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**Confronting the Chronic Care Challenge  
Panel Three: Empowering Consumers and Patients to Share  
Responsibility for Cost and Quality  
Partnership for Quality Care  
March 19, 2008**

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[START RECORDING]

**DIANE SOSNE:** Hi, and good afternoon. I don't know, where is that voice in the sky coming from? Good afternoon, and I want to welcome people back for the last, I think, panel, presentation of our program. My name is Diane Sosne. I'm a registered nurse, and I'm president of SEIU Healthcare 199NW.

We represent about 22,000 registered nurses, other professional, technical and service workers in hospitals, ambulatory care and home health and hospice throughout the state of Washington, and our members deliver what I call cradle to grave care, so beginning of life to end of live, and I'm delighted to be here today with my colleague, Scott Armstrong, president and CEO of Group Health Cooperative.

Back home in the other Washington, Group Health and SEIU work together in a coalition called Health Washington, and it includes other partners like the Hospital Association, Children's Alliance, other unions and other advocates in supporting an agenda of health care reform.

Our coalition has lobbied for children's health coverage as well as funding to reduce the number of uninsured adults, and I'm also glad to be part of the partnership for quality care since I believe it takes the provider community and front line caregivers, so our members working with our employers, to not only in our home state but nationally be

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leaders in fixing our broken health care system, and when I talk about health care system, I mean both the disease care, treating people who are already ill, but equally as important the wellness care.

When, in nursing, as a nurse, I'm dealing a lot with the nursing shortage and one of the things we talk a lot about is just being on this verge of this massive retirement of the baby boomer - the nurses who are going to be leaving, and who's going to take our shoes, and when I was reflecting on the speakers this morning and looking around the room, I don't think I saw very many people in their 20s. Is there anybody in their 20s, or anybody in their 30s? Okay, we have like two or three.

So herein lies the rough, in a sense. Not only do we have this challenge to change our broken health care system, but I would say we need to do it before we retire.

[Applause].

**SCOTT ARMSTRONG:** Thank you, Diane. I do want to tell you I feel like I'm in my 30s [laughter]. What Diane didn't say in her introduction of the two of us is that she and I have been working together, known each other for nearly 20 years and we haven't agreed on everything, but we're very excited about the agenda that the PQC creates and that brings us together.

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There's a lot of work for us to do, not just here in D.C., but in our own state in Washington, and we're eager to align our efforts and to do some great things.

It's my great pleasure now to introduce this group of panelists, people who will tell you more about Group Health Cooperative, because a few of them work there, but a group of people who are here to talk about an area in our agenda today that's focused on empowering consumers and patients to share responsibility for cost and quality.

Today, of course, you know our medical system is structured around the assumption, the fault assumption, that patients are passive recipients of their care. This, we believe at PQC, this we believe in our organizations, has got to change. It's got to change for a couple of different reasons.

The argument comes at a couple of different levels. First of all, it is a fiscal issue. We know that the most cost effective way for our health care to be provided is through a system that helps our patients take care of themselves day in and day out, because we all know most health care in fact is provided in our homes by ourselves.

Second, it is a quality issues. We know that the best path to affordability is through quality of care, and that high quality care is a result of patients taking responsibility for their own health and being actively

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engaged in their care, so for this reason we are very excited about the agenda here in the next part of our meeting, and so to lead us through this work, let me introduce all of our panelists, and then from there we'll let them tell you're their stories.

First, from SEIU 1199 NW, Gerda Cunningham; she's a registered nurse. She's from Seattle, Washington. She's on the staff at Group Health Cooperative and she's a case manager for congestive heart failure. She'll talk about a program to address congestive heart failure that was initiated by her, her colleagues, front line staff and it ultimately was endorsed and supported in our organization.

We have Dr. Matt Handley and James Hereford, both also colleagues of ours from Group Health who will talk about the way that we're using our organization's investment and information technology to not just inform our care providers and not just inform our patients but actually to engage our patients as active participants in the promotion of their own health. The work that they'll talk about is very excited and we're very proud of it.

From Catholic Healthcare West, Kathleen Farrell will describe a congestive heart failure management program that has a slightly different focus from those that you may have heard of already. She will be describing this program that serves a highly uninsured community and describe the ways in

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which her program has confronted very difficult financial issues that are relevant when serving that type of population.

And finally our moderator for this panel, Mitra Behroozi not only runs one of the largest benefit funds in the nation the SEIU 1199 Pension and Benefits Fund, but she's also a commissioner for MedPAC, which, as we all know, is responsible for advising Congress on Medicare payment policy.

So, please join me in welcoming a very distinguished panel and our moderator, here they are [applause].

