Title: Chronic Disease Management Team Drives Care Delivery Using A Quality Measure Performance Dashboard

Abstract:

Background: Health care reform has drawn attention to national improvement efforts to improve care transitions for patients with heart failure. Chronic disease management (CDM) teams are vital to move healthcare delivery forward to improve health and healthcare for patients and chronic disease populations.

Purpose: To show the impact of a collaborative multidisciplinary CDM team in driving improved performance of heart failure specific Joint Commission quality measures.

Intervention: A CDM team within a large academic medical center was motivated by a national quality initiative to improve the quality and transitions of care for patients with HF. The CDM team has aligned with organizational goals and strategically implemented quality improvement strategies using a systemic approach. This team meets monthly and uses a quality performance dashboard to track data and quality driven improvement performance. Engagement from many disciplines has played a vital role in the improvement of quality measures to ensure minimized variance and improved care and safety for patients with HF.

Findings: From fiscal Year 2013 (FY13) through FY15 the CDM team focused on 6 quality metrics and improved overall performance from 33% to be 67% of metrics at or above the national benchmark (NB) (source HF-GWTG®). Three clinical metrics focused on evidence-based care directed to measure left ventricular function and based on those results to prescribe ACEI/ARB and an evidence-based beta-blocker at time of discharge. Prescription of discharge medications improved from below the NB in FY13 to above the NB in FY15. Three additional quality metrics focused on care transitions. One metric targeted discharge instructions and showed an improved by 8%, but remained no different than the NB. Two quality metrics focused on care post discharge. Follow up (FU) visit within 7 days or less improved by 9% from FY13 to FY15 and remains above the NB. A FU visit within 72 hours of discharge remains below the NB, but has improved from FY13 to FY15 by 11%.

Implications for Practice: The CDM team has influenced multiple care coordination and quality efforts that continue to drive care delivery forward while demonstrating many best practices.