



# USING A PRACTICAL CLINICAL MODEL TO COMMUNICATE ABOUT VETERANS' PARKINSON'S DISEASE CARE:

## The Siebens Domain Management Model (SDMM) in Care Coordination for Health Promotion and Activities in Parkinson's Disease (CHAPS)

**Karen Connor PhD, RN, MBA**  
Principal Investigator VA-HSR&D-NRI Multi-Center Study  
Email: [Karen.Connor@va.gov](mailto:Karen.Connor@va.gov)

**Hilary C. Siebens MD**  
Siebens Patient Care Communications, Seal Beach, CA  
Email: [info@siebenspcc.com](mailto:info@siebenspcc.com)

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# Special Thanks

from Dr. Connor to:

- *CHAPS Intervention Design Team Collaborators:*  
Barbara Vickrey MD, MPH; Virginia Janovsky MN, MS, RN-BC; Erik J Ernst, DNP, MBA, MS, RN; Ed Farag MD, and Eric Cheng MD, MS
- Lisa Edwards, BA for project management
- Innumerable patients, their families, and clinical professionals who have taught us over many, many years.

# Special thanks to Megan Connor, MPH for learning ACCESS programming

Assessment Main Menu - Microsoft Access

File Home Create External Data Database Tools

## ASSESSMENT MAIN MENU

Return to Main Menu

View Assessment Section Status    View Assessment Summary Information    View Priority Problem List

View ALL Care Plan Tasks    View ALL Care Plan Tasks NOT Completed    View ALL Care Plan Tasks NOT Completed (Select Date Range)    View Assessment Notes

Overall Assessment Date: 2/25/2013    Before clicking "Return to Main Menu", Please click the box to the left if any data was entered or changed in the assessment

**INFORMATION TO LOOK UP IN CPRS:**  
These sections include items that are to be completed prior to conducting the assessment.

Patient Information	Prevention	Depression
Appropriate Diagnosis	Medication	Advance Directive
Cognitive Screen	Height/Weight/BMI	Source of Medical Care

### ASSESSMENT SECTIONS

<b>INTRODUCTION</b>	<b>COMMUNICATION</b> (Communication Preference or Deficit and Health Literacy)
PATIENT INFORMATION	PREFERENCES (Advance Directives, Cultural)
APPROPRIATE DIAGNOSIS	PSYCHO-SOCIAL ISSUES (Sense of Support, Social Isolation)
COGNITIVE SCREEN (including MoCA-Blind)	FUNCTIONAL ABILITIES 1 (Vision and Hearing, Physical Activity)
PREVENTION	FUNCTIONAL ABILITIES 2 (Equipment, Mobility, ADLs, IADLs)
MEDICATION (Medication Reconciliation and Adherence)	SAFETY (Falls, Driving, Driving Ability)
GASTRO-INTESTINAL (Weight and Nutrition/Dental, Gastro-Intestinal, Saliva and Drooling)	SOURCE OF MEDICAL CARE (Providers and Hospitalizations)
MOTOR-RELATED Motor Complications and ON/OFF Effects	ACCESS TO CARE
SLEEP (Sleep History, Epworth Daytime Sleepiness)	SERVICES
NON-MOTOR-RELATED (Urology, Pain, Speech, Psychosis/Hallucinations/Delirium, Impulse Control Disorder, Perceptions of Health)	ELDER ABUSE SCREEN
MOOD CHECKLIST 1 (Depression, WHO-5, PHQ-2, and PHQ-9)	<b>END OF INTERVIEW</b>
MOOD CHECKLIST 2 (Anxiety, PHQ-4, and Apathy)	RESOURCES

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Form View    Num Lock    Filtered

Section 9 - Microsoft Access

**NON-MOTOR-RELATED (I/II)**  
**Pain, Urology, Speech, Psychosis/  
 Halucinations/Delirium, ICD, Perceptions of Health**

Return to Assessment Menu  
 Go to Mood Checklist  
 Back to Sleep

Study ID:  Patient First Name:   
 Assessment Type:  Patient Last Name:

Date of Interview:  Click in the box to the left in order to auto-populate today's date

**PAIN (I)**

1. During the past 4 weeks, have you had pain not related to your PD?	Yes No DK/Refused
2. How much did the pain interfere with your normal work or day to day activities (including both work outside the home and housework)?	Not at all A little bit Moderately Quite a bit Extremely DK/Refused

**UROLOGY (I)**

**"The next question will involve sexual function. Symptoms of PD may include problems with sexual function. If you feel you have problems with this, please let me know. We may be able to direct you to get some help with this."**

