

Robert Wood Johnson Foundation

 Washington
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SCHOOL OF MEDICINE



DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation



Designing Primary Care for Diabetes Self Management

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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*



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

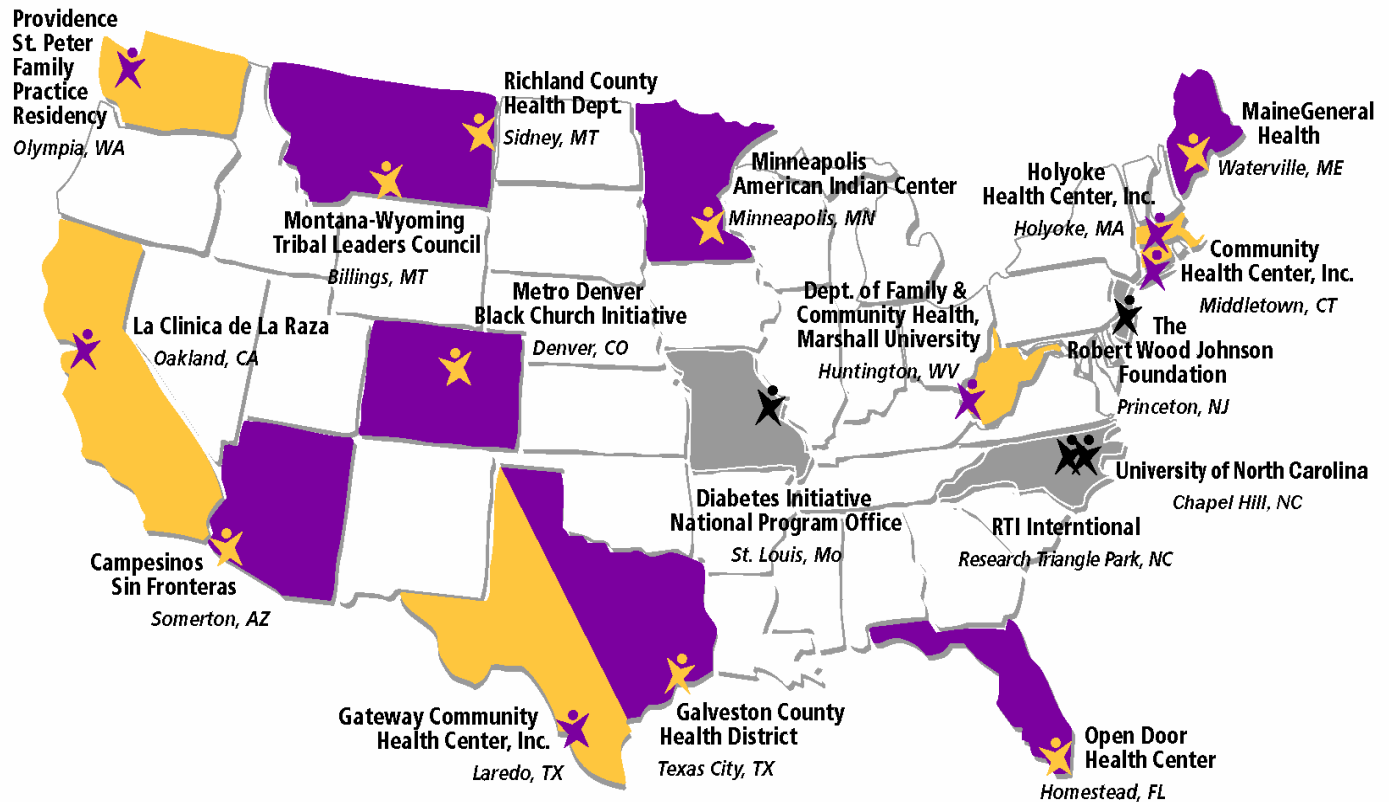


Background, cont'd

- 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”



