PS3-21:

Making the Most of Your Healthcare Appointments Intervention for Older Adults

Angela Hochhalter, PhD^{1,2}; Jennifer Rush, BS¹; Lisa Sklar, DO¹; Juhee Song, PhD¹; Alan Stevens, PhD^{1,2}

¹Scott & White Healthcare; ²Texas A&M HSC

Background and Aim: Active engagement in healthcare can foster healthy behaviors and promote health, especially among older adults dealing with the complexities of managing comorbid chronic illnesses. This study tested the efficacy of an intervention for increasing patient engagement and improving health-related quality of life among older adults with multiple chronic illnesses. **Method:** The intervention, Making the Most of Your Healthcare, uses evidence-based behavior change techniques to deliver publicly available patient education materials. We report the results of a three-group randomized controlled study conducted in a primary care setting. Seventy-nine participants were assigned to the intervention group, an attention control group, or usual care. The intervention and attention control groups attended a two-hour workshop and participated in two phone calls; one before and one after a naturally-occurring medical encounter. The intervention group's contacts were on patient engagement and the attention control group contacts were on general safety. Self-report measures were gathered by telephone interviews at baseline and six-months following baseline. **Results:** Differences were not found for patient activation, self-reported health or unhealthy days in the past month. The treatment group showed improved self-efficacy for self-management following intervention. **Conclusions:** Contrary to expectations, patient activation scores improved for both the treatment and usual care groups but not the attention control group. These initial findings suggest potential benefits for short-term, low-intensity patient engagement interventions. The intervention can be refined based on participant feedback. Additional testing is required to determine whether changed in patient activation with a refined intervention are possible.

Keywords: Patient engagement, Patient appointment interventions, Healthy patient behaviors

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PS3-22:

Medical Homes: A Comparison of the Factors that Predict Utilization across the Lifespan

Karon Phillips, PhD, MPH; Scott & White Memorial Hospital

Background: Not having access to a regular source of health care has been noted as one of the main contributors to the existence of health care disparities among ethnic minority populations (Lurie & Dubowitz, 2007). Utilizing a medical home has been proposed as a method to aid in the elimination of health disparities. A medical home is defined as a health care practitioner or facility that a person regularly utilizes for their primary care. Hispanics are less likely than whites to have a regular doctor that they had visited in the past year and African Americans are more likely than whites to visit the emergency room for non-urgent care (Doty & Holmgren, 2006). It is these conditions that brought about the rise of the medical home model. **Aim:** To examine several demographic and health-related variables that can have a significant impact on whether or not younger and older adults have medical homes. **Methods:** The data for this study came from the 2001 Health Care Quality Survey, conducted by the Commonwealth Fund. The respondents were 6,299 adults ages 18 to 99 that responded to the telephone survey. For this analysis, the respondents were divided into the following two age groups in order to compare outcomes by age: 18-49 and 50 and older. **Results:** The older people in the 18 to 49 age group were more likely to have medical homes. Female younger adults were more likely to have a medical home. Younger Non-Hispanic Whites were less likely to have a medical home. Married older adults were more likely to have a medical home. Younger adults with more education and higher incomes were more likely to have a medical home. Having health insurance and more health conditions were both significant predictors of having a medical home for both age groups. **Conclusions:** The demographic factors that predicted whether or not a client

had a medical home varied by age group, but there were some common factors. Being able to afford health care increases the likelihood of having a medical home. Racial/ethnic minorities are not less likely to have a medical home.

Keywords: Medical home model, Medical home utilization, Demographic health disparities

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PS3-23:

Osteoporosis Treatment in a Home Health Care Population

Cheri Rolnick, PhD, MPH¹; Julie Switzer, MD²; Jody Jackson, RN, BSN¹; Nicole Schneider, BA¹; Jeanne Dutkowski, MS, C-ANP²; Denise Edgett, PHN¹

