CASE STUDY #4

Empowering Clinicians:
Value-Based Care Partnership

Improving Resident Experience and Outcomes while Reducing Cost by Promoting Value-Based Care

Depression is a widely prevalent condition among the long-term care patient population. Screening is critical in identification of depression in the long-term population, as studies show that nearly **30% of patients have major or minor depression** yet go unnoticed or untreated.[1] Untreated depressive symptoms can lead to poor quality of life, patient decline, and reduced function and social participation.

- Depression screenings are standard of care, with 90% of TeamHealth's long-term care ACO patients receiving a depression screening and a documented plan of care. This performance compares favorably to the national average of only 39% percent of patients receiving a depression screening.[2]

Management of diabetes improves patient outcomes and slows the progression of secondary conditions related to the disease process. TeamHealth's long-term management strategy focuses on preventative care and ongoing maintenance of patients, including use of proper medications and management of A1C.

- Diabetic blood glucose control is imperative to quality of life and reduction of hospital readmissions. HgA1c is a good measure of blood sugar control over time. For TeamHealth's diabetic population aged < 65 in a long-term setting, **92% of patients maintain an HgA1c ≤ 9**. This is far greater than national average of 55% of patients with a HgA1c in control.[2]

Easing Difficult Conversations and Delivering Better Care

By analyzing reports of individuals for whom it's time to start broaching advance care-planning conversations, TeamHealth clinicians engage in advance care-planning conversations routinely in care delivery. These conversations can be more effective with validation and evidence of a resident's decline. With these results, TeamHealth improves outcomes by implementing a standard of high-quality, evidence based care within the clinical practice, reducing readmissions by effectively utilizing in-person and on-call care strategies and collaborating with facility staff and healthcare providers across the continuum.

1 https://trialsjournal.biomedcentral.com/articles/10.1186/s13063-019-3534-x#:~:text=Up%20to%2030%25%20of%20nursing,home%20residents%20and%20remain%20untreated.

2 https://qpp-cm-prod-content.s3.amazonaws.com/uploads/608/2022%20Quality%20Benchmarks.zip