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

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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 Inter Med 2002;162:1013
### Chronic Conditions per Medicare Beneficiary

<table>
<thead>
<tr>
<th>Number of Conditions</th>
<th>Percent of Beneficiaries</th>
<th>Percent of Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>19</td>
<td>4</td>
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<tr>
<td>2</td>
<td>21</td>
<td>11</td>
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<td>3</td>
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<td>4</td>
<td>12</td>
<td>21</td>
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<td>5</td>
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<td>18</td>
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<tr>
<td>6</td>
<td>3</td>
<td>13</td>
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<tr>
<td>7+</td>
<td>2</td>
<td>14</td>
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</table>

**Summary:**
- 24% of beneficiaries have 6 conditions, causing 66% of expenditures.
The IOM Quality Chasm Report

Conclusions:

“The current care systems **cannot** do the job.”

“Trying harder will not work.”

“Changing care systems will.”
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?
Collaborative Care: Cycle of Self-Management Support

Before the Visit
- Gather Clinical Data
  - Data
  - Screenings
  - Specialist reports
- Gather Patient Experiences
  - Symptom monitoring
  -Medication taking
  - Stresses

CARE PLAN

During the Visit
- Provider Exam
  - Set agenda
  - Review clinical and patient experience information
  - Collaborate to set SMART goals in care plan
- Nurse/MA Coaching & Support
  - Create action plan
  - Assess barriers
  - Support change
  - Patient education & skill building

After the Visit
- Specialist Referrals
  - Coordinate care referrals
- Community Linkages
  - Patient education programs
  - Fitness and nutrition
  - Faith-based health promotion programs
- Peer Programs
  - Volunteer health organizations
  - Web-based chat rooms
  - Text groups

Follow Up
- Action plan
- Problem solve

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

"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

New Health Partnerships
Improving Care by Engaging Patients
“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
Three System Change Strategies

• Create a Team

• Shared Care Plan

• Extend Care into the Community
We will know who you are and we will be ready for you.
At the center of patient care are face-to-face healing relationships.
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 (3)
  - Sleep disturbance
  - Fatigue

# of Quality measures? 56

There is a lot to be done!

- Too much to be done by just one person
- Too important to be left to chance
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
Post-Appointment Order Sets

- Planned Care Appt
- Order sets
- Empowered Team
- Pt. Questionnaire
- Prescription Mgm’t
- 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.”
Empowered Teamwork

- Planned Care Appt
- Order sets
- Empowered Team
- Pt. Questionnaire
- Prescription Mgm’t
- Visit Summary
- Annual Exam
- Rapid Access
- Intentional Behaviors

• Nursing staff full partners
• Nexus of organization of our practice
• Filter

**Between Visit**

• Extension of me when dealing with patients; patients recognize this.
• Coordinates transitions (hospital, NH, Hospice)
• Manages & returns most phone calls
• Does prescriptions

**Visit**

• Med. Reconcil.
• Initial review of lab
• Pt education
• Immunizations
• Colonoscopy
• Sx driven tests (PFT, EKG)
• Diabetic foot exam/eye exam
• Present patient (↓ info drop-off)

**The Boss**

• Updates EHR
• Completes all paperwork
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
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?
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?
# Roles and Tasks

<table>
<thead>
<tr>
<th>Role</th>
<th>Primary Care Provider</th>
<th>Primary Care Nurse</th>
<th>Medical Assistant</th>
<th>Clinical Care Manager</th>
<th>Nutritionist, PT, OT</th>
<th>Clerical Staff, PCR</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>Introduce SMS and patient role</td>
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<td></td>
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<td>Set visit agenda</td>
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<tr>
<td>Collaboratively Set Goals</td>
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<td>Provide information and training to patients</td>
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<td>Create an Action Plan</td>
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<td>Link patients with system and community resources</td>
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<td>Proactive follow up</td>
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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 and analysis 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*
“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
Leaves with scripts, referrals, and instructions
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

BACKGROUND

BARRIERS

SUCCESSES

ILLNESS...  

ACTION PLAN

REMEMBER

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
Population Management Work Flow

Start

**Program Assistant**: Prints structured worksheets containing CV risk factor information including:
- Labs
- Medications
- Blood pressure
- Immunizations
- Allergies
- PCP visit info
- Care Management or classes

**MD**: Reviews worksheets, identifies appropriate interventions, and 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 10-20 min/pt

**Program Assistant**: Enters information regarding follow-up interval into a tracking system. And 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
Self-Management Support – 5A’s

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

**Assess** READINESS to Change
- Not ready
- Unsure
- Ready

IMPORTANCE in relation to other values
- Low
- Medium
- High

CONFIDENCE of success
- Low
- Medium
- 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: □ Phone__________ □ Other _________
   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: □ Phone__________ □ Other _________
Follow-up Signature:_______________________

*Required to bill Wellmark (Individual visit - S9445)
Whatcom County and Beyond

- PatientPowered.org
- Web platform
- Health 2.0
- http://www.patientslikeme.com/
Support in the Community
What Determines Population Health? Not Just Medical Care!
Academic Medical Center
Patient Council
Develop training and educational materials
Developing Bulletin Boards
Designing charting and documentation forms
Participating in the design of Web sites
Improving the Patient Portal to EMR
“Academic Detailing”
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.
Participating on the QI team, teaching classes in the Healthier Living Series, and training peer support group facilitators.
What is the work of the medical home?

**Improving Health Behaviors**

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

**REACTIVE**
- Diagnosis and Treatment based on medical S & S
- “Chief Complaint”

**PROACTIVE**
- Looking for “medical risk” populations to target outreach
- “scrubbing” the panel for care needs
- Population-based prevention and promotion

**Better Health Outcomes**

*NEW HEALTH PARTNERSHIPS*

*IMPROVING CARE BY ENGAGING PATIENTS*
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
  - Supports providers with systems and resources to make the right thing easier
# Care Segmentation Tool

## Disease or Condition:

<table>
<thead>
<tr>
<th>Degree Of Self-Management Chosen By Patient</th>
<th>Degree of Disease Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mild</td>
</tr>
<tr>
<td>High “self care” (Very confident)</td>
<td>Vigorous activity limited</td>
</tr>
<tr>
<td>Medium “shared care” (Somewhat confident)</td>
<td></td>
</tr>
<tr>
<td>Low “delegated care” (Not confident)</td>
<td></td>
</tr>
</tbody>
</table>
Opportunities to Implement Interventions to Promote System Change

• Before the Encounter

• During the Encounter

• After the Encounter

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

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

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
Resources

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