

The Medical Home and Practice-Based Nurse Care Management

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Seminar Purpose

- To give practical information and methods to enhance practice improvement
- Schedule
 - Why are we here
 - Brief Background
 - The Nurse Care Manager Model
 - Introduction of the model (using Care Management Plus)
 - Demonstration of the tools
 - Hands on—applying the model to practice
 - Discussion of relevance and feasibility of NCM Model

The Current Primary Care Delivery System is Inadequate

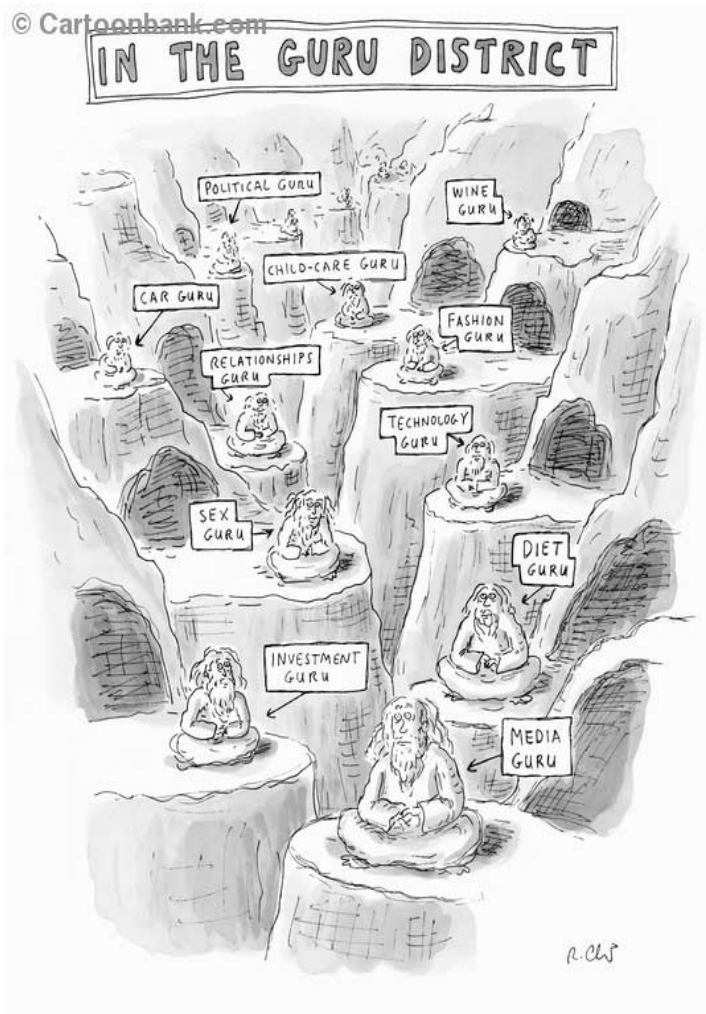
- “LJ, I cannot continue to do what I am doing now [referring to care of diabetic patients] and stay in practice.” Primary care physician in rural Oregon
- The Seven Hour Problem—It would take a PCP 7 hours per day to perform all of the recommendations fo the USPSTF. [Yarnell, 2207]
- It would take a PCP 18 hours a day to provide all recommended preventive and chronic care services to a typical patient panel. As a result, only half of evidence-based care is provided. [Bodenheimer, 2008]

Seeking the meaning of life

- “Oh wise guru, what is the meaning of life?”
the seeker asks
- “Ah, the meaning of life,” the guru intones.
“Life is a teacup.”
- “What? I schlep all the way up here and you
tell me life is a teacup?”
- The guru shrugges. “Okay, maybe it’s not a
teacup.”

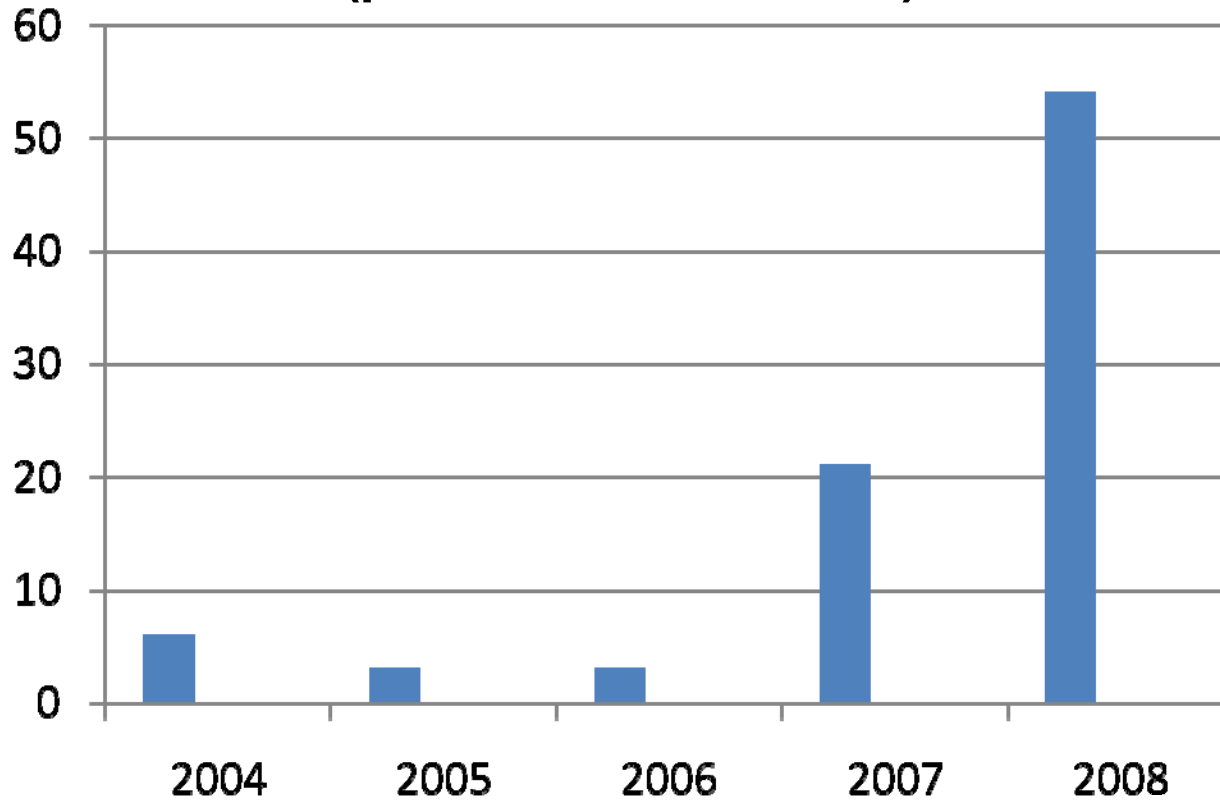
From Plato and Platypus Walk into a Bar by Cathcart and Klein

