This product was developed by the RWJ Diabetes Self Management Program at Community Health Center, Inc. in Middleton, CT. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

# Improving Diabetes Care

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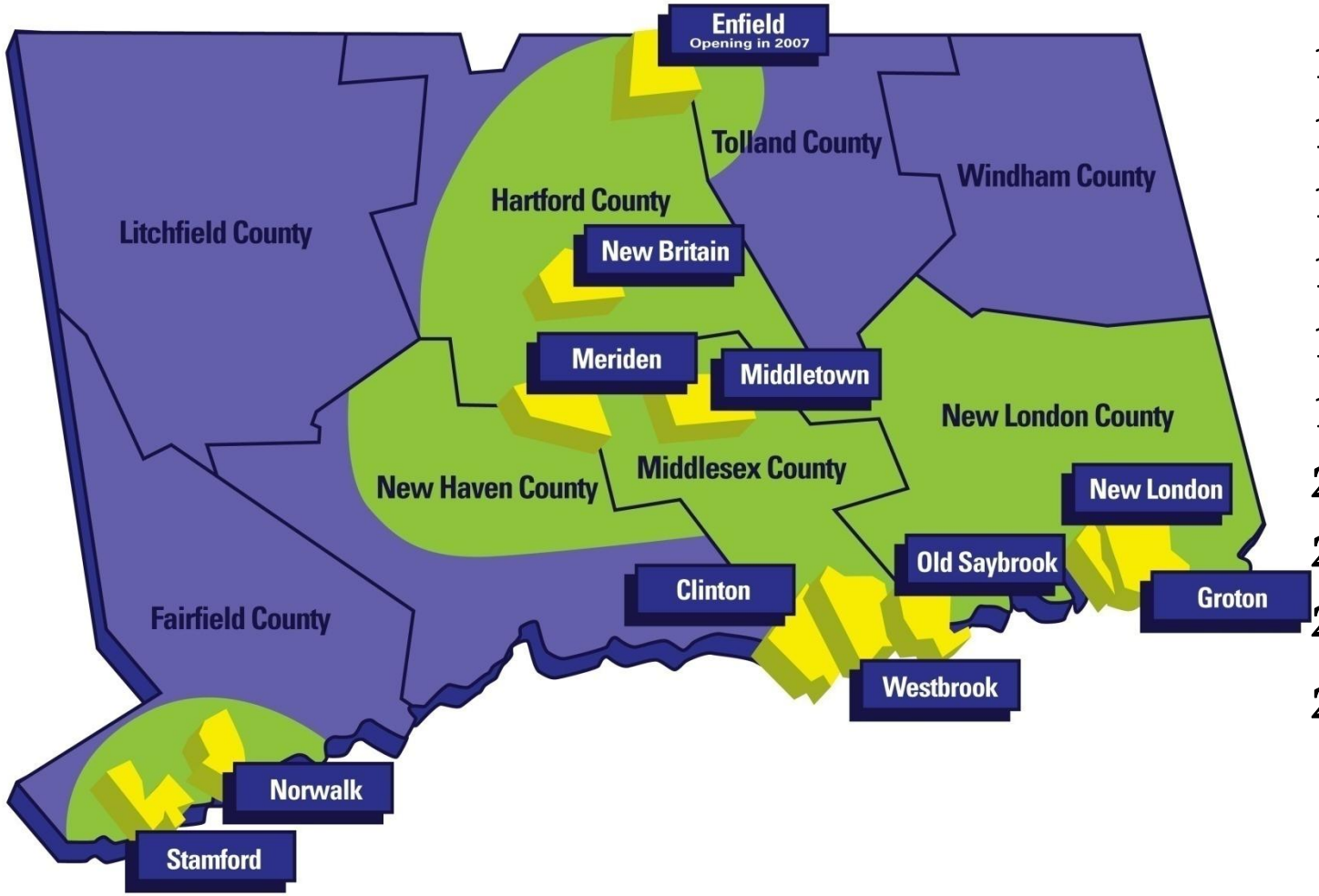
# Community Health Center, Inc.




1972- Middletown
1980- Old Saybrook
1990- Meriden
1992- New London
1994- Groton
1995- New Britain
2001- Clinton
2005- Norwalk
2005- Stamford
2007- Enfield*

# CHC Inc. Services



**Health Care Services:** **Ages: ALL**

- Medicine
- Dentistry
- Behavioral Health

**Locations:**

Primary care offices, schools, and shelters

**Specialties**: OB, HIV/AIDS, and chronic diseases

**Other Services:**

- Eligibility Assistance and Outreach
- Language Line interpretation Services
- Domestic Violence Services
- Vinnie's Jump & Jive (Community Dance Studio)

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Community Health Center, Inc.

# 2006 in Review

**Patients Consider CHC their Health Care Home: 70,000**

| **Patients by Practice** (2006) | |
|---|---|
| Medical Care | 30432 |
| Dental Care | 21581 |
| Mental Health Care | 3192 |

| **Patients by Condition** (2006) | |
|---|---|
| Chronic Disease | 11244 |
| Psychiatric Disorder | 3192 |
| Pediatric and Adolescent Care | 19642 |

# Innovations in Healthcare Delivery

- Advanced Access Scheduling
  - Increase capacity and timeliness
  - Decrease waste and delay
- 340B Pharmacy program
  - 50% decrease in drug cost for uninsured
- Weitzman Center for R&D
  - Research, Publication, Consulting, and Symposium
- Electronic Health Record: wireless, fully electronic system in all CHC sites
- Integrated Diabetes Self Management

# Main Conclusions/Lessons Learned from RWJF SM Project

I. Underserved patients with diabetes can successfully take part in diabetes self management and improve their clinical outcomes

