

# Report

## Idaho Primary Care Providers' Experiences and Needs in Treating Patients with Chronic Conditions: Phase 1 – In-depth Interviews

*Presented to:*

Idaho Heart Disease and Stroke Prevention Program &  
Idaho Diabetes Prevention and Control Program  
Bureau of Community & Environmental Health, Division of Health, Idaho Department of Health & Welfare



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## Technical Note on Interpretation of Qualitative Findings

**Findings are qualitative.** This document reports the opinions and experiences of participants, but it cannot be assumed that these findings are representative of the views held by an “average” or a “representative” member of a segment. The reason: the method is qualitative, meaning that respondents were not randomly selected, and the discussion was not standard across the interview groups. Instead, discussions were dynamic, and some questions were discussed in some groups and not others because of time and opportunity. Sometimes, new and important topics arising in an earlier group were probed more fully in later groups.

When evaluating the comments recorded in this report, consider the following:

1. Respondents’ views may contradict those of the reader. Their statements may blatantly contradict reality. When this occurs, it signals an opportunity to rethink the product or service in respondents’ terms – an opportunity for product improvement, communication, and marketing intervention.
2. The in-depth interviews (IDIs) comprise professionals with varying backgrounds and expectations. They will often contradict one another. This is one of the benefits of qualitative research: It allows researchers to generate a range of responses, develop hypotheses, deepen understanding, and observe differing market segments.
3. Expect participants to be real people, responding spontaneously. Some remarks may produce insights, but others will not.
4. Qualitative research is dynamic: No two IDIs or focus groups are alike because the mix of respondents and moderator differs each time. Questions and answers may not have exactly the same meaning from one group to the next. When interpreting respondents’ statements, consider the context of the discussion and participant mix. Participants’ answers should not be viewed as statistically “reliable,” but instead as revealing the rich texture of opinions, concerns, and reactions within the target market.
5. Readers should review the summary carefully. Then consult the Interview Transcript Notes (Appendices C and d, pp. 40-**Error! Bookmark not defined.**) for specific examples, wording, and support or contradiction of the summary statements.



## Executive Summary

The Idaho Heart Disease and Stroke Prevention Program and the Idaho Diabetes Prevention and Control Program sought information that would guide their programs and services aimed at decreasing the negative impact of chronic diseases, especially hypertension and diabetes, on Idahoans.

This project sought learn providers' insights and advice on ways to improve the Programs' support of them in following best practices to treat and manage hypertension and the other main risk factors for heart disease and stroke.

### Method

We conducted one focus group with 12 operations staff from Federally Qualified Health Centers in Idaho, and 14 in-depth interviews (IDIs) with primary care providers from across Idaho in July, 2010.

### Findings

Most providers described some lifestyle counseling and interventions they used, all containing the basic message to eat better and less, and to move more. For diabetes, many focused on reducing patients' consumption of refined carbohydrates and on weight reduction; for high blood pressure some targeted sodium consumption and weight reduction. Most talked about increasing exercise to some degree, usually by walking.

#### Little Consistency in Lifestyle Counseling Techniques, Tools, Recommendations

Providers varied greatly in their enthusiasm for lifestyle interventions and their reliance on lifestyle counseling. Likewise, the techniques and tools they used were not consistent or systematic across providers. Several expressed little faith in people's ability to make lifestyle changes – among those were even a few who also described a success story involving a major lifestyle change, usually including significant weight loss. Although all providers relied on medications, the Behavior Skeptics placed nearly all their faith in medications and believed the most likely lifestyle change people would make was to take their medicine.

Some providers depended on printed handouts to patients, explaining their disease and ways to manage it. Many of those providers were interested in such printed or other resources that public health programs might offer.

### Tobacco

Most providers discussed tobacco or smoking in some way. The plurality of comments linked tobacco-related counseling to hypertension, and mentioned efforts to discourage patients from tobacco use. Most knew of Quitnet or Quitline.

### Diabetes Educator

Providers were essentially bimodal in their use of diabetes educators. For the most part, those with access to a diabetes educator referred patients to that service. Those employed in large,





multi-provider practices, especially those affiliated with a hospital or large corporate entity, were most likely to have such a resource available. Others would refer to an educator if one were available. Yet, many patients decline the service because of cost, or lack of confidence in its worth, or both. For those patients, diabetes education remains the provider's responsibility, or is shifted to an endocrinologist in extreme cases.

### **Patient Barriers**

Providers identified numerous patient barriers to effective management of chronic diseases. The pervading barrier, regardless of a patient's resources, is that the best remedies – diet, exercise, weight loss- are the hardest. Pills are much easier. Depression is a significant barrier that frequently compounds the difficulties of controlling appetite and engaging in physical activity. Insufficient social and professional support also contributes. To succeed, most people require a network of supportive others – family is most important in helping in all of the daily activities around food, medication, and exercise that will get a person back to health. Follow-up visits with the provider are also necessary. Many people fail because one or more of those supports is absent or inadequate. The costs of care, medicine, and a healthful lifestyle were perhaps the most apparent barriers, mentioned consistently by every provider.

### **Provider Barriers**

Providers' most frequently identified barrier to effective disease management, and especially to promoting lifestyle changes is the time constraint they experience, with 10-15-minute limits on patient encounters. They attributed their press to the insurance reimbursement structure that pays for interventions, prescriptions, and procedures, and not for prevention and health promotion. They also cited operational inefficiencies, especially in their EMRs, which almost all fell short of expectations.

### **The Good News: There's Appetite for Change**

Most of the respondents had well-considered ideas about how to improve patient care, and participated because they wanted to contribute those ideas. They ranged from operational improvements to restructuring the practice model, offering group-visit and health-promotion options, and changing the insurance reimbursement structure.

### **Provider Sources of Best-practice Information – Most Did Not Mention JNC or ADA**

Every provider named several sources of best-practice information, of which trade or research publications such as the *Journal of the American Academy of Family Practice Physicians* were most frequently nominated. They also named numerous online resources, e.g., UptoDate, WebMD, POEM. Some listened to drug representatives, and most were influenced by CMEs and conferences, often organized by their statewide professional association. The JNC and ADA were mentioned only late in the conversation, by fewer than half of providers.





## **Manifest Best-practice Implementation**

A significant proportion (22%) of those describing how they would treat a woman with 135/85 blood pressure and probable diabetes either ignored the BP, or explicitly said it was not problematic.

## **The Department Is Not Currently Seen as an Expert or Resource in Disease Management**

The Department as a public health resource and potential contributor to the management of chronic disease is invisible to most providers. Their uneasy relation to Medicaid overshadows all other associations with the Department. The rare provider had experience with a Health District. The rest were unaware of the Department's communications or public health services, except for Quitnet, which most perceive as successful. None was aware of the Chronic Disease Self-management Program, though most considered it a good resource, once described.

## **Providers Described Areas of Need Where Department Could Help**

When apprised of the Department's public health role providers identified ways it could support their work. Some asked for specific materials and services, such as brochures and posters, diabetes educators, and the self-management program. Some suggested a Resources Web site that would link providers and patients to services and community resources.

They also described more generally some desirable changes in their own operations or in the prevailing model of medical practice. Those included operational improvements to increase efficiency; movement toward a planned-care or medical-home model; the development of group-visits as a patient-support and education forum; and the change of Medicaid reimbursement and co-pay structures to encourage chronic disease management.

## **How the Department Should Communicate with Providers**

The Department should consider a three-level communication strategy with providers: Direct contact with the provider; communications mediated through professional associations, conferences, and CMEs; and indirect communication via direct-to-patient messages.

