

Self-Empowerment for Diabetes and Hypertension

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Mary's Center

- DC metropolitan region
- 8 locations, 5 health centers
- Founded in 1988 by Maria Gomez, a DC public health RN
- Serve individuals from nearly 50 countries
- Mission: building better futures



Social Change Model:

- Based on the principle that treating individuals and families for their health problems alone is insufficient
- Health care + education + social support = good health, stable families, and economic independence.

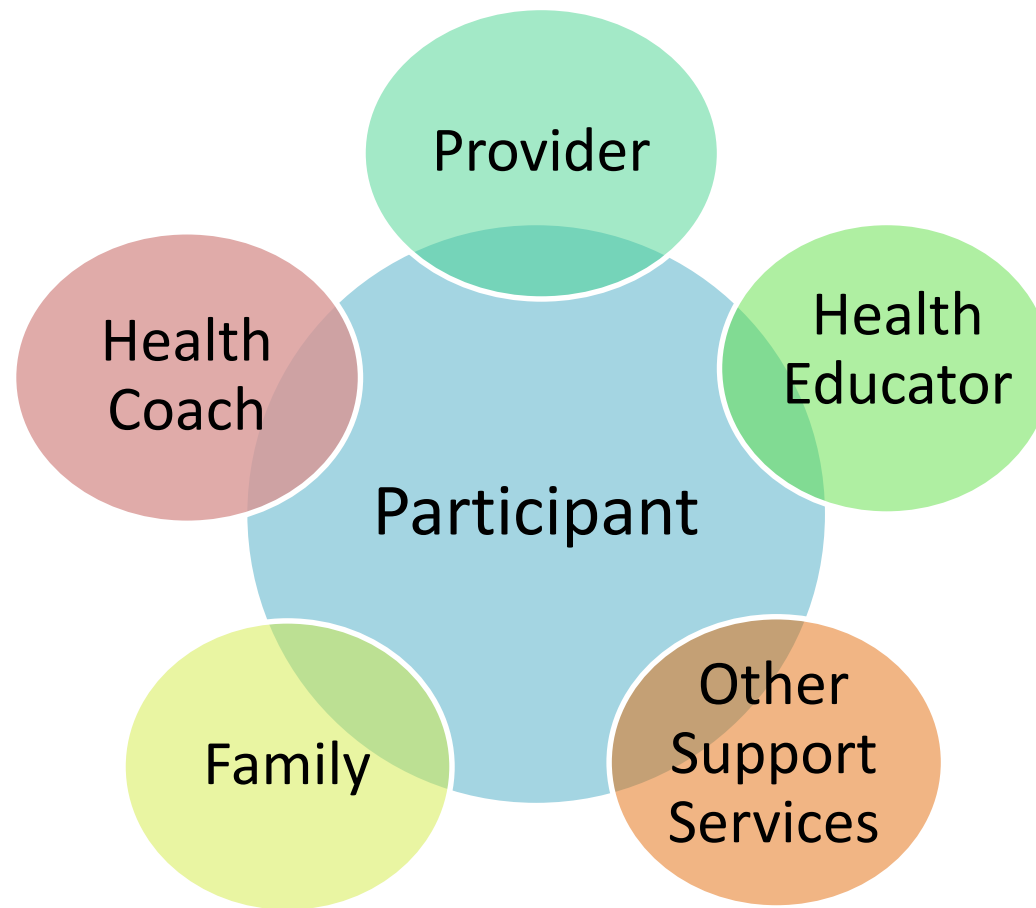


Quality Leader

- Health Center Quality Leader Award from the Health Resources and Services Administration (HRSA)
- Based on outcomes for
 - Chronic Disease Management
 - Preventative Care
 - Perinatal/Prenatal Care
- Patient Centered Medical Home



Self-Empowerment Program – A Participant-Centered Approach



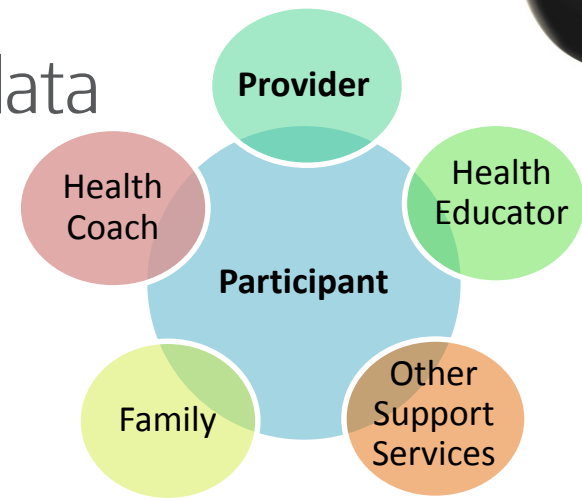
Description of Program

- Care coordination/medication management program
- Participants who demonstrate interest in receiving extra support for self-management
- Partner with health coach
 - Biweekly check-ins to support home monitoring, medication management, and lifestyle changes
- Receive daily text or voice message reminders to take medications and check BP/BC
- Develop personal goals
- Learn to navigate the healthcare system



