MACIPA Systematic Case Review Program

A Multidisciplinary Approach to Diabetes Care

PURPOSE

This collaborative report outlines how Mount Auburn Cambridge Independent Practice Association, Inc. (MACIPA) improved clinical outcomes for diabetes patients who were not at goal by implementing the Systematic Case Review (SCR) program, a patient-centered approach to care designed to address the unique challenges of individual diabetes patients. In addition to detailing this approach, the report examines a specific case study, highlights the results of these efforts, and looks at next steps.

Overview of the SCR Program

Building on earlier care improvements achieved under existing pay-for-performance contracts, MACIPA created the SCR program. This program identifies patients who are not meeting care targets, works with them to identify manageable goals, and develops a care plan for each patient based on recommendations from a multidisciplinary committee. This plan is then shared with the patient's primary care physician (PCP) and implemented with the help of Health Coaches.

I. Patient Identification The MACIPA Quality Department formulates a list of diabetes patients who are not at goal, and refers those patients to a Health Coach. Prior to the first meeting, the Health Coach gets buy-in from the patient's PCP. PCPs may also refer their patients to the program.

II. Health Coach Assessment Health Coaches meet with patients to identify factors that are impeding their improvement and create a customized plan for success.

III. Findings Presented to the SCR Committee Health Coaches share their findings on new patients, problematic cases, and soon-to-be-discharged patients.

IV. SCR Committee Recommendations Incorporating feedback from the Health Coaches, the SCR Committee recommends potential adjustments in care to the patient's PCP.

V. Care Plan Implementation With the patient's PCP on board, a plan to improve the patient's diabetic measures is established and implemented. Health Coaches continue to meet with the patient over a total of six months; the SCR Committee reviews patient cases as needed.

VI. Patient Discharge After six months, the patient is discharged. Health Coaches will help the patient create a relapse prevention plan.

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SCR Program: Steps I and II

The first step of the SCR program is to identify diabetes patients who are out of goal and verify with their PCP that they may benefit from additional support; the second step calls on Health Coaches to make introductions and initial assessments.

I. Patient Identification

By reviewing claims data and patient electronic health records (EHRs), the MACIPA Quality Department identifies patients who are not at goal, and sends the list to Health Coaches Skaina Germain, Hannah Groesbeck, and Nasya Smith, led by Betsy Pollock, MSW ACSW LICSW, MACIPA Director of Social Work. Diabetes patients whose HbA1c levels are poorly controlled—primarily those with levels between 9.0% and 10.0%—are often referred to SCR's Metabolic Team: endocrinologist Ed Kowaloff, MD, and MACIPA Director of Pharmacy, Gene Muise, MS, RPh.

After researching the patient's chart in the EHR, the Health Coaches reach out to the identified patients' PCPs to get their consent and confirm that the patient would benefit from Health Coach support. Once the patient's PCP provides consent and informs the patient, the Health Coach contacts the patient and schedules introductory meetings.

II. Health Coach Assessment

Health Coach meetings can be conducted over the phone or in person at the patient's home. These half-hour meetings occur once a week or twice a month, depending on the patient's need, and help the team uncover issues that often do not arise in a 15-minute appointment with a PCP. The meetings examine factors such as family dynamics, psychosocial issues, nutrition and exercise habits, prescription adherence, and other barriers to proper treatment. Health Coaches may handle 40–60 cases each at any given time.

More importantly, these initial meetings enable the Health Coaches to build a relationship with each patient. Using a patient-centered approach that takes into account the patient's strengths, they help set manageable, short-term goals to motivate patients to take better care of themselves and their chronic disease.

"Health Coaches have been able to uncover a wide variety of behavioral and mental health obstacles that can impact outcomes. Additionally, patients are sometimes much more forthright with a Health Coach about their true eating habits than they are with a physician."

—Betsy Pollock, LICSW, MACIPA Director of Social Work

From Left to Right: Skaina Germain, Nasya Smith, and Hannah Groesbeck

SCR Program: Steps III and IV

These steps of the SCR program leverage the expertise of a multidisciplinary committee—including endocrinology, pharmacy, psychiatry, and the Health Coaches—to determine the best way to address the needs of diabetes patients.

