Moderator:

- Edwin B. Fisher, PhD

Presentations:

- Holyoke Health Center, Inc.
- Community Health Center, Inc.
- Open Door Health Center
- Center for African American Health

DIABETES INITIATIVE

A National Program of The Robert Wood Johnson Foundation

Ongoing Follow Up and Support in Diabetes Self Management

Capstone Meeting

Tucson, Arizona

October 18 – 20, 2006

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)

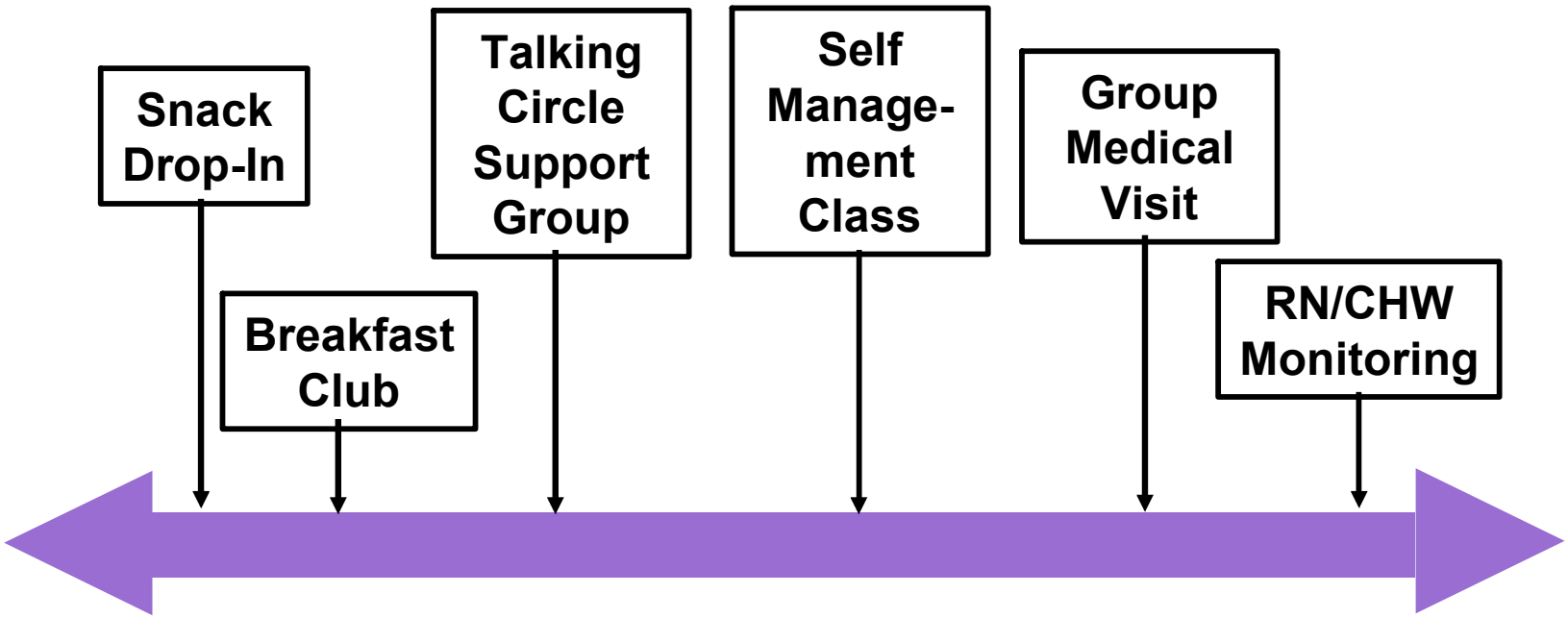
Key Features of Ongoing Follow Up and Support

- **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

Proyecto Vida Saludable: An Innovative Approach to Self-Management for Latino Patients with Type 2 Diabetes

A Model for Patient Engagement in Self-Management

Presented by Dawn Heffernan RN,MS

Diabetes Program Manager, Holyoke Health Center

Funded by the Robert Wood Johnson Foundation

Engagement in Self-Management Requires Multiple Levels of Support

- Organizational
  - Senior management
- Providers and Support Staff
  - Diabetes Health Disparities Team,
  - Self-management team
  - Clinical staff,
  - Education and support services staff
- Patient

Patient support for

Key Strategies for Patient Engagement in Self-Management

- Knowing your population
  - One of the highest diabetes mortality rates in the state
  - Nearly 100% of our patients live 100-200% below Fed. Poverty Level
  - Many suffer from substance abuse and mental health problems
  - Majority of patients are monolingual Spanish speaking
  - Low literacy rates
- Importance of Focus Groups
  - Learning from patients, clinicians and support staff

