Medical Home Collaborative Care Can Work: The Community Volunteer in Medicine (CVIM-PA)

Patricia Davidson, DCN, RDN, CDE, LDN, FAND
Assistant Professor, West Chester University

Betty J. Colletta, RN, BSN, CDE
Diabetes Case Manager

Mary Brennan Wirshup, M.D., FAAFP
Vice President of Medical Affairs
Community Volunteers in Medicine

Disclosure to Participants
All presenters confirm that they:
• Have no Conflict of Interest (COI) or Financial Relationship Disclosures to report
• Will not discuss or Endorse Products
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Objectives
• Describe factors that have led to a paradigm shift that promotes interprofessional collaborative care.
• Describe unique components of a Volunteer in Medicine (VIM) model of health care.
• Describe our outcomes utilizing an interprofessional collaborative care and patient-centered model.
Paradigm Shift Toward Integrated Care (IC)
• IC occurs when primary medical care (nurses, dietitians/nutritionists, physician assistants, and physicians) and behavioral health care coexist and collaborate in the same health setting.
• Food security and nutritional status are a crucial and often missing piece of the team.
• A public health framework is critical.

Epidemiology
• 16.8% of US adult population has both a MH disorder and a medical condition.
• 30% of adults with a chronic medical condition have a co-morbid MH condition.

Reasons for Collaborative Care
• Synchronously addressing physical, mental and behavioral health needs
  • Reduces reports of stress
  • Improves self-care
  • Improves self esteem
  • Perceptions that illness is manageable

Driving Factors For Integration
• Increasing health coverage
• Early nutrition intervention
• Decrease health cost from co-morbid conditions
• Patient engagement in care
• Clinical information systems that support high-quality care, practice-based learning, and quality improvement
• Care coordination

Paradigm Shift Toward Interprofessional
• Recovery and Reinvestment Act of 2009
• Affordable Care Act of 2010
• “IPE, which brings together students from two or more professions, encourages learning about, from and with one another to enable effective collaboration and improve health outcomes for individuals, families, and communities”
  (WHO, 2010)

Health Management Models
PCMH, CCM, Self-Management
Three Important Changes in Health Management
- Chronic disease is the major reason for seeking healthcare in the U.S.
- Treating chronic medical conditions requires a different model of care
- The “new” models of care require a change in both patient and provider roles

The Global Burden of Disease
WHO, projected - by the year 2020, shift from acute to chronic illness

Changing Roles: Partnership = Collaboration & Self-management Education
HCP
Clinical Expertise
EBP
Patient
Patient / HCP Team
Knows their experiences, motivations, willingness for change

Models Promoting Self-management Skills Chronic Care Model to the Patient Centered Medical Home

Patient Centered Medical Home (PCMH)
- National Committee for Quality Assurance (NCQA)
- Team-patient relationship vs patient-provider
- Stepped care
  - Least disruption, expense (pt and staff), intensive and extensive

Patient Benefits
- Holistic and therapeutic
- Shared management (chronic disease)
- Engaging experience
- Fosters adherence
- Patient is not alone
- Increased provider time
- Patient satisfaction
Provider Benefits
- Improved efficiency
- Multi-disciplinary team experience
- Fewer hospital admits/ED visits
- Guideline implementation and adherence focus

Self-efficacy: “the confidence to perform a specific behavior”

Volunteer in Medicine “VIM” clinics
“Culture of Caring”
- Community directed initiative - driven by one man’s vision to provide healthcare to the uninsured
- 64% of VIM clinics have (AAFP)
- Support services:
  - 70% lab services
  - 63% diagnostics and
  - 55% receive financial contributions

Who Is In Need... The Uninsured
Characteristics of the Nonelderly Uninsured, 2015

VIM = Medical Home

Call Us, Maybe

Dr. Mary Wirshup
MD, FAAFP
Community Volunteers in Medicine
West Chester, PA
Community Volunteers in Medicine provides compassionate primary medical and dental care and health education to people who live or work in the Chester County region who lack access to insurance, in order to support their goals to lead productive, healthy, and hopeful lives.

CVIM History

- CVIM was started in May 1998 by two prominent businessmen on the Paoli Hospital Board
- Dr. Jack McConnell at Hilton Head, S.C.
- Helen Heidelbaugh – Founding President and CEO

CVIM Mission Statement

CVIM is a community-based, volunteer nonprofit organization providing primary medical and dental care to low income, working people in Chester County without insurance, enabling them to continue to be contributing members of the community.

Who We Serve

- Roughly 68% are 40-60
- 55% are female

Who WE SERVE

- Uninsured
- Live or work in Chester County, PA
- Below the 300% poverty level

Diabetic patients by ethnic group

-Roughly 68% are 40-60
-55% are female

CVIM's Medical Home

- Personal Passions & Beliefs
- Community Needs
- YMCA Memberships
- Nutritional Counseling
- Cooking Classes
- Acupuncture
- Farm Share Memberships
- Exercise Program
Health Care Home

Coordinated Care: 35,178 patient visits in fiscal year 2016

Access to Care:
1,575 new patients came to CVIM for care

Medical Patients:
3,392 people served through CVIM medical programs

Dental Patients:
3,353 people served through CVIM dental programs

Financial Impact:
Provided a total estimated value of care to the community of $5.9 million

HOW WE DO IT

Volunteers
• 390 Volunteers/53,000 hours of time and talent

Community Partners
• $2,431,621.21 of medications were procured for our patients

Students
• 200 students do clinical rotations each year, receiving more than 11,000 hours of hands-on experience

