Patient-Centered Specialty Care

Module 2
Instructional Webinar

Strategies for Closing Gaps in Care

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- With respect to the issue of coverage, each Anthem member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. If Members have any questions concerning their benefits, they may call the Member Services number listed on the back of their ID card.

Objectives

- Close Gaps in Care
- Understand market data available to assess Gaps in Care
- Implement workflow and redesign strategies to Close Gaps in Care
- Complete Next Steps

What is a Gap in Care?

Gaps in Care, or Care Opportunities, are situations in which there are active or potential gaps in care associated with recommended evidence-based care and our clinical quality metrics

Discrepancy between recommended best practices and care actually provided:

- Best practices as defined by evidence-based guidelines
- To successfully close gaps in care requires pre-visit, visit and post-visit planning
- Requires mechanisms for identifying and tracking gaps in care

Measurement criteria, consistent with the National Quality Forum (NQF), were applied to the selection of Program measures:

- **Measureable and reportable** in order to maintain focus on priority areas where the evidence is highest that measurement can have a positive impact on healthcare quality.
- **Useable and relevant** to ensure that Providers can understand the results and find the results compelling to support quality improvement.
- **Scientifically acceptable** so that the measure, when implemented, will produce consistent (reliable) and credible (valid) results about the quality of care.
- **Feasible to collect** using data that is readily available for measurement and retrievable without undue burden.

Anthem Imperative

Program measures:

- Impact revenue
- Identify the specific patient level care activities that need to happen. When a program measure is not met, we call this a ‘gap in care.’

Gaps in care get closed by:

- Identifying patients with open gaps
- Getting those patients in the provider door
- Having the care team prepared to close that gap (planned visit)
- Closing that gap and documenting/coding appropriately

Planned visits can be setup to tackle one type of gap (i.e., HTN visit) **or multiple gaps in a chronic condition** (diabetes: AIC, urine protein screening, blood pressure, medication, etc.)

Scope and Impact

Scope & Impact

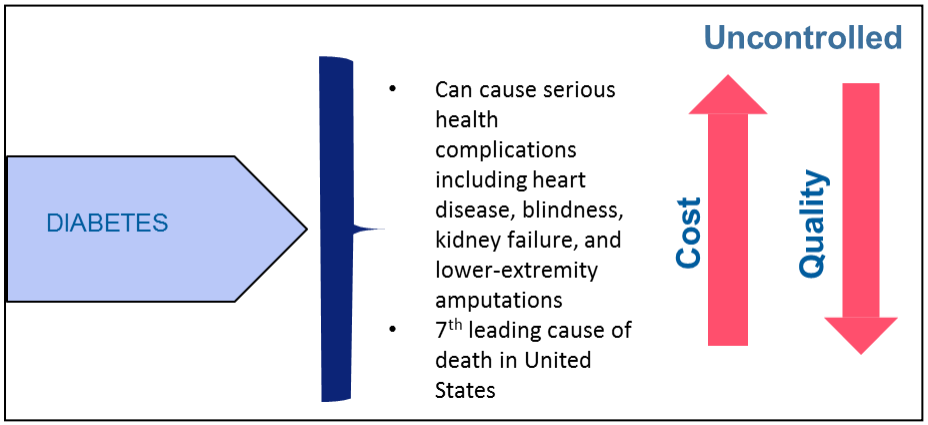
- According to a 2004 Partnership for Solutions report, 48% of the U.S. population has one or more chronic conditions; all their care represents 83% of total health care spending
- Patients with chronic conditions visit their health care providers, fill prescriptions and are hospitalized more often than the general population
- Patients with chronic conditions are more likely to experience poorly coordinated care which can lead to adverse drug interactions, unnecessary or duplicate tests or procedures, conflicting information from multiple providers, and increased health care costs

Gaps in Care Increases Health Care Risks

Scope and Impact

Diabetes

- 29.1 million people have diabetes – about 1 in every 11 people; 1 of 4 do not know they have diabetes
- 86 million people have pre-diabetes – about 1 of every 3; and 9 out of 10 do not know they have pre-diabetes



