Reducing Morbidity and Mortality for the Chronically Ill

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Improving Chronic Illness Care
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Chronic Illness and Medical Care

- Primary care dominated by chronic illness care
- Clinical and behavioral management increasingly effective and increasingly complex
- Inadequate reimbursement and greater demand forcing primary care to increase throughput—the hamster wheel
- Only 50% of patients getting evidence-based care
- Unhappy primary care clinicians leaving practice; trainees choosing other specialties
- Talk of the “collapse” or “demise” of primary care
- BUT, safety net organizations showing private medical care that we can improve care
- AND, that low income folks can mange their health effectively with appropriate information and support

Is Primary Care really Moribund?

It may well be:

- **Without major changes to practice organization**
- **Reimbursement will help but will not be sufficient.**

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What Patients with Chronic Illnesses Need

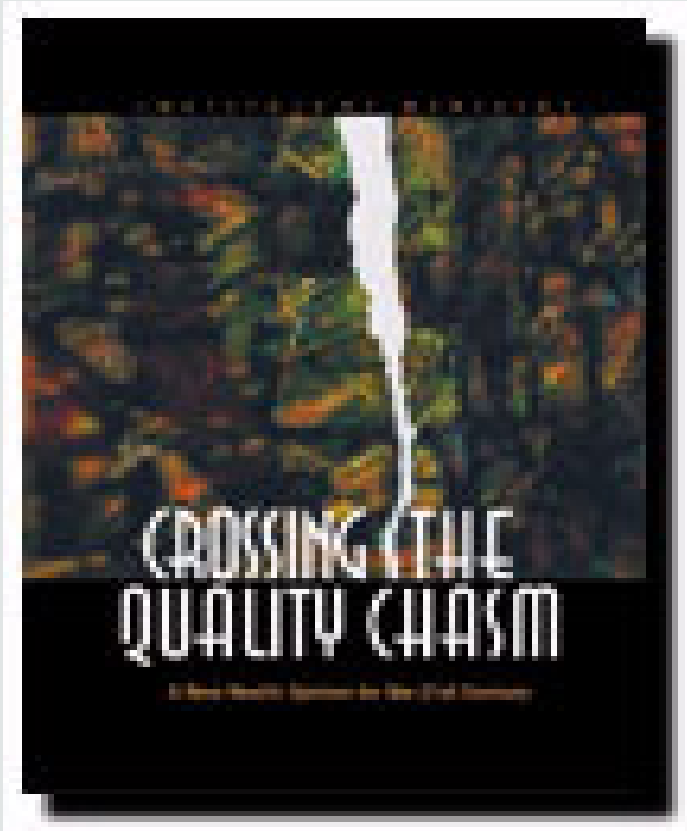
- A “continuous (and coordinating) healing relationship”
- With a care team and practice system organized to meet their needs for:

- Effective Treatment (clinical, behavioral, supportive),
- Information and support for their self-management,
- Systematic follow-up and assessment tailored to clinical severity, and
- Coordination of care across settings and professionals

Why are we doing so poorly?

The IOM Quality Chasm report says:

- "The current care systems **cannot** do the job."
- "Trying harder will not work."
- "Changing care systems will."



