Facilitating diabetes self-management in general practice

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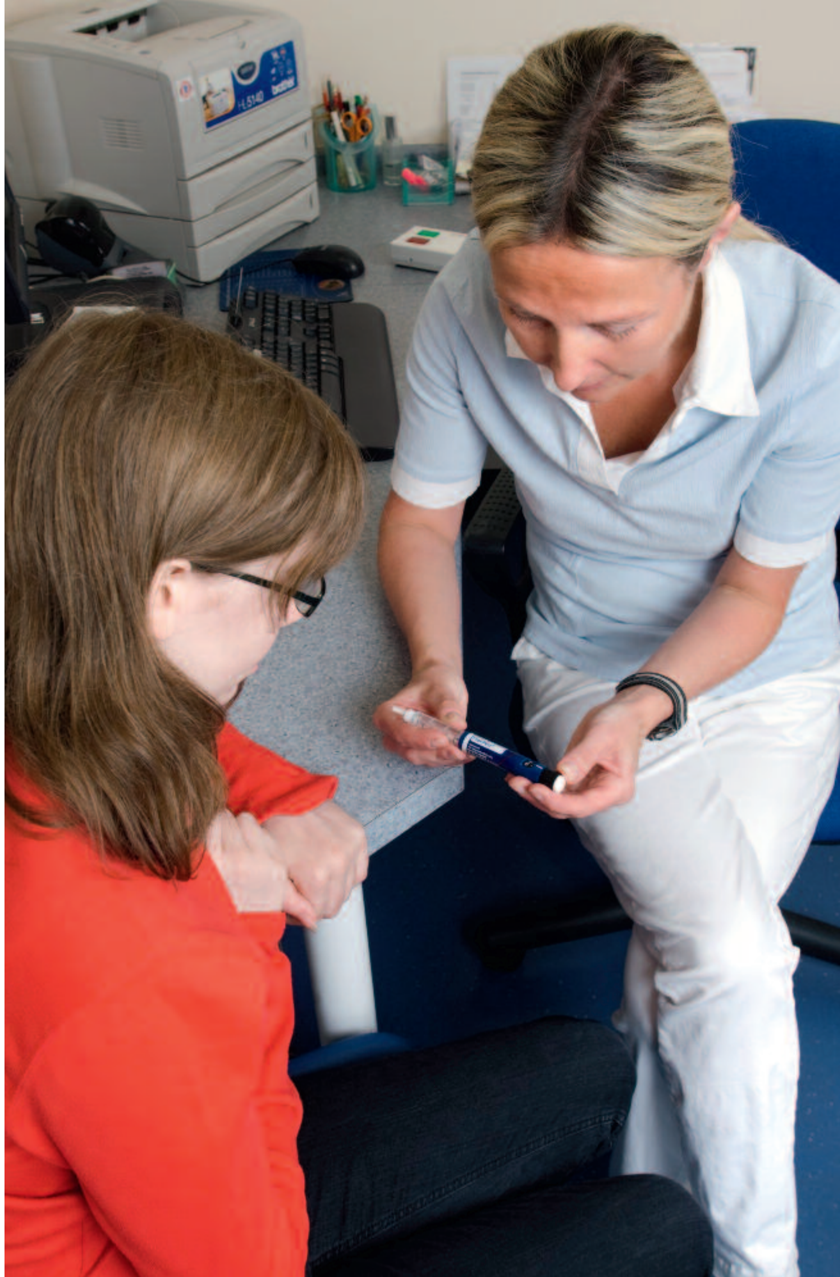
Collaboration between patient and physician can lead to a patient-centred approach to diabetes care in general practice that prioritises patient needs and optimises health outcomes.



Self-management in diabetes is essential to diabetes care. A collaborative approach to engaging patients in diabetes self-care to help them achieve and sustain desirable behavioural, lifestyle and medication practices is highly challenging but preferable to being authoritarian in approach.

This article, written from the perspective of a clinical diabetes educator, focuses on the general practice care of people with diabetes and explores key principles in facilitating informed diabetes self-management, melding clinical evidence with practical advice. The main concept proposed is that a patient-centred approach, determined through collaboration between patient and physician, will prioritise patient needs and optimise health outcomes in diabetes.

