

# HEALTHCARE TRANSFORMATION: CHRONIC DISEASE MANAGEMENT IN THE PRIMARY CARE SETTING

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# DISCUSSION OVERVIEW

- ◉ Analyze & Prioritize Population Needs
- ◉ Clinical Practice Guideline Development
  - Key team members
  - Suggested guideline content
- ◉ Standing Order Sets
  - Content
  - Nurse Coach Support
- ◉ Care Plans & Patient Engagement
  - Development
  - Workflow
- ◉ Quality Metrics & Reporting

# POPULATION ANALYSIS & PRIORITIZATION

- ⦿ ICD-9 Frequency
- ⦿ Claims analysis
- ⦿ Benchmarking
- ⦿ Community data

# CLINICAL PRACTICE GUIDELINE DEVELOPMENT

- Chronic Condition Selection
- Key Team Members
- Suggested Guideline Content
  - Diagnosis & Coding
  - Evidence Based Care Guidelines
  - Medication Management
  - Clinician & Patient Education
  - References

# STANDING ORDER SETS

- ◉ Content

- ◉ Workflow Considerations

- Nurse Coach
- Clinical Support Staff

- ◉ Education & Tracking

- Physicians
- Clinical Staff
- Reporting

# CARE PLANS: ENGAGING OUR PATIENTS

- ◉ Content
- ◉ Care Coordination
- ◉ Workflow
- ◉ Leveraging the EMR
  - Biometrics
  - Patient Portal



**Personal Diabetes Care Plan for Patient Name**

<b>HbA1c</b> Their personal goal to go here	<b>Your HbA1c</b> Results (most recent 3 values)	
	Date & Time	HbA1c

Blood pressure should be less than	<b>Your Blood Pressure</b>		
	Date	Time	BP

LDL cholesterol should be less than 100 (LDL is the "lousy" cholesterol which increases your risk for heart attacks and strokes)	<b>Your LDL</b> Results (within 3 years)	
	Date & Time	LDL

<b>Weight:</b> Their personal goal goes here	<b>Your Weight</b>		
	Date	Time	Wt - Scale

**Your Diabetes Medications**  
Their medications here

**Your High Blood Pressure Medications**  
Their medications here

**Your Cholesterol-lowering Medications**  
Their medications here

- What we want you to do:**
- Take your medications as prescribed by your provider and listed above.
  - Monitor your blood sugars at least \_\_\_ times daily/weekly and bring in your blood sugar monitor or a written record of your blood sugar results to your next visit.
  - Follow the diet recommended by your primary care provider or nutritionist.
  - Lose weight if you are above a healthy body weight.
  - Exercise 30-60 minutes per day or as recommended.
  - Don't smoke
  - Examine your feet daily for sores, cuts or boils.
  - Read educational material if given to you today.
  - Have an annual dilated eye exam.
  - If you have any questions about your medications or treatment plan please contact your provider.

