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Diabetes Self-Management Support in Primary Care: Building the proactive and prepared health care team

7th Annual NPSF Patient Safety Congress

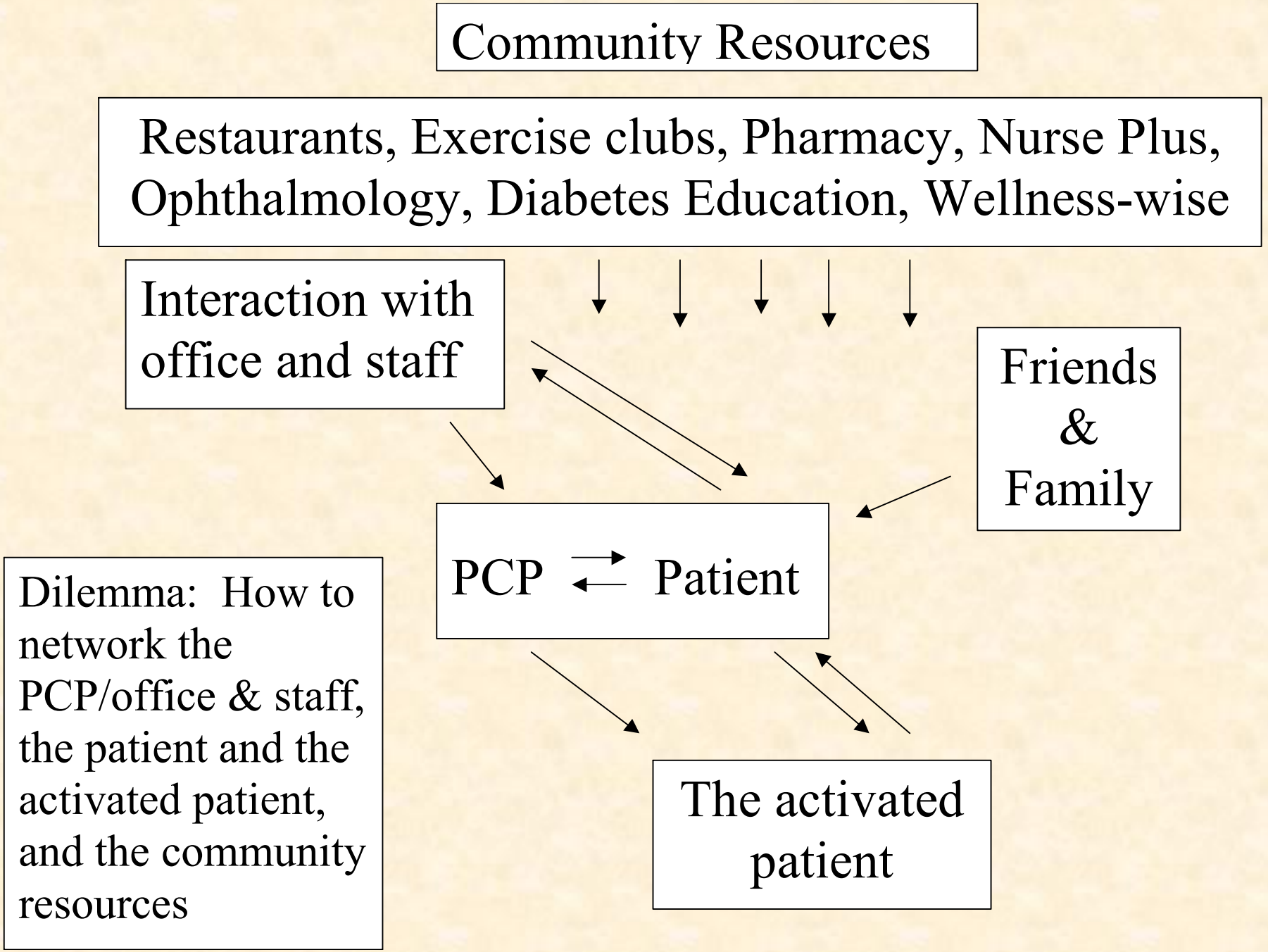
