

---

# A Model for Self Management Support in the Patient- Centered Medical Home

Trissa Torres, MD, MSPH, FACPM  
Medical Director, Genesys HealthWorks  
Genesys Health System, Grand Blanc  
March 25, 2009

*Developed by Genesys HealthWorks; Appropriate citation required.*

# Patient Centered Medical Home

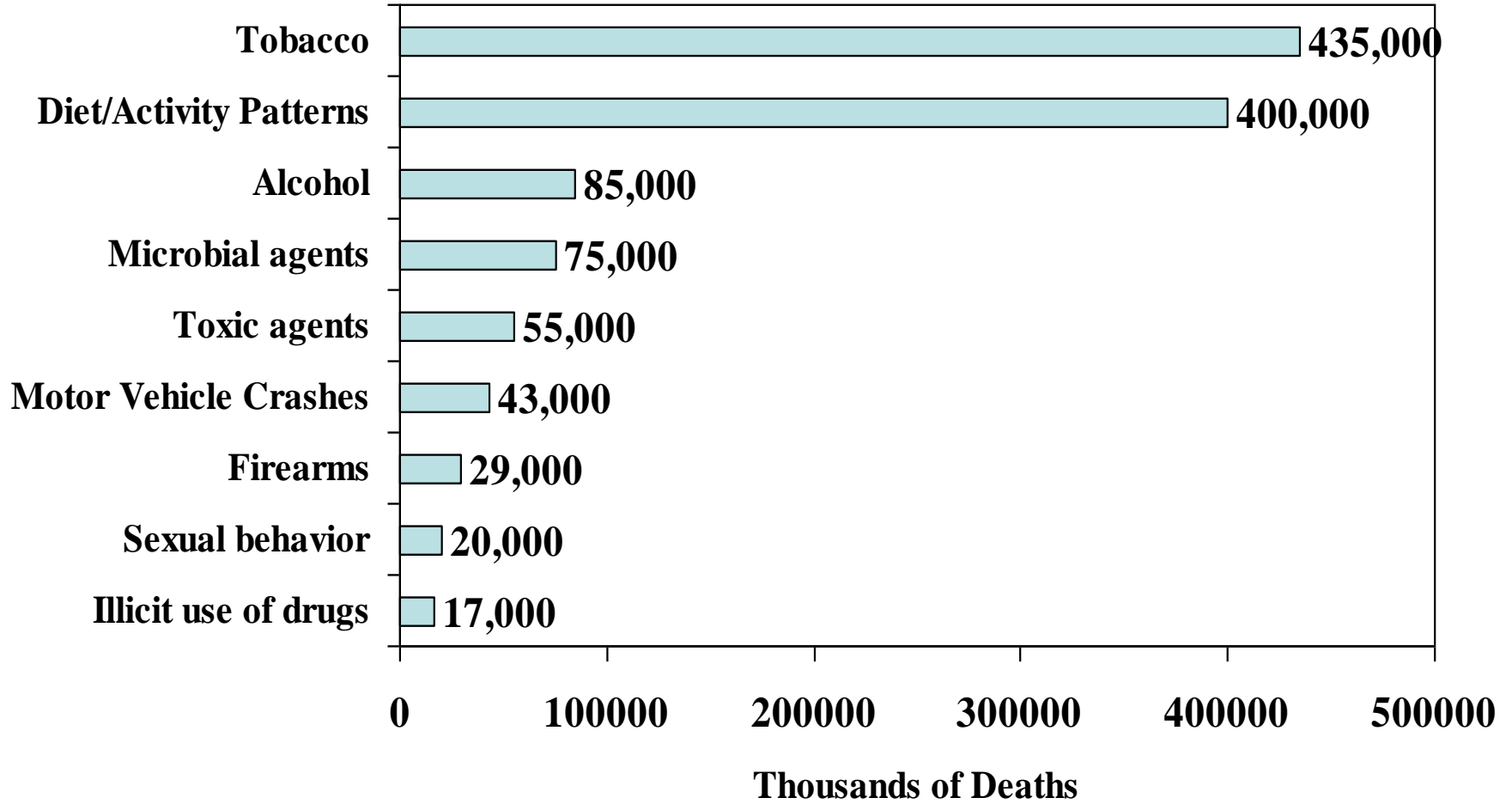
---

- Role in health care reform
- Access and costs are most urgent needs
- But Access to WHAT?...A system that achieves the Triple Aim!!!
  - *Improves Population Health*
  - *Controls inflationary healthcare costs*
  - *Improves the experience of healthcare for both patients and providers*
- Real value of PCMH is in the ability to **prevent** and manage chronic disease
- Philosophy: improving health as key cost containment effort

