Supporting Care Coordination within the PCMH

Supported by the Center for PCMH Advancement

Welcome

Guy Mansueto
PCPCC Co-Chair
Center for PCMH Advancement

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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

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

Registration Link

http://bit.ly/Hm5lJT

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 Woman & Families

Melinda Abrams, MS
Vice President, The Commonwealth Fund

Registration Link

http://bit.ly/HPLT6J

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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

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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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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:

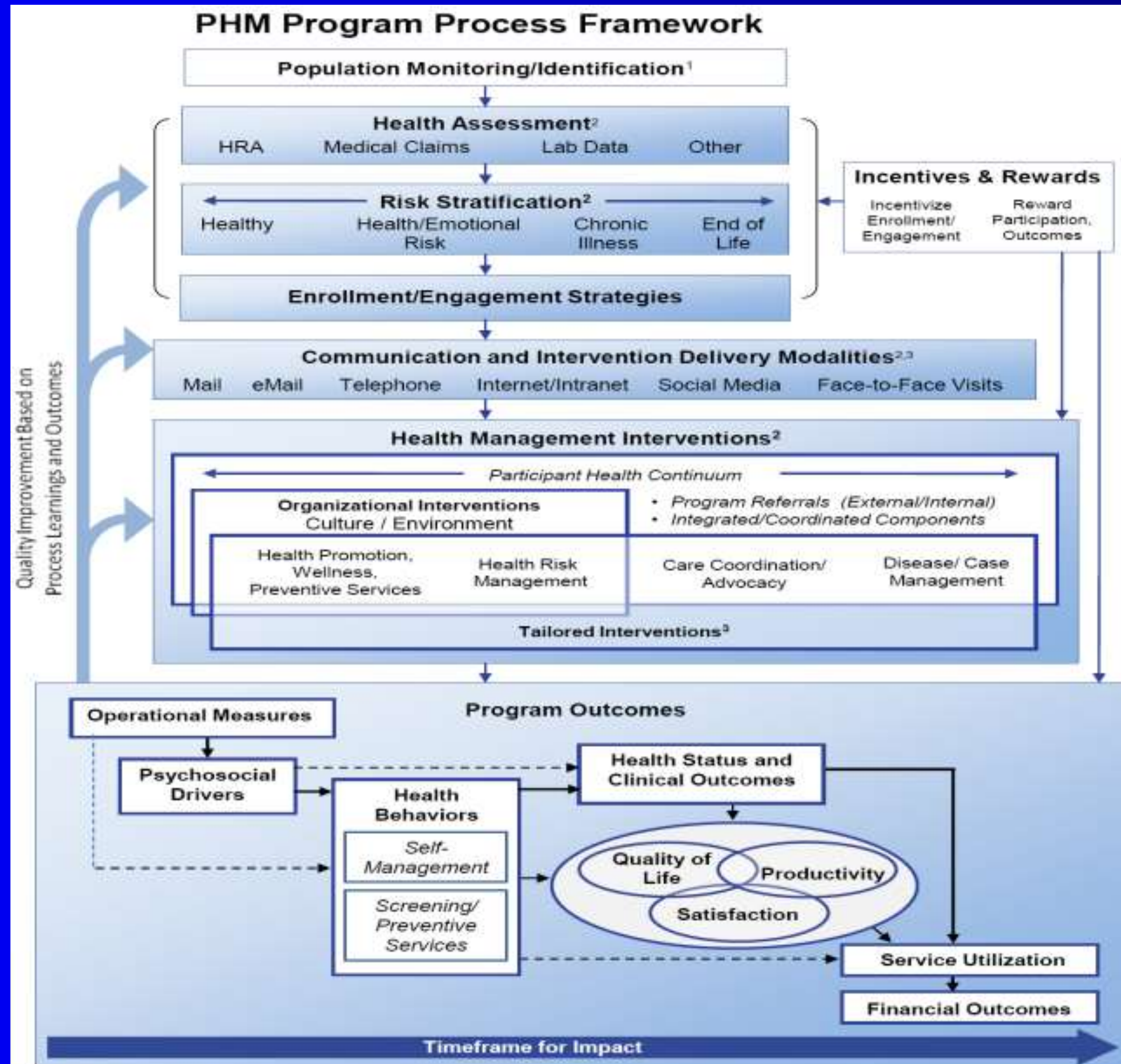
1. Proactive, accountable and patient-centric
2. Physician-guided
3. Enabling informed and activated patients
4. Teaming

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

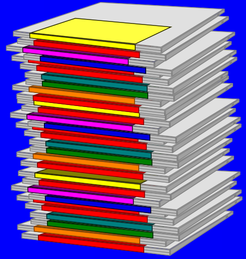
http://www.carecontinuum.org/phi_definition.asp

