Incorporating The Chronic Care Model To Improve Satisfaction And Outcomes

Marcia A. Potter, Col, USAF, NC, DNP, FNP-BC,
Candy Wilson, Lt Col, USAF, NC, PhD, APRN, WHNP-BC

Objectives

The learner will:
1). Identify elements of the Chronic Care Model that can be used to implement the elements of planned care:
2). Explain how clinical leaders can improve staff activation and engagement:
3). Describe how the Chronic Care Model can be used to help patients improve self-efficacy

Background

The Military Health System is designed for episodic rather than longitudinal care;
The emphasis on episodic care results in fragmented care, poor health care delivery, stressed health care teams, and frustrated patients;
Longitudinal care is needed to address chronic health conditions and assist patients to become activated and engaged;
The Chronic Care Model emphasizes specific elements to create longitudinal, relationship-based, patient-centered care

Purpose

The purpose of this project was to incorporate elements of the Chronic Care Model into daily practice create activation and engagement, as evidenced by:
Staff satisfaction
Patient satisfaction,
Patient health outcomes

Abstract

Patient activation and engagement can be powerful enablers for health outcomes; just as important are staff engagement and satisfaction. This author re-designed clinic templates to accommodate a time-based element of longitudinal care and implemented skill-based competencies to provide collaborative, team-based care to patients with type 2 diabetes. Twenty-two adults with diabetes and 6 staff members caring for them participated in a 12 week process improvement project utilizing the Chronic Care Model to link satisfaction and health outcomes. Patients completed satisfaction surveys at the end of their clinical encounters; staff completed satisfaction surveys pre- and post-implementation. The authors analyzed hemoglobin A1C levels pre- and post- implementation. The surrogate markers for engagement and activation are confidence and conviction; these increased for both staff and patients, hemoglobin A1C levels decreased. Staff satisfaction remained relatively stable. Clinical implications include broad application of the CCM to daily practice, improved self-efficacy, healthier populations, and health care cost reductions.
Key words: patient activation, patient engagement, staff activation, staff engagement, Chronic Care Model, type 2 diabetes

Conceptual Framework

Ray's Theory of Bureaucratic Caring
Chaos Theory
The Chronic Care Model (CCM)

Literature Review

- ~500 articles, randomized controlled trials, and systematic reviews applying the CCM to self-efficacy, improved health outcomes, and improved patient and staff satisfaction
- Varied in research design, sample size, and tools used to measure patient activation and engagement. supported the concept of patient self-efficacy as crucial to improving health outcomes.
- Not all elements of the CCM had to be employed in order to see improvement

Methods

- Staff Satisfaction survey
- Confidence/Conviction Ruler (CCR)
- Patient Satisfaction Survey

Interventions

Planned, proactive visits
Employ all staff to top of their skillsets
Allot time specifically to address the chronic health issue separately from acute health care issues
Incorporate shared decision-making with patients in order to create activation and engagement.

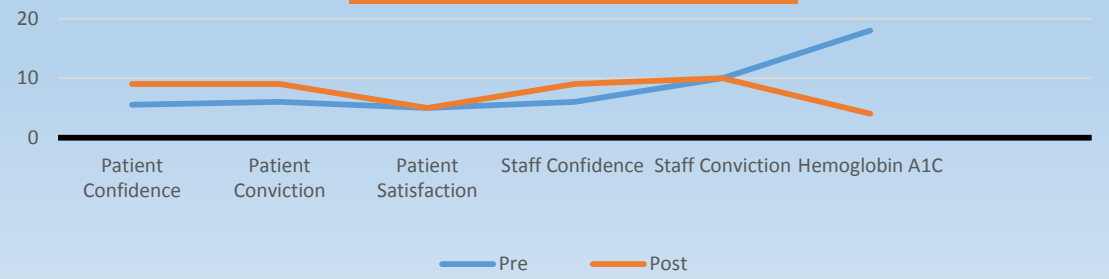
Nursing Protocols :
Contact the patient
Assess: Patient self care
Plan; Upcoming needs
Implement: Needed orders
Evaluate: Understanding

Medical Technician Protocols
Review the record:
Assess: Completion needed data
Plan: Upcoming needs
Implement: Reminder call prn
Evaluate: Understanding

Clinician Protocols:
Review the NURSING notes
Confirm information with patient
Identify goals
Identify needed resources
Create tailored plan of care with patient

Appointment Template
3 Acute (15 mins)
Single new problem, needs to be seen within 24 hours
4 Routine (15 mins)
Single new problem, needs to be seen within 7 days
4 Well (30 mins)
Preventive care visit, ATC standard: within 28 days
4 Established (30 mins)
Care of chronic illness, ATC standard: NONE

OUTCOME MEASURES



Results

Patient Satisfaction:
- Empowerment
- Self Efficacy
- Hopefulness

Staff Satisfaction
- Shift in locus of problem-solving: from external to team-based
- Role Efficacy
- Role Satisfaction

Patient Health Outcomes
- Avg decrease in HbA1C was 14.0%

Conclusion

- Health outcomes improved within 3 months of implementation
- Staff Satisfaction increased as role efficacy increased
- Patient Satisfaction indicated difference in understanding purpose of healthcare
- Health outcomes improve as efficacy increases within the clinical microsystem stakeholders
- Direct care cost reductions can be realized nearly immediately

Implications for Practice

The Chronic Care Model can be successfully implemented in a Primary Care Practice to improve: patient and staff satisfaction; role and self efficacy; and health outcomes.

References

Coleman, K. A. et al. (2009). Evidence on the chronic care model in the new millennium. *Health Affairs, 28*(1), 75-85.
Davidson, A. W. et al. (2011). *Nursing, caring, and complexity science: For human-environment well-being.* New York, NY: Springer Publishing Company.
Deen, D. L et al. (2012). The impact of different modalities for activating patients in a community health center setting. *Patient Education & Counseling, 2012 Oct; 89 (1): 178-83.*, 178-83.
Devoe, J. E.. et al (2013). The OCHIN community information network: Bringing together community health centers, information technology, and data to support a patient-centered medical village. *Journal of the American Board of Family Medicine, 26*(3), 271-278.
de Vries, H. K. et al(2008). The effectiveness of tailored feedback and action plans in an intervention addressing multiple health behaviors. *American Journal of Health Promotion*, 417-25
Piatt, G. A. et al. (2006). Translating the chronic care model into the community: Results from a randomized control trial of a multifaceted diabetes care intervention. *Diabetes Care, 29*(4), 811-817.
Stepleman, L. R. et al (2010: 32(19)). Validation of the patient activation measure in a multiple sclerosis clinic sample and implications for care. *Disability & Rehabilitation*, 1558-67.
Townsend, A. W. et al(2006 Sept: 2(3)). Self-managing and managing self: Practical and moral dilemmas in accounts of living with chronic illness. *Chronic Illness*, 185-94.
Wagner, E. H. et al (2001). Improving chronic illness care: Translating evidence into action. *Health Affairs, 20*(6), 64-78.