Delivery System Design

Mike Hindmarsh
Hindsight Healthcare Strategies/
Affiliated with MacColl Institute for Healthcare Innovation

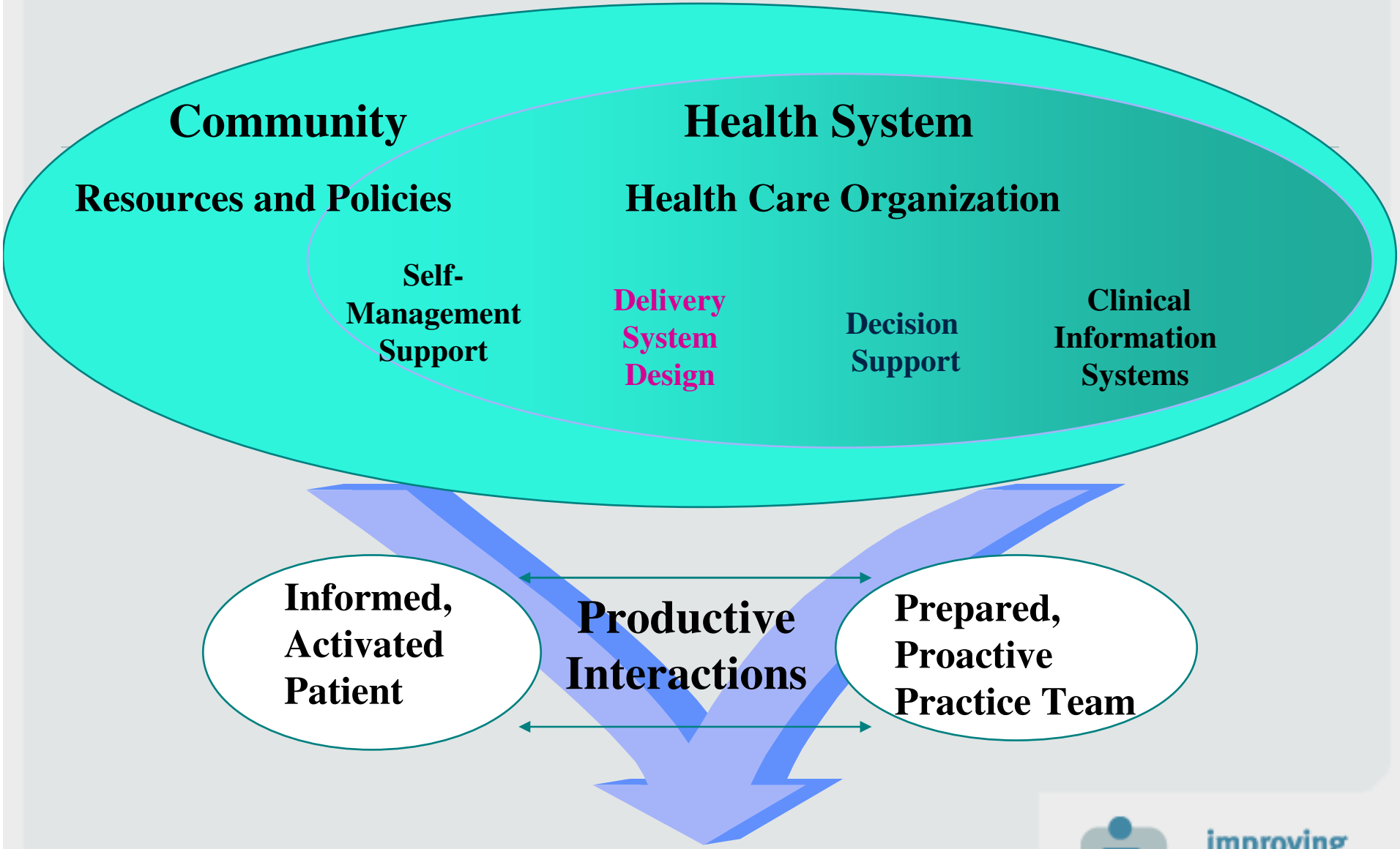
SNI California SEED Collaborative

Los Angeles, CA

June 13, 2007

improving chronic illness care

Chronic Care Model



improving chronic illness care

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

To improve outcomes in chronic illness

- Patients must be prescribed and taking proven therapies
- Patients must be managing their illness well
- Patient course must be followed for changes in status and reinforcement

The problem

- Patients are frustrated by waits and discontinuities, often don't receive proven services and often feel they are not heard.
- Providers feel they have little control over their work life, are stressed by demands for productivity despite older, sicker clientele and the reduced variability in their clinical day.

