Meeting the Needs of the Community: A System for Redesigning Care

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- Ms. C is a 68yo woman with cough and shortness of breath and risk factors for Type II diabetes. She calls her doctor who cannot see her until the following week.
- Two days later she is hospitalized with shortness of breath. She is dxed with “CHF”, discharged on captopril, “no added salt diet” with encouragement to see her MD in three weeks
- When she sees her MD, he does not have information about the hospitalization
- PE reveals rales, S3 gallop, edema and possible depression
- Ms. C is told she has “a little heart failure”, encouraged not to add salt, and Captopril is increased. Her depression is not addressed.
- She is told to call back if she is no better
- Two weeks later Ms. C calls 911 because of severe breathlessness and is admitted.
- Fuller history in the hospital reveals that she has been taking the Captopril prn because it seems “strong”, and she has never added salt to her diet, so her diet hasn’t changed.
- Further tests reveal elevated blood glucose. She is warned of impending diabetes.
- She is discharged feeling ill and frightened.

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Four Biggest Worries About Having A Chronic Illness (Age 50 +)

1. Losing independence
2. Being a burden to family or friends
3. Receiving care in a timely fashion
4. Affording medications

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The Increasing Burden of Chronic Illness

For Example: Patients with Diabetes Need

Additional Diagnoses*	45%
Functional Limits**	50%
> 2 Symptoms***	35%
Not Good Health Habits	30%

*Arthritis (34%), obesity (28%), hypertension (23%),cardiovascular (20%), lung 17%)

** Physical (31%), pain (28%), emotional (16%), daily activities (16%)

*** Eating/weight (39%), joint pain (32%), sleep (25%), dizzy/fatigue(23%), foot (21%), backache (20%)

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Differences between acute and chronic conditions (Holman et al, 2000)

	Acute disease	Chronic Illness
Onset	Abrupt	Generally gradual and often insidious
Duration	Limited	Lengthy and indefinite
Cause	Usually single	Usually multiple and changes over time
Diagnosis and prognosis	Usually accurate	Often uncertain
Intervention	Usually effective	Often indecisive; adverse effects common
Outcome	Cure possible	No cure
Uncertainty	Minimal	Pervasive
Knowledge	Prof.'s - knowledgeable Patients - inexperienced	Prof.'s and patients have complementary knowledge and exp.'s

Problems with Current Disease Management Efforts

- Emphasis on physician, not system, behavior
- Lack of integration across care settings hindering quality care
- Characteristics of successful interventions weren't being categorized usefully
- Commonalities across chronic conditions unappreciated

