Engaging Family Supporters to Improve Diabetes Care: The VA CO-IMPACT Randomized Trial and Clinician Toolkit

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Caring for Complex Chronic Conditions Research Center

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Center for Health Equity Research and Promotion
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Veteran and Care Partner Participants

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Overview

Why focus on family supporters (‘Care Partners’) in diabetes and other chronic condition care?

Co-IMPACT Program, Randomized Trial

Qualitative feedback from participants

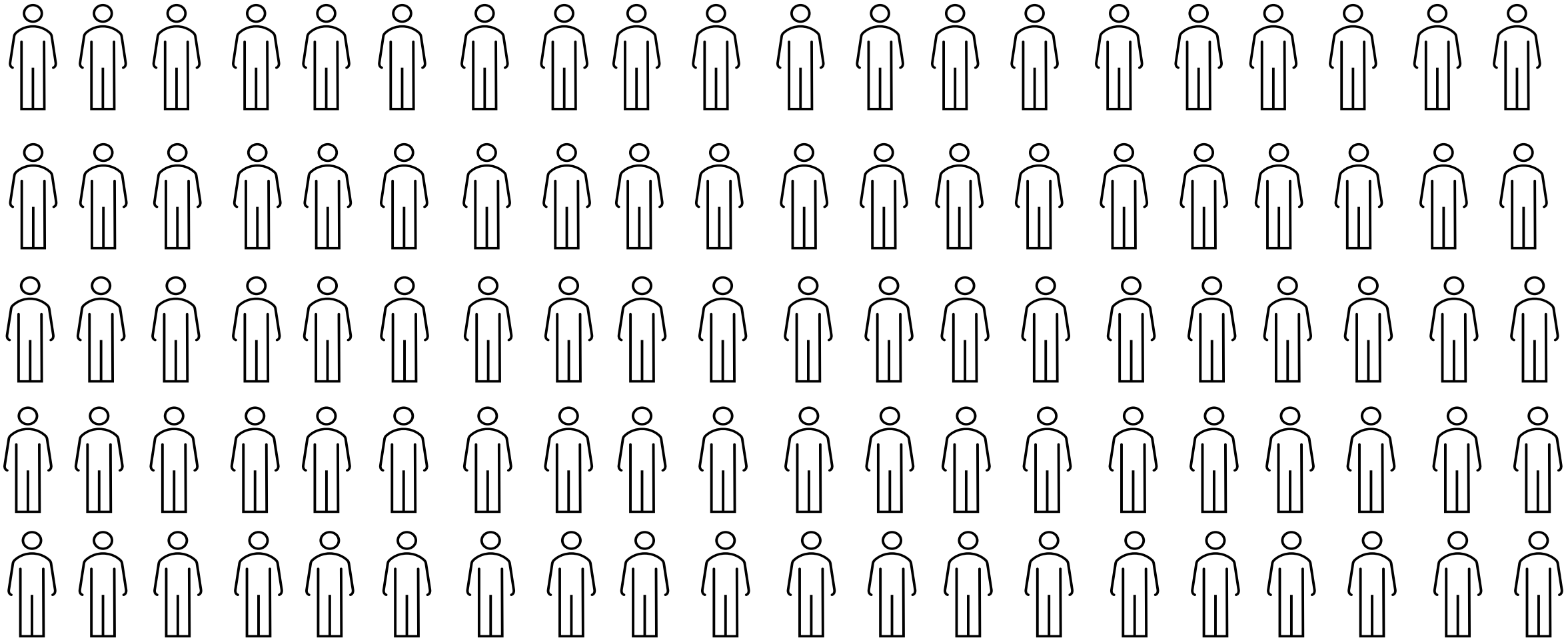
CO-IMPACT Dissemination extension efforts

Poll

What is your primary role in VA?

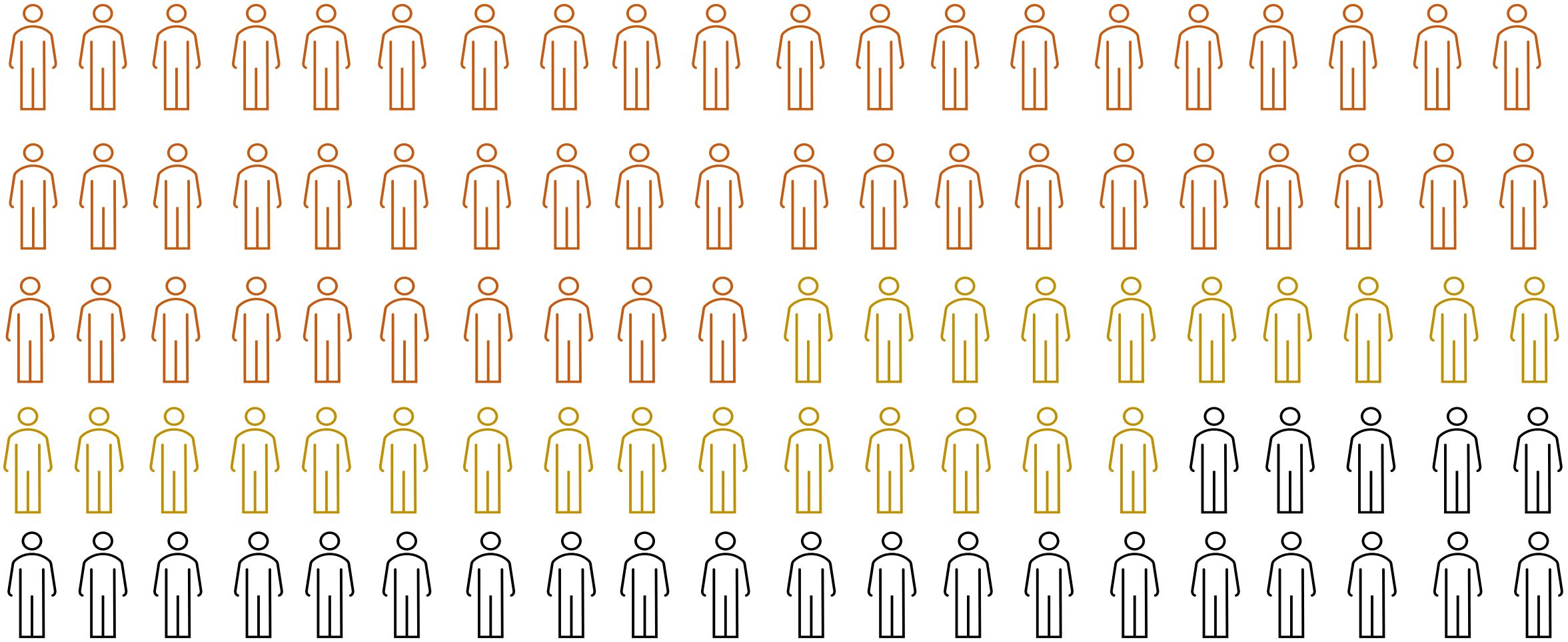
- Clinical / patient care
- Caregiver support
- Operations or administrative
- Research
- Student/Trainee
- Other

Focus on Care Partners



% Functionally Independent Adults Getting Regular Help with Diabetes Management from Family

Rosland 2013; Rosland 2010; Sayers 2008; Silliman 1996; Connell 1991



50-75% Functionally Independent Adults Get Regular Help with Diabetes Management from Family

Rosland 2013; Rosland 2010; Sayers 2008; Silliman 1996; Connell 1991

In Chronic Condition Care, Family Support…

- Making day-to-day decisions about self-care or illness care
- Checking sugar or blood pressure at home
- Managing and using medications
- Tracking clinician recommendations and sending to other providers
- Health system navigation

Accommodate

Listen

Support Decision Making

Motivate

Encourage

Problem Solve

Remind

Facilitate

Which Adults with Chronic Conditions Receive Support?

About half of involved family members live **outside** the patient's home.

Patients with low health literacy, multiple comorbidities, and comorbid depression **involve family in care more often.**

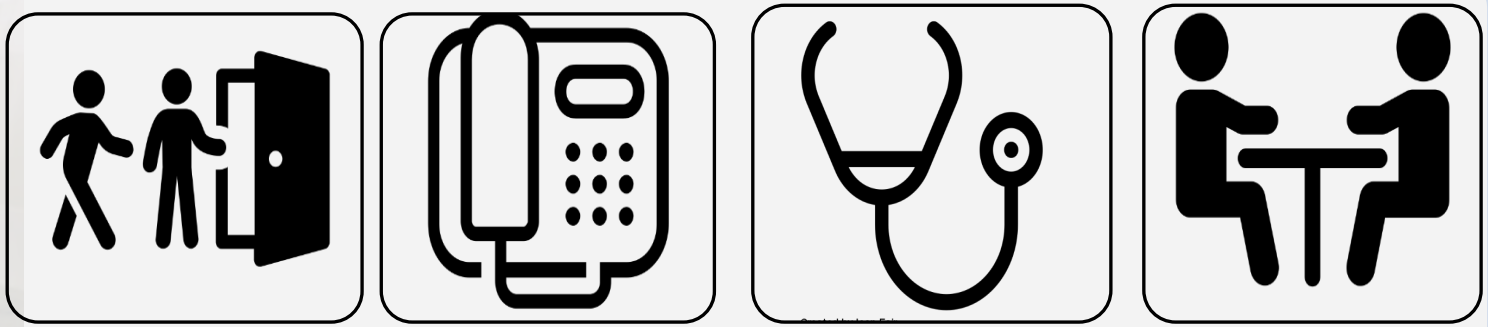
Mayberry 2014, Janevic, Rosland 2013; Rosland 2011; Wolff 2008; Glasser 2001; Silliman 1996

Family Discussions About Diabetes Health Care

When you talk with your care recipient about their health, they mention that they… (% sometimes or more)	**N=947**
Have "bothersome symptoms"	670 (72.2%)
Should do more to stay healthy ("such as lose weight, exercise, or stop smoking")	510 (55.1%)
Are concerned about medication side effects	433 (46.8%)
Are having trouble paying for medications or health care	287 (31.0%)
Are not getting support they need to manage health problems	279 (30.2%)
Are confused about health care provider instructions	259 (28.0%)

