Setting Goals for Setting Goals: Implementing Self-Management Support in Primary Care

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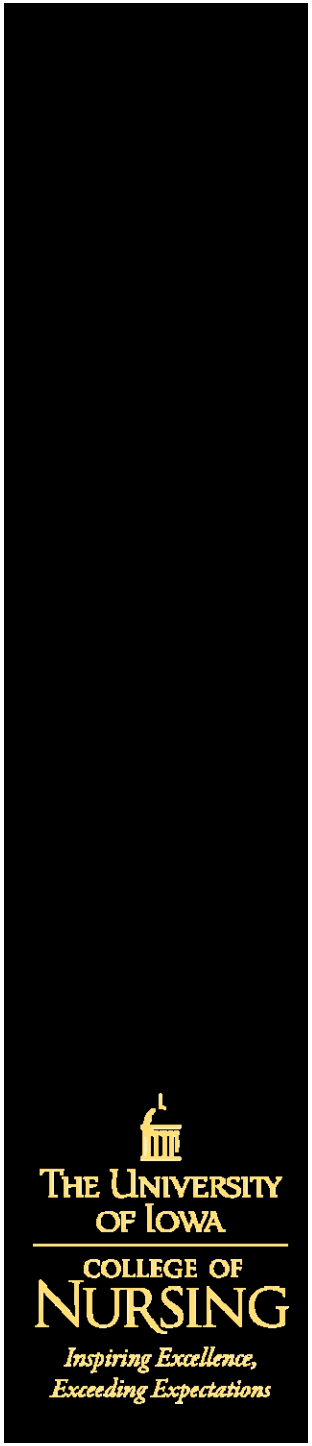


Today

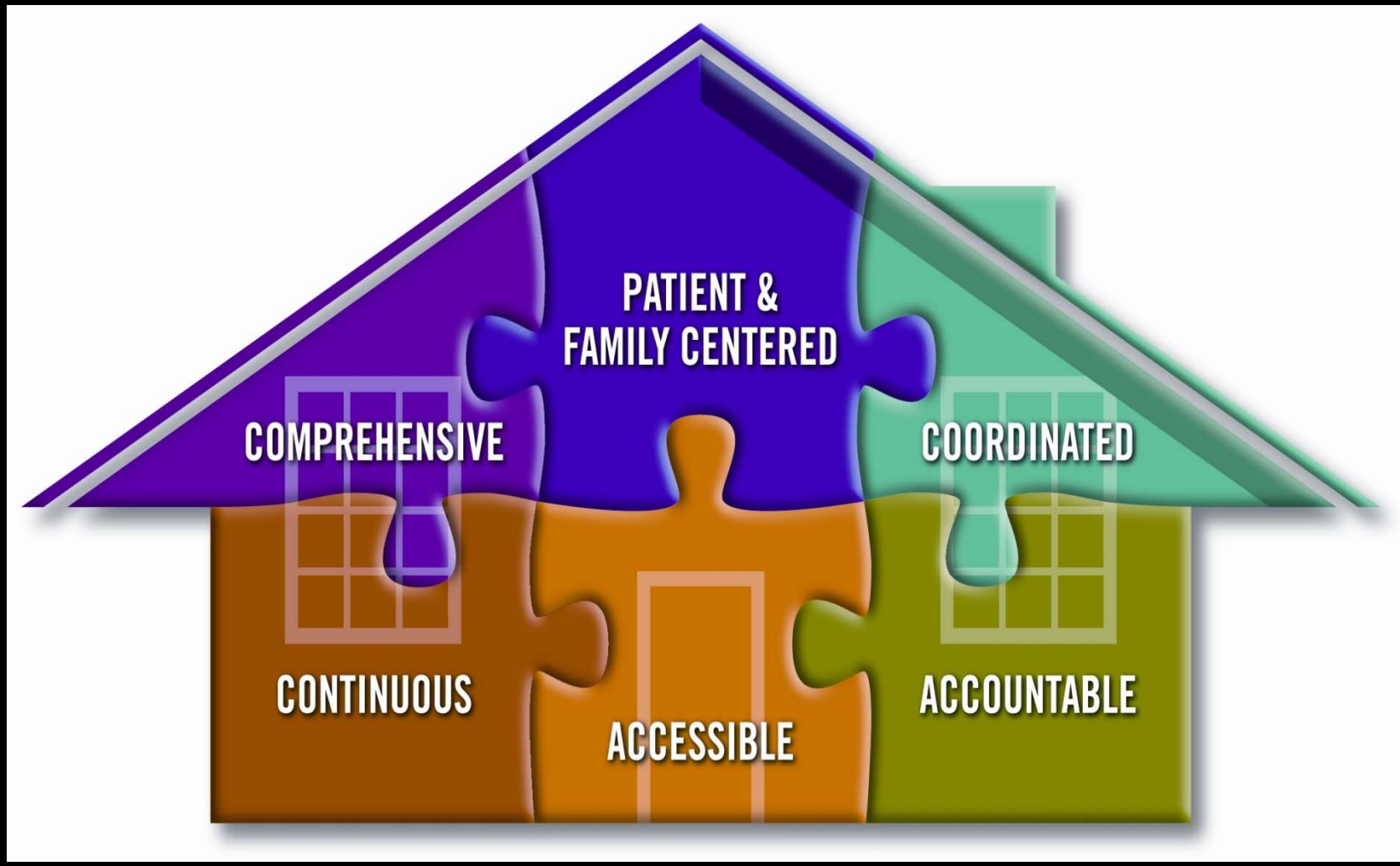
- The Landscape of Diabetes Self-Management
- The *Living with Diabetes* Intervention for Collaborative Goal Setting
- Lessons learned from Implementing the *Living with Diabetes* Intervention
- First Steps to Using the *Living with Diabetes* Intervention in Your Practice

