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Foundations of Cardiometabolic Health Certification Course

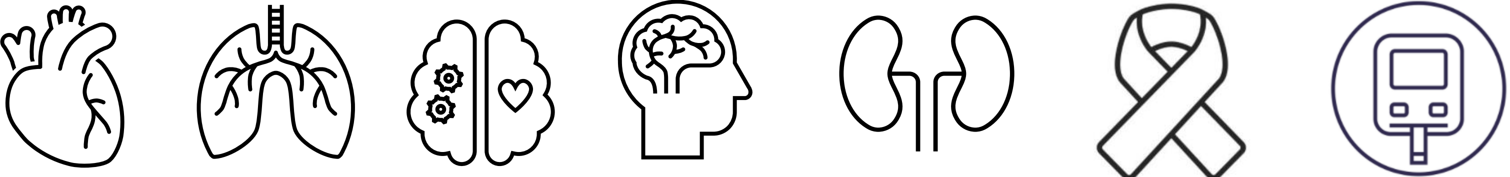
Certified Cardiometabolic Health Professional (CCHP)

Team Based Care Coordination

A Necessary Approach for Prevention and Chronic Disease Management

Melissa Magwire RN MSN CDCES

Chronic Disease facts:



- Defined as a condition(s) lasting 12 months or longer that require ongoing medication attention &/or limit activities of daily living.
- Leading cause of death and disability in the United States
- The leading driver of growing annual US health care costs

https://www.cdc.gov/chronicdisease/index.htm2021

Question

The percentage of adults in the US with at least 1 chronic disease is:

a) 25%

b) 60%

c) 35%

d) 50%

The percentage of adults in the US with at least 2 or more chronic disease is:

a) 25%

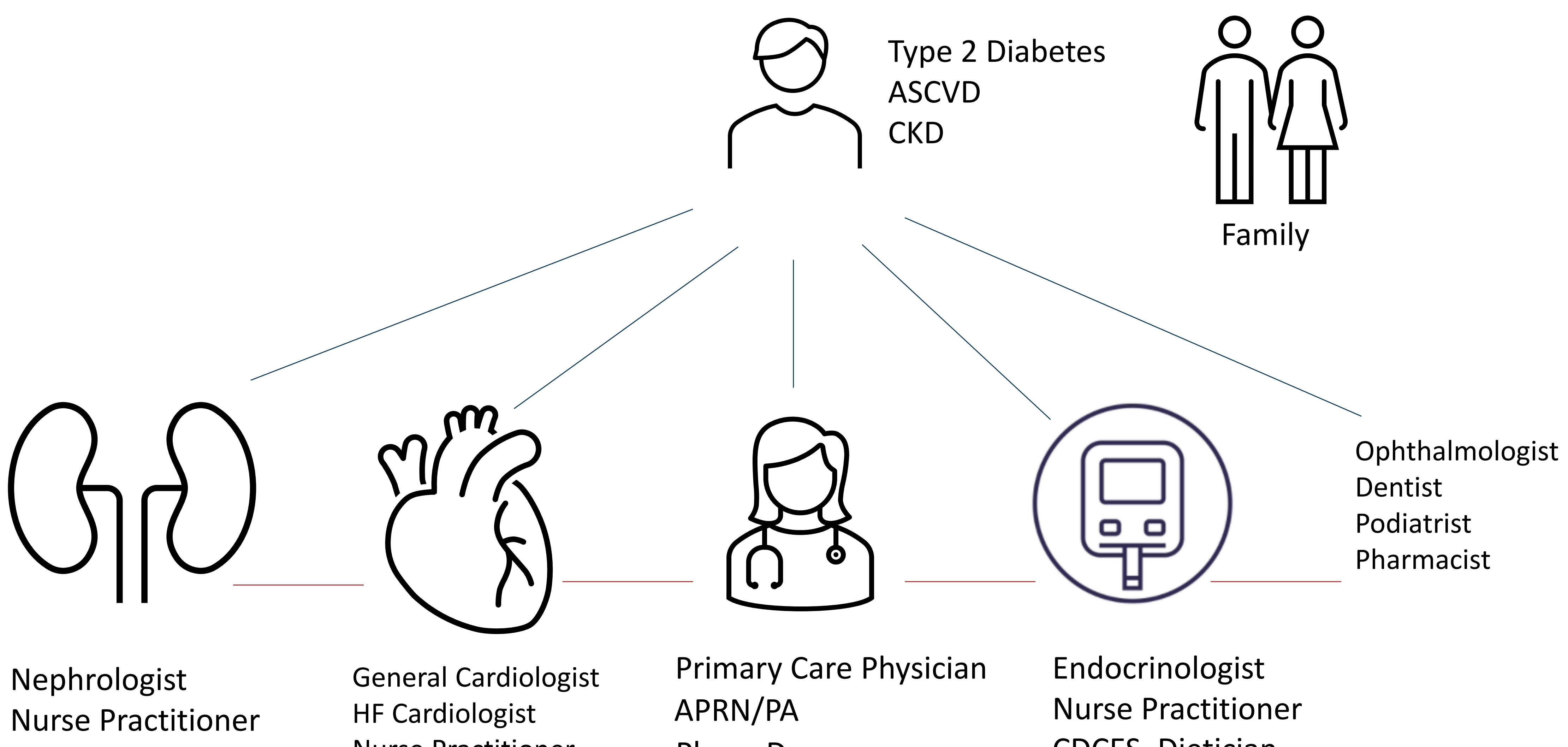
b) 15%

c) 40%

d) 35%

https://www.cdc.gov/chronicdisease/index.htm2021

Crowded Care Landscape



Brief History of Care Coordination

- Care Coordination model created due to the prevalence and cost of chronic disease seen in the fee for service delivery model
- Evidence revealed that care coordination was leading to improved outcomes and a potential for cost savings
- 2015 Medicare began offering care coordination reimbursement for aspects of care coordination

However

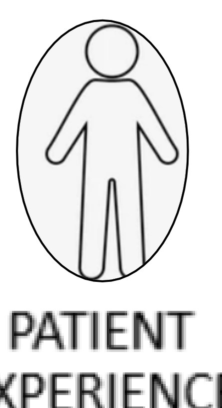
- Within the initial 15 months resulted in only a 5% update in use of care coordination billing codes

Williams et al. BMC Health Services Research (2019) 19:92 https://doi.org/10.1186/s12913-019-3916-5

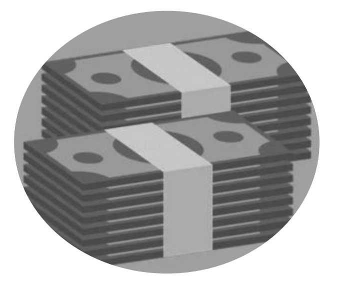
Quadruple Aim - A Coordinated Approach

Communication techniques and education coupled with interventions influence health outcomes as well as the need for interventions/consultations

Patient satisfaction can be a driver of the Provider experience, leading factor to improving the experience for the provider is an improved sense of comfort when communication with the patient and family members



Positive patient experience improved outcomes provider experience cost



Neutral in the short term – studies suggest minimal impact on visit length, positive impacts on patient satisfaction, perceived patient number of unmet concerns

Haverfield, M. C., Tierney, A., Schwartz, R., Bass, M. B., Brown-Johnson, C., Zionts, D. L., ... & Zulman, D. M. (2020). Can patient–provider interpersonal interventions achieve the quadruple aim of healthcare? A systematic review. Journal of general internal medicine, 35(7), 2107-2117

Building an Effective Team for Coordination

Foundational elements for a successful, coordinated team approach to complex patient care:

- A defined scope, rationale, and key partnerships
- Effective information exchange
- A trained and available workforce
- Evaluation and improvement of care coordination
- Patient and family engagement

Williams, M. D., Asiedu, G. B., Finnie, D., Neely, C., Egginton, J., Rutten, L. J. F., & Jacobson, R. M. (2019). Sustainable care coordination: a qualitative study of primary care provider, administrator, and insurer perspectives. BMC health services research, 19(1), 1-10.

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Scope, Rationale, and Key partnerships

