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Summary



INTRODUCTION

The purpose of this manual is to help you begin improving care for your chronically ill patients. It is designed not only to impart information about how to improve, but also to help you to take action on the information you read. The materials are laid out in a step-by-step fashion with “To Do” lists at the end of each section.

As you work through these materials think about how the ideas presented can be applied to your practice. Think about the staff in your office and how they can be used in new ways to improve the practice’s overall functioning. Think about how processes of caring for patients can be improved streamlined or re-invented. Be creative; test bold ideas that challenge how your practice is run. Success is far more likely if you consider how to redesign your care rather than patching up the current system that may not be meeting yours or your patients’ needs.

This manual was created to give you:

1. A step-by-step process to begin testing change in your practice setting, and
2. The tools necessary to test and implement those changes and measure your success.

The manual represents five years of experience creating office practice change through collaborative learning environments similar to the Institute for Healthcare Improvement’s Breakthrough Series Collaboratives. We’ve learned that successful collaborative participants tend to create system change in their practices in a similar way. There’s a sequence to how they test and implement practice changes that leads to improved outcomes faster than teams that don’t follow this specific sequence.

You may be part of a large health system, large medical group, small medical group or solo practice. Regardless of size, this manual is aimed at the practice level so that any provider can implement change for their populations of chronically ill patients.

Overview of the Improvement Sequence

The improvement sequence begins when a motivated practitioner wants to change his or her chronic care processes.

FIRST STEP is familiarizing your entire team with two key improvement strategies: the Chronic Care Model as a system for redesigning your current care delivery, and the Model for Improvement as a quality improvement strategy that teaches the team how to make rapid changes to their practice.

SECOND STEP is organizing your care team by assigning clear roles and responsibilities in the care of patients with chronic illness. Much in the same way the team is organized to handle an acute event like a laceration, the team knows who does what and when at the time of the chronically ill patient visit.



STEP THREE calls for adopting and/or adapting existing disease-specific guidelines for the condition of interest. These guidelines can be adopted from national, regional or local sources depending on the provider's needs and situation.

STEP FOUR involves getting to know your patient population's care needs. Being able to identify all members of the condition population along with their key clinical data allows the provider to begin planning for systems that ensure delivery of evidence-based clinical care on a regular, proactive basis. Building a database to store the data for use during future visits and for performance reporting is absolutely essential to successful improvement.

STEP FIVE is when measures to track your improvements are chosen. These measures relate to the clinical priorities set out in the adopted guideline.

STEP SIX is planning care. Conducting planned patient visits generated by the practice helps you better manage their chronic care needs without the noise inherent in the acute care visit generated by the patient. The process for conducting planned visits is described in the pages to come.

STEP SEVEN is providing self-management support to patients at every visit. The patient becomes empowered to be responsible for their health. The care team works with patient to collaboratively set realistic goals, and follow-up regularly to problem-solve barriers and set new goals as appropriate.

The successful provider team will start with one patient and test changes to the delivery of care. Building on successful changes with successive patients leads to a system implemented for all patients, regardless of condition or disease. As your team tests new ways of delivering care and implements the successful changes, there must be ongoing training for all staff and a malleable performance feedback system to inform continued improvement.

Once the processes for a proactive visit are in place, the team can begin to address patient needs opportunistically. Many chronically ill patients will show up for acute care before the provider has a chance to schedule planned care. This is an opportunity to create systems to deliver as much of the routine chronic care as possible in the acute setting. Systems such as standing orders and reminders can help the provider "pack" the chronic care needs into the acute visit, and then ensure that planned visits are scheduled in the future.

We will now guide you through each of the steps in detail ...



STEP ONE:

There is a recipe for improving quality that involves evidence-based guidelines, system change strategies and quality improvement methods. You are all familiar with evidence-based guidelines, so let's start with the system change strategy.

The Chronic Care Model

The Chronic Care Model (CCM) is an organizational approach to caring for people with chronic disease in a primary care setting. The system is population-based and creates practical, supportive, evidence-based interactions between an informed, activated patient and a prepared, proactive practice team. The CCM identifies essential elements of a health care system that encourage high-quality chronic disease care: the community; the health system; self-management support; delivery system design; decision support, and clinical information systems. Within each of these elements, there are specific concepts ("Change Concepts") that teams use to direct their improvement efforts. Change concepts are the principles by which care redesign processes are guided. The bulleted items below are the change concepts associated with each component of the model that once implemented result in improved patient and system outcomes.

The Community - Mobilize community resources to meet needs of patients

Community resources, from school to government, non-profits and faith-based organization, bolster health systems' efforts to keep chronically ill patients supported, involved and active.

