MEG Medical Education Group

Polling Question

In which setting do you work?

A. Academic Medical Center
B. Society or Association
C. Healthcare System/Hospital
D. Medical Education Company
E. Gov't/VA
F. Other

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MEG Medical Education Group

First Fridays Webinar Series: Medical Education Group (MEG)

October 7th, 2011

This webinar is being recorded

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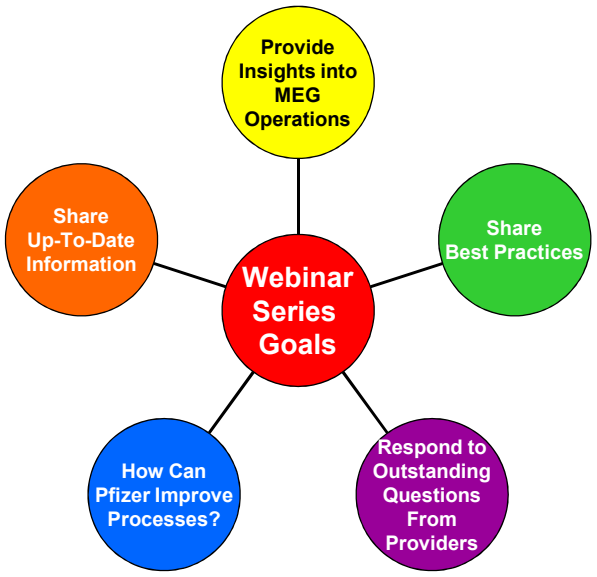

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Agenda

- Welcome
- *Using the Architecture of Continuing Professional Development to Build the Patient-Centered Medical Home*
  - Shelly Rodrigues, Deputy Executive Vice President, California Academy of Family Physicians
  - Mary Ales, Executive Director, Interstate Postgraduate Medical Association
- *What is the Role of CME in Patient Centered Care?* Bob Meinzer, Senior Director, National CME, New Jersey Academy of Family Physicians
- Q and A
- Closing Remarks

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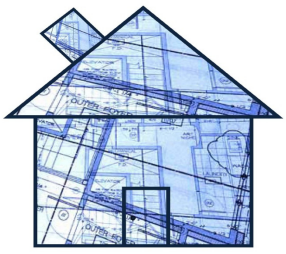
Calls for Grant Applications

- Clinical Areas
  - Adult Immunization
  - Improving Care for Patients with Renal Cell Carcinoma (RCC): Supporting Practice Improvement in Community Oncology Setting
  - Improving Care for Patients with Non-Small Cell Lung Cancer: Accelerating Adoption of New Guidelines and Evidence-Based Practice Change
- Due Date: 10/15/2011
- Expected approximate monetary range of oncology grant applications: $25,000-$100,000

PCMH and Education: The Perfect Match



Mary Ales
Interstate Postgraduate Medical Association

Shelly Rodrigues, CAE
California Academy of Family Physicians

Disclosure

- Mary and Shelly have no financial conflicts or interests to declare.

- Mary Ales: maless@ipmameded.org
- Shelly Rodrigues: srodrigues@familydocs.org

2 Minute Introduction

Primary care is in trouble. There is an overwhelming amount of work, poor compensation, health care costs are skyrocketing, physician pipeline is drying up and the population is aging and becoming sicker with chronic conditions. The patient centered medical home (PCMH) is a new model of primary care that has proven results in patient's health and physician's satisfaction.

A patient centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a personal physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience and optimal health throughout their lifetime.

IGNITE

Fun, thought provoking, social, local, global

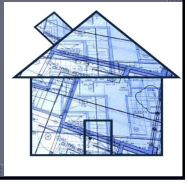
5 minutes, 20 slides, 15 seconds a slide

Generally occurs after hours

Spend 5 minutes "igniting" the PCMH

CME Professionals as Builders

Our Role in building the Patient Centered Medical Home



Patient Access to Care

Ready access

- Expand **access** beyond 5 minute phone call or 7 minute office visit
  - eVisits, secure messaging, tele-medicine, etc.
- Getting **appointments** promptly
- Keeping **wait times** brief; and having care team members available when needed
- **Accommodating** limited physical mobility, cognitive impairment, language barriers, or cultural differences

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Patient Centered Primary Care Collaborative

Patient Provider Communication

Coordination and communication

- A "**go-to" person** to navigate system, and help patients understand their condition and what they need to do
- Providers organized in **teams**
- Help **choosing specialists** and getting appointments in a timely manner
- Ensuring *other* providers have patient's information ahead of time
  - Health information exchange
- Help patients **understand** results recommendations
- Smooth **transitions** between settings

6

Patient Centered Primary Care Collaborative

Managing Patient Populations

Measure	Summary Results							
	Q2-08	Q3-08	Q4-08	Q1-09	Q2-09	Q3-09	Q4-09	Q1-10
HF-01: Left Ventricular Function	50.0	24.6	26.7	25.2	19.0	17.4	9.7	10.3
HF-02: ACE Inhibior Therapy	0.0	75.0	57.1	38.5	57.1	71.8	7.9	3.7
HF-03: Weight Measurement	50.0	91.3	88.9	82.8	90.6	92.0	88.3	87.8
HF-04: Warfarin Therapy for Pat. With AF*	0.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0
HF-05: Patient Education	0.0	0.0	22.3	2.6	14.2	17.3	18.4	17.9
HF-06: Beta-Blocker Therapy	0.0	0.0	62.5	50.0	42.9	53.6	4.8	3.3

*Results included only two eligible patients in Q4 2009. No patients were eligible in Q1 2010.

Hypertension

Measure	Summary Results							
	Q2-08	Q3-08	Q4-08	Q1-09	Q2-09	Q3-09	Q4-09	Q1-10
HTN-01: Blook Pressure Screening	94.2	99.2	99.4	99.4	99.5	99.7	85.3	87.5
HTN-02: Blood Pressure Result < 140/90	63.7	70.4	63.6	60.9	61.5	63.2	62.9	62.6
	78.9	84.8	81.5	80.2	80.5	81.4	74.1	75.0
	78.9%	84.8%	81.5%	80.2%	80.5%	81.4%	74.1%	75.0%

Preventive Care

Publically reported data, accessed from Telligen

Measure	Summary Results							
	Q2-08	Q3-08	Q4-08	Q1-09	Q2-09	Q3-09	Q4-09	Q1-10

Patient Self Management Skills

Patient support and empowerment

- Expanding patients' and caregivers' **capacity** to get and stay well (efficacy)
- Support for **self-management** - tools and services that help patients and caregivers better manage their conditions
- Patient **partnership** with clinicians – choosing treatment options, goals, plans, team members, etc.
- **Trust and respect** – patient preferences, physical and emotional comfort, and privacy

7

Patient Centered Primary Care Collaborative

Track and Coordinate Care

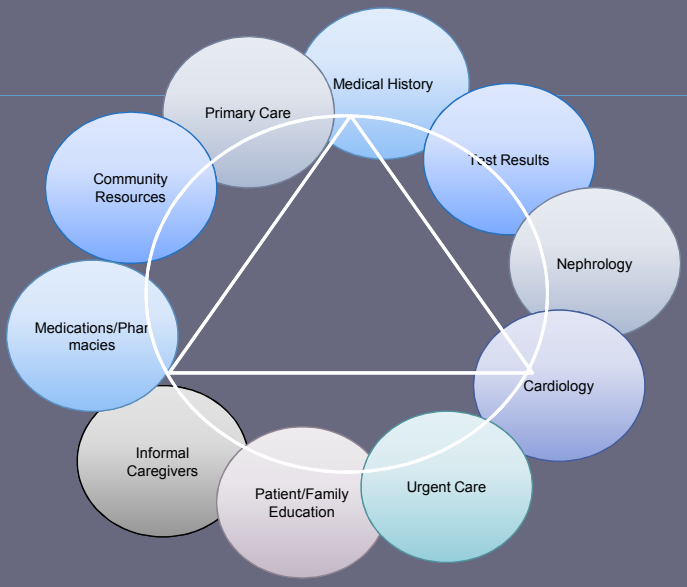
The level of care coordination needed will increase with greater system fragmentation, greater clinical complexity, and decreased patient capacity for participating effectively in coordinating one's own care.

Mr. Andrews is a 70 year old man with congestive heart failure and diabetes. He uses a cane when walking and recently has had some mild memory problems. His PCP, Dr. Busy, is part of a small group physician practice focused on primary care. The PC clinic includes a lab, but they refer their radiology test to a nearby radiology center. Mr. Andrews also sees Dr. Kidney, a nephrologist, and Dr. Love, a cardiologist. Both specialties are part of a specialty group practices that is not affiliated with Dr. Busy's clinic. The specialty practice includes an on-site lab, radiology clinic, and pharmacy. Mr. Andrews has prescriptions filled at the specialty clinic pharmacy after his appointments with Drs. Kidney and Love and picks up medications prescribed by Dr. Busy at the pharmacy near his home. Mr. Andrews has a daughter who lives nearby but works full time. Because he ahs trouble getting to the grocery store to do his shopping, he receives meals at his home 5 days a week through a senior support services. His daughter has hired a caregiver o help Mr. Andrews with household tasks for two hours, three days a week.

During a recent meal deliver, the program staffer noticed that Mr. Andrews seemed very ill. He called an ambulance, and Mr. Andrews was taken to the emergency department. There he was diagnosed with CHF exacerbation and was admitted. During his initial evaluation, the admitting physician asked Mr. Andrew about which medications he was taking, but the patient could not recall what they were or the doses. They physician at the hospital contacted Dr. Busy, who provided a full medical history and general list of medications. Dr. Busy noted that Mr. Andrews my have had dosing changing after a recent appointment with Dr. Love. In addition, Dr. Busy noted that Mr. Andrews may be missing medication doses because of his forgetfulness. He provided the hospital team with the contact information or Drs. Love and Kidney. He also asked that a record of Mr. Andrew's hospital stay be sent to his office after discharge.

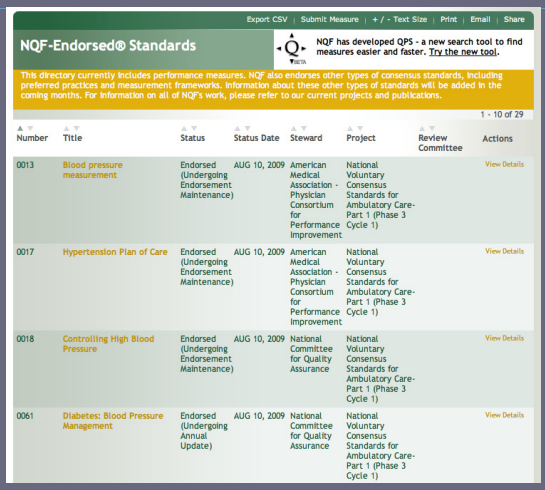
Mr. Andrews was discharged from the hospital one week alter. Before going home, the nurse reviewed important information with him and his daughter who was taking him home. They went over several new prescriptions and details of a low-salt diet. She told him to schedule a follow-up appointment with his primary care physician within 2 day and to see his cardiologist in the next 2 weeks. Mr. Andrews was very tired so his daughter picked up the prescriptions from a pharmacy near the hospital; rather than the one Mr. Andrews usually uses.

From AHRQ Care Atlas



From AHRQ Care Atlas

Clinical Performance Measures



Export CSV | Submit Measure | + / - Text Size | Print | Email | Share

NQF-Endorsed® Standards

NQF has developed QPS - a new search tool to find measures easier and faster. Try the new tool.

This directory currently includes performance measures. NQF also endorses other types of consensus standards, including preferred practices and measurement frameworks. Information about these other types of standards will be added in the coming months. For information on all of NQF's work, please refer to our current projects and publications.

