Care Coordination and the Role of the Diabetes Educator

Mary Ellen Wolf, BSN, RN, CDE
Care Coordinator, Healthways
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Abbreviated History of PCMH

- 1967 - American Academy of Pediatrics introduces term “medical home”
- 1978 - World Health Organization (WHO) supports principle of Primary Health Care
- 2002 - Birth of Chronic Care Model emphasizing role of primary care to prevent, manage, treat chronic illness.
- 2006 - American College of Physicians develops The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care and proposes fundamental changes in the way primary care is delivered and paid for.
- 2007 - AAFP, AHA, AAP, ACP endorse Principles of PCMH
- 2010 - The Patient Protection and Affordable Care Act (ACA or health care reform law) is signed into law by President Obama

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What is PCMH Coordinated Care?

- Comprehensive
- Patient focused
- Coordinated
- Accessible
- Quality/Safety

What is Care Coordination?

- A function that helps ensure that the patient’s needs and preferences are met over time with respect to health services and information sharing across people, functions, and sites
- The deliberate organization of patient care activities between 2 or more participants (including patient) involved in a patient’s care to facilitate the appropriate delivery of health care services

Patient Centered Medical Home (PCMH)

- Patient-centric care delivery model
  - Treatment coordinated through primary care physician
  - Provide necessary care
  - When needed
  - Where needed
  - In a manner the patient can understand
- Goals
  - Higher quality of care
  - Lower costs
  - Improved patient and provider experience of care

Source: American Nurses Association
What is Driving Change?

- Increased cost
- ACA 2010
- More patients in primary care demands overhaul of entire primary care system
- Fragmented care
- Lack of accountability
- Aging population
- Simultaneous call for new delivery methods, payment systems, quality of care, reduced cost

Patient Centered Medical Home

- Ideal framework for patients with complex, chronic conditions
- Works with varied payers including Medicare, Medicaid, private insurers
- Demonstrated improved quality of care, cost reduction
- Resulting in reduced ER visits, hospitalization

Getting It RIGHT

- Select the RIGHT patient – those truly in need and most vulnerable with complex, multiple chronic diseases
- At the RIGHT time – transitions
- Coordinate the RIGHT care - visits with registered dietitian, PCP and specialist follow up

Components of Effective Care Coordination

- Targeting – Enroll those who will benefit most. High risk of hospitalization, ER visits, multiple chronic diseases
- Teams – Multi-disciplinary teams with a designated coordinator to deliver majority of the intervention while supported by other team members
- PCP Collaboration – Update PCP re: changes to patient care
- IT – Documentation of care coordination
- All team members will receive initial training in care coordination and regular specific feedback on overall program outcomes

Care Coordinator Job Description

- Identify healthcare needs
- Assess readiness to change
- Collaborate with healthcare providers
- Assist with transitions in care
- Assist with goal setting/lifestyle changes
- Ongoing healthcare teaching
- Identify need for referrals, ancillary services
- Refer to community resources

So, what’s old is new again!

Think........the nursing process
CDEs as Care Coordinators

- Joint Position Statement of the ADA, AADE, AND - goals aligned with basic tenets of diabetes education
- DSME/S shown to be cost effective reducing admissions/readmissions, complications
- Algorithm defines 4 critical time points and focuses on self-management skills necessary at each critical time point

Care Coordination and AADE Position Paper

- At diagnosis
- Annual review outcomes
- Complicating factors
- Transitions

Current State of DSME/S

- 6.8% = Number of people with NEW diagnosis T2 DM who receive DSME/S with private health insurance participated in DSME/S within 12 months of diagnosis
- 4% = Medicare participants received DSME/S and/or MNT

Diabetes Education Algorithm

- Healthy eating
- Being active
- Taking medication
- Monitoring
- Problem solving
- Healthy coping
- Reducing complications

Barriers to Care

- Barriers – health system, HCP, community resources, P WD
- How/when to refer
- Lack of access to DSME/S services, providers
- Misconception that 1-2 initial visits provide skills for lifelong self-management
- Lack of mental health providers that accept private insurance
will give you the new algorithm

jkb1, 5/9/2016
Biggest Threat to Access and Quality of Care in America?

• COST

Healthways, In Partnership With Insurance Company

• 300 RNs
• 20 Program Consultants - data analytics
• IT – Insurance companies are in the data business!
• Quality Measures – monthly input from Care Coordinators

National Health Expenditure Rising Toward 20% of GDP

*Years 2013 and forward are CMS projections.

