Care Management Plus: Technology + People to improve outcomes for at-risk persons

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More information at caremanagementplus.org

Why do we need care innovation?

Ms. Viera

- a 75-year-old woman
- with diabetes,
- systolic hypertension,
- mild congestive heart failure,
- arthritis and
- recently diagnosed dementia.

She comes to clinic with 5 issues …

+ two more ‘hallway issues’!

What can a primary care team do?

Past: Heroism in the face of multiple illnesses

Multiple diseases increase risk and coordination *exponentially* (5+ : 90 x risk of hospitalization; 10x Rx; 13 providers vs. 2) . Managing in a primary care panel would take 18 hrs/day. Patients have better process scores, but *worse* preventable Hospitalizations.

Intervention: Care Management Plus

Dissemination to over 170 clinical teams

Referral
- For any condition or need
- Focus on certain conditions

Care management

Care manager
- *Assess & plan*
- *Catalyst*
- *Structure*

Technology
- *Access*
- *Best Practices*
- *Communication*

Evaluation
- Ongoing with feedback
- Based on key process and outcome measures

Larger infrastructure: Electronic Health Record, quality focus

Anderson, 2004 ; Woolf, 2002; Baron, 2007, 2010; Werner 2008

CM+ can help you transform…from fragmented, confused care to proactive, effective care

Training

- Team-based
- In-person + on-line
- Experiential
- 5 faculty
- 27+ CEUs/CME

- $1500/person
- 130 paid participants in 2011
- Market : ~50,000 participants

HIT

- Adjunct to EHR
- Population management
- Care management tracking
- Clinical summaries
- Helps qualify for quality reporting, medical home, care coordination payments

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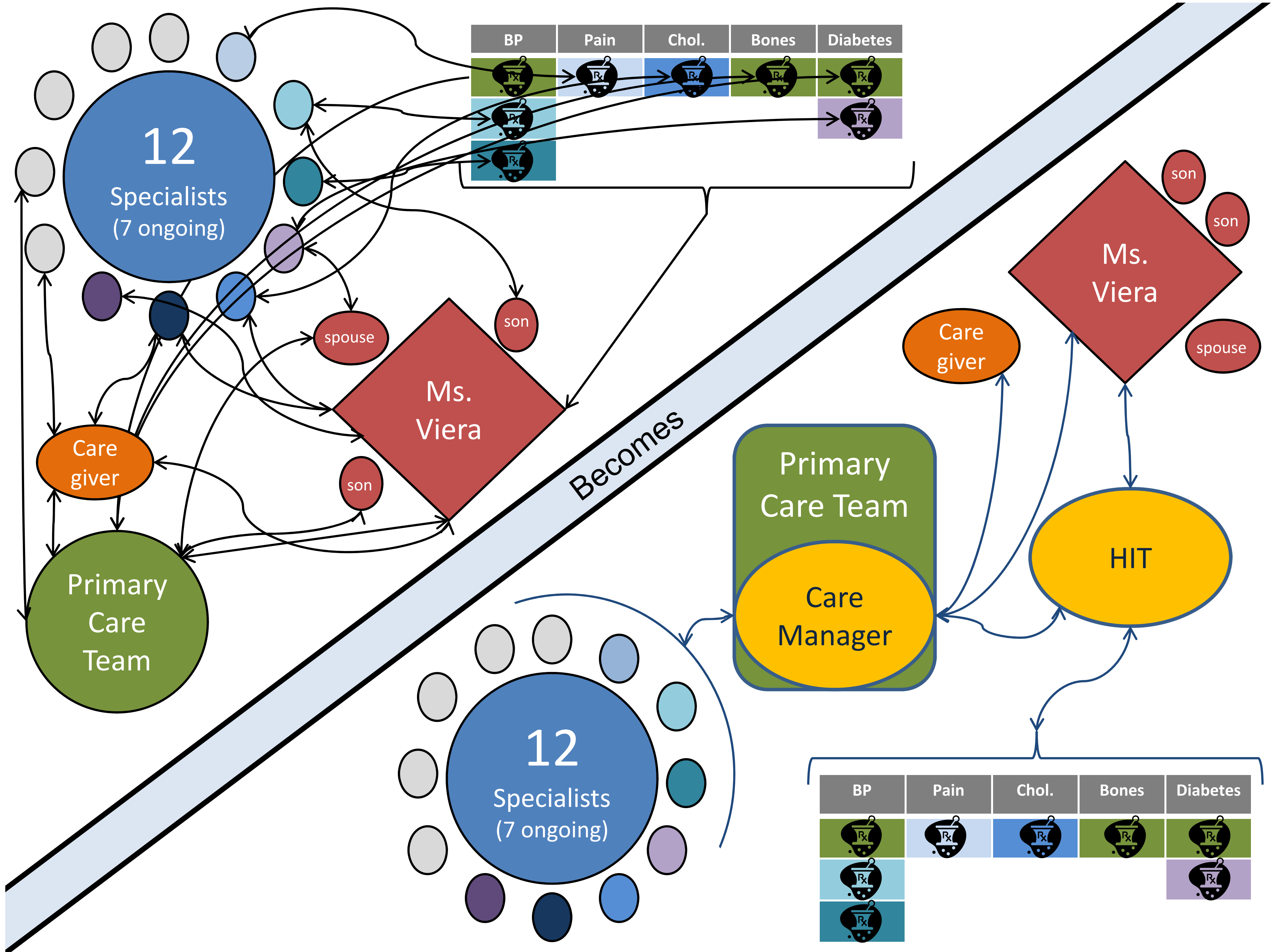
- $50 user license/year + costs
- $100k in contracts in 2011
- Market: ~10,000 clinics

