Introduction:
Administration for Community Living (ACL) Innovation Grantees are requested to provide to the fullest extent possible, the following information to inform the development of dissemination, education and training materials by the ACL funded National Resource Center on Nutrition and Aging (NRCNA). These materials are intended to showcase the learnings of the inaugural recipients of ACL Innovation Grantee funding and support the replication of lessons learned across the national Aging and Nutrition network.

To complete this Capstone Assignment, respond to all of the questions below to the best of your ability in writing. All assignments should be completed in Times New Roman or Calibri font, 11 or 12 point font, and double-spaced. The due date for this Capstone Assignment is: January 1, 2020 at 5:00pm ET. Submit the assignment and any accompanying materials via email zip file to both:

Phantane Sprowls, Office of Nutrition and Health Programs, Administration for Community Living (Email: Phantane.Sprowls@acl.hhs.gov)

Uche Akobundu, Director, National Resource Center on Nutrition and Aging (uche@mealsongheelsamerica.org)

Title: Taking Charge of Diabetes

Key Innovation Project Parameters:
Provide information in response to the categories below to summarize who your ACL Innovation Grant project was meant to serve, in what type of location, in what way, leveraging what kind of staff and other resources:
Population targeted (age, demographic characteristics, etc): adults age 65+ with Type 2 Diabetes

- Geography (suburban, urban, rural): urban
- Service delivery setting: Health Promotion Council (HPC) and Thomas Jefferson University Hospital’s Primary Care Team (JPCT) and Center for Urban Health (CUH) partnered to bring 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 preferred community location.
- Staffing model/FTEs (paid/unpaid, #FTEs):
  - HPC: 0.95 paid FTE, 0.23 in-kind FTE
  - Family Food LLC (register dietitian): 3 FTE
  - JPCT: 0.32 paid FTE, 0.15 in-kind FTE
- Total grant funds received: $250,000
- Total funding leveraged from organization (cash/ in-kind): $82,304 in-kind
- Number of staff/FTEs dedicated to innovation project: 14 staff total of 4.65 FTE

Background:

The innovation challenge Taking Charge addressed the gap in care transitions for older adults, specifically for patients diagnosed with diabetes. The gap contributes to the continued decline in patient health outcomes and increases in health care costs. Taking Charge addressed patient care beyond the clinical walls 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.

Older adults are among the fastest growing age groups, with the large population born between 1946 and 1964 having started to turn 65 in 2011. According to Public Health Management Corporation’s 2015 Household Health Survey, a random digit dialed telephone survey conducted every 2 years, there are 290,795 adults over age 60 living in Philadelphia. Of these, 65% (191,416) reported having high blood pressure and 27% (78,148) reported having diabetes. In addition, 85.1% of older adults with diabetes also report having high blood pressure, 82.7% are overweight or obese, and 12.9% smoke cigarettes. Among older adults with diabetes, 58.7% are below 200% of the federal poverty level (FPL); 25% live below 100% FPL.
Summarize the suite of innovation products/solutions they identified to address the challenges noted above (what they were, and how they would address the need).

(1) **Screening and intake:** The intervention was led by HPC’s health coach and JPCT, which began with a detailed screening and intake assessment to confirm the patients’ eligibility and interest, establish framework for the program, and build rapport. In addition to patient records and information included in the referral, HPC’s health coach used the intake assessment to gather the following: food/cooking preferences, personal cooking ability, current kitchen equipment, scheduling needs, and patient background and goals.

(2) **Medical Nutrition Therapy:** Medicare MNT legislation defines MNT as “nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional”. Leveraging Medicare, patients received up to three hours of MNT, including an initial assessment session with a RD to review medical condition, medications, dietary habits, and other key nutrition factors in health self-management. Patients participated in an initial assessment and planning session, as well as additional follow up throughout the duration of the intervention.

(3) **Nutrition education:** Nutrition education sessions followed the patients’ initial assessment and communication of dietary recommendations from the RD. Nutrition education was designed to build patients’ knowledge of basic nutrition concepts as well as skills in the areas of food shopping/selection and cooking, including reading food labels, healthy preparation of foods, and basic recipe cooking. Sessions were delivered in the home or in a community setting of the patient’s preference.

(4) **Health self-management:** Stanford’s evidence-based Diabetes Self-Management Program (DSMP) is an evidence-based intervention proven to mitigate diabetes burden and reduce health care costs. Patients were referred to group-based DSMP services in their communities to further reinforce the message and engage them in assistance to successful self-management diabetes.

(5) **Referrals for Additional Diet-Related Supports:** Many of Philadelphia’s older adults face significant financial barriers to maintaining a good health. In particular, 15.3% cut a meal due to cost; 32% received food stamps. Because access to healthy food that aligns with dietary recommendations is a critical component to successful self-management of diabetes, HPC’s health coach provided additional resources based on patients’ intake assessment and as appropriate throughout the intervention. These included food security resources such as enrollment in SNAP benefits or emergency food support, as well as meal delivery services aligned with patients’ dietary needs.
Project Partners:

HPC is known for its ability to manage and foster collaborative relationships with many types of organizations, including: government, health care, social service, senior-serving, and business. HPC’s strategy for managing partnerships begins with clear and detailed MOUs/subcontracts prior to initiating shared work, and includes: regularly convening project partners to establish and maintain clarity of roles and responsibilities, as well as mutual accountability for project deliverables; communicating results from program evaluation at appropriate intervals to support continuous quality improvement and shared understanding of collective outcomes. HPC measures the effectiveness of its partnerships by conducting partnership surveys to assess communication, satisfaction with the partnership, and reciprocity. HPC will leverage expertise in convening partners to manage proposed partners and cultivate new ones, as needed.

HPC’s main partner for Taking Charge is Thomas Jefferson University Hospitals (TJUH). Thomas Jefferson University and Jefferson Health is an academic medical center dedicated to educating the health professionals of tomorrow in a variety of disciplines; discovering new treatments and therapies that will define the future of clinical care; and providing exceptional primary through complex quaternary care to patients in the communities served throughout the Delaware Valley. Specifically, within this healthcare system, HPC will work with JPCT for implementation and service delivery, and the CUH for evaluation purposes. JPCT comprises staff members from the primary care office and members of JeffCare Alliance. JeffCare Alliance is the population health division within TJUH. It includes a clinical team comprising Population Health nurse practitioners and Population Health registered nurses that are embedded in primary care offices to provide comprehensive care management for the most complex, high risk patients. The mission of CUH is to facilitate collaborative work with Jefferson Health, Thomas Jefferson University, and community partners to strengthen the capacity of diverse urban individuals, families, organizations, and communities to address issues that improve health and advance health equity.

