

Assertive Outreach Follow-up for Adolescents With IDDM

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Little is known about the impact of psychosocial interventions in IDDM (1, 2) and even less about the non-compliant population of adolescents who do not arrive for follow-up visits.

Golden et al. (3) demonstrated that intervention in a poorly compliant juvenile IDDM population using a comprehensive support system reduced the frequency of RDKA. Consequently, it was decided to adapt the Program for Assertive Community Treatment (4), which was initially designed to reduce hospitalization in the mentally ill, for use in a noncompliant adolescent diabetic population. This model of intervention stresses the role of the case manager as taking on an outreach responsibility for maintaining contact with poorly compliant patients and their families by using telephone calls, home visits, or letter prompts.

The pediatric diabetes clinic at the Soroka Medical Center is a tertiary referral center for southern Israel. An assertive outreach follow-up program operates alongside a traditional multidisciplinary approach. The extent of the community outreach and the responsibility taken by the case manager for supervising the young person's diabetic

self-care, are significant points of departure from traditional models of IDDM follow-up.

The criteria for inclusion in the assertive follow-up are significant lapses in diabetic review (more than one missed appointment in succession) and hospitalization for RDKA. The case manager works closely with the diabetes clinic team and consults with relevant community services—family physicians, school nurses, and community-health nurses.

The following case vignette highlights the clinical application of the model. M, aged 17, was diagnosed as suffering from IDDM at the age of 13 and underwent cataract extraction 2 yr later. She has been admitted for RDKA on three occasions with significant noncompliance in insulin administration, adherence to diet, and medical follow-up.

After defaulting on clinic attendance on two subsequent occasions after discharge from hospital, the case manager initiated telephone contact and suggested a home visit to clarify why she had not attended for review. The home visit facilitated a discussion of M's anger that she had required cataract removal after being a model diabetic patient for 2 yr.

Over a period of 11 mo of follow-

up, weekly telephone contact was used to supplement regular meetings with the case manager held every 3–4 wk. Home visits were utilized on two further occasions at times of defaulting from clinical follow-up. HbA_{1c} levels have been acceptable (<12%), and M has not been admitted with RDKA.

Only preliminary findings can be reported on the use of this program on an adolescent IDDM population over a 12-mo period, but we have been impressed by the powerful interaction that develops between the case manager and a young person during such a follow-up and the need to use this interaction therapeutically.

The extent of family involvement in follow-up will vary according to the perceived impact of family interactions on the young person's diabetes self-care. The developmental needs of the adolescent with regard to developing a sense of autonomy from their family also needs to be considered.

The case manager maintains weekly telephone contacts with the patient in addition to meetings every 2–3 wk. During periods of relative stability of diabetes self-care, as gauged by clinical assessment, blood glucose, and HbA_{1c} readings, contact may be maintained through community health workers.

Depending on the individual needs of the patients, the case manager should be able to take on between a 10 and 20 patient workload.

Funding of this program has occurred through normal running costs of the diabetes clinic. Wherever possible, home visits of patients take place during working hours, and if an after-hours visit occurs, a flexible working roster is achieved.

The diabetic team needs to reorient themselves toward an assertive outreach model of follow-up. Questions relating to the patient's responsibility of diabetes self-care, duration of such follow-up, prevention of staff burn-out, and cost-effective use of resources need to be adequately dealt with on an ongoing basis.

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IDDM, insulin-dependent diabetes mellitus; RDKA, recurrent diabetic ketoacidosis; DCCT, Diabetes Control and Complications Trial.

The cost-effectiveness of this program will be clarified through comparing rates of hospitalization for RDKA in a group of young diabetic patients receiving traditional multidisciplinary team follow-up, compared with a group matched by age receiving assertive outreach follow-up.

This model of follow-up shares some features with the intensive insulin regime in the DCCT (5). Weekly telephone contact and continuity of the relationship between the patient and the patient's family were stressed in the DCCT protocol. However, the DCCT excluded patients with poor compliance from the treatment regime.

We believe that an assertive out-

reach program offers a cost-effective approach in improving compliance in a juvenile IDDM population, thereby reducing rates of hospitalization for RDKA. We suggest a more widespread use of this model of follow-up.

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