ADVANCING INTEGRATED HEALTHCARE

Breakfast of Champions

Care Transformation Collaborative of R.I.

JUNE 11, 2021

Agenda

Topic and *Presenter(s)*	Time
Welcome & Introductions – *Pano Yeracaris, MD MPH CTC-RI Chief Clinical Strategist*	5 mins
PDSA: Potentially Avoidable ED Visits – PCHC and a panel discussion with adult and pediatric practice leaders discussing the "The Changing Role of the PCP (and inter-professional care team) Under Capitation • *Jonathan Gates, MD, Chief Medical Officer, Accountable Care, Providence Community Health Centers* • *Lillian Nieves, PharmD, Clinical Pharmacist, RI*	25 mins
Panel Discussion – • *Moderator: Patricia Flanagan, MD, Hasbro Children's Hospital, & Brown Univ. Pediatrics Professor* • *Bryan Burns, DO, Physician, Esse Health, & Chief Medical Officer, Effectus Healthcare Solutions, MO* • *Sue Kressly, MD, FAAP: Founding partner of Kressly Pediatrics, Current Chair of the American Academy of Pediatrics Payer Advocacy Advisory Committee, PA*	55 mins
Wrap-Up & Next Steps –Breakfast of Champions Survey and CME Credits Link	5 mins

CME Credits

- CME Credits – Please request session credits when filling out the evaluation at the end of the meeting.
- Evaluation/Credit Request Form: https://forms.office.com/r/wzmaJhrPxV

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Today's Objectives

1) Learn about a Quality Improvement effort, collaborating with pharmacy, to reduce avoidable emergency department and inpatient utilization in patients with diabetes.

2) Understand changes in clinician and clinical team workflows under primary care capitation for pediatric and adult practices.

3) Learn about practice-level data that supports performance improvement under capitation and opportunities to improve panel management.

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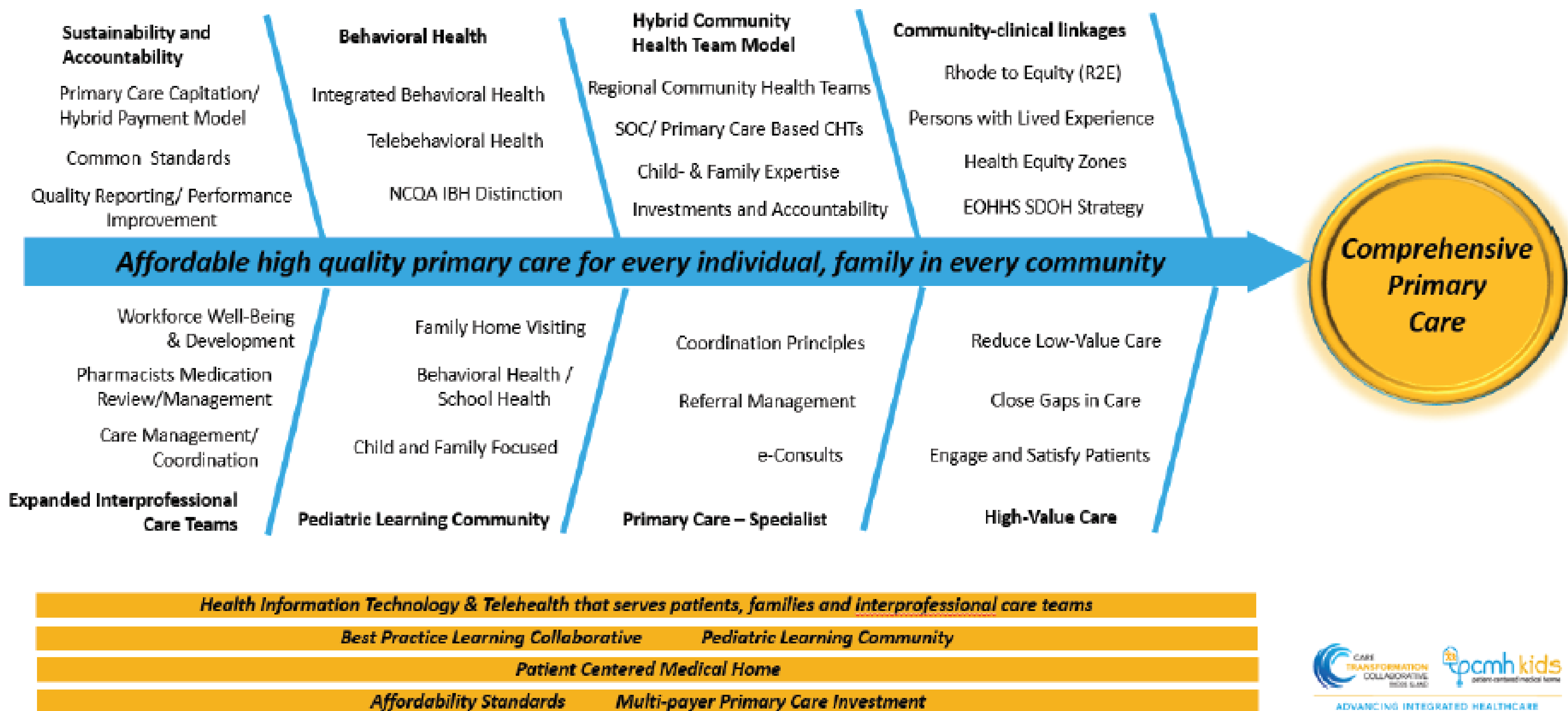
Roadmap to High-Quality Comprehensive Primary Care



