Milestone 2 Action Group: Self-Management Support

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Hello everyone. This is Rose Langdon from TMF Health Quality Institute. Welcome to our Milestone 2 Action Group: Self-Management Support. And this session is entitled Sustaining the Action. I'd like to start things off today with a few announcements. A new post-event survey has been developed with the aim of capturing information that will help us understand our audience as we plan for future events. We are requesting that all attendees, practices, panelists, faculty and other guests complete the attendance and organization demographics portion of the survey, as well as provide feedback on today's discussion. Up to ten attendees participating in the same room may be listed on the survey. We appreciate the presenters' time and effort in preparing for and sharing their valuable knowledge. Any statements about the quality or utility of any product or vendor made during this presentation is an expression of the opinion of the person making the statement only and is not an opinion nor endorsement for the Center for Medicaid and Medicare, TMF Health Quality Institute or the host of the presentation. And now let me introduce you to our discussion leaders for today's session. We have representatives from Springfield Healthcare Center in Ohio and Summit Medical Clinic in Colorado. The Ohio Northern Kentucky Regional Learning faculty will be leading and facilitating this discussion with us. And now as we always do, we ask you to go up to the annotation toolbar to the far left of the screen, click on the black arrow and show us where you're participating from. I see everybody's catching on real quick here. We have people from all over the United States. This is great. It's a good topic, and we hope to have a very lively discussion. And now I'm going to ask you to click that black arrow off again so you do not accidentally annotate on other slides. Keep in mind that this is your action group. We want to be very interactive, and we're going to use chat, polls and then afterward the forum. The more activity we have, the more learning. I'd like you to go to the Chat bubble at the top of your screen now and open that box to prepare you for chatting in your questions or your comments. And you can start off by asking a question or giving us a comment about what you want to learn today. Be certain that you chat to all participants. And now I'd like to turn the microphone over to Kelly with our Ohio team. Kelly, take it away.

Thanks so much Rose, and again, welcome everybody. And thank you. Thank you all for joining today. So we're going to go a little bit into what's happening on the Self-Management Support Action Group forum. And it's been a little quiet. Our subscription notifications are not working yet. They're working very hard to fix that though. But in its stead, we have been posting some really great tips, tricks, resources, advice, a lot of stuff you should all check out and would probably benefit from just around different ways to sustain momentum through change and helping patients with different chronic

diseases also sustain the momentum for change. Through that change. So where we went last time, we identified partnerships that support patient self-management support goals and talked through warm handoffs with those community resources to ensure that that connection is made and the appointments are kept and that relationship is built. What's been discussed on the forum again is a lot of resources and materials. And some information about communication strategies for engaging your patients. And then where we're going now today is a little bit about supporting your patients in their continued attainment of their self-management goals and exploring strategies to sustain robust self-management interventions within your practice team. So both from the patient side and from the practice side. And a little more about our discussion today. We hope you guys get some insight from your peers into how you can support your patients in their continuation of self-management. And identify tools and different actions that help sustain the changes that you guys are implementing. And explore different strategies again to sustain that robust self-management intervention within your practice team. So throughout, and as always with webinars and these national conversations, we really welcome your comments and questions and sharing your own insights and perspectives. We welcome you to do that. And you can either do that through the Chat line or the Q and A line. And those are in the panel on the right-hand side of your screen. So please feel free to ask questions and share your comments throughout. So now we're going to have our panelists introduce themselves and give a little bit about their practice and background. So we're going to welcome Kim Blackburn with Springfield Healthcare Center introduce herself and the team.

Thank you Kelly. This is Kim Blackburn. I am the care coordinator, care manager for the practice. We have two internal medicine providers and just recently in January of this year welcomed our new nurse practitioner. We empanel close to 3,000 patients and probably since this slide, even more than that if we updated our number. So anxious to give whatever information that I can to be helpful today.

Great, thank you so much. And then we're going to go ahead and have Dr. Arora with Summit Medical Clinic introduce himself and his team with him. I think you guys are on mute. There's a red button right to the, right next to your name. If you click it, it'll unmute your line.

Thank you Kelly. Our practice is in Colorado Springs. We have one MD, and we are accompanied by three mid-levels. Two of them are a nurse practitioner, and one is a physician assistant. We have about 3,100 empanelled patients. And I would love to share regarding the workflow of these, of what we do in our SMS on a day-to-day practice in our office.

Great, thanks so much again for joining. We're glad you are here with us. And now I'm going to verbally pass it over to Dr. Barb Tobias, and she's going to take us through our case study. And then a poll, and we're going to get into practice discussion. So Barb?

