



The Waves of Change in Health Care

Thursday, June 4, 2015 • Renton, Washington

Highlights

- 200 participants from 66 organizations
- Keynote Address: "Whole-Community Cooperation and Health by Design," by Dr. Marc Pierson
- Five themes: Chronic disease self-management, patient-centered care, medication reconciliation, palliative care and hospice, and health equity
- Six C's: Change, Collaboration, Communication, Community, Commitment, Connections

Report

"The Waves of Change in Health Care" conference took place on Thursday, June 4, 2015 at Renton Community Center. The conference continued a community conversation that began in 2012 when health care and human services professionals and others in south King County met to discuss new ways to work together to decrease avoidable hospital admissions. Hospitalizations contribute significantly to the cost of health care—costs borne by insurance companies, taxpayers (Medicaid and Medicare), patients, and families.

Progress has been made in and around King County (see the quarterly Community Readmission Reports published by Qualis Health).

The 2015 conference drew more than 200 participants from 66 organizations—hospital and home health care administrators, discharge planners, nurses, physicians, pharmacists, policymakers, social service providers, consumers, community leaders, and others whose roles involve empowering patients and families to manage their health care.

To view the 2015 conference program, [click here](#). Event photos are available on Facebook ([click here](#)). Photos should be accessible whether or not you have a Facebook account.

Keynote Address



Whole-Community Cooperation: Health by Design

Our keynote speaker was Marc Pierson, MD, Cambridge Management Group, a board-certified emergency physician and internist who is a leader in promoting design and implementation of accountable-care programs.

Dr. Pierson emphasized paradigm needed to create change in health care systems, so that medical, behavioral, and social services are integrated and the health care community interacts in a way that supports individual recovery.

“Perfect parts do not make a perfect whole.

“It is the interactions of the parts that determine the effectiveness of the whole.”

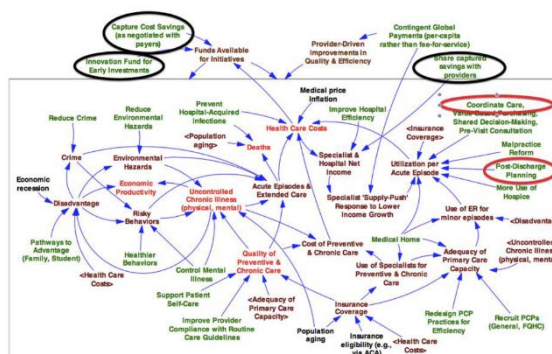
—Organizational theorist Russell Ackoff, known for Systems Thinking (as quoted by Dr. Marc Pierson)

Population health takes more than just medicine, says Pierson. Health and medicine are not the same thing. Health care is the business of medicine, and only a small subset of health—maybe 20 percent. If we address the social determinants of health, we should see less need for health care. Unhealthy behaviors (e.g., tobacco use, unhealthy diet, lack of exercise, alcohol use, unsafe sex) comprise influence about 30 percent of health. Socioeconomic factors such as education, employment, income, and family support network influence about 40 percent of health.

The federal government sets the purpose (and can change the purpose) that defines the kind of system we have to create. States set policies that enable integrated purchasing and design. Twenty-two states have innovation plans, including multi-payers and system transformation. Oregon may be leading in health care innovation.

Washington State is making headway with Accountable Communities of Health, a locally-governed public-private partnership that will manage shared resources. One or more Accountable Risk-Bearing Entities (ARBE) in each region will compete for Medicaid physical and/or behavioral health care contracts, and may serve all individuals or focus only on high-needs population. Regional Extension Centers (nine in our state) will self-organize to provide opportunities for collaborative design and learning. Training of community health workers to guide patients to the information they need as well as through the system is of critical importance. The "triple aim" of population health, per capita cost, and experience will be met through shared health and recovery services, community services, and system supports.

Community System Levers



A diagram from Dr. Pierson's [presentation](#) illustrates the complexity of the U.S. health care system.