1 - 10 of 29

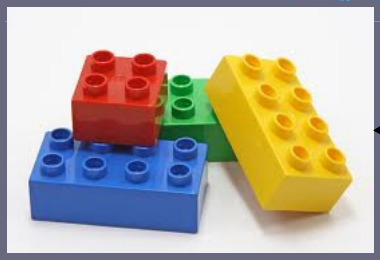
Number	Title	Status	Status Date	Steward	Project	Review Committee	Actions
0013	Blood pressure measurement	Endorsed (Undergoing Endorsement Maintenance)	AUG 10, 2009	American Medical Association - Physician Consortium for Performance Improvement	National Voluntary Consensus Standards for Ambulatory Care-Part 1 (Phase 3 Cycle 1)		View Details
0017	Hypertension Plan of Care	Endorsed (Undergoing Endorsement Maintenance)	AUG 10, 2009	American Medical Association - Physician Consortium for Performance Improvement	National Voluntary Consensus Standards for Ambulatory Care-Part 1 (Phase 3 Cycle 1)		View Details
0018	Controlling High Blood Pressure	Endorsed (Undergoing Endorsement Maintenance)	AUG 10, 2009	National Committee for Quality Assurance	National Voluntary Consensus Standards for Ambulatory Care-Part 1 (Phase 3 Cycle 1)		View Details
0061	Diabetes: Blood Pressure Management	Endorsed (Undergoing Annual Update)	AUG 10, 2009	National Committee for Quality Assurance	National Voluntary Consensus Standards for Ambulatory Care-Part 1 (Phase 3 Cycle 1)		View Details

www.qualityforum.org

Advanced Electronic Communication

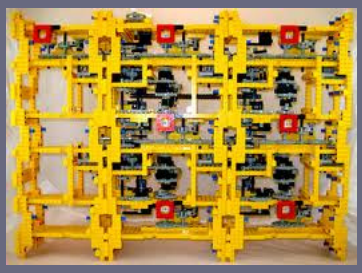
What is our role as CME/CPD Professionals?

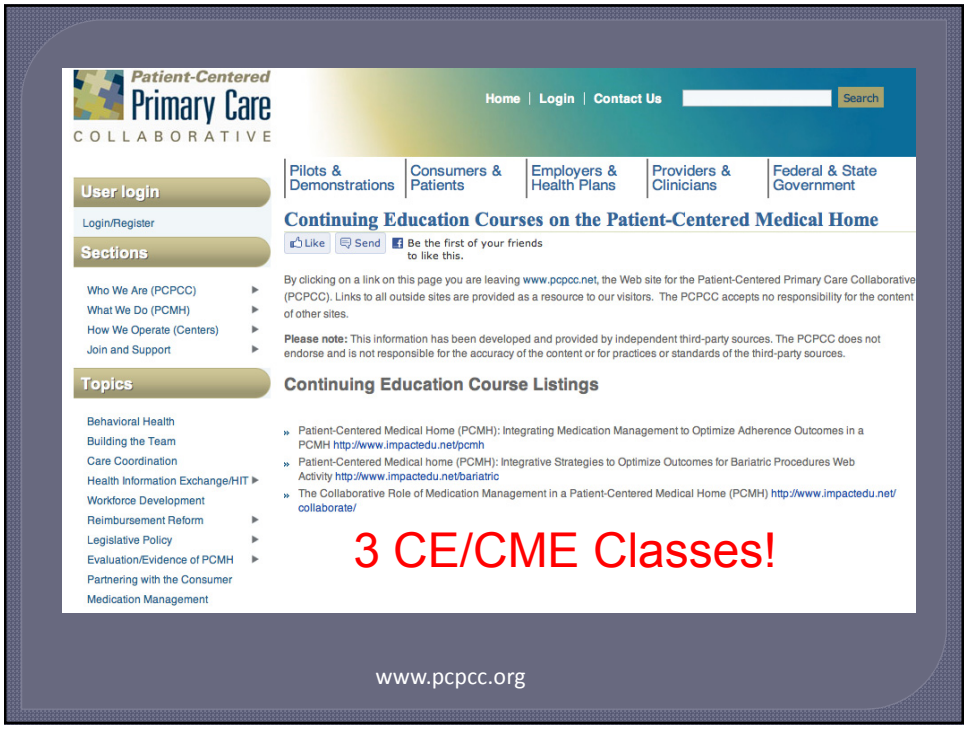
New Skills and Tools



Everybody can build this

But do they have the skills and tools to build this? Do you?

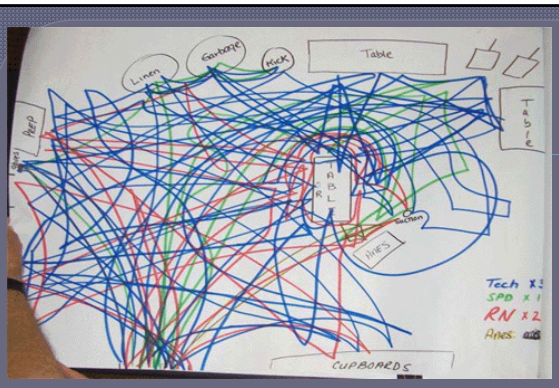




www.pcpcc.org

No "I" in Team

We may award individual credit, but implementing PCMH requires the team.



Process redesign requires analysis of how care is delivered

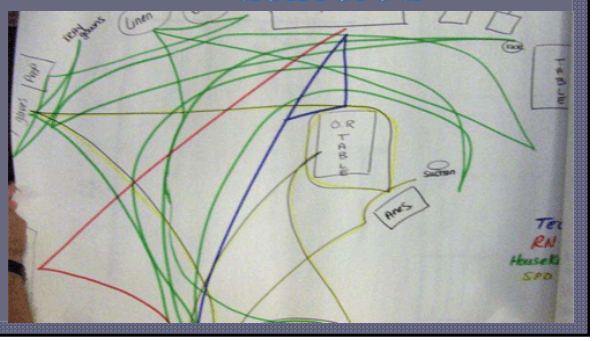
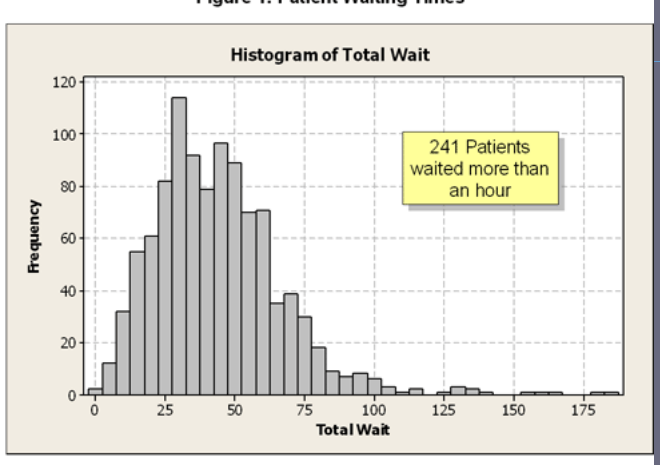


Figure 1: Patient Waiting Times



Source: Lansing Ophthalmology, 2007. Data were collected over a five-day period

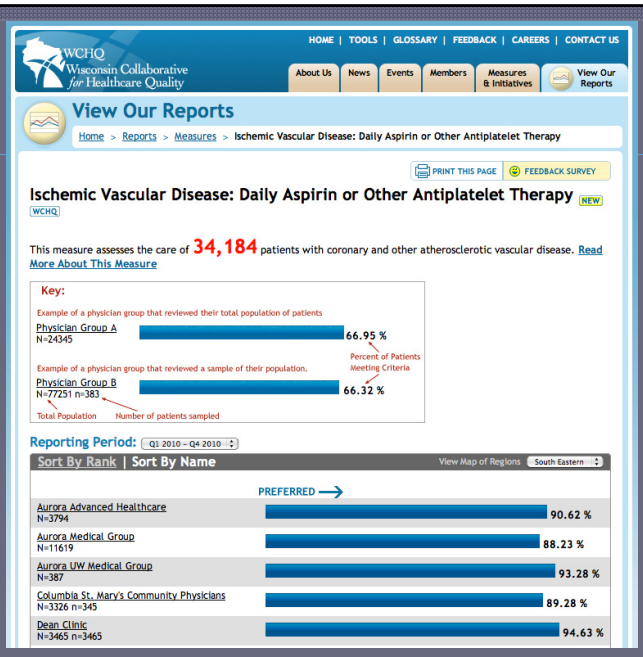
Lansing Ophthalmology, 2007 from Commonwealth Foundation

Figure 2: Top Five Traffic Flow Patterns

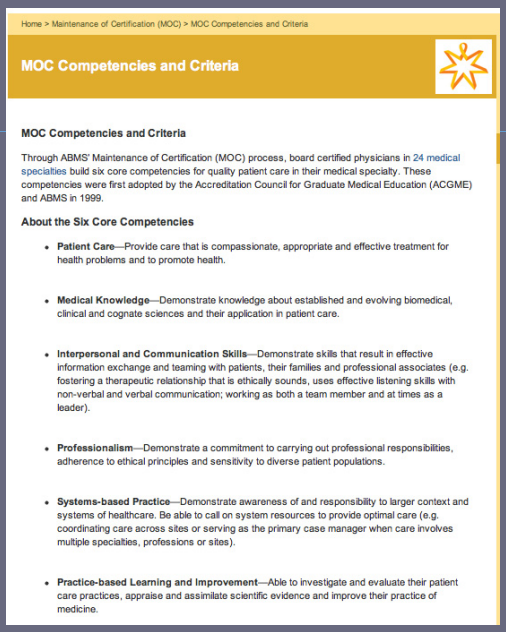
Pattern 1 Check-in Podium *(a routing station)* History EPIC exam *(refraction, or measurement of near- or far-sightedness)* Dilation Doctor's exam Check-out	242 patients, Average time: 79 minutes (45 spent waiting)
Pattern 2 Check-in Podium History Doctor's exam Check-0ut	159 patients, Average time: 58 minutes (37 spent waiting)
Pattern 3 Check-in Podium History Dilation Doctor's exam Check-out	90 patients, Average time: 68 minutes (45 spent waiting)
Pattern 4 Podium History Doctor's exam Check-out	64 patients, Average time: 55 minutes (35 spent waiting)
Pattern 5 Check-in Podium History EPIC exam Dilation Doctor's exam Test Check-out	45 patients, Average time: 94 minutes (53 spent waiting)

Source: Lansing Ophthalmology, 2007.

My learners only
want clinical information …



www.wchq.org


Home > Maintenance of Certification (MOC) > MOC Competencies and Criteria

MOC Competencies and Criteria

MOC Competencies and Criteria

Through ABMS' Maintenance of Certification (MOC) process, board certified physicians in 24 medical specialties build six core competencies for quality patient care in their medical specialty. These competencies were first adopted by the Accreditation Council for Graduate Medical Education (ACGME) and ABMS in 1999.

About the Six Core Competencies

- **Patient Care**—Provide care that is compassionate, appropriate and effective treatment for health problems and to promote health.
- **Medical Knowledge**—Demonstrate knowledge about established and evolving biomedical, clinical and cognate sciences and their application in patient care.
- **Interpersonal and Communication Skills**—Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically sounds, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader).
- **Professionalism**—Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.
- **Systems-based Practice**—Demonstrate awareness of and responsibility to larger context and systems of healthcare. Be able to call on system resources to provide optimal care (e.g. coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).
- **Practice-based Learning and Improvement**—Able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence and improve their practice of medicine.

www.abms.org

Susan Hogeland, CAE

"CAFP is excited to undertake, at last, a Patient Centered Medical Home project in Fresno, California with the Fresno Unified School District's Joint Health Management Board and two outstanding primary care medical groups there, with strong family physician support."

CAFP-Fresno

Since 2005, CAFP has been active in PI/QI, and with experience running four IHI-model collaboratives, believes that practice transformation is the key to success in family medicine and primary care.

In its 2010 Strategic Plan, the California Academy of Family Physicians (CAFP) committed to completing a pilot PCMH project that linked practice redesign, quality improvement, in-practice coaching, CME, certification, and payment for physicians/practices.

