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This product was developed by the Robert Wood Johnson Foundation Diabetes Initiative. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.



**DIABETES INITIATIVE**  
A National Program of The Robert Wood Johnson Foundation



## Two Approaches to the CDE's Role in Redesigning Primary Care

**AADE's 2007 Annual Meeting & Exhibition**

**Carol Brownson: [cbrownso@im.wustl.edu](mailto:cbrownso@im.wustl.edu)**



# *Objective*

To describe the role of the CDE in two different approaches to improving organizational capacity and patient services to support self management



## *Background*

- Most patients with diabetes are cared for by their primary care provider
- Among the elements of the Chronic Care Model, Self Management Support has received somewhat less attention than other components of the model
- The patient - clinician encounters are brief and do not allow enough time to address all aspects of self management, resulting in gaps in care

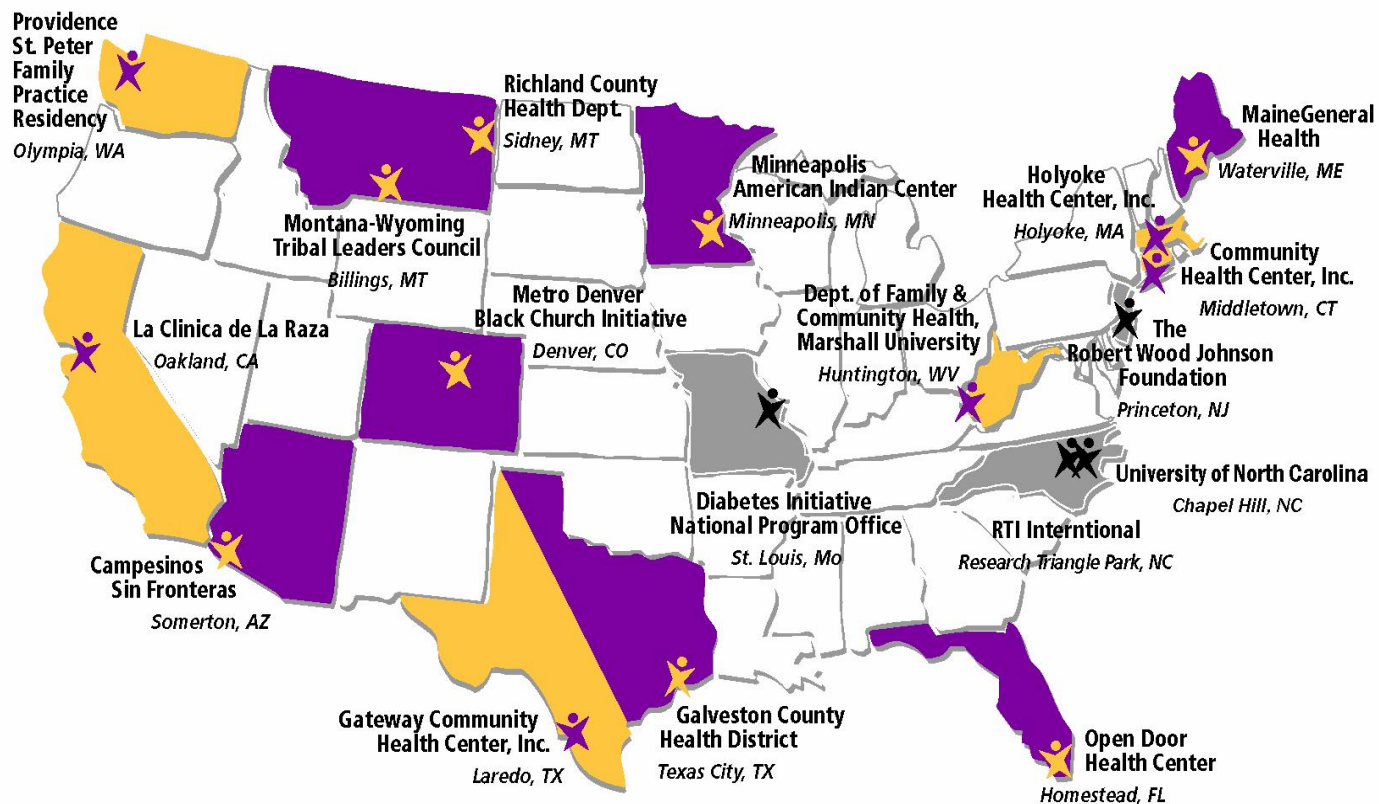


## *Background, cont'd*

- To address this gap, the Robert Wood Johnson Foundation launched the *Diabetes Initiative* in 2002 to demonstrate and disseminate successful models of self management support
- One of two programs of the Initiative, *Advancing Diabetes Self Management* (ADSM) was implemented to “demonstrate that comprehensive models for diabetes self management can be delivered in primary care settings and can significantly improve patient outcomes”



