NATIONAL TRANSITIONS OF CARE COALITION

Successful Strategies to Increase Patient Activation

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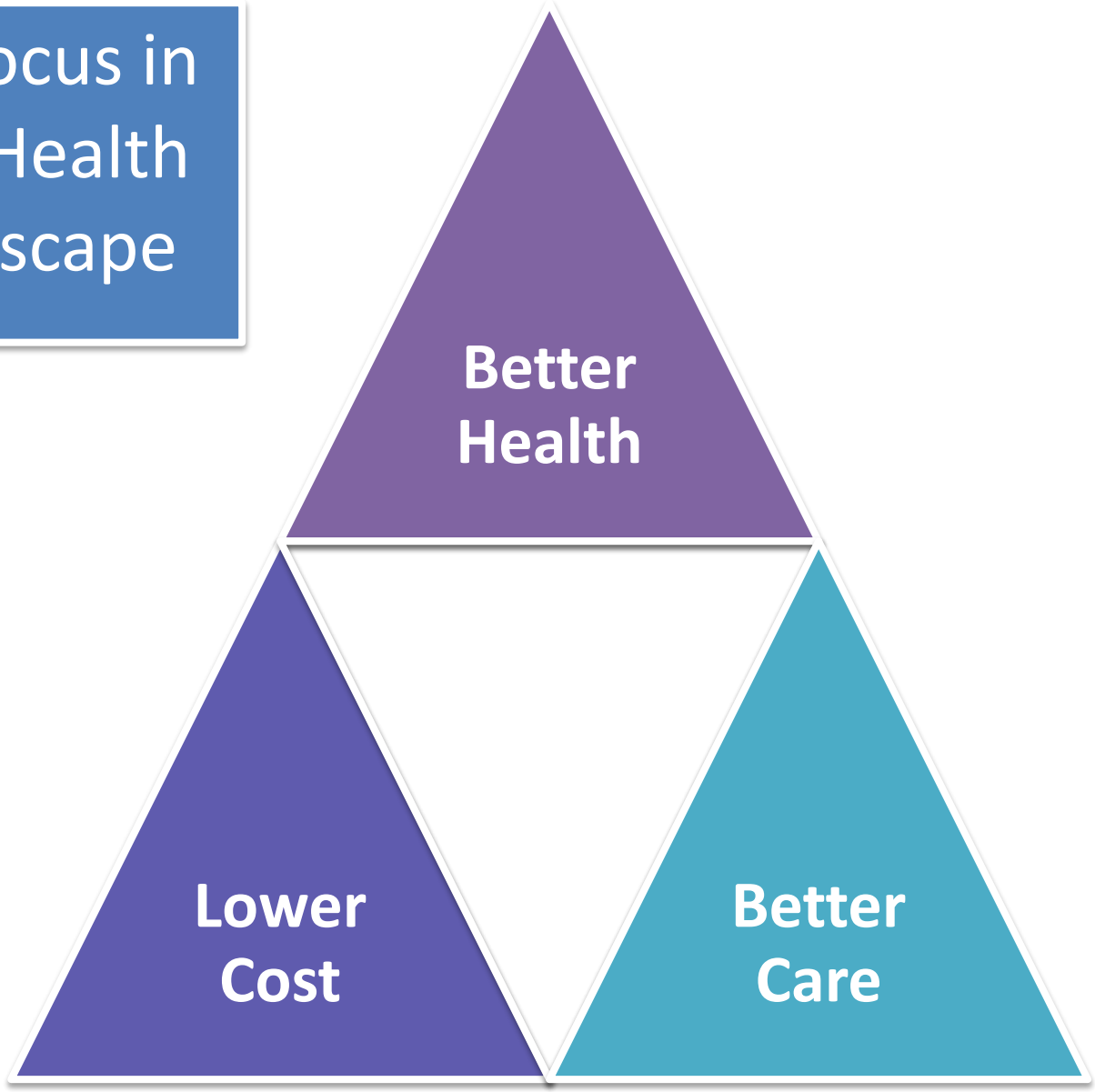
NTOCC is a 501(c)(4) nonprofit coalition.

Current Focus in The New Health Care Landscape



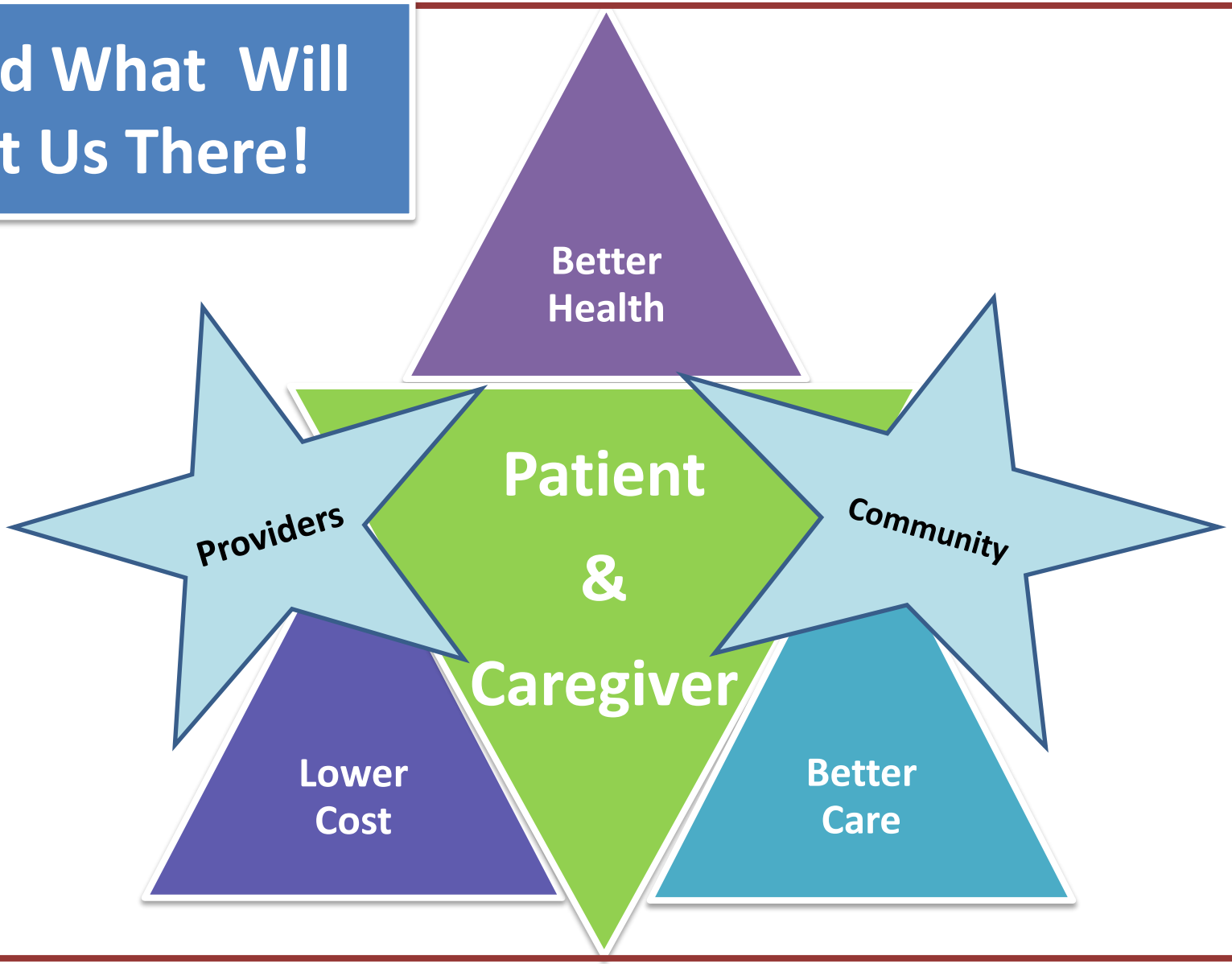
It is A National Priority!

