

Communities Working Together for Prevention and Wellness

Meeting the Chronic Health Care Challenge

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Partners in Care Foundation: Mission

- Partners is a think-tank and a proving ground
- Partners changes the shape of health care by creating high-impact, innovative ways of bringing more effective clinical and social services to people and communities
- Partners' direct services test, measure, refine and replicate innovative programs and services, and bring needed care to diverse populations

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 – opportunity for high impact through innovation
 - Proving ground available – evidence-based
 - Sustainable

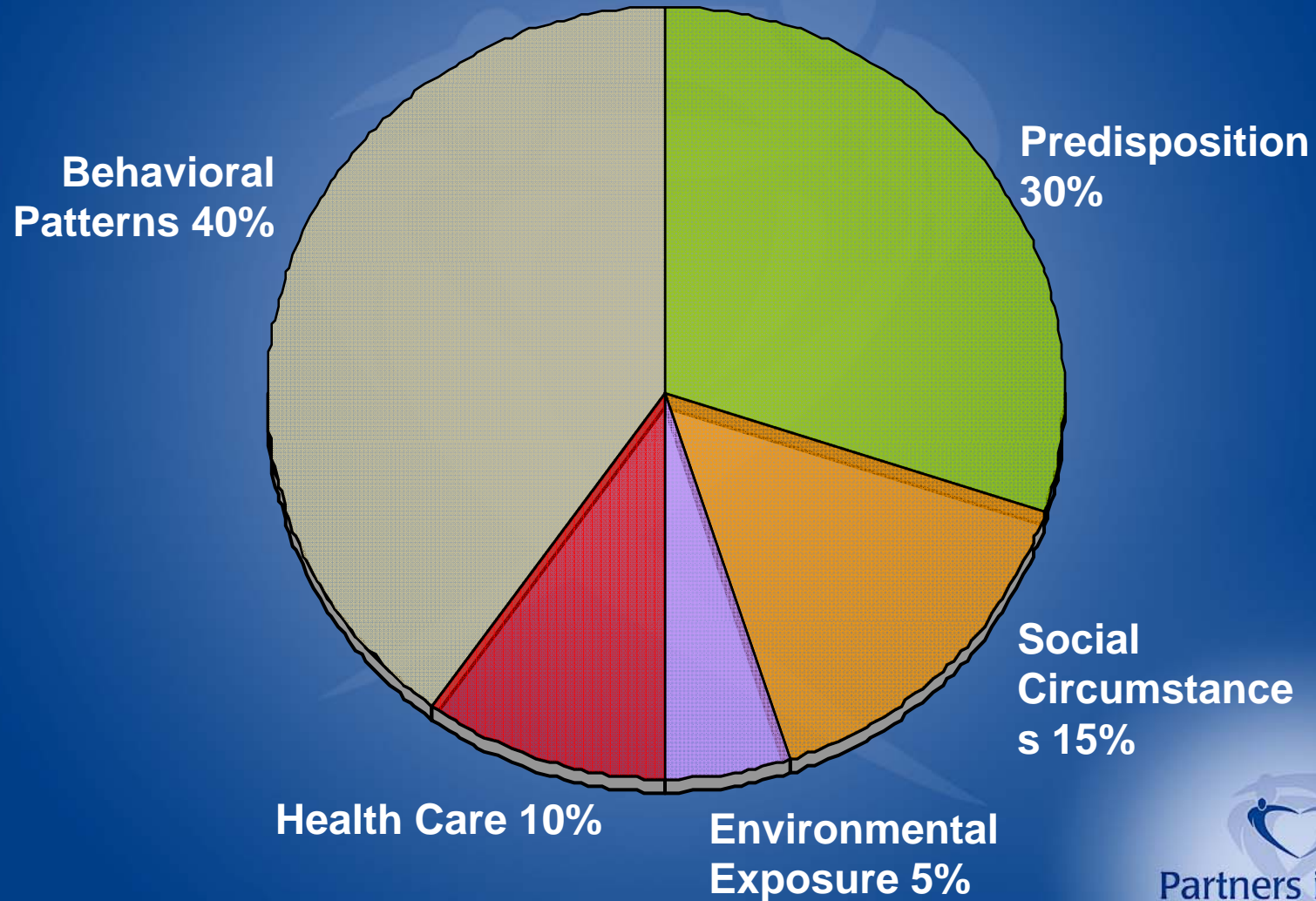
The Strategic Environment: Challenges and Opportunities

