The Power of Communication: Empowering and Engaging Patients as Partners in Managing Care Decisions

Friday, September 19, 2014
12:00 – 1:00 pm ET

Sponsored by Merck Foundation

www.alliancefordiabetes.org
The Alliance to Reduce Disparities in Diabetes aims to help decrease diabetes disparities and enhance the quality of health care by improving prevention and management services.

- National program founded and supported by the Merck Foundation.
- Launched in 2009.
- Developed and implemented comprehensive, evidence-based diabetes programs that:
  - Applied proven, community-based and collaborative approaches
  - Enhanced patient and HCP communications
  - Mobilized community partners
  - Disseminated important findings
  - Increased policy maker awareness at all levels of changes to reduce health care disparities in diabetes
  - Promoted collaboration and information exchange
Agenda

- Welcome and Introductions
- Finding the Time: Integrating Community Health Workers Into Clinical Care Teams to Improve Patient Connections
- Empowering Patients: Using Shared-Decision Making to Build Trust and Activate Patients
- Ensuring Resonance: Building Culturally-Tailored Interventions to Reach Patients
- Panel Discussion: The Value Proposition for Taking Time to Talk: Empowering Patients by Placing Them at the Center of the Care Team
- Audience Q&A
- Closing Remarks
Alliance to Reduce Disparities in Diabetes

Kavita K. Patel MD, MS

Engelberg Center for Health Care Reform
The Brookings Institution
kpatel@brookings.edu
Affordable Care Act – Innovation?
Key Reforms

- Persons with diabetes no longer denied insurance or forced to pay higher premiums
- Focus on prevention and wellness tools
- Access to coverage with potential for subsidies and essential health benefits
- No lifetime limits on benefits
- Young adults can stay on plans up to age 26
- Increased focus on chronic diseases
  - CMMI
  - Private payers
  - ACOs, PCMH, etc
Free Preventive Care

- Type 2 screening
- Obesity screening and counseling
- Nutrition counseling (for diabetics)
- BP Screening
- Gestational Diabetes screening
Patient Engagement and Why it Matters

- Payment Efforts
- Delivery system reforms
- Shift to person-based care from provider-based care
- Shared Decision-Making
The Problem

• A few years ago, the practice held a series of focus groups with their patients. They were surprised to learn that their patients’ primary concern was being unable to navigate across the silos of their medical care.
• Specifically, patients expressed difficulty coordinating care when they were referred out to a specialist.
• Each physician they saw would change medications and when the patient experienced problems, they didn’t know which doctor to contact.
The Solution

- Meaningful patient engagement
- Meaningful patient engagement
- Meaningful patient engagement
- Meaningful patient engagement
- Need I say more???
Thank You
kpatel@brookings.edu
Kavita Patel, MD, MPH
Managing Director, Clinical Transformation and Delivery, Engelberg Center for Health Care Reform, The Brookings Institution

Erin Kane, MD
Family Physician, Baylor Community Care
Medical Director, Chronic Disease Project and Community Care Navigation

Monica Peek, MD, MPH
Assistant Professor, Section of General Internal Medicine; Associate Director, Chicago Center for Diabetes Translation Research, University of Chicago

Megan Lewis, PhD
Director, Patient & Family Engagement Research Program Center for Communication Science, RTI International
Finding the Time: Integrating Community Health Workers Into Clinical Care Teams to Improve Patient Connections

Erin Kane, MD
Baylor Scott and White Health Care System
Project Setting

Baylor Community Care

- 5 clinics throughout Dallas/Fort Worth
- Low-income, uninsured patients with chronic diseases
- 35% of patient population with a diagnosis of diabetes
- Limited access to formal CDE led diabetes education programs

Goal: To optimize primary care for “at-risk” patients with diabetes

  • Tactics:
    - Embed community health workers within the patient centered medical home
Patient Demographics

