Introductions

“Jump in feet first” activity – 10 minutes

• Index cards........ each person has a card marked A or Z with a question on it.

• Partner with a person who has the “other” letter. A asks Z, then Z asks A.

• Stick to the script! Read the question on your card to the other person EXACTLY as written.
Familiar Patient Scenario

- Patient discharged from hospital
- Returns home to baseline behavior
- Continues non-adherence with recommendations
- Agency discharges
- Patient rehospitalized
- Cycle of “the same” continues
Integrated Chronic Care Model

- General Overview:
  - Self management support
    - To elicit behavior change
  - Application of the following components to every appropriate aspect of chronic care management
    - Motivational Interviewing (Miller and Rollnick)
    - SBAR (adapted by Kaiser Permanente in 1990’s from U.S. Navy)
    - Teach Back
    - SMART Goals

Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>- EVNA key personnel attended Chronic Care Presentation by Baptist Health Care at HCA conference</td>
</tr>
<tr>
<td>2009</td>
<td>Review HBCCM with NE Health executives, Board of Directors and Senior Staff, gain support.</td>
</tr>
<tr>
<td>June 2010</td>
<td>3 key employees to Little Rock for PentaHealth “Train The Trainer” course, achieve certification.</td>
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<tr>
<td>July 2010</td>
<td>Identify Chronic Care “Guiding Team”</td>
</tr>
<tr>
<td>August 2010</td>
<td>Baptist Faculty come to EVNA for 2 day on site training with “Guiding Team”</td>
</tr>
</tbody>
</table>
| September 2010| ▪ Develop initial work plan and timeline  
                         ▪ Develop vision statement for home – based chronic care  
                         ▪ Awarded grant from NYS Health Foundation  
                                 ▪ To hire 2 Clinical Nurse Specialists  
                                 ▪ CVP and CDE (job descriptions) |
| October 2010| Applied for grant from The Eddy Foundation  
                      ▪ Research component (preliminary meetings w/ Dr. W. Foley at RPI)  
                      ▪ Chronic Care training costs |
### Timeline (continued)

| October 2010 | Develop schedule for curriculum delivery  
|             | • 2.5 hour blocks, once weekly  
|             | • 4 weeks  |
| October 2010 | Introduced HBCCM model to Liaison and Intake staff  |
| November 2010 | • Directors Group job descriptions updated to reflect leadership of HBCCM and staff engagement  
|             | • Joint supervisors/Director Roll-out  |
| December 2010 | VP, Director EVNA attends all team meetings to review the model, vision and summary of progress/timeline  |
| January 2011 | • Revise job descriptions of clinical and support staff to reflect expectations  
|             | • Administer Clinical Attitude Survey (Wagner) before staff trained  
|             | • Develop tracking process for staff certification  
|             | • Begin staff training  |
| May 2011 | Began modified training for office staff  |

### Timeline (continued)

| June 2011 | • Development of Chronic Care Coordinator position  
|           | • Revise new hire orientation schedule to include a brief overview of HBCCM.  
|           | • Establish timeline for new staff to be trained (after 6 months successful employment)  |
| October 2011 | Develop annual employee certification “refresher”  |
| November 2011 | Chronic Care Coordinator assumed role  |
| February 2012 | Chronic Care Committee established (replacing Guiding team). Purpose: further grow and integrate the Chronic Care model and its principles into the culture and day to day operations of the EVNA at all levels.  |
| October 2012 | Outreach, training provided to Eddy Senior Care (PACE) program  |
| March 2013 | New Chronic Care coordinator trained at Sutter Care at Home, Fairfield, CA  |
Timeline (continued)

<table>
<thead>
<tr>
<th>Present</th>
<th>Committee identifies and recruits Chronic Care Champions</th>
</tr>
</thead>
</table>
| Near Future | • Meeting facilitation training for Champions  
• Original Trainers (Little Rock 3) recertify  
  • Online course for recertification now available |
| Future | • Outcome studies  
• Use survey data to modify training based on EVNA findings |

