

# Developing Effective Practice Reform Strategies in Practice Redesign

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Care Management Plus: Dissemination of Information Technology Tools for the Care of Seniors

[www.caremanagementplus.org](http://www.caremanagementplus.org)

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# Outline

1. Roles of health information technology
2. Key features of practice redesign
3. Next steps - start with an office Quality Improvement plan

# Case Discussion: Mrs. J

78 year old with Diabetes, HTN, High Lipids


- Her husband brings her to clinic for a check up and mentions he is concerned about her recent confusion with medicines and low blood sugar after taking extra pills.
- What do you focus on? What's most important?
- What quality measures apply to Mrs. J?
- How do you address these issues for others?

# Patient Worksheet

- Summary of patient information
  - Conditions, medications, allergies
- Lab and clinic data relevant to chronic conditions
  - Function, Diabetes, heart failure, depression, hypertension
- Includes advisories for preventive care and chronic conditions

# Patient Worksheet

Wilcox, Proc of AMIA Symp, 2005

16 November 2006		 <b>Patient Worksheet</b> Selected to Print for: All Patients, All Sections, Last Clinical Note			u1.07.0 Comprehensive Version		
<b>PATIENT NAME</b> TEST, BED		<b>SEX</b> F	<b>DOB</b> 01/01/1911	<b>MIN#</b> 650730	<b>MRN#</b> 5992114		
<b>Problem:</b>							
Diabetes Mellitus, Type 2 Hyperlipidemia		<b>Chronic conditions</b>					
<b>Active Medications:</b>							
1. - Glucophage (Metformin HCl), 500mg, Tablet, 1 TABLET, Daily 2. - Simvastatin, 40mg, Tablet, Oral; 1 TABLET, Daily 3. - Lisinopril, 10mg, Tablet, Oral; No dose for 11/16/2006 4. - Calcium Carbonate/Vitamin D (Calcium 500 W/Vitamin D), 500-200, Tablet, 1 TABLET, BID							
<b>Allergies:</b>							
(-) Penicillins - A Drug Allergen Group; Reaction(s): Rash							
<b>Disease Management:</b>							
<b>ADL</b> 11/16/2006 5		<b>Pain Score (0-10)</b> 11/16/2006 4		<b>MMSE</b> 11/16/2006 24			
<b>Preventive Care:</b>							
<b>Pap Smear</b> No Data		<b>Mammogram</b> No Data					
<b>Clinical Laboratory Data:</b>							
<b>HgbA1c (&lt;=7.0)</b> No Data		<b>U.A. Protein</b> No Data		<b>uAlb:Cr (&lt;=30)</b> No Data		<b>24 Urine Albumin (&lt;=30)</b> No Data	
<b>Serum K</b> No Data		<b>Lipid Profile</b> No Data		<b>LDL (&lt;=100)</b> No Data		<b>Trig (&lt;=150)</b> No Data	
<b>HCT</b> No Data		<b>HsCRP</b> No Data		<b>Homocysteine</b> No Data		<b>TC/HDL Ratio</b> No Data	
<b>Clinic Data:</b>							
<b>Date</b> 01/16/2006		<b>Weight</b> 144 lbs		<b>BMI (&lt;=25)</b> 23		<b>Weight Class</b> Normal	
<b>Date</b> 01/12/2005		<b>Weight</b> 155 LBS		<b>BMI (&lt;=25)</b> 25		<b>Blood Pressure (&lt;=130/80)</b> 122/74 mmHg	
<b>Date</b> 05/12/2003		<b>Weight</b> 50.00 N/A		<b>BMI (&lt;=25)</b> -		<b>Heart Rate</b> 74	
<b>Last foot exam:</b> 11/2005		<b>Abnormal</b>		<b>Last dilated retinal exam:</b> 11/2005		<b>Abnormal</b>	
<b>Reminders:</b>							
<b>Lab</b>							
<input type="checkbox"/> Creatinine - Patient on Metformin product(s) and no Creatinine on record.							
<input type="checkbox"/> HgbA1C - Urine Albumin Test - DL - Serum Cr (should be done on all Patients with Diabetes)							
<input type="checkbox"/> HCT - Serum K (should be done on all Patients with Diabetes)							
<b>Procedure:</b>							
<input type="checkbox"/> Mammogram - Suggested yearly for women age 40 and above, every 1-2 years age 50 and above.							
<input type="checkbox"/> Pneumovax - Suggested for all Patients age 65 and older, and those with chronic lung disease.							
<input type="checkbox"/> Tetanus Immunization - Suggested yearly.							
<input type="checkbox"/> DEXA Screening - Suggested for women age 65 and over. Follow-up screening for those treated for osteoporosis recommended every 2-3 years.							
<input type="checkbox"/> Colon Cancer screen - Suggested yearly rectal test or sigmoidoscopy Q 5 years, or colonoscopy Q 10 years.							

