



CALIFORNIA  
HEALTHCARE  
FOUNDATION



## Promoting Effective Self-Management Approaches to Improve Chronic Disease Care: Lessons Learned

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# **Promoting Effective Self-Management Approaches to Improve Chronic Disease Care: Lessons Learned**

*Prepared for*

CALIFORNIA HEALTHCARE FOUNDATION

*by*

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## About the Foundation

The **California HealthCare Foundation**, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at [www.chcf.org](http://www.chcf.org).

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# I. Executive Summary

SELF-MANAGEMENT SUPPORT IS PART OF A SET OF strategies to improve chronic disease care and curb the escalating economic and public health impact of chronic illness. Through their daily decisions about diet, exercise, self-measurement, and medications, people with chronic illness play the central role in determining the course of their disease. They need the support of their health care providers to make and sustain changes in these areas. The California HealthCare Foundation (CHCF) has determined that while many health care organizations are interested in helping their patients manage their chronic conditions, they need new organizational capacity, clinical skills, and strategies to be able to do so.

The Foundation conducted a two-year initiative in 2006–2007, *Promoting Effective Self-Management Approaches to Improve Chronic Disease Care*, to give health care organizations the training and tools to enable them to support their patients' growth in self-management. The initiative focused on diabetes, which causes heavy use of health care services and is amenable to self-management strategies. CHCF awarded grants of \$65,000 to 10 health care organizations around California, each with a significant number of low-income people among its patients. The grantee organizations were diverse in size, location, and resources, and included community health centers, Federally Qualified Health Centers (FQHCs), a county health department, and a medical practice in a large integrated delivery system. All showed a willingness to make permanent changes to integrate self-management support into care delivery.

The initiative had three major components to help grantees develop systems and practices to provide self-management support to their patients: system redesign, staff training, and measurement and feedback. CHCF made resources and experts available to the grantee organizations to support each of these activities. In addition to funding, the grantees received access to consultation on workflow and evaluation, on-site staff training and training tools, and several opportunities for in-person and teleconference meetings with project staff, consultants, and each other. The final project meeting took place in Oakland on November 28, 2007. CHCF also offered two levels of incentive bonuses for grantees that

fulfilled up to 10 requirements reflecting a high level of organizational engagement in the process.

The project design encouraged grantees to tailor the intervention to local needs and capabilities and continue to experiment throughout the grant period. Specially trained nonphysician staff members, such as licensed vocational nurses or community health workers, play key roles in self-management support, and the sites made different decisions about how to integrate support into the process of care, and which staff members would play key roles. (The variations are illustrated in the four case descriptions.)

Training was a major component of the initiative. All sites had at least one day-long, on-site training session with an expert in diabetes behavior change; the number of participating staff members per site ranged from 30 to 200. In addition, follow-up “booster” sessions and a training video were provided. The training provided both key concepts and hands-on experience in motivational interviewing, a key clinical technique to help patients set goals, identify and problem-solve about barriers, and build confidence in their ability to make needed changes. Many grantees considered the intensive training sessions a turning point for their programs.

Measurement was another essential part of the initiative. With technical support from the project’s evaluator, the grantees were responsible for tracking and reporting data on their patients and provider team members every quarter, and for assessing organizational capacity at the beginning and end of the project. They used a core set of measures that were tracked across all sites, and were shown their data and comparative data from the other sites every quarter. Overall, the quarterly data show positive trends across the indicators. All grantees made positive change in at least six of 21 impact measures, with the greatest improvements taking place in priority areas for this initiative. In addition, all sites made statistically significant changes in 15 of the 16 dimensions of organizational capacity, which project leaders regard as the first step in promoting

behavioral change and clinical improvements for patients.

The CHCF initiative produced the following lessons for the field:

#### **Lessons about self-management support:**

- Core elements of integrating self-management support into care are motivational interviewing training, measurement, and feedback.
- The self-management support model used in this initiative can and should be adapted based on organizational resources and priorities.
- Patient behavior change and improvements in clinical outcomes take time. Institutional change is the first step and priority, and lays the groundwork for other changes.
- Self-management support is part of a broader set of changes laid out in the Chronic Care Model, all of which are necessary to improve chronic disease care. The dimensions include self-management support, decision support, delivery-system design, clinical information systems, the organization of health care, and alliances with the community.

