Robert Wood Johnson Foundation

Washington
University in St.Louis
SCHOOL OF MEDICINE

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Designing Primary Care for Diabetes Self Management

CDC Diabetes Translation Conference 2007

Carol Brownson, Gowri Shetty, Mary O'Toole,
Victoria Anwuri, Ed Fisher

Objectives

- To describe key components of organizational support for self management in primary care, and

- To illustrate improvements in self management support using examples from the *Diabetes Initiative*

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Washington
University in St.Louis
SCHOOL OF MEDICINE

Robert Wood Johnson Foundation

Background

- Most patients with diabetes are cared for by their primary care provider

- The patient - clinician encounters are brief and do not allow enough time to address all aspects of self management, resulting in gaps in care

- Among the elements of the Chronic Care Model, Self Management Support has received somewhat less attention than other components of the model

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"

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Washington
University in St.Louis
SCHOOL OF MEDICINE

Robert Wood Johnson Foundation

Organizational Supports for Self Management

1. Patient care teams
2. Continuity of care
3. Coordination of referrals
4. Documentation of SM support services
5. Ongoing quality improvement
6. Patient input
7. Staff training and education
8. Integration of SM into primary care

1. Patient Care Team

- A patient care team is a group who works together to provide a patient the best possible care

Examples….

- La Clinica de la Raza, Oakland CA (LaClinica)
  - *Promotoras* are an integral part of the patient care team
  - Promotoras teach classes, facilitate support groups, lead walking clubs, conduct home visits. They participate in regularly scheduled team case conferences

- St. Peter Family Medicine Residency Program, Olympia WA (SPFM)
  - Physician faculty members, resident physicians, nurses, and medical assistants (MAs) comprise the team
  - MAs maintain patient registries, organize and participate in group medical visits, perform planned visits, conduct telephone follow up with the patients to support goal setting and identify patient needs

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Washington
University in St. Louis
SCHOOL OF MEDICINE

Robert Wood Johnson Foundation

2. Continuity of Care

- Continuity of care is achieved through assignment of patients to a primary care provider and through routine planned visits with appropriate members of the care team

Example….

- Gateway Community Health Center, Laredo TX
  - the team developed an audit tool for the patient records that enables members of the team to document patient visits and lab information in a standardized format. The audit tool includes information on routine visits, tests ordered, and follow up on test results

3. Coordination of referrals

- At the organizational level, coordination of referrals is supported by systems to track incomplete referrals and ensure follow-up with patients and/or specialists to complete referrals
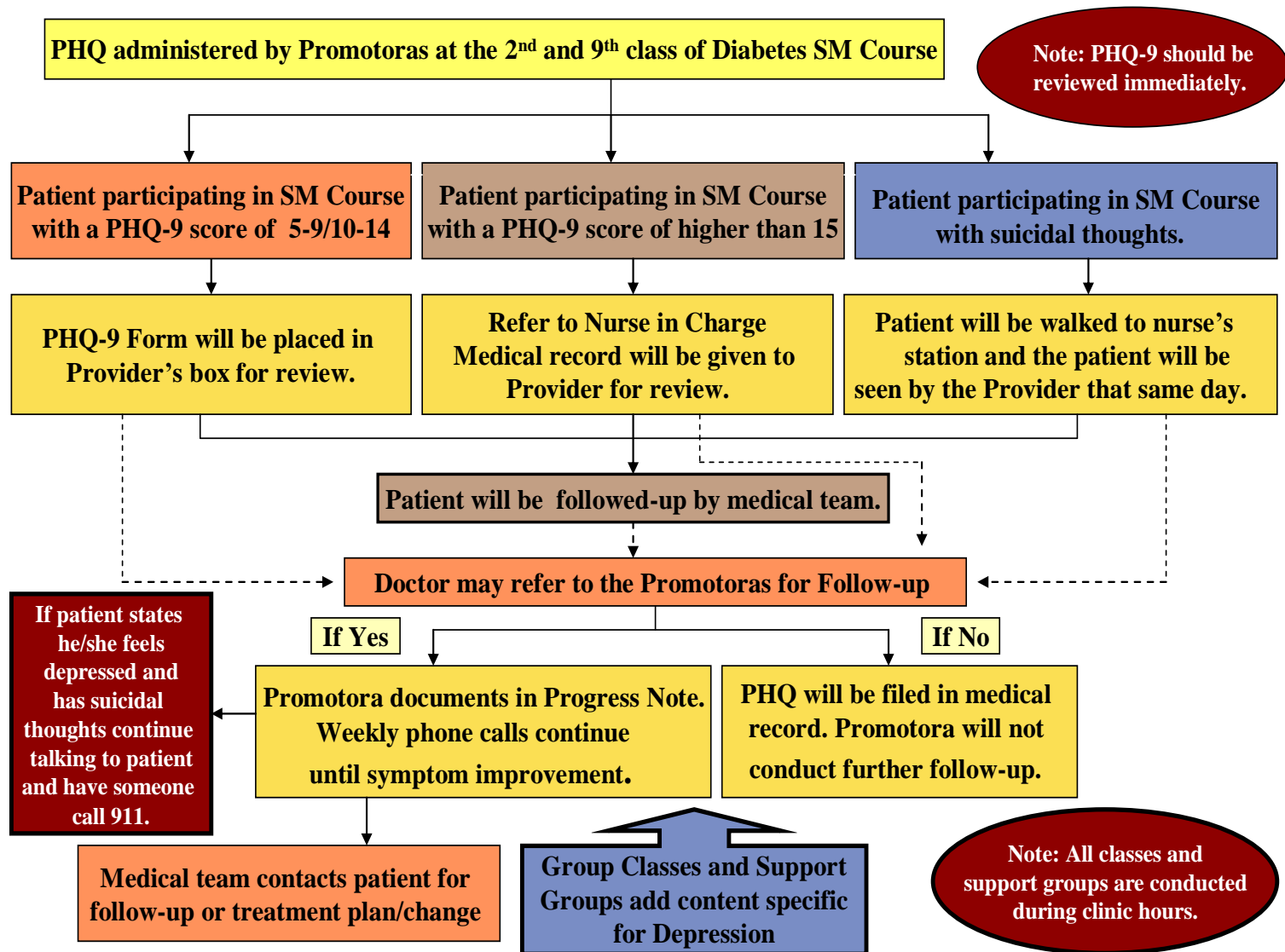
Examples….

