

Integrating the Care Model into an Effective Health Care Plan

Prevalence of Chronic Conditions

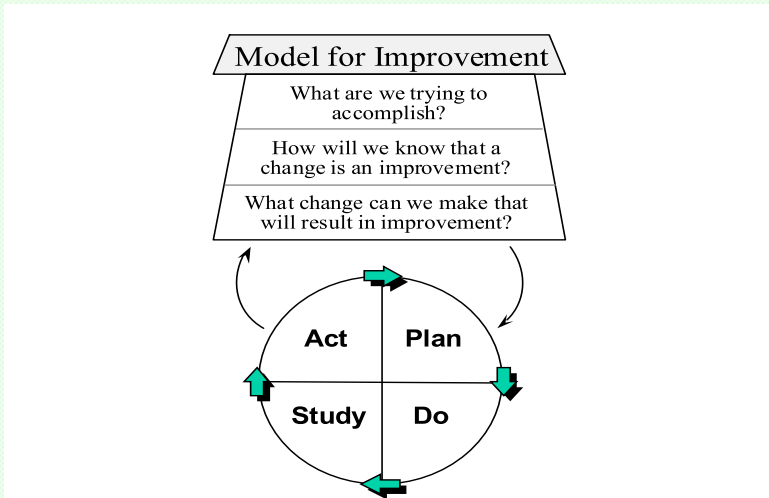
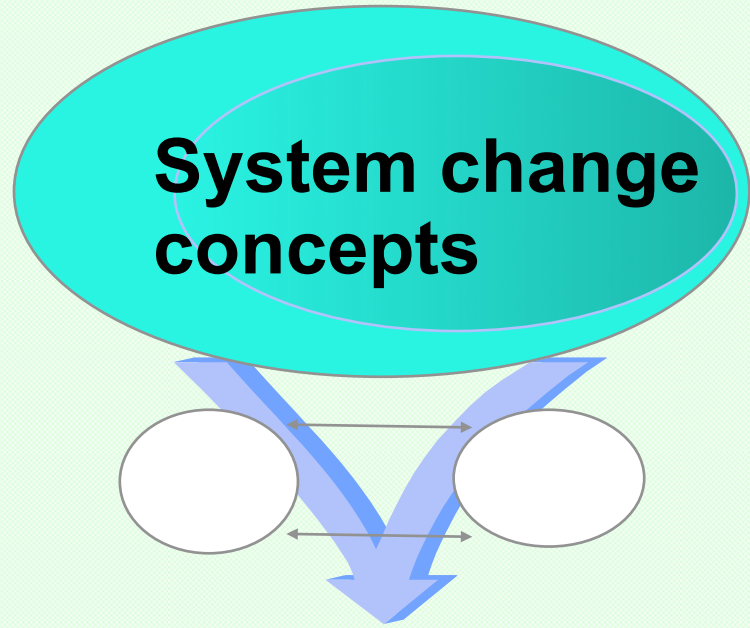
- 10.3% have heart disease
- 23% have high blood pressure
- 6.2% have diabetes
- 5% have depression
- 3% have or had a diagnosis of cancer

Gaps in Care

- 25% of patients with diabetes have heart disease risk addressed
- 27% of patients with hypertension are adequately treated
- 45% have had colon cancer screening
- 25% of people with depression are receiving adequate treatment

