

This product was developed by the Advancing Diabetes Self Management Project at La Clínica de La Raza, Inc. in Oakland, CA. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

# **Use of the Transtheoretical Model for Change and Peer Support to manage poorly controlled diabetes in Mexican-Americans GP13**



A demonstration project funded by the Robert Wood Johnson Foundation, Advancing Diabetes Self-Management Initiative

32<sup>nd</sup> Annual Meeting of  
the AADE

Washington, DC

August 10-13, 2005

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La Clínica de la Raza

Oakland, CA

# *La Clínica de la Raza*

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# *La Clínica de la Raza*

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- ◆ Characteristics of Population Served
  - ◆ A community health center serving 30,000 patients a year
  - ◆ 84% Latino; 85% < federal poverty level
  - ◆ 20 sites in 3 counties; based in Oakland, California
- ◆ Characteristics of Targeted population for Program (Advancing Diabetes Self Management Program)
  - ◆ A1c>9
  - ◆ Social support inadequate

# *Purpose of Program*

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- ◆ Pilot test the stages of change model to interpret patients' readiness to change and tailor interventions based on the psychological processes of change.
- ◆ Train health promoters to enroll and support patients' efforts at self-management, and plan culturally appropriate activities that provide patients with an opportunity to meet goals
- ◆ Assess movement through the stages of change for
  - ◆ Diet: following a meal plan of the patient's choice
  - ◆ Exercise: 30 minutes of moderate intensity exercise 5 days/week
  - ◆ Medications: Taking them 90% of the time
  - ◆ SMBG: Minimum one time each day

# *Responsibilities of the Promoters*

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- ◆ Enroll patients in the program and administer all questionnaires
- ◆ Stage patients every 3 months and counsel them using transtheoretical model methods
- ◆ Identify patients with depression and encourage avenues of support
- ◆ Act as liaison between provider and patient
- ◆ Lead classes, support group, walking club
- ◆ Attend biweekly promoter meetings and provider case conferences
- ◆ Maintain proper documentation on all interactions with patients

# *Stages of Change*

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- ◆ **Pre-contemplation (I can't; I won't)**  
The client is not yet considering change or is unwilling or unable to change
- ◆ **Contemplation (maybe)**  
The client acknowledges concerns and is considering the possibility of change but is ambivalent and uncertain
- ◆ **Preparation (I will)**  
The client is committed to the change and is planning to make the change in the near future but is considering what to do.
- ◆ **Action (I am doing)**  
The client is actively taking steps to change but has not yet reached a stable state.
- ◆ **Maintenance (I have been doing)**  
The client has achieved initial goals and is now working to maintain those goals.

# *Pre-Contemplation*

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- ◆ (Express concern) I'm concerned that...
- ◆ (Raise doubts about client behavior) Why do you think it is important to ...?
- ◆ (Normalize behavior) Lots of people find it difficult to ... For a variety of reasons. What are some of the things that get in the way for you?
- ◆ (Provide information) Are there any questions you would like to ask me or do you want some written information about...?

# *Contemplation*

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- ◆ (Normalize ambivalence) Some people don't like to ..., yet they know it is important.
- ◆ (Consider the cons) What is it that makes it difficult for you?
- ◆ (Consider the pros) What would be some reasons to start doing it?
- ◆ (Self re-evaluation) How much does your family know about your diabetes? How do you think your diabetes affects them?
- ◆ (Examine options) If you were to start ....., what do you think you would do?
- ◆ (Emphasize client control) With any chronic condition, you are the one in charge. Your health depends on your ability to make the changes



# *Preparation*

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- ◆ (Clarify the client's own goals and strategies for change) Tell me what you are planning to do about... Ask for specifics such as how often, when, how long, etc.
- ◆ (Anticipate problems before they occur) What are some things that could get in the way of achieving your goal?
- ◆ (Lower barriers to change) What do you need to do so that this is not going to get in your way?
- ◆ (Help the client to enlist social support) Who do you need to help you achieve your goal?
- ◆ What do you need from them?



