HEALTH MANAGEMENT ASSOCIATES

Virtual Care Management: Hypertension and Diabetes

Community Health Centers
Virtual Training Series
April 26, 2021

IDAHO PRIMARY CARE ASSOCIATION

Healthy Idahoans Living in Healthy Communities

Our Mission

To promote and support vibrant, effective community health centers in providing accessible, affordable, and high quality healthcare to all Idahoans

Our Work

Health center administration

We help health centers strengthen business operations through support in financial management, health information technology, emergency preparedness, workforce development and medical, behavioral health and dental practice integration.

Quality improvement

We assist health centers achieve the best patient outcomes through innovative quality improvement programs utilizing the highest clinical standards, fostering patient engagement and coordinating care within the larger healthcare system.

Outreach and enrollment

We help health centers provide health insurance education and enrollment assistance to community members, many of whom face barriers in accessing healthcare.

Governmental relations

We monitor the changing healthcare policy environment and connect health center leaders with elected officials on the local, state and federal levels. We engage with the Idaho Department of Health and Welfare and the Department of Insurance to create strong and lasting relationships.

Network management

We support payment reform and value based reimbursement by collaborating with insurance companies to control costs and increase quality of care.

WEBINAR HOUSEKEEPING

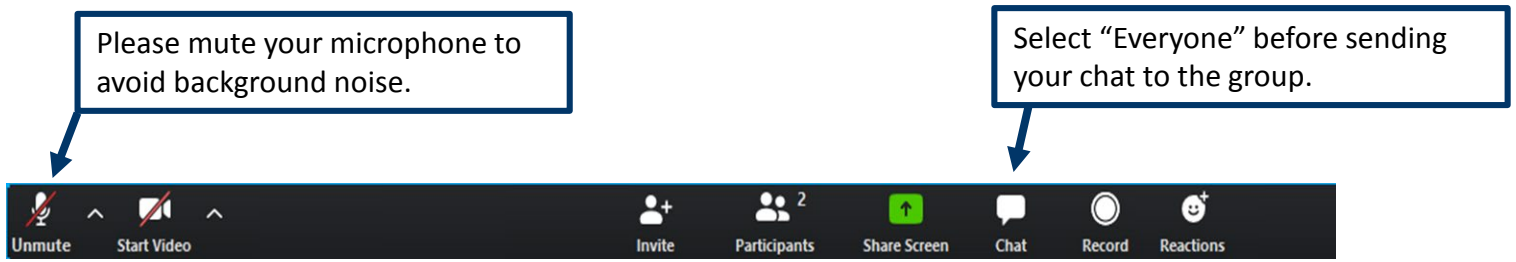
We are Recording

Mute/Unmute Mics

Asking Questions

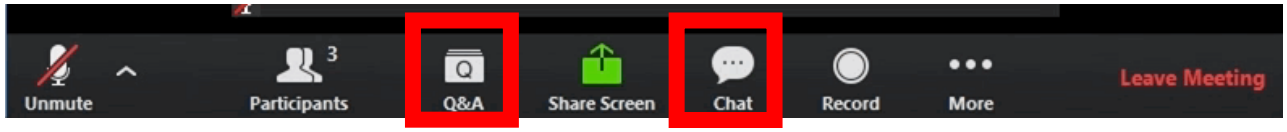
Evaluations

- Questions?
  - Use the chat function for questions
  - Email:

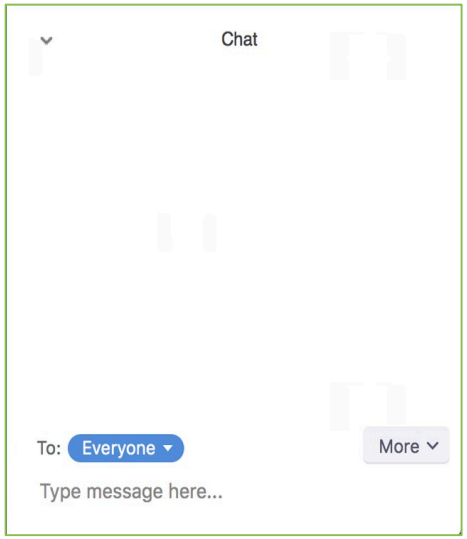


CHECK YOUR TECH – LET'S CHAT

- At the bottom of your screen, click on the Chat Icon to open the chat panel



- Type in your
  - Name
  - Your Role



VIRTUAL TRAINING SERIES

- ✓ February 22 –Care Management Best Practices and ROI
- ✓ March 22 - Population Health and Care Management – Using Data to Focus on Populations of Greatest Need
- ➢ **April 26 - Virtual Care Management for Diabetes and Hypertension**
- \+ May 24 - Maximizing Fee-for-Service Care Management Revenue and Preparing for Value-Based Reimbursement