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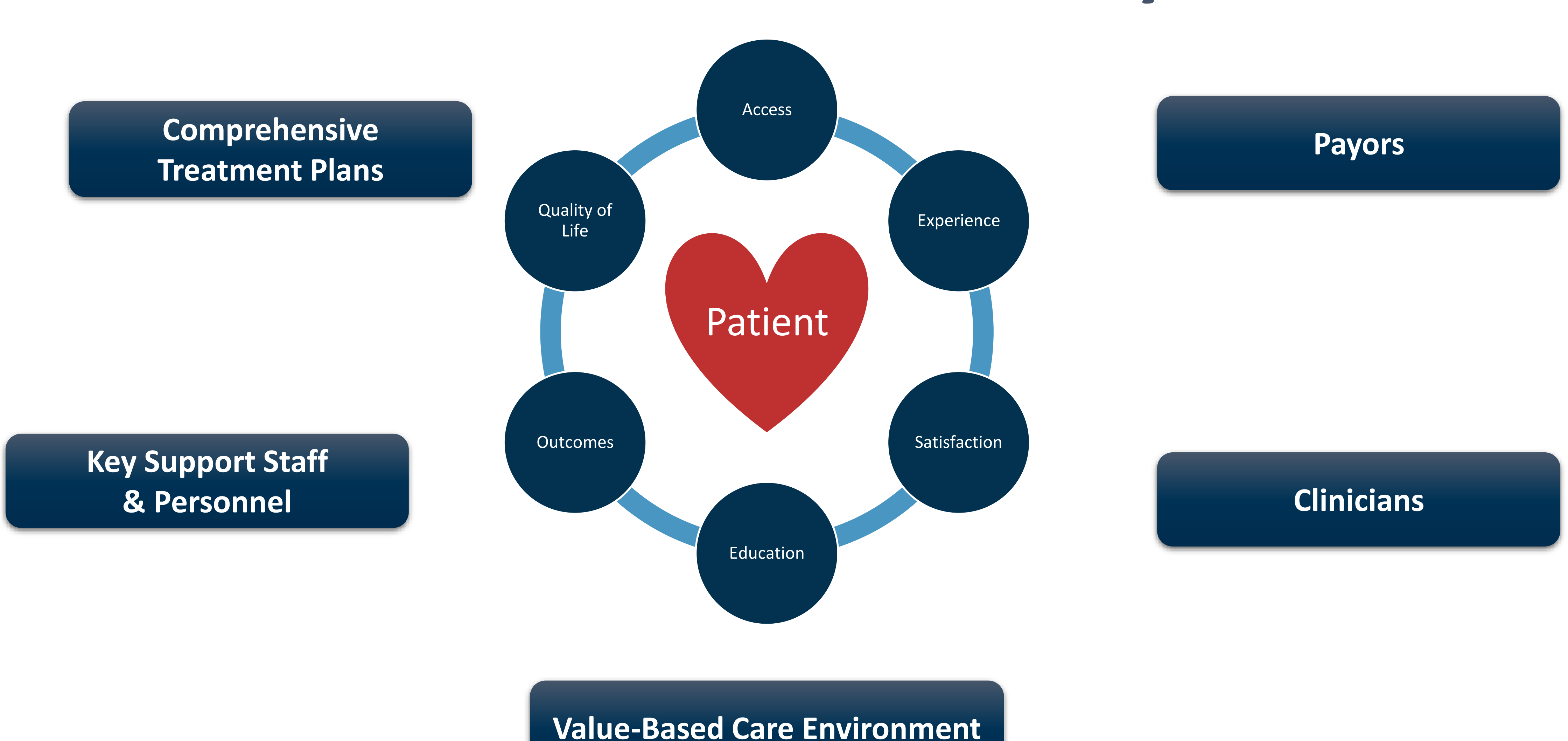
Patient-Centered, Coordinated, Comprehensive Model of Care Delivery



Essential Cardiometabolic Team Members

Cardiometabolic Patients

Podiatrist, Ophthalmologist, Therapist

Cardiometabolic Practitioner Team

Physician, Nurse Practitioner, Physician's Assistant

CM Care Coordinator, Diabetes Educator, Clinical Pharmacist, Registered Dietitian

Collaborating Specialists (e.g., Endocrinologist, Cardiologist, Nephrologist ,Primary Care)

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Trained and Available Workforce