Current Processes – Initial Referral

- Participants are referred by their providers based on assessed need for additional support to manage hypertension and/or diabetes
 - Home monitoring
 - Medication titration
 - Navigating healthcare system
- *Not solely based on biometric data



Reason for Referral (what kind of support is needed)

Current Diabetes Medications

Risk Category (Check one)

- Fragile: frequent episodes of hypoglycemia in spite of elevated A1c, elderly, Cr>2, moderate-severe liver disease
- High risk: A1c > 12%
- Moderate risk: A1c 9-12%
- Low risk: A1c 7-9%

Glucose Targets

A1C target (Check one)

- 6.5-7%
- 7.1-8%
- Other _____

Fasting Glucose Targets (Check one)

- 90-130 mg/dl for most patients
- 100-140 mg/dl for older patients and those with significant co-morbidities ("Fragile")
- Other _____



Insulin Titration Plan:

Basal Insulin Titration

- Standard
- Individualized: _____

Prandial Insulin Titration

- Standard
- Individualized _____

Mixed Insulin Titration

- Standard
- Individualized: _____

Blood Sugar Monitoring Frequency

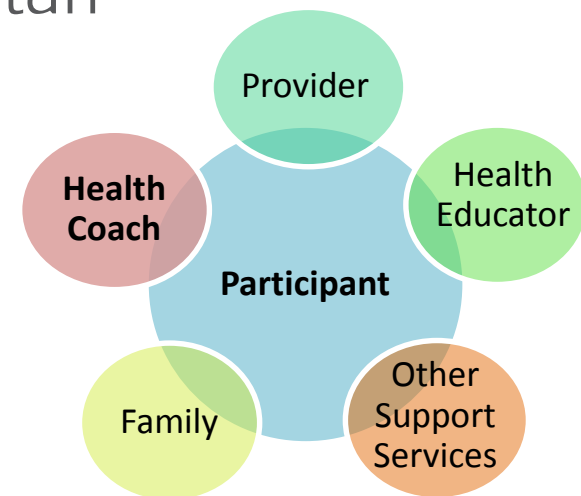
- Fasting
- Postprandial
- Bedtime
- Before meals
- Pre-Breakfast and Pre-Dinner
- Random
- Other (specify) _____

Other notes: _____



Current Processes – Pre-Enrollment Meeting

- Nurse or panel assistant meets with the participant via warm handoff from provider
- Assesses appropriateness for enrollment
 - Engagement
 - Ability to monitor at home
 - Ability to communicate with staff
 - Willingness to make changes



Current Processes – Pre-Enrollment Assessment

- Nurse or panel assistant initiates disease management education during initial referral
 - Diet, exercise, disease complications, safety
- Assists participant in acquiring home monitoring supplies and medications
- Identifies and addresses barriers to medication adherence and home monitoring



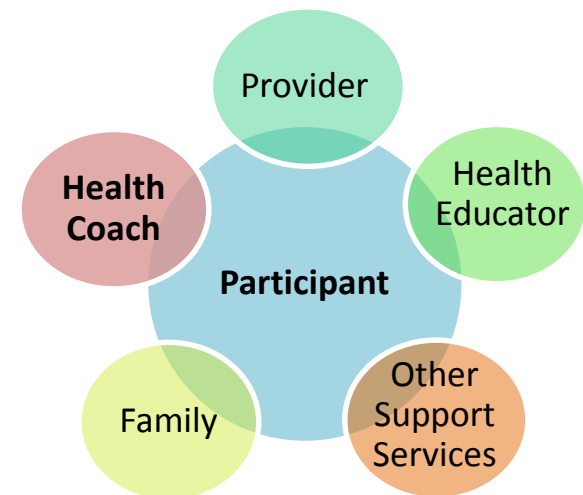
Current Processes – Initial Referral

- If appropriate for enrollment:
 - 1-week follow-up appointment for formal enrollment with nurse or panel assistant
 - Appointments with other support services
- If not appropriate, or not interested:
 - Follow-up with provider with note to re-assess for readiness



