Disease Management: Key Aspects of Implementation, Physician Engagement and Patient Empowerment.

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Montefiore
An Integrated Delivery System

- **Multiple levels of care**
  - **Inpatient Care**
    - Two general hospitals
    - New Children's Hospital
    - Total: 1,062 beds; 57,000 discharges; 4,000 newborns
  - **Ambulatory Care - 2 million visits/year**
    - Emergency Services
    - 19 community primary care centers
    - 3 major specialty care centers
    - Clinics, ambulatory surgery
  - **Post-acute care**
    - 80-bed SNF, 22-bed rehab unit
    - Home health agency - 405,000 visits
- **Geographic concentration**
  - **90% of MMC's patients from Bronx, Westchester**

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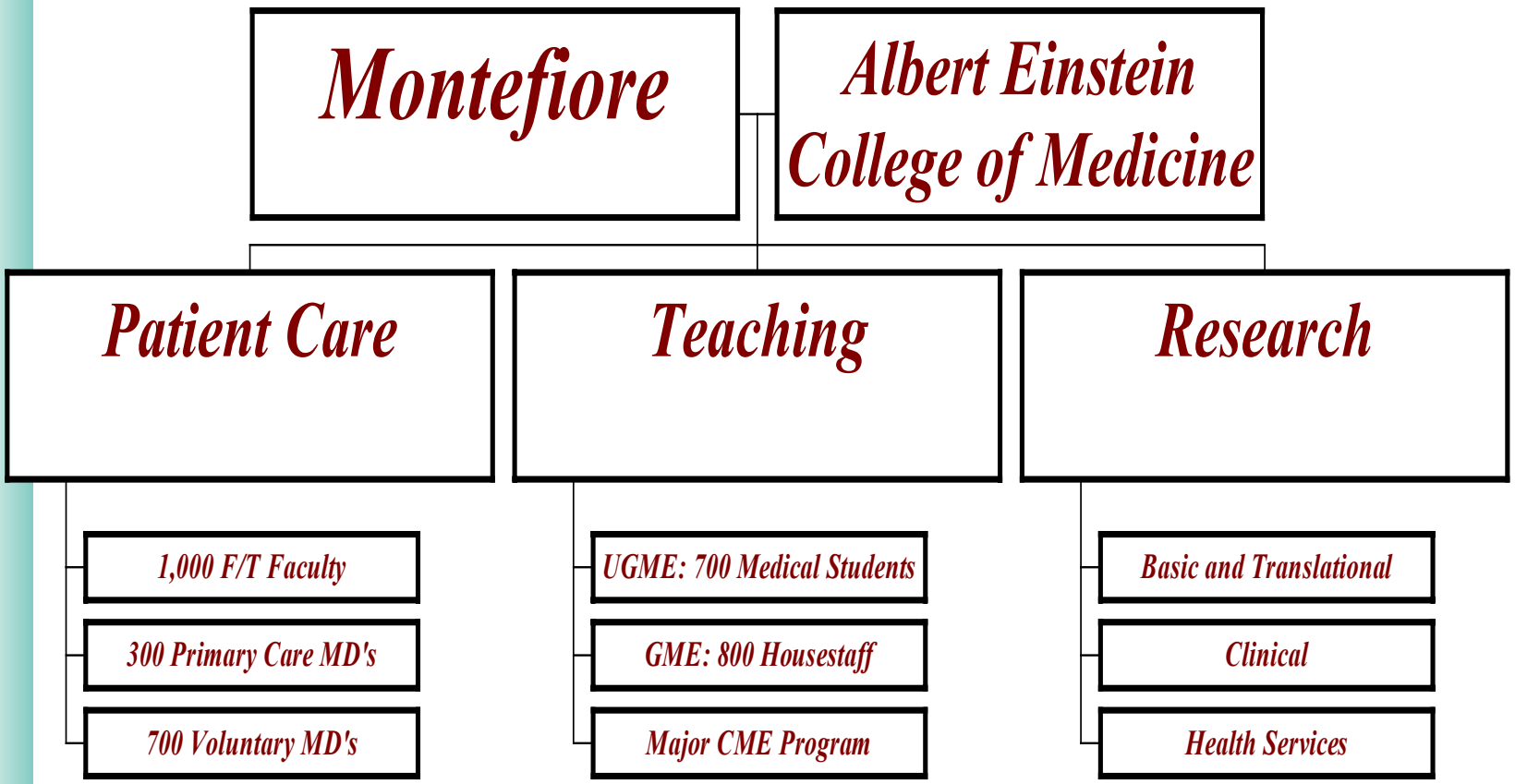
Montefiore
An Academic Medical Center



