Delaware Health Sciences Alliance

Creating Health Partnerships by Engaging Individuals, Providers, and Communities in Health Decisions
DHSA Welcome

Kathleen Matt, PhD
Executive Director, DHSA
Dean, College of Health Sciences, UD
A special thanks to our sponsors:

- Nemours
- Alfred I. duPont Hospital for Children
- University of Delaware College of Health Sciences
- Delaware Rehabilitation Institute
Conference Welcome

Ronald Myers, MD
Professor and Director, Division of Population Science, Department of Medical Oncology
Associate Director of Population Science, Kimmel Cancer Center
Thomas Jefferson University
ronald.myers@jefferson.edu
Patient-centered care is “care that is respectful of and responsive to individual patient preferences, needs, and values (and ensures) that patient values guide all clinical decisions.”

(Crossing the Quality Chasm, IOM, 2001)

“the most important attribute of patient-centered care is the active engagement of patients when fateful health care decisions must be made – when an individual patient arrives at a crossroads of medical options, where the diverging paths have different and important consequences with lasting implications.”

(Barry and Edgman-Levitan, NEJM, 2012)
Decision Support Interventions

• “Decision support interventions help people think about choices they face; they describe where and why choice exists; (and) they provide information about options, including where reasonable, the option of taking no action.”

• Decision support interventions can be used for one-way delivery of information to patients (non-mediated) or in the context of a two-way interaction between a patient and a health care provider (mediated).

(Elwyn et al., 2010)
Change is Difficult

“There is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than a new system.

For the initiator has the enmity of all who would profit from the preservation of the old (system) and merely lukewarm defenders in those who would gain in the new one.”

Machiavelli, *The Prince*
Plenary Speakers

• Engaging Individuals
  – Margaret Moore, Co-Director, Institute of Coaching, McLean Hospital

• Engaging Providers
  – Karen Sepucha, PhD, Senior Scientist, Health Decision Research Unit, Massachusetts General Hospital

• Engaging the Community
  – Sandra Hassink, MD, FAAP, Director, Nemours Pediatric Obesity Initiative, A.I. DuPont Hospital for Children
Agenda

• Welcome

• Margaret Moore: Engaging Individuals
  – Panel Discussion (Michael Peterson, UD)

• Break

• Karen Sepucha: Engaging Providers
  – Panel Discussion (Douglas Tynan, Nemours AI Dupont)

• Lunch

• Sandra Hassink: Engaging the Community
  – Panel Discussion (Michael Rosenthal, CCHS)

• Closing Remarks and Networking
Engaging Individuals

Margaret Moore, MBA
Co-Director, Institute of Coaching at McLean Hospital
(an affiliate of Harvard medical School Institute of Coaching)
Engaging Individuals to Thrive

Coaching for Sustainable Change

Margaret Moore
Founder & CEO
Wellcoaches Corporation
www.wellcoaches.com

Co-Director
Institute of Coaching
McLean Hospital, affiliate of Harvard Medical School
www.instituteofcoaching.org

Co-Leader
National Consortium for Credentialing Health & Wellness Coaches
www.ncchwc.org

Coach Meg
www.coachmeg.com
margaret@wellcoaches.com
Agenda

- Why do we need coaching in healthcare to engage individuals?
- Coaching mechanisms of action – what makes coaching work?
Mental energy crisis

Only 20% of adults are thriving (mentally)
Physical energy crisis

Only 5% engage in top healthy habits

- Regular exercise
- Healthy weight
- Fruits & veggies
- Healthy fats
- Non-smoking
- Moderate drinking
Mapping Biology to Psychology

Steve Cole, PhD
UCLA School of Medicine

Science of Adult Development

Robert Kegan, PhD, Harvard University

Medicine is designed for acute not chronic care
It is hard to sustain health-giving habits
What does it take to change?

