Panel I: Empowering Patients for Self Management through Disease Journey

Expert Faculty:
Marti Funnell, University of Michigan Medical School
Integration of Diabetes Self-Management Education into a Patient-Centered Medical Home

Ruth D. Lipman, Ph.D.
American Association of Diabetes Educators
Panel I: Empowering Patients for Self Management through Disease Journey
Project Description

• Design & Implement Diabetes Self-Management Education Programs within the Patient Centered Medical Home model
  – Culturally appropriate
  – Reproducible
• Aims
  – Expand access to care
  – Increase patient involvement in their care
    • Improve clinical outcomes
    • Reduce costs
    • Enhance patient satisfaction
### Project Progress: Interim Process and Health Outcome Results

<table>
<thead>
<tr>
<th>Institution</th>
<th>Tennessee</th>
<th>Ohio</th>
<th>Oklahoma</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution</td>
<td>Vanderbilt University School of Medicine, Nashville, TN</td>
<td>Ohio University College of Osteopathic Medicine, Athens, OH</td>
<td>Oklahoma University College of Pharmacy, Oklahoma City</td>
<td>Jacksonville Urban Disparity Institute (JUI) University of Florida at Shands</td>
</tr>
<tr>
<td>Target Population</td>
<td>People with T2D who attend My Health Team at Vanderbilt</td>
<td>Caucasian adults in Appalachia diagnosed with diabetes</td>
<td>Adults with T1D or T2D who are non-compliant with DSME/T or DSM</td>
<td>Impoverished, African American adults with T1D or T2D</td>
</tr>
<tr>
<td>DSME/T Team Composition</td>
<td>1 CDE (RN, Education Assistant (Level 2) with BS</td>
<td>CDEs, diabetes educators and 15 CHWs</td>
<td>PharmD, CDEs, and CHWs</td>
<td>5 level 3 educators (RN), 1 CDE (RN), 5 Level 1 and 2 educators</td>
</tr>
</tbody>
</table>
Lessons Learned

• CHW provide a communication bridge between patient and educator
• Level 1 & 2 educators broaden outreach meeting patients where they are at
• Change the perception that diabetes education staff are culturally different from they people served
• CHW turn patient focus ideals into realities
Challenges

• Community resources can be limiting factor
• CHW worker recruitment, especially for time limited position can be difficult as there are competing options available for qualified individuals
• There are insufficient diabetes educators to meet community needs
• Needing to address newly discovered barriers
Key Next Steps

• Finalize clinical data collection
• Conduct patient focus groups
  – patient engagement
  – shared medical decision making
• Qualitative and quantitative data analysis
• Presentation and publication of study results
Value Added

“....The CHW has been an invaluable addition ..... She brings cultural relevance to the program, a community face, a caring compassion to support the emotional needs of the patients, and the energy and knowledge of the community and its resources to meet their needs...”
Project IMPACT™ Diabetes

Benjamin M. Bluml, RPh
American Pharmacists Association Foundation
Panel I: Empowering Patients for Self Management through Disease Journey
Project Description

- **Project IMPACT™ Diabetes**, **IMProving America’s Communities Together**, is a national initiative that aims to improve care for patients with diabetes through community-based interdisciplinary teams that include pharmacists.
- 25 Communities
- 17 states

*Getting quality diabetes care to patients who need it most...*
Project Progress:

*Interim Process and Health Outcome Results*

- Role-based Tool Kit and Knowledge Base
- Over 2,000 patients engaged
- Patient Self-Management Credential
- Inter-disciplinary patient care underway
- Minimum dataset collection – quarterly beginning January 31
- Qualitative interviews conducted in all 25 Communities
Lessons Learned

• Pharmacist-provided diabetes care may not be readily embraced in every situation at the current time. This model is currently working in care settings where efficiency is essential and resources are scarce.

• Each site is motivated to provide high quality care and most importantly has an unwavering commitment to their patients.

• Even just one person serving as a champion for the initiative is enough to cause impactful process changes.
Challenges

- Improper incentive alignment
- Local IRB approval
- Personal mentorship needed at a Community level, hard to automate and achieve same quality
Key Next Steps

• Monitoring care delivery
• Data collection and analysis
• Creation of the stakeholder interview montages
• Create a plan for communications and spread framework in 2013
Self-Management Credential

- Knowledge Assessments
  - 36 questions, 6 areas of focus

- Skills Assessments
  - Glucose monitoring, nutrition planning, medication dosing, stress management, foot and skin care

- Performance Assessments
  - 10 key process/goal measures

Achievement Levels:
- Beginner
- Proficient
- Advanced
Systematic Approach...

