

RIGHT CARE INITIATIVE
TEAM BASED CARE:
A LOCAL EXAMPLE
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Three Care Management Projects: Lessons Learned



- Diabetes Care Management
- Heart Failure Care Management
- Depression Care Management

Diabetes Care Management

- 2 year Pay for Performance Funded Project
- utilized team* - reached out to patients identified via EMR reports to have suboptimal care and engage them in self-management activities
- improved the coordination of care of patients with Type 2 diabetes and increase their follow-up, access to education and appropriate specialty care *via care management.*

*Team = LVN, Certified RN Case Manager, Pharmacist, Analyst, Statistician

Diabetes Care Mgmt: Outcome Data 2011

Category	Pre Care Mgmt (average)	Post Care Mgmt (90-180 days post, average)	Change
A1c (n=49)	7.9	7.5	-0.4*
BP (n=65)	141/80	131/75	-10*/-5*
LDL (n=32)	98	91	-7

* Values statistically significant

- Patient experience (n=89)
 - I appreciated being contacted by UCDHS to help me with my diabetes care. **4.6**
 - How would you rate your overall experience with this phone contact? **4.8 (79% excellent)**
 - Would you welcome being contacted by UC Davis Health System for similar referrals in the future? **100% yes, including those who declined any offered services**

Heart Failure Care Management

- 1 year Pay for Performance Funded Project (data being compiled)
- Utilized a multi-disciplinary team: Certified Heart Failure RN, Pharmacist, PCP, Cardiologist – HF specialty, TOC team
- Goals:
 - ▣ increase primary care provider heart failure knowledge
 - ▣ support heart failure patients
 - ▣ reduce preventable ED visits, admissions and re-admissions to hospital
- Primarily telephonic after one clinic visit in the PCN
- Education and medication needs addressed
- PCP kept in the loop
- Provide PCP Education series

Heart Failure Outcomes

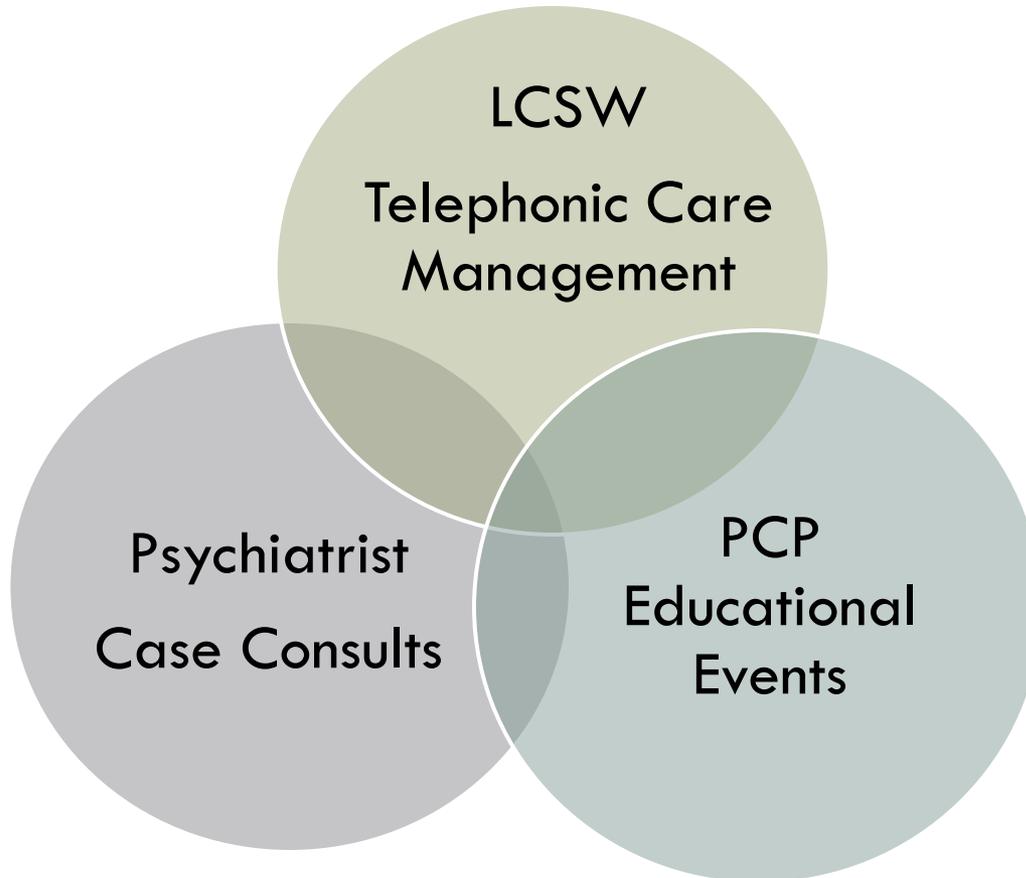
- Data presently being compiled include:
 - Appropriate medication regimen
 - Medication adherence
 - NYHA Functional Class
 - Hospitalizations, re-admissions, ED visits

