pcc primary care collaborative

Convening + Uniting + Transforming

Lunch & Learn

PCC Lunch and Learn

Thursday, January 27, 2021 | 11:00 AM - 12:00 PM ET

Lunch and Learn Co-chairs and Presenters

Irene Dankwa-Mullan, MD, MPH
Deputy Chief Health Officer,
IBM Watson Health

Jack Westfall, MD, MPH
Director,
Robert Graham Center

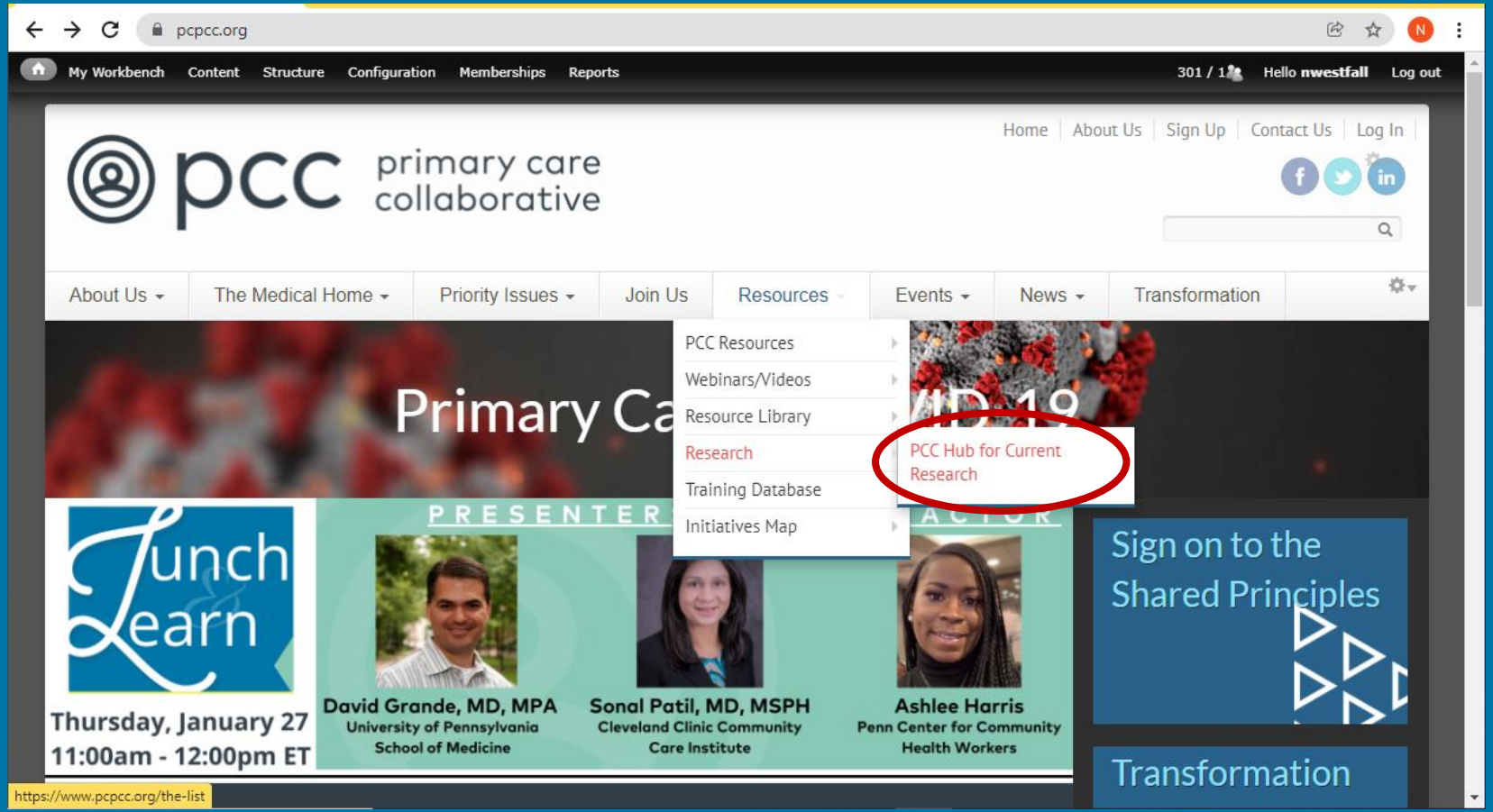
David Grande, MD, MPA
University of Pennsylvania