The 14 Sites of the Diabetes Initiative





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



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

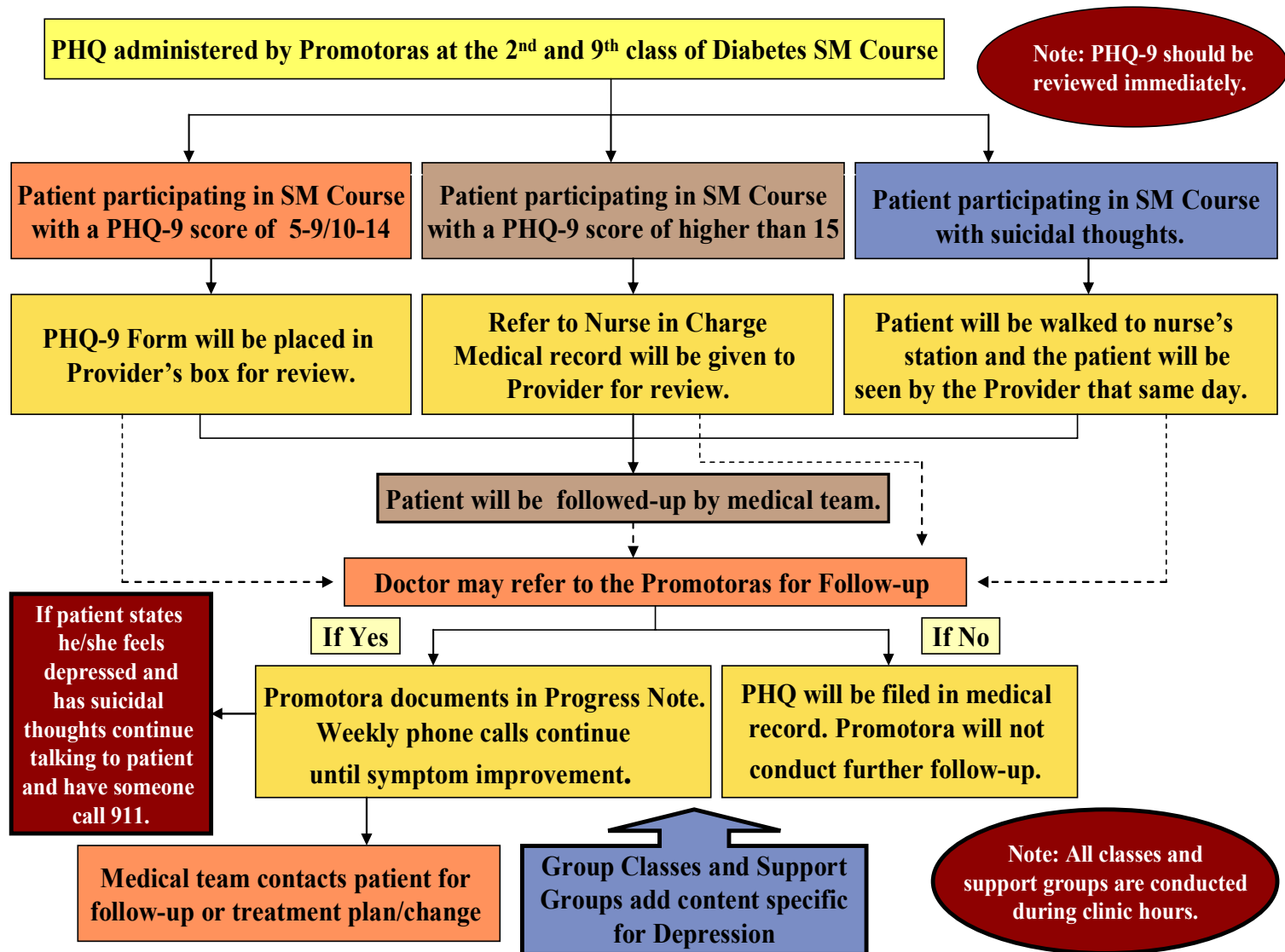
Examples....

- 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





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)



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



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



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



8. *Integration of Self Management into Primary Care*

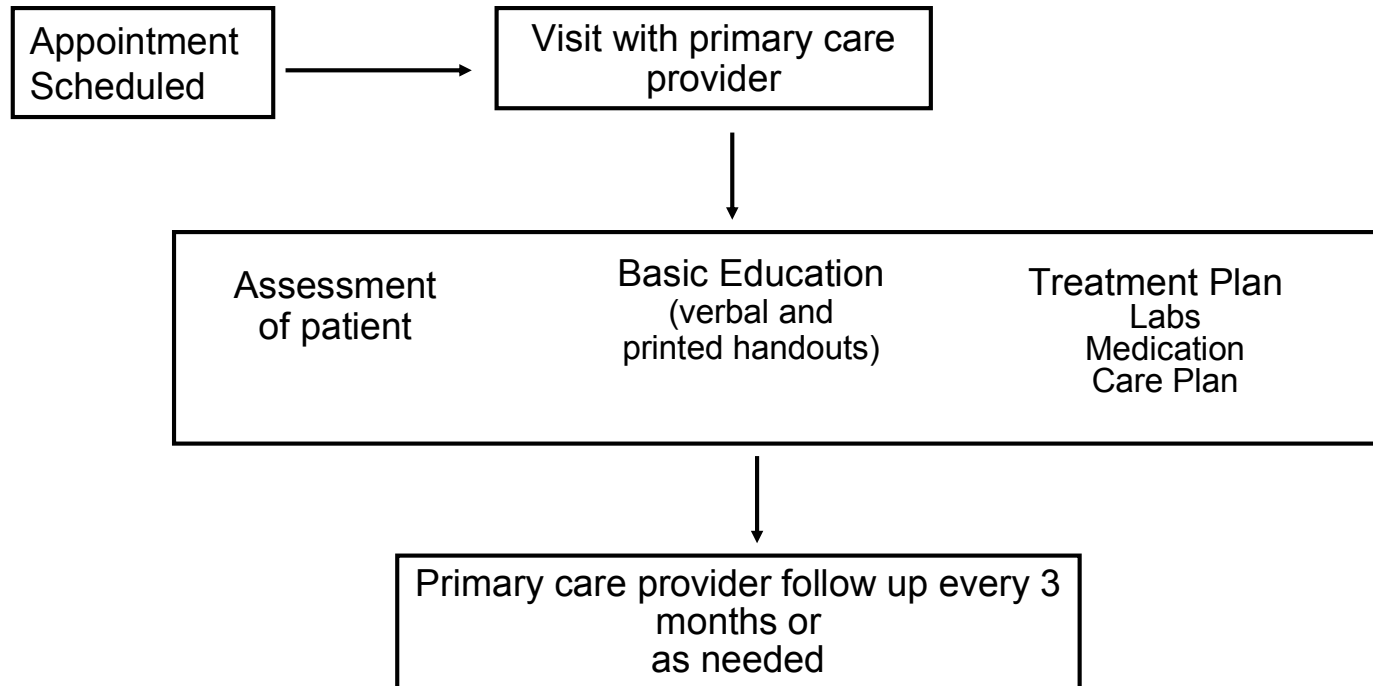
- Ultimately, to be effective, self management support must be integrated into and supported by a system designed for chronic illness care

