Expanding the Medical Neighborhood: Approaches to Collaborative Care

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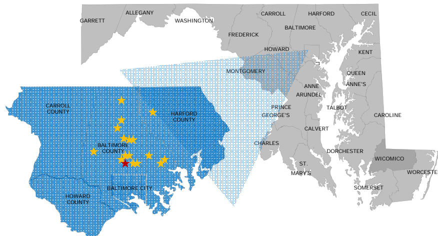
Dr. Motter-Mast is a graduate of the Philadelphia College of Osteopathic Medicine. She completed her residency at the University of Maryland Medical System. She sees patients in an ambulatory office in a suburb of Baltimore as a family medicine physician. She sees all ages of patients, and provides services in women's health. Dr. Motter-Mast has been seeing patients for 15 years, and divides her time in the office with administration duties for her hospital system. She has developed and deployed the patient-centered medical home (PCMH) model in the primary care offices of the Greater Baltimore Health Alliance (GBHA) across 15 practices. She develops and directs the care team model placed in the PCMHs and leads the initiatives for population health and accountable care organization quality metrics. Dr. Motter-Mast has worked with specialists to develop clinical care pathways to focus on clinical quality, better patient experiences, and better health outcomes. Dr. Motter-Mast believes that now is the time for primary care to shine. The difficulty lies with the responsibility of quality and cost of care falling back on the primary care provider for many services engaged in by the patient, and other providers and services not ordered by the primary care provider. Although this is a challenge for the primary care provider, this exemplifies the true leadership potential of the primary care provider to direct and support the patient through their health care needs to achieve the best outcomes at the lowest costs for the patient.

Learning Objectives

1. Compare approaches to collaborative care across practice settings in the medical neighborhood.
2. Identify steps to implement or adapt collaborative care agreements or pathways in his or her practice including where to begin and why.
3. Discuss challenges or barriers to anticipate and plan for in the development of collaborative care agreements or processes.

Audience Engagement System

GBMC HealthCare System



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The GBMC HealthCare System

- **Greater Baltimore Health Alliance (GBHA)(2011)**
  - ACO in the Medicare Shared Savings Program (2012)
  - Private practicing physicians
  - Greater Baltimore Medical Associates (GBMA) (200+)
- **GBMC Medical Center** (300 beds)
- **Gilchrist Hospice Care** (ADC 600)

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GBMC's Vision Phrase:

To every patient, every time, we will provide the care that we would want for our own loved ones.

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What do we want for our own loved ones? The GBMC HealthCare *Quadruple* Aim

1. The **Best *Health* Outcomes**
2. The **Best *Care* Experience**
3. Lowest Cost (**Least *Waste***)
4. With the **Most *Joy*** for those providing the care

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Polling Question #1

Why do we need to collaborate in healthcare?

A. Many patients with chronic conditions lack the knowledge and skills to effectively manage their conditions.
B. It improves the health outcomes of patients with chronic conditions.
C. Many patients have limited health literacy.
D. The cost of the chronic care may be reduced.
E. All of the above.

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PCMH Model

Transform healthcare delivery
- Continuity of care
- Evidence-based medicine

Build a system
- Continuous
- Reliable
- Integrated
- Compassionate
- Connected Care

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Meet one team.
Connect to an entire health network.

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Why PCMN?

- Connect primary care with their community based hospitals, specialists, and other health resources
- Helps patients have collaborative care from **ALL** their health care providers
- Helps patients manage their care more proactively

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We are building a *system* of care

1. **Better care coordination** through the eyes of the patient (patient-centered) leading to better health, better care, and lower cost.
2. **The Patient Centered Medical Home** is the fundamental building block
   - Your physician and their team are **accountable**
   - They are **available** - extended hours
   - They use **electronic records** and patient registries
   - **Patient portal**
   - **Health Information Exchange (HIE)**

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Delivering the Right Care to Patients at the Right Time

5% of Patients

Dying
Advanced Illness
Complex Illness

Chronic Disease
~15 – 30% of Patients

Healthy Individuals
Individuals with Asymptomatic Conditions
~ 60 – 80% of Patients

Medical Neighborhood
PCMH
Specialists
Palliative Care
Hospice
Home care

Primary Care Patient Centered Medical Home (PCMH)

Polling Question #2

Which payment structure in the future will require collaboration for value based payments?

