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DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Key Features of Ongoing Follow Up and Support in the Robert Wood Johnson Foundation Diabetes Initiative

www.diabetesinitiative.org

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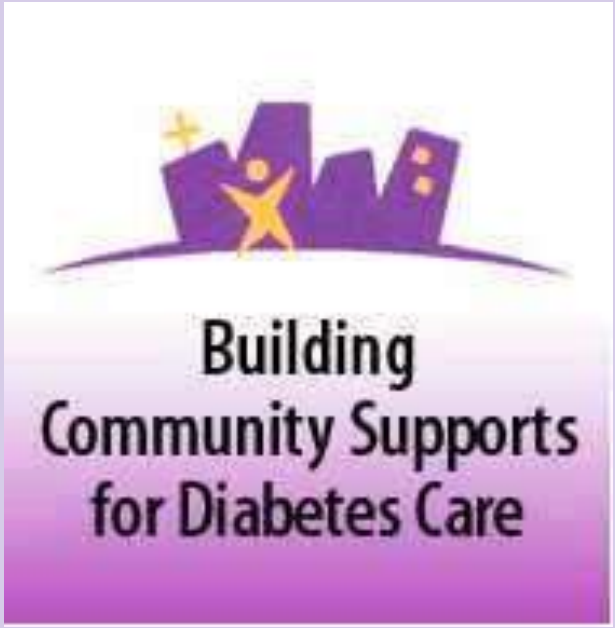
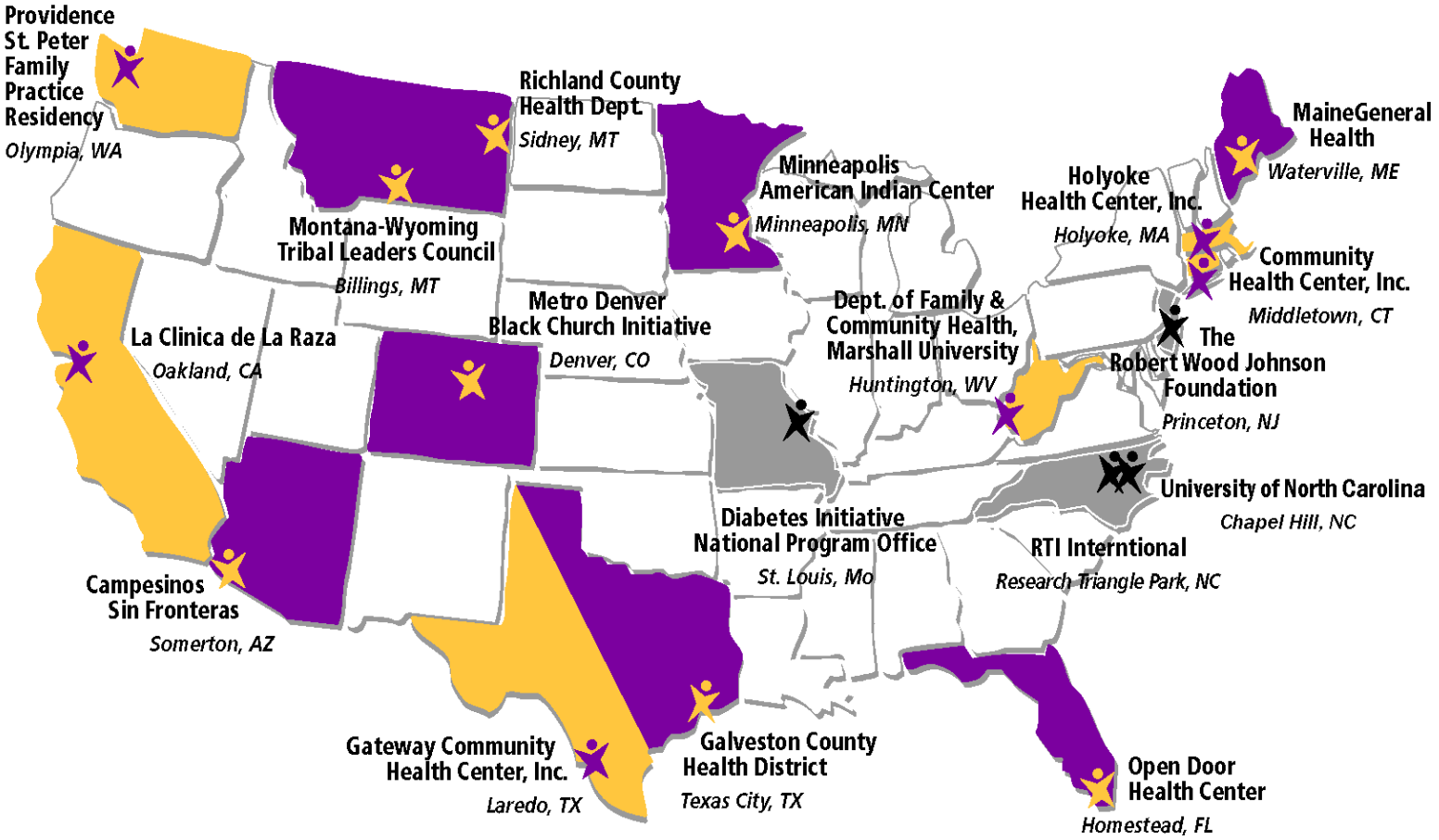
Society of Behavioral Medicine
San Diego – March, 2008