Chronic conditions

Medications

Allergies

Functional status

Preventive care summary

Pertinent labs

Pertinent exams

Passive reminders

Organized by illness

- My Health
- Select Patient
- Clinic Schedule
- Web Forms
- HELP/Tandem
- Demographics
- Problems
- Clinical Notes
- Allergies
- Rx
- Lab
- Micro
- Lab Order Entry
- Message Log
- ECG
- Image Acquisition
- Report Manager
- HotText
- Radiology
- Insurance
- Meds Review
- Vital Signs
- Encounters
- ESign
- 4Medica
- Height/Weight
- CAC INR
- CAC
- E-Resources
- Need Help?
- Password
- What's New?

**Web Forms** Settings

Type: **Progress Notes - Ge**

Status: **Preliminary/Signable**

Load Last Form: **SOAP Note**

Load Data POC: **Senior Clinic at LDSH**

Worksheet Save & Print Save & Sign Save Clear

Level of physical Activity: [ ] times/week

[ ] Minutes/Session

Patient has Consulted with a Dietitian?  When? [ ] [mm/yyyy]

Patient has Consulted with a Diabetes educator?  When? [ ] [mm/yyyy]

Do you need more education on diabetes issues?

**Eye Exam**

Date of Exam: [ ] [ ] [ ] [ ] [ ] [ ]

Abnormal  Normal  Unknown Clear

Sno:	Have you recently had ...?	All No	Yes	No
------	----------------------------	--------	-----	----

1.	Low blood sugar reaction? (a) If so, did you need help from another person? <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
----	---	--	--------------------------	--------------------------

2.	Sores on your feet or legs?		<input type="checkbox"/>	<input type="checkbox"/>
----	-----------------------------	--	--------------------------	--------------------------

3.	Pain or numbness in your feet or legs? <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Leg <input type="checkbox"/> Right Leg		<input type="checkbox"/>	<input type="checkbox"/>
----	---	--	--------------------------	--------------------------

4.	Changes in your Vision(+Changes)? <input type="checkbox"/> Visual Acuity <input type="checkbox"/> Cataracts <input type="checkbox"/> Macular Degeneration Comments: [ ]		<input type="checkbox"/>	<input type="checkbox"/>
----	---	--	--------------------------	--------------------------

5.	New Sexual difficulties? (+specifics) <input type="checkbox"/> Difficulty obtaining Erections <input type="checkbox"/> Difficulty Climaxing <input type="checkbox"/> Difficulty maintaining Erections <input type="checkbox"/> Decreased Libido Comments: [ ]		<input type="checkbox"/>	<input type="checkbox"/>
----	--	--	--------------------------	--------------------------

6.	Recent admission to hospital or ED? (+details) <input type="checkbox"/> Hospital Admission Diabetes Related <input type="checkbox"/> ED Visit Diabetes Related <input type="checkbox"/> Hospital Admission Not Diabetes Related <input type="checkbox"/> ED Visit Not Diabetes Related Comments: [ ]		<input type="checkbox"/>	<input type="checkbox"/>
----	---	--	--------------------------	--------------------------

7.	Pain or tightness in your chest?		<input type="checkbox"/>	<input type="checkbox"/>
----	----------------------------------	--	--------------------------	--------------------------

8.	Nausea or discomfort after eating?		<input type="checkbox"/>	<input type="checkbox"/>
----	------------------------------------	--	--------------------------	--------------------------

9.	Difficulty with personal stress?		<input type="checkbox"/>	<input type="checkbox"/>
----	----------------------------------	--	--------------------------	--------------------------

10.	Do you smoke? (+packs/day) Packs/day: [ ]		<input type="checkbox"/>	<input type="checkbox"/>
-----	--	--	--------------------------	--------------------------

# Geriatric Assessment: Patients to Target

- Age threshold >65, >75, >85
- Vulnerable Elders Survey (VES-13)
  - Function-based tool for screening community-dwelling
  - Score of 3 or greater indicates increased risk for health deterioration (2 pts for age over 85, 2 pts for fx difficulty)
  - Simple
  - Can be administered over the phone

# Assessing Care Of Vulnerable Elders (ACOVE)

- Identified vulnerable elders
- Defined quality indicators based on literature review and expert panel for 22 conditions that affect older persons
- Examined as process of care (by structured interview and chart review) for each condition  
[http://www.rand.org/pubs/working\\_papers/WR515.3/](http://www.rand.org/pubs/working_papers/WR515.3/)

# ACOVE Findings

- Overall 54% of quality indicators met
- High numbers of quality indicators met for common diseases in older persons (hypertension, diabetes)
- Low numbers (29-41%) of quality indicators met for geriatric conditions (incontinence, etc.)

# Geriatric Domains

1. Medications
2. Mobility/Falls
3. Cognition
4. Function
5. Social Support
6. Advance Directives
7. Hearing
8. Vision
9. Health Assessment
10. Incontinence
11. Nutrition
12. Depression

# Mrs. J

What do you focus on? What's most important?