Thanks. To set the stage, we're starting off with Mr. Kenneth Robinson. He's a 54-year-old middle school teacher. He teaches phys ed. And he's seeing your team for a follow-up on his initial set of diabetes self-management goals. He had identified previously and has succeeded in losing ten pounds over the last six months. He's been able to reduce his A1C from an initial value of 8 to 6.5, and happily his BMI is now in the optimal range. So going to our WebEx poll, as you all and your teams think about Mr. Robinson,

what would your next steps be now that he's met his initial SMS goal? Choose any that apply to how your team would approach this. So you can choose A, creating a new goal for another of his chronic conditions. Or B, just building upon the initial goal to further self-management. C, monitoring for sustained self-management of the initial goal that he created before moving on. Or D, ask the patient what he'd like to focus on next. Again, more than one choice may apply to your team's approach.

And for the audience's benefit, the poll is to the right of your screen. And we encourage everyone to participate and select as many as you believe apply.

And while our participants are responding to the poll, I'm actually going to switch back to the case study so we can review it a little bit and see what strategies we would take. And we'll give just a couple of more seconds for participants to respond. Alright. We'll go ahead and close. And the results should pop up here in just a second.

10:47

Okay. So it looks like there's been a fairly even split. Just a few of you, 5 percent, said that you would create a new goal. And then it looks like most folks are choosing B, C and D, building an initial goal to further self-management, monitoring for sustained self-management, and then moving back to the patient and asking the patient what they prefer to focus on next. Okay, we'll continue to integrate these themes as we go to our panelists and hear their approach. And before we flip this over to the panelists, I'd also like to introduce Judith Schaefer who's our subject matter expert. So Judith, do you want to say a few words about your role on the panel? And Judith you just need to unmute your line. You can click the.

So sorry, took me a minute.

There you go.

To get back to the list of invitees. Hi, I'm Judith Schaefer. I work at McCall Center for Healthcare Innovation in Seattle, Washington, and delighted to be with you in learning about self-management support. It's one of my major interests. I've led several collaboratives on self-management support. And also am really active in helping teams transform their primary care practices to patient-centered medical homes.

Thanks Judith. We're grateful to have you on the panel. So let's take Mr. Robinson. He's at his goal weight. Not easy to do. Turning first to Springfield Healthcare Center, Kim, how do you help him continue the momentum, be mindful that he's sure to have setbacks?

Well first, do you want me to explain the choice that we would make for our next step, Barb, and then talk about?

Yeah, that would be terrific.

Okay. Well I chose D, and the reason for that is because I don't know if you can still see the question, but it was the only one that talked about ask the patient. And you know, I am by no means an expert on this,

but over the last couple of years we found that the greatest success stories come from you know, when you're self-managing a patient just finding out what it is that they're motivated to do, and working on what they're motivated to do. And that is sort of where we found that line between care management and case management over to self-managing the patient, really trying to empower the patient to take ownership. So if he's successful, I mean I've had Mr. Robinsons in my office before. And I actually have a Mrs. Robinson who fits this exact case study. And just really finding out from her or him, you know, how are you feeling about your success? What is it that you want to work on next? Are you more fearful of setbacks or triggers that may cause a setback? Or are you more feeling so empowered by this success that you're ready to move on and tackle another item, you know, on their list. Whether that be another chronic condition or just you know, taking this particular one just a step further.

That's great. And I can't wait to hear what Mrs. Robinson said when you asked her that. But we'll turn now to Summit Medical Clinic. Dr. Arora, and your team, what did you choose, and how would you help Mr. Robinson continue his momentum in the face of setbacks as well?

Well we had chosen both B and C, but I think the main emphasis that I would concentrate on is on C, which is trying to maintain or sustain the target that he has achieved. And the reason for that is we see that so many times a patient do well, and then they kind of lose track or lose insight of what they are doing. And then they regress into, you know, into the state where they were before. And then trying to get them back to the second time is very, very challenging from what I have seen. So my first preference is trying to maintain the momentum and sustain what he has achieved over these past few months.

That's an important point. How would you envision your role and the role of your team in helping him maintain his weight? What kinds of thing would you all implement in terms of contacting him and reminding him, but also inspiring him to do that?

