



Safety Net Medical Home Initiative: *Transforming Practices into Medical Homes*

PCI Pt. 2: Self-Management Support in the PCMH

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with Guest Speakers:

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- **Emily Montoya, Registered Dietician, High Plains Community Health Center, CO**
- **Dawn Heffernan, RN, MS, CDE, Diabetes Program Manager, Holyoke Health Center, MA**
- **Michael Meza, MD, Clearwater Valley Hospital, Orofino, ID**
- **Joan Pernice, RNC, MS, Clinical Health Affairs Director, Massachusetts League of Community Health Centers**



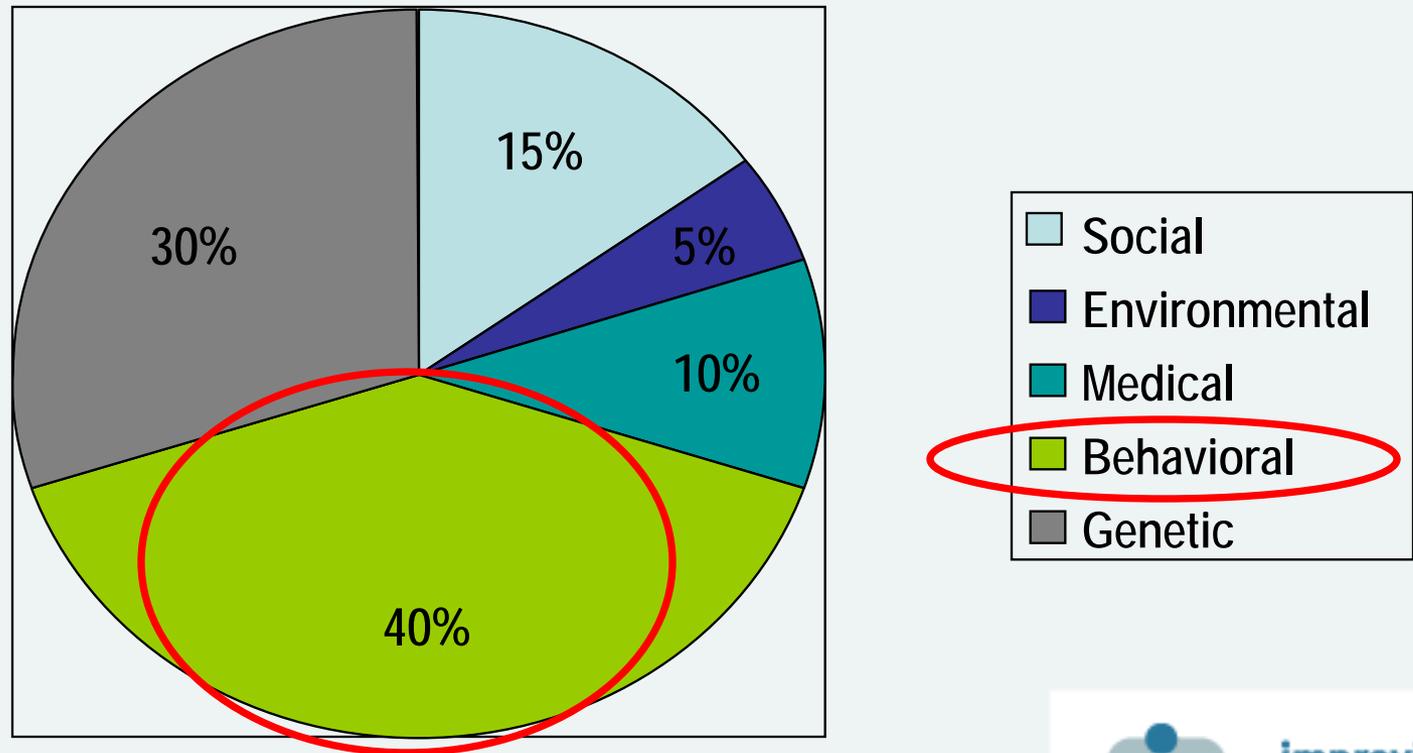
Patient-Centered Interactions: Self-Management Support

Judith Schaefer, MPH
MacColl Institute

**Commonwealth Safety Net
Medical Home Initiative
October 28, 2010**



Determinants of Health and Their Contribution to Premature Death



Schroeder, NEJM 357; 12



Change Concept: Patient-Centered Interactions

- **Respect** patient and family values and expressed needs.
- Encourage patients to **expand their role** in decision-making, health-related behaviors, and **self-management**.
- **Communicate** with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.
- Provide self-management support at every visit through **goal setting and action planning**.



