Patient Referrals to Self-Management Programs

Janet Tennison PhD, MSW, LCSW
Senior Project Manager
• Quality Innovation Network (QIN)
• Quality Improvement Organization (QIO)
• CMS Quality Strategy:
  – Eliminating disparities
  – Strengthening infrastructure and data systems
  – Enabling innovation
  – Fostering learning organizations

QIO Program Fact Sheet – Handout.
Million Hearts® Targets

Changing the Environment

Reduce smoking

By 2017...
The number of American smokers has declined from 26% to 24%

Reduce sodium intake

Americans consume less than 2,900 milligrams of sodium each day

Eliminate trans fat intake

Americans do not consume any artificial trans fat

Optimizing Care in the Clinical Setting

Focus on the ABCS

Aspirin use when appropriate
Of the people who have had a heart attack or stroke, 70% are taking aspirin

Blood pressure control
Of the people who have hypertension, 70% have adequately controlled blood pressure

Cholesterol management
Of the people who have high levels of bad cholesterol, 70% are managing it effectively

Smoking cessation treatment
Of current smokers, 70% get counseling and/or medications to help them quit

Stay Connected

http://millionhearts.hhs.gov/be_one_mh.html
facebook.com/MillionHearts
twitter.com/@MillionHeartsUS
millionhearts@cdc.gov

Million Hearts® promotes clinical and population-wide targets for the ABCS. The 70% values shown here are clinical targets for people engaged in the health care system. For the U.S. population as a whole, the target is 65% for the ABCS.
We want to hear from you!

Type questions into the Questions Pane at any time during this presentation
Today's Learning Objectives

• Learn about the **benefits** of self-management programs and how to establish a referral **workflow** in the primary care setting.

• Understand the **need** for care coordination/formal **referral management** in the primary care setting and how these fit into health care transformation efforts.
Presenters

Janet Tennison, PhD, MSW, LCSW
Senior Project Manager

Deanne Curtis
Self-Management Workshop Graduate
Self-Management Definition and Benefits
What is self-management?

Systematic education and supportive interventions to increase patients’ **skills** and **confidence** to manage their own health problems

## Differences

<table>
<thead>
<tr>
<th>Traditional Patient Education</th>
<th>Self-Management Education</th>
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<tr>
<td>• Technical skills</td>
<td>• Skills to act on problems</td>
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<td>• Problems with disease control</td>
<td>• Problems identified by patients</td>
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<td>• Disease-specific knowledge</td>
<td>• Improving confidence</td>
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<td>• Goal is compliance to improve outcomes</td>
<td>• Goal is increased self-efficacy to improve</td>
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<td>• Health professional is educator</td>
<td>• Health team, peers are educators</td>
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Differences

Traditional

• Professionals are experts, patients passive
• Behavior change externally motivated
• Non-compliance is personal deficit

Collaborative

• Providers experts about disease; patients experts about lives
• Behavior change internally motivated
• Lack of goal achievement requires modifications

Self-Management Programs

Stanford University

- Chronic Disease
- Diabetes
- Chronic Pain
- Cancer Survivors
- HIV

Diabetes Empowerment Education Program (DEEP)

Others available in your state (National Diabetes Prevention Program, Falls Prevention, etc.)
Stanford Diabetes Self-Management Program

An evidence-based program for patients with diabetes

- Developed and tested by Stanford University research experts
- Self-management focused
- 6 weeks of workshops, 2 ½ hours, led by trained peer leaders who have diabetes
- No cost
- Family members, caregivers encouraged to attend; also free
- Many workshop locations throughout the state
<table>
<thead>
<tr>
<th>Workshop Topics</th>
<th>Week 1</th>
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Highly Effective Program

Numerous studies reveal program efficacy, i.e., one randomized, controlled trial found:

“At 6 and 12 months after workshop completion, 345 participants with DM2 had **significant improvements** in depression symptoms; fewer symptoms of hypoglycemia; better communication with physicians; reported increased healthy eating and reading food labels; increased patient activation and self-efficacy”

Why It Works

Deanne Curtis

• Self-Management Workshop Graduate
Care Coordination/
Referral Management in Today’s
Health Care Environment
Care Coordination is Key

• Potential to improve the effectiveness, safety and efficiency of the American health care system

• Well-designed, targeted care coordination delivered to the right people can improve outcomes for patients, providers and payers

MACRA/MIPS

- Advancing Care Information Category

**Base Score:** The base score accounts for 50 points of the total Advancing Care Information category score. To receive the base score, clinicians must provide the numerator/denominator or yes/no for each objective and measure. CMS proposes six objectives and their measures that would require reporting for the base score:

- **Protect Patient Health Information (yes/no)**
- **Patient Electronic Access (numerator/denominator)**
- **Coordination of Care Through Patient Engagement (numerator/denominator)**
- **Electronic Prescribing (numerator/denominator)**
- **Health Information Exchange (numerator/denominator)**
- **Public Health and Clinical Data Registry Reporting (yes/no)**

MIPs Performance Scoring

• QUALITY
  – Replaces the Physician Quality Reporting System (PQRS)

• IMPROVEMENT ACTIVITIES
  – New category

• ADVANCING CARE INFORMATION
  – Replaces the Medicare EHR Incentive Program, also known as Meaningful Use.