Immediate safety concerns

Hypoglycemia: confusion, seizures, brain injury,  
cognitive loss, death

Delirium: BS, meds, multiple: infection, hypoxemia, etc.

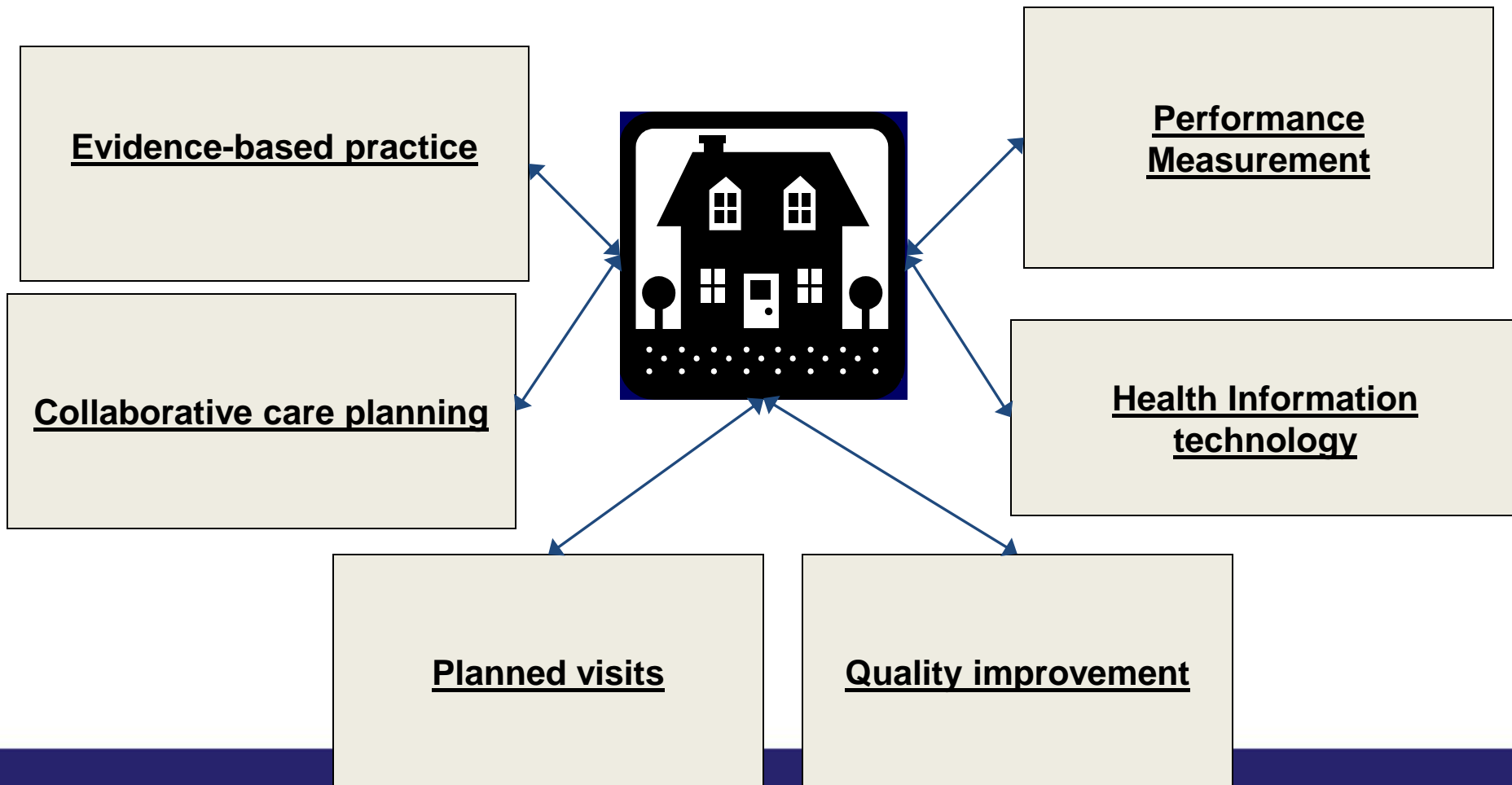
Chronic: Diabetes, HTN, High Lipids

Geriatric Domains: cognition, fall risk, caregiver,  
nutrition

Multiple quality measures apply

Clinic Population: How do you know? How do you  
address these issues for others?