Technical Assistance/coaching offered – Complete the request form or contact the IPCA and we will call you!

THE HEALTH MANAGEMENT ASSOCIATES TEAM

Karen L. Hill, PhD, MSN, ANP-C
Senior Consultant

Lisa Harrison, MS, MHS, PA-C
Senior Consultant

Nancy Jaeckels-Kamp, RN
Managing Director

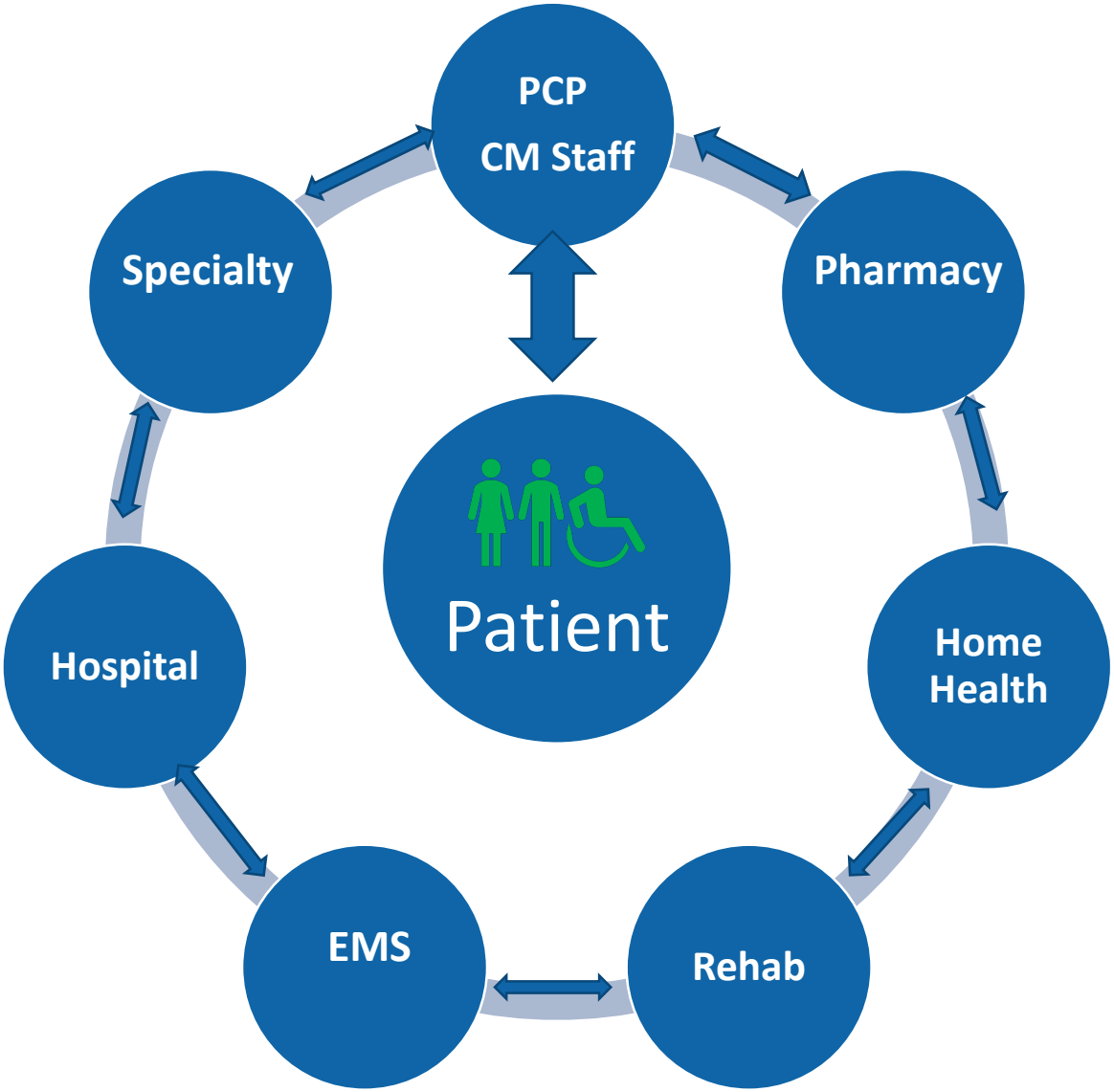
VIRTUAL CARE MANAGEMENT

- Saves time when caregivers' schedules are filled
- Eliminates travel, especially when patients are difficult to transport
- Offers a smarter way to monitor patients
- A perfect idea for patients who need a quick check-in
- Proposes uninterrupted, efficient communication without having to deal with typical office waiting room delays caused by other patients
- Some virtual care managers can diagnose, recommend treatment, prescribe medication and offer a second opinion

A QUICK REVIEW….

- Coordinated Care Management Cycle
- Core Values and Responsibilities
- Patient Identification and Risk Stratification
- Population Health
- Data Gathering

COORDINATED CARE MANAGEMENT MODEL



CARE MANAGEMENT: CORE VALUES AND RESPONSIBILITIES

- Health Equity
- Risk-stratify, identify and track patients
