DIABETES INITIATIVE

A National Program of The Robert Wood Johnson Foundation

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.

www.diabetesinitiative.org

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Clinic-Based Strategies for Ongoing Support

www.diabetesinitiative.org

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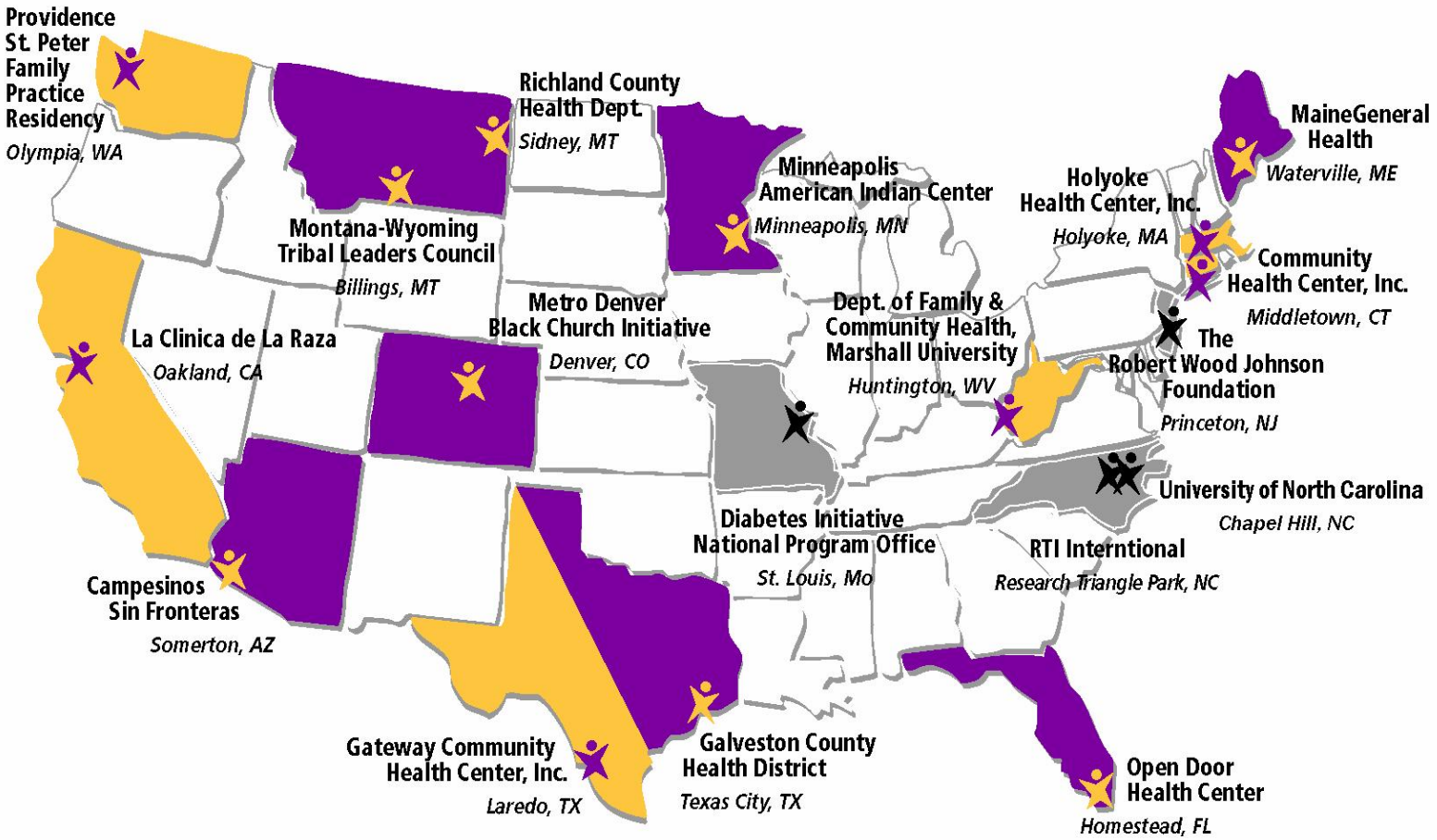
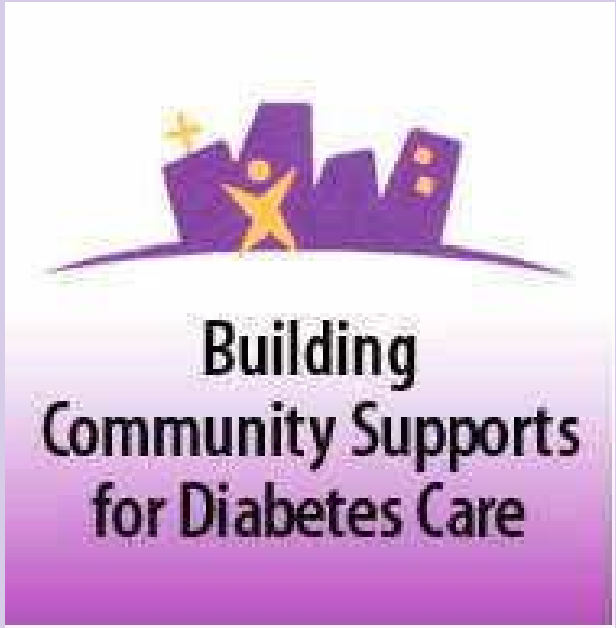
American Diabetes Association
Chicago – June, 2007

