- 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.

Managing Chronic Disease in the Primary Care Setting Through Patient Self-Management

March 9, 2006

Providence | Health System

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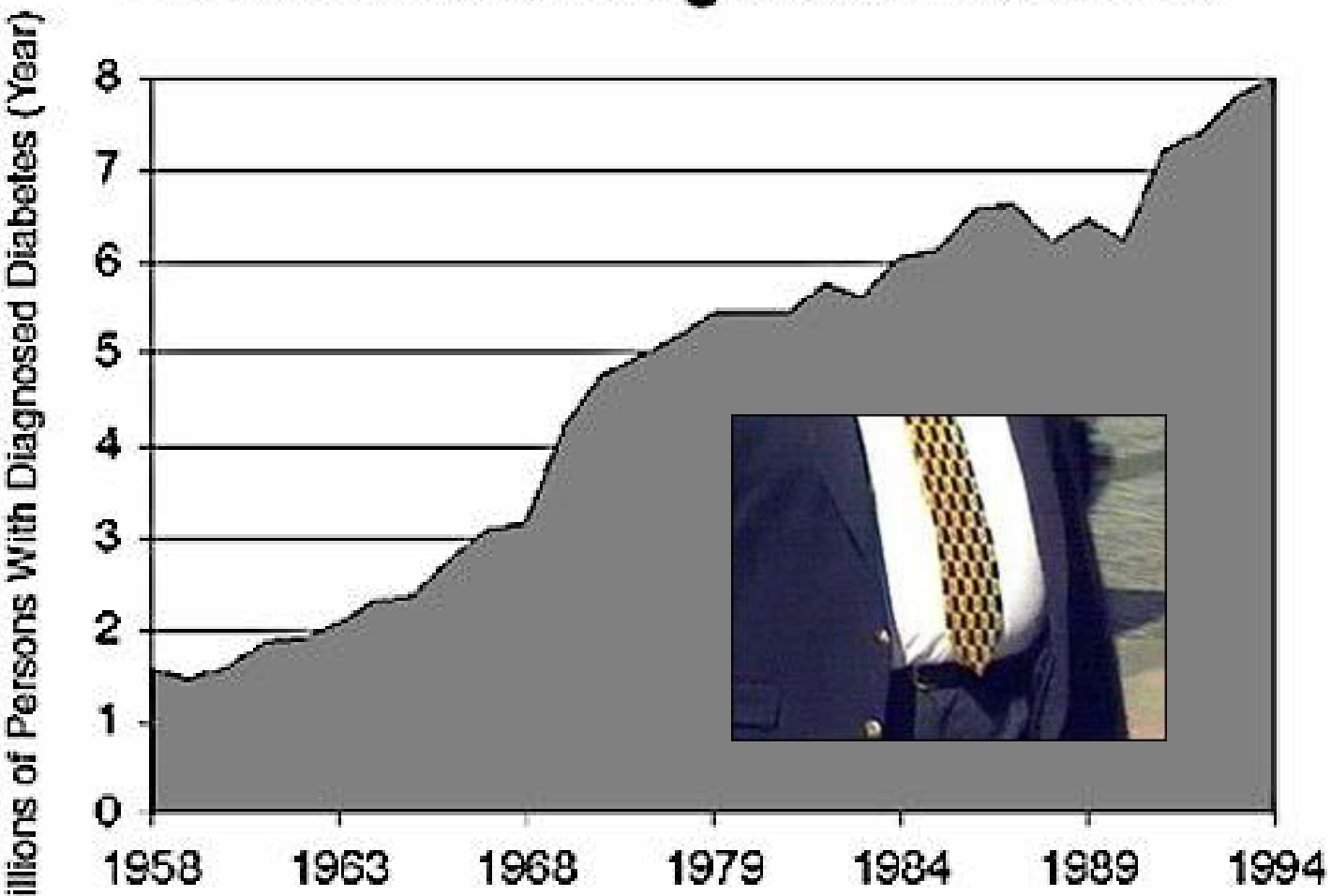
Objectives:

- Understand that Primary Care is becoming more about chronic disease management than acute care
- 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 you can redesign your practice to better support patients with chronic disease

Prevalence of Diagnosed Diabetes

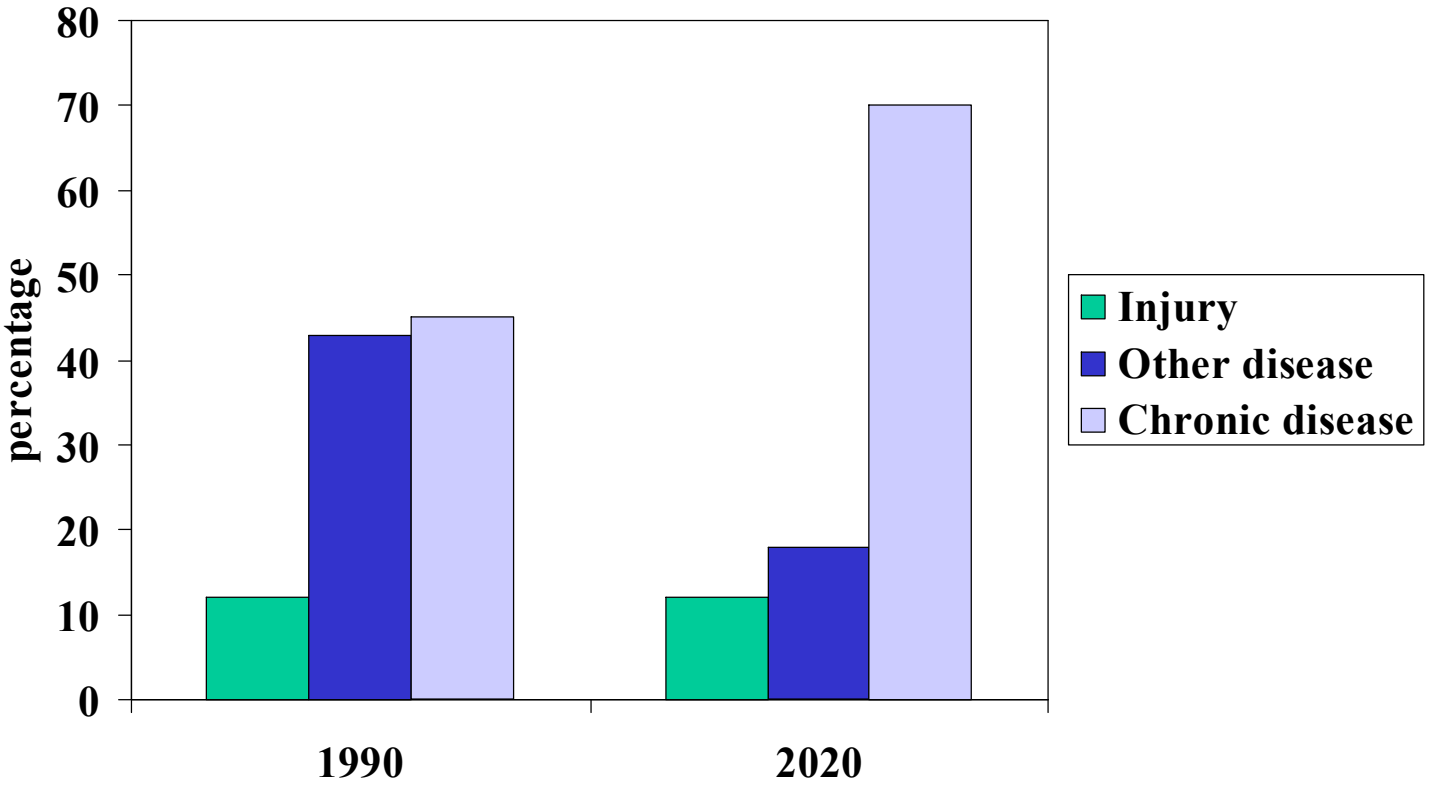


Source: The data for this chart comes from *Diabetes in America. 2nd Edition* (p. 63) by National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, 1995.

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

What we will see in Practice…



BMJ

Perspective:

Ours

"Why didn't you come to me sooner?"

The Patient

"The red are for the illness, the blue are for the side effects of the red and the green are for the effects of the blue."