PDSA: Potentially Avoidable ED Visits

- Jonathan Gates, MD, Chief Medical Officer, Accountable Care, Providence Community Health Centers
- Lillian Nieves, PharmD, Clinical Pharmacist, RI

Disclaimer

- Neither Dr. Gates nor Lillian Nieves have any conflicts of interest to declare.
- We work at an FQHC – why would we!
- We welcome collaborative work on these topics, and are open to sharing learnings, tools, and other aspects of this initiative.

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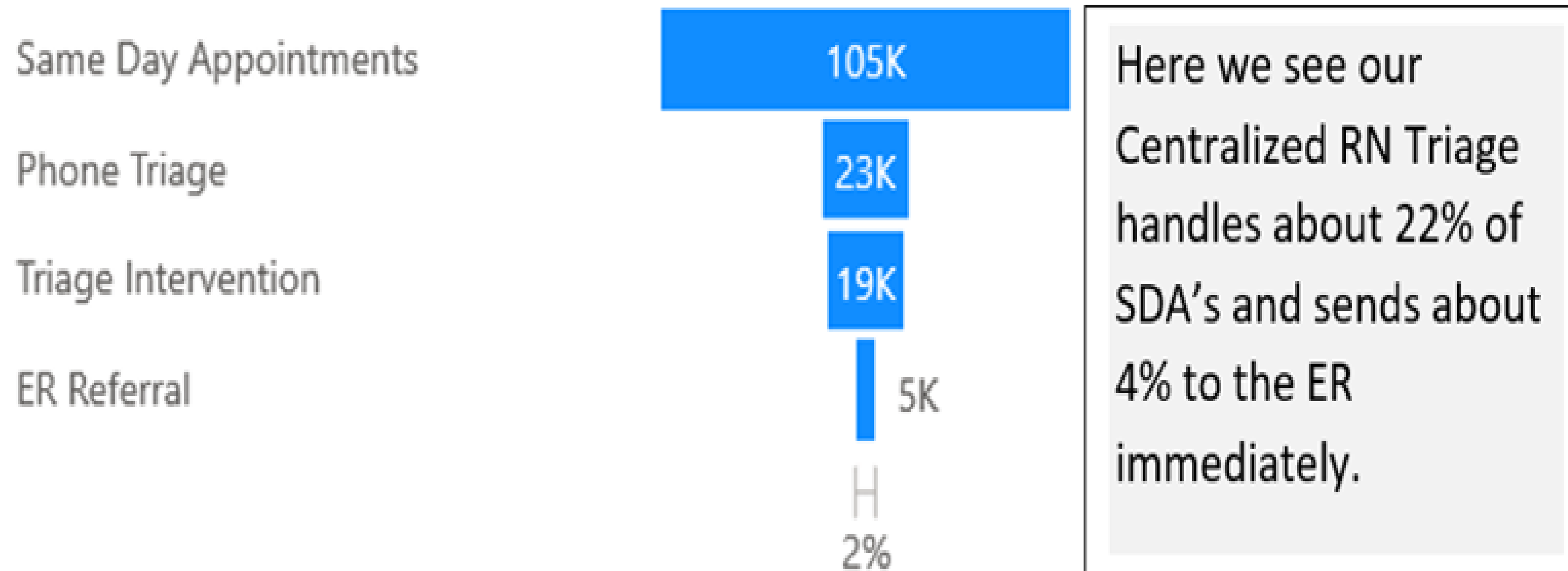
- Avoidable ER visits are often out of convenience or lack of access = “high-velocity risk”
  - Historically well managed by same day appointments
    - Problem: growth of attributed lives = schedules are full by 9:45am
    - After the call center switches to only allow sick calls to care teams and pass hot list call to triage nurses
  - Highly dependent on patient’s perception of the severity of their symptoms and can be short or long in duration