**MITRA BEHROOZI:** Thank you very much to our distinguished introducers. I'm just going to say two things that struck me about this panel. One is that certainly throughout the day, our first panelist, Dr. Madvig of Permanente, the role the patient can't be overstated in assuring that our health care system delivers care most effectively and efficiently, but unfortunately too often consumer empowerment or patient empowerment is used out there as a euphemism for what Stuart Guterman identified as cost shifting. It might be called cost sharing, but it's really cost shifting which really doesn't, in the end, do a whole lot to bring down costs or improve quality.

This panel is going to tell you about real engagement, real empowerment of patients as consumers of their own health care, as participants in their own health

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care. We at the 1199 funds do periodic polls of our members, and it is a consistent theme that our members know that they need to take care of themselves. They know they need to lose weight, get preventive screenings, all of the kinds of things that our panelists have been talking about and they want information and tools to do that, so our panelists are going to tell you about that, and we're going to start with Gerda Cunningham. [Applause].

I'm sorry. I blew my first task as a moderator. I introduced the wrong panelist first. I'm so sorry, Gerda; and it's Kathleen Farrell who's going to be going first.

**KATHLEEN FARRELL:** Well, good afternoon. I always feel like I'm in trouble when I'm called Kathleen. My father called me Kathleen, and any time he said that I knew I was in trouble, so it's kind of intimidating to me to come up here and be Kathleen, so.

I run a heart failure program for a small community hospital. It's pretty intimidating to be in this room with such incredibly gifted people and to share and to network with so many people regarding chronic disease management, but the one thing that has proven to be so evident to me is that it doesn't matter how big or how small our population, we're all faced with the same challenges and it's pretty exciting really.

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Nationally, there is more than 550,000 patients - more than half a million patients - each year that are diagnosed for the first time with heart failure each year, and that accounts for over five million patients throughout the year, throughout the country at any given time who have a diagnoses of heart failure. It's very costly to the health care system being over \$33 billion in care. It's Medicare's number one admitting diagnosis, and at Marian Medical Center where I work, Catholic Healthcare West's facility, it is our - alternates with our number one diagnosis of heart failure versus pneumonia or COPD, respiratory distress.

The Marian Medical Center's located in Santa Maria, which is part of Santa Barbara County and that's just south of San Luis Obispo, about halfway between L.A. and San Francisco, and it's a very interesting population. Although we service about 90,000 people, about 20 to 24-percent of our patients are uninsured or underinsured, and this represents a huge problem for our program often, and often a challenge for our hospital.

About 51-percent of our population is Latino, and when I started this program in 2002, people always say they're very impressed that I'm a coordinator for a heart failure program, but please don't be impressed because not only do I do the clinical management and share articles regarding evidence based medicine with our providers, but I

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also assembly my admission packets, lick them closed and put them through the mail meter. Essentially I'm a department of one and I have a nurse who works for me just a few hours a week who's bilingual in Spanish, and that was critical to the success of my program, with meeting 51-percent of our population is Hispanic, and oftentimes these Hispanic patients with all of their cultural differences are not at all interested in listening to this Swedish girl stand up and talk to them.

But heart failure rates throughout the country within 30 days average about 18-percent, and at Marian we go up to about 18-percent; however, with patients enrolled in my program the readmission rate within 30 days is only about 1-percent, and that really shows that a small, grassroots program that provides basic patient education can really assist patients.

My main goal is to help my patients to manage their disease process rather than having it manage their lives. This program was started when the Robert Wood Johnson Foundation awarded a grant to the vice president of home care, and she chose to begin a heart failure management program, and to date - actually there's an error on this slide - I was hired in 2002 and I've enrolled over 800 patients at this time in the program.

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It's essentially a telephonic case management program where I call patients about once a week; however, if their symptoms are high and they're having a lot of problems I've been known to call patients daily, and I will follow them up to about a year unless the patients choose to continue enrollment in my program, so as long as they haven't had a re-hospitalization, then I'll continue to follow them as long as they need it or want it. If they're re-hospitalized, their year count will start immediately again.

One of the benefits with our program is that through the software that I use to manage my patients, physicians can have updates in real time. If they choose to access my program they can do so via the intranet and also I will fax them reports consistently after every patient interaction via fax modem.

We provide very basic educational information in both written as well as in spoken dialogue. It's at a seventh grade written level, and it's available in both Spanish and English, and we emphasize self care for our patients, specifically about patient compliance with their medications, daily weight monitoring, lifestyle behaviors and changes, although some of you in this room might be surprised to hear that the youngest patient I've ever enrolled in my program was 20, and the oldest patient I have in my program currently is 99, and certainly I manage these patients a little bit

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differently where I'll work with lifestyle and behavior modification considerably more with my patients who are in their 20, 30 and 40-year-olds versus the 99 year old. As far as I'm concerned, as long as he's not having any symptom exacerbation and his quality of life is good he can eat whatever he chooses. That's okay with me.