National Quality Strategy Priorities

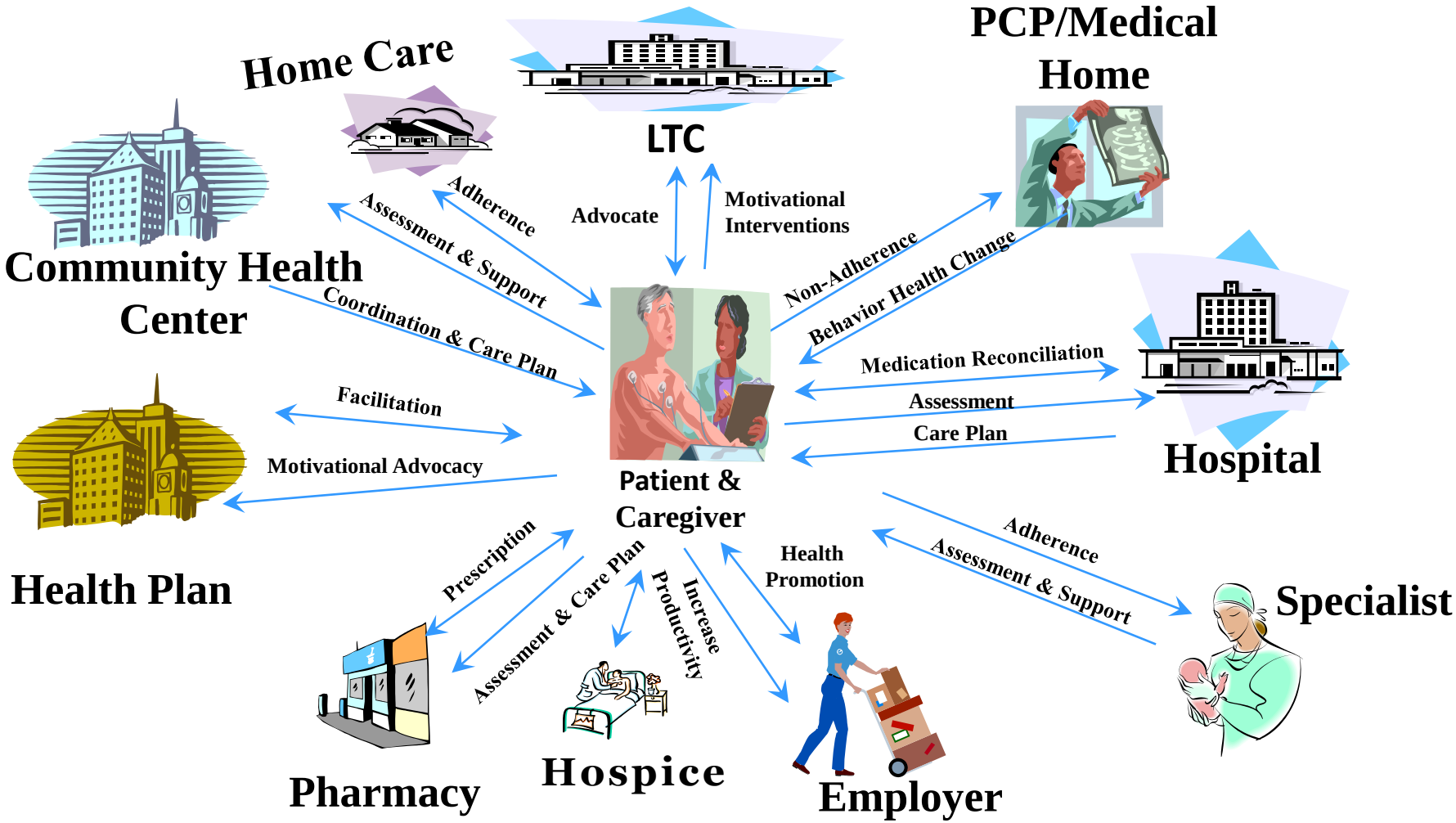
- Making care safer
- **Ensuring person- and family-centered care**
- **Promoting effective communication/coordination of care**
- Promoting the most effective prevention and treatment of leading causes of mortality
- Working with communities to promote wide use of best practices to enable healthy living
- Making quality care more affordable

A full summary of the National Quality Strategy is available at
www.ahrq.gov/workingforquality

And What Will Get Us There!



Recognizing that Care Coordination is a Collaborative process supported by Multidisciplinary Teams in Multiple Healthcare Settings what are the Considerations for Patient Engagement?



How Many Providers Does it Take to Engage a Patient?

- How many times do we ask the same questions of the patient & family caregiver?
- How many phone calls does a medically complex patient get from the health care team?
- Are we reaching consumers through an method they will respond to? i.e. phone, mobile device, texting, Skype, email, video
- Are we a help or a hindrance?

A Simple Question?