What we know about primary care visits?

- 50-70% are largely informational or informative (including check-backs for chronic illness care) yet they are organized like acute visits
- US average is 16.3 minutes
- Patients are given an average of 20 seconds to tell their story before they are interrupted

What we know about primary care visits? (cont.)

- When uninterrupted, 50% of patients finished their story in 60 seconds or less, 80% in 2 minutes or less.
- For the same set of patient characteristics, physicians varied the interval between visits from 4-20 weeks.
- Non-physician staff are generally more likely to adhere to protocols

improving chronic illness care

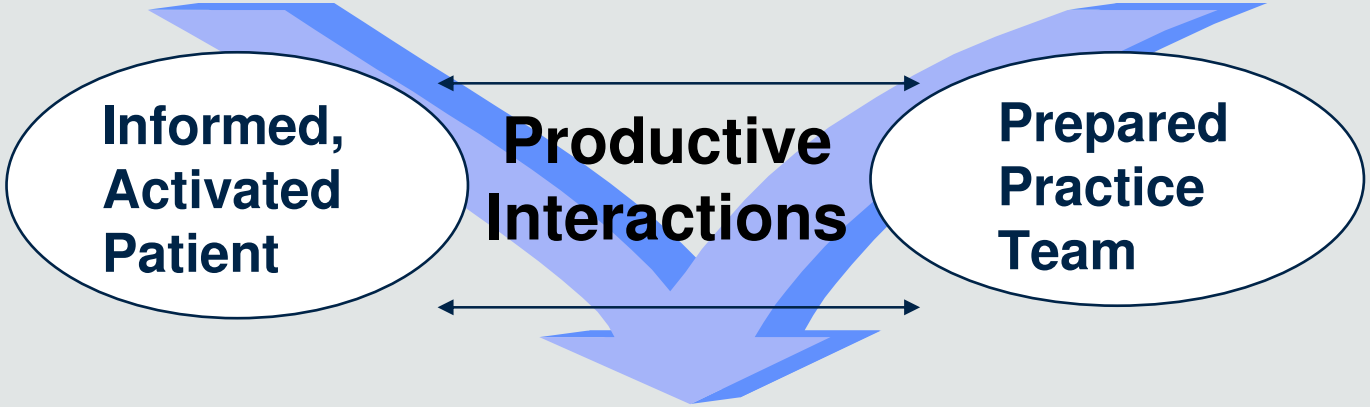
What we know about primary care visits? (cont.)

- For pediatric patients with asthma, continuity of care is associated with 50-60% reductions in ER use and hospitalizations
- The physician part of the visit is shorter when non-physician staff are used to their capacity.

Old interaction vs. new interaction

Between doctor/NP/PA and patient	Between patient and care team
Face-to-face	Multiple methods
Problem-initiated and focused	Based on care plan: “planned visit”
Topics are clinician’s concerns and treatment	Collaborative problem list, goals and plan
Ends with a prescription	Ends with a shared plan of care

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

improving chronic illness care

Define roles and tasks

Distribute them among the team members.

Care is a team sport

- Team development
- Review process for care
- Assign tasks, matching licensure and skills.
- Cross train staff
- Use protocols and standing orders

improving chronic illness care

Example of task distribution

Microalbuminuria testing

- Receptionist recognizes patient has diabetes, attaches req. to chart
- MA collects specimen
- RN reviews slip, recognizes out-of-range tests, orders confirmatory test, discusses possible need for ACE inhibitor
- MD discusses and prescribes ACE inhibitor
- RN calls pt. to check on med. adherence and side effects

Roles in Team Care

ROLE	PRIMARY CARE PROVIDER	PRIMARY CARE NURSING STAFF	MEDICAL SPECIALIST	CLINICAL CARE MANAGER	RESOURCE COORDI-NATOR	CLERICAL STAFF	

improving chronic illness care

Use planned interactions to support evidence-based care

One-on-one, group, telephone, email, outreach….the possibilities are endless

improving chronic illness care

What is a Planned Visit?

- A Planned Visit is an encounter with the patient initiated by the practice to focus on aspects of care that typically are not delivered during an acute care visit.
- The provider's objective is to deliver evidence-based clinical management and patient self-management support at regularly scheduled intervals without the "noise" inherent in the acute care visit.

improving
chronic
illness care

What does a Planned Visit look like?