- When contacting providers directly, use two approaches: (1) customize communication mode (email v. U.S.Mail v. FAX v. phone) as much as possible, based on knowledge about individual preferences, but (2) supplement with multiple modes, channels, and transmissions for nearly everyone. Look to pharmaceutical representatives as a model of what works.
- Network with providers through professional associations, contributing to newsletters, conferences, CMEs, professional discussion groups, etc. Cultivate spokespersons and relationships with professional thought leaders.
- Go directly to the consumer with marketing and public education to promote lifestyle changes, and to increase awareness of resources.

## **The Department's Strategic Opportunities**

The findings suggest four areas of strategic opportunity for the Department:

1. Build the Idaho Public Health brand as experts in, and purveyors of, health behavior.
2. Build an integrated communication strategy linking goals and messages across professional, stakeholder, and lay audiences
3. Serve medical providers with behavioral health resources.





- a. CMEs and other training in behavioral health counseling
- b. Behavioral health services and modules available for patient referral, e.g., Quitnet / Quitline, Chronic Disease Self Management Program
- c. Brochures in hard-copy and electronic format with health educational information; online database identifying public health, community, and other resources to promote health
4. Engage the broader health community, especially Medicaid, as liaison and collaborator in restructuring the reimbursement systems to support behavioral health promotion.

## The Department's Next Steps

Turn the findings into action.

1. Use the findings to inform creative brainstorming and strategic planning of ways to meet the needs and overcome the barriers identified by providers. Some of these solutions exist. Some are explicitly named by providers. Some are not yet invented, but must be created without regard to the solutions offered, or the currently available resources. Those require a new, far-sighted vision. Be sure to address the following areas of need:
  - a. Educational and resource materials providers would use, e.g., brochures, pamphlets, posters, web resources
  - b. Services, e.g., coach, CDE, Chronic Disease Self Management
  - c. Communications, channels, spokespersons e.g., outreach and networking to professional organizations, association newsletters, presentation at conferences, specific CME offerings, use of spokespersons, keep-in-touch roster, direct-to-consumer, point-of-sale, point-of-service, BP machines
  - d. Improving providers' understanding of and adherence to guidelines, e.g., JNC7
  - e. Workflow improvements and integration with EMR, group visits, planned care, team health
  - f. Resources and reimbursement: Consider engaging the Medicaid program in innovative collaboration to knit public health with providers to change the incentive structure for both providers and patients, and improve chronic disease outcomes
2. Use the strategic planning process to develop a model of public-private collaboration that will engage PCPs and deliver quick and enduring benefits to them, the system, and their patients.
  - a. Begin by engaging broad-based collaboration across the Department's chronic disease programs
  - b. Extend to the Health Districts
  - c. Extend to Medicaid
  - d. Extend to provider organizations
3. Test the most feasible solution options in the follow-up online survey questionnaire, and the in-clinic process-improvement demonstrations.
4. Develop and implement a plan of action; pilot it; measure and evaluate impact; franchise what works, and revise or abandon what doesn't.





## Introduction

The Idaho Heart Disease and Stroke Prevention Program and the Idaho Diabetes Prevention and Control Program sought information that would guide their programs and services aimed at decreasing the negative impact of chronic diseases, especially hypertension and diabetes, on Idahoans.

Goal. This project aimed to learn providers' insights and advice on ways to improve the Programs' support of them in following best practices to treat and manage hypertension and the other main risk factors for heart disease and stroke. The objectives were to:

- Understand PCPs' experiences, frustrations, successes, and needs in managing hypertension and diabetes.
- Identify barriers to providers' promoting lifestyle changes among at-risk patients.
- Identify tools and systematic approaches to help providers promote lifestyle changes in at-risk patients.
- Identify guidelines used, and their source (e.g., JNC7 and the American Diabetes Association Clinical Practice Recommendations, released annually).
- Evaluate adherence to best practices, especially lifestyle interventions, for patients diagnosed with or at-risk for HBP and diabetes.
- Identify sources of best-practice information and the most effective methods and modes to communicate best-practice updates to providers

## Method

We conducted one focus group with 12 operations staff from Federally Qualified Health Centers in Idaho, and 14 in-depth, 60-minute interviews (IDIs) with primary care providers from across Idaho in July, 2010.

### ***Participant Selection***

The focus group was held at the close of a training conference that the FQHC staff attended. All operations staff members attending the training were invited to attend. The first 12 expressing interest were enrolled in the focus group.

The IDI respondents were selected from among providers completing an online screening survey in response to an invitation sent to them from e-Rewards by U. S. Mail. Included in the mailing was e-Rewards standard invitation to a 5-minute online screening survey for \$9, along with a second letter from the sponsoring programs – Heart Disease and Stroke Prevention Program, and Diabetes Prevention and Control Program explaining the project, and requesting participation (Appendix A, p. 29).

The 5-minute online survey screened respondents for region, practice type, and other relevant attributes. It offered qualified respondents an honorarium of \$151 to doctors and \$101 to mid-levels, for completing an hour-long phone interview about chronic disease management (Appendix A, p. 29, for the survey outline).





Among those volunteering to participate, respondents were chosen to include Idaho primary care providers with a broad range of experience in various practice settings, geographies, and regions of the state.

## Interview Outline

Strategic Intelligence, in collaboration with the Stroke and Heart Disease Prevention Program and the Diabetes Prevention and Control Program developed an in-depth interview outline to guide the interview. It addressed the following topics.

- PCPs’ experiences, frustrations, successes, and needs in managing hypertension and diabetes.
- Barriers to providers’ promoting lifestyle changes in at-risk patients
- Tools and systematic approaches to help providers promote lifestyle changes in at-risk patients
- Providers’ awareness and use of guidelines to chronic disease management (e.g., JNC7, JNC8, and the American Diabetes Association Clinical Practice Recommendations, which are released annually).
- Adherence to best practices, especially lifestyle interventions, for patients diagnosed with, or at-risk for, HBP and diabetes.
- Sources of best-practice information and the most effective methods and modes to communicate best-practice updates to providers. See Appendix B: Interview Outline, p. 35 for details.

## Participant Attributes – Professional Title

As seen in Table 1, we scheduled interviews with ten doctors and four mid-levels, of which one was a nurse practitioner (NP), and the remainder were physician assistants (PAs). All participated.

Table 2 shows that the doctors were distributed relatively evenly across regions. Because we had no qualified mid-levels from North Idaho, we compensated by interviewing more from Southeast Idaho.

**Table 1: Professional Title of Interview Respondents**

	Count	Percent
Medical Doctor	7	50%
Doctor of Osteopathic Medicine	3	21%
Physician Assistant	3	21%
Nurse Practitioner	1	7%
Total	14	100%

**Table 2: Professional Type by Region**

Professional Type	Region			Total
	North	Southwest	Southeast	
Doctor	3	4	3	10
Mid-level	0	1	3	4
Total	3	5	6	14





## Counties Represented

As seen in Table 3, the 14 respondents reported from 13 different Idaho counties; two were from Idaho’s most populous county, Ada. Table 4 shows that most of the practices represented in both North Idaho and Southeast Idaho were in rural or frontier locations; most in Southwest Idaho were urban.

