

A Framework for Transformational Change: Social Work Values and Skills Impacting Systems of Care

Examples from the U.S. Experience – Global Challenges

W. June Simmons, LCSW

President and CEO

Partners in Care Foundation

6th International Conference on Social Work in Health and Mental Health

June 29, 2010

Dublin, Ireland



Today's Outline

- Unique Value of Social Work Guiding Change
- Our Strategic Environment – Economic Crisis, Demographic Imperative and Shifts in Health Patterns – U.S. data reflects Global Challenge
- A Framework for Change
- Moving From Incremental Change to Tipping Point
- Call to Action

Social Work – a Key Champion for Changing Healthcare

- Social Work's Ecological Perspective
- Comprehensive perspective of delivery system
- Designing from patient experience
- Designing from systemic flaws
- Skills in collaboration
- Source of Vision: lead/guide, but not the voice

Partners' Mission

- Partners in Care Foundation changes the shape of healthcare and social services so they work better for everyone. With our community collaborators and funders, Partners develops, tests, and disseminates high-impact, innovative models of care that bring more efficient and effective health and social services to diverse people and communities.
- Our areas of emphasis and evidence-based new models of care address the issues of:
 - Access to Care
 - Aging Well
 - End-of-Life Care
 - Families at Risk
 - Prevention

Worldwide Economic Crisis – Opportunity for Basic Change

Adversity = Opportunity

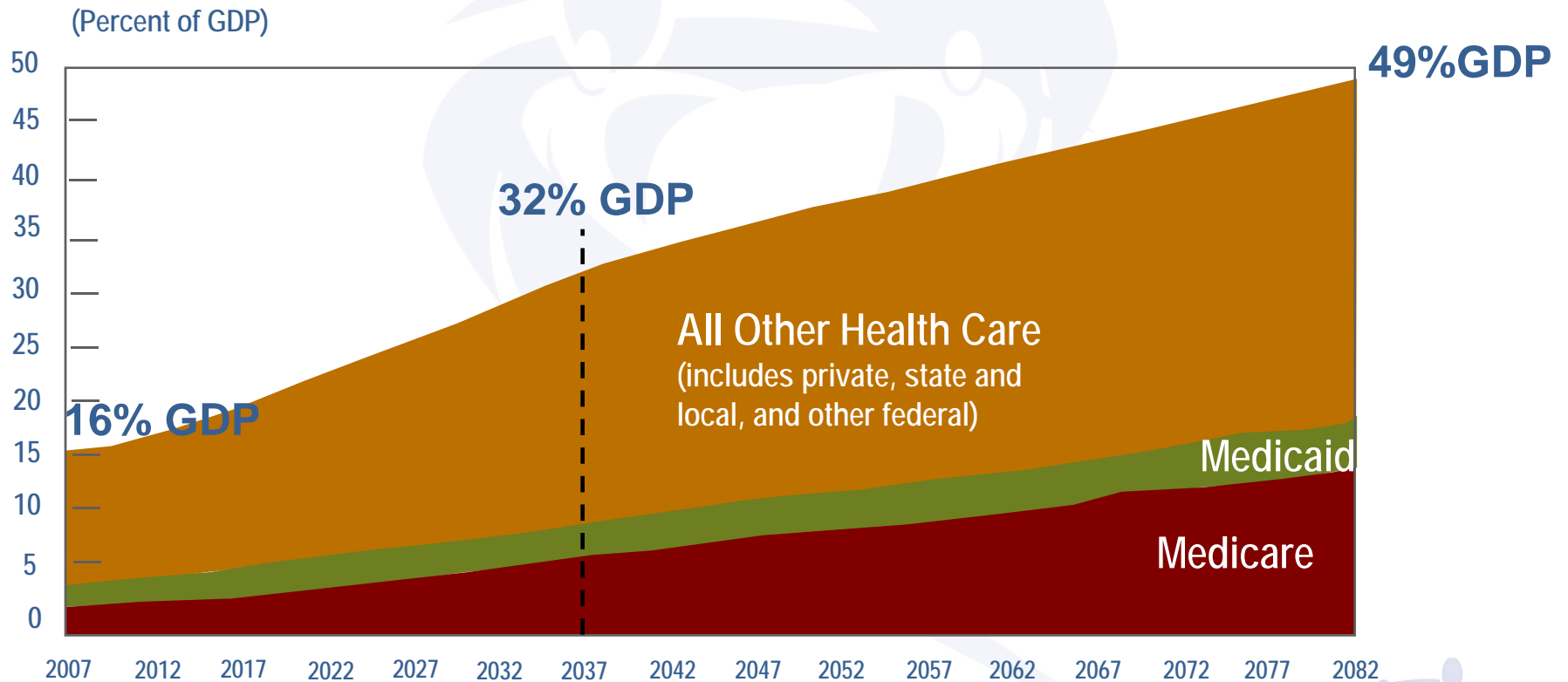
Strategic Environment – challenges and opportunities

- World economy in crisis
- Health care costs continue to rise
- In USA failings of system are profound and widely acknowledged
- Pressure is building for transformation



