PATIENT ENGAGEMENT: CASE STUDY

Care Management Plus

Case Example: Care Management Plus

- 2001: John A. Hartford Foundation awarded Geriatric Interdisciplinary Teams in Practice grant to Intermountain Healthcare
- Objective: To develop and study impact of nurse care managers and special computer tools in primary care offices
- Model: Medical home, coordinated care, patient-centered

Care Management Plus

- OHSU Faculty
  - David Dorr, C0-PI
  - K. John McConnell
  - Kelli Radican
  - Susan Butterworth
- Intermountain Faculty
  - Cherie Brunker, Co-PI
  - Liza Widmier
  - Ann Larsen
  - Mary Carpenter
- Columbia University Faculty
  - Adam Wilcox
- Advisory Board
  - Tom Bodenheimer
  - Larry Casalino
  - Eric Coleman
  - Cheryl Schraeder
  - Heather Young
  - Steven Counsell

Care Management Plus Results*

Health outcomes

- ✓Reduced hospital admissions
- ✓Increased guideline compliance
- ✓Reduced mortality

Cost savings

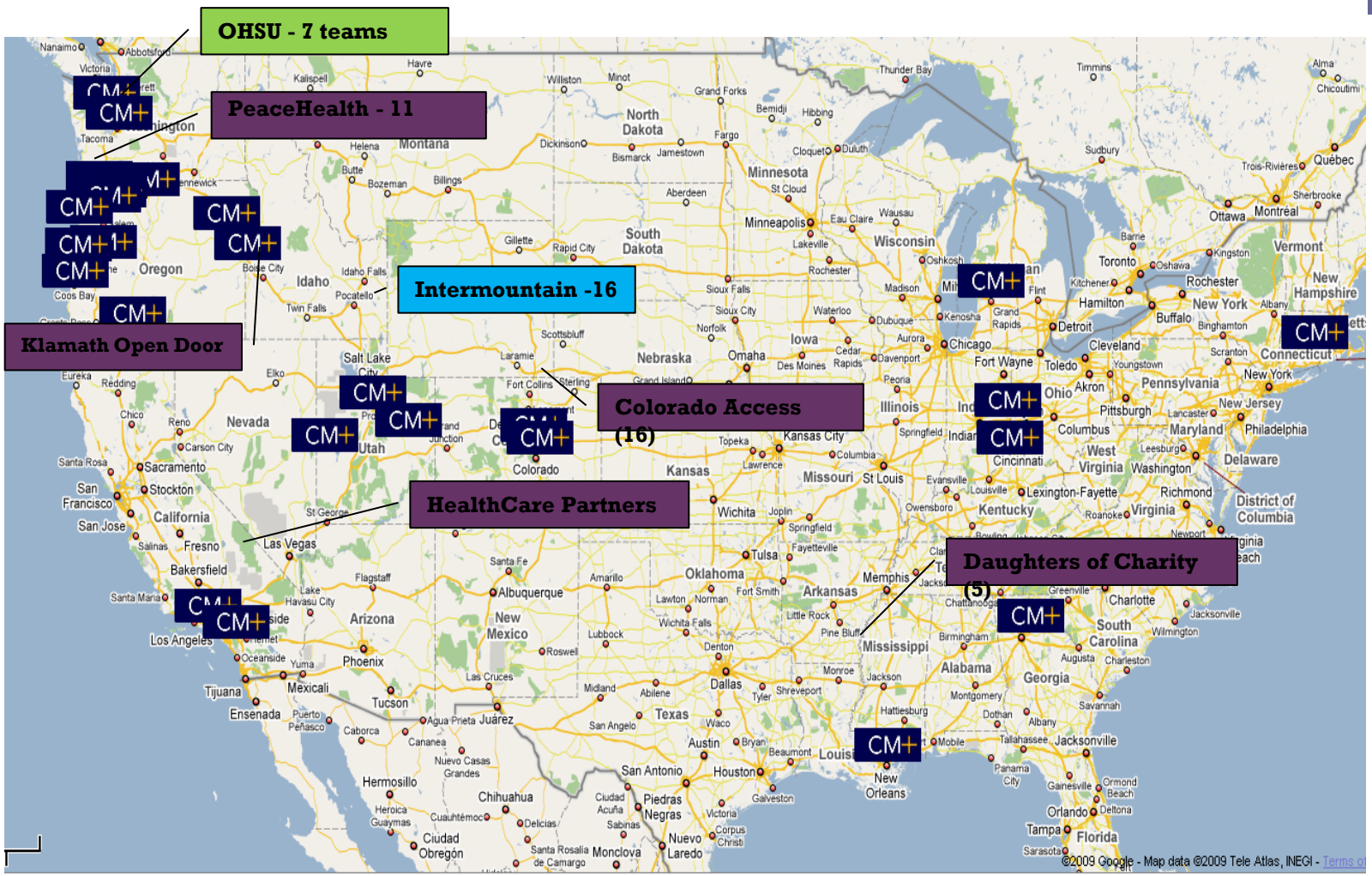
- ✓For patients with complex illness, estimated savings in Medicare $163k per practice with cost of $90K
- ✓$640 saved per patient per year
- ✓8-12% increase in practitioner productivity

