

Geriatrics Research at Intermountain

- Advancing Geriatric Education through QI (AGE QI)
- Cognitive Care: Assessing & Addressing Memory Loss in Primary Care – Kelly Davis Garrett
- Care Management Plus (CM+)

CM+: Dissemination of Information Technology Tools for the Care of Seniors
www.caremanagementplus.org

CM+ funded by the John A. Hartford Foundation, Intermountain Healthcare, the National Library of Medicine, and AHRQ





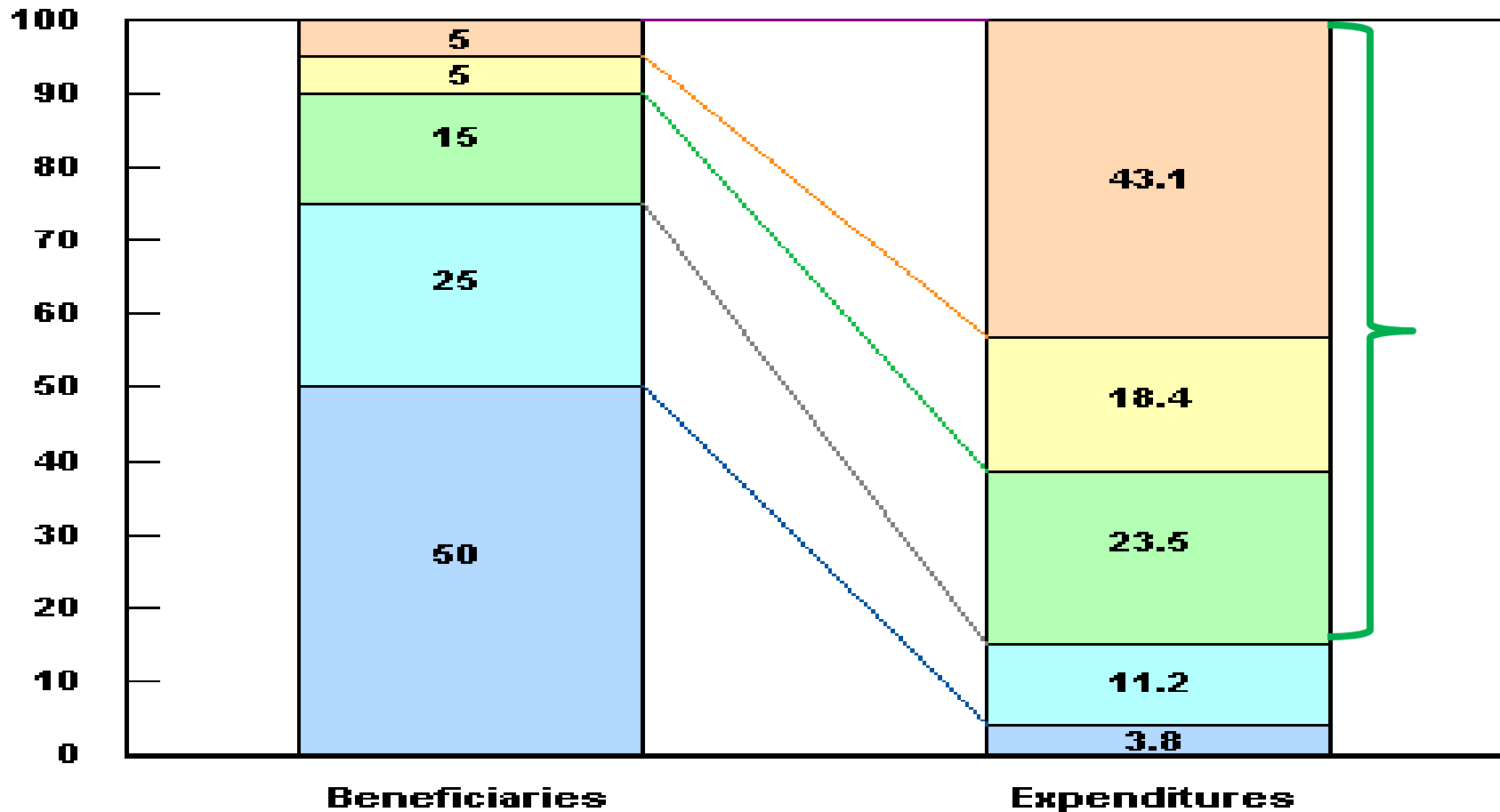
care
management
plus

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Health Care Costs



- Quartile with highest needs accounts for 88% of expenditures; top 5% account for 43% of expenditures.
- Systems (both technology and health systems) have difficulty meeting these needs.