A. MIPS (Merit-Based Incentive Payment System)
B. APMs (Alternative Payment Models)
C. Bundled Payments
D. Fee For Service
E. Answers A,B, and C only

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How to Get Started

- Decide on desired **impact**
- Gather key **stakeholders**
- Decide on form of **agreement/compact**
- Formulate a **process**
- Decide on **metrics** for success
- Seek out **partnerships** in the community

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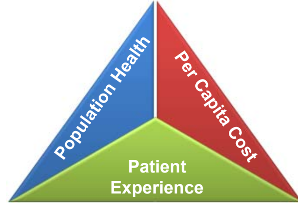
Impact

- Quality Scores
- Utilization
  - Practice based
  - ED utilization
  - IP utilization
- Cost
- Partnerships

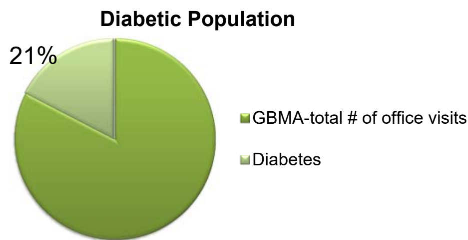


2014/2015 ACO Quality Reporting

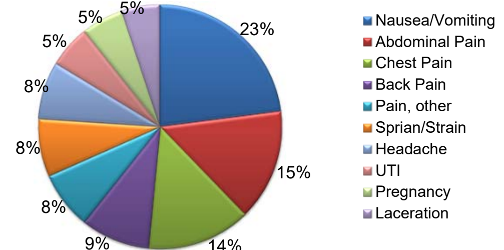
LAMOS, MARK A — *Data includes visits up to 4/27/15*

MeasureID	Measure Description	Sample Size	PCP Rate*	Our ACO Rate*	CMS Target Goal*	CMS Max Point Goal*
CARE1	Medication reconciliation	8	100.00%	94.22%	80%	90.00%
CARE2	Falls Risk …	319	56.31%	72.29%	35.55%	73.38%
CADCOMP †	CAD Composite	96	87.50%	83.36%	69.96%	79.84%
CAD2	Lipid Control	96	94.79%	85.12%	N/A	N/A
CAD7	ACE/ARB with LVSD or DM	33	66.67%	78.35%	N/A	N/A
DM2**	a1C Poor Control >9%	109	5.50%	16.08%	40%	10.00%
DMCOMP †	Diabetes Composite	109	44.04%	26.95%	25.78%	36.50%
DM13	BP Control	109	88.07%	83.44%	N/A	N/A
DM14	LDL Control	109	71.56%	50.67%	N/A	N/A
DM15	a1C Control	109	89.91%	66.72%	N/A	N/A
DM16	Daily Aspirin with IVD	26	96.15%	88.66%	N/A	N/A
DM17	Tobacco Non Use	109	67.16%	86.86%	N/A	N/A
HF6	Beta Blocker with LVSD	1	100.00%	98.00%	60%	90.00%
HTN2	Blood Pressure Control	341	86.27%	60.31%	68.03%	79.65%
IVD1	LDL Control	110	74.55%	49.74%	57.14%	78.81%
IVD2	Aspirin or Antithrombotic	110	94.55%	79.03%	78.77%	97.91%
PREV5	Mammography	151	77.48%	71.05%	65.66%	99.56%
PREV6	Colorectal Cancer Screening	445	78.88%	56.72%	63.29%	100.00%
PREV7	Influenza Vaccination	637	72.37%	49.24%	58.6%	100.00%
PREV8	Pneumococcal Vaccination	319	82.79%	59.90%	70.66%	100.00%
PREV9	BMI Screening and Follow Up	658	72.34%	53.94%	66.35%	100.00%
PREV10	Tobacco Screening and Intervention	652	96.32%	92.73%	60%	90.00%
PREV11	BP Screening	236	54.20%	53.65%	60%	90.00%
PREV12	Depression Screening and Follow Up	582	86.77%	67.01%	23.08%	51.81%