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An Historic Note: The Genesis of Disease Management Concepts

Originated from Ground Breaking Recommendations in the 90s that Said Health Care Leaders Should:

- **Apply "systems thinking" to health care**
- **Employ "evidence-based" care principles**
- **Utilize "industry standard" quality improvement principles (ie, CQI)**

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Disease Management
Members of Development Team

- Specialist and Primary Care Physician Co-Champions
- Nurse Clinician Leaders
- Other Clinicians
- Case Managers
- Educators
- Home Care Providers
- Experts in CQI Principles
- Experts in Quality Outcome Measurements
- Pharmacists
- Others (OT/PT, RT, , X-Ray, etc.)

Teams must be multidisciplinary and include participants from all organizational levels.

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Delivering Disease Management

Guiding Principles:

1. Wherever possible, apply *evidence-based management* to maximize likelihood of successful delivery of *evidence-based medicine.*
2. Work aggressively to engage and empower patients
3. Emphasize:---The doctor is in charge!

   Strive for active PCP engagement and behavior change

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Evidence-based Management

DEFINITION:

A process whereby important operational and strategic decisions are made based on evidence from well conducted management research.

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Evidence-based Management

Goals:

To minimize the problems of under-use, over-use and mis-use of management techniques and strategies.

Disease Management:
Key Design and Implementation Components

PHYSICIAN ENGAGEMENT

- Guidelines---that are good
- Education----that is effective
- Decision Support—that is at the P.O.C
- Incentives---that are fair

PATIENT EDUCATION

Teach:

- Problem Solving
- Self Empowerment

INTEGRATE/COORDINATE CARE

- Case Manager
- I.T.

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Best Management Practice for *Engaging Physicians* in Best Practice Programs

Changing Physician Behavior

Good*

•Well done clinical practice guidelines

PLUS

• Specific educational techniques (academic detailing; opinion leaders, interactive sessions)

• Decision support at the POC - prompts and reminders/office staff support

• Incentives

Less Good

•Guideline that are:

--clumsy, hard to use

--used unchanged from national societies

--given alone

•Didactic lectures

•Registries alone

•Feedback on performance

Don't Know

•Full power of incentives

•Full value of primary care teams

•Full value of electronic IS

•means more likely to improve physician performance and patient outcomes

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Best Management Practice for *Engaging Physicians* in Best Practice Programs

Clinical Care Guidelines

Good

- **based on scientific evidence**
- **Current, state-of-the-art**
- **simple and easy to follow and use**
- **only 2-3 key issues included**
- **Users allowed to pilot and critique**
- **all aspects are deliverable (e.g. access to specialists)**
- **updated frequently**

Less Good

- **Use of national guidelines with no local "flavor"**
- **not evidence-based**
- **not reviewed regularly**
- **difficult to follow**
- **not flexible**
- **not easily applicable to regular practice**

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MONTEFIORE DIABETES LIPID MANAGEMENT PROGRAM:

APPROACH TO DRUG TREATMENT OF HYPERLIPIDEMIA (part 1)

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Goal LDL < 100 mg/dL & Non-HDL <130 mg/dL

If not at Goal AND

TG < 200 mg/dL	TG = 200-500 mg/dL*	TG > 500 mg/dL*
1. Statin 2. Cholesterol Absorption Inhibitor (CAI)	1. Statin 2. Cholesterol Absorption Inhibitor (CAI)	High Potency Statin -OR- Fibrate
Alternative Approach 1. Add Resin OR 2. Add Niacin Note: Niacin is relatively contraindicated in diabetics or if Homocysteine is elevated	Alternative Approach 1. Add Resin OR 2. Add Niacin Note: Niacin is relatively contraindicated in diabetics or if Homocysteine is elevated	Alternative Approach 1. Combination therapy** OR 2. Fish Oil

Additional Notes concerning drug therapy:

- ➔ Always assess patient adherence before altering medication schedule
- ➔ See following pages for more details concerning drug therapies
- ➔ Use combination therapy as needed to achieve LDL goal
- ➔ Consider referral if unable to achieve LDL goal

*Weight reducing diet is essential. Either low fat or low carbohydrate diet may be tried

**Be cautious of combination of statin and fibrate

Improving Preventive Care by Prompting Physicians

E. Andrew Balas, MD, PhD; Scott Weingarten, MD; Candace T. Garb, BS; David Blumenthal, MD; Suzanne Austin Boren, MHA; Gordon D. Brown, PhD

Literature review, 33 studies, 1,547 clinicians, 54,693 patients

Overall, prompting (delivered before a scheduled encounter) increased preventive care performance by 13%.

