

Equity Minded Team-Based Care

Part 2: Evidence-based Practice Strategies Equity Minded Teams Can Use



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KEY WORDS

- Non-compliance
- Adherence
- Partnership
- Patient Centered Care
- Empowerment
- Language
- Health Literacy
- Teach Back
- Shared Decision Making
- Motivational Interviewing
- Care Management
- Population Health
- Social Needs
- Care Coordination
- Upstream Thinking

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In the U.S.

- Health care teams are called on to provide care and improve health outcomes for complex and chronically ill patients
- Two groups experience problems with their health care more intensely and more frequently than any other
 - High Need, High-Cost Populations
 - At Risk or Vulnerable Populations

Most at risk to experience healthcare inequities

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Health Equity

Everyone has a fair and just opportunity to be as healthy as possible.

- Requires removing obstacles to health
 - Poverty
 - Discrimination and related consequences including powerlessness
 - Lack of access to good jobs with fair pay
 - Quality education
 - Housing
 - Safe environments
 - Health care



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The Case of Mrs. F

C.F. is a 54-year-old woman with type 2 diabetes. She was seen in the clinic to follow up on a recent emergency room visit for bilateral foot pain. Previously she had been diagnosed with diabetic neuropathy and started on gabapentin 300mg three times daily. She was having side effects of fatigue and was unsatisfied with her circumstances. Her last visit to her primary care provider was 3 months earlier when she was restarted on oral agents for diabetes, after refusing short-term insulin or home blood glucose monitoring. She had insulin glargine available and used it on occasion. Her glycated hemoglobin was 15.8 g/dL when measured 8 months earlier.

At this visit her views and potential complications from long-term hyperglycemia were discussed. She declined short-acting insulin and referral to endocrine, podiatry or dietetic assessment. She agreed to lab work and restarting gabapentin at bedtime with a slow taper over time. She refused to follow up in 2 weeks but "would call when she was ready and not before".

When the healthcare team met, the provider updated the team on the agreed upon plan. Some team members felt this was non-compliant behavior and it was time to dismiss her from the practice because she was refusing to accept the complete treatment plan.

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Words Matter

- Compliance linked to coercion
 - Non-compliance conveys what the patient isn't doing
- Adherence reflects conformity
 - Non-adherence has replaced compliance
- **Partnership** describes the alliance between the healthcare team and the patient to support interactions of self-management
 - Key to patient centered care

Equity Minded Healthcare Teams practice in partnership with patients to improve health outcomes

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The Problem of Patients Not Following Plans of Care

Patients who do not follow recommended plans of care

- 10% of all hospital stays
- 125,000 deaths/year
- Overall cost to the healthcare system \$100-259 billion annually



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Reasons Why

Review of Literature Consistently Identifies These Reasons:

- Denial
- Depression
- Dementia
- Cultural Issues
- Alcohol and Substance Misuse
- Costs of Treatment/Financial Constraints



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Denial

- Can be a coping mechanism
- Can interfere with getting necessary care
- Fear often underlies denial
- Affects a person's self-efficacy

Self-efficacy: "One's own belief in their ability to perform specific self-management activities"



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Tasks of Chronic Illness

- To understand the physical illness and management of symptoms and pain
- To maintain roles and relationships
- To carry out routine and self care activities
- To manage emotional changes



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Depression

- 10% of Americans suffer from depression
- Linked to decreased education, marital instability, decreased income
- Results in loss of optimism, self-worth and self-efficacy; lowered energy
- Interferes with chronic illness care
- Depressed patients are 3x more likely to be labelled non-compliant than non-depressed patients
- Persons with complex chronic mental illnesses (i.e., severe depression, bipolar disorders, schizophrenia) have the most difficulty managing their chronic conditions



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Dementia

- Early onset dementia
 - can be nonapparent to the healthcare team
 - Subtly impair skills needed to carry out self-management of their chronic conditions
- Later stages
 - Patients have less cognitive and functional ability to manage chronic conditions
 - Demonstrate behaviors that make management more difficult; challenge to caregivers



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Cultural Issues

The greater the discrepancy between the cultural background of the healthcare team members and the patient and family, the greater the likelihood for:

- Miscommunication
- Medical mistrust
- Stigmatizing language, Labelling, Stereotypes and Bias

Cultural differences can affect the meaning and understanding of how illnesses or symptoms should be managed and how communication between the healthcare team and the patient should occur or is able to occur.

