Care Coordination Newsletter

NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM

CC Spotlight

This month we would like to recognize the team at McKenzie Health System for their innovation with the Prevention/Wellness initiative. Leaders Billi Jo Hennika, VP of Operations and Deborah Ruggles, Director of Healthcare Practice along with their team have managed to successfully complete over 1,000 wellness visits, exceeding the amount of their attributed lives. They also welcomed their new Care Coordinator Heather Merriman, RN who since joining the McKenzie team in September has contacted over 300 patients to build her caseload. Heather's passion for managing chronic disease patients and coordinating their care is a welcome compliment to this high performing care team. See the "tip of the month" to learn about the wellness innovation strategies at McKenzie.

Cardiovascular Disease Preventive Health Strategies

Now that the New Year is upon us, we all profess our resolutions to make improvement in our health ranging from dieting and more exercise to changing lifestyle habits overall. Those of us in healthcare understand clearly the prevalence of Americans living with Cardiovascular Disease (CVD) and that Coronary Heart Disease (a result of CVD) is the #1 cause of death in the U.S.. Coronary Heart Disease accounts for the largest total cost burden of approximately $165.4 billion followed by hypertension, stroke and heart failure also caused by CVD. Of the approximate 81 million Americans living with CVD, 43.7 million of them are above 60 years of age (Source: American Heart Association, 2015). With the adult population (age 65-84 years) expected to grow 16% by 2050, expanded CVD prevention is needed to promote successful aging and increase functional life vs. survival rates alone in order to reduce healthcare costs moving into the future (Source: www.nih.gov, 2010). According to an article published by the Cleveland Clinic in June of 2015, more

Tip of the Month

McKenzie's wellness program success, as shared by Billi Jo Hennika, began with leadership taking this initiative forward and making it a priority. Their Preventive Care Coordinators, look at the patient schedules and change patient visits to wellness visits if appropriate. They also run reports to see which patients have not been in for their annual wellness visit and make calls to those patients to get them scheduled. The providers in the practices take this initiative very seriously and ensure that staff schedule the patient for their next wellness visit in one year before leaving the office. Billi Jo emphasizes that their success is due to a tremendous team effort with everyone on the team making this initiative a priority.

than 17 million Americans with CVD have Coronary Artery Disease (CAD), the build up of fat within arteries around the heart (also known as atherosclerosis). Elevated Low-density-lipoprotein (LDL) cholesterol levels are known to contribute to atherosclerosis and has become a major indicator of risk for CAD and Stroke. Statin therapy drugs have been utilized to combat high LDL levels in patients for the past several years. Based on numerous randomized control trials and expert panel peer review of this evidence, the American College of Cardiology and the American Heart Association issued clinical guidelines in 2013 shifting the sole focus of statin use on LDL target levels to specific groups of patients who might benefit most from this therapy (Source: www.aafp.org).

Subsequent to the publishing of the statin use clinical guidelines, the Center for Medicare and Medicaid Services (CMS) proposed and adopted for the 2016 Medicare Shared Savings Program (MSSP) an additional quality measure related to statin therapy. This is the 34th ACO Measure and is focused on reporting the percentage of beneficiaries who were prescribed or were already on Statin Medication Therapy during the measure year and who fall into any of 3 categories:

1. High-risk adult patients (>21 y.o.) who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic CVD.

2. Adult patient (>21 y.o.) with any direct or fasting LDL cholesterol level >190mg/dL

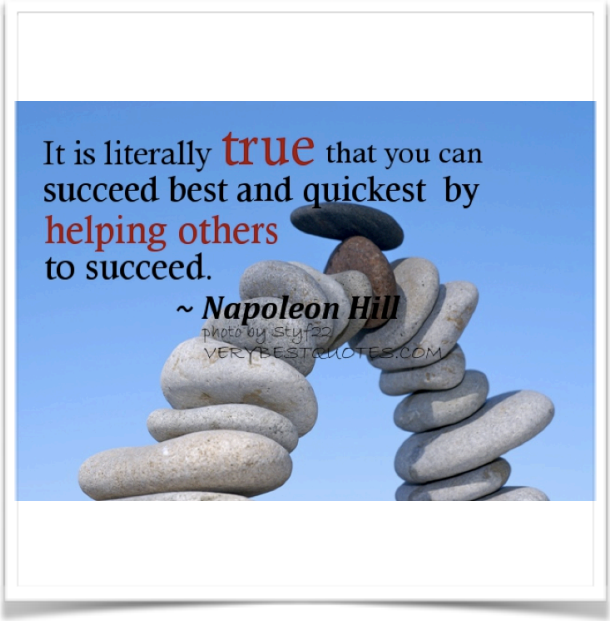
3.Patients aged 40-75 with a diagnosis of diabetes with a fasting LDL cholesterol level of 70-189 mg/dL who were prescribed or were already on statin medication therapy during the measurement year.

This new quality measure will be a "reporting" measure and not a performance measure for the next three years.

Though statin medication therapy is being found to have value in reducing CVD, lifestyle modifications remain critical to atherosclerosis/ CVD reduction. Promoting a renewed spirit for effecting positive lifestyle change in 2016 in our health coaching activities with patients remains our most valued prevention health strategy.