Ashlee Harris
Penn Center for Community Health Workers

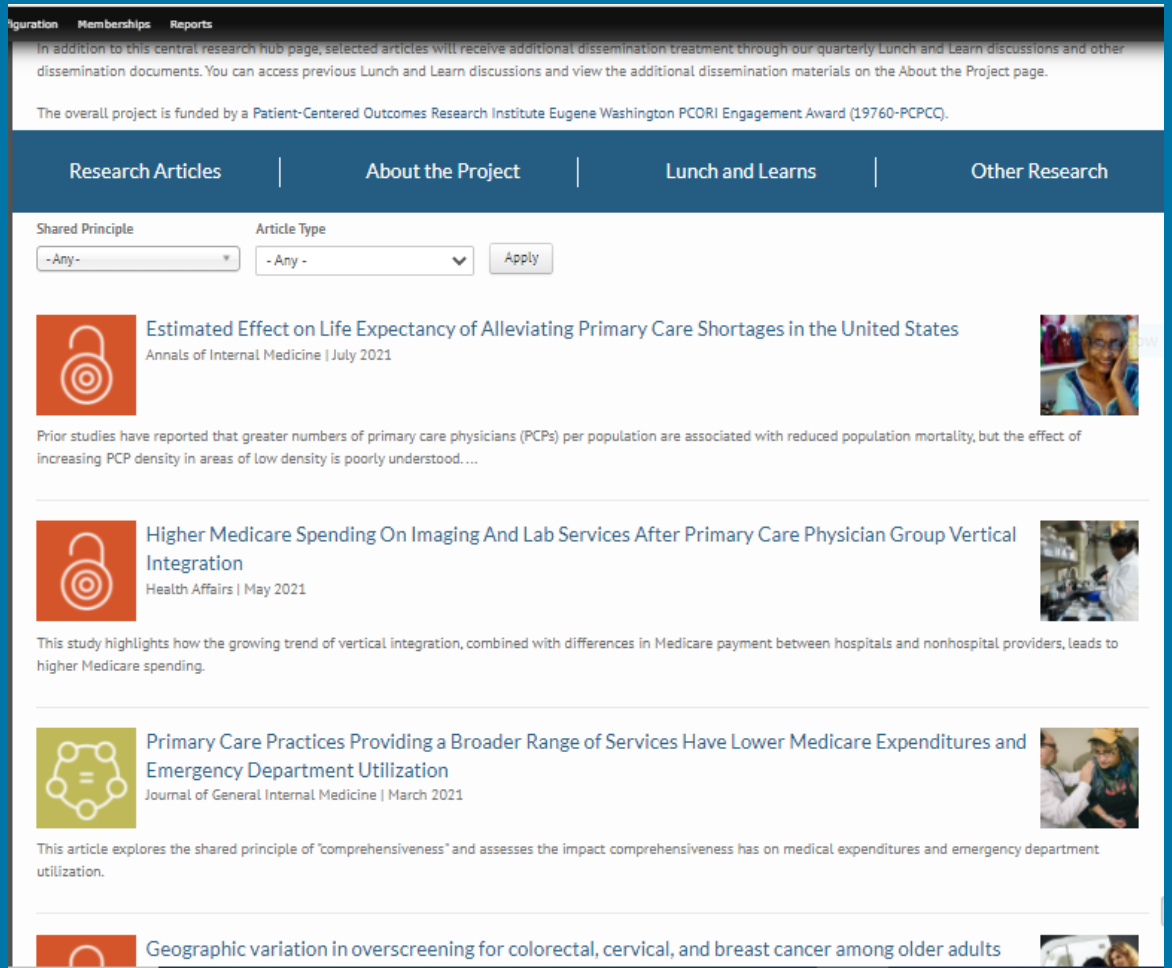
Sonal Patil, MD, MSPH
Cleveland Clinic Community Care Institute