Primary Care Revitalization Gurus



- The Medical Home (1977)
- Practice Redesign (1993)
- Chronic Care Model (1998)
- Idealized Design of Clinical Office Practices (1998)
- IOM Quality Chasm, Six Aims: Safe, Effective, Patient-centered, timely, efficient, equitable health care
- Future of Family Medicine's "New Model of Care" (2004)
- TransformMED (2005)
- AAFP Practice Enhancement Forum (2005)
- Joint Principles of the Patient Centered Medical Home (2007)
- The Medical Neighborhood (2008)

**PubMed Citations for “Medical Home” in the title and
reference
to primary care
(performed 11/29/2008)**



Medical Home Definition

Grumbach and Bodenheimer, JAMA 2002

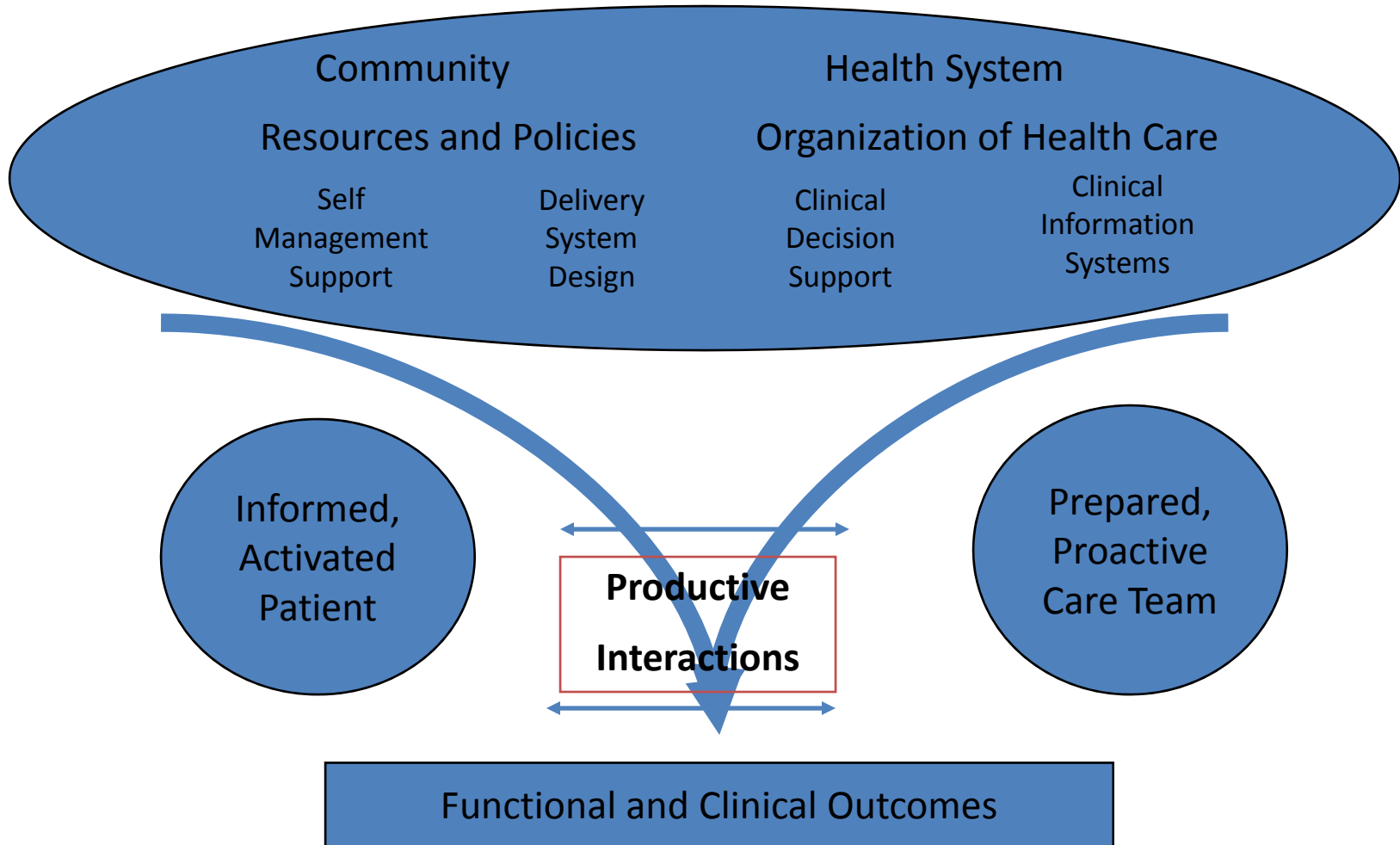
- The medical home is a point of access to health care that is organized around the patient's needs built on a relationship between a patient and a physician. It is a primary health care based capable of providing 90% of health needs but also coordination specialty referrals, and ancillary services. The medical home is a source of first contact care and comprehensive care across a continuum of preventive, acute and chronic health care needs. It is a place where they get to know your.