Ongoing throughout process

• Communication w/ Baptist faculty
• Monthly project updates from VP/Director to all staff
• Monthly updates to NE Health Executives, NE Health Board Quality, NE Health Board of Directors, NE Health System Leadership
• Celebrate small successes/accomplishments as they occur
Annually

• VP/Director EVNA attends all team meetings with update
• “Refresher course” for all trained employees at team meetings.
• Reassess and adjust
• Continue to review current studies and clinical evidence

Getting started

• Program MUST begin with Administration
• Baptist Health Care program selected –
  – Parallel program, with similar organizational structure to EVNA
  – Integration allowed implementation while still complying with traditional Home Care guidance
• “Little Rock 3” – key clinicians selected for train the trainer course.
Now that we’re trained to train.......... 

• Logistics of training existing staff  
  – 2010 
    • 127 nurses 
    • 83 rehab staff 
    • 89 home health aides 
    • 299 clinical staff to train 
  - 2012 **
    • 163 nurses 
    • 99 rehab staff 
    • 115 home health aides 
    • 377 clinical staff 

**2011 consolidation of 3 home care agencies over 6 month period as part of St. Peter’s Health Partners
Set the tone at first contact

• Intake /Liaison—
  — Liaison staff trained in model
    • Hospital, SNF, other referral centers
  — “scripted question”
    • “I have some areas we need to focus on to help prepare you for discharge, but before we start with my list.......Can you tell me what you are the most concerned about when you leave here and return home?”

• Stop, wait and listen for an answer.
  — establishes interest and empathy from the beginning and engages the patient

Staff are expected to....

• Demonstrate use of patient centered care
• Demonstrate behavior change competency
• Demonstrate use of evidence based guidelines
• Demonstrate collaborative relationship with patients
• Sign new job description upon certification
Staff Training/Certification

• Initial Certification
  – After 6 months successful employment
  – Once weekly for 4 weeks
  – 2.5 hour sessions
  – Take home assignments
  – Respect adult learning styles
  – Must pass test, w/ remediation if not passed

EVNA Sample Course Outline

DAY ONE:
• 8:15 am - Breakfast
• 8:30 am - Introductions
• 8:45 am – Overview Integrated Chronic Care Model and agency history w/ Chronic Care
• 9:45 am - Break
• 10:00 am – Self Management Support and Preparing for Behavior Change
• 10:45 am – Motivational Interviewing
• 11:15 am – Wrap up and plan for Session Two
## EVNA Sample Course Outline

### DAY TWO
- 8:15 am - Gathering and report back
- 8:45 am - Motivational Interviewing
- 10:00 am - Break
- 10:30 am - Activity - MI
- 10:45 am - Discussion
- 11:00 am - Reflective Listening/Change
  - Talk/Ambivalence
- 11:15 am - Wrap up and plan for Session Three

### DAY THREE
- 8:15 Review –
  - Open Ended Question activity
    - Engaging the patient
  - Ambivalence - “I know I should, but.....”
- 8:45 Pros and Cons
  - Activity
- 9:15 Importance/Confidence Ruler
- 9:30 Break
- 9:45 Goal Setting
  - Long Term Goals
  - SMART Goals
- 10:30 SBAR
- 11:15 Review and Questions
  Plan for Week Four
EVNA Sample Course Outline

DAY FOUR

• 8:15 Review – Update
  – Questions/Comments
  – Videos
  – SBAR review
  – Maslow’s Hierarchy
• 9:00 Health Literacy
  – Activity
• 9:45 Break
• 10:00 Final Review/Questions
• 10:30 Perspective –
• 11:00 Test -

Chronic Care Committee

• Purpose: further grow and integrate the Chronic Care model and its principles into the culture and day to day operations of the EVNA at all levels.
• Composition
  – 14 members, Chronic Care Coordinator is Chair
  – Main and branch office represented
  – Interdisciplinary representation
• Monthly meetings
Chronic Care Coordinator

