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Breakthrough improvement for CHF patients in a primary care setting shows what can be achieved through structured Collaborative action

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Objective:
To increase the proportion of CHF patients receiving optimum evidence-based care to 85%.

Methods:
A year-long, system-wide chronic disease Collaborative was established for clinical teams to seek ways to achieve breakthrough improvements in care for patients with congestive heart failure (CHF). The Collaborative implemented the Chronic Care Model using the Institute for Healthcare Improvement's (IHI) Breakthrough Series Collaborative Learning methodology and the IHI Model for Improvement to achieve its goals.

Results:

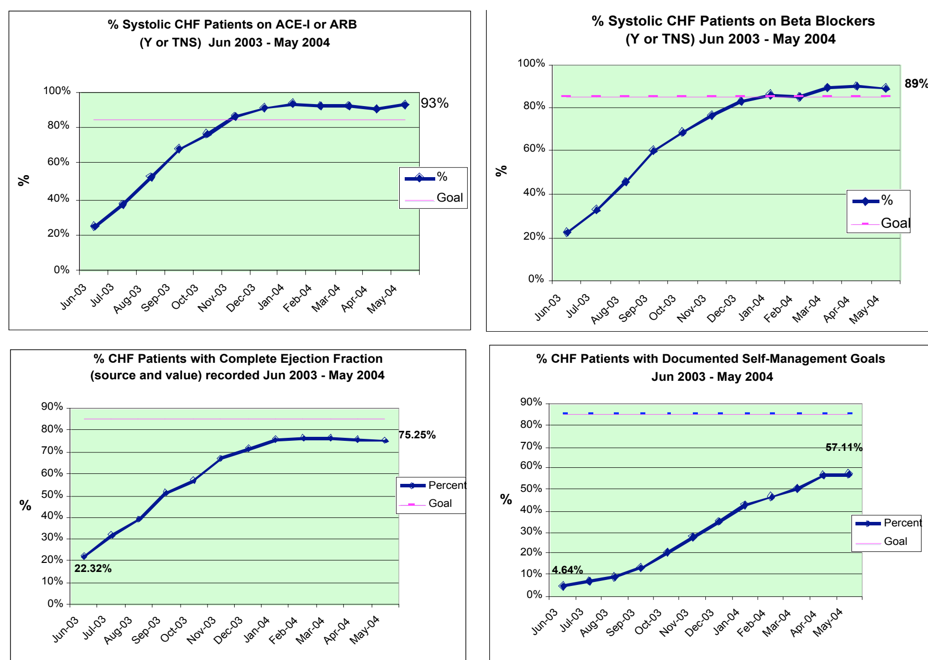

Figure 1. Run-charts tracking % of patients for ACE-I/ARB, beta-blockers, ejection fraction and self-management goals over the period of the Collaborative (n=820).

Translating clinical practice guidelines for heart failure into a focused aim statement, measures and targets embedded in a flow sheet (encounter form) greatly helped to implement evidence-based practice. Decision-support tools and protocols were developed to support achieving the collaborative measures. These included: Patient Reminder sheets from clinical practice guidelines; B-blocker titration protocol; Diuretic protocol; Patient registries from probabilistic patient lists; Testing of multi-disciplinary care approach, including Registered Nurse, Registered Dietitian/Nutritionist and Pharmacist; Testing of a Shared-Care arrangement between General Practitioners and Cardiologists; Policy for reviewing echocardiograms via tele-health in rural communities; Implemented a new way of partnering, combining health and community, public and private, grass roots and more formal planning people, regulatory and professional bodies, funding agencies and practitioners; Fostered new networks, particularly at the local primary care level for team development; Achieved limited and isolated success at a systems level to understand and implement shared care between primary care and specialist physicians.

Conclusions:

- It is possible for primary care physician practices to deliver specialist-level of care for CHF patients, as demonstrated by the significant changes in the core process measures of drug utilization and self-management goal setting.
- Information systems are a fundamental support for chronic disease management and a necessary part of the re-design process.
- Self-management is key to long-term success of Chronic Disease Management.
- The Chronic Care Model proved very valuable as a systems framework for overall health systems transformation.

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