

Medicaid Advisory Committee

February 27, 2012

General Services Building
Salem, Oregon

Time	Item	Presenter
9:00 ²	Opening Remarks	Co-Chairs
9:05	Approval of Minutes – November 2012 & January 2013	MAC Members
9:10	Oregon Health Authority <ul style="list-style-type: none"> • Update on CCO Transformation Plans 	Rhonda Busek, OHA
9:20	Oregon Medicaid Expansion <ul style="list-style-type: none"> • Overview of the report • Summary of estimated financial effects of the ACA 2014-2020 	Gretchen Morley, OHA
9:50	Break	
10:00	Practical examples of successful patient engagement strategies <ul style="list-style-type: none"> • Use of activation to improve the care experience • PeaceHealth’s Team Fillingame • Lessons from Washington’s Medicaid program and use of the PAM 	Mary Minniti, CPHQ Program and Resource Specialist, Institute for Patient- and Family-Centered Care
11:00	Consumer-Directed Health Care and Medicaid <ul style="list-style-type: none"> • Review approaches to CDHC matrix • Next steps 	OHPR staff
11:50	Public Comment or Testimony	
11:55	Closing comments	
12:00	Adjourn	Co-Chairs

CCO Transformation Plan: Update

Rhonda Busek

Estimated financial effects of expanding Oregon's Medicaid Program under the ACA 2014-2020

Gretchen Morley

Successful Examples of Patient Engagement Strategies

Mary M. Minniti, CPHQ
Institute of Patient- and Family-Centered Care

Oregon Medicaid Advisory Committee
February 27, 2013



Objectives

- ▼ Provide framework for patient and family engagement
- ▼ Provide examples of practical strategies for engaging patients and families
 - Highlight Team Fillingame's PCPCH
 - Share other local and national examples
- ▼ Summarize key considerations to create partnerships

Patient- and Family-Centered Core Concepts

- ▼ People are treated with **respect and dignity**.
- ▼ Health care providers communicate and share complete and unbiased **information** with patients and families in ways that are affirming and useful.
- ▼ Clients/patients and families are encouraged and supported in **participating in care and decision-making** at the level they choose.
- ▼ **Collaboration** among clients/patients, families, and providers occurs in policy and program development and professional education, as well as in the delivery of care.



Patient- and family-centered care is working with patients and families, rather than just doing to or for them.



Patient and Family Engagement

Patient and family engagement is a priority consideration essential to health reform at four levels

- ◆ At the **clinical encounter**...patient and family engagement in direct care, care planning, and decision-making.
- ◆ At the **practice or organizational level**, patient and family engagement in quality improvement, safety and health care redesign.
- ◆ At the **community level**, bringing together community resources with health care organizations, patients, and families.
- ◆ At **policy levels** locally, regionally, and nationally.



Why Patient- AND Family-Centered Care?

Social isolation is a risk factor.

The majority of patients have some connection to family or natural support.

Individuals, who are most dependent on hospital care, are most dependent on families...

The very young;
The very old; and
Those with chronic conditions.





 **PeaceHealth**

Building Team

- Shared Training Experiences:
 - Communication and Team Training
 - Patient Activation Measure and Coaching for Activation
 - Managing Transition and Change
 - Personality Styles
 - Quality Improvement - Plan-Do-Study-Act
- Structured Team Meetings:
 - Ongoing role clarification and problem solving
 - Development of new processes
 - Opportunity to develop relationship; share feelings/ experiences



PeaceHealth

Enhancing the Patient Experience

It takes a team to provide excellent healthcare today.

You are its most important member!

Your values, beliefs, and needs help shape the choices you make to maintain your health.

Building on the strengths of the individual patient and supporting their continued growth and success in reaching their health goals.

“Fixing is not the same as Healing”



PeaceHealth
Medical Group

Patient-Centered Medical Home Pilot

- Patient Advisors recruited from panels of impacted patients
- Extensive use of advisors in development of:
 - New Patient Orientation, Focus on Team
 - Use of Patient Activation Measure and Coaching for Activation
 - Creating welcoming space in the lobby with computer, magazines, etc.
 - Use of Shared Decision-making Programs with patients faced with critical decision-making [back surgery, menopause, advanced directives, etc.]
 - Just-in-time surveys on monthly newsletter, patient education materials



Tools to Help Patients and the Healthcare Team

- **Shared Decision-making Programs**
 - Booklets, DVD or VHS
 - On key topics: Choosing Healthcare That's Right for You; Living with Heart Failure; Back Surgery, Breast Cancer Treatment Options, etc.
- **Patient Activation Assessment and Coaching for Activation website**
- **Knowledge and Access to community resources**
 - Oregon Tobacco Quit Line
 - Living with Chronic Conditions Classes



What is the PAM survey?

