THE ROBERT WOOD JOHNSON FOUNDATION

Washington University in St. Louis SCHOOL OF MEDICINE

UNC SCHOOL OF PUBLIC HEALTH

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

# *Implementing Community-Based Self-Management Programs in Diverse Communities*


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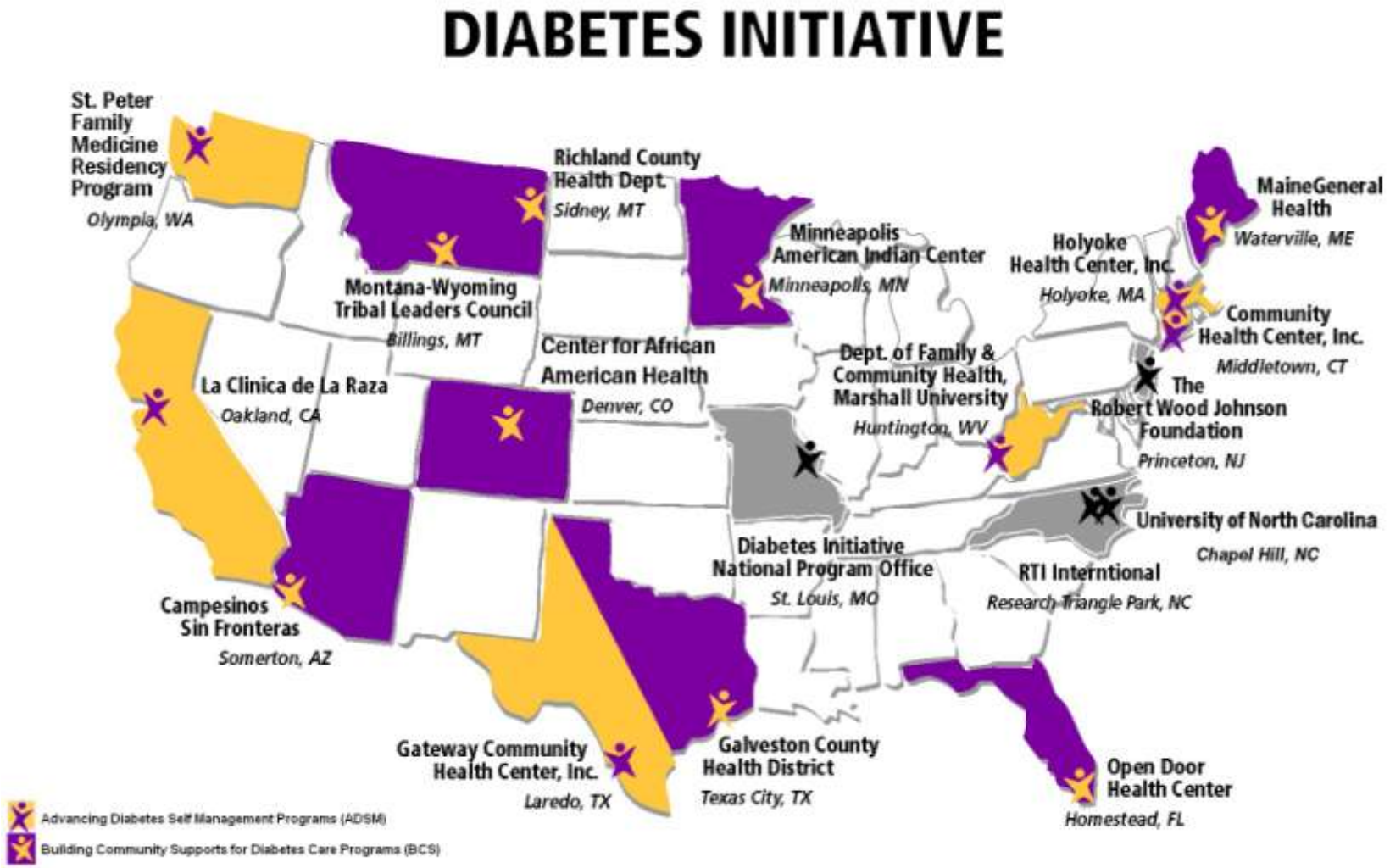
American Diabetes Association
San Francisco – June, 2008

http://www.diabetesinitiative.org/

# *Diabetes Initiative of the Robert Wood Johnson Foundation*

***Demonstrating feasible, sustainable self management programs as part of high quality diabetes care in primary care and community settings***


# *The 14 Sites of the Diabetes Initiative*



# *3 Fundamental Aspects of Diabetes*

1. **Centrality of behavior**
   - Diet
   - Exercise
   - Monitoring
   - Medication management
   - Psychological/emotional status
2. **In every part of daily life – 24/7**
3. **For "the rest of your life"**