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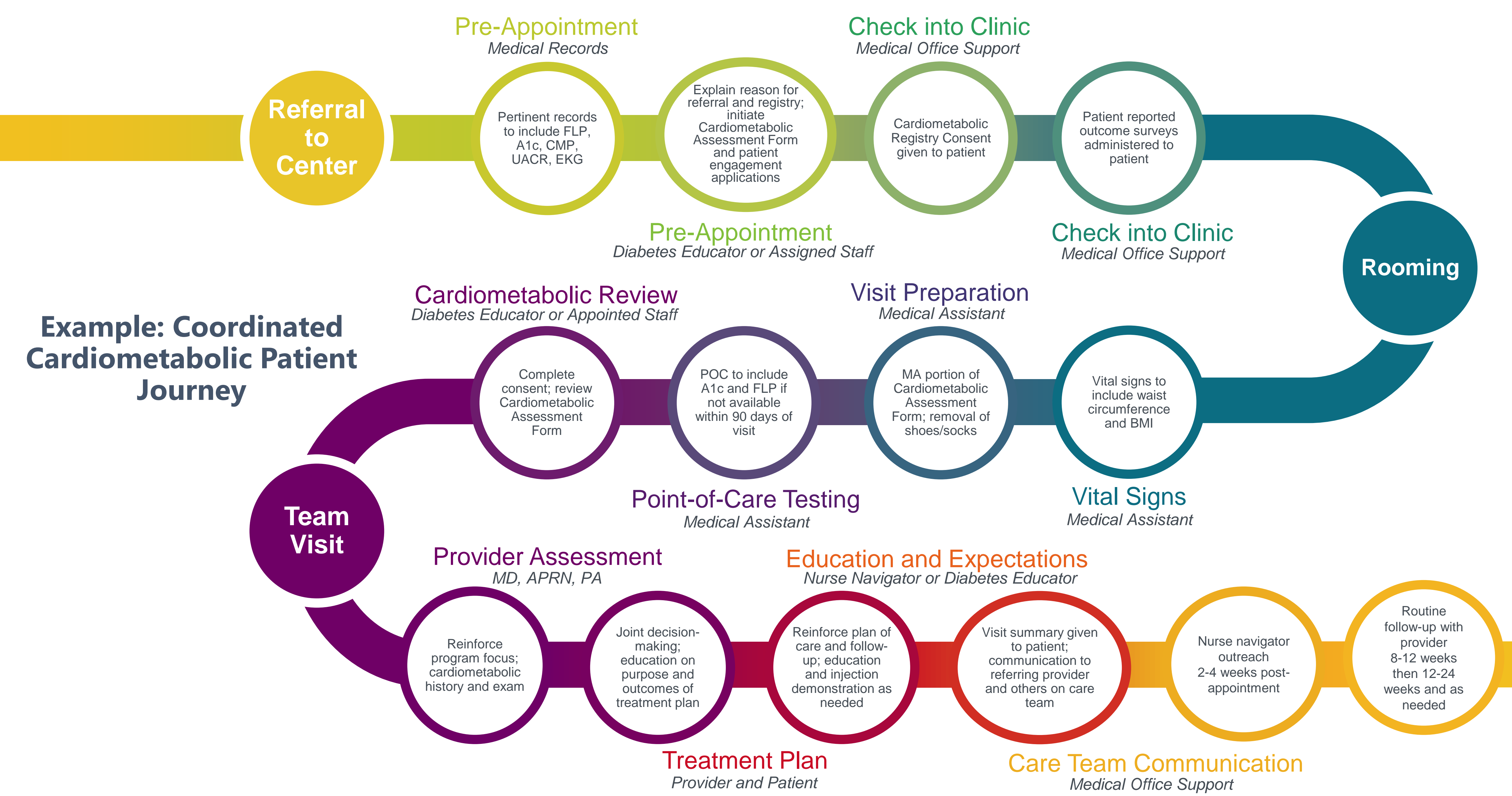
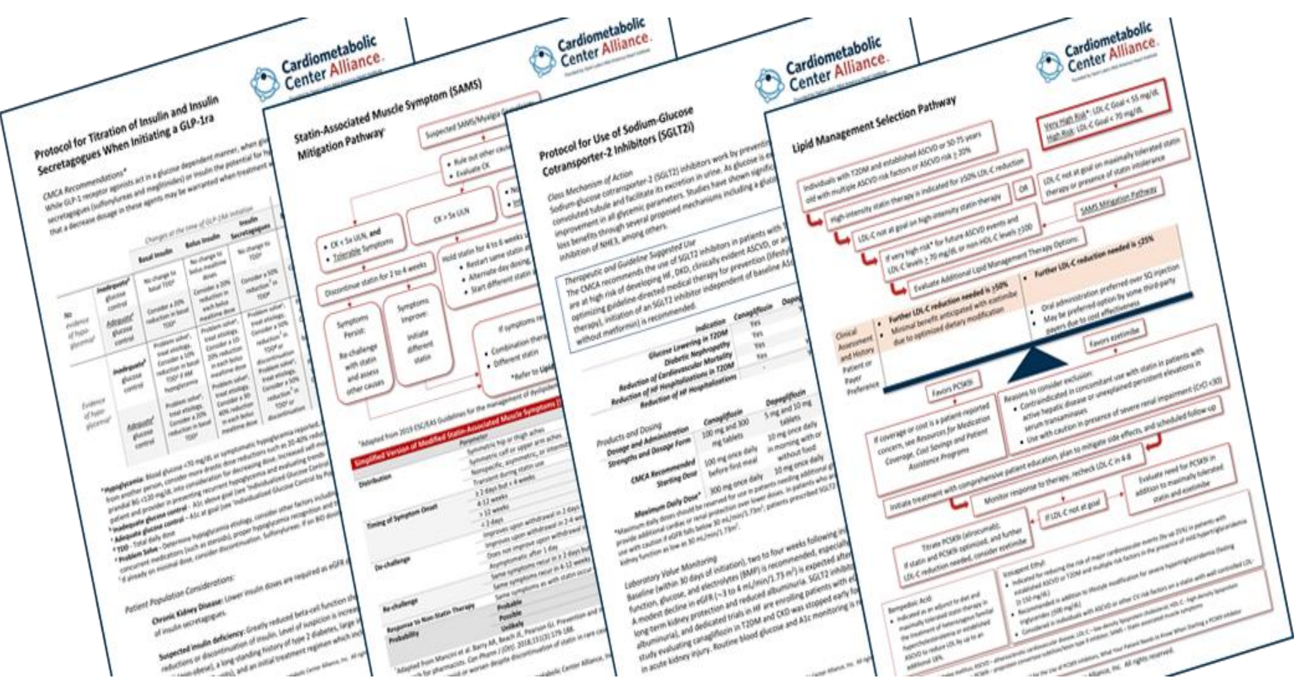

