

### STRATEGIES FOR SUSTAINING PATIENT AND FAMILY ENGAGEMENT

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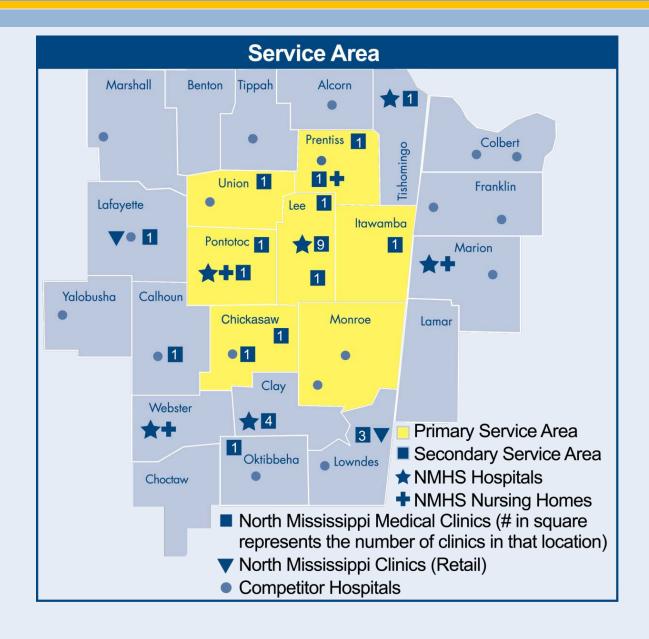




- NMMC- Tupelo (tertiary, 650 beds)
- 5 Community Hospitals
- Preferred Provider Organization
- TPA
- 35 Clinics
- School-based Nurses
- Nursing Homes
- Home Health Care
- JV Outpatient Centers











# Mission: To continuously improve the health of the people of our region

Vision: To be the provider of the best patient-centered care and health services in America



## NMHS Patient Engagement Principles

- Focus on Key Disease States
  - CHF, Diabetes, COPD
- Active Learning
  - Move away from Passive Learning Strategies
- System Coordination No Silos
- Link Intervention to Outcomes





#### The Three E's

- > Engagement
- What are the patient goals?
- Barriers to success
- Building Relationship
- > Empowerment
- Encouragement
- Support
- Self-management Action plan
- Education
- Treat each patient individually





## Congestive Heart Failure

- A Leading Discharge Diagnosis
- Highly Dependent on Patient Understanding and Activation
- Traditional Methods Ineffective (Brochures, Hospital Lectures, Videos)
- Patient Profile Older Adults, Low Healthcare Literacy





## Self Care College

- •CHF Patients Go Through 3 Modules Weight, Dietary, Pharmacy
- •Post-Simulation Huddle Review Potential Gaps in Care
- •Results Reported to In-House Provider
- •Patient Receives 30-Day Follow Up Transition Coach or Nurse Link







#### **Care Transitions Intervention**

- Low cost, low intensity model
- Targeted to Medicare FFS Patients with functional limitations
- A home visit and three follow up phone calls
- "Transition Coach" is the center piece of intervention
- Focus on empowering the patient by modeling behavior
  - practice runs
- Ask the patient for a "goal"
- Obtain a correct medication list
- Timely PCP Follow-up





