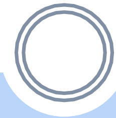
Diabetes Care Coordination Triple Aim Initiative



OF THE
PALM BEACH COUNTY MEDICAL SOCIETY

PRESENTED BY:
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MEDICAL DIRECTOR, FOUNDCARE, INC.

Objectives

- Understand the Triple Aim concept.
- Understand the concept of population health management.
- Learn a holistic approach to patient care by taking into consideration all the determinants of health.

The Triple Aim

- The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance.
  - Improving the patient experience of care (including quality and satisfaction);
  - Improving the health of populations; and
  - Reducing the per capita cost of health care.

Source: http://www.ihi.org/Topics/TripleAim/Pages/Overview.aspx

The Triple Aim

Better Care

Better Health

Better Value

ENGAGE PATIENTS

Definitions

- Population Health:
  - The health outcomes of a group of individuals, including the distribution of such outcomes within the group. An approach to health that aims to improve the health of an entire human population.
- Care Coordination:
  - The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.

TRIPLE AIM: Health-Experience-Affordability

HealthPartners Clinics

Total Cost Index

1.0100
1.0000
0.9900
0.9800
0.9700
0.9600
0.9500
0.9400
0.9300
0.9200

1.0005
0.9200
97%
98%
9%
34%
100%
90%
80%

34%
32%
30%
28%
26%
24%
22%
20%
18%
16%
14%
12%
10%

4Q04 1Q05 2Q05 3Q05 4Q05 1Q06 2Q06 3Q06 4Q06 1Q07 2Q07 3Q07 4Q07 1Q08 2Q08 3Q08 4Q08 1Q09

DECREASE Total Cost Index (compared to statewide average)
< 1 is better than network average

INCREASE % patients with Optimal Diabetes Control*
* controlled blood sugar, BP & cholesterol AND daily aspirin use AND non-tobacco user

INCREASE % patients "Would You Recommend" HealthPartners Clinics

Source: https://www.healthpartners.com/hp/about/triple-aim/

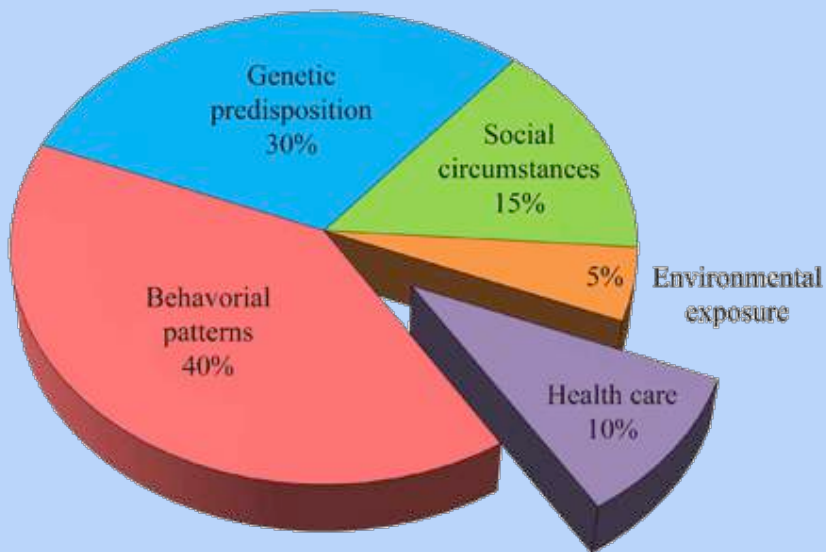
Hemoglobin A1c as Indicator

- Results of a 1% reduction in HbA1c:
  - 14% reduction in risk of MI
  - 21% reduction in risk of diabetes-related death
  - 37% decrease in microvascular complications:
    - Nephropathy
    - Neuropathy
    - Retinopathy
  - Average savings of +/- $2,100 per year