Let's Get On With It—Round 2

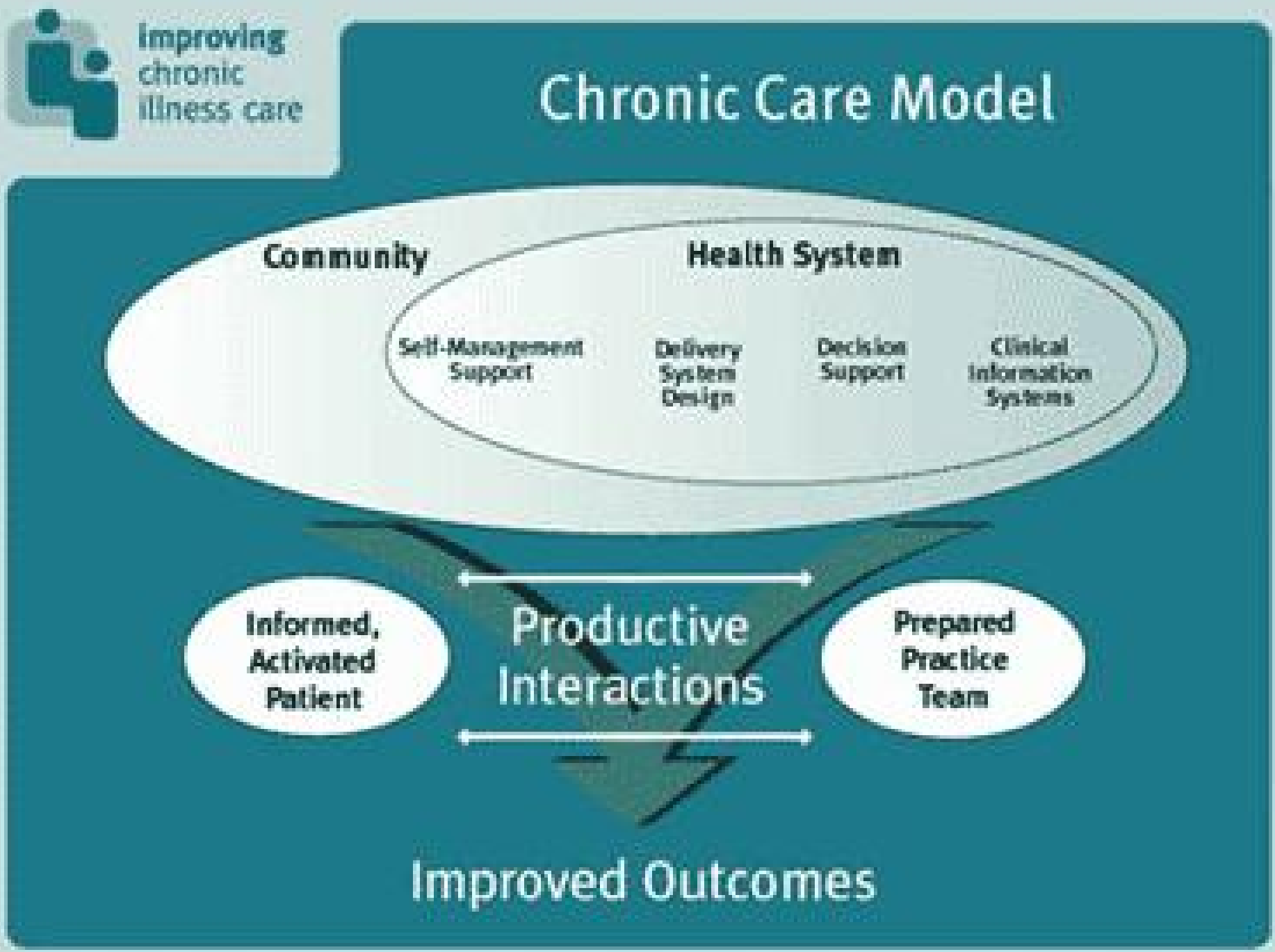
May 4-6, 2005
Orlando World Center Resort Marriott
Orlando, FL

Devin Sawyer, MD
Faculty Physician
St Peter Family Medicine Residency Program
May 4th-6th, 2005


