## AGENDA

### Behavioral Health Skills Training

**August 28, 2020**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
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</table>
| 9:00-9:10AM     | **Opening Remarks**  
Alexandra Hulst |
| 9:10-10:10AM    | **Delivering Patient-Centered Care to Multiply-Disadvantaged Patients**  
Alexander Blount, EdD  
*University of Massachusetts Medical School*  
*Integrated Primary Care, Inc.*  
Integrating behavioral health into primary care is a start in meeting the array of needs that patients bring, but it is only a start. In their 2001 *Crossing the Quality Chasm* report, the Institute of Medicine called for the relationship of patients to their healthcare professionals to change profoundly. They called for the patient to be the “source of control” in designing his or her care, and to do that the patient should have “unfettered access” to all medical records and information about their care. The IOM has called for partnership between health professionals and patients, even multiply-disadvantaged patients who don’t feel enfranchised to be partners with their doctors and health teams. This talk will offer highlights from my book, *Patient-Centered Primary Care: Getting from Good to Great*, introducing innovations drawn from around the country and showing tools for building the partnerships that have seemed elusive for so long. |
| 10:10-10:20AM   | **Break**                                                            |
| 10:20-11:05AM   | **Practicing Patient-Centered Language**  
Alexander Blount, EdD  
*University of Massachusetts Medical School*  
*Integrated Primary Care, Inc.*  
The previous session covers an overview of the T.E.A.M. Way and embracing mutual growth, rather than transformation. During this time we will practice using language of the T.E.A.M. Way and open the floor to an extended Q&A. |
| 11:05-11:15AM   | **Break**                                                            |
| 11:15-12:15PM   | **Empowering You to See Data as an Opportunity**  
Jennifer Funderburk, PhD  
*Rochester VA*  
It can be challenging to overcome the reaction that most people have when you mention the words “research,” “data,” “program evaluation,” or “quality improvement,” especially within a healthcare environment that is increasingly asking its administrators and providers to consider these in practice as well as monitor quality while balancing patient needs as well. Within the context of integrated primary care, it is even more difficult due to the inclusion of multiple healthcare providers contributing to the team, as well as how data has lagged behind its actual implementation. The objective of this presentation is to help you see how the data can be useful to you and how to effectively include it in your practice. |
| 12:15-12:25PM   | **Break**                                                            |
| 12:25-12:55PM   | **Cultural Transformation Tools that Support Integration and Collaboration**  
Bronte Smith, MHA  
*Rocky Mountain Health Plans*  
Heather Steele, MHA  
*Rocky Mountain Health Plans*  
This session will provide applicable tools that can enhance the culture and collaboration among primary care teams and behavioral health staff. When there is alignment of values, behaviors, and a clear understanding of what motivates each staff member, it can create a strong cultural foundation that results in higher levels of innovation, job satisfaction, and overall facilitation of team-based care. |
| 12:55-1:05PM    | **Break**                                                            |
Engaging Families as Care Partners
Sara H. Qualls, PhD
University of Colorado – Colorado Springs

Families who are critical care partners need to be engaged efficiently and effectively in your healthcare system. This session focuses on practical strategies for engaging families as partners in care of your older patients. From assessment to implementation of treatment, intentional engagement supports their critical roles that improve quality of care without overwhelming your team.

2:05-2:10 PM
Closing
Delivering Patient-Centered Care to Multiply-Disadvantaged Patients

Alexander Blount, EdD
Professor Emeritus of Family Medicine
University of Massachusetts Medical School
The ideas in this presentation are pursued in much greater detail, along with numerous tools for implementation in a book entitled:

Patient-Centered Primary Care: Getting from Good to Great (Springer, 2019) [https://www.integratedprimarycare.com/copy-of-training](https://www.integratedprimarycare.com/copy-of-training)

I also offer consultation and training through my company, Integrated Primary Care, Inc. [integratedprimarycareinc@gmail.com](mailto:integratedprimarycareinc@gmail.com)
Learning Objectives
At the conclusion of this talk, the participant will be able to:

1. Describe a group of multiply-disadvantaged patients and explain why they are so hard to engage in patient-centered care as it is usually practiced in the Patient-Centered Medical Home model.

2. Describe the changes in language used in notes and in conversations in front of patients that can make transparency possible so that patients can be partners in their care.

3. Describe routines of practice that enhance patients' experience of their strengths and abilities to participate meaningfully in their care and in self-care.
These are unprecedented times

• In healthcare, an unprecedented pandemic has led to disruptions in care.
  • The routines of care (e.g., annual physicals, regular visits to manage chronic illness, visits for non-urgent complaints) have been disrupted in ways that make a return to previous patterns unlikely for many people.
  • Primary care is on the verge of financial collapse.
  • The move to telehealth platforms was implemented broadly in a two-month period.
  • The COVID pandemic has made all of us feel vulnerable in a way that is new for many of us, though not for all.
Social tensions have led to an unprecedented response to ongoing patterns of racism and injustice.

- Recent police killings of African-Americans have drawn broader responses in protests and public indignation than previous incidents.
  - 31 of the largest 100 cities in the last 3 months have passed new restrictions on the ability of police to use deadly force such as choke holds.

- The acknowledgement by the Majority of the injustices faced by minorities and of systemic racism seems much more far reaching than in the past.

- How this will play out in the longer term in structural social changes is still to be seen, but the likelihood of major change has not been this high since the 1960’s.

- Healthcare professionals, possibly related to the change of their image to that of “heroes,” have a new level of credibility in society to advocate for social justice.
Healthcare and Social Justice

• Health outcomes (chronic disease rates, rates of behavioral and medical morbidity, quality of life ratings, birth outcomes, and life expectancy) all correlate in a monotonic relationship with income.

• Whenever you are discussing the correlations of income and health outcomes, you are also discussing the impact of systemic racism.

