

Advanced Models of Primary Care: Care Management Plus pilot and dissemination

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www.caremanagementplus.org

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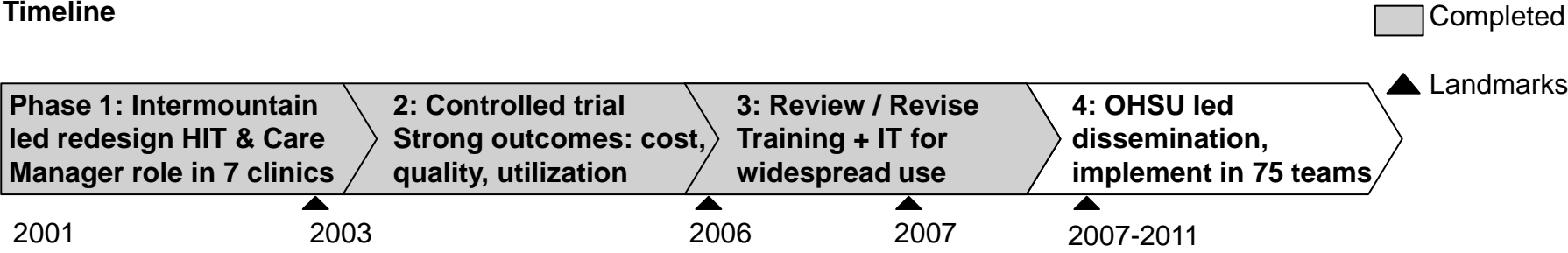


CARE MANAGEMENT PLUS: BIOGRAPHICAL INFORMATION

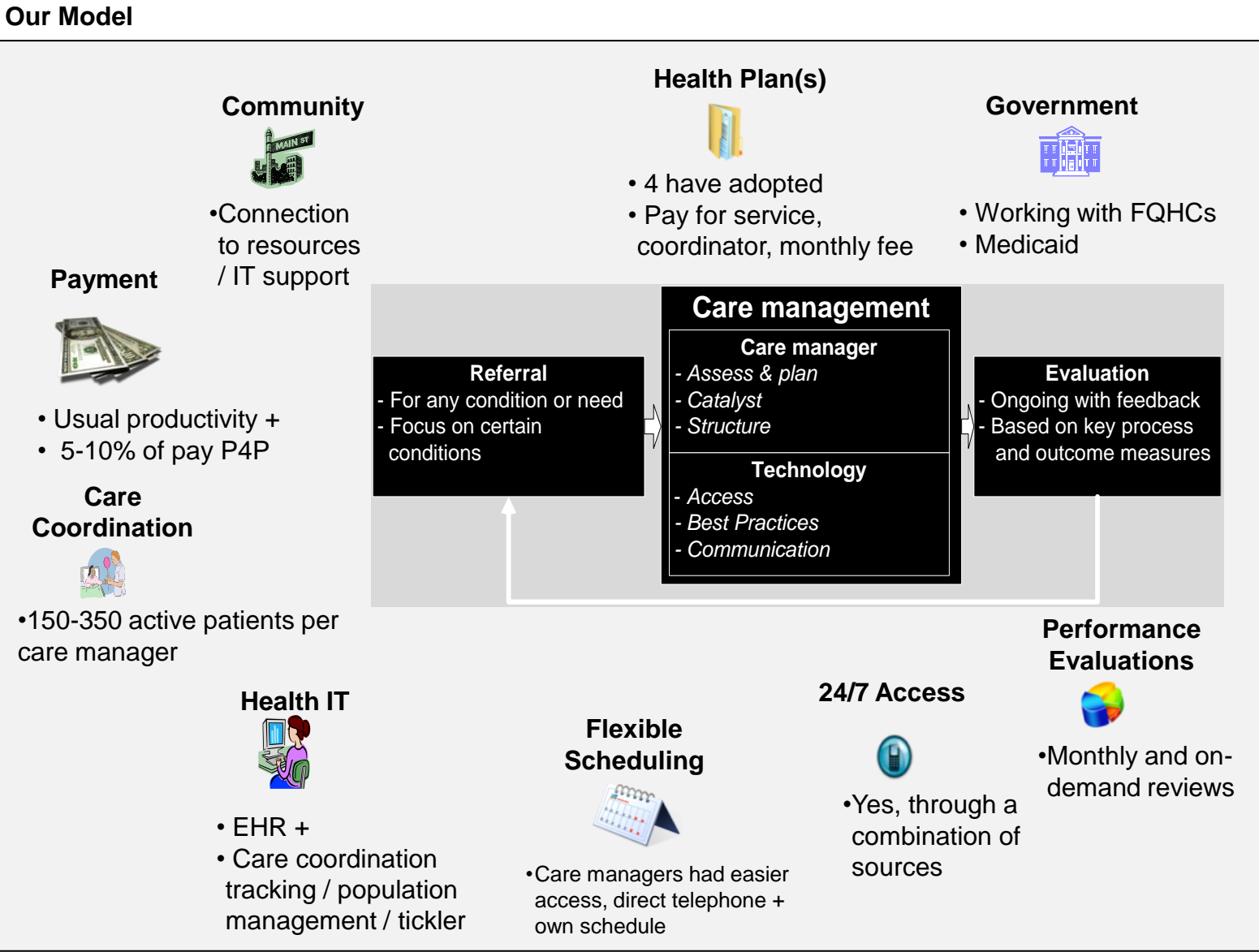
Intermountain Healthcare Medical Group has a successful medical home program in Utah with redesigned HIT + embedded care managers; OHSU has dissemination phase, training over 75 clinical teams.