Biggest challenge to achieving health equity



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Questions an Equity Minded Healthcare Teams Asks

1. Does our communication cause blame on the person we are partnering with in care?
2. Are we reinforcing stereotypes?
3. Does our communication include unnecessary opinions or information?
4. Does our language express disapproval?
5. How would this patient feel when they read their documentation?

Allows the Team to:

- Unlearn stereotypes
- Shift from biased care
- Use neutral language



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Misuse of Alcohol & Drugs

Interferes with ability to follow through on care:

- Shifts priorities
- Apathy, depression and hopelessness
- Often factor of other social needs: employment, housing



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Costs of Treatment

Economic barriers affect someone's ability to carry out a plan of care

- Patients make choices based on costs of treatments and what they can or cannot afford
- Exist even if patients have health insurance (i.e., high deductible, co-pays, out of pocket expenses for medications, etc.)

Costs cause patients to adapt care plans to varying degrees



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About Care Plans

FACT: Few patients can carry out all healthcare recommendations all the time

- Patients with chronic conditions are asked to manage complex treatment regimes often on their own with little or no support
- Often do not include patient abilities, preferences and decisions
- Frequently patient caregivers or support persons are left out
- Unmet Social Needs impact patient success

Result is a High risk for failure



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The Equity Minded Team Asks

NOT

"How can we get patients to comply with our plans?"

INSTEAD

"How can we partner with patients & families to create care plans they are willing to follow?"



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Health Equity

Improving Outcomes, Ensuring Equity

Strategies Equity Minded Teams Can Use

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Practice Patient Centered Care

Person Centered Care

- The practice of caring for patients in ways that are meaningful and valuable to the individual patient

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

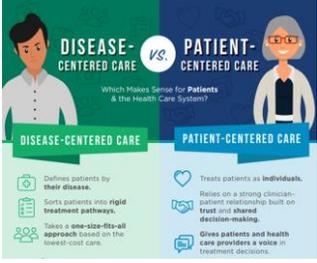


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Health Outcomes of Patient Centered Care

- Increased quality and safety of care
- Greater quality of life and well-being of patients
- Greater engagement of patients & caregivers
- Greater job satisfaction among healthcare professionals



DISEASE-CENTERED CARE

- Defines patients by their disease.
- Sorts patients into rigid treatment pathways.
- Takes a one-size-fits-all approach based on the lowest-cost care.

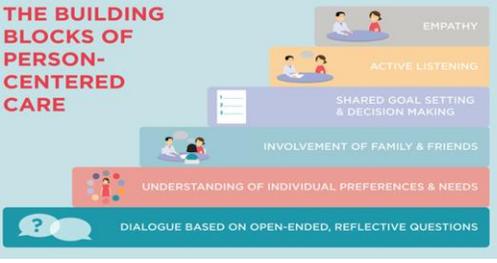
PATIENT-CENTERED CARE

- Treats patients as individuals.
- Relies on a strong clinician-patient relationship built on trust and shared decision-making.
- Gives patients and health care providers a voice in treatment decisions.

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THE BUILDING BLOCKS OF PERSON-CENTERED CARE



- EMPATHY
- ACTIVE LISTENING
- SHARED GOAL SETTING & DECISION MAKING
- INVOLVEMENT OF FAMILY & FRIENDS
- UNDERSTANDING OF INDIVIDUAL PREFERENCES & NEEDS
- DIALOGUE BASED ON OPEN-ENDED, REFLECTIVE QUESTIONS

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CMS Endorsed Components Underpinning Person Centered Care



Person-Centered Care

- Empowers Recipient of Care
- Improves Quality of Life
- Supports Independence
- Promotes Positive Well-being
- Honors Choice
- Promotes Respect

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Evidence-based Examples of Empowering Patients



Questions Are the Answer

- AHRQ Evidence-based health education initiative
- Designed to support patient engagement
- Question Builder App now available
- Access tools and resources at: <https://www.ahrq.gov/questions/about/index.html>
- Patients who ask questions and make sure they understand the answers get more timely, accurate diagnoses and have better outcomes

