GET BETTER TOGETHER:
Building Capacity for Chronic Disease Self-Management

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History and background

Seven Oaks General Hospital – established in 1980 with the included mandate of preventing illness.

Joseph Zuken Fitness Centre in basement led to awareness of potential for a comprehensive wellness facility.

Needs study and tour of US facilities, assisted by the Medical Fitness Association
Wellness opens October, 1996

- 80,000 square foot facility
- Self-supporting department of Seven Oaks Hospital
- Exercise equipment and classes
- Health education space and programming
- Rehab Clinic and work injury management program

NOT JUST A GYM: The Elements of Medical Fitness

- Medically supervised
- Degreed, certified staff
- Clinically integrated programs
- Mediated physical activity
- Risk Reduction focus
- Primary and secondary prevention
- Experts in behaviour change theory
Not everyone has the same idea about what wellness should be …

The WELLNESS Mission

**MISSION:** a state-of-the-art medical fitness facility dedicated to improving the health status of the community through health promotion, disease prevention, and rehabilitation services.

**VISION:** to lead a shift toward illness prevention and wellness in the health care system and to inspire members of our community, particularly those deconditioned by illness, injury or inactivity, to adopt healthy lifestyles and learn to be well.
The Shape of Canada

- Aging and Health Challenged Population
- Obesity Epidemic
- Unhealthy lifestyles related to behaviour, built environment, working conditions

### Prevalence of Chronic Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>65+ (%)</th>
<th>30-64 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis/Rheumatism</td>
<td>47.3*</td>
<td>16.6</td>
</tr>
<tr>
<td>Back problems</td>
<td>24.1*</td>
<td>22.7</td>
</tr>
<tr>
<td>Heart disease</td>
<td>19.8*</td>
<td>3.5</td>
</tr>
<tr>
<td>Diabetes</td>
<td>13.5*</td>
<td>4.4</td>
</tr>
<tr>
<td>Thyroid condition</td>
<td>12.9*</td>
<td>5.9</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>10.7*</td>
<td>2.3</td>
</tr>
<tr>
<td>Asthma</td>
<td>7.6</td>
<td>7.3</td>
</tr>
<tr>
<td>COPD</td>
<td>7.4*</td>
<td>3.1</td>
</tr>
<tr>
<td>Mental illness</td>
<td>6.1</td>
<td>8.8*</td>
</tr>
<tr>
<td>Cancer</td>
<td>5.5*</td>
<td>1.4</td>
</tr>
</tbody>
</table>

**Data source:** 2003 Canadian Community Health Survey

**Note:** Based on self-reports from a checklist of diagnosed conditions. *Significantly higher than estimate for other age group (p<0.05).
**Number of Chronic Conditions**

Percentage distribution of household population aged 30 or older, by number of chronic conditions and age group, Canada, 2003

*Data source: 2003 Canadian Community Health Survey  Note: Based on self-reports from a checklist of diagnosed conditions. *Significantly different from estimate from 30-to-64 age group (p<0.05).*

**Prevalence of Obesity in Canada**

Nutrition: Findings from the Canadian Community Health Survey – Adult Obesity in Canada: Measured Height and Weight. Ottawa, ON: Statistics Canada, 2004
# Heart & Stroke Foundation Report on Baby Boomers

<table>
<thead>
<tr>
<th>Lifestyle Risk Factor</th>
<th>The Bad News About Baby Boomers:</th>
<th>Compared to today’s seniors Boomers are in worse shape</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A Decade Ago*</td>
<td>vs. Today**</td>
</tr>
<tr>
<td>Sedentary Lifestyle/Physical Inactivity</td>
<td>43%</td>
<td>52%</td>
</tr>
<tr>
<td>Obesity (BMI &gt;30 kg/m²)</td>
<td>19%</td>
<td>30%</td>
</tr>
<tr>
<td>Regular or Daily Smoker</td>
<td>29%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11%</td>
</tr>
</tbody>
</table>

*A Results from Canadian Heart Health Survey (1986-1992) for adults 35-49. Body Mass Index (BMI) was measured at special clinics. “Sedentary lifestyle” defined as not being physically active during leisure time at least once a week during preceding month.