- Identify care gaps
- Assess patients' understanding of health issues and identify barriers to care
- Promote self-efficacy, education and advocacy
- Partner with the patient, family, and team, create care plans using patient-centered SMART goals
- Document and collaborate with PCP team
- Support patients across the continuum of care

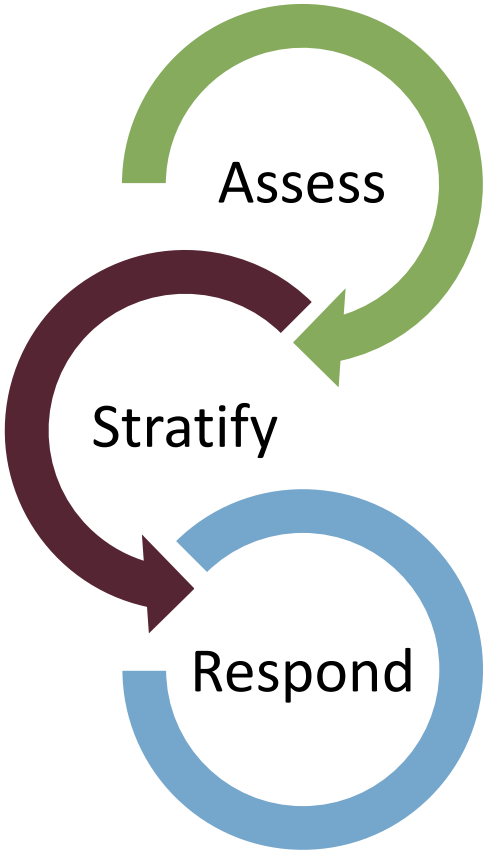
POPULATION HEALTH MANAGEMENT (PHM) SYSTEMS

PHM systems include these capabilities:

- ✓ Data aggregation
- ✓ Data analysis and risk stratification
- ✓ **Care management and coordination**
- ✓ **Patient engagement and outreach**

DATA DRIVING OUR CARE MANAGEMENT MODELS AND POPULATION HEALTH FOCUS

- Data helps us understand your population and tells the story
- Risk stratification drives level of need and determines workflow
- Risk stratification of the population will drive the focus and the staff needed for care management
- Structure and tools support care management
  - Health Risk Assessments
  - Registries and dashboards
  - Case Reviews



Chat Time!!

Respond in the Chat:

How much of your care management has been conducted virtually over the last year?

