

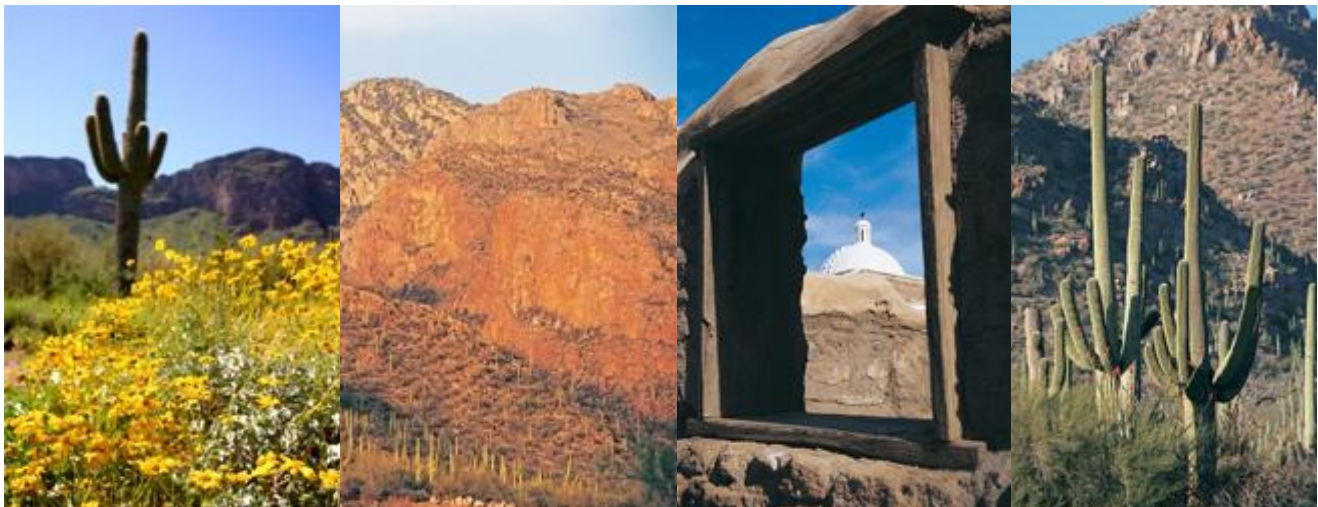
DIABETES INITIATIVE

A National Program of The Robert Wood Johnson Foundation



DIABETES SELF MANAGEMENT IN REAL-WORLD SETTINGS: IT CAN BE DONE – MAKING IT HAPPEN

**CAPSTONE MEETING PROCEEDINGS
OCTOBER 18-20, 2006 – TUCSON, ARIZONA**



DIABETES SELF MANAGEMENT IN REAL-WORLD SETTINGS: IT CAN BE DONE – MAKING IT HAPPEN

PROCEEDINGS OF THE CAPSTONE MEETING OF
THE ROBERT WOOD JOHNSON FOUNDATION DIABETES INITIATIVE
Tucson, Arizona
October 18 – 20, 2006
JW Marriott Starr Pass Resort and Spa

The *Diabetes Initiative*, a program of the Robert Wood Johnson Foundation (RWJF), is dedicated to demonstrating that comprehensive self management programs can be implemented in real world primary care and community settings. It encompasses two national programs: Advancing Diabetes Self Management (ADSM) and Building Community Supports for Self Management (BCS).

Starting in 2003 and over the course of the following 45 months, 14 grantee projects developed strategies, tested and modified their approaches, collaborated with each other and shared promising practices for diabetes self management. Organizers of these projects learned how to effectively reach their target populations and demonstrated that self management of diabetes can work in real world settings.

The Capstone Meeting, held October 18-20, 2006, in Tucson, provided a forum for sharing lessons learned from the *Initiative* and launching an effort to disseminate learnings nationwide. Participants presented findings, participated in panel discussions, and heard from keynote speakers who applauded the groundbreaking work that was done across the country.

Key Topics

The meeting was centered around grantee presentations on key topics central to the lessons emerging from the *Initiative*. The presentations were grouped in the following four panels:

- Models for Partnerships that Build Community Supports for Diabetes Care
- Community Health Worker Approaches to Implementing Self Management
- Models for Engaging and Keeping Patients Involved in Self Management
- System Changes and Program Design to Support Self Management

Presentations by invited speakers addressed the following additional key topics:

- Important Trends in Diabetes Care and the Central Role of Self Management
- Emotional Health and Healthy Coping in Diabetes Self Management
- Payers' Perspectives
- The National Perspective: U.S. Representative Diana DeGette
- Making Changes Happen – a Presentation by noted author David Bornstein

Grantee presentations focused on only one component of each project. For more complete information about each grantee project, see *Stories and Descriptions of 14 Programs to Improve Self Management* included in this packet. Slides for presentations can be found on the Diabetes Initiative website – <http://diabetesinitiative.org>.

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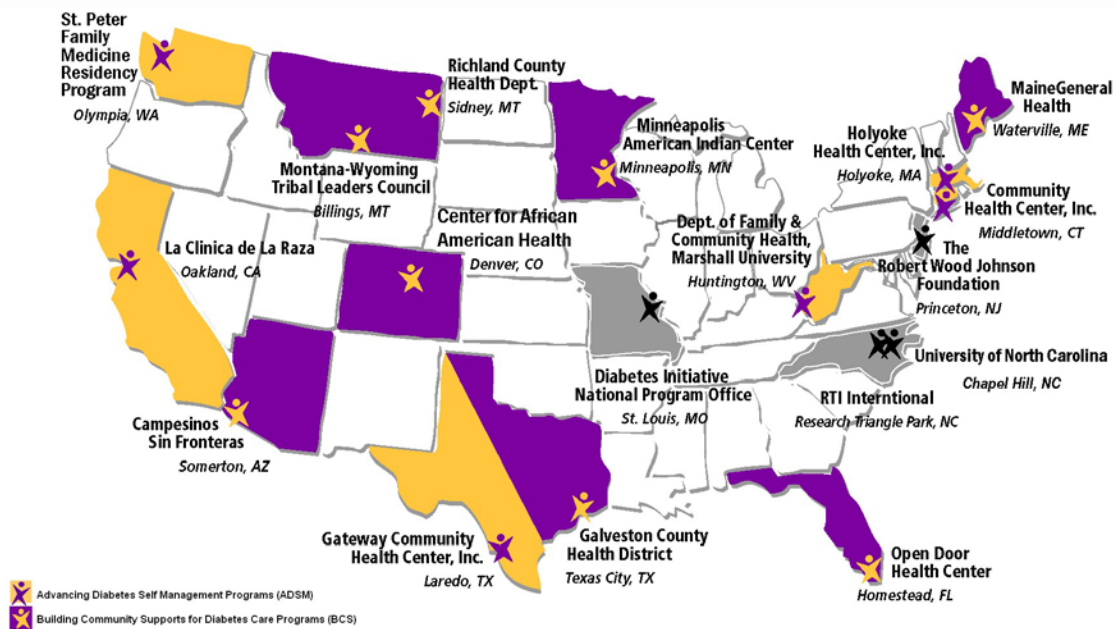
Support for the Diabetes Initiative is provided by grants from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

Overview and Keynote

Overview – Background and Rationale for the *Diabetes Initiative*

Edwin B. Fisher, Ph.D., national program director of the *Diabetes Initiative*, opened the meeting by reviewing the background and rationale for the *Diabetes Initiative*. Leading up to the Initiative, research had shown the value of diabetes self management programs, but most of this research had been carried out in university or medical research centers. The purpose of the Initiative, then, was to show that such programs could be implemented successfully in the real worlds of primary care and community health programs.

