

Building the Medical Home: the Role of Care Management Plus



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

www.caremanagementplus.org



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Care Management Plus

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CM+ care management plus

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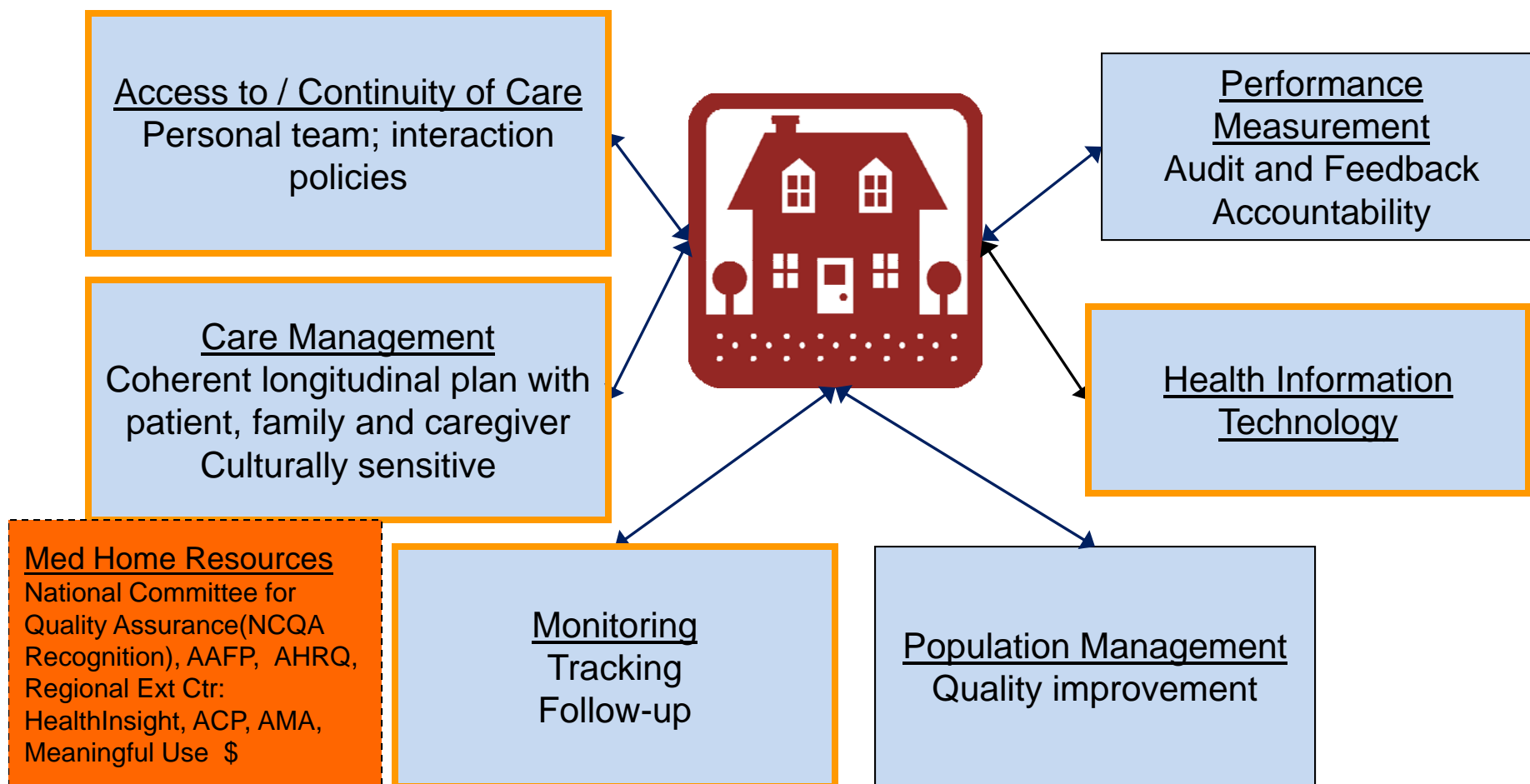
Many Contributors and Collaborators: THANK YOU!