# *Key Functions as Program Framework: Resources & Supports for Self Management*

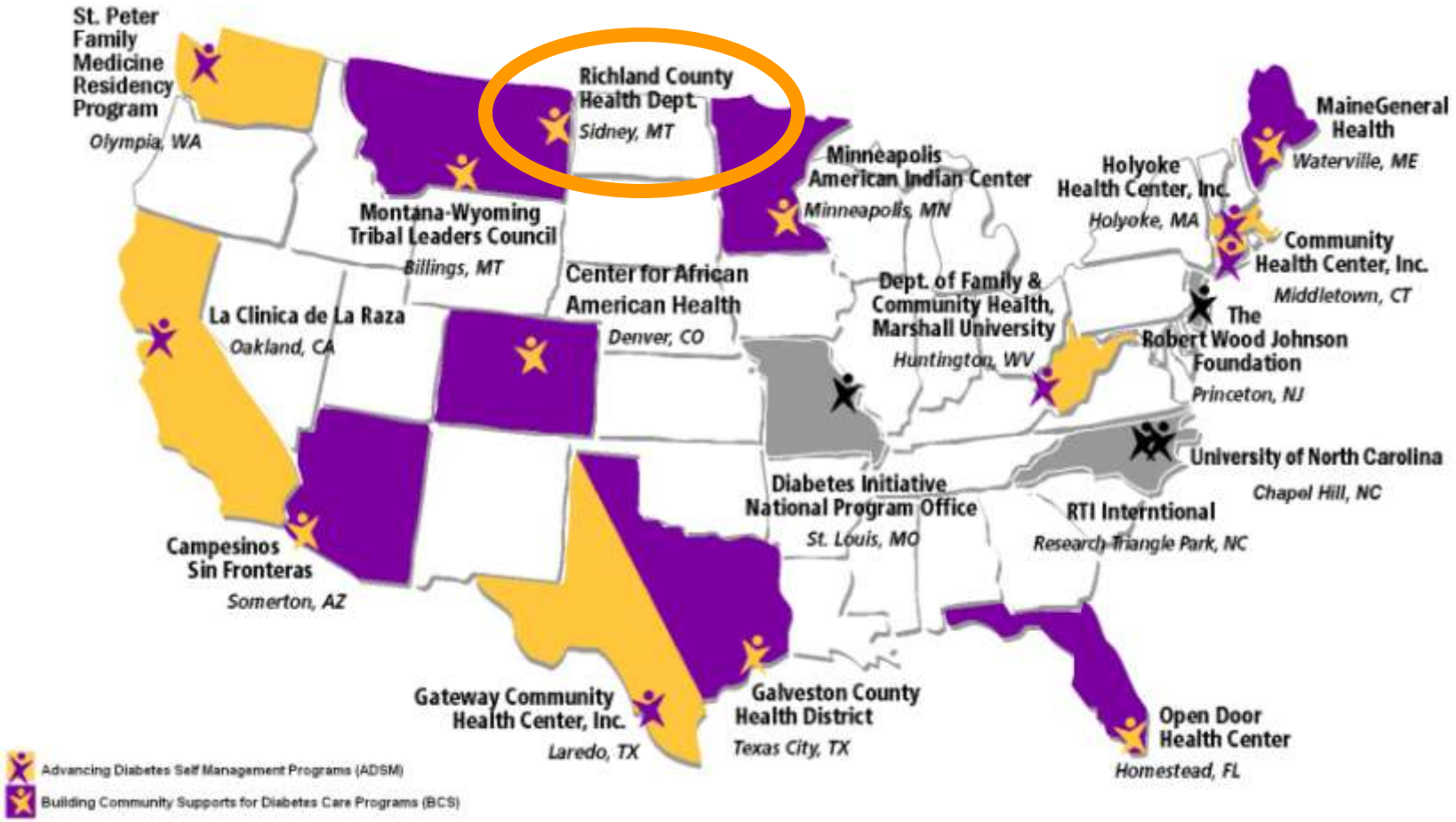
- **Individualized assessment**
  - **Including consideration of individual's perspectives, cultural factors**
- **Collaborative goal setting**
- **Enhancing skills**

  **Diabetes specific skills**

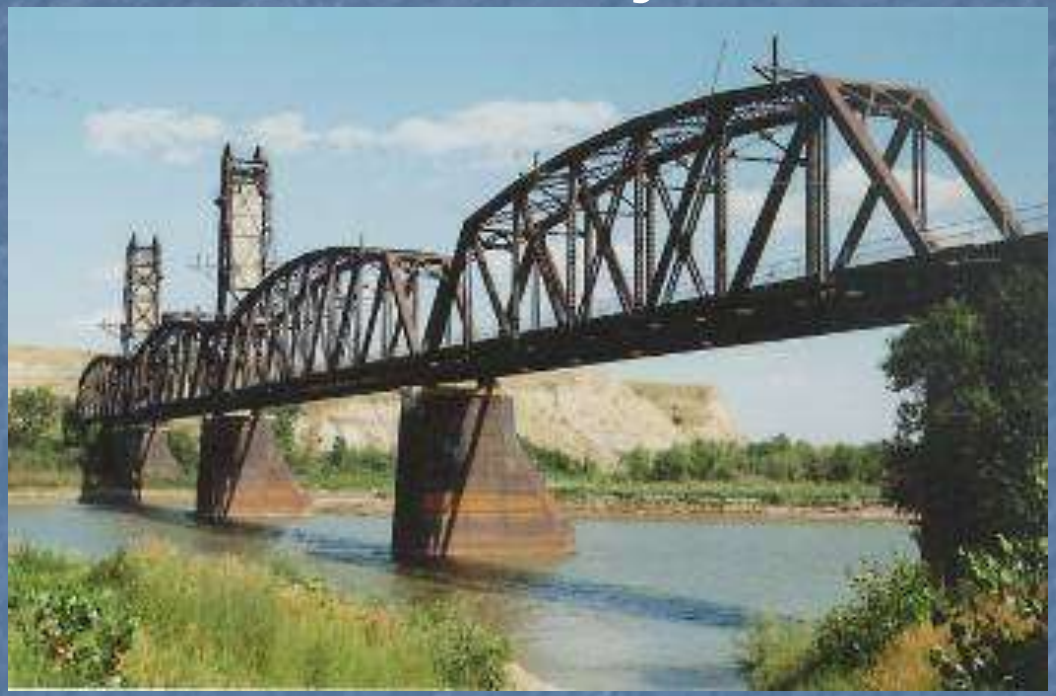
  **Self-management and problem-solving skills**

  **Includes skills for "Healthy Coping" and dealing with negative emotions**
- **Ongoing follow-up and support**
- **Community resources**
- **Continuity of quality clinical care**