From over 300 applications, fourteen grantees were chosen from around the country, representing all regions, urban areas to frontier towns, and African American, American Indian, and Latino/Latina communities. They are depicted on the map, below.



As depicted in the map, the Initiative included two programs. *Advancing Diabetes Self Management* included 6 sites that demonstrated implementation of self management in primary care settings. *Building Community Supports for Diabetes Care* included 8 sites, each supporting self management through a community-clinic partnership.

With two different programs and such diverse sites and populations, the Initiative faced a challenge. How could it identify a common self management program that would be applicable in such different settings? The solution was to identify a common set of key Resources & Supports for Self Management that individuals with diabetes need. These are the things people with diabetes need to live their lives and manage their disease the 8,760+ hours a year they are not in a doctor's office. They are listed in the box at the top of the next page.

All fourteen sites were encouraged to address as many of the Resources & Supports as they could, but they were also encouraged to do so in their own way. In this way, a common set of key functions that self management programs need to address was combined with substantial local flexibility in developing ways to address them.

Resources & Supports for Self Management

- Continuity of quality clinical care
- Individualized assessment
- Collaborative goal-setting
- Key skills both for disease management and healthy behaviors such as healthy eating, physical activity, and healthy coping
- Ongoing follow-up and support to help people adjust their plans as problems arise, stay motivated, and see their providers when they need to
- Community resources, e.g., for purchasing healthy foods or getting physical activity in safe, attractive environments

The individual who receives only updated medications and tests from a physician a few times a year is receiving care that is far less than state-of-the-art.

In addition to the broad model of Resources & Supports for Self Management, the Initiative has identified a number of lessons learned. These and the sessions of this Capstone Meeting in which they are discussed are as follows:

- Approaches to developing effective community-clinic partnerships to support self management – *Models for Partnerships that Build Community Supports for Diabetes Care, p. 5*
- Contributions to diabetes management of Community Health Workers or *Promotoras* – *Community Health Worker Approaches to Implementing Self Management, p. 8*
- Ongoing follow-up and support – probably the most important component for sustained self management – *Models for Engaging and Keeping Patients Involved in Self Management, p. 10*
- Approaches to addressing depression, other negative emotions, emotional well being, and healthy coping in diabetes management – *Promoting Healthy Coping and Addressing Negative Emotion in Diabetes Management, p. 15*
- Organizational factors and infrastructure to support self management programs – *System Changes and Program Design to Support Self Management, p. 13*

Further information about all of these, including papers that have been published, detailed presentations, program descriptions, and a large library of specific program tools are available at the Initiative's website: <http://diabetesinitiative.org>

Keynote Address

Important Trends in Diabetes Care and the Central Role of Self Management

Keynote speaker Dr. James Gavin III, a leader in the field of diabetes research, management and education, discussed trends in diabetes care and the central role of self management. He provided data to demonstrate the increasing scope and seriousness of the problems that obesity and diabetes pose for public health. He emphasized the importance of metabolic control in diabetes management. Research from a variety of areas shows that controlling blood sugar results in reduced complications and improved health status for those with diabetes. He showed how the kinds of self management programs demonstrated by grantees in the *Diabetes Initiative* contributes to better diabetes management and, thus, to improved health and well being. He challenged all present to take the lessons learned in the *Diabetes Initiative* and translate them into practice.

Models for Partnerships that Build Community Supports for Diabetes Care Grantee Panel #1

In her opening remarks, panel moderator Dr. Elizabeth Baker stressed the importance of two key issues related to collaboration and building partnerships: shared definition of goals and processes involved in collaboration. She presented a framework for understanding the components necessary for partnerships to be successful. The grantee presenters in this panel reported on the establishment of social networks and the key strategic partnerships they developed to influence health behaviors among individuals within the cultural dimensions of diabetes self management particular to their American Indian, Hispanic, and rural populations. Highlights of the presentations are as follows:

Minneapolis American Indian Center: A Circle Paradigm Promotes Holistic Community Partnerships

The Minneapolis American Indian Center and the Native American Community Clinic (NACC) chose to organize their community partnership around a “circle paradigm”. Kimberly Rinderknecht Plessel of the NACC presented this model as a holistic approach, asserting that the whole self – body, mind, spirit, and emotion – must be addressed to positively affect health. The circle paradigm also recognizes all partners as equal contributors and promotes the concept of fluid leadership.

The partnership’s Full Circle Diabetes Program aimed to ensure that diabetes programming would be grounded in community-identified health priorities, promote community ownership of the initiative, provide a variety of holistic supports for diabetes care, and continually evaluate and improve programming. To accomplish these objectives, the Diabetes Community Council was created to engage community members in the partnership. Talking Circle discussions among community members built trust, fostered communication, and promoted a collective vision and mission among the partners. Barriers were addressed, and the partnership continuously monitored its initial objectives and worked to ensure that they were met. Additional partners were invited to fill gaps in services, and an evaluation plan was created with contributions from all partners.

The Full Circle Diabetes Program is successful in large part because of its highly integrative partnership. Interdependence of the partner organizations is both recognized and promoted to accomplish the collective vision of providing holistic supports for diabetes care.

Richland County Health Department: An Ecological Approach Provides a Comprehensive Model to Initiate and Sustain Diabetes Self Management

At a local Kiwanis meeting in 1999 in Sidney, Montana, a remote town in the eastern part of the state with a population of less than 4500 (U.S. Census), a partnership was born. Lisa Aisenbrey, project director for the Richland County Community Diabetes Project, told how the Richland County Health Department, Sidney Health Center, and Richland County Commission on Aging came together to form the Richland Health Network (RHN), with the mission of building healthy communities through networking, health promotion, and volunteerism. Initially the partnership was formed to avoid duplication of services, but the RHN soon found that far more could be accomplished by working together than could be accomplished by any of the member organizations alone. The RHN identified diabetes as an area of community-wide

concern and dedicated efforts toward building a community environment that would support diabetes self management. In 2003 they were awarded a RWJF Building Community Supports for Diabetes Care grant. The RHN set out to involve the community in changing community norms and improving community health. The RHN evolved by sharing resources, advancing common goals, and making sustainable clinical and community connections. Changing social norms proved an immense challenge, but the RHN persevered, learning that simple changes, such as using alternatives to “disease labeling” for its events and programs made a huge difference in community turnout. RHN also discovered that their programs were instrumental in increasing visibility of the partnership and building an infrastructure for a more streamlined systems-based approach to self management overall.

Their initial efforts created synergy; over time, many new community partnerships have developed and become active in the mission to build a healthier community. Project participants have reported a 46% weight loss and 58% increase in exercise, while emergency room and hospital admissions due to diabetes have both decreased by a third. In addition, the community has embraced healthier restaurant menu choices promoted by the annual “Tasty Fork” contest.

