Podcast 39 – Reaching Out to Close the Gap in Cardiovascular Care

Transcript

[Voiceover] Michael Konstan: Welcome to Cardi-OH Radio, a podcast of the Ohio Cardiovascular and Diabetes Health Collaborative, also known as Cardi-OH. This is Dr. Michael Conston from the Case Western Reserve University School of Medicine, and I serve as the principal investigator for Cardi-OH, a statewide network of Ohio's seven medical schools. Cardi-OH is funded by the Ohio Department of Medicaid and shares best practices to improve cardiovascular health, diabetes outcomes, and to eliminate health disparities in Ohio's Medicaid population. The opinions and recommendations in this podcast are those of the presenters and not those of Cardi-OH and its sponsors and are not intended to be a substitute for medical advice. I hope you enjoy today's podcast.

Susan Davis: Hello, I am Dr. Susan Davis, associate professor of family and community medicine at the University of Cincinnati College of Medicine. I am a family physician and geriatrician and interim podcast lead for Cardi-OH's Team Best Practices. In this podcast, we will discuss outreach as a part of population health management. With me today is Dr. Shari Bolen. Dr. Bolen is a professor of medicine at Case Western Reserve University School of Medicine, a general internist, and co-principal investigator of Cardi-OH. Dr. Bolen directs the Population Health and Equity Research Institute at the MetroHealth System and has successfully led regional and statewide efforts to improve hypertension and glycemic control in primary care clinics serving diverse populations. Thank you for being here, Dr. Bolen.

Shari Bolen: Thanks for having me.

Davis: Dr. Bolen, to start with, what do you mean when you talk about health outreach in the context of cardiovascular health and disease?

Bolen: Well, thanks for asking me that question because outreach can be defined in different ways by different people. In this context, I'm talking about health outreach as when we do something health-related to a patient when they are not at the clinic. An example of this might include providing vaccinations in a community setting or calling a patient to work with them on a health issue such as blood pressure control or smoking cessation. In contrast, sometimes you'll hear the word "inreach," and that's used when we do something while a patient is being seen at the clinic to improve care. For instance, having a standard process to ensure we ask all patients if they smoke or use tobacco and then offering smoking cessation medications and support to people who use tobacco products.

Davis: So, how do you think health systems do focused outreach on specific groups? When do they incorporate this into care for patients?

Bolen: Yeah, I'll talk about two different populations or groups that I think it's important to mention. The first is that most outreach efforts by the health system or clinic are focused on areas where there are care gaps. For instance, they might focus on outreach based on a particular condition. This could include outreach to all patients whose last blood pressure was high, but who have no upcoming appointment to re-engage them in care. The second piece I'd like to mention is something that we encourage health systems to do, and that's really looking at their outcomes by race, ethnicity, or by socioeconomic status to conduct tailored outreach to specific groups as part of a larger approach to eliminate disparities in a particular condition.

Davis: How does outreach fit into cardiovascular quality improvement efforts you have worked on in the past and currently?

Bolen: Outreach is typically part of a bundle of activities that we do to improve a particular outcome. For instance, in a hypertension best practice bundle that's been used successfully in improving blood pressure control across diverse populations within the last decade, we've seen a bundled approach where there are several key elements. One is accurate blood pressure measurement. The second is monthly follow-up and staff-led visits until the blood pressure is controlled. The third is a treatment algorithm that prioritizes once-daily low-cost medications. And the fourth is outreach, which is part of that bundle to re-engage patients in care. That bundled approach has really been shown to improve blood pressure control in our region across the diverse health systems. In our region in particular, with about 120,000 people, we improved blood pressure control from 60% of patients under good control to around 75% using that bundle. In that approach for outreach, which was developed by Kaiser Permanente, they use an electronic health record-based registry to identify patients whose last blood pressure was not well controlled and did not have a follow-up in the next month, then they reached out to contact those patients and bring them back into care.

Davis: Interesting. That seems to be focused on people with elevated blood pressure and the diagnosis of hypertension. But what about outreach for other people with cardiovascular risk factors such as people who use tobacco or who have diabetes?

Bolen: Yeah, this kind of outreach approach has been shown to be successful in other cardiovascular conditions. For instance, this was mirrored in diabetes as well. We did this as part of a similar statewide bundle, except instead of blood pressure control, we were focused on blood sugar control and really looking at some of those same key elements: having a treatment algorithm, making sure we had monthly follow-up until the blood sugar was controlled, and then outreach as part of those efforts. Those studies have also shown benefits to improvement in blood sugar control using that same bundle. Other studies in our region and nationally have shown benefits to care coordination outreach for people with diabetes when that outreach is done from the health system or clinic. For individuals that use tobacco, outreach can check on tobacco use status and assess their interest in cutting down or quitting. For those who are interested, one could then offer a referral to assistance like the Ohio Quit Line or other smoking cessation resources. That outreach work can then be documented in the electronic health record so when there is a follow-up in-person visit, the clinician can follow up on progress towards the tobacco cessation goal.

