Chronic Care Assessment and Planning Report

Executive Summary

Prepared for the
Central Kenai Peninsula Hospital Service Area

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Prepared by:

Public Health Resource Group, Inc.
120 Exchange Street
Portland, ME 04101
(207) 761-7093
www.phrg.com

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CENTRAL KENAI PENINSULA HOSPITAL SERVICE AREA
CHRONIC CARE ASSESSMENT AND PLANNING REPORT

I. Background

In April of 2004, Public Health Resource Group (PHRG) delivered the Heath Care Service Needs Assessment of Central Kenai Peninsula report to the Central Kenai Peninsula Hospital Service Area Board (CKPHSAB). The goal of the study was to identify key health care service needs in those communities based on findings from a random digit dialed health survey of adults in the region. PHRG utilized selected tools from its Community and Institutional Assessment Process (CIAP) for the study. The report:

1. Described the health status, utilization patterns and service needs of the population in the Kenai Region using the data collected for this study;
2. Identified priority health service issues; and,
3. Formulated strategic recommendations for next steps that the CKPHSAB might consider to improve health care services in the community.

The Heath Care Service Needs Assessment established chronic care services as a fundamental need in the Central Kenai Peninsula, with a particular need for services to prevent and manage chronic diseases/conditions. This pattern clearly indicated a need for a better understanding of chronic care services in the region—one that includes community support services and policies, primary and specialty medical care, and the role of patients and families in care seeking behaviors, self management opportunities and barriers to care.

The CKPHSAB subsequently contracted with PHRG to complete a Chronic Care Assessment and Planning study of Central Kenai Peninsula during Winter 2004 – 2005. This study is designed to identify clinical and non-clinical (community and patient level) service gaps to persons diagnosed or at risk of developing chronic medical conditions. It provides the information necessary to plan prevention and management programs to improve the health status of the population. It should assist the CKPHSAB and local stakeholders in developing sustainable programs that build on existing chronic care services in the region.

II. Study Outline

The study provides a review of key chronic disease mortality and hospital utilization indicators for Peninsula residents in Section A, Health Status Indicators of Chronic Conditions. In Section B, we completed a chronic care Community Health Resources Assessment and in Section C, a Primary Care Practice Assessment. Together they describe chronic care services in the Central Kenai Peninsula, including information on the availability and integration of services that have been demonstrated to positively impact prevention and management of chronic conditions, and an assessment of the infrastructure, the resources available, and the process of providing evidence based care to patients with chronic conditions at a number of local primary care practices.

A. The Health Status Profile of Chronic Conditions

The most recent health-related data were obtained from publicly available mortality and hospital utilization databases to produce and analyze selected chronic disease health indicators for the hospital service area, the peer region, the state, and the nation. They consist of mortality indicators (rates per 100,000 population) for several chronic medical conditions, and counts and proportions of Ambulatory Care Sensitive (ACS) hospital admissions to the Central Peninsula General Hospital (CPGH). ACS hospitalizations are by and large the result of care associated with chronic conditions such as heart disease, diabetes, and respiratory disease. Research has demonstrated that hospital admissions for ACS conditions can be avoided with high quality disease management and patient self-

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management and adherence to treatment regimens. We were unsuccessful in obtaining data on hospital admissions for all residents, regardless of what hospital they used (patient origin data), thus we could not construct and analyze ACS hospitalization rates for the community—a superior method of measuring the impact of chronic disease on the population and hospital resources. See Appendix B for the Health Status Profile of Chronic Conditions and ACS Hospitalization Admissions and Days data.

B. The Community Health Resources Assessment

The Community Health Resources Assessment provides information on the availability and integration of services that have been demonstrated to positively impact prevention and management of chronic conditions. PHRG's Community Health Resource and Linkage Assessment tool (see Appendix D) was used to obtain information on the continuum of services available in the Kenai region for prevention, education, screening, diagnosis, and treatment, in addition to self-management and support services, of a number of chronic conditions identified for this study, including chronic disease risk factors (obesity, smoking, etc.). Seven criteria were measured to illustrate aspects of each service/program. The primary focus is on access[1] to care but there is also a focus on community provider linkages to physician practices—a major component of integrated chronic care. The data collected was used to determine the gaps in the current services available to patients with chronic conditions and to identify opportunities for better patient care integration between providers for prevention, diagnosis and treatment of chronic conditions.