And I work with our home care department. If I feel that a patient needs more hands-on care in their home then I can get a referral and have a home care nurse go out and see our patients and this will help tremendously. I also try and see our patients if they're ever hospitalized, and oftentimes that's when my initial referral comes from is when a patient is hospitalized then I will see them in the hospital and provide discharge instructions meeting our JACO standards regarding smoking cessation, discharge instructions on heart failure regarding behavior modification, taking your medications, daily weight and such.

A lot of our health disparities were because of the fact that despite having a highly Spanish-speaking population; however, once that I was able to hire a nurse part time that has really resolved that issue, although she's only working four hours a week. I am currently seeking to have funding to have her working half time with a laptop computer where she's mobile in the community and works at our clinics affiliated with Marian Clinics as well as with our

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public health department, and that will actually work tremendously well for this population, because I recognize a lot of the differences in the culture of working with our Hispanic population that they much prefer the face to face contact versus telephonic follow-up.

We will always work with our hospital where our IT department has linked the software that I use with our hospital operating system, so that any time that a patient is admitted to the hospital with a DRG representative of heart failure I have the opportunity to see the patient, to provide education to them, to screen them for potential appropriateness for our program.

And I work with our patients tremendously on full case management. If they need household repairs done I work with community benefit issues so that they can get repairs done to their home at low cost or no cost. If they cannot afford a scale, we will provide them with a scale. If they do not have food in the house, we'll get them into nutritional programs to get them adequate nutrition, so we'll work with full case management.

I had a client who requested information on community resources for transportation; however, when I sent him the information and called to follow up with him he admitted to me that he was legally blind, so unfortunately he couldn't read anything that I had mailed to him, and this was a great

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challenge for me, but I was able to work with a volunteer organization in our community who sent a businessman out to see him who now visits him twice a month and helps him with paying his bills, reading his mail and taking care of his business, and let me tell you; as a nurse that was something that was tremendously rewarding to me, not just managing him from a clinical standpoint but helping him with community resources.

A lot of barriers to our expansion have been funding. Marian has chosen to continue to pay my salary and to support our program because of the benefits for our patients and we truly are always looking for additional funding for IT budget and the infrastructure because our system is sorely outdated at this point. It needs to be upgraded into the 2008 standards, but readmission rates, as I talked about, considerably different for patients who are enrolled in our program; only 1-percent versus 18-percent nationally and 18, 23-percent for Marian, and this really demonstrates a tremendous cost savings to patients as well as patients who come into our hospital have a much shorter length of stay.

These patients, because of the education that they have -- and this is proven time and time again through any disease management program - that patients are queued into their systems so that they are managing their disease process that they will recognize signs and symptoms of an

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exacerbation or problem early enough to seek care so that if they are in fact hospitalized it will be for a shorter length of stay or they can be treated as an outpatient, and at Marian we have shown that we've saved up to about \$1,800 for each case, for each admission to our hospital, and that's a considerable case savings.

Since I started seeing patients in the hospital and assisting the nurses with providing discharge instructions we have met our JACO measures up to 98, 99 and 100-percent in this past year where before I was seeing patients it was always a challenge to meet our JACO standards as well as our CHW initiatives in order to meet all of our criteria for discharge instruction with helping our patients.

And the key learnings that we found is that it takes someone who is dedicated to a program like this, and some would say that I'm probably more than dedicated; that I'm absolutely passionate about what I do and passionate about my patients, and although we have such a small grassroots program it really doesn't matter. The challenges are the same. The obstacles are the same and the benefits are tremendous.

We have found that we've got tremendous benefits in working with our home health department and our palliative care programs. IT involvement is very, very critical to having a good software program that you can use, and the

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program is definitely well positioned to look for additional funding since we can prove statistically that our patients do much better.

Physician involvement is very key, and the majority of our physicians, especially my primary care doctors, also state that they are delighted to refer the patients there because these patients, as many of you know, are very complex, multisystem issue patients who can often require a lot of time, and the 15 minutes it was mentioned that the doctors can talk to them; these patients want a lot more time, and so they are very happy to have additional assistance managing them from a nurse.

And I also network for our patients who are uninsured or underinsured to get their medication, because certainly if they don't have their medication they're going to have system exacerbation. We've seen in our ER and our hospital far more - one of the main benefits, and I alluded to that earlier, was that patients cannot afford a scale because daily weights are so critical for our patients that I was networked with a pharmaceutical company for getting scales for my patients; however, they stopped funding that program but it meant so much to my patients and it was recognized as being so important that one of the detail people who worked for this pharmaceutical company donated money to our foundation for my

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program to provide scales for my patients, so we've been able to continue that process, so that's been terrific.

I'd like to thank you all for listening and thank you all for this wonderful opportunity to learn, to network and to share information about our program. Thank you [applause].

**MITRA BEHROOZI:** Okay, so let me make sure I get this right. This is going to be Dr. Matt Handley from Group Health Cooperative.

