Ongoing Follow Up and Support in Diabetes Self Management

www.diabetesinitiative.org

CDC Diabetes Translation Conference
Atlanta, May, 2007
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., “HbA1c” 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

- Snack Drop-In
- Breakfast Club
- Talking Circle Support Group
- Self Management Class
- Group Medical Visit
- RN/CHW Monitoring
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
Ongoing Follow-Up & Support in a Free Clinic

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Homestead, FL
May 2, 2007
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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”

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<th>Traditional Patient Care:</th>
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<tr>
<td>• Monthly Provider Visits</td>
<td>➢ Limited DSME</td>
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<tr>
<td>• Diagnostic Tests</td>
<td>➢ No exercise opportunities</td>
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<tr>
<td>• Podiatric Care</td>
<td>➢ No “hands-on” education</td>
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<tr>
<td>• Limited DSME from Providers</td>
<td>➢ No peer support</td>
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<tr>
<td>• Med Pickup</td>
<td>➢ Limited family involvement</td>
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<tr>
<td>• Volunteer Nutritionist</td>
<td>➢ Community not involved</td>
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<tr>
<td></td>
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Boring!

- Like having Black Beans without White Rice!

“It’s a Cuban thing!”
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
OFUS on Three Levels

Open Door Health Center

- Local Radio Stations
- Local CBO's
- Churches
- Support Group/Group Appt.
- Cooking Classes
- Supermarket Tours
- "Diabetes 101"
- Adult Fitness
- Diabetes Presentations

Community

- ODHC Patient Family
- Adults with DM Type 2

ODHC: Clinic as platform for community program

- Baptist Health South FL
- Miami-Dade AHEC
- BU/FIU UM
- HFSF
- RWJF Susan G. Komen
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!!
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 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
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
Building Community Supports for Diabetes Care – Medical Group Visits: Much more than just a patient visit

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)
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.
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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 ongoing 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