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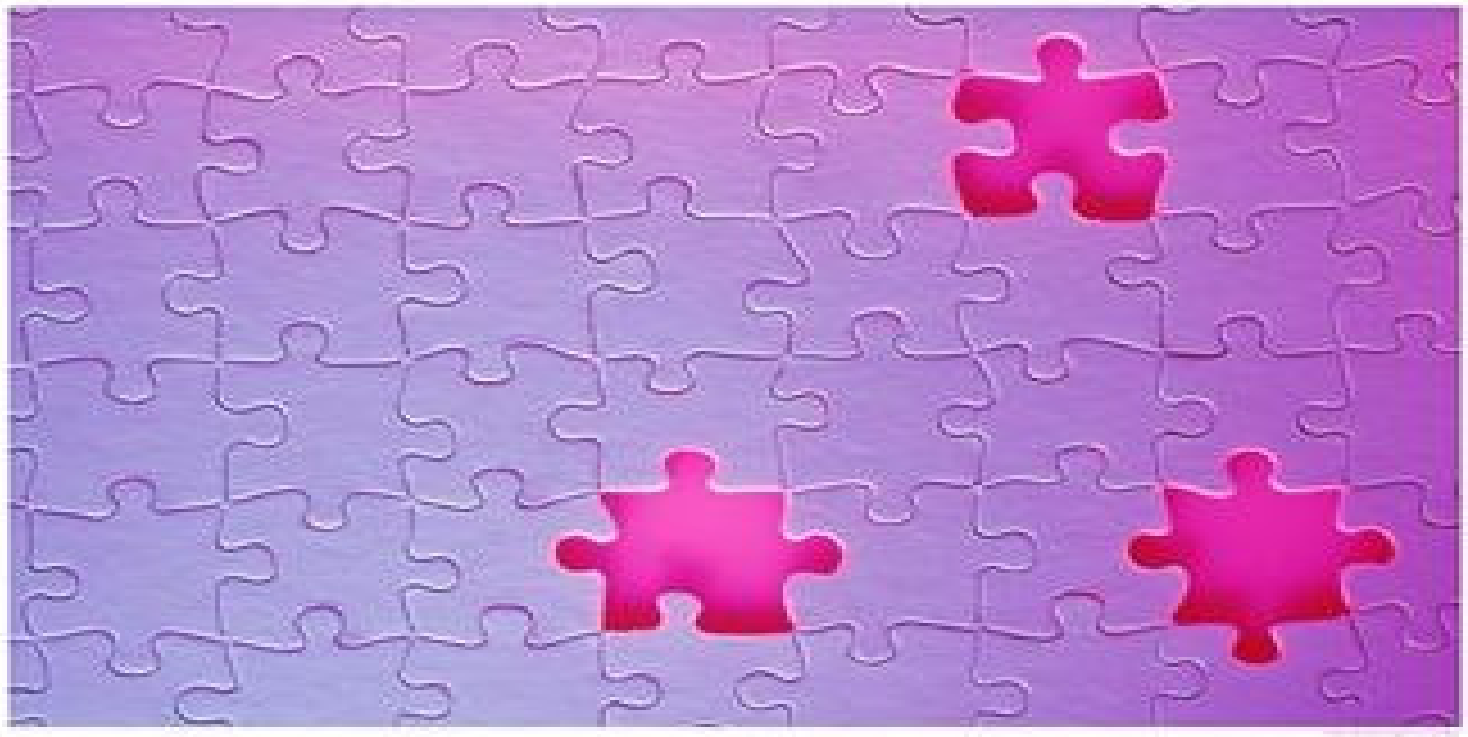
What kind of changes to practice systems improve care?



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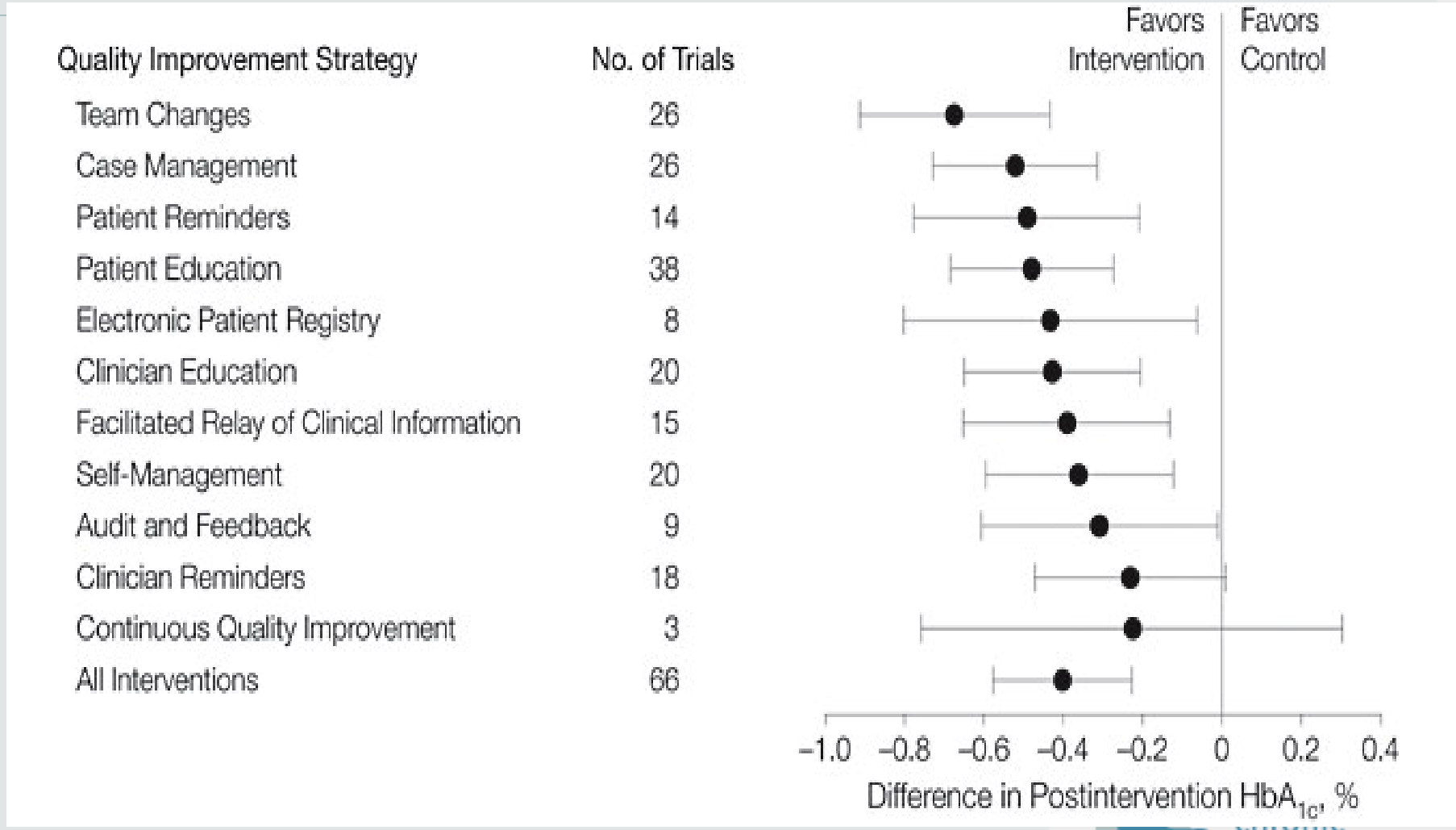
Postintervention Differences in Serum HbA1c Values