- Encourage patients to participate in effective community programs
- Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
- Advocate for policies that improve patient care

Health Systems - Create an organization that provides safe, high quality care

A health system's business plan reflects its commitment to apply the CCM across the organization. Clinician leaders are visible, dedicated members of the team.

- Visibly support improvement at all levels of the organization, beginning with the senior leader
- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of errors and quality problems to improve care
- Provide incentives based on quality of care (financial or otherwise, or both?)
- Develop agreements that facilitate care coordination within and across organizations

Self-Management Support - Empower and prepare patients to manage their health care

Patients are encouraged to set goals, identify barriers and challenges, and monitor their own conditions. A variety of tools and resources provide patients with visual reminders to manage their health.



- Emphasize the patient's central role in managing his or her health
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
- Organize internal and community resources to provide ongoing self-management support to patients

Delivery System Design - Assure effective, efficient care and self-management support

Regular, proactive planned visits which incorporate patient goals help individuals maintain optimal health, and allow health systems to better manage their resources. Visits often employ the skills of several team members.

- Define roles and distribute tasks among team members
- Use planned interactions to support evidence-based care
- Provide clinical case management services for complex patients
- Ensure regular follow-up by the care team
- Give care that patients understand and that agrees with their cultural background

Decision Support - Promote care consistent with scientific data and patient preferences.

Clinicians have convenient access to the latest evidence-based guidelines for care for each chronic condition. Continual educational outreach to clinicians reinforces utilization of these standards.

- Embed evidence-based guidelines into daily clinical practice
- Share evidence-based guidelines and information with patients to encourage their participation
- Use proven provider education methods
- Integrate specialist expertise and primary care

Clinical Information Systems - Organize data to facilitate efficient and effective care

Health systems harness technology to provide clinicians with an inclusive list (registry) of patients with a given chronic disease. A registry provides the information necessary to monitor patient health status and reduce complications.

- Provide timely reminders for providers and patients
- Identify relevant subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with patients and providers to coordinate care
- Monitor performance of practice team and care system

So what does all this mean?

Successful system change means you will redesign care within each of the six components of the CCM; it does not mean tweaking around the edges of an acute care system not capable of handling the needs of the chronically ill. You will be building a new system that works in concert with your acute care processes. You will accomplish this by testing the above change



concepts and adapting them to your local environment. The remaining steps in this manual help focus where you can start making these changes.

Tools that can help

After learning more about the chronic care model (see www.improvingchroniccare.org), there are two things that may assist you in understanding how it directs system change. The first is the Assessment of Chronic Illness Care, which is a diagnostic survey that you and your team can complete together. The ACIC helps you identify that current state of your chronic care; what's working and what is needed to achieve redesign in all components of the CCM.

The other tool is the ACT Report (see www.improvingchroniccare.org). This report provides concrete examples of teams that have redesigned their care based on the CCM. Some of these stories and the practices they represent should resonate with you and your team.

Step 1 To Do List

- Read about Chronic Care Model
- Complete the ACIC to help you diagnose what is working and not working in your current chronic care
- Read the Act Report

There needs to be a quality improvement process!

This is the final ingredient in the recipe. The Model for Improvement* is a simple yet powerful tool for accelerating quality improvement changes in your organization. Developed by Associates in Process Improvement, the model has two parts. In the first part, your team will address three fundamental questions. These questions will guide your team in creating aims, measures, and specific change ideas. Secondly, your team will use Plan-Do-Study-Act (PDSA) cycles to allow these changes to be easily tested in your work environment. These successful tests of change pave the way for real-world implementation within your system. A brief synopsis of the model is presented below. There is considerably more detail available on the Institute for Healthcare Improvement's Web site: www.ihl.org.

*The Model for Improvement was developed by Associates In Process Improvement, www.apweb.org/API_home_page.htm

Three Key Questions for Improvement

AIM – What are we trying to accomplish?

When you answer this question, you are creating an aim statement – a statement of a specific, intended goal. A strong clear aim gives necessary direction to your improvement efforts. Your aim statement should include a general description of what your team hopes to accomplish, and a specific patient population on which your team will focus. A strong aim statement is specific, intentional, and unambiguous. It should be aligned with other organizational goals, and all those involved in the improvement process should support it.



MEASURES – How will we know that a change is an improvement?

Your team will use a few simple measures to see if the rapid cycle changes in care are working. They can also be used to monitor performance over time. These measurements should not be confused with research. Where research focuses on one fixed and testable hypothesis, the methods for measuring improvement rely on sequential testing using practical measurement strategies. Keep in mind that the measures your team uses should be simple and directly aligned with your aim statement.

IDEAS – What changes can we make that will result in an improvement?