Multiple Interventions provides ample opportunity for engagement

- 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

Objectives for Engagement

- Positively impact patients lifestyle behaviors
- Improve patients self efficacy
- Increase patients skills and knowledge related to self care behaviors

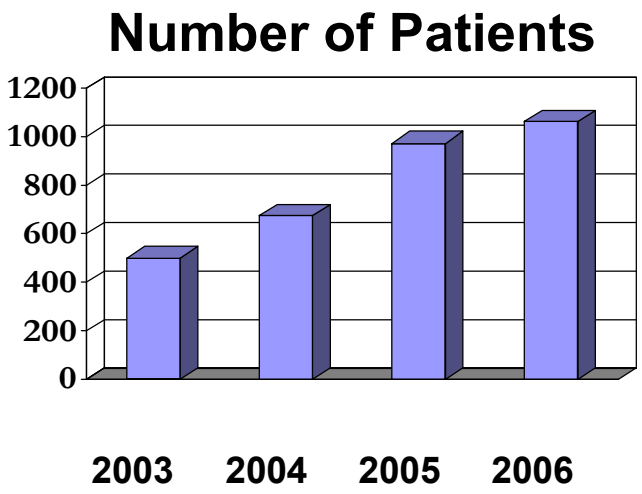
Key Strategies for Patient Engagement in Self-Management

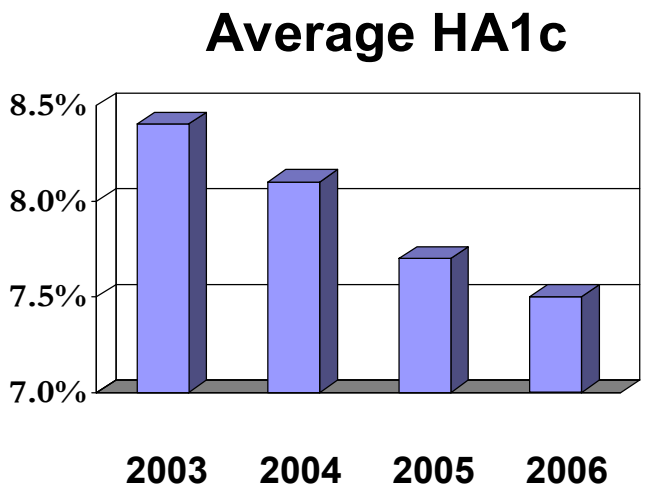
- Health Literacy
- Self Efficacy
- Goal Setting
- Problem Solving
- Monitoring and Follow up
- Incentives
- Address barriers
- Family member involvement
- Opportunities to be involved match patient needs and comfort zone
- Hands on Learning Opportunities

Key Strategies for Patient Engagement in Self-Management

- Culturally & Linguistically Appropriate Interventions
- Staff education
  - Committed, dedicated, open minded
  - Ability to implement behavior change techniques into patient interactions
  - Recognize when you have an opportunity
  - Ongoing self and program evaluation
  - Supervision
- Power of the relationship

Year	01/01/02-01/01/03	01/01/03-01/1/04	01/26/04-01/26/05	01/26/05-1/26/06
Number of Patients	499	675	873	1061
Average HA1c	8.40%	8.10%	7.70%	7.50%





Listen to the Heart Beat of the Patients and the Programs

- Seizing the Moment
- Lead Community Health Workers
- Community Health Workers
- Community Mentor
- Volunteers

Important Lessons

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?

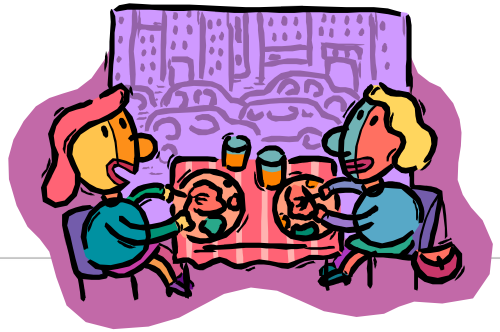
After two years: good news/bad news

- 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

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!