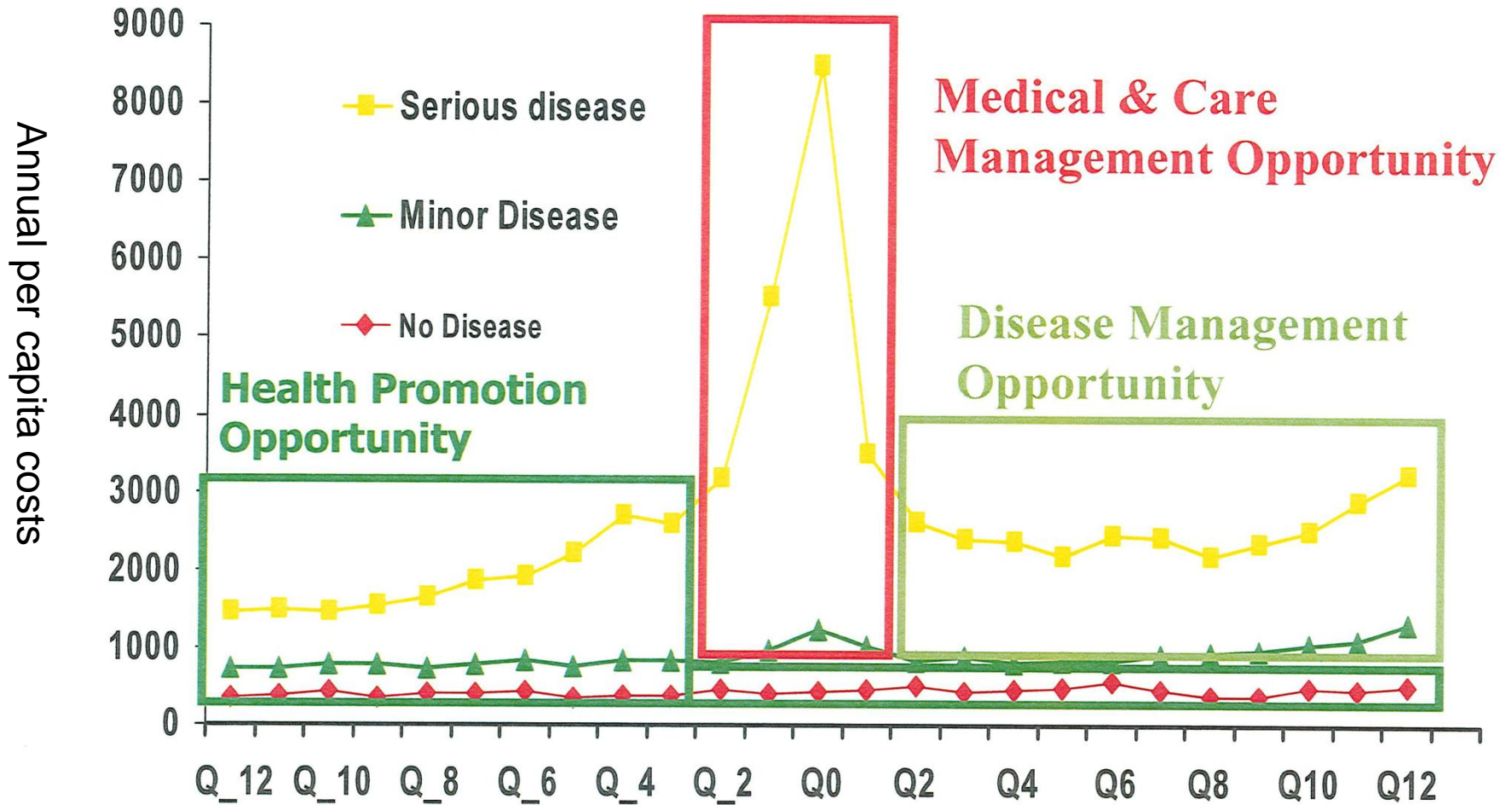


# Opportunity for Improvement:

## ACTUAL CAUSES OF DEATH IN THE UNITED STATES IN 2000



# Opportunity for improvement:



Medical and Drug Costs only

# Joint Principles of the PCMH

---

Personal physician – Physician-directed medical practice – Whole person orientation – Coordinated and/or integrated care – Quality and safety – Enhanced Access - Payment