# *The 14 Sites of the Diabetes Initiative*





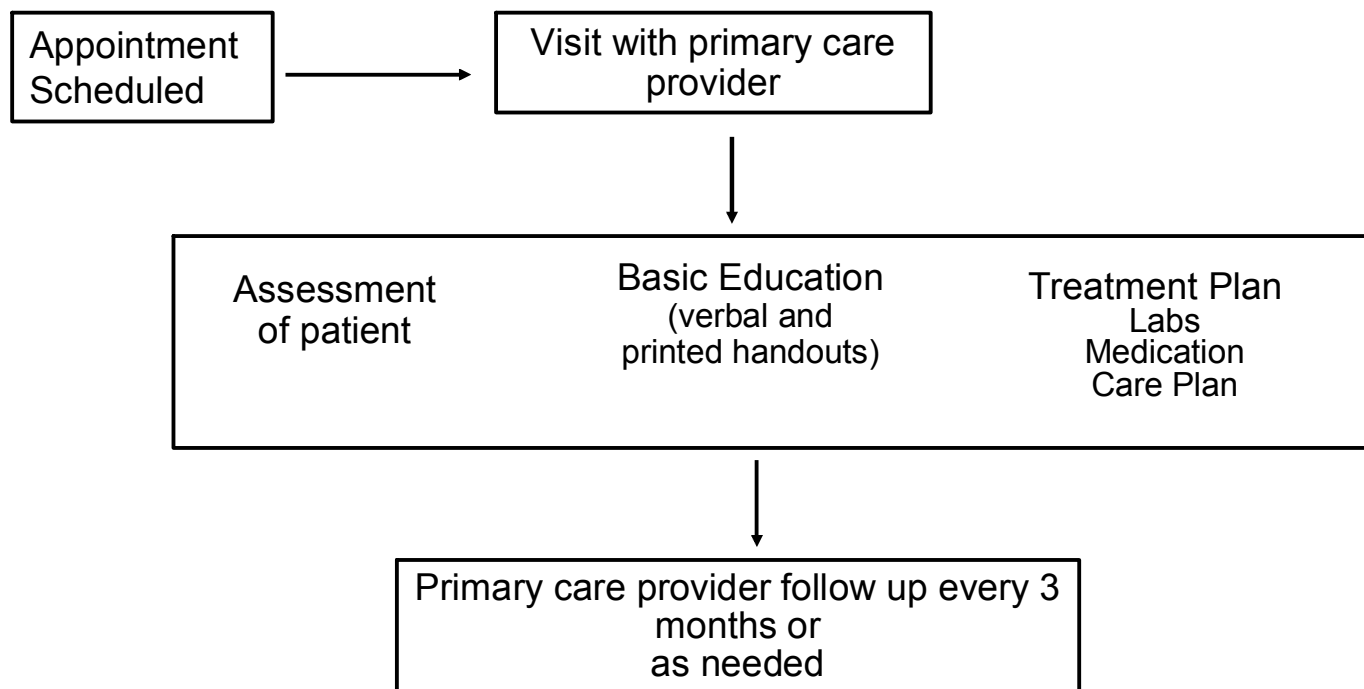
## *Resources & Support for Self Management*

- Individualized assessment
- Collaborative goal setting
- Education and skills training, e.g., AADE7™
- Follow-up and support
- Community resources
- Continuity of quality clinical care

“Training in self-management is integral to the treatment of diabetes. Treatment must be individualized and must address medical, psychosocial and lifestyle issues.” AADE website.