Additional partners include Philadelphia-based organizations within the aging network, food insecurity organizations, and a meal delivery service specializing in meeting needs of individuals at acute nutritional risk due to health. Philadelphia Corporation for Aging (PCA) and Center in the Park (CIP) are two of the region’s premier organizations serving senior citizens. PCA is the nation’s fourth largest, and Pennsylvania’s largest, Area Agency on Aging; CIP is an active and vibrant community center that promotes positive aging and fosters connectivity for older adults in Philadelphia. HPC currently partners with both organizations through HPC’s ACL-administered Chronic Disease Self-Management for Older Adults and Adults with Disabilities grant, and provide Diabetes Self-Management Education (DSME) and Chronic Disease Self-
Management Education (CDSME). Coalition Against Hunger (food insecurity organization) was selected as a partner because of its over 20 years of experience providing healthy food distribution and education to Philadelphia’s vulnerable residents. Each of these partners has agreed to receive referrals from Taking Charge in order to provide additional services to participants.

**Barriers:**

**Partnerships**

- Sub-contract and BAA agreements needed to be submitted at the time of IRB submission, thus all documents had to be finalized simultaneously. EPIC reports, a healthcare software that stores patient’s medical record at Jefferson Hospital, were unable to be generated until IRB was approved. However, JPCT staff was able to report de-identified data to assist with planning efforts. Project partners met monthly and communicated frequently to ensure program progress. This challenge did not affect program goals or objectives but delayed the provision of services to participants.

- HPC was not able to receive approval as a CMS designated provider to bill Medicare for Medical Nutrition Therapy services at the time of program implementation. Thus, HPC/JPCT/HUC agreed to subcontract with Family Food LLC, a local organization that has billing capability to provide reimbursable in-home medical nutrition therapy by registered dietitians. This challenge did not affect project goals or objectives but delayed the provision of services to participants.

- Scheduling of Family Foods, LLC medical nutrition therapy sessions provided by registered dietitians, and nutrition education sessions provided by HPC Health Coach was initially challenging due to scheduling conflicts, varying availability, and staff transitions. However, upon revision of scheduling strategy, both services were conducted in separate occasions improving participant enrolment.

**Medical Data Access**

- Data sharing agreement was executed between HPC, Jefferson and Family Food LLC to ensure that data sharing platforms complied with HIPPA standards to protect patient identifiable information, and for RD and HC to share notes with medical providers. As a result of the legal restrictions to access electronic medical records (EMR) by partners outside of Jefferson Health Care System, a Taking Charge email and a File Transfer Protocol (FTP) site, a standard Internet protocol for transmitting files between computers on the Internet over TCP/IP connections, needed to be developed to allow
HPC and Family Food LLC access patient information exported from their EMR. Data collection was a significant and time-consuming challenge for the project which required staff time to conduct meetings, ensure communication and achieve a data sharing agreement among partners that would satisfy the requirements of Thomas Jefferson Institution.

- There was restricted access to medical records, impacting the ability to complete medication adherence evaluations.

**Patient Recruitment and Enrollment**

- Once IRB was approved and contract executed, the first EPIC report was run to identify patients that met the inclusion criteria for Taking Charge participation. However, the number of potential patients to be enrolled was significantly smaller than anticipated due to other research studies being conducted at Jefferson Hospital that targeted the same population. Thus, eligibility criteria for program participants was modified to increase the potential impact of the program. IRB was also modified in order to allow the research team to offer the program to additional patients.
  
  **Old criteria:** older adults aged 65+ who are diagnosed with Type 2 diabetes and are admitted at least two times to Thomas Jefferson University Emergency Department or Hospitals within a 12-month period.
  
  **New criteria:** older adults aged 65+ who are diagnosed with Type 2 diabetes and are admitted at least **one time** to Thomas Jefferson University Emergency Department or Hospitals within a **24-month period** and have at least **2 hours** of medical nutrition coverage based on their insurance plan.

- Two hundred and thirty-eight patients were identified as potentially eligible participants through EPIC. Of those, 146 engaged in conversations with Taking Charge staff. Of the 146 patients reached, 28 were interested in enrolling in the program, 15 were determined to be ineligible after discussion with the coordinator and 7 patients had deceased or moved out of their residencies. Thirty-four patients or their family members indicated they might be interested, but never called back. Other reasons for lack of interest in the program included having been recently hospitalized, deafness, lack of time, diabetes reported as already under control or taking steps to control their diabetes or being involved in similar programs or studies.

- Once the patient was contacted by research staff and informed consent was obtained, Taking Charge verified MNT hour availability based on the patient’s insurance plan. A minimum of 2 hours of MNT coverage was required to participate in Taking Charge to allow for insurance reimbursement of services provided by the Register Dietitian. Upon
insurance verification and if the patient did not have available MNT hours, Taking Charge staff communicated the ineligibility status to the patient.

- Once all patients with insurance were reviewed, the most frequent exclusion criteria were non-English speaking, dementia, residing in nursing facility and patients whose hospitalizations were not at all related to diabetes or diabetes complications for example elective orthopedic procedures. Additional issues that were not formally part of the exclusion criteria included patients living too far from Jefferson location (ex. Northeastern PA, far western PA), patients living outside of RD licensed state, and patients who had elevated glucose levels not due to diabetes (related to pancreatic cancer, high dose of steroids).

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

In the future, data requests should include as many exclusion criteria as possible. 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 ER.

In the age of cell phones, most people do not answer their phones when they do not recognize the number. This seems to be an issue in this project as well. Future considerations to address this should include having a specific phone number that identifies the caller as “Jefferson” or “Health Promotion Council”. Another solution would be to utilize text messages as individuals may be more likely to read a message before deleting.

Products:

A. One-pager/program fact sheet: provided to program and community partners for distribution to potential participants to increase outreach and awareness. Fact sheet includes the following information: overview, inclusion criteria, strategic partners and contact information.

B. Nutrition Assessment and Dietary Intake Form.

C. Morisky Medication Adherence Questionnaire.

D. Program scripts for Jefferson Center for Urban Health: to be used during initial call with eligible patients to obtain consent for participation in research study.