What is Self-Management Support?

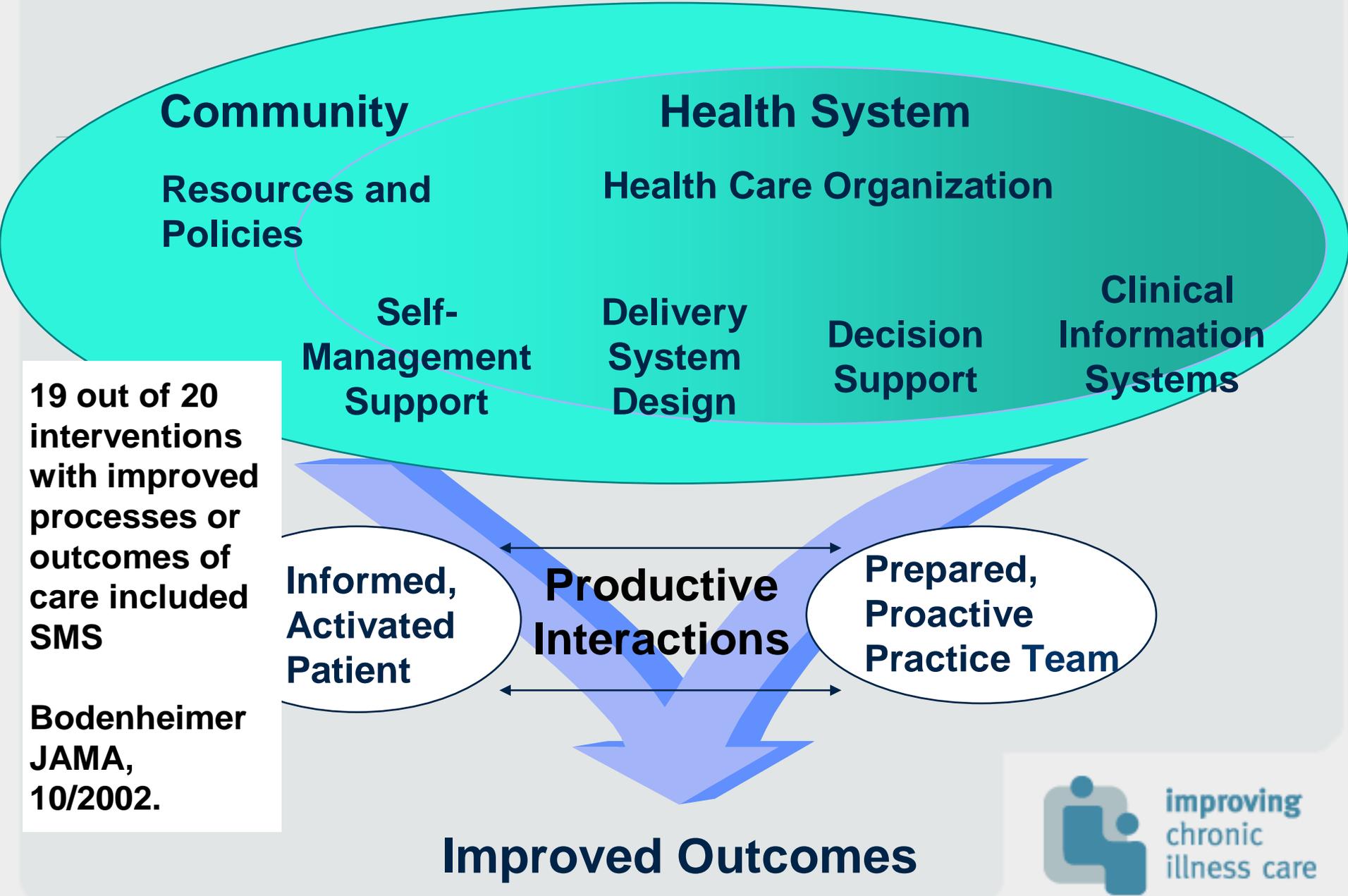
The goal of self management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment.

