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Patient and Family-Centered Sustainable Health Care

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Objectives – What is/are..

1. Patient and family-centered care?
2. Drivers to achieve a health outcomes focus (policy, economics, business strategies, health outcome goals?)
3. Ways of measuring performance in the industry?
4. Drivers for these ways of measuring?
5. Approaches to ensuring quality? How affected by recent market and policy changes?
6. Shifts can be expected in the short and long term perspectives?
7. Some game-changing events now or in the future?
8. Information needs for healthcare professionals and patients re: these coming trends?
9. Policy/advocacy/communications needed by our region to ensure cutting edge, effective, and high quality healthcare?

Case Study

- Ms. S is 54 years old, works as a nurse, cares for her disabled mother, two teen/ish children, and is the back-up babysitter for her 2 year old granddaughter
- She is active in her church ladies' group
- Because of increased expenses and her older daughter moving back home, she has taken an extra part-time job to help with expenses
- Ms. S has felt stressed and overwhelmed for many months now, gets most of her comfort from cooking and eating with friends, and cannot remember the last time she did any regular exercise

Case Study (2)

- Ms. S has been feeling tired lately – even when she goes to bed early, she does not feel rested when she awakens
- She finds herself urinating more frequently and even gets up to urinate at least begun having a little wine with meals to relax herself and has restarted an old smoking habit she quit more than 5 years ago
- She is having increasingly frequent episodes of mid-epigastric abdominal pain that improves somewhat when she ingests antacid tablets
- Her daughter thinks she should talk to someone about these symptoms...

Case Study (3)

- Although her daughter makes her an appointment to see her physician, Ms. S becomes impatient while waiting for the physician, and just asks for a prescription medication to help her abdominal pain
- She leaves the physician's office with a prescription for Ranitidine and goes to work her part-time job
- Her daughter calls her best friend – and asks her what she should do? She is worried that she will lose her mother just like she lost her aunt who died of a stroke at age 57 two years ago
- ??????

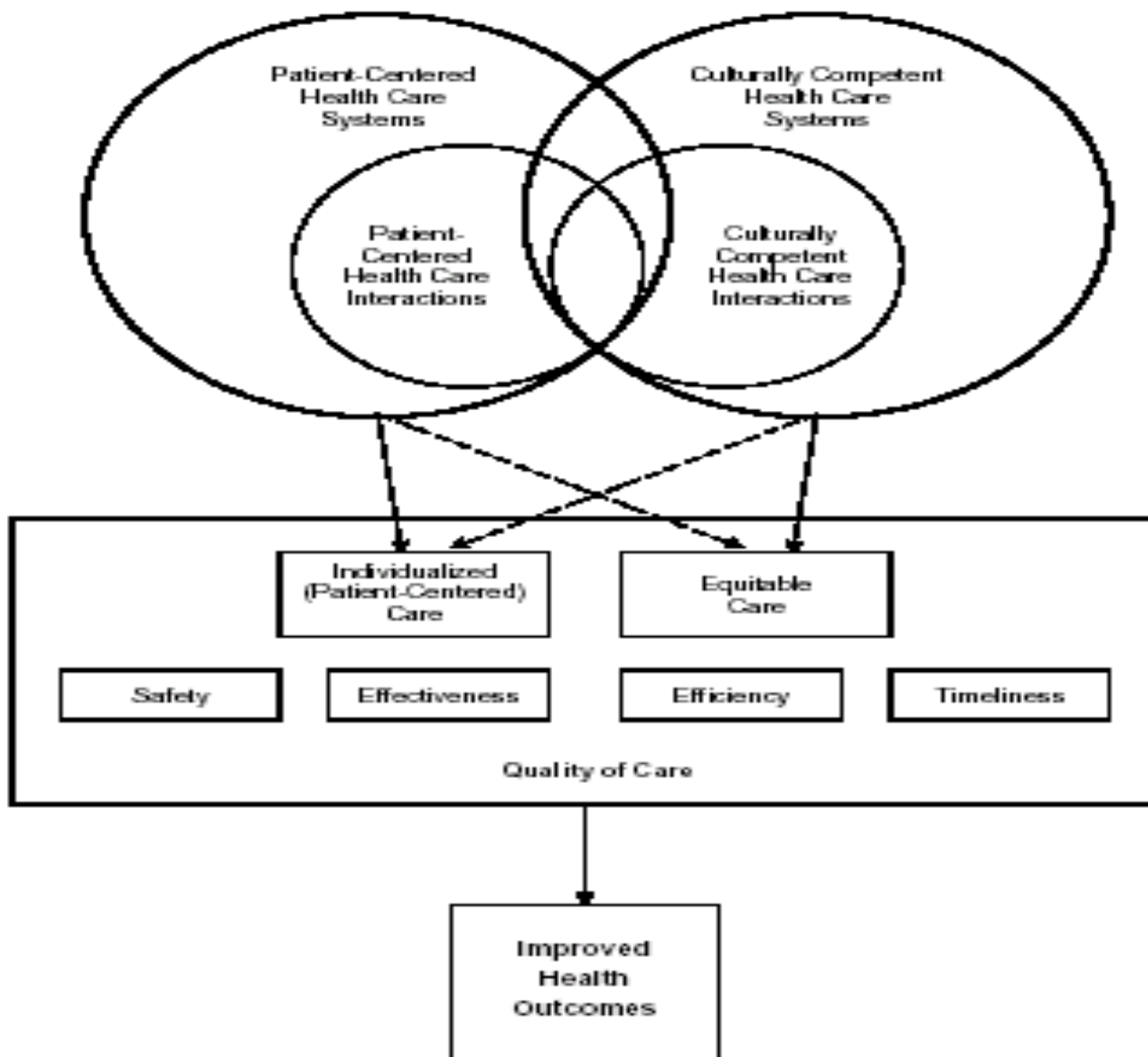
Case Study (4)

