Supporting Care Coordination within the PCMH

Supported by the Center for PCMH Advancement

Welcome

Guy Mansueto
PCPCC Co-Chair
Center for PCMH Advancement
Supporting Care Coordination within the PCMH

Supported by the Center for PCMH Advancement

Executive Educational Series – Part 1 of 3

Date: Friday, April 6, 2012
Time: 1 - 2:30pm ET
Speakers:
- Jaan Sidorov, MD, MHSA, FACP
  Sidorov Health Solutions
- James Crawford, MD, PhD
  North Shore-Long Island Jewish Health System
Register Today
Parts 2 and 3

Registration Link
http://bit.ly/Hm5lJt

Implementing Care Coordination within the PCMH Model

May 17th, 2012
1:30 p.m. - 3:00 p.m. EST

Improved care coordination is a critical success factor for medical homes. In this webinar, we’ll review models and effective implementation practices. In addition, we’ll take a close look at Geisinger’s team approach to achieving improved care across the continuum and how it’s program, established in 2006, improves quality and reduces total cost of care.

Jane Brock, MD, MSPH
Chief Medical Officer, Colorado Foundation for Medical Care

Thomas Graf, MD
Chairman, Community Practice and Associate Chief Medical Officer, Population Health, Geisinger Health System

The Medical Home Experience: Care Coordination and the Patient's Role in Shared Decision Making and Team Communication

July 12th, 2012
1:00 p.m. - 2:30 p.m. EST

In this webinar, we will explore the definition of the care team and care coordination as well as the key elements of care coordination within the PCMH. We will also talk about the patient’s perspective by reviewing Christine Bechtel’s research on patients and the delivery system as a whole – its challenges and potential solutions – including care coordination and the medical home.

Christine Bechtel
Vice President, National Partnership for Women & Families

Melinda Abrams, MS
Vice President, The Commonwealth Fund
Supporting Care Coordination within the PCMH

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“I just want my doctors to talk to each other.”
- Quote from forward by Christine Bechtel, vice president, National Partnership for Women & Families

This report features 3 core elements:
1) Expert-authored articles on the definition, role and function of care coordination, as well as tools for implementation, and measurement and monitoring of its effectiveness.
2) Case examples
3) Summary of survey responses from select practices
Supporting Care Coordination within the PCMH

Supported by the Center for PCMH Advancement

Jaan Sidorov, MD, MHSA, FACP
General and Internal Medicine Physician
Principal, Sidorov Health Solutions

Author/Speaker:
Disease Management Care Blog –
http://diseasemanagementcareblog.blogspot.com; Health Affairs, Wall Street Journal, NPR’s “All Things Considered,” Disease Management Advisor

Professional Affiliations:
Board of Directors of the Disease Management Association of America (DMAA), Medical Director in the HP Medical Informatics Center of Excellence, Chair of Board of NORCAL Mutual Insurance
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Supporting Care Coordination within the PCMH Model

Jaan Sidorov, MD, MHSA
The Disease Management Care Blog
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Tel: 570-490-6618

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Outline

- Define PHM and describe its “key” ingredients
- Review the evidence that it saves money
- Review “quick hits”
- Look at what’s at stake
“Population Health Management”

“Population-based” approach to care that is:
1. Proactive, accountable and patient-centric
2. Physician-guided
3. Enabling informed and activated patients
4. Teaming

PHM rests upon three core principles:
1. the central care delivery and leadership roles of the primary care physician;
2. the critical importance of patient activation, involvement and personal responsibility;
3. the patient focus and capacity expansion of care coordination provided through wellness, and chronic care management programs

http://www.carecontinuum.org/phi_definition.asp
Population Health Management Framework Detail

PHM Program Process Framework

1. Population Monitoring/Identification
   - Health Assessment
     - HRA
     - Medical Claims
     - Lab Data
     - Other
   - Risk Stratification
     - Healthy
     - Health/Emotional Risk
     - Chronic Illness
     - End of Life
   - Enrollment/Engagement Strategies
   - Communication and Intervention Delivery Modalities
     - Mail
     - eMail
     - Telephone
     - Internet/Intranet
     - Social Media
     - Face-to-Face Visits