III. Findings Presented to the SCR Committee

After meeting with patients, Health Coaches report their findings to the SCR Committee during weekly meetings. Issues covered include new patients, problematic cases, and soon-to-be-discharged patients. Health Coaches continually assess the patient to identify additional roadblocks and ways to overcome these obstructions.

The Committee includes:

- Betsy Pollock and the Health Coach Team, who provide expertise on psychosocial issues the patient may be facing.
- Dr. Kowaloff and Gene Muise—the Metabolic Team—who examine the patient's prescribed therapies.
- Psychiatrists Donald Meyer, MD, and Robert Levin, MD, who assess the patient for behavioral health issues.

IV. SCR Committee Recommendations

Once the Committee has performed a thorough review of the patient's status and situation, they arrive at a short list of recommendations. The Metabolic Team may make suggestions, including alterations in prescribed therapies or referral to specialists. If a change to the patient's medications is recommended, Gene Muise will provide feedback to the patient's PCP; Dr. Kowaloff will reach out to PCPs with advice regarding recommended medical interventions.

If a behavioral health issue is detected, Dr. Meyer or Dr. Levin may refer the patient to a psychiatrist. If a patient is already being treated for a psychiatric condition, the psychiatrists may suggest changes to the patient's drug regimen.

The SCR Committee will continue to assess patients throughout the six-month process as often as necessary.

MACIPA SCR Committee

Foreground (left): Nasya Smith, Health Coach. Background (left to right): Edward Kowaloff, MD; Betsy Pollock, MSW, ACSW, LICSW; Donald Meyer, MD; Gene Muise MS, RPh

SCR Program: Steps V and VI

The final steps of the SCR program involve implementation of the recommendations developed by the SCR Committee and agreed upon by the PCP. Progress is monitored until the patient is discharged.

V. Care Plan Implementation

After a care plan has been created, the Health Coaches then work with the patients to implement recommended treatment changes as approved by the patient's PCP. Over the remaining months of the program, the Health Coach continues to work with the patients.

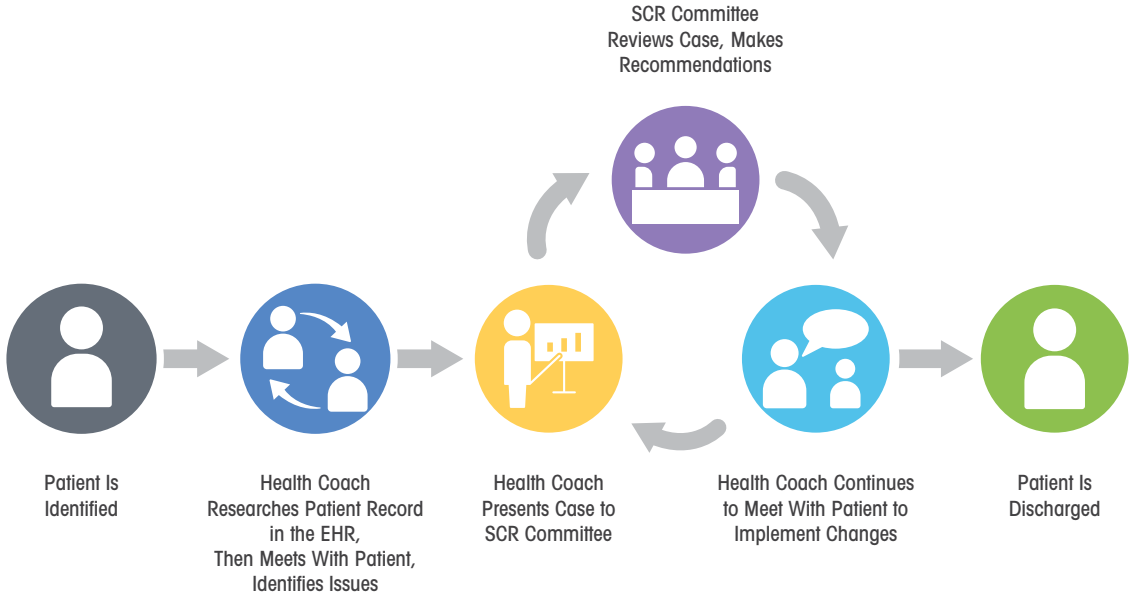
Health Coach assistance may include creating a nutrition or exercise plan, helping patients learn how to properly use new prescriptions, or discussing avoidable triggers that may cause the patient to make unhealthy choices. Pertinent measures are monitored along the way.