Population Health Management Framework Detail



Usual Care

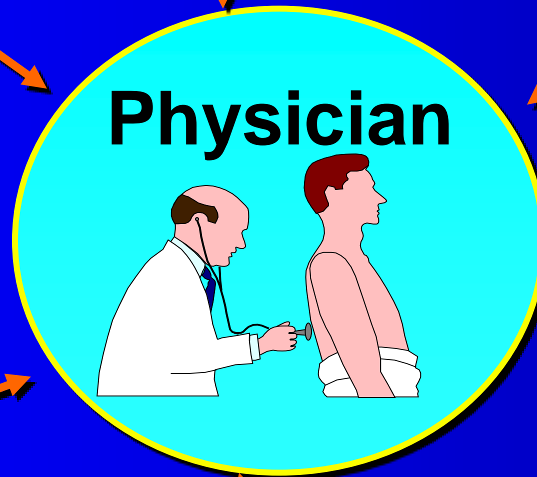
Records



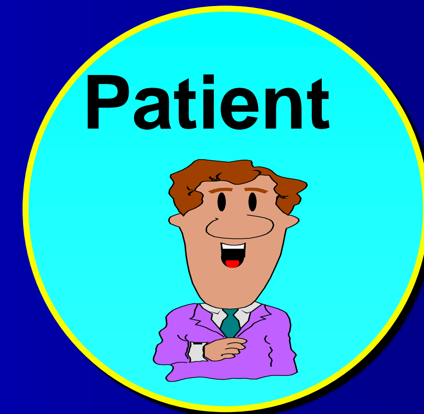
Support Staff

Triage

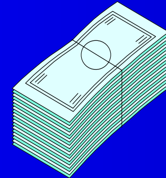
Physician



Patient



Nurses



Money

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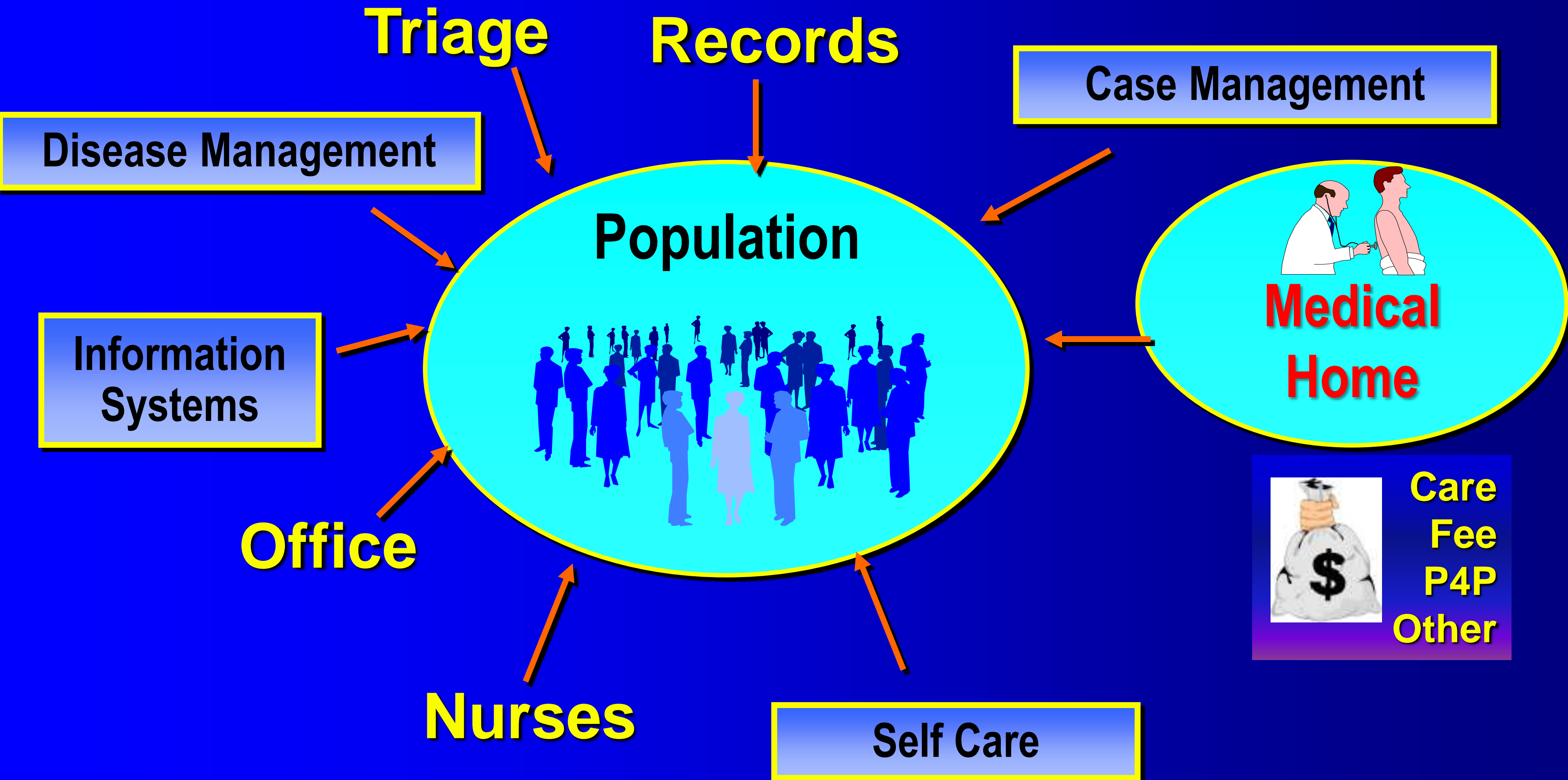
Population Health Management



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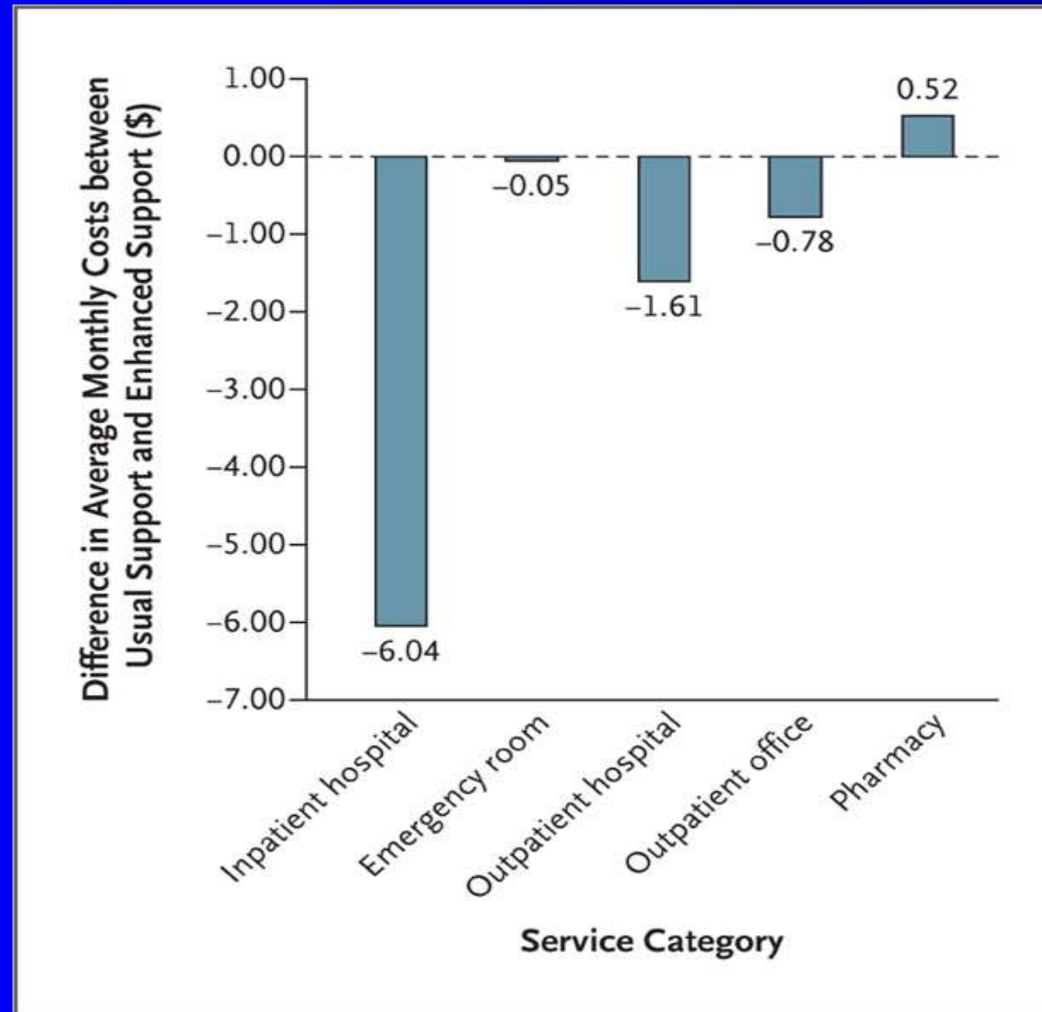
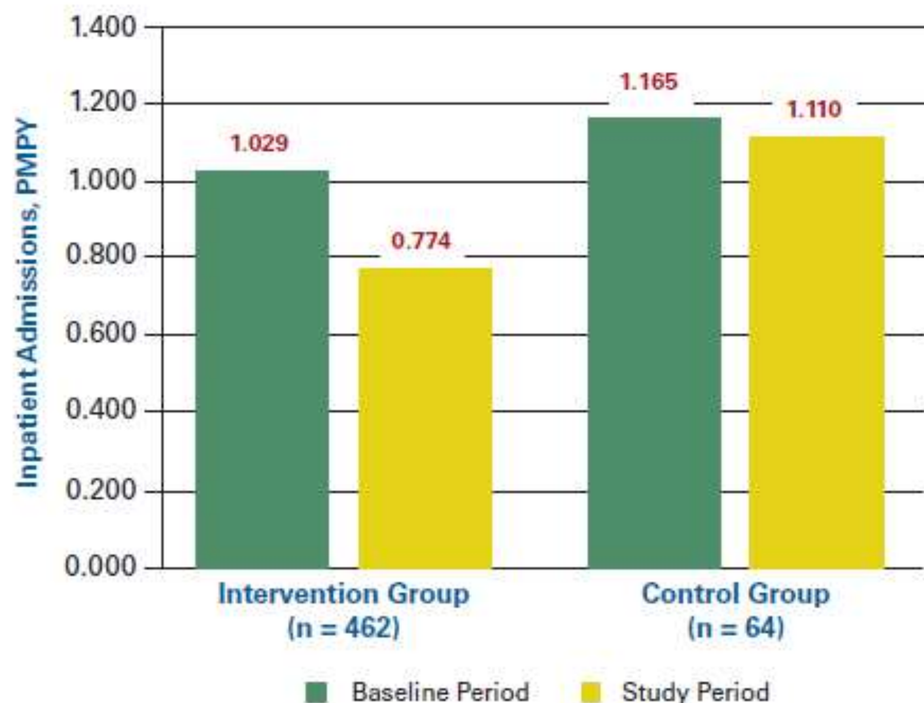
“Population Health Management”