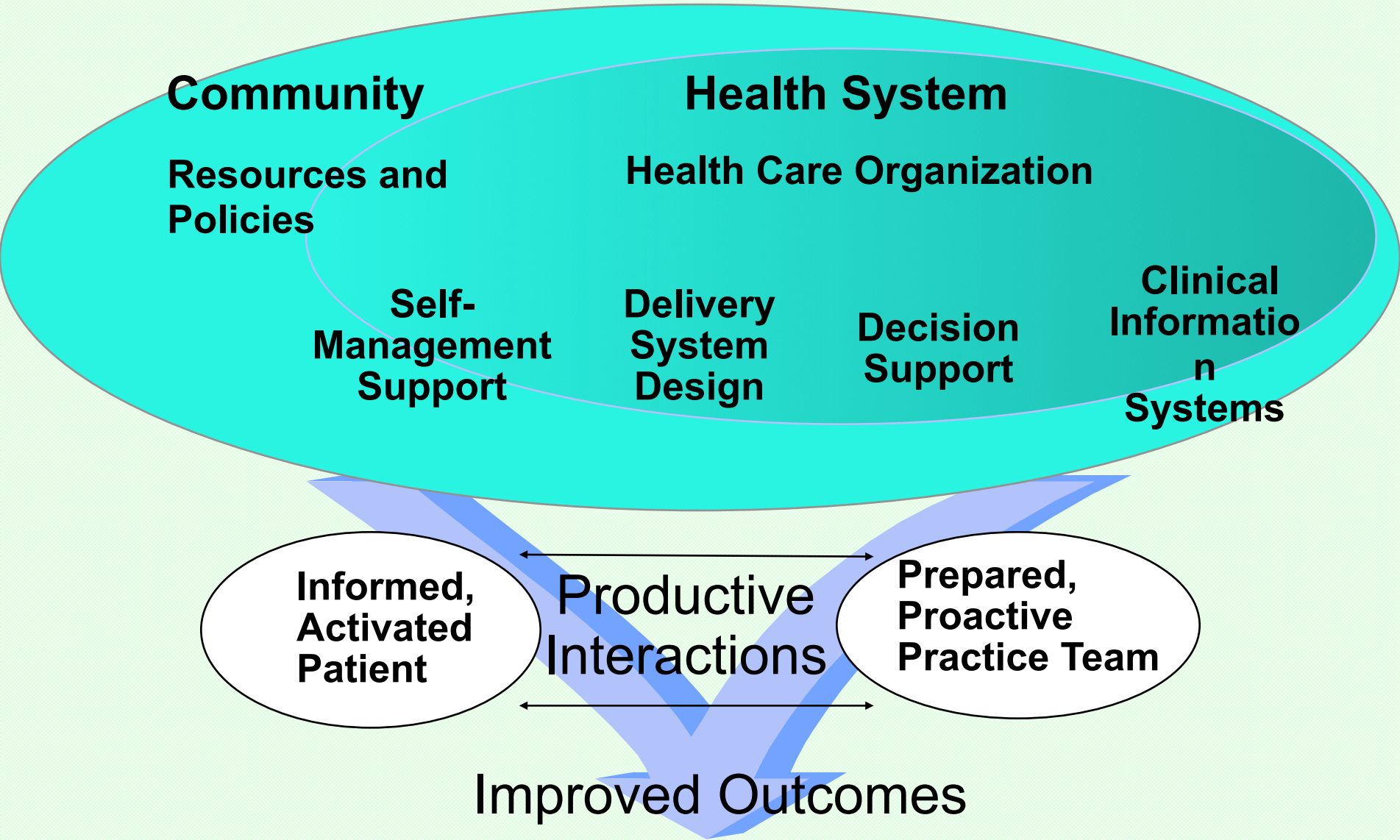
If you look at quality indicators for each of these conditions, the uninsured fare the worst

A Strategy for Improving Outcomes



System change strategy

Care Model



Self-Management Support

We're only with patients for a very brief time...

- Emphasize and empower patient's active role in managing their health and health care
- Use effective self-management support strategies
 - Assessment, goal-setting, action planning, problem solving and follow-up
- Organize internal and community resources to provide support

Delivery System Design

Efficient and effective clinical care

- Define roles and tasks among team members
- Use planned interactions to support evidence-based care
- Provide case management services
- Ensure regular follow-up
- Give care patients understand and that fits their culture

Decision Support

Consistent with guidelines & patient preference

- 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

Clinical Information System

Organize patient data for efficient & effective care

- 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

Health Care Organization

Everyone has a role in quality...

- Support for improvement at all levels, starting at the top
- Promote effective improvement strategies aimed at comprehensive system change
- Open and systematic handling of errors and quality problems
- Provide incentives based on quality of care
- Develop community agreements for care coordination

Community Resources & Policies

Mobilize your community

- Encourage patients to participate in effective programs
- Form partnerships with community organizations to support or develop programs
- Advocate for policies to improve care
- Reach out to payors to coordinate guidelines

Community

Resources & Policies

- Networking with DCP, churches, senior housing
- Health Fairs in community
- Free access to hospital weight loss program

Health System

Organization of Health Care

- Monthly report to the BOT/QA/PI
- Board approves smoking cessation program
- JACHO reaccreditation

Self-Management Support

- Patient Bulletin board
- 'Diabetes Express Day'
- PECS graphs
- Patient Education packets
- Smoking cessation program

Delivery System Design

- 'Diabetes Express Day'
- Staff & provider education
- Dental referral system
- DCA machine for all sites

Decision Support

- Dental in-service for providers
- LEAP & SMG forms
- Meetings with CEO & team
- Peer Review includes Clinical guidelines
- Patient letter
- Expand 340B formulary

Clinical Information Systems

- PECS conversion
- Registry: 2,056pts
- Eye & nutrition tracking
- Tool for improvement & outreach
- Facilitates partnerships

Problem/Need: Diabetes causes significant morbidity & mortality for patients. 7% of CHC users have diabetes.

