Patient Centered Approaches: Collaborative Goal Setting and Problem Solving

Joan K. Bardsley RN CDE MBA

Medstar Research Institute, Hyattsville MD
Ms. S

- Type 2 diabetes
- A1C: 9.4%
- BMI: 32
- Smokes 1 ppd
- Maximum dose metformin and glyburide
- Rarely monitors glucose levels
- Frequently does not keep appointments
- Always promises to do better
The Textbook Plan for Ms. S

• “Non Compliant”
• Stop smoking
• Follow your diet
• Exercise every day
• Check your blood sugar at least twice a day
• If you don’t lose weight: the “NEEDLE”
Messages to Ms. S

• You need to do what I tell you
• You are a bad patient
• You are a failure
• You are a “diabetic”, not a person
The Real Ms. S

- Works at a convenience store at varying times of the day
- Recently separated from husband
- Son has severe asthma
- Handles stress by smoking and eating chocolate
- Insurance does not cover diabetes supplies or medications
The Cornerstone Of Patient Centered Care

- **Given:** Best clinical advice, treatment and diabetes education

- **How to differentiate “great” from “just plain good”:**
  
  **RESPECT**

  1. Respect for the role of the person with diabetes
  2. Respect for the persons need to know
  3. Respect for feelings

Respect For The Role Of Person With Diabetes: The Role of the Health Care Provider

1. Hundreds of small and large decisions

2. Utilize A1C as a tool for making changes

3. The “self” in self-management is the person with diabetes

1. Encouragement and support are essential

2. Teach how to use data, not as a report card or measurement of someone self-management efforts

3. Self-care is enhanced when the person has played a major role in its creation, based on individual priorities, values and culture and lifestyle
Respect For:

• The Need to Know
  ▪ Pathology and practical aspects of living with diabetes
  ▪ Not just mechanics: how they affect the person
  ▪ Health care providers can’t heal: only help to guide

• Feelings
  ▪ Often patient uncomfortable raising with provider
  ▪ Often providers never ask
  ▪ Anger, fear, frustration, and most especially guilt, particularly in type 2 over having developed the disease and genetically passing on to children

Weiss reference
• DAWN is the largest global psychosocial diabetes study ever undertaken

• Objective: to assess perceptions and attitudes regarding diabetes care among people with diabetes and health care professionals (HCP)

• Focus: psychological health. Studies have shown that psychological health is associated with better diabetes outcomes
Methodology

- Telephone or face-to-face interviews with total of:
  - 5,109 patients (500/country)
  - 2,705 MD (200/country; 23% specialist)
  - 1,122 nurses (100/country; 53% specialist)

- Interviews carried out between May-August 2001

*Scandinavia: Sweden, Denmark, Norway.
Key findings

1. Diabetes self management is less than optimal
Patients do not follow treatment recommendations

Patient report

Type 1

Type 2

Overall

USA

% patients completely following most recommendations
Patients do not feel their diabetes is under control

% patients with ‘great extent’ of control

Base: all respondents
Opportunities To Promote More Effective Self-Management

• Create self-management plans collaboratively, respecting the patient’s individual strengths, needs and concerns

• Help patients identify their personal sources of motivation; motivation is the key to effective self-management

• Address patients’ emotional needs; psychological health and effective self-management often go hand-in-hand

• Provide education and psychosocial support at diagnosis since this is a critical time and on an ongoing basis

Key findings

1. **Diabetes self management is less than optimal**
2. **Self-management problems are due in large part to psychological problems. Psychological problems are common but rarely treated**
Psychological problems: common, rarely treated (US)

- ~80% of HCPs recognize psychological problems as important reasons for self-management problems, yet:
  - <65% of HCPs feel able to identify and evaluate psychological problems
  - <33% of HCPs feel able to provide necessary psychological support
  - ~10% of patients report psychological treatment

Base: all respondents.
Psychological Distress is Common

• 85.2% reported a high level of distress at the time of diagnosis, including feelings of shock, guilt, anger, anxiety, depression and helplessness.

• Many years after diagnosis (mean duration = 15 years), problems of living with diabetes remained common, including fear of complications and immediate social and psychological burdens of caring for diabetes.