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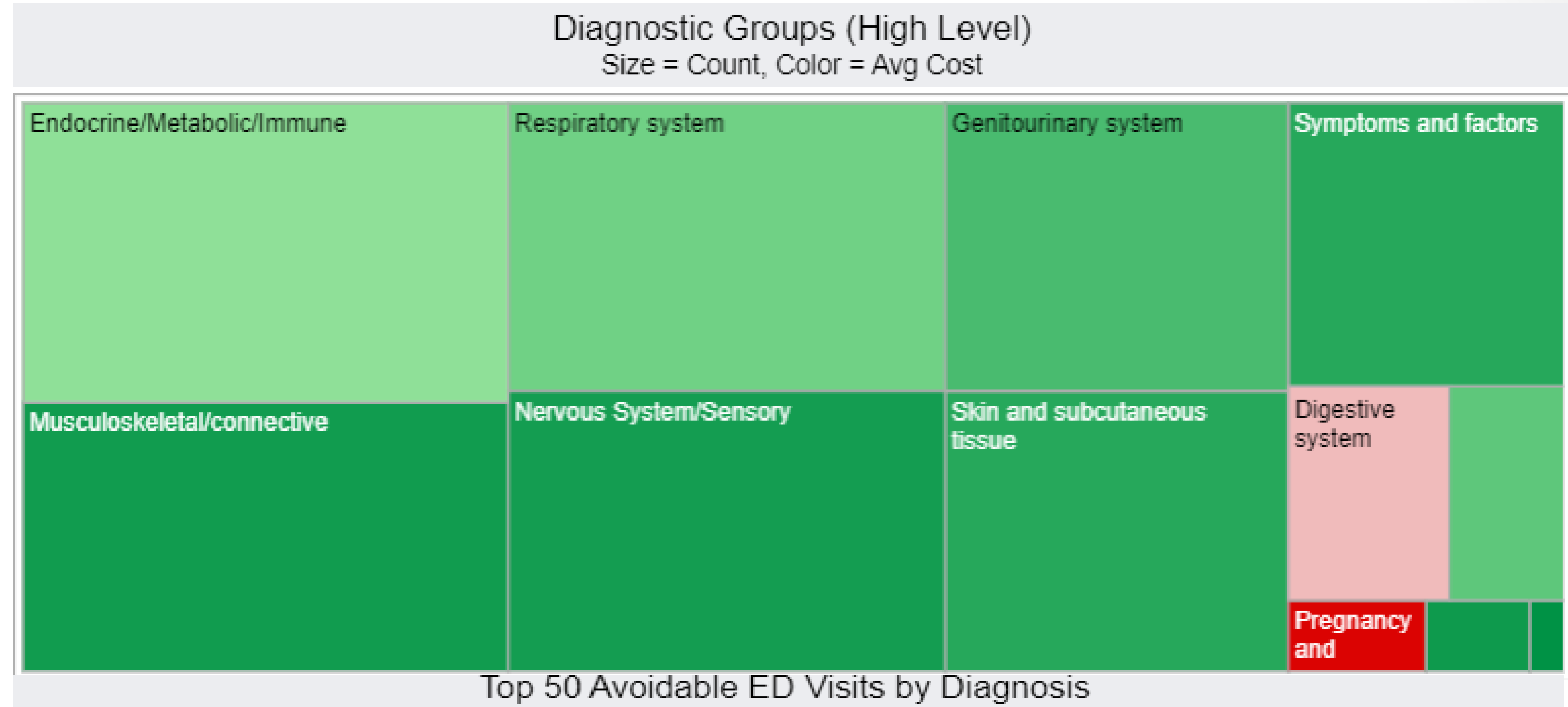
Avoidable ER Visits PDSA Background

Analysis of avoidable ER visit diagnoses showed that many of the patients' presenting complaints could in fact, be symptoms connected with poorly diabetes and hypertension

10% of ER admissions were directly labeled "Diabetes Mellitus Type 2 with Hyperglycemia"

Another 2% with Hypoglycemia



Top 50 Avoidable ED Visits by Diagnosis

Diagnosis Description	Avoidable Visits	Pct Of Avoidable Visits
Headache	23	6.46%
Acute upper respiratory infecti..	13	3.65%
Cough	4	1.12%
Nausea with vomiting, unspeci..	20	5.62%
Vomiting, unspecified	1	0.28%
Low back pain	13	3.65%
Rash and other nonspecific sk..	4	1.12%
Acute pharyngitis, unspecified	2	0.56%
Streptococcal pharyngitis	2	0.56%
Unspecified asthma with (acut..	8	2.25%
Dizziness and giddiness	17	4.78%

