



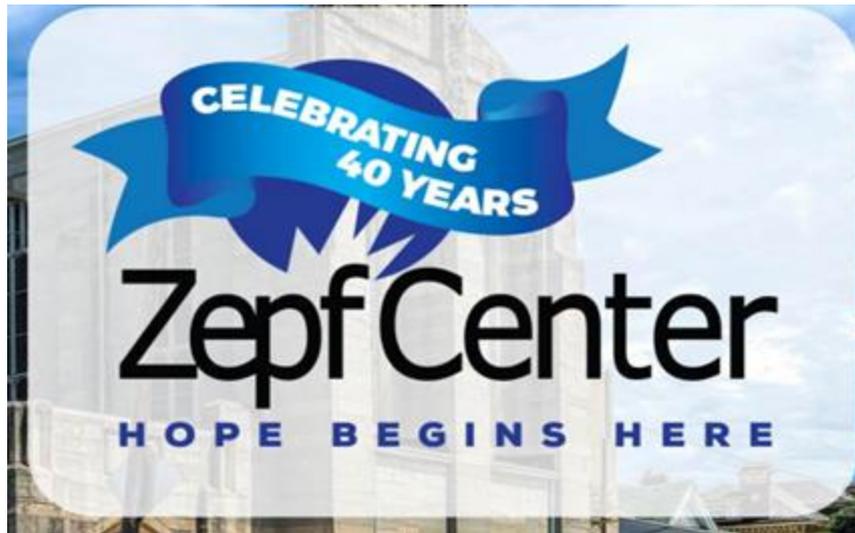
# SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

## Applying CQI to Zepf Center's PBHCI Initiative: *A CQI Prequel*

Lisa Faber, MA, PD, Zepf Center

Tom Naylor, MOL, Lead CM, Zepf Center

Phyllis Panzano, PhD, Evaluator, Decision Support Services, Inc.



- Ohio's Lucas (Toledo, Ohio) and Wood Counties
- Cohort V
- Populations: SPMI; Co-occurring; AOD
- PBHCI Model: Partnership with FQHC (Neighborhood Health Association – NHA)

# Evolution of IHC @ Zepf

PARTNERSHIP WITH FQHC (NHA)

PBHCI PARTNERSHIP MODEL (NHA)

OHIO HEALTH HOME

Fall  
2012

Summer  
2016

Fall  
2016

Standards & Regs: TJC-BH; PBCHI, CARF-BH and CARF HH

# Core Question

“What can Zepf do to create a more sustainable IHC model that advances a culture of wellness?”

# First step: Revisit core elements of IHC Models in BH settings\*

# Core Elements\*

- Patient and Family Centered Care
- Culturally Appropriate Care
- Comprehensive Care Plan
- Use of continuing care strategies
  - care management & coordination, transitional care
- Self-Management, and self-management support
- Team-based care
- Full Array of Services to support wellness
  - PC, MH, SA, Prevention, Health Promotion
- Quality Improvement Processes
- Evidence Based Practice/Clinical Guidelines
- Outcomes measurement
- HIT & EHR Meaningful Use
- Enhanced Access to care

[http://www.integration.samhsa.gov/Regulations\\_and\\_Standards\\_for\\_Integrated\\_Health\\_Care\\_Programs-Real\\_World\\_Challenges\\_and\\_Synergies.pdf](http://www.integration.samhsa.gov/Regulations_and_Standards_for_Integrated_Health_Care_Programs-Real_World_Challenges_and_Synergies.pdf)

[http://cwrupsychiatry.org/uploads/files/W9\\_rev\\_Core\\_Elements\\_of\\_IHC\\_All\\_Ohio\\_Institute\\_on\\_Community\\_Psychiatry\\_2015\\_3\\_12\\_15\\_FINAL\\_copy.pdf](http://cwrupsychiatry.org/uploads/files/W9_rev_Core_Elements_of_IHC_All_Ohio_Institute_on_Community_Psychiatry_2015_3_12_15_FINAL_copy.pdf)

# Prequel Part 1: Decision

## WHAT? PLACE GREATER EMPHASIS ON

- Self-management: A set of activities that individuals with chronic health conditions must undertake to live well with chronic health conditions.
- Self-management support: What others (e.g., staff, peers, family members) do to assist individuals with chronic illness develop and strengthen their self-management skills.<sup>6</sup>



