12-month Outcomes of Community Care Teams for Primary Care Practices Transforming towards PCMH

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Background
The transformation of primary care to PCMH is one of the fundamental strategies for achieving higher quality care at lower cost. Multidisciplinary team-based care is also considered a crucial tactic for meeting our society’s healthcare needs.

The Lehigh Valley Health Network (LVHN) enhanced support to primary care practices by deploying multi-disciplinary teams called Community Care Teams (CCT) to practices to help manage their high-risk patients. The premise was that CCTs should help at the earliest possible stage.

Practice level: CCTs should increase overall practice effectiveness/efficiency by offsetting some of the workload from high-risk patients.

Patient level: CCTs should improve outcomes of patients directly managed by the CCT team.

Purpose
Evaluate the effectiveness of CCTs within the LVHN model, both at the practice level (patients not engaged with CCT but belonging to practices with CCTs) and patient level (patients directly engaged with CCT services).

Intervention
Modelled after Vermont Blueprint for Health, each CCT was designed to support 3 to 4 primary care practices in the short-term management of high-risk patients with chronic diseases.

Each team consisted of a RN Care Manager, who functioned as the team leader, a behavioral health specialist, a social worker, and a clinical pharmacist.

Management: CCT provided support for disease self-management and goal setting, addressed behavioral health, social, and economic problems, and connected the patient to Network and community resources.

DC Reconciliation: Hospital discharge reconciliation phone calls
Wellness: Patients engaged with CCT practices compared with those patients not engaged with CCT had a significantly lower probability of unplanned admission and readmission.

High Risk Registry
Patients were identified for CCT services either (a) through a high-risk registry developed internally by a lead physician specialized in informatics; or (b) on-site clinician referrals to the CCT team.

Methods

Practice Selection:
Wave 1 (July 2012): 3-year experience with practice transformation in South Central PA


Wave 2 (July 2013): population with perceived greatest need, more urban practices with transitory patient panels.

Setting:
LVHN, a large health care delivery system in southeastern PA, serving 5 counties and moving towards ACO but still operating in a fee-for-service environment.

Design and Participants:
A nonrandomized longitudinal study design comparing the CCT practices/patients with non-CCT comparison groups.

Practice level (Wave 3) analyses compared 29,881 patients (5% high risk) from the 6 CCT practices not receiving team services to 22,360 (5% high risk) from 3 non-CCT practices which were also transforming towards PCMH.

Patient level (Wave 1) analysis: 406 patients received CCT services (68% high risk); 176 care management and 230 hospital discharge reconciliation calls. These patients were compared to 406 patients from the same CCT practice who did not receive CCT services.

Practice Level Outcomes: Within group analyses were used due to significant group baseline differences for some outcomes.

Wave 1: There were significantly reduced probabilities of an unplanned admission and readmission post-CCT for patients in CCT practices but not in non-CCT practices, but only among high-risk patients.

While there was significant improvement for other quality indicators, it occurred for both CCT practices and non-CCT practices transforming towards PCMH.

Survey Data: There was no significant change in Practice Joy (MQoL) or Patient satisfaction (CHAPSI).

Conclusion:
While more rigor will be brought to future analyses, we hope to overcome this limitation via propensity score matching and multilevel modeling.

Another major gap was the need to improve the strategy used for selecting patients for CCT intervention. Despite the use of a predictive risk score, prioritizing the very large list of high-risk patients remains a challenge. We hope that the addition of a brief measure of patient activation will be particularly helpful for selecting the riskiest/costliest patients for CCT intervention as well as tailoring CCT services to different types of patients.

While more rigor will be brought to future analyses; we hope the current evaluation highlights the utility of performing such formative evaluations.