- Diabetes can cause serious health complications including heart disease, blindness, kidney failure and lower extremity amputations
- Without weight loss and moderate physical activity 15-50% of people with pre-diabetes will develop Type 2 diabetes within 5 years
- Total medical costs and lost work and wages for people with diagnosed diabetes is $245 billion

Medication Adherence → Hospitalization Risk

Scope and Impact

"A large observational study has shown significantly higher hospitalization rates among patients with poor medication adherence. Among diabetes patients, the 1 year risk of hospitalization was 13% for patients with high adherence and 30% for patients with low adherence. Similarly, hypertension patients with high adherence had a 19% risk of hospitalization compared to a 28% risk for patients with low adherence."[1]

- More than $628,000 on hospitalizations for ASC conditions Diabetes and HTN
- More than $1.3 million on hospitalizations for Diabetes, HTN, HF and Angina

Medication Adherence Measures	Eligible	Compliant	Rate	Potential Missed Opportunity
Oral Diabetes	688	448	65.1%	240
Hypertension (ACE/ARB)	2394	1783	74.5%	611
Cholesterol-Statins	2237	1518	67.9%	719

Call to Action

[1]Thinking Outside the Pillbox A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease, New England Health Care Institute Research Brief – August 2009

Source: 2015-16 PCMS Scorecard - Claims incurred through 11/30/2015, paid through 2/29/2016

