



# 2005 APHA Annual Meeting Session #4116:

## Community Based Chronic Care Services

- Lessons Learned
- Blue Hill Project

# Lessons Learned

- We know a lot about best practice chronic disease care
- We have good tools for population need assessments
- We have some tools for practice and quality of care assessment/planning
- We have several proven practice improvement processes—IHI, office Microsystems (Dartmouth) are examples

# Lessons Learned

- We need better rapid assessment tools
  - For understanding patients barriers
- We need to do a better job at integrating patient barriers information into practice changes
- We have not linked practice and community resources for patient care very well

# Lessons Learned

- Practice change is difficult and takes a long time
- Technology changes can be very challenging
- Single disease initiatives may not carry over to other diseases
  - Registries, EMRs, workflow changes, time
- Sustaining practice and system change takes funding that may not be available

## Blue Hill Multiple Condition Chronic Care Project

- A two year project starting in January 06
- Based on a comprehensive assessment and plan
- Will address seven chronic conditions with a modified IHI process
- Interventions at both the practice and community levels
- Four practices with 12 physicians and 8 mid-levels
- Funding from the Physician Foundation for Health Systems Excellence

# Blue Hill Multiple Condition Chronic Care Project

- Hyperlipidemia
- Hypertension
- Congestive Heart Failure
- Diabetes
- Chronic obstructive Pulmonary disease
- Obesity
- Major Depression

Assessment - Health Conditions,  
Patient Barriers including structural  
(e.g. transportation)

**Community**

Health Status

+

Policies

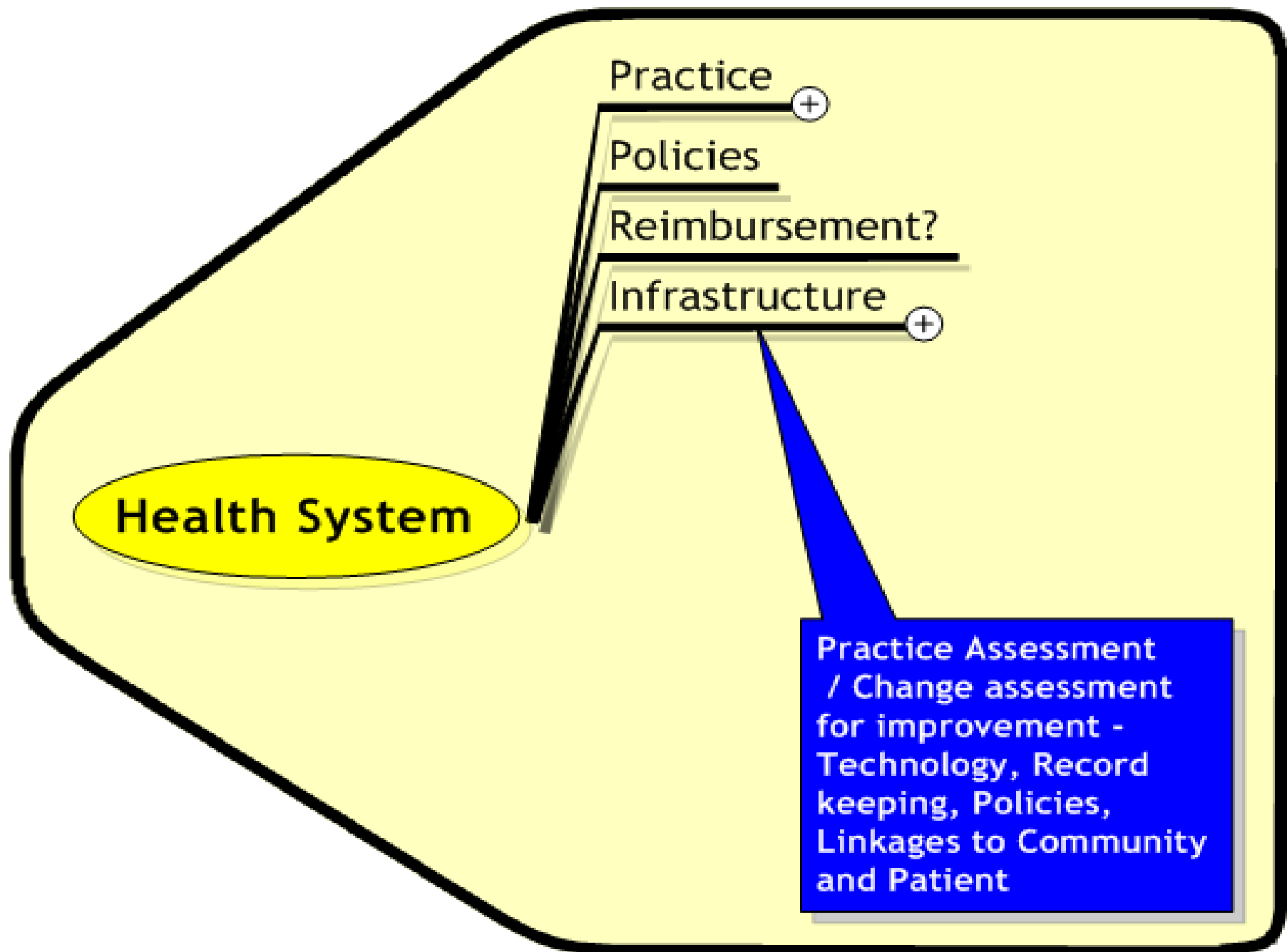
Culture?

Health Care Resources

+

Gov / NG Organizations

+



Practice +

Policies

Reimbursement?

Infrastructure +

Health System

Practice Assessment  
/ Change assessment  
for improvement -  
Technology, Record  
keeping, Policies,  
Linkages to Community  
and Patient

# BH Community Level Intervention

- Web based information system
  - Local/regional resource directory for the care of chronic conditions
  - External information resource links
  - Community events—screenings, health fairs, etc.
  - Self administered risk profiling program
- Health Services Linkages
  - Providers
  - Community organization/employers
  - Community members/patients and families

## BH Practice Level Intervention

- Practice consensus on key disease targets for change
- Decision support resource to generate patient visit flowsheets
- Follow-up system for referrals to external resources

## BH Patient Level Impact

- Treatment Barriers:
  - Access to services (i.e., transportation)
  - Provider communication
- Self Management Tools
  - Knowledge, skills and attitudes
  - Family Support
  - Patient adherence to treatment strategies

## BH Evaluation Plan

- Use of Community Resources
- Improvement in Linkages
- Changes in Practice Infrastructure
- Changes in Patient Outcomes
- Changes in Patient and provider satisfaction

# Summary and conclusions

# PHRG Chronic Care Services Improvement Roadmap

## A Roadmap to Identify, Implement and Evaluate Quality Improvement for Chronic Care