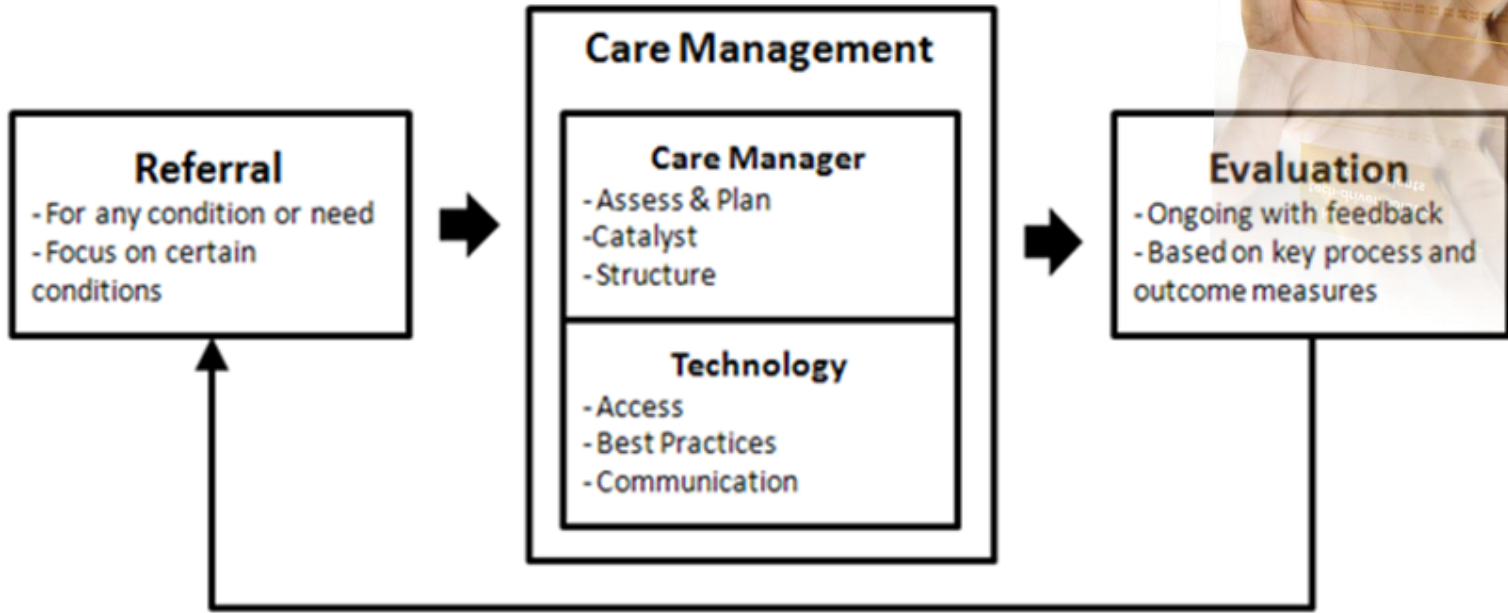
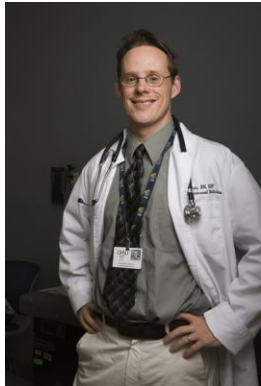
# Elements of Medical Home



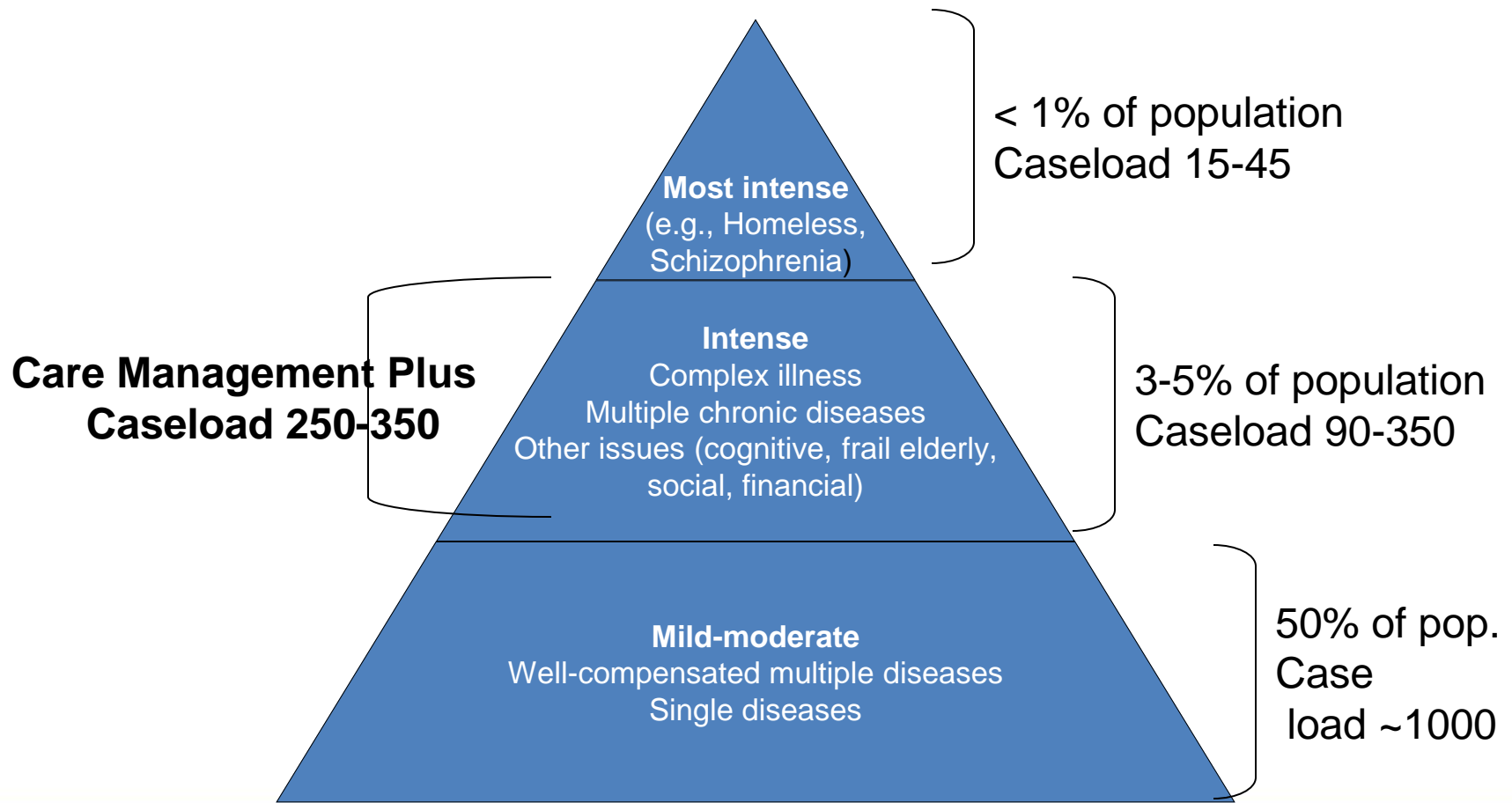
# Requirements for Effective Collaborative Care