It can be viewed in two ways: as a portfolio of techniques and tools; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership.

Adapted from Bodenheimer, CHCF, 2005



Care Model



19 out of 20 interventions with improved processes or outcomes of care included SMS

Bodenheimer JAMA, 10/2002.



Collaborative Self-Management Support: Core Competencies

- Assessing patients' needs, expectations and values
- Collaboratively setting an agenda for the visit
- Sharing information effectively
- Doing collaborative goal setting, action planning and problem solving
- Providing ongoing follow-up and support



Collaborative Care: Cycle of Self-Management Support



"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

Key SMS Components

- “Nothing about me without me” - include patient values and experiences in all care interactions
- Organize SMS roles and distribute tasks among your health care team
- Train care team to use motivational techniques
- Document and share a plan of care so patients know what to expect and what to do, and follow up has context
- Sustain support with planned problem solving follow up



The Safety Net Medical Home Initiative

***Patient support
groups***

***Test results
automatically
sent to patients
in advance of
appointment***

Agenda cards

***Group
appointments***

***Health coach as
part of the team***

System Supports:

**“Making the right thing to do
the easy thing to do”**

***Telephone and
e-mail follow-up***

***Menu of
community
services***

***Computer
prompts for goals***



**improving
chronic
illness care**

Online Resources

- <http://www.newhealthpartnerships.org>
- <http://www.chcf.org/topics/chronicdisease>
- <http://www.improvingchroniccare.org>
- <http://patienteducation.stanford.edu/>



The Safety Net Medical Home Initiative



HIGH PLAINS COMMUNITY HEALTH

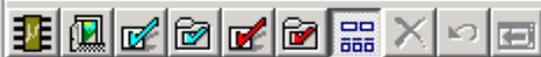
Monette Sutphin, Operations Officer

Emily Montoya, Registered Dietician

HIGH PLAINS COMMUNITY HEALTH

- ✘ Rural, agriculture area in SE Colorado
- ✘ In 2009, served 7,814 patients / 27,878 visits
- ✘ 3 MD's, 4 mid-levels, 2 dentists, 2 hygienists
- ✘ Have been involved in HD Collaboratives since 1999
- ✘ Office redesign 2002
- ✘ Patient facilitators & cross-training







Age/Sex Specific | DM/HTN/Asthma/Depression | **SMG** | PHQ-9 | Mood Questions | SBIRT Brief Screen

PATIENT GOALS

- Patient Goals - Keep Fasting Blood Sugar Under 130 or A1C < 6.5.
- Patient Goals - Begin Regular Exercise, ___ times Per Week
- Patient Goals- Take Medications as directed
- Diabetic Diet _Low Fat
- Patient Goals - Decrease Weight By ___ (lbs)
- Start taking aspirin 81 mg daily
- Patient Goals - Cut Smoking To Zero Packs Per Day
- Annual Othamology/Retinal Exam
- Patient Goals - Keep Fasting Blood Sugar Under (70-180).
- Patient Goals- to improve my food choices
- Patient Goals reduce stress

- Patient Goals check feet daily
- Spiritual Counseling or Pastoral Care
- Psychological Counseling
- Other Patient Goals

What goal:
How much:
How often:

The patient states that the level of confidence is a ___ on a one to ten scale that they will be able to acheive this goal.

- Asthma SM Goals**
- Patient Education - Action Plan Asthma
 - Environmental Control Measures
 - Abstinence From Smoking
 - Avoid Exposure Allergens
 - Avoid Exposure Triggers

