CHRONIC DISEASE WORK GROUP

MARCH 27TH, 2018

Welcome and Introductions

Introduce yourself: Name, organization, and county

WELCOME

Review Proposed Agenda Items

- ✓ Logic Diagram
  - ✓ Domain one investments
  - ✓ Target Population
  - ✓ Core Principals of Chronic Disease Prevention and Control
- ✓ Discussion
- ✓ Next steps and closing

Project 3D - **Chronic Disease Prevention and Control**
Goal: Integrate health systems and community approaches to improve chronic disease management and control.

1.) Project Implementation Plans Due 10/31/18

2.) Implement plans by 12/31/19

CPAA Investments/Inputs

Value Based Payment
Training/Technical Assistance/Workforce
- Chronic Care Model
- Chronic Disease Self Management Program
- Community Paramedicine
- Develop learning collaborative
- Support hiring additional staff
- Increase awareness and establish connections to community resources

Population Health Management
- EHR system support
- HIE expansion to coordinate care

Financial Sustainability
- Start up costs to incorporate EB Chronic Disease Control tools
- Support to Expand Paramedicine

Partner Inputs

- Implement changes in staff configurations and workflows to conform with EBM for chronic disease prevention and control
- Conduct universal screenings of Chronic Disease
- Establish and maintain relationships with partnering providers.
- Make investments in HIE
- Build and/or expand on relationships with community resources for chronic disease management
- Utilize MCO to distribute information about community resources to targeted populations
- Expansion of home visiting and programs to address environmental concerns
- Identify champions

Implement 6 Pillars of Wagner's Chronic Care Model in the Primary Care

1. **Self Management Support**
   a) Providers will assist patients with self management goals by using evidence-based self-management tools, using group visits to support self management, setting and documenting self management goals collaboratively with patients and systematically monitoring and following up on those goals
      - Utilize "Assessment, Advice, Agree, Assist and Arrange" protocol from CCM
2. **Decision Support: Provide Clinical Care that is consistent with scientific evidence and patient preferences**
   a) Embed evidence based guidelines into daily clinical practice and share these guidelines with patients to increase their knowledge and confidence in self management of chronic diseases.
   b) Integrate specialty expertise in primary care
   c) Use "teach back method" to ensure patients understand plan
3. **Delivery System design**
   a) Use registry to regularly assess disease control, adherence and ensure follow up is taking place.
   b) Using planned interactions to support evidence based care
   c) Standardized Referral process to CDSM or community resources for social determinants of health
   d) Provide clinical case management services for complex patients
4. **Clinic Information System (Population based Care)**
   a) Utilize a registry to:
      - provide care reminders for providers and identify relevant patient subpopulations for proactive care
      - Facilitate individual patient care planning
      - Monitor performance of team.
5. **Community Based Resources**
   a) Encourage Patients to participate in effective programs
   b) Form partnerships with community organizations to support and develop interventions that fill gaps in needed service
6. **Health Care organization**
   a) Develop quality improvement process by reviewing clinical data, quality of care and patient satisfaction. Incentives can be provided based on quality of care
   b) Develop agreements with community organizations to facilitate coordination of care.

Chronic Care Support from the Community

1. **Self Management Support**
   a) Community based resources for chronic disease self management will establish linkages to PCP/ED and maintain a fixed proportion of open appointments
2. **Clinic Information System**
   a) Community based resources will utilize a registry with the capacity for bidirectional information sharing for care coordination
3. **Community Based Resources**
   a) Community based resources will establish linkages to PCP/ED and maintain a fixed proportion of open appointments to provide services that address transportation and/or housing social determinants of health.
4. **System Organization**
   a) Develop quality improvement process by reviewing data, quality of care and patient satisfaction. Incentives can be provided based on quality of care
   b) Develop agreements with community organizations to facilitate coordination of care.

Supplemental Activities to Chronic Care Model in the Primary Care and Community

Implement an evidence based chronic disease management tool
a) Implement Stanford Chronic Disease Self-Management Program
b) Million Hearts Campaign or the similar initiative Healthy Hearts Northwest
c) CDC National Diabetes Prevention

Partner with EMS/Community Paramedicine

Cross Project Elements

Bi-Directional Care Coordination
- Once established with a PCP implementing collaborative care, behavioral and physical healthcare services can be integrated and the patient can be exposed to whole person care.

Pathways
- At risk populations can be linked to HUB
- The HUB can be used to identify and social determinants of health affecting CPAA chronic disease population (Housing, Education and Social Service Referral HUB)
- Education about conditions, medications or needed services (Education and Medication Management Pathways)
- Will address comorbid BHD (Behavioral Health Pathway)
- Increase access to care for adults and children (Medical Referral, Health Insurance, Developmental Screening and Medical Home Pathways
- Support prevention and control of CD (Medication Management and Smoking Cessation pathways)

Transitional Care
- Patients with a chronic disease diagnosis being discharged from acute care can receive referral for Evidence-Based Chronic Disease Management tool.

