This product was developed by the Proyecto Vida Saludable at the Holyoke Health Center, Inc. in Holyoke, MA. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

Proyecto Vida Saludable

Healthy Lifestyles Program

Center or Disease Control Presentation
Dawn Heffernan RN, MS
Project Manager

Patricia Sarvela
Development Director

Holyoke Health Center
Sponsored by Robert Wood Johnson Foundation

Holyoke Health Center

- JCAHO accredited
- Federally Qualified CHC
- Western Massachusetts
- 15,000 patients
- 120 employees
  - ✓ 20 medical providers
  - ✓ 4 dentists
  - ✓ On-site retail pharmacy

- Highest Diabetes mortality in state
- Patients are 89% Latino/Puerto Rican
- 100% live at or below the poverty level

Beginning our Diabetes Programming 1998-2005

- Know and understand patients documented needs and health disparities
- Know what outcomes you want to target and achieve
- Establish indicators for success
- Effective use of registry data as evidence
- Identify Physician Champion and key staff
- Use your own internal data to support need for funding
- Work with local, state and national funders

Building Staff Capacity
Readiness for New Programming

- Every new HHC staff member is oriented in HDC, CCM and PDSA improvement model.
- Administrative time BUILT IN to the work day for meetings, planning, implementation.
- Staff held accountable for outcomes
- Regular feedback given on reports. What do they say and what does it mean?
- Grant writing reflects accurate data and current program needs

HHC's Organizational Aim

- Improve the care of our patients with chronic diseases by redesigning our delivery system and implementing the components of the Chronic Care Model.
- Maintain a functional patient registry.
- Increase provider and staff awareness of guidelines for chronic conditions
- Foster patient self-management
- No disconnect between *practice and theory*

Making it Happen

- Documented improvements in patient care.
- Improvement in staff and patient satisfaction.
- We see what we do makes a difference
- Grants from State, Federal and Private Funders.
  - 2000--- $65,000.
  - 2001---$125,000.
  - 2002---$370,000.
  - 2003-2004 $700,000 +
- All grant proposals written using internal data
- Development director involved in programs

Working Together: Our Team

- Tereza Hubkova, Physician Champion
- Dawn Heffernan RN, MS Project Manager
- Donna LaRocque LPN
- Diana Soto Life style Coordinator
- Jeannette Rodriquez Promotora Coordinator
- Maly Kentish Medical Assistant

Diabetes Collaborative

- Importance of the use of PDSA cycles, current PDSA cycle works on:
- Improving number of patients who have lipid profiles
- Identifying patients who have not been to the health center in four months-outreach conducted
- Piloting goal setting with patients including of a new goal form
- Improving Blood Pressure control

Diabetes Project Focus:

- Holyoke Health Center's Latino patients with Type 2 diabetes.
- To date we have enrolled 270 patients in diabetes self-management programs.

Overall Goal of our Project:

Engage HHC's clinical and support staff and patients with type 2 diabetes to improve and maintain positive behavior changes and health outcomes by providing a series of programmatic interventions such as: ***Breakfast Club***

Planning our Interventions:

- Four patient focus groups
- One provider group
- One nurse-medical assistant
- Focus group goal
- Developed need-based interventions for patients
- Specific training on diabetes education and self-management for our clinical teams/staff.

Focus Groups: Lessons Learned

- Patients face many barriers to diabetes self management
- Staff attitudes
- Support Groups
- Clinic hours do not accommodate all patients needs for services.