**Change is good…you go first....**
Mac Anderson & Tom Feltenstein

**Change or Die**
Alan Deutschman

**Changing for Good**
Prochaska, Norcross, DiClemente
Changing our Minds

“We cannot solve our problems with the same thinking we used when we created them.”
Insight to action to insight to action to insight...
Our brains learn by making new connections
Lasting change – imagine a new brain network
Health and wellness coaches facilitate a partnership and change process that enables clients to change their mindsets, and develop and sustain behaviors proven to improve health and well-being, going beyond what they have been able to do alone.
Coaches see the butterfly in the chrysalis
<table>
<thead>
<tr>
<th>Expert Approach</th>
<th>Coach Approach</th>
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<tbody>
<tr>
<td>Authority</td>
<td>Partner</td>
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<tr>
<td>Educator</td>
<td>Facilitator of change</td>
</tr>
<tr>
<td>Defines agenda</td>
<td>Elicits client’s agenda</td>
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<tr>
<td>Responsible for client’s health</td>
<td>Client is responsible for health</td>
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<tr>
<td>Solve problems</td>
<td>Foster possibilities</td>
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<tr>
<td>Focus on what’s wrong</td>
<td>Focus on what’s right</td>
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<tr>
<td>Has the answers</td>
<td>Co-discover the answers</td>
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<tr>
<td>Interrupt if off topic</td>
<td>Learn from client’s story</td>
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<tr>
<td>Working harder than client</td>
<td>Client working as hard as coach</td>
</tr>
<tr>
<td>Wrestle with client</td>
<td>Dance with client</td>
</tr>
</tbody>
</table>

![Expert and Coach Illustration](image-url)
Explore Coaching Mechanisms of Action

1. Growth-promoting relationship
2. Self-motivation
3. Capacity to change
4. Process or journey of change
Relationship: Improve Vagal Tone - WHY

- Calm down…
- Slower breathing & heart rate
- Brain function – attention, working memory
Relationship: Improve Vagal Tone - HOW

- Shared out-breath
- Shared positive emotions
- Authentic empathy
- Physiological resonance
Tame frenzy to generate mindfulness

- Negative mental static or noise
- Impairs pre-frontal cortex and focus
Foster self-compassion

- I am warm and patient
- I accept you, I am not judging you
- I am working to understand what it is like to walk in your shoes
Physician empathy improves clinical outcomes

Conclusions

Patients of physicians with high empathy scores were significantly more likely to have good control of hemoglobin A1c (56%) than were patients of physicians with low empathy scores (40%, $P \leq 0.001$).

The proportion of patients with good LDL-C control was significantly higher for physicians with high empathy scores (59%) than physicians with low scores (44%, $P \leq 0.001$).

Autonomy is a universal, biological drive

- There is no one else like me
- I march to my own drummer
- I make my own choices
- I am in the driver’s seat

I've been thinking about you lately.

I wish you wouldn't do that.

I have something for you, Earl.

Oh?

I've made a list of ways in which I think you could improve yourself.

Now don't get defensive. I'm just trying to help you be happy.

Flush!

How about that! It did make me happy!
Get out of sales and into fishing
No differences in weight loss were found between patients whose physicians discussed weight or did not.

Patients whose physicians used motivational interviewing–consistent techniques lost an average of 1.6 kg 3 months post-encounter; those whose physician used motivational interviewing–inconsistent techniques gained or maintained weight.

**Conclusions**

*Use of motivational interviewing techniques during weight loss discussions predicted patient weight loss.*

Move yourself to the passenger seat

Put your patient in the Driver’s Seat
Elicit Self-Motivation – The Power Source

- Inside-out works better than outside
- Autonomous - Present & Future
- Co-dependence with confidence
Why am I exercising?

External

- **Expert** – I am doing it because my wife will get upset if I don’t

- **Inner critic** – I should do it because my friends say it’s good for me

Autonomous

- **Present** – I love my fitness class

- **Future** – I want to be fit and strong so that I have the energy I need from morning to night to make a difference every day
How to improve your self-motivation?

- Dig deeper to get to the why behind the why
Motivation & confidence are co-dependent
Develop capacity to change

Whether you think you can, or think you can't, you're right.

(Henry Ford)
Positive Emotions Broaden Thinking

Open-minded
Flexible
Creative
Adaptable
Peripheral vision
Big picture
Positive Emotions & Resilience

- Level of positive emotions predicts level of resilience
- Tipping point ratio is 3:1
- Above 3:1 you thrive and are resilient
- Below 3:1 you languish

- 80% of adults have ratios below 3:1
- www.positivityratio.com
Positive Emotions improve Physical Health

- Chronic stress (negativity) damages health
- Long term positive emotions prevents getting ill and reduces morbidity - longevity impact comparable to not smoking – several years
- High positivity people have more effective immune systems, get fewer colds and flu
- Positive emotions reduce physical symptoms such as pain
- Happy people are more likely to engage in healthy behaviors

