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Improving Diabetes Self-Management and Coordination of Care Among SASH Participants

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Disclosure Statement

"I declare that there are no relationships, conditions, or circumstances that present a conflict of interest relevant to the content of this presentation."

Introduction- What is SASH?

SASH is a non-profit, state-wide organization which coordinates the resources of social service agencies, community health providers, and housing organizations to support Vermonters who choose to live independently at home.

All SASH participants receive annual health assessments, health coaching, and check-ins with Wellness Nurses.

Participants' providers, health history, problem lists and medication lists are documented by SASH

24% of SASH participants have an established diagnosis of diabetes

Introduction- DM and SASH

In 2015, 25.2% of seniors (~12 million) were diagnosed with diabetes

Diabetes remains the 7th leading cause of death in the US

Estimated between 2015-2030:

- Prevalence of diabetes will increase by 54% to more than 54.9 million
- Annual death climb 38% to 385,800
- Total annual medical and societal costs related to diabetes will increase 53% to more than $622 billion

Currently there is no established SASH method to:

- assist individuals with managing their diabetes
- document how participants are managing their diabetes
- coordinate care between participants, SASH staff, and providers

Available Knowledge

- A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics (2015) indicated that diabetes self-management education and support is cost-effective by reducing hospital admissions and readmissions, as well as estimated lifetime health care costs related to a lower risk for complications

- The use of team care, coupled with appropriately chosen pharmacologic therapy and patient education that fosters the development of critical thinking skills and the ability to make self-management decisions, have been shown to improve glycemic control and cardiovascular outcomes

Available Knowledge

- The Palo Alto Medical Foundation designed and implemented "Champion", a novel team-based model that includes providers offering evidence-based patient self-management support, and unlicensed health coaches working with selected patients between physician visits to support patients' self-management of hypertension and diabetes. Champion standard work improved glycemic control over the first 6 months and physicians' experience with managing chronic care

Rationale

Implementation of a personal diabetes record among SASH participants will:

- Empower the SASH participant to manage their own disease
- Assist SASH in documenting how participants manage their disease
- Assist the provider in understanding how the participant is managing their disease
- Serve as a tool for better coordination of care between participant, SASH organization and provider

Purpose & Aims

- Develop a personal diabetes record to be used by SASH participants.
- Pilot test an educational program for both participants and staff on the use and importance of the personal diabetes record.

SASH® a caring partnership
SUPPORT AND SERVICES AT HOME

Methods —

VERMONT
DEPARTMENT OF HEALTH

- Met with members of VT DOH, SASH program director, site coordinators, Wellness Nurses and PCPs to determine what information would be most informative to develop a plan of care.

- With the assistance of SASH director, site coordinators and Wellness Nurses, identified which sites had the highest frequency of diabetics.

- Modifying and adopting existing diabetes self-management tools to meet the needs of participants, SASH and health care providers.

Interventions — Diabetes Self Management Tool

	Finger Stick/Insulin Given				Blood Pressure	Oral Medications Taken? (yes/no)	Exercise (Min)
	Morning	Afternoon	Evening	Night			
Ex:	125/ 5 U	65/0 U	225/ 10 U	175/0 U	130/90	yes	30
1	/	/	/	/			
2	/	/	/	/			
3	/	/	/	/			
4	/	/	/	/			
5	/	/	/	/			
6	/	/	/	/			
7	/	/	/	/			
8	/	/	/	/			
9	/	/	/	/			
11	/	/	/	/			
12	/	/	/	/			
13	/	/	/	/			
14	/	/	/	/			
15	/	/	/	/			

Interventions-Diabetes Self Management Tool

I perform finger sticks (ex: once a day, 4 times a day, on occasion):

_____

My insulin is given as follows:

Name Of Medication	How I Administer

My oral diabetes and blood pressure medications are as follows:

Medication	Dose	How Many times/day	What time of day

Interventions- Self Management Tool

Test	How Often	Vt Dept Health Goal	My Goal
Hemoglobin A1C	Every 3-6 months	Below 7%	
Blood Pressure	Daily	130/80	
Cholesterol- Total	Yearly	Less than 200	
Cholesterol LDL (ie, "bad" cholesterol)	Yearly	Less than 129	
Cholesterol HDL (ie, "good" cholesterol)	Yearly	Greater than 40	
Triglycerides	Yearly	Less than 150	
Urine Test for Protein	Yearly		