Lessons Learned: Focus Groups Low literacy levels

Programmatic Interventions

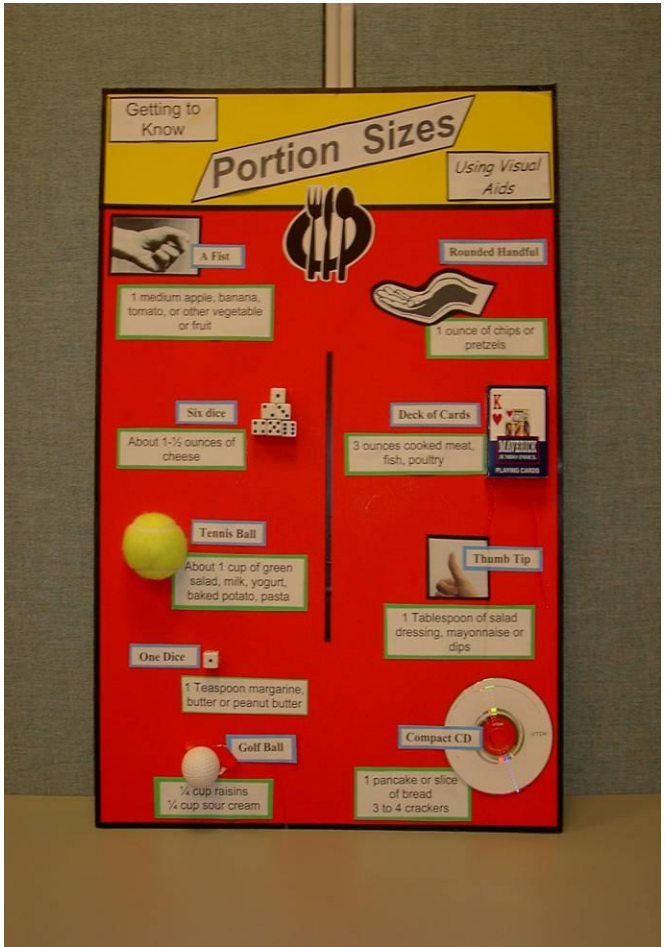
Breakfast Club

- Skipping breakfast is common.
- Hands on experience with nutritional concepts.
- Patients benefit from weekly coaching.
- Patients motivate each other in a group setting and benefit emotionally from the social support.

Programmatic Interventions: Diabetes Education Classes

Diabetes Education Classes

- Research based Diabetes Empowerment Education Program (DEEP)
- Importance of Low Literacy materials
- Patients respond to the use of self management related incentives



Community Based Learning

Supermarket Tours

- Importance of hands on experience outside of class
- Patients learn how to read label and compare prices with hands on experience.
- Patients learn from repetition, practice, and coaching.

Diabetes Education Classes: Graduation Photo

Exercise Classes

- Patients report they feel better when exercising.
- Patients are able to improve the hemoglobin A1C levels through regular exercise and dietary changes.
- Patients are instructed at their individual pace.
- Low impact aerobics, walking, dance and yoga.

Promotoras de Salud

- Trained by Midwest Latino Research Center using the Diabetes Education and Empowerment Program (DEEP)
- Leadership Training at Enlace
- Completed Community Health Worker training by Outreach Worker Training Institute
- Supported by Promotora Coordinator
- Work 15-20 hours a week

Working with Promotoras de Salud

- Promotoras develop a positive and unique relationship that allows them to motivate patients
- Promotoras need ongoing training, support, and supervision from staff
- Promotoras are enthusiastic, self motivated and gain self satisfaction by working with patients
- Improves self efficacy and self management for promotoras and patients.

Promotoras in Action

“I am proud of the work that I am doing with the patients and it is so important. I have learned so much through the diabetes programs and then through the orientation and training at the health center. I have a sense of responsibility and can give back to others what I have learned. Being a promotora has given me the opportunity to get to know many patients one on one and now I have the skills to help them to learn how to manage their disease.”

Damaris Lopez, HHC Promotora

Social Marketing:

- Patients respond to social marketing “in-reach” efforts:
- Story Board
- Star Patient Board
- Event and Class Calendar
- Diabetes posters and individual class flyers and information
- Handouts in English and Spanish
- Brochures
- Ongoing and open communication with patients is key

Star Patient

“This is a great program. My mom and I have learned a lot and have made lots of healthy changes in our life. We love coming to the exercise classes everyday.”

Daniel Burgos 51 years old

Making Changes

"I am very happy with this program. It has helped me a great deal. I have learned how to eat right and to take control of my diabetes.

Thank you."

Lydia Burgos 70 years old

Graduate of Diabetes Education

Exercise Class participant

Chronic Disease Self-Management Program (CDSM): Spread

All Patients with a Chronic Disease will be eligible for CDSM Program

- Two staff members trained as Chronic Disease Self-Management Master Trainers
- Seven staff members trained as Chronic Disease Self-Management Leaders

Chronic Disease Self-Management Program: Spread

- Three Classes offered to patients
- All trainers involved in the class
- CDSM Program Kick off
- March 30th staff learn about CDSMP
- Two new CDSMP Classes (English/Spanish) began in April

Chronic Disease Self-Management Program