• Low income and low education on one hand, and race and ethnicity on the other intersect in reciprocal ways with health risk, morbidity and mortality.

• Social justice demands we go beyond “equality of access” to “equity in care.”

Our Mission is Clear

“Treating BH conditions as early as possible, holistically, close to a person’s home and community, and in a culturally and linguistically appropriate manner leads to the best health outcomes.”

Primary Care is the only setting for a population approach to behavioral health

The vast majority of people will not accept a referral to specialty MH or SA offered by a PCP. It is care in primary care or no care at all.

Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders service system Arch Gen Psychiatry. 1993 Feb;50(2):85-94.
Behavioral Health Integration is Foundational for Achieving Equity in Healthcare

“…racial and ethnic minorities are less inclined than whites to seek treatment from mental health specialists. Instead, studies indicate that minorities turn more often to primary care.”

The IOM has been trying to fix healthcare for a long time.

• “Crossing the Quality Chasm” is a watershed report in 2001 began a series of best practices reports.

• The IOM offered 10 rules to begin to fix healthcare:
  • some focused on a redesign of the delivery of care (e.g., practice patterns, data management) – became the drive for a Medical Home
  • some focused on a change in the relationship of the physician and other healthcare staff to the patient – became the idea of Patient-Centered Care

Changing care delivery processes is easier than changing relationships.

- In early implementations of the PCMH, changing care delivery processes were stressful on doctors and patients, (satisfaction of both went down) but practice changes could be accomplished in 2-4 years.
- Changing the relationship of doctors and patients did not progress nearly as well.
- The evaluation of the National Demonstration Project on the Patient Centered Medical Home concluded that doctors needed to develop “new mental models” of care.
- The IOM’s call for the patient to be “the source of control” in their care was not being realized.
- By 2015, the IOM was calling for “explicit and partnered determination of goals and care options” between patients and health professionals. Frampton, et al. 2017.
Defining “patient-centered” care

But isn’t everything we do for our patients? That’s all patient-centered, right?

IOM called for:

• patients to be the “source of control” in planning their care (2001)
• to have “unfettered access” to their own medical information (2001)
• A partnership between physicians and patients and their families in planning treatment (2015)
• Patient-centered care requires meeting patient needs for MH and SUD treatment (2006)

## The Patient Perspective on Integration

<table>
<thead>
<tr>
<th>Level of Integration</th>
<th>Patient's Understanding of the Relationship of Professionals</th>
<th>Patient’s Description of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated</td>
<td>Doc supports patient getting care from MH practitioner. Information can be exchanged when necessary.</td>
<td>&quot;My doctor is glad that I am seeing a therapist.&quot;</td>
</tr>
<tr>
<td>Co-located</td>
<td>Doc initiated referral to BHC. Information shared in EMR and in person when necessary.</td>
<td>&quot;My doctor referred me to a behavioral health clinician who works at the clinic.&quot;</td>
</tr>
<tr>
<td>Integrated</td>
<td>Professionals work as a team and share information regularly. Any member can speak for the team.</td>
<td>&quot;My doctor added a member of her team to work with me so that I could get more help with the stresses in my life.&quot;</td>
</tr>
<tr>
<td>Patient-Centered Integration</td>
<td>The patient is a participant with the team in the setting of goals and developing the care plan.</td>
<td>&quot;I talked with my doctor and other team members. Now we all understand my life situation and my health needs better and can decide what to do next.&quot;</td>
</tr>
</tbody>
</table>
Primary Care Doctors are “Under Siege”

• The Pandemic
• Payment system weighted toward specialists
• Still lowest salaries, high burn out (internal medicine and family medicine in top 5)
• The “clutch plate” in the medical system

• If truly “patient-centered” care does not make their lives easier in the long run, it is a non-starter.
“Complex” patients add stress for “patient-centered” approaches

These patients have been identified with various names:

- Complex Trauma victims
- Multiple chronic illnesses Heartsink patients
- High utilizers Somatizers
- Low health literacy. Underprivileged

“The over-serviced and underserved”

I call them “multiply-disadvantaged” patients.

Patients that have complex needs including BH problems, who don’t seem to do their share of their chronic illness care, who are high utilizers, and who don’t get better, can feel like “the last straw” to some physicians who are deciding whether primary care is a viable setting in which to practice.

It helps to know who you are dealing with

- Patients who have multiple illnesses and are high-utilizing – called “complex patients”
- Low income and many are members of underserved minorities – called “disadvantaged patients”
- Patients with trauma histories as shown on the ACES screen or their PTSD “trauma victims”

- Statistically, these are almost the same people.
- I call them “multiply-disadvantaged patients” to reflect the three literatures about them.

The 3 literatures have overlapping descriptions about the population they are describing.

**Increased incidence of:**
- Depression
- Anxiety
- Medically unexplained symptoms
- Substance use disorders
- Multiple chronic illnesses
- Diabetes
- Osteoarthritis
- Lung disease
- Metabolic risk markers
- Hypertension
- Heart disease
- Homelessness or insecure housing
- Problems with social determinants of health

**Relationships with health professionals:**
- Difficulty forming trusting relationships or partnerships
- Suspicious of Health Professionals
- HP is more frustrated with relationship with patient
- HP experiences extra stress from providing care and needs support
- HP underestimates incidence of trauma

**Aspects of effective care:**
- HP is committed to helping patient become a partner in the plan of their care
- HP takes a strength-based approach
- Need a team to provide good care
Multiply-Disadvantaged Patients

• Show low “patient activation.” They don’t take care of themselves.
• They tend to share many doctors’ expectations that in medical care, the doctor is in charge and the patient “complies.” They don’t expect care to be a “partnership” and they don’t feel the self-efficacy to participate.
• Many experience the interaction with a physician, not in terms of care or benevolence, but in terms of asymmetries of power.
• Even very “patient-centered” practitioners take a more directive approach to these patients, confirming patients’ expectations about medical care.
• A setting in which they feel they have no power or control, such as a visit to a hospital or other medical setting, can trigger a re-experiencing trauma reactions.

