Using the Patient-Centered Medical Home (PCMH) and Care Management to Improve Cardiovascular Health

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Right Care Initiative

June 8, 2015

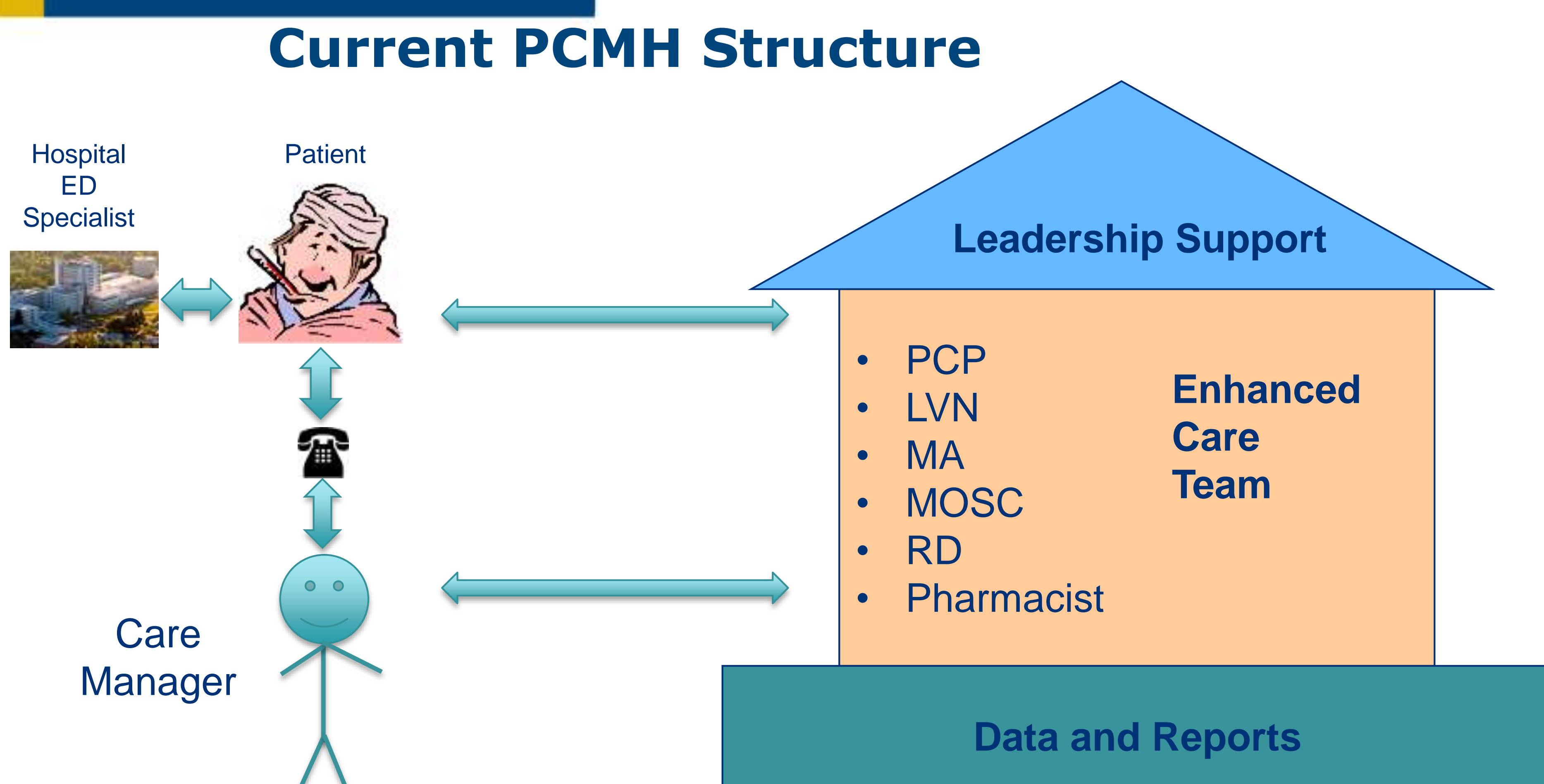
Overview

- Share the structure of the UCDHS PCMH
- Describe our program to support self-management and coordinate care
- Highlight innovative features of our medical home
- Share preliminary effectiveness of our interventions

Journey to NCQA PCMH Recognition

- 18 Primary Care offices with over 90 providers were recognized by NCQA in July 2014
- 153,500 Patients as of May 1, 2015
- First system wide recognition for UC Campuses
- Medical students, residents, and nursing students all work in our PCMH

Current PCMH Structure



Can the critical elements of NCQA PCMH Recognition be used to improve cardiovascular health?