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

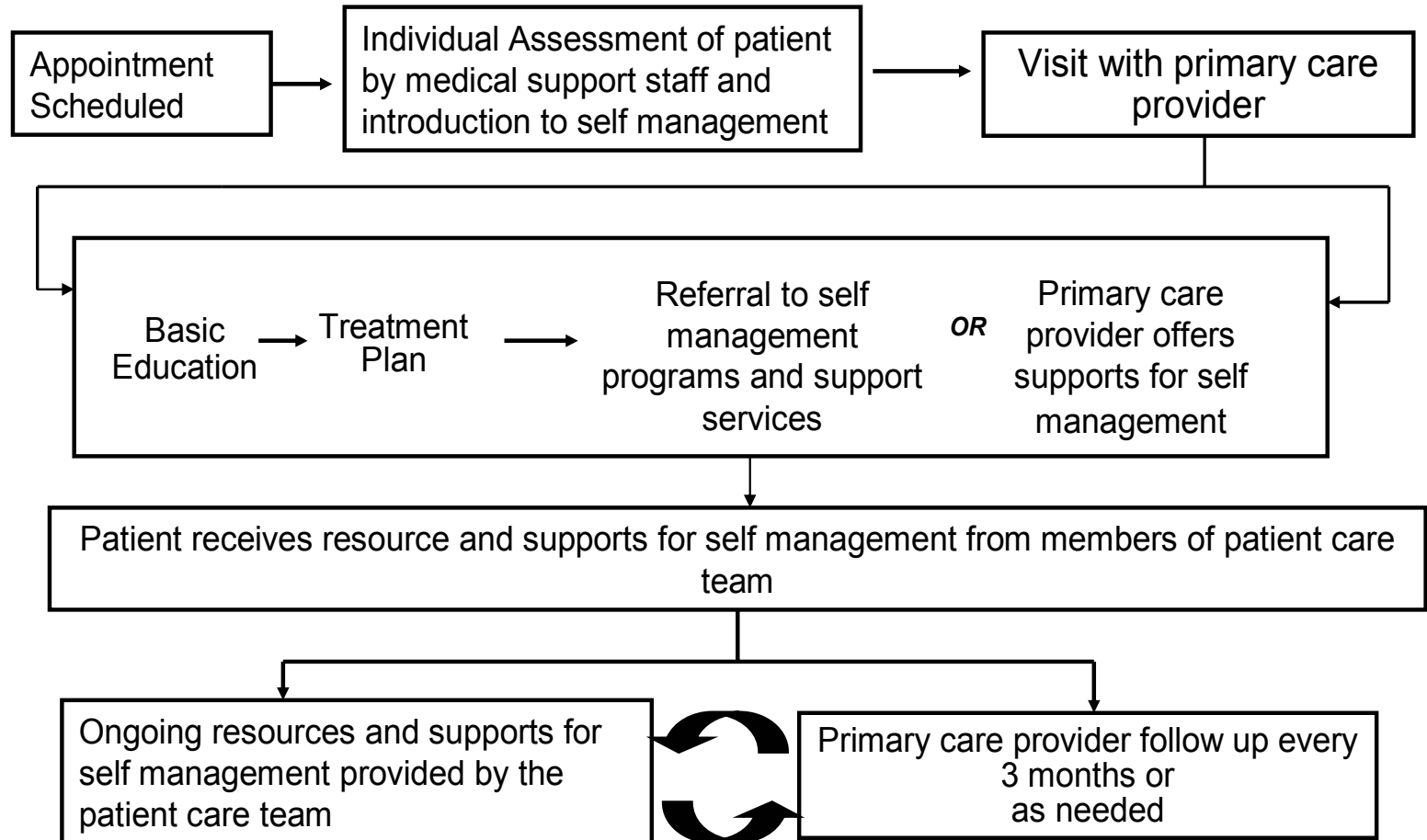


Standard or Usual Care for People with Diabetes





Integration of Diabetes Self Management into Primary Care





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.....

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–Thank you! –