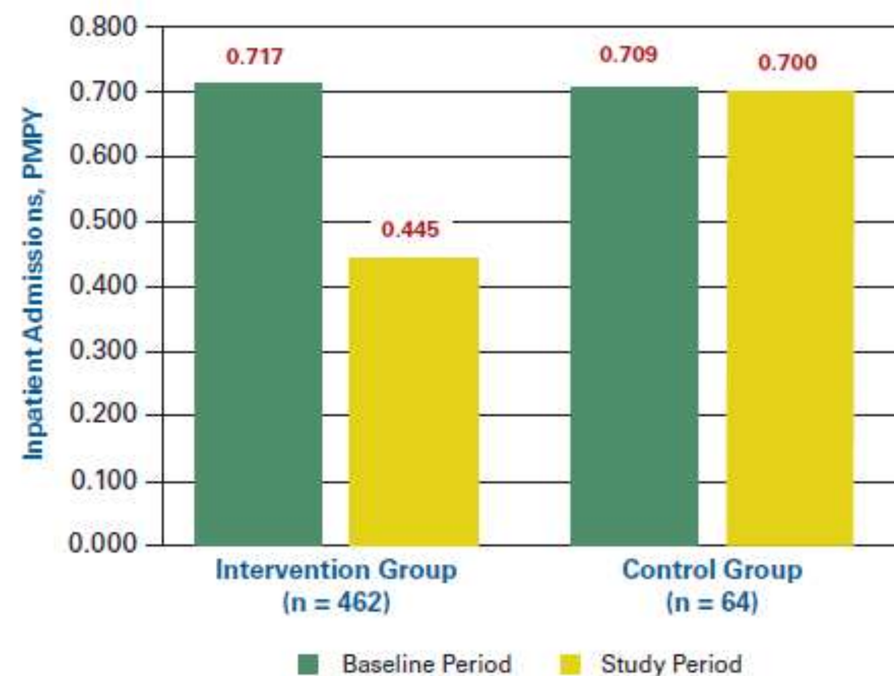
But….Does It Work?

Enhanced vs. Usual Support, According to Service Category.



Wennberg DE et al. N Engl J Med 2010;363:1245-1255.





From Rosenzweig et al: Diabetes disease management in Medicare advantage reduces hospitalizations and cost. Am J Manag Care 2010 16(7):e157

Diabetes				
Diabetes related				
Inpatient days	0.28 (0.012)	0.32 (0.005)	–0.05[c]	–0.15
Emergency visits	0.22 (0.005)	0.20 (0.002)	0.02[c,d]	0.09
Outpatient/ambulatory	4.99 (0.03)	4.87 (0.02)	0.13[c]	0.03
Prescriptions, 30 day	20.92 (0.09)	22.03 (0.07)	–1.11[c]	–0.05
Medical costs	$3378 ($31)	$3627 ($15)	–$249[c]	–0.07
Total				
Inpatient days	**1.42 (0.04)**	**1.50 (0.01)**	**–0.08**	**–0.05**
Emergency visits	**1.12 (0.02)**	**1.06 (0.01)**	**0.06[c,d]**	**0.06**
Outpatient/ambulatory	19.89 (0.14)	18.94 (0.07)	0.95[c]	0.05
Prescriptions, 30 day	81.57 (0.31)	87.41 (0.26)	–5.84[c]	–0.07
Medical costs	**$11,359 ($114)**	**$12,142 ($50)**	**–$783[c]**	**–0.07**
Percentage with A1C test	**0.61**	**0.58**	**0.02[c]**	**0.04**
Percentage with retinal exam	**0.26**	**0.23**	**0.02[c]**	**0.10**
Percentage with microalbumin urine test	**0.39**	**0.33**	**0.06[c]**	**0.18**

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

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

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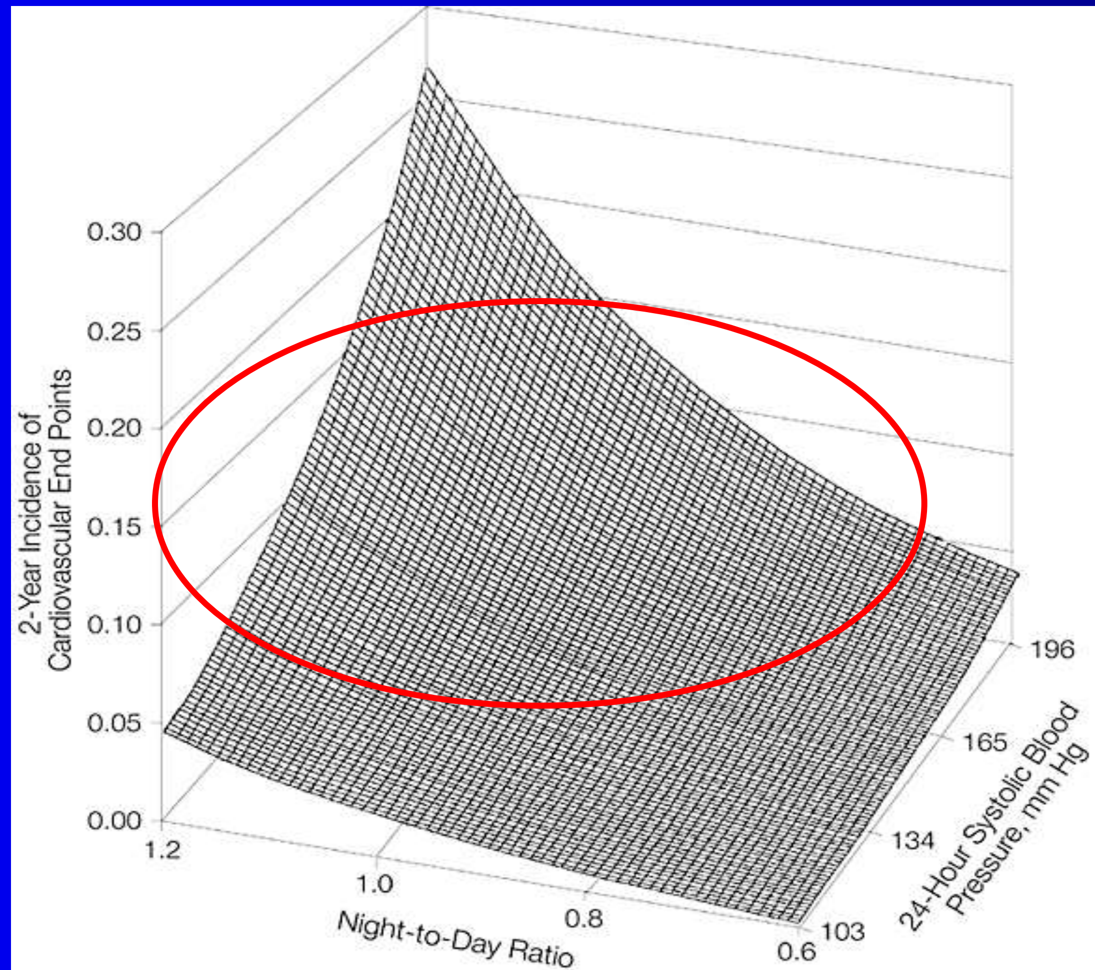
PHM Ingredients
1. Risk Stratification