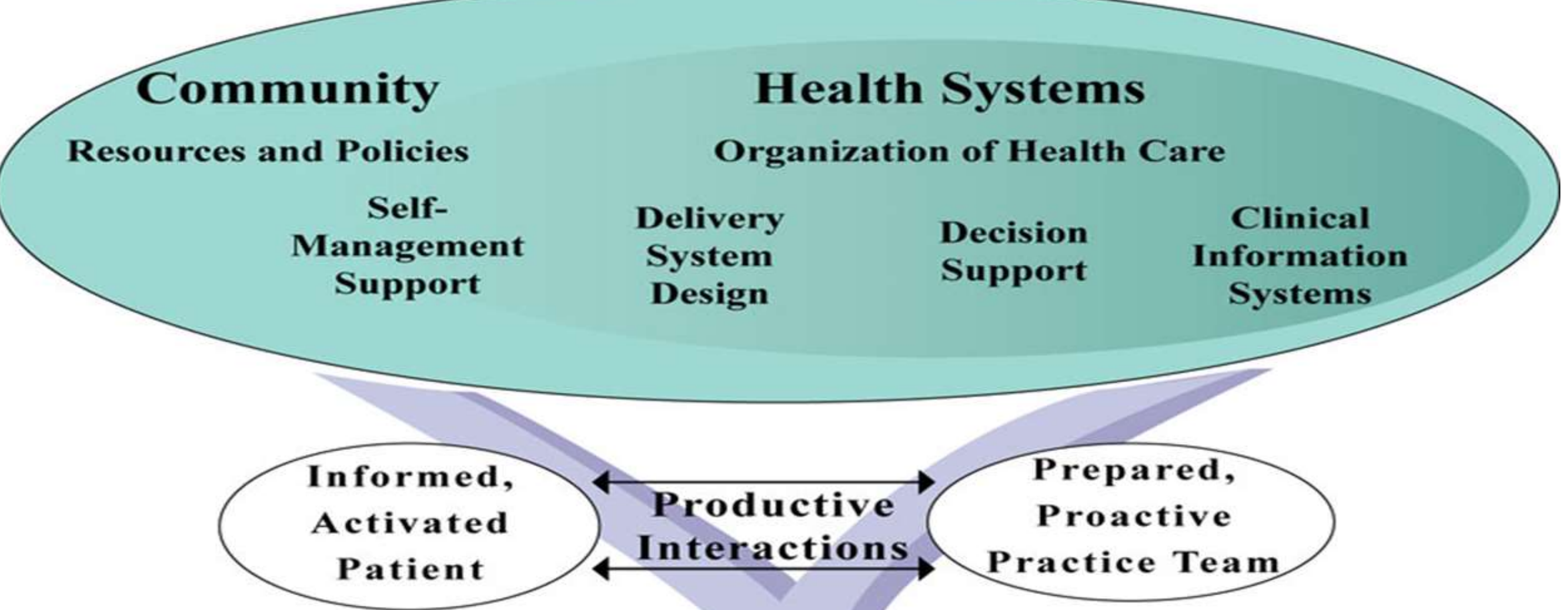
- Robust self-management support
- Enhanced access
- Use of evidence based guidelines
- Tracking and coordination of care through the medical neighborhood
- Population Management

Health Management and Education

Self-Management Education

- Utilizing the empowerment model
- Multidisciplinary educator team promotes, designs and delivers individual and group education to patients at risk for or those engaged in managing chronic illness