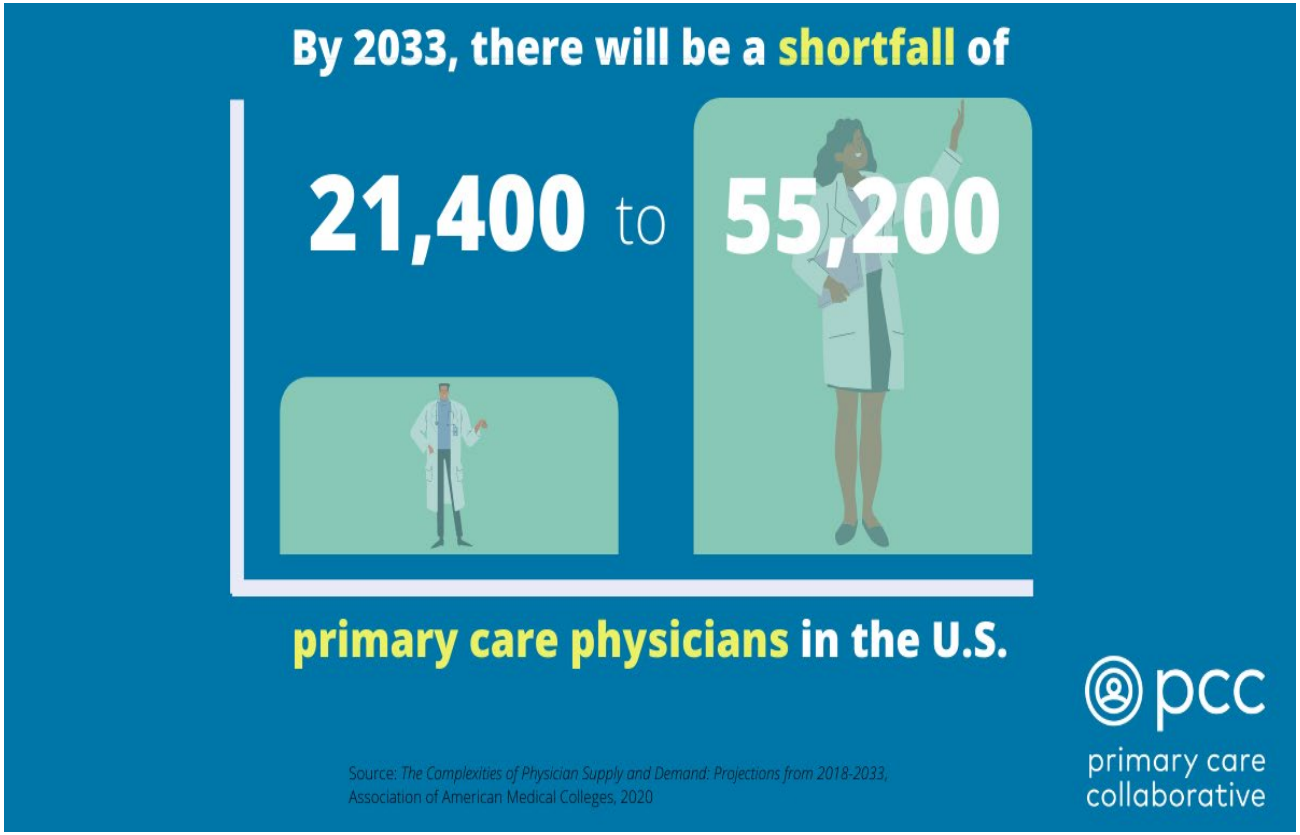
PRE-PANDEMIC: DECLINING USE OF PRIMARY CARE AMONG ADULTS

- 142 million primary care visits among 94 million member-years were examined
- ***Visits to PCPs declined by 24.2%,*** from 169.5 to 134.3 visits per 100 member-years
- ***PCP preventive visits increased*** by 40.6% from 15.1 to 21.5 visits per 100 member-years ***but still only 1 in 5***
- ***Problem-based visits declined by 30.5%*** from 154.5 to 112.8 visits per 100 member-years
- The proportion of ***adults with no PCP visits in a given year rose*** from 38.1% ***to 46.4%***
- ***Visits to alternative venues, such as urgent care clinics, increased by 46.9%***

Ishani Ganguli, MD, MPH; Declining Use of Primary Care Among Commercially Insured Adults in the United States, 2008–2016. Ann Intern Med Feb 2020

PRIMARY CARE WORKFORCE – FACING SHORTAGES

NATIONALLY



The ability of current primary care providers to meet demand is lowest in rural and frontier areas compared with urban areas.