Joint Principles of the Patient Centered Medical Home: AAFP, AAP, ACP, AOA. 2007

1. Personal physician
2. Physician directed medical practice
3. Whole person orientation
4. Care is coordinated and/or integrated
5. Quality and safety
6. Enhance access
7. Payment

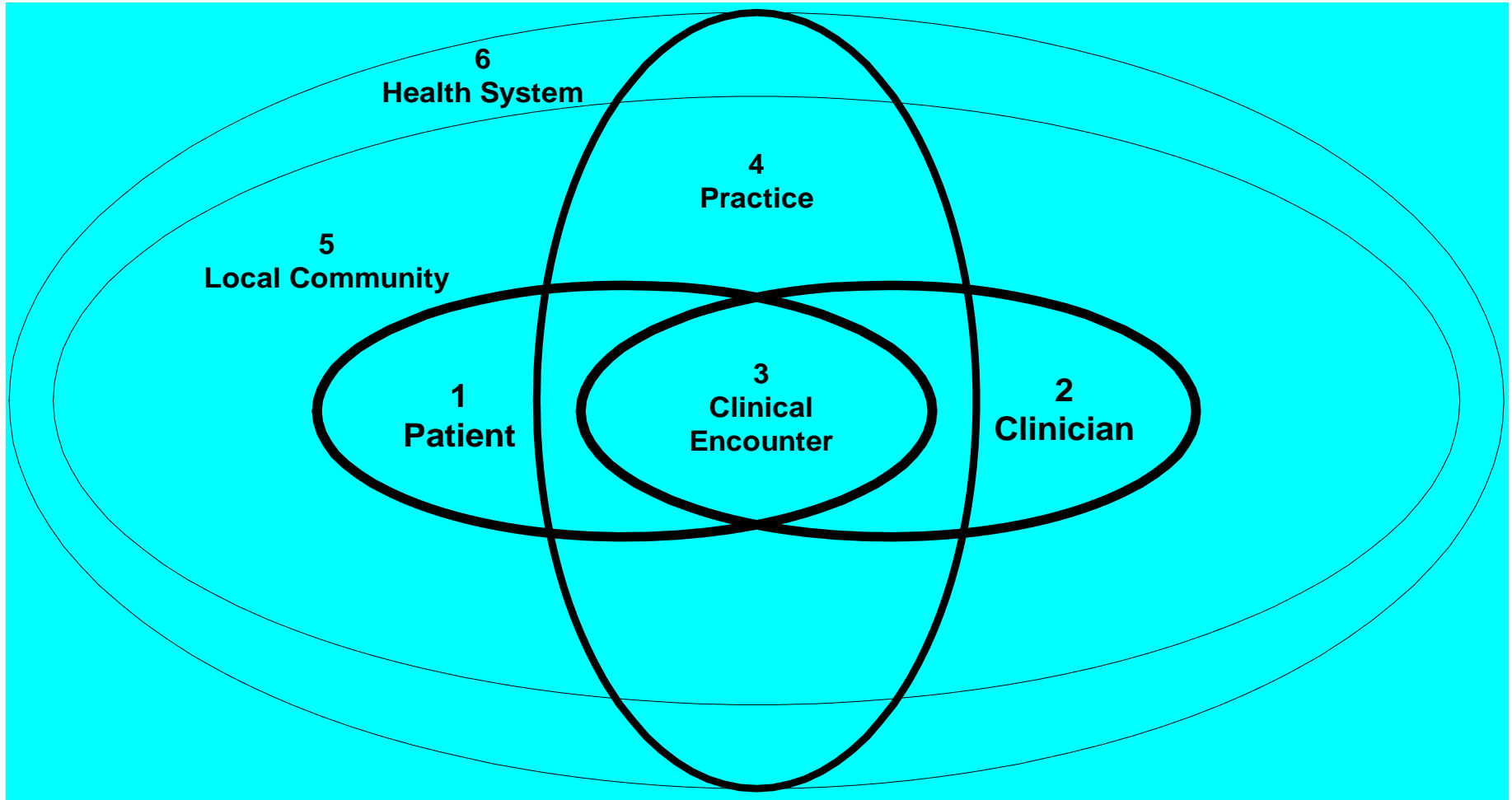
Patient Centered Primary Care Collaborative, www.pcpcc.net

The Chronic Care Model



Adapted from: Wagner, EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998;1;2-4. (Used with permission.)

