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

<table>
<thead>
<tr>
<th>Clinical Indicators</th>
<th>Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>% patients with A1c &lt;8</td>
<td>61%</td>
</tr>
<tr>
<td>% patients with BP &lt; 140/90</td>
<td>75%</td>
</tr>
<tr>
<td>% patients with LDL &lt;100</td>
<td>60%</td>
</tr>
<tr>
<td>% patients with retinal eye exam</td>
<td>15.9%</td>
</tr>
<tr>
<td>% patients with foot exam</td>
<td>75%</td>
</tr>
<tr>
<td>% patients with Micro albumin test</td>
<td>61%</td>
</tr>
<tr>
<td>% patients having diabetic education</td>
<td>100%</td>
</tr>
<tr>
<td>% patients with depression screening/treatment</td>
<td>100%</td>
</tr>
</tbody>
</table>
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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