03.21.2005

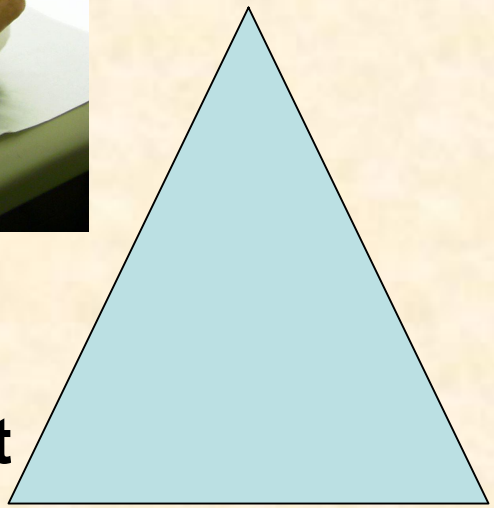

Causes of Fatigue
Symptom Cycle
Disease
Fatigue
Vicious Cycle
Tense muscles
Depression
Stress/Anxiety
03.21.2005


Community Resources
Restaurants, Exercise clubs, Pharmacy, Nurse Plus, Ophthalmology, Diabetes Education, Wellness-wise
Interaction with office and staff
Friends & Family
PCP Patient
Dilemma: How to network the PCP/office & staff, the patient and the activated patient, and the community resources
The activated patient


Improving chronic illness care
Chronic Care Model
Community
Health System
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared Practice Team
Improved Outcomes

The Non-Clinical Staff

The Patient



The Provider

The Medical Assistant

The Activated Patient

The Medical Assistant

- Traditionally involved in rooming and ‘vitaling’ a patient prior to PCP visit
- Respond to and answer to the PCP
- Relationship with patient typically not well developed
- Job performance measured by ability to perform tasks and keep the provider moving

The Provider

- Trained to identify disease by signs and symptoms and dictate treatment
- Really good at acute care with willing and motivated patients
- We SOAP every patient
- And we try to apply this skill to asymptomatic patients with chronic disease

The Patient

- Expect to be SOAP'ed
- Tend to be passive participants
- Wait for the "treatment plan" that they must follow
- Often offer minor symptoms at the chronic care visit ("can you look at my toenail")
- Don't identify with the MA as anyone other than the "health care host"


CDEMS Registry
Group Visit
Follow-up Phone Call
Data Entry
Provider Visit
Data Entry
Planned Visit
Phone Call
Self-Management Goal Cycle (SMG)
A Provider Approach to Quality Goals:
BBSWAR – Big Bad Sugar WAR
Background
Barriers
Success
Willingness-To-Change
Action Plan
Reinforcement

The Medical Assistant

- CDEMS registry management
- The Planned visit
- Group visits
- Self-Management goal setting
- Patient phone support
- Role model and mentor to the patient
- “The Motivator”, “The Advocate”

MA planned visits: (see standing orders)

- Use CDEMS to time invite
- They follow the standing orders signed by the provider
- 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

New MA skills

- Identify a patient's stage of change
- Basic understanding of healthy lifestyle with a few "key messages"
- Coach the willing patient to a specific doable goal and document it
- The foot check
- Camp SPANK……

What changes?

- MA:patient develop a more valuable relationship
- Shared responsibilities begin to develop
- Provider has more time during their visit because of the pre-planning and preparation
- More likely to work with an activated patient

The Provider

- What do you do with that extra time?
- Do you SOAP them? Or…

Big Bad

Sugar WAR

In the 15 minute encounter: Do the Big Bad Sugar W.A.R.