Ideas for change to be tested come from evidence provided by previous research. These ideas are distilled into the design principles of the Chronic Care Model. They are used to develop testable ideas from your team’s own observations of the current system, stories from others, and creative thinking. When selecting specific ideas to test, consider whether an idea is directly linked to your stated aim, if it’s feasible, and if its implementation can provide good potential for learning.

PDSA Cycles

The PDSA (Plan-Do-Study-Act) cycle is a method for rapidly testing a change - by planning it, trying it, observing the results, and acting on what is learned. This is a scientific method used for action-oriented learning. After changes are thoroughly tested, PDSA cycles can be used to implement or spread change. The key principle behind the PDSA cycle is to test on a small scale and test quickly. Traditional quality improvement has been anchored in laborious planning that attempts to account for all contingencies at the time of implementation; usually resulting in failed or partial implementation after months or even years of preparation. The PDSA philosophy is to design a small test with a limited impact that can be conducted quickly (days if not hours!) to work out unanticipated “bugs”. Repeated rapid small tests and the learnings gleaned build a process ready for implementation that is far more likely to succeed.

Parts of the PDSA cycle

Plan – In this phase, your objectives are defined and your team makes predictions about what will happen, and why it will happen. Your team will also prepare for the next step by answering the questions of who, what, where, and when.

Do – In this phase, your team will carry out the plan and collect the data. This will include documenting experiences, problems, and surprises that occur during this test cycle.

Study – In this phase, your team will analyze the test cycle and reflect on what you have learned. You will compare results with the predictions made in the planning stage, and draw conclusions based on the collected data.

Act - In this last phase, your team will decide if there are any refinements or modifications needed to the change you have tried. This may lead to additional test cycles, which starts the process all over again with *Plan*.

Step 1 To Do List

- Review more about the Model for Improvement on the Institute for Healthcare Improvement Web site: www.ihc.org



After reviewing these materials, you are now ready to begin redesigning your system of care by implementing the change concepts in the Chronic Care Model. You will use the rapid cycle methodology of the Model for Improvement as the way to test small changes repeatedly until they are ready for implementation in your whole population of patients.

STEP TWO:

- **Organizing your team**

“Patients reap the benefits of more eyes and ears, the insights of different bodies of knowledge, and a wider range of skills. Thus team care has generally been embraced by most as a criterion for high quality care.”

-Dr. Edward H. Wagner, BMJ, February 2000

The health care team needs to organize itself to deliver effective clinical care and to continuously monitor and improve quality of care. Understanding how your team operates to meet both these needs is critical to improving patient outcomes. The team is more than the clinical staff; non-clinical staff can play an important role. From the two-person office to the ten-person multi-specialty group, collaborative team functioning needs to be a priority to be better prepared for patient care. A prepared team is critical to fostering productive interactions between patients and the care team.

In the article, “Putting Population-Based Care Into Practice: Real Option or Rhetoric?” (link to article can be found online at www.improvingchroniccare.org) Stephen Taplin, et al say that the mere existence of a core group, working together in a clinic for a number of years, does not automatically ensure nor indicate that the group functions as a team. To do so, group members must establish and share a common vision and learn to problem-solve by communicating in ways that maximize the skills unique to each member. This effort requires strong leadership and encouragement. Team members should be assigned roles that are in sync with individual areas of strength or interest. Some essential team roles include: meeting organization; long-term strategizing; maintaining a shared vision; and strong cheerleading to keep the team focused on its mission and goals in the face of inevitable resistance to change. This is not the case in current practice.

Tom Bodenheimer, MD, notes in his conversations with California physicians that many of them worry that their staff cannot perform both the clinical and self-management support functions necessary to effective patient care. Consequently, the physician takes on all roles and responsibilities. This is not a sustainable strategy as the burden of chronic illness increases. Bodenheimer emphasizes the need to delegate work to all staff, clinical and non-clinical. Non-physician staff are more likely to adhere to protocols than physicians, and should therefore be employed to do more of those care processes. For example, nursing staff can do simple screenings. Chart preparation and information gathering for the visit can be delegated to office staff, and medical assistants can conduct clinical and behavioral assessments to prepare for further clinician review. Broadening staff roles and creating a more cohesive care team reinforces the concept of team-based care, and thereby increases both patient and team satisfaction.



Finally Taplin et al suggest looking beyond providers for prospective team members. Certain skills have been shown to be helpful to team functioning, and should be considered. When choosing team members. For instance, is this person a team player, an excellent listener, a good communicator, and a problem solver? Is this person creative, innovative and/or enthusiastic? Finally, choose people who see the need for improvement and who wish to participate in and support the process.