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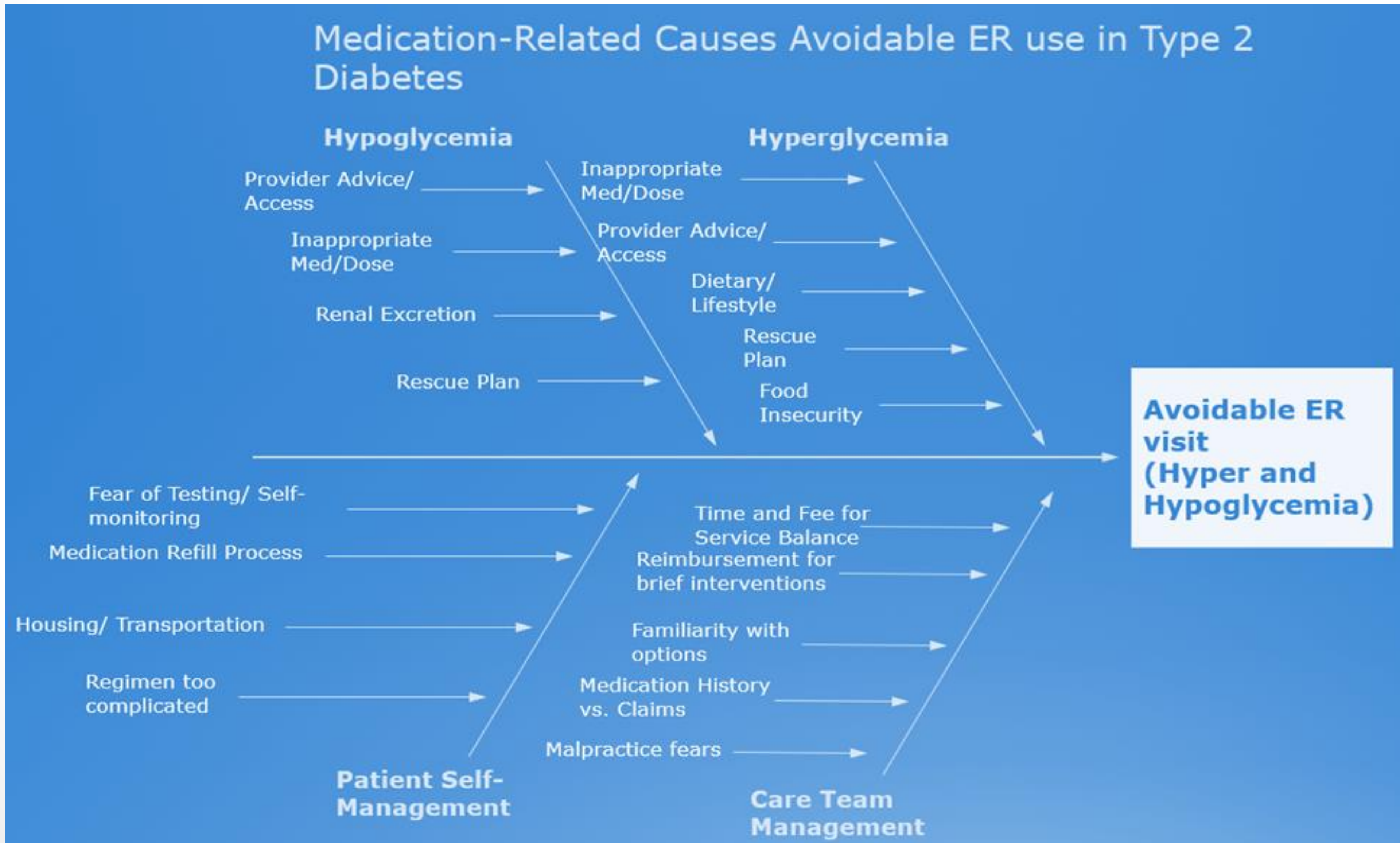
Cause and Effect Analysis



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Hypothesis

- High utilization patients with diabetes and at risk for polypharmacy may be able to reduce ER utilization through rigorous pharmacist medication therapy management and diabetes education.
- Key points –
  - Polypharmacy likely to cause confusion and increase risks of medication mismanagement at transitions of care
  - High utilizing patients are self-selecting as unable to manage their healthcare under the current conditions
  - Reimbursement for education on diabetes has not been cost effective for practices to dedicate resources generally speaking – perhaps a high yield population would help

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- PCHC internal metrics on patients at the time of pharmacy team intervention were:

Average of ER6Mos	Average of Risk	Average of ATI	Average of A1c	Average of #MedicationsPre	Average of SBP	Average of DBP
1.50	15.56	9.75	11.02	15.75	136	83

- *NB: PCHC Average patient risk = 1. High risk patients ~6.*

- Where the Average of ER6Mos is the average number of ER visits for the patients in the preceding 6 months as calculated by the RIQI dashboard. The Risk score is the Johns Hopkins ACG risk score, the ATI is the Ability to Impact Score. The A1c is both lab and PCHC point of care values. N=20
  **not all patients have data for all measures*

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Avoidable ER Visits: Moderate through Very High RUB Diabetics on more than 7 medications make up ~50% of all diabetic avoidable ER visits