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).

Resources & Supports for Self Management

- Individualized Assessment
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Key Features of Ongoing Follow Up and Support

Not Time Limited

- What's wrong with this picture?
  - 8 Sessions Health Coach if GHb > 8
  - If GHb falls to 7, Health Coach terminated
- "OK, You've got type 1 diabetes. We'll put you on insulin for two weeks and see if that cures you."
- That ongoing support needs to be ongoing does not mean it's ineffective.
- No more than that insulin needs to be ongoing

Personal connection is critical

- Based in an ongoing relationship with a provider
- Not necessarily physician
- Critical are:
  - Time to get to know individual
  - Links to rest of team
- Community Health Workers

On-Demand

- Available on demand and as needed by the recipient
- Community based events, e.g., health fairs
- Weekly breakfast clubs
- Monthly diabetes breakfast
- Yearly party to which family invited
- *Talking Circles* in American Indian communities
- Group Medical Visits with additional activities

Proactive or Staff Initiated

- Diabetes is progressive and management is influenced by life changes
- Keep individuals from "falling between the cracks"
- Refer to other components of Resources and Supports for Self-Management
- Contact initiated by provider every 2 to 4 months
- Holyoke: database triggers contact by RN/CHW team
- Low demand – communicate interest rather than surveillance
- Also, newsletters, mailings, etc.

Motivational

- Especially for those with long Hx, motivation may be more critical than skill
- Nondirective Support – accepting individual's goals and views of things, encouraging more than "taking over"
- CHWs – 30% of encounters categorized as providing encouragement or motivation
- Support groups

Core Common Language and Concepts

- Examples:
  - "HbA1" vs. "blood sugars" vs "Metabolic Control"
  - "Action Plan" vs. "Problem Solving"
- Consistency
  - Avoids confusion
  - Reinforces importance – when something is important, we tend to give it a single name
- Marshall University/New River Health Association trained all staff in common self management model

Not Limited to Diabetes

- Diabetes is woven through all of life so must address the diverse concerns or challenges the individual faces
- Programs can be general – e.g., weight management, physical activity, chronic disease self management groups
- Reduce or avoid stigma by programs directed toward general public
- Gain support for program by linking to broad interests

Extend to Community Resources – Broaden the Team

- Nonhealth partners, e.g., youth programs, housing authority, churches, beauty salons, barber shops
- Advisory boards and committees
- Culturally specific organizations, e.g., *Talking Circles* in American Indian communities
- Classes and activities for family, friends, etc.
- Community campaigns, mailings, etc

Variety – Range of "good practices" rather than single "best practice"