**Keep your commitment between now and your next visit:**  
Individualized self-management goals here

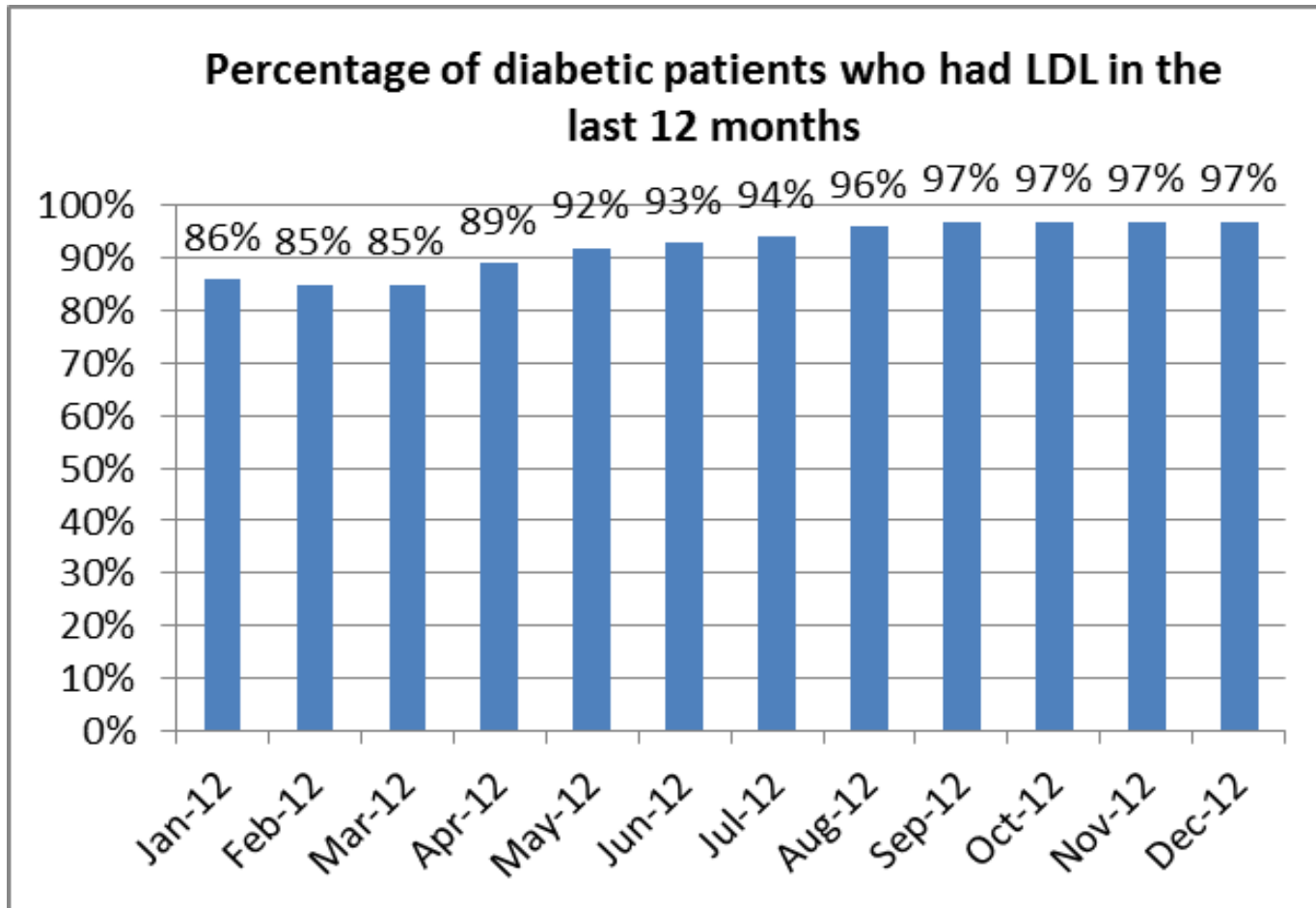


# QUALITY METRICS & REPORTING

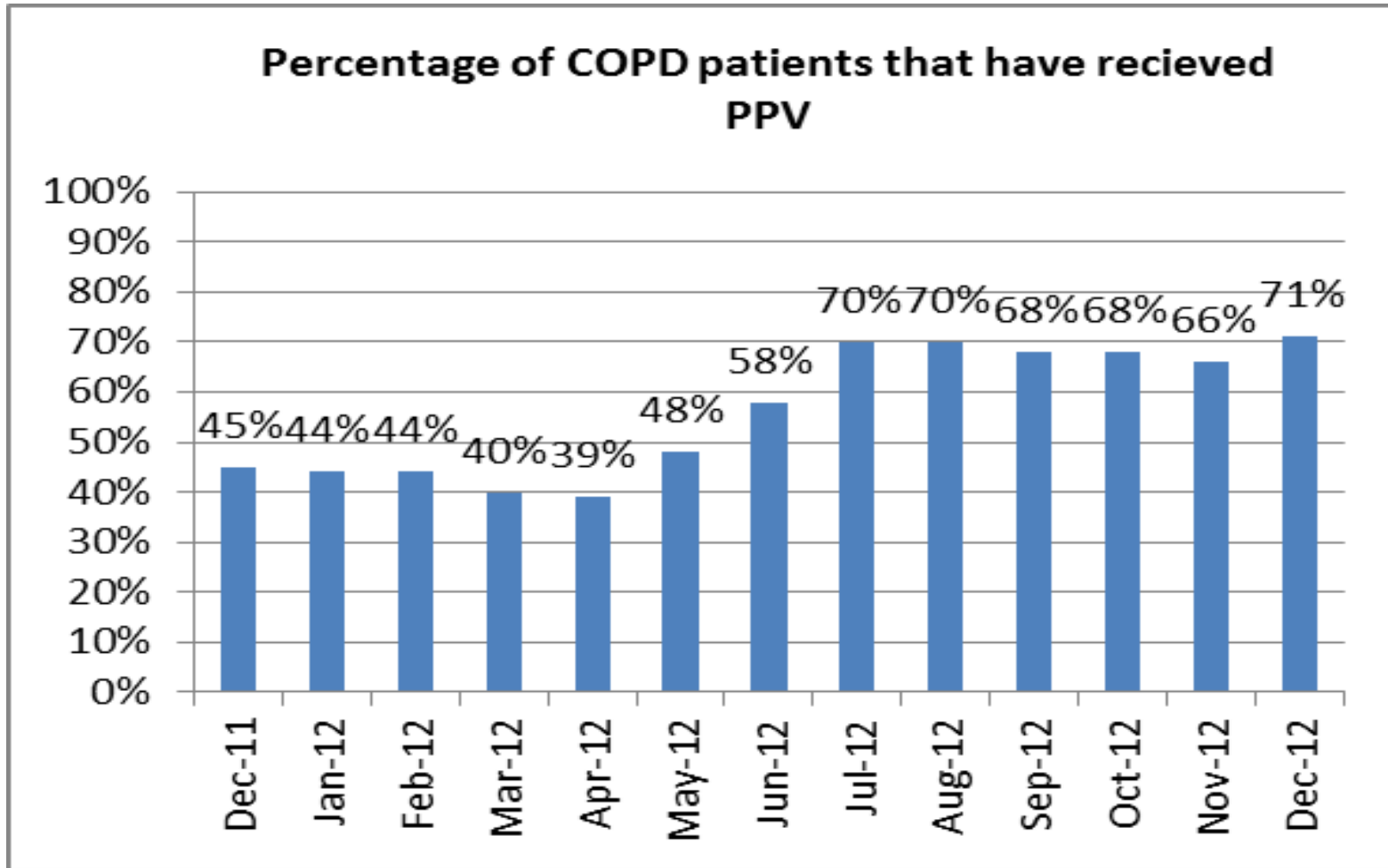
- ◉ Selection of metrics
- ◉ Setting Goals
- ◉ Monitoring
- ◉ Process Improvement



