Centralized population health coordinators improve care for patients with chronic disease

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A centralized chronic disease management program produced significant improvements in the care of patients with diabetes, hypertension or cardiovascular disease treated at practices in the Massachusetts General Hospital (MGH) primary care network. The results of a six-month pilot study, published online today in the *American Journal of Managed Care*, have led to expansion of the program to all practices in the MGH primary care network.

"We found that patients cared for at practices that were assigned centralized support as part of a population health program for chronic disease management had greater improvements in outcomes than did patients at practices not receiving this centralized support," says Jeffrey Ashburner, PhD, MPH, of the MGH Division of General Internal Medicine , lead author of the report. "Population health management and clinical registries can identify patients with gaps in care outside the context of a face-to-face clinical visit, allowing the health care team to take action. Our study demonstrated that dedicated centralized personnel working with practice staff can have a significant impact on improving outcomes for patients with chronic disease."

Population health management programs focus on the provision of care to a panel of patients through networks of individual clinical practices. In addition to the care provided at traditional, face-to-face patient visits, population health management also seeks to identify patients with

chronic diseases who may need additional intervention to meet clinical goals, allowing practice staff to reach out to those patients rather than waiting for a patient-initiated visit. But it has not been clear whether non-visit-based population health activities should be handled by individual practice staff or centrally managed by network-based staff.

The current study was conducted within the MGH Primary Care Practice-Based Network, made up of 18 practices located at the hospital, at MGH-affiliated community health centers and in the greater Boston area. All network practices use electronic health records and a computerized practice management tool initially established for cancer screenings, which was expanded to include chronic disease registries - which compile data on the health status and care of patients with shared health needs - for diabetes, cardiovascular disease and hypertension.

To investigate the impact of centralized chronic disease management, four network-based population health coordinators were assigned to 8 of the 18 network practices in 2014. They received special training in chronic disease management, preventive health, health coaching and use of the electronic health record and the clinical registries. They met regularly with practice physicians to review information on patients who needed additional clinical intervention and to develop action plans ranging from ordering overdue laboratory testing, to obtaining results of in-home blood pressure monitoring, to scheduling office visits.

Of the more than 160,000 patients cared for in the network, there were 12,316 with diabetes, 12,591 with cardiovascular disease and 41,591 with hypertension. For each group of patients, the researchers compared outcomes - such as whether patients were receiving appropriate and timely testing and monitoring and whether they achieved clinical goals, such as target A1C levels for patients with diabetes or cholesterol levels for those with cardiovascular disease - at practices with centralized population health coordinators to those at practices without coordinators.

While all of the network practices showed significant increases in chronic disease outcomes during the six-month study period from July through December 2017, those improvements were measurably greater at practices where central population health coordinators worked closely with practice staff. Practices with coordinators showed greater improvement in the percentages of patients who received appropriate testing and in those who achieved clinical targets. As a control measure, the researchers also compared the percentages of patients who received appropriate cancer screenings during the study period, which the central coordinators did not focus effort on these registries, and found no significant differences between the practices with and without coordinators.

"Since our study was limited to six months, after which the program was expanded to all MGH primary care practices, we need longer-term follow-up to assess outcomes over time," says Ashburner, who is an instructor in Medicine at Harvard Medical School. "But our results clearly show that a population health management program in which centralized coordinators work closely with practice staff provides even greater improvement in clinical outcomes for patients with diabetes, cardiovascular disease or hypertension."

Provided by Massachusetts General Hospital

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