The Landscape of Diabetes Self-Management

Gains from improved medical management for diabetes aren't benefitting all patients

Depending to the study and measures used, 30-60% of Americans with diabetes have suboptimal glycemic control, blood pressure, lipids, and renal function

On the Road to Improvement through Practice Redesign?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CONTINUOUS
ACCESSIBLE
ACCOUNTABLE

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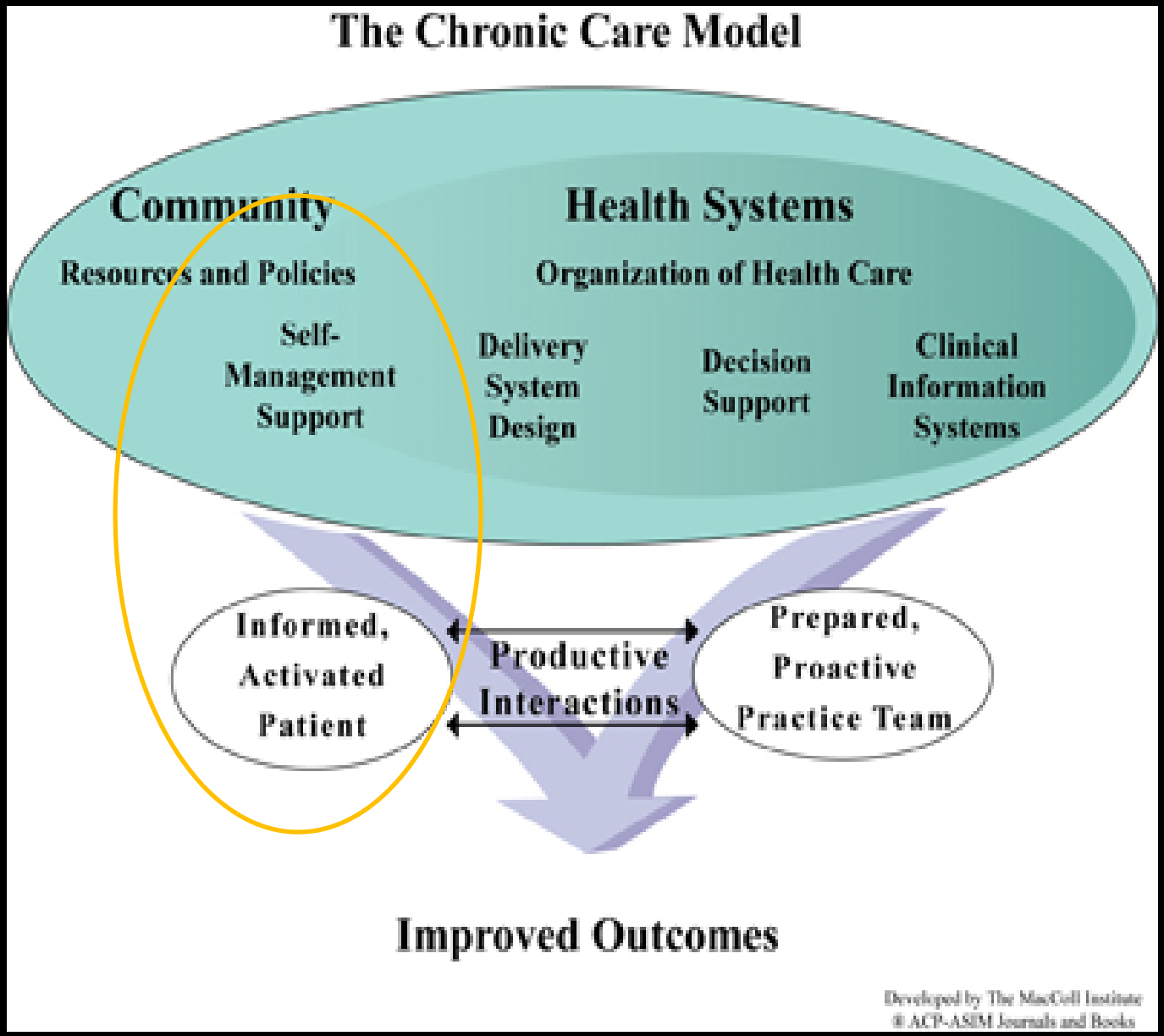
The Chronic Care Model
Community
Resources and Policies
Health Systems
Organization of Health Care
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Improved Outcomes
Developed by The MacColl Institute
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Why Self-Management?