Satisfaction

- ✓Patient: "A life-saver"; "The reinforcement was wonderful"; "They really care"; "Gave me more time and answers"
- ✓Practitioners: "I am working smarter, not harder"; "Patients are less anxious, care more consistent, team is stronger"; "Wish I had these skills years ago"; "Computer tools are an absolute godsend"

**Peer-reviewed references available online at www.caremanagementplus.org*

Dissemination to 75 Clinical Teams



Ann Larsen, RN, CDE

- Along with her other accomplishments, Ann brings 18 years of experience as a care manager for high risk, medically-complex patients in the primary care setting. She pioneered care management at Intermountain Healthcare, where she received the 2009 Intermountain Medical Group Nursing In Excellence Award, and was a key participant in the Hartford Grant, Evaluating the Impact of Care Management in Primary Care. Ann has trained nurses across the country in the patient-centered, care management concept and presented her work at both local and national conferences.

PATIENT ENGAGEMENT: CASE STUDY

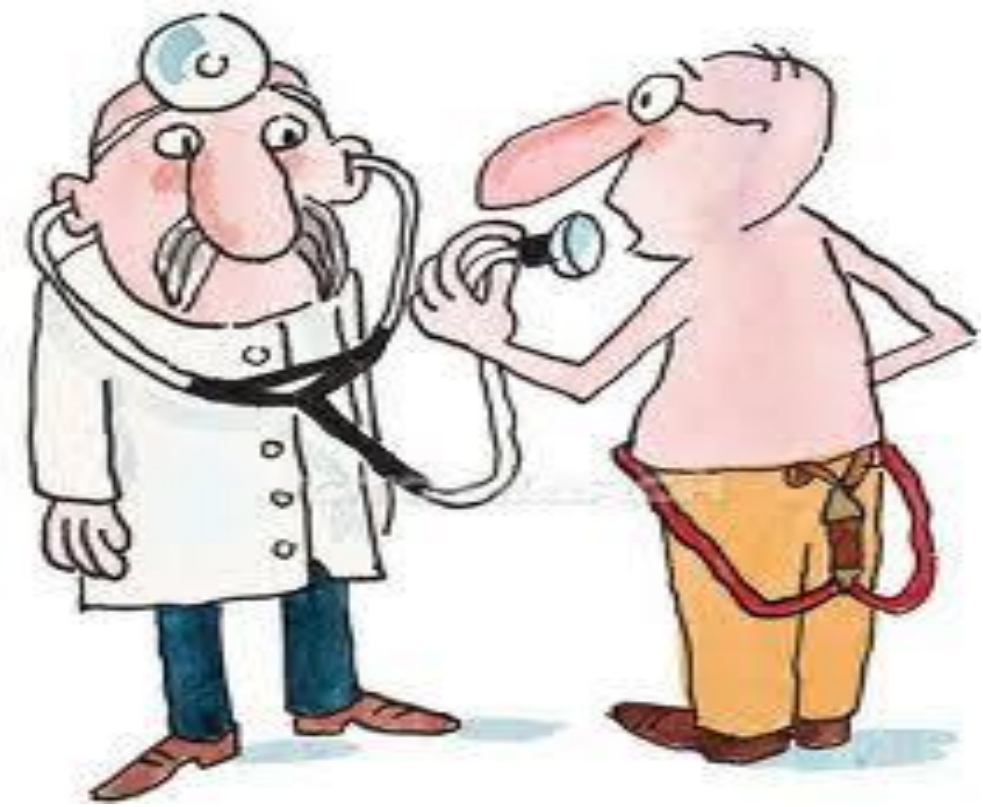
Ann Larsen, RN, CDE

December 4, 2014

Objectives

- Share my work as a care manager in primary care setting
- Discuss engagement strategies that worked for me

Patients Won't Hear You Until You Hear Them



Reframing Our Perspective

INSTEAD OF:

"What is the Matter?"