- The Patient Activation Measure [PAM] is a 10-13 question survey that assesses an individual's knowledge, skills and confidence essential to self management
- The PAM uncovers why an individual behaves the way they do...while pointing to behaviors most amenable to change and how to change them
- Existing patients are assessed as they come in for office visits
- All new patients complete PAM and the PHQ-2 in first visit

 PeaceHealth

Visual Scan of PAM responses

When all is said and done, I am the person who is responsible for managing my health condition.	Strongly Disagree	Disagree	Agree	Strongly Agree
Taking an active role in my own health care is the most important factor in determining my health and ability to function.	Strongly Disagree	Disagree	Agree	Strongly Agree
I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition.	Strongly Disagree	Disagree	Agree	Strongly Agree
I know what each of my prescribed medications do.	Strongly Disagree	Disagree	Agree	Strongly Agree
I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself.	Strongly Disagree	Disagree	Agree	Strongly Agree
I am confident I can tell my health care provider concerns I have even when he or she does not ask.	Strongly Disagree	Disagree	Agree	Strongly Agree
I am confident that I can follow through on medical treatments I need to do at home.	Strongly Disagree	Disagree	Agree	Strongly Agree

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What is Patient Activation? PAM

- How confident do I feel to manage my health?
- What knowledge do I have about my conditions?
- What skills do I have to do that which is necessary to maintain and improve my health?
- Assessing and understanding this key “vital” sign can help us be better “coaches” for those who seek your help...



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Activation Level ↓	Coaching For Activation – Right Resource for Patient Needs		
4	Care Facilitator / Peer Support	Health Coach RN, WC	NP + Team
3	Health Coach	NP + Team	NP, RN, WC
2	Wellness Coord	RN, WC, NP	MD, RN, WC
1	RN Care Mgr	NP	MD, RN
Acuity →	Low	Medium	High

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Activation Model = Patient-centered Approach

- ▶ Giving the patient's agenda attention and priority
- ▶ Ask-- don't tell
- ▶ The goal is to build capacity-- not just compliance
- ▶ Listening, joint-problem solving, affirmation
- ▶ Addressing the specific challenges associated with the individual's level of activation
- ▶ Developing skills and knowledge that lay a foundation for the next higher level
- ▶ Building confidence by a series of small successes

 **PeaceHealth** **Coaching for Activation Website**

Coaching for Activation
BY INSIGLIA HEALTH

Diabetes Asthma COPD CHF CAD Lifestyle Hypertension **High Cholesterol**

▶ Activation Level 1
▶ Activation Level 2
▼ Activation Level 3
Condition & Symptoms
Medication
Diet & Nutrition
Physical Activity
Stress & Coping
Smoking Cessation
▶ Activation Level 4
▶ Resource Library

Condition & Symptoms - Level 3
Select Level: 1 2 3 4 Contract All Expand All Print this Page

Goal: Find out what the individual understands about cholesterol - why high cholesterol is bad, what risk factors increase it, and what their ideal target should be

Possible Action Steps

- Identify and address any gaps in knowledge related to high cholesterol
- Address any misconceptions
- Be sure they understand their cholesterol numbers and targets

Supporting Resources

- [What Causes High Blood Cholesterol?](#)
- Symptoms of High Blood Cholesterol
- Risk Assessment Tool
- What Makes Your Cholesterol High or Low?
- Cholesterol Tracker

SERVING SIZE CARD:
Cut out and fold on the dotted line. Laminate for longtime use.

1 Serving Looks Like ...	1 Serving Looks Like ...
GRAIN PRODUCTS	VEGETABLES AND FRUIT
1 cup of cereal flakes = fist	1 cup of salad greens = baseball
1 pancake = compact disc	1 baked potato = fist
½ cup of cooked rice, pasta, or potato = ½ baseball	1 med. fruit = baseball
1 slice of bread = cassette tape	½ cup of fresh fruit = ½ baseball
1 piece of cornbread = bar of soap	½ cup of raisins = large egg
DAIRY AND CHEESE	MEAT AND ALTERNATIVES
1½ oz. cheese = 4 stacked dice or 2 cheese slices	3 oz. meat, fish, and poultry = deck of cards
½ cup of ice cream = ½ baseball	3 oz. grilled/baked fish = checkbook
FATS	
1 tsp. margarine or spreads = 1 dice	2 Tbsp. peanut butter = ping pong ball

PeaceHealth

INFORMED MEDICAL DECISIONS.ORG
The care you need and no less. ■ The care you want and no more.

HOME | ABOUT US | CONTACT | SITEMAP

About The Foundation | We are a non-profit organization advancing research, policy, and clinical models that assure patients are fully informed and involved in decisions that affect their health and well-being.

Did You Know?
Bed rest for back pain is no longer recommended. In fact, too much bed rest can actually be harmful.

Ask the Experts
Professor Gary Schwitzer
Mr. Schwitzer is an associate professor at University of Minnesota School of

PeaceHealth **Referrals to Community Resources**

OREGON.gov

Text Size: A+ A- A Accessibility

Tobacco Prevention & Education Program (TPEP)

Oregon Tobacco Quit Line

Want some free and friendly help to quit smoking or chewing? Call us!

Call these numbers for free from anywhere in Oregon:

- 1-800-QUIT-NOW (1-800-784-8669)
- Español: 1-877-2NO-FUME (1-877-266-3863)
- TTY: 1-877-777-6534
- Or register online at: www.quitnow.net/oregon/

The Quit Line is open seven days a week, 5:00 AM to 12:00 AM (Pacific time)

Should you call the Quit Line?