Complexity Science, the Ecology of Health Care

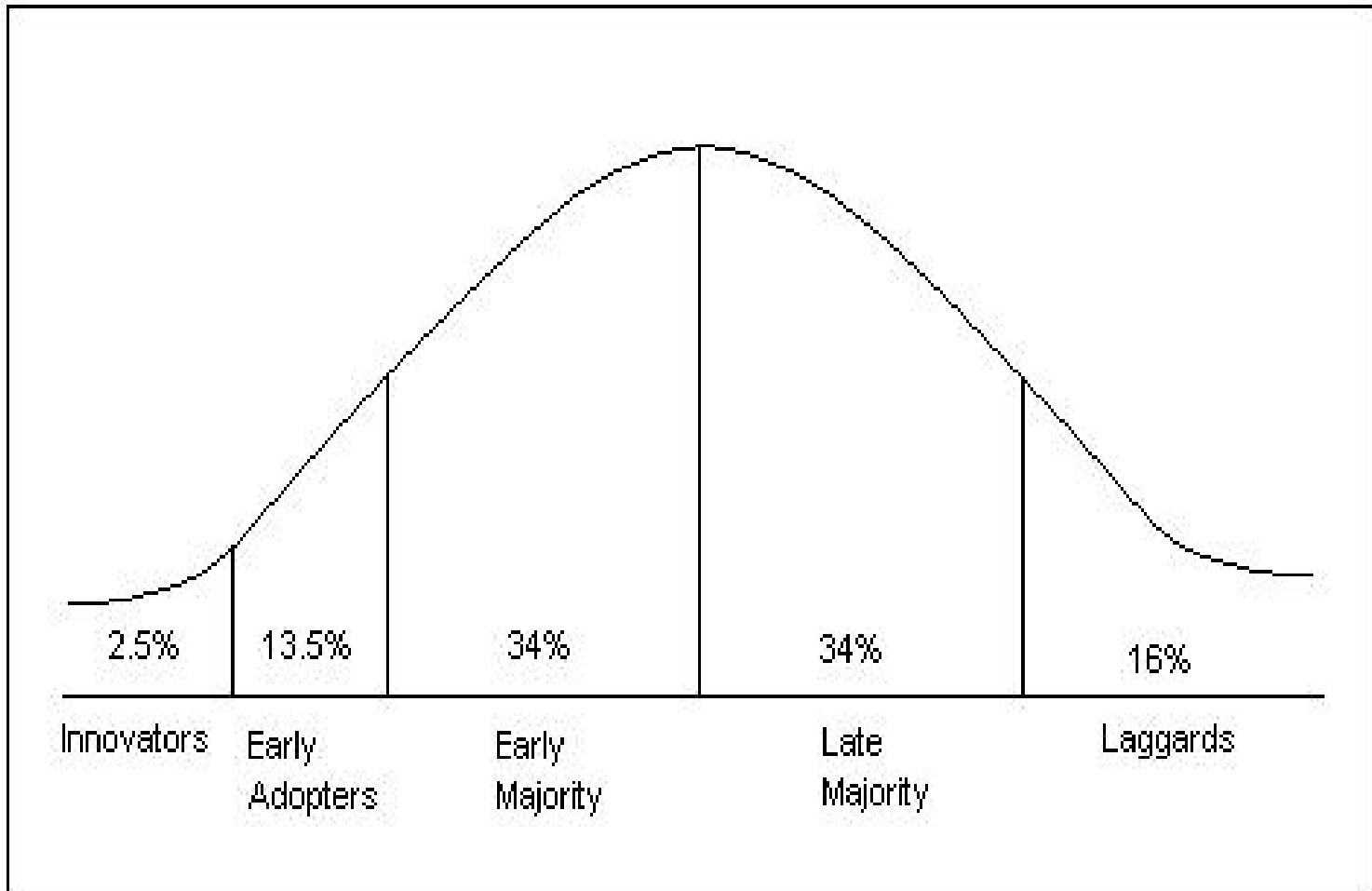


Crabtree BF et al. "Understanding practice from the ground up,"
The Journal of Family Practice 2001; 50(10):883.

Burden of long term illness

- Patients with chronic disease account for 78% of health costs
- Most primary health care revolves around patients with chronic disease
- The primary care system has been built around 15 minute visits and 99213 E&M billings
- The epidemiology of chronic illness care is out of synch with the delivery system

Adopter categorization on the basis of innovativeness—Where are we at?



Rogers, E. M. & Shoemaker, F. F. (1971). *Communication of Innovation*. New York: The Free Press

Primary Care Delivery Questions

- What is the most valuable work of family physicians?
- What is the optimum pattern of work for physicians?
- What is the optimal system for managing patients with complex illness—staffing, risk stratification, information technology, registries?

Team Care-Nurse Care Managers

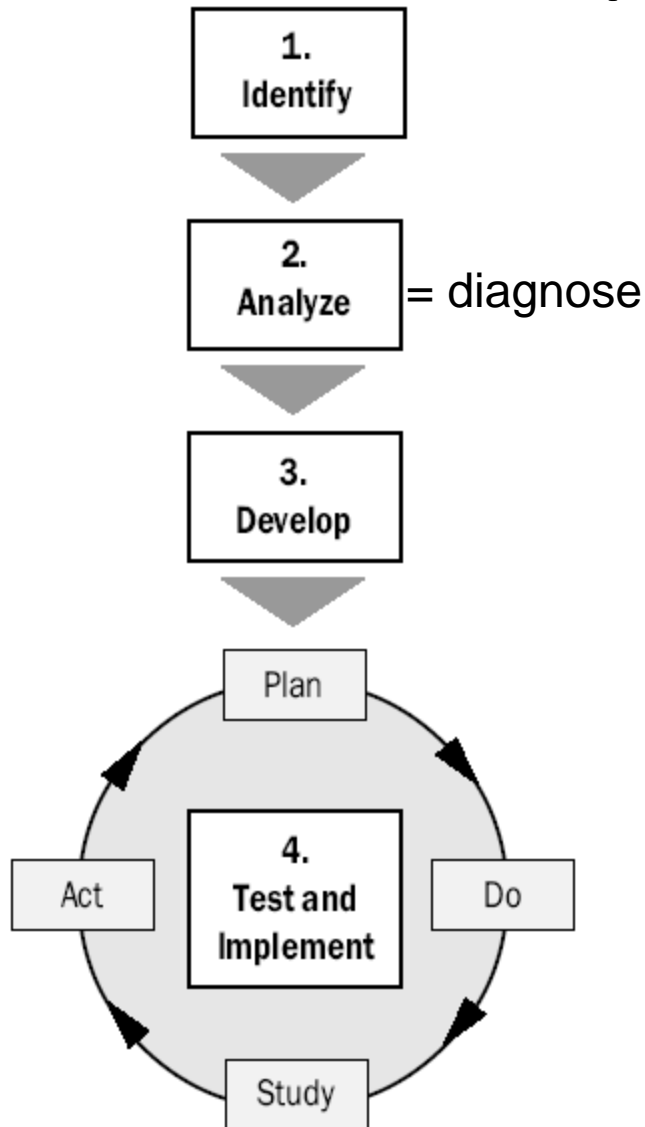
- Care Management Plus—a program to improved the quality and efficiency of care in primary care practices