**Table 3: County by Region**

	Region			Total
	North	Southwest	Southeast	
Kootenai	1			1
Nez Perce	1			1
Shoshone	1			1
Ada		2		2
Adams		1		1
Canyon		1		1
Gem		1		1
Bannock			1	1
Bonneville			1	1
Cassia			1	1
Gooding			1	1
Jefferson			1	1
Lemhi			1	1
Total	3	5	6	14

**Table 4: Region by Population Density**

Idaho Region	Population Density			Total
	Urban	Rural	Frontier	
North	1	2	0	3
Southeast	2	3	1	6
Southwest	3	2	0	5
Total	6	7	1	14

## Nature of the Respondents’ Medical Practice

As seen in Table 5, the plurality of respondents worked in hospital-affiliated practices and in independent, multi-provider practices. The respondents were about evenly split between urban and rural geographies; one provider reported from a frontier location. Urgent Care and Free clinics were more likely to be in an Urban setting; whereas, independent, solo, and Federally Qualified Health Centers were mostly or exclusively rural (but not frontier) - based. Hospital-affiliated clinics were relatively evenly distributed across the three geographies.

**Table 5: Work Setting \* Population Density**

Work Setting		Population Density			Total
		Urban	Rural	Frontier	
Work Setting	Hospital-affiliated, multi-provider practice	2	1	1	4
	Independent, multi-provider practice	1	3	0	4
	Solo Practice	0	2	0	2
	Urgent Care	2	0	0	2
	Federally Qualified Health Center or Look-alike	0	1	0	1
	Free Clinic	1	0	0	1
Total		6	7	1	14





As seen in Table 6, nearly two-thirds of the IDI respondents currently use electronic medical records, with another 14% expecting to adopt one within six months. This proportion exceeds the 46% of U.S. providers estimated to have adopted an EMR by November, 2009. Those without EMR were more likely to work in North Idaho and in rural geographies, to work in free or federal-grant clinics (FQHC), though all FQHCs in the focus group had some level of EMR.

**Table 6: Population Density and EMR Use**

Population Density	Use an EMR in Practice			Total
	No	Will Adopt One Soon	Yes	
Urban	1	1	4	6
Rural	2	1	4	7
Frontier	0	0	1	1
Total	3	2	9	14
TOTAL %	21%	14%	64%	100%

**Table 7: Respondent EMR**

EMR	Count	Percent
Not Asked	6	42.9
eClinicalWorks	3	21.4
SOAPware, Cerner	1	7.1
OmniMD	1	7.1
HELP-2 possibly	1	7.1
CPSI	1	7.1
PowerWorks	1	7.1
Total	14	100.0

**Table 8: Work Setting by Use of EMR in Practice**

Work Setting	Use an EMR in Practice			Total
	No	Will Adopt One Soon	Yes	
Hospital-affiliated, multi-provider practice	0	0	4	4
Independent, multi-provider practice	1	0	3	4
Solo Practice	1	0	1	2
Urgent Care	0	1	1	2
Federally Qualified Health Center or Look-alike	0	1	0	1
Free Clinic	1	0	0	1
Total	3	2	9	14





## Numbers of Providers and Patients per Respondent Practice

As seen in Table 9, practices ranged in size from solo practices with just one doctor and one assistant to practices with up to 12 doctors and many mid-levels and support staff. Nonetheless, the median practice size was relatively small, with just two doctors, one mid-level, and 2-4 support clinical staff members<sup>1</sup>. On average, respondents had been in practice for 12-13 years, and ranged in experience from a third-year resident to a 34-year practitioner. On average, they worked full-time, consulting with about 75 patients per week, although one doctor had recently left a 10-hour-per-week position. On average, providers estimated that about half of their patients were age 45 or older, half were overweight or obese, four in ten had hypertension, and about two in ten had Type II diabetes.

**Table 9: Practices’ Providers and Patients**

Title	N Responding	Minimum	Maximum	Mean <sup>1</sup>	Median	Std. Deviation
Number of physicians	10	1	12	3	2	3.4
Number of Mid-levels	9	0	12	2	1	3.6
Number of Nurses	7	0	3	2	2	1.0
Number of MAs	8	1	5	2	2	1.8
Number of Years in Practice	14	2	34	13	12	9.3
Patients Seen Per Week	14	10	110	72	75	26.4
Percentage of Patients 45 or Older	14	30%	75%	47%	50%	14%
Percentage of Patients who Are Overweight	14	30%	67%	46%	50%	12%
Percentage of Patients with HBP	14	20%	67%	36%	40%	13%
Percentage of Patients with Type II Diabetes	14	5%	33%	19%	18%	9%
Number Responding to All Listed Questions	6					

<sup>1</sup>Means are rounded to the nearest whole number.

<sup>1</sup> Only ten respondents were asked questions concerning the numbers of providers in the practice.





## Findings and Analysis

This section summarizes the findings from the focus group and the 14 IDIs. Detailed transcript notes of the focus group and the IDIs appear in Appendices C and D, p. 40 - **Error! Bookmark not defined.**

### ***What Works in Managing Hypertension and Diabetes, and Why***

Providers typically described a success story and explained what had worked, and why. Their answers fell into two main categories: The patient's engagement, manifested in actions and outcomes and medications. They commented on how their own practices, counseling and resources, as well as the presence or absence of other resources support contributed to those two categories.

#### **It's All About Engagement**

Success boils down to how actively the patient engages in her or his healing. Providers operated in deference to this equation, and at least half explicitly attributed successful outcomes, first and foremost, to patients' motivation or to their compliance to the recommended changes. The most stunning successes they described involved dramatic weight loss, which often reduced or eliminated the need for medications.

The question then is how to engage patients. Providers' approaches reflected their beliefs about whether, in what ways, and under what conditions patients' would engage. Most relied heavily on the least difficult, most consistently effective intervention – medicine. One touted the only weight-control intervention he believed to be backed by scientific evidence of success – surgery. All providers educated patients in one way or another, many about their disease process, and most about the need to limit the intake of certain foods. By necessity, some educate patients in the use of insulin and other medications. Most acknowledged barriers preventing patient engagement or regimen implementation, some of which included barriers preventing providers from delivering optimal care.

#### **Focus on Engagement – Behavior Enthusiasts Favor Baby Steps and Empowerment**

Providers varied along the entire continuum in how much they invested in engaging patients to change. Several expressed little faith in people's ability to make lifestyle changes – among those were even a few who also described a success story involving a major lifestyle change, usually including significant weight loss. These Behavior Skeptics placed their faith in medications and believed the most likely lifestyle change people would make was to take their medicine. A few, who might be described as "Behavior Enthusiasts," articulated the goal as engagement. Like many, they identified the problems as ignorance, fear, and the many barriers to lifestyle change. But unlike most, they saw the solution as behavioral "baby steps." Those focusing on the "go-slowly," patient-engagement approach sought to build rapport and understand patients' current lifestyle patterns, including the barriers and assets that would support healthful change. They calibrated their recommendations to the patient's willingness and abilities, even asking patients to nominate changes they could make. For one patient, this meant reducing the number of sugar-sodas from ten to two per day. A couple of providers described using motivational interviewing





in this process. A few explicitly empowered patients: one PA said he tells patients “...it’s a team process between me and them.” An NP believes the most powerful thing she tells patients is, “you are the queen of your health care. I’m here to offer you advice, and the best medicine can offer. But you make the decision.”

### **Educate to Engage**

Providers mentioned a variety of approaches to patient education. Several “Behavior Enthusiasts” were adamant that patients learn the nature and course of their disease, and the threats it poses. One FQHC provider developed her own materials to explain the disease process of hypertension. She believed that those materials made a great difference in patients’ adherence to regimens. One PA explained that he describes the disease course to scare patients into taking care of themselves.

Many providers focused less on explaining the disease, and more on educating patients about how to manage it. At least half described healthy-eating tips they gave patients. For diabetes, many focused on reducing patients’ consumption of refined carbohydrates and on weight reduction. For high blood pressure they targeted sodium reduction, moderation in alcohol use, and weight reduction.

