Making Change – Easier Said Than Done: *It Takes Courage*

Alan Glaseroff MD, CMO
Humboldt IPA
Health Disparities Collaborative
Anaheim, CA 2/27/08

With Many Thanks to:

David S. Sobel, MD, MPH

Director

Patient Education and Health Promotion

The Permanente Medical Group, Inc

Kaiser Permanente Northern California

and

William H. Polonsky, Ph.D Psychology, CDE

Director

Diabetes Behavioral Institute

La Jolla, CA

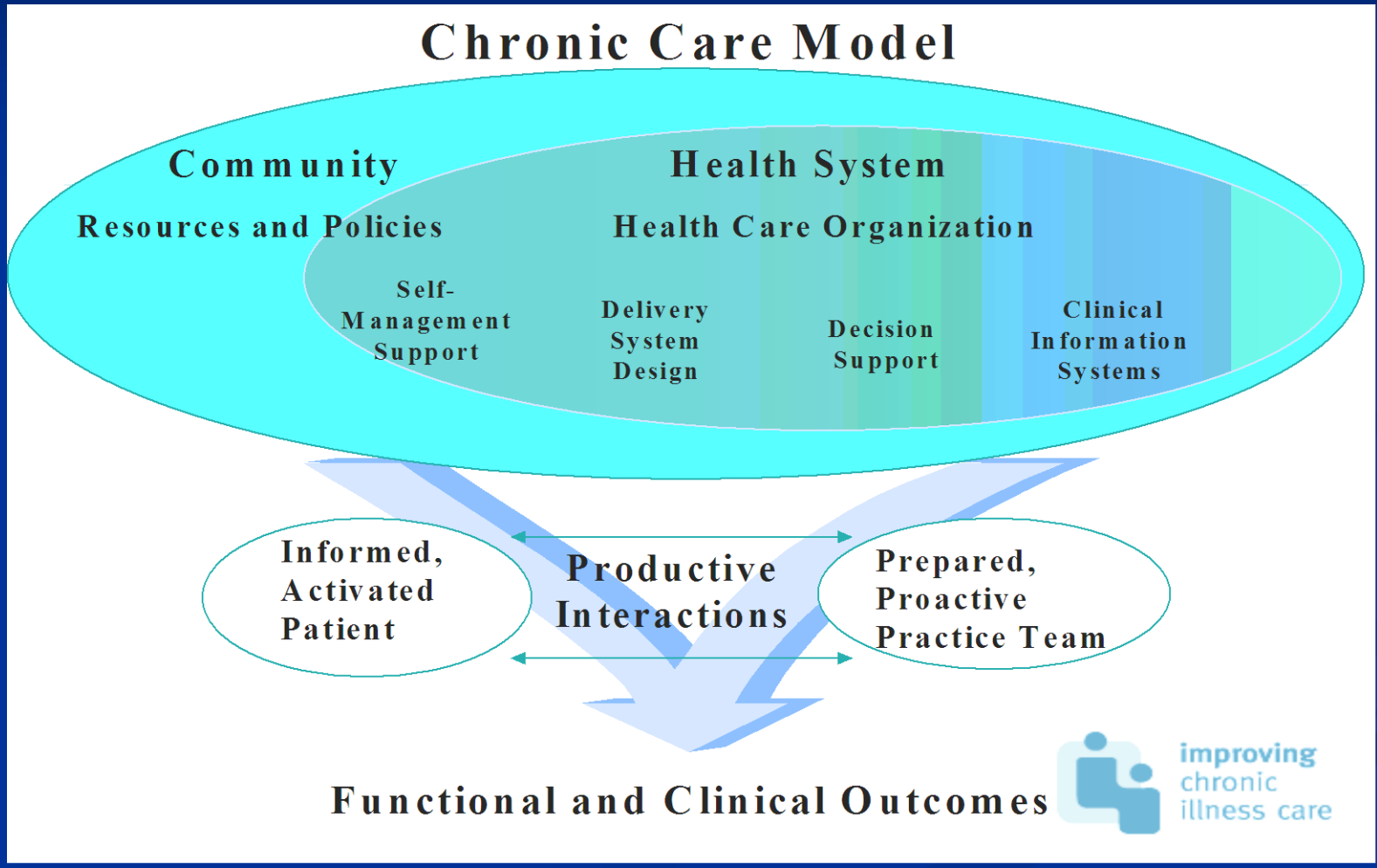
Will *Plus* Vision

- If not now, when?
- If not us, who?
- What to do?

Trust is in the Balance

- *"To shoulder the responsibility to change health care…requires one final element of trust – trust in the workforce…Our premise is this: to achieve the health care we want, we will have to re-envision, and largely retrain, the health care workforce, so that they can become citizens in the improvement of their own work."* Don Berwick 2003

The Wheel Invented!