Rising Health Care Costs Will Continue to be a Significant Threat To U.S. Economy

Projected Spending on Health Care as a Percentage of Gross Domestic Product (GDP)



Source: The Long-Term Outlook for Health Care Spending, November 2007, Congressional Budget Office

Note: Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

Shift in Population Causes Redesign of Health System in U.S. and Worldwide

- Longer life span and delayed disability
- Shift from episodes of injury and illness to **CHRONIC PROGRESSIVE CONDITIONS**
- Requires new paradigm for health & healthcare

Dual Impact: Aging and Chronic Disease

- Rapid growth of older populations – longer life span
- 87% of persons aged 65 and over have at least one chronic condition; 67% have 2 or more
- 99% of Medicare spending is on behalf of beneficiaries with at least one chronic condition
- 1.7 million Americans die of a chronic disease each year
- Chronic diseases affect the quality of life of 90 million
- Ethnic and income health disparities intensify the issues

What is a chronic disease?

- Arthritis
- Chronic lung disease
- Diabetes
- Heart condition
- Cardiovascular disease
- Chronic pain
- Depression
- Cancer
- Stroke
- Any ongoing health condition

Four chronic conditions cause 2/3 of all U.S. deaths annually:

Heart Disease

Cancer

Stroke

Diabetes

Opportunity for Impact: Chronic Conditions

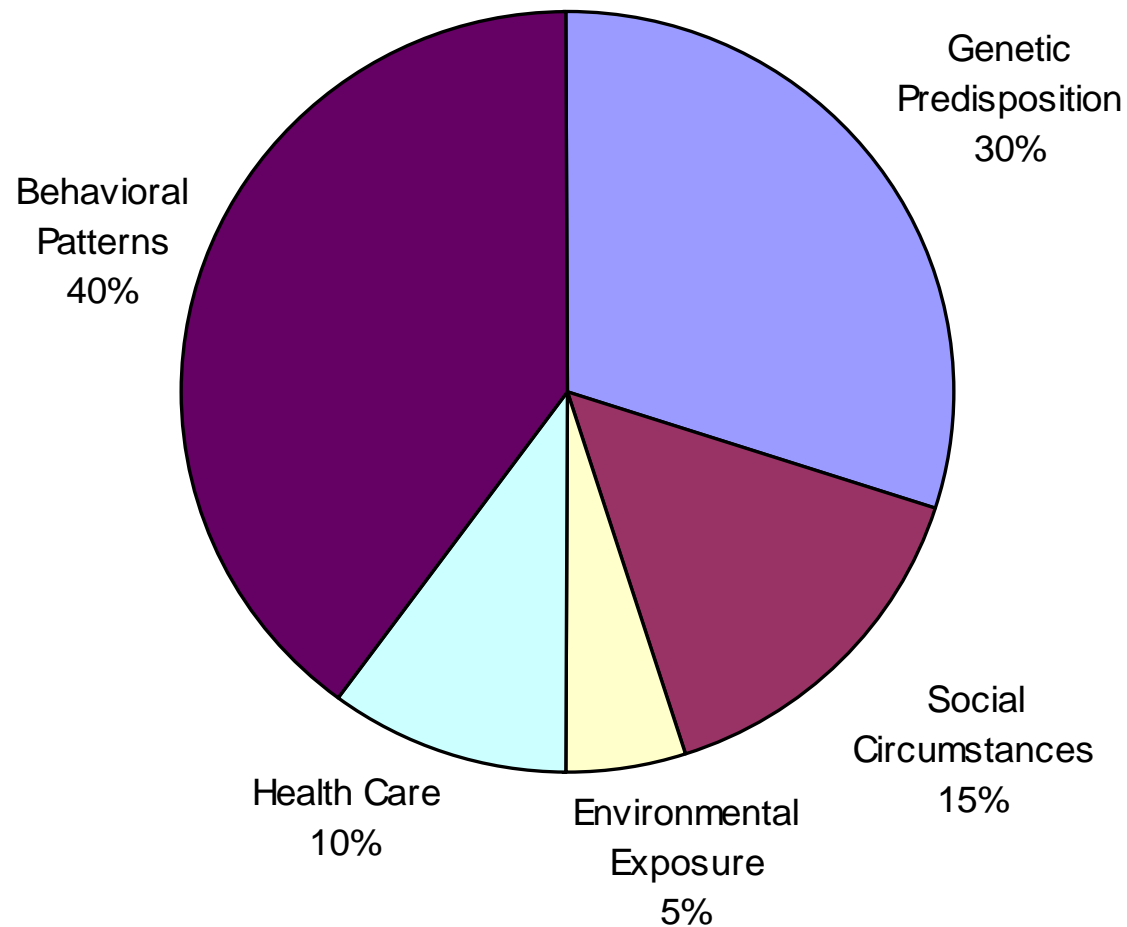
- ~50% of Americans have a chronic condition
 - ~25% have multiple chronic conditions.
- 7 of 10 deaths in US each year due to chronic disease.
- ~ 7% of Medicaid population but 54% of costs.
- ~ 80% of health care costs go to 20% of patients -- those with chronic diseases.