# *Richland County Health Department, Sydney, Montana*

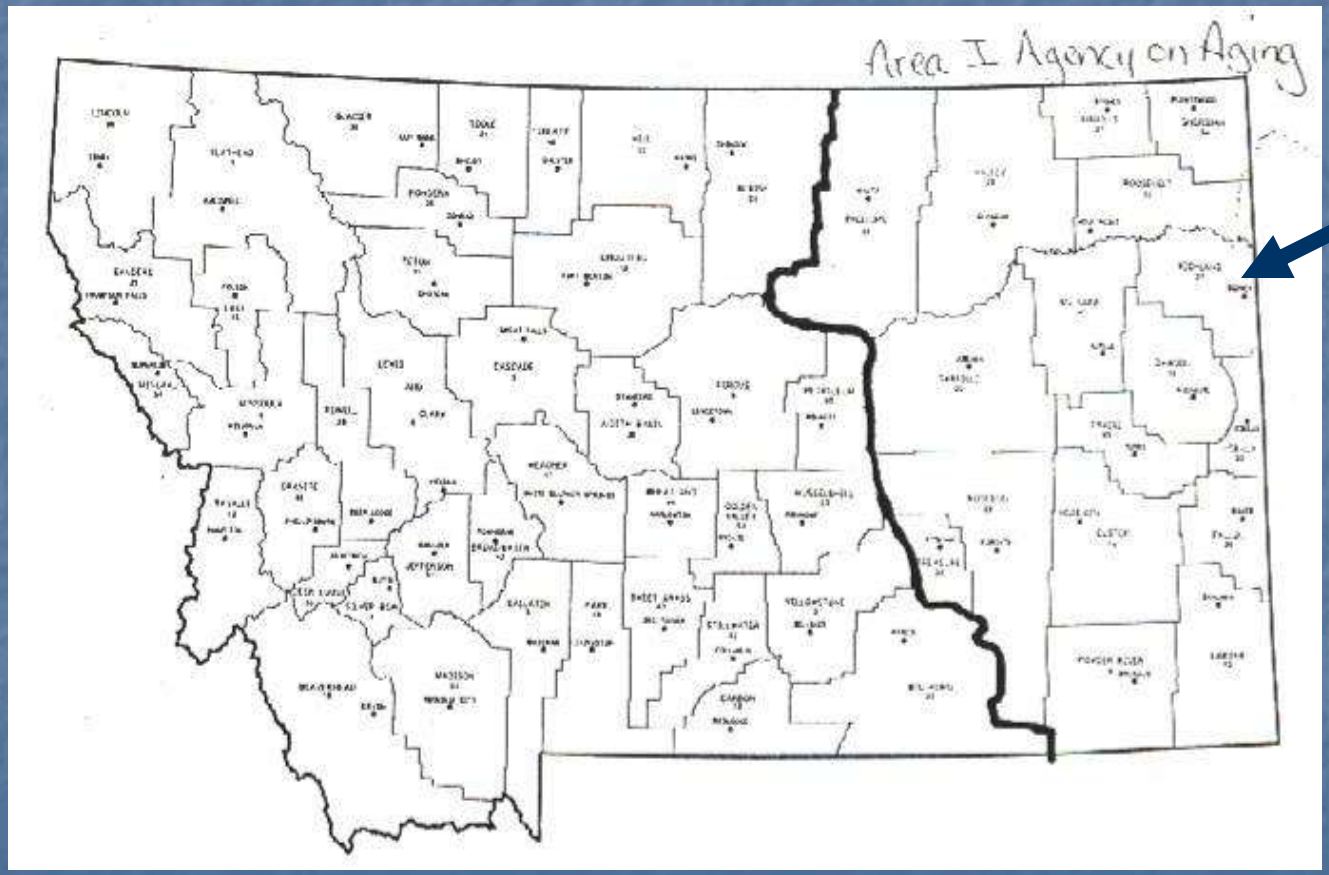


# The Richland County Community Diabetes Project Richland County, Montana



**Lisa Aisenbrey, RD, Diabetes Project Director**

# Richland County, Montana



# Community Profile

- Frontier, aging community on the border between North Dakota & Montana
- Population: 9,155 (4.6 persons per sq. mile)
- Farming (beets), ranching, oil, small business
- 1/3 older adults
- Median household income (1999) is 32K

# Culture

- Scandinavian, German homesteaders, ranchers
- Seasonal migrant farmworkers (Hispanic, Native American)
- Near 2 Native American Reservations, one Indian Service area
- Small percentage Native American, Hispanic, Black American, Asian.
- Hardy, independent, stoic, resistant to change, wary of outsiders, private, loyal to neighbors and friends.

# Richland Health Network


- Richland County Commission On Aging
- Richland County Health Department
- Sidney Health Center (hospital, clinic, pharmacy, extended care, fitness center, assisted living)

# Community Collaboration

- Communities in Action
- WIC, At-Risk home visiting
- Richland County Nutrition Coalition
- Sidney Health Center Community Health Improvement Committee
- Parish Nursing
- RSVP
- Literacy Volunteers of America
- LIONS Club
- American Diabetes Association – Montana
- Montana Migrant Council (on Advisory Board)
- McCone County Senior Center
- Montana Diabetes Project
- Sidney Public Library
- Eastern Montana Mental Health
- Health Fair Planning Committee at hospital
- Media
- And more…