• 41% percent reported poor well-being, and indicated that they wanted greater acknowledgement and support for their distress.
Psychological problems (US)

‘Psychological problems play only a small part in non-compliance’

Base: all respondents
Key findings

1. Diabetes self management is less than optimal
2. Self-management problems are due in large part to psychological problems. Psychological problems are common but rarely treated
3. Good communication between patients and health care professionals is associated with better outcomes
Relationship with provider predicts diabetes outcomes (US)

- **Good diabetes control**: 37% for poor relationship, 25% for good relationship.
- **Good adherence**: 38% for poor relationship, 22% for good relationship.
- **High diabetes distress**: 49% for poor relationship, 26% for good relationship.

% patients
1. Diabetes self management is less than optimal
2. Self-management problems are due in large part to psychological problems. Psychological problems are common but rarely treated
3. Good communication between patients and health care professionals is associated with better outcomes
4. Access to team diabetes care is also associated with better outcomes
SHIELD Study

- Survey of 22,001 individuals with diabetes or at risk (3,367 type 2; 5,419 HR; 5,683 LR)
- Only 22% of type 2’s agreed that type 2 is not as serious as type 1
- In each group, 85% agreed obesity can aggravate/contribute to the onset of chronic disease
- Only 17% would rather take medications than change lifestyle
SHIELD Study: Exercise

- 63% were advised to get more exercise
- 26% exercised regularly
- 21% exercised in the previous week
SHIELD Study: Diet

• >50% told to change their diet
• 70% “tried to lose weight”
• 34% maintained desired weight
What is wrong with this picture?

• In spite of all that we know and can do, the personal and health care burden of diabetes continues to rise
• Frustrated/dissatisfied health professionals
• Frustrated/dissatisfied patients
• Person with diabetes has gotten “lost”
• Promise of diabetes care has not been realized
What can we do?

Better understand patient and provider points of view

Teach effective strategies to better support our patients
The Good Old Days
Empowerment fundamentals

- Persons with diabetes provide 99% of their own care
- Each is responsible
- Therefore each person is the final decision-maker
Textbook Definition of Empowerment

Helping people discover and use their own innate ability to gain mastery over their diabetes.
Real Definitions of Empowerment

“You can teach me but you can’t make me.”

Diabetes is self-managed and I am the “self.”
Strategies to support patients

- Address patient concerns
- Problem-solving
- Self-directed goal setting
Opportunities To Enhance Patient-Provider Communication

- Ask patients at each visit
  - What concerns you most about your diabetes?
  - What is the hardest thing for you right now about living with diabetes?
- Ask patients to identify diabetes-related successes as well as challenges
- Offer support and encouragement
- Provide diabetes education; educated patients communicate more effectively

Skovlund SE, Peyrot M. *Diabetes Spectrum* 2005;18:136
• It’s all one thing
• Communicate
• Listen
Concerns Assessment Form

1. What is hardest or causing you the most concern about caring for your diabetes at this time?

2. Please write down a few words about what you find difficult or frustrating about the concern you mentioned above.

3. How would you describe your thoughts or feelings about this issue? (e.g. confused, angry, curious, worried, frustrated, depressed, hopeful)
4. What would you like us to do during your visit to help address your concern? (Please circle the letters in front of all that apply)

A. Work with me to come up with a plan to address this issue.
B. I don’t expect a solution. I just want you to understand what it is like for me.
C. Refer me to another health professional or other community services

http://www.med.umich.edu/mdrct/education/documents/emh/ConcernsAssessment.pdf
ALE

• A(sk): what is the hardest thing for you about living with/caring for people with diabetes?

• L(isen): Actively

• E(mpathize): Ask questions Reflect
Motivational Interviewing

- Directive counseling style for helping patients explore and resolve ambivalence

- May be particularly relevant for patients who demonstrate a low readiness to change (importance x confidence=readiness)

- Tone is nonjudgmental, empathetic, encouraging

- No attempt to convince, persuade or advise

- Reflective listening are used to help patients identify their own health goals and discrepancies in their behavior that influence achieving these goals
Self-directed behavioral goal-setting

- Explore the problem
- Clarify feelings
- Develop a plan
- Commit to action
  - How important is this to you?
  - How confident do you feel
- Experience and evaluate learning
LIFE plan for diabetes

- Learn
- Identify
- Formulate
- Experiment and Evaluate
Ms. S’s plan

• Take care of son’s needs first
• Handle the increased stress from recent separation and financial pressures
• Live a long and healthy life
Our collaborative plan

• Address Ms. S’s stress and financial concerns
• Refer for social work support
• Refer for medication and other financial support
• Identify one thing she will do for herself and her diabetes
Empower our patients

Empowerment is helping people discover and use their own innate ability to gain mastery over their diabetes.