PCMH AT WORK: HYPERTENSION AND DIABETES

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CASE PRESENTATION

- January 2010: 54 yo A woman with longstanding poorly controlled HTN, lupus, & infrequent office visits presented for a physical. Had missed a 2 week f/u visit in 2008. Had gained 8 lb. BMI 44, BP 188/78, 172/102.

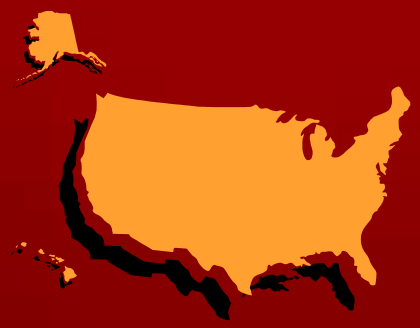
- PLAN: Rx for lisinopril/HCTZ and f/u visit in 2 weeks

…NEXT CHAPTER

- February 2011: call from ICU resident. Pt admitted for hemorrhagic stroke. BP in the ER was 180/100.

- Brief chart review: patient had missed 2 week follow-up visit 1 year before!

- U.S. Population ~314 million
- Maryland Population ~5.9 million
- # of doctors in Maryland =28,339 physicians (1/2013)



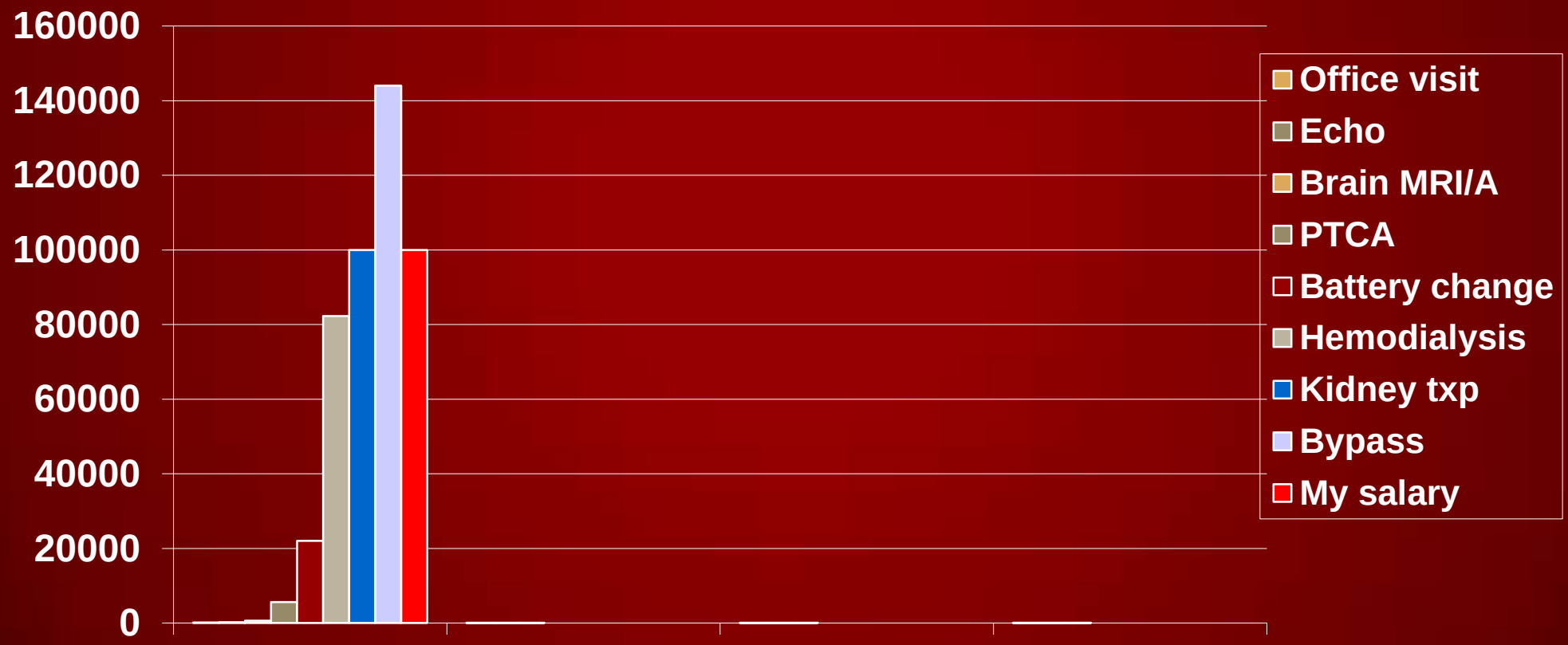
- 2005-2008 NHANES 10 31% of U.S adults have HTN
  - Prevalence is unchanged in recent years
  - 70% on meds
  - ***46% had controlled HTN***
  - 86% of those with uncontrolled HTN were *insured*