Diabetes Initiative of the Robert Wood Johnson Foundation

Real world demonstration of self management as part of high quality diabetes care in primary care and community settings



The 14 Sites of the Diabetes Initiative



Key Aspects of Diabetes

- Behavior is Central
- 24/7
- 6 hours a year with physician's, dietitians, etc
- 8,760 "on your own"
- *For the rest of your life*

Resources & Supports for Self Management

- Individualized Assessment
- Collaborative Goal Setting
- Instruction in Skills
- Ongoing Follow Up and Support
- Community Resources
- Continuity of Quality Clinical Care

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Key Features of Ongoing Follow Up and Support

Not Time Limited

- What's wrong with this picture?
  - 8 Sessions Health Coach if GHb > 8
  - If GHb falls to 7, Health Coach terminated
- "OK, You've got type 1 diabetes. We'll put you on insulin for two weeks and see if that cures you."
- That ongoing support needs to be ongoing does not mean it's ineffective.
- No more than that insulin needs to be ongoing

Personal connection is critical

- Based in an ongoing relationship with a provider
- Not necessarily physician
- Critical are:
  - Time to get to know individual
  - Links to rest of team

On-Demand

- Available on demand and as needed by the recipient
- Community based events, e.g., health fairs
- Weekly breakfast clubs
- Monthly diabetes breakfast
- Yearly party to which family invited
- *Talking Circles* in American Indian communities

Proactive or Staff Initiated

- Diabetes is progressive and management is influenced by life changes
- Keep individuals from "falling between the cracks"
- Refer to other components of Resources and Supports for Self-Management
- Contact initiated by provider every 2 to 4 months
- Holyoke: database triggers contact by RN/CHW team
- Low demand – communicate interest rather than surveillance
- Also, newsletters, mailings, etc.

Variety – Range of "good practices" rather than single "best practice"

- 60% to 70% of patients report not having received self-management interventions (Austin *Endo Practice.* 2006 12(Suppl 1):138-141)
- Reaching and engaging more important than efficacy
  - Intervention of 75% efficacy that reaches and engages is more beneficial than 100% efficacy that does not engage
- Use varied channels – telephone, drop-in groups, scheduled groups
- ***Many "good" better than few "best" practices***

Motivational

- Especially for those with long Hx, motivation may be more critical than skill
- Nondirective Support – accepting individual's goals and views of things, encouraging more than "taking over"
- 30% of Community Health Worker encounters categorized as providing encouragement or motivation
- Support groups