Rosland et al, Family Systems Health, 2012

Family Impact on Diabetes Health Care



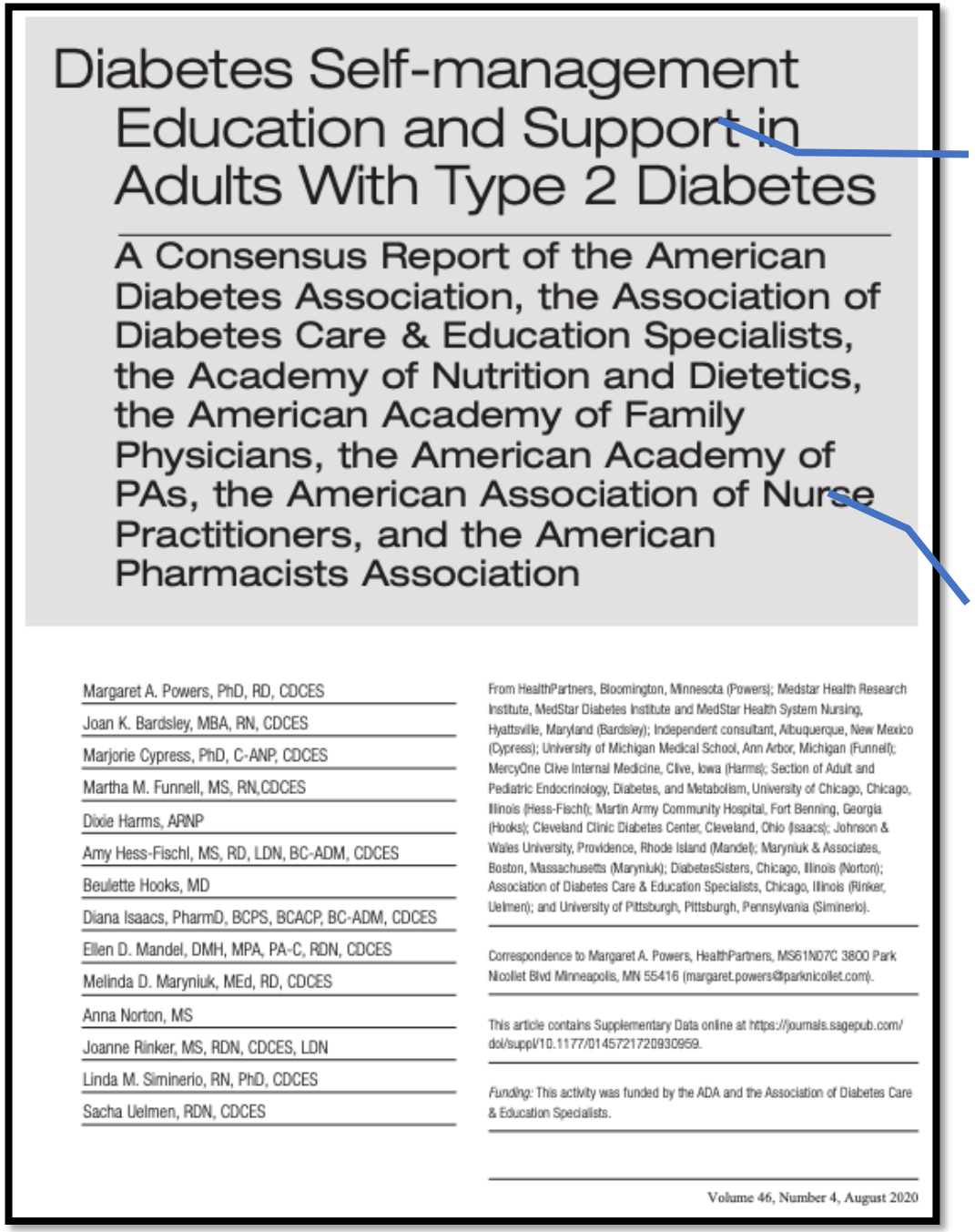
50% of adults with chronic conditions regularly bring family members into primary care visits

25% talked on phone with patient's clinical team in the last year

61% of Veterans with uncontrolled diabetes had a family member who regularly helped them prepare for medical visits

70% regularly discussed the medical visit with a family member afterwards (debriefing)

Rosland 2013; Rosland 2010; Wolff 2010; Wolff 2008



Diabetes Self-management Education and Support in Adults With Type 2 Diabetes

A Consensus Report of the American Diabetes Association, the Association of Diabetes Care & Education Specialists, the Academy of Nutrition and Dietetics, the American Academy of Family Physicians, the American Academy of PAs, the American Association of Nurse Practitioners, and the American Pharmacists Association

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DIAGNOSIS

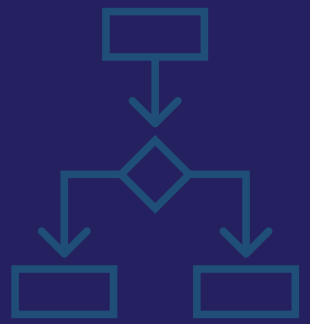
"**Involving family members and/or significant others in ongoing education and support** is a key part of the process."

EDUCATION

"**Family members and peers are an underutilized resource for ongoing support and often struggle with how to best provide help.** Including family members in the DSMES process can help facilitate their involvement. Such support people can be especially helpful and serve as cultural navigators in health care systems and as liaisons to the community. "

What Do Care Partners Need to Have More Impact?

- Information about diabetes
- Information about the patient's diabetes regimen
- How to help with 'skilled' diabetes care tasks
- How to encourage patient positively and avoid (inadvertent) barriers
- How to communicate with healthcare team and help patients participate actively in health care

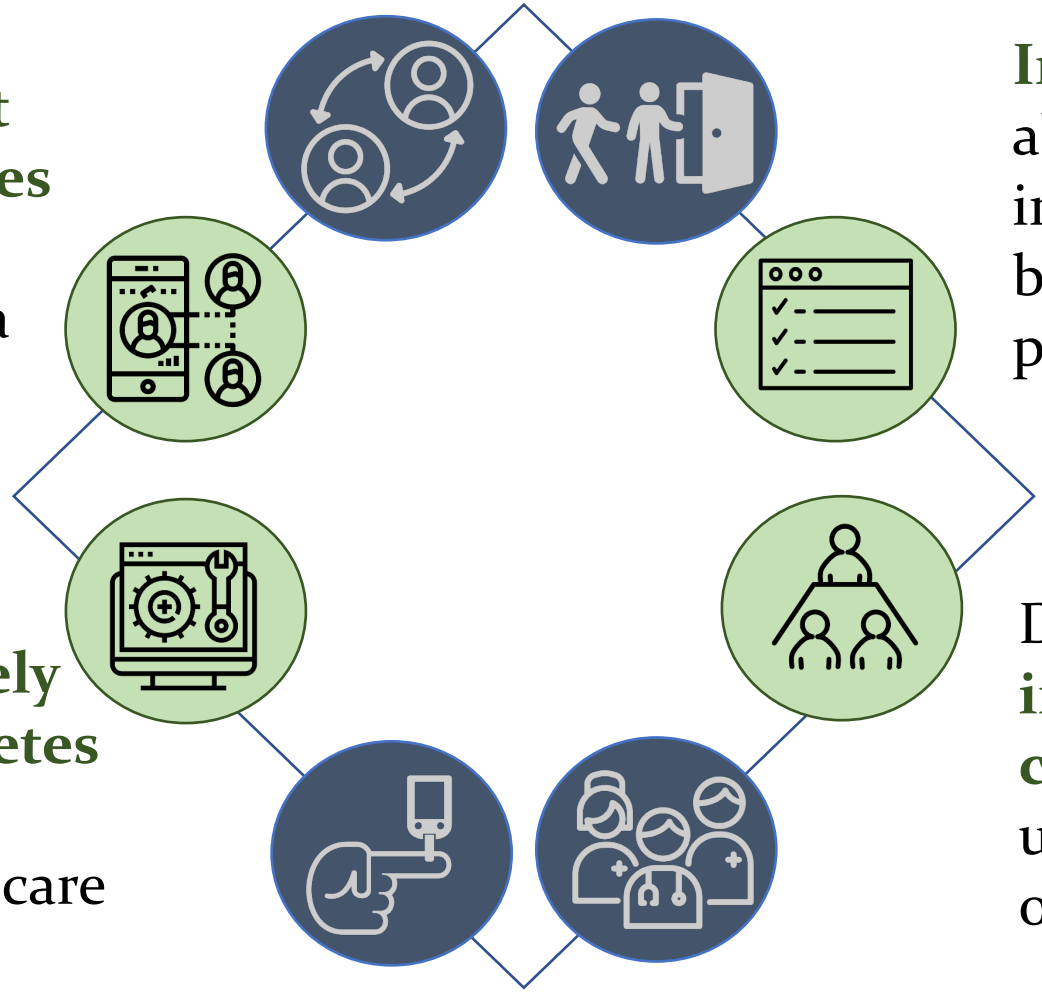


Caring Others Increasing EngageMent in PACT (CO-IMPACT) Program & Study

CO-IMPACT Principles

Develop tools to **increase engagement of adults with diabetes and their "Care Partners"**, even from a distance

Give Care Partners techniques to **effectively support patient diabetes management** and participation in health care



Increase communication about patient-specific information and plans between Care Partners, patients, and healthcare team

Design all components to **fit into the existing primary care workflows**; and be usable as stand-alone tools or educational resources

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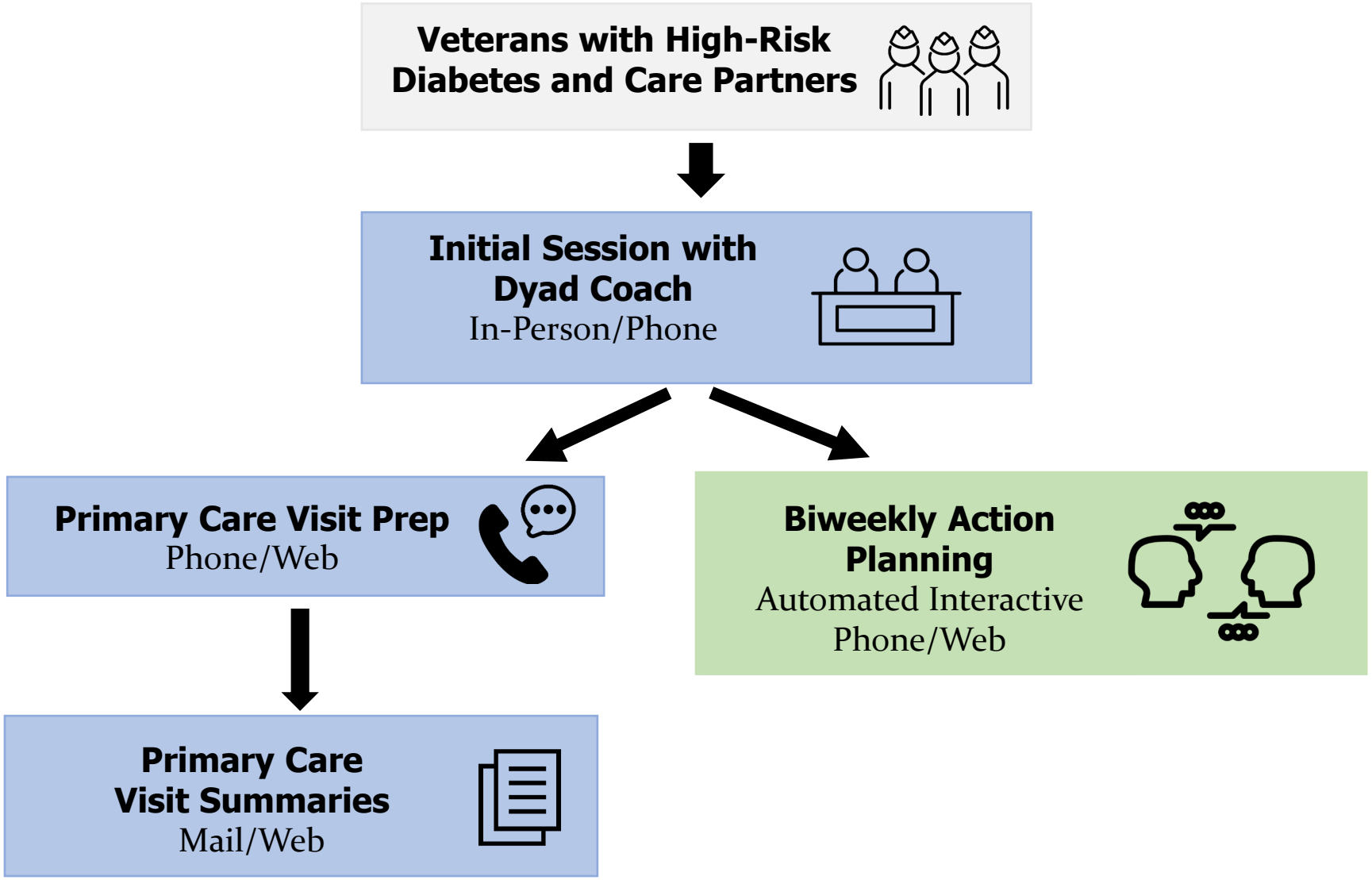
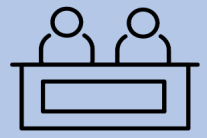
CO-IMPACT Program Design