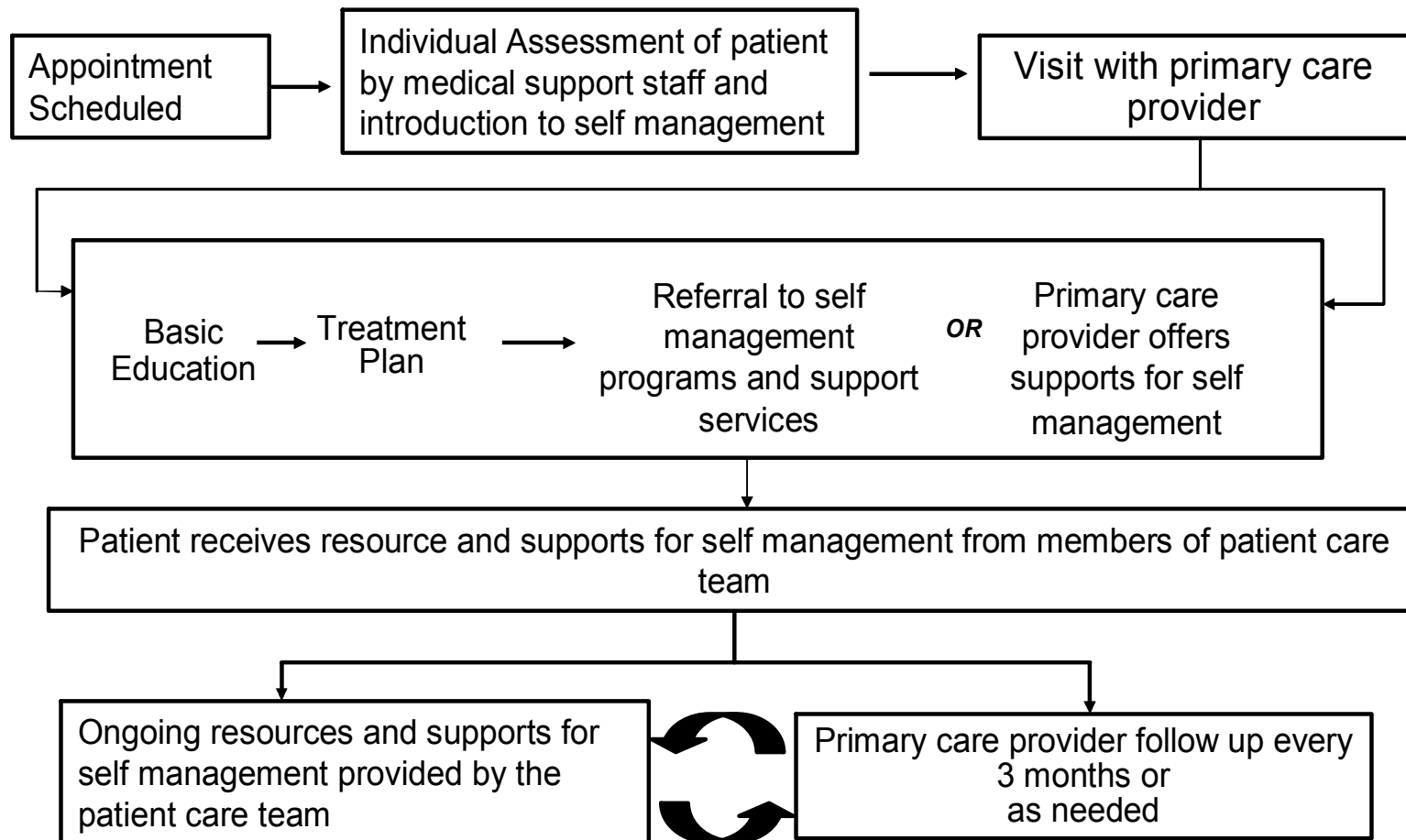


## Standard or Usual Care for People with Diabetes





## Integration of Diabetes Self Management into Primary Care







## *Our presenters.....*

St. Peter Family Medicine Residency Program,  
Olympia, WA

- Jan Wolfram, RN, MN, CDE
- Shari Gioimo, MA

LaClinica de la Raza, Oakland CA

- Joan Thompson, PhD, MPH, RD, CDE
- Carlos Flores, MPH



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## *CDE Role in Redesigning Primary Care: Training MAs in the CCM*

Jan Wolfram RN, MN, CDE  
Shari Gioimo, Medical Assistant  
Providence St. Peter Hospital, Olympia, WA  
August 3, 2007

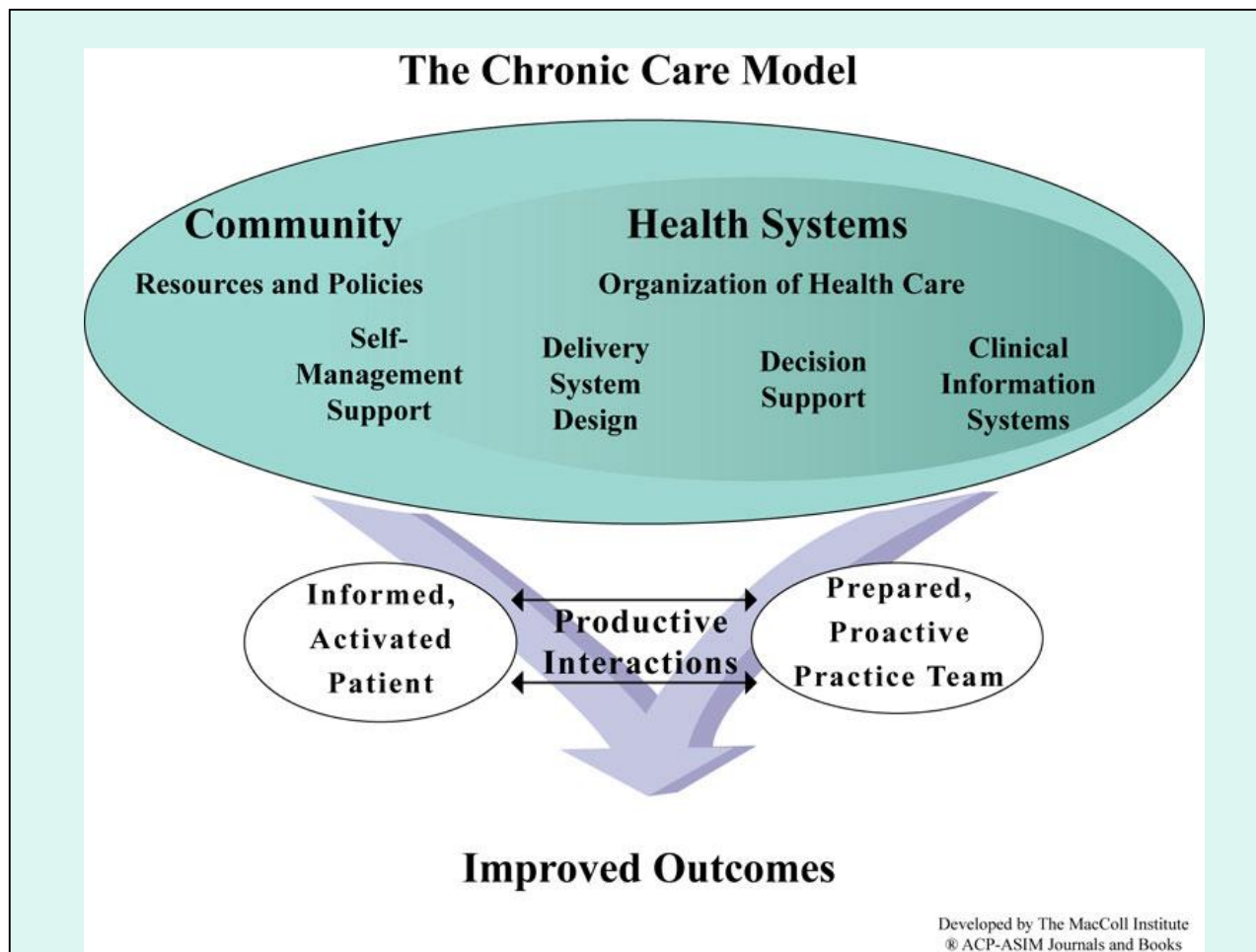


# *PSPH Medical Assistants & Boldt Diabetes Center*





# *CDE's & Medical Assistants Work Within the CCM*





# *Expanded Role of the Medical Assistant*

- Data Registry Entry
- Goal Setting
- MA Patient Planned Visits
- Organized Patient Group Visits
- Referrals to Health Specialists (CDE's)
- Initiate Standing Orders
- Provide Follow-Up Phone Calls to Patients
- Foot Checks
- Immunizations
- DM Education Reinforcement





# *Dr. Devin Sawyer*





# Primary Care Self-Management Goal Cycle





## *Considerations for the MA Curriculum*

- American Association of Medical Assistants
- Western Washington Area Health Education Center
- Health Care Assistant Law in the State of Washington





