Delivery System Design

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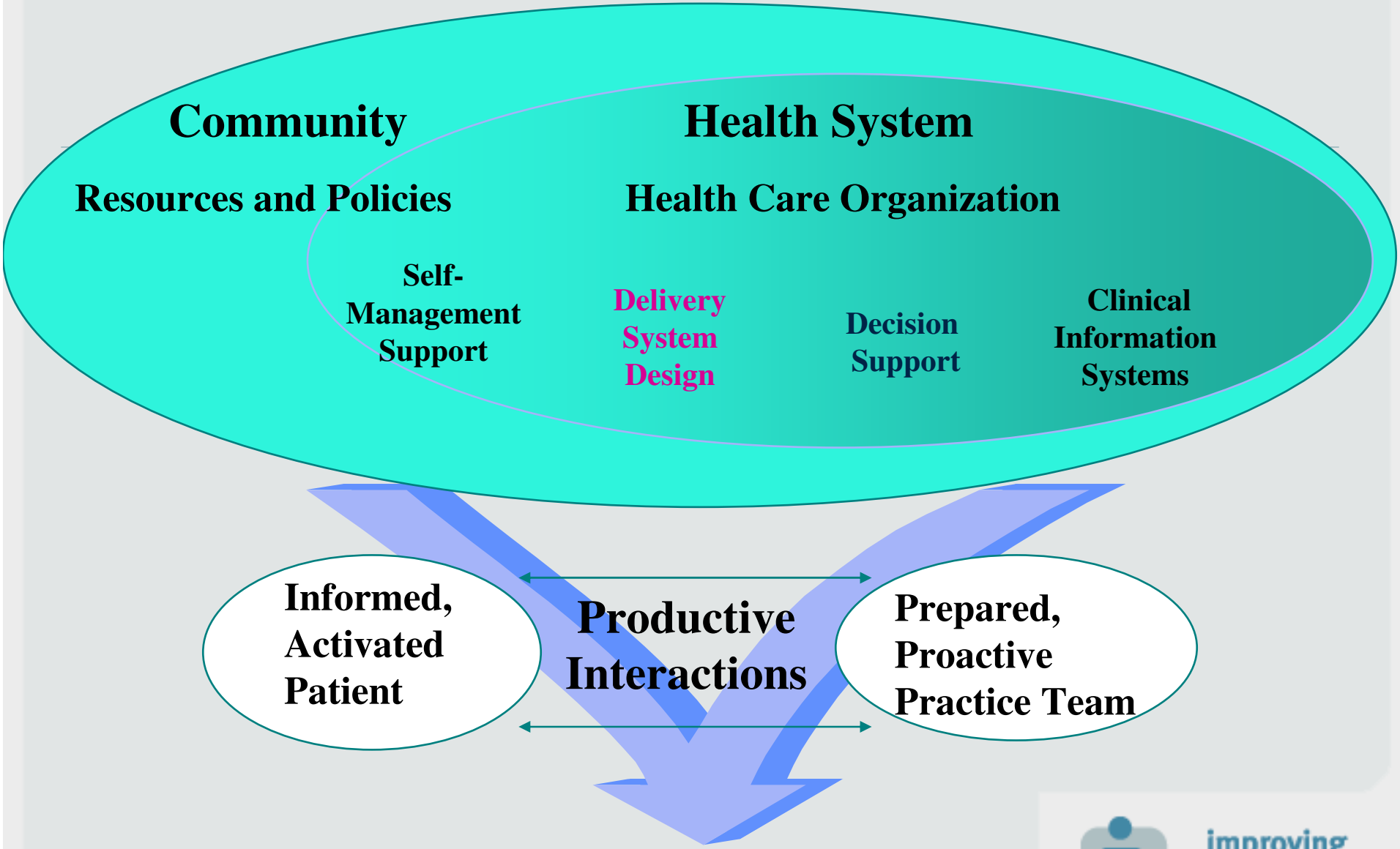
Chronic Care Model



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Delivery System Design

- Define roles and distribute tasks among team members.
- Use planned interactions routinely to support evidence-based care.
- Intensify treatment if goals not reached—stepped care and care management
- Ensure regular follow-up.
- Give care that patients understand and that fits their culture.

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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

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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 rushed and stressed by demands for productivity despite older, sicker clientele.

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

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

- The physician part of the visit is shorter when non-physician staff are used to their capacity.

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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

Define roles and tasks

Distribute them among the team members.

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	

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Use planned interactions to support evidence-based care

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

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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

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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.

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Group Visits: Introduction

- **Effective**
- **Not for everyone**
- **Logistically complex**
- **Must replace routine care for impact**

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Intensify treatment if goals not reached —stepped care and care management

1. Start by revisiting the treatment plan and adherence
2. Is there a self-management action plan?
3. If adherent and working on self-management, step up pharmacologic therapy
4. If patient needs more support, consider case management

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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

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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

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Ensure regular follow-up by the primary care team

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Making follow-up work for you

- Develop process for follow-up
- Tailor follow-up to patient preferences and clinical needs
- Eliminate unnecessary visits—consider other ways of communicating
- Schedule follow-up.
- Monitor for missed follow-up.
- Reach out to the no-shows.

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Give care that patients understand and that fits their culture.

You are the experts!

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Contact us:

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