96% of DM & CVD patients have Self Mgmt Goal

Health Educator SM Goal F/U

Entry details for current selection

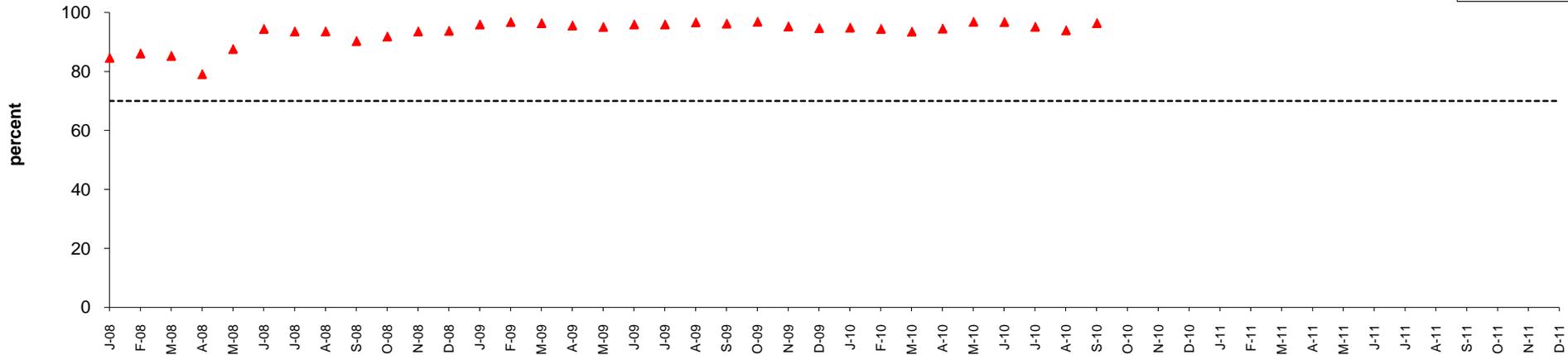
Prefix Modifier Result Status Episode Onset Duration Value

WHY HEALTH COACHES?

Percent of DM Patients with Self Management Goal Setting

96.5

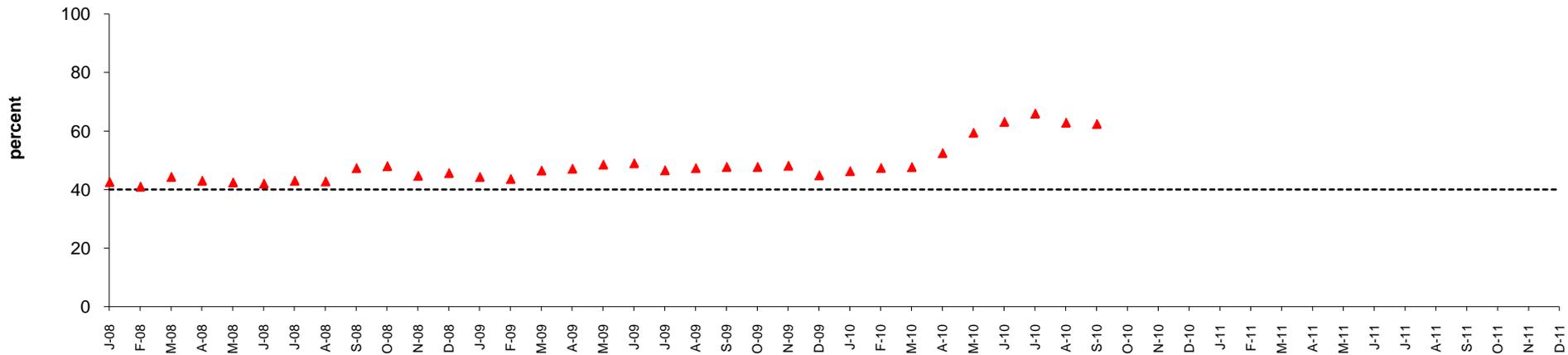
▲ Total



Percent DM patients with BP < 130/80 (12 months)

62.9

▲ Total



FUNDING, RECRUITMENT, & TRAINING

- × 2 funding sources:
 - + Federal: HRSA Outreach grant
 - + State: Office of Health Disparities grant
- × Recruitment: growing our own experts
- × Training:
 - + Motivational Interviewing
 - + Consistent messaging

ROLE OF A HEALTH COACH

- ✘ Health coach interaction initiated by provider
 - + Provider communicates with HC—provides some focus for the interaction.
- ✘ Patient Centered:
 - + What is the one thing you would really like to work on right now to improve your health?
 - + What is the hardest part about taking care of your diabetes right now?