The Chronic Care Model

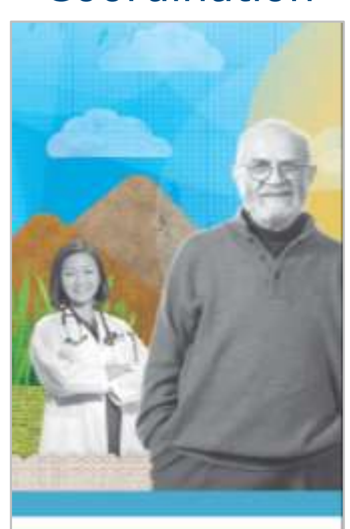


Improved Outcomes

Developed by The MacColl Institute
® ACP-ASIM Journals and Books

Education Resources

Healthy living	Weight Management	Smoking Cessation	Care Coordination



Cardiac Focused Education Resources

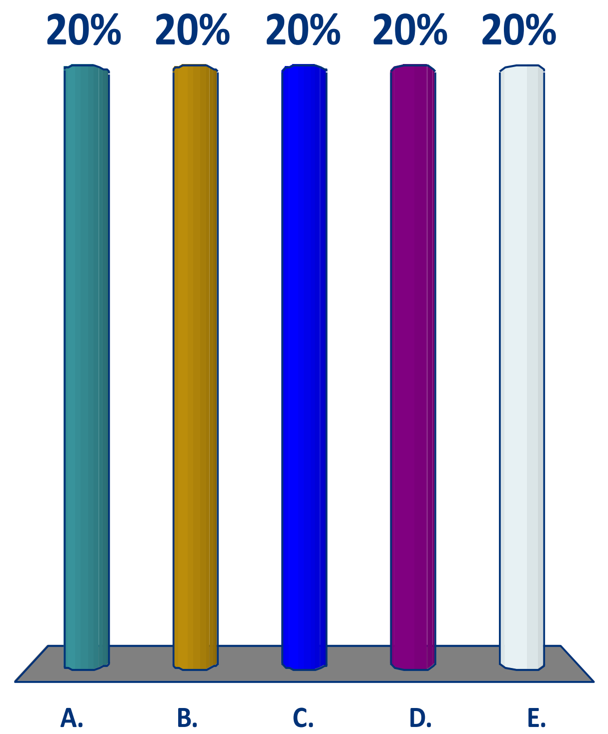
- Keep the Beat! Strategies for a Healthy Heart
- DO MORE with Heart Failure
- 8 Weeks to a Healthier You
- SToP: Stop Tobacco Program
- Achieving a Healthy Weight
- Living Light and Living well
- Stress Management

Education Story

- Patient “JH”

Which of the following is not associated with motivational interviewing?

A. Assessing what factors are personally important to the patient
B. Understanding the barriers associated with making a change in their health behavior
C. Convincing a sedentary patient that exercise will actually make them feel more energy
D. Assessing and building patient confidence
E. Helping the patient set a realistic goal



What are the steps for motivational interviewing…

- Assess Importance
- Assess Confidence
- If either are too low, discuss barriers
- Give information, but allow patient to set goal
- Create a specific action plan
- Write it down
- Revisit at the next encounter

Enhanced Access:
Use of Technology to Meet Patient Needs

MyChart and "Ask the Diabetes Educator"

Emmi videos

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Health System > Health Management and Education > Online Education

Emmi: On-Demand eLearning

Emmi is a series of web-based programs that make complex medical information easy to understand. These interactive, web-based programs, allow you to learn about a specific condition at your own pace. Most Emmi programs take about 20 minutes to complete. You can view them as many times as you like. We encourage you to share them with friends and family. All you need is access to the internet.

Asthma

Depression

Diabetes, Type 2

Heart Failure

Hypertension

Smoking Cessation

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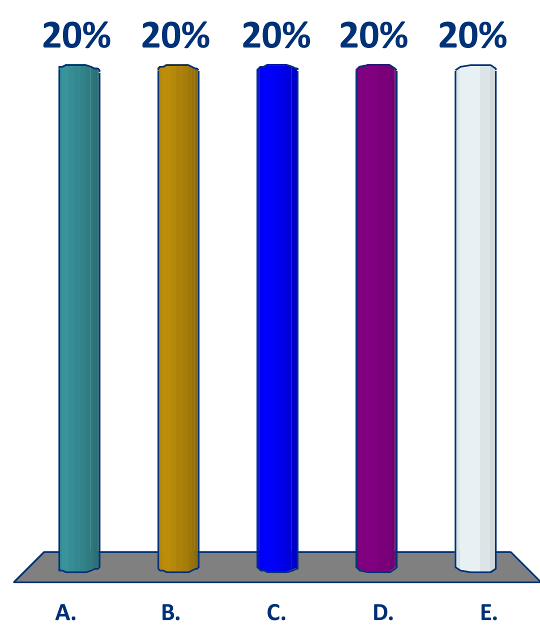
Use of evidence based guidelines: Shifting Culture

- Pharmacy Pilot
  - Use of ADA, ACC Guidelines for DM, HTN, CVD
  - 7 clinics , 2 pharmacists
- Monthly Physician Quality Report
  - A1C Control
  - LDL control and statin use in diabetes
  - Blood pressure control

Tracking and Coordination of Care through the Medical Neighborhood

Research from the University of Washington has demonstrated that a program utilizing a Care Manager for diabetes patients can do which of the following:

A. Improve depression symptoms
B. Improve control of blood sugar
C. Improve Quality of Life
D. Lower costs
E. All of the above



