

*Improving Outcomes
through Diabetes Self-
Management Support:
Personal Action toward Health (PATH)*

Presented by

Paula Ackerman, MS, RD, CDE
yooperfive@hotmail.com
Handouts available at:
www.diabetesinmichigan.org

1

*Diabetes Self-Management
Support (DSMS)*

- Standard 7 of the 2007 National Standards for DSME
 - *A personalized follow-up plan for on-going self-management support will be developed collaboratively by the participant and the instructor(s). The patient's outcomes and goals and the plan for on-going self-management support will be communicated to the referring provider.*

2

*Diabetes Self-Management
Support (DSMS)*

- **Definition**
 - *Activities to assist the individual with diabetes to implement and sustain the on-going behaviors needed to manage their illness.*
 - *The type of support provided can include behavioral, educational, psychosocial or clinical.*

3

*Components of Self-
Management Support (SMS)*

www.newhealthpartnerships.org

- **Emphasize client role**
 - Set expectations
- **Include family**
 - Positive support = positive outcomes
 - Negative support = negative outcomes
- **Share info**
 - Feelings, record keeping
 - Ask what they want to learn, how they like to learn

4

*Components of Self-
Management Support (SMS)*

- **Build relationships**
 - Ask open ended questions
 - Reflective listening
 - Express Empathy
 - Affirmations
- **Collaborate on goals and action plans**
 - Problem solving
 - Follow up on progress

5

Behavior Change

- **Success dependent on:**
 - **Positive expectation or hope**
(the belief that change will do some good)
 - **Confidence or self efficacy**
(the belief that they can make the change, even with some slip ups)

6

5 Step Behavioral Change Protocol

1. Explore the Problems or Issue (Past)
2. Clarify Feeling and Meaning (Present)
3. Develop a Plan (Future)
4. Commit to Action (Future)
5. Experience and Evaluate the Plan (Future)

Funnell MM, Tang TS, Anderson RM (2007). From DSME to DSMS: Developing Empowerment-Based Diabetes Self-Management Support. Diabetes Spectrum Vol 20, No 4, pp 221-226.

7

5 Step Behavioral Change Protocol

1. What's the Problem/Issue

- Elicit change talk: "What is the hardest part of caring for your DM?"
- Ask for specific examples

2. Clarify Feelings/Meaning

- What are your thoughts on that problem/feeling
- "How do you *feel* when your BG runs high?"

8

5 Step Behavioral Change Protocol

3. Develop a Plan

- What does CLIENT **WANT** to change and reasonably **CAN** do?
- Ask: "Where would you like to be re: this change in 1 month, 3 months, 1 year?"
- Discuss barriers? Support systems
- What are the costs/benefits? (Decisional balance)
- Assess importance: "How important is it (scale of 1-10) for you to do something about this?"

9

Decisional Balance (Tool for exploring ambivalence)

	CONCERNS	BENEFITS
Quitting smoking	Negatives of smoking Mother died of cancer Father died of emphysema Personal illness My children will smoke Cost Smell Cough	Positives of quitting Breathe and feel better Please my family Have more money Not embarrassed of smell
Still smoking	Negatives of quitting Wt gain Fail at quitting Life not as fun More stressed	Positives of Smoking Relaxation Wakes me up I enjoy it Helps me think

10

5 Step Behavioral Change Protocol

4. Commit to Action

- Ask: "Are you willing to do what is needed to solve this problem?"
- What...where...when...how are you going to do it?
 - SMART Goals
- Assess confidence: "How confident are you that you can accomplish this goal (scale of 1-10)"
- How will you know if you have succeeded?
- Ask: "What is one thing you will do when you leave here today?"

11

Assess Readiness to Change

Readiness = importance X confidence

- How important is it to the client to change.
- How confident is the client about making the change.