Cost over installation year: ~$50,000 per clinic
Savings: $200-300,000 per clinic
NET BENEFIT: $150,000-250,000



BP
Pain
Chol.
Bones
Diabetes
12
Specialists
(7 ongoing)
spouse
son
son
Ms.
Viera
Care
giver
Primary
Care
Team
Becomes
son
son
Ms.
Viera
spouse
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giver
Primary
Care Team
Care
Manager
HIT
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Specialists
(7 ongoing)
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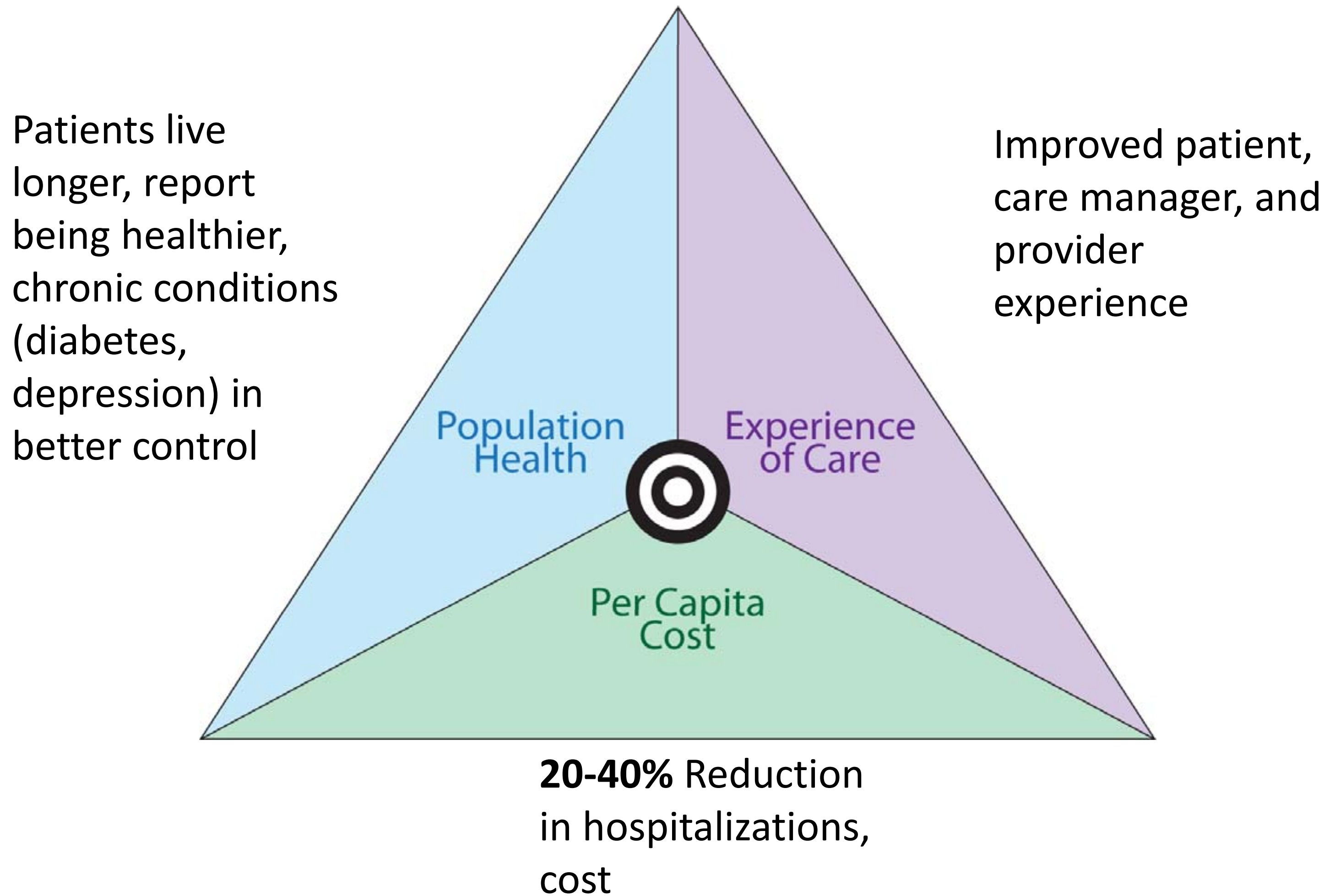
Evidence-based …

