QUALITY IMPROVEMENT STRATEGIES FOR MULTIPLE CHRONIC CONDITIONS

More than one in four Americans are affected by multiple chronic conditions (MCC).[1] The prevalence of MCC increases as people age and the growing number of individuals affected by MCC are attributed to a growing aging population, increased life expectancy, and an increase in factors associated with chronic conditions, such as obesity, tobacco use and physical inactivity. In addition, healthcare costs attributed to MCC are substantial, with almost three quarters of total healthcare spending in the United States associated with care for Americans with MCC. People affected by MCC are at risk of early mortality, poor functional status and hospitalization, as well as facing significant out-of-pocket expenses for healthcare and prescription drugs.

What are Multiple Chronic Conditions?

Conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living. MCC can include diabetes, arthritis, heart disease, hypertension, asthma, and chronic respiratory conditions, as well as mental health illnesses and substance use disorders.

OVERVIEW OF MCC

The leading chronic diseases in South Dakota (SD) are high cholesterol, hypertension, and arthritis.[2] Approximately 26% of SD adults aged 18 and older are affected by MCC, having two to three chronic conditions. More than half of those affected with two or more MCC are aged 55 and older. In addition, MCC affects specific SD populations at a higher rate, including American Indians, individuals with less than a high school education, and individuals with an annual household income of less than $15,000.

[1] National Center for Chronic Disease Prevention and Health Promotion. 2018, August 14). *Multiple Chronic Conditions.* Retrieved from https://www.cdc.gov/chronicdisease/about/multiple-chronic.htm
[2] The Behavioral Risk Factor Surveillance System, South Dakota Department of Health, 2011-2016.

South Dakota's healthcare systems and providers are working to address MCC, focused on examining available data to understand issues affecting patients and expanding their approach to address these issues.

EVIDENCE-BASED APPROACHES TO ADDRESS MCC

Provider Reminder and Recall Systems	**Definition:** Inform healthcare providers it is time for a client's test or that the client is overdue for services. The reminders can be provided in different ways, such as in client charts or by e-mail.
	Implementation Strategies: Systems should focus on improving compliance through a computer reminder system that reviews patient records. In addition, tagged notes, stickers in patient charts, and cards given to patients to help prompt healthcare providers, as well as reminders sent to the physician between patient visits can be useful strategies.[3]
Client Reminders	**Definition:** Client reminders are written (letter, postcard, email) or telephone messages (including automated messages) advising patients they are due for preventative care such as informing patients that they are due for cancer screening or vaccinations.
	Implementation Strategies: Reminders can work through a variety of methods, including phone call (by clinic staff or electronically), patient portal, e-mail, text, letter, and postcard. Additional strategies include providing information (e.g. pamphlets) on regular preventative care.[3]
Provider Training	**Definition:** Training designed to equip healthcare teams with tools and knowledge on caring for persons with MCC across settings. The goal of training is to promote increased quality of care. Addressing these gaps, as well as the need for improving providers' cultural competencies, will ensure that the current and next generations of providers are proficient in caring for individuals with MCC and in interacting with family caregivers.
	Implementation Strategies: Training can be supported through various strategies, including development and dissemination of information relevant to general care of individuals with MCC for use in training programs and ensuring that healthcare providers receive training on monitoring the health and well-being of family caregivers for individuals with MCC. An additional strategy includes developing and fostering training within traditional and nontraditional professional settings that emphasize increased competency in palliative and patient-centered approaches.
Motivational Interviewing	**Definition:** A counseling approach that is a directive, client-centered style involving engaging, focusing, evoking, and planning processes with the goal of engaging clients, eliciting change talk, and evoking client motivation to make positive changes.
	Implementation Strategies: A motivational interviewing style of communication can be incorporated into routine patient care through asking open-ended questions and probes, affirming patients when they share information, reflecting on what patients say, summarizing, and assessing a patient's confidence, ability, and commitment to achieving agreed-upon goals. This style of interviewing can be used regardless of medical condition and regardless of area of practice (physician, nurse, social worker, dietician, etc.).

[3] Strategy 6R: Reminder Systems for Immunizations and Preventive Services. Content last reviewed December 2018. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/health-promotion-education/strategy6r-reminder-systems.html