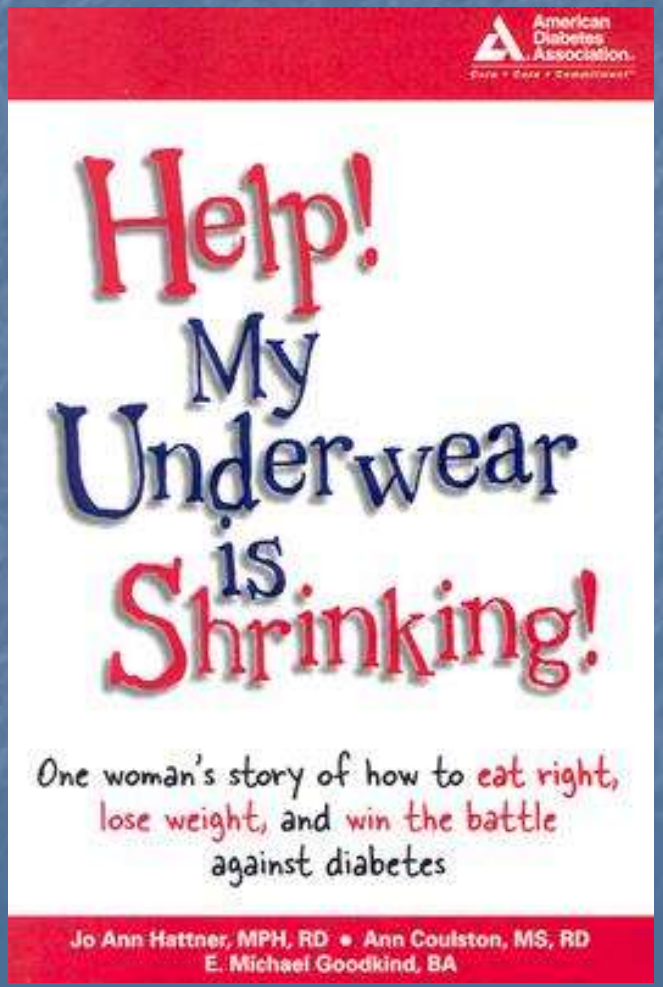
# Project Components

- **Addressing the whole person with diabetes**
  - **Physical activity**
  - **Healthy eating**
  - **Social support**
  - **Diabetes education**

# Diabetes Education Center

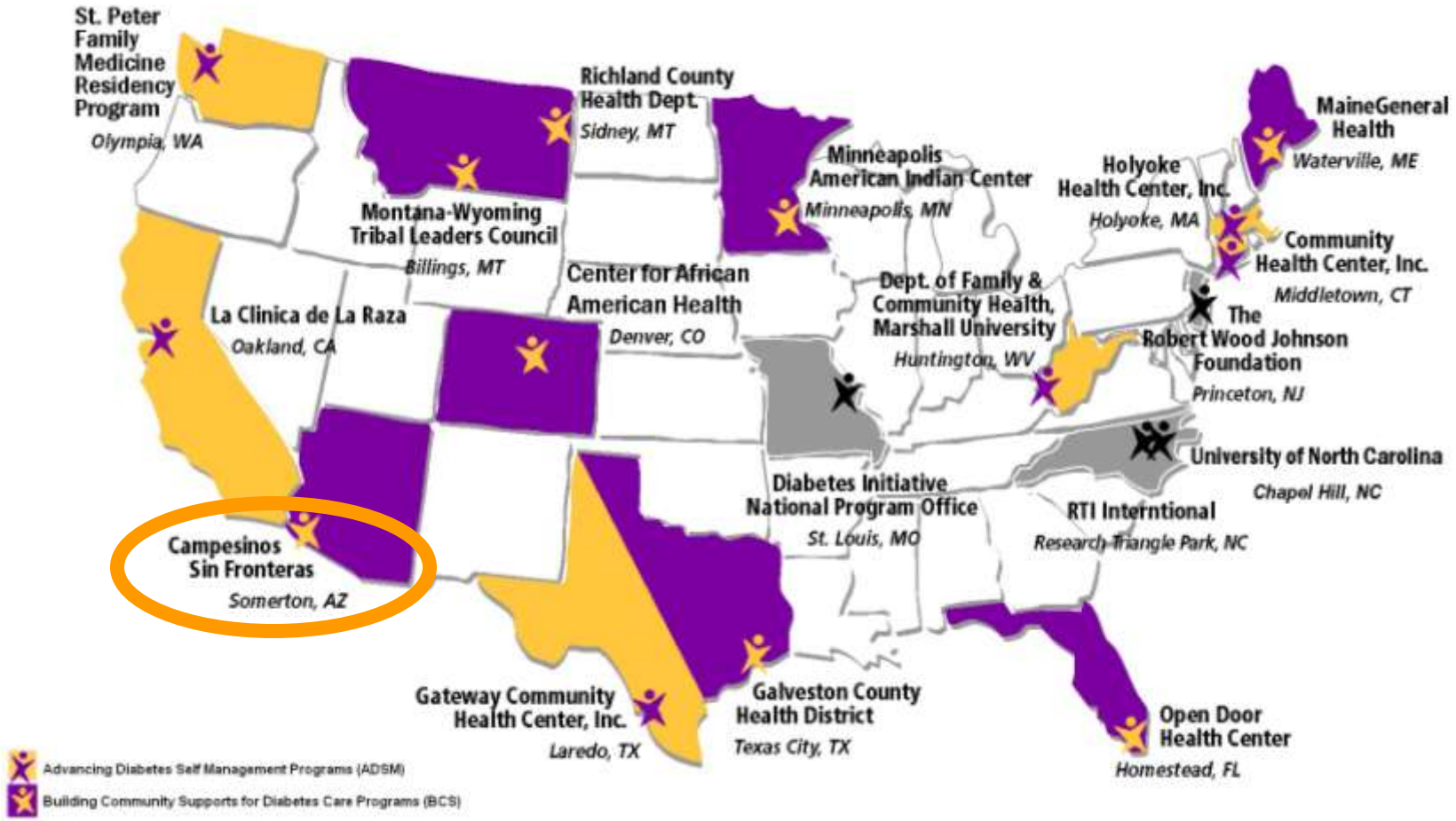
- Formal group and individual diabetes self management education in medical setting
  - Housed at Sidney Health Center
  - Staff: RD, RN, Coordinator
- Physician referral required
- Coordinated by Public Health
  - Linked with community projects
  - Strong source of referrals
- Diabetes Quality Care Monitoring System
- Achieved ADA recognition!!