Positive Emotions are a Vital Sign

“You tested positive for being negative.”
Use your Character Strengths

Wisdom and knowledge: Creativity, Curiosity, Open-mindedness, Love of learning, Perspective

Courage: Authenticity, Bravery, Persistence, Zest

Humanity: Kindness, Love, Social Intelligence

Justice: Fairness, Leadership, Teamwork

Temperance: Forgiveness, Modesty, Prudence, Self-regulation

Transcendence: Appreciation, Gratitude, Hope, Humor, Spirituality

Find your top five character strengths at:

www.viacharacter.org
Experiment to find a synergistic formula

- Invest in a period devoted to experimenting
- If you don’t notice benefits in first 2-3 weeks, try something else
- Look for synergy among 3-4 new habits
Facilitate change process

- Vision, plan, and goals
- Social support
- Accountability
- Navigating setbacks
Just-in time learning
Engaging Individuals to Thrive

Coaching for Sustainable Change
Delaware Health Sciences Alliance

Creating Health Partnerships by Engaging Individuals, Providers, and Communities in Health Decisions
Engaging Individuals

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Christiana Care Health System
Delaware Health Sciences Alliance

Creating Health Partnerships by Engaging Individuals, Providers, and Communities in Health Decisions
Engaging Providers

Karen Sepucha, PhD
Senior Scientist, Health Decision Research Unit
Massachusetts General Hospital
Shared Decision Making at Mass General: Engaging Clinicians

November 30, 2012
Karen Sepucha
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www.massgeneral.org/decisionosciences
Disclosure

• Supported by funding from
  – Informed Medical Decisions Foundation
  – Massachusetts General Physician’s Organization
Goal

Every patient facing a significant medical decision is well informed, meaningfully involved and receives treatment that matches their goals.
Agenda

1. What do we know about the quality of medical decisions?
2. What do we know about ways to improve decision quality?
3. How can we integrate shared decision making into routine care?
4. How does this fit into organizational priorities?
Evidence of a Problem

Medical Practice Variation
40 Years of Research
Documenting Inconsistent Care

The DECISIONS Study
A Portrait of How Americans Make Common Medical Decisions
Decisions Study

Nationally representative sample of 3,010 English speaking adults 40+

• Surgery
  – Back surgery, knee/hip replacement, cataracts

• Cancer screening
  – Prostate, colorectal, breast

• Medications
  – High blood pressure, high cholesterol, depression
What Did Patients Know?

For 7 out of 9 decisions, fewer than half could get more than one of the 4-5 knowledge questions right.

Fagerlin et al. MDM 2010
Were pros and cons discussed at all?

- Surgery
- Screening
- Medication

Zikmund Fisher et al. MDM 2010
Whose preferences are driving decisions?

- Surgery
- Screening
- Medication

- Dark red: Asked Patient
- Light blue: Made Recommendation

Zikmund Fisher et al. MDM 2010
What DECISIONS Tells Us

- Patients not well-informed
- Patients are not usually meaningfully involved
- Patients preferences are not consistently part of the discussion
Forces sustaining poor quality

Patients:
Making Decisions in the Face of Avoidable Ignorance

Clinicians:
Poorly “Diagnosing” Patients’ Preferences

Poor Decision Quality
Unwanted Practice Variation
What do we know about ways to improve decision quality?
Shared Decision Making

Interactive process between patient (and family) and clinician(s)

– Engage patient in decision making

– Accurate information about options and outcomes

– Tailor treatments to patient’s goals and concerns

SDM in clinical guidelines

• Chemoprevention for breast cancer: “Clinicians should *inform* patients of the potential benefits and harms of chemoprevention.”

• Screening for osteoporosis: “… clinicians also should consider each patient's *values and preferences* and use clinical judgment when discussing screening with women...”

• Coronary revascularization: “Shared patient/physician decision making for many scenarios would be expected and may result in the patient deferring coronary revascularization while maintaining medical therapy.”
Patient Decision Aids

• Tools designed to help people participate in decision-making
• Available in different media (online, DVD, booklets)
• Provide information on the options
• Help patients clarify and communicate their goals and treatment preferences
Evidence of Impact

In 86 RCTs of decision aids for 30+ screening or treatment decisions, use has led to:

– Increased knowledge
– Greater comfort with decisions
– Increased participation in decision-making
– Fewer people remaining undecided
– Fewer patients choosing major surgery

Cochrane Review of Decision Aids

• Use of DAs resulted in:
  – 20% fewer chose major elective surgery (RR 0.80, N=11 trials)
  – 15% fewer chose PSA screening (RR 0.85, N=7 trials)

Impact on costs and surgeries

- Group Health demonstration project
- Decision aid implementation, feedback on surgical rates, surgeon training in SDM

- Bottom line:
  - Total costs reduced by 12-21%
  - Total knee replacement surgeries reduced by 38% and total hip replacements reduced by 26%.