Campesinos Sin Fronteras: Building Community Support for Diabetes Care in Migrant and Seasonal Farmworker Communities in Yuma County, Arizona: A Model for Partnership Building

Emma Torres, director of Campesinos Sin Fronteras (CSF), a community-based non-profit organization, presented CSF’s key partnership with Sunset Community Health Center (SCHC) as a model for building community supports for diabetes care. SCHC, a federally qualified health center, provides medical and dental services to low-income underinsured and uninsured populations at 5 clinic sites in Yuma County, Arizona. These clinics serve over 4,000 migrant and seasonal workers – CSF’s target population. These two organizations were natural partners because of their shared objectives including improving the quality of care and providing comprehensive personalized diabetes care and support for this population.

The partnership has overcome barriers by focusing on its mission, celebrating participants’ successes, and staying the course with vision, perseverance, patience, and hard work. Key strategies were shared that have helped the two organizations meet their objectives include use of a culturally sensitive approach to diabetes management and use of *promotoras*, or community health workers, to help improve healthcare access and act as liaisons between patients and health care providers.

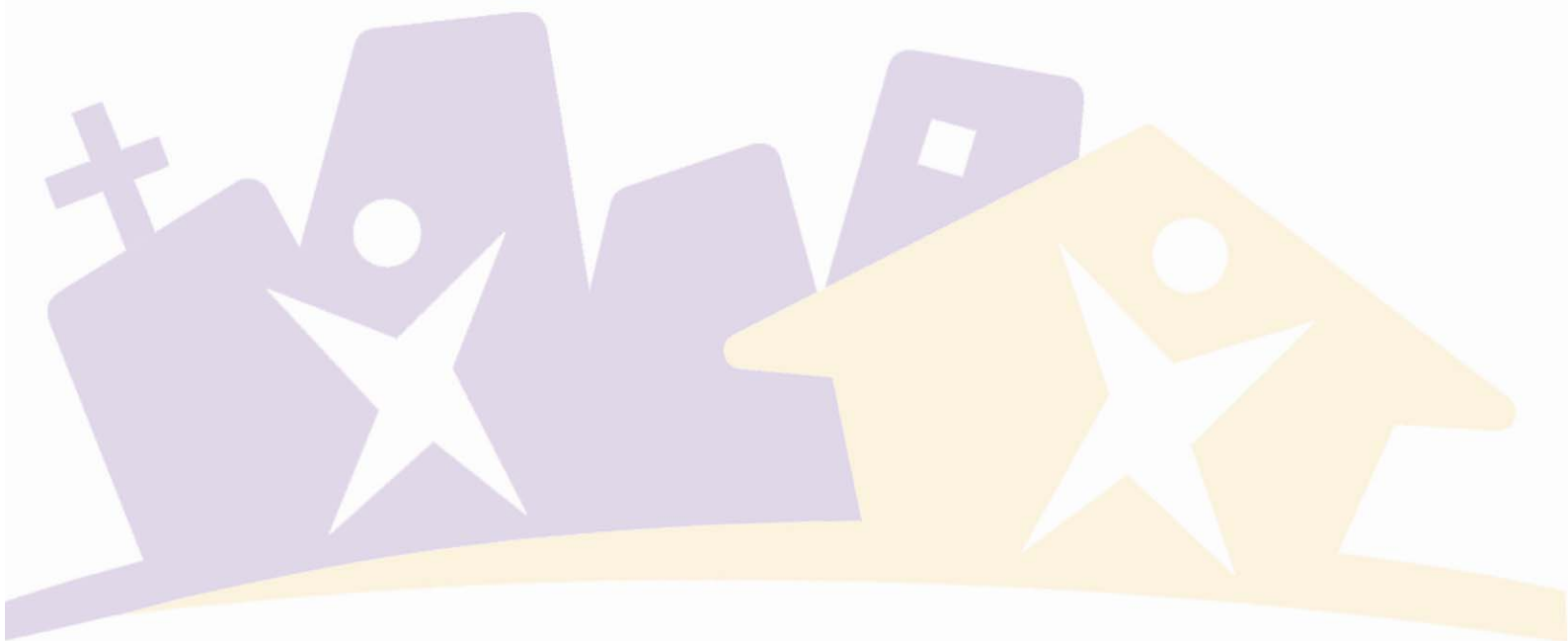
The results are impressive. CSF and SCHC have established a Family Diabetes Care Institute, a collaborative effort to offer comprehensive, quality diabetes care – the first of its kind in the Yuma area. The Institute provides a strong infrastructure for diabetes care in the community that includes reciprocal referrals, joint programming and ongoing guidance and support groups for participants and a shared use of resources. They have succeeded in providing farmworkers with access to diabetes prevention and treatment, and health indicators among participants are improving. In addition, the Campesinos Diabetes Management Program is being disseminated as a model diabetes management program.

Montana-Wyoming Tribal Leaders Council: Eastern Shoshone Diabetes Self Management Program

The Montana-Wyoming Tribal Leaders Council (TLC) presented the partnership journey of one of the American Indian tribes involved in the BCS project, the Eastern Shoshone tribe. The tribe had developed the Eastern Shoshone Diabetes Self-Management Program, and tribal community health representatives began doing home visits and conducting diabetes education classes. Through this process, they discovered that many of the people with diabetes felt overwhelmed by the disease or were in denial of its existence, and many were also depressed. They needed community support and one-on-one contact with people to help them overcome their sense of defeat.

Cheryl Belcourt, TLC Project Coordinator, stressed the need to build community support through collaboration. She pointed out how critical it is in the American Indian community to first establish 'buy-in' from Tribal leaders to avoid community resistance to change.

The Eastern Shoshone Diabetes Self-Management Program provided more individualized diabetes education than previously available and helped people with diabetes cope with their stress and depression. To accomplish this, the TLC built partnerships with Black Hills State University, the Wind River Service Unit, and the Shoshone Business Council. Through much planning and communication with their partners, their diabetes programming began to accomplish its goals. The community has made the leap from diabetes denial to acceptance, and the physical and mental well-being of the program's participants has improved. With training and support from Black Hills State University and feedback from participants, the program is progressing to include family education.



Community Health Worker Approaches to Implementing Self Management Grantee Panel #2

Dr. Ann Albright chaired this session and set the stage by emphasizing the central role community health workers (CHWs) play in diabetes care. Their role in diabetes care has been recognized by many diabetes organizations, include the AADE. She described how CHWs greatly increase outreach to and engagement of the intended audience, especially in underserved populations. They also provide instructions in key skills for self management and problem solving, provide emotional support and encouragement, and facilitate effective communications among patients and their caregivers. CHWs offer unique services and functions that complement traditional health care. *Diabetes Initiative* grantees described the variety of roles CHWs play at their sites.

La Clinica de La Raza: Health Promoters Use Stages of Change to Improve Diabetes in Urban Mexican-Americans

In Oakland, California, La Clinica de La Raza has a rich history of community outreach. One of their *Diabetes Initiative* project goals was to use CHWs or “health promoters” to engage patients in their care and help them understand and apply medical information about diabetes self management in their daily lives.

Integration of health promoters into La Clinica’s programming had many challenges. Many of the health promoter recruits needed specialized training, but did not speak English and had a low level of literacy. Lack of personal transportation, need for child care, and funding for the health promoters were other obstacles. La Clinica overcame these barriers by finding unique ways to engage low-literacy health promoters, including providing numerous ongoing training and practice sessions and providing bus passes, child care, and other incentives to potential health promoters.