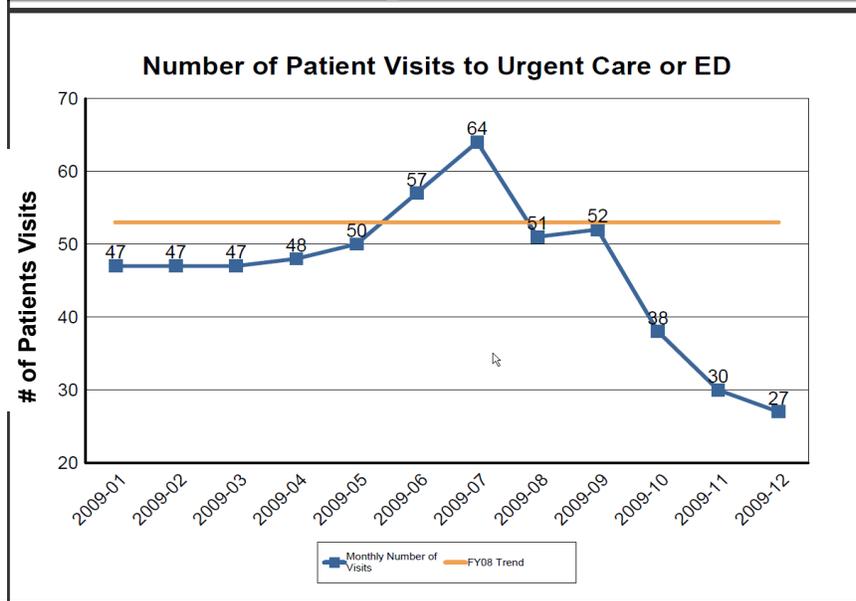
- **Are you ready to quit?** - Call and we'll help you make your quit plan.
- **Are you not quite ready to quit?** - Call and we'll help you get started.
- **Have you tried to quit and it didn't work?** - It can take more than one try to quit for good. Don't be discouraged. Call us. We'll help you make a new quit plan.
- **Have you already quit?** - We know it's hard for a while. If you need some help to stay tobacco-

Living a Healthy Life with Chronic Conditions

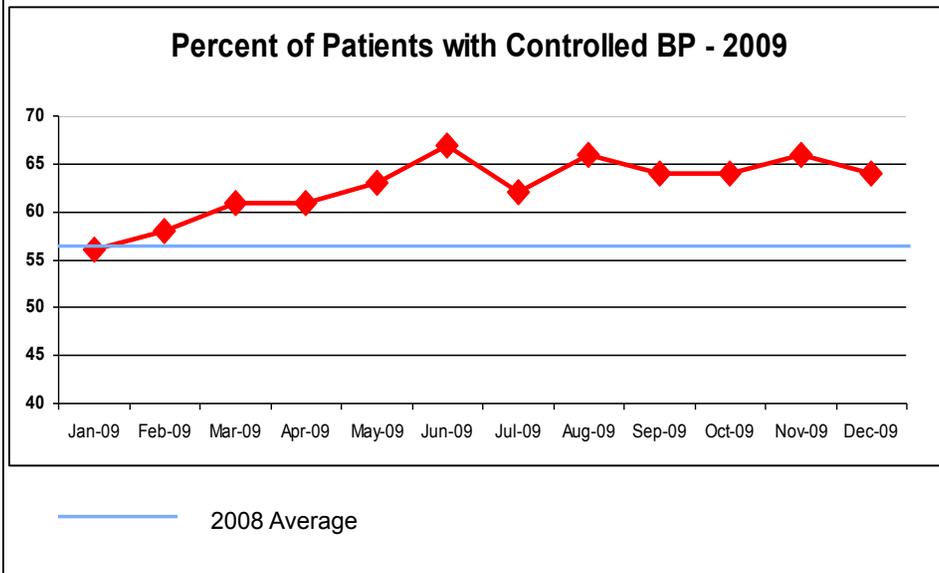
Self-Management of Heart Disease, Arthritis, Diabetes, Asthma, Bronchitis, Emphysema and others