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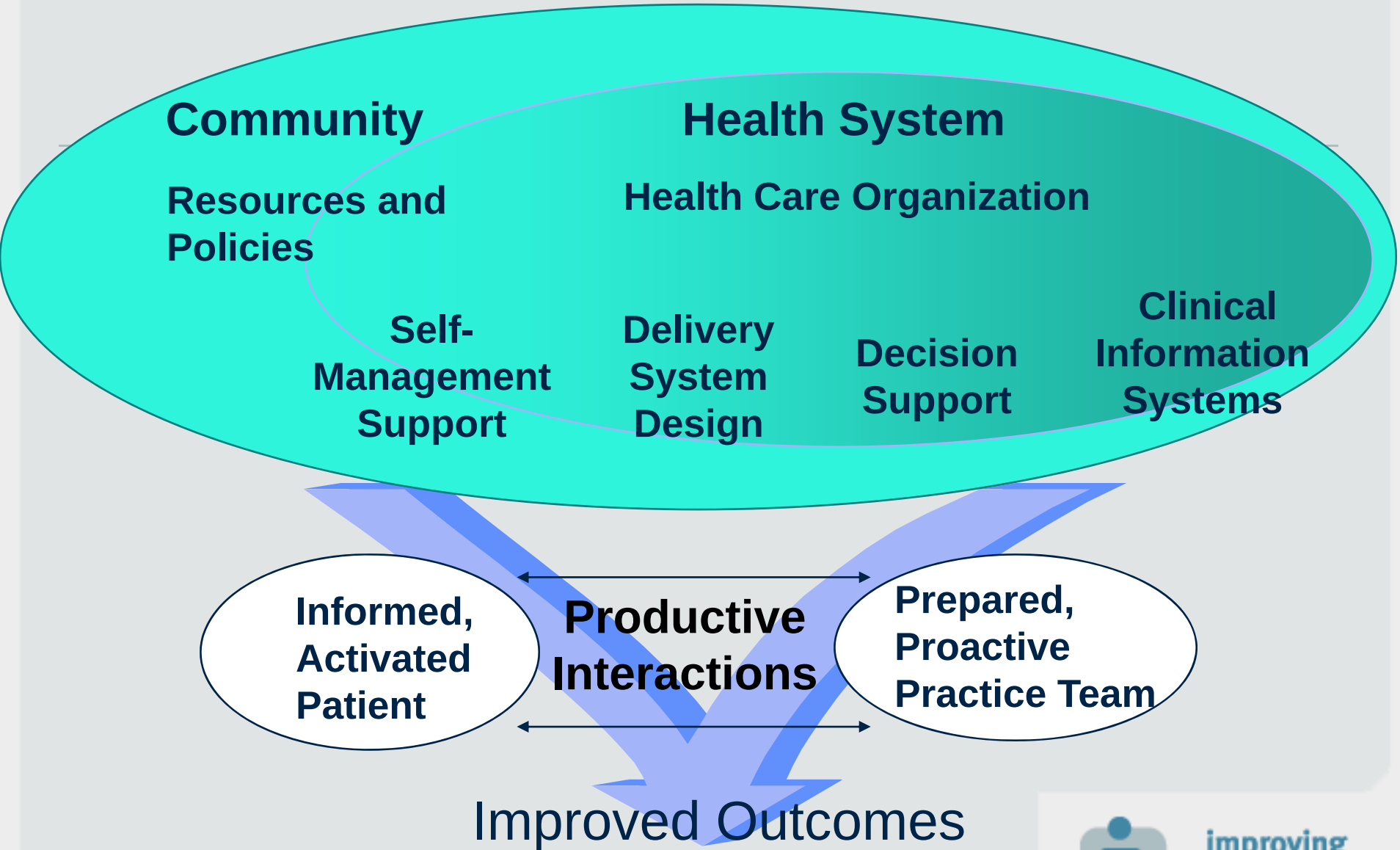
Chronic Care Model



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Model Development 1993 --

- **Initial experience at GHC**
- **Literature review**
- **RWJF Chronic Illness Meeting -- Seattle**
- **Review and revision by advisory committee of 40 members (32 active participants)**
- **Interviews with 72 nominated “best practices”, site visits to selected group**
- **Model applied with diabetes, depression, asthma, CHF, CVD, arthritis, and geriatrics**

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Essential Element of Good Chronic Illness Care

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What characterizes a “prepared” practice team?

Prepared Practice Team

At the time of the visit, they have the patient information, decision support, people, equipment, and time required to deliver evidence-based clinical management and self-management support

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What characterizes an “informed, activated” patient?

Patient understands the disease process, and realizes his/her role as the daily self manager. Family and caregivers are engaged in the patient’s self-management. The provider is viewed as a guide on the side, not the sage on the stage!

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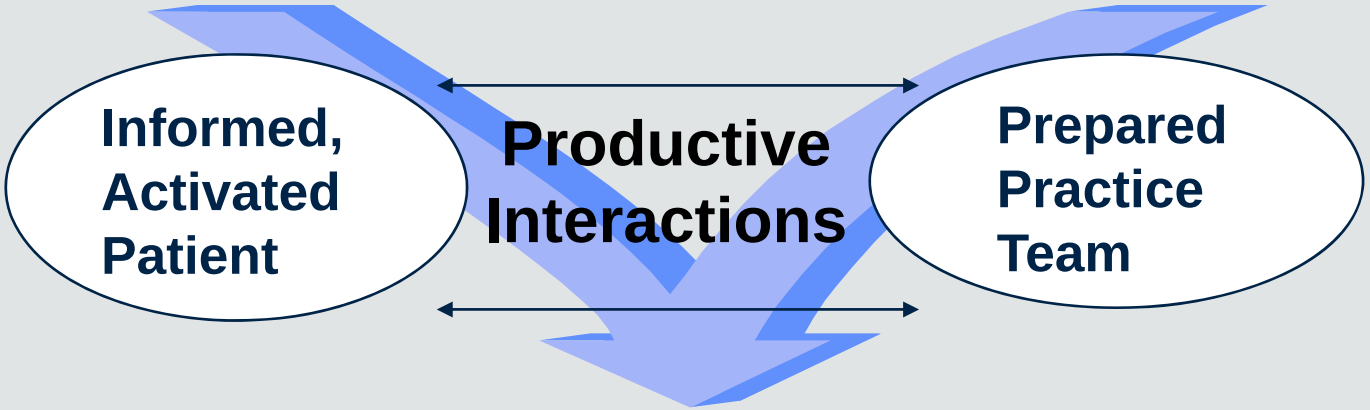
How would I recognize a productive interaction?