The strategies proved successful. La Clinica developed a cadre of well-trained, highly motivated health promoters that have become the foundation for advancing diabetes self management in the community. The scope of the health promoters’ work includes providing culturally appropriate and accessible health information, teaching self management skills, following up on patients’ needs for self management education, advocating for patient needs, and leading or assisting weekly group meetings to keep participants engaged. Both healthcare providers and health promoters were trained to assess stages of patients’ readiness to make behavior change using the Transtheoretical Model of Change so that interventions could be customized according to each patient’s readiness to change a particular behavior. Joan Thompson, nutritionist and preventive medicine supervisor at LaClinica de La Raza, reported that the health promoters have been effective in helping patients translate clinical recommendations into self management practices for diabetes and other chronic diseases.

MaineGeneral Health: Lay Health Educators: A Social Marketing Strategy Addresses the Community Resources and Policy Component of the Chronic Care Model

Lay Health Educator (LHE) is the term used to describe community health workers at the MaineGeneral Health site in Waterville, Maine. Natalie Morse, director of Community Health Improvement at MaineGeneral Health, described a community based, social marketing–driven program they developed called “*Move More.*” Project organizers learned from focus groups that

people prefer “gentle encouragement” to healthier living as opposed to heavy handed persuasion techniques, so the program is built upon non-directive peer support from LHEs.

Move More’s volunteer LHEs are trained to give basic information about the need for physical activity and a healthy diet and to provide non-directive support. They are part of their communities and spread the word about resources and supports in the community (e.g., walking trails) for people with diabetes to become physically active and better manage weight and diabetes. In this sense, they fit into the “community resources and policy” aspect of the Chronic Care Model, a framework influential to the design of the *Move More* program.

Like La Clinica, *Move More* also faced some difficulties integrating LHEs into its programming. The concept of social marketing was met with skepticism, and health professionals were slow to recognize the valuable contributions LHEs could make. Ms. Morse attributes their success in overcoming these barriers to the RWJF *Diabetes Initiative* funding that allowed formative research to be conducted and strategies to be developed accordingly, including the network of volunteer LHEs. *Move More* is a model for a low-cost program that can be replicated and sustained in rural settings.

Galveston County Health District: *Take Action Galveston*

In Galveston, Texas, The Galveston County Health District (GCHD) developed the “Take Action Galveston” program to improve diabetes self management in the surrounding community. Multi-week *Take Action* classes provide people with diabetes and members of their primary support systems with the knowledge and skills to manage their disease and lead a healthy life.

To reduce barriers to class participation for potential participants, GCHD recruited and trained community health “coaches” to teach the classes. The idea was that coaches would extend the reach of GCHD by teaching the classes in non-traditional, community-based settings (e.g., churches, senior centers, etc) in their own communities. Although the number of coaches outweighed that of participants initially, the numbers soon tipped in the opposite direction as the program gained community support. As of October 2006, *Take Action* has provided diabetes education to over 700 participants. Program organizers found that, with training and support, a lay person can successfully teach the classes. The program’s more than 50 coaches have greatly increased the reach of GCHD and its services to populations previously without access to diabetes education. Through their partner organizations in the community, the program has also spread to many areas outside the GCHD service area.

According to Darlene Cass, GCHD diabetes educator, 97% of the people who completed a class evaluation reported making changes in the management of their diabetes because the program provided them with new information and skills to support better self management.

Models for Engaging and Keeping Patients Involved in Self Management Grantee Panel #3

The third panel was moderated by Dr. Ed Fisher who stressed that diabetes is a life-long condition. He cited studies that have shown that people with diabetes who incorporate self management into their lives and sustain it have better metabolic control and quality of life. Successful diabetes self management requires a high level of engagement from the patient and also requires ongoing follow up and support. As a panel of grantees discussed, self management programming must take into account the population served and offer multiple opportunities for patient engagement. It must then address how to keep the patient engaged and how to support the patient once they complete the program.

Diabetes Initiative grantees have developed innovative approaches to providing ongoing support and have identified key features of this critical component to diabetes care.

Holyoke Health Center: *Proyecto Vida Saludable: An Innovative Approach to Self-Management for Latino Patients with Type 2 Diabetes*

The Holyoke Health Center (HHC) *Proyecto Vida Saludable* diabetes project in Holyoke, Massachusetts, focuses on improving care and self management support for patients with type 2 diabetes through a series of programmatic interventions. As project director Dawn Heffernan discussed, patient engagement starts with organizational and provider support. The Center's management, health providers, and staff must be committed to the patient self management philosophy and resources must be allocated accordingly. It is also critical that the staff understand the population it is serving. Prior to program development, HHC conducted several focus groups to help them better understand their patients and what was needed to help improve their diabetes self management. They discovered that the majority of patients spoke only Spanish, lived far below the poverty level, and had very low literacy and health literacy. HHC was then able to educate its staff accordingly and create helpful, culturally and linguistically sensitive, interactive educational experiences. For example, when they realized their patients didn't eat breakfast, the staff created "The Breakfast Club," where patients were introduced to new foods and learned about healthy nutrition, portion control, and label reading. The staff also realized that their programs needed to be fun and exciting to engage participation, and there needed to be multiple opportunities for patients to become involved. Intervention activities included chronic disease self management classes, diabetes education classes, exercise classes, individual appointments with the diabetes educator and nutritionist, and a snack club. Community health workers, or *promotoras*, were central to the project and served as liaisons between the health center and the community.

Overall, the program hoped that engaging patients would positively affect their lifestyle behaviors, increase their skills and knowledge related to self management behaviors, and improve their self-efficacy for self management behaviors. The staff used a combination of strategies, such as goal-setting, problem solving, family member involvement, incentives, hands-on learning opportunities, and patient monitoring and follow up to accomplish these goals. Over the course of the project, the number of patients more than doubled, and their average blood glucose measures steadily decreased. As Ms. Heffernan stated, the key to the program was developing relationships with patients and offering a variety of ways for patients to interact with the health center staff.

Community Health Center, Inc.: *A Model for Engaging and Keeping Patients Involved in Self Management*

The Community Health Center (CHC) in Middletown, Connecticut had a plan. It would deliver personalized, individual self management education for all interested patients with type 2 diabetes. Primary care providers would refer patients to the program, which would involve two certified diabetes educators (CDEs) who would provide individualized care, group visits, and events such as cooking clubs to attract and sustain client participation. Over time, the Center realized that only part of the plan was working. Over 200 patients were enrolled in the program, but many were only attending their primary care visits, not taking advantage of the “extra” visits and programs the self management program offered.

CHC realized that many patients were depressed, and before they could truly become engaged in self management programming, their depression had to be addressed. Two interventions were implemented: clinical management and solution focused brief therapy. Another problem identified was that the medical staff were not trained to assist with patient self management. To address this, eight staff nurses were trained in motivational interviewing, health education techniques, specific diabetes educator skills, and self management goal (SMG) setting – a critical feature of CHC’s diabetes programming. These nurses could then participate in diabetes care teamwork at the center, integrating self management more fully with provider visits and conducting quarterly self management goal setting follow-up with patients who had seen a CDE. CHC also increased its capacity to facilitate self management goals with patients who did not seek the services of a CDE. Diabetes self management programming was expanded to include special activities, such as cooking clubs, salsa dancing, diabetes bingo, and walking programs.

