- 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.

THE ROBERT WOOD JOHNSON FOUNDATION

Washington University in St. Louis
SCHOOL OF MEDICINE

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

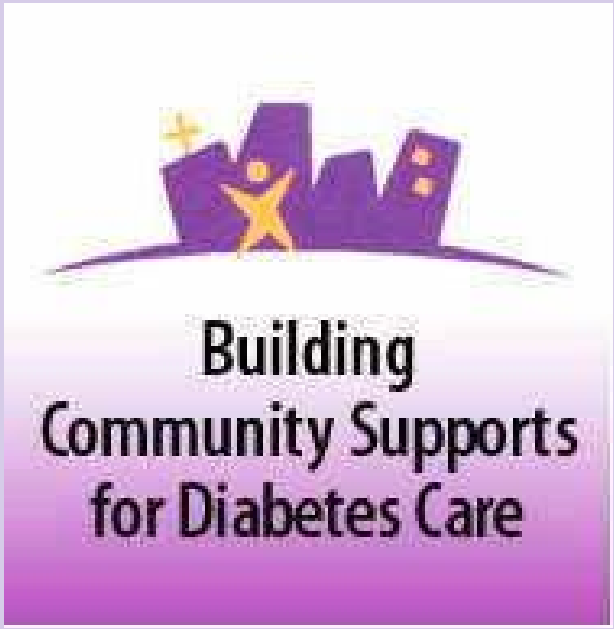
Ongoing Follow Up and Support in Diabetes Self Management