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Improving Residents' Compliance With Standards of Ambulatory Care

Results From the VA Cooperative Study on Computerized Reminders

Conclusion:

...Computerized reminder systems versus no reminders improved compliance with certain standards of care

Significance achieved with:

Diabetes: Eye and Foot Exams

Smokers: Cessation Counseling

Elderly: Pneumococcal Vaccination

No effect noted with: lipid management in CAD, HbA1c level reduction, anticoagulation in atrial fibrillation or beta blocker post MI

Types of Physician Incentives

Goal: Create Rewards for Improving Quality of Care

- Financial
  - **remove financial barriers and disincentives**
  - **increase financial reward (bonus, enriched payment, better contracts, P4P)**
- Non Financial
  - **CMEs**
  - **tools to improve practice efficiency**

  (electronic IT support)
  - **resources to enhance patient care**

  (case managers, care teams)
  - **public recognition of excellence**

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Best Management Practice for *Engaging Physicians* in Best Practice Programs

Additional adjunctive components and strategies likely to be effective but requiring further study

- **THE CHRONIC CARE MODEL**
- **Creating primary care teams**
- **Planned visits**
  - ***individual or group***
  - ***involves RNs, MD, pharmacists, etc.***
- **Office re-engineering**
  - ***change staff job descriptions to improve patient flow and support clinicians***

Some studies have shown benefit, others not

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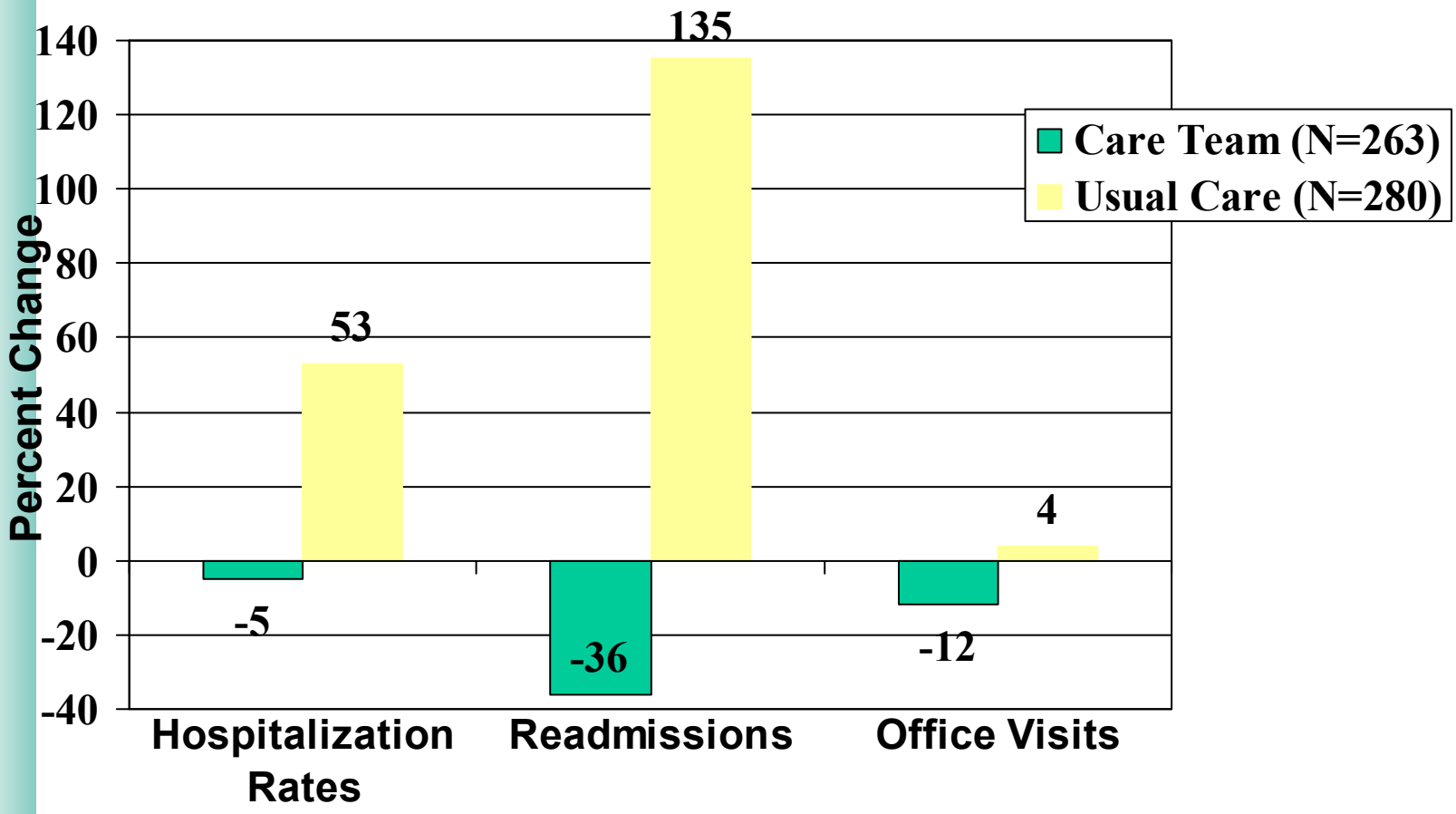
Physician, Nurse, and Social Worker Collaboration in Primary Care for Chronically Ill Seniors

