



Chronic Disease Management; A Model of Change in a CMHC

Data and Models; Vermont Medical Home Project
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Partners in the Vermont model

- ▶ Robert Wood Johnson Foundation/Center for Health Care Strategies, Inc.
 - ▶ Office of Vermont Health Access
 - ▶ Vermont Department of Mental Health
 - ▶ Various Primary Care practitioners
 - ▶ Washington County Mental Health Services
 - ▶ Health Care and Rehabilitation Services of Southeastern Vermont
 - ▶ Northwest Counseling and Support Services
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Model goals

- ▶ Empowerment of consumers to foster active participation in a client centered approach to physical health management
 - ▶ Enhancing systems and supports for care of individuals with psychiatric disabilities and chronic illness conditions
 - ▶ Progressive integration of primary care and community mental health provider systems
 - ▶ Improving knowledge of health care needs by mental health provider community
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Medical Home Model

- ▶ Originated in special needs pediatric populations
 - ▶ Establishes the clinical practice as locus for service coordination and overall care management
 - ▶ Relies on support staff to assist the family in navigating the complex network of specialty and ancillary services
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Chronic Illness Care

- ▶ Improving Chronic Illness Care – Wagner/McColl Institute Seattle, Wash.
 - ▶ More productive interactions with patients if they are active participants
 - ▶ A delivery system designed to include self-management supports
 - ▶ Encourage effective communication
 - ▶ Provide decision support regarding “best practice”
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Improving Chronic Illness Care Challenges

- ▶ Inconsistent approaches to patient teaching and self-management strategies
 - ▶ Lack of knowledge regarding community resources
 - ▶ Especially for persons in SMI population there are issues of trauma, self esteem issues, and increased possibility of negative historical relationships with medical personnel
 - ▶ Utilize the existing familiarity of providers and consumers with WRAP and Recovery models.
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Vermont Model Components

- ▶ Buy in of program leadership
 - ▶ Financial support of Medicaid authority
 - ▶ Staff/leadership training in use of Medical Home Model
 - ▶ RN leadership on care partner relationships
 - ▶ Monthly progress updates with data collection
 - ▶ Staff and Nursing Interventions Treatment Matching for Stages of change for Diabetes/chronic health care needs
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Buy in of program leadership

- ▶ Administrative, clinical, and nursing leadership must actively be involved with program promotion and QI/QA for at least first 3 years of project, then continue some degree of involvement
 - ▶ Leadership must be willing to prioritize resources needed to overcome any unforeseen gaps in the program operations
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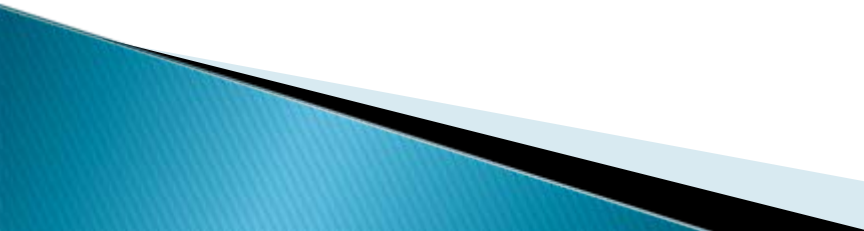
Financial support of Medicaid authority

- ▶ Office of Vermont Health Access provided assistance with original grant
 - ▶ Provided access to data to assist identification of consumers who would benefit from program
 - ▶ Now is providing payment (FFS) for RN activities related to health and wellness of consumers
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Staff/leadership training in use of Medical Home Model

- ▶ All staff must be given initial training on Improving Chronic Illness Care (ICIC) model and specific information on medical conditions to be addressed
 - ▶ Follow up training by RN Care Partner critical for staff updates, new staff training, problem solving and relationship building
 - ▶ Leadership must understand and address resource issues as they appear via program training
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RN leadership on care partner relationships