1. Is there anything you would like to tell me about this now?	Yes No DK/Refused
Please specify:	

**"Now I am going to ask you a few questions regarding urine control"**

2. Have you had trouble with urine control? For example, an urgent need to urinate, a need to urinate too often, or urine accidents?	Normal: No urine control problems. Slight: I need to urinate often or urgently. However, these problems do not cause difficulties with my daily activities. Mild: Urine problems cause some difficulties with my daily activities. However, I do not have urine accidents. Moderate: Urine problems cause a lot of difficulties with my daily activities including urine accidents. Severe: I cannot control my urine and use a protective garment or have a bladder tube. DK/Refused
3. Is this new or worsened since you last saw your doctor?	Yes No DK/Refused

Record: 1 of 1 | Filtered | Search | Num Lock | Filtered

Form View

# Special Thanks

from Dr. Siebens to

- Drs. Connor and Vickrey for this research opportunity
- Thomas Land Publications for *Topics in Stroke Rehabilitation* (Ken and Mary Killion)
- CARF International for support through distribution of the *Siebens Health Care Notebook*

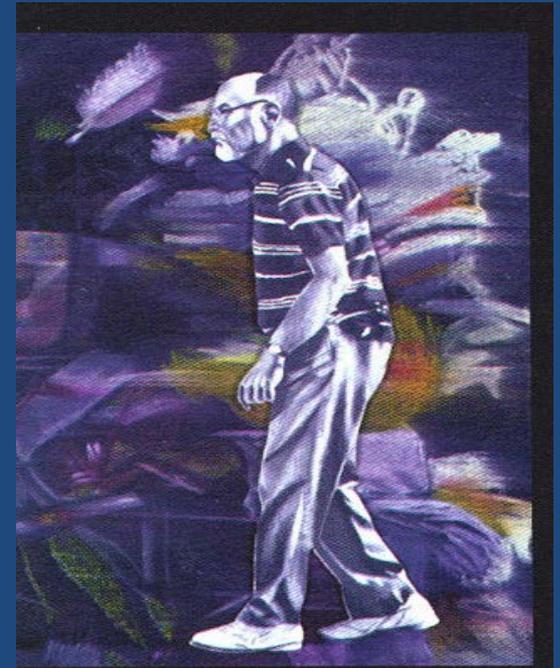
# DISCLOSURES

**Karen Connor PhD, RN, MBA**  
**Nothing to Disclose.**

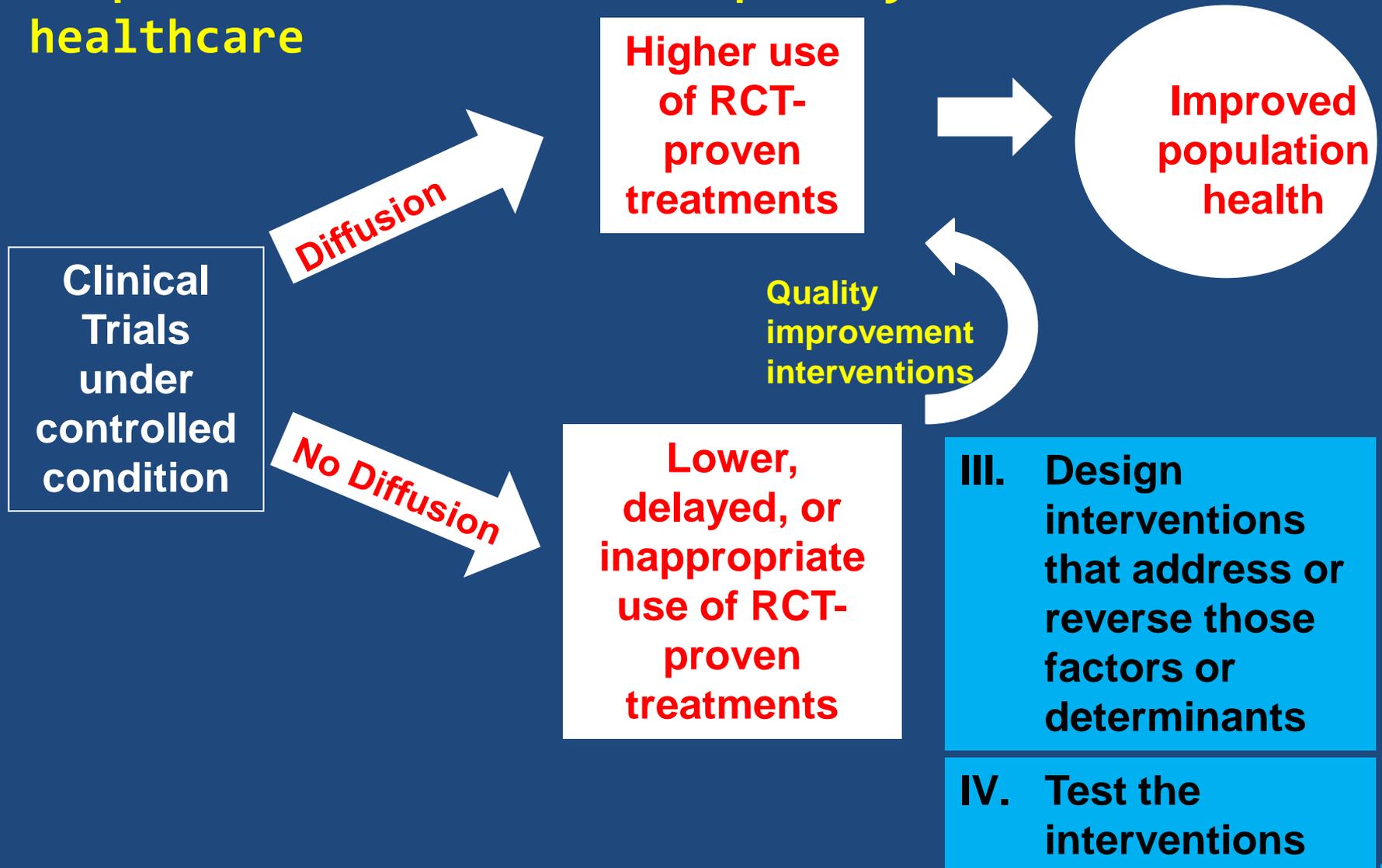
**Hilary C Siebens MD is Principal,**  
**Siebens Patient Care Communications,**  
**a health care consulting practice. Tools used in**  
**consulting are mentioned in this presentation.**