**MATT HANDLEY, M.D.:** Hi there; a pleasure to be here. I'm the luckiest person in the room probably, professionally and personally, but professionally I both get to work developing tools to help take better care of our patients both from the quality perspective and the informatics perspective, and then I use them in my own practice, so I may lapse into stories about the care I actually personally provide instead of just talking about large populations, partially because it's right after lunch, so anything we can do to spice things up we're going to do.

So I'm going to talk - we just heard Kathy tell an amazing story of heroism, really, which is what our system kind of requires of people who work in most settings. I'm going to go back to talking about an area in medicine which we spent a lot of time in the morning on, which is the island of rationality. In our non-system there are these areas

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where you have the sweet spot, especially where there's integration of financing and care delivery and a multispecialty group practice, so I'm going to talk some about the incredible innovations we've done there, and then James is going to talk about how we're working to try to bring some of that learning to help patients that don't have the advantages that those systems provide.

I'm also going to talk in a fundamentally different way about things or at least a different lens on things that we heard this morning. This morning was kind of about - and I'm going to draw a stark comparison mostly to make the point, not that these people aren't doing the work this way - was about diseases and body parts and not about patients too often, because patients don't have a disease or illness. They have wellness needs and they have multiple chronic illnesses and co-morbidities, so many of Kathy's patients have diabetes, gout, COPD, all kinds of different things, and to them we can't have systems that require them to go to special clinics for each of their different problems where being a patient becomes a full-time job, so we don't want to do that.

So the current system - I love this picture because this is how I think it's ended up being. We have asked our patients to be the integrators, and as much as we want to empower patients, if we don't supply them with ways to do

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that I would challenge you to think about the last time you went to a physician's office and you were given verbal instructions, probably about three or four things, and if you were quizzed about an hour later that would be interesting; a day later that would be interesting; and in a month I think we'd have a very low recall.

I certainly would, so how do we expect, when I go especially to providers that work in different systems using different paper records that literally, as I used to do, scribble on the exam room table paper and hand it to people with my handwriting, how do we expect patients to keep track of their care plans if we take the time to develop one?

So we need to build tools around patients to support this, and I'm going to tell a little bit about how we've gone about doing that using technology, and I'm going to start with an ad that we did that kind of showed that shift toward being even more patient centered than we had been.

[Video played]

So health care is an activity that you want privacy. We all do. We want things to be set up around our needs, not the doctors' office needs, so what I'm going to talk about is a story about how we went beyond the bricks and mortar. We blew up the model, the currency of health care which currently is the in-person office visit toward meeting a patient's needs in a way that matters most to them, whether

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it's a phone visit, an in person visit or an electronic secure message.

And some work that I participated in with Kaiser kind of tried to envision what that future might be like about five or six years ago, and the idea was how do we put the patient at the center? How do we integrate information and bring it together on their behalf, customize it to both their clinical circumstances and their preferences? Things we often do not do, and then allow seamless transitions, because as things are relatively fragmented, even in an integrated delivery system there's hospital care, nursing home care, outpatient surgery, specialty care, primary care. How do we make sure everybody has the same play book that revolves around the patients' needs instead of around the doctors' needs? So when we put in our electronic medical record we actually turned it on first for our patients so they could see an electronic medical record that's shared between patients and docs.

We've also done some work expanding on some of the work that you've heard about, undoubtedly, just by the fact that you're here, about the idea of a medical home, and I would argue that by being patient centered and organizing around patients, there's evidence that suggests this may be as or more important than all of the stuff we've talked about

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like getting people on the right medicines and things like that, and making sure they have the right diabetes test.

So having a personal relationship with a physician and a clinical team you almost always are ideally including nurses, medical assistants, other health care professionals that all work together on behalf of a patient is a huge enhancer for the patient.

We designed our system to try to support that relationship at the center. Rather than it's about the technology, it's about the patient and how we best meet their needs.

When we talk with patients we work to meet them for all of their health needs, so every time I see a patient I do the same thing all day long. No matter what kind of a doc you are you do the same thing. You make people feel cared for. You get their list. You have your list. You figure out what you're going to work on. You get the information to make informed decisions based on their preferences and then you have a plan for following that up. That's all you do. The only thing different is your list, their list, their decisions and how you plant to do that, but the core thing is recognizing that what matters is what the patient can actually accomplish on their own behalf rather than what the "right thing to do" is.

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When I ran a sports medicine clinic for a while I had a patient come in that wasn't doing well because they were failing physical therapy, and I figured out that it took 23 hours a day if they were to actually do all of the physical therapy exercises they had been prescribed, so they of course did a half an hour and they had omitted all the ones that mattered, so working collaboratively to come up with something is the key.

The more patients know and the more we organize information for them the more comfortable they are taking an active role in decision making, so all the information and the literature about patients getting balanced, accurate information based on high quality evidence shows that patients make different decisions than doctors would for them, and they're more comfortable with both their health outcomes and the process when they do that, so we strive to have that be an integrated part of things.