http://www.ncbi.nlm.nih.gov/pubmed/21293325

OUTCOMES OF UNCONTROLLED HYPERTENSION

- Stroke
- Heart failure
- Coronary artery disease
- Kidney failure
- Peripheral vascular disease
- Premature death

THE COST OF UNCONTROLLED HTN (2010 $)



HYPERTENSION: INEXPENSIVE TO TREAT

- Exercise = free!
- 3 month supply of HCTZ = $0.17/pill
- 99213 visit ~$70
- Omron home BP cuff = $69.99
- Diet

CLEAR TARGETS

Home BP

- <130/<80

Doctor's Office

- <140/<90
- Diabetic/renal failure <130/<80
- Elderly <145/<90
- JNC 8 modifications

LOTS OF MEDICATIONS

- ACE-inhibitors
- Angiotensin receptor blockers
- Beta blockers
- Combination BP agents
- Direct renin inhibiors
- Nitrates

- Novel agents?

- Aldosterone inhibitors
- Alpha blockers
- Calcium channel blockers
- Combination BP/chol meds
- Loop diuretics
- Thiazide diuretics

PATIENTS?


smoking
obesity
stopping meds
co-morbidities
inactivity
salt
alcohol
Cocaine use
Anxiety/mental health issues

THE SYSTEM?

Access

- Uninsured/ under-insured
- Culture, language, health literacy

Apathy

- Medical inertia
- Complex co-morbidities

Bias

- ?
- “non-compliant patients”

SMALL PRACTICE PCMH

PCMH

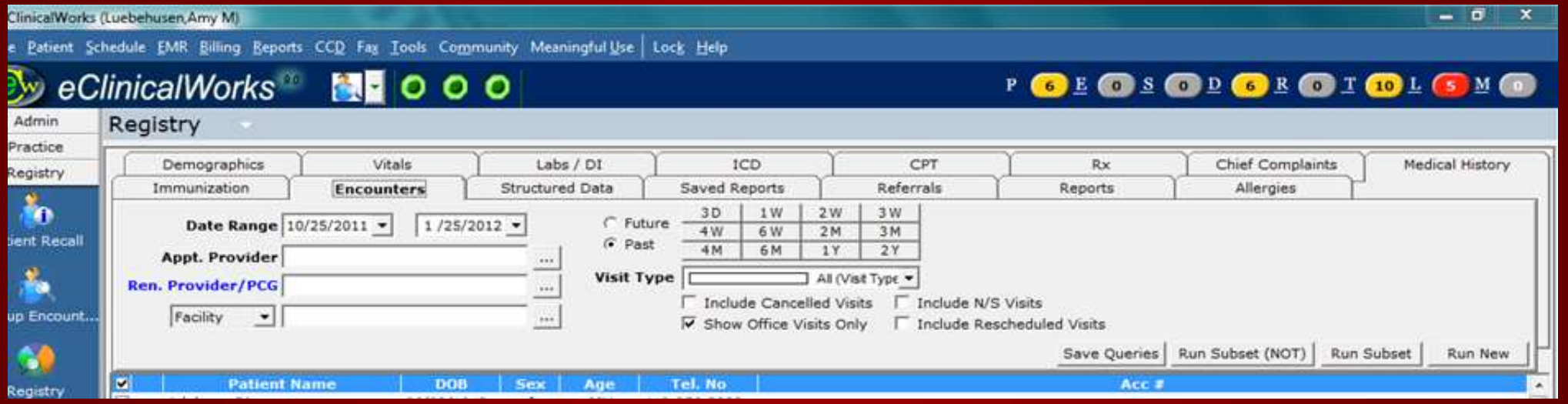
"It is a model of practice in which a team of health professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access and communication, care coordination and integration, and care quality and safety."

