

# New Health Partnerships: Improving Care by Engaging Patients

*Doriane C. Miller, MD*

*National Program Director*

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# Learning Objectives

- Definition of Collaborative Self-Management Support (CSMS)
- Evidence base for efficacy
- Gaps in Practice
- Linkage to patient centered care
- Role of CSMS in quality improvement
- Understand the business case for CSMS

# Collaborative Self-Management Support: Definition

- Collaborative goal setting and shared decision making
- Regular follow-up, monitor and assess progress towards goals, relating plans to patient's social and cultural environment
- Tracking and ensuring implementation, including linking support programs to the individual's regular source of medical care and monitoring their effects on a patient's health

# Institute of Medicine

## Patient Centeredness and Quality of Care

- Crossing the Quality Chasm: safe, effective, timely, efficient, equitable and patient-centered
- Patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions
- Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes

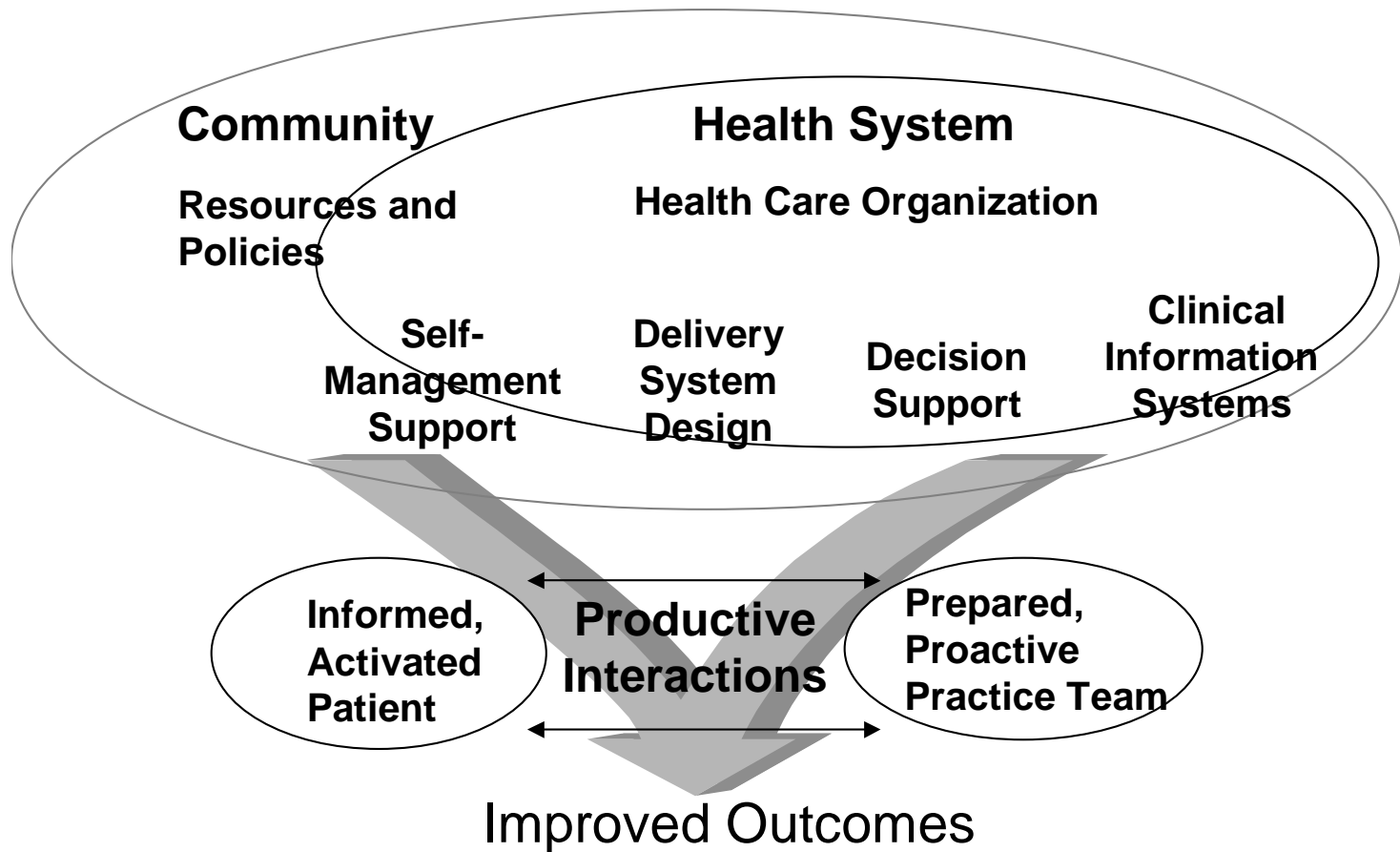
# Evidence Base for Self-Management Support