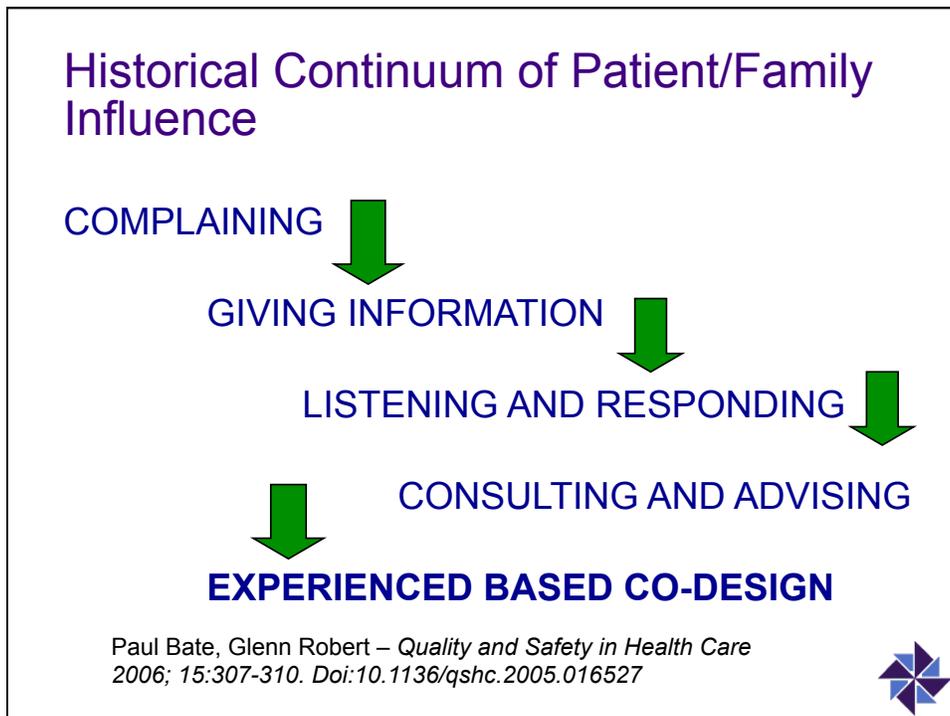
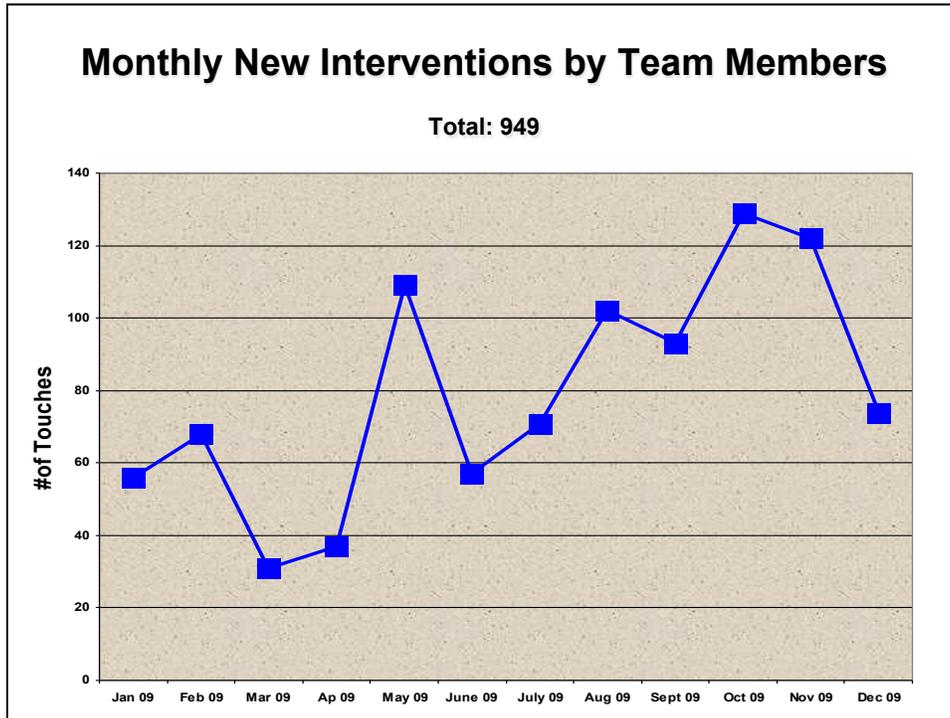
Kate Lorig, RN, DrPH, Halsted Holman, MD
David Sobel, MD, Diana Laurent, MPH
Virginia González, MPH, and
Marian Minor, RPT, PhD

Reduction in Urgent Care- ED Visits



Hypertension Results







Shared Care Plan
Health Record
A Washington Health Record Bank

Communicate. Relax.

Manage.



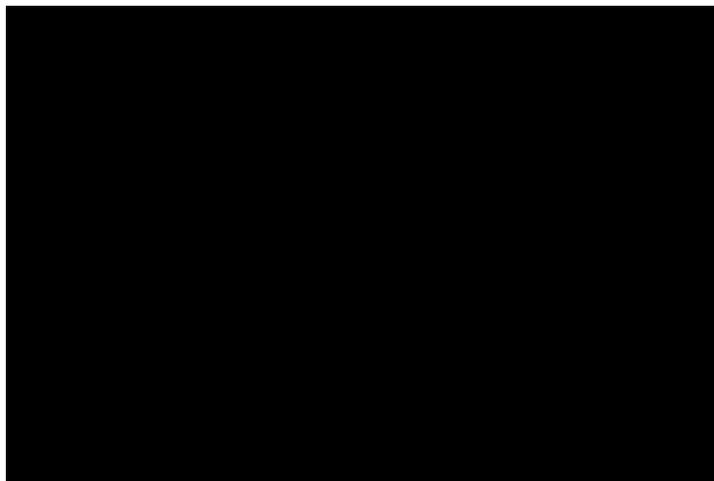
- A Patient Self-Management Tool
- Facilitates information flow across org. boundaries and care team members
- Has generated intense positive interest
- Improved safety and accuracy between patient/healthcare team

Surprising

Built through iterative patient input on paper then moved to electronic

www.sharedcareplan.org

Impact of Personal Health Record on Patient and Family Engagement





Partnerships Create Success

- ▼ MOMS is funded by Medicaid administrative dollars and operated by WVP Health Authority in Oregon
- ▼ MOMS mentors are recruited within the recovery community – effectively through word of mouth, newspapers and outreach. As program spread, engaged former MOMS clients as a recruitment source
- ▼ Training and support are key!

