# Collaborative Care Management:
## A New Model for Disease Management

MEDecision, Inc.

June 22, 2005

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*Care Management Solutions*

# Summary

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- **"Collaborative Care Management" requires the appropriate sharing of resources, information and responsibility for Patient outcomes across the distributed care team: case and disease managers, physicians, therapists, patients and care givers.**
  - The technology for creating and sharing valuable, patient-centric clinical summaries from robust, readily available sources of data is in production.
  - Evidence-based or specialty-society protocols are increasingly available for common (single) conditions, though use and acceptance lags production.
  - But progress depends more on teamwork than on technology.
- **There is a logical path that leads to full-blown RHIOs paved with stepping stones requiring incremental investments in Collaborative Care Management that produce value with each step.**

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# MEDecision's Vantage Point

# MEDecision's Position

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- **We are the software leader in Collaborative Care Management.**
  - Collaborative Care Management enables all members of a Patient's Care Team to share information about the Patient's history and status, combined with clinical "best practice", to improve the quality of care and outcomes.
  - MEDecision focuses on health care Payers and the emerging Regional Health Information Organizations (RHIOs) as principal customers.
  - MEDecision's Integrated Medical Management (IMM) solution set is the most comprehensive, functionally integrated and adaptable suite of products in production today.
- **We create "Actionable Intelligence" for the health care system.**
  - MEDecision provides authorized stakeholders with access to the new Payer-based Health Record (PBHR) in a flexible and responsive care management environment to accelerate decisions, automate processes and resolve quality assurance questions on the spot.

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# The Electronic Health Record

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- **How does the PBHR fit in?**

# MEDecision's Position

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- **Today, we have a more than 60 Payer customers nationally, managing care for 1 out of every 6 insured people.**
  - 15% of top 433 MCOs;
  - 21 of the BlueCross BlueShield Plans;
  - Significant pockets of managed Medicaid business;
- **Collaborative Care Management is most likely in markets with progressive Payers that represent a significant portion of each physician's practice.**
  - We have market-dominant Payers in more than 30 markets.
- **The bridge from the Payer space has been iEXCHANGE® Web.**
  - In production or being implemented in half of the markets.

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# MEDecision's Position

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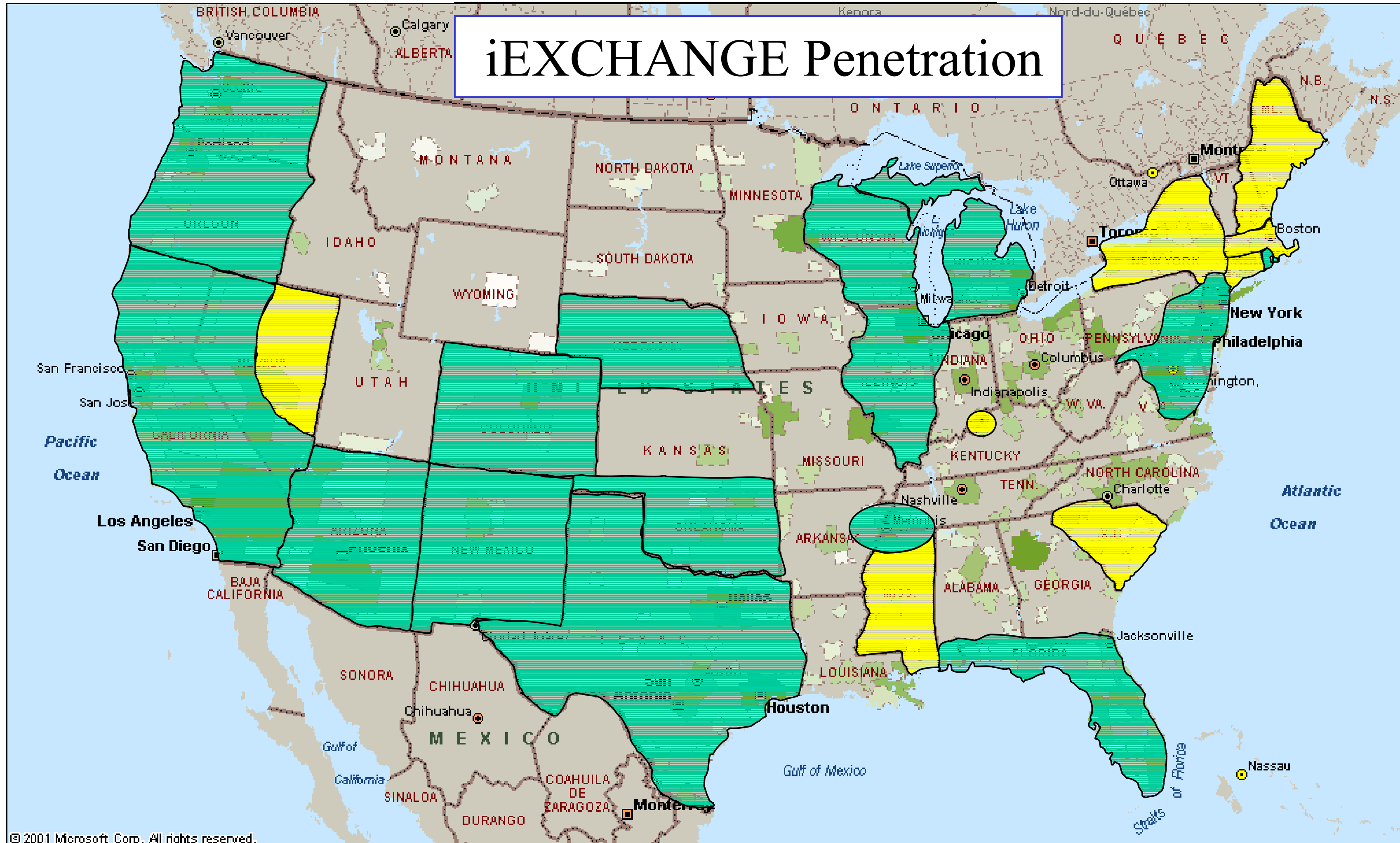