### **Tobacco**

Ten of the 14 individual providers and at least one person in the provider focus group discussed tobacco or smoking, in a total of 13 separate occurrences. The plurality of comments linked tobacco-related counseling to hypertension, and mentioned efforts to discourage patients from tobacco use. Most knew of Quitnet or Quitline.

Five of the 14 individually interviewed providers linked smoking to hypertension and implied or stated outright that they address it when counseling patients about controlling their blood pressure. Another said he counsels all smokers to quit, regardless of their diagnosis. Another four mentioned smoking-cessation resources in the context of the broader array of resources to which she or he directs patients. Three cited smoking as a behavior similar to others that threaten health (e.g., maladaptive eating, inactivity) and are difficult to alter, or one they address in the context of other lifestyle factors.

### **No Standard Approach to Diet, Exercise**

There was no standard approach, and no standard dietary or exercise advice, or materials across providers. Their lifestyle counseling varied greatly from specific to general, and the nature of the specific dietary, exercise, and weight loss advice varied as well. Some helped patients do a rudimentary diet analysis, identifying sources of unhealthy excess, and helping them choose gradual improvements. Some described specific dietary tools or heuristics, such as the plate method, or a Do’s and Don’ts list based on avoiding “white,” refined foods, and replacing them with “brown,” “whole” foods. Two favored an approach explicitly opposed by several: eating special diet foods, such as Nutrisystem or Jenny Craig to lose weight. Several dismissed or outright opposed appetite suppressants or other dieting drugs, although one said he sometimes refers patients having trouble losing weight to a provider who prescribes such drugs.





Some suggested that patients not strive to lose more than 3-4 pounds per week, whereas others urged patients to a goal of around 1 pound per week. Yet others expressed frank pessimism about diets and people's ability to lose weight at all, at least long-term.

Most encouraged to increase exercise to some degree, usually by walking. Whereas some stressed starting modestly, e.g., 10 minutes per day; others set the bar high, telling patients to strive for 30 to 60 minutes, five times weekly. One told patients they needed to exercise 60-90 minutes daily in order to lose weight.

### **No Standard Materials**

Most Behavior Enthusiasts provided handouts to patients. Several had favorites they had made or received from another source. Drug companies are a source of diabetes education, especially dietary information and recipes. A few FQHC focus group participants especially liked the IDHW Living with Diabetes pamphlets, which they described as "FANTASTIC." A few providers use printed handouts to explain patients' disease and ways to manage it.





Many of those who use print materials were interested in such printed or other resources that public health programs might offer. One was interested in a Department Web site that would provide brochure ware and other resources.

A number of providers expressed little enthusiasm for printed materials. They were reluctant or completely resistant to increasing their library, either because of limited space, or because they had honed their collection to just the right materials. Other providers did not use printouts, saying that plenty of information was available on the Internet and elsewhere, if patients wanted it. Yet, several believed their patients were generally unlikely to access the Internet.

**Opportunity.** Providers suggested several kinds of printed materials they would find useful:

- Very simple, language-free explanations of disease processes and intervention for diabetes and hypertension.
- Resource Web site to download brochures, direct patients to, and get updates about community events and supportive resources.

### **Broad Agreement about Diabetes Education but Limited Access**

Nearly every provider agreed that a certified diabetes educator (CDE) is highly desirable for patients newly diagnosed with diabetes. Some considered it good for long-term patients. Providers agreed that diabetes educators can do the educational heavy lifting that reassures patients they can successfully live with and manage their disease. The CDE supports patients' dietary, exercise, and other lifestyle changes, and trains them to use their equipment. Also especially important for insulin users is the CDE's instruction in administering medication.

### **Only About Half of Patients Can Access a Diabetes Educator**

The proportions of patients referred varied widely across practices, as did the proportion of referred patients who actually used the service. At the top end, more than one provider said they referred 100% of newly diagnosed patients. At the other extreme, one said he referred about 5% - the most severe cases - to a diabetes educator. As explained by one provider,

*"I might send a newly diagnosed person to a diabetes educator (through the hospital). First, I get a sense of who is ready to make a change, then I send them to the diabetes educator. I usually offer it to everyone. The response is occasionally, 'I know how to eat'."*

Despite this apparent range, providers were essentially bimodal in their use of diabetes educators. Most of the relatively urban providers had access to a CDE or nutritionist through a local hospital, or in the Treasure Valley, through Humphreys Diabetes Center. They accounted for about half of the providers interviewed, who served roughly half of the patients represented in the study. They were most often employed in large, multi-provider practices, especially those affiliated with a hospital or a large corporate entity. Most of them referred newly diagnosed patients to a diabetes educator.

The other providers, most of whom worked in rural or frontier settings, did not have ready access to a diabetes educator. As a result, they retained responsibility for the diabetes and lifestyle education patients received. For the most severe cases, PCPs referred to an endocrinologist. Some had a nurse who could instruct in the use of monitoring machines and medication. Some rely on durable equipment and home health providers to deliver this





instruction. Providers without consistent access to a CDE frequently expressed the need for one. On the other hand, most providers named cost as a barrier to some patients' use of the CDE.

### **Some Patients Decline Diabetes Education**

Providers agreed that between 10% and 90% of patients decline a diabetes education referral, mostly because of cost. Yet, most patients who do attend diabetes education find it helpful. Providers generally noted that patients who follow through with diabetes education typically manage their disease better than those who do not.

### **Dieticians – Mostly a Substitute for Diabetes Educators**

Patients were less consistently referred to dieticians than to diabetes educators, unless the dietician was affiliated with the primary source of diabetes education. No provider consistently referred people with hypertension or overweight to a dietician, unless diabetes was also diagnosed. One provider complained that he did not like referring patients to dieticians because they contradicted his instructions to strictly eliminate refined, “white” foods from the diet, by instead emphasizing portion control for a variety of foods.

In most places, dieticians when available, worked for a local hospital, although in the Treasure Valley dieticians were available through numerous sources.

### **General Agreement on BP and Glucose Monitoring**

Several providers described recommending or prescribing glucometers for diabetes patients, and home blood pressure machines for those with hypertension. Several said they give patients a clinic-branded BP log to record and track their numbers. Some suggested patients keep a food log, and also bring their glucose records with them at their regular visits. One urged patients to bring their machines to the office to calibrate against the doctor's machines. These assignments were one way providers help patients understand and take control of their health.

### **General Agreement about the Importance of Social Support from Family, Groups, Providers**

Several “Behavior Enthusiasts” stressed the importance of family support in successful chronic disease management. This might involve a spouse packing a healthful lunch for a truck-driver or learning to cook more healthfully. It can include an entire family agreeing to eat the same foods and join in the increased activity required of the person with diabetes or hypertension. One provider began her interview with an inspirational story.

*“A typical, Hispanic, non-English-speaking woman, with Type II DM, who was also insulin dependent. Her family rallied around her so well. She didn't want to go the store, she was depressed, but her family rallied, and helped her pay. ...they helped her see a diabetes educator. When I saw her yesterday, she came in with a younger son. They've stood by her the whole way, supported her. ... Even learning to cook and eat differently, as a family is really hard. Everyone made a change because of this person. It's rare to see that much change in the family. ...As an office we've gone out of our way to help, because she's so motivated. Some people just stand out because they try so hard. As a team we rallied because of getting to know all the family by their first names, from our receptionist onward. It's also an office team effort. ... I try to emphasize family importance when I see family available. I point that out, when I'm seeing someone who is a regular, reinforcing their importance in the process.”*





## Exercise and Weight Loss Support

Some providers mentioned the availability of gyms and exercise groups. Two especially liked Curves for Women because of its sensitivity of women's health struggles. More than one provider mentioned the Medicaid coupons that can be spent on various services, including athletic club attendance. One provider considered that a terrific waste, given the relatively short-term gain from such a membership, compared to the more lasting impact of a dietician or diabetes educator.