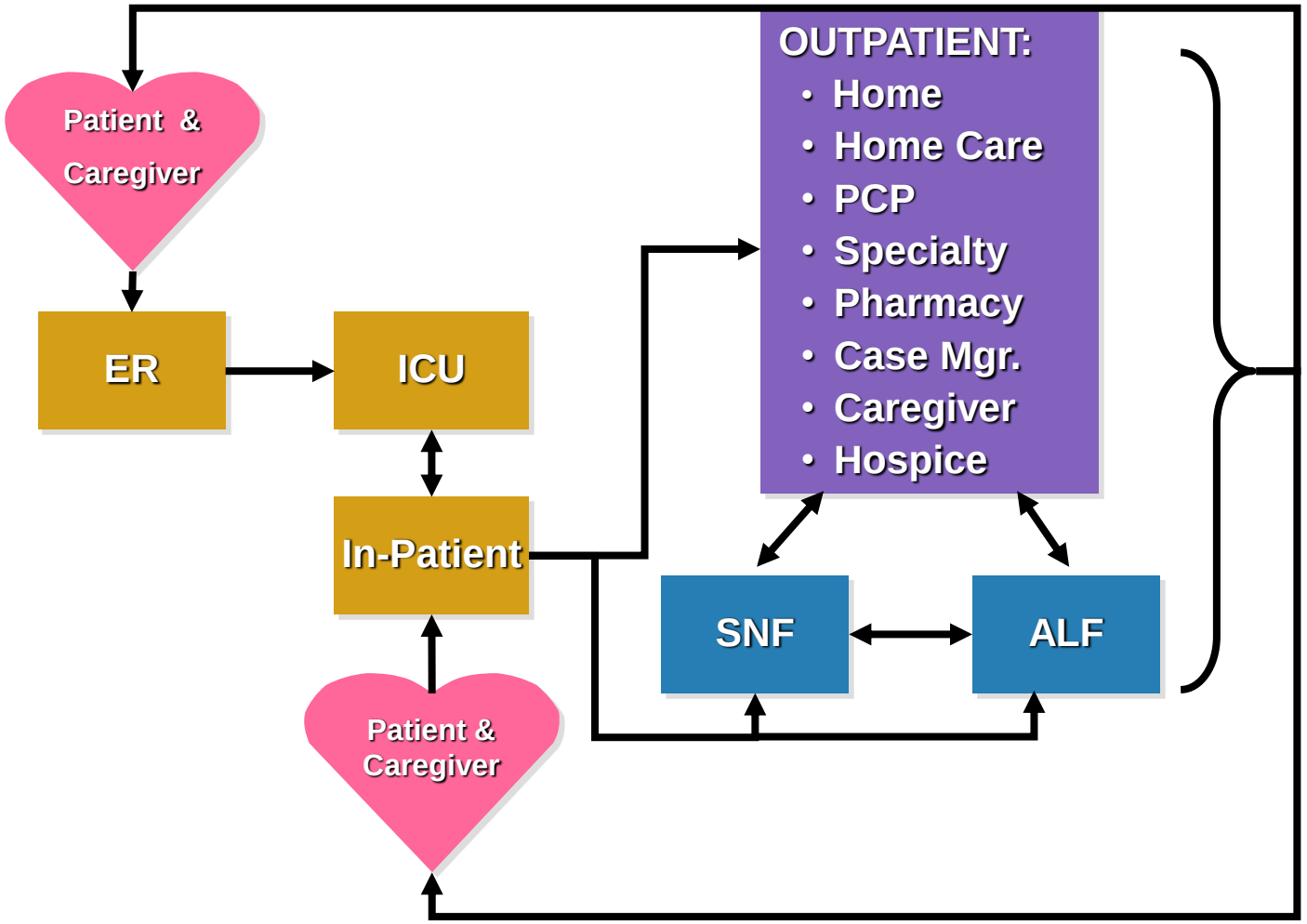
- Does encouraging older patients and their caregivers to assert a more active role in their care transition reduce rates of rehospitalization?

17. Coleman EA et al. Arch Intern Med 2006

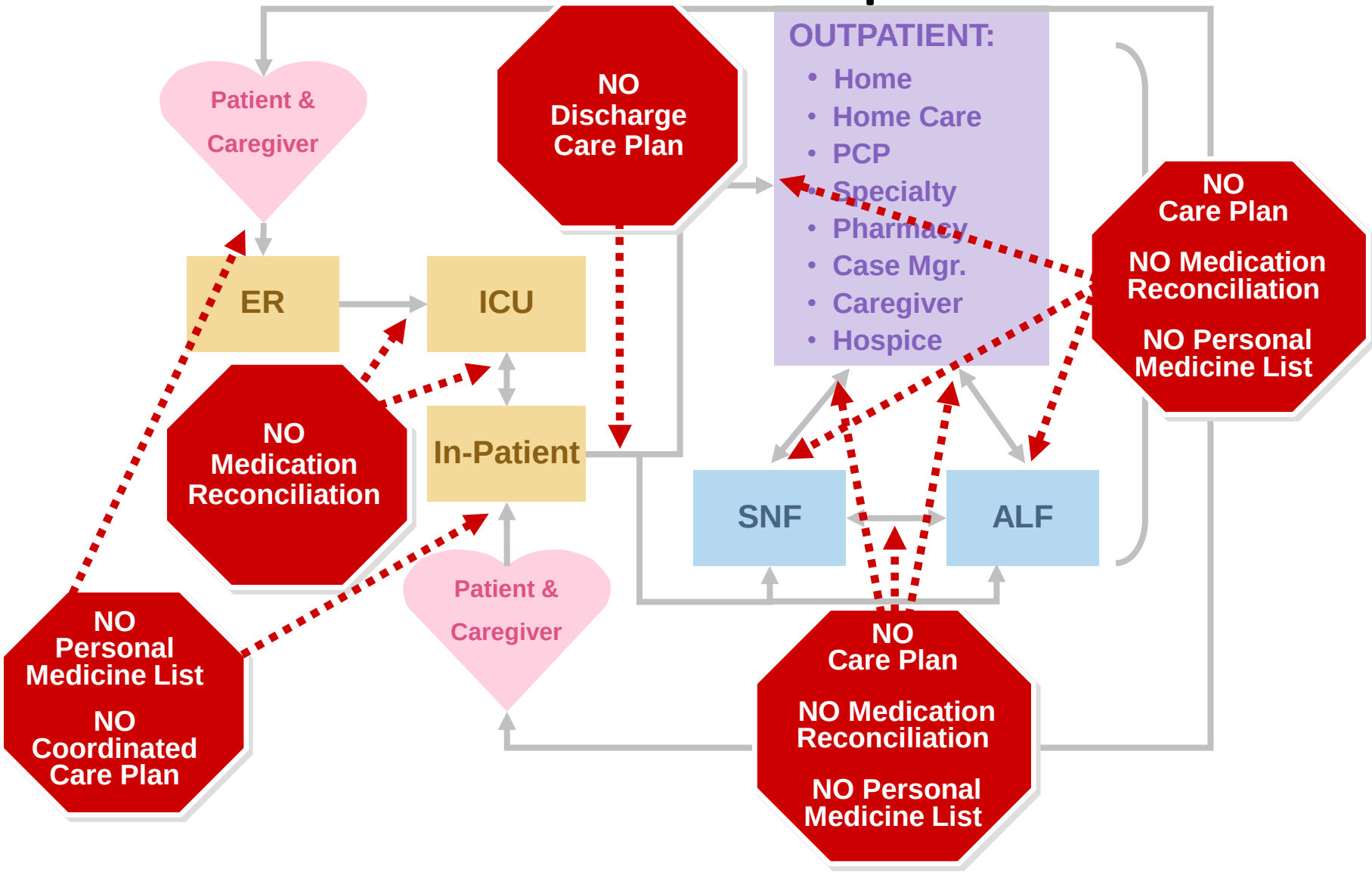
A More Difficult Question?

How do we engage patients and their caregivers to take a more active role in their care and become an active part of care treatment, adherence and collaboration?