## *More Considerations for the MA Curriculum*

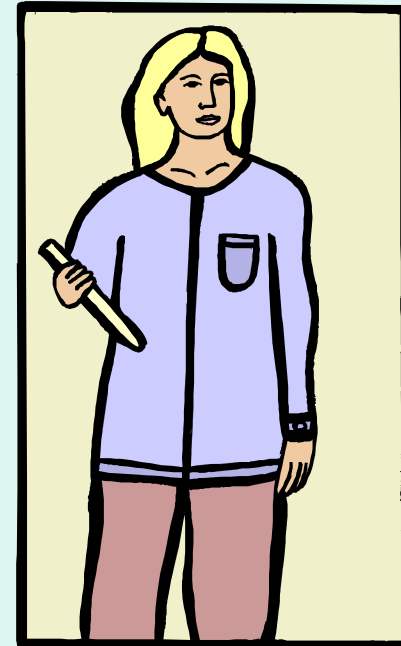
- Review of MA Focus Group Results
- Review of MA Curriculums from Local Technical Community Colleges
- Literature Search on MA Training for Diabetes Care
- Review of Published Diabetes Knowledge Surveys for Patients



# *Medical Assistant Learner Characteristics*

## Characteristics of MAs in Primary Care

- 18 Medical Assistants
- Most Caucasian
- Trained locally
- Significant Family Responsibilities

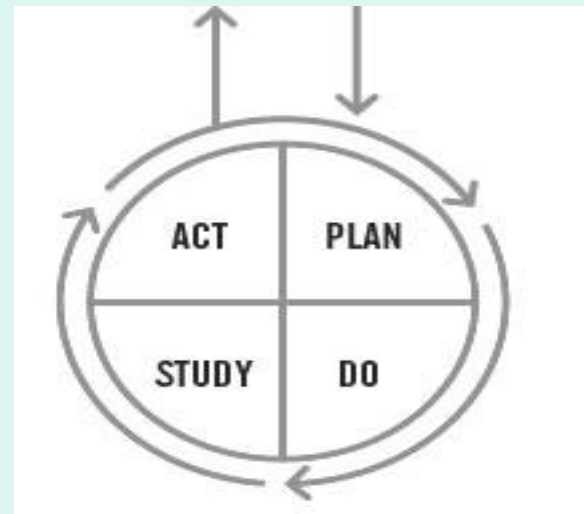




# *Rapid Cycle Improvement Process*

## Rapid Cycle Improvement Process

- MAs attended patient DM classes.
- MAs gave feedback.
- PPT slides for MA training edited.
- Classes revised





# *MA Curriculum Matrix*

<b>Reporting Conditions</b>		X	X		
<b>Goal Setting</b>		X	X	X	X
<b>Long-term Complications</b>	X		X	X	X
<b>Acute Complications</b>	X				
<b>Diabetes Treatments</b>	X	X	X	X	X
<b>Pathophysiology of Diabetes</b>	X	X	X	X	X
<b>Age, Race, Gender Awareness</b>		X	X	X	X
	<b>Registry Data Entry</b>	<b>Telephone Follow-Up</b>	<b>Planned Visits</b>	<b>Provider Visit</b>	<b>Group Visit</b>



# *Applied Educational Theories*

- Mezirow Transformational Learning
  - Experience
  - Reflection
  - Discussion
- Knowles Adult Learner
  - Independent Learner



## *Educational Methods*

- Cognitive Methods: Lectures, Discussion, PPT slides
- Behavioral Methods: Role-Play, Phone Scripting, Computer Practice; Diaries for Food, Blood Glucose, & Exercise
- Kinetic Methods: Self-Blood Glucose Monitoring, Glucose Gel and Tablet Tasting, Injection of Normal Saline



## *Shari Gioimo, Medical Assistant*



- Active Participant in the Diabetes Initiative
- National Consultant to Clinics Expanding the MA Role
- Certified Trainer in Chronic Disease Self-Management



## *Clinical Life before the MA Expanded Role*

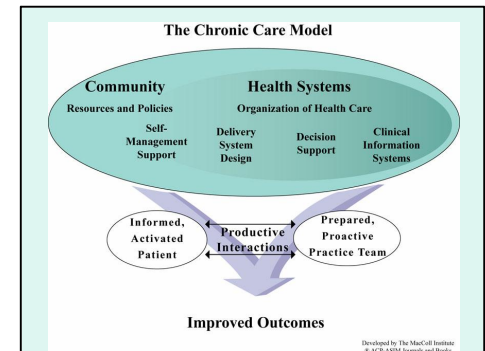
- The MA traditionally “roomed” and “vitaled” the patient prior to the PCP visit
- The MA was dependent on the PCP direction
- The MA-Patient Relationship was not well developed
- The MA role was to perform tasks and keep the office flow moving





# *Delivery System Design*

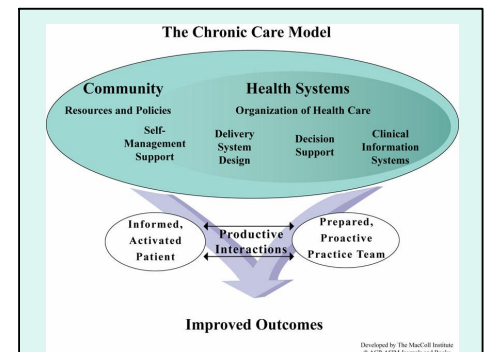
- Individual “Planned Visits” with MA and Patients
- MA Organized Group Visits with PCP and Patients