- 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



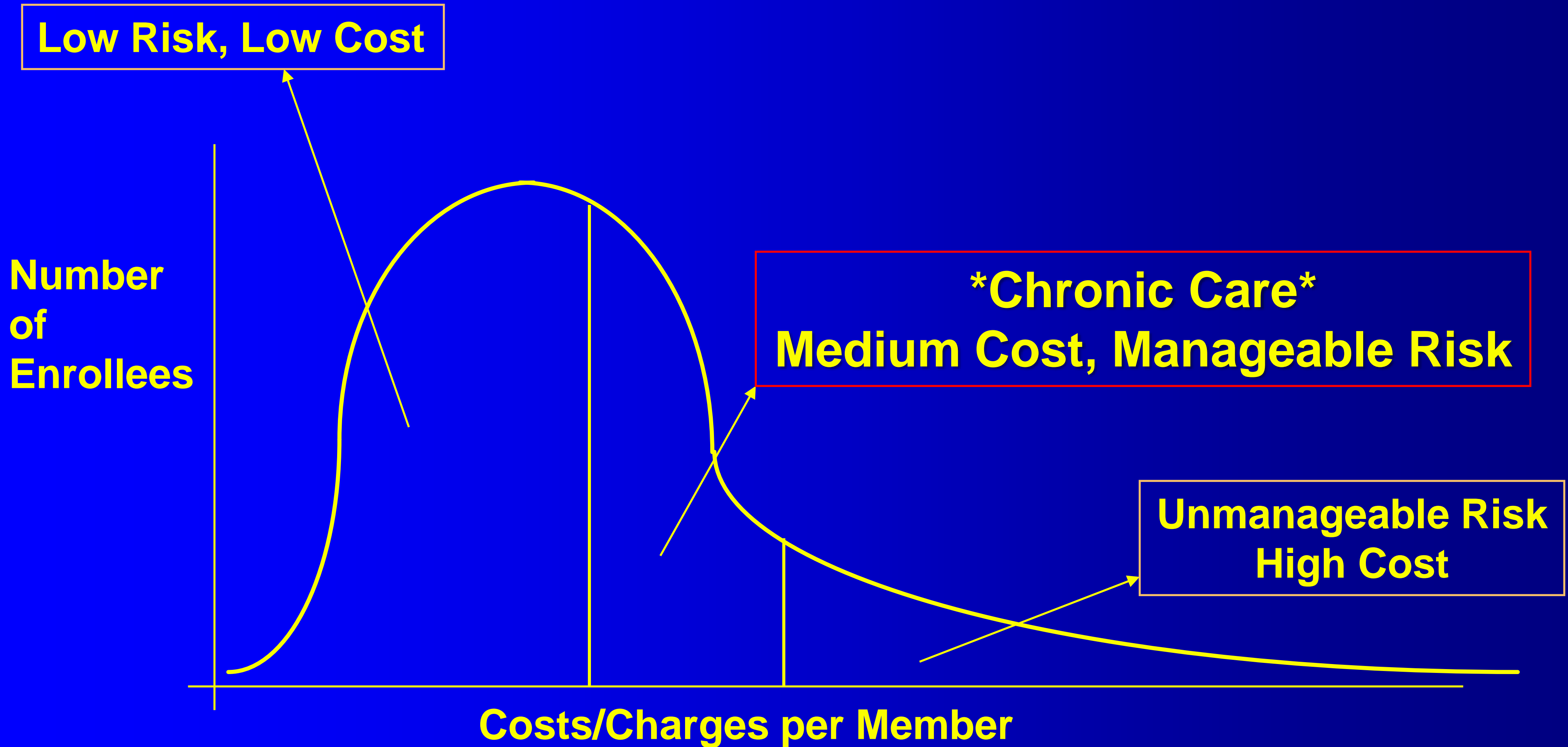
Staessen, J. A. et al. JAMA 1999;282:539-546.