- Community Health Center, Middletown CT (CHC)
  - Screens for depression and refers to behavioral health as needed. Care is documented in the same record to facilitate coordination among providers and and mutual reinforcement of goals and treatment plans

Gateway Community Health Center, Laredo TX
Depression Screening and Follow-up Protocol

PHQ administered by Promotoras at the 2nd and 9th class of Diabetes SM Course

Note: PHQ-9 should be reviewed immediately.

Patient participating in SM Course with a PHQ-9 score of 5-9/10-14

Patient participating in SM Course with a PHQ-9 score of higher than 15

Patient participating in SM Course with suicidal thoughts.

PHQ-9 Form will be placed in Provider's box for review.

Refer to Nurse in Charge Medical record will be given to Provider for review.

Patient will be walked to nurse's station and the patient will be seen by the Provider that same day.

Patient will be followed-up by medical team.

Doctor may refer to the Promotoras for Follow-up

If Yes

If No

If patient states he/she feels depressed and has suicidal thoughts continue talking to patient and have someone call 911.

Promotora documents in Progress Note. Weekly phone calls continue until symptom improvement.

PHQ will be filed in medical record. Promotora will not conduct further follow-up.

Medical team contacts patient for follow-up or treatment plan/change

Group Classes and Support Groups add content specific for Depression

Note: All classes and support groups are conducted during clinic hours.

4. System for documentation of self management support

- Well developed systems include charting of the patient's care plan, self management goals and progress by all care team members and referral specialists

Examples….

- MAs enter patient goals in CDEMS, conduct follow up and enter progress (SPFM)

- *Promotoras* maintain detailed progress notes on self management plans which are printed as a flow sheet for providers at the time of a patient visit (LaClinica)

- CDEs record self management goal information on log sheets; one copy goes in the chart and one to the patient (CHC)

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Washington University in St.Louis
SCHOOL OF MEDICINE

Robert Wood Johnson Foundation

5. *Ongoing Quality Improvement (QI)*

- Ongoing QI is accomplished by patient care teams that use data to identify trends and undertake processes to achieve measurable goals

- Registries or electronic medical records provide the data on key indicators used by the team

- Many sites use the Plan, Do, Study, Act (PDSA) rapid cycle improvement process to test changes

- Sites worked together to develop a QI tool (The "PCRS") for assessing organizational capacity to provide self management support as part of quality chronic illness care

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Washington
University in St.Louis
SCHOOL OF MEDICINE

Robert Wood Johnson Foundation

6. *Patient Input*

- Seeking patient input is an essential component of the patient centered model of care. Patient input not only improves services and service delivery, it can also increase both patient and provider satisfaction

Example….

- Patient input can be solicited through focus groups, surveys, suggestion boxes, participation in patient advisory committees etc.

- Holyoke Health Center used patient feedback to revise the structure and format of their educational activities, which resulted in higher enrollment

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Washington University in St.Louis
SCHOOL OF MEDICINE

Robert Wood Johnson Foundation

7. *Staff Training and Education*

- Training and continuing education of providers and staff in self management has been associated with significant improvement in their knowledge as well as improvements in care practice

Example….