The Other Three Wheels…

- *"The person who invented the wheel was pretty smart. The person who invented the other three was a genius…*

Uwe Rheinhardt, *health economist*

Brief History

- Humboldt Diabetes Project (CHCF) 2003-2004
- Creating Confidence in Chronic Care (CHCF) 2004-2006
- Quality Allies Learning Community (IHI/CHCF) 2004- 2005
- Humboldt Breast Medicine Project (CHCF) 2004-2006
- Aligning Forces for Quality (RWJ) 2007- present
- End of Life/POLST (CHCF, St Joseph Foundation) starting

Background On HDNIPA

- Started in 1996
- 380 member IPA (240 physicians, 80 mid-levels, 60 mental health professionals)
- <6,000 HMO members, 5,000 PPO and self-insured
- > 95% of all providers ***including safety net***, average practice size 3 MDs
- Rural county the size of Connecticut with 130,000 population
- Generally score high in quality measures and consumer satisfaction

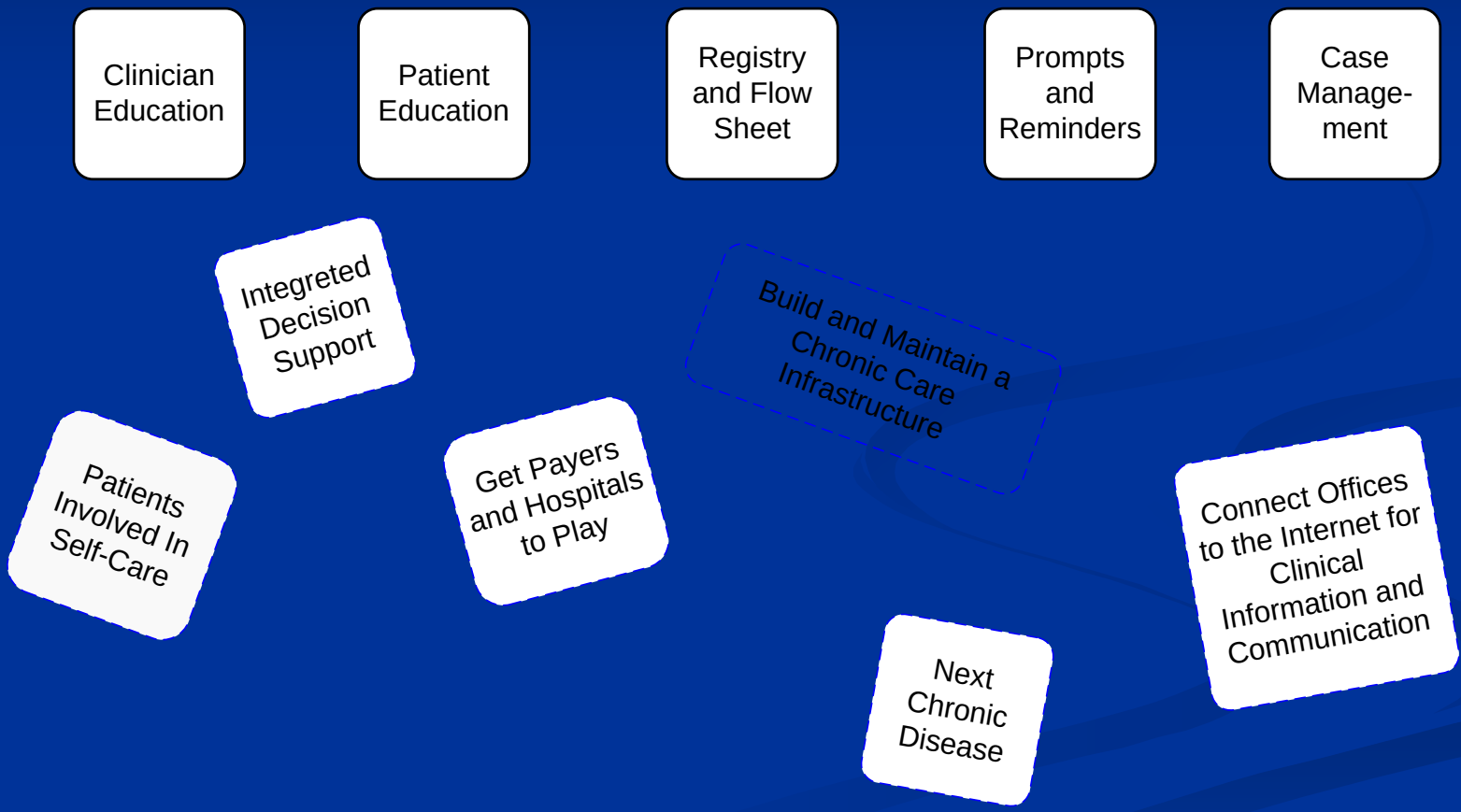
Humboldt Diabetes Project

- CHCF-funded research project started 11/02
- PACES site for International Diabetes Center
- *County-wide effort* coordinated by IPA (>95% of all clinicians in the county, including MDs, advanced-practice clinicians, behavioral health providers) but…
- IPA manages only 10% of lives in Humboldt County (little managed care)
- Solution: *information must come from clinical setting* (too many payers for administrative data solution)
- To accomplish goal, *must win hearts and minds of clinicians* (no "command-and-control")