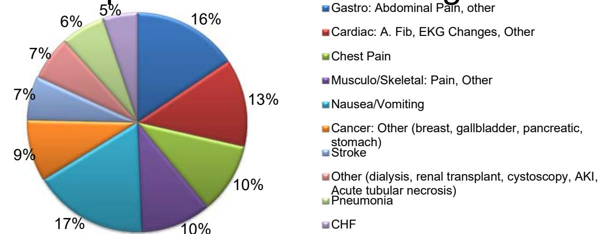
Diabetes Composite Measure



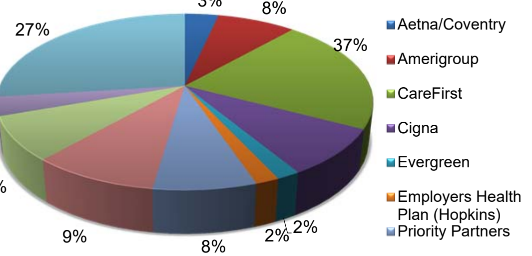
Top 10 ED Diagnosis

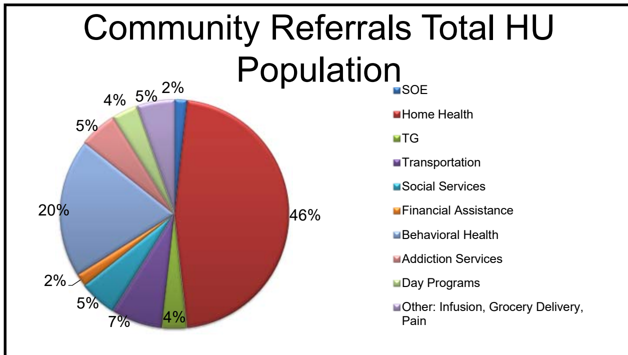


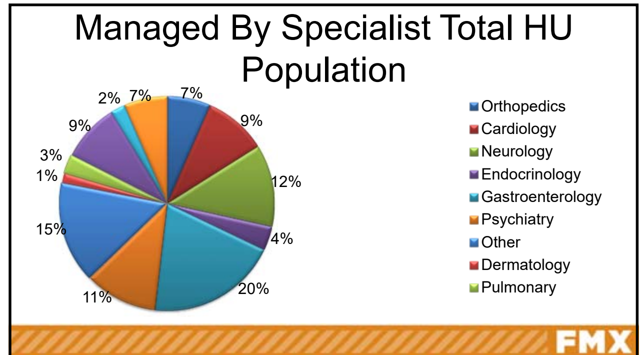
Top 10
Inpatient Admission Diagnosis



Breakdown by Insurance




Community Referrals Total HU Population
46%
20%
5%
4%
5%
2%
2%
5%
7%
4%
SOE
Home Health
TG
Transportation
Social Services
Financial Assistance
Behavioral Health
Addiction Services
Day Programs
Other: Infusion, Grocery Delivery, Pain