- **Lorig KR, Sobel DS, Stewart AL *et al.* Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial. Med Care 1999; 37(1):5-14.**
- Heterogenous group of patients with CHF, arthritis, chronic lung disease and stroke
- Six month trial participating in chronic disease self-management program
- Improvements in cognitive symptom management, health distress, communication with provider
- Fewer hospitalizations and days in the hospital

# Evidence Base for Self-Management Support

- **Lorig KR, Ritter P, Stewart AL *et al.* Chronic disease self-management program: 2-year health status and health care utilization outcomes.** Med Care 2001; 39(11):1217-23.
- Longitudinal study, following patients who participated in 6 months chronic disease self-management program
- Patients able to maintain gains of reduced ED and hospitalizations
- Improved quality of life

# Chronic Care Model



# Promoting Self-Management Support in the Chronic Care Model: Evidence of Outcomes

- Review of 4 of CCM components of 39 studies on diabetes
- Analysis of interventions based on presence of self-management, clinical information systems, delivery system redesign, decision support
- No single component emerged as essential or superfluous
- 19 out of 20 interventions with improved processes or outcomes of care included self-management support

Bodenheimer, et.al. JAMA, October, 2002.

# NCQA Criteria: Patient Centered Medical Home

- Access and Communication
- Patient Tracking and Registry
- Care Management
- **Patient Self-Management Support**
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communication

# Gaps in Practice

- Provider lack of awareness/skills
- Provider doubt about effectiveness
- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients inadequately supported to manage their illnesses

# Missed Opportunities to Engage Patient in Care

2004 Commonwealth Fund International Health Policy Survey

Percent saying doctor	AU	CA	NZ	UK	US
Does NOT give clear instructions	10	12	8	13	13
Does NOT make goals and plans clear	14	15	13	19	20
Does NOT tell you about treatment choices or ask for your opinion	35	35	30	50	44

# Self-Management Support and The Planned Care Model

- Delivery system redesign: assure delivery of effective and efficient clinical care and self-mgt
- Decision support: promote SMS consistent with scientific evidence and patient preferences
- Clinical information systems: organize pt and population data to facilitate SMS
- Health care organization: create a culture, organization and mechanisms that promote SMS
- Community: mobilize community resources to promote SMS

# Learning Collaboratives 1 & 2

- 7-11 months
- 26 teams: rural/urban, ethnic mix, condition-specific and cross-cutting projects, safety net and FFS
- Core competencies, system redesign, IT, community linkages
- Business Case
- Patient and/or family involvement