- ◆ (Acknowledge difficulties in the early stages of change) What have you learned about yourself since you began ....?
- ◆ (Engage client in treatment) You are in charge of your own treatment. You know what you need to do to make your diabetes better controlled. What has changed for you since you began ....
- ◆ (Identify high risk situations) Since you began ....., was there ever a time when you just quit doing it? (Indicate that this is a normal part of the change process).
- ◆ (Elicit as much detail as needed to help the patient problem solve). Examples: What happened? How has your routine changed? What can you change so that this doesn't happen again?
- ◆ (Assess strengths and social support). Who helps you to keep up with .... How does that person help you?
- ◆ Is there anyone else whose help you need? What would that help include?

# *Maintenance*

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- ◆ (Affirm commitment) When you committed to ....., you did it for a specific reason. Do you remember what that reason was? Have you discovered other reasons that motivate you now?
- ◆ (Affirm client's resolve and self efficacy) Can you image yourself keeping your diabetes under good control? Describe how you will make sure that you maintain good control.
- ◆ (Incorporate positive rewards). How can you celebrate your success in ....
- ◆ (Review long term goals) What do you see as your long term goal related to ....?

# *System Changes – Computerized information system*

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Added behavioral outcomes flow sheet

- ◆ Referral and subsequent weight, height,
- ◆ BMIPHQ-9 depression screen and group participation
- ◆ First, last, and total number of promotor contacts
- ◆ Stage of change and date for 4 behaviors
- ◆ Name of promoter, date of enrollment and/or disenrollment
- ◆ Self efficacy data
- ◆ Goals and progress
- ◆ Participation in group activities (classes, walking club)

# *System Changes –Community Linkages*

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- ◆ Contractual partnership between Robert Wood Johnson Foundation, Lumetra (California) and La Clínica for graphic design and production of educational materials for providers and patients
- ◆ Kaiser-Permanente – curriculum La Diabetes y Su Salud, and Lo Básico
- ◆ Local fitness centers - discounts to patients

# *System Changes – Delivery System*

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- ◆ Depression screening with the PHQ-9
- ◆ Open enrollment for Depression group
- ◆ Referral to health promoter program
- ◆ Use of stage specific questions during patient consult
- ◆ Monthly diabetes clinic days in addition to regularly scheduled diabetes appointments

## *System Changes – Organization of Health Care*

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- ◆ Provider release time provided for case conferences with promoters
- ◆ Project involves coordination between different Departments (Mental Health, Family Medicine, Preventive Medicine, and Planning)

# *System changes – Decision Support*

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- ◆ In-services for providers on the transtheoretical model
- ◆ Written guide of stage-specific questions provided
- ◆ Case conferences between promoters and providers
- ◆ Direct communication between promoters and providers regarding patient issues