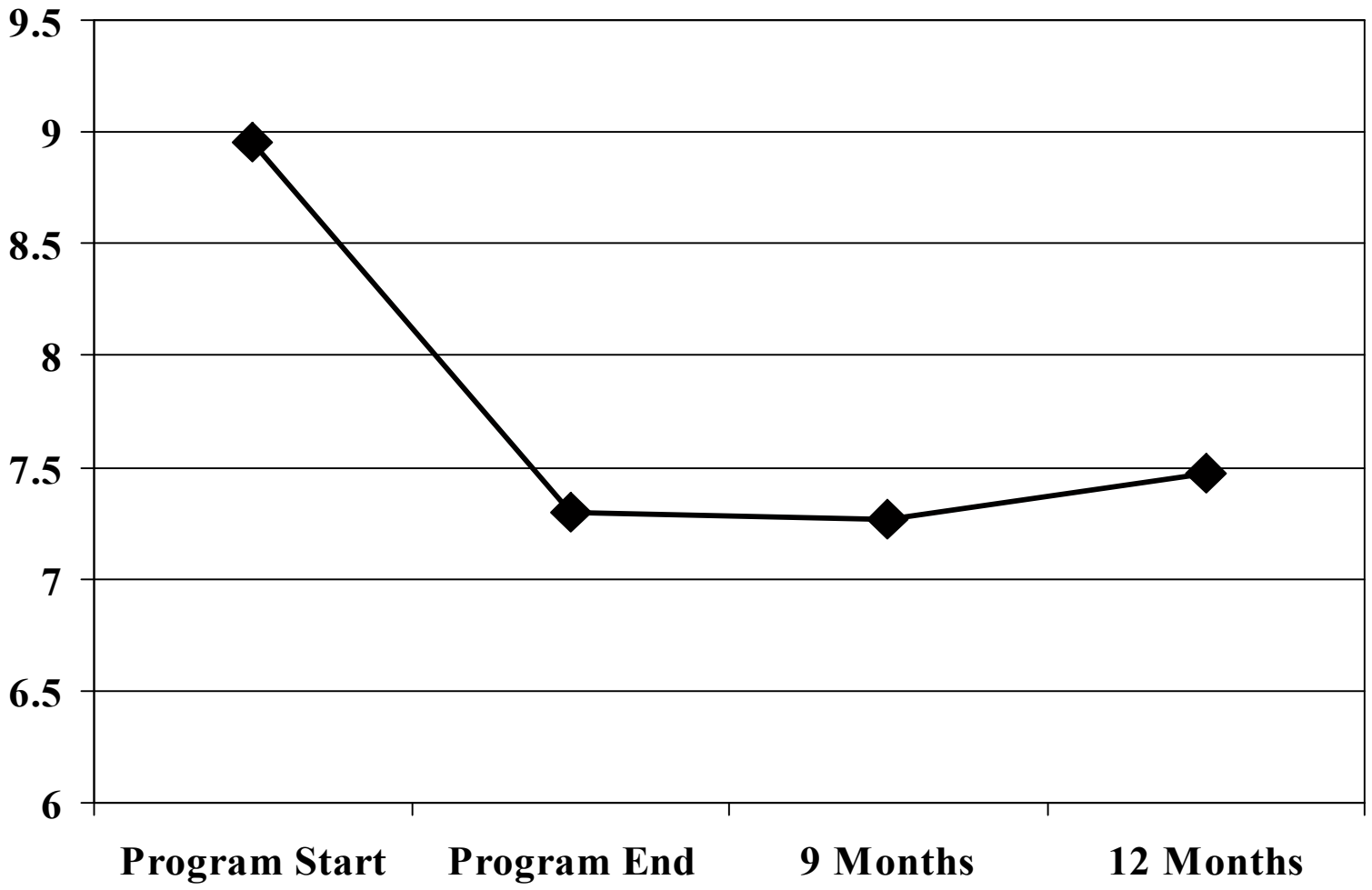
- 60% to 70% of patients report not having received self-management interventions (Austin *Endo Practice.* 2006 12(Suppl 1):138-141)
- Reaching and engaging more important than efficacy
  - Intervention of 75% efficacy that reaches and engages is more beneficial than 100% efficacy that does not engage
- Use varied channels – telephone, drop-in groups, scheduled groups
- ***Many "good" better than few "best" practices***

