Patient Activation Goal of Chronic Illness Grant

UCSD Extension Part of Half Million Dollar Pilot Program to Address Ills of Non-Acute Care

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UC San Diego Extension, the County of San Diego and a George Mason University professor have launched a $535,000 pilot program to work with physicians, nurses and others to promote patient activation and family caregiver support to better manage the complicated treatment of those with chronic illnesses such as high blood pressure, Alzheimer's disease, diabetes and heart disease.

"Patient activation is teaching health care consumers to have the knowledge, skills, beliefs, and confidence to better manage their health," says Grace Miller, director of healthcare education at UC San Diego Extension. "This is especially important for the estimated 125 million Americans with a chronic disease because they need ongoing care and account for a large portion of health care costs."

Mark Meiners, George Mason University professor of health policy, is developing a coordinated, low-cost team approach to chronic illness care with UC San Diego Extension and the physician's strategy portion of the San Diego Long-Term Care Integration Project, which is sponsored by the County's Aging and Independence Services.

"According to recent studies, physicians and people with chronic illness are increasingly dissatisfied with the health-care process, including problems in communicating results of examinations, coordinating follow-up care and ensuring that prescription directions are followed," says Meiners.

The program, Team San Diego, emphasizes team care strategies in a health care system that is increasingly fragmented and built to deliver acute care. If the program proves successful in San Diego, the research may be used to help develop programs nationwide.

UC San Diego Extension is coordinating a 14-hour training program for physicians, nurses, social workers, mental health workers, and intake specialists to increase understanding and share resources on behalf of the aged and disabled.

The unique aspect of the program is the promotion of patient activation to the network of caretakers - often consisting of home health nurses, social workers, pharmacists and social service providers - for people with chronic illnesses. The network keeps the patient's primary care physician informed about additional treatment or services provided by other health care entities.

"By building a network or community of caregivers for people needing chronic care management, we are essentially creating a new health care philosophy," says Meiners. "The information gained from this project will allow us to better understand chronic care management, create an informed team of health care providers and ultimately improve patient outcomes."

To improve the current communication channels, the care networks will communicate electronically about comprehensive and coordinated health and social programs for individuals with complex needs. These "after hours" services include all of the activity and services needed to implement a patient's care once he or she leaves the primary care physician's office, perhaps including arranging for personal care assistance or home-delivered meals.

The project, funded by the California Endowment and the Alliance Healthcare Foundation, builds on an earlier planning grant awarded to Meiners that found physicians and community providers cited lack of coordination of care across settings as a major obstacle to optimum outcomes for vulnerable populations.

In addition, physicians pointed to difficulty providing quality care with greater demands for paperwork and lower levels of reimbursement, as well as the inability to follow their patients' behavior around the clock. Team San Diego hopes to make inroads in alleviating these issues.

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