Well first of all, what we do is when they have achieved their target of what we have set off with the patient, we try to give them a little bit of a lag time before we call them on the phone or bring them to the office. What we do is in our EMR we kind of, we have a reminder tab that we can send, you know, to our care managers. So if we say that okay, Mr. Robinson has achieved his A1C or has maintained his weight let's say for the sake of simplicity, he has maintained his weight. We would call him in about, you know, four to six weeks over the phone. The way we do this is we put a reminder straight into the care manager of the care coordinator inbox, and on that particular date it would pop up and they would make a phone call to try to get in touch with Mr. Robinson and see where he is doing with his weight. So we use a simple electronic tool which is available in our EHR to try to help us to track the progress of Mr. Robinson.

That's an important way to use your technology to support, to support that piece of it. I'll turn it over to Judith. And you can weigh in as well.

Hi. Yes, well you know, the interesting, one interesting part about the poll is that all of the answers were good answers. Any of those tactics would have been a real improvement on not following up at all. I think sustaining motivation is really hard. And particularly if you've made progress or even met your goal. You know, patients, there's a chance that Mr. Robinson is feeling good about himself. He may feel

the benefits of having lost that weight. But many times when patients are asked to make changes, the really, the reward they get is really that they may not be getting worse. In other words, we don't always have in managing our chronic condition, the boost that you get from feeling different or, and that's particularly true for instance with hypertension. You may not even notice, but getting your hypertension under control is really important. So in sustaining motivation, it's really important to praise, acknowledge and praise the efforts that patients have made. They may not be all the way to their goal, but we should celebrate any successes that patients do. And I also think that as people talked about before, that motivation, what patients want to do is important. So building bridges between the clinical goals that you talk about with your patients, for instance the hemoglobin A1c number or an optimal weight, help them understand and connect that to what they're trying to do in their life. Often when we ask about self-management goals, we put it in clinical terms. But if we can translate those goals into something that the patients care about, that really sustains their motivation. So building bridges like that is very important. And then I would say making goals, smart goals so Kelly, at the beginning referred to some things that were posted for you in the tools and resources section. And one of those talked about SMART goals, which are, it's really another way of talking about action plans and making things really accessible to people. Helping people understand how to implement the actions that they need to take in their own life. So that's an important aspect of this.

20:01

But I would say that the most important thing in sustaining any relationship with the patient is to make sure that they feel like you're their guide on the side. That you're in their court. That you support them. And they never feel blamed, no matter whether they were successful or not. They really feel like you're their support.

That's great. I think it is important that we figure out how to build those bridges between the self-management goals that the patient creates with our own clinical goals that are often not perceptible to patients like an A1c that's at an optimal value or as you mentioned a blood pressure. Judith, I'll turn this over after you to the other panelists too. A question came in on the Chat line, especially as we're talking about patient created goals to differentiate shared decision making from self-management. Are you able to do that?

Well I can certainly give one view on shared decision making. I'm a researcher and a quality improvement person. And the term shared decision making to me means a set of very specific tools, a process that you use with patients, particularly when the patient preference has a large role to play in making a decision usually about a very discreet activity. People use shared decision making tools about various treatments or even screenings for various kinds of cancer or other kinds of health care decisions. But self-management is a larger concept. It is, it's true when we support self-management in patients we are collaborating with them around goals set by the patient. So that's one difference. So I think that self-management support is a larger concept. It has to do with an ongoing maintaining of their health and optimizing of their health in, with respect to their chronic conditions. Whereas shared decision making is usually a much more discreet conversation about a particular decision with regard to screenings or tests or maybe treatment options.

Thanks Judith. I think that's helpful. So I think if we were looking at our diabetic patient, perhaps a shared decision making tool could be around which type of medication management the patient prefers, whether it's an insulin, a short-acting insulin perhaps hypoglycemic or other types of medical management. Whereas self-management, as you described, is an umbrella term. It's much larger framework to describe what the patient would like to do to impact their own health. Kim, getting back to you, I'm interested too, you guys chose option D. And what did Mrs. Robinson choose, and when you go and ask patients again what their next step would be, has it surprised you?