C. The Primary Care Practice Assessment

PHRG's Practice Assessment for Quality Chronic Care (Appendix F) was used to evaluate the infrastructure, the resources available, and the process of providing evidence based care to patients diagnosed with one or more chronic medical conditions (in particular cancer, congestive heart failure, COPD, depression, diabetes, high blood pressure, high cholesterol, and/or obesity) at the primary care practice level. Using information from this assessment we will describe current practice procedures, and recommend practice improvement interventions including how practices can be better integrated to community resources for more comprehensive prevention and management of patients with chronic conditions.

III. Results and Recommendations

A. The Health Status Profile of Chronic Conditions

All cause mortality is high in the Kenai region compared to Fairbanks and the state based on both crude (disease burden) and age-adjusted rates. The age-adjusted rate is also higher than the US rate. The higher rates are due in part to higher death rates for chronic conditions, including diseases of the heart, total cancer, stroke, heart attacks, diabetes and Chronic Obstructive Pulmonary Disease (COPD). Death rates for specific treatable cancers such as cancer of the breast, prostate gland, and colorectal area are not elevated

[1] Agency Name / Contact Information / Service Description, Place / Location, Average Length of Time for Appointment, Number of Providers / Licensure Type(s), Population Served, Insurance Coverage, and Linkage to Primary Care.

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while lung cancer mortality is elevated. These data support the findings from the 2004 study that chronic disease is a significant problem in this population.

Overall ACS hospitalization counts at the CPGH based on 2003 hospital admissions data show that 13.2% of the admissions and 12.5% of patient days are for patients admitted with one or more ambulatory care sensitive condition. Admissions for diabetes are low while admissions for heart and respiratory conditions are high.

B. The Community Health Resources Assessment

From the Community Health Resources Assessment we attempted to determine how well the community's health care needs are currently being met by existing resources, what additional resources are needed, and how existing resources can be better linked to primary care practices and patients for prevention, diagnosis and treatment of chronic disease. The following recommendations are specifically geared towards the community's health care needs found to be most essential.

1. Disease Specific Education and Screening: Disease specific education and screening services for asthma, hypertension and high cholesterol are currently available in the Kenai region. Similar services are needed for patients with Chronic Obstructive Pulmonary Disease and Congestive Heart Failure.

2. Services to Assist Patients Self-Manage Their Conditions: Currently there are self-management services available in the community for cancer, mental illness and substance abuse. However they are not comprehensive (do not address behavioral risk factors, for example). Additional resources are needed in the community to assist patients in managing other chronic conditions such as heart disease and respiratory disease (asthma, COPD, etc.).

3. School-based Health Programs: Health care programs specifically geared to prevention of chronic disease among adolescents are limited, in large part due to funding. Initiatives, such as the Communities that Care SAMHSA grant which, if funded, will focus on preventative measures to reduce risk behaviors among targeted population groups, including youth in schools, are critical to fill this gap.

4. Specialty Care Services: Specialty care services are currently available for many chronic diseases. However the frequency and on-site availability of outside medical specialists for some conditions such as COPD are limited. The routine hospital-based clinical consults currently provided for cardiology should be expanded for other chronic conditions. Other rural specialty access models should be explored rather than relying only on clinical consults from specialist out of the area.[2]

5. Additionally, because many courtesy and consulting physician specialists are located in Anchorage and Washington state it may be difficult to increase the number of physician visits to the Kenai Peninsula—the implementation of a telehealth program that enables link-ups with specialty providers as needed will help fill the need for specialist care in the community.

[2] Deprez RD. "Specialty Service Models for Rural Hospitals." A Governance Institute Special White Paper, The Governance Institute, 2005.

6. Linkages: Linkages between mental health providers and primary care practices are minimal. We recommend this issue be explored to determine how to improve the collaboration between these two very important providers for patients with chronic conditions. Improvements in linkages could range from, at a minimum, better provider-to-provider information sharing about services and appropriate referrals, to transfer of patient information between providers in order to achieve better integration of patient care. A more collaborative working relationship that includes routine follow-up regarding patient care is a reasonable goal.

7. Within the limits of patient confidentiality and information security, community service providers should routinely be in contact with patient/client's primary care provider regarding care and treatment protocols.