80% of Health Dollars Spent on Chronic Conditions in U.S.

- 31% of Americans are obese
- Adults are not physically active (28-34% aged 65-74; 35-44% aged 75+)
- Rates of obesity in children (16-33%)
- Type II diabetes skyrocketing – 40% increase in '90s. 6.9% of Americans; 20% among 65+
- Ethnic health disparities dramatic



Determinants of Health and Contribution to Premature Death

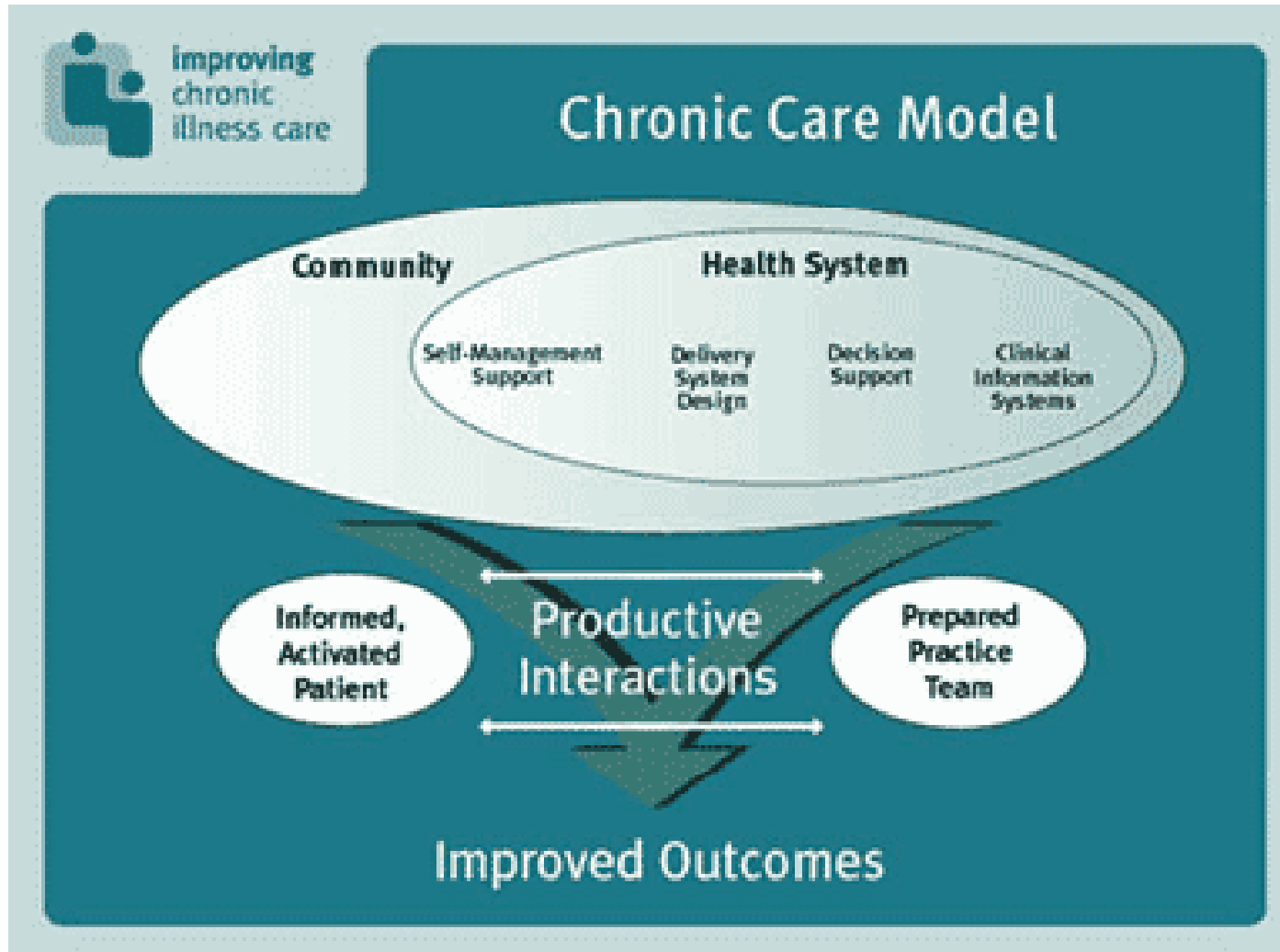


Source: Stephen A. Schroeder, MD. *We Can Do Better*. NEJM 357:12

New Models of Care are Urgently Needed

- Reallocation of existing dollars from care to prevention and promoting health
- Strengthen community and home care – reduce use of institutions
- Reduce fragmentation – increase integration to address chronic disease

Chronic Care Model



[Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998;1(1):2-4.]