TRY:

"What Matters to You?"

Individualize the Intervention

- Traditional
  - Make the patient "Fit" our process

- Patient-Centered
  - Focus on individual needs
  - Customize the interventions to "Fit" the patient

Everyone Has a Story

- Patients want to tell their story
- ASK the right questions
- LISTEN

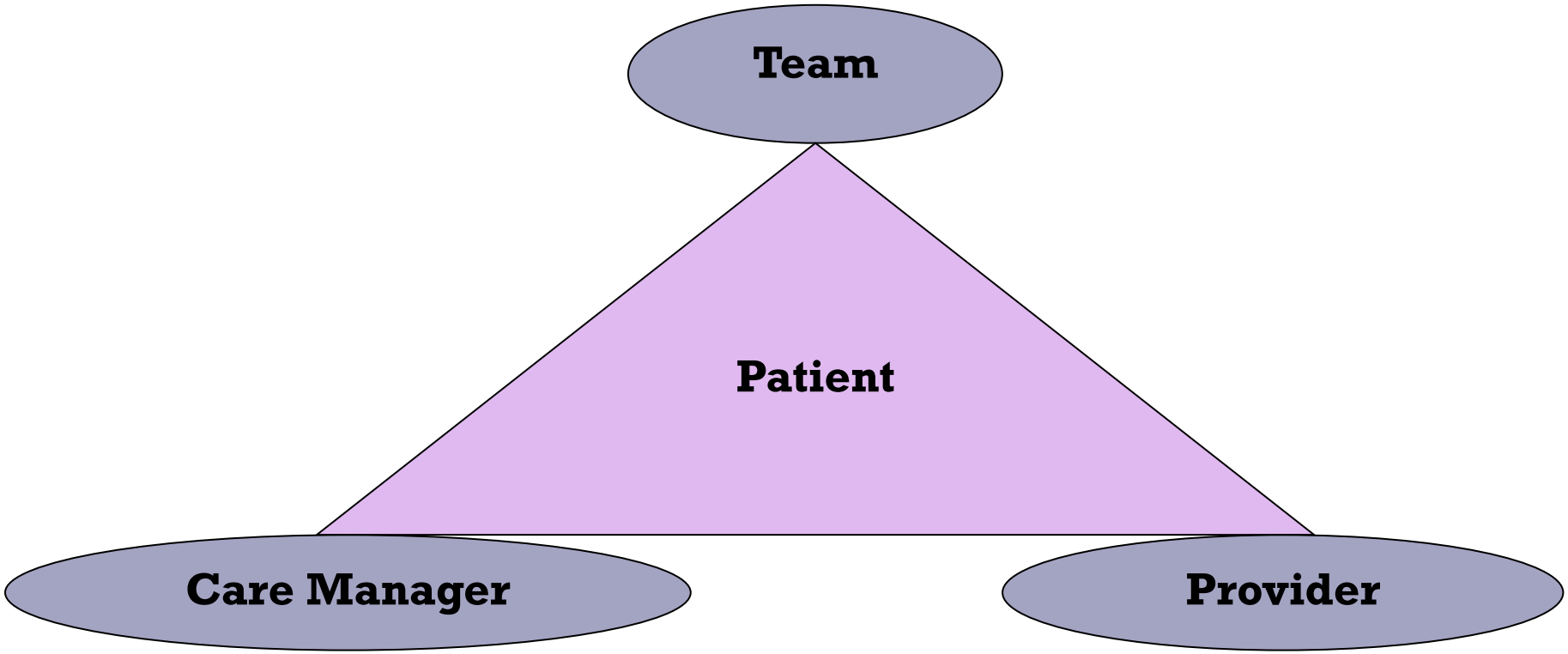
It's all about the team

Working Together to Provide the Best Care

Relationships Are the Key to Success

- Mary Kay Ash and the invisible sign
- Patch Adams: "Look beyond what you see."

Relationships:
Based on Respect & Trust



Patient Engagement

- Patient engagement enhances adherence to therapy
- Motivational Interviewing = Engagement
- The more proficient the MI—the more engagement
- Patients are experts in themselves
- Open-ended questions:
  - "What"
  - "How"
  - "Tell me"

Identify Barriers, Challenges, Fears & Stressors

- Age, Finances, Education, Insurance, Homelessness, Unemployed, Gender, Marital Status, Language, Living Arrangement, Cultural, Anxiety, Caregiver, Family Adaptability, Home Environment, Depression, Health Literacy, Lower Cognitive Function, Motivation, Embarrassment, Social Support, Loss of Control, Illness, Access to Care, Severity of Disease, Hopelessness, Medication, Social Isolation, Age, Dementia, Etc.