- Chronic illnesses require patients to engage in many self-care activities, or “self-manage” their disease
  - Multiple provider visits
  - Medication regimens
  - Exercise
  - Diet

Self-Management: The Good News

- Self-management improves outcomes
- Self-management for one condition positively affects other comorbid conditions
- Self-management education improves disease-specific outcomes
- Interventions facilitating diabetes self-management improve patient outcomes

Self-Management: The Bad News

- Most patients with diabetes do not access formal self-management education
- Most diabetes care happens in primary care, where the quality and amount of self-management education is low or absent
- Behavioral counseling, goal setting and follow-up – all seen as key to self-management – are seldom reported

But Supporting Diabetes Self-Management In Primary Care Is Not Easy

The Reality of Diabetes Self-Management for Patients

- Outcomes are not improved through the simple transfer of knowledge, but by actually *engaging* in appropriate self-care
- This process requires
  - Practical application in the context of daily life
  - Ongoing problem-solving
  - (Often significant) lifestyle changes

The Reality of Diabetes Self-Management
Diabetes Self-Management
Support for Practices

- Patient characteristics impact self-management
  - Literacy is a powerful barrier to self-management and a primary determinant of how patients rate their support
  - Even in Chronic Care Model systems, goal setting and follow-up are least commonly reported
- Providers feel they lack preventive/behavioral counseling skills

Rothman (2004) JAMA; Sarkar (2006) Diabetes Care;
Sussman (2006, 2008) Annals of Fam Med; Wallace (2010) Nursing Research

So how should we support patient self-management in (overwhelmed) primary care settings?

The *Living with Diabetes* Intervention

Materials Needed to Aid With Diabetes Self-Management Education in Primary Care

- IN 2006, The American College of Physicians Foundation (ACPF) commissioned the development of low-literacy materials to assist patients with self-management
- A multi-site (UNC-CH, UCSF, LSU) interdisciplinary team (RN/PhD, MD/MPH, PharmD, Health Psychologists, Health Educators) was assembled

Seligman, Wallace & DeWalt (2007) American Journal of Health Behavior

Diabetes Resources for Primary Care

Existing

- Focused on the negative
- Disease-focused
- High literacy level
- Lacked visual appeal

Need

- ?

Development process involved 30+ focus groups with patients and providers, cognitive interviewing, and *seemingly endless* revisions

Key Aspects

- Careful text development
- Professional photographs
- Parallel development in Spanish
- Limited Content
- Patient-Centered
- Active Tone

Pictures Help Tell the Story

- Patients looked at pictures first
- Particularly liked pictures of food comparisons

Too Much

Right Size

Key realization . . .