# Social support & Continuing Education




- Diabetes Education Group
- Goal Setting
- Newsletter
- Resources at Public Library
- Community Resource Book
- Chronic Disease Self-Management Class
- Ambassadors (lay health workers)
- Local Worksite Wellness Programs

# *Campesinos Sin Fronteras, Somerton, Arizona*



# *"Campesinos Diabetes Management Program" (CDMP)*

A collaborative between
Campesinos Sin Fronteras,
Sunset Community Health Center,
University of Arizona College of Public Health
and Yuma County Cooperative Extension

*Floribella Redondo, Program Manager*

*Maria Retiz, Promotora de Salud*

# CDMP's Target Population

## Farmworkers and their Families


# Needs of Target Population

Hispanic/Mexican farmworkers are greatly affected by diabetes due to:

- Limited access to health care services
- Working poor
- Lack of health insurance
- Lack of transportation
- Lack of knowledge and education on disease

# Promotora Model

- Effective to reach minority and underserved populations
- Have trust and respect from their community members
- Have gained medical providers' appreciation for their contribution to improving the health of their families and community members
- Represent the cultural, linguistic, socio/economic and educational characteristics of the population they serve
- Most Promotoras are members of a farmworker family or are ex - farmworkers

# Promotoras Outreach and Education

Promotoras reach the targeted population at their work site, their homes, churches and community

Promotora Diabetes Class

# Community Support Services Offered by Promotoras

- Diabetes Self-Management Education Classes
- Promotora Advocacy and Referral
- Home Visits
- Diabetes Support Groups
- Family and couple support
- Physical Activity

# Community Support Services Offered by Promotoras

- *Patient Diabetes Education*
  Through educational sessions participants learn about diabetes and how to manage it
- *Family Diabetes Prevention*
  Through home visits, participant and family members are provided the tools to control and prevent diabetes.
- *Healthy Cooking Classes*
  Through classes and home visits participants and family members learn about proper food portions and healthy food

# Physical Activity

## Low Impact Aerobics

- 75% of participants reported this being their first time in their lives performing this kind of activity

# Services Offered by **Sunset Community Health Center**

- Medical Care
- Case Management
- Monitor Medical Compliance, Medication Use
- Diabetes Education Program
- Patient - Physician Communication

# Participant follow-up

- Patient Support

  Promotoras help the participants to monitor and control their diabetes through advocacy, home visits and phone calls

- Diabetes Portable Record

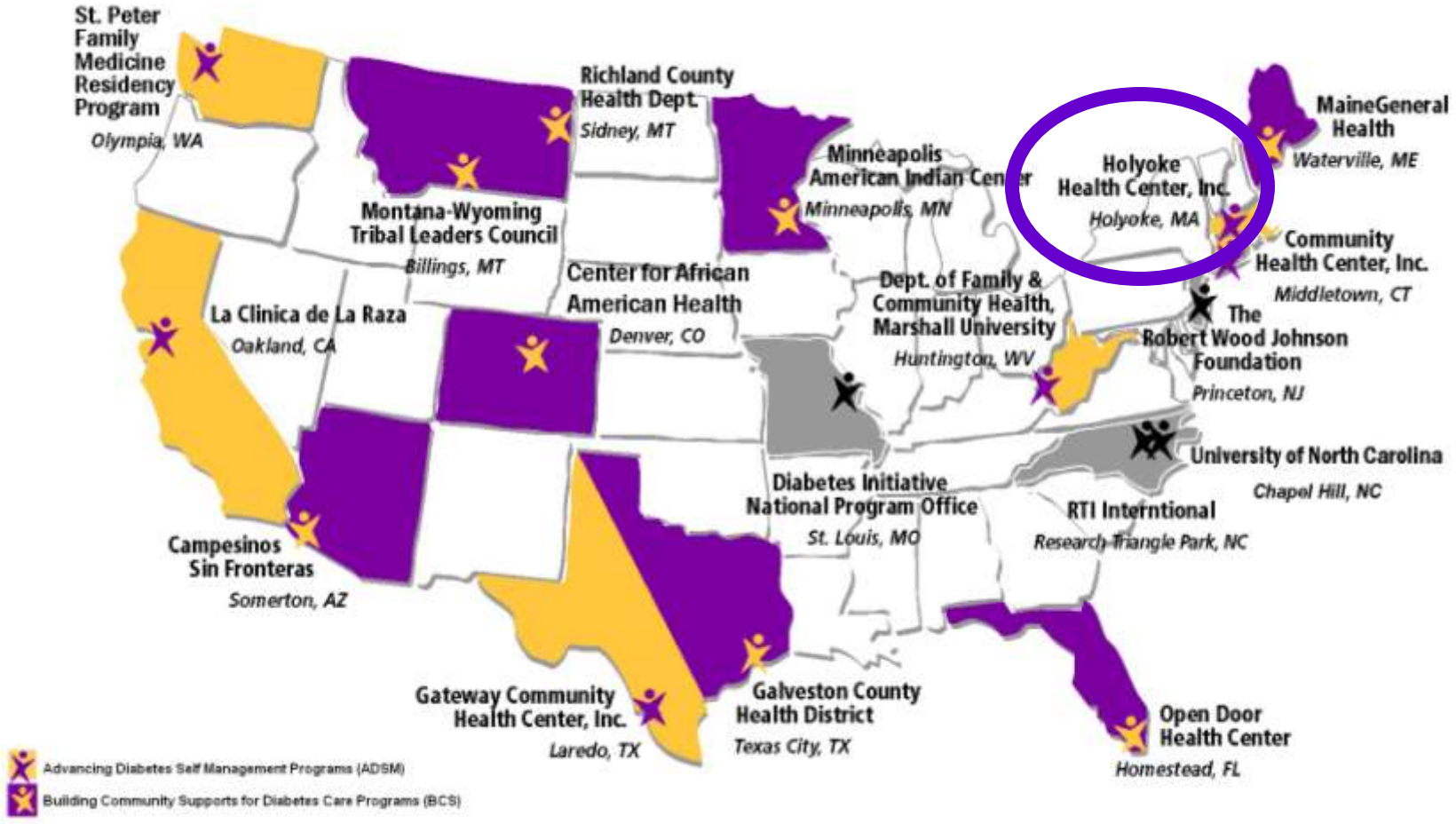
  Participants use this document to keep a record of their doctor's office visits in the U.S and Mexico

# Results

- Over 12 months, mean decrease of glycated hemoglobin of 0.58 percentage point
- Among those who began ≥ 7%, mean decrease of 1.0 percentage point
- Decreases in glycated hemoglobin correlated with
  - Attendance at support groups
    $r$ = -.343 ($p$ = .004)
  - Instrumental support or advocacy
    $r$ = -.410 ($p$ = .001)

Ingram et al. ***The Diab Educator*** 2007: Suppl 6, 172S-178S.