Yeah, actually. It's greatly surprised me. And a couple different responses to a couple different patients I've worked with. And the reason why we did choose D is because it was all about asking the patient. And like they said, the others were very helpful, and they were all things that we would touch on at some point. Of course we would concentrate on you know, that strict follow-up just to make sure they're maintaining their goal. But again, even establishing the follow-up, we have asked the patient. First of all, once that readiness for change has been assessed and their motivation has been assessed, we establish by asking them, you know, would it be okay if I either called you or do you feel like you would be more successful if, you know, we brought you back to the office in a few weeks to see how you're doing? And sort of reassess the goal at that point. With this particular patient that I have in mind, she is actually much older than our case study, but she was very ready to change. She dropped her A1c, as I think 86 years old, she dropped her A1c by three points in just a matter of eight weeks I believe. And she just had an underlying theme that kept going on, and that was she trusted me. We had a great relationship. And she felt like when I did that follow-up phone call with her, I truly cared about her success. And so I think it's super that aside from all these boxes that we're checking and tasks that we're doing is at the very foundation of this, the patient has to know when you do those follow ups that you truly are in their corner. That you got their back, and you truly care about their success. And as soon as she realized that, I think I sent her a card saying hey, way to go. Your blood sugars are looking great. She became very self-motivated to continue. And even months after we had stopped asking her to bring in her blood sugars, she would come in to get her pro-times drawn, she would bring her blood sugar charts that we made with her. And finally one day after probably six months she said, you know, do I need to be bringing you these blood sugars? And I said, well you tell me. Does this help you, or are you finding this burdensome? And so we agreed that maybe she start bringing them in once a month. And then we just kind of spread that out, just bring them in at your visit. So that she still knew that we were concerned about the outcome and the numbers. But more importantly, about her taking ownership of what she was doing. And now she felt that we had given her the support, and she felt sort of self-empowered to deal with it. But later on, Barb, we can talk about some steps in the backward direction that she took. And I think we're going to get to that maybe in a little bit about, you know, what do you do if they do lose momentum?

Well I think that's a good point. And I think making sure that the patient is the one who informs us on how they would like to be held accountable helps us. We don't have to think and do that for them. So I think your point about whether it's a call or an office visit, what will be most meaningful to them to create some of that sustained accountability. And then, Dr. Arora and Gerilynn [phonetic] and Shalanda [phonetic] too, how would you all go about working with the patient. And we know that the setbacks,

any of us who have tried to lose weight, there's always going to be a setback. So what's your approach around that?

Well in, from a practitioner standpoint, you know, if there's a regression of a condition that could adversely affect the health, you know, we project that they will get worse or be admitted or some other complication can happen, what we have done is we have covered a time in our, you know, on a weekly basis to go out and do a home visit on these patients. And many of times we have found that the thing that's preventing them or promoting them to regress has a lot more to do with psychosocial environment rather than the true medical management. So that's approach that we have generally taken for people who are regressing with potentially life-threatening complications. But other things like, you know, if they're unable to maintain their weight or their weight is going up, we usually do that like over the phone. And in our, again, when we see the patient as a follow-up we can actually plot the clinical markers like hemoglobin and A1c or LDL or body mass index, or other parameters of [inaudible] liver function tests, whatever it may be. We can actually trend it in a graphic format that can go back to, as far back as two years so the patient can really visualize from a line graph to see how they're progressing in some of their disease management by the professional. And then our care manager meets with them right after the office visit to go off the care plan that we have made in that short visit.

That's great. And I think that data can be very powerful. And I think it speaks to what Judith described as a bridge between clinical goals and self-management goals. I'm wondering Dr. Arora if you could also describe a bit more the home visits that you just referenced.

Sure, well it came to us around Thanksgiving of last year when we were looking at these emergency room visits and said, you know, how come no matter what we do. We bring them to the office. We follow them up over the phone. We make sure that we remind them of a scheduled appointment, and yet it's the same folks that keep going to the emergency room and not being admitted. But go for some of the, you know, outpatient-related conditions that perhaps could be treated. So we started tracking these folks down, and we identified, you know, what we call, you know the frequent flyer to the ER.

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And so we, a day or two before our care manager would call them and say hey, listen, you know we really want to come by and do a home visit. And so you know, we told them we're going to be in so-and-so in a timespan of about an hour or so. And then we come by and then talk to them. Most of the actually recognize why we were there. So you know, when we approach them and say do you know why we're here? And said yeah, been going to the ER too frequently. And we have seen the drop of those patients who have started using the emergency room. And then these folks what we have seen has become, you know, if they were to go they would notify the office first, or they would call us and let us know first that this is what is going on. And then what's the reason they go by to the ER.

So you're making these home visits along with your care manager?

That's correct, yes.

Yeah. And it's great you've seen some results in terms of decreased ED, unnecessary ED visits. What was their response in terms of having you in their home?

Well I think we're very good. You know, we've had most of the patients who welcome us into our home. And we see things that we would never, ever, you know, see if they were in the office. We know the barrier to causing them to fail. But a lot of it, what we have noticed, is more like either the confusion, the medication. I had a patient who we went by to do a home visit and couldn't even figure out where her insulin was. And finally we found it under the mattress or something like that. You know that gives us an insight. So when these folks come into the office and we emphasize on the points what we have seen at home. That, you know, do you have this? Do you have that? You know, we went by to see a patient in the house, and you know, there's no refrigerator. She doesn't know what the medication is. And so those types of things we really then can custom tailor the SMS for that particular patient since we know what environment are they in.