**Age**
- 19-44
- 45-64
- 65+

**Education Level**
- Less than High School
- High School/GED
- Trade
- College

**Ethnicity**
- White
- African American
- Hispanic
- Other

**Primary Language**
- English
- Spanish
- Other
Community Health Worker led diabetes self management education

- 1:1 visits, included family members
- 6 visits over 1 year
- Protocol based teaching

CHW requirements

- Medical assistant background
- 160 hour CHW certification classes
- American Academy of Diabetes Educators Level 1 training
Community Health Workers

- Trusted peer
- Bilingual
- Frequent contact with patient, very accessible
- Protocols focus on:
  - Medication adherence
  - Understanding disease and complications
  - Lifestyle changes: diet, exercise
  - Improving patients’ confidence in managing their disease

Enables providers to task-shift these topics to CHWs.
Integration of Responsibilities

**DHP Responsibilities**
- Diabetes education
- Assess barriers
- Follow-up
- Basic patient care duties

**PCP Responsibilities**
- Have confidence in DHP
- Verbalize support
- Shadow DHP, review protocol
- Be available

**Patient Responsibilities**
- Comply with lifestyle modifications & med mgmt
- Participate in intervention
- Share info about health status

**Facilitators**
- Strong PCP-DHP relationship
- Direct communication (EMR and in-person)
- Time
- Training and support

- Cultural competence
- Time to build trust
- Team approach
- Motivation
- Open communication
DEP patients with at least 2 measures within specified period were included in the analysis. Visits listed are quarterly. The most recent measure was used. Data source is the registry used for the DEP. Data extracted January 6, 2014.
A Population View: Glycemic Control Improves

DEP patients with at least 2 measures within specified period were included in the analysis. Visits listed are quarterly. The most recent measure was used. Data source is the registry used for the DEP. Data extracted January 6, 2014.
Self-Management Confidence Improves

**Perceived Competence in Diabetes**

The *Perceived Competence Scale for Diabetes* (PCSD, Geoffrey C. Williams) is a 4-item questionnaire measured on a 7-point scale that evaluates how confident and capable a patient believes he/she is able to manage and control his/her diabetes. **The questionnaire:**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel confident in my ability to manage my diabetes</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2. I am capable of handling my diabetes now</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3. I am able to do my own routine diabetic care now</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>4. I feel able to meet the challenge of controlling my diabetes</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

*A person’s score on the PCS is calculated by averaging his/her responses on the four items.*

**DEP patients had significantly higher scores on the PCSD one year post-baseline. The mean PCSD score increased from 22.53 to 24.18 (n= 342, p<.0001).**
• DEP participants, compared to control group, had:
  – Reduction in mean hospital encounters
  – Reduction in mean hospital length of stay
  – Reduction in mean cost per inpatient encounter
  – No observed changes in mean emergency department encounters or costs

• Toolkit in development:
  www.diabetestoolkit.org
Empowering Patients: Using Shared-Decision Making to Build Trust and Activate Patients

Monica E. Peek, MD, MPH
University of Chicago
Section of General Internal Medicine
Chicago Center for Diabetes Translation Research
SDM Domains

Information Sharing → Deliberation → Decision Making/Implementation
SDM and Diabetes Outcomes

- SDM is central to the **chronic care model**
- SDM correlates with **positive health indicators**
  - Better diagnostic accuracy, informed consent
  - Improved glucose control, lowered BP, shorter hospitalizations
  - More efficient visits, fewer malpractice claims, less doctor-swapping
  - Potential mxns: self-efficacy, pt satisfaction, adherence, trust and pt understanding
- **Implications for the Patient Centered Medical Home**
  - Average physician has 160,000 patient interviews
Patient Empowerment

Our patient empowerment program is an intensive, ten-week series of classes at our partner clinics. The program combines culturally-tailored, evidence-based diabetes education with skills training in communication and shared decision-making, a process whereby patients are equal partners in determining their treatment plans.

