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
Specific Lessons Learned

• Community Health Workers
• Ongoing Follow Up and Support
• Healthy Coping – Integrating Attention to Negative Emotions in Self Management
• Community-Clinic Partnerships
• Organizational and System Features to Support Self Management Programs

• For Reach, to counter law of halves: Many Good Practices rather than Few Best Practices
Key Niche of Self Management

- Quality clinical care ≈ 2 hours per year
- 8,764 hours “on your own”
- Clinical care a critical part, but only sets the plans
- **Self management is the core of diabetes care** to help individuals implement in the 8,764 hours the plans they develop in the 2
Resources & Support for Self Management

• Individualized assessment, including consideration of individual’s perspectives, cultural factors
• Collaborative goal setting
• Building skills
  Diabetes specific skills
  Self-management skills
  *Includes skills for “Healthy Coping” and dealing with negative emotions*
• Ongoing Follow-up and support
  – Choices
  – Tied to diverse professions’ involvement, team care
  – Extensive care
• Community resources
• Continuity of quality clinical care
Resources & Supports for Self Management

Partnerships
Teams
CHWs

• Individualized assessment, including consideration of individual’s perspectives, cultural factors
• Collaborative goal setting
• Building skills
• Ongoing Follow-up and support
• Community resources
• Continuity of quality clinical care
Ecological Model of Self Management and Chronic Care

Community & Policy

System, Group Culture

Family, Friends Small Group

Individual Biological Psychological

Health System
Organization of Health Care

Community Resources and Policies
Informal Social Networks

Self Management Support
Delivery System Design
Decision Support
Clinical Information Systems

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
More Lessons Learned

• Good organization and warm fuzzy can go together

• Involve medical and nursing team
  – Don’t give up on primary care!
  – Roles as part of team that includes self management
  – “Now I get to practice medicine”

• Start partnerships small and let success bring more to the table

• Tools are essential!

• Systems are too!
More Lessons Learned

• Self management – goal setting, choose alternatives, monitor, revise – applies to system change
• Goals need skills, information, opportunities, and resources to take wings
• Self efficacy from skills, problem solving
• Good diabetes care is not competent physician, 3X per year, Rx, and shame for not losing weight
• Celebrate with our clients and patients and selves!
• Honor all our stories
Dimensions, Not Categories

- Good control – Bad control
- Treatment – Post-Treatment
- New Program – Established Program
- Best Treatments – Unproven Treatments

Dimensions to replace them:
- Opportunities for improvement, quality of life
  “God isn’t through with me yet”
- Education and support modalities “for the rest of your life”
- Programs need to grow and change
- Many good treatments
# Dimensions, Not Categories

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In simple terms, people with diabetes need

1. Good health care
2. Someone with whom to figure out how they want to manage their diabetes
3. Opportunity to learn the skills they need to manage diabetes the way they want
4. Ongoing support to help them
   – figure out how to implement their plan
   – stay motivated when things get tough
   – get back in touch with the clinic when they need to
It Takes a Village – And a Team!

• To provide care – involve providers and professionals and nonprofessional staff and volunteers at all levels of self management programs

• To manage diabetes – individual and “the diabetes care team”

• To disseminate
  – Professionals
  – Organizations
  – Governments
  – Policy

  Energy, Inventiveness, Stories & Evaluations of Grantees
  Lessons Learned
  Tools
  Prestige of RWJF