Whither the Chronic Care Model?

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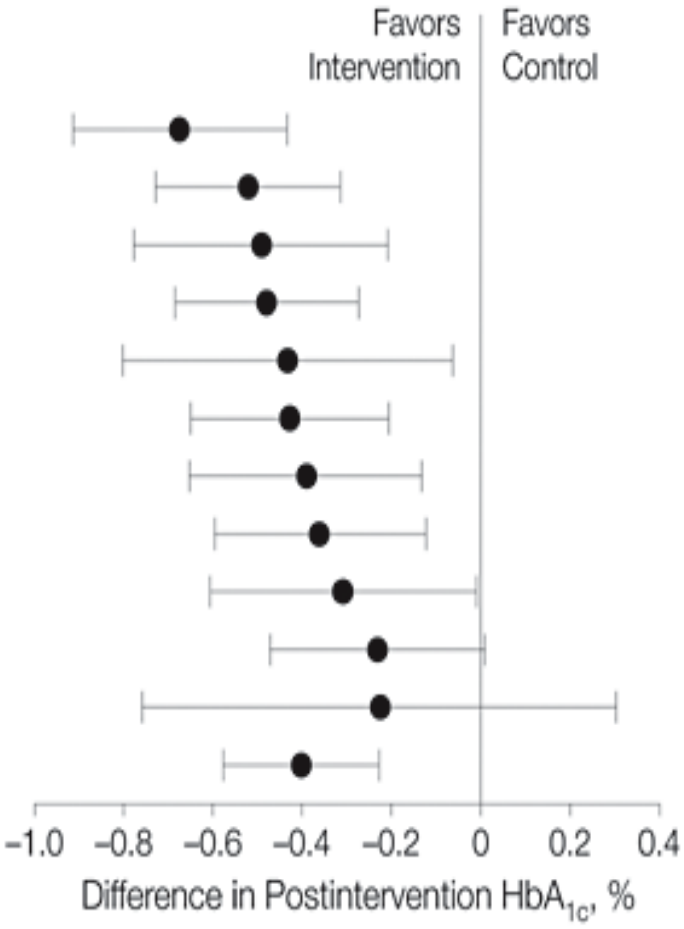
What do Patients Need to Optimize Outcomes?

- **Drug or other treatment that gets them safely to their therapeutic goals**
- **Effective self-management support**
- **Preventive interventions at recommended time (planned interactions)**
- **Evidence-based monitoring and self-monitoring**
- **Follow-up tailored to severity (proactive follow-up)**

Findings from a Meta-analysis of Studies of Interventions to Improve Diabetes Care

Quality Improvement Strategy	No. of Trials
Team Changes	26
Case Management	26
Patient Reminders	14
Patient Education	38
Electronic Patient Registry	8
Clinician Education	20
Facilitated Relay of Clinical Information	15
Self-Management	20
Audit and Feedback	9
Clinician Reminders	18
Continuous Quality Improvement	3
All Interventions	66