Opioid Response
- Physicians can utilize the "Assessment, Advice, Agree, Assist and Arrange" protocol from CCM to incorporate MAT treatment and referral to SUD community resources

Reproduction & Maternal/Child Health
- Chronic disease screenings and referrals for chronic disease self management programs can be done at post partum checkup

Target Populations

- **Medicaid beneficiaries with an Asthma diagnosis that do not have an up to date Asthma Action Plan**
  Sub Group: residents of Grays Harbor, Lewis, and Wahkiakum counties
- **Two or more hospital ED visits in the last 6 months and one or more chronic illnesses**

Medicaid beneficiaries with an Diabetes diagnosis
Sub Group: Mason, Thurston, and Grays Harbor counties
Sub-Group: that have not completed an annual Eye exam or HbA1c Test

- **Medicaid beneficiaries with heart disease**
  Sub Group: Thurston, Lewis and Mason Counties
- **Medicaid beneficiaries in the CPAA region with tow or more chronic diseases or with one or more chronic disease and a comorbid behavioral health disorder**

3D Pay for Performance Metrics

Child and Adolescence Access to PC
- Ages 12-24 months
- Ages 2-6 Years
- Ages 7-11
- Ages 12-19

Inpatient hospital utilization
(18-64)

Medication Management asthma
(5-64yrs)(75% compliance)

Outpatient ED visits
per 1000 member months

Percent Homelessness
(Narrow Definition)(18-64)
(exclude duals)

Statin Therapy for Cardiovascular Disease Prescribed

Comprehensive Diabetes care
- Eye exam, retinal
- HbA1c Testing/hemoglobin
- Medical attention for Neuropathy

Domain 1 Investments

Training/Technical Assistance/Workforce

- Chronic Care Model
- Chronic Disease Self Management Program
- Community Paramedicine
- Increase awareness and establish connections to community resources

Population Health Management

- EHR system support
- HIE expansion to coordinate care

Financial Sustainability

- Start up costs to incorporate EB Chronic Disease Control tools
- Support to Expand Paramedicine

Domain 1 Investments Discussion

Discussion 1:

- **How can we support partnering providers in the development/expansion of HIE and/or the implementation of evidence based approaches**

Discussion 2:

- **Which domain 1 investments should be highest priority and which are the lowest priority?**
- Discussion 3:
- **What change management software or high level reporting toolkits are organizations using?**
- **What are some potential barriers and gaps in data practices of potential partners?**

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Financial Sustainability

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Proposed Target Population

PAY FOR PERFORMANCE METRICS

- 1.Child and Adolescence Access to primary care
  - Ages 12-24 months
  - Ages 2-6 Years
  - Ages 7-11
  - Ages 12-19
- 2.Inpatient hospital utilization (18-64)
- 3.Medication Management asthma (5-64yrs)(75% compliance)
- 4.Outpatient ED visits per 1000 member months
- 5.Percent Homelessness (Narrow Definition)(18-64) (exclude duals)
- 6.Statin Therapy for Cardiovascular Disease Prescribed
- 7.Comprehensive Diabetes care
  - Eye exam, retinal
  - HbA1c Testing/hemoglobin
  - Medical attention for Neuropathy

PROPOSED TARGET POPULATIONS

- **Medicaid beneficiaries with an Asthma diagnosis that do not have an up to date Asthma Action Plan**
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Core Elements of Implementation

IMPLEMENT 6 PILLARS OF WAGNER'S CHRONIC CARE MODEL IN THE PRIMARY CARE

1. **Self Management Support**
   a) Providers will assist patients with self management goals by using evidence-based self-management tools.
2. **Decision Support: Provide Clinical Care that is consistent with scientific evidence and patient preferences**
3. **Delivery System design**
4. **Clinic Information System (Population based Care)**
   a) Utilize a registry
5. **Community Based Resources**
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CHRONIC CARE SUPPORT FROM THE COMMUNITY

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Questions for the Group

- What does implementation of the 6 pillars of Wagner's Chronic Care Model look like for your organization?

1. What would be the most beneficial to implement?
2. What would require the most support/changes to implement?
3. What would be the easiest pillar to implement or perhaps is already implemented?

Next Work Group

- April will be a in person meeting

- Topics for next meeting?

Next Steps and Closing

- Develop LOI/RFP
  - RFQs are being reviewed
  - Format to follow
- Assessment survey has been extended until March 30th.
- Potential chronic disease event in collaboration with Qualis taking place early May.
- Group follow-up to Alexandra Toney **toneya@crhn.org**
  - Submit any requested training or work group
  - Feedback on logic diagrams

Thank You!