II. Depression is extremely prevalent and must be dealt with in an integrated fashion

III. Patients choose to engage in SM in different ways. Programs must be flexible and offer varied options

IV. Creative solutions are needed to maintain engagement over the long term

# I. Clinical/Behavioral Outcomes

## 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 <130/80 compared to only 26.9% upon enrolling in RWJ
- 60% of goals were attained (attainment score of 3-4 on a four point scale

# II. Depression and Diabetes

- Integration of care
- Key elements of the models:
  - All diabetic patients screened for depression with PHQ9
  - Using available resources
  - Self management and depression care were complementary
  - Primary care delivery
  - Emphasis on non-pharmacologic treatments
  - Cultural factors
  - Group sessions
  - Lay-health workers

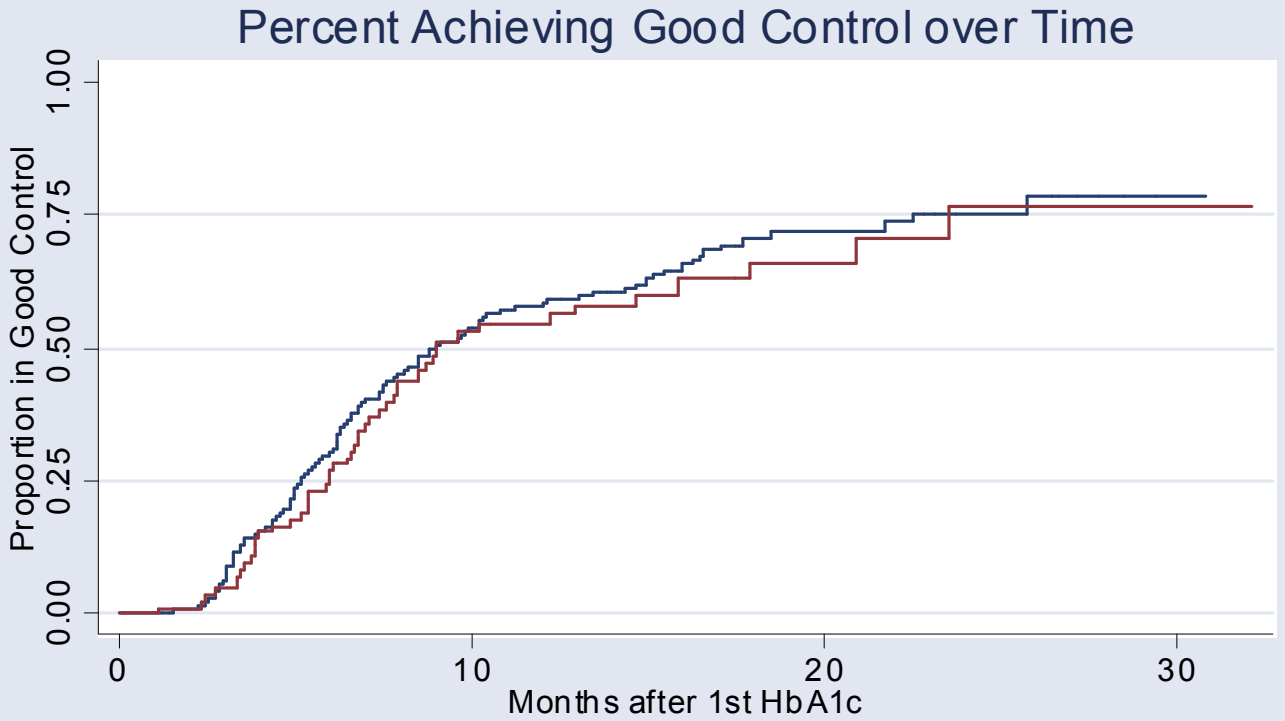
# Screening Results

- 739 patients screened
- 31% had PHQ9 score $\geq$ 10 (moderate to severe depression)
- Range 30-70%

# Key Characteristics Of Integrated Models

- Emphasize primary care-based treatment of depression
- Promotoras: Peer coaches, focused on behavior change
- Culturally focused models: i.e. incorporating Native American beliefs and traditions into counseling program
- Mind-body focus: Relaxation, inter-relationship of physical and psychological symptoms, emotional and spiritual factors, yoga sessions
- Integrated MH/DM care: Coordinated treatment between on-site primary care, behavioral health, and self management educator

# $HbA_{1c}$ over Time: Patients in Poor Control



# III. Providing Options for SM

I. **CDE individual session**

- Initial contact with bilingual, empathetic CDE's
- Roughly six 30 minute sessions covering a defined curriculum
- Emphasis on individual goal setting
- SM goals recorded, tracked, and attainment score recorded at each follow up
- Quarterly CDE follow-up (visit/phone)

II. **Group sessions**

- 6 sessions, 2 hours, didactic/participatory
- Special activities (cooking clubs, salsa, DM bingo, walking)

III. **Needed a 3rd way:**

- Events such as cooking clubs or exercise groups attracted a relatively small number of participants, usually female
- Complex and fragmented lives contributed to patients' keeping medical visits but not "extra" visit
- Only about 1/3 of diabetic patients engaged in DM self management

# Expand the Reach with Teamwork: Planned Care

- Conduct morning team huddles to review charts of patients coming in
- Review EHR 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
- Provide separate nursing visits for education and self management goal setting

# IV. Maintaining Engagement Over the Long Term

- Evidence shows that duration of contact is associated with improved SM outcomes
- Diabetes self management is for the long term
- Patients who "graduate" or lose contact with SM team often revert to old behaviors

# New Strategies

- How to provide SM education to a large population of patients, and maintain contact over the long term?
- Maintenance sessions (quarterly)
- Drop in sessions
- Telephone
- Internet/email

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# Thank you