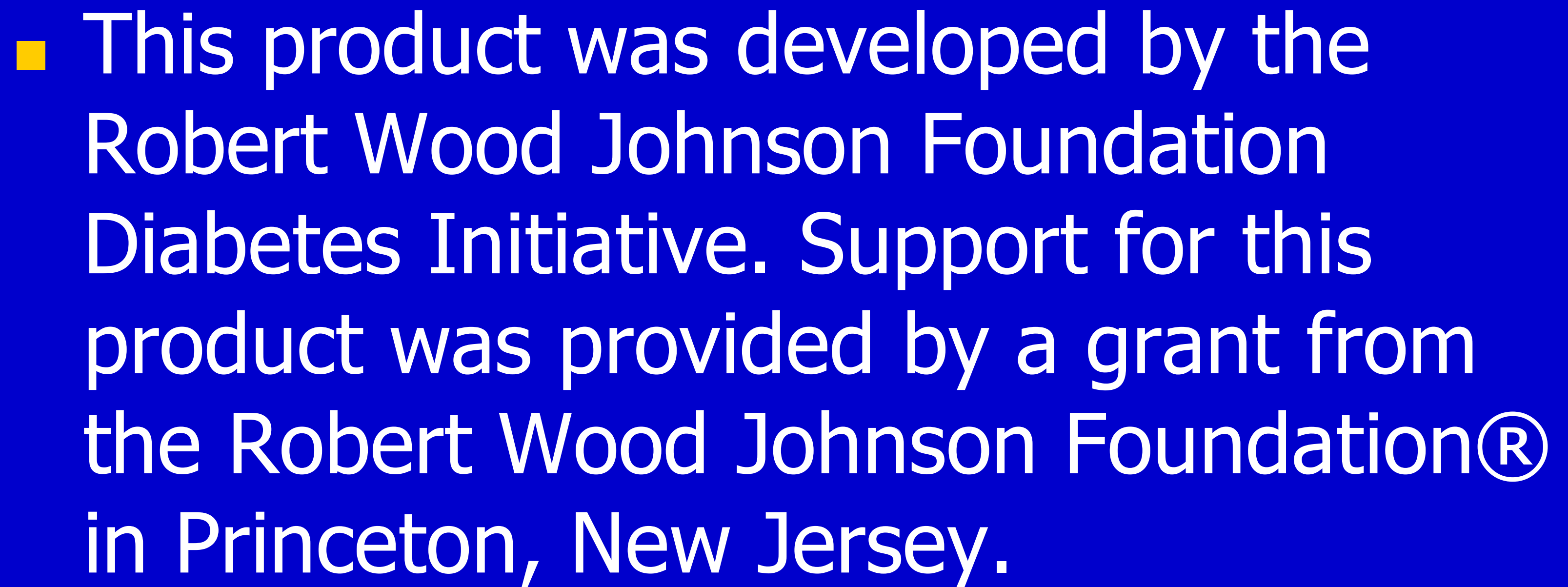

This product was developed by the Robert Wood Johnson Foundation Diabetes Initiative. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

Linking Clinical and Community Support for Diabetes Self Management

Gowri Shetty, MS, MPH

Edwin Fisher, PhD., Carol Brownson MSPH, & Victoria Anwuri MPH

Robert Wood Johnson Foundation *Diabetes Initiative*
Washington University in St. Louis
http://diabetesnpo.im.wustl.edu/
Email: gshetty@im.wustl.edu

