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THE ROBERT WOOD JOHNSON FOUNDATION

Washington University in St. Louis
SCHOOL OF MEDICINE

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

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