Health Coaching for Self-Management

Supporting Change with Diabetes Patients

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LEARNING OBJECTIVES:

- At the end of this presentation, participants will:
- Know knowledge and skills patients learn as self-managers
- Know principles underlying self-management programs and why self-management works
- Know best practices for integrating self-management into healthcare programs
- Understand how patient self-management differs from, but complements, traditional patient education and support
- Know skills and strategies for supporting patients to "do" self-management

WHAT DOES SELF-MANAGING PATIENT LOOK LIKE?

- Think of patient with diabetes who you feel is "self-managing" very well. Describe this patient. What does the patient do, know, or feel that makes him//her an ideal self-manager?
- Think of patient with diabetes who you feel is not self managing at all. Describe the patient. What does the patient do, know, or feel that makes him//her a poor self-manager?
- What are the key differences? Identify the "common characteristics" that differentiate the **effective** self-managing patient and the **ineffective** self-manager.

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PROFESSIONAL VS. SELF-MANAGING TIME

Disease Management Time over 1 year

- **GP visits per annum = 1 hour**
- **Visits to specialists = 1 hour**
- **PT, OT, Dietician = 10 hours**
- **Total = 12 hours**
- **364.5 days managing on own or 8748 hours**

Barlow, J. Interdisciplinary Research Centre in Health, School of Health & Social Sciences, Coventry University, May 2003.

WHY PATIENT SELF-MANAGEMENT?

- Good for Healthcare System
  - Nearly half of all Canadians have Chronic Condition = 16.5 million Canadians
  - As population ages, number of Canadians in need of chronic care will rise
  - Most patients have multiple risk factors and multiple conditions requiring management
  - Shift from acute to chronic disease = shift from provide-based to patient-based care
- Good for Individual
  - Patients feel and do better when they are in control

WHAT IS PATIENT SELF-MANAGEMENT?

- *The tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include having confidence to deal with medical management, role management, and emotional management.*
  - ***Report of a Summit. The 1st Annual Crossing the Quality Chasm Summit.* September 2004**

- *Involves (person with chronic disease) engaging in activities that protect and promote health, monitoring and managing symptoms and signs of illness, managing impact of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimens.*
  - **Center for Advancement of Health, Flinders University**

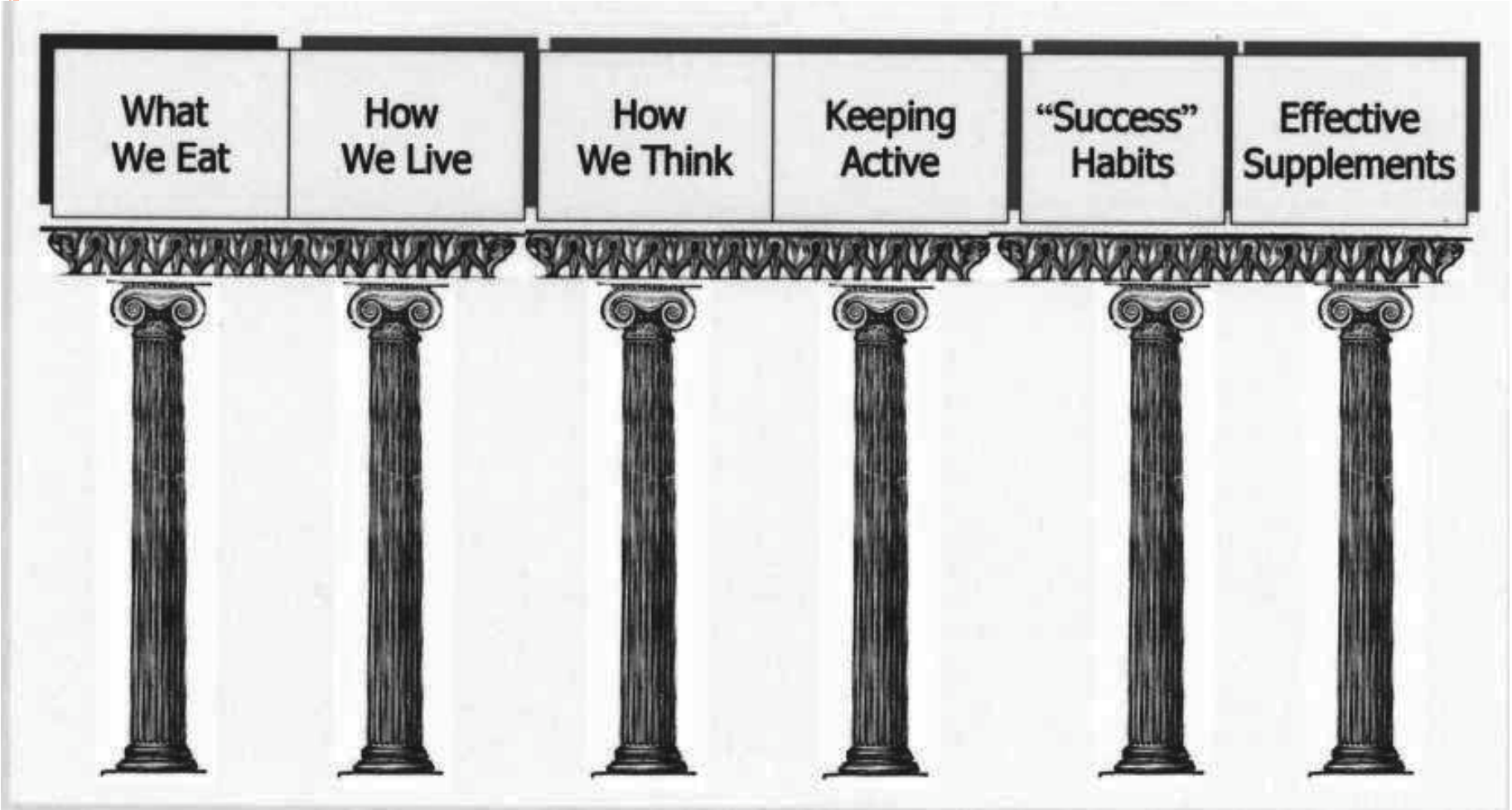
Why Self-Management for Diabetes?