Black beans are

NOT

photogenic

But Materials Alone Won't Work

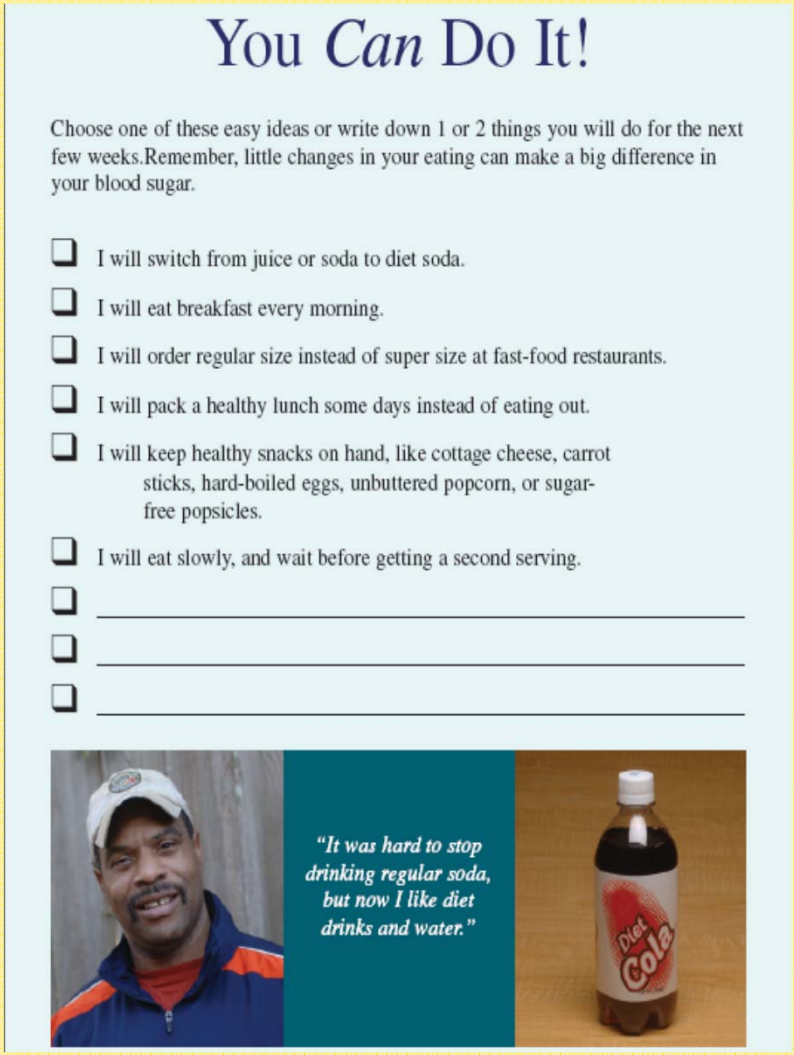
- Patients often know what to do, but they need assistance with making behavior changes – lectures don't work!

BUT

- Primary care providers feel ineffective – even fatalistic – about behavioral counseling

Behavior-Change Counseling in Primary Care

- Materials coupled with a simple strategy for behavior change counseling
- Counseling relies on "Action Plans"
- Action Planning chosen because of its demonstrated feasibility in primary care
- Action planning is reinforced in patient materials



You *Can* Do It!

Choose one of these easy ideas or write down 1 or 2 things you will do for the next few weeks.Remember, little changes in your eating can make a big difference in your blood sugar.

- ❑ I will switch from juice or soda to diet soda.
- ❑ I will eat breakfast every morning.
- ❑ I will order regular size instead of super size at fast-food restaurants.
- ❑ I will pack a healthy lunch some days instead of eating out.
- ❑ I will keep healthy snacks on hand, like cottage cheese, carrot sticks, hard-boiled eggs, unbuttered popcorn, or sugar-free popsicles.
- ❑ I will eat slowly, and wait before getting a second serving.
- ❑ _____
- ❑ _____
- ❑ _____

Lorig (2006) Medical Care;
Bodenheimer (2009) Patient Education and Counseling

Feasibility Study: It worked!

