HEALTH TAPESTRY

Perspectives from volunteer “health connectors” on goal setting and implementation in a multi-component intervention for supporting patient self-management of chronic conditions

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Introduction

- In the **Health TAPESTRY approach**, used in varied projects and with varied populations, trained volunteers connect with clients
- In **Health TAPESTRY-HC-DM (Health Connectors for Diabetes Management)**, volunteer "Health Connectors" help clients with **goal setting & behaviour change**
- This presentation was **co-created with two volunteer Health Connectors**

The Health TAPESTRY Approach

AIM

To help people stay healthier for longer in the places where they live, using an interprofessional primary health and social care delivery approach **centred on meeting a person's health goals and needs.**

Health TAPESTRY-HC-DM

Health TAPESTRY-HC-DM is a motivational, educational **self-directed** approach where volunteer health connectors and technology help to strengthen connections between:

- Individuals (patients)
- Activated interprofessional primary care teams,
- & a personalized set of community activities and resources

to support self-management and coordinated care for diabetes and health in general.

Goals & Behaviour Change in TAP-HC-DM

- The program worked from patients' prioritized health goals and needs
- **Purpose:** to build capacity for chronic condition self-management
- Volunteer health connectors, with technology and interprofessional teams, supported patients in:
  - Setting SMART goals
  - Goal attainment

The Client Population

- 18+, diagnosed with diabetes and hypertension
- From 2 clinics of the McMaster FHT

- "Falling through the cracks" in terms of diabetes self-management – at least one of:
  - Uncontrolled A1C (10 or higher)
  - Newly diagnosed with diabetes (last 6 months)
  - End-stage organ damage/other complications of diabetes (e.g. renal dysfunction, diabetic neuropathy])
  - Doctor referral/recommendation

Volunteer Health Connectors

- Community members – *not health professionals as part of this role*
- Ranged in age from 19-63
- Backgrounds include:
  - Undergraduate health students (n=10)
  - Advanced degrees or graduate students (n=6)
  - Personal/family experience with diabetes (n=3)
  - Foreign-trained health professionals (n=2)
  - Working or retired local professionals (n=2)

The Intervention

1) **e-Health Technology** - self-directed client use of the *Health TAPESTRY Healthy Lifestyle App* , and *kindredPHR* (Personal Health Record)
    - Healthy Lifestyle App includes modules on Diabetes, Hypertension, Sleep, Exercise, Medications, Nutrition, and Goals

2) Volunteer 'Health Connectors'

- Connecting through home visits, phone calls or kindredPHR messages

- Providing motivation, resources, tech support, and connections to community programs

The Intervention

3) Inter-professional Teams – reports created by App modules will go back to 'Huddle' teams within each clinic which include a variety of health providers

- E.g. Family doctors, pharmacists, occupational therapists, nurse practitioners, system navigators, dietitians

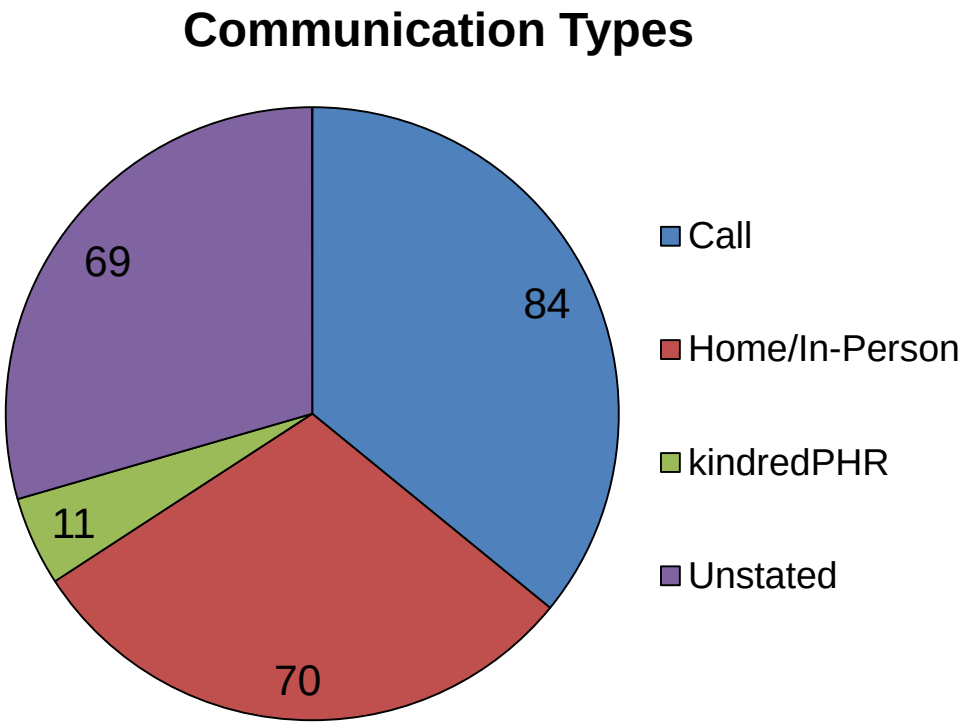
4) Community Engagement – through connection with volunteer coordination partner agency, and to the clients through volunteer or clinic recommendations