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

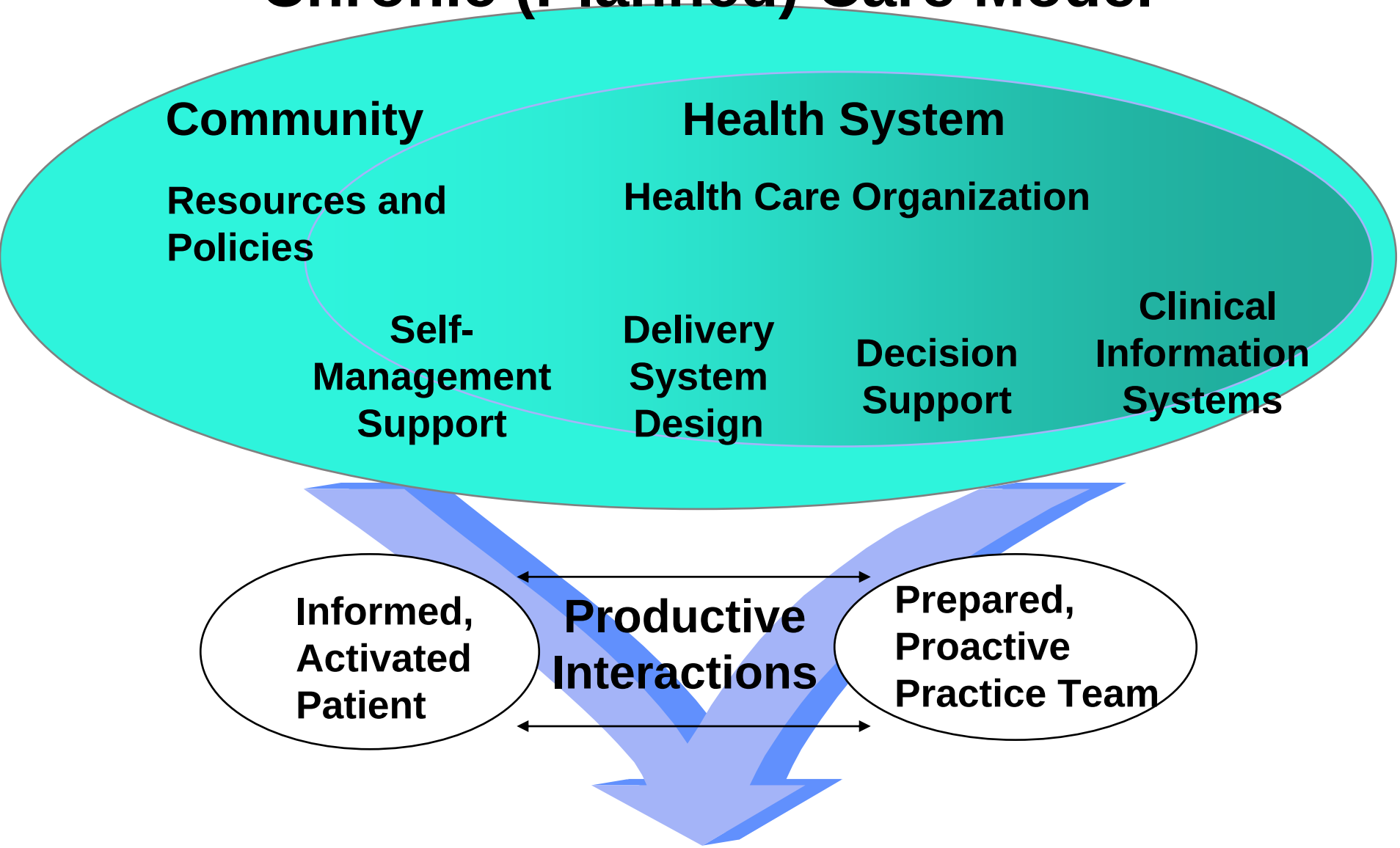
Toward a planned care oriented system

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

Integrated changes with components directed at:

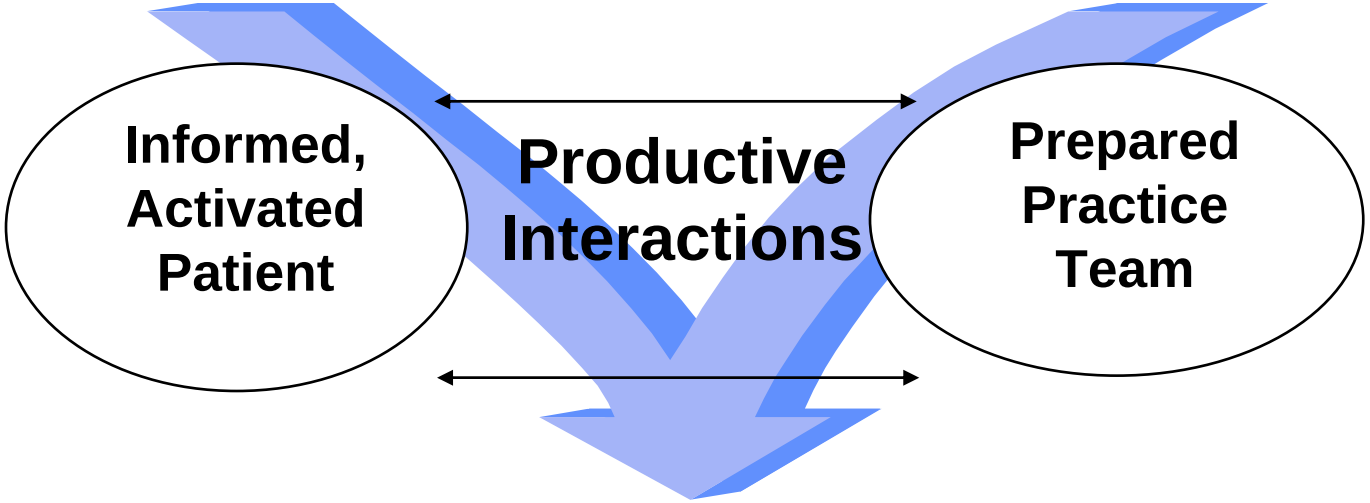
- **Greater use of non-physician team members,**
- **planned encounters and follow-up,**
- **modern self-management support,**
- **care management for high risk patients**
- **Population or panel management using registry functionality**

Chronic (Planned) Care Model



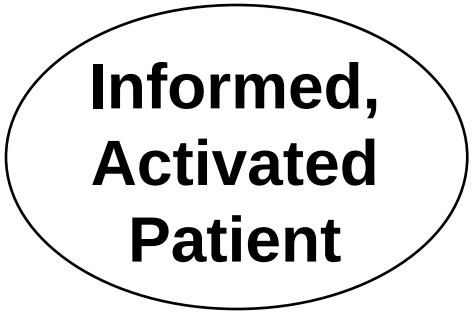
Improved Outcomes

What distinguishes good care from usual care?