Example: Coordinated Cardiometabolic Patient Journey
Referral to Center
Pre-Appointment
Medical Records
Pertinent records to include FLP, A1c, CMP, UACR, EKG
Explain reason for referral and registry; initiate Cardiometabolic Assessment Form and patient engagement applications
Pre-Appointment
Diabetes Educator or Assigned Staff
Check into Clinic
Medical Office Support
Cardiometabolic Registry Consent given to patient
Patient reported outcome surveys administered to patient
Check into Clinic
Medical Office Support
Rooming
Vital signs to include waist circumference and BMI
Vital Signs
Medical Assistant
Visit Preparation
Medical Assistant
MA portion of Cardiometabolic Assessment Form; removal of shoes/socks
POC to include A1c and FLP if not available within 90 days of visit
Point-of-Care Testing
Medical Assistant
Cardiometabolic Review
Diabetes Educator or Appointed Staff
Complete consent; review Cardiometabolic Assessment Form
Team Visit
Provider Assessment
MD, APRN, PA
Reinforce program focus; cardiometabolic history and exam
Joint decision-making; education on purpose and outcomes of treatment plan
Treatment Plan
Provider and Patient
Education and Expectations
Nurse Navigator or Diabetes Educator
Reinforce plan of care and follow-up; education and injection demonstration as needed
Visit summary given to patient; communication to referring provider and others on care team
Nurse navigator outreach 2-4 weeks post-appointment
Routine follow-up with provider 8-12 weeks then 12-24 weeks and as needed
Care Team Communication
Medical Office Support

Trained and available workforce- Effective Information Exchange

- Identify Team members and their comfort level/knowledge
- Identify your “experts” and those that want to become “experts”
- Learning opportunities
- Daily Care Huddles



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Patient and Family Engagement

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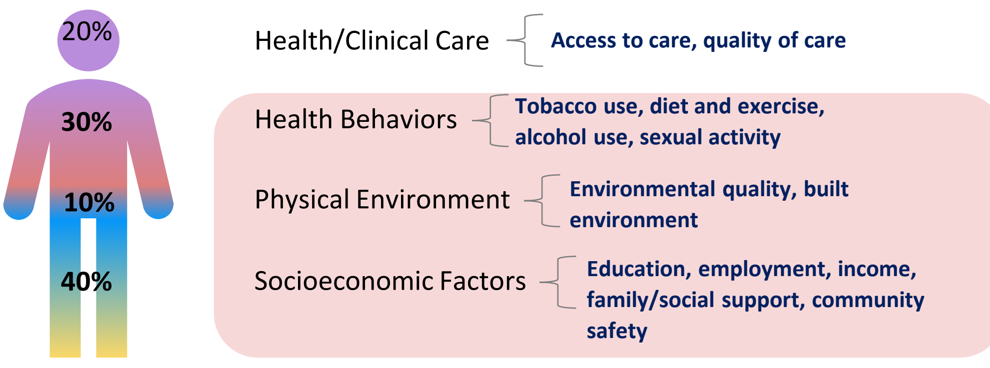
Elements for Successful Engagement

