CURRENT STATE OF DELIVERING SELECTED PREVENTION SERVICES

DIABETES SELF-MANAGEMENT PROGRAM

- *Data on glycemic control provide sufficient evidence that self-management education is effective in community gathering places for adults with type 2 diabetes*
- *The Diabetes Self-Management workshop is given 2½ hours once a week for six weeks, in community settings such as churches, community centers, libraries and hospitals.*
- *Six months after the workshop, participants show significant improvements in depression, symptoms of hypoglycemia, communication with physicians, healthy eating, and reading food labels. They also had significant improvements in patient activation and self-efficacy.*
- *Geared towards people with type 2 diabetes and their care givers.*
- *Covers several diabetes specific topics including blood sugar goals, sick day guidelines and foot care.*
- *Delivered by lay educators and provided at no cost.*
- *Offered by Area Agencies on Aging and CT Community Care.*
- *Delivered in churches, senior centers, senior housing, libraries, etc.*
- *Offered in both English and Spanish.*

DIABETES SELF-MANAGEMENT EDUCATION & SUPPORT PROGRAM:

- *Hospital based program administered by Certified Diabetes Educators either individually or in a group settings.*
- *There are 26 sites in Connecticut that offer DSMES with AADE/ADA recognition.*
- *3 non hospital programs include 1VNA, 1 rehab facility and 1 CT Community Care Inc.*
- *Medicare and CT based insurance covers 10 hours of diabetes self-management training (DMST) plus 3 hours of medical nutrition therapy (MNT) in the first year then 2 hours of DSMT and 2 hours of MNT per calendar year in subsequent years. Requires referral from treating physician, nurse practitioner, clinical nurse specialist or physician assistant*
- *13,767 participants have attended hospital based programs since 2014.*

DIABETES PREVENTION PROGRAM:

- *Based on many peer-reviewed studies and recognized by the CDC as a lifestyle change program encouraging 5-7% weight loss and increased physical activity.*
- *It is a year-long program: 16 weekly sessions and eight months of bimonthly sessions.*
- *There are DPP online programs available (evidence less understood than the in-person programs).*
- *The evidence based DPP has shown 58% reduction in progression to diabetes using an intensive lifestyle intervention when compared to Metformin with a 31% reduction.*
- *In CT, administered by the YMCAs, Fairfield HD, St. Francis and Hartford Hospitals (employee health plan) and Origin Fitness (a Naturopath office).*
- *Requires a minimum of eight participants for group based sessions.*
- *Key challenge is filling the classes or meeting the participant's requirement.*
- *Data is collected by the CDC (in order to maintain recognition as a certified site) and it is sent to the State twice a year.*
- *Referrals from PCP clinicians are very helpful to engage the patient*
- *Services provided by trained health coaches (CHW's, Nurse*)

ASTHMA HOME ASESSMENT AND SELF-MANAGEMENT EDUCATION (***Putting on AIRS***):

- *Local Health Departments deploy services for home visits upon receipt of referrals from providers, emergency departments and school nurses.*
- *Intervention includes three home visits in the course of six months including self-management education education and environmental triggers remediation.*
- *An Environmental Specialist conducts the environmental assessment of the home with the family to identify asthma triggers and give recommendations on how to eliminate or reduce triggers in the home.*
- *An Asthma Education Specialist conducts asthma education and reviews prescribed medications, its usage and how to properly administer them.*
- *Follow-up phone calls are conducted with the client/family/caregiver at two-weeks, three and six month intervals.*
- *Field staff provides reports back to primary care providers with information about recommendations given at home. Feedback to providers includes control status, medication and overall self-management.*
- *The program criteria requires participants' asthma severity as being classified as being "poorly controlled" upon entrance and targets participation of 75% children and 25% adults.*

CURRENT STATE OF DELIVERING SELECTED PREVENTION SERVICES

- *All protocols have been recently revised to conform with latest CDC Community Guide recommendations.*
- *Six Local Health Departments (Central CT, Waterbury, Stratford, Milford, Ledge Light and Northeast) implement the Putting on Airs program at no cost to the client and offer near state-wide coverage.*
- *Patient volume between 2007 and 2015 is about 1,400-2,000 (to be confirmed) patients served. About 150 patients per year.*
- *The CDC measures success if client has participated in 60% of the program- determined by the state of CT to be 3 visits.*
- *Middlesex Hospital also runs an asthma home visiting program, providing in part services to areas of the state that Putting on AIRS does not cover. Participants are mostly ED utilizers in their hospital.*

SELF-MONITORED BLOOD PRESSURE:

- *Patients are trained to use validated, and usually automated, blood pressure measurement devices on a regular basis in familiar settings, usually at home.*
- *Patients are provided a home blood pressure device to monitor their readings.*
- *A QI expert works with health system staff on developing protocols to implement SMBP into routine practice and trains staff on methods to train and provide support to patients (e.g. motivational interviewing)*
- *The patient population that benefits most from SMBP are those with uncontrolled hypertension, however health systems may choose to identify other at-risk population subsets such as smoking or overweight patients.*

MEDICATION THERAPY MANAGEMENT:

- *Individual consultation with community based pharmacist by patients with uncontrolled hypertension and medication adherence concerns.*
- *MTM Services provided by MTM certified community pharmacists following evidence-based guidelines.*

CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS:

- *Evidence based self-management program developed by Stanford University.*
- *Series of workshops presented by non-medical leaders that engage participants in learning how to manage their chronic disease (including hypertension) with the goal of better health outcomes.*

CHECK. CHANGE. CONTROL. PROGRAM:

- *Evidence based program designed to eliminate high blood pressure as a health disparity and achieve the goal of improving cardiovascular health by 20%, while reducing cardiovascular mortality by 20% by 2020 (AHA 2020 Impact Goal)*
- *Currently being implemented in two churches in Bridgeport & Waterbury.*

MILLION HEARTS LEARNING COLLABORATIVE:

- *A Community System of Care for Hypertension in Bridgeport area.*
- *Optimus Health Center in Bridgeport uses community outreach methods to locate patients with undiagnosed and uncontrolled hypertension.*
- *People within high-risk Bridgeport neighborhoods are screened for high blood pressure.*
- *Those screened with BP over 140/90 are referred to primary care for clinical support.*
- *Optimus patients and Bridgeport Pharmacy clients with uncontrolled hypertension and/or medication adherence concerns are identified and offered Medication Therapy Management services.*
- *Optimus patients are also offered self-monitored blood pressure support.*
- *DPH and local partners identify individuals in the community with undiagnosed hypertension and refer them to care*
- *Health coaches/CHWs/Patient Navigators and other community resources provide support for home blood pressure monitoring to promote self-management.*
- *Uses a data collection system to track referrals and patient outcomes and link with EHRs and a health information exchange.*

WISEWOMAN PROGRAM:

- *DPH Integrated program with the National Breast and Cervical Cancer Early Detection Program.*
- *Offers hypertension screening and self-management supports for women aged 40-64 participating in the NBCCEDP.*
- *Provides low-income, under-insured or uninsured women with chronic disease risk factor screening, referral to lifestyle programs, and referral services for the prevention of cardiovascular disease.*
- *Eleven healthcare organizations in CT participate in the WISEWOMAN program.*