Community Health Workers in Ongoing Follow Up and Support

Community Health Workers

- Personal, have time, often of individual's community
- Linkage to clinical and other resources
- Reinforce and trouble-shoot basic education
- Provide emotional support and encouragement to:
  - Encourage Healthy Coping
  - Maintain motivation
- Teach classes
- Organize for advocacy, community action

Mean Hemoglobin A1c Levels at Start, End, and 9 and 12 Months Following Promotora-Led Self Management Classes, Gateway Health Center, Laredo, Texas



Group Medical Visits

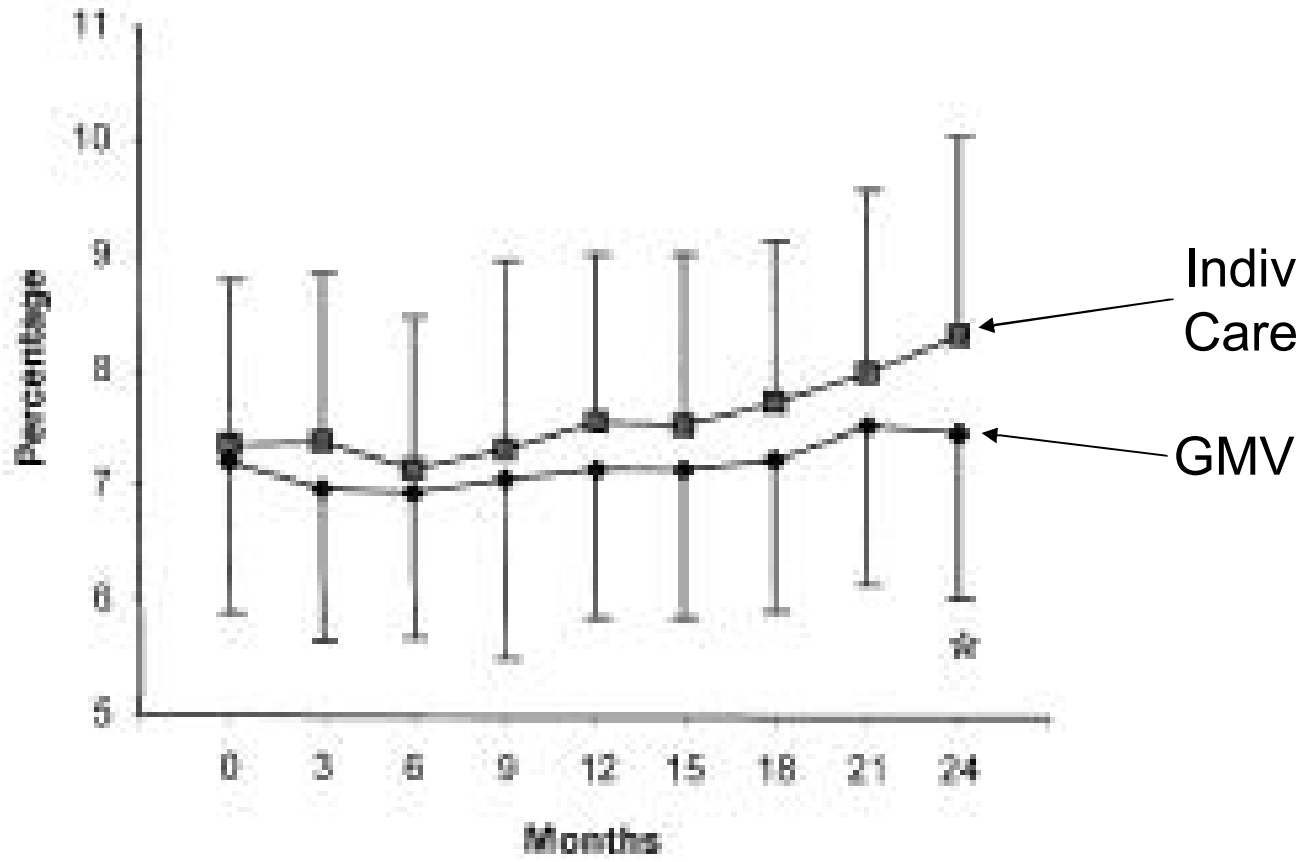
Group Medical Visits

- All patients with common characteristics, e.g., all with diabetes, CHF, arthritis, or chronic disease
- 2 – 3 hour block
- Clinical assessment and medical care
- Group discussion and support
- Educational sessions
- Group activities – exercise, cooking classes, etc.