Blount, A. (2019). When the doctor-patient divide is a chasm. In A. Blount, Patient-Centered Primary Care: Getting from Good to Great, Springer, pp. 77-91
To successfully address complexities of new practice patterns and multiply-disadvantaged patients requires an enhanced team.

• “High touch” care including care management and BH expertise has been shown to be necessary and cost effective for the highest utilizing patients (outside of the very elderly and the very sick).

• Evidence says doctors need to be part of a team that can take some of the tasks of primary care, leaving them to do what they do best, diagnose and treat disease.

Patient-centered team-based care for lower provider burnout

• High-functioning teams are difficult to develop.
  • “The doctor is responsible for everything” training received by physicians and other staff makes it difficult to move to a team in which the doctor is facilitative leader of well-trained team members (and in some situations, not the leader).

• Working with the same team members consistently (team structure) has been shown to improve physician and team cohesion (team culture).

• Cohesive team culture (communication, participation, mutual support, effort, shared objectives) lowers burnout and improves satisfaction for physicians and staff.

• High-functioning teams are associated with increased provider and patient satisfaction, lower error rates, better communication with patients, better adherence by patients, and better health outcomes.

Multiply-disadvantaged patients do best in Trauma-Informed Care

Trauma-Informed Care embodies the patient-centered “rules” of the IOM:

• Safety – requires understanding the patients’ experience of care
• Transparency and trustworthiness – patients have access to all information about their care
• Choice – meaningful choice in the direction and goals of care
• Collaboration and mutuality – shared decision making in pursuing goals
• Empowerment – interactions focus on patients’ strengths and successes as much as possible.

Meeting the needs of MDPs could embody social justice and contribute to saving primary care.

• Being ineffective with a significant portion of their patients is stressful to providers.

• High-functioning teams are needed to care for the patients with the lowest incomes, highest burdens of illness and highest rates of mortality.

• High-functioning teams have been shown to increase work enjoyment and satisfaction for both for doctors and other team members.
Getting to partnership for patient-centered care is a goal of several current evidence-based approaches.

Among current approaches to partnership:

- Motivational Interviewing
- Shared Decision Making
- Minimally Disruptive Medicine
- Improving Health Literacy
- Relationship-Centered Care
- Culturally Informed Care
- Coaching Patients to assertively relate to their physicians

Blount, A. (2019). Bridging the chasm: the current state of the art. In A. Blount, Patient-Centered Primary Care: Getting from Good to Great, Springer.
The T.E.A.M. Way

• T – Transparent

• E – Empowering

• A – Activating

• M – Mutual

“T” is for Transparent

• Patients having access to all the notes about them is coming, if you don’t have it yet.
  • Over 44,000,000 patients have Open Notes already (https://opennotes.org).
  • Multiply-disadvantaged patients are more positive about open notes than patients in general, if they are shown how to access them by smart phone.

• Those who write the notes need to learn a bit of new phrasing to take the blaming elements out of standard professional language.
  • E.g., “this is an obese 34 yo female with T2 DM.” to “Mary Smith is 34 years old. She struggles to manage her type 2 diabetes and to control her weight.”
  • "He is not adherent to his medication” becomes “he has chosen not to take the prescribed medication.”

• As team members get more competent in patient-centered language, they can move discussions about patients from the hall into the exam room.
  • It saves time
  • Best way to involve new team member in the care (passing the relationship).
  • It is a real time enacting of the patient as part of their care planning team.

“E” is for Empowering

• Using the Trauma-Informed Care definition of “empowering” as care in which interactions focus on patients’ strengths and successes as much as possible.
• “Empowered” patients should not be confused with “enfranchised” patients, as medical professionals often use the term.
• Builds self-efficacy of multiply-disadvantaged patients, engaging them in their care.
• Builds health professionals’ experience of self-efficacy with this population, lowering stress and burnout potential.
• Making the change requires training and practicing empowering questioning by the whole team.
“A” is for Activating

- Patient activation for self-management of health, as measured by the Patient Activation Measure, correlates with income, education, assessment of one’s health status and self-efficacy in impacting one’s health. Multiply-disadvantaged patients show the lowest levels of activation. (Problem that the measure is a-contextual at lower levels of activation.)

- These patients tend to believe that the patient’s job in healthcare is to “do what the doctor tells you,” though they tend to fail or choose against that course of action.

- Their health self-efficacy can be built by impacting patients’ (and their doctors’) attributions about their commitment and abilities to improve their health and functioning.

- Empowering interviewing (last slide) can be directed toward changing both the patients’ and their doctors’ attributions about the patients’ impact on their health.

- An observation about the patient’s past success can be linked to a more general attribution about the patient’s commitment and likely future health improvement.

### ATTRIBUTION GENERATOR  (1 from each column)

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>It looks to me like . . .</td>
<td>. . you are determined to . .</td>
<td>. . work on goals to make yourself</td>
</tr>
<tr>
<td></td>
<td></td>
<td>healthier.</td>
</tr>
<tr>
<td>I suspect that . . .</td>
<td></td>
<td>. . prevent health problems down the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>road.</td>
</tr>
<tr>
<td>I may be wrong, but I am thinking . .</td>
<td>. . your values are helping you to . .</td>
<td>. . be sure to get the information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>you need to maintain your health.</td>
</tr>
<tr>
<td>I get the impression that . .</td>
<td>. . you are getting more confident</td>
<td>. . follow through on treatments on</td>
</tr>
<tr>
<td></td>
<td>that you can . .</td>
<td>your own.</td>
</tr>
<tr>
<td>You are making me believe . .</td>
<td>. . for the sake of your family, you</td>
<td>. . maintain the lifestyle changes</td>
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<tr>
<td></td>
<td>are going to . .</td>
<td>you have made.</td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>. . you are getting back on track to .</td>
<td>. . get your life back from the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>effects of (illness).</td>
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</tbody>
</table>
“M” is for Mutual

• First large study of Open Notes found that patients liked having access to their notes, but they also wanted to have their thoughts about their care represented in their medical records. Doctors didn’t like the idea.

