



Coordinating Care Across the Continuum: Making it Work for Patients



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Larry's Story

- ▶ 67
- ▶ Type II Diabetes
- ▶ Hypertension
- ▶ BMI 29
- ▶ A1C 10.2
- ▶ Patient for 10 yrs




The Team Responds

- ▶ Provider refers to Community Care Teams (CCT) for nutrition, diabetes education and exercise advice.
- ▶ Met with CCT Nurse. Educated on carbohydrate counting, healthy diet.
- ▶ Referred him for a fitness assessment and personal training sessions with a trainer at the YMCA.
- ▶ Has three additional meetings with CCT
- ▶ 4 months later patient has lost 15 pounds and is at his goal weight, HBA1C went from 10.2 to 6.2, and he feels great!


Jim's Story

- ▶ 34 year old morbidly obese male referred to CCT for new diagnosis of diabetes, exercise advice and smoking cessation.
- ▶ BMI 40
- ▶ Newly Diagnosed Diabetes
- ▶ Smoker
- ▶ Referred to CCT for diet, exercise advice and smoking cessation



The Team Responds

- ▶ Jim meets with CCT Nurse and Nutrition Educator
- ▶ Pt was placed on a carbohydrate controlled diet, up to 240-275 grams of carbohydrate per day
- ▶ Is exercising 30-45 minutes at the YMCA, cardio and weight training daily.
- ▶ Is contemplating smoking cessation in 3-4 months.
- ▶ Patient states this has been very helpful for him since he really had no idea where to start.
- ▶ Meets with CCT RN monthly for weights and "pep talks" and to answer questions.
- ▶ Has lost 45 lbs. and is doing well


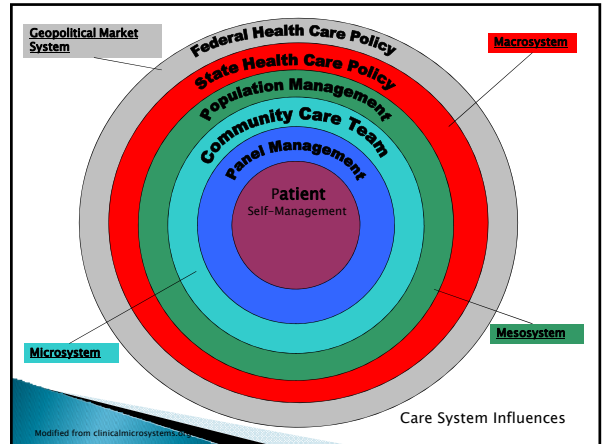


How Do We Make this the Norm? Where Do We Start?

- ▶ Have a Shared Sense of Purpose/Goal
- ▶ Understand the Care System and Influence Pathways
- ▶ Understand the care needs
- ▶ Overall Program Design
- ▶ Care Program Design
- ▶ Communication/Coordination Medical Home and Community Care Teams
- ▶ Measured outcomes

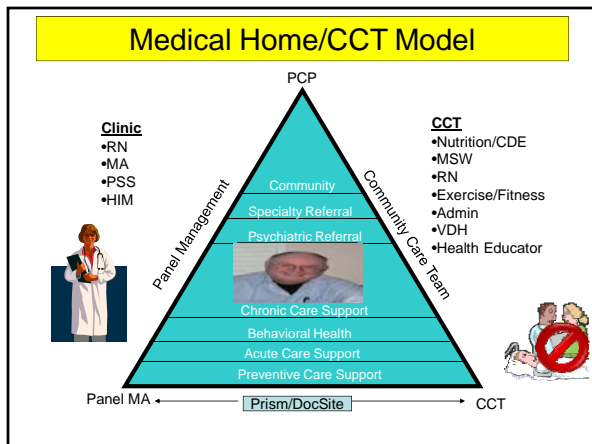
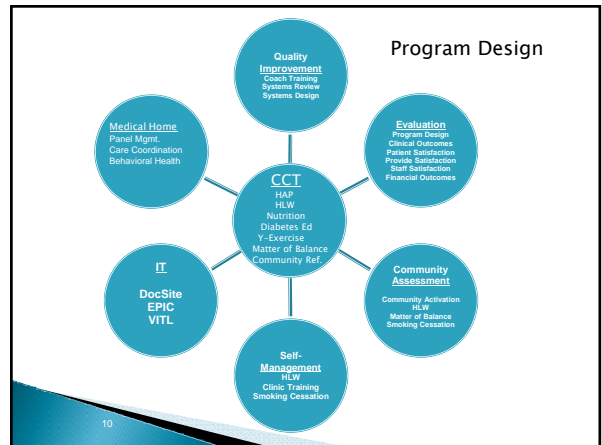
Shared Sense of Purpose What's Your Goal?