# *Holyoke Health Center, Holyoke, Mass.*

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# Holyoke Health Center

**Federally Qualified CHC**

**Western Massachusetts**

**17,277 medical patients**

**6,722 dental patients**

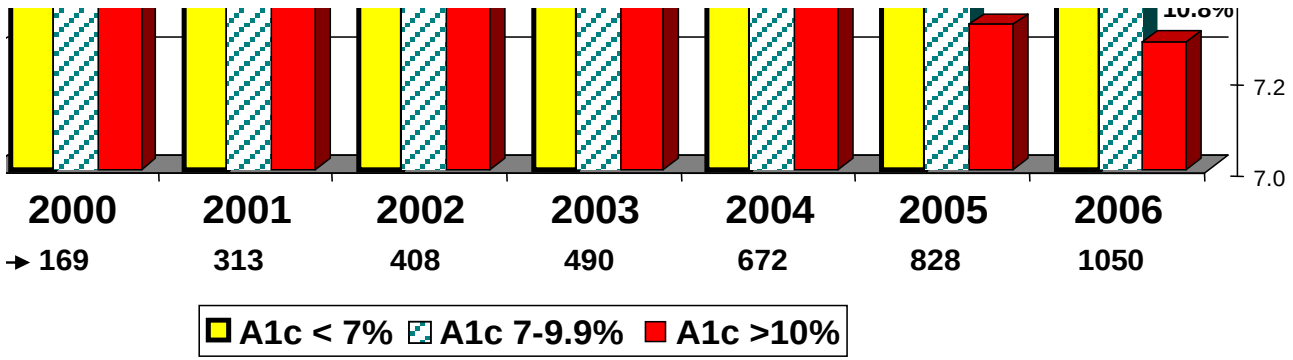
**One of the highest diabetes mortality rates in Massachusetts**

- **≈ 100% of patients live at or below poverty level**

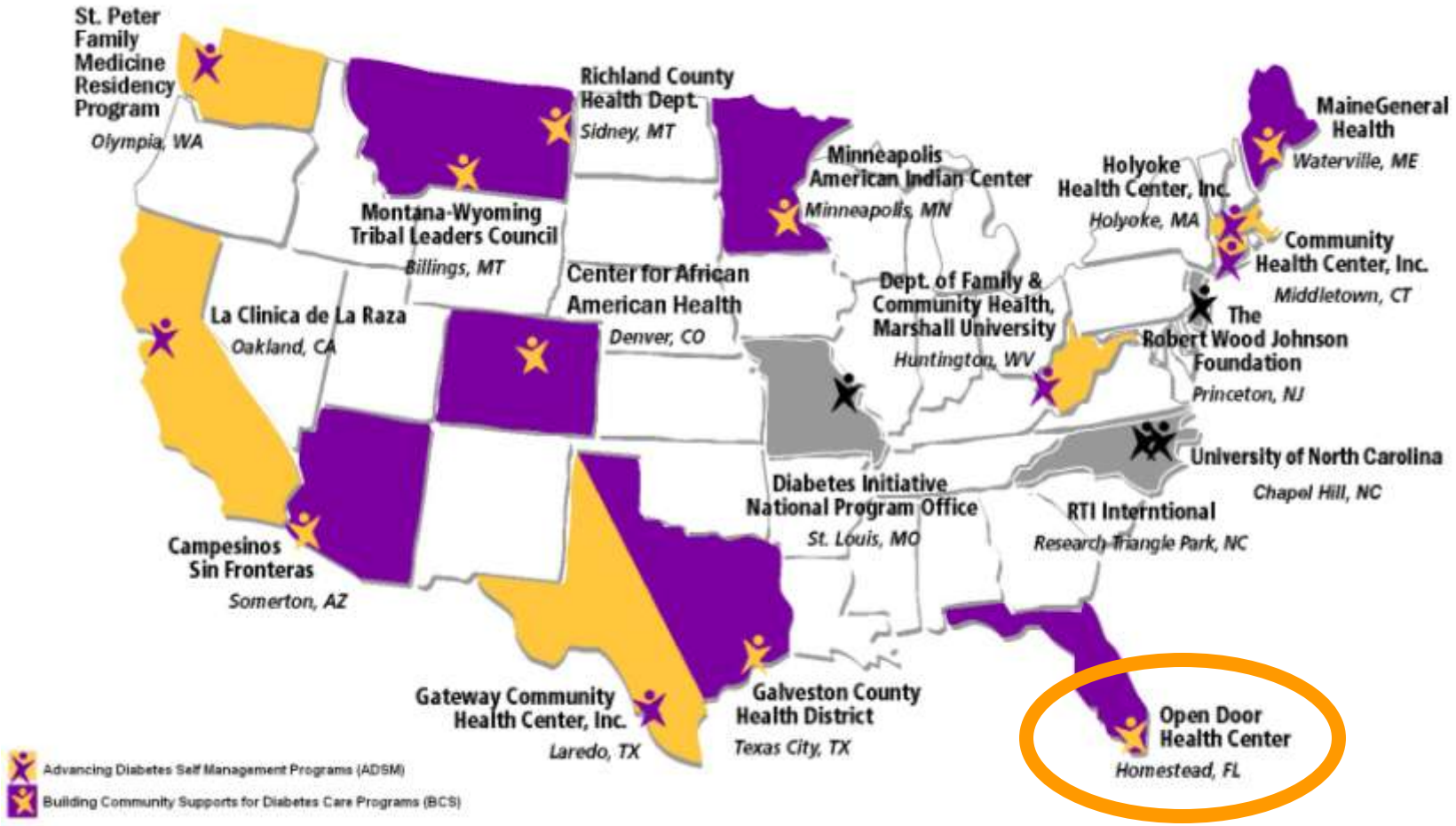
# Multiple Interventions

- Diabetes Education Classes
- Chronic Disease Self-Management Classes
- Community Health Workers
- Exercise Classes
- Individual Appointments with the diabetes educator and the nutritionist
- Breakfast Club
- Snack Club
- CHW – RN follow up of those out of contact