- Diabetes is a life-long chronic condition
- Diagnosis of diabetes may = crisis or opportunity for change
  - Life-long history of "unhealthy behaviours" (insidious, incremental)
  - "Wake-up" call
- Managing diabetes = managing (changing) health (lifestyle) behaviours
  - Behaviours are modifiable
  - Only the individual can effectively modify behaviours
- Self-management = life-long commitment and challenge

WHAT SELF-MANAGING PATIENTS CAN DO?

- Know condition, seriousness, consequences and treatment options
- Negotiate plan of care and monitor the plan
- Engage in activities that protect and promote health
- Monitor and manage symptoms and signs of condition
- Manage impact of condition on physical functioning, emotions interpersonal relations
- Use medications as prescribed; knows, monitors and manages side effects of treatment
- Engage in problems solving and communicates problems and barriers to healthcare professional

DIABETES: 6 PILLARS OF HEALTH



Professional Management or Self-Management Tasks?

Stanford's Peer-based Self-Management

- Stanford University licensed program, extensively researched and evaluated
  - Based on Bandura's Model of Self-Efficacy
  - Principles of Modeling, Goal Setting, Problem Solving
- Designed for all patients with chronic conditions
  - Skills: Goal setting, action planning, problem solving, communications, informed decision making
  - Content: Stress, depression, fatigue, exercise, nutrition, medication management, living will
- Small-groups of 12 – 20 persons
  - 2 1/2 hours per week for 6 weeks
  - Co-led by lay persons with chronic health conditions
  - Leaders are role models: "I am doing it; so can you"
  - Leaders trained, follow script, workbooks

What Do People Learn in Self-Management?

New Knowledge

- From PSM program leaders
- From other participants

Practical Skills

- Getting started skills (e.g., exercise)
- Problem-solving skills
- Communication skills
- Working with health care professionals

Practical Skills (cont'd)

- Dealing with anger/fear/frustration
- Dealing with depression
- Dealing with fatigue
- Dealing with shortness of breath
- Evaluating treatment options

Cognitive Techniques

- Self-talk
- Relaxation techniques

When is Patient Able to Self-Manage?

- **Patient has Knowledge**
  - Has “evidence-based” information and access to reliable resources
  - Able to understand information and how to ask for clarification
  - Able to apply information to own situation
- **Patient has Self-Confidence**
  - Desire to make decision and to change behavior
  - Willingness to accept responsibility for behavior and consequences
  - Capacity to self-manage: know when to act on own, when to seek more information, when to go for help

Role of Health Professionals

- Provide Healthcare (manage disease)
- Educate (about disease and what effects it)
- Support patient self-management
  - Assess current lifestyle and changes needed
  - Explore goals and desire to change
- Coach for lifestyle change
  - Stimulate change
  - Support change
  - Sustain change