Arterburn et al Health Affairs 2012
How do we get “shared decision making” to happen in routine care?
Mr. M’s Story

- 71yo man referred to orthopedics, worsening right hip pain, x-rays confirm severe degenerative changes
- Orthopedic surgeon: “I went over in some detail different treatment options. He very much wishes to proceed with right THR.”
- Discussed with family and friends, saw PCP for pre-op clearance, sent decision aid
Massachusetts General Hospital  
Yawkey Center for Outpatient Care  
55 Fruit Street, Suite 3700  
Boston, Massachusetts 02114

Dear Dr. [Name]

Re: Hip Replacement Surgery

I am writing to tell you that at this time I will not be proceeding with my right hip replacement procedure. Therefore, will you please cancel my appointments for pre-admission testing on July 12, 2005, and for surgery on July 28, 2005.

About six months ago I added daily biking to my exercise routine and after three months found that the nighttime hip pain was gone. When I saw you in May, I was not sure if this important change to my life style would hold. It has so far.

Based on a conference with Dr. [Name] my primary care physician, and on a viewing of the very helpful information on a DVD that he prescribed (Treatment Choices for Hip Osteoarthritis), sent to me by Massachusetts General’s Patient and Family Learning Center, I have decided that waiting for the surgery is the best decision.

Thank you for your help and patience.

With kind regards,
What if...
A brief history

• 1988 Al Mulley (Chief of General Medicine at MGH) created first shared decision making program

• 1989 Foundation for Informed Medical Decision Making started (by Al Mulley and Jack Wennberg)

• 1997 Health Dialog started (MGH investor)
Shared Decision Making Program

• 2005 pilot program launched

• Three components:
  – Patient: Patient decision aids (~30)
  – System: IT to order through EMR, centralized distribution
  – Providers: training in SDM skills

Nearly 20 years after first decision aid created at MGH
Adult primary care at MGH

• 15 practices
  – Hospital-based
    • Resident training, women’s health, geriatrics
  – Community health centers
    • Latino health, refugee medicine
  – Suburban practices
• > 200 staff physicians and nurse practitioners, 140 internal medicine residents
• >200,000 patients
Flexibility in use of decision aids

- Most practices use a model of prescriptions by clinicians at visit
- Some practices delegate prescriptions to health educators and medical assistants
- Incorporation into “pre-visit” and “end-of-visit” planning
- Group viewings
Monthly rates of decision aid orders

Fairly low use, wide variation among practices and providers
Some common responses

• “I do this already”

• “It will take too much time”

• “My patients aren’t interested in this, they want me to make the decision”
Focus on bright spots

• Top 10 users accounted for ~ 40% of total prescriptions
• Have had multiple positive experiences, find them very useful
• Users were much more likely to have seen a program
Clinician “Training”

- 1-hour course at regular practice meeting
  - Overview of shared decision making program
  - Prescription data (practice level and provider level)
  - Viewing of video decision aid (practice director’s choice: colorectal cancer screening, knee osteoarthritis, advance directives)
  - Discussion of use in practice

- 1 hour CME credit for physicians
- 15 practices hosted education session
Feedback from clinicians

- Useful to view a decision aid
  - “Now I know what my patients will be seeing”
  - “I could never cover this information in a visit, it’s very thorough”
- Demonstration of ordering process very helpful
  - “I didn’t know it was so easy to send these videos”
- Comparative data on use across practices and among providers
  - “Spurs me on to prescribe!”
CME sessions increase decision aid use (c-chart)
• 53% were “users” and had personally prescribed a decision aid (47% “non-users”)

• Users still more likely to…
  – have watched a video DA (63% vs. 23%, p <0.001)
  – to feel that programs definitely helped provide better care for patients (72% vs. 34%, p<0.001)

• Most frequent barriers cited:
  – Not remembering to prescribe (63%)
  – Few patients eligible for the available programs (21%)
Patient self-prescriptions

- Patients received order slips from medical assistants at time of check-in
- Order slip described top 12 most popular programs
- Patients checked off desired programs and returned slip to medical assistant
2-week pilot, November 2011