## WHY?

1. Aligned with philosophy of hope, empowerment and culture of wellness and chronic illness care  
<https://vimeo.com/websedge/review/127624326/a29e4796c0>
2. Strongly tied to client-centeredness
3. Supports efforts to sustain IHC programming
4. Recognized by regulatory agencies and certification organizations as a core element of IHC in BH settings

Self-Management

Self-Management Support

**Critical Skills for Activating Self-Management**

Thu, Feb 4, 2016 2:00 PM EST

It is difficult for people to improve their health unless they recognize the benefits of change and are dedicated to achieving new milestones. As a provider of integrated primary and behavioral health services, your job involves helping people to identify their personal motivation and health goals. Join this webinar to learn the key steps to activating self-management, particularly for chronic conditions, among the people you serve. Hear from three national peer pioneers working to build provider competency in activation of self-management, highlighting the skills you will need to start and sustain new health behavior with service recipients.

**Presenters:**

- Sue Bergeson, Vice President of Consumer Affairs, Optum Health
- Larry Fricks, Deputy Director, Center for Integrated Health Solutions
- Harvey Resenthal, Executive Director, New York Association of Psychiatric Rehabilitation Services, Inc.
- Tamara Reed, Director, Peer Services, New York Association of Psychiatric Rehabilitation Services.

After this webinar, participants will:

- Understand the importance of tapping into individual strengths and motivation to set person-centered health goals
- Recognize the key skills needed to support activation of self-management
- Gain resources and references for additional information on activation of self-management

Registration is free and closed captioning is available upon request.

The audio for this webcast is via computer speakers and not telephone. We recommend using external speakers for desktop computers to ensure best audio quality.

**Making Integrated Care Work**

CONTACT US: 202.684.7457

**SAMHSA-HRSA Center for Integrated Health Solutions**

Integrated Care Models | Workforce | Financing | Clinical Practice

Operations & Administration | Health & Wellness

**E-SOLUTIONS MARCH 2014**

Feature article: Self-Management Supports: The Ideal for Person-Centered Care

Grantee Feature: Center for Human Development

Quick Tips: 7 Self-Management Support Tasks for your Team

Featured Resource: Self-Management Resource Library

Hot Topics  
Webinars

**Self-Management Supports: The Ideal for Person-Centered Care**

**AHRQ Agency for Healthcare Research and Quality**

Advancing Excellence in Health Care

Self-Management Support

Visit the Self-Management Support Resource Library

Self-management support is an important part of improving primary care services. It aims to help clinicians teach their patients how to take informed responsibility for their own health care.

**What is Self-Management Support?**

Self-management support is the help given to people with chronic conditions that enables them to manage their conditions day to day.

Using self-management support skills and tools, primary care teams can help people to:

- Manage their chronic conditions
- Develop the confidence to make healthy choices

**Why is Self-Management Support important?**

An increasing number of people have at least one chronic illness that requires day to day management. Outcomes for these patients with complex needs can be improved by helping them become more active in self-care.

In addition, to become recognized as a patient-centered medical home (PCMH), practices may be asked to demonstrate that they make use of self-management support principles and techniques.

**How to implement Self-Management Support in your practice**

Self-management support can be incorporated into daily practice in a variety of ways. These include:

- Using all members of the care team
- Using each medical office visit to identify, encourage, and track patients' behavior change efforts
- Supporting patients by referring them to community-based programs

Explore the concept... | See more evidence... | Get started...

Self-Management Support Resource Library

## HOW?

1. Use PBHCl carryover funds (approved by HRSA) to support “try out” of Stanford’s chronic disease self-management program (CDSMP)”
2. Expand CDMSP “try-out” by participating in a small, multi-agency pilot study

# Prequel Part 2: Stanford's CDSMP Pilot Study\*

\* <http://www.thenationalcouncil.org/wp-content/uploads/2013/10/2-18-Webinar-Slides.pdf>

# Sources of Support for Pilot

## 1. Lead Organization: Wellness Management and Recovery Coordinating Center of Excellence.

(<http://www.thenationalcouncil.org/wp-content/uploads/2013/10/2-18-Webinar-Slides.pdf>)

## 2. Five participating BH agencies:

- Centers for Families and Children (Cohort I)
- Community Support Services (Cohort IV)
- Harbor, Inc. (Phase I, HH)
- Southeast (Cohort I and VII)
- Zepf Center (Cohort V)