[Dorr Da, et al. Implementing a multidisease chronic care model in primary care using people and technology. *Disease Management*.2006;9:1-15]

Redesigning care through quality improvement

- A **general** approach
 - Set measurable, meaningful goals
 - Diagnose the issue and generate change
 - Plan-Do-Study-Act
- For primary care, we might adopt **specific lessons**
 - Previous primary care redesign efforts
 - Team-based care
 - Care management
 - Implementing protocols / measures

General approach to managing redesign



1. Identify	Determine what to improve
2. Analyze	Understand the problem
3. Develop	Hypothesize about what changes will improve the problem
4. Test/ Implement	Test the hypothesized solution to see if it yields improvement; based on the results, decide whether to abandon, modify, or implement the solution

From USAID

Goals to manage in the Medical Home

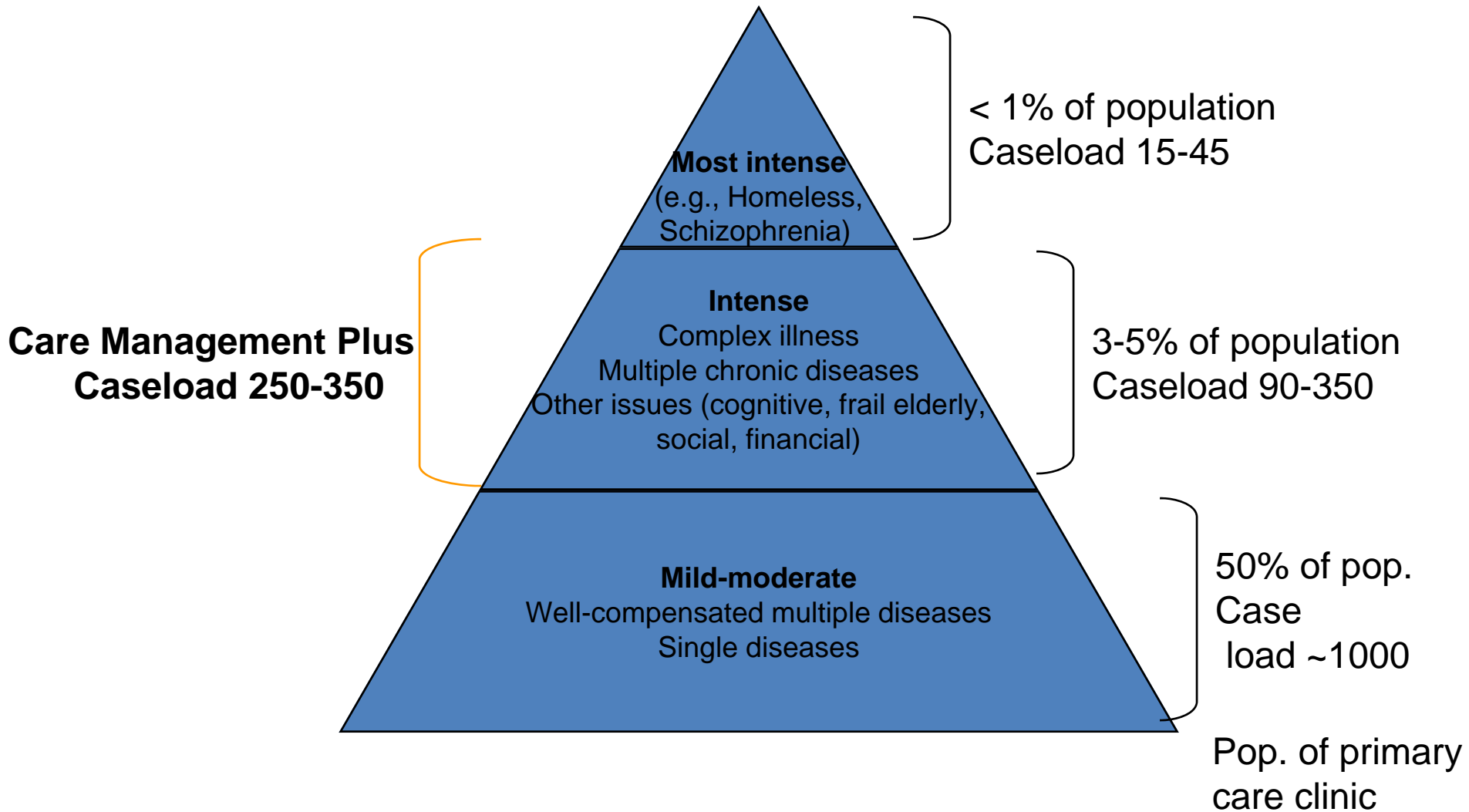
Goals	Example elements
Access to and Continuity of Care	Respond to needs for appointment and communication
Patient Monitoring	Assess and track; provide self-management support
Care Coordination / management	Care planning; Coordinate information / referrals
Population Management	Identify 3 populations of interest; use guidelines