- Ms. S calls her daughter the next afternoon saying she felt nauseous when she arrived at work, but worked with several patients, grabbed bites of MacDonald's hamburgers a co-worker picked up. She vomited multiple times throughout the shift and is now in the emergency department of the local hospital.
- What do you think is going on?

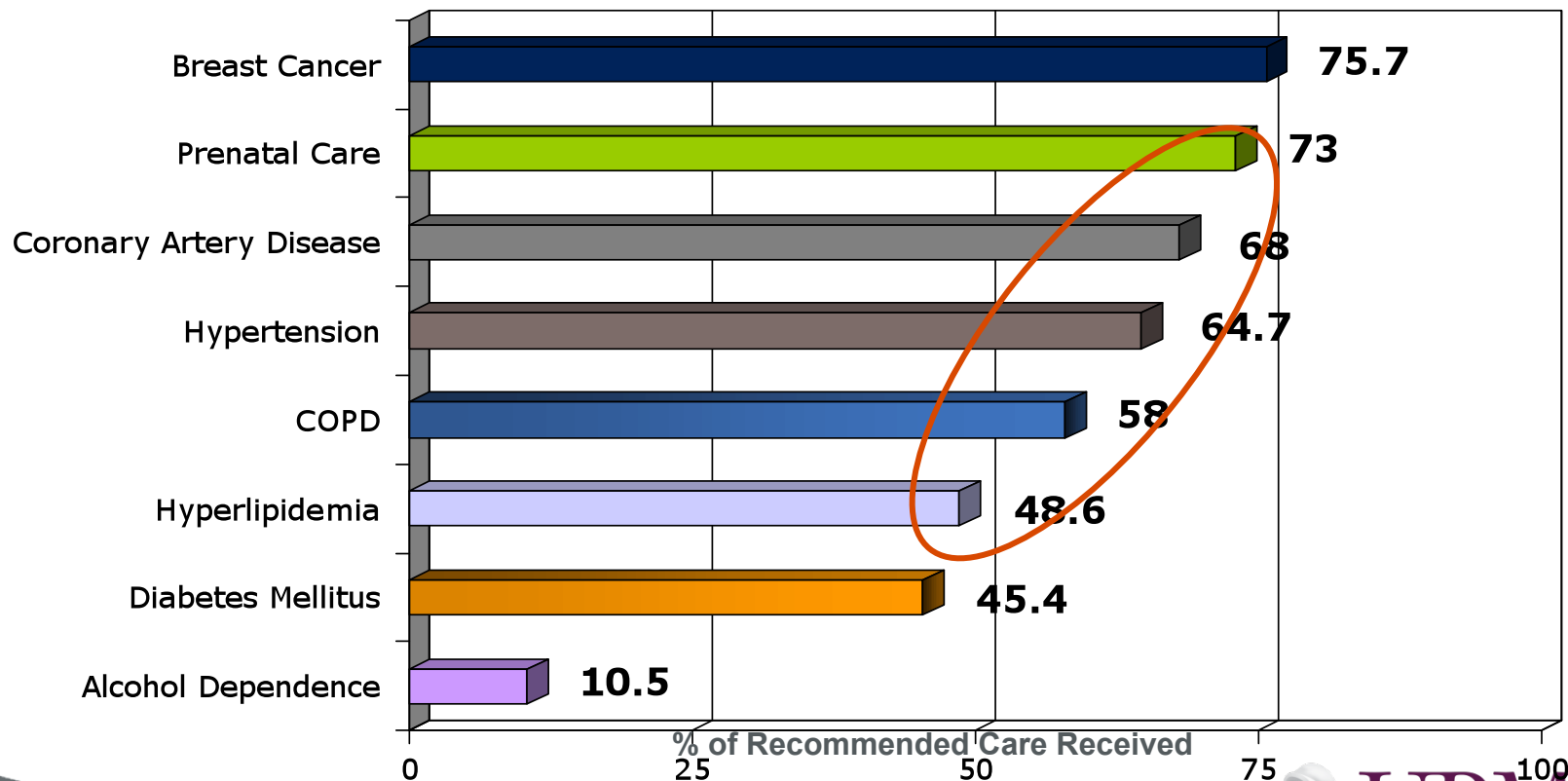
Identifying Chronic Illness

- ~50% of people with chronic illness have multiple conditions
- But there are many deficiencies in the management of diseases such as diabetes, heart disease, depression, asthma and others.
- Those deficiencies include:
 - Rushed practitioners not following established practice guidelines
 - Lack of care coordination
 - Lack of active follow-up to ensure the best outcomes
 - Patients untrained to manage their illnesses

**Figure 1. Patient-Centeredness and Cultural Competence
Integral to Health Care Quality**



Adherence to recommended care is low for chronic conditions



Source: McGlynn et al. NEJM 2003



CONDITION**SHORTFALL IN CARE****AVOIDABLE TOLL**

Diabetes

Average blood sugar not
measured for 24%29,000 kidney failures
2,600 blind

Colorectal cancer

62% not screened

9,600 deaths

Pneumonia

36% of elderly didn't
receive vaccine

10,000 deaths

Heart attack

39% to 55% didn't receive
needed medications

37,000 deaths

Hypertension

Less than 65% received
indicated care

68,000 deaths

Source: Elizabeth McGlynn, et al. "The Quality of Health Care Delivered to Adults in the US." NEJM 2003; 348:2635-45