- The provider team proactively calls in patients for a longer visit (20-40 minutes) to systematically review care priorities.
- Visits occur at regular intervals as determined by provider and patient.
- Team members have clear roles and tasks.
- Delivery of clinical management and patient self-management support are the key aspects of care.
- Protocols need to be prepared before initiating planned visits that include medication management

improving chronic illness care

Example: Patients with type 2 diabetes. Step One

- Choose a patient sub-population, e.g., all patients A1c >9.5 from registry
- Identify patients who have not been seen recently as priorities
- Review chart for needed medical management

improving chronic illness care

Step Two: Patient Outreach

- Have front office call patient and explain the need for planned visit
- Allow patient to choose day and time for visit
- Ask patient to come to lab for A1c one week prior to visit
- Ask patient to bring in all medications and any blood sugar data

Step Three: Preparing for the Visit

- MA prints patient summary from registries and attaches to front of chart

- Care manager (usually nurse or pharmacist) who runs the planned visit reviews medications and labs prior to visit, and consults with physician as needed

improving chronic illness care

Step Four: The Visit

- Review and tweak patient's medication regimen
- Examine feet
- Referrals for eye care/other specialties as needed
- Self-management education
- Self-management goal setting with an patient action plan
- Schedule follow-up
- Different team members can do different portions of these tasks

improving chronic illness care

Step Five: Follow-up

- Does not need to be in-person visit (use phone, email)
- Check success in achieving action plan
- Problem solve as needed
- Schedule additional follow-up as needed

improving chronic illness care

Delivery system redesign: Planned visits

- Planned group visits for diabetics significantly reduced HbA1c levels and hospital use for diabetics in Kaiser system (RCT) [Sadur et al. Diabetes Care 1999;22:2011]
- Individual planned diabetes mini-clinic visits can improve outcomes if the patients actually come to the visits [Wagner EH et al. Diabetes Care 2001;25:695.]

.

improving chronic illness care

Delivery system redesign *and* clinical information systems:

planned visits + reminders

A Cochrane Review looked at trials comparing a control group with patients who had planned follow-up visits *and* whose physicians had reminder prompts. 5 trials were found: the intervention group had significantly lower HbA1c in all 5 trials.

[Griffin, Kinmouth. Cochrane Review, 2001]

improving chronic illness care

Delivery system redesign: Planned visits

- A Danish study of 970 patients with diabetes cared for by 474 physicians, comparing usual care with planned visits and other improvements, found that HbA1c, blood pressure, and lipids were significantly lower in the intervention group.

Olivarius et al. BMJ 2001;323:970.

improving chronic illness care

Delivery system redesign: Planned visits

- **Peters and Davidson demonstrated that patients attending a nurse-led diabetes planned visit clinic had improved HbA1c levels that were also lower than usual care patients. Aubert came to similar conclusions.**

Peters and Davidson, Diabetes Care 1998;21:1037

Aubert et al. Annals Intern Med 1998;129:605.

improving chronic illness care

Delivery system redesign: Planned visits

- **According to a Cochrane review, seven studies in which nurses conducted planned diabetes care visits all demonstrated a positive impact on glycemic control. The review concluded that nurses "can even replace physicians in delivering many aspects of diabetes care, if detailed management protocols are available, or if they receive training."**

Renders et al. Interventions to improve the management of diabetes mellitus in primary care, outpatient and community settings. Cochrane Review. In Cochrane Library Issue 3, 2001.

improving chronic illness care

Group Visits: Introduction

- Patients brought in by clinically relevant groups
- Patients can receive:
  - Specialty service as needed/available
  - One-on-one with medical provider
  - Medication counseling
  - Self-management support training
  - Social support
- Multiple Models for Group Visits

improving chronic illness care

Provide clinical case management services for complex patients.

Knowing who needs more support and finding a way to deliver it.

improving chronic illness care

What is case management?