Outline

- I. Medical Home Features
- II. CM+ Model, Outcomes
- III. Patient Experience
- IV. Implementation, Dissemination

Medical Home Model

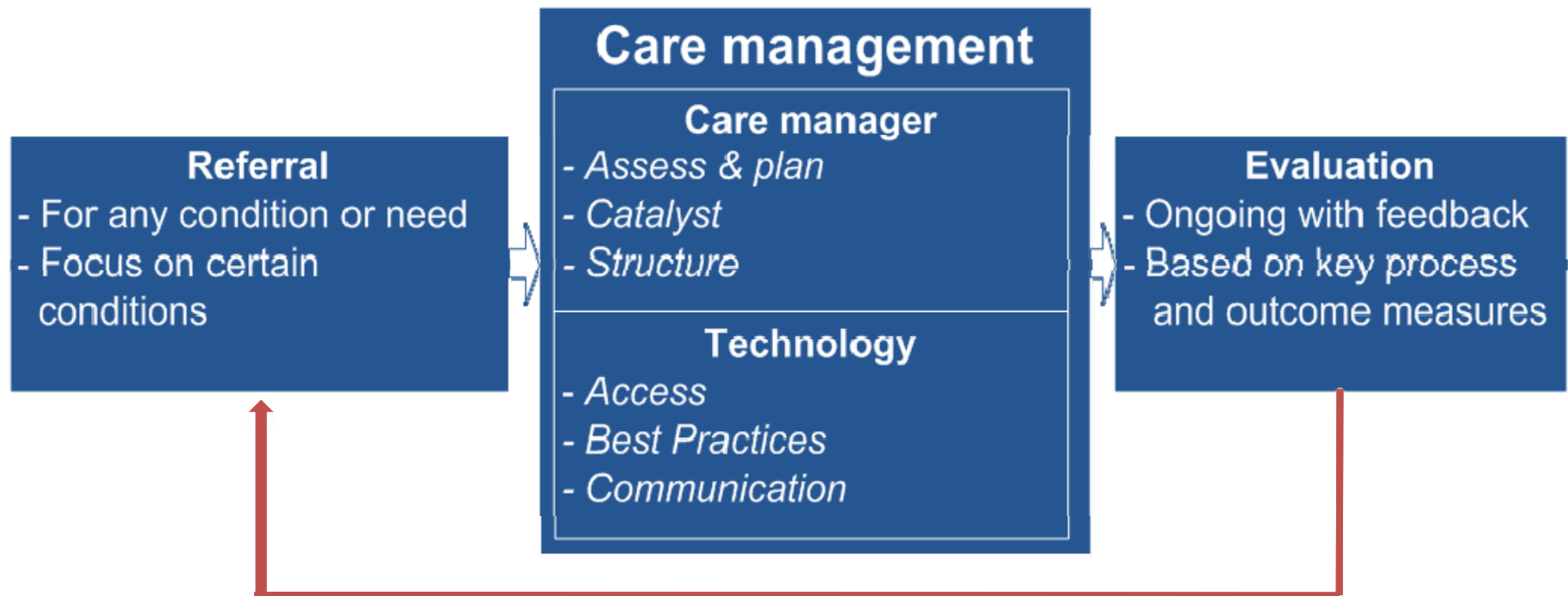
Health care teams partner with patients & caregivers to ensure that all of their health care is effectively managed and coordinated.