The TRIPLE aim of health care



Patients live longer, report being healthier, chronic conditions (diabetes, depression) in better control

Improved patient, care manager, and provider experience

20-40% Reduction in hospitalizations, cost

www.caremanagementplus.org/pubs.html

Efficient yet effective use of tools

Enroll and Create Tasks

Summary Graphs: Overall Team Comparison **Breakouts by Measure:** --Please Select--

-Prevention- -Diabetes- -Asthma- -CAD- -Hypertension-

DIABETES

Team Name	A1c < 7.0% (18+): Target Score: 52%	Score	N	LDL: Target Score: 55%	Score	N	Pneumovax: Target Score: 75%	Score	N
OHSU GIM		52%	201		57%	201		70%	200
Cascade		50%	201		57%	201		76%	200
Diamond		46%	263		59%	263		61%	263

Manage and Complete Tasks

Care Manager Encounter Tickler List

Care Manager: <----- All -----> **d Date:** 11/23/2009 ... 12/23/2009 ... Run

Care Manager: All Care Managers
For Time Period: 11/23/2008 to 12/23/2009

	Scheduled Date	Scheduled Time	Encounter Type	Reason	EHR ID	First Name	Last Name	Phone	PCP	Notes
Select	2009-12-18		Telephone Contact	Clinical Protocol(s)	4582317	Mariah	Bouchard	456.732.5236	Carl Generic	Quality Measure: Age PHQ2: 0 Lab Date: 12/01/2009
Select	2009-12-17	08:00	Telephone Contact	Goals	4582317	Mariah	Bouchard	456.732.5236	Carl Generic	PHQ9 Follow-Up:
Select	2009-11-16	13:00	CM Office Visit	Status Check	88888888	zzzzbugs	zzzzbunny			Meet with family and patient to discuss care plan

Patient-centered summary

Generate
Summarized Clinical
Information

Patient Worksheet

Binnes, Harry	**PRINT**

MRN: 1324234 **Sex:** M **DOB:** 01/24/1956
Phone: 9874584587 **PCP:** Parnel Fieldman
Care Manager: Susie Example **Caregiver:**

Next Care Management Encounter

Sched Date	Sched Time	Encounter Type
01/06/2010	09:00 AM	CM Office Visit

Last Care Management Encounter

Sched Date	Sched Time	Encounter Type
12/04/2009	08:00 AM	Telephone Contact

Diagnoses

Diabetes, Cystic Fibrosis, Anemia

Medications

Medication	Dosage	PRN	Med Start Date
albuterol		☐	08/07/2008

Goals

Status	Follow Up Date	Goal	Note	score	Set Date
Completed	12/21/2009	Nutrition		10	12/05/2009
Completed	12/21/2009	Activity		5	12/05/2009
Completed	11/13/2009	Activity		6	11/13/2009
Completed	11/13/2009	Nutrition		8	11/13/2009
Pending		Meds			10/06/2009