Chronic Care Model – Social Work Leadership Roles

- Self Management – Patients educated and activated to take control
- Delivery System Re-Design – Coordinated Team approach with systematized follow-up
- Community – Alliances and partnerships with health providers, state programs, local agencies, schools, faith organizations and businesses

Need to work with whole person and family

- Facing complex and fragmented system
- Need to integrate personal care and medical care
- Interdisciplinary team needed
- Fundamental re-design is required – in large, complex system
- Both systemic and individual changes face the same human challenge in changing behavior
 - The natural realm of social work

Building Infrastructures for Health

- Physician offices need to connect to community resources to build health
- Creation of widespread community-based programs to address lifestyle change are needed – especially to manage risks like diabetes progressing, heart disease & falls
- Evidence-based programs are essential

Background

What is Evidence-Based Programming?

- Tested models or interventions that directly address the health risks of the target population
- Advantages:
 - Provides tangible scientific evidence that program works
 - Increases likelihood of successful outcomes
 - Increases effective use of resources

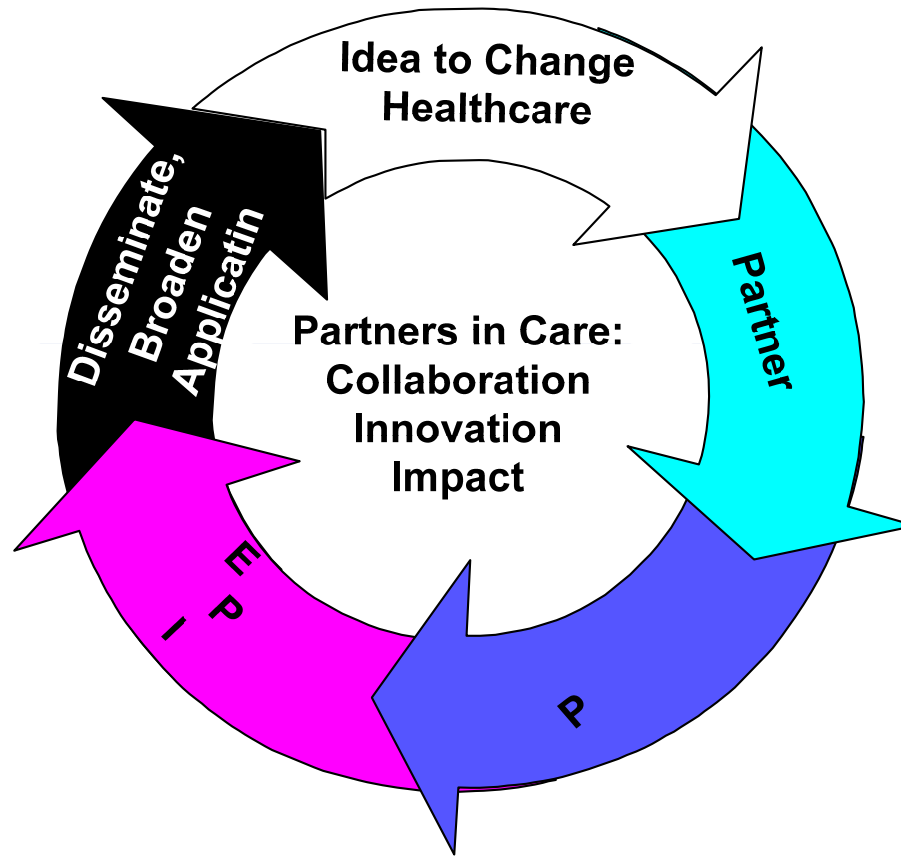
Background

Evidence-Based Models



“Evidence-Based Disease Prevention” program refers to a program that closely replicates a specific intervention that has been tested through randomly controlled experiments with results published in peer-reviewed journals

The Partners Model of Change



Take evidence-based practice to new environments, adapt for extended use, disseminate results, begin again with new partners.

Finding the Focus for Change

- Commit to Driving Change
- Follow Your Passion
- The 80/20 Rule is Key
 - Focus on powerful well-documented problems
 - Find the voice for the vision
 - Make the project visible and measureable
 - Drive change with results from day one to finish

Our Framework for Change

- Identify an issue that is relevant to our mission and strengths:
 - Impacts a large population
 - Causes significant suffering and harm
 - Costly – significant expenditures in place
 - Promising and Practical – opportunity for high clinical and financial impact
 - Proving ground available
 - Strong product champion

Core Program Strategies:

- **Drive** provider practice change
- **Lead** creation and adoption of healthy behaviors
- **Change** design and delivery of home care and community services

Focus of All Interventions – Behavior Change

- New Models of Care – Practice Change
 - Systems
 - Organizations
- New Ways of Living
 - Individuals and Families
- Brief Negotiation Principles Apply to Both Types of Change
 - Stages of Change/Readiness Assessment
 - Query vs. Direction
 - Goals and Action Plans
 - Tracking Progress with Peers



Stages of Change

- Stages of Change Model (Prochaska & DiClemente 1983)
 - Pre-contemplation (no interest in suggested change)
 - Contemplation (thinking about change, but plans not made)
 - Preparation (planning how to make the change)
 - Action (change initiative launched)
 - Maintenance (sustains new behavior)

Readiness Ruler - A Simple Tool

How ready are you to consider
changing _____?



Assess Readiness

Why a 5 and not a 2?

