New Models of Care: Diabetes and the Triple Aim

Healthcare is changing, what does that mean for you? For your profession? For your patients?

WHAT ARE THE BIGGEST DRIVERS FOR CHANGE?
REIMBURSEMENT CHANGES

- Moving from Fee for Service to VALUE
  - Outcomes/ Cost
  - Improved Population Health at Lower Cost
- MACRA and MIPS
- Advance payment models
  - Accountable Care Organizations
  - Bundled Payments

MACRA
MIPS and APMs

What’s it all About?

Medicare’s Merit-Based Incentive Payment System (MIPS)

- The MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program
- It starts in 2019 but report on 2017

Medicare’s Merit-Based Incentive Payment System (MIPS):
Fee-for-Service with Bigger (and More Complex)
Adjustment for Measured Performance

A single MIPS composite performance score will factor in performance in 4 weighted performance categories:

- Quality
- Resource use
- Clinical practice improvement activities
- Meaningful use of certified EHR technology

Source: CMS, Oct 2015

TODAY

- Payment Changes Everything
- ALPHABET SOUP
  - MACRA, MIPS, ACO
- New Roles for Diabetes Educators
  - Practice Coaching
  - Care Management
HOW WILL QUALITY BE MEASURED?

Proposed Rule
MIPS: Quality Performance Category
• Selection of 6 measures
  – 1 cross cutting measure and 1 outcome measure or another high priority measure
  – Select from individual measures or a specialty measure set
  – Population measures are automatically calculated

Proposed Rule
MIPS: Quality Performance Category
• Key Changes from Current Program (PQRS):
  – Reduced from 9 measures to 6 measures
  – Emphasis on outcome measurement
• Year 1 weight: 60% of MIPS score

PQRS - ONE CROSS CUTTING MEASURE (Pick One)
• Diabetes: Hemoglobin A1c Poor Control (>9)
• Controlling High Blood Pressure (<140/90)
• Closing the Referral Loop: Receipt of Specialist Report

PQRS- Overall 281 measures! (Need Five)
• Yearly lipid test
• LDL < 100
• Yearly Eye Exam
• Communicating eye exam to responsible provider
• Medical Attention Nephropathy
• BMI screening and follow up plan
• Yearly Foot exam

Types of Advanced Payment Models (APMs)

<table>
<thead>
<tr>
<th>Episode Based</th>
<th>BUNDLED PAYMENT</th>
<th>Whole Patient</th>
<th>ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment linked to quality and cost for a specified episode of care</td>
<td>Examples: Cancer, chronic condition episodes (e.g., pregnancy, back pain)</td>
<td>Chronic disease episodes (e.g., DIABETES, COPD, liver)</td>
<td>Payment linked to quality and cost for a specified population</td>
</tr>
<tr>
<td>Examples: Accountable care organizations, Medical home, with pop. health accountability</td>
<td>Comprehensive care for high risk patients (e.g., DIABETES)</td>
<td>Specialty-based care teams with accountability (e.g., DIABETES)</td>
<td>Capitated care with pop. health accountability</td>
</tr>
</tbody>
</table>
State Expenditures on Medicaid and K-12 Education

Future Directions for High-Value Health Care

- Effective treatments for unmet health needs
- Innovations to better target use of medical technologies to patients who will benefit
- Wireless/remote personal health tools and supports, telemedicine
- Lower-cost methods of treatment or sites of care
- Better care coordination
- Non-medical strategies for health improvement – such as targeted assistance to high-risk individuals, and support for accessing social and community services to prevent complications
- Self-Management Support for Behavior Change

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WHAT ABOUT DIABETES COSTS?

THE COSTS OF DIABETES

- Economic burden diabetes (all ages) and undiagnosed diabetes, gestational diabetes, and prediabetes (adults) exceeded $322 billion in 2012,
  - $244 billion in excess medical costs and $78 billion in reduced productivity.
- Largest component of medical expenditures attributed to diabetes is hospital inpatient care (~43% of costs)

THE ROAD TO HIGH VALUE CARE

Reimbursement Changes
- Good/Bad news is what we do is inexpensive and therefore high value
- We need to reposition who we are within the health care system
- Reimbursement change it is not in the future-
  - New MIPS payments start with 2017 data
  - ACOs already widespread

Diabetes as the Vanguard Disease in Health Care Delivery Changes
- Diabetes (and Joslin) has long been the vanguard condition where key health system changes were developed and spread
  - Self-Management Education
  - Team Based Care
  - Chronic Care Model
  - Registries and Population Management
  - Patient Centered Medical Home and Neighborhood
WHY DIABETES?

C
Costly
Common
Complex
Calculable/ Measureable
Complications preventable

Impact Value Based Reimbursement
An Opportunity to Reposition CDEs

Cost Centers
e.g. Diabetes Care-
Dietitians, Educators,
Endocrinologists, Behavior
Change
PREVENTING COMPLICATIONS

Saving Centers

Revenue Centers
e.g. CT surgery, PTCA, Ortho

Cost Centers

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Mental Shift: Population Management

• Shift from treating one patient at a time to managing populations of patients
• Shift from looking at only a single patient to looking at a population of patients within the practice

The First Step to Improve Population Health

A Diabetes Registry

A “Registry” is a searchable list of all patients with a particular condition
Elliot P. Joslin: The First Diabetes Registry

- “Ledgers” were recorded in accounting books, 1892
- Began the first work in epidemiology for chronic diseases
- Largest collection of clinical data in the world

HOW MANY OF YOU CURRENTLY USE QUALITY MEASURE DATA ON YOUR PRACTICE?

