Chronic Care Models: Transferability to Heart Failure

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Executive Medical Director
Group Practice Forum
Learning Objectives

• The audience will learn about the elements of the Chronic care model

• Attendees will gain an understanding of task grids and process mapping models

• Participants will learn how the basic care excellence principles for any chronic disease translate well into heart failure care models
- Can you list the key elements of your heart failure initiatives that follow the principles of disease state and population health models of care?

- What key HF dashboard metrics have you added to empower your health care teams to measure and then perform QI cycles?
Heart Failure Patient Journey

CONGESTIVE HEART FAILURE

Patient Journey

Emergency Room

Emergency Room Staff

Community

Specialist, Primary Care Physician, Home Care Nurse

Patient Presents at ER: Triage

Patient Treated in ER

Inpatient:

Patient Stabilized

Pre-Discharge Planning

Pre-Discharge Assessment

Discharged Home

CHF Treatment and Clinical Assessment:
- Obesity
- Hypertension
- COPD
- Kidney Disease
- Anemia
- Diabetes

Pre-Discharge Assessment:
- Disease Education
- Current Status
- Health Literacy Assessment
- Assess further barriers to care

Discharge “Plan of Care”:
- Medication Reconciliation
- Comprehensive Cardiac Rehab Program

Home Care Assessment for ADL (Activities of Daily Living):
- Review health literacy
- Confirm Rx refills
- Refer to cardiac rehab
- Confirm PCP Meeting

Post Discharge Clinical Monitoring:
- Patient Assessment
- Clinical Assessment (if required)

Home Care Assessment for ADL (Activities of Daily Living):
- Review health literacy
- Confirm Rx refills
- Refer to cardiac rehab
- Confirm PCP Meeting

Post Discharge Clinical Monitoring:
- Vital Signs
- Weight
- Shortness of breath

Post Discharge Clinical Monitoring:
- Patient Assessment
- Clinical Assessment (if required)

Home Care Assessment for ADL (Activities of Daily Living):
- Review health literacy
- Confirm Rx refills
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*Remote technology available
Chronic Care Model (CCM)

- Community
- Resources & Policies

Health System
- Health Care Organization
- Clinical Information Systems
- Decision Support
- Delivery System Design
- Self-Management Support

Productive Interactions
- Informed, Activated Patient
- Prepared, Proactive Practice Team

Improved Outcomes

Slide from E. Wagner
Sample Patient Journey

Tier 1 Patient Journey

Initial Visit
- MD reviews patient's history
- Conduct routine physical
- Perform basic labs and order diagnostic
- MA schedules follow-up visit with MD

MD: 45 minutes
MA: 15 minutes

Diagnosis (MD)
- Labs show patient has 10 year risk ≥ 20%
- Patient has established vascular disease
- Patient identified by MD as high risk (Tier 1)
- MD outlines detailed care plan and interacts with members of Tier 1 care team
- MA schedules group education class for patient

MD: 30 minutes
MA: 15 minutes

Group Education Class
- Knowledge gained:
  - Atherosclerosis
  - Lipoprotein
  - Hypertension
  - 20 minutes
- Reflected importance of:
  - Dietary
  - Physical activity
  - Lifestyle choices
  - Community resources
- MA schedules follow-up visit with NP

MD: 45 minutes
NP: 60 minutes
MA: 105 minutes
CDE: 30 minutes
Dietician: 30 minutes

Follow-up Visit (NP)
- Review care plan
- Assess any gaps in knowledge
- Refer as appropriate
- MA schedules referral

NP: 30 minutes
MA: 15 minutes

Follow-up Visit (MD)
- MD: 30 minutes
MA: 15 minutes

NP Diabetes Specialist: 30 minutes
Dietician: 30 minutes
CDE: 30 minutes

Certified Diabetes Educator
- MA schedules follow-up visit with MD

Week 1
Week 2
Week 4
Week 6
Week 8
Week 16

Center for Cardiovascular Disease Prevention
Tier 1 Patients Have 24/7 Access

GPF
Group Practice Forum
### The Patient Pathway Highlights Team-Based Care Models: Every Member Plays A Part

**Shared Responsibilities to Reach a Common Goal**

<table>
<thead>
<tr>
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<th>Patient Registry</th>
<th>Motivational interview</th>
<th>Checked medication adherence</th>
<th>Updated EMR</th>
<th>Distributed educational tools</th>
<th>Lifestyle SMBG (diet/exercise)</th>
<th>Outreach to patient after appointment</th>
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<tr>
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Evidence Suggests that Process Mapping Can Reduce Costs

- Harvard Business Review, September 2011
  - Porter/Kaplan
- Time-Driven-Activity-Based-Costing
- MD Anderson Pilot
Clinical performance measures are derived from evidence-based practice guidelines. They can be used for quality improvement, public reporting, accountability or pay for performance. Reporting allows for group, regional and national comparison data. In most cases, optimal performance is not known because we have not been measuring.
Measuring and Improving Quality

- Map processes to eliminate waste and remove delays.
- Identify a set of balanced measures.
  - Build performance measurement into your processes.
  - Choose the appropriate statistics to plot.
  - Use sampling when needed to conserve resources.
  - Plot data in time order every month.
  - Develop excellent visual displays.
  - Monitor measurement results.

- Use small-scale, rapid PDSA cycles to continuously improve.

