From Medical System to Health System: Connecting Medical Practice to Community

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Agenda

- Overview of STEPS to Health King County
- Model for connecting medical care with public health/community resources
- Implementation strategies and case studies
- Critical success factors and challenges

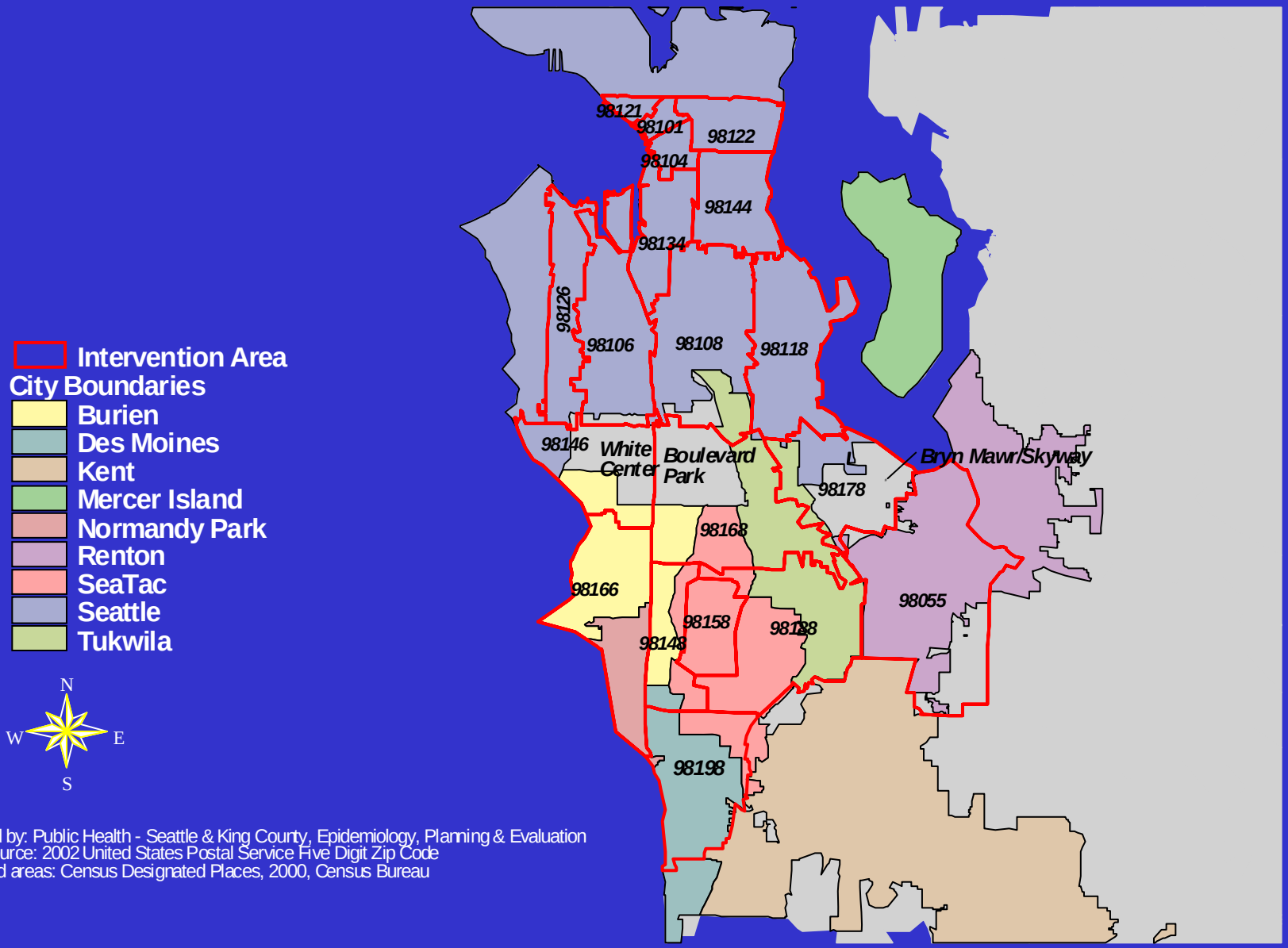
STEPS to Health King County: Mission

STEPS to Health brings together diverse individuals and groups to equip communities with tools that reduce health disparities; prevent and manage asthma, diabetes, and obesity; and promote healthy environments and lifestyles for people of all cultures.