Not Limited to Diabetes

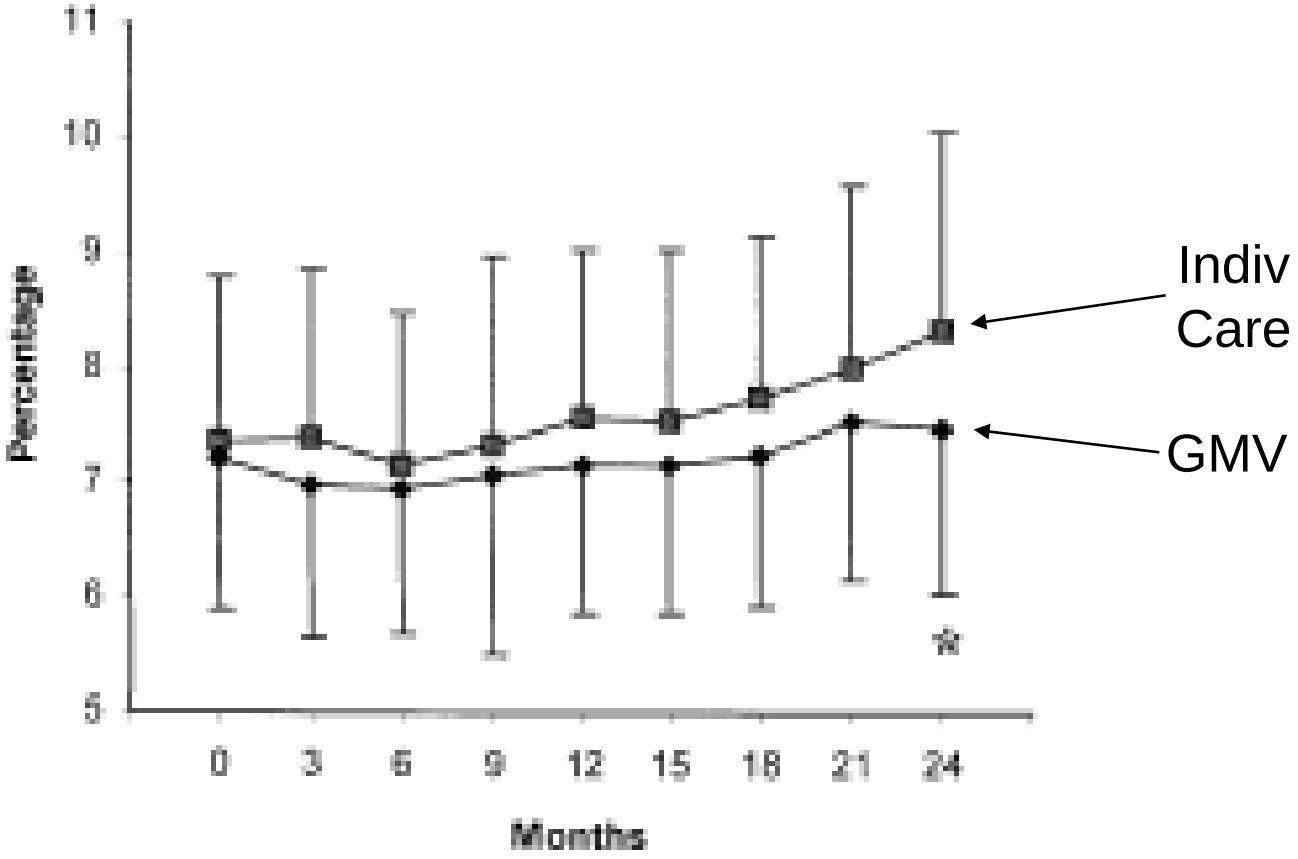
- Diabetes is woven through all of life so must address the diverse concerns or challenges the individual faces
- Programs can be general – e.g., weight management, physical activity, chronic disease self management groups
- Reduce or avoid stigma by programs directed toward general public
- Gain support for program by linking to broad interests

Group Medical Visits

Group Medical Visits

- All patients with common characteristics, e.g., all with diabetes, CHF, arthritis, or chronic disease
- 2 – 3 hour block
- Clinical assessment and medical care
- Group discussion and support
- Educational sessions
- Group activities – exercise, cooking classes, etc.

GHb Results of Group Medical Visits



At 5 years, GHb =	7.3 in GMV
	9.0 in Individual Care

Trento et al., *Diab Care* 2001 24: 995-1000; 2004 27: 670-675

Community Health Workers

- Personal, have time, often of individual's community
- Linkage to clinical and other resources
- Reinforce and trouble-shoot basic education
- Provide emotional support and encouragement to:
  - Encourage Healthy Coping
  - Maintain motivation
- Teach classes
- Organize for advocacy, community action

Holyoke Health Center, Inc. Advancing Diabetes Self Management

Executive Director: Jay Breines, M.D.
Project Director: Dawn Heffernan, R.N., M.S.