Many different things to different people

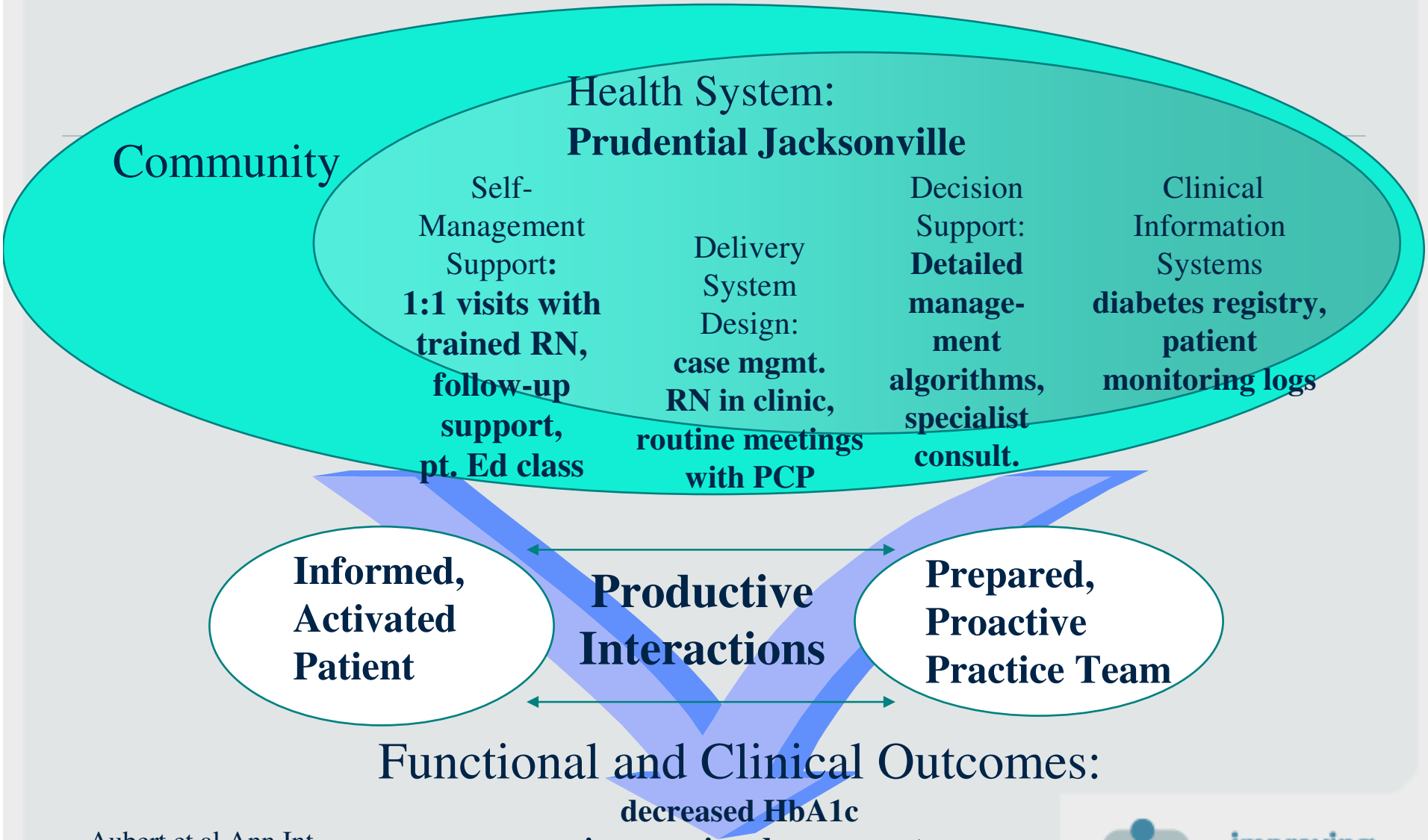
- Resource coordination
- Utilization management
- Follow-up
- Patient education
- Clinical management

Case mgmt: Positive clinical trials

- clinically skilled case manager using protocols
- close linkages to primary care and specialty expertise
- close follow-up and strong self-management support