And what time would you like to call your doctor's office? It's probably like our patients, and it's probably outside of your working hours, so they - it turns out we're not open to receive calls then, but we can get web messages which is when most of our web messages now come in, so how do we meet the information needs of patients in the way that meets their life and at the time that it meets their life? So we've set that up for 24/7.

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What we did is we built - we took the same basic vendor for an electronic medical record you saw with Kaiser, who we collaborate on often on these things, and have a clinical data infrastructure where we know their data and both patients and doctors can see the same data. It's not a separate PHR from a stand alone insurance company that's not connected to care. It's a shared record that patients write to with secured messages to us and they can see all their lab, pharmacy, et cetera.

That helps improve the quality of care, the efficiency of care delivery, because an awful lot of time is spent finding information in the communication with patients, so here's what it looks like. The lower screen, the background screen is what I see in my clinic, or my patient sees with me in clinic. The top screen, which of course has better formatting because of our fabulous web team, is the view the patient would have of their own medical problems.

The after visit summary; when I leave the doctors' office - of course I'm a 50-year-old man; I go every decade or so - but if I were to see the doctor, I would lose any piece of paper I was given. I do that now in all aspects of my life. We can access that through My Group Health, the shared records seen by the patient for after visit summaries which then the patient clicks on. It shows the instructions that we worked on together in the visit including any

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educational links that I brought in and we looked at together and our premise is then from the exam room to the living room. You should see the same quality of information so that patients can go over it again and again as necessary.

We receive lab results automatically, so even an abnormal lab result that doesn't require counseling is automatically released to the patient; again, formatted a little nicer than what we see. Not only that, patients see trends over time, and because most people don't know what an AST is, let alone a CBC, all the medical jargon; we put that in context with links to balanced and accurate health information so that patients can click on it and find out about it, empowering patients to know more about their health.

Now, some organizations will have someone come up who's a zealot, and I am that guy. I am the zealot. I take care of a thousand patients still and I absolutely love this stuff, and in some organizations, having gone and visited them, there are three people out of 400 physicians that actually do this stuff, and I wanted to demonstrate that this is a system property in our place, so this is just - as I grab the week of February 25 - we have 47-percent of our members on line with us, our adult members. In addition we have almost 14,000 parents looking at their kids' charts and working with us on-line, 51,000 visits to the health record,

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50,000 people looking at their labs - or 50,000 labs looked at - 13,000 after visit summaries looked at, 6,400 secure messages back and forth with clinical teams. This is just part of the fabric of how we take care of our patients.

In our group there are -- I believe we now have a little over 800 physicians and over 90-percent of them have worked with their patients on-line. Those that haven't are set up in places like emergency rooms without continuous long-term relationships.

We began this in 2003, putting in the technology infrastructure to support these kinds of innovations. By 2005 we had all 30 sites rolled out. We put in \$25 million. It's going to take us seven years to get that back. Now, a lot of people worry about where the savings go from EMRs, and our story's a little different than what's mostly written about. Most people write about the benefits that come from the health insurer, and in our system what's interesting is that we saved on transcription, delivery system costs, \$4 million in those three years. We actually, by presenting the information to the doctor at the time of the visit rather than having them call about high cost medications, we actually have I think the highest generic use in all of the Kaisers also, of the Permanente groups.

You can't do that without tools to support it, and it used to be calling someone on the telephone and now that

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information's available in the medical record. We've got back a lot of our buildings because we don't have to pass the paper chart around, and we've also saved over \$2.5 million related to medical record management because that medical record's available anywhere instantly rather than having to move a paper chart.

Patients are very satisfied; don't have to go through all the gory details. Ninety-five-percent of patients are incredibly satisfied with their on-line experience with how the technology works and the age distribution is fascinating. It is exactly symmetrical, peaking in the early 50s. I have many people in their 80s on line with me. Those are the people, arguably, who it's most important for, because it's so hard for them to come in.

This is fascinating. We asked patients what would you do if you didn't have secure messaging? And the key take-home for me is that 7-percent of the time they wouldn't have talked to us at all, and that shows us the barrier we present to patients that blocks them getting the care they need. This lowers that barrier in an effective way.

And even when a visit happens it's incredibly enhanced by patients communicating with us about a topic beforehand. In my practice, before anyone comes in to see me, two days before, they get a message saying Dr. Handley would like to be really well prepared to make sure you get

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value out of your visit. Please send him a message, reply to this, to let him know how he can best help you and what you're trying to get out of the visit.

It helps patients organize. It helps me organize and occasionally makes it so I can meet a patient's needs without them having to come in, which is a great advantage to them and lower overall system costs.

Over 90-percent of patients would recommend these services to their friends and colleagues and for 66-percent of patients - this is our business case in a way - it's extremely or very important, these functionalities, in deciding what health plan to buy in the future, so it's a stickiness issue for us. Not only is it in the patient's best interest. It's in our best interest to support them this way.