# *Decision Support*

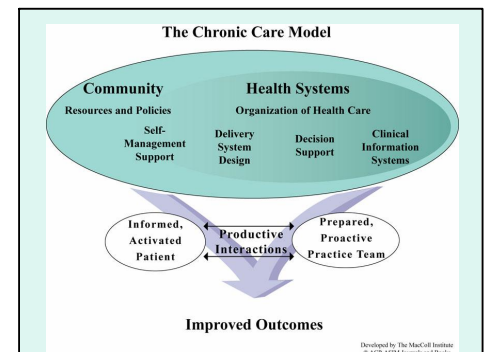
- Standing Orders:
  - **Introduce the Idea of Self-Management**
  - Laboratory (Tests A1c, etc.)
  - Immunizations
  - Foot Checks
  - Referral to CDEs and specialists





# *Self-Management Support*

- Goal setting using the Transtheoretical Model
- Follow-up phone calls to “check-in”
- Goal Trotter’s Walking Club
- Newsletters

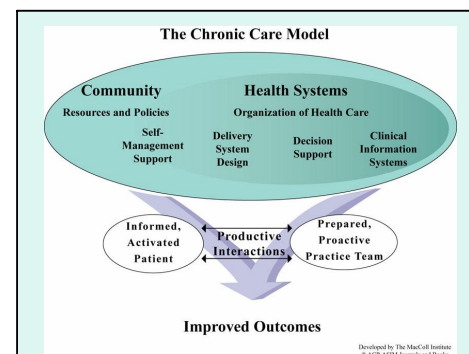




# *Clinical Information Systems*

## Data Input into CDEMS Registry

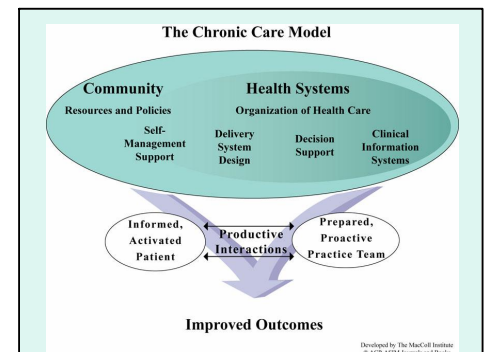
- **Self-Management Goals**
- A1c
- Lab Results
- Immunizations
- Eye Exams
- Smoking Cessations
- Medications
- Vital Signs





## *Interaction with the Community*

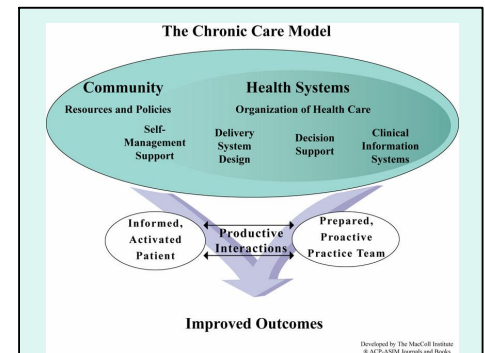
- Consult with local CDE's regarding questions on diabetes.
- Consult with other community agencies and programs such as the Food Bank, YMCA, and Senior Centers.





# *Health Systems Support*

- MAs give administrative leaders and doctors feedback.



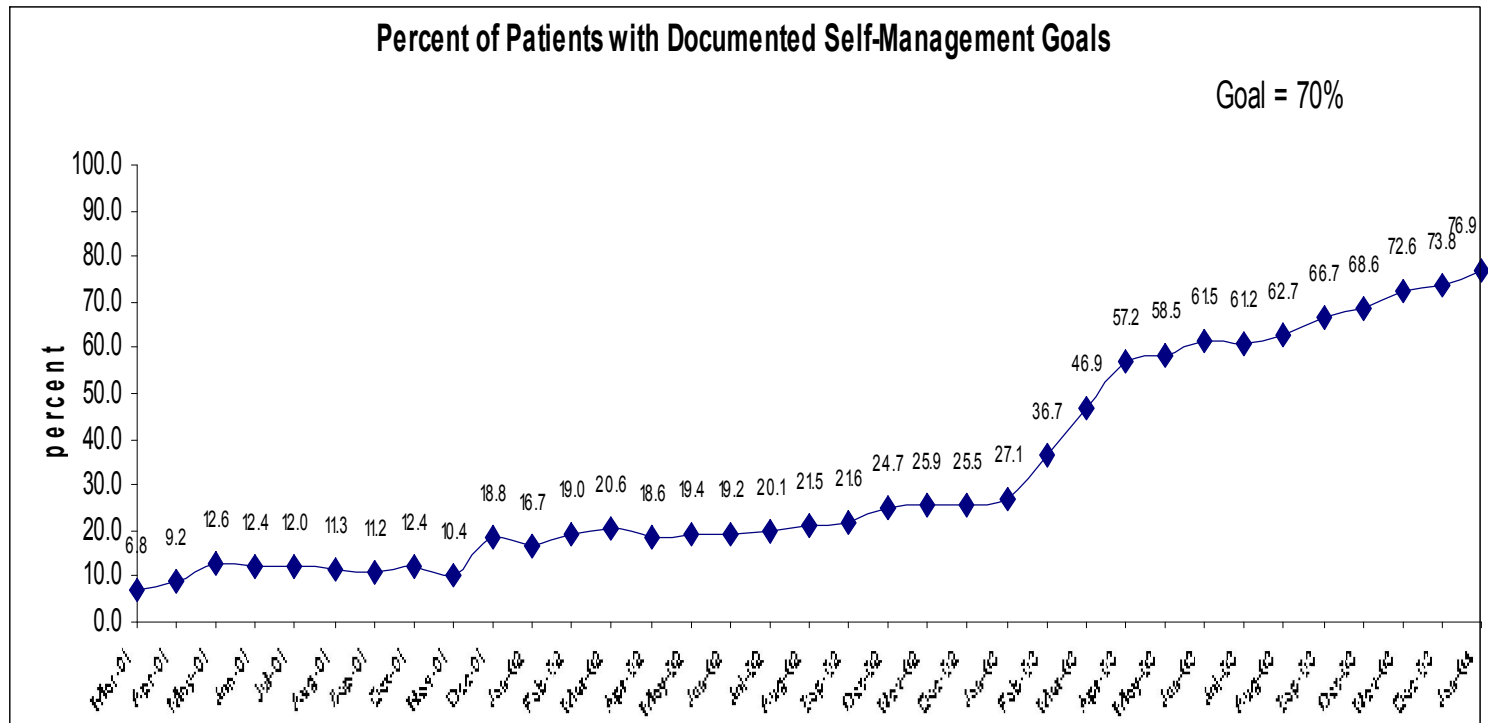


## *Clinical Life After the MA Training*

- MA-Patient relationship is better.
- MA patient care is more organized.
- MAs receive more respect from team members.
- MAs reinforce patient education.
- MA retention rate is higher.