PHQ

Date	PH2 Score	PHQ9 - Severity	Q9 Suicide	Followup
12/02/2009	6	25	3	
11/05/2009	3	17	3	12/04/2009
07/07/2009		10	2	
07/02/2009			0	

Functional Status

Date	ADL	IADL	MMSE	Pain
07/08/2009			2	9
12/11/2009				

Care Actions

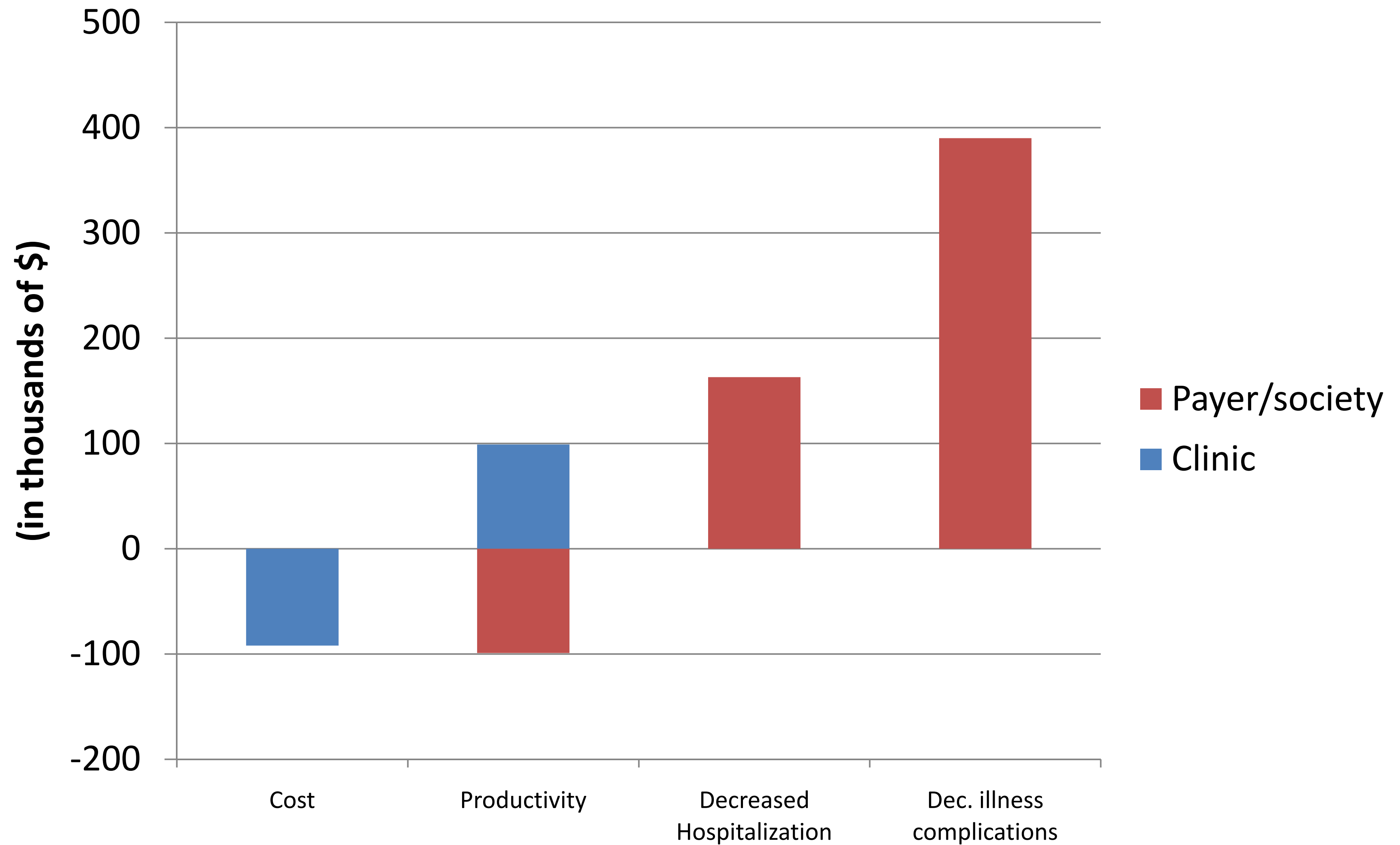
Diabetes Date/Value Status Preventative Care Date/Value Status