Depression Care Management

- 2 year Pay for Performance Funded Project
(presently finalizing data)
- Goals:
 - ▣ increase primary care depression knowledge
 - ▣ support patients with co-morbid depression through telephonic contact
- utilize multi-disciplinary team

Depression Program Overview

8



PHQ-9 Scores: Average Reduction

9

2011 n=19

➤ PRE: 19

Moderately Severe

➤ POST: 12

Moderate depression

2012 n=45 and counting

➤ PRE: 16

Moderately Severe

➤ POST: 9

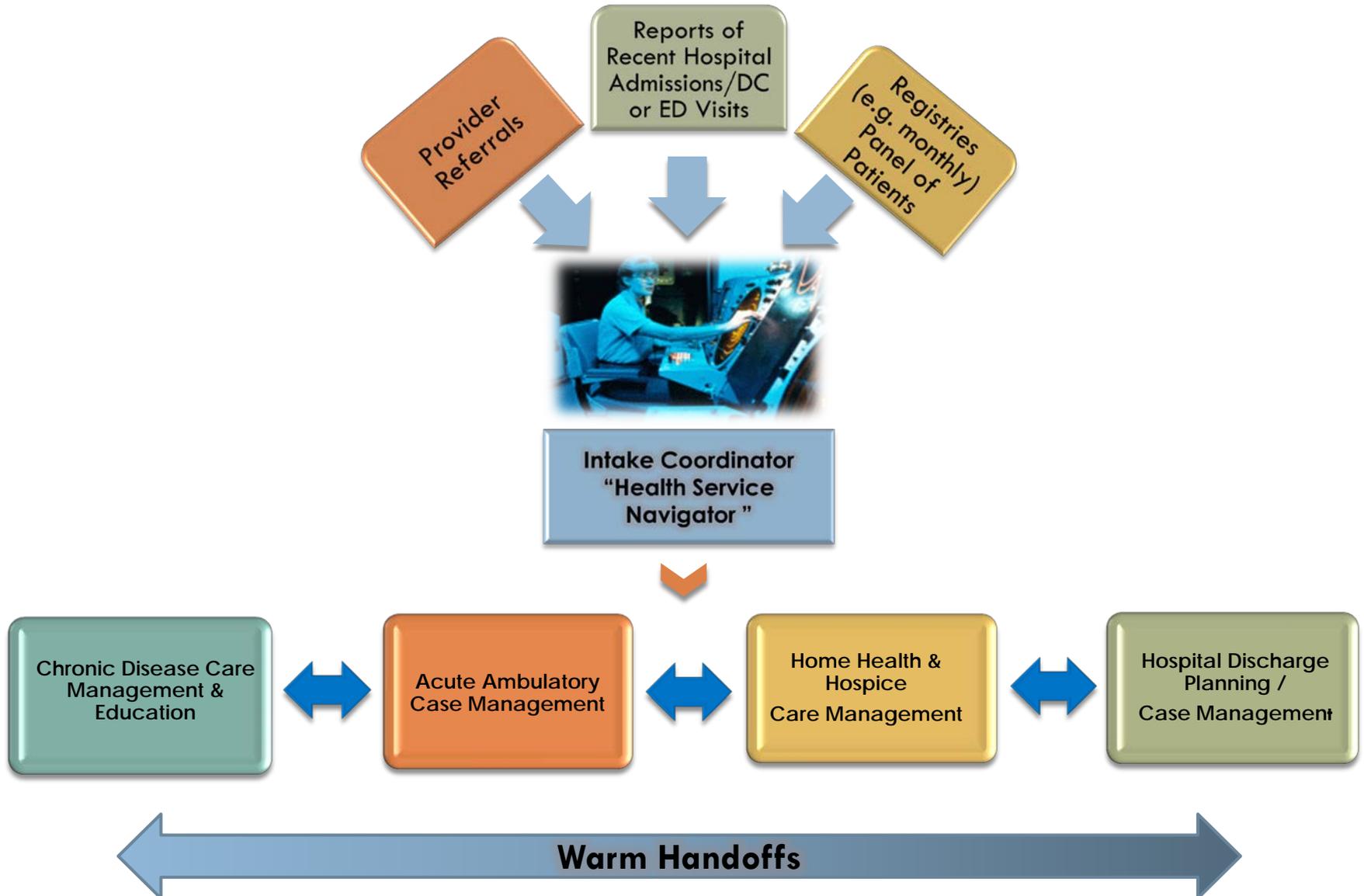
Mild depression

Also: Improved PCP confidence and efficacy in treatment and appropriate drug selection

Chronic Disease Management Care Coordination Program

- Overarching goal to provide primary care providers support by:
 - ▣ Offering payor neutral, system wide, longitudinal patient support
 - ▣ Utilizing four resource groups to help manage patients
 - ▣ Reducing excessive PCP contacts/calls
 - ▣ Reducing *inappropriate* ED utilization
 - ▣ Reduce *avoidable* hospitalization/re-admits

Care Coordination





Thank You

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