Case Study (5)

- Ms. S's Physical Exam in the ED
 - BP 170/98, HR 88, T 37, R 16, Weight 80 kg, BMI 32
 - Skin is damp and she is sitting up on bed, anxious, and uncomfortable
 - Neck supple without distended neck veins; Carotid pulses strong without bruits
 - Lungs clear to auscultation and percussion
 - Tachycardic, no murmurs or ectopy
 - Abdomen obese, soft, generalized tenderness to palpation without organomegaly or rebound
 - Extremities without deformities or edema

Case Study (6)

- Ms. S
 - Glucose = 315
 - Urinalysis – unremarkable
 - Hemoglobin = 14
 - Total cholesterol = 250
 - CXR – No evidence of cardiomegaly, pulmonary infiltrates
 - Electrocardiogram – No acute changes or ventricular enlargement
 - Abdominal ultrasound – Gall stones



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What factors affect caring for Ms. S?

Case Study (7)

- Factors affecting care of Ms. S
 - Patient resistance to care
 - Multiple clinical issues
 - Work schedule between 2 jobs
 - Need for acute and chronic care
 - Need for patient education
 - Need to engage her family
 - Need for health care system support

Care Issues

- Emphasis on physician, not system, not individual behavior
- Lack of integration across care settings hindering quality care –
 - Uses urgent care centers and emergency departments rather than one primary care clinician
- Available interventions not being used successfully
- Commonalities across chronic conditions unappreciated
 - Multiple conditions respond to diet and exercise