Target Population

- People with household incomes less than 200% of the federal poverty line
- All races/ethnicities

Intervention Area



Created by: Public Health - Seattle & King County, Epidemiology, Planning & Evaluation
Data source: 2002 United States Postal Service Five Digit Zip Code
Labelled areas: Census Designated Places, 2000, Census Bureau

Leadership Team

- Public Health-Seattle/KC
- Seattle Parks and Rec.
- KC Parks
- WSU Coop. Extension
- Seattle School District
- Highline School District
- Tukwila School District
- ALAW
- REACH
- Feet First
- Austin Foundation
- Highline Hospital and Clinics
- Harborview Hospital and Clinics
- Children's Hospital
- Group Health Comm. Found.
- UW Center for Public Health Nutrition
- CHPW
- Harris & Smith Public Affairs
- Healthy Aging Partnership
- YMCA

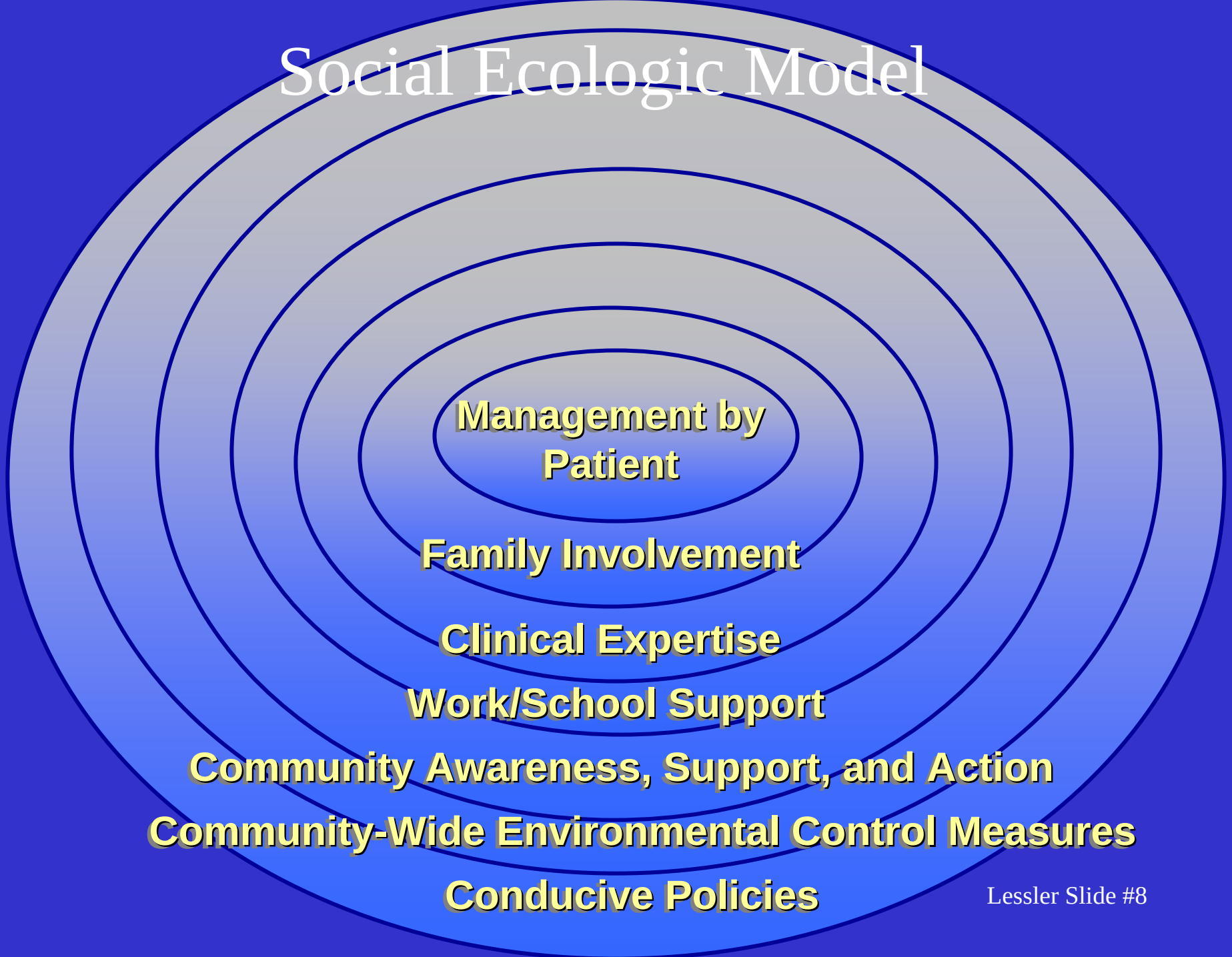
Governance and Decisionmaking

- Participatory and democratic
- Decisionmaking by Leadership Team
- Balance across conditions, sectors, and primary and secondary prevention
  - 20 funded partners
  - CBOs (physical activity, built environment)
  - Schools, health care organizations, public health

“Noncompliance is not a patient problem, it is a system failure.”

