THE ROLE OF GOAL SETTING IN THE DIABETES CASE MANAGEMENT OF ABORIGINAL AND NON-ABORIGINAL POPULATIONS IN RURAL SOUTH AUSTRALIA

MD THESIS

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TABLE OF CONTENTS

ABSTRACT

This thesis examines goal setting in people with diabetes as part of chronic disease management in a rural setting. Good quality diabetes care includes a team approach, regular follow-up, patient education and patient centred interventions. Shared goal setting and written management plans are central to this. Rural general practitioners work closely with their own health services, however there is little published work on case management and goal setting in these communities.

This work seeks to answer two hypotheses around goal setting in General Practice. Firstly that: Goal setting when used by patients with diabetes type 2 in a rural setting will result in improved clinical outcomes and improved social/emotional outcomes. Secondly that: Goal setting can be successfully performed in rural Australian General Practice as part of case management of diabetes.

The studies were performed in a rural setting (Eyre Peninsula) with a significant (10-20%) Aboriginal population. A randomised controlled trial (Trial 1) used goal setting alone, and two observational trials (Trials 2 and 3) used goal setting in conjunction with a service coordinator to plan diabetes care. These two observational trials were part of the larger Coordinated Care Trials in South Australia (HealthPlus). A fourth observational trial incorporated self-management strategies (Trial 4) with goal setting in an Aboriginal community. Outcomes included physical and biochemical indices, quality of life data (SF36), prescribing costs, service costs and hospital admissions.

Goal setting consistently identified problems related to social, emotional, health maintenance and medical issues. Patients were able to formulate their own solutions to these problems with help in each trial. Goal achievement was 60% in non-Aboriginal trials despite limited resources to address social issues. In Trial 1 goal setting was associated with reduced disability ratings but not improved SF36 scores. HbA1c improved from 7.7 to 7.4 with both intervention (goal setting) and control (structured care) groups.

Goal setting identified significant service gaps that were needed to fulfill ideal care. Case management (Trials 2 and 3) therefore required considerable structural reform at a clinical and practice level to be satisfactorily implemented. The interactions between providers,

particularly allied health workers and general practitioners, needed to be formalised. Service coordinators in these trials and Aboriginal Health Workers in the Aboriginal trials provided care where this was otherwise not available, and in doing so created new and valuable linkages.

The Aboriginal Trials (Trials 3 and 4) identified social and family issues as primary problems affecting diabetes care. Goal setting was less successful partly because community and family issues took precedence over personal problems, and partly because it was impossible to address the social problems in the trial context. Goal setting in Trial 4 was associated with 26% goal achievement, 46% improvement in diabetes knowledge and a fall in HbA1c from 7.8 to 7.4.

General practitioners found goal setting time consuming and were frustrated by inadequate service provision. They tended to concentrate on medication issues at reviews. Accurate hand held records were favoured by local specialists and hospital services. Patients and carers enjoyed the additional time spent exploring issues.

Goal setting alone was not associated with improved health outcomes beyond those provided by structured care. Goal setting assisted by service coordinators was associated with small reductions in prescribing costs and hospital admissions, so that savings did not offset the costs of the service coordinators. Chronic Disease Self Management (CDSM) strategies were an alternative model to incorporate goal setting into care for Aboriginal people with diabetes.

Care planning was incorporated into the Medical Benefit Schedule under the Enhanced Primary Care package in November 1999 and includes a requirement to set goals by General Practitioners. Service coordinators may be better placed to set goals that are patient generated in view of the time required. Future research should explore this role as a way of enhancing delivery of diabetes and other chronic disease care in general practice.