Mission Impossible?



In your clinic, you see Mr. R
a 74-year-old man with
diabetes, hypertension, hyperlipidemia,
coronary artery disease and arthritis

Patient Worksheet

- Prepares the team for clinic visit
- Then is given to the patient as a reinforcing summary of visit

Wilcox, Proc of AMIA Symp, 2005

16 November 2006		Patient Worksheet			u1.070 Comprehensive Version																			
Selected to Print for: All Patients, All Sections, Last Clinical Note																								
PATIENT NAME TEST, BED	SEX F	DOB 01/01/1911	MRN# 650730	MRN# 5992114																				
Problems																								
Chronic conditions																								
Active Medications																								
1. - Glucophage (Metformin HCl), 500mg, Tablet, 1 TABLET, Daily 2. - ... 3. - ...																								
Allergies																								
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Disease Management																								
Functional status																								
Preventive Care																								
Preventive care summary																								
Clinical Laboratory Data																								
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Reminders																								
<p>Lab</p> <ul style="list-style-type: none"> [] Creatinine - Patient on Metformin product(s) and no Creatinine on record. [] HgbA1C - Urine Albumin Test - LDL - Serum Cr (should be done on all Patients with Diabetes). <p>Procedures</p> <ul style="list-style-type: none"> [] Mammogram - Suggested yearly for women age 40 and above, every 1-2 years age 50 and above. [] ... [] DEXA Screening - Suggested for women age 65 and older. Follow-up screening for those treated for osteoporosis recommended every 2-3 years. [] Colon Cancer screen - Suggested yearly fecal test or sigmoidoscopy Q 5 years, or colonoscopy Q 10 years. 																								
Passive reminders																								
Organized by illness																								

Mr. R's Office Visit

Mr. R comes to clinic with several problems

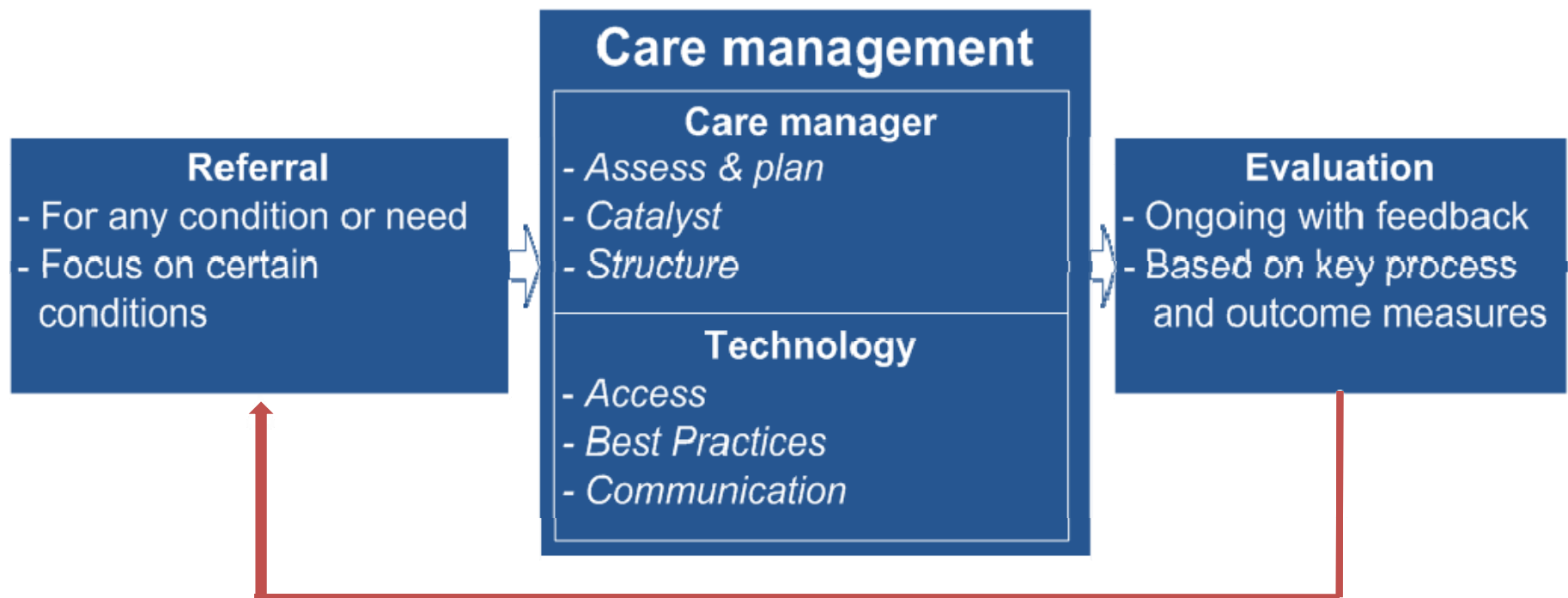
1. Hip and knee pain
2. Trouble taking all of his current 12 medicines
3. Dizziness when he gets up at night
4. Low blood sugars in the morning, and
5. A recent fall