American Association of Diabetes Educators
Los Angeles, August, 2006

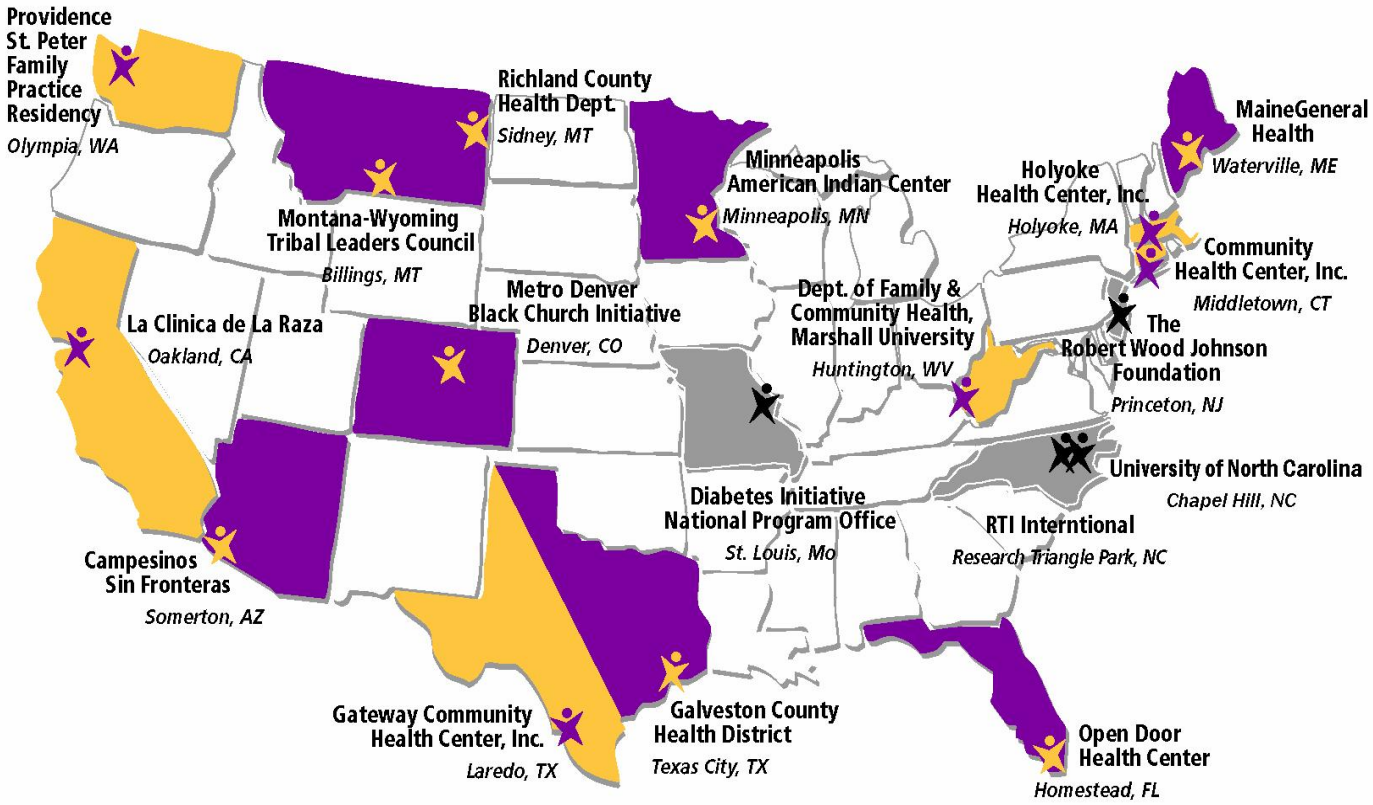
Ed Fisher, National Program Director

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



The 14 Sites of the Diabetes Initiative



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)

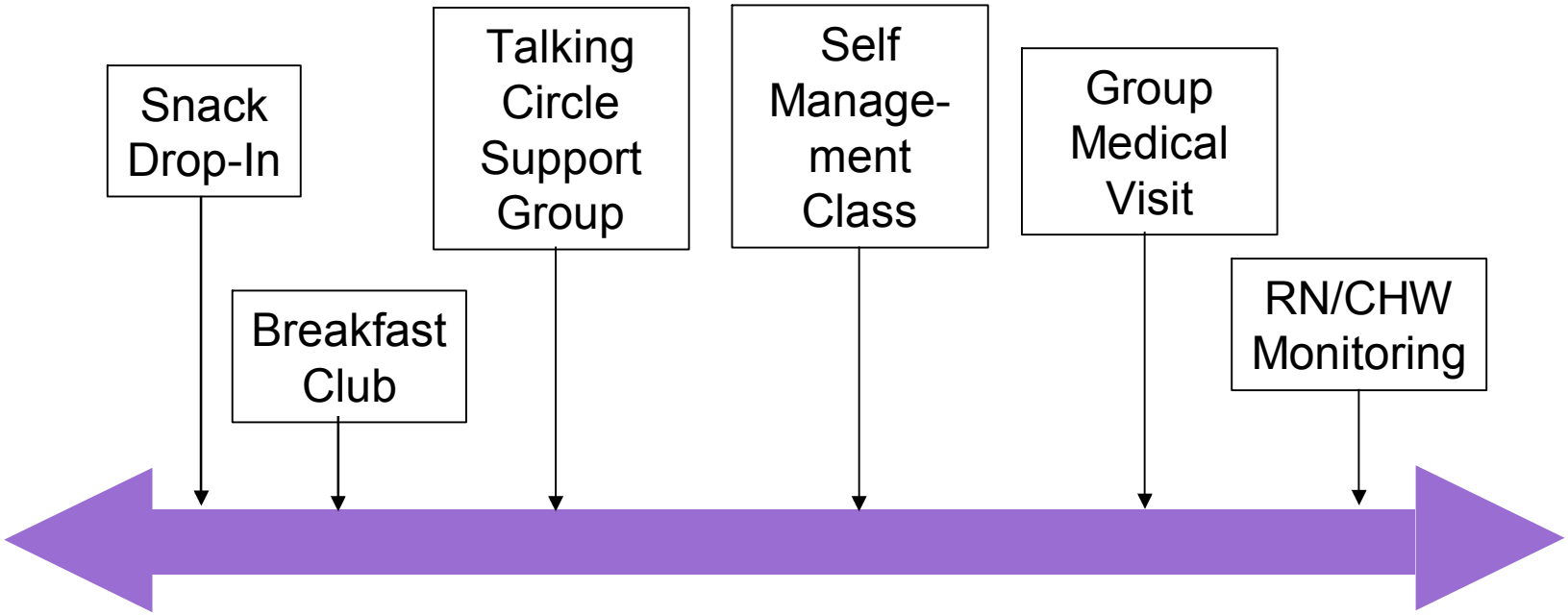
Key Features of Ongoing Follow Up and Support

- **Personal connections is critical**
  - Based in an ongoing relationship with the source or provider
- **On-Demand/Staff-Initiated Paradox:**
  - 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 Paradox
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