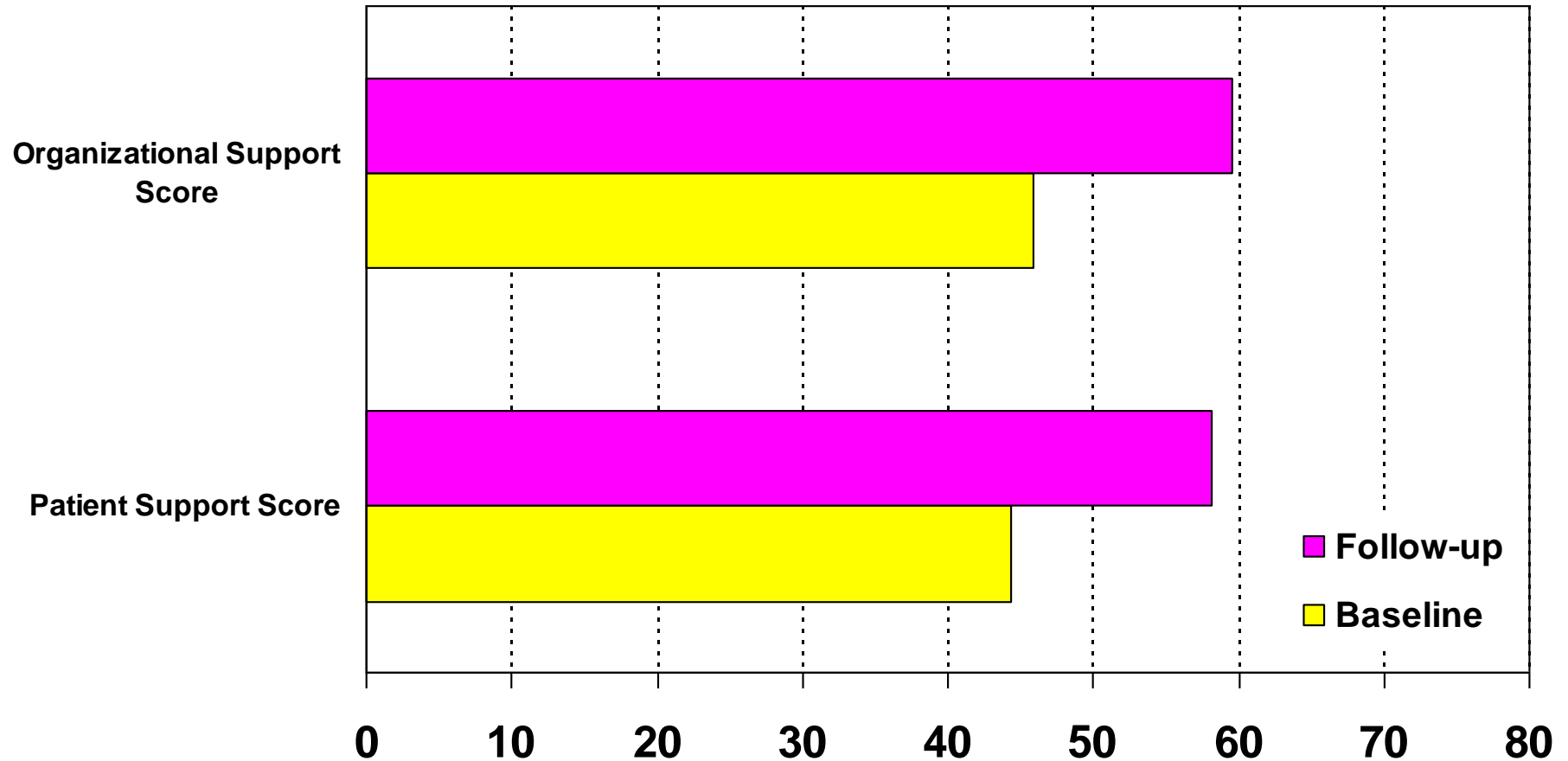
# Learning Community

## Primary Care Resources and Supports Survey

### 3 Measures with Greatest Change -- Baseline to Follow-up

- Goal setting (patient support measure)
- System for documenting self-management support services (organizational support measure)
- Integration of SMS into primary care (organizational support measure)

# Learning Community Primary Care Resources and Supports Survey



- n=20 sites at baseline; n=18 sites at follow-up
- All pre/post changes significant at  $p < .01$

# Results

- Sustained trends in documented patient self-management goals
- Spread of self-management support training within practice groups
- Robust practice models for adoption/replication in varied settings
- Business case for safety net and fee-for-service
- Inclusion of patient/family in program and policy-level decisions in the health care organization

# Provider-Patient Projects

- Fargo Health Center: Patient-Provider webportal and blog for diabetes
- Cambridge Health Alliance: Community Resources brochure and audiotape (literacy and multiple languages)
- Medical College of Georgia: Patient Peer Trainers for self-management support web portal for multiple sclerosis patients