2. Health Management Interventions
   - Organizational Interventions
     - Culture / Environment
     - Health Promotion, Wellness, Preventive Services
     - Health Risk Management
   - Care Coordination / Advocacy
   - Disease / Case Management
   - Tailored Interventions

3. Operational Measures
   - Psychosocial Drivers
   - Health Behaviors
     - Self-Management
     - Screening / Preventive Services

4. Program Outcomes
   - Health Status and Clinical Outcomes
   - Quality of Life
   - Productivity
   - Satisfaction
   - Service Utilization
   - Financial Outcomes

Timeframe for Impact

1. For a more detailed discussion of monitoring and identification flow please refer to the work of the Operational Measures Workgroup.
2. Represents example components for each Essential Element. Does not necessarily reflect the universe of components.
3. Communication may utilize one or more touch points within the provider system.
Population Health Management

- Triage
- Records
- Disease Management
- Information Systems
- Office
- Nurses
- Self Care
- Case Management
- Medical Home
- Care
  - Fee
  - P4P
  - Other

© Disease Management Blog SHS
“Population Health Management”

But....Does It Work?
Enhanced vs. Usual Support, According to Service Category.

From Dall et al: Outcomes and lessons learned from evaluating TRICARE’s disease management programs. Am J Manag Care 2010; 16(6): 4388

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- Percentage with A1C test: 0.61 vs. 0.58, 0.02c
- Percentage with retinal exam: 0.26 vs. 0.23, 0.02c
- Percentage with microalbumin urine test: 0.39 vs. 0.33, 0.06c
Polling Question

What additional features do you feel is necessary for successful case management?

A. Employed by the primary care site(s) and not by a health insurer
B. Advance practice licensing that includes medication prescribing
   C. Expertise in maximizing the health insurance benefit.
“Key” PHM Ingredients That Can Be Adapted to the PCMH
PHM Ingredients

1. Risk Stratification

- Multi-dimensional and computer analytic process that uses HRAs and multiple other data associations
- Assesses patients’ future “trajectory” into higher risk categories such as hospitalization, death or elevated claims expense.
- Other predictions: obesity, diabetes mellitus and other chronic conditions.
- Detects “invisible” patients
- Challenges: loss of information transfer, poor fit with clinical work flows and questionable “actionability.”
Uneven distribution of risk
Not All Hypertension is Created Equal

2. Patient Enrollment

- Recruitment that uses incentives, is culturally appropriate via multiple channels, including mail, telephony and social media.
- Opt-in” vs. “opt-out”
- Data are stored in Registries: multi-sourced repositories of formatted data
  - Easy extraction and manipulation of individual or grouped information including demographic, insurance claims, survey, clinical and other data.
- Challenges: recruitment rates typically run 5-15% thanks to limited patient incentives and lack of physician buy-in, time and compensation of work effort.
The “Return on Investment”

Return On Investment

Increasing Enrollment

Positive

Negative
PHM Ingredients

3. Multiple Communication Channels

- Old: print materials, one-on-one face-to-face and telephonic instruction
- New: education that leverages behavior change using psychological principles of recruitment, engagement, assessment of barriers, formulation of strategies to overcome barriers, goal setting, coaching, support and follow-up.
- Includes “texting,” variations of email and social media such as Facebook.
- Challenges: disconnected from the electronic health record and physician input
4. Enter Care & Case Management

- Collaborative assessment, planning, facilitation and advocacy for care options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.

- Provides education, promotes informed decision making, develops a care plan that coordinates insurance benefit designs, psychosocial issues, input of family, community resources and the physicians’ judgment.

- Associated with greater frequency of self care, control of lifestyle behaviors, problem solving, medication compliance and improved outcomes.