Personal Mentor

Primary goal is to activate the client:

- Role models a success story/enhances client's belief in self
- Navigates client through appropriate community/health resources
- Encourages client to focus on reaching personal goals
- Engages with client in community activities
- Engages with client in educational activities
- Monitors compliance of sobriety and maintenance of healthy lifestyle
- Meets at least weekly with client
- Assists with transportation and various areas of need

Results in Marion County

The number of babies taken at birth for a positive drug screen in Marion county has dropped from:

- 114 in 2005
- 12 in 2010 and
- 9 in 2011.
- None of the babies born positive in 2010 & 2011 were born to mothers who were involved in the MOMS Program.



- Member Advisory Committee established – Fall 2010
- Steering Committee creates by-laws, posts video stories on the CareOregon website – Winter 2011
- MAC members participate in Health Care Action Day at the Oregon Legislature – Spring 2011
- MAC hosts a member Open House to inform members of their role – Winter 2011 & 2012

CareOregon Member Advisory Council

Issues the Member Advisory Council Addresses

- Promoting health and wellness through preventive care, exercise and good nutrition
- Advocating for equitable, high quality health care for all Oregon Health Plan members
- Supporting CareOregon members' needs through peer to peer assistance
- Working with the State on Health System Transformation

Interested in Sharing Your Opinion or Joining the MAC?

The advice from MAC participants comes from the personal experiences of individual members, though the MAC's goal is to reflect the views of the broad membership. To share your thoughts with the Member Advisory Council or get information about how to become more involved, contact the MAC by e-mail at mac@careoregon.org or call us at 503-416-5758.

As a CareOregon member you have something very valuable to contribute to improving our health care system. Your Member Advisory Council is helping to improve the services of CareOregon and our provider network. Your opinions and volunteer time can both be important contributions to our efforts.



Meet Diane, a member of the MAC.

CareOregon Outreach & Partnership

The voices of CareOregon's members matter.
Is your voice being heard?

You're invited to CareOregon's Member Open House

Tuesday, January 25, 2011
11:30 a.m.—1:30 p.m. at CareOregon, 315 SW 5th Ave
*Lunch is provided. Space is limited. RSVP by January 17th.

RSVP by sending an email to healthevent@careoregon.org, calling 503-416-5758 or filling in the attached card and returning it to CareOregon



Come learn about CareOregon's Member Advisory Council (MAC), how they are working for you, and how you can get involved.

CareOregon's MAC is made up of CareOregon members who are concerned about health care issues.

They would like to introduce you to their work and learn from you what you consider important in a health plan

We're Better Together

We will treat each other with respect.



"I will ask for a translator in advance, and bring a caregiver if I need them."



"I will treat you with dignity and honor your cultural needs."

We're Better Together

We will be ready for our visit together.



"I will make a list of one to three most important things to talk about."



"I will make sure your biggest health concerns are addressed."

We will honor each other's time.



"I will arrive 15 minutes early in case I need to fill out papers or have any tests."



"My staff will tell you if I'm taking longer than expected with other patients."

We will recognize each other's needs.



"I will bring my health plan ID and anything else needed to provide my care."



"I will recognize that you may have other needs, such as transportation."

We will treat each other with respect.



"I will ask for a translator in advance, and bring a caregiver if I need them."



"I will treat you with dignity and honor your cultural needs."

We will focus on one to three priorities.



"If I have more issues, I'll make another appointment."



"I'll help you set priorities for our visit, and assure you we can meet again."

We will be open.



"I will find out what any tests or lab results mean."



"I will help you understand your test results and my diagnosis."

We will talk honestly.



"I will try to understand the risks and benefits of each medical option."



"I will recommend options, including preventive measures and lifestyle changes."

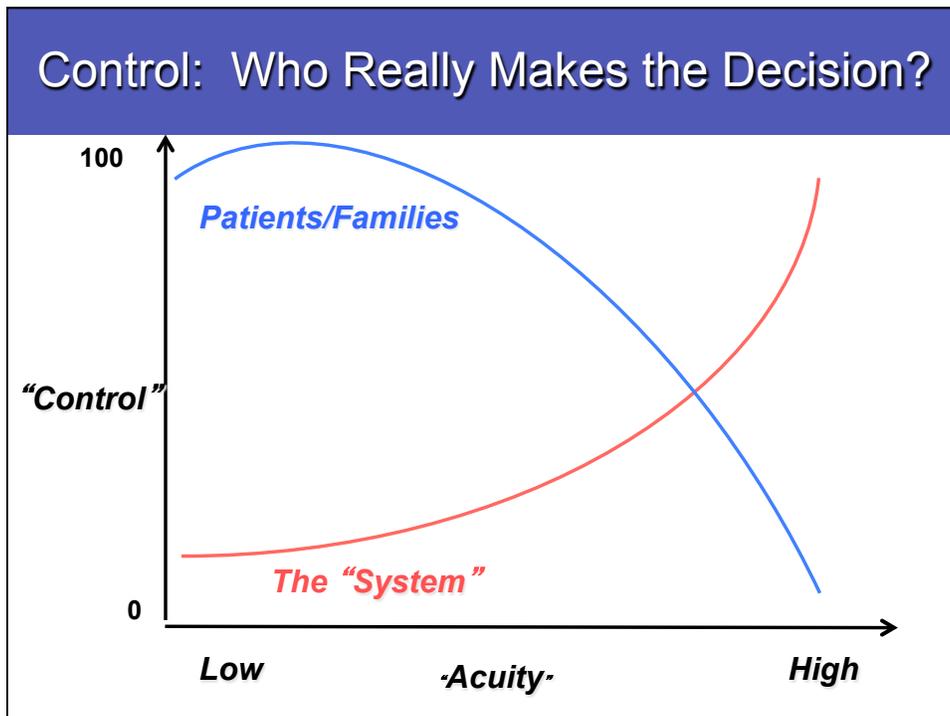
We will agree on a treatment plan.