JAMA

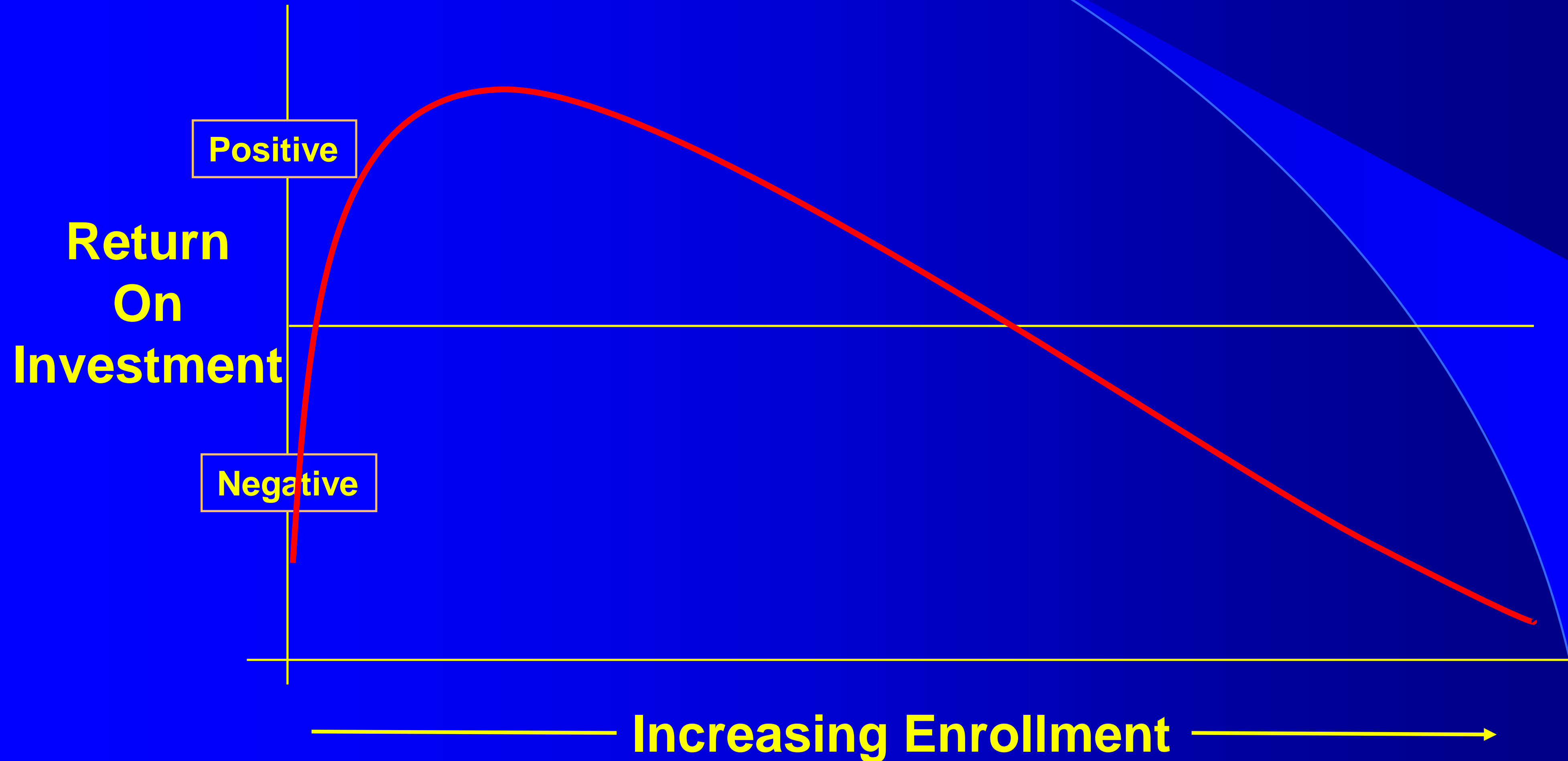
PHM Ingredients
2. Patient Enrollment

- 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.

PHM Elements
2. Patient Enrollment



The "Return on Investment"



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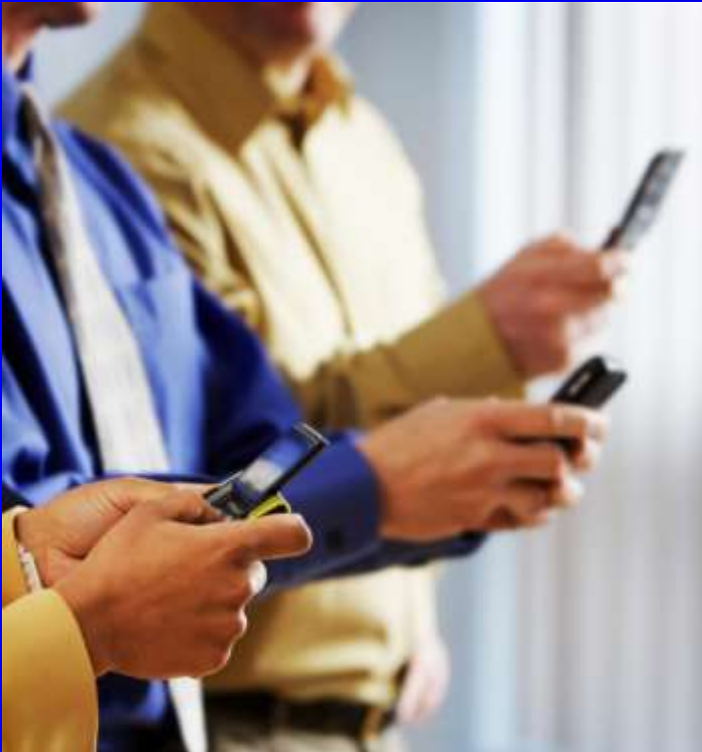
PHM Ingredients
3. Multiple Communication Channels



- 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

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

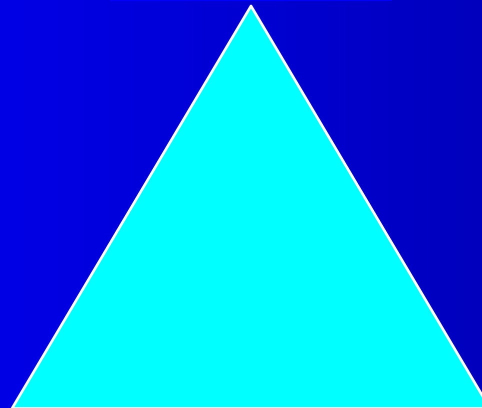
“Quick Hits”

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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RTI Project Number 0207964.025.000.001

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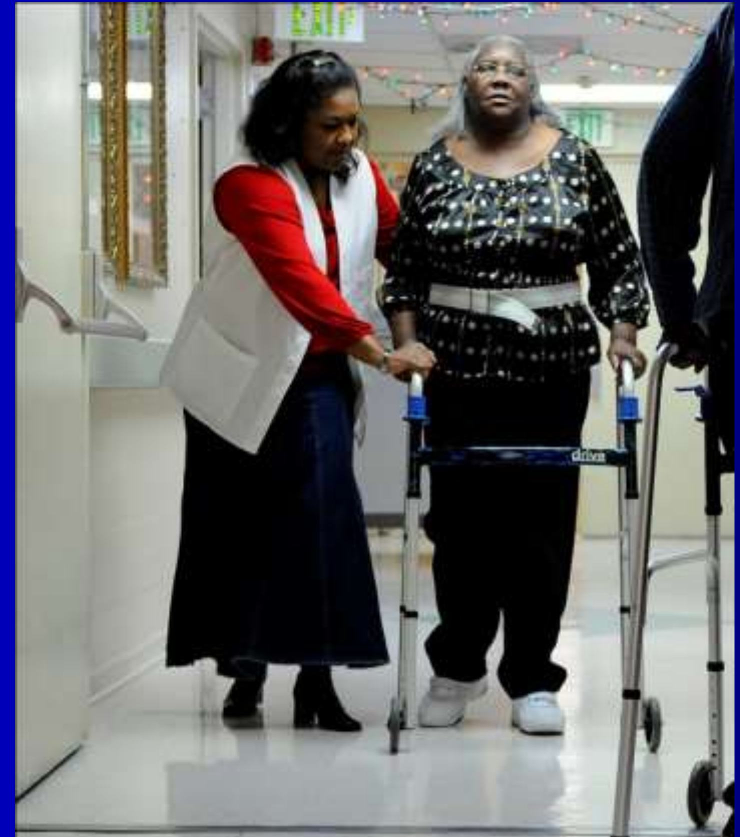
Shared Services Model Option

Centrally coordinated PHM support:

- Short time window
- Available competencies
- Unburden physicians
- *Complements* medical homes



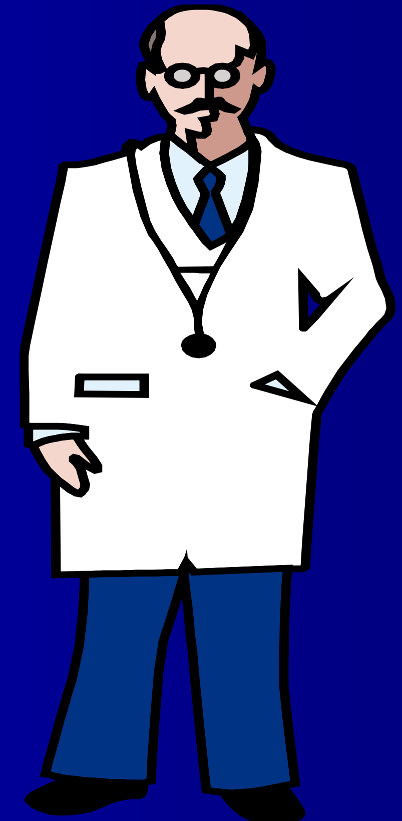
1:1500

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”



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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

Healthwatch

THE HILL'S Healthcare Blog

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?)