• The “Patient-Centered Care Plan” provides a process for patients to finally have the sort of input in their care that the IOM originally envisioned. This makes “partnership” official.

• The structure of the plan has sections found commonly in care plans plus sections that can only be provided by the patient.
  • Who (outside of the professionals) can see my records or offer opinions about my care.
  • What professionals can do when I am overwhelmed or destabilized in a visit.
  • What I want my health team to know about me, my values, and my choices.
  • What I have chosen as my health goals.

• Several implementations in single practices and in large health systems tried: Generally the durability of the program depends on IS support so that all professionals in the health system who open the patients’ records can see the plan. It is an “official” document on the system.

• The process is time consuming. Best to start with multiply-disadvantaged patients. They report that having a PCCP done with the health team tended to transform the patient/doctor/team relationship.

Following the T.E.A.M. Way

• It is a process better described as mutual growth rather than transformation.

• Several elements that support this growth:
  • Consistency of team membership
  • Adequate time for team discussion and learning
  • Flexibility of roles within the team. (e.g., Who can engage a particular patient best?)
  • Some coaching or training on appreciative inquiry within the team mirroring empowerment interviewing with patients
  • QI/PDSA as basic to the work of the team

• Retaining team members is crucial to consistency and to the maintenance of team expertise.
  • Career ladders of increasing responsibility and expertise within the team
  • Team as a training vehicle for the larger system. “Teaming” is a skill.
After the break:

- We will practice using the language of the TEAM Way.
- And have an extended Q&A

Thank you for your attention. Please feel free to contact me at ABlountEdD@gmail.com

And get access to a lot of free materials at www.integratedprimarycare.com
Medical notes need to change

“There is a critical distinction between documentation and communication: Communication can document, but documentation alone rarely communicates what matters most. Too often, the welter of data loses the story of the patient.”

• CMS is allowing billing for complexity without endless repetitive lists of illnesses.

• Seems like a good time to learn to make them communicative to patients as well.

Change your language to engage with and activate your patient.

- Your documentation is always an interpretation of events.

<table>
<thead>
<tr>
<th>Negative/passive words</th>
<th>Positive/active words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffers from</td>
<td>Struggles with</td>
</tr>
<tr>
<td>Refused to take</td>
<td>Decided against</td>
</tr>
<tr>
<td>Didn’t keep apt</td>
<td>Was unable to be here</td>
</tr>
<tr>
<td>Was non-compliant with</td>
<td>Had not seen value of</td>
</tr>
<tr>
<td>Arrived late</td>
<td>Was determined not to miss</td>
</tr>
</tbody>
</table>

- Help me with the list.
Empowering Language

Interviews highlight successes in patients’ caring for their own health and in coping with terrible adversities in their lives. These can be noticed by any member of the care team.

- **Studying exceptions to problem patterns** in self-care: times of sobriety, the times their A1c was lower, the small improvement in activity levels.
- **Noticing the problem events that didn’t happen**: List of cigarettes not smoked, drinks not taken, failures to keep appointments that didn’t happen.
Activating Language

• Find an attribution you can make about the patient’s active role in addressing their situation, their health, their family’s wellbeing.
• Use words like “determined to,” ”committed to,” “on a mission to”
• Express optimism about the patient’s progress toward their goal.
Follow Up

• Take 10 minutes to write a piece of the clinical note that you could read to the patient, that uses an empowering approach and activating language.

• Pick a spokesperson to report out what you have done. (We will not get to all of the groups.)

Questions?

For further contact: ABlountEdD@gmail.com
www.IntegratedPrimaryCare.com
EMPOWERING YOU TO SEE DATA IN A NEW LIGHT

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ACKNOWLEDGEMENTS & CONFLICTS OF INTERESTS

- The views expressed today are mine and do not reflect the official policy of the Department of Veterans Affairs or other departments of the United States government.

- Conflicts of Interest: None

- This material is based upon work supported by the VA Center for Integrated Healthcare.
WHO ARE YOU?

What type of provider are you (most of the time)?

1) Healthcare Administrator
2) Primary Care Provider (MD or NP or PA)
3) Nurse
4) Integrated Behavioral Health Provider
5) Specialty Behavioral Health Provider
6) Other
LET'S PLAY
DO YOU HAVE THIS AS YOUR INITIAL REACTION?
OR THIS?
WHAT IF I SHOWED YOU THIS?

An mRNA Vaccine against SARS-CoV-2 — Preliminary Report

Lisa A. Jackson, M.D., M.P.H., Evan J. Anderson, M.D., Nadine C. Rouphezal, M.D., Paul C. Roberts, Ph.D., Mamoodikoe Makhene, M.D., M.P.H., Rhea N. Coler, Ph.D., Michele P. McCullough, M.P.H., James D. Crappell, M.D., Ph.D., Mark R. Denison, M.D., Laura J. Stevens, M.S., Andrea J. Pritijses, Ph.D., Adrian Mcdonnuur, Ph.D., et al. for the mRNA-1273 Study Group

Article: Figures/Media

DOI: 10.1056/NEJMc202483

July 14, 2020
OBJECTIVES
WHAT HAPPENS IF YOU DON'T PAY ATTENTION TO THE DATA?
SOME DATA IS EASIER TO UNDERSTAND THAN OTHERS
STEPS ON HOW DO YOU BECOME A GOOD CONSUMER OF DATA?
STEP 1: BE OPEN-MINDED

Don’t cringe when someone shows you data as it may actually be helpful in informing your clinical practice.
STEP 2: DON’T ACT BLIND, LOOK TO SEE IF THERE IS ANY EVIDENCE

- Google Scholar, PubMed, PsychInfo
- Pay attention within your professional organizations as often times they try to highlight important new data
STEP 3: DON’T GET TRICKED AND TAKE THE DATA AT FACE VALUE

- Question the data—
  - How many people? Who asked?
  - What exactly was provided?
  - How was it measured?
Rensselaer Polytechnic Institute

Program Evaluation of PCBH within University Health clinic

53 of the 134 who attended more than 2 appointments, this is their outcomes

BY NOT QUESTIONING HOW PCBH WAS DEFINED

UNDERMINED VALIDITY OF THE DATA
Statistical vs Clinical Significance

**Statistical Significance**
Is this difference unlikely?

\[ p < .05 \]

Does it matter to a statistician?

