7CCs and the Art of the Chronic Conditions Consultation

A Framework for conducting a Chronic Conditions Consultation

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Idols of the Mind

Larry Weed is a hero of mine. Professor of Medicine at Vermont University, he is a 'disruptor' of traditional approaches to medical education. He believes that we have a misplaced faith in the unaided human mind. This 'idol of the mind' was described by Francis Bacon 400 years ago. He believes that doctors have a responsibility to assist their minds with tools that improve the reliability of their decision making.

Prof Weed developed the Problem Orientated Medical Record, with it's familiar SOAP framework (Subjective, Objective, Assessment, Plan). This has formed the basis of the RACGP approach to medical record keeping and has been taken up in all our desktop clinical software systems.

> **"The organisation of the medical record should be a matter of immediate concern to practicing physicians and students."**
>
> *- Larry Weed*

Dr Weed's article 'Medical Records That Guide and Teach' was published in the NEJM in 1968 – it must have seemed revolutionary at the time.

"The beginning clerical clerk, the house officer and the practising physician are all confronted with conditions that are frustrating in every phase of medical action. The purpose of this article is to identify and discuss these conditions and point out solutions. To deal effectively with these frustrations it will be necessary to develop a more organised approach to the medical record, a more rational acceptance and use of premedical personnel and a more positive attitude about the computer in medicine. Eventually, for every physician all three areas will be an obligatory part of his professional environment if he is to play a significant part in the total health-care job that will have to be done. The organisation of the medical record should be a matter of immediate concern to practicing physicians and students."

Patient streams

In general practice we identify three distinct patient streams, each of which has different values and care needs.

The acute stream consists of patients who require urgent or semi-urgent care for the diagnosis and management of a problem (which may be new or may be an exacerbation of a chronic condition)

The routine stream consists of patients who require check up, risk factor management, review, or ongoing management of a particular condition.

The chronic stream is for patients who we know have one or more chronic conditions that we value seeing regularly to provide systematic, proactive care.

Frameworks

The SOAP system as developed by Prof Weed has proven its value over many years for guiding clinicians in diagnosis and problem solving for acute presentations, and for the management of routine consultations.

The workload of general practice is evolving. Now more than 50% of our encounters are related to the management of chronic conditions. I believe it is time to explore a new framework for chronic condition consultations.

I recently attended the excellent REST emergency management course run by ACRRM. This course teaches the DRSABCD framework – a system for managing emergency presentations. An emergency situation fills us all with anxiety. It is reassuring to have learnt a consistent approach to handling any acutely unwell patient

Managing patients with multiple co-morbidities and with a diverse range of care needs can also be overwhelming, particularly to those who are learning the skills of general practice. Having a consistent approach to consulting such ‘tricky’ patients can ‘guide and teach’, and optimise the care provided to every patient, at every opportunity.

Chronic disease management benefits from a proactive approach. This includes reviewing each patient’s progress at regular scheduled appointments. These appointments are referred to as comprehensive chronic conditions consultations.

The Seven Care Components

I'm suggesting that there are 7 Care Components to a comprehensive chronic conditions consultation. In our practice, we have found that this 7CC scaffold improves the consistency and effectiveness of our consultations, and increases our efficiency.

This framework is designed to be a collaboration between a GP and the practice nurse working in the role of care manager. The continuity and collaboration of this micro-team is an important determinant of success in chronic disease management.

Here then are the 7CCs – The Things we Do for Love

The 7CCs of a Chronic Condition Consultation

1. Concerns
2. Care Team
3. Challenges
4. Conditions
5. Concurrence
6. Confidence
7. Calendar

1 The Comprehensive Core, Changes and Concerns

How are you going?
Overall, on a scale of 1 to 10, how do you rate your health?
Have their been any changes since we last met? Are you better or worse? How has your overall score changed?
Any particular concerns at the moment?

The answer to this overall question can be fascinating and very useful.

Overall quality of life depends on many factors apart from objective medical health. Patients with multiple advanced conditions will often score their health as 8 or 9 out of 10. Others will score themselves at 3 or 4 with what we might consider to be nuisance complaints.

Roughly, if a person score themselves 8 or higher, we're doing OK. 5 or less and there may be some options for improvement.

What would have to be better for you to score yourself an 8?

In a patient-centred consultation, It is important to acknowledge any particular concerns the patient has up front. If it possible to deal with them in this consultation, do so. (look at the painful knee, or the skin spot that has changed) If it not possible to deal with them at this consultation, demonstrate that their concerns are important to you by scheduling a follow up time.

2. Care Team and Communications

Patients, their carers, and their GP should be able to identify all the members of a patient's 'integrated care team', and position themselves as the patient's partner in overseeing the whole team.