## 3. Ohio Department of Aging (Leader Training)

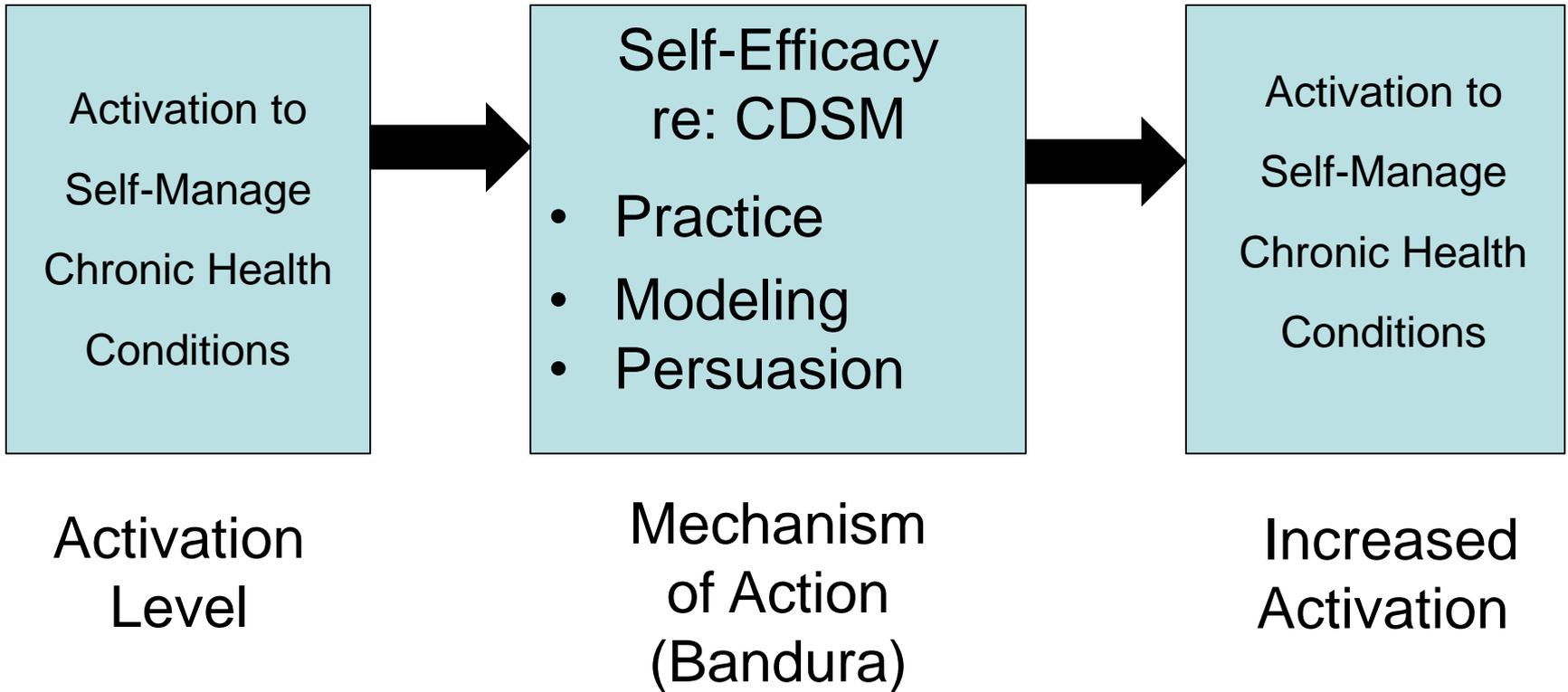
## 4. Ohio Department of Health (Leader Training)

## 5. Ohio - MHAS (Participant Workbooks)

# What is CDSMP?

1. Stanford University's Chronic Disease Self Management Program (<http://patienteducation.stanford.edu/>)<sup>8</sup>
2. Developed by Kate Lorig, PhD and colleagues
3. Geared to help clients with chronic illness gain confidence to manage symptoms and health conditions and take action
4. Interactive, 6-week long workshop (1 day/week; 2.5 hour session) led by persons who have a chronic health condition or care for someone who does

# How does it work?



# Is CDSMP Effective?

1. Numerous studies found positive health impacts for adults with chronic physical health conditions
  - RCT involving 1000+ individuals; improved self-efficacy, reduction in negative health symptoms such as pain and fatigue; improved health behaviors
  - See: (<http://patienteducation.stanford.edu/>)
2. Encouraging findings for adults with severe and persistent mental illness but few studies for this population .
  - Druss et al, 2010, HARP study
  - Lorig et al, 2013, Michigan study

