

Planned Care

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Part 6

1

Delivery System Design

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

2

To Improve Outcomes in Chronic Illness

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- Patients must be prescribed and taking proven therapies
 - Patients must be managing their illness well
 - Patient course must be followed for changes in status and reinforcement

3

The Problem

- Patients are frustrated by waits and discontinuities, often don't receive proven services and often feel they are not heard
- Providers feel they have little control over their work life, are stressed by demands for productivity despite older, sicker clientele and the reduced variability in their clinical day

4

What we know about primary care visits?

- 50-70% are largely informational or informative (including check-backs for chronic illness care) yet they are organized like acute visits
- US average is 16.3 minutes
- Patients are given an average of 20 seconds to tell their story before they are interrupted

5

What we know about primary care visits? (cont.)

- When uninterrupted, 50% of patients finished their story in 60 seconds or less, 80% in 2 minutes or less.
- For the same set of patient characteristics, physicians varied the interval between visits from 4-20 weeks.
- Non-physician staff are generally more likely to adhere to protocols

6

What we know about primary care visits? (cont.)

- For pediatric patients with asthma, continuity of care is associated with 50-60% reductions in ER use and hospitalizations
- The physician part of the visit is shorter when non-physician staff are used to their capacity

7

Old interaction vs. New interaction

Between doctor/NP/PA and patient	Between patient and care team
Face-to-face	Multiple methods
Problem-initiated and focused	Based on care plan: "planned visit"
Topics are clinician's concerns and treatment	Collaborative problem list, goals and plan
Ends with a prescription	Ends with a shared plan of care

8

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

9

Define roles and tasks

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Distribute them among the team members

10

Use planned interactions to assure evidence-based care and support self-management

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One-on-one, group, telephone, e-mail, outreach....the possibilities are endless

11

What is a Planned Visit?

- ←—————→
- A Planned Visit is an encounter with the patient initiated by the practice to focus on aspects of care that typically are not delivered during an acute care visit
 - The provider's objective is to deliver evidence-based clinical management and patient self-management support at regularly scheduled intervals without the distractions inherent in the acute care visit

12

What does a Planned Visit look like?

- The provider team proactively calls in patients for a longer visit (20-40 minutes) to systematically review care priorities
- Visits occur at regular intervals as determined by provider and patient
- Team members have clear roles and tasks
- Delivery of clinical management and patient self-management support are the key aspects of care

13

How do you do a Planned Visit?

You Plan It!

14

Example: Depression, Step 1

- Choose a patient sub-population, e.g., all patients receiving anti-depressive therapy
- Review registry or other database to identify patients and dates of most recent contact
- MD reviews list for patients at highest risk (via evidence-based criteria)

15

Step 2: Patient Outreach

- Patients identified and contact information obtained
- Receptionist calls patient and explains the need for planned visit using script
- Depressive symptom and treatment adherence questionnaires sent
- Patient chooses day and time for visit

16

Step 3: Preparing for the Visit

- RN/LPN/MA prints any relevant patient summaries from registries and attaches to front of chart
- MD reviews medications and recent clinical data (questionnaire or labs) prior to visit
- Additional services arranged (e.g., pharmacist to review adherence and/or adverse effects)

17

Step 4: The Visit

- Review patient's assessment data and clinical status
- Adjust therapy by protocol
- Review self-management goals and action plan, identify obstacles
- Collaboratively revise goals
- Create a new patient action plan
- Arrange needed services
- Schedule follow-up

18

Step 5: Follow-up

- Does not need to be in-person visit (use phone, e-mail)
- Check adherence to action plan
- Problem-solve as needed
- Schedule additional follow-up as needed

19

Structured Diabetes Visits – Denmark

- Primary care practices randomized to intervention or control
- Intervention practices received quarterly reminders, guidance and supporting data for structured visits with their diabetic patients
- Guidelines and patient education materials also supplied
- Intervention practices reduced HbA1c 0.5% on average in comparison with controls

20

Group Visits: Introduction

- Patients brought in by clinically relevant groups
- Patients can receive:
 - Specialty service as needed/available
 - One-on-one with medical provider
 - Medication counseling
 - Self-management support training
 - Social support
- Multiple models for group visits

21

Group Visit Content

- Brief individual clinician conversation and assessment — option for private consultation
- Guideline recommended procedures (flu shots, foot exams) performed when feasible
- Educational offering
- Peer discussion
- RCTs in Kaiser system with seniors and diabetics showed reduced utilization, better disease control, greater satisfaction

22

Ensure regular follow-up by the primary care team

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The alternative to lost to follow-up...