I received some letters about you since we last met. They said…….
Anyone else you have seen? What did they say?

It is very useful to have a place in your record where you record all the people who provide care to your patient. It can also be helpful to note when the next visit with them is due. (We use the scratchpad in our database for this purpose)

Don't forget to ask about the following, and review any communications

- Consultants
- other Clinicians (allied health and other GPs)
- Chompers (don't forget the dentist)
- Chemist

"Everyone in health has three jobs.
Do the Work.
Improve the Work
Work the Team"

Each health provider has three jobs.

Do the Work – provide the best care they can to each person they see.
Improve the work – improve the care that they provide.
Work the team – make it easier for each members of a person's care team to do their own three jobs.

Does the patient have the right care team they need to best look after heir health? What information will the other members of this patient's care team need to provide best possible care.

3. Challenges

What are the patients general goals for their health?

I want to be able to go to my granddaughters wedding in December.
I want to get back to golf
I want my pain to be better so I can get down to the shops

Don't forget:

- Calories In – Is their diet satisfactory?
- Calories Out – How active are they?
- Ciggies and Coldies/Chardies
- Cool things – what does your patient do for fun? How do they restore themselves
- Catnap – How is your patient sleeping?

The skills of practice nurses in motivational interviewing are invaluable in identifying and developing plans to address each patient's challenges.

4. Conditions

Each record should have an accurate problem list of that patient's current conditions.

Confirm with the patient that our summary of their health is correct.

Run through this list, with special attention to specific disease-focused targets.

Your diabetes control has been good – your HbA1C is 6.8 and we were trying to get it below 7. Have you had any hypos?
I see you heart attack was in 2008. Are you getting any angina now? Are you still taking aspirin?
How's your heart going? Can you still walk 100m? How have your daily weight checks been going?

Update the description field for each condition with relevant historical and progress notes and key targets

CCF – Idiopathic cardiomyopathy 2011 (Dr Mumford) Initial EF 12%. Echo 2013 EF 33%. Last admission APO 2012. Stable weight 70kg

5. Concurrence

Check the patient's medication chart for concurrency.

Is there any similarity between what we think they are taking and what they are actually taking?

Does the patient have a PCEHR? Is the Shared Health Summary current?

Add an updated health summary and medication list to the patients hand held record.

How will we inform the rest of the patient's care team about significant changes?

6. Confidence and Chores

What tasks does the patient have before next visit? It is good to keep a list of 'actions arising' as the consultation progresses. It is most important to provide written advice.

- Increase Lasix to 1 morning and 1 lunchtime
- Make appt with Cardiologist for January
- Check your weight each day and ring me if it greater than 73kg
- I'll see you in Feb and get these blood tests the week before.

What are the foreseeable risks for this patient in the next three months. Will they recognise them, and know what to do? Does this patient need a specific action plan?

One of our key goals is to improve our patients self management skills.

How confident are you (on a scale of 1 -10) that you can manage all these things on this list?

It has been said that a patient's confidence in managing their health should be a vital sign, like blood pressure.

"A patient's confidence in managing their health should be a vital sign, like blood pressure"

Do you have what you need (people and tools) to look after yourself till I see you again.
What referrals, letters, repeat prescriptions and diagnostic test requests will this patient néed before they see me again?

We provide each patient with a blue folder which contain their health summary, medication list, recent results, chores, information, referrals and requests.

Don't forget to ask about

- carers
- cars (do they need assistance with transport)

7. Calendar, Check Up and Charge

Where is the patient up to in their Care Calendar? When do we see them again? Three monthly, six monthly, or do they need an earlier review.

Are they due for their annual preventative healh CheckUp? If 'yes', schedule that for next visit. That needs some specific checklists and activities.

For CDM to be sustainable we need to take advantage of the funding that is available to support it. What item number should be claimed for this consultation? A new GPMP/TCA? A review? Is a SIPP due? A health assessment? A HMR?

Summary

At the end of this chronic condition consultation, we will be sure

- ☐ we have identified our patients concerns and have plans in place to deal with them
- ☐ we have identified all members of our patients care team, and our communications from them and to them are up to date
- ☐ we have addressed our patients core challenges and goals
- ☐ we have identified all of our patient's current problems and the interventions required for each
- ☐ our medical record is up to date, our medication list is accurate, and the patient's Shared Health Summary and hand held record are current
- ☐ our patient has everything they need before the next visit and have confidence about what they should do and what they need to do.
- ☐ here is a schedule for dealing with our patients preventative health needs, and we have established the next review of their health, and that know how to contact us before then if they develop new concerns.

For the last forty years, Larry Weed has advocated for a disciplined approach to medical record documentation so as to optimize the care provided to each individual patient.

I hope that he would approve of the 7CC approach to chronic condition consultations.