Programatic Consistency with Local Variability

– Health Care Services that are:
  - Patient-centered,
  - Pharmacist-supported, and
  - Inter-disciplinary
The Wellness Recovery Action Plan (WRAP) for Type 2 Diabetes

Joanne Di Napoli, MA
Riverview Medical Center Foundation
Panel I: Empowering Patients for Self Management through Disease Journey
Slide of your choice: Creation Story

- “The Doctors” Story
- Mary Copeland’s Story
- Why WRAP with Diabetes?
Project Description

• Goal: To improve the health outcomes of 50 newly diagnosed individuals with type 2 diabetes.

• Project compares two groups: one receiving standard treatment and one receiving Diabetes WRAP model.

• Study hypothesis: WRAP group will show significant improvement in comparison to standard group on outcome measures.
Project Progress: Interim Process and Health Outcome Results

• WRAP education curriculum developed by Mental Health Association of NJ.
• Orientation and training completed for key study personnel.
• Recruited new project manager.
• Preliminary identification of potential study subjects and avenues for recruitment.
• Awaiting IRB final approval.
Lessons Learned

• Adapting and integrating an existing model of care from one medical specialty (mental health) to another (medicine) is challenging.

• Keep patient recruitment strategy focused.

• When using a mental health education model in a medical setting, be sure you have a mental health professional on the team (duh).
Challenges

• IRB Process.

• Orienting busy practitioners/educators to participating in a research study.

• Implementing a research protocol in a community hospital setting.
Key Next Steps

• Obtain final IRB approval.
• Initiate formal patient recruitment.
• Ongoing recruitment education to internal and external constituents.
• Review final curriculum with key study personnel.
• Share early findings with key stakeholders:
  – Community Diabetes Awareness Day
  – Insurers
  – Primary Care Association of NJ
Diabetes Self Management through Peer Support and Community Outreach from the Patient-Centered Medical Home

Alivio Medical Center
An Active Presence for a Strong Community

Peers for Progress
Peer Support Around the World
A program of the American Academy of Family Physicians Foundation

TransformED
TRANSFORMING MEDICAL PRACTICES

NCLR
NATIONAL COUNCIL OF LA RAZA

UNC
GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

Bristol-Myers Squibb Foundation
Together ÒN Diabete
Communities Uniting to Meet America’s Diabetes Challenge
“Just say no” – Nancy Reagan

Individual Empowerment  OR  Social and Community Support

“It takes a village” – Hillary Clinton
Human beings are more effective and happier when they have someone
- they can *talk to* about personal matters
- who *cares about them*
- who can *help them* when they need help


Good parents: “…whilst always encouraging their children’s autonomy, are none the less available and responsive when called upon… ‘dependency’ has had so baleful an influence…often happened that whenever attachment…is manifest…it has not only been regarded as regrettable but has even been dubbed regressive. I believe this to be an appalling misjudgment.” (Bowlby, J. *A Secure Base: Parent-Child Attachment and Healthy Human Development*. 1988. Basic Books. P. 12)
We all worked together and it really made me feel I could do it.
Project Description

• Promotores – Compañeros en Salud
• Patient-Centered Medical Home
• Community Outreach
• Link these in demonstration at Alivio Medical Center, Chicago – Services to 400/4,000 PWD
• National Collaborative Learning Network on Peer Support
Project Progress: Interim Process and Health Outcome Results

• Site selected from national search
• Program model developed with broad input from
  – Clinical and outreach components of Alivio Medical Center
  – Integration of inputs from NCLR, TransforMED, PfP
• Specification of roles of Compañeros
  – Portion of time in clinic
  – Organizationally based in Compañeros en Salud
Lessons Learned

Person With Diabetes

Clinical Resources
- Primary Care – Patient-Centered Medical Home

Community
- Compañeros

- Linking to clinic & community resources
- Delivering consistent, integrated DSME
- Providing ongoing Peer Support for DSM
- Enhancing clinical care
Challenges

• Integration of community, peer-based, and clinical resources is challenging
  – Organizational change
  – Peer support and clinical care are distinct from and complementary to each other (Piaget: differentiation before integration)

• Neither clinic nor community outreach/support alone can provide all of what the patient needs to become healthy
  – Building trust in team approach
Key Next Steps

- PCMH process that includes peer support as part of the team
- Building ongoing support component
  - Case conferences
- Recruiting, hiring and training peer supporters
- Ongoing support for peer supporters
- Pilot testing, ongoing training
Four Key Functions of Peer Support

- Assistance in daily management – “the nurse/doctor tells me what to do; the peer supporter shows me how to do it”
- Social and emotional support
- Linkage to clinical and community resources
- Ongoing support