Effective communication exchange



80% of what influences health is related to social determinants of health—patients' behaviors, socioeconomic conditions and other factors that can be challenging to address in clinical visits

- Screen for Social Determinants of Health
- Encourage family
- Consistent messaging
- Care Coordinator
- Use of patient portal
- Follow up calls
- Support groups

Modifiable Determinants of Health (with associated weights) Impacting Health Outcomes
Going Beyond Clinical Walls: Solving Complex Problems (Robert Woods Johnson Foundation) 2014. Retrieved from https://www.nrhi.org/uploads/going-beyond-clinical-walls-solving-complex-problems.pdf

Attributes of a Successful, Coordinated Patient Care Plan

Overarching goal is to construct a plan that patients can successfully follow

AHA Managing Cardiovascular Risk in People living with Diabetes

- Assess
- Acknowledge
- Assist
- Decision Making
- Review and Monitor Plan

Building a Successful Treatment Plan

A successful treatment plan is one that your patients will follow. This guide emphasizes developing a treatment plan with all patients with type 2 diabetes and their caregivers first to improve their chances of successfully starting and continuing guideline-directed management and therapy. During your discussion, include the patient's atherosclerotic cardiovascular disease (ASCVD) risk, lifestyle habits and modifications, the potential benefits of pharmacotherapy, and cost, and ask patients what treatment plan might work best for them. The figure below outlines a recommended approach based on recommended guidelines (Figure 1).

