AtlantiCare

Taking You Well Into The Future

The Enhanced Care Center

Improving Care for Patients with Diabetes and Hypertension

8-14-2014

High Level Project Interventions

- Selected Diabetes/Hypertension primary care as project
- Practice is in Atlantic City
- Opened 1-3-2014
- Practice is a Primary Care Medical Home (PCMH) which is relationship based team care
- Added features include the utilization of health coaches (diverse in language and culture) and a social worker
- An electronic medical record and patient registry
- IT connection with both hospitals and a commitment to constant high-touch contact with patients and their family/caregivers

Patient Demographics

- 57% male, 43% female
- Average age is 53.8 years
- 41% speak a language other than English
- 69% have Medicaid, 23% Charity Care and remaining have Medicare with Medicaid or pending Medicaid

Response to the Monthly Survey

- Finding the Learning Collaborative to be helpful
- Our project is on target
- Our project has support from senior leaders
- Completed 2 PDSA Cycles of Improvement
- Interest to alter partner list

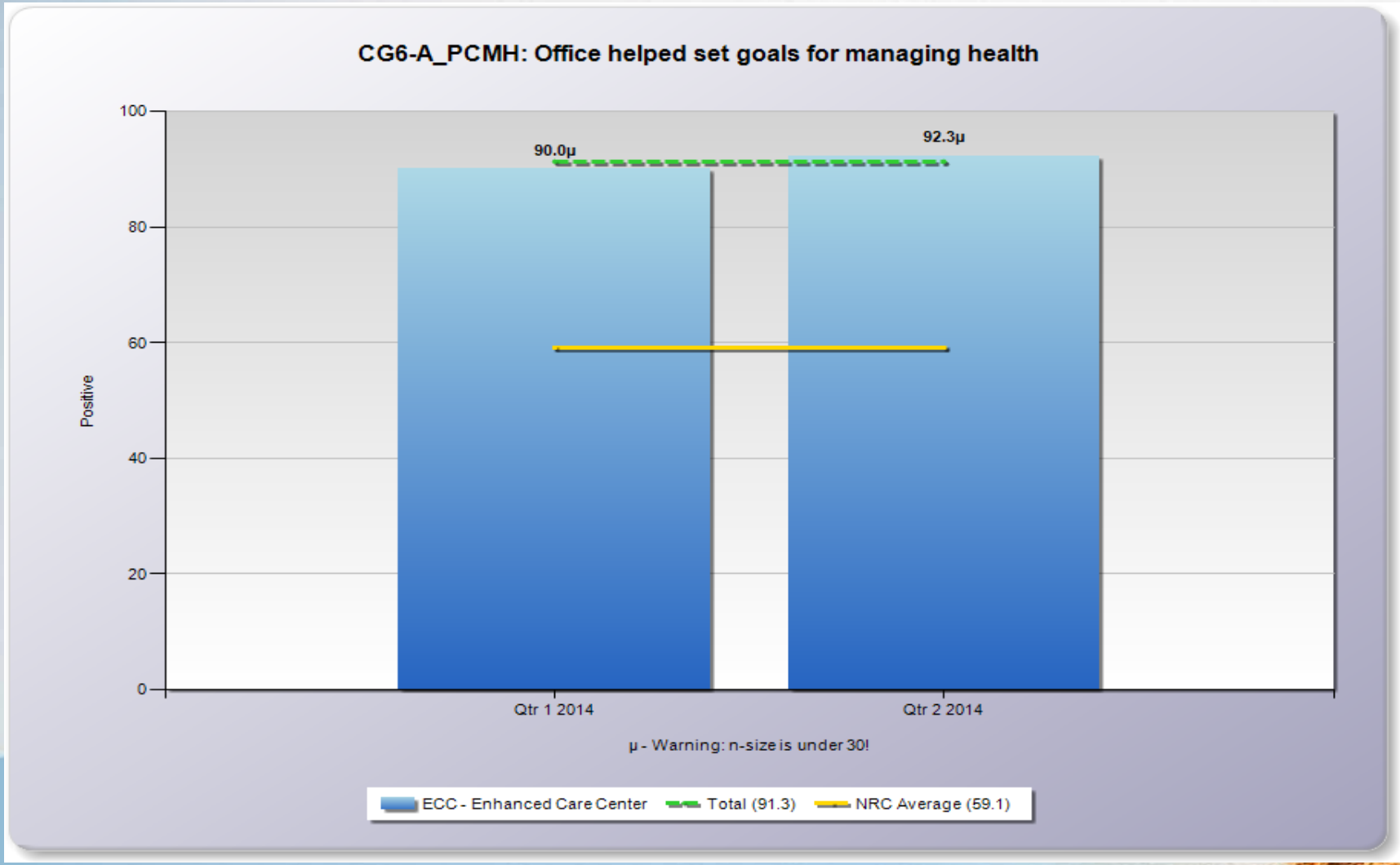
Project Achievements to Date

- Best Growth- Enrolled and provided care to 147 patients
- Best Quality- Collecting cohort health outcome data
- Best Customer Experience-Collecting cohort customer experience data via CG-CAHPS
- Best Finances- Maintaining costs on current budget

Quality Outcomes Year To Date

Clinical Indicators	Percentage of Patients
% patients with A1c <8	61%
% patients with BP < 140/90	75%
% patients with LDL <100	60%
% patients with retinal eye exam	15.9%
% patients with foot exam	75%
% patients with Micro albumin test	61%
% patients having diabetic education	100%
% patients with depression screening/treatment	100%

Customer Experience Outcomes



One example of 45 indicators we can track on CG-CAHPS

Project Observations

- Many patients coming to project are very sick, with delayed care in past, many ED visits and inpatient admissions
- Too early to determine cost savings and return on investment
- How attribution fits into overall project operation
- How Universal Metrics of the project are operationalized

Project Challenges

- Recruiting the “right patient” to the program while anticipating attribution match
- Needing patient paradigm shift to embrace PCMH rather than ED for care when not life-threatening
- Covering medication costs for charity care patients who do not qualify for other insurance
- Determining what patients will benefit the most
- Overcoming the social issues of the patient population
- Engaging the non-engaged patient

Project Successes

- Many patients already reduced A1c and BP
- Patients needing support, education, diet change and motivation to maintain medication regimen
- 25% patients receiving medication assistance prescriptions due to social work intervention

Questions and Answers

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