Shojania, K. G. et al. JAMA 2006;296:427-440.

Toward a chronic care oriented system

Reviews of interventions in other conditions show that practice changes are similar across conditions

Integrated changes with components directed at:

- better use of non-physician team members,
- planned encounters, and
- modern self-management support
- care management
- enhancements to information systems
- Education and reminders to influence physician behavior

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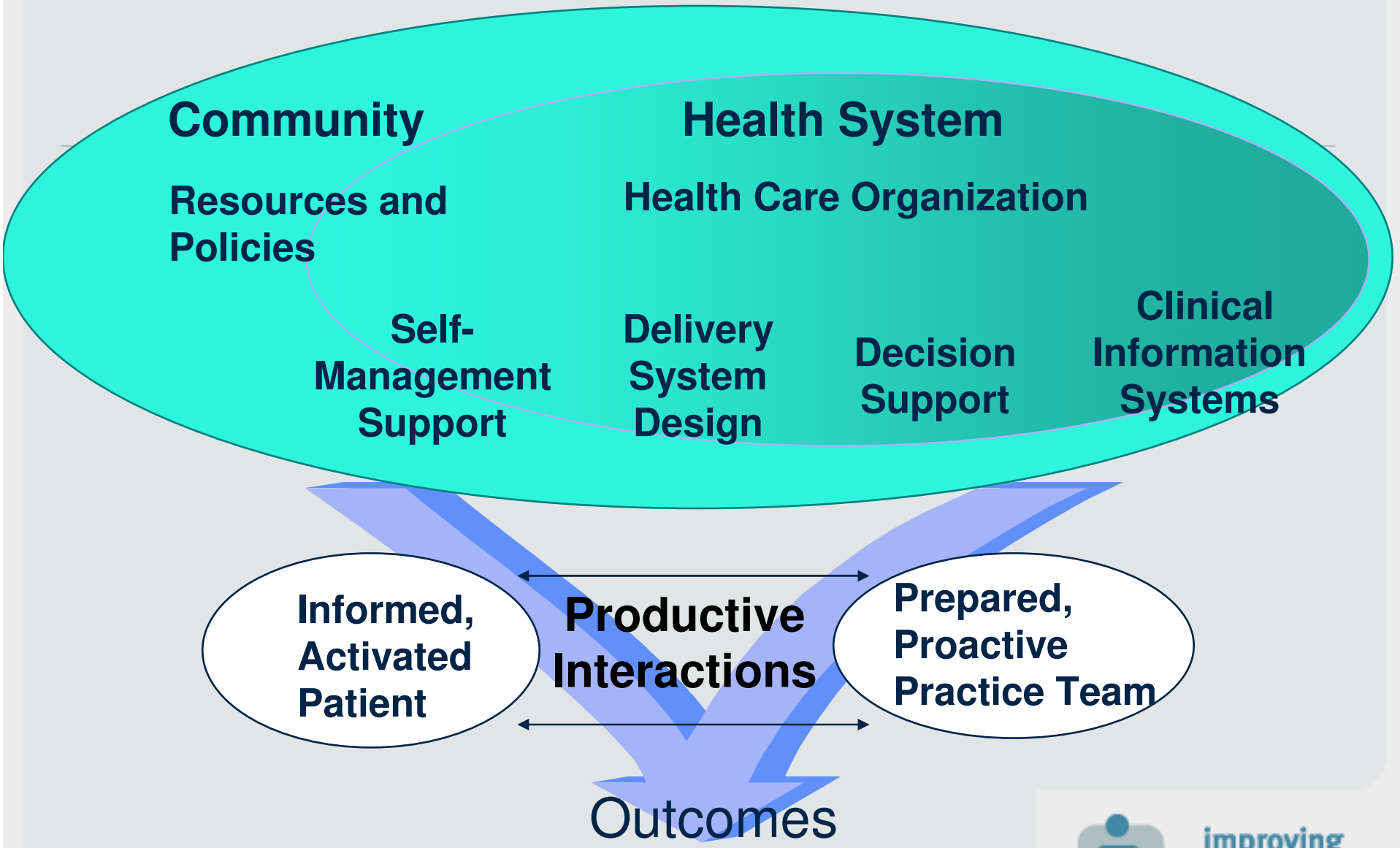
Chronic Care Model