Paraphrasing Paul Farmer

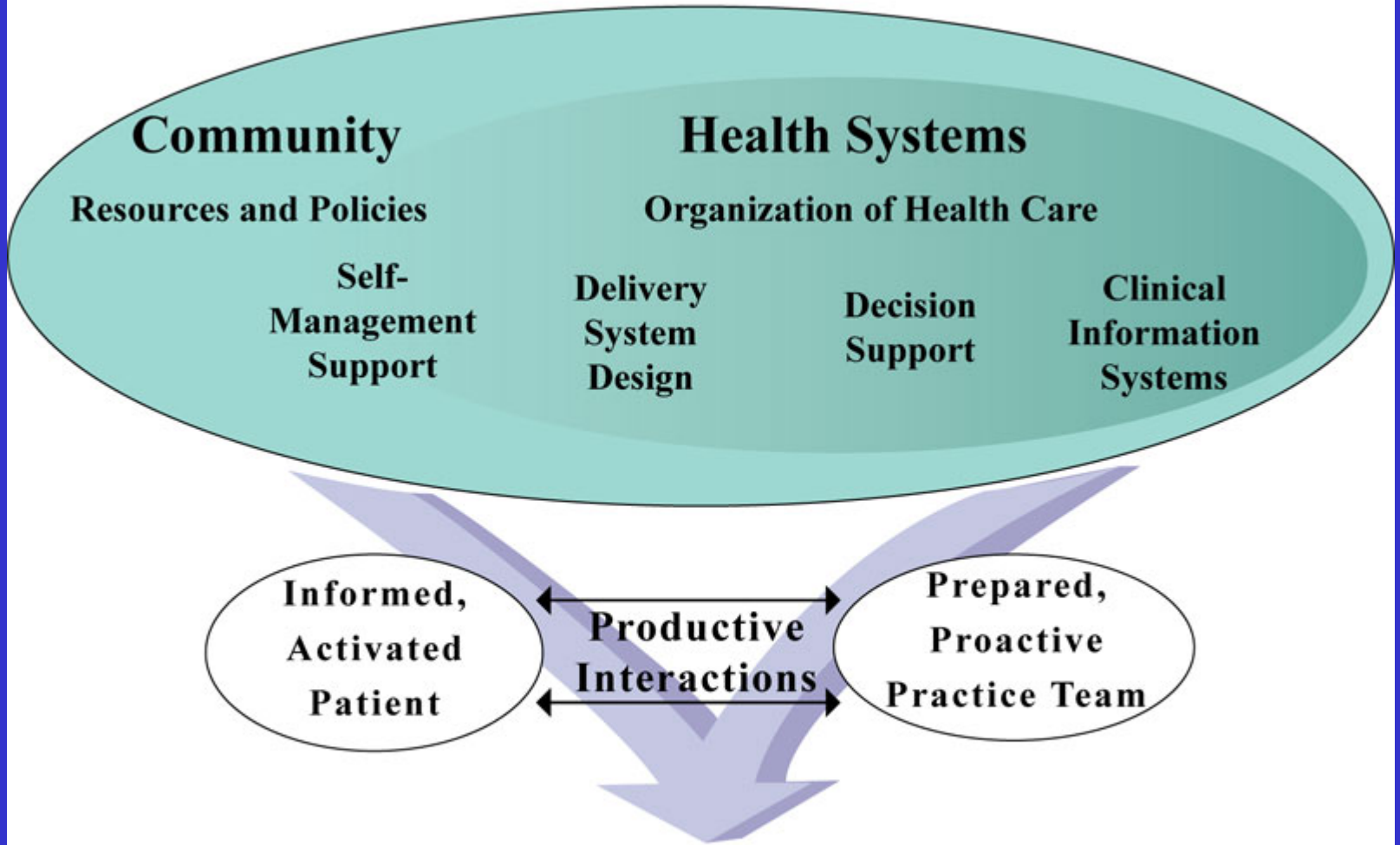
Social Ecologic Model



Deficiencies in Chronic Care

- Clinic
  - Rushed practitioners not following established guidelines
  - Lack of care coordination
  - Lack of active follow-up
  - Patients inadequately trained
    - From www.improvingchroniccare.org
- Community
  - Lack of resources
  - Lack of coordination/integration
    - Consistent messages
    - Connection to medical practice
  - Lack of supportive policies