And as he is leaving

6. He is stressed in helping care for his wife who has dementia
7. Money is running low for additional medications

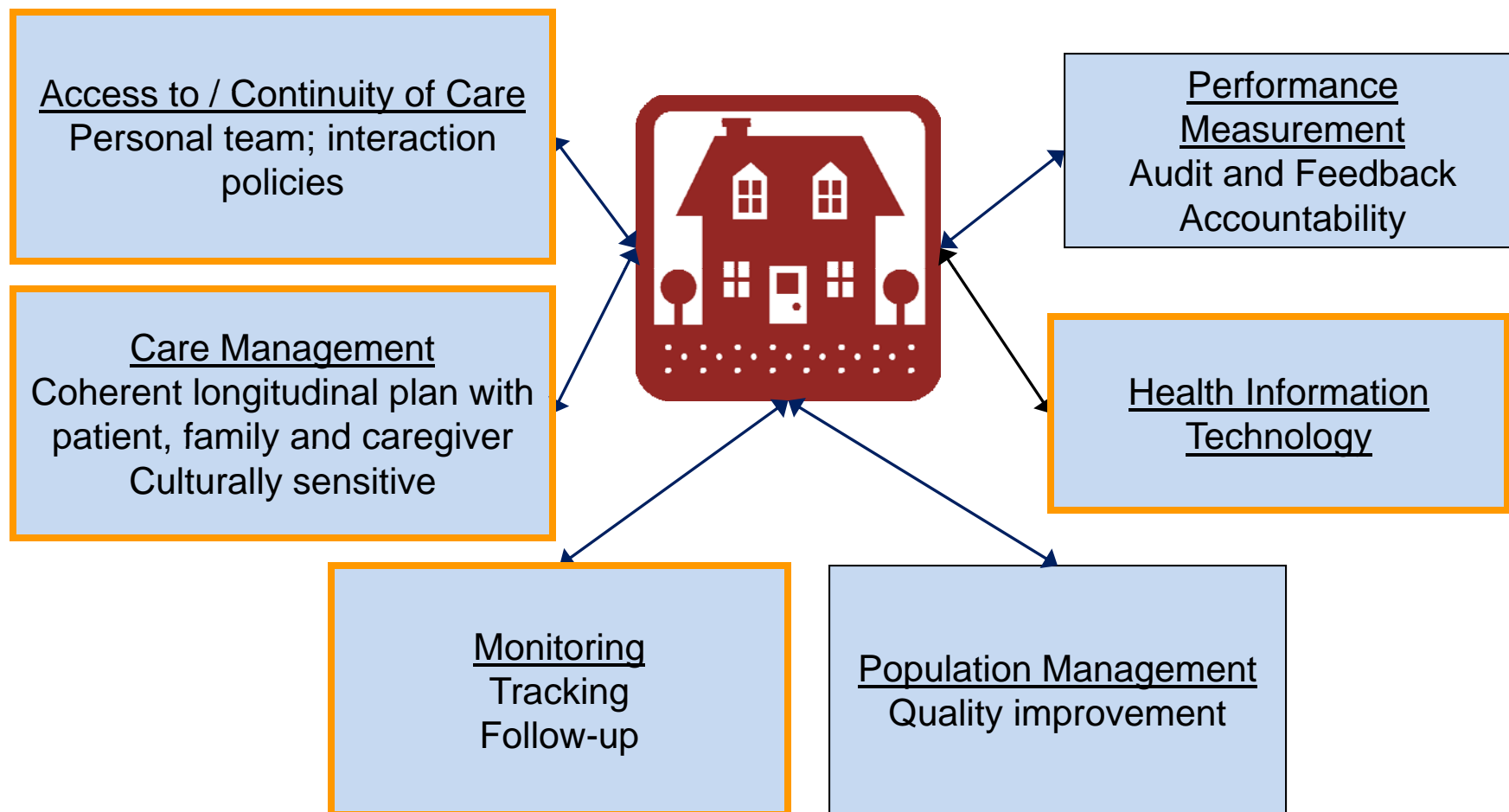
What could we provide that might help him and his family?