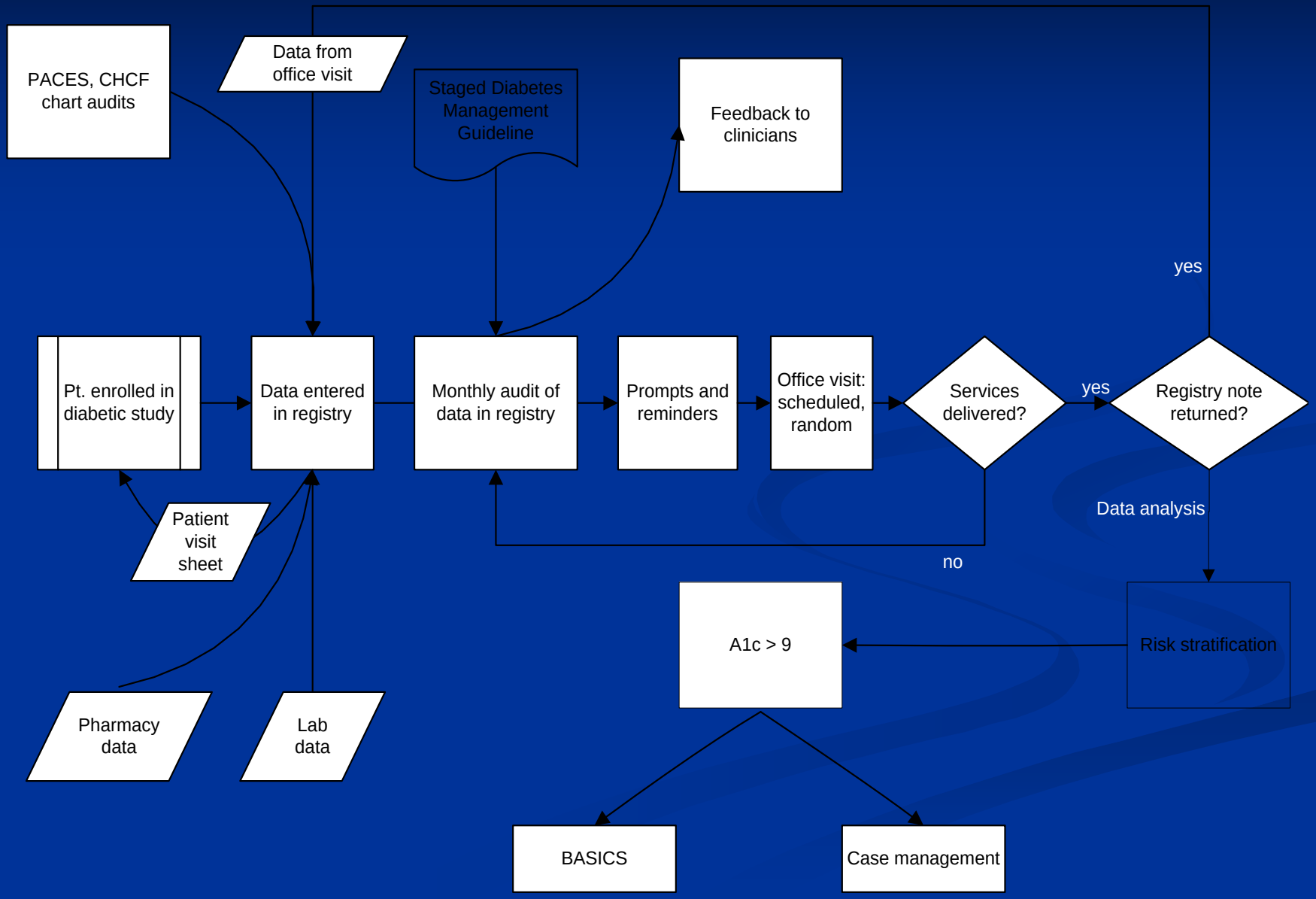
System Design

"Invite the implementers into the planning process..."