• 50 % Chronic Care
• 50 % Patient Care
• Chronic Care Responsibilities
  – Consistently model use of Chronic Care techniques
  – Conduct new Staff Training
  – Conduct annual refresher courses
  – Participate in new employee basic orientation with overview
  – Chair Chronic Care Committee
  – Schedule and facilitate CC Interdisciplinary Case Conferences
    • Including participate in identifying patients for discussion
  – Facilitate Focused Care Conferences
  – Resource for all staff/available for Co-visits
  – Member of Clinical Specialties Team
  – Meet monthly with VP Director and Director Clinical Specialties

Interactive Process
Interactive Process

- Management support
- Staff Initial Training
- Chronic Care Committee
- Refresher/review
- Modeling
- Implementing
- Trainer recert and education
- Professional & community outreach

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Supervision visits
Program Review
Monthly IPCC visits
Keeping Staff engaged and current

• Additional Tools/Strategies
  – Bulletin Boards
  – Laminated key concept cards
  – Email success stories and tidbits

• Encouraging communication
  – Face to face
  – Electronic
  – Utilize all available technology

Clinician survey

• Adapted from:
  – "Copyright 1996-2013 The MacColl Center. The Improving Chronic Illness Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's MacColl Center for Health Care Innovation".
  – 20 questions
    • Likert “like” scale measuring frequency of Chronic Care Management behaviors
Sample Survey Questions

<table>
<thead>
<tr>
<th>Use open ended questions when first getting to know my patient. (Avoid questions that will illicit yes or no responses)</th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I ask permission to give advice before I give it</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Try to facilitate the patient’s problem solving instead of just giving them the answer</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help tie the patient’s future aspirations to their disease management goals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set small achievable goals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Try never to threaten dire consequences when talking to the patient about their disease management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Funding/Grants

- The Eddy Foundation – grant to fund initial training of clinical and office staff
- NYS Health Foundation Grant – 2 years funding to support the start up of Clinical Nurse Specialty Program, and hiring of 2 CNS
  - CDE – Certified Diabetic Educator
  - Cardiac CNS – Clinical Nurse Specialist
- Funding from both grants now completed.
Chronic Care Interdisciplinary Case Conference

- Monthly by care team
  - Scheduling challenges
  - Clinician expectation and commitment to participate
- Strategic Patient selection
- Clinicians/supervisors/coordinator suggest patients for discussion
- Format
  - Ground rules
  - Time keeper
  - SBAR
  - Recorder

Focused Case Conference

- Challenging patients that need more time
  - Complex
  - Non adherent
  - Critical issues
  - Recycled discussions at monthly interdisciplinary conference
Getting staff buy in

• Demonstrate /share success
• Empower
• Share the evidence
• Consistency
• Repetition

SHOW THEM.......”IT WORKS”

From the field

• “I LOVE EMPOWERING THE PATIENT.... (they love it too)

• The basic training.... is SO good for all of us delivering care to folks because it makes us respectful of people in general, and can change the patient’s notion of respect for all too

• Everyone is individual and unique and they way they do things is right for them

• Empowers the patient and the professional can relax...or can get off their 'I know best'

• Makes patients feel successful and increases motivation and honesty in communication.

• Patients talk and share better with you, and they feel better about themselves and try new things.

• This offers a clear, vetted and trainable model that works.

• “No one has ever asked me what I think WE should be doing about my care before”
Health Literacy

• According to the American Medical Association report, Health Literacy and Patient Safety: Help Patients Understand, "poor health literacy is a stronger predictor of a person's health than age, income, employment status, education level, and race".