Numerous providers mentioned the help that support groups can provide to weight loss. Among the options, Weight Watchers was most frequently identified as a good provider that some recommended, if patients seemed interested.

**Barrier.** Providers recognized the cost barriers associated with fee-based support options, though some also noted the positive motivational impact of paying for help to achieve a difficult lifestyle change.

**Opportunity.** Some were interested in knowing more about low-cost or no-cost opportunities within the community, or through the Department, to support behavior changes. These might include the Department's Chronic Disease Management Program, or possibly motivational or other coaches. It could also take the form of a community resource databank where providers and others could find a list of activity and health-supporting resources in their area.

## Patient Visits to the Provider Improve Health, But Patients Encounter Barriers

Providers identified patients' follow-up visits as a key factor in successful disease management. Yet many patients fail to visit consistently.

**Practice Barriers.** Repeatedly, providers explained that they lacked the staff, the technology, the operational efficiency, or a combination to identify and call patients for follow-ups. They decried patients' habit of bundling many health-care concerns together in one visit, reducing the time and opportunity to address chronic disease management. Numerous agreed that a team-based approach to chronic care was desirable, but not within their reach.

Just one provider described having the proper staff, the EMR, and the operational infrastructure to identify and call patients for follow-up visits. Her clinic also reminded patients of local, regular health fairs where they could get low-cost diagnostics and supplies. But hers was the clear exception.

Work schedules and cultural views about health care are another barrier to consistent follow-ups. Providers identified truck drivers as having special difficulty following a routine of self care, and in returning for regular follow-up visits. One also identified a "farmer" mentality justifying a disinterest in health-directed activities. This view is expressed in such declarations as "you're going to get old and die of something."

## Medications

Providers most consistently discussed medications as a primary tool in helping patients manage their chronic conditions. Some providers noted that hypertension medication was especially successful because multiple generics make it relatively inexpensive, and marketing has





heightened public awareness of the importance of controlling high blood pressure by taking the prescribed medicine. Medication was also key to managing diabetes.

Many, if not most, providers described an active use of medication to stabilize the disease condition immediately, allowing patients time to get their bearings and begin making lifestyle changes. This was even true of several responding to the case history of “Linda” with borderline hypertension (135/85) and possible Type II diabetes.

Whether concerning diabetes or hypertension, most providers acknowledged with some resignation that taking a pill is easier, and so more likely to be accomplished, than losing weight or exercising. On occasion, they encountered a patient who bargained to avoid medication by making lifestyle changes. A few such patients returned, successful in their changes.

**Barriers.** The drug management of diabetes is complicated by many interacting factors. Those include the relation of food consumption and exercise to drug use and the frequent need for multiple medicines to manage such related conditions as hypertension and hyperlipidemia. Also, some of the diabetes medicines are expensive name-brands, as are the glucose monitoring supplies.

Drug side effects also reduce adherence for both hypertension and diabetes. Two providers explained that patients sometimes complain or decrease their doses because they feel worse when their blood glucose reduces to normal, or relatively more healthy levels.

**Opportunity.** Several providers noted that when patients resist taking medication, the provider explains that doses may be reduced or eliminated entirely with proper weight and lifestyle changes. For some that is incentive enough.

## ***Patient Barriers in General***

Providers identified numerous patient barriers to effective management of chronic diseases.

### **Healthy Living is Hard**

The pervading barrier to chronic disease management, regardless of a patient’s resources, is that the best remedies are the hardest. Providers are keenly aware of people’s struggle to increase their physical activity and limit their intake of the tasty, calorie-dense, relatively nutrient poor foods that are readily available. They identify certain cultural sources as barriers to change, including the irregular and sedentary work lives of truckers, an independent and anti-medicine attitude among some rural and agrarian groups, and eating and food-preparation patterns of Hispanic families.

### **Depression is Common and Hinders Engagement**

Depression frequently compounds the difficulties of controlling appetite and engaging in physical activity. It is consistently identified as a major barrier to the treatment of overweight, hypertension, and especially diabetes. The diagnosis is frightening and even psychologically debilitating to some people, especially if insulin injections are prescribed.





### **Lack of Social Support**

To succeed, most people require a network of supportive others – family is most important in helping in all of the daily activities around food, medication, and exercise that will get a person back to health. Friends and community programs such as Meals-on-Wheels may fill in as well. Primary care providers and professional educators are key to diagnosing, charting progress, and offering encouragement and corrective advice. Many people fail because one or more of those support sources is absent or inadequate. Some identified people living alone and non-English speaking Hispanic mothers responsible for traditional family care as being especially vulnerable to the hazards of inadequate family or social support.

### **Language and Foreign Culture**

A few identified language barriers as problematic in communicating the causes of disease and the sometimes complicated management strategies. Spanish is the most frequently encountered foreign language, but increasingly, providers serve refugees and other foreign-born patients who speak a range of foreign languages. Illiteracy compounds difficulties, whether for native English speakers or others. Add to that the Greek-like opacity of medical jargon in some patient materials, and nearly any patient can be rendered powerless to understand and manage a frightening disease condition.

**Opportunity.** Numerous respondents called for very simple materials explaining the basic disease processes and management regimens. One focus group participant said their clinics need so-called “language-free” materials using pictures and diagrams -- materials that would communicate to nearly anyone, regardless of literacy or English proficiency.

### **Cost – Consistently Identified As a Barrier**

Providers consistently described cost as an important barrier to patients. They cannot afford to visit the provider often enough. They cannot afford healthful foods or gym memberships. They cannot afford the right drugs and other supplies. Health insurers intensify this focus on cost by insisting that all generic drug options be attempted before more expensive, name-brand preparations are allowed, providers complain. This practice postpones progress to good health for some patients.

Yet, according to several, the cost of medicines is not as great a barrier as in years past. One provider asserted that especially for hypertension, clinicians can choose from several effective, low-cost generics. Many explain that even for diabetes, one of the greatest financial barriers is the cost of glucose test strips. Although insurance covers medications, and some people are eligible for low- or no-cost test equipment, there is no consistent coverage of the testing supplies.

### **Cost and Insurance – Few Solutions**

Underlying the entire discussion of cost was the issue of health insurance. Providers are annoyed by the oversight and restrictive intrusions into their practice, and the burdensome paperwork imposed by insurers. They are increasingly aware of Medicaid and Medicare restrictions on coverage. Two talked about Medicaid’s movement toward outcomes-based reimbursement, after the phase-in step of reimbursing based on the documentation of certain processes.





A few discussed cost as it applies to their uninsured and underinsured patients. One said she sends patients to local “free” clinics, although one she identified is not free, but rather sliding-scale.

**Patient Barriers.** A main barriers to follow-ups is cost. One frustrated provider suggested a dramatic solution:

*“We encourage people to come for no reason at all – sniffle with Medicaid. We need to discourage that with a co-pay, but in the same light, we need to figure out a way to get people to live healthier. We encourage people to do things with their health that don’t matter much to their health, but when it comes to diabetes, many don’t have access. If I could remove cost or co-pay for Diabetes center for people who have no health insurance, and then have co-pay for everything that’s not a chronic disease. Then it turns away dumb visits. Don’t throw up barriers to good chronic-disease care.”*

Another has adopted his own solution, which he describes as serving the many uninsured in his community, and the large group of underinsured like he and his family who have only catastrophic health coverage. He has migrated his solo practice to a cash-only model. He files no insurance claims, although he does provide patients with claim numbers for labs and imaging, so they can submit reimbursement claims directly. He estimated that he saves his practice 25% in overhead, and has passed much of that saving on to patients.

