The Diabetes Initiative of the Robert Wood Johnson Foundation (USA-Non-profit)
www.diabetesinitiative.org

Section I: Summary

In 2003 the Robert Wood Johnson Foundation awarded grants to 14 communities/projects from diverse communities across the United States under a new program called the Diabetes Initiative. The goal of the Initiative is to demonstrate feasible and sustainable strategies for diabetes self-management in real-world primary care and community settings. The Initiative has identified key resources and supports for self-management (individualized assessment, collaborative goal setting, enhancing skills, follow-up and support, community resources, and continuity of quality clinical care). Over the course of almost four years, the projects developed strategies, tested and modified their approaches, collaborated with each other and shared promising practices for diabetes self management.

Section II: Statement of Purpose

The Robert Wood Johnson Foundation (RWJF) is a private philanthropic organization dedicated to improving health and healthcare in the United States. In 2003 RWJF awarded grants to 14 communities/projects under a new program called the Diabetes Initiative. The Initiative promotes diabetes self-management in real-world primary care and community settings through two national programs - Advancing Diabetes Self Management (ADSM) and Building Community Supports for Self Management (BCS). The fourteen projects selected represented a wide range of urban and rural communities, ethnicities and geography. Six projects focused on self-management in primary care settings and eight projects focused on supporting self-management through community-clinic partnerships.

The Initiative developed a program model that could be applied across all the projects based on key resources needed to address diabetes self-management, with flexibility to address local needs and circumstances. Termed Resources and Supports for Self Management (RSSM), these key components included:

- 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 to help with purchasing healthy foods or getting physical activity in safe, attractive environments, etc.

The fourteen communities used a variety of intervention strategies and approaches tailored to local needs and culture. Examples of four types of approaches are outlined below.

Building Community Supports: Minneapolis American Indian Center
The Minneapolis-St. Paul metropolitan area is home to over 34,000 Native Americans who comprise the poorest of all the city's ethnic groups. The Full Circle Diabetes Program is a collaboration among the Minneapolis American Indian Center Ginew/Golden Eagle Program, the Native American Community Clinic and the Diabetes Community Council. The program is a community-clinic partnership based on a holistic, "circle model" that provides the community with increased physical, mental, emotional, and spiritual supports for diabetes care. Members of the Native American Community were recruited to form the Diabetes Community Council that designed community-based activities to improve resources for diabetes management. The community clinic participated in the planning process and provided expertise and consultation on diabetes care. The program provided a variety of supports to address physical, mental, emotional, and spiritual wellbeing, including: physical activities, case management, and access to regular medical care and supplies (physical supports); diabetes education classes (mental supports); supportive "Talking Circle" and Council-led events (emotional supports); and cultural sensitivity in activities and emphasis on the teachings of elders and ancestors in the community (spiritual supports).

Utilizing Community Health/Lay Workers: MaineGeneral Health
MaineGeneral Health is a healthcare system in the state of Maine, United States. MaineGeneral Health collaborated with the Kennebec Valley Diabetes Care Initiative Advisory Group, an inter-organizational collaborative in rural Maine, to create the "Move More" program. Move More uses community health workers, known as lay health educators (LHEs) to educate and promote lifestyle change related to diabetes. Program organizers discovered through focus groups that people preferred "gentle encouragement" for changing lifestyle, so the program uses a strategy of non-directive peer support from LHEs to encourage lifestyle change. In particular, the Move More program targets middle-age and older adults with type 2 diabetes or pre-diabetes with a goal of increasing physical activity through a social marketing strategy based on the "5 P" model: Places, Price, Product, Promotion, and Policy. Places refers to locations to deliver positive health messages, such as work sites, clinics, churches, and media. Price refers to the cost to participants, in both dollars and time and effort, to change behaviors. Product is the goal of 150 minutes of physical activity a week. Promotion refers to strategies to make exercise interesting and attractive. Policy refers to working with other community partners to promote physical activity and other behavioral changes. The LHEs are peer volunteers, many of whom have diabetes themselves, who are used to implement the 5

components. LHEs are trained in the basics of physical activity, nutrition, and motivational strategies. They have access to resources such as walking maps and pedometers to help incentivize participants. They also have the flexibility to provide ongoing "friendly support" to participants through email, phone, and face-to-face meetings.