CO-IMPACT Program Design

Veterans with High-Risk Diabetes and Care Partners

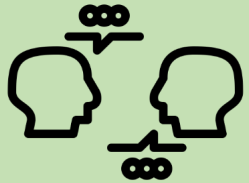
Initial Session with Dyad Coach
In-Person/Phone



- Veteran diabetes risk status
- Veteran diabetes regimen
- Care Partner roles in goal setting
- Care Partner communication skills
- PACT team roles
- Patient activation

Primary Care Visit Prep
Phone/Web

Biweekly Action Planning
Automated Interactive
Phone/Web



Primary Care Visit Summaries
Mail/Web

CO-IMPACT Program Design

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- Screen for actionable problems
- Summary to Care Partner
- Prompt goal setting

CO-IMPACT Program Design

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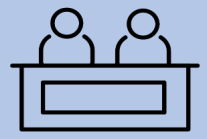

- Question list
- Information from home
- Care Partner Role

- Veteran diabetes risk status
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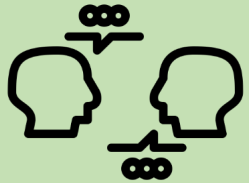

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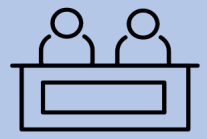

- Question list
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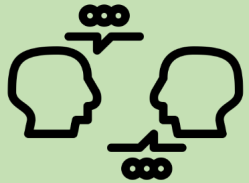
Phone/Web

Biweekly Action Planning
Automated Interactive
Phone/Web

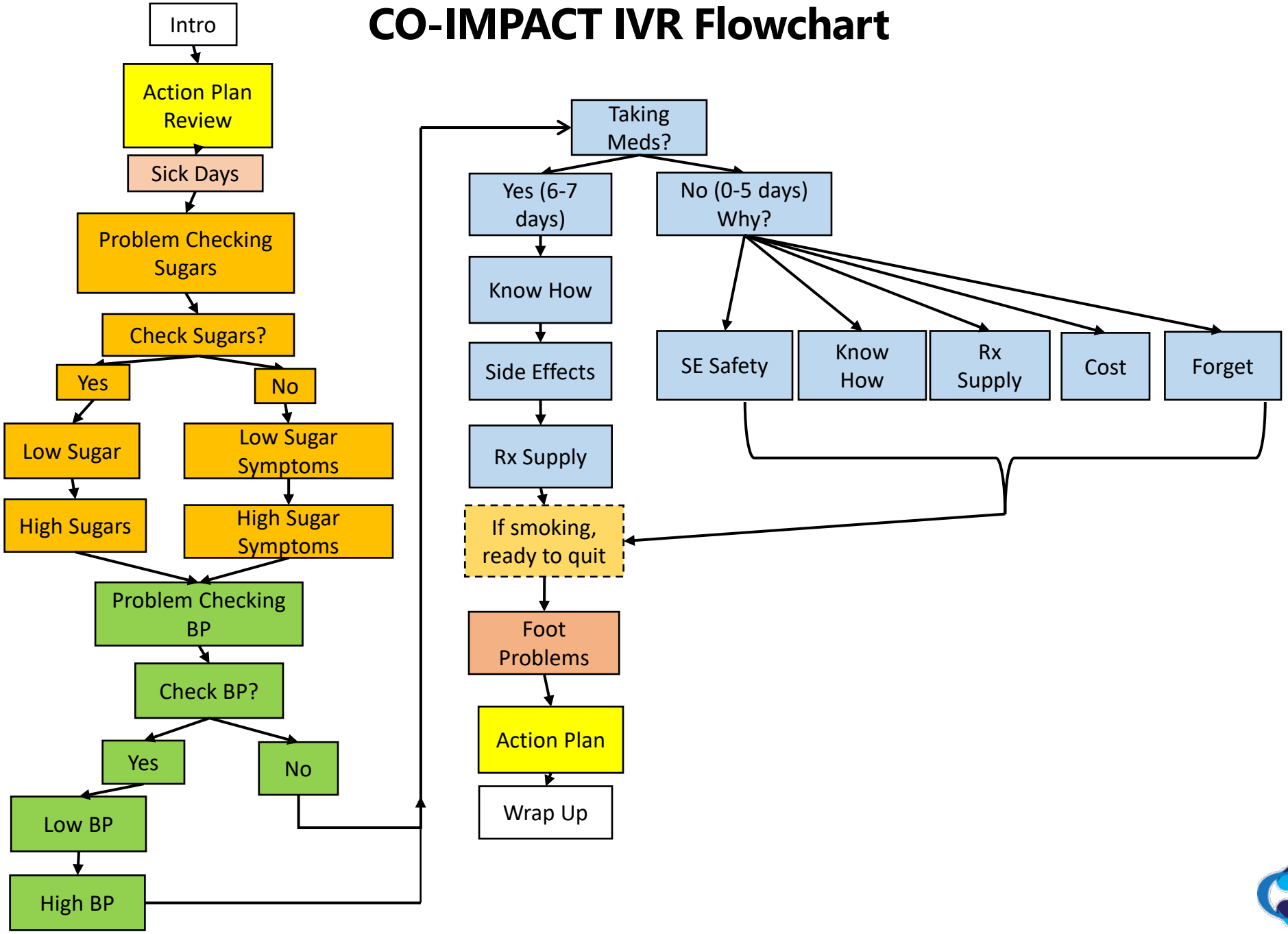


- Screen for actionable problems
- Summary to Care Partner
- Prompt goal setting

Primary Care Visit Summaries
Mail/Web

- Generated from medical record
- Copy sent to Care Partner

CO-IMPACT IVR Flowchart



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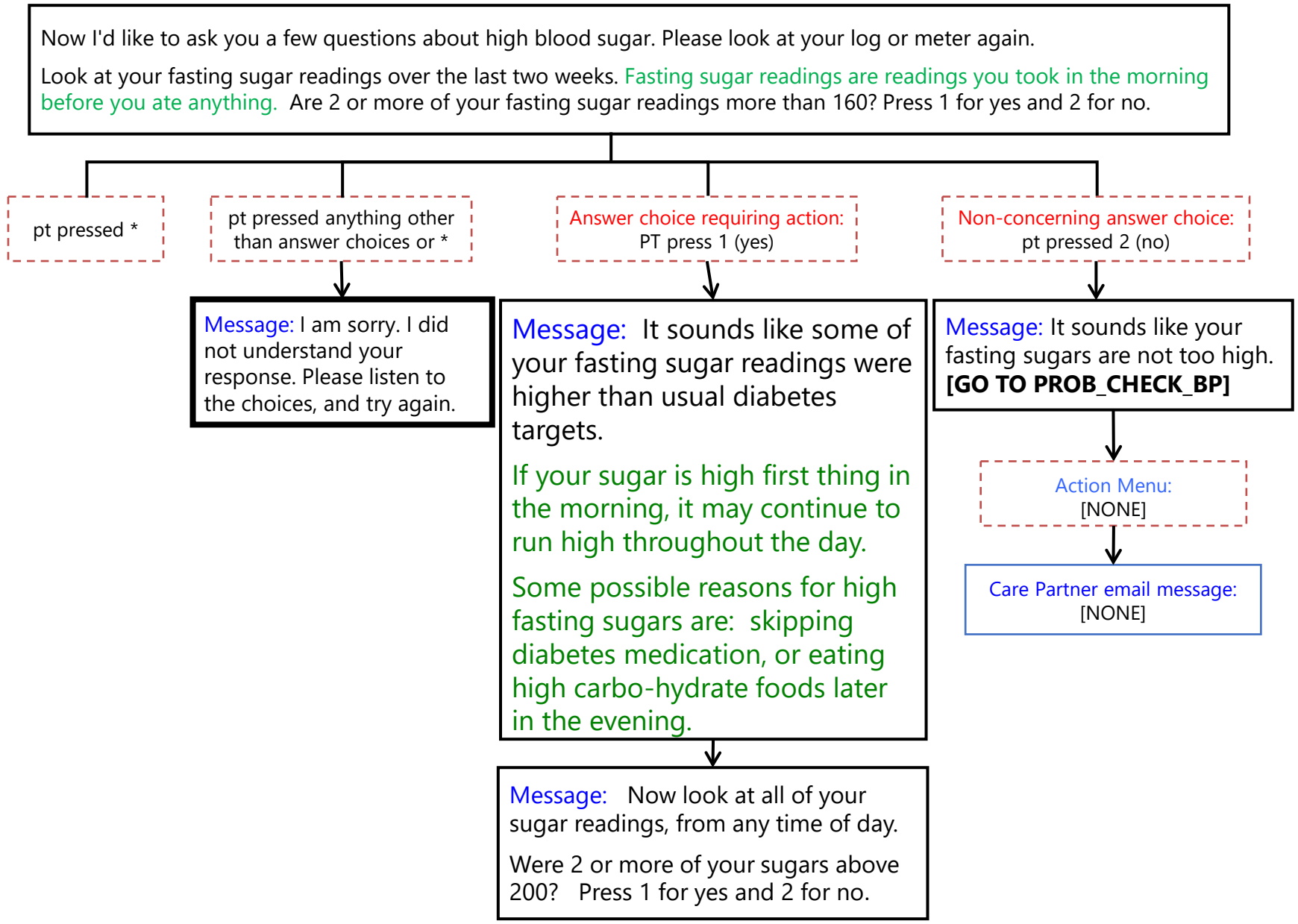
Topic Example: High Sugars



