

COVER

READMISSIONS

Hospitals update their
playbooks to make
patients active members
of the care team

Health Coaching

BY TRACY GRANZYK WETZEL



Clint Coon is a computer network manager for the Iowa Department of Safety, still working full time at 66 years of age while managing health conditions affecting his heart, kidneys, vasculature and sleep—in addition to cancer.

Achieving effective communication between two specialty groups is an accomplishment; managing five at once is nearly miraculous. But Coon has a partner on the inside—Dave Swieskowski, M.D., CEO of Mercy Clinics in Des Moines. Swieskowski is a data hound who believes that systems must be redesigned to better harness technology developed over the last 50 years. And he strongly believes patients must be more involved in their own care.

Engaging patients at Mercy Clinics is now part of daily operating procedure. At the forefront is their physician office-based health coach program, which allows Mercy to proactively manage the blood pressure, glucose levels and immunization rates of more than 25,000 patients.

“Any clinical goal we set, we can hit pretty easily,” Swieskowski says. “Cholesterol, cancer screening—it’s all the same process. Any type of follow-up that needs to be done, we think we can get 95 to 97 percent of patients to do so.”

Mercy has been tracking patient outcomes for about 15 years, and success is equal parts patient and provider effort. Through the health coach and shared decision-making programs, patients are trained to become active participants in their care. Health coaches ask patients to set health behavior goals versus outcome goals, and together, coach and patient develop a behavior-change plan with one- to two-week follow-up compared with the typical three months.

“You have to know your patients, track them and measure what is going on with them,” Swieskowski says.

The majority of Coon’s health care takes place at Family Medicine in Urbandale, Iowa. After discharge from a recent hospital stay, Coon’s first stop was the clinic. He walked in without an appointment, and within minutes was in his coach’s office, filling in gaps of information not yet received from the hospital.

“This kind of relationship is greatly appreciated—this go-between, or breaking down of the extended time you can’t reach a doctor,” he says. “I think patients are more comfortable



because they get a fairly rapid response.”

Health & Human Services has made patient engagement a priority. In March, Secretary Kathleen Sebelius released the National Strategy for Quality Improvement in Health Care. The strategy, mandated by the Affordable Care Act, defines three broad aims and six national priorities, including “Ensuring that each person and family are engaged partners in their care.”

The pressure to reduce avoidable readmissions underscores the need to engage patients better. In an April 2, 2009, *New England Journal of Medicine* article, Stephen Jencks, M.D., reported that 50.2 percent of Medicare beneficiaries readmitted within 30 days had not seen a physician between discharge and readmission.

Though many readmissions are planned, experts say some could be avoided partly by helping patients understand their conditions and what they need to do once they’re out of the hospital, and then to stay in contact with them to

EMPOWER THE PATIENT: Alicia Knight, R.N., a health coach with Mercy Clinics in Des Moines, Iowa, explains to Clint Coon how a healthy diet can contribute to managing his multiple health conditions.

make sure they are following through.

“The best organizations will thrive in new ways when thinking differently about engaging patients,” Institute for Healthcare Improvement President and CEO Maureen Bisognano said at the American College of Healthcare Executives national conference in March. “We need to understand the entire journey of our patients.”

‘Not Just the Medical Stuff’

Health systems in search of excellence, like Mercy Clinics, are leading the way in coordinating care for their patients and engaging them in the process.

Steven Counsell, professor of medicine at Indiana University and a scientist at the Center

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for Aging Research, designed the Geriatric Resources for Assessment and Care of Elders program, first implemented at Wishard Health Services in Indianapolis. The GRACE program uses a team approach combining transitional and primary care via home visits, and engaging patients in a care plan individualized to their needs. A social worker and nurse practitioner perform an in-home assessment of patients; collaborate with the GRACE team, which includes a geriatrician, pharmacist and mental-health case manager; and remain the link between patient and primary care physician. Weekly team conferences keep everyone on target.

"It's not just the medical stuff," Counsell says. "You can have a great plan for heart failure, correct medications, home health with follow-up on blood pressure and weight, but unless you uncover the psychosocial issues—screen for depression or cognitive impairment, lack of social support or health literacy issues—these things send the best-laid plans out the window."

In a 2007 trial of 951 seniors 65 and older, high-risk patients enrolled in the GRACE program experienced fewer trips to the emergency department, were hospitalized less frequently and cost the health care system \$1,500 less in Year 2 compared with their nonintervention cohorts. Counsell and his colleague Dan Clark, a behavioral researcher at the Center for Aging Research, published results of the trial in the Dec. 12, 2007, issue of *The Journal of the American Medical Association*.

Counsell says such longitudinal programs are critical. "The longer you're with that patient, trust grows. We saw patients who refused to change medications or start antidepressants in Year 1, [but were] willing to make changes in Year 2 once they felt the health care team was aligned with their goals."

Clark says just giving patients information is insufficient. "We have to provide the support networks. We can be specific about exercise, but if they live in a world without role models—people eating unhealthy foods or not exercising—combined with the emotions related to illness, much additional support is needed." GRACE protocols are available at <http://medicine.iupui.edu/IUCAR/research/grace.asp>.

At the IU Roybal Center for Transitional Research on Chronic Disease Self-Management Among Vulnerable Older Adults sponsored by the National Institute on Aging, Clark also is overseeing a pilot program to encourage 20 elder-

ly, low-income individuals to participate in an exercise program. Participants in this socioeconomic group often don't have access to reliable transportation to attend exercise classes at a community center. Through the program, each participant receives a desktop computer and participates virtually from home, as an instructor leads an exercise program approved by the American College of Sports Medicine.

"The program is keeping patients engaged socially and they are having fun doing so," Clark says. "We are working on funding for doing this on a larger scale to test feasibility and efficacy."