A consultant for the Fresno United School District, and its Joint Health Management Board (JHMB), a self-funded plan, contacted CAFP. With more than 25,000 employees and dependents covered by the plan, 70% of whom have at least one chronic condition, they were looking for a way to improve health markers, and decrease costs.

CAFP-Fresno

The CAFP-Fresno project is designed to educate Fresno primary care physicians in the PCMH model and transform their practices to improve health outcomes and reduce costs for the community of Fresno. This project will have the following stages:

(1) Research, planning and design;
(2) Physician education and implementation;
(3) Physician engagement and data collection;
(4) Analysis and review; and
(5) Evaluation of opportunities for broader implementation.

Broad support exists for this project in the Fresno community, including, most saliently, the support of Fresno physicians and JHMB.

** CAFP has received an educational grant from Pfizer to support a portion of the development of the transformation curriculum.*

CAFP-Fresno

After 18 months of strategy sessions, meetings with stakeholders, trips from SF to Fresno, conference calls, budget revisions, and one new baby for the CAFP staff lead, on August 30 the health plan allocated $564,000 to the budget to pay physician practices for transformation.

- We have identified groups to participate via community meetings, surveys, personal invitations, and meetings with the medical groups.
- Application process ends with the October 10 selection of the groups.
- Metrics and payment methodology are being finalized.
- The curriculum for transformation *, matching quality improvement and CME, is under development as we speak, working with our consultants, staff, and master faculty members.
- Deep dives into the practices, with the coaches will begin ASAP. Education and training sessions will begin in December 2011/January 2012.

Fay Fulton Brown

"The Georgia Academy of Family Physicians' leadership embraced the model of the medical home and decided to jump in and begin the transformation process rather than wait for state government, local businesses, or insurers. It is the only project nationally that primary care physicians have utilized their own resources (personal tuition dollars and cash reserves from the Georgia Academy) to initiate the change needed for primary care to survive in the current environment."

Georgia Academy of Family Physicians

In November 2010, about the same time the CAFP was beginning its pilot exploration, the Georgia Academy of Family Physicians launched the Patient Centered Medical Home University. This 18-month educational program assists small practices, of five or fewer physicians, in achieving the National Committee for Quality Assurance (NCQA) recognition as a Patient Centered Medical Home (PCMH).

The GA-AFP expects the following outcomes:

- Improved efficiencies and quality
- Reduction in emergency room visits and hospital admissions
- Improved provider and staff satisfaction
- Improved clinical outcomes (breast cancer screening, BMI monitoring, blood pressure control, cholesterol screening and control, increase in pneumococcal vaccinations)

GA-AFP

- As of March 31, 2011 four practices in Georgia that have received recognition through NCQA - http://recognition.ncqa.org/index.aspx.
- A total of 27 practices are part of this initiative to transform their practice. Twenty-two of these practices are family medicine, one is an internal medicine practice, and three are family medicine residency programs. The outreach in Georgia of these 27 include the cities of Ocilla, Athens, Statesboro, Rome, Thomasville, Dawsonville, Conyers, Duluth, Thompson, Oakwood, Lawrenceville, East Point, and Atlanta.

Karla Graue Pratt

The power of collaborative learning and the meaningful changes it brought 31 primary care practice teams in our recently concluded Patient-Centered Medical Home Collaborative has energized Academy leadership and staff to continue this important work. We're currently committed to Quality Improvement Coaching in the Beacon Community project and working to develop the next iteration of the PCMH Collaborative.

Washington Academy of Family Physicians

The Washington Patient-Centered Medical Home Collaborative (PCMHC) – in partnership with the Washington Department of Health, is a learning collaborative aimed at providing education and support to primary care practices that improve patient health outcomes by:

- Transforming primary care delivery Integrating quality improvement and data collection methods into practice
- Increasing efficiency and satisfaction for both patients and the health care team
- Incorporating population-based strategies for patient management
- Developing and applying strategies to expand and sustain improvements to care

In January 2009, WAFP began recruiting and by May, there were 31 primary care practices (family medicine, internal medicine, and pediatricians) participating in the collaborative. The program focus is on the implementation of four quality improvement strategies to meet evidence based clinical measures for diabetes and asthma. These measures are consistent with the Ambulatory Care Quality Alliance, (AQA), and the National Commission for Quality Assurance (NCQA), and the National Quality Forum (NQF).

WA-AFP

The four strategies include:
1. Use of a registry
2. Use of condition specific decision support tools
3. Creation, use, and monitoring of practice wide protocols
4. Education and support of patients in performing self-management of their disease

The second phase or long-term program focus is to assist primary care practices in transforming how care is delivered by adopting practice characteristics identified in the Patient Centered Primary Care Collaborative (PCPCC). The Collaborative believes that, if implemented, the patient centered medical home will improve the health of patients and the viability of the healthcare delivery system Physician. http://www.pcpcc.net/joint-principles

WA-AFP

Each participating practice will have a Quality Improvement Coach (QIC) to assist in the implementation of the measures. Practices will report on non-protected data measures, and receive performance feedback.

In addition, successful implementation can assist physicians and practices in:
- Becoming recognized by NCQA as a Physician Practice Connections - Patient Centered Medical Home (PPC-PCMH)
- Collecting additional payment from Medicare's Patient Quality Reporting Initiative,
- Receiving continuing medical education (CME) credit from many professional societies

Patient Centered Medical Home Collaborative, which just concluded its second year of a two year collaborative with its "Outcomes Congress" where 31 clinic participants shared their best practices were shared and outcomes celebrated. The final results are currently being evaluated and published into a report we hope to share in the coming months.

These are just three …

- Several state AFP chapters including Wisconsin, Colorado, Pennsylvania, Florida, Texas ….
- AAP and ACP
- Payors including Blue Shield and Sutter
- Kaiser Permanente
- Private practices and small groups
- Large groups and FQHC
- And at least 100 other pilots …

PCMH in a Nutshell

Physician offices that are Patient Centered Medical Homes benefit the patients in the following manner:

- Healthier outcomes;
- Empowered with a better relationship with their doctor and health plan;
- Safe, effective care delivered with compassion;
- More resources for better-informed healthcare decisions;
- Help from a trusted resource in navigating what can be a complex system of care.

Questions?
Thanks!

What is the Role of CME in Patient Centered Care?

Bob Meinzer
Senior Director
National CME
New Jersey Academy of Family Physicians

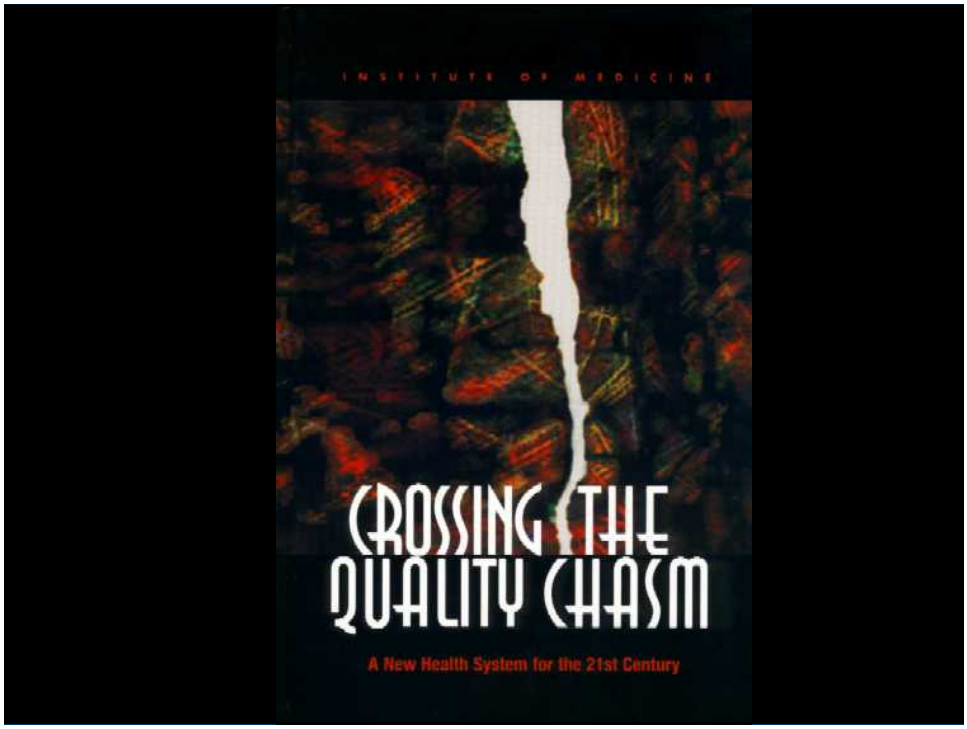
Bob Meinzer

Senior Director National CME
New Jersey Academy of Family Physicians

- 28 years in Pharma / 9 years in CME
- 9 months CME consultant to an integrated healthcare system
- 1 year Executive Director of a National Stroke Prevention Coalition
- 12 years FP provider
- No conflicts

Objectives

- Describe patient centered care
- Identify patient communication tools that improve self-care
- Integrate a patient centered approach into CME that provides a shared responsibility to improve outcomes

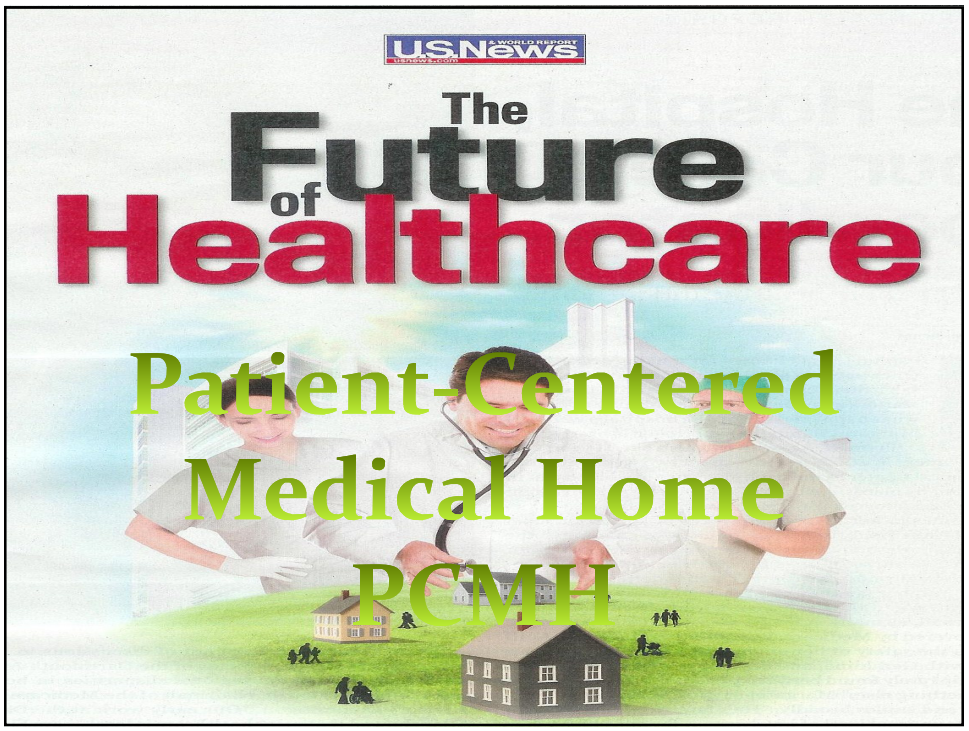


Patient Centered Care

Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that that patient values guide all clinical decisions

Committee on Quality of Health Care in America: Crossing the Quality Chasm

Patient Protection & Affordable Care Act (PPACA)

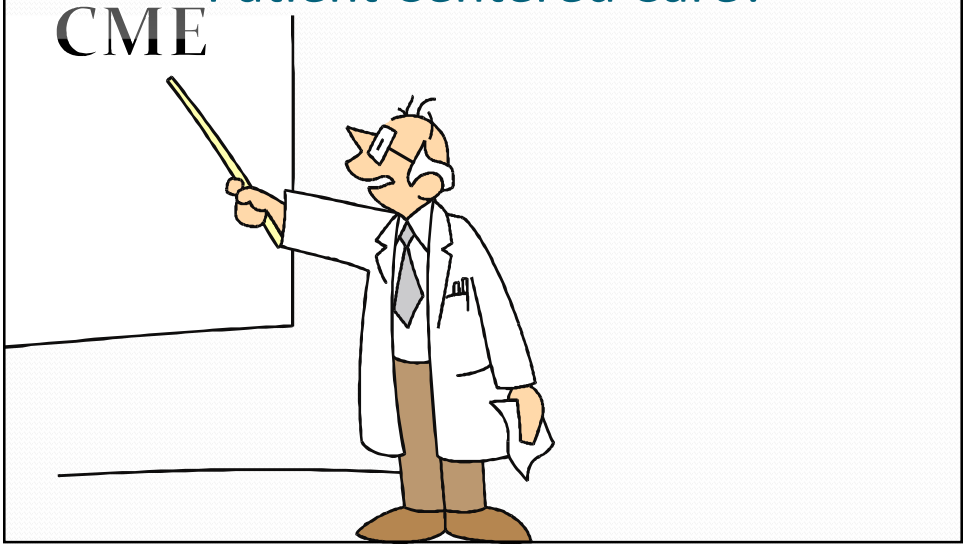


What is the PCMH?

