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Care Huddles: Leading the Shift from Fee to Value

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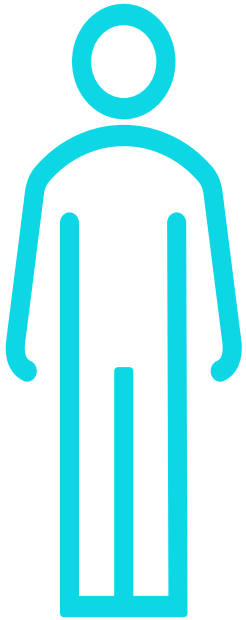
Objectives:

Understand	What is a Value Based Care Model and Why Does it Matter?
Learn	Learn how a multidisciplinary team can develop and implement a care huddle process in a rural ambulatory setting.
Identify	Identify key roles of team members in care huddles.
Impact	See how care huddles can positively impact patient care and outcomes.

Our Why:

Meet John: Our High-Risk Patient



- John, 22, Male, Type 1 Diabetic
- Multiple admissions and emergency room visits for high blood sugar and diabetic ketoacidosis (DKA)
- 4 ICU admissions in 2021
- Struggling to care for himself and manage his disease
- Labeled non-compliant

What is Value Based Care?

Do more of what matters	Do it better	Do it proactively
Right care, place and providers	Better quality and safety	Lower total cost of care

Why Embrace Value in Rural Health?

- **High** provider **turnover**
- **High** Advanced Practice Provider (APP) to Physician **ratios**
- **Lack of access and community resources** for disease management, illness, and social determinant of health concerns.
- **Higher emergency room visits**
- Prevalence of **poorly managed chronic disease** in rural communities
- **Higher cost of care** compared to urban settings

Developing Care Huddles:
A Multidisciplinary Approach

Planning	Development	Pilot	Sustain
Business Plan • Proposed program • Clinic demographics, including risk stratification • Additional people resources • Cost savings • Revenue • Additional expenses • Metrics	**Standard Work Committee** • Determined pilot diagnosis • Structure • Communications to patients • Communications within office • Team member responsibilities **Meeting Structure** • Four months • 1.5 hour every two weeks • Focused on development and review of processes	**Provider & Leadership Champions** • Attended all pilot huddles **Care Huddle Pilot** • One provider, one clinic • One hour per week • Four patients • Allow time for debrief **Care Huddle Expansion** • Two huddles per week each location • One hour per huddle • Providers assigned • 4-6 patients per provider	**Rural Rising Risk Process Improvement Committee** • Monthly, each location • One hour per month • All care huddle team members included • Focuses on refining and developing office and care huddle processes, developing diagnosis-based care plans, team education, identifying internal and community resources.

Care Huddle:

Objectives and Importance of the Population Health Nurse

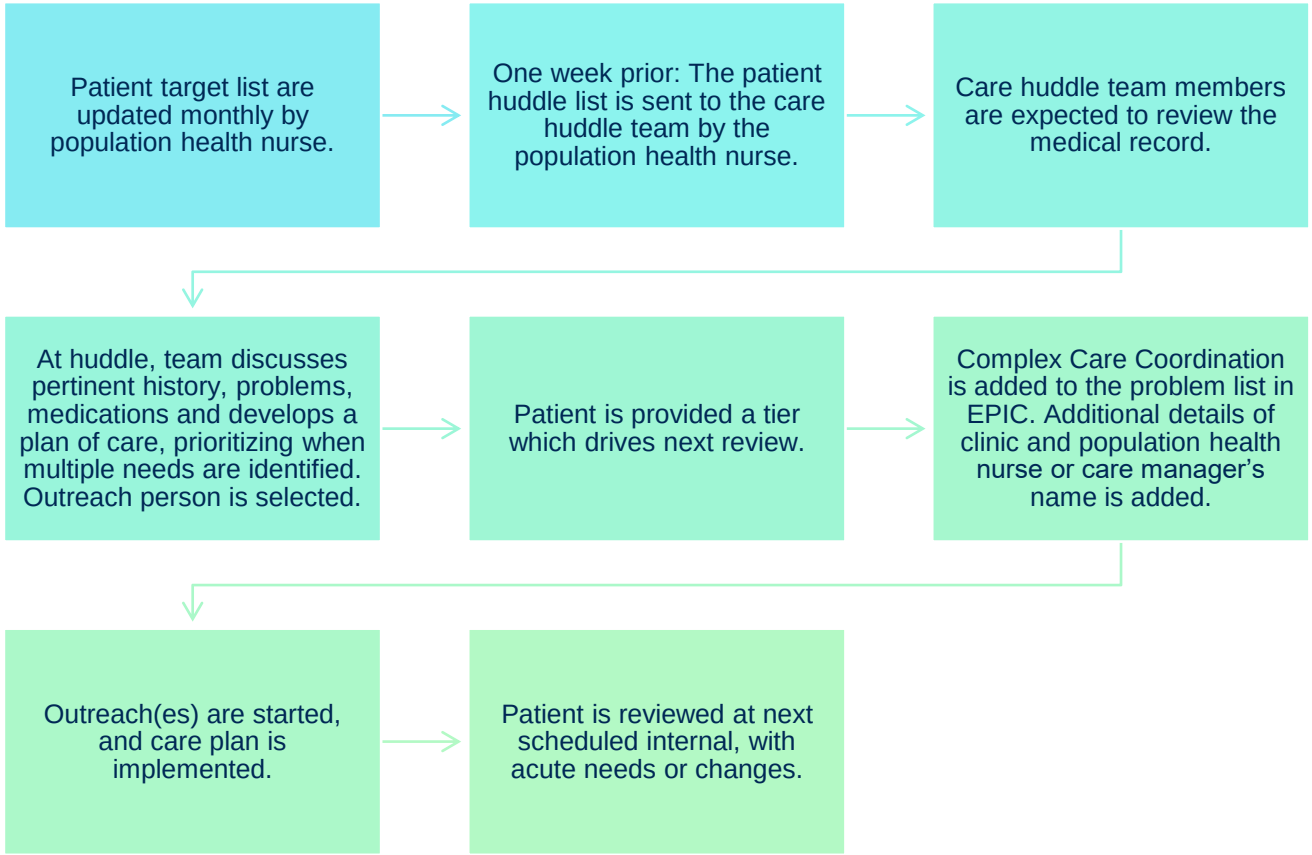
Objectives

- ✓ Develop plans of care for those at risk for high or unnecessary healthcare events.
- ✓ Improve disease, symptom(s), and quality of life
- ✓ Improve chronic disease management and medication adherence
- ✓ Increasing access and affordability

Population Health Nurse

- ✓ Tracking metrics
- ✓ Care huddle list management
- ✓ Documents care huddle notes and follow up plans
- ✓ Emergency room visit and hospitalization review and follow up
- ✓ Patient education
- ✓ Close monitoring and triage for at risk patients

Care Huddle Workflow



Care Huddle Team:

Roles & Responsibilities

Provider

- Leads huddle and starts with a win
- Presents the patient: history, medical problems, medications
- Ensures participation of all members

Population Health Nurse

- Reviews any pertinent information at end of huddle not previously covered
- Creates and manages care huddle notes
- Recommends interventions to optimize care, works directly with non-risk contract patients
- Oversees follow up of ED and hospitalization list.

Pharmacist

- Present formulary options to improve patient adherence and/or outcomes
- Reviews past interactions (if applicable)
- Recommends optimized medication plan
- Collaborates with patient (collaborative agreement with provider)

Care Manager

- Focused on working with risk contract patients.
- Reviews past interactions (if applicable)
- Recommends interventions to optimize care, works directly with risk contract patients

Behavioral Health

- Reviews past interactions (if applicable)
- Shares any concerns with GAD7 or PHQ screenings
- Recommends interventions to optimize care, works directly with patients

Care Huddle Tiers:

How often do we discuss our patients?

Tier 1	Tier 2	Tier 3
Very uncontrolled or deteriorating, high coordination of care needs	Multiple chronic conditions, uncontrolled, moderate coordination of needs	Almost controlled, stable, minimal coordination of needs
PCP visit at least every 3 months	PCP visit every 3-6 months	PCP visits every 6-12 months
High utilization of pharmacist, care manager, social worker, and/or population health nurse	Utilization of pharmacist, CM, SW, and/or PHN for short-term needs/acute problems	Minimal utilization of pharmacist, CM, SW and/or PHN
Huddle review every 3 months	Review in huddle every 3-6 months	Review in huddle yearly and prn

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Clinic Demographics

	Lakeview Clinic			Greenville Clinic		
Panel Size FTE	**Pre-Pilot June 2021**	**Pilot Nov 2021**	**Current April 2023**	**Pre-Pilot June 2021**	**Pilot Nov 2021**	**Current April 2023**
Panel	**4243**	**4247**	**4476**	**4321**	**4496**	**5379**
Physician	**0**	**0**	**2**	**2**	**2**	**3**
Advanced Practice Provider	**3.75**	**3.6**	**2.6**	**2**	**2**	**1.8**
Walk In	**0**	**2**	**2**	**2**	**2**	**2**
Care Manager	**1**	**1**	**1**	**1**	**1**	**1**
Social Worker	**1**	**1**	**1.5**	**1**	**1**	**1.5**
Population Health Nurse	**0**	**1**	**1**	**0**	**1**	**1**
Pharmacist	**0**	**0.5**	**1**	**0**	**0.5**	**1**

Key Performance Indicators

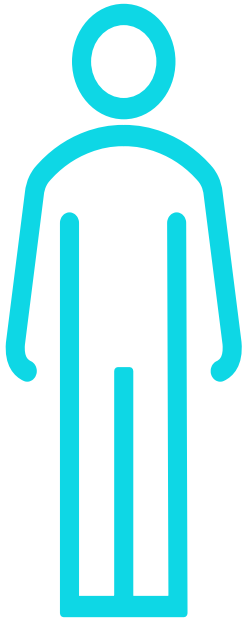
	Lakeview Clinic			Greenville Clinic		
	Business Plan January 2021 / July 2021	July 2022	December 2022	Business Plan January 2021 / July 2021	July 2022	December 2022
Total Medical Per Member Per Month (PMPM)	$629.03	$556 w/Rx	$598 w/Rx	$670.91	$465 w/Rx	$412 w/Rx
Emergency Visits/1000 (EDK)	696	599	498	636	468	527
Inpatient Admissions/1000	70	18	18	39	16	17

Patient Outcome: A1C >12

	Lakeview Clinic		Greenville Clinic	
	October 2021	October 2022	October 2021	October 2022
A1C >12	19	6	26	14

Checking in on John:

Our High-Risk Patient



- Identified though our care huddle patient identification process
- Team approach to care and actively discussed at care huddle
- Helped identify barriers and provided real solutions that worked for John
- Disease and self-management education, including the importance of medication adherence
- Outcome: Improved A1C, no emergency room or hospitalizations in 2022

Thank you

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