- Meets all of the challenges:
  - Using predictive modeling to prioritize patients and needs
  - Facilitating patient enrollment
  - Advocating on behalf of the intelligent adoption of guidelines
  - Collaborating & Integrating providers

Nurses, your ship has come in!
Features of Successful Case Management
Health Professionals Who Are...

- Mobile
- Interact with patients more than once a month
- “Top of license”
- Connected
- Dedicated

- Credentialed
- Telephonic & face to face
- Patient self-care
- Change Agents
“Quick Hits”
Triangulation on the Truth

(Multiple studies…)

(...point in the same direction!)

Accuracy

Speed

Completeness
PHM Program Design: Soufflé vs. Soup
Central “Administration”
Peripheral “Distribution”

September 2010

Evaluation of Medicare Care Management for High Cost Beneficiaries (CMHCB) Demonstration: Massachusetts General Hospital and Massachusetts General Physicians Organization (MGH)

Final Report

Prepared for
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Centers for Medicare & Medicaid Services
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3040 Cornwallis Road
Research Triangle Park, NC 27709

RTI Project Number 020764.025.000.001
Shared Services Model Option

Centrally coordinated PHM support:

- Short time window
- Available competencies
- Unburden physicians
- Complements medical homes
1:1500
The Physicians

- Business case for quality
- Today’s dollars for tomorrow’s savings
- Location of care
- Level of care
- Population-based responsibility
- Teaming
- Money, Patients or Time
- “Physician Stuff”
Polling Question

What additional ingredient would you choose to aid physician engagement?

1. Local physician opinion leaders charged with engaging their colleagues
2. Inclusion of participation in care management programs as an element in physician credentialing
3. Insisting that they view a rebroadcast of this excellent presentation by Dr. Sidorov
Debt panel chairmen call for second look at the public option

By Alexander Bolton - 11/10/10 03:37 PM ET

The chairmen of President Obama’s fiscal commission are calling for a second look at a robust government-run healthcare program, which Congress shelved last year following acrimonious debate.

Former Clinton White House Chief of Staff Erskine Bowles and former Sen. Alan Simpson (R-Wyo.), the chairmen of the National Commission on Fiscal Responsibility and Reform, suggested reviving the public option in the future if healthcare costs continue to soar.
Thank you
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(So how are we actually supposed to do this?)

James M Crawford, MD, PhD
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Chair, Department of Pathology
Hofstra North Shore-LIJ School of Medicine
Manhasset, NY
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Savings and improved health care are to be achieved through “Coordinated Care”.
What is “Coordinated Care”?

Chronic Disease Management
Management of “Ambulatory Sensitive Conditions”
- prevention of hospitalization and ED visits
  Heart Failure, COPD, Diabetes, CAD…..
Transitions in Care (“up”, “down”, and “over”)
Medication Reconciliation
Safety & Reduction in Errors
Screening and Follow-through
Emergency Medicine and Follow-through

*PubMed published papers
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*Jan 21, 2012
Coordinated Care

NIH PubMed: Citations per year*

*Jan 21, 2012
PCMH vs ACO
PCMH vs. ACO

Medical Home:
Patient Centered Healthcare focusing on “physician practice”

Accountable Care Organization:
Coordinated Care at the “health system” level
Accountable Care

NIH PubMed: Citations per year*

*Feb 10, 2012
PCMH vs ACO

PCMH Practices

Hospitals
Emergency
SNF, Rehab

Specialists

Pharmacy, Laboratory, Imaging
Population Health Management Framework Detail

PHM Program Process Framework

1. Population Monitoring/Identification
2. Health Assessment
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   - Medical Claims
   - Lab Data
   - Other
3. Risk Stratification
   - Healthy
   - Health/Emotional Risk
   - Chronic Illness
   - End of Life
4. Incentives & Rewards
   - Incentivize
   - Enrollment
   - Engagement
   - Participation
   - Outcomes
5. Enrollment/Engagement Strategies
6. Communication and Intervention Delivery Modalities
   - Mail
   - eMail
   - Telephone
   - Internet/Intranet
   - Social Media
   - Face-to-Face Visits

