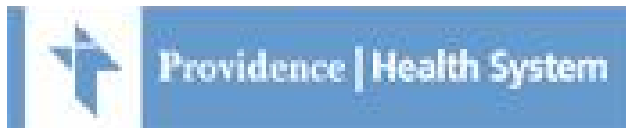


This product was developed by the St. Peter Family Medicine Residency Program in Olympia, WA. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

# Primary Care & Diabetes: Changing Care Through Collaboration and Self-Management

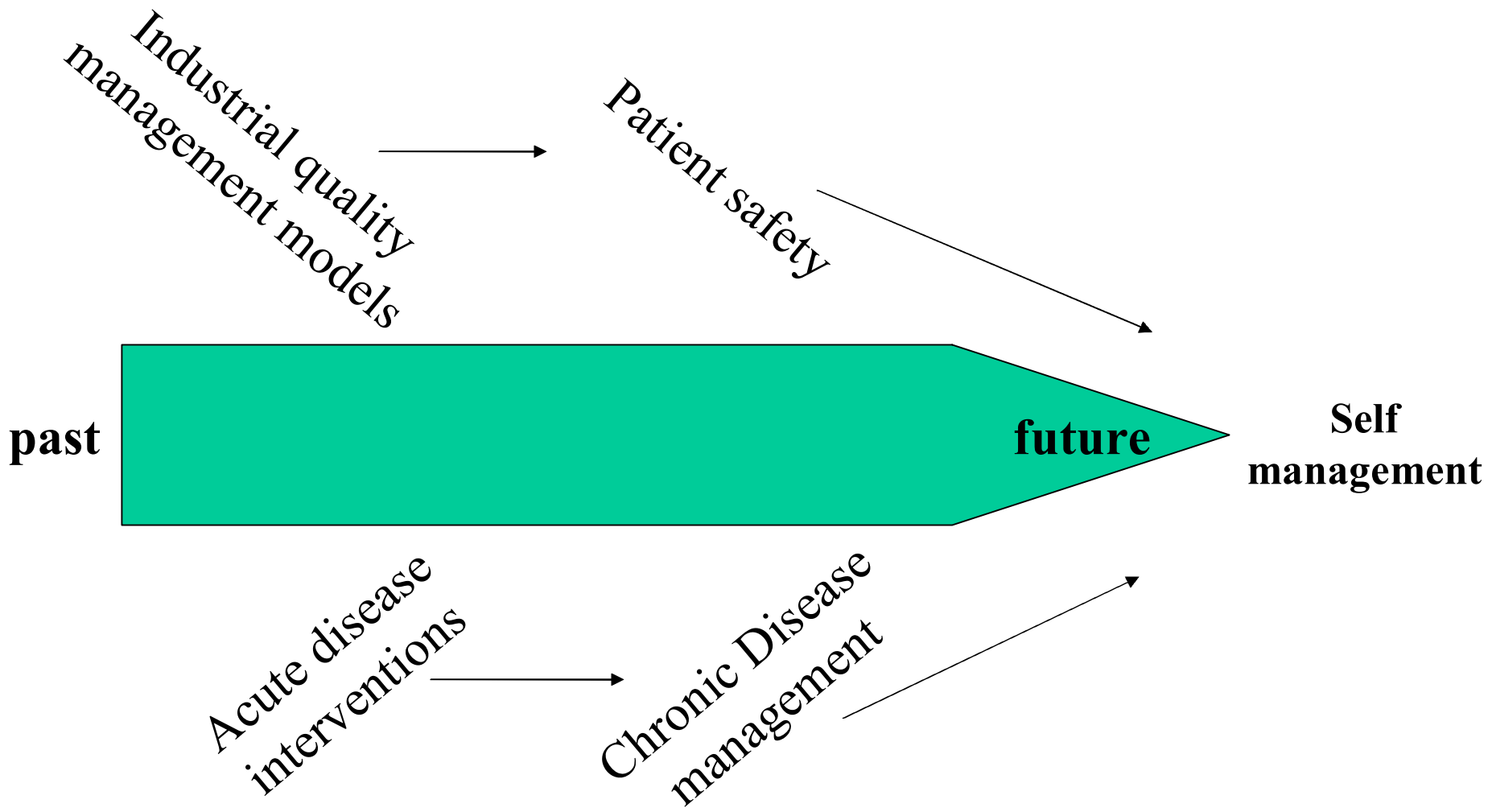
November 12, 2004



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# Objectives:

- Understand self management as the new trend in primary care.
- See self management as the answer to care for chronic disease.
- Understand several examples of how we are doing this at St. Peter Family Medicine in Olympia.



**Primary Care & Diabetes: Changing Care Through Collaboration and Self-Management**

# Quality Management Mandate

- With some success at the assembly line, employers mandated quality improvement techniques for healthcare.
- But, with complexity increasing faster than costs, the same success in healthcare processes remain elusive.

# To Err is Human

- At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies.

- IOM 1999

# First Do No Harm: Patient Safety

- Industrial Quality Management: engineering, statistics,...process improvement for inanimate objects.
- Regulatory approaches: JCAHO, NCQA, ... economic, legalistic approach...creates barriers to entry, gives regulators job security, sets up for sanctions for providers,...

*What is missing?*

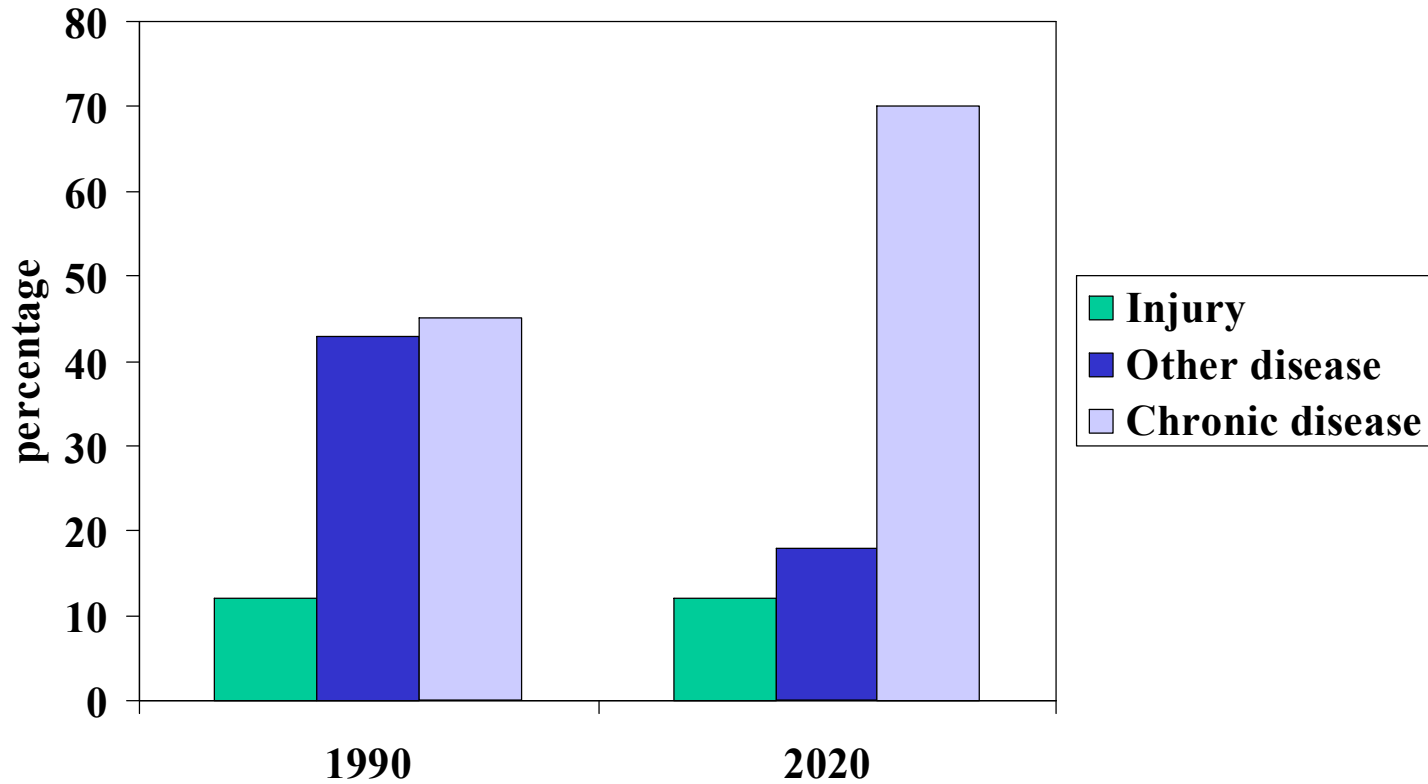
# Patients

- A new quality model exploits the very weakness of previous quality models...the autonomy of the patient is encouraged to take control of their own disease.