#### **Lessons about system design and patient flow:**

- For self-management support to be effectively integrated into care, sites need to rethink their team composition and workflow.
- Clinical and administrative champions are needed in each site.
- It is possible to integrate self-management support into primary care without making physicians the major agents of the intervention. Doctors’ participation is essential, but they are already at their limit, and can play a supportive, rather than primary, role. In addition, this approach cannot be imposed on them; their buy-in must be secured.
- Some questions remain about the roles for medical assistants and community health workers

in self-management support; there is agreement that to be effective team members, they need considerable training and mentoring.

#### **Lessons about training:**

- On-site staff training and hands-on experience for all participating team members, with regular boosters, are key.
- Confidence-building is key, for both providers and patients. It is important to celebrate success and focus on what patients can do. Action plans can be very useful, but they must be used in a way that does not undermine the patient's confidence.

#### **Lessons about measurement:**

- Measurement and reporting are a critical dimension of self-management support for all participants, including the organization, individual providers, and patients.
- Many organizations have a steep learning curve in developing appropriate measurement systems and learning to use the data to motivate change.
- Feedback to providers is a critical component of closing the measurement loop, so they can understand how to readjust their interventions.

## II. The Initiative to Integrate Self-Management Support into Clinical Practice

### Transforming Health Care to Meet a Growing Public Health Challenge

The United States now spends three of every four health care dollars treating the 45 percent of the population with chronic disease. This segment of Americans is expected to grow by 1 percent a year in the future, making chronic disease an escalating public health and economic challenge for the nation.<sup>1</sup>

People with chronic illness play the central role in determining the course of their disease through their daily decisions about diet, exercise, self-measurement, and medications. Because behavior change is inherently difficult, even when serious health outcomes are at stake, people are most likely to make needed changes with support from their health care providers. Because patients' daily activities are so critical to successful health outcomes, health care providers are having to reshape their own thinking, behaviors, and delivery systems to support healthful behaviors.

The Chronic Care Model, the basis for a host of initiatives addressing these issues, identifies self-management support as one of six dimensions of integrated chronic care. The model was developed by Ed Wagner, M.D., director of the MacColl Institute for Healthcare Improvement in Seattle, and his colleagues.<sup>2</sup> It has three targets: the health care system, the patient, and the provider. Besides self-management support, the other areas of provider activity are decision support, delivery-system design, use of registries (clinical information systems), organization of health care, and alliances with the community. These activities clearly dovetail with self-management support, as will be seen below.

Self-management support transforms the patient-provider relationship into a collaborative partnership and organizes the health care team around the pivotal role of the patient. The process engages patients and providers in a partnership to identify health goals, choose specific actions, acquire needed information, and monitor progress. It incorporates principles of motivational interviewing (in a nutshell, “ask, don’t tell”) and self-directed learning. It uses a team approach, not just because physicians lack the time to provide comprehensive support during the encounter but also because offering it at multiple points in the office visit



increases its effectiveness. Because these are complex changes for health care organizations, they typically mean redesigning the delivery system and adopting new ways of thinking and acting to integrate self-management support into systems of care.

There is strong evidence that self-management support improves patients' health-related behaviors and results in improved clinical outcomes. In a 2005 paper and literature review for the California HealthCare Foundation (CHCF), for example, Thomas Bodenheimer, M.D., and colleagues reported "significant associations between improved information-giving by the physician, more participatory decision-making, enhanced self-efficacy, healthier behaviors, and better outcomes in patients with diabetes."<sup>3</sup>

### **A New CHCF Self-Management Initiative Builds on a Previous One**

CHCF has found that while health care organizations are interested in providing self-management support, they need concrete strategies and new organizational capacity to do so. This was a major finding of the foundation's first self-management initiative, *Promoting Consumer Partnerships in Chronic Disease Care*, which ended in 2005.