Strategies for Engaging and Supporting Diabetes Self-Management in a Multicultural Setting

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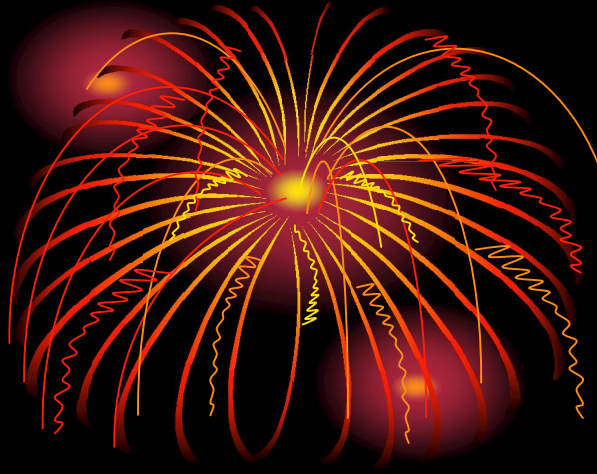
OPEN DOOR HEALTH CENTER

Prescription for Health
DIABETES PROJECT

Objectives



- To improve Diabetes Type 2 self - management with cultural competence & sensitivity
- To strengthen community support

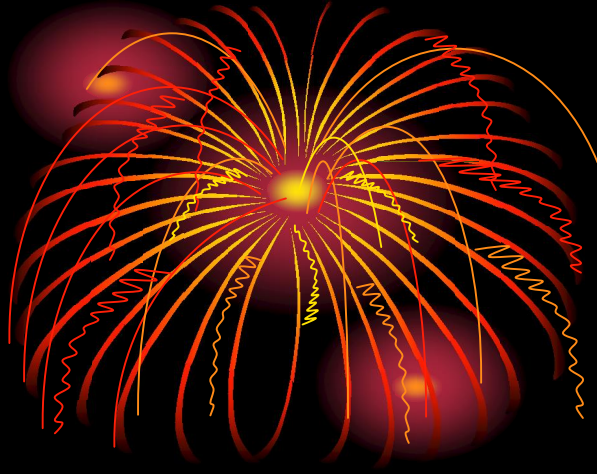
Key Strategies

- Support Groups/ Group Appointments
- Multi-cultural Cooking Classes
- Supermarket Tours
- “Diabetes 101 Classes”
- Adult Fitness Classes

Addressing Barriers

- Lack of Access to Resources
  - Expanded Pharmaceutical Program use
  - Healthier Groceries “on-site”
- Lack of Diabetes Knowledge
  - “Diabetes 101”
  - Popular Education method
- Inability to apply diabetes information
  - “Hands-On Education”
  - Peer Educators/supporters

Present Model



Local Radio Stations

We Care

Local CBO's

After School Programs

Churches

Support Group/Group Appt.
Cooking Classes
Supermarket Tours
"Diabetes 101"
Adult Fitness
Diabetes Presentations

Open Door Health Center

Community

ODHC Patients

Adults with DM Type 2

Baptist Health South FL

Miami-Dade AHEC

BU/FIU UM

HFSF & Susan G. Komen

RWJF

ODHC: Clinic as platform for community program

Important Outcomes

- Improved patient education
- Data collected show improved Hb A_1c correlated with improved clinical outcomes
- Increased access to resources
- Continued positive impact expected “down the road”

Lessons Learned

- Communication techniques matter
- Modeled behavior= best teacher
- Interventions in illiterate

  Multi-ethnic communities are "Challenging"

Key Lesson to Share

- ***Improved Diabetes Self-management in a multi-ethnic community is possible through innovative collaboration and cultural sensitivity***

To the Robert Wood Johnson Foundation Diabetes Initiative NPO, the NAC, guest presenters and our fellow grantees we say …

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

Empowering the African-American Community To Live Well
"Meeting People Where They Are"

Grant Jones
Executive Director

Jo Ann Pegues, RD
Focus on Diabetes Project Manager

The Center for African American Health
Empowering the Community to Live Well!

CENTER FOR AFRICAN AMERICAN HEATH FOCUS ON DIABETES

Overview

- Participant Engagement
- Organizational Transition
- Lessons Learned

KEY OBJECTIVES

- Present 6 week curriculum
- Utilize African American Faculty
- Conduct physical activities each session
- Provide hands-on cooking class

STRATEGIES

- Present materials at 4-5th grade level
- Provide transportation to class
- Allow hands on examples
- Demonstrate
- Reinforce and encourage

Participant Involvement Barriers

- Low literacy level
- Lack of transportation
- Not used to exercising
- Lack of instruction from primary care provider
- [illegible]anding seriousness of

Addressing Barriers

- Identification
- Applying Trans Theoretical Model
- Revision of Curriculum
- Individual Attention

Transition and Outcomes

- The Center for African American Health Emerges from the Metro Denver Black Church Initiative
- Health Focus

LESSONS LEARNED

- Lack of knowledge about the cause
- The impact of low health literacy on health outcomes is significant
- Obesity and inactivity disproportionately affect diseases in African Americans
- Approximately 40% of blacks have literacy problems

Lessons learned:

- There is need to address preventable causes of health disparities among blacks at the community level;
- African Americans need a trusted source of health information;
- A strong voice is needed to advocate for health needs of African Americans
- The CAA-Health is uniquely

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