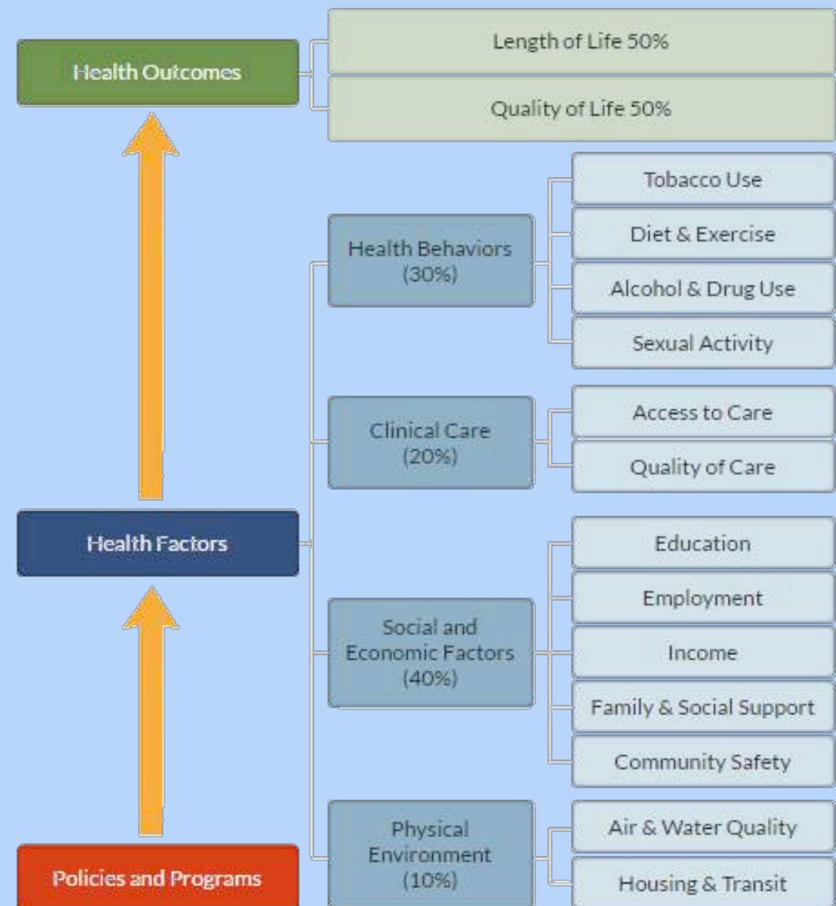
Source: Stratton I M, Adler AI, Neil H A et al. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35). BMJ 2000; 321 (7,258): 405-12.

Determinants of Health and Health Outcomes

Proportional Contribution to Premature Death



Source: *N Engl J Med.* 2007 Sep 20; 357(12):1221-8, Figure 1.