To help organizations integrate self-management support into primary care services, therefore, CHCF launched a new initiative, *Promoting Effective Self-Management Approaches to Improve Chronic Disease Care*, in late 2006. This project, designed in consultation with experts who advised on the first round, provided structured tools and assistance to enable grantees to support self-management and monitor the results for both patients and providers. The goals of the initiative were to enhance organizational capacity, improve understanding of self-management support, and produce healthier and more confident patients, as well as more satisfied providers and staff. A broader goal was to reduce health care utilization and costs.

CHCF Senior Program Officer Veenu Aulakh, M.P.H., comments, "For improvements in chronic care to occur, patients must have the knowledge, skills, and confidence to manage their own health. While the chronic care model has been broadly implemented, the least understood component of the model is how to best support patients in self-management. This initiative was designed to delve deeper into understanding how to integrate self-management support into practice within the constraints of a busy clinic caring for patients with complex needs."

People with diabetes are heavy users of health care, and the exacerbations of the disease—many of them preventable—can be devastating and costly. Thus the foundation focused on diabetes and cardiovascular disease for its second initiative, calling this "a continuum of chronic conditions with clear self-management strategies where we believe health care systems can have a significant impact when partnering with patients to increase their self-management skills."<sup>4</sup>

The many challenges faced by low-income people and their safety-net providers greatly compound the difficulty of coping with chronic disease. While the foundation did not limit the grants to safety-net organizations, it required that the proposed interventions be relevant and appropriate to safety-net populations, including people with low levels of health literacy and non-English-speaking and limited English-speaking populations.

Ten health care organizations around the state (see Appendix) were awarded grants of \$65,000 and began two-year self-management support projects in December 2006. A heterogeneous group, they vary widely in size and resources, representing diverse rural and urban settings. They include community health centers, Federally Qualified Health Centers, a county health department, and a medical practice in a large integrated delivery system. Several offered the intervention in multiple clinics.

All the grantees chose to target patients with diabetes, many of whom also have co-existing conditions, such as hypertension. (Forty-four percent of people with chronic conditions have two or more of them.) Some sites offered the intervention to all their diabetic patients, while others worked with a smaller number, selected on the basis of higher risk (HbA1c [blood sugar] level) and/or greater motivation to manage their diabetes. Most patients in the initiative have low incomes and are either uninsured, underinsured, or enrolled in a government program, such as Medi-Cal. Most have limited health literacy; many are Hispanic; and some speak only Spanish.

The project had three major components: system redesign, staff training, and measurement and feedback. CHCF made resources and experts available to the grantees to support each of these activities. In addition to financial support, grantees received access to consultation on workflow and evaluation, on-site staff training and training tools, and several opportunities for in-person and teleconference meetings with project staff, consultants, and each other. The final project meeting took place in Oakland on November 28, 2007. CHCF also offered two levels of incentive bonuses for grantees who fulfilled up to 10 requirements, reflecting a high level of organizational engagement in the process.

CHCF designed the project so that grantees could tailor the intervention to local needs and capabilities and continue to experiment throughout the grant period. At the outset, they had access to a workflow consultant to help them analyze workflow and staff roles and determine the most efficient way to integrate self-management support into patient care—for example, to take advantage of wait times and make the best use of physicians' limited time with patients.

While all sites used a team approach, they made different decisions about which staff member(s) would serve as the main agent, or initiator, of the

intervention and how to integrate it into the process of care. Specially trained nonphysician staff members played key roles in self-management support at some sites. Several organizations made licensed vocational nurses (LVNs) the main agents, and some identified important roles for *promotoras* (community health workers) and/or medical assistants. Physicians played varied roles in the process in different organizations, as well. The four case descriptions illustrate some of the variations among the grantee programs.

The grantees also were creative about developing their own resources for patients and staff to augment those provided by the foundation. Monterey's patient-oriented A1c campaign and Samuel Dixon's self-management mission statement, both described below, are examples.

### Training in Core Concepts and Techniques

The centerpiece of the initiative's training component was a day-long training session, on site, with William Polonsky, Ph.D., a professional trainer and expert on diabetes behavior change. Polonsky also made follow-up visits to some sites, and key staff had additional "booster session" training that gave them hands-on experience with patient actors.<sup>5</sup> The grantees also built their own regular staff training sessions into organizational routines.