Program coordinator, Joan Christison-Lagay, reported that over 2300 SMGs have been set by the 489 patients enrolled in CHC’s diabetes self management program and the numbers for various health indicators, such as blood pressure, cholesterol, and blood glucose level, have substantially improved. The program now hopes to improve provider involvement to help even more diabetes patients become engaged in self management.

Open Door Health Center: *Strategies for Engaging and Supporting Diabetes Self-Management in a Multicultural Setting*

The Open Door Health Center (ODHC) in Homestead, Florida, is a free clinic that provides primary health care as well as diagnostic and education services for the uninsured poor. Their “*Prescription for Health*” diabetes project was developed to sensitively and effectively improve diabetes self management and build community supports for diabetes care among their multi-ethnic population, many of whom come from Mexico, Haiti, and other Caribbean countries.

Several barriers to patient engagement in self management were identified. The first was a lack of access to resources. ODHC improved this problem by providing an extended pharmaceutical program and healthier groceries on site. Patients also lacked diabetes knowledge and the ability to apply diabetes information. To address this issue, *Prescription for Health* taught “Diabetes 101” classes and used the “popular education” methods, hands-on education and peer support to enhance learning and skills for self management.

Project coordinator, nutritionist, and lifestyle coach, Laura Bazylar, found that lifestyle-related activities, such as a three-time a week exercise program, quarterly supermarket tours, and bi-monthly cooking classes, were popular and effective ways to reach target populations and keep

them engaged in their self management activities. Regularly scheduled group support visits ensured continuity of care.

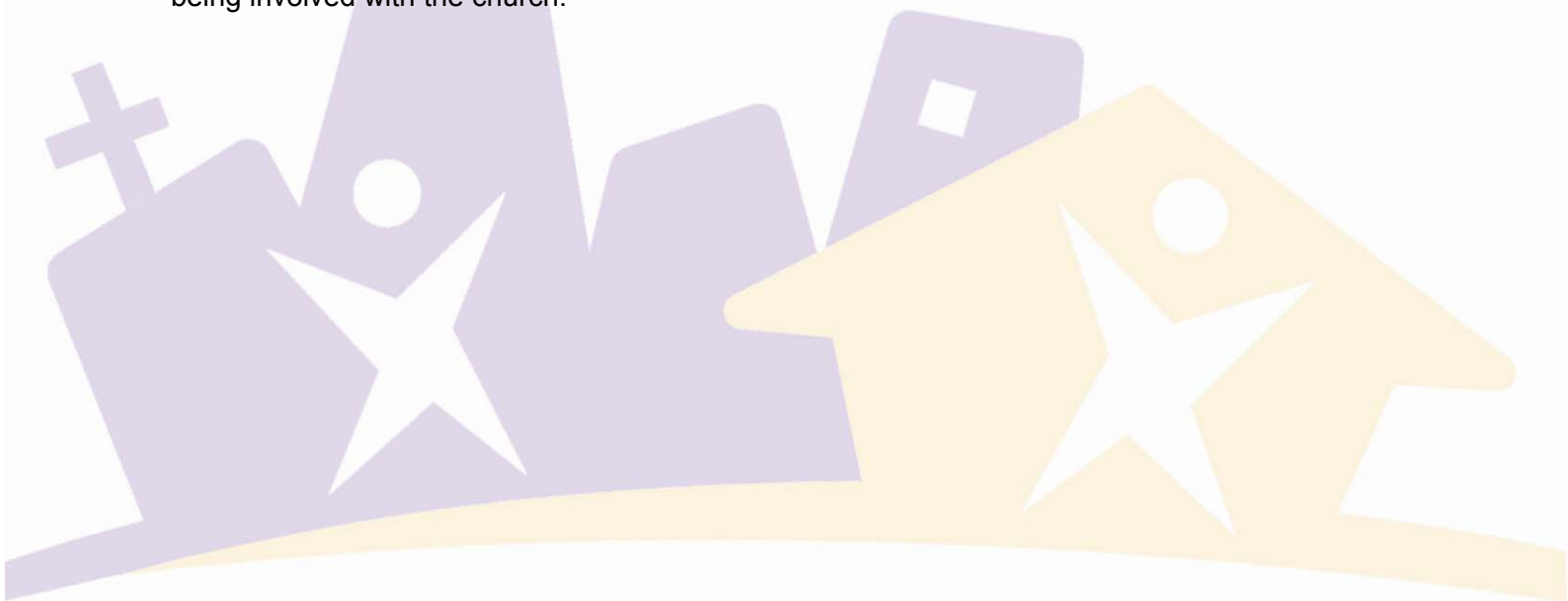
Through cultural sensitivity and collaboration among partners in academia, the faith community, local health providers, volunteers, and other community based organizations; *Prescription for Health* increased patient access to resources, improved patient education, and improved patient clinical outcomes. The program discovered that patient engagement starts with proper communication techniques and modeling of healthy behaviors and requires ongoing interventions and follow-up to maintain progress.

Center for African American Health: Empowering the African-American Community to Live Well: “Meeting People Where They Are”

In metropolitan Denver, the Center for African American Health (CAAH) developed a program called *Focus on Diabetes* aimed at supporting self management among the African-American community by “meeting people where they are.”

The *Focus on Diabetes* project teaches people with diabetes, and those who care for them, how to manage the disease. CAAH conducts a 6-week class every eight weeks on the importance of healthy eating, physical activity, monitoring blood sugar, medications, and understanding and recognizing depression for managing diabetes.

Program staff recognized that participants had a low literacy level, often had no transportation to class, were not used to exercising, and were not receiving enough information or instruction from their primary care providers. Strategies to increase participant engagement included presenting the material at an appropriate grade level, providing transportation to class, using hands-on examples, providing demonstrations, and providing frequent encouragement. The program also worked with African-American churches on outreach and walking programs. Recognizing that African-Americans needed a trusted source of health information and making that source one that was already a part of their lives – the church – was the key to engaging patients in self management. Grant Jones, Executive Director, expects a long and productive partnership with churches because of the sense of community and involvement people get from being involved with the church.



System Changes and Program Design to Support Self Management Grantee Panel #4

Panel 4 was chaired by Dr. Russ Glasgow who framed the session with his opening remarks about the importance of organizational support for self management. He reviewed the work of the *Diabetes Initiative* in further defining the elements of organizational resources and supports for self management and summarized the tool developed to measure capacity for providing self management support in primary care. Four grantee presenters discussed ways to develop infrastructure needed to support diabetes self management.

Gateway Community Health Center: Comprehensive System of Care for Patients with Diabetes

The Gateway Community Health Center (GCHC) located in Laredo, Texas, incorporates community health workers, or *promotoras*, into the medical practice as a key component of a comprehensive system of support for self management. Through teaching group classes, leading support groups that reinforce topics from class, and providing individual support, the *promotoras* become the main point of contact for patients after the development of treatment plans and between doctor follow-up visits.

Promotoras at GCHC undergo over 300 hours of training and evaluation in diabetes self management and other areas such as leadership, listening skills, advocacy, problem solving, mental health training, stress management, and communication skills. They then take on the important roles of assessing patient needs, acting as a patient advocate, making individual contact as needed, documenting patient progress and outcomes, and acting as a liaison to the healthcare team.