What would help you move you from a 5 to a 7?

What are some reasons for making a change?

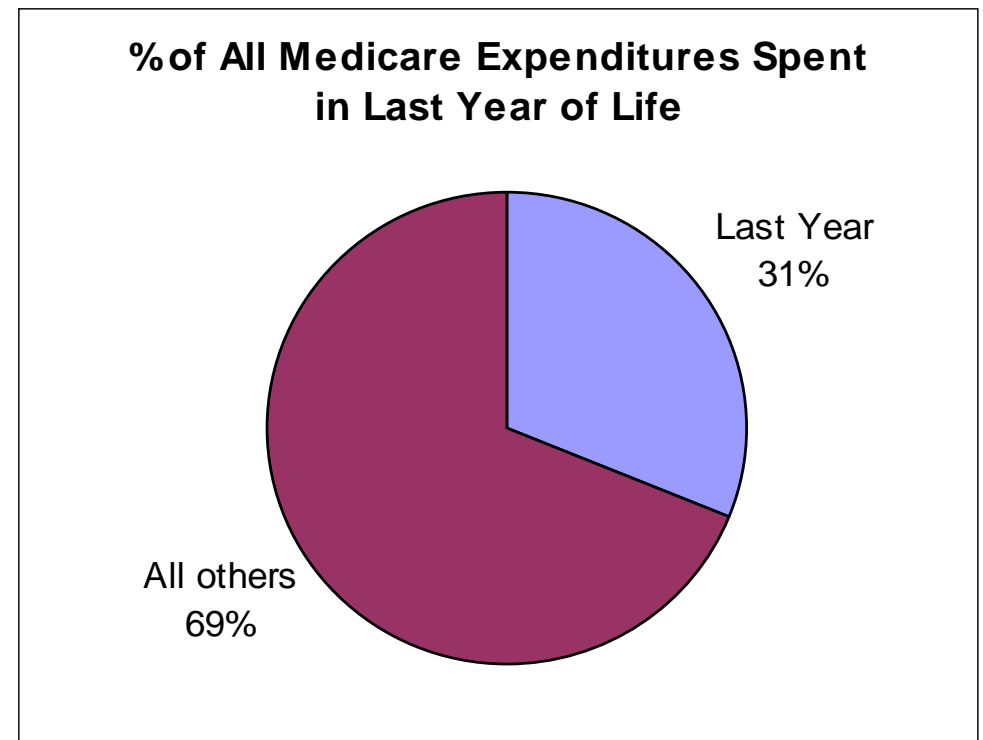
What barriers might you encounter when making this change?

Core Program Strategies:

- **Drive** provider practice change

Opportunity for Impact: End-of-Life Care

- 27.2 - 30.6 % of Medicare dollars spent on last year of life
 - Half of that spent on last 2 months of life
- Partners' Response: Decrease use of inappropriate acute care
 - Palliative Care – In-Home and Hospital-Based
 - Promoting Use of Advance Directives



James D. Lubitz, and Gerald F. Riley Trends in Medicare Payments in the Last Year of Life, NEJM, 328:1092-1096

Palliative Care at Home

- Example of change “over time”
 - Complex intervention – major change
 - 15 years of work & multiple funders
 - major results with Kaiser Permanente
 - Challenges in further spread/now alleviating
 - major example of physician and nurse leader advocates and inter-disciplinary approach

AICC – Advanced Illness Care Coordination

- Based on prior work (Dan Tobin, Veterans Administration) – with powerful physician partners
- Simple but powerful intervention – relies on interdisciplinary work, but social work intervention
- Important findings and social work friendly
- Strong metaphor for power of “patient”- engagement/activation & brief interventions

Core Program Strategies:

1. **Lead creation and adoption of healthy behaviors in all adults, especially elders and people with chronic conditions by:**