Care Management Plus fills in core gaps in many clinics through a proactive, flexible system.



Medical Home Model

Health care teams partner with patients & caregivers to ensure that all of their health care is effectively managed and coordinated.



What services does Care Management Plus provide?

In all, 4,735 patients (1,582 seniors) were seen in 2004-05, receiving 22,899 services (9,434 for seniors).

Service category	All patients	Seniors
ALL	22,899	9,434
Following evidence-based protocols	12,955 (56.6%)	4,421 (46.9%)
General education	6,808 (29.7%)	2,252 (23.9%)
Communication	6,789 (29.7%)	4,199 (44.5%)
Motivating patients	6,243 (27.3%)	2,247 (23.8%)
Social issues / barriers	8,221 (35.9%)	3,608 (38.2%)

Dorr et al, JGIM 2007

Patient Information : Form

Patient Information

ID Number: Last Name: TEST First Name: TEST DOB: Age: Sex: M

Phone: (800) 800-8000 Cell Phone: Email: PCP: Allen, Mitch PCP Phone: (800) 888-8888

Insurance: Mailhandlers Facility: ABC Clinic Diab Collaboration FPP: 2.Confused/Chaotic

Date of Referral: 3/30/2004 * Care Mgr: John Status: Active

Diag. Date	Diagnosis	Status
Edit 2/28/2005	CHF	Active
	ty	Active
Edit 3/30/2004	Depression	Active

Sched Date	Sched Time	Encounter Type	Status
Edit 4/30/2005		Telephone Contact	Pending
Edit 1/30/2005		Hon	
Edit 1/26/2005		Telephone Contact	Resolved
Edit 10/18/2004		Telephone Contact	Resolved

Patient Search

ID Number:

Last Name:

First Name:

Care Mgr:

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

Diab Assess Date: 3/4/2005

Diagnosis Encounter Meds MH Instruments Pediatric Assess

Diabetes History Diab Pre/Post Knowledge Assess Patient Goals HF Follow-Up

Generate Clinical Note by Date *

Initial Care Manager Tracking (CMT) data base

Record: of 1

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 8:30 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

Before 3/10

IHC. Also email
 Do. wait pay at
 pm free
 812-33 000
 5 people
 PCP Access Test
 who 14 people
 Home - do impant
 Back - head
 Turn on 5' 10" 100 lbs
 7-10 days
 3 m.