A basic premise of self-management support is that people want to live long and healthy lives, even if they don't always do what is best for themselves or make the changes recommended by their providers. The main reason for the gap, says Polonsky, is that they encounter barriers that keep them from making desired changes. Some are practical, such as inadequate time or money to follow diet and fitness or medication recommendations, and some are emotional and attitudinal, such as depression, doubts about the benefits of the change, or a lack of confidence in one's ability to change.

Polonsky stresses that confidence is a strong predictor of lasting behavior change. In addition

to imparting key concepts in his training sessions with the grantees, Polonsky taught them practical behavioral techniques, based on the motivational interviewing approach, to help patients set goals, identify barriers, work out solutions, and build confidence in their ability to make positive changes. The trainees' hands-on experience made them more aware of their habitual ways of working with patients and enabled them to practice the new approaches. CHCF also supplied grantees with a training video developed specially for this project. The video, which features Polonsky working with patients, reinforces key concepts and illustrates the use of motivational interviewing to enhance self-management.<sup>6</sup>

At the final grantee meeting and in follow-up interviews, several participants described their training experience as a turning point for their programs. Many expressed a desire for additional on-site training in the future.

Indeed, training was a major topic of discussion at the final meeting. The group explored possible ways to expand staff training opportunities, such as through a "train the trainers" program and a professionally developed curriculum. They discussed what it would take to create a network of effective trainers throughout the state, and how to instill in nonclinical staff members a sense of the limits of their knowledge, so they could judge when to answer patients' questions and when to refer them to others. Some participants said it would be helpful to have financial support to enable medical assistants to attend classes. The group also talked about frequent staff turnover, a common problem for several grantees, which only heightens the need for frequent staff training.

### Monitoring Results and Using Data to Support Improvement

Another critical dimension of self-management support and this initiative is what Alan Glaseroff, M.D., medical director of Humboldt-Del Norte IPA, calls "involving people with their numbers."<sup>7</sup> The grantees were responsible for tracking and

reporting data on their patients, provider team members, and organizational capacity. The project's evaluator, Seth Emont, Ph.D., M.S., of White Mountain Research Associates, LLC, advised on data collection and compiled and analyzed the data.

Every quarter between April 2006 and October 2007, the grantees surveyed patients about their experience and satisfaction and reported the aggregate results to CHCF. They did the same for providers' satisfaction with self-management support, and they also reported patients' documented self-management goals and clinical outcomes. The grantees used a core set of measures that were tracked across all sites, and they were shown their unblinded data every quarter, with comparisons to other grantees. (Data were collected on 15 sites in all because two grantees reported on multiple sites.)

Overall, the quarterly data show positive trends across the indicators. All grantees made positive change in at least six of 21 impact measures, with the greatest improvements taking place in priority areas for this initiative. (See more details below.)

### Organizational Capacity

In addition to the quarterly surveys, the grantees assessed their institutional capacities at the beginning and end of the project (February 2006 and November 2007, respectively). The planning and self-evaluation tool for this assessment has 16 dimensions, divided equally into the complementary categories of patient support and organizational support. The first group is composed of elements of service delivery shown to enhance patient self-management in areas such as medication management, healthy eating, and emotional health. The second group is composed of system changes that must be made to integrate and sustain self-management support.

All sites made statistically significant changes in 15 of the 16 dimensions of organizational capacity. The greatest institutional gains were in the priority areas for this initiative. Among the patient-oriented

measures, the largest changes related to the supports for patient involvement, problem-solving skills, and goal-setting. And related to organizational systems for integrating and sustaining this support, the top scores were for education and training, patient input, and documentation of self-management support. At the final meeting, Emont called particular attention to this solid evidence of institutional change. “Organizationally and culturally,” he said, “a shift is taking place.” This new capacity lays the groundwork for greater progress by individual patients.

### Provider Satisfaction

Every quarter, the core members of the self-management support teams were asked these questions:

1. How satisfied are you with how well you and your staff are helping your patients manage their chronic illness?
2. How satisfied do you think your patients are with how you are helping them manage their chronic illness?
3. How satisfied are you with how well you and your staff are involving patients in their own care?
4. How satisfied are you that your patients’ self-management goals and plans are assessed in a standardized manner?
5. How satisfied are you that the self-management tools and protocols your clinic is using are making a difference in your patients’ clinical outcomes?