The UW TEAMcare Model

- Patients with Diabetes and Depression
- Nurse Care Manager-PCP- Interdisciplinary Team
- Behavioral activation is a primary objective
- Treat to Target Protocols for chronic disease
- Timely outreach and monitoring

TEAMcare Outcomes

- Significant clinical improvements:
  - HbA_{1c}, LDL, SBP and SCL-20 depression outcomes ($p > 0.001$);
  - Greater number of adjustments in: insulin ($p > 0.01$); antihypertensives ($p > 0.01$); statins, oral hypoglycemic and antidepressant medications ($p > 0.01$)
- Improved Health Related Quality of Life Scores ($p > 0.001$)
- Decreased costs by $600 per person for capitated patients and $1100 in fee for service patients

UC Davis Care Coordination Team

- PCP
- RN Care Manager
- LCSW Care Manager
- Pharmacist
- Psychiatrist

Care Coordination

- Care Mangers work telephonically with patients identified via report or physician referral
- Care managed patients typically have multiple co-morbidities, polypharmacy, frequent ED or hospitalizations and are at physical or psychological risk
- Multidisciplinary care teams provide systematic and longitudinal support as patients transition through the health system

Care Management Actions

Since 2012, we have outreached to approximately 23,000 patients and successfully engaged with over 10,000

- Clarify the plan of care documenting medical goals and patient goals
- Assess medical risks and comorbidities
- Identify psychosocial barriers and resources
- Coach patients to assist with health behavior change
- Educate and assist patients to achieve better medication adherence
- Identify care gaps for preventive care or chronic disease monitoring

Care Coordination Current Enrollment Process

Current State:

1. PCP identifies patients who may be suited for care coordination
2. Patient is referred to Care Coordination and/or identified via Daily Report
3. Chart reviewed by Health Services Navigator (deferred/enrolled)
4. CC team followed until their goals are met or at baseline, or no longer wanting to participate
5. Health Services conducts final review for patient to return to PCP or specified CC team

Patient Engagement

- Physician referral engagement 76%
- ED/Hospital report engagement 37%
- Frequency of telephonic or My Chart contact
  - 2 documented calls per month
  - 3-4 My Chart messages per month

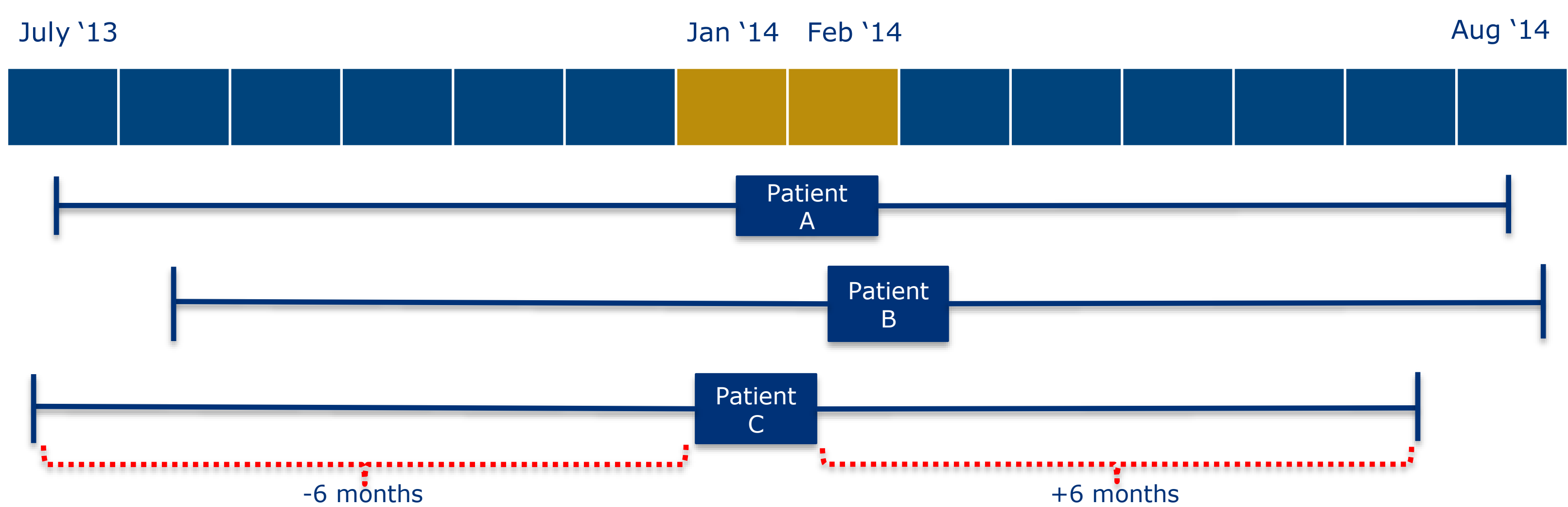
Care Coordination Stories

- Patient “LW”