# Methods: The best laid plans of mice and men often go awry.

## Timeline Issues:

- CDSMP Leader Training Schedule
- Recruitment of clients

## Measurement issues:

- Insignia Health
- Feasibility

## Design issues:

- Quasi-experimental, comparison group morphs into exploratory study

# Pilot Study Participants

PROFILE	Leaders (n = 45*)	Clients (n = 146)
<b>Gender</b>	<ul style="list-style-type: none"> <li>• 80% female</li> </ul>	<ul style="list-style-type: none"> <li>• 70% female</li> </ul>
<b>Race</b>	<ul style="list-style-type: none"> <li>• 70% White</li> <li>• 25% Black/African-Am</li> <li>• 5% Multi-racial</li> </ul>	<ul style="list-style-type: none"> <li>• 50% White</li> <li>• 31% Black/African-Am</li> <li>• 9% Multi-racial</li> <li>• 10% Other/Missing</li> </ul>
<b>Ethnicity</b>	<ul style="list-style-type: none"> <li>• 2% Hispanic or Latino</li> </ul>	<ul style="list-style-type: none"> <li>• 10% Hispanic or Latino</li> </ul>
<b>Age</b>	<ul style="list-style-type: none"> <li>• Not collected</li> </ul>	<ul style="list-style-type: none"> <li>• Average=48; range 22-78</li> </ul>
<b>Education</b>	<ul style="list-style-type: none"> <li>• 50% with Master's degree</li> </ul>	<ul style="list-style-type: none"> <li>• 50% HS/GED</li> <li>• 36% received additional education</li> <li>• 14% &lt;HS/GED</li> </ul>
<b>Other SM Programs?</b>	<ul style="list-style-type: none"> <li>• 47% (e.g., WMR, WRAP, WHAM)</li> </ul>	<ul style="list-style-type: none"> <li>• 22% (e.g., WMR, WRAP, WHAM)</li> </ul>

\* Includes 15 peer support specialists

# Leaders & Participants Met Criteria

## **Have Chronic PH Condition:**

- 67% of Leaders and 78% of Clients

## **Have Chronic MH Condition:**

- 29% of Leaders and 100% of Clients

## **Care for Someone with Chronic PH Condition**

- 47% of Leaders and 29% of Clients

## **Care for Someone with Chronic MH Condition**

- 16% of Leaders and 7% of Clients

# Measures & *Preliminary* Findings: Self Management

# Self Management

## Patient Activation Measure (PAM)

# PAM Background

1. Patient activation reflects an individual's perceived ability to manage his or her illness and health behaviors, and to act to take effective action (Hibbard et al., 2004).
2. Judith Hibbard created the PAM
3. PAM purchased by Insignia Health and available in 2 forms: PAM 10 and PAM 13 (for purchase)
4. Extensive Rasch Analysis led to calculation of patient activation in terms of:
  - a 0-100 scale with 100 as the highest activation
  - 4 activation levels from 1 (least activated) to 4 (most activated)

**PAM<sup>®</sup>**  
**Patient Activation Measure<sup>®</sup>**

Level 1    Level 2    Level 3    Level 4



Measure. Engage. Activate.



# PAM Sample Questions

(4-point A-D scale)

- Beliefs: Taking an active role managing my health conditions is the most important factor to determine my health and my ability to function.
- Confidence: am confident I can follow through with medical treatments that I need to do at home.
- Action: I know how to prevent further problems from developing with my health conditions.
- Sustain: I can maintain healthy lifestyle changes like good diet and exercise even in times of stress.

# Workshop Participants versus Comparison Group at Baseline

	Workshop Participants Mean (SD) n=110	Comparison Group Members Mean (SD) n=36	< <i>p</i>
PAM Score	62.18 (20.54)	63.73 (20.37)	NS
PAM Level	2.76 (1.02)	2.91 (1.01)	NS

# Workshop Participants at Baseline versus Post Workshop

	Baseline Mean (SD)	Post Workshop Evaluation Mean (SD)	<b>&lt; p</b>
PAM Score	62.57 (19.87)	74.65 (21.11)	.01
PAM Level	2.79 (1.01)	3.19 (.96)	.01