Managed By Specialist Total HU Population
7%
9%
12%
4%
20%
11%
15%
1%
3%
9%
2%
7%
Orthopedics
Cardiology
Neurology
Endocrinology
Gastroenterology
Psychiatry
Other
Dermatology
Pulmonary
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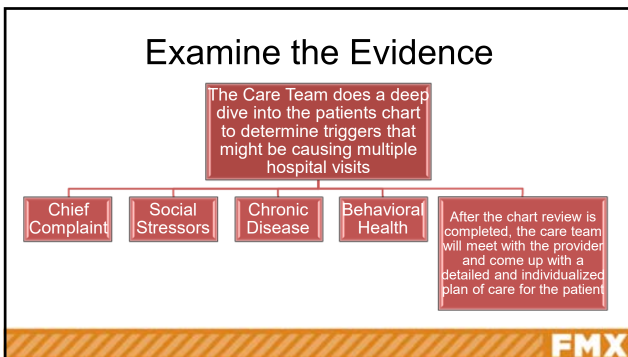
Examine the Evidence
The Care Team does a deep dive into the patients chart to determine triggers that might be causing multiple hospital visits
Chief Complaint
Social Stressors
Chronic Disease
Behavioral Health
After the chart review is completed, the care team will meet with the provider and come up with a detailed and individualized plan of care for the patient
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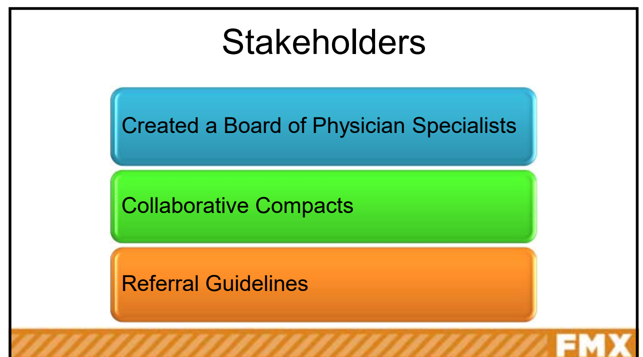
Stakeholders
Created a Board of Physician Specialists
Collaborative Compacts
Referral Guidelines
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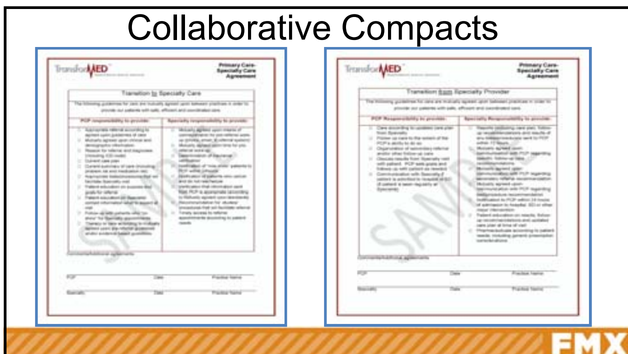
Collaborative Compacts
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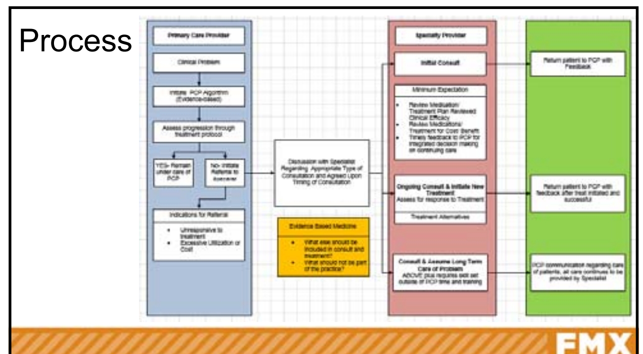
Process
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Polling Question #3

Participation in a Practice Transformation Network will equal points for the MIPS category for Clinical Practice Improvement Activity. True or False?

A. True
B. False

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Diabetes Composite Measure

- All or nothing measure for diabetic patients 18-75 years of age
- All individual component measures must be met:
  - HbA1c < 9.0%
  - Retinal or dilated eye exam
- All measurements assessed on monthly basis

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DM Composite Performance

	Overall DM Comp	A1c	Eye exam	Goals
2015 ACO DM Comp Score	18.45%	29.42 %	22.66%	report
2016 ACO DM Comp Score	31.24%	29.08%	38.55%	70th percentile

- 2015 rate based on sample of 3,281 Medicare beneficiaries
- 2016 YTD based on all GBMA EMR diabetic patients seen as of 7/1/2016

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Reporting Process

- CMS ACO Quality Reporting
  - Annual process where ~3,500 Medicare patients are sampled for reporting for all ACO measures, including diabetes composite
- Data warehouse monthly reports
  - Monthly process where all EMR patients, regardless of insurance type, are included in sample

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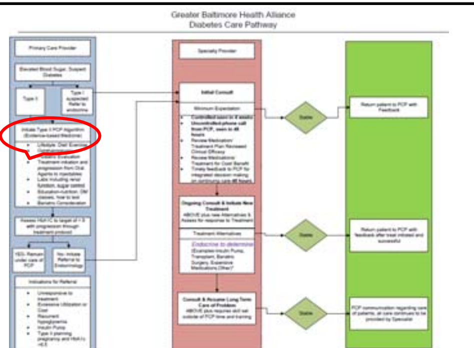
Evidence Based Guidelines



Diabetes Care Standards

(evidence based guidelines)

LABORATORY /DIAGNOSTIC TESTS	
•**HbA_1C** for all patients with Diabetes •Every 3 months if last HA_1C > **6.9%** •Every 6-12 months if last Hb A_1C ≤ **6.9%** •**Urine Microalbumin** for all patients with Diabetes: Every 12 months •**Serum Creatinine** for all patients with Diabetes: Every year OR Every 6 months for patients on ACE, ARB or diuretics •**Serum K^+** for all patients on diuretic therapy: Every 6 months	•**Lipid Panel** for all patients with Diabetes: •Every year if LDL ≥ 100 mg/dL OR •Every two years if: LDL < 100, HDL >50or Triglycerides less than 150 •8-12 weeks after change in cholesterol lowering medication •**ALT and/or AST** for all patients with Diabetes: Every year OR 8-12 weeks after change in cholesterol lowering medication •**Hemoccult** for all patients age 50 and older : Every year