- ▶ Nurse Care Partner must do outreach to consumers
 - ▶ Also must do outreach to local home health/visiting nurse programs
 - ▶ Go to initial visits with consumers to PCP to establish contact, also to assess need in consumer/PCP relationship
 - ▶ Provide ongoing support, education, and training of individual clinicians—feed the ones who get it, poke the ones who don't
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Monthly progress updates with data collection

- ▶ Leadership—Administrative, Clinical, and Medical must meet monthly to establish PDSA cycle as method of assessment and progress
- ▶ Plan, Do, Study, Act model (Institute for Healthcare Improvement)
 - Plan – objectives, questions, predictions
 - Do – implementation, documentation of ups and downs
 - Study – Analysis of data, match to prediction, summarize
 - Act – Changes needed, next steps


Treatment Matching for Stages of change

- ▶ Using Prochaska and DiClemente's model of stages of change to assess, match, and direct treatment using variety of supports
 - ▶ Positive behavioral supports
 - ▶ How to extend RN time out to gain financial stability for services
 - ▶ A program built for use of peer support and services to maximize effectiveness of model
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Precontemplation Stage

- ▶ *Consumer Thoughts/Concerns*
- ▶ During the precontemplation stage, patients do not even consider changing.
- ▶ Change as an option is not realized.
- ▶ In denial – “nothing is wrong”
- ▶ Feel immune – “happens to others”
- ▶ Hopeless/Powerless – “I can’t do it”
- ▶ Interactions may become argumentative on consumers part


Precontemplation Stage

- ▶ *Staff Intervention steps;*
 - ▶ Start with brief and simple advice as some patients will indeed change their behavior at the directive of their physician/provider
 - ▶ Develop a positive relationship
 - ▶ Provide education on disease progress and management
 - ▶ Listen to the patient regarding what they are happy with and not happy with regarding the possible change issue. Empathy makes more change than confrontation.
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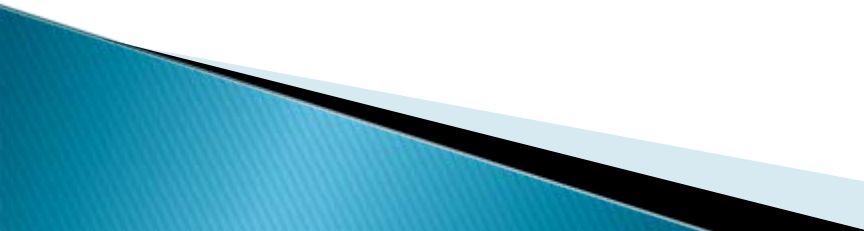
Precontemplation Stage

- ▶ What are some thought provoking questions that could be asked?
 - “How does your behavior (what you do) create problems for you?”
 - "What would have to happen for you to know that this is a problem?"
 - "What warning signs would let you know that this is a problem?"
 - "Have you tried to change in the past?"


Precontemplation Stage

- ▶ *RN/Medical Supports*
 - ▶ Establish relationship
 - ▶ Assess client understanding of health problems/needs
 - ▶ Assess client ability to manage health care needs (e.g.: accurately use blood testing equipment, interpret results and take actions, knowledge about medications, exercise, diet, etc.)
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Contemplation Stage

- ▶ *Consumer Thoughts/Concerns*
 - ▶ During the contemplation stage, patients are ambivalent about changing.
 - ▶ Pre-grieving the loss of less stringent or exacting lifestyle – “is the gain worth the pain?”
 - ▶ Barrier assessment/Bargaining – “What do I have to change and how significant a struggle will it be?”
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Contemplation Stage

- ▶ *Staff Intervention steps;*
 - ▶ Support, encourage, empathize, validate, and praise
 - ▶ Maintain a positive relationship,
 - ▶ Personalize risk factors
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Contemplation Stage

- ▶ Pose questions that provoke thoughts about patient risk factors
 - "How have you decided to change at this time?"
 - "What were the reasons for not changing?"
 - "What would keep you from changing at this time?"
 - "What are the barriers today that keep you from change?"
 - "What might help you with that aspect?"

