Module 3: Successful Strategies for Caring for a Client with Diabetes

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Objectives

By the end of this module, students will know…

I. How to overcome barriers to behavior change
   A. Prochasko's Stages of Change
   B. Specific patient education strategies, helping to develop a plan for change
   C. Intervention examples

II. Opportunity for participants to share what works

III. Question & Answer Session

How to Overcome Barriers?

How to overcome barriers?

- Identify
- Acknowledge
- Address
- Monitor

Stages of Change

Understanding Change

- Prochasko's Stages of Change
  - Pre-contemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance

Pre-contemplation

- Individuals are **unaware** of problems or that there is a need for change.
- Uninformed or under-informed of the consequences of their behaviors.
- Not being diagnosed with diabetes.

Examples:

- Mass media campaign (T.V. newspaper, radio)
- Health fair
- Posters

Pre-contemplation

- During the pre-contemplation stage, patients do not even consider changing .
  - Smokers who are "in denial" may not even see that the advice applies to them personally.
  - Patients with high cholesterol levels may feel "immune" to health problems that strike others.
  - Obese patients may have tried unsuccessfully so many times to lose weight that they may have simply given up.

Published by: American Academy of Family Physicians

Contemplation

- The stage where people become **aware** of the problem (being diagnosed with diabetes) and are now contemplating or thinking about changing or/not changing their behavior.
- There is an **intention** to change behaviors in the next six months that will affect their diagnosis of diabetes.

Examples:

- Client-focused education
  - Focus on the importance of healthy lifestyle and screening.

Contemplation

- During the contemplation stage, patients:
  - Are ambivalent about changing
  - Feel that giving up an enjoyed behavior causes them to feel a sense of loss despite the perceived gain.
  - Assess barriers (e.g., time, expense, hassle, fear, "I know I need to but……) as well as the benefits of change.

Published by: AAFP

Preparation

- The stage that *combines* **intention** and **behavior**.
- These individuals are intending to take action in the next month for the first time or in the past have been unsuccessful.
- Specific plans of action are developed in this stage as the individual chooses among alternative potential solutions. (i.e. perform physical activity for 30 minutes 4 times a week).
- Should be recruited for action-oriented activities

Examples:

- Support services- resources
  - Support group, referral to specialist, health educator

Preparation

- During the preparation stage, patients prepare to make a specific change.
- They may experiment with small changes as their determination to change increases.
  - For example, sampling low-fat foods may be a move toward greater dietary modification.
  - Other behaviors indicating they are aware that change is needed are:
    - Switching to a different brand of cigarettes
    - Drinking less alcohol
    - Exercising longer and more often

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Action

- The stage where individuals **change** their behavior, experiences or environment in order to help with their diagnosis of diabetes.
- Requires commitment, time and energy, and during this stage, patients need the most support and motivation.
- The question being asked "is this new plan (behavior change) working?

Example

- Support group
- Motivation

Action

- The action stage in the one that most Physicians are eager to see their patients reach.
- Many failed New Year's resolutions provide evidence that if the prior stages have been glossed over, action itself is often not enough.
- Any action taken by patients **should be praised** because it demonstrated the desire for lifestyle change.

Published by: AAFP

Maintenance

- The stage in which people work to **prevent relapse** and consolidate gains attained during actions.
- An example would be to maintain increased physical activity level, which brought both weight and A1c down. This helps to relieve their symptoms of diabetes.

Example

- Support group
- Motivation

Maintenance

- Maintenance and relapse prevention involve incorporating the new behavior **"over the long haul."**
- Discouragement over occasional "slips" may halt the change process and result in the patient giving up.

- Published by: AAFP

5 Things to Keep in Mind When Starting to Set a Goal

1. Be Realistic
   - No one can eat healthy and be active 100% of the time.
2. Keep it Doable
   - Start with small and gradual changes. Small changes will lead to big changes.
3. Be Specific
   - When making a plan help your client to decide: what, when where, and how long.
4. Be Flexible
   - Plan ahead to handle things that might come up, such as bad weather, sickness, or work and family responsibilities.
5. Make it Enjoyable
   - Change doesn't have to be painful, it should be fun.

Goal Setting in Action - An Example

Scenario/Task: *Your client was just diagnosed a pre-diabetic. Help her to create a positive action plan to increase her physical activity in order to try to avoid becoming a full blown diabetic.*

In creating her action plan, you should help your client to decide:

- What is the one thing she can do, or keep doing, to manage the amount of calories she is burning off?
- How often will she do this? (Be specific)
- What will she need to do to make it happen?
- When she will start?
- What are things that might get in her way (roadblocks)?
- How will she handle the roadblocks?
- Who can she turn to for support?

Be the Support Your Client Needs

- Make sure to check-in with your client on the progress of his/her goal(s).
- Ask about any roadblocks that s/he may have ran into and about how s/he may have dealt with it.
- Remind your client that everyone slips up from time-to-time and encourage them to stick with their goal(s).

Specific Patient Education Strategies

- One on one strategy
- Cultural strategy
- Familial strategy
- Strengths strategy
- Collaboration strategy

Intervention Examples

- Regular visits with Doctor
- Healthy cooking classes (interactive)
- Supermarket tours (interactive)
- Label reading (interactive)
- Exercise (classes, walking groups etc.)
- Know your numbers (BP,BS, etc.)

Case Studies

Case #1 – Weight Loss/Eating a healthy diet

Patient/client – You are told by your doctor that you need to lose weight. You have tried this many times before, but it is hard. S/he gave you a diet to follow, but it doesn't include the foods you like. You don't know what else to try and would like to ask your doctor for more information to help you lose weight, but s/he seems busy and you don't want to get lectured. So you talk to the community health worker/outreach worker that is available at the clinic.

Case #1 – Weight Loss/Eating a healthy diet

Community health worker –

Taking what you learned earlier today, work with the patient on way to approach eating a healthy diet.

Case #2 – Taking medicine

Patient/client – Your doctor prescribed some medicine for you, but you keep forgetting to take it. It is just too hard to remember with your schedule! You are worried that if you mention this to your doctor that s/he will get angry at you or you will be scolded, and you aren't in the mood for a lecture.

Case #2 – Taking medicine

Community health worker –

Taking what you learned earlier today, work with the patient on way to remember his/her medications.

Case #3 – Following up with Appointments

Scenario: The doctor has asked the community health worker to do a home visit to a patient who has not returned for his/her follow-up appointments

Patient/client: You haven't been going to your doctor appointments because you feel that when you go you are scolded for what you are doing wrong and you don't understand exactly what is happening to your body, because you feel no pain.

Case #3 – Following up with Appointments

Community health worker –

Taking what you learned earlier today, work with the patient on way to remember his/her medications.

Question and Answers