Adapted from the CMS / NCQA criteria

Goal : Care coordination / care management

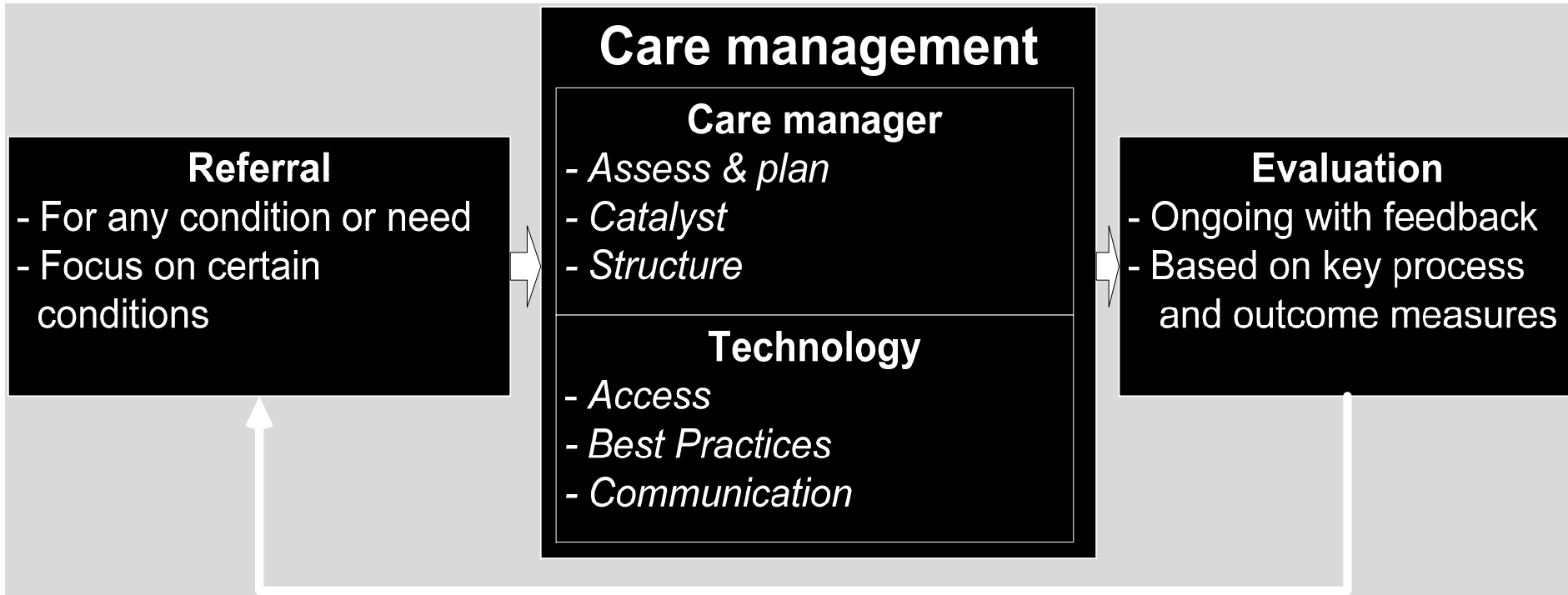
- Perform Care Management : create and follow-up on an integrated care plan
- Coordinate Information : reconcile medications, keep problem lists
- Follow Referrals : coordinate with other physicians for critical referrals
- To manage this goal, you must
 - Implement team-based care management system
 - Have a system for medications, problem tracking

Team-based Care management varies by intensity and function for different populations and needs.



Nurse care management helps fill in several gaps; example of Care Management Plus

In primary care clinics



www.caremanagementplus.org;

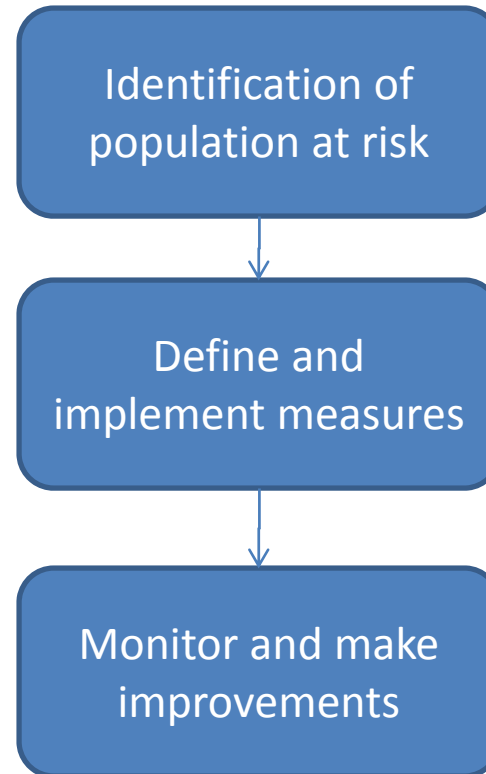
References: Dorr et al, JAGS, 2008; Wilcox, Proc AMIA, 2005; Dorr et al., HSR, 2005