# Parkinson's Disease (PD)

- 1.5% of those > 65 yrs old
- Chronic, progressive neurological condition
- Motor (tremor, rigidity, postural instability, bradykinesia) manifestations
- Wide range of non-motor manifestations: autonomic, cognitive, and psychiatric
- PD cost burden estimate: \$14.4 billion/year (\$8.1 billion medical expenses and \$6.3 billion in indirect costs)



# Health Services Research Goal: create and test interventions to overcome disparities in access or quality of healthcare



# Previous PADRECC Health Services Research

- Analyzed existing PD health outcome measures and established need for newer generation of such measures
- Developed first set of quality indicators for PD – now exported to national efforts of American Academy of Neurology, National Quality Forum, AHRQ, and Medicare
- Identified selected gaps in PD quality of care in VA and associated factors (specialty access, race)
  - Among Veterans with PD:
    - 69% received recommended care some of the time
    - 49% received counseling about these indicators
    - 46% reported that if a care need was identified in the previous 6 months, that need was unmet

# Previous PADRECC Health Services Research (con't)

- New Care Model and Interventions needed
- 38 evidence-based PD care goals/indicators chosen by Task Force to guide the new PD care management model
- Developed and piloted novel PD care approach in VA, building on this research
- Received new VA funding for 4-year multi-center RCT of a nurse-led care management program for PD

# Approach to New Model for Higher Quality PD Care

- **Chronic Care Model-based intervention**
- **Based on prior work in dementia care and depression care (TIDES) in VA**
- **Empiric model derived from Internal Medicine/Geriatrics/Physical Medicine & Rehabilitation**

# CHAPS MODEL

## *Health System*

and

## *Community*

GLA, Las Vegas, Long Beach,  
Loma Linda, San Diego  
VA Resources and Policies

Local APDA, LA-CRC, NPF, PRO  
Resources and Policies

### *Delivery System Redesign*

(CHAPS Nurse Care Managers, SDMM & SHC Notebook)

### *Decision Support*

(Parkinson's disease Specialists, Evidence-based protocols & Empiric expertise)

### *Clinical Information Systems*

(Care management registry/tracking tool)

### *Self-management*

(Coaching by CHAPS Nurse Care Manager in goal setting, coping, problem-solving & SHC Notebook)

*Prepared Proactive Care Management Team*

Productive, Veteran-Centered Communications and Interactions

*Informed Veterans and Their Care Partners*

**IMPROVED OUTCOMES**

# Elements of “Re-Designed” Nurse Care Manager-Led, Telephone Intervention

- Care protocols including standardized assessment, computerized system to track and prompt actions
- Collaboration with Veteran in unmet need problem prioritization
- Care coordination with subspecialists for management of motor manifestations
- More active surveillance of needs, closer follow-up of non-motor treatment
- More education and counseling and links to VA and community resources

# Francis W. Peabody, MD

- **“One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.”**

## The Care of the Patient

JAMA 1927; 88:877-882.