230 Maple Street
Holyoke, MA 0104

dawn.heffernan@hhcinc.org
www.hhcinc.org

Holyoke Health Center

Federally Qualified CHC

Western Massachusetts

17,277 medical patients

6,722 dental patients

One of the highest diabetes mortality rates in Massachusetts

- **≈ 100% of patients live at or below poverty level**

Multiple Interventions provides ample opportunity for ongoing follow up and support

- Chronic Disease Self-Management Classes
- Community Health Workers
- Diabetes Education Classes
- Exercise Classes
- Individual Appointments with the diabetes educator and the nutritionist
- Breakfast Club
- Snack Club

Community Health Workers

- Bridge between the community and the health center
- Co-lead Programs
- Outreach
- Teaching
- Social Support
- Telephone Follow-Up
- Joint Visits with Providers
- Goal Setting/Problem Solving
- Collaboration with the nurses and providers in the clinic

Nurse and Community Health Worker Collaboration

- Follow up and support for patients not seen by their provider in the last 4 months
- Registry report generated every month
- Patients identified
- Nurses call patients, send letters and then refer to the community health workers
- Community health workers reattempt phone contact, letter and then provide a home visit to patients address

Breakfast Club

- Eleven Sessions
- Nutritious Breakfast
- Correct Portion Sizes
- Balanced Meals
- Variety of Foods
- New food products introduced
- Label reading
- Hands on learning opportunities
- Incentives and raffles

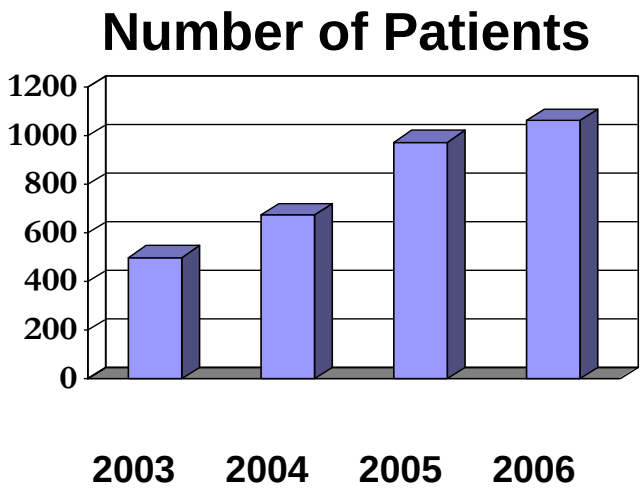
Supermarket Tour

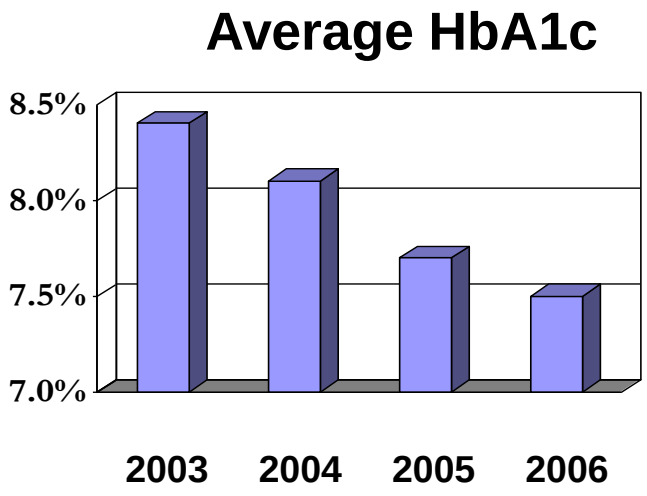
- Practice skills learned in class
- Patients with low literacy levels benefit
- Assess patient knowledge of products and food selection
- Hands on learning