- Assessment of self-management skills and confidence as well as clinical status
- Tailoring of clinical management by stepped protocol
- Collaborative goal-setting and problem-solving resulting in a shared care plan
- Active, sustained follow-up

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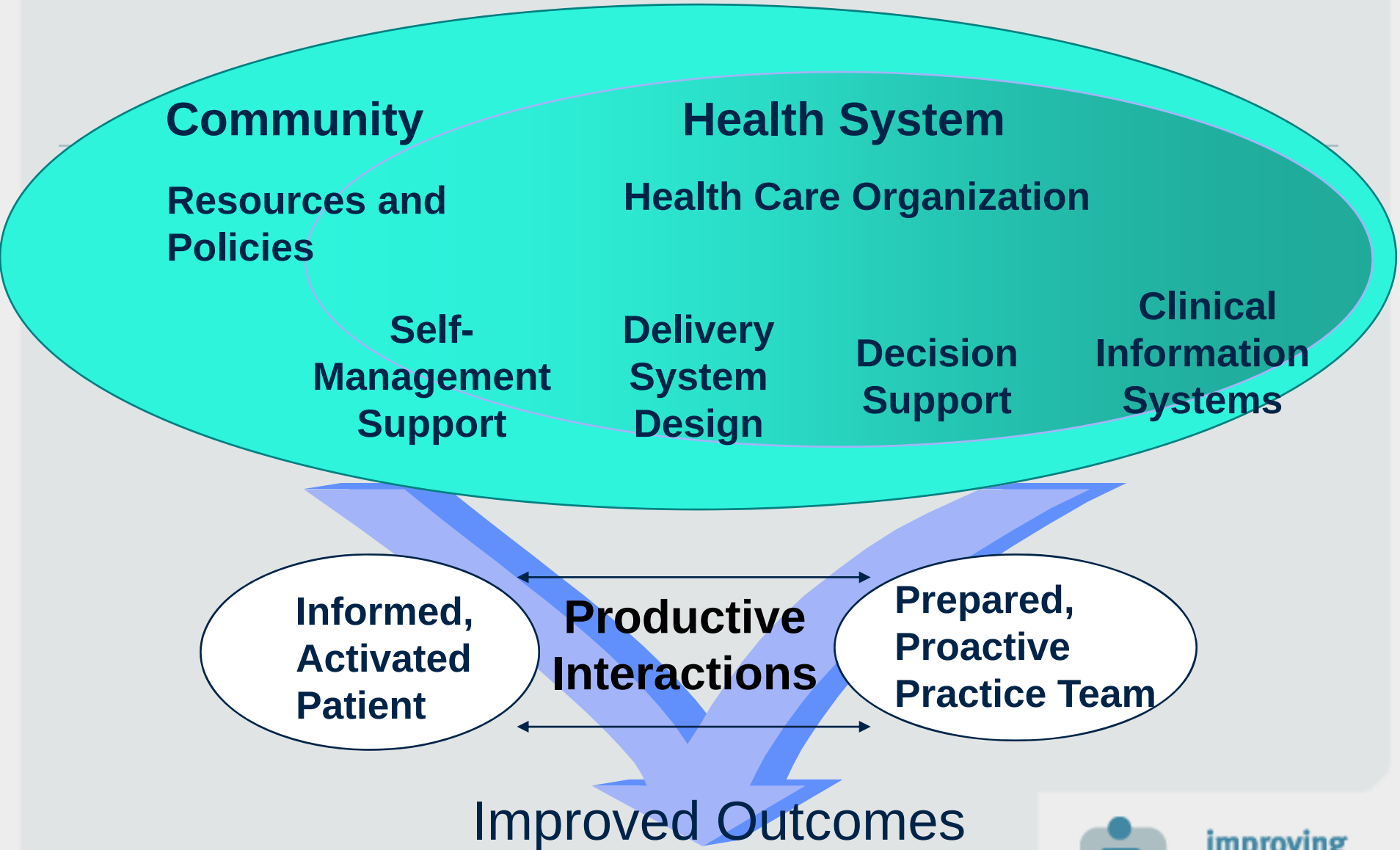

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Self-Management Support

- Emphasize the patient's central role
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving, and follow-up
- Organize resources to provide support

