Collaboration and Transparency: Working together to transform care

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Self-Managing Care: From Ideas to Solutions

Toronto, CA

February 17, 2010

NEW HEALTH PARTNERSHIPS
IMPROVING CARE BY ENGAGING PATIENTS

SMS – A Brief History

- Operational – “A portfolio of tips and tools”
- Relational – “A fundamental change in the culture of care to collaborative relationships”

  – Tom Bodenheimer, www.chcf.org

“Old” Culture

- Fragmented, reactive
  - not planned or coordinated
- Dependent on physician, not team based
  - clinical, administrative, clerical
- Patient education focus, not self-management focus
- Language -“Non compliant, non adherent”
  - “Frequent flyers, high utilizers”

Tips and Tools

- Operational approach – goal setting, action planning and problem solving
- Get them active - patient activation, behavior change
- Get them informed– classes, materials

- Acknowledge the patient's role

Current Culture

- Interaction Based –Motivational Interviewing
  - Ask Tell Ask, Summarize, Roll with Resistance
- Relationship building - Agenda setting, problem solving
- “Let the patient lead”
  - CDSMP
  - No agenda classes - Funnell

Cultural Horizon

- Follow up – Ongoing healing relationship
- Tailoring – “attachment theory”
  - 48% non-collaborators
  - 20% more likely to die in 5 yrs
- Just in time monitoring
  - Patients using their own health data to manage

Collaborative Care: Cycle of Self-Management Support

Gather Clinical Data
- labs
- screenings
- specialist reports

Gather Patient Experiences
- symptom monitoring
- medication taking
- stressors

Improved Outcomes
- Increased Healthy Behaviors
- Improved Clinical Outcomes
- Increased Collaboration between Patient and Provider
- Improved Physician Satisfaction and Retention

Front Office
- build relationships
- explore needs and preferences

Provider Exam
- set agenda
- review clinical and patient experience information
- collaborate to set SM goals in care plan

Nurse/MA Coaching & Support
- create action plan
- assess barriers
- support change
- patient education & skill building

Follow Up
- revise action plan
- problem solve

Specialist Referrals
- coordinate care referrals

Community Linkages
- patient education programs
- fitness and nutrition
- faith-based health promotion programs

Peer Programs
- voluntary health organizations
- web-based chat rooms
- lay-led groups

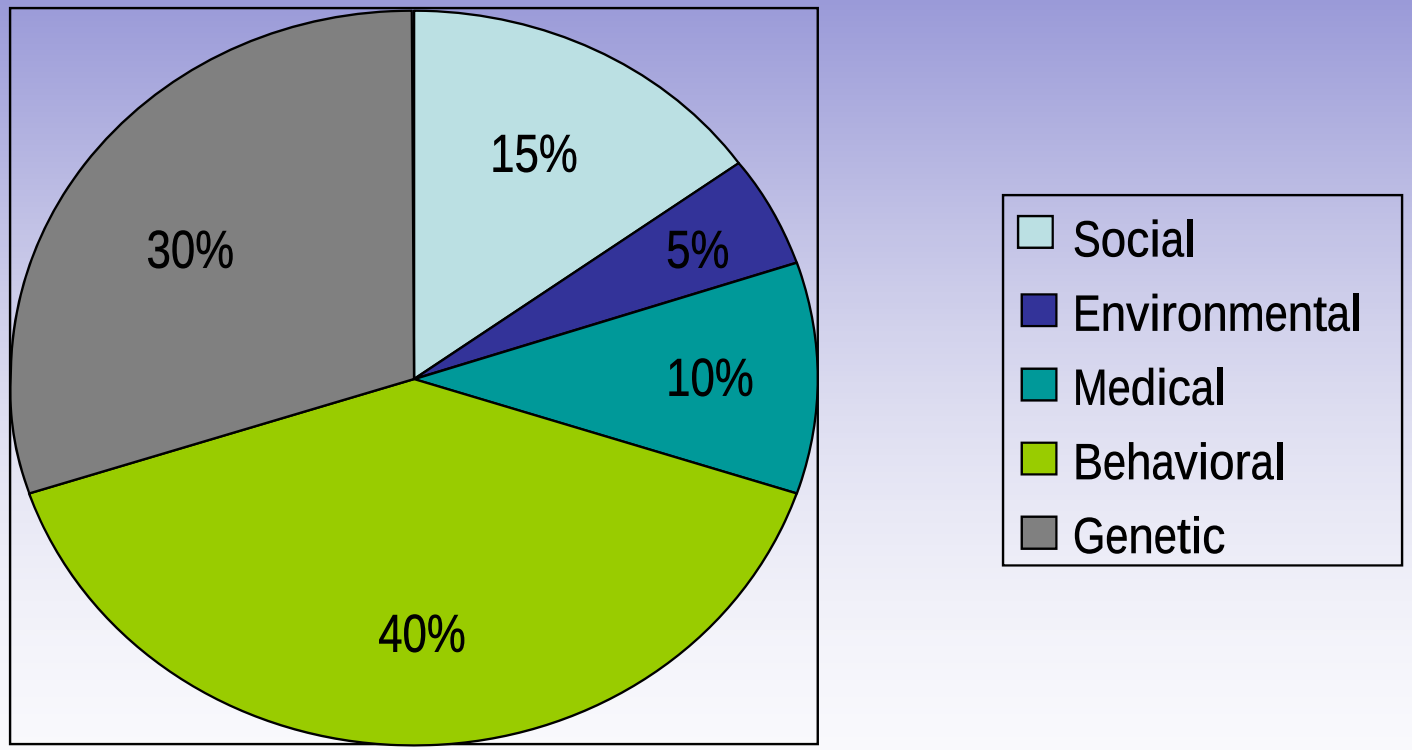
"The purpose of self management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment." —Bodenheimer 2005

For more information, tools and links, go to:
www.NewHealthPartnerships.org

Three Key Strategies

- Involve patients and families at every level
  - Ask values, preferences, confidence, experience of care
- Implement the Patient Centered Medical Home
- Become part of a Caring Community

