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Linking Clinical and Community Support for Diabetes Self Management

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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 & Supports for Self Management

- Individualized Assessment
  - Individualized Goal Setting
  - Assistance in learning self-management skills
- Follow-Up and Support
- Access to Resources
- Supportive Community Norms
- Access to quality clinical care
Ecological Model of Self Management

- Community & Policy
- System, Group Culture
- Family, Friends Small Group
- Individual Biological Psychological
Diabetes Initiative and Ecological Perspectives on Self Management

- Access to Resources
- Ongoing Support, Encouragement, Skills
- Individualized Assessment & Goal-Setting

- Community & Policy
- System, Group Culture
- Family, Friends, Small Group
- Individual Biological Psychological
## Community Organization in RWJF Diabetes Initiative

<table>
<thead>
<tr>
<th>Number of Intervention Levels</th>
<th>N</th>
<th>Types of levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>57</td>
<td>95% individual</td>
</tr>
<tr>
<td>2</td>
<td>47</td>
<td>94% individual, 57% group</td>
</tr>
<tr>
<td>3</td>
<td>27</td>
<td>100% individual, 63% group, 44% physical environment</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
<td>100% individual, group, and physical environment, 67% social environment</td>
</tr>
</tbody>
</table>
“…how to **strengthen the community environment** in which individuals self-manage their diabetes”

“…extend self management beyond the clinical setting and **into the communities** where people with diabetes live.”

“…multiple **communication channels**, facilitating access by bringing **programs into neighborhoods**, and using peers in key roles”

Examples of interventions:

“community education, such as **innovative outreach and education through pharmacies or nail salons**; and

“community support for patients … such as working with **supermarkets, neighborhood gardens and restaurants**, working with **employers** …, and **enabling services such as transportation and child care**”
Diabetes Initiative -- Key Intervention Strategies

- **Intervention Components and Strategies**
  - Community Health Workers/ Promotoras/ Coaches/ Parish Nurses deployed from clinics, communities, worksites, and/or shared by clinics and communities (9/14)
  - Group medical visits
  - Family education & support
  - Self Management activities addressing depression and other emotional factors
  - Integrated case care for diabetes and depression
  - Support groups
  - Church based education classes
  - Worksite interventions
  - Intergenerational activities
  - Exercise classes
  - Walking clubs
  - Social marketing campaign
  - "Low demand" activities Breakfast Clubs, Snack Clubs and Drop-in Clubs
  - Community events
  - Use of Transtheoretical Model to address variability in readiness to change in CHW, group and other interventions
Examples of Coordination
Clinic ↔ Community

Development of coalitions or partnerships
Using Clinics and their resources as a base for supporting key community programs for intended audiences
Expanding group medical visits to include group support, education and activity sessions
Using lay health workers to bridge clinic and community
Pros of Coordination Clinic with Community

Coordination of care and goals
Clear messages -- avoid conflicting messages
Sharing of resources
Consistent web of influences to support maintenance of individuals’ health behavior
Clinic as Platform for Community Program

- Clinic Site
  - Social Services
  - Radio Station
  - After School Prog
  - Churches
  - Worksites

Migrant Workers

Patients

Adults w/ DM

Group Med Visits
CHWs
Walking Clubs
Self Mgmt Class
Support Group
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
Clinic Linkage with Community

Utilization of community resources
- Directories of community resources
- Referrals to community exercise groups, weight management classes, etc.

Provide services to community based organizations and groups – presentations in classes and activities, consultation, board membership

Initiate organizational linkages with Community Based Organizations

Clinic based participation activation
Community Linkage with Clinic

Community based *patient activation*

- e.g., Michigan bumper stickers: “Do you know your Hemoglobin A1c?”

Community based self management groups

- Collaborations with/siting at clinical providers
- Market to providers as referral source

Co-sponsoring screenings and health fairs to encourage disease detection and awareness

Marketing of services
Community Linkage with Clinic

Community Health Worker shared between community group and clinic – to function as bridge

Reciprocal referrals among clinic staff and Community Health Workers of community organization
Promotoras, Community Health Workers, Lay Health Workers
Focus of 9 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
Examples of Reciprocity:
Community ↔ Clinic

Community council for community program planning

Clinic participates in community meetings and classes

Hiring of case manager by clinic direct result of input from community council

Shared case management staff to institutionalize collaborative nature of programs
Barriers to Coordination Clinic with Community

Lack of knowledge of community resources among providers!

Provider concerns over quality/appropriateness of community programs

Variety of perspectives among primary care and community organizations

Differences in organizational cultures especially regarding who is responsible for individual’s behavior

Differences in perspectives can slow program development and implementation
  
  e.g., “need” for medical approval of benign promotion of physical activity
Questions????