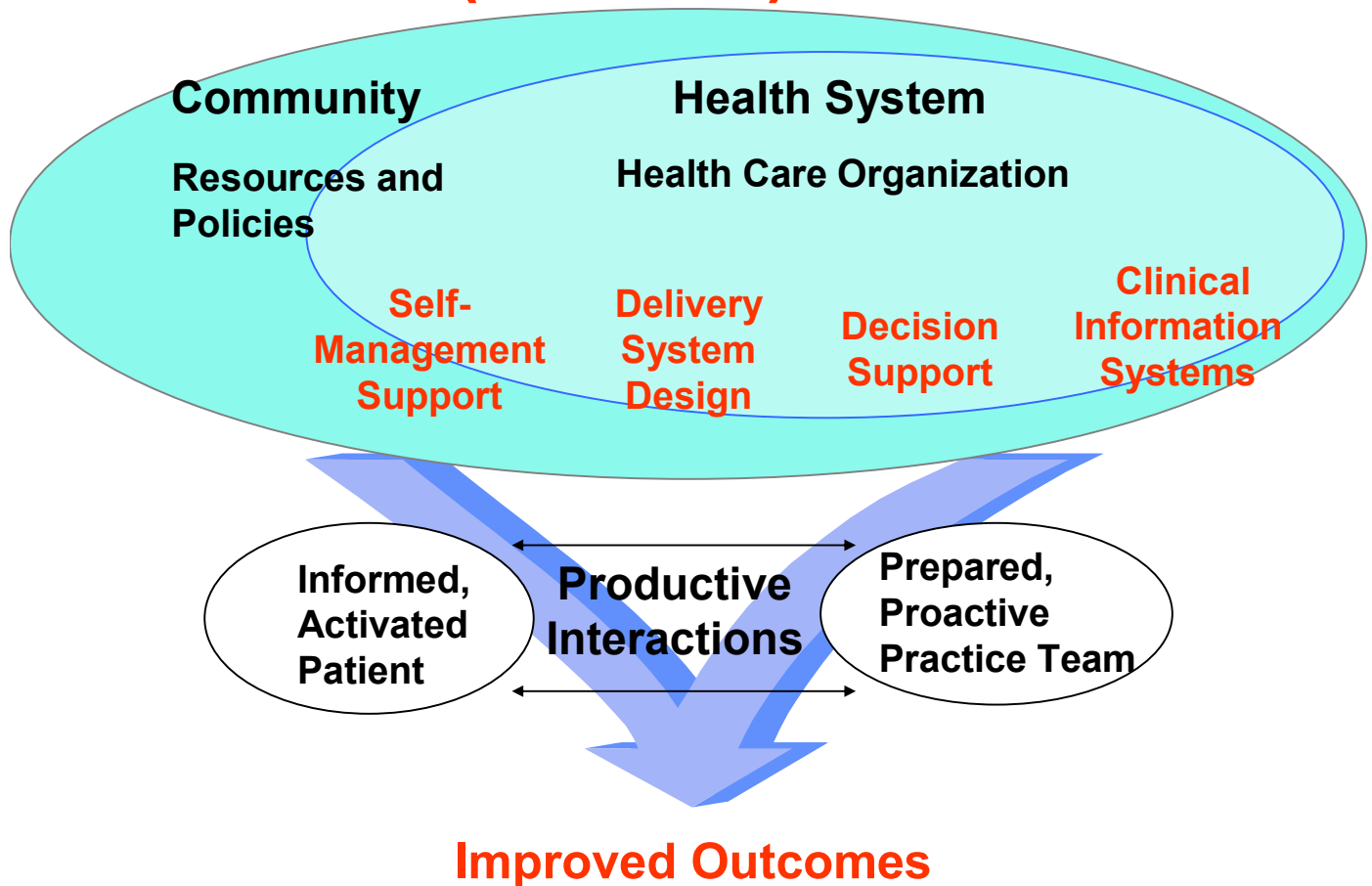


MaineHealth Learning Community Framework for Improvement

Planned (Chronic) Care Model



5 Key Changes of the Planned (Chronic) Care Model

I. **Self-Management Support** - Educate patients about their chronic illness

- Deliver consistent, focused messages by using MaineHealth Clinical Integration patient educational and self-management tools.
- Promote self-management skills.
- Use a collaborative, supportive approach to setting goals with patients.
- Engage patients in the use of the Self-Care Report from the Clinical Improvement Registry (if applicable).