Two Dozen Curated Articles to Shape Primary Care Policy & Practice

https://www.pcpcc.org/the-list



Two Dozen Articles to Transform Primary Care Policy and Practice



Providing

cc.org/resource/primary-care-practices-providing-broader-range-services-have-lower-medicare-expenditures

ure Configuration Memberships Reports

This article was featured in the July 22, 2021, Lunch and Learn discussion

In this segment of the July Lunch and Learn discussion, Dr. Eugene Rich, Senior Fellow at Mathematica, presented the paper and answered questions from the audience.

Summary of Discussion Highlights:

- Expand team-based care:
  - Utilize the full range of the primary care workforce including mobile pharmacists, mobile health workers, social workers, and so on, allowing each profession to work at the top of their license.
  - Conduct more research on the range of services provided in practices that include NPs and PAs.
- Integrate behavioral health and primary care:
  - When practices provide a broader range of services (including counseling), their Medicare beneficiaries subsequently experience fewer ED visits and lower total spending.
  - Include team members who have behavioral health skills and take advantage of existing primary care physician competencies.
    - E.g., family medicine has historically included training in basic mental health counseling and cognitive behavioral therapy.

Full Resource/Source: Journal of General Internal Medicine

View Edit Revisi

Contact Us My account Log out Sign Up

About the Project

The Two Dozen Articles to Reform Primary Care Policy and Practice is a product of PCC's Bridging the Gap in Primary Care Research project, funded by a Patient-Centered Outcomes Research Institute Eugene Washington PCORI Engagement Award (19760-PCPCC). This two-year project (2021-2022) addresses, in part, shortcomings in the dissemination of primary care research, which can slow down the adoption of research results that can improve care. The project aims to identify important primary care patient-centered outcomes research/comparative effectiveness research and health services research results and engage key stakeholders in disseminating these select, high-impact results in different ways.

PCC is partnering on this project with the North American Primary Care Research Group (NAPCRG), which has vast experience in primary care research and dissemination strategies, including getting input from patients about research priorities and an annual process for crowdsourcing the highest-impact research results (research "pearls"). The 24 research articles on the list were curated by two different groups of experts and leaders, described below.

- Add

Methods

The PCC worked with the North American Primary Care Research Group (NAPCRG), a multidisciplinary organization for primary care researchers, and the PCC-formed Research Dissemination Workgroup (RDWG) to identify and select the most relevant primary care research. The result is a list of the most relevant and actionable patient-centered outcomes research/comparative effectiveness research (PCOR-CER) and health services research (HSR) articles spanning primary care specialty groups.

NAPCRG undertook a structured review process to select the top primary care clinical research articles, which included:

- a review of NAPCRG "pearls," the top 10 best studies presented at NAPCRG's

Upcoming Lunch and Learns

Join us for our next discussion:

Thursday, January 27, 2022
11:00 a.m.-12:00 p.m. EST

More information and registration

Attending for the first time? Watch this short intro video.

Lunch and Learns

December Lunch and Learn Discussion

October Lunch and Learn Discussion

July Lunch and Learn Discussion

Workgroup Leadership

The PCC formed a Research Dissemination Workgroup (RDWG) to identify the most relevant primary care research and inform the translation and dissemination of its selected articles. Its goal was to enhance the accessibility of research results and engagement with the findings across diverse audiences, including patients.