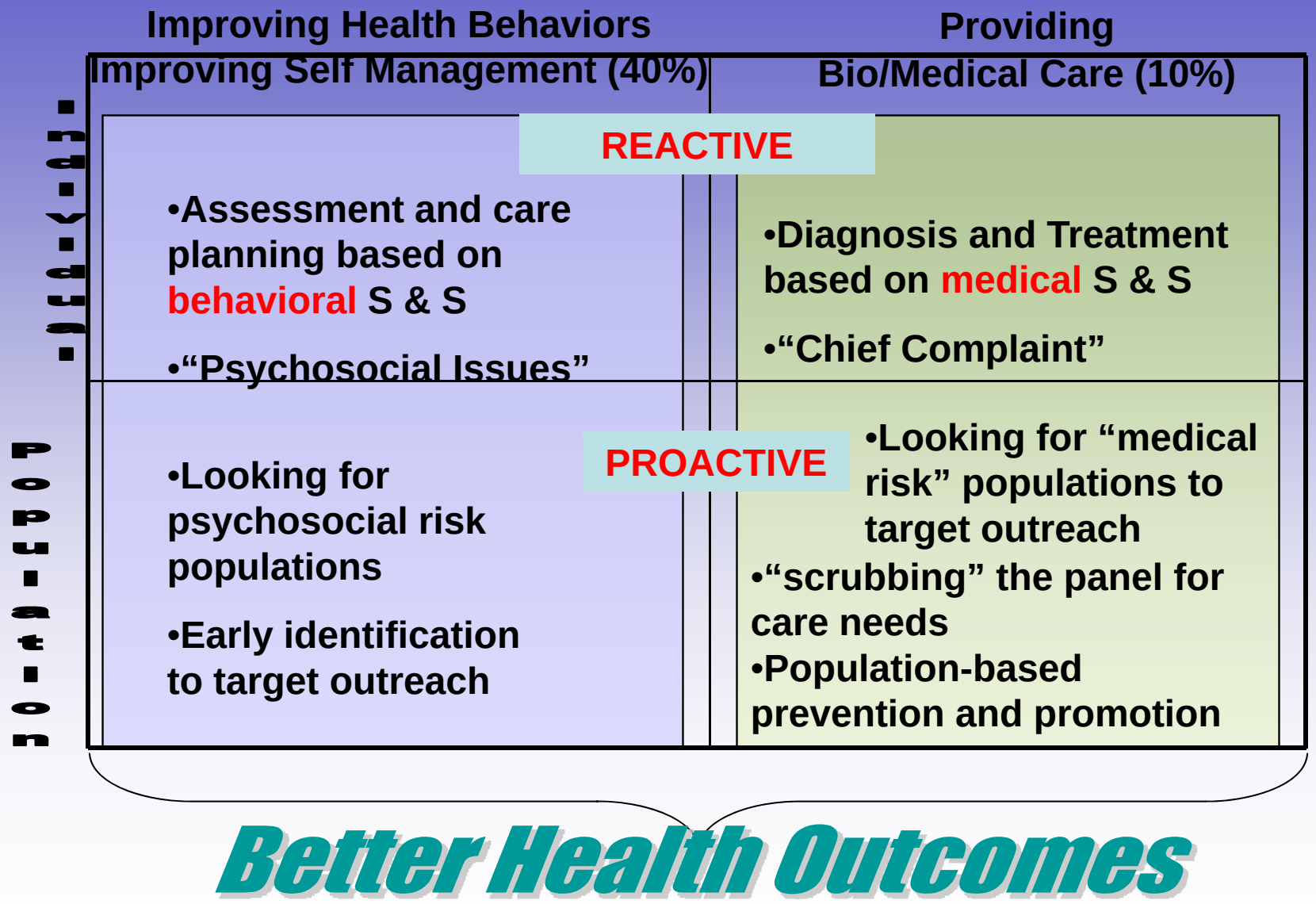
Determinants of Health and Their Contribution to Premature Death



Schroeder, NEJM 357; 12

"I was able to get in one last lecture about diet and exercise."

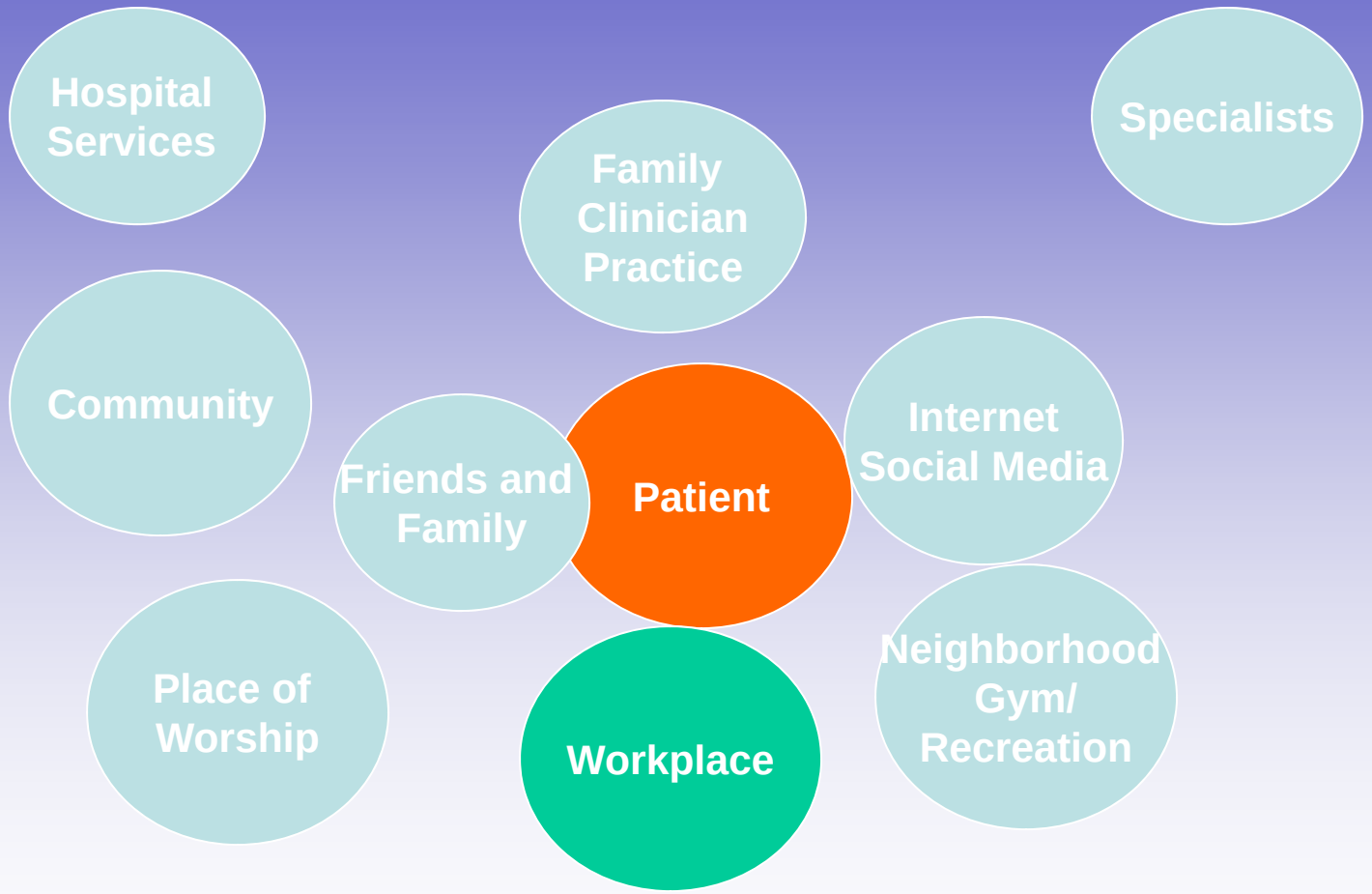
What is the work of the medical home?