Tremendous work by all of our Community Care Coordinators and Coaches in 2015!

Keep sharing your stories in 2016 as more Rural Communities join us in this transformational journey



Patient Stories from the Field

Case #1: This patient was signed up for PCHH program on 8/27/15. The CC initial encounter with this patient was on 11/12/15. This patient was very non adherent with her medications. She was taking Coumadin and her PT/INR were way out of range due to her lack of adherence in medication management. She did not know what any of her medications were and was basically just taking what she wanted when she wanted. Since working with this patient she now has a home health nurse who sets up her meds weekly. She may not know the specific name of her medications, but she now knows that the "white pill is for blood pressure, and I take it every day." This patient was calling her PCP daily, several times for multiple reasons. She now does not call the clinic like she used to and her PCP has the CC set in with her on all of her appointments because she is more receptive to what he has to say when the CC is present. She is on the CC weekly call list so that way she can keep the patient on track with her health and medications.

Case #2: This patient was signed up for PCHH program on 9/17/15 with the initial CC encounter was on 10/5/15. This patient was an ER frequent flyer with 2 visits in September and 3 in October due to her non adherence with her asthma plan of care. This patient did not take her asthma medications, smoked, and never made any follow up appointments. During her admission in November for respiratory distress the CC was able to meet her and educate on the affects asthma and how her non adherence to her plan of care was having on her life at such an early age. Since their meeting, the patient filled her prescriptions for her asthma medications and made her first follow up appointment with her PCP. She is now on the CC weekly call list and has not had any ER visits since discharge.

Case #3: A 61 y.o. female was referred to care coordinator (CC) by the PCP office in early May for chronic illness management (and a 28 pound weight gain in 2 weeks – non CHF related). Patient has hx. of COPD (on continuos home oxygen), CHF, HTN, CKD, PVD with weeping non-healing wounds to bilateral lower extremities (LE), and depression. Her BMI=77.40 a year ago, GFR=26 from April 2015. Patient was noted to be cooperative, pleasant, and motivated. Goals were set per patient which included LE wound healing and weight loss. Was noted in the EMR from previous hospitalization earlier this year that the patient was to follow-up with a nephrologist (per patient, was unaware of this). Early into care coordination with the patient, appointments made to followed up with the nephrologist & a physician at the wound care clinic. Patient showed good adherence with medication treatment and physician appointments, seeing specialist in a timely fashion, and compliance with treatment plan. Currently, patients BMI 12/2015=67.48 and GFR=46 and LE wounds are healed for the last 3 months. Several written educational tools have been provided, reviewed, and referred to during CC encounters. The tools include COPD & CHF zones and healthy eating instructions. Per patient, she states she has placed the two "Zone" educational tools on her refrigerator to refer too. Home health (HH) services was implemented early on for added support and resources. A collaborative relationship was established with the HH nurse to develop the patients plan of care. HH service was discontinued last month.

During the weekly CC phone encounter (weekly encounters with CC as she has had a UTI and upper respiratory infections and was on steroids for a few weeks), pt. stated she had a 15 pound weight gain over the last 2 weeks. Patient stated she had a new onset of bilateral ankle edema and increase swelling to abdomen and noted in the last week an increase in shortness of breath (SOB) on exertion. The CC did not note any SOB, wheezing, or difficulty finishing her sentences during their phone conversation. Pt. states called the PCPs office and was referred to contact the nephrologist. Pt. states did not mention the ankle swelling or increased SOB to the PCP office. CC contacted the PCP and patient was seen earlier that afternoon. VSS, O2 sat=97% on 3L per N/C (normal setting), lungs clear but diminished with no wheezing. Changes made in oral diuretics and with help from the CC, an earlier follow-up appointment was made with the nephrologist.

Case #4: A 59-year-old male patient with diabetes and CHF was referred to the diabetes educator. In October, the Care Coordinator received a message from the diabetes educator reporting the patient had been to see her that day. During the visit, she discovered he had been out of Toujeo and Novolog for two weeks and did not have the money to refill the prescriptions. Fasting blood sugars were running in the 300's. The patient's diabetes is managed by his PCP, so the Care Coordinator reported this to the PCP's nurse. That office had samples of Humalog, but not Novolog, and had samples of Toujeo. The nurse obtained orders to switch from Novolog to Humalog and was able to provide samples of both medications.

In November, the diabetes educator called stating she just finished meeting with the patient and she was sending him to see the Care Coordinator. She reported the patient had edematous, erythematous bilateral lower extremities. When the patient arrived at the Care Coordinator's office minutes later, his legs were assessed and found to be as previously described. The skin was also cracked and weeping serous fluid. The patient informed the Care Coordinator they had been that way for approximately 4 days. The PCP's office was immediately contacted and the patient was scheduled to see one of the other physicians in the office that same day. He was started on antibiotics and was successfully managed as an outpatient.

When the Care Coordinator met with the patient early in December, they discussed both situations to help him discover ways he could approach similar problems in a more effective manner. The patient verbalized he now recognizes that he

cannot wait to seek help when his legs begin to swell and he also cannot go without his insulin. He stated in the future he will call when he needs medication samples and he also will not delay in calling the next time his legs swell.

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