Have fun! Quality is a journey, not a destination.
Example: Dashboard
The healthcare provider had updated information on recent patient/provider encounters
The healthcare provider had the most recent (even hours old) imaging studies
The healthcare provider had the most recent lab data
The healthcare provider actually had accurate medication lists
The healthcare provider knew who was responsible for coordinating the patient’s care
The healthcare provider could manage and coordinate a patient’s care without face to face contact
Technology was utilized to capacity
The healthcare provider actually knew which specialists were most effective and efficient
## Evolution of payment reform

**Past and Emerging Models of Accountability in Provider Payments**

<table>
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<tr>
<th>Supporting Better Performance</th>
<th>Paying for Better Performance</th>
<th>Paying for Higher Value</th>
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<tbody>
<tr>
<td>Pay for reporting. Payment for coordination. Case management fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).</td>
<td>Pay for performance. Provider fees tied to one or more objective measures of performance (e.g., guideline-based payment, nonpayment for preventable complications).</td>
<td>Shared savings with quality improvement. Providers share in savings due to better care coordination and disease management.</td>
</tr>
<tr>
<td>Partial or full capitation with quality improvement. Systems of care assume responsibility for patients across providers and settings over time.</td>
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Evolution of Expectations for Physicians—Clinical Integration

- Team-based care
- Focus on the top of license/training & interest
- Improved communication
- Improved data flow & access
- Right patient at the right time
- Patient-centered aligned incentives – outcomes, quality, cost
- External accountability – outcomes, quality, cost
Transforming an Idealized Model Into Reality: Patient-centered, Team-based Approach to Care

**Elements of an Idealized Model of Care**¹

- Patient-centered care
- Team approach to care
- Elimination of barriers to access
- Advanced information systems, including a standardized electronic health record (EHR)
- Redesigned, more functional offices
- Whole-person orientation
- Care provided in a community context
- Focus on quality and safety
- Enhanced practice finance
- Defined basket of services

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Four Critical Success Factors

- Teamwork
- Change Management
- Leadership
- Communication
Teamwork

Effective teamwork is a skill set that can be learned by all groups, not just the special few.
CHANGE IS NOT PLEASANT!
Change is not an isolated event

- Change in one area will create change in another area.
The Change Curve

Satisfaction

Denial

Resistance

Exploration

Commitment

Hope

Reaction to the change process:

"I'm happy as I am."

"This isn't relevant to my work."

"I'm not having this."

"Could this work for me?"

"I can see how I make this work for me."

"This works for me and my colleagues."

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Chaos is part of the process
Reactions to Change

- 15% Angry
- 40% fearful, skeptical, and distrustful
- 30% uncertain but open
- 15% hopeful and energized

Sustainable change must address each of these.
Change initiatives become sustainable by engaging the whole practice in the effort.
Challenge…
Keep change alive on a number of levels:

- The individual
- The small group/team
- The entire practice system
- And don’t forget about your patients!
Foundation of Transformation

6 Core Change Leadership Functions:

1. Understand systems level thinking
2. Model the culture change
3. Engage others in a shared vision
4. Promote optimal information flow
5. Delegate
6. Recognize the value of team
Leadership

Leadership at all levels within the practice is often a struggle -- particularly around transformation.
Communication

Communication within a practice is a major limiting factor for success.
Transitioning The Continuum of Care with Bi-Directional Communication

- Home Care
- LTC
- PCP/Medical Home
- Community Health Center
- Health Plan
- Hospital
- Specialist
- Pharmacy
- Hospice
- Employer
- Patient

Roles and Interventions:
- Adherence
- Advocate
- Motivational Interventions
- Non-Adherence
- Behavior Health Change
- Medication Reconciliation
- Assessment
- Care Plan
- Facilitation
- Motivational Advocacy
- Prescription
- Assessment & Care Plan
- Increase Productivity
- Health Promotion
- Assessment & Support
As the number of people involved in a communication process increases, so does the complexity of the communications and the potential for misunderstanding.
Communication formula:
\[
\frac{n(n-1)}{2}
\]
- 2 people, 1 communication channel
- 4 people, 6 communication channels
  - 12 people, 66 channels
  - 15 people 105 channels
Coordinated care team

Patient empowerment

Health literacy

Patient population management

Electronic medical records

Patient Care Pathway Creates a Map of the Patient Experience through the Healthcare System
Transition Connector

- Collaborative Team
  - Patient
  - Physician
  - Pharmacist
  - Nurse
  - Social Worker
  - Case Manager
  - Allied Health
    - Respiratory Therapist
    - Dietitian
    - Physical Therapist
    - Educator

- Community Team
  - PCP
  - Specialist
  - Skilled Nursing Facility
  - LTC Services
  - Pharmacy
  - Community Clinic
  - Home Care
  - GCM/CM
  - Rehabilitation
  - Hospice
  - Community Resources
  - Health Plan
  - Medical Home
Heart Failure Patient Journey

CONGESTIVE HEART FAILURE

Emergency Room:
- Patient Presents at ER TRIAGE
- Discharged Home
- Patient Stabilized

CCU/Inpatient:
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Team Responsibilities in Ensuring a Safe and Successful Care Coordination

- Educate the patient and ensure patient & caregiver understanding on their disease process and factors that can influence their condition
- Ensure the patient has the resources to manage their disease after transition
- Make certain that the transition will be for the individual patient and they feel confident they can manage
- Ensure that the patient understands the plan for transition of care and their medication plan to the next transition setting
- Make certain that the patient has access to the follow up care and therapy
The Bottom Line: Value

- Quality / Cost
  - Maximize the numerator
  - Decrease the denominator
LEADERSHIP
The leader always sets the trail for others to follow.