- Pilot with 4,700 patients, 72 doctors, 7 primary care clinics (+ 6 control clinics)
- Patient population: 5% of most at-risk older adults and patients with complex chronic illnesses.
- Duration : 6 years (+ 2 for dissemination)

Timeline



Care Management Plus: MODEL DESIGN



Care Management Plus: RESULTS

Health outcomes

- ✓ **Reduced** hospital admissions: Absolute reduction in patients with complex illness **4.5%** at one year; **8.7%** at two years; reduction in all patients **2.9%** at two years.
- ✓ **Increased** Guideline Compliance: **24-42%** increased compliance for diabetes, depression.
- ✓ **Reduced** mortality: Absolute reduction of 2.8% at 1 year and 3.4% at two years



Cost savings / Productivity

- ✓ **Total Savings:** For patients with complex illness, estimated savings in Medicare **\$163k** per practice with cost of \$90k.
- ✓ **Savings** per patient: Decrease of **\$640-\$1650*** per patient per year
- ✓ **Increased** productivity: **8-12%** increase in work Relative Value Units per physician

Satisfaction

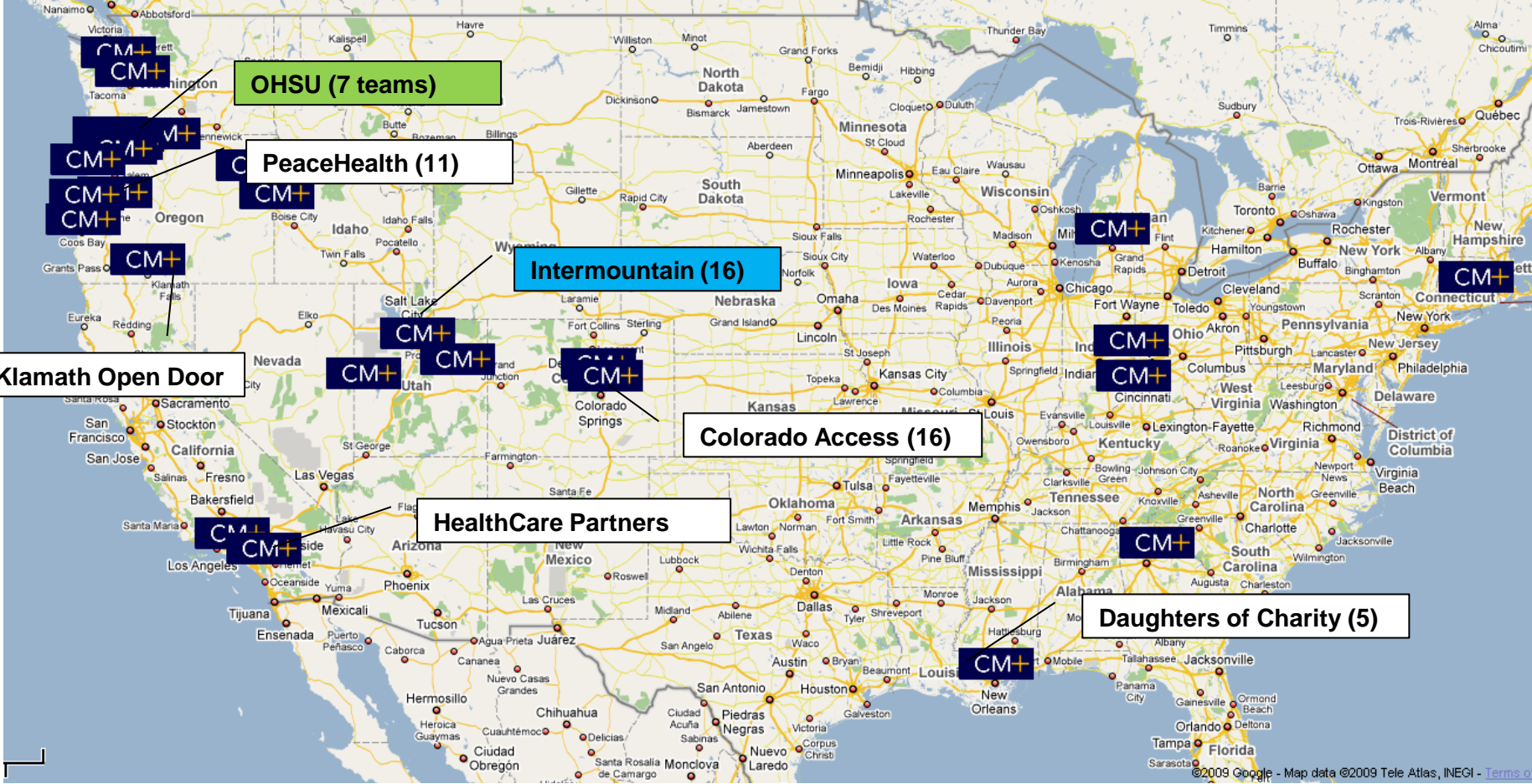
- ✓ Patient / Families: ‘ a life-saver’, ‘the reinforcement was wonderful’, ‘they really care’, ‘[CM] gives me more time ... and answers’
- ✓ Physician/ Nurses: ‘I am working smarter, not harder’, ‘Patients are less anxious, care more consistent, team is stronger’, ‘Wish I had these skills years ago’, ‘[Computer tools are] an absolute godsend’

Deaths: 6.5% died in CM+ and 9.2% in control at 1 year; 13.1% died in CM+ and 16.6% in control at 2 years.