Type 2 diabetes – 90+ % of all adult diabetes

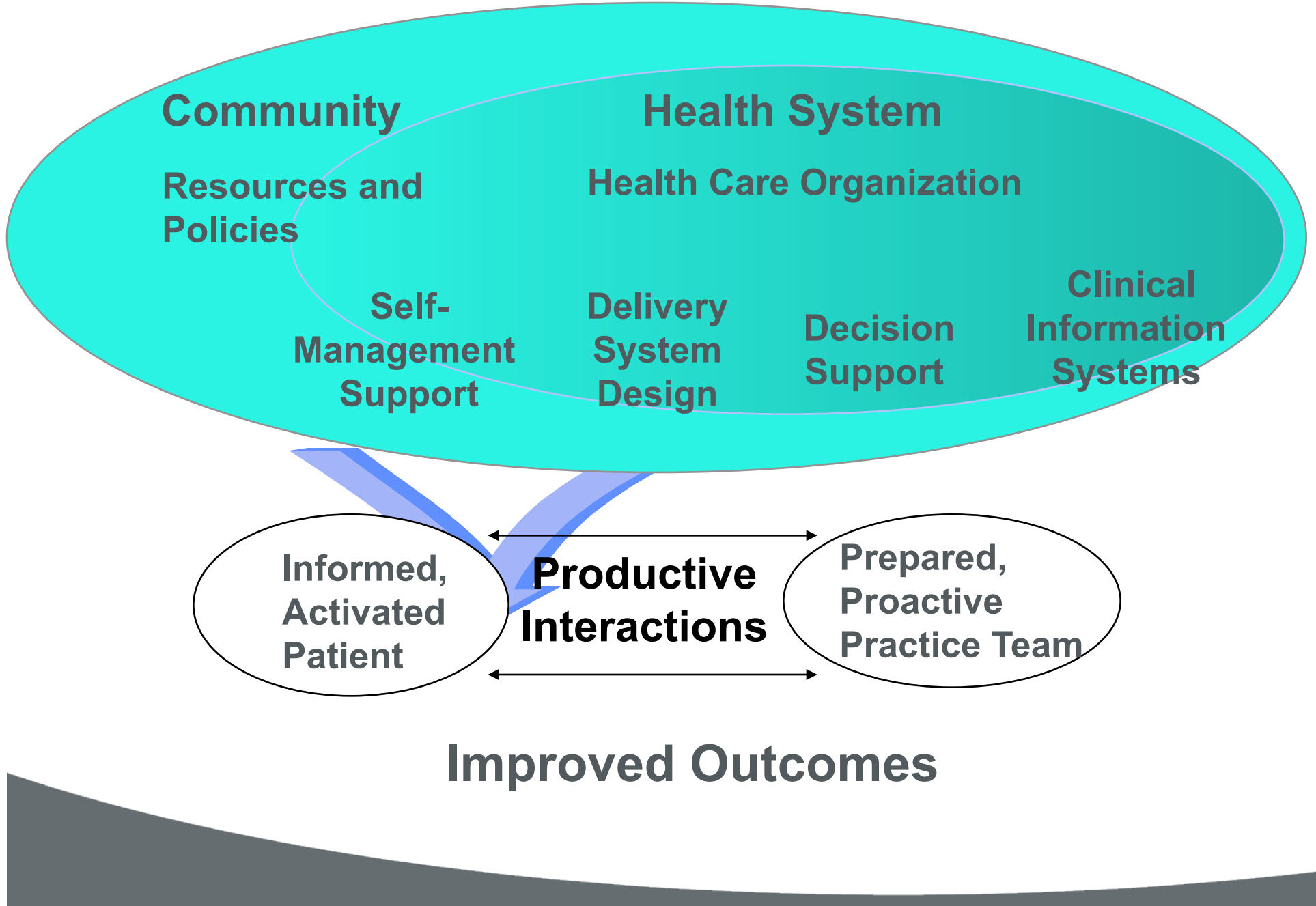
A person is more likely to develop type 2 diabetes if:

- Family history of diabetes
- Ethnic group member
- Overweight or obese
- More than 45 years old
- Had diabetes while pregnant (gestational diabetes)
- Have pre-diabetes (glu elevated, but no diabetes dx)
- Hypertensive
- Abnormal cholesterol (lipid) levels
- Sedentary
- Have polycystic ovary syndrome (PCOS)
- Have blood vessel problems affecting the heart, brain or legs
- Have dark, thick and velvety patches of skin around the neck and armpits (acanthosis nigricans.)