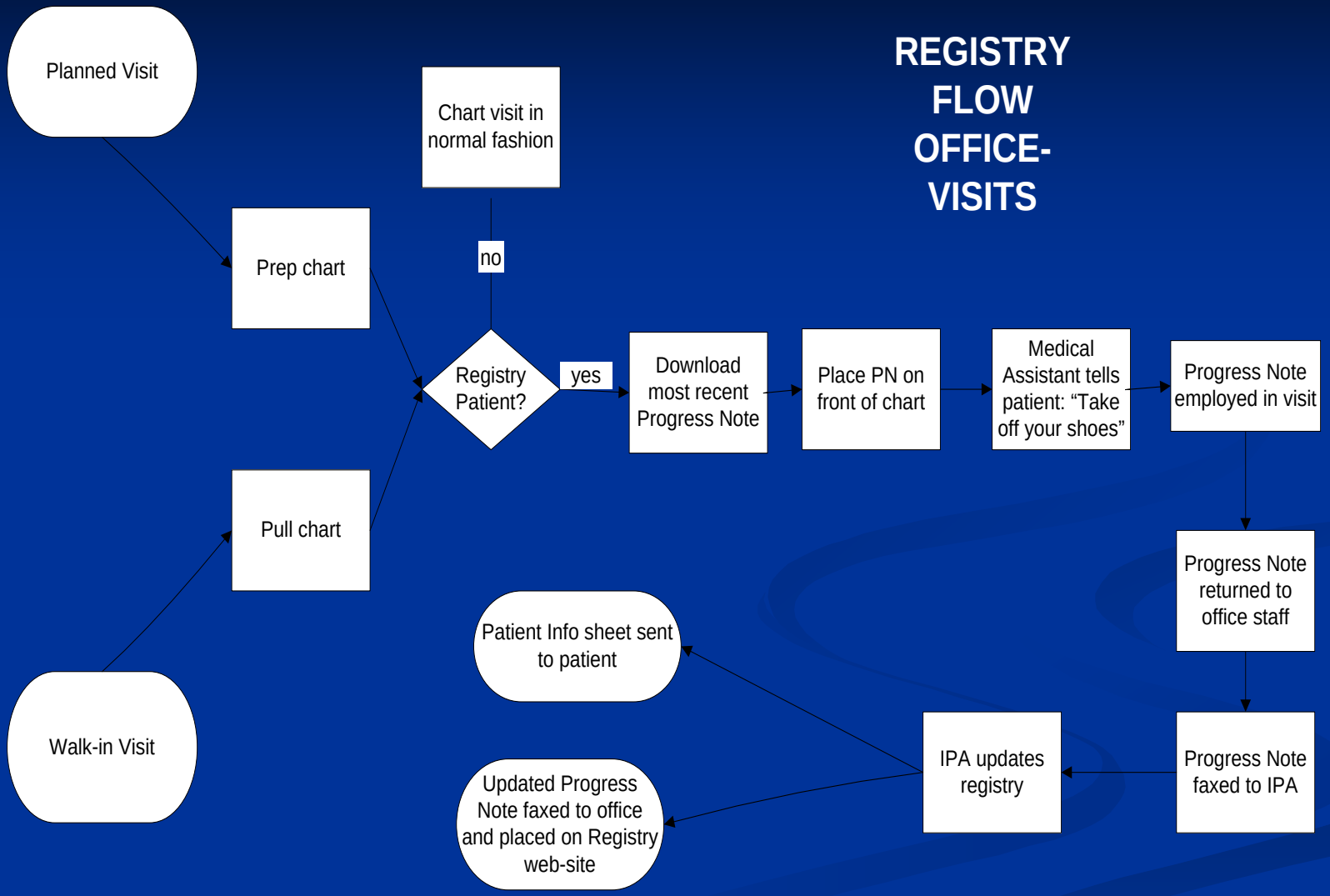
Project Interventions and Support



DIABETIC PROJECT FLOW DIAGRAM



REGISTRY FLOW OFFICE-VISITS



Encounter Note — My Clinic

Encounter Provider		Encounter Type	

Chart #	C-10348	Last	Example6	First	Susan	MI		Age	57
DOB	7/3/1947	Clinic	My Clinic	PCP	Dr. Care	Address	6843 Millwood Dr.		
City	Cedwick	State	TX	Zip	78537	Phone #	(512) 555-5486		
Emer Contact				Emer Contact #		Sex	Female		
Race	Hispanic	Language	Spanish	Homeless	Not Homeless				
Migrant	Not Migrant	Fed Pov Lvl		Insurance	Other				
Insurance Name	Commerical	Case Manager							

Vitals

Vitals	Last Visit	This Visit	Hi
Date	12/12/2003	/ /	
Weight	192.8		
Height	5' 0.0"		
Pulse			
Resp Rate			
Temp			
Systolic BP	134		
Diastolic BP	66		
BMI	37.6		
Waist Circ In.			