Team roles for the medical home

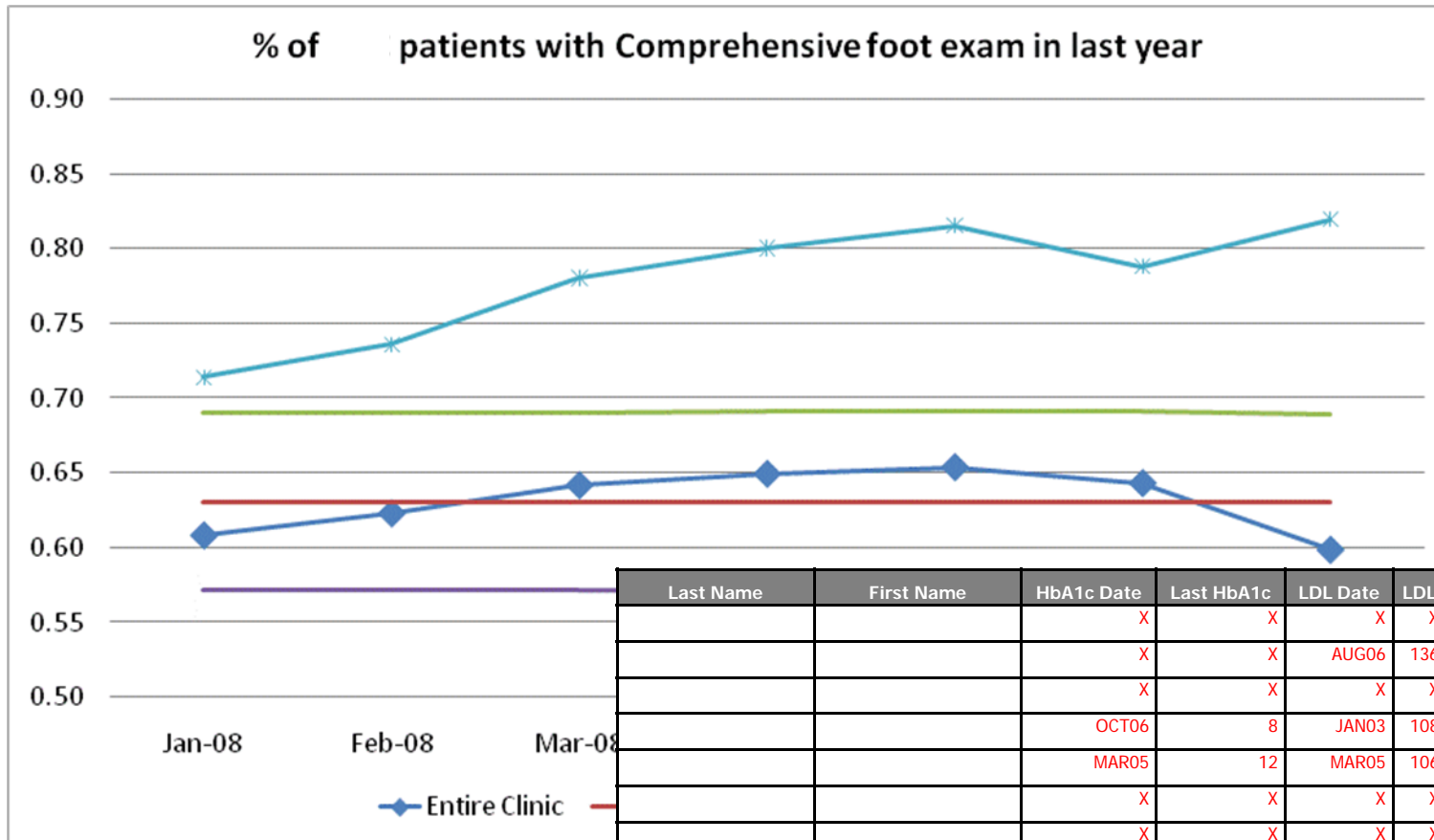
Goal	Management required	Example roles
Access	Documented, efficient processes for calls & appointments	Scheduler: tracking, knowledge; RN: protocols for rapid return
Care management	Documented and reliable system of care	Care manager: perform evaluations, education; MA: assist with evaluation; Physician: refer, set protocols
Patient Monitoring	Proven Follow-up	Care manager: track patients; Clinic manager: run reports and follow-up
Population management	Interaction with population data over time; identify at-risk	Panel / care manager: follow guidelines, protocols

Tools to aid in measurement

- Registries
- Standard measures
- Run charts
- Tickler systems
- Integrated decision support



Registries



Last Name	First Name	HbA1c Date	Last HbA1c	LDL Date	LDL	BP	Eye Exam	Foot exam	Goal s
		X	X	X	X	/.	X	X	
		X	X	AUG06	136	/.	X	X	
		X	X	X	X	/.	X	X	
		OCT06	8	JAN03	108	/.	X	X	
		MAR05	12	MAR05	106	/.	X	X	
		X	X	X	X	/.	X	X	
		X	X	X	X	/.	X	X	
		X	X	X	X	/.	X	X	
		X	X	X	X	/.	SEP05	X	
		X	X	X	X	/.	X	X	
		X	X	X	X	/.	MAY07	X	
		X	X	X	X	/.	X	X	

Tracking efforts

- Major gap:
 - Follow-up of PDSA is limited by the REAL WORLD
- How to fill?
 - Tickler about tasks at hand
 - Fit cycles into daily workflow
 - Use information systems *sparingly*

Call

Care Manager Encounter Tickler List

Care Manager: Ann Larsen

Sched. Dt. and Time	Encounter Type	Enc. Reason	MMH	First Name	Last Name	Phone Number	Pri
2/17/04	Telephone Contact	DM F/U				(801)	Wo
2/17/04	Telephone Contact	DM F/U				(801)	Wo
2/17/04	Telephone Contact	DM F/U				(801)	Wo
2/17/04	Telephone Contact	DM F/U				(801)	Wo
2/17/04	Telephone Contact	Depression F/U				(801)	Ob
2/17/04	Telephone Contact	Dep F/U				(801)	Sm
2/17/04	Telephone Contact	DM F/U				(801)	Wo
2/17/04 8:30 AM	CM Office Visit					(801)	Wo
2/17/04 9:00 AM	Class					(801)	Sm
2/17/04 9:00 AM	Class					(801)	Met
2/17/04 9:00 AM	Class					(801)	Ob
2/17/04 9:00 AM	Class					(801)	Wo
2/17/04 10:40 AM	MD Office Visit	DM F/U				(801)	Wo
2/17/04 1:50 PM	MD Office Visit	DM F/U				(801)	Rur
2/17/04 3:00 PM	CM Office Visit					(801)	Wa
2/17/04 3:50 PM	MD Office Visit					(801)	Wo

Population Tickler

Before 3/10

IHC. Also detail
do. want pay
pm free
812-33-003

5 people
 PCP Approves Test
 who if parents - do making
 Client - do infant
 Home - gen name
 Back - head
 2-3 who - hospital
 Turn on 5' 10" 100 lbs
 7-10 days
 3 m.