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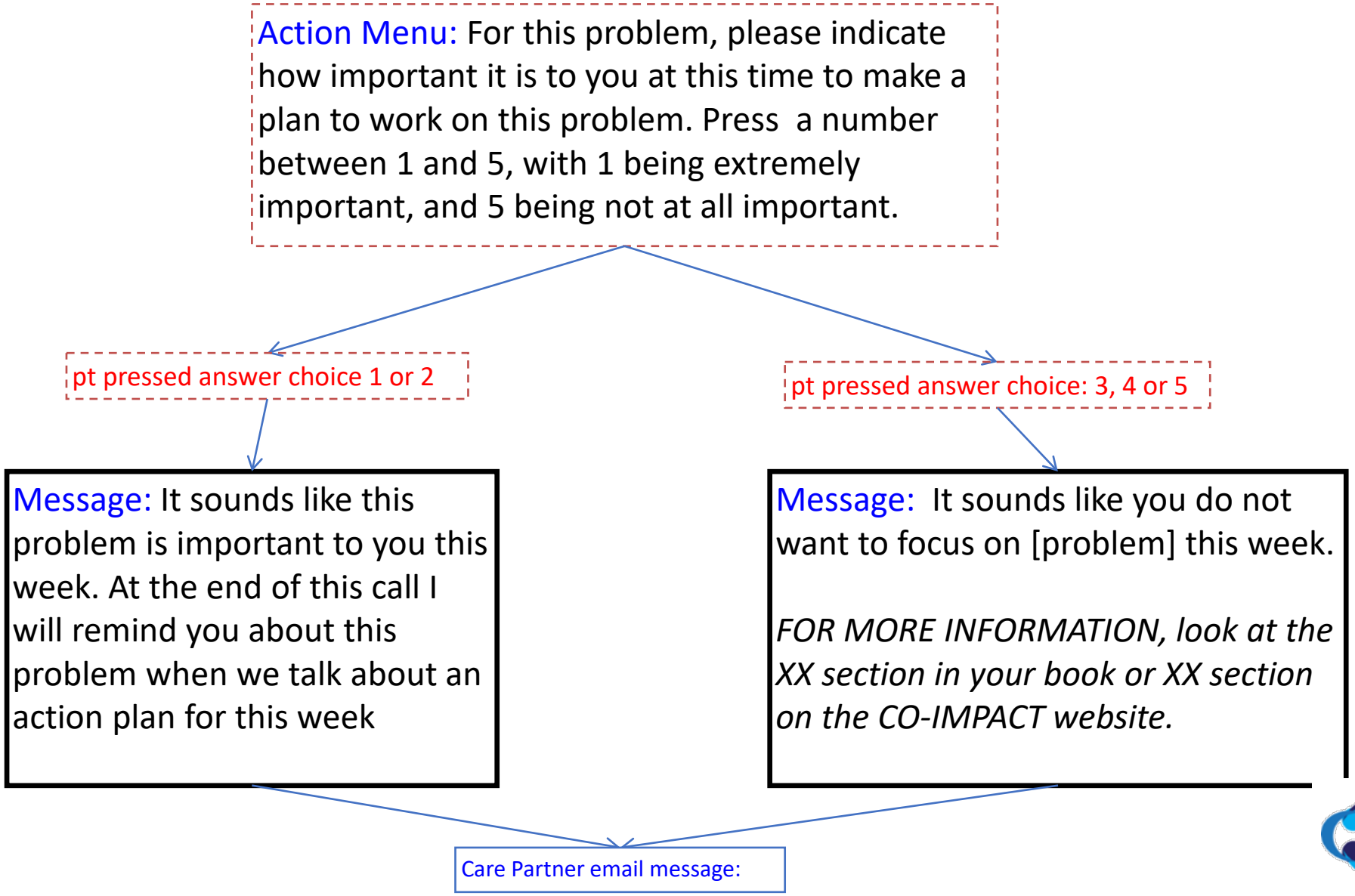
CO-IMPACT IVR Action Menu



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Sample Care Partner Automated Email

Template: IVR Summary E-mail Message to CP

Introduction

Your Patient Partner completed their most recent CO-IMPACT Study telephone call on [date] at [time]. Read below for a summary of:

- any urgent issues
- updates on regular monitoring
- any issues that your partner may have reported

*****Potentially Urgent Concern(s)*****
Your Patient Partner's primary care provider has been notified of the following potentially urgent concern(s). More information about this issue is listed towards the end of this email, in the list of reported issues.

- a **fasting blood sugar level above 300** and two or more above 200 in the past two weeks

Update on Action Plans
STATUS OF ACTION PLANS FROM LAST CALL: Your partner reported they spent time working on their diabetes action plans they made after their last automated phone call.

WHAT IT MEANS: They can be congratulated! However, there may be some action plans they still want to work on.

HOW YOU CAN HELP:

- Ask how well their action plan worked to address their diabetes concern.
- If they changed their diabetes or health routine, ask if there is a way you can help them keep up the new routine.
- If they were not able to make the changes they wanted to make, ask what they learned from trying to make the change. Then discuss how they might change their plans to address their diabetes concern this week.
- For more tips: Go to the *Action Planning* section of the CO-IMPACT website at http://xxxxxx or in your Patient Partner's CO-IMPACT handbook.

Update on Checking Sugars
Your partner reported that they checked their blood sugars at home 5 days in the last week.

Urgent Issues (if any)

Action Plan Update

Any 'important' issues + Tips + Handbook section

Participant Website

VA IIR 2015-2020
Study Aims and Outcomes

Determine the Effect of the CO-IMPACT Intervention on:

- Engagement in treatment and health behaviors
- Physiologic health

Among patients at high-risk for diabetes complications, compared to usual primary care

Primary Patient Outcomes - Change Over 12 Months in:

- Patient Activation (PAM-12)
- Diabetes-Specific Cardiac Event Risk (UKPDS-5 year)
  - Modifiable: HbA1c, BP, cholesterol, smoking
  - Patient Characteristics: Age, sex, race/ethnicity

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Study Design

Study Protocol:
https://bit.ly/3uapcqF

PRIOR TO ENROLLMENT

High-Risk Diabetes Registry ▶ Letter ▶Phone call

Recruit N = 240 VHA patients with high-risk diabetes and 240 Care Partners

BASELINE ASSESSMENTS

Patients: Survey, BP measurement, venipuncture for HbA1c and lipid levels in person

Care Partners: Survey by phone

RANDOMIZATION

Randomize by patient-Care Partner dyad
Stratify by in vs. out of home Care Partner

INTERVENTION | **USUAL PRIMARY CARE**

6-MONTH ASSESSMENTS

Patients: Brief (15 min) survey by phone or mail

Care Partners: Brief (15 min) survey by phone or mail

12-MONTH ASSESSMENTS

Patients: Survey, BP measurement, venipuncture for HbA1c and lipid levels in person

Care Partners: Survey by phone

Inclusion Criteria

Patient

- **Diabetes diagnosis & high-risk for complications**
  - **Poor glycemic control (last HbA1c >8%)**

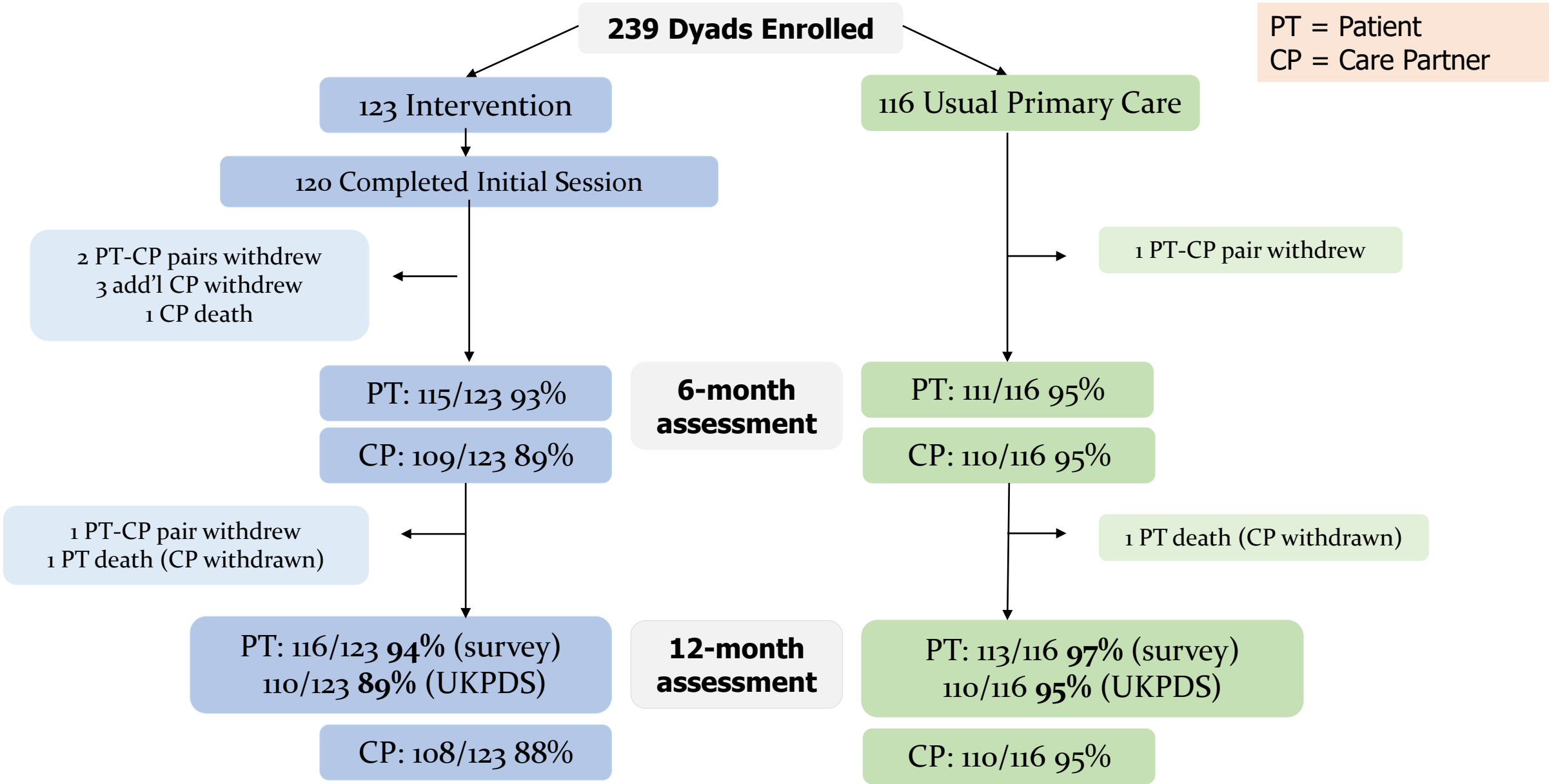
    OR
  - **Poor BP control (average SBP >160, last SBP >150)**
- Age 30-70 years old
- Active VA primary care user
- Diabetes cared for by PCP
- Does not live in a nursing home or assisted living
- Does not have significant cognitive impairment, life-limiting severe illness
- Does not need help with basic activities of daily living (ADLs)
- Has not had serious mental illness, or active substance use disorder in the last two years
- Not pregnant or planning pregnancy in the next 12 months

Care Partner

- **Talk with Veteran at least twice per month about their health or healthcare**
- **Veteran would like them to be more involved in their care**
- **Can live in same or different household**
- **Does not receive pay for taking care of the patient**
- At least 21 years old and lives in the US
- Does not have a diagnosis of dementia, or serious mental illness
- Does not need help with basic activities of daily living
- Does not have a life-limiting severe illness

