ThedaCare Physicians

Managing Patients With Multiple Chronic Conditions

Admissions/ER visits improved from 27% to 0% by the end of the measurement period.

Project Goals

ThedaCare Physicians had identified the management of patients with chronic diseases as an opportunity to improve the health of the communities it serves. ThedaCare Physicians' staff previously focused on each individual chronic disease state for hypertension, diabetes, and cardiovascular disease. Recognizing that many patients have multiple comorbidities, ThedaCare combined the care and management of these chronic conditions.

Located in northeastern Wisconsin, ThedaCare Physicians is part of a community health system that encompasses 4 hospitals, home health, senior services, behavioral health, and employee wellness. The group's 132 physicians and 69 midlevels provide primary care (family practice, internal medicine, and pediatrics) at 23 clinics. Approximately 420,000 office visits are conducted each year.

Recent Improvements and Outcomes

Using Lean processes, a study at 1 clinic site focused on patients with diabetes and hypertension. Staff and others were engaged in organizing diabetes improvement work, resulting in increased staff knowledge of the diabetes disease process. Admissions/ER visits improved from 27% to 0% by the end of the measurement period. Referrals to the Diabetes Self-Management Program remained steady at 6. At program baseline, 100% of smokers received advice to quit, and this rate continued to the program's completion.

Tobacco use rate declined to 18% from 27%. Patient participants averaged at least 2 office visits per year at both the onset and completion of the program.

Sustaining Strategies

To sustain its disease management program, ThedaCare monitors various improvement metrics on a daily basis and identifies opportunities to improve the care of the patient. Daily huddles with providers and staff focus on the needs of patients with diabetes and hypertension, including visible tracking of services needed and completed daily. Training of medical assistants includes diabetes education and the use of motivational interviewing. ThedaCare uses Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) surveys from Press Ganey knowing that patients with higher satisfaction with their experience will be more engaged in their care.

Future Plans

Development of a Diabetes Education Alert in its electronic medical records (EMR) system will be prioritized. Additional planning is underway in the following areas:

- Pioneer accountable care organization (ACO) work focused on chronic conditions
- Week-long improvement event for patients with A1C >9
- Introduction of telephone reminder system for chronic disease management
- Week-long improvement event related to diabetes education at rural sites
- Systemwide visible individualized patient Plan of Care in EMR
- Diabetes education for staff at "Lunch and Learn" at all clinic sites
- Deployment of quality teams at clinic sites focused on monthly improvement opportunities

Lessons Learned

Through its ongoing chronic disease management work, ThedaCare Physicians has gained insight into what drives patients to achieve self-management (or not). This work continues with active Plan-Do-Study-Act (PDSA) in progress. Involving front-line staff in quality improvement helps providers help patients meet their goals. Integrated IT support is important, and IT work takes time. Cost/economy continues to be a barrier for patients. Provider and administration leadership is key. Despite an intense focus on this group, the population of those with chronic diseases continues to grow.

AMGA American Medical Group Association

AMGF American Medical Group Foundation®

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