Patient Driven Care

- ***Patients are the most important factor in their own outcomes (and need to do the heavy-lifting)***
- ***Patients are the experts in themselves***
  - ***Health 2.0 is a "Reformation"***
  - ***What is role of Care Team?***
  - ***What is role for community?***
- ***Services designed from patient point-of-view to meet patient needs and preferences***

The Medical Home: It Depends on Your Point-of-View…



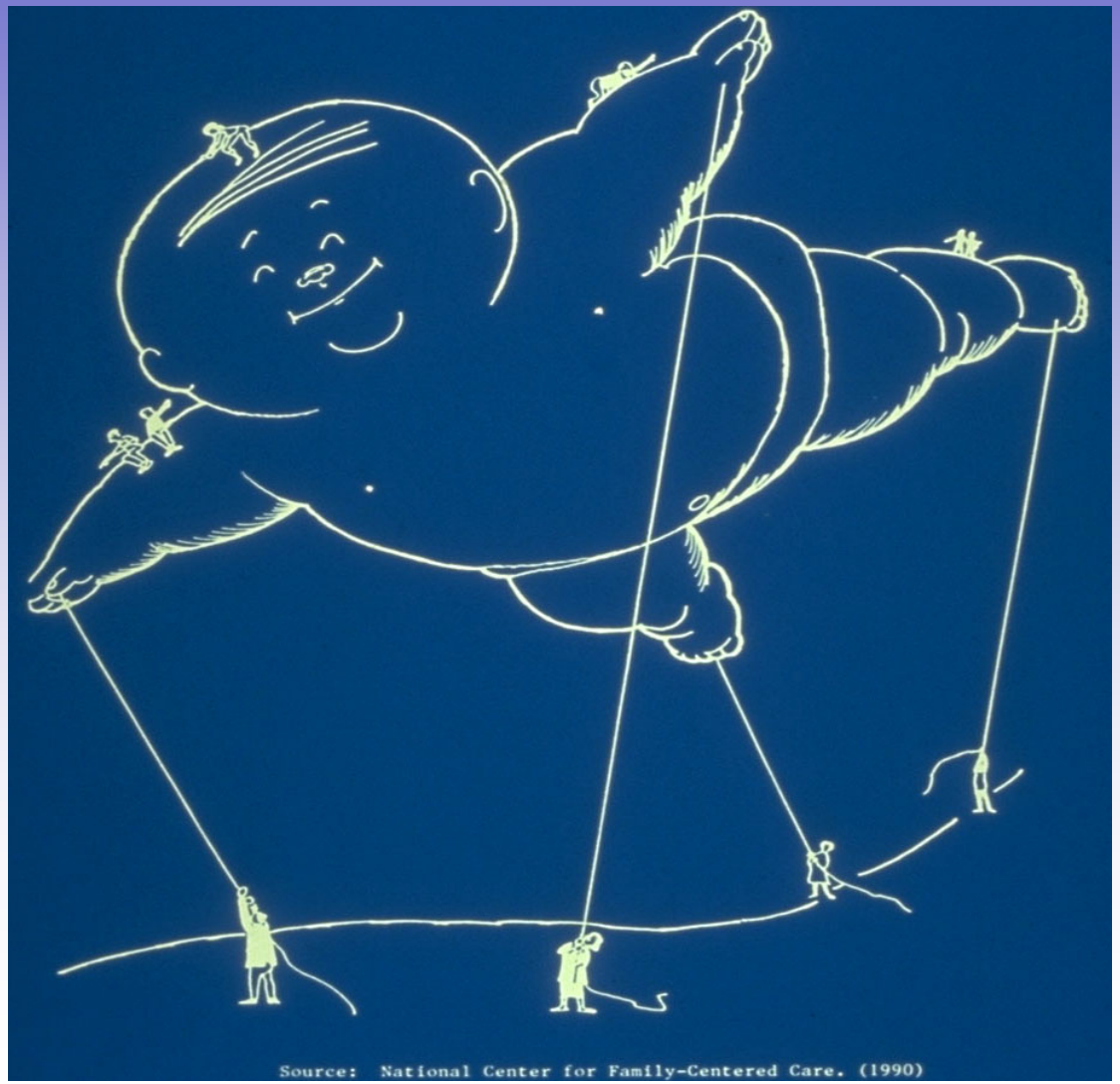
The “empowered patient” view…

What is Patient Centered Care?

- **System-Centered:** Needs of, or benefits to, the system drive the delivery of care.
- **Patient- and/or Family-Focused:** Staff focus their approach to care based on staff ideas of patient and family needs. Interventions are done to and for the patient and family instead of with the patient and family.
- **Patient- and Family-Centered:** Priorities and choices of the patient and family drive the delivery of care.

System-Centered Care

Patient-Focused Care



Family-Focused Care

Patient- and Family-Centered Core Concepts

- People are treated with **respect and dignity**.
- Health care providers communicate and share complete and unbiased **information** with patients and families in ways that are affirming and useful.
- Individuals and families build on their strengths through **participation** in experiences that enhance control and independence.
- **Collaboration** among patients, families, and providers occurs in policy and program development and professional education, as well as in the delivery of care.

Photo: Health Canada/Santé Canada

“The Big Ask”

- Patient Satisfaction to Patient Experience
- From – “Are you happy with us?”
  - Press Gainey
    - To – “Are we meeting your needs?”
    - CAHPS
- To – “How is what WE are doing working for you?”
  - PACIC, ACES
  - Patient Activation Measure