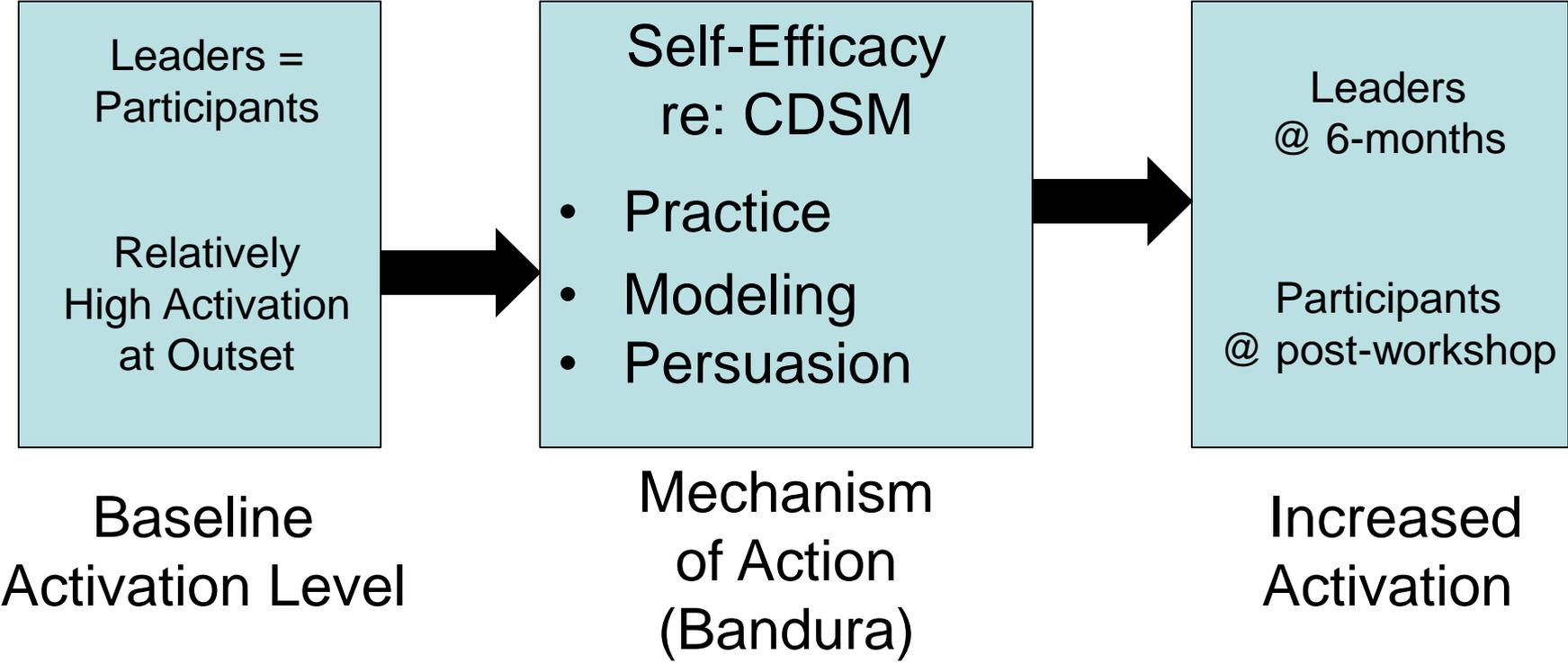
# Workshop Participants at Baseline versus Six-Month Follow-up

	Baseline Mean (SD)	Follow-Up Mean (SD)	$< p$
PAM Score	65.89 (21.81)	79.05 (17.15)	NS
PAM Level	2.96 (1.02)	3.17 (.89)	NS

# Workshop Leaders at Baseline versus Six-Month Follow-up

	Baseline Mean (SD)	Follow-Up Mean (SD)	$< p$
PAM Score	60.87 (14.24)	80.63 (14.15)	.01
PAM Level	2.86 (.79)	3.62 (.59)	.01

# Re-cap of PAM Findings



# Measures & Preliminary Findings: Self-Management Support

# Self – Management Support

## Patient Assessment of Chronic Illness Care (PACIC)

# PACIC – 20\* Background

1. MacColl Institute
2. Self-report measure of “quality” of chronic illness care (CIC) from patient perspective along five dimensions at the core of Wagner’s Chronic Care Model:
  - Patient Activation
  - Delivery System
  - Patient-Centeredness
  - Problem Solving
  - Follow-up
2. Dimensions pertain to organizational “culture” and “climate” for self-management support
3. Created parallel version for staff for this project

