Indiana Chronic Disease Management Collaborative Charter

Breakthrough Series Collaborative on Improving Care for People with Chronic Conditions: Diabetes and Congestive Heart Failure (CHF)

WHAT IS A COLLABORATIVE

The Breakthrough Series Collaboratives were developed by the Institute for HealthCare Improvement (IHI) in the mid 90's to facilitate health system change. This learning method relies on the adoption of the Model for Improvement developed by Associates for Process Improvement. The model is a quality improvement strategy that demonstrates the power of rapid cycle tests of small change that build towards sustainable change within an organization.

INDIANA CHRONIC DISEASE COLLABORATIVE

The State Department of Health and Indiana Office of Medicaid Policy and Planning are sponsoring chronic disease management programs for Medicaid patients with diabetes and CHF. Program components include-

- Collaborative Learning Sessions for teams from participating practices (teams will include a physician, nurse and or office manager). These Learning Sessions will allow for introduction of the Program, the Model for Improvement and the Chronic Care Model; a model for health system change to improve care for chronically ill patients developed by the Robert Wood Johnson Foundation's national program Improving Chronic Illness Care. The Collaborative model consists of three Learning Sessions with Action Periods to follow allowing for testing of implementation processes.
- Coaching and tools for physician offices to implement in their practices.
- Centralized Call Center to manage lower risk patients through periodic reminder calls of important tests/exams and assessment of functional status.
- Nurse Care Managers to manage higher risk patients through the application of disease specific care management protocols.
- A web based registry with disease specific modules having reminder call functionality
- Indiana Consensus Practice Guidelines for Diabetes and CHF.
- Promotion of self-management skills utilizing the Stanford Self Management Model.
- Measurement and Evaluation of program effectiveness.

PROBLEM STATEMENT

In 2000, approximately 125 million people in the United States had some type of chronic illness and by 2020 it is estimated to grow to 157 million. By 2010, 17% of our GDP will be spent on health care, and 78% of these costs will result from chronic diseases including almost 80% of total Medicaid expenditures, and this is increasing as our population ages. Numerous surveys and audits have documented gaps between well-

established guidelines for the clinical aspects of care and how practitioners are actually delivering care. Providers feel resource constrained and too rushed to meet the, clinical, educational, and psychological needs of chronically ill patients and their caregivers. Patients experience care that is uncoordinated, impersonal and unsupportive, which may leave them feeling incapable of meeting the day-to-day needs of managing their chronic condition.

MISSION

State, national, and local partners are working together to implement a model of care for people with chronic conditions. We will initially target diabetes and congestive heart failure (CHF) and then will include diabetes and CHF, HIV, and other chronic diseases. Participating organizations will focus on diabetes and CHF in this first collaborative session. The clinical priorities of each condition are based on currently available scientific evidence. The principles used to improve care for these two conditions include:

1. implementation of the Chronic Care Model in the primary care settings
2. creation of a network of care management to support primary care in the management of these patients.

The resulting efforts of the teams in this Collaborative will serve as a template for managing a variety of other chronic illnesses and for implementing the system state-wide.

We will implement the collaborative model statewide in a phased approach over a twelve- month period by sharing the best available scientific knowledge on the care for people with these conditions, and by learning and applying methods for change in the delivery of primary care. Participants in this Collaborative will learn and implement an organizational approach to caring for people with chronic disease that utilize and support a comprehensive, sustainable locally based care network. This network will include primary care providers, nurse care managers, and a centralized call center.

COLLABORATIVE GOAL

The long-range goal of this Collaborative is to maximize the length and quality of life for patients with chronic conditions and satisfy patient and caregiver needs, while maintaining or decreasing the total cost of care. This will be achieved by implementing the Chronic Care Model that focuses on delivering evidence-based clinical care and providing strong support for self-management.

Tools will be provided to participating organizations that will assist them in achieving this overall Collaborative goal as well as each organization's own specific aims for each condition. Examples of potential aims for participating primary care teams that are consistent with the Collaborative mission and goals include:

For Diabetes Patients

- At least 75% of patients will have a HbA1c level of less than 8
- At least 60% of patients will have a BP of less than 130/80

- **At least 70% of patients will have documented self-management goals**
- At least 95% of patients will have smoking status documented
- At least 70% of these smokers will have been offered cessation assistance
- At least 70% of patients will have a dilated eye exam on an annual basis
- At least 90% of patients will have a monofilament foot exam on an annual basis
- At least 80% of patients will have two or more diabetes related office visits each year
- **A 30% reduction in the total number of hospital days**

For CHF Patients

- **At least a 50% reduction in hospital readmissions for CHF patients**
- At least 50% of patients will have documentation of NYHA class
- **At least 70% of patients will have documented at least one self-management goal**
- At least 95% of patients will have smoking status documented
- At least 70% of these smokers will have been offered cessation assistance
- At least 90% of patients will have a BP of less than 160/90
- At least 70% of patients on an ACE inhibitor
- At least 40% of patients on a beta blocker

Each team is expected to measure the aims in bold and to specify at least two to three additional aims, from these lists that are appropriate for their pilot populations. These measures will be tracked throughout the Collaborative on a monthly basis to ensure that changes made by the teams are resulting in an improvement.

METHODS

Each health system is expected to focus on the population of Medicaid patients with diabetes, CHF, or both conditions during the duration of the Collaborative that have been identified by the Medicaid system and the Chronic Disease Management System (CDMS) a web-based patient registry. Clinical data on identified patients will also be entered into CDMS by nurse care managers and physician office staff. Participating health systems will plan to change practices and systems in order to improve clinical management and office efficiency. The Chronic Disease Management Program will aid participating teams to capitalize on the learning and improvement from this focused project by coaching the senior leaders of the participating organizations to develop a system for spreading the practice redesign to other locations/offices/clinics.

COLLABORATIVE EXPECTATIONS

The Chronic Disease Management Program will:

- Provide evidence-based information on subject matter, application of that subject matter and methods for process improvement, both during and between Learning Sessions that include IHI's Model for Improvement and the Chronic Care Model

- Provide a Centralized Call Center for all Medicaid patients in the Chronic Disease Management Program;
- Provide Nurse Care Managers for all high risk Medicaid patients in the Chronic Disease Management Program;
- Provide a registry (CDMS) which will be available for all patients in the health system, regardless of whether they are in the Medicaid program;
- Offer coaching to organizations;
- Provide communication strategies to keep organizations connected to the Planning Group and colleagues during the Collaborative.

Participating Organizations are expected to:

- Perform pre-work activities to prepare for the Learning Session;
- Connect the goals of the Chronic Disease Management Program work to a strategic initiative in the organization;
- Conduct health system redesign based on all six components of the Chronic Care Model to improve care for these patients
- Provide a senior leader to serve as a sponsor for the team working on the Breakthrough Series, serve as champion for spread of the changes in practice within their health care system, and attend at least the first Learning Session;
- Send a team to all three Learning Sessions;
- Provide resources to support their team including resources necessary for Learning Sessions, time to devote to testing and implementing changes in the practice, and active senior leadership involvement;
- Perform tests of change in the organization that lead to implementation of improvements in the practice between learning sessions;
- Make well-defined measurements that relate to their aims at least monthly and plot them over time for the duration of the Collaborative;
- Share information with the Collaborative, including details of changes and data to support these changes, both during and between Learning Sessions.