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Open Notes

- Simple – give patients and caregivers access to their electronic health record
- RWJF funded study
- Takeaways:
 - little change in provider workload, few patients worried or confused by their notes
 - patients overwhelmingly approved of note sharing as a practice
 - patients reported reading notes helped them feel more in control of their health and health care

Evidence indicates that when health professionals offer patients and families ready access to clinical notes, the quality and safety of care improves




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Communication and Relationship

- Language & Culture
 - CLAS Standards (Culturally & Linguistically Appropriate Services)
 - <https://thinkculturalhealth.hhs.gov/clas>
- Health Literacy

One half of all adults lack the literacy skills needed to function and navigate the healthcare system

 - Team Members must be aware of how the patient's health literacy impacts their decision-making capability and health related outcomes
 - Directs the plan for patient education and care management



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HEALTH LITERACY

noun



Health literacy is the ability to access, understand, appraise and use information to make **healthy choices**.

World Health Organization
www.who.int

Skills necessary to participate in health care and maintain good health

- Reading and writing
- Calculating numbers
- Communicating with health care professionals
- Using health technology (digital literacy)



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Health Literacy Universal Precautions

Steps that practices take when they assume that all patients may have difficulty comprehending health information and accessing health services

- Simplifying communication with and confirming comprehension for all patients to reduce the risk of miscommunication
- Making the healthcare environment easier to navigate
- Supporting patient's efforts to improve their health

AHRQ Health Literacy Universal Precautions: <https://www.ahrq.gov/health-literacy/improve/precautions/index.html>



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Quick Screen

Evidence-based Questions Team Members Can Ask:

- “How often do you need to have someone help you when you read instructions, pamphlets or other written material from your doctor or pharmacy?”
- “How confident are you filling out medical forms by yourself?”

Both Health Literacy Universal Precautions & Quick Screen Questions can be used in practice. These are not “either or” strategies!




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Teach Back

AHRQ Teach Back Resources: <https://www.ahrq.gov/patient-safety/reports/engage/interventions/teachback.html>

An evidence-based health literacy intervention to confirm that you have explained medical information clearly so that patients and their families understand what you communicated to them

- Use anytime patient education is needed**

Validates:

- you have explained medical information clearly
- that patients and/or family members have a clear understanding of what you have told them



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Outcomes Related to Teach Back

- heart failure, arthritis, diabetes

Increased patient knowledge of their health condition

- Signs and symptoms
- Rationales for treatments
- Medication side effects
- When to seek help

Increased confidence in self-management of their health condition

- Symptom monitoring
- Lifestyle changes
- Treatment adjustment
- Knowing when to seek medical advice

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Shared Decision Making

<https://www.ahrq.gov/health-literacy/professional-training/shared-decision/tools/factsheet.html>

..... a process of communication in which clinicians and patients work together to gain knowledge to make optimal healthcare decisions that align with what matters most to patients (AHRQ)

Health Outcomes of Shared Decision Making

- Increased patient engagement
- Improved patient health outcomes and satisfaction with care
- Reduced health disparities by building trust and improving communication
- Promotes evidence-based care

Shifts from "What's the matter with you?" to What matters to you?"

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The SHARE Approach

5 Essential Steps of Shared Decision Making

- 1** **S** **Seek** your patient's participation.
- 2** **H** **Help** your patient explore & compare treatment options
- 3** **A** **Assess** your patient's values & preferences
- 4** **R** **Reach** a decision with your patient.
- 5** **E** **Evaluate** your patient's decision.

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Motivational Interviewing

- A guided method of communication to elicit and strengthen motivation to change behavior
- Based on Prochaska and DiClemente's Stages of Change Model
- MI health coaching shows an increase in patient activation
- Evidence supports MI as an effective chronic care management intervention – positively impacts health outcomes

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Outcomes of Motivational Interviewing

- Improves Patient Activation
- Collaborates to identify the patient's knowledge, skill and confidence regarding change processes
- Supports patient autonomy to enhance their perception of choice about change
- Provides a process for patients to discover their own path to change
- Offers an opportunity to express empathy that values and reinforces the patient's experience and understanding
- Provides direction towards the target behavior that the patient chooses

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Care Management

Care management is a set of activities designed to assist patients and their support systems in managing medical conditions more effectively

Goals:

- Improve patients' functional health status
- Enhance coordination of care
- Eliminate duplication of services
- Reduce the need for expensive medical services
- Increase patient engagement in self care