Workgroup Co-chairs:

Eugene Rich, MD

Joseph LeMaster, MD, MPH

- Eugene Rich, Senior Fellow, Director on Healthcare Effectiveness | Mathematica
- Joseph LeMaster, MD, MPH, Professor | University of Kansas School of Medicine

Workgroup Members:

- Sanjay Basu, MD, PhD, Director of Research | Harvard Center for Primary Care
- Wendy Bennett, MD, MPH, Associate Professor | Johns Hopkins Medicine
- Arlene Bierman, MD, Director | Agency for Healthcare Research and Quality (AHRQ)
- Marjorie Bowman, MD, MPA, Chief Academic Affiliations Officer | Department of Veterans Affairs
- Irene Dankwa-Mullan, MD, MPH, Deputy Chief Health Officer | IBM
- Daniel Dawes, JD, Director | Satcher Health Leadership Institute at Morehouse School of Medicine
- Susan Edgman-Levitan, PA, Executive Director | John D. Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital
- Bianca Frogner, PhD, Deputy Director | Primary Care Innovation Lab
- Stephanie Gold, MD, Assistant Professor | University of Colorado Denver, Department of Family Medicine
- Ann Greiner, MCP, President and CEO | Primary Care Collaborative
- Jane Kogan, PhD, Associate Chief Research and Translation Officer | University of Pittsburgh Medical Center
- Julia Murphy, Director, Dissemination | Peterson Center on Healthcare
- Monica O'Reilly-Jacob, PhD, FNP-BC, Assistant Professor | Boston College, Connell School of Nursing
- Michael Parchman, MD, MPH, Senior Investigator | MacColl Center for Health Care Innovation
- Susan Reinhard, RN, PhD, FAAN, Senior Vice President and Director | AARP
- Renee Turchi, MD, Faculty | Drexel University College of Medicine

The PCC also established the regular Lunch and Learn discussion series to evaluate and disseminate the policy implications of select articles identified by the Research Dissemination Workgroup. The Lunch and Learn series is another dissemination channel that is meant to inform and educate a wide range of primary care stakeholders of the most relevant and actionable primary care research. In these meetings, primary care researchers, advocates and policymakers are brought together to discuss the key messages and policy implications of the most important research identified by the RDWG, with the goal of better

JAMA Internal Medicine | Original Investigation

Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities
A Randomized Clinical Trial

Shreya Kangovi, MD, MS; Nandita Mitra, PhD; Lindsey Norton, MSS, MLSP; Rory Harte; Xinyi Zhao, MPH; Tamala Carter, CHW; David Grande, MD, MPA; Judith A. Long, MD

Discussant: Ashlee Harris – Penn Center for Community Health Workers

Funding Source: PCORI-1310-07292; NHLBI K23-HL128837

Penn LDI

NIH National Heart, Lung, and Blood Institute

pcori®

Social Determinants of Health

Photo Credit: JGJ Consulting
Gottleib et al Am J Prev Med 2017

Community Health Workers

IMPaCT

1. Patient-centered
2. Standardized
3. Evidence

Research

Original Investigation

Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes

A Randomized Clinical Trial

Shreya Kangovi, MD, MS; Nandita Mitra, PhD; David Grande, MD, MPA; Mary L. White; Sharon McCollum; Jeffrey Sellman, BA; Richard P. Shannon, MD; Judith A. Long, MD

AJPH RESEARCH

Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial

Shreya Kangovi, MD, MS, Nandita Mitra, PhD, David Grande, MD, MPA, Hairong Huo, PhD, Robyn A. Smith, BS, and Judith A. Long, MD

Objective

In a multi-center randomized controlled trial (VA, FQHC, AMC), determine whether 6 months of CHW support leads to improved outcomes

Methods

- Participants:
  - Uninsured or publicly insured
  - Residents of a high-poverty region in Philadelphia
  - ≥2: hypertension, diabetes, obesity and tobacco dependence, one in poor control
- Outcomes assessed at 6, 9 months:
  - Self-rated physical health, mental health, chronic disease control, patient activation, quality of primary care, and all-cause hospitalizations