Chronic Conditions

Diagnosed Conditions	Dx Date	D/R
DM Type 2	1/12/00	
MicAlburia	1/3/81	
Neuropathy	4/3/02	
Hypertension	8/15/01	
Dyslipidemia	3/8/00	
DepressionNOS	10/3/01	

Potential Conditions	Add
Retinopathy	
Nephropathy	
CAD	
Post-MI	
PAD	
MDD-recurrent	
MDD-single	
Insomnia	
Chronic Pain	

Dx Date=diagnosis date, D/R=diagnosis resolved

Medications

Class	Name	Date	D/C	C/I	Dec
AG Inhibitor	*Class*	8/15/01			
Biguanides	*Glucophage*	2/11/00			
Insulin	*Class*	4/3/02			
Sulfonylurea	*Class*	1/16/02			
TZD/Glitazon	*Class*	11/29/00			
ARB	Class	7/24/02			
Antiplat/Thromb	ASA	1/3/02			
Statins	Class	1/16/02			
Smoke Cess	*Class*	10/3/01			

Other Medications to Consider		Add	C/I	Dec
Beta Blocker	Class			
Diuretic	*Class*			
ACE Inhibitor	Class			
SSRIs	Class			

D/C=discontinue, C/I=contra-indicated, Dec=decline

Laboratory Test Results

Test	Value	Date	PRef	Ref	Dec
HbA1c	12.2	12/12/03			
Chol	220	12/12/03			
LDL	132	12/12/03			
LDL Goal					
HDL	50	12/12/03			

Laboratory Test Results

Test	Value	Date	PRef	Ref	Dec
Triglyc	186	12/12/03			
MiAl/Cr	108.7	12/12/03			
Potassium	4.1	12/12/03			
Creat	0.6	12/12/03			
TSH					
ALT	11	12/12/03			
AST	10	12/12/03			

PRef=previous referral, Ref=referral, Dec=declined

Other Diagnostic Tests

Test	Result	Date	PRef	Ref	Dec
Echo					
EKG					
CardioStrssTes	Negative	5/8/02			
Pap Smear	LSIL	4/19/03			
Mammogram	2-Negati	10/24/02			
Colposcopy	CIN1	8/9/03			
ColonCaScreen	Colonos	3/12/03			

Vaccinations and Immunizations

Vac/Imm	Date	PRef	Ref	Dec
Hep B vac #1				
PPV23				
Flu Vac	12/12/03			
IPV/OPV #1				

Risk Factors

Family History	Status	Y	N	U
FamHxPhysAbuse				
FamHxTrauma				

Behaviors		C	P	N
SM BG	current			
Smoking				
SubstanceAbuse	never			
TobaccoETS				

C=current, P=past, N=never, Y=yes, N=no, U=unknown

Other Measures

Test	Value	Date	PRef	Ref	Dec
Exercise wk	7	11/20/02			
LVEF	50	5/8/02			
CurrentFunction					
Current PHQ					
NewEpiFunction					
New Epi PHQ					

Consults and Education

Cons/Edu	Date	PRef	Ref	Dec
Foot Exam	7/3/02			
DM Edu	6/3/02			
Nutrit Edu	6/3/02			
Retinal Exam	5/28/00			
CVD Educ				
Etoh/Drug Tx				
CSD FU				
Depression Scrn	12/3/01			
Ment Health				
Ca S-D Making				
Pt Mammo Rslts				
Pt Pap Results				
Wt Mgt Plan				
Dental Exam				
PCPDentalCnsl				
AdviseQuitTob	12/12/03			
SM Goal Set	12/12/03			

Other Notes

SM Goal Desc
Meter Type:
Encount Note: private
CSD FU Desc private
Dep Tx Plan:

Reminders

Colon Cancer Screeni	1
No Self Management G	1
Abnormal Pap Requirin	3
Fasting Lipid Panel not	3
Pap Smear Results Not	3

Change in HbA1c Percentages

10/03-10/04

	Baseline		Study End	
	N	Average	N	Average
All study participants	338	7.1	338	6.9
Starting A1c<7	177	6.1	177	6.5
Starting A1c 7 to 9	134	7.7	134	7.2
Starting A1c >9	27	10.5	27	8.2

In general, would you say your health is: (check one box)

	Excellent	Very Good	Good	Fair	Poor
B	4%	19%	37%	30%	10%
F	5%	27%	42%	22%	4%

How effective do you believe your health care provider is in managing your diabetes?

	Not effective at all	Not very effective	Somewhat effective	Effective	Very effective
B	1%	3%	18%	45%	34%
F	<1%	1%	13%	44%	41%

How effective do you believe you are in caring for your diabetic patients?

	Not effective at all	Not very effective	Somewhat effective	Effective	Very effective
Baseline	-	3%	32%	57%	8%
F/U	-	-	27%	56%	17%

Compared to a year ago, how effective are you in caring for your diabetic patients?

	Less effective	Somewhat Less effective	Same effectiveness	Somewhat More effective	More effective
F/U	-	-	27%	41%	33%

Note: The sum of the categories may not add to 100% due to rounding.