II. **Healthcare (Delivery) System Design** - Identify care team in your practice and clarify roles for each team member:

- Identify roles/expectations of each team member.
- Find opportunities to enhance team functionality and communication.
- Identify additional team members as needed to carry out planned changes.

III. **Decision Support** - Incorporate evidence based guidelines and Standards of Care into daily workflow:

- Connect with specialists on tough cases.
- Use the NHLBI Asthma and Obesity guidelines.
- Use the AHA/ACC Cardiovascular Disease Secondary Prevention guidelines.
- Use the following resources to help you screen for, diagnosis, and treat depression:
 - The Patient Health Questionnaire (PHQ-9)
 - Depression Clinical Tools on the MaineHealth website including Diagnosis and Management of Depression using the PHQ-9
 - eLearn modules at [Http://elearn.mmc.org/depression](http://elearn.mmc.org/depression)
- Use the ADA Standards of Care, and TARGET Diabetes tools that incorporate these Standards (e.g. flowsheets, algorithms) to improve consistency of care for patients with diabetes.

IV. *Clinical Information Systems* - Use a registry or an electronic medical record (EMR) to improve care:

- Track population and outcomes data on key asthma, cardiovascular, depression, and diabetes measures.
- Identify opportunities to improve care and outcomes by using a registry or an EMR to identify patients who would benefit from pro-active care – e.g.
 - Identify patients with HbA1c > 9.0% by using the Diabetes Progress Report in the Clinical Improvement Registry and create a specific plan to improve glycemic control (e.g. referral to diabetes educator, intensifying medical treatment, etc.).
 - Identify patients with persistent asthma who have not been prescribed a controller medication or who do not have a documented severity classification and proactively get them in for an asthma visit. Refer patients to a care manager or to asthma education.
 - Identify patients with a PHQ-9 >15 for referral to a care manager, medication review, and self-care action plan.

V. *Community* - Partner with professionals in your community who provide resources for patients with asthma, cardiovascular disease, depression, and diabetes:

- Identify and connect with clinical educators e.g. asthma and diabetes educators, in your community.
- Increase referrals for initial and follow-up to formal Diabetes Self-Management Education.
- Integrate nurse care managers as applicable for your team.
- Identify your local Healthy Maine Partnership and use their resources for patient support.
- Connect patients with local support groups or health education classes held at your local hospital.
- Identify the closest MaineHealth Learning Resource Center or the health education center at your local hospital.

MaineHealth Learning Community

Plan Do Study Act Road Map

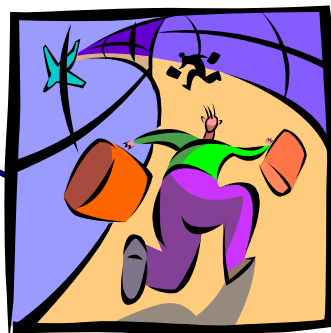
Develop Your Roadmap:

Identify the change you would like to attempt and plan an approach for testing it.



Run The Course:

Take the steps that have been planned to test the change.



PLAN

DO

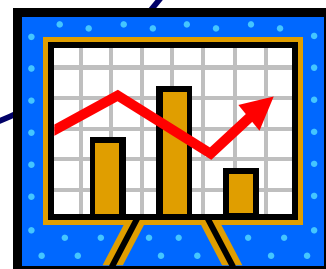
ACT

STUDY



Choose Your Path:

Decide if the results you have seen are the direction you want to go.
If so, move forward.
If not, try a different change.



Review Your Progress:

Look at the data you have gathered to decide if the change you have tried is the best fit.

PDSA Cycle of Change

During an improvement process, you are encouraged to try frequent, small tests of change to improve the care of patients with asthma, cardiovascular disease, depression, and diabetes in your practice. We suggest you use “PDSA” cycles to plan and study the improvement changes you put in place.

P = Plan: *Develop Your Roadmap*

This is the change you want to test. It includes whom you are testing the change, when you are testing, where you are testing, and what you expect to happen. It also includes how you will test the change and how you will collect data to “study” the change. Remember when planning to keep your initial changes small (e.g. try a new form in the office for 1 day or 1 week; see how a new process for referral to diabetes education works for the next 5 patients).

D = Do: *Run the Course*

This is the action you take to carry out the change or test within your practice.

S = Study: *Review Your Progress*

This is the process you use to study the change that was actually put in place, or tested. It should include what actually happened, including observation of problems and successes. It includes what you learned and how the outcome compares to your prediction made during planning. Again, remember to keep the “study” small (e.g. what happened over one week, with the last five patients).

