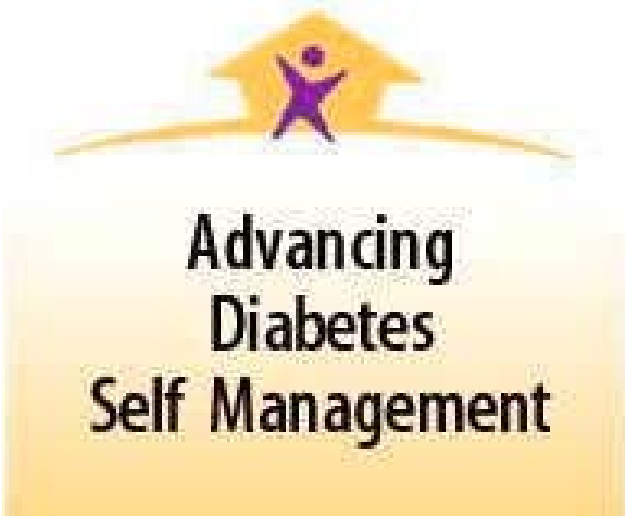
Robert Wood Johnson Foundation

Diabetes Initiative



National Program Office
Division of Health Behavior Research
Washington University School of Medicine
Presented by Carol Brownson

National Program Office

Division of Health Behavior Research,
Diabetes Research & Training Center
Departments of Medicine & Pediatrics
Washington University

Edwin Fisher, Ph.D., Director
Carol Brownson, M.S.P.H., P.H.L.C., Deputy Director
Patricia Fazzone, D.N.Sc., M.P.H., R.N., Deputy Director
Robyn Housemann, Ph.D., M.P.H., Evaluation Coordinator
Andrea Deen, M.P.H., Program Coordinator
Gisela Paluga, Program Secretary, 314/286-1930
gpaluga@im.wustl.edu

Robert Wood Johnson Foundation

Diabetes Initiative

Promoting **self management** as part of **quality diabetes care** through **primary care** and **community settings**

Self Management in Chronic Care Model

Effective self-management means more than telling patients what to do. It means giving patients a central role in determining their care, one that fosters a sense of responsibility for their own health. Using a collaborative approach, providers and patients work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way.

(M. Von Korff, J. Gruman, J.K. Schaefer, S.J. Curry and E.H. Wagner, "Collaborative management of chronic illness," *Annals of Internal Medicine* 127 (1997): 1097-1102.)

Self Management *Behaviors*

- Identify goals
- Acquire skills for pursuing goals, including disease management skills
- Implement skills
- Identify and anticipate barriers or challenges that may undermine efforts
- Develop plans for minimizing, avoiding or coping with barriers/challenges
- Gain support from professionals, family, friends, and organizations in the community
- Recognize and value progress, benefits
- Maintain skills and modify regimen as needed

Self Management *Interventions*

Programs should address:

- Understanding of diabetes and its impacts
- Understanding of role of behavior in managing diabetes and reducing the risk of acute and chronic complications
- Goal setting and problem solving skills
- Health behaviors: exercise, diet, coping skills
- Disease-specific skills (usually ≤ 20% of program content)
- Role management – social support, connections to work and family, normal functions of daily life
- Emotion management – managing depression or stress, adaptation to change, interpersonal relationships
- Follow up and monitoring

December, 2001: The Robert Wood Johnson Foundation & The Center for the Advancement of Health