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, NHE Web Tables

Care Coordinator Program at Healthways

• PCPs, NPs central role in controlling costs and quality
• Total care of patients provided, organized, coordinated by 5-15 providers known as “panels”
• Panels, as a team, responsible for aggregate quality and cost outcomes of their pooled population
• Savings shared and provide powerful incentive to control costs

Reducing Costs in the Mid-Atlantic Region

• Healthways – population health company
• 2011 started PCMH Program to address steep increases in healthcare costs in MD, DC, VA
• Contracts with largest private payer in Mid-Atlantic region (3.3 million members)
• Program rewards PCP for providing, arranging, coordinating, managing quality, efficient and cost effective health care

Healthways Care Coordinator Resources

• Home based services
• Enhanced monitoring
• Expert Consultation
• Community Based Programs
• Hospital Transitions of Care Coordination
• Case Management
• Comprehensive Medication Review
• Behavioral Health Care Coordination
• Health Coaching
• Telemedicine
How is the Cost of Care Controlled?

• Referral to specialists, referral patterns
• Data on all claims ER, Hospitalization, Pharmacy costs
• Screening exams at free standing facilities vs facility based centers
• Referral to care coordinator resources

Case Study #1 (cont.)

• Sees 9 specialists, non-compliant with follow up care
• Barriers – mostly tied to his learning disability - include:
  – Knowledge deficit
  – Lack of motivation
  – Financial constraints
  – Lack of support system
  – Negative emotions/ineffective coping
• Non-adherence to keeping appointments, plan of care

Case Study #1

• April, 2015: Patient hospitalized for DKA
  – Blood Glucose in ER = 1227
• 13 medications
  – Most of the dosages changed prior to discharge
• Patient verbalized understanding of medication regimen & discharge instructions
• Care Coordinator called patient within hours of discharge
  – Quickly assessed lack of understanding of medication and discharge instruction
  – Patient learning disability biggest barrier to care

Case Study #1 (cont.)

• Care Coordinator activities
  – Arranged for patient to see PCP 2 days after hospital discharge
  – Arranged for a home based assessment
  – Care coordinator accompanied patient to all endocrinology visits
  – Forwarded all specialist progress notes to PCP
  – Referred to behavioral health care coordinator (Magellan network)
  – Referral to psychiatrist, counselor, to address depression, lack of self care
  – Identified state assistance to alleviate some of financial burdens
  – Scheduled all appointments with specialists
  – Scheduled follow up care with PCP for preventative health

Case Study #1 (cont.)

• Care Coordinator met with PCP and discussed patient
  – PCP shook her hand and said, “Oh, thank God!”
  – Patient had visited ER approximately 200 times in 12 months
  – PCP believed ER visits may have a mental health component
• Patient diagnosis included multiple chronic conditions
  – Uncontrolled type 2 diabetes (A1c 13.3%) with gastroparesis
  – HTN (160/x90s)
  – Coronary artery disease with 3 cardiac caths
  – Depression with an inpatient stay for suicidal ideation
  – Sleep apnea (not compliant with CPAP)

Casestudy Outcomes

• A1c decreased from 13.3% to 8.7%
• SMBG QID and demonstrates proper administration of his insulin
• Wears CPAP every night
• Financial assistance helped provide all prescribed medication
• Taking all medications as prescribed
• Makes and keeps all follow ups with PCP and specialists
• PHQ2 negative
• Blood pressure 130s/70’s-80’s.
• Tighter blood glucose control improved symptoms of gastroparesis
• Zero ER visits in past 5 months
Without Care Coordination

- Continued compulsive ER visits
- Uncontrolled DM, HTN, Depression
- Would not have had access to mental healthcare resources

Case Study Outcomes

- Blood pressure 130s/80s
- Fasting blood glucose in low 100s
- Improved understanding of his chronic conditions and self care
- Taking medications as prescribed
- Keeping medical appointments with PCP, specialists

Case Study #2

- PCP asked Care Coordinator to contact patient
- Uncontrolled DM, HTN
  - HbA1c 17%
  - BG 450 mg/dl
  - B/P 167/105
- Chronic conditions diagnosed when patient presented to the ER with a complaint of “my hernia is hanging out”
- Surgery postponed until he was metabolically stable

With Care Coordination

- Barriers
  - Non-adherence – related to financial constraints
  - Knowledge deficit of daily self care
  - Lack of financial resources
- Care Coordinator actions:
  - Procured BG meter
  - Referred for DSME/S
  - Scheduled appointment for annual eye exam
  - Medication teaching

Case Study #2 (cont.)