ACP website on PCMH model, 2011

KEY FEATURES (NCQA)

- Access and continuity
- Population management
- Care plan
- Care coordination
- Measure/improve performance
- Patient resources

POPULATION MANAGEMENT



IDENTIFYING AND HELPING HIGH-RISK PTS:

- Don’t assume. Assess barriers.

CARE MANAGEMENT

Care plan

- High risk patients
- Barriers assessment
- Follow-up

Care coordination

- Track ER/hospital visits
- Information from specialists
- Discharge follow-up/ Med Rec

CARE COORDINATION

- CRISP Encounter notification system (ENS)
- Medication reconciliation
- Lab interfaces
- Referral tracking

DATA-DRIVEN PRACTICE

PATIENTS: THE UNTAPPED RESOURCE!

- Equip
- Empower
- Engage

THREE INTERVENTIONS:

- Registry to identify high-risk (quarterly)
- DASH Diet
- Self-monitoring

MEASURING PROGRESS AT GSIM

- Year 2011: 47.71%
- Year 2012: 66.04%
- Last qtr 2012: 68.14%
- Dec 2012: 74.42%

- 2013: 80.85%
- 2014: 78-79%

CONCLUSIONS

- Hypertension is a prevalent condition posing major risk
- Barriers to hypertension control are individual & systemic
- Data identifies areas for practice improvement
- Simple strategies in PCMH improve hypertension control
- Patients can control hypertension with our help

“Be the change you wish to see in the world.”

- Gandhi

PAYMENT REFORM: MIXED MODEL PAYMENT

- Movement away from fee-for-service model to quality-of-care
- Payment for care-coordination
- Stake in cost-savings (besides the rewards of success + U.S. economic viability)

Data extraction

NQF 18

STONE RUN
FAMILY MEDICINE

Allscripts Pro EHR Reporting Module

Results | Information

Criterion: CQM [2011]-Controlling High Blood Pressure (NQF 0018)

Description: The Percent of patients 18-85 years of age who had a diagnosis of hypertension and who's BP was adequately controlled during the measurement year.

Details: Denominator – patients >= 17 and <= 84 years of age before the beginning of the measurement period with an active diagnosis of hypertension <= 6 months after the measurement start date with at least one billable encounter
Numerator – patients in the denominator with a diastolic blood pressure of < 90 mmHg and a systolic blood pressure of < 140 mmHg during the most recent encounter

1. Patients >= 17 and <= 84 years of age before the beginning of the measurement period
2. Patients with an active diagnosis of hypertension:
    a. ICD-9: 401, 401.0, 401.1, 401.9
3. Patients with systolic and diastolic blood pressure documented
4. Patients are **excluded** based on the following:

STONE RUN FAMILY MEDICINE

Allscripts Pro EHR Reporting Module

Results | Information

NQF 0018 - Controlling High Blood Pressure

Reporting period: 01/01/2013 to 12/31/2013

* Report results were calculated using Allscripts Professional EHR version: 12.1

Details: Denominator - patients >= 17 and <= 84 years of age before the beginning of the measurement period with an active diagnosis of hypertension <= 6 months after the measurement start date with at least one billable encounter
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By Location

Location Name	Numerator	Denominator	Percentage
Stone Run Family Medicine	376	620	60.6%

By Caregiver

Caregiver Name	Numerator	Denominator	Percentage
Baker, Barry O PAC	159	284	56.0%
Steiner, Stefanie M DO	147	256	57.4%
Weidner Jr, Joseph K MD	265	421	62.9%