Implications for Self Management of 3 Fundamental Aspects of Diabetes

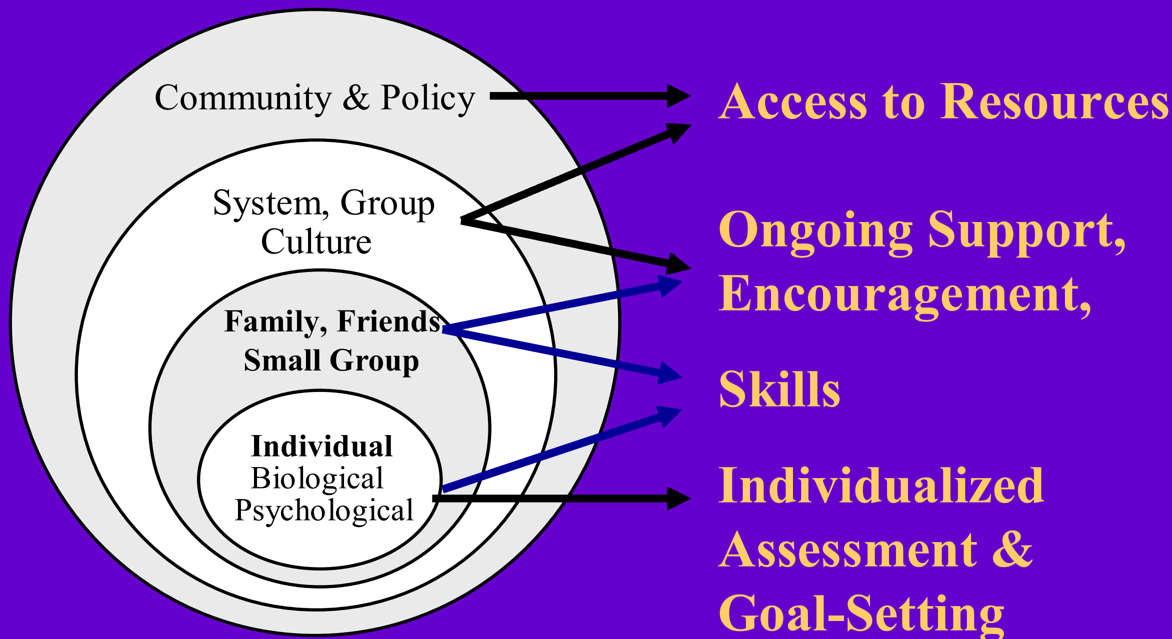
1. **Centrality of behavior**
   - Diet
   - Exercise
   - Monitoring
   - Medication management
   - Psychological/emotional status
2. **In every part of daily life – 24/7**
3. **For “the rest of your life”**

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

Diabetes Initiative and Ecological Perspectives on Self Management



Community Organization in RWJF Diabetes Initiative

Number of Intervention Levels	N	Types of levels
1	57	95% individual
2	47	94% individual, 57% group
3	27	100% individual, 63% group, 44% physical environment
4	6	100% individual, group, and physical environment, 67% social environment

Community Organization in RWJF Diabetes Initiative Building Community Supports for Diabetes Care

"…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"

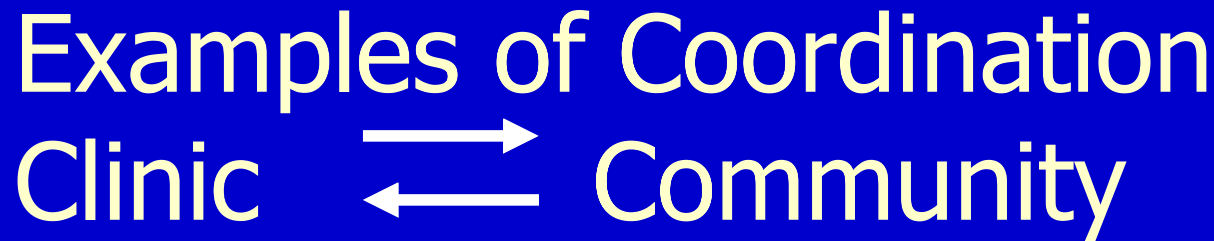
Examples of interventions:

"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

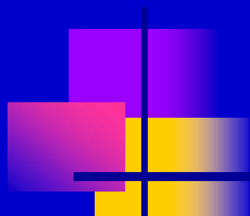


- Development of coalitions or partnerships
- Using Clinics and their resources as a base for supporting key community programs for intended audiences
- Expanding group medical visits to include group support, education and activity sessions
- Using lay health workers to bridge clinic and community