Care Actions

Diabetes	Date/Value	Status
A1c in Last 6 mo	10/06/2009	OK
A1c < 7	9.1	**A1c out of Range**
LDL Last Year	09/30/2009	OK
LDL < 100	130	**LDL HIGH**
Last Doctor's Visit is not available		

Preventative Care	Date/Value	Status
Patient > 50 needs flu shot at least once		**YES**

Return on Investment per clinic



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Thank you!

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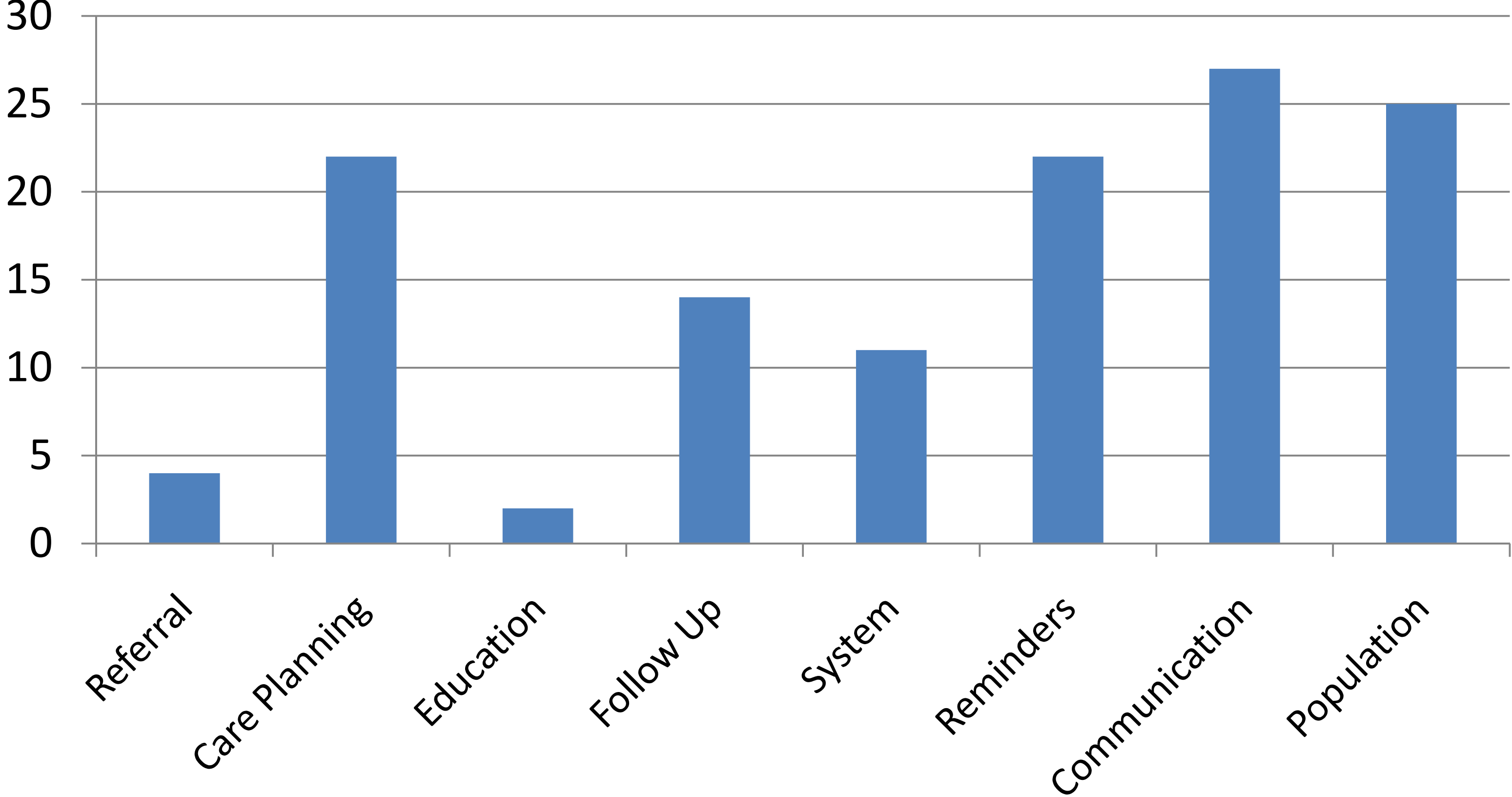
Additional Slides for topics

