ACTIVATING CLINICAL CARE & SUPPORT STAFF TO IMPROVE PATIENTS' HEALTH OUTCOMES THROUGH MEDICATION ADHERENCE

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FQHC Background & Introduction

- Family Health Network has been providing primary healthcare since 1972, with a special focus on services to the vulnerable, uninsured and underinsured
  - Operates five medical health centers, four school-based health centers, eight school-based dental programs and one dental clinic that serve Cortland and Cayuga counties and the contiguous counties of Tompkins, Madison, Chenango, Broome and Tioga
  - In 2017, approximately 8% of patients were uninsured, 50% had either Medicare or Medicaid, 42% had third party payers, 39% were of age 17 or younger, 55% were below 200% of the federal poverty level FPL, 2.5% were Hispanic, and 54% were women
  - Only source of care in three of the six communities served
  - Services include: family practice/general practice, dentistry, occupational health services, obstetrics/gynecology, pediatrics, school-based services, behavioral health, substance abuse, 340B pharmacy services, insurance enrollment, and care coordination
  - Staffing: 7 Physicians, 4 FNPs, 5 PAs, 1 DDS, 2 RDH, 21 Nurses, 11 MAs, 1 LCSW-R, 2 OB/GYNs, 5 Care Coordinators

Embracing an Integrated Care Model through Care Coordination

- FHN has focused mostly on untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity, poor nutrition, smoking, and substance abuse.
- Due to limited resources we have a combination of both a team based care and population health management style of delivery.
  - Team based in that it's not provider dependent, but the MA, LPN, and Care coordinator are all sharing responsibilities with accountability amongst each other.
  - Population Health delivery in the sense of utilizing PVP (pre visit planning), "gap in care" reports, and any quantitative quality report that provides the details of patients in need of care.
- The importance of care coordinators has been two fold in that:
  - It helps *to assist patients* with chronic or complex conditions *in managing medical conditions more effectively through education, and more extended interaction than a 15 minute office visit.*
  - It has also addressed the "coordination" within our own organization. With the introduction of EHR's, despite the foreseen intent, there seems to be fragmentation that slows care and undermines accountability. The use of "information technology" has increased poor communication, and care coordination has been a great asset with team huddles (communicating face to face) to ensure that the care needed is appropriate, and timely.
  - Given the shift toward VBP, the care coordination has helped our providers and team to more effectively direct their efforts toward the specific and immediate needs of our patients. It also has shown to provide more control to the PCP over the care of their patients since it requires the sharing of information from all involved in the patients care.

FHN

Protocols and Policies

- FHN uses guidelines from American Heart Association, JNC-8, and American Diabetes Association
- Our care for patients with Diabetes and Hypertension is based on these guidelines, including medication regimens
- FHN reviews these guidelines with provider staff as they are published, usually within 6 months of publication
- Staff training on the latest evidence is provided by the CMO and other FHN physicians
  - Providers are encouraged to share the latest information learned at trainings and at conferences
- Providers take part in quarterly review of patient charts. This is not specific to hypertension or diabetes, but looks at all aspects of primary care
- FHN does not do high risk case conferencing

Medication Adherence Strategy

- Does FHN have a specific Medication adherence strategy/policy?
  - Well, no P&P, however with review of medications staff assess if there is nonadherence due to a lack of resources (SDH) or deliberate non-compliance.
  - FHN does have a patient and staff engagement strategy
- Care Team
  - Provider, LPN/MA/Care Coordinator
- Care Coordinators
  - Prepare pre-visit planning reports and validate the data on all patients
  - Identify high risk patients who they will meet with when seen by the provider
  - FHN uses the following criteria for identifying high risk patients:
    - Hypertension – last BP ≥ 140/90, Diabetes – last A1c ≥ 9.0,
    - Depression – last PHQ-9 ≥ 12 or if patient has all three conditions

Team Based Care

- Team huddles occur each morning from 8:00 a.m. to 8:15 a.m.
- Tasks to be accomplished for each visit are highlighted
- Next, LPN/MA perform medication reconciliation during the patient intake
- Provider will manage medications
- Care Coordinator will work with patient on self-management goal setting and provider self management tools
- Care Coordinator may also provider loaner BP cuffs to patients for home monitoring
- Care Coordinators conducting NDPP for patients
- Care Coordinators are training in motivational interviewing
- Care Coordinators will also make contact with patients in between visits to assess adherence to self-management goals

Population Health Management/in-between care considerations

- Our care team members are definitely involved with indirect/ between OV patient care.
  - Nurses and care coordinators identify those who are due for both chronic disease and routine follow ups. Whether it is working off a specific report, working refill desktops, etc.
  - Calls are made/letters are sent regularly.
- All of our sites welcome patients to come in for a nurse visit for additional education with BP cuffs/ glucometers/injections/diet/etc.
  - This helps encourage patients to be more compliant/controlled when they have the skills and knowledge to self monitor and recognize body's response. This very often correlates to taking the correct dose of medications.

Our results

- Quantitative –

HRSA Clinical Quality Indicators

Clinical Measure	National Data 2016	FHN 2016	FHN 2017
Asthma Medication	87.4%	70.4%	81.5%
CAD Lipid Therapy	79.5%	78.9%	89.6%
IVD Antithrombotic	78.4%	84.1%	90.3%
HTN Control	62.4%	73.3%	76.4%
Diabetes - Poor Control	32.1%	21.6%	22.7%

Our results

- Qualitative –

So "Frank" was not doing anything about his diabetes. He was a truck driver and his A1C was steadily rising higher, resulting in his DOT license/ livelihood being threatened. Both his PCP and Care Coordinator spent a great amount of time stressing the importance of medication adherence, changing his eating patterns, and following up with him very closely (weekly) to keep him on track. His A1C dropped down (from 11.7-> 8.4) to where he could get his DOT license renewed and get back to work in a matter of two months(Jan. 19th to March 12th). It took a team to be able to guide him, communicate, and consistently follow up. Continue to follow him monthly to be sure he doesn't "slip".

Lessons Learned

- Initially there was a lot of push back when implementing pre-visit planning and huddles
- It helped that the CMO was used as a guinea pig for this process
- It was also made clear that this was not going away
- Now most nurses and providers want this
- Care Coordinators do not need to be nurses and in fact it sometimes is advantageous when they have other skills
- Giving feedback on quality measures helps
  - Organization wide quality data is given at Quality Improvement meetings
  - Providers receive quarterly report cards

Key Takeaways

- Try to broadcast when milestones are achieved
  - Ex. – when Fidelis incentive payment increase six fold from 2015 to 2016
  - Ex. – when CDC designated FHN as a high performing FQHC
- In hiring additional personnel (i.e. – Care Coordinators), Senior Management needed to be shown the business case for change in staffing
  - Ex. – PCMH incentive payments, DSRIP incentive payments
- Small successes lead to growth of the program

Closing

- Dr. Douglas Rahner, drahner@familyhealthnetwork.org
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- Q&A