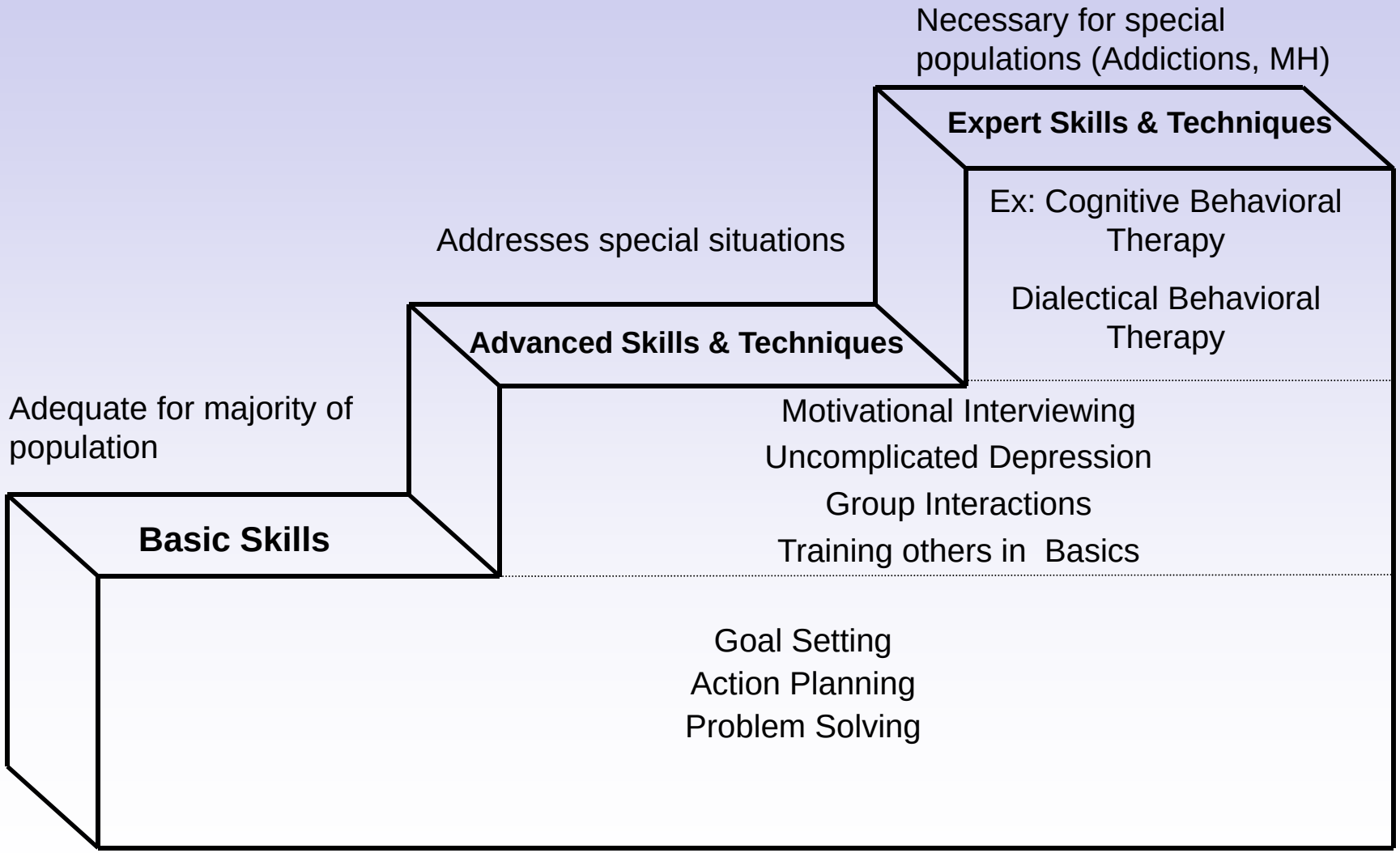
“The Big Ask” – Sub-populations

- Elicit values and preferences – What’s important?
- Look at changes in life situation – “What else?” “Tell me more?”
- “Just in time” asking to plan changes in care
- Surveys, focus groups, patient advisory panels

CareSouth Carolina – Who Are We?

- Private, non-profit community health center with services that began in 1980. Began with one office, one doc, 4 staff members….. And Ann Lewis!
- Ten offices located in eight federally designated Medically Underserved Communities (MUAs) in rural South Carolina
- System of Care involving hospitals, nursing homes, private providers, numerous health and social agencies, schools, medical student training for USC; and many others
- 30 providers, 40,000+ patients, 290+ staff
- JCAHO accredited since 1999
- Integrated behavioral health system
- On a journey of quality improvement since 1999