Over the six quarters of data collection, roughly half of the sites had positive trends in providers’ satisfaction with their ability to provide self-management support. The mean percentage of providers answering “extremely satisfied” to questions 1, 4 and 5 showed significant progress over this period.

As noted, increasing provider satisfaction was one of the goals of this initiative. Primary care physicians can feel discouraged about the lack of progress with their chronically ill patients. An intervention that helps them battle burnout and develop skills for strengthening patients’ control over their future is beneficial to them as well as to their patients. Glaseroff observes that physicians need to learn to let go of the notion of noncompliance and appreciate the complexities of their patients’ lives, especially those with low incomes and related disadvantages. “This is about giving people hope, giving them something they can do well at. Over time this will produce results.”<sup>8</sup>

Cheryl Laymon, director of the Samuel Dixon Family Center, comments that for her clinic’s providers, learning to collect and use data was key. Providers learned to see individual patients as part of a population and to observe trends in their care and outcomes—a new perspective for them. This enabled them to “look past individuals to groups, stay focused on solutions, and see the progress they’re making.”

### Patient Indicators

The patients in the CHCF initiative were asked 11 questions every quarter, with four possible answers: “I do not agree,” “I’m not sure,” “I agree a little,” or “I agree a lot.” The most significant changes for patients took place in the third category, lifestyle changes, particularly related to meal plans.

*How I feel about taking care of my diabetes:*

1. I can tell my doctor what is wrong with me even if my doctor does not ask me.
2. I am sure that I can follow my diabetes care plan.
3. I know what I need to do to take good care of my health.
4. What I do can make a big difference in my health.

*My plan for diabetes care:*

5. My doctor and I work together on a plan to help control my diabetes.
6. My doctor asks for my ideas when we work on my diabetes plan.
7. My doctor helps me make a diabetes plan I can follow every day.

*Making changes in my life:*

8. Over the past week, I was able to stick with my meal plan.
9. Over the past week, I was able to stick with my exercise plan.
10. (if applicable) Over the past week, I took all of my prescribed medicines when I was supposed to.
11. Over the past week, I checked my blood sugar when I was supposed to.

In addition, the grantee organizations tracked the patients' documented goals as well clinical measures, including HbA1c levels, blood pressure, LDL levels, and body mass index. While there was positive change in documented self-management goals (positive changes occurred in nine of 15 sites), the only aggregate clinical indicator to approach statistical significance over this relatively short period was a reduction in LDL levels.

Monterey County's A1c campaign stands out as an example of what can be done to involve individual patients with their numbers. They created a popular patient education campaign that teaches about the significance of A1c levels and uses patients' data to motivate them to improve. Educational posters are posted throughout the clinic, and patients receive special stickers when their levels are below 7. Through these strong graphic devices, which are reinforced throughout the process of care, even patients with limited English and literacy are empowered to track their results and see their progress. Clinic Medical Director Laura Solorio,

M.D., describes a positive feedback loop: when the patients see that their doctors are interested in the numbers, they get more interested themselves, and vice versa.

One of the tools available to CHCF grantees was an action plan, "My Diabetes Plan," which providers could use to structure the conversation with patients about goals and steps toward them (see example at [www.chcf.org](http://www.chcf.org)). As the project results show, measurable clinical improvements are difficult to achieve and, at best, take time. At the final meeting, the grantees agreed that it is important to emphasize patients' successes and not "set them up for failure" with overly ambitious goals. Many felt that while the action plans are a useful tool for providing consistent self-management support and collaborative problem-solving, clinicians should regard them as facilitating a process rather than as an end in themselves.

Emont and Glaseroff were strong voices for the benefits of using data instruments and data. At the final meeting, they reminded the participants of the maxim about management and measurement,<sup>9</sup> and encouraged the grantees to continue surveying their patients and providers and measuring outcomes. Most participants report that they intend to do so. For some, this measurement activity is an explicit part of their broader quality improvement efforts.