- U.S. health care system is in crisis
- Failings of system are profound and widely acknowledged
- Pressure is building for transformation

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

Determinants of Health & Contribution to Premature Death



New Models of Care are 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 diseases

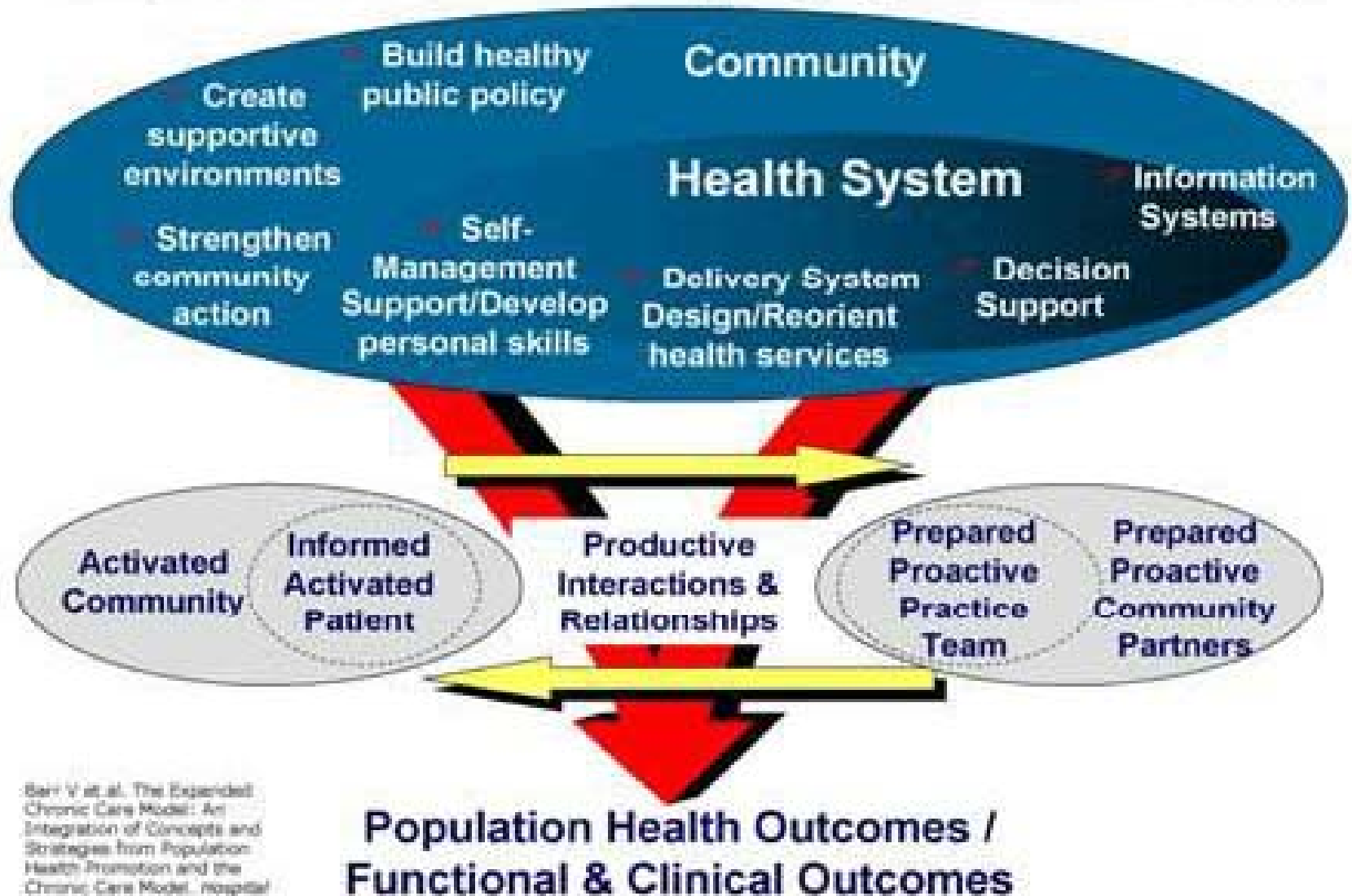
Building Infrastructures for Health

- 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

