Care Coordination and the Role of the Diabetes Educator

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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, AQA, AAP, ACP endorse Principals 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

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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

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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 deliver of health care services

Source: American Nurses Association

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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

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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

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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

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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

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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

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So, what's old is new again!

Think……….the nursing process

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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

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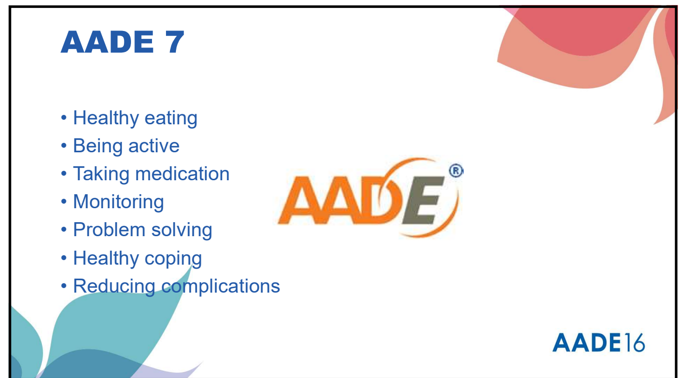

Care Coordination and AADE Position Paper

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

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Current State of DSME/S

- 6.8% = Number of people with NEW diagnosis T 2 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

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Diabetes Education Algorithm

Diabetes Self-management Education and Support for Adults With Type 2 Diabetes: Algorithm of Care

ADA *Standards of Medical Care in Diabetes* recommends all patients be assessed and referred for:

Nutrition – Registered dietitian for medical nutrition therapy ⟺ **Education** – Diabetes self-management education and support ⟺ **Emotional Health** – Mental health professional, if needed

Four critical times to assess, provide, and adjust diabetes self-management education and support			
1 *At diagnosis*	2 *Annual* assessment of education, nutrition, and emotional needs	3 When new *complicating factors* influence self-management	4 When *transitions* in care occur
When primary care provider or specialist should consider referral:			
❑ Newly diagnosed. All newly diagnosed individuals with type 2 diabetes should receive DSME/S ❑ Ensure that both nutrition and emotional health are appropriately addressed in education or make separate referrals	❑ Needs review of knowledge, skills, and behaviors ❑ Long-standing diabetes with limited prior education ❑ Change in medication, activity, or nutritional intake ❑ HbA_{1c} out of target ❑ Maintain positive health outcomes ❑ Unexplained hypoglycemia or hyperglycemia ❑ Planning pregnancy or pregnant ❑ For support to attain and sustain behavior change(s) ❑ Weight or other nutrition concerns ❑ New life situations and competing demands	Change in: ❑ Health conditions such as renal disease and stroke, need for steroid or complicated medication regimen ❑ Physical limitations such as visual impairment, dexterity issues, movement restrictions ❑ Emotional factors such as anxiety and clinical depression ❑ Basic living needs such as access to food, financial limitations	Change in: ❑ Living situation such as inpatient or outpatient rehabilitation or now living alone ❑ Medical care team ❑ Insurance coverage that results in treatment change ❑ Age-related changes affecting cognition, self-care, etc.

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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

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Slide 15

j9 will give you the new alogrythmn
jkb1, 5/9/2016

Biggest Threat to Access and Quality of Care in America?

- COST

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National Health Expenditure Rising Toward 20 % of GDP

National Health Expenditure (NHE) Total Cost and Share of GDP, 2007-2023

Year	National Health Expenditures ($ in billions)	NHE as % GDP
2007	$2,304	15.9%
2008	$2,414	16.4%
2009	$2,506	17.4%
2010	$2,604	17.4%
2011	$2,705	17.4%
2012	$2,817	17.4%
2013	$2,919	17.4%
2014	$3,080	17.7%
2015	$3,244	18.0%
2016	$3,403	18.1%
2017	$3,587	18.1%
2018	$3,786	18.1%
2019	$4,020	18.3%
2020	$4,274	18.5%
2021	$4,543	18.8%
2022	$4,825	19.1%
2023	$5,119	19.3%
2024	$5,425	19.6%

***Years 2013 and forward are CMS projections.**

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, NHE Web Tables, July 2015

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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

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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

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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

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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

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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

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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

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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 instructions
  - Patient learning disability biggest barrier to care

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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

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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’s/90s)
  - Coronary artery disease with 3 cardiac caths
  - Depression with an inpatient stay for suicidal ideation
  - Sleep apnea (not compliant with CPAP)

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Case Study 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

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Without Care Coordination

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

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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

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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

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Without Care Coordination

- No referral for education
- No supplies for blood glucose testing
- High likelihood he would not have continued taking medications, exacerbating his chronic conditions

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Case Study #2 (cont.)

- 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

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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

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Slide 31

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Perhaps adived up cases. Start the Presentation with the background up front, go into the pricipas sof case management
jkb1, 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

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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

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Example of Care Coordination Costs and Avoided Cost

Category	Care Coordination Cost	Cost Avoided	
Physician Fee for Care Plan	$200		
Physician Fee for CP Maintenance	$100 x 2		
LCC Care Plan Monthly Fee	$380 x 9		
Cost Share Waiver for Professional Services	$1,500		
Home Based Services	$400		
Enhanced Monitoring	$500		
Comprehensive Medication Review	$200		
All Other	$800		
		1 Admission	$21,000
		3 ER Visits	$3,600
		Physician Fees	$800
TOTAL	$7,220		$25,400

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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, 1million 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

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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

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Quality Measures

- PCP engagement with program
- Appropriate use of services to reduce gaps in care
- Effectiveness of care/Population management
- Patient access

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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

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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

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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

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Questions

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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

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