2017 Grantee

Offering Nutrition-Focused Diabetes Self-Management in Pennsylvania

Summary:

To address patient care beyond the clinic walls, Health Promotion Council of Southeastern Pennsylvania, Inc. offered a multi-component, home-based intervention to improve health outcomes at the patient level, and reduce health care costs at the system level, for adults 65 and older with Type 2 Diabetes.

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Stanford Self-Efficacy for Diabetes Survey

Survey to measure participant confidence with activities related to nutrition, health, and diabetes self-management.

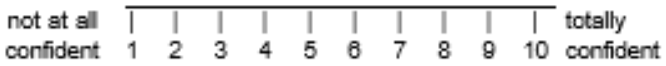
SMRC
Self-Management
Resource Center

Self-Efficacy for Diabetes

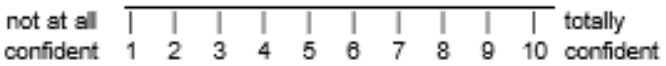
We would like to know how confident you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly at the present time.

1. How confident do you feel that you can et your meals every 4 to 5 hours every day, including breakfast every day?

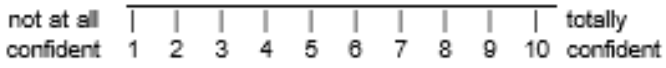
2. How confident do you feel that you can follow your diet when you have to prepare food with other people who do not have diabetes?



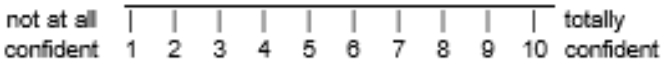
3. How confident do you feel that you can choose the appropriate foods to eat when you are hungry (for example snacks)?



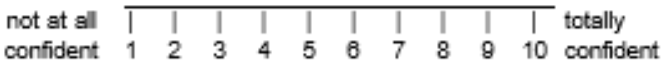
4. How confident do you feel that you can exercise 15 to 30 minutes, 4 to 5 times a week?



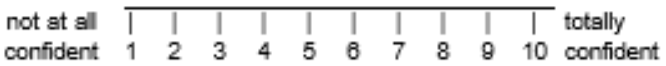
5. How confident do you feel that you can do something to prevent your blood sugar level from dropping when you exercise?



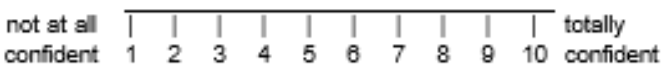
6. How confident do you feel that you know what to do when your blood sugar level goes higher or lower than it should be?

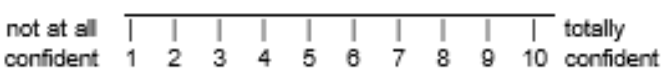


7. How confident do you feel that you can judge when the changes in your illness mean you should visit the doctor?



8. How confident do you feel that you can control your diabetes so that it does not interfere with the things you want to do?





Scoring

The score for each item is the number circled. If two consecutive numbers are circled, code the lower number (less self-efficacy). If the numbers are not consecutive, do not score the item. The score for the scale is the mean of the six items. If more than two items are missing, do not score the scale. Higher number indicates higher self-efficacy.

Characteristics

Tested on 186 subjects with diabetes.

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No. of items	Observed Range	Mean	Standard Deviation	Internal Consistency Reliability	Test-Retest Reliability
8	1-10	6.87	1.76	.828	NA

Source of Psychometric Data

Stanford English Diabetes Self-Management study. Study reported in Lorig K, Ritter PL, Villa FJ, Armas J. Community-Based Peer-Led Diabetes Self-Management: A Randomized Trial. The Diabetes Educator 2009; Jul-Aug;35(4):641-51.

Comments

This 8-item scale was originally developed and tested in Spanish for the Diabetes Self-Management study. For internet studies, we add radio buttons below each number. There is another way that we use to format these items, which takes up less space on a questionnaire, shown also in the PDF document. This scale is available in Spanish.

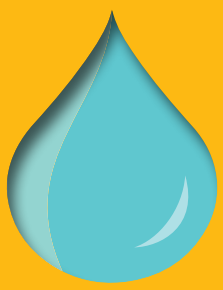
References

Unpublished.

Summary Brief

Snapshot of project and findings.

ORGANIZATION:
Health Promotion Council
TAKING CHARGE OF DIABETES



ABOUT US

Health Promotion Council of Southeastern Pennsylvania, Inc., a nonprofit corporation, was founded in 1981 to implement community-based hypertension education and control programs. Known then as Southeastern Pennsylvania High Blood Pressure Control Program and funded by the Pennsylvania Department of Health, it was as part of a national hypertension control effort organized by the National Heart Blood and Lung Institute (NHLBI). When NHLBI disease control efforts broadened to include cholesterol and tobacco control, HPC took on these additional disease prevention concerns and changed its name accordingly.

PROJECT PURPOSE

- To address patient care beyond the clinical walls by offering a multi-component, home-based intervention to improve health outcomes at the patient level and reduce health care costs at the system level for adults 65+ with Type 2 Diabetes.