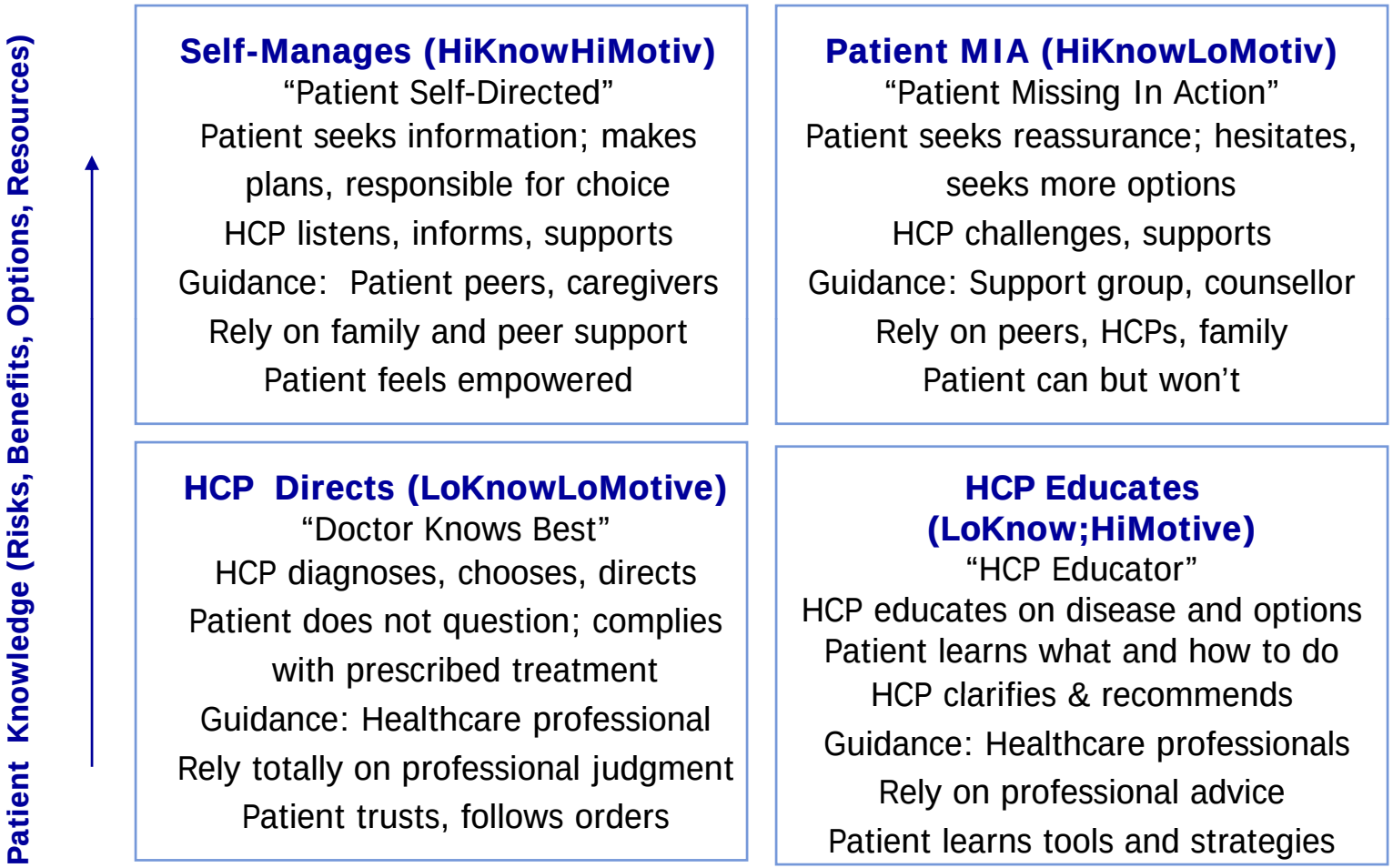
Role of Health Coaching in Diabetes Management

- Diabetes health coaching process is designed to complement and enhance individual's medical support team by providing information, motivation and support throughout lifestyle change program.

- It is not a replacement for medical care and can work in conjunction with other aspects of diabetic care, such as medically supervised dietary counselling or educational programs.

Sanders, J., The Diabetes Coach Approach Workbook

ROLE OF HCP DEPENDS ON PATIENT READINESS



Health Education vs. Health Coaching

	Health Education	Health Coaching
Problems Defined	**Disease-related, by professional**	**Lifestyle-related, patient defined**
What is Taught	**Information about disease, care, treatment**	**Skills for changing lifestyle behaviours**
Assumption about Change	**Knowledge leads to change**	**Motivation and confidence (plus knowledge) needed**
Goal	**Compliance with prescribed therapy**	**Self-efficacy**
Teachers	**Healthcare professionals**	**Peers**, family, professionals

10 Steps to Health Coaching

1. Identify Health Issues & Lifestyle Change Options
2. Set Agenda
3. Explore Motivation (Ask RIC!)
4. Decision Line
5. Generate Specific Goal Options
6. Select and Refine Specific Goal
7. Create Action Plan
8. Identify & Address Barriers
9. Check RIC!
10. Review & Refer

What can you do to be healthier?