The Chronic Care Model



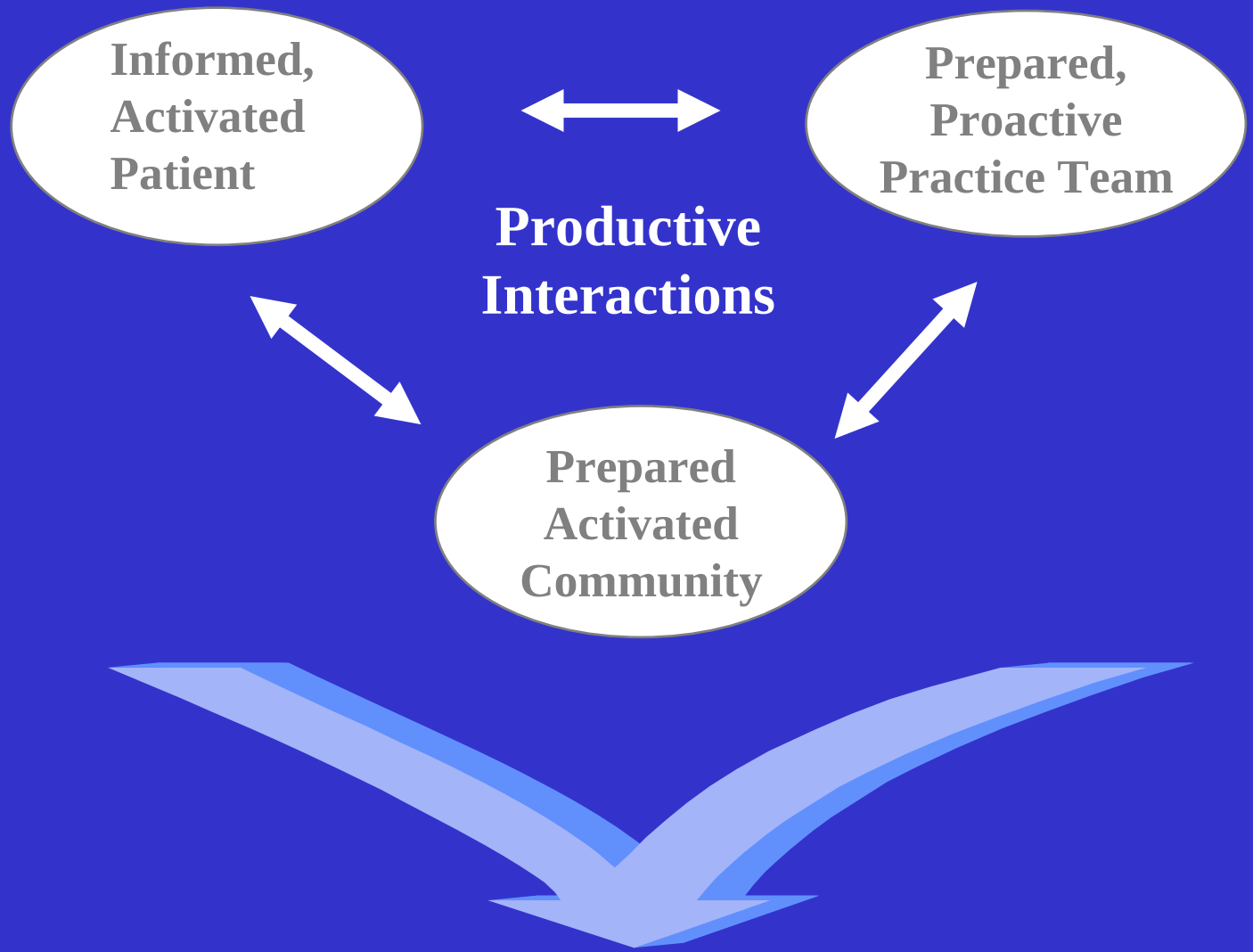
Improved Outcomes

Chronic Care Model: “Outside In”

- Medical care system
- Information systems
- Decision support
- Delivery system design
- Self-management support

Chronic Care Model: “Inside Out”

- Health care system
- Community resources and policies



Lessler Slide #13

Health System Design: A Model for Implementation

Structure: Clinical Practice

Information Systems
Teams
Tools

} 5A's

Structure: Community Capacity

Physical activity and nutrition programs
Patient education and self management support

Supportive Policies

Unify, support (environment, finance), connect

Process

Communication and Coordination

Assess

Advise

Agree

Assist

Arrange

Outcome

Functional and Clinical

STEPS Strategies for Improving the Structure of Clinical Practice

- Encourage clinical sites to work together *locally*
  - Joint “QI” planning by local clinics
  - IHI/ICIC “mini-collaboratives”
  - Emphasize planned (a.k.a. chronic) care model
- Provide technical assistance
  - Current guidelines and best practices
  - Quality improvement strategies
- Identify and emphasize common messages
  - Evidence-based care provided in an evidence-based manner

Clinical Practice: Create Functional Teams

- Provide support for QI process (e.g., funding of champion, technical assistance)
- Define roles
  - Who is responsible for 5A's?
- Train team members
  - Disease specific knowledge
  - Brief behavior change counseling
  - Knowledge of community resources and tools/processes for linking patients to resources

Build Capacity by Leveraging Community Resources

- Inventory and share available tools
  - Patient education/self-management materials
    - E.g., translated materials (see www.ethnomed.org)
  - Protocols
  - Existing “information” lines (telephonic and web-based)
- Training and skill development
  - Harborview opens training on behavior change counseling to RNs, MAs, CHWs, etc. from other community organizations

Ways to Manage Your Diabetes

- These topics are very important to your health
- No patients do these perfectly
- It's best to work on one at a time
- You won't be pushed into changing
- Which one do you want to discuss?

Adapted from Stott, Rollnick, & Pill (1995). Family Practice 12(4):413. By permission of Oxford University Press and authors.