County Health Rankings model © 2014 UWPHI

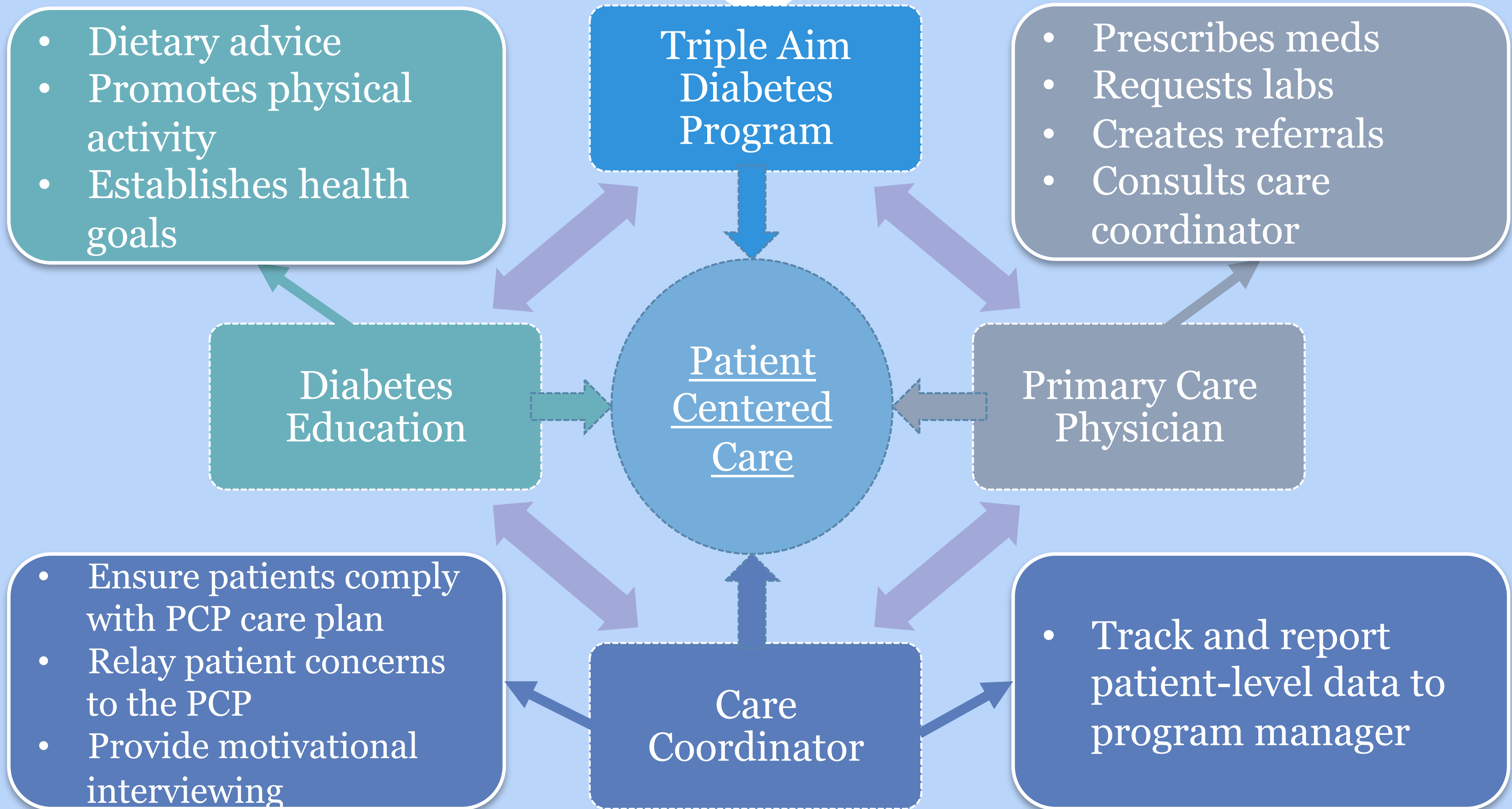
Role of the Care Coordinator

- Establish and build rapport with patients and clinic staff
  - At FoundCare, scheduled monthly visits with each clinician
  - Monthly patient groups held at the clinic
- Provide motivational interviewing
  - Identify gaps in and barriers to care
  - Help in setting goals; provide encouragement & empowerment
  - Facilitating behavioral change
- Utilize data collection and analysis
  - Regular check-in with nursing & support staff
- Navigate patient cases
  - Facilitate continuity of care

Patient Engagement

- Call patients regularly to review current goals and medication concerns
  - Weekly calls ideal, at least every 2 weeks
- Assist patients to navigate medical services and community services
  - Linguistically-appropriate services
- Provide disease-specific information through monthly educational sessions
  - Average 10-12 participants per evening session

Framework for Patient-Centered Care



FoundCare Program Update

- Eligible patients: Type 1 or 2 diabetes, < 65 years old, HbA1c% ≥ 9
- Patients referred by PCP
- Current enrollment: **50 active patients**