**Clinical Significance**
Is this difference important?

Does it matter to a clinician?
STEP 4: IF THERE IS NO DATA, CONSIDER HELPING PEOPLE COLLECT IT
SUGGESTIONS

- Consider partnering with others in your community, who might want to help for free
  - Academics, Organizations, Students
- Consider methods to collect data that are easier than others
  - Electronic Health Record
  - Surveys
- Get Creative!!!


Consider Research and Evaluation track presentations at Collaborative Family Healthcare Association
LET’S FLIP THE COIN
WHAT HAPPENS IF YOU PAY TOO MUCH ATTENTION TO THE DATA?
I have to get this patient out of here, I’ve already been with her for 31 minutes.
Implementation of Evidence-based Alcohol Screening in the Veterans Health Administration

Katharine A. Bradley, MD, MPH; Emily C. Williams, MPH; Carol E. Achtmeyer, MN; Bryan Volpp, MD; Bonnie J. Collins, PA-C, MPA; and Daniel R. Kielahan, PhD

Background: Despite evidence-based guidelines, brief alcohol screening and counseling have not been routinely integrated into most primary care practices in the United States.

Objective: To describe the results of the implementation of evidence-based alcohol screening by the Veterans Health Administration (VHA) in 2004, as the first step toward implementation of brief alcohol counseling.

Study Design: This observational study of outpatients from all 21 VA networks collected the following 2 data sources from the VA Office of Quality and Performance: (1) Medical record reviews, designed to compare VA networks quarterly, evaluated whether established VA patients had documented screening for alcohol misuse and documented follow-up assessment for alcohol use disorders among those who screened positive for alcohol misuse (January-March 2003); and (2) Mailed patient satisfaction surveys from 2004, which oversampled patients new to the VA response.

The Veterans Health Administration (VA) recently replaced a program of annual screening for alcohol use disorders with a program of annual screening for alcohol misuse (risky drinking and alcohol use disorders) as the first step toward implementation of evidence-based brief alcohol counseling. This article describes the adoption and nationwide implementation of an alcohol misuse screening performance measure in 2004. Although no formal prospective evaluation of this program was conducted, we present results of performance monitoring regarding alcohol screening and follow-up for the 21 VA networks through March 2008, comparing results based on medical record reviews and patient surveys.
Measuring Performance of Brief Alcohol Counseling in Medical Settings
A Review of the Options and Lessons from the Veterans Affairs (VA) Care System

Katharine A. Bradley MD, MPH, Emily C. Williams MPH, Carol E. Ach MN, Eric J. Hawkins PhD, Alex H. S. Harris PhD, MS, Madeleine S. Fr Thomas Craig MD, MPH & Daniel R. Kivlahan PhD

FIGURE 1. Patient reports of alcohol-related advice among VA outpatients who screened positive for alcohol misuse on surveys: the percent advised increased as AUDIT-C scores increased.

Quality Concerns with Routine Alcohol Screening in VA Clinical Settings

Katharine A. Bradley, MD, MPH,1,2,3,4,5 Gwen T. Lapham, MPH, MSW,1,5 Eric J. Hawkins, PhD,1,6 Carol E. Ach, ARNP, MN,1,5 Emily C. Williams, PhD, MPH1,5, Rachel M. Thomas, MPH, and Daniel R. Kivlahan, PhD1,2,6

1Health Services Research & Development (HSRD), Veterans Affairs (VA) Puget Sound Health Care System, Seattle, WA, USA; 2Center of Excellence in Substance Abuse Treatment and Education (CESATE), Seattle, WA, USA; 3General Medicine Service, Veterans Affairs (VA) Puget Sound Health Care System, Seattle, WA, USA; 4Department of Medicine, University of Washington, Seattle, WA, USA; 5Department of Health Services, University of Washington, Seattle, WA, USA; 6Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, WA, USA.

BACKGROUND: Alcohol screening questionnaires have typically been validated when self- or researcher-administered. Little is known about the performance of alcohol screening questionnaires administered in clinical settings.

OBJECTIVE: The purpose of this study was to compare

CONCLUSION: Use of a validated alcohol screening questionnaire does not—in and of itself—ensure the quality of alcohol screening. This study suggests that the quality of clinical alcohol screening should be monitored, even when well-validated screening questionnaires are used.
ANOTHER EXAMPLE

Screened for:
✓ Alcohol misuse
✓ Tobacco Use
✓ PTSD Symptoms
✓ Suicidal Ideation
✓ Homelessness
✓ Intimate Partner Violence
✓ Checked Medications
RECOGNIZE IT’S A BALANCE
Think about how data can help inform your practice
CREATING MEANINGFUL CHANGE
CULTURAL TRANSFORMATION TOOLS THAT SUPPORT INTEGRATION AND COLLABORATION

Heather Steele, MHA & Bronte Smith, MHA
Discuss importance of organizational culture
Define an effective integrated care-team
Identify best practices and challenges
Provide tools and strategies to create an effective and collaborative team
Organizational culture encompasses values and behaviors that contribute to the unique social and psychological environment of a business.

