Session 1:
Change is Good! You Go First!
Implementing Self Management Support through Interdisciplinary Team Care

Judith Schaefer, MPH
Self-Managing Care: From Ideas to Solutions
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Hamster Care

Use of statins in pts with MI

- 60% of patients over age 65 with a history of a heart attack were on a cholesterol-lowering medication
- 33% knew the result of their most recent cholesterol measurement

Ayanian et al Arch Intern Med 2002;162:1013
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Chronic Conditions per Medicare Beneficiary

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<th>Number of Conditions</th>
<th>Percent of Beneficiaries</th>
<th>Percent of Expenditures</th>
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</tbody>
</table>

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The IOM Quality Chasm Report

Conclusions:

- "The current care systems cannot do the job."
- "Trying harder will not work."
- "Changing care systems will."

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How can we get it all done?

Delivery System Design

- You have been referring the diabetes patients from your clinic to a diabetes educator located at the hospital in your community, but her hours were recently cut back, and she will now be far less available to your patients. You want to deliver the best possible care to your diabetes patients, but how can you get it all done?
  - How can you optimize the staff you already have to support guideline-driven patient care and self-management?
  - What can you do to improve the percentage of diabetes patients who get the care they need?
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"U.S." SMS Toolkit for Clinicians

- High Impact Changes
  - before, during and after the visit
- Big Picture Cycle of SMS
  - proactive care delivery process
- Brief descriptions and links to tools

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Three System Change Strategies

- Create a Team
- Shared Care Plan
- Extend Care into the Community
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We will know who you are and we will be ready for you.

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

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Mrs. Peters

- 65 year old annual exam
  - DM2
  - HTN
  - Depression
- Prevention
- New c/o
  - Heartburn
  - Sleep disturbance
  - Fatigue

# of Quality measures?
There is a lot to be done!

- 65 year old annual exam
  - DM2 (9)
  - HTN (17)
  - Depression (10)
- Prevention (27)
- New c/o
  - Heartburn (20)
  - Sleep disturbance
  - Fatigue

# of Quality measures? 56

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There is a lot to be done!

- Too much to be done by just one person
- Too important to be left to chance

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Core Team Model: Plan Ahead, Share the Load

- Right thing happens by default
- Staff work full level of ability
- Minimize work MD does that is within skill set of others
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Post-Appointment Order Sets

• Planned Care Appt
• Order sets
• Empowered Team
• Pt. Questionnaire
• Prescription Mgmt
• Visit Summary
• Annual Exam
• Rapid Access
• Intentional Behaviors

“The next appointment starts today”

• A plan, a promise to continue the relationship
• “We want to see you again, and we will plan ahead to make that most meaningful.”

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Empowered Teamwork

• Planned Care Appt
• Order sets
• Empowered Team
• Pt. Questionnaire
• Prescription Mgmt
• Visit Summary
• Annual Exam
• Rapid Access
• Intentional Behaviors

Nursing staff full partners

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The Boss

- Nexus of organization of our practice
- Filler

Between Visit
- “Excess of me when dealing with patients, patients recognize this.
- Coordinates transitions (hospital, NH, Hospice)
- Manages & returns most phone calls
- Does prescriptions

Updates SHH
- Completes all paperwork

Visit
- Initial review of lab
- IR education
- Immunizations
- Colonoscopy
- Six driven tests (PFT, EKG)
- Diabetes foot exam/eye exam
- Present patient

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Take Home Messages

- It’s all about planning ahead
- Sharing the load
- Enjoying the work!

Team Strategies

- The patient and family are the heart of the team – involve them at every level!
- Prepare for the visit – include patient preferences and experience with clinical
- Examine office flow and standardize your practice – do a walkabout
- Design for the population – collect patient feedback often

Optimizing the Care Team

- Assure clinicians and staff work to their highest level of experience, skills and licensure – patients learn from everyone
- Use standardized protocols to move work away from the provider
- Optimize team communication
- Utilize regular proactive follow up
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What about Flow?