Why self-management is important

Twelve hours! That is the time per year the average person with diabetes spends discussing their diabetes with a health professional. It is, therefore, not optional but inevitable that self-management is a cornerstone of diabetes therapy, as nearly all outcomes are mediated through the individual's behaviour.

In recent years and at an international level, diabetes care has moved away from the traditional medical model of telling the person what to do, involving covering the basics, judging their compliance and teaching them. Rather the model is now individualised and patient-centred and, as health professionals, we ask the person what they perceive they want and need; we have a partnership approach. Successful self-management programs typically involve change at multiple levels: patient–clinician, practice environment changes, and health system and policy changes. Key principles in facilitating diabetes self-management are shown in the box on page 19.

Key points

- **Patient-centred, team-based care is an integral component of diabetes care.**
- **Self-management education and ongoing support are effective at reducing glycosylated haemoglobin (HbA_{1c}).**
- **SMART principles should be used to set collaborative goals.**
- **Practice redesign may be necessary to accommodate chronic disease management.**

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Self-management education in diabetes

The philosophy of our approach influences the type of self-management provided. Clinicians who believe they are mainly responsible for a patient's wellbeing may be less able to adopt an approach that acknowledges the central role of the person with diabetes in their own care. Health professionals are responsible for providing information, evidence-based care and support to patients, and are not primarily responsible for guaranteeing a patient carries out prescribed activities. Self-management education is effective: it has been shown to decrease glycosylated haemoglobin (HbA_{1c}) levels by up to 1%. However, effectiveness is directly correlated with the amount of time spent with the person. Moreover, the benefits of education decrease over time, and so sustained improvements require time and follow up.

Yet we know that many patients fail to reach clinical targets. Why does this occur? Often we may blame the person rather than reviewing our own practice. Are we just giving general instructions and not teaching the person to manage their disease? Are we providing ongoing support or are we just giving out brochures? Are the metabolic and behavioural targets mutually developed with the patient, and are they individualised and practical? And are we reviewing progress in a timely manner and being proactive in troubleshooting and up-titrating treatment?

The education process

Diabetes education is about individualising care in a person with diabetes through assessing the person, planning with them what they need, implementing or providing them with the knowledge and skills necessary to achieve their goals, and then evaluating the effectiveness of the diabetes education.

Assessment is necessary to 'identify the person' in the patient and establish trust. Clearly this step may not be necessary in a well-established GP–patient relationship. Assessment also determines the person's needs, priorities and most urgent concerns, such as 'my aunt died from diabetes after she had an amputation'. You can evaluate their current knowledge of diabetes and expose any myths that they may have taken note of, such as 'my mother died soon after she went onto insulin; insulin is dangerous so I don't want to use that!' Clinical data augments the assessment, and also helps determine individualised clinical targets and potential barriers to achieving these targets (for example, the cost of medications).

Planning helps develop what the person needs and wants. It is important not to assume that the person shares the same goals or values as health professionals. Substantial evidence exists for a significant difference in the needs and wants for education as identified by people with diabetes and by their health professionals. Indeed, in most cases, agreement occurs in approximately 30% of occasions. Moreover, not every person needs the same information. That is why standardised 'classes', although they may be of some benefit, should not make up the total education package.

Key principles in facilitating diabetes self-management in general practice

- Have a partnership approach
- Listen to the person's story
- Set collaborative and achievable goals
- Ensure the person has adequate knowledge and skill to undertake self-management
- Provide ongoing support and follow up, which are critical

Traditional diabetes education dogma suggests that implementation of self-management education begins with what the patient wants to discuss, not with the health professional's agenda. The environment should be conducive to learning, and not a busy waiting room. It is important to be specific, clear and not rushed, and yet the session should be brief. We often think we need to 'give as much information as possible' but, in general, people will only remember about 25% of any 20-minute consultation. So, for the key messages: repeat, repeat, repeat! Also, it is important that we are careful with the language used: neither medical jargon nor judgemental terms (for example, noncompliant) should feature.