Goals of the Diabetes Initiative

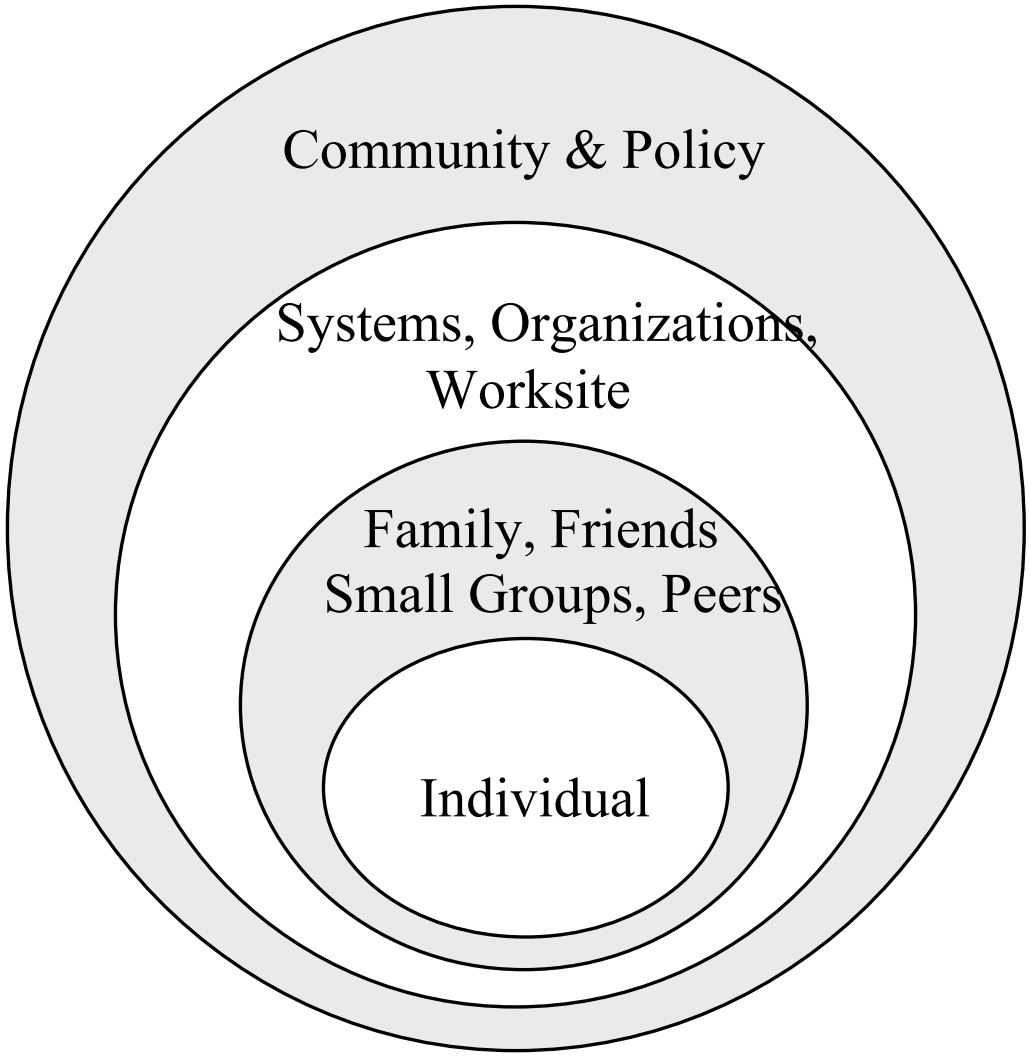
- Demonstrate value of programs promoting diabetes ***self management*** as ***part of quality care*** in ***primary care*** and ***community settings***
- Identify key elements of such programs, e.g.,
  - Goal setting
  - Use of lay health workers
- Identify how contextual variables influence self management (and programs that support self management in those contexts)
- Identify ways to promote improved self management, e.g., through Learning Network