Critical community lessons from the [ReThink Health Model](#) (Fannie E. Rippel Foundation) include:

1. Capture and Reinvest
2. Whole Community
3. CHW-network

See also [Powerpoint slide 43](#).

Dr. Pierson cited success in Jonkoping, Sweden, which set a target of 8.3 percent of the local economy for health care. U.S. models include:

- **Grand Junction, Colorado**—where providers are designing a coordinated, accountable system of care that integrates primary care and behavioral health, uses outcomes-based payments to enable transformation, and engages individuals in their care.
- **Intermountain Healthcare, Utah**—which has implemented a shared accountability plan, redesigning care by consistently using evidence-based practices, engaging patients in their health and health care choices, and aligning financial incentives so that everyone has a stake in health care.

Linkage Mapping

- Work Together for Population Health
- Create Shared System Purpose
- Map System Connections
- Focus on Interactions
- Criteria for Prioritizing Improvements
- Ideal Design
- Reinvest Savings on Interactions

Support for community health worker training should be an initial investment—strengthening support between medical visits, between institutional settings, and between medical systems. For cost savings, look at providing coaching for people with chronic conditions to support healthy behaviors. Other advice:

- Create medical homes.
- Recruit primary care providers for safety network clinics.
- Recruit providers for private practice.
- Redesign primary care practices for efficiency.
- Prevent hospital-acquired infections.
- Improve hospitals to reduce ineffectiveness.
- Ensure person-centered care.
- Improve discharge care by providing a coach and coordination for routine care.
- Extend hospice and end-of-life care.
- Enable POLST.

The community network of care must be trustworthy, safe, equitable, timely, efficient, and affordable. Life occurs in the large spaces—between visits, between organizations, and between EMRs. Managing change in these in-between places is not for the faint of heart—courage and experience are required. Dr. Pierson warns that attempts by non-trustworthy parties will fail, that competitors must become allies and work toward integration. The right sequence of support is essential.

In closing, Dr. Pierson offered a gentle reminder:

- It is about people working together
- It is about place.
- It is about conversations that lead to commitments.

Dr. Pierson's presentation slides are available [online](#).

General Sessions



Medication Reconciliation in Transitions of Care

Jeff West, RN, MPH, of Qualis Health identified the key steps in medication reconciliation, explored how the [MARQUIS Medication Reconciliation Implementation Toolkit](#) applies to different populations and settings, and made a business case for medication reconciliation. The goal is to eliminate unintended discrepancies

between the patient's *accurate* historical medication list and their current medication list.

The MARQUIS Medication Reconciliation Implementation Toolkit was a recommended pre-conference reading (see link above). Note: MARQUIS materials are free, but each individual needs to register to download material to honor the copyrights.

Learn more by reviewing Mr. West's presentation ([click here](#)). To print the Qualis Health handout, "Tips for Obtaining Best Possible Medication History," [click here](#).

Elements of Best Possible Medication History

- Name of medication
- Dose
- Route
- Strength
- Formulation
- Schedule
- Indication
- Start-stop dates
- Adherence
- Last dose
- Hx of Allergies/Reactions/A DE
- Pharmacies
- Prescriber(s) contact info

"A Day in the Life"

Kimberley Herner, MD and Jackie Shreve-Swaner, RN Care Manager, of UW Medicine/Valley Medical Center, and a Full Life Care patient and family caregiver discussed their experiences in getting the supports and services needed to maintain health, with focus on patient-centered care, consumer engagement, community-based care coordination, and caregiver support.



Living Well Throughout the Age Wave

Alexandra N. Schwartz, DSHS/ Aging and Long-Term Support Administration, facilitated a panel presentation on chronic disease self-management programs, with Kathryn Ramos, Patient Health Education Resources, Clinical Improvement and Prevention, Group Health Cooperative; Kimberly Cole-Nash, African Americans Reach and Teach Health (AARTH); and Michael Woo, LICSW, NHA, Kin On Community Care Network. A [Group Health video](#) focused on "Living Well Workshops: Working together to live healthier" (03:13). Learn more by reading [Evidence-based Chronic Disease Self-Management Program for Older Adults](#) and viewing the panel's presentation ([click here](#)).



