# Group education tool: The Conversation Map® programme

*Meagan A Brown, Courtney S Davis*

**Educating people with type 2 diabetes on healthy lifestyle and behaviours is important to facilitate self-management and successful treatment of the condition. The Conversation Map® education tools offer a patient-centred approach to diabetes learning to be used in a group setting. In this article, the authors describe the tool kit and its evidence base. They also provide practical take-home lessons for implementing the programme, which can be applied to any other educational group programme.**

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### Article points

1. This article discusses the Conversation Map® programme, which is an interactive tool kit to assist clinicians in providing quality education in a model that promotes a patient-centred approach.
2. It is designed to allow open discussion among patients and dispel untruths, while allowing patients to express concerns and actively learn how to manage diabetes in a healthy manner.
3. The authors include practical tips for implementing conversation maps and group education programmes.

### Key words

– Conversation map tools
– Group education
– Healthy behaviours

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Educating people with type 2 diabetes on the importance of lifestyle changes is critical to their success with self managing the condition (American Diabetes Association, 2013). It is known that individuals may be more receptive to education provided in a group setting with those with similar experiences than on a one-to-one basis with a healthcare professional (Reaney et al, 2012). The Conversation Map® education tools developed by Healthy Interactions®, Inc (Chicago, IL, USA) offer this peer-to-peer approach to group education. The tool kit allows patients to share information and personal experiences of diabetes while a trained facilitator (a healthcare professional) mediates the conversation to ensure accurate facts are shared and important concepts are covered. In this article, we describe the tool kit and the evidence base for using conversation maps. We also provide practical, take-home messages for implementing the programme, which can be applied to any other educational group programme.

## Development of the tool kit

The Conversation Map programmes are available in 38 different languages and have been used in approximately 120 countries (Healthy Interactions, 2016). The programmes aim to promote personal health engagement and provide an environment in which patients have an opportunity to share their experiences in a meaningful way to help others, while also dispelling myths about diabetes care.

The Conversation Map education tool kit consists of table-sized (3×5 feet) maps, which address the fundamentals of diabetes care and assist in patient self-management education. Figure 1 shows some examples of the US Diabetes Conversation Map tools. Map tool topics include "On the Road to Better Managing your Diabetes"; "Diabetes and Healthy Eating"; "Monitoring Your Blood Glucose"; "Continuing Your Journey with Diabetes"; and "Caring for Gestational Diabetes". The maps are interactive and provide a "game-like" approach. Group sessions should ideally contain three to 10 people with one trained facilitator. The format allows self-directed learning and encourages accountability, support and understanding from patients who experience the same barriers.

**Page points**

1. Live training sessions and webinars are provided for free by Healthy Interactions® to teach healthcare professionals how to use the tools effectively and become facilitators of the programme.
2. There have been a few studies that have investigated the use and effectiveness of conversation maps for group education sessions on diabetes.

Additional information can be found elsewhere on the development and use of conversation maps (Sperl-Hillen et al, 2011; Reaney et al, 2012).

### Facilitator training

Live training sessions and webinars are provided for free by Healthy Interactions to teach healthcare professionals how to use the tools effectively and become facilitators of the programme. Along with the training sessions, which last approximately 4 hours, the trainee receives a free Conversation Map kit, which includes everything required to lead the group sessions.

## Current evidence base

In December 2011, Sperl-Hillen et al (2011) described the use of conversation map tools in a randomised controlled trial. The primary outcomes were satisfaction and behavioural and emotional outcomes. The secondary outcomes were blood glucose, blood pressure, lipids, cost and comorbidities. Participants were divided into three groups: group education (using maps), individual education and conventional care. In this trial, mean $HbA_{1c}$ concentrations decreased in all groups, but decreased significantly more in the individual education cohort compared to group education cohort and usual care group.

Another randomised controlled trial investigated the impact of reinforcing diabetes self-care in individuals who had previously had at least 3 hours of prior diabetes education (Beverly et al, 2013). Individuals were either randomised to a group map-based education programme of four 1-hour sessions, or group education on cholesterol or blood pressure, which acted as the control. The map-based education group showed modest improvements in $HbA_{1c}$ levels at 3 months post-intervention, but the improvement was not maintained at 6 and 12 months post-intervention. People in the control group did not improve $HbA_{1c}$ levels at any time during follow-up.

A recent retrospective case–control study was carried out investigating any improvements in diabetes, hypertension and hypercholesterolaemia in people who had attended one or more Conversation Map education class compared to those who had not (Crawford and Wiltz, 2015). The $HbA_{1c}$ in the intervention group decreased by 14 mmol/mol