Current Processes – Enrollment

- Reviews components of Self-Empowerment program
- Assures participant agreement and completes signed participant contract
- If participant is uninsured, provides monitoring supplies



EMPOWERMENT PROGRAM PARTICIPANT AGREEMENT FORM - DIABETES

Dear Participant,

Thank you for your interest in the Empowerment Program at Mary's Center! The goal of this project is to help increase communication between your health care team and you to help control your blood sugar. Before beginning the program we would like to tell you a few things about the program:

- First, you will meet with your primary care provider (PCP) to discuss your diabetes medication.
- You will then meet with a nurse or medical assistant to get a glucometer, learn about how to use it at home, and how to write down your blood sugar readings.
- On Mondays through Saturdays you will receive a voicemail message or text message to your phone reminding you to take your medicine and use the machine to check your blood sugar.
- Every one to two weeks someone from Mary's Center will call you on the phone to find out how you are doing, to ask you for your blood sugar readings, and to make changes to your medication if needed.
- You are strongly encouraged to meet with the Nutritionist to learn more about how your diet can help to control your diabetes, to meet with Health Educator to learn more about diabetes, and to attend a group session to learn more about diabetes and how to manage your health.

By signing this document you are agreeing to:

1) Receive reminders on your cellular phone:

- o Via Text Message or Voice Mail
- o In Spanish or English

Preferred Phone Number _____

- 2) Work hard to remember to take your medication and record your blood sugar as prescribed
- 3) Speak to a nurse/medical assistant on the phone to discuss your progress
- 4) Attend your appointment with your PCP at least every 3 months to discuss your progress
- 5) Consider speaking with the nutritionist or a health educator or attending a group session along with other Mary's Center participants to learn about how to make changes to your diet and lifestyle to help you manage your diabetes.

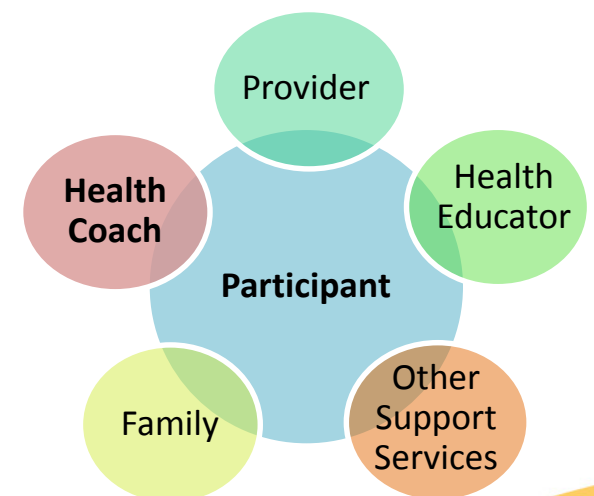
Your nutritionist appointment is _____.

Your health educator appointment is _____.



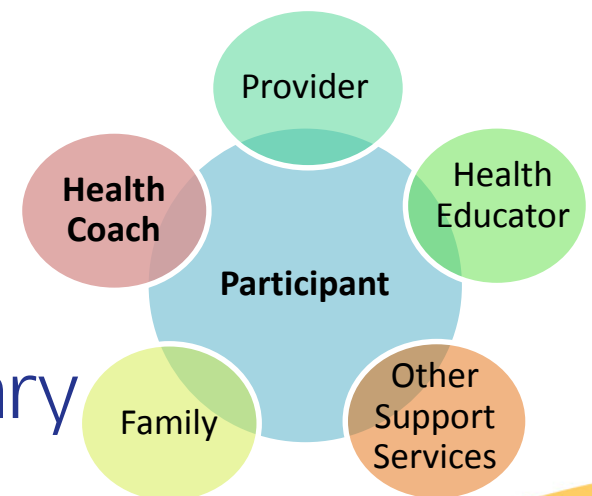
Current Processes – Enrollment

- Education continues
 - Blood glucose/blood pressure monitoring education
 - Insulin injection techniques and other medication administration and safety protocols
 - Disease process and self-management education
- Goals and Care Plan
- Follow-up plan with participant



Current Processes – Follow-Up

- Health coach contacts participant every 2 weeks as determined during enrollment
 - Via phone calls, text messaging, or in-person contact
- Assessment
 - Participant’s status and progress
 - home monitoring logs
 - symptoms of hypo/hyperglycemia, hypo/hypertension, evaluate causes and review safety action plans
- Titrates medication per titration plan or provider consult, if necessary