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New Models of Primary Care

- AAFP – combines CCM, medical home, and pay for coordination and performance
- ACP – “advanced medical home” has same three ingredients

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Does the CCM Work?

The Evidence Base

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Organizing the Evidence

1. Randomized controlled trials (RCTs) of interventions to improve chronic care
2. Studies of the relationship between organizational characteristics and quality improvement
3. Evaluations of the use of the CCM in Quality Improvement
4. RCTs of CCM-based interventions
5. Cost-effectiveness studies

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Essential Elements of Good Chronic Illness Care

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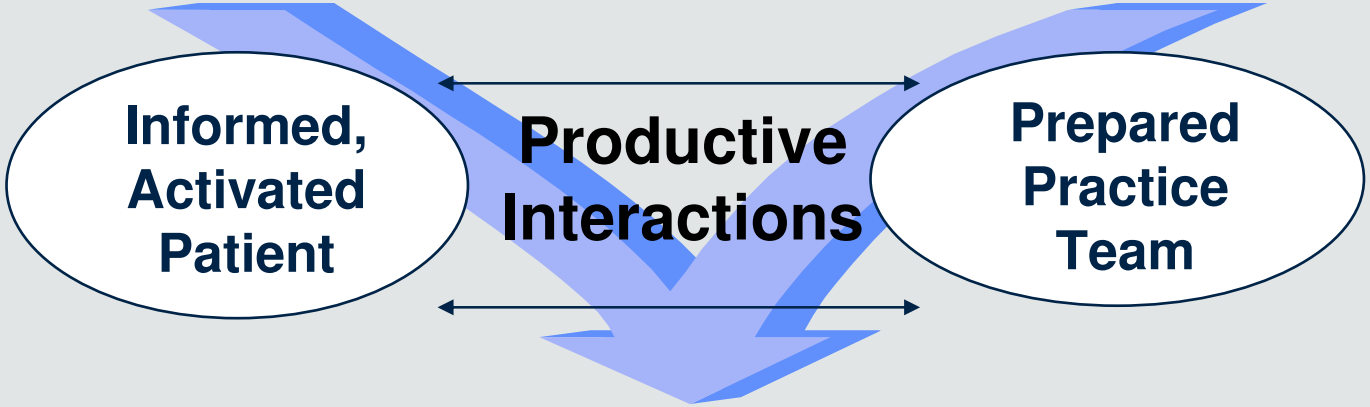
How would I recognize a productive interaction?



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

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What characterizes an “informed, activated patient”?

Informed, Activated Patient

They have the motivation, information, skills, and confidence necessary to effectively make decisions about their health and manage it