Patient satisfaction; the more use of these tools the higher the satisfaction of patients with our organization overall, not just with the tools and what that does is it allows us to provide an experience that isn't limited to buildings and sitting down with people. It's about - this, in a way, is the most transformative thing that has happened since I've been a physician for 23 years. It's great to have the EMR aspect which just helps make the right thing the easy thing to do and brings together the information, but people kind of presume that you did that all the time. The truly

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transformative thing is bringing the patient in in this way, in a way that other groups have - well, actually Teddy Tan [misspelled?] in the back there is now the expert on his sabbatical about the innovations happening around the country in small groups being able to do this, but it's challenging without that integrated group to have this become a system property, so our next task has been to say, well, if you're lucky enough to get care in our system, we can do these cool things and we've been trying to work and say how can we meet the needs of patients that aren't enrolled in our health plans? And James is going to talk about that [applause].

**JAMES HEREFORD:** Thank you, Matt. Matt and I have a friendly competition about who has the best job in health care, which is one of the best competitions to be in, and as Matt said, it's more about the system properties of our organization. It's not that we're such technology geniuses or understanding health care operations so fundamentally better. It's that our system allows us, because of the integration of care and the integration of financing of care, to do things that other systems simply have a difficult time doing, but we're not just that system. We have 5,000 affiliate providers. A third of our members get their care outside of our group practice, so that presents a real challenge for us, and I'm going to talk a little bit about how we're starting to address that challenge as well as

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broadening our services to people who don't even get their insurance coverage through Group Health.

So we have this product we call Momentum, and it's an integrated suite of health and wellness solutions for employers and purchasers, so that I'm sure if you've been around health care at all in the last decade you've heard about disease management. You've heard about now more recently wellness programs and this harkens back to the point that Matt made early on is that disease management programs and wellness programs tend to focus on body parts and issues as opposed to the whole person.

So what we tried to do is build a suite of products that integrated, that really focused on the entirety of the patient's needs, because a chronic care patient who has diabetes also has prevention needs and wellness needs that we can address, and we try to do this in a very similar way, albeit with limitations because, as part of my responsibilities I own the entire IT infrastructure.

It is a real advantage to have control of the IT infrastructure because it allows us to deliver information to our providers in a way that I simple cannot replicate in our networks with our affiliate providers, so we're trying to get as close of an approximation as possible.

So the key components of this - first of all I'm going to talk about the health profile and then I'm going to

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talk about health coaching, and I want to make sure I get plenty of time for Gerda's comments because she runs an incredible program.

Our health profile builds on the best of both worlds, so there are health risk assessments everywhere. Our health profile really is a clinically relevant health profile, meaning that it helps provide clinically relevant information to providers. Now, if you happen to get your care from a Group Health provider, that information is integrated deeply into the electronic medical record. The provider can see the report, but we can also write logical triggers against that information to make sure that alerts fire if certain conditions or certain risks are present, and of course the patient gets information about their health risks and then support, and this is the other critical component of this.

In our group practice we talk about the medical home. It's the key leverage, the key support mechanism in where we've broken down the barriers really connecting visit to the exam room to the living room.

That is the principal way that we focus support to the patient to make sure they have the information they need and the support they need to manage their health care effectively.

We don't have that same advantage in all of the areas that we serve, and so we've turned to lifestyle coaching and

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health coaching as mechanisms in which our ends reach out, but not in the typical disease management fashion in which you're saying make sure you get your hemoglobin Alc done, because that's a fundamental part of good diabetic management. It's more about really understanding and activating patients, people, in a way that allows them to be better managers of their own health care, because you can talk to people all you want about going to get a lab test, but they don't understand the importance of that lab test nor are they really motivated, because of other psychosocial factors to do it, it won't matter, so that's the idea around coaching.

So I've talked a little bit about the health profile. It's a clinically relevant tool. It's a foundational program to - or element of our Momentum program and it provides critical data for us, both within our group practice but also outside our group practice to really support patient activation around specific risk factors that they may have.

You get instantly clinically valid accurate assessment. We have narrative feedback so you see many of the same integration points that Matt pointed out in the medical record to a consistent set of content. We use the Healthwise knowledge base, but there are many different sources of content, and then again coaching.

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Coaching is a critical element of this where you don't have the primary care provider and integrally integrated. Somebody's having more fun than I am [laughter]!

So this idea of interpersonal engagement where you have a coach that reflects advances in behavioral theory so we've learned a lot in the last two decades about how do you really engage patients in a way that they can engage in health care activities and with the system, because most people, being a layperson - you notice I have MS - I'm just a recovering mathematician. I'm not an MD. I'm not the dumbest guy in the world. I'm also not the smartest. The health care system is baffling, and you think about it to an insider. I think it's baffling. Can you imagine what it's like? And you probably can, because it's your mothers and your wives and your daughters and your sons who have to deal with it, and without somebody who can help guide people and help understand and translate all of the gobbledygook that we've been able to come up with through the science of medicine into terms that people can understand, relate to, and understand then what behaviors and actions they need to take, it's almost insurmountable the barrier that we present.