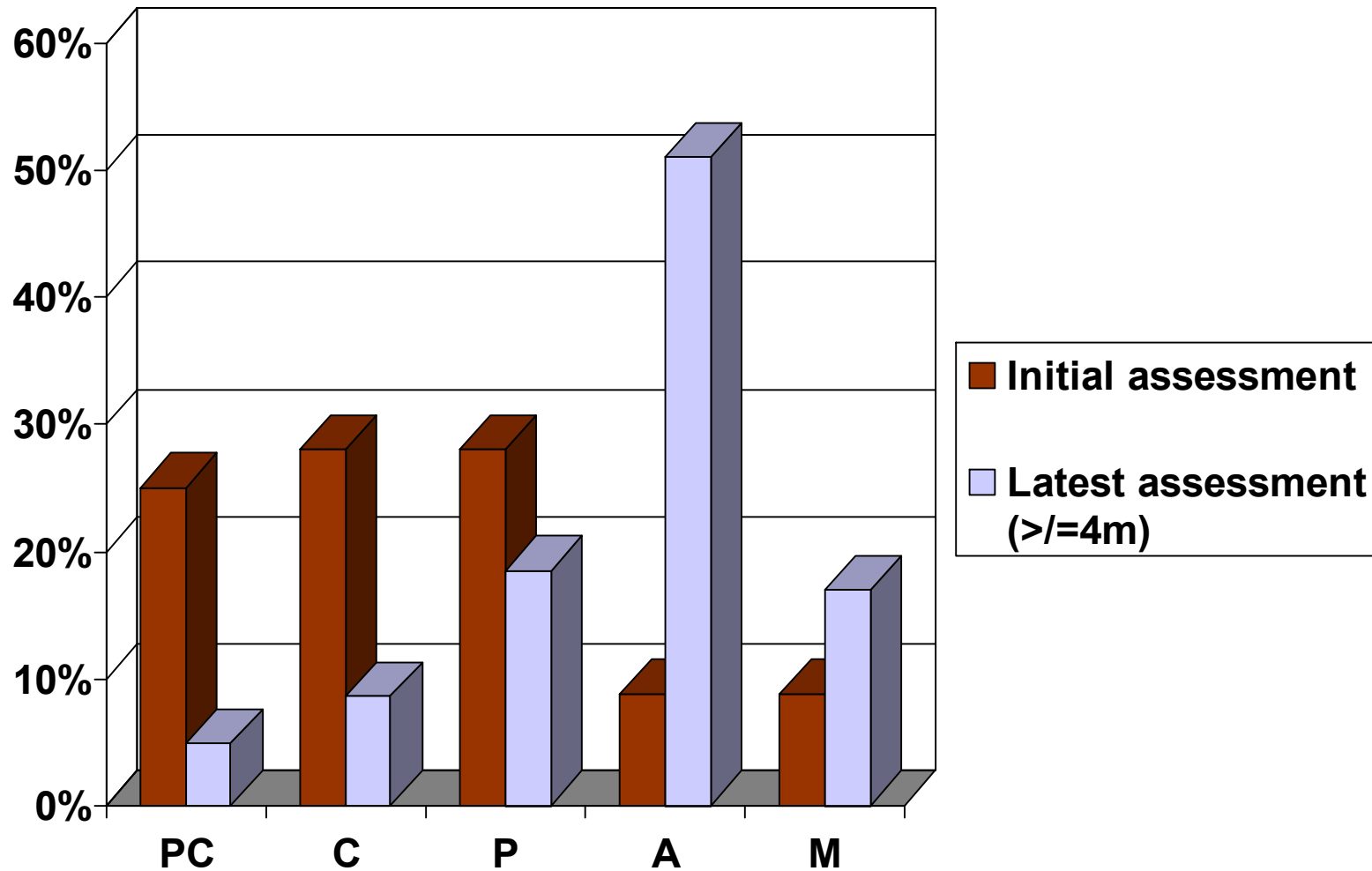
## *System changes – Self management support*