Plus, in the first months of the pandemic, the number of health care visits fell, which resulted in financial losses for many providers, causing layoffs and furloughs within the health care workforce.

THE PANDEMIC HAS CHANGED PATIENT EXPECTATIONS

- ✓ U.S. Centers for Disease Control and Prevention found a 154% increase in telehealth visits during the last week of March 2020, compared to the same dates in 2019, and
- ✓ 61% said the time spent in the virtual waiting room was also shorter than an in-person visit.
- ✓ 79% of patients said that scheduling a telemedicine follow-up visit was more convenient than arranging an in-person follow-up, according to Massachusetts General Hospital.
- ✓ According to the The American Journal of Accountable Care, "The use of telemedicine has been shown to allow for better long-term care management and patient satisfaction."

HYPERTENSION AND DIABETES

- 7 of the top 10 causes of death in 2014 were from chronic diseases.
  - Including: heart disease, diabetes
- Chronic conditions account for 84% of our national health care spending
  - 3.8 trillion-dollars in annual health care costs are driving reform
- Low income, and underserved populations receive lower scores on 40% of quality measures, patient experience and chronic care management scores.
- **Program initiatives such as HRSA HTN management**
- **Remote Patient Monitoring (RPM)**

CHATTERFALL!

What are some of your biggest telemedicine challenges?

FOCUS ON ADAPTING VIRTUAL CARE MANAGEMENT

While many clinics had some ability to provide primary care services via telehealth, COVID-19 has spring-boarded this work to a new level

OPPORTUNITIES

- New payment mechanisms (both federal and states) have made virtual care more possible
- Not all COVID-19 telehealth payment mechanisms will remain in place however many will
- Many patients prefer the convenience of virtual care
- Payers, providers and patients have come to realize that virtual primary care is effective and efficient
- A well-integrated virtual care team can provide comprehensive services to meet the needs of complex patients

FOCUS ON ADAPTING VIRTUAL CARE MANAGEMENT AND PRIMARY CARE

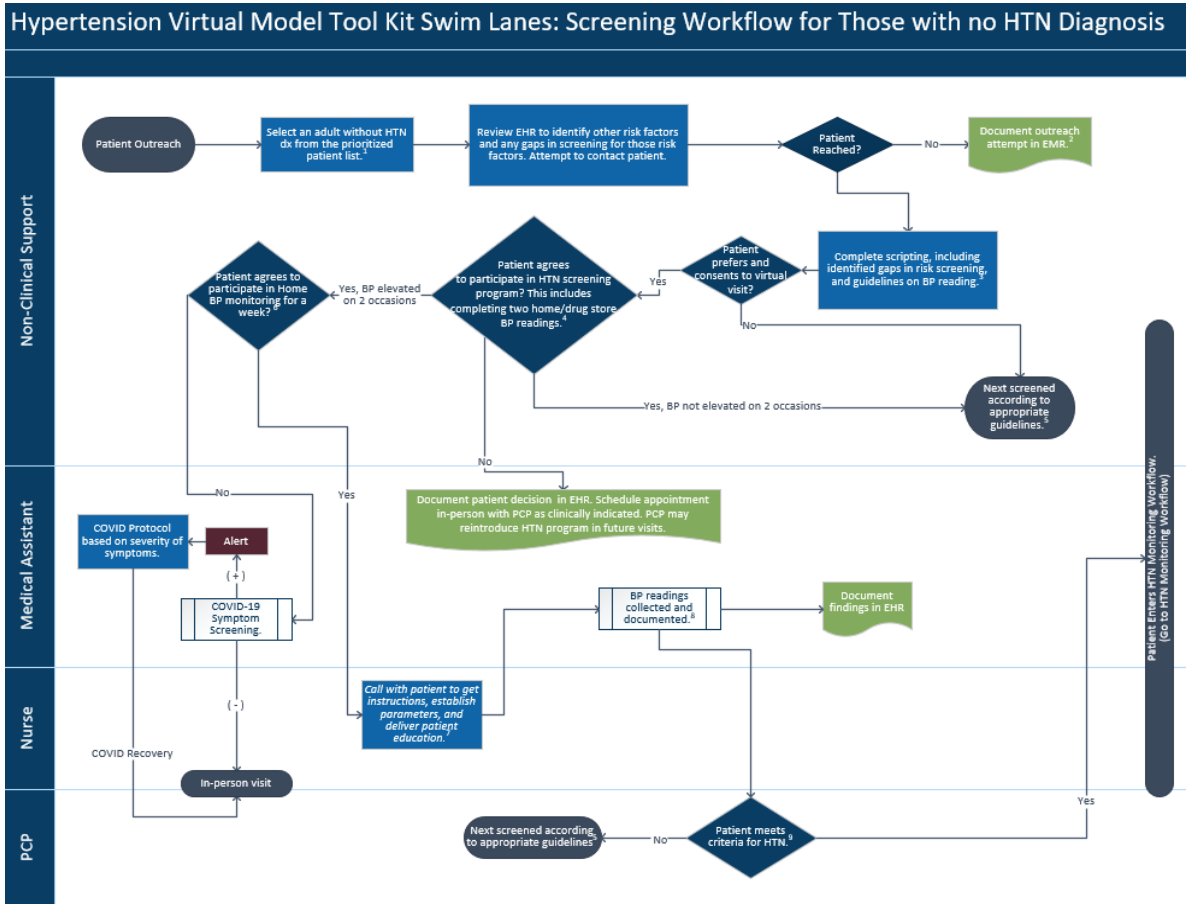
While many providers offer some primary care services via telehealth, the need to adapt practices quickly, shift clinical models, and ensure quality care continues to be a focus

