EXECUTIVE SUMMARY

ORGANIZED, EVIDENCE-BASED CARE:

Planning Care for Individual Patients and Whole Populations

May 2013

For more information, see the Organized, Evidence-Based Care Implementation Guide.

What

Organized, evidence-based care (OEBC) is care that is based on scientific evidence and planned and delivered so that the team optimizes the health of their entire panel of patients. OEBC in a Patient-Centered Medical Home (PCMH) consists of designing each encounter to meet a patient's preventive and chronic illness needs, using planned interactions and ensuring appropriate follow-up care. Evidence-based guidelines are embedded into daily clinical practice as well as shared with patients. High-risk patients are identified to determine they are receiving appropriate care management services.

Why

To achieve desired health outcomes, care must be organized, accurate, and effective. Well-organized care allows patients to get the care they need, when and how they want it. Many healthcare services, especially those for patients with chronic illnesses, are predictable and benefit from planning. Using proven preventive interventions, clinical assessments, and treatments removes much of the variability offered by ad hoc decisions, and are more accurate and effective. Planned visits address many of predictable health issues by using available resources more efficiently and meeting patients' most important preventive or illness related needs in the care visit. This can result in more efficient visits for individual patients, particularly those who require ongoing interactions, such as the chronically ill. Practices can also use information systems to anticipate the care needs of their entire patient population.

The concepts behind OEBC build on more than 15 years of experience in health systems implementing the Chronic Care Model, a widely used framework to establish the elements needed at a practice and system level to reliably deliver organized, evidence-based care for populations of patients.

Implementation Overview

Planned Care

- Know what patients need and organize visits to deliver those services. Many services that patients need are predictable. Planned care is an opportunity to create an agenda for the visit including predictable services.
- Identify key clinical tasks associated with evidence-based care (e.g., performing a diabetic foot exam, administering a PHQ-9, giving a flu shot).
- Decide who on the team should perform each task.

- Review patient data prior to the visit to identify which services may be needed.
- Structure the visit so that relevant members of the team deliver all needed services. Standing orders facilitate this process.
- Identify patients with recurring needs or who are overdue for needed care with patient registries.
- Address unpredictable patient-initiated visits with brief and efficient practice team huddles (10-15 minutes) to review up-to-date patient information.
- See the Patient-Centered Interactions Implementation Guide for information on including self-management in care plans and care visits. Work with patients to set patient-directed goals or clear targets (e.g., weight loss, increased exercise). Reiterate these patient-directed goals in every interaction with the patient and ask about progress made since the last care visit.

Decision Support

- Incorporate decision support (interventions delivered via a computer program to help healthcare providers make appropriate clinical decisions).
- Use point-of-care reminders based on clinical guidelines.
- Structure care around evidence-based guidelines. Guidelines influence critical data maintained in registries and patient summaries that determine service needs in planning care. Performance measures that may affect recognition or payment are increasingly evidence-based and may include use of guidelines. Protocols derived from evidence-based guidelines enable non-clinicians to play larger roles in clinical care (e.g., adjusting medication doses by protocol).

Care Management

- Decide which segments of the practice population need care management. High-need patients typically have chronic conditions, often multiple chronic conditions, and are at higher risk for morbidity and mortality. Caseloads cannot be large and should range from 50–150 patients.
- Decide which service type is required for each segment. A service may be better provided by a practice team member with less training than a provider, such as a medical assistant.
- Develop or "steal" a data-based case identification strategy. Use a comprehensive strategy based on data. Do not decide care management needs patient by patient as this wastes time and results in excessive caseloads.
- Identify and train a clinical care manager. In ambulatory practices, the clinical care manager is predominantly a nurse. Training varies on the practice and may be specialized based on patient population (e.g., geriatric care). Care managers are members of the primary care team working together with the primary care provider on a collaboratively developed treatment plan. Typical tasks include:
  - **Follow-up.** Monitor and assess patients at regular intervals.
  - **Self-management support.** Provide information and counseling to help patients set goals and develop action plans.
  - **Medication management.** Reconcile medication. Evaluate medication adherence, effectiveness, and toxicity. Recommend guideline-directed regimen changes.
  - **Emotional support.** Monitor psychosocial state and recommend appropriate mental health or supportive interventions when necessary.
  - **Care coordination.** Keep track of care that patients receive from other providers, institutions, or agencies.
- Create a support structure for the care manager. Providers should conduct weekly reviews of the care manager's caseload to ensure the program's goals are met, care is safe, and of high quality.

What Progress Looks Like: PCMH-A Level A

The PCMH-A a is self-assessment tool to help practices understand their current level of "medical homeness," identify opportunities for improvement, and track their progress toward practice transformation. It is also a learning tool that can help start conversations within a practice about patient-centered care. The PCMH-A is scored on a 1–12 scale, which is divided into four levels (D, C, B, and A). A "Level A" item score indicates that most or all of the critical aspects of the key change addressed by the item are well established in the practice. An overall Level A score indicates that the practice has achieved considerable success in implementing the key design features of the PCMH.

Level A PCMH-A Items

For more information, see the Patient-Centered Medical Home Assessment (PCMH-A).

16. Comprehensive, guideline-based information on prevention or chronic illness treatment…guides the creation of tailored, individual-level data that is available at the time of the visit.

17. Visits…are organized to address both acute and planned care needs. Tailored guideline-based information is used in team huddles to ensure all outstanding patient needs are met at each encounter.

18. Care plans are…developed collaboratively, include self-management and clinical management goals, are routinely recorded, and guide care at every subsequent point of service.

19. Clinical care management services for high-risk patients…are systematically provided by the care manager functioning as a member of the practice team, regardless of location.

20. Behavioral health outcomes (such as improvement in depression symptoms)… are measured and tracked on a population-level for the entire organization with regular review and quality improvement efforts employed to optimize outcomes.

31. Behavioral health services…are readily available from behavior health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement.

Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

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