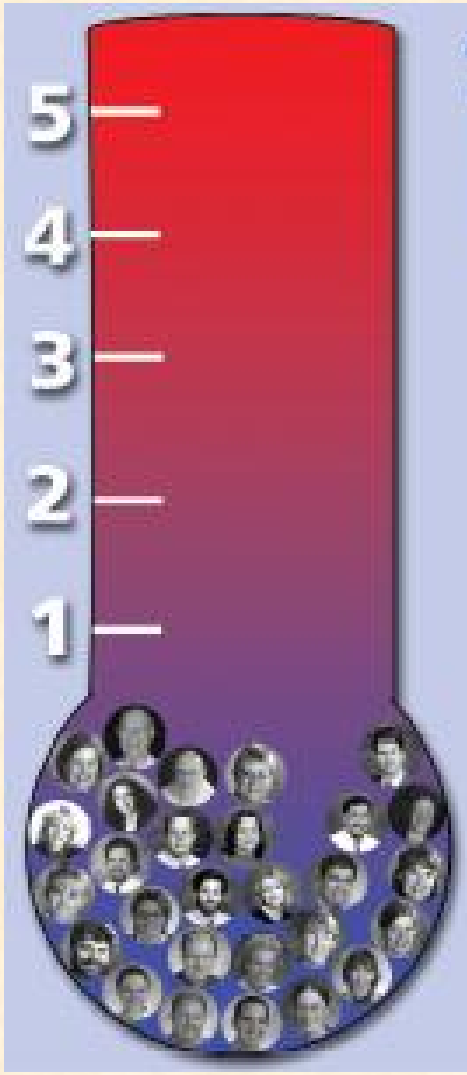
- Background
- Barriers
- Successes
- Willingness to change
- **Action plan**
- Reinforcement