More than new infrastructure

- Need “pathways to health”
 - methods to identify those who will benefit
 - brief methods to open the door to change
 - skills and tools to enhance class completion
 - alternatives available for continuing involvement in healthy lifestyle

The Expanded Chronic Care Model: Integrating Population Health Promotion



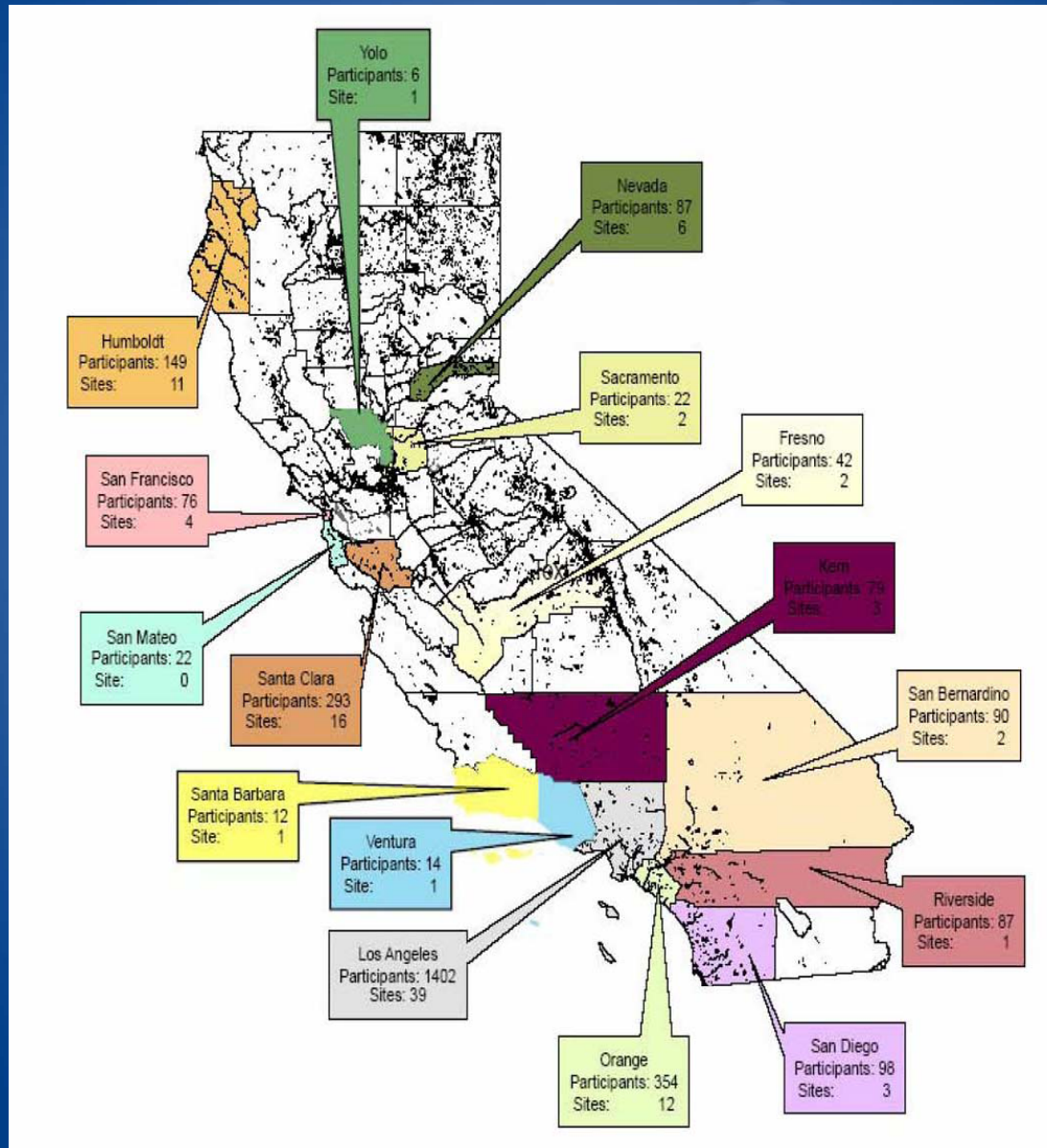
Sarr V et al. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. *Hospital Quarterly* 2003;7(1):73-82