Transition Issues Dramatically Impact Patients & Their Caregivers



The Points of Engagement for Patients, Their Caregivers & Providers are Multiple



“We’ve medicalized so many things, but transitions are not medical events. It’s about the team working together. It’s a person event.”

Jennifer Fels, RN, MS, Director, Southwestern Vermont Medical Center

Defining Patient Engagement

"Actions individuals must take to obtain the greatest benefit from the health care services available to them"

This definition focuses on behaviors of individuals relative to their health care that are critical and proximal to health outcomes, rather than the actions of professionals or policies of institutions.

Engagement is not synonymous with compliance.

http://www.cfah.org/pdfs/CFAH_Engagement_Behavior_Framework_current.pdf

Compliance means an individual obeys a directive from a health care provider.

Engagement signifies that a person is involved in a process through which he harmonizes robust information and professional advice with his own needs, preferences and abilities in order to prevent, manage and cure disease.

The definition is agnostic about the many factors that have been shown to influence these behaviors, although we recognize that they are complex and many and include individual characteristics (e.g., age, self-efficacy, literacy), disease characteristics (e.g., acuity, co-morbidities, treatment demands), characteristics of the setting (e.g., type of provider; information availability) and cultural norms.

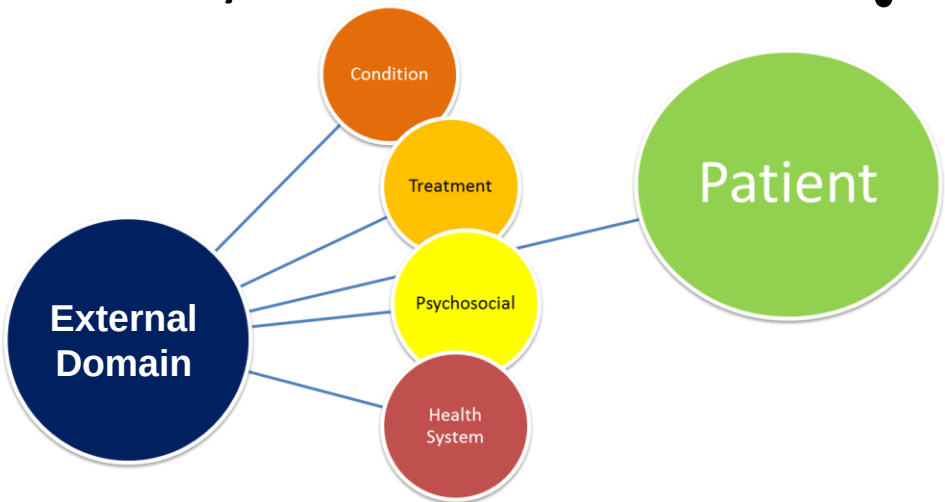
Case Management Adherence Guide Focus

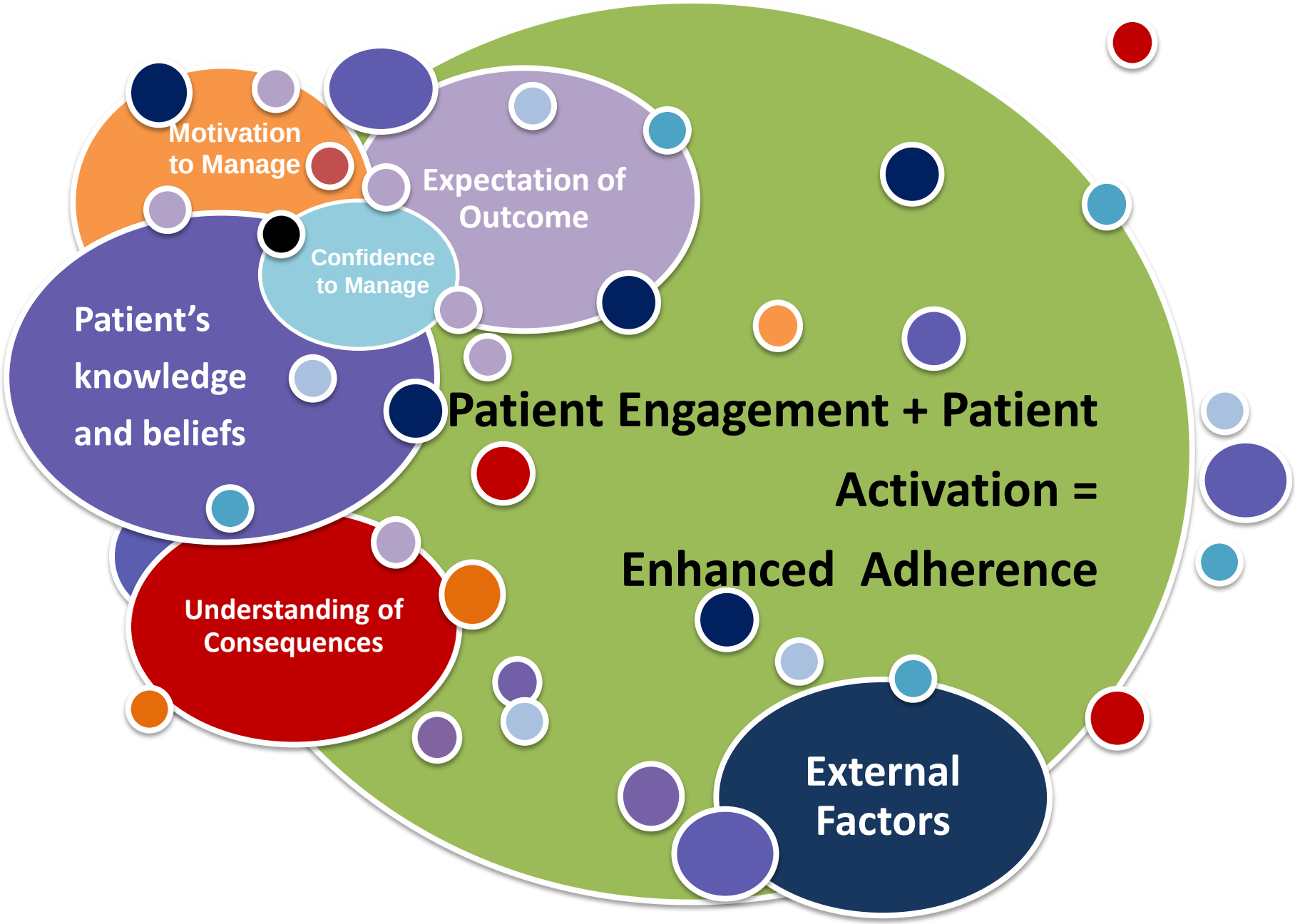
Five external domains:

- Patient
- Condition – Medical & Behavioral
- Treatment
- Psychosocial
- Health System

Patient-related domain:

- Knowledge and beliefs
- Motivation to manage
- Confidence in management
- Expected outcome
- Understanding of the consequences