Opportunities and Challenges:

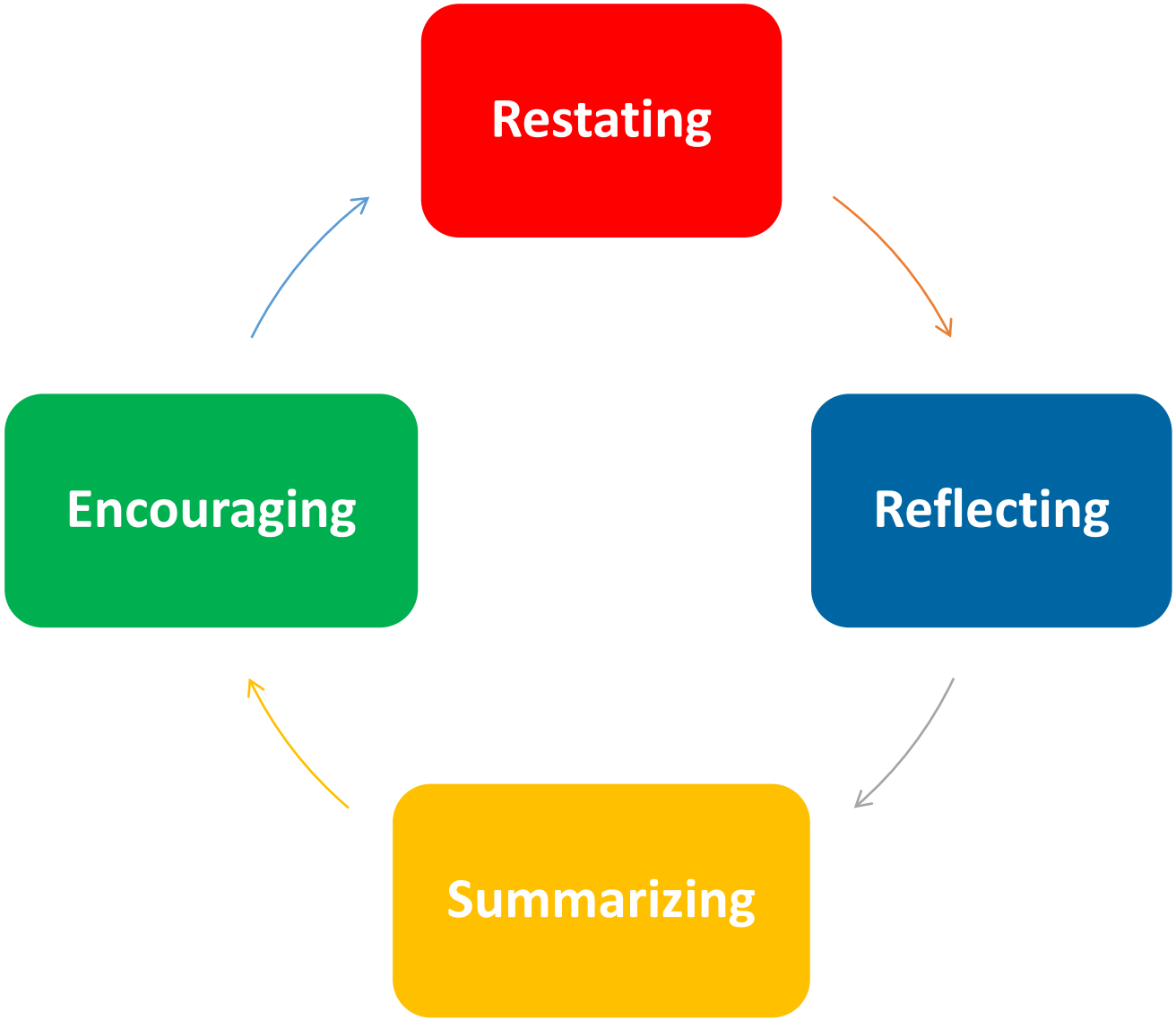
- Care teams risk losing patient allegiance and market share if they do not pivot to new models of care
- To be effective, care management practices need to leverage the multidisciplinary team via telehealth
  - ! Team members need to learn new skills and competencies to be effective providing virtual care
- Patients will require different kinds of supports to manage chronic illnesses via virtual models of care