¹HealthPartners; ²Regions Hospital

Background and Aims: Only a small proportion of home health care patients at risk for fracture receive appropriate treatment. Patients with more comorbidities are least likely to receive treatment. The purpose of this study was to examine osteoporosis prevention and treatment among home health care (HHC) patients at risk for fragility fracture. **Methods:** All patients who received HealthPartners Integrated Home Care services in 2006 were identified. ICD-9 diagnosis codes & pharmaceutical data were examined between 1/1/04-12/31/05 to determine risk status (high vs. average). Patients with a diagnosis of osteoporosis, osteopenia, or Vitamin D deficiency, a history of previous fragility fracture, stroke or those taking a glucocorticoid (at least two orders) were categorized as high risk. Pharmaceutical data (e.g., estrogen, bisphosphonates) was obtained during the same two-year period to determine treatment status. Descriptive statistics were used to document proportion at high risk, with each risk factor and proportion of high risk receiving treatment. Inferential statistics (Pearson's chi square, Fischer's exact test) tested differences in characteristics (age, gender, race, number of comorbidities) among high risk patients with and without treatment. **Results:** A total of 2798 patients were in HHC during this timeframe. Of these, 754 were high risk and 2044 average risk. Approximately one-third (34%, 259 of 754) of high risk patients received osteoporosis medication compared to 4% (85 of 2044) of average risk ($p<0.0001$). We found no treatment differences based on age. Those with higher comorbidity profiles were less likely to receive treatment (28% or 121 of 435 vs. 72% or 314 of 435, $p<0.0001$). **Conclusions:** Only a small proportion of home health care patients at risk for fracture received adequate treatment. Patients with more comorbidities were least likely to receive treatment. The home health environment presents a good context in which an intervention to improve the quality of care for those at risk for fracture can be accomplished. Since the individuals identified are receiving medical and nursing care within an integrated healthcare delivery system, an opportunity exists to develop a program to increase treatment rates for those at greatest risk.

Keywords: Osteoporosis prevention, Fragility fracture in home health care, Patient fragility risk factors

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PS3-24:

Promoting Innovations in Quality Improvement: Lessons from a Medicaid Health Plan

Clarissa Hsu, PhD¹; Maggie Jones, MPH¹

¹Group Health Research Institute, Center for Community Health and Evaluation, Seattle, WA

Background/Aim: Concerns about the quality of care delivered in the U.S. health care system gained national momentum with the release of the Institute of Medicine's reports *To Err is Human: Building a Safer Health System* and *Crossing the Quality Chasm*, which revealed that patients were not receiving the quality or level of care that they needed and called for fundamental change to the health care system. To address this need, health plans across the country have used varying approaches to support quality improvement (QI)—pay-for-performance (P4P) being the most commonly used and discussed approach. However, P4P programs also have many

challenges in design and execution, particularly for Medicaid providers. In order to find an alternative that overcame the challenges of P4P, CareOregon—a non-profit health plan serving Medicaid and Medicare enrollees in Oregon—developed the Care Support and System Innovation (CSSI) Program. An evaluation was conducted to assess the overall impact of the CSSI program in promoting comprehensive improvements in quality of care among network providers and the extent to which it offers a viable alternative to P4P. **Methods:** Data were collected from the 48 medical practices that participated in the CSSI Program between 2005 and 2007. Data collection strategies included site visits, telephone interviews, document review and a web-based survey. Qualitative data were coded and analyzed using a grounded theory approach, emphasizing identification of themes judged meaningful to the study subjects. Quantitative data were analyzed through the use of descriptive statistics and chi-squared analysis. **Results:** The evaluation found that the CSSI Program successfully addressed many challenges inherent in P4P. The CSSI Program successfully engaged providers, fostered a culture of quality improvement within its provider network, and provided practices with the opportunity to develop sustainable and innovative solutions to address quality concerns. Success of the program was attributed to CareOregon's focus on building relationships while providing technical assistance and responsive funding. **Conclusions:** The CSSI Program has provided valuable support for improving quality of health care delivery and encouraged innovation among participating providers. The model provides a viable alternative for overcoming many of the challenges faced by pay-for-performance and other quality improvement programs.

Keywords: Quality of health care delivery, Care Support and System Innovation Program, Quality improvement assessments

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PS3-25:

Raising Literacy and Capacity for Incontinence and Skin Care in Dementia: Needs Assessment of Family/Friend Caregivers and Healthcare Providers

Jody Jackson, RN, BSN¹; Donna Bliss, PhD, RN²; Cheri Rolnick, PhD, MPH¹; Kenneth Hepburn, PhD³; Casey Arntson²