CMSA's CMAG 2013 Adherence Model

External Factors

Socioeconomic/Psychosocial Factors

Potential Barriers

- Out of pocket costs to include competing priorities such as the choice between food and medications
- Lack of money management skills
- Meeting insurance requirements for deductibles and co-pays
- Out-of-network providers or limitations of provider coverage
- Potential loss of income due to missed work time – for either the patient or the caregiver
- Loss of job or financial support
- Transportation costs
- Additional incidental costs
- Caregivers, babysitters, or equipment needs [29,30]

External Factors

Assessment of Social Dimension

- Belief and Perceptions about illness, disability, and death
- Trust or distrust in the medical system
- Family support and requirements
- Employment issues and concerns to include illness-related productivity
- Societal issues
  - Individual's immediate environment
  - Access to care
    - Geography and economy - specialist availability?
    - Travel to seek medical care from rural areas
    - Telemedicine: broadband access?
- Education, income, and occupation
- Living conditions to include housing, number of persons in home, and availability of essentials for living
- Environmental issues
- Safety issues

Care Disparities

Priority populations:

- Minority groups
- Low-income groups
- Women
- Children (age 0-17)
- Older adults (age 65 and over)
- Residents of rural areas
- Individuals with special health needs, including individuals with disability and individuals who need chronic care or end-of-life health care.

External Factors

Health System Issues

- Multiple providers
- PCP to hospitalist to specialist
- Polypharmacy
- Confusion regarding follow up care
- Coverage for reimbursement
- Locations of each provider
- Potential for transportation issues
- Patient Experience
- Distances
- Time management (caregivers; patients)
- Communication
- Information Transfer
- Presence of EHR/PHR
- Access to medical information by all providers
- Medication Record(s)
- Current; history – by all prescribers
- Medical history information

Health Complexity

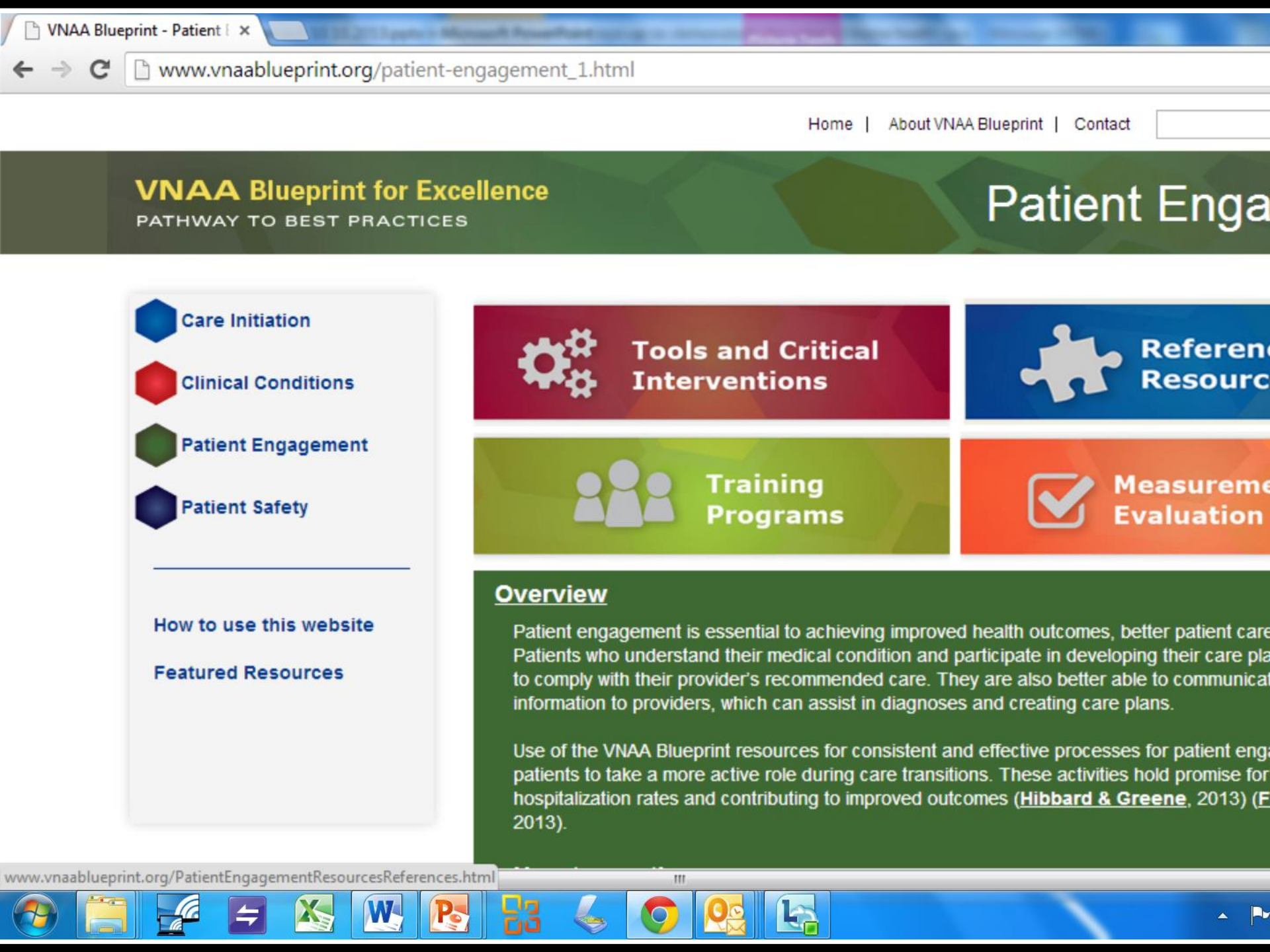
Health Complexity is the interference in standard care by behavioral, social, physical, and health system factors, which require a shift from standard care to individualized care in order for patient outcomes to improve[1]

de Jonge P, Huyse FJ, Stiefel FC, Case and Care complexity in the Medically ill. *Med Clin North AM*. Jul 2006

Health Complexity Assessment Grid

Baseline	HEALTH RISKS AND HEALTH NEEDS					
Lucinda	HISTORICAL		CURRENT STATE		VULNERABILITY	
Total Score = 38	Complexity Item	Score	Complexity Item	Score	Complexity Item	Score
Biological Domain	Chronicity **HB1**	3	Symptom Severity/Impairment **CB1**	3	Complications and Life Threat **VB**	3
	Diagnostic Dilemma **HB2**	0	Diagnostic/Therapeutic Challenge **CB2**	3		
Psychological Domain	Barriers to Coping **HP1**	1	Resistance to Treatment **CP1**	2	Mental Health Threat **VP**	2
	Mental Health History **HP2**	2	Mental Health Symptoms **CP2**	2		
Social Domain	Job and Leisure **HS1**	1	Residential Stability **CS1**	0	Social Vulnerability **VS**	1
	Relationships **HS2**	0	Social Support **CS2**	1		
Health System Domain	Access to Care **HHS1**	2	Getting Needed Services **CHS1**	3	Health System Impediments **VHS**	3
	Treatment Experience **HHS2**	3	Coordination of Care **CHS2**	3		