- 10-fold increase in orders
- Topics ordered by patients very different from those by docs
- MAs stopped in second week (discouraged by high refusal rate)
- Need both patient and providers to be engaged
How does this fit into organizational priorities?
Mass General/Partners

- Pioneer ACO
- BCBS Alternative Quality Contract

- Focus on triple aim
  - Costs
  - Quality
  - Patient experience
Surgical appropriateness

• Decision support tool for high cost elective surgical procedures

• Key elements:
  – Clinically appropriate
  – Patient well-informed and wants the procedure

• Providers not allowed to book OR unless document clinical appropriateness and decision quality
Model on Ontario arthritis centers

1. Patient referred to specialist
2. Examined at referral center, view decision aid, complete survey
3. If meet clinical criteria and informed patient preference then see specialist
Other initiatives

• Quality improvement: OB/Gyn department
  – Q1: tied to viewing of decision aid and completion of needs assessment questionnaire
  – Q3: tied to ordering of patient decision aid

• Clinical referral management system
  – Link decision aid to referral to orthopaedics

• Training for internal medicine residents
Lessons learned

• Comparative data are strong motivator
  – Nothing gets doctors going like seeing how they stack up against peers
• Patient feedback is strong motivator
  – Stories help
• Physician champion role important
  – Gets attention, trust, making connections
• Infrastructure to make things easier
  – Building into workflow, familiar interface, collaborators

• Aligning incentives to reward decision quality
Mr. M’s “B” Case

• 2 years later, hip pain became more bothersome and he was ready for surgery

• Went back to original surgeon and underwent total hip replacement

• Good relief of pain and improvement in function, no regrets
Goal

Every patient facing a significant medical decision is well informed, meaningfully involved and receives treatment that matches their goals.
Our project team and collaborators

Health Decision Sciences Center, MGH
  • Karen Sepucha
  • Lauren Leavitt
  • Sharon Floramo
  • Sarah Hewitt

John D. Stoeckle Center for Primary Care Innovation, MGH
  • Leigh Simmons
  • Susan Edgman-Levitan

Informed Medical Decision Foundation
  • Michael Barry
  • Richard Wexler
  • Meg Gassert

Blum Patient and Family Learning Center
  • Jen Searl
  • Elaine Kwiecien

General Medicine Division, MGH
  • Beth Walker Corkery

MGH Lab of Computer Science
  • Mary Morgan

Massachusetts General Physicians Organization
Delaware Health Sciences Alliance

Creating Health Partnerships by Engaging Individuals, Providers, and Communities in Health Decisions
Engaging Providers

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Creating Health Partnerships by Engaging Individuals, Providers, and Communities in Health Decisions
Engaging the Community

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Chair, Governor’s Council on Health Promotion and Disease Prevention
Director, Nemours Obesity Initiative, A I duPont Hospital for Children
Governor’s Council on Health Promotion and Disease Prevention

SANDRA G HASSINK, MD, FAAP
CHAIR, GOVERNOR’S COUNCIL
DIRECTOR NEMOURS OBESITY INITIATIVE
A I DUPONT HOSPITAL FOR CHILDREN
WILMINGTON, DE
“A Council on Health Promotion and Disease Prevention is hereby established and its members are charged to advise the Governor and executive branch state agencies on the development and coordination of strategies, policies, programs and other actions statewide to promote healthy lifestyles and prevent chronic and lifestyle-related disease.

http://dhss.delaware.gov/dhss/dph/dpc/chpdp.html
Chronic Diseases and Related Risk Factors in the United States

**Leading Causes of Death***

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percentage (of all deaths)</th>
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<tbody>
<tr>
<td>Heart Disease</td>
<td>25</td>
</tr>
<tr>
<td>Cancer</td>
<td>20</td>
</tr>
<tr>
<td>Stroke</td>
<td>15</td>
</tr>
<tr>
<td>Chronic lower respiratory disease</td>
<td>10</td>
</tr>
<tr>
<td>Unintentional Injuries</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3</td>
</tr>
<tr>
<td>Pneumonia/influenza</td>
<td>2</td>
</tr>
<tr>
<td>Alzheimer’s disease</td>
<td>2</td>
</tr>
<tr>
<td>Kidney Disease</td>
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</table>