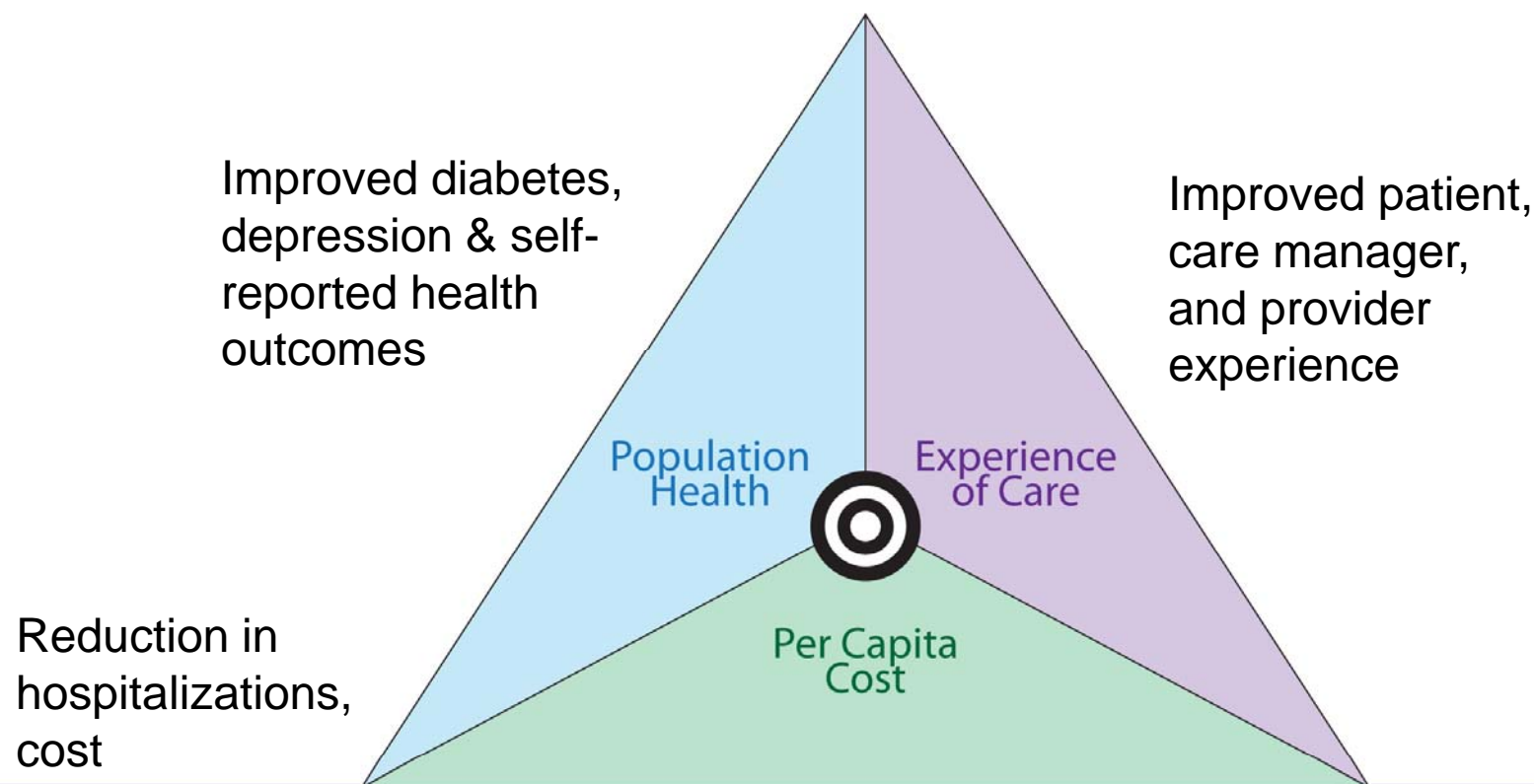
Population Tickler

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Summary of studies from CM+

TRIPLE aim of health care: Health Affairs May 2008

Berwick, Nolan, Whittington



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www.caremanagementplus.org/pubs.html