Tools & Resources for Patient Engagement


VNAA Blueprint - Patient
www.vnaablueprint.org/patient-engagement_1.html
Home | About VNAA Blueprint | Contact
VNAA Blueprint for Excellence
PATHWAY TO BEST PRACTICES
Patient Enga
Care Initiation
Clinical Conditions
Patient Engagement
Patient Safety
How to use this website
Featured Resources
Tools and Critical Interventions
Referen Resourc
Training Programs
Measureme Evaluation
Overview
Patient engagement is essential to achieving improved health outcomes, better patient care
Patients who understand their medical condition and participate in developing their care pla
to comply with their provider's recommended care. They are also better able to communicat
information to providers, which can assist in diagnoses and creating care plans.
Use of the VNAA Blueprint resources for consistent and effective processes for patient enga
patients to take a more active role during care transitions. These activities hold promise for
hospitalization rates and contributing to improved outcomes (Hibbard & Greene, 2013) (F
2013).
www.vnaablueprint.org/PatientEngagementResourcesReferences.html

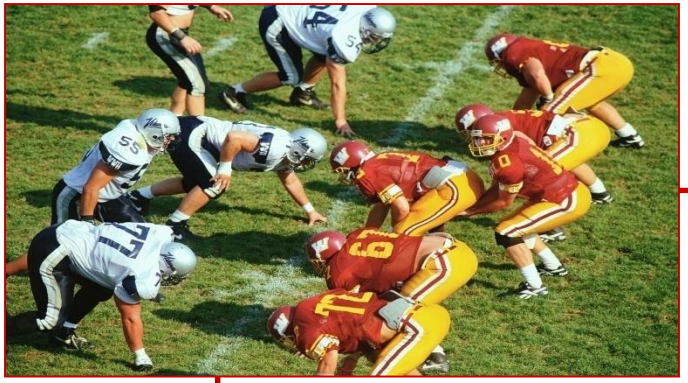
Moving Towards Collaborative Care

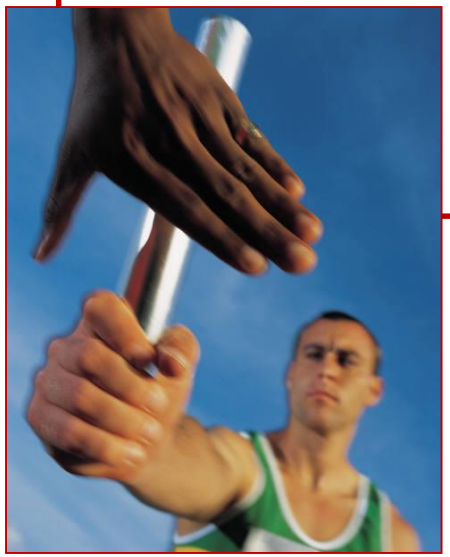
Table 1
Conventional vs. Collaborative Care

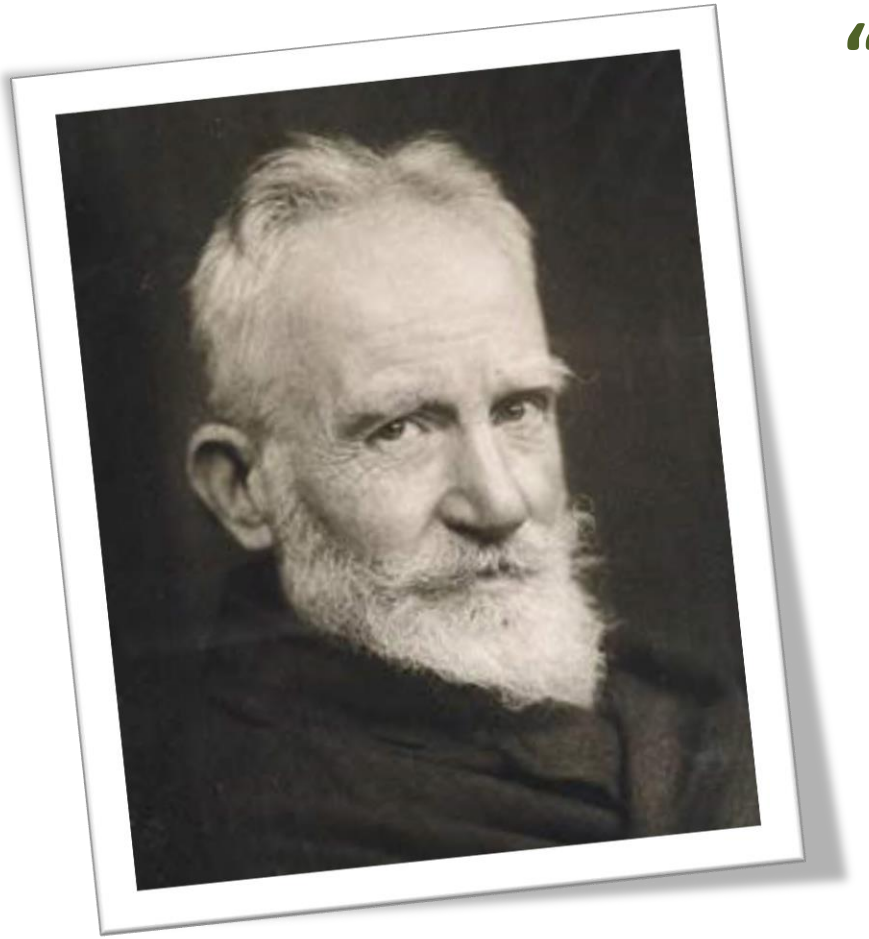
Conventional	Collaborative
Authoritarian	Collaborative
Autonomous practice culture	Team culture
Physician driven, with physicians accountable for care outcomes	Patient centered, with team members sharing responsibility for care outcomes
Episodic, fragmented	Continuous, coordinated
Primary care delivered in one-size-fits-all, 15-minute visits	Primary care delivered via individualized visits, phone calls, and online communication
Payment based on quantity (fee for service)	Payment based on value (considers both quality and cost)
Reactive, focused on illness	Preventive, focused on health
Communication is inconsistent	Communication is imperative

Source: Robert Wood Johnson Foundation (November 2011). **Implementing the IOM Future of Nursing Report—Part II: The Potential of Interprofessional Collaborative Care to Improve Safety and Quality.** Accessed on 04/06/2012 at http://www.rwjf.org/humancapital/product.jsp?id=73585

To Make
It All Work,
We Must Learn
How to
Communicate
with Each
Other.







“The biggest problem with communication is the illusion that it has been accomplished.”