A = Act: *Choose Your Path*

This is your refinement of your plan as a result of the information you gained from Do and Study. It includes the changes you will make before your next PDSA test cycle and your readiness to implement the change.

In the following pages, we have included examples of PDSA cycles that are adapted from actual PDSA cycles reported by teams working on process improvements in their practice. Teams are encouraged to rotate focus to each of the 5 Key Change areas by doing this you are implementing elements of the “Chronic Care Model” in your practice!

You will find a “PDSA” worksheet at the back.

PDSA Tip Sheet

What change can we make that will result in an improvement?

- Changes based on scientific evidence
- Change based on the Chronic Care Model
- Changes that worked for another practice
- Changes that you see on storyboards at meetings
- Changes that you hear about on teleconferences or read about on websites

Why test changes before implementation?

- To evaluate the actual results against the expected results
- To learn how to adapt the change to your specific practice environment
- To identify unanticipated effects of the change
- To minimize resistance to full implementation

Plan-Do-Study-Act (PDSA)

- Be systematic in your approach to PDSA Cycles
- Be diligent about documenting each step in the PDSA Cycle

Testing on a Small Scale

- Test the change with members of your improvement team that helped develop it before introducing to the change to others in your practice
- Test the change side-by-side with existing practice operations
- Test using the rule of one (one clinician, one patient, one day, one week)

How will we know if the change is an improvement?

Data...Data...Data

- **Plan** Develop a data collection process
- **Do** Collect data during the test
- **Study** Compile and analyze the data collected during the test
- **Act** Summarize your findings and make a decision to adapt the change for another test or implement as is

PDSA Examples for the 5 Key Changes

I. *Self-Management Support* - Educate patients about their chronic illness

- Deliver consistent, focused messages by using MaineHealth Clinical Integration patient educational and self-management tools.
- Promote self-management skills.
- Use a collaborative, supportive approach to setting goals with patients.
- Engage patients in the use of the Self-Care Report from the **Clinical Improvement Registry** (if applicable).

PDSA examples for this category:

- Use the Asthma, Cardiovascular, Depression, and /or Diabetes Self-Care Report from the **Clinical Improvement Registry (CIR)** to review key clinical goals with patients.
- Develop a Self-Care Action Plan with each patient (MaineHealth plan is available at www.mainehealth.org).
- Incorporate healthy weight messages into the practice and patient visits.
- Use the MaineHealth patient education booklets (asthma, cardiovascular disease, depression, and diabetes) with recently diagnosed patients and have staff review targeted topics with them.
- Set up a system in your office to ensure that patients with chronic conditions are referred to (and complete!) Living Well With Chronic Conditions.

II. *Healthcare (Delivery) System Design* - Identify care team in your practice and clarify roles for each team member:

- Identify roles/expectations of each team member.
- Find opportunities to enhance team functionality and communication.
- Identify additional team members as needed to carry out planned changes.

PDSA examples for this category:

- Engage and maximize all staff members by having them work to their full potential; e.g.,
 - The MA could remove the patient's socks and do a visual foot exam prior to the doctor seeing the patient.
 - The MA or nurse could talk with the patient about setting a self-management goal prior to the doctor seeing the patient.
- Implement standards orders for missing lab tests for the patient, e.g.,
 - LDL; HbA1c
- Identify time for your team to meet, plan and evaluate PDSA's, review progress, etc.
- Designate a central location in your office for all self-management educational tools (file drawer, shelf, etc) so all staff can regularly access the materials for patients.
- Engage others in your practice by: Sharing your monthly run charts either at meetings or in staff only areas.
- If you have access to a care manager in your practice, invite her/him to be a team member to suggest ways to improve care in the practice.

III. **Decision Support** – Incorporate evidence based guidelines and Standards of Care into daily workflow:

- Connect with specialists on tough cases.
- Use the NHLBI Asthma and Obesity guidelines.
- Use the AHA/ACC Cardiovascular Disease Secondary Prevention guidelines.
- Use the following resources to help you screen for, diagnosis, and treat depression:
 - The Patient Health Questionnaire (PHQ-9)
 - Depression Clinical Tools on the MaineHealth website including Diagnosis and Management of Depression using the PHQ-9
 - eLearn modules at <http://elearn.mmc.org/depression>
- Use the ADA Standards of Care, and TARGET Diabetes tools that incorporate these Standards (e.g. flowsheets, algorithms) to improve consistency of care for patients with diabetes.