Self-management Support Steps to Build Skills and Confidence



Source: Connie Davis. RNP

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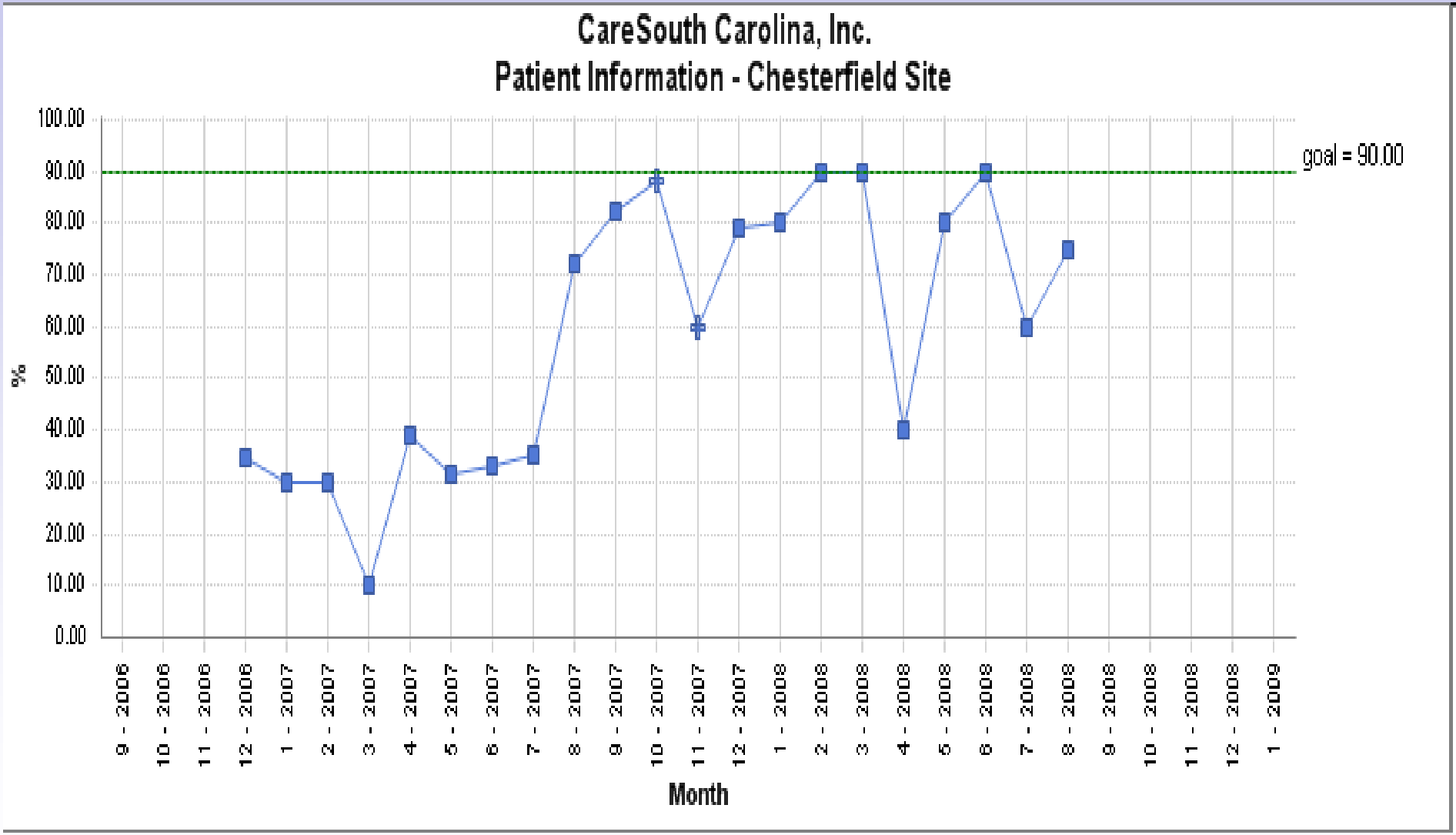
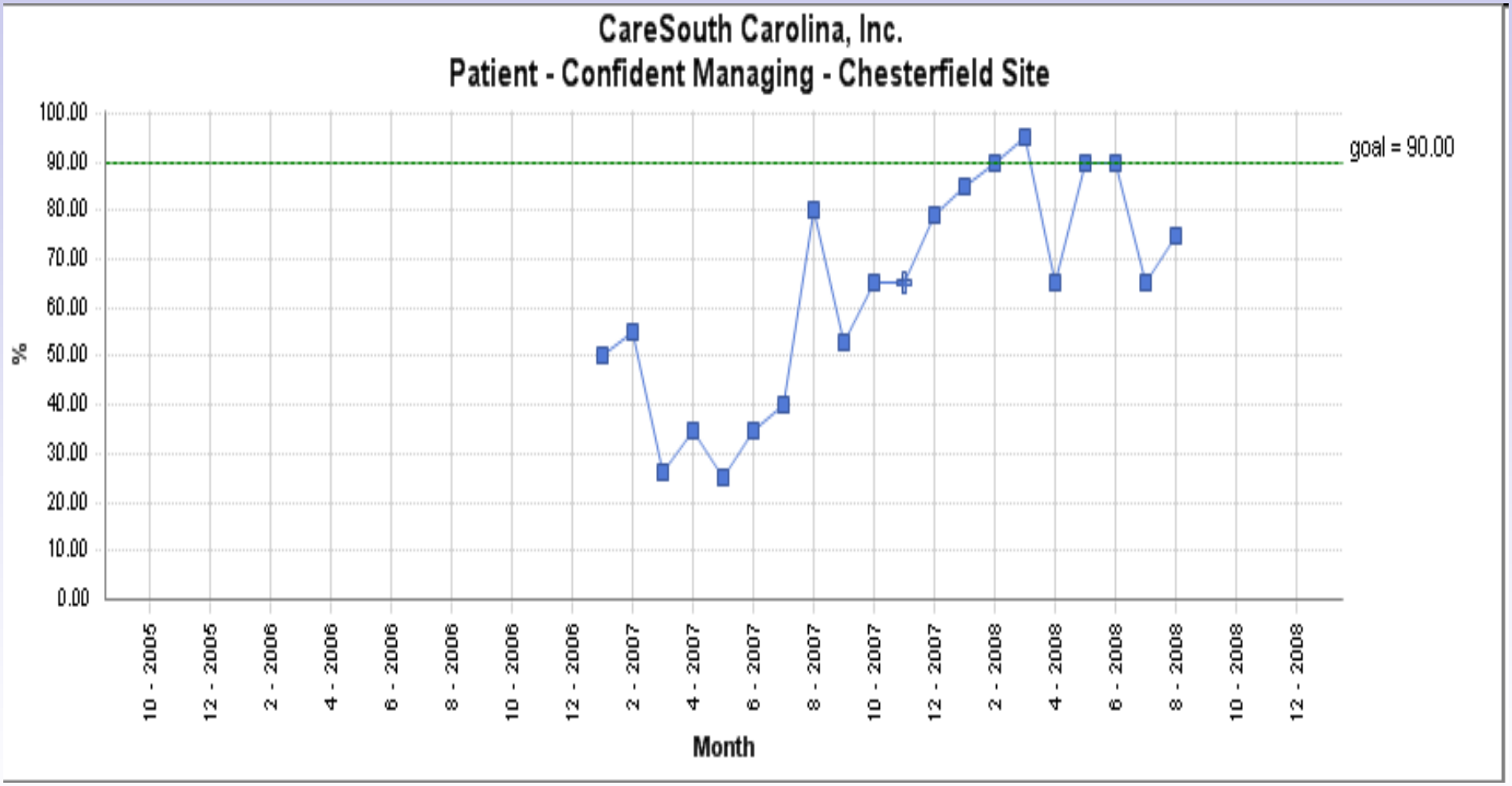
The CareSouth Carolina ASKS

- Ask about understanding, confidence, self management goals
- Depression screen for all chronic illness patients
- Patient focus groups for re-design




CareSouth Carolina, Inc.
Patient - Confident Managing - Chesterfield Site
100.00
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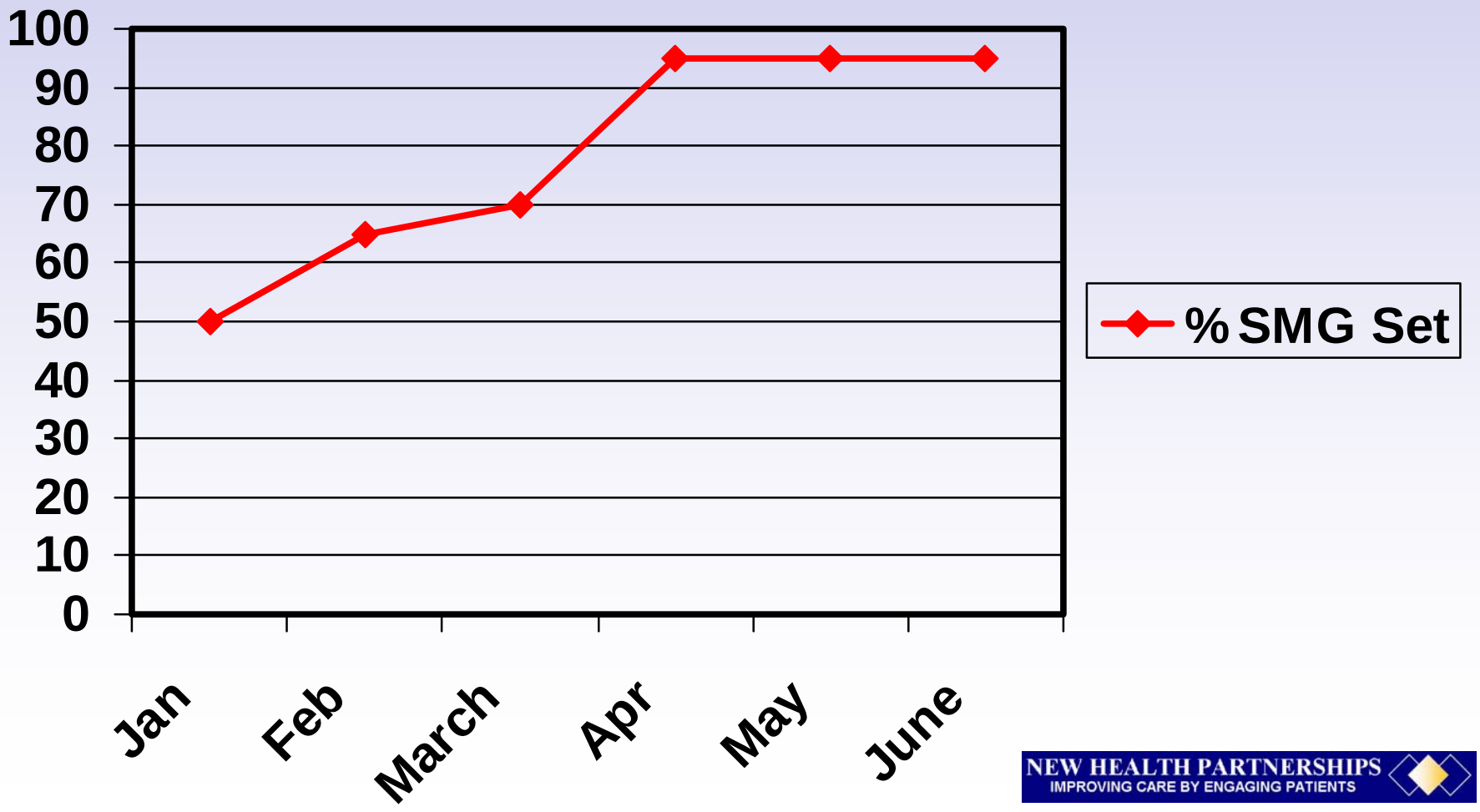
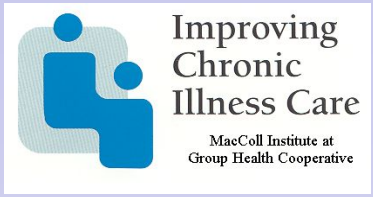
Month