Our Presenters:

- Dawn Heffernan, Diabetes Program Manager
  Holyoke Health Center, MA
  --*Maximizing Patient Choice*

- Sally Hurst, Rural Outreach Coordinator
  Marshall University, WV
  --*Medical Group Visits: Much more than a patient visit*

- Connie Norman, Full Circle Diabetes Case Manager
  Minneapolis American Indian Center, MN
  --Full Circle Diabetes Program

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Maximizing Patient Choice

Self Management in a FQHC

AADE Annual Meeting 2006

Dawn Heffernan

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

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

Chronic Disease Self-Management Program

- Six, two hour sessions
- Intervention Focus
  - Goal Setting
  - Problem Solving
  - Cognitive Techniques
  - Breathing Techniques

Individual Appointments with Diabetes Educator and Nutritionist

- Medication Management
- Nutrition Therapy
- Self-Monitoring Blood Glucose
- Prevention of Complications
- Exercise
- Preventative Health Care
- Diabetes Self-Management Programs
- Goal Setting/Problem Solving

Drop In Snack Club

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

Exercise Class

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

Interventions

- Flexible
- Initiated by patients and providers
- Allow for repetition of programs
- Low Literacy
- Social
- Fun
- Interactive

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Medical Group Visits-- More than a patient visit

AADE Annual Meeting 2006

Los Angeles, CA

Sally Hurst

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.