HARBORVIEW MEDICAL CENTER
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STEPS GRANT RN CASE MANAGEMENT CARE MAP – DIABETES

Dilated Eye Exam	Annual	
Smoking Status/ Cessation	Document annually	
Immunizations	Flu annually; Pneumovax once or twice per guidelines	
Education session	Every 3 yrs if controlled	

Self Management Goal Setting/ Motivational Interviewing

- Address Barriers to Self Care
- Use "Ways to Manage Your Diabetes" Self Management Goal Setting Card to assist patient with Self-Management Action Plan form
- Follow-up on goal achievement at every interaction.
- Offer Chronic Disease Self Management Workshop through PFRC, REACH Support Groups if ethnic or Senior Wellness Programs if patient age >55 yrs.
- Document Self Management Goals in ORCA

Diabetes Education

- Administer pretest
- Provide patient education packet in person, in mail or email web resources.
- Schedule for PFRC Survival Skills, Food and Fitness or Diabetes Q&A class
    - if pretest score <4/4 correct
    - annually if DM control less than ideal or every 3 yrs if ideal control maintained
    - if patient agrees to attend
- Provide specific Flyer for appropriate REACH class if member of racial/ethnic minority group.

Diabetes Referrals – listed under specific triage and barrier to care category.

- General References
    - Crisis Clinic Infoline http://www2.ci.seattle.wa.us/crisisclinic/
    - King County Public Health Safety Net http://www.metrokc.gov/health/kchap/safetynet.htm
- Diabetes Specific
    - HMC and Community Resources for Diabetic Patients
    - PENDING - STEPS Referral sources

Medication Management Guidelines

1. Review past and present prescription history in Mindscape.
2. Main HMC pharmacy number is 206-731-7958
    a. Significant medication discounts available
    b. No patient will be denied medications based on inability to pay.
3. Community clinics often have their own pharmacies or contracts with local pharmacies in their area.
4. New prescriptions (verbal or written orders)
    a. ER/UCC

STEPS Strategies for Building Community Infrastructure

- Fund development and/or expansion of community resources that support patients with chronic disease
  - Support groups (e.g., chronic DZ support groups using Lorig model)
  - Community health workers
  - Walking programs
  - Policies that make it easier to carry out provider advice/action plan, e.g.:
    - Extending hours of community centers
    - Requiring nutritional labeling of menus at restaurants
    - Medicaid reimbursement for CHWs

STEPS Strategies for Building Community Infrastructure

- Promote integration across community partners
  - Annual “contractors’ conference”
  - Integration committee
    - Knowledge of each others’ services
    - Cross-referral
    - Systematic referral processes
- Provide technical assistance to help CBOs connect to medical care sector

Putting It All Together: Connecting the Community

- Clinical practices develop infrastructure and processes necessary to connect patients with community resources
- CBOs reach out and educate practices about services they can provide
- Clinical practices and CBOs develop systematic referral processes and ongoing relationships that are patient centered (based on 5A's principles) and allow for communication of relevant patient/client information
- Clinical practices and CBOs work together to build capacity

Connecting Medical Practice to Community

- Examples
  - "Begin small, think big"
  - Think: "PDSA": Small tests of change

Ranier Valley Health Coalition: Case Study #1 – "Begin Small, Think Big"

- New effort to undertake focused, intensive work in smaller, well-defined geographic area
- "STEPS within STEPS"
- Created with no funding (except for linkage coordinator)
- One clinic and one community center begin work together
- Patients referred to aerobic swim program; community center bills clinic monthly for low income patients; clinic obtains small grant from local foundation to cover costs
- Large county hospital takes note; planning to replicate

Rainier Valley Health Coalition: Critical Success Factors

- Expression of community interest
- “Convener”
- Built from the ground up
- Taps existing needs and wants within the community
- Local leaders/advocates (physician at a community clinic; director of a community health center)
- Community-based “PDSA” effort

Putting It All Together: Case Study #2 – Obese Children

- Strong Kids
  - Collaboration between YMCA, Seattle Children's Hospital and STEPS to Health King County
  - Behaviorally oriented, community-based program that incorporates evidence-based strategies to promote overall health and well-being for overweight children (ages 8–14) and families struggling with health issues related to lifestyle
- Program implemented at three YMCAs; recently expanded to five additional YMCAs
- Marketed to pediatric practices by respected physician champion
- Follow-up with interested practices by Strong Kids staff to describe and implement referral process

“Strong Kids” Outcomes

- 94 parent-children dyads referred
- 41 dyads enrolled
- Pre-post child/family surveys
  - 11% increase in families with < 3 hrs screen time per day ($p < 0.05$)
  - 35% increase in days with vigorous exercise ($p < 0.05$)

STRONG KIDS / STRONG TEENS
Recruitment & Referral Tracking Form

***STRONG KIDS/ STRONG TEENS* Eligibility**
- BMI> 85th percentile for age AND
- Adult & child both medium/high readiness to change (≥ 4) AND
- English-speaking

Check appropriate age / program

☑	Age	YMCA Location	Dates
	8-11	Meredith Matthews, Seattle	
	8-11	Highline	
	12-14	Auburn Valley	

Date _____

Patient name_____

Date of Birth_____/_____/_____

Weight _____ Height _____ BMI%ile ☐ 85-95%ile ☐ >95%ile

Provider Name _____Clinic Ph #/Clinic stamp_____
(print / stamp)

READINESS TO CHANGE (circle response)

