A Team Approach to Chronic Care

Jennifer Heidmann, MD
Eureka Internal Medicine
jheidmann@cox.net
707-443-9371

Our practice includes 7 primary care internists and 10 internal medicine subspecialists. One year ago, one of my partners and I became involved in the Breakthrough in Chronic Care Collaborative(BCCP), with the goal of improving care in patients with diabetes and coronary artery disease (CAD).

What we discovered is in order to make changes to improve care, including regular use of a diabetes and CAD registry, we had to make our office run more efficiently. This led to regular team meetings with our staff, including the receptionists, medical assistants, filer, and often our local IPA liaison (also involved in BCCP) and our practice administrator. We meet twice per month, from 12:15-1:00, with no interruptions.

The results over the last year include improvement in our data collection, and thus in the actual outcome measures, such as lipid control and hemoglobin A1C levels. Perhaps more importantly, we have made several steps to improve systems in our office, at every level. We have structured meetings with minutes, old business, "pet peeves", "opportunities for excellence", and long-term projects. Each staff member is encouraged to contribute. Changes in office procedure are planned and executed, usually in small steps, and reevaluated at each meeting. The staff and physicians are much more satisfied and hopefully this extends to patient satisfaction with improved efficiency, a happy staff, and better outcomes in their health.

Other members of our group at large, physicians and staff, have been inquiring about our successes, and there is interest in extension of the model to others in the practice. The goal is to spread what works for us in order to standardize care and improve efficiency of our group as a whole.