• 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 Regional 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

Community & Policy

System, Group
Culture

Family, Friends
Small Group

Individual
Biological
Psychological
Ecological Perspectives and Resources & Supports for Self Management

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

- Community & Policy
- System, Group Culture
- Family, Friends Small Group
- Individual Biological Psychological
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

Community & Policy
- System, Group Culture
- Family, Friends, Small Group
- Individual Biological Psychological

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

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

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

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

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

Open Door Health Center

- We-Care Social Services
- Radio Station
- After School Prog
- Churches
- Worksites

Migrant Workers

Open Door Patients

Adults w/ DM

- Tues Diabetes Club
- CHWs
- Walking Clubs
- Self Mgmt Class
- Support Group
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

Others