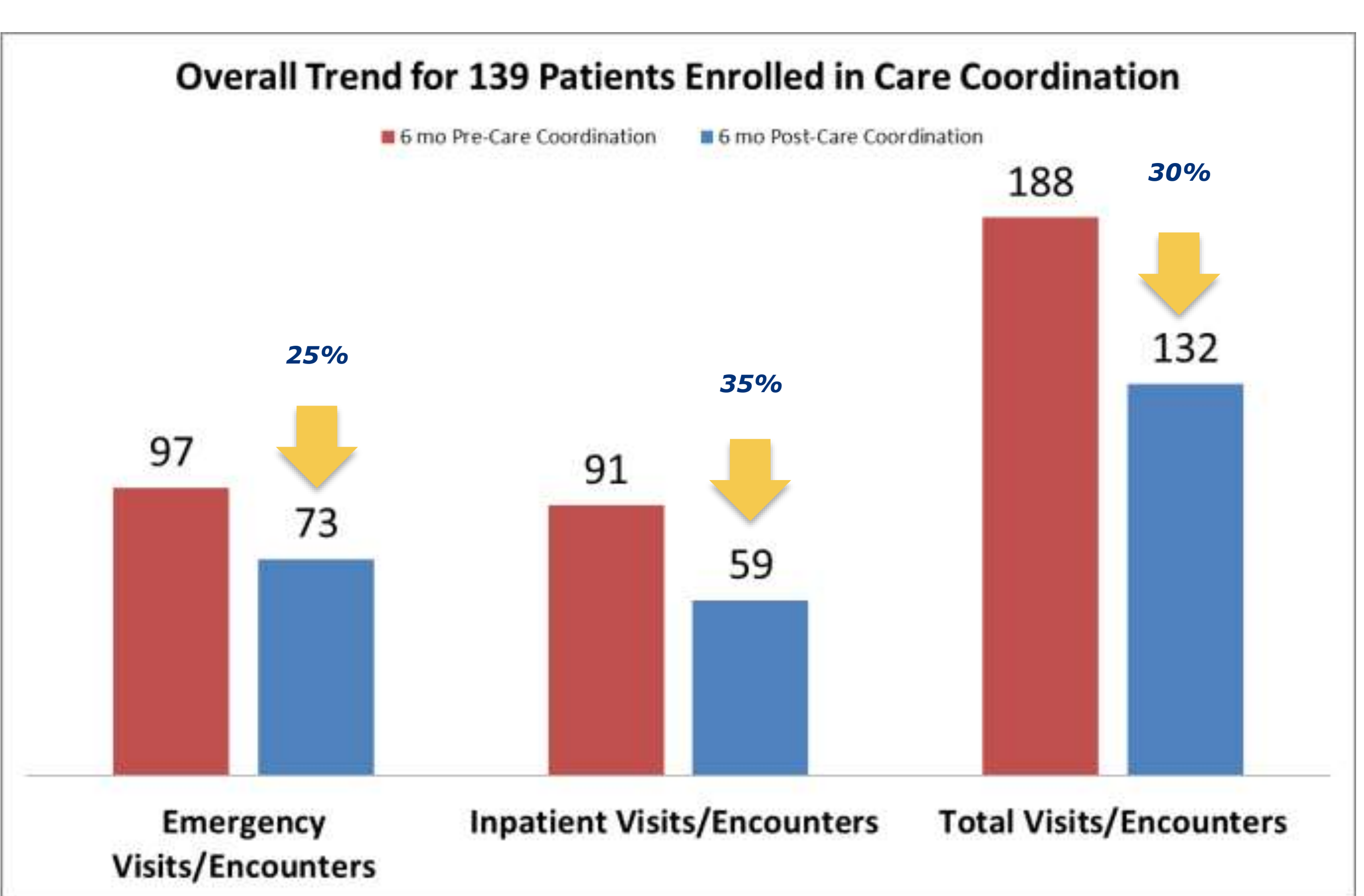
- Patient “DL”