# Caring About Patients Requires Getting to Know Them... It Takes...

- Listening and time for it...
- Information, managed well...
- Where begin in patients with multiple chronic conditions?

Prigatano GP. The important of the Patient's Subjective Experience in Stroke Rehabilitation. *Top Stroke Rehabil* 2011;18:30-34.

Sandel E. Stroke, Disability, and Unconscious Bias Interrelationships and Overdetermination in Medical Decisions. *Top Stroke Rehabil* 2011;18:70-73.

# Vignette 1

- 66 year-old (100% service connected), retired (worked in building)
- lives with his wife and multiple dogs in a house
- Parkinson's Diagnosis in the 1990s
- on 23 different pills (all prescription)
- prior stroke with residual left side weakness
- worsening tremors and moderate foot and jaw pain
- taking medications for depression
- dragging left foot/trouble with balance.

# Vignette 2

- 85 year-old Veteran, retired high school teacher,
- was caregiver for wife prior to her death 2 years ago;
- lives in a single family home with son (travels a lot).
- Parkinson's disease for at least 8 years (3 meds)
- on 17 different meds (12 prescription, 5 OTC),
- pain unrelated to PD,
- misses going to church due to price of gasoline,
- limited driving and few social contacts.

# Organizing Information for Quality, Patient-centered Care

I. Current Challenges

II. History of Information Organization

III. Contemporary Theoretical Models for Information Organization

IV. A Practical Clinical Model –

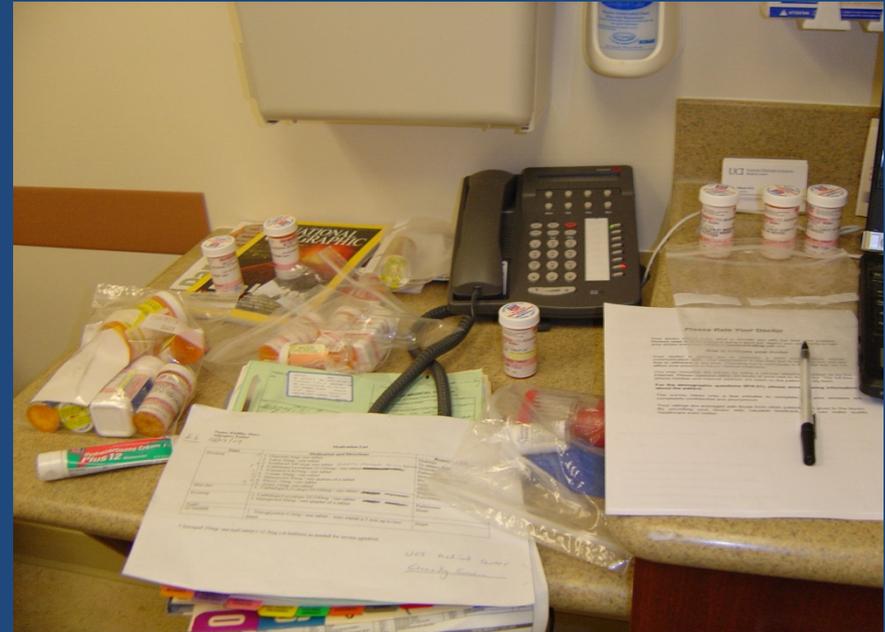
The Siebens Domain Management Model(SDMM)

V. The Approach in the CHAPS Project

# I. Current Challenges

## Information To Be Managed

- Multiple medications
- Multiple physicians
- Multiple transitions and...
- Multiple medical, psychological, functional, environmental issues



# What's also happening?

- **Hospitalists and PCPs – deficits in information transfer**  
(Kripliani et al *JAMA* 2007;297:831)
- **Patients unclear on what's going on (health literacy issues...)  
and experience coordination problems**  
(Weinberg et al *Health Services Research* 2007;42:7)
- **Care organization is chaotic...**  
(Lee TH, Mongan JJ. *Chaos and Organization in Health Care* 2009 )

# Information Abundance

- Positive aspects
  - We can get to know patients quickly
  - We can help patients in multiple ways
- Problems
  - Experiences: patients, ours aren't optimal
  - Others?

# Information Abundance

- Cognitive consequences of too much information/stimulation?
- Decision-making abilities
  - ✓ of Veterans and other patients
  - ✓ of their loved ones/families
  - ✓ of physicians, nurses, and other health care providers

# Publications on Magnitude of Information

- ***The Paradox of Choice – Why More is Less*** Barry Schwartz 2008
- **The Data Deluge**  
cover article of *The Economist* Feb 27-Mar 5, 2010
- ***The Information – A History, A Theory, A Flood***  
James Gleick 2011

# I. Current Challenges (con't)

The Multiple Medical Languages  
all “English” ...