Lucia S. Sommers, DrPH; Keith I. Marton, MD; Joseph C. Barbaccia, MD, MPH; Janeane Randolph, MSW



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Disease Management: Engaging Physicians to Ensure Successful Implementation

Obtain Early Clinician Participation and Leadership

- Include Key Clinicians in Program Strategy Planning
- Include Key Clinicians On All Design Teams
- Choose "Friendly" Clinicians for the Pilots
- Develop a "Clinician Champion" Working Committee
- Develop a Clinician Champion in Every Office
- Favor Those Requesting Participation
- Target Practices with Evidence of High Utilization

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Disease Management: Engaging Physicians to Ensure Successful Implementation

Obtain Solid Buy-In From Clinicians

- Focus on Improving Quality & Outcomes As Major Goals
- Make Guidelines Evidence-Based Wherever Possible
- Choose Only 2-3 Most Important Issues—Be Simple
- Avoid Contentious Issues
- Request Clinicians to "Try It Out" for a Defined Period
- Let Clinicians Critique and Challenge the Protocols
- Make Sure All Aspects of the Protocols are Deliverable (e.g. Access to Specialists)
- Show Sensitivity to Complicated Operational Issues

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Disease Management: Strategies to Achieve Excellence in Patient Education

- Follow evidence-based management
- Assess readiness to change
- Utilize a team-approach, including pharmacists
- Utilize self-management tools
- Consider incentives

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Best Management Practices for *Engaging Patients* in Best Practice Programs

Patient education

Good

TEACH SELF-MANAGEMENT SUPPORT----which includes;

- **Information giving**
  - **-ask-tell-ask; closing the loop**

PLUS

- **Collaborative decision making**
  - **-establish an agenda**
  - **-assess readiness to change**
  - **-goal setting**

Less Good

- **Traditional didactic, disease specific knowledge-transfer only**

Don't Yet Know

- **Best way to communicate**
  - **-face-to-face (1-on-1 or groups)**
  - **-telephone (live, IVR, landline, cellular)**
  - **-electronic (RPM, internet, video)**
  - **-broadband (TV)**
- **Who should communicate**
  - **-physicians, nurses, pharmacists, SW, peers, psychologists educators.**

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Best Management Practice for *Engaging Patients* in Best Practice Programs

PRINCIPLES of SELF-MANAGEMENT SUPPORT

Definition: ***The assistance caregivers give to patients to encourage daily decisions that improve health-related behavior and clinical outcomes***

Goals*: To aid and inspire patients to become informed about their condition and motivated to take an active role in their treatment to improve their health-related behavior*

Components*: Information giving(education about their condition) PLUS Collaborative decision making.*

Patients are given information, expertise and tools; they now become responsible for their day-to-day health decisions

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Information Giving

Aim is to make sure the patient really understands the information they are given --50% now leave the office confused.