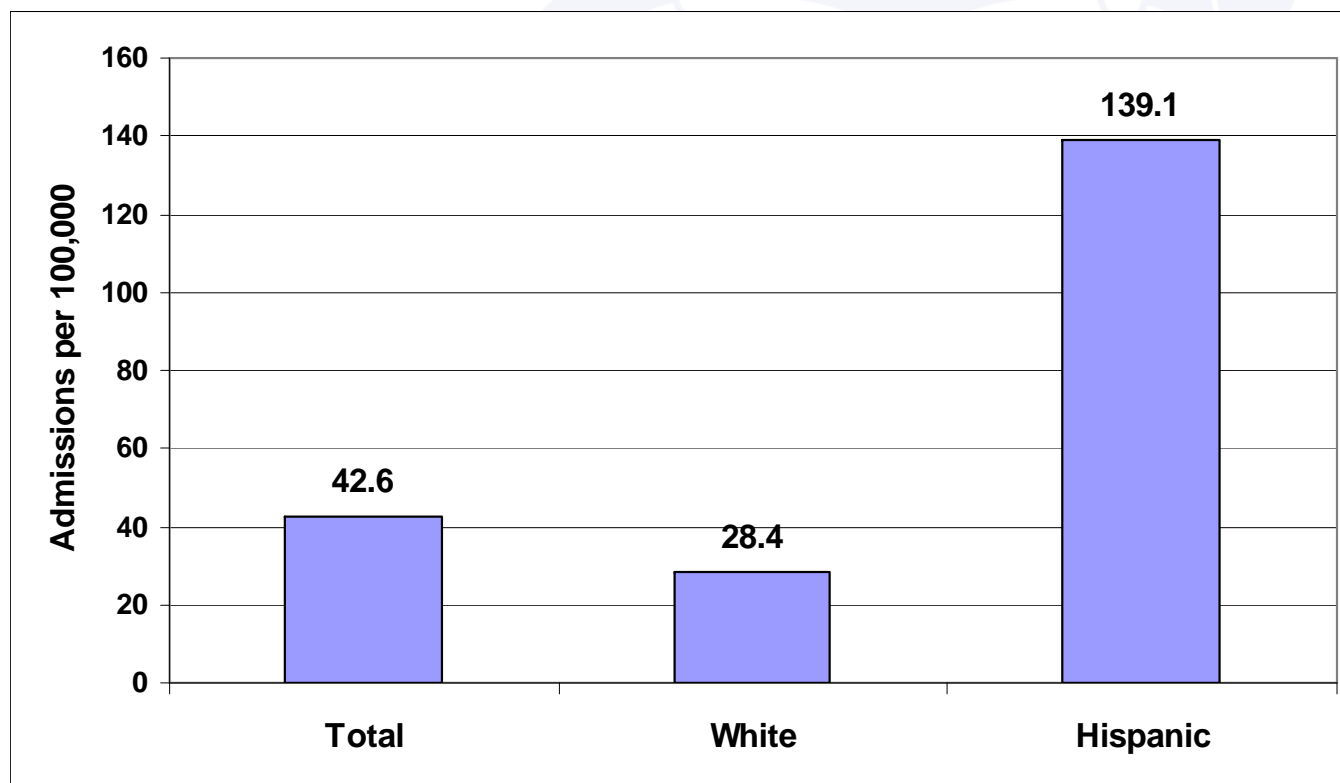
Creating and spreading evidence-based programs that improve physical and emotional health and quality of life for individuals by empowering them to change their health-related behaviors

40% of Deaths in U.S. Attributed to Modifiable Risk Factors

- Smoking was king
- Obesity and lack of physical activity
- Chronic conditions result:
 - Diabetes
 - Respiratory conditions
 - Cardiovascular
 - Arthritis
 - Cancer

Ethnic Health Disparities: Diabetes Among Hispanics

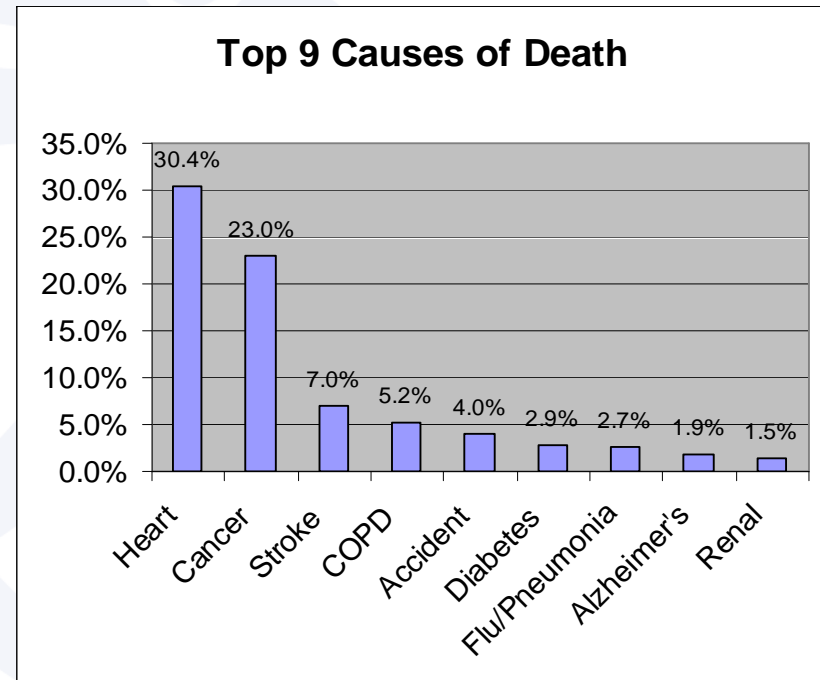
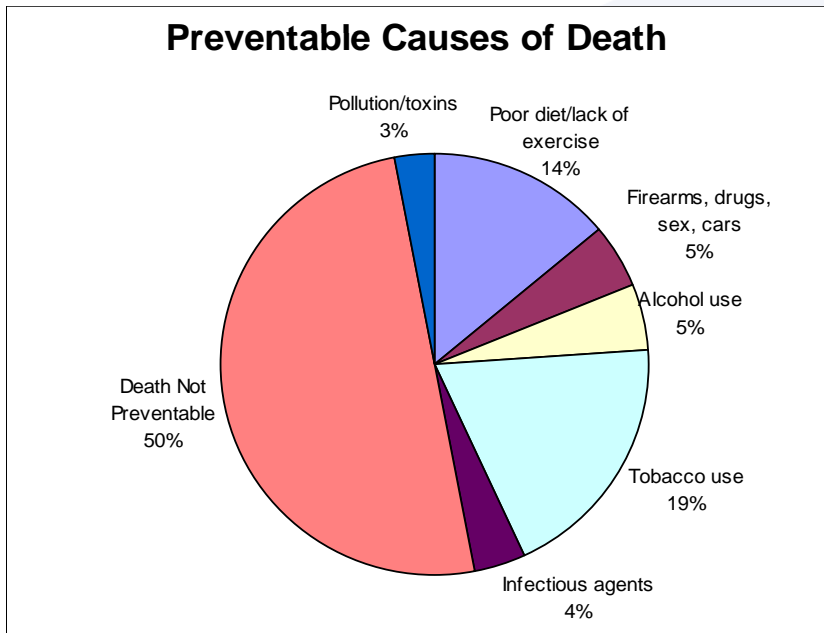
Admissions for uncontrolled diabetes without complications per 100,000 population, age 65 and over, by ethnicity, 2004



