Ongoing Follow Up and Support

Strategies for Successful Self Management

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Ongoing follow up and support improves life with diabetes

Because diabetes is "for the rest of your life," a key component of successful diabetes self management programs is ongoing follow up and support. Studies have shown that people with diabetes who incorporate self management into their lives and sustain it have better metabolic control and quality of life. Diabetes Initiative grantees have developed innovative approaches to providing ongoing support and have identified key features of this critical component of diabetes care.

Key Features of Ongoing Follow Up and Support

On Demand — To fit into people's lives — "for the rest of their lives"— some support activities need to be available on demand or as needed. Examples include breakfast clubs, supermarket tours, drop-in snack clubs, and exercise classes.

Proactive — To keep individuals from "falling between the cracks," contact needs to be proactive and provided on a routine basis whether people seek it out or not. Examples include planned visits, phone contact, newsletters, and similar contacts.

Additional Features of Ongoing Follow Up and Support

Based on an exisitng relationship

Individuals with diseases like diabetes want consistent contact with someone who knows them, is familiar with them, and cares about them. This can be the primary care provider but can also be another member of the diabetes care team.

Motivational (nondirective or directive support)

Especially for those who have had diabetes for many years, the focus of follow up and support is really on motivation and encouragement rather than teaching new skills or provoking major changes. Such support should be nondirective — accepting individuals' views of things, helping them work on their own goals, and providing encouragement. If people encounter a problem they don't know how to solve, a more directive, take-charge approach may be needed.

Inclusive of environment and community resources

A person's living environment and community can influence healthy behaviors and influence use of resources. By using community resources, programs can expand capacity and variety, ensure community investment, and build trust and accessibility for follow up and support.

Not limited to diabetes

Diabetes and diabetes management affect every aspect of a person's life — family, work, mental and physical health, etc. It may be just as important to talk about — and help problem solve around — the fact that someone has just lost their job, for example, as it is to talk about healthy diet and physical activity.

The **Diabetes Initiative of the Robert Wood Johnson Foundation** includes 14 projects around the United States, all demonstrating that self management of diabetes is feasible and effective in diverse, real-world settings. Specific lessons learned from the Initiative include:

- The importance of Community Health Workers in diabetes self management
- Approaches to depression, negative emotions and healthy coping in diabetes self management
- Approaches to providing ongoing follow up and support for self management, since diabetes is "for the rest of your life"
- How to develop effective partnerships between clinical and community organizations
- System and organizational factors to support self management programs in primary care settings

For more information, protocols, publications, and other materials, visit: ***www.diabetesinitiative.org***

Key Lessons Learned...

Providing options for patients

In addition to regular primary care visits, Holyoke Health Center, Inc, located in Holyoke Mass., has a variety of program activities to provide ongoing follow up and support for patients with diabetes. The variety gives patients a choice in how they learn and develop skills for self management.

One activity, the Breakfast Club, is an interactive educational experience where patients are introduced to new foods and learn about healthy nutrition, portion control, and label-reading. Other activities include a chronic disease self management class, supermarket tours where patients learn skills to shop for healthy foods, a drop-in snack club, diabetes education classes, and exercise classes.

Patients also receive individual appointments with a diabetes educator or nutritionist and have access to community health workers who serve as liaisons between the community where patients live and the health center. They help with goal-setting, problem-solving, do telephone follow up with patients, and co-lead some program activities. Contact: Holyoke Health Center, Inc. at 413-420-2200

A patient meets one-on-one with a diabetes educator

Patients get more of what they need

In partnership with the Marshall University School of Medicine, the New River Health Association, a rural primary care clinic in W.Va., uses medical group visits (MGVs) to enhance follow up and support for patients. Each patient is assigned to a team of providers, each of whom has a defined role and is responsible for specific tasks in preparation for the MGV. During MGVs, patients meet together with other patients and the provider team where they set goals for diabetes self management and engage in problem-solving. Group discussion provides opportunities for patients to learn from and support each other.

Group Visits: Patient Benefits

- Almost no wait time for appointments
- More interaction with the healthcare team
- More time for discussion, Q & A
- Family members and support people are welcome
- Patients learn from and support each other
- Patients can schedule themselves

Benefits to providers include having more time to focus on patient self management, being better-prepared for patient visits, the ability to develop a partnership with patients that facilitates engagement of patients in their own self management. Contact: Department of Family and Community Health, Marshall University at 304-691-1198

Effective partnership

The Full Circle Diabetes Program is a partnership among the Minneapolis American Indian Center (MAIC), the Native American Community Clinic (NACC), and the Diabetes Community Council. The Circle Model promotes a fluid "leadership circle" that recognizes that many people contribute to the vitality of the program. MAIC engages Native American community members who have diabetes or are concerned about diabetes to participate in the Diabetes Community Council. The Council provides invaluable insight into the barriers of diabetes self management and resources available in the community.

Culturally applicable interventions developed by the partners empower patients to connect to community resources. The range of interventions includes: case management, community talking circles, self management classes, diabetes breakfasts and intergenerational events.

The participatory nature of program-planning and intervention fosters participation, ensures relevant programming, and provides a supportive environment for diabetes self management. Contact: Minneapolis American Indian Center at 612-879-1708

A community talking circle