Workshop: Therapeutic education: from the physician and psychologist perspectives

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THERAPEUTIC EDUCATION: From the Physician and Psychologist Perspectives

João Raposo & Ana Covinhas
APDP - Portuguese Diabetes Association

16th MGSD congress
10th - 12th April 2019
Conceptual framework

• “In this illness the doctor must be a teacher more than in any other illness.

His job is not so much to treat the patient but to teach him how to treat himself.

He has to explain the basic ideas about the physiology of the illness so that the patient can understand the therapy …” (1925)
Planear a Gravidez na Diabetes
Cuidar dos Pés no Verão
Toda a Verdade Sobre a Água
Como Comprar Alimentos Mais Saudáveis
Maria Barroso
A pessoa com diabetes precisa ser cuidada.
10 Soluções para gerir a Diabetes
Exercício e Diabetes
Topics for this morning

• APDP
• Diabetes – Burden of disease
• The patient
• Patient Education
  • Empowerment, capacitation/activation, literacy
  • Technology
• Chronicity
• Communication
• Multidisciplinary team
• Disease phases and possible interventions
Number of people with diabetes worldwide and per region in 2017 and 2045 (20-79 years)
Global Burden of Disease (DALY’s)
Have you ever tried to change some of your behaviour(s)?

Have you ever been told you had to change some of your behaviour(s)?

Have you ever been told by a “stranger” you had to change some of your behaviour(s) to stay as healthy as possible?
Glucose Monitoring: Recommendations

• Most patients using intensive insulin regimens (multiple-dose insulin or insulin pump therapy) should perform SMBG:

  • Prior to meals and snacks
  • At bedtime
  • Occasionally postprandially
  • Prior to exercise
  • When they suspect low blood glucose
  • After treating low blood glucose until they are normoglycemic
  • Prior to critical tasks such as driving

Glycemic Targets:
Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S55-S64
Glucose Monitoring: Recommendations (2)

• When prescribed as part of a broad educational program, SMBG may help to guide treatment decisions and/or self-management for patients taking less frequent insulin injections B or noninsulin therapies. E

• When prescribing SMBG, ensure that patients receive ongoing instruction and regular evaluation of SMBG technique, SMBG results, and their ability to use SMBG data to adjust therapy. E

Glycemic Targets:
Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S55-S64
DECISION CYCLE FOR PATIENT-CENTRED GLYCAEMIC MANAGEMENT IN TYPE 2 DIABETES

REVIEW AND AGREE ON MANAGEMENT PLAN
- Review management plan
- Mutual agreement on changes
- Ensure agreed modification of therapy is implemented in a timely fashion to avoid clinical inertia
- Decision cycle undertaken regularly (at least once/twice a year)

GOALS OF CARE
- Prevent complications
- Optimise quality of life

ASSESS KEY PATIENT CHARACTERISTICS
- Current lifestyle
- Comorbidities i.e. ASCVD, CKD, HF
- Clinical characteristics i.e. age, HbA1c, weight
- Issues such as motivation and depression
- Cultural and socio-economic context

ONGOING MONITORING AND SUPPORT INCLUDING:
- Emotional well-being
- Check tolerability of medication
- Monitor glycaemic status
- Biofeedback including SMBG, weight, step count, HbA1c, BP, lipids

CONSIDER SPECIFIC FACTORS WHICH IMPACT CHOICE OF TREATMENT
- Individualised HbA1c target
- Impact on weight and hypoglycaemia
- Side effect profile of medication
- Complexity of regimen i.e. frequency, mode of administration
- Choose regimen to optimise adherence and persistence
- Access, cost and availability of medication

IMPLEMENT MANAGEMENT PLAN
- Patients not meeting goals generally should be seen at least every 3 months as long as progress is being made; more frequent contact initially is often desirable for DSMES

SHARE DECISION-MAKING TO CREATE A MANAGEMENT PLAN
- Involves an educated and informed patient (and their family/caregiver)
- Seeks patient preferences
- Effective consultation includes motivational interviewing, goal setting and shared decision-making
- Empowers the patient
- Ensures access to DSMES