# The Electronic Health Record

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- **How does the PBHR and EBM fit in?**

# Collaborative Care Management

# Disease Management

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- **IDENTIFYING: requires data collection, standardization and analysis**
  - Issues: Timeliness, Accuracy, Clinical Relevance, Cost

EBM

- **PLANNING: requires accepted assessments & protocols**
  - Issues: Detail Data, Multi-Conditions, Consensus Building, Cost

EBM

- **INTERVENING: requires access, information and adaptability**
  - Issues: Consensus, Coordination, Compliance, Cost

EBM

- **COACHING: requires organization, time, credibility and repetition**
  - Issues: Access, Message Consistency, Influence, Coordination, Cost

EBM

- **REPORTING: requires data, discipline and tools**
  - Issues: Timeliness, Completeness, Normative Comparisons, Cost

EBM

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# IDENTIFYING Candidates

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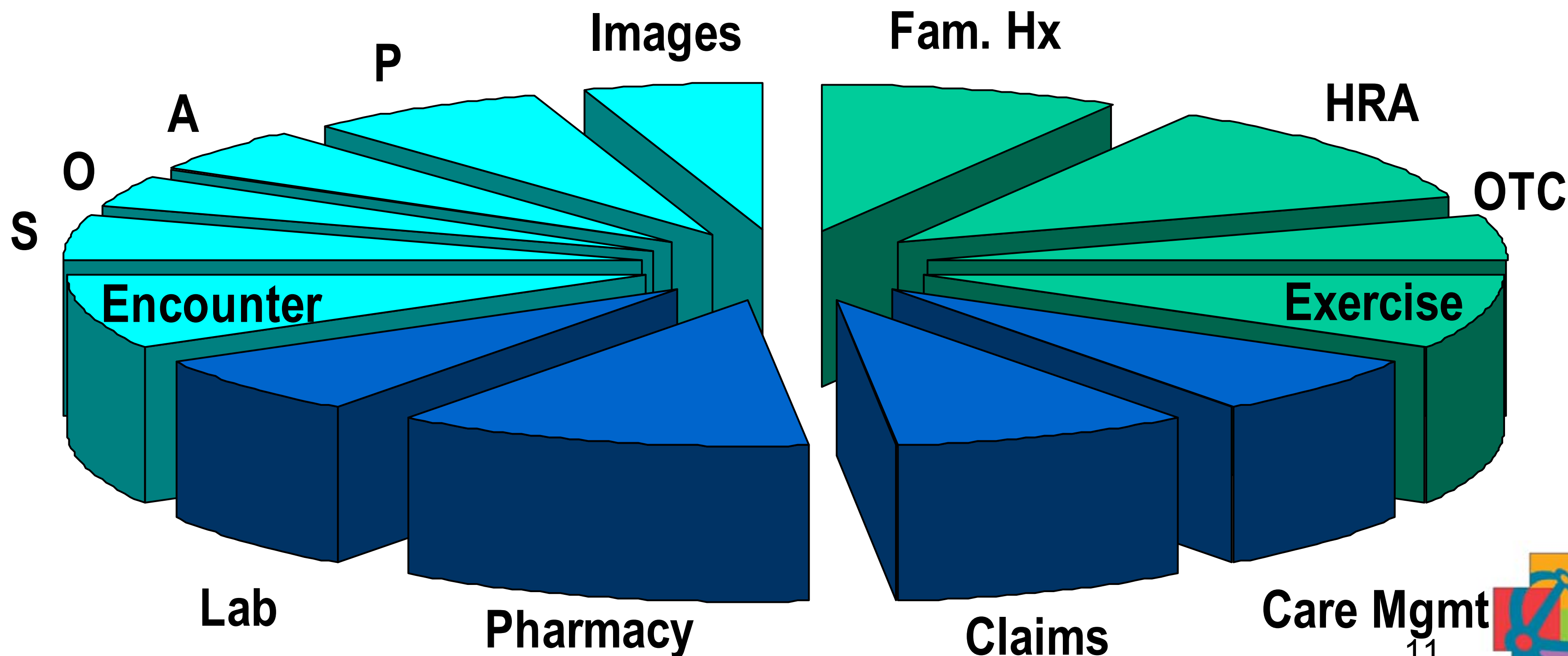
- Electronic data about Patients are distributed in multiple repositories.