- **Use an "ask-tell-ask" technique which provides information in a manner directed by the patient.**
- **"Close the loop" assesses patients comprehension of the information**

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Best Management Practice for *Engaging Patients* in Best Practice Programs

Collaborative Decision Making

" ***a process by which clinician and patient consider available information about the medical problem , including treatment options, and then consider how these fit best with the patient's preferences for health status and outcomes"***

The process includes:

- **Establish an agenda**
  ---letting patient decide what topic is to be discussed at each session
- **Assessing readiness to change utilizing:**
  ---the "transtheoretical model"—best for single behavior change
  --- "motivational interviewing"---best for multiple behavior changes
- **Goal setting**
  ---using an "action plan", help set realistic targets patients can achieve

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TRANSTHEORETICAL MODEL

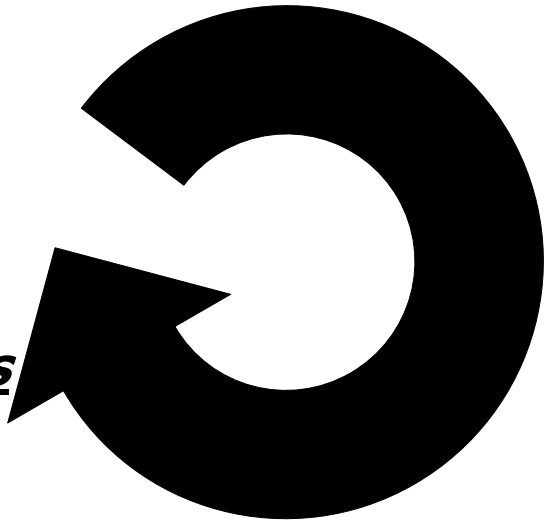
Overview

- TTM, (*Prochaska and DiClemente, 1984*) provides a framework for understanding the process of:
  ---change of problem behaviors
  ---adoption of positive behaviors.
- This framework gives the provider information useful in the tailoring of an individualized intervention to meet the patient's stage of readiness to change.
- It is based on the concept that people move through progressive stages of readiness to change, and that fewer than 1 in 5 patients at any point are ready to change
- It suggests that strategies to create change must be focused and relevant for each stage

Behavior Change: Stages and Strategies

1.Pre Contemplation
- -Denial
- -Defensive
- -"I have no problems"
- -*No intention to change within 6 months*

2.Contemplation
- –Aware of problem
- –Ambivalent
- –*Not ready yet for action - maybe within 6 months*



5.Maintenance
- -*Change lasted > 6 months*
- -Proud of success

4.Action
- -*Successfully changed, but <6 months*
- -At risk for relapse

3.Determination/Preparation
- –Commitment to change soon
- –Can overcome barriers
- –*Change likely within one month*

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Best Management Practice for *Engaging Patients* in Best Practice Programs

Motivational Interviewing (MI)

- **Takes the view that behavior change requires two components----knowledge PLUS self-confidence in the ability to change.**
- **The goal of the interview is thus to assess the patient's current feelings about their understanding of the *importance* of and sense of *confidence* that they can make the necessary change in life-style behavior**
- **Therefore the aim of MI is to create confidence in the patient's ability to change rather than simply to focus on getting them to comply with care-giver advice**

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Best Management Practice for *Engaging Patients* in Best Practice Programs

<u>Key Aspects of the Patient Interaction</u>

ITS ALL ABOUT EXCELLENCE IN COMMUNICATING

1.Gain Trust

2. Build Rapport

3. Embark on Goal Setting

4. Apply Effective Strategies to Achieve Goals

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Best Management Practice for *Engaging Patients* in Best Practice Programs

Principles in the Use of Telephone Support

- **Telephone counseling should be structured and follow behavior-change strategies rather than be free-flowing**
- **Each call should have a specific goal and not try to accomplish too much at one time**
- **Patients most likely to benefit should be targeted. These may include patients with multiple chronic conditions, limited health literacy or gaps in care**
- **The most effective programs are closely linked with outpatient care and clinician follow-up**
- **Regular screening and assessment tools should be used to determine intensity of service**

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Best Management Practice for *Engaging Patients* in Best Practice Programs