STONE RUN FAMILY MEDICINE

NQF 18 Stone Run Family Medicine

STONE RUN
FAMILY MEDICINE

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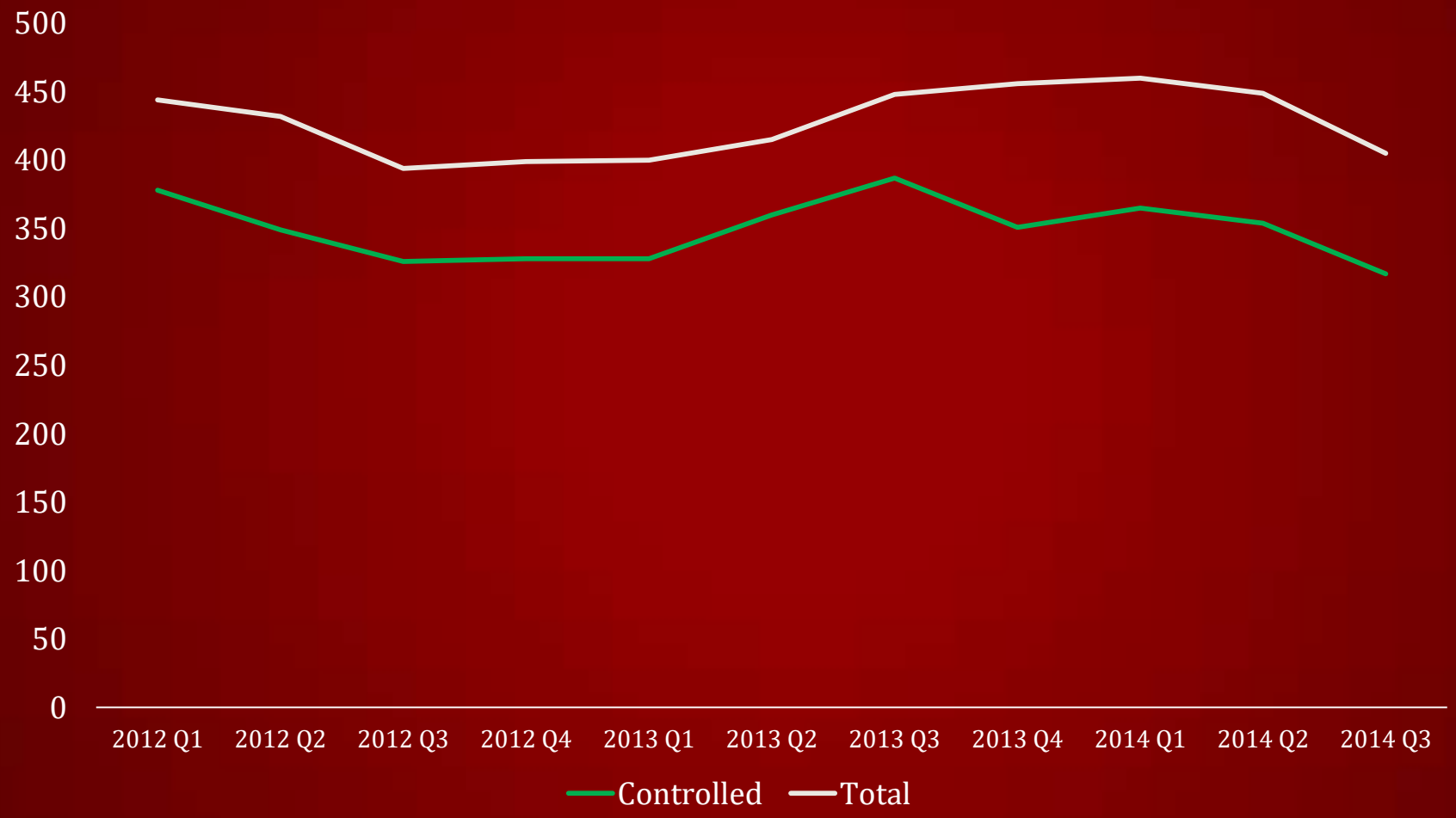

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FAMILY MEDICINE

Allscripts Pro EHR Reporting Module

- For PCMH, better if
  - Excluded acute visits from chronic visits
  - Accounting for higher blood pressure threshold in older adults

  EHR company nonsense
  - More recently, report not available
  - Removed NQF18 report from reporting module
  - New online reporting module to those who purchase a “stimulus set 2” package
  - Ensures that those who have not paid for the Stimulus Set 2 package cannot attest in 2014 using Stage 1 Criteria.

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Chronic Disease Self-Management Program (Better Choices, Better Health Workshop)

- Six week course – renamed “Living Well”
- Teaches patients how to self manage their chronic conditions
- Led by trained non-health professional volunteer leaders
- Senior Services and Community Transit of Cecil County
- Union Hospital of Cecil County Community Liaison
- Target those with hypertension and those who frequent utilizers of the emergency department

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Chronic Disease Self-Management Program (Better Choices, Better Health Workshop)

- Techniques to deal with problems such as frustration, fatigue , pain, and isolation
- Appropriate exercise for maintaining nad improving strength, flexibility, and endurance
- Appropriate use of medications
- Communicating effectively with family, friends, and health professionals
- Nutrition
- Decision Making
- How to evaluate new treatments

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