E. Screening Assessment Form/Eligibility Criteria Checklist.

F. Taking Charge Care Coordinator Survey.
G. Taking Charge Participant Satisfaction Survey.

H. Services checklist: to be used by Health Coach, JPCT/HUC and RD to ensure participant’s needs are being met and they are referred to appropriate community partners. Service checklist document includes the following information: resources in the area that provide DSMP programs, food assistance, housing assistance, utilities assistance, understanding and applying for medical insurance, locating a primary care provider, employment opportunities, finding a PCP, connection to social activities, physical activity opportunities, vision benefits, finding a caregiver and prescription help.

I. Recipes to be distributed to participants and be used by RD and health coach. Recipes include: whole wheat pasta alfredo, smoothies, turkey chili, grilled and roasted vegetables, salmon burgers, shrimp tacos and many others that use fruits, vegetables, whole grains, lean proteins and low-fat dairy to follow USDA guidelines.

J. Nutritional handouts to be distributed to participants and be used by RD and health coach. Handouts include the following information: MyPlate, American Diabetes Association resources, portion size, label reading and health snacks.

K. Program introduction letter: letter mailed to all eligible participants to introduce the program before contacting them by phone. Letter includes brief information on the program, recruitment process, benefits, and contact information.

L. Stanford Patient Educational Research Center’s Self-Efficacy for Diabetes survey conducted pre and post program.

M. Verbal Consent for Use/Disclosure of PHI.

Replication Tools:

The only tool that could be used to replicate the model is the “Stanford Self-Efficacy for Diabetes Survey” (Noted with letter “L” in the appendix). All other tools are specific to HPC or JPCT institutions and are not useful to replicate the model in other systems.

Outcomes:

<table>
<thead>
<tr>
<th>PROGRAMMATIC OUTCOMES</th>
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<tbody>
<tr>
<td><strong>Process Objective 1:</strong> Create a seamless care coordination system (IT, service provision, referrals; clinic to community communication etc.) for older adults aged 65+ who are diagnosed with Type 2 diabetes and are admitted at least two times to Thomas Jefferson</td>
</tr>
</tbody>
</table>
University Emergency Department or Hospitals within a 12-month period where diabetes self-management has been identified as a contributing factor.

**Indicators:**
- Referral process from IT/EPIC
- Referral process from JPCT to HPC
- Communication processes
- Referral process to partners
- Data collection and analysis

**Results:**
- Communication, reporting, referral and data collection systems were successfully developed and implemented among Jefferson Care Team, Family Food LLC and Health Promotion Council. Successful coordination remained throughout the program.
- The Institutional Review Board (IRB) application was amended to reflect changes in patient eligibility criteria to older adults aged 65+ who are diagnosed with Type 2 diabetes and are admitted at least one time to Thomas Jefferson University Emergency Department or Hospitals within a 24-month period and have at least 2 hours of medical nutrition coverage based on their insurance plan.

**Process Objective 2:** 90% of the JPCT, HPC, and CUH will report satisfaction with the care coordination system.

**Indicator:**
- Satisfaction instrument

**Results:**
- Satisfaction survey among the care coordination team was administered semi-annually.
- Results show 100% of JPCT, HPC and CUH reporting satisfaction with the care coordination system.

**Process Objective 3:** 90% of Taking Charge participants will report satisfaction with the overall program.

**Indicator:**
- Satisfaction instrument

**Results:**
- Among Taking Charge participants who completed the program, 100% reported satisfaction with the overall program.

<table>
<thead>
<tr>
<th>Process Objective 4: 80% of Taking Charge program participants will attend at least 75% of scheduled MNT sessions completed scheduled sessions</th>
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<tbody>
<tr>
<td><strong>Indicator:</strong></td>
</tr>
<tr>
<td>• # of sessions completed</td>
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<tr>
<td><strong>Results:</strong></td>
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<tr>
<td>• 80% of Taking Charge program participants attended 40% of scheduled sessions.</td>
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<tr>
<th>Process Objective 5: 90% of Taking Charge participants referred for health and social service supports (ex: food assistance; housing assistance; transportation; health insurance; prescription assistance) will contact needed service organizations.</th>
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<tbody>
<tr>
<td><strong>Indicators:</strong></td>
</tr>
<tr>
<td>• # referrals made</td>
</tr>
<tr>
<td>• # client contacts completed with community service providers</td>
</tr>
<tr>
<td>• # and type of service obtained</td>
</tr>
<tr>
<td><strong>Results:</strong></td>
</tr>
<tr>
<td>• Utilizing the tracking tools, referral protocol and forms approved by IRB, 100% of Taking Charge participants seen by the Health Coach were offered referral services, but no services were used by participants.</td>
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<tr>
<th>PATIENT CENTERED OUTCOMES</th>
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<tbody>
<tr>
<td><strong>Outcome Objective 1:</strong> 4% or less of Taking Charge of Diabetes clients will be admitted to TJUHs hospitals or Emergency Departments for diabetes medical management within 12 months of enrolling in the Taking Charge of Diabetes program.</td>
</tr>
<tr>
<td><strong>Indicator:</strong></td>
</tr>
</tbody>
</table>
- # of patients readmitted to Jefferson hospital or ED for diabetes medical management related reason

**Results:**
- EPIC report run showed a limited number of eligible participants based on inclusion criteria. Thus, the team decided to expand the inclusion criteria and eliminate the stratification process to increase the pool of eligible participants while allowing the patient to determine their engagement with the program.
- Eight patients out of thirteen who received medical nutrition therapy through Taking Charge reported to visit the ED at least once after being enrolled in the program.

### Outcome Objective 2: 90% of Taking Charge participants will demonstrate increased knowledge and self-efficacy related to healthy eating and diabetes management.

**Indicator:**
- Change in nutrition knowledge
- Change in self-efficacy

**Results:**
- Utilizing the tracking tool, protocol and instruments approved by IRB, 100% of Taking Charge participants demonstrated increased knowledge and self-efficacy related to healthy eating and diabetes management.

### Outcome Objective 3: 80% of Taking Charge participants will report positive behavior change related to healthy eating and diabetes management.

**Indicator:**
- Change in dietary habits

**Results:**
- Utilizing the tracking tool, protocol and instruments approved by IRB, 67% of Taking Charge participants reported positive behavior change related to healthy eating and diabetes management.

### Outcome Objective 4: 90% of Taking Charge participants will report Type 2 diabetes related medication adherence as prescribed.
Indicator:  
- Medical adherence

Results:  
- Due to restrictions and limitation in accessing medical records, Taking Charge was unable to assess medication adherence as prescribed.