Palliative Care and Hospice—Intentional Conversations and Warm Handovers

Dr. Mimi Pattison, Medical Director at CHI Franciscan Hospice and Palliative Care, helped participants gain a better understanding of relationship-centered care and the value of collaborative decision-making that provides "The Best Care Possible" and serves to reduce hospital readmissions. Learn more by viewing Dr. Pattison's presentation ([click here](#)).



Health Equity: What's it got to do with care transitions?

Linn Gould of Just Health Action discussed how social, political, environmental, and economic factors interact to disproportionately impact some populations more than others. She also described actions that are being taken to reduce these inequities. A [PBS News Hour video](#) that looks at "Why African-American seniors are less likely to use hospice" (07:39) was shown. Learn more by reading [Defining equity in health](#) and viewing Ms. Gould's presentation ([click here](#)).



Appreciation

The planning team is most appreciative of the support received from these sponsors:

- Aging and Disability Services
- Alzheimer's Association—Western and Central Washington State
- Asian Counseling and Referral Service
- Careage Home Health
- CarePatrol franchisees (Eastside, Seattle, Greater West Seattle and South King County)
- CHI Franciscan Hospice and Palliative Care
- Chinese Information and Service Center
- Clinic Network | UW Medicine | Valley Medical Center
- Developmental Disabilities Administration | DSHS
- Family Resource Home Care
- Fidelis Secure Home
- Full Life Care
- Home Care Referral Registry of Washington State
- Kelley-Ross Pharmacy
- King County Department of Community and Human Services
- KWA Home Care
- Lifelong | Chicken Soup Brigade
- Philips Healthcare | Lifeline
- Professional Registry of Nursing, Inc.
- Providence Hospice of Seattle
- Qualis Health
- ResCare Home Care
- Senior Services
- University of Washington Professional & Continuing Education
- Washington Dental Service Foundation

- **Potential dates:** Of the options provided, the 2016 dates receiving the greatest support are (all Thursdays): May 12 (98 percent), May 19 (95 percent), and June 16 (93 percent).
- **Topics:**
 - **Themes:** The evaluation survey indicated the highest level of interest in the following topics:
 - Tier One (“Very Interested” at 70 percent or higher):
 - Aging and Disability Resource Networks
 - Area Agency on Aging (AAA) programs
 - Networking
 - Partnership communications
 - Social determinants of health
 - Transportation options
 - Tier Two (“Very Interested” at 60 percent to 69 percent):
 - Behavioral health
 - Chronic disease self-management
 - Health literacy & communications
 - Hot spots (geographic or social)
 - Housing with services
 - Long-term care options
 - Medicaid, Medicare & dual-eligibles
 - Palliative care
 - Patient education & activation
 - Patient transfer/hand-over
 - Tier Three (“Very Interested” plus “Somewhat Interested” exceeds 90 percent):
 - Caregiver support
 - Home care services
 - Hospice services
 - **Design:** Provide more variety—perhaps half general sessions and half breakout sessions—allowing more time for Q&A and to move about. Design activities and/or seating to encourage more networking.
 - **Speakers:** Align topics, connecting all sessions to the overall theme and the goal of improving care transitions. Ensure that all facilitators/moderators know the panelists and their key points and takeaways in advance.
- **Promotion:** Post the conference agenda further in advance.
- **Pre-conference activities:** In addition to recommended readings, craft a problem statement that can be worked on in advance and then discussed at the conference. Consider videotaped site visits.
- **Planning team:** Fifteen individuals (11 new) from 10 organizations expressed interest in helping to plan future care transitions conferences.
- **Sponsors/exhibitors:** Thirteen individuals from 11 organizations (seven new) requested information about future sponsorship and exhibit opportunities.

Contact

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