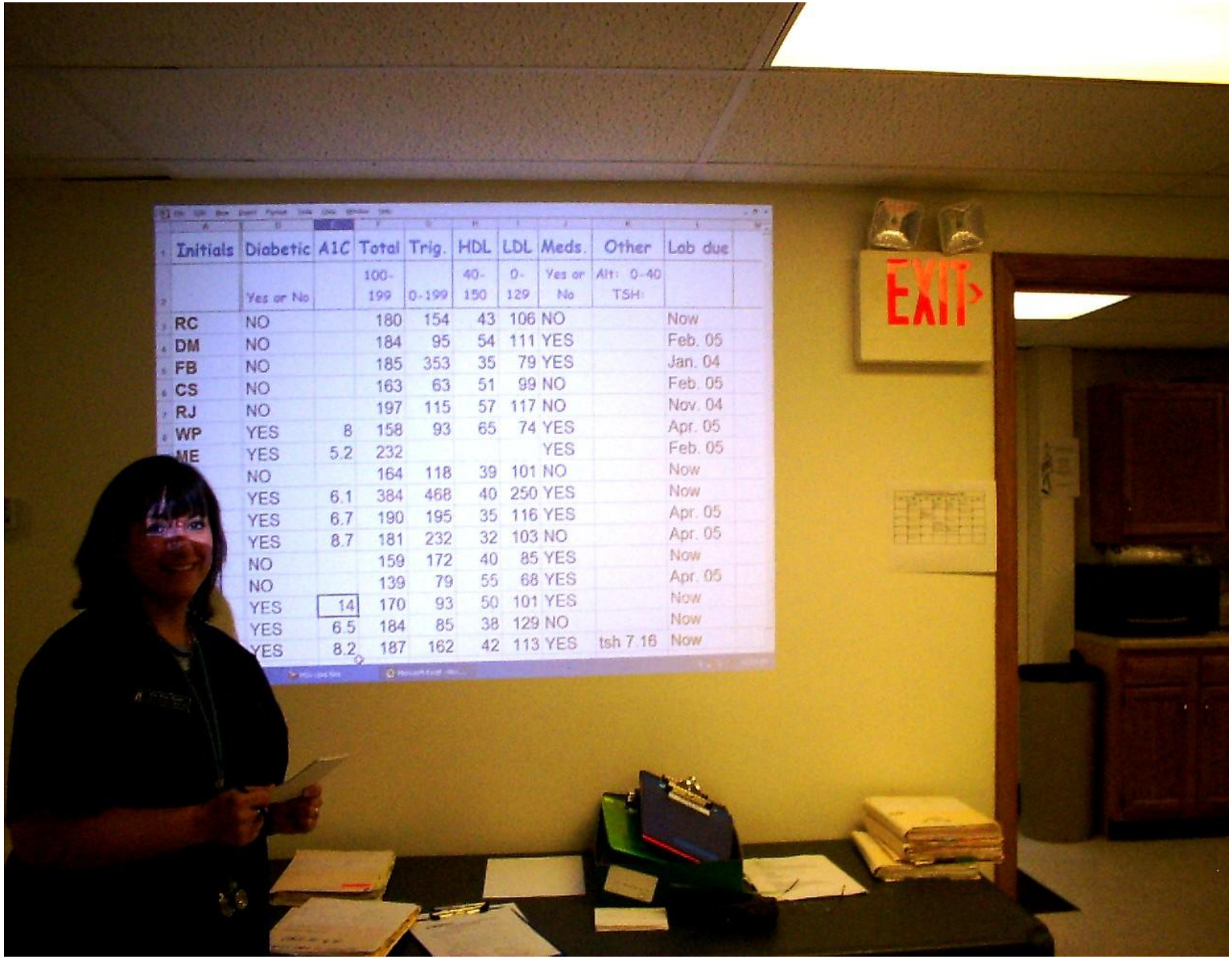
Teams share case management

- 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.

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.



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 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
- Relaxed setting/healthy snacks
- 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

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Full Circle Diabetes Program

Building Community Supports for Diabetes Care

AADE Annual Meeting
Los Angeles, August 2006

Connie Norman

Full Circle Diabetes Program

- A collaboration among the Minneapolis American Indian Center, Native American Community Clinic and Diabetes Community Council
- Our mission is to build community supports for Native Americans ages 16 to 85 years living in the Twin Cities metro area of Minnesota who have type 2 diabetes

Full Circle Diabetes Program

- Ongoing Follow-up and Support (OFUS)
  - Framework
    - The Circle Model has promoted effective partnerships between the community center, clinic and council of Elders
    - Strengths of our framework promote OFUS
  - Specific Strategies
    - Clinic-initiated case management
    - Community-initiated talking circles

Strengths of Framework

- Expands program capacity for OFUS
  - Promotes a common mission across several agencies
  - Promotes holistic programming
    - Ensures that services are culturally appropriate
    - Increases variety of services addressing physical, mental, emotional and spiritual aspects of health
    - Patients are empowered to stay connected to programming through a variety of outlets
  - Increases total number of services
    - Increases opportunities for follow-up and support

Strengths of Framework

- Ensures community investment for OFUS
  - Leadership of the Chronic Disease Self-Management Program
  - Talking Circle Facilitation
  - Coordination of Intergenerational Events
  - Active Testimonial Outreach to patients

Strengths of Framework

- Builds trust and accessibility
  - Community-based education opportunities
    - Increases availability of providers
    - Keeps patients / participants connected
    - Encourages patients to seek clinical care when they are ready
    - Multiple entry points into the program

Clinic-Initiated Case Management

- Individualized care
  - Identification of patient specific needs
    - Physical
    - Behavioral
    - Emotional
    - Environmental
  - Development of action plans
    - Builds trust
    - On-going follow-up that promotes patient accountability

Clinic-Initiated Case Management

- Case Management Meetings
  - Engages diverse disciplines
    - Providers
    - Case Manager
    - Dietitian
    - Patient Advocate / Social Worker
  - Provides opportunities to triage patients
  - Fosters proactive care
  - Promotes delivery of consistent messages

Clinic-Initiated Case Management

- Active Outreach
  - Quarterly reminder letters promote timely clinic appointments
  - Referrals support patient specific needs
  - Advocacy ensures patient access to resources

Community-Initiated Talking Circles

- Led by community members living with diabetes
- Culturally appropriate resource
  - Honors the importance of spirituality
  - Builds strength by sharing personal testimonies
    - Provides opportunities to learn from the life stories of each other
    - Reduces barriers to understanding "because we speak the same language and share the same values"

Community-Initiated Talking Circles

- Impact of Chronic Disease Self-Management Program
  - OFUS for participants that have completed the Chronic Disease Self-Management Program
  - Facilitators of talking circles have completed the leaders training for the Chronic Disease Self-Management Program
    - Encourages on-going action planning

Key Lessons

- The Circle Model as an organizational framework promotes both clinic and community-initiated OFUS
- OFUS should be promoted through multiple strategies at the organizational, community and individual levels to best meet diverse patient needs.

Thank You!