Community-Wide DM Results

Measure	October, 2003 *(n=802) Chart audit*	October, 2004 *(n=778) Chart audit*	January, 2007 *(n=4330) Registry*
HbA1c control: >9% (poor control)	7.7%	6.9%	5.2%
HbA1c control: <7% (good control)	52%	55%	59%
Patients with BP <140/90	62%	59%	67%
Patients with BP <130/80	32%	33%	37%
Patients with LDL<130	60%	73%	78%
Patients with LDL <100	32%	44%	49%

ODCHC DM Results

Measure	October 2006 *(n=1461)*	October 2007 *(n=1782)*
HbA1c control: >9% (poor control)	14%	16%
HbA1c control: <7% (good control)	54%	56%
Patients with BP <140/90	68%	69%
Patients with BP <130/80	37%	39%
Patients with LDL<130	83%	77%
Patients with LDL <100	55%	49%

"Tell Us About Your Visit?" - Attitudes

1-I Do Not Agree

4-I Agree Alot

	2007	2008
	N= 199	
1. I can tell my health care provider what is wrong with me even if my health care provider does not ask me.	3.70	
2. I am sure I can follow my diabetes care plan.	3.54	
3. I know what I need to do to take good care of my health.	3.70	
4. What I do can make a big difference in my health.	3.79	
5. My health care provider and I work together on a plan to help control my diabetes.	3.80	
6. My health care provider asks for my ideas when we work on my diabetes plan.	3.64	
7. My health care provider helps me make a diabetes plan I can work on every day.	3.67	

“Tell Us About Your Visit?” – Behaviors

1-I Do Not Agree

4-I Agree Alot

	2007	2008
■ 9. Over the past week I was able to stick with my exercise plan.	2.80	
■ 8. Over the past week I was able to stick with my meal plan.	3.04	
■10.Over the past week, I took all of my prescribed medicines when I was supposed to.	3.80	
■11.Over the past week, I checked my blood sugar when I was supposed to.	3.36	

Sustaining Spread

- Open Door Community Health Clinics and other members of North Coast Clinics Network embracing IPA community-wide approach to chronic care (shared registry)
- Meet bi-weekly with ODCHC Medical Director and Chronic Care Coordinator (FNP/CDE), UIHS Diabetes Program Director
- Co-teaching with ODCHC Clinical Psychology Head
- Current community clinical focus:
  Diabetes/Hypertension