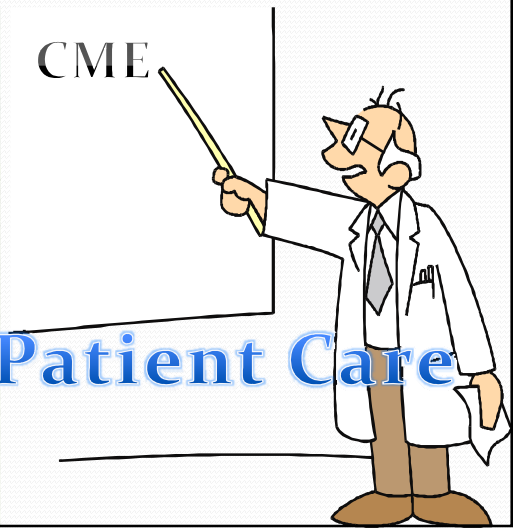
- Patient Centered
- Comprehensive Care
- Coordinated Care
- Superb Access to Care
- A Systems-Based Approach to Quality and Safety

A *patient-centered* medical home implies a commitment to seeking and valuing the voice of the patient and family in care decisions. AHRQ Publication No. 10-0083-EF

What is CME's role in Patient Centered Care?



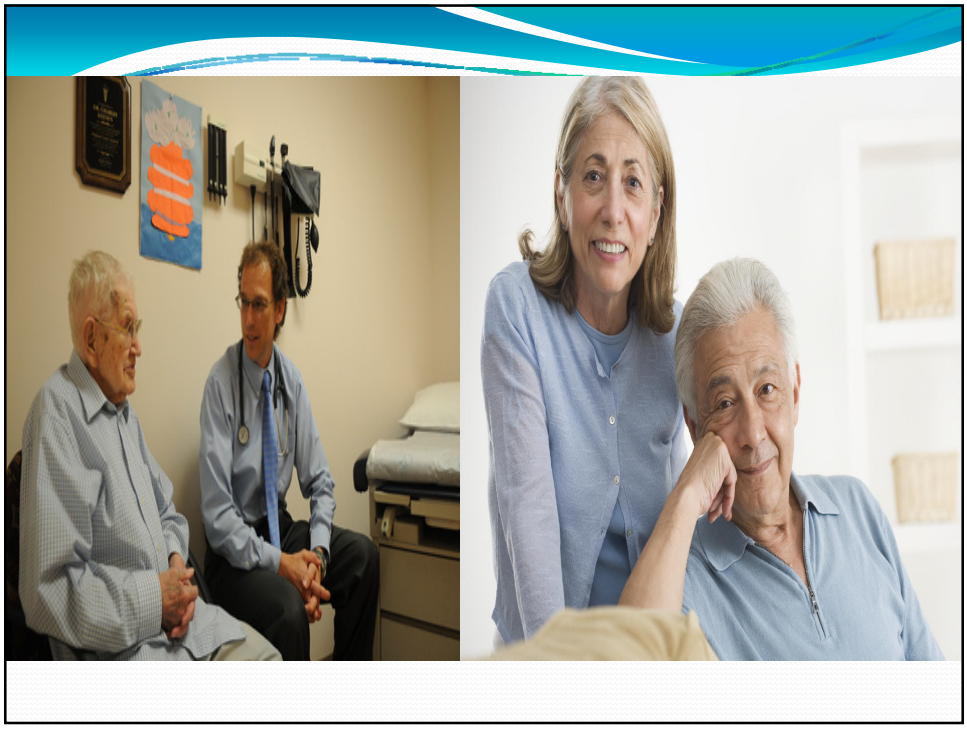
What's the Goal?



Improved Patient Care

Patient Centered

Healthcare has been evolving away from a disease centered model and toward a patient centered model



CME Report

Volume 4, No. 3 • June 2008

Meeting the Challenge:

A Family Physician's Guide to the Diagnosis and Management of Parkinson's Disease

An Evidence-based CME Consensus Recommendation from an Expert Panel

EB CME

Paul Deetz is a 54-year-old male who has had a right-sided tremor for 2 years. He works in sales, is married and has 5 children, 3 still at home. He complains of pain in his right foot and shoulder. He drags his right foot a little when walking. He is right-handed and has difficulty brushing his teeth, but denies difficulty using utensils, buttoning, or rising from a chair. He still rides his motorcycle. He denies any drug use, legal or illegal.

James Parkinson first described the disease that bears his name in an 1817 piece titled, "An Essay on the Shaking Palsy." In it, he identified 6 cases, 3 of which he observed on the streets of London.[1] Today, Parkinson's disease (PD) is the second most common neurodegenerative disease after Alzheimer's disease, affecting between 1% and 2% of individuals over 65 years of age; up to 6% of those in nursing homes.[2-4]

PD is a degenerative, progressive disorder of the central nervous system (CNS) that includes a variety of motor and non-motor symptoms. Motor problems are the hallmark of the disease and include resting tremors, slowness (bradykinesia), and rigidity. Later in the disease, postural instability appears that may lead to falls and impinge on movement and the quality of life.[5]

The number of people afflicted with PD is expected to rise as the average age of the population increases. That, coupled with current shortages of neurologists in many parts of the country—a situation expected to continue in the near future—will require that family physicians be comfortable diagnosing and treating the disease.[6,7]

The New Jersey Academy of Family Physicians (NJAFP) recently convened a panel of experts to develop recommendations for the appropriate diagnosis and management of PD by family physicians, particularly those whose patients do not have easy access to specialty care. The discussion also included recommendations for providing care and support for PD caregivers.

Epidemiology

An estimated 340,000 Americans were diagnosed with PD in 2005, a figure that is expected to nearly double by 2030.[4] However, given the frequent misdiagnosis and underdiagnosis of the disease, the number of people with PD is likely higher.[8,9] The age- and gender-adjusted incidence rate is 13.4 per 100,000 (95% confidence interval [CI]: 11.4, 15.5), with rates highest in Hispanics.[10] Gender differences are significant, with an incidence rate in men twice that in women (19.0 per 100,000 [95% CI: 16.1, 21.8] vs 9.9 per 100,000 [95% CI: 7.6, 12.2]).[10]

(cont. on p. 3)

NJAFP New Jersey Academy of Family Physicians

Resources for Caregivers

National Association of Area Agencies on Aging (AAA)
http://www.n4a.org/
202-872-0888
Local AAAs offer caregiver information and support, including respite care.

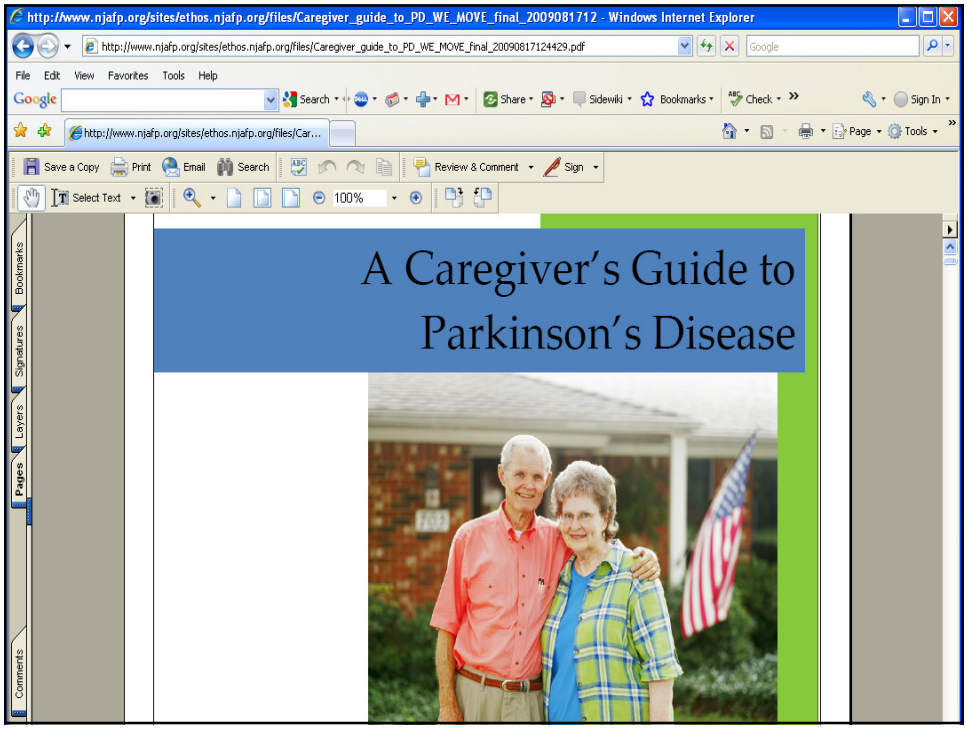
National Family Caregiver Support Program
http://www.aoa.gov/prof/aoaprog/caregiver/caregiver.asp
1-800-677-1116
This program provides information to caregivers about available services; assistance to caregivers in gaining access to services; individual counseling, organization of support groups, and training to caregivers to assist them in making decisions and solving problems relating to their caregiving roles; respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and supplemental services, on a limited basis, to complement the care provided by caregivers.

Caregivers Information from the US Government
http://www.usa.gov/Citizen/Topics/Health/caregivers.shtml
1-800-333-4636
Official information and services from the US government including: finding help to provide care; government benefits; legal matters and end-of-life issues; long-distance caregiving; and support resources for caregivers.

National Caregivers Library
www.caregiverslibrary.org
(804) 327-1112
An extensive online library for caregivers.

National Parkinson Foundation
www.parkinson.org
1-800-327-4545
Offers information about support groups throughout the country, as well as information about the disease, treatments, and research.

Michael J. Fox Foundation for Parkinson's Research
http://www.michaeljfox.org/
Provides information about the disease and coping for patients as well as caregivers.


http://www.njafp.org/sites/ethos.njafp.org/files/Caregiver_guide_to_PD_WE_MOVE_final_2009081712 - Windows Internet Explorer
A Caregiver's Guide to Parkinson's Disease


My Medical Home
Brandon Temple/AAFP

"Increasing the effectiveness of adherence interventions might have a far greater impact on the health of the population than any improvement in specific medical treatments."