8. A regularly updated web-based community services directory that lists comprehensive information on all community health care agencies and providers—including complementary and alternative medicine providers, medical specialists, and community health clinics—would benefit both patients and providers alike. Paper copies could be distributed to those providers and agencies that do not have Internet access.

C. The Primary Care Practice Assessment

The Primary Care Practice Level Assessment shows that a number of health care initiatives are currently underway for chronic conditions both in primary care practices and at the hospital. Three practices currently use electronic health record (EHR) systems and another intends to implement a system within the year. EHRs have demonstrated value in improving quality of health care to patients. The hospital has built relationships with several medical specialists from tertiary care centers in and out of Alaska that assist in filling care needs not available locally, and provides comprehensive care through the Diabetes Center and the Cardiac Rehabilitation Department. Many practices have also developed linkages with medical specialists and collaborate in providing patient care through consultations and patient referrals. Additionally, a number of practices are aware of quality improvement programs and work to implement care protocols that these programs have shown to be effective.

Although several initiatives are in place, practice changes are still indicated to better meet the care needs of patients with chronic conditions. The following recommendations are meant to assist primary care practices, the hospital, and other health care providers in developing and implementing sustainable quality improvements in the local health care delivery system.

9. Organization of the System of Care: Most practices did not report having organized healthcare teams and of those that did, the teams only reviewed patient care for particular cases (e.g. pain contracts, operations). In addition, practices do not have incentives to participate in quality improvement initiatives. Primary care practices, including the internists and health center, should consider the development (or expansion) and implementation of healthcare teams and practice-based incentives for improving the quality of chronic care. While difficult to achieve, both will work to improve care by motivating staff to take part in quality improvement efforts.

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10. Practice use of Evidence-Based Guidelines: Currently several practices are using protocols for the treatment and management of diabetes, hypertension, and chronic pain. Management techniques (for example, writing "prescription lists" for goal setting) have been extremely useful in improving quality of care. We recommend an effort be undertaken to incorporate existing protocols and expand protocols for other chronic conditions into the practices throughout the region.

11. Patient Education and Self-Management Methods: The physician practices have programs and agencies in the Central Kenai community and practice staff (such as the case manager and nursing staff at the health center) available that may assist in filling all of the self-management tasks, including problem solving, decision-making, resource utilization, the formation of a patient-provider partnership, action planning, and self-tailoring—it is critical that appropriate relationships are developed and maintained by each practice.

12. Integration of Care: Future practice level assessments should include a more in depth analysis of primary care providers linkages with all health care related services and providers, including not only specialists and hospital based programs, but community health programs within schools, support groups and with complementary and alternative medicine providers.

13. Delivery System Design/Clinical Information Systems: We recommend that practices implement an EHR where possible[3] or a patient registry for chronic care through the expansion of best practice tools and educational resources already in use.

Several of the primary care practices we interviewed for this study and CPGH have many quality improvement initiatives already in place. These should not only be maintained, but be used as a base for building future initiatives towards community-wide practice change through implementation of the chronic care model. A mechanism is needed to disseminate and spread these initiatives to all primary care practices in the community. This is not an easy undertaking but one that if successful will go a long way to ensure that the quality of patient care in the Kenai region is consistent with best practice guidelines and protocols. In summary we recommend that:

- A quality improvement forum be established to plan and develop future quality initiatives, build community support, and improve linkages with health care providers in the region. The CPGH, the CKPHSAB, physician leaders and other key stakeholders should take the lead in this effort.

The physician practices in the Central Kenai community will improve the quality of chronic care and patient health outcomes by implementing programs and changes identified by the Idealized Design of Clinical Office Practice (IDCOP), a three-year initiative organized by the Institute for Healthcare Improvement (IHI). These include many of the recommendations suggested in this report—**organizing a healthcare improvement team, development of evidence based protocols, utilizing community resources and staff for management, building collaborative relationships with consulting medical specialists, including frequent hospital clinics or telehealth, and developing a patient registry or clinical information system.**

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[3] Although electronic systems and software are designed to be ideal, many practices may not have the financial resources to implement them. In this case, practices may still maintain a registry of patients within a PC, for example using Microsoft Excel, or in paper format with index cards.

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