## Michigan Primary Care Consortium (MPCC) definition of PCMH adds a footnote on “**Patient-centered**”

- *This model of care recognizes the central role of patients and – when appropriate – their families, as stewards of their own health. In the Patient-Centered Medical Home, the team of health professionals guides and supports patients and their families to help them achieve their own health and wellness goals.*
- We choose to focus our PCMH “Construction” efforts in this area

# Self Management Support

---

Adapted from the IHI:

- *Self-management support* is the care and encouragement provided to people to help them understand their central role in preventing and managing illness, make informed decisions about care, and engage in healthy behaviors.

# GENESYS

## HEALTHWORKS

---

- Focusing on **health** rather than just disease
- Promoting continuous **healing relationships** with primary care physicians
- **Health Navigators support** patients and providers, linking with community resources to promote health
- Integrating and aligning a coordinated network of providers working in **teams**
- Working together through **community partnerships** in a common vision with special attention to the poor and vulnerable
- Achieving **outcomes** that:
  - Improve health
  - Improve the experience of healthcare
  - Contain costs

# Building the PCMH at Genesys PHO

---

- Identified 11 lead practices of 150 primary care physician group, then 15 to follow (all with full EMO), plan for ongoing scale-up
- Practice goal: Provider to set health goal with **every patient**
- When health goal documented in EMO – generates referral for follow-up with a Health Navigator (adjusted to patient and practice preferences)
- Health Navigator provides ongoing self management support
- Track engagement and effect rates over time

# Health Navigator Roles

---

- Support Patients
- Support Practices
- Link to Community Resources

***...to improve health, improve the experience of healthcare for patients and providers, and keep costs down***

# Health Navigator

---

- Supports the practices to systematically identify and engage patients in setting health goals and following up over time
- Supports the patients to commit to health behavior change goals, make a specific plan, overcome barriers, identify resources and follow through
- Links to community resources to optimize their use for patients and practices

# Health Navigator

---

A Health Navigator is a practice team member who cultivates relationships with the practice, their patients, and community resources to support health behavior change

*\*\*\*Because change takes place in the context of relationships*

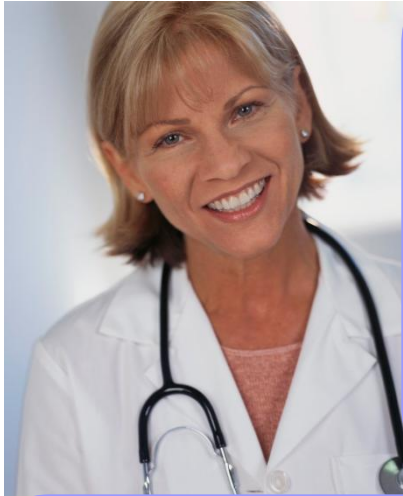
# Health Navigator Approach for All Patients

---

- Support: *“Your practice team cares”, “We want to help”*
- Emphasis on healthy lifestyles
- Emphasis on self care
- Meet people where they are...
- Physician engagement
- Referral to available services
- Support in accessing those services
- Consistent follow up over time

# Patient Case

43 year old female with hypertension, family history of diabetes, elevated BMI



Physician: *"We have discussed your medications and your lab results, now let's talk about your health goals. How would you like to improve your health over the next year?"*

Patient: *"I really want to lose weight."*

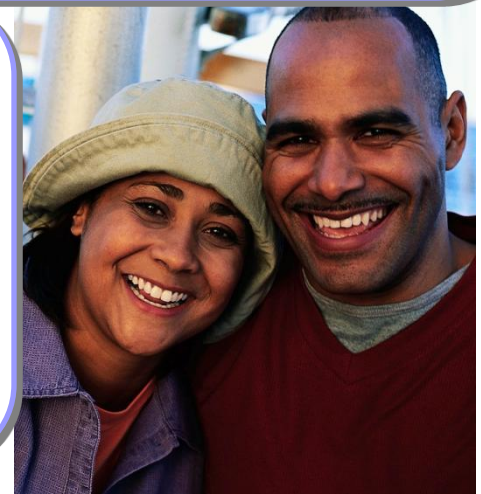
Physician: *"Eating healthy and exercising are very important to managing your blood pressure and preventing diabetes. The next step is for our Health Navigator to follow up with you to help you make a specific plan for healthier diet and physical activity."*