- Multi-site trial
- 240 Patients with Type 2 Diabetes
- Materials and action planning introduced during routine diabetes appointment
- Follow-up by phone at 2, 4 and 12 weeks
- Medium effect sizes for all of our intermediate outcomes
- Positive results for behavior goal recall, self-reported achievement of behavior goal, and satisfaction

Wallace, DeWalt, Seligman et al. (2009) Patient Education and Counseling; DeWalt, Davis, Wallace et al. (2009) Patient Education and Counseling

Implications for Implementation

- Non-Clinicians conducted the intervention
- Took only 10-12 minutes per encounter
- Outcomes comparable to interventions incorporating 12-15 hours of in-person patient contact

Wallace, DeWalt, Seligman et al. (2009) Patient Education and Counseling; DeWalt, Davis, Wallace (2009) Patient Education and Counseling

Let's Talk Action Planning

What is an Action Plan?

A goal that is:

1. Simple
2. Specific
3. Time-limited
4. Achievable

Key Components of Action Plans

1. What will you do?
2. When will you do it?
3. For how long, or how much?
4. How often?
5. How confident are you on a scale from 0-10 that you can do this action plan? Adjust plan until a rating of 7 or higher can be stated.

Practice

So where do we go from here?

Dissemination

- Patient materials and a very short, one page primer on action planning have been widely distributed by the ACPF

- Universally positive feedback about the patient materials

Little Implementation in Real Life

Resources to Support Implementation

- Engaged CHCs to develop a “package” the intervention for use in community settings
- Focus is on ensuring intervention fidelity while allowing for adaptation to the context of clinic settings
- Unique in that it doesn’t expect complex clinical systems to adapt to an intervention, but allows sites to choose how to best implement given their resources and existing structure

