

# Improving Diabetes through Collaborative Goal Setting (CGS) in Primary Care

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## INTRODUCTION

- Diabetes is a serious chronic disease with major health, economic and social impact
- Diabetes self management is complex<sup>1</sup>
- Individuals need to perform & sustain daily self-care activities in order to manage their condition<sup>2</sup>
- Evidence supports the use of CGS as an effective, patient-centered intervention to improve diabetes outcomes<sup>3, 4, 5, 6, 7, 8, 9, 10</sup>

## AIMS

- To determine impact on:
  - Diabetes self-management
  - Psychosocial self-efficacy
  - Patient action plan adherence
  - Provider satisfaction with CGS training

## METHODS

- Design:** Single cohort-Pre-test/post-test
- Sample:** 15 Adults with uncontrolled Type 2 Diabetes (≥ 8%), average age: 60.5 yrs, 66% Male, 86.7% Caucasian
- Setting:** Family Practice Clinic in Texas
- Intervention:** Providers utilized Diabetes Action Planning (DAP) tool for behavior change conversations with patients and individualized action plan- 3 MO.
- Measures:**
  - Glycemic control:** HbA1c collected in clinic
  - Psychosocial self-efficacy:** Diabetes Empowerment Scale (DES-SF) administered
  - Diabetes Action Plan Adherence:** Administered an adapted 3-item questionnaire
  - CGS Provider Satisfaction Survey:** satisfaction with training and action plan
- Analysis:** Descriptive, Wilcoxon sign-rank

# RESULTS

## CGS improves HbA1c and Psychosocial Self-Efficacy in Patients with Type 2 Diabetes

*An individualized diabetes action plan involving patients in the shared decision-making process and taking the patients' needs and priorities into account positively impacts diabetes outcomes*