**Results from Canadian Community Health Survey (2003/04) for adults 45-59. BMI measured during Cycle 2.2 of survey and rate is for age 45-54. Inactivity defined as less than 1.5 kcal/day of physical activity, based on self-report of frequency, duration and intensity of leisure-time physical activity.

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# Causes of Unhealthy Lifestyles

![Image of human evolution](image)
Caloric Intake (per Person/Year)

1970
- Protein: 588 lb
- Vegetables: 1,396 lb
- Fruits: 241 lb
- Grains: 1,136 lb
- Carbohydrates: 1,497 pounds

2000
- Protein: 621 lb
- Vegetables: 425 lb
- Fruits: 260 lb
- Grains: 206 lb
- Carbohydrates: 1,775 pounds

Eating more of everything:
- Carbohydrates (fruits, grains, sugars, and vegetables)
Energy Expenditure

<table>
<thead>
<tr>
<th>Activity</th>
<th>Calories burned</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-mail colleague (1 min)</td>
<td>2</td>
</tr>
<tr>
<td>Ride elevator (2 mins)</td>
<td>3</td>
</tr>
<tr>
<td>Order take-out (1 min)</td>
<td>1</td>
</tr>
<tr>
<td>Load dishwasher (10 mins)</td>
<td>23</td>
</tr>
<tr>
<td>Watch TV</td>
<td>35</td>
</tr>
<tr>
<td>Go to car wash</td>
<td>35</td>
</tr>
<tr>
<td>Play video game</td>
<td>53</td>
</tr>
<tr>
<td>Mow lawn/riding mower</td>
<td>88</td>
</tr>
<tr>
<td>Walk to colleague’s office (1 min)</td>
<td>4</td>
</tr>
<tr>
<td>Take stairs (2 mins)</td>
<td>19</td>
</tr>
<tr>
<td>Cook meal</td>
<td>70</td>
</tr>
<tr>
<td>Wash dishes</td>
<td>80</td>
</tr>
<tr>
<td>Play cards</td>
<td>52</td>
</tr>
<tr>
<td>Wash car at home</td>
<td>104</td>
</tr>
<tr>
<td>Play basketball</td>
<td>280</td>
</tr>
<tr>
<td>Mow lawn/power mower</td>
<td>193</td>
</tr>
</tbody>
</table>

Percent of Americans

- Drive to work
- Take public transportation to work
- Walk to work

1960 1980 2000

Calories burned

- Drive to work: 100
- Take public transportation to work: 60
- Walk to work: 20
- 1960: 100
- 1980: 60
- 2000: 20
Outreach and community animation

Leadership in healthcare

CREATE CHANGE:
A Brief Intervention For Health Behaviour Change

What The Busy Health Professional Needs To Know

Steve Holt, Ph.D., C. Psych.

Wellness Institute at St. Joseph’s Healthcare Hamilton

1075 King St. West, Hamilton, ON L8S 2X2
(905) 526-6611

Behaviour Change training for health professionals

Older Adult Conference
Risk Reduction Clinic
Screening for Metabolic Syndrome
ALCOA partnership
Wellness 10 years later

- 5500+ Members
- 350,000 visits per year
- 475 Cardiac Rehab patients per year
- Integrative approaches to CDM (e.g. Pulm. Rehab)
- 3900 Health Education participants
- Busy physiotherapy and rehab clinic
- Growing Business Health Services component and Health Risk Assessment

Our Successes

- Self-sustaining
- Ability to renew and stay competitive
- Exceeding industry benchmarks
- Reaching the target high risk population
- Achieving Improved health status and behaviour
- Awards (Top 100, MFA)

Individual success stories
Wellness Success Stories

Wellness Success Story: Freedom from "Prison"

In September of 2006, at the age of 70, Ben Karasick started at the Wellness Institute. He arrived with a weight of 296 pounds, a BMI of 45, and a diagnosis of hypertension. Despite his size, Ben was determined to make a change for his health.

Ben started his wellness journey with a focus on exercise and healthy eating. He began walking one mile each day, gradually increasing the distance. In just two months, he had lost 20 pounds. His progress motivated him to continue, and he set a goal of walking 10,000 steps per day.

