

## CAREMANAGEMENTPLUS

Funded by the John A. Hartford Foundation, Care Management Plus was initially developed at Intermountain Healthcare and is now being implemented in many clinics across the United States. Oregon Health and Science Center is the coordination center for dissemination, also funded by the Hartford Foundation. The initial geriatrics and information technology training at Intermountain Healthcare was in-person with 7 care managers for an afternoon every other month for 2 years. This afforded the opportunity for care managers to implement new tools and to bring cases for discussion. They were educated by a geriatrician in both senior care and chronic illness protocols and given tools to manage care of complex patients. Teaching sessions also included care manager generated topics and case discussions. We implemented the Patient Worksheet, a summary of chronic conditions, pertinent test and study results, and recommendations for care, and the Message Log, asynchronous messaging within the information system. We evaluated the use of care management, the Patient Worksheet, and Message Log. We also measured the total number of outpatient clinic visits during the same time period. For each measure, we calculated the number of senior (65+) patient encounters/uses/visits. **Results:** From 11/1/2004 to 11/1/2005, there were 3,543,657 outpatient visits to Intermountain Healthcare Clinics, including 301,831(8.5%) seniors. There were 12,525 care management patient encounters among the 7 care managers, of which 5,042 were with senior patients. The Patient Worksheet was printed 329,475 times, 90,585 times with seniors. There were 939,805 Message Log notes stored, 229,278 for seniors. The odds ratio for care management, the Patient Worksheet, and Message Log being used for a senior patient versus a non-senior patient were as follows: care management, 7.34 (7.08-7.61, p < 0.00001); Patient Worksheet, 5.39 (5.24 – 5.44, p < 0.00001); Message Log, 11.26 (11.16 – 11.36, p < 0.00001). **Conclusions:** A model for chronic disease management can be implemented broadly without neglecting senior patients. Indeed, analyses show that seniors were more likely to receive care both for chronic illness and social issues than other populations, indicating a focus on their specific needs. By combining geriatrics and chronic illness care, our system allows primary care clinics to implement a broad array of guidelines while managing scarce resources.



## Background

For vulnerable elders and others with multiple chronic conditions and variable social, emotional, or physical support, creating an appropriate plan and facilitating self-management can be challenging. Physicians may have *limited training* and *lack the time and tools* to most effectively care for those with chronic disease or frailty.

For those most in need, an interdisciplinary approach with specially trained clinic based care managers and information technology tools were developed. This primary care model serves as a Medical Home.

## Information Technology Tools

### Patient Worksheet

- summary of chronic conditions
- pertinent test and study results
- recommendations for care

### Care Manager Tracking Tool

- stand alone or integrate into EHR
- Documentation of Care Manager work
- Integration of decision support tools

Chronic conditions  
Medications  
Preventive care summary  
Pertinent labs  
Pertinent exams  
Passive reminders  
Organized by illness

## Former Geriatrics Curriculum

- Needs Assessment
- Care Manager input
- Geriatric Topics
- Discussion of Care Manger current cases
- On-Site, In-Person
- Every other month for 2 years
- About 30 hours total
- Electronic messaging with Geriatrician for case follow up and discussion

## Updated Curriculum

- Former topics molded into On-Line training
- Assignments
- Discussion board
- Expert Calls
- Start with 2 days In-Person Training “Jump start” especially for new positions
- “Hands on” for practicing tools: geriatric assessment
- Followed by 8 weeks of On-Line Modules
- About 2 hours/week: 30 hours total



## Training Objectives

Care Managers who successfully complete the Curriculum will gain skills to:

- Teach patients with multiple chronic diseases to organize, prioritize, and implement suggested self-management strategies
- Identify barriers to care and intervene to overcome or eliminate these when possible
- Coordinate resources to ensure that necessary services are provided at the most appropriate level of care and at the appropriate time
- Identify patient situations at-risk for destabilization and intervene to eliminate the risk when possible
- Gather, interpret, and use data to identify problems and trends and to demonstrate outcomes and cost-effectiveness



## Summary

The Curriculum was updated to facilitate adoption and widespread implementation of CAREMANAGEMENTPLUS.

## Key Features of Former and Updated Curricula

1. Geriatrics and information technology components
2. Emphasis on teaching self-management and supporting patient goals
3. Motivational Interviewing: care manager role as coach and facilitator
4. Teach evaluation of clinic population (incorporating principles of Quality Improvement)
5. Part-time commitment to encourage “on-the-job” training
6. Taught over period of weeks to foster application of tools
7. Innovation of curriculum based on evaluation and participant needs as they are identified

See CareManagementPlus.org

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