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 preform 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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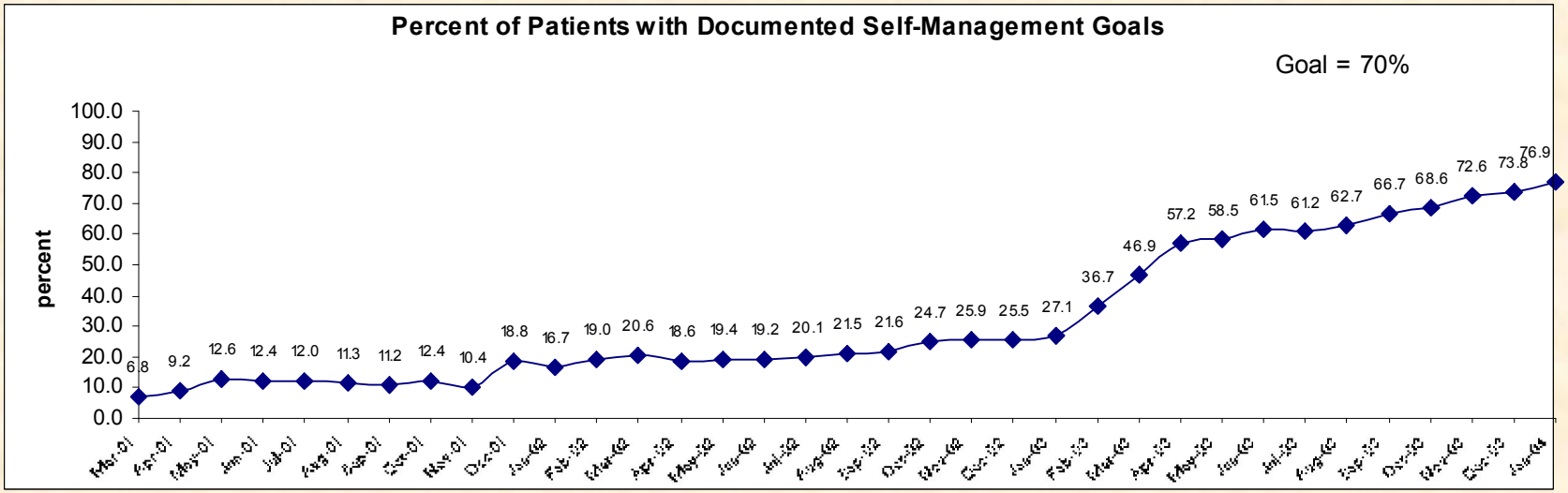
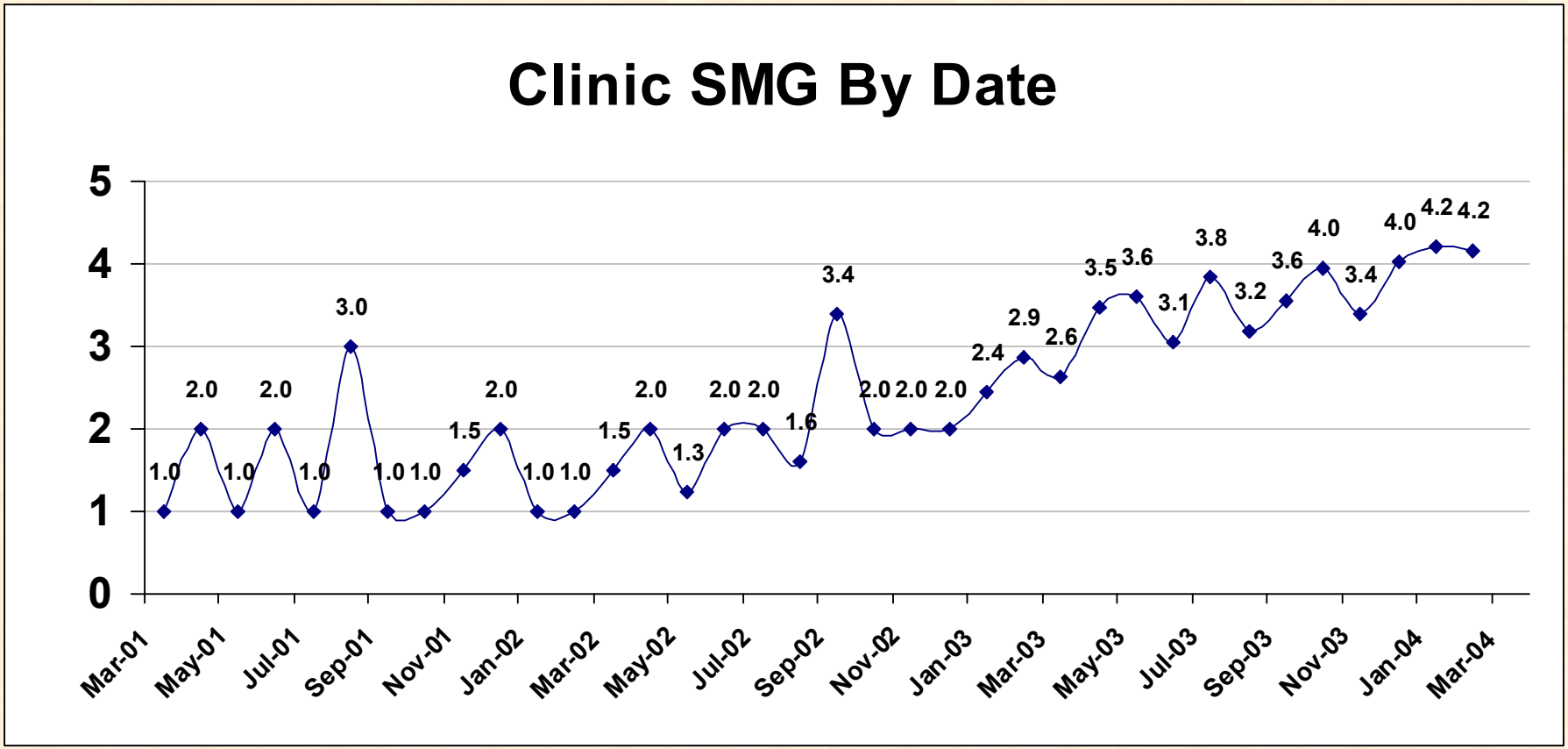
A Caring Difference You Can Feel

% of patients with goal



SMG quality over time:



Understand that 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”**

Self-Management: What works?

- 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 ≥ 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 through phase I of grant cycle

Patients are not all the same:

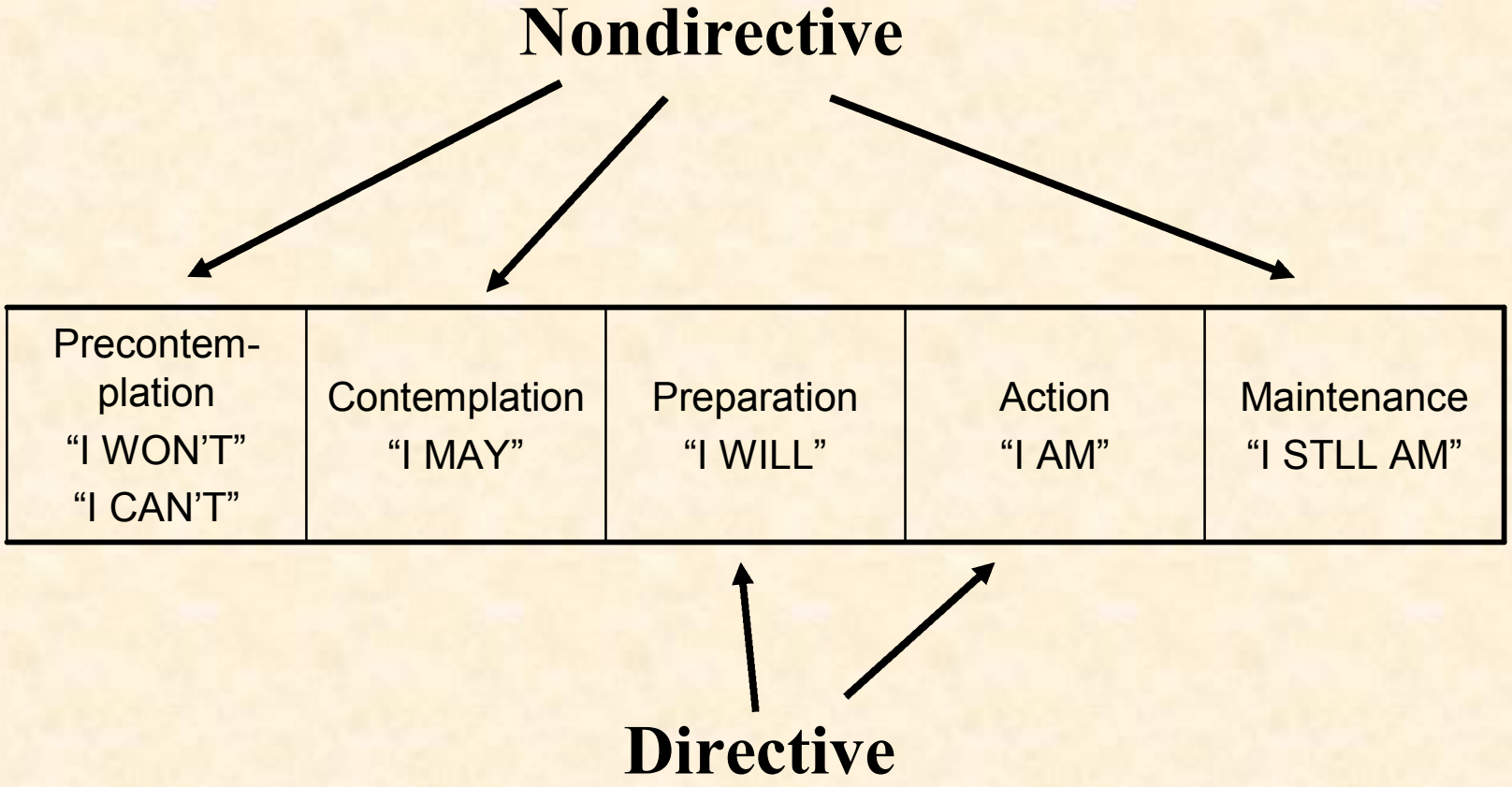
It helps to understand behavior and behavior change and apply it to patient care**:**

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

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 vs Directive Support
"Patient Centered Care & Negotiation"



The Patient: what has changed?

- Actively involved in their care
- Identifies the MA:provider team as their “doctor”
- Held to the goals (“accountable”) they have set for themselves (we remember…)
- Once used to their new role come prepared to participate, particularly at group visits

Other team members? Other Patients

- Piloting a program where *Patients are supporting Patients*
- One patient calls another about 2 months after the provider visit to “check-in” with their SMG
- Sent a card with a patient’s information that they return to us with feedback
- Provides additional support and accountability
- Bridges the gap between the planned/provider visit & reinforcement MA call, and the beginning of the next cycle

Other team members? Other staff (buddy system)

- *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

Questions?

- Contact info:
  - devin.sawyer@providence.org
  - (360)493-7525
  - 525 Lilly Road, Olympia, WA 98516
  - shari.gioimo@providence.org