ROLE OF A HEALTH COACH

- × **Collaborate** to set Self-Management Goal
- × **Create** action plan
- × **Assess** barriers
- × **Connect** to clinic and community resources
- × **Support** change: follow-up
- × **Provide** patient education and skill building

CONNECTIONS TO RESOURCES

Plan and Return | Consults | **CLASSES/RESOURCES** | Instructions/Goals | Fitness RX | Outline View

REFERRAL RESOURCES

Diabetes Class

Aug 12 and 19, Sept 16 and 23, Thursdays Part 1- What Is Diabetes and How to Care For It by Mary Shy, FNP and Certified Diabetes Educator. Part 2- How to Eat Right for Diabetes by Emily Montoya, Registered Dietitian.

Nutrition Class

By Emily Montoya, Registered Dietician. FREE! 5:45-7:30, OCT 7-HEARTY HEATING, Oct 14 FAMILY FEAST, Nov 18, HEART HEALTH, Food and recipes provided.

Healthier Living Colorado Classes

FREE 6 week class. Patients get help with the challenges of living with an ongoing condition like heart disease, lung disease, diabetes, or arthritis. Helps patients cope with fatigue, frustration, pain, and stress.

Tomando Control Classes

FREE SPANISH 6 week class 5:30-8 pm. Patients get help with the challenges of living with an ongoing condition like heart disease, lung disease, diabetes, or arthritis. Helps patients cope with fatigue, frustration, pain, and stress.

Silver Sneakers

Tues and Thurs 9-10 am LCC Fitness Center. Muscular strength, range of motion, activity for daily living skills, hand held weights, elastic tubing with handles, resistance ball. A chair is used for seated and/or standing support. \$37.12 /4 mos. FREE w Mcaire + AARP, Humana, Secure Horizons

Saturday Stroll

LCC Fitness Center

Lamar Community Bldg Workouts

Community Building Punch Card

Tobacco Cessation

Patient Navigator

Kacee Lucero, Heart Smart Patient Navigator, helps patients overcome barriers to medical care, assists with making appointments, paying for medications, and finding resources for patients.

Community Health Worker

Crystal Cook, Community Health Worker, provides community outreach and education, helps community members better manage and understand their chronic conditions, and provides info on cardiac risk, blood pressure checks, and FREE cholesterol screenings.

Registered Dietitian

Meet one on one with Emily Montoya, Registered Dietician, to learn how food choices play a role in energy level, bone health, weight management, and risk for heart disease, diabetes, and some cancers.

SBIRT Health Educator

Meet one on one with Lisa Thomas, SBIRT Health Educator, to learn healthy levels of alcohol use, alcohol and substance use risk to health, education about substance use, and, if necessary, referral to treatment.

Health Coach

Hispanic Health Coach

Culturally competent assistance for Spanish speaking patient who need help with SM goals, education, and removal of barriers to better health

Prowers Co Community Referral Team

CERT: Assistance for you, your child, your family or someone you care about. Amy Hobbs, Project Coordinator, will help families with info about services in Prowers County, referrals, advocacy, case management, planning and problem-solving.

Outreach Department

Becky Olivas and Maura Gonzales enroll eligible patients into assistance programs: CACP, HPC Slide, Migrant, Women's Wellness Connection, Medicaid, CHP+, and OB programs.

Compassionate Drug Program

Pharmaceutical companies offer many assistance programs for patients who cannot afford their medications. See Rome in our dispensary.

Mental Health

Mental Health Clinician, sees patients in our main medical facility to integrate physical and behavioral health.

Provider Appointment

Other: FREE TEXT

Dentist / Dental Care

A healthy mouth is important for overall health. Some chronic diseases cause poor dental health and poor dental health contributes to some chronic diseases. See a dentist regularly

Dawn Heffernan, RN, MS, CDE
Diabetes Program Manager
Dawn.heffernan@hhcinc.org



Holyoke Health Center: Self-Management and the Medical Home

- JCAHO accredited
- Federally Qualified CHC
- Western Massachusetts
- 23,000 patients
- 93,000 patient visits/year
- 256 employees & volunteers
 - ✓ 29 medical providers
 - ✓ 4 dentists
 - ✓ On-site retail pharmacy