Self-Management: First Blush

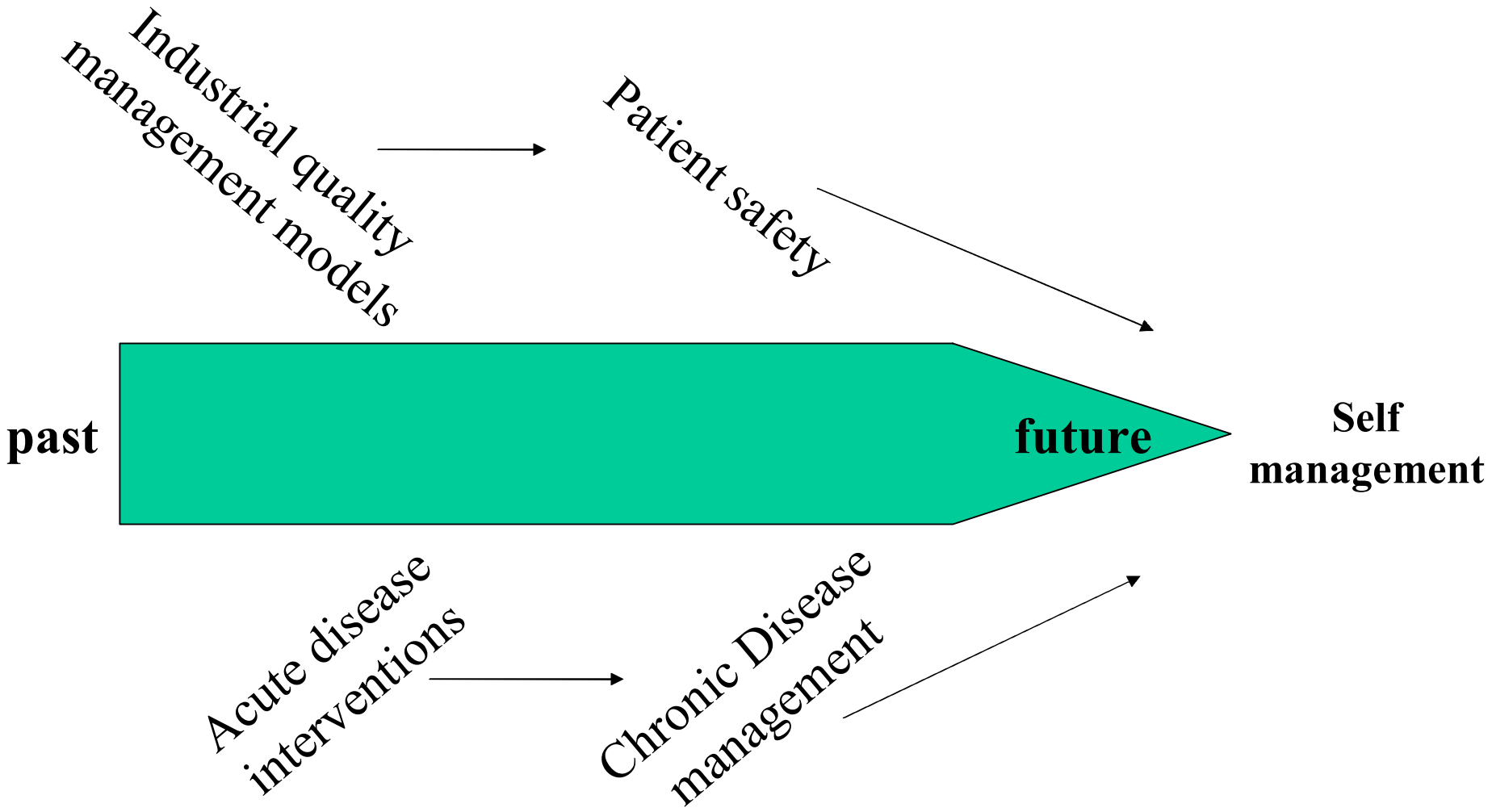
- Checking blood sugars
- Taking meds (pills and shots)
- Eating right (CDE, doctor, other diabetics)
- Exercising (30 mins/day, 150 mins/week)
- Checking feet
- Making appointments (PCP, eye doc, CDE)

What is missing?

Polly 1996

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?

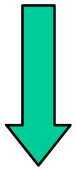

Industrial quality management models
Patient safety
past
future
Self management
Acute disease interventions
Chronic Disease management