	ADULT	CHILD
1. How concerned are you about your child's (your) weight?	Not Concerned 0 1 2 3 4 5 6 7 8 9 10 Very Concerned	Not Concerned 0 1 2 3 4 5 6 7 8 9 10 Very Conce
2. How ready are you & your family (you) to make a change?	Not Ready 0 1 2 3 4 5 6 7 8 9 10 Very Ready	Not Ready 0 1 2 3 4 5 6 7 8 9 10 Very Ready
3. How confident are you that you can be successful?	Not Confident 0 1 2 3 4 5 6 7 8 9 10 Very Confident	Not Confident 0 1 2 3 4 5 6 7 8 9 10 Very Confic

Please note any information that a YMCA Total Health Coach should know before starting your patient in an exercise program:

☐ Asthma ☐ Type 2 Diabetes
☐ ADHD ☐ Hypertension
☐ Other _____

Medications: _____

The above named patient is cleared to participate in an exercise program.

_____
Provider signature Date

Parent/guardian Name _____

Address _____

Phone _____

I agree to allow the STRONG KIDS staff to contact me to participate in *STRONG KIDS* at the YMCA.

_____
Parent/guardian signature Date

FAX to Strong Kids – Attn. Mo Pomietto at 206.987.7802
(or mail to Strong Kids, c/o Mo Pomietto, 1100 Olive Way, Suite 500, Mail-Stop MPW8-1, Seattle WA 98101)

YMCA of Greater Seattle

STRONG KIDS

Clinical Site:
FAX:

Provider Feedback Form

Patient Name _____

Date ____/____/_____

Provider: _____

☐ Enrolled

Attendance
Has attended _____ out of _____ sessions.
Participating family member is _____ who is the child's father/mother/grandparent/other_____.
Comments: _____

Medical Concerns
☐ None
☐ Explain_____

Goal-Setting
Child's goal_____

Parent's goal_____

Other Comments from YMCA Total Coach
(e.g. favorite activities, strengths/weaknesses, parenting issues, etc.)

YMCA Total Health Coach Name(s)_____
YMCA Phone #:

Critical Success Factors: Clinical Delivery System to Community

- Leverage community resources
  - YMCA
  - Children's Hospital
- Bridging expertise – physician champion
- "Felt need" – addressing pediatric overweight
- System for referral and communication

Putting It All Together: Case Study #3 – Asthma and Diabetes

- Community Health Workers
  - CHWs are from participating communities, receive rigorous training, and have personal experience with asthma and diabetes
  - Provide assessment, education, and action planning
  - Encourage actions to implement plan
  - Promote access to care by encouraging appointment keeping
  - Connect clients to community resources

CHWs: Linkage to Primary Care

- CHWs work with clinics to identify patients who can benefit from CHW
- Clinic provider invites patient to participate in CHW visit
- CHW contacts patient
- CHW sends primary provider visit report
- Providers can call, email, or fax requests to CHW

CHW: Asthma Outcomes

Indicator	Baseline	Exit
Asthma Symptoms	N=44	N=44
Symptom free days/nights, past 2 weeks	8.5	12.2*
Symptom free nights, past 2 weeks	9.8	12.5*
Health Care Utilization		
% with hospital stay, past 12 months	12%	5%
% with ED visit, past 12 months	46%	21%*

* $P < 0.05$

Connecting to Primary Care: ED Case Management in Chronic Disease

- ED visit for asthma or diabetes treated as "sentinel" event
- RN Case Managers based in ED case manage patients
  - Medical and behavioral components; detailed protocols
  - Link patients to community resources, esp. the diabetes CHWs
  - Link patients to primary care home (HMC or community clinic)

Connecting to Primary Care: ED Case Management in Chronic Disease

- Over 250 patients enrolled in ED case management to date
- Preliminary results based on initial 90 patients, 54 with diabetes
  - Nearly half connect to PCP
  - CM patients with DM have 1.0% decline in A1C ($p = .06$)
- ER use declined in the CM group relative to comparison groups (NS)
- Primary care visits in the CM group increased after being connected to PCP ($p < 0.05$)