Partners'
Response:
DPHP's
Club de Salud
[Wellness Club];
Healthier Living

2006 National Healthcare Disparities Report

Opportunity for Impact: Prevention of Premature Deaths

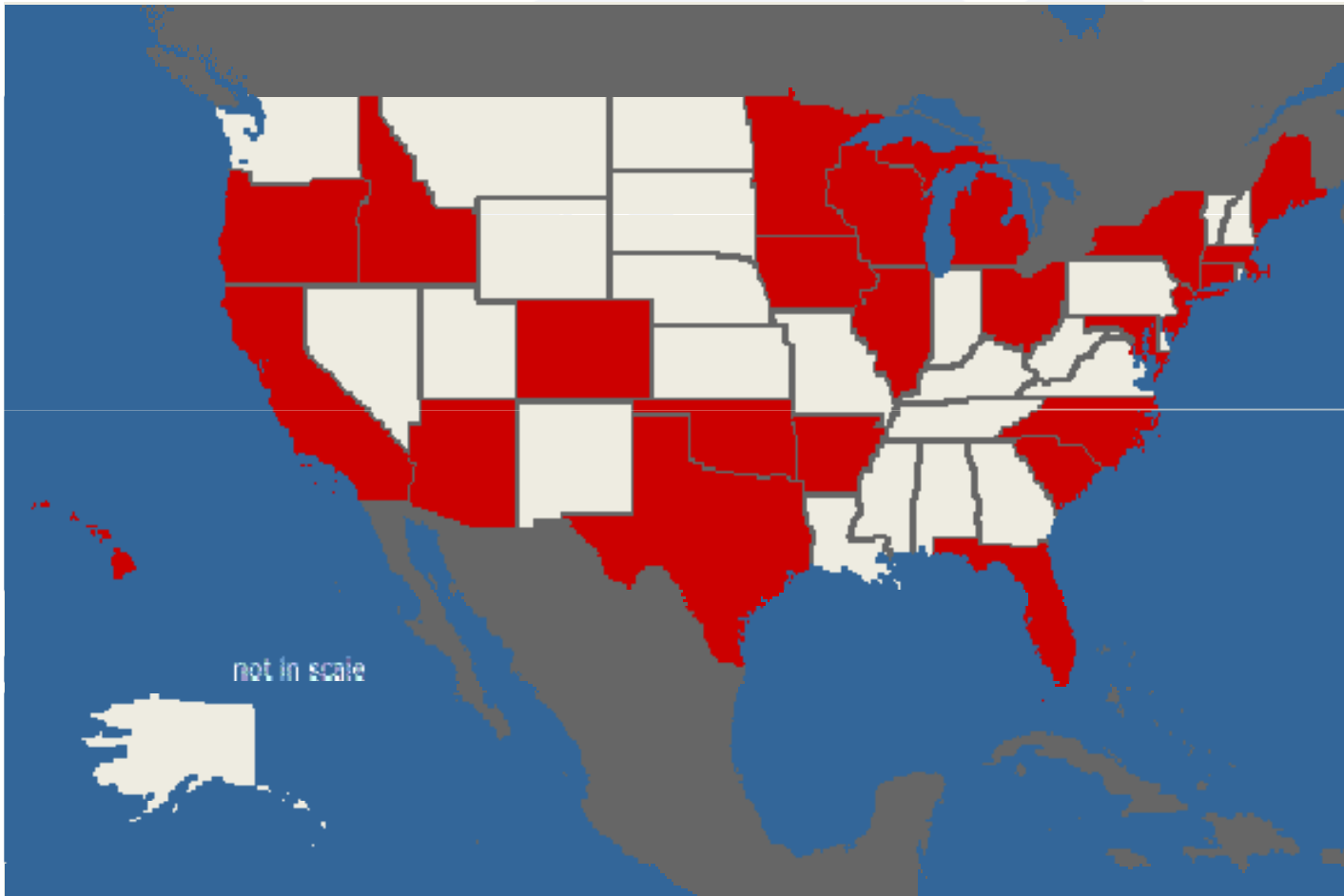


Source: Mokdad, Ali H., Marks, James S. and Stroup Donna F. et. al. Actual Causes of Death in the United States, 2000. JAMA. 2004;291:1238-1245