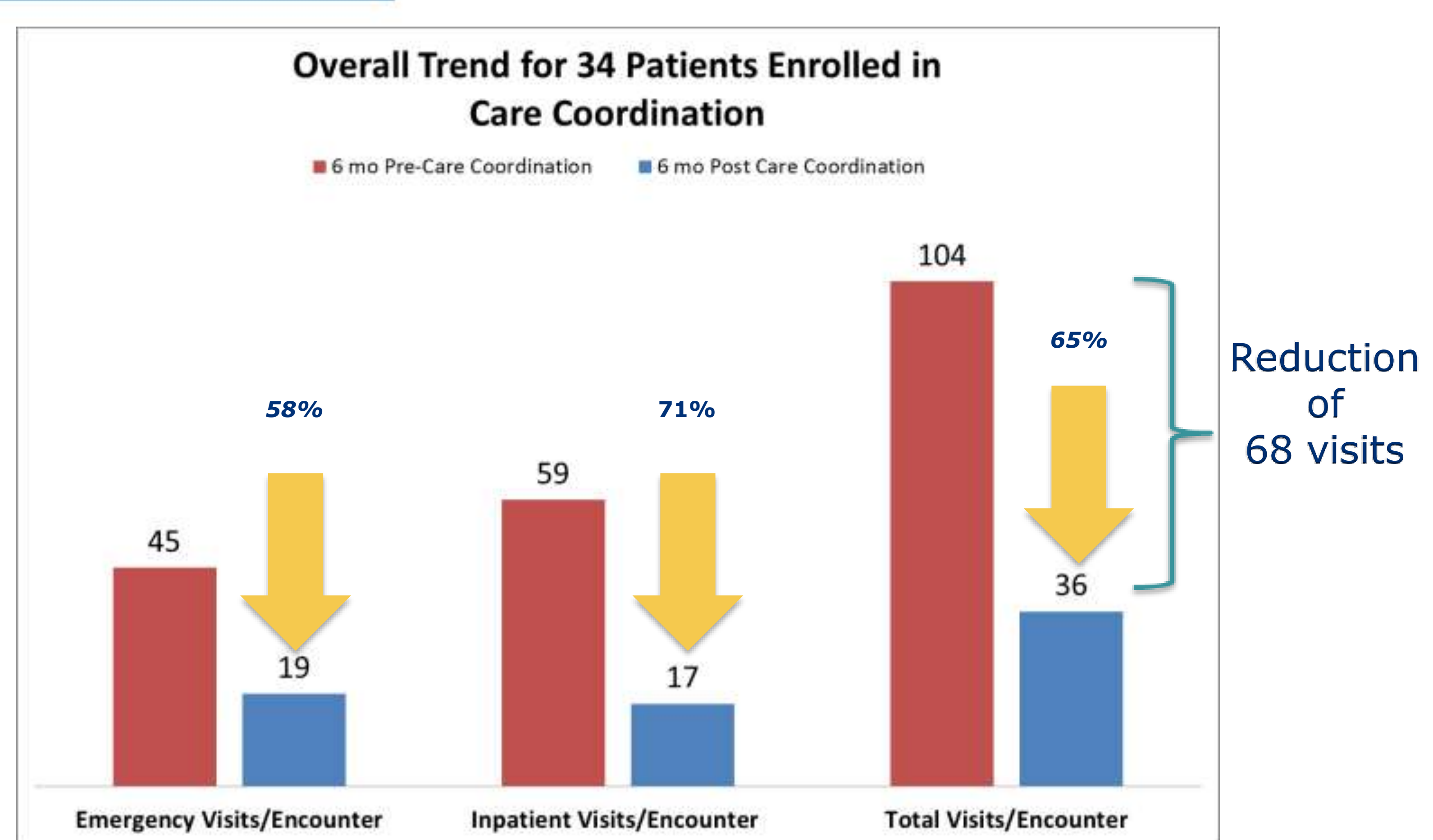
Does our model of Care Coordination reduce costs?

Methodology



- Data from patients enrolled between January 1, 2014 – February 28, 2014
- Patients' ED and IP data were pulled 6 months prior and 6 months after care coordination enrollment


Overall Trend for 139 Patients Enrolled in Care Coordination
6 mo Pre-Care Coordination
6 mo Post-Care Coordination
97
73
25%
91
59
35%
188
132
30%
Emergency Visits/Encounters
Inpatient Visits/Encounters
Total Visits/Encounters



Overall Trend for 34 Patients Enrolled in Care Coordination
6 mo Pre-Care Coordination
6 mo Post Care Coordination
45
19
58%
59
17
71%
104
36
65%
Emergency Visits/Encounter
Inpatient Visits/Encounter
Total Visits/Encounter
Reduction of 68 visits

Takeaways

- We annualized the data from the observation period and determined the reduced utilization for 1 year and estimated the financial impact.
- Potential cost avoidance was greater than the expense of the program.