**Outcome Objective 5:** 50% of Taking Charge participants will reduce hemoglobin A1c within 12 months

Indicator:  
- Hemoglobin A1c level

Results:  
- 56% of Taking Charge patients (whose data was available to assess) showed a reduction in hemoglobin A1c within 12 months as noted in their medical record.

**Outcome Objective 6:** 70% of Taking Charge participants will achieve at least one of their personal action plan goals (weight loss, increased physical activity, etc.)

Indicator:  
- % of participants achieving one of their personal goals

Results:  
- Utilizing the tracking tool, protocol and instruments approved by IRB, 67% of Taking Charge participants achieved at least one of their personal action plan goals (included major dietary changes to better manage diabetes).

**Impact (fiscal and non-fiscal)**

Lessons learned are the impact of this project. 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 is focused on understanding the importance of planning, funding, technology, health insurance billing, data sharing, partnership
and staffing needs to succeed in replicating Taking Charge (see details in lessons learned section)

such as increased collaboration with local health care entities/Indian Health Services, improved well-being in the OAA target population - especially those that benefit from the senior nutrition program, decreased health care utilization and/or need for costly institutional care, and increased access to benefits such as food assistance and opportunities for social connectedness.

Successful applicants will be expected to have demonstrated knowledge and a proven track record of expertise concerning the nature of nutrition for older individuals and the business of nutrition program administration within the OAA aging services network.

One Piece of Advice:

Funding:

If justifying a budget to cover the planning period is an issue, factor into overall budget or consider applying for additional funding elsewhere. Start up time can be significantly long depending on legal, contracts, IRB and other 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.

For questions you may have while completing this assignment, please reach out to:

Phantane Sprowls, Phantane.Sprowls@acl.hhs.gov

Uche Akobundu, uche@mealsonwheelsamerica.org.
Project Summary

Health Promotion Council (HPC), Thomas Jefferson University Hospital (TJUH), and their partners will execute the program Taking Charge of Diabetes (Taking Charge) to help individuals self-manage their Type 2 diabetes. The goal of Taking Charge is to improve the health outcomes and quality of life among adults age 65+ with Type 2 diabetes by establishing an innovative and replicable community-clinical integration model. Grounded in evidence showing the positive impact of medical nutrition therapy, health self-management education, and other nutrition supports (referral to community programs that provide meals, access to affordable, healthy food, diabetes education and support to find additional food resources), Taking Charge will expand health care beyond the clinical walls by providing patients with a diagnosis of Type 2 Diabetes by providing a multi-component, home-based intervention that offers patients streamlined access to a robust suite of evidence-based nutrition support.

Through Taking Charge, a Registered Dietician (RD) and Health Coach (HC) from HPC will seamlessly integrate within the TJUH primary care team to become part of TJUH’s transitions of care support. Taking Charge brings a RD and HC into the patient’s home and provides medical nutrition therapy, menu planning, cooking/shopping assistance and education and connection to community resources in their area. The RD and HC will refer patients to appropriate food resources in their area and communicate to the health care team. This creates a multi-disciplinary support team designed to improve health outcomes at the patient level and reduce health care costs at the system level.

Inclusion criteria:
- 65+
- Utilized Jefferson or Methodist ED one time in the last 24 months as a result of uncontrolled or poorly controlled Type 2 diabetes
- HbA1c >9.0%, OR
- Random glucose level >300mg/dl
- At least 2 hours of MNT coverage by health insurance plan

Strategic Partners
- Center in the Park
- Coalition Against Hunger
- Philadelphia Corporation for Aging
- Share Food Program

For more information about Taking Charge please contact Vanesa Karamanian, Project Director, at 267-350-7685 or vkaramania@phmc.org.
Thank you for participating in this program. This survey will help us better understand your food choices and how we can best assist you with managing your diabetes. Your answers will be kept confidential. Only research staff will have access to your answers. You may skip any question you do not want to answer.

Name:____________________________________ Patient ID_______________________________ Date:_____________________________________

□ Entry  □ Exit

First, we will ask questions about what you ate and drank during the past week. Choose the one best answer that describes you.

1. Think about the vegetables you ate during the past week. On average, how many cups of vegetables did you eat per day?
   □ 1 cup    □ 2 cups    □ 3 cups    □ 4 cups

2. Think about the fruits you ate during the past week. On average, how many cups of fruit did you eat per day?
   □ 1 cup    □ 2 cups    □ 3 cups    □ 4 cups

3. Think about the grains you ate during the past week, including refined grains (white rice and white bread) and whole grains (brown rice, whole wheat bread, and whole wheat pasta). In the past week, what amount of your grains were whole grains?
   □ All were whole grains
   □ More than half were whole grains
   □ Half were whole grains
   □ Less than half were whole grains
   □ None were whole grains
4. Think about what you drank during the past week. How often did you drink regular soda, sports drinks or punch, such as Coca-Cola, Gatorade, Kool-Aid, Sunny Delight, iced tea? Choose the response that best describes you

□ 0-2 times
□ 3-5 times
□ About once a day
□ 2 or more times a day, on most days

5. Think about the meals you ate in the past week. About how much of these meals were balanced meals? A balanced meal is one where half of your plate is filled with fruit and vegetables and the other half is filled with whole grains and protein.

□ All were balanced
□ More than half were balanced
□ Half were balanced
□ Less than half were balanced
□ None were balanced

6. On how many days were you physically active for at least 30 minutes?

□ 0 days
□ 1-2 days
□ 3 days
□ 4-6 days
□ 7 days (every day)
This next set of questions asks you about general nutrition and practices related to diabetes. For each question, choose what you think is the best answer. Select only one answer for each question.