# Percent of Patients with Self-Management Goals







# Quality of Patient Self-Management Goals

## 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 ...**

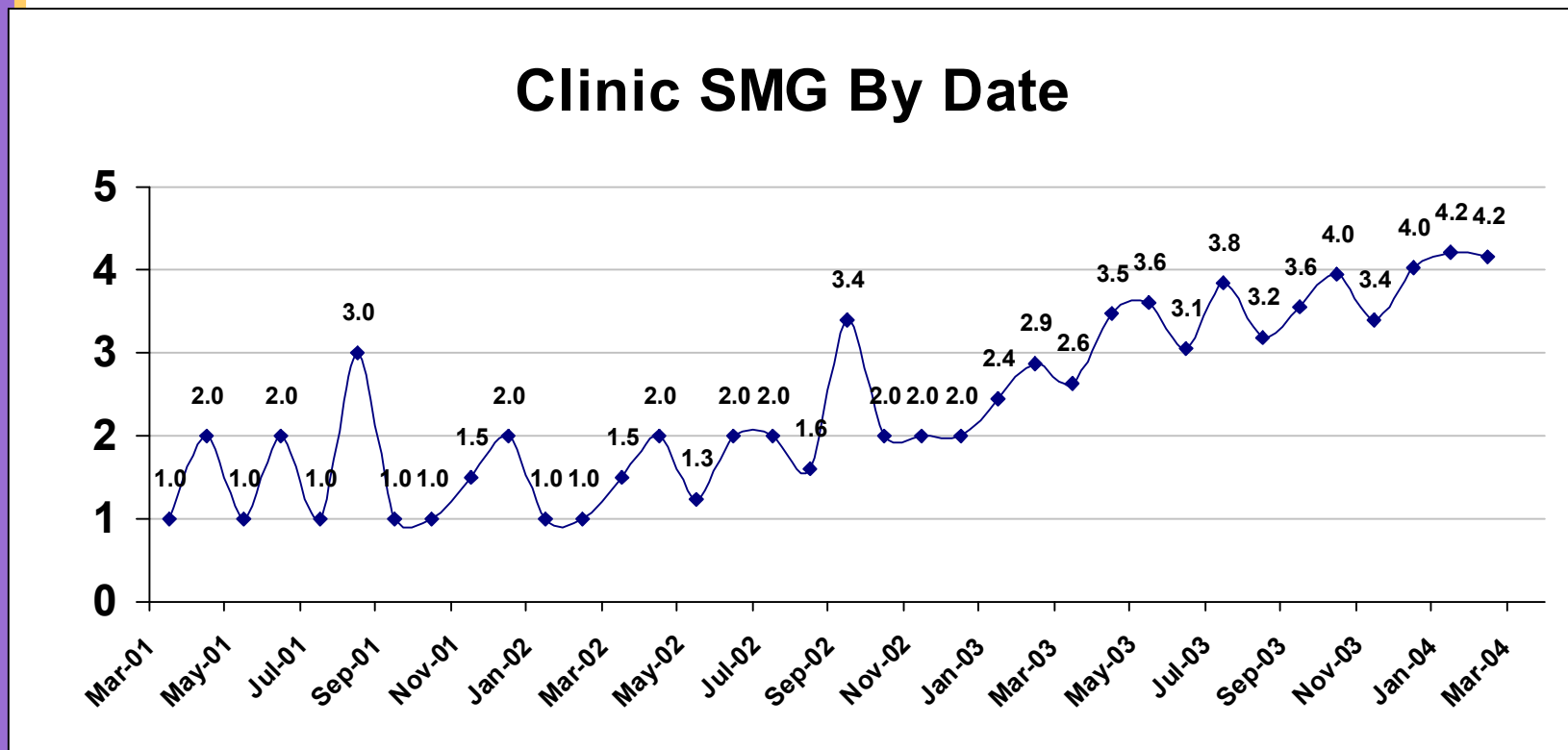
- 1 point-Activity (what they are planning on doing)
- 1 point-Duration (how much)
- 1 point-Frequency (when...morning, noon, night MWF etc.)
- 1 point-Location (where are they going to perform this new activity)
- 1 point-LOS Score (a patient's self-assessment of how likely they will to be successful,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

**Providence St. Peter Hospital**

A Caring Difference You Can Feel



# Quality of Self-Management Goals Over Time





# *Opportunities*

- The MA Curriculum *A Work in Process*
- CDE's deliver MA training in local settings.
- Business expansion with referrals.
- Expand resource base for the CDE 's and the Family Medicine Teams.