Understand Your Data

Gaps in Care Data

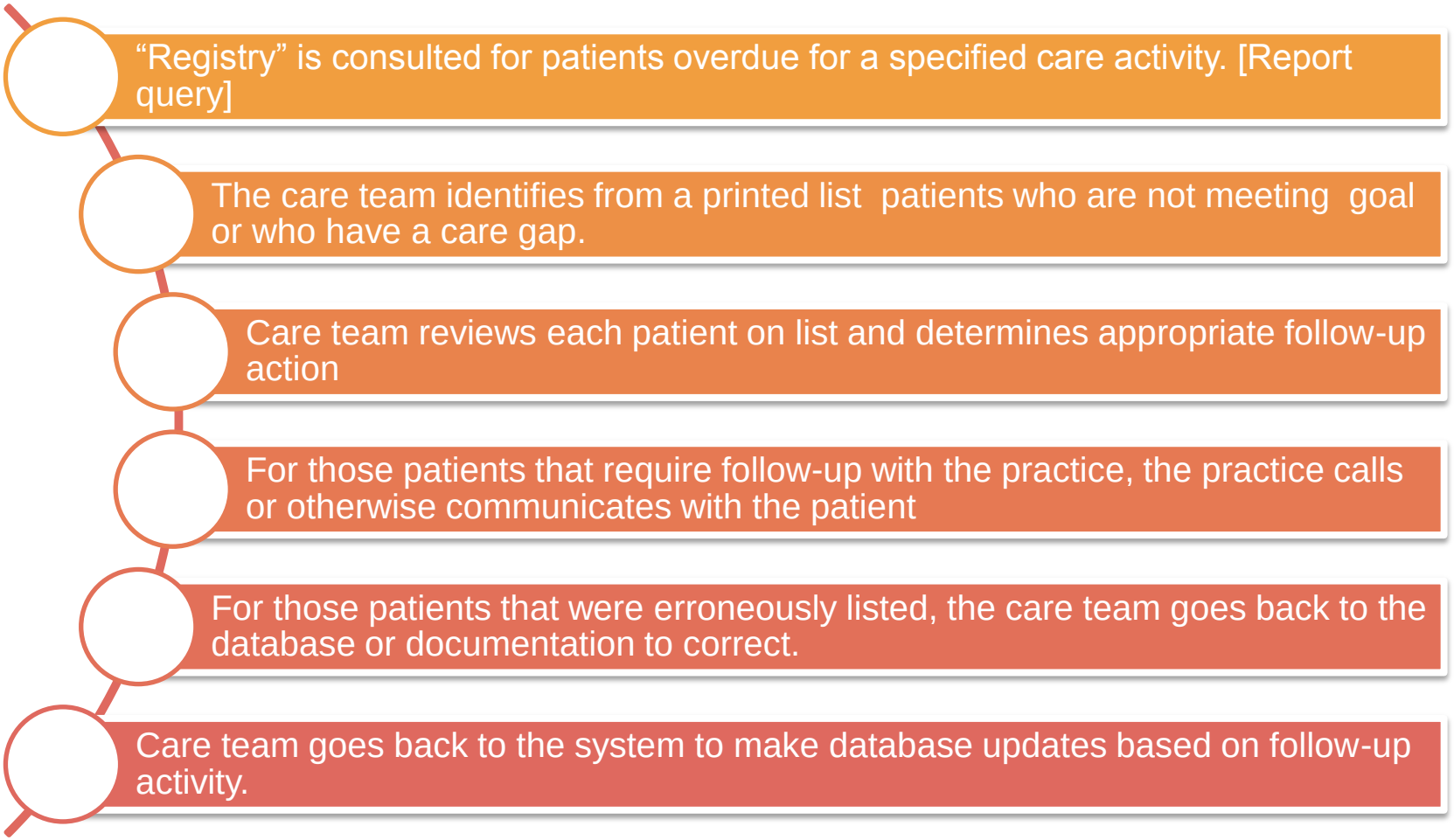
Leveraging Data to Close Gaps in Care

- Identify and track patients with open Care Opportunities and Future Care Opportunities
- Cross reference disease registries
- Identify opportunities in operational processes, workflows and clinical outcomes
  - Use clinical practice guidelines
  - Track, capture and report on standards of care
  - If no formal tracking or reporting through Electronic Health Record (EHR), review charts to evaluate how information is captured and documented

Process Workflow and Practice Redesign Strategies

Identify and Close Gaps in Care

Example Workflow



(Metzger, 2004)

Establish the Protocol Closing Gaps in Care

- Explore and implement alert capabilities, such as in an EHR
- Population Management
  - Establish a registry
  - Risk Stratify Population
- Establish visit and outreach structure
  - Consider standing orders using Evidence-Based Guidelines
- Create structure for planned visits
  - Medication Management (adherence and reconciliation)
  - Review/monitoring of patient condition(s)
- Provide self-management support (all members of the practice)
- Focus on Care Gaps to assure they are closed
- Implement PDSA and monitor reports
- Create feedback loops
  - Establish regular monitoring and reporting on initiatives to close care gaps
- Celebrate successes to continue to build momentum in closing gaps in care

Implementing a Registry

- Options range from using an Excel worksheet to maximizing your Electronic Medical Record
- Incorporate evidence-based guidelines
- Consider Electronic Medical Record integration

Identify Patients and Populate Report

- Use information from medical records/EMR

Determine Staff Workflow to Support Registry Use and Maintain Registry

- Update at each patient visit
- How often, when and who will check to ensure that register is accurate and up-to-date with most current guidelines