CM+ care management plus

Guideline Adherence: Results

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

* $p < 0.01$

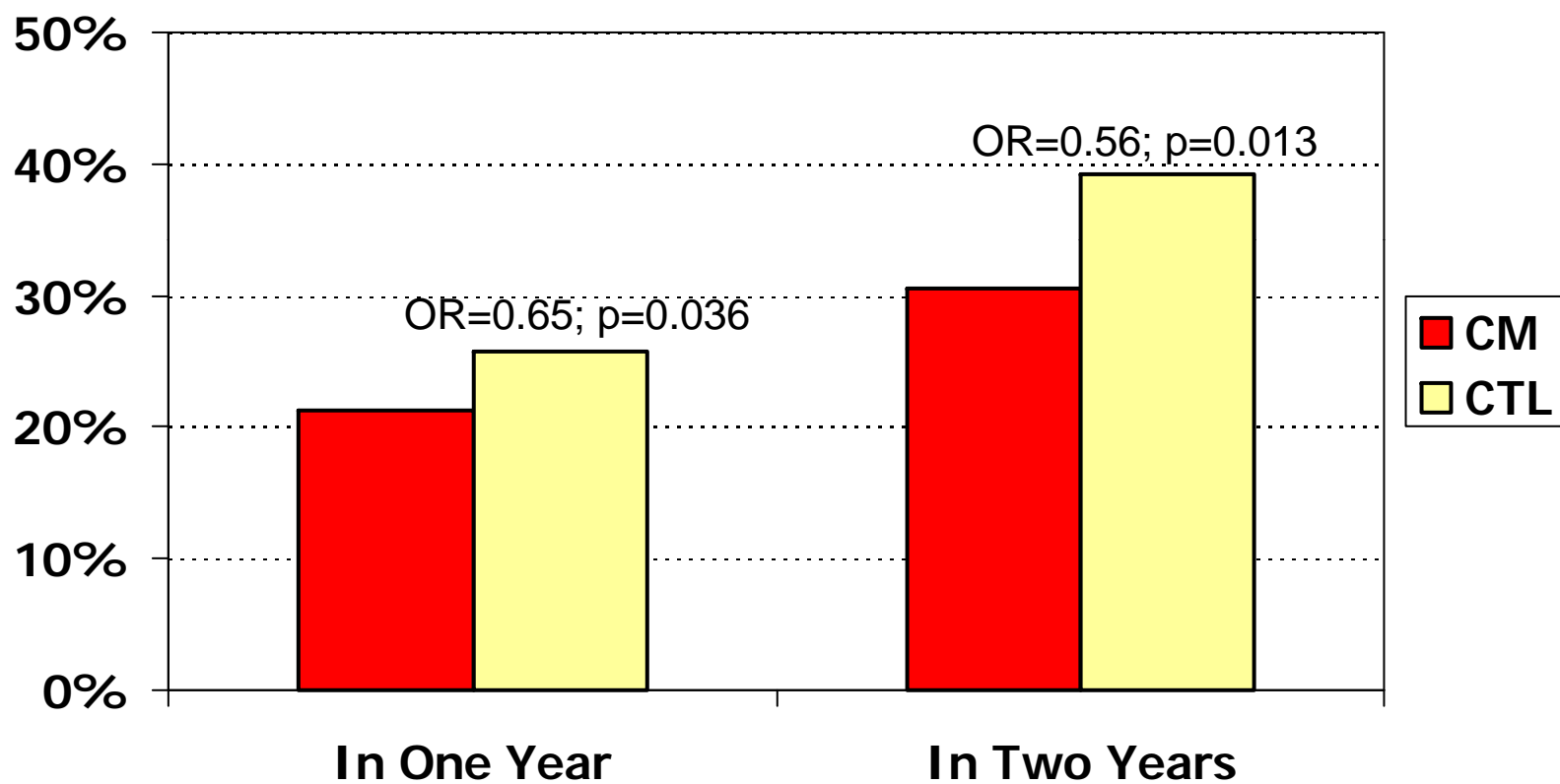
Dorr, HSR, 2005

In CM+, Odds of dying were reduced significantly.

Variable	Time	CM+	Control	Difference
All Patients		(N=1,144)	(N=2,288)	
	at 1 year	6.5%	9.2%	-2.8%
Deaths	at 2 years	13.1%	16.6%	-3.4%
Diabetes only		(N=557)	(N=1114)	
	at 1 year	6.2%	10.6%	-4.4%
Deaths	at 2 years	12.9%	18.2%	-5.3%

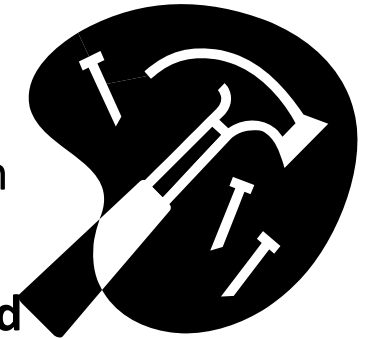
Dorr, JAGS, 2008

Odds of admission (any cause) were reduced by 27-40%.



