Simple Steps Improve Diabetes Self Management

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — Here's what doesn't work when trying to help patients self-manage their diabetes:

► Urging them to use more will power. "You need to get serious about your diabetes."

► Threatening them with bad outcomes. "Do you want to go blind?"

► Giving them advice. "Maybe if you joined a nice fitness center …"

These strategies don't work because they're based on the flawed premises that people are unmotivated, lazy, or in denial about their diabetes, said William Polonsky, Ph.D., at a meeting sponsored by the American Diabetes Association. "There's no evidence for this, and there's pretty good evidence that this is wrong."

Although data on how to help patients improve self-care are scarce, seven core behavioral strategies seem likely to make a difference, said Dr. Polonsky, a psychol-

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DR. POLONSKY

ogist who founded and directs the Behavioral Diabetes Institute, San Diego. The strategies follow:

► **Make it real.** Many patients don't think that having diabetes is a big deal. Give them personalized metabolic feedback about their hemoglobin A_{1c} (HbA_{1c}) levels, blood pressure, and lipid levels. Instead of talking about "good" or "bad" levels, talk about "safe" ranges, and being in a "safe place" or "unsafe place" with these metabolic measures, he suggested.

A pilot study he led recently invited 36 patients with type 2 diabetes to a "Diabetes Extravaganza," a festive 2-hour group session designed to make diabetes seem more "real" by helping patients understand their metabolic data. Before the end of the session, patients were given a form with their HbA_{1c}, blood pressure, and LDL cholesterol levels and asked to check off whether their levels were "safe" or not. The average baseline HbA_{1c} level of 9.1% declined to 7.9% just 3 months later, a mean decline of 1.2% that was statistically significant.

► **Make it hopeful.** Pop quiz: Diabetes is the leading cause of adult blindness, amputation, and kidney failure. True or false?

False. Poorly controlled diabetes leads to these problems. "Well-controlled diabetes is the leading cause of nothing," Dr. Polonsky said.

► **Make it understandable.** Be cautious about use of jargon. Explain the reasons for your recommendations, and be specific about procedures. On the flip side, don't provide too much information. Dr. Polonsky likes to quote the poet William Butler Yeats: "Education is not the filling of a pail but the lighting of a fire."

Make patient visits interactive by asking what the patients heard from you and what they'll do. Make sure their recall is in agreement with yours.

► **Make it implementable.** Ask questions that help patients develop a step-by-step plan for taking action. One example: "I'm glad you've decided to start exercising. What's the first step you'll take to do that?"

► **Make it collaborative.** Shared decision making works best to motivate patients, Dr. Polonsky said. Some physicians invite patients to pull a chair up to the computer to fill out the electronic medical record together. "This becomes an opportunity to talk together," he said.

► **Make it often.** Patients who have more contacts and time with you or your staff are more likely to do well. "This is probably the most impossible" strategy for busy providers, he said. A 2003 study suggested that using case managers (nurses) for more frequent patient contacts doubled the likelihood of diabetes being well controlled.

► **Make this possible for clinical practice.** Start by adopting even one strategy to incorporate these ideas into your practice. Schedule group patient visits (such as the diabetes extravaganza), or form "teamlets" of staff and family volunteers to comanage patients. Early evidence suggests that automated phone call systems might help patients feel more connected to care.

Lastly, "Make sure patients leave a visit with a follow-up appointment," he said. ■