3 Key Aspects of Diabetes Management

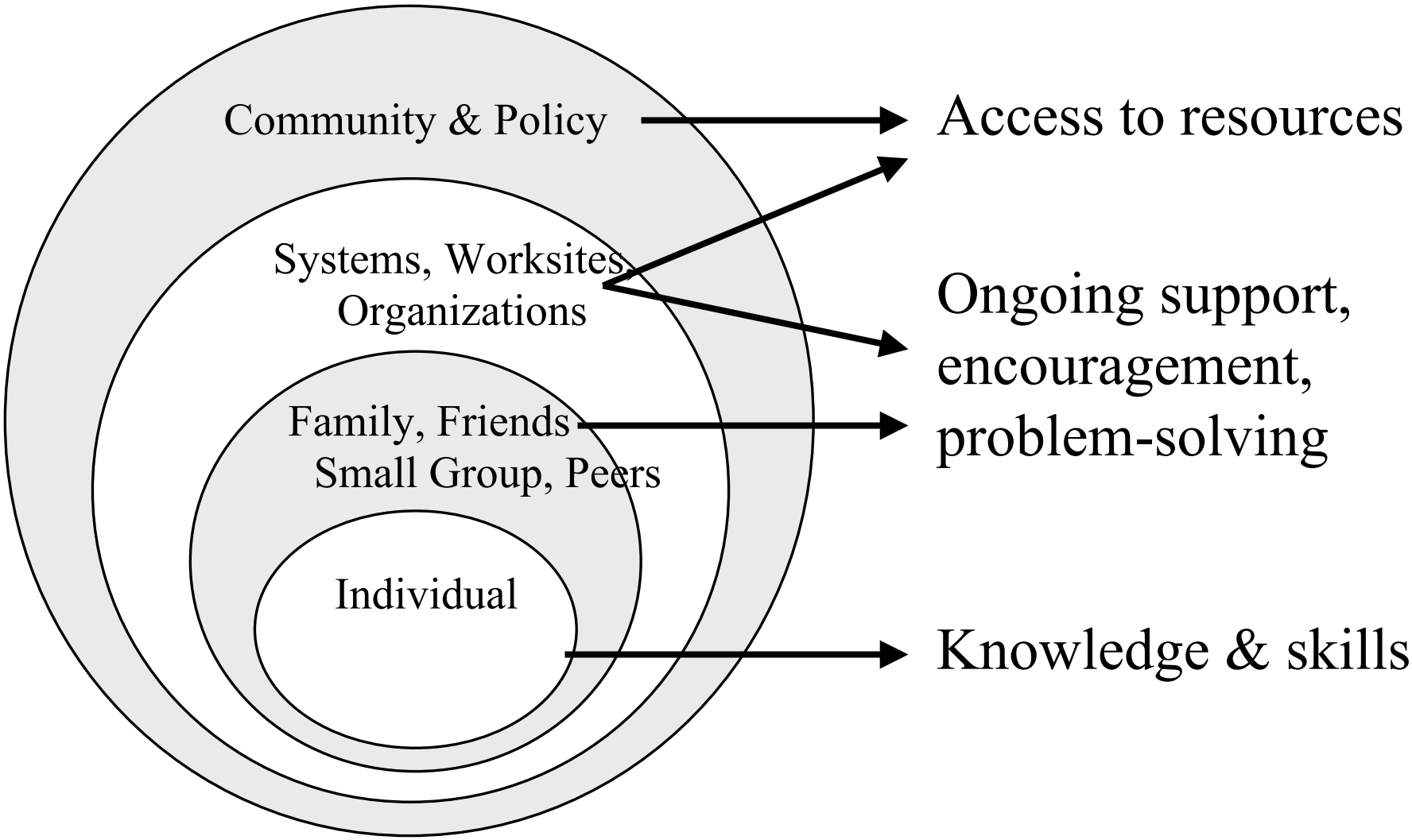
1. Centrality of health behavior
   - Diet
   - Exercise
   - Blood glucose monitoring
   - Medication management
   - Psychological/emotional management
2. In every part of daily life (“24/7”)
3. For the rest of your life

3 Key Aspects		***Self Management***
1. Health behavior	→	**Knowledge & skills**
2. In every part of daily life	→	**Access to resources**
3. For the rest of your life	→	**Ongoing support, encouragement & problem solving**

Ecological Perspectives in Health Behavior



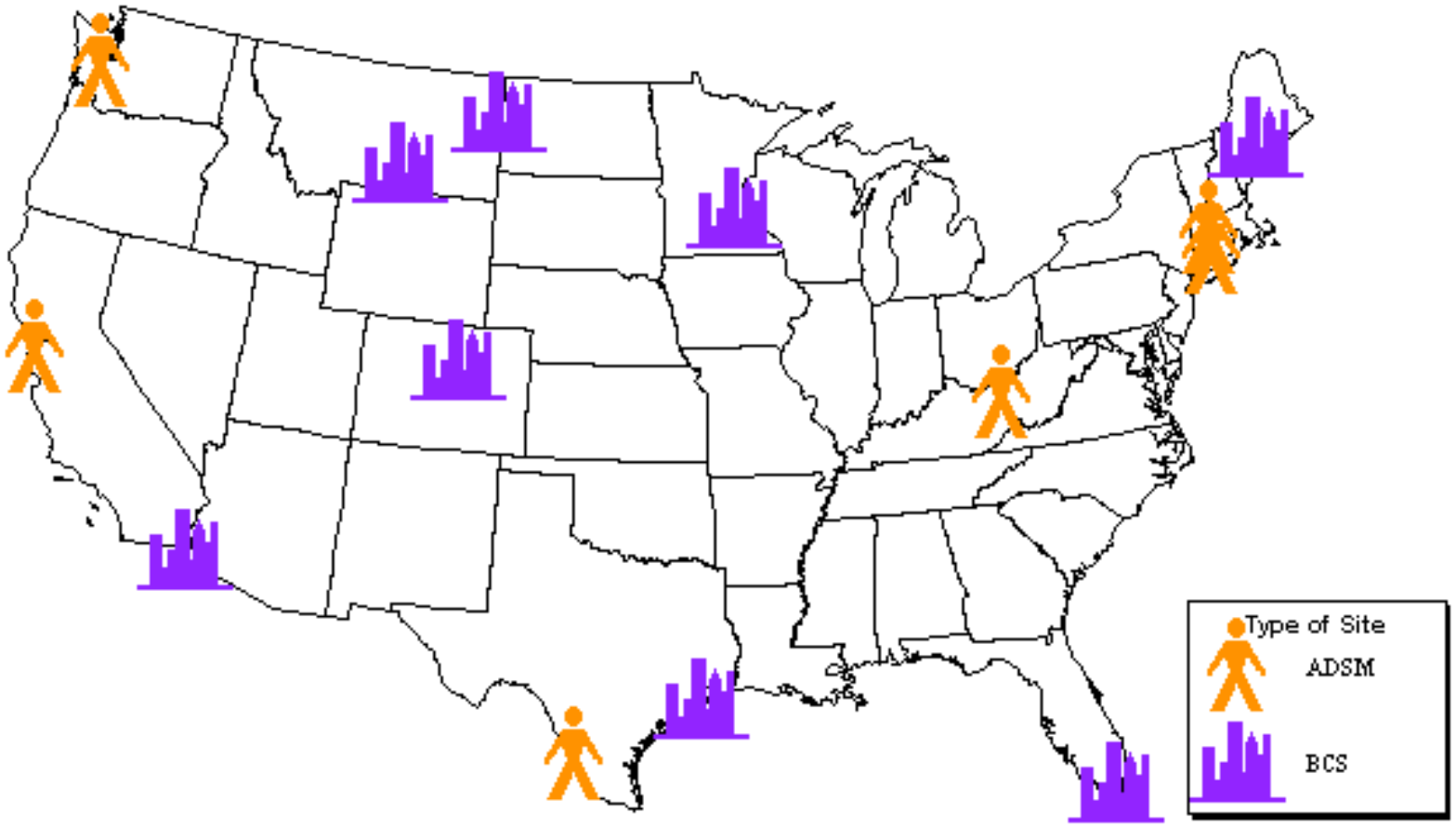
Ecological Perspective of Self Management