Additional Communication/ Monitoring Vehicles

- **Electronic**

  --internet-based support, on-line chat rooms

- **Remote Patient Monitoring**

  (scales, glucose, BP, medications, etc)

  --telephonic (landline, cellular)

  --internet-based

  --broadband (TV)

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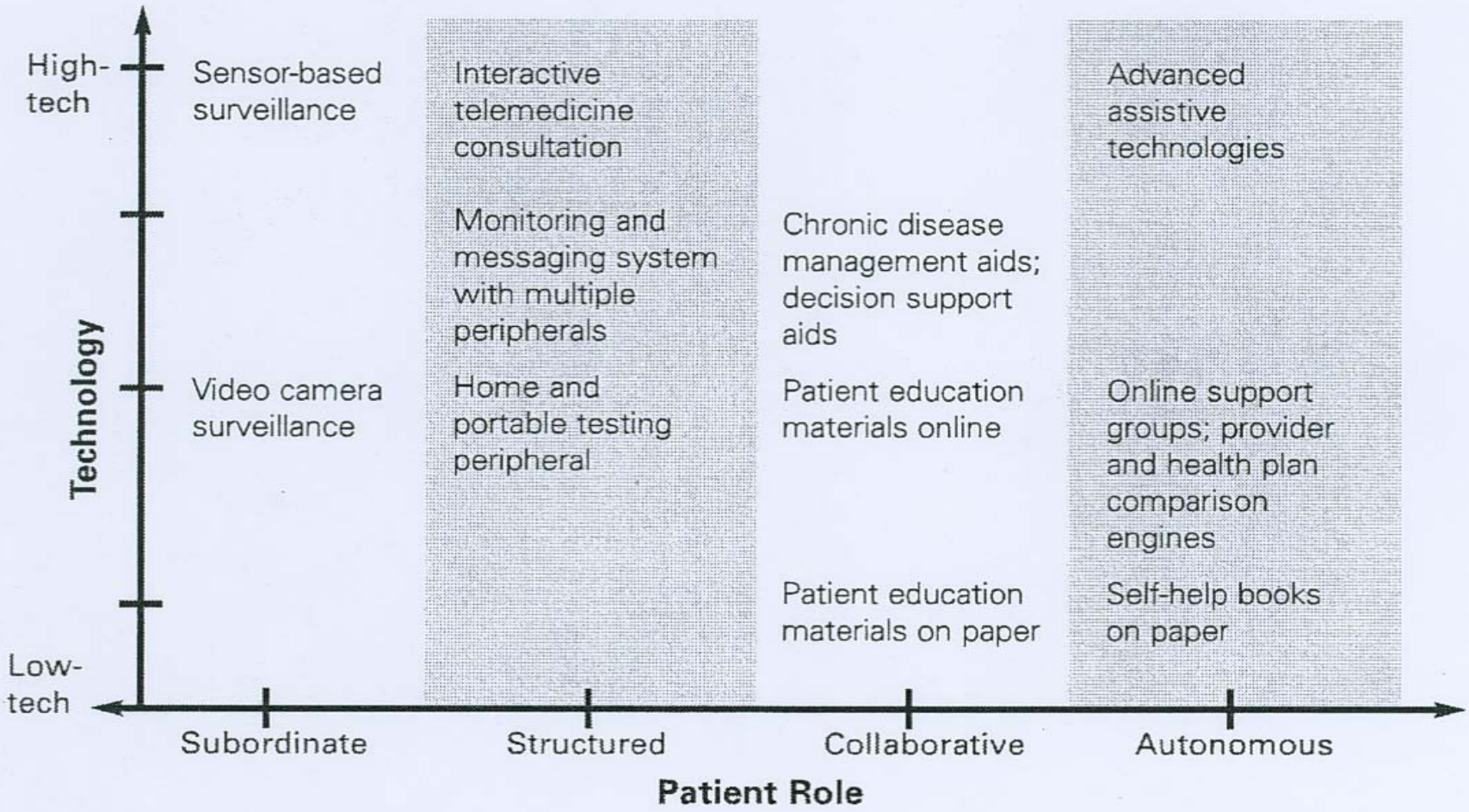
Segmenting Self-Management Tools by Patient Role