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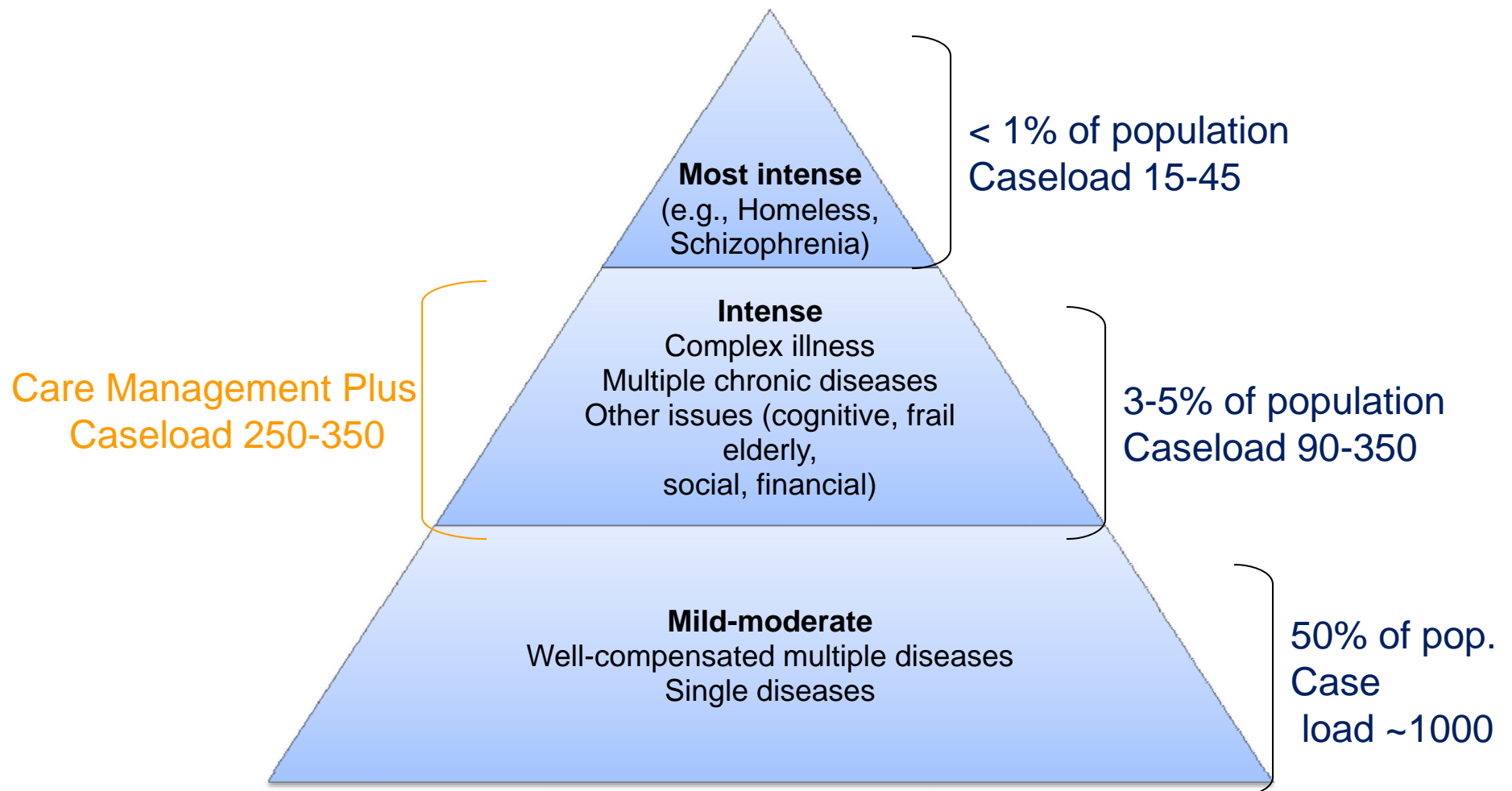
Care Management Plus fills in core gaps in many clinics through a proactive, flexible system.

In 182 clinics and health care settings ...



Teamwork and culture Surrounds ALL

Care management varies by intensity and function for different populations and needs.