Demonstrating and evaluating programs to promote self management of diabetes in primary care settings

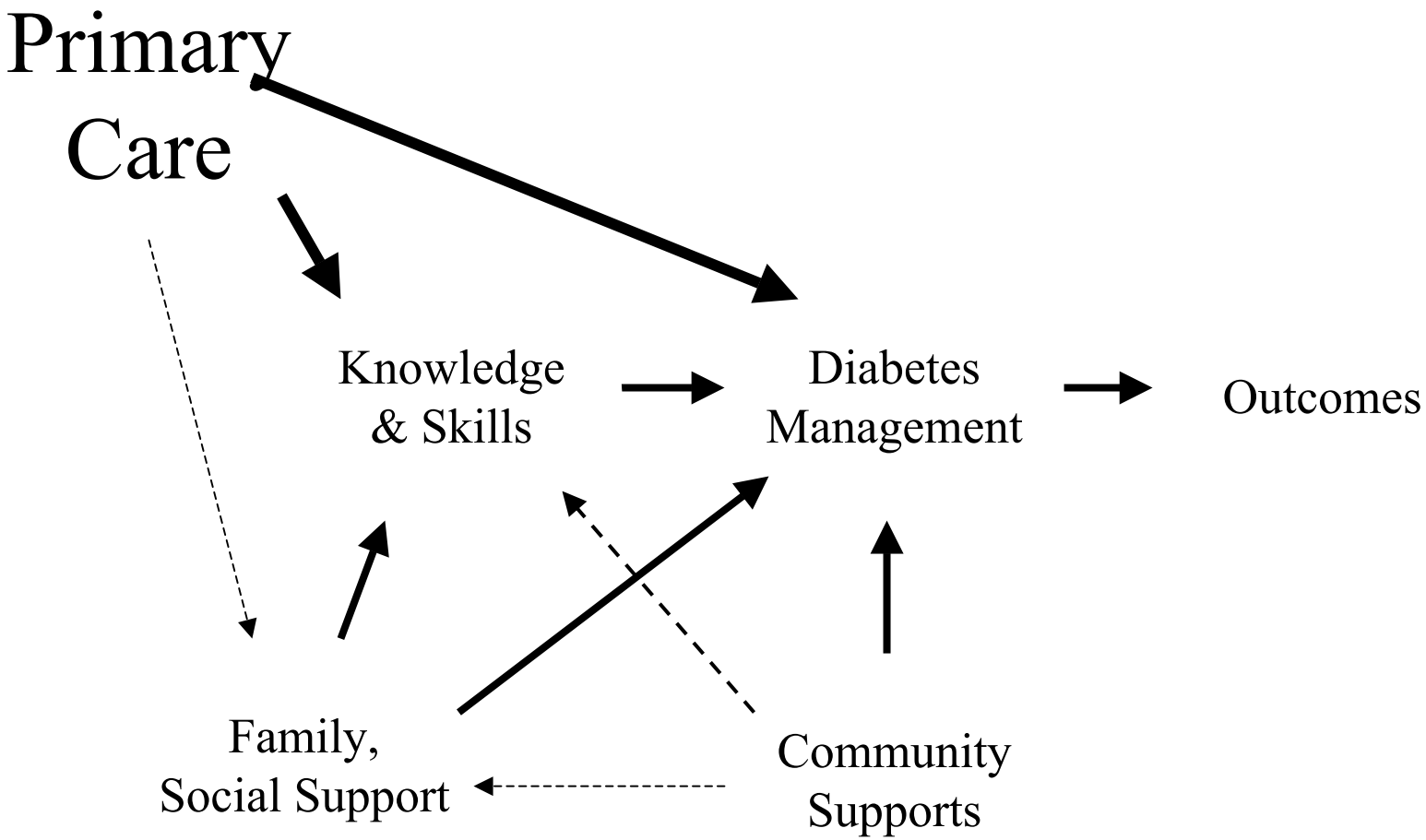
Demonstrating and evaluating community collaborations to support self management of diabetes and diabetes care