Peace, Love, and Understanding

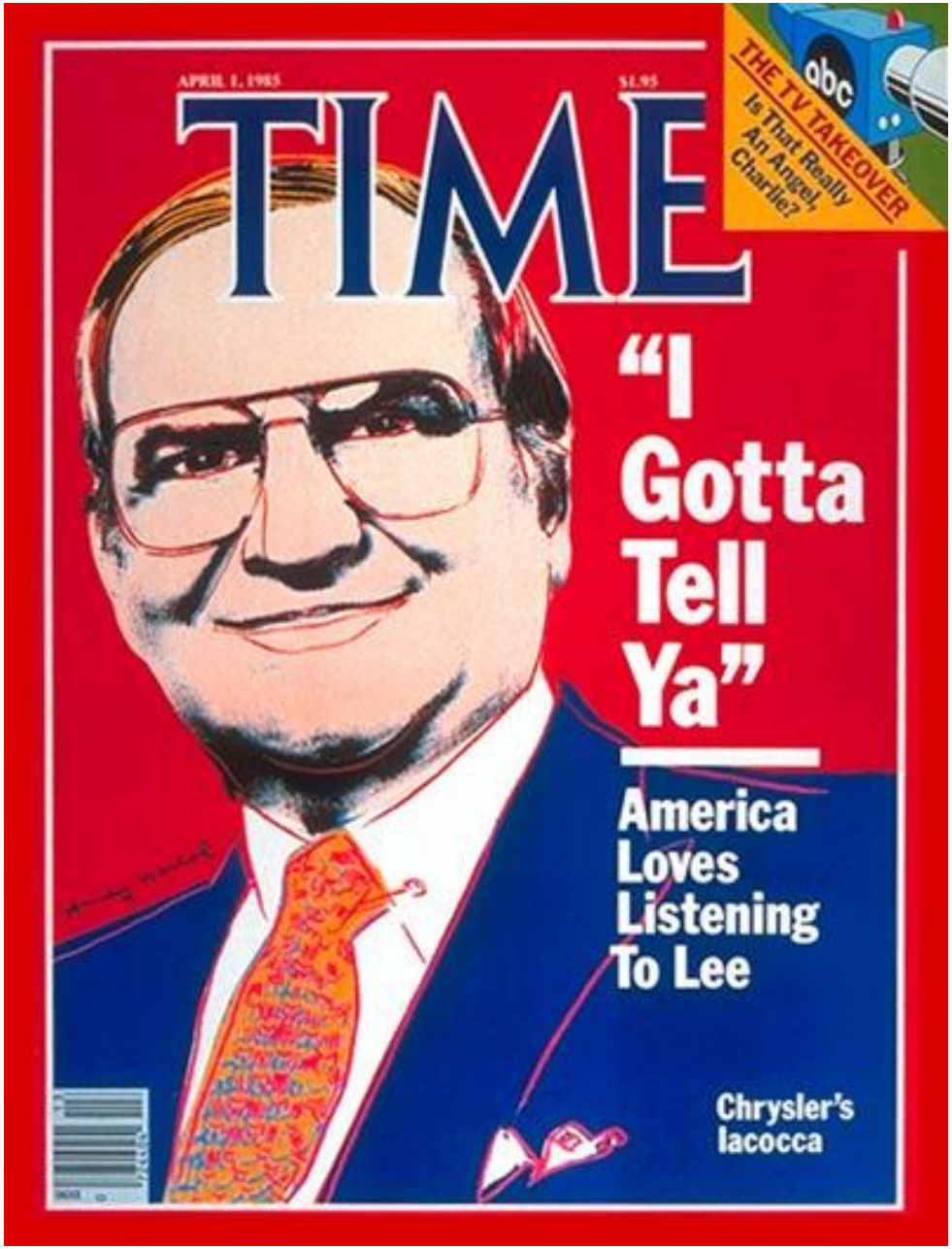
And Medical Care

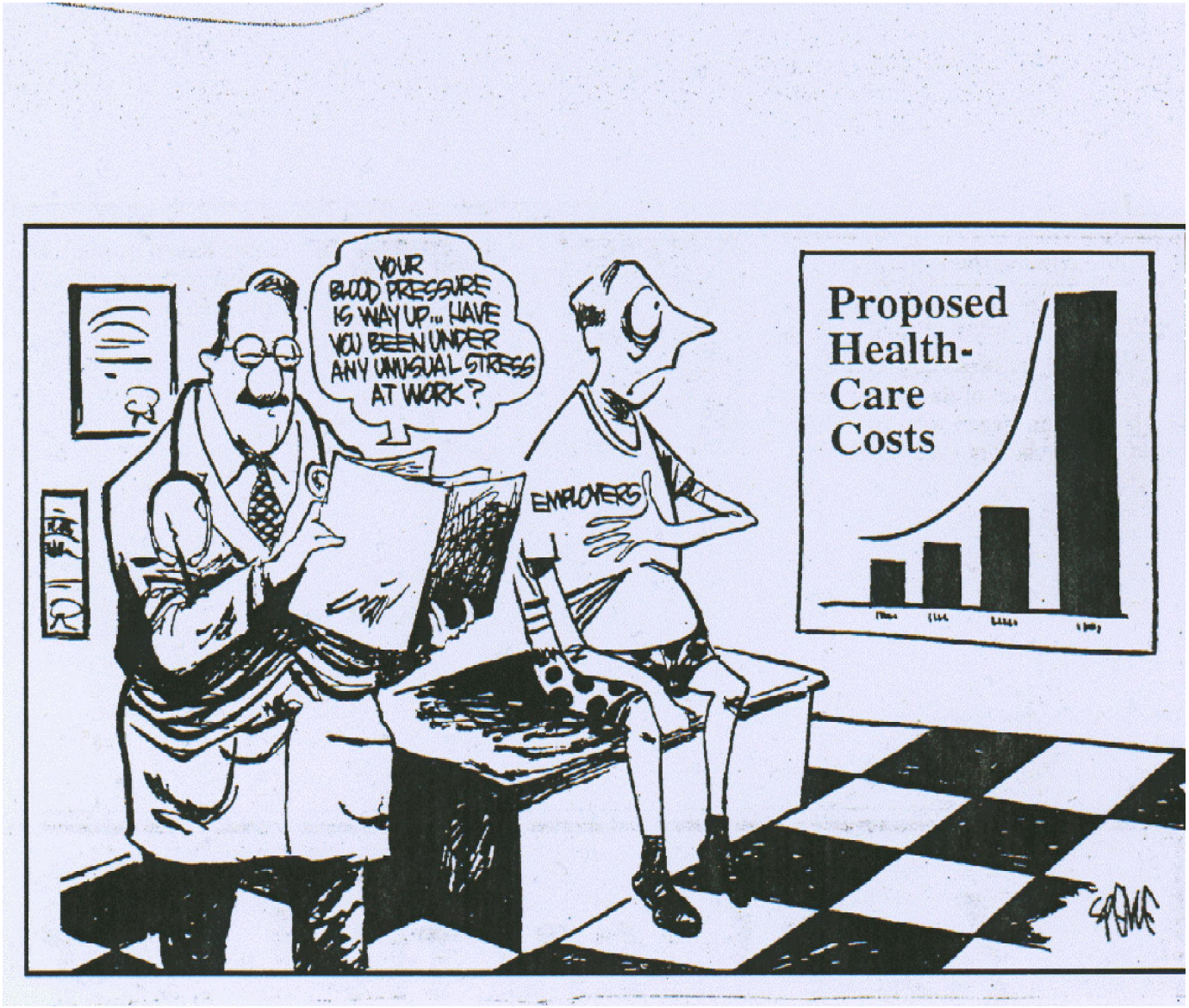
The 70s

Toyota

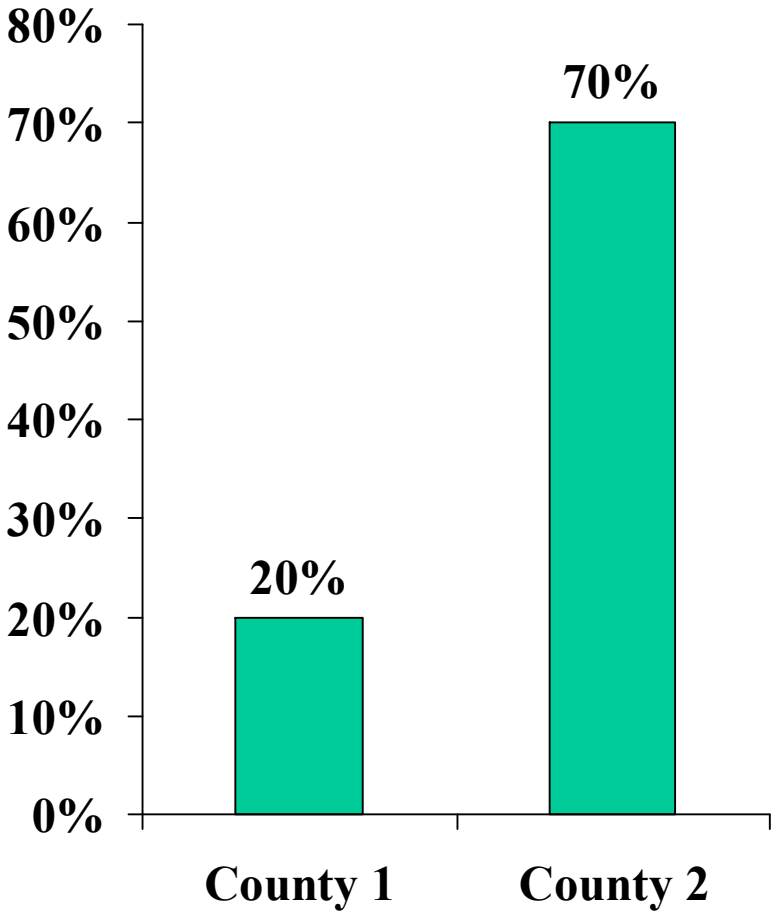
 Variation

 Cycle time


APRIL 1, 1985
$1.95
TIME
THE TV TAKEOVER
Is That Really An Angel, Charlie?
abc
"I Gotta Tell Ya"
America Loves Listening To Lee
Chrysler's Iacocca


YOUR BLOOD PRESSURE IS WAY UP... HAVE YOU BEEN UNDER ANY UNUSUAL STRESS AT WORK?
EMPLOYERS
Proposed Health-Care Costs

Regional Variation in Medical Practice



- Hysterectomies by age 70 in two counties in Maine

Wennberg 1980's

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

Your Top Priority for MACROvascular risk reduction in for Polly: *the evidence*

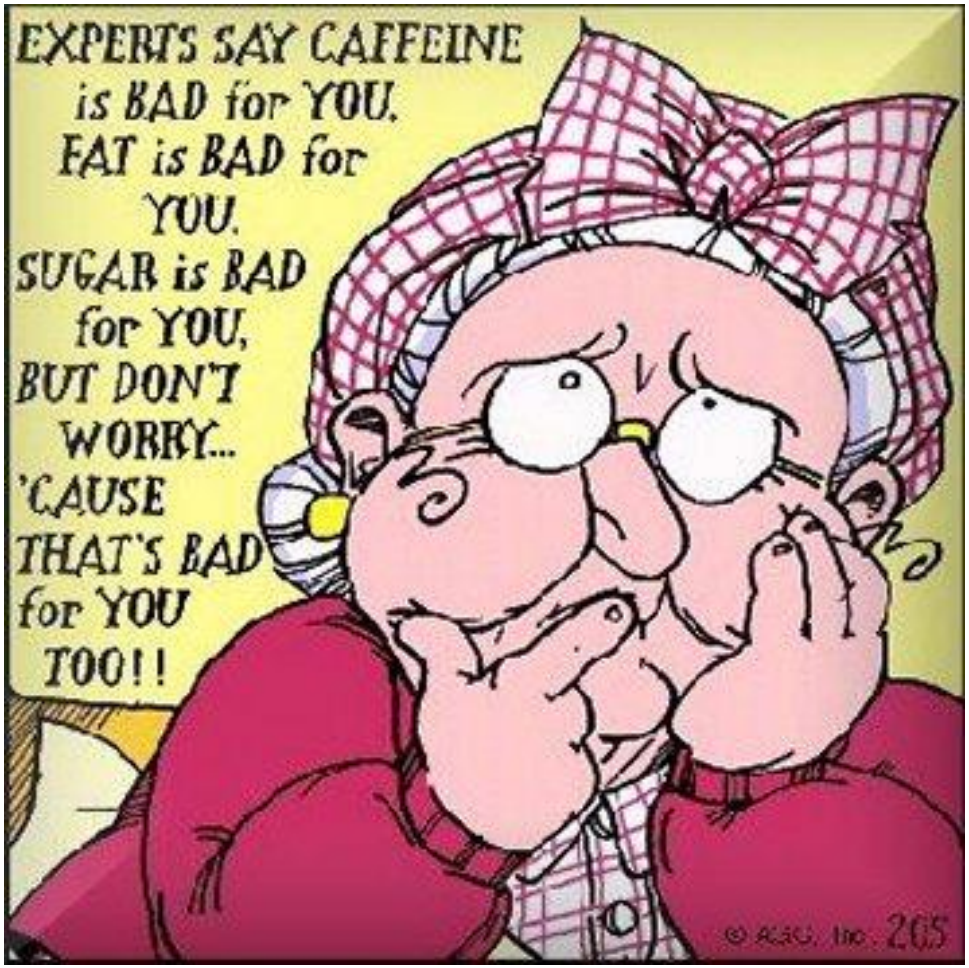
1. Stop smoking
2. ASA
3. BP
4. Lipids
5. Diet
6. Exercise
7. ACEI

