Journey in managing practice variation in Diabetes and Hypertension (Part 2/2)

For Part 1 of this presentation, go to http://rightcare.berkeley.edu/sacramento-university-of-best-practices

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Medical Director, Continuum of Care
Sharp Rees-Stealy Medical Group
San Diego
Silver List
Clinic Staff

- A1c > 9
- BP >160/100
  
  And
- No appointment within 2 months
3 Dedicated RNs for DM and HTN

- Call patients to make sure they are taking meds.
- Then ensure labs have been tested
- Not taking meds---- Task physicians

2 Care Specialists obtain appointments

8 Diabetes Disease managers A1c> 8.5%
List 1
Diabetes Disease Managers

1. A1c ≥ 8
2. List of DM patients not seen in past year

Workflow:
Manage the Diabetes care
Schedule f/u appointments
List 2
DDM+ Care Specialist

- LDL > 100 or
- BP > 140/90

Workflow:
Manage LDL as per protocol.
BP recheck appointments and
No appointment within 2 months
List 3
Staff and Data management

- Missing lab values (A1c, LDL, Microalbumin)
- No appointment with PCP 6 months

Workflow
- Automated Phone calls
- ‘MySharp’ messaging
- Care specialist will schedule with PCP
Outreach using MySharp messages and new telephonic messages

New motto: Minimize the number of lists which go out to the Doctors and Clinic sites
Teamwork - Who is on your team?

- Physicians
- Diabetes Care Managers
- Care Specialists
- Clinic staff

Pharmacist/Pharmacy tech
Dr. Ron Kwok
Physician Champion

Diabetes Disease Managers Team
Q4. Among elderly patients who were one week post discharge from the hospital, what % medications were not being taken at all?

A. 10%
B. 20%
C. 30% [X]
D. 60%
Medication Therapy Management (Refill clinic)

- Refill Request
  - Pharmacy e-script
  - Pharmacy fax
  - Patient walks in
  - Patient calls
  - MySharp

- Refill Clinic

- Sharp-Rees - Stealy
  - Family Medicine Providers
  - Internal Medicine

- Pharmacy Technician

Align stakeholders | Workflows | Team based | Patient engagement | Healthcare reform | Total Cost Of Healthcare | Lessons
Medication Therapy Management
Sample Protocol

**Antihypertensive**

- Verify if BP measured in past 12 months
- Indication of medication
- Strength and dosage of medication
- Date of last physician appt (within 6 months)
- Laboratory monitoring
Timeline on the CIP in ‘All or none’ bundled care

- Change in BP criteria
- Centralized process

Dec-11, Jan-12, Feb-12, Mar-12, Apr-12, May-12, Jun-12, Jul-12, Aug-12, Sep-12, Oct-12, Nov-12, Dec-12, Jan-13, Feb-13, Mar-13, Apr-13, May-13, Jun-13, Jul-13, Aug-13

48% Goal
Teamwork

- Physicians
- Diabetes Care Managers
- Care Specialists
- Clinic staff
- Pharmacist/pharmacy tech

OK. Now you have a team. But how effective are they?
Q5. One effective way to engage patients in self management of their chronic disease is....

A. Make sure to provide all ‘care instructions’ in one session

X B. Present yourself as part of Care Team (who works with your PCP/office staff)

C. Provide generic education material

D. My way or the highway
Engage the patient

*Partner with me*

- Step by step wellness Plan
- Coordination of care across the system
- Face to face interaction
- Patient specific education material
- Shared care plans
- Medication adherence reporting
- Form personal connection
Patient Driven Care

“The needs of the patient come first.”

“Nothing about me without me.”

“Every patient is the only patient.”

Patients largely produce their own outcomes!
Program Key Elements

- Target Population
- Dedicated Care Manager
- Team Based Care
  - MD + DM + Clinic Team
- Shared Action Plan
  - In patient’s own words
- Intake Visit
  - Face to Face
  - Shared trust
  - Socio-behavioral assessment
- Proactive Care Management
  - Follow-up and Check-ins
Patient Engagement

High Blood Pressure and Diabetes

How am I doing?

Blood Pressure Goals
- Systolic (upper number): 120 or less
- Diastolic (lower number): 80 or less

Diabetes and High Blood Pressure may affect your health:
- Kidneys — increases your risk of kidney failure and need for dialysis
- Heart — increases your risk of heart attacks and heart failure
- Brain — increases your risk of strokes

Keeping your blood pressure and diabetes under control will keep you healthy and prevent complications

SHARP Rees-Stealy Medical Centers

High Blood Pressure and Diabetes

How do I know I have high blood pressure?
The only way to find out is to have your blood pressure checked regularly.