Our Volunteers
• We have 91 providers delivering a variety of services to meet the numerous needs of our patients
  • From acupuncture to rheumatology, from prevention to management, we cover medical, dental, behavioral health, and social services

Community Support
100% supported by philanthropy

OUR PATIENTS WITH DIABETES

Diabetes Incidence at CVIM
• 371 of our patients at CVIM have diabetes
  • The majority are female
  • Mean age of 46
  • 95% T2DM
  • All are high risk
    – CD + comorbidities + socioeconomic issues

• We are also working with 214 patients with pre-diabetes
  – Promoting Prevention = stopping diabetes before it starts
COLLABORATIVE CARE

MEDICAL DIRECTOR, MARY B. WIRSHUP, MD, FAAFP

“Stronger patient / provider relationships impact patient’s diabetic care”

Endocrinologists
Primary Care Providers
Medical Specialties

External services provided by our community partners + relationships

Diabetes Case Manager
CDE
Diabetes Educators
Registered Nurses
Health Coach/Exercise Physiologist

Nutrition
Dispensary
Complementary Services
Dental
Laboratory
Data Entry

PATIENT CENTERED MEDICAL HOME

DIABETES/CHRONIC DISEASE MANAGEMENT TEAM

DIABETES CHRONIC DISEASE MANAGEMENT

Meeting Evidence Based Practice Standards

Diabetes Flow Sheet
- ABC’s
- Foot exam
- Microalbumin
- Ophthalmology
- Vaccinations
- Behavioral health screenings – Including diabetes distress

How is it working?
- Our numbers have increased annually for the following...
  - Eye exam
  - MNT
  - Foot exam
  - Urine microalbumin
  - Lipid profile
  - HA1C
"I want to ring the bell"

This is what it is all about

Uptown Funk

How CVIM Achieves Health Outcomes
Putting it into action

CVIM Process
Flow sheet  Reports  Chart Review

CVIM Process
Dispensary Pharmacist – refill reports  Case management  Professional Practice in-services
Case 1 Oct 2012
K.P. is a 58 Y/O Asian female, Primary language- Lao, ESL (no reading or writing), no medical care for 4 years
Ht: 5'4" Wt: 168# BMI: 29
Hx reports good gen health + no hx of medical illnesses for self or family. no medications
Social hx: Lives with her husband and adult son, works P/T as seamstress, Non-smoker, ETOH denies use, NKDA
Reason for visit – to establish medical care

Meds Following Initial Visit
Levemir 10 units subq w/eve meal
Metformin 500 mg w/eve meal
ASA 81 mg po q daily
Lisinopril 2.5 mg q daily

Case 1 May 2017
K.P. is a 63 Y/O Asian female, Primary language- Lao, ESL (no reading or writing)
Ht: 5'4" Wt: 168# BMI: 29
Current tx: T2DM, vit b12 deficiency, Lyme arthritis + rotator cuff tendonitis
Social hx: Lives with her husband and adult son, works P/T as seamstress, Non-smoker, ETOH denies use, NKDA

Recent Labs
<table>
<thead>
<tr>
<th>Current Labs (2017)</th>
<th>11/2012 1st visit</th>
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<tbody>
<tr>
<td>HbA1c</td>
<td>11.3</td>
</tr>
<tr>
<td>B/P</td>
<td>124/78</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>244</td>
</tr>
<tr>
<td>HDL</td>
<td>63</td>
</tr>
<tr>
<td>LDL</td>
<td>154</td>
</tr>
<tr>
<td>TG</td>
<td>135</td>
</tr>
<tr>
<td>Microalbumin</td>
<td>50</td>
</tr>
<tr>
<td>Annual Dilated eye exam</td>
<td>Healthy eye - no DM Retinopathy</td>
</tr>
</tbody>
</table>

Current Meds
<table>
<thead>
<tr>
<th>Current meds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin 1,000 mg BID</td>
</tr>
<tr>
<td>Januvia 100 mg AM</td>
</tr>
<tr>
<td>Losartan 25 mg q daily</td>
</tr>
<tr>
<td>Lipitor 20 mg q HS</td>
</tr>
<tr>
<td>ASA 81 mg q daily</td>
</tr>
<tr>
<td>Multivitamin q daily</td>
</tr>
<tr>
<td>Vitamin B12 1,000mg q daily</td>
</tr>
<tr>
<td>Treating acute conditions</td>
</tr>
<tr>
<td>Naprosyn 500 mg BID w/ food</td>
</tr>
<tr>
<td>Doxycycline 100 mg BID</td>
</tr>
</tbody>
</table>
2012 - 2017

A lot can happen in 5 years

CVIM Success: PCP – Pt Centered Medial Home for KP
Practitioners
- Nutrition Health Educators/ RDNs
- DSME CDEs
- GYN
- Ophthalmology
- Podiatry
- Dermatology
- Social Services
- Surgery + special diagnostic

Services and Partnerships
- Vaccine clinic - county health department
- Mammography
- Dispensary
- Laboratory
- Orthopedics - x rays
- Diagnostic studies & surgery

How Model Worked for KP
- Majors events
- Dispensary/ student support
- Drug/Nutrient interaction
- Dietary Pattern
- Language barrier

Patient Case Take-away
- Relationship is key to chronic disease management
- Know what resources are available: for the patient & within your team/medical home
- Address the whole person – unpack what the disease state means to them
- Listen to your patients: perceptions, needs, and concerns
- Motivational interviewing - negotiate
- Always use Teach Back – language is not a barrier
- Support them during the difficult times

Take Home Messages
- Number of factors have led to a paradigm shift that promotes inter- professional collaborative care
- Unique components of a Volunteer in Medicine (VIM) model of health care.
- Interprofessional collaborative care works