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Delivery System Design

- Define roles and distribute tasks amongst team members
- Use planned interactions to support evidence-based care
- Provide clinical case management services
- Ensure regular follow-up
- Give care that patients understand and that fits their culture

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Features of Case Management

- Regularly assess disease control, adherence, and self-management status
- Either adjust treatment or communicate need to primary care immediately
- Provide self-management support
- Provide more intense follow-up
- Provide navigation through the health care process

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Decision Support

- Embed evidence-based guidelines into daily clinical practice
- Integrate specialist expertise and primary care
- Use proven provider education methods
- Share guidelines and information with patients

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Clinical Information System

- Provide reminders for providers and patients
- Identify relevant patient subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with providers and patients
- Monitor performance of team and system

Health Care Organization

- Visibly support improvement at all levels, starting with senior leaders
- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of problems
- Provide incentives based on quality of care
- Develop agreements for care coordination

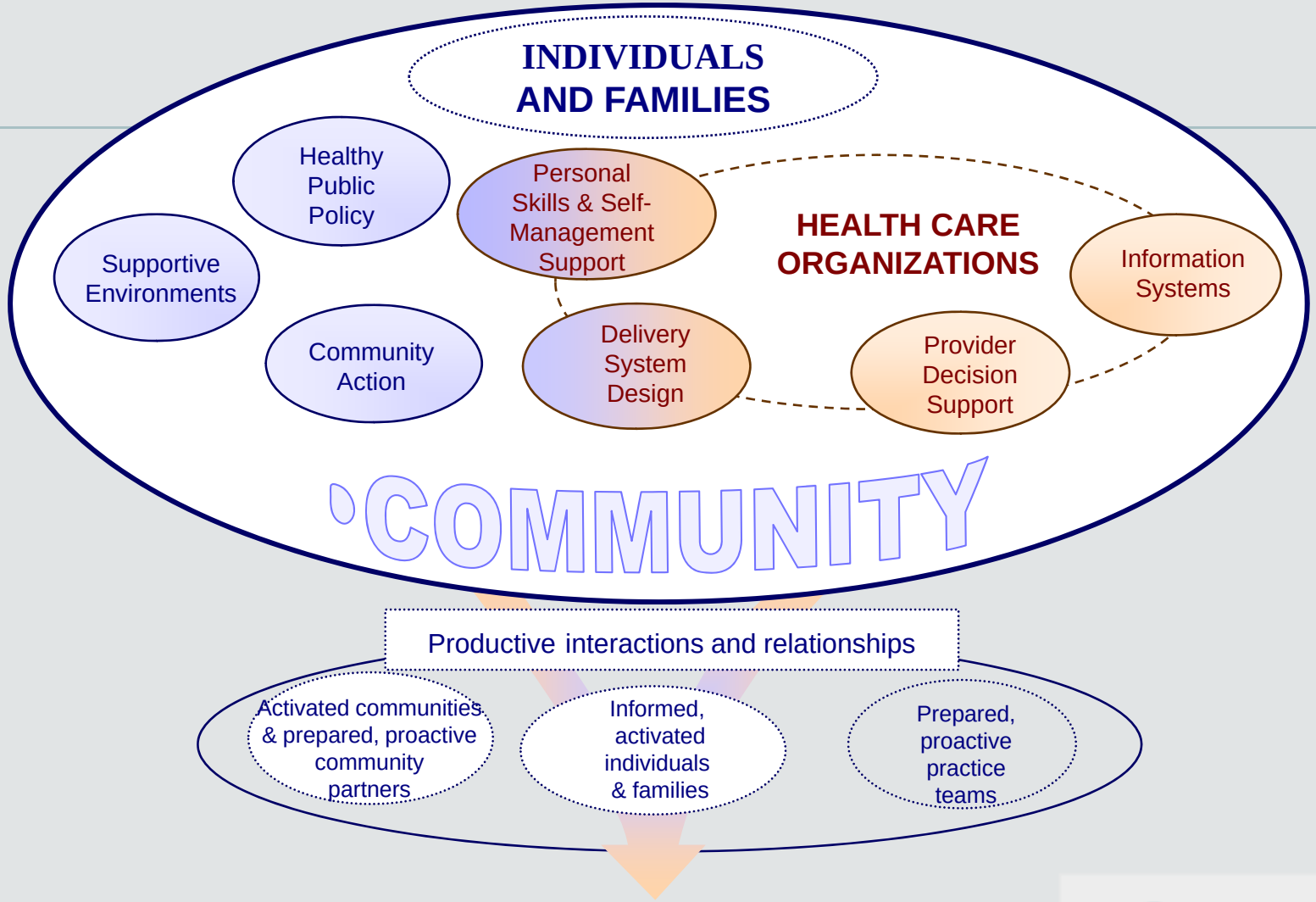
Community Resources and Policies

- Encourage patients to participate in effective programs
- Form partnerships with community organizations to support or develop programs
- Advocate for policies to improve care

