Robert Wood Johnson Foundation

Washington University in St. Louis
School of Medicine

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Ongoing Follow Up and Support

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Resources & Supports for Self Management

- Individualized Assessment
- Collaborative Goal Setting
- Enhancement of Skills
- ***Ongoing Follow Up and Support***
- Community Resources
- Continuity of Quality Clinical Care

Key Features of Ongoing Follow up and Support

- Personal
- Available on-demand
- Proactive or staff initiated
- Motivational
- Consistent in terminology and concepts
- Not limited to diabetes
- Inclusive of community resources
- Available via a variety of program options

Personal

- Based in an ongoing relationship with a member of the patient care team
- Not necessarily with a physician
- Critical are:
  - Time to get to know individual
  - Links to rest of team
- Community Health Workers often are ideal in this role

Community Health Workers and Ongoing Follow up and Support

- Provide emotional support, social support and encouragement
- Reinforce and trouble-shoot basic education
- Act as a bridge between the community and the health center
- Facilitate linkage to clinical and other resources
- Organize for advocacy, community action

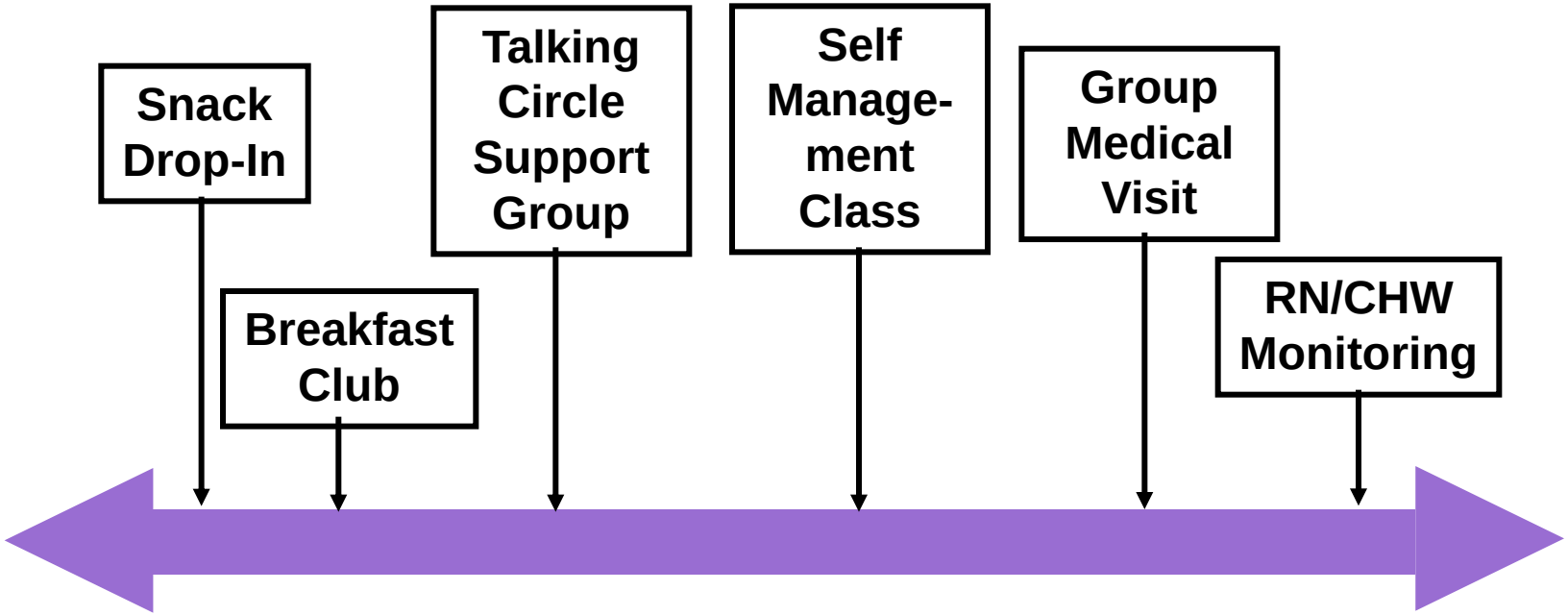
Available On-Demand

- Available as needed by the recipient
- Examples include:
  - Community based events, e.g., health fairs
  - Breakfast clubs
  - Walking clubs
  - Drop-in snack clubs
  - Parties to which family invited
  - *Talking Circles* in American Indian communities

Proactive or Staff Initiated

- Regular contact
  - Phone calls
  - Meetings
  - Newsletters
- Low demand contacts to
  - communicate interest rather than surveillance
  - keep individuals from "falling through the cracks"
  - create opportunities to provide other Resources and Supports for Self-Management as needed

On-Demand to Staff Initiated: A Critical Continuum



On-demand, Varied Contacts to Suit Individual Preferences

Staff-Initiated Contacts to Maintain Contact and Prompt Engagement

Motivational

- Especially important for those with a long history of diabetes
- Effective of strategies:
  - Use of Nondirective Support– i.e., accepting individual's goals and views of things, encouraging more than "taking over"
  - Use of Community Health Workers (CHW) – 30% of CHW encounters in the Diabetes Initiative were categorized as providing encouragement or motivation
  - Use of Support groups

Consistent in Terminology and Concepts

- Consistency avoids confusion, e.g.,
  - "HbA1" vs. "blood sugars" vs "Metabolic Control"
  - "Action Plan" vs. "Problem Solving"
- Consistency reinforces importance – when something is important, we tend to give it a single name

Not Limited to Diabetes

- Diverse concerns or challenges the individual faces must be addressed
- Program examples:
  - Programs that address overall well-being – e.g., weight management, physical activity, chronic disease self management groups—link broader interests which helps gain program support
  - Programs directed toward general public (i.e., not labeled by disease) may reduce or avoid stigma and enhance participation

Inclusive of Community Resources

Examples include:

- Non-health partners, e.g., youth programs, housing authority, churches, beauty salons, barber shops
- Advisory boards and committees
- Cultural specific organizations
- Classes and activities for family, friends, etc.
- Community campaigns, mailings, etc

Variety of Program Options

- ***Many "good" better than few "best" practices***
- Multiple interventions provide ample opportunity for ongoing follow up and support
- Use of varied program opportunities enhances patient participation and engagement, e.g.,
  - Breakfast Club
  - Chronic Disease Self-Management Classes
  - Community Health Worker contact
  - Diabetes Education Classes
  - Exercise Classes
  - Individual Appointments with the diabetes educator, nutritionist or other team members as needed
  - Snack Club

Culture Shift??

- Personal connection with staff
- On demand as well as staff initiated contacts
- Motivational
- Common language and concepts
- Not limited to diabetes – person-centered
- Extends to community, neighborhood, family
- Variety of alternatives for individual preferences

Program culture that makes central the role, needs, and preferences of the individual in self management

For more information see:

Fisher EB, Brownson CA, O'Toole ML & Anwuri VV: ***Ongoing Follow-Up and Support for Chronic Disease Management in the Robert Wood Johnson Foundation Diabetes Initiative.*** ***The Diabetes Educator*** Volume 33, Supplement 6, June 2007, 201S-207S

http:diabetesinitiative.org