Health Management Interventions

- Organizational Interventions
  - Culture / Environment
  - Program Referrals
  - (External/Internal)
  - Integrated/Coordinated Components
- Health Promotion, Wellness, Preventive Services
- Health Risk Management
- Care Coordination/Advocacy
- Disease/Case Management

Tailored Interventions

Operational Measures
- Psychosocial Drivers
  - Self-Management
  - Screening/Preventive Services

Health Behaviors

Program Outcomes
- Health Status and Clinical Outcomes
  - Quality of Life
  - Productivity
  - Satisfaction
  - Service Utilization
  - Financial Outcomes

Timeframe for Impact

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Lessons from Medicare’s Demonstration Projects on Disease Management and Care Coordination

Lyle Nelson
Health and Human Resources Division
Congressional Budget Office
(Lyle.Nelson@cbo.gov)

January 2012
Working Paper 2012-01
Working Paper Series
Congressional Budget Office
Washington, D.C.
“Disease Management”

Patient education
Motivational programs to promote behavioral change
Monitoring of patient symptoms and metrics (biometrics, laboratory)
Monitoring of patient adherence to treatment recommendations
Monitoring of providers’ adherence to evidence-based practices

Providing feedback to patients’ primary care physicians

CBO Report, January 2012
“Disease Management”

Patient education
Motivational programs to promote behavioral change
Monitoring of patient symptoms and metrics (biometrics, laboratory)
Monitoring of patient adherence to treatment recommendations
Monitoring of providers’ adherence to evidence-based practices

Providing feedback to patients’ primary care physicians

Typically are focused on a specific chronic disease

CBO Report, January 2012

North Shore LIJ
“Care Coordination”

Managed flow-of-information between providers within the Primary Care Practice between practice sites (specialists, ancillaries, inpatient)

Proactive management of Transitions-in-Care includes identifying when patients undergo a transition-in-care!

Helping patients access medical and social support services

Address patients’ multiple chronic conditions

CBO Report, January 2012
The Data Elements: Patient

Data Interoperability
  current: Ambulatory EHR, Inpatient EHR, Laboratory, Claims Medications
  future: Emergency (EDIS), Imaging (PACS), Pharmacy

Data Completeness
  Specialists (scanned documents vs. common EHR usage)

Data Access: Information at the point-of-care

EXECUTION: *The Care Plan*
  Access and input: multiple providers
  Critical Pathway: the chronological order of execution
The Data Elements: Population

Population Segmentation
  by disease condition
  by beneficiary coverage (contracts)
  *by Care Plans: What do your patients need, and when?*

Population Reporting
  Patient Registries
  Population Metrics

THE LEARNING HEALTHCARE SYSTEM
  *The best data is your own*
  Monitor your practice patterns and outcomes
  Modify, innovate, improve
Patient Centered Medical Home

Specialists
Ancillaries
Imaging
Laboratory
Pharmacy
Emergency
Hospitals
Admissions
Discharge
Medications
Rehabilitation
Home Care
Home Devices
Home visits
Social Care
Community Resources
Access to healthcare
Screening
Who really does this stuff?

Low-intensity Disease Management

Medium-intensity Disease Management

High-intensity Care Coordination
Care Coordination

The “isolated” PCMH

The PCMH as part of an integrated healthcare system
Polling Question

Is your Physician Practice part of an Integrated Health Network?

(Yes, No, N/A)
Polling Question

If you have Care Managers within your practice, how many patients are in their panel?