7. What nutrient do fruits have that helps reduce the risk of heart disease, stroke, diabetes and some cancers?
   - [ ] Protein
   - [ ] Fiber
   - [ ] Sodium
   - [ ] Calcium

8. What is the recommended portion of your grains that should be whole grains each day?
   - [ ] All
   - [ ] Half
   - [ ] Less than half
   - [ ] None

9. If a person felt like eating something sweet, but was trying to cut down on sugar, which would be the best choice?
   - [ ] Milk Chocolate
   - [ ] Frosted Flakes
   - [ ] 100% Fruit Juice
   - [ ] Banana with plain yogurt

10. Which would be the best choice for a low fat, high fiber breakfast?
    - [ ] Sausage & eggs
    - [ ] Bagel & cream cheese
    - [ ] Oatmeal & low fat milk
    - [ ] Carrot muffin

11. What is the recommended amount of moderate physical activity that you should do?
    - [ ] 30 minutes 1 day a week
    - [ ] 45 minutes 3 days a week
12. When reading a food label, what should you look at first?
- Fat
- Serving size
- Vitamin
- Calories
- Sodium

13. The target blood sugar range before meals for people with diabetes is:
- 60-90 mg/dl
- 80-130 mg/dl
- 100-180 mg/dl
- I don’t know

14. The BEST method for home blood sugar testing is:
- Urine testing
- Blood sugar testing
- Both are equally good

15. The A1c test measures your average blood sugar level for the past:
- 7 days
- 6 weeks
- 2-3 months
- I don’t know

16. Hyperglycemia means:
- High blood sugar
- Low blood sugar
- I don’t know
17. A person with low blood sugar may have

- Fruity smelling breath
- Headache and shakiness
- Constant thirst and frequent urination
- I don’t know

18. If you are beginning to have a low blood sugar reaction, you should:

- Exercise
- Lie down and rest
- Drink 4oz of juice
- Take rapid acting insulin

19. For a person in good control of their diabetes, what effect does exercise have on blood sugar?

- Lowers it
- Raises it
- Has no effect

20. The nutrient that has the greatest effect on blood sugar is

- Carbohydrate
- Protein
- Fat
- I don’t know

21. To care for your feet, you should

- Look daily for redness and sores
- Soak daily in hot water
- Rub daily with alcohol
- Use iodine on cuts or sores
- I don’t know
Are you currently taking any medications for your diabetes? □ Y □ N

Medication Adherence Questionnaire (MAQ)

Individuals have identified several issues regarding their medication-taking behavior and we are interested in your experiences. There is no right or wrong answer. Please answer each question based on your personal experience with your diabetes medication.

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<thead>
<tr>
<th>Question</th>
<th>No=0</th>
<th>Yes=1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you sometimes forget to take your diabetes medications?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. People sometimes miss taking their medications for reasons other than forgetting. Thinking over the past two weeks, were there any days when you did not take your diabetes medicine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever cut back or stopped taking your medication without telling your doctor, because you felt worse when you took it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. When you travel or leave home, do you sometimes forget to bring along your diabetes medication?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Did you take your diabetes medicine yesterday?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. When you feel like your diabetes is under control, do you sometimes stop taking your medicine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Taking medication everyday is a real inconvenience for some people. Do you ever feel hassled about sticking to your diabetes treatment plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. How often do you have difficulty remembering to take all your medications?</td>
<td>Never/Parely=0 Once in a while=1 Sometimes=2 Usually=3 All the Time=4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

High Adherence: 0  Medium adherence 1-2  Low Adherence 3-8
### Medication Reconciliation

**Review actual medication bottle, box, tube**

1. **Med (including strength):**
   - By what route: oral, injectable
   - How often: ___________________
   - Is patient taking it exactly as listed on the bottle/box? Yes: NO
   - If no, how is the patient taking it? ___________________

2. **Med (including strength):**
   - By what route: oral, injectable
   - How often: ___________________
   - Is patient taking it exactly as listed on the bottle/box? Yes: NO
   - If no, how is the patient taking it? ___________________

3. **Med (including strength):**
   - By what route: oral, injectable
   - How often: ___________________
   - Is patient taking it exactly as listed on the bottle/box? Yes: NO
   - If no, how is the patient taking it? ___________________

4. **Med (including strength):**
   - By what route: oral, injectable
   - How often: ___________________
   - Is patient taking it exactly as listed on the bottle/box? Yes: NO
   - If no, how is the patient taking it? ___________________

5. **Med (including strength):**
   - By what route: oral, injectable
   - How often: ___________________
   - Is patient taking it exactly as listed on the bottle/box? Yes: NO
   - If no, how is the patient taking it? ___________________

Comments:

Are you taking any additional prescription medication(s)? □ Y □ N

1. **Med (including strength):**
   - By what route: oral, injectable, topical, inhalation, other
   - How often: ___________________
   - Is patient taking it exactly as listed on the bottle/box? Yes: NO
   - If no, how is the patient taking it? ___________________
   - For what condition is this med being used? ___________________

2. **Med (including strength):**
   - By what route: oral, injectable, topical, inhalation, other
   - How often: ___________________
   - Is patient taking it exactly as listed on the bottle/box? Yes: NO
   - If no, how is the patient taking it? ___________________
   - For what condition is this med being used? ___________________

3. **Med (including strength):**
   - By what route: oral, injectable, topical, inhalation, other
   - How often: ___________________
   - Is patient taking it exactly as listed on the bottle/box? Yes: NO
   - If no, how is the patient taking it? ___________________
   - For what condition is this med being used? ___________________

4. **Med (including strength):**
   - By what route: oral, injectable, topical, inhalation, other
   - How often: ___________________
   - Is patient taking it exactly as listed on the bottle/box? Yes: NO
   - If no, how is the patient taking it? ___________________
   - For what condition is this med being used? ___________________