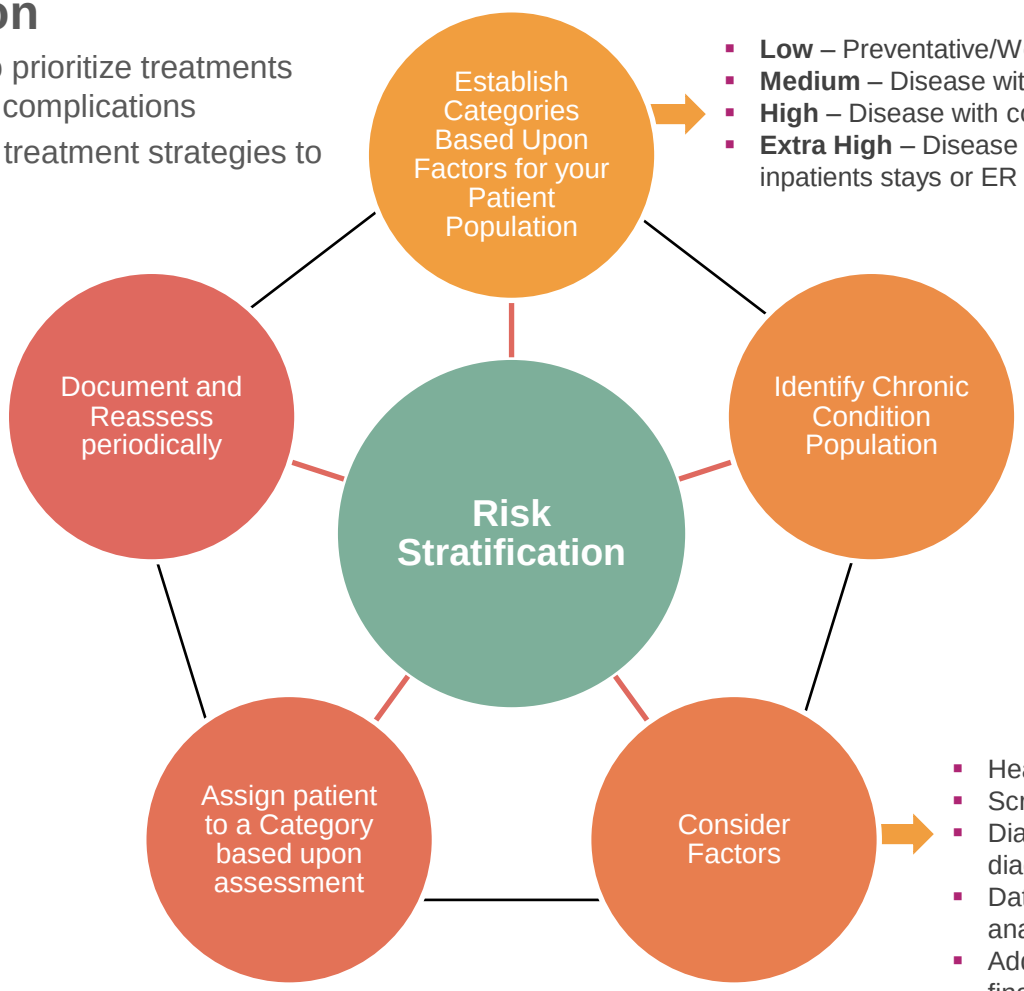
Use Registry to Manage Patient Care and Support Population Management

- Track when the next visit, test or contact should take place based on care guidelines
- Generate patients lists sorted according to overdue status
- Produce exception reports (e.g., all patients without a self-management goal)
- Prepare performance feedback reports on key measures for individual PCPs and practices

Risk-Stratify Population

Risk Stratification

- A risk-based strategy to prioritize treatments can help prevent future complications
- Allows for personalized treatment strategies to match patient's needs



- **Low** – Preventative/Wellness
- **Medium** – Disease with no complications
- **High** – Disease with complications
- **Extra High** – Disease with complications, inpatients stays or ER usage

- Health Assessments
- Screening Tools
- Diagnosis and comorbid diagnoses
- Data mining and trend analyses
- Additional factors: social, financial

www.ahrq.gov/professionals/prevention-chronic-care/decision/mcc/johnson_grant.pdf
www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/medicaidmgmt/medicaidmgmt3a.html

Planned Care Visit
Patient-Centered Planned Care

Improved Outcomes
- Increased Healthy Behaviors
- Improved Quality, Safety, and Clinical Outcomes
- Increased Collaboration between Patient, Care Team, and Medical Neighborhood
- Improved Physician and Staff Satisfaction and Retention
- Reduced Cost Trends