PROJECT LENGTH

- Two years

KEY PARAMETERS

- **Population targeted:** Adults age 65+ with Type 2 Diabetes
- **Geographic setting:** Urban
- **Service delivery setting:** Clinical and community based
- **Services offered:** Medical nutrition therapy (MNT), personal health coaching that included nutrition education in the form of personalized shopping and cooking instruction, and linkages to additional community resources out of the clinical setting, into the patient's home or preferredbcommunity location.
- **Number of staff/FTEs dedicated to innovation project:** 14 staff/total of 4.65 FTE
- **Total grant funds received:** $250,000
- **Total project period:** Two years (2017 – 2019)
- **Total funding leveraged from organization (cash/in-kind):** $82,304 in-kind

PROJECT COMPONENTS

- Partnership between two hospitals (Thomas Jefferson University Hospital and Jefferson Health) and the Health Promotion Council
- Provision of nutrition services including Medical Nutrition Therapy and nutrition education
- Provision of an evidence-based self-management intervention – Diabetes Self-Management Program (DSMP)
- Establishment of a referral network established to support diet-related programmatic supports (i.e., Food Stamps, emergency food supplies, targeted meal delivery services aligned with dietary needs, etc.)

SUCCESSES AND LESSONS LEARNED

Partnerships

- Sub-contract and BAA agreements needed to be submitted at the time of IRB submission, thus all documents had to be finalized simultaneously. Given that this process took significantly longer than expected, a lesson learned for startup projects is to include a minimum of 6 months to foster new relationships, learn institutional legal and contract restrictions/requirements, and write, submit and receive approval of IRB documentations.
- Partnership with local community organizations has been instrumental to this program as they are deeply connected with the community and understand the needs, challenges, and resources available to participants. Community partners were invited to join Taking Charge of Diabetes Advisory Group. Each of these partners were integrated in the program to receive referrals from enrolled participants in order to provide additional services including access to nutritious food, health insurance, prescription assistance, transportation, and housing assistance.

Data Access and Billing

- Integrating the registered dietitian as a hospital employee and the Health Coach as a community organization employee will allow better integration of roles while efficiently servicing the patient, the hospital and the community.
- Consider having a robust system to access medical records and health insurance billing structure for all partners involved in the project to facilitate referral, scheduling and loop back to medical provider.
- Understanding MNT billing system for different health insurance plans was a significant undertaking. It is important to have the knowledge MNT billing best practices and health insurance plan implications including reimbursement policies of all insurers to identify patients that are fully covered, have co-pays or are not covered.
- It would be imperative to have access to medical records with future programs in order to complete medication adherence evaluations and facilitate loop back to medical provider.

Patient Recruitment and Enrollment

- Data requests should include as many exclusion criteria as possible and driven by the capabilities of the HIT system you are using. For example, any data within Epic that is placed in a structured data field could be used. For example, knowing the patients' primary language spoken, patients requiring an interpreter, diagnosis of dementia (as well as all the variations of dementia), identification of dementia medications, and limiting patient population to only zip codes within acceptable distance for the intervention. The primary and secondary admission or discharge diagnoses are not helpful since they often do not reflect the full scope of why the patient was in the hospital or emergency room (ER).
- In the age of caller identification (CID), most people do not answer their phones when they do not recognize the number. Future considerations to address this should include having a specific phone number that identifies the caller by contactname (for example "Jefferson") or agency name (for example "Health Promotion Council"). Another solution would be to utilize text messages as individuals may be more likely to read a message before deleting.

PROJECT IMPACT

- Taking Charge has a strong potential to inform future public health practices and community-clinical partnerships for the delivery of health care services to the aging and nutrition community. Emphasis was focused on understanding the importance of planning, funding, technology, health insurance billing, data sharing, partnership and staffing needs in order to complete this innovation project.

ADVICE TO PEERS

Organizations seeking to replicate this project will need to have demonstrated knowledge of and expertise in delivering nutrition services for older individuals, as well as a proven track record of successfully administering nutrition programs within the Older Americans Act aging services network.

Funding

- Be sure to factor into overall budget or consider applying for additional funding elsewhere to cover the costs of any needed project planning time. The time needed to get a project off the ground can be significantly longer than anticipated depending on legal/contracting processes, IRB application and review, and other unanticipated institutional restrictions.

Technology

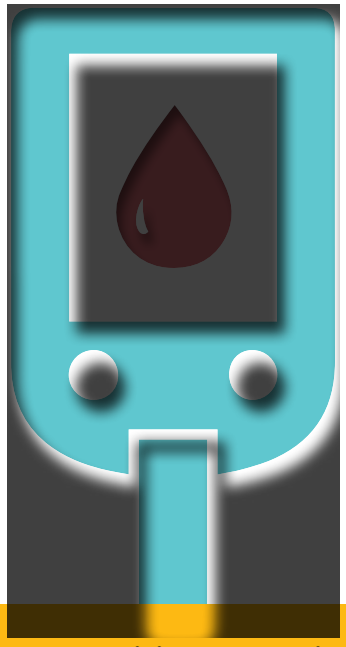
- Consider providing in-home health education using telehealth. Technology can potentially be used to do both individual and group activities/classes.
- Consider having a robust system to access medical records and billing system for all partners involved in the project to facilitate referral, scheduling and loop back to provider.

Partnership

- Partner with an organization or health care institutions that has RDs who can provide MNT and capability for billing services already in place.
- Partner with a local community organization as they are deeply connected with the community and understand the needs, challenges, and resources available to patients.

Staffing

- Staffing would require a program coordinator to manage the communication needed for all the moving pieces and partnerships involved as well as ensuring services are provided as proposed.
- Consider integrating the RD as a hospital employee and the health coach as a community organization employee allowing better integration of roles and servicing the patient, the hospital and the community.



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