Visits	How Often	My Last Visit (Date)	My Next Visit (Date)	Telephone #
Primary Care Provider	3-6 mos			
Foot Exam	Yearly			
Dilated eye exam	6 mos – yearly			
Dental Exam	6 mos - yearly			

Interventions- Process

1. Identify willing participants w/ diagnoses of diabetes
2. Conduct pre-participation “interview”
3. Administer “My Diabetes Tool Kit” binder
   - Binder divided into 5 sections with educational material
   - Contains diabetes self-management forms
4. Meet with participants on a weekly basis to discuss successes, challenges, answer questions, provide new education
5. Monthly “pop-up” site-wide activities
   - Healthy breakfast make-over
   - Nutrition and Diabetes with free lunch

Study of the Interventions/Analysis

- Qualitative data obtained from 1:1 meetings with participants on usefulness of tool/program
- Questionnaires completed by participants to gage satisfaction of tool, perceived ease to use, and helpfulness.
- Determine how many of the participants were able to achieve their health goals (ie, target A1C levels, daily glucose levels, weight and blood pressure).
- Wellness Nurse survey of DM knowledge and confidence.

Ethical Considerations

- Medical information will be kept private and secure
- When adapting and implementing a personal diabetes record, evidence based practices will be used
- Interventions will be offered to all participants, regardless of age, race, gender, ethnicity or socioeconomic status
- Participants will not be coerced or forced to participate

Results

- 5 participants enrolled, all from Town Meadow Senior Housing
- 2 participants completed the tool in its entirety
  - 1 stated that he will be continuing to utilize the tool going forward
  - 1 had a f/u with PCP and determined he is now pre-diabetic
- 3 participants stated that they felt that their diabetes was already well controlled and that they had their own methods to manage diabetes
- 2 participants interviewed stated that they manage their diabetes through diet and exercise. 1 participant is not taking any oral medications or insulin to manage their diabetes. 3 participants have typically recorded their daily finger sticks using their own record-keeping methods.

Results

- SASH Wellness Nurses surveyed, 24 out of 37 total responded (65%)
- Responses include: strongly agree, somewhat agree, neutral, somewhat disagree, strongly disagree

I am aware of which participants have an established diagnosis of diabetes					
If a participant were to be NEWLY diagnosed with diabetes, I feel as though this would be made known to me as the wellness nurse					
I feel the majority of participants who have diabetes are doing a good job of managing their diabetes					
I feel confident in my knowledge of diabetes to teach/coach participants					
I feel like I have the necessary resources at hand to coach/teach participants on how to best manage their diabetes					
I feel like I have an established relationship with my participants' PCPs so that shared communication on diabetes management is available					

Results

- Wellness Nurses surveyed felt:
  - Unsure if they would be made aware of a new diagnosis of diabetes
  - Most of their residents did not manage their diabetes well
  - They could potentially help educate/coach residents on diabetes but did not have the resources to do so readily available
  - Did not have a strong relationship with residents' PCPs

Discussion

- 3/5 participants have been living w/ diabetes > 10 years and already have methods to manage their diabetes
- Wellness Nurses surveyed felt they could potentially help educate/manage residents' diabetes but did not have the tools/resources to do so.
- Wellness Nurses have access to central, on-line portal which could be used to store Diabetes Self-Management Tool and educational material
- Recruitment was challenging. > 5 individuals with diabetes were identified, however after learning of the project, were unwilling/uninterested in participating

Limitations

- Small sample size
- Focused on one SASH site
- Individuals who could potentially benefit most from intervention were not enrolled
- Did not include pre-diabetics

Conclusions

- Diabetes Self-Management program was most useful to individuals with new diagnoses of diabetes
- Self-Management could be most useful among non-compliant diabetics, however participation was voluntary and those individuals could be resistant to participating in a program
- SASH Wellness Nurses have a need for diabetes education and management materials
- Diabetes Self Management Tool will be stored in central electronic repository for Wellness Nurses to use for newly diagnosed diabetics or those requiring further education/support in their management

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