Your Top priority for MICROvascular complications for Polly: *the evidence*

1. Smoking Cessation
2. Blood Sugar Control
3. Screen
4. BP control
5. ACE inhibitor
6. Diet
7. Exercise

Your top priority for everything else:

- Screen for depression
- Immunizations
- Routine health maintenance
- Weight loss
- Diet
- Exercise
- Dental health



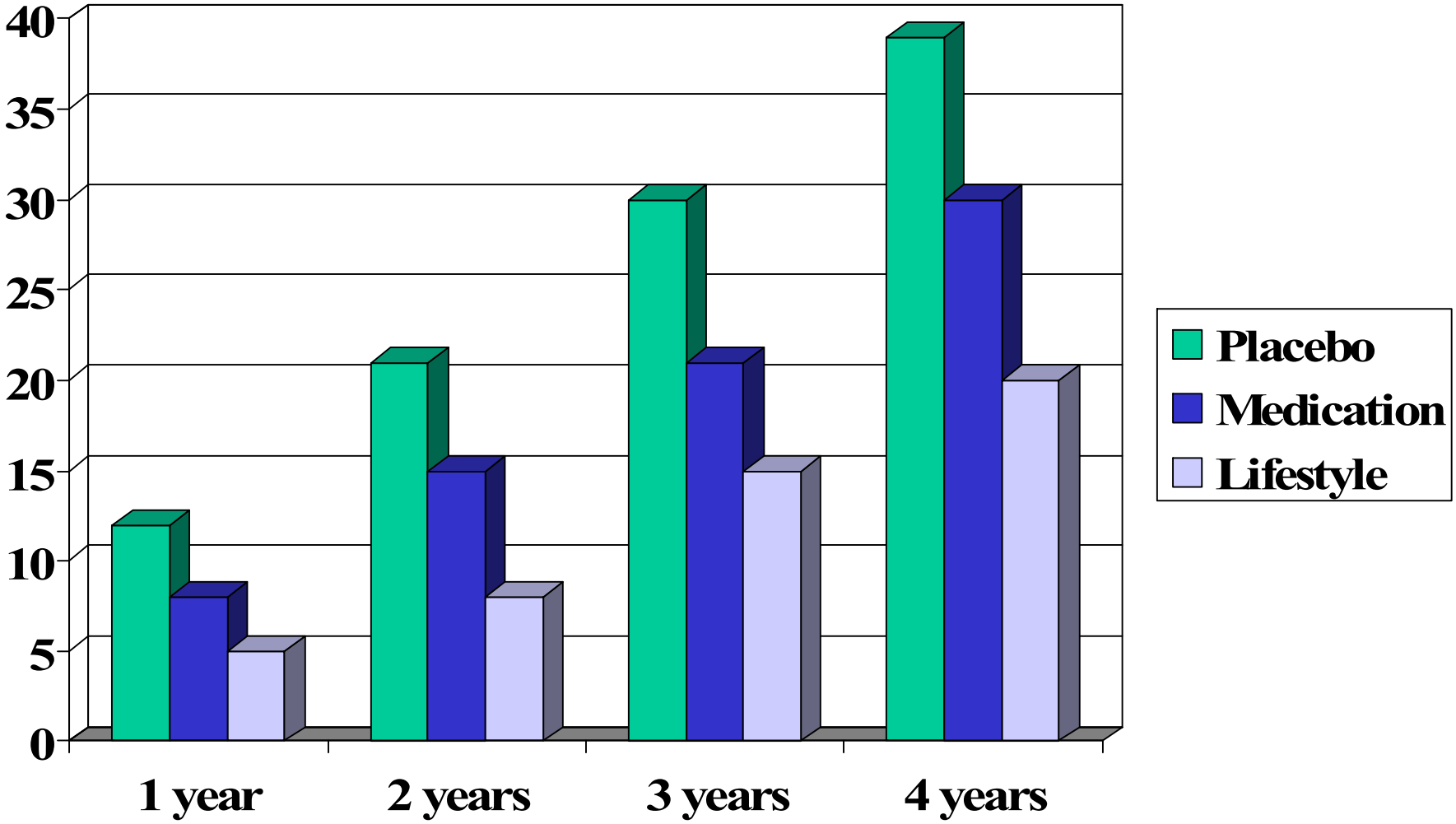
Is there hope?...yes! *the evidence*

Diabetes Prevention Program

- 3234 patients with "pre-diabetes" followed for 5 years
- Given **placebo**, a **diabetes medication**, or **lifestyle modification** (diet and exercise)
- Primary outcome: *who got diabetes DMII?*

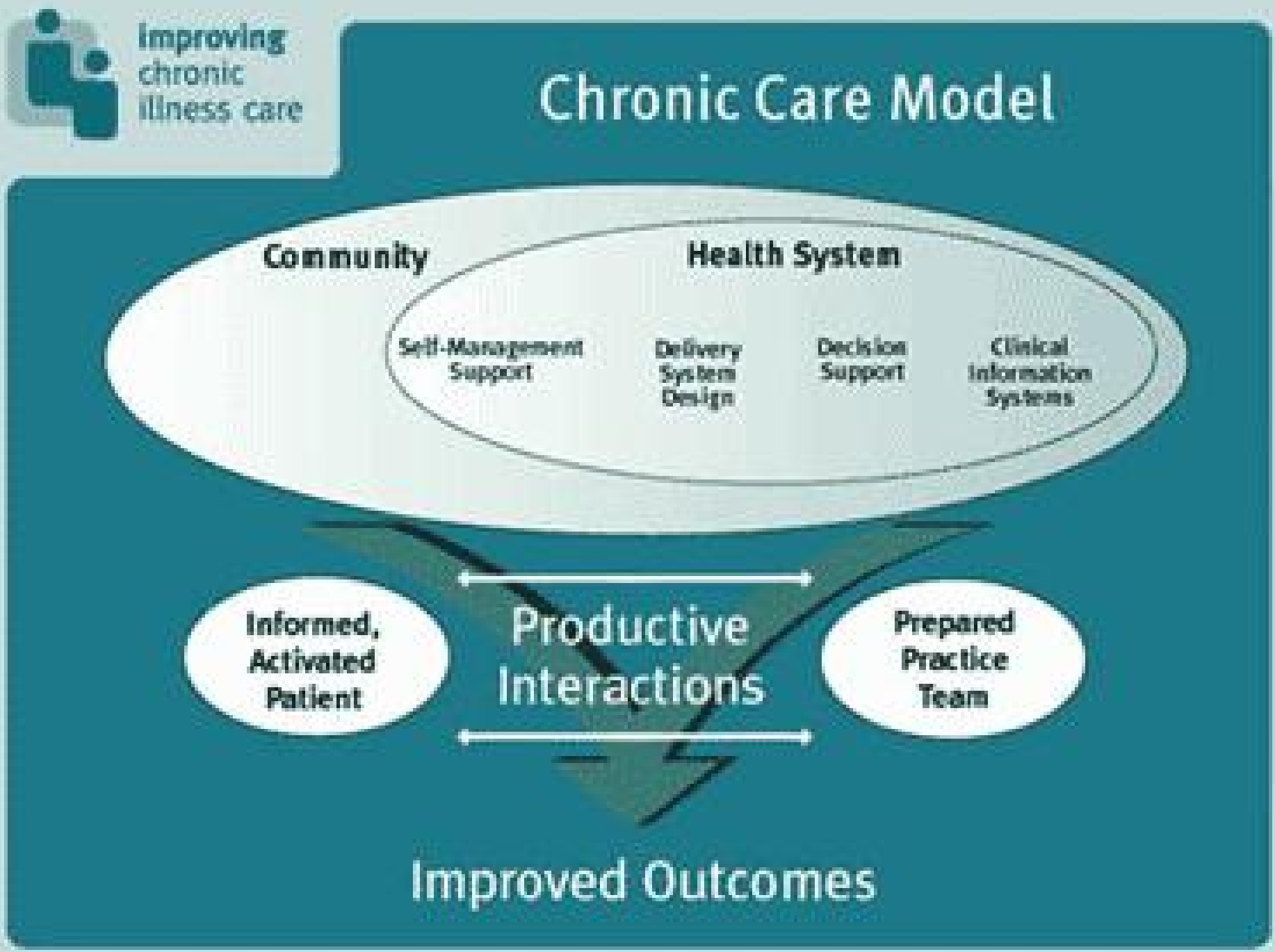
What happened?