The goals of our patient classes are to:

1. Increase patient knowledge of diabetes;
2. Help patients acquire necessary skills in diabetes management;
3. Support patients as they try to live healthier lives with diabetes, both in the classroom and via community resources;
4. Empower patients to take a more active role with their physician in making decisions about their health care, by effectively communicating their treatment preferences and addressing barriers to shared decision-making.

Sheila Harmon, RN CDE was a key contributor to developing the Diabetes Empowerment Program. She loves seeing patients’ excitement when they make lifestyle changes and see results. “This Empowerment Curriculum fits in with what I believe,” says Sheila. “You may have diabetes but it doesn’t have to have you. You are Victorious!” Sheila is Regional Operations Manager for the Near South Region of Access Community Health Network.

Related Content

Our patient empowerment classes have had great success. See our relevant publications for more detail.

- "Culturally tailoring patient education and communication skills training to empower African-Americans with diabetes." Forthcoming in Translational Behavioral Medicine

IMPROVING DIABETES CARE AND OUTCOMES ON THE SOUTH SIDE OF CHICAGO
The Chronic Care Model

Community Partnerships

Quality Improvement

Community Health Systems

Patient

Practice Team

Productive Interactions

Provider Training

Patient Activation
SDM/Patient Activation: Diabetes Empowerment Program

- Patient communication training
  - Culturally tailored diabetes education
  - Shared decision-making
  - Weekly staff-led classes

- SDM
  - Interactive Education
  - Video, Game, Role-Play

- Improvements:
  - Confidence
  - Behaviors
  - Diabetes control

- [www.southsidediabetes.org](http://www.southsidediabetes.org)
# Results: Diabetes Self-Management

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Time Point</th>
<th>Adjusted Mean</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes Self-Efficacy (0-100 scale)</strong></td>
<td>Baseline</td>
<td>68.8</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>80.4</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>78.4</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>6-month Follow Up</td>
<td>80.1</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td><strong>Follows an Eating Plan (0-7 days)</strong></td>
<td>Baseline</td>
<td>4.1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>4.6</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>4.6</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>6-month Follow Up</td>
<td>4.3</td>
<td>0.28</td>
</tr>
<tr>
<td><strong>Exercise (0-7 days)</strong></td>
<td>Baseline</td>
<td>3.3</td>
<td>-</td>
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<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>3.7</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>3.1</td>
<td>0.45</td>
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<tr>
<td></td>
<td>6-month Follow Up</td>
<td>3.6</td>
<td>0.14</td>
</tr>
<tr>
<td><strong>Blood Sugar Testing (0-7 days)</strong></td>
<td>Baseline</td>
<td>4.5</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>5.4</td>
<td>&lt;.0001</td>
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<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>5.1</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>6-month Follow Up</td>
<td>4.8</td>
<td>0.24</td>
</tr>
<tr>
<td><strong>Self Foot Care (0-7 days)</strong></td>
<td>Baseline</td>
<td>4.5</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>5.2</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>5.5</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>6-month Follow Up</td>
<td>5.8</td>
<td>&lt;.0001</td>
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</table>
Results: Shared Decision-Making

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Time Point</th>
<th>Adjusted Mean</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision-Making Confidence (0-100 scale)</td>
<td>Baseline</td>
<td>85</td>
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<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>94.3</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>94.2</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>6-month Follow Up</td>
<td>92.4</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Physician SDM (0-100 scale)</td>
<td>Baseline</td>
<td>74.6</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>77.6</td>
<td>0.12</td>
</tr>
<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>75.4</td>
<td>0.72</td>
</tr>
<tr>
<td></td>
<td>6-month Follow Up</td>
<td>80.2</td>
<td>0.02</td>
</tr>
<tr>
<td>Patient SDM: Information Sharing (0-100 scale)</td>
<td>Baseline</td>
<td>76.6</td>
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<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>80.6</td>
<td>0.17</td>
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<td>3-month Follow-Up</td>
<td>78.8</td>
<td>0.46</td>
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<tr>
<td></td>
<td>6-month Follow Up</td>
<td>86.5</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Patient SDM: Decision Making (0-100 scale)</td>
<td>Baseline</td>
<td>34.4</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>42.6</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>44.5</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>6-month Follow Up</td>
<td>41.9</td>
<td>0.048</td>
</tr>
</tbody>
</table>