- PCPese
- Neurologese
- PTese and OTese
- Nursingese
- Administratorese
- Surgeonese
- Internistese
- Physiatriese
- Is this an issue for clinicians caring for Veterans with Parkinson's Disease?

# Sharing Information

## Levels of Detail

- **Within a discipline, detail...**  
**(professional granularity)**
- **Between/among disciplines, less detail needed...**  
**(less granularity)**
- **With patients (see below)**

# The Multiple Medical Languages all “English” ...

- **Clinicians, reflect:**
  - **Who reads your documentation?**
  - **Do you document with these readers in mind?**
  - **What are uses of your documentation?**

# II. History (brief) of Clinical Information Organization

- **Prior to SOAP Notes (pre-1969)**

- **Advent of SOAP Notes**

Weed LL. Medical records that guide and teach. *N Engl J Med* 1968; 278:593-600 and 652-7 (conclusion)

Weed LL. *Medical Records, Medical Education, and Patient Care: The Problem-Oriented Record As a Basic Tool*. Chicago:Year Book Medical Publishers; 1969.

- **Challenges in Organizing Problem Lists**

Weed L. What physicians worry about: how to organize care of multiple-problem patients. *Modern Hospital* 1968 (June):90-94.

## II. History (brief) of Clinical Information Organization

- Traditional documentation/SOAP notes do not elicit patients' function and home environmental issues
- Sites and practitioners all have different documentation formats that are evolving

# III. Contemporary Theoretical Models for Clinical Care

- **Biomedical Model**

- **Biopsychosocial Model**

Engel G. The need for a new medical model: a challenge for biomedicine. *Science* 1977;196:129-136.

- **Problems in applications of the biopsychosocial model**

Alonso Y. The biopsychosocial model in medical research: the evolution of the health concept over the last two decades. *Pt Educ Counsel* 2004;53:239-244.

Siebens H. Proposing a Practical Clinical Model. *Top Stroke Rehabil* 2011;18:60-65.

# III. Contemporary Theoretical Models for Clinical Care – What's New?

- **Biopsychological Model**

Stineman MG. A model of health Environmental Integration. *Top Stroke Rehabil* 2001;8:34-45. see also *PM&R* 2010;2:1035-1045

- **International Classification of Functioning, Disability, and Health (ICF)**

World Health Organization. *The International Classification of Functioning, Disability, and Health*. 2001, Geneva

# III. Application of Theoretical Models Across Time and Space

- Quality of Life/Patient Goals
- How merge clinical data and QOL information
- What are clinicians suppose to do?!



Kemp B. Quality of life, coping, and depression in Kemp B, Mosqueda L. *Aging with a Disability – What the Clinician Needs to Know* 2004 pp. 1-307.

Reuben D, Tinetti ME. Goal-oriented Patient Care *NEJM* 2012;366:777.

Stineman MG. The clinician's voice of brain and heart: a biopsyo-ecological framework for merging the biomedical and holistic. *Top Stroke Rehabil* 2011;18:55-59.

## IV. What's Needed?

### A Simplifying Interdisciplinary Framework

#### Siebens Domain Management Model (SDMM)

- Applies to any patient of any age with any disease(s)/condition(s) in any care setting
- Comprehensive, yet efficient
- Provides structure yet flexibility
- Understandable by *anyone*

# A Simplifying Interdisciplinary Framework

## Siebens Domain Management Model (SDMM)<sup>1</sup>

Four domains:

I. Medical/Surgical Issues

II. Mental Status/Emotions/Coping

III. Physical Function

IV. Living Environment

Siebens H. Applying the Domain Management Model in treating patients with chronic disease. *Jt Comm J Qual Improv* 2001;27:302-314.

Siebens H. Proposing a practical clinical model. *Top Stroke Rehabil* 2011;18:60-65.

# A Simplifying Interdisciplinary Framework

## Siebens Domain Management Model (SDMM)<sup>1</sup>

Each Domain with several Sub-domains:

### I. Medical/Surgical Issues

Symptoms, Diseases, Prevention

### II. Mental Status/Emotions/Coping

Communication...Behavioral symptoms, Spirituality, Preferences

### III. Physical Function

BasicADLs, Intermediate/Instrumental ADLs, Advanced ADLs

### IV. Living Environment

A. Physical, B. Social, C. Financial/Community Resources

# Benefits of SDMM Applications?

- Does it create a standardized flow of *relevant* information to both providers and patients?
- Does it facilitate:
  - team communication?
  - more meaningful interactions  
between providers and patients?
- Is clearer communication generally associated with decreased medical risk and better patient follow-through of treatments?