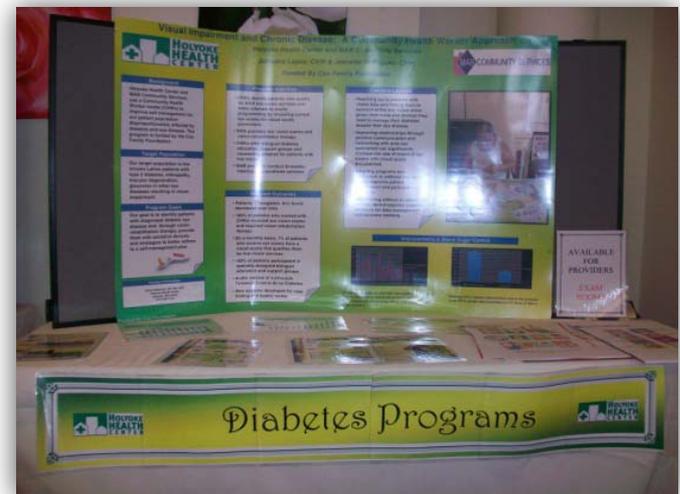


- One of the highest diabetes mortality rates in Massachusetts
- Nearly 100% of our patients live at or below the poverty level



Developmental History of the Diabetes Self-Management Programs

- 1999 Bureau of Primary Care Health Disparities Collaborative
- 2003 Robert Wood Johnson Diabetes Initiative
- Massachusetts Department of Public Health
- Cox Foundation
- NIH Diabetes Case Management R01



Diabetes Self-Management Programs

- Stanford Diabetes CDSM 6 weeks 2 112 hrs peer led programs
- Breakfast Club with Healthy*i*/Merck Diabetes Conversation Maps curriculum
8-10 weeks
- Twice a month Diabetes Support Group and Snack Club
- Daily onsite exercise program
- Supermarket Tours
- Healthy Weight Program
- Community Health Workers/Mentors
- Individual appointments with diabetes educators and nutritionist
- Medication Therapy Management

Self Management: One Patient's Story - "Doña Sonrisa"

"Damaris spoke with me on the phone several times to invite me to the diabetes programs and I politely listened. I thought, I have had diabetes for years, what can they teach me?"

But one day, I went to my doctor and my doctor told me, your A1c is 10.9 and your diabetes is totally out of control.

This was my wake up call. I knew I had to do something or I would be dead soon."

Patients Self-Management Participation: Tomando Control de Su Diabetes

- January 12, 2010 – February 23 2010
- Stanford Diabetes Chronic Disease Self-Management Program (Tomando Control de Su Salud)
- Six, two hour sessions
- Intervention Focus
 - Goal Setting
 - Problem Solving
 - Cognitive Techniques
 - Breathing Techniques

“I opened my mind. Let me see what they have to say”



Breakfast Club



“The first class was so successful, I decided to take the Breakfast Club.”

Patient Self-Management Participation

- June- August 2010 Breakfast Club with Supermarket Tour
- Eight - Ten Sessions utilizing Healthyi/Merck Diabetes Conversation Maps
- Nutritious Breakfast
- Correct Portion Sizes
- Balanced Meals
- Variety of Foods
- New food products introduced
- Label reading
- Hands on learning opportunities
- Incentives and raffles



Supermarket Tour offered at the end of the Breakfast Club and Diabetes CDSM



Patient Accomplishments in the Programs

Learning

- Basic Nutrition Concepts
- Strategies to decrease portion sizes
- Blood glucose monitoring and analysis of BG #'s
- Medications (insulin adjustment)
- How to manage moods and stress
- How to reach out and get support

Behavior

- Decreased portion sizes by 50%
- Reduced Sodium consumption dramatically by replacing canned vegetables with frozen
- Read labels to make healthier choices
- Ask for the nutrition facts at local restaurants

Pre Self-Management Program Health Indicators	Current Health Indicators
Ha1c 10.9	Ha1c 6.6
Blood Pressure 152/72	Blood Pressure 132/70
HDL 37	HDL 38
LDL 92	LDL 52
Triglycerides 156	Triglycerides 70
Weight 253	Weight 273.6
Rapid Acting Insulin 20 units before meals	Rapid acting insulin 2-10 units before meals
Lantus Insulin 60 twice a day	Lantus Insulin 60 twice a day

Doña Sonrisa's Story Continues...

