archi
Bottom line. Balanced health. Better beings.

The Atlanta Area Diabetes Collaborative

Health systems in Atlanta have made great strides in improving their patient's ability to self-manage chronic diseases like diabetes. Hospitals and clinics have robust disease management programs that have good success with the patients who are able to access those programs. However, there are many patients who are unable to access these programs due to low health literacy, lack of transportation, or comorbidities that impact single disease management.

In 2017, several health systems in metro-Atlanta completed their community health needs assessment and identified diabetes as a pressing issue for their community. Those health systems—Grady Health System, St. Joseph's Mercy Care, Wellstar, Piedmont Hospital, and Kaiser Permanente—wanted to find new ways to collaborate around diabetes and determine if a joint effort to impact diabetes at a population health level was feasible. The Atlanta Area Diabetes Collaborate was borne of this effort and the diabetes pilot was launched in 2018. The pilot was funded by the organizations within the collaborative, using a pooled funding model.

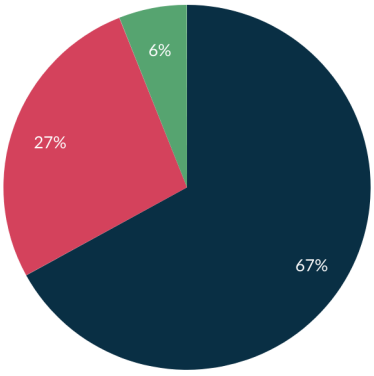
Patients recruited for this pilot were offered the opportunity to enroll in an online Diabetes Self-Management Education program and/or a telephonic coaching program focused on improving patient ability to manage diabetes while addressing the social needs that were impacting their ability to manage their health.

KEY ACCOMPLISHMENTS

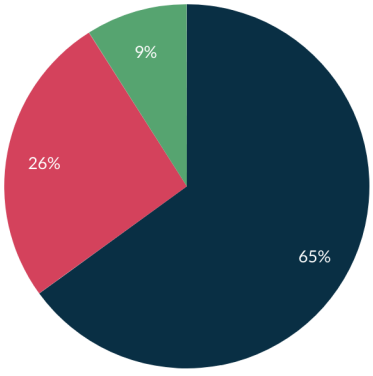
This pilot program showed that that a person-centered coaching program focused on addressing the nonclinical needs of patients is highly effective in improving clinical outcomes. Patients reported higher levels of knowledge about diabetes management and reported high levels of satisfaction with the pilot. Many reported better clinical outcomes at three months after graduation from the program. Most patients had lower A1C scores, weight, and blood pressure.

This pilot also highlighted the complex nature of patients being seen at safety-net hospitals and Federally Qualified Health Centers, with 73% of patients identifying at least one social support need and almost half (49%) identifying two or more social support needs.

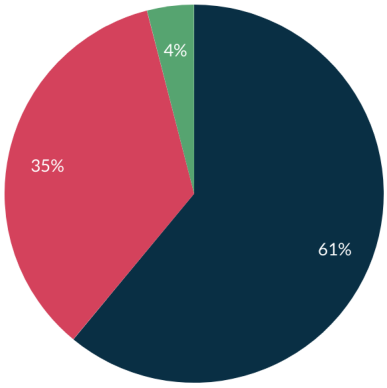
A1C at 3-months Post-Graduation



Blood Pressure at 3-months Post-Graduation



Weight at 3-months Post-Graduation



Decreased Increased No change

PATIENT FEEDBACK

Patients reported a high level of satisfaction with the pilot.

"I was using some of my medicines at certain times of the day or not using them at all because I wasn't home. She [the ARC counselor] taught me tricks about taking my meds with me so I would have them at the right time."

"She [the ARC counselor] gave me all kinds of stuff I hadn't thought about or even knew about. She was very knowledgeable about things that would help me, and she did a very good job…she stayed on it."

"Prior to working with [the ARC counselor], my exercise is only walking from home to the grocery store. But now I go 2 miles beyond the grocery store and turn back. She let me know that exercise helps with diabetes."

"I'm going to the diabetic clinic more and going to the podiatrist, but only due to the resources she gave. I'm very, very thankful."

"She explained the benefits of exercise and eating properly. That was the most important thing to me."

"Her being there for me. Answering questions that I didn't understand about my diabetes and its effects on my body. I love her. I wish I could be back talking to her."

"I told myself I could stick myself for the rest of my life or change. The only thing I knew about diabetes was the cutting off the toes. I told myself I'm going to beat this. Doctors can't believe the changes I've made."

MOVING FORWARD

There is still a lot of work to be done with respect to collaboration across health systems to target population health, but these results are promising. Identifying and removing the nonclinical barriers to health can contribute to improved health outcomes for patients who need it most. Patients reported high levels of satisfaction with the interventions offered in the pilot, which in turn resulted in better health outcomes.

For all of the findings, please see the Diabetes Interim Report, visit www.archicollaborative.org

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Atlanta Regional Collaborative for Health Improvement

404.413.0288 | info@archicollaborative.org | archicollaborative.org