*Patients' Perceived Involvement in Care, Scale 1
* Patients' Perceived Involvement in Care, Scale 2
# Results: Health Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Time Point</th>
<th>Adjusted Mean</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1c</strong></td>
<td><strong>Baseline</strong></td>
<td>8.8</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>8.4</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>8.3</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>6-month Follow Up</td>
<td>8.6</td>
<td>0.32</td>
</tr>
<tr>
<td><strong>HDL</strong></td>
<td><strong>Baseline</strong></td>
<td>52.2</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>52</td>
<td>0.71</td>
</tr>
<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>52.9</td>
<td>0.40</td>
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<tr>
<td></td>
<td>6-month Follow Up</td>
<td>54.1</td>
<td>0.02</td>
</tr>
<tr>
<td><strong>Self-Reported Physical Health (0-100 scale)</strong></td>
<td><strong>Baseline</strong></td>
<td>38.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>40</td>
<td>0.16</td>
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<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>40.7</td>
<td>0.04</td>
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<tr>
<td></td>
<td>6-month Follow Up</td>
<td>39</td>
<td>0.92</td>
</tr>
<tr>
<td><strong>Self-Reported Mental Health (0-100 scale)</strong></td>
<td><strong>Baseline</strong></td>
<td>46.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10-week Follow-Up</td>
<td>48.6</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>48.1</td>
<td>0.048</td>
</tr>
<tr>
<td></td>
<td>6-month Follow Up</td>
<td>48.8</td>
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<tr>
<td><strong>SBP</strong></td>
<td><strong>Baseline</strong></td>
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<td>10-week Follow-Up</td>
<td>133.6</td>
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<tr>
<td></td>
<td>3-month Follow-Up</td>
<td>137.6</td>
<td>0.29</td>
</tr>
<tr>
<td></td>
<td>6-month Follow Up</td>
<td>134</td>
<td>0.71</td>
</tr>
</tbody>
</table>
Cultural Tailoring in the DEP

- Storytelling and testifying
- Group goal setting
- Family/social network included
- Modify traditional diets
- Community resources
- “Who Wants to Have a Say in Their Health Care?” game
- Shared Decision-Making video
“It changed how I interact with the doctor… by me seeing the video, I did have the presence of mind to at least ask, ‘What is this [medication] for? How often should I take it?’” [Film]

“They kind of built me up… we’d be like we’re at a doctor’s session … and then she would say things that she know is not right either, but then she wants to know are we going to catch on to it and just let it go or will we just speak up? … sometimes you don’t be wanting to question your doctor and it be kind of hard, especially if you really like them and stuff. So, she was just like building us up so that you’ve got to be able whether you like the doctor or not.” [Role play]  

Peek ME, Harmon SA, Scott SJ, Eder M, Roberson TS, Tang H, Chin MH.

Raffel KE, Goddu AP, Peek ME.
"I Kept Coming for the Love": Enhancing the Retention of Urban African Americans in Diabetes Education. 
Diabetes Educ. 

“I Kept Coming for the Love”
Enhancing the Retention of Urban African Americans in Diabetes Education

Purpose
The purpose of the study was to investigate how retention strategies employed by the Diabetes Empowerment Program (DEP) contributed to retention.