Reliability Data for SMG Set



Does SMS Make a Difference?

- Depression: 64% of 1,410 patients in depression registry have a 50% reduction in severity
- Diabetic Control: 50% of 3,500 patients with diabetes are in control (HbA1c < 7.0)
- BP Control: 55% of 8,300 patients with diabetes and HTN have blood pressure in control
- Moving to 0% Disparity in chronic conditions that have as great as 300% disparity on our area.
- Patient Confidence: 84.6% of patients are very confident they can manage their health
- Continuity with Provider: 83.7% of all visits are with provider of patient's choice



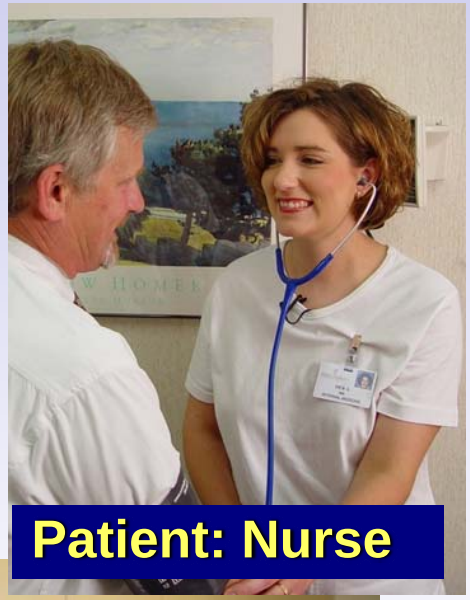
Transforming Safety Net Practices into Patient-Centered Medical Homes

Joint Statement Definition

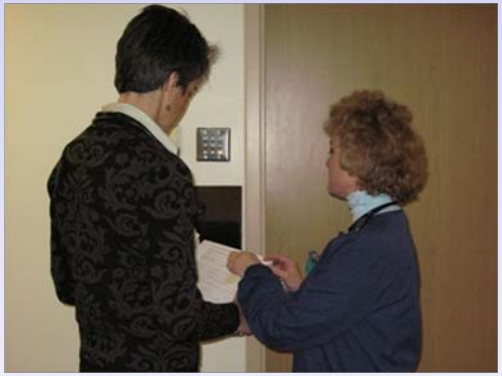
The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that **facilitates partnerships** between individual patients, and their personal physicians, and when appropriate, the patient's family.

http://www.medicalhomeinfo.org/Joint%20Statement.pdf

At the center of primary care are face-to-face healing relationships.



Patient: Nurse



Nurse: Physician

Nurse: Nurse

Patient: Physician

We will know who you are and we will be ready for you.

Borgess Ambulatory Care, Kalamazoo, MI

Change Concepts

Engaged Leadership

Empanelment- I know who my healthcare team is

Patient-Centered Interactions

Continuous, Team-Based Healing Relationships

Organized, Evidence-Based Care

Enhanced Access

Care Coordination

Quality Improvement Strategy

Ocean Park Community Health Center, San Francisco

- Planned Care Appt
- Community Health Coaches
- Walking Clubs
- Patient Education in 8 languages
- After Visit Summary
- Behaviors

“Teamlet” Model

- Primary Care Physician
- 1-2 Medical Assistants
  - Lay “coaches”

- Action Planning and follow up by MA’s
- MA’s may accompany patients in doctor visit

- Bodenheimer, 2008

The Patient

The Medical Assistant

The Provider

Leaves with scripts, referrals, and instructions

Other Activated Patients

The Patient

Integrated plan
Medical
&
SMG

The Provider

The Medical Assistant

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First key service: **MA planned visits**

Planning and preparation:

Do goal setting on

patient determined goal

Assure all information

is up to date in chart

The Provider – Integrated medical plan and self management goals

B ACKGROUND
B ARRIERS
S UCCESSES
W ILLINGNESS…
A CTION PLAN
R EMEMBER

NON-DIRECTIVE COUNSELLING

And our Group Visits…

Patients helping Patients…

The MINI-group visit

The Open-Office Group visit

Stressors, depressed mood, barriers, difficulty coping ALWAYS covered

Coping strategies develop

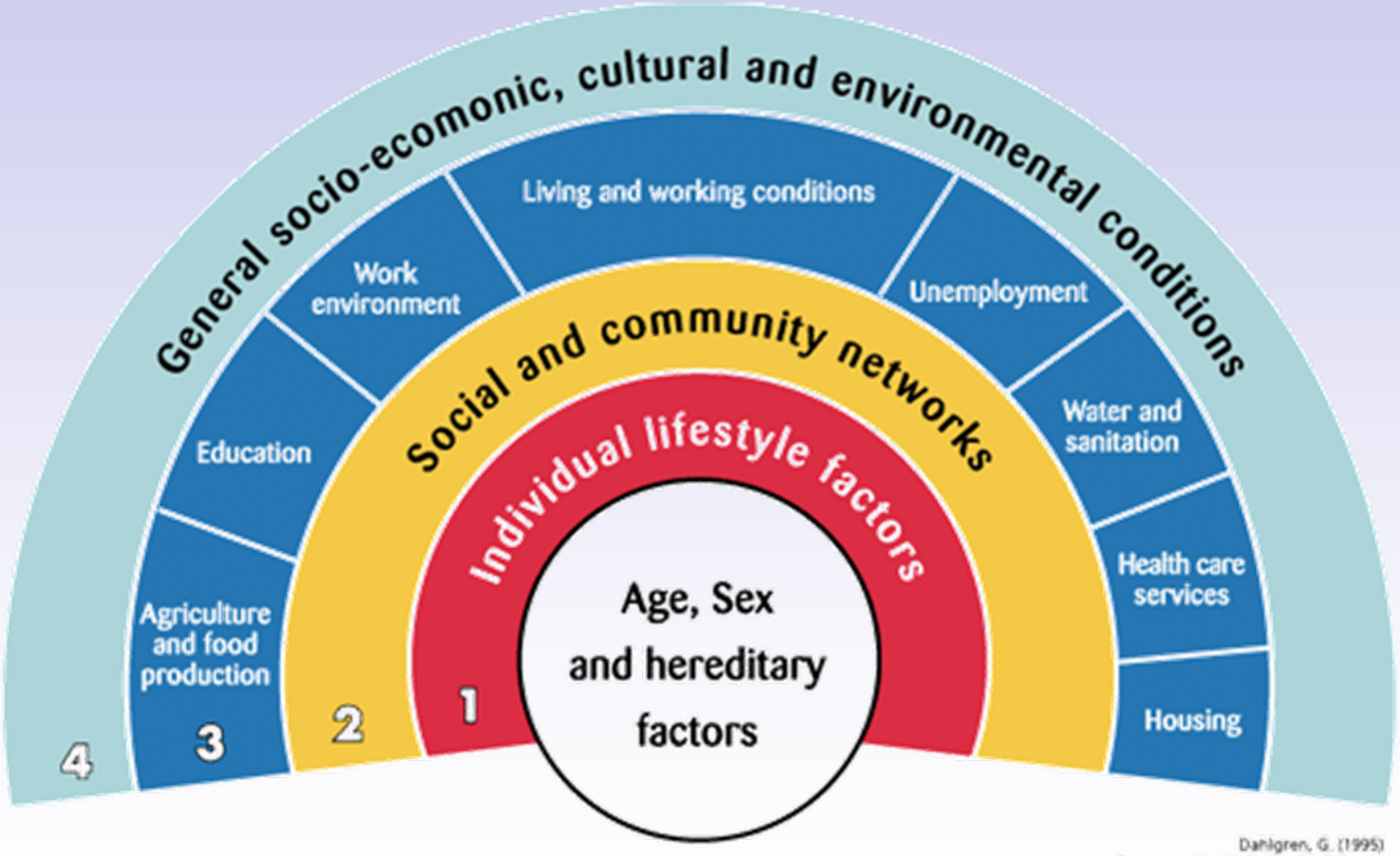
Both involve goal setting

Closing the Divide

- **Medical homes can reduce or eliminate racial and ethnic disparities in access to and quality of health care**
- Safety net clinics are less likely than private doctors' offices to be medical homes
- "Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients."

Anne Beal et al. The Commonwealth Fund, June 2007

What Determines Population Health? Not Just Medical Care!



Dahlgren, G. (1995)
European Health Policy Conference:
Opportunities for the Future. Vol 11 - Intersectoral Action for Health.
Copenhagen: WHO Regional Office for Europe

Aligning Forces for Quality: Communities of Collaboration

- RWJF funded projects
- 14 communities/regions/states
- The goal is **to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities and provide models for national reform**.

http://www.rwjf.org/qualityequality/af4q/

AF4Q Focus Areas

- Improving quality across all settings
- **Engaging consumers**
- **Measuring** provider performance
- Increasing **public reporting**
- Engaging nurses to be active leaders
- Addressing **inequities**
- Overcoming **language barriers**

Practice Environment in Humboldt

- 25 primary care practices in various sizes, types and stages of transformation ***(all in the Humboldt IPA)***
  - 7 community health centers
  - Many 1-3 clinician practices in private practices (one 17 MD Internal Medicine practice)
  - No large integrated multispecialty group
  - Managed care covering 10% of population
- How to rapidly improve chronic disease care in the community?
- ***Our Pathways to Health:*** peer-led SMS ***"Kate Lorig Model"***

Humboldt Del Norte IPA, Eureka, CA

Participating on the QI team, teaching classes in the Healthier Living Series, and training peer support group facilitators.

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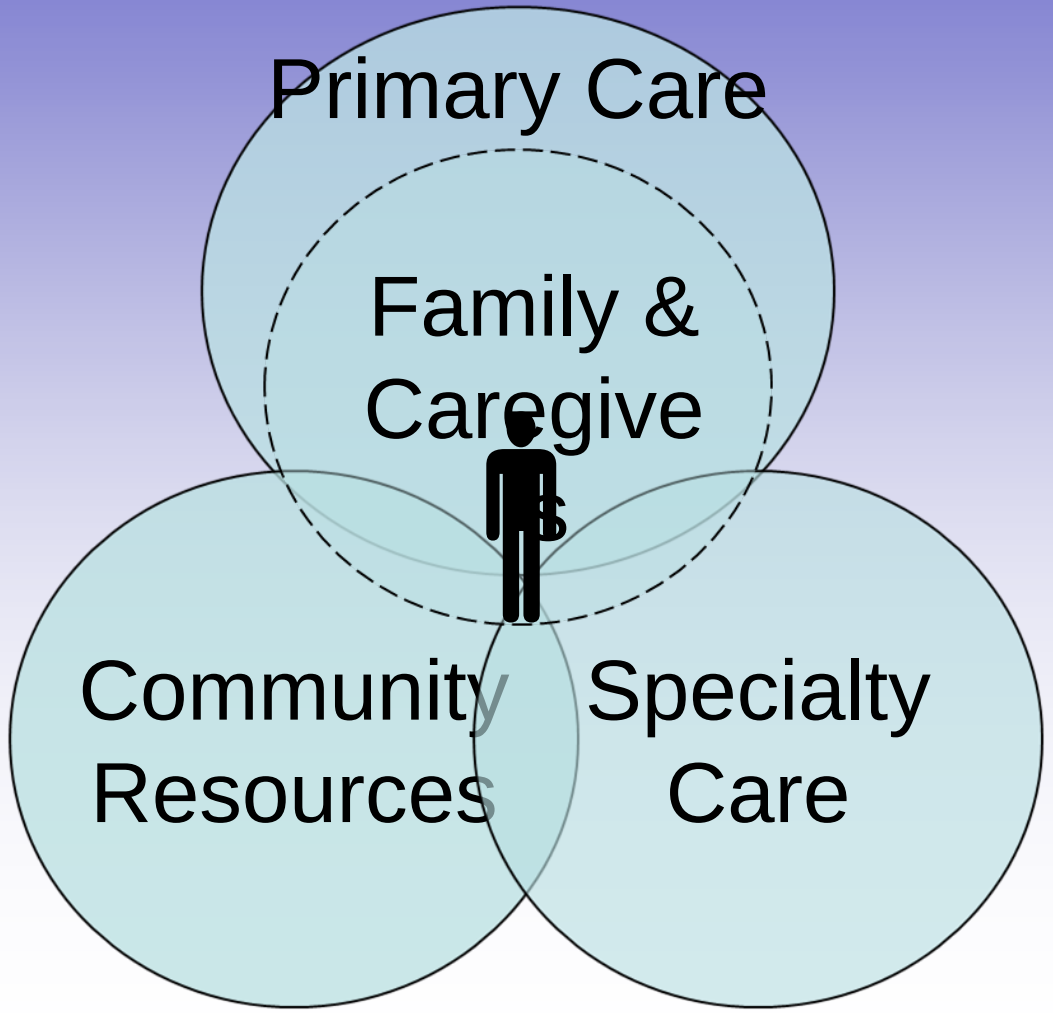
BC Patients as Partners