RB Haynes, Cochrane Collaboration

61

High costs seen in medication nonadherence: study

New England Healthcare Institute Study

Modern Healthcare August 11, 2009

- Patients who do not adhere to their prescriptions cost the healthcare system about **$290 billion** a year.
- One-third to one-half of patients—especially those with chronic illnesses—improperly follow prescriptions, leaving themselves vulnerable to hospitalizations and medical risk.
- The larger spending could be avoided if patients adhered to medication orders given by physicians

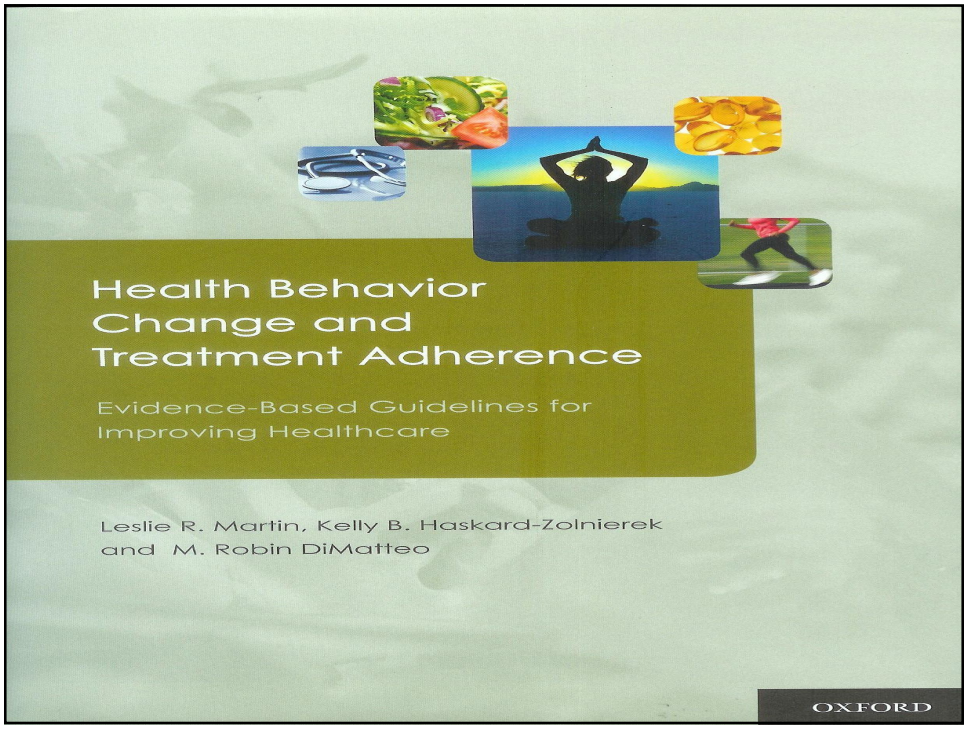


Table 8.2 Patient-centered versus traditional care.

Patient-centered	Traditional
Focus on how illness affects all aspects of the patient's life	Focus on how illness affects the patient physically
Holistic approach	Biomedical, focused approach
Shared decision-making regarding illness management	Health-care professional makes decisions and prescribes them to the patient
Promotion of good health, including psychosocial aspects	Focus on curing illness
Focus on improving the relationship	Focus on improving the patient's physical health only
Patient and clinician as experts, working together	Health-care professional as expert
Encourages patient autonomy, fosters self-management skills	Encourages patient to follow directives accurately

High costs seen in medication nonadherence: study

New England Healthcare Institute Study

Modern Healthcare August 11, 2009

Reasons for non-adherence:

- Cost
- Unpleasant side effects
- Confusion about the regimen
- Forgetfulness
- Language barriers
- Feeling "too good" to take medication

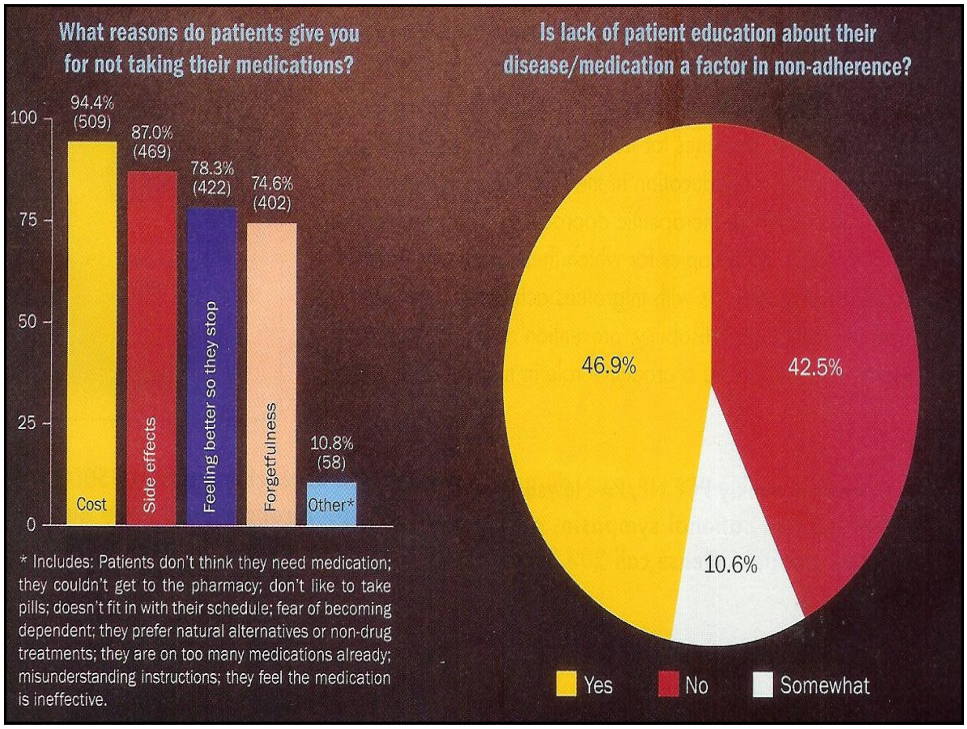
Main Reasons for Non-Adherence

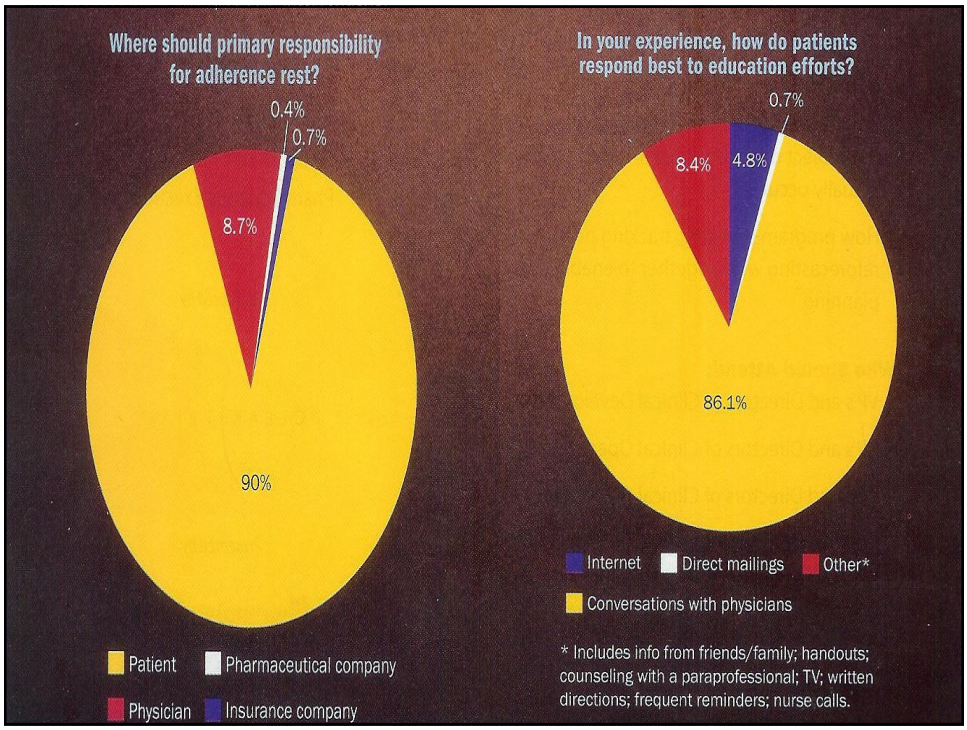
US Outcomes Research Group Merck

"Medication Nonfulfillment Rates and Reasons:"

Pharmaceutical Executive August 2010

- Concerns about medication
- Lack of perceived need for the treatment
- Affordability


What reasons do patients give you for not taking their medications?
100
75
50
25
0
94.4% (509)
87.0% (469)
78.3% (422)
74.6% (402)
10.8% (58)
Cost
Side effects
Feeling better so they stop
Forgetfulness
Other*
* Includes: Patients don't think they need medication; they couldn't get to the pharmacy; don't like to take pills; doesn't fit in with their schedule; fear of becoming dependent; they prefer natural alternatives or non-drug treatments; they are on too many medications already; misunderstanding instructions; they feel the medication is ineffective.
Is lack of patient education about their disease/medication a factor in non-adherence?
46.9%
42.5%
10.6%
Yes
No
Somewhat


Where should primary responsibility for adherence rest?
0.4%
0.7%
8.7%
90%
Patient
Pharmaceutical company
Physician
Insurance company
In your experience, how do patients respond best to education efforts?
0.7%
8.4%
4.8%
86.1%
Internet
Direct mailings
Other*
Conversations with physicians
* Includes info from friends/family; handouts; counseling with a paraprofessional; TV; written directions; frequent reminders; nurse calls.

Just What the Doctor Ordered

A system approach to assessing patient adherence

Presented to the CME community including Pfizer Medical Education Group

Prepared and Submitted by:

IPMA Practice-changing CME | University of Cincinnati | Healthcare Performance Consulting | University of Virginia Health System

December 2008

Adherence from the Physician's Perspective

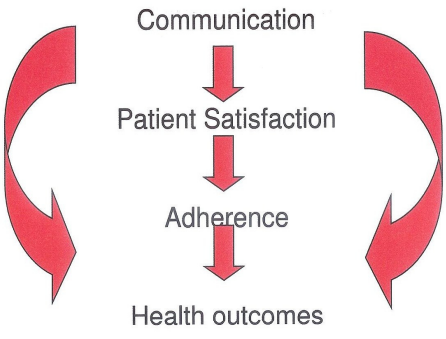
- Physicians know adherence is an issue but place responsibility on the patient
- System barriers exist
- Adherence is not assessed pre-treatment
- Adherence is not assessed with failure of therapy
- Few resources or systems are available
- Communication is key

The Missing Link to Improving Outcomes

Enlisting the Help of the Largest Health Care Workforce—Patients

Editorial JAMA Sept. 22/29, 2010

Communication Matters



Physician Communication and Patient Adherence to Treatment: A Meta-Analysis Haskard Zolnierek, Kelly B. PhD*; DiMatteo, M Robin PhD† Medical Care: August 2009 - Volume 47 - Issue 8 - pp 826-834

Conclusion:

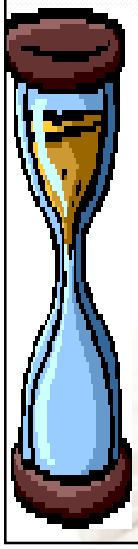
•Communication in medical care is highly correlated with better patient adherence

•Training physicians to communicate better enhances their patients' adherence.

•Findings can contribute to medical education and to interventions to improve adherence, supporting arguments that communication is important and resources devoted to improving it are worth investing in.