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

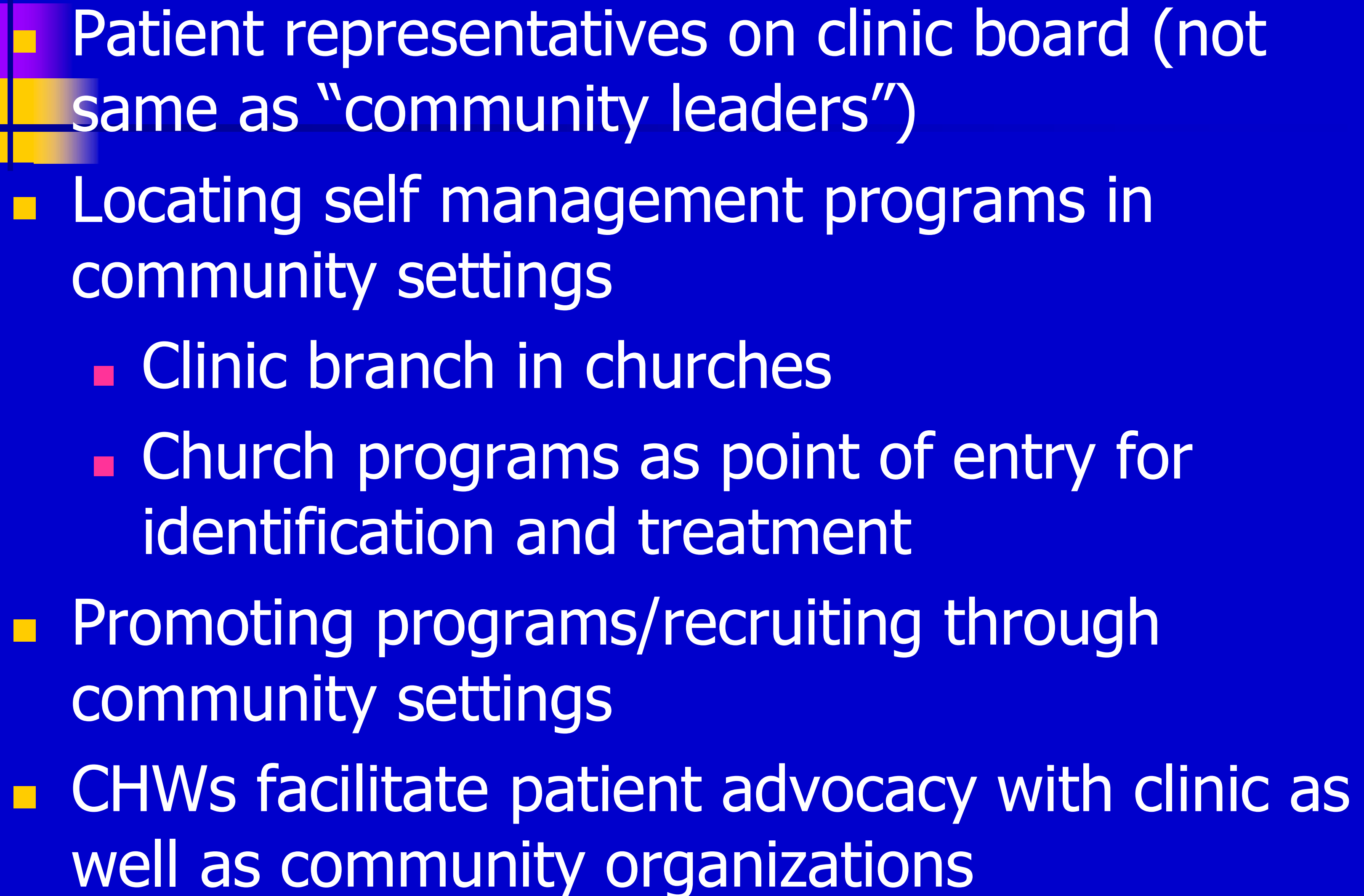
Migrant Workers

Patients

Adults w/ DM

- Group Med Visits
- CHWs
- Walking Clubs
- Self Mgmt Class
- Support Group

Clinic Linkage with Community



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

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????