If from cat office

3 cont

Patient Information

ID Number: Last Name: TEST First Name: TEST DOB: 8/16/1977 * Age: 19-44 Race: Black/African A Sex: M

Phone: (800) 800-8000 Cell Phone: Email: PCP: Allen, Mitch PCP Phone: (800) 888-8888

Insurance: Mailhandlers Facility: ABC Clinic Diab Collaboration FPP: 2.Confused/Chaotic

Date of Referral: 3/30/2004 * Care Mgr: John Status: Active

Patient Search

ID Number:

Last Name:

First Name:

Care Mgr:

Diag Date	Diagnosis	Status
	CHF	Active
<input type="button" value="Edit"/>	3/30/2004 Anxiety	Active
<input type="button" value="Edit"/>	3/30/2004 Depression	Active

Sched Date	Sched Time	Encounter Type	Status
		Telephone Contact	Pending
		Home Visit	Resolved
<input type="button" value="Edit"/>	1/26/2005	Telephone Contact	Resolved
<input type="button" value="Edit"/>	10/18/2004	Telephone Contact	Resolved

MH Packet Date	Symp	Severity	Fctnal	Diff	Dysth.	Q9	Suicide State	Suicide Risk	[Mood 1 2 3]	MoodImp	MoodSx	AnxImp	AnxSx
<input type="button" value="Edit"/>	1/26/2005	1	3	Somewhat	<input checked="" type="checkbox"/>	0		No Risk					
<input type="button" value="Edit"/>	9/1/2004	0	4	Not	<input checked="" type="checkbox"/>	0		No Risk		16	45	14	52
								1. Thoughts Only					

Diab Assess Date

Diagnosis Encounter Meds MH Instruments Pediatric Assess

Diabetes History Diab Pre/Post Knowledge Assess Patient Goals HF Follow-Up

*

CMT database - example

Integrated Decision support

- Gap:
 - How do we bring forward the important information (about a person's goals, conditions, and needs) with knowledge (about evidence-based practices)?
- Solution: Summaries (e.g., worksheets, patient flowsheets, etc)

Patient Worksheet

Wilcox, Proc of AMIA Symp, 2005

16 November 2006		Patient Worksheet Selected to Print for: All Patients, All Sections, Last Clinical Note			u1.070 Comprehensive Version	
PATIENT NAME TEST, BED		SEX F	DOB 01/01/1911	MRN# 650730	MRN# 5992114	
Problems						
Diabetes Mellitus, Type 2 Hype rlipidem ia		Chronic conditions				
Active Medications						
1. - Glucophage (Metformin HCl), 500mg, Tablet, 1 TABLET, Daily 2. - Simvastatin, 10mg, Tablet, Oral; 1 TABLET, Daily 3. - Lisinopril, 10mg, Tablet, Oral; No dose for 1 4. - Calcium Carbonate/Vitamin D (Calcium 500/W-Vitamin D), 500-200, Tablet, 1 TABLET, BID		Medications				
Allergies						
(-) Penicillins - A Drug Allergies Group; Reaction(s): Rash						
Disease Management						
ADL		Pain Score (0-10)		mMSE		
11/16/2006	5	11/16/2006	4	11/16/2006	24	24
Preventive Care						
Pap Smear		Mammogram				
No Data		No Data				
Clinical Laboratory Data						
HgbA1c (<=7.0)		UA Protein	uAlb/Cr (<=30)	24 Urine Albumin (<=30)	Serum Cr	
No Data	-	No Data	-	No Data	-	No Data
Serum K		Lipid Profile	LDL (<=100)	Trig (<=150)	HDL (>=45)	CHOL (<=200)
No Data	-	No Data	-	No Data	-	No Data
HCT		HsCRP		Homocysteine		
No Data	-	No Data	-	No Data	-	-
Clinic Data						
Date	Weight	BMI (<=25)	Weight Class	Blood Pressure (<=130/80)		Heart Rate
01/16/2006	144 lbs	23	Normal	01/16/2006	122/74 mmHg	01/16/2006
01/11/2005	155 LBS	25				
05/12/2003	50.00 N/A	-				
Last foot exam: 11/2005		Abnormal		Last dilated retinal exam: 11/2005		Abnormal
Reminders						
Lab						
[] Creatinine - Patient on Metformin product(s) and no Creatinine on record.						
[] HgbA1C - Urine Albumin Test - LDL - Serum Cr (should be done on all Patients with Diabetes)						
[] HCT - Serum K (should be done on all Patients with Diabetes)						
Procedure s						
[] Mammogram - Suggested yearly for women age 40 and above, every 2 years age 50 and above.						
[] Pneumonia - Suggested for all Patients with Diabetes.						
[] Tetanus Immunization - Suggested for all Patients with Diabetes.						
[] DEXA Screening - Suggested for women age 65 and over. Follow-up screening for those treated for osteoporosis recommended every 2-3 years.						
[] Colon Cancer screen - Suggested yearly fecal test or sigmoidoscopy Q 5 years, or colonoscopy Q 10 years.						

Chronic conditions

Medications

Allergies

Functional status

Preventive care summary

Pertinent labs

Pertinent exams

Passive reminders

Organized by illness

Breakout sessions

- 3 scenarios
 - Set a goal for the overall project
 - Create a *first step* PDSA cycle for the scenario
 - Plan : Diagnose issues, look at baseline evidence and previous work
 - Do : Identify realistic change hypotheses
 - Study : Measure the effects
 - Act : Review the effect and start the new cycle
- Be specific about tools