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North Shore LIJ

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

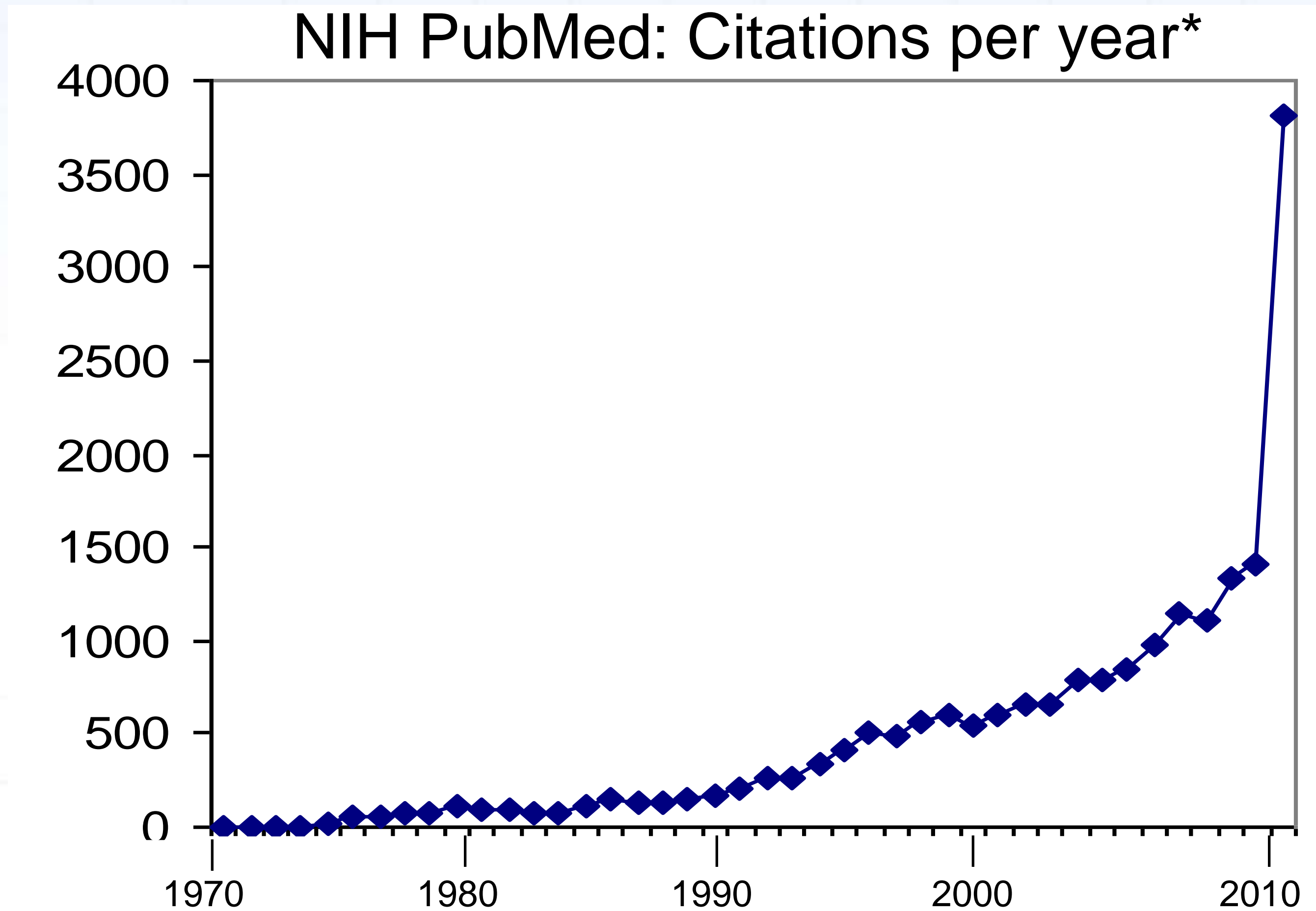
*PubMed published papers

Literature: "Coordinated Care"

Search topic	first citations	Pubmed #*
Coordinated Care	ca. early 1970's	382
Continuity of Care	ca. late 1960's	12,782
Care Continuum	ca. mid 1960's	13,682
Transitions in Care	ca. late 1980's	1,058
Integrated Care	ca. mid 1950's	23,649
		47,817