http://www.impactbc.ca/files/IHNs_-_Executive_Summary.pdf



Support in the Community

Technology: Necessary but not sufficient

MCG Health System

Things to ask my doctor:

Current Symptoms:

The medications I am currently taking:

Instructions from my doctor:

s, I should call:

Shared Care Plan

https://www.sharedcareplan.org/CarePlan/Medications/

Google

Shared Care Plan
Your Personal Health Record

SIGNED IN: John Doe
My Registration
Sign Out

• SCP Printout Options

John Doe
1/1/1950, 55 years old, male

Home | Care Team | About Me | Diagnoses | Next Steps | Health Log | **Medications** | Reactions | History

My Active Meds | My Discontinued Meds | Meds on Record

Prescribed Medications (HELP)

These are medications that you are currently taking that a healthcare professional has advised you to take, including vitamins and supplements available over-the-counter. When you remove a medication you are no longer taking, it will still be visible on the My Discontinued Meds page.

	Start Date	RX By	Brand (Generic) Name & Strength	Directions	Use	OTC?	B	L	D	N
⚠	10/15/2002	Dr. King	COREG 25MG TABLET (CARVEDILOL 25MG TABLET)	Take 1 tablet(s) by mouth twice a day.	beta blocker (slows heart); decreases blood pressure	N	1		1	
⚠	12/24/2002	Dr. King	FS-METFORMIN 500MG TABLET (METFORMIN HCL 500MG TAB PO)	Take 1 pill(s) by mouth three times a day.	Glucose control	N	1	1		1

↳ **Comments:** Take with food

University Hospitals Health System

Rainbow Babies & Children's Hospital

Patient Resume
"My Comprehensive Medical History"

Rainbow Babies & Children's Hospital
Medical Record #
Date last revised:

PATIENT INFORMATION		PRIMARY CARE PHYSICIAN	
Patient's Name (Nickname): Address:		Physician Name: *Date care began:* Specialty: Address:	
Date of Birth		Phone:	
Parent/Caregiver(s) (Relationships) Address:		FAX: E-Mail:	
Other Parent/Caregiver: (Relationship)		Home Phone: Cell: E-Mail	

Emergency Contact Information

Name / Relationship Phone:

BASELINE: Temp Resp Heart rate Blood Pressure Pulse-ox

Unusual lab values Other **DNR/DNAR** on file? Yes No

Blood transfusion Yes No Currently enrolled in Blood Conservation Program? Yes No

Insert Photo of Patient Here

ALLERGIES & REACTIONS: *List all of the patient's allergies here.*

IV – Central Lines

Broviac Size Date Placed	Mediport Needle Used Date Placed

Medical Diagnosis / Date	Surgical Procedures / Date

Parent/Caregiver please type or write most current information where indicated on this form.

Patient Last Name:
Patient Date of Birth:
Date Last Revised:

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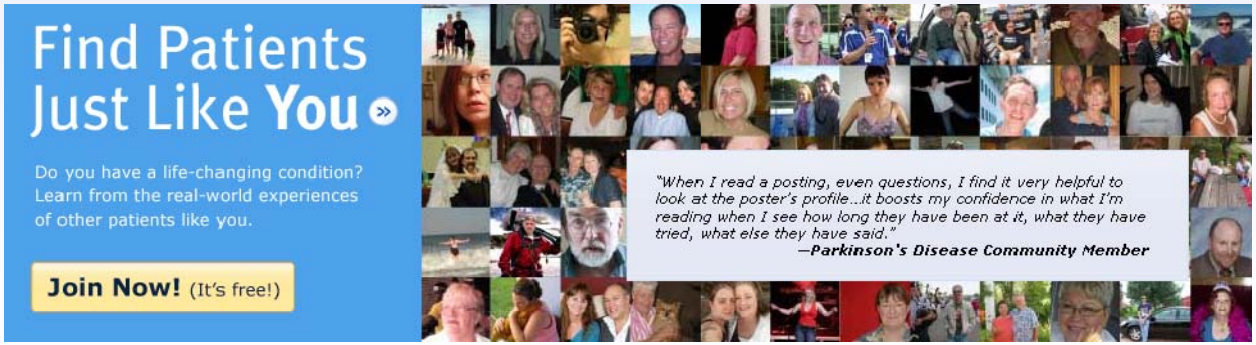
Whatcom County and Beyond

- PatientPowered.org
- Web platform
- Health 2.0
- http://www.patientslikeme.com/



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Shared Care Plan

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Truly Shared Care Plan

- Shared Data
  - HbA1c and walking club experience
- Shared Team
  - Specialists and Aunt Margaret
- Shared Goals
  - Reducing BP and marimba classes

Pitfall: Single Condition Thinking

- "Those With Multiple Conditions Cause Bulk Of Medicare Spending Growth"

  Sunday Health Policy UpDate *(Health Affairs Web Exclusive)*
  August 27, 2006

  – "**Virtually all of the growth in Medicare spending over the past 15 years can be traced to patients who were treated for five or more medical conditions during the year**, according to a new study by economists Kenneth Thorpe and David Howard released today as a Web Exclusive on the Web site of the journal *Health Affairs*. These beneficiaries alone accounted for 76 percent of total Medicare spending in 2002, up from 52.2 percent in 1987."

Resources

www.selfmanagementtoolkit.ca

www.NewHealthPartnerships.org

www.improvingchroniccare.org

www.chcf.org

www.IFCC.org

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