


Congestive Heart Failure Quality Assurance Training for Rural Hospitals

Embedding the Chronic Care Model in Health Care Quality Initiatives



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Objectives

- Provide overview of *Chronic Care Model (CCM)*
- Explore methods to implement the *CCM* in your practice

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76 Million “Baby Boomers” Turn 65 Over the Next Ten Years

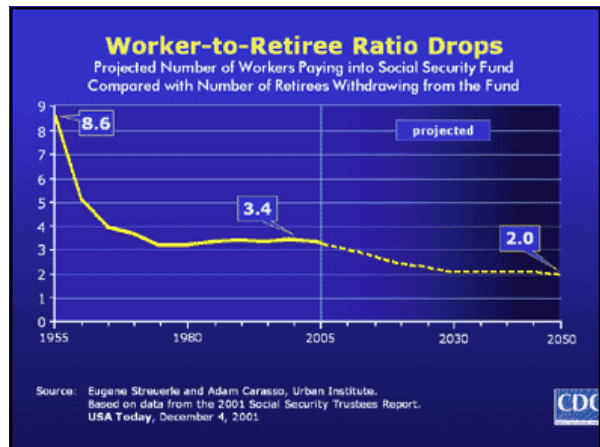
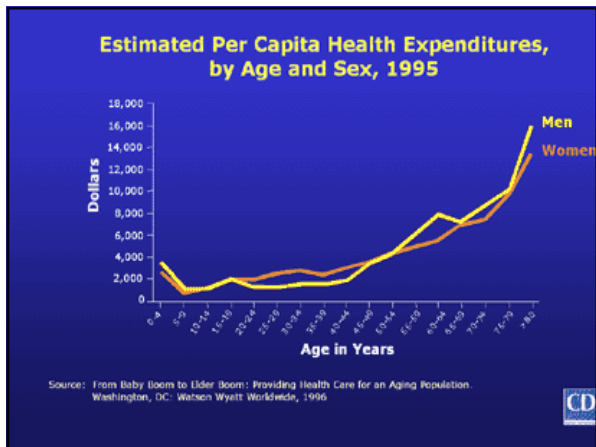


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Three Biggest Worries About Having a Chronic Illness (Age 50+)

1. Losing Independence
2. Being a Burden to Family or Friends
3. Not Being Able to Afford Needed Medical Care

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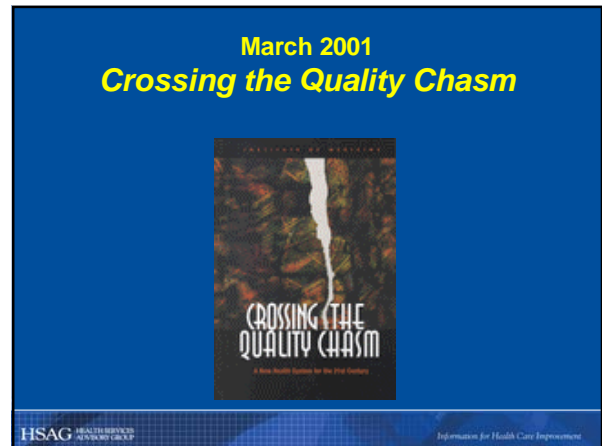
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Number of Chronic Conditions per Medicare Beneficiary

Number of Conditions	Percent of Beneficiaries	Percent of Expenditures
0	18	1
1	19	4
2	21	11
3	18	18
4	12	21
5	7	18
6	3	13
7+	2	14

} **63%** } **95%**

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- ### Chasm's Core Message
- Quality of health care in U.S. falls short of our knowledge
 - Between the care we have and the care we could have, there's not just a gap, but a chasm
 - The problem *is not* individual doctors, providers, staff, or hospitals
 - The problem *is* poor systems & organizations/facilities
 - Individuals working within and with groups can fix the gaps
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- ### Why a Chronic Care Model?
- U.S. health care system not designed to treat chronic lifelong illnesses
 - Rushed practitioners
 - Unable to follow guidelines
 - Lack of care coordination
 - Lack of active follow up
 - Inadequate patient training
 - Characteristics of successful interventions not categorized usefully
 - Commonalities across chronic conditions unappreciated
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- ### Improving Chronic Illness Care (ICIC): A national program of the Robert Wood Johnson Foundation
- Mission: *To improve the health of chronically ill patients by helping health plans and provider groups, especially those that serve low income populations, improve their care of the chronically ill.*
- Developed in 1993
 - Group Health Cooperative, WA
 - Literature Review, Interviews and Site Visits
 - Published in 1996, E. H. Wagner, et. al.
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Essential Element of Good Chronic Illness Care

Informed, Activated Patient
↔ Productive Interactions ↔
Prepared Practice Team

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What is a “Prepared” Practice Team?