AGREE ON MANAGEMENT PLAN
- Specify SMART goals:
  - Specific
  - Measurable
  - Achievable
  - Realistic
  - Time limited

ASCVD = Atherosclerotic Cardiovascular Disease
CKD = Chronic Kidney Disease
HF = Heart Failure
DSMES = Diabetes Self-Management Education and Support
SMBG = Self-Monitored Blood Glucose

ADA/EASD -2018
Educational Activities essential to the management of pathological conditions, managed by health care providers duly trained in the field of education, designed to:

- Help a patient (or a group of patients and their families) to manage their treatment and
- Prevent avoidable complications
- While keeping or improving their quality of life.

- It produces a therapeutic effect additional to that produced by all other interventions
Depicted are patient and disease factors used to determine optimal A1C targets.

**Approach to the Management of Hyperglycemia**

<table>
<thead>
<tr>
<th>Patient / Disease Features</th>
<th>More stringent</th>
<th>Less stringent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risks potentially associated with hypoglycemia and other drug adverse effects</td>
<td>low</td>
<td>high</td>
</tr>
<tr>
<td>Disease duration</td>
<td>newly diagnosed</td>
<td>long-standing</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>long</td>
<td>short</td>
</tr>
<tr>
<td>Important comorbidities</td>
<td>absent</td>
<td>severe</td>
</tr>
<tr>
<td>Established vascular complications</td>
<td>absent</td>
<td>few / mild</td>
</tr>
<tr>
<td>Patient attitude and expected treatment efforts</td>
<td>highly motivated, excellent self-care capabilities</td>
<td>less motivated, poor self-care capabilities</td>
</tr>
<tr>
<td>Resources and support system</td>
<td>readily available</td>
<td>limited</td>
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American Diabetes Association Dia Care 2018;41:S55-S64
Problem – the patient side

“It is difficult to remain an emperor in presence of a physician and difficult even to keep one’s essential quality as man.

The professional eye saw in me only a mass of humors, a sorry mixture of blood and lymph”
Expert patients

"people who have the confidence, skills, information and knowledge to play a central role in the management of life with chronic diseases”
Patient narrative definition

• My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes.

National Voices. A narrative for person-centred coordinated care. 2013
What about Quality of Life?

- In terms of parental QOL, some randomized controlled studies show that diabetes-specific QOL scores do not differ between insulin pump groups and MDI groups, with similar results on parenting stress.

- Interestingly, a small follow-up study to the JDRF trial found that children (8-17 years old) randomized to CGM reported greater anxiety and negative affect around blood glucose monitoring compared to children randomized to standard blood glucose monitoring. Others found that pain, discomfort, problematic equipment, intrusiveness and other hassles as barriers.
WHAT DOES THE PATIENT DO WITH ALL THIS DATA IF THE DOCTOR CANNOT USE IT?

• Health is not about technology; it is about people.
• People here include not just the patient but also the provider workforce.
• If the workforce is not willing to embrace new technology and adapt it to their traditional knowledge of medicine, change will be piecemeal rather than systemic.
• In light of this, a more bottom-up approach was prescribed, where the patient (or citizen) was placed at the centre.
How to cause psychological problems?

- Diagnosis of chronic disease
- Unclear cause but hereditary component
- Treatment important
  - Time consuming and painful
- Management affect life of a family
- Self control and self management importants
- Terrible results of an unwise lifestyle
- Health professionals uncertain about treatment goals and regimes
- Health professionals give contradictory information

Robert Tattersall, 1995
People only change behaviour if they feel connected, if they feel it’s meaningful for them, if they feel some attention and affection !!!
### Chronic Relationship

<table>
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<tr>
<th>Risks</th>
<th>Potentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Get too familiarized with the patient and not be able to promote his Autonomy</td>
<td>Time to:</td>
</tr>
<tr>
<td>- Be paternalist/protector. This can lead to a submissive attitude from the patient</td>
<td>- Establish a Commitment</td>
</tr>
<tr>
<td>- It became easier to make judgments</td>
<td>- Know the person, his family, social context, cultural and religious habits</td>
</tr>
<tr>
<td>- The patient may be inhibited to talk about some concerns or behaviours to avoid the HCP disappointment</td>
<td>- Meet and address the patient’ weaknesses and strengths</td>
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Therapeutic Relationship (also known by *Therapeutic Alliance*)