## *Contacts*

- Jan Wolfram RN, MN, CDE  
janet.wolfram@providence.org
- Shari Gioimo MA  
Shari.Gioimo@providence.org



# *PSPH Medical Assistants & Boldt Diabetes Center*





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*Self-Management in Primary  
Care: Expanding the Reach of  
CDEs Through Health Promoters*

**AADE 2007**

**Carlos Flores, MPH  
Joan Thompson, PhD, MPH, RD, CDE**





# *Objectives*

- List different ways a health promoter (promotora) can be used as a physician extender
- List ways a CDE is involved in program development and quality improvement using the Chronic Care Model



# *Recruitment and Initial Training*

- Recruitment
  - Promotoras selected by their doctors. They have diabetes or a family member with diabetes.
- Initial Training (ten 2 hr sessions)
  - Diabetes self management skills,
  - Collaborative goal setting, action plans and problem solving
  - Counseling methods and confidentiality
  - Group facilitation







# *Promoter On-going Follow-up and Support*

- **Selected topics (every 2 weeks for 3 hours)**
  - Stages of change model
  - Depression and stress management – 18 hours
  - Medications
  - Cardiovascular disease
  - Meal planning methods
  - Smoking cessation
  - Food stamps, food bank, emergency services
  - Complications of diabetes
  - Asthma
  - Documentation of patient intervention
- **Monitoring –**
  - Clinical information system



# *Roles and Responsibilities of Promoter as Physician Extender*

- Provide follow-up and support through one on one phone counseling
- Lead/facilitate groups – walking club, support group, depression group
- Serve as liaison between patient and provider - case conferences.
- Serve as advocate for patients' needs
- Provide diabetes self management education – teach classes
- Facilitate participation in health care system



# *Promoter Intervention and Documentation*

- **Promoter intervention included**
  - Self management education in 4 areas
    - Meal planning
    - Exercise
    - Self monitoring of blood sugar
    - Medicine adherence
  - Determination of stage of change
  - Use of stage specific questions designed to move the patient along the continuum of change
  - Goal setting, barriers identification and problem-solving
  - Social support
- **Documentation**
  - Stage of change every 3 months
  - Clinical outcomes (A1c, LDL-cholesterol, blood pressure)

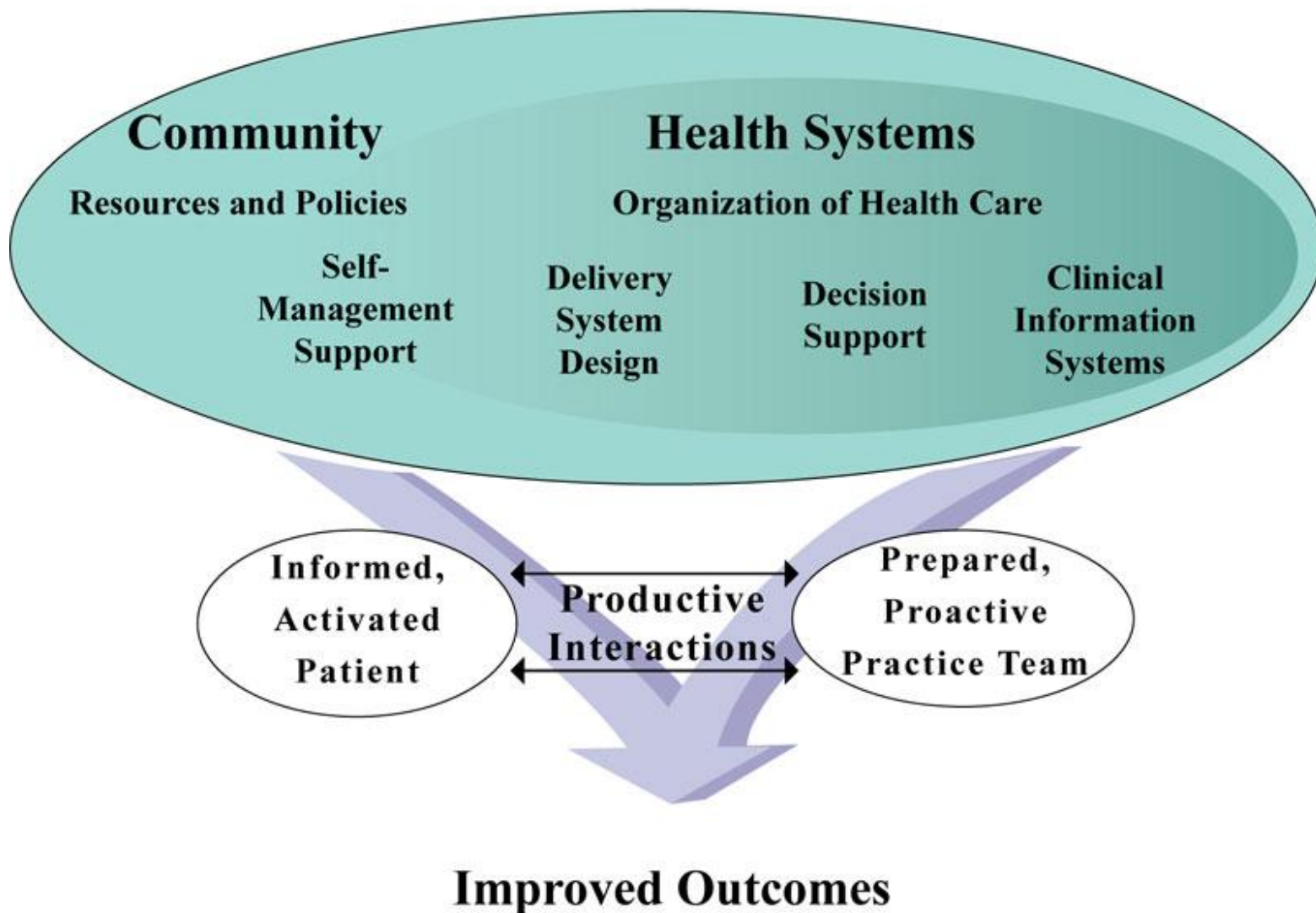


## *Comparison of Change in A1c, From Baseline to 6 Months and Baseline to 1 Year in the Total Sample*

	HbA1c (n=142)
Baseline	8.73
6 months	8.37 (p<.015)
1 year	8.25 (p<.004)