Engaging and Keeping Patients Involved: Community Health Center Inc.
The Community Health Center, Inc. (CHC) is a federally qualified health clinic in the state of Connecticut, United States that provides comprehensive primary care services to over 50,000 primarily poor, uninsured, or under-insured patients in the state. The CHC implemented an Advancing Diabetes Self Management program in three communities with an extremely high incidence of diabetes. In this program, primary care providers refer patients to the program and patients receive individualized self-management education and support from two certified diabetes educators. Program activities included cooking clubs, dancing classes, educational games, and walking programs. Over time, clinic staff realized that many of the program clients were not taking advantage of all of the extra program activities and supports. Further investigation led to the identification of two issues that needed resolving before patients could be fully engaged in self-management programs and practices. First, staff realized that many of the patients were suffering from depression and that they would have to address this issue initially in order to engage patients later. Second, it was identified that medical staff needed more training in patient self-management. Two initiatives were established to address these primary barriers to program success. To address the issue of depression, the clinic implemented patient clinical management including individualized assessment and depression screening, and patient referrals for solution-focused brief therapy visits with a psychologist or licensed social worker. To address the staff training issue, 8 nurses were trained in motivational interviewing, health education techniques, diabetes educator skills, and self-management goal setting. Using these tools, nurses could more effectively integrate diabetes self-management with provider visits.

System Changes and Program Design: St. Peter Family Medicine Residency Program
The St. Peter Family Medicine (SPFM) Residency program is affiliated with a University of Washington hospital that serves over 300,000 residents in rural Washington state, US. The clinic developed a systems approach focused on four practice innovations to redesign medical team–patient interaction: the planned medical assistant (MA) visit; the provider visit; the mini-group visit; and open office group visit. In this model, the MA has an expanded role to take vital signs, complete physician standing orders for labs, referrals, etc., and discuss self-management goal setting. The MA also does followup calls with the patient two weeks later to review goals and offer support and reinforcement. Physicians were also trained in collaborative goal setting, with systems implemented to track goals and goal quality. After the planned MA visit, patients are then offered a choice of an individual visit with the

physician or a mini-group visit. The mini-group visit is a one-hour visit with two or three patients and the MA-physician team to discuss medical issues and self-management goals. The mini-group visit provides a venue for social support and group problem solving. The patients are offered additional mini-group visits every three to four months with the same group of people. The open office group visit is offered as a supplement to an individual or mini-group visit, and involves seven to 12 patients and the provider team in a discussion forum driven by patient questions. This provides another opportunity for patients to share experiences, offer support, and ask questions.

Section III: Outcomes

Projects of the RWJF Diabetes Initiative have been successful in implementing programs that address diabetes self-management through a variety of approaches and strategies. In doing so, a number of key "lessons learned" have emerged that can help make these programs more easily translate to other communities and settings. These key lessons include:

- *Infrastructure (re)design can help improve patient self-management.* Organizational and system features should facilitate self-management and empower patients to take control of their care. The Diabetes Initiative developed a tool for practice teams to improve their organizational structure in this regard, called "*Assessment of Primary Care Resources and Supports for Chronic Diseases Self Management."*
- *Ongoing followup and support is essential.* Routine contacts by the physician team, as well as followup visits as needed encourage patients to maintain their self-management regimen and goals.
- *Stress, depression, and health coping must be addressed.* Depression screening and availability of psychological support are important in keeping patients healthy, and coping strategies are beneficial for all patients whether or not they are clinically depressed.
- *Many good practices may be better than a few best practices.* Having a variety of options for learning diabetes self-management skills may be more effective than limiting programs to just one or two intervention strategies. Different communities and populations will respond differently to a given strategy, so flexibility and choice is key to finding an approach that can be successful.
- *Community health workers can play an important role.* Community health workers are called by different names – health coach, promotora, lay health educator, etc. – but their primary purpose is to provide education and emotional support in ways that are not always possible in the clinical setting. Health workers have traditionally been used in underserved communities, however all diabetes patients could benefit from the services they provide.

- *Clinic-community partnerships can improve access to resources.* Since most diabetes management takes place in daily life, not in the clinic, partnerships between community organizations, clinics, and other groups and associations can facilitate greater access to tools and resources for diabetes patients.

Section IV: Additional Resources

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