Prepared Practice Team

At the time of the visit, they have the patient information, decision support, people, equipment, and time required to deliver evidence-based clinical management and self-management support

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What is an “Informed, Activated” Patient?

Informed, Activated Patient

Patient understands the disease process, and realizes his/her role as the daily self manager. Family and caregivers are engaged in the patient’s self-management. The provider is viewed as a guide on the side, not the sage on the stage!

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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
- Collaborative goal-setting and problem-solving resulting in a shared care plan
- Active, sustained follow-up

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Chronic Care Model

1. **Community**
Resources and Policies

2. **Health System**
Organization of Health Care

3. Self-Management Support

4. Delivery System Design

5. Decision Support

6. Clinical Information Systems

Informed, Activated Patient
↔ Productive Interactions ↔
Prepared, Proactive Patient Team

Improved Functional and Clinical Outcomes

Figures from Wagner EH. Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness? *Effective Clinical Practice* 1998;1:2-4. Used with permission.

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Decision Support

- Embed evidence-based guidelines that describe stepped-care into daily clinical practice.
- Integrate specialist expertise into primary care.
- Use proven provider education modalities to support behavior change.
- Inform patients about guidelines pertinent to their care.
- Ensure culturally competent care.

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Makes Doing the Right Thing Easy

Orders for Patient Admitted with Congestive Heart Failure

1. Admit _____
2. Telemetry Yes No
3. Diagnosis: CHF secondary to: _____ EF= _____
4. Other Diagnosis: _____
5. Allergies: _____ Height _____ Weight _____
6. Activity: bed rest with bathroom privileges Other: _____
7. VS hours
8. Weight on admission and daily
9. Sterc f/VOs
10. O₂ to keep sat >= 92%
11. Diet: Low salt (2 gm) Low salt ADA Other: _____
12. Cardiac Rehab/Education referral Yes No
13. Smoking Cessation Education Yes No
14. Case Management/Social Service Yes No
15. Cardiology consult Yes No Call _____
16. Medications: see reverse for ACA/ANA guidelines Reason not on ACEI/ARB _____

ACE Inhibitor/ARB _____	<input type="checkbox"/> EF<40%	<input type="checkbox"/> K<5.5	<input type="checkbox"/> SBP<90
Diuretic _____	<input type="checkbox"/> Other _____		
Potassium Supplement _____			
Beta Blocker _____			
17. Labs: CMP with Mg on admission

Delivery System Design

- Define roles and delegate tasks among team members.
- Use planned visits to support evidence-based care.
- Build effective case management functionality into practice.
- Assure continuity by the primary care team.
- Assure regular follow-up.

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Delivery System Design

Case Management

- Regularly assesses disease control, adherence, and self-management status
- Provides navigation through the health care process
- Adjusts treatment/communicates need to primary care provider immediately
 - self-management support

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Clinical Information System

- Include clinically useful and timely information on all patients in a registry.
- Identify relevant patient subgroups and provide proactive care.
- Facilitate individual patient care planning through the registry.
- Provide reminders and feedback for providers and patients.

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Self-Management Support

- Emphasize the patient's central role.
- Assess patient's beliefs, behavior, and knowledge.
- Advise patients by providing personalized information.
- Agree on collaboratively-set goals.
- Assist patients with problem-solving.
- Arrange a specific follow-up plan.