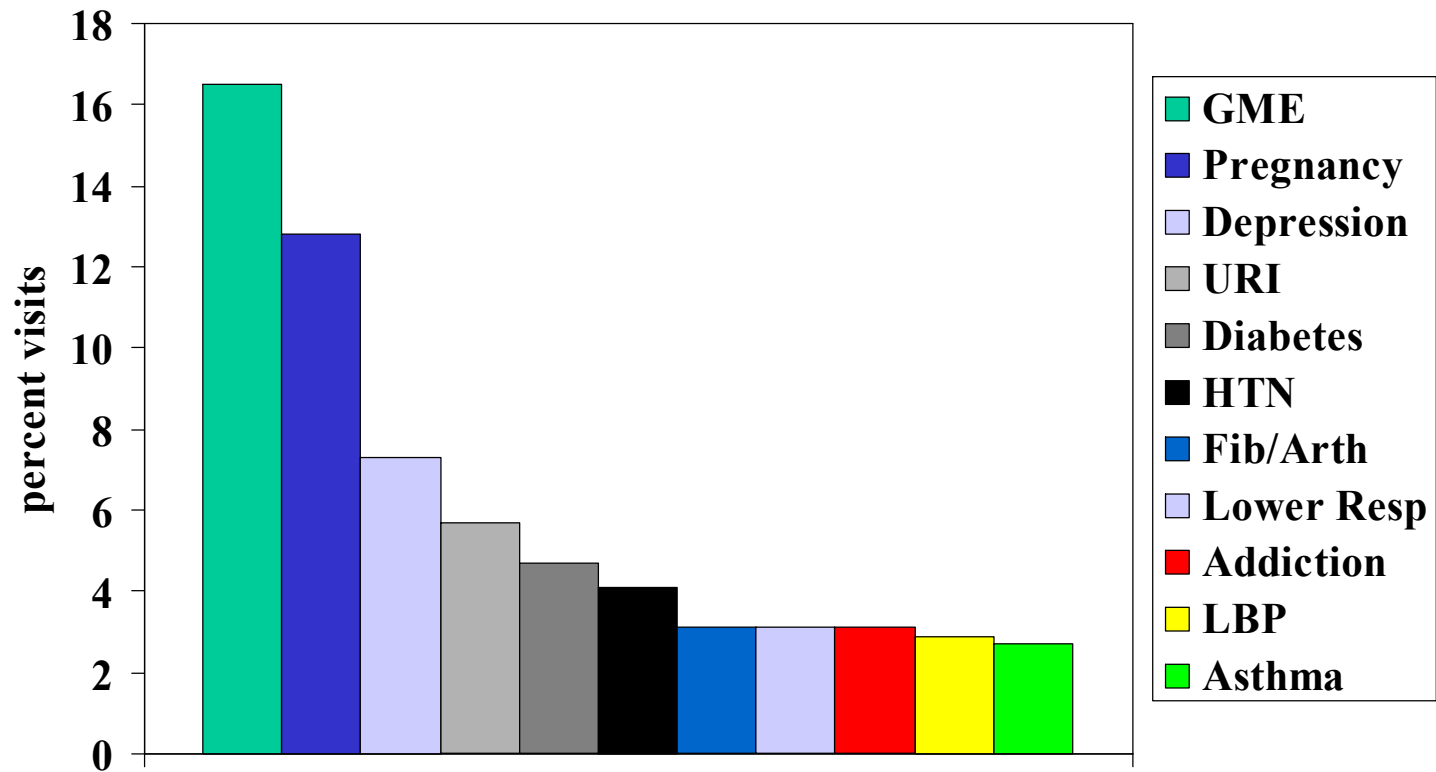
Self management



# What we will see in Practice...



# What we see in our practice now



# Prevalence of Diabetes & IGT:

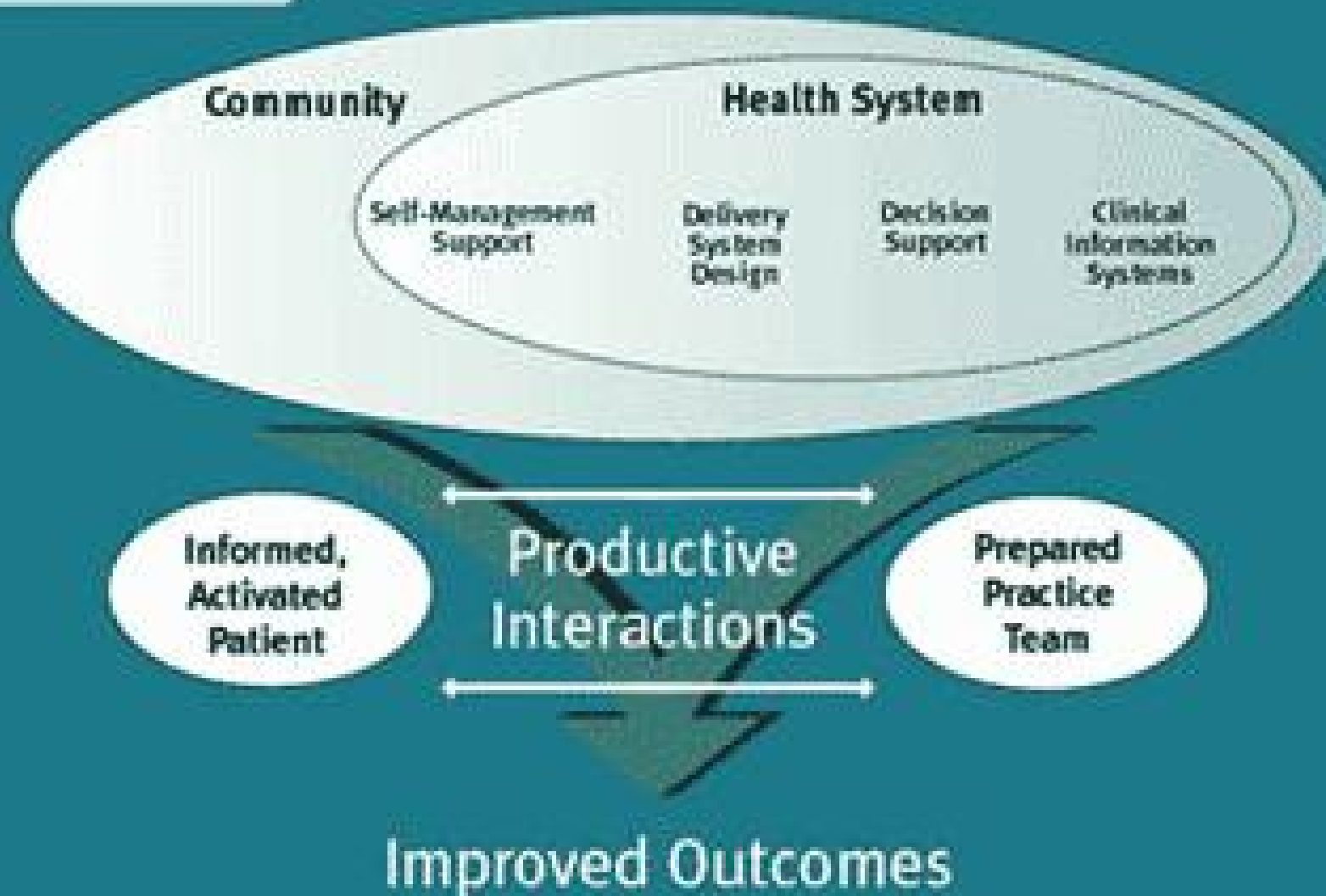
- WHO estimates that those with DM worldwide will double from 140 million to 300 million in the next 25 years
- ...and 40-45% of persons age 65 years of age or older have either type 2 diabetes or IGT
- CDC estimates that 1 in 3 born in 2000 will develop diabetes in their life time