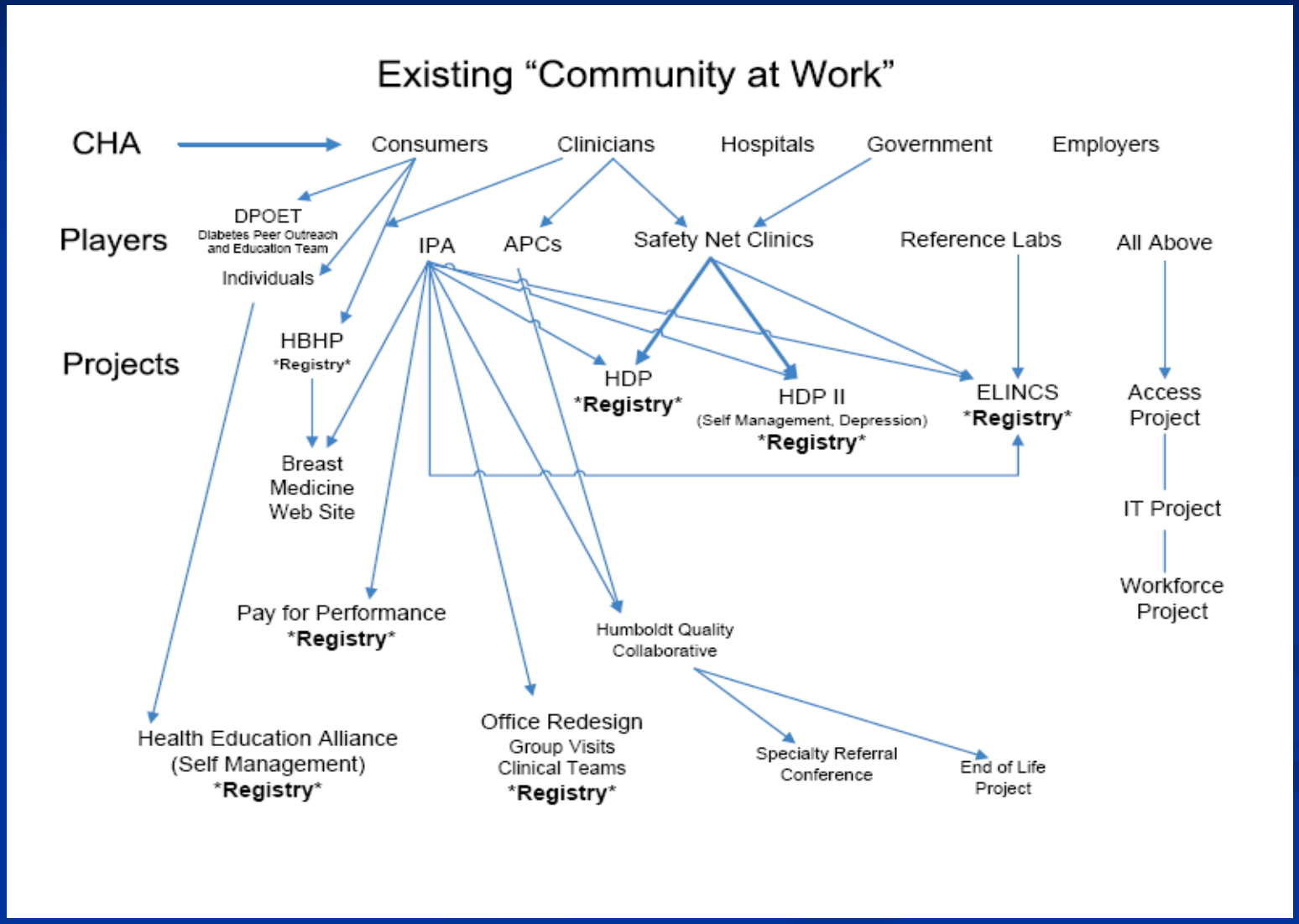
Breast Medicine Project

- *Same approach* (clinical champions, clinical leaders group, larger "kick-off" conference with patient voices, site champion network, data/feedback to clinicians, etc)
- Web-based decision support tool
- Registry
- Self-management *(Community Breast Health Project)*

Results

IPA Results for P4P	2005	2006
% Annual Mammogram (> 40yo women)	75%	85%

Chronic Care as a Social Movement



What We Have Learned So Far

- Redesign is necessary to implement the care model successfully
- Clinician morale is tied to "becoming citizens in the improvement of their own work"
- Self-management is the major determinant of outcome
- Access should be patient-centered

What We Have Learned So Far

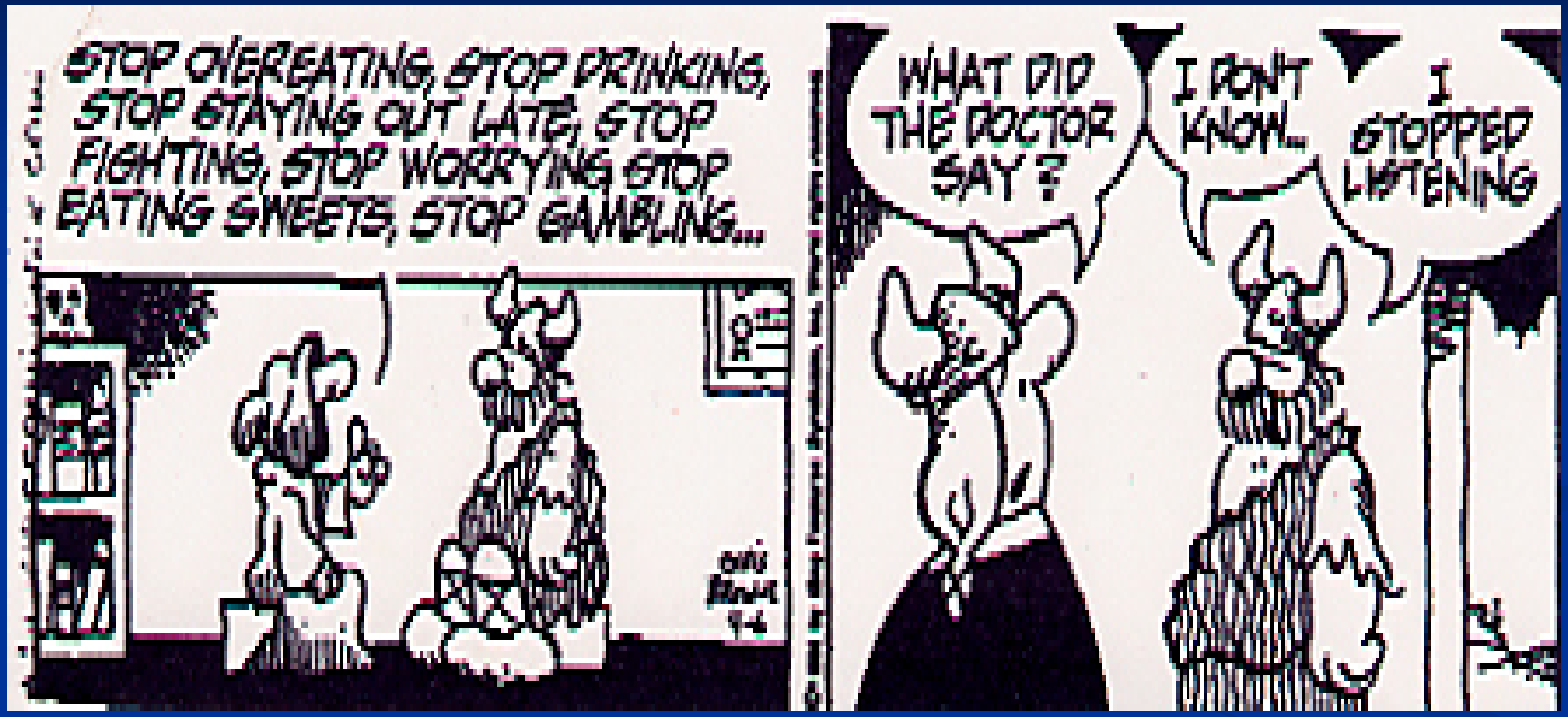
- Psychosocial aspects of chronic disease are critical
- Patients may learn more by modeling behaviors of other patients than from formal classes
- Technology can be an important force for patient empowerment and population-based care

Why Do Our Patients Struggle?

