- This product was developed by the Robert Wood Johnson Foundation Diabetes Initiative. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

Linking Community and Clinical Programs for Chronic Disease Management: Lessons from Diabetes

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1a Reunion Regtional Latinoamericana y del Caribe de Medicina Conductual

Mexico City, June, 2005

Implications for Self Management of 3 Fundamental Aspects of Diabetes

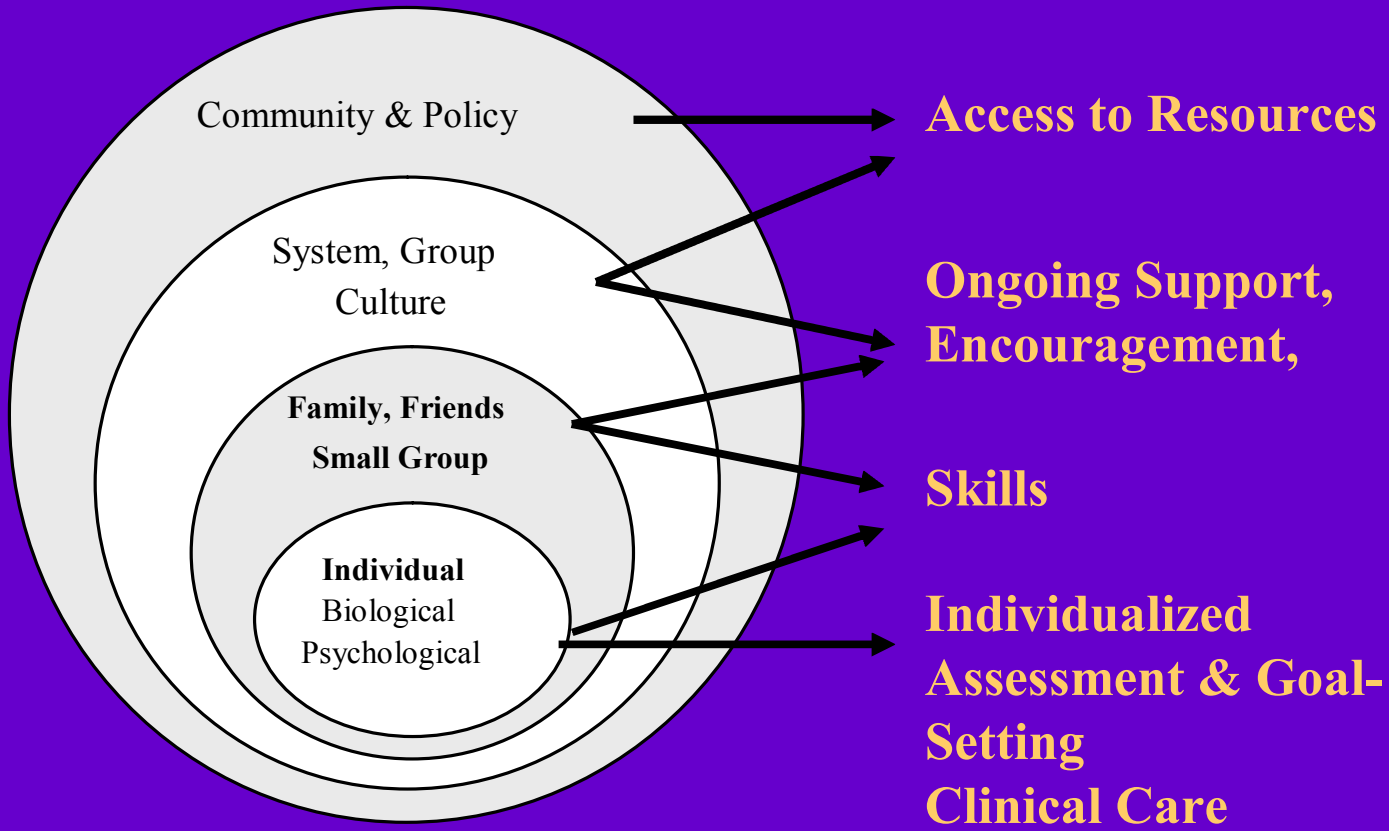
1. Centrality of behavior
   - Diet
   - Exercise
   - Monitoring
   - Medication management
   - Psychological/emotional status
2. In every part of daily life – 24/7
3. For “the rest of your life”

Resources & Support for Self Management

- Individualized assessment, including consideration of individual's perspectives, cultural factors
- Individualized, collaborative goal setting
- Assistance in learning self-management skills
  - Disease management skills
  - Healthy eating and physical activity
  - Problem solving and avoiding temptations
  - Skills for coping with negative emotions and developing sustaining relationships
- Follow-up and support
- Access to resources
- Continuity of Quality Clinical Care