Is Primary Care  
ready for this challenge?  
(historically created to respond to  
symptom-based acute care)...



Improving  
chronic  
illness care

# Chronic Care Model



# Diabetes:

## Evidence Based Medicine...

- HBA1C as close to 5 as possible
- BP consistently less than 130/80
- LDL less than 70
- Screen for end organ damage
- Screen for/treat/monitor depression
- Teach good nutrition and benefits of exercise

# Self-Management: First Blush

- Checking blood sugars
- Taking meds (pills and shots)
- Eating right (CDE, doctor, other diabetics)
- Exercising (30 mins/day, 150 mins/week)
- Checking feet
- Making appointments (PCP, eye doc, CDE)

*What is missing?*

# Patients live this 24/7/365

- “The patient’s right and responsibility to make decisions that make sense *within the context of their lives*”
- “Must acknowledge and support *the patient’s role as the key decision maker* in self-management”
- “Education and support (must be) refocused on helping patients *make & achieve goals* and outcomes *that they themselves* have selected”
- Centrality of behavior, in every part of daily life and for “the rest of your life”
- Patient role? Provider role? Staff role? Others?



# How do we respond?

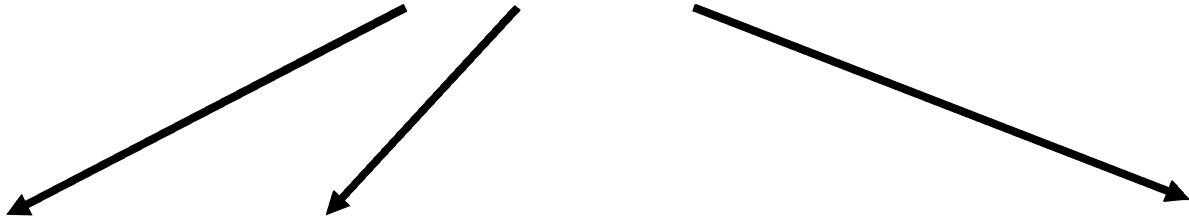
We use the Chronic Care model, but we also need to **understand behavior and behavior change:**

- Non-directive support vs. Directive support
- TTM (readiness-to-change) model
  - Pre-contemplative (I won't, I can't), contemplative (I may), preparation (I will), action (I am), maintenance (I still am)