## **Handling Challenges and Building on Successes**

Perhaps the most meaningful sign of the success of this initiative is that the grantees intend to continue providing self-management support to their patients. In addition, some project sites are working toward extending the intervention to other chronic conditions and/or to new parts of their institutions or new service areas. In their final meeting, which focused on consolidating lessons learned and sustaining projects in the future, the grantees had a chance to share experiences and discuss ways to build on what they had learned. They also discussed common challenges, of which the most frustrating is staff turnover. The recommended response is the

same as it is for creating self-management support programs: frequent training.

At this meeting, the group heard two presentations on what might be called “advanced self-management support” — significant team redesign and community outreach efforts that are natural next steps for organizations to take toward sustainable self-management support. The first presenter was Glaseroff, who described the multifaceted diabetes initiative he has led in Humboldt County since 2003. “We’re working to create a community-wide social movement,” he said, “involving patients, health care providers, politicians, and employers around the notion of improving the community’s health.” The use of data that are continually fed back to local clinicians is an integral part of the process, along with training in collaborative primary care strategies. The grantees expressed special interest in his initiative’s Health Education Alliance, which uses an adult learning theory-based curriculum that has been certified by the American Diabetes Association. The Alliance is part of an evolving community-based self-management referral system in Humboldt County that also features a peer-led support group called Peer Outreach Education Team (POET).

Bodenheimer reported briefly on his pilot project to introduce a “teamlet” model for working with San Francisco General Hospital’s chronically ill patients. Family practice residents are paired with “coaches” (*promotoras* or medical assistants) in teamlets that, by covering several aspects of the patient visit, can spend longer than the requisite 12 to 15 minutes with each one. All coaches are culturally concordant with patients. When the coach knows what he or she is doing, he said, the teamlets are successful and the physicians like being part of them.

Bodenheimer said his motto is “train to sustain.” He described his staff training work, aimed at bringing about “the key paradigm shift—from directive to collaborative.” He tells staff members, “Stop telling people what to do and start asking.” His training curriculum involves six one-hour sessions, followed

by ongoing practicing and mentoring. Participants expressed interest in getting copies of his curriculum and observing his training sessions.

### III. Summary: Lessons for the Field

In summary, the CHCF initiative *Promoting Effective Self-Management Approaches to Improve Chronic Disease Care* produced the following lessons for the field:

#### Self-Management Support

- Core elements of integrating self-management support into care are motivational interviewing training, measurement, and feedback.
- The self-management support model used in this initiative can and should be adapted based upon organizational resources and priorities.
- Patient behavior change and improvements in clinical outcomes take time. Institutional change is the first step and priority, and lays the groundwork for other changes.
- Self-management support is part of a broader set of changes laid out in the Chronic Care Model, all of which are necessary to improve chronic disease care. The dimensions include self-management support, decision support, delivery-system design, clinical information systems, the organization of health care, and alliances with the community.

#### System Design and Patient Flow

- For self-management support to be effectively integrated into care, sites need to rethink their team composition and workflow.
- Clinical and administrative champions are needed in each site.
- It is possible to integrate self-management support into primary care without making physicians the major agents of the intervention. Doctors' participation is essential, but they are already at their limit and can play a supportive role. In addition, this approach cannot be imposed on them; their buy-in must be secured.
- Some questions remain about the appropriate roles for medical assistants and community health workers; there is agreement they need considerable training and mentoring to be effective team members.

## Training

- For all participating team members, on-site staff training and hands-on experience, with regular boosters, are key.
- Confidence-building is key, for both providers and patients. It is important to celebrate success and focus on what patients can do. Action plans can be very useful, but they must be used in a way that does not undermine confidence.

## Measurement

- Measurement and reporting are a critical dimension of self-management support for all participants, including the organization, individual providers, and patients.
- Many organizations have a steep learning curve in developing appropriate measurement systems and learning to use the data to motivate change.
- Feedback to providers is a critical component of closing the measurement loop, so they can understand how to readjust their interventions.