Results

Participant Flow Chart



Patient Baseline Characteristics

	Intervention (N=123)	Usual Primary Care (N=116)
Age at Baseline (years), median (IQR)	62 (12)	64 (16.5)
Female	6 (4.9%)	2 (1.7%)
White, Non-Latino[a]	88 (72.1%)	91 (79.1%)
Completed College	29 (23.6%)	27 (23.3%)
Income[b]		
<$30,000	35 (29.2%)	39 (34.2%)
$30,000 to < $50,000	31 (25.8%)	34 (29.8%)
$50,000 to < $75,000	31 (25.8%)	17 (14.9%)
$75,000 and above	23 (19.2%)	24 (21.1%)
Use insulin at baseline	78 (63.4%)	64 (55.2%)
Years since diabetes diagnosis, median (IQR)	11 (14)	10 (12.5)
Hemoglobin HbA1c	8.4 (1.5)	8.6 (1.8)
Systolic blood pressure	141.0 (18.3)	139.3 (18.5)
Cholesterol to HDL Ratio, median (IQR)	4.6 (2.0)	4.3 (1.8)

[a] Intervention, n=122, Usual Care, n= 115; [b] Intervention, n=120, Usual Care, n=114

Care Partner Baseline Characteristics

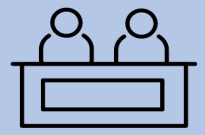
	Intervention (N=123)	Usual Primary Care (N=116)
Relationship to Patient		
Spouse/Partner	75 (61.0%)	70 (60.3%)
Friend	25 (20.3%)	16 (13.8%)
Adult child	9 (7.3%)	18 (15.5%)
Other relative	14 (11.4%)	12 (10.3%)
Care Partner Lives in Patient Household	86 (69.9%)	82 (70.7%)
Female	109 (88.6%)	106 (91.4%)
White, Non-Latino[a]	100 (94.3%)	92 (94.8%)
Completed College	25 (20.3%)	30 (25.9%)
Income[b]		
<$30,000	33 (28.7%)	34 (31.5%)
$30,000 to < $50,000	31 (27.0%)	31 (28.7%)
$50,000 to < $75,000	29 (25.2%)	21 (19.4%)
$75,000 and above	22 (19.1%)	22 (20.4%)
Care Partner has Diabetes[c]	22 (18.2%)	24 (20.7%)

[a] Intervention, n=106, Usual Care, n= 97; [b] Intervention, n=115, Usual Care, n=108; [c] Intervention = 121, Usual Care = 116

Rates of Receiving Intervention Components

Veterans with High-Risk Diabetes and Care Partners

Initial Session with Dyad Coach
In-Person/Phone

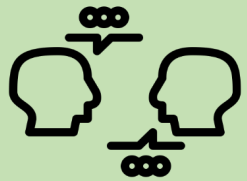


- 120/123 of patients completed the session

- 76% of eligible visits had a completed call
- 80% of enrolled patients had at least one call

Primary Care Visit Prep
Phone/Web

Biweekly Action Planning
Automated Interactive
Phone/Web

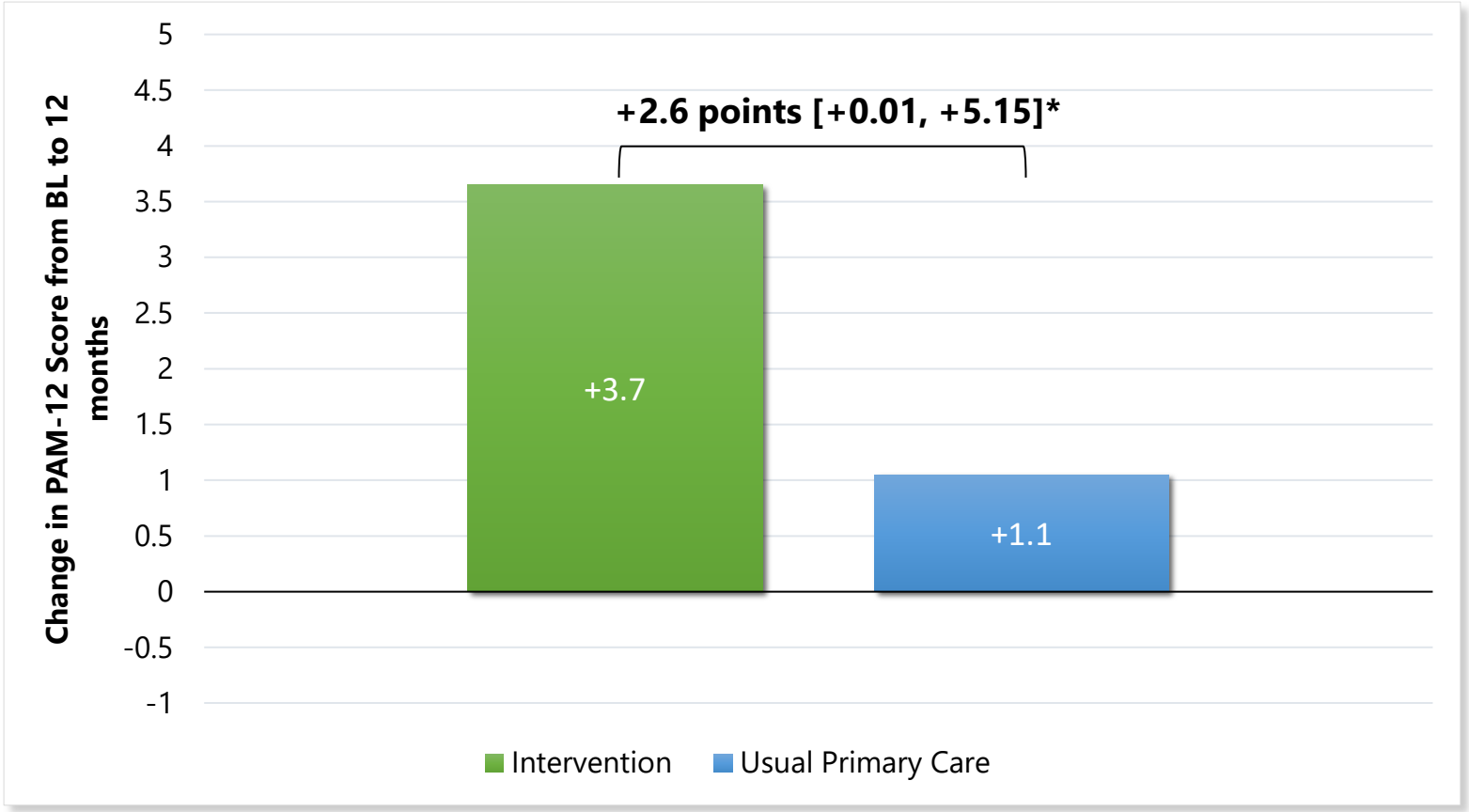


- 77% of calls completed per Veteran

Primary Care Visit Summaries
Mail/Web

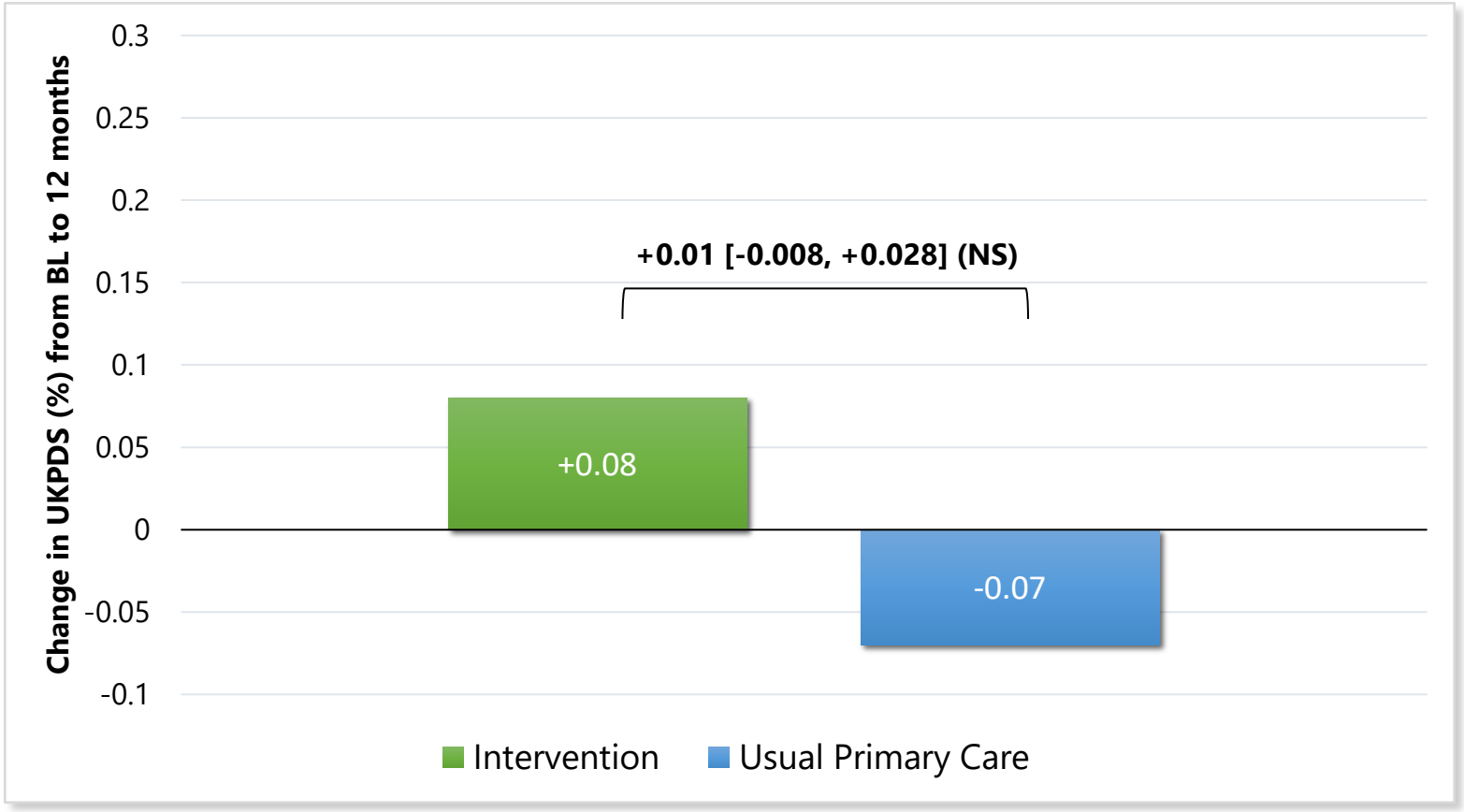
- 97% of completed visits had a Visit Summary sent and uploaded
- 92% of enrolled patients were mailed at least one summary

Patient Activation
Adjusted change over 12 months



Models adjusted for: baseline level of outcome, two stratification variables (CP in/out home, PAM cutoff), and insulin use.