The organizational culture influences the way people interact, the context within which knowledge is created, the resistance they will have towards certain changes, and ultimately the way they share (or the way they do not share) knowledge.

Organizational culture represents the collective values, beliefs and principles of organizational members.
How do you define an effective integrated care team?
Let’s Talk Data!

• In 2017, the University of Michigan Behavioral Health Workforce Research Center conducted a qualitative case study to identify workforce factors associated to the success and challenges of the integrated care model.

Best Practices

Culture of Collaboration

Challenges

Provider Disagreements
“Turf Issues”
Disagreement about provider roles

“There is a professional desire to have some degree of exclusivity, some clarity, some pride or ownership, and that can be really good. At the same time, having overlapping roles or responsibilities becomes difficult. There are bureaucracy challenges with that; to say that something can be everyone’s role means that no one takes central ownership to do it.”

“People get a little protective sometimes of their own turf and feel sometimes they hold the burden [of their professional role].”
Team Huddle!

“Most people dive into [forming integrated care teams] as though it is business as usual. It’s not business as usual at all. Frequently, you’ve got [behavioral and physical health care units] that have not typically meshed very well, or even understood each other very well.”

“I believe that the biggest thing is that really good integrated care, just like any good care, comes down to also finding out if people are on the same page in terms of values. Do people really believe in things like building relationships? What we found is that before you do the integrated care, there’s a lot of work [in aligning values] that is often missed.”
THE “WHY” BEHIND MOTIVATION

Understanding how individuals work best and align work to their motivators has been shown to:

- Produce higher quality work
- Allows for shared-decision making
- Higher employee satisfaction
- 150% more likely to live happier life
- Drives engagement

Who am I as a provider?
Who am I as a member within my specific care team?
Who am I as a member of the entire integrated care team?

Culture Works- Motivator Assessment
MOTIVATORS ASSESSMENT

What helps you feel engaged, enabled and energized in your work?

What is it that makes you want to quit a job?

What factors increase or decrease your level of motivation?
**Worksheet: Motivators Assessment Profile**

<table>
<thead>
<tr>
<th>Top 7 Motivators &amp; Bottom 3 Motivators</th>
<th>What’s confirming?</th>
<th>What’s a surprise?</th>
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<table>
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**Worksheet: Job Sculpt an Ideal**

<table>
<thead>
<tr>
<th>Responsibility or Assignment</th>
<th>Identities or Motivators Impacted</th>
<th>People to involve &amp; First Steps</th>
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<tr>
<td>WHAT CAN I ALTER?</td>
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<td></td>
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<tr>
<td>WHAT CAN I TRANSFER?</td>
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<td>WHAT CAN I ADD?</td>
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**Worksheet: Are You Engaged?**

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<th>Your Current Responsibilities</th>
<th>#1 Identity</th>
<th>#2 Identity</th>
<th>#3 Identity</th>
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**WHAT MOTIVATES ME**

**JOB SCULPTING EXERCISES**

What follows is a series of four exercises that will require some introspection, all with the intention of helping you answer the following critical questions:

- **Who am I?** - Discover what’s important to you.
- **Where do I want to go?** - Evaluate your current role and responsibilities against your motivators and identities.
- **How will I get there?** - Sculpt your work to align with what drives you.

From the Authors
<table>
<thead>
<tr>
<th>Impact</th>
<th>Teamwork</th>
<th>Problem Solving</th>
<th>Challenge</th>
<th>Developing Others</th>
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<th>Pressure</th>
<th>Variety</th>
<th>Money</th>
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<td>Becky</td>
<td>Sam</td>
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STOP
Collaborate and Listen
THE MOTIVATION SHIFT

Motivation 1.0
- Physical/Biological
- Safety
- Belonging/Love
- Esteem
- Self Actualization

Maslow’s Hierarchy of Needs

Motivation 2.0
- Autonomy
  Provide the freedom to come up with solutions to challenges that directly impact my work
- Mastery
  Allow me to continue to grow in skill and experience
- Purpose
  Show me how my work contributes to a larger mission

Motivation 3.0

Daniel H. Pink
DRiVE
The Surprising Truth About What Motivates Us
DEVELOP INTRINSIC MOTIVATION AT WORK

- Task
- Time
- Team
- Technique
DEVELOP INTRINSIC MOTIVATION AT WORK

Create a work environment that encourages and cultivates mastery.
DEVELOP INTRINSIC MOTIVATION AT WORK
IMPLEMENTING DRIVE AT WORK

Unlocking Motivation Worksheet Instructions:

- Autonomy: Do I have or can I encourage or allow self-direction in this task or project?
- Mastery: Can this task or project allow team members get better at something that matters to them? Can they use this knowledge to educate others?
- Purpose: How does this task or project fit into the big picture of the practices common purpose?

<table>
<thead>
<tr>
<th>Daily Task/Action</th>
<th>Drive Questions</th>
<th>Yes/No</th>
<th>How?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finishing Chart Notes</td>
<td>Autonomy</td>
<td>Yes</td>
<td>Be involved in the development of your own templates to chart your notes</td>
</tr>
<tr>
<td></td>
<td>Mastery</td>
<td>Yes</td>
<td>Allow for best practices to be developed that save time, improve communication between team members, training opportunities</td>
</tr>
<tr>
<td></td>
<td>Purpose</td>
<td>Yes</td>
<td>Completing chart notes allows your team to understand how your work with the patient contributes to the purpose of helping each patient overcome health challenges to live their best life</td>
</tr>
<tr>
<td>Question</td>
<td>Description</td>
<td></td>
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<tr>
<td>---------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where are we?</td>
<td>Discover baseline of current practice culture to objectively see opportunities for improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are we?</td>
<td>Mission, Vision and Value statement are created and practice will define their purpose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who are we?</td>
<td>Assessments are used to discover personality types, strengths and motivators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where are we headed?</td>
<td>Brainstorm and outline how to implement changes that influence culture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We have arrived!</td>
<td>Establish how to measure success and monitor progress of change</td>
<td></td>
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</table>
### OTHER RESOURCES TO CONSIDER