Volunteer Training

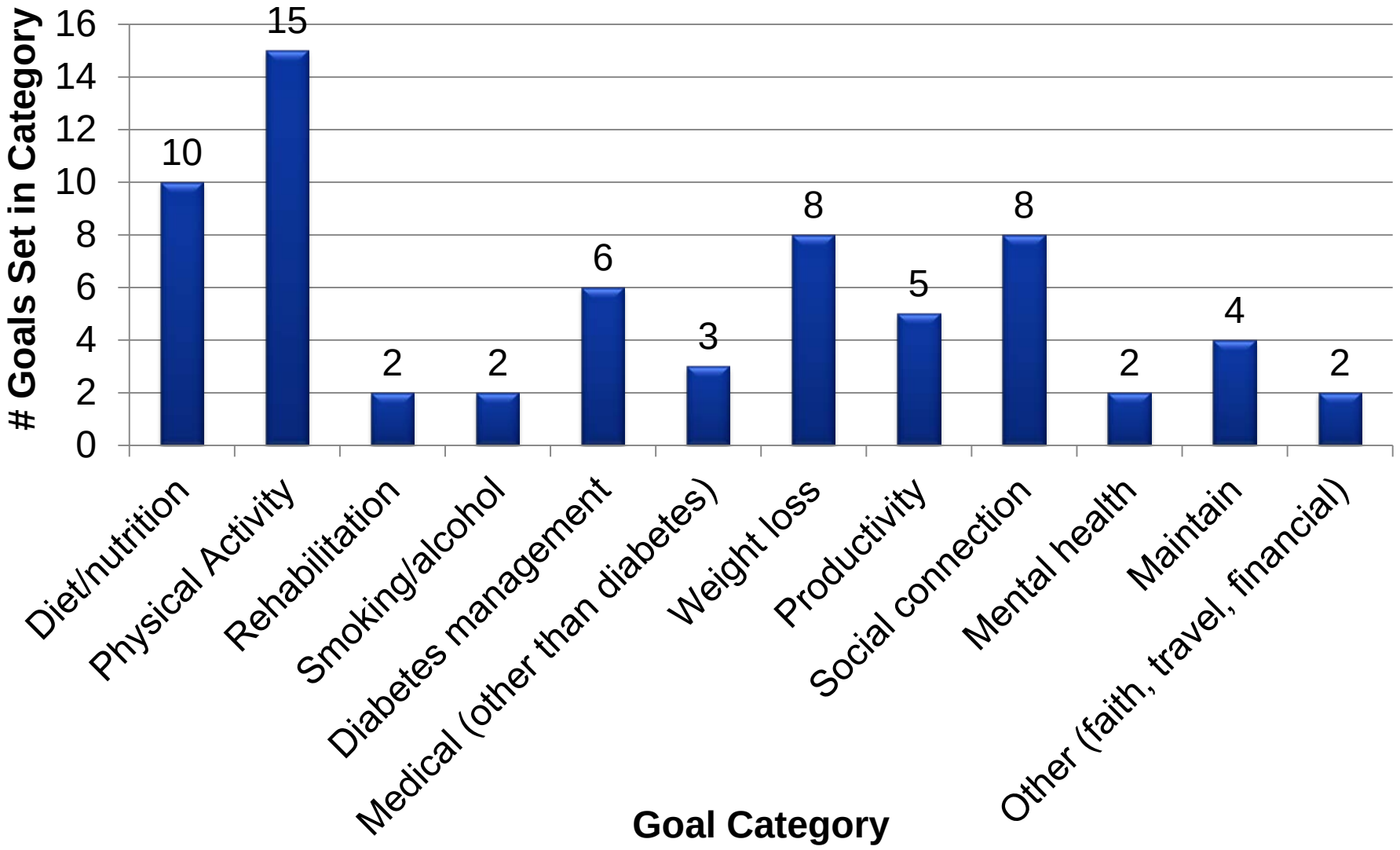
- *Multi-modal:* in-person, online, paper manual
- Featured topics relevant to goal setting and behaviour change for clients with multiple diagnoses, e.g.:
  - Motivational interviewing
  - Diabetes
  - Hypertension
  - Health promotion & disease prevention
  - Stages of change