Advantages of a General System Change Model

- Applicable to primary and secondary preventive issues, prenatal and pediatric, mental health and other age-related chronic care issues
- Once system changes in place, accommodating new guideline or innovation much easier
- Fits well with other redesign initiatives – such as improved access
- Approach is being used comprehensively in multiple care settings and countries

Ontario's Chronic Disease Prevention and Management Framework



Improved clinical, functional and population health outcomes

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Getting Started in Chronic Disease Prevention and Management

- Primary Care
- Acute/Specialty Care
- Mental Health and Addictions
- Children and Youth
- Seniors Health and Wellness
- Maternal Newborn
- Palliative Care/End-of-life

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Primary Care

- Build the team structure
- Obtain guidelines
- Collect some baseline data on the population
- Set performance measures and targets
- Call in patients for planned visits
- Set self-mgmt goals at the visit
- Conduct follow up on shared care plan

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Mental Health and Addictions

- Care coordination with Primary Care and other settings where applicable
  - Integration with FP
  - Co-location
  - Smooth transitions
- Same information across settings
- Assess backlogs and bottlenecks
- Improve supply
- Reduce wait times

Acute/Specialty Care

- Self-management training for RNs
- Multi-disciplinary patient reviews
- Resident training in Chronic Care Model
- Improved discharge planning with an eye toward care coordination and standard protocols
- Engage pharmacy in discharge planning

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Seniors Wellness and Health

- Lay-led self-management training in the community
- Engage families and caregivers
- Ensure primary prevention/health promotion with linkages to primary care
- Incent wellness through program incentives
- Partner with clinical case management for targeted populations (home care, LTC)

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Children and Youth

- Similar to primary care in need for CDM infrastructure
- Link to mental health for youth
- Engage family and caregivers in self-management support training
- Engage community programs to promote primary prevention
- Coordinate multi-disciplinary cross sectoral services

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Maternal Newborns

- Outreach to underserved populations
- Education and self-management support for mothers, fathers and family
- Connect mothers and newborns to primary care givers, pediatric providers and community supports
- Link to mental health for postpartum supports

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Palliative/End-of-Life Care

- Community-wide education about end-of-life issues
- Advance directives
- Caregiver self-management support and preparation for palliative care/death
- Linking acute and hospice care for smooth transitions

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- Mrs. C is discharged after her first bout of breathlessness with information about CHF, risk factors for diabetes, and assurance of rapid PCP follow-up
- The discharge nurse notes Mrs. C's conditions and care in the EHR and then sends an email to PCP's office about her recent hospitalization.

- The primary care nurse ensures the physician sees the information and calls Mrs. C to schedule a follow-up within 48 hours. Mrs. C is added to the care team's registry which prompts team to her future care needs.
- Mrs. C is scheduled for 30 minutes: 15 minutes with her physician and 15 minutes with the nurse (or medical asst.). The physician explains CHF and diabetes to her. He orders the appropriate diagnostic test for diabetes and assures her that all will be fine recognizing her fear and shock. He closes the loop with her to make sure she understood his recommendations and then briefly explained the concept of self-management support.
- Mrs. C then visits with the nurse who steps her through a collaborative goal setting and action planning process. While Mrs. C is a bit overwhelmed, she is assured that her care team will follow-up in the next couple of days by phone to make sure she understands her clinical and self-management care plan and to report on the results of diabetes test.
- The nurse calls within 48 hours and informs Mrs. C that she should be able to manage her blood sugar by better diet and exercise. She reviews the CHF medications with Mrs. C and adjust dosage since it seems to be bothering her.
- She is scheduled for a follow-up visit in one week to discuss her blood glucose in more depth. She is encouraged to call her team should she have any concerns or symptoms in the meantime.
- Mrs. C understands the hard work she needs to do to manage her conditions but is thankful for such a caring team.

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For more information please see our web site:

www.improvingchroniccare.org

Or contact me at hindmarsh.m@ghc.org

Thank you

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