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# Patient Data Sources

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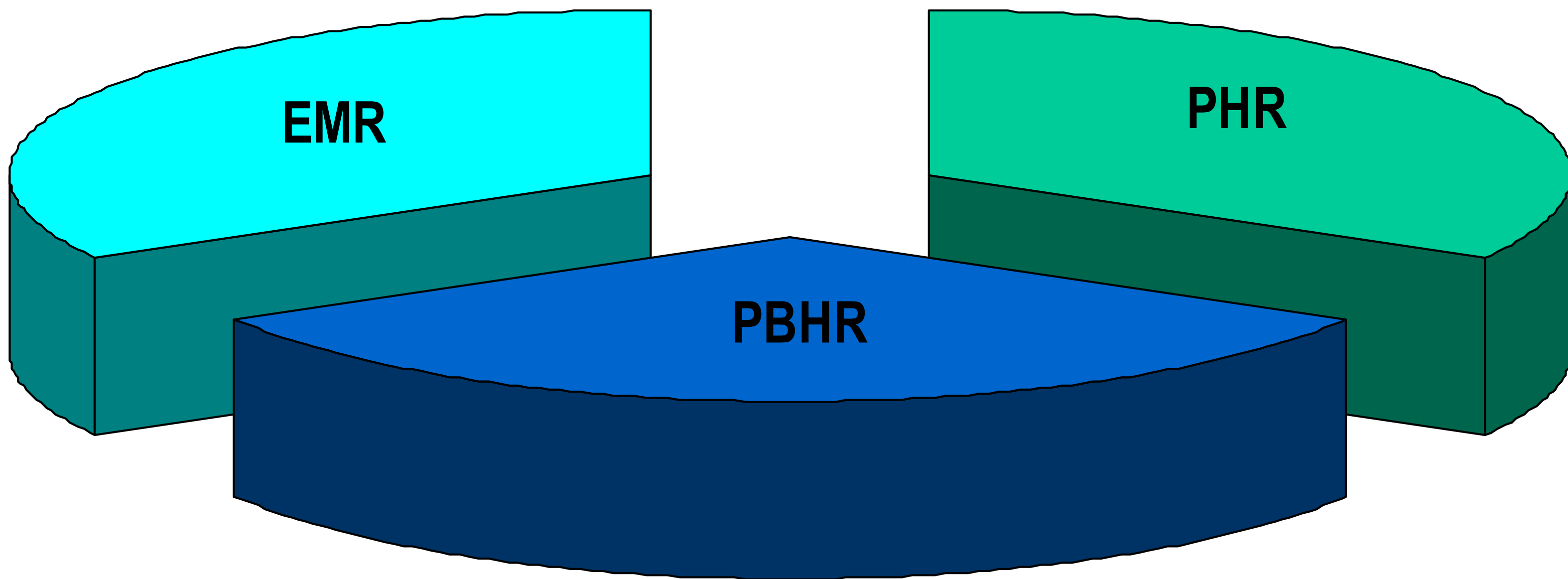
- Three primary systems are used to integrate and store Patient Data.



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# Patient Data Sources

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- Our challenge is to intelligently "weave" these primary sources of Patient data together.