So we have packaged this, as we are likely to do in almost all instances, at least one modality is our wellness web site, so a way of being able to bring large amounts of

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content and support together. The coaches can refer to this so they can say here's a place, here's a resource.

We have other modalities because we don't depend only on the web as a delivery mechanism, but of course the web presents some very nice features in terms of the ability to package up a lot of information easily and make it easy to use.

It also includes action planning so that people can then start to engage and have a way of continuing through and relating to their coach and to their own behaviors about the changes that they're going to make in their lifestyle.

We, of course, incent, because that's a significant component in any wellness and behavioral change is to have the right incentives, and it's interesting that it really doesn't take a lot of incentives. It's more the matter of there's something there to be able to shoot for. There's a goal, and some goal structures around incentives are very helpful. Quite frankly, we've found that some of the most important and influential goal structures are those that are peer generated, so people who get involved with social walking groups and some of those things, or even diabetic classes where you have a group visit of diabetics who come together, and that's social support, so there are all kinds of manifestations of that.

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And of course self management support has been alluded to many times today. Most of health care does not happen within our walls, within our institutions. The vast majority of health care happens outside of that, and certainly the vast majority of health care decision making happens outside of the walls of health care institutions, so how do you support patients where they're at in a way that they can understand to be really able to engage in the activities that make a difference in their health care status.

[Video played]

So just evidence that behavioral change is possible with any individual, right? So with that, thank you very much for allowing us to show what we're up to, and it's my pleasure to turn this over to Gerda Cunningham. Thank you [applause].

**GERDA CUNNINGHAM, R.N.:** I feel very honored to speak here today on behalf of our congestive heart failure program in Seattle, Washington, and listening to my colleagues here I feel if wouldn't already be a Group Health patient and a Group Health employee I'd really want to apply for a job there. It sounds like a really cool place to work! It's very awesome.

I have listened with great interest to some of the presentations today, and have noted that heart failure has

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been really on the forefront of the discussion here because it is the number one chronic illness which is showing up repeatedly in our Medicare population, and we have taken this upon ourselves nine years ago to create a program based on a staff member's personal interest and the cooperative interest in decreasing cost really with a high focus on improving quality of care, and this I hear reflected again and again in this meeting and in our ongoing conversations at Group Health.

This slide here is very interesting because the numbers and predictions really haven't changed at this point and remain pretty accurate and our next discussion is treating chronic illness and preventing the co-morbidities which are leading up to illnesses like congestive heart failure, coronary artery disease and so on.

Our program was started in 1998 and has been growing over all these years from initially three R.N staff covering an area from Olympia, Washington to Everett, Washington and bordering the east side of Bellevue, so we cover quite a large area.

We have serviced probably several thousand patients at this point and are holding caseloads of approximately 100 to 120 patients each case manager.

One of the cornerstones of our learnings and the work that we are doing has been is connecting closely with

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cardiology and a cardiologist mentor who provides ongoing education and consultations.

We also have learned that - and specifically congestive heart failure - having a patient be seen at least once by a cardiologist provides ultimately better care because it is quite specialized.

Guidelines change. We now not only look for medication guidelines. We also are using more and more implantable devices like defibrillators and biventricular pacemakers and pacemakers, so it is of utmost importance to have someone with skill like a cardiologist see a patient and create a plan of care, and we have that opportunity at Group Health.

We basically, in our heart failure program, are supporting optimal medical care per national guidelines and best practice models. This has really shown to reduce cost and again rephrasing quality of care and really improving quality of care equals reducing cost, and it's something that our program has demonstrated over a time. It's like almost we can forget the search about decreasing cost once you improve quality of care.

And we have a program which schedules our interactions with patients and that can be either by phone or in clinic where we see our patients and our program follows also medication and treatment protocols. We're somewhat of

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an odd species as case managers. We're not nurse practitioners and don't have prescriptive authority, but we are a bit like nurse clinicians. We are really physician extenders, if you will, because we do create plans of care for physicians, but are working very independently which really does also cut down on physician time.

I like this phrase anticipatory care plan or sick day plan. We know that when our patients have congestive heart failure, it is a chronic disease which is treatable and not curable, which means that we anticipate that they are going to have exacerbations. Any flu, pneumonia, bronchitis, other illnesses can put our heart failure patient in exacerbation without them eating a lot of salt or doing anything else, so it is important to anticipate and educate patients about these anticipatory events that we can't immediately treat and plan for.

We monitor other chronic conditions, which is incredibly important to do because they affect, really, the heart failure outcomes. We provide a lot of care coordination between physicians foremost, between home health departments, social services, physical therapy, nutrition therapy and sometimes we refer to pulmonary and to nephrology.

