Implementing Community-Based Self-Management Programs in Diverse Communities

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American Diabetes Association
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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
The Richland County Community Diabetes Project
Richland County, Montana

Lisa Aisenbrey, RD, Diabetes Project Director
Richland County, Montana
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)
- McCona 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 $\geq 7\%$, mean decrease of 1.0 percentage point
- Decreases in glycated hemoglobin correlated with
  - Attendance at support groups
    \[ r = -0.343 \quad (p = 0.004) \]
  - Instrumental support or advocacy
    \[ r = -0.410 \quad (p = 0.001) \]

Holyoke Health Center, Holyoke, Mass.
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 Massachusetts
Changes in HbA1c — 2000 - 2006

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<tr>
<th>Year</th>
<th>HbA1c</th>
<th># of Patients</th>
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<tbody>
<tr>
<td>2000</td>
<td>169</td>
<td></td>
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<tr>
<td>2001</td>
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<td>2005</td>
<td>828</td>
<td></td>
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<tr>
<td>2006</td>
<td>1050</td>
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Average HgbA1c

<table>
<thead>
<tr>
<th>Year</th>
<th>Average HgbA1c</th>
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</thead>
<tbody>
<tr>
<td>2000</td>
<td>51.4%</td>
</tr>
<tr>
<td>2001</td>
<td>30.7%</td>
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<tr>
<td>2002</td>
<td>51.4%</td>
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<tr>
<td>2003</td>
<td>31.1%</td>
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<tr>
<td>2004</td>
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<tr>
<td>2005</td>
<td>29.9%</td>
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<tr>
<td>2006</td>
<td>52.6%</td>
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</table>

% of Patients

- A1c < 7%
- A1c 7-9.9%
- A1c >10%

- 2000: 12.2%
- 2001: 10.8%
- 2002: 17.4%
- 2003: 18.2%
- 2004: 19.9%
- 2005: 17.9%
- 2006: 19.5%
Open Door Health Center
Homestead, Florida
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
- Community resources
- Continuity of quality clinical care
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

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

Healthy Eating
  Being Active
  Monitoring
  Taking Medication
  Problem Solving
  Healthy Coping
  Reducing Risks

Clinical Status & Quality of Life
The Evidence IS There!!


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
No Country for Old Men
Protagonist/Antagonist/Solution – 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)
Call for Proposals
Diabetes Peer Support

Evaluation Grants of $500,000 to $1 million are available to document the contributions of peer support interventions for those with diabetes. University-based researchers, health systems, and similar organizations are invited to apply. Eligibility criteria include experience in (a) diabetes management and/or use of peer-based interventions in health promotion and chronic disease management and (b) research or program evaluation.

APPLICATION SCHEDULE
Brief preliminary project descriptions are due July 1, 2008.
Applications are due September 1, 2008
Funding of successful applications commences January 1, 2009.

In addition to Evaluation Grants, Peers for Progress anticipates meeting its goals through activities such as: Promoting peer support programs; encouraging networking peer support programs; hosting an international webpage to circulate program materials and curricula; and funding demonstration projects in diverse international settings.

Peers for Progress promotes peer support as a central part of diabetes care worldwide. It is a program of the American Academy of Family Physicians Foundation in partnership with the American Association of Diabetes Educators and the American Academy of Family Physicians. It is funded through an unrestricted grant from the Eli Lilly and Company Foundation, Inc.

Request for applications available at www.peersforprogress.org

• $500,000 to $1 Million
• Nonbinding 300-word descriptions due July 1
• Proposals due September 1
• Information at peersforprogress.org
Contact

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