Lourdes Rangel, Special Projects Coordinator, said the involvement of *promotoras* is beneficial to providers as well as patients. Providers can focus their limited time with a patient on medical issues knowing that patients will receive self management support from a *promotora*. The patient benefits from having a *promotora* who expands on the information given by the provider and answers questions about how to use the information. Patients often feel more comfortable asking the *promotora* questions about information that they do not understand. *Promotoras* teach skills and provide the support patients need to become successful self managers.

GCHC's comprehensive system of care for patients with diabetes also includes a drug assistance program, dental hygiene services, medical services, a podiatry clinic, behavioral health assistance, disease management courses, diabetic supplies, yearly eye exam, assistance with diabetes-related laser eye surgery, and glaucoma screening. Integration of *promotoras* into the system of care, though, has been one of the most significant aspects of the system that has improved the health status of patients with diabetes.

St. Peter Family Medicine Residency Program: Primary Care Re-Designed: Four Steps to Patient Self Management

At the St. Peter Family Medicine Residency Program, a primary care facility in Olympia, Washington, a systems approach emphasizing patient centeredness and practice innovation led to a successful re-design of diabetes care in that setting. Dr. Devin Sawyer, faculty physician, described four innovations: the planned medical assistant (MA) visit, the provider visit, the mini-group visit, and the open office group visit.

One of the key innovations was the expansion of the role of MAs. MAs meet with patients in a planned visit, complete standing orders, work on self management goals with patients and follow up with them. By the time the patient meets with a provider, lab reports are available and the patient has had to think about or work on a self management goal. To facilitate successful goal setting and ensure that the practice team reinforces each other as they work with patients on self management, providers were given training in collaborative goal setting, and systems were implemented to track goal setting and goal quality.

The mini-group visit and the open office group visit are additional options for patients. The mini-group visit involves a small number of patients in a provider visit. The mini-group visit has the added value of providing a forum for social support and problem solving among the group. The open office visit is an educational session offered to patients and families in which the agenda is driven by patient questions. Like the mini-group visit, patients can learn from and support each other in this forum.

The changes built stronger relationships among providers and patients. The valuable relationship developed between the patient and MA during planned visits and follow up helps the MA better understand the patient's needs. With background provided by the MA, the provider can have a more informed, focused and productive discussion with the patient during the visit. Responsibility for self management is shared by members of the provider team and the patient. The end result is that both patient self-management and provider satisfaction improve.

Marshall University Department of Family and Community Health: *Dissemination of Regional and Statewide Self Management Resources and Training*

The West Virginia Advancing Diabetes Self Management Program is a partnership among Marshall University, rural health centers and churches. The program has emphasized the integration of changes in health care systems that facilitate self management education and support. Project goals have included disseminating self management communication materials using social marketing strategies, equipping and supporting partner agencies to lead ongoing self management workshops, and promoting expansion of medical group visits through mentoring and consultation.

The partnership developed or implemented a number of self management resources: the "Help Yourself" Chronic Disease Self Management Program, a communications plan and behavior change materials, patient self-assessment tools, and a model for medical group visits. The partnership then broadened its scope as it began to share these self management resources with area support groups, diabetes coalitions, primary care clinics, state collaboratives, the United Mine Workers Health and Retirement Fund, and the West Virginia Diabetes Control Program. This commitment to ongoing technical assistance and support for self management included training and support for the West Virginia State Collaborative effort, assistance with data collection and evaluation, and development of new self management materials, including a toolkit and website.

Dr. Richard Crespo of the Department of Family and Community Health at the John C. Edwards School of Medicine at Marshall University in Huntington, West Virginia, also spoke about the importance of ongoing follow up and support for both providers and patients. The project learned the importance of training community leaders and peers in key roles involved in providing self management support. They also learned the importance of offering a variety of ongoing support interventions to appeal to different needs and interests and to keep people engaged over time in maintenance of healthy self management behaviors.

Guest Panels

In addition to the four themed panels presented by grantees, outside experts addressed emotional health issues and presented payer perspectives.

Promoting Healthy Coping and Addressing Negative Emotion in Diabetes Management

A key focus of the *Diabetes Initiative* was emotional health, including but not limited to depression. In a panel discussion moderated by Dr. Fisher, National Advisory Committee member Dr. David Marrero, and immediate past president of the American Association of Diabetes Educators, Malinda Peebles, discussed their work and perspectives on healthy coping and addressing negative emotions as part of diabetes management. Key points included the following:

- Depression, poor metabolic control, treatment adherence and increased health care costs are all inter-related
- Negative emotion as well as depression is a problem that needs to be addressed in self management
- Healthy Coping is a key self management behavior and one of the AADE 7™

The panel discussed how the *Diabetes Initiative* demonstrated a variety of strategies to support healthy coping including: support groups, self management classes, community health worker interventions, counselors on the diabetes care team, medication, and as-needed referral care.

There was discussion regarding:

- use of the PHQ-9 as a screening instrument
- individual and group therapy sessions
- incorporation of cultural traditions into treatment
- the use of a mind-body approaches – e.g., relaxation, yoga, discussions of physical and psychological symptoms of depression

Payer Perspectives

The final panel discussion, Payer Perspectives, was led by Dr. Ronald Aubert, National Advisory Committee Chair and included panelists Drs. Gail Wilder of Building Services 32BJ Health Fund (the Janitor's Union) and Bruce Barter of CenCorp Health Solutions, a subsidiary of Centene Corporation.

Panel participants discussed the need for evidence-based information to support changing models of reimbursement, and noted that providers are constantly looking for ways of better managing increasing healthcare spending. Dr. Barter shared his belief that most management companies' see themselves as payers rather than intermediaries. He expressed the opinion that this perception needs to be further explored.

Dr. Wilder discussed how non-traditional groups in healthcare management – such as labor unions – can help develop programs to outreach to their membership. The Janitor's Union, for example, insures their members and is invested in keeping them healthy and productive over the long haul.

Special Guests and Insights

Two special guest speakers were invited to share insights and information on special topics at the Capstone meeting.

U.S. Representative Diana DeGette (D-Colorado), co-chair of the House Congressional Diabetes Caucus, provided an overview of the work of the Caucus and diabetes related legislation. Congresswoman DeGette noted that change is needed in our nation's healthcare models, including those that have an impact on people with diabetes. In particular, she said she would like to see more programs for prevention which would decrease the need for expensive treatment.

David Bornstein, author of *"How to Change the World: Social Entrepreneurs and the Power of New Ideas"* shared his perspective on social change with program participants. He shared case stories from his work that identified practices common to innovative organizations and qualities of successful entrepreneurs. He tied his message to the impact of work being done by Diabetes Initiative grantees.

Conclusion

Dr. Ed Fisher, NPO Director, closed the meeting with reflections on the Diabetes Initiative and the Capstone Meeting. He summarized key themes and ideas from the meeting, including:

- Self management is central to diabetes management, not just an "add-on" if time and resources permit
- Across all the sessions, the recurrent theme of the importance of teamwork and multiple providers of care and support – diabetes management isn't for heroes or "Lone Rangers" but for cooperating teams.
- Similarly, dissemination will require a kind of teamwork with efforts at local, regional and national levels, the importance of innovative ways of gaining support for existing programs, policy changes, public understanding of the importance of self management and support for it, and, not the least among these, compelling stories of successful programs such as provided by the grantees.