12

Follow-Up Questions

- **How many of you track outcome data 3-6 mo post program completion?**
 - Do you see improvements in most clients?
- **How many of you track data beyond that first follow-up contact (1 yr, 2 yr, etc)?**
 - Are they still meeting their behavior change goals?
- **How many of you run a diabetes support gp?**
- **How many of you use the 2 hours DSMT follow-up yearly? Or MNT hours?**

19

Diabetes Self-Management Support (DSMS)

- **Why?**
 - Most do well 3-6 months post program, but the **progressive nature of diabetes** and the **lack of symptoms** (of hyperglycemia) often lead to **less careful monitoring** (of BG, food, etc) and ultimately...worsened glycemia as time goes by

20

Stanford's Chronic Disease Self-Management Program

- **What is it?**
 - Program designed to help people with chronic conditions learn to better manage their condition
 - Support people encouraged to attend (helps enhance understanding/importance of self-care)
- **Goal:**
 - Enable participants to build self-confidence to assume a major role in maintaining their health and managing their chronic condition

21

Stanford's Chronic Disease Self-Management Program

- **4 Assumptions**
 - Those with chronic conditions have similar concerns and problems.
 - They must not only deal with their condition, but also the impact on their lives and emotions.
 - When provided training and a detailed manual, lay people with chronic conditions can teach this workshop effectively (if not more effectively than hcp)
 - The way this is taught is as important (if not more) than the subject matter taught.

22

Stanford's Chronic Disease Self-Management Program

- **Meet once a week for 6 weeks**
 - 2 ½ hour sessions (with 20 minute break)
 - Not diabetes specific
 - Meet in groups of 10-16 people (similar to a support group)
- **Led by 2 trained leaders:**
 - At least one leader is living with a chronic condition or is a caregiver of a person with a chronic condition
 - Can pair a hcp with a lay leader or have 2 lay leaders with chronic conditions

23

Stanford's Chronic Disease Self-Management Program

- **How to become a leader?**
 - Must attend 4 day training
 - Provided a detailed, scripted leaders manual (must follow)
- **To offer classes, you have to operate under a licensed organization**
 - Cost dependent on # classes taught
 - ~\$500 for 3 years

24

Stanford's Chronic Disease Self-Management Program

- Positive Health Outcomes: when compared to 6 mo prior to program, participants
 - Exercised more
 - Display better coping strategies and symptom mgt
 - Have better communication with their MD
 - Show improvement in self-reported health, disability, social activities and health distress**
 - Have more energy and less fatigue** ** Seen 2 yrs post program
 - Have less MD and hospital visits**

25



PATH (Personal Action Toward Health)

Michigan's Chronic Disease
Self-Management Program

www.mipath.org

26

PATH

- **DOES NOT** replace traditional education with a doctor or hcp, nor diabetes education or MNT. It complements and reinforces it.
- Sessions are highly interactive with emphasis on strategies to help people manage and cope with their chronic condition more effectively.
 - Weekly goal setting for behavior change
 - Problem solving
 - Brainstorming activities
 - Leaders participate/model

27

Class 1

- **Workshop Overview/Expectations**
 - Come to all sessions/be on time
 - Be respectful to others/their ideas
 - Maintain confidentiality
 - Give new ideas a 2 week trial
 - Set weekly action plans
 - Contact buddy weekly
 - Turn off phones

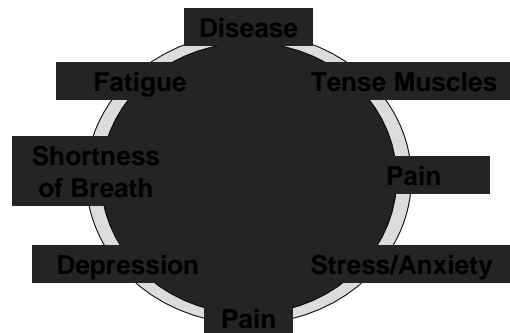
28

Class 1

- **Intro**
 - Leader introduces self and any chronic condition they or someone close to them has
 - Name 2-3 problems due to that condition
- **Acute versus chronic conditions**
- **Using your mind to manage symptoms**
 - Connection of mind and body
 - Symptom management (see symptom cycle)
 - Self-management tool box
 - Distraction techniques

29

Symptom Cycle



30

Class 1

■ Action Plans

- Answer: what, how much, when, how often
- Confidence level of 7 or more

■ Closing

- Discuss topics to be covered next week
- Ask permission to contact participants during the week to support them in their action plan
 - Leaders will contact all participants in week 1, then participants will buddy up for contact in future weeks