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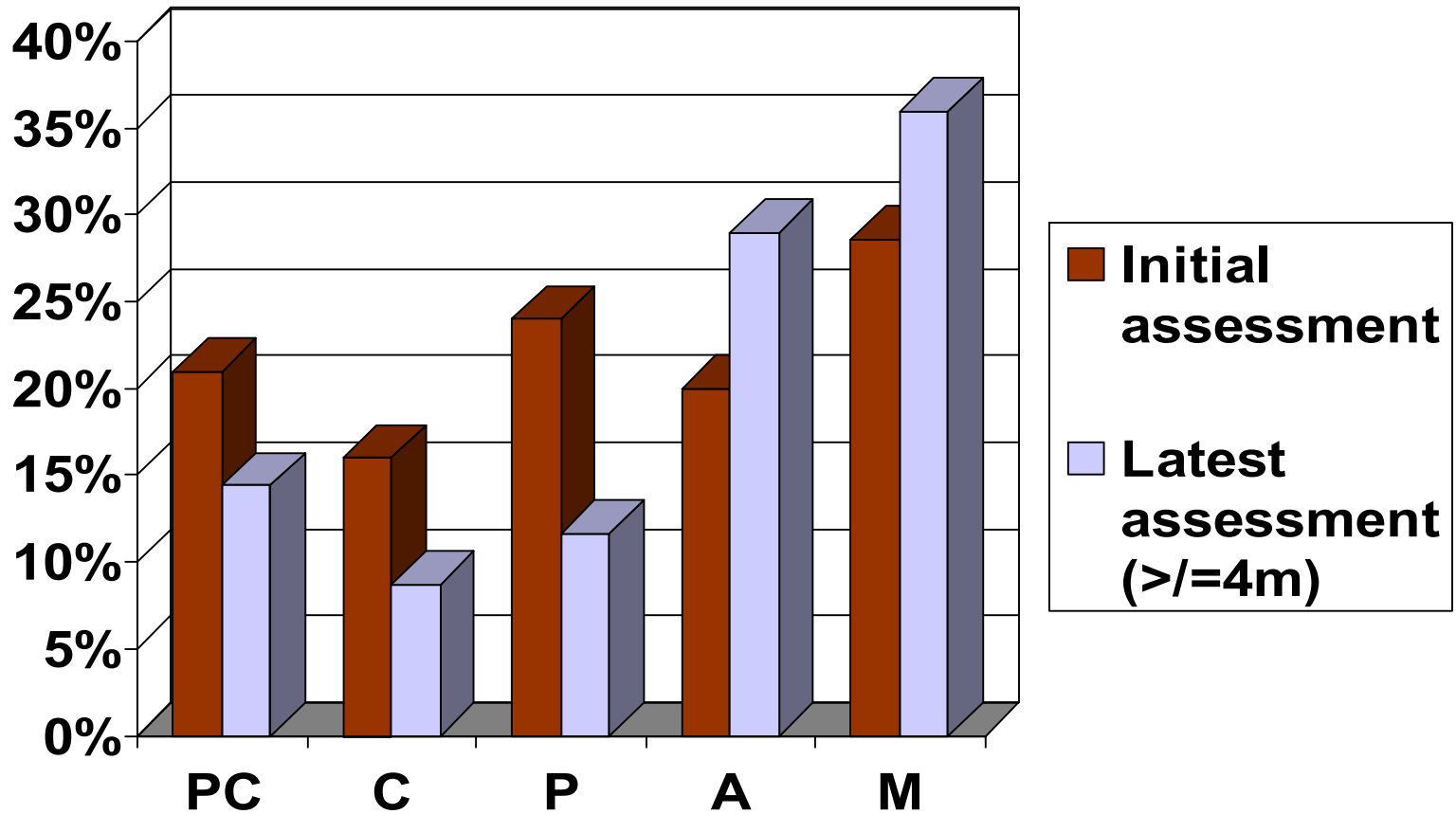


- ◆ Health promoters call patients weekly during the first 6 months.
- ◆ Diabetes classes – 4 class series monthly
- ◆ Walking club – 3x per week
- ◆ Depression group – weekly
- ◆ Support group - weekly