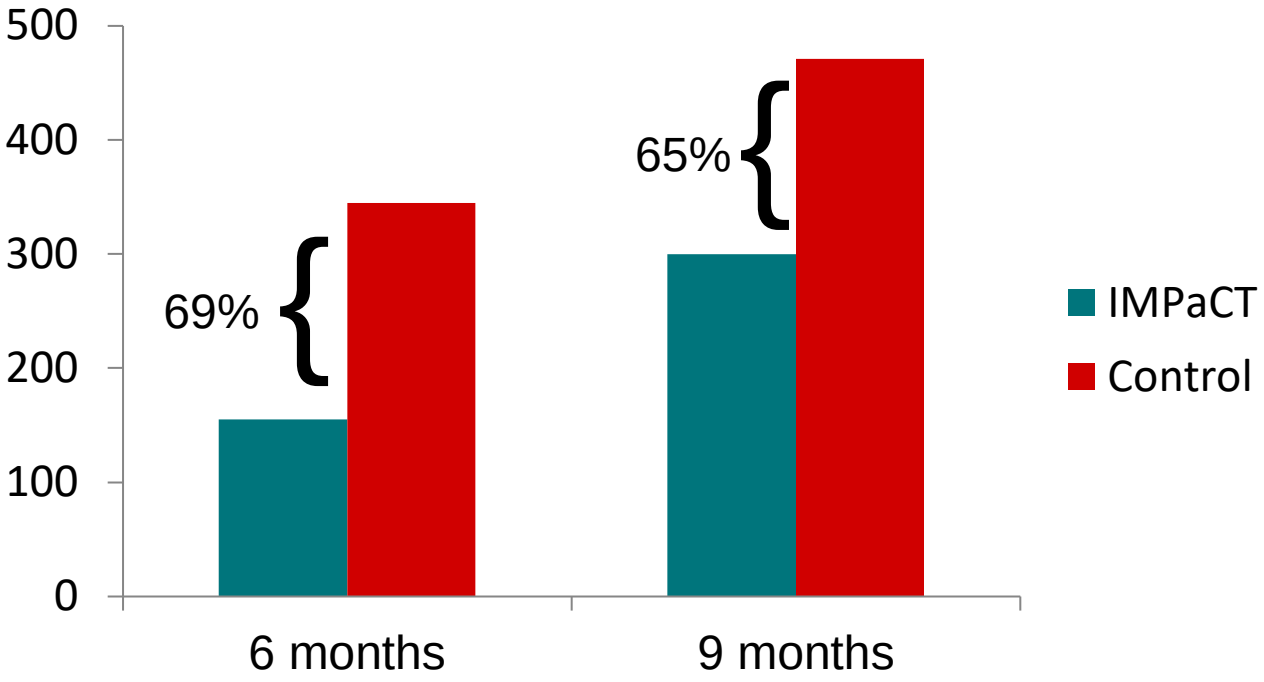
Participants (n=592)

Age, years	52.6
African-American	94%
Household Income < 15K	65%
Trauma History	98%
Baseline Chronic Disease Control	
Systolic Blood Pressure (mmHg)	161.6
Obesity (BMI)	42.5
Diabetes (HbA1c%)	10.5
Tobacco dependence (Cig per day)	9.3

Outcomes

	Diff-in-diff	P value
∆Self-rated Physical Health	-0.7	0.30
∆Self-rated Mental Health	0.8	0.41
∆Patient Activation	1.9	0.06
∆Chronic disease control		0.21
Systolic blood pressure (mmHg)	-6.3	
Obesity (BMI)	-0.2	
Diabetes (HbA1c%)	-0.2	
Tobacco dependence (Cig per day)	-0.5	
	Odds Ratio	P value
Highest quality (CAHPS)	1.8	<0.001

Total hospital days



Outcomes

	Diff-in-diff	P value
Mean length of stay	-3.1	0.06
	Odds Ratio	P value
Repeat admissions	0.4	0.02
30-d readmission	0.3	0.04