Clark emphasizes the need to address the social issues that hold some patients back from being engaged. Getting people into groups with whom they feel comfortable improves participation and maintenance. Once patients overcome the initial anxiety of joining a new group, they find it more like a family and don't want to quit.

Bronson's Ongoing Journey

For the Bronson Healthcare Group in Kalamazoo, Mich., patient engagement is an evolutionary process, starting well before reporting requirements and potential penalties. Leaders at Bronson Methodist Hospital, a 2005 Malcolm Baldrige National Quality Award winner, are never satisfied no matter how well the organization performs.

"We are on a continuous journey," says James Greene, a board member who also serves on the quality oversight committee. "We have a culture here to provide a great patient experience that has evolved over a number of years."

Bronson has been working to reduce readmissions for four years. "We discovered they are multifactorial and we really studied each one, looking at age of the patients, which units they were on, medications and nutrition—did they know who they should have followed up with?" says Cheryl Knapp, R.N., vice president of accreditations and quality standards. "We want to be consistent with every patient, every time."

Bronson leaders dedicated resources to take a deeper dive into heart failure, knowing the organization wasn't where they wanted it to be. The Bronson Home Health Care Heart Failure Pathways was one result of the effort, enlisting primary care providers and home-health nurses to teach patients about the disease, including which symptoms to monitor at home, while focusing on adherence and prevention.

"We use teach-back methods when talking to patients about their medications, weight loss



and changes to their medications,” says Tina Sullivan, R.N., nursing director of adult medical services. “This forces patients and caregivers to tell us in their own words what they understand and lets us know what needs to be reinforced. The most important piece is getting patients to ask questions.”

Ann West, a 75-year-old heart-failure patient, has been in and out of the hospital six times since August 2010, though not always because of her heart condition. Stacy Ochsenrider, R.N., is West’s heart-failure care transition-team coach, part of a newer Bronson program set up after Bronson participated in IHI’s Reducing Readmissions by Improving Transitions in Care Collaborative.

The transition team consists of a nurse practitioner and two nurses who follow heart-failure patients in the hospital and 30 days after discharge. It helps coordinate care from the hospital to home or to a skilled nursing facility.

“Over the past year, the transition coach program has had more than 850 patients referred and has had success in preventing readmissions,” Ochsenrider says. “Additionally, we

identified opportunities for improvement across the continuum of care. We’re listening and learning more about the patient’s needs and implementing interventions accordingly.”

Bronson board member Greene notes that “in the hospital, everything is done for the patient. As a result, nine times out of 10, patients will not remember medications given to them while in the hospital or what is told to them at discharge. They return home to a medicine cabinet filled with medication they’ve already purchased and wonder why they should not continue to take them. Stacy and home health go over information provided in the hospital again, helping the patient get into a new mind-set.”

Despite heart issues, West retains her independence with the help of her husband who is a willing caregiver, and Ochsenrider as her transition coach. She also has a standing order at Bronson as an outpatient, so when she feels short of breath, she can call a special number and avoid going to the hospital.

So far, West says with evident pride, “I haven’t used it.”

Online technological innovations also are

GOING MOBILE: Robin Beck, M.D., medical director of House Calls for Seniors at Wishard Health Services in Indianapolis, is on her way to making a house call to an elderly patient’s home. The program uses a team approach combining transitional and primary care via home visits, and engaging patients in a care plan individualized to their needs.

Photograph courtesy of Wishard Health Services

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FOLLOW ME: The Bronson Home Health Care Heart Failure Pathways program enlists primary care providers and home-health nurses to teach patients about their disease, including which symptoms to monitor at home, while focusing on adherence and prevention. Ann West (left), a 75-year-old heart-failure patient, has been in and out of the hospital six times since August 2010. Stacy Ochsenrider, R.N. (right), is West's heart-failure care transition-team coach. The transition team consists of a nurse practitioner and two nurses who follow heart-failure patients in the hospital and 30 days after discharge.

helping to engage patients in their care.

Community Health Network in Indianapolis established an e-business department, led by a former critical care nurse turned vice president, Dan Rench. Rench and his team sought to capitalize on the proliferating use of hand-held devices to help patients better comply with medication use.

"We were the first health care system in the United States to custom develop an iPhone app, now free to anyone in world," Rench says. The Pillbox app was launched in 2009 and can be downloaded on iTunes at www.pillboxapp.com. Pillbox allows users to enter their medications, schedule when to take the medication and input doctor information. Pulling from a drug database, it also provides prompts for specific items to discuss with physicians.

"We had 5,000 to 6,000 downloads of the app per month for the first six months," Rench says. "We continue to receive positive feedback on the iTunes site, but know apps have since been developed that have improved upon our initial technology. We are at work on a 2.0 version, which will include an alert letting users know it's time to take their medication even if the app is not open."

As a registered nurse, Rench appreciates

how tools like Pillbox simplify and improve medication compliance.

And Rench's team has just begun. To improve real-time scheduling at their MedCheck urgent care centers, they developed an online and smart phone scheduling tool (www.medcheckwebahead.com), allowing patients and families at home to view wait times at each of the six clinics and to schedule an appointment.

MedCheck volumes increased 22 percent in the first quarter of 2011 compared with the first quarter of 2010, and the team credits the ease of smart phone scheduling with helping to boost utilization. "Sick kids get to stay on the couch until their appointment versus sitting on an uncomfortable chair in a waiting room," Rench says.

The pressure to improve outcomes, reduce readmissions and bend the cost curve is only going to grow, so providers and patients must find more effective ways to engage with each other. That will require teamwork and new skills on everybody's part.—Tracy Granzlyk Wetzel is a freelance writer in Chicago. ●



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