Patient Name	Prescribing Provider
Lantus, Levemir, Basaglar, Tresiba Basal Insulin (specify type) _____	Starting Dose _____
Instructions	Starting Risk Level (circle one): Low: A1c 7-9% Moderate: A1c 9-12% High: A1c > 12% Fragile: frequent episodes of hypoglycemia in spite of elevated A1c, elderly, Cr>2, moderate-severe liver disease
Glucose targets:	
A1c target (circle one) a. 6.5-7% b. 7.1-8% c. Other	Fasting glucose targets (circle one) a. 90-130 mg/dl for most patients b. 100-140 mg/dl for older patients and those with significant co-morbidities ("Fragile") c. Other

Basal Insulin Titration Plan: Standard

Select dose change of given number or % of current dose, whichever is higher

average FBG >7 days	Fragile/Low	Moderate	High
>180 mg	+2	+4/20%	+6/20%
141-180	+1	+2/10%	+3/10%
121-140	0	+1/5%	+2/10%
91-120	-2	0	0
<90	-3/10%	-2/5%	-4/10%

Basal Insulin Titration Plan: Custom (detail titration plan below)

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If repeated hypoglycemia is reported		
BS at time of symptoms	Low/Moderate/High	Fragile
Symptoms of hypoglycemia with BS > 70	Maintain current dose for 1-2 weeks and follow-up	Reduce dose by 5%
BS 60-70	Reduce dose by 10%	Reduce dose by 15%
BS <60	Reduce dose by 20%	Reduce dose by 25%

Additional Notes

Provider Signature: _____ Date: _____

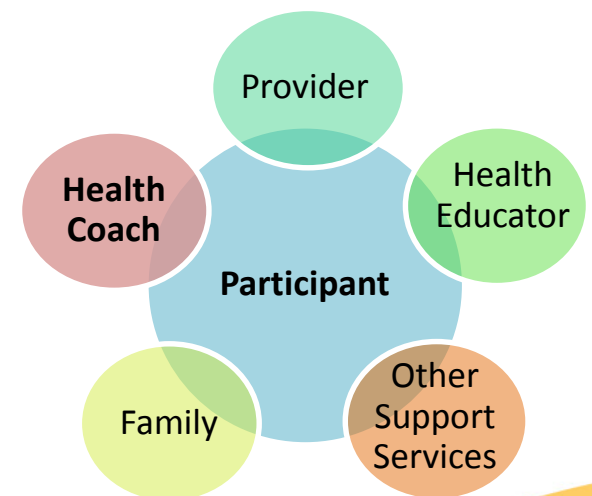
Notes to RN:
 When at goal:
 - When target is reached, do not increase insulin dose further. Decrease frequency of patient-provider contact to every 2-4 weeks.
 - HbA1c is checked at 3 months after insulin initiation during provider visit.

If patient is not at goal and not at maximum insulin dose, patient will continue with titration for another 3 months



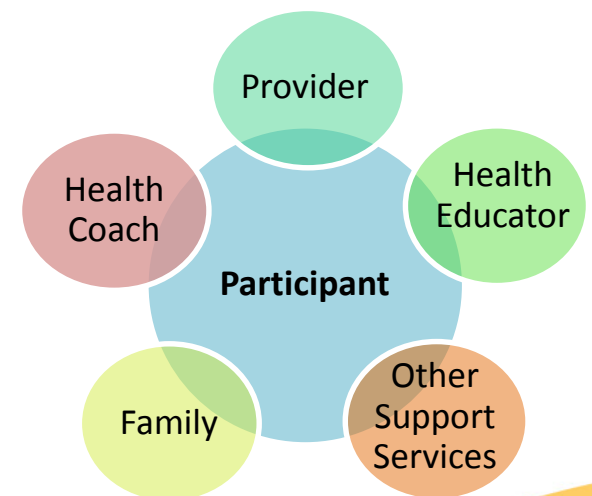
Current Processes – Follow-Up

- Continues disease education
- Continues healthcare system navigation education
- Contacts provider with status updates, discusses need for medication adjustment if necessary



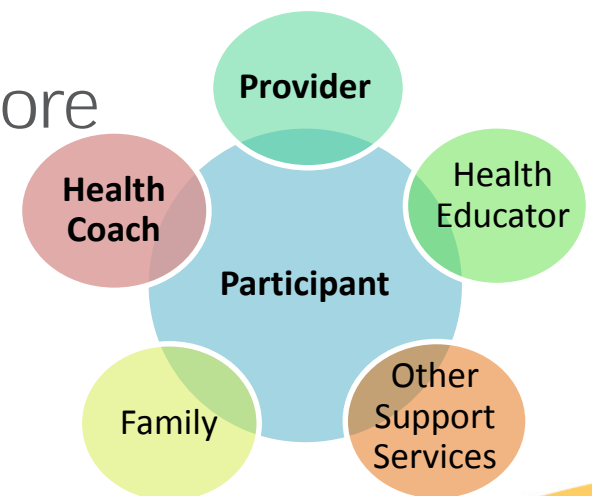
Current Processes – Graduation

- Graduation requirements
 - Participant-specific goals met
 - A1c, clinic BP and BG measurements
 - Home monitoring BP and BG measurements
 - Diet and exercise, other behavior modification as needed
 - Complication prevention
 - Healthcare navigation goals met
 - Medication
 - Communication with clinic
 - Insurance