- http://ndep.nih.gov/media/fs_africanam.pdf



Chronic Care Model



Refinements to the Chronic Care Model

- Based on more recent evidence (2003), five additional themes were incorporated into the CCM:
 - Patient Safety (in Health System);
 - Cultural competency (in Delivery System Design);
 - Care coordination (in Health System and Clinical Information Systems)
 - Community policies (in Community Resources and Policies); and
 - Case management (in Delivery System Design).

http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18

Transformation of Current Health Care

- Needed to overcome these deficiencies
- Transform from a system that is reactive (responds when a person is sick) - to one that is as proactive (focused on keeping a person healthy) as possible.
- Improving Chronic Illness Care (ICIC) created the Chronic Care Model to speed this transition -
 - Summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels.

Self-Management Support

- Emphasizes the patient's central role
- Uses effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving, and follow-up
- Organizes resources to provide support

Delivery System Design

- Defines roles and distributes tasks amongst team members
- Uses planned interactions to support evidence-based care
- Provides clinical case management services
- Ensures regular follow-up
- Gives care that patients understand and that fits their culture

Features of Case Management

- Regularly assesses disease control, adherence, and self-management status
- Either adjusts treatment or communicates need to primary care immediately
- Provides self-management support
- Provides more intense follow-up
- Provides navigation through the health care process

| Week of: _ / _ - _ / _ | Blood Sugar | | | Took Medicines | Food Description and Amount | Physical Activity Description and Number of Minutes |
|---------------------------|-----------------|-----------------|-----------------|--|--------------------------------|--|
| | Time Reading | Time Reading | Time Reading | Note Time of Day | | |
| SUNDAY | | | | <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ p.m. <input type="checkbox"/> _____ p.m. | | |
| MONDAY | | | | <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ p.m. <input type="checkbox"/> _____ p.m. | | |
| TUESDAY | | | | <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ p.m. <input type="checkbox"/> _____ p.m. | | |
| WEDNESDAY | | | | <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ p.m. <input type="checkbox"/> _____ p.m. | | |
| THURSDAY | | | | <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ p.m. <input type="checkbox"/> _____ p.m. | | |
| FRIDAY | | | | <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ p.m. <input type="checkbox"/> _____ p.m. | | |
| SATURDAY | | | | <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ a.m. <input type="checkbox"/> _____ p.m. <input type="checkbox"/> _____ p.m. | | |

It is important to have routine tests to help you and your health care provider monitor your diabetes. You can use this sheet to help you keep track of your exams and lab tests.

Provider visits:

| | Provider Name | Visit Date | Visit Date | Visit Date | Visit Date |
|------------------------------------|---------------|------------|------------|------------|------------|
| Health care provider visit | | | | | |
| Foot exam with a monofilament test | | | | | |
| Annual eye exam | | | | | |
| Annual dental exam | | | | | |

Tests:

| | Goal | Date/Value | Date/Value | Date/Value | Date/Value |
|--|------|------------|------------|------------|------------|
| Weight | | | | | |
| Blood pressure | | | | | |
| Hemoglobin A1c test (blood sugar control for the past 2-3 months) | | | | | |
| HDL cholesterol ("good" cholesterol, helps keep bad cholesterol levels lower) | | | | | |
| LDL cholesterol ("bad" cholesterol, if too high can clog arteries and lead to heart attack and stroke) | | | | | |
| Triglycerides (a form of fat that circulates in the blood; it is affected by simple sugars that are eaten) | | | | | |
| Urine microalbuminuria (measure of protein in the urine, which is a way to find early kidney damage) | | | | | |
| Urine creatinine (measure of protein in the urine, which is a way to find early kidney damage) | | | | | |

What have we learned?

- Start where the patient is willing to begin...
- Take small steps
- Move quickly
- Learn from failures
- Data, data, data...