("strong" endorsements by physicians)

poor self-discipline	53.2%
poor will-power	50.0%
not scared enough	36.9%
not intelligent enough	16.3%

Polonsky, Boswell and Edelman, 1996


STOP OVEREATING, STOP DRINKING, STOP STAYING OUT LATE, STOP FIGHTING, STOP WORRYING STOP EATING SWEETS, STOP GAMBLING...
WHAT DID THE DOCTOR SAY?
I DON'T KNOW..
I STOPPED LISTENING

What Doesn't Work With Patients

- Labeling patient as "unmotivated," "unwilling to change," or "non-compliant"
- Taking sides in the patient's ambivalence
  - Giving advice
  - Transmitting technical diabetes info
  - Threatening bad outcomes
    - *"You'll go blind if you don't do what I tell you."*
  - Urging more willpower
    - *"If you would just try harder…"*
- Caring more than the patient…

Why Do Clinicians Struggle With QI?

- Is it poor self-discipline?
- Is it poor will-power?
- Are they not scared enough?
- Are they not intelligent enough?

- *All of these attitudes surface in meetings of QI professionals. How does it feel?*

What Doesn't Work With Clinicians

- Labeling clinician as "unmotivated," "unwilling to change," or a "laggard" (though they do exist)
- Taking sides in the clinician's ambivalence
  - Giving unasked-for advice
  - Threatening bad outcomes
    - *"You'll go broke/be sued/be fired if you don't do what I tell you."*
  - Urging more willpower
    - *"If you would just try harder…"*
- Caring more than the clinician does…

Motivational Interviewing : QI Applications

- Self-management principles apply to behavior change in clinicians as well as they apply to patients
  - Invite the implementers into the planning process
  - PDSA cycles as action plans
  - Avoid prescriptive behavior
  - Don't "care" (i.e. micromanage) too much: Trust in the workforce
  - If not successful, look in the mirror: *"Why isn't it working? What am I doing to hinder the success of others?"*

The Overarching Approach

- READY TO CHANGE. The clinician/practice team must be interested in improving their practice quality

- KNOW WHAT TO DO. The clinician/practice team must have a clear and achievable plan for improving practice quality

Self-Management Support is more than Patient Education

- Patient Education
  - Information and skills are taught
  - Usually disease-specific
  - Assumes that knowledge creates behavior change
  - Goal is compliance
  - Teachers are health care professionals
  - Didactic
- Self-Management Support
  - Skills to solve patient-identified problems are taught
  - Skills are generalizable to all chronic conditions
  - Assumes that confidence yields better outcomes
  - Goal is to increase self-efficacy
  - Teachers can be professionals or peers
  - Interactive

adapted from Bodenheimer, Lorig, et al JAMA 2002;288:2469.

Applied to QI Efforts

- Clinician Education
  - Information and skills are taught
  - Usually disease-specific
  - Assumes that knowledge creates behavior change
  - Goal is compliance with guidelines
  - Teachers are health care QI Leaders
  - Didactic
- QI Support
  - Skills to solve practice-identified problems are taught
  - Skills are generalizable to all chronic conditions
  - Assumes that successes yield better outcomes
  - Goal is to increase self-efficacy
  - Teachers can be QI professionals or peers
  - Interactive

Behavior Change Strategies

- Begin with your patient's interests
- Believe that your patient is motivated to live a long, healthy life
- Help your patient determine exactly what they might want to change
  - *Identify and respect ambivalence*
  - *Present their issues back to them*
  - *Establish "importance" of behavior change*
- Develop a reasonable, detailed action plan

Applied to QI

- Begin with your colleague's interests
- Believe that your colleague is motivated to practice good medicine
- Help your colleague determine exactly what they might want to work on first in their practice
  - *Identify and respect ambivalence*
  - *Present their issues back to them*
- Develop a reasonable, detailed action plan for change

Courage

- 30% of care in the HDP was supplied by advanced practice clinicians (mid-level practitioners)
  - Physician turf concerns must not obstruct APC, educator, pharmacist and peer roles as chronic care team members
- Patient education should be the rule, rather than the exception, in chronic care
  - Education should be transformed into a community-based group process that attracts those seeking information and support

Finally…

- QI leaders need to examine how their behavior may be hindering empowerment at the practice level
- Physicians need to examine how their behavior may be hindering empowerment at the non-physician colleague and staff levels
- The care team needs to examine how its behavior may be hindering empowerment at the patient level