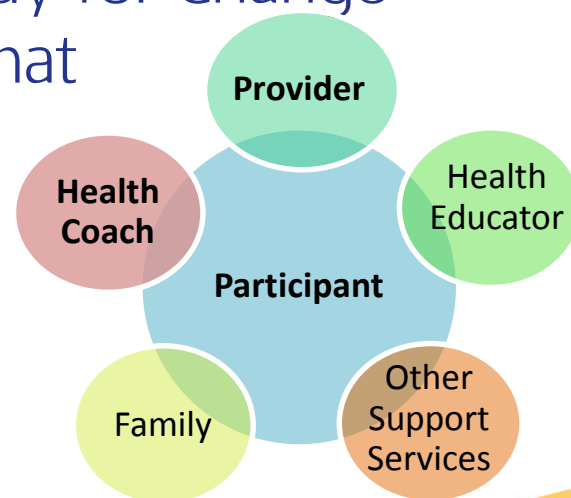
Current Processes - Graduation

- Once goals have been met
 - Slow decrease from biweekly check-in calls
 - Every 4 weeks for 3 months until next provider visit
 - Every 3 months during provider visits
 - Graduate participant from formal check-ins, silently follow for 6 months via chart reviews
 - If progress maintained without direct contact from program, officially graduate from program – continue following only by data pulls
 - If regression at any point, return to more consistent follow-up and progress as needed