# Holyoke Health Center, Holyoke Massachusettes
# Changes in HbA1c — 2000 - 2006



# *Open Door Health Center*
# *Homestead, Florida*

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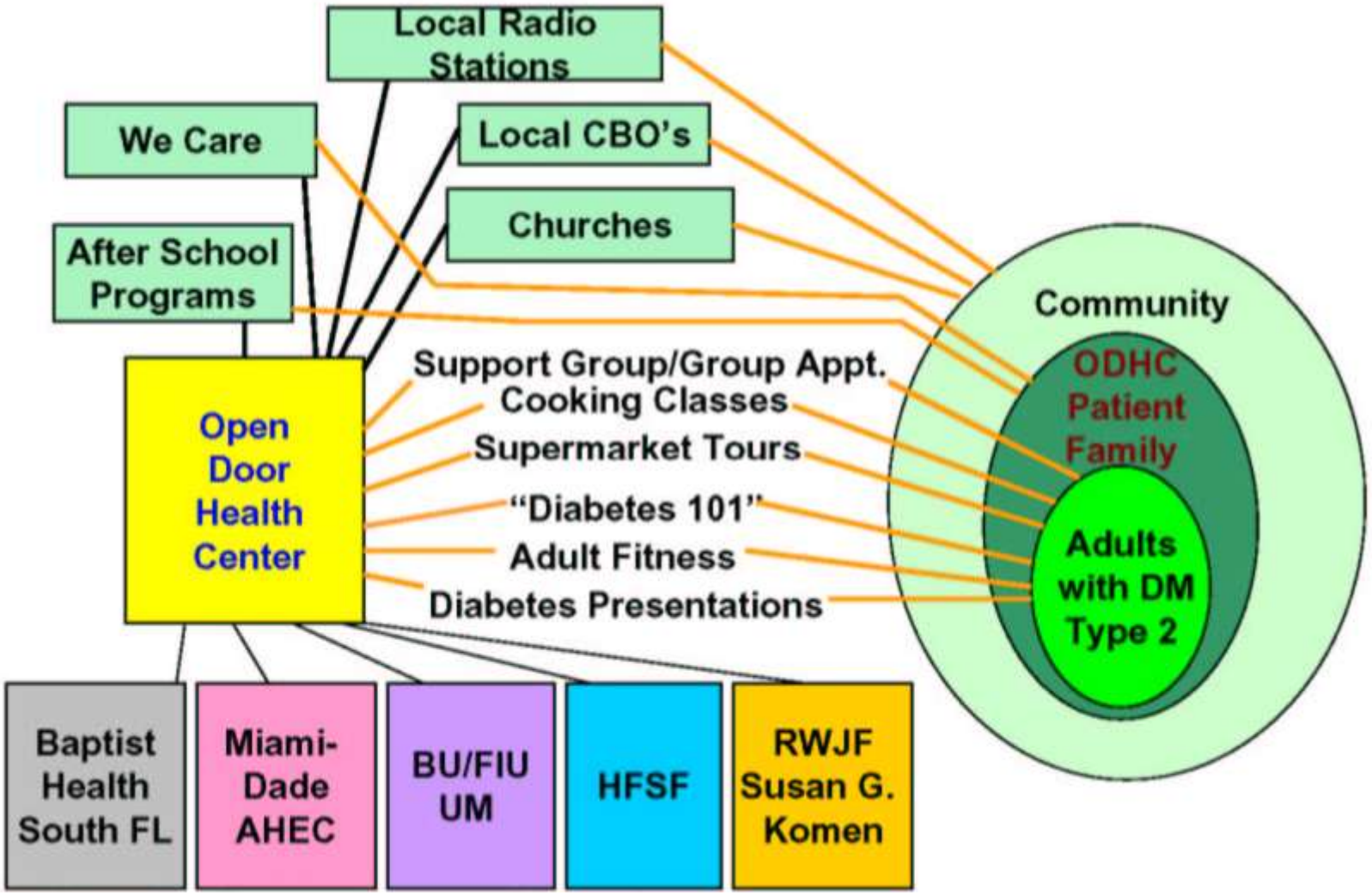
# *Clinic as Platform for Community Programs*



# *Core Concept: Resources & Supports for Self Management*

- **Individualized assessment**
  - **Including consideration of individual's perspectives, cultural factors**
- **Collaborative goal setting**
- **Enhancing skills**