Yeah I can't imagine anything more powerful than a home visit and building the trust that Kim talked about. It truly shows the patient that you care around that too. Kim, did you want to respond to, next steps and setbacks are kind of merged into some of the same types of recommendations. But I wanted to turn it back over to Kim and then have Judith weigh in.

Sure. I mean I think with anything that you deal with when you're setting a goal, you have to up front anticipate setbacks. You know I would say the vast majority of the time, regardless of the circumstance, there's going to be some sort of setback. And my particular patient that I mentioned earlier, taking care of a very elderly husband who had you know, severe dementia. He was looking for a facility to possibly have to go to. Her daughter lost her very young husband suddenly of a heart attack out of state. And so she had a lot of stress. And we had already early on identified that a lot of her evening blood sugars that were so high were due to sort of stress eating after she would kind of get her husband tucked away at night and safe in bed. He would go to bed pretty early. So one, just identifying what might be a trigger that, just the same way as an alcoholic. What's the trigger? You know, maybe you can no longer go to the bar with the friends because that would be a trigger for you. So for a diabetic who struggles with evening eating, you know, okay once you get your husband put in bed, what's something that we could do to avoid that trigger of you wanting to sort of stress eat at that time. So just one, helping them understand that setbacks are okay. That they're going to have them. That we just need to figure out a plan together. And again, going back to, I can't stress enough, that relationship building. Knowing that she can pick up the phone and call me and say, oh boy, you know, I haven't done so great this week. I don't know how to get back on track. Not making her feel judged. Making her feel like this is a very normal part of the process. And then establishing together hey you know what, you've done this once. You've been very successful. We know what to do. Let's just together, you know, get you back on track. So we've seen great success with that. But other people, you know, have setbacks. And it's because another root issue needs to be addressed before we move on. And talking about the SMART goals, I think what I've found is sometimes I go into a room, and I'm thinking, okay, I need to sort of talk to this patient about setting a goal for their A1c. But I find out that maybe their real goal is to get five grandchildren and a daughter who moved back home out of the house so that they can focus on their

health. So the only way to do that is to have lengthy conversations, meaningful conversations. And trusting relationships so that you can sort of get to the root of the issue.

Thank you. So I hear you. I think normalizing setbacks, both for the staff and for patients as we're talking about self-management is really key to understand that this is a part of the process and not a failure so that we're not blaming ourselves as providers nor the patient. Judith, did you want to weigh in as well?

Well Kim did a great job of helping us see some of the nuances as the work of dealing with setbacks that are inevitable as she said. Normalizing them. I'm just going to take one second to say what the components of SMART goals are. Because I think if we think about how granular we can get and how we think, and we think about how having this kind of conversation moves it into the patient's life rather than into some clinical setting. So the goals need to be the S is specific. The M is measureable. In other words I need to be able to tell whether I've done it or not. If our answer to that is too vague, we can't, we can't tell. If we haven't specified enough, and we can't measure it, then we really can't tell whether we've done it or not. It needs to be achievable or attainable. We can't, we can't expect that patients can make a grand leap. So those pieces need to be bite-size. It needs to be relevant. In other words, something I want to do. Something that's going to move me towards my goal. And it needs to be time bound. It needs to be something, the goals need to be something I'm going to do this week. Even on, say I'm going to do it Tuesday and Thursday night that I'm going to walk around the block. So if you do those SMART goals well, then it really moves that idealized goal into an actionable plan for patients and their lives. And I think that really does help.

That's great. We had a call come in from the Chat line as well to Dr. Arora. Dr. Arora, could you tell us a bit about how you're coding your home visits and how those are reimbursed?

I believe that there is a special code for a home visit. That is what they do. I believe our billing company tells us. It codes a little bit higher than 99213. But the code for the home visit. I can research that a little bit and, you know, have it conveyed across. But I don't know the code right off the back of my mind.

Yes there is one, and I know there's one specifically for Medicare too. And have you found that to be a good investment of your time? Certainly it takes you away from your ambulatory patients. You have to carve our significant transportation time. How has that worked for your practice?