"If I have any questions about my health or my plan, I will ask you to explain."



"I will give you a written plan, and be sure you are comfortable with it."



Understanding Current Reality

- ▼ People with the support of their families manage their health 24/7 365 days a year
- ▼ 6000 hours/year to manage our health
- ▼ ~ 3-6 hours/year spent with our health care provider.
- ▼ Every 2 hours a decision/choice is made that impacts overall health of a patient with diabetes
- ▼ How much time/\$\$\$ is spent to support self-management?

California HealthCare Foundation Team Up for Health

TEAM UP FOR HEALTH
Partnering with Patients & Families for Better Chronic Care

<p>GETTING STARTED: A NEW MODEL OF CARE <i>Why we created this resource and how to use it</i></p>	<p>TEAM+PRACTICE TRANSFORMATION <i>Improving how we work with patients and clinic teams</i></p>	<p>PATIENT+FAMILY ENGAGEMENT <i>Equipping patients and opening up our practices</i></p>	<p>PROACTIVE SUPPORT OUTSIDE THE VISIT <i>Supporting patients in their day-to-day lives</i></p>
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www.teamupforhealth.org/



Patient and family advisors at Ocean Park Health Center, San Francisco, CA



Patient and family advisors planned the "walk and talk"

Team Up for Health Humboldt Open Door Clinic

Redesigning the clinic's bulletin boards.

Helping to improve community resource referrals.

Reviewing the telephone system.

Developing a patient/friendly business card for clinic patients.

Promoting provider engagement.



Patient Advisory Board



Most patient visits are 15 minutes. You may want to use this form to help organize your thoughts.

Give this form to your Medical Assistant or provider.

** Some concerns are best addressed over time or may need another visit.*

Things I want to remember for my appointment

What is the main reason for your visit today?

Other things you would like your provider to know about

Patient use only

This form was useful: YES NO

Provider use only

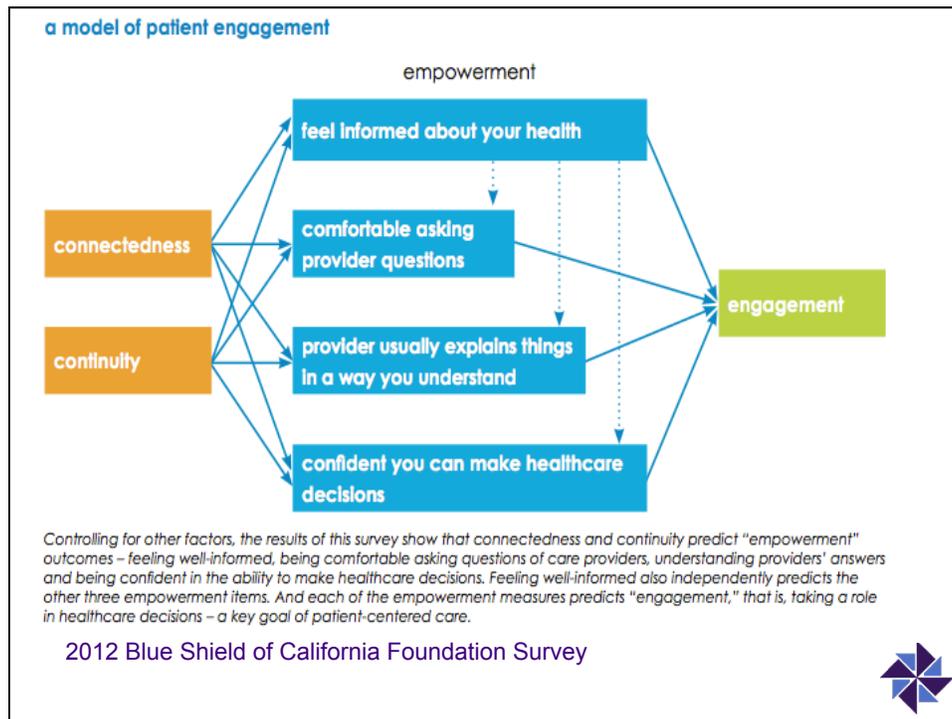
This form was useful: YES NO

Things to consider	Counseling	Symptoms	Side Effects
Test Results	Concerns	Referrals	Insurance
Forms	Family Needs	My Care Plan	Nutritionist
Prescriptions			



Humboldt Open Door Clinic





Results

Continuity and connectedness foster relationships that empower and engage patients.

- ◆ 21 percentage point gap between those who have continuity feel very informed about their health than those who don't.
- ◆ 27 percentage point gap between those who are well known at clinic feel very informed than those without a connection.