# The Chronic Care Model







# *System Changes Involving the Promoter, CDE and Other Players*

- **Community linkages**

- Promoter is the link to the community
- Promoter routinely distributed diabetes information at Farmers Market and health fairs
- CDE instrumental in arranging a contractual partnership between Robert Wood Johnson Foundation, Lumetra and La Clinica for production of educational materials

- **Delivery System**

- Physician referral to health promoter program
- CDE developed provider/promoter guide to Stages of Change intervention
- CDE provided training to promoters to enhance their knowledge and counseling skills
- Promoter contributed to continuity and coordination of care



# *System Changes Involving the Promoter, CDE and Other Players*

- Organization of Health Care
  - CDE involved in program planning, leadership and oversight
  - CDE attends all diabetes related continuous quality improvement committees
  - Promoter became integrated into the clinic's activities
- Decision Support
  - Promoter attended quarterly case conferences with providers





# *System Changes Involving the Promoter, CDE and Other Players*

- Clinical Information System
  - An additional registry flow sheet was developed to document patient activities and assessment using stages of change in areas of behavior change, self efficacy, social support
  - Promoters did some of the data entry
  - CDE tracked promoter adherence to program expectations and provided feedback



# *System Changes Involving the Promoter, CDE and Other Players*

- Patient Self Management
  - Promoters provided self management support
  - Promoters led groups (diabetes classes, walking club, support group)
  - CDE developed a series of stage specific pamphlets on each of the 4 behavioral areas
  - Promoters used Stages of Change for assessment and for stage specific intervention strategies
  - Promoters used Viva la Vida, a bilingual low literacy manual for diabetes education, developed by the CDE
  - Promoter and mental health specialist co-facilitated depression groups



# *Stages of Change and Behaviors*

## Stages - definition

- Pre-contemplation – I can't; I won't
- Contemplation – maybe I will
- Preparation – I will
- Action – I am doing
- Maintenance – I have been doing

## Behaviors - recommendations

- Exercise – 30 min 5 days a week
- Blood sugar monitoring – at least 1x/d
- Healthy eating – follow meal plan 5 days
- Taking medications – 9 out of 10 times



# Pre-Contemplation: Exercise



**What if I'm not ready to exercise?**

You may not be ready for exercise today. Some people find it hard to exercise. Do any of these reasons fit for you? Check any that apply and/or add your own.

- ☐ I'm too tired after work.
- ☐ I don't have the time.
- ☐ I can't because of my knees.
- ☐ It's too hot (or cold).
- ☐ My neighborhood is not safe.
- ☐ I don't like it.

Add your own: \_\_\_\_\_

\_\_\_\_\_



**How would you like things to be different?**

Check any that apply and/or add your own.

- ☐ I would like to feel better.
- ☐ I would like to have better-controlled blood sugar levels.
- ☐ I would like to have more energy.
- ☐ I would like to lose weight.

Add your own: \_\_\_\_\_

\_\_\_\_\_



**What can exercise do for you?**

Exercise has short-term and long-term benefits. Check any that you are interested in.

## Short-term benefits:

- ☐ It lowers blood sugar levels.
- ☐ It helps you handle stress better.
- ☐ It helps you sleep better.
- ☐ It gives you more energy.

## Long-term benefits:

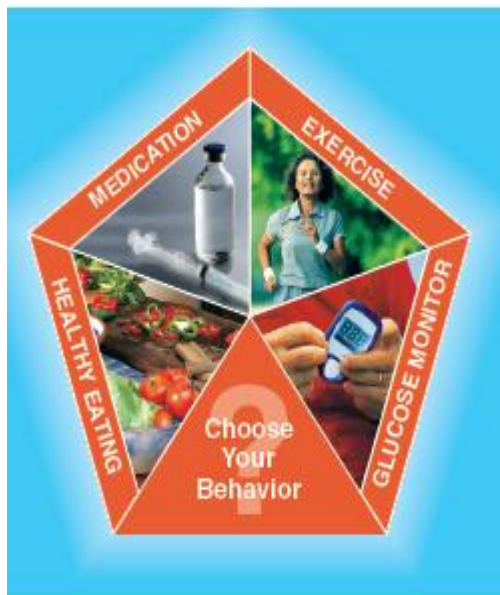
- ☐ It helps keep weight under control.
- ☐ It helps improve blood pressure and cholesterol.
- ☐ It helps prevent fractures.
- ☐ It helps improve pain from arthritis.



# Provider Guide

Guide to

## *Stages of Change Interventions*



USING THE TRANSTHEORETICAL MODEL  
FOR YOUR PATIENTS WITH DIABETES

## Contemplation

1. **(Normalize ambivalence)**  
Some people don't like to....., yet they know it is important.
2. **(Consider the 'cons')** What is it that makes it difficult for you?
3. **(Consider the 'pros')** What would be some reasons to start doing it?
4. **(Self re-evaluation)** How much does your family know about your diabetes? How do you think your diabetes affects them?
5. **(Examine options)** If you were to do start ....., what do you think you would do?
6. **(Emphasize patient control)** With any chronic condition, you are the one in charge. Your health depends on your ability to make the changes that are right for you.



# *Educational Materials*

## Viva la Vida

- Guide to Stages of Change Interventions
- Thinking about checking your blood sugar (Pre-contemplation)
- Thinking some more about checking your blood sugar (Contemplation)
- Preparing to check your blood sugar (Preparation)
- Checking your blood sugar (Action and Maintenance)
- Stage specific series for additional topics:
  - Following a meal plan
  - Taking medications appropriately
  - Doing exercise
- All educational materials available in English and Spanish at:  
<http://www.lumetra/resource-center/index.aspx?id=164>  
<http://www.diabetesinitiative.org>