5. **Med (including strength):**
   - By what route: oral, injectable, topical, inhalation, other
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is patient taking it exactly as listed on the bottle/box? Yes NO</td>
<td></td>
</tr>
<tr>
<td>2. For what condition is this med being used?</td>
<td></td>
</tr>
<tr>
<td>3. Med (including strength):</td>
<td></td>
</tr>
<tr>
<td>4. By what route:oral, injectable, topical, inhalation, other</td>
<td></td>
</tr>
<tr>
<td>5. How often:</td>
<td></td>
</tr>
<tr>
<td>6. Is patient taking it exactly as listed on the bottle/box? Yes NO</td>
<td></td>
</tr>
<tr>
<td>7. For what condition is this med being used?</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Are you taking any vitamin, mineral or other supplements (including</td>
<td></td>
</tr>
<tr>
<td>probiotics, herbals &amp; botanicals)?</td>
<td></td>
</tr>
<tr>
<td>Supplement (including strength):</td>
<td></td>
</tr>
<tr>
<td>8. By what route:oral, injectable, topical, inhalation, other</td>
<td></td>
</tr>
<tr>
<td>9. How often:</td>
<td></td>
</tr>
<tr>
<td>10. Is patient taking it exactly as listed on the bottle/box? Yes NO</td>
<td></td>
</tr>
<tr>
<td>11. For what condition is this med being used?</td>
<td></td>
</tr>
<tr>
<td>Do you have any food intolerances, sensitivities or other allergies?</td>
<td></td>
</tr>
<tr>
<td>HYPOGLYCEMIA</td>
<td></td>
</tr>
<tr>
<td>Have you ever had a hypoglycemic/low blood sugar episode? Yes NO</td>
<td></td>
</tr>
<tr>
<td>if yes...</td>
<td></td>
</tr>
<tr>
<td>Why do you think it happened? Skipped meal; Didn’t eat enough; Ate the</td>
<td></td>
</tr>
<tr>
<td>wrong things; Exercise caused it; My medications caused it; Other:</td>
<td></td>
</tr>
<tr>
<td>How often does it happen? Once daily, Once or twice weekly, Once or</td>
<td></td>
</tr>
<tr>
<td>twice monthly, Rarely, Other:</td>
<td></td>
</tr>
<tr>
<td>What time of day does it happen (chose multiple if necessary)? Morning</td>
<td></td>
</tr>
<tr>
<td>Afternoon; Evening; Overnight/while sleeping</td>
<td></td>
</tr>
<tr>
<td>if it happens different times of the day, when does it happen MOST</td>
<td></td>
</tr>
<tr>
<td>often? Morning; Afternoon; Evening; Overnight/while sleeping</td>
<td></td>
</tr>
<tr>
<td>if you were able to check your blood sugar, what was the value?</td>
<td></td>
</tr>
<tr>
<td>How do you feel when you get a low blood sugar?</td>
<td></td>
</tr>
<tr>
<td>Shaky, sweaty, nervous/anxious, irritable, fast heartbeat, blurred/</td>
<td></td>
</tr>
<tr>
<td>impaired vision, weakness/fatigue, lightheaded/dizzy, nauseated,</td>
<td></td>
</tr>
<tr>
<td>tingling in lips/face, lack of coordination</td>
<td></td>
</tr>
<tr>
<td>Have you ever become unconscious/passed out due to low blood sugar OR</td>
<td></td>
</tr>
<tr>
<td>needed help from someone else to treat your low blood sugar? Yes No</td>
<td></td>
</tr>
<tr>
<td>How do you treat your low blood sugar? Juice, Juice with sugar in it,</td>
<td></td>
</tr>
<tr>
<td>Sugary candy, Chocolate candy, Crackers, Eat my regular meal, Glucose</td>
<td></td>
</tr>
<tr>
<td>tablets or gel, Other:</td>
<td></td>
</tr>
</tbody>
</table>
Phone Script Template

(This is the template language for a phone contact/questionnaire. Fill in the appropriate sections, and adapt for your study.)

Hello, my name is______. I’m from Thomas Jefferson University Hospital’s Department/Division of Center for Urban Health or Care Coordination. May I please speak with < First Name>?

Person Not Available
Thank you. I am calling on behalf of Jefferson. Please ask < First Name> to call me back at __________. That number again is ___________. Have a good day. Goodbye.

Wrong Number
I apologize for the inconvenience. Thank you. Goodbye.

Voicemail/Answering Machine
Hello. This is <name> calling on behalf of Jefferson. We have an important message for < First Name>. Please have < First Name> call me back at _______. Thank you. Goodbye.

(Explain how you obtained name of subject)

You recently were in the Hospital/ED for a condition related to diabetes. Our electronic health records show that you have used Jefferson Hospitals for diabetes related conditions at least once in the past twenty-four months. I’m calling today because you were identified by Jefferson as someone who might benefit from participating in a nutrition support program called “Taking Charge” focused on helping people better manage their diabetes. Does this sound like something you’d be interested in hearing more about?

The “Taking Charge” research study is a program being offered by Jefferson Hospital and the Health Promotion Council, a non-profit organization that provides education and services to help people manage their health
conditions. The Taking Charge program is for adults aged 65 and older who may be having a hard time managing their diabetes. In the first session of the program, you will talk with a registered dietitian and health coach. Based on how you answer questions, you will be placed into one of two nutrition intervention levels – the standard program or a more intensive program. Depending on the intervention level in which you are placed, you will be asked to take part in 5 to 8 sessions lasting between 1-2 hours each. The program, taught by a registered dietitian and a health coach, will last approximately 6 months. Some of the visits can be conducted in your home or a public location, and other visits will be completed by telephone. Topics will include a personalized diabetic meal plan taking into consideration your food preferences and ability to grocery shop and cook. The team will support you in reaching lifestyle goals that you set for yourself, and will connect you to additional community resources if needed. With your permission, we will contact your primary care provider to obtain a signed order for the medical nutrition therapy for billing purposes only, obtain information about your medications and most recent labs related to your diabetes, and share information about your progress in the program.

As part of this program, you may be referred to community services that can help you improve your nutrition through better access to healthier, more affordable food choices. If we make the referral with your permission, the evaluators from Jefferson will follow-up with the community service organization to see if they were able to assist you.

(State risks and potential benefits of research to participant.)
You may not benefit from the program, however we hope that you will find the program helpful in managing your diabetes. This program is being offered at no out of pocket cost to you.

Your participation in this study is entirely voluntary, and you can refuse to participate or stop your participation at any time without penalty or loss of benefits to which you are otherwise entitled, and without affecting your care at Jefferson.

During the first session, the registered dietitian or health coach will ask you a series of questions about diabetes and the kinds of things you are doing to manage your health condition. If any question makes you feel uncomfortable, you don’t have to answer it. I also want to assure you that any information you provide will remain strictly confidential. Your name will not be identified or associated with any specific responses, and it will not appear in any published materials which result from this research.

Would you like to participate in the study?

(If no) Thank you for your time. I won’t call you again.
(If yes)

Great, ________ from HPC will be calling you in the next few days to discuss the program and talk to you about how you are currently managing your diabetes and your nutritional needs. She will ask some questions about how you usually shop for food, cook your meals, and how you are managing your health condition at home.

The Taking Charge program feels it is important to communicate with your primary care provider and/or specialist managing your diabetes. Do we have your permission to provide information about your participation with your healthcare providers, including your personalized meal plan, information about your medication management, any low blood sugar episodes and your lifestyle goals as well as obtain relevant medical information about your diabetes such as medications you are taking and recent lab tests? Yes/ No

Participation in the program is voluntary. You can chose to end your participation in the program any time you want. If you choose not to participate it will not affect the care that you get at Jefferson. If you no longer want to be in the program, you can let the Health Coach or RD know. You will not be compensated for participating in the Taking Charge research program.