- ▶ We aim to improve care to our patients by implementing a patient centered medical home and community care team.
- ▶ The process begins with identifying and evaluating our patients and their current health status and ends with improved outcomes.
- ▶ By working on this process we expect to:
 - Improve quality
 - Engage and empower patients
 - Educate, and foster a team approach to care management
 - Improve efficiency within the practice
- ▶ It is important to do this now because the 1:1 visit alone leaves Primary Care unsustainable.


Care and System Needs

- ▶ Patient Needs
- ▶ Staffing/Nursing Perspective
- ▶ Provider (MD, NP, PA, MSW) Perspective
- ▶ Community Needs
- ▶ Population Needs
- ▶ State Objectives
- ▶ Federal Objectives

Community Care Team

- ▶ 5 FTE's per 20,000 patient lives
- ▶ Type of FTE based on Needs Assessment
- ▶ Located off site
- ▶ See patients in clinic, at CCT office, patients home, YMCA or where ever works for patient



Community Care Team

- › Providers refer via the EHR or by FAX.
- › CCT provides in person 1:1 support, in groups or by phone, 3-6 visits, commonly 4 interactions.
- › Helps patients set realistic goals and timelines utilizing motivational interviewing, action planning and short term goal setting
- › Focuses on achievable realistic outcomes with patients, addressing barriers that may interfere with success.
- › Short term case management, most often provided by our medical social worker.
- › We allow CCT patients to re-engage with the team as necessary after graduation

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Community Care Team

Services include:

- › Health coaching around nutrition, exercise and stress management
- › Basic Diabetes Education
- › Medication Management
- › Behavioral/Mental Screening and support and referral
- › Connection to community and financial resources



Integrated Behavioral Health

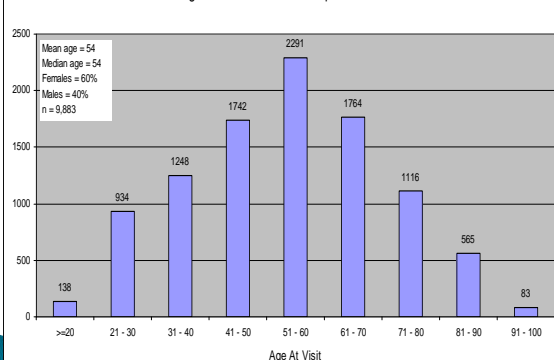
- › In Clinic LICSW
- › Provides immediate consultation.
- › Is a full member of the clinical team.
- › Works with CCT on follow up and referral
- › Patients "DO" come back for visits.
- › Short term intervention and support.
- › Complicated long term referred out.