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

Guideline Adherence: Results

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

* $p < 0.01$

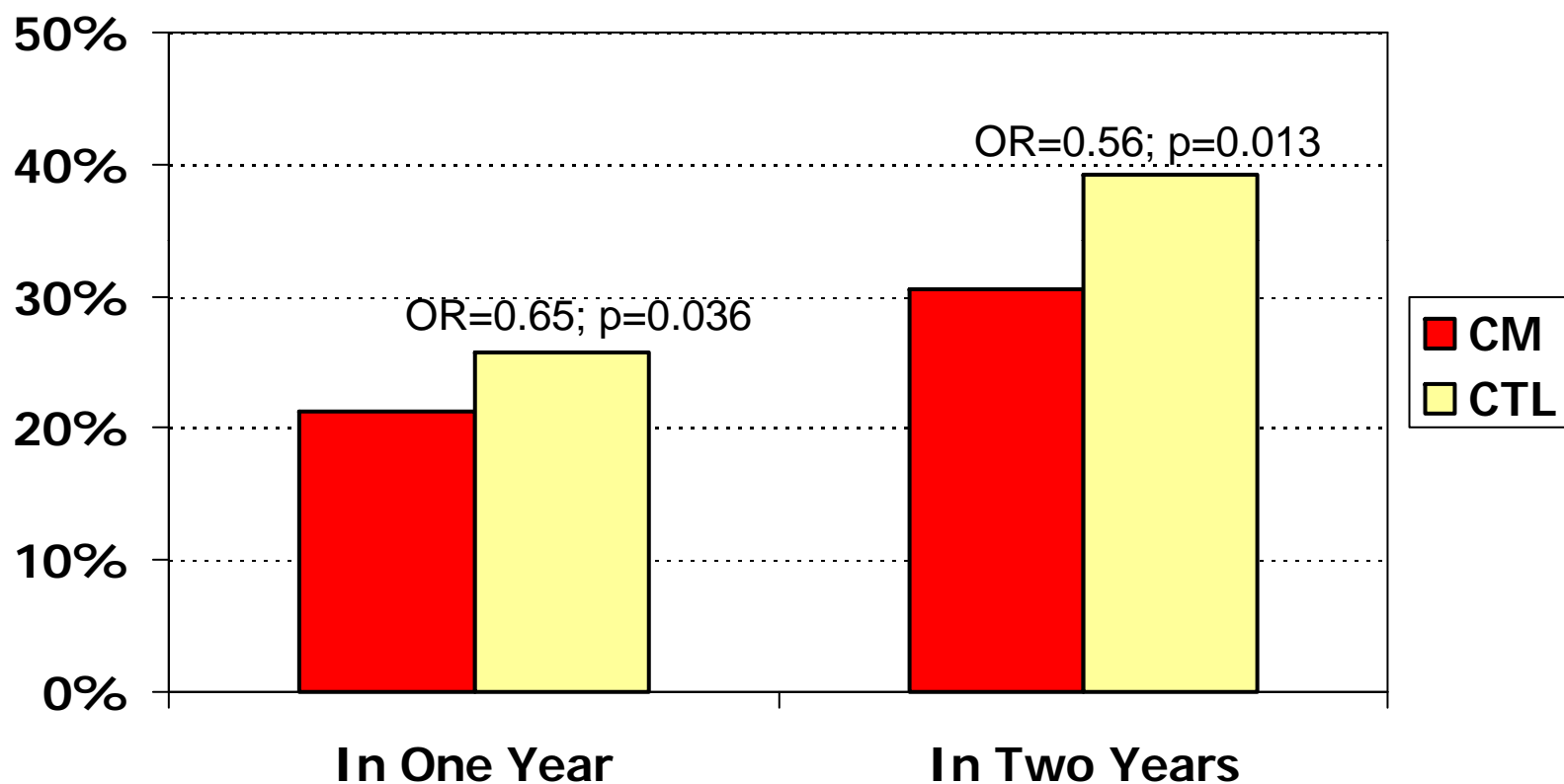
Dorr, HSR, 2005

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		(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%.



Physicians were more efficient through better documentation, a slight increase in visits, and a change in practice pattern.

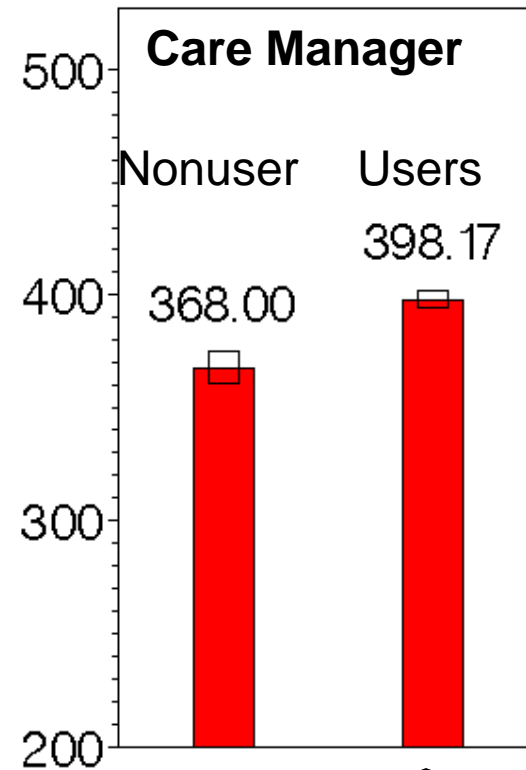
- Physicians who referred to care managers:

8% more productive

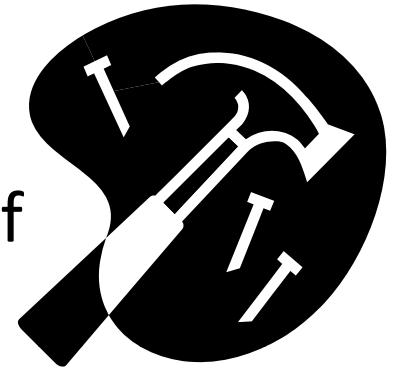
- Than peers in same clinic

Dorr, AJMC, 2007

WRVU Mean



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.

AHRQ

- 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

Goals to manage in the Medical Home

Goals	Example elements
Access to and Continuity of Care	Respond to needs for appointments and communication
Patient Monitoring	Assess and track; provide self-management support
Care Coordination / management	Care planning; Coordinate information / referrals
Population Management	Identify 3 populations of interest; use guidelines

Adapted from the CMS / NCQA criteria

Components: TEAM READINESS

The right people on the team with the right training is a core principle.

Patients are taught to self-manage and have a **guide** through the system.

Care managers receive special training in

- Education, motivation/coaching
- Disease specific protocols Care for seniors / Caregiver support
- Connection to community resources

Providers / Other Staff:

- Need to participate in protocol development/ implementation / adaptation
- Need to learn about care management (usually from the care managers)

An opportunity for life-saving aid ...



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

Let Mr. R tell you about care management ...



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Team help: Care Manager and Mr. R

The **team (including the patient)** recognizes and refers...

The care manager then

- **assesses** patient's readiness to change, disease states, cognitive status, safety
- **prioritizes** cognition / depression, social issues and disease states
- **co-creates** a care plan
- **facilitates** that care plan
- **documents** progress
- **communicates**

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Care Management Plus Dissemination