Client Communications by Volunteers

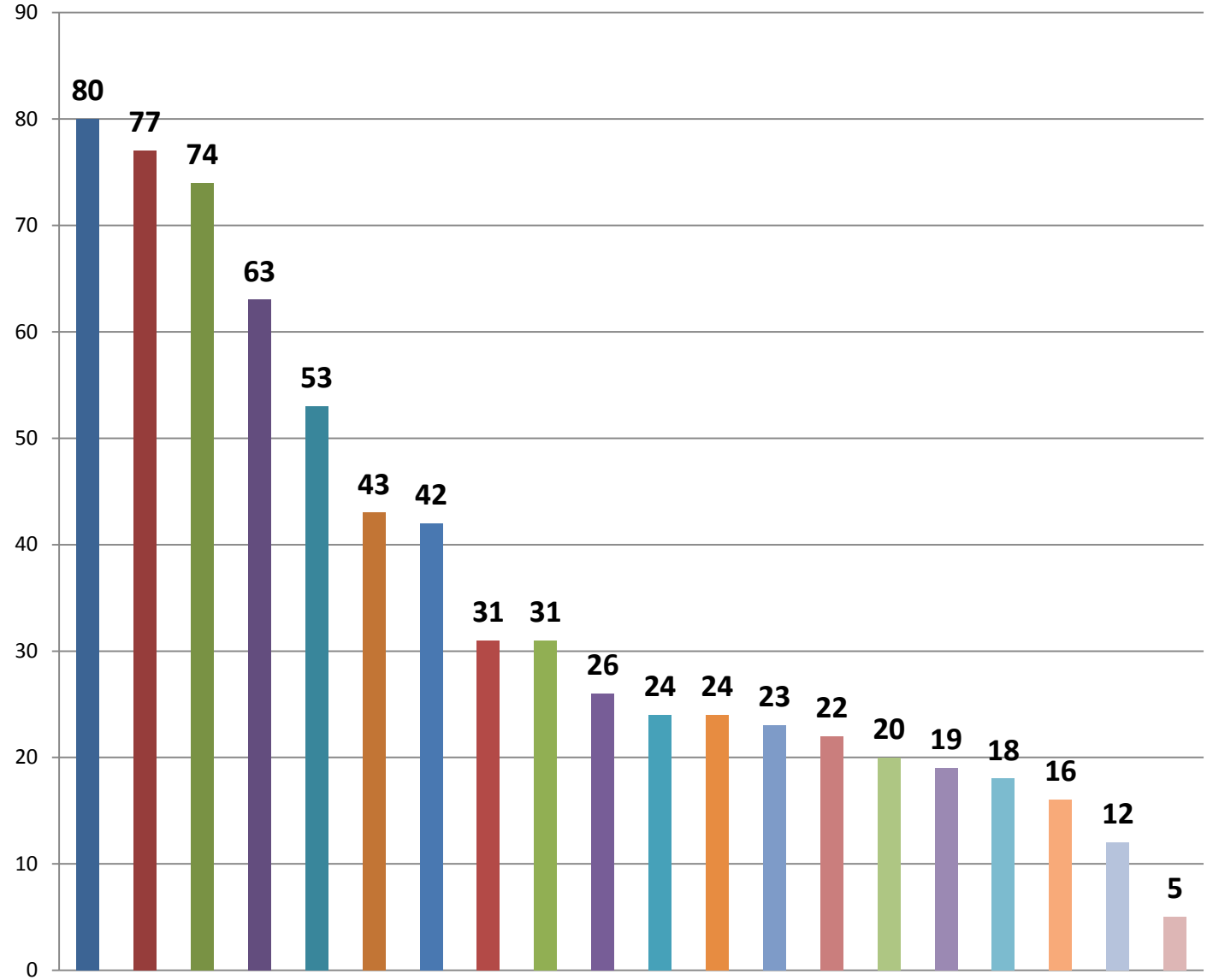
- From March-November 2016, there were 234 client communications conducted by 20 volunteers to 28 clients
  - 84 calls
  - 70 home/in-person visits
  - 11 online messages via kindredPHR
  - 69 unstated types