**Actual Causes of Death†**

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percentage (of all deaths)</th>
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</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>15</td>
</tr>
<tr>
<td>Poor diet/lack of exercise</td>
<td>10</td>
</tr>
<tr>
<td>Alcohol</td>
<td>5</td>
</tr>
<tr>
<td>Infectious agents</td>
<td>2</td>
</tr>
<tr>
<td>Pollutants/toxins</td>
<td>2</td>
</tr>
<tr>
<td>Firearms</td>
<td>1</td>
</tr>
<tr>
<td>Sexual behavior</td>
<td>1</td>
</tr>
<tr>
<td>Motor vehicles</td>
<td>1</td>
</tr>
<tr>
<td>Illicit drug use</td>
<td>1</td>
</tr>
</tbody>
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† Adapted from McGinnis Foege, updated by Mokdad et. al.
Costs to Delaware

- **Obesity**
  - The most recent estimates for Delaware show that medical expenditures related to obesity in the state are more than $207 million a year.

- **Tobacco**
  - A CDC study on smoking-attributable costs estimates that tobacco smoking in Delaware results in about $722 million a year in direct medical expenditures and indirect costs including lost productivity.
Significant Racial Disparity Exits

White and African American Adults, 2009: Significant Disparity for Obesity

Source: DHSS, Division of Public Health, Behavioral Risk Factor Survey (BRFS), 2009.
Diabetes Prevalence Mirrors Disparity in Obesity

Delaware Adults With Diabetes: 2009

Source: DHSS, Division of Public Health, Behavioral Risk Factor Survey (BRFS), 2009.
Impact on Youth

• “No longer considered to be a condition of primarily adult onset, type 2 diabetes has become increasingly common among children aged 6-11 years and adolescents aged 12-19 years.”

• “The increase in type 2 diabetes among children and adolescents has emerged in parallel with an alarming rise in the number of young people who have become overweight or obese.”

Disability

- Prevalence of tobacco use, obesity and diabetes is significantly higher among people with disabilities.
  - Obesity: 25.8% v. 42.2%
  - Diabetes: 5.3% v. 15.5%
  - Smoking: 17.1% v. 23.3%
- **18.3%** of Delaware adults report a disability of some type, which limits their activities.
- **7.2%** report a disability which requires special equipment.

Integrated approach to a complex problem

The Council finds that the problem is complex and influenced by:
- the structure and quality of Delaware’s health care system,
- the presence and strength of our health policy framework,
- the extent to which our environment supports health and healthy decisions, and each individual’s capacity to engage in healthy behaviors.
Building a healthier future, a life course approach

- Goal is to make optimal health achievable for all Delawareans.
- To realize this goal, we propose
  - a path that encourages health at every step,
  - that recognizes and rewards commitment to health at all levels.
  - From the individual to the community, from the health care provider to the employer, from the business owner to the policy maker, we all have a stake in building a healthier future.
How did we develop the recommendations?
Process: Overview of Concept Mapping Steps

**Planning:** Planners and key issue advisors developed a focus prompt and identified participants.

**Idea Generation:** Communities of interest and expertise were identified, and responded with brainstormed ideas.

**Structuring:** Communities of interest and expertise sorted and rated the results of the idea development, authoring the structure and value domain of the issue.

**Representation:** CSI computed the maps, pattern matches and “go zones,” and prepared them for interpretation.

**Interpretation and Use:** Strategies and tactics for action will follow directly from the interpretation of the results. Pattern matches and go zones will help to build consensus on action.
Defining the Issue

Specific Aim:
- Use the concept mapping process to identify specific recommendations for the Governor and executive state agencies to promote health and to prevent chronic and lifestyle-related diseases statewide.

“To promote healthy lifestyles and prevent chronic and lifestyle-related disease in Delaware, a specific thing that needs to happen is...”
Identifying Key Informants

- Over 650 participants were invited to brainstorm online, including:
  - Council members
  - Medical and healthcare professionals
  - State employees
  - Researchers and educators
  - Community advocates and outreach coordinators
  - Food and agriculture manufacturers
  - Public relations and media representatives

- A subset (73) of these individuals were later invited to sort the ideas.
- All participants were later invited to rate the ideas on importance and feasibility.
Eliciting Knowledge and Opinion

• Council meeting brainstorming session: 2/15/11
• Online brainstorming session: 2/24/11-3/23/11 (264 website visits)

706 statements generated
120 final statements

require nutritional labeling on menus at restaurants and fast food establishments. (3)
ensure early screening for early detection to prevent or delay chronic illnesses. (49)
promote better insurance coverage for evidence-based pharmacological interventions. (60)
encourage communities with “free spaces” to create community gardens. (85)
make assisted exercise programs available, at no cost or very low cost, to people with disabilities. (105)
Organizing Knowledge and Opinion