Ben also began to pay attention to his diet. He eliminated sugary snacks and cooked more meals at home. His wife, Carol, supported him throughout his journey, helping him find healthy alternatives to his favorite foods. Within six months, Ben had lost a total of 80 pounds.

Today, Ben walks three miles each day and maintains a weight of 216 pounds. His story is a testament to the power of dedication and support. "I feel like I've been given a new lease on life," he says. "I'm healthier, fitter, and happier than ever before." Ben encourages others to take charge of their health and make changes that can improve their quality of life.

Tips for Keeping Your: Healthy, well-thy & wise

1. Start with small steps. Even if it’s just a 10-minute walk, it’s a start.
2. Choose foods that are good for your heart. Focus on whole grains, lean proteins, and lots of vegetables.
3. Stay hydrated. Drink plenty of water throughout the day.
4. Get enough sleep. Aim for 7-9 hours per night.
5. Connect with others. Reach out to friends and family for support.

Media response and messaging

Wellness Institute

Get better together with peers and program

Grant expands testing program

Healthy, well-thy & wise

Georgia’s Wellness Resource: a lot of value in a lot of people. And most, it’s a prescription for better living.
Gaps and opportunities

- Primary Care struggling with CDM
- Need for other practitioners, not just docs + nurses
- Limits of social marketing
- Gap between lifestyle prescription and follow through
- Can we bring Wellness to the community?

Best Practices CDM and Prevention

- Need for a portable, sustainable best practices model for addressing CDM and prevention
- Stanford’s Chronic Disease Self-Management model seemed to encapsulate what WI had been learning about motivation.
Chronic Disease Self-Management Program

- Chronic Disease Self-Management Program (CDSMP) was developed at Stanford University Patient Education Research Center.
- Developed as a collaborative research project between Stanford and the Northern California Kaiser Permanente Medical Care Program.
- Goal: decrease care costs & prevent further chronic disease by increasing self-management behaviours.

Get Better Together: CDSMP in Manitoba

- CDSMP/Get Better Together is a workshop given in 2 ½ hours, once a week, for 6 weeks
- People with different chronic health problems attend the program together in community settings.
- Workshops are facilitated from a highly detailed manual by two trained leaders, one or both of whom are peers with a chronic health condition themselves.
Peer Leadership

When a program was delivered by health professionals, participants LEARNED more. When delivered by peer leaders, participants DID more to change their lifestyle.

Role of GBT! Groups in Health Care

- Highly participative with self-efficacy as the goal
- Not a replacement for disease-specific education
- Particularly effective if more than 1 condition
- Allows primary health practitioner focus to be on assessment & treatment work within their parameters (time constraints, etc.)
Program Evaluation

Stanford did a randomized controlled trial (n=1,000)

- Results:
  - Fewer days in hospital.
  - Trend towards fewer outpatient visits and hospitalizations.
  - Decreases in health distress, fatigue, disability, and social role & activity limitations.
  - Improvements in exercise, self reported general health, cognitive symptom management, & communication.

Process for Building Self-efficacy

It is the process in which CDSMP is taught that makes it effective:

- Mutual support and success builds the participants’ confidence in their ability to manage their health and maintain active fulfilling lives.
  - Action planning – small, achievable weekly goals with confidence interval built in.
  - Feedback & problem-solving
  - Brainstorming
  - Problem-solving steps
CDSMP in Canada

- Shown to be effective in diverse populations, including inner city minority populations in large US centers.

- Canadian trainers report similar effectiveness in Canada, including large centers, rural areas & Aboriginal communities.
  - BC 1992, ASMP (precursor to CDSMP) - significant improvements in health status, pain, disability, depression & self-efficacy to manage symptoms.

Diabetes vs. Chronic Disease results in Canada

BC – Used pre- & 6-month post comparison design

- DSMP: Statistically significant improvement in communication with physicians, self-efficacy self-reported health, medication compliance, less pain & distress, & a trend toward decreased health care utilization.