George Bernard Shaw

7 Tips for Clinicians

- Use plain language
- Limit information (3-5 key points)
- Be specific and concrete, not general
- Demonstrate, draw pictures, use models
- Repeat/Summarize
- Teach-Back (Confirm Understanding)
- Be positive, hopeful, empowering

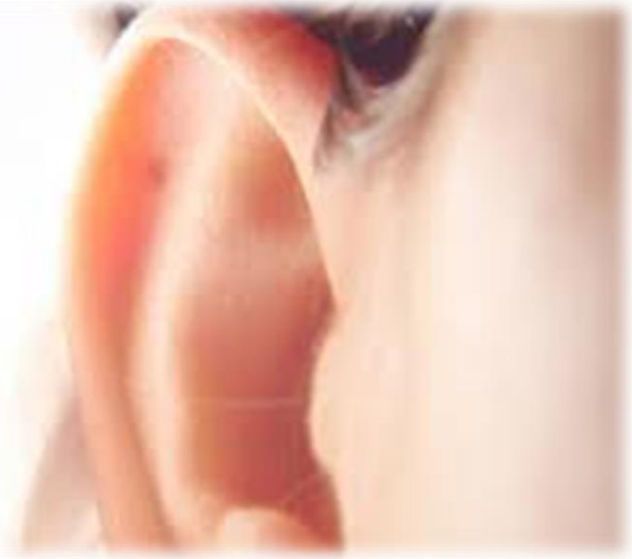
Effective Communication = Effective Engagement

Open and honest conversations are critical to promote interprofessional approach to patient care

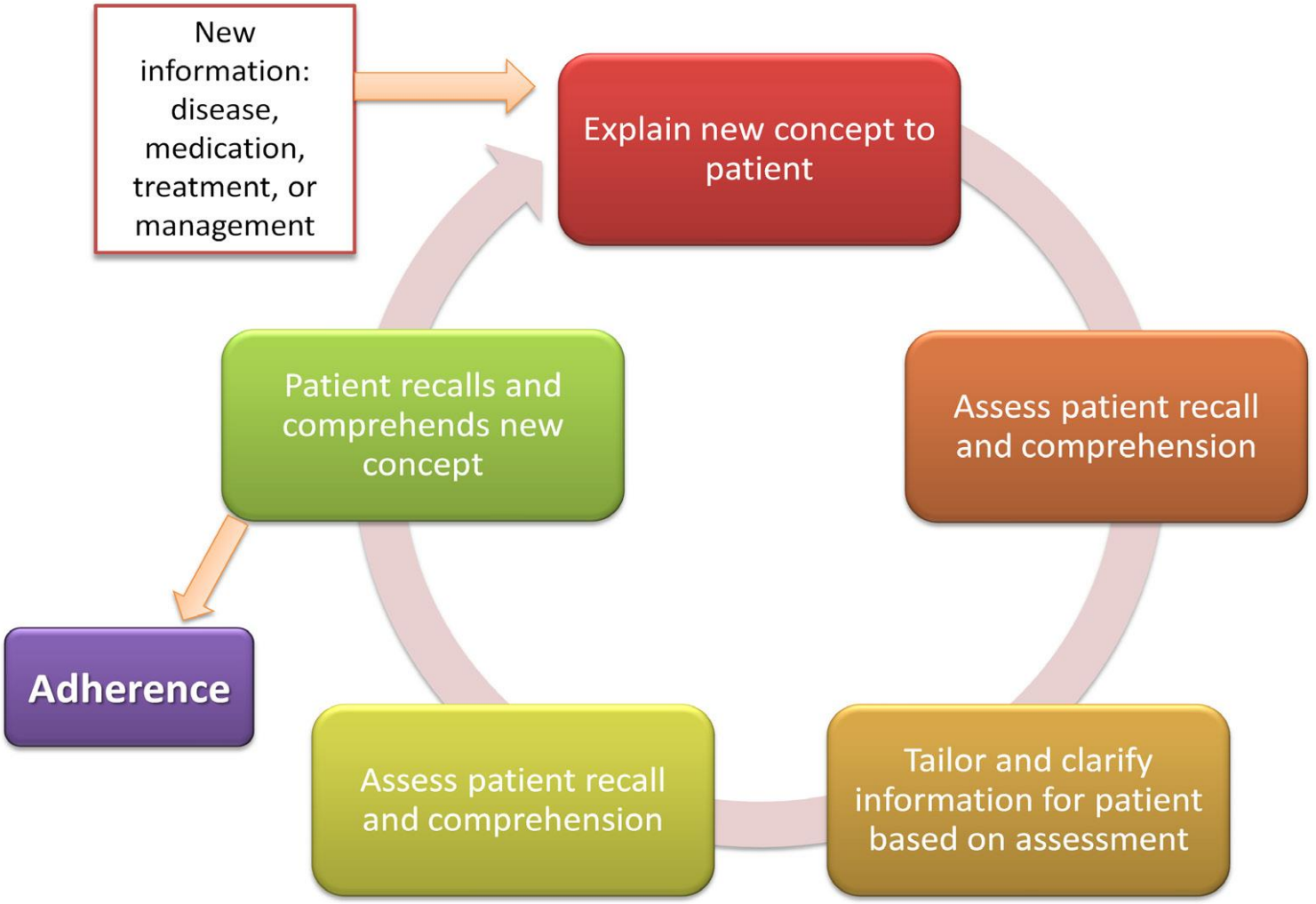
Bring **active listening skills** into everyday conversations