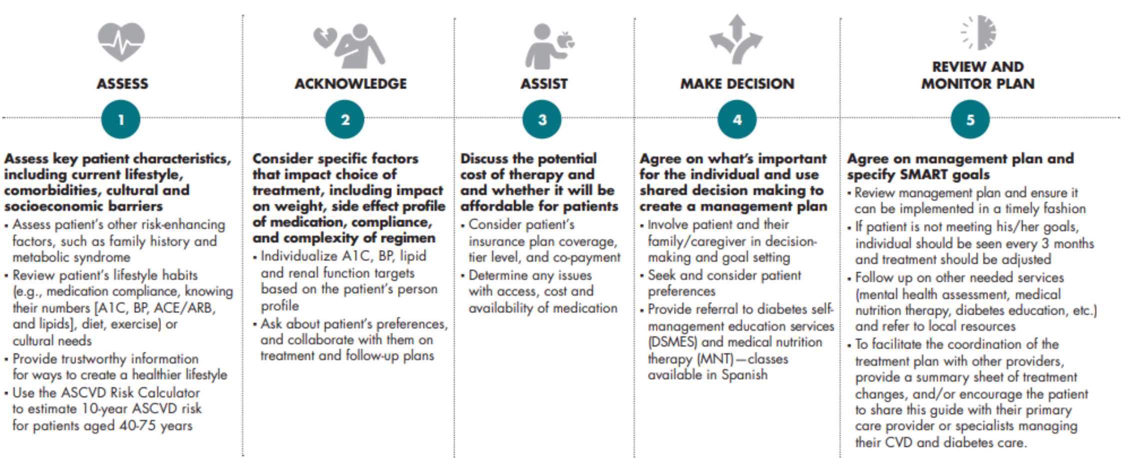


Figure 1. Assess and Discuss to Develop a Shared Treatment Plan

https://knowdiabetesbyheart.org/kdbh_shared-decision-making-guide_final

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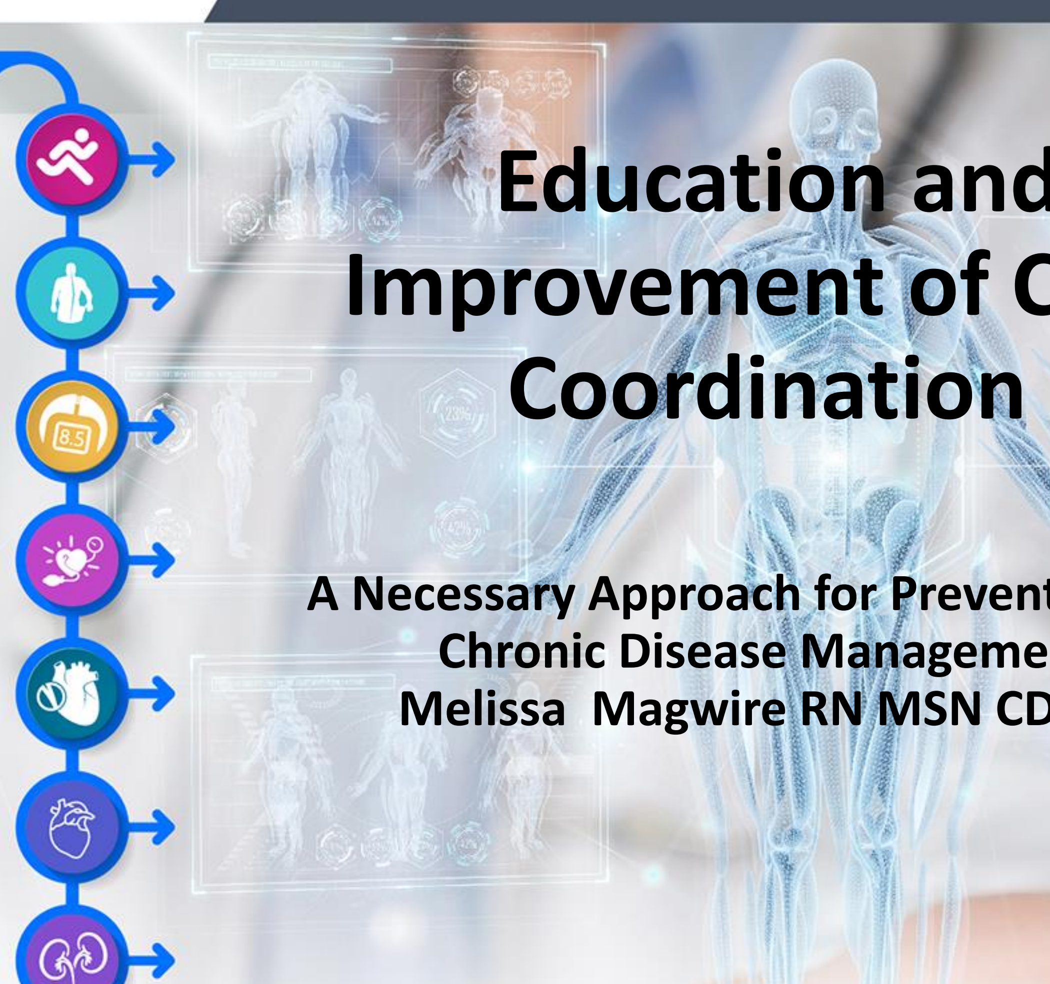

Education and Improvement of Care Coordination

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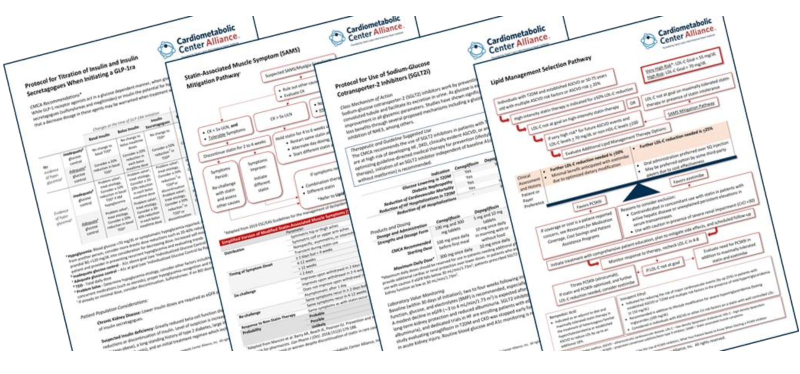
Care Team Education