## Appendix A: Grantee Case Studies: Four Projects

### **Southern California Permanente Medical Group** (Riverside)

Kaiser Riverside has five Population Care Nurse Clinics serving the large and heterogeneous Riverside area. The 270,000 Kaiser members in this area have varied levels of income and literacy as well as diverse ethnic backgrounds. Approximately 18,000 have diabetes. Self-management support and action planning are integrated into Kaiser Permanente's Diabetes Roadmap, the national framework for diabetes care for all Kaiser members. In Riverside, Project Manager Jeanie Taylor, R.N., says that diabetic patients are introduced to action planning by registered nurses (RNs) in their roles as clinicians, health educators, and case managers. Licensed vocational nurses (LVNs) then make follow-up phone calls to provide health care coaching. Focus group discussions with patients have shown that the follow-up calls help them stay focused on their action plans and on track with medications, lab tests, and so on. This is manifested in the self-management support initiative's data: patients' confidence levels and progress toward goals increased following the phone calls. Surveys of staff by Kaiser's Care Management Institute (CMI) also found that the organization's RNs value the action planning tool as a guide for their conversations with patients, and that the self-management support process has spurred professional growth for LVNs. Kaiser Riverside plans to continue using the self-management support model with diabetic patients in its five Riverside clinics, and will also apply the model to other chronic conditions, starting with heart failure. In addition, Kaiser's CMI and Inter-Regional Nursing Council are helping to integrate action planning nationally by sharing the value of incorporating it into care models. The CHCF initiative's action planning tool is now in use in Kaiser Permanente facilities in Ohio, the Northwest, Georgia, Colorado, and Hawaii, as well as in Riverside.

### **Monterey County Health Department** (Salinas)

As a Federally Qualified Health Center (FQHC), this grantee serves the low-income population of the Salinas area, working in collaboration with the Community Health Department. More than half of its patients speak only Spanish, and all of its medical assistants are bilingual. Two of its seven clinics participated in the CHCF self-management support project—Alisal Family Practice, located in East Salinas, and Laurel Internal Medicine, based on the campus of the county hospital. Sixty-five percent of the patients of the Laurel Internal Medicine Clinic have diabetes. The diabetes educator is the main agent of the self-management support intervention, but everyone in the clinic has been educated in self-management support and plays a role. The most distinctive innovation of Monterey County's project is its A1c program, which uses posters to draw patients' attention to their A1c levels and colorful stickers to reward them when they keep it below 7. They plan to continue the A1c program. In addition, they are looking for ways to use goals and report cards to help patients feel successful, and they want to develop mini-group visits for peer support. The medical director also is working with the county's public health nurses to help them incorporate more self-management support into their work with chronically ill patients. Monterey County participates in the Center for Disease Control's (CDC) *Steps to a Healthier U.S.* initiative. Project leaders reported on their self-management support program during a recent CDC site visit, and they also have reported on it to other community health providers.

## Northeast Valley Health Corporation

(northeast Los Angeles County)

Northeast Valley is a nonprofit FQHC whose patients are predominantly Hispanic, low income, and medically indigent. Many speak only Spanish. There are about 1,600 people with diabetes in its four adult medicine clinics. In its two smaller clinics, all diabetic patients are entered into the disease registry and case managed by the Family Medicine Care Coordinator, while only high-risk patients (with A1c levels of 9 or greater) are entered into the registry and case managed. All providers and care coordinators use the My Diabetes Plan. At the outset, the organization worked with an expert consultant to analyze workflow and redesign care delivery. Family medicine care coordinators (usually LVNs) became the main agents of the self-management support intervention, and were given special training for the job. Clinic physicians, who also received training, were enthusiastic about having a standardized process for supporting self-management, and surveys showed early positive results for both patients and providers. However, about eight months into the project, Northeast Valley lost all of its care coordinators, typifying the staff turnover problem that plagues many safety-net providers. After a dip in survey results, Northeast's patients and providers are again showing progress in self-management. The organization plans to continue the intervention in the future, and it may increase the role of medical assistants if it can find the resources to adequately train and mentor them. Leaders also plan to support self-management for patients with other conditions, such as asthma and hypertension, and to continue to evaluate the impact of the intervention.