improving chronic illness care

Diabetes Nurse Case Management



Aubert et al Ann Int Med 1998;129:605

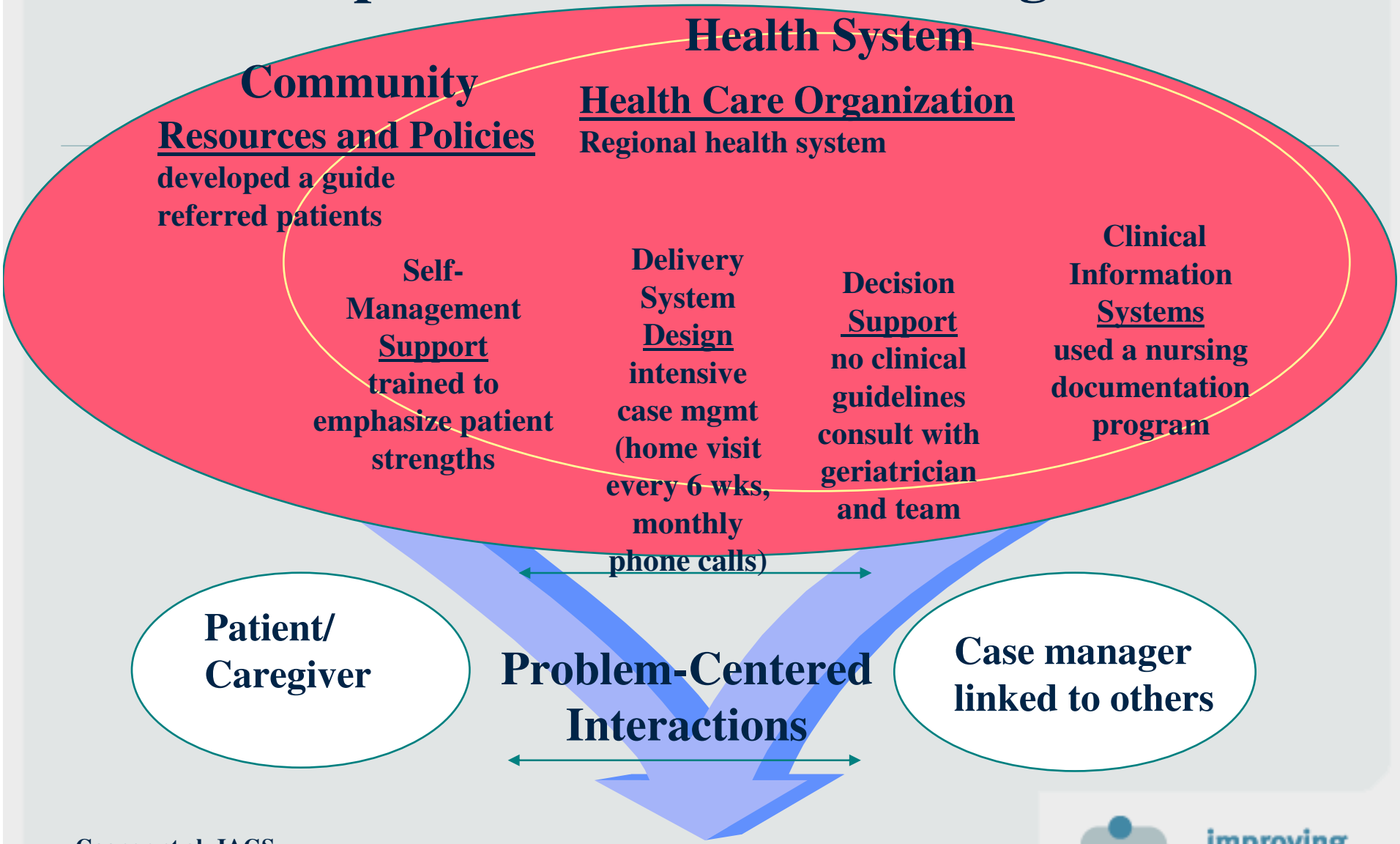
improving chronic illness care

Case mgmt: Negative clinical trials

- nurse or social worker without specific clinical experience or training
- no clear goals or protocols
- limited connection to primary care

improving chronic illness care

Non-specific Nurse Case Management



Gagnon et al, JAGS 1999; 47:1118-1124

Increased hospitalization
No change in functional status

improving chronic illness care

Key changes for case management

- Develop patient selection criteria
- Determine availability of services
- If available, work together
- If not, review team roles and tasks and fill in gaps.
- Assure that patients receive CM services.

improving chronic illness care

Features of effective case management

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

improving chronic illness care

What do you do if you can't hire a clinical case manager?

- Evidence suggests that non-professionals can be trained to perform follow-up and assessment.
- That alone when linked to a physician or nurse case manager has improved outcomes in depression and arthritis
- Automatic Voice Response telephone systems can perform this function.

improving chronic illness care

Ensure regular follow-up by the primary care team

The alternative to lost to follow-up…

improving chronic illness care

Making follow-up work for you

- Develop process for follow-up
- Tailor follow-up to patient and provider needs
- Eliminate unnecessary follow-ups
- Schedule follow-up.
- Monitor for missed follow-up.
- Reach out to those not attending follow-ups.

Follow-up could be…

- Face-to-face
- Clinical case manager
- Outreach worker
- In groups
- Phone
- E-mail

How to start

- To initiate chronic care improvement, changing primary care is the hardest, because the daily stresses are so great
- Starting with planned visits, within primary care but separate from the physician, is a good way to start

improving chronic illness care

How to start

- A planned care clinic can often be established with no budget or a very small budget. It requires senior leader support to arrange space and assign the necessary personnel to the planned care clinic 1 day or 1/2 day per week.
- Appointment clerk, medical assistant, health educator, pharmacist, nurse, physician. Also, use students

improving chronic illness care

Bottom line:

Planned visits, whether group or individual, are key to improved chronic care

improving chronic illness care

Contact us:

- **www.improvingchroniccare.org**

improving chronic illness care