Contemplation Stage

- ▶ *RN/Medical Supports*
 - ▶ Develop working relationship
 - ▶ Identify what client sees as needing
 - ▶ Provide individualized information/education
 - ▶ Explore complications/risks of not taking action
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Preparation Stage

- ▶ *Consumer Thoughts/Concerns*
- ▶ During the preparation stage, patients prepare to make a specific change.
- ▶ Experiment with small changes – “I’ll try this once”
- ▶ Sample low-fat/low sugar foods – “Wonder what this is like?”
- ▶ Change types of foods, cigarettes, etc – “Lets see how different this really is”
- ▶ Reduce exposure to harm – “Maybe I could be a little more careful”

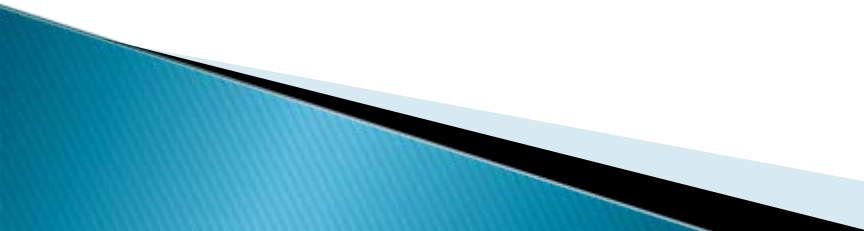
Preparation Stage

- ▶ *Staff Intervention steps;*
- ▶ Encourage addressing the barriers to full-fledged action
- ▶ Figure out possible charts, rewards, etc. that may support success
- ▶ Keep up with suggestions and questions.
 - "What things (people, programs and behaviors) have helped in the past?"
 - "What would help you at this time?"
 - "What do you think you need to learn about changing?"


Preparation Stage

- ▶ *RN/Medical Supports*
 - ▶ Explore previous efforts, supports, success, failures
 - ▶ Work with client to identify expected gains
 - ▶ Ongoing provision of information/education
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Action Stage

- ▶ *Consumer Thoughts/Concerns*
 - ▶ The action stage is the one that most providers are eager to see their patients reach.
 - ▶ More active experimentation with new and healthy alternatives – “Hey, this is not as bad as I thought”
 - ▶ Any action taken by patients should be praised – “It’s great even taking small steps”
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Action Stage

- ▶ *Staff Intervention steps;*
 - ▶ Ask for progress reports, go over any charts or other data to support changes
 - ▶ Search for how changes may be able to be more global—in as many settings as the person is in daily.
 - ▶ Are there new benchmarks that should be reached for?
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Action Stage

- ▶ *RN/Medical Supports*
- ▶ Assist client to develop small steps/short-term goals they see as “do-able” (Use Healthy Changes Tool)
- ▶ Assist to identify perceived barriers and ways to overcome them
- ▶ Help to identify available resources and supports, make or obtain referrals as indicated
- ▶ Explore incentives
- ▶ Coordinate communication among health care team members for consistent approach
- ▶ Affirm efforts, successes, avoid criticizing lapses
- ▶ Evaluation of current progress and planning future steps/goals

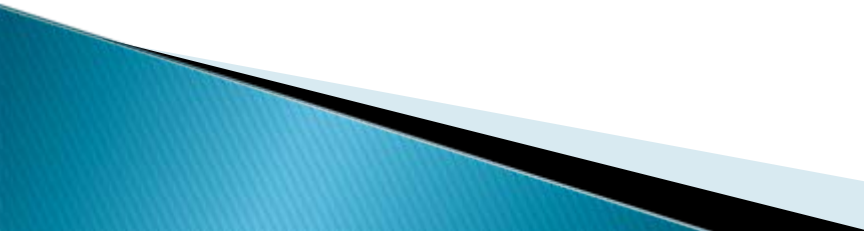
Maintenance and Relapse Prevention

- ▶ *Consumer Thoughts/Concerns*
- ▶ Maintenance and relapse prevention involve incorporating the new behavior "over the long haul."
- ▶ Keeping on the change track – “eyes on the prize”
- ▶ Slips here can create discouragement, important for support persons to be positive on the progress made to this point – “Nobody’s perfect so I can just keep trying to meet my goal”
- ▶ Most consumers find themselves "recycling" through the stages of change several times before the change becomes truly established – “It’s great to be back doing better again, that slip was tough”