Drop In Snack Club

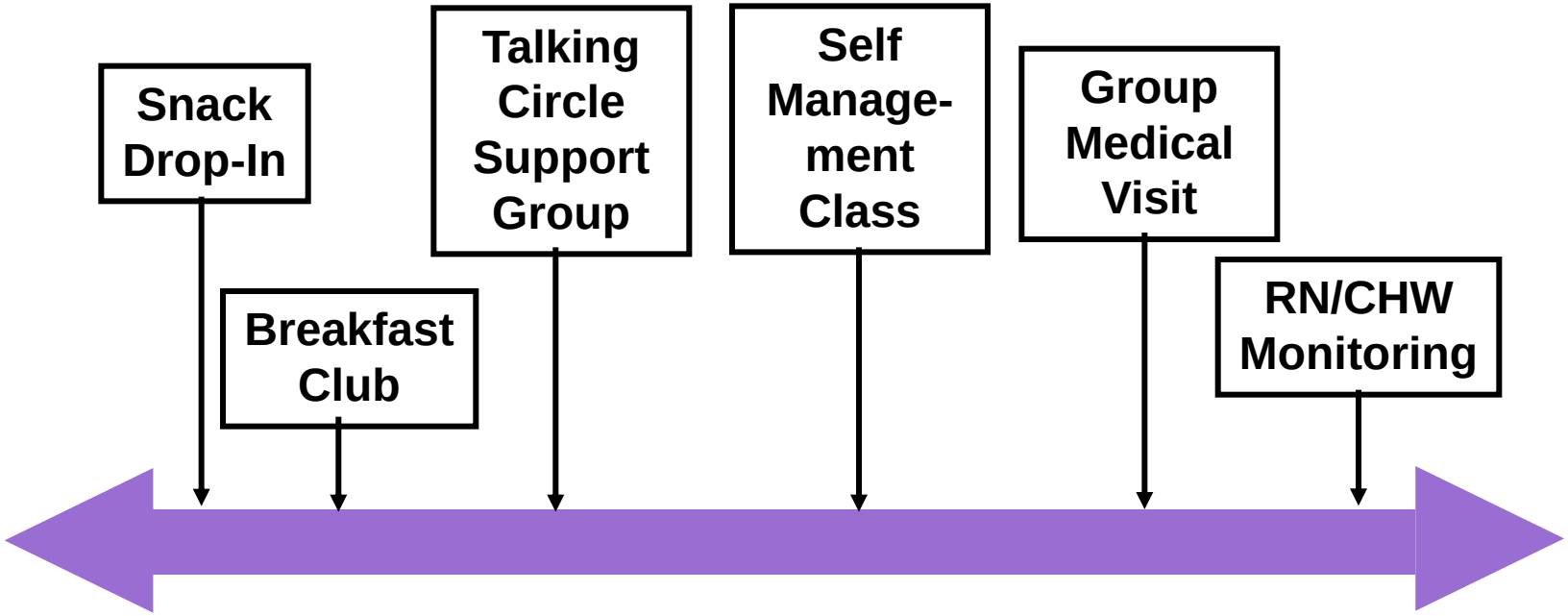
- Informal gatherings
- Meet Program Staff
- Diabetes Bingo
- Raffles with healthy prizes
- Goal Setting
- Problem Solving
- Referral to other programs

Year	2002	2003	2004	2005
Number of Patients	499	675	873	1061
Average HbA1c	8.40%	8.10%	7.70%	7.50%