5-Year Cardiac Risk
Adjusted change over 12 months



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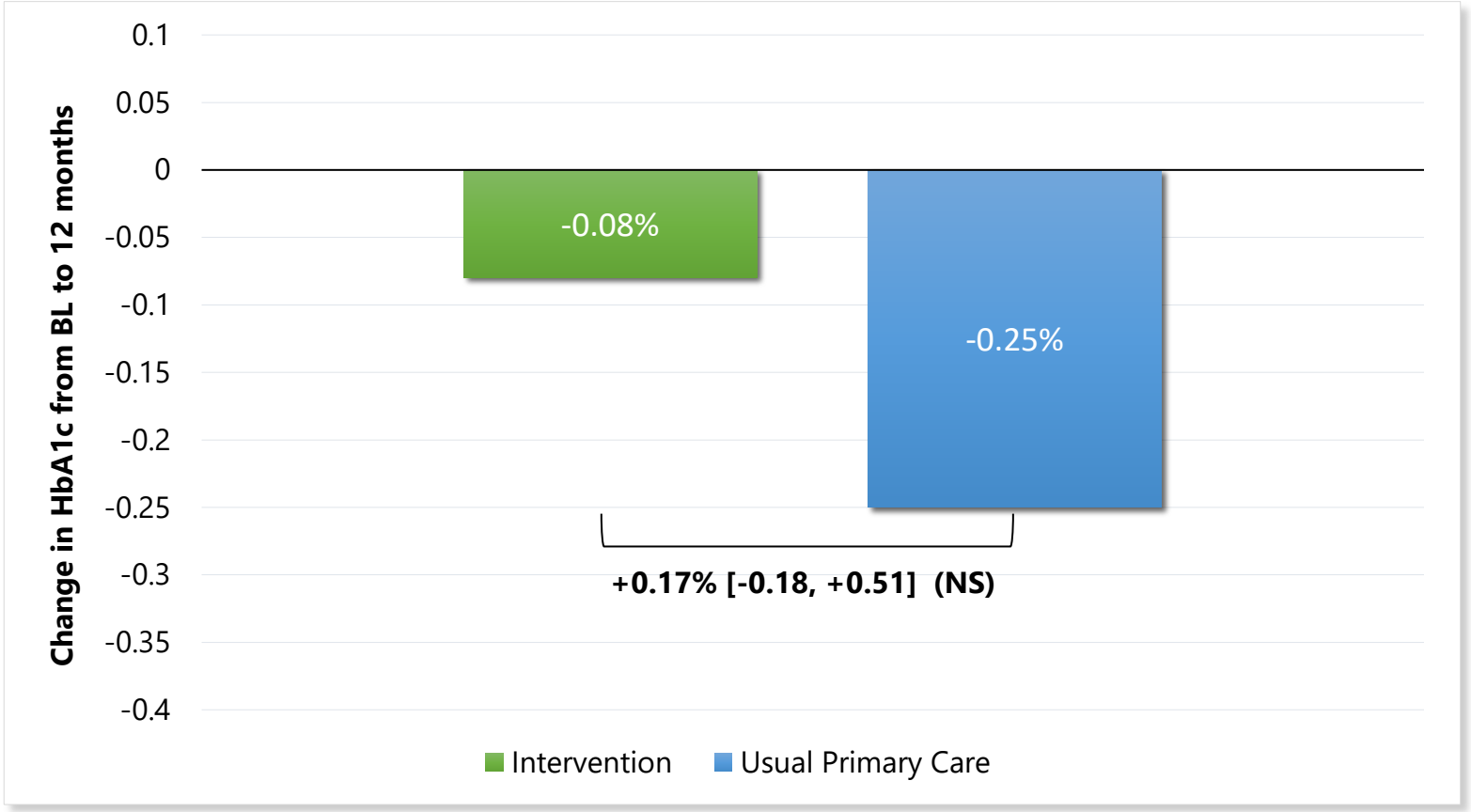
HbA1c
Adjusted Change over 12 months



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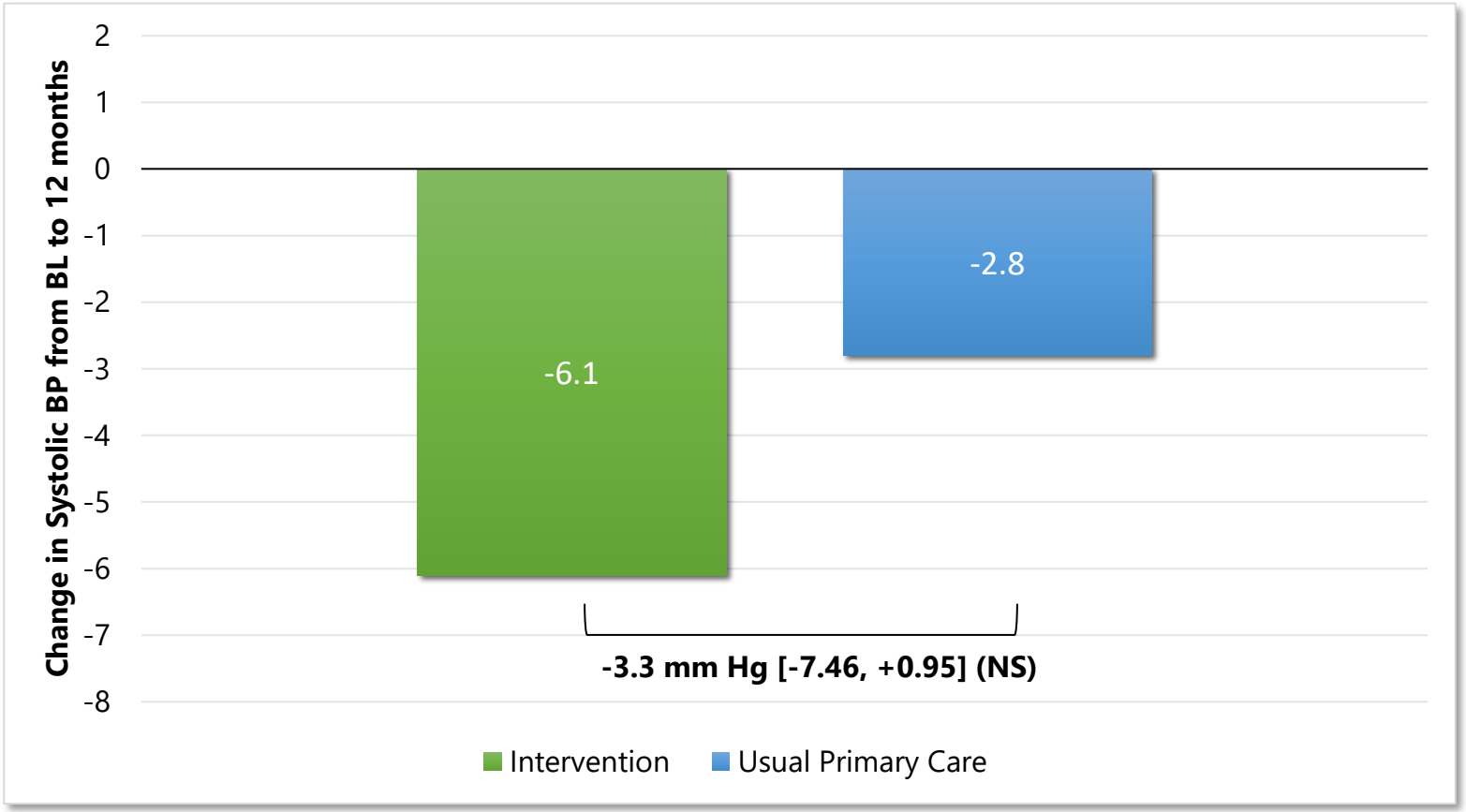
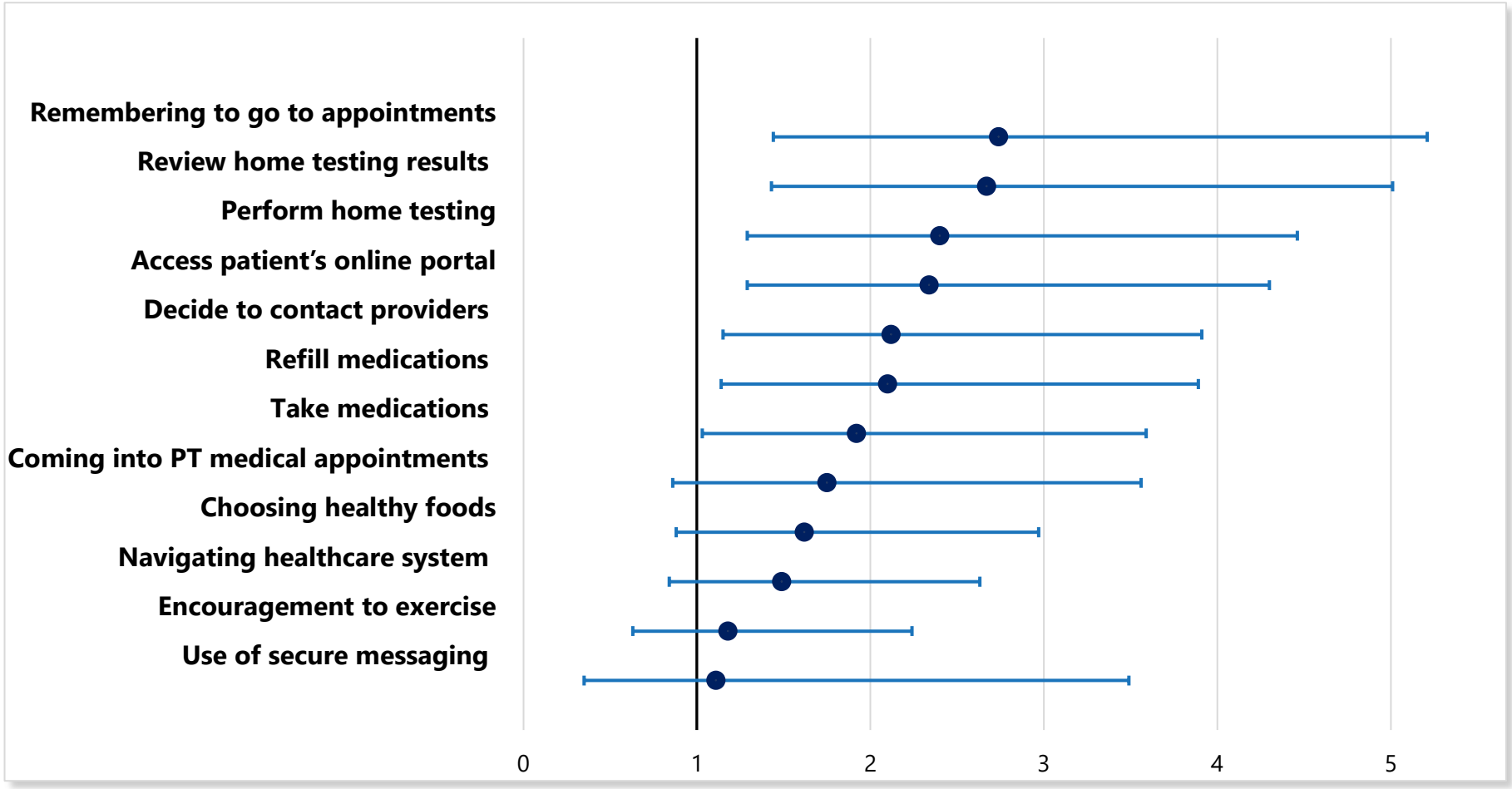
Systolic Blood Pressure
Adjusted change over 12 months



Models adjusted for: baseline level of outcome, two stratification variables (CP in/out home, PAM cutoff), and insulin use.

