Quality Improvement of a Geriatric Chronic Care Management Program

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Purpose

Geriatrics practices in academic medical centers aim to provide high quality senior chronic care management (CCM). Geriatrics nurses can empower themselves with The HealthSciences Institute Chronic Care Professional (CCP) program and certification to improve the quality of CCM.

Background

There is a large population of patients in this practice with multiple chronic illnesses. The top three billed diagnoses in 2016 were dementia, diabetes, and hypertension.

Patients with multiple chronic illnesses are high users of health services, resulting in increased provider and clinical staff non-face-to-face time spent with these patients.

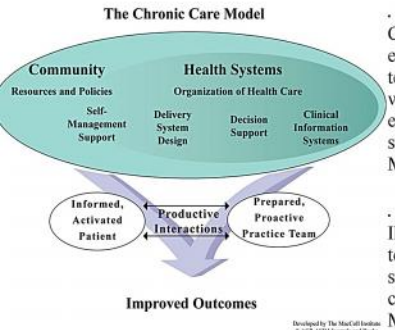
The Centers for Medicare and Medicaid Services (CMS) established separate billing codes for CCM to provide payment of care coordination and care management for a patient with multiple chronic conditions within the Medicare Fee-For-Service Program.

CMS data show that 2/3 of people on Medicare have 2 or more chronic conditions; unfortunately, CCM services were received by less than 3% of beneficiaries in CT in 2015 and 2016.

CCM services are typically provided outside of face-to-face patient visits and include:
- creation and maintenance of an electronic person-centered comprehensive care plan
- structured recording of patient health information (PHI)
- coordinating and sharing PHI timely within and outside the practice
- managing care transitions
- medication reconciliation and oversight of self-management of medications
- ensuring timely receipt of preventive care
- a continuous relationship with a designated member of the care team
- patient support for chronic diseases to achieve health goals
- 24/7 patient access to care and health information

Conceptual Framework

Evidence suggests The Chronic Care Model may be used as a guide for practice change to improve patient care and health outcomes, including for older adults.



. The Assessment of Chronic Illness Care (ACIC) is an evidence supported tool that was developed to help teams improve chronic illness care, with content derived from specific evidence-based interventions for the six components of the Chronic Care Model.

. The Patient Assessment of Chronic Illness Care (PACIC) is a validated tool that measures patient report of specific actions or qualities of care, congruent with the Chronic Care Model, that they have experienced in care delivery.

Together, the ACIC and PACIC provide both consumer and provider assessments of important aspects of chronic illness care.

Interventions

2 RNs and 1 APRN enrolled and participated in the 40 hour CCP program online from January 2018 to August 2018. As each module was completed, the nurses integrated evidence-based content and strategies into CCM using rapid Plan-Do-Study-Act cycles. The PACIC tool was administered to CCM enrolled patients at an office visit or via mail throughout the project timeframe. The ACIC tool, version 3.5, was administered to geriatrics staff who reached consensus on score pre and post intervention for care of dementia, diabetes, and hypertension.

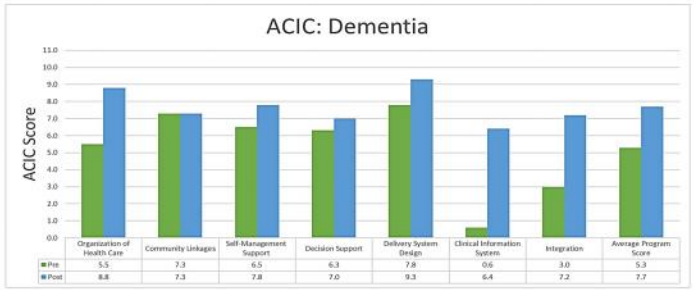
Outcomes

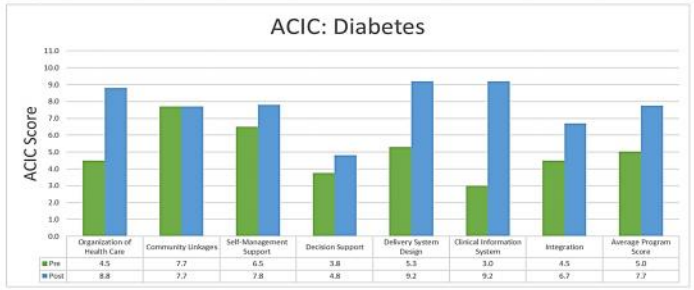
Chronic Care Professional Certification

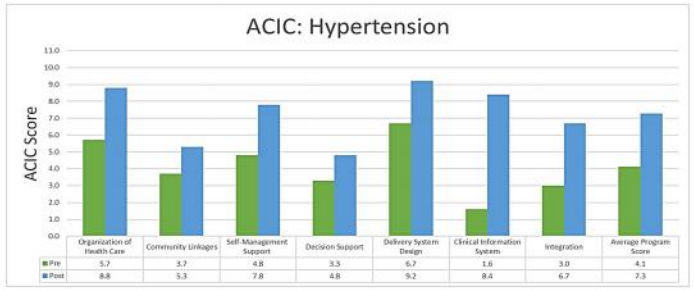
The number of CCP certified nurses pre intervention was 0 and post intervention was 2.

Assessment of Chronic Illness Care (ACIC)

ACIC scores (total possible=11) pre to post intervention increased 45.3% from 5.3 to 7.7 for **Dementia**, increased 54% from 5.0 to 7.7 for **Diabetes**, and increased 78% from 4.1 to 7.3 for **Hypertension**, indicating improved chronic illness care.







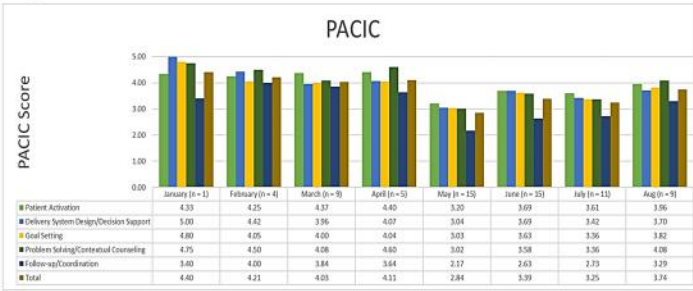
Rationale

Nurses are a key component of the CCM program, as they provide patient centered care planning and lead clinical staff in provision of CCM services. The CCP program educates on evidence-based medical care and patient support, including content and interactive training on population health improvement, chronic diseases, lifestyle management, behavior change theory, motivational interviewing, and health coaching.

Outcomes

Patient Assessment of Chronic Illness Care (PACIC)

The average PACIC score (total possible=5) pre intervention was 4.4 and post intervention was 3.74, a 15% decrease. Scores trended down followed by an upward trend. These trends may be due to initial small sample sizes combined with challenges of survey administration, including changes to staff workflow, difficulty explaining survey purpose to patients and families, patient reports that some questions were irrelevant to them, and adjustment to a new electronic medical record.



Application to practice

Advanced practice nurses (APN) can empower themselves and their clinical staff to improve the quality of CCM for their older adult patient populations with CCP education and certification. Professional development of clinical staff is an essential component to building a competent team capable of delivering high quality CCM services.

Organizational support, such as reimbursement and paid time off for continuing education, as well as administrative time for APNs and clinical staff to develop and incorporate new processes into workflows are key to ensure successful practice transformation and high quality chronic illness care.

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Acknowledgements

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Further Information

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