An organized sequence of planned electronic or face-to-face interactions that ensure that patients' needs are met.

What characterizes an “informed, activated patient”?



They have goals and a plan to improve their health, and the motivation, information, skills, and confidence necessary to manage their illness well.

What have successful practices done to implement self-management support?

Goal

To help patients take a more active role and be more competent managers of their health and healthcare.

- **Forge linkages with self-management programs in community**
- **Organized and trained team members to provide basic self-management support**
- **Made self-management support a part of every interaction**

Community Resources and Policies

<u>Goal</u>

To help patients access effective and useful services and resources in the surrounding community.

Examples: self-management programs, safe physical activity, peer support, financial support

What characterizes a “prepared” practice team?

Practice team and interactions with patients organized to help patients reach clinical targets and self-management goals.

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Delivery System Design

Goal

To organize the practice team and other systems to assure that all patients receive planned evidence-based care and follow-up tailored to severity.

Decision Support

Goal

To integrate evidence-based guidelines into the flow of decision-making through reminder, order entry, or other systems.

Clinical Information System

Goal

To ensure that clinicians and other staff have ready access to patient information on individuals and populations to help plan, deliver and monitor care.

What have successful practices done to implement the CCM?

- **Built an effective clinical team.**
- **Defined roles and tasks and distributed them among the team members.**
- **Trained staff to perform tasks and monitored performance.**

What have successful practices done to implement the CCM?

- **Plan and organize their visits and other encounters**

  a) Prior to visit, huddle to review registry to identify needed services

  b) Organize team to provide those services – e.g., MA trained to do foot exams, receptionist arranges retinal exams.

What is a Planned Visit?

- **A Planned Visit is an encounter that uses patient data, team and practice organization, and decision support to assure a productive interaction.**
- **Can be patient-initiated or practice-initiated**
- **Pre-visit planning (huddle) ensures that patient needs are met; post-visit huddle organizes follow-up.**

Health Care Organization

Goal

To ensure that practices within the organization have the leadership, motivation, information and resources needed to continuously improve their care systems.

What have successful practices done to implement the CCM?

- **Practice leaders help others envision a different future, and engage them in the process of change.**
- **Performance measured routinely**
- **Use a defined strategy for continuous improvement**
- **QI team communicates regularly with senior leaders to discuss successes and barriers.**

Evidence on the Effectiveness of the CCM

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.

Coleman et al. Health Affairs . 2009 Jan-Feb;28(1):75-85.

Newer Emphases in Chronic Care

- Clinical inertia and treating to target.
- Planned follow-up and Care Management.
- Care coordination, shared care

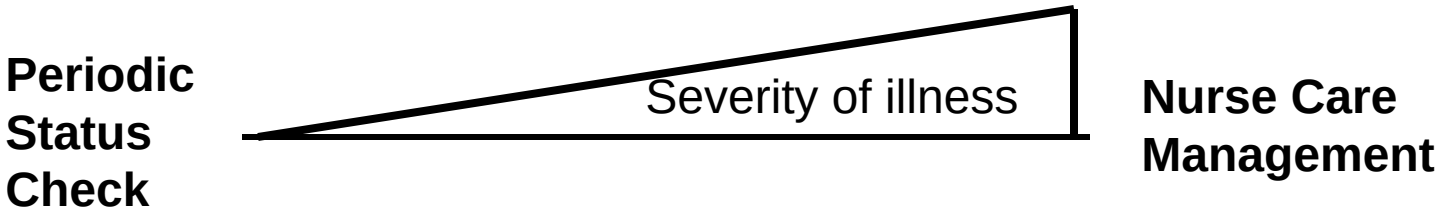
Clinical Inertia

- **Patient has not reached treatment goal**
- **Patient is adhering to treatment**
- **Therapy has not been intensified**
- **Recent studies show that less than one-half of diabetic patients with HbA1c's >8% have evidence of drug intensification**
- **Interventions—protocol-driven care through decision support or care management**

First described by Phillips et al., Ann Int Med 2001

Planned follow-up and Care Management

- Higher risk patients (poor disease control, frailty, etc.) benefit from organized follow-up (monitoring).
- Follow-up can range in intensity from periodic status checks to active care management.