Diabetes Initiative Funded Sites



Diabetes Initiative

Self Management in the Context of Primary Care

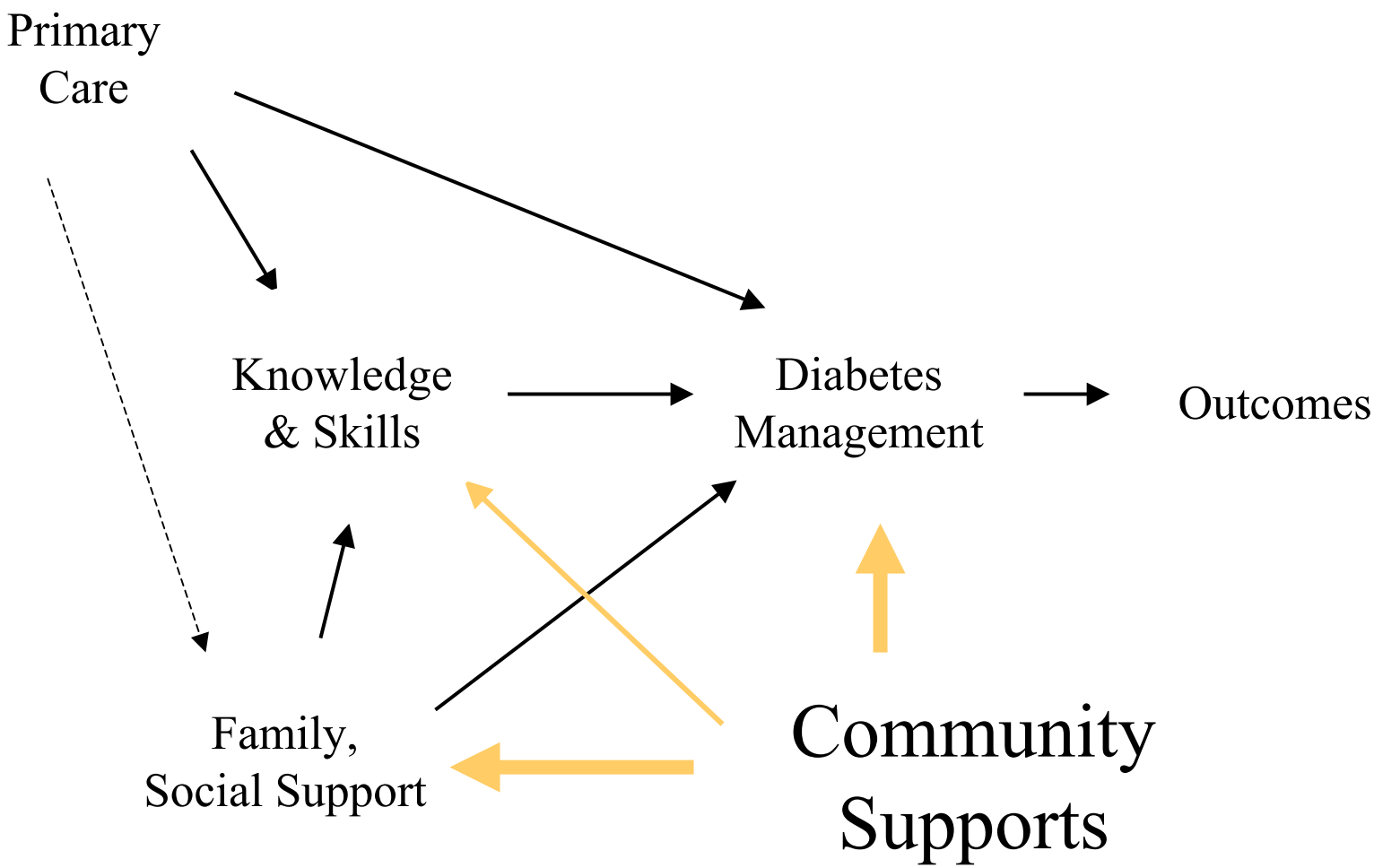


ADSM: Key Characteristics of Grantees

Site	Ethnicity	Area Served	Select Strategies
Dept of Family and Community Health Huntington WV	**White/ African American**	**Rural**	**Group medical visits; TTM; tx depression**
Holyoke HC, Inc. Holyoke, MA	**Hispanic**	**Urban**	**Information system; LHWs; family focus; Breakfast Club**
Community HC, Inc. Middletown, CT	**H/AA/W/ other**	**Urban**	**Group visit; family focus; tx mental health; LHWs**
Providence-St. Peter Family Practice Residency Olympia, WA	**White**	**Urban**	**Group medical visits; MD and MA planned visits for goal setting f/up**
Gateway CHC, Inc. Laredo, TX	**Hispanic**	**Border Town**	**Lorig and CDC SM classes; LHWs**
La Clinica de La Raza-Fruitvale Health Project, Inc. Oakland, CA	**Hispanic**	**Urban**	**TTM; strong community focus; LHWs**

Diabetes Initiative

Self Management in the Context of Community Supports



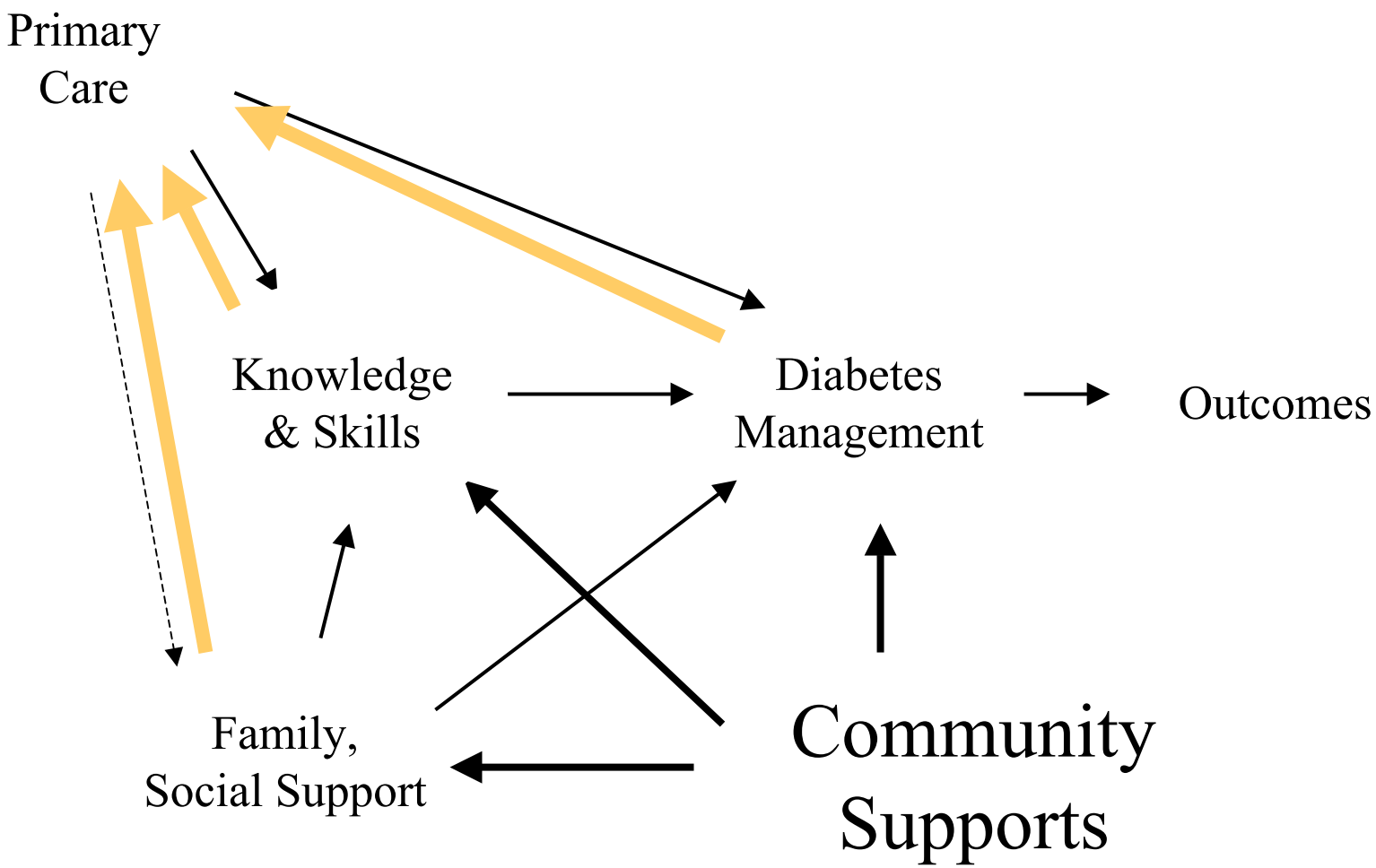
Building Community Supports for Diabetes Care

Projects	Population	Setting
Open Door Health Center, Homestead FL	Haitian, Mexican, African American	Rural—Free Clinic
MaineGeneral Health, Waterville ME	Uninsured, poor White	Rural--KennebecValley Region
Richland Co Health Dept, Sidney MT	45+ White, American Indian, Hispanic	Rural—Frontier
Metro Denver Black Church Initiative, CO	African American	Urban—Faith based, community placed
Campesinos Sin Fronteras, Yuma Co, AZ	Hispanic migrant and seasonal farm workers	Rural—Border
Galveston Co Health District, Texas City, TX	Hispanic, African American, White	Rural County--Mainland
Minneapolis American Indian Center, MN	Native American Indian	Urban—Community Center
MT-WY Tribal Council, Billings, MT	Native American Indian	Reservation

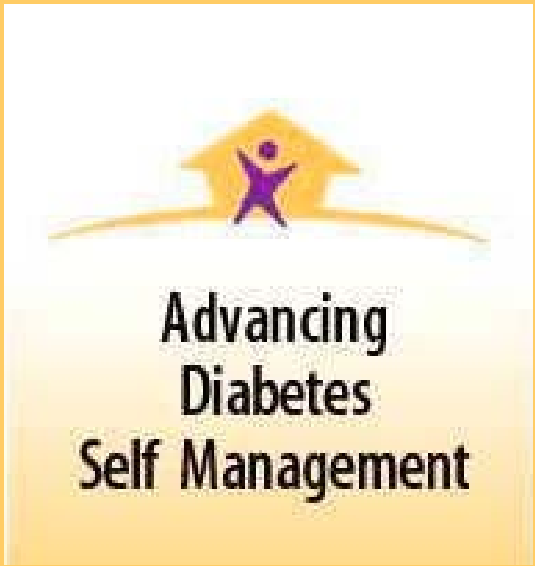
Selected Strategies in Building Community Supports for Diabetes Care

- Lay health workers/ *Promotoras*
- Family education and support
- Community advisory groups
- Community events: feasts/ fairs/ outreach
- Environmental interventions, e.g., walking trails, grocery store programs
- Agency collaboration/ networking/ referral
- Self management education
- Support groups

Community Support: Impacts on Care?



Diabetes Initiative



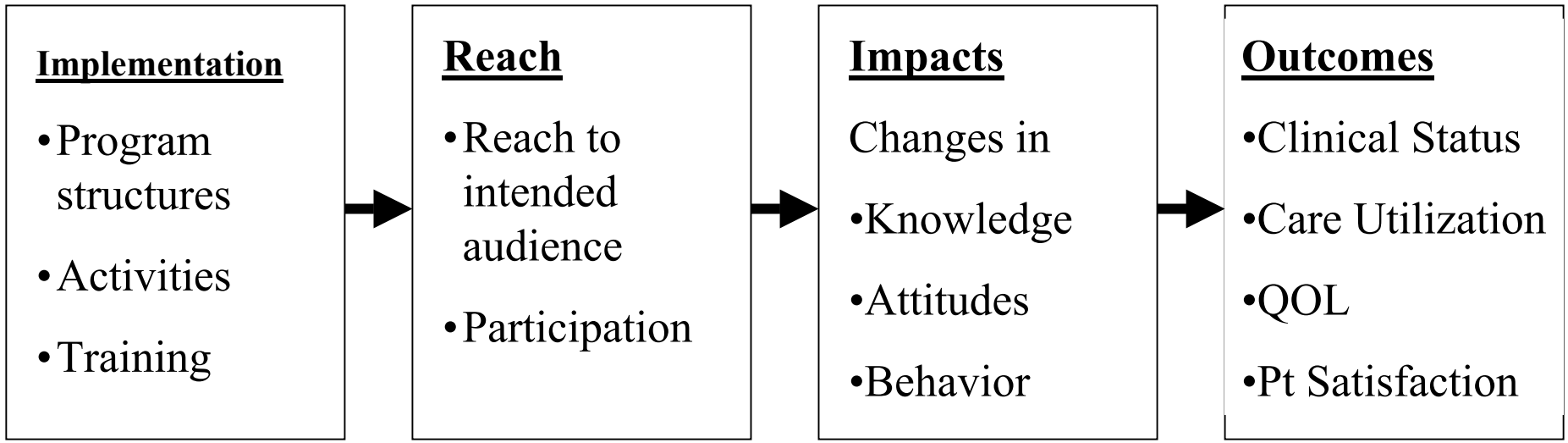
Evaluation Plan

Evaluation Objectives

- Process evaluation
  - Characterize interventions , level of participation, client satisfaction, feasibility
- Cross-site evaluation
  - Show overall impacts
  - Evaluate relationships among exposure to key interventions and improved clinical and quality-of-life outcomes
- Strategic/cross cutting issues (e.g., role of goal setting, social support, lay health workers)
  - Articulate role in diabetes care
  - Develop protocols for national use

Evaluation Based on:

PRECEDE-PROCEED (Green & Kreuter) & RE-AIM (Glasgow)



Across all 14 sites

Expect "*Equifinality*"

- ***Equifinality***: Accomplishment of ***similar objectives*** by ***diverse methods*** following ***diverse paths***
  - characterizes health promotion
  - differentiates it from the ideal of rational care in clinical medicine
  - poses challenges for institutionalizing prevention in health care financing

Equifinality in Self Management

Key Elements	Diverse Implementations
Goal Setting	Primary care provider, RN, Interactive video, Coach
Diabetes Management Skills	Group classes, individual instruction, print materials, community programs, Coach/*Promotora*, web resources
Problem Solving	
Monitoring & Feedback	PCP, RN, web-based automated monitoring
Ongoing Support, Encouragement	Coach, outbound phone service, web-based monitoring, support groups

Robert Wood Johnson Foundation

Diabetes Initiative

http://diabetesnpo.im.wustl.edu

cbrownso@im.wustl.edu

Robert Wood Johnson Foundation Staff

Terry Bazzarre, Ph.D., Senior Program Officer
Anne Weiss, M.P.P., Senior Program Officer
Sara Thier, M.P.H., Program Associate
Mary Ann Scheirer, Ph.D., Evaluation Officer
Fred Hunter, Financial Analyst
Fran Ferrara, Program Assistant
Jeanne M. Stives, Program Assistant
Paul A. Tarini, Senior Communications Officer
Maureen Cozine, Communications Associate
Joan E. Barlow, Production Associate

National Advisory Committee

Ronald E. Aubert, PhD, MSPH – Chairman, Merck-Medco Managed Care

Patricia J. Barta, MPH, RN, CDE, Sr. Prog Officer, Ctr. for Health Care Strategies

Martha M. Funnell, MS, RN, CDE, Director of Admin., U. Mich DRTC

Joanne M. Gallivan, MS, RD, Director, National Diabetes Education Program

Russell E. Glasgow, PhD, Senior Scientist, Kaiser Permanente, Colorado

Sheldon Greenfield, MD, Professor, Tufts University School of Medicine

Sherman A. James, PhD, Professor, University of Mich School of Public Health

David G. Marrero, PhD, Professor, Indiana University School of Medicine

M. LaVerne Reid, PhD, MPH, Professor, North Carolina Central University

Veronica J. Richardson, RN, IHI National Director, Bureau of Primary Health Care

Aracely Rosales, BS, Principal, Rosales Communications

David M. Stevens, MD, Director, Clinical Branch, Bureau of Primary Health Care

Judith Wylie-Rosett, EdD, Professor, Albert Einstein College of Medicine Bronx

RTI External Evaluation Team

Douglas B. Kamerow, M.D., M.P.H., Chief Scientist

Joe Burton, M.S., Health Services Researcher

Lucy A. Savitz, Ph.D., MBA, Senior Health Research Analyst

Thank you!!