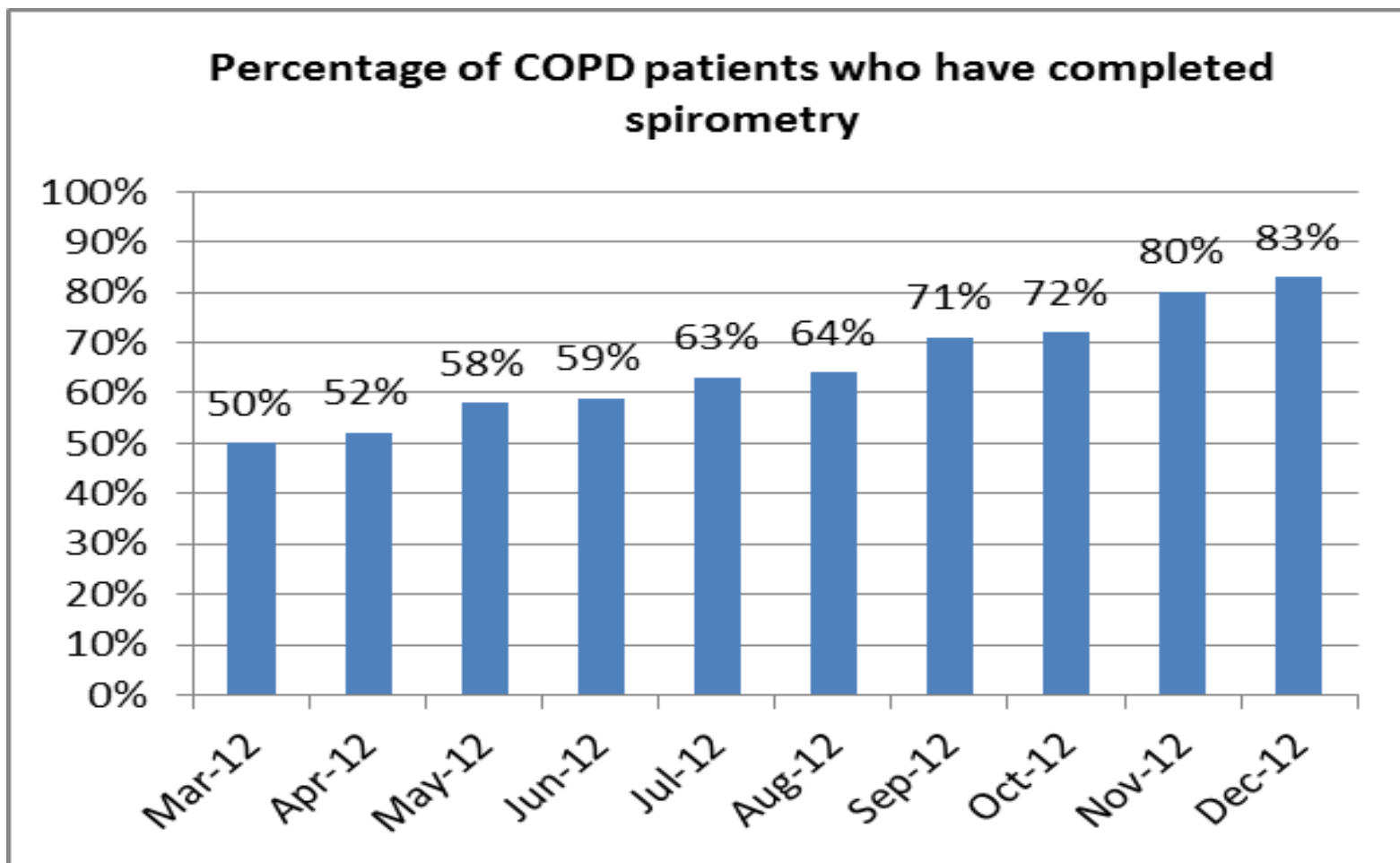
# DIABETES METRICS:



# COPD METRICS:



# COPD METRICS:



# LESSONS LEARNED

- ◉ Change in culture is imperative
- ◉ Must have buy-in from key stakeholders
- ◉ Be prepared to help the team work through change
- ◉ A solid IT infrastructure & team is a must

QUESTIONS??

Thank you!

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