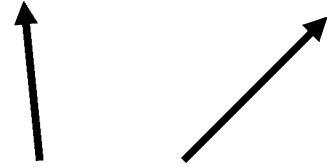
# Nondirective vs Directive Support

- Directive- “Check-on” patient
  - Taking responsibility for tasks/care, take charge/control, and monitor their health
  - Directing choices and feelings, problem solving
- Nondirective- “Check-in” with patient
  - Cooperating without taking over
  - Accepting patients choices and feelings and recognizing limitations
  - Offer range of suggestions
  - Show interest in their wellbeing

# Nondirective



Precontem- pation “I WON’T” “I CAN’T”	Contemplation “I MAY”	Preparation “I WILL”	Action “I AM”	Maintenance “I STLL AM”
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# Directive

# Humanizing chronic disease *is* self management

- “All day every day for the rest of your life”
- Planning and preparation
- Team approach
- Nondirective support
- Opportunities to try new behaviors

# Background...

- We are a Residency Program practicing and teaching full scope FM
- 35,000 patient visits a year
- 6 FPs, 3 ARNPs, and 18 Residents. UW & other medical students. Primary support staff – MAs
- Approx. 300 patients with diabetes
- Participated in WSDC II in 2000-2001, and RWJ SM grant phase I in 2002-2003 & phase II 2004-2006

# Lessons learned so far:

- Meta-analysis of effects of self management on HBA1c
- Relative to controls, self management results in improvement of HBA1c:
  - **.76 point at immediate follow up**
  - .26 point at follow ups  $\geq$  4 months after treatment
- Only **predictor of success**: *Duration and frequency of contact* “Interventions with **regular reinforcement** are more **effective** than one-time or short-term education”
- SPFM has seen a **.42 point reduction** in HBA1c over 15 months

# Our *re-design* includes...

- Registry to support patient care (CDEMS)
- MA Planned Visits with goal setting
- Provider Visits with emphasis on patient goal setting
- Group Medical Visits (3 types)
- Exercise opportunities
- Patient Mentoring (buddy system)
- Newsletter

*What do you want to hear about?*

# Patient Data Registry (CDEMS)

- Free from the DOH, developed locally
- MA's do data entry and use for patient outreach
- PCP's use patient report with the patient visit
- PCP/MA team can query their data to target care (outliers), for patient recall, and for patient goal reinforcement



# How do we teach this to the MA's?

- A new curriculum for the MA's (*A new service for diabetes educators?*)
- Skills in-service; foot checks, CDEMS, planned visits, phone skills, group visits
- Shadowing
- On the job training

# MA planned visits: (see standing orders)

- They follow the standing orders
- Introduce SMG setting
- Occur 1 week before provider visit
- 90% of our MA's perform planned visits
- This frees up some of the provider time



How do we do and teach this to  
the providers?

**Big Bad**

**Sugar WAR**

# The 15 minute encounter: A tool Big Bad Sugar W.A.R.

- Background
- Barriers
- Successes
- Willingness to change
- **Action plan**
- Reinforcement

# The Goal- *An Action Plan*:

- Something the patient comes up with and WANTS to do
- Should be REASONABLE
- Behavior specific
- Should answer the questions:
  - What?
  - How much?
  - When?
  - How often?
- Confidence level (likelihood-of-success) 1-10

# Patient Goal Quality

- Evaluate, record, and track patient SMG quality (in CDEMS)
  - 1 point for **activity** (what- i.e.: briskly walk, *or* stop skipping breakfast)
  - 1 point for **location** (where- i.e: around Capital Lake, *or* at home and at the office)
  - 1 point for **frequency** (how often- i.e: M,W,F, *or* 5 days a week)
  - 1 point for **time/duration** (how long- i.e.: for 45 minutes at 7:00 am, *or* 8 am before I leave for work)
  - 1 point for **LOS score** (from 1 to 10)

# Self Management Quality



*How hot are you?*

*The ideal goal is patient initiated and patient orientated having taken into account all previous successes and any current barriers, is small and reachable and is very specific. Our hope is that a patient is able to build on a series of small successes that, collectively, lead to big rewards.*