Open-ended Questions: "What" "How" "Tell me more"

- Reason for referral
- Why they came to see you
- What they have been told
- What do you think is wrong
- Question/Concern
- Challenge, Frustration, Fear
- Source of Stress
- What is hardest thing for you about having ___?

Ask

- If you were to believe (you could manage your diabetes), what would be different?
- What does it mean to you to (take insulin?)
- What help do you feel you need?
- What have you learned from your illness?
- Who would care for you if you became ill?
- Are you the primary caregiver for someone?
- Do you feel safe?

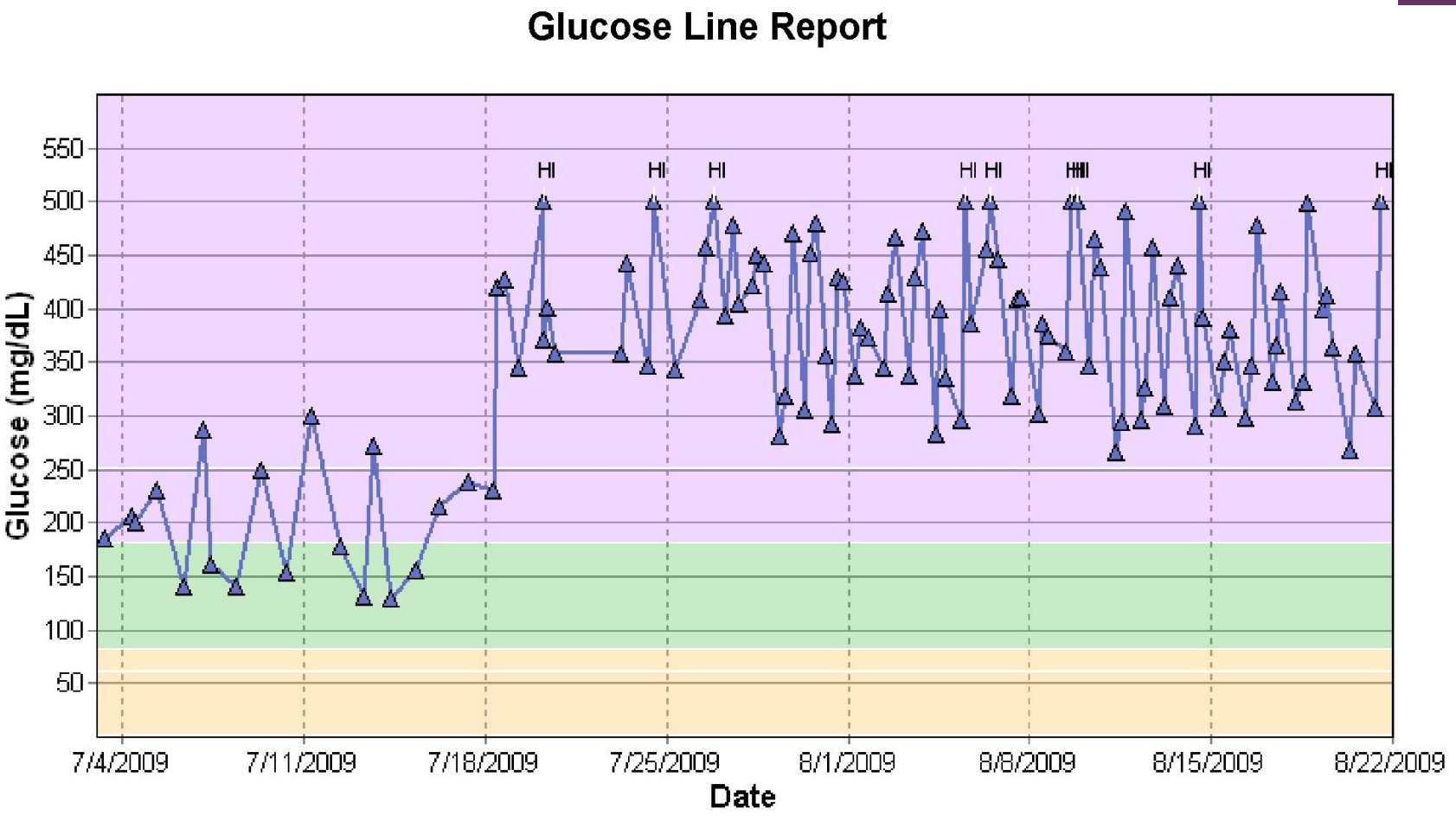
Senior Wellness Group

- Provides social support
- Is efficient and effective
- Can be combined with preventive screening events
- Enhances engagement