ǂ Among those with index admission

Conclusions

- Addressing outcomes that matter to patients:
  - Better experience/quality
  - Decreased acute care utilization
  - Prior studies have shown mental health benefits
- Persistence of effect
- Favorable ROI for Medicaid

Ashlee Harris

Penn Center for
Community Health Workers

http://chw.upenn.edu/

Home Blood Pressure Monitoring in Cases of Clinical Uncertainty to Differentiate Appropriate Inaction from Therapeutic inertia

Sonal J. Patil, MD, MSPH

Staff, Clinician-Investigator

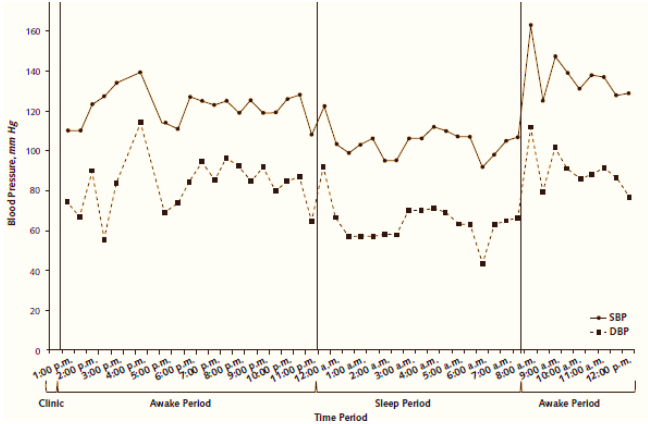
Wellness and Preventive Medicine Department, Cleveland Clinic Community Care Institute

January 27, 2021

Funding: This project was funded by American Academy of Family Physicians (AAFP) Joint Grants Award Program

White coat effect in treated hypertension is not associated with adverse long-term cardiovascular outcomes.

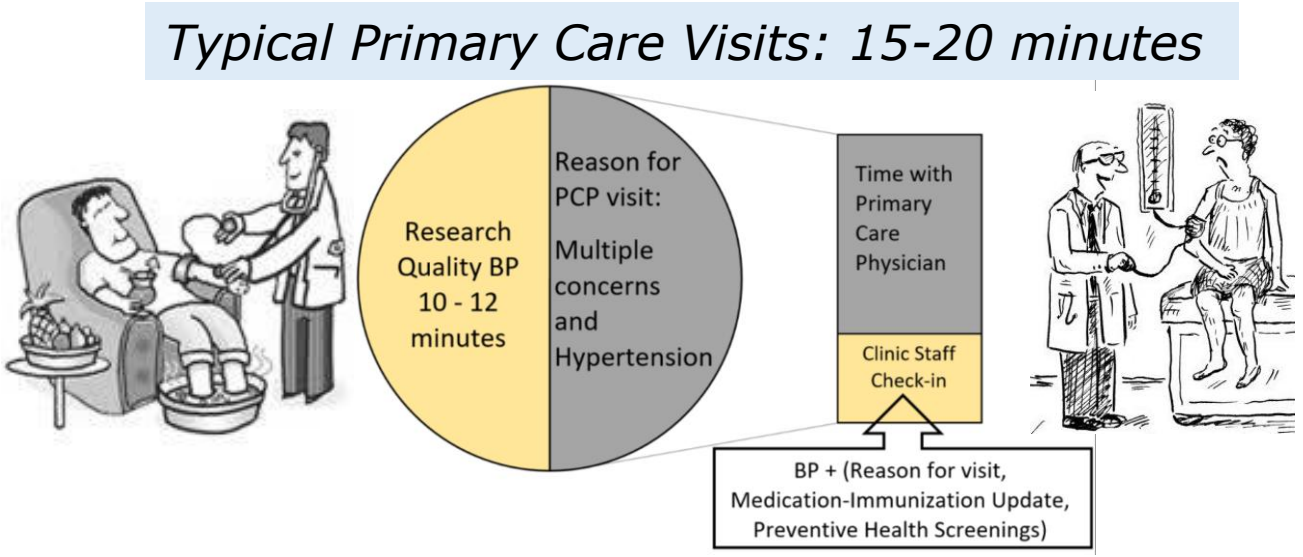
Blood pressure (BP) is a physiologic parameter that fluctuates throughout day.