Numerous providers actively pursue inexpensive options for their patients, including generic medications, free samples, and the occasional pro-bono provider. One aggressively notifies patients of the community’s frequent health fairs that offer reduced-price check-ups and labs.

## **Practice Barriers in General**

The most frequently mentioned barrier to effective disease management, and especially to promoting lifestyle changes is the time constraint providers experience and describe as “productivity” pressures. They routinely mentioned the 10-minute or 15-minute limit per encounter, but most also describe visits in which they spend 45 minutes. They attribute their press to the insurance reimbursement structure that pays for interventions, prescriptions, and procedures, and not for counseling, prevention and education.

Operational inefficiency. Providers enumerated other barriers, including inadequate EMRs and under-performing operational systems. Those ranged from mildly inefficient to completely dysfunctional processes that are ingrained and resistant to change. Most providers lacked the time or skill to change them.

Lack of corporate support for change. Several described ideas they had advanced to improve care, only to be rejected by their corporate management or employer. Those included group visits, or a more team-based approach to care, a health-promotion program, and the need for a diabetes educator

Lack of skill in supporting behavioral change. As one doctor explained, providers hesitate to broach the topic of weight control because people don’t like to be told they are fat. Some lack all faith in anything except drugs or surgery to improve chronic disease. And the approaches





undertaken to promote patients' lifestyle changes vary radically from one another, with many lacking or contradicting the fundamental principles of evidence-based techniques. One provider frankly admitted he was no good at lifestyle counseling. By many providers' own accounts, that may be true of a significant proportion of them, despite their most sincere efforts.

### ***The Good News: There's Appetite for Change***

Most of the respondents participated because they were interested in the topic and wanted to contribute their ideas. Many have thought extensively about how to improve chronic care management for their patients.

- Operational process improvement. One provider recognized the value of revising the work flow, and improving process efficiency within the medical practice. One opportunity was to standardize patient triage.
- Medical home and planned care model. One invoked the "medical-home" concept, suggesting that a patient should in theory be able to make multiple visits in one trip to her multi-provider clinic – one for an acute infection, another for a routine check-up, and a third for a maintenance follow-up. She described recent operational process training to help the staff develop a "planned care model" of chronic disease management. Such a system would save providers and patients time with various improvements. It could involve organizing processes and reminding both providers and patients of regular follow-up visits, grouping related disease-management visits together, tracking chronic disorders in registries, and coordinating labs to coincide with visits – arriving to be reviewed at the visit, not after it. This clinic was working through such an operational update with CHF. Similar principles would serve for other conditions.
- Group visits. Several wanted to develop a group-visit option, where patients could come together for specific disease-management education, group support, and individual consultation. The visits could center around such conditions as diabetes, hypertension, congestive heart failure, or COPD.
- Community-based health promotion initiative. One provider in a multi-clinic practice described a similar aspiration:

*"I'd like to build a wellness program, but I don't have resources. I'd like to have people come and tell them this is our program for the year. Cost would cover a number of visits, nutritional consult, monthly educational meeting, screening, prevention, diet, stress test, yearly. I'd like to offer a package to people, and once they've paid for it, they would use. In combination with PT, dietician, hospital, etc."*

Another provider in a small town wanted to develop a community-wide project of health improvement focusing on diet, activity, and weight loss. It would resemble one that an employee in his clinic developed among co-workers as their version of *Biggest Loser*.

- Reimbursement reform. Many providers complained about the restrictions on reimbursement that pay PCPs only for interventions, but not for counseling to promote health or prevent lifestyle-related disorders. If not for the press to produce billable visits, most providers believe they would spend more time helping patients understand and implement effective disease management. One provider urged a restructuring of the co-pay system for Medicaid, explained as follows.

*"[I would] remove the cost or co-pay for diabetes center for people who have no health insurance. And then have a co-pay for everything that's not a chronic disease."*





*Then it turns away dumb visits. Don't throw up barriers to good chronic-disease care."*

## **Electronic Medical Infrastructure-Mission Critical but Mostly Unsatisfactory**

A surprisingly high 53% of the providers interviewed (nine of the 17 institutions represented) used EMRs. This contrasts positively with the estimated 46% of providers nationwide in late 2009 who used electronic medical records<sup>2</sup>. Yet, it is consistent with the recent groundswell of EMR adoption, prompted by federal stimulus monies, and facilitated by numerous large insurers and EMR provider organizations that have subsidized the costs<sup>3</sup>.

Providers believe in EMRs and use them to the extent they know how. Those in this study universally endorsed the tracking, aggregation, and review of patient data as important. They considered electronic medical records as the right tool for the job. Those with EMRs recorded key vital and chronic-disease signs and accessed those records, with more or less success, to track and review patient progress. One also hoped to learn how to get brochures and other print-outs from the EMR. Another hoped that the jargon-laden printouts currently available on his EMR would soon be replaced with more patient-friendly options.

But, the horizon for optimal function of EMRs may be years away. Only one PCP in the 17 institutions represented experienced the full support of an optimally functioning, well integrated EMR. That one EMR system did what most hope for when investing the huge resources required to install and implement them. It connected records across in-patient and out-patient encounters, labs, and medications, and across the network. It permitted providers to track, review and print an individual patient's key signs, e.g., HA1c or BP or cholesterol, or weight, or a combination across time. It acted as a registry, to identify and prompt follow-ups for a group of same-diagnosis patients, and to evaluate health outcomes across patients, and more. The other EMRs ranged from good but requiring additional customization, networking, or user training to frankly disappointing, and in need of significant add-ons, upgrades, or replacement. The one described as working best is an in-house product developed more than two decades ago, refined over that time to allow increasingly user-friendly data entry, informative outputs, and group integration.

## **Sources of Information about Best Practices: Most Did Not Mention JNC**

Every provider named several sources of best-practice information. The most frequently named sources were such trade or research publications as *Family Practice News*, *Family Practice Management* the *Journal of the American Academy of Family Practice Physicians*, and *JAMA*. Physician assistants and nurse practitioners also named publications specific to their professional associations, e.g., *JAAPA*. Occasionally respondents mentioned the American Diabetes Association as a source. Just four nominated JNC7 as a guideline source and authority. One of those complained that JNC7 was confusing and biased, compared to JNC6.

<sup>2</sup> Ashish K. Jha, A.K., DesRoches, C.M., Shields, A.E., Miralles, P.D., Zheng, J., Rosenbaum, S., and Campbell, E.G. (2009). Evidence of an emerging digital divide among hospitals that care for the poor. *Health Affairs*, 8(6), w1160-w1170 (Published online 26 October 2009), doi: 10.1377/hlthaff.28.6. Also: Monegain, B. 2009. Survey: U.S. physicians lag behind those in other countries in IT use. *Healthcare IT News*, Published in partnership with Himss. w1160 <http://www.healthcareitnews.com/news/survey-us-physicians-lag-behind-those-other-countries-it-use>.

<sup>3</sup> Johnson, A. Doctors get dose of technology from insurers. *The Wall Street Journal*, Monday, August 9, 2010, B1-B2.





## **Web Resources**

Most providers said they use both hard copy and electronic resources, although some strongly preferred one or the other medium. Most electronic resources were used for searches, although a few providers reported subscribing to a regularly emailed communication. Electronic sources included Uptodate.com, WebMD.com, QuantiaMD.com, eMedicine.com, Medscape.com. Three mentioned Epocrates.com, although one cautioned that it is drug-company sponsored, and therefore must be considered as potentially biased.