9 Trainings* from September 2006 – January 2011

Leaders

- 114 trained
 - Includes 24 physicians

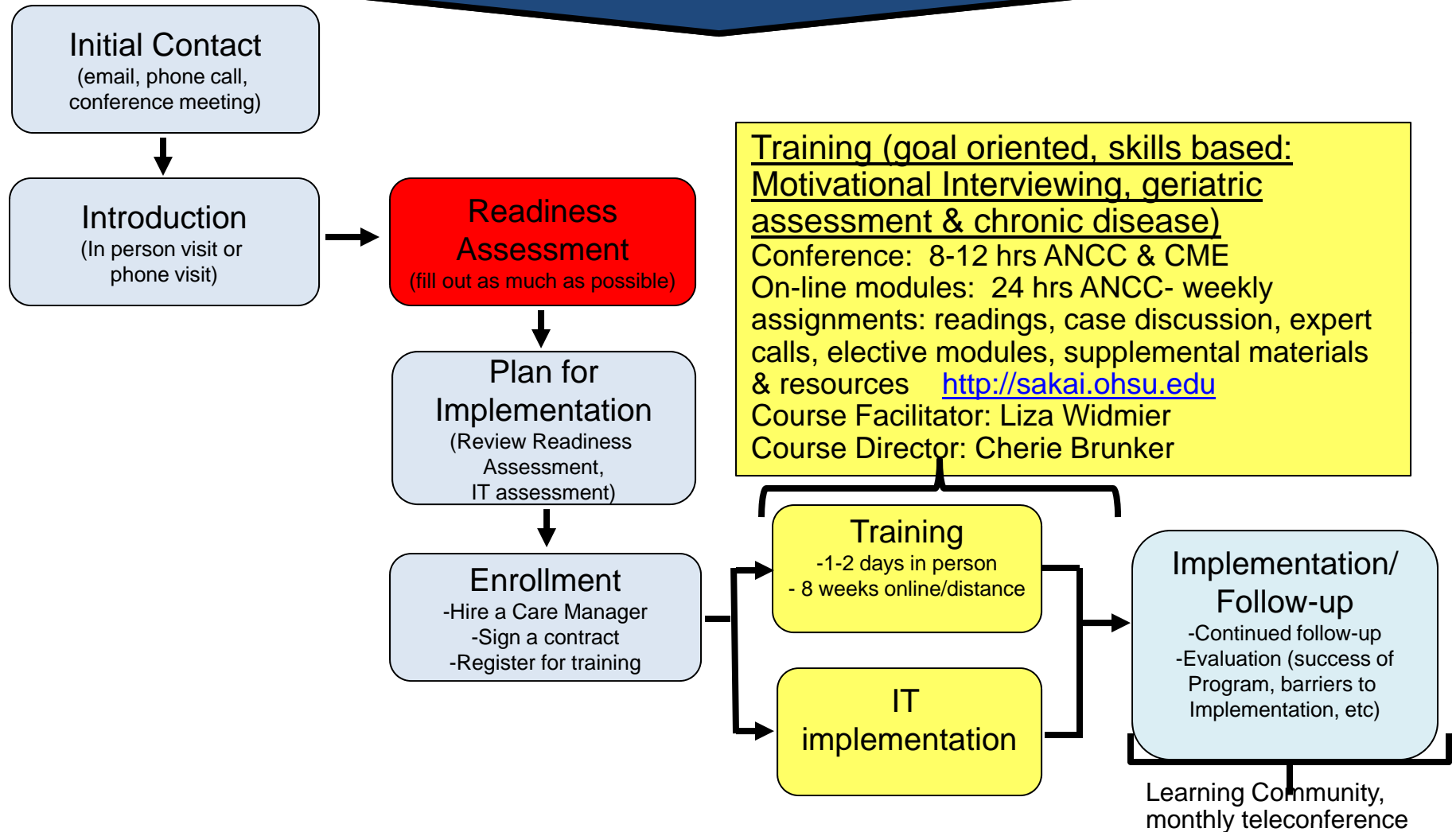
*Over 5,000 hours of continuing education awarded-
ANCC & AMA CME