Health Navigator at follow up: *"Your doctor asked me to follow up with you in regards to your health goals. Is this a good time to talk?"*

Patient : *"I'm in the grocery store."*

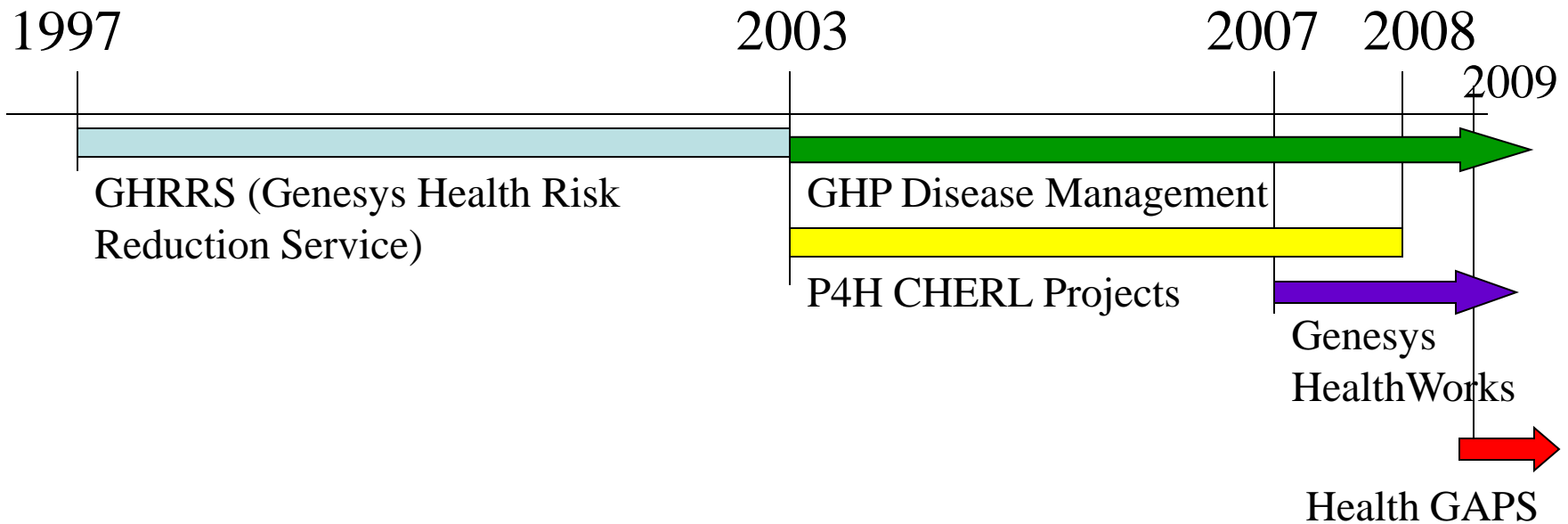
Health Navigator: *"Do you want me to call you back later?"*

Patient: *"No, This is perfect timing. Maybe you can help me make some better food choices while I am shopping!"*



# Evolution of the “Health Navigator”

---



*Within our Health System and community, the Health Navigator concept and design has been developed, tested and evolved through a variety of pilot and research projects over the past 11+ years*

# Genesys Health Risk Reduction Service (GHRRS) 1997-2003

## Description

- Physician referred telephone-based counseling service to support patients and employees in lifestyle change

## Target Population

- Health System employees and their spouses
- Medicare patients who smoked
- Cardiac Rehab patients post program
- Inpatient smokers on hospital discharge
- Pregnant smokers from the residency clinic
- Patients identified and referred by their physicians

## Target Risks/Diseases

- Smoking, physical inactivity

## Reach and Effect Rates

- Worked with 1400 patients
- 25% tobacco quit rates
- 55% of patients significantly increased their levels of physical activity
- Associated \$200-\$500 savings in annual medical claims with low risk behaviors