Adapted from
www.NewHealthPartnerships.org

Planned Care Visit

Example Practice Workflow

Pre-Visit Planning

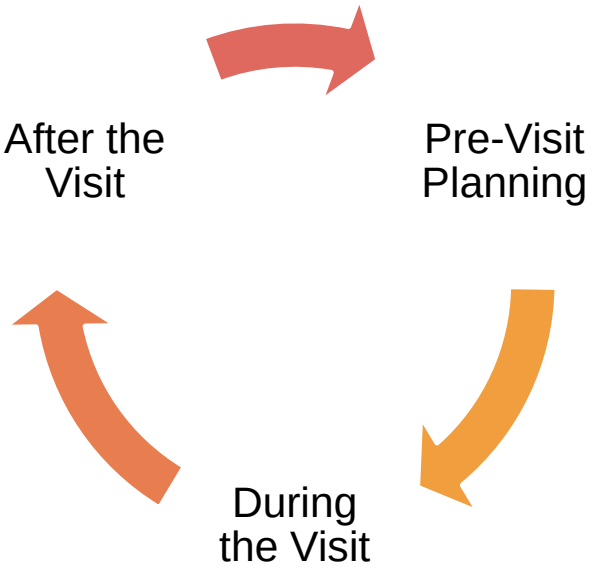
- Review medical records/registry
- Utilize Standing Orders
- Pre-Visit Questionnaire (Include depression Screening)

During the Visit

- Review Pre-visit Questionnaire
- Physical examination
- Medication Management, Adherence, Reconciliation
- Review Self Management Goals
- Care Plan formulation
- Determine eligibility for internal Anthem programs

After the Visit

- Monitor follow-up and reassessment
- Referral to community resources (if applicable)



Use Standing Orders

To enable greater autonomy and efficiency, practices should:

- Use standing orders for everything that does not require direct physician input:
  - Lab ordering
  - Screenings
    - EKG's, Chest X-rays, cervical cancer
  - Referrals (mammography, colon cancer screening, cardiac rehabilitation, nutrition counseling)
  - Next appointment intervals
- Educate staff throughout the practice on defined standing orders and their use
- Ensure everyone is functioning at their max licensure
- Create a multidisciplinary team

Pre-Visit –
Establish a Protocol

Consider which patients to whom staff will outreach

- High-Risk Patients
- Patients past due or planned care visit

Consider who will make outreach

- Office staff or MA
- Care Coordinator

Consider when and how outreach will occur

- Upcoming or past due gaps
  - Will calls or reminders be sent 30 or 60 days prior to due date?
- Pre-Visit Planning
  - Will out reach call be made within 7 days of visit?
  - Are standing orders in place to support completion of Evidence-Based Guidelines (EBG) care?
  - Can pre-visit questionnaire be completed via phone or sent to patient (patient portal, email, mail)?
  - Are PCP/other specialist notes on file? Does outreach need to be made to other physicians?
  - Review list of medication
  - Follow-up calls post discharge from inpatient stay or ER
  - Will outreach occur while patient is in hospital to begin Transition of Care planning or within 48 hours?

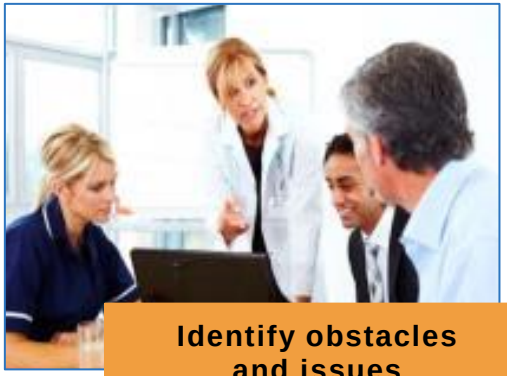
Pre-Visit –
Leveraging Care Team Huddles