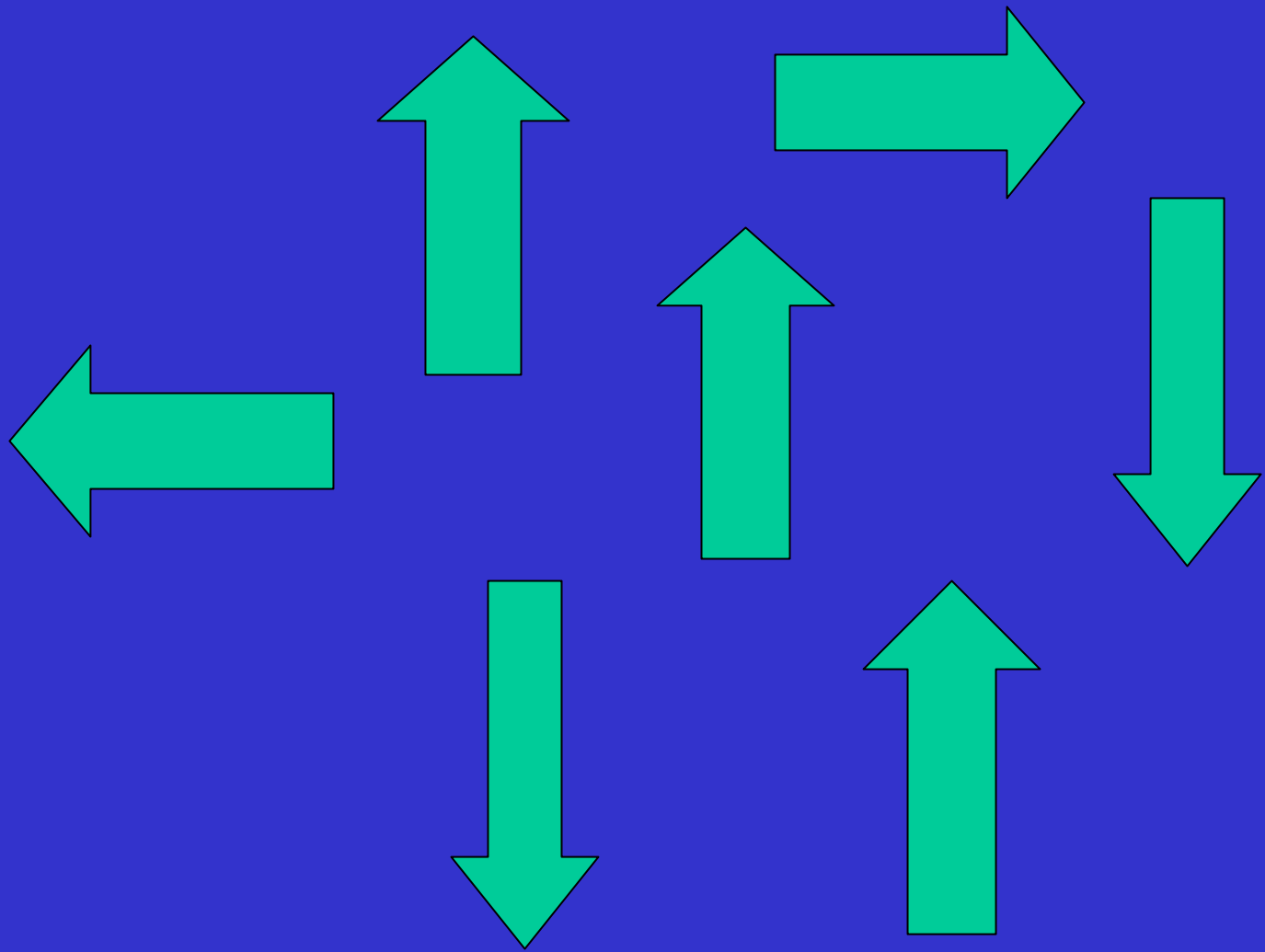
Connecting to Community: Examples with Older Adults

- Preventing disability and managing chronic illness in frail older adults: RCT of a community-based partnership with primary care
  - Collaborative project with two Pacific Northwest HMOs in Seattle area and large senior center
  - Patients with chronic illness referred for physical activity counseling/planning and chronic illness self-management
  - Decreased utilization and improved clinical outcomes in intervention group
    - Leveille SG, et al. JAGS 1998;46:1191-1198.