## Funding Source

- Direct investment of the Health System, ended with budget cuts

## Description

- Three successive Prescription for Health Projects linking health behavior change services to primary care practices, 2003-2008

## Target Population

- Patients of 15 practices in 3 communities – Flint, Grand Rapids, Marquette

## Target Risks/Diseases

- Tobacco use, unhealthy diet, physical inactivity, risky drinking

## Reach and Effect Rates

- Served ~800 patients
- Achieved statistically significant improvements in health behaviors and outcomes including smoking, physical activity, diet, BMI, and health status
- 85% of patients were referred to additional resources beyond CHERL and ~1/2 of those connected

## Funding Source

- Robert Wood Johnson Foundation (RWJF) and Agency for Healthcare Research and Quality (AHRQ)



# Disease Management 2003- present

## Description

- Telephone-based service focusing on self management of disease primarily through healthy lifestyles

## Target Population

- Low income (<175% FPL), uninsured adults age 18-64 in county

## Target Risks/Diseases

- Diabetes, asthma, chronic back pain

## Reach and Effect Rates

- Served over 4,600 patients
- Achieved statistically significant improvements in healthy lifestyles and disease specific measures at 6 months compared to baseline, trends consistent over 5 years of the project
  - >50% of sedentary patients increase their physical activity
  - >50% increase fruit and vegetable intake
  - >50% improve low fat food choices
  - ~15% of smokers quit
  - 75-90% of patients with positive health habits maintain them
  - Demonstrated association of ~0.8 reduction in HgbA1c for every positive lifestyle change

## Funding Source

- Initially funded by local foundations, then ongoing funding was incorporated into the administrative budget for the health plan

# Health Navigator - Key Learnings

- Work as a member of the team
- Strengthen the relationship between patient and provider
- Use patient successes to garner provider support
- Practices need both individual patient feedback and performance feedback
- Most patients are receptive to support, particularly when perceived as part of their doctor's care
- Some patients need more help than others
- Meet people where they are!
- People with the biggest challenges can often realize the biggest successes
- Information is often not the deficit
- Be a community resource expert
- Address mental health issues

- Blue Cross and Blue Shield Physician Group Incentive Plan (PGIP) Patient Centered Medical Home (PCMH) Pilot Project
- In January 2009, 11 primary care practices were engaged as leaders in PCMH development with a focus on engaging their patients in setting health behavior goals
- Through 2/13/2009, providers have engaged 345 patients in setting 749 health goals
- Most frequent goals set focused on nutrition, physical activity, weight management, tobacco, and stress management.
- Only 6% (20/345) of these patients declined ongoing support. The remainder will be followed by Health Navigators to support lifestyle change over time... Outcomes will be tracked

# Sustainability of Health Navigators in the PCMH

---

- Health Navigator infrastructure best supported at the practice group level
- Funds allocated for case management, disease management, care coordination, and/or self-management support can provide sustainable funding stream

# Patient Story:

---

Ms. G. is a 51-year-old female with a history chronic pain for the past seven years. Her health goal is to better cope with her pain.

In addition to pain, Ms G:

- Struggles with hypertension and obesity
- Feels sad and blue most days
- Needs physical therapy
- Smokes 1 pack of cigarettes per day
- Lacks the motivation to start exercising
- Has financial barriers to care

# Patient Story:

---

## The Health Navigator:

- Listened to the concerns of Ms G
- Referred her back to PCP for assistance with depression
- Facilitated the referral process for physical therapy
- Offered information on smoking cessation program
- Sent her a pedometer to encourage exercise, and literature with additional resources

# Patient Story:

---

By three month follow-up Ms. G.:

- Feels better about self and able to control pain better
- Met with her PCP and was given an antidepressant
- Started physical therapy
- Reduced the number of cigarettes smoked per day
- Started a diet and exercise regimen
- Accepted a scholarship for free 1 year membership to Genesys Athletic Club
- Has hope for the future

---

*The real value of PCMH  
is in the ability to  
**prevent and manage**  
chronic disease!*

---

# Additional Information

---

[www.genesyshealthworks.org](http://www.genesyshealthworks.org)

[www.aboutcherl.org](http://www.aboutcherl.org)

Trissa Torres, MD, MSPH, FACPM

Genesys Health System

810-606-6251

[trissa.torres@genesys.org](mailto:trissa.torres@genesys.org)