Primary Care

- Build the team structure
- Obtain guidelines
- Collect some baseline data on the population
- Set performance measures and targets
- Call in patients for planned visits
- Set self-management goals at the visit
- Conduct follow up on shared care plan

Update on Diabetes Project

- DM project started in CMI in 1999
- Leadership recognized great variability in care
- Guideline medicine was being developed however all organizations nation-wide were struggling with successful implementation.
- Evidence based information was starting to catch on but implementation remained problematic
- Project expanded to all practices in 2003
- Now an ongoing project

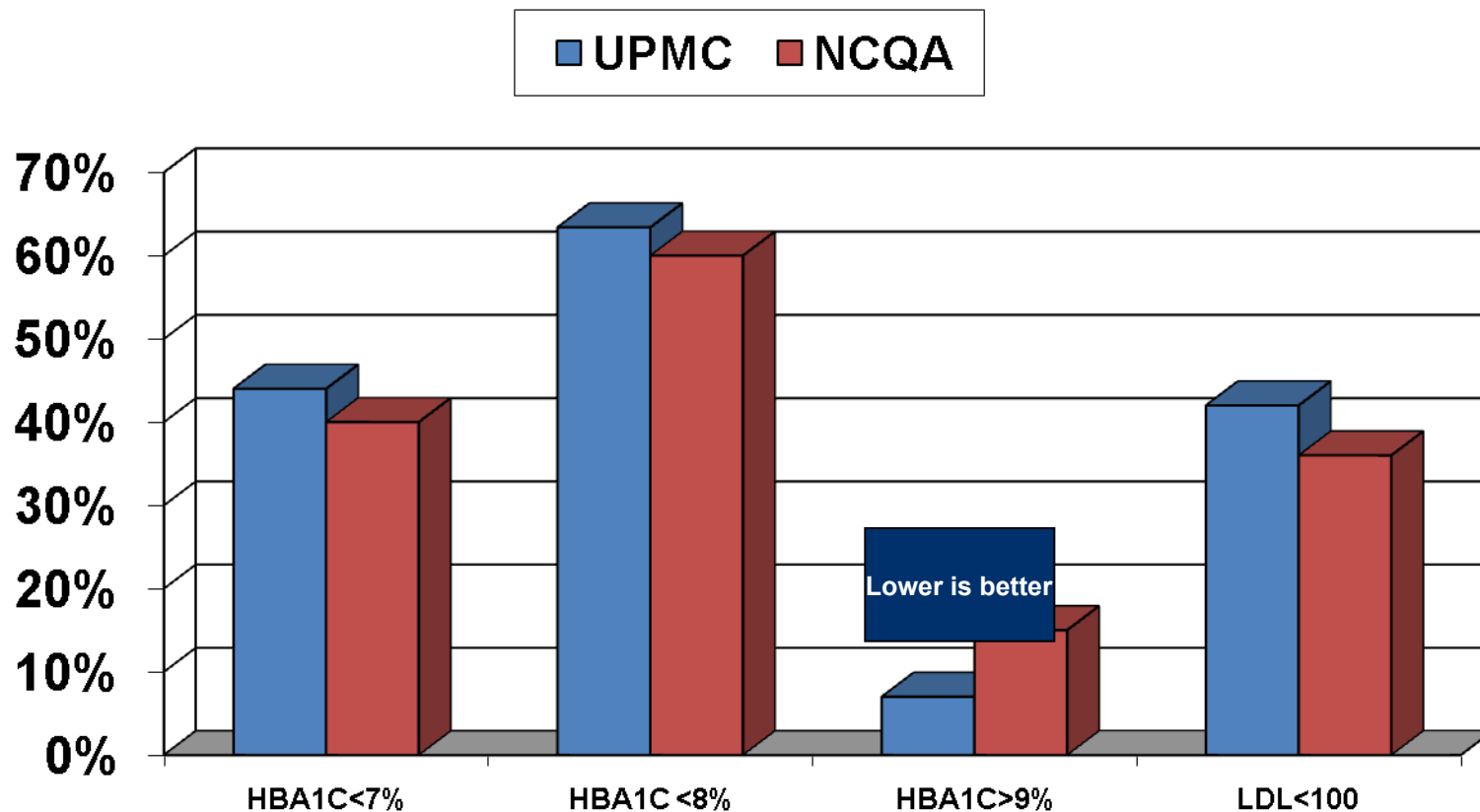
CMI Efforts - Key Features

- Physician leadership demanded 100% participation
- Evidence-based presentations on standards of care and need to control glucose, lipids, blood pressure and use aspirin
- Prospective and retrospective assessment of care was done in many practices.
- Intervention tracking at the time of encounter
- Ongoing education, tracking and re-education
- Chart tools/ population analysis tools in the paper world