- Team members must have ACCESS to relevant patient information
- Implement BEST PRACTICES
- And COMMUNICATE effectively

# Care Management Plus Program



# Care management varies in intensity and function for different populations and needs



# CM Role in Measuring Quality

- Knowledge of Best Practice Guidelines
- Population Management
  - Diabetes
    - Standards of Care (Call patients--Self Management)
    - HbA1C (every 3-6 months)
    - Urine Microalbumin <30 (yearly)
    - Lipid LDL <100 (yearly)
    - BP in control < 130/80
    - Target High Risk A1C > 8
  - Asthma
    - ER admit
    - Control
    - Target: High beta agonist use

# CM Summary

- Focus on:  
Independence/Prevention/Wellness
- Empower patients to Self-Manage
- Reduce Fragmentation of Care
- Promote Teamwork!!
- Promote Quality & Optimal Use of Resources
- Opportunity for Innovation

# Does CM+ make a difference?

## Study design:

- Retrospective cohort
- Comparison of care managed (CM) patients (7 clinics) with patients from similar clinics w/out care managers (n=4)
- CM patients matched to controls on key characteristics

## Outcomes

- Disease control, death, hospitalization
- Efficiency

# Guideline Adherence in Diabetes: Results

Outcome	Odds Ratio
Overdue for HbA1c test	0.79*
HbA1c Tested	1.42*
HbA1c in control (<7.0)	1.24*

\* $p < 0.01$

Dorr, HSR, 2005

# Physician Perspectives of Care Management

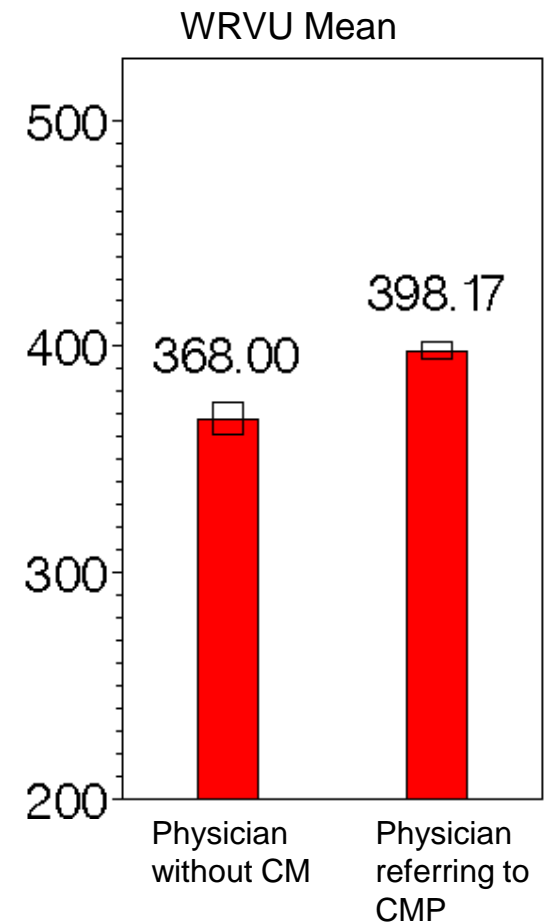
- improved productivity
- improved quality of care
- better understanding of patient status
- higher provider satisfaction

Care Management Journals 2007

# Results: Cost Savings / Productivity

Physicians who referred to care managers were more efficient through better documentation, a slight increase in visits, and a change in practice pattern.