Those who became diabetic



Is Primary Care ready for this challenge?

(historically created to respond to symptom-based acute care)…


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

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?

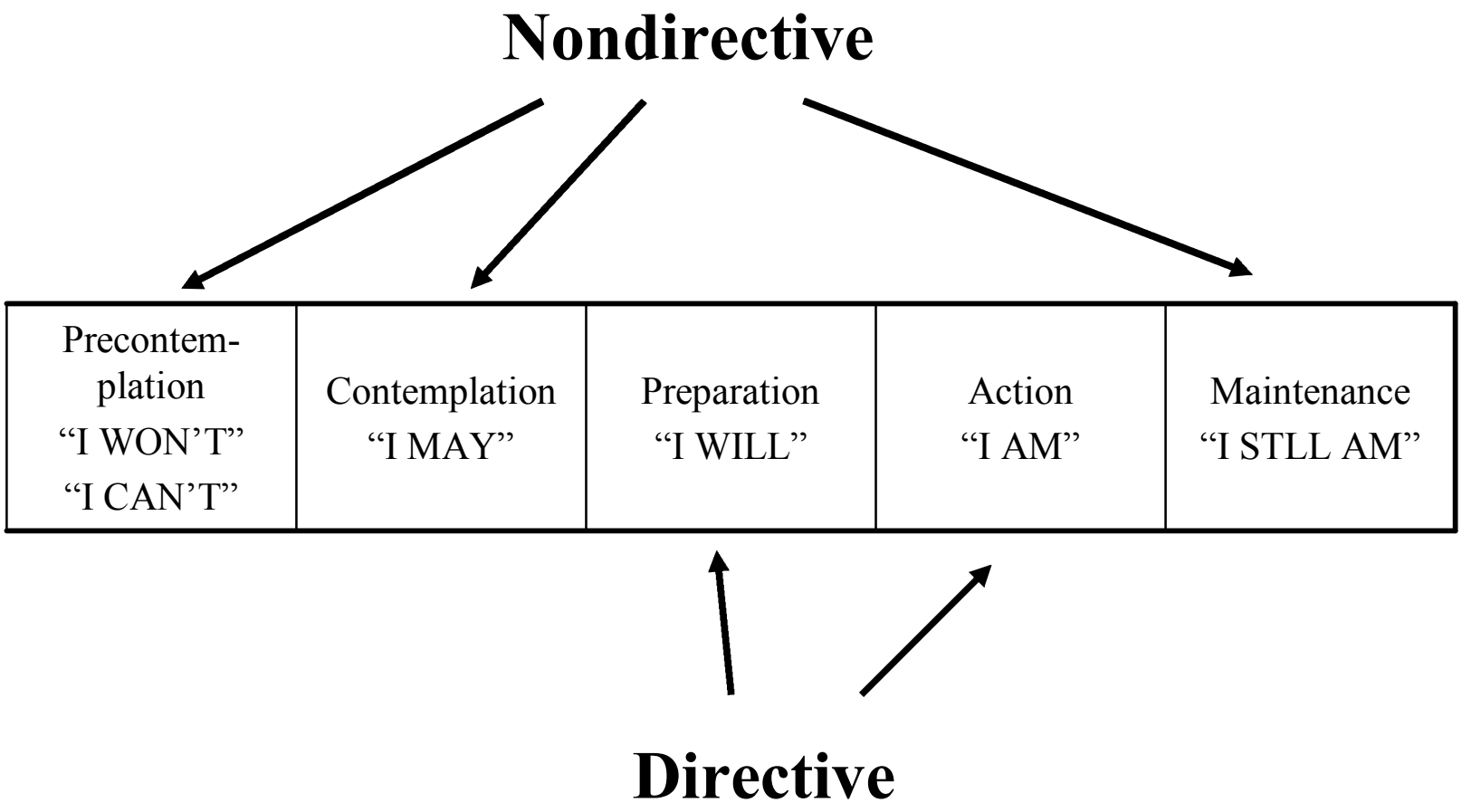
How do we respond?

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
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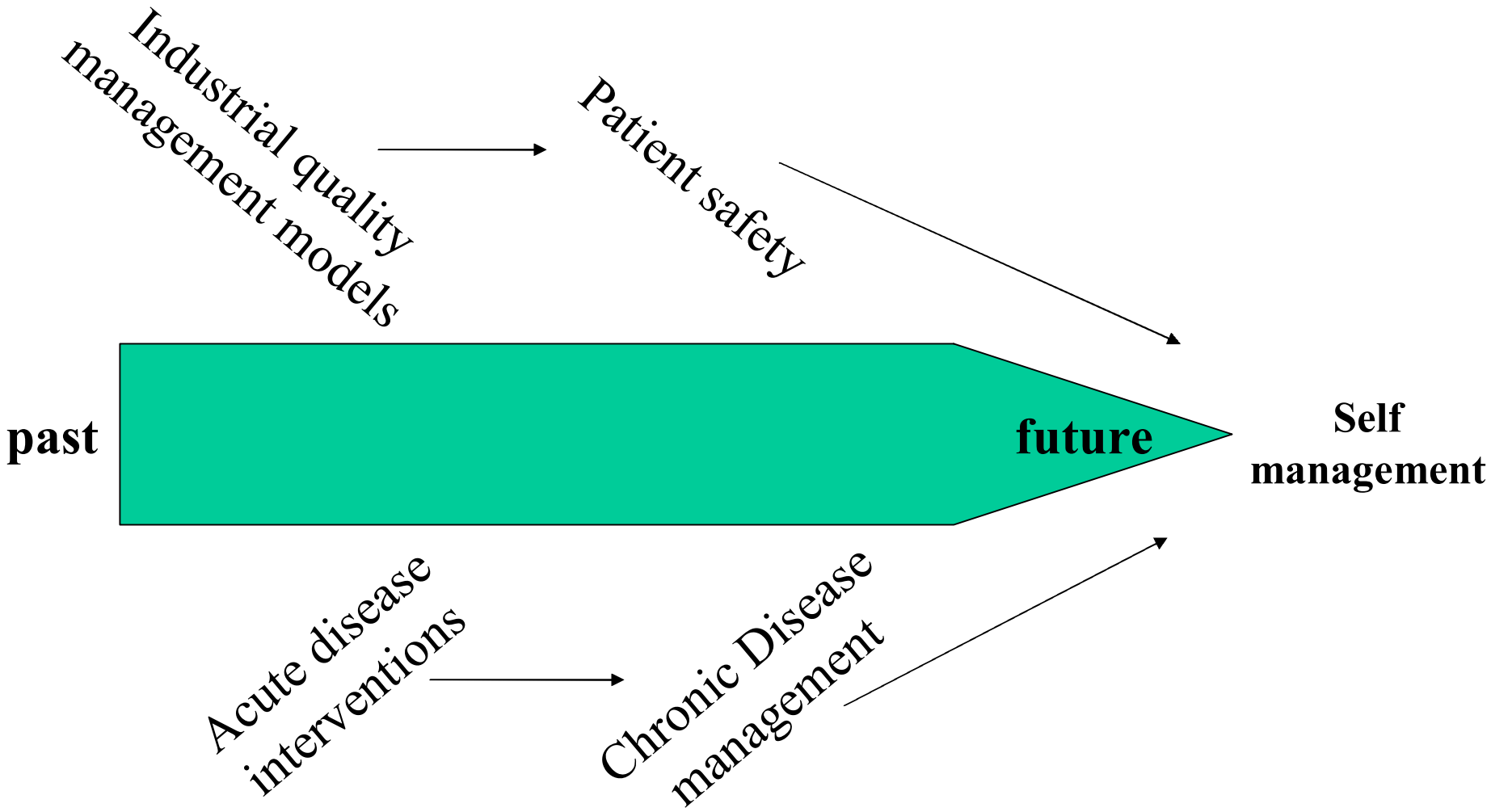
Directive


Industrial quality management models
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Chronic Disease management

“All day every day for the rest of your life”

- Planning and preparation
- Team approach
- Nondirective support
- Opportunities to try new behaviors

…but how do we work with a patient to be successful as we define it?