Additional Team Members Round out your team with staff members from the clinic or from administrative branches who can be helpful toward achieving your aims. Possibilities include front office staff, case manager, health educator, medical assistant, pharmacist, and information system staff.

Characteristics of High Functioning Teams

The following articles may prove useful:

- Stephen Shortell: The role of perceived team effectiveness in improving chronic illness care
- Ed Wagner: Effective Teamwork and Quality of Care

Step 2 To Do List

- Start thinking about organizing the team, and what everyone's roles and responsibilities will be. Read Taplin and Shortell articles.
- Meet to discuss everyone's thoughts about how to function as a team, and when to meet regularly.

STEP THREE:

- **Adapt or adopt guidelines**

Adapt or Adopt Guidelines

Guidelines are critical to care, but we have made life easy.

In order to define your team's aim statements, you must first review some evidence-based guidelines. The best source of guidelines is the National Guideline Clearinghouse, www.guidelines.gov.

A distillation of guidelines to the basic expectations of care is the next step in getting organized for better care delivery. Some example for diabetes, congestive heart failure and asthma are listed below. Other conditions and their expectations for care can be found on the Bureau of Primary Health Care's "Health Disparities" Web site at www.healthdisparities.net/Diabetes_Measures2003-2004.html



Review the guidelines and expectations for care with all team members. Consider what parts of the guidelines may need to be adapted to your local environment. Discuss how the team as a whole can be involved in implementing the processes within the guideline. Do NOT leave implementation up to one person in the practice.

For example, to screen for neuropathy in patients with diabetes, a monofilament sensation test is evidence-based practice. Ensuring that all patients with diabetes receive this test annually requires team effort. Here is how one Washington State based primary care practice implemented the guideline.

Guideline Processes for Diabetic Foot Exams	Person Responsible	When/How/Why
Foot sticker placed on front of chart for all patients with diabetes	Front Desk	At check-in/on MD's advice/after a new diagnosis
Determine date of last foot exam	Medical assistant or person doing vitals	Taken from flow sheet in chart. Annual exam unless otherwise noted. Flowsheet placed on front of chart.
Shoes and socks removed (if due)	Medical assistant or person doing vitals	Date of last exam triggers removal of socks and shoes
Explanation of foot exam (when needed)	Medical assistant or person doing vitals	As shoes and socks are being removed and other vitals being assessed
Monofilament placed on top of chart	Medical assistant or person doing vitals	To make sure right equipment is at hands of provider
Sensate test performed	Trained provider (RN, PA, NP, MD)	Results recorded on flowsheet

Step 3 To Do List

- Make sure you and your team is comfortable with the guidelines and the expectations for care.
- Begin thinking about how to implement guidelines using all members of your team

STEP FOUR:

- **Reviewing data to understand care needs of patients**
- **Assemble key clinical database for these patients**

The Chronic Care Model supports the concepts of proactive population-based care. Population-based care is attention to the health care needs of the entire population of patients, not just those



that show up for appointments. Population-based care relies on several different support activities, including:

- identifying health problems within a defined population of patients to create a subpopulation,
- defining and assuring evidence-based interventions for members of each subpopulation, and
- regularly monitoring patient progress.

It is important to remember that a particular patient may belong to several different subpopulations. For example, a 65 year old woman with diabetes who smokes is in at least three subpopulations: >65 for preventive health care needs, people with diabetes, and tobacco use. Identifying your subpopulation and understanding their general planned care needs is the backbone of the population-based care delivery system. Without identification of the subpopulation members, changes in care cannot be achieved. To identify members, a clinic needs to be able to access data that can distinguish subpopulations with different health problems. ICD 9 or CPT codes from billing data are the most common source for making these distinctions. The ability to tie billing codes to individual patients allows lists to be generated to contact and track patients for delivery of proven interventions and to monitor their progress over time.

Once the subpopulation is identified you may want to choose a subset of patients to conduct small tests of change. This can be your “pilot” population. Recommended size for this group can be up to 200 patients. If the disease population is smaller than 200, then you simply work

with the whole subpopulation. Once you have tested changes in the pilot population and have stable processes of care, you can expand the change to the rest of the clinical subpopulation.

For the pilot subpopulation you will need to get a “sense” of their care to date. Identify the gaps in your care by reviewing a small non-purposeful sample of charts (10-20) and compare their current care to the expectations for care on the preceding pages. This process allows you to see how well you are delivering guideline-based care and what care elements tend to be overlooked in your target population. This brief review will help you target your key changes, which become the basis for measuring how you will affect your patients’ care.

Assemble Key Clinical Database for the Patient

In order to care for your patients you need data that is readily accessible at the point of care. The paper chart is not always the most useful tool for this purpose since it can be disorganized and often not available at the time of care.