N=5,769
Active NHP Patients
with Diabetes

N=1,067
Very High,
High,
& Moderate
Resource Utilization
Band patients

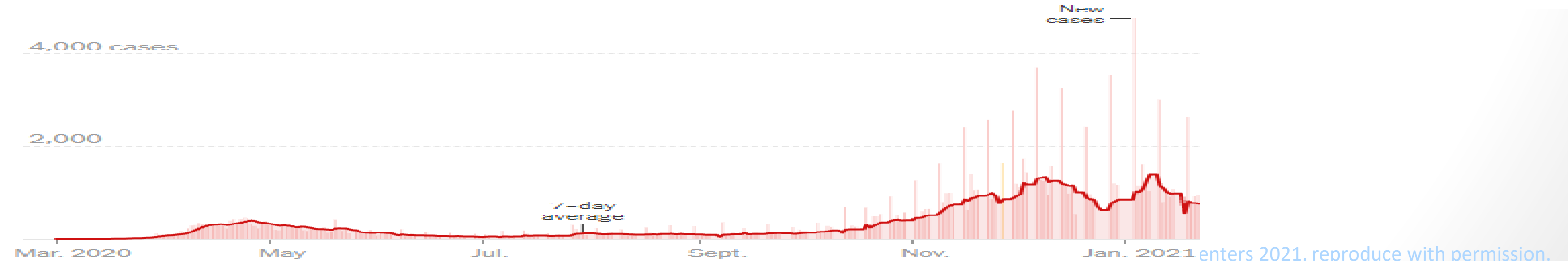
ER Number of Visits By Months

2019 | 2020

ER Visit Count

180
160
140
120
100
80
60
40
20
0

Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec



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- Full time pharmacist
  - CDOE
  - CVDOE
  - CMTM
- Full time Certified Pharmacy Technician II

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- Many 'causes' of avoidable ER visits could be mitigated with a 'sick day' plan
- **PCHC felt that these high level diagnostic groups may offer a way to structure 'Sick Day' plans**

- Pharmacist counseling was first addressed by 'Symptom Management' with top 6 Avoidable ER visit diagnoses explicitly listed

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Avoidable ER Visits PDSA Results

- ER use decreased an average of 1.5 visits per 6 months
- A1c level decreased an average of 2.3
- #medications decreased an average of 5.3
- #doses per day decreased an average of 9 per day
- Systolic and Diastolic blood pressure declined 5 and 8 mmHg, respectively

Pre MTM/CDOE	POST	
ER 6 Months	ER 6 Months	Delta
1.50	0.00	-1.50
Average A1c	Average A1c	
10.70	8.38	-2.32
Avg # Medications	Avg # Medications	
15.75	10.63	-5.13
Avg. #Doses/Day	Avg. #Doses/Day	
20.63	11.56	-9.06
Avg. Systolic BP	Avg. Systolic BP	
137.64	132.57	-5.07
Avg . Diastolic BP	Avg . Diastolic BP	
82.93	74.86	-8.07

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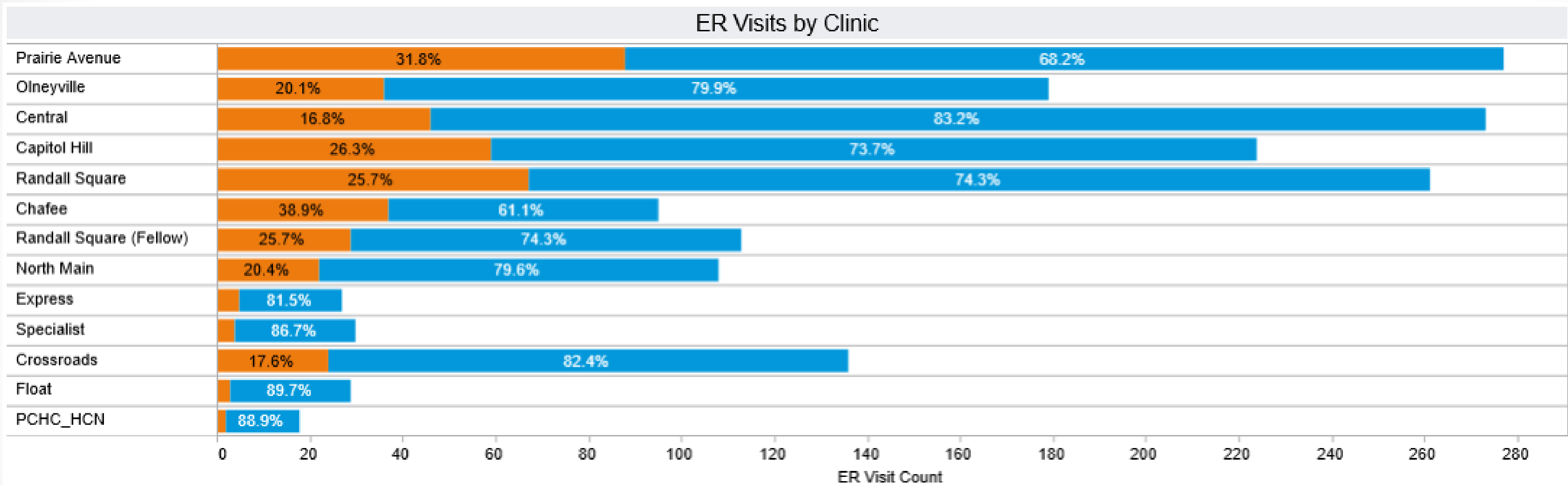
Which clinics need the most help?