- **Prepare** for the visit
- **Plan** ahead
- **Negotiate** agenda early
- Ask **permission** to share what you think you know
- Negotiate a **plan**

P

P

N

P

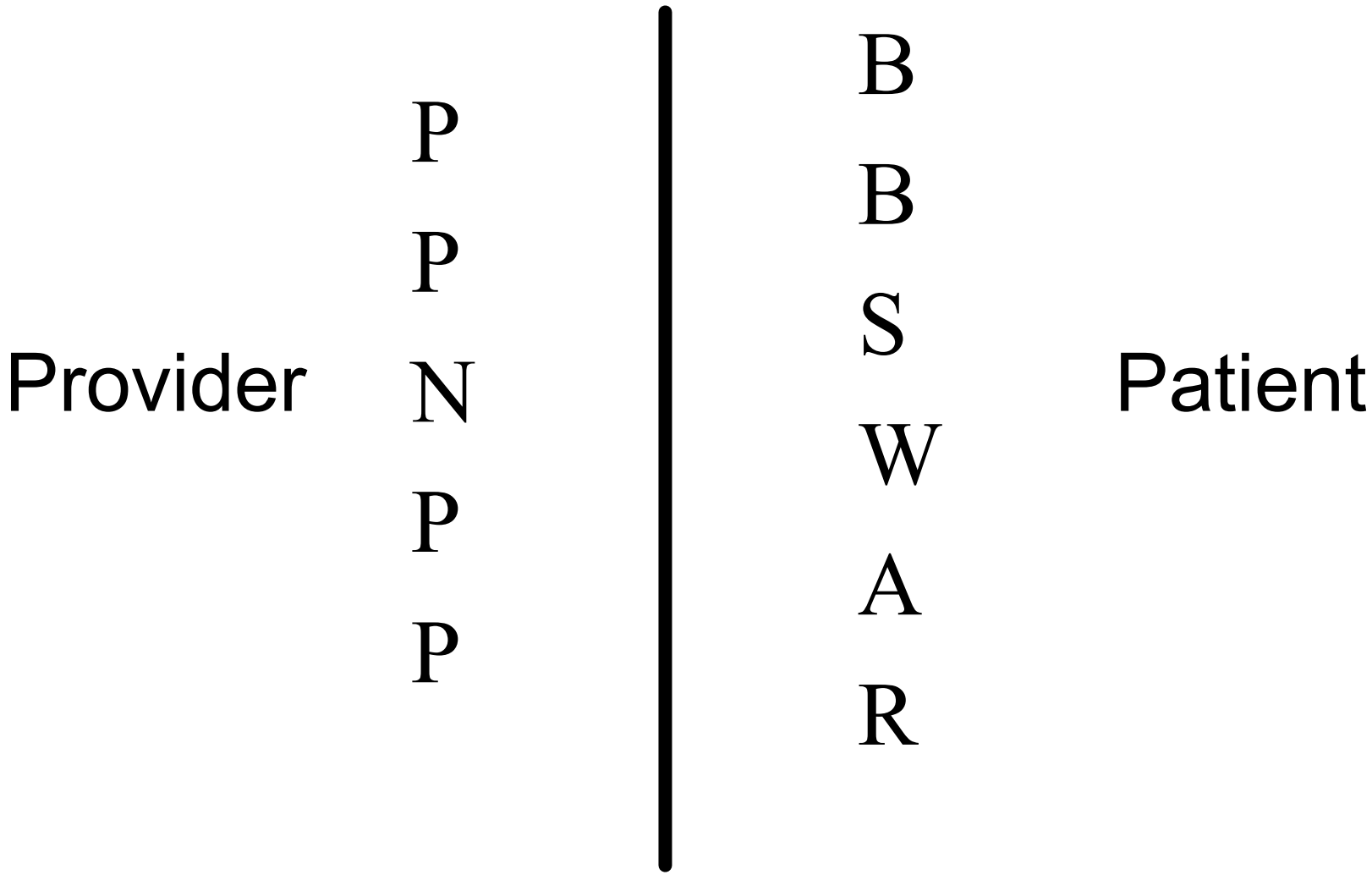
P

How do we help patients help themselves?

- Explore **Background**
- Discuss **Barriers**- "day-to-day" problems
- Ask about **Successes**
- Are they **Willing** to make a change? Do they have goals?
- Help then set an **Action** plan
- **Remember** and Reinforce

B
B
S
W
A
R

How do we do this all at the same time and in 20 minutes?



Patient leaves with:

- A script, referral, immunization, lab order, etc… that you think is important
- A specific action plan that you have reached collaboratively that is patient driven and patient oriented, specific and doable, that the patient feels is important
- Patient may return next time more engaged understanding that their disease is not your burden, and more empowered to participate in their care

Who we are and what we are doing…

- We are a Residency Program practicing and teaching full scope FM
- 32,000 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 ≥ 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…

- Computer registry to support patient care (CDEMS…Centricity)
- MA Planned Visits with patient action plans
- Provider Visits with emphasis on patient goal setting and action plans
- Group Medical Visits (3 types)
- Key messages for providers re:
  - nutrition and exercise opportunities

What do you want to hear about?


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

Patient Data Registry (CDEMS…Centricity)

- Track and target specific groups of patients
- MA's use it to time invites, target outliers, track labs/referrals/immunizations, etc…
- PCP's use it to support the evidence based, guideline driven, interventions we all need to do
- PCP/MA team can query their data for quality improvement efforts, and for patient goal reinforcement

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"

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: *standing orders signed by PCP*

- 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

How do we teach this to the MA's?

- A new curriculum for the MA's
- Camp SPANK, aka Skills in-service; foot checks, CDEMS, planned visits, phone skills, group visits
- Shadowing
- On the job training