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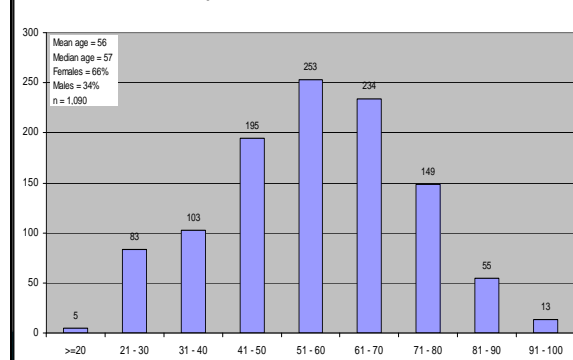
Program Communication Plan

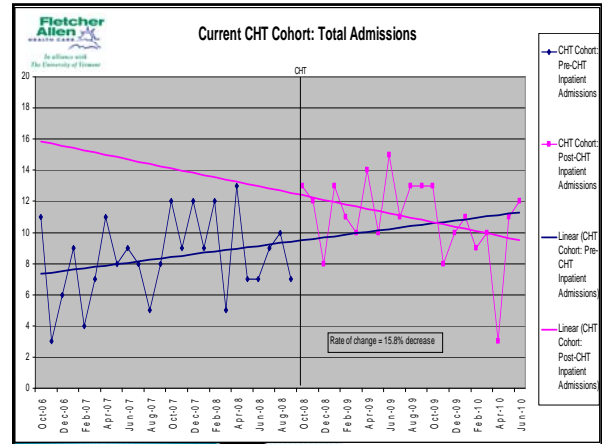
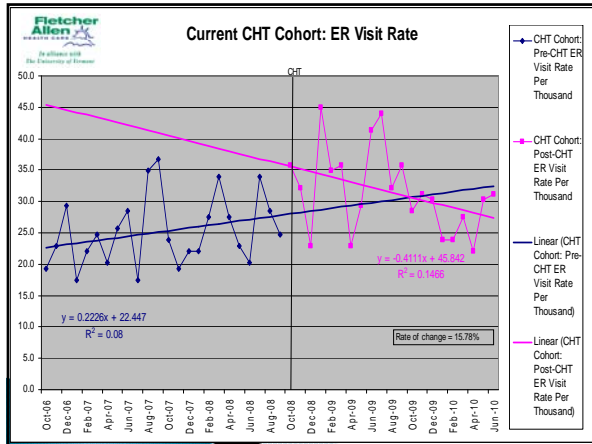
- › A CCT member meets with providers monthly for 30 minutes to discuss any current patients and new patients.
- › Regular check-ins with other staff on an informal basis, since the majority of the patient meetings are held at the practice.
- › CCT Team meets every Monday to discuss cases to ensure appropriate care coordination
- › CCT staff copies providers, nurses, behaviorist and others at the practice as needed on visit notes.
- › It can take 1 to 2 years to fully integrate a CCT.

Age Distribution of Aesculapius Cohort



Age Distribution of Current CHT Cohort






Significant Findings

- ▶ Six month follow-up data after “graduation”
 - Diabetes patients engaged in CCT
 - **59%** of patients with a baseline HbA1c greater than 7 lowered their HbA1c to below 7 at 6 month follow up. The control group had a rate of 7.5%.
 - **100%** of patients with a baseline depression score of moderate or severe depression lowered their score to mild/not clinically significant
 - **100%** of patients with a baseline anxiety score of moderate or severe anxiety lowered their score to mild anxiety at follow up

Significant Findings

- ▶ Six month follow-up data after “graduation”
 - Behavioral Health referrals
 - **75%** of patients with a baseline depression score of moderate to severe lowered their score to mild/not clinically significant at follow up.
 - **70%** of patients with a baseline anxiety score of moderate or severe anxiety lowered their score to mild/not clinically significant at follow up.

Martha



- ▶ 70 year old female.
- ▶ Type II diabetes
- ▶ Controlled by diet and exercise.
- ▶ Patient referred to CCT for help with HbA1C and weight loss.
- ▶ Two appointments with CCT. Monthly calls after.
- ▶ Education on carbohydrates. Plan for diet control and exercise. Agreed to walk 30 minutes/day.
- ▶ She has lost 40 pounds, is exercising daily
- ▶ Her blood sugars have been 100-120. She says she hasn't felt this good in years!

Questions?

