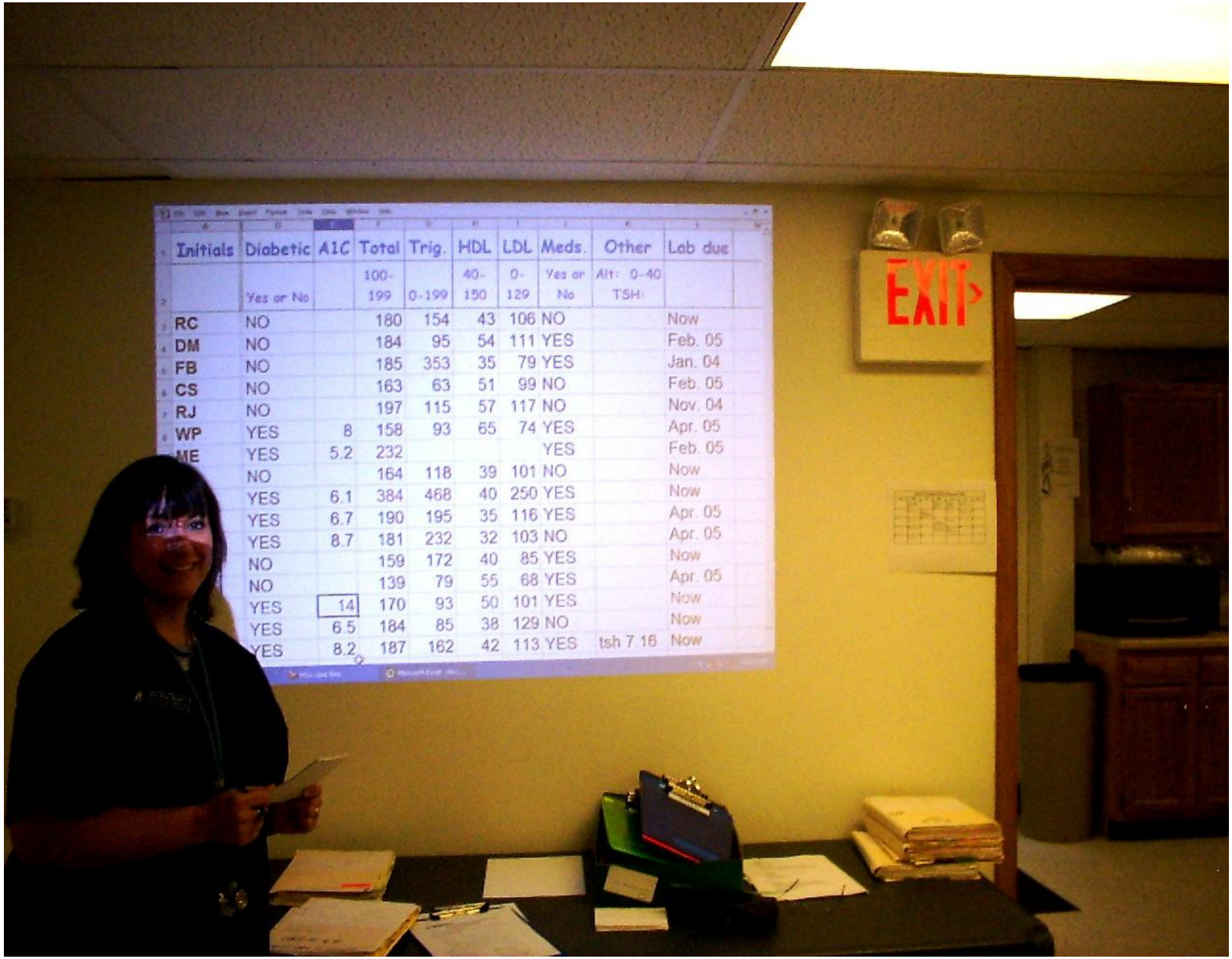

EXIT

Teamwork

- a chance to focus on quality care and refine systems to make improvements;
- a break from the routine of individual patient care;
- team members have an opportunity to share ideas and perspectives about patient care;
- providers have more time to encourage patient self management because they get help with routine tasks;
- Patients are valued member of the team.

Teams share case management

- each team member has a role and outlined tasks that are done to prepare for the group;
- lab results are reviewed and shared with team and patient, lab work that's needed is ordered;
- planning allows comprehensive quality focused; preventive standards are met.



Initials	Diabetic	A1C	Total	Trig.	HDL	LDL	Meds.	Other	Lab due
	Yes or No		100-199	0-199	40-150	0-129	Yes or No	Alt: 0-40 TSH:	
RC	NO		180	154	43	106	NO		Now
DM	NO		184	95	54	111	YES		Feb. 05
FB	NO		185	353	35	79	YES		Jan. 04
CS	NO		163	63	51	99	NO		Feb. 05
RJ	NO		197	115	57	117	NO		Nov. 04
WP	YES	8	158	93	65	74	YES		Apr. 05
ME	YES	5.2	232				YES		Feb. 05
	NO		164	118	39	101	NO		Now
	YES	6.1	384	468	40	250	YES		Now
	YES	6.7	190	195	35	116	YES		Apr. 05
	YES	8.7	181	232	32	103	NO		Apr. 05
	NO		159	172	40	85	YES		Now
	NO		139	79	55	68	YES		Apr. 05
	YES	14	170	93	50	101	YES		Now
	YES	6.5	184	85	38	129	NO		Now
	YES	8.2	187	162	42	113	YES	tsh 7.16	Now

Patients get more of what they need

Mechanism for referrals –

- Routine follow-up appointments are made;
- Referrals to specialists and preventive health referrals are made;
- Referrals to self management groups and community resources.

Patients are engaged

- Patients are responsible for:
  - checking their med list
  - communicating trends in their health
  - understanding their labs
  - partnering to manage their care
- Individual goal are set and documented
- Patient/provider relationship shifts to more of a partnership and patients understand their role
- Group discussion gives opportunity for patients to give and get support from each other

Patients are supported to learn self management skills

- Individual goal are set and documented
- Problem-solving occurs
- Patient/provider relationship shifts to more of a partnership and patients understand their role
- Group discussion gives opportunity for patients to give and get support from each other

Group Visits Benefit Patients

- Almost no wait time for appointment
- More participation with medical team
- Discussion time/Q&A
- Patients learn from and support each other
- Patient centered visit
- High patient satisfaction
- Patients can schedule themselves
- Family members and support welcome

Maintenance and Support

- Help Yourself Support Group
  - Patients can drop in as needed;
  - Providers and nurses can refer patients that need on going follow-up and support;
  - Informal structure allow the agenda to be defined by the group;
  - Goal setting at end of every visit

Conclusion

Medical Group Visits are a strategy that provide on-going follow-up and support to patients AND the clinical team

Medical Group Visits have advanced the understanding of self-management skills and communication for both patients AND the clinical team

Medical Group Visits are fun for all