**QR-5 I will walk on a treadmill at home on M-W-F at 6 a.m. for 30 minutes. LOS Score=8/10**

**QR-4 Go to YMCA and do water aerobics for 1 hour from 5-6 p.m. everyday.**

**QR-3 Ride bike 3 times per week around neighborhood.**

**QR-2 Check blood sugars 2 times per day.**

**QR-1 Quit Smoking.**

## Quality Rating Scores ...

- 1 point-Activity (what they are planning on doing)
- 1 point-Duration (how much)
- 1 point-Frequency (when...morning, noon, night MWF etc.)
- 1 point-Location (where are they going to perform this new activity)
- 1 point-LOS Score (a patient's self-assessment of how likely they will to be successful, from 1-10)



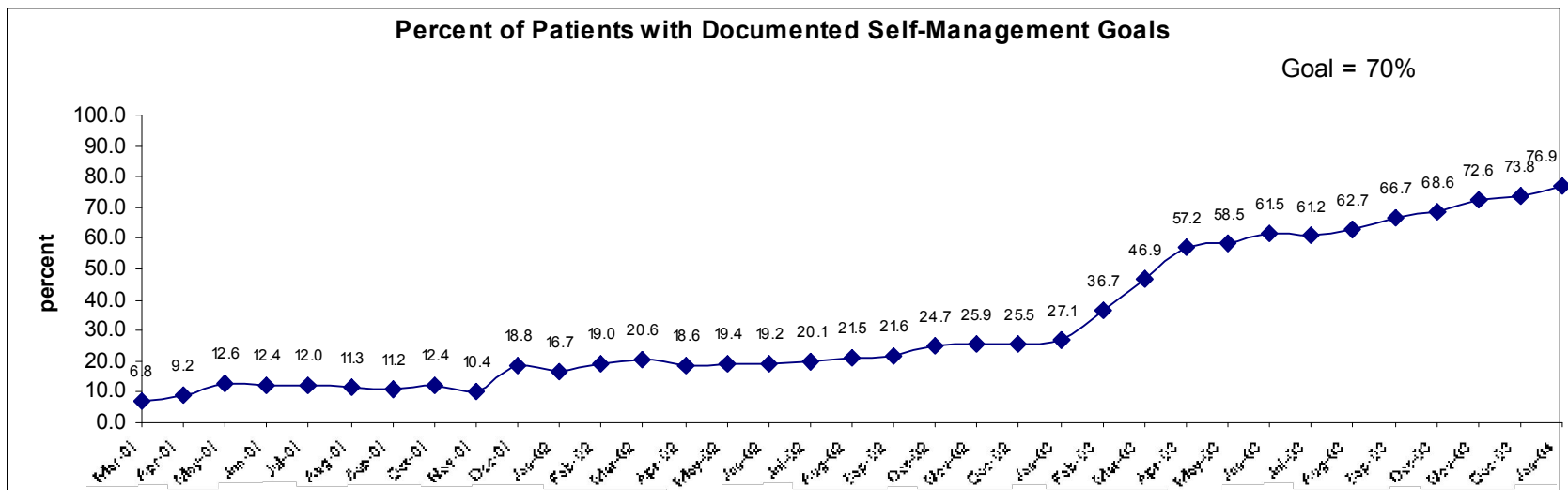
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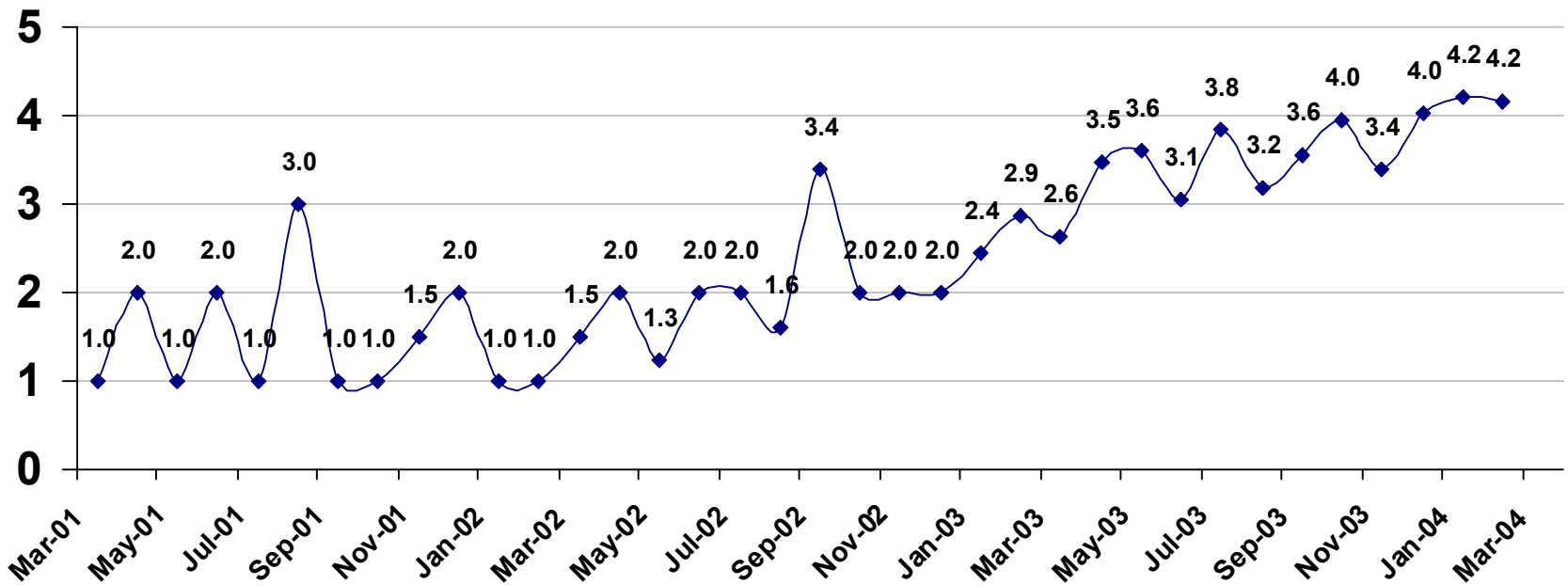