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

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

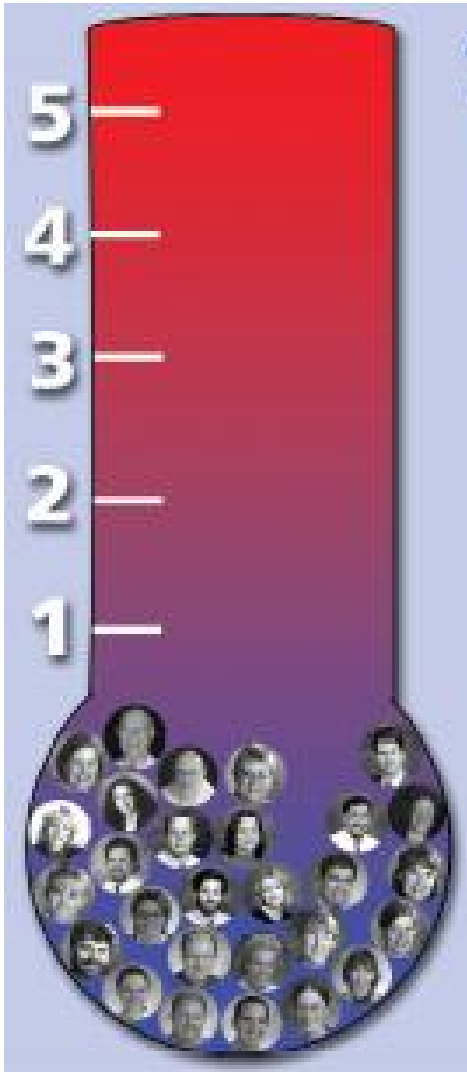
Patient Goal Quality

- 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 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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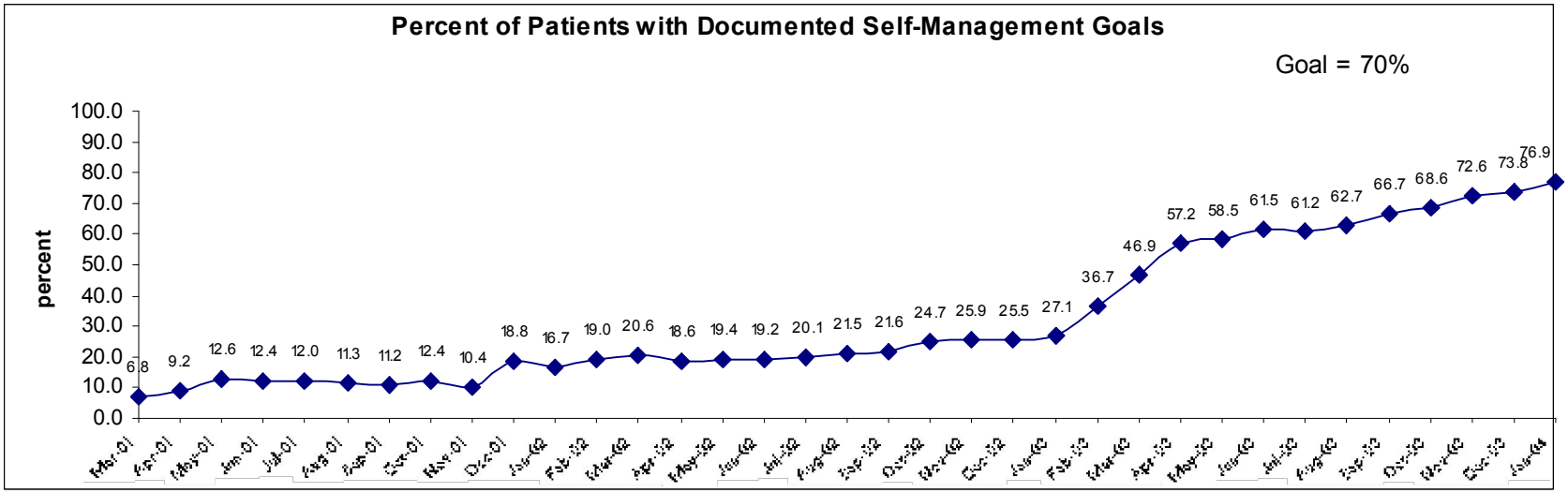
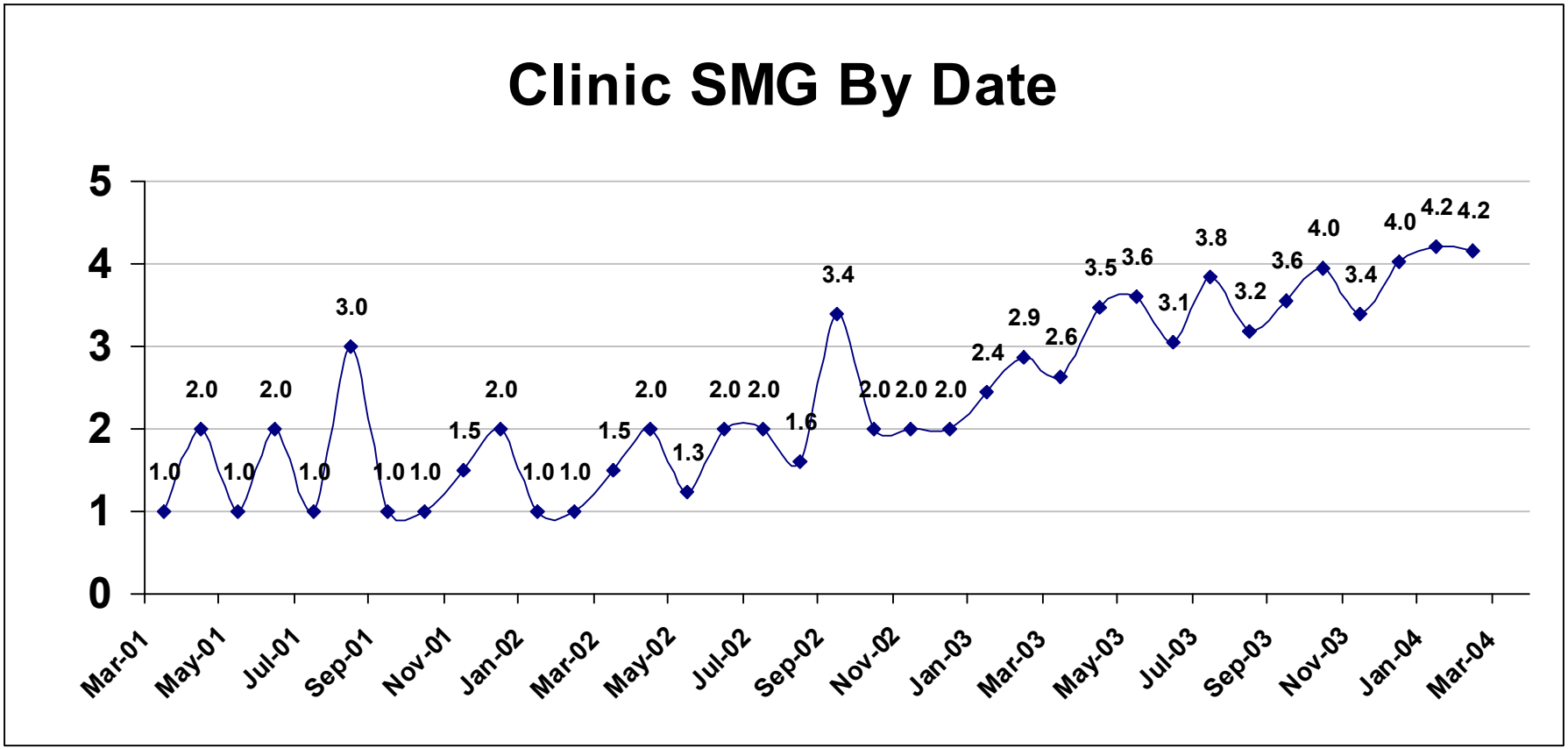
A Caring Difference You Can Feel

% of patients with goal



SMG quality over time:

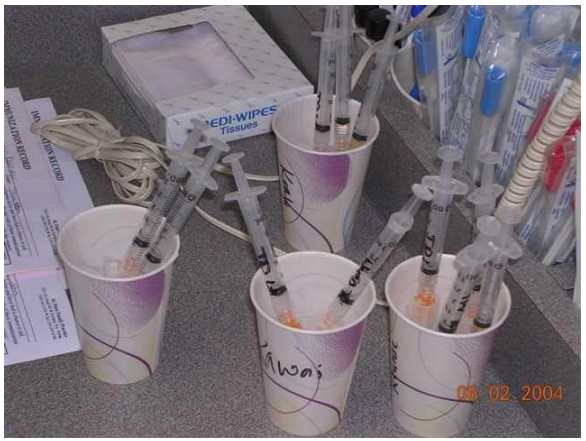


The Group Visit

Group Visits; defined…

- A group of patients connected in *some way*, meeting together with their *health care team* (PCP, MD/DO/ARNP/PA, RN's, MA's, front office, etc…) to take care of *their health care needs*, the same needs that are currently met with traditional medical primary care
- (**Not** a support group, **not** education classes, although they may feel better supported and become better educated)