31

Class 2

■ Feedback/Problem solving

- Leader begins to share action plan progress
- Each participant shares how they did (2-3 min)
- If not successful, discuss problems/barriers and brainstorm solutions (if they desire)
 - List ideas to solve problem
 - Select one method to try
 - Assess results
 - If doesn't work, try another idea
 - *Accept that problem may not be solvable now*

32

Class 2

■ Dealing with Difficult Emotions

- Break into pairs (*not someone you came with*)
- Discuss "What about your condition makes you feel difficult emotions? What causes them?"
- Brainstorm ideas to deal with difficult emotions

■ Intro to Physical Activity

- Benefits of activity
- **Goals:** 20-30 min mod activity 3-5 days/wk and 8-10 strengthening exercises 2-3 days/wk
- Have 2-3 share their goal and what problems they may face...brainstorm solutions

33

Class 2

■ Setting Action Plans

■ Closing

- Participants choose a buddy (not someone they came with)
- Participants will call their buddy during the week to check on status of goal and to provide support.
- Review topics to be covered next week

34

Class 3

■ Feedback/Problem Solving

■ Better Breathing

- Causes of and managing shortness of breath
- Diaphragmatic "belly" breathing

■ Muscle Relaxation

- Jacobson Progressive Muscle Relaxation
- CD/audio tapes

35

Class 3

■ Managing Pain and Fatigue

- Brainstorm causes and management techniques for pain and fatigue

■ Endurance Activities

- FIT: Frequency, Intensity, Time

■ Action Plan and Closing

- Track physical activity + eating for 2 days
- The rest is the same as class 2

36

Class 4

- **Feedback/Problem Solving**
 - Share 1-2 thing you learned from keeping food and activity records
- **Future Plans for Health Care**
 - Advanced directives
- **Healthy Eating**
 - General guidelines
 - Discuss barriers to healthy eating and brainstorm solutions

37

Class 4

- **Communication Skills**
 - “I” versus “you” messages
- **Problem Solving**
 - Break up into pairs and practice problem solving
 - Reconvene and report on their problems and solutions you came up with
- **Action Plan and Closing**

38

Class 5

- **Feedback/Problem Solving**
- **Medication Usage**
 - Purpose and effects of meds
 - Med responsibilities
 - Remembering to take meds
- **Making Informed Treatment Decisions**
 - Evaluating treatments

39

Class 5

- **Managing Depression**
 - Symptoms and management
- **Positive Thinking**
 - Positive versus negative thoughts/messages
- **Guided Imagery**
 - “A Walk in the Country”
 - CD/audio tape
- **Action Plan and Closing**

40

Class 6

- **Feedback/Problem Solving**
- **Working with your health care provider (hcp) and health care system (hcs)**
 - Discuss problems with hcp and hcs
 - Brainstorm solutions
- **Planning for the Future**
 - Review of self-management tools
 - Goal setting for the next 3-6 months.

41

Class 6

- **Looking Back**
 - Problems caused by condition (compare to list done the first session)
 - Go around the room to share what we have accomplished
 - Begin with leader, then ask for volunteer
 - Visualization exercise
- **Closing**
 - Encourage participants to continue to contact each other for support

42

Concerns

- **Dealing with different personalities**
 - Talks too much
 - Doesn't speak up
 - Yes, but
 - Non-participant
 - Constantly negative
 - Cries often
 - Person in crisis
- **Promoting program, filling up a class**

43

Promoting PATH

- **Physicians**
 - 18 X more likely to attend if MD recommends
- **Local Diabetes Educator/CDE**
- **Brochures and flyers**
 - Diabetes Support Group/DSMT mailing list
 - Pharmacies
 - Anywhere you go
- **Press release to media (print, TV, radio)**
 - Local monthly and quarterly newsletters

44

Promoting PATH

- **When and where offered:**
 - For us (rural): spring and fall best; avoid winter
 - Take to groups that already meet/worksites (lunch hr)
 - Word of mouth from past attendees
 - Promote where ever you go.
 - Keep a database of interested people
 - Call them when new classes offered
 - Native American gp does ongoing classes every 6 wks
 - Have them fill out a contract stating they will attend classes
 - Call prior to first class or all classes