Yeah. You know it does take a chunk out, you know, from the afternoon, Friday afternoon. The way that I tend to catch up is then I do a short brief Saturday clinic to cover for the patients that we miss out on Friday afternoon. But I think that the reward is not in the term of financial, but also very, very satisfying in that we are really, these patients, we've become a part of their life. They feel that we are very involved in their care. They know they can trust us. And if there is anything they would call us right away. Because of that degree of trust we have seen we have established with these patients. Again, you know, unfortunately the time becomes a limiting factor that on one of the Friday we can at most do four, if not five, if not sometime when we try to stretch it out to five we would get a little bit later. But yes, I think in more in term of the dollars amount is a satisfaction that we get that we can actually make a difference in their life.

Thanks for that. Okay. And then as we just move to our last theme around sustaining the team focus. And we talked earlier a little bit about how we help patients maintain in the face of setbacks. But certainly not all of our patients are Mr. Robinsons. And we have many patients that we can't get to the first goal, whether it's smart or not so smart.

40:16

And so I'm wondering if our panelists can respond to how do we sustain our self-management team focus in the light of team setbacks and other frustrations? As well as what's gratifying like the home visit and relationships. So Kim, how do you stay inspired in all of this when not all of your patients are achieving what Mr. Robinson or Mrs. Robinson are?

Yeah, that's the, probably the most frustrating part of the whole thing. You know sometimes you feel like despite all your efforts or whatever, you just aren't seeing the success that you would like to, and the patient's not feeling that. One, I would say we want to empower our staff with as much knowledge and understanding of how to have meaningful conversations. Through getting them training on motivational interviewing. The SMART goals. You know, so that they feel like they know how to break down these conversations and truly have a meaningful self-management follow-up. Because we have had all of our nursing staff participate in this. I'm not the only one who does self-management follow-up. As a matter of fact our physicians have sort of put more of an emphasis on their regular nurses doing a lot of these follow-up phone calls and leaving the high-risk patients more for me. And I'm just sort of a support to kind of keep things going. But as far as motivation, one, I just am trying to teach them to truly listen. You know if they feel like they've hit sort of that brick wall over and over, really listen to the patients. What are they really telling you over the phone? Is there an underlying issue and reason that they're not meeting those goals consistently? What's going on with them? And then at that point, they would probably be referred to me as okay, there's something deeper going on here that you need to dig for. But again, that goes back to relationships. And then as far as motivating our staff, my whole thing with this is I want to give them the taste of success. I want them to feel, see excitement and remember why we all went into health care and nursing in the first place. And that's to help patients. And there's nothing greater than at the end of the day knowing that you've helped make a difference in someone's life. And so I'm hoping that the more that they taste success, and the more they implement these basic things of listening, relationship building, that this will just become an everyday thing. That they won't even know a self-management patient from a regular patient. It just sort of all becomes a way of life around here, if that makes sense.

It does, and I think integrating self-management into how we approach our patients and how we support them is really the vision that we approach all patients with, how can we help them. Rather than what we do for them. And I think that's also the part that gets exhausting is when we feel as providers that it's up to us to cure or to manage all by ourselves. So Dr. Arora and Gerilynn and Shalanda, how do you all sustain the momentum, including celebrating your successes?

Hello, this is Gerilynn. In the morning we have huddles. And with those huddles we discuss high-risk patients. And we try to include all of the providers to involve them with the care management needs of the patient. And with all the staff, we try to get them to own each other's patients. It's not my patient or

your patient. It's our patient, and just you know, have them be aware that this is a high-risk patient. They are coming in. And we need to talk with them. They've met this goal, or they haven't met this goal that's been set. And that's basically how we start our day, and hopefully, you know, we'll have some successes through the day.

That's great.

Dr. Arora.

Shalanda has a point to make.

Oh good.

Hi this is Shalanda. I just, just to emphasize what Gerilynn was speaking about. What we do is just to make it a whole team support. So you know, a patient's success or failure, I think, reflects our team. So we like to, in our huddles kind of come up with a care plan of how we can get the patient focused and more motivated. Then as a team, you know, if we have a successful patient, we like to have a spokesperson kind of share our patient's story just to get the whole team motivated and realize that yes we do have those hard days. But you know, there are very, a lot of moments where we do have those patient successes. So we like to have patient stories during those meetings as well.

That's really helpful. I wonder, and I'm going to turn this back over to you all, Shalanda and Gerilynn and Dr. Arora, we had a question come in. What resources did you use to teach staff motivational interviewing? The questioner was wondering about outside consults. Or was there a handbook or perhaps resources on the Collaboration site? And then I'll have Kim answer that as well.