- What can we do before the visit?
  - Send a visit prep form
  - Ensure lab and other information is up to date
  - Phone patient to check on action plan
- During the visit?
- After the visit?

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Roles and Tasks Assessment

- What are the tasks involved in delivering SMS in your system?
- Who does each task?
  - Do they want this role?
  - Are they trained to do it?
  - Are there issues of scope of practice?
  - Would standing orders facilitate expanding roles?

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Roles and Tasks

| Role          | Care Provider | Clinical Nurse | Medical Assistant | Clinical Care Manager | Nutritionist/PT/OT | Clerical Staff/PCR | Other
|---------------|---------------|----------------|-------------------|----------------------|-------------------|-------------------|--------
| Introduce SMS and patient role |               |                |                   |                      |                   |                   |        
| Set visit agenda |               |                |                   |                      |                   |                   |        
| Collaboratively set goals |               |                |                   |                      |                   |                   |        
| Provide information and training to patients |               |                |                   |                      |                   |                   |        
| Create an action plan |               |                |                   |                      |                   |                   |        
| Link patients with system and community resources |               |                |                   |                      |                   |                   |        
| Proactive follow up |               |                |                   |                      |                   |                   |        |
Core Attributes of Effective Teams

- Cohesiveness, sense of interconnectedness and mutual respect
- Defined, shared goals and specific, measurable operational objectives
- Clear definition of tasks, appreciation of capabilities of team members and assignment of roles
  - At least one person identified as “hub” for the team
- Clear communication structures and processes
- Clinical and administrative systems that support effective workflow
- Focus on planning the work, with systems to examine and improve performance

Key Implementation & Sustainability Factors

- Work with what you’ve got – existing personnel
- Training for the functions that each team member regularly performs and cross-training to substitute for other roles
- Leadership and protected time for team members plan and improve processes over time
- Pilot test before taking innovations to scale and collect real-time data to support improvement
- Peer and patient engagement with the team approach
- Stability and continuity of team composition
- Collegial and cooperative environment, “pods”
- Aligned financial incentives
- Stakeholder support (including patients, staff, payers, community organizations, etc.)

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
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“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

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The Patient
The Medical Assistant
The Provider
Leaves with scripts, referrals, and instructions

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The Patient
The Medical Assistant
The Provider
Other Activated Patients
Integrated care Medical & SMG
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

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The Provider – Integrated medical plan and self management goals

**BACKGROUND**

**BARRIERS**

**SUCCESSES**

**W ILLNESS**

**ACTION PLAN**

**REMEMBER**

**NON-DIRECTIVE COUNSELLING**

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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
Population Management Work Flow

**MD:**
- Reviews worksheets,
- Identifies appropriate interventions,
- Checks off instructions for Program Assistant to communicate to the patient, including:
  - Lab studies
  - Medication adjustment
  - Referrals
  - F/U appointments

Requires approx. 15 min per 10 worksheets

**Program Assistant:**
- Contacts patient in doctor’s name and communicates interventions and/or referrals, collects other information (i.e. Aspirin use) as indicated by the physician on the worksheet
- Faxes or calls Rx to Pharmacy
- Sends Lab requisition
- Books classes/TAVs/appointments
- Enters data
- Confirms patient allergies and current medications

Requires 10B20 min/pt

**Program Assistant:**
- Enters information regarding follow-up interval into a tracking system.
- Places worksheet in outpatient chart.