120 statements were sorted into groups

Each statement was rated twice (Importance & Feasibility)

- Work quickly and effectively under pressure
- Manage resources effectively
- Decide how to manage multiple tasks
- Organize the work when directions are not specific
- Manage time effectively
Building the Results

• The Raw Materials:
  – Statements
  – Sort Input from each participant
  – Rate Input from each participant

• The Tools
  – Aggregation of Sort Data
  – Similarity Matrix
  – Multidimensional Scaling
  – Cluster Analysis
Conceptually similar ideas appear closer together.

partner with farming communities to establish more fresh fruit and vegetable stands. (36)
work with food manufacturers in Delaware to improve the nutritional quality of their products. (39)
make nutritious foods, especially fruits and vegetables, affordable and available to all residents. (107)
Conceptually *different* ideas appear farther apart.

- make nutritious foods, especially fruits and vegetables, affordable and available to all residents. (107)
- have employers as leaders in support of healthy work places and prevention efforts. (113)
- promote the understanding that oral health conditions require the same quality of care as other health conditions. (64)
Revisiting the Emerging Structure: A “Regions” Perspective

Implement Policies and Programs that Support Health

- Develop Policy and Funding
- Evaluate Effective Outcomes
- Create an Environment that Supports Healthy Choices
- Make Healthy Food Available
- Focus on Schools
- Educate for Health
- Take a Whole Person Health Approach
- Build Individual Capacity to Achieve a Healthy Lifestyle
- Increase Access to Coverage for Prevention and Care
- Support Integrated Consistent Care
- Create a More Responsive Health Care System
- Create a Healthy and Supportive Environment
- Build Capacity for Individual Health

Create a Healthy and Supportive Environment

CREATE A HEALTHY AND SUPPORTIVE ENVIRONMENT
Implement Policies and Programs that Improve Health

- Develop and implement policy and strategy that supports healthy communities in Delaware.
- Develop and implement policy and strategy that decreases tobacco usage.
- Incentivize businesses to provide a workplace that encourages healthy living.
- Evaluate the effectiveness of current health promotion and disease prevention programs in Delaware.
CREATE A HEALTHY AND SUPPORTIVE ENVIRONMENT

- Ensure that exercise/physical activity and healthy eating programs and services are high-quality, culturally appropriate, accessible, available and affordable.
- Improve the physical environment, including public transportation, throughout Delaware to improve opportunities for safe physical activity.
- Make nutritious foods affordable and available to all Delawareans.
- Establish and ensure adherence to food and beverage standards in places where Delawareans spend their time.
- Work with food industry, including food processors, distributors, growers and retailers in the state and region to improve the nutritional quality of commercially available foods and beverages.
CREATE A HEALTHY AND SUPPORTIVE ENVIRONMENT

- Ensure children in schools have access to affordable and healthy foods and beverages.
- Ensure children have access to physical activity opportunities in schools.
- Ensure children receive quality health education, nutrition education and physical education in schools.
- Ensure children in child care have access to healthy foods and beverages and opportunities for physical activity.
- Ensure children receive quality health education, nutrition education and physical education in child care.
Create a More Responsive Health Care System

- Standardize and support evidence-based practice to lead to consistently delivered, high level of care.
- Measurably improve the accessibility and promotion of integrated primary and preventive care for all residents, incorporating mental, oral and vision health.
- Build a responsive and accessible system of care. Consider both existing systems and innovative approaches.
- Establish universal use of Electronic Health Records for all Delaware residents.
- Ensure that patients and the public at large are educated and empowered to use patient-managed technology and communication for prevention and care.
- Establish and support health care workforce recruitment and retention strategy.
BUILD CAPACITY FOR INDIVIDUAL HEALTH

- Under a unifying theme, develop, fund and implement statewide, targeted and culturally appropriate campaigns to promote healthy lifestyles and prevent lifestyle-related diseases.
- Engage community-based organizations (schools, workplaces, health care, faith based organizations) to promote healthy lifestyles.
- Improve health literacy, so Delawareans have the capacity to obtain, process, and understand basic health information and services needed to make appropriate healthy decisions.
- Enhance individual capacity to engage in healthy behaviors.
LIFESPAN