It will be important that we are able to reach you to check in to see how you are doing in the program as well as set up times for the RD or Health Coach to come to your home or meet you at a public location. What is the best number to reach you? _______________________________

Is it OK for us to leave a detailed voice mail at that number? Yes No

Before we get started, I would like to tell you that if you have questions about this research you can call Dr. ________ (fill in) at ________ (provide phone number/email). Also, if you have questions about your rights as a research participant, you can contact the Thomas Jefferson University Office of Human Research at 215-503-8966.

What questions do you have about the Taking Charge program? Just to make sure I explained everything correctly, can you tell me in your own words what the Taking Charge program is about and what you will be asked to do if you choose to participate? What do you think the risks and benefits are to participants in the study?

If you are interested I can try to connect you with ________ -- at HPC right now, is that OK?

Answer is YES.
Great, please wait a moment while I put you on hold and try to reach _________ @ HPC.

**Able to connect:**

Thank you for holding. I was able to reach ______ at HPC and she/he is going to call you within the next few minutes at _____________ number.

Thank you again for taking the time to speak with me today. Please feel free to contact me at any time. Again, my name is <name> and you can contact me at____________

**Unable to connect:**

Thank you for holding. I was NOT able to reach ______ at HPC. I will send her/him a message and ask that she/he call you in the next 1-2 days at _____________number.

Thank you again for taking the time to speak with me today. Please feel free to contact me at any time. Again, my name is <name> and you can contact me at____________

**Answer is NO**

OK, then let’s schedule a good time for _____ from HPC to call you. What is the best time of day for you? (Schedule 15-20 minute intake call) Thank you so much for your time. I look forward to speaking with you on Date: ______Time_____. Can I confirm the number at which I can reach you for that call? Is it___________?
Screening Call Assessment Form: Stratification; Shopping/Cooking Habits

Establish framework for the program:

a. Benefit to member – Personalized education about healthy eating, assistance with meal planning to help manage their diabetes, support in self-management activities to help prevent complications associated with diabetes, communication with their primary care provider and/or endocrinologist, connection to additional community resources if needed.

b. Scheduling/time commitment expectations – Overview of meetings with Registered Dietitian and Health Coach:
   Depending on stratification: 3 interactions with a registered dietician and 2 interactions with health coach, or
   4 interactions with registered dietician and 2-4 interaction with health coach

c. Incentives provided – Member will receive quick, easy to prepare recipes and shopping lists to help them better manage their diabetes, (will the standard level intervention receive recipes and shopping lists?), access to a health coach for questions, support, and motivation so they can manage their diabetes.

This program, depending on the patient’s needs has two levels: standard or advanced.

Self-rated health status:
In general, how would you rate your health?
   1- Excellent
   2- Very good
   3- Good
   4- Fair
   5- Poor

Patients answering Fair or Poor would be placed in the Advanced intervention.

Health Literacy:
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
   1- Never
   2- Rarely
   3- Sometimes
   4- Often
   5- Always
Patients answering Sometimes, Often, or Always would be placed in the Advanced intervention.

Support System in Home:
Do you live alone? Yes, No
If you live with someone else, does that person(s) help you with your meals or your diabetes? Yes, No
Patients living alone or those who do not get support from the person in their home would be placed in the Advanced intervention.

Food Insecurity:
Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more: Often True, Sometimes True, Never True, Unable to assess
Within the past 12 months we worried whether our food would run out before we got money to buy more: Often True, Sometimes True, Never True, Unable to assess
Patients answering Often True or Sometimes True would be placed in the Advanced intervention.

<table>
<thead>
<tr>
<th>Eligibility Criteria Checklist- INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meeting location</strong></td>
</tr>
<tr>
<td>Are you able to have a Registered Dietitian and Health Coach meet you at your home?</td>
</tr>
<tr>
<td>If not, are you able to get to a nearby public location for a meeting? Where? Confirm they have reliable transportation or can access public transportation</td>
</tr>
<tr>
<td><strong>Shopping location</strong></td>
</tr>
<tr>
<td>Are you able to meet a Health Coach at the grocery store you most often utilize when shopping for food? If no, why not? LIST possible reasons</td>
</tr>
<tr>
<td><strong>Cooking location</strong></td>
</tr>
<tr>
<td>If the RD recommends a cooking demonstration for you, could you cook with the HC in your home to prepare a meal?</td>
</tr>
<tr>
<td>If not, are you able to meet the Health Coach at a public location to cook together? If they don’t feel comfortable having someone in their home consider community locations. Have list of possibilities prior to call and make sure sites allow you to use their space</td>
</tr>
<tr>
<td><strong>Schedule commitment</strong></td>
</tr>
<tr>
<td>Are you able to schedule up to 6 meetings with the Dietitian and Health Coach? Each of these visits would be about an hour to 2 hours in length.</td>
</tr>
</tbody>
</table>
| Are there particular days of the week or times of day that would work best for you? | Day preference: Sn  M  T  W  Th  F  Sa  
Time preference: Morning  Midday  Evening |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduling first meeting</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| Can we schedule the first meeting now while we are on the phone?  
How about (options)?  
This first meeting will be with both the Health Coach and the Dietitian (names). One of us will call you the day before and also the morning of the scheduled visit to confirm this time still works with you. | Wouldn’t the first meeting be just with the RD? |
**Taking Charge**  
**Care Coordination Satisfaction Survey**

Thank you for taking this survey. Your responses will be used to improve overall processes of the ‘Taking Charge’ program. All responses will be anonymous.

Please mark your level of satisfaction on the following items:

<table>
<thead>
<tr>
<th></th>
<th>Very Dissatisfied</th>
<th>Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Taking Charge’ program overall</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Communication between Jefferson Primary Care Team (JPCT), Center for Urban Health and Health Promotion Council.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Communication between ‘Taking Charge’ staff and strategic partners (CIP, SHARE, Coalition Against Hunger).</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Process of recruitment of participants and follow-up.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Process of referral to outside agencies and follow-up with those providers of services.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>System of data sharing (to and from HPC/JPCT)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Engagement with non-Jefferson providers.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Thinking about communication between JPCT, HPC, and CUH, why did you give this rating? What is working well? How can communication be improved?

Thinking about communication between ‘Taking Charge’ staff and strategic partners (primary care providers, community-based service providers, etc). Why did you give this rating? What is working well? How can communication be improved?
Thinking about the Taking Charge program overall, what is working well? How could the ‘Taking Charge’ program be improved overall?