Kilbourne et al (2007) Implementation Science

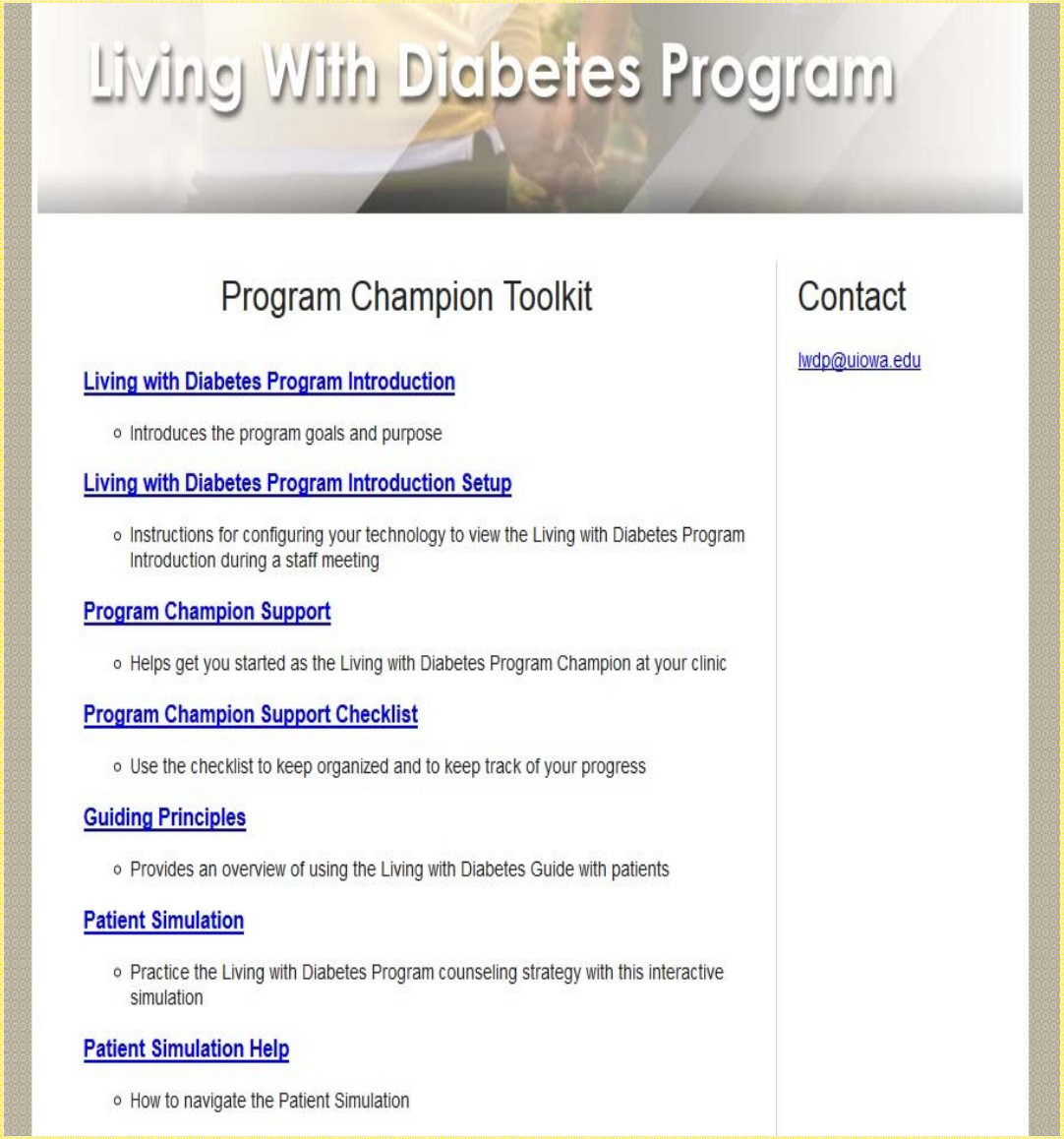
Resulting Resources

Introduction

Support Checklist for Planning

Interactive Simulations

Technology Troubleshooting



Test in Three FQHCs

Two Models for *Doing* the Intervention

Clinic RNs

- Did online training together
- Asked to do the intervention with every patient with diabetes
- Initial in-person session and one or two follow-up calls

Care Managers/Health Educators

- Introduced during a provider meeting and went through tutorial on their own
- Initial in-person session and ongoing sessions thereafter

Experiences Specific to Model

Clinic RNs

- Reached 29% of targeted patients
- Remained task-oriented and uncertain of effect

Care Managers/Health Educators

- Only reached “high risk” patients (10-20%)
- A greater sense of responsibility for “their” patients

Universal Challenges

- Communication, particularly between providers and staff setting goals
- Getting “on message” with patients

The EHR does not fix all

Ongoing Questions

- Who needs to conduct goal setting? Does this have to be used with those with a clinical background?
- Is collaborative goal setting is best done with outside resources?
  - An outside call center in another study seemed to be an option that was more reliable
- Can the intervention be effective using existing structures and resources?

Wolf (2013) JGIM

Some Promising Results

Use of Intervention	Average Change in A1C for Patients Goal Setting	Average Change in A1C for Patients NOT Goal Setting
All Sites	-1.1%	-0.4%
Clinic RNs	-0.8%	-0.1%
RN Care Managers	-0.9%	-0.5%
PharmD-Run Health Educator Service	-1.5%	-1.0%
No Intervention		+1.1%

Greater Improvement in Self-Care for Those Doing Goal Setting

Moving Forward for Those Interested in Using the Intervention

1. Plan for Change

Complete	Action
	Map current information, processes, and available resources for diabetes self-management support in your clinic
	Identify methods of tracking patient goals in your clinic • In an EMR, other tracking systems and/or • Designating one person to follow-up on patient goals
	Identify teamwork deficiencies around diabetes self-management support • Are there additional support needs related to functioning as a team? • Are there areas where *communication* between team members needs to improve before patients' behavioral goals can be tracked?
	Define the goal of your intervention as Program Champion • State in one sentence what will be achieved, who will be involved (whose behavior will change), and when and where the change will occur. For example, "All primary care clinicians will begin using the Living with Diabetes counseling strategy and materials with diabetes patients, and tracking behavioral goals in a new EMR field, beginning on February 1st.
	Identify a team goal related to the using the Living with Diabetes Program • Some examples of process goals: o 80% of patients with diabetes have a behavioral goal o Of patients who have received the materials, 75% have received a phone call within 1 month about the goal o 90% of patients with diabetes given the materials o Action plans/goals set and/or progress recorded for 75% of diabetes patients seen during March • Some examples of clinical outcome goals: o Reduction in A1Cs o Improvements in patient satisfaction
	Develop an implementation plan

Steps

- Look Over the Hardcopy Program Champion Checklist
- Email Me (andrea-wallace@uiowa.edu) to Gain Access to Online Training Resources
- Start on an Implementation Plan
- Attend the June Webinar to Discuss Plans and Troubleshoot Together

Barriers to Ponder

- Clarity of Commitment: Goals for Setting Goals
- Ownership of patients' health by those doing the counseling
- Valuing the person doing the counseling as integral to the team
- Communication, Communication, Communication

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