Limitations

- Annualization of a short period of observation
- Financial assumptions are from entire health system data cost, thus actual cost may not be truly accurate
- Did not evaluate random “non-care coordinated” patient population for comparison

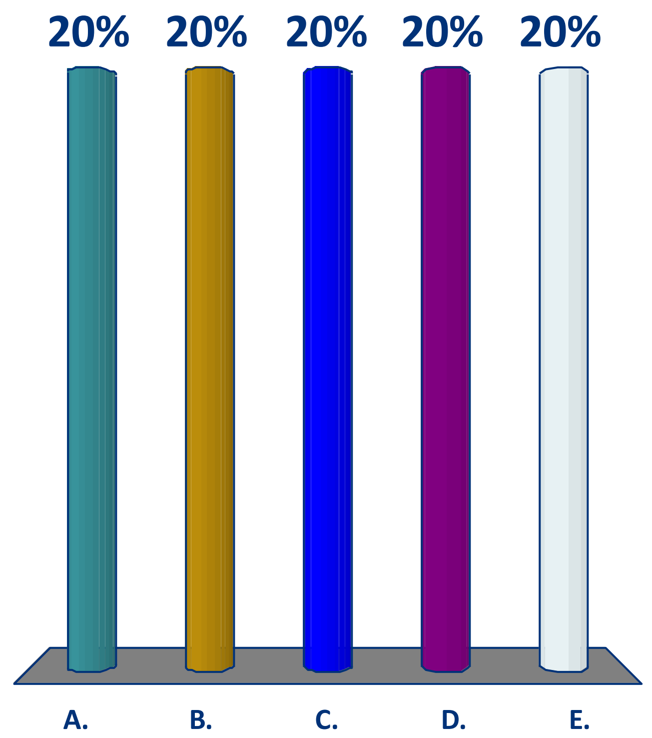
PCMH Next steps: In-Clinic Care Management

- Value Stream Improvement project- Davis Clinic Pilot
  - Care manager working onsite in clinic for designated time each week
    - Assist highest risk patients with transition of care after hospital and ED
    - Address high risk care gaps
  - Evaluate the need for onsite health coach

Population Management

How is CMS testing Value Based Prevention?

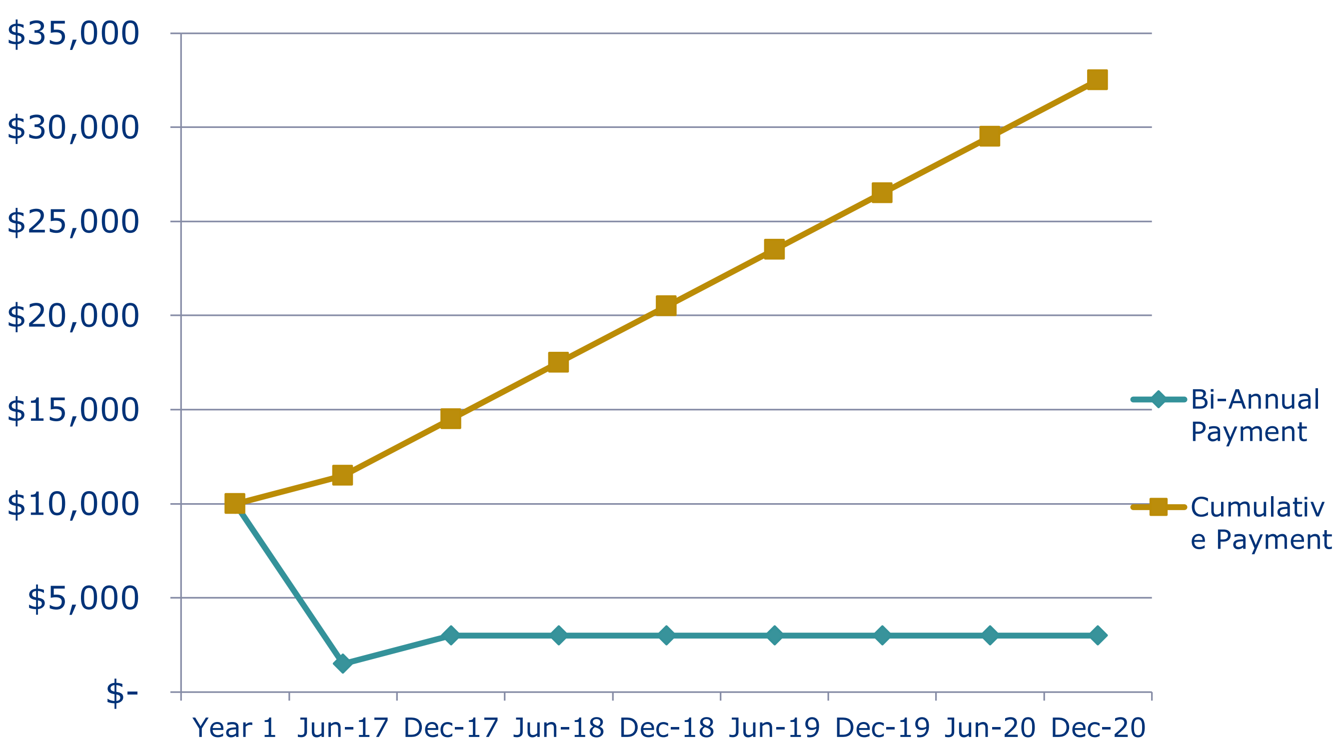
A. Paying providers who collect patient's blood glucose log information
B. Including pharmacy benefits for nicotine gum
C. Paying providers extra for giving a 2nd Tdap (tetanus-diptheria-acellular pertussis vaccine) 5 years after the first
D. Payments to patients for using an activity tracker and achieving the personal goal monthly
E. Sliding scale payment for reducing cardiac risk across a providers entire panel