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Diabetes Care Standards

(evidence based guidelines)

HEALTH SCREENS AND SERVICES	
•**Breast cancer screening**[6] for all women age 50-74- Mammogram- •Every year •**Colorectal Cancer screening**[7] for all patients 50-75- •Colonoscopy- Every 10 years, or •Flexible sigmoidoscopy- Every 5 years, or •Fecal occult blood test or Fecal immunochemical test- Every year •**Osteoporosis screening**[8] for all women age 65 and older- •DXA- Once	•**Dilated Eye Exam** for patients with Diabetes every year •**Foot Exam** for patients with Diabetes every year •**Follow up Visits**[10] scheduled for all patients with hypertension: •Monthly, until target BP reached or •Every 6 months if target BP goals are being met •**Nutrition Education-** Comprehensive education for all patients with newly diagnosed diabetes, comprehensive education for all diabetic patient who never had formal education, OR refresher diabetic education every year as needed

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Partnerships

- Bay West Endocrinology Associates
  - DM Care Pathway
- Geckle Diabetes and Nutrition Center
  - Diabetes education classes in primary care practices
  - 1:1 diabetes education for patients embedded in primary care practices
  - Samuelson Foundation Grant
- Local grocery stores
  - Dieticians to help patients learn to shop and read labels
- Community health clubs
  - Engage patients in supervised programs for diet and exercise
- Pharmaceutical Companies
  - Educate staff members around adherence and engagement topics

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Class and 1:1 Education

- Partnership with Geckle Diabetes and Nutrition Center
  - Journey for Control Conversation Map guided classes
    - Two 90-minute classes
    - Every other month at 6 PCP locations
  - 1:1 sessions with RD, CDE
    - Medication, Nutrition, Monitoring
    - Every other month for 4-hours at 6 PCP locations

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Work Flow Created for Care Team

- Beginning in April 2016 RN Care Managers began tracking outreach calls as follows:
  - 1st Call
  - 2nd Call
  - Letter
  - Scheduled Appointment
  - Endocrinology office
  - Eye office
  - A1c now meets
  - Eye exam now meets
  - Notes in chart

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Metrics

"What get's measured, get's done!"

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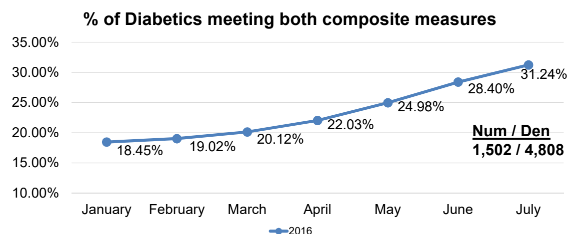
Diabetes Composite Progress



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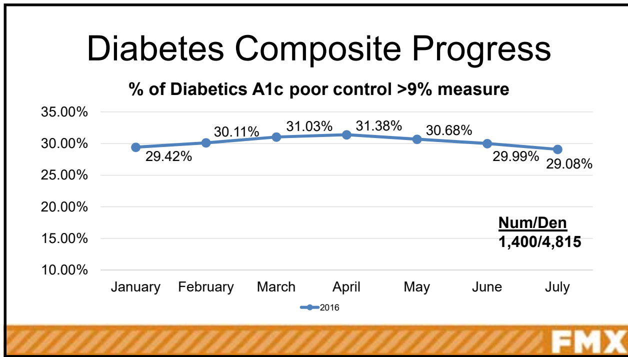

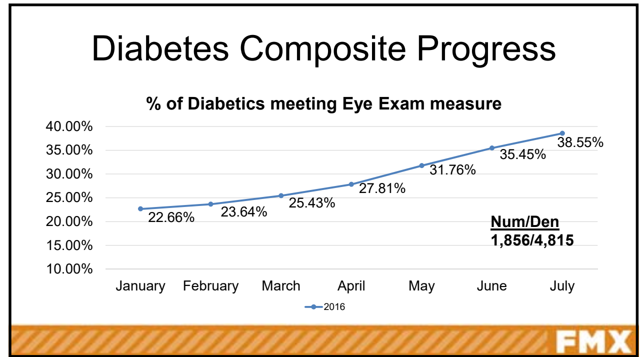

Class and 1:1 Education

- Metrics
  - January through July 2016
  - Attended both classes

	Before	After (3 months)
A1c	9.2%	8.0%
LDL	82	97.9 (only 3 had LDL f/u)
BMI	38.21	38.23
Blood Pressure	124/76	126/76