California Evidence-Based Initiative 2006

- California Departments of Aging and Health awarded 4-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*



Statewide Program Reach



Statewide Program Reach

- 19 counties...and growing
- 25 major partnering organizations
- 135 participating locations
- 189 program facilitators
- 3,745 participants to date

Current Evidence-Based Programs

- *Matter of Balance*: managing concerns about falls
- Healthy Moves for Aging Well
- *Medication Management Improvement System (MMIS)*
- *Healthier Living*: managing ongoing health conditions



What must a person do to manage Chronic Disease?

- Manage the disease(s)
- Maintain their life roles
- Deal with the emotional consequences of the disease(s)

Healthier Living: the Stanford Model

- Powerful method for patient activation – vs. health education
- Engages individuals in goal setting and action plans with peer support
- Available in multiple languages

Chronic Disease Self-Management Small Group Program - What Is It?

- 10-16 people
- People with many different diseases and comorbid conditions in same group
- 2 ½ hours per week for 6 weeks
- Peer taught

What is Taught?

- Managing symptoms-(*pain, fatigue, depression, shortness of breath*)
- Exercise
- Relaxation Techniques
- Healthy Eating
- Communication Skills
- Medication management
- Problem Solving
- Action Planning

California Medical Center Small Group Demonstration Project

- 1,000 people with various chronic diseases followed for 3 years – mostly in Spanish
- 6-month improvements in health outcomes
 - ↑ Self-rated health & energy
 - ↓ Disability & fatigue
 - ↓ Social and role activities limitations
 - ↓ Distress with health state
- Improvements in utilization/costs
 - Average .8 fewer days in hospital in past 6 mo. (p=.02)
 - Trend toward fewer outpatient & ER visits

One year On Line positive results include:

- Fatigue
 - Health Distress
 - Shortness of Breath
 - Pain
 - Communications with Physicians
 - Exercise
 - Self-Efficacy
- p<.05

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74% return rate*

Models for Patient Recruitment California

- Health Systems
- Physician Groups
- Harvard Research Results
- Community Partner Organizations

Our Network of Partners

Key project partners include:

- AoA/CDA/CDPH
- National Council on Aging
- California Association of Physician Groups (CAPG)
- Avanti Hospital System
- Catholic HealthCare West
- Health Care Partners/Facey/AltaMed
- The Health Trust
- Kaiser Permanente
- AltaMed

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
- Part of a 24-state national initiative – moving toward a social enterprise

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**

Seize the Opportunity

- A time of potential transformation
- Must rise to the occasion
- Going to scale is key

Green “Handouts”

- Please go to the partners in care website to download this presentation
- WWW.PICF.ORG
- Click on [Presentations](#)