## Samuel Dixon Family Health Centers

(Santa Clarita Valley, Los Angeles County)

Samuel Dixon operates community health centers in two sites, one rural and one in the city of Santa Clarita. Although 93 percent of patients who use the health centers are employed, they have low incomes and are either underinsured or uninsured. All staff members are bilingual, as most patients are Hispanic. This is a small, nimble program with just three providers and an executive director. As a not-for-profit organization, Samuel Dixon has a governing board, and its members have been educated about self-management along with others in the organization. To provide self-management support, this small staff uses a team model: The physician is the clinical leader, the physician's assistant plays a key role, and the medical assistant provides backup. The director reports that their day-long training with Polonsky was a turning point for them in understanding how to support patients in self-management. During the project, Samuel Dixon's lead staff wrote a full-page "Self-Management Mission Statement: A Philosophy of Patient Care" that concludes, "We encourage our staff to actively seek out barriers and work with our patients to develop action plans that support the patient as the head of the healthcare team." The organization plans to continue supporting self-management for patients with diabetes and other chronic conditions, and providing appropriate training and refreshers for staff members. They are considering having providers use the CHCF initiative's patient satisfaction survey, with its emphasis on goals, as a tool in their interactions with all their patients.

## Appendix B: Report Interviews

**Veenu Aulakh, M.P.H.**

Senior Program Officer  
California HealthCare Foundation  
Oakland, CA

**Thomas Bodenheimer, M.D.**

Adjunct Professor, Dept. of Family and Community Medicine, University of California  
San Francisco, CA

**Seth Emont, Ph.D., M.S.**

Principal White Mountain Research Associates, LLC  
Danbury, NH

**Alan Glaseroff, M.D.**

Medical Director  
Humboldt-Del Norte IPA  
Eureka, CA

**Cheryl Laymon**

Executive Director  
Samuel Dixon Family Health Centers  
Val Verde, CA

**William Polonsky, Ph.D., C.D.E.**

President  
Behavioral Diabetes Institute  
San Diego, CA

**Debra Rosen, R.N., M.P.H.**

Program Director, Chronic Disease Programs  
Northeast Valley Health Corporation  
San Fernando, CA

**Laura Solorio, M.D.**

Medical Director  
Clinic Services Division  
Monterey County Health Department  
Salinas, CA

**Jeanie Taylor, R.N., M.S.N., C.D.E.**

Nursing Project Coordinator  
Care Management Department  
Southern California Permanente Medical Group  
Riverside, CA

## Appendix C: Grantees

Arroyo Vista Family Health Center,  
Los Angeles, CA

Brookside Community Health Center  
San Pablo, CA

LifeLong Medical Care  
Berkeley, CA

Monterey County Health Department  
Salinas, CA

NorthEast Valley Health Center  
Los Angeles, CA

Petaluma Health Center  
Petaluma, CA

Samuel Dixon Family Health Center  
Val Verde, CA

Solano Coalition for Better Health  
Solano County, CA

South Bay Family Healthcare Center  
Torrance, CA

Southern California Permanente Medical Group  
Riverside, CA

## Endnotes

1. Improving Chronic Illness Care, “The Chronic Care Model,” 2007.  
[www.improvingchroniccare.org](http://www.improvingchroniccare.org)
2. Ibid.
3. Bodenheimer T., K. MacGregor and D. Sharifi C. *Helping Patients Manage Their Chronic Conditions*. California HealthCare Foundation, June 2005, page 17.  
[www.chcf.org/topics/chronicdisease/index.cfm?itemID=111768](http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=111768)
4. California HealthCare Foundation Request for Proposals, “Promoting Effective Self-Management Approaches to Improve Chronic Disease Care.” September 2005, page 2.
5. That is, actors specially trained to portray patients.
6. California HealthCare Foundation, Patient Self-Management training video.  
[www.chcf.org/topics/chronicdisease/index.cfm?itemID=124673](http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=124673)
7. Dr. Glaseroff, a Humboldt County physician who participated in the first self-management support initiative, was a speaker at the November 2007 final meeting and an interviewee for this report. The quotation is from his comments at the final meeting.
8. Interview with Dr. Alan Glasseroff, January 8, 2008.
9. “What gets measured is what gets managed.”



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