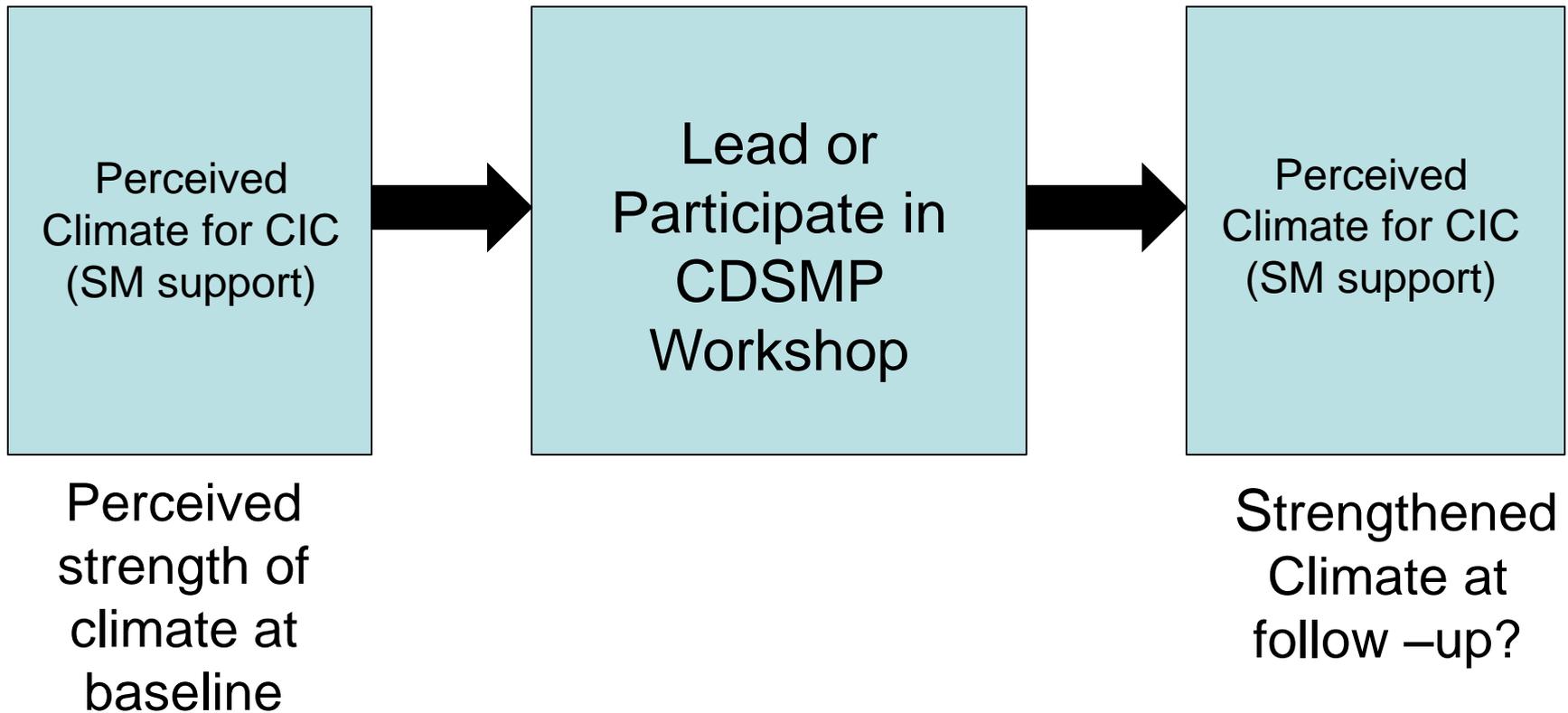
# PACIC – 20 Sample Questions

(5-point, A-D scale)

In the past 6 months I was.....

- Patient Activation: Asked to talk about problems with my meds and side effects.
- Delivery System: Given a list of things I can do to improve my health.
- Patient-Centeredness: Asked to talk about my goals for caring for my chronic health conditions.
- Problem Solving: Helped to plan ahead so I can take care of my chronic health condition(s) even in hard times.
- Follow-up: Asked whether visits with other types of doctors such as eye specialists were helpful to me.