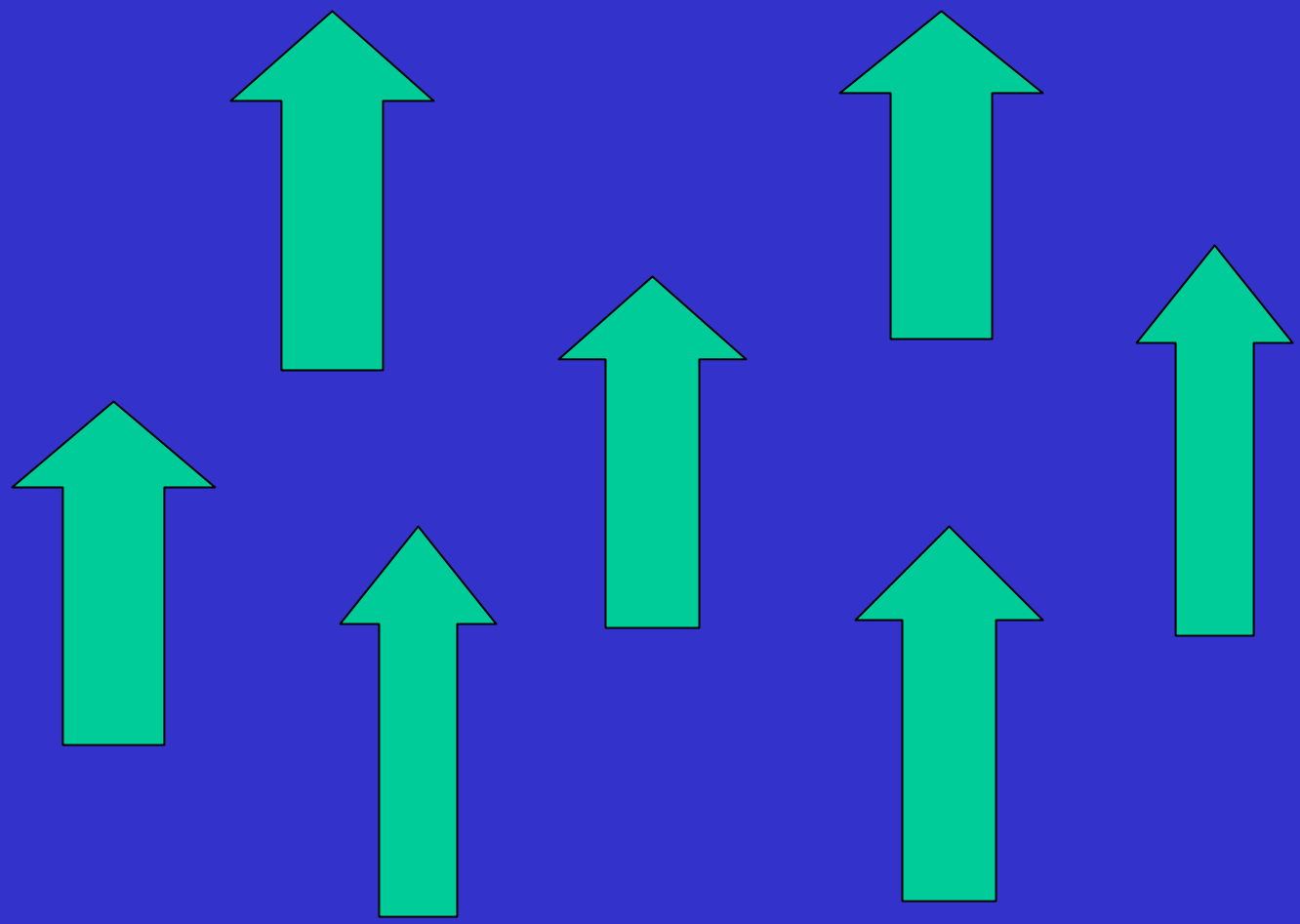
Connecting to Community: Examples with Older Adults

- Collaboration – medical sector and community
- Champions – Community Center Director, HMO medical director
- Bridging clinician: ARNP at Community Center communicates with patients' PCP
- Resources – grant funding

Connecting Medical Care to Community: Getting from Here…



Connecting Medical Care to Community: Getting from Here… to There



Connecting Medical Care to Community: Critical Success Factors

- Forum for convening sectors (e.g., coalition)
- Leveraging existing expertise and resources
- Senior leader support in medical care systems, CBOs, and government agencies
- “Bridge people” who have feet in both clinic and community
- Champions in clinics and community (early adopters)
- Ability to offer clinics technical assistance and money
- Availability of and access to ready to use tools (e.g., registries, patient educational materials, guidelines, community resource Web pages/phone lines)

Involving Clinicians

- Primary Care: A View from the Trenches
  - Working harder to stay even
  - 20-22 visits per day
  - Practice costs rising faster than reimbursement (often forcing clinics to get by with fewer support staff)
  - Increasing demands for accountability (P4P)
  - Increasing fragmentation of the delivery system
  - Struggling with EMR purchase and/or implementation
  - Struggling to prioritize prevention and chronic DZ control efforts

Primary Care: Leverage Points

- Address a “felt need”
  - Clinicians
    - Want to “do the right thing”
    - Recognize that they will increasingly be held accountable
  - Strategy
    - Offload demands on time, and increase “self-efficacy of clinician
    - Assist in improving quality of care
      - Make it easier to do the right thing
    - Example: Smoking “quit lines”

Primary Care Leverage Points: Link to Practice

- Cultivate “physician champions” and “bridging professionals”
- Leverage the clinic team
  - Office staff, RNs, MAs, etc
  - Patients

Key Questions: Sustainability

- Who convenes?
- Who pays?
- What policies facilitate?
  - Break down silos (e.g., Public Health vs. Medical Care vs. Schools)
  - Revisit assumptions
    - E.g., HIPAA

Challenges

- Fragmentation of medical care delivery
  - Every practice is its own system
  - Plans and payers (private and government) have narrow perspective and short time horizon
- Poor alignment of incentives
  - Making it “worth” a clinician’s time
  - Lack of accountability for follow-through and outcomes in medical sector
  - What are incentives for plans and purchasers?
- Primitive systems for connecting and communicating across sectors
- Lack of resources
- Policies that impede rather than promote needed change

From Medical System to Health System: Connecting Medical Practice to Community Ultimate Keys to Success

- Motivation fed by tough-minded optimism
- Staying power
- Ideas worth striving for
  - John Gardner, former Secretary of HEW and founder of Common Cause, in *Self-Renewal*, 1963