Steps to Improving Quality

- Critical first step = MEASURE IT!
- Most providers overestimate the effectiveness of their care
- Measure quality
  - Look at population or practice level outcomes
  - Measure quality
    - By Provider
    - By Practice
    - By Region
- Reducing variation

Sharing Quality Data: At Your Own Risk?

- Typical Reactions
  - Denial: It’s not my patients
  - Anger: Attack the data
  - Bargaining: My patients are sicker
  - The 7 stages of grief leading to …Acceptance
  - In improvement science, you don’t have to be perfect to work to improve

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The Role of Primary Care in Diabetes

- Essential!
- In the US (where there is preponderance of specialists in general) – only 5000 endocrinologist for 29 million patients
- Improving diabetes care requires a focus on primary care

The Patient-Centered Medical Home

The Patient-Centered Medical Home and Diabetes

- Many if not most efforts focus on DM
- PCMH is a journey, not a destination
- Key attribute- population health approach, team based care, high risk ID and care management
- How effective can they be without our help?

Bojadzievski T, Gabbay R. The Patient-Centered Medical Home and Diabetes. Diabetes Care 2011;34:1047-1053

Practices Often Struggle to Become PCMHs

- Effective tools to help practices
- Practice Coach
- IT’S SMS FOR A PRACTICE (as opposed to a patient)
  - Negotiated goal setting
  - Problem solving
  - Empowering
  - Team Dynamics
  - Cheerleading

Sound Familiar???

BUT WHAT DOES THIS HAVE TO DO WITH DIABETES EDUCATORS?

HELPING THOSE THAT ARE STRUGGLING WITH THEIR DIABETES

New Roles for Diabetes Educators
New Roles for Educators

• LESS DSME MORE DSMS
• Focus on changing behavior with evidence based approaches
• Pt engagement and adherence are key
  – Big buzz in health care right now – how much do we know?
• Demonstrating value!
  – Be the quality person of the practice

New Roles for Educators

• Practice Coaching
• Population Management
• Risk stratification
  – Can diabetes educators be the go-to for high risk patients?
• Care management

Risk Stratification

What is Risk Stratification?

• What is risk stratification and how does it relate to population health management at the practice level?
  – Bitton: It is an intentional, planned and proactive process carried out at the practice level to effectively target services to patients. It represents a move from a reactive single physician to a more proactive team of providers to address the total health needs of the total population of patients. It responds to the question, How do we keep our sickest patients from getting sicker? There isn’t a perfect way to stratify risk. The “how” of getting that list varies.

Concentration of health care expenditures
U.S. civilian noninstitutionalized population, 2012

Source: Center for Financing, Access, and cost Trends (CFAT), Household Component of the Medical Expenditure Panel Survey (MEPS) 2012

AACE'17
Why Risk Stratify?
• Identify patients with highest needs – prioritize
• Utilize limited practice resources effectively
  – Use to determine visit frequency
  – Maintain access to care

Why Risk Stratify?
• Biggest bang for the buck is to focus on high risk!
  – Prevent unnecessary transitions in care for the patient (ER visits and hospitalizations) – prevent sentinel events
  – Decrease the utilization of resources downstream
• BETTER HEALTH AT LOWER COST!

Approaches to Risk Stratification
• Practice Based
  – Advanced scoring
  – Simple scoring
  – Number of chronic illnesses
  – Provider gestalt
• Electronic Based
  – EHR
  – Registry

Stratifying Diabetes Patients

Care Management (CM)
• A high level clinical intervention that is added to the usual “planned care” provided by practices
• CM targets “high-risk” patients that are not responding to prescribed treatment plan
NCQA Care Manager Definition

“A care manager is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.”

Care Manager Role

The care manager’s role is designed to ensure that these vulnerable patients receive optimal preventive care and dedicated assistance in managing their acute and chronic illnesses across multiple health care settings.

Evolving Role That Encompasses Many Branches

Evidence for Care Management

- Quality improvement strategies lead to small to modest improvements in glycemic control
- Team changes and care management showed more robust change and were the most effective QI strategies

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Care Management in an Urban Latino Population


RISK STRATIFICATION AND CARE MANAGEMENT

BOTTOM LINE:
You Are Trying To Identify
Your Sickest 5-10% Patient Population

Care Management
• Most effective when Care Managers can titrate medications
• Standing orders and appropriate MD supervision

Models for Care Management
• Telephonic
  – Health Plans, Employers, Carve Outs
  – Less Effective
• Embedded in Practice
• Can Travel Between Practices
  – PRIDE program at UPMC

The Triple Aim

Improving the Patient Experience
• Empathy and Support
• Care and Education on Demand
• Can Technology Help?
Impact Value Based Reimbursement
An Opportunity to Reposition CDEs

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• Population Management
• Risk stratification
• Can diabetes educators be the go to for high risk patients?
• Care management
• Medication Titration
• Added VALUE to the system
• Demonstrating that VALUE

YOUR THOUGHTS?
HOW CAN DIABETES EDUCATORS IMPACT THE TRIPLE AIM?