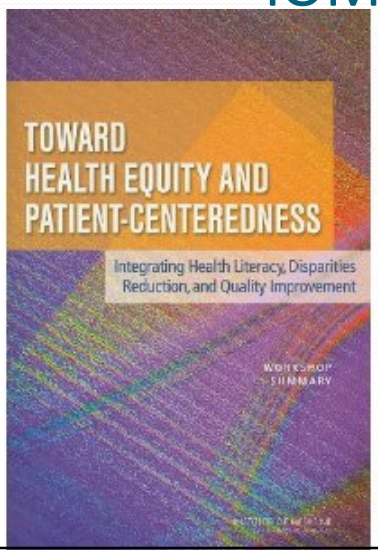
Physician Barriers to Empowering the Patient

Time



Patient Barriers to Adherence

IOM 2009



Integrating Health Literacy, Disparities and Quality Improvement

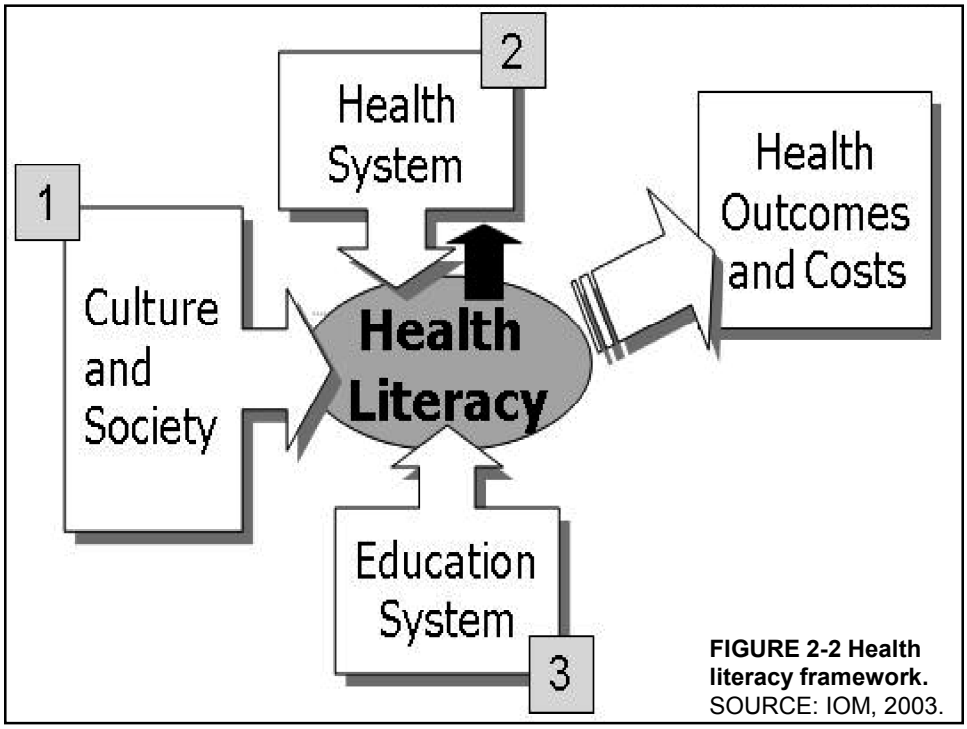


FIGURE 2-2 Health literacy framework.
SOURCE: IOM, 2003.

Health Literacy

- Low health literacy is common
- We do not have good strategies for knowing who is struggling with health information
- Health literacy universal precautions is structuring the delivery of care in the practice as if every patient may have limited health literacy

AHRQ Annual Meeting 2009 NC Program on Health Literacy

80

The federal government's new health literacy action plan cites a 2007 study led by a University of Connecticut economist

The costs to the health-care system of low health literacy, such as patients not taking their medications or seeking appropriate treatment, amount to as much as $238 billion a year.

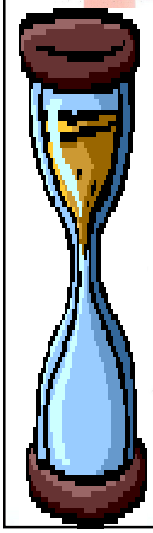
The Scope of Low Health Literacy

One out of five American adults reads at the 5th grade level or below, and the average American reads at the 8th to 9th grade level, yet most health care materials are written above the 10th grade level.

The **Partnership for Clear Health Communication at the National Patient Safety Foundation™**

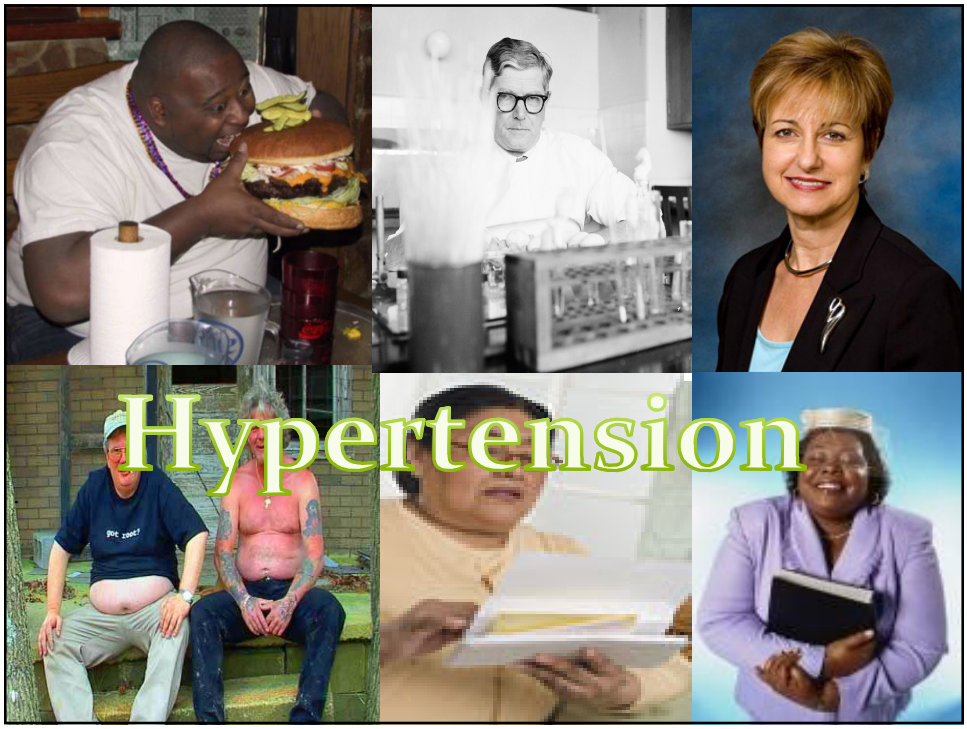
Health Literacy Universal Precautions Toolkit

1 Question Screen



- How confident are you filling out medical forms by yourself?
  - Extremely
  - Quite a bit
  - Somewhat } At risk
  - A little bit } At HIGH risk
  - Not at all

Powers BJ et al JAMA 2010;304(1):L76-84



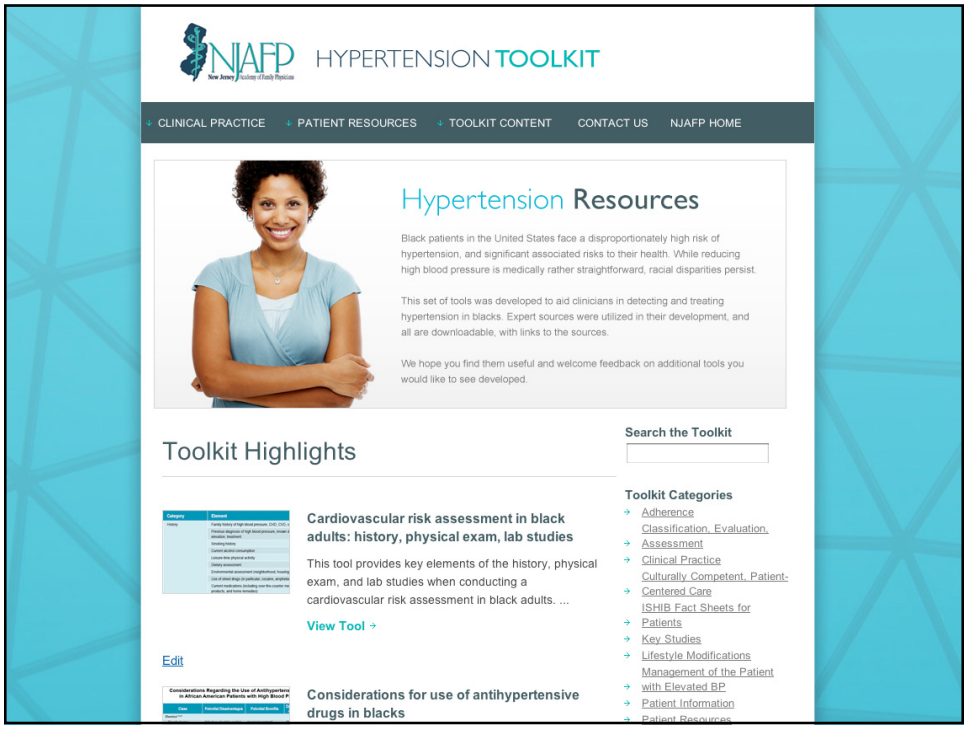
High BP vs. Hypertension

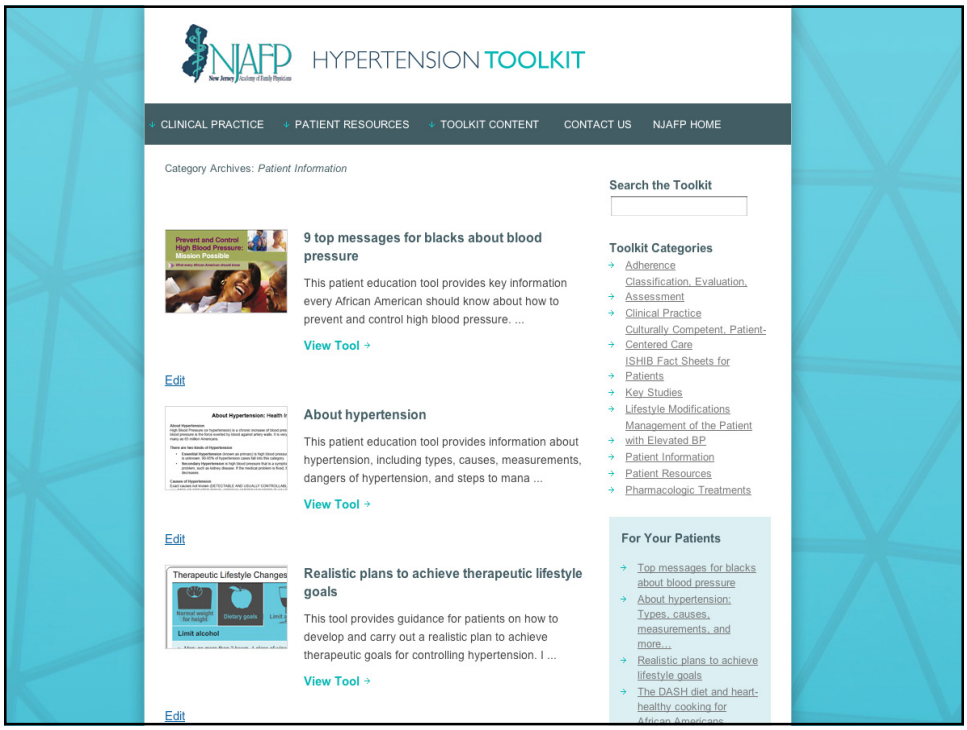
Low income African American women in New Orleans

- "High blood pressure"— too much or too thick blood; made worse by rich diet, red meat, and best treated by medication
- "High-pertension"— acute condition due to blood rising rapidly to head; caused by anxiety or nervousness and not affected by medication


Improving Blood Pressure Control In Your Black Patient


E-Learning Program & Physician Toolkit


NJAFP
New Jersey Academy of Family Physicians
HYPERTENSION TOOLKIT
CLINICAL PRACTICE
PATIENT RESOURCES
TOOLKIT CONTENT
CONTACT US
NJAFP HOME
Hypertension Resources
Black patients in the United States face a disproportionately high risk of hypertension, and significant associated risks to their health. While reducing high blood pressure is medically rather straightforward, racial disparities persist.
This set of tools was developed to aid clinicians in detecting and treating hypertension in blacks. Expert sources were utilized in their development, and all are downloadable, with links to the sources.
We hope you find them useful and welcome feedback on additional tools you would like to see developed.
Toolkit Highlights
Cardiovascular risk assessment in black adults: history, physical exam, lab studies
This tool provides key elements of the history, physical exam, and lab studies when conducting a cardiovascular risk assessment in black adults. ...
View Tool
Edit
Considerations for use of antihypertensive drugs in blacks
Search the Toolkit
Toolkit Categories
Adherence
Classification, Evaluation, Assessment
Clinical Practice
Culturally Competent, Patient-Centered Care
ISHIB Fact Sheets for Patients
Key Studies
Lifestyle Modifications
Management of the Patient with Elevated BP
Patient Information
Patient Resources