Ecological Model of Self Management

Ecological Perspectives and Resources & Supports for Self Management

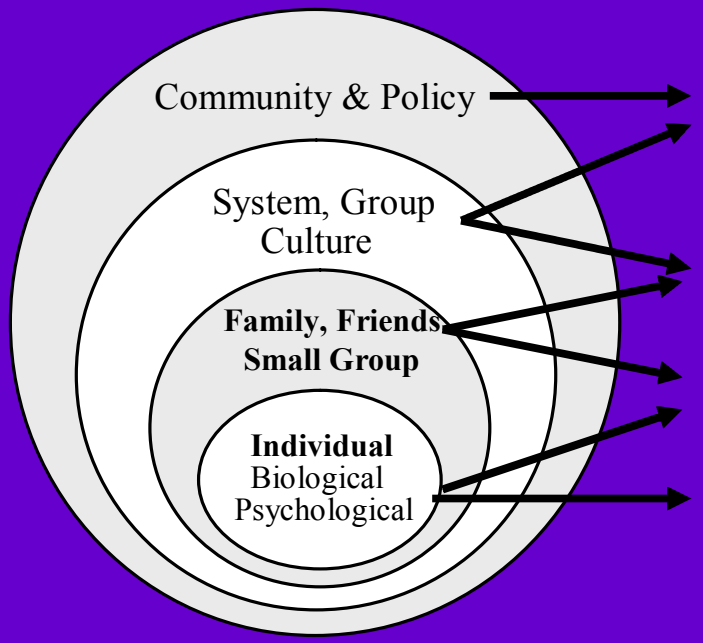


Diabetes Initiative of the Robert Wood Johnson Foundation

Promoting ***self management*** of diabetes through primary care settings

Community collaborations to support ***self management*** of diabetes and diabetes care

Diabetes Initiative and Ecological Perspectives on Self Management



Access to Resources

Ongoing Support, Encouragement,

Skills

Individualized Assessment & Goal-Setting Quality Clinical Care

Building Community Supports for Diabetes Care

Advancing Diabetes Self Management

How to Extend Primary Care into the Community, into the Daily Lives of People with Diabetes

Strategies in Clinical Care

- Regular visits, 3 - 4 times per year, ***scheduled even if all going well***
- Phone calls from clinic staff
  - Quarterly calls as routine
- Facilitate patient calls for information, problem solving
  - Identify staff member to handle such calls routinely, triage to PCPs

Strategies in Clinical Care, cont

- Link patients to community programs
- Annual party
- Low demand, low commitment activities -- e.g., “Breakfast Club” for support and information sharing
- Self management class members created informal support network among themselves

Telephone Outreach

- Ongoing phone calls from nurses
- Phone calls at least monthly
  - Review of patient education
  - Adherence
  - General health status
  - Problem solving
  - Access to care
- Reduced GHb relative to usual care

Weinberger et al. *J Gen Intern Med* 1995 10:59–66.

Telephone Outreach

- In Korea
- 2 times per week for first month
- Weekly for months 2 to 3
- Total = 16 calls; average call length = 25 minutes
- Led to 1.2 percentage point reduction in GHb relative to 0.6-point increase in usual care

Kim & Oh. *J Adv Nurs* 2003 44:256–261.

Combination of Telephone Access and Automated Systems

- Among low-income and ethnic minority patients
- Automated phone calls through which patients reported self-monitored blood glucose levels
- Individually tailored phone follow-up by nurses
- Resulted in
  - Improved GHb
  - Increased self-efficacy
  - Decreased depressed mood

Piette et al., *Diabetes Care* 1999 22:1302–1309; *Medical Care* 2000 38:218–230; *Am J Med* 2000 108:20–27.83; *Diabetes Care* 2001 24:202–208.

Group Medical Visits

- All patients with common problem (e.g., diabetes) scheduled for a group visit in a 2- or 3-hour block of time
- Physicians and other staff carry out basic assessments and individual medical visits within this group visit
- Visit also includes educational and supportive discussions or other activities.
- Relative to usual care: impressive impacts on GHb as well as other measures

Trento et al. *Diabetes Care* 2004 27:670–675; *Diabetes Care* 2001 24:995–1000

Group Medical Visit becomes "Diabetes Club"

- Weekly *Diabetes Club*

  "Tuesday is Diabetes Day"

  Link to refill of Rx
- Discussion/support group, cooking demonstration, exercise
- If time for appointment with PCP, organized in conjunction with club
- Can attend as often as like, with or without appointment
  - Nonattendance is ***not*** "noncompliance"
- Attendance by other social service providers (e.g., food pantry)
- Involve families, friends
  - Use to coordinate other appointments

Promotoras, Community Health Workers, Lay Health Workers

Focus of 5 of 14 Diabetes Initiative projects

Used for:

- Program implementation & planning
- Promoting access to and use of screening and other types of care
- Education for self management
- Counseling for adherence, adjustment, quality of life
  - Implementation of Transtheoretical Model (Stages of Change Model)
- Advocacy
- Reach to disadvantaged, minorities

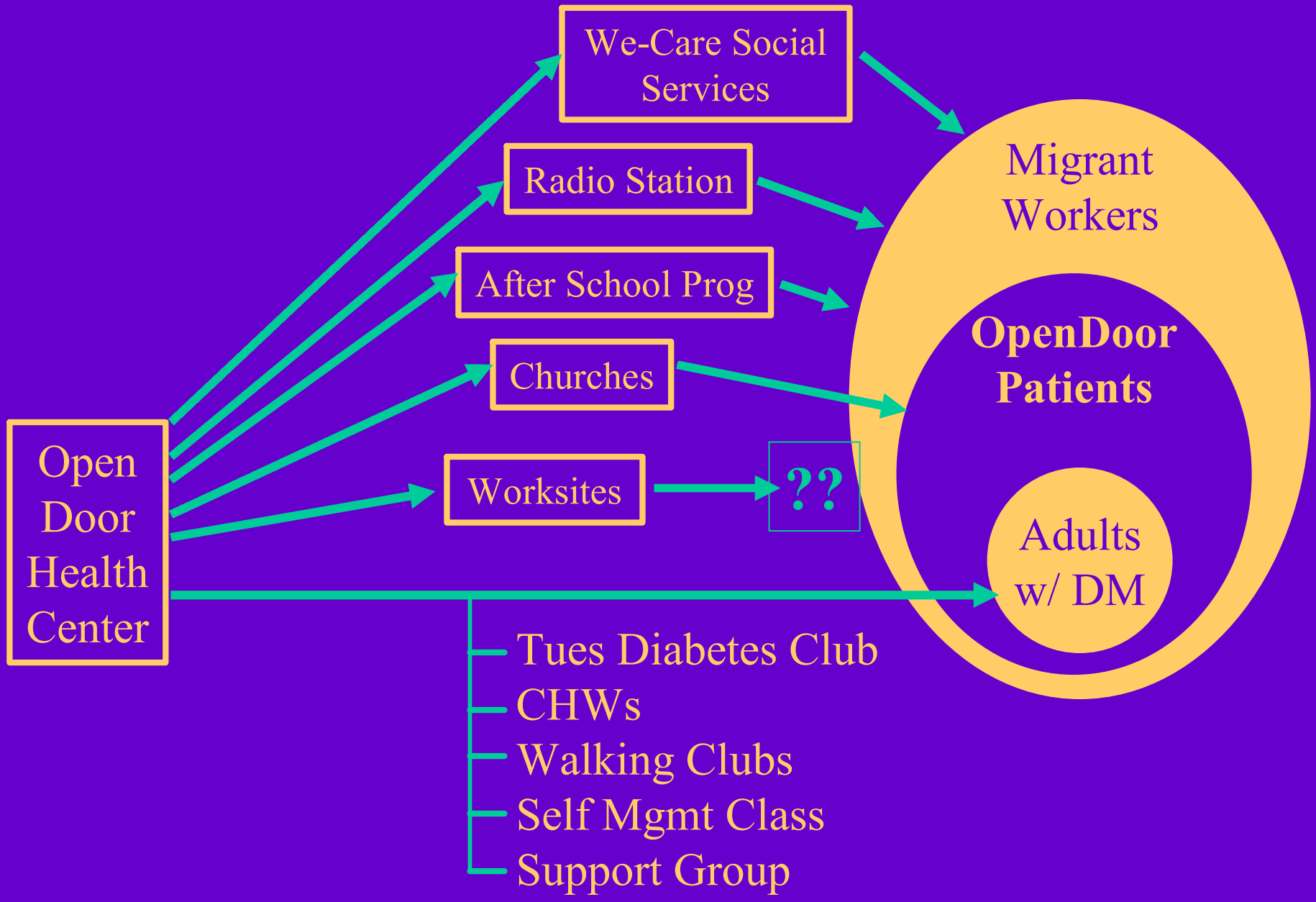
Reciprocity between

Clinic and Community

Clinic Linkage with Community

- Patient representatives on clinic board (not same as “community leaders”)
- Locating self management programs in community settings
  - Clinic branch in churches
  - Church programs as point of entry for identification and treatment
- Promoting programs/recruiting through community settings
- CHWs facilitate patient advocacy with clinic as well as community organizations

Example of Community Programs vis a vis Audience Analysis



Adult Health Management

Lifestyle Risk Factors

- Physical Activity
- Healthy Diet
- Nonsmoking
- Moderate Alcohol Consumption

Emotional Management -- Stress, Depression, Anger, etc.