Electronic data systems such as simple registries are one way to store patient data on populations for use in individual care and to track outcomes across the population. The advantage of this type of system is that summaries of care can be printed at the time of the visit. You can then use the summaries to collect new data to update the registry. You can also extract population data for monthly reports that track your progress. Teams that implement registries are better prepared for patient visits and find that it can make for simpler charting.. There are both public domain and proprietary registries available to use in practice. The California Health Care Foundation



has two excellent publications on registries: a primer in registry use and functionality, and a comparison of various registry products currently available. To access these publication go to: www.chcf.org/topics/view.cfm?itemID=102741

If you are currently using an Electronic Medical Record, make sure that the registry functionality is available in your system. You can review this functionality by going to: www.improvingchroniccare.org/tools/Registry%20Evaluation%20Form.doc

The most important thing is to not wait for a technological solution to the question of how to create a clinical database. If neither of these options will work for you, a simple card file can be employed to keep track of a few key measures that guide clinical care. Instructions for setting up a card file registry are located on the ICIC Web site.

Step 4 To Do List

- Choose the condition(s) you want to tackle.
- Identify your patients with the target condition. Are billing or coding data available?
- Pick a set of measures to track your progress.
- Take a quick sample of patients that you have identified and assess how your practice is doing on your measures.
- Decide how you want to track data on the population. Do you want to use a card file (non-computerized method), an electronic registry or adapt your EMR?

STEP FIVE

- **Choose measures**

Choose Measures

Measurement is a critical part of testing and implementing changes in your practice. Measures, driven by evidence-based guidelines, tell a team whether the changes they are making actually lead to improvement. There are three types of measures:

Clinical Outcome Measures: patient-level disease measures (e.g. A1c, BP, LDL levels)

Process Measures: care delivery measures (routine screenings and other processes that impact clinical outcomes), and

Balancing Measures: measures to ensure that as the first two types of measures are made, other aspects of the health systems aren't interrupted (e.g., patient/provider satisfaction, wait times, cost of care, etc.)

Measurement for improvement should not be confused with measurement for research. The difference is outlined in this chart:

	Measurement for Research	Measurement for Learning and Process Improvement
Purpose	To discover new knowledge	To bring new knowledge into daily practice
Tests	One large "blind" test	Many sequential, observable tests



Biases	Control for as many biases as possible	Stabilize the biases from test to test
Data	Gather as much data as possible, "just in case"	Gather "just enough" data to learn and complete another cycle
Duration	Can take long periods of time to obtain results	"Small tests of significant changes" accelerates the rate of improvement

Adapted from the Institute for Healthcare Improvement Web site: www.qualityhealthcare.org

Be sure to select a mix of measures. The recommended number of measures is 5 to 8.

Choose or adapt your measures from these examples used by many other teams and organizations around the country. An example using diabetes is provided below. Measures for other conditions such as HIV, depression, and others can be found on the condition-related Health Disparities Collaboratives Web site; i.e., www.healthdisparities.net/collaboratives_depression.html or www.healthdisparities.net/Cardiovascular_Measures2003_2004.html



	Goal	Type of Measure O=Outcome P=process B=Balance
DIABETES		
<i>Office flow/satisfaction</i>		
• cycle time from beginning of appointment to end	45	O
• % of staff rating their workplace as excellent	45 min	B
• % of patients saying their care is excellent	30	B
	30	B
<i>Diabetes-specific</i>		
• % of patients with a HbA1c level of less than 8	75	O
• % of patients with a BP of less than 130/80	60	O
• % of patients with LDL<100	60	O
• % of patients will have smoking status documented	95	P
• % of these smokers will have been offered cessation assistance	70	P
• % of patients will have a dilated eye exam on an annual basis	70	P
• % of patients will have a monofilament foot exam on an annual basis	90	P
• % of patients will have two or more diabetes related office visits each year	80	P
<i>Self-management</i>		
• % with self-management goals	60	P
• % with improved self-confidence in managing their condition	45	O

Data for each of your measures is plotted and reviewed on a monthly basis in order to track your improvement. The measures will provide the means to assess progress toward your aim. A simple standard to monitor your team’s progress is a set of annotated time series graphs (line graphs or run charts). These show progress on the measures of outcomes related to your aim. The following two graphs are examples. Example EXCEL templates are available on our Web site www.improvingchroniccare.org that simply require you to plug in the monthly numbers for your pilot population in order to graph the data.