On-Demand – Staff Initiated
A Critical Continuum



On-demand, Varied Contacts to Suit Individual Preferences

Staff-Initiated Contacts to Maintain Contact and Prompt Engagement

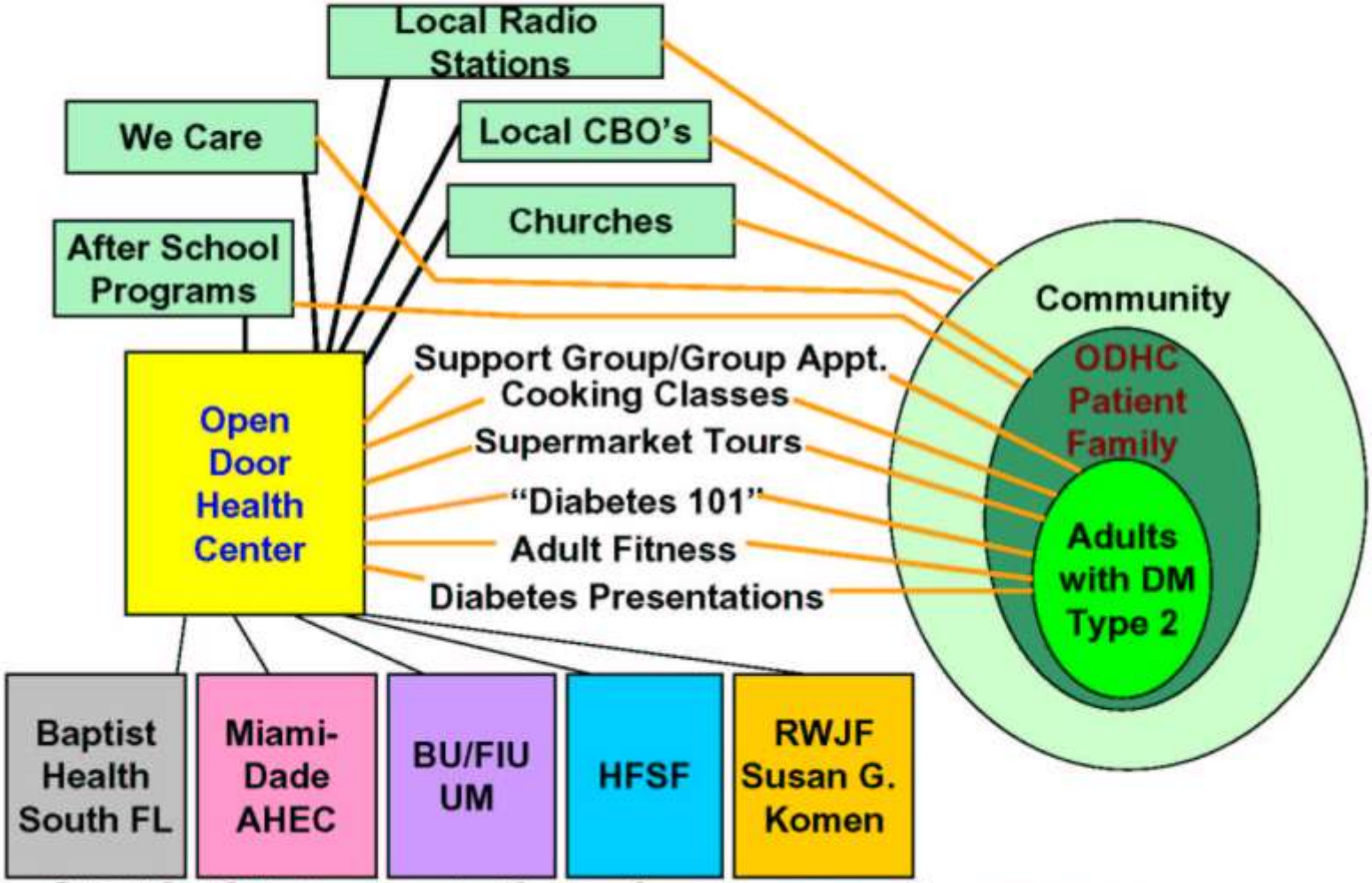
Open Door Health Center Building Community Support for Diabetes Care

Program Director: Nilda Soto, MD
Project Coordinator/ Nutritionist and Lifestyle Coach: Laura Bazyler, MS, RD, LD/N

1350 SW 4th Street
Homestead, FL 33030

nsoto26@msn.com
www.opendoorhc.org

OFUS on Three Levels



ODHC: Clinic as platform for community program

Peers for Progress

Connections for Better Living | DIABETES

- **Demonstrate**
- **Evaluate**
- **Promote**
- **Peer Support for Diabetes Management**
- **Around the World**

Program Development Center in Dept. of Health Behavior & Health Education, University of North Carolina at Chapel Hill
American Academy of Family Physicians Foundation
American Association of Diabetes Educators
Unrestricted grant from Eli Lilly and Company Foundation, Inc.

WHO Conference:
Peer Support in Diabetes
November, 2007

Australia	Gambia	Saudi Arabia
Bangladesh	India	Singapore
Bermuda	Indonesia	Switzerland (WHO)
Brazil	Jamaica	Turkey
Cameroon	Mexico	Ukraine
Canada	Netherlands	United Kingdom
China	Pakistan	United Republic of Tanzania
Egypt	Philippines	United States

Pandu Diabetes (Diabetes Champions) in Indonesia

- Organised by the Indonesian Diabetes Association (Persatuan Diabetes Indonesia)
- Program to prepare or create diabetes leaders /motivators all over the country
- Helping patients to change their behavior / lifestyle
- Patients helping each other in self management of diabetes (peer to peer)
- Activate the organization/members/ health personnel
- Improve self - management of the members

Pandu Diabetes Units/Clubs

Jakarta: 7000 members
Banten : 600 members
Bogor : 650 members
Lampung: 300 members
West Java : 3000 members
Central Java: 3000
East Java : 2000
Gorontalo : 400
North Sulawesi : 400
South Sulawesi : 300

North Sumatera : 700
West Sumatera : 250
South Sumatera : 400
Kalimantan : 2000
North Maluku : 300
Bali : 400
Lombok : 200
Flores : 200
Timor :100