Million Hearts Cardiovascular Disease Risk Reduction Model

- Begins as a research pilot then expanding based on results
- Patients will receive a individualized 10 year risk percentage based on the AHA/ACC risk calculator
- Focus on high risk patients (>30%)
- No reward for specific blood pressure values or cholesterol target numbers
- Tiered monthly payment based on how much risk reduction for each individual
  - $10 ppm for >10% risk reduction
  - $5 ppm for 2-10% risk reduction
  - No payment for <2% risk reduction (avoid overtreatment)
  - In aggregate, could provide significant resources for a practice

Payment Model: Average Practice Potential to Earn > $34,000 extra



Assumptions

- 4.4 providers per practice
- 400 Beneficiaries
- 50 High Risk Beneficiaries
- <10% Risk Reduction in Measurement Period 1: Jun 2017
- >10% Risk Reduction in subsequent Measurement Periods

Million Hearts Bundle Project

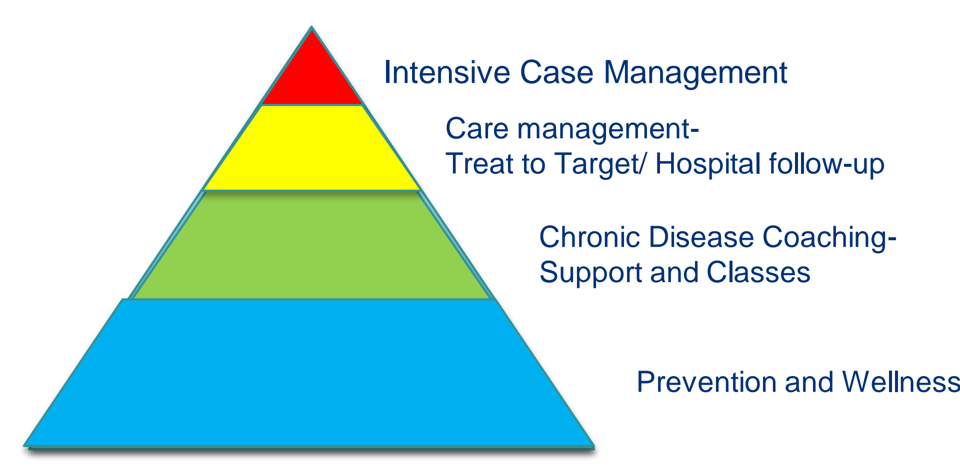
- Antiplatelet therapy
- Blood pressure <140/90
- Cholesterol <100 or Taking a Statin
- Smoking- Tobacco Free

- Patients currently active with Care Coordination who have CAD or DM
  - 43% have achieved the bundle

- Our goal is to reach 90% by September 30, 2015

Next steps for UCDHS PCMH

- Formal segmentation of population by risk



Appropriate resource provided to each level

More PCMH Next Steps-
Changing the Enhanced Care Team

- Shifting office roles
  - Previsit planning
  - Panel Management
  - Expanding embedded pharmacist from 7 to 11 clinics
- Increase access to performance data
  - PCMH Dashboard and Physician Quality Reports
    - Smoking cessation counseling
    - Statin use for patients with CAD

Conclusions

- Improving population health takes a change in our care delivery system
- Technology can provide new methods for supporting self-management
- Care managers reduce avoidable hospitalization and can help reduce physician burnout
- Pharmacists will be a crucial part of treat to target programs for cardiovascular disease
- Setting goals is important for patients and health systems!

Questions?

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