Relationship Management

Screening and Early Detection -- Mammography, Colon Cancer, etc.

Medical Management -- Hypertension, Diabetes, etc.

(?? Genetic Moderation of Each of Above ??)

Adult Health Management

Lifestyle Risk Factors

- Physical Activity
- Healthy Diet
- Nonsmoking
- Moderate Alcohol Consumption

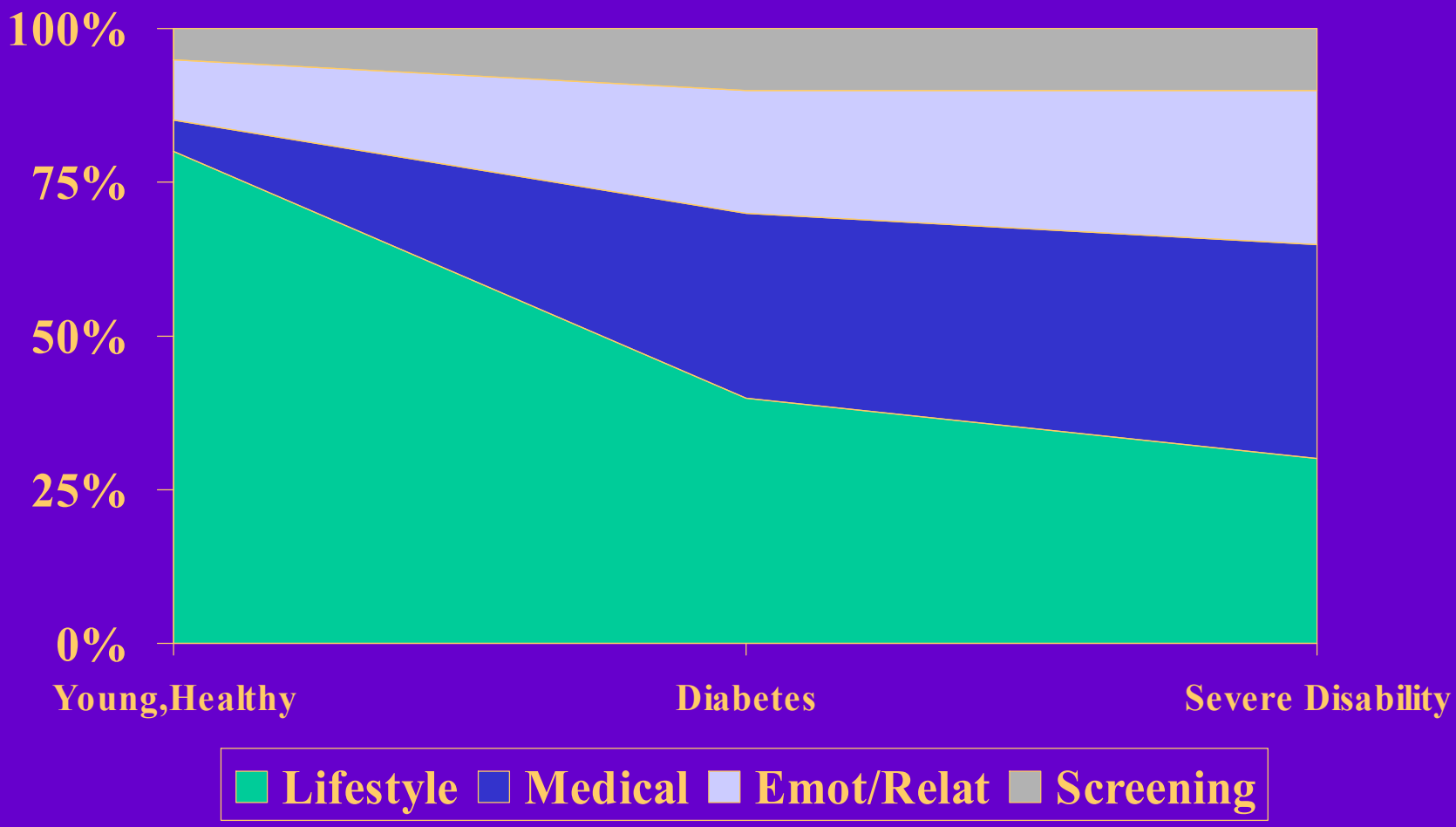
Emotional and Relationship Management

- Stress, depression, anger, etc.
- Social ties and relationships
- "Healthy Coping"

Screening and Early Detection -- Mammography, Colon Cancer, etc.

Medical Management -- Hypertension, Diabetes, etc.; genetic screening and counseling

Adult Health Management



What would you say are the key characteristics of a community in which it would be good to live with diabetes?

Accessible primary care

Walkable

Healthy food

Others??????????????????