Electronic Health Record

**"EHR"**

**EHR = PBHR + EMR + PHR!**

# Uses for the EHR

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- **The EHR becomes the source data for:**
  - Patient-centric Risk Assessment & Predictive Modeling.
  - Comparison to Evidence-based Medicine treatment plans and identification of "Treatment Opportunities."
  - Populating care management systems in Payer, Provider and Disease Management organizations.
  - Public Health and Surveillance programs.
  - Clinical research with unidentified records and data.

# PLANNING for Care

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## Targeted at Patients

- *Patient-specific* Action Plans based on General and Condition-Specific Assessments
- Program introduction letters to patients
- "Ask your doctor" worksheets
- “Readiness to change” approach to education
- Accurate and focused educational content
  - *Delivered by Care Managers and Physicians*
  - *Multiple Media: Mail, Internet, IVR*

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clopidogrel
COUMADIN
dipyridamole

5. Have you had a heart attack? help — Yes

5.A. How long ago was your heart attack? — < 12 months

5.B. Have you made lifestyle changes to reduce your risk for another heart attack? help — Yes

5.C. Did you attend cardiac rehabilitation classes following your heart attack? help — Yes

5.D. (If no and eligible) Would you consider attending cardiac rehabilitation now?

5.E. Has your provider told you that you cannot take beta blocker medications (contraindicated)? — No

5.F. (If no or unknown) What beta-blocker medications are you taking? help

**Select all that apply**

acebutolol
atenolol
BETAPACE
betaxolol
bisoprolol
BLOCADREN

5.G. Has your provider told you that you cannot take ACE inhibitor medications (contraindicated)?

5.H. (If no or unknown) What ACE inhibitor medications are you taking? help

ACCUPRIL
ACCURETIC
ACEON

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Help | How do I...? | Log out

## Proposed plan of care | Case ID:

**Patient**

Name: **WOOD, DEBBIE ANN** ID: **234569780-01**

Sex: Female DOB: 05/05/1955 Age: 50 LOB: HMO

Plan code: ECC01 Client code: Indemnity

### New problems identified by: 2005 CAD Assessment

| Select to open | Problem description | Question/answer |
|---|---|---|
| ☑ | Attention priority: Current tobacco user | Use of tobacco products - Yes |
| ☑ | Attention priority: Facilitate access to diabetes classes | Willing to attend diabetes education classes - Yes |
| ☑ | Attention priority: High risk for cardiovascular event | Date of stroke - < 12 months |
| ☑ | Attention priority: High risk for cardiovascular event | Date of myocardial infarction - < 12 months |
| ☑ | Attention priority: High risk for cardiovascular event due to changes in condition | Unstable angina - Yes |
| ☑ | Attention priority: Member has not attended diabetes classes | Attended diabetes classes - No |
| ☑ | Attention priority: Member is lacking regular medical evaluation and/or testing | Last appointment date - > 6 months |
| ☑ | Attention priority: Positive depression screening | Feeling down, depressed or hopeless - Yes |
| ☑ | Attention priority: Positive depression screening | Loss of interest - Yes |

# PLANNING for Care

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## Targeted at Providers

- Program introduction letters to providers
- Physician "Event and Intervention" report
- Patient Clinical Summary with EBM Overlays
- Clinical guidelines in abbreviated and full formats
  - *Multiple Media:  Internet, Mail, IVR*
  - *Accurate and focused educational content for Patient*

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## Nursing plan of care

Print friendly

**Patient**

Name: **WOOD, DEBBIE ANN** ID: **234569780-01**
Sex: Female DOB: 05/05/1955 Age: 49 LOB: HMO
Plan code: ECC01 Client code: Indemnity

**Existing problem(s)**

View all | View open

Edit Delete Save Cancel

Add a new problem

| | Problem & status | Goals | Interventions | Outcomes | Barriers | Target | Opened |
|---|---|---|---|---|---|---|---|
| ◉ | Attention priority: Facilitate access to cardiac rehabilitation<br><br>(Open - New Problem) | - Service or care will be arranged by care manager<br>- Member will demonstrate understanding of the process and importance for obtaining services or care | - Explain the process for enrollment in cardiac rehabilitation<br>- Facilitate process for enrollment to cardiac rehabilitation | - Goals partially met | - Behavioral<br>- Lack of Transportation | | 03/28/2005 |
| | 03/28/2005 11:10 AM ET MGR: | | | | | | |
| ○ | Education: Exercise recommendations<br><br>(Open - New Problem) | - Member will demonstrate understanding of risk factors for condition/behavior<br>- Member will set a regular schedule to meet physical activity goals | - Encourage member to find external support: such as a walking or workout partner<br>- Instruct member to seek provider approval before starting an exercise program | | - Denial | | 03/28/2005 |