Goal, Objective	Key Action Steps	Expected Outcome	Data, Eval. & Measurement	Responsibility	Comments
<p>A. CHC will improve health outcomes for diabetics A1. 90% of all users with DM will have 2 HbA1c measurements 91+ days apart</p> <p>A2. Identify new diabetic and at-risk patients in community</p>	<p>A1a. Perform on-site HbA1c if last was >91 days ago</p> <p>A1b. Purchase two additional DCA for East & North sites</p> <p>A2a. Conduct 4 health fairs: Greenwood Senior Center, Faith Baptist Church, Iglesia Santo Cristobol, Mayflower Mall</p> <p>A2b. Advertise fairs in churches, weekly community papers: Al Dia and Sassy Seniors Weekly</p>	<p>A1a. Increase by 10% the # of diabetics with 2 HbA1c's 91+ days apart by Dec '05. On-going</p> <p>A1b. By Jul 30, 2005</p> <p>A2a. Four fairs conducted by Dec 31, 2005</p> <p>A2b. Ads run February, July, Sept, and Oct 2005</p>	<p>A1a. PECS reports. On-going activity</p> <p>A1b. Purchase Invoice</p> <p>A2a. Four fairs conducted</p> <p>A2b. Ad invoices</p>	<p>A1a. DM Project Director</p> <p>A1b. Managers for East & North sites</p> <p>A2a. Director of Community Health</p> <p>A2b. Director of Community Health</p>	<p>A1a. 62% DM pts had 2 HbA1c's 91+ days apart Dec '04, a 15% increase from Dec '03</p> <p>A2a. Mayflower Mall Fair held 3/05; 3 new diabetics referred into care</p> <p>A2b. Al Dia Ads run Sept '05, Sassy Seniors Weekly ads run Nov '05</p>

Problem/Need: Cardiovascular disease is a leading cause of death in the US. 13% of CHC users have hypertension.

Goal, Objective	Key Action Steps	Expected Outcome	Data, Eval. & Measurement	Responsibility	Comments
<p>B. CHC will improve health outcomes for pts with CVD</p> <p>B1. 90% of users with HTN will have at least 2 BP measurements annually</p> <p>B2. 70% of patients with CAD and high cholesterol will achieve LDL <100</p> <p>B3. Spread Care Model to include cardiovascular disease</p>	<p>B1. Using PECS, track patients with HTN using recall, reminder, and outreach</p> <p>B2. Eligible patients will be placed on lipid lowering agents</p> <p>B3a. Establish CVD team, aims and measures</p> <p>B3b. Provider/staff education: Care Model, measures</p> <p>B3c. Populate patient data into PECS</p>	<p>B1. By Dec '05, 90% of users with HTN will have 2 BPs in last 12 months</p> <p>B2. By Dec '05, 70% of users with HTN will have 2 BPs in last 12 months</p> <p>B3a. Team and measures established by Sept '05</p> <p>B3b and B3c. On-going beginning Sept '05</p>	<p>B1. and B2. PECS reports. On-going activity</p> <p>B3a. and B3b. QA and provider meeting minutes, PECS reports</p> <p>B3c. PECS reports</p>	<p>Clinical Director</p> <p>Clinical Director</p> <p>Clinical Director, DM Project Director</p> <p>B3c. Data entry worker</p>	<p>B1. 78% of users with HTN had 2 BPs in 12 months Dec '04</p> <p>B2 . 64% of pts with CAD and high cholesterol Had LDL<100 Dec '04</p> <p>B3a. DM Project Director will work closely with team to spread Care Model to CVD</p>

Strategic Planning & the Care Model

Creating the Culture...

- Integrating the Care Model requires organizational vision and strategic planning
- Make the Care Model 'business as usual'
- Integrate the Care Model into Performance Improvement activities
 - JCAHO
 - Peer Review
 - Quality Measures and Indicators
- Develop timelines to track progress, identify barriers, and stay on course
- An informed board is an engaged board

Resources

- Health Disparities Collaboratives & National Measures
 - <http://www.hdpcc.org>
- Improvement and Care Model Change Concepts
 - <http://www.improvingchroniccare.org>
- Clinical Guidelines
 - <http://www.guidelines.gov>