Additionally, Dr. Fisher recalled Dr. Russell Glasgow's emphasizing the "law of halves" – a treatment or intervention is liable to work with only about half of those to whom it's applies. Only about half of those who might benefit will accept it. Only about half of these will continue to use it – leading to a net benefit to 12.5% of those with whom one started. This points to the importance of **many good practices** rather than one or a few **best practices** in providing multiple channels and formats through which individuals can find Resources & Supports for Self Management that meet their living patterns and needs. This is especially important given the large numbers of those with diabetes who receive little or know preventive care or self management education and support. Implementing one or two best practices is unlikely to reach the majority of these individuals.

The information shared during this meeting will be used to advance the field of diabetes self management in primary care settings and communities. Those interested in learning more can visit <http://diabetesinitiative.org>. Materials tools, publications, and other information are available for unrestricted use and sharing with the public.

Diabetes Initiative Capstone Meeting Agenda

Objectives:

- Showcase outcomes and accomplishments of grantees' work
- Promote dissemination of lessons learned to partners in diabetes care

Thursday, October 19, 2006

- 8:00 – 8:15 am **Welcome**
National Program Office and RWJF
- 8:15 – 9:15 am ***Important Trends in Diabetes Care and the Central Role of Self Management***
James R. Gavin III, MD, PhD, Keynote Speaker
President and CEO, Microislet Inc.
Clinical Professor of Medicine, Emory University School of Medicine
Exec Vice President for Clinical Affairs, Healing Our Village, LLC.
Board of Directors, the Robert Wood Johnson Foundation
- 9:15 – 11:55 am **MODELS FOR PARTNERSHIPS THAT BUILD COMMUNITY SUPPORTS FOR DIABETES CARE**
- 9:15 – 9:35 ***Collaboration: Moving Beyond the Basics***
Elizabeth Baker, PhD, MPH, Moderator
Associate Professor of Community Health in Behavioral Science and Health Education, Saint Louis University School of Public Health
- 9:35 – 9:50 ***A Circle Paradigm Promotes Holistic Community Partnerships***
Kimberly Rinderknecht Plessel and Lisa Hakanson
Minneapolis American Indian Center
- 9:50 – 10:05 ***An Ecological Approach Provides a Comprehensive Model to Initiate and Sustain Diabetes Self Management***
Lisa Aisenbrey
Richland County Health Department
- 10:35 – 10:50 ***Building Community Support for Diabetes Care: Effective Strategies Targeting Minority and Underserved Populations***
Emma Torres
Campesinos Sin Fronteras
- 10:50 – 11:05 ***Eastern Shoshone Diabetes Self Management Program***
Gordon Belcourt and Kathy Langwell
Montana-Wyoming Tribal Leaders Council

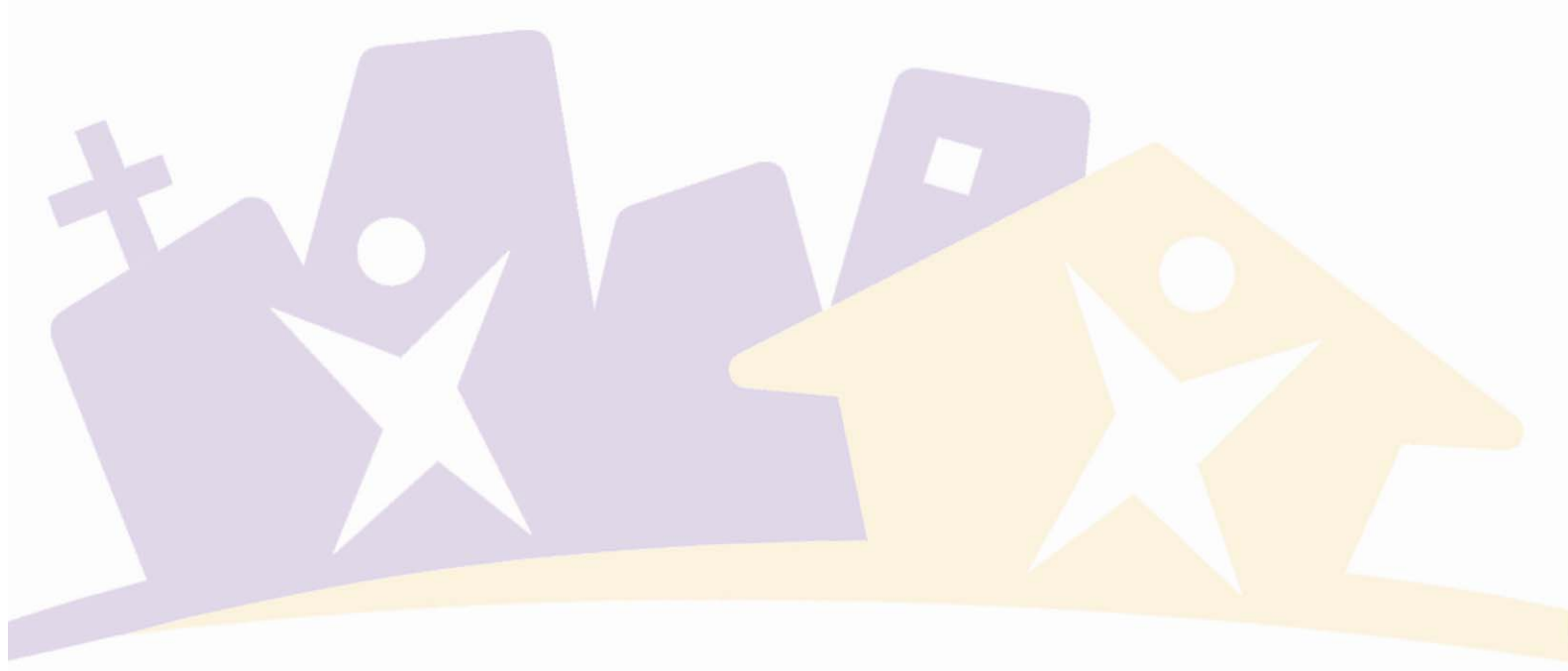
- 11:05 – 11:55 **Group discussion**
Discussants: Kathryn Coe, LaVerne Reid
- 1:00 – 1:45 pm **Cross-site Evaluation Update**
Douglas Kamerow, MD, MPH
Lauren McCormack, PhD, MSPH
Joe Burton, MS
RTI International
- 1:45 – 2:15 pm **The Honorable Diana DeGette**
U.S. Representative, Colorado, First District
- 2:15 – 3:15 pm **Promoting Healthy Coping and Addressing Negative Emotion
in Diabetes Management**
Ed Fisher, PhD
National Program Director, RWJF Diabetes Initiative
Discussants: David Marrero and Malinda Peoples
- 3:35 – 5:30 pm **COMMUNITY HEALTH WORKER APPROACHES TO IMPLEMENTING SELF
MANAGEMENT IN COMMUNITY SETTINGS**
- 3:35 – 3:55 **Setting the Stage**
Ann Albright, PhD, RD, Moderator
President Elect, Health Care and Education, American Diabetes
Association
Program Chief, California Diabetes Program
- 3:55 – 4:10 **Health Promoters Use Stages of Change to Improve Diabetes in
Urban Mexican-Americans**
Claire Horton and Joan Thompson
La Clinica de La Raza
- 4:10 – 4:25 **Lay Health Educators: A Social Marketing Strategy Addresses the
Community Resources and Policy Component of the Chronic Care
Model**
Natalie Morse, MaineGeneral Health
- 4:25 – 4:40 **Take Action Galveston**
D. Darlene Cass
Galveston County Health District
- 4:40 – 5:30 **Group Discussion**
Discussants: Joanne Gallivan and Donna Rice