Cardiocom Telescale®

- Daily weight and symptoms
- Precision weight measurement
  - Accurate to +/- 0.1 lb.
  - Detect ≥ 45 cc's of fluid
- Instant, objective feedback
  - Current weight
  - Variance to previous day
  - Dry weight
- Comprehensive Symptom Alert System
  - -Symptoms scored
  - -Symptom variance trended

Technology platform – enabled by broadband connection

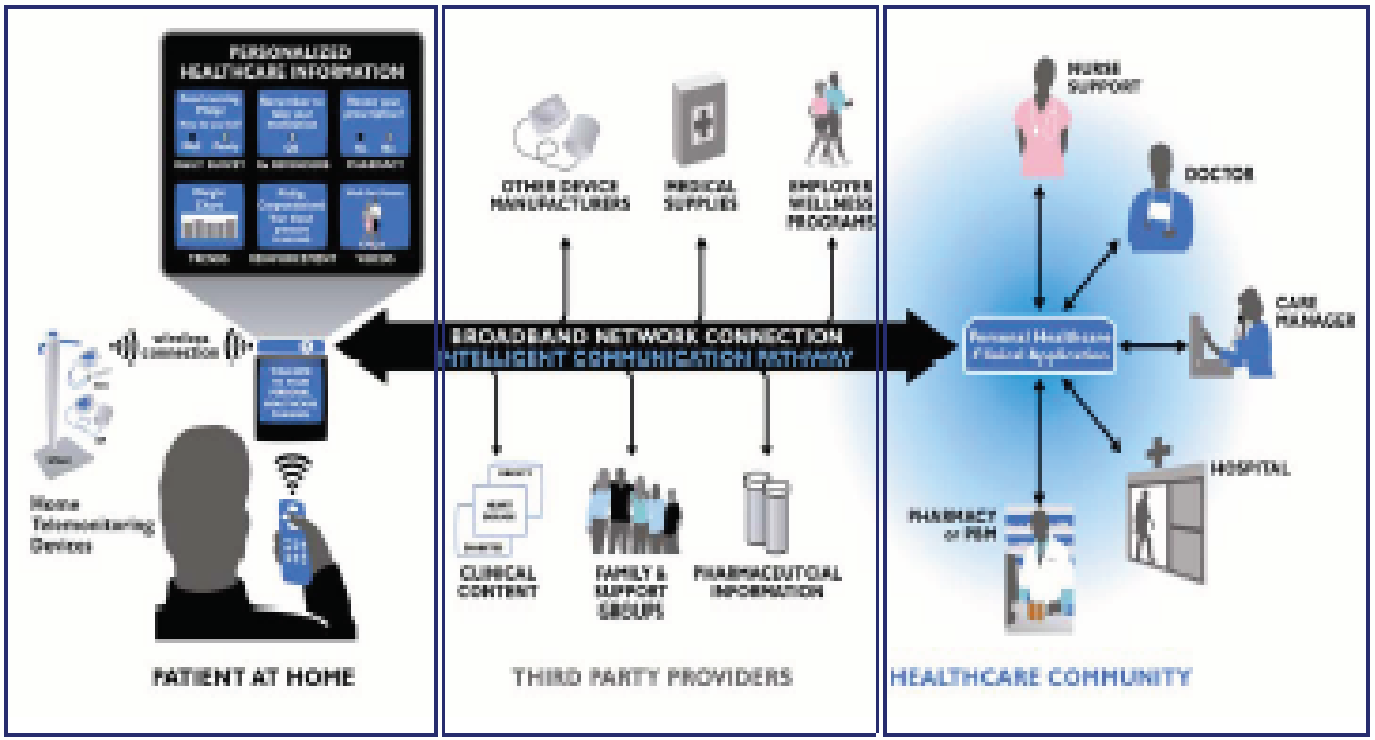
Benefits

Enables Patient Self-Management

Facilitates Communication

Enables Intervention Delivery

motiva



Components

Self-Management Tools

Communication Platform

Clinical Application

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Best Management Practice for *Engaging Patients* in Best Practice Programs

Who should be communicating with and educating the patient?

LOTS OF PEOPLE!