Huddles help individual team members

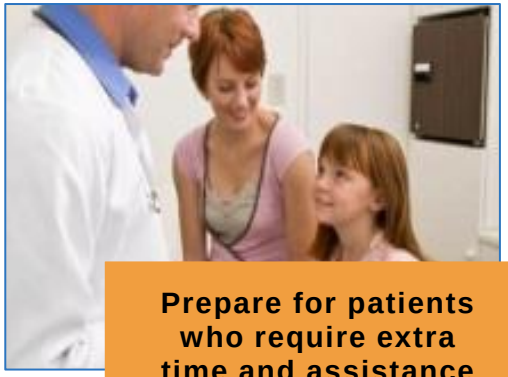
Communicate Effectively

Avoid duplication of work

Plan for last minute schedule changes



Identify obstacles and issues



Prepare for patients who require extra time and assistance

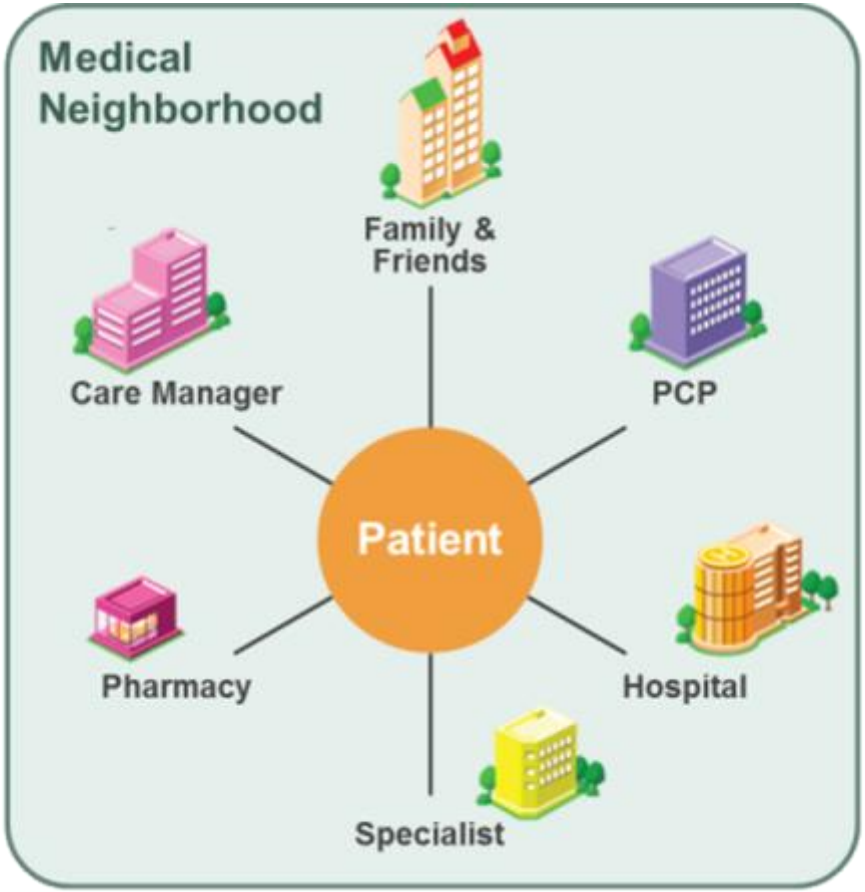
Post Visit –
Steps for the Care Team

Self-Management Support (SMS) Plan

- Obtain patient education materials (patient action plan)
- Education on disease, therapy and self-management tasks
- Referral for smoking cessation (when applicable)
- Proper use of medications, awareness of potential side effects, when to contact office regarding medication regimen

Post Visit –
Coordinating Care in the Medical Neighborhood

- Establish a Care Compact and/or relationships with PCPs
- Develop relationships with community resources and track value of resources
- Create a workflow to track and monitor status of referrals
- Communicate or share your internal process with PCPs and inquire about their processes



Incorporating Care Coordination into the Planned Visit

- Facilitates the provision of comprehensive health promotion and chronic condition care
- Helps ensure ongoing, proactive, planned care activities
- Builds and uses effective communication strategies between family, PCPs, specialists, community professionals and community connections
- Helps improve, measure, monitor and sustain quality outcomes (clinical, functional, satisfaction and cost)

Electronic Health Record

Registry

Care Alerts

Evidence-Based Guideline (EBG)