# Evidence in Support of SDMM

- Use by early-adopting experienced MDs (physiatrists, surgeon, geriatricians, others)
- Included in *Bates' Guide to Physical Examination and History Taking* (2009, 2013), *Bates' nursing edition* (2012)
- **Research publications using SDMM to organize information**  
(see Kim et al, *PM&R*, 2013;5:182-188, at Greater Los Angeles VA; Siebens et al, *PM&R* 2012;548-555)
- **Successful SDMM integration in inpatient rehab team conferences in HealthSouth, a major rehabilitation hospital corporation in the US**
  - (>100 hospitals and >100,000 discharges annually)

# V. THE APPROACH IN CHAPS

Integrating the **SDMM** and  
Including the Veteran using the  
Siebens Health Care Notebook

# Order of CHAPS Assessment (early draft)

1. Communication and Education
2. Medication
3. Source of Medical Care
4. Functional Limitations (Tremors/Dyskinesias, On/Off Effects...)
5. Weight/Nutrition/Dental (GI, Exercise, Vision, Hearing...)
6. Non-motor (speech, urology, psychosis, pain, perception of health...)
7. Sleep/Safety (falls, driving, etc)
8. Psycho-social issues
9. Mood checklist
10. Long Term Planning
11. End-of-Life Resources
12. Prevention
13. Elder Abuse

# List of Problem Areas/Care Plans

(early draft)

1. Understanding Parkinson's Disease
2. Cognitive Impairment
3. Communication/Continuity
4. End-of-Life
5. Exercise
6. Functional Limitations  
(ADL, IADL, Hearing, Vision)
7. Gastro-Intestinal
8. Impulse Control Disorder
9. Long-Term Planning  
(Advance Directive, DPHC,  
Money Management)
10. Medication
11. Mood (Depression, Anxiety, Apathy)
12. Motor Problems  
(Dyskinesia, Dystonia, Tremor)
13. Psychosis (Delirium, Hallucinations)
14. Safety (Abuse, Falls, Driving)
15. Sleep and Fatigue
16. Speech and Swallowing
17. Urology
18. Weight/Nutrition/Dental
19. Prevention

# Organizing CHAPS Assessment & Problem Areas with Care Plans - Integration of the SDMM<sup>1</sup>

## CHAPS Assessment Headings and Questions integrating SDMM Domains, Sub-domains

- |  |   |
|--|---|
| <b>I. <i>Medical/Surgical Issues</i></b><br><b><i>(The Body)</i></b> | <b>II. <i>Mental Status/Emotions/Coping</i></b><br><b><i>(The Mind)</i></b> |
| <b>1 Prevention</b>  | <b>10 Hearing</b>   |
| <b>2 Medication</b>  | <b>11 Vision</b>  |
| <b>3 Motor-Related</b>   | <b>12 Speech</b>  |
| <b>4 Gastro-intestinal-Related</b>                                   | <b>13 Cognitive Impairment</b>  |
| <b>5 Weight/Nutrition</b>  | <b>14 Psychosis/Hallucinations</b>  |
| <b>6 Swallowing</b>  | <b>15 Depression</b>  |
| <b>7 Urology-related</b>   | <b>16 Anxiety</b>   |
| <b>8 Pain</b>  | <b>17 Understanding Parkinson's Disease</b>                                 |
| <b>9 Sleep and Fatigue</b>   | <b>18 Coping/Self-management</b>  |
|  | <b>19 Apathy</b>  |
|  | <b>20 Impulse Control Disorder</b>  |
|  | <b>21 Preferences/Long term care planning</b>                               |

<sup>1</sup> © Hilary C Siebens MD 2005  
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# Organizing CHAPS Assessment & Problem Areas with Care Plans - Integration of the SDMM<sup>1</sup>

CHAPS Assessment Headings and Questions Integrating SDMM Domains, Sub-domains.

## III. *Physical Function* (Activities)

- 22 Functional Limitations
- 23 Falls
- 24 Physical Activity (Exercise)
- 25 Driving

## IV. *Living Environment* (Surroundings)

- A. Physical – home etc
- B. Social
  - 26 Elder Abuse
- C. Financial & Community Resources
  - 27 Access to Care
  - 28 End of Life Resources

<sup>1</sup> © Hilary C Siebens MD 2005  
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# Partnering with Veterans & their Care Partners

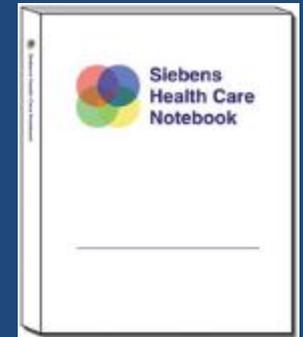
## One Conceptual Approach (SDMM)<sup>1</sup>