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Heart Failure Symptom Awareness and Action Plan	Symptom	Action
If you have:	<ul style="list-style-type: none"> • No shortness of breath • A small amount of ankle swelling • No weight gain • No chest pain • No change in your usual activity level 	<p>Your symptoms are under control.</p> <ul style="list-style-type: none"> • Continue taking your medications as ordered • Continue to weigh yourself every day • Follow a low-salt diet • Keep all physician appointments
If you have any of the following:	<ul style="list-style-type: none"> • Weight gain of 2 or more pounds • Increased cough • Increased swelling • Increased shortness of breath with activity • Increased number of pillows needed to sleep 	<p>You may need an adjustment of your medications.</p> <p>Call your health care contact for instructions:</p> <p>Name _____</p> <p>Number _____</p>
If you have any of the following:	<ul style="list-style-type: none"> • Shortness of breath at rest • Wheezing or chest tightness at rest • Need to sit in chair to sleep • Weight change of more than 5 pounds over or under normal weight • Dizziness, extreme fatigue, or falling 	<p>You need to see a doctor now.</p> <p>Call your doctor now:</p> <p>Name _____</p> <p>Number _____</p>
If you have:	<ul style="list-style-type: none"> • Unrelieved shortness of breath • Unrelieved chest pain • Confusion or fainting 	<p> Call 9-1-1 immediately</p>

MSHO HF QI Initiative

Community Resources and Policies

- Identify effective programs and encourage patients to participate.
- Form partnerships with community organizations to support or develop evidence-based programs.

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Health Care Organization

- Include measurable goals for chronic illness in the business plan.
- Senior leaders visibly support improvement in chronic illness care.
- Use effective improvement strategies aimed at comprehensive system change.
- Promote good chronic illness care through benefit packages.
- Encourage better chronic illness care through provider incentives.

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How Can We Change Outcomes?

- Improve processes by focusing interventions on guidelines, feedback, and role changes
- Address multiple areas for more impact
- Remember . . . patient-centered changes are most powerful

Renders et al. *Diabetes Care*. 2001;24:1821

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When Implementing the CCM, Keep in Mind . . .

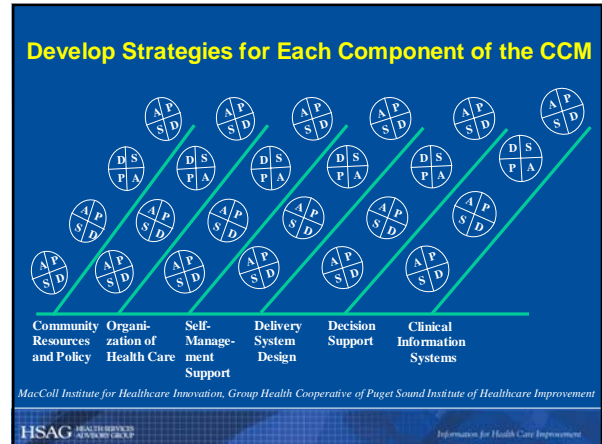
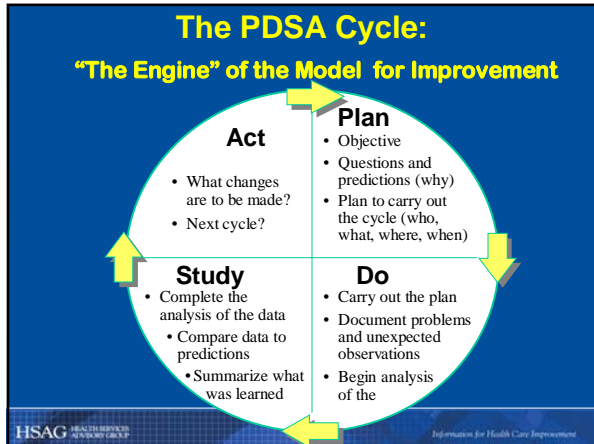
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Three Fundamental Questions For Improvement

- What are we trying to accomplish?
- How will we know a change is an improvement?
- What changes can we make that will result in an improvement?

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To Summarize

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- ### Chronic Care Should Be
- Provider-oriented
 - Practice team has the expertise and resources required to deliver effective clinical and behavioral care at each interaction
 - Patient-oriented
 - Patients have the information, skills, and confidence to effectively manage their condition
 - Practice-oriented
 - Providers and patients conduct productive interactions
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- ### Essential Elements for Improvement
- Leadership support
 - Measurement system
 - Expertise
 - Disease Management
 - Quality Improvement
 - Opportunity to collaborate with your peers
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