NJAFP
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HYPERTENSION TOOLKIT
CLINICAL PRACTICE
PATIENT RESOURCES
TOOLKIT CONTENT
CONTACT US
NJAFP HOME
Category Archives: Patient Information
9 top messages for blacks about blood pressure
This patient education tool provides key information every African American should know about how to prevent and control high blood pressure. ...
View Tool
Edit
About hypertension
This patient education tool provides information about hypertension, including types, causes, measurements, dangers of hypertension, and steps to mana ...
View Tool
Edit
Realistic plans to achieve therapeutic lifestyle goals
This tool provides guidance for patients on how to develop and carry out a realistic plan to achieve therapeutic goals for controlling hypertension. I ...
View Tool
Edit
Search the Toolkit
Toolkit Categories
Adherence
Classification, Evaluation, Assessment
Clinical Practice
Culturally Competent, Patient-Centered Care
ISHIB Fact Sheets for Patients
Key Studies
Lifestyle Modifications
Management of the Patient with Elevated BP
Patient Information
Patient Resources
Pharmacologic Treatments
For Your Patients
Top messages for blacks about blood pressure
About hypertension: Types, causes, measurements, and more...
Realistic plans to achieve lifestyle goals
The DASH diet and heart-healthy cooking for African Americans


NJAFP
HYPERTENSION TOOLKIT
CLINICAL PRACTICE
PATIENT RESOURCES
TOOLKIT CONTENT
CONTACT US
NJAFP HOME
Realistic plans to achieve therapeutic lifestyle goals
Search the Toolkit
Therapeutic Lifestyle Changes
Normal weight for height
Dietary goals
Limit alcohol
Physical fitness
No tobacco use
Dietary Goals
Low fat
Low sodium
High potassium
Adequate calcium
Eat more grains, fresh fruits, and vegetables.
Eat fewer overall fats and use healthier fats, such as olive oil.
Eat fewer processed foods and fast foods.
Read labels and pay attention to the sodium and fat content of foods.
Identify high-sodium foods (e.g., potato chips or hot dogs) that can be comfortably omitted.
Identify low-sodium, high-potassium snacks (e.g., dried fruits, bananas, orange juice, raw vegetables).
Tool Details
This tool provides guidance for patients on how to develop and carry out a realistic plan to achieve therapeutic goals for controlling hypertension. It includes steps towards achieving normal weight, dietary goals, limiting alcohol, physical fitness, and no
Toolkit Categories
Adherence
Classification, Evaluation, Assessment
Clinical Practice
Culturally Competent, Patient-Centered Care
ISHIB Fact Sheets for Patients
Key Studies
Lifestyle Modifications
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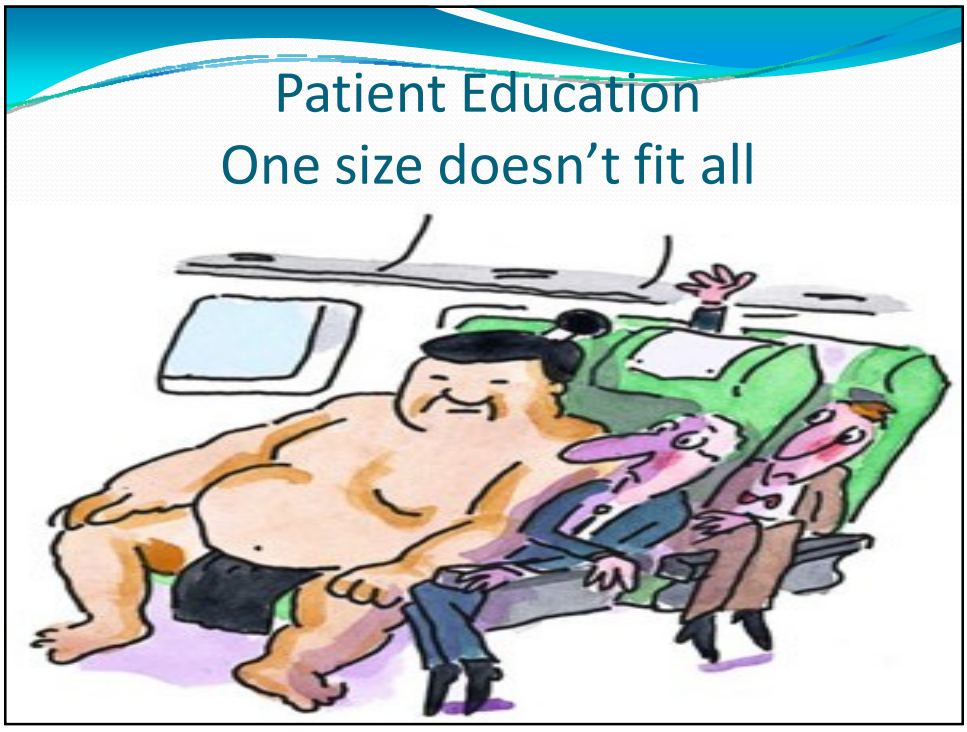
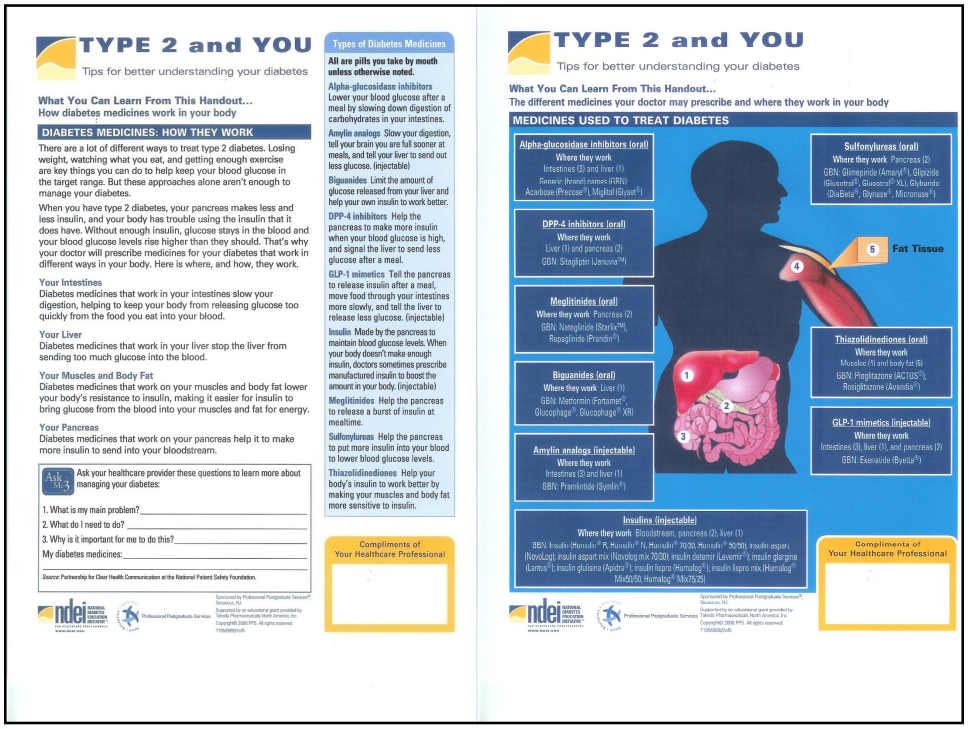

Patient Education
One size doesn't fit all



TYPE 2 and YOU

Tips for better understanding your diabetes

What You Can Learn From This Handout...
How diabetes medicines work in your body

DIABETES MEDICINES: HOW THEY WORK

There are a lot of different ways to treat type 2 diabetes. Losing weight, watching what you eat, and getting enough exercise are key things you can do to help keep your blood glucose in the target range. But these approaches alone aren't enough to manage your diabetes.

When you have type 2 diabetes, your pancreas makes less and less insulin, and your body has trouble using the insulin that it does have. Without enough insulin, glucose stays in the blood and your blood glucose levels rise higher than they should. That's why your doctor will prescribe medicines for your diabetes that work in different ways in your body. Here is where, and how, they work.

Your Intestines
Diabetes medicines that work in your intestines slow your digestion, helping to keep your body from releasing glucose too quickly from the food you eat into your blood.

Your Liver
Diabetes medicines that work in your liver stop the liver from sending too much glucose into the blood.

Your Muscles and Body Fat
Diabetes medicines that work on your muscles and body fat lower your body's resistance to insulin, making it easier for insulin to bring glucose from the blood into your muscles and fat for energy.

Your Pancreas
Diabetes medicines that work on your pancreas help it to make more insulin to send into your bloodstream.

Ask ME 3 Ask your healthcare provider these questions to learn more about managing your diabetes:

1. What is my main problem?_____
2. What do I need to do? _____
3. Why is it important for me to do this?_____

My diabetes medicines:_____

Source: Partnership for Clear Health Communication at the National Patient Safety Foundation.

Types of Diabetes Medicines

All are pills you take by mouth unless otherwise noted.

Alpha-glucosidase inhibitors Lower your blood glucose after a meal by slowing down digestion of carbohydrates in your intestines.

Amylin analogs Slow your digestion, tell your brain you are full sooner at meals, and tell your liver to send out less glucose. (injectable)

Biguanides Limit the amount of glucose released from your liver and help your own insulin to work better.

DPP-4 inhibitors Help the pancreas to make more insulin when your blood glucose is high, and signal the liver to send less glucose after a meal.

GLP-1 mimetics Tell the pancreas to release insulin after a meal, move food through your intestines more slowly, and tell the liver to release less glucose. (injectable)

Insulin Made by the pancreas to maintain blood glucose levels. When your body doesn't make enough insulin, doctors sometimes prescribe manufactured insulin to boost the amount in your body. (injectable)

Meglitinides Help the pancreas to release a burst of insulin at mealtime.

Sulfonylureas Help the pancreas to put more insulin into your blood to lower blood glucose levels.

Thiazolidinediones Help your body's insulin to work better by making your muscles and body fat more sensitive to insulin.