Evaluation, support and follow up are key components in the sustaining of behavioural changes.

Goal setting

There are several simple steps that can help a person with diabetes in the setting of effective behaviour change goals. These are described below.

- Ask the person to write down their goals – this gives them ownership and accountability, allows them to record what is important to them and illustrates their readiness to change.
- Ask the person what they want to achieve – set positive goals such as 'I will eat fruit at morning tea' rather than 'I won't eat cake'.
- Apply SMART (Specific, Measureable, Attainable, Realistic and Timebound) principles to each goal – an example of a SMART goal is ' I will walk for 10 minutes each day for the next two weeks'. Clinician-imposed goals or vague recommendations such as 'you need to increase your exercise' are not effective. Address any potential barriers to success. The health professional's role is to fine-tune, support and reassure.
- Address one issue at a time – do not blame the person if a goal is not achieved. Review past success, reward and reiterate; if the goal is not achieved, find out why, reassess and discuss solutions.
- Ask the person how confident they are on a scale of one to 10 in achieving the goal – if they score less than seven, the goal is unlikely to be achievable and another needs to be set.

One of the most important roles of health professionals in chronic disease management is listening to the patient.

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System or work practice change

The behaviour change approach applies to both the individual with diabetes and also the system of practice used. The great pioneer physician in diabetes, Dr Elliott P. Joslin, noted the following about the importance of the team approach to diabetes care in his book, the *Diabetic Manual – for the Doctor and Patient*: 'Experience, the nurse, the doctor, the parents, the grandparents, the brothers and sisters working together [with the patient] will finally bring success'.

This book, first published in 1919, educated how the patient as the primary point of focus could become sufficiently resourced and upskilled through self-managing their diabetes to take control of their disease. However, patient-centred management requires a fundamental change from the acute health care systems model to chronic care, and is a concept that even today challenges busy health care practices.

Chronic care programs are being increasingly implemented in general practice but, in my experience, many practices continue to be based on the traditional model of acute episodic care.

Practice redesign to accommodate a chronic care program needs to involve all staff in contact with the patient. It is essential the staff 'team' members agree on a common vision of patient-centred care. Although this sounds straightforward, it is often a major shift for many health professionals, most of whom have been trained and socialised in clinician-centred practices, where interventions are chosen by the clinician and patients are expected to comply. Many health professionals may struggle to give up this philosophy, but practices in which diabetes self-management is promoted cannot be both primarily clinician-centred and patient-centred. In contrast, it is recognised that to achieve evidence-based metabolic outcomes, the high priorities in care as perceived by physicians should be communicated with people with diabetes in such a way that engages and helps motivate them to recognise these priorities and hence include metabolic targets as goals in their self-care.

Through this collaborative method, both patient- and physician-desired outcomes can be achieved using the patient-centred approach, and health care will be optimised.

Fundamental to successful team-based care is the need to achieve clarity and consensus about the vision for care and the roles each team member will adopt. Specific strategies for incorporating diabetes self-management into a general practice include the following:

- using a team of professionals who have been trained in providing some diabetes education; these include diabetes educators, practice nurses, dietitians and podiatrists
- implementing case management co-ordination by a practice nurse
- using interactive technology to enhance self-management (e.g. smartphone apps that monitor exercise)
- developing 'mini clinics' to systematise care, yet retaining enough flexibility in the system to address individual patient needs
- using standardised documentation tools or electronic medical records.

A key to success can be making small changes towards a large goal, otherwise the temptation to 'go back to old ways' is too great when confronting an obstacle. Making change is often difficult, and financial pressures, nursing shortages and market competition may reduce the willingness and ability of the general practice to change.

Conclusion

Patient self-management should be an integral component of diabetes care. It should be an ongoing, iterative process and patient-centred; use collaborative team-based goal setting and decision-making; and include problem solving and systematic follow up and support. All this needs to be underpinned by a system of care that enables this philosophical approach of patient-centred care and leads objectively to improved patient outcomes. **ET**

COMPETING INTERESTS: Associate Professor McGill has performed consultancy work for Johnson and Johnson, Eli Lilly, Novo Nordisk and Merck Sharp and Dohme.

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