CMI Efforts - Key Features

- Deployment of DM nurse educators in key practices = UPMC HP care managers
- Utilization of system resources to facilitate care - Health plan, Quest labs, Diabetes Institute, Information technology
- Medical management team involvement in the practices
- E record tools - best practice alerts as the mainstay of the program
- DM patient reminders at the time of encounter

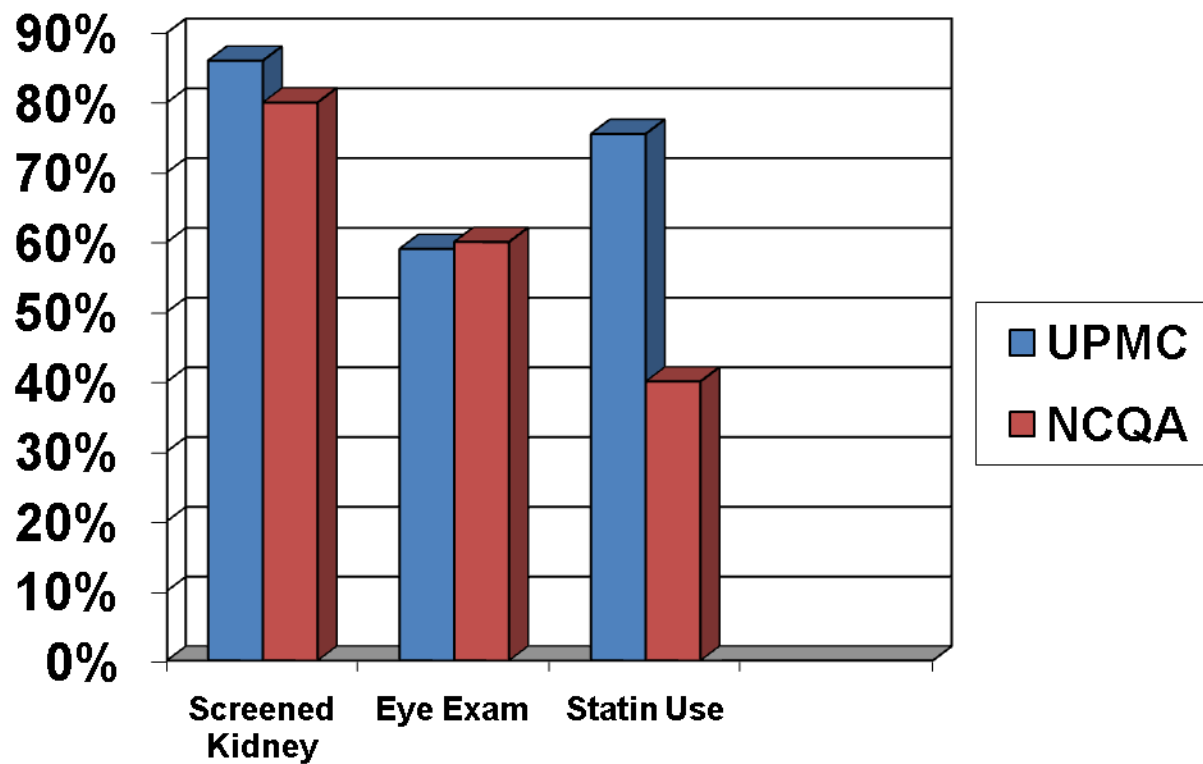
Diabetes Results for 29,392 Patients 26,000 of these in CMI



**UPMC results compared to requirements for
NCQA recognition**



Diabetes Results (n= 29,392)



Diabetes results

- % patients over age 55 on ACE/ARB - 82%
- BP <140/90 - 64.1%
- % non smokers - 76.7%
- % patients queried about tobacco - 90%
- Influenza vaccine - 74%
- Pneumovax - 70%

Readmission Initiative

- In 2012 CMS will no longer pay for readmissions in Core diseases- CHF, AMI, Pneumonia and COPD
- PSD has been piloting a program to improve the transition of care from hospital to home
- Critical step is that many patients who are readmitted within 30 days of hospital discharge are never seen by a provider
- PSD will be calling all patients who are discharged and scheduling them within 5 business days of admission to a visit with their PCP
- In prior pilots this step significantly decreased readmissions for CHF- we hope to extend this to all of the above diseases.

Lessons Learned

- No longer business as usual
- Patient – centeredness must come first
- Legislative initiatives will dictate certain processes
- Team approach is key
- If we are successful, patients will be happier and healthier!

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????QUESTIONS???