# Information Sharing

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## “Doc Talk” Card



**Things to ask my doctor:**

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**Current Symptoms:**

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**The medications I am currently taking:**

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**Instructions from my doctor:**

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**Follow-up appointment:**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Location: \_\_\_\_\_

**If I have a problem or questions, I should call:**

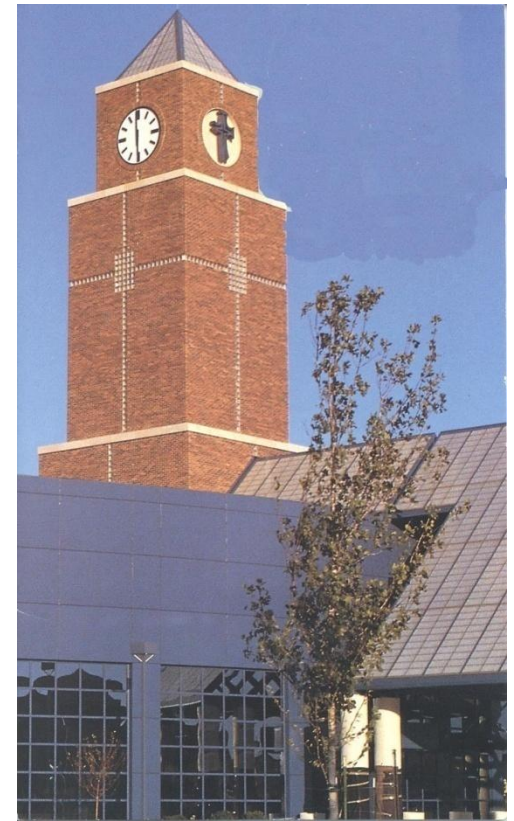
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# Virtual Communities for Patients and Providers

- Web-based resource center for patients and providers
- Content regularly reviewed and refreshed by expert faculty
- Web conferences and monitored discussion groups
- Common portal of entry for patients and providers
- User groups delivery systems, patient advocacy groups
- Endorsements via purchaser/payers, professional societies, patient advocacy groups
- Launched Fall 2006, v 2.0 completed May 2008
- Merger with revised IHI.org projected July 2009

# Mercy Clinics, Inc.

- Des Moines, IA & suburbs
- 27 Clinics, 140 Physicians
  - 70% Primary Care
- 793,000 patient visits in FY06
- 100% Fee-for-Service
- Virtual Private Practice
  - All revenue & expenses are tracked to individual doctors
  - The difference is the doctors' salary



# Population Health Coach

- MCI has 14 full time Health Coaches
- Must be RNs
- Group training for 2 hours twice a month
  - How to use registries
  - Health Behavior Change
  - Change concepts using PDSA cycles
  - Shared Medical Appointments workshops
  - Diabetes management classes
  - Medication Adherence
  - Depression Screening
  - Health Literacy

# Health Coach Job Description

## Five Essential Functions:

- Oversees the **disease registry** database...
- Conducts **pre-visit chart review**...
- Works with patients and families on **Self-Management Support**...
- **Coordination of Care** across the care continuum...
- Involvement in **QI activities**...

# Coaches Oversee the Registry

- Make sure data is entered into the registry
- Contact patients overdue for visits or not meeting goals (*opportunities list*)
  - 90% of patients respond positively
- Review performance report outcomes

*“A Registry is the single most important step to improve chronic care”*

# Pre-visit chart Review

## *Coaches plan the visit*

- Health Coaches review the charts of patients before the patient is seen
  - Review for chronic disease standards of care, Preventive health care, immunizations
- Labs and referrals are done before the patient is seen – *(based on standing orders)*
  - More effective than doctor review and frees up doctor time

# Self-Management Support

- Health Behavior change
  - 5A's: Assess, Advise, Agree, Assist, Arrange
- Medication Adherence
  - Only 40% of MCI patients are highly adherent
  - Major area for health behavior change
- Didactic Education
  - Provided or arranged by Health Coaches
- Shared Medical Appointments
- Liaison between the patient and care team