Methods
An experienced moderator conducted in-depth interviews (n = 7) and 4 focus groups (n = 29) with former DEP participants. Interviews were recorded, transcribed, and coded using iteratively modified coding guidelines. Results were analyzed using Atlas.ti 4.2 software.
Building a SDM Foundation

- **Empower patients (Pt/MD relationship)**
  - Let them know you value their opinion (and why)
  - Tell them about the “3Ds” (Discuss, Debate, Decide)
  - Increase their expectations about involvement in care (partners)
  - Chronic SDM: multiple micro-decisions to revisit over time

- **Address uncomfortable barriers**
  - Trust
  - Perceived discrimination
  - Cultural differences

- **Involve support staff (organizational culture)**
  - Staff meetings
  - Resources in waiting room (SDM video, posters/flyers)
  - Pre-visit coaching by LPN, MA (goals for discussion, 2 key questions)
  - Diabetes/health educator; incorporate SDM messages/skills
Acknowledgements

- Marshall Chin
- Monica Peek
- Tonya Roberson
- Anna Goddu
- Molly Ferguson
- Nora Geary
- Deb Maltby
- Yolanda O’Neal
- Kristine Bordenave
- Michael Quinn
- Doriane Miller
- Lisa Vinci
- Andrew Davis
- Elbert Huang
- Nyahne Bergeron
- Jonathan Dick
- Shantanu Nundy
- Seo Young Park
- Neha Setha
- Emily Lu
- Robert Sanchez
- Deborah Burnet
- Karen Kim
- Dawnavan Davis
- Sheila Harmon
- Daniel Rowell
- Yue Gao
- Sang Mee Lee
- Julie Whyte
- Chef Brian Alston
- Shelley Scott
- Mickey Eder
- Peggy Hasenauer
- Louis Philipson
- Marla Soloman
- Hui Tang
- Robert Nocon
- Katie Raffel
- Ndang Azang-Njaah
- Gwen Burrows
- Braunda Anderson
- Melishia Bansa
Ensuring Resonance: Building Culturally-Tailored Interventions to Reach Patients

Megan Lewis, Ph.D.
Alliance Model

- Individualized programs addressed the unique needs of each community and prioritized the needs of the most vulnerable community members.
Did clinical outcomes improve?

<table>
<thead>
<tr>
<th></th>
<th>% in Good Control</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1c</strong></td>
<td></td>
</tr>
<tr>
<td>Program Participants</td>
<td>33***</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>37</td>
</tr>
<tr>
<td><strong>Blood pressure</strong></td>
<td></td>
</tr>
<tr>
<td>Program Participants</td>
<td>37***</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>39</td>
</tr>
<tr>
<td><strong>LDL cholesterol</strong></td>
<td></td>
</tr>
<tr>
<td>Program Participants</td>
<td>54</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>57</td>
</tr>
</tbody>
</table>

First  Last

*** p < 0.001
Did patient-reported outcomes improve?

<table>
<thead>
<tr>
<th>Patient-reported Outcomes</th>
<th>N</th>
<th>First Mean (SD)</th>
<th>Last Mean (SD)</th>
<th>Difference Mean (SD)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSSM</td>
<td>243</td>
<td>2.50 (1.02)</td>
<td>2.79 (0.94)</td>
<td>0.29 (1.01)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>DSC</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>General diet</td>
<td>546</td>
<td>3.72 (2.04)</td>
<td>4.74 (1.79)</td>
<td>1.02 (2.23)</td>
<td>&lt; 0.001</td>
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<tr>
<td>Specific diet</td>
<td>550</td>
<td>4.04 (1.50)</td>
<td>4.57 (1.51)</td>
<td>0.53 (1.68)</td>
<td>&lt; 0.001</td>
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<tr>
<td>Exercise</td>
<td>552</td>
<td>2.63 (2.11)</td>
<td>2.94 (2.16)</td>
<td>0.31 (2.48)</td>
<td>0.003</td>
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<tr>
<td>Glucose</td>
<td>552</td>
<td>4.11 (2.27)</td>
<td>5.02 (2.07)</td>
<td>0.90 (2.53)</td>
<td>&lt; 0.001</td>
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<tr>
<td>Foot care</td>
<td>553</td>
<td>4.14 (2.50)</td>
<td>5.53 (2.02)</td>
<td>1.39 (2.56)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Smoking status N (%)</td>
<td>549</td>
<td>80 (15)</td>
<td>87 (16)</td>
<td>--</td>
<td>0.262</td>
</tr>
<tr>
<td>PACIC</td>
<td>257</td>
<td>3.47 (0.92)</td>
<td>3.98 (0.83)</td>
<td>0.51 (0.99)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>PDC</td>
<td>375</td>
<td>4.92 (1.34)</td>
<td>6.16 (0.92)</td>
<td>1.25 (1.50)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>VR-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCS</td>
<td>561</td>
<td>42.10 (10.35)</td>
<td>42.85 (10.29)</td>
<td>0.74 (8.64)</td>
<td>0.023</td>
</tr>
<tr>
<td>MCS</td>
<td>561</td>
<td>43.32 (10.88)</td>
<td>47.80 (10.89)</td>
<td>4.48 (11.99)</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>
Empowerment