Actually we used the resources on the Collaboration site. It had a webinar, maybe about a year and a half ago, regarding motivational interviews. So we just reviewed that and, you know, make sure all our staff are, you know, pretty well versed and focused on motivational [inaudible].

Yeah go ahead.

Yes and then since we do have a lot of new staff, we are looking to start another class to, you know, motivate the rest. Get everybody up to speed on motivational interviewing.

That was my question. How do you orient new staff? And then who teaches those classes to new staff?

We look for outside resources, so right now we currently are looking for an outside, you know, specialist who does motivational interviewing. So it's not someone specific in our office. We just reach out to someone within the community.

Okay. And Kim, how has your staff gotten up to speed in motivational interviewing? You mentioned that you, the doctors, nurses and all are sort of involved in this as well.

Yeah, we, several resources actually. And I apologize that I don't have them in a nice, neat list to verbalize them to you. But one, we have a rep that we have established to come out. He's actually a

pharmacist, and they're from I believe it's from Pfizer. But they come out and will do a whole class on motivational interviewing. And actually before they did our class, we sat down sort of put in our own case studies. And what we've done is since the whole self-management strategies are fairly new to us as a practice, we had some setbacks in the beginning of just trying to get this documented within the EHR. And now that we have that up and running, I want to make this very specific for the nurses. And so what we've done is we've wrote a whole policy and procedure about even the beginning, how do you open up that conversation? What does that conversation look like? Doing some role playing with them on Wednesday afternoons at our staff meeting. Just getting them comfortable, digging deeper. Sometimes I think we think digging deeper, asking more questions is being nosey. But again, if you have a great relationship with your patient, asking questions or tell me more about that, becomes just a way of natural talking. So we've used that several times after care management conferences. I have certainly brought back different resources. We've had lots of meetings. Lots of just kind of laying out some scripting for them to rehearse and practice. So that's some of the things that we're doing, you know, to keep them empowered.

Yeah I think those resources are truly helpful. And I also think using your toughest cases and opening those up to everyone is a way to keep the momentum going and, as we said earlier, normalizing that we all have challenges. And so how do we use our collective wisdom to support each other is key. Judith, do you want to add some additional comments?

50:09

This has been a tremendous conversation. These, you all are really inspiring to me. Much of what I have to say you've already said. I will bring up a couple of points. But I want to thank you for your really obviously experience and cogent work with this. It's really helpful. I think about two things. When I think about motivation. I mean that's where we all begin, just as we have to help our patients stay motivated. So how do our teams stay motivated? And I think that you might think about that in two ways. One is, what do we, set a goal. What do we want to do as a team to improve our self-management support? And we also might track data. So using quality improvement techniques to see how we're doing. Are we doing well? Of course we have, we have sort of anecdotal work that we can do with patients because we know their stories, which are wonderful, wonderful feedback mechanisms for us. Will help us understand how we're doing. But if we track the goals that we set with patients, what percentage of our patients who have chronic conditions or even starting with one chronic condition, have a self-management goal set that may be part of this whole initiative. And then the second one, besides tracking data and using it then in quality improvement, to have a champion for self-management support. You know a lot of, I mean, clinics might have people who are especially good at smoking cessation techniques, or they have a particular area. Many clinicians have a particular area that they have a particular interest in. And someone like the people on the call today could be really effective champions for self-management support. And then when that person, give that person enough, a little time or the responsibility and the time to encourage quality improvement at every level for self-management. Even MAs who have a role in maybe asking patients how their goals are going or everybody on the team can play a role in self-management and asking them to think, how can we as a team improve? And doing some goal setting and action planning ourselves. Not as a team around our

self-management goals, our self-management support goals for us helping patients. There's a story, I have a really quick story about a physician who was in one of the first collaboratives I led on self-management support, and he was from an independent practice in Iowa. And he became, through our collaborative, convinced that self-management support was the way to go. Because he saw how helpful it could be to have other team members doing many of these activities that clinicians, that providers had been doing up front. And that maybe they weren't doing them as effectively or at least very definitely they didn't have much time as they needed. So he became involved in team care and figuring out how to support team care. And I'd just like to tell you that he was a convert. And he found ways to get help from, for, he wondered because their practices were virtual private practices. In other words, every provider supported the work that was done in their own practice with their billing. That meant that paying for coaching support and other things like that had to come out of that fund. So he found ways to, he found that having a team-based self-management support strategy enabled him to save money because it was so much more efficient. He also worked with insurance companies for enhanced payment. He looked at billing codes and made sure that the coding was optimal for their, for the level of care that they were then delivering after they had developed these teams. So he was able than more than support coaching, self-management support coaching by really looking at these mechanisms. So I think there's a way to keep it going financially, as well as motivationally. Other people, I'd like to say one more thing. Yes.