PDSA examples for this category:

- Keep copies of the PHQ-9 and the guideline, Diagnosis and Management of Depression Using the PHQ-9, in each exam room.
- Ensure that all providers in your office have completed depression eLearn module1: Using the PHQ-9 for Diagnosis and Management of Depression.
- Use TARGET Diabetes flow sheets as a template for adhering to ADA recommended schedules for diabetes testing.
- Post AH! Asthma flipchart guidelines and peak flow reference charts in exam room for easy access by providers.
- Post a BMI Chart in exam room for easy access by providers and patients.
- Use the Office Visit Summary from the **Clinical Improvement Registry** (or one of your own design from the registry you are using) on the front of the patient chart prior to the visit.

IV. **Clinical Information Systems** – Use a registry or an electronic medical record (EMR) to improve care:

- Track population and outcomes data on key asthma, cardiovascular, depression, and diabetes measures.
- Identify opportunities to improve care and outcomes by using a registry or an EMR to identify patients who would benefit from pro-active care e.g.,
 - Identify patients with HbA1c > 9.0% by using the Diabetes Progress Report in the **Clinical Improvement Registry** and create a specific plan to improve glycemic control (e.g. referral to diabetes educator, intensifying medical treatment, etc.).
 - Identify patients with persistent asthma who have not been prescribed a controller medication or who do not have a documented severity classification and proactively get them in for an asthma visit. Refer patients to a care manager or to asthma education.
 - Identify patients with a PHQ-9 >15 for referral to a care manager, medication review, and self-care action plan.

PDSA examples for this category:

- Ensure that all asthma, cardiovascular, depression, and diabetes are identified in your registry.
- Establish or confirm the integration of your registry within your office workflow e.g.,
 - Are you able to enter information into your registry and pull the information out of your registry using a report system on a regular basis?
- Use the **CIR** to generate a list of patients needing care for example:
 - For depression: patients with a PHQ-9 score over 15 who have not been referred to a care manager or have not received depression education materials.
 - For diabetes: patients not seen in the last 6 mos; patients with HbA1c > 9.0%; LDL > 100; patients needing eye exam, etc.
 - For asthma: patients without an asthma severity classification; patients needing a flu shot; patients with persistent asthma who have not prescribed a controller medication.
 - For cardiovascular disease: patients with a BP>140/90; HDL>40; tobacco status not documented and treatment offer not recorded

V. **Community** – Partner with professionals in your community who provide resources for patients with asthma, cardiovascular disease, depression, and diabetes.

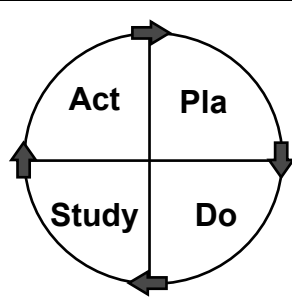
- Identify and connect with clinical educators e.g. asthma and diabetes educators, in your community.
- Increase referrals for initial and follow-up to formal Diabetes Self-Management Education.
- Integrate nurse care managers as applicable for your team.
- Identify your local Healthy Maine Partnership and use their resources for patient support.
- Connect patients with local support groups or health education classes held at your local hospital.
- Identify the closest MaineHealth Learning Resource Center or the health education center at your local hospital.

PDSA examples for this category:

- Invite your local asthma/diabetes educator(s) to your practice to update staff on clinical standards of care for asthma/diabetes.
- Set up a system in your office to ensure that patients with diabetes are referred to (and complete!) a diabetes self-management training program.
- Using your registry or EMR, run a list of your patients with diabetes not meeting goals (e.g. HbA1c > 9.0%) and ask your local diabetes educator to let you know which of these patients have never been through formal Diabetes Self-Management Education program (formerly know as ADEF). Work with your local educators to get as many of these patients into the program as possible.
- Contact your local Healthy Maine Partnership to identify walking trails in your community.
- Contact your local supermarket to set up a healthy foods tour for your patients.

Practice Name: _____ Date: _____

MODEL FOR IMPROVEMENT



CYCLE FOR LEARNING AND IMPROVEMENT

Objective:

PLAN:

Questions:

Predictions:

Plan for change or test: who, what, when, where

Plan for collection of data: who, what, when, where

DO: Carry out the change or test; Collect data and begin analysis.

STUDY: Complete analysis of data; Summarize what was learned.

ACT: Are we ready to make a change? Plan for the next cycle.

Adapted from the Institute for Healthcare Improvement's Breakthrough Series – www.ihl.org – 617.754.4800

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