*Jan 21, 2012

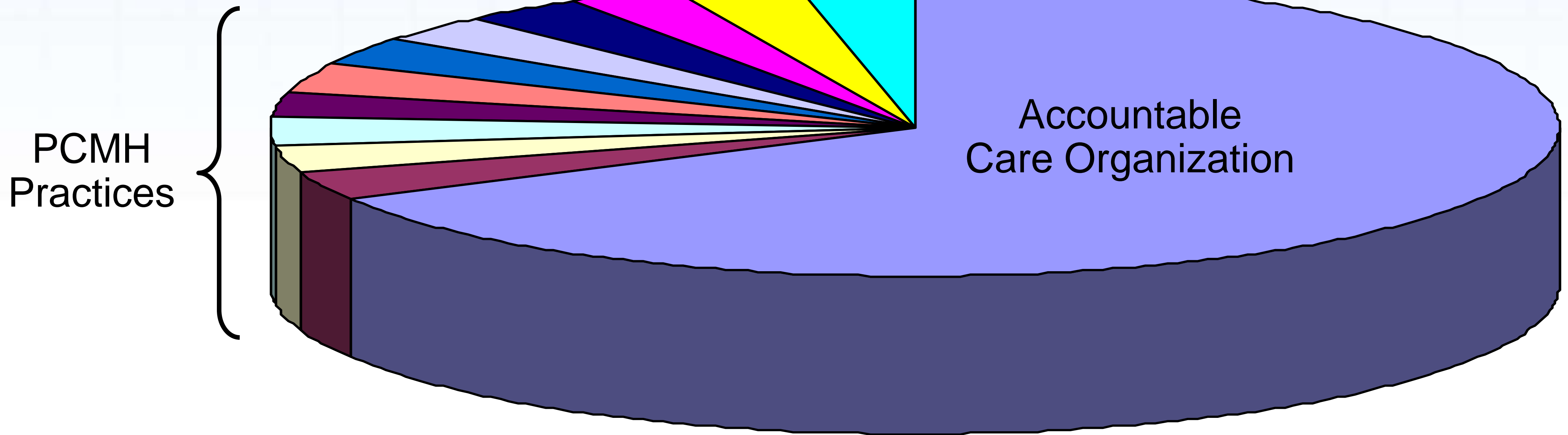
Coordinated Care



North Shore LIJ

*Jan 21, 2012

PCMH vs ACO



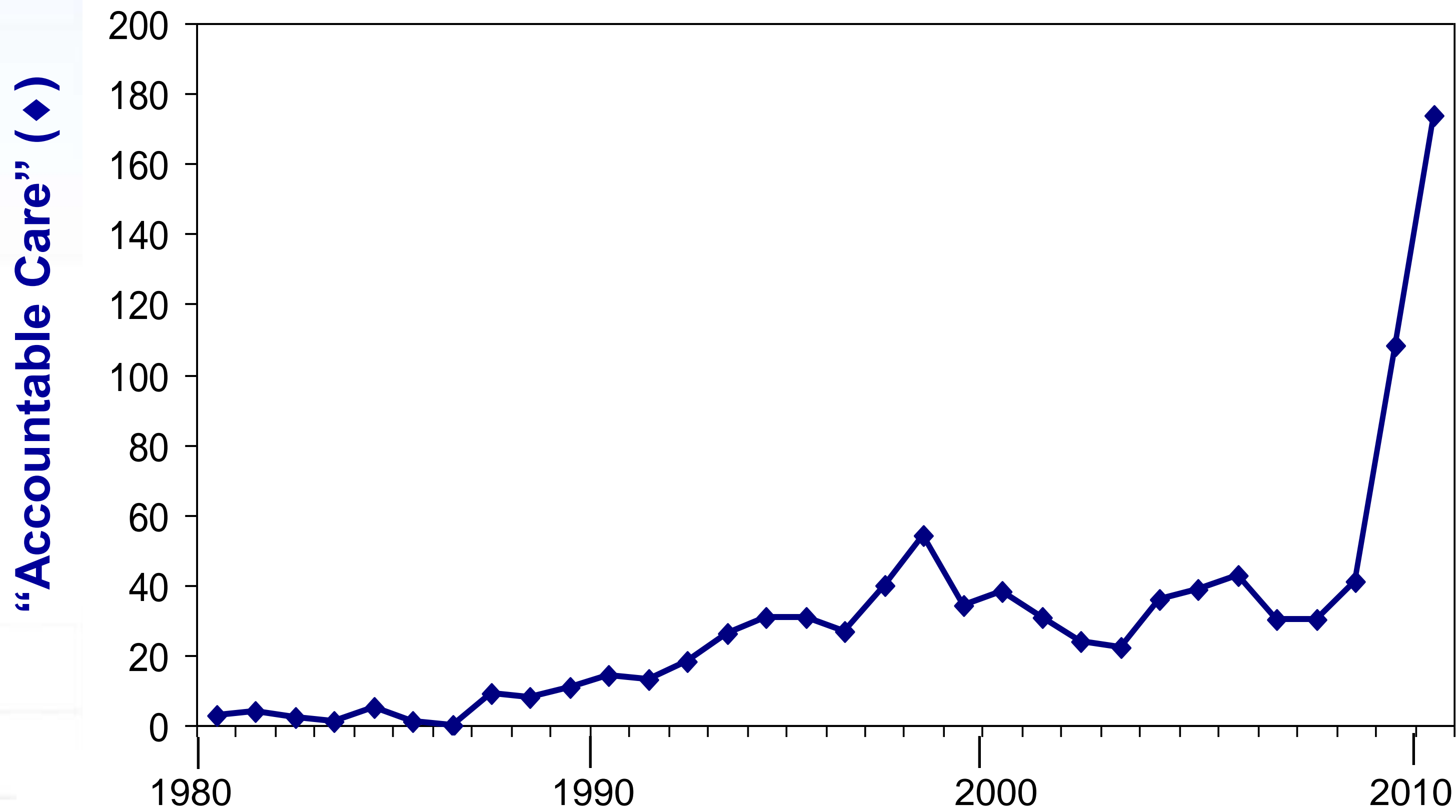
PCMH vs. ACO

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

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

Accountable Care

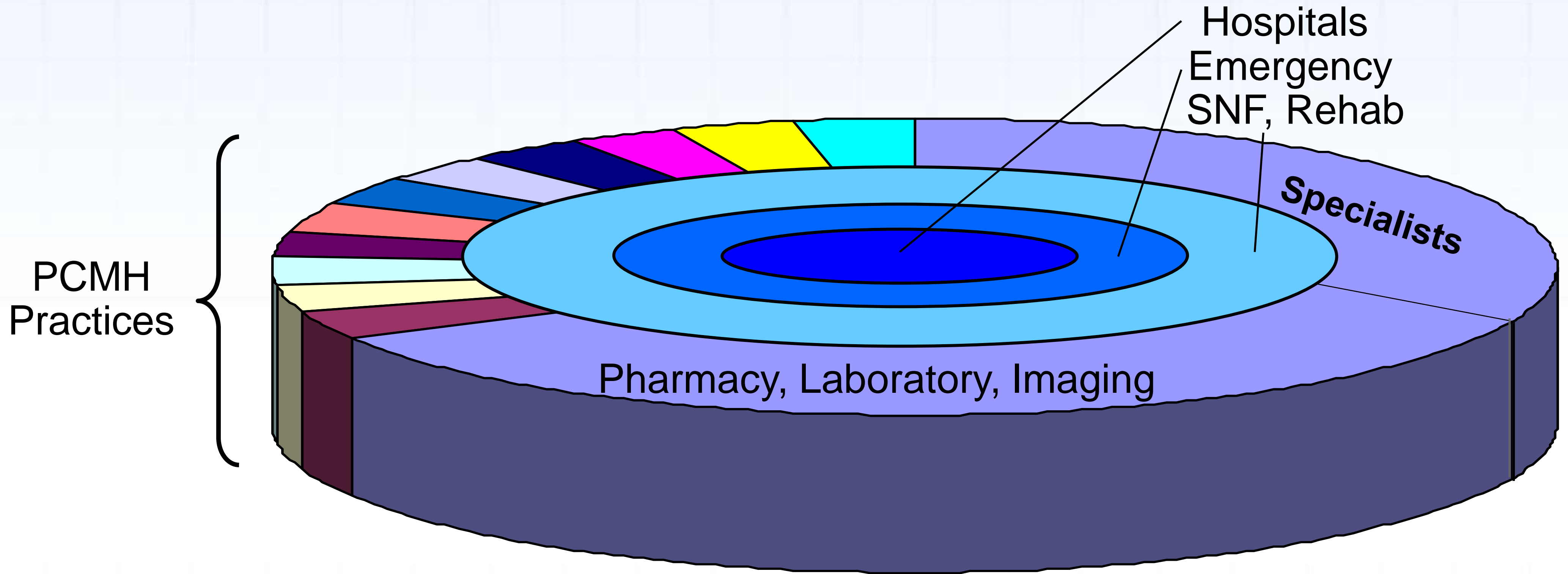
NIH PubMed: Citations per year*



North Shore LIJ

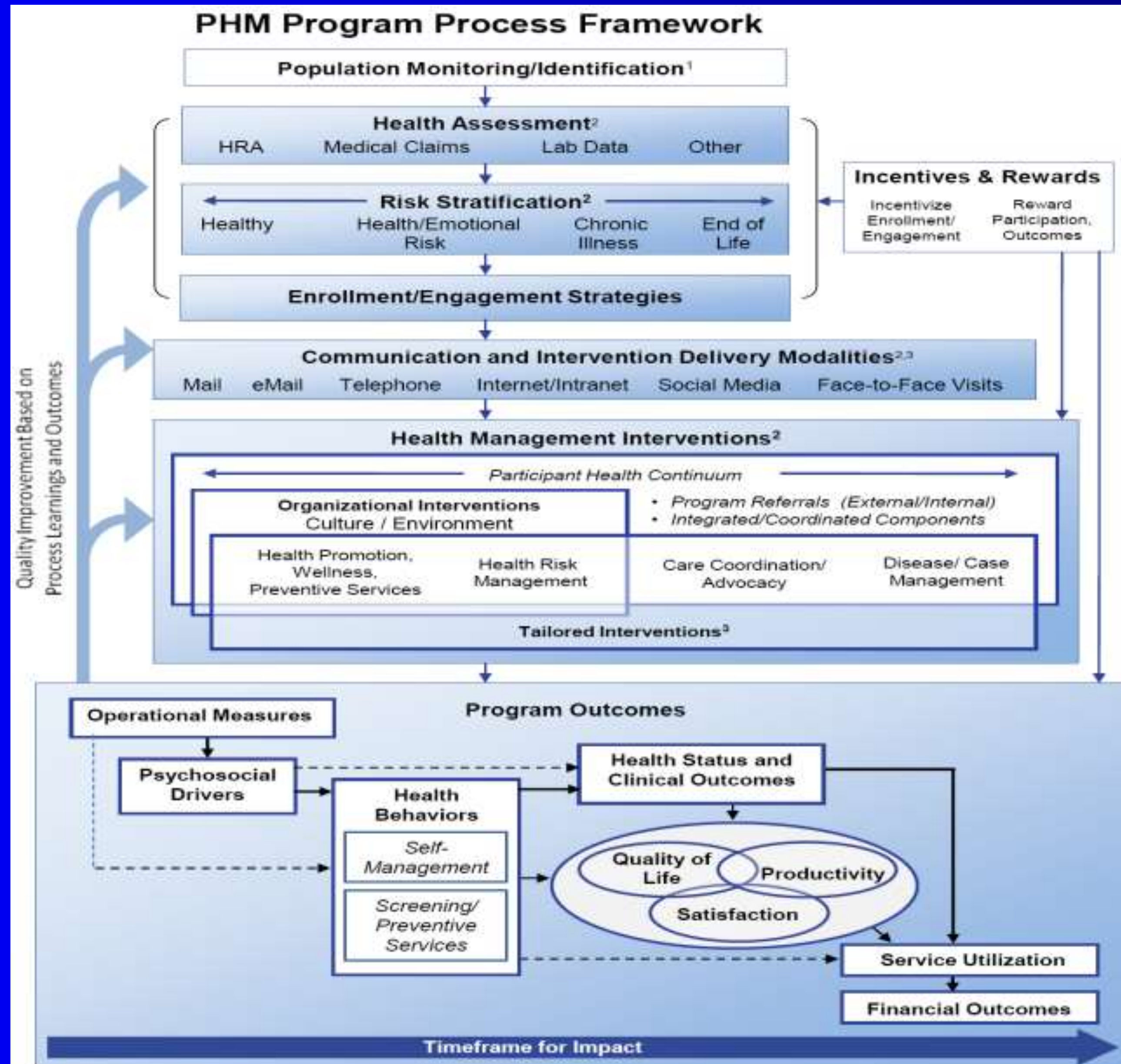
*Feb 10, 2012

PCMH vs ACO



North Shore LIJ

Population Health Management Framework Detail



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

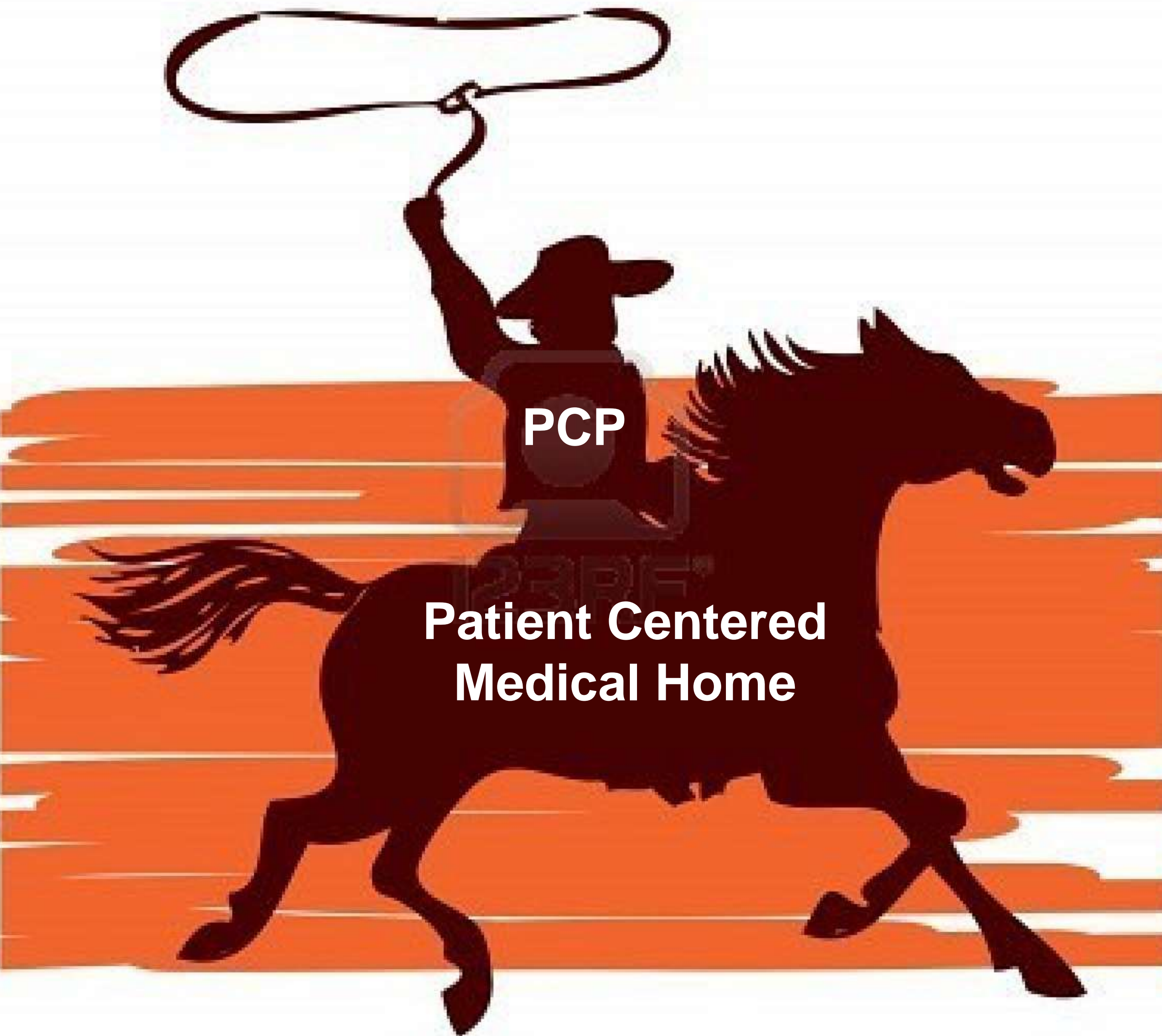
EXECUTION: *The Care Plan*
- Access and input: multiple providers
- Critical Pathway: the chronological order of execution

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



- Specialists
- Ancillaries
  - Imaging
  - Laboratory
- Pharmacy
- Emergency
- Hospitals
  - Admissions
  - Discharge
  - Medications
- Rehabilatation
- 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

Care Coordination

The “isolated” PCMH*

- Care coordinators, Nurse Care Managers
- Healthplans: 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)

Gaps: Medicare Demonstrations

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

Medicare Demonstration Projects

"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

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"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		Physicians integrated into Care Team Leadership as champion of change EHR selection with these in mind: future roles of personnel workflow design
Failure to identify practice core values		Retention of practice core values: care delivery guidelines existing preventive services
Inadequate commitment to change		Persisting through transitional inefficiencies
Lack of time spent on reflection and relationship-building during change		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

Supported by the Center for PCMH Advancement

Thank You

Guy Mansueto
PCPCC Co-Chair
Center for PCMH Advancement

Register Today

Parts 2 and 3

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

Registration Link

http://bit.ly/Hm5IJT

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 Woman & Families

Melinda Abrams, MS
Vice President,
The Commonwealth Fund

Registration Link

http://bit.ly/HPLT6J