The power of monitoring, follow-up and protocol adherence

- **Study of hypertension control among native Canadians with diabetes**

- **All patients monitored by home nurse:**
  Controls – nurse reports to PCP
  Intervention –nurse adjusts meds by protocol

- **Control BP - 151/84 → 134/77**
- **Intervention BP – 150/87 → 126/76**

Tobe et al., CMAJ. 2006 Apr 25;174(9):1267-71

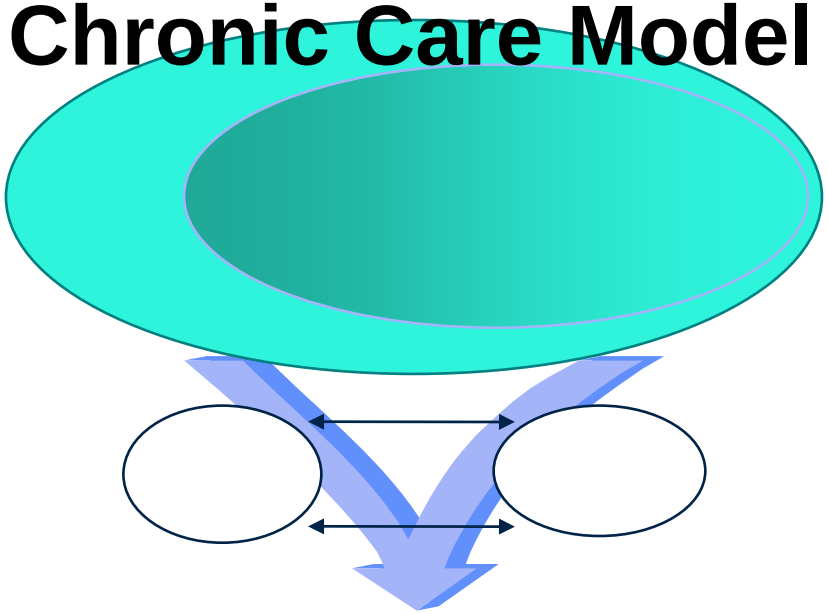
Care Management

- **Definition: The provision of more intensive monitoring, clinical and/or psychosocial management, and self-management support to high risk patients.**
- **Usually provided by a nurse or other health professional.**
- **Effective for attaining disease control but less so for reducing costs in complex, high risk patients.**
- **Care management appears to be far more effective when the care manager:**
  < is an integral member of the PCP practice team
  < can influence medications—foster treat to target
  < is supported by relevant medical specialist(s).
  < has some face-to-face patient contact

The major primary care professional organizations proposed the Patient-centered Medical Home

- **An Amalgamation of the Pediatric Medical Home and Chronic Care Models**

Chronic Care Model



Improved Outcomes

Medical home – Chronic Care Model
Duplicative, Complementary or Antagonistic?

- **Both emphasize and support patient role in decision-making and care**
- **PMH underscores primary care's responsibility for access, continuity, comprehensiveness, and coordination**
- **CCM redesigns care delivery for planned, whole person care**
- **Both models advocate that every health care experience (visit, referral, admission,etc) connects the patient back to their PCP.**

What are the key features of a Patient-Centered Medical Home?

- **Engaged leadership**
- **Quality improvement strategy**
- **Empanelment (linking each patient with a provider)**
- **Continuous, team-based healing relationships**
- **Patient-centered interactions**
- **Organized, evidence-based care**
- **Care coordination**

Where is the CCM in the PCMH?

- **Engaged leadership**
- **Quality improvement strategy**
- **Empanelment (linking each patient with a provider)**
- **Continuous, team-based healing relationships**
- **Patient-centered interactions**
- **Organized, evidence-based care**
- **Care coordination**
- **Health Care Organization**
- **Health Care Organization Information Systems**
- **Information systems/Pro-active Care**
- **Practice redesign (team care)**
- **Self-management support/ Activate patients**
- **Practice redesign (planned care, care mgt,), Decision support, Info. Systems**
- **Community resources, care management**

Transformed practices are motivated

Extrinsic Motivators	Intrinsic Motivators
Public reporting	Pride in performance
Management edict	Want to be leaders
Financial incentives	Joy in work

Successful practice transformation

- **Recognizes its difficulty and prepares practices for it.**
- **Includes a focus on the experience of those providing care.**
- **Assures that routine care delivery is different.**
- **Involves staff and patients in continuous process change.**

Visit us:

- http://qhmedicalhome.org/safety-net/index.cfm
- http://www.improvingchroniccare.org/