For CHF got to:

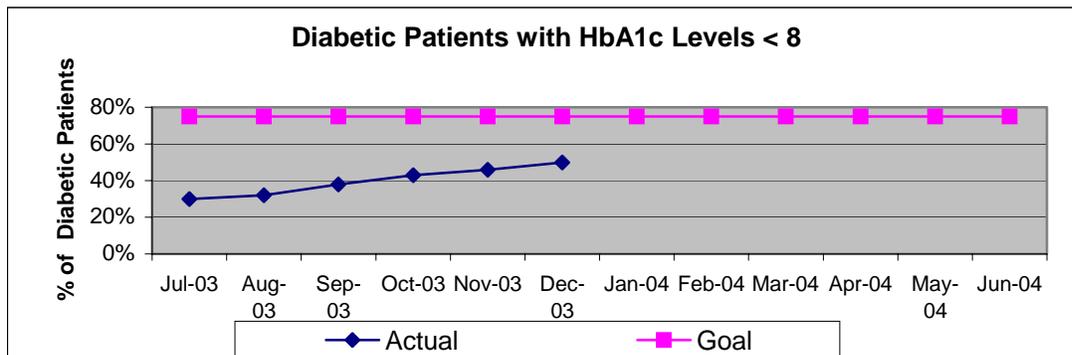
www.improvingchroniccare.org/improvement/docs/CHF_Reporting_Template.xls

For diabetes go to:

www.improvingchroniccare.org/improvement/docs/Diabetes_Reporting_Template.xls

Step 5 To Do List

- Make sure you and your team is comfortable with the guidelines and the expectations for care.
- Begin thinking about how to implement guidelines using all members of your team



STEP SIX:

- **Change care for your first patient**
- **Planned Visits**

Change care for your first patient

The next few sections will show how you can start testing practical changes with actual patients. You will be given some guidelines for how to prepare and run planned visits, and how to deliver evidence-based clinical management and self-management support during the visit. We have provided a PDSA planning form to help plan your changes on page xx. Remember, as you read through materials, to think about how to make this process real in your practice. How can other staff in your practice be involved? How can you engage the patient as a participant in their care? Then begin testing one patient at a time; knowing that you soon will have designed planned care that can be implemented with all patients. You will also learn how to deliver planned care in unplanned or acute care visits; what we call Opportunistic Care.

The Planned Visit

Many healthcare providers believe themselves to already be doing “planned” visits. They note that their patients with chronic conditions come back at defined intervals. Yet upon closer inspection, these visits may look a lot like acute care: the provider might lack necessary information about the patient’s care needs; provider and patient might have different expectations for the visit; and staff may not be fully utilized to help with the organization of the visit and delivery of care. These “check-back” visits, while scheduled in advance, are often not efficient nor productive for the provider and patient. Try the following suggestions for organizing the planned visit:

Assign Team Roles and Responsibilities

Use the “roles grid” on page xx to identify the logistical and clinical tasks that necessary for the preparation and execution of the visit. For example, the following questions might need to be addressed: who is going to call the patient to schedule the visit? Who will room the patient? If the patient has diabetes, who will take off shoes and socks? Who will examine the feet? Who will print off the patient encounter form for use during the visit? All tasks need to be delegated to specific team members so that nothing is left to chance.



Call a Patient in for a Visit

Develop a script for the call, and decide who on the team will make the call. Set the tone and expectations for what the visit will address. The following is a sample script you can adapt to your setting.

“Hello Ms. Smith. This is Karen calling from Dr. Brown’s office. He is interested in making sure all of his patients with chronic conditions are receiving the best possible care. He has asked me to have you come in for visit to discuss your (insert condition here). If you have other health concerns, we may have to address those at a future visit. By focusing on just your (condition here) both you and he can better manage your health. Can we set up a time that is convenient for you? When you come please bring all your current medications (and anything else pertinent to the condition). Thank you. We will call you a day before the visit to make sure you are still able to come.”

If you choose to mail an invitation to patients, be sure to track who responds and who doesn’t. Less than 50% of patients will respond to a letter. You will need to plan on contacting non-responders in another way.

Deliver Clinical Care and Self-management Support

In preparation for the visit, print an encounter form from your registry or pull the chart in advance so that you can review the patient’s care to date. We have provided a sample encounter form. Document what clinical care needs to be done during the visit.

The Acute Care Visit and Planned Care

Regardless of how much you plan, patients still arrive unexpectedly with acute exacerbations. As long as your patient is stable, use this opportunity to provide all or some of their routine chronic care. At least you didn’t have to call them to schedule an appointment! Then you can fold them into your planned care visit schedule. To take advantage of this opportunity, try the following:

Get as Much Done as You Can

1. Consider developing standing orders for these kinds of visits.
2. Make sure the team knows their roles and responsibilities around the standing orders.
3. Find or develop a tool to keep track of what you’ve done and still need to do.
4. Introduce the concept of self-management to the patient and discuss how you would like them to start having planned visits with your team, and why.
5. Schedule their first planned care visit!