0.75-point increase in diabetes empowerment score

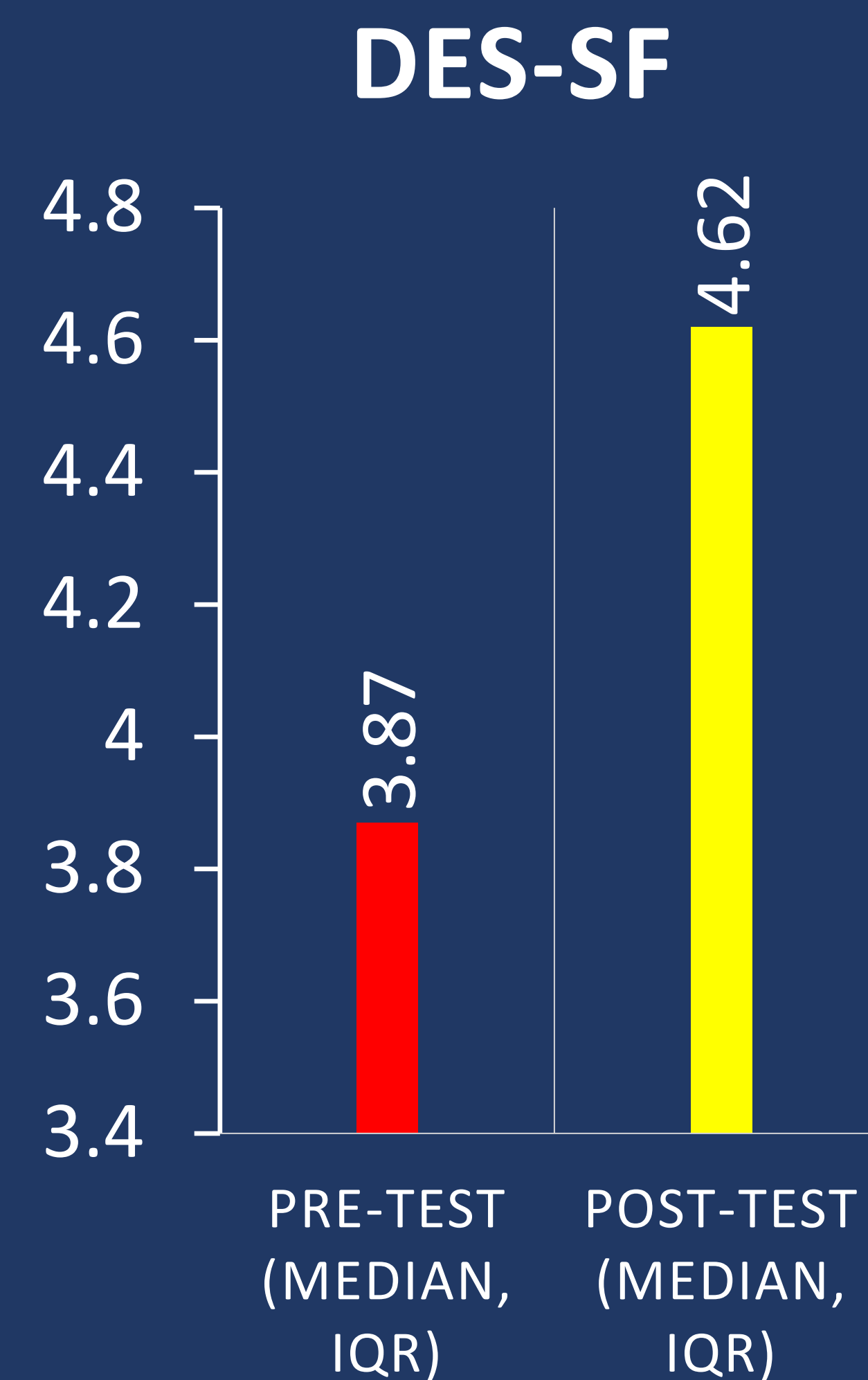


Table 1 HbA1c & DES-SF Results

Measure	Pre-Test	Post-Test	Z
HbA1c, M(IQR)	8.7% (4.7)	7.9% (3.9)	*-3.41
DES-SF, M(IQR)	3.87 (2.75)	4.62 (1.75)	*-3.42
<b>*p&lt;0.001</b>			

### DIABETES ACTION PLAN (DAP)

We are working to improve care for our patients with diabetes. Your provider would like to discuss your health goals with you today. Even small steps can make a huge difference!

Which of the 2 healthy behavior changes below seem most important to you right now that you would like to work on in the next 2-4 weeks?

**Take my medications**  
Taking medications regularly is important to keep your blood sugar under control

**Check my blood sugar**  
If you know your blood sugar is too high or too low, then you will be able to take action to correct it

**Be more active**  
Being active is one of the best things you can do for your health and to control your blood sugar

**Eat a healthy diet**  
Eating Right is the most important way to control your blood sugar

How important is this behavior change to me on a scale of (0 not important at all, 10 extremely important?) 0 1 2 3 4 5 6 7 8 9 10

Specific Goal: (e.g., I would like to lose 20 pounds)

What will you do: (e.g., Exercise)

How will you do it: (e.g., Walk)

How much: (e.g., 15 minutes)

How often: (e.g., 3 times a week)

Where: (e.g., around the neighborhood)

When: (e.g., Mon/Wed/Fri)

How confident am I that I will be able to make this change on a scale of 0-10 (0 not confident at all, 10 extremely confident)? 0 1 2 3 4 5 6 7 8 9 10

Who will support me in my goal?

What can get in my way of achieving my goal? How will I overcome it?

Next Follow up Date: \_\_\_\_\_ (Video/telephone/In person)