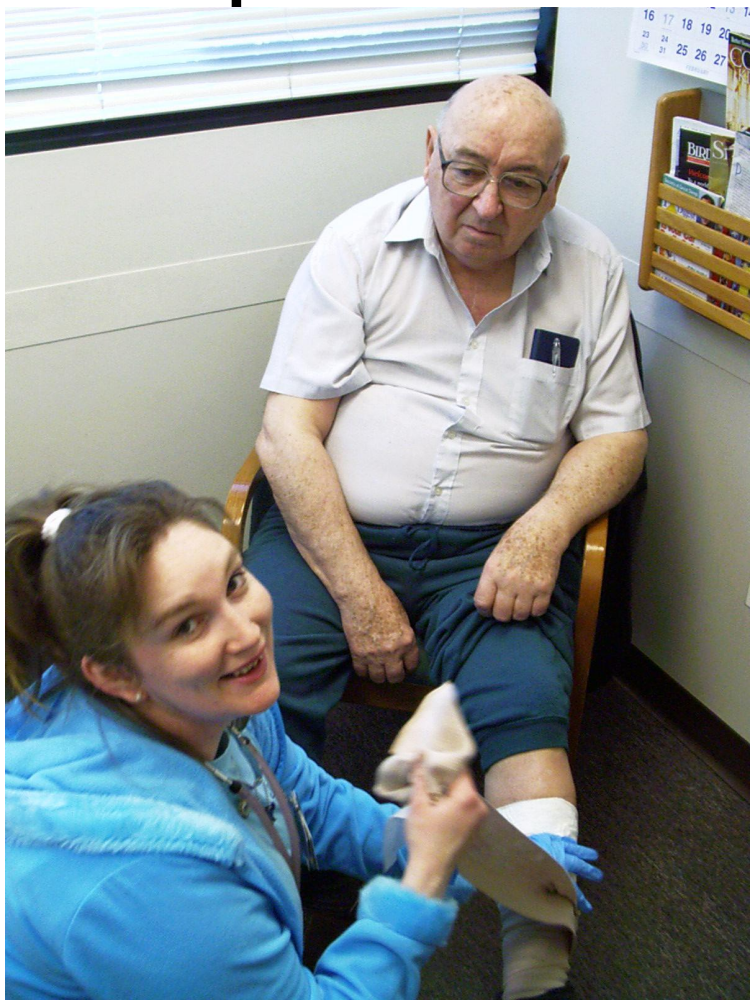
Group Visits; why try?



- Improved disease outcomes
- More efficient, planned care
- If planned right can help $$
- Patient satisfaction is high
- Patient self-management better supported
- Improved patient psychosocial wellbeing
- Provider satisfaction can be higher
- Staff satisfaction usually high
- Diversify our services and give patients CHOICES

Group Visits; which patients?

- Chronic disease
- Well Child Care
- Pregnancy
- Adult health main.
- Adolescent health
- Families
- Family group visits
- …etc…



Group Visits; which patients?

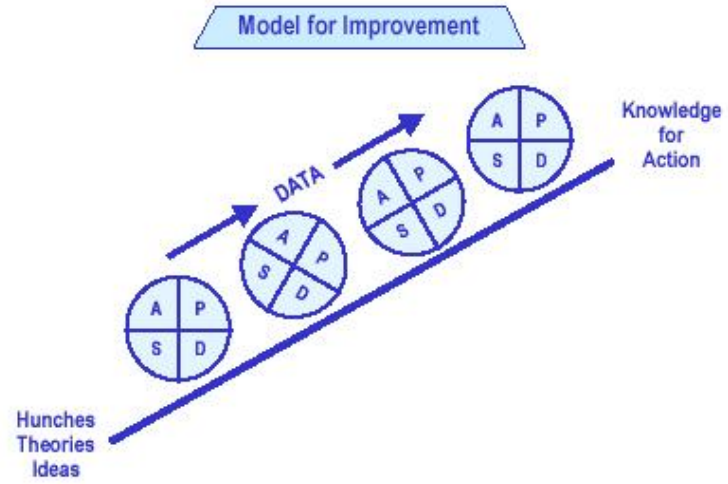
- Any patient or group of patients where you already know what it is you need to do as their PCP
- Any patient who visits without a symptom
- Any patient who would benefit from meeting others with the same problem or issue

Group Visits; how to get started-

- Need a provider willing to try something new
- Need support staff to work harder than they already are (and get rewarded for their efforts)
- Need a creative team willing to break from the traditional 1:1 patient:doctor, 15 minute, patient focused but provider driven visit
- Need “support from above”
- Lastly, need willing patients whose needs you understand

Group Visits: step two…

- Identify the need, identify the patients (patient registry, EMR, searchable database)
- Start small (PDSA cycles- start with just a few patients, one visit, minimal staff, use existing documentation and space)



- STUDY the experience and plan for the next

Group Visits: Our experience

- Diabetes Group visits- 3 types meeting different patien
  - Traditional
  - Open Office
  - "Mini" visit

DGV- Traditional

DGV- Open Office

DGV- “Mini” visit

Group Visits: Our experience

- Adolescent OB Group Visit

Group Visits: Our experience

- Group Well Child Care
  - Matched by age
  - Matched by family (the group family health maintenance visit)

Group Visits: Our experience

- The Group Family Home Visit

Group Visit: getting paid

- Provide the same care you would otherwise and document appropriately, then bill as you would routinely

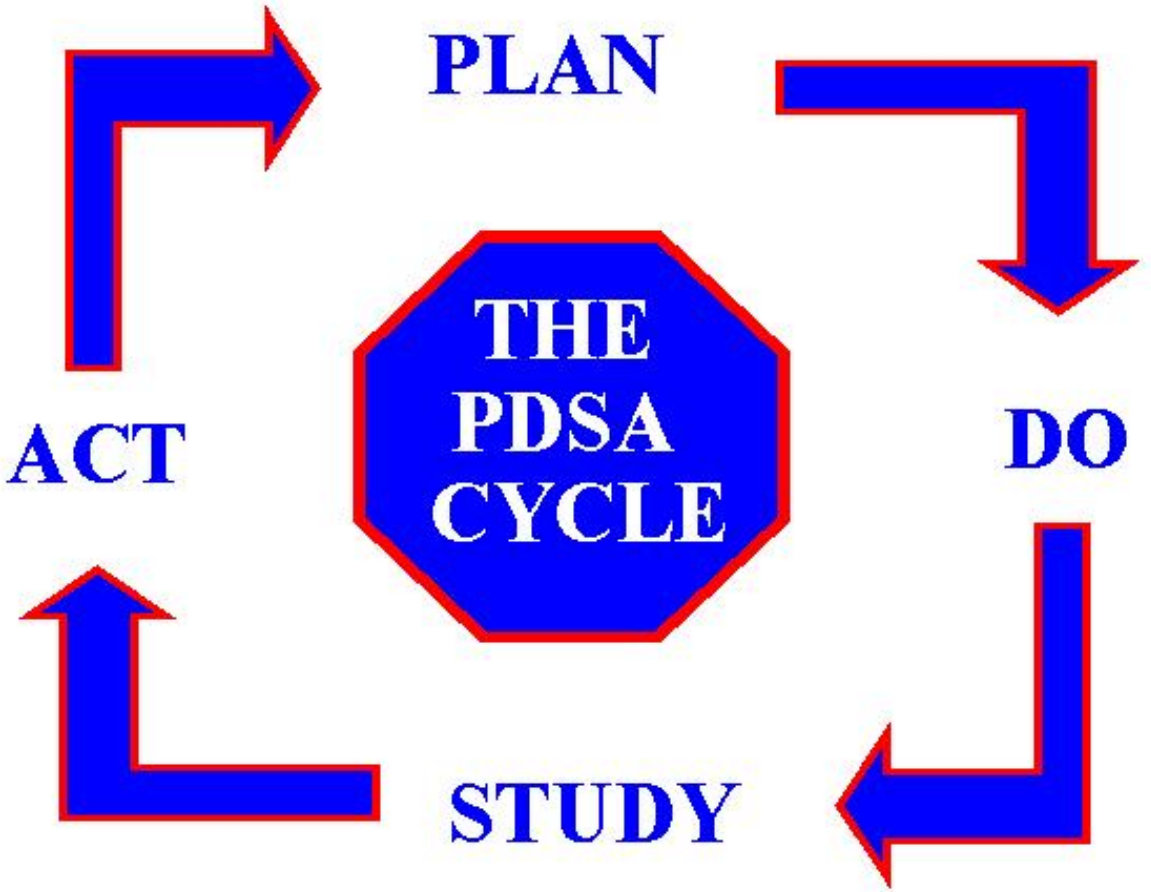
Key Messages:
Exercise opportunities

A walking club

"SPFP Moves With You"…
an exercise video

Key messages: Nutrition examples

An Action Plan



An Action Plan:

- Something you WANT to do
- Something REASONABLE and SPECIFIC
- Should answer these questions:
  - What?
  - How much?
  - When?
  - How often?
- Confidence level (likelihood-of-success) 1-10

This is called “Self-Management”

Work with your neighbor to come up with an action plan for your practice…

Contact Info…

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  kevin.haughton@providence.org
- St Peter Family Practice Residency Program (360) 493-7525