45

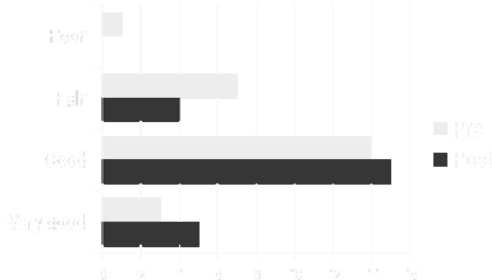
Cost of PATH

- **Michigan's program is low or no cost (grant funded or used as community benefit)**
 - Ours: \$10 for whole program
 - Used to help offset travel costs of peer leaders
- **Linked with some insurance plans in parts of US**
- **Part of National Health Care in England and Australia**

46

My PATH results (Health)

"In general, would you say your health is..."



47

My PATH results (Coping)

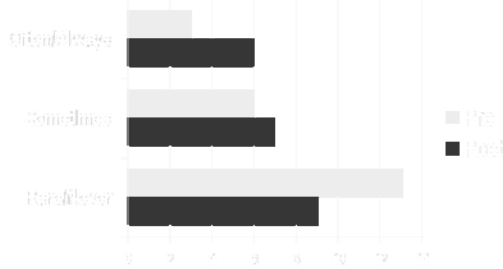
"When feeling down, pain or unpleasant symptoms, how often do you use positive self-talk?"



48

My PATH results (Coping)

“When feeling down, pain or unpleasant symptoms, how often do you practice visualization or guided imagery?”



49

My PATH results (Coping)

“When feeling down, pain or unpleasant symptoms, how often do you play mental games or sing songs to keep your mind off the discomfort?”



50

My PATH results (Symptoms)

“How much time in the past month were you discouraged by your health problems?”



51

My PATH results (A1C)

	Client	Pre prog	3-6 mo post	2009
■ Munising, MI	KB*	6.9%	5.9%	5.7%
	LB*	6.1%		
■ Apr/May '08	SB*	7.2%	6.8%	7.0%
	JD*	8.8%	7.5%	
■ 10 with DM	LD*	6.9%	6.4%	6.5%
	SG*	8.0%	8.1%	7.8%, 6.8%
■ * Attended DSMT before PATH	NH*	6.9%	6.1%	6.5%
	JN*	5.9%	5.5%	5.2%
	VS*	5.7%	5.9%	5.7%
■ ** Attended DSMT after PATH	JT**	6.5%	5.9%	
	GS*	6.0%	5.7%	

My PATH results (A1C)

	Client	Pre prog	3-6 mo post	2009
■ Munising, MI	LB*	5.6%	5.7%	5.3%
	ME*	6.5%	6.3%	5.8%
■ Sept/Oct '08	GG*	6.9%	6.2%	
	MH*	5.7%	5.7%	
■ 10 with DM	EH*	7.6%		7.7%
	DO*	8.1%	7.4%	6.7%
■ * Attended DSMT before PATH	MC**	11.6%	9.8%	12.6%, 13%
	ED**	6.5%	6.6%	
■ ** Attended DSMT after PATH	MH**	7.5%	8.3%	6.3%
	NC**	6.1%		5.6%

53

PATH Participants



54

PATH Participants



55

Stanford's Diabetes Self-Management Program

- Specific to persons with type 2 diabetes
 - At least 1 peer leader with diabetes
 - Attend 4½ day training (1 day crossover training if already a chronic disease self-management program)
- Originally developed in Spanish
 - Improved health status, behavior and self-efficacy and fewer ER visits seen at 4 mo & 1 yr post program
 - Piloted among English speaking clients (2008)
 - Potential competition with DSMT

56

Stanford's Diabetes Self-Management Program

- Topics covered:
 - Dealing with symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress and emotional issues of diabetes
 - Appropriate exercise
 - Healthy eating
 - Appropriate use of meds
 - Working with hcp

57

For more Info....

- **Stanford self-management program**
 - www.patienteducation.stanford.edu/programs/cdsmp.html
 - (650) 723-7935
 - Self-management@stanford.edu
- **Stanford Program in Michigan (PATH):**
 - www.mipath.org
 - UPDON: (906) 228-9203 or yooperfive@hotmail.com

58



QUESTIONS

Copies of today's slides
available at:

www.diabetesinmichigan.org

59