

# Population Management for Chronic Conditions

(Warren Taylor, MD)

## The I's have it

- Integration – Med Group, Hospital, and Insurance all in one system – develop the right systems and most efficient workflow
- Unified cost structure that creates Incentives allowing you to do the right thing – capitated payment for the system or population
- Clinical Information systems that allow for population management and the right thing to get done easily (EBM, reminders, monitoring, feedback)
- Culture of Quality Improvement – collaboratives, shared innovation, dissemination of best practices – find the right ways to do things
- Expertise in Implementation – know how to diffuse and drive changes in the organization using our infrastructure and culture

# Population Management Levels of Care

## Advanced Disease

Complex Co-morbid Conditions  
Complex Psychosocial Issues  
Frail Elderly

Need close surveillance of symptoms, medication titration, and intensive self-management education:

- Not in control
- Adherence problems/ Depression
- Complex medication regimen
- Co-morbid conditions

- Need Medications
- Under Control
- Lifestyle Changes

Specialty Care

**Level 3**  
**1-5%**

Specialty MD Care  
Coordination with case/care management, eCare

Assisted Care for Multiple Risk Factor Management  
- Meds, Get to Goal, Lifestyle Change

**Level 2**  
**20-30%**  
Nurse or PharmD Care Management  
PMA with MD  
eCare

Primary Care with Support -  
Meds, Get to Goal, Lifestyle Change

**Level 1**  
**65-80%**  
PCP Care, PMA, Coach, Pharmacist  
eCare, Web