How do I treat my high blood pressure?
- Stop smoking
- Physical activity (the goal is 30 minutes per day)
- Maintain a healthy weight
- Eat less salt
- Eat less processed foods

What will I do starting today?
- Avoid salty foods
- Limit alcohol
- Exercise
- Take my medicines
- Reduce weight
- Decrease or stop smoking
Measure patient engagement rate

<table>
<thead>
<tr>
<th>Disease Management</th>
<th>LII &amp; LII Refs</th>
<th>LII &amp; LIII Non-Data Refs</th>
<th>Eng Status</th>
<th>Closed Eng</th>
<th>Closed Non-Eng</th>
<th>Decl</th>
<th>Eng Rate</th>
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<tbody>
<tr>
<td>CAD</td>
<td>326</td>
<td>35</td>
<td>72</td>
<td>32</td>
<td>119</td>
<td>21</td>
<td>28.81%</td>
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<tr>
<td>Asthma</td>
<td>251</td>
<td>12</td>
<td>91</td>
<td>10</td>
<td>41</td>
<td>7</td>
<td>38.40%</td>
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<tr>
<td>Diabetes</td>
<td>958</td>
<td>223</td>
<td>371</td>
<td>50</td>
<td>241</td>
<td>61</td>
<td>35.65%</td>
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<tr>
<td>Obesity</td>
<td>419</td>
<td>5</td>
<td>31</td>
<td>4</td>
<td>49</td>
<td>37</td>
<td>8.25%</td>
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<tr>
<td>COPD</td>
<td>n/a</td>
<td>148</td>
<td>55</td>
<td>21</td>
<td>13</td>
<td>7</td>
<td>51.35%</td>
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<tr>
<td>CHF</td>
<td>n/a</td>
<td>424</td>
<td>151</td>
<td>117</td>
<td>46</td>
<td>11</td>
<td>63.21%</td>
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<tr>
<td>Overall DM</td>
<td>1954</td>
<td>847</td>
<td>771</td>
<td>234</td>
<td>509</td>
<td>144</td>
<td>36%</td>
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</tbody>
</table>

Healthier Living classes 2013 YTD – 15 workshops 118 participants

63% completion rate.
Timeline on the Continuous Improvement Process
‘All or none’ bundled care

52% have advanced perfect care

Centralized process

Change in BP criteria

48% Goal

Timeline on the Continuous Improvement Process ‘All or none’ Bundled Care

Change in BP criteria

VARIATION

Goal

Dec-11  Feb-12  Apr-12  Jun-12  Aug-12  Oct-12  Dec-12  Feb-13  Apr-13  Jun-13  Aug-13

30.0%  34.0%  38.0%  42.0%  46.0%  50.0%

VARIATION

Goal
Addressing Variation

S : Analyzing what works

A: Adjust and do again
Change is hard

Align stakeholders → Workflows → Team based → Patient engagement → Healthcare reform → Total Cost Of Healthcare → Lessons
Q5. Bundled (All or none) Diabetes care measures are...

A. Made up by Hattie Hanley for RCI awards

B. Only for Health plan ratings

C. Only in California

D. Components of IHA P4P, Medicare stars, CMS ACO, Meaningful use, PQRS and possibly SGR fix

X
Healthcare reform - Leverage it

Value based payments

Clinical Quality Measures

Value Based Payments

Align stakeholders  Workflows  Team based  Patient engagement  Healthcare reform  Total Cost Of Healthcare  Lessons
## Alignment of Clinical Quality Measures across payers = Population Health

<table>
<thead>
<tr>
<th>Million Heart/Right Care Initiative/10th Scope CQMs</th>
<th>CMS PQRS*</th>
<th>ONC Meaningful Use</th>
<th>PQRS CV Prevention Measures Group</th>
<th>ACOs</th>
<th>HRSA UDS</th>
<th>Medicare Advantage Star rating</th>
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</thead>
<tbody>
<tr>
<td>Aspirin Use</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>BP Screening</td>
<td>Yes</td>
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<td>Yes</td>
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<td>Yes</td>
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<td>BP Control</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Chol Control – Pop</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chol Cont – DM</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Chol Cont – IVD</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td></td>
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</tbody>
</table>

*Physician Quality Reporting Services*
Qs: What is the average annual End Stage Renal Disease cost per patient requiring dialysis?

A. $10,000
B. $40,000
X C. $70,000
D. Half a million

Source: Kidney disease statistics for the United states National Kidney and Urologic Diseases Information Clearinghouse
**Preliminary RCI Goals: Improve Clinical Outcomes**

Heart attack, stroke prevention and other associated complications focused on heart disease, hypertension and diabetes patients

<table>
<thead>
<tr>
<th>New complication/1000 Advance perfect care beneficiaries (n=10,770)</th>
<th>Controlled (n= 5041)</th>
<th>Uncontrolled (n=5729)</th>
<th>Reduction in complication</th>
<th>Annual Cost avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Myocardial Infarction</td>
<td>2.98</td>
<td>4.71</td>
<td>33% reduction</td>
<td>$360,000 ($30,000 per episode)</td>
</tr>
<tr>
<td>Renal failure requiring dialysis</td>
<td>0</td>
<td>0.52</td>
<td>100% reduction</td>
<td>$210,000 ($70,000 annual per ESRD)</td>
</tr>
<tr>
<td>Retinopathy</td>
<td>20.42</td>
<td>25.48</td>
<td>20% reduction</td>
<td>$107,500 (43X $2000 low annual t/t cost per DR)</td>
</tr>
</tbody>
</table>
“It’s not just about competing with each other, it’s about competing against disease”
Lessons learned

- Align stakeholders
  - Organization scorecard
- Patient care workflows
  - Keep it simple and centralized
- Team based healthcare
  - Who is on your team?
- Patient Engagement
  - Measure
- Healthcare reform
  - Leverage it
- Total cost of healthcare
  - Demonstrate the ROI
- Change is hard
  - RCI-UBP Network support.
Thank You.
Any questions?
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