- What EBGs are currently in place?
- Access reputable EBGs and a process to monitor changes to the guidelines
- Define gaps in care with reference to indicators based on current guidelines
  - What are they missing and why are they seeing gaps in care
- Develop processes
- Educate all staff on practice accepted EBGs
- Present the results back to your team
  - Raise awareness and seek agreement on how to identify the problems

Next Steps

Next Steps

Step 1: Evaluate current workflows for patients

Step 2: Identify potential opportunities for improvement and implement Quality Improvement activities

Step 3: Identify how reports can be incorporated into workflow

Step 4: Determine who will review reports

Step 5: Determine the day and time for report review

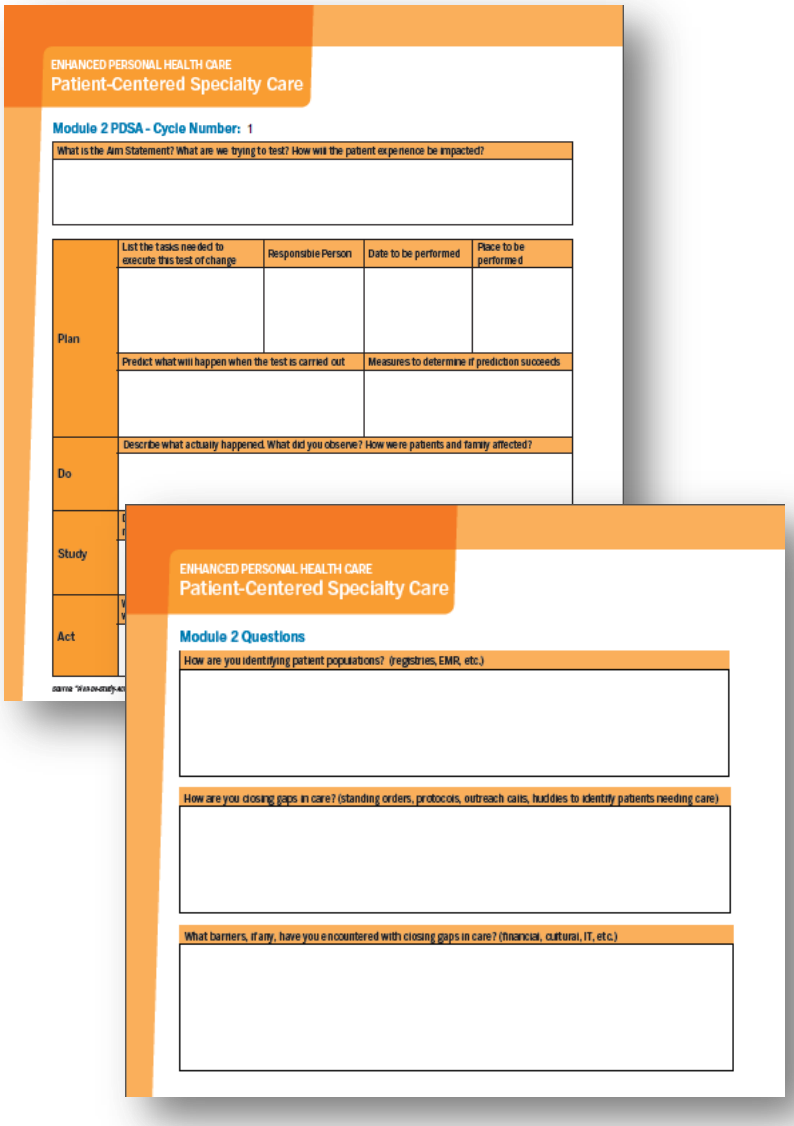
Step 6: Identify tasks to be completed for patient management

Step 7: Create a Care/SMS Plan with patient and review

Step 8: Develop a schedule to educate patients? (scheduled appointment/proactive phone call)

Step 9: Determine time to call patient and schedule appointment

Next Steps *(continued)*


ENHANCED PERSONAL HEALTH CARE
Patient-Centered Specialty Care

Module 2 PDSA - Cycle Number: 1

What is the Aim Statement? What are we trying to test? How will the patient experience be impacted?