23

Making Follow-up Work for You

- Develop process for follow-up
- Tailor follow-up to patient and provider needs
- Eliminate unnecessary follow-ups
- Schedule follow-up
- Monitor for missed follow-up
- Reach out to those not attending follow-ups

24

Follow-up could be...

- Face-to-face
- Clinical case manager
- Outreach worker
- In groups
- Phone
- E-mail

25

Definitions

Disease
Management

**Organized, multi-
component interventions
directed at all members of
a population defined by
clinical condition**

Case
Management

**Clinical and/or
educational and/or social
services provided to
individual clients with
high needs**

Care
Management

Ditto

26

Does case management require a nurse or clinical case manager?

- Evidence suggests that non-professionals can be trained to perform follow-up with assessment – that alone, when linked to a physician or nurse case manager, has improved outcomes in depression and arthritis
- AVR can perform same function
- Regular interaction with expert physicians
- Face to face contact with patient

27

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28

What does it take to change clinical and health status in chronic disease?

1. Clinical management by evidence-based protocol
2. Ongoing support of patient self-management
3. Regular follow-up with assessment of severity, self-management and treatment
4. Intensity increased with patient need

Traditional practice teams often are limited in their ability to assure these, especially #4

29

The Clinical Spectrum of Case/Care Management

Social worker

Nurse

Advanced
practice nurse

Arranging
social
services

Coordinating
clinical and
social services

Assessment,
education,
follow-up

Clinical
therapy

30

Is Case/Care Management Effective?

- For frail elders - mixed results
- For mental illness (depression) - yes
- For diabetes, heart disease and asthma - yes

31

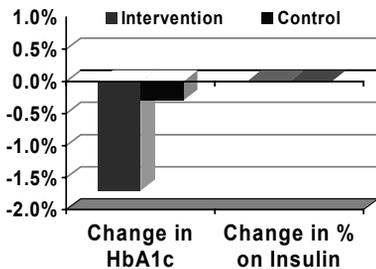
Diabetes

- Recent meta-analysis* found 15 studies of diabetes CM meeting quality criteria
- Most were conducted either in managed care or community clinics and were part of larger system changes
- HbA1c, BP, LDL improved in all studies where measured
- Average HbA1c reduction 0.5%

*Norris et al, Am J Prev Med 2002;22 (4S):15

32

Nurse Case Management RCT-Aubert et al. Change in Treatment and Glycemic Control Between Baseline and 12 Months



33

Heart Disease

- Review of 11 RCTs of disease management for CHF, 10 centered around a nurse case manager*
- Most reduced hospitalization, improved adherence to guidelines, but only one showed improved QOL and none reduced mortality
- Most effective interventions involved patient education, multidisciplinary teams and specialized follow-up
- Telephone-based systems designed to enhance primary care follow-up not effective
- Two recent RCTs of telephone-based CM showed mixed results on hospitalization

*McAlister FA et al. Am J Med 2001;110:378

34

Meta-analysis of CHF Programs

Phillips et al. JAMA 2004; 291:1358-67

- 18 RCTs from 8 countries
- Intervention generally began in hospital with post-discharge support
- Follow-up ranged from single home visit to extensive visiting, phoning
- 25% reduction in readmission (NNT=12)
- 25% greater improvement in QOL, 13% reduction (p=.06) in all-cause mortality
- Net savings \$359-536 per month of intervention
- Effectiveness unrelated to age, severity, country or duration of follow-up

35

More Recent Trials

- Findings more positive than negative, but negative trials appearing – even positive trials don't improve QOL or mortality
- Questions needing to be addressed
 - A. Does CM need to begin in hospital?
 - B. Post-hospital contact — By what means? When? Where?
 - C. Is drug adjustment important to outcome?
 - D. How long does F/U need to be?
 - E. How much contact with primary care and cardiology is optimal?

36

A) Does CM need to begin in hospital?	Probably helpful, but not essential if post-hospital care prompt
B) Post-hospital contact—By what means? When? Where?	1. Some face-to-face 2. Soon after discharge 3. At least one home visit
C) Is drug adjustment important to outcome?	Probably
D) How long does F/U need to be?	Two studies show effectiveness of a single early home visit - <6 mos.
E) How much contact with primary care and cardiology is optimal?	CM needs to assure that there is one care plan understood by all

37

Effectiveness of Clinical Case Management

Case management effectiveness increases with:

- CM's ability to influence clinical management
- Extent of contact with primary provider(s)
- Integration into larger chronic disease management system

38

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39