<u>Domain Medical Name</u>	<u>Domain Plain Name</u>	<u>Plain Phrases for use with Patients</u>
I Medical/Surgical Issues	Body	Health Issues Your Body
II Mental Status/Emotions/Coping	Mind	Your Mind and feelings
III Physical Function	Activities	What You Do
IV Living Environment	Surroundings	Where you Live and Work

<sup>1</sup> Table 2 from Siebens H. Proposing a practical clinical model. *Top Stroke Rehabil* 2011;18:60-65. (operationalizing the biopsychosocial and biopsychosocial-ecological models)

<sup>2</sup> Plain phrases from *Siebens Patient Care Notebook*, © 2008.

# Partnering with Patients: Siebens Health Care Notebook (3-ringed binder, owned by patients)



- **Verbal vs. Print Media – not the same, many considerations**

Johnson A, Sandford J. Written and verbal information versus verbal information only for patients being discharged from acute hospital settings to home: systematic review. *Health Educ Res* 2005;20:423-429.

- **Older adults process visual (print) info better than aural (hearing/sound)**

McKhann G, Albert M. *Keep Your Brain Young* 2002

- **Universal Design Considerations (health literacy, etc)**

# Partnering with Patients – Considerations

- **With patients, share what they *need to know* (not what's *nice to know*)**

Gloria Mayer, Ed.D, RN, FAAN, [iha4health.org](http://iha4health.org)

- **Consider:**
  - Amount of information given to patients
  - Timing for giving information
  - Media/format of information
  - Utility of medium over the Continuum (multiple points of contact)

# “My Action Plan”

## A CHAPS Communication Tool

My\_Action\_Plan\_Template.5.7.13EE.docx - Microsoft Word

Home Insert Page Layout References Mailings Review View Acrobat

1 2 3 4 5 6 7 8

**Coordination for Health Promotion and Activities  
In Parkinson’s Disease (CHAPS)**

**My Action Plan (Initial)**  
[Veteran’s Name]  
[Date]

REMEMBER – Use your Siebens Health Care Notebook to organize your health information. Take it with you to all your health care appointments!

HERE ARE NEXT STEPS YOU CAN DO:

- \* Read through your Notebook.
- \* Write your name inside the Notebook.
- \* Put this Action Plan in Section 2.
- \* Add any other information asked for in the Notebook *if* you want to and have the time.

(Terms Body, Mind, Activities, Surroundings © Hilary C. Siebens 2008 used with permission.)

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**THE BODY, SECTION 1**

- \* Review your medications. See the list I put in your notebook.
- \* Consider using [www.mymedschedule.com](http://www.mymedschedule.com) for maintaining your medication list, reminders, and refill reminders.
- \* Review the protein-levodopa fact sheet.
- \* Try different ways to deal with problems: to reduce disturbing your sleep, reduce liquids that you drink after 7 pm.

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**THE MIND, SECTION 2**

- \* Consider joining us for the VA’s Parkinson’s Disease at Home Telephone support group/education program.
- \* Write a note on “Questions for Health Care Providers” to ask your doctor for referrals for: 1) dental services 2) eye services 3) OT safety evaluation

Page: 1 of 3 Words: 452 English (U.S.) 100%

# Vignette 1

66 year-old (100% service connected), retired (worked in building), enjoys reading his Ebook, and lives with his wife and multiple dogs in a house; Parkinson's diagnosis in the 1990s.

- On 23 different pills (all prescription)
- BMI 34, Type 2 Diabetes mellitus, hypertension
- Had a stroke with residual left weakness
- Worsening tremors
- Moderate foot and jaw pain
- Urinary frequency
- Problem with vision and tracking with both eyes
- Taking meds for depression
- Sometimes dragging left foot/trouble with balance
- No falls but in prior year had one with hypoglycemia
- Uneven gravel surfaces outside home

# Vignette 1

## *I. Medical Issues*

- On 23 different pills (all prescription)
- BMI 34, Type 2 Diabetes mellitus, hypertension
- Had a stroke with residual left weakness
- Worsening tremors
- Moderate foot and jaw pain
- Urinary frequency

## *II. Mental Status/ Emotions/ Coping*

- Problem with vision and tracking with both eyes
- Taking meds for depression

## *III. Physical Function*

- Sometimes dragging left foot/trouble with balance
- No falls but in prior year had one with hypoglycemia

## *IV. Living Environment*

- Uneven gravel surfaces outside home

# Vignette 1- Progress to date

- Expresses pride in being part of research, talking about the research in his VA PTSD Support group
- Reports seeing progress in his management of 20 medical problems (e.g., tremors better with less caffeine)
- Using SHC Notebook:
  - Records information in notebook (wife too if pt requests help)
  - Brings Notebook to all 10 appointments in last 3 months
  - One provider stated, "I'm very impressed with this notebook", appreciates seeing it at visits
- *Newly* using MyHealthVet with help of wife
- Since Care Manager made Veteran aware of his fall risk (PD, stroke, & environmental hazards)
  - Veteran asked PCP Questions (written in Notebook) about unsteady walking
  - PCP and Veteran discussed several assistive device choices
  - Veteran prescribed a rollator...."I love it!"