Plan

List the tasks needed to execute this test of change | Responsible Person | Date to be performed | Place to be performed

Predict what will happen when the test is carried out | Measures to determine if prediction succeeds

Do

Describe what actually happened. What did you observe? How were patients and family affected?

Study

Act

ENHANCED PERSONAL HEALTH CARE
Patient-Centered Specialty Care

Module 2 Questions

How are you identifying patient populations? (registries, EMR, etc.)

How are you closing gaps in care? (standing orders, protocols, outreach calls, huddles to identify patients needing care)

What barriers, if any, have you encountered with closing gaps in care? (financial, cultural, IT, etc.)

Please complete the following:

Please refer to the CDT Learning Collaborative Activities checklist or the PCSC Provider Toolkit to access each event and view the session.

- **Submit completed Module 2 PDSA Worksheet to PCSC@anthem.com** (View Module 2 PDSA Sample on Provider Toolkit)
- View Module 3 Webinar: Enhancing the Efficiency of Care
- View Module 3 Instructional Webinar: Impacting Quality and Cost of Care

Appendix

Gaps in Care –
Evidence-Based Findings

Addressing Barriers

Commonly Reported Barriers for Older Adults and Medicare Members

- Low health literacy
- Cost of the screening
- Older adults may not be aware of recommended services or what is covered by Medicare
- Some older adults do not have a primary care provider
- Older adults may be deterred from receiving services due to physical or social barriers

Access Barriers/Barriers for Older Adults Living in Rural Areas

- Couldn't get through on phone
- Couldn't get appointment soon enough
- Waiting too long in doctor's office
- Not open when they could go
- No transportation or transportation difficulties
- Limited health care supply
- Lack of quality health care
- Social isolation
- Financial constraints

Due to time and resource constraints, physicians often fail to provide patients with needed services. For example, only about half (54.9%) of adult patients receive all recommended preventive care services.

Gaps in Care –
Evidence-Based Findings

Addressing Barriers

Screening among older diverse populations

- The most common reason for not having a mammogram among Black women 65 years of age and older was that the doctor did not recommend a mammogram
- For Hispanic and White women in this age group, the most common reason was that a mammogram was not needed or not necessary

Diabetes barriers for older adults

- Lack of diabetes related education, comorbid conditions and transportation barriers were commonly reported by older adults

Gaps in Care –
Evidence-Based Findings

Recommendations for Interventions to Close Quality Gaps

Interventions shown to be effective at closing care caps in older adults

- Text messages
- IVR (Interactive Voice Response) calls
- Phone calls most effective
- e-Mail – second most popular

Overall effectiveness

- Older adults (77%) – said they'd be likely to schedule an appointment for preventive services in response to a personal message from their doctor
- Screenings – Older adults are most likely to schedule: colonoscopy, blood pressure, mammogram, vaccination (in order from most to least)
- For older adults – greater trust in one's own physician was associated with utilization of routine checkups, prostate specific antigen tests and mammograms, but not with flu shots. Blacks had significantly less trust in their own physicians and greater trust in informal health information sources than did Whites
- For older adults with diabetes – providing access to appropriate educational materials, referrals to other specialists and assistance with transportation or pharmacy delivery could address these barriers

Website Resources

PCSC Provider Toolkit

- Module 2 Tools/Resources

Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse of evidence-based clinical practice guidelines

- www.guideline.gov

U.S. Preventive Services Task Force

- www.uspreventiveservicestaskforce.org

AHRQ Clinical Guidelines and Recommendations

- www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/index.html

CDC – Enhancing Use of Clinical Preventive Services Among Older Adults

- www.cdc.gov/aging/pdf/Clinical_Preventive_Services_Closing_the_Gap_Report.pdf

The Guide to Community Preventive Services

- www.thecommunityguide.org/index.html