California Health Improvement Project (CHIP)
Promoting Team Care and Support for High Risk High Cost Patients

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Problem Statement and Underlying Causes

5% of people account for 50% of health care costs and many high risk high cost patients with chronic conditions have poor health care experiences and outcomes.

- Primary care providers are increasingly overwhelmed and burned out and there are not enough of them to meet the demand.
- Many people with chronic conditions are not well served by 15 minute appointments, which is frustrating for patients and providers.

Primary care providers are overwhelmed and high risk high cost patients have poor health care experiences and outcomes.

Teams are trained and change work processes to work to full capacity and provide effective care to high risk patients.

Project Description

Stanford Coordinated Care is a model for care of “high utilizers” with complex chronic conditions. Our whole team offers training to enable clinical teams to work to limits of licensure to provide cost effective and high quality patient-centered care to high risk patients. Effectiveness of the SCC team training workshops will be measured.

Goal and Objectives

Long Term Goal: Effective clinical teams will recapture the joy of practice and be better able to provide patient-centered care to people with chronic health conditions, improving their outcomes and experience of care, and reducing cost of care.

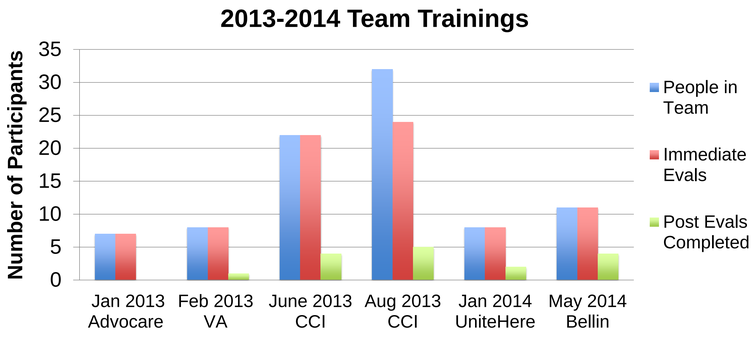
Short Term Goal: Develop, deliver and evaluate SCC clinical team training workshops which enable practice changes promoting patient centered team care for patients with chronic health conditions.

Output-oriented Objective: Six teams will participate in workshops at SCC in 2013-2014 and at least two members of each team will complete evaluations immediately after the workshop and at 3 - 6 months to assess the impact of the training towards meeting their stated goals.

Outcome-oriented Objective: 80% of respondents completing evaluations 3-6 months after training will report implementing patient centered/team practices as a result of the training.

Outputs & Outcomes

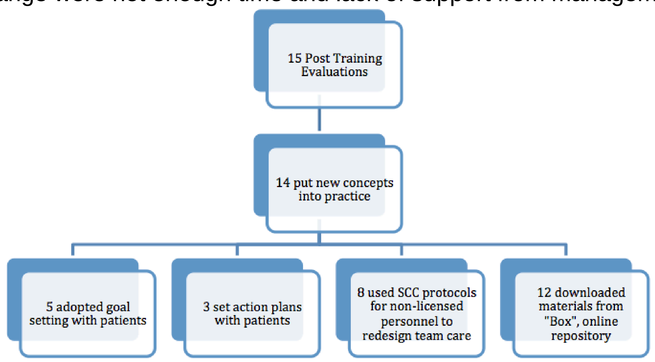
Outputs Achieved



Outcomes Achieved

Changes Reported

Six team trainings have been held as of June 2014. The evaluation process was not adequate for the first two groups. Adoption of new practices ranged from 0-80%,with an average of 30%. Barriers to change were not enough time and lack of support from management.



Post-training Comments

“If looking for an idea on controlling highest cost patients, this is where to start. Well thought out program.”
“Appreciated hearing from different team members.”
“SCC protocols to expand team role of non-licensed personnel very useful.”
“We will redesign clinic workflow.”
“Motivational interviewing training is very useful.”
“Patient advisory groups!”
“Amazing, highly pragmatic. Provided nuts and bolts.”
“Use of Patient Activation Measure, impact of Adverse Childhood Experiences.”
“Huddles, visibility wall, ongoing quality improvement”
“You have given us the spark and the information to transform our practice.”
“It’s the future!”

Lessons Learned

- Spend less time “teaching” and more time working with teams on “next steps.”
- Improved “pre-work” processes with teams resulted in more customized trainings.
- Having the whole SCC team teach about their roles modeled a team approach and helped overcome doctors’ concerns about sharing responsibility for patient care.
- Teams with management **and** clinical teams attending reported the greatest success.
- An on-line “box” improved trainees’ access to reference materials and protocols which will now be on the SCC website, improving general access.

The happy SCC team

About My Organization

Stanford Coordinated Care is a service for Stanford employees and dependents enrolled in Stanford’s self-insured health plans. We provide patient-directed team care to patients accounting for the top 20% of the costs, either primary care or care support to those who get primary care elsewhere. The SCC Team provides, measures and continually improves coordinated clinical care for these high risk patients to improve outcomes, promote patient self-efficacy and experience of care and reduce cost of care. Medical assistants/Care Coordinators have their own panel of patients, stay with the patient throughout the clinic visit, scribe the visit, order routine tests and med refills per protocol and support the patient between clinic visits.

Contact Me

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CHCF HEALTH CARE LEADERSHIP PROGRAM

To learn more about CHCF go to:
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