



# ST. LOUIS POST-DISPATCH

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2006  
NATIONAL LEAGUE  
CHAMPIONS

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YADI!**



**DIAB**

A National Program of The Robert Wood Johnson Foundation

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ty in St. Louis  
SCHOOL OF MEDICINE

THE  
ROBERT WOOD  
JOHNSON  
FOUNDATION



**DIABETES INITIATIVE**  
A National Program of The Robert Wood Johnson Foundation



# *Capstone Meeting Wrap Up*

Tucson, Arizona  
October 18 – 20, 2006



# *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*



**Advancing  
Diabetes  
Self Management**



**Building  
Community Supports  
for Diabetes Care**

# 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  $\approx$  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

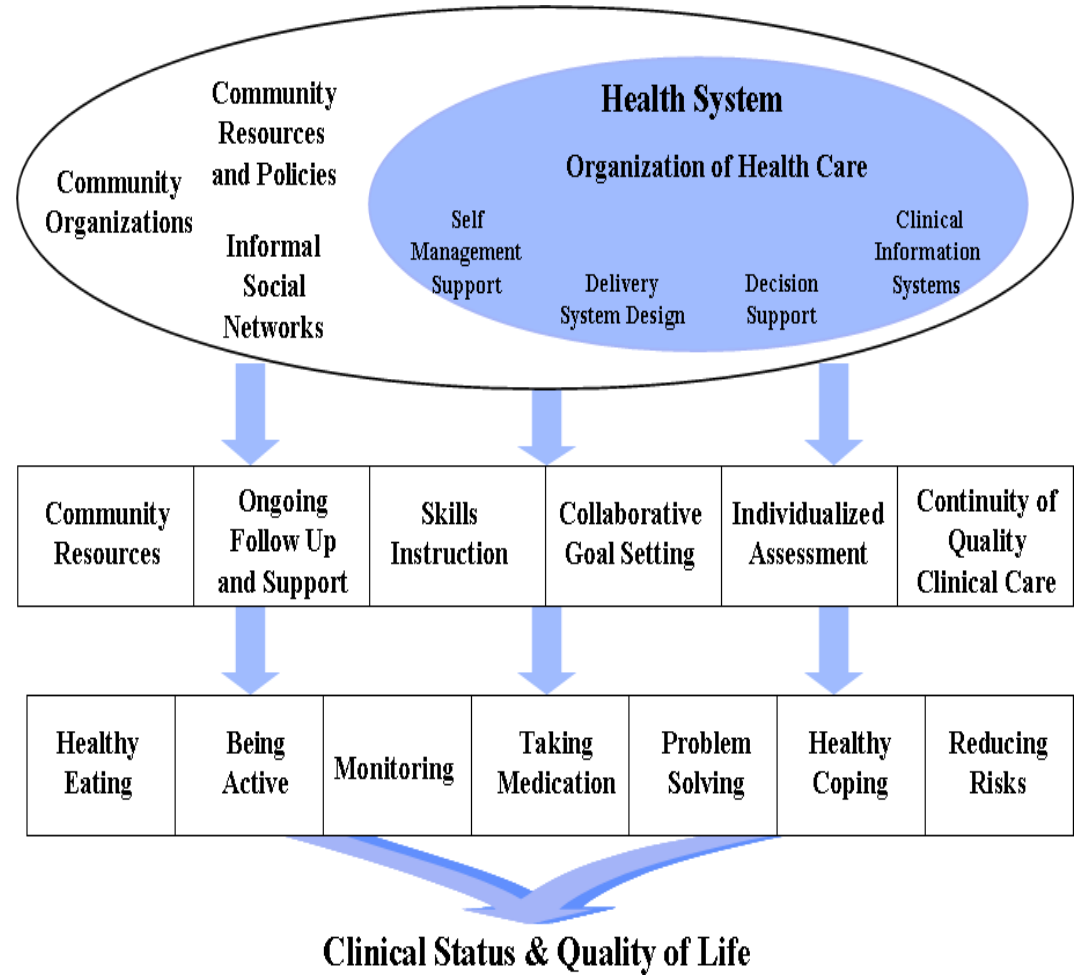
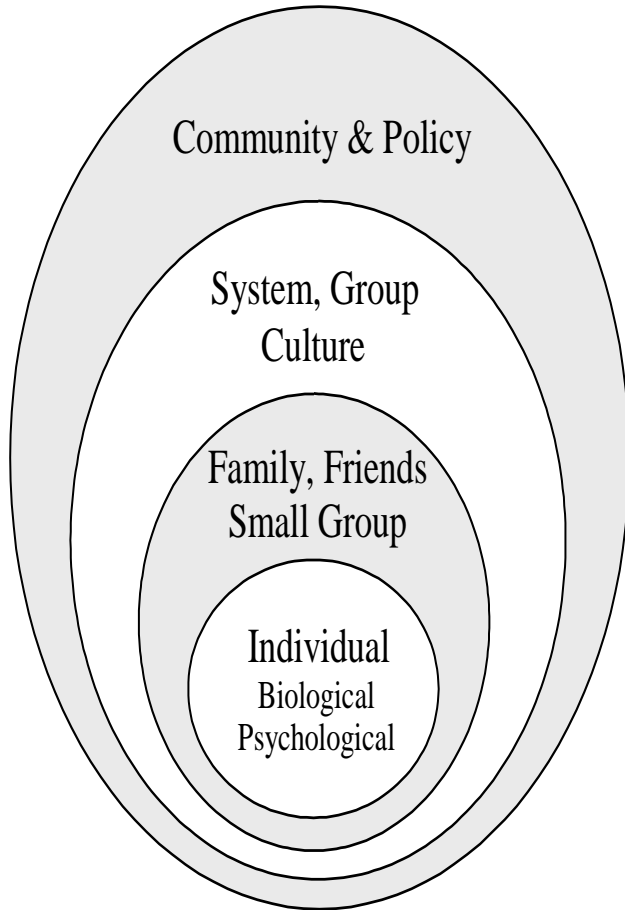
- Individualized assessment, including consideration of individual's perspectives, cultural factors
- Collaborative goal setting
- Building skills
  - Diabetes specific skills
  - Self-management skills
  - Includes skills for “Healthy Coping” and dealing with negative emotions
- Ongoing Follow-up and 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





## 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

**The NPO Does Not Know Everything!!**

***But Cardinals Rule!!***

# 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

<b>Categories to Get Rid Of</b>	<b>Dimensions</b>
Good control – Bad control	Opportunities for improvement, quality of life “God isn’t through with me yet”
Treatment – Post-Treatment	Education and support modalities “for the rest of your life”
New Program – Established Program	Programs need to grow and change
Best Treatments – Unproven Treatments	Many good treatments

## **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