VI. Patient Discharge

After six months, the patients are officially discharged from the SCR program. However, those who feel they are not able to maintain the plan on their own may remain in the program and continue working with their Health Coach.

Health Coaches also help patients fill out a Relapse Prevention Form to identify any additional negative behaviors. Health Coaches will follow up with each patient at three and six months after discharge to ensure improvements are maintained.

SCR Process



"We know that every patient is different, and we speak with them about better ways to manage their disease that build on existing strengths. We employ a non-judgmental, strength-based approach to meet patients where they are to get them help and see them beyond the label of a 'Type 2 diabetes patient'."

—Health Coach Skaina Germain

SCR Program: Case Study

The case study presented below is just one of many examples of a patient who went through the SCR program and, after implementing the recommended treatment, had outcomes that were objectively improved from baseline measurements.

I. Patient Identification A female patient whose last recorded HbA1c level was around 8% was referred by her PCP to the SCR program after she had missed a few annual visits.

II. Health Coach Assessment In her first meeting with a Health Coach, the patient appeared distraught. The Health Coach administered a Patient Health Questionnaire (PHQ-9), a nine-question assessment focused on depression. On a scale of 1 to 27, with 1 indicating minimal depression and 27 indicating severe depression, the patient's score of 21 showed that she was in severe depression at the time. The Health Coach also learned that the patient had been the victim of abuse.

III–IV. Findings Presented/Committee Recommendations The Health Coach presented these findings to the SCR Committee, who recommended a psychiatric referral.

V. Care Plan Implemented During the next few weekly sessions, the Health Coach worked with the patient to identify goals and discuss the barriers to meeting them. Because the patient expressed an interest in increasing her physical activity, the Health Coach helped her to set a goal of using the treadmill she had in her home. The patient and the Health Coach also discussed other habits that may have been contributing to her elevated HbA1c levels.

VI. Patient Discharge At six months, the Health Coach and the patient filled out a Relapse Prevention Form, which she used to self-identify triggers for problematic behavior. These included the summer season, when overeating occurred, and shopping without a grocery list, which led to impulse purchases of carbohydrate-heavy foods. The Health Coach will follow up with this patient at three months after discharge and again at six months to ensure the patient is following the agreed-upon plan.

***Outcomes:** At discharge, the patient's HbA1c level had fallen to 6.2% from roughly 8%, and she had also lost 18 pounds. Additionally, the patient had been seeing her psychiatrist regularly, and her PHQ-9 assessment score was an 8 (indicating mild depression), down from 21.*

"We've also discovered a patient who was illiterate and unable to understand the written instructions shared with them at the doctor's office. Because of Health Coaches, we're able to identify these problems and make the necessary recommendations."

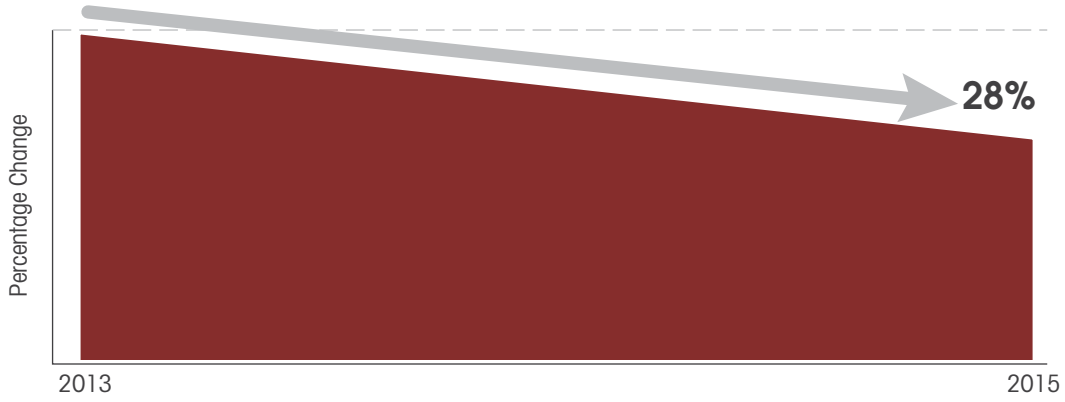
—Betsy Pollock, LICSW, MACIPA Director of Social Work