Goals Set *(Total Goals Set with Volunteers: 67)*



Narrative Content (n=198)*



- Exercise
- DM management
- Technology
- Goals & motivation
- Diet/nutrition
- Connections
- Other health issues
- Medications
- Social
- Healthcare team
- Pain
- Scheduling
- Productivity
- Sleep & energy
- Other
- Blood pressure
- Weight loss
- Mental, emotional
- Life story
- Alcohol, smoking

*22 narratives described being unable to reach client

Goal Attainment

- **Outcome Measure:** Goal Attainment Scaling (GAS);
  - score ranges from -10 to 110 across top 3 goals,
  - based on response option scores for each question of +2/+1/0/-1/-2

- **Findings:**
  - Four month mean score higher in intervention than control (7.50 [7.92] difference)

Clients' Stories

- Goal setting was particularly meaningful to some clients, for example:
  - **"Client 8"**– goals of healthier eating, reducing blood sugar, strengthening legs through exercise, weight loss
  - **"Client 18"** – goals of walking, increasing fruit/vegetable intake & decreasing meat/bread/junk food, slow & healthy weight loss

Client Readiness to Change

- Volunteers noted: not all clients seemed ready to change
- In fact, most clients self-reported as already in action/maintenance stages of change at the beginning of the study
  - *1.84 (0.77) on 1-5 scale of stages of change (lower indicates more readiness)*
- The 4 month timing also could be seen as relatively short for change, but longer could result in difficulties retaining more complex clients

Volunteer Perspectives on Goal Setting & Behaviour Change

- Volunteers **followed up** on goal setting, **motivated** clients *(22 references)*
- Some barriers to goal setting and change:
  - Volunteers described some frustration in ability to fully change client behaviour – only able to follow up *(8)*
  - Some needs beyond volunteer scope *(14),* e.g.
    - Medical issues beyond diabetes/hypertension
    - Specifically clinical issues
    - Going out into community beyond client's home

Value or benefits of the program to clients

- Volunteers **build rapport** with patients, support them in their health changes and goal setting *(11 references)*
- **Reminder** or reflective process for clients to think about their health *(11)*
- Gain more resources for health management *(8)*
- Gain knowledge about diabetes and hypertension *(6)*

Impacts of the Program on Clients… *(1/2)*

- Learning more about lifestyle changes and making those changes *(17 references)*
- Improved understanding of diabetes care (e.g. blood sugar, medications, complications) *(16)*
- Communication between client and clinic is more open *(6)*

Impacts of the Program on Clients *(continued)*

- Learning of & joining community programs (6)
- New knowledge of what's available at clinic (6)
- No impact on diabetes management (7)
- No change in working with clinic (7)

Conclusion

- **Goal attainment is difficult!**

- A regular, motivating follow up **could still help** in goal attainment and could potentially lead to lasting behaviour change

- Volunteers experience similar tensions as health care professionals in the difficulties of managing clients with multiple chronic conditions
  - Focus on *individual, client-set goals* could help by working with what matters most to that person

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QUESTIONS?

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