“Hello, Computer”

Most EHRs, as implemented, STILL don't have necessary functions



ICCIS Interactive Quality Reports

Selected Measure: Diabetics with hemoglobin A1c measured in the past 6 months (18-75)

Total: 7 Print

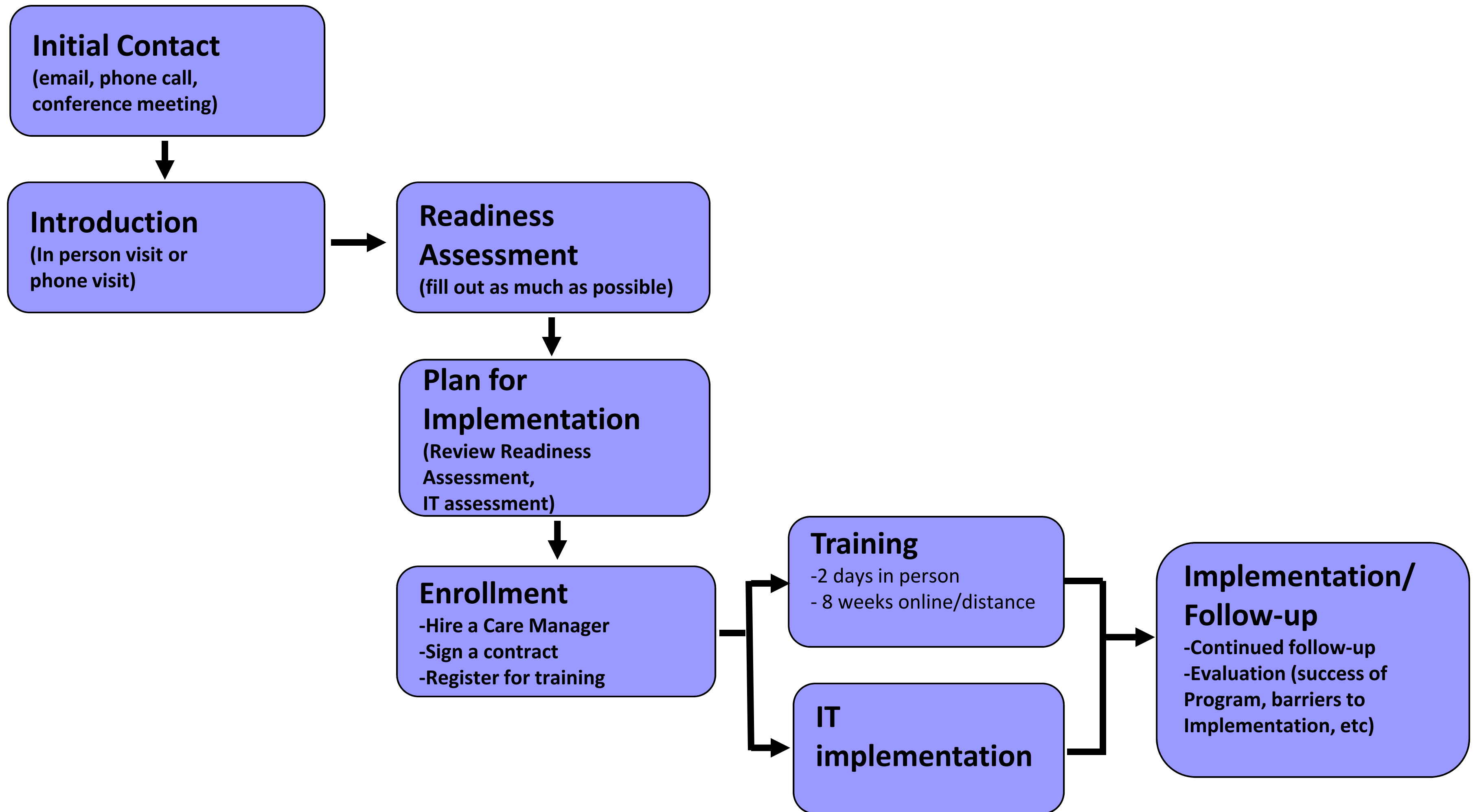
Value Adherence Rate: 57.143% **Date Adherence Rate: 85.714%**