Total: 22,200 members

Rapat Kerja Nasional

Perkemahan Diabetes Nasional 2006

Via Renata Hotel & Exclusive Bungalows Cimacan - West Java, 11 Maret 2006

Consensus re: Key Functions of Peer Support

- Assistance, consultation in applying management plan in daily life
- Social and Emotional Support
  - Encouragement of use of skills, problem solving
  - Personal relationship
- Linkage to clinical care

Introduction to the Symposium

Society of Behavioral Medicine 2008

Sustaining Behavior Change in Health Promotion – Diabetes Prevention and Management, and Weight Loss

Ed Fisher, PhD – University of North Carolina

Pilvikki Absetz, PhD – Health Promotion Unit, National Public Health Institute, Helsinki, Finland;

Robert W. Jeffery, PhD – Division of Epidemiology and Community Health, University of Minnesota

Brian Oldenburg, PhD – International Public Health Unit, Monash University, Melbourne, VIC, Australia

General Emphasis on Behavior *Change*

- Most intervention models in field examine ways of initiating new behaviors
- Emphasis on skills that are assumed to be:
  - useful in real world
  - maintained by naturally occurring consequences
- Common implicit assumption that if behavior change somehow "takes," maintenance will be automatic
- 1 – 2 year follow up generally highly esteemed
- Average individual with type 2 diabetes may live 3 – 4 decades with their disease

The Best Quotation in Behavior Science Over the Last 50 Years

"generalization [or maintenance of behavior change] should be programmed, rather than expected or lamented“

Baer, D. M., Wolf, M. M., & Risley, T. R. (1968). Some current dimensions of applied behavior analysis. ***Journal of Applied Behavior Analysis,*** *1*, 91-97

Self Regulation for Maintenance of Weight Loss

- Participants lost mean 19.3 kg in previous 2 years
- Randomized to:
  - Quartlery newsletters (control)
    4.9 kg regain in 18 mos
  - Internet-based daily self-weighing and self-regulation
    4.7 kg in 18 mos
  - Face-to-face daily self-weighing and self-regulation
    2.5 kg regain in 18 mos
- Daily self-weighing associated with decreased risk of regaining 2.3 kg or more ($P<0.001$)

Wing, Tate, Gorin, Raynor & Fava. *NEJM* 2006 355 (15):1563-1571.

Weight Loss Maintenance Randomized Controlled Trial

- Participants had lost ≥ 4 kg (mean = 8.5 kg) in 6-month program
- Randomized to 30 months of:
  - Self-directed – regained 5.5 kg in 30 mos
  - Interactive technology intervention – regained 5.2 kg in 30 mos
  - Monthly individual contact – regained 4.0 kg in 30 mos
- Both Interactive and Individual Contact
  - Adherence to diet and physical activity (225 minutes per week)
  - Key theoretical constructs (motivation, support, problem solving, and relapse prevention)
  - Self monitoring, accountability, prolonged continuous contact, and motivational interviewing.

Svetkey et al. JAMA 2008 299(10):1139-1148

Predictors of Change in Diabetes Self Management

- Review of programs to enhance diabetes self management (Norris et al., *Diabetes Care* 2001 24: 561-587.):
  - "Interventions with regular reinforcement are more effective than one-time or short-term education"

- Review of effects of self management on metabolic control (Glycosolated hemoglobin) (Norris et al., *Diabetes Care* 2002 25: 1159-1171.)
  - Only predictor of success: ***Length of time over which contact was maintained***

Not Just Diabetes
Smoking Cessation Interventions

- Meta-analysis of Kottke et al. (*JAMA* 1988 259: 2882-2889)
  "Success was ***not associated with novel or unusual interventions***. It was the product of ***personalized smoking cessation advice and assistance***, ***repeated*** *in* ***different forms*** by ***several sources*** over the ***longest feasible period***."

- AHRQ meta-analysis: Greater likelihood of smoking cessation with greater length of intervention (Fiore et al. *Treating tobacco use and dependence*. USDHHS, 2000).

Adoption and maintenance of lifestyle change in preventing type 2 diabetes – different predictors, different strategies for sustained change?

Pilvikki Absetz, PhD
Health Promotion Unit, National Public Health Institute, Helsinki, Finland

Maintenance of Weigh Loss: Theoretical and Empirical Concepts

Robert W. Jeffery, PhD
Division of Epidemiology and Community Health, University of Minnesota, Minneapolis, MN, USA

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Discussant and General Questions

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