Shared Care Plan

Truly Shared Care Plan

- **Shared Data**
  - HbA1c and walking club experience

- **Shared Team**
  - Specialists and Aunt Margaret

- **Shared Goals**
  - Reducing BP and marimba classes
Patient Name: ______________________________
Date: ___________

Self-Management Support – 5A’s

Agree
To an agenda - what does the patient want to work on?
*Patient Goal: ____________________________________________

Assess

READINESS to Change
/boxshadow
don
Not ready
/boxshadow
don
Unsure
/boxshadow
don
Ready
/boxshadow
don
Importance in relation to other values
/boxshadow
don
Low
/boxshadow
don
Medium
/boxshadow
don
High

Commitment of success
/boxshadow
don
Low
/boxshadow
don
Medium
/boxshadow
don
High

Advise

What would the patient like to talk about? ____________________________________

Information exchanged (elicit-provide-elicit):

Assist

Patient to develop a personal action plan (if patient is ready).

• Emphasize personal choice and control
• Reassess importance, confidence, readiness
• Do not confront resistance with force – use reflective listening

1. Options for behavior change
(usually there are many possible courses of action)

2. Patients preferred option: ____________________________

3. Are there barriers the patient needs help with (depression)?

4. Follow up plan  -  When: ___________  How: ___________

Educator Signature: ______________________________
Arrange:
to contact the patient between visits.

*Follow-up Contact:
Completed on - Date: ___________

1. Results of behavior changes
2. Barriers encountered (if any)
3. Preferred option for new plan
4. Follow up plan  -  When: ___________  How: ___________

Follow-up Signature: ______________________________

Required to bill Wellmark (Individual visit - S9445)

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Whatcom County and Beyond

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

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Support in the Community
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Who Cooks?

___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________

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Family HealthCare Center, Fargo, ND

Creating a Patient Advisory Council, developing patient portals on the Center’s website, and planning, implementation, and evaluating group visits.

___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________

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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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What is the work of the medical home?

- **Improving Health Behaviors**
  - Providing Bio/Medical Care (10%)
  - Improving Self Management (40%)

**Reactive**
- Diagnosis and Treatment based on medical S & S
  - "Chief Complaint"
- Looking for "medical risk" populations to target outreach
- Assessment and care planning based on behavioral S & S
  - "Psychosocial Issues"
- Looking for psychosocial risk populations
- Early identification to target outreach
- "scrubbing" the panel for care needs
- Population-based prevention and promotion

**Proactive**
- Necessitates a shift from trying to accomplish everything by the physician in the office visit
- Involves treating the ENTIRE population, not just those individuals accessing care
- Provides support systems to make the right thing easier

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Population Management

- The goal is to raise the level of care for all patients in your practice
  - Necessitates a shift from trying to accomplish everything by the physician in the office visit
  - Involves treating the ENTIRE population, not just those individuals accessing care
  - Provides support systems to make the right thing easier

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Care Segmentation Tool

- Disease or Condition:

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Opportunities to Implement Interventions to Promote System Change

• Before the Encounter
  - Pre-visit contact (phone, mail or e-mail)
  - Waiting room assessment
  - Patient education material
  - Posters
  - Pamphlets on “Talking to your provider”
  - Community outreach

• During the Encounter
  - Review assessments
  - Feedback on achievements vs. goals
  - Identifies priorities for visit
  - 5As Counseling
  - Targeted patient education materials

• After the Encounter


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Opportunities for System Change Before the Encounter

• Pre-visit contact (phone, mail or e-mail)
• Waiting room assessment
• Patient education material
• Posters
• Pamphlets on “Talking to your provider”
• Community outreach

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Opportunities for System Change During the Encounter

• Review assessments
• Feedback on achievements vs. goals
• Identifies priorities for visit
• 5As Counseling
• Targeted patient education materials
• Referral for more SMS

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Opportunities for System Change

After the Encounter
- Referrals (Health Education, etc)
- Further 5A counseling
- Phone calls follow-up
- Mailed patient education
- Peer support
- Newsletters
- Follow-up visits
- e-mail/internet sites
- Community Resources

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Resources

www.selfmanagementtoolkit.ca
www.NewHealthPartnerships.org
www.improvingchroniccare.org
  www.chcf.org
  www.IFCC.org