- Integral across all sites and time points
- Patient-centered approach to self-management
- Comprehensive and tailored education
- Some sites coached patients on how to communicate with healthcare providers and what to expect during medical encounters

“I think a lot more people are knowledgeable about the impacts of diabetes through education classes, I think they’re more aware... I think there’s a lot more awareness about themselves, about how they play a role and how they themselves can make a difference.”

(Principal Investigator, Round 3)
Access

- All sites across all time periods increased access to self-management education
  - Classes held at different locations to overcome transportation challenges
  - Materials made more accessible by considering literacy levels and adaptation to be culturally and linguistically appropriate
  - Classes scheduled at convenient times for patients

“She’s [the diabetes education promoter] just able to be more effective in her education and advice with the patients. She understands them, she’s, you know, so it’s kind of culturally relevant, and it’s in their language and, you know, she talks about Hispanic foods in a way that, to eat healthfully and where it’s not so foreign and strange to them.”

(Clinician, Round 3)
Support

• All sites across all time periods
• Patient support groups supplemented individual education
• Family members invited to attend sessions
• Enhanced formal support outside of program setting
  • Community health workers deployed in community settings

“We go to their house, we include their family members, we encourage family members to come to the education and fitness class with them...we recognize it has to be a team effort.”

(Case Manager, Round 1)
Addressing Local Needs and Barriers

• Transportation issues, food security, distrust of health care system, lack of community resources for physical activities

• Local partnerships addressed unique barriers and supported program growth

“So we have... a structure in place that picks people up by taxis... that is so dignified and it works. Who would have thought you have to incorporate taxi fare into something like diabetes education? But you do.”

( Diabetes Educator, Round 3)
Care Coordination

- Emerged as a fundamentally important issue over time
- Referral systems, contractual agreements, and partnerships to enhance coordination
- Developed reminder systems, providers discussed program activities during medical encounters, or used tracking systems to locate people who had not attended the program
- Grantees were able to build stronger relationships between patients and providers

“We work directly in the primary care office with the primary care provider... so that same patient comes in. They discovered their hemoglobin A1C is over 10, they get a direct referral to us, which then gets them a direct referral to the DSME classes that are offered here. Before, patients would often have to wait sometimes 3 months to get an appointment with the nurse, the certified diabetes educator, and now they can get an almost immediate pass through to that.”

(Clinician, Round 3)
We asked patients to report experiences before, during and after the Alliance.

**Prior to Enrollment**
- Depression
- Poor patient-provider communication

**During Program**
- Emotional support
- Education
- Improved communication

**After the Alliance**
- Better quality of life
- Improved mental well-being
Conclusions

• The Alliance programs implemented programs that empowered patients, and changed important clinical and patient-reported outcomes.

• The process evaluation identified important practices that can be used in other programs to enhance patient empowerment.
Panel Discussion: 
The Value Proposition for Taking Time to Talk: 
Empowering Patients by Placing Them at the Center of the Care Team
Audience Q&A
Closing Remarks
The Power of Communication:
Empowering and Engaging Patients as Partners in Managing Care Decisions

Friday, September 19, 2014
12:00 – 1:00 pm ET

Sponsored by Merck Foundation