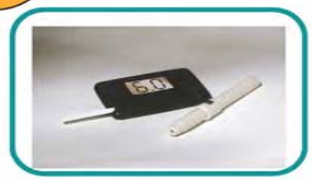
Patient Label Here

PATIENTS and PROVIDERS:
Managing Diabetes Together

Smoking
Quit Date: _____ [ ]

KEEP IT REALISTIC SMALL CHANGES ARE OK!

Food and Diet
Start Date: _____ [ ]



Check My Blood Sugar Regularly
Start Date: _____ [ ]

Medications
Start Date: _____ [ ]

Exercise
Start Date: _____ [ ]

Other Lifestyle Change?
What: _____
Start Date: _____ [ ]

1. What would you like to do to improve your health? (Please choose one of the objects above, checking the box located next to the object.
2. When would you like to begin addressing your personal goal? _____
3. Where / How would you do it? _____
4. How Often Would you do it? _____
5. What would prevent you from changing your lifestyle?_____
   _____
6. How will you go about overcoming those barriers? _____
7. How confident are you that you can accomplish your personal goal? (Rate your confidence level on a scale of 1 to 10 with 10 being completely confident) 1 2 3 4 5 6 7 8 9 10

Is Patient Ready to Change?

Trans Theoretical Model of Change (TTM)

Prochaska and DiClemente, 1986

- Assesses patient readiness
- Circular - "wheel of change" - 6 stages
  - Pre-contemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance
  - Termination/Relapse

PROMPTING CHANGE W/MOTIVATIONAL INTERVIEWING

Develop Discrepancy:

- Used to create dissonance
- Repeat back pros and cons stated by patient
- Ask patient to discuss his/her goals as they relate to treatment
- Creates ambivalence; more likely to change when current behaviour ≠ goals
- Allow patient to come up with answers
- Do not make patient feel threatened or pressured

PROMPTING CHANGE W/MOTIVATIONAL INTERVIEWING

Develop discrepancy

Patient is not taking BP medication as prescribed; history significant for stroke.

"Mr.. J., I noticed that you have skipped doses of your blood pressure medication. What are your thoughts on how this might affect your goal of taking the medication to reduce your risk of stroke?"

Amplify costs of current behavior against goals

"So at the moment there are both problems and from smoking, but what about the future?"

"What do you think is the importance of sticking with your diet versus giving in to your friends' pressures?"

Decisional Balance Prompt Sheet

Health Coaching Australia

The decision that I am considering is whether or not to work on _____ to improve my health.

	Don't Change Anything	Make Some Changes
Good Outcomes	**1. What's working for you now?** • Easier, less effort • Less Stressful • Less time required • Can do what I like • ?	**3. What benefits would you expect from changing things?** • What's in it for me? • What short & long term benefits will I get? • ?
Not so Good Outcomes	**2. What's the downside of what you are doing now?** • Short & long term negative consequences • ?	**4. What's the downside of changing things?** • Harder, more effort • More Stressful • More time required • ?

"Does this help you to make a decision one way or the other?"

From Goals to Action Plans

- *Action Planning*
  - Something you want to do
  - Reasonable (can expect to accomplish this week)
  - Behavior-specific
  - Answer question: What, how much, when, how often
  - Confidence level of 7 or more

Healthy Goals Action Plan

Specific Goal: _____

_____

_____

For the Specific Goal, write in one or two sentences: What are you going to do? How often? When will you start? When will you review your progress? How will you track your progress?

Action Steps: **Tick when achieved**

Write down all the steps that you will need to take in order to achieve your goal.
How will you remember to do these things?
What might get in the way of achieving your goal? What can you do to avoid this?
What can you do to increase your confidence in achieving your goal?
Do you have a backup plan?
How do you need to be thinking to maximise your chances of success?
Who or what can support your efforts?

1. _____ ☐
2. _____ ☐
3. _____ ☐
4. _____ ☐
5. _____ ☐
6. _____ ☐
7. _____ ☐
8. _____ ☐
9. _____ ☐

How much do you want to achieve this goal?
(Not at all) 1 2 3 4 5 6 7 8 9 10 (Very much)

How confident are you that you can achieve this goal?
(Not at all confident) 1 2 3 4 5 6 7 8 9 10 (Very confident)

Summary of Professional Support/Coaching

- **Clinical Information and Management**
  - Education about disease (illness/disorder)
  - Treatment options (benefits/risks) and evidence; alternatives
  - Skills training and feedback to manage disease
  - Intervention (acute, emergency)
- **Motivation and Support**
  - Support for symptom management (anticipate, prepare)
  - Engage in decision making (present options based on patient preference)
  - Respect for patient choice and autonomy

Institute for Optimizing Health Outcomes

Optimizing Life and Optimizing Therapy

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