Coordinated Team Approach to Address Patients with Multiple Gaps in Care

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STATEMENT OF PROBLEM

While population management interventions have largely focused on outreach for a specific disease or screening test (care gaps), a more coordinated and integrated approach is needed to address patients who have multiple care gaps. Lack of coordinated outreach efforts contributes to patient disengagement.

AIM

- Merge multiple data sources in a meaningful way to determine true patient care gaps
- Coordinate effective outreach programs to minimize efforts and engage patients
- Engage care team members in timely care gap closure

INTERVENTION INCLUDING CONTEXT AND MEASUREMENT

- Healthcare Associates is a large academic primary care practice at BIDMC.
- Program was designed as a pilot to address care gaps in a subset of the HCA population, 4359 patients, under one payor contract. Using data from OMR and insurance claims, we identified 883 patients with one or more gaps in care. In total, these patients had 1489 care gaps.
- A report was designed to combine care gap lists that were based on condition or preventive health screening and appointment data into a single, patient-focused report, listing all care gaps identified for each patient.
- The care gaps included preventive and wellness measures for colorectal, breast, and cervical cancer screening; chlamydia testing; adolescent well visits; for patients with diabetes: A1C testing (frequency and results), diabetic retinopathy screening, and urine microalbumin testing; for patients with hypertension, blood pressure.
- Those patients needing appointments in the practice without an upcoming visit scheduled, received outreach to schedule the appropriate length appointment. Patients who only required follow-up with a specialty (e.g., mammogram) were also called to review gap and facilitate scheduling.

APPROACH TO ASSESS PERFORMANCE AND SUCCESS

Assessment will include:

- Measures of success include effectiveness of outreach, point of care reminders, and care gap closure.
- For those patients with care gaps without an upcoming scheduled visit, we measured outreach effectiveness by the percentage of patients outreached who scheduled an appointment, and the percentage of those patients within the cohort who kept their appointments.
- The impact of point of care reminders effectiveness is measured by the percentage of patients whose care gaps are addressed at the visits.
- Overall effectiveness was measured by reporting the total rate of care gap closure as well as the total number of patients for whom all care gaps have been closed.

FINDINGS TO DATE

Outreach activities:

- 577 (65.3%) patients were missing a single care metric and 306 (34.6%) patients had two or more care gaps.
- 364 of 883 (41.3%) patients were identified for outreach.
  - For patients needing primary care appointments, 129/235 (54.8%) patients scheduled appointments. Of those 129 appointments, 89.9% were kept.
  - There were 129 patients who were called for assistance in addressing care gaps by specialty providers. Results of this latter outreach in calculating the number of care gaps subsequently completed by patients with specialty care is not yet available - data from claims/EHR will be analyzed.
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FINDINGS TO DATE (CONTINUED)

- HCA Performance on select Quality Measures by Payor by Month, Impact of targeted multi-care gap intervention piloted for BCBS:

  ![Graphs showing performance trends.]

- As of 12/31/2015, 204 (23%) patients had closed all care gaps, and 548/1489 (36.8%) total care gaps had been closed. 413/941 (43.9%) remaining care gaps represent procedure need to be done outside of primary care (mammogram, colonoscopy, and diabetic eye exams) including the 129 patients who received outreach for only these care gaps.

- Final results to be available mid-March

LESSONS LEARNED

- Timely data-driven patient centered care is essential for the success of population health management.
- Lack of coordinated outreach efforts contributes to patient disengagement.
- Utilizing only claims is inefficient due to inherent time lags associated with this data. Conversely, EHR data often fails to capture procedures done external to the respective health network. Efforts directed to address patients’ care gaps must integrate both sources of information and then coordinate patient centered strategies to affect them.
- It is the combined effects of identification of patient care gaps prior to patient visits by using large data pools, outreach by clinical support staff, introduction of care needs by medical assistants, and ultimately timely and direct provider-patient interactions that leads to success in these measures.

NEXT STEPS

- Strategize how to expand this pilot to cover entire HCA population using the Population Health Database.
- Analyze traditional HCA outreach efforts to determine how to better communicate entire range of preventative health measures on a patient by patient basis.
- Identify additional opportunities to engage non-physician and non-nursing staff in population health efforts.