Source: 2012 Blue Shield of California Foundation Survey



Results

Information plays a fundamental role in empowerment.

- ▼ Informed: 67% comfortable asking questions.
- ▼ Less informed: 33% comfortable asking.
- ▼ Strong relationship between being well informed and very confident in decision making (7 out of 10) drops to 44% when not informed.

Source: 2012 Blue Shield of California Foundation Survey



Patient- and Family-Centered Care Builds Engagement

Dignity and Respect Participation

Information Sharing Collaboration

“Notably, the extent to which patients feel informed about their health and confident about taking a role in their care decisions predicts their engagement independently of—and more strongly than— their education, income, gender, race/ethnicity, language spoken at home, and the type of care facility they use. That suggests that clear information can help level the healthcare playing field across population groups.”

2012 Blue Shield of California Foundation Survey



PCPCH Core Attributes

The influence of Patient and Family Advisors

✓ **PERSON AND FAMILY CENTERED CARE**

Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.

Communication, education and self-management support, experience of care

Critical Factors to Keep in Mind as Patients and Families are invited as partners at all levels

Meaningful Participation

Appropriate assessment and coaching & matching patients to opportunities

Human anxiety/ fear of retribution- vulnerability

Communication skill development that emphasizes listening/respecting; leadership behavior that acts on patient/family information

Underestimating support for growing new roles

Education, developmental support, safe opportunities to learn new skills; facilitators/coaches



Key Essentials for Engagement Success

- ▼ The framework of Patient- and Family-Centered Care critical to authentic partnerships
- ▼ Engagement is a mutual experience between patients and health care professionals
 - Engagement ≠ Doing what doctor says
- ▼ Strengths-based focus that listens to what matters to patient and family is starting place – too often we assume we know
- ▼ Advisory roles can help engage patients in their own health

“Patient and family advisors have allowed me to step outside the medical system and view our service from a fresh perspective. I am humbled by the board member’s insight and tireless volunteer spirit. Those in the medical system cannot identify patient needs as these frequently turn out to be the exact opposite of what we believe patients want.”

Dan Murphy, Medical Director
St. Charles Family Practice
Redmond, Oregon 2012

Washington Medicaid Study

Tailored Client Coaching Approach

• The client:

- Is in charge of the care plan;
- Sets the pace for change based on perception of need and readiness for change.

• The nurse's role:

- Encourage client confidence - that their actions can make an impact on their health and independence
- Discuss and offer options that allow the client to increase their ability to manage their own care to improve quality of life and/or health outcomes
- Ask the client what ideas they have to better manage their health

Taken from the Presentation *Tailoring Coaching and Activation Supports* Health Activation Symposium 2009 Washington State Aging and Disability Administration Chronic Care Management Project Overview and Findings

Washington Medicaid Study

Survey Findings

- In all five of the areas of health measured by survey—Overall Health Rating, Patient Activation Measure, Overall Self-Sufficiency, Pain Impact, and Quality of Life Scale—the results consistently pointed to better self-reported health outcomes in the treatment group than the comparison group.

Taken from the Presentation *Tailoring Coaching and Activation Supports* Health Activation Symposium 2009 Washington State Aging and Disability Administration Chronic Care Management Project Overview and Findings