- Blood pressure 130s/80s
- Fasting blood glucose in low 100s
- Improved understanding of his chronic conditions and self care
- Taking medications as prescribed
- Keeping medical appointments with PCP, specialists

Transitions in Care Pose Health Threats

- April, 2016 Kaiser Health News publishes article declaring hospital discharge as “one of the most dangerous junctures in medical care
- Fragmented care at different facilities post discharge
- Different computer systems
- PCP not notified of admission or discharge so unaware of needs
- Many patients do not have a PCP
Ignore J18

Perhaps adived up cases. Start the Presentation with the background up front, go into the principas sof case management.

jkbc1, 5/9/2016
Identifying Patients With Greatest Need

- Multiple hospitalizations or ER visits in the last 3-6 months
- Frequent PCP and/or multiple visits to specialist
- Multiple urgent care visits for chronic condition management
- Medication non-adherence
- Deteriorating physiologic indicators/symptoms
- Deteriorating behavioral health status
- Other indicators of instability identified by the PCP

Measuring Success

- After one year participating PCPs cut costs by $38 million (1.5%)
- After 2 years, PCPs cut costs by $98 million (2.7%)
- In 2012, 1 million members, almost all employed, ave age 42, were in medical homes
- 80% of PCPs in network participate in program
- Our program savings in line with those reported by 10 physician groups across US that treated Medicare patients in ACO

How is Success Measured?

- Reduced hospital admissions
  - 13.5% decrease per 1,000 members 2011 – 2015
- Reduced ER admissions
  - 7.3% decrease per 1,000 members 2011 - 2015

NCQA Data Demonstrates Success

- NCQA PCMHs cut the growth in outpatient ED visits by 11% over non-PCMHs for Medicare patients
- Medicare fee-for-service beneficiaries receiving care in NCQA-recognized PCMH practices had lower total annual Medicare spending than beneficiaries in comparison practices
- Medical home implementation resulted in lower payments to acute care hospitals and fewer emergency department visits

Example of Care Coordination Costs and Avoided Cost

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<thead>
<tr>
<th>Category</th>
<th>Care Coordination Cost</th>
<th>Cost Avoided</th>
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<tbody>
<tr>
<td>Physician Fee for Care Plan</td>
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</tr>
<tr>
<td>Practice Fee for CP Maintenance</td>
<td>$100 x 2</td>
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<tr>
<td>LGC Care Plan Monthly Fee</td>
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<tr>
<td>Cost Share Waiver for Professional Services</td>
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<tr>
<td>Home Health Services</td>
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<tr>
<td>Educational Material</td>
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<tr>
<td>Comprehensive Medication Review</td>
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<tr>
<td>All Other</td>
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<tr>
<td>1 Admission</td>
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<tr>
<td>3 ER Visits</td>
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<tr>
<td>Physician Fees</td>
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</tr>
<tr>
<td>TOTAL</td>
<td>$27,420</td>
<td>$27,420</td>
</tr>
</tbody>
</table>

Quality Measures

- PCP engagement with program
- Appropriate use of services to reduce gaps in care
- Effectiveness of care/Population management
- Patient access
Member Survey Of Patients in PCMH Program

- Conducted quarterly
- 80% response rate!
- 5 questions
  - Do you understand your care plan
  - Care coordination is helpful
  - Do you have sufficient time with your provider
  - Do you have access to information needed to manage your health
  - Has your health improved

Looking Ahead

- Patient-centered care more than a trend
- Long-term relationship with specific point of contact with team of providers
- That point of contact must be accountable for coordinating care
- Secondary point of contact if primary not available

Next Generation for PCMH

- Moving the needle on lifestyle changes
- Creative partnerships
  - Some providers opening offices at the Y
  - Hubs of providers together in 1 facility

Patient and Family Involvement

- Assess readiness to manage care
- Assess capability to manage care
- Illness creates vulnerability, especially on the day of discharge
- Need for transition system pre and post discharge

Questions