Evaluation of Group Medical Visits

- Randomized to GMV or individual care
- 4, quarterly visits
- Clinical tests several days in advance to allow review before visit
- Individual meeting at visit prn
- Structured educational curriculum including weight loss, self management skills like food shopping, etc.
- Group discussion

GHb Results of Group Medical Visits



At 5 years, GHb = 7.3 in GMV
9.0 in Individual Care

Trento et al., *Diab Care* 2001 24: 995-1000; 2004 27: 670-675

Program Examples

Department of Family and Community Health, Marshall University School of Medicine
New River Health Association

Project Director: Richard Crespo, PhD
Project Coordinator: Sally Hurst, BA

1600 Medical Center Drive, Suite 1400
Huntington, WV 25701

shurst@marshall.edu

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)

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

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

Range of Opportunities for Contact, Assistance, Support

Open Door Health Center Building Community Support for Diabetes Care

Program Director: Nilda Soto, MD
Project Coordinator/ Nutritionist and Lifestyle Coach: Laura Bazyler, MS, RD, LD/N

1350 SW 4th Street
Homestead, FL 33030

nsoto26@msn.com
www.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

“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*

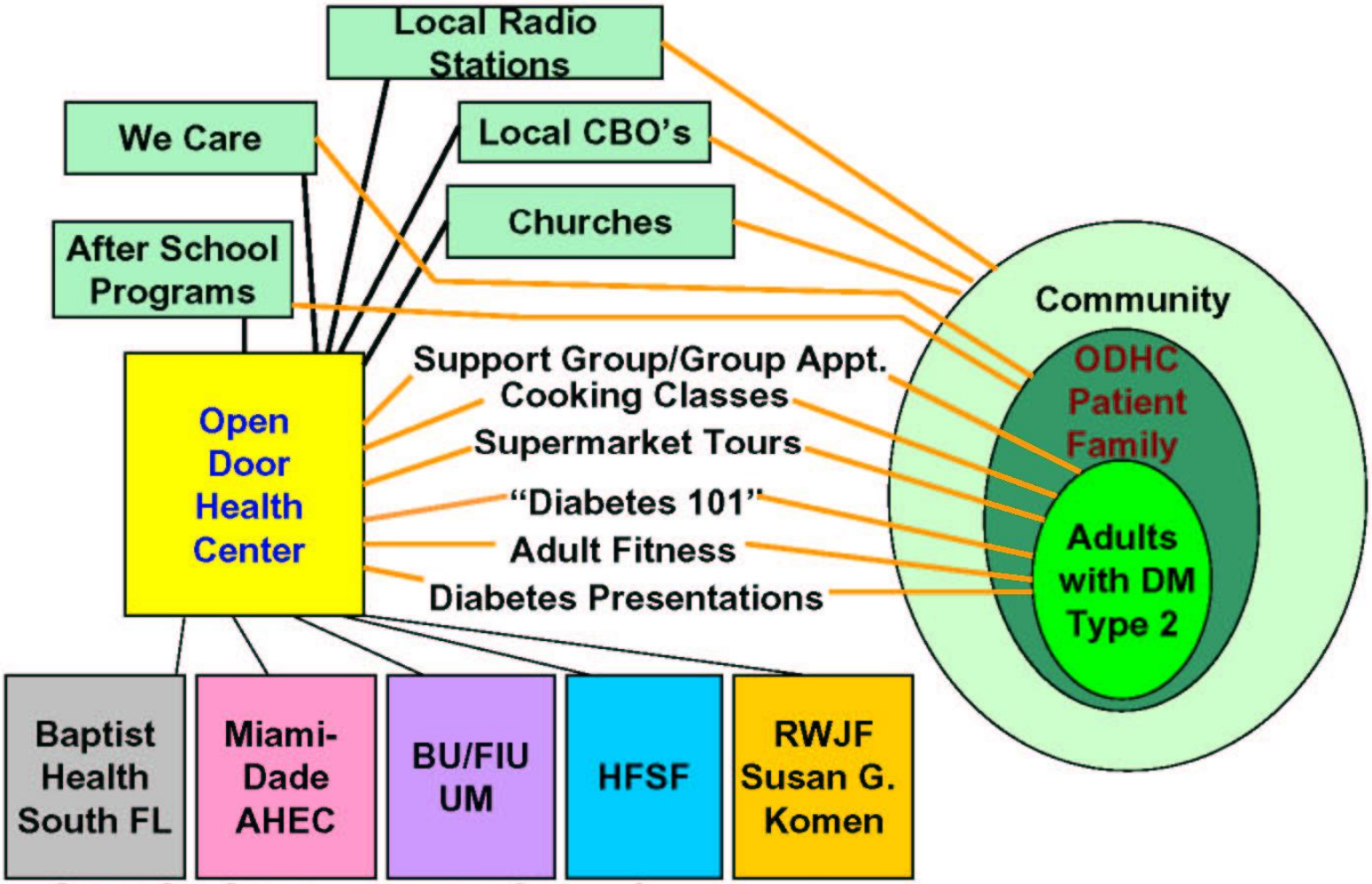
- *"Team" can schedule patients for additional visits as needed*