Care Partner Role Changes

Adjusted Odds of Increase in Support Role over 12 months, CO-IMPACT vs. Usual Care



Models were controlled for baseline HbA1c, age, sex, insulin use, and Care Partner cohabitation with patient
‡ N for each model excluded patients who indicated the task was relevant to their diabetes care, or who indicated their Care Partner provided maximal (5/5) support at baseline.

Zupa et. al, JGIM 2021 (In press)

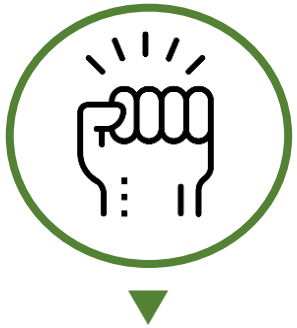
Secondary Outcomes

94% of Veterans and 83% of their Care Partners reported **the program helped** the Veteran improve their diabetes management.

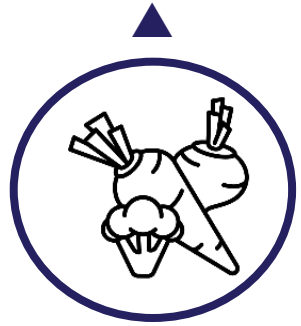
Veterans reporting that they were **satisfied with VA support for involving their Care Partner** in their healthcare rose from 53% to 84% in the intervention group (50% to 68% in usual care group)

'Autonomy support' from CP increased by 0.3 points more in the intervention group (adjusted)

Patient self-efficacy for diabetes management increased by 0.4 points more in intervention group (adjusted)



Reported healthy eating increased by 0.7 days per week more in the intervention group (adjusted)



No differences between groups in other SM behaviors, diabetes distress

CHERP
Center for Health Equity Research and Promotion
VA HSR&D Center of Innovation

Summary

- Patient activation and diabetes self-efficacy improved significantly more in the CO-IMPACT program than in usual primary care.
- Physiologic measures of diabetes complication risk did not show significant differences
- Care Partner involvement in diabetes-specific care tasks and goal setting, and use of positive communication, significantly increased more in CO-IMPACT
- Dyads assigned to CO-IMPACT had high participation levels and high satisfaction with the program

Interpretation & Implications

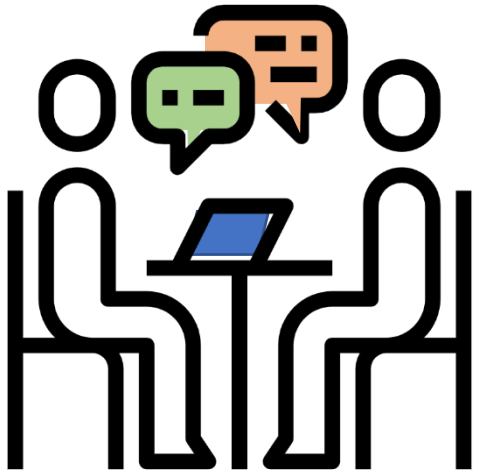
- Limitations include
  - Male sample
  - Low-intensity focus on Care Partners
  - Comparison group also received very robust diabetes care
- Benefits to fundamental Veteran and Care Partner diabetes management roles were observed from a high-user satisfaction, low-person power intervention
- Components of the intervention can be used in different education & care settings
- Ongoing research (FAM-ACT, NIDDK DK115733) is examining supporter training
  - In community-based, lower resourced setting
  - With more direct & intensive family supporter training
  - In comparison to a conventional patient-focused diabetes education program

Qualitative Feedback

Why We Collected Qualitative Data

Two main purposes

- Explain how we had a positive impact, or why we didn't
  - For example, quotes that show how Veterans with diabetes were more activated, or how CP got more involved
  - Why there was not an impact on HbA1c
- Identify what we could improve in the future
  - Future use of CO-IMPACT tools
  - Future studies



Data Collection

- Veteran and Care Partner (CP) participants in the intervention arm were asked open-ended questions about
  - each component of the CO-IMPACT program; and
  - how they work together differently on managing diabetes overall
- Two-part question structure
  - closed-ended inquiry
  - open-ended follow up

Example

Did the automated calls help you manage your diabetes?

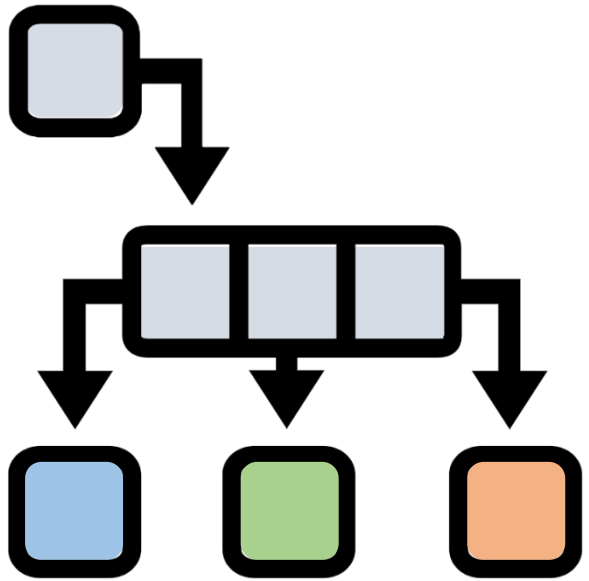
- *If yes*, Please tell me a little more about how they helped.
- *If no or somewhat*, What would have made them (more) helpful?

Review and Analysis

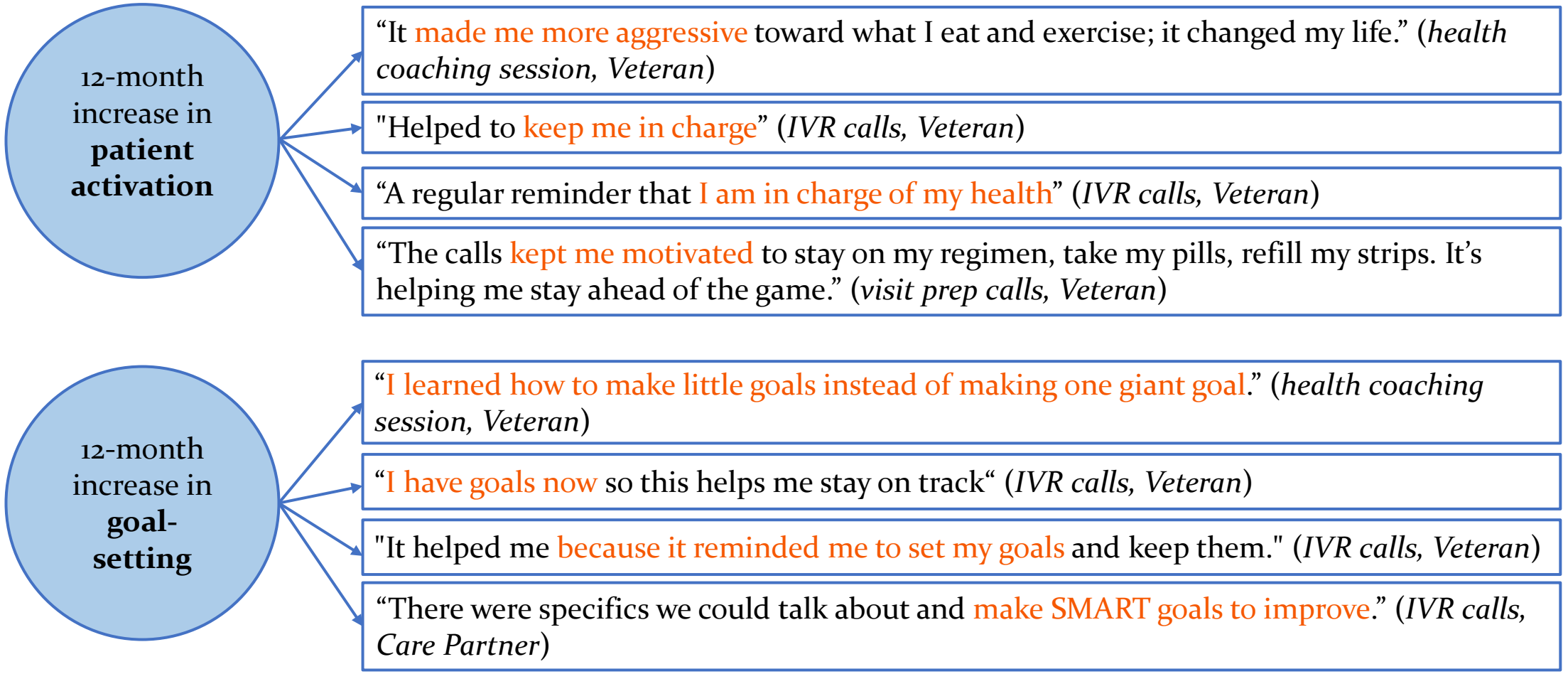
- Comments were reviewed and categorized using structured themes.

  Sample categories

  - Overall valence (positive, neutral, negative)
  - Suggestion
  - Behavior change (Veteran or Care Partner)
- Emergent themes related to *patient activation* and Care Partner role change outcomes were applied



Quantitative Findings Expressed in Participants' Own Words: Changes in Patient Activation and Goal-Setting



Quantitative Findings Expressed in Participants' Own Words: Changes in Care Partner Roles

Finding	Illustrative Quote
CP helps Veteran keep medical appointments	"[Appointment reminder emails] helped me make sure he went to his appointment. I made sure he did not forget the appointment." (*appt. reminder emails, Care Partner*)
CP asks Veteran about home testing results	"I paid more attention to what his numbers were and about his healthcare." (*health coaching session, Care Partner*) "She would get my meter and read it, what was this? And check why was it high?" (*CP email summaries, Veteran*)
CP helps Veteran perform home testing	"There was a long time he wasn't checking his sugar, and now he is checking it on a daily basis because I help him." (*health coaching session, Care Partner*) "Again, she got in my business because [CP] received it. I would have to slow down on sugars and blood pressure and making sure I test every day." (*CP email summaries, Veteran*)"
CP reminds Veteran to take medications	"It put [CP] and myself on same plane on managing diabetes, making sure we have a well-rounded diet and taking my metformin at a specific time every day." (*CP email summaries, Veteran*)

What We Learned: Common Themes (Veterans)

Veterans and Care-Partners used CO-IMPACT components as *reminders*	"They helped me to remember to take my blood sugar/pressure." (*IVR calls*)
	"A lot of times I would almost forget to take my logs with me. Whenever she would call I would remember I need to write them down to take them with me." (*visit prep calls*)
	"It keeps me on top of the situation and it doesn't slip my mind. Sometimes I have so much to do, I forget. But when I get a call or receive stuff in the mail, I read it all and it puts me right back on top of everything." (*patient visit summaries*)

What We Learned: Common Themes (Veterans & CPs)

CPs learned more about *how they can support the Veteran with their diabetes management*

Veteran
"First of all, [CP] has learned a great deal, she seems to understand that what happens with me, anything I take can affect my numbers." (*health coaching session*)
"[CP] was able to read the booklet too. If she had a question for me and I couldn't answer it she would look it up" (*handbook*)
Care Partner
"Made me more conscious of things I should pay attention to. (*health coaching session*)
"I found out more information, things I didn't even know, so I could read up on it and be better prepared to help." (*CP email summaries*)