¹HealthPartners; ²University of Minnesota; ³Emory University

Background and Aims: Incontinence can occur in Alzheimer's disease or dementia (AD). Skin damage is frequently a physical complication. Few AD support programs directly address these problems. The purpose of this study is to assess and better meet the needs of informal caregivers and healthcare providers of persons with AD about issues of incontinence and perineal skin care. **Methods:** Audiotaped focus groups or interviews are being conducted with informal (family/friend) caregivers (goal n=56) and healthcare providers including physicians and nurse practitioners (NPs) (goal n=10) to determine needs for raising literacy and care capacity related to incontinence and skin damage. This assessment addresses health literacy content (e.g., knowledge, skills) as well as attitudes and preferred methods of receiving content. Results of this assessment, review of literature of current evidence and recommendations by expert clinical consultants will guide development of an informational and supportive intervention. **Results:** To date, 30 informal caregivers have participated in discussions (mean age 60; 75% female; 50% of care recipients are incontinent). A total of 11 healthcare providers participated in discussions (8 MDs, 2 NPs, 1 Pharmacist; mean age 53; 64% female; mean years of professional experience 23). Literacy needs of informal caregivers include prevalence and reasons why incontinence occurs in AD, when to discuss with healthcare provider and terms to use, types and photos of skin damage that can occur, indications for various absorbent and skin care products, and "step by step" instructions on ways to manage. Literacy needs of providers include evidenced-based recommendations for non-pharmacological management strategies, terms used by families and patients to refer to incontinence, referral or follow-up visit with specialist nurse, and utilization of provider (primary care, geriatrics) who has established relationship with patient. Preferred methods of learning/dissemination for both caregivers and providers include informational brochure, FAQ sheet, and guide to skin care products. Few preferred computer-based materials. **Conclusions:** Family/friend caregivers and

healthcare providers of individuals with AD have indicated health literacy needs related to incontinence and associated skin damage and have identified preferred ways of addressing these needs.

Keywords: Incontinence and perineal skin care, Health literacy, Caregivers and health providers

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PS3-26:

Reasons for Not Achieving Optimal Secondary Prevention Care for Coronary Artery Disease

Thomas Kottke, MD, MSPH¹; James Smith, MD²

¹HealthPartners Research Foundation; ²HealthPartners Medical Group

Background and Aims: Adherence to four secondary prevention goals (not using tobacco, LDL measured and <100 mg/dl within one year, blood pressure <140/90 at last visit, and daily aspirin) significantly improves outcomes for patients with coronary artery disease (ICD 9 410-414). However, a significant proportion of patients fail to achieve these four goals. We wished to determine the reasons why patients with CAD failed to achieve care goals in our multispecialty medical group. **Methods:** We abstracted 170 randomly-selected records of patients with CAD who failed to achieve care goals. **Results:** The two most frequent reasons for failure to achieve care goals were: the care team overlooked care needs at the time of an acute care visit (n=98), and the patient failed to return for follow-up (n=28). Other less frequent reasons were: The patient was offered treatment but declined (n=14); the clinician changed a medication in response to a value that was out of range, and the patient was not yet due for follow-up (n=10); and, the patient was not invited back for follow-up (n=9). The following reasons were observed in only one case each: Co-morbid conditions did not justify aggressive goals; the ordering physician failed to follow-up on a completed test; and, the patient was intolerant of statins. Eight patients failed to meet the optimal CAD care goal for other unique reasons. **Conclusion:** Providing clinical care teams with the tools to better track patient care needs (e.g., electronic patient identification and follow-up systems) could significantly reduce secondary prevention care gaps in our medical group.

Keywords: Coronary Artery Disease, Patient care outcome goals, Secondary prevention care

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PS3-28:

Telemedicine Specialty Consultation in a Medically Underserved Community

Ted Palen, PhD, MD, MSPH¹; Mike Bodily, MBA²

¹Colorado Permanente Medical Group; ²Kaiser Permanente Health Plan of Colorado

Background and Aims: During the current national health care reform discussions, health information technologies (HIT) are receiving a lot of attention as means of lowering health care costs, improving access to health care, reducing errors during the delivery of healthcare, and improving health outcomes. Patients in rural or medically underserved areas find it difficult to obtain and maintain adequate access to health care. Telemedicine (TM) services can exchange video and audio information between healthcare providers and patients in different locations. For individuals in rural communities TM may improve access to care through the use of novel care delivery models. We are conducting a proof of concept (POC) study to evaluate the use of TM consultation between a primary care clinic in a medically underserved region of southern Colorado and a specialty care (endocrinology) clinic in Denver. **Methods:** This is a prospective health services POC study. We are taking advantage of a "natural experiment," the expansion of primary care services into a medically underserved area of southern Colorado, to examine the requirements for establishing TM services between a rural primary care clinic and metropolitan based specialists. **Results:** Technical requirements included establishing network capabilities (512 kbps ISDN, H.320), 2 Mbps IP (H.323 or SIP), wireless LAN connection,