1 RN care manager per up to 100 patients support
1 RN care manager per 100-249 patients
1 RN care manager per 250-500 patients
1 RN care manager over 500 patients
The “isolated” PCMH*

Care coordinators, Nurse Care Managers
Health plans: Telephonic and web-based

The PCMH as part of an integrated healthcare system

Case coordinators
Nurses and Nurse Care Managers
Home Care specialists
Health Plans: Telephonic and web-based

→ “Care Maintenance Organization”

Nurse Coordinators, Actuaries
Information Technology specialists
Gaps: “isolated” PCMH

Health Information Technology

- Does the Electronic Health Record work?
- Patient registries, alerts, data analysis
- Data interoperability: labs, referrals, transitions, meds
- Can patients be tracked?
- Health Information Exchanges

Personnel

- “practice transformation”
- Compliance (and collegiality) of specialists, ancillaries

The narrow margin for financial operation of a Practice
Gaps: “integrated” health system

Assembly of an “integrated physician network”
  Incentives (or lack thereof) for Coordinated Care
  Fee-for-Service utilization versus risk-sharing
  Perpetuation of FFS models vs. “value” alternatives

Health Information Technology
  Functionality of EHR: “system” or “physician office”
  Data interoperability
  Low priority of individual PCMH practices in “system HIT”

“Care Maintenance” Structure
  Present/assembled (or not)
  Integrated with PCMH practices (or not)
Lack of Integration of Care Managers with Physician Practices

Telephonic Programs that stood apart from Physician Practices

Inability to obtain data from Hospital Admissions
(Note: Medicare does not require pre-authorization)

“Care Maintenance” Structure
  Present/assembled (or not)
  Integrated with PCMH practices (or not)
Successes: Medicare Demonstrations

- Care Managers as integral part of Physician Practices
- Telephonic Programs integrated with in-person contact
- Proactive monitoring and support of Care Transitions
- Education/Support of Physician adherence to guideline-based care
- Home telemonitoring and video conferencing
“On average, the 34 disease management and care coordination programs had little or no effect on hospital admissions or regular Medicare expenditures.”

- Fees-at-risk: had no effect
- Care Managers ↔ Physicians:
  - 7% reduction in hospital admissions
  - 3% reduction in regular Medicare expenditures
- Care Managers: either “telephonic”, “independent”
  - no effect on hospital admissions, expenditures

CBO Report, January 2012
"Low-hanging fruit"

Ambulatory Sensitive Hospital Admissions
  Diabetes
  Heart Failure
  Chronic Obstructive Pulmonary Disease
  → Management of single conditions

Transitions-in-Care
  Medication Reconciliation
  Post-acute Care

Patient Engagement
  Education
  Motivation
  Information
The big challenges

- Poor social support systems
- Barriers in access to health care
- Difficulties in adapting best-practice guidelines on a disease-by-disease basis to complex patients with multiple co-morbidities
- Behavioral and Mental health
  - Depression

Crabtree BF et al., *Med Care* 2011; 49: S28-S35
Practice Transformation

Physicians separate from Care Team
Leadership resistant to change
Selection of EHR without understanding:
  changing roles of personnel
  workflow redesign
Failure to identify practice core values
Inadequate commitment to change
Lack of time spent on reflection and relationship-building during change

Physicians integrated into Care Team
Leadership as champion of change
EHR selection with these in mind:
  future roles of personnel
  workflow design
Retention of practice core values:
  care delivery guidelines
  existing preventive services
Persisting through transitional inefficiencies
Team meetings:
  changing relationships and roles
  *This is not “forced” time.*

Crabtree BF et al., *Med Care* 2011; 49: S28-S35
Wise CG et al., *Milbank Quarterly* 2011; 3: 399-424
Conclusions

“Independent PCMH” or “PCMH in an integrated system”:
- Integration of Care Managers and Physicians
- EHR selected and implemented with “changing roles” and “workflow” redesign clearly in mind
- Successful Change Management
- (in an imperfect world), accomplishment of:
  - information management through care transitions
  - systematic management of a population
  - whilst tackling the “low hanging fruit”, paying attention to the “big challenges”
“Patients” vs. “People”

“Health is not being free of infirmity. Health is doing what you can in spite of your infirmities.”

*René Jules Dubos, PhD (1901 – 1982)*
1959: The Mirage of Health
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QUESTIONS
Supporting Care Coordination within the PCMH

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Thank You

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