<table>
<thead>
<tr>
<th>Resource</th>
<th>Format</th>
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</thead>
<tbody>
<tr>
<td>Drive – The surprising truth about what motivates us</td>
<td>10 minute animated video</td>
</tr>
<tr>
<td>Simon Sinek – Start with Why</td>
<td>18 minute Ted Talk</td>
</tr>
<tr>
<td>Personal Growth Motivation: The Drive to Change</td>
<td>Psychology Today Article</td>
</tr>
<tr>
<td>The Pinkcast</td>
<td>Newsletters and Short Videos from Dan Pink</td>
</tr>
</tbody>
</table>
THANK YOU

♦ Heather Steele, MHA
  ▪ Heather.Steele@rmhp.org

♦ Bronte Smith, MHA
  ▪ Bronte.Smith@rmhp.org
REFERENCES

• Agency for Healthcare Research and Quality
• University of Michigan: Behavioral Health Workforce Research Center
• Center for Integrated Health Solutions
Engaging Families as Care Partners

Sara Honn Qualls, Ph.D., ABPP
Kraemer Family Professor of Aging Studies, Professor of Psychology
Director, Gerontology Center
University of Colorado-Colorado Springs
Learning Objectives

At the conclusion of this session, the participant will be able to:

• Identify effects of caregiving on family caregivers
• Recognize roles family caregivers have in primary care
• Name assessment tools for screening caregivers and eliciting information about patients from them
• Describe key components of caregiver support programs
• List necessary large systems changes in caregiver communication, documentation and shared decision-making to reduce patients’ healthcare costs
From our mountains to yours....
• Despite traditionally patient-centric American healthcare system, myriad factors → emphasis on families
• Rising incidence of chronic illnesses, functional limitations with rapidly aging population (20% over 65 by 2030)
• Decreased hospital lengths of stay and emphasis on preventing bounce-backs
• Families seen as one key to implementing outpatient treatment plans, decreasing hospital utilization and lowering costs
Engage, Support, Empower

• Many family members don’t identify themselves as caregiver

• How do we engage them?

• Many family caregivers feel isolated and unsupported

• How do we risk stratify them and provide tailored services?

• Many family caregivers feel marginalized by integrated healthcare teams

• How do we embrace and empower them as partners in care?
Who are the family caregivers?
Family Caregiving in America

• 40 M Americans engage in some form of caregiving activity in a year (NAC/AARP, 2015)
• Numbers increasing because of demographics, medical advances
Prototypical Caregiver

49 year old woman with some college experience is providing 20+ hours of care weekly for aging mother.

Spouses mean age 62

7% of CGs are over age 75

Size of CG workforce for older adults in US:

• 34.2 million
• 14% of adults
• 85% for family
• 82% for 1/18% for 2

AARP & National Alliance on Caregiving (NAC), 2015

The majority of middle-aged adults have more parents than children.

Eldon Weisheit in Cutler, 2002
What do caregivers do?
# Activities of Daily Living (ADL’s)

<table>
<thead>
<tr>
<th>Instrumental</th>
<th>Basic</th>
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<tbody>
<tr>
<td>Transportation</td>
<td>Bathing</td>
</tr>
<tr>
<td>Medication monitoring</td>
<td>Dressing</td>
</tr>
<tr>
<td>Shopping</td>
<td>Toileting</td>
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<tr>
<td>Appointments</td>
<td>Transferring</td>
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<tr>
<td>Food preparation</td>
<td>Ambulating</td>
</tr>
<tr>
<td>Finances</td>
<td></td>
</tr>
<tr>
<td>Home maintenance/cleaning</td>
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</tbody>
</table>

AARP & National Caregiving Alliance, 2015
Emotional caregiving

- Normative in families
- Increases in value and salience with age
- Caregiver/care recipient relationship renegotiated
- Acquaintances and casual friends often exit

Berg & Upchurch, 2007; Carstensen, 2006; Fingerman et al, 2009
Provide Health Care Services

- Medication management
- Appointment management and preparation
- Medical master record – “history” in health system
- Wound care
- Rehabilitation therapies
- Catheter care
- DME management
- Increasingly complex medical interventions

*In healthcare systems, these services are defined within scopes of practice of particular disciplines.*

AARP & NAC, 2015
In sum, family members provide significant care that is...

- Valuable to society
- Interpersonal and often intimate
- For family members or friends
- Within an existing relationship context
- That typically has years if not decades of history
Health and Functional Interruptions

Chronic -> Acute -> Chronic->...
Not surprisingly, this work has effects on caregivers...

- **Negative effects** –
  - Burden – role entrapment, losses, workload
  - Mental health – depression
  - Physical health – chronic conditions negatively affected; reductions in immune functioning, mortality increase

- **Positive effects** –
  - Personal growth
  - Relationship enhancement
  - Mortality boost
3 Considerations and Steps to Improve Partnership with Caregivers

What can YOU do to partner with caregivers?
Key Consideration 1: 
*Family reports on daily functioning can provide critical information that may assist with early detection and disease management.*
Janet and Howard

Howard was shocked by his diagnosis of Parkinson’s disease, but Janet was not.

Janet has noticed the changes in his gait and balance, and worries about the intermittent tremors. She’s been researching diets and exercise options online to try to change their lifestyles to reduce his symptoms. She’s skeptical of medications because of their side effects.

Howard thinks she is making a lot out of nothing. Indeed, he has been too depressed to want to get out much anyway. He tells his medical providers that he’s fine.
Families interface with multiple care systems:

...As health providers

...and as health inhibitors
Families are missing on the **INTERPROFESSIONAL TEAM**

Team does not know

- What family knows about daily functioning?
- Who provides what help to person at home?
Key Consideration 1:
Family reports on daily functioning can provide critical information.