Update Update

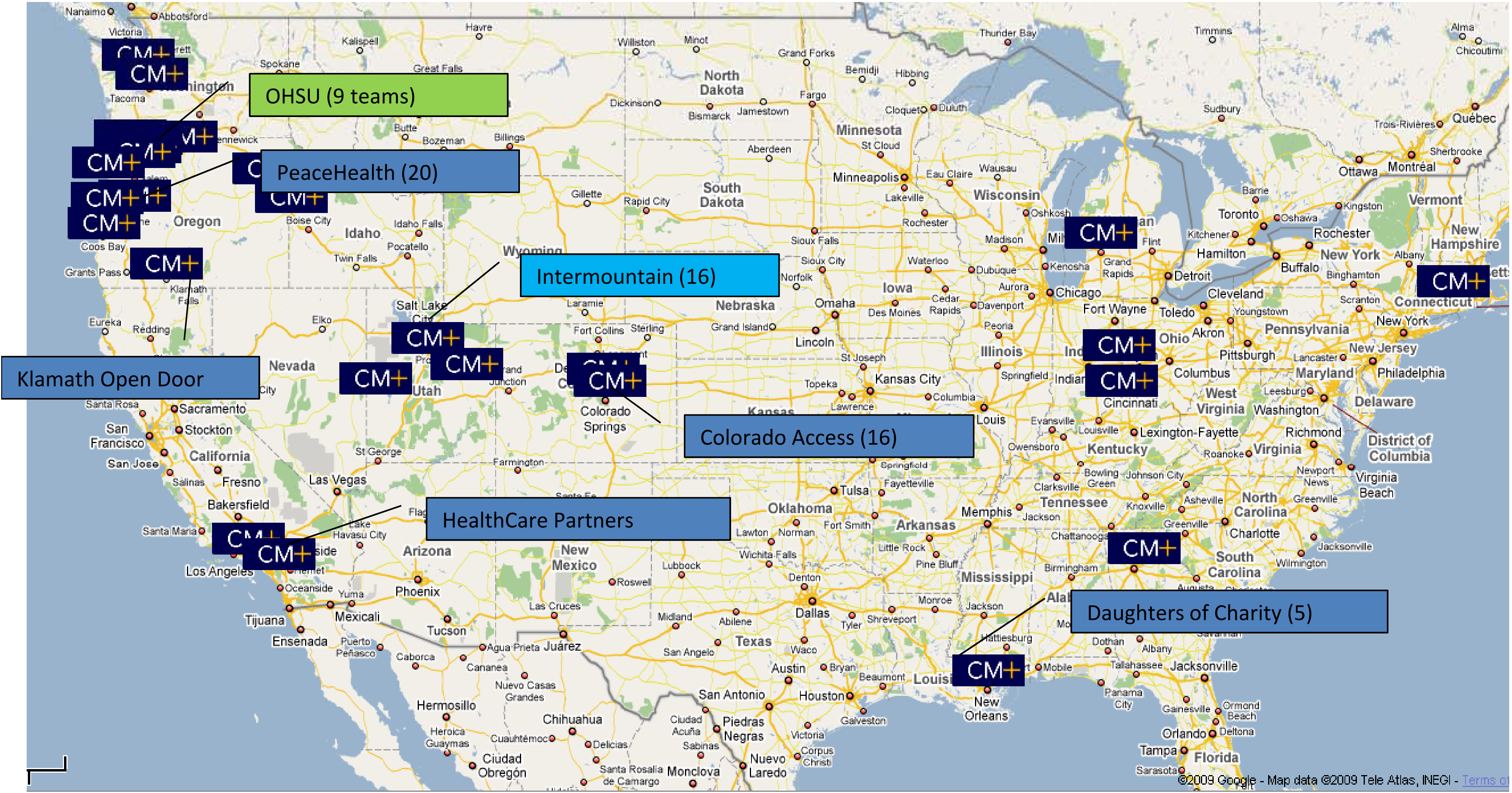
No Longer in Practice	Assign to CM Task	Patient	Phone	Physician	Lab	Lab Result	Lab Date	Exclude from ALL Diabetes	Exclude from this Measure ONLY
☐	☐	Binnes, Harry	9874584587	Parnel Fieldman	A1C	9.1	10/06/2009	☐	☐
☐	☐	Cline, bobby	987.546.7765	Hillary Caseman	A1C	6.1	09/30/2009	☐	☐
☐	☐	Gibbs, Jenny		Carl Generic				☐	☐
☐	☐	Holden, Henry		Carl Generic	A1C	7.7	10/06/2009	☐	☐
☐	☐	Montoya, Jerry	124.256.3526	Hillary Caseman	A1C	5.9	10/02/2009	☐	☐