Okay. We just did have a question though about the physician that you just referenced. If he has anything in terms of anything he's written about that or any resources that describes that particular approach. Do you know if there's something?

I do think he, yes, he has written about it. And in response to our asking him because so many people wanted to know about it. And I can make that document available for you to post online.

Thanks. And I'm sorry. You had another point.

Well no, there's just, so once you have a champion and you've started to measure your self-management support processes, so you've got the equivalent of hemoglobin A1C for your practice on self-management support. You've got some notion about how well you're documenting, and you can see what affect that's having. Then the other thing is to make it hard to not do it right, you know. To make it easy to do it well and make it hard to do it wrong. And you can do that in two ways by establishing really clear workflows and by also using specific tools that are good prompts to make sure. Like the smart set is a very good example of a tool. But if you think about the way in which a self-management support interaction might go across the team members in your practice, and you do a workflow to describe that, it really helps you understand where some of the gaps might be or where some things may be falling through the cracks. And

That's great too. I just want to, okay.

I just want to reference the other tool that Kelly mentioned at the beginning that's already posted. A lean tool called an A3. And it's really an action plan for team change. And it's already on the website. Sorry Barb. That's all.

No that's great. Paulette has her hand raised and just wanted to make sure she got her question in as the time draws near.

Sure.

Paulette?

I just wanted to ask Dr. Arora who all accompanies him on his home visits. Is it him and his RN from his office, or does he do these visits on his own?

Yeah. This is Dr. Arora. So it's the RN from the office and, you know, then we have a care coordinator. And sometimes we even take one of the MAs with us. So there's a minimum of three if not four.

Oh, okay. That's great. That's great.

So Judith thank you too. You'll make those resources available. And I know Kim we also got a request to if you would be able to share how you all script and role play and the kinds of cases you use to help support and sustain this training with your staff too. We can help you post that if you've got it.

Barb, if we had 20 seconds I forgot to mention something that Judith was talking about that we utilize that I feel might be helpful.

Go for it.

So talking about trying to help, you know, empower your team members to sort of all be giving very detailed-specific workflow, I just finished two weeks ago sort of our self-management bible for each team if you will. Each one of those three-ring binders contains identical information for each set of nurses for each doc. And it has a divider, hypertension, CHF, and diabetes. And those are our three chronic conditions that focused on for CPC. Within each of those tab dividers are resources. Some of those resources, like for stress reduction or you know, to increase exercise and activity, are all the same. But then within each of one of those diagnosis or chronic conditions are very specific things that we're training the nurses on. So under CHF it's the core measure sheet from the hospital. You know, the green, yellow and red. Are these signs and symptoms you have in the green zone, in the yellow zone, or in the red zone? And if they are in one of those zones, then what do you do? If they're, you know, not able to pay for their medications, at what point do you refer them to the care coordinator? So it's a very clear-cut bible with, you know, as basic information as what's a normal blood sugar. What's a normal A1c? What's a great blood pressure? What do you do if they gain more than three to five pounds? Because that way you're sort of evening out the board whether it be an MA or an LPN. And sometimes as LPNs if you don't work with CHF a lot, or hypertension a lot, sometimes you sort of forget what the normals are in some cases. So we just put together a great little binder that's helped tremendously for our staff.

1:00:05

That's great. And anything you can share, we can certainly help to make that available if you're willing. We appreciate all your hard work on that. We've had great discussion. It's 2:00 Eastern Time. We have

two slides that Judith has prepared that summarize much of this. And you all will have that for your reference.

Yes again, thank you so much for everybody who joined. Even though the subscription notifications are not working on the Collaboration site, we've got a link here that will take you to the self-management support forum. And we encourage you to let us know what tools and strategies you all use to support and monitor continued self-management progress with your patients, as well as within your team. We love hearing from you and sharing your stories. It is always beneficial to everybody involved. So I'll go ahead and pass it to Rose and close out for the day. Thanks everyone.

Thank you very much. As this WebEx closes, you will automatically be directed to a survey. Your feedback on this survey is used to continually improve our learning opportunities. In addition, please remember that it is important to accurately collect information on each individual and each organization in attendance. If you are not from a specific region or practice, please select not applicable in both the region and practice ID dropdowns, and then select your organization. Should multiple people be viewing this session together in the same room, up to ten people may be added to the same form. Again, thank you, and we look forward to talking to you again. Have a great day.