# DM/CM Clinical Content Architecture

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1. Questions
2. Patient responses
3. Problem List
4. Goals
5. Interventions **EBM**
6. Barriers
7. Readiness to change (Prochaska model)
8. Outcomes (of the interventions)
9. Help function
10. Patient reports & letters
11. Physician reports & letters



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# INTERVENING with Care

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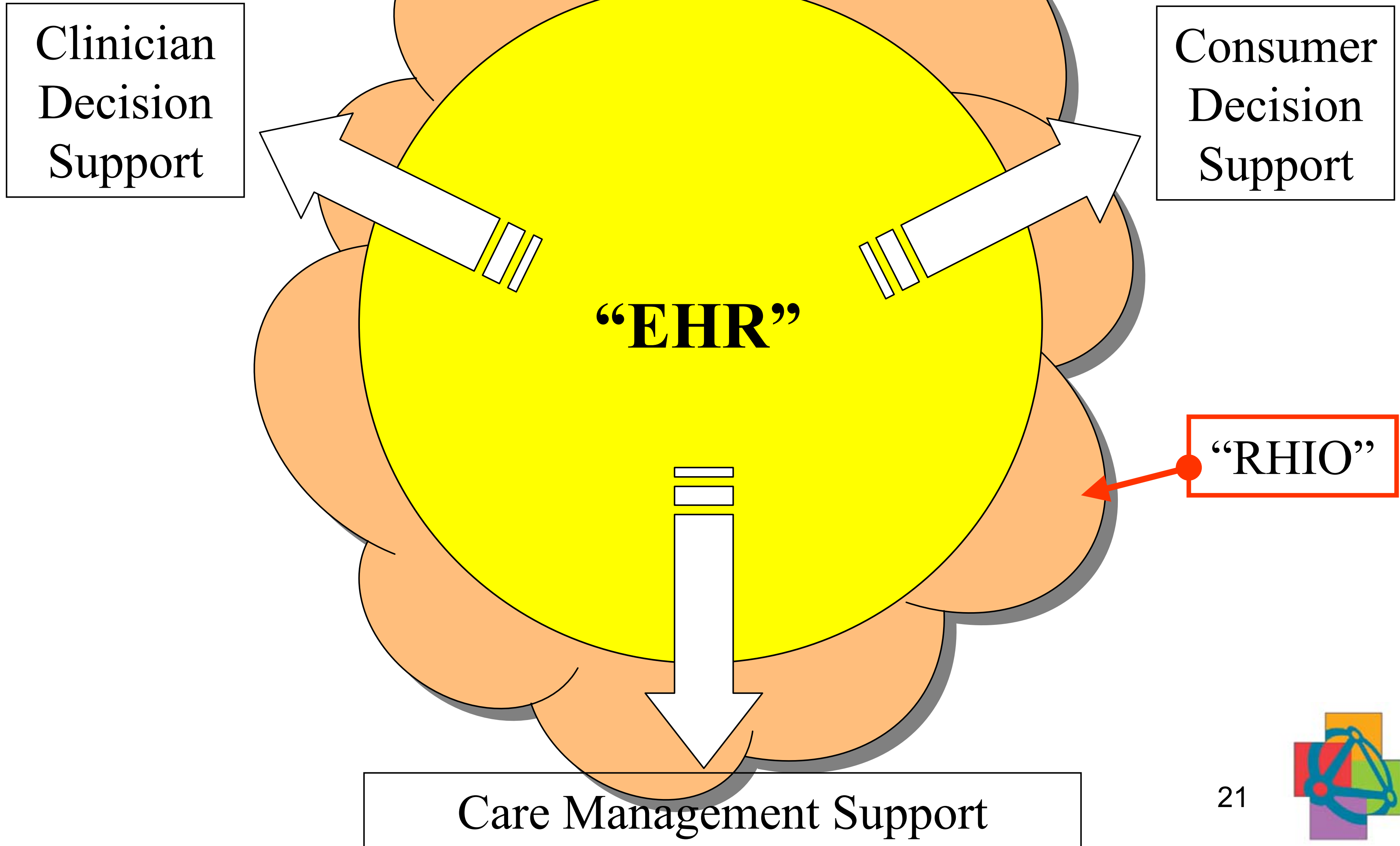




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