

## PROFILES IN INNOVATION

## STANFORD COORDINATED CARE, Palo Alto, California

**Stanford Coordinated Care (SCC) is a program that serves Stanford University and Hospital's employees and their dependents who are living with chronic and sometimes complex medical conditions.**

SCC's primary care and chronic care support teams work with patients to identify health goals and jointly create care plans, tracking patient progress toward self-actualization using the Patient Activation Measure (PAM). SCC aims to improve patient health outcomes and reduce hospitalizations and ED use while achieving top patient experience ratings.

- ▶ **Population:** The 440 insured patients with complex medical needs who are Stanford employees or their dependents. SCC is exploring the possibility of extending services to students and Medicare beneficiaries as well.
- ▶ **Delivery Model:** Upon joining the program, SCC patients are assigned to care teams and complete a comprehensive intake process that focuses on the question "Where do you want to be in a year?" Care teams include a physician, registered nurse or other provider, and a care coordinator (a medical assistant who has been trained to act as a coach and navigator). The program also has a social worker who specializes in trauma informed care, a physical therapist who specializes in chronic pain, and a clinical pharmacist. SCC regularly assesses patients' progress on the PAM scale. Early studies of the clinic's work showed a 39 percent decline in ED utilization and 25 percent decline in hospital admissions comparing 271 patients for 6 months pre- and post-enrollment. Staff and patient-satisfaction ratings are in the 99th percentile.
- ▶ **Financing:** The up-front investment in SCC came from Stanford, but the program itself operates under a capitated payment model. Stanford is self-insured.

**KEYS TO SUCCESS**

The SCC model includes many practices focused on improving care and reducing costs, including:

1. **Listening to patients' goals.** SCC providers organize care around patient goals and work to engage patients so they feel they have hope. Action steps are scaled to what the patient can realistically achieve;
2. **Employing human-centered design.** The SCC teams talk to people about their needs and design a program to fit the population they are trying to serve. Data is used to identify the population and shape the care model;
3. **Emphasizing self-management.** Using the PAM model as a guideline, SCC care focuses on helping patients manage their health issues on their own whenever possible; and
4. **Serving all audiences.** In addition to paying careful attention to patient needs, SCC staff remain sensitive to the needs of payers, organizations that provide resources for the clinic, and the surrounding medical community.

## Spotlight: Helping Patient's Achieve Self-Activation

SCC patient care is organized around helping patients achieve a higher level of self-activation and disease self-management, as defined by the PAM tool developed by Judy Hibbard, DrPH, at the University of Oregon. PAM parameters are used to assess patients using a four-point scale: (1) Are they starting to take a role in their care?; (2) Are they building self-knowledge and confidence?; (3) Are they taking action?; and (4) Are they maintaining healthier behaviors? Fifty-eight percent of SCC patients have improved PAM scores significantly. SCC staff also consider other factors that affect how people care for themselves, such as depression, loneliness, and a lack of social support.

Research shows that as patients progress along the PAM scale, they show significant improvements in high-density lipoprotein (HDL) and triglyceride levels, smoking-cessation behaviors, weight management, and maintaining preventive-health measures. Studies also show a corresponding reduction in health care costs.

SCC's approach often succeeds in helping patients feel better by using creative ideas that go beyond clinical care. For example, an SCC patient who had suffered a stroke fell into depression because his left hand was paralyzed and he could no longer work as a barber. The SCC team focused on getting him back into the barbershop. As his self-esteem returned, he began to care more about his medical conditions. His diabetes came under control, and he became more adherent to his medication regimen, which included blood thinners necessary to prevent additional strokes.

Another patient with Parkinson's disease, who was rapidly declining and depressed, voiced regret over losing the ability to run. One year later, he ran an eight-mile race by working with the team to gradually build up to this goal, rather than accepting his decline as unavoidable. While these are not conventional 'medical' treatments, these strategies allowed these individuals to get their lives back, improving their mental and physical health as they regained confidence.

## BEHIND THE INNOVATION



**Alan Glaseroff, MD and Ann Lindsay, MD**, are co-directors of Stanford Coordinated Care, a new clinic model designed to help people with complex medical conditions take a partnership role in their health care. They also both serve as clinical professors of medicine at the Stanford University School of Medicine.

## PROFILES IN INNOVATION SERIES FROM THE *COMPLEX CARE INNOVATION LAB*

These profiles highlight the organizations and individuals participating in the Center for Health Care Strategies' [Complex Care Innovation Lab](#). The *Innovation Lab*, made possible by Kaiser Permanente Community Benefit, is bringing together innovative organizations from across the country working to improve care for vulnerable populations with complex medical and social needs. Participants are exploring new ways to advance complex care delivery at the local, state, and national level. For more information, visit [www.chcs.org](http://www.chcs.org).