# Is involvement in CDSMP linked to changes in perceptions of Climate for CIC /SM Support?



# PACIC at Baseline: Leaders vs Participants

	Leaders (n=45) Mean (SD)	Participants (n=119) Mean (SD)	<i>p</i>
PACIC Global	3.35 (.62)	3.50 (1.02)	NS
Patient Activation	3.67 (.59)	3.62 (1.10)	NS
Delivery Systems	3.12 (.79)	3.46 (1.10)	NS
Patient-Centered	3.32 (.87)	3.45 (1.12)	NS
Problem Solving	3.35 (.61)	3.60 (1.17)	NS
Patient Follow-Up	3.33 (.58)	3.38 (1.18)	NS

# Workshop Participants at Baseline Versus Six-Month Follow-up

	Baseline Mean (SD)	6- Month Follow-Up Mean (SD)	<i>P</i> <
PACIC Global	3.29 (1.06)	3.87 (.82)	.02
Patient Activation	3.23 (1.21)	3.94 (.93)	.04
Delivery System	3.30 (1.20)	3.74 (.96)	.10
Patient-Centered	3.35 (1.17)	3.90 (.82)	.03
Problem Solving	3.47 (1.21)	4.14 (.82)	.01
Follow-Up	3.13 (1.14)	3.71 (.53)	.07

# Workshop Leaders at Baseline Versus Six-Month Follow-up

	Baseline Mean (SD)	6 - Month Follow-Up Mean (SD)	<i>P</i> <
PACIC Global	3.22 (.47)	3.92 (.35)	.00
Patient Activation	3.53 (.42)	4.16 (.46)	.00
Delivery System	2.86 (.50)	3.65 (.42)	.00
Patient-Centered	3.13 (.70)	3.93 (.42)	.00
Problem Solving	3.22 (.51)	3.91 (.41)	.00
Follow-Up	3.34 (.52)	3.96 (.53)	.01

# Recap of PACIC Findings



Strength of  
climate at  
baseline

# Leader Beliefs About CDSMP for Adults with SPMI

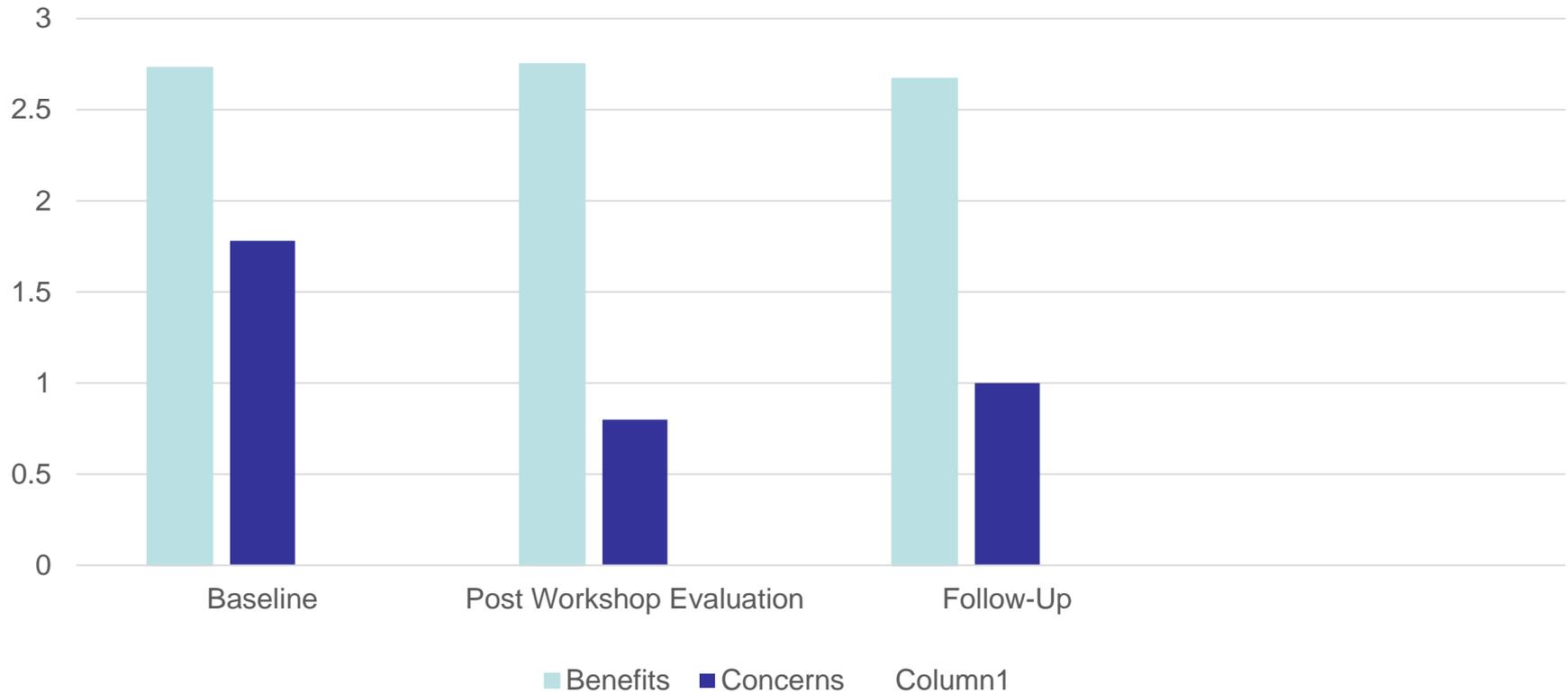
# Beliefs About CDSMP and Adults with SPMI: Post – Leader Training vs Post- Workshop