Provider Dashboard	**Definition:** An interactive tool that houses data allowing for better examination of MCC patterns, including opportunities for improvement and care. **Implementation Strategies:** Most electronic health records come equipped with a dashboard that can be adapted to fit the needs and level of access of each healthcare team member. Additional dashboards may be incorporated through quality improvement programs utilized by facilities to review specific performance measure data as well.
One-on-One Patient Education for Clients	**Definition:** A face to face meeting intended to impart information and education to the recipient with the ability to exchange ideas and provide shared decision making. It allows for the identification of problems and barriers, as well as helps build trust and allows for accurate and timely information exchanges. It may also include other members of the family and care giving team. **Implementation Strategies:** Face-to-face meetings include, clinical meetings focused on an evaluation of patient, diagnosis, prognosis, and needs or health meetings focused on wellness and prevention. Effective meetings include communication that is patient centered, including comfort and acceptance and noted responsiveness/empathy and reacting positively to patient responses.
Reduce Structural Barriers to Increase Screening	**Definition:** Methods employed to assist with lessening patient burdens or obstacles that make it difficult for people to access screening for multiple chronic conditions or other healthcare needs. **Implementation Strategies:** Interventions designed to reduce these barriers may facilitate access to services by: reducing time or distance between service delivery settings and target populations, modifying hours of service to meet client needs, offering services in alternative or non-clinical settings (e.g., mobile mammography vans at worksites or in residential communities), eliminating or simplifying administrative procedures and other obstacles (e.g., scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits).
Provider Assessment and Feedback	**Definition:** Focuses on evaluating provider performance in delivering or offering services to clients (assessment) and presenting providers with information about their performance in providing those services (feedback). Feedback may describe the performance of a group of providers (e.g., mean performance for a practice) or an individual provider, and may be compared with a goal or standard. **Implementation Strategies:** Data is key to quality improvement to ensure quality provider care. Data can be collected through an audit of electronic health records or paper charts of patients seen during specific time periods. Clinical provider peer review also provides an alternative method to assess provider performance and a patient's experience. Frequent distribution of this data presents providers with feedback on their progress towards meeting goals or standards.[4]
Develop Quality/Performance Measures	**Definition:** Quality/performance measures are tools that help us measure or quantify healthcare processes, outcomes, and patient perceptions. They can help measure organizational structure and systems that are associated with the ability to provide high-quality healthcare or that relate to one or more quality goals for healthcare, such as quality improvement, public reporting, or pay-for-performance program. **Implementation Strategies:** Quality/performance measures can be developed by implementation of small-scale demonstrations, which are easier to manage than large-scale changes. Small-scale demonstrations or small tests of change also allow you to refine the new processes, demonstrate their impact on practices and outcomes, and build increased support by stakeholders. Plan-Do-Study-Act (PDSA) is a typical process used when developing initiatives based on quality improvement.
Team Based Care	**Definition:** A care model that includes strategic redistribution of work among members of a practice team, such as a physician, nurse, and/or medical assistant, etc. to share responsibilities for better patient care and address gaps in care coordination. **Implementation Strategies:** Team-Based Care can be implemented through adoption of models such as Medicaid Health Homes or Patient-Centered Medical Centers in which utilization of a care team approach enhances patient experience, improves population health, and reduces cost of care.[5]

[4] Module 8. Collecting Data With Chart Audits. Content last reviewed May 2013. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod8.html

[5] American Medical Association. (2015, October 7). *Implementing Team-Based Care, Engage the entire team in caring for patients.* Retrieved from https://edhub.ama-assn.org/steps-forward/module/2702513

Comprehensive Telehealth Interventions	**Definition:** Telehealth is the use of digital information and communication technology, such as through computers or mobile devices, to access healthcare services remotely and manage that healthcare. These may be used from home, work, or other digitally accessible places to improve or support healthcare services.
	Implementation Strategies: Actively using patient portals and electronic health records is an easy way to incorporate routine telehealth. Remote monitoring programs such as utilization of video appointments at various locations or eICU are a good way to provide outside expertise while limiting barriers such as travel and staffing costs.
Self-Care Management	**Definition:** Supports people with chronic conditions that enables them to manage their health on a day-to-day basis, including providing information, providing patient-centered care, helping patients set goals and make plans to live healthier, and creating a team of healthcare providers and staff who understand their roles and responsibilities.[6]
	Implementation Strategies: Within the community setting, strategies to support self-care management include translating and replicating chronic disease self-management programs, in multiple settings, enhancing sustainability of evidence-based self-management activities and programs, and improving the efficiency, quality and cost-effectiveness of self-care management activities and programs. Learn more about South Dakota's self-management programs, Better Choices, Better Health SD and Diabetes Self-Management Education and Support Program.
Health Information Technology	**Definition:** Health information technology (health IT or HIT) involves the exchange of health information in an electronic environment and includes a variety of methods used to manage information about people's health and healthcare, for both individual patients and groups of patients.
	Implementation Strategies: Health Information Technology can be incorporated into practice through use of clinical decision support tools such as provider dashboards, health information exchange networks and performance measure programs or through reporting to computerized disease registries. Use of electronic medical records which incorporate provider order entry and electronic prescribing are also an easy way to utilize HIT.

Health Care Spotlight

- **Falls Community Health (FCH),** a Federally Qualified Health Center, has been operating as a Patient-Centered Medical Home (PCMH) since 2014 to support underserved and uninsured patients. Under this model, FCH works in basic care teams consisting of a provider, a licensed practical nurse, and a registered nurse who is shared between two providers, as well as additional staff as needed. Teams participate in daily huddles as well as monthly meetings where they review clinical quality measures and discuss patients that are in need of more complex care. Executive leadership and front-line staff was instrumental in implementation of this model. Utilizing this team-based care approach allows for enhanced care coordination for patients, increased continuity of care, quicker identification of patients who are at an increased risk for poor health outcomes and a more proactive approach to patients' healthcare needs.

- **Horizon Health Care, Inc.** partnered with the SD Department of Health to implement client reminders and provider assessment and feedback, at three clinic sites in the southeastern portion of the state, with an aim of increasing breast, cervical, and colorectal cancer screening rates. Throughout the one-year project period, Horizon implemented mailed, EHR portal, and phone call reminders to patients due or overdue for the identified preventive cancer screenings. Over 1,550 reminders were distributed throughout the project period. Horizon also implemented a provider feedback process that included monthly reports with unblinded provider and clinic level rates for breast, cervical, and colorectal cancer screening. In total, rates of screening for the three measures increased by 93% during the year!

Learn more about Healthcare Referrals to Chronic Disease Programs available in South Dakota.

[6] Self-Management Support. Content last reviewed October 2018. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/self/index.htm