Friday, October 20, 2006

- 8:00 – 9:00 am **Insight and Inspiration from Social Entrepreneurs**
David Bornstein, Author
How to Change the World: Social Entrepreneurs and the Power of New Ideas
- 9:00 – 11:30 am **MODELS FOR ENGAGING AND KEEPING PATIENTS INVOLVED IN SELF MANAGEMENT**
- 9:00 – 9:20 ***Ongoing Follow Up and Support in Diabetes Self Management***
Ed Fisher, PhD, Moderator
National Program Director, RWJF Diabetes Initiative
- 9:20 – 9:35 ***Proyecto Vida Saludable: An Innovative Approach to Diabetes Self-Management for Latino Patients with Type 2 Diabetes***
Dawn Heffernan
Holyoke Health Center, Inc.
- 9:35 – 9:50 ***A Model for Engaging and Keeping Patients Involved in Self Management***
Joan Christison-Lagay
Community Health Center, Inc.
- 10:10 – 10:25 ***Strategies for Engaging and Supporting Self Management in a Multicultural Setting***
Laura Bazyler
Open Door Health Center
- 10:25 – 10:40 ***Empowering the African-American Community to Live Well: “Meeting People Where They Are”***
Grant Jones and Jo Ann Pegues
Center for African American Health
- 10:40 – 11:30 ***Group Discussion***
Discussants: Pat Barta and Judy Wylie-Rosett
- 1:00 pm – 2:50 pm **SYSTEM CHANGES AND PROGRAM DESIGN TO SUPPORT SELF MANAGEMENT**
- 1:00 – 1:20 ***Setting the Stage***
Russ Glasgow, PhD, Moderator
Senior Scientist, Kaiser Permanente Colorado Clinical Research Unit
- 1:20 – 1:35 ***Comprehensive System of Care for Patients with Diabetes/Cardiovascular Disease***
Lourdes Rangel
Gateway Community Health Center

- 1:35 – 1:50 ***Primary Care Re-Designed: Four Steps to Patient Self Management Support***
 Devin Sawyer
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- 1:50 – 2:05 ***Dissemination of Regional and Statewide Self Management Resources and Training***
 Richard Crespo
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- 2:05 – 2:50 ***Group Discussion***
 Discussants: Angela Herman, Veronica Richardson, Judith Schaefer
- 3:10 – 3:30 pm ***Putting It All Together: Resources & Supports for Self Management, System Changes to Support Them, and Chronic Disease Care***
 Ed Fisher, PhD
- 3:30 – 4:05 pm ***Payer Perspectives—Panel discussion***
Chair: Ronald Aubert, PhD, National Advisory Committee Chair
 Vice President, Clinical Analytics, Outcomes and Reporting
 Medco Health Solutions, Inc.

Panelists: Gail Wilder, MD – Janitor’s Union
 Bruce Barter, MD – Centene Corporation
- 4:05 – 4:30 pm ***Closing Comments and Next Steps***
 Ronald Aubert, PhD, and National Program Office
- 4:30 pm ***Meeting Adjourns***



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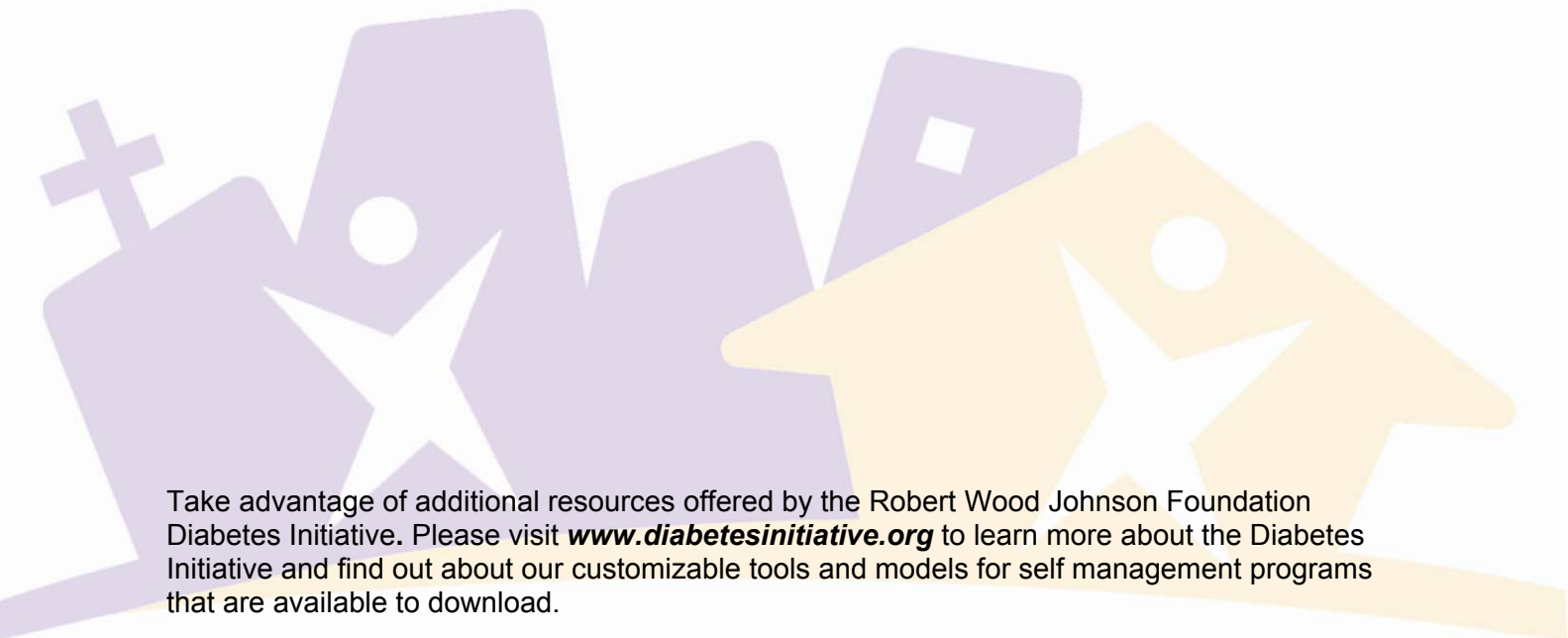
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A stylized graphic at the bottom of the page features two hands, one purple and one yellow, holding a white star. The hands are rendered in a simple, blocky style. The purple hand is on the left, and the yellow hand is on the right. The star is positioned in the center, overlapping both hands. The background of the graphic is a light purple and yellow gradient.

Take advantage of additional resources offered by the Robert Wood Johnson Foundation Diabetes Initiative. Please visit www.diabetesinitiative.org to learn more about the Diabetes Initiative and find out about our customizable tools and models for self management programs that are available to download.