Compliments of Your Healthcare Professional

ndei — National Diabetes Education Initiative — Professional Postgraduate Services

TYPE 2 and YOU

Tips for better understanding your diabetes

What You Can Learn From This Handout...
The different medicines your doctor may prescribe and where they work in your body

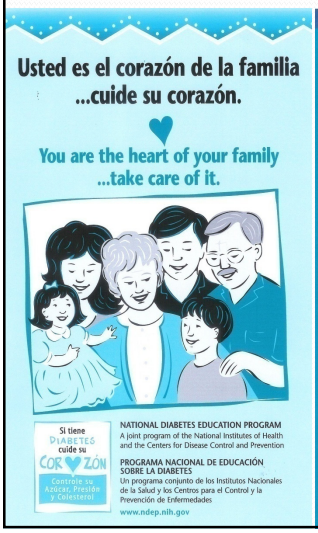
MEDICINES USED TO TREAT DIABETES

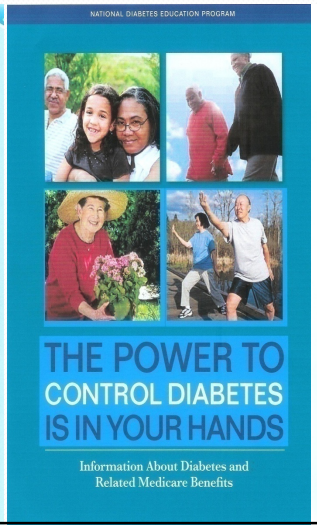
Compliments of Your Healthcare Professional

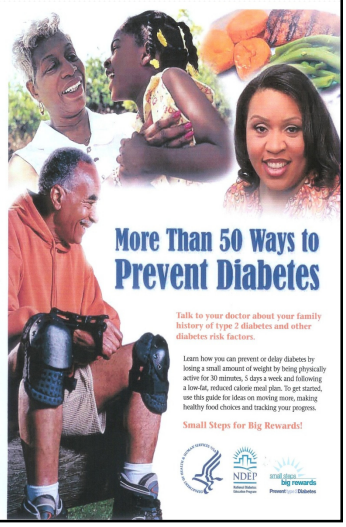
ndei — National Diabetes Education Initiative — Professional Postgraduate Services

The Office of Minority Health

Patient Education







Shared Decision Making

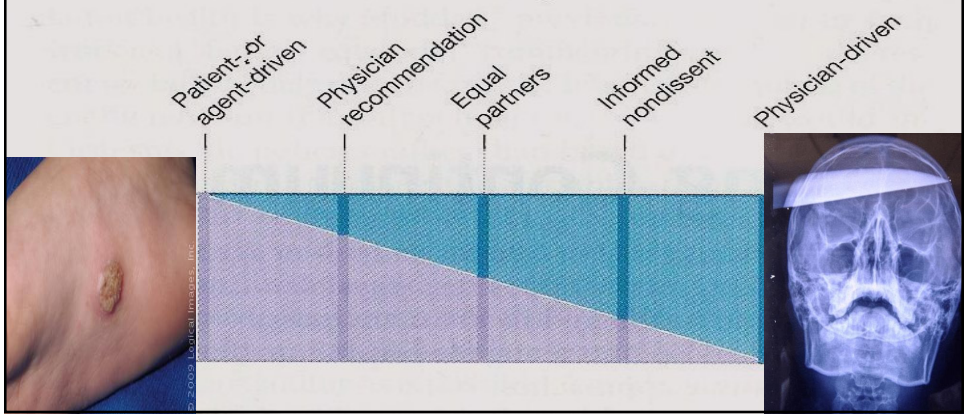
Shared Decision Making

- 2+ participants
  - Provider
  - Patient
- Information is shared
  - Knowledge (provider)
  - Values and preferences (patients)
- Participants build consensus
- Agreement is reached

The Shared Decision-Making Continuum

JAMA August 25, 2010 Vol 304, No. 8

Figure. Shared Decision-Making Continuum



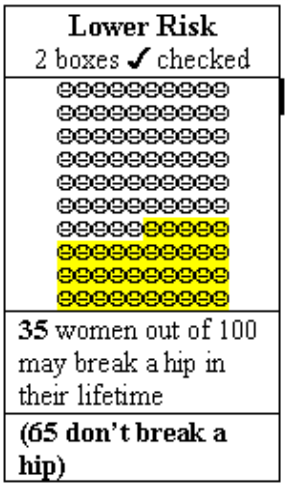
Decision Aids

- **Designed to**
  - Provide information on options
  - Help people participate in decision making
  - Help clarify and communicate personal values
- **NOT designed to**
  - Advise people to choose one option over another
  - Not meant to replace physician consultation

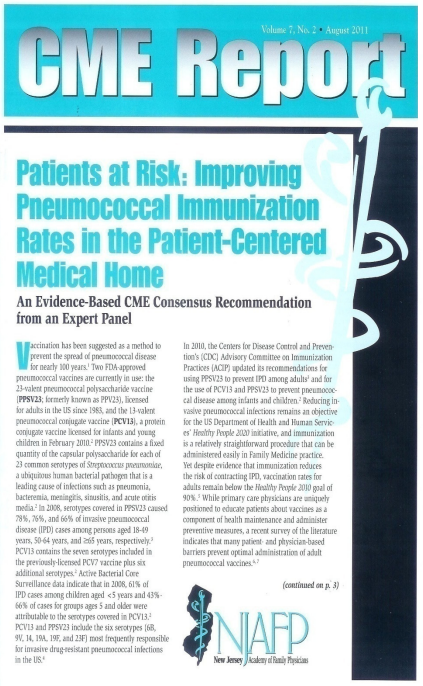
PREPARE PATIENTS TO MAKE INFORMED, VALUES-BASED DECISIONS WITH THEIR PHYSICIANS

Cornelia Ruland
http://www.dbmi.columbia.edu/homepages/cmr7001/sdm/html/decision_support.htm

Presenting Risk Information
What are the odds?



- **Similar profile:** Probability of outcome in people 'like me' who experience the problem
- **Format:** Use quantitative, qualitative and graphic formats (100 faces) to enhance understanding
- **Framing:** Risk message + 'Positive' message improves message framing


CME Report

Volume 7, No. 2 • August 2011

Patients at Risk: Improving Pneumococcal Immunization Rates in the Patient-Centered Medical Home

An Evidence-Based CME Consensus Recommendation from an Expert Panel

Vaccination has been suggested as a method to prevent the spread of pneumococcal disease for nearly 100 years.[1] Two FDA-approved pneumococcal vaccines are currently in use: the 23-valent pneumococcal polysaccharide vaccine (**PPSV23**; formerly known as PPV23), licensed for adults in the US since 1983, and the 13-valent pneumococcal conjugate vaccine (**PCV13**), a protein conjugate vaccine licensed for infants and young children in February 2010.[2] PPSV23 contains a fixed quantity of the capsular polysaccharide for each of 23 common serotypes of *Streptococcus pneumoniae*, a ubiquitous human bacterial pathogen that is a leading cause of infections such as pneumonia, bacteremia, meningitis, sinusitis, and acute otitis media.[3] In 2008, serotypes covered in PPSV23 caused 78%, 76%, and 66% of invasive pneumococcal disease (IPD) cases among persons aged 18-49 years, 50-64 years, and ≥65 years, respectively.[3] PCV13 contains the seven serotypes included in the previously-licensed PCV7 vaccine plus six additional serotypes.[3] Active Bacterial Core Surveillance data indicate that in 2008, 61% of IPD cases among children aged <5 years and 45%-66% of cases for groups ages 5 and older were attributable to the serotypes covered in PCV13.[3] PCV13 and PPSV23 include the six serotypes (6B, 9V, 14, 19A, 19F, and 23F) most frequently responsible for invasive drug-resistant pneumococcal infections in the US.[3]

In 2010, the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) updated its recommendations for using PPSV23 to prevent IPD among adults[4] and for the use of PCV13 and PPSV23 to prevent pneumococcal disease among infants and children.[2] Reducing invasive pneumococcal infections remains an objective for the US Department of Health and Human Services' *Healthy People 2020* initiative, and immunization is a relatively straightforward procedure that can be administered easily in Family Medicine practice. Yet despite evidence that immunization reduces the risk of contracting IPD, vaccination rates for adults remain below the *Healthy People 2010* goal of 90%.[5] While primary care physicians are uniquely positioned to educate patients about vaccines as a component of health maintenance and administer preventive measures, a recent survey of the literature indicates that many patient- and physician-based barriers prevent optimal administration of adult pneumococcal vaccines.[6,7]

(continued on p. 3)

NJAFP New Jersey Academy of Family Physicians

Overcoming Barriers: Communicating with Patients and Parents about Pneumococcal Vaccination

- *Uncertainties about vaccine efficacy*
- *Concerns about safety*
- *Vaccination not recommended/discussed by provider*
- *Payment, insurance concerns*

The CDC, American Academy of Family Physicians, and the American Academy of Pediatrics have created *Provider Resources for Vaccine Conversations with Parents* (***www.cdc.gov/vaccines/spec-grps/hcp/conv-materials.htm#providers***), which includes specific suggestions for responding to common concerns

Physician Barriers

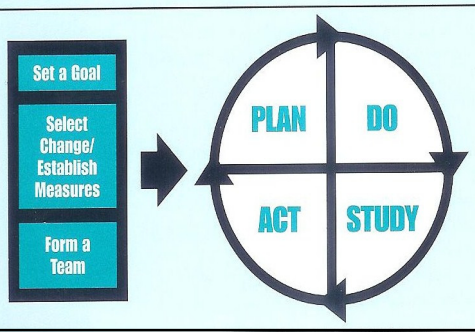
- *Uncertainty of patient's vaccination status*
- *Lack of standing orders regarding vaccination*
- *Lack of office-based systems or procedures to promote vaccination*
- *Limited time allotted per visit*
- *Concerns about vaccine efficacy in immunocompromised patients*

Resources for Creating Standing Orders

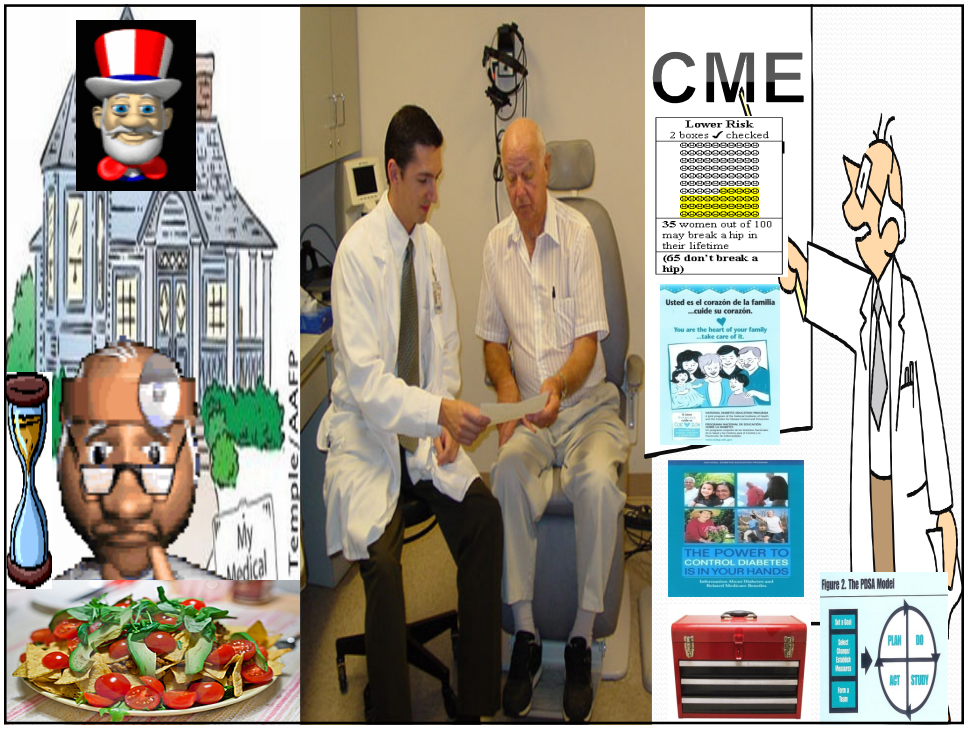
Immunization Action Coalition (*www.immunize.org*):
Sample standing order protocols for nearly all vaccines

Society of Teachers of Family Medicine Group on Immunization Education (*www.immunizationed.org/standingorders*):
CDC-funded toolkit for creating standing orders

Figure 2. The PDSA Model



PLAN	• *Convene a team of providers, nurses, and staff* • *Appoint a "vaccine champion" to oversee daily assessment* • *Agree that all persons who have authority to take vital signs will tag charts of patients age 65 and older for immunization status* • *Physician will use this cue to discuss immunization*
DO	• *Require physician to confirm documentation and record patient response/immunization* • *Set up spreadsheet or database to track outcomes*
STUDY	• *Audit charts after 1 month* • *Compare charts with database* • *Evaluate for immunization rate, number of unclear "missed opportunities"*
ACT	• *Convene monthly feedback sessions for staff* • *Distribute a follow-up survey* • *Offer rewards/incentives for staff based on reaching goals.*



Until Next Time…

- Please join us for our next webinar – CS2Day Data Capture
  - George Mejicano, MD, MS, Associate Dean & Director University of Wisconsin Office of Continuing Professional Development
  - Friday, November 4, 2011
  - 11am ET
- Current grant window: September 1 – October 15 for activities starting after January 1, 2012
- See what providers are doing to move education forward
  - PfizerMedEdGrants
    - Resource Center
      - Publications
      - First Friday Webinars
    - Transparency Report
  - Follow us on twitter: PfizerMEG