- ✓ 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



# 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** 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%)

Peer-reviewed references available online at [www.caremanagementplus.org](http://www.caremanagementplus.org)

# Patient

- 78 year old with coronary artery disease, Class C heart failure, diabetes type 2, inflammatory bowel disease
- Clinic Perspective

# His Perspective

- Making change
- Total person
- Feedback
- Spectrum of care
- Integration of physical, mental, spiritual
- Quality of Life

# Reporting What You Do and Getting Credit: Medicare Care Management Program (MCMP) Example

- 3 year demonstration program in 4 states

00:11:32 | Save | Cancel | Check

Demographics DM HF CAD PC

**DM Confirmation** ?

DM Confirmed: Yes

**DM1 \* & DM2 : Latest HbA1c Result** ?

HbA1c Test: Yes

Date Drawn: 06/10/2009

Value: 6.6

**DM3 : Blood Pressure Management** ?

Most Recent BP: Yes

Date Taken: 06/10/2009

Systolic: 168

Diastolic: 75

**DM4 \* & DM5 : Latest LDL-C Result** ?

LDL-C Test: Yes

Date Drawn: 12/10/2008

Value: 122

**DM6 \* : Urine Protein Testing** ?

Med. Attention Nephropathy: Yes

**DM7 \* : Eye Exam** ?

Performed: Yes

**DM8 : Foot Exam** ?

Performed: Yes

**Comments (200 chars. max.)**

DM 6 patient on Lisinopril  
DM8 foot exam 02/10/09

**Patient Status** ?

Pt. Data: Complete

Warnings: No

Locked By: Unlocked

Updated: 02/10/2010 01:25 PM

Last User: admin

Topic	Dx.	Rank
DM	Yes	5
HF	No	----
CAD	No	----
PC	Yes	----
PC-1: BP		38
PC-5: Mammo		----
PC-6: Colo.		41
PC-7: Flu		41
PC-8: Pneumo		22

**Database Info.** ?

Perf. Year: FY2

Min. Date: 07/01/2008

Max. Date: 06/30/2009

Mode: Browsing

\* Claims-based measure

00:14:57 | Save | Cancel | Check

Demographics DM HF CAD PC

**HF Confirmation** ?

HF Confirmed: Yes

**HF1 : LVF Assessment Result** ?

LVF Result: Yes

**HF2 \* : LVF Testing** ?

Hospitalized: Claim Not Found

LVF Performed:

**HF3 : Weight Measurement** | Comments

	Pre-filled	Visit Date	Weight	Invalid	Why Invalid
*					
	<input checked="" type="checkbox"/>	06/03/2009	Yes	No	
	<input checked="" type="checkbox"/>	02/25/2009	Yes	No	
	<input checked="" type="checkbox"/>	01/07/2009	Yes	No	
	<input checked="" type="checkbox"/>	12/01/2008	Yes	No	
	<input checked="" type="checkbox"/>	11/25/2008	Yes	No	

**HF5 : Patient Education** ?

HF Education: Yes

**HF6 & HF7 : LVSD & Drugs** ?

Has LVSD: No

Beta Blocker:

ACE-I/ARB:

**HF8 : Atrial Fibrillation** ?

Atrial Fibrillation: Yes

Warfarin: Yes

**Patient Status** ?

Pt. Data: Complete

Warnings: No

Locked By: Unlocked

Updated: 02/09/2010 02:11 PM

Last User: admin

Topic	Dx.	Rank
DM	No	----
HF	Yes	1
CAD	No	----
PC	Yes	----
PC-1: BP		40
PC-5: Mammo		----
PC-6: Colo.		45
PC-7: Flu		45
PC-8: Pneumo		23

**Database Info.** ?

Perf. Year: PY2  
 Min. Date: 07/01/2008  
 Max. Date: 06/30/2009  
 Mode: Browsing

\* Claims-based measure

# Meaningful Use of Health Information Technology by CMS

Federal register, 556 page rule

Stage 1 2011: 25 requirements

Stage 2 2013

Stage 3 2015

[www.cms.hhs.gov/Recovery/11\\_HealthIT.asp](http://www.cms.hhs.gov/Recovery/11_HealthIT.asp).