Hospitalizations: Complex illness including diabetes: 1 year – CM+ 21.2%, Control 25.7%; 2 years 30.5%; control 39.2%; all: 31.8% vs 34.7% at 2 years (-2.9%); * Higher is for patients with 1+ hospitalization per year.

Peer-reviewed references available online at www.caremanagementplus.org

Dissemination : to more than 75 clinical teams



Care Management Plus : a proven medical home model for high need, high cost beneficiaries
www.caremanagementplus.org

Care Management +: DISSEMINATION AND ADVICE FOR FUTURE MODELS

Care Manager

- Nurses or social workers best, although multiple options for small clinics
- **Training** individual and team essential: core competencies – e.g., care of older adults, prioritization, behavioral / motivational interviewing, and assessments.

Health IT

- **Proactive, meaningful use for care coordination:** populations, reminders about care plans, summaries, performance measurement
- **Technical assistance is critical** : need to enhance use of HIT to be successful in the clinic.
- Use to measure implementation of components: in our 75 teams, we found **73% of components adopted.**

Reimbursement

- Reimbursement is critical to effective, sustainable models; for example,
 - **Pay for proactive care:** care coordination calls, goals, motivational interviewing, education
 - Per member per month with sustained usual care
- At-risk patient populations should be targeted, but not exclusively