"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

Holyoke Health Center, Inc. Advancing Diabetes Self Management

Executive Director: Jay Breines, M.D.
Project Director: Dawn Heffernan, R.N., M.S.

230 Maple Street
Holyoke, MA 0104

dawn.heffernan@hhcinc.org
www.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
- Teaching
- Social Support
- Telephone Follow-Up
- Joint Visits with Providers
- 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

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

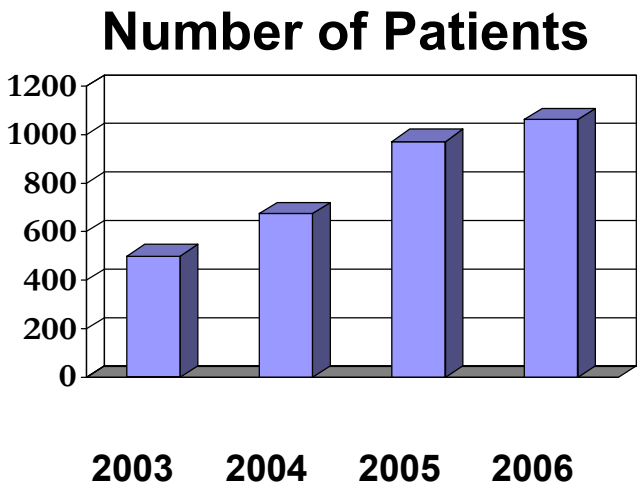
Supermarket Tour

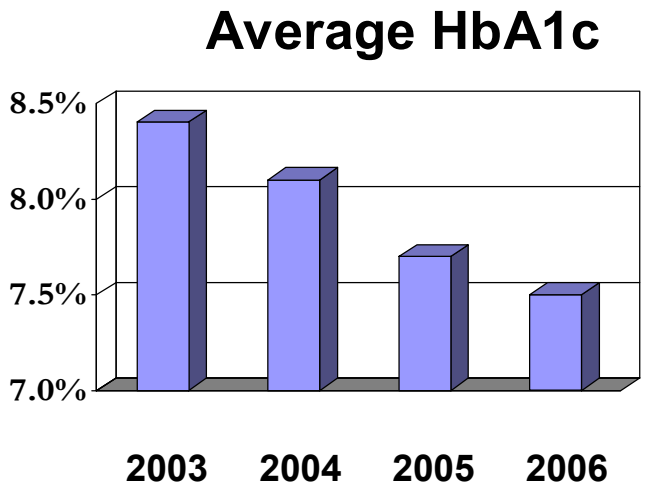
- Practice skills learned in class
- Patients with low literacy levels benefit
- Assess patient knowledge of products and food selection
- Hands on learning