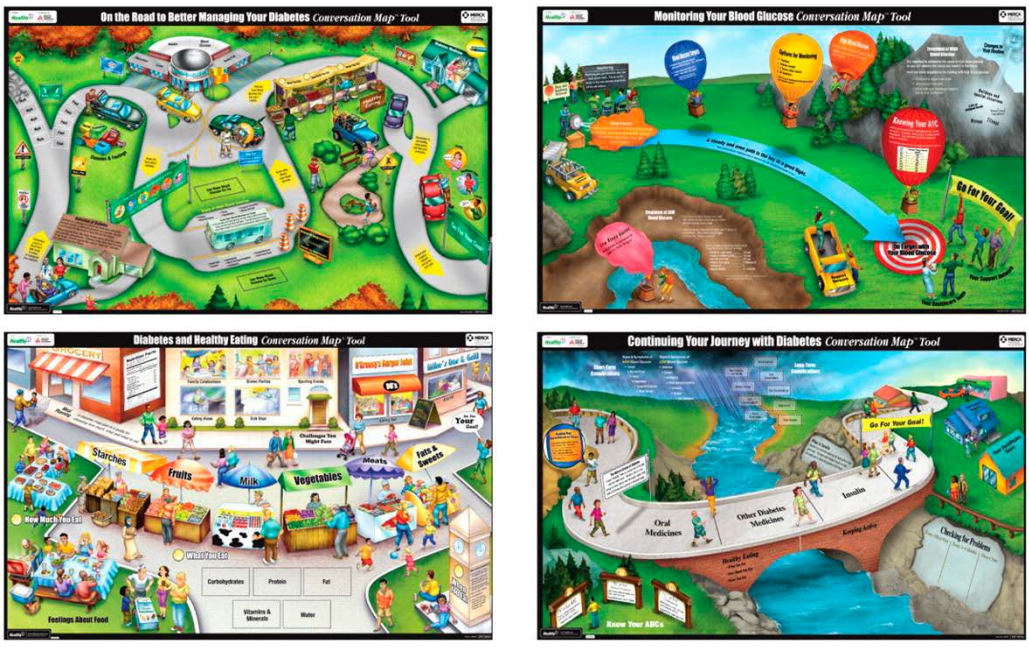


*Figure 1. Examples of the US Diabetes Conversation Map® tools produced by Healthy Interactions®, Inc (Chicago, IL).*

(1.3%), while, in the control group, there was no significant change in $HbA_{1c}$. There were also more favourable outcomes in blood pressure and LDL-cholesterol values in the group who attended classes.

In the UK, a collaboration with Healthy Interactions, Diabetes UK and Eli Lilly saw conversation maps trialled and rolled out across the UK. The initial drafts of the maps were piloted by Diabetes UK in February 2008 in 56 people with type 2 diabetes of differing durations in one 1-hour session. Eighty-four per cent of participants rated the way of learning using the tool as very effective, and 81% said that the experience was very effective compared with other ways of learning. Following these results, a roll-out strategy across in the UK was developed. Roll-out used existing diabetes educators, with nine lead facilitators (specialist nurses and dietitians) and by the end of August 2010, 99 training sessions had taken place, with 1542 healthcare professionals trained in the use of the Map tools (Cradock et al, 2010).

## Use of conversation maps in a rural population

In 2011, the University of Mississippi School of Pharmacy, Jackson, MS, used the US Diabetes Conversation Map tools in diabetes education sessions in two rural communities in the Mississippi Delta. There were no pregnant women in the classes, so the gestational diabetes map was not used. One setting was alongside a medication therapy management (MTM) programme in a federally qualified health centre in Yazoo City, Mississippi, and the other was alongside an employee-based MTM programme in Greenwood, Mississippi. Before beginning the series of diabetes education classes, participants at both sites were screened for health literacy as part of a larger project. Most participants were identified as having low health literacy, which was useful information that allowed facilitators to slightly alter their conversations during the diabetes education sessions.

The employee-based site had 15 participants enrolled, who were mostly assembly-line workers. The group was well acquainted with each other and attended classes during their lunch break in order to not disrupt work productivity. As each map generally takes about 2 hours to complete, the solution was to split each map over two sessions (eight 1-hour sessions). There was also only one facilitator, so all participants attended the same session. In the federally qualified health centre, there were only four participants per group. Since there were no time restrictions, these sessions could last the recommended 2 hours.

## Practical lessons learned

Following the sessions using the Conversation Map tools in the rural populations the following lessons were learned and may be useful when launching your own map-based education programme or any other group education session.

- Beginning the group education sessions with introductions and an ice-breaker can be helpful to manage participant expectations and make participants feel more comfortable with each other and fully engage in the session.
- Group sessions using the Conversation Map tool were held with four to 15 people, even though the preferred maximum number of participants is 10. With increasing participant numbers, it can be difficult to keep the group focused for the entire session. This is especially true if participants are already acquainted with each other, as in the employer-based MTM group. Smaller groups would provide fewer distractions and more opportunities for each participant to contribute.
- It is expected that each group will have their own dynamics. Typically, there are those who are generally quiet, and those who are fairly talkative who may dominate the discussion. Facilitators must encourage those who are quiet to participant, while sensitively ensuring that others do not dominant the session. It can feel uncomfortable to quieten the more talkative group members in fear of offending; however, asking specific, direct questions to quieter members can improve

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3. Ensuring that correct information is circulated is vital as, occasionally, participants will provide incorrect information.

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the balance. In our experience, gently interrupting the talkative participant and changing the direction of the discussion often works to keep the conversation moving.

- Ensuring that correct information is circulated is vital as, occasionally, participants will provide incorrect information. It is important that this is corrected in a gentle, non-threatening manner. One way to do this is to repeat the question to the entire group and ask if there are any other thoughts. Often, someone else will bring up the correct answer and the facilitator can expand. Providing patient handouts also ensures that correct information is available. Facilitators should research available resources and identify those that may be helpful for the participants, keeping in mind the average reading level of group participants. The Healthy Interactions website has handouts available to facilitators to download. There are also many other online resources that may provide additional information that would augment the topics being discussed, such as the "Living with Diabetes" section from the American Diabetes Association website (www.diabetes.org) and Diabetes UK (www.diabetes.org.uk).
- Bring scrap paper so each participant has the opportunity to take notes during the discussion. There can be a lot of information covered in each session, so many participants may benefit from taking their own notes to review after the sessions.
- Scheduling group sessions at a convenient time for most participants is of great importance. A mid-week session may be well-attended by those who are not employed, but offering a session on the weekend or an evening would be helpful if many of your patients work during weekday hours.

## Conclusion

Diabetes education is a vital part of helping people understand the condition and take the steps to preventing long-term complications. Individual education is a widely used method, but often time is a limitation, so developing and testing different tools to deliver education is vital to ensure an understanding that will lead to informed decisions. ■

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