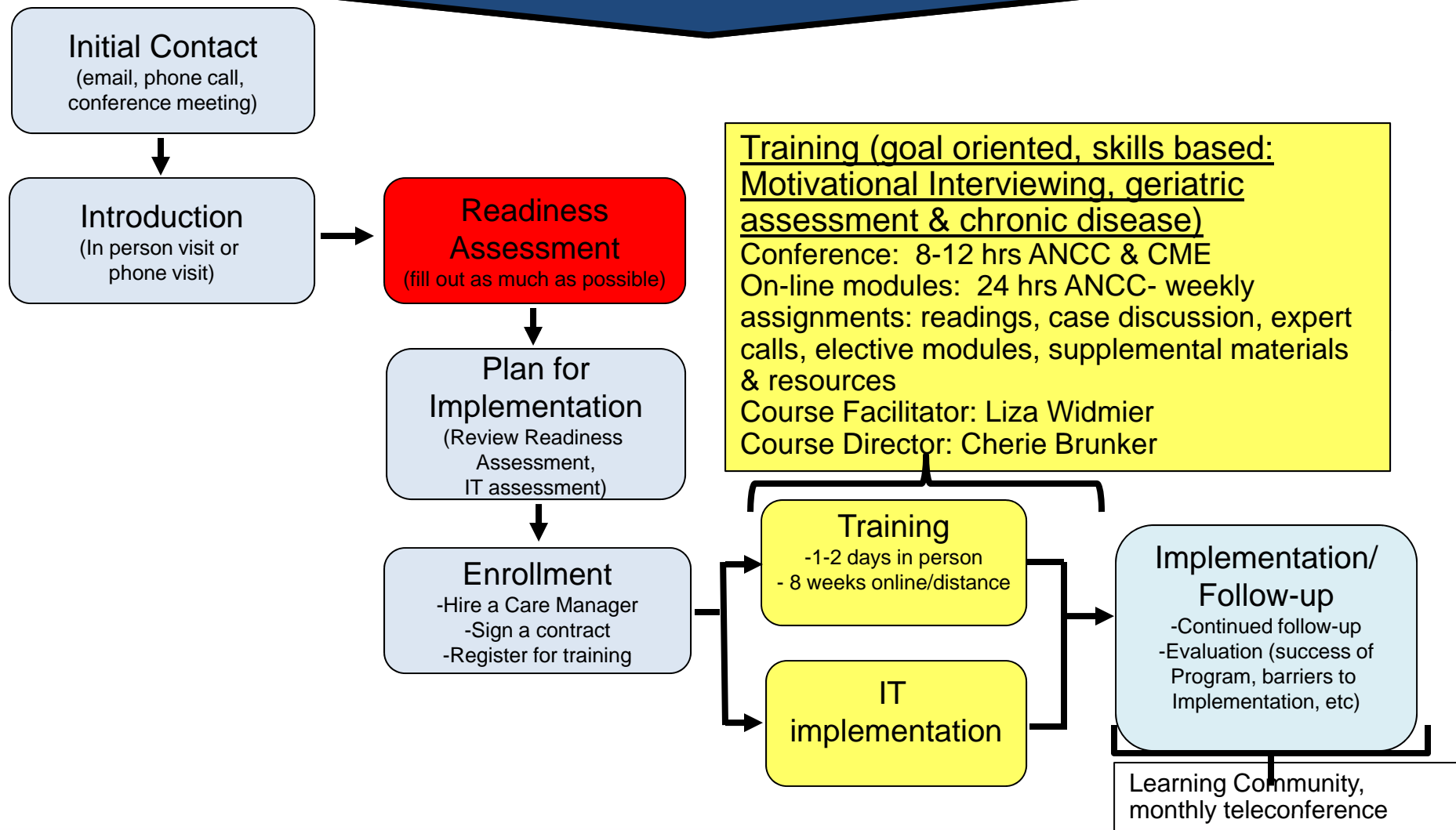
Dorr, JAGS, 2008

The Agency for Healthcare Research and Quality, AHRQ Mission



- 1 of 12 agencies within the U.S. Department of Health and Human Services.
- AHRQ is dedicated to improving the **Quality, Safety, Efficiency, and Effectiveness** of health care for all Americans
- Information from AHRQ's research helps people make more informed decisions and improve the quality of health care services.
- **CM+ will be included in AHRQ's 2010 National Healthcare Quality Report (NHQR)** and National Healthcare Disparities Report (NHDR)
 - Documents current trends in effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care

Steps to Implementation



CM+ Training: 182 clinical teams



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Implementing Primary Care Medical Home: CM+

- Learners:
 - Nurses, social workers, physicians, care coordinators, care managers, administrators, and many others ...
- Patients: diverse, rural, Veterans, older adults, homeless, Hurricane Katrina survivors, indigenous populations, Native Americans, Southeast Alaskans, frail elderly, pediatric
- Participation is crucial
 - Collaborative
 - Immersive
 - Continuous
- Our promise: by practicing and participating, the learner will gain important insight and skills

Care Management Plus Dissemination

9 Trainings* from September 2006 – January 2011

Leaders

- 114 trained
 - Includes physicians

*Over 5,000 hours of continuing education awarded-
ANCC & AMA CME

Care Managers

- 209 trained

RN	72%
APRN	3%
LPN	5%
Nurses Total	80%
Social Work	15%
Medical Asst.	3%
Other	2%

Objectives of Care Manager Training

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