Drop In Snack Club

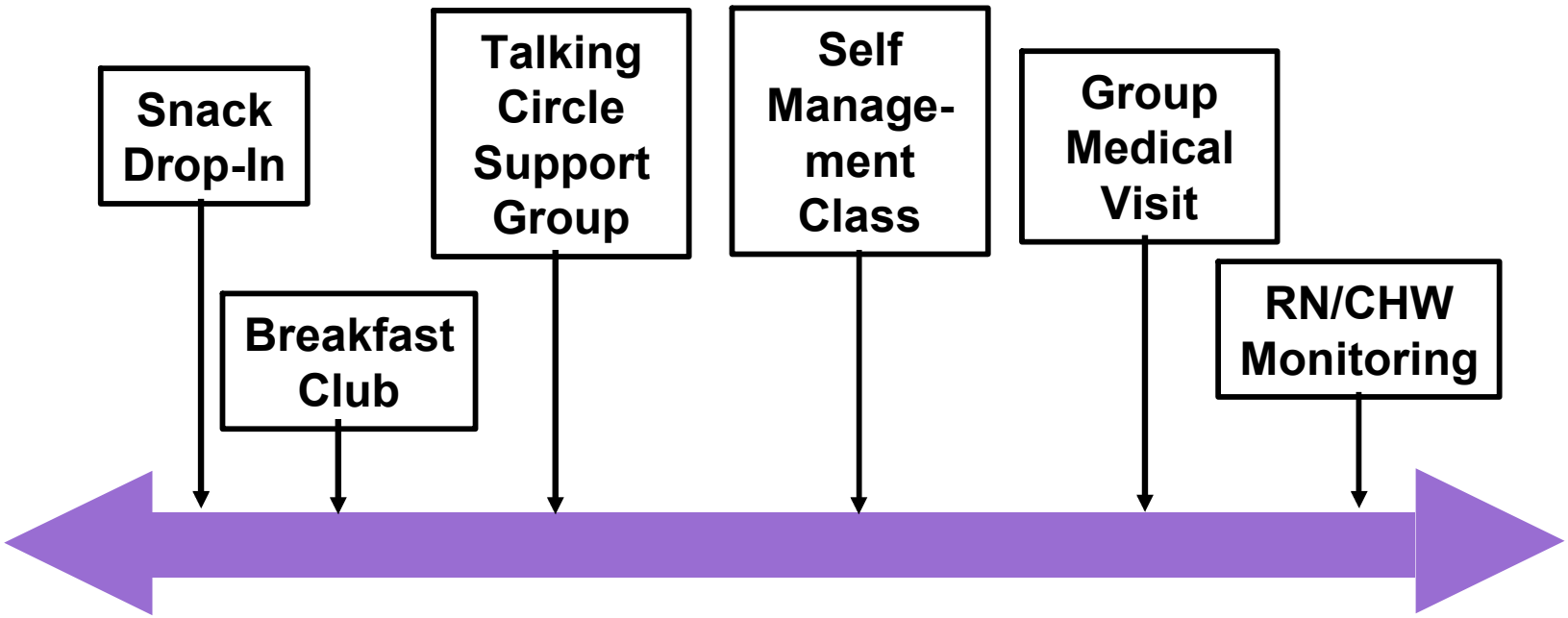
- Informal gatherings
- Meet Program Staff
- Diabetes Bingo
- Raffles with healthy prizes
- Goal Setting
- Problem Solving
- Referral to other programs

Year	2002	2003	2004	2005
Number of Patients	499	675	873	1061
Average HbA1c	8.40%	8.10%	7.70%	7.50%





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

- Special Issue of *The Diabetes Educator*:
  Promising Approaches to Diabetes Self Management: Lessons from the Diabetes Initiative of the Robert Wood Johnson Foundation
  Due in Late June/Early July

- Fisher, Brownson, O'Toole & Anwuri:
  Ongoing Follow-Up and Support for Chronic Disease Management in the Robert Wood Johnson Foundation Diabetes Initiative

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