Physicians and patients are reluctant to intensify treatment when they are uncertain if the single elevated clinic BP truly reflects patient's hypertension control status.

Clinic BPs are known to be least accurate. Repeated out of office BP measurements accurately reflect hypertension control status.

However, physicians' hypertension control rates continue to be calculated and ranked based on the last documented single conventional clinic BP (rarely research quality BP measurement)



Research Question: When physicians and patients are uncertain about intensifying treatment in presence of an elevated clinic BP reading, will documenting average home BPs improve hypertension control rates and clinical decision making?

Patients:

Hypertension + recent Clinic BP high (>140/90) + No change in hypertension management at current visit or prior 4 weeks

Intervention:

Home BP monitoring twice daily for 2 weeks
- Proper home BP measurement technique taught and verified initially and when returning home BP machine using checklists

Outcomes:

- ❑ Change in hypertension control rates by substituting clinic BPs with average home BPs
- ❑ Physician responses to average Home BP notifications
- ❑ Patients surveyed for their opinions on home BP monitoring
- ❑ Chart review 6 months later to check subsequent clinic BPs and physician responses to those clinic BPs

What did we find?

2/3rd of patients (59/90) with clinic BP in uncontrolled hypertension range had controlled hypertension with average Home BPs (<140/90)

Of the 31 patients with uncontrolled hypertension by average home BPs only 14 (15%) needed medication changes.

Average Home BP documentation improved hypertension control rates

Substituting average home BP for last clinic BP in 13 of the 278 hypertensive patients improved an individual physician's hypertension control rates by 5%.

20 patients with average home BP in controlled hypertension range had a subsequent elevated clinic BP within 6 months - Physicians did not change medications (appropriate inactions).

Participant Survey responses to Home BP monitoring

Improved health behaviors :

"Reduce salt intake because one day I ate a small pack of pretzels in the evening, my BP….was noticeably higher than other days "

"It made me consider how my anxiety affects blood pressure." "Breathing exercises, mental happy thoughts."

"Increased frequency and intensity of exercise"

Improved understanding of their hypertension control:

"Assured me that my bp is lower when I'm not near a health professional."

"I thought it was better controlled, but realized it was not." "Started taking blood pressure medication afterwards."

Recommendations for clinical practices:

67% of patients said that nurses did not follow the proper BP measurement steps. *"They should follow the same rules"*

"Have those of us affected bring in some 'kitchen' readings."

We could not predict clinic BP cutoff for which patients are more likely to have average home BP reading <140/90

Clinic BP cutoff (n)	Average Home BP <140/90	
	N	
Below 160/95 (n= 39)	25	64%
Above 160/95 (n=51)	34	67%

16 patients had systolic clinic BP >170 and 10 of those patients had average home BP of < 140/90.

In sum, hypertension guidelines and performance measures do not consider the impact of conventional clinic BP measurements on BP thresholds. Average Home BPs should be used for estimating hypertension control rates and for clinical decision making.

Policy and Practice Implications:

- ❑ Loan or prescribe valid Home BP monitors (www.validatebp.org). Insurance coverage of valid home BP machines may reduce disparities
- ❑ Team-based care to facilitate home BP monitoring. 3 days or maximum 7 days of twice daily home BP readings are enough
- ❑ Trust patient's self-report of home BP readings if they own valid BP monitors to improve patient engagement
- ❑ EHR's should have discrete extractable data fields for average Home BP entry
- ❑ If documented, last recorded average Home BP should be used for calculating hypertension control rates irrespective of follow-up clinic BP readings.


Thank you!
NUHA
WAREG
MPH