- Assist patients access:
  - Health care
  - Medications
  - Specialists
  - Community resources
  - Disease-specific information through monthly education sessions in partnership with UF Extension

Case Study

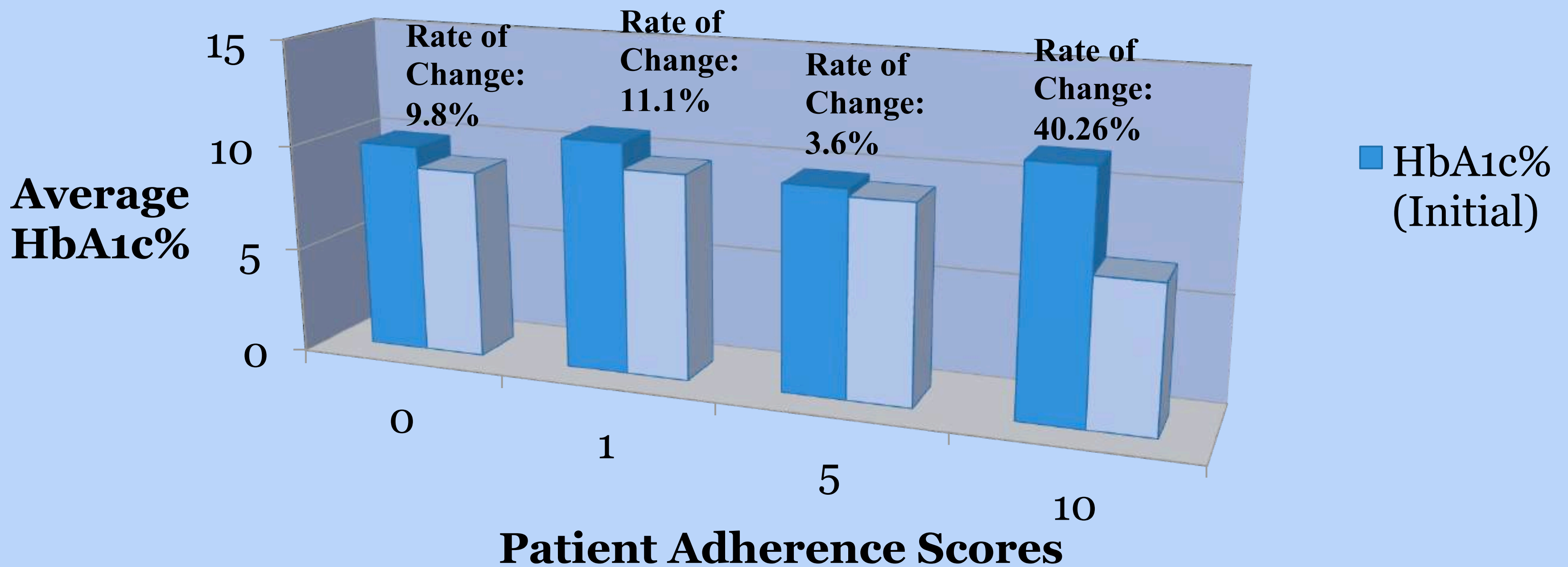
P.S. is a 50 year old female with type 2 diabetes. She wants to lose weight, however she has little time for herself as she is raising her three grandchildren with no support. She shares that she feels depressed and overwhelmed. Through the Triple Aim Diabetes program, the patient received information about nutrition, exercise, and community supports. Goal-setting has helped the patient establish an exercise plan and make changes in her diet. Referrals to mental health services and community supports for grandparents raising children helped decrease stress levels. **A1c went from 9.5% to 7.4%.**