We paved the way for end of life care, and that's a huge discussion we have, because the patients we manage are

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very ill and are expected to decline in some time. While we try to keep them stable, we do manage mostly the advanced heart failure type patient.

What that means, when we talk about end of life care, is when a patient comes to us we solicit information that's very simple, like do you have a durable power of attorney? What would you like to do when your status declines? And we provide education around that and what to anticipate, and we try to address a code status or in Washington state we have a post form which is a physician's advanced directive and the patient gets to sign that and very specifically state their wishes and then the physician signs that.

The discussion can happen between the physician and the patient, between the nurse case manager and the patient or sometimes the three of us in a team meeting.

When this is done this can actually decrease cost in a major way because most patients do not want to have major heroic treatments, and again this brings the patient to the center of all of our discussions.

I love Matt's slide about where the patient is really at the center and that is what we try to provide with our program is collaborative care planning in an ongoing way and reassessing our efforts and educating the patients. This is an ongoing effort.

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The program goals we have is really to improve, again, the quality of care. Now, increasing functional status capacity of the patient and quality of life; that's really a big mouthful, but it happens. We see it happening. They are providing the appropriate tools for the patients, supporting the appropriate treatment plans and we notice that our patients actually - they couldn't walk from their bed to the bathroom and now they can walk around in their house or apartment. It may not seem much to us in terms of measurement, but it's huge, and they can come to the doctors' office, whereas before they were only homebound.

We provide connections with our Silver Sneakers program. Everybody in this room should know about Sit and Be Fit which is on television every morning and we advise our patients to use that program. It's really quite exciting to us to see patients become more mobile and independent.

We have decreased hospital admissions and readmissions and one of our later slides will show that we have actually looked at all admissions and not just heart failure admissions, and our numbers remain very promising, and of course patient satisfaction is tremendous. I have multiple, multiple patients tell me I would have left this organization if your program wouldn't have started, and that's an ongoing, exciting feedback to us as nurses, to our

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organization, to say this type of a program really works and we can build up on that.

We do follow admission and exit criteria because we would like to service as large a population as we possibly can and we do have certain referral sources that we've received referrals from, and this is a little bit about the actual case management data collection process. We do assess very extensively all the needs of our patients. We do follow up sometimes once a month. We have sometimes daily follow-ups for patients, depending on their care needs, and again risk assessment of any other co-morbidities.

Depression can worsen heart failure. Anemia can worsen heart failure. Sleep apnea can worsen heart failure. Diabetes, uncontrolled, can worsen heart failure and many more. Smoking, alcohol abuse; we address all of those in our assessments to be very broadly aware of what the needs of the patients are going to be.

We custom tailor educational material. Every one of our patients gets a heart failure work packet. We have developed magnets which belong on the patient's refrigerator so that they can never, ever lose our phone numbers and it has a symptom checklist so that if the family walks by the fridge and their grandma's short of breath, there's a phone number to call us.

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We do have 24-hour service not directly to us but connected to our consulting nurses, so we work with them very closely for after-hour care needs.

We do send free scales out to those in need. I can skip that one.

Intermittent reinforcement; the question always comes up why are we keeping patients so long in our program? I want to make sure that you all understand when a patient has a chronic disease, oftentimes there's decreased oxygenation in the brain happening. If they have diabetes, they have small vessel disease and they cannot remember all instructions. This is why a case management program and educated nurses and staff have to continuously reinforce the plan of care and what's expected of us and of the patient to coach them to basically partner with them about what the goals are going to be and to achieve the necessary outcomes.

Setting goals with patients is really important because they are the ones who will let us know what they are wanting and willing to do and then obviously end of life care transfer is an important piece to what we do.

This is a slide which really tells you why we need case manager intervention, which can be incredibly helpful to improve care.

Matt already talked so much about our technical support and epic here; I really don't need to talk much more

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other than we communicate on-line with patients. We do use a tracking support, CareTracker, for hospital admissions and all admissions and this is an interesting piece of data which shows heart failure case management analysis.

The 32-percent readmission is actually covering all hospital readmissions which includes the hip fracture, the fibrillation, the MI. This is an incredibly good data because it's not just heart failure readmission.

Again, co-morbidities; this is kind of current patient population; and functional class, we do focus as you can see on the very sick patients a lot of high risk patients; and current clinical status in terms of improvement, stable, stable improved and worse.

Team meetings on a regular basis and ongoing staff development is really important in any disease management program and we are going to focus on improving referrals to our department so there will be growth.

One of the cornerstones of our learnings has been that a case management program is incredibly important to help an organization manage the chronically ill patients and improve outcomes, improve quality of care, decrease cost and optimize treatment plans and support physician efforts.

I feel very privileged that I was able to give this presentation. Thank you very much [applause].

[END RECORDING]

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