Transforming Workflow Processes for Chronic Disease Management

*Learning & Action Networks Session*

Rebecca Durham: Workflow
Janet Tennison: Self-Management
Kelly Dowland: MA-Led Program
Chronic Disease List

- High blood pressure
- High cholesterol
- Chronic kidney disease
- Arthritis
- Diabetes

- Depression
- Alzheimer’s disease
- Cancer
- Osteoporosis
- Asthma
Chronic Disease Facts

- More than 145 million people, or almost half of all Americans, live with a chronic condition.
- The number of people living with diabetes is projected to increase.

Huang E S et al. Dia Care 2009;32:2225-2229
Partnership for Solutions: Johns Hopkins University, Baltimore, MD for The Robert Wood Johnson Foundation (September 2004 Update). "Chronic Conditions: Making the Case for Ongoing Care".
Developed by Janet Tennison, PHD, Adapted from Kirsch et. al., 2008
Objectives

• Apply evidence-based practices for chronic disease management by:
  • Transforming workflow and promoting efficiencies by streamlining processes
  • Implementing self-management processes for patients with chronic diseases
• Recognize how Medical Assistants can be better utilized to facilitate self-management
Hypertension Facts

• 1 in 3 Americans has hypertension that is not controlled

• Among the 35.8 million persons with uncontrolled hypertension, 32.0 million (89.4%) reported having a usual source of health care

• More than half (51.8%), an estimated 14.1 million, of Medicare beneficiaries with hypertension had uncontrolled hypertension

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6135a3.htm
Table Exercise

1. Patient with HTN presents for care and completes intake for BP appointment
2. Patient’s assessment and vital signs completed
3. Assessment and vital signs entered into the medical record
4. Provider assesses patient
5. BP management is addressed with patient
6. Patient is scheduled for follow-up as medically indicated
Workflow Processes to Improve Outcomes

- **Accuracy of blood pressure (BP) readings**
- **Use of the electronic health record (EHR)**

**DO YOU MEASURE BLOOD PRESSURE? Assess Your Clinic**

**Accuracy of Blood Pressure Readings**

- Use validated, automated device\(^1,2\)
- Maintain automated machine regularly\(^1\)
- Perform measurement with patient seated in chair with back support\(^1\)
- Perform measurement with patient feet flat on the floor or a footstool, legs uncrossed\(^2\)
- Perform measurement after patient rests quietly for 5 minutes. Be sure the patient has emptied the bladder prior to the measurement\(^5\)
- Perform measurement with patient arm and cuff at mid-sternal level\(^5\)
- Have multiple cuff sizes available and use appropriately\(^5\)
- Have cuff measurement guide readily available and used
- If initial measurement is above goal, repeat the measurement twice at one minute intervals and average the last two of the three blood pressure readings\(^6\)

**Office Policies and Procedures**

- Have written blood pressure measurement training standards for office staff and providers - review annually\(^6\)
- Have written blood pressure measurement training standards for patients\(^5\)
- Have blood pressure measurement training material for home monitoring available and distribute to patients\(^5\)\(^7,8\)\(^9\)
- Schedule yearly blood pressure measurement training for new staff, office staff and providers\(^1\)\(^10\)\(^11\)
- Designate patient educator for hypertension and accurate home measurement\(^5\)
- Review the patient record before the office visit to identify ways to improve blood pressure control\(^5\)
- Provide blood pressure check for patients without co-payment or appointment\(^5,11\)

**Documentation, Alerts, EHR**

- Have and maintain clear blood pressure documentation standards\(^5,11\)
- Maintain system to alert provider of elevated blood pressure readings\(^12\)
- Maintain system (e.g. EHR) to alert patient of missed appointment or overdue blood pressure check\(^12\)\(^13\)\(^14\)
- Use EHR to query patients with a diagnosis of hypertension\(^14\)\(^15\)\(^16\)
- Use EHR to query rates of controlled and uncontrolled hypertension\(^14,16\)
- Use EHR to provide a visit summary and follow-up guidance that can be printed for the patient\(^16\)
Workflow Processes to Improve Outcomes

• **Accuracy of BP readings**
  - Patient seated in chair with back support
  - Patient feet flat on the floor or a footstool, legs uncrossed
  - Patient rests quietly for 5 minutes. Be sure the patient has emptied the bladder prior to the measurement
  - Perform measurement with arm and cuff at mid-sternal level
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• **EHR**
  - Maintain system to alert provider of elevated blood pressure readings
  - Use EHR to provide a visit summary and follow-up guidance that can be printed for the patient
Exercise

What new steps can you add to the workflow that can improve chronic care from what you have seen so far?