- **PHYSICIANS**
- **Nurses—case managers, RNs, NPs**
- **Clinical pharmacists**
- **Support staff**
- **Social Workers**
- **Educators**

In fact, best is to create a "primary care team" to share the responsibilty of doing this

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Examples of Patient Incentives

Products

- Computers for tracking their condition
- Disease monitoring devices

Financial

- Waiving co-pays
- Gift certificates (pharmacy, sports clubs)
- Coupons (for dietetic foods, health magazines)

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Improving Adherence to Prescribed Medications: The Potential Impact

Strengthening adherence may have greater impact on improving health outcomes than:

- Improved diagnosis
- More effective treatments

McDonald HP. *JAMA* 2002;288:2868-2879.

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Facts About Understanding Instructions and Adherence

- **50% of patients leaving a physician's office can not accurately recall the instructions**
- **70% of patients who did understand instructions were complaint**
- **15% of patients who made one or more mistakes in recalling instructions were compliant**
- **Poor health literacy and specifically held health belief systems are also major factors in adherence**

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Physicians Can Play a Key Role in Influencing Adherence

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Tips for Clinicians

COMMUNICATION IS KEY!!

- Limit information (3-5 key points)
- Give most important information FIRST
- Be specific and concrete, not general
- Layer information
- Repeat & summarize
- Confirm understanding
- Be POSITIVE, hopeful and empowering

Use Pictograms

Spoken instructions	14%*
Spoken + Pictogram	85%*

www.usp.org :
- Free library of 81 pictograms

*Houts, Pt Ed & Counseling, 2001

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Be Aware:
Miscommunication in 1 of 3 crucial areas leads decreased adherence

1. Patient's beliefs about illness and medication
2. Patient's action plan for dealing with illness
3. Patient's appraisals of effectiveness of the plan

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Best Management Practice for *Implementing* Best Practice Programs

Case Management

Studied mostly in diabetes, asthma, CHF, CAD, reported to be effective in many studies

Good

- **working with patients**
- **working with physicians**
- **working with office staff**
- **working with the system**

Less Good

- **ignoring or marginalizing the physician**
- **Telephonic only**

Don't Know

- **which qualifications/experience best suited**
- **which conditions best suited for case management**
- **What form of case management is most effective**

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Role of Information Systems in Disease Management

Facilitates the following essential processes:

- **Identification of eligible patients (registries)**
- **Delivery of "best practice" clinical care guidelines**
- **Automatic/manual alerts, prompts and reminders**
- **Efficient updating of "best practice" protocols**
- **Ready availability of critical patient information for all providers (e.g. problem lists, drug information, labs, x-rays)**
- **Allows inter-provider communication**
- **Permits easy tracking and reporting of outcomes**

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Disease Management :Essential Ingredients for Successful Implementation

I. Obtain Strong Endorsement/Support from Senior Leadership

II. Obtain Early Clinician Participation and Leadership

III. Utilize Intensive Education of Patients and Physicians

IV. Establish Effective Decision Support

V. Track and Report Outcomes

VI. Create Attractive Incentives

Disease Management Models in Current Use

TWO MAIN MODELS

Predominatly Patient Focus

Goal: To improve quality by communicating directly with patients.

- Aim is to improve self-management skills
- Contact is in the patients home, via telephone, mailings, internet
- May use web-based, 2 way communication and/or remote devices

Physician may be notified of patient's status but there is NO effort to induce physician behavior change

The Chronic Care Model

Goal: To enhance communication with the patient AND try to reorganize the physician practice

- Improve patient self-management skills
- Redesign the delivery system to create: multidisciplinary care teams, group visits, use of case managers for sickest patients,
- Utilizes clinical information systems and decision support, such as patient registries, prompts and reminders around guideline adherence, performance feedback

Disease Management Models in Current Use

A HYBRID MODEL---in use at Montefiore

Incorporates BOTH the office-based AND telephonic strategies

- Office-based disease management RN is placed in PCP office to:

--Identify patients eligible for DM

--Review appropriateness of enrollment with PCP

--Undertake baseline hx. and deliver customized pt. education

-Diet, exercise, medications, self-monitoring, problem-solving etc

--Develop care plan with PCP

--Act as decision support to encourage best practice care

--Link to other professional staff as needed (SW, pharmacist, etc)

- When stable, refers patient to telephonic program for ongoing care

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Conclusion

Disease Management will reach it's real potential only once:

- ✓ ***Evidence based management practices are applied broadly to encourage the delivery of evidence based medical care***
- ✓ ***Physicians are actively engaged and leading the effort***
- ✓ ***Patients are empowered and part of the team***

This portends an exciting future for this approach to care!!

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