Examining Examples of Consumer-Directed Healthcare in the Oregon Health Plan

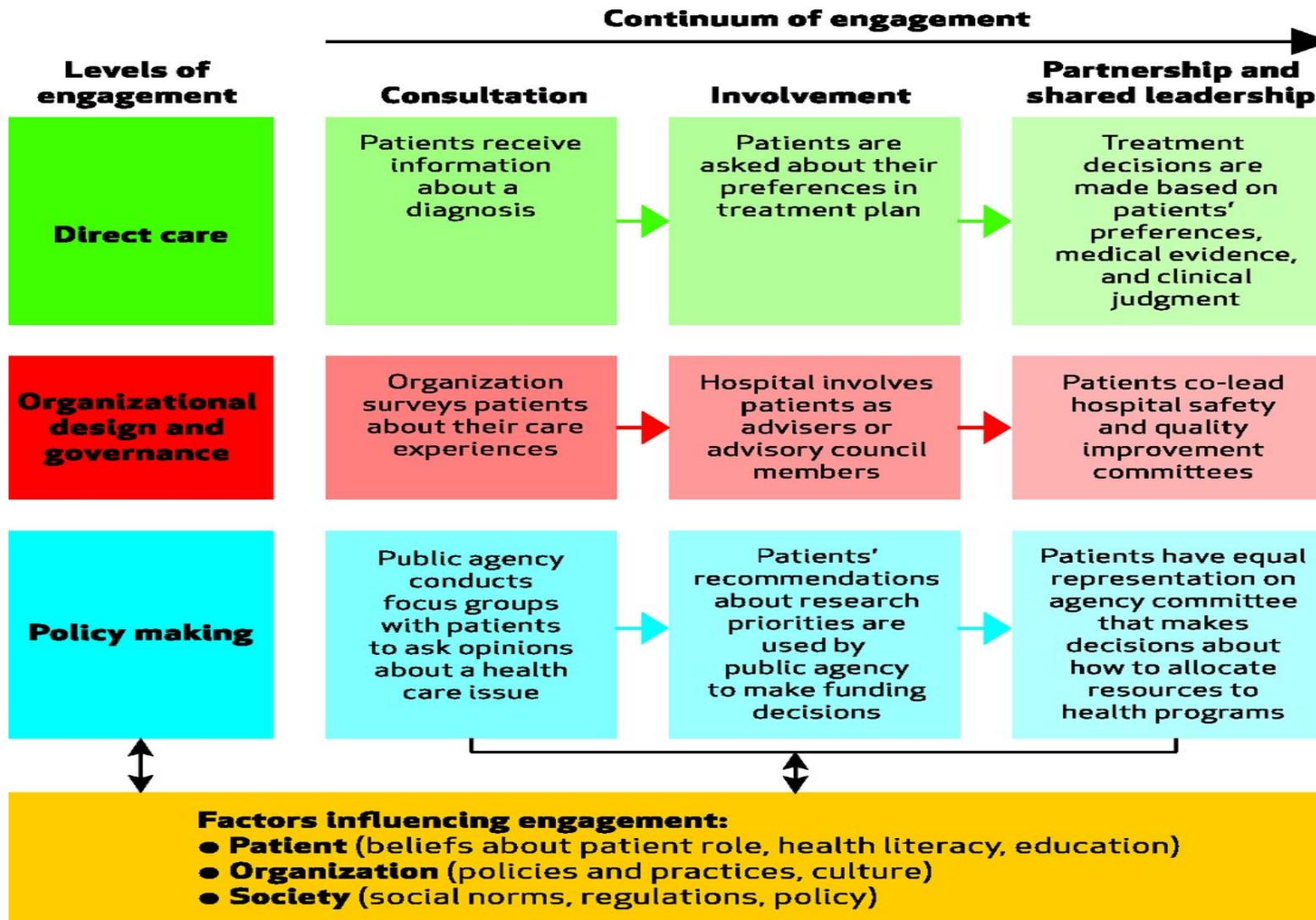
Jason Gringerich

Oliver Droppers

Presentation Overview

- Orient to and review with the committee several approaches to consumer-directed approaches to health care (CDHC)
- Offer examples for each approach at different points in the health care continuum
- Explore CHDC as another opportunity to activate and engage patients in an effort to empower individuals
- Proposed next steps for the committee around this work

A Multidimensional Framework For Patient And Family Engagement In Health And Health Care.



Approaches to CDHC

- Allocate control of limited Medicaid funds to enrollees
- Remove barriers to the high value care
- Incentivize health behaviors and cost effective utilization by individuals enrolled in Medicaid
- Assistance with decision support
- Train patient-centered medical homes and providers in techniques for patient engagement/motivation
- Centers of excellence

Approaches to Consumer Directed Healthcare

- A. Allocate control over Medicaid funds to enrollees
- B. Address barriers to the healthy choices and high value care
- C. Incentivize health behaviors and cost effective utilization by individuals enrolled in Medicaid

Approaches to Consumer Directed Healthcare

- D. Assistance with decision support
- E. Train health care professionals in evidence-based techniques for patient engagement/motivation
- F. Centers of Excellence

Exploring CDHC impact on...

- Health Plans/CCOs
 - Plan design, incentive management and tracking
- Providers
 - Coordinate, educate, track, share
- Consumers
 - Learn, respond, engage

Approach A: Allocate Cost

- Health Plans/CCOs
 - Plan design, patient education, provide transparent cost information
- Providers
 - Less change except where consumers would have more provider/service choice
- Consumers
 - Learn, shop, prioritize

Approach B: Eliminate Barriers

- Health Plans/CCOs
 - Identify and address barriers (system, society, consumer)
- Providers
 - Restructure practice to eliminate barriers; aid in addressing consumer barriers
- Consumers
 - The barrier is gone!

Approach C: (Dis)Incentives

- Health Plans/CCOs
 - Create and implement incentive system around consumer behaviors where change would improve health/lower costs
- Providers
 - Work with patients to encourage them to respond to incentives
- Consumers
 - Engage and receive rewards

Approach D: Decision Support

- Health Plans/CCOs
 - Provide/acquire decision support
 - Incentivize providers to use them
- Providers
 - Incorporate decision support tools
- Consumers
 - Participate with providers in shared decision-making

Approach E: Patient Activation

- Health Plans/CCOs
 - Provide/acquire tools/educational materials
 - Incentivize health care professionals to use them
- Providers
 - Measure and change patient interactions order to maximize meaningful activation
- Consumers
 - Engage/Activate

Approach F: Centers of Excellence

- Health Plans/CCOs
 - Identify Center of Excellence(s) (COEs) and structure plans to encourage their use where appropriate
- Providers
 - Specialize, raise standards, become COE
- Consumers
 - Use COEs

Next Steps

- Continue to learn about patient engagement, activation, and shared-decision activities using examples in Oregon
- Assess gaps and opportunities in our state that may help to inform and enhance consumer directed approaches statewide from a Medicaid policy perspective
- Solicit information from key stakeholders
 - Invite additional perspectives to the conversation
- Over the next several months
 - Staff will perform additional research and develop an Oregon environmental assessment
 - Work with committee to formulate draft recommendations

Public Comment

Closing remarks

Adjourn