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Strategy?

- Sort by Cost, then
- Site, then
- Provider, highest avoidable rate to lowest

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Questions

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Appendix

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Specific context for this PDSA

- Overall, PCHC's avoidable ER visit percentages as of Q1 of 2020 are: UHC 29.7%, NHP 41.7%
- High RUB, Polypharmacy-risk patients with DM Baseline:
  - Our analytics show an avoidable ER rate of 23.3% (7/2020), an average of 26 avoidable ER visits per month
  - Our goal is to reduce this by 10%, or 2-3 visits per month, with secondary goals of improving quality of A1c control and addressing polypharmacy in this population
- Primary Desired Outcome
  - To reduce avoidable ER rate by 10%, or 2-3 visits per month
- Secondary Desired Outcomes
  - Improve A1c control and address polypharmacy

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Avoidable ER Visits Sick Day Plan

Sick Day Plan: Put into note in the counseling section

Be prepared for sick days with your sick box. Check that you have enough medication, including insulin. Check expiration date of items at least twice a year.

Start to follow this sick plan:

- if you're NOT feeling well- even if glucose levels are normal or
- if your glucose levels are above 270 two times in a row
- if your glucose levels fall below 72

If you're not already monitoring your blood glucose levels, start monitoring them when you start this sick plan.

If you can manage okay then, follow the plan. If you're too sick to manage your diabetes or need assistance call your doctor or your diabetes care team.

If you take any of the following medications stop them while you're following this sick plan. They put you at an increased risk of dehydration.

- canagliflozin (Invokanna), dapagliflozin (Farxiga), empagliflozin (Jardiance), ertugliflozin (steglatro)
- (canagliflozin/metformin (Invokamet), dapagliflozin/metformin (Xigduo XR), empagliglozin/metformin (Synjardi XR), steglatro/metformin (Segluromet)

If you use long acting insulin continue injecting same dose {x} This type of insulin is not responsible for food intake.

If you use rapid or meal time insulin and you're not eating enough you will need to decrease your dose by {x}. If you skip your meal you do NOT inject meal time insulin.

If you use mixed insulin (rapid and long acting together) you need to decrease your dose by {x}

It is important that you continue to monitor your blood sugars every 2 to 4 hours and communicate with your doctor and diabetes care team if your blood sugar continues continues to be below 72 or greater than 270.

When to call your doctor for help

- if you cannot keep fluids down for 4 hours
- your blood glucose stays above 270 for more than 24 hours
- your blood sugar stay above 270 despite two extra rapid insulin doses
- you can't keep your blood glucose levels above 72
- your unine ketones are moderate to high or dark purple
- your blood ketone is greater than 1.5
- you feel drowsy, confused, have difficulty breathing, or have severe abdominal pain
- you have persitent vomiting or diarrhea for more than 4 hours
- you have a temperature of 101.5° F (38.6 °C) or greater

If you can't contact your doctor, or you feel frighened or unsure, go to the nearest emergency room or call 911.

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Hypoglycemia Plan	Put into counseling section
Here is what may happen when your blood sugar (glucose) is low:	
Feel shaky, sweaty, dizzy, coufused, may have difficulty speaking, hungry, weak or tired, headach, nervous or upset	
LOW blood glucose levels	
	If your blood glucose is below 72:
	Take 15g of glucose (for example: 4oz of regular fruit juice, 4 glucose tablets, 4oz [1/2] of regular soda [not diet], 1 tablespoon of honey, 2 tablespoons of raisins)
	Wait 15 minutes and check your blood sugar. If is still below 72, take another 15g of glucose, retest your blood glucose
	If is still below 72 call call 911
	If your blood glucose is above 72, and if your next meal is more than 1 hour away, eat a snack to keep your low blood sugar from coming back.
	You can eat a slice of bread, noodle soup, saltine crackers, greek yogurt, milk, or breakfast cereal.
	If your blood glucose levels stay above 72, keep testing every 2-4 hours for as long as you're sick. Make an appointment with your doctor to discuss your
	sick day plan and deci and decide if you need any adjustments to your diabetes management.
	Do NOT drive if your blood glucose levels are below 90.
Food Management	
Try to eat noodle soup, saltine crackers, toast with peanut butter [if not allergic], plain rice, greek yogurt, frozen fruit, jello, apple sauce, milk, soy or almond milk.	
Fluid Management	
Drink water, gatorade, emergen-C every 1 to 2 hours. Pay attention to how many times you go to the bathroom to urinate and pay close attention to the color of your urine.	
If you're not voiding every 2-3 hours and the color of your urine is dark yellow, you need to increase your fluid intake.	
Recovery	
Once you start to feel better, if your blood sugar is below 270 and above 72 consistently and you're eating and drinking well, you may start to take your medications again if you stopped them.	
When to call for help	
It is important that you continue to monitor your blood sugars every 2 to 4 hours and communicate with your doctor and diabetes care team if your blood sugar continues to be below 72 or greater than 270.	