A Step Forward:
Develop and test simple, rapid screening tools for families to report changes in functioning (e.g., ADL/IADL’s, life concerns, wellness)
Key Questions for Caregiver accompanying a patient with chronic disease

- What is the hardest decision you are facing in how to care for your loved one?
- What is different about your loved one today vs 5 years ago? How are you helping differently?
# Behavior Problem Checklist

**ADL, IADL, Attributions for the Problem**

<table>
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<th></th>
<th>Activity</th>
<th>1</th>
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<th>4</th>
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<td>Bathing</td>
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Key Consideration 2: Family caregivers are at risk of negative health and mental health effects, yet are critical care partners.
Kanisha and Martha

Martha hid her diabetes from the family for years. She administers herself insulin and has been through diabetes education classes but has not been successful in changing her food intake significantly.

When she was hospitalized last week to get her “blood sugar” under control, her daughter Kanisha learned for the first time about her mother’s diabetes and the hypertension, peripheral neuropathy, and retinopathy. Kanisha already knew about her mother’s drinking problem and depression.

The physician and case manager have asked Kanisha to help her mother change her diet and reduce alcohol intake. If Kanisha knew how to do that, she would have done it years ago! How can she possibly fix this now?
Key Consideration 2: Families are impacted by chronic disease, especially caregivers

A Step Forward: *Routinely screen caregivers for role structures, distress, and risks*
Screening for Burden

1-Question Screener for Burden (Schulz and Beach, 1999)

- How much of an emotional strain is it on you to provide the help directly or arrange for help to be provided for your relative?

3-Question Screener for Burden (Liew et al, 2019)

- Are you afraid what the future holds for your relative?
- Do you feel your health has suffered because of your involvement with your relative?
- Do you feel you have lost control of your life since your relative's illness?

Line in the Sand

- Everyone has limits about what they are willing and able to do. What part of caregiving will be especially hard for you? What are your limits?
Assessment of Self-Care/Coping

• What do you need to do to get from start to finish?
• What do you do to relax when you’re stressed out?
• How have you and your family managed other difficult times?

Barry Jacobs
360° Screening

• Objective Burden
  • Length of time in role
  • Amount of ADL/IADL

• Subjective Burden

• Positive Meaning – To what extent have you grown as a person or found meaning in this caregiving role?

• Rigid norms of obligation – To what extent do you feel trapped by your relative’s illness?

• Low perceived support – To what extent do you feel supported by family and friends in your caregiving role?

Questionnaire option: Caregiver Reaction Scale

Key Components of CG Interventions

• Professional Support
• Psychoeducation
• Behavior management
• Counseling
• Self-care/relaxation training
• Multi-component interventions, typically engaging family members in increasing their support of primary caregiver

Gitlin & Hodgson, 2015
Necessary Steps

• **Solid research base for interventions:**

• Best Practice Caregiving website— Benjamin Rose Institute and Family Caregiver Alliance

• **Brief family caregiver clinical protocols with proven ROI:**

• Stanford University School of Medicine current efforts to review family caregiving literature and create feasible protocols. Led by Nirav Shah, MD with 6 physician research fellows
Key Consideration 3:
Families who navigate across care systems need

- education on care team and care plan
  - *what* is in the plan
  - *how* it will be accomplished
- reporting structure that links to EHR
  - patient portal
  - family portal
- support for resilience under stress
Families are missing on the INTERPROFESSIONAL TEAM

Team does not know

• What family knows about daily functioning?
• Who provides what help to person at home?

Families rarely know -

• What do disciplines do?
• How do they work?
• Whose scopes of practice overlap?
• How do communication patterns vary across disciplines?
Kanisha’s dilemma

• Professionals assigned her 2 tasks: get her mother to reduce alcohol intake and change her diet
  • WHAT: exactly what amount of alcohol and diet change?
  • HOW: what is the role change that is being asked of Kanisha?

• How will professionals know her actions or her impact?
Howard’s team’s dilemma

• Howard’s health care team assigned him to take medication that
  • Howard doesn’t believe he needs because he has no problem
  • Janet (wife) doesn’t trust so will not administer

• Who knows that they need to work with Janet to increase her engagement in appropriate med administration?
Key Consideration 3:
Families who navigate across care systems need
- education on both *what* and *how*
- reporting structure that links to EHR

A Step Forward:
*Integrated care (and training) could include*
- *interview CGs about family system – roles in health*
- *track family implementation in EHR explicitly*
- *add family portal, with education resources*
- *use family session(s) to address disease management*
Care recipients and Caregivers Need the WHAT and the HOW

- Accomplish evaluation
- Change roles
- Interpret reports
- Resolve conflict
- Decide when it is time

- Diagnosis
- Risk
- Resources
- Treatments

What

How
Train Staff in Language with Families
Warm hand-off – pushing through resistance

• You are running a marathon, not sprint. Let’s keep you in shape.
• You deserve support.
• If not you, who? We must prioritize your strengths to sustain you for the patient.
• At some stages of care, big decisions must be made that really change your relationships in important ways. These are hard. I encourage you to get some good ideas from a counselor about how to talk with your loved one(s) about the challenges and decisions you face.
• Even if you aren’t ready today to make big changes, I hope you will learn now about the options for getting help providing care, for that point in the future when you need it.
Social Services
and Mental
Health

Follow-Up
(office or
home)

Health Care
Visit

Illness
Information

Care Skills

Coping

Coaching

Decisions

Family
Intervention

Counseling
In sum...

• Families provide majority of health care to older adults ... yet are not part of the healthcare team

• We need studies of various approaches that might help families participate more effectively in care teams, reduce family distress and increase resilience, and increase the likelihood of desirable home-based lifestyle and care management.

• Health systems can act NOW to consider how to
  • Obtain information from families about daily functioning and health management
  • Assess well-being of caregivers
  • Support family caregivers with education, support services, and partnership


