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THE CURE FOR HAMSTER HEALTH CARE

TIRED OF cramming everything—diagnosis, treatment and prevention—into a 10-minute office visit? You are not alone. The *British Medical Journal* recently shared your pain in an article entititled "Hamster Health Care."[1] Feeling like a hamster, running on a treadmill while at the same time keeping one toe* in the dike to hold back the floodwaters of ill health, is a potent source of frustration and demoralization for health care providers.

Avid readers of these pages know that right here in Oregon there exist large gaps between what patients *are actually* receiving, and what they *should* be getting in the way of prevention.[2,3] Is it possible to solve this problem in some way without exhorting already overburdened clinicians to do still more in less time?# The subtitle of the article speaks to a possible solution: "time to stop running faster and redesign health care." But how can this be done?

THE CHRONIC CARE MODEL

The Chronic Care Model[4,5] is designed to address the problem that acute symptoms and concerns tend to crowd out the less urgent (but at least equally important) need to optimally manage chronic illness. The Table summarizes the changes proposed by The Chronic Care Model, which allow more efficient management of chronic diseases.

A recent review[6] showed that 32 of 39 studies of specific elements of the model aimed at diabetes found improvement in at least one process or outcome measure. Eighteen of 27 published studies concerned with congestive heart failure, asthma, or diabetes demonstrated reduced health care costs or lower use of health care services.

OREGON'S EXPERIENCE

While things often look different here in Oregon, for this concept Oregon's experience is consistent with published findings from elsewhere. What follows is a description of how 16 Oregon medical practices (hereafter referred to as "teams") have applied the Chronic Care Model to diabetes care over the last year. Teams participated in group learning managed by OMPRO, with some encouraging results.

PLANNED VISITS

Along with preventive care, the guidelines for chronic disease care recommend that patients set goals that get incorporated into self-management plans, but this takes time that is often not available during a visit for an *acute* problem. Therefore, many teams are scheduling *planned* visits—e.g., specifically for diabetes care. Support staff ensure that patients have had all labs drawn in advance, and physicians are provided with a brief summary of relevant data, a list of routine preventive care that is now due, and the patient's self-management goals. Physicians reported that more of the precious visit time was spent talking to the patient and less time was wasted searching for information.

GROUP VISITS

An interesting twist on the planned visit involved seeing multiple patients at once. Group visits addressed typical clinical care as well as educational, social and psychological concerns. Health care team membership varied based on the needs of the group, but included a physician or nurse practitioner, podiatrist, diabetes educator, social worker or pharmacist. While some patients spent part of the visit one-on-one with providers, others participated in facilitated group discussions. Working out the kinks was challenging, but patients and clinic staff felt the group visits were successful and efficient and increased provider and patient satisfaction.

STANDING ORDERS

These involve delegating certain routine aspects of care to other members of the team. "We've had standing orders for years," reported one participant. Making them "real" was a challenge. In one successful example, medical assistants learned to look systematically for patients who needed an eye exam or flu vaccine. Medical assistants were also authorized to get these patients the

Elements of the Chronic Care Model[7]

Challenge	Solution	
Reliable and timely access to critical clinical information is needed for high-quality care	Clinical Information System	Registries track individual patients and populations, provide reminders, and feedback on performance
Practice teams need information to make appropriate clinical decisions	Decision Support	Evidence-based clinical practice guidelines are integrated into daily practice
Physician 15-minute acute-care visits are not effective	Delivery System Design	Visits are planned; many aspects of care are delegated to other members of the practice team
Little support for or assessment of patient self care	Self-Management Support	Patients' skills and confidence to manage their disease are assessed as needed and encouraged
Organizational structures and incentives often do not support effective chronic care	Health Care Organization	Chronic care is a priority for purchasers, insurers and providers, and incentives reflect this
Practices cannot provide all the services and supports that patients and families need	Community Resources and Policies	Providers and patients are linked to local resources including exercise programs, senior centers and self-help groups

* Or paw, or whatever. # This is really hard for us to write, y'know.

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routine preventive care they needed. The medical assistants reported pride and increased job satisfaction with their expanded role.

SELF-MANAGEMENT SUPPORT

Outcomes in chronic conditions probably depend more on what patients do out of the office than what providers do in the office. The teams tested a number of ways to help patients better care for themselves. One of the teams discovered that their lab technician was an excellent resource. When patients went to the lab for their pre-visit blood work, the technician talked about the importance of self-management and gave them a form to complete that would help them identify some concrete self-management goals. Patients were asked to bring the form to their next provider visit. Providers reported that reviewing the patient's expectations before the visit led to more productive interactions.

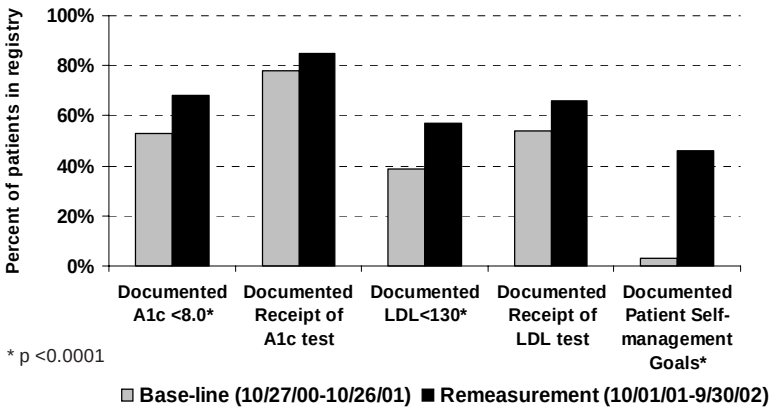
REGISTRIES

Registries are databases with information on all patients in the clinic with a specific condition. Each team created a registry of diabetes patients both to track the care being given to their population, and to identify the needs of individual patients. The creation of these registries led to an important realization: "It's the patients we *weren't* seeing that were the problem," said one team member. As clinics used their registries to assess their performance in ordering hemoglobin A1c and cholesterol tests, they discovered the value of finding people who were not coming in for visits. Teams created the registries using everything from free software on a stand-alone PC to sophisticated interfaces for electronic medical records. Regardless of the form, registries are a powerful tool in the redesigned clinical practice.

RESULTS

The teams have invested significant effort in this process, and most thought it was well worth the work. Quantitative outcomes also improved with this project. Percentages of patients with A1c <8, LDL <130, and chart documentation of a self-management goal were significantly bettered over the course of this project (see Figure).

Oregon diabetes team outcomes, 2002



Source: OMPRO, October 2002

THE WAVE OF THE FUTURE?

So is implementation of the Chronic Care Model the future of health care in Oregon? To be sure, this model isn't the answer for all that ails our health care system or for all clinics. The practical experience of clinics that have participated in the OMPRO project suggests that it is possible to work differently rather than harder, and that the Model can yield important benefits for patients and providers. More information about the Chronic Care Model and efforts to implement it (called Collaboratives in the jargon of the field) can be found at: *http://www.improvingchroniccare.org, http://www.ompro.org/diabetescollaborative,* and *http://www.ihi.org/collaboratives.*

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