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Community Health Center, Inc Connecticut

A Model for Engaging and Keeping Patients Involved in Self Management

Daren Anderson, MD
Chief Medical Officer
Joan Christison-Lagay, MAT, MPH

The Original Plan

The Plan: Deliver personalized, individual, self management education for all interested patients with type 2 diabetes

- All staff kick-off meeting to introduce the program
- Referrals to be made by PCPs and other staff
- CDE's to be trained in SM goal setting

The Rationale: Two knowledgeable and engaging CDE's (one bilingual) providing individualized care, group visits and events such as cooking clubs would attract and sustain the participation of clients.

What Happened?

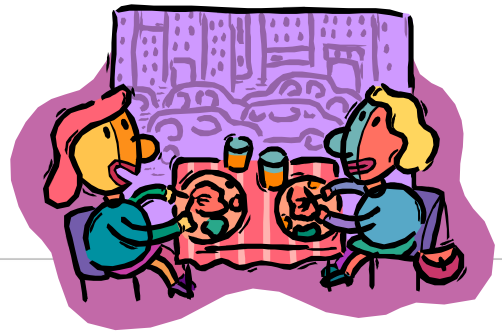
After two years: good news/bad news

- over 200 patients had been enrolled
- these 200 represented only a subset of patients with diabetes. Many more were not being touched by SM
- the no-show rate was higher than for medical care visits

Maybe there were silent SMGs being set….

"I will **not** see a CDE on Mon, Wed, and Fri, starting now. I am a confidence level of 9!"

"I will come for the free lunch and not come back. Confidence level, 10."



Identified Barriers

- Many patients were depressed
- Events such as cooking clubs or exercise groups attracted a very small number of participants, usually female
- Complex and fragmented lives contributed to patients' keeping medical visits but not "extra" visits
- Non RWJ program staff were not trained in SM

What To DO?

Recognize the impact of depression on diabetes and provide behavioral services and other healthy coping strategies to address the problem. CHC implemented:

- Solution focused brief therapy, a clinical intervention provided by a psychologist and two LCSW's
- Healthy Coping Skills, a program of relaxation and meditation offered by an RN trained in meditation therapy

What to DO?

Train staff nurses, who see patients *daily* for medical visits, in

- motivational interviewing
- health education techniques
- reviewing SMGs facilitated by CDE
- self management goal setting
- utilizing the specific skills of the CDE as needed

Eight have now been trained.

What to DO?

Expand the Reach with Teamwork: Planned Care

Conduct morning team huddles to review charts of patients coming in

- review CDEMS and address needs using PCP, RN and MA (i.e., foot check, A1C, review SM goals)
- utilize nurses trained in SM to facilitate goals before or after the patient's visit with the provider
- as necessary, provide separate nursing visits for education and self management goal setting

The Last Two Years: Engaging Patients More Fully

Through program expansion, patients were engaged with SM at many levels

- Initial contact with empathetic CDE's
- Quarterly CDE follow-up (visit/phone)
- Special activities (cooking clubs, salsa, DM bingo, walking)
- Follow up and facilitation of SM by staff nurses

Results To Date

Over 2300 self management goals have been set by 489 patients enrolled in RWJ. Change among these patients:

- Average A1C: **–0.7666**
- Average LDL: **– 23.3**
- Average HDL: **+ 1.4**
- Average overall cholesterol: – **28.8 pts**
- **42.3%** of the 489 patients now have BP <80/130 compared to only 26.9% upon enrolling in RWJ

The Last Frontier: Ideas to Improve PCP Involvement

Using provider report cards to catch their attention, encourage PCPs to more fully recognize the importance of:

- utilizing team members
- trying different patient interaction techniques

Train PCPs in motivational interviewing and the tenets of self management goal setting

The annual provider meeting this year will be a "kick off" training on these concepts. The trainer is a "won over" retired surgeon!

Key Message

The ADSM program at CHC has evolved over time and is still evolving. It has become apparent that the successful implementation of a plan to address chronic diseases requires the understanding and training of staff at **ALL** levels and a new way of delivering care.

After 3½ years, CHC is there!

Thank you RWJ for allowing us the opportunity and time to grow!