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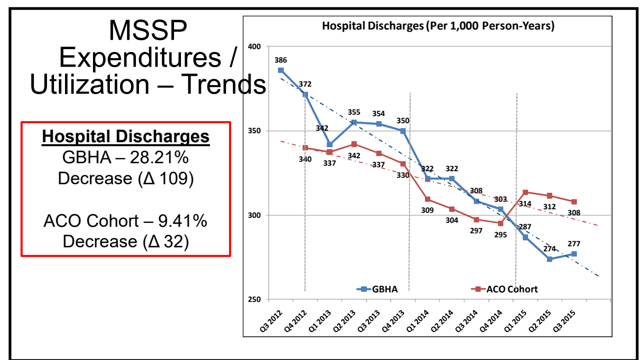
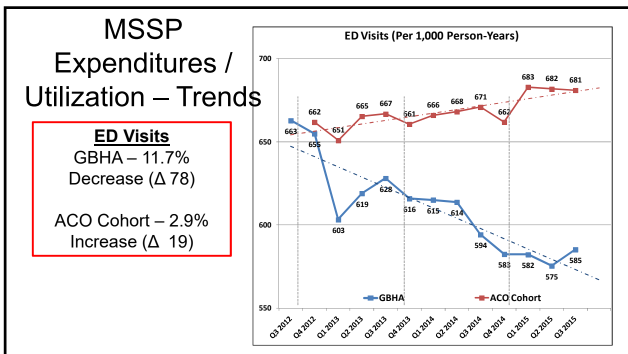
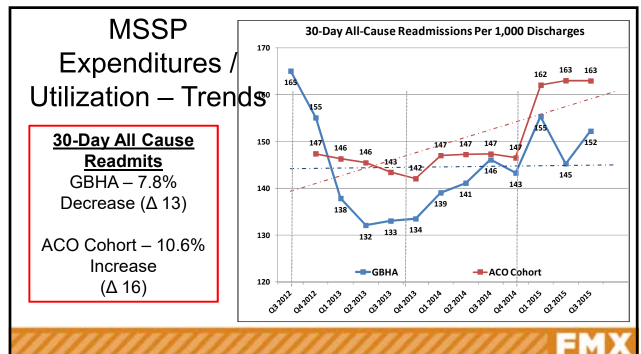
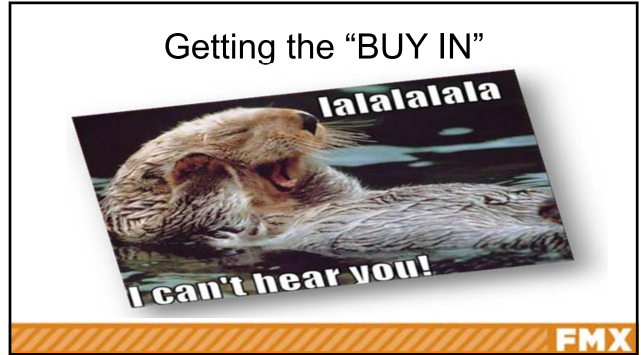






Getting the "BUY IN"



Practice Recommendations

- Pick an area to impact
- Decide on stakeholders
- Facilitate conversations
- Document agreed on collaboration
- Metrics
- Look within your community for partners

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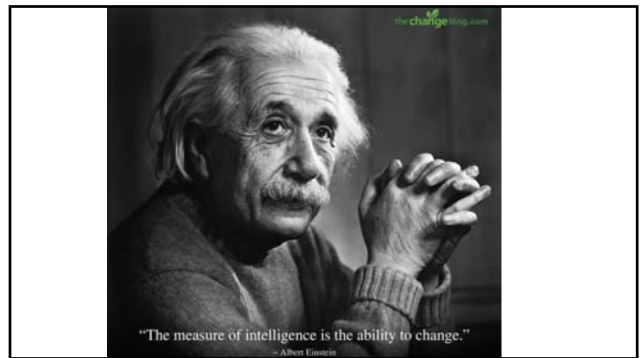

Questions

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