Why Connect Your Patients to Self-Management Support?

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Making Sense of Healthcare Transformation

ACA: Affordable Care Act
ACO: Accountable Care Organization
RCCO: Regional Care Coordinating Organization
PMPM: Per Member Per Month
PPPM: Per Person Per Month
ROI: Return on Investment

PCMH:
Patient Centered Care
Patient Centered Medical Home
Patient Centered Medical Neighborhood

Care Coordination
Bundling
Why does this matter to you?

Engaging the person is the only way to successfully impact clinical outcomes... as opposed to process measures.
Self-Management (SM)

For our purposes today, self-management is what I do, or do not do, when I am not with my health care provider.

Self-Management Support (SMS)

For our purposes today, self-management support is how the community-based organization, the practice, and the health system, can support me in making better choices.
What’s Self-Management?

• Education
  – Support
  – Self-efficacy
• Highly interactive sessions
• Focus on building skills, sharing experiences and support.
• Programs are designed to help people gain self-confidence in their ability to manage their disease and cope with health problems affecting their lives

Evidence-based Self Management Programs

• Stanford Suite of Self-Management Programs
  – CDSMP
  – Tomando Control de su Salud
• National Diabetes Prevention Program (NDPP)
• Physical Activity programs
  – N’Balance
  – A Matter of Balance
  – EnhanceFitness
  – Tai Chi’s
Benefits to the Practice

- External resource
- No need to re-create the wheel
- Reinforces communication “feedback loop”
- Documents self-management in PCMH terms
- Documents the shift in patient interaction
- Quality measures
- Delivery of data to practice
- Patient activation and patient engagement
- Increase in patient confidence levels

Steps to Implementing Self-Management Support

1. Enlist Clinical Leaders
2. Involve the Care Team
3. Provide Additional Support
4. Look Beyond Assumptions
5. Community Partners
6. Tools
Patient Centered Medical Home (PCMH)

PCMH is a shift in viewing the person as a whole being at the center of their own health. PCMH is a primary care, team-based approach to meeting a patient’s health care needs. NCQA is the gold standard for national PCMH recognition.

2014 NCQA MUST PASS Certification Process

- PCMH 1, Element A: Patient-Centered Appointment Access.
- PCMH 2, Element D: The Practice Team.
- PCMH 4, Element B: Care Planning and Self-Care Support.
- PCMH 5, Element B: Referral Tracking and Follow-Up.
- PCMH 6, Element D: Implement Continuous Quality Improvement.
NCQA PCMH 2014 Standard 4

• **PCMH 4: Care Management and Support**

B. Care Planning and Self-Care Support (MUST PASS):
   Patient Preferences, Treatment Goals, Assesses and Addresses Barriers, SM Plan, Provided in writing

C. Medication Management

E. **Support Self-Care and Shared Decision Making**: 1) EHR patient-specific education resources, 2) educational materials, 3) **self-management tools**, 4) shared decision-making aids, 5) **structured health education such as group classes and peer support**, 6) list of 5 community service areas of import, 7) assesses usefulness of identified community resources

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NCQA PCMH 2014 Standard 5

• **PCMH 5: Care Coordination and Care Transitions**

B. **Referral Tracking and Follow-Up** (MUST PASS)

C. Coordinate Care Transitions
Documentation of Transformation

- Care plans
- Self-management goals
- Community resources
- Referrals
- Accountability

Readiness and Activation

- Readiness and Activation Levels for All Involved
  - Practice
  - CBO
  - Patient

- Time and Money

- Staying “Shiny”
What do we bring to the table?

- Statewide network of local trained CDSMP series leaders
- Program Coordinators working with local organizations on referrals
- Mechanism for tracking referrals and feedback including communication log/ patient goals
- Centralized data collection
- Messaging tips for clinic staff
- Ongoing support
Messaging

• How to Recommend

• How to Refer

• Quick Basics of Self-Management

• Quick Goal Setting

Lessons Learned in Partnerships, Referral Systems, and Enrollments

• Care Compact, Collaborative Agreement, or MOU

• Referral Logs and Follow-Up

• Contact Person

• Patient Panel versus Patient Referral

• Readiness Assessments

• Yes....”and”.... Messaging
Centralized Referral Systems

- Collaborative effort to streamline referral process from multiple sources to multiple sites, classes, or programs
- HIPAA Considerations
- Staffing
- Return on Investment?

Referral Form

Healthier Living Colorado™
A self-management class for your patients with chronic conditions
Fax Referrals to: 303-984-6962
Questions: Join@C4AWinfo or 303-984-1643

PATIENT INFORMATION

Patient Name: ____________________________
Date of Birth: ________ Gender: □ Male □ Female
I understand that C4AW will inform my primary care provider of my participation in Healthier Living Colorado™.
Patient Signature: ____________________________ Date: __________
Address: ___________________________________ City: __________ State: __________ Zip Code: __________
Best Phone number to reach you: __________
Best time of day to contact you: __________
May we leave a message? □ Yes □ No
Language: □ English □ Spanish □ Other: __________________________

PROVIDER INFORMATION

Provider Name: ____________________________ Email: ____________________________
Clinic: __________________________________
Phone: __________ Fax: __________
Falls Screening Referral Form

PATIENT INFORMATION

Patient Name ________________________________
Date of birth __/__/______ Gender □ Male □ Female
I understand that COAW will inform my provider about my participation in this falls risk screening.
Name ____________________________ Date __/__/______
Address ____________________________
City ____________________________ Zip Code ____________________________
Best phone number to reach you ____________________________
Best time of day to contact you ____________________________
May we leave a message? □ Yes □ No
Language □ English □ Spanish □ Other ____________________________

PROVIDER INFORMATION

Provider Name ____________________________ Phone ____________________________
Email ____________________________ Fax ____________________________
Position ____________________________ Fax Referral to: 303-964-5962
Reason for referral ____________________________ Questions: admin@coaw.org or 503-964-5962
Centralized Referral Systems
Referral Process

1. Provider introduces CDSMP opportunity to patient.
2. Patient agrees and signs referral form.
3. COAW and clinic meet to discuss self-management.
4. Clinician introduces CDSMP opportunity to patient.
5. Provider uses letter for follow-up with patient in goal-setting.
6. COAW mails patient letters to providers with program explanation.
7. Patient attends CDSMP.
8. COAW communicates with practice weekly regarding patient who declines scheduling for class.
9. Referred patient contacts COAW coordinator.
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Ready?

Thank You

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