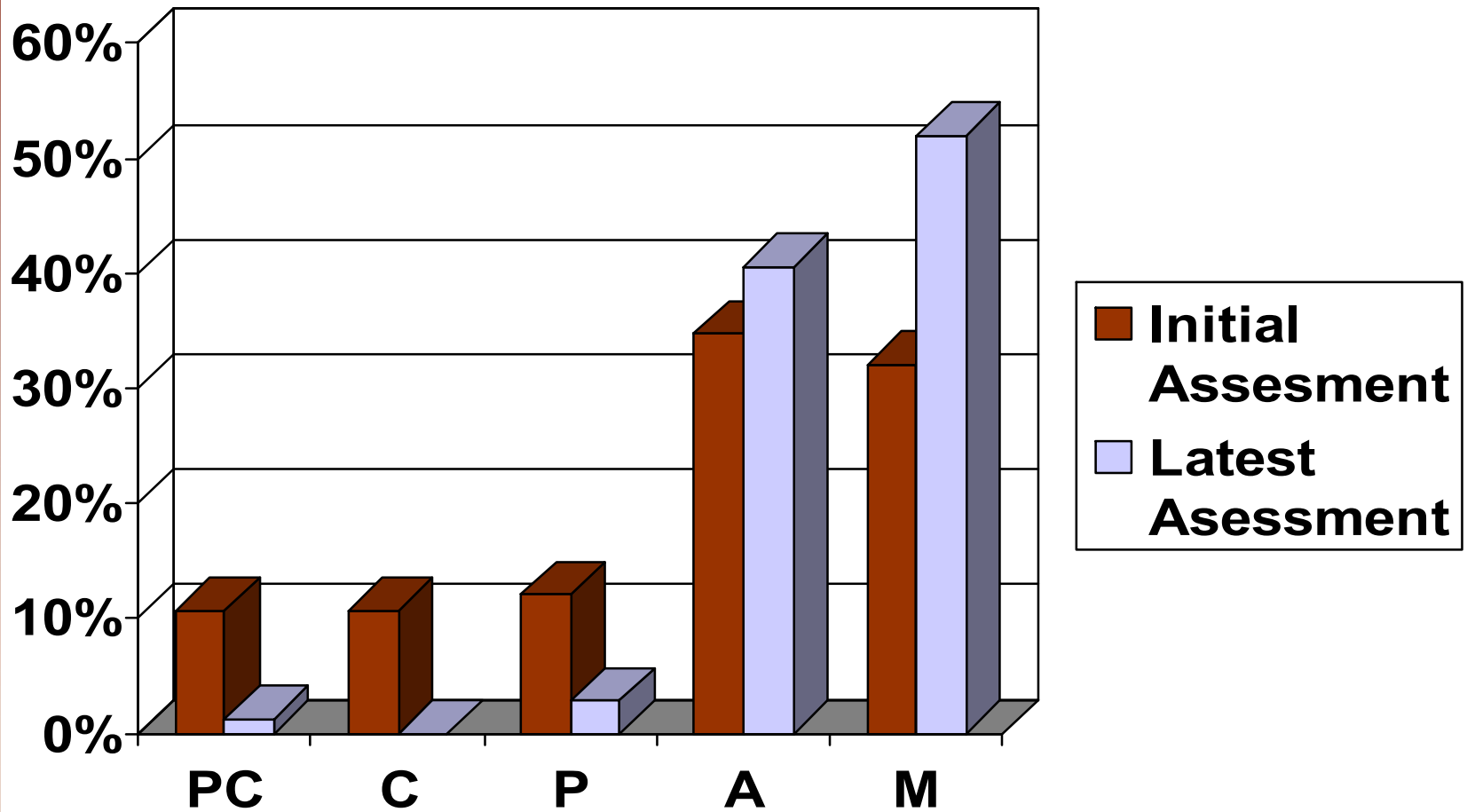
# Results: Meal Planning



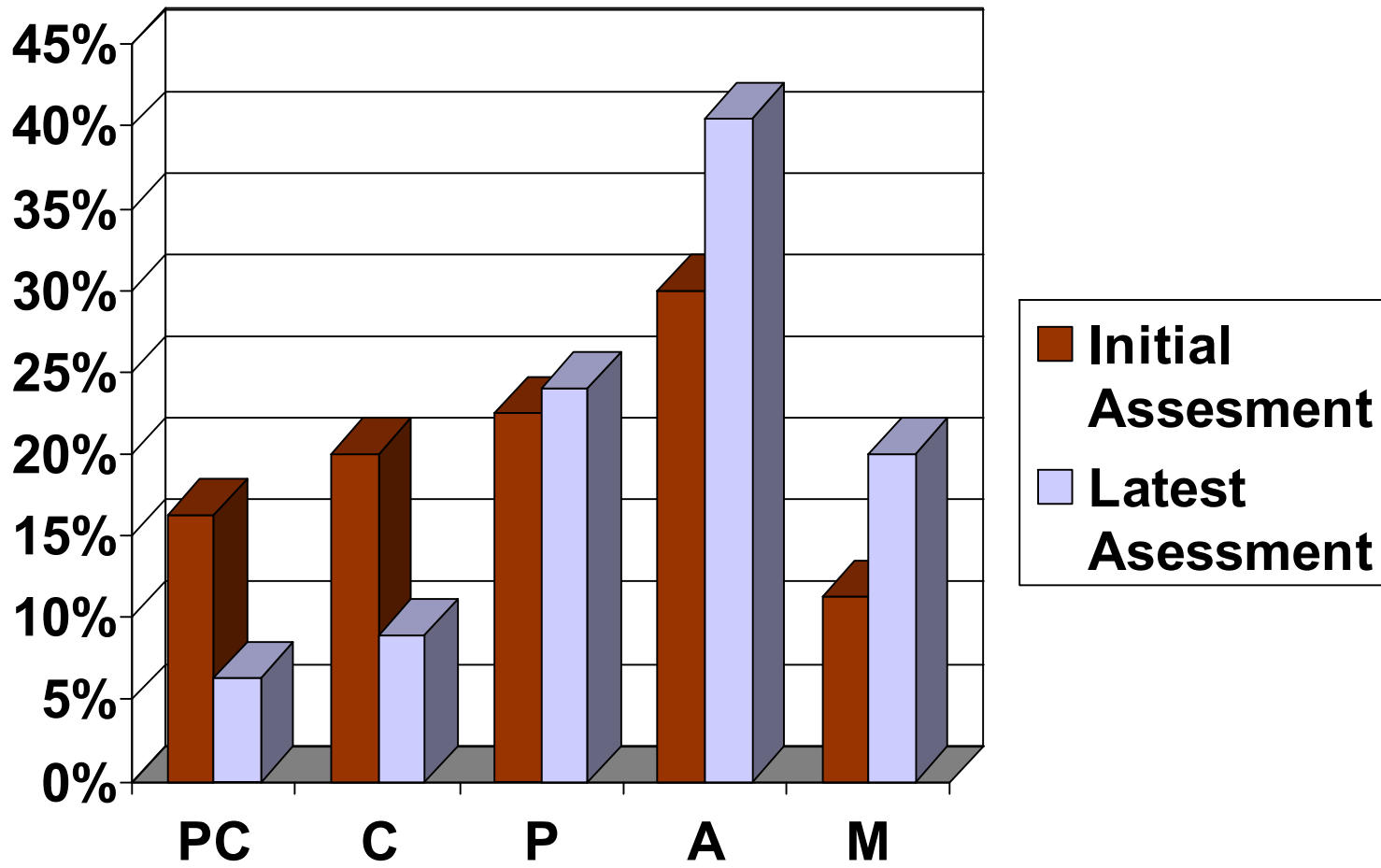
# Results: Self-Monitoring Blood Sugar



# Results: Medication



# Results: Exercise





# *Lessons shared*

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- ◆ The transtheoretical model can be successfully integrated into medical management for diabetes.
- ◆ Intervention needs to be customized to the patients' stage of readiness.
- ◆ Promoters are successful in staging patients and facilitating movement through the stages of change.
- ◆ Promoters can be effectively integrated into clinical practice.

# Challenges

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- ◆ Availability of target population (extended time in Mexico, no phone contact available in California)
- ◆ Liability issues discourage home visits by promoters and exercise activities on campus
- ◆ Limited literacy skills for some promoters and extensive documentation required for this demonstration project
- ◆ Reaching enrollment goal of 300 among an already “difficult to control” population