- CDSMP: 3 years of program evaluation, same improvements.
Tools for Self-Management

Subjects covered include:
- Techniques to deal with problems such as frustration, fatigue, pain and isolation
- Appropriate exercise for maintaining and improving strength, flexibility and endurance.
- Healthy nutrition
- Appropriate use of medications
- Communicating effectively with family, friends, and health professionals
- Making informed treatment decisions

Get Better Together Delivery Model

Stanford University

Master Trainers

Train Peer Leaders  Deliver Courses

Deliver Courses
Get Better Together History

- Researched best practices for Chronic Disease Mgmt.
- Started training staff (at Stanford) and developing proposal in 2004
- Funding by Wellness Institute, WRHA and Winnipeg Foundation

In kind partnerships with Primary Care Clinics:
- Hope Centre
- 601 Aikins
- ACCESS River East
- McPhillips Medical Group
- Mount Carmel Clinic
- Youville Centre
- Klinic CHC

CDSMP Pilot Deliverables

- Up to 240 Participants
- Up to 60 Trained Leaders
- 15 Workshops
- 5 Leader Training Sessions
- Evaluation of efficacy of the program in diverse communities across Winnipeg.
- Operational and sustainability plan
Winnipeg Program Evaluation

3-Phase pilot Interim Report (Aug. '06)
- 8 sessions in 7 clinics
- At outset participants self-rated health was poorer than Stanford study
- By week 6, participants improved communication with physicians & amount of time spent exercising; improvements in time walking, self-efficacy, & use of cognitive symptom management techniques reached statistical significance.

Tracking Results

- Community Clinics
- Volunteer Leaders
- Participant feedback:

“This program has helped me out of a depressed slump I was in. Everyone is shocked to see how well I’m doing now.“
-ACCESS River East participant

“I usually come to programs but don’t stay the whole time. This one made me want to stay and do more.”
-Hope Centre participant & Peer Leader
Underpinning Research on Self-management & self-efficacy

- Behaviour change research shows that importance & confidence are the necessary ingredients for lasting behaviour change
- Odds of becoming ready to make a change can be boosted by health practitioner behaviours, but we cannot cause or create a change in our clients

Role of Self-Management Programming for Participants

- Group self-management –self-help allows people a facilitated process to support them through what they really have to do on their own
  - Grieve & come to terms, accept, problem-solve, plan & continue processing
  - Make choices about what they are ready, willing & able to do about it
## Reasons People Change

### Relevance (Personal Importance)
- People change for **personally relevant reasons** that matter & make sense to them

### Risks
- People change to avoid perceived risks that matter to them

### Rewards
- People change in order to achieve a beneficial outcome that is important to them

## Reasons People Change

### Roadblocks
- The odds are greater of making a change if the roadblocks / barriers / obstacles seem manageable

### Repetition
- The odds of change are greater if people are frequently confronted with their reasons to change
EPE

- Elicit, Provide, Elicit — when giving information, ask what they want, provide answers, ask what they want to do next with the info.
- Ask questions like:
  “Does this make sense for you?”
  “How would this fit in your life?”

Information Exchange After Assessment

FRAMES

Feedback — provide personally relevant assessment
Responsibility — changing is their personal responsibility & their choice
Advice — ideas, suggestions of what it seems might help, others’ successful experiences
Menu of Options — brainstorm & lay out options
Empathy — validate emotions, challenges & hard work
Self-Efficacy — Confidence level
Emily’s introduction to GBT!

- Received letter
- Felt in a rut
- Decided to try it once
- Group setting
- Small steps
- Support from facilitators
  - non-judgmental
  - Had “been there”

Symptom Cycle

Disease

Fatigue
Shortness of Breath
Depression
Difficult Emotions

Vicious Cycle

Tense Muscles
Pain
Stress / Anxiety
Parts of An Action Plan

1. Something YOU want to do
2. Achievable
3. Action specific
4. Answers the questions:
   - What
   - How much
   - When
   - How often
5. Confidence level of 7 or more

Personal Benefits Since

- Taking an Aquasize class
- Joined Diabetes support group
- Dietician
- Compliments from Doctor
GBT! Peer Leader & Spokesperson

Direction and Vision:
Continuing to Build Community Capacity

Get Better Together continues in Winnipeg region and expands to other RHA’s with WI as a provincial hub for CDSMP/Get Better

- Master Training and support
- Leader Training and support
- Program administration and evaluation
- Materials and licensing

SO that communities can create and sustain their own GBT!