# Meaningful Use Stage 1, sample of measures

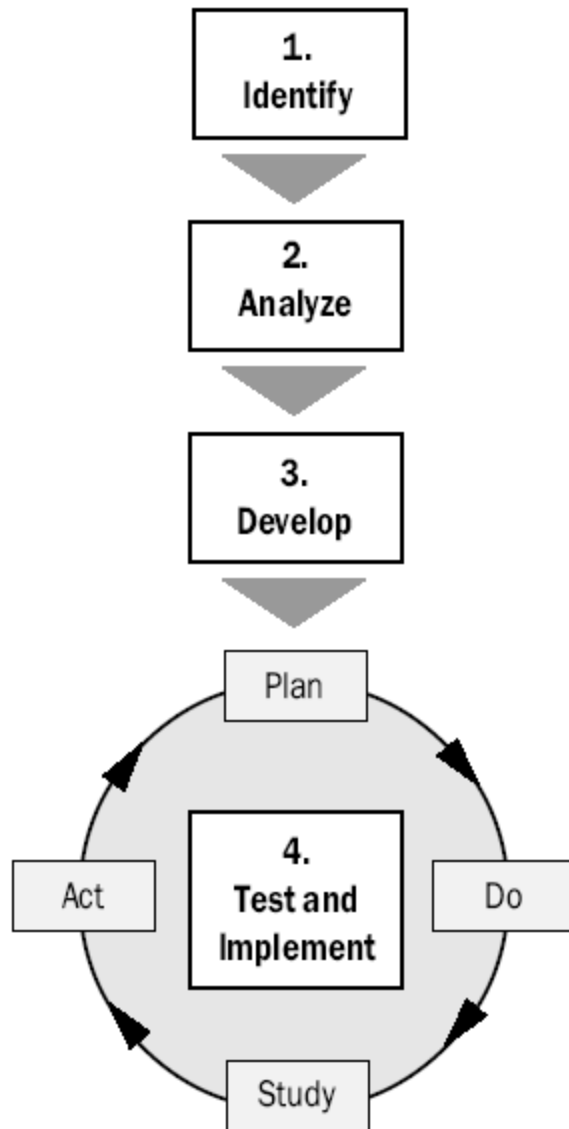
- 80% of orders must use computerized physician order entry
  - 80% of unique patients must have their demographics and vital signs recorded
  - 50% of patients must receive preventative or follow-up care reminders
  - Capacity to exchange key clinical info must be performed (problems, meds, allergies, test results)
- \$44,000 over 5 yrs, \$63,750 for practices at least 30% Medicaid

**[www.cms.hhs.gov/Recovery/11\\_HealthIT.asp](http://www.cms.hhs.gov/Recovery/11_HealthIT.asp)**

# Resources

- TransforMED
- METRIC (AAFP)
- Quality Improvement Organizations
- Regional Extension Centers (RECS)

# Evaluating process



1. Identify	Determine what to improve
2. Analyze	Understand the problem
3. Develop	Hypothesize about what changes will improve the problem
4. Test/ Implement	Test the hypothesized solution to see if it yields improvement; based on the results, decide whether to abandon, modify, or implement the solution

From Massoud, et al, 2001

# Getting Started

1. TEAM comes to consensus on GOALS, start DOCUMENTATION, identify problems and run PDSA CYCLES.
2. Focus: COMMUNICATION: UNDERSTANDING, FEEDBACK, RESPECT, CONNECT
3. Establish TEAM roles (especially who will do care management, follow-up, and population management)
4. Plan incremental change, series of cycles

# Evaluating Processes

- Documenting processes
  - How do you know what is happening now and what needs to be fixed?
  - Examples: team discussions, observing and writing down processes
- Testing processes
  - How will you know your changes are successful?
- Monitoring processes

# Training



# Care Management Plus Training: In-Person

## Conference

- Model & Outcomes of Care Management Plus
- Role of Care Manager, Motivational Interviewing
- Diabetes, Depression, Dementia, Geriatric Assessment/Tools, Case Discussion
- Patient/Family Assessment and Caregiver Support
- Quality Improvement for the office & Population View
- Work Groups: Projects
- Use of Care Manager Tracking Database
- Introduction to On-line learning

Care Manager, Clinic Manager, Physician Attend

CEU: 12 hours credit

# Online Course Hosted by OHSU

OHSU Sakai : Care Management Plus W09 : Home - Windows Internet Explorer

https://sakai.ohsu.edu/xsl-portal/site/e331bfa0-3e2a-4a75-bfbb-4964232215ed

Google sakai.ohsu.edu

OREGON HEALTH & SCIENCE UNIVERSITY

View Site As: - Select Role -

Welcome, Liza - [Logout](#)

My Workspace Care Management Plus W09 Care Mgmt + AY07-08 Development Resource ~Care Management Plus ~Care Management Plus Su08

## Care Management Plus W09

Home Syllabus Announcements Resources Submissions Evaluations Gradebook Site Editor Lessons Forums Mailtool Site Statistics Help

Liza Widmier

### Worksite Information

Options

**Continual Improvement**

**POLICY**  
*Adopt & Commit*

**PLAN**  
*Create & Organize*

**DO**  
*Communicate & Implement*

**CHECK**  
*Monitor & Correct*

**ACT**  
*Review & Adjust*

Designed for nurses involved in care management or planning to be care managers.