Determine How To Meet Regularly

At least until new roles are well integrated into the normal work flow, many practices have team huddles for 5-10 minutes in the morning to review the schedule and identify chronic care patients coming in that day for an acute care visit. Decide how best to meet as a team to manage these patients. Determine the best intervals and timing for these meetings and stick to them. They help the team stay focused on the redesign in your practice and create a sense of “one for all” spirit in practice.



Step 6 To Do List

- Watch the Planned Care Video with your whole team.
- Assign roles and tasks using the team roles grid.
- Talk about who would like to do what as part of the team
- Call patient tomorrow to schedule a planned visit
- Consider using standing orders for some care processes
- Prepare a plan for role changes if patient shows for an acute visit.

STEP SEVEN:

- **Building Self-management Support into the Planned Visit**

What is Self-management?

“The individual’s ability to manage the symptoms, treatment, physical and social consequences and lifestyle change inherent in living with a chronic condition.” Barlow et al, Patient Educ Couns 2002;48:177

What is Self-management Support?

Supporting patients in the tasks of managing their own chronic condition(s) calls for more than education, in which patients gain knowledge about their condition. Patients need to have the skills and confidence to effectively manage the condition on their own. Researchers have described three categories of tasks that patients with chronic conditions perform. The first is managing the illness (such as learning to take medications and monitor the condition), the second is to carry on normal roles and activities and the third is to manage the emotional impact of the illness. Since every patient with a chronic condition is a self-manager, responsible for most of his or her own care, support of self-management is an ongoing activity for the health care team. The goal of self-management support is to assist and sustain the patient's ability to engage in self-management behaviors that fit within their own life patterns. The creation of a personal action plan is an important way in which providers can support their patients’ self-management goals. Another key skill is to help patients learn to solve problems.

Getting Started

Prepare to introduce the concept of self-management to the patient. Help the patient understand that they are the managers of their health with your assistance.

Help the patient determine his or her own priorities. Ask about and understand their health beliefs, and address problems from the perspective of the patient. Ask the patient about their living circumstances. Asking about these issues and working to understand the patient’s perspective will allow you to collaboratively set self-management goals that the patient wants, versus based solely on your clinical priorities, if the two are not congruent. (NOTE: Once you have the patient achieving success in setting their own personal health care goals, you can weave in your desired goals over time.) Assess the patient’s confidence in carrying out a plan, and be sure to follow-up to help them achieve the goal and problem-solve barriers.

It is recommended that the physician, nurse practitioner or physician’s assistant introduce this concept as a prescription for care to increase acceptance by the patient. The provider may then



want to pass the patient to someone who can help set goals. There are tools on page xx for setting goals with patients.

Collect data about goals set and achieved to be used in the next visit. The patient encounter form from the registry or a structured encounter form of your making is critical to successful data capture. Make sure these data are entered in the registry or are easily accessible for use at the next visit.

Agree on when and how you and patient will follow-up on the self-management goals that were set, and write this in the patient plan. Agree on an interval between planned visits based on clinical need and patient preference. Make sure follow-up to all clinical and self-management task is part of your daily practice of care and that the patient receives a copy of the plan.

Making a specific plan

The plan should contain all of the following steps:

- *Exactly **what** are you going to do?* How will you eat less, how far will you walk, what meditative technique will you practice?
- ***How much** will you do?* Will you walk 2 blocks walk for 20 minutes, not eat between meals for 2 days, practice yoga for 10 minutes?
- ***When** will you do this?* Will you do this before lunch, in the shower, when I arrive home from work?
- ***How often** will you do the activity?* It's recommended to decide to do something three or four times a week. If you do more, so much the better but the goal is to do your activity often enough to be successful, and yet not feel pressured on a daily basis.
- ***Anticipated barriers*** Help the patient imagine what might get in the way of their plan.
- ***Potential solutions for barriers*** Have the patient come up with ideas that might help them overcome the barriers
- ***Follow-up plan*** When, where and how will you check in with the patient about their experience with the plan
- ***Confidence rating*** On a scale of 1-10, with 1 being no confidence that the plan can be completed to 10 being absolutely certain that they can complete the plan, have the patient rate their confidence level.

When implementing an action plan, the start slowly and build successes. If they can walk only for one minute, suggest walking one minute once every hour or two, not with walking a mile all at once, start the program. If the goal is to lose weight, set a goal based on existing eating behaviors, such as not eating after dinner, rather than drastically changing eating patterns.