Refers to the relationship between a Healthcare Professional and a Patient. It presumes a strong **engagement** that result in beneficial change for the patient.
The process where the Healthcare Professional use:

communication techniques and a personalized interaction with a specific person who have a specific disease, taking in account his emotions, cognitions, beliefs, wishes and needs, in order to provide tools that promote and develop his skills, self confidence and autonomy for the disease management.
There are many subtle ways for communicating with others such as:

- Body language
- Gestures
- The tone of voice that can give clues to our mood, emotional state, expectations or opinion.

**COMMUNICATION**

Accurate, Effective and Unambiguous communication is extremely important in a Therapeutic Education process.
Verbal Communication

✓ Listen carefully
✓ Use open questions

Notice that towards an open question, people tend to give a 32 seconds to 2 minutes answer, but the HCP’s interrupt them in-between 18 / 23 seconds

✓ Practice positive unconditional acceptance
✓ Access to what the person already knows and be sure on what the person wants to know
✓ Then provide the adequate amount of information

Notice that 13% only wants to know practice information; 47%, additional information and just 40% wish to receive all the information about his disease.
For a successful **Therapeutic Education** process, the HCP must use some competencies such as:

- **Empathic comprehension** (accept the differences in others)
- **Authenticity** (congruent with the attitude)
- **Emotional Maturity** (decentralize from ourselves and question your own ideas)
- **Self awareness** (be aware of countertransference that may occur)
For a successful **Therapeutic Education** process, the HCP must (also) approach the patient in a **multidisciplinary team**:

- Consider the patient in the centre of multidisciplinary team
- Be careful with the person’s privacy
- Inside the multidisciplinary team there are different relationships, none is more important than others, but each one is unique
- Sharing decisions (what?! / When?!/ with whom?! )
Therapeutic Education approach considers:

- General Expectations
- Illness Perception
- Health Beliefs
- Coping Strategies
- Social and Family Involvement
- Economic Cultural and Religious Context
- Acceptance phase of the disease
Psychological Acceptance phases of the disease:

- Shock
- Denial
- Revolt
- Negotiation
- Sadness / Depression
- Acceptance
Therapeutic Education

- General Expectations
- Illness Perception
- Health Beliefs
- Coping Strategies
- Social and Family Involvement
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... and....

- Motivation degree for each Behaviour change
Transtheoretical Model's stages of change

`assess the stage of a client's readiness for change and to tailor interventions accordingly` [(Prochaska et al., 1992)](http://example.com)
**Precontemplation stage**: No intention to change behaviour in the foreseeable future. Many people at this stage are unaware of their problems.

**Contemplation stage**: Aware of problem, seriously thinking of overcoming it, not yet taken action or made any preparations.

She / He is AMBIVALENT

MOTIVATIONAL INTERVIEW
Motivational Interviewing

A form of collaborative conversation for strengthening a person's own motivation and commitment to change toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of **acceptance and compassion**

It is a **person-centered counselling style** for addressing the common problem of **ambivalence** about change by paying particular attention to the language of change.

**Motivational Interviewing technics:**

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self efficacy
“assess the stage of a client’s readiness for change and to tailor interventions accordingly” [(Prochaska et al., 1992)]
**Preparation stage**: The individuals have decided to take action in the next month and have been unsuccessful in taking action in the past year.

**Action stage**: The individual actually changes his/her behaviour.

**Maintenance stage**: The individual is attempting to maintain the behaviour change by working to prevent relapse. In addition, the action and maintenance stages have strict time frames, in that people are described as being in the action stage if they have changed their behaviour for a period of 1 day to 6 months and as being in the maintenance stage if they have changed their behaviour for more than 6 months.
Let’s get Practical:

• But, above all, we, Healthcare Professionals, have to meet the real person **NOT** the person we think he is

Avoid prejudgements !!!
It takes 7 seconds to build a prejudice based on someone's appearance.
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Thank you!
Merci!
Obrigado!
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