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Managing Care for Chronically Ill and At-Risk Populations

- Enhanced Primary Care Management
 - **Chronic Care Management**
 - **Remote Patient Monitoring**
- Transitional Care Management
 - **Acute Transitional Care**
- Integrated Care Management
 - **Complex Case Management**



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Delivery Features of Successful Care Management Models

- **Teamwork.** Multidisciplinary care teams with a single trained care coordinator as the communication hub and leader
- **Coordination.** Extensive outreach and interaction among patient care coordinators and care team with an emphasis on face-to-face encounters among all parties and collocation of teams
- **Responsiveness.** Speed provider responsiveness to patients and 24/7 availability
- **Feedback.** Timely clinician feedback and data for remote patient monitoring
- **Medication Management.** Careful medication management and reconciliation, particularly in the home setting
- **Outreach.** The expansion of care to the community and home
- **Integration.** Linkage to social services
- **Follow Up.** Prompt outpatient follow up after hospital stays and the implementation of standard discharge protocols



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Population Health

- Requires a departure from traditional care delivery in which care is focused on a single patient's needs at a particular point in time
- Instead, now must think of the entire patient population as well as the individual patient
- Identifies who and who isn't getting care
 - Important in reducing disparities



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- Provides a **"proactive"** way to identify high risk patients so the practice or healthcare organization can shift to anticipating and responding to their care needs

- Multiple interventions occur at different levels
- Allows for stratification:
 - **High Need patients**
 - are partnered with an RNCM who regularly reviews the patient record, assesses risk factors, coordinates care, support self-management and follows up
 - **Patients with chronic illnesses**
 - may be partnered with Care Management that can provide anticipatory guidance, implement standardized treatment protocols, provide self-management support, facilitate care coordination
 - **Healthy populations**
 - may be offered health promotion strategies to support wellness
 - **All populations** should receive tailored prevention interventions and targeted messaging to stay well



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Identifying Social Needs & Social Drivers Impacting Health

Individual Level = Social Need
Population Level = SDoH

WHY?

People do not live their health in the hospital or clinic.
They live their health in the community.



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Individual Social Needs Assessment

Use Validated Screening Tools:

- Accountable Health Communities Core Health Related Social Needs Screening Tool (CMS)
- The EveryONE Project - Social Needs Screening Tool
- PRAPARE – Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences Tool

Quick Screen - Evidence-based Screening Question You Can Ask (USA Model)

- **"Do you ever have difficulty making ends meet at the end of the month?"**
- If yes, Implement SDoH Screening Tool, Adjust plan of care and Connect to resources



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Learn About SDOH in Your Community (Population)

- Community Health Assessments & Improvement Plans
 - Completed by Local Health Departments every 3-5 years
 - Publicly posted usually on Health Department website
- County Health Rankings & Roadmaps
 - <https://www.countyhealthrankings.org/>
- Population Health Tools by Zip Code
 - City Health Dashboard
 - <https://www.cityhealthdashboard.com/>
 - AARP Livability Index
 - <https://livabilityindex.aarp.org/>



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Coordinate & Connect to Needed Resources

80% of patients say that they would find it helpful for their healthcare providers to share information about community resources, help them apply for resources and follow up if they were in need

- Within Your Work Settings
 - Nurse colleagues working in RN Case Manager, Care Manager and Care Coordinator roles
 - Nurses involved in discharge planning, transitional care and chronic care management
 - Social Workers are social resource specialists
- United Way 2.1.1 <https://www.211.org/>
- Public Health Department/Public Health Nurse

Follow Up on Referrals with Patients is Key!



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In Conclusion

Equity Minded Teams:

- Recognize that addressing disparity improves the health for individuals, families and communities - **Engages at all levels**
- Is aware of the social determinants of the communities they serve and screens for the social needs of the patients they care for – **Identifies & Connects to Resources**
- Understand the unique challenges of persons with high needs or who are vulnerable – **Tailors care to patient abilities, preferences, decisions, goals**
- Avoid stigmatizing language and labelling of patients that perpetuates harmful stereotypes and bias – **Practices Cultural Humility**
- Empower patients and caregivers - **Provides pathways for partnership and engagement**



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Part 2: Next Steps

- Video: Team Based Care – Kate's Story
- Review Posted Resources & Tools
- Questions/Contact:
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