Davis: So, Dr. Bolen, as you know, I'm a primary care provider in Ohio and I see Ohio Medicaid patients. Can you share some best practices on how to reach out to my patients who have cardiovascular risk factors that have been shown to be effective in your experience?

Bolen: Outreach can be done via different modalities, such as phone calls, texting, MyChart messaging, or mailing a postcard or letter. We really do need more comparative data to shed light on what works best for whom, but we do know that outreach is effective with uptake ranging from 10 to 25% when using a standardized outreach process within safety net practices. One successful approach used across health systems includes a tiered approach where first health systems send messages via the patient portal. They can then set up an automated process with a vendor for those not on a patient portal to text message patients. If they don't have text capability, that could be an automated phone message that goes as a voice message. If there's no phone number, a message could be sent by a mailed postcard. Mailing is generally more expensive than texting and automated calls, which is why most systems use the free patient portal followed by texting and phone messages before moving to a mailed option.

Davis: Dr. Bolen, how would I create my own outreach message for my patients? What sort of things should an outreach message say?

Bolen: Typically, an outreach message should have three elements. First, a sentence letting a patient know why you're reaching out. The second is a sentence about the importance of controlling a particular condition, such as blood pressure or blood sugar. And third is a call to action. For blood pressure, it might be: "Our records show your last blood pressure was high (greater than or equal to 140 over 90 or 130 over 80). As you may know, high blood pressure puts you at risk for heart attack, stroke, visual problems, and headaches. Please call our office at 123-4567 to schedule a nurse blood pressure visit within the next month". For diabetes, it might mention a high hemoglobin A1C and the risk for kidney damage, blindness, and nerve pain, then ask them to schedule a clinical pharmacist visit.

Davis: So, in a primary care practice, in your opinion, who should be empowered to do cardiovascular outreach to patients? Does it always have to be a physician or advanced care provider?

Bolen: This really differs by practice, and we encourage people to use a wide range of care team members including front desk staff, community health workers, medical assistants, nurses, care coordinators, or social workers. It can be an automated outreach followed by a person doing live outreach for non-responders. If a person is doing the outreach, they should be trained on key phrases to engage patients and ensure they address barriers to follow-up, like transportation, in conjunction with a social worker or community health worker.

Davis: I'm wondering how often should outreach be done in the context of cardiovascular disease or diabetes?

Bolen: This depends on the topic and other efforts happening in your system, but we recommend doing this outreach effort at least once a year. Some systems send up to three reminders about two weeks apart if there is no response, as three reminders seems to be the "sweet spot" for uptake without feeling like you are harassing someone. If you have a large list, assume about 15 to 20% will call back and uptake the outreach, so you may need to stagger the outreach to ensure sufficient capacity when people call back.

Davis: Dr. Bolen, the bottom line always seems to be about cost in dollar values. What is our so-called return on investment in community outreach for the health care system? What does it cost the system typically, and will it penalize my practice?

Bolen: The cost to the health system for automated outreach is typically made up for by patient volume and billing as well as value-based payments for quality metrics. In one health system using this approach for adolescent immunizations, the average visits generated $24 in gross reimbursement for $1.77 in messaging expenses per vaccine given. In general, the amount received highly outweighs the costs. The cost is higher if hiring a care coordinator or community health worker for live calls but using care coordinator billing codes and receipt of value-based payments for higher quality metrics will help offset those costs.

Davis: Interesting. This information has been terrific, Dr. Bolen. What are some high-level takeaways you'd like our listeners to have?

Bolen: One is to re-emphasize that outreach is one opportunity to engage patients in care until their condition is controlled. The second is that the use of registries and automated outreach, followed by more time-intensive outreach for non-responders, is an efficient and effective approach to improving cardiovascular health.

Davis: So, Dr. Bolen, how might listeners find out more about hypertension and diabetes outreach toolkits?

Bolen: We have both a diabetes and a hypertension clinical quality improvement toolkit on our website at Cardi-OH.org. These toolkits include the full bundle I described, as well as the results of those projects and a dedicated outreach section.

Davis: That sounds like a great resource for our listeners. I'm really grateful for these insights, Dr. Bolen. That's all the time we have for today. Thank you so much for being here today.

Bolen: Thank you, Dr. Davis, I really enjoyed the conversation.

Davis: And a special thank you to you, our listeners, for tuning in to Cardi-OH Radio.

[Voiceover] Konstan: This concludes today's podcast. Be sure to visit Cardi-OH.org to learn more about the Ohio Cardiovascular and Diabetes Health Collaborative.

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