  **Diabetes specific skills**

  **Self-management and problem-solving skills**

  **Includes skills for "Healthy Coping" and dealing with negative emotions**
- **Ongoing follow-up and support**
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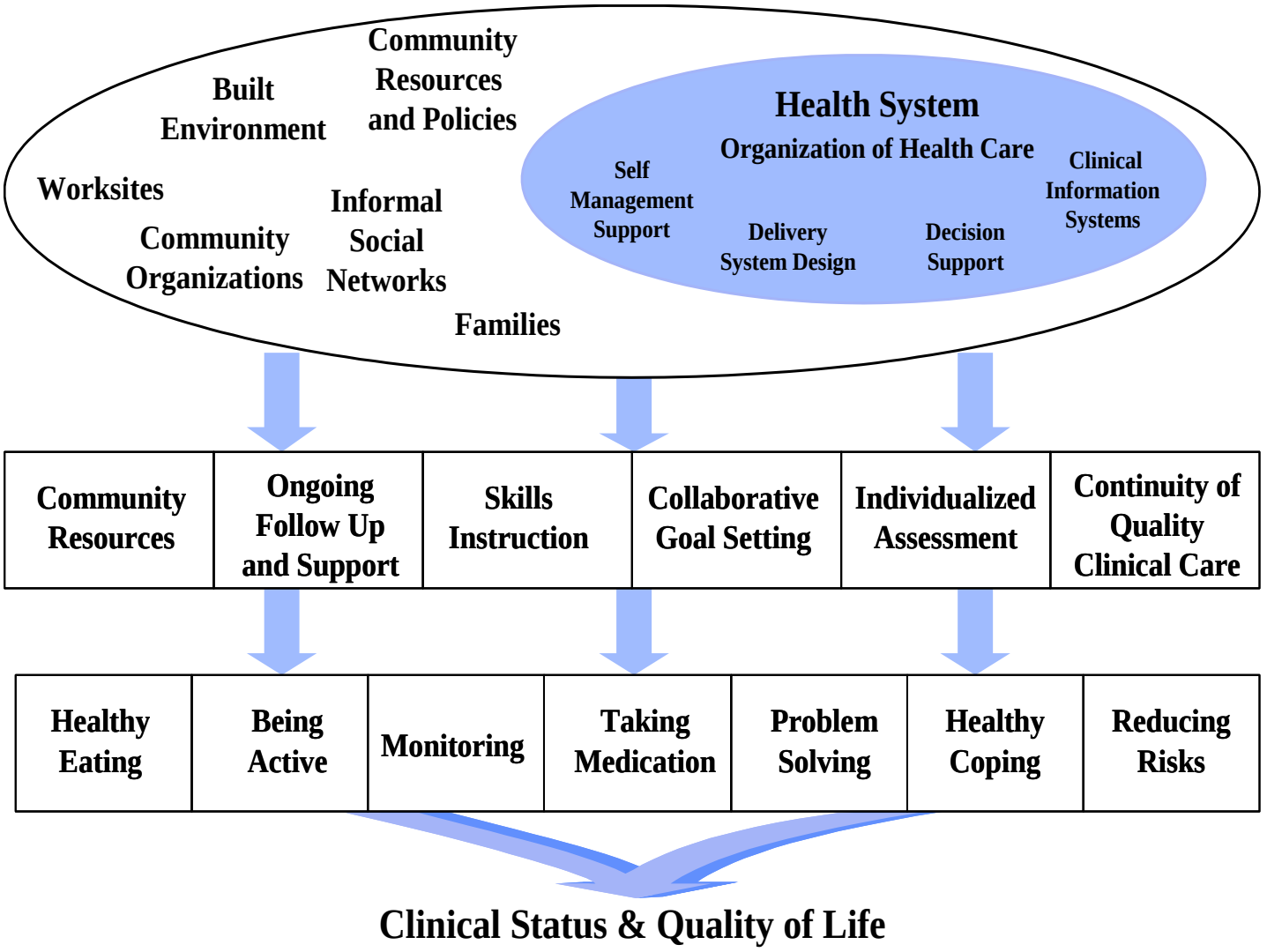
# Tri-Level Model of Self Management and Chronic Care

**Organization & System**
*e.g., Chronic Care Model*

**Implementation**
*e.g, Resources & Supports for Self Management*

**Impacts**
*e.g., AADE 7 Self-Care Behaviors*



# *The Evidence* **IS** *There!!*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# *The Critical Piece??*

- **Policy change** and changes in guidelines/practices rest on **political processes** at least as much as rational processes and evidence
- **Have data** on **clinical outcomes**
- Need a **change in perspective**, expectations about what health care should entail, at least as much as we need better data

# *Needed Shift in Public Understanding*

High Quality Diabetes Care:

- Elite internist or endocrinologist
- 15 minutes, quarterly
- Rx adjustments
- Exhortation to lose weight; diet plan
- Pat on back and good luck

High Quality Diabetes Care:

- 15 minutes, quarterly w/ pt-centered clinician
- Self management classes, support groups
- Activities, classes for healthy eating, physical activity
- Bimonthly calls from/prn access to Comm Hlth Wrkr (linked to nurse, pcp)
- Healthy community

# *"Well how is this different than just good clinical care?" J. Shapiro, NPR*

**8,766 = 24 X 365.25**

**6 hours a year in the doctor's office or with dietitian or other health professional.**

**8,760 hours on your own**

- **Healthy diet**
- **Physical activity**
- **Monitor blood sugar**
- **Take medications, insulin**
- **Manage sick days**
- **Manage stress – Healthy Coping**

# *What the individual needs*

- **Help figuring out what might work in her/his daily life**
- **Skills to do it**
- **Ongoing encouragement and support – it's for the rest of your life (and help when things change)**
- **Community resources**
- **Tying it all together with good clinical care**

# *World Views that Frame Self Management*

Newtonian Physics – Quantum Physics

Linear Systems – Integrative Systems

Positivism – Post Modernism

"Just Say 'No'!" – "It Takes a Village"

PC – Macintosh

Narrative
Protagonist/Antagonist/Solution – *No Country for Old Men*
*Fargo*, Cohn Brothers

Magic Bullets – Multicausality

Cute Child/Sick/Heroic Doctor – Self Management

# *Challenge to Communicating What We Do*

- No magic cures, breakthroughs
- Skills and influences are subtle and diffuse, not dramatic and tangible
- How to describe diabetes self management so that it is appreciable, more than "just good medical care"

# *The Story*

For folks with diabetes

- 6 hours a year with the doctor, 8,760 "on your own"
- "Different strokes for different folks," but need
  - Help to figure out how you want to manage your diabetes
  - Help learning the skills to do it
  - The encouragement and community resources to stay with it
- It can be done with real people in real places

# *Dissemination Resources and Activities*

- **diabetesinitiative.org**
- Assessment tool for SMS in primary care (PCRS)
- Special supplement to *The Diabetes Educator* (June 2007)
- Clinic community partnership framework and checklist for self assessment
- Business case handbook
- Report of the collaborative learning network
- Healthy coping guide (in process)
- Sustainability document (in process)
- Numerous products from individual grantees (web)


- **$500,000 to $1 Million**
- **Nonbinding 300-word descrip-tions due July 1**
- **Proposals due September 1**
- **Information at peersforprogress.org**

# Contact

http://www.diabetesinitiative.org

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