ORGANIZATIONAL STRUCTURE

The Value of Teaching Patients to Administer Their Own Care

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Today, health systems operate on a spectrum of how involved patients are in the delivery of their care. On one end, traditional providers inform patients of their options, make a recommendation, and proceed to deliver care to a relatively passive patient. On the other, patients and their families are engaged in conversations with care teams, discussing goals and creating care plans together — with patients taking a more active role in the decision-making process. Over the past 20 years, health care as a whole has been moving toward the patient-centered care-end of the spectrum. What's the next step? Care that is truly delivered by patients themselves. A few health systems are blazing this frontier. Judging from the early results, other provider organizations should seriously consider following suit.

Patient-administered care occurs when providers train individuals to deliver their own care, on their own time, without supervision from or dependence on a licensed professional. Not every procedure can be transferred from the provider to the patient, but many can be — including pain management, dialysis, and the intravenous administration of antibiotics. Procedures that are repetitive, linear (where each step builds on the previous one), and limited in complexity make good candidates. Ultimately, each health system must consider

its own context in determining which procedures are good candidates.

Patients can independently provide their own care in two settings: in traditional care facilities or at an outside location such as their home or office. Here are examples of each:

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Parkland Health & Hospital System, which serves more than 1 million patients annually in metropolitan Dallas, is one of the largest public health systems in the United States. Located in a state that did not expand Medicaid under the Affordable Care Act, it serves nearly a third of Dallas's under- and uninsured population. Starting in 2009, Dr. Kavita Bhavan, an internist, and her team sought to improve patient care while also decreasing the need for hospital resources like staff time, medical supplies, and hospital rooms and beds.

Bhavan's team identified the costly procedure of providing intravenous antibiotics as a promising place to start. After medical procedures and surgeries, preventing infections is a top priority for a patient's health. Historically, patients would receive a series of intravenous

antibiotics in a hospital room for weeks after a procedure. Over the last 40 years, insured patients had the option to receive them in outpatient settings (e.g., infusion centers). This added flexibility for insured patients, reduced the use of hospitals' resources, and decreased the costs for insurance companies.

For under- and uninsured patients, however, outpatient infusions were not an option. Instead, hospitals provided this care in the inpatient setting for several hours a day over 26 days, on average. Bhavan's team saw this as an opportunity.

The team identified medically stable patients in need of IV antibiotics and offered to teach them how to administer their own care. In a series of sessions, patients learned each stage of the process and displayed their proficiency by performing the procedure with the clinician, then solo in front of the clinician, and finally on their own without supervision. Patients were sent home with a week's worth of supplies and delivered their own care, on their own time. Once a week, they returned to the clinic for a check-in and to collect the next week's supplies. (Parkland also provides printed materials and online instructional videos that patients can access at any time for guidance.)

In the first four years of this effort, over 1,000 patients were trained to self-administer IV antibiotics in their homes. These patients experienced a 47% lower 30-day hospital-readmission rate than those receiving treatments in an outpatient facility while the mortality rates of both groups were similar. Because patients delivered their own care, in their own settings, significantly fewer hospital resources were needed while patients reported higher levels of satisfaction. The program was so successful that many fully insured patients opted for Parkland's self-care program over their covered-benefit outpatient option.

The effort with uninsured patients reduced the number of bed days in Parkland hospitals by nearly 28,000 and saved approximately $40 million system-wide over four years. Self-care patients experienced higher levels of satisfaction and independence and better outcomes than patients receiving traditional care and generated system-level savings.

Patients can also self-administer their own care for longer-term and more complex conditions. An example is a dialysis program implemented at the Central Texas Nephrology Associates (CTNA) clinic in Waco, Texas, by CTNA's medical director, Dr. Richard Gibney, and his team. Unlike Parkland and intravenous antibiotic administration, dialysis treatment is not as well suited for at-home care delivery. This is largely due to the size and expense of a dialysis machine.

Starting in 2015, Gibney's team began offering patients the option of administering their own care at the clinic. Those who accept begin a flexible 12-step training and coaching process. Each step increases the patient's involvement in and responsibility for his or her own dialysis. This starts with becoming familiar with the machinery and its operation, learning proper cleaning and preparation, and working with a CTNA provider to deliver the care. As their comfort and competency grows, patients take on more responsibility, establishing their own IV lines, setting and monitoring the dialysis machine, and ending the process by successfully removing needles and cleaning up.

In 2016, nearly 40% of CTNA's 751 patients performed their own dialysis while experiencing fewer hospitalizations and a lower mortality rate than patients receiving dialysis the conventional way. Patients delivering their own dialysis experienced better outcomes and the health system minimized costs by avoiding unnecessary hospital visits. CTNA benefitted as well. It's staff work burden shifted: Providers' role changed from

performing every step of the process to serving as coaches and supporters of patients doing their own care. The resulting redeployment of staff resources led to higher productivity and throughput for the clinic.

Regardless of the setting, a successful approach to patient-administered self-care requires the following:

- Patients (or caregivers like family members) must be prepared and willing to take on elements of their own care and to work with providers to learn the necessary skills. Care organizations need to develop a standard process for training patients.
- Practitioners must be trained to support patient-administered care. They must learn to see themselves as coaches and the patient as an integral partner. They must recognize that patients' capabilities to provide their own care may differ and evolve over time, and they must be able to connect with the patient, wherever in the journey that person might be.
- A standard protocol should be developed. This includes methods for distributing equipment, supplies, and medication. Another important part of the protocol is how patients and providers should respond to adverse events. Health systems must offer easy access to outpatient and inpatient services to address any needs that arise.
- A care organization that has a value-based-payment system (one that reimburses providers on the basis of outcomes and cost containment) will have a much easier time adopting the self-care model than one that still relies on a fee-for-service payment (one that reimburses providers on the volume of procedures completed). The reason is obvious: Patient-administered care realizes savings by avoiding spending in the first place; in a fee-for-service model, this is lost revenue.

There are challenges and limits to implementing self-care programs. Not all clinicians are willing to cede power to patients. Not all procedures can be delivered by non-licensed individuals. Not all patients are willing, qualified, or able to take on their own care.

However, given the huge potential of self-care to deliver safer, higher-quality care at a lower cost, provider organizations should look for the conditions and procedures where it can be applied.

Innovation does not always require radically new tools and processes. Sometimes, it simply requires a new way of looking at relationships. Turning a provider from someone who does things to patients into an expert coach who works with people to care for their own needs is a major innovation.

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