Need to **be fully in the moment** for meaningful communication to occur

Connect on a personal level to build trusting relationships

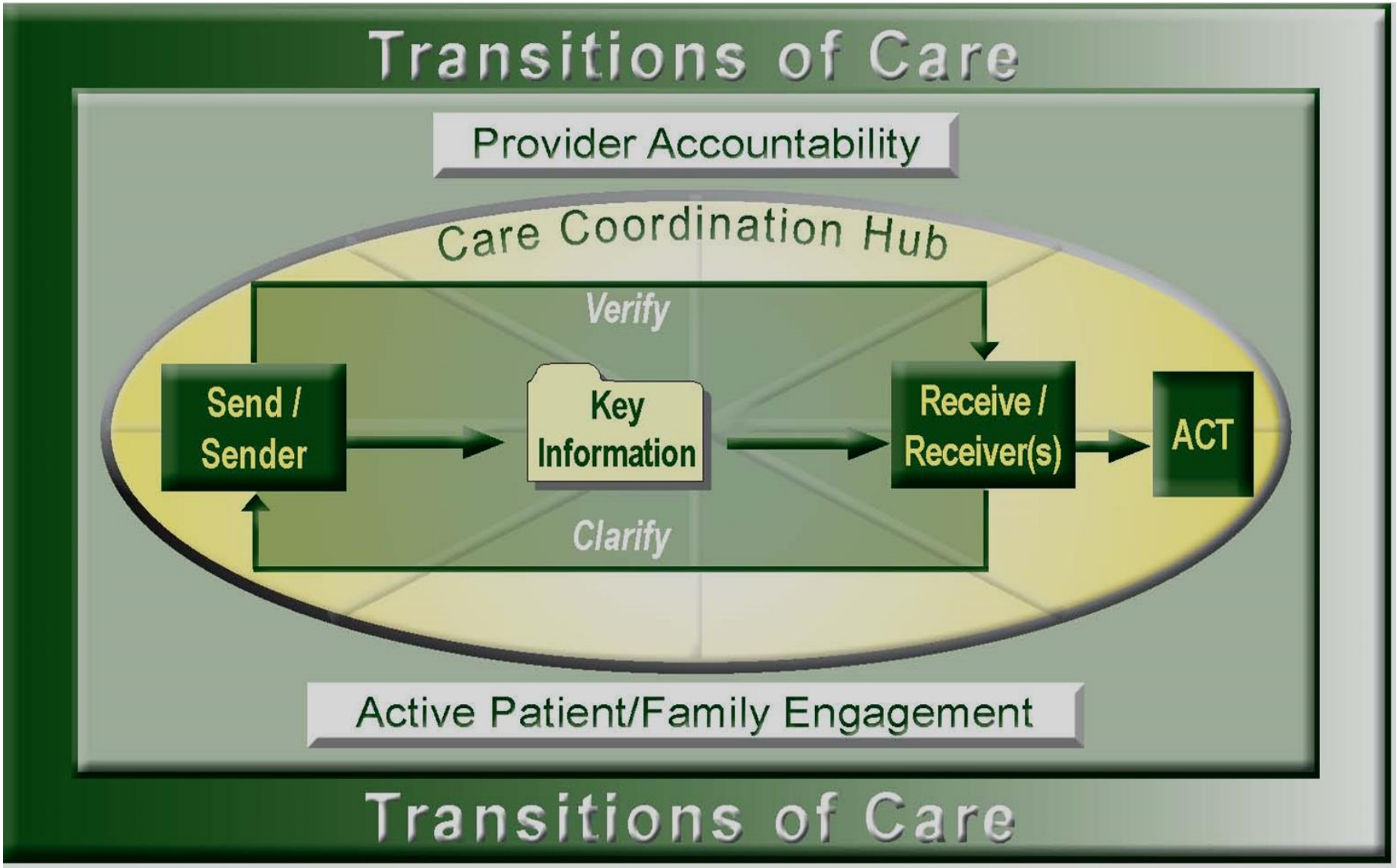


Teach-Back: Closing the Loop



Adapted from Schillinger D et al. Arch Intern Med 2003.

Improving Communication



NTOCC Measures Work Group, 2008

Responsibilities of Health Professionals for Seniors in Transition

Sending health care team

- Stable for transfer
- Patient/caregiver understand and are prepared
- Transfer information is complete
- Contact person's name and number

Receiving health care team

- Review transfer information promptly and clarify
- Incorporate patient's goals/preferences in care plan
- Document contact information

Core Competencies for Interprofessional Collaborative Practice

Values/Ethics for Interprofessional Practice

- Work with individuals of other professions to maintain a climate of **mutual respect and shared values.**

Roles/Responsibilities for Collaborative Practice

- Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of the patients and populations served.

Interprofessional Communication

- Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.

Interprofessional Teamwork and Team-Based Care

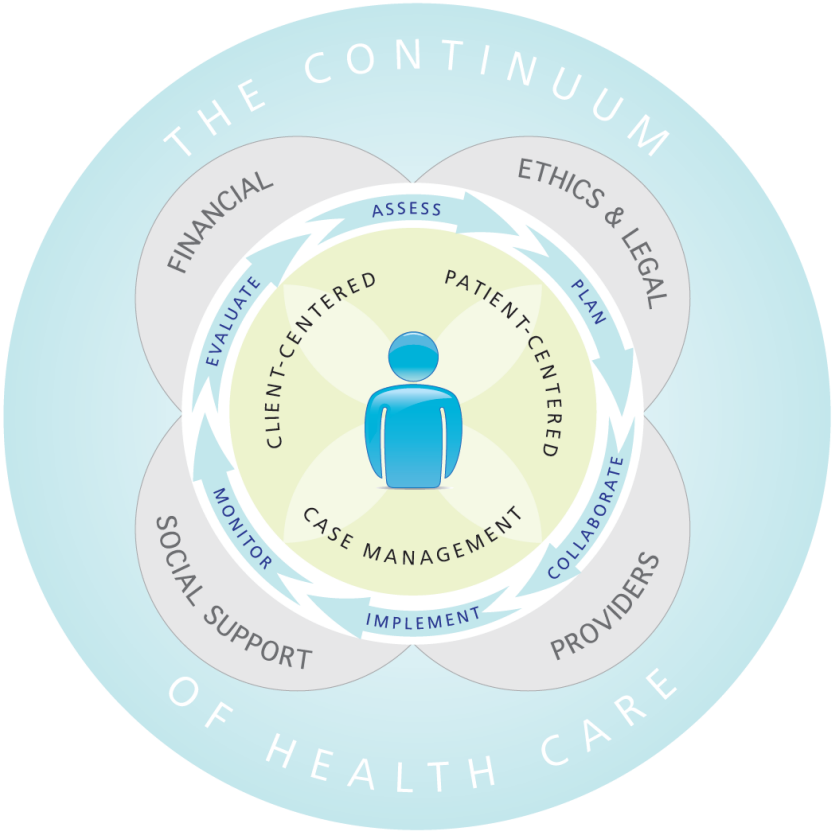
- Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.

Source: Robert Wood Johnson Foundation (November 2011). Implementing the IOM Future of Nursing Report—Part II: The Potential of Interprofessional Collaborative Care to Improve Safety and Quality. Accessed on 02/25/2012 at www.rwjf.org/humancapital

Characteristics of High-Performing Collaborative Teams

Shared Goals	• Everybody is working toward the same goals. Promoting patient- and family-centered care is paramount.
Clear Roles	• Team members are clear on how to work together and how to accomplish tasks. No individual members are more important than the team.
Mutual Trust	• People have solid and deep trust in each other and in the team's purpose. Each team member respects the team processes and other members.
Effective Communication	• Everyone understands goals and knows what is expected. Criticism is constructive and is oriented toward problem-solving and removing obstacles
Measurable Processes/Outcomes	• Documenting processes and outcomes as well as sharing successes; for example, improved clinical outcomes or patient satisfaction.

Case Manager Skills Are Required For Success in These New Models!



Knowledge and experience with care coordination

Focus on patient-centered processes

Assessment, planning, facilitation across care continuum

Knowledge of population-based care management strategies

Meaningful communication with patient, family, care team

Care Transitions Measure – CTM-3

1. The hospital staff took my preference and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.

2. When I left the hospital I had a good understanding of the things I was responsible for in managing my health.

3. When I left the hospital I clearly understood the purpose for taking each of my medications.

Waves of Change

- ***Changing is like Breathing – And we all know what happens when we stop Breathing***

Questions

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