National Response: Evidence- Based Programs for Preventing Disease and Promoting Health - Activation

The National Scene

States Implementing AoA Funded Evidence-Based Programs



AR, AZ, CA,
CO, CT, FL, HI,
ID, IL, IA, ME,
MD, MA, MI,
MN, NJ, NY, NC,
OH, OK, OR,
SC, TX, WI

Administration on Aging's Approved Evidence-Based Programs

- *Healthy Moves for Aging Well**
- Medication Management Improvement System*
- Chronic Disease Self-Management Program
- A Matter of Balance
- Enhance Wellness
- Active Choices
- Enhance Fitness
- Strong for Life
- Healthy IDEAS or PEARLS
- Prevention & Management of Alcohol Problems in Older Adults

*Developed by Partners in Care



California Evidence-Based Initiative 2006

- California Departments of Aging and Health awarded 3-year grant from Administration on Aging
- Initiative brings evidence-based programming to age-based organizations
- Partners in Care is the state program office, *California Health Innovation Center*



Partners California Experience

CDSMP/Healthier Living: How it works

- Offers participants effective and practical coping strategies to manage their health conditions
- The program includes a series of 2-½-hour workshops presented over a 6-week period by two trained leaders
- Curriculum includes behavior modification and coping strategies to enable participants to better cope with their chronic diseases, manage their medications, and increase physical activity levels
- Effective communication skills with family, friends, and health professionals
- Participants report significant improvement in their general health as well as improved attitude and gained skills

Partners California Experience

CDSMP / Healthier Living: Outcomes

- Impacts patient self-efficacy
- Creates engaged patient
- Supplements health care services

Partners California Experience

CDSMP Effect on Utilization

- Fewer outpatient visits
- Fewer emergency room (ER) visits
- Fewer hospitalizations
- Fewer days in hospital
- More appropriate utilization of health care resources

Target Sectors For Adoption / Engagement



Core Program Strategies:

- **Change** design and delivery of home care and community services

Partners California Experience

Medication Management Improvement Systems (MMIS): Why we need it

Medication-related problems and errors are:

- Serious: 1.5 million preventable adverse drug events (ADEs) annually; 7,000 deaths per year. ^{1,3}
- Frequent: Up to 48% of community dwelling older adults have medication-related problems ²
- Costly: Drug-related morbidity/mortality for seniors > \$170 billion (incl. hospital and SNF admissions)
- Preventable: $\geq 25\%$ of ADEs in ambulatory settings

1. IOM (1999) *To err is human: Building a safer health system*. Kohn, L., Corrigan, J., Donaldson, M. (Eds.) National Academy Press, Washington D.C.
2. Zhan C, Sangl J, Bierman AS et al. Potentially inappropriate medication use in the community-dwelling elderly: findings from the 1996 Medical Expenditure Panel Survey. *JAMA*. 2001; 286:2823-9.
3. IOM (2006) *Preventing Medication Errors*.

Partners California Experience

MMIS Evolution

- **Hartford Phase 1993-2003 Home Health Agency**
 - Vanderbilt Univ. randomized controlled trial to improve medication use; developed, tested, disseminated and adopted
- **AOA Evidence-Based Prevention Initiative, 2003-2007**
 - Community-Based Medication Intervention
 - Model successful in Medicaid waiver programs
- **2006–2010, Hartford Foundation**
 - Taking meds management statewide (CA) first; then nationwide in care management!

Current Rapid Change: Readmissions

- National average re-admissions of Medicare patients within 30 days: 20%
- Planned reduction in revenues by 2012
- Evidence-based models to reduce readmissions

Key Elements of Social Work Change Initiatives

- Proven & important problem – DATA!
- Stories – examples from practice of needed change
- Case for sustainability
- Social work support for data integrity and broad communications impact
- Product champion –
 - Bring the vision to the VOICE for change
 - Benefits to both build change partnership for the future

Changing American Culture

- We are in the service of a great vision
 - Mainstreaming access to powerful tools for health
 - Building a platform for better quality of life
 - Less pain
 - Less illness
 - Greater mobility and better function
 - This is a MISSION, not a PROJECT

Going to Scale

- This is challenging work that needs to:
 - Reach large numbers of people – a new “utility”
 - Maintain fidelity
 - Be sustainable/cost-effective and consumer-engaging
- New models for success: moving toward social enterprise : new partnerships and business cases

Time For Positive Change – Seize The Crisis

- Social Work Perspective Essential
- Right Partnerships Key For Broader Skills & Access
- The Time is Now!

Green “Handouts”

- Please go to the Partners in Care website to download this presentation
- www.picf.org - Click on Presentations
- You can also find information and Toolkits on other evidence-based model programs