EXAMPLES OF VIRTUAL CARE MANAGEMENT WORKFLOWS FOR HYPERTENSION

- Prioritizing patients based on risk stratification
- Enrollment of newly diagnosed patients into ongoing self-management
- Patient outreach and engagement
- Coordination for remote patient monitoring device needs
- Patient check in visits for BP updates, labs, etc.
- Ensuring appropriate PCP and specialist visits
- Addressing SDOH in helping to manage HTN
- Patient education



Patient Engagement in Virtual Care Management



Facilitates Population Health Management for the most common chronic diseases

Removes barriers to guideline-based care

Enables provision of education, severity assessments, and routine monitoring

Where appropriate, some of these telehealth services can be delivered by non-clinician staff

Rebuilds practice visit flow with needed and often neglected care

VIRTUAL CARE TOOLKITS CURRENTLY DEVELOPED

Toolkits include resources and tools in the following areas:

- ✓ Virtual care workflows, screening and management
- ✓ Based on evidence-based guidelines
- ✓ Patient engagement and communication tools
- ✓ Patient education, intervention tools and self-management
- ✓ Staff roles and skills needed
- ✓ Training materials

Hypertension Management Program Example: *Self Monitored Blood Pressure & Resources*

Hypertension management program to support identified and at-risk members by using a dynamic and personalized care management approach:

The program has several offerings including:

- Utilization of risk screens for proactive member identification
- Acquiring machines for home Self-monitored Blood Pressure (SMBP) at no cost to the member
- Infrastructure for robust data collection
- Established care team relationships for outreach are a key factor for success; Provider and care team engagement and collaboration

SMBP	Outreach	Toolkit	Scheduling Follow-Up	Ongoing Monitoring
				

AUDIENCE QUESTION:

Moving forward, what would be the next steps to engage in more virtual care for care management?

WRAP UP

- Please complete the poll for a quick evaluation of today's session
- Additional questions in the chat box will be reviewed and responded to after the webinar
- Recording of the webinar will be sent out
- If you would like to request Technical Assistance on this topic or the other webinar topics, please contact the IPCA – a TA request form will also be sent out after this webinar (virtual Models of Care Toolkits, too!)
- Also, collaborative coaching and sharing sessions could be help for smaller numbers of CHC teams, could be regionally etc.
- **Next Webinar is May 24th: Noon – 1:00, Maximizing Fee-for-Service Care Management Revenue and Preparing for Value-Based Reimbursement**