	Post Leader Training Mean (SD)	Post Workshop Mean (SD)	< <i>p</i>
I can successfully co-lead a workshop.	3.15 (.59)	3.65 (.49)	.01
I have the skills to insure workshops are run with fidelity.	3.15 (.74)	3.70 (.47)	.01
I expect workshops to be well-attended at this agency.	2.89 (.66)	3.37 (.60)	.05
<b>I expect workshops to be engaging to adults w/SPMI.</b>	<b>2.89 (.57)</b>	<b>3.68 (.58)</b>	.01
<b>Adults w/SPMI can self-manage their chronic health issues.</b>	<b>2.83 (.79)</b>	<b>3.67 (.49)</b>	.01

# Beliefs About CDSMP and Adults with SPMI: Post – Leader Training vs Post- Workshop

	Post Leader Training Mean (SD)	Post Workshop Mean (SD)	<math>p</math>
<b>Adults with chronic health issues make effective leaders for workshops.</b>	<b>3.06 (.64)</b>	<b>3.72 (.46)</b>	.01
Workshop participants are better off when leaders don't give professional advice.	3.00 (.52)	3.44 (.73)	.09 (NS)
<b>Participants in workshops will become better at self-managing their illness.</b>	<b>2.88 (.70)</b>	<b>3.65 (.49)</b>	.01
Global Scale	3.00 (.48)	3.60 (.37)	.01

# Average # Benefit and Concerns Mentioned: Three Points in Time



# Benefits Mentioned at All Time Periods

	Baseline	Post Workshop	Follow-Up
Educates/Provides Information	22.76%	14.55%	25.00%
Supports Self-Management of Illness	15.45%	12.73%	25.00%
Participants Receive Support from Group	13.01%	18.18%	20.83%
Assists Participants in Setting Goals & Creating Action Plans	8.94%	18.18%	12.50%
Encourages Self-Reliance/ Independence	5.69%	3.64%	6.25%
Empowers Participants	1.63%	1.82%	10.42%

# Concerns Mentioned at All Time Periods

	Baseline	Post Workshop	Follow-Up
Participation/Recruitment of Participants	16.67%	18.75%	11.11%
Maintaining Attendance	11.54%	18.75%	33.33%
Appropriateness of Program for BH Clients	10.26%	12.50%	11.11%
Keeping Clients Engaged & On-Track	6.41%	12.50%	5.56%
Time Needed to Implement Program	6.41%	6.25%	11.11%
Finding an Appropriate Meeting Space	2.56%	6.25%	11.11%

# Pilot Study Take-Aways

## Lessons Learned:

- Expect the unexpected: requires commitment to stay the course
- Bottom-up and top-down buy-in was key at participating agencies.

## Findings:

- PAM findings: support CDSMP mechanism of action
- PACIC findings: intriguing and deserve more thought
- Discriminant validity (more to come)

# Updates, Issues and Next Steps

## Recent developments:

- Continue to offer CDSMP Workshops
- Family and friends now attend workshops

## Issues:

- Other subgroups that might benefit from SM programs?
  - First episode psychosis
  - LGBTQQIA
  - AOD
- Align peers with practices: WMR, WRAP, WHAM, CDMP
- Align participants with practices

# Updates, Issues and Next Steps

## Next Steps:

- Shift from Prequel to CQI
- Increase the number of certified facilitators
- Get peers involved in the recruitment process
- Run more peer-led groups
- Educate family/friends about self-management support
- Identify policies and practices expected to bolster the culture and climate of self-management support

# Questions?