The Chronic Care Model

Lessons from the Field

All Grantee Meeting – June 23, 2005

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Few Statistics about ANHC

- Founded in 1972 – largest FQHC in Alaska
- Provided 48,991 visits (medical, dental, MH/SA, enabling) to 13,298 patients in 2004
- 330 grantee including HCH and Ryan White III (b)
- No managed care in Alaska

Collaboratives at ANHC

- Diabetes – 1998
  - 10% of patient population
- HIV/AIDS – 1999
  - 155 active patients
- Depression – 2003
  - Estimated in 30% patients

Chronic Conditions are Increasing

Diabetes…………... 30% increase over the last ten years*

Asthma…………….75% increase from 1982-1996#

Heart Failure…….. Triple the number of new cases from 1970-1992 ##

+ Aging of Population

+ Diversity **++ Obesity**

Source:

*Diabetes data- CDC, National Center for Health Statistics, data from the National Health Interview Survey. U.S. Bureau of the Census,

National Center for Health Statistics: National Health Interview Survey, 1982-1996. 60-1995 MMWR 1998;47(no. SS-1)

O'Connell JB, Bristo MR. Economic impact of heart failure in the United States: Time for a Different Approach. J Heart Lung Transplant. 1994;13(4):S107-S112.

The Care Model

The Evidence

- *Motivation* and *adherence* are not genetically determined
- Behavioral interventions are consistently successful in raising adherence
- *Noncompliance is not a patient problem; it is a system failure*

Self-Management Support HIV/AIDS

- Viral load and CD4 trend graphs are printed for individual clients to illustrate the course of their illness/care
- Implementation of the medication adherence protocol which includes a pre-HAART assessment and 6 month follow-ups
- Development of a "Patient Plan" prescription for self-management
- Peer educator conducts biannual (Sexual)Health Education/Risk Reduction sessions with all clients

Self-management Support Diabetes

- Provide free diabetes classes in English, Spanish and Samoan, and Hmong class planned
- “Action Plan” form given to patients after nurse check-in for goal setting; confidence and importance of plan reviewed at each diabetes visit
- Free one-on-one diabetes self-management education

Self Management Support Depression

- Drop-in Depression clinic on Wednesday evenings focusing on self management and solution finding skills
- All chronic disease patients are screened for depression
- Follow up phone calls with patient within two weeks regarding goals

Decision Support

- Providers select evidence-based guidelines as their standards of care
- Guidelines are embedded into documentation templates
- Monthly team & 'Joint Collaborative' meetings
- Program policies, procedures, and protocols accessible via ANHC's intranet.
- "Journal Watch" distributed quarterly to all providers involved in HIV care.

Clinical Information Systems

- Maintain HIV/Depression patient registries utilizing the CAREWare & PECS databases
- Track patient appointments and lab results through Medical Manager
- Generate reports via Infopoint linked to Medical Manager
- Use Microsoft Outlook to create a weekly schedule of appts with notes for each patient outlining what will be needed at their appt.
- QCP reminder sent to patients & providers

Clinical Information Systems

- Include clinically useful and timely information on all patients in a registry
- Provide reminders and feedback for providers and patients
- Identify relevant patient subgroups and provide proactive care
- Facilitate individual patient care planning through the registry
- Depression flow sheet includes PHQ9 scores, self-management goals, and labs

Delivery System Design

- Computerized reminder system for providers and letters to patients
- Standing orders for nursing and lab to preorder overdue labs and make referrals
- “Diabetes stamp”
- Conduct Group visits
- PHQ9 forms in English and Spanish available in all exam rooms

Delivery System Design

- Clinical Encounter Referral Forms (CERFs) generated from CAREWare - immunizations, screenings, labs, etc. due are highlighted for provider reference at the patient's visit
- Lists of patients who are due for labs or a visit are generated monthly and given to the care coordinators to follow-up
- Reporting schedule has been developed for key measures and data tracking of all data points

Organization of Health Care

- Measurable goals for chronic illness are in the Strategic Plan and outcomes are reported to the BOD quarterly
- Senior leaders support improvement (CEO and Medical Director actively involved)
- Clinician champions
- Encourage better care through provider incentive compensation system
- Chronic Disease Coordinator position

Community Linkages

- Formed partnerships with Latino and Samoan community organizations
- Pearle Vision Grant & partnerships with local eye clinics
- Partnership with local ADA and Lion's Club
- Established relationship with Schools of Nursing, Social Work, and Counseling at two local universities

Community Linkages

- Communication system in place with ADAP pharmacy for tracking of medication adherence
- Provide education and outreach to locations (including correctional and rehab facilities) each month on HIV prevention
- HIV Peer Educator sits on the State Prevention Planning Group
- Care Coordinators attend monthly meetings with local ASO

Clinical Outcomes - HIV/AIDS

- 94% of patients with clinical indications for HAART therapy have received it (Goal: 75%)
- 77% of patients on HAART therapy have received a medication adherence assessment in last 6 months (Goal: 75%)
- 85% have had a medical visit in the last 4 months (Goal: 85%)
- 22% of patients on HAART have an undetectable viral load <50 copies/mL; 40% have viral loads <100 copies/mL. (Goal: 65%)

Clinical Outcomes - Diabetes

- 63% of POF had documented self-management goals within previous 12 months (Goal: 80%)
- 50% of POF had two HbA1c's within 12 months (Goal: 90%)
- 56% of POF had dilated eye exam in past year (Goal: 70%)
- 69% of POF had foot exam within past year (Goal: 80%)

Clinical Outcomes - Diabetes

- 76% of POF had a lipid screening within past 12 months (Goal: 90%)
- Average HbA1c for POF 7.6 in May 2005 (Goal: <7)
- Many collaborative patients no longer state Depression as their primary diagnosis

Lessons Learned

- Sustaining change is hard work!
- Spread is more difficult than we anticipated
- Following through on PDSA cycles doesn't always happen.
- When the model works, it works well.
- Even when reminder systems and other practice tools are put in place, success still depends on provider buy-in

Lessons Learned

- Lots of continued training and culture shift is needed
- More case managers are needed to support our efforts and to supplement provider time
- Good partnerships (teamwork) make changes happen

Issues to resolve

- Provider buy-in for standing orders
- Staying focused on data-driven PDSAs
- Engaging nurses in change process
- Increasing case management capacity
- Successful implementation of EHR
- Integration of the Chronic Care Model into the core structure of the agency

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