• Individuals with limited health literacy incur medical expenses that are up to four times greater than patients with adequate literacy skills, costing the health care system billions of dollars every year in unnecessary doctor visits and hospital stays. (www.ama.org)
Diabetes

**Every Day**
- Take your medications as prescribed at the same times everyday
- Eat a balanced diet spread throughout your day – DON’T SKIP MEALS!
- Be as active as you are able
- Test and control your blood sugar

**Green Zone**
- < NOW MORE DETAILS >
- You are at goal when in this zone and are considered stable.
- You are not experiencing signs of high or low blood sugar.
- You are able to take your medications as prescribed
- You are following your prescribed diet and exercise program
- You are testing your blood sugar regularly, as prescribed
- Your blood sugar is in the recommended range
- You are able to keep your Home Care Nurse and/or Doctor Appointments

**Yellow Zone**
- You are not able to take medications as prescribed or test your blood sugar.
- Your blood sugar is under 70 and does not respond to carbohydrate intake (i.e., milk, glucose gel).
- You are experiencing signs and symptoms of high or low blood sugar.
- Blood glucose is over 200 in 3 consecutive tests.
- You are ill for more than 24 hours.
- Your temperature is over 101.4.
- Vomiting or diarrhea lasting for more than 8 hours (follow sick day rules)

**Emergency!! Call 911 or have someone take you to the Emergency Room!**
- If your blood glucose is under 20
- You are unable to stay awake even during the day
- You are very confused

ASKS OPEN ENDED QUESTIONS

<table>
<thead>
<tr>
<th>Response</th>
<th>Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2</td>
</tr>
<tr>
<td>Little</td>
<td>3</td>
</tr>
<tr>
<td>Some</td>
<td>63</td>
</tr>
<tr>
<td>Most</td>
<td>119</td>
</tr>
<tr>
<td>All</td>
<td>29</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
</tr>
</tbody>
</table>

...of the Time
Provide frequent praise for success

<table>
<thead>
<tr>
<th>Response</th>
<th>ALL CLINICIANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>1</td>
</tr>
<tr>
<td>LITTLE</td>
<td>2</td>
</tr>
<tr>
<td>SOME</td>
<td>28</td>
</tr>
<tr>
<td>MOST</td>
<td>74</td>
</tr>
<tr>
<td>ALL</td>
<td>114</td>
</tr>
<tr>
<td>NO RESPONSE</td>
<td>0</td>
</tr>
</tbody>
</table>

...OF THE TIME

Before visit ends discuss plans for next visit

<table>
<thead>
<tr>
<th>Response</th>
<th>ALL CLINICIANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>3</td>
</tr>
<tr>
<td>LITTLE</td>
<td>11</td>
</tr>
<tr>
<td>SOME</td>
<td>35</td>
</tr>
<tr>
<td>MOST</td>
<td>92</td>
</tr>
<tr>
<td>ALL</td>
<td>73</td>
</tr>
<tr>
<td>NO RESPONSE</td>
<td>5</td>
</tr>
</tbody>
</table>

...OF THE TIME
Set small achievable goals WITH patient

Give patient copy of action plan
Ask patient what their goals are for condition/future

- All clinicians

- Of the time

FACILITATING PATIENT PROBLEM SOLVING, RESIST "FIXING"

- Rehab
- CHHA
- LTHHCP
- SW

- None
- Little
- Some
- Most
- All
- N/R
In conclusion:

• As we have been so wisely taught........
  – Before your computer is packed
  – Before your hand is on the door handle and your back is turned...

MAKE IT CLEAR

• If you have questions.......
  – We have time !

Thank you for your attention!
Resources/Reference


- http://www.ph.ucla.edu/hs/HS_200A_F07_class_webpage/Readings_112807_Improving_Chronic_Illness_Care.pdf

- http://www.saferhealthcare.com/sbar/what-is-sbar/

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Resources/Reference

- http://www.nchealthliteracy.org/instruments.html
- http://www.improvingchroniccare.org
- http://www.grouphealthresearch.org
- http://www.ihi.org/knowledge/Pages/Tools/SBARToolkit.aspx
Resources/References

• http://nnlm.gov/outreach/consumer/hlthlit.html


• Kotter, John, Rathgeber, Holger, Our Iceberg is Melting, St. Martin’s Press, 2006.

• Rollnick, Stephen, Miller, William R., Butler, Christopher, Motivational Interviewing in Health Care, Guilford Press, 2008.

Resources/Reference

• Suter, P, Hennessey, B, Duckett, K. Integrated Chronic Care Management: Care Delivery Redesign, Course Manual. March 2013