# Vignette 2

85-year old Veteran, retired high school teacher, was Caregiver for wife prior to her death 2 years ago; son who travels a lot lives with Veteran in a single family home. Parkinson's disease for at least 8 years (3 meds) with multiple comorbidities

- 17 different meds (12 Rx, 5 OTC)
- Lightheaded w/ standing x 3mos
- Peripheral-neuropathic pain or arthritic pain
- Difficulty hearing
- No depression or anxiety
- Self rates health good
- Uses Internet daily
  - Uses MyHealtheVet for med refills
- Has a will, Advance Directive, Trust, and Power of Attorneys
- Independent in BADLs, help with IADLs (like housekeeping), using cane (tri and quad) and rollator
- Misses going to church due to no preferred drivers
- No falls (though lightheaded...)
- Vet pre-fills meds , Son verifies
- Drives short distances only
- Limited income; has enough \$ for food
- Trouble with med refills and reaching MDs, needs transportation to medical appointments.

# Vignette 2

## I. *Medical Issues*

- 17 different meds (12 prescription, 5 OTC)
- Lightheaded w/ standing x 3mos
- Peripheral-neuropathic pain or arthritic pain
- Serial mgmt for pancreatic lesion

## II. *Mental Status/Emotions/Coping*

- Difficulty hearing
- No depression or anxiety
- Self rates health good
- Uses Internet daily
- Uses MyHealthVet for med refills
- Has a will, Advance Directive, Trust, and Power of Attorneys

## III. *Physical Function*

- Independent in BADLs, help with IADLs, using cane and rollator
- Misses going to church due to no preferred drivers
- No falls (tho lightheaded...)
- Vet pre-fills meds , Son verifies
- Drives short distances only

## IV. *Living Environment*

- Limited income; has enough \$ for food
- Trouble with med refills and reaching MDs, needs transportation to medical appointments

# Vignette 2 -- Progress to date

- Veteran very pleased with CHAPS program
  - Responded to awareness of apathy lecture with insight of “no social contacts”
    - ✓ Renewed driving license
    - ✓ Resumed going to church
    - ✓ Actively considering VA Adult Day Health Care referral that he has been reluctant to accept for several months

# Components of CHAPS, Provider-centered

- Comprehensive multiple-dimensional CHAPS Structured Assessment
- Organized in a clinically-intuitive manner (SDMM)
- List of problems triggered by algorithms embedded in assessment
- Problem-specific education
- Referrals:
  - ✓ Medical resources to learn about PD and behavior management (e.g., VA telephone-support group with by VA neuropsychologist presenting about Apathy)
  - ✓ Community resources

# Components of CHAPS, Veteran-centered

- Collaborative care planning (Veteran & CHAPS CM)
- Prioritizing/validating issues for patients to raise with providers
- Teaching patient to self-manage through use of **Siebens Health Care Notebook**
- Encourage use of MyHealthVet
- **My Action Plan**

# Components of CHAPS, Veteran-centered

## Siebens Health Care Notebook (organized by SDMM)

- Veteran utilizes this to organize information
- Place to keep medication list
- Place to record issues/concerns to share with
  - 1) Provider at next visit
  - 2) CHAPS care manager for next phone call encounter
- Tool to take to all appointments to show VA and Community providers and to participate in decisions

“Keep it going” – Dr. A, non-VA neurologist (for peripheral-neuropathy workup) when Veteran showed him the SHC Notebook (Vignette 2).

# Challenges & Observations

- Comprehensiveness at first may seem overwhelming to patient and nurse; however,
  - Identified issues often inter-related
  - Addressing one issue helps resolve another, may empower/encourage Veteran
  - There is time to work through issues
  - Expectation is that CPRS notes will become shorter as problems get addressed

# Progress to Date

- Rolling enrollment across VISN 22; Goal N=400
- Currently 107 outpatient Veterans enrolled across:
  - Greater Los Angeles
  - Las Vegas
  - Loma Linda
  - Long Beach
  - San Diego
- 104% (cumulative/expected) enrollment to date!
- Intervention implementation progressing nicely
- Will outcomes be any better compared to controls?

**THANK YOU!**