Future Plans: Co-facilitate Support Group and Snack Club

Mentors/Volunteers allow patients to continue with their diabetes self-management and give back to the program

Special Training orientation and ongoing supervision are provided

Future Goals: Exercise Program and Weight Loss



Key Resources and Support for Self- Management

- Self-Management is a complex set of behaviors
- Individual assessment
- Collaborative goal setting
- Skills enhancement
- Follow-up and support
- Access to resources in daily life
- Continuity of quality clinical care

Fischer B, Edwin PhD, Brownson A. Carol, et al Ecological Approaches to Self Management. American Journal of Public Health
September 2005, Vol 95, No 9

Dona Sonrisa's Closing Statement

“As long as Holyoke Health Center continues to take my health insurance (and I hope that is forever), I will never change my health center. The care here is very comprehensive, everyone talks to one another, the education is unbelievable, and I have a whole team of people to help me. My eyes are now open and I truly believe these programs have saved my life.”



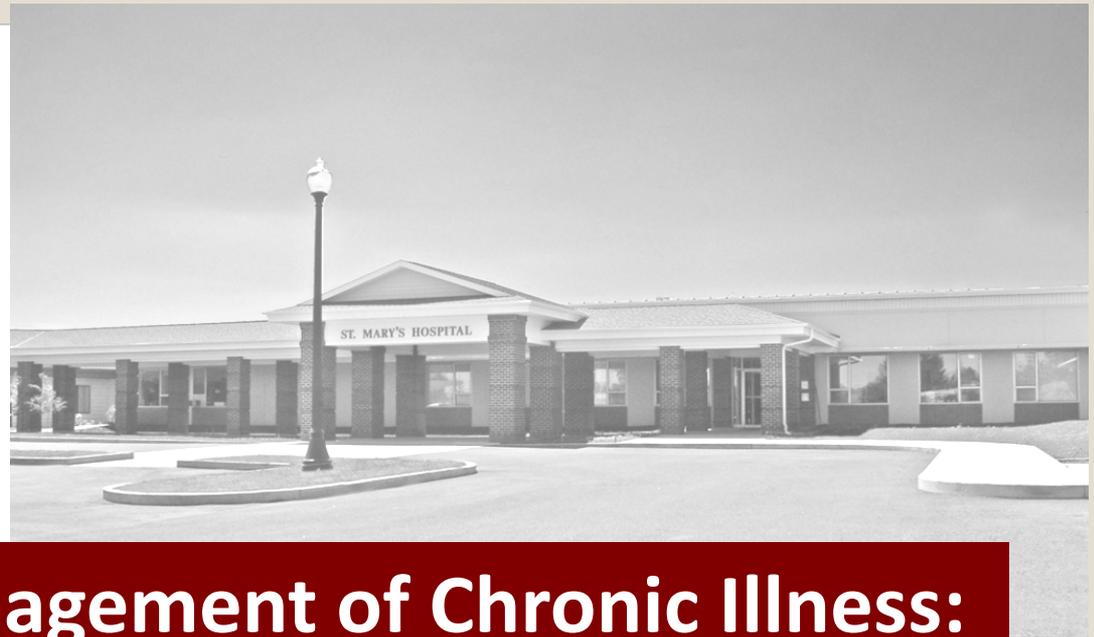
St. Mary's

Hospital and Clinics | Cottonwood, Idaho



Clearwater Valley

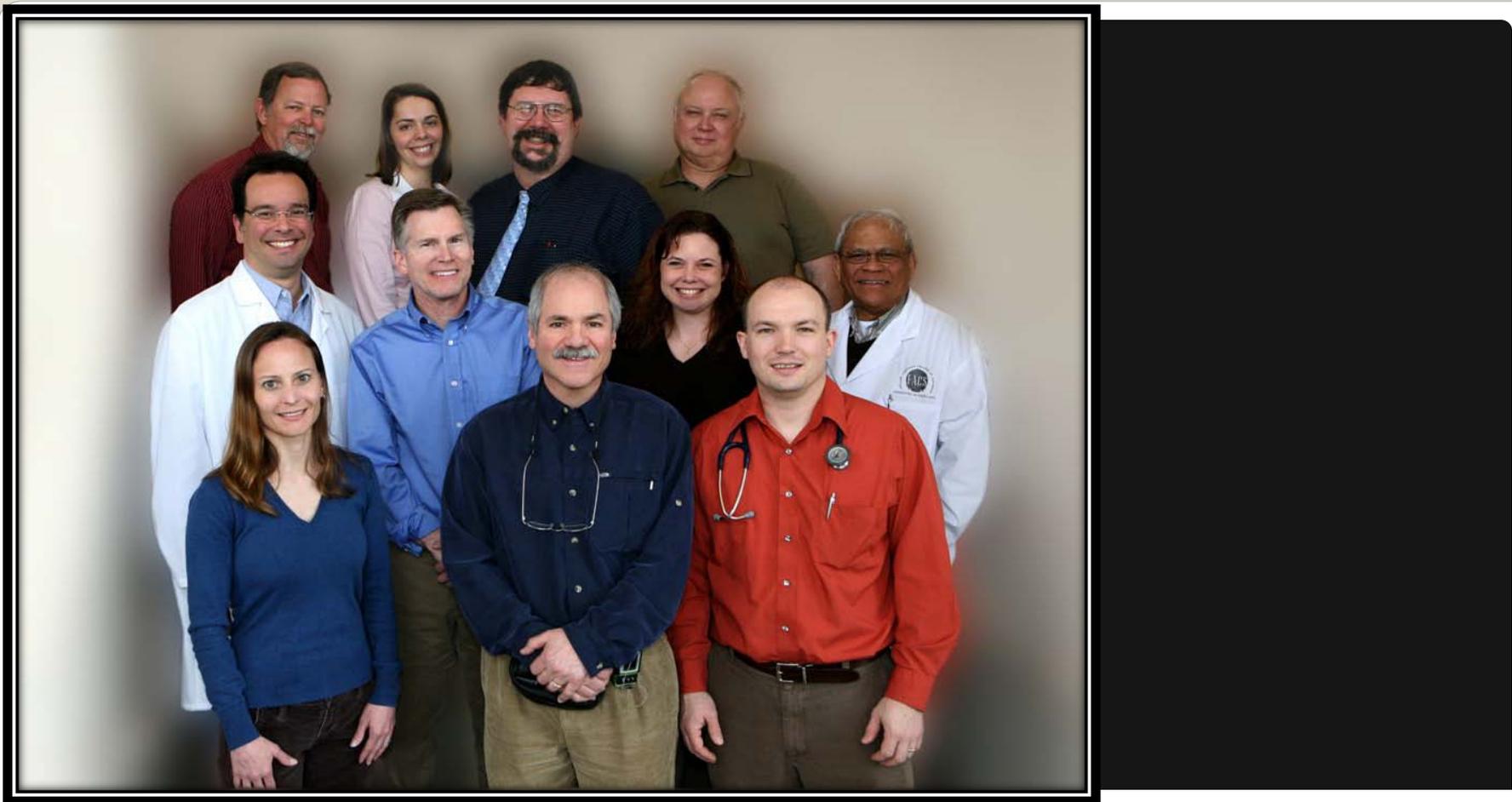
Hospital and Clinics | Orofino, Idaho



Patient Self-Management of Chronic Illness: A Team Approach



Michael Meza, MD
Gary White



The Providers at Clearwater Valley
Hospital & Clinics (CVHC)

- Managing a chronic illness is a time consuming and complex process
- Needed: a new model of care



- The right teacher
- The right time
- The right information



Medical Home Model

- Education and supportive interventions to increase patient skills and confidence
- Regular assessment of progress and problems
- Goal setting
- Problem solving support
- Patient chooses healthy behavior

The Steps

- Meal planning
- Medications
- Carb counting of meals
- Food labels
- Sample menus
- Exercise program

New patient interaction: 90 minutes

- Glucose checks before meals, after meals, at night and record
- Meal logs reviewed
- 2 week follow up appointments

Follow-up: 30-45 minutes

- Essential
- Small Spiral Notepad
- 1 Page = 1 day ease of review
- Date on top of each page
- Time, glucose, meal eaten, # of grms CHO

Logging Results

- Speedometer
- Create a Map
- Patient's Choice: Lifestyle changes or on-going medication
- Monitoring creates map for effective medication management
- No log = no medication change!

**Glucose Monitoring:
How often and why?**

- Care and encouragement helps patients understand their central role in managing their illness
- Patients make informed decisions about care
- Engage in healthy behaviors
- Adapting everyday activities and roles to the condition
- Dealing with the emotions arising from having the condition

Key Points