Maintenance and Relapse Prevention

- ▶ *Staff Intervention steps;*
 - ▶ Track and reward progress
 - ▶ Analyze how some efforts didn't seem to help
 - ▶ Uncover new motivations and supports for increasing what is working well
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Maintenance and Relapse Prevention

- ▶ *RN/Medical Supports*
 - ▶ Reinforce integration of changes into everyday life
 - ▶ Emphasize/praise success while reassuring that relapses do occur and are not “failures”
 - ▶ Assist to identify strengths and limitations in making changes
 - ▶ Encourage client to track progress/changes and to keep their health care team apprised
 - ▶ Ongoing assessment, planning, implementation, and evaluation
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Challenges of Care

- ▶ Overeating – impulse control, self soothing, and sometimes medication related
 - ▶ Smoking – 2–3 packs a day not so atypical
 - ▶ Co-occurring Disorders
 - ▶ Poor diet choices due to limited purchase/preparation skills
 - ▶ High intake of caffeine, sugar sweetened products,
 - ▶ Low self esteem – sometimes via Tx providers
 - ▶ Unemployed/low physical activity levels
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Data on Outcomes in VT Model

- ▶ Study Group – Currently we have data completed over 2 years on 20 individuals. 26 originally joined this cohort, 5 ceased participation and 1 is deceased.
- ▶ A1C changes – the Average A1c change for the cohort was .4, with a range of 1.7 decrease to a 1.1 increase. 5 were below 6.0 at end of time period
- ▶ Weight Changes – The average weight loss was 6.2 lbs, with a range of 35 lbs loss and a 7 lbs gain.


Data on Outcomes in VT Model

- ▶ Blood pressure Changes - average $-19/+3$
 - ▶ Cholesterol - 14 of group had readings above 200, with 9 persons actively taking statins.
 - ▶ 60% of cohort diagnosed with heart disease,
 - ▶ 30% of cohort diagnosed with Sleep apnea
 - ▶ 50% of cohort active smokers
 - ▶ 50% of cohort diagnosed with COD
 - ▶ 65% of cohort diagnosed with psychotic disorder
 - ▶ 90 % of cohort diagnosed with depression
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Other changes noted

- ▶ Employment Changes – noted anecdotally that consumer interest in employment services and gaining employment increased during this time period.
 - ▶ Housing Changes – also noted that consumer interest in gaining new housing increased in this time period.
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Other changes noted

- ▶ Health Cost Changes - data on this is difficult to quantify due to average of nearly 60% of cohort is dual eligible, thus Medicare info is needed to validate this area. Anecdotal observation was of a decrease in use of hospital ED care and increase in PCP appointments.
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Vermont Model Improvements

- ▶ Connecting practices with local agencies and state program offices through physical co-location or electronic links – EHR can increase integration and improve care
 - ▶ Address conflicts with Medicare and Medicaid coverage in new chronic care models via Medicaid
 - ▶ Development of peer services statewide may be best long term model
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References

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- ▶ Miller WR, Rollnick S. Motivational interviewing: preparing people to change addictive behavior. New York: Guilford, 1991:191-202.
- ▶ Zimmerman, G. L., Olsen, C. G., and F. Bosworth, M. F.; A 'Stages of Change' Approach to Helping Patients Change Behavior American Family Physician® Vol. 61 /No. 5 (March 1, 2000)