Proposed Rule Includes Referral to Self-Management Education Programs

Defined clinical performance improvement activity (CPIA) in MIPs:

“Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following:

– Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; and/or

– Provide a guide to available community resources.”

Source: 42 CFR Parts 414 and 495, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed rule, Appendix H, Page 954
Care Coordination in MACRA

• CLINICAL PRACTICE IMPROVEMENT ACTIVITIES (15% of total score in year 1)
  – Clinicians rewarded for activities focused on care coordination, beneficiary engagement and patient safety.
  – Clinicians may select activities that match their practices’ goals from a list of more than 90 options.
  – In addition, clinicians would receive credit in this category for participating in Alternative Payment Models and in Patient-Centered Medical Homes.
1. **Accountability** is shared - creates ambiguity – don’t know who is responsible to make it work

2. PCPs lack time to create personal relationships with other providers decreasing communication

3. Added time/effort to achieve effective referrals not well reimbursed

4. Most PCPs lack dedicated personnel or information infrastructure to coordinate care effectively

How to Improve Referral Rates

• **Commit** to doing it
• Identify clinic and provider **champions** to promote program and share successes
• Analyze your workflow
• Dedicate a person or team to sign patients up for self-management workshops
• **Train** staff and providers on how to use motivational interviewing to get patients to attend
Commit to Formally Implement a Referral System

- Consider implementing a quality improvement activity
  - How will you implement and evaluate a workflow process?
  - Use metrics (number of patients referred?)
  - Consider use of a Plan-Do-Study-Act (PDSA) cycle
    - Start slow: test process with one provider/MA team and roll out to others if successful
Analyze Your Workflow

- Do you want to focus on a specific population to begin (patients with diabetes, fall risk)?
- How will you identify patients (e.g., pre-visit planning, huddles, run EHR registries daily)? Who will do this (e.g., dedicated person or persons—best practice)?
- Who will sign patients up for workshops before they leave the clinic (best practice)?
Clinic and Provider Champions*

• Identify a clinic and provider champion who will promote and cheerlead your efforts as a clinic
• Make it fun: have contests
• Communicate successes to all clinic staff, payers, patients, board members and anyone else you want to know

*Studies show they are crucial to success
Train All Providers and Staff

- About workshops and their benefits
- About commitment to send patients to workshops and processes
- How to motivate patients to go (what to say and how to say it)
- Dedicated person keeps registration portal on desktop/laptop and learns to use it
The Power of the Recommendation

• Patients may not follow through on recommendations due to lack of:
  – Commitment
  – Understanding
  – Interest in referral need

• Patients won’t go to appointments just because we tell them to or it’s in their best interest
Why is self-management relevant to patients?

• We must connect behavior change with what matters to patients
• Patients will ultimately change behavior for their own reasons, not ours
• We are better off asking questions about why patients would want to change a behavior (attend a self-management workshop) rather than telling them they should
Check on Patient Satisfaction at Visit

• One major reason patients are no-shows is because they are unhappy with the current visit
• Don’t want to cause friction by mentioning their dissatisfaction
• They already made up their minds that they won’t come back or go to a referral appointment
Check In Before They Check Out

- Quick questions to elicit a response:
  - “Did I meet your needs today?”
  - “Tell me what you think about our visit today.”
Recall Campaign

Plan a recall campaign

– More time and resource intensive, but reaches a greater number of people

– Identify patients with diabetes, pre-diabetes or other chronic diseases using your EHR and run lists
  • Send out letters asking them to call for appointments or for referral assistance
  • Call patients and schedule over the phone
Consider Holding Workshops in Your Clinic

• Some workshops can be held in your clinic – we can help with coordination
• Patients are more likely to attend because they are familiar with your clinic
• OR – even better, send your staff to become trained peer leaders
EHR Care Plan and Documentation

• If you are very smart, you will have a formal care plan in your EHR where you document patients’ care coordination activities
• The care plan is updated at every visit
• You can then code for complex chronic care management for Medicare beneficiaries with two or more chronic illnesses
HealthInsight Experts

Provide free assistance to help you with numerous improvement processes:

• How to use your EHR to identify your patients with diabetes and improve their care
• Help you begin or improve clinical data reporting required for MACRA/MIPS (old PQRS)
• Provide clinical indicators training and disparity awareness education for your staff
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<tr>
<th>Nevada</th>
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<tbody>
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<tr>
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<td>Janet Tennison, PhD, MSW, LCSW</td>
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• Understand the **need** for care coordination/formal referral management in the primary care setting and how these fit into healthcare transformation efforts.
Type questions into the **Questions Pane** at any time during this presentation.
Thank You!

Please complete post-webinar survey

Annual Quality Conference Roadshow:

• Southern Nevada
  November 1

• Northern Nevada
  November 3

• New Mexico
  November 9

• Oregon
  November 15

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References


- **Chronic Conditions: Making the Case for Ongoing Care Partnership for Solutions,** Partnership for Solutions, Johns Hopkins Univ. 2002.


- 42 CFR Parts 414 and 495, Medicare Program;

- Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed rule, Appendix H, Page 954

- Million Hearts Website: http://millionhearts.hhs.gov/