### Recent Announcements

Options

There are currently no announcements at this location.

### Messages & Forums Notifications

Options

Forums None

Internet | Protected Mode: On 100%

gadgets 8:25 PM

# Care Management Plus Training: On-Line for Care Managers

8 weeks On-line modules, weekly assignments

- <http://sakai.ohsu.edu>
- Expert calls
- Discussion board

Course Facilitator: Liza Widmier

Course Director: Cherie Brunker

Course Consultants: Pat Berry, Susan Butterworth, Maggie Lynch

CEU: 20 hours credit

- Pain
- Palliative & Hospice Care
- Advance Directives
- Hypertension
- Asthma & COPD
- Dizziness, Falls & Safety
- Frailty
- Others

# Care Manager Tracking Database

- Organizes and documents the work of care managers, Care Plan
- Chronic Disease Management: geriatrics, depression, heart failure, diabetes, hypertension
- Provides reminders for preventive care, follow-up of chronic disease, goals of care
- Provides data for queries and reports (can serve as a comprehensive “registry”)
- Best if integrated with EHR

# Patient Information

ID Number:  Last Name:  First Name: 
 DOB:  \* Age:   Sex:

Phone:  Cell Phone:  Email: 
 PCP:  PCP Phone:

Insurance:  Facility: 
 Diab Collaboration FPP:

Date of Referral:  \* Care Mgr:  Status:

### Patient Search

ID Number:   
 Last Name:   
 First Name:   
 Care Mgr:

Diag. Date	Diagnosis	Status	Sched Date	Sched Time	Encounter Type	Status
<input type="button" value="Edit"/> 2/28/2005	CHF	Active	<input type="button" value="Edit"/> 4/30/2005		Telephone Contact	Pending
<input type="button" value="Edit"/> 3/30/2004	Depression	Active	<input type="button" value="Edit"/> 1/30/2005		Hon	
<input type="button" value="Edit"/> 3/30/2004	Depression	Active	<input type="button" value="Edit"/> 1/26/2005		Telephone Contact	Resolved
<input type="button" value="Edit"/>			<input type="button" value="Edit"/> 10/18/2004		Telephone Contact	Resolved

MH Packet Date	Symp	Severity	Fctnal	Diff	Dysth.	Q9	Suicide State	Suicide Risk	[Mood 1 2 3]	MoodImp	MoodSx	AnxImp	AnxSx
<input type="button" value="Edit"/> 1/26/2005	1	3	Somewhat	<input checked="" type="checkbox"/>	0		No Risk						
<input type="button" value="Edit"/>							No Risk		16	45	14	52	
<input type="button" value="Edit"/>							Low Risk						

Diab Assess Date

Diagnosis

Encounter

Meds

MH Instruments

Pediatric Assess

New Patient

Save Patient

Delete Patient

Generate Clinical Note by Date

Diabetes History

Diab Pre/Post Knowledge Assess

Patient Goals

HF Follow-Up

CMT database - example

Call

### Care Manager Encounter Tickler List

Care Manager: Ann Larsen

Sched. Dt. and Time	Encounter Type	Enc. Reason	MMH	First Name	Last Name	Phone Number	Pri
2/17/04	Telephone Contact	DM F/U				(801)	Wo
2/17/04	Telephone Contact	DM F/U				(801)	Wo
2/17/04	Telephone Contact	DM F/U				(801)	Wo
2/17/04	Telephone Contact	DM F/U				(801)	Wo
2/17/04	Telephone Contact	Depression F/U				(801)	Obi
2/17/04	Telephone Contact	Dep F/u				(801)	Sm
2/17/04	Telephone Contact	DM F/U				(801)	Wo
2/17/04 6:30 AM	CM Office Visit					(801)	Wo
2/17/04 9:00 AM	Class					(801)	Smt
2/17/04 9:00 AM	Class					(801)	Met
2/17/04 9:00 AM	Class					(801)	Obi
2/17/04 9:00 AM	Class					(801)	Wo
2/17/04 10:40 AM	MD Office Visit	DM F/U				(801)	Wo
2/17/04 1:50 PM	MD Office Visit	DM F/U				(801)	Rur
2/17/04 3:00 PM	CM Office Visit					(801)	Wa
2/17/04 3:50 PM	MD Office Visit					(801)	Wo

# Task List

Before 3/10

IHC. Also detail

Do. wait pay at Smith

pm from 8:30-3:30

5 people

pcp Approve Test

who 14 papers

Home - do ink sent

Back - gen have

Turn on 5' 2" 100

7-10 deep - 300

If from cat effeder

Dr. McBride

# Practice Redesign: Adopting Care Mgt.

## 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



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# DISCUSSION