



The CAHPS Ambulatory Care Improvement Guide

Practical Strategies for Improving Patient Experience

Section 6: Strategies for Improving Patient Experience with Ambulatory Care

6.L. Planned Visits

To download the Guide's other sections, including descriptions of improvement strategies, go to <https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html>.

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6.L. PLANNED VISITS

6.L.1. The Problem

When patients with chronic illness report that their clinicians do not explain things well, they are often referring to inadequate support for, or training in, self-management of their illness. In many cases, clinical teams are not prepared to provide this kind of information during the patient’s visit. Sometimes, the problem is that they are trying to fit it into an acute care visit, whether or not the reason for the visit is related to the chronic illness.¹ A study by RAND found that patients received adequate counseling and teaching (i.e., interventions known to be a “best practice” for certain conditions) only 18 percent of the time.²

“Too often, caring for chronic illness features an uninformed passive patient, interacting with an unprepared practice team, resulting in frustrating, inadequate encounters.”

6.L.2. The Intervention

One antidote to this problem is the planned visit, which is a component of the Chronic Care Model developed by Ed Wagner and colleagues at the MacColl Institute for Healthcare Innovation. The purpose of the visit is to ensure that the clinical team reviews the care for each patient with a chronic illness and is proactive in providing the patient with all the elements of evidence-based care for his or her condition, including training in self-management.

Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. *JAMA* 2002;288(14):1775-9.

These visits are pre-scheduled one-on-one visits, 20 to 40 minutes in length. During the visit, the clinical team and the patient review the patient’s progress and work on clinical and self-management topics. A typical visit might cover some challenging aspect of self-management, such as medication adherence. Other health professionals, such as pharmacists, nurses, and nutritionists, may also play a role by identifying appropriate patients, preparing for the visit, or participating with the primary care physician in the visit.

Planned visits can be used for:

- Specialty services
- One-on-one visits with the primary care provider

¹ Kern, DH and Mainous AG III. Disease management for diabetes among family physicians and general internists: opportunism or planned care? *Fam Med* 2001;33(8): 621-5.

² McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003;348(26): 2635-45.

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- Reviews of medications and adherence
- Psychosocial support³

6.L.3. Benefits of This Intervention

Because planned visits give clinicians and patients the opportunity to review and strengthen the patient’s self-management of his or her chronic illness,³ they can fill the gap left by acute care visits that—because of their focus on immediate symptoms—frequently allow little time for this kind of interaction.

Effective planned visits can lead to better clinical control of the illness (e.g., improvements in indicators such as blood pressure, cholesterol, HbA1c), reduce symptoms, improve overall health, and increase patients’ sense of control over their health by providing them with ways to manage their own illness. They may also lead to fewer acute care visits, reduced costs, and greater patient satisfaction.

There is little literature on the effectiveness of planned visits because they are only one component of the Chronic Care Model. (Read about this model at [http://www.improvingchroniccare.org/index.php?p=The Chronic Care Model&s=2](http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2).)

However, more general studies of the effects of follow-up visits for chronic illness found that they improve the management of disease. For example, one study found that children and adolescents with regular follow-up visits for diabetes had better glycemic control, fewer episodes of diabetic ketoacidosis, and reduced likelihood of developing retinopathy compared to children and adolescents with irregular follow up.⁴

6.L.4. Implementation of This Intervention

Based on experience with planned visits that focus on better medication management among patients 75 and older, the Improving Chronic Illness Care program at the Group Health Research Institute recommends the following steps to conducting planned visits:⁴

- Choose a patient population to focus on (e.g., diabetics, asthmatics, heart disease patients).
- Generate a list of patients at particular risk within the group. Patients at risk could include:
 - Those who are not adhering to their medications.
 - Those with clinical evidence of poor disease control.
 - Those who have not received important medications or other services indicated for their condition.

³ Wagner E. System changes and interventions: delivery system design. Improving Chronic Illness Care. IHI National Forum, Orlando, FL; 2001.

⁴ Jacobson AM, Hauser ST, Willet J, et al. Consequences of irregular versus continuous medical follow-up in children and adolescents with insulin-dependent diabetes mellitus. *J Pediatr* 1997;131(5): 727-33.

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- Call patients and explain the need for a visit.
- Schedule the visit and instruct the patient to bring all medications.
- Prepare for the visit (e.g., attach patient summaries to the front of the chart; to identify the patient’s concerns, prepare “Doc Talk” cards as described in “Tools to Help Patients Communicate Their Needs”).
- Reviews medications prior to the visit. (Physician consults with the pharmacy, if necessary.)
- At the visit:
 - Review the patient’s concerns and questions.
 - Review the patient’s clinical status and treatment.
 - Review medications; eliminate any unnecessary drugs and adjust remaining medications as necessary.
 - Discuss and resolve adherence issues with patient.
 - Collaboratively develop an action plan that the patient can and will follow.

Learn more in a presentation produced by the Improving Chronic Illness Care program, available at

http://www.imvingchroniccare.org/index.php?p=Planned_Care_Visit_Video&=30.

Read More About Planned Visits

- Wagner E. System changes and interventions: Delivery system design. *Improving Chronic Illness Care*. IHI National Forum, Orlando, FL; 2001.
- Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. *JAMA* 2002;288(14):1775-9.
- Revere D, Dunbar PJ. Review of computer-generated outpatient health behavior interventions: Clinical encounters “in absentia.” *J Am Med Inform Assoc* 2001;8(1):62-79.
- Kern DH, Mainous AG III. Disease management for diabetes among family physicians and general internists: Opportunism or planned care? *Fam Med* 2001;33(8):621-5.
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