# Health Behavior change

- The patient sets the goals for improving health
- Assess
  - Readiness for change
  - Importance of change
  - Confidence of success
- Assist the patient to create a plan for change
  - Identify barriers and plans to overcome them
- Follow-up is done by phone in 1 week

### 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-elicite):

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

**Dealing with  
resistance**

- 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: \_\_\_\_\_

# MCI Self- Management Support Encounter Form

# SECAT Performance Reports

## South

Jan-07

### ALL Diabetes Data: February 1, 2006 - January 31, 2007

Provider	Agey	Borchardt	Brightwell	Brown	Evert	Herman	McCoy	Zachary	Zea	Goal
Total Patients	95	125	47	148	98	7	127	60	16	
<b>Process goals:</b>										
HgA1c last 12 mo.	98%	95%	94%	98%	95%	100%	93%	100%	100%	94%
LDL last 12 mo.	94%	96%	91%	97%	89%	100%	93%	98%	100%	94%
SBP last 12 mo.	97%	96%	94%	98%	94%	100%	93%	100%	100%	94%
Microalb last 12 mo.	76%	74%	83%	90%	83%	100%	75%	87%	88%	90%
DRE last 12 mo.	25%	19%	9%	32%	31%	0%	33%	37%	19%	70%
<b>Outcome goals:</b>										
% HgA1c < 8.0	89%	93%	88%	90%	81%	71%	87%	90%	75%	75%
% HgA1c < 7.0	64%	73%	65%	71%	56%	57%	67%	58%	62%	50%
% LDL < 130	88%	94%	98%	93%	90%	86%	96%	96%	94%	75%
% LDL < 100	60%	76%	77%	71%	67%	43%	80%	81%	63%	65%
% SBP < 140	95%	84%	95%	92%	89%	86%	94%	85%	100%	70%
% SBP < 130	70%	60%	70%	60%	64%	86%	75%	57%	75%	65%

# Financial Case

10 providers & 1.6 FTE Health Coaches

<u>North Clinic - Diabetes Visits</u>				<b>Coach Introduced</b>	
	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007 annualized</u>
Total Diabetes Visits	733	824	881	1334	1446
Per Cent 99214	47%	62%	58%	62%	67%
Weighted average charge / visit	\$105	\$113	\$111	\$113	\$115
Total Diabetes EM Charges	\$76,769	\$92,746	\$97,546	\$150,523	\$166,516
Microalbumin	365	479	739	2058	2,083
UACR charges	\$10,950	\$14,370	\$22,170	\$61,740	\$62,498
HgA1c	1274	1389	1384	2024	2135
HgA1c charges	\$34,398	\$37,503	\$37,368	\$54,648	\$57,642
<b>Total Office DM charges</b>	<b>\$122,117</b>	<b>\$144,619</b>	<b>\$157,084</b>	<b>\$266,911</b>	<b>\$286,656</b>
Yearly Gross Differential		\$22,502	\$12,465	\$109,827	\$19,745
<b>Yearly Net Differential</b>		<b>\$15,751</b>	<b>\$8,726</b>	<b>\$76,879</b>	<b>\$13,821</b>

# 2006 North Clinic Health Coach Financial Summary

## Revenue

EM visit & lab differential	\$76,879
Level 1 visits (1801 * \$25)	\$45,025
Offset Dr. & Nurse work	\$15,183
P4P - 2006 actually paid	<u>\$114,000</u>
<b>Total Revenue</b>	<b>\$251,087</b>

## Comments

1801 visits @ \$25 net estimate is probably low

## Expenses

Health Coach Salary - RN-II	\$36,728	0.7 time salary & benefits
Health Coach Salary - LPN	\$36,434	0.9 time salary & benefits
Differential Microalbumin cost	\$ 9,932	\$6.29 for 1579 tests
Differential HgA1cost	<u>\$ 4,763</u>	\$7.50 for 635 tests
<b>Total Expenses</b>	<b>\$87,856</b>	

**Contribution to Overhead      \$163,231**

# For more information...

- [www.newhealthpartnerships.org](http://www.newhealthpartnerships.org)