SCR Program: Results

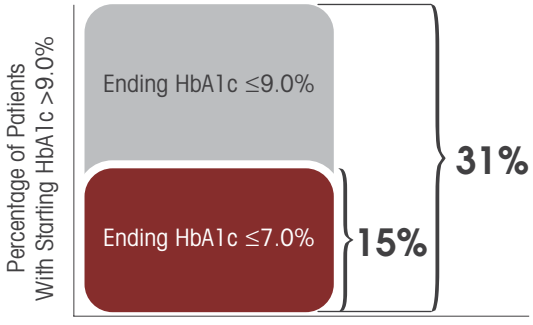
The SCR program has already yielded compelling improvements in the care of MACIPA's patients, specifically in terms of HbA1c and blood pressure control.

- In 2015, the percentage of MACIPA diabetes patients with an HbA1c level greater than 9.0% was 28% lower than the 2013/2014 overall average for the practice.
- For MACIPA diabetes patients with consistent Health Coach follow-up, the program helped them achieve an average HbA1c reduction of 10.7%.
- For any MACIPA patients with consistent Health Coach involvement, average systolic blood pressure declined by 5.3%; 31% of these patients with a starting systolic blood pressure at or above 140 mmHg had lowered their systolic blood pressure to below 140 mmHg after working with Health Coaches.

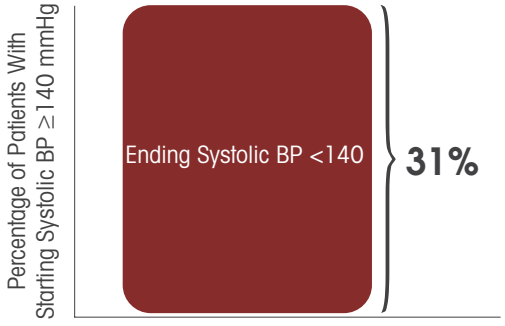
Percentage Change in MACIPA Diabetes Patients with HbA1c >9.0%, 2013–2015



Impact of the SCR Program on Diabetes Patients: HbA1c Reduction, 2013–2015



Impact of the SCR Program on All Patients: Systolic Blood Pressure Reduction, 2013–2015



Conclusion

The success of the SCR program resulted from the MACIPA team's ability to identify patients who were struggling with managing their disease, determine their unmet needs, and provide them with personalized support. Through Health Coaches, MACIPA was able to uncover underlying issues that may not have been apparent during a routine physician visit—issues that were causing these patients to consistently fall short of their goals. By taking the time to provide these patients with one-on-one support, and addressing their unique challenges, the MACIPA team was able to substantially improve the diabetic quality measures within their organization.

Next Steps

The encouraging results of the SCR program so far have compelled MACIPA leadership to promote broader adoption of the program among all of its primary care providers. Furthermore, because this program has been successful in improving core diabetes measures, the SCR team has plans to expand the program to other disease states, including cardiovascular disease, COPD, and asthma; they have added a cardiologist to their team to better treat these patients.

"With patients who are engaged and have consistent health coaching, we're seeing reductions in HbA1c levels of almost 11%."

—Gene Muise, MS, RPh, MACIPA Director of Pharmacy

ABOUT MACIPA

MACIPA is a physician member organization located in the greater Boston area, consisting of more than 500 physicians caring for roughly 80,000 patients. This provider network has privileges at Mount Auburn Hospital. MACIPA has roughly two decades of experience with risk contracting, and was one of the first groups to accept the Blue Cross Blue Shield of Massachusetts (BCBSMA) Alternative Quality Contract (AQC) for both HMO and PPO populations. Additionally, MACIPA is one of the original 32 Pioneer Accountable Care Organizations (ACOs).

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