Bridging the Gap: Using Comprehensive Approaches to Manage HTN and Diabetes

IHC Care Coordination Conference
June 15, 2016

Agenda

• About The Iowa Clinic
• Commitment to Population Health
• Focus on HTN and Diabetes
  – Measure Up Pressure Down
  – Together 2 Goal
• Successes, Lessons Learned, & Future
• Questions

Largest Physician Owned Multi-Specialty Clinic
More than 200 providers; 40 specialties
400,000 patient visits annually
10 locations
Primary Care locations: Level 3 PCMH recognized
Road to Population Health

• Pilot Program June 2014
• Full Implementation January 2015
• Staffing

Population Health Goals

• Improve overall health and health outcomes
• Decreasing costs to consumers
• Improving consumer satisfaction
  – The Iowa Clinic Experience

Improve Health and Outcomes

• Identifying high risk populations
• Close care gaps
• Care management
  – High Risk
  – Transitional
• Clinical Health Coaching
• Patient Centered Medical Home
Decrease Consumer Costs

• Post acute follow up: Patient education, PCP visits
• Identifying barriers to care, & high risk behaviors & conditions early
  – Care gaps
  – Annual well care visits
• Focus on high cost meds, utilization, service location

The Iowa Clinic Experience

• 5 STARS EVERY TIME
• Press Ganey
• CG-CAHPS: GPRO

The Fourth Aim: Transparency

• Critical to success of Pop Health program
• Monthly reports to providers
  – Quality performance measures
  – Cost/Spend/Utilization
• Measure results to Board
Resources
- Clinical Care Committee
  - Protocol development
  - Monitoring performance results
- Physician Champions
  - Education
- Community Resources
  - Iowa Department of Public Health
  - Dallas County Public Health Care Coordination
  - Telligen: Diabetic Self Management Education
  - Hy-Vee, Million Hearts, Diabetic Assoc, Heart Assoc, etc

Targeted Focus: Diabetes & HTN
- 64,725 Primary Care patients (12/31/15)
- 22,258 patients dx of Diab and HTN

Initiatives
- American Medical Group Association (AMGA)
  - Measure Up Pressure Down (1/1/2013)
  - Together to Goal (1/1/2015)
- IDPH Grant
  - Clinical Innovations HTN and Diabetes
- Dallas County Public Health
  - Care Coordination focus on Diabetics
HTN Focus

- **Measure Up Pressure Down**
  - Measurement period 1/1/13-12/31/14
  - Focus: BP check every patient every visit – even specialists

- **IDPH Clinical Innovations: HTN portion**
  - Measurement period 9/1/15-6/30/16
  - Focus: Pt education: Self management, self monitoring, diet & exercise. Community resources: connecting patients

HTN Outcomes

- **Measure Up Pressure Down**

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<thead>
<tr>
<th>BP in control &lt;140/90</th>
<th>BP not recorded at visit</th>
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<tr>
<td>63%</td>
<td>76%</td>
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<td>1/1/2013</td>
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- **IDPH Clinical Innovations: HTN**

<table>
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<tr>
<th>BP &gt; 140/90</th>
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<tr>
<td>83%</td>
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<td>81%</td>
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<td>9/1/2015</td>
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<td>12/1/2015</td>
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Diabetic Focus

• Together 2 Goal
  – Brand new initiative
  – Baseline data received 5/20/16
  – Measurement period: 1/1/15-12/31/16
  – Focus: Improve care for 1 million people with Type 2 Diabetes
    • Empowering patients
    • Improve care delivery
    • Leverage information technology
• IDPH Clinical Innovations: Diabetes portion
  – Measurement period 9/1/15-6/30/16
  – Focus: Pt education: Self management, self monitoring, diet & exercise. Community resources: connecting patients

Diabetes Outcomes

• Together 2 Goal: Baseline Data
  – 61.4% pts HbA1c <8.0
  – 21.0% pts have no HbA1c recorded
  – 77.0% pts BP <140/90
  – 2.4% pt have no BP recorded
  – 83.6% pts have received medical attn for nephropathy
  – 67.1% pts have Rx of statin or documented reason

• IDPH Clinical Innovations: Diabetes
  – HbA1c > 9.0
  – 90% in 9/1/2015
  – 89% in 12/1/2015
  – 90% in 9/1/2015
  – 89% in 12/1/2015
Lessons Learned

- Physician champions crucial to provider engagement and buy in
- Important for Care Managers to meet patients during office visits
  - Sets foundation for developing relationships
- Continuous monitoring and feedback
  - Not just to CMs, but providers as well
- Transparent reporting drives change
  - Physicians are competitive by nature

Looking to the Future

- Together 2 Goal
- At risk contracts
- Pre-Diabetics and rising risk patients
- Possibility of diabetic education program