- The ADSM project in West Virginia centered their staff and patient education in the Chronic Disease Self Management Program to
  - Build internal support for self management services
  - Standardize their approach to self management and promote the use of consistent messages to patients
  - Promote good modeling
  - Create a supportive environment for employees

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Washington
University in St.Louis
SCHOOL OF MEDICINE

Robert Wood Johnson Foundation

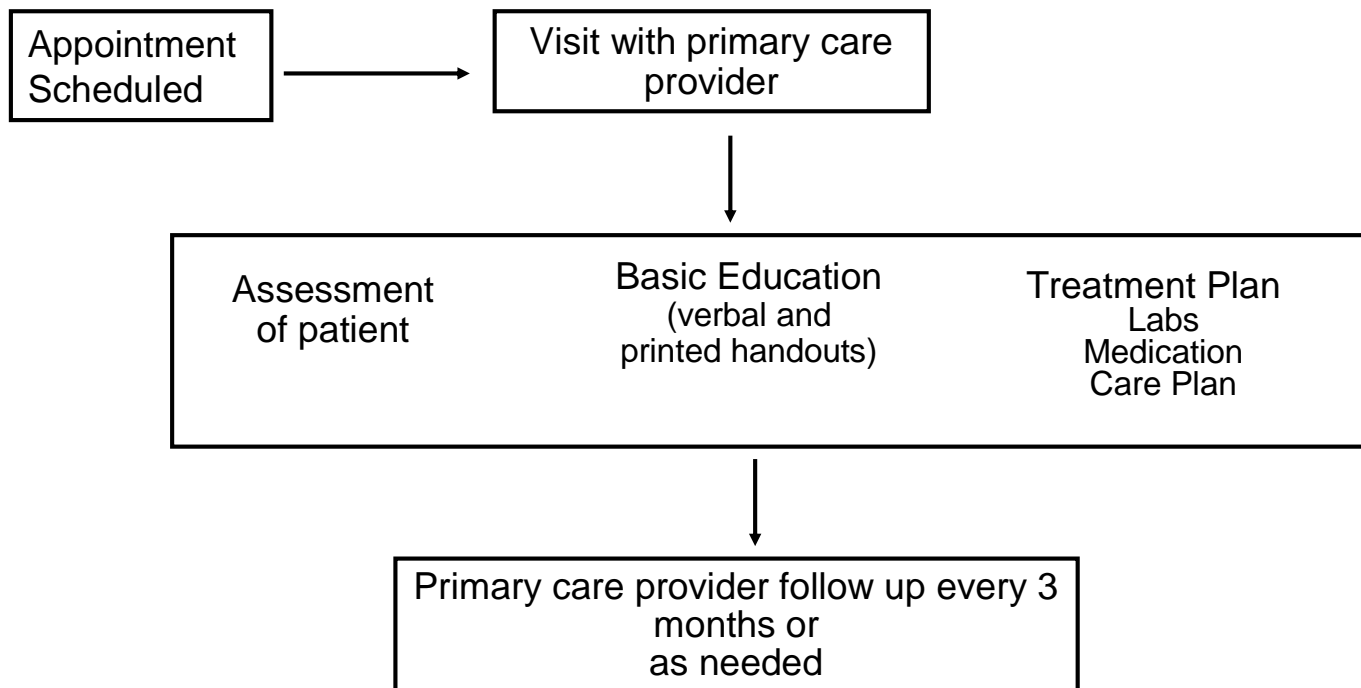# 8. *Integration of Self Management into Primary Care*

- Ultimately, to be effective, self management support must be integrated into and supported by a system designed for chronic illness care

Examples….

- Existing services may be expanded, redesigned or networked in new ways
  - Gateway expanded *promotora*-led services and linked them with the primary care system
  - CHC integrated their primary care and behavioral health services for people with diabetes and mental health conditions
  - Many sites added new services to more fully support patient self management

Standard or Usual Care for People with Diabetes

```
┌──────────────┐          ┌──────────────────┐
│ Appointment  │  ───────▶│ Visit with       │
│ Scheduled    │          │ primary care     │
│              │          │ provider         │
└──────────────┘          └──────────────────┘
                                   │
                                   ▼
```

Assessment of patient	Basic Education (verbal and printed handouts)	Treatment Plan Labs Medication Care Plan

```
                    │
                    ▼
┌────────────────────────────────────────┐
│ Primary care provider follow up every 3 │
│ months or                               │
│ as needed                               │
└────────────────────────────────────────┘
```

Integration of Diabetes Self Management into Primary Care

Appointment Scheduled → Individual Assessment of patient by medical support staff and introduction to self management → Visit with primary care provider

Basic Education → Treatment Plan → Referral to self management programs and support services **OR** Primary care provider offers supports for self management

Patient receives resource and supports for self management from members of patient care team

Ongoing resources and supports for self management provided by the patient care team

Primary care provider follow up every 3 months or as needed

Lessons Learned…..

- System change is a long-term commitment

- Factors that affect quality improvement of self management support in primary care:
  - organizational readiness for change
  - support from organizational leaders
  - incentives for quality care
  - resources to enable and sustain system changes

For more information……..

Visit us: www.diabetesinitiative.org

Contact us:

Carol Brownson

314-286-1915

cbrownso@im.wustl.edu

–Thank you! –

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Washington
University in St.Louis
SCHOOL OF MEDICINE

Robert Wood Johnson Foundation