0.8% decrease in HbA1c

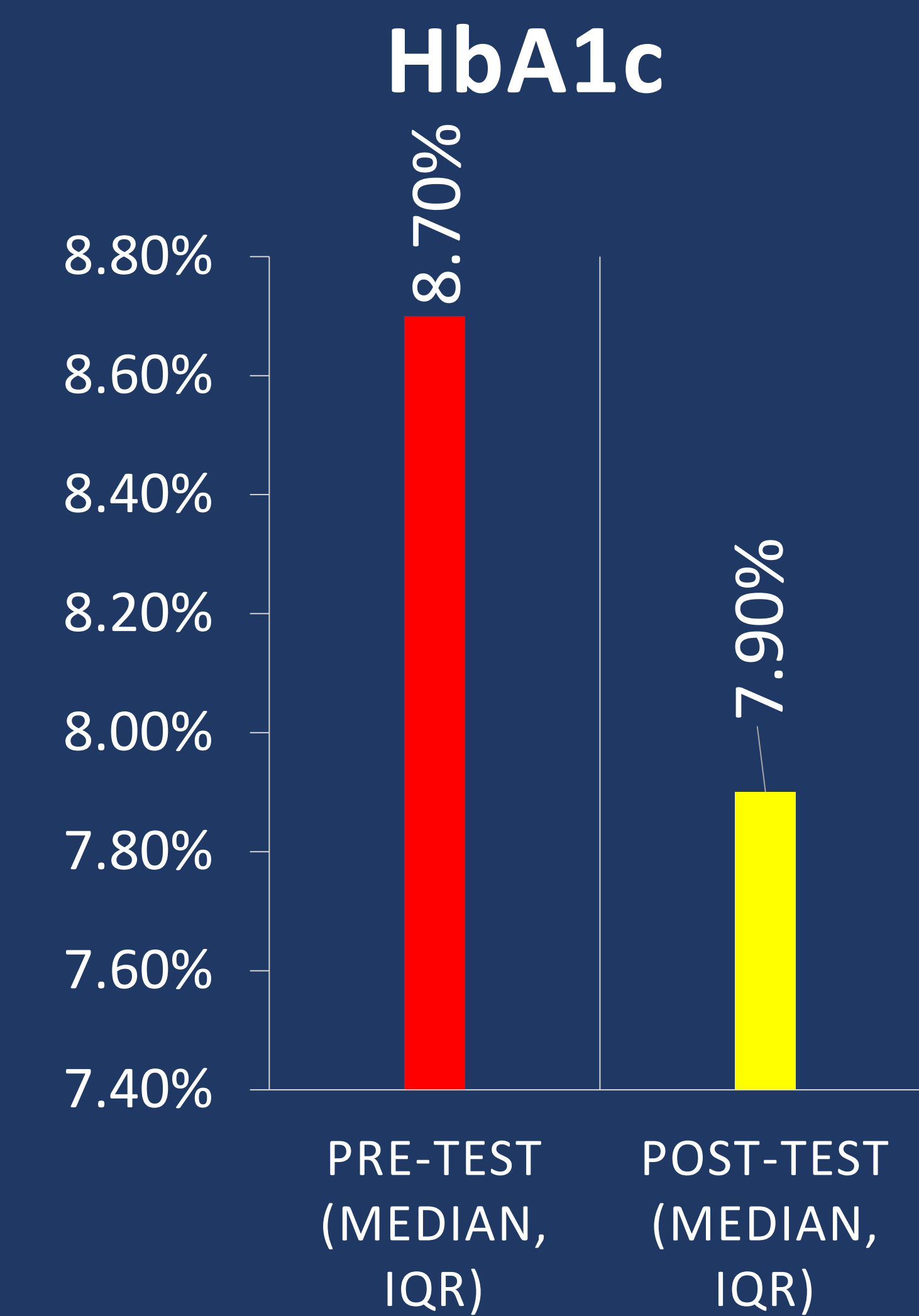


Table 2 Action Plan Adherence Results

Item	Wk 4	Wk 12
Remembered action plan (N,%)	15 (100)	14 (93.3)
Achieved goal(s); behavior sustained (N,%)	14 (93.3)	11 (73.3)
Did not achieve goal; some behavior change (N,%)	1 (6.7)	4 (26.7)
Agreed to follow action plan (N,%)	15 (100)	15 (100)

## PROVIDER RESULTS

- 100% of providers (N=3) agreed or strongly agreed that the action plan...
  - Made behavior change discussions easier
  - Helped encourage behavior change
  - Training should be provided to other providers (MA/RNs)
  - Changed the way they discuss health behavior with patients

## DISCUSSION

- A CGS can be **successfully delivered** in a **primary care** setting yielding improvements in diabetes outcomes.
- Follow-up at regular intervals** allowed patients to stay on track and provided reinforcement to reach goal(s)
- Providers felt they could have more **meaningful conversations** with their patients
- Future Direction:**
  - Screening for Social Determinants of Health (**SDOH**) and its impact on diabetes self-management to achieve **equity**
  - Replicating in **culturally diverse or remote populations**
  - Developing **digital solutions** to facilitate self-management monitoring
  - Modality agnostic** service delivery

## ACKNOWLEDGMENT

- Dr. Kim McMillin, MD, Director Population Health, Baylor Scott & White Health

## REFERENCES