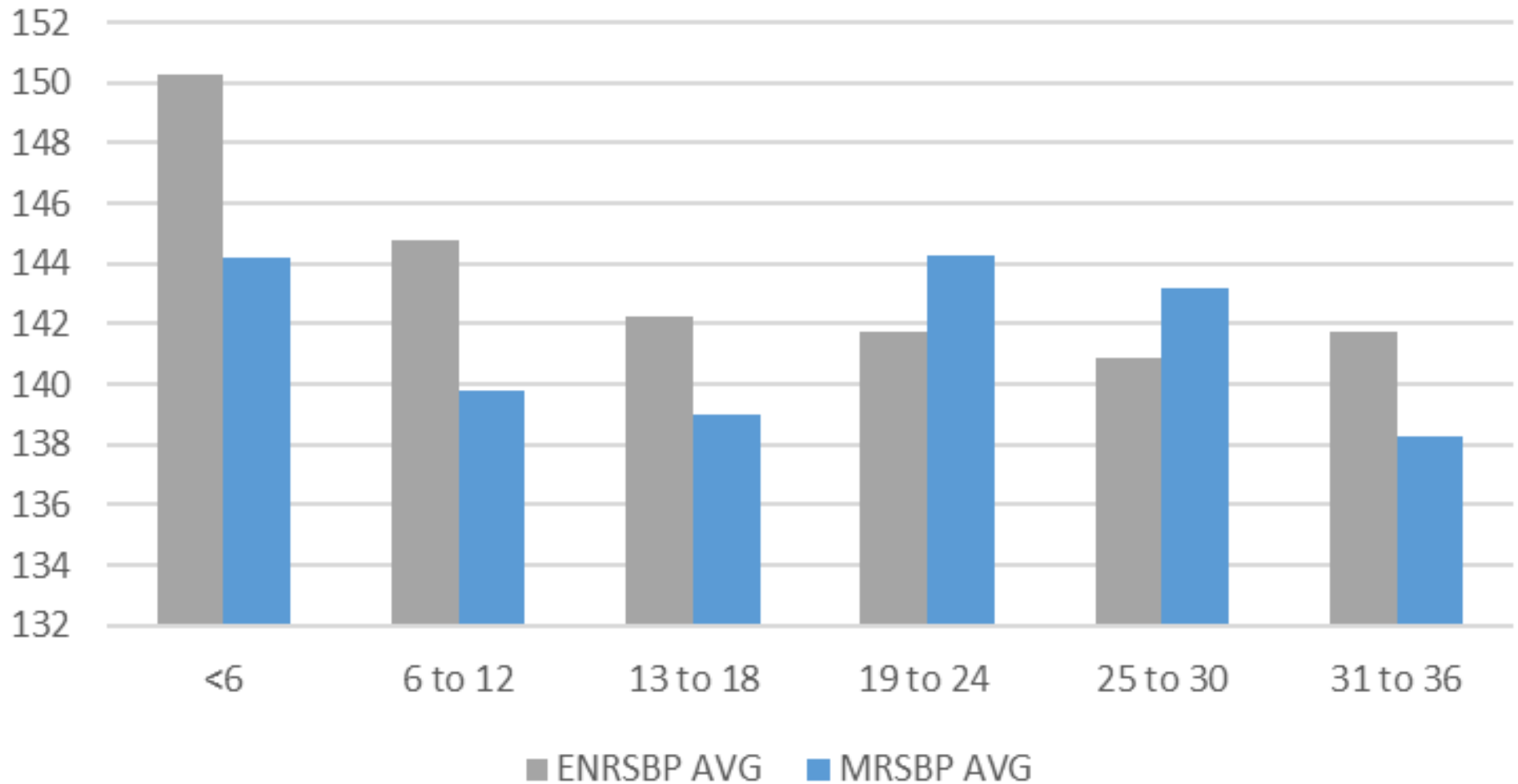


Current Processes - Withdrawal

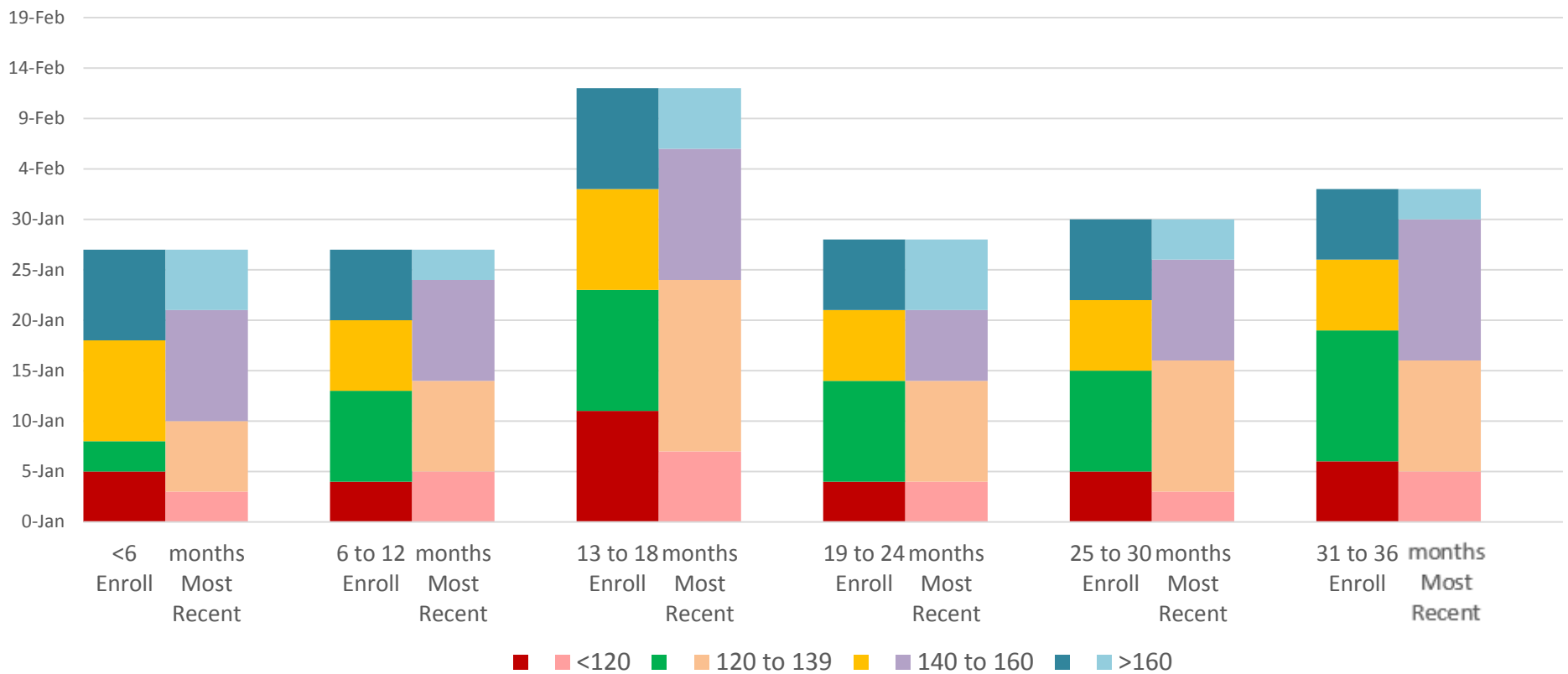
- Withdrawal from formal follow-ups if
 - Expressed lack of interest in participation
 - Unable to be contacted and no-shows to provider appointments
 - Refusal to make adjustments based on recommendations after attempting to address barriers to behavior change
- *Withdrawal conditions are fluid and each individual participant is discussed with Self-Empowerment staff and/or provider prior to discharging
- Withdrawal is necessary to ensure Self-Empowerment staff can focus time on participants that are ready for change
- Participants are withdrawn with notation that re-engagement will be attempted at subsequent provider visits



