

PRISM Meeting

The Planned Care Model – Interactive Component

Goal: To provide the attendees an opportunity to implement the teachings of the planned care model using a patient example.

Objectives: Attendees to brainstorm planned care model ideas from each of the major components of the model; Self-management support, Delivery System Design, Clinical Decision Support, Clinical Information Systems, Community Resources.

Structure:

1. Break the group into two sections. One facilitator to each group.
2. Each section is provided a patient visit example of the standard practice model. Instructions to the group; brainstorm methods to implement the Planned Care Model to improve the experience for the staff and the patient.
3. Have a member of the group write the ideas on a flip chart. Divide the ideas into the following sections; Self-management support, Delivery System Design, Clinical Decision Support, Clinical Information Systems, Community Resources.
4. Have a member of each break-out group provide a summary of their discussion to the whole group.

Example 1:

Larry Lizard is at your office for his yearly physical. You spend 25 minutes of his 30 minute appointment reviewing his 3 inch thick chart stuffed with his history of diabetes, cold-bloodedness and excema (scaly manifestation). After a brief physical and a script for a defoliating lotion you remember as he is leaving that he is a tobacco user...

Doc: Larry, You really need to cut out the cigarettes. You know that smoking and diabetes is putting you at very high risk for a heart attack.

Larry: Doc, I have heard it a million times. I am working on it.

Doc: You really should try to quit.

Larry: Your right, see you next year.

Self-management support:

1. Posters / literature in the waiting room / exam room
2. Self-care tool to identify barriers and confidence in quitting.
3. Collaborative goal setting.
4. Refer to tobacco helpline

Delivery System Design: prepared / proactive practice team.

1. Charts: Tobacco documentation stamp / problem list
2. Tobacco use as a vital sign at every visit
3. Training for clinical staff on tobacco cessation
4. Empower nurses to handout helpline information

5. Fax referral to Helpline at provider's fingertips.
6. Follow-up call to review collaborative goal setting.
7. Schedule a visit to address tobacco use.

Clinical Decision Support:

1. Treating Tobacco Use and Dependence: US Dep Health and Human Services.
2. Medication Guides

Clinical Information Systems: The CIR / EMR allows a practice to pull a list of...

1. Rates of tobacco use in your practice
2. Patients using tobacco and interested in quitting
3. Patients using tobacco who have diabetes

Community Resources:

1. Have them easily available for providers and patients.
2. Fax referrals
3. Detailed info for patients and staff for each referral resource. Contact info, cost, insurance, hours, etc...

Example 2: Mrs. Wheezy brings her 6 year old son in for a 15 minute visit for cough. She mentions that they were in the ER 2 weeks ago and were given a horrible tasting medicine for 3 days. There was some sort of breathing in and out device. A pink one he was using before the visit and now a blue one and purple one after the visit. She does not have the medicines with her. Reviewing the chart you see that he has been on albuterol, pulmicort, flovent, xopenex and accuneb at different times over the past 4 years. 14 minutes into the visit you are able to figure out what medications he has been on. You start to wheeze...

Self-management support:

1. Set goals with family / determine barriers
2. Review action plan / school plan
3. Device use education
4. Educate to always bring asthma meds / devices to appointments
5. Refer to asthma education

Delivery System Design: prepared / proactive practice team.

1. Front Staff:
 - Mark charts so that front staff knows when an asthmatic has an appointment
 - Increase time of appointment
 - Place asthma encounter forms on the chart
 - Distribute ACT (asthma survey) to family to complete in waiting room
2. Nurses:
 - Vital signs including peak flow
 - Pulmonary function testing before provider sees patient
 - Trained to provide asthma education: Symptoms, prevention, meds, devices
3. Provider:
 - Schedule a follow-up visit / chart to nurse for follow-up call

Clinical Decision Support:

1. Asthma encounter forms / ACT / Action Plans
2. National guidelines / medication Guides
3. Specialist referral

Clinical Information Systems: The CIR / EMR allows a practice to pull a list of...

1. Patients with asthma in your practice
2. Patients with persistent asthma
3. Track Flu shots / medications / admissions / ER visits / office visits

Community Resources:

1. Have them easily available for providers and patients.
2. Fax referral for asthma education
3. Detailed info for patients and staff for each referral resource. Contact info, cost, insurance, hours, etc...