Maintenance of Healthy Lifestyle

Lowest:
Premature Mortality
Morbidity & Cost

Modifiable Risk Factors
- Obesity
- Smoking
- Poor Nutrition
- Sedentary Lifestyle
- Stress/Anxiety
- Cholesterol
- Hypertension
- Diabetes
- Heart Disease
- Stroke
- Cancer

Improvement in Risks

Highest:
Premature Mortality
Morbidity & Cost

No Attention to Risk Factors
When we all understand and believe that the potential for avoiding chronic diseases is within our control, we will take action and improve our health.
Delawareans

- 25% Delaware adults with a high school education or less smoke cigarettes, compared to only 7.3% college graduates.
- 41% Delaware adults with a high school education or less meet recommendations for physical activity. Increases to 55% among college graduates.
- More than half of all U.S. adults has less than basic health literacy skills.
- Persons with limited health literacy skills have higher use of treatment services and lower use of preventive services.
Objective: Under a unifying theme, develop, fund and implement statewide, targeted and culturally appropriate campaigns to promote healthy lifestyles and prevent lifestyle-related diseases.

- Provide training, technical assistance and resources, which includes respect for cultural differences, to communities for effective targeting and planning of evidence-based health promotion campaigns.
- Promote the use of existing guidelines for physical activity and nutrition in health promotion messages.
- Ensure that media and group educational initiatives take into account the health literacy/numeracy, cognitive and physical skills and needs of their audiences.
- Ensure that education occurs across the lifespan.
- Create a campaign to promote breastfeeding and to increase the support for breastfeeding mothers in the workplace.
- In developing these campaigns, obesity prevention and early intervention should be incorporated as a priority.
- Develop and deliver messages about PCMH to communicate the benefits of the approach and the critical role of community based and non-medical services.
Objective: Engage community-based organizations (schools, workplaces, health care, faith-based organizations) to promote healthy lifestyles.

- Educate decision makers and key leaders about the importance of prevention and early detection.
- Promote prevention programs through new or existing grassroots groups and coalitions.
- Provide resources, tools and web-based information systems to organizations conducting health promotion.
- Increase staffing in proportion to increased responsibilities within the Division of Public Health to oversee and assist with provision of health promotion campaigns and educational activities.
- Fund community-based cooking and food shopping classes, with special emphasis on at-risk communities.
Objective: Improve health literacy, so Delawareans have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

- Develop, implement and evaluate model curricula for health and science literacy in schools and adult education programs.
- Educate parents and parents-to-be about how to be role models for their children to develop healthy lifestyle habits.
- Create a healthy living “Healthline” that provides education and support for improving health behaviors.
- Promote understanding about relationships between oral health conditions and healthy living.
- Include more health content (stress management, nutrition, obesity prevention, health literacy) in continuing and adult education programs.
- Provide caregivers and support professionals with health and wellness information specific to their needs
- Promote a tailored approach to health promotion between providers and patients, including those with disabilities and their support persons.
Objective: Enhance individual capacity to engage in healthy behaviors

- Support local coalitions and trained lay health workers from communities to address tobacco use, physical activity, nutrition and chronic disease prevention.
- Expand and enhance health promotion community outreach from health and academic institutions and organizations.
- Maintain tobacco cessation, Quitline, and other cessation services and resources, and promote their use.
- Provide assisted exercise and other health promotion programs, at no or very low cost, to people with disabilities.
- Focus new attention on prevention of tobacco use among young adults 18-25
Delaware Health Sciences Alliance

Creating Health Partnerships by Engaging Individuals, Providers, and Communities in Health Decisions
Engaging the Community

Peggy Geisler
Sussex County Health Promotion Coalition

Rosa Rivera
Henrietta Johnson Medical Center

Tom Stephens, MD
Westside Family Healthcare

Terry Casson-Ferguson
Christiana Care Health System
Delaware Health Sciences Alliance

Creating Health Partnerships by Engaging Individuals, Providers, and Communities in Health Decisions
Closing Remarks

Ronald Myers, MD
Director, Division of Population Science
Thomas Jefferson University
Welcome to the DHSA Community Engagement Forum

Creating Health Partnerships by Engaging Individuals, Providers, and Communities in Health Decisions

Announcements

Get Started with Microsoft SharePoint Foundation!
11/18/2012 6:18 PM

Add new announcement

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“Develop the strength to do bold things, not the strength of suffer.”

Machiavelli, *The Prince*
Delaware Health Sciences Alliance

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