# % of patients with goal



# SMG quality over time:

## Clinic SMG By Date



# The Group Visit

- Developing patient oriented self-management curriculum
- More providers (faculty), more staff being trained
- More patients coming
- Now an educational expectation for residents
- High patient satisfaction
- Outcomes in 2001-2003:
  - HbA1C of our practice: 7.7
  - HbA1C of those who come to DGV: 6.3

# New models of Group Visits

- “Traditional” Group Visit
  - 15 to 20 patients for 2 hrs with 2 hrs of pre and post work, with teaching, goal setting
- Open Office Group Sessions
  - 10 patients with patient initiated agenda
- “Mini” Group Visits
  - 4 patients in 1 hour with 1 provider during a traditional clinic session

# Exercise Opportunities

- Walking Club
- Pedometer Program
- *“SPFP Moves With You”* Video

# Patient Mentoring (buddy system)

- *Patients are supporting patients*
- *Administrative staff are supporting patients*
- One patient (or staff) calls another patient about 2 months after the provider visit to “check-in” with their SMG
- Sent a card with a patient’s information
- Provides additional support and accountability
- Bridges the gap between the planned/provider visit and the beginning of the next cycle

# What is next? Spread...

- Graduate trained providers
- Continue grant work- *Phase II*
- In-service local provider clinic- *Elma*
- Provide training to local MA's
- Develop MA training curriculum
- Washington State STEPS grant

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