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Avoidable ER Visits HypER Plan

HypERglycemia Plan: Put into note in the Counselling Section

Here is what may happpen when your blood sugar is high:

very thristy, need to pee more often than normal, very hungry, sleepy, drowsy, blurry vsion, wounds take longer heal, nausea, vomiting, difficulty breathing, fruity breath smell, stomach pain, loss of conciousness.

If your blood sugar is above 270, start writing them down so you can share with your doctor and diabetes care team.

If you're taking insulin and you experience:

- your blood glucose levels not going down less than 270 in 24 hours
- you feel abdominal pain
- you feel drowsy or confused
- you have difficulty breathing

Call your doctor, go to the nearest urgent care, emergency room or call 911.

Start monitoring your urine or blood ketone levels if your sugar rises above 270 and stays there for 4 consecutive hours

- If your urine ketone level is moderate to high, call your doctor or diabetes care team. The ketone strip will turn dark purple the higher the amount of ketones your urine.
- If you use blood ketone strips call, call your doctor or diabetes care team if the levels are above 1.5

If you have diarrhea or vomiting and cannot tolerate fluids, stop taking {metformin/glp1-ra, sglt2 inh or sulfonylurea)

If you can keep food and drink down, you may not need to stop taking medication. Monitor your urine or blood ketone levels every 2 hours.

Monitor your blood sugar every 2 hours and refer to your diabetes sick plan.

Insulin Management

DO NOT STOP TAKING INSULIN unless advised by your doctor or diabetes care team.

If you use basal insulin {name of insulin} continue to take the same dose of {x}

If you use meal time or rapid acting insulin {x} you may need to increase your dose

- Step 1: Start to increase the dose of one single injection by 2-4 Units [breakfast] [lunch] [dinner]
- Step 2: Keep monitoring your blood sugars every 2 hours

If after 4 hours your blood sugar is still greater than 270 take another extra dose of 2-4 units extra units following steps 1 and 2 above

After 4 hours there is still no effect on lowering your blood sugar, call your doctor, go to the nearest urgent care, emergency room or call 911.

Food Management

Try to eat noodle soup, broth, sugar free jello, saltine crackers, toast with peanut butter [if not allergic], greek yogurt, milk, soy or almond milk.

Fluid Management

Stay hydrated and drink water 1 to 2 hours. Pay attention to how many times you go to the bathroom to urinate and pay close attention to the color of your urine.

If you're not voiding every 2-3 hours and the color of your urine is dark yellow, you need to increase your water intake. Avoid sugary drinks if our sugars are consistently above 270.

However, if your blood sugar is below 270 you can drinks with sugar like gatorade, regular gingerale (not diet), emergen-c.

Recovery

Once you start to feel better, if your blood sugar is below 270 and above 72 consistently and you're eating and drinking well, you may start to take your medications again if you stop

When to Call for Help

It is important that you continue to monitor your blood sugars every 2 to 4 hours and communicate with your doctor and diabetes care team if your blood sugar continues to be below 72 or greater than 270.

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Avoidable ER Visits Sick Day Box

Preparations for Managing Sugars during sick days	
Sick Box	
	shoe box/plastic box/
	glucose gel/tablets
	2 qt clear sugary liquid (gingerale/100% fruit juice)
	2 qts clear salty liquid (chicken broth/ramen noodles/canned chicken soup)
	2 qts sugar free jello/diet soda
	thermometer
	Acetaminophen/Ibuprofen
	extra box glucose test strips
	extra box of lancets
	box of urine and/or blood ketone test strips
	if use insulin extra pen needles/alcohol swabs/insulin pump/cgm supplies
	extra insulin in the refrigerator at all times
	pen/paper to recor blood glucose readings
	alarm clock to serve as a reminder to check blood glucose regularly
	Names/phone numbers of doctors/pharmacy/current list of meds/allergies
	Sick day instructions
Hypoglycemia bag	
	Glucometer/supplies
	100% Fruit Juice
	1 can of soda
	glucose gel/ tabs
	honey
	raisins
HypERglycemia bag	
	glucometer/suppliles
	water

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Panel Discussion: The Changing Role of the PCP (and Inter-Professional Care Team) Under Capitation

- Moderator: Patricia Flanagan, MD, Hasbro Children's Hospital, & Brown Univ. Pediatrics Professor
- Bryan Burns, DO, Physician, Esse Health, & Chief Medical Officer, Effectus Healthcare Solutions, MO
- Susan Kressly, MD, Pediatrician & Owner, Kressly Pediatrics, & Medical Director, Office Practicum, PA