The abilities to document exclusions at multiple levels and generate targeted population-based review cycles avoid the problems caused by static quality reports and allow providers to efficiently focus outreach efforts on high risk populations.

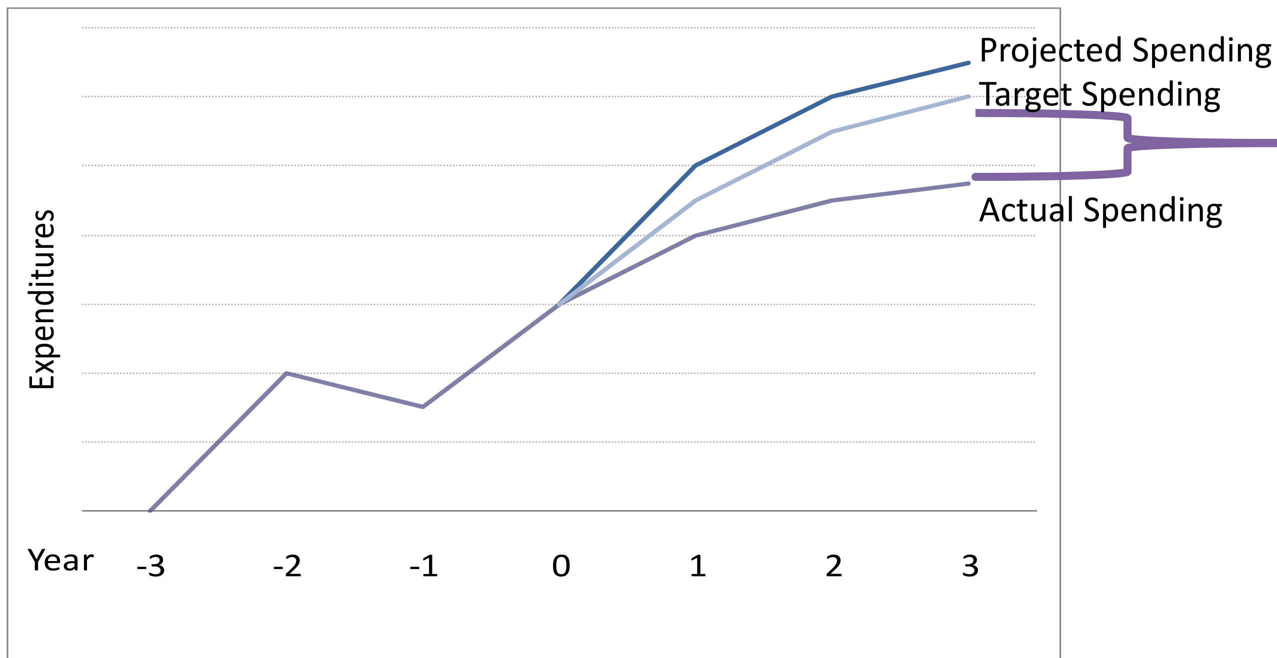
Stages to Implementation



What have we learned about dissemination in rolling out the program to over 170 clinical teams?



Changing incentives for people and providers



1. **Shared Savings**
   Example :
   Accountable Care Organizations

2. **Tiered payments**
   Example : Medical Home with risk adjustment

3. **Meaningful use of HIT**

4. **Care coordination / management payments**

Clinic Revenue with CMP