Healthy Mind Body Class

- Integrates physical and mental health
- Provides support for depression

How We Teach


Glucose Line Report
Glucose (mg/dL)
550
500
450
400
350
300
250
200
150
100
50
HI
7/4/2009
7/11/2009
7/18/2009
7/25/2009
8/1/2009
8/8/2009
8/15/2009
8/22/2009
Date

Cruise Director

- Setting health boundaries
- Sometimes less is best
- Leave the responsibility where it belongs

Who's Working Harder?

- If you are working harder than your patient, there may be a problem!!

Coach versus Enforcer

- If you push - they will push back!

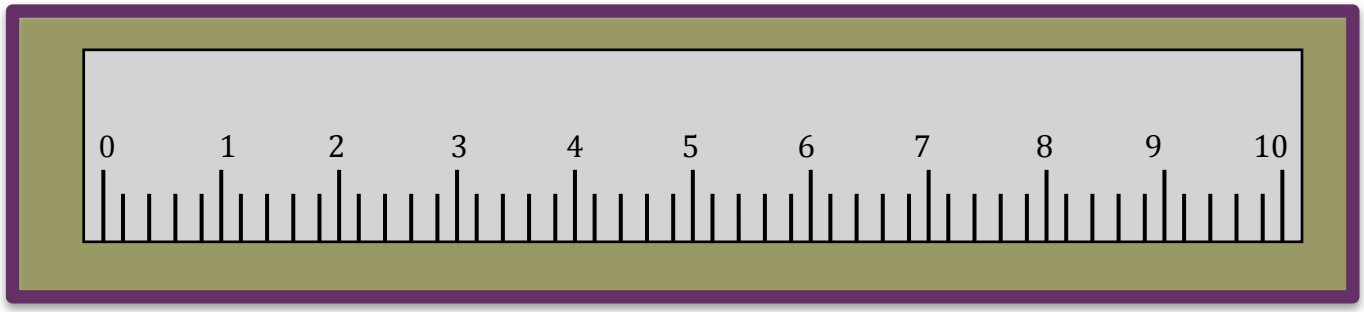
Like a River, Roll With It!
Find a New Way to Talk to Them

Walter's Wiggles

Readiness + Motivational Interviewing

- Match intervention with stage of change
- BUT DON'T STOP THERE
- Use motivational interviewing to help move patient along

Assessing Importance, Confidence, Priorities, Effort…



- How important is it for you to [check your sugars]?
- What makes you a __ and not a 0 or 1? What else?
- What would it take to move you to a [1 or 2 points higher]? What else?

Family Pattern Profile*

I. Disconnected/Avoidant
   - Isolated, seeks little support

II. Confused/Chaotic
   - Confused problem, attach quickly, chaos in family

III. Balanced/Secure
   - Close friends, sense of humor, able to trust, seek support

Who do you talk to when you are stressed out or need help?

- "No one" = Avoidant
- "Everyone" = Chaotic
- "Family or Friend" = Balanced

**Brenda Reiss-Brennan, Intermountain Healthcare*

Match the Intervention to FPP

I . Avoidant

- "It must be a little uncomfortable for you to come talk to me."
- Happen to bump into at physician appointment
- Call and ask if good time to talk

II. Chaotic

- Set boundaries
- Set regular appointments
- Engage the team

III. Balanced

- Educate
- Negotiate good times to talk

Learning Style

- "How best do you like to learn?"
- Visual, verbal, hands-on

Health Literacy

- "Do you have a hard time understanding what your doctor tells you?"

Medication Adherence

Instead of….

- "Do you take your medications as prescribed?"; or
- "Do you forget to take your medications?"

Ask…

- "If it's okay with you, tell me all about your medications."; or
- "I'd love to see how you take you medication. Can you show me?"; or
- How many times a day/week do you forget to take your medication?

What other concerns do you have that we haven't discussed yet?

Collaborative Goal Setting

- What is your goal?
- What is your biggest roadblock?
- Evoke Change Talk
  - First: Desire, Ability, Reasons, Need to Change
  - Then: What, How, Where
- What can we [the team] do to help you with your goal?
- Stick with best practice and evidence guidelines

Success

- Patients feel listened to and validated
- They are receptive to considering change
- They can verbalize the benefits; which means they are talking themselves into change!

Build a Bridge:

From where the patient is to where s/he wants to go…