Feedback
Self-Management Definition

Systematic education & supportive interventions to increase patients’ skills and confidence to manage their own health problems

Patient Education ≠ Self Management

Research Findings

- Didactic education alone does not improve outcomes of asthma, diabetes and hypertension care.¹
- Strategies that empower, activate and engage patients in a more collaborative process are more effective than traditional educational approaches.²

Patient Education + Self-Management = Success

Yes, if you are:

• Assessing patients’ needs
• Setting a goal with them
• Developing an action plan to meet the goal
• Arranging regular follow up to review progress towards the goal
Assessing Patient Needs

- Understanding of diagnosis/treatment
- Goals for care/desired outcomes
- Perception of associated problems
- Preferred solutions to problems
- Concerns about health/diagnosis
- How health decisions are usually made
- Education preferences (class, webinar, book)
Setting Goals

- The most important reasons why I want to make this change are:

- My main goals for myself in making this change are:

- I plan to do these things in order to accomplish my goals:
  
  **Specific Action** | **When?**

- Other people could help me with change in these ways:
  
  **Person** | **Possible ways to help**

- These are some possible obstacles to change, and how I could handle them:
  
  **Possible obstacles to change** | **How to respond**

- I will know that my plan is working when I see these results:
My Diabetes Plan

Name: ___________________________ Date: ________________

1. How are you doing with managing your diabetes?
   - [ ] Excellent
   - [ ] Good
   - [ ] Not Good
   - [ ] Not Sure

2. How were the results of your last A1C test (sometimes called the Hemoglobin AIC test, a three-month average of your blood sugars)?
   - [ ] Excellent
   - [ ] Good
   - [ ] Not Good
   - [ ] Not Sure

3. I am doing well with:
   - [ ] Exercising.
   - [ ] Eating better foods.
   - [ ] Taking my medicine.
   - [ ] Checking my blood sugar.
   - [ ] Cutting down on smoking.
   - [ ] Reducing my stress.
   - Other: ___________________________

4. I want to do better with:
   - [ ] Exercising.
   - [ ] Eating better foods.
   - [ ] Taking my medicine.
   - [ ] Checking my blood sugar.
   - [ ] Cutting down on smoking.
   - [ ] Reducing my stress.
   - Other: ___________________________

5. To improve my health, I will work on one of my chosen activities. Here is what I can do:

   How much: ___________________________
   How often: ___________________________

6. This is how sure I am that I will be able to do this: (circle a number)
   - [ ] Not sure
   - [ ] Very Sure
   - [ ] Very Sure
   - [ ] Very Sure
   - [ ] Very Sure
   - [ ] Very Sure
   - [ ] Very Sure
   - [ ] Very Sure
   - [ ] Very Sure
   - [ ] Very Sure
   - [ ] Very Sure
MA Workflow Managers

Expanded Pre-Visit Work for Dedicated Medical Assistant

Dedicated Medical Assistant as Flow Manager

New Staffing Models for Primary Care. WIHI, October 10, 2010. Available at IHI.org/WIHI
Dedicated Medical Assistant standard work for rooming Geriatric patients

Patient Care Checklist

- Patient has Advance Care Planning documents on file
- A Falls Risk Assessment has been completed in the current calendar year
- A PHQ-2 or PHQ-9 has been completed in the current calendar year

Visit Information

Falling down
- Are you bed or wheelchair confined?
- Do you use an assistive device such as a cane or walker?
- Have you fallen in the past year?
- Do you have difficulty walking, getting out of bed or chair?
- Are you afraid of falling?

Fractures in the past year
- Have you broken any bones in the past year?

New Staffing Models for Primary Care. WIHI, October 10, 2010. Available at IHI.org/WIHI
Discussion Question

How can you add self-management elements into your workflow?
Implementation Ideas – Having a Standardized Process

- How do you implement all the steps? Who does what, when, where, how?
  - Promote team-based care; use your entire staff
  - Consider using a well trained medical assistant to oversee program
  - Use EHR self-management templates
  - Give patients copies of their action plans
  - Identify and use community resources like Chronic Disease Self-Management Education (CDSME)
Medical Assistant Led Chronic Disease Management

Kelly Dowland, Care Coordinator Director
St. Mark’s Family Medicine Residency
Utah HealthCare Institute
• Hypothesis: An MA-led care coordination team can provide significant assistance in improving patients’ ability to self manage (and clinical outcomes)
• Developed 2-day training session for nursing staff at St. Mark’s Family Medicine
• Staff implemented processes and now have fully functioning care coordination program
Training Content

• Identify high-risk patients
• Assess needs
• Care coordination plan development
• Implementing care plan
• Developed tracking tools in EHR
• Community resources
  – Motivational interviewing
  – Health literacy
  – Stages of change
St. Mark’s Family Medicine
Care Coordination Program

• We developed our own formal program after HealthInsight training and assistance
• Bill for care coordination
• Patient success story
• In the beginning coordinated 15-20 patients; now 40-50 patients
• Higher level of care to all of our patients with having the care coordinating mind set
• Formal process for all medical assistants to be trained
• Every medical assistant is a care coordinator for 2 or more patients
• Continue to evaluate and make changes to improve our processes
Billing Care Coordination

• Care coordination is a billable service.
• There are specific guidelines to follow if you are going to bill for these services. Please refer to your CPT 2014 book (pgs 45-47)
• The codes that we use are:
  – 99487
  – 99488
  – 99489
• We are getting reimbursed from multiple insurance companies at this time
• Billing care coordination and care transition pay my salary
Patient Success Story

- We help our patient’s help themselves
Contact Information

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Self-Management Resources

Training materials and toolkits:


Health Literacy for Diabetes Materials


Video:

Self-Management Resources

Patient Assessments:
• Chronic Disease
• Stages of Change
  – http://www.uri.edu/research/cprc/measures.htm

Improving Chronic Illness Lecture Series:

Free Kaiser Permanente Motivating Change Online Programs:
  – http://www.kphealtheducation.org/chronic_conditions/