What We Learned: Common Themes (Veterans & CPs)

Veterans and CPs were *talking more about the Veteran's diabetes*

Veteran

"Beforehand, [CP] and I did not talk as much about my diabetes … but as we had specific coaching it helped us talk about it every night, even if she was traveling." (*health coaching session*)

"If she did not receive those emails, we would not have talked about it." (*CP email summaries*)

Care Partner

"I talked to him more about his food intake and things that we didn't discuss before." (*health coaching session*)

"It helped me learn how to talk to him about different things." (*IVR emails*)

What We Learned: Common Themes (Veterans & CPs)

CO-IMPACT facilitated *Veteran-CP teamwork*

Veteran

"She knew what my appointment was, and saw what my sugar levels and cholesterol levels, were, so we could work together on eating better." (*patient visit summaries*)

"It put [CP] and myself on same plane on managing diabetes, making sure ***we*** have a well-rounded diet and taking my metformin at a specific time every day." (*Care-Partner email summaries*)

Care Partner

"It helped me remember that he had an appointment which would allow me to help him plan and ask certain questions to the doctor." (*appointment reminder emails*)

"I think it really helped him and for me to pinpoint questions he was going to ask and encouraged him to write things down for his visit to the doctor." (*health coaching session*)

What We Learned: Veteran Suggestions

Include More Information	"The biggest helper might have been having meal plans and specific suggestions on meal plans and choices." (*health coaching session*)
	" It would be nicer if there was more info and if they were explained in more detail." (*patient visit summaries*)
Preference for calls from people over IVR calls	"The responses weren't very personalized. Maybe have humans follow up to unanswered questions."
	"It was nothing personal, hard to answer a computer, it would be helpful to have a live person and have different questions."
	"A real person instead of a robot would make it better."

What We Learned: Care Partner Suggestions

Include More Information	"I think more written information , so I could sit down with [Veteran] and go over things." (*health coaching sessions*)
	"If there were more practical examples or scenarios stuff." (*health coaching sessions*)
Include more contacts directed to CP	"I feel like there should be calls to the care partner as well. I may see him doing stuff differently and I'd like to get feedback too." (*IVR calls*)

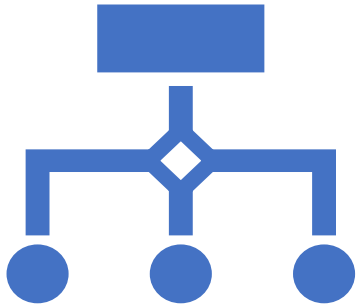
Qualitative Data Conclusions

- Participant comments give us insight into Veterans' and Care Partners' *lived experience* of CO-IMPACT
- Examination of comments reveals overarching themes that may explain *how* CO-IMPACT influenced Veteran outcomes
- Common themes emerged from comments on *multiple CO-IMPACT components*, suggesting unique value for each one

> The biggest thing it did: it helped us look at it from a different perspective and put more emphasis on getting the answers we needed, and doing what we needed to do to solve some of the issues we needed to, and **realize the only people that could really do it was *us*.**
> -- *Veteran*

Dissemination

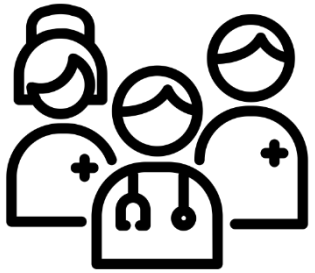
FY21 Dissemination Extension Goals



Disseminate the full CO-IMPACT program and stand-alone CO-IMPACT components to VA sites, primary care teams, and directly to patients and Care Partners.

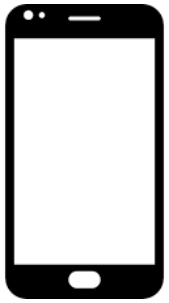
Work with partners to develop a pragmatic strategy for wider VHA dissemination.

FY21 Dissemination Strategies



Healthcare Systems & Provider Networks

Patients and Care Partners



Technology Adaptation

Outreach Examples

VA Outreach

- VA Dole Caregiving Research Center
- VA Office of Social Work Caregiver Support Program
- VA Office of Primary Care
- RIVET High Risk Veterans Tools SharePoint

Non-VA Outreach

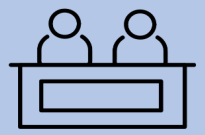
- Association of Diabetes Care & Education Specialists podcast (https://www.diabeteseducator.org/news/adces-podcasts)
- OhioHealth Virtual Diabetes Self-Management Classes

CO-IMPACT Toolkit for Healthcare Professionals

Veterans and Care Partners

- Call Script
- Visit Planning Worksheet
- Getting the Most Out of Appointments PDF for PT/CP

Intro Session
Can be used at in-person or virtual visits, or DM classes

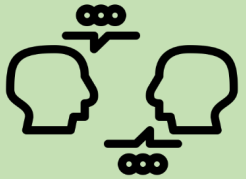


- Slide deck
- Healthcare Professional Script
- Diabetes Health Profile Worksheet
- 'Best Phrase' Activity Cards
- Action Planning Worksheet
- Handbook Worksheets

Visit Preparation
Can be used via phone or secure message

Visit Summaries
Care Partners can be given or mailed a copy

Check-In Calls
Can be used by 'live' professional or automated system



- Graphical Flow of Automated Calls
- Example from Automated Call Script
- Example Summary Email for Care Partners

CO-IMPACT Toolkit

The CO-IMPACT Program was designed to be used by healthcare professionals, adults with diabetes,and their Care Partners. These materials were originally developed and tested for adults with type 2 diabetes, but they can be helpful for adults with other types of diabetes or other chronic health conditions.

This toolkit contains materials from the CO-IMPACT Program in a format that is flexible for use in various settings.

CLICK HERE IF YOU ARE A PERSON WITH DIABETES OR THEIR CARE PARTNER

CLICK HERE IF YOU ARE A HEALTHCARE PROFESSIONAL

https://www.complexcaring.pitt.edu/co-impact-toolkit

CO-IMPACT Toolkit for Healthcare Professionals

The CO-IMPACT toolkit for healthcare professionals includes descriptions of all sessions and tools, information on how they were used in the original CO-IMPACT Program, and tips on how they can be used in other settings. You can download a **full PDF version** of our toolkit, or browse the toolkit online using the links below.

Go Straight To:

Introduction

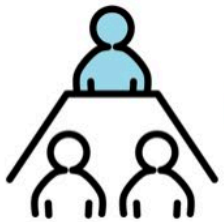
Most adults with chronic health conditions like diabetes have family members or friends who are regularly involved in their medical and self-care. These family supporters (called 'Care Partners' in this program) are an important resource who can help people with diabetes increase their confidence, their ability to manage diabetes day-to-day, and their active involvement in their healthcare. Many studies have shown that adults with active Care Partners have better diabetes outcomes. However, healthcare teams lack structured and realistic approaches to work with Care Partners.

CO-IMPACT Professional Toolkit

The CO-IMPACT Program included these four main tools:

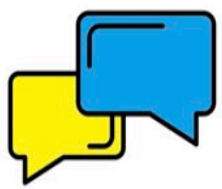
Intro Session	Handbook	Check-In Calls	Visit Preparation
• Care Partner orientation to patient diabetes status and regimen • Helpful ways for Care Partners to communicate with patients about diabetes • Care Partner techniques to help patient set and follow-through on health goals • Care Partner orientation to 'who's who' on the patient's healthcare team • Patient and Care Partner techniques to make the most of healthcare visits	• Tip sheets for all topics in Intro Session • General diabetes care information • Worksheets and logs	• Phone script for asking the patient about new actionable diabetes issues • Suggested actions for patients and Care Partners if important issues are identified • Prompts to encourage patient empowerment and collaborative action planning	• Patient and Care Partner guide to listing questions and preparing home information for an upcoming medical visit • Patient prompts to specify what role they want the Care Partner to play at the visit • Patient after-visit summaries for the Care Partner

Click on the links below to access more information on each tool or session:



Intro Session

Handbook



Check-In Calls

Visit Preparation

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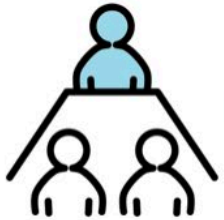
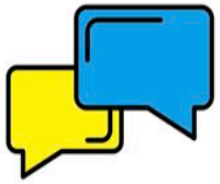


Intro Session

Handbook ✓



Check-In Calls

Visit Preparation

Handbook Contents

Section	Content
Diabetes Health Information	• Sick days • Sugar levels • Blood pressure • Medications • Smoking • Foot care • Helpful internet links
Action Planning	• Planning to make health changes • Make a SMART plan • Examples of SMART plans • Action planning worksheet
Patient-Care Partner Teamwork	• Tips for Patients: talking with Care Partners about health • Tips for Care Partners: getting the conversation flowing, positive and helpful conversations
Partnering with Healthcare Professionals	• Getting the most out of appointments (for patients and Care Partners) • Visit planning worksheet* • Patient event worksheet* • Between appointments (for patients and Care Partners)
Logs and Charts	• Blood sugar and blood pressure log* • Medication chart*

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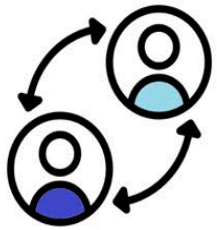


CO-IMPACT Toolkit for People with Diabetes and a Care Partner

Living with diabetes can be tough. Many people with diabetes feel frustrated by the demands of their self-care. Advice can be confusing, taking medications can be hard, and monitoring symptoms can be challenging.

The CO-IMPACT Program is for people with diabetes and a trusted family member or friend (called a **Care Partner**). The Care Partner can help the person with diabetes reach their health goals.

Click on the topic below to learn how a person with diabetes and their Care Partner can work as a team to manage diabetes.

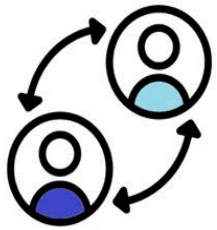
Diabetes Health Information »

Action Planning »

Person with Diabetes-Care Partner Teamwork »

Partnering with Healthcare Professionals »

Worksheets and Logs »



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Diabetes Health Information »

Action Planning »

Person with Diabetes-Care Partner Teamwork »

Partnering with Healthcare Professionals »

Worksheets and Logs »

Person with Diabetes-Care Partner Teamwork

It is helpful for the person with diabetes to talk about diabetes care at least once per week with their Care Partner.

Click on the topic below to learn how to start a conversation and practice positive communication when talking about diabetes care.

- Guidelines for Weekly Talks
- Tips for the Person with Diabetes: Talking with Care Partners about Health
- Tips for Care Partners: Getting the Conversation Flowing
- Tips for Care Partners: For a Positive and Helpful Conversation
- Examples of Supportive Care Partner Comments
- Tips for Care Partners: When the Person with Diabetes Needs More Help

Explore CO-IMPACT Topics

Diabetes Health Information

Action Planning

Person with Diabetes-Care Partner Teamwork

Partnering with Healthcare Professionals

Worksheets and Logs

Contact Information

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Caring for Complex Chronic Conditions
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