### Taking Charge – Satisfaction Survey

**Overall how satisfied were you with the program?**

<table>
<thead>
<tr>
<th>Very dissatisfied</th>
<th>Somewhat dissatisfied</th>
<th>Neither satisfied or dissatisfied</th>
<th>Somewhat satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Would you recommend this program to a friend or family member?**

☑ Yes

☐ No

**Rate the following aspects of your experience:**

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My knowledge about nutrition and diabetes increased as a result of this program</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I enjoyed the personal shopping session</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I enjoyed the personal cooking session</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I will be able to apply what I learned in this program to my daily life</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
I would have liked to be enrolled in the program longer

What was most valuable or enjoyable to you about this program?

Which resources or ideas presented in the meeting do you think you will use?

What are the reasons you might not use the resources or ideas?

What changes would you recommend to the program?

Which topics or activities would you like to see included for a future program?
### Services Checklist (DRAFT)

<table>
<thead>
<tr>
<th>Questions</th>
<th>PCA</th>
<th>CAH</th>
<th>CIP</th>
<th>Manna</th>
<th>BenePhilly</th>
<th>PHA</th>
<th>DHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you interested in receiving Diabetes Self-Management Program (DSMP)?</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you in need of affordable, assisted, or emergency housing?</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Do you feel insecure about having enough food on a daily basis?</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Are you in need of assistance with transportation in order to participate in this program?</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you find yourself in need of an advocate or legal assistance?</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Do you feel safe remaining at home alone? Are you in need of a caregiver?</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Are you in an emergency situation with utilities, food, shelter, or crime victim assistance?</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Do you need help understanding Medicare and Medicaid or applying for insurance?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Are you in need of a Primary Care Provider?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Do you need help paying for Utilities?</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Are you interested in help finding employment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Would you like to be connect to social activities near you?</td>
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<td>Would you like to be connected to physical activity support groups near you?</td>
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<td>Do you find yourself at risk for fall and would like to participate in a support group to learn how to reduce your risk of falls?</td>
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<td>Fruit and Greens Smoothie</td>
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<td>Cucumber Dip with Pita Chips</td>
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<td>Any Days a Picnic Chicken Salad</td>
<td><a href="https://whatscooking.fns.usda.gov/recipes/supplemental-nutrition-assistance-program-snap/any-days-picnic-chicken-salad">https://whatscooking.fns.usda.gov/recipes/supplemental-nutrition-assistance-program-snap/any-days-picnic-chicken-salad</a></td>
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<td>Cream of Broccoli Soup</td>
<td><a href="https://whatscooking.fns.usda.gov/recipes/supplemental-nutrition-assistance-program-snap/cream-broccoli-soup">https://whatscooking.fns.usda.gov/recipes/supplemental-nutrition-assistance-program-snap/cream-broccoli-soup</a></td>
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<td>Oven Baked Sweet Potato Fries</td>
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<td>Side</td>
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<td>Chicken, Mushroom and Barley Soup</td>
<td><a href="http://www.diabetes.org/mfa-recipes/recipes/2016-1-chicken-mushroom-and-barley.html#">http://www.diabetes.org/mfa-recipes/recipes/2016-1-chicken-mushroom-and-barley.html#</a></td>
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<td>Dijon Chicken and Broccoli noodles</td>
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<td>Dining Out</td>
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<td>Dollar Store Shopping and Making a Healthy Plate</td>
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<td>Fast Food Tips</td>
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<td>Fridge Free Foods</td>
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<td>Healthy Foods for People with Diabetes</td>
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<td>Money Saving Tips</td>
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<td>Smart Snacks</td>
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<td>Using Food Labels</td>
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<td>Whole Grains</td>
<td>Learning Zone express <a href="https://www.learningzonexpress.com/grains-handouts.html">https://www.learningzonexpress.com/grains-handouts.html</a></td>
<td>Available for purchase</td>
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<Date>

<PCP’s name>
<PCP’s address>

Dear <PCP>,

Your patient, <name> is participating in a program called Taking Charge, which is being offered by the Center for Urban Health at Thomas Jefferson University Hospital and the Health Promotion Council (HPC), a non-profit organization that provides education and services to help people manage their health conditions. Your patient is receiving Medical Nutrition Therapy and other nutrition education services to increase the knowledge and skills to better manage their diabetes. Taking charge program is offered to older adults (aged 65+) with diabetes who have received services in the ED or been admitted to the hospital for a potentially diabetes related reason 2 or more times in the past year. If you have any questions, please do not hesitate to contact me.

Thank you

Sincerely,

Rickie Brawer, PhD, MPH, MCHES
Principal Investigator
Center for Urban Health
Thomas Jefferson University Hospitals
211 S. 9th St., Suite 300
Philadelphia, PA 19107
215-955-2396
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 eat 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 or share 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?

not at all | | | | | | | | totally confident 1 2 3 4 5 6 7 8 9
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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<th>No. of items</th>
<th>Observed Range</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Internal Consistency Reliability</th>
<th>Test-Retest Reliability</th>
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Source of Psychometric Data


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.

This scale is free to use without permission

Self-Management Resource Center
Verbal Consent for Use/Disclosure of PHI

This template should be used in addition to the OHR-BE when PI has received approval for a waiver of written authorization to collect protected health information.

Your responses to study questionnaires are confidential and will be protected to the best of our ability. Your name or any other identifying information will not be used in reports or publications resulting from this study.

The information we are collecting from you is called protected health information, or PHI, and you have certain rights regarding this information. We will protect the confidentiality of your PHI in accordance with federal and Pennsylvania state laws.

The information we are collecting includes: (Provide concise description of PHI to be collected. Also describe uses of the PHI if not previously stated.)

- Names (individual etc.)
- Address (street, city, county, zip code)
- Telephone
- Birth Date
- Date of treatment; Admission Date-Discharge Date
- Medical Record Numbers
- Medical insurance payment information
- Medical history related to diabetes diagnosis including most recent labs

Your information will be shared with personnel involved in this research study. Other people and/or entities with whom your information will be shared are:

Your primary care physician with your approval

Choose the following appropriate statement:

- We will stop using your information at the conclusion of the study.

If you want to withdraw your permission for us to use your information for this research study, you must submit a written request to:

Rickie Brawer
Do you agree to participate in this research study by responding to study questionnaires and allowing us to use your information for this study?

Thomas Jefferson University IRB
Approval Date 02-18
Expiration Date 03-19
Annual review due 6 weeks before expiration
Investigator writes name of participant and signs to verify verbal response of subject:

Name of research participant

○ YES Date: __ __ Signature of investigator: __ __

Printed name: ___________________