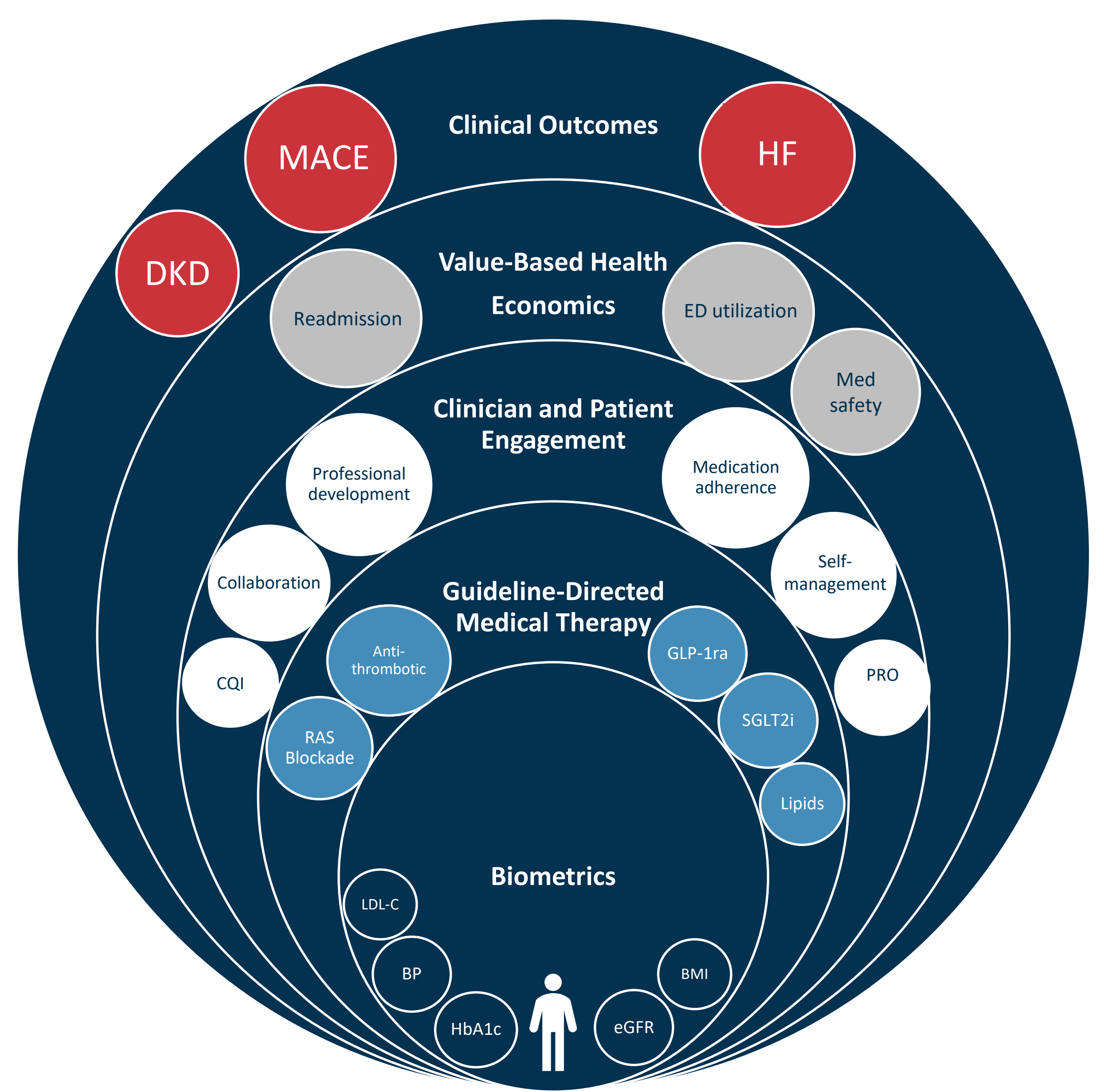
- Consistent messaging across the entire team
- Empower non-physician staff to keep things moving forward



- Team Goals and Strategic Planning
- Buildings Teams and Optimizing Workflows
- Individualized Action Plan
- Registry Management
- Referral and Encounter Documentation Quick Tips
- Metrics and Benchmarking Guidance

- Therapy Selection Pathways
- Treatment Protocols
- Practical Considerations
- Drug Class Overviews
- Algorithms

Measuring Success of Care Coordination at the Patient Level



Impact of Successful Care Coordination beyond the individual patient

Patient Profile

Dapagliflozin 10 mg daily

Semaglutide 1 mg once weekly

Valsartan 160 mg BID

Rosuvastatin 40 mg daily

Ezetimibe 10 mg daily

Aspirin 81 mg daily

A1c: 10.2% → 7.1%

BP: 148/92 mmHg → 126/78 mmHg

LDL: 101 mg/dL → 51 mg/dL

Weight: 219 lbs → 196 lbs

BMI: 31.4 → 28.1

Diabetes Distress Score (DDS): improved

Program Outcomes

Proportion of patients with A1c 9% or more → improve by 20% in 12 months

Proportion of patients with LDL < 70 mg/dL → improve by 20%

Proportion of patients with 5% or greater total body weight loss → improve by 20%

Proportion of patients with BP < 140/90 mmHg → improve by 20%

Proportion of patients on optimal GDMT → improve by 50%

Proportion of patients with top box score (HCAHPS) → improve to 90%ile

Health System Cost Effectiveness

ED Utilization

Inpatient Utilization

New Events/Complications

HF Rehospitalizations

Overall Star Rating Improvement

Total Cost of Care

Thank you