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LIFE UNDER CAPITATION

AVERAGE DAILY PRACTICE LIFE- ESSE HEALTH

- 14-20 Visits per day
- 4.5 days per week
- 20-40% Under capitated arrangements
- 80% of revenue via capitated contracting
- Salary Averages 2-10 times MGMA norms
- Highest Quality Medical Group Midwest- UHC and Aetna- 2019/2020

PHYSICIAN PATIENT CARE ADJUSTMENTS

- Working knowledge of medical coding and risk factor adjustment
- Thorough understanding of medical costs of care
- Increased awareness of patient population
- Increased Daily Preparation
- Increased need for team approach

PATIENT CARE GOALS

- Fewer visits per day
- Longer visits per patient
- Higher quality of care

PRACTICE/ORGANIZATIONAL NEEDS

- Revenue
- Provider and Administrative Engagement
- Education on coding/RAF score impact
- Accurate, up to date data
- Time
- Organizational analytic and physician support
- Revenue

ANALYTIC PEARLS AND PITFALLS

- Data accurate and transparent
  - Practice level, Physician level
- Frequent actionable reporting
  - Monthly
- Financial Data Transparent
- Best Practices

POTENTIAL OUTCOME

- Increased satisfaction
- Improved quality
- Pathway to full capitated risk

Pediatrics and Capitation

Sue Kressly, MD, FAAP
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@kiddrsue
www.linkedin.com/in/susan-kressly

Shifted Mindset

- Given the resources, how can we best serve ***ALL*** of the population we are collectively responsible for?
- Shared information is needed.
- Innovative thinking must be rewarded.
- Team empowerment is essential.
- Change thinking from equality to equity:
  not all patients get the same thing
  but each patient gets what *they* need.

What Data Does the Practice NEED?

- Defined population roster with updated contact information (***monthly is best***) and agreed upon process to reconcile the panel differences
- Total cost of care per patient ("cost efficiency") and split into reasonable buckets:
  - Surgery (does this include oral surgery for wisdom teeth?)
  - ED
  - Radiology
  - Lab
  - Cardiology
  - Urgent Care
  - Rehab
  - DME
  - Sleep
  - Chiropractic Care
  - Other

What Else Does the Practice NEED?

- Near-real time feed for ED and Urgent Care utilization
- Identified unmet care gaps quarterly (agree on well visit intervals and “annual” for 3+ age group)
- Information on comparative specialist costs, common lab and drug costs
- Cost of preventive care (including vaccines) must be excluded from total cost of care calculations
- Must agree on ***meaningful pediatric risk adjustments*** (including parental SDoH)
- Must provide additional monies/remove disincentives for caring for premature babies, complex patients and catastrophic illnesses
- Remove mental health carve-out arrangements

What’s a Reasonable Panel Size?

- VERY dependent on age of patients distribution
  - YOUR (pre-COVID) utilization data should drive the baseline (pre-COVID)
  - 0-12 month olds: 7 well visits through 12 months of age, average 3.5 “sick visits” per year (PA experience)
  - 16 year olds: 1 well visit, 0.9 sick visits (PA experience)
- Depends on whether PCP is providing mental health services in the medical home
- Depends on whether incentives around optimizing PCP vs specialists
- Depends on complexity of patients in panel: this is ***NOT*** evenly distributed (some pediatricians have expertise and are more comfortable)
- Need at least 25% of practice covered lives to change practice behavior

Capitated vs Bill-Aboves

CAPITATED

- E/M office visits: sick and well
- Telehealth visits

BILL-ABOVE

- Vaccines
- Immunization Administration Codes
- Screenings (developmental, depression, risk, behavioral assessments)
- Fluoride varnish
- In house labs (lead, hemoglobin, UA, rapid strep, rapid COVID, rapid flu)

Depends on amount of capitation: care coordination and non-direct care codes, after hours codes

Changing the Mindset of the Practice Team

- From reactive to proactive, from practice-centered to family-centered
- Adopting “right care, right place, right time” attitude
  - No assumptions about what the patient wants, ask: “how can I best connect you to care today?”
  - Not everyone needs an office visit (and you may prevent some patients from getting the right care if that’s how you think)
- Automate where you can, use people where they matter most, eliminate “churn”
- Function as a TEAM (eliminate “not my job” mentality)
- Providers must be aligned in care, use care pathways where possible
- Everyone on the practice must understand the total cost of care and their role

Upcoming Meetings

- **CTC-RI Clinical Strategy Committee Meeting:**

  June 18, 7:30-9:00am

- **CTC-RI Community Health Team Oversight Committee Meeting:**

  June 25, 9:00-10:00am

- **Breakfast of Champions:**

  September 10, 7:30-9:00am

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