Tips for Creating a Successful Action Plan

- Begin with something the patient wants to do
- Make the goal reasonable (something the patient can reasonably expect to be able to accomplish this week)
- Strive for a change that is behavior-specific (losing weight is not a behavior; not eating in the evenings while watching television is a behavior)



- Ensure that the plan answers these questions: *what; how much; when* (think about the day/the week – which days, what times, etc.); *how often?*
- Start when the patient has a confidence level of 7 or greater (this is the belief that they can, and will, complete the entire contract)

Goals versus behavior-specific changes

Keep in mind the difference between a healthy change, a goal that is set to reach that change and the behavior required to attain that goal. For example:

- **Healthy Change:** *Lose weight*
Goal: *lose 4 pounds in the next month*
Behavior: *eating carrots for a snack, not chocolate*
- **Healthy Change:** *Exercise more*
Goal: *exercise for 20 minutes twice a week*
Behavior: *walk to work*
- **Healthy Change:** *reduce stress levels*
Goal: *spend 15 minutes a day relaxing*
Behavior: *listen to meditation tape*

Example Action Plan

Name: *Joe Smith*

Date: *June 22, 2004*

Phone: *(206) 555-1234*

The healthy change I want to make is: *Start a walking program*

My goal for the next month is: *To walk three times per week*

The steps I will take to achieve my goal are (what, when, where, how much, how often):

I will walk around my neighborhood for 15 minutes, directly after I get home from work on Monday, Wednesday, and Friday.

The things that could make it difficult to achieve my goal include:

My sister may need to talk on the phone after work, and it might be too late to go after we talk.

My plan for overcoming these difficulties includes:

I can ask my sister if she absolutely needs to talk that day. If I have to miss a regular walking time, I can make up that day by driving to the park on the weekend and walk for 15 minutes in the morning, then resume my regular plan the following week.

Support/resources I will need to achieve my goal include:

I need to buy a new pair of sneakers and extra-cushioned socks so that my feet don't get blisters. I would feel more comfortable walking if I had a dog with me. I can ask my neighbors if I can 'borrow' Sparky, their dog.



My confidence level (scale of 1-10, 10 being completely confident that you can achieve the entire plan.) 8

Review date: *June 29, 2004 (in one week)* Review method (phone, email, in-person): *In-person*

Problem-solving Techniques

It can be helpful to remind patients that change often takes time and effort. Hearing a health care provider reiterate that self-management can require persistence, and that success is possible – even when obstacles are encountered - can be just what the patient needs when the going gets a bit rough. The following method has been shown to help patients find solutions to problems.

- **Identify the problem**
Help the patient get to the root of the issue. For example, is it that they have problems maintaining a diet when they eat out, or their family doesn't understand their wishes to eat a healthier diet?
- **List ideas to solve the problem**
Help the patient come up with many ideas, some they have tried before to some that may seem ridiculous, and to come up with a list of ideas that might work.
- **Choose one method to try**
Out of all the options listed, help the patient choose one, or a combination of ideas that they think will work for them.
- **Try it for 2 weeks.** Encourage patients to give each idea a good trial period to see if it will work.
- **Evaluate the results**
After the patient's given the idea a fair trial, assess the outcome.
- **Try another idea if the first one doesn't work**
Have the patient return to their list of ideas and try another.
- **Locate other resources**
Resources can be friends, family, members of their health care team, or a community link such as the public library or a health fair.
- **Accept that the problem may not be solvable right now**
Remind the patient that if the solutions they came up with this time haven't worked, that it doesn't mean that other solutions won't be effective at another time, or that different problems can't be solved using this solution. Encourage them to keep trying; do your best to foster hope and persistence.

Other useful resources for delivering self-management support can be found on page xx of the appendices.

Much of the content above has been adapted from Lorig et al, [Living a Healthy Life with Chronic Conditions](#). Bull Publishing Company, 2000.



Step 7 To Do List

- Watch the self-management support section of the Planned Care Video with your whole team.
- Assign self-mgt. support roles and tasks using the team roles grid.
- Test your process with one patient already scheduled for a visit
- Conduct a follow-up interaction around set goal(s)
- Prepare a plan for role changes if patient shows for an acute visit.
- Design ways to record goals, etc in the medical record or registry.

IN SUMMARY

This manual is designed to get you started at redesigning your care delivery to better meet the needs of the chronically ill patient. Remember to think hard about how these materials can be made relevant to your practice setting and style. Be creative when testing ideas for improving. To use a well-worn adage, “Think outside the box!” The acute care model of care is a reactive model for just-in-time care, and in general it serves you well. But for the increasing populations of patients with chronic care needs, a more proactive system needs to be in place. You are one of the early creators of that system.

We welcome, and are seeking, your feedback on this manual. Please send suggestions or comments to Mike Hindmarsh, Manager of Clinical Improvement, at:
mike@improvingchroniccare.org

Thank you!