Current Outcomes Data - FoundCare

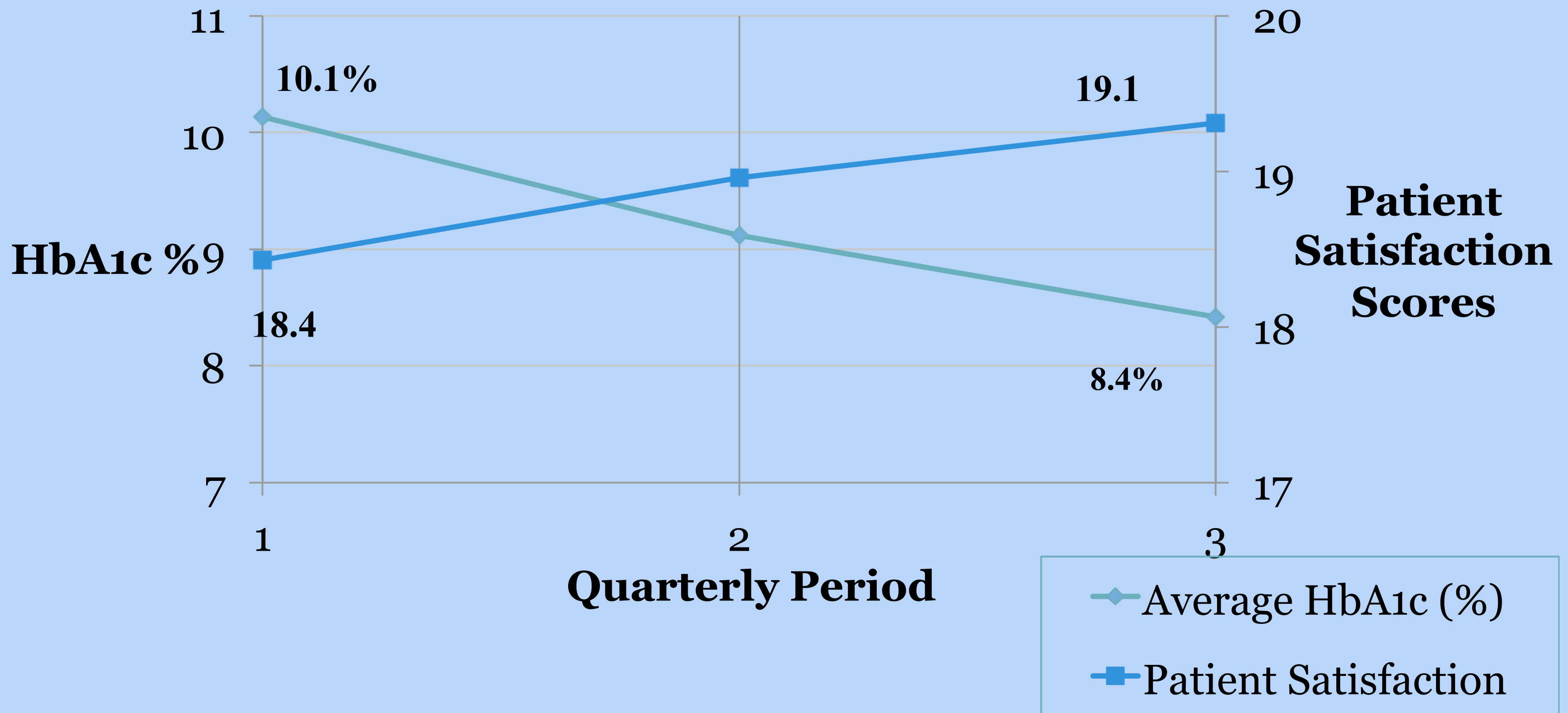
A1C
9%
DECREASE

LDL
9%
DECREASE

Adherence Affects Outcomes



Replicating Results



Summary

- Team-based approach
- Considers multiple determinants of health
- Focused on measurable outcomes
- Recognizes policy-level constraints

- Next Steps:
  - Care coordination training & certification - useful for PCMH, ACOs, readmission prevention, etc.
  - Replicable model for any chronic condition

Q & A