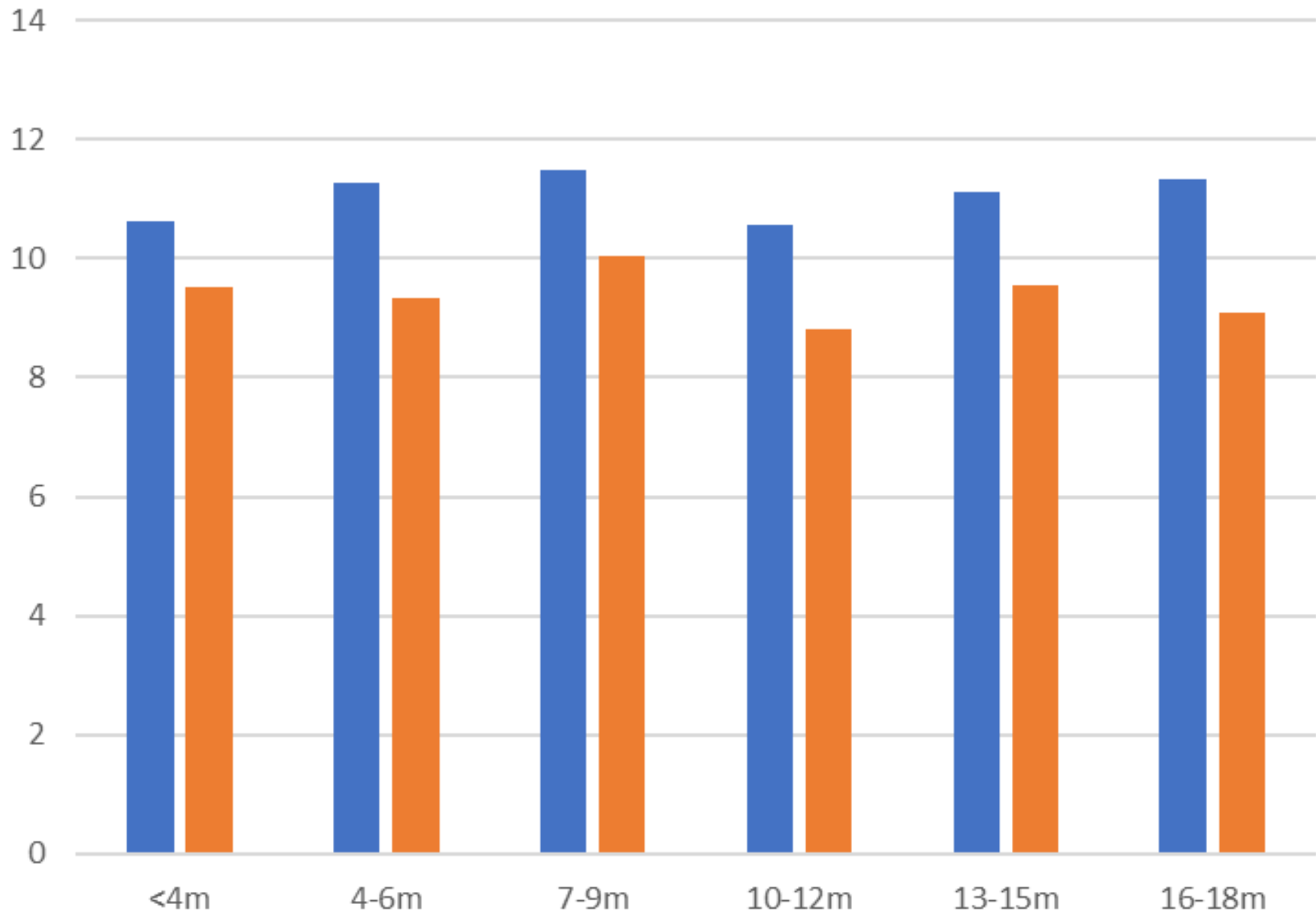
Average SBP - current versus enrollment



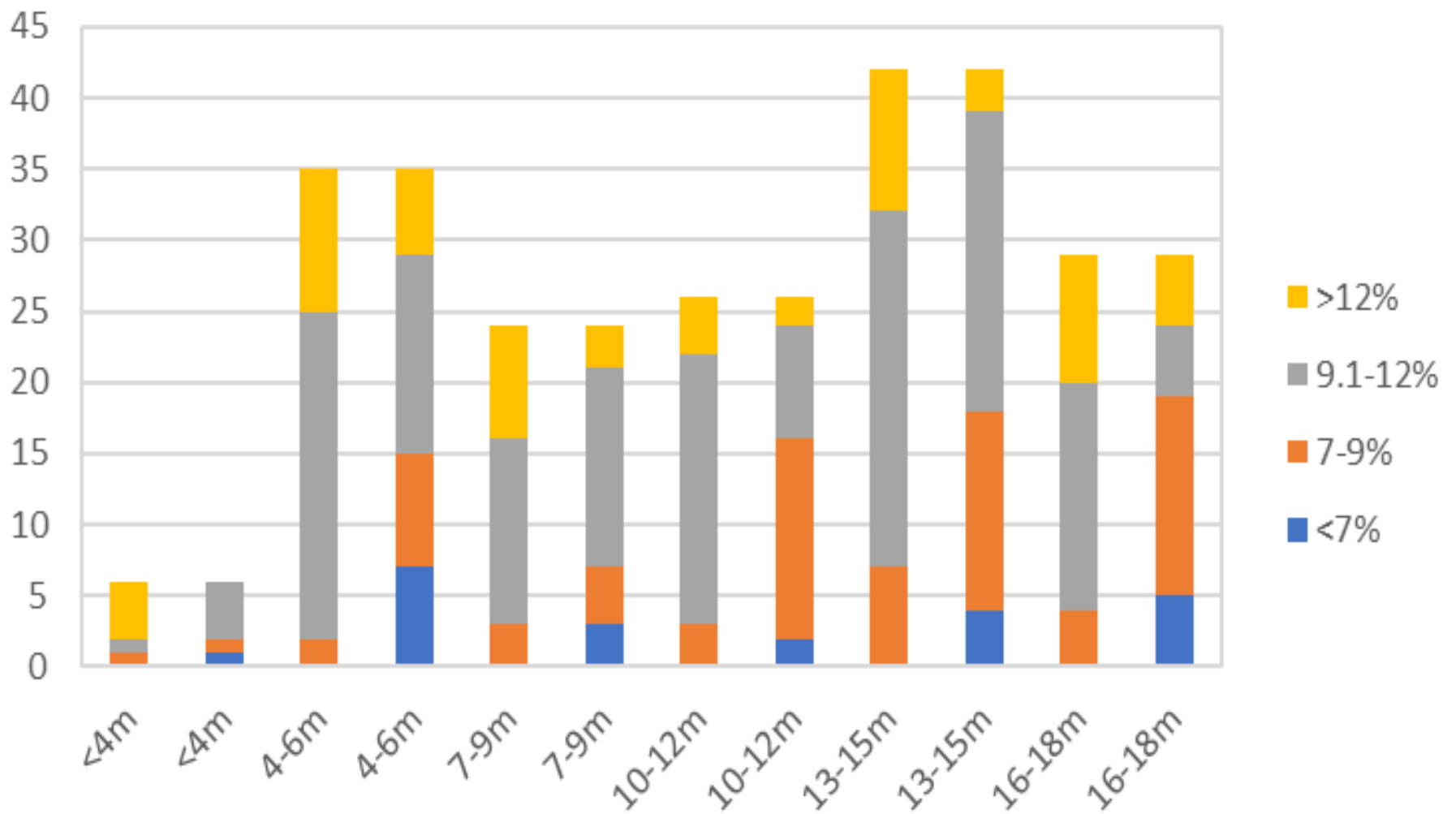
Blood Pressures: Enrollment vs Most Recent by Time in Program



Average A1C, enrollment versus most recent



A1C Distribution by amount of time in program



Challenges

- Data analysis
- EHR challenges
- Standardization across clinics and among providers and Self-Empowerment team members
- Other responsibilities of staff members



Next Steps

- Adjustment of current processes and staffing structure to accommodate growing participant panels
- Development of concrete graduation goals to maintain gains and prevent need for re-enrollments, and integration of graduation processes into EMR
- Development of more complete education materials
- PDSAs to test and develop best practices