Care Managers

- 209 trained

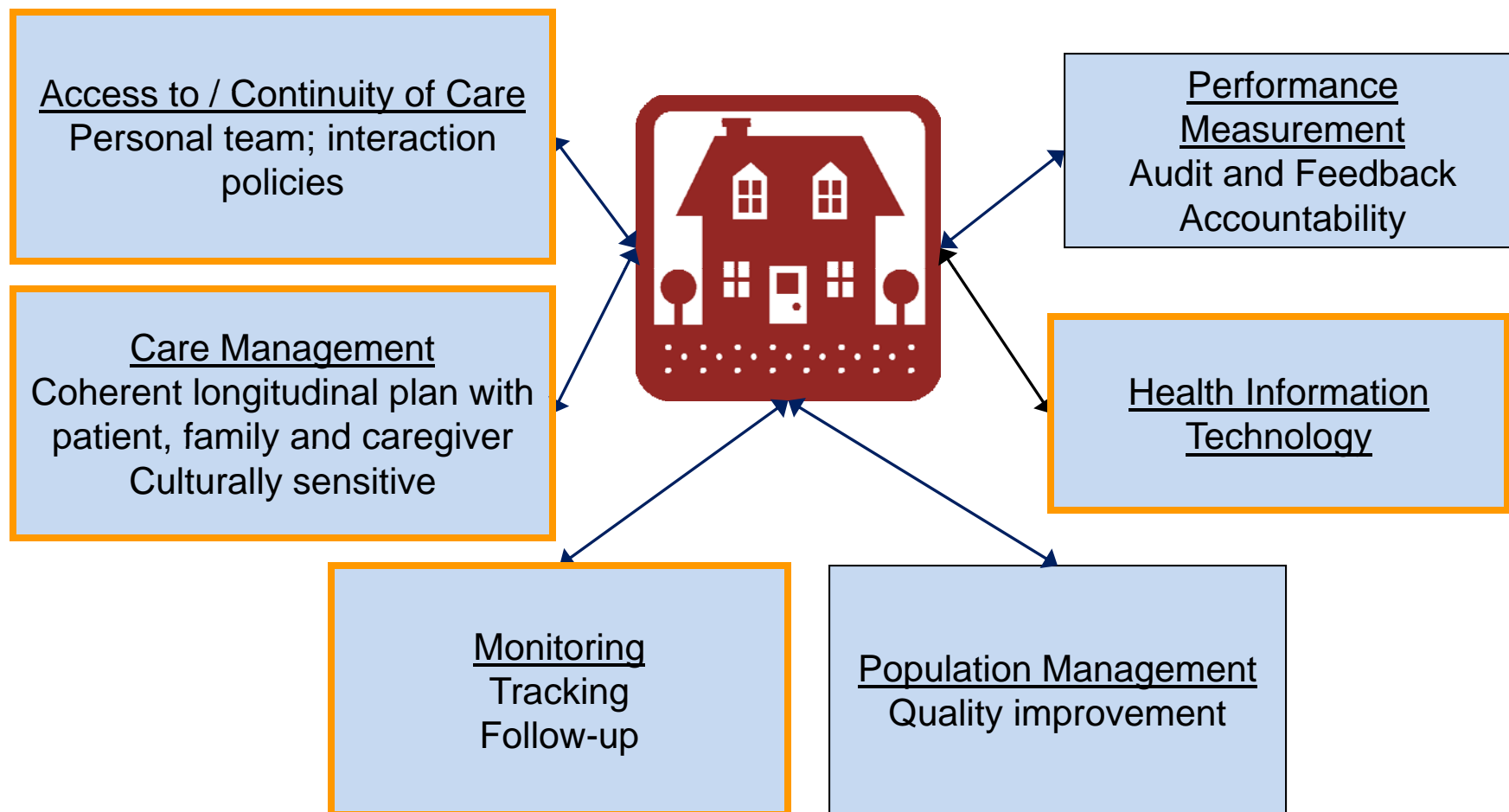
RN	72%
APRN	3%
LPN	5%
Nurses Total	80%
Social Work	15%
Medical Asst.	3%
Other	2%

Steps to Implementation



Medical Home Model

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



Thanks! and questions?

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Or visit www.caremanagementplus.org

Technology **helps** the team plan and enact high quality care.

- Care management tracking
- Patient worksheet (summary sheet)
- Dosage expertise / specification
- www.caremanagementplus.org

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 detail
 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
 7-10 days
 3 m.

Population Tickler

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Patient Worksheet

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. - Glimepiride (Metformin HCl), 500mg, Tablet, 1 TABLET, Daily 2. - Lisinopril, 10mg, Tablet, 1 TABLET, Bid 3. - Calcium Carbonate/Vitamin D (Calcium 500/W-Vitamin D), 500-200, Tablet, 1 TABLET, Bid					
Allergies					
Allergies (Group): Reaction(s): Rash					
Diabetes Management					
Functional status					
Preventive Care					
Preventive care summary					
Clinical Laboratory Data					
Pertinent labs					
HgbA1c (<=7.0) UA Protein UAIB/Cr (<=0) 24 Urine Albumin (<=0) Serum Cr					
No Data - No Data - No Data - No Data -					
Serum K Lipid Profile LDL (<=100) Trig (<=150) HDL (>=45) CHOL (<=200) TC/HDL Ratio					
No Data - - - - - No Data -					
HCT hsCRP Homocysteine					
No Data - No Data - No Data -					
Clinic Data					
Pertinent exams					
Date Weight BMI (<=25) Weight Class Blood Pressure (<=130/80) Heart Rate					
01/15/2006 144 lbs 23 Normal 01/15/2006 122/74 mmHg 01/15/2006 74					
01/12/2005 144 lbs 23 Normal 01/12/2005 154/84 mmHg - -					
Last foot exam: 11/2005 Abnormal Last dilated retinal exam: 11/2005 Abnormal					
Reminders					
Lab					
[] 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). [] Serum K - Lipid Profile - LDL - Trig - HDL - CHOL - TC/HDL Ratio [] hsCRP - Homocysteine [] 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.					

Care Manager Training Objectives

On successful completion of Training, the Learner 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

Training Objectives, Continued

- 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