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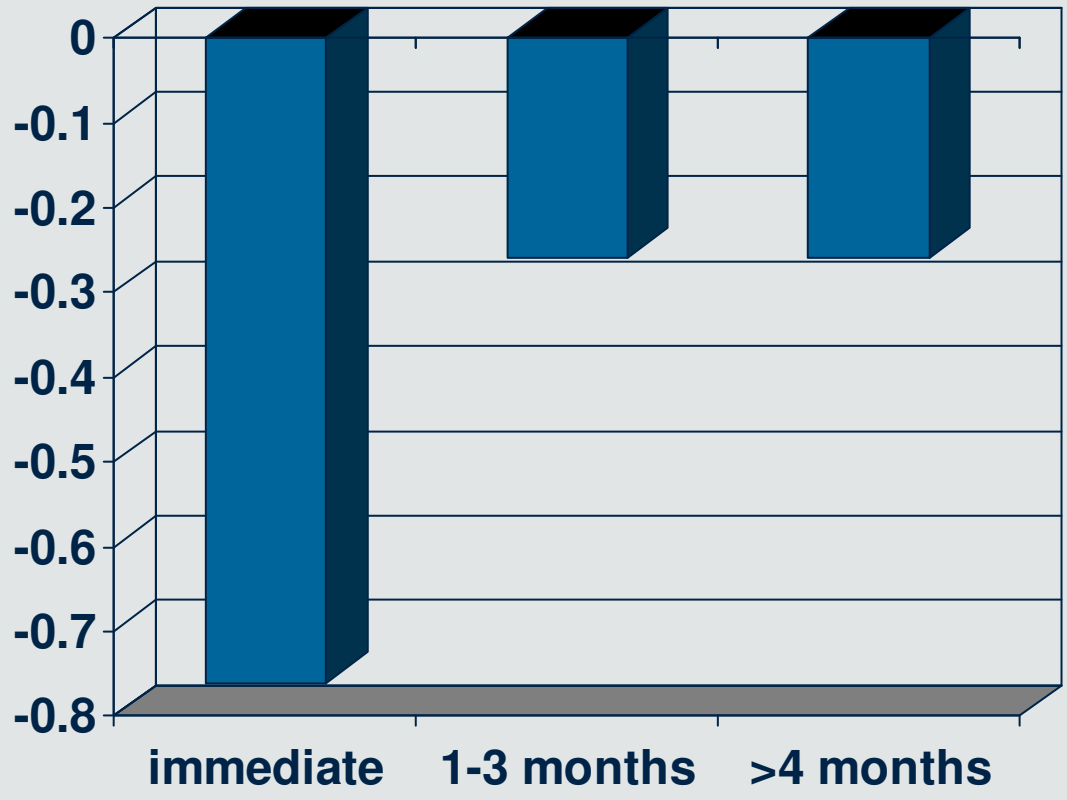
Self-Management Support

- 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 practice team and resources to provide support.

Effects of Self-management Education on HbA1c Levels across 31 RCTs



Norris et al, Diabetes Care 2002; 25:1159

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Organizing self-management Support – the 5 A's

- **Assess** knowledge, behaviors and confidence routinely
- **Advise** from scientific evidence and present information
- **Agree** on goals and treatment plan for improving self-management
- **Assist** patients in overcoming barriers
- **Arrange** helpful services

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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.

What characterizes a “prepared” practice team?

Prepared Practice Team

They have the patient information, decision support, and resources necessary to deliver high-quality care. Practice organized to make optimal care routine/the default.

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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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Decision Support

- Adopt and 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.

Clinical Information System: Registry

- A database of clinically useful and timely information on all patients provides reminders and feedback and facilitates care planning for individuals or populations, and proactive care
- Many commercially available EHRs do not have these capabilities
- Data MUST be entered once and only once—most efficient is to use registry summary as visit record AND data form

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Health Care Organization

- Senior leaders visibly support improvement at all levels.
- Align clinical improvement with business goals
- Promote effective improvement strategies aimed at comprehensive system change.
- Provide incentives based on quality of care.
- Develop agreements for community resources and care coordination.

Challenges in Implementing the CCM

- Teams spent considerable time searching for/developing tools
- Some teams felt intimidated by taking on the whole model – asked for a sequence
- Many changes were made in ways that were not sustainable logistically or financially (e.g., double data entry)
- CCM elements implemented as "special events" rather than part of routine care
- Many achieve process improvements but outcomes don't change

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In what order should we make changes?

1. **Assure leadership support and form improvement team**
2. **Create a registry and use it to measure performance and identify patients who need more**
3. **Make planned visits part of every patient's care—first for individual patients, then try group visits**
4. **Develop reliable strategy for delivering the 5A's, first in planned visits**
5. **Continuously review performance and processes to reduce waste and increase reliability.**

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Why do practices who have changed their system not see improvements in key outcome measures (e.g., measures of disease control)?

The systems aren't in place to get every patient to target!

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To improve the levels of disease control in one's practice

- **Changes to the system must influence the care of every patient so that they:**

  1. receive planned, continuous care
  2. understand and agree to their treatment plan
  3. receive protocol-driven treatment intensification directed at reaching clinical goals,
  4. have self-management goals and activities regularly reviewed, updated and reinforced.

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Contact us:

- **www.improvingchroniccare.org**

thanks

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