One provider enthusiastically described a favorite source as POEM: Patient-Oriented Evidence that Matters, available through the AAFP<sup>4</sup>. One said he sets his Web browser to open to Googlenews so he can keep abreast of the breaking health headlines. This allows him to know about, and sometimes answer, patients' questions about such late-breaking findings.

## **Drug Representatives**

Several providers said they get updated information from pharmaceutical representatives, both about medications and the prevailing treatment guidelines. Yet, others eschewed drug reps as biased sources. For the smaller and rural offices, the issue is moot because drug representatives have decreased or discontinued their visits.

## **Associations, Conferences, CMEs: Networking and Marketing Channels for the Department**

Most providers described conferences of their statewide and national provider associations, and CMEs as a main way to keep them updated. Several described influential CMEs that have affected their chronic disease management. At least one urged the Department to connect with professional associations and attend conferences to deliver important news to providers.

## **Idaho Department of Health and Welfare – Public Health as Information Source**

No one mentioned IDHW as a source of information about best-practices. Most said they had never received any communication from the Department. And everyone responded to probes as if IDHW were synonymous with Medicaid, despite the questions' emphasis on "public health."

## **Evidence of Best-practice Implementation with Borderline BP**

Providers varied in their response to Linda, described to nine of the 14 respondents as a woman, age 45 with 190 random blood glucose check, 35 BMI, and 135/85 blood pressure. Some focused on her weight; all discussed her diabetes; and most addressed her blood pressure in some way. Some talked about the numerous follow-up tests they would order to confirm diabetes, and check for related signs. Several focused on an aggressive drug intervention; whereas a couple described her as a good candidate for lifestyle change and weight loss.

Five of the nine said they would explicitly address the blood pressure with at least a patient conversation and further monitoring, and most with medication. Two described it as "pre-hypertension." Two alluded to the greater concern about, or need for tighter control of, blood pressure because Linda probably had diabetes.

<sup>4</sup> <http://www.aafp.org/afp/2003/0315/p1196.html> (7/23/10 10:30 AM).





By contrast, one of the nine providers said nothing about blood pressure, and one explicitly said that the BP was fine.

## ***Perceptions of IDHW and What It Could Do to Reduce Chronic Disease***

Most respondents said they decided to participate in the study because they were keenly interested in the topic. Many had ideas they wanted to share their ideas with the Department.

### **Nearly Everyone Associated IDHW Exclusively with Medicaid**

Despite the repeated reminder that the study was sponsored by the public health division of IDHW, and sought to learn how public health could help providers, all except two associated the Department almost exclusively with Medicaid. They said they had little or no prior experience with the public health branch of the Department. Only two believed they had received any information from the Department about any public health issues or services – one of those had served on the statewide Diabetes Collaborative.

### **Little Awareness of Public Health Initiatives**

Eight of 12 providers said they were aware of Quitnet or Quitline, and more than one mentioned the free pharmaceuticals provided to some using it. Seven had referred patients to it, and one described it as “very successful.” He had heard about it from a patient, and he considered Quitnet a good model of how to achieve effective health promotion, and how to market a health resource. One provider knew of it, but did not refer patients to it very much, because he believed his patients did not have Internet access. Three who had heard of Quitnet questioned its effectiveness, mostly because of skepticism about any behavior change. One who had not heard of it before the study thought it would be a “*great resource.*” The other had “*real concern about government involvement in medicine.*” He explained that “*There are other, better ways for those problems to be addressed,*” although he did not wish to elaborate in the phone conversation.

## ***The Department’s Action Opportunities***

Providers asked for specific materials and services from the Department. They also described more generally conditions that would help them improve care to their patients. Some of those involved changes they would like to see in their own practices or communities, and would not necessarily emanate from the Department. We describe those here to frame the context of need to reveal respondents’ breadth of creative thinking about solutions

### **Patient-education Materials**

Some providers asked for printed materials, posters, or pamphlets. One declared enthusiastically, “*Living with Diabetes pamphlets are FANTASTIC!*” Providers asked for simple, straightforward pamphlets or posters about several topics: salt in the diet; “10-steps to prevent diabetes” or “control HBP;” simple explanation of HBP – causes, outcomes, mechanisms. Most stressed the importance of simplicity. One emphasized the need for materials that do not require reading skills. They should contain cross-cultural symbols and images accessible to users with a 3<sup>rd</sup>-grade education.

No one asked for blood pressure recording logs and generally said they did not need them. Several routinely give patients such logs provided by their corporate entity, complete with the





company logo. One provider has patients construct their own to promote engagement, and to prove their motivation.

Several providers believed that both they, and many of their patients would benefit from Internet-based or electronic resources suggested several electronic services. They suggested several desirable ones.

- Some were interested in instructional DVDs or videos, or Web-based educational materials that patients could access in the waiting room.
- Several said they would like to have a robust Department Web site, containing brochure ware and other resource information and links to programs and supports. It would act as a resource repository and access site.

By contrast, some said they had no space for such a video- or computer station in their office, or that their patients did not have access to the Internet.

### **Community and Department Services**

Diabetes education was the most frequently identified service that patients needed. Whether this educator would be the first available in the community, or an adjunct to existing ones, she or he was considered a valuable resource. This was especially true if the education were reduced-cost or no-cost.

Providers had not heard of the Chronic Disease Self-management Program, but were enthusiastic about it as a resource to their patients, once it was described to them. Most thought it would be especially useful if delivered in person, at a nearby, community location. Some thought a Web-based delivery system would serve some patients well.

Quitnet-style online support. Several providers said they would like to see a Quitnet-style online support service available to facilitate weight loss, and possibly other disease self-change endeavors related to managing hypertension and diabetes.

Home visits. In general, providers did not independently nominate such other services as personal coach or trainer, or promotora as specific needs, but agreed such services would be valuable to their patients. One provider did volunteer the need for home-visits to people with chronic conditions, especially diabetes. The goal would be to understand the living, cooking, and eating environment, and help conduct a pantry inventory. The provider making this recommendation had worked in home health and considered the insights gained in those visits to be invaluable in helping patients overcome health barriers.

### **Medicaid and Other Cost-related Changes**

Most providers asked for changes in Medicaid reimbursement to better pay for health-promotion, prevention, counseling and disease-management education. A few asked for vouchers for supplies or for prescribing exercise and coaching. One recommended a basic shift in the co-pay structure to emphasize chronic management, and discourage acute-condition visits.

*"...remove cost or co-pay for Diabetes center for people who have no health insurance. And then have co-pay for everything that's not a chronic disease. Then it turns away dumb visits. Don't throw up barriers to good chronic-disease care."*





### **Quality-related Improvements to Practice**

Most described changes or resources that would improve their practice. Several described processes or people that did not work at optimum efficiency, thus wasting time, health-care dollars, and ultimately reducing the quality of healthcare outcomes.

**More staff.** Several expressed the need for additional staff to conduct follow-up calls, or provide education and training that would extend the PCP's bandwidth. Yet, some said they had enough staff, and just needed a different incentive (reimbursement) structure.

**EMR.** The EMR was a prime source of wasted opportunity and disappointment. Many providers expressed the need to improve the function of their EMR to provide more helpful feedback and tracking to them and patients; to deliver patient-friendly educational materials; to be more user friendly in recording notes, for example with templates; and to set up planned-care schedules that would provide ticklers when patients were due for labs, visits, or other follow-up actions.

**Group visits.** Several described a group-visit approach as one process improvement that would provide needed social support to patients, allow for efficient education delivery, and focus care on chronic disease management.

**Workflow improvement.** One provider enthusiastically described a recent process-improvement CME that she and other clinic colleagues attended. It helped them analyze and improve their current workflow in treating congestive heart failure (CHF) and promoting patient engagement in self-management. One part of the solution was to develop planned care steps and EMR prompts. Another was to standardize processes across staff and departments. This kind of process improvement, once applied to the flow around one chronic disease, could be adapted to improve such others and diabetes care or hypertension management.

### **How IDHW Can Communicate with Providers**

Everyone said they are busy and often do not read the information sent to them. The best ways to reach them depended on the person, and sometimes on the day or week. About half of respondents advised the Department to communicate with them via email; whereas, the other half preferred U.S.Mail. One said communicate with the office manager, but another said the office manager was exactly the wrong person.

### **Multi-method, Multi-channel, Multi-transmission**

One solution to the communication bottlenecks is to customize communications as much as possible, in the ways providers prefer, but to back-up those approaches using multiple modes, channels, and transmissions.

### **Big Pharma and Quitnet as Role Models**

One provider commented that the Department could take a lesson from pharmaceutical companies in how to get their messages out to providers themselves. They should hire young, attractive, smart people to go door-to-door to medical practices, like the drug companies do.

More than one provider urged the Department to go directly to the consumer with advertising about such offerings as the Chronic Disease Self Management Program. One explained that





Quitnet was the model of effective Department marketing. He had found it on his own because of the marketing. Another learned about it from his patients, who prompted him to research it, and refer them and other patients to it.

Along a similar line, some suggested the Department provide literature and display posters at points of sale and service, such as pharmacies and provider waiting rooms and visit rooms. Of course, this suggestion begged the question of how the provider organizations would first learn of and approve the postings.

### **Network and Communicate through Professional Associations**

At least one provider urged the Department to connect with professional associations and attend conferences to deliver important news to providers.

## **Next Steps**

The Department can take steps to turn these findings into action.

5. Use the findings to inform creative brainstorming and strategic planning of ways to meet the needs and overcome the barriers identified by providers. Some of these solutions exist. Some are explicitly named by providers. Some are not yet invented, but must be created without regard to the solutions offered, or the currently available resources. Those require a new, far-sighted vision. Be sure to address the following areas of need:
  - a. Educational and resource materials providers would use, e.g., brochures, pamphlets, posters, web resources
  - b. Services, e.g., coach, CDE, Chronic Disease Self Management
  - c. Communications, channels, spokespersons e.g., outreach and networking to professional organizations, association newsletters, presentation at conferences, specific CME offerings, use of spokespersons, keep-in-touch roster, direct-to-consumer, point-of-sale, point-of-service, BP machines
  - d. Improving providers' understanding of and adherence to guidelines, e.g., JNC7
  - e. Workflow improvements and integration with EMR, group visits, planned care, team health
  - f. Resources and reimbursement: Consider engaging the Medicaid program in innovative collaboration to knit public health with providers to change the incentive structure for both providers and patients, and improve chronic disease outcomes
6. Use the strategic planning process to develop a model of public-private collaboration that will engage PCPs and deliver quick and enduring benefits to them, the system, and their patients.
  - a. Begin by engaging broad-based collaboration across the Department's chronic disease programs
  - b. Extend to the Health Districts
  - c. Extend to Medicaid
  - d. Extend to provider organizations
7. Test the most feasible solution options in the follow-up online survey questionnaire, and the in-clinic process-improvement demonstrations.
8. Develop and implement a plan of action; pilot it; measure and evaluate impact; franchise what works, and revise or abandon what doesn't.





## Summary

Most providers described some lifestyle counseling and interventions they used, all containing the basic message to eat better and less, and to move more. For diabetes, many focused on reducing patients' consumption of refined carbohydrates and on weight reduction; for high blood pressure some targeted sodium consumption and weight reduction. Most talked about increasing exercise to some degree, usually by walking.

### **Little Consistency in Lifestyle Counseling Techniques, Tools, Recommendations**

Providers varied greatly in their enthusiasm for lifestyle interventions and their reliance on lifestyle counseling. Likewise, the techniques and tools they used were not consistent or systematic across providers.

### **Diabetes Educator**

Providers were essentially bimodal in their use of diabetes educators. For the most part, those with access to a diabetes educator referred patients to that service. Yet, many patients decline the service because of cost, or lack of confidence in its worth, or both. In those cases, diabetes education remains the provider's responsibility, or is shifted to an endocrinologist in extreme cases.

### **Patient Barriers**

Providers identified numerous patient barriers to effective management of chronic diseases. The pervading barrier, regardless of a patient's resources, is that the best remedies – diet, exercise, weight loss- are the hardest. Pills are much easier. Other barriers include depression, insufficient social and professional support, and the costs of care, medicine, and a healthful lifestyle.

### **Provider Barriers**

Providers' most frequently identified barrier to effective disease management is the limited encounter time, which they attribute to the insurance reimbursement demands. They also cited operational inefficiencies, especially in their EMRs, which almost all fell short of expectations.

### **The Good News: There's Appetite for Change**

Most of the respondents had well-considered ideas about how to improve patient care, and participated because they wanted to contribute those ideas. They ranged from operational improvements to restructuring the practice model, offering group-visit and health-promotion options, and changing the insurance reimbursement structure.

### **Provider Sources of Best-practice Information – Most Did Not Mention JNC or ADA**

Every provider named several sources of best-practice information, of which trade or research publications most frequently nominated. Most were influenced by CMEs and conferences, often organized by their statewide professional association. The JNC and ADA were mentioned only late in the conversation, by fewer than half of providers.





## Manifest Best-practice Implementation

A significant proportion (22%) of those describing how they would treat a woman with 135/85 blood pressure and probable diabetes either ignored the BP, or explicitly said it was not problematic.

## The Department Is Not Currently Seen as an Expert or Resource in Disease Management

The Department as a public health resource and potential contributor to the management of chronic disease is invisible to most providers. It is overshadowed by Medicaid. Most were unaware of the Department's communications or public health services, except for Quitnet, which most perceive as successful. None was aware of the Chronic Disease Self-management Program, though most considered it a good resource, once described.

## What the Department Can Do

The Department could support providers' work with

- specific materials and services, such as brochures and posters, diabetes educators, and the self-management program;
- a Resources Web site that would link providers and patients to services and community resources;
- assistance in making operational improvements to increase efficiency; movement toward a planned-care or medical-home model; the development of group-visits as a patient-support and education forum;
- help in changing Medicaid reimbursement and co-pay structures to encourage chronic disease management.

## How the Department Should Communicate with Providers

The Department should consider a three-level communication strategy with providers: Direct contact with the provider; communications mediated through professional associations, conferences, and CMEs; and indirect communication via direct-to-patient messages.

- When contacting providers directly, use two approaches: (1) customize communication mode (email v. U.S.Mail v. FAX v. phone) as much as possible, based on knowledge about individual preferences, but (2) supplement with multiple modes, channels, and transmissions for nearly everyone. Look to pharmaceutical representatives as a model of what works.
- Network with providers through professional associations, contributing to newsletters, conferences, CMEs, professional discussion groups, etc. Cultivate spokespersons and relationships with professional thought leaders.
- Go directly to the consumer with marketing and public education to promote lifestyle changes, and to increase awareness of resources.

## The Department's Next Steps

Turn the findings into action.

1. Use the findings to inform creative brainstorming and strategic planning of ways to meet the needs and overcome the barriers identified by providers.
2. Use the strategic planning process to develop a model of public-private collaboration that will engage PCPs and deliver quick and enduring benefits to them, the system, and their patients.





3. Test the most feasible solution options in the follow-up online survey questionnaire, and the in-clinic process-improvement demonstrations.
4. Develop and implement a plan of action; pilot it; measure and evaluate impact; franchise what works, and revise or abandon what doesn't.

