Robert Wood Johnson Foundation

Diabetes Initiative

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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.

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

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

<table>
<thead>
<tr>
<th>1. Health behavior</th>
<th>Knowledge &amp; skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. In every part of daily life</td>
<td>Access to resources</td>
</tr>
<tr>
<td>3. For the rest of your life</td>
<td>Ongoing support, encouragement &amp; problem solving</td>
</tr>
</tbody>
</table>
Ecological Perspectives in Health Behavior

- Individual
- Small Groups, Peers
- Family, Friends
- Systems, Organizations, Worksite
- Community & Policy
Ecological Perspective of Self Management

- Community & Policy: Access to resources
- Systems, Worksites, Organizations: Ongoing support, encouragement, problem-solving
- Family, Friends, Small Group, Peers: Knowledge & skills
- Individual
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

Advancing Diabetes Self Management
Self Management in the Context of Primary Care

Primary Care

- Knowledge & Skills
- Diabetes Management
- Outcomes

Family, Social Support

Community Supports
## ADSM: Key Characteristics of Grantees

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

Building Community Supports for Diabetes Care
Self Management in the Context of Community Supports

Primary Care

Knowledge & Skills

Diabetes Management

Outcomes

Family, Social Support

Community Supports
## Building Community Supports for Diabetes Care

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

- Primary Care
- Knowledge & Skills
- Diabetes Management
- Outcomes
- Family, Social Support
- Community Supports
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)

Implementation
• Program structures
• Activities
• Training

Reach
• Reach to intended audience
• Participation

Impacts
Changes in
• Knowledge
• Attitudes
• Behavior

Outcomes
• Clinical Status
• Care Utilization
• QOL
• Pt Satisfaction

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

<table>
<thead>
<tr>
<th>Key Elements</th>
<th>Diverse Implementations</th>
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</thead>
<tbody>
<tr>
<td>Goal Setting</td>
<td>Primary care provider, RN, Interactive video, Coach</td>
</tr>
<tr>
<td>Diabetes Management Skills</td>
<td>Group classes, individual instruction, print materials, community programs, Coach/Promotor, web resources</td>
</tr>
<tr>
<td>Problem Solving</td>
<td></td>
</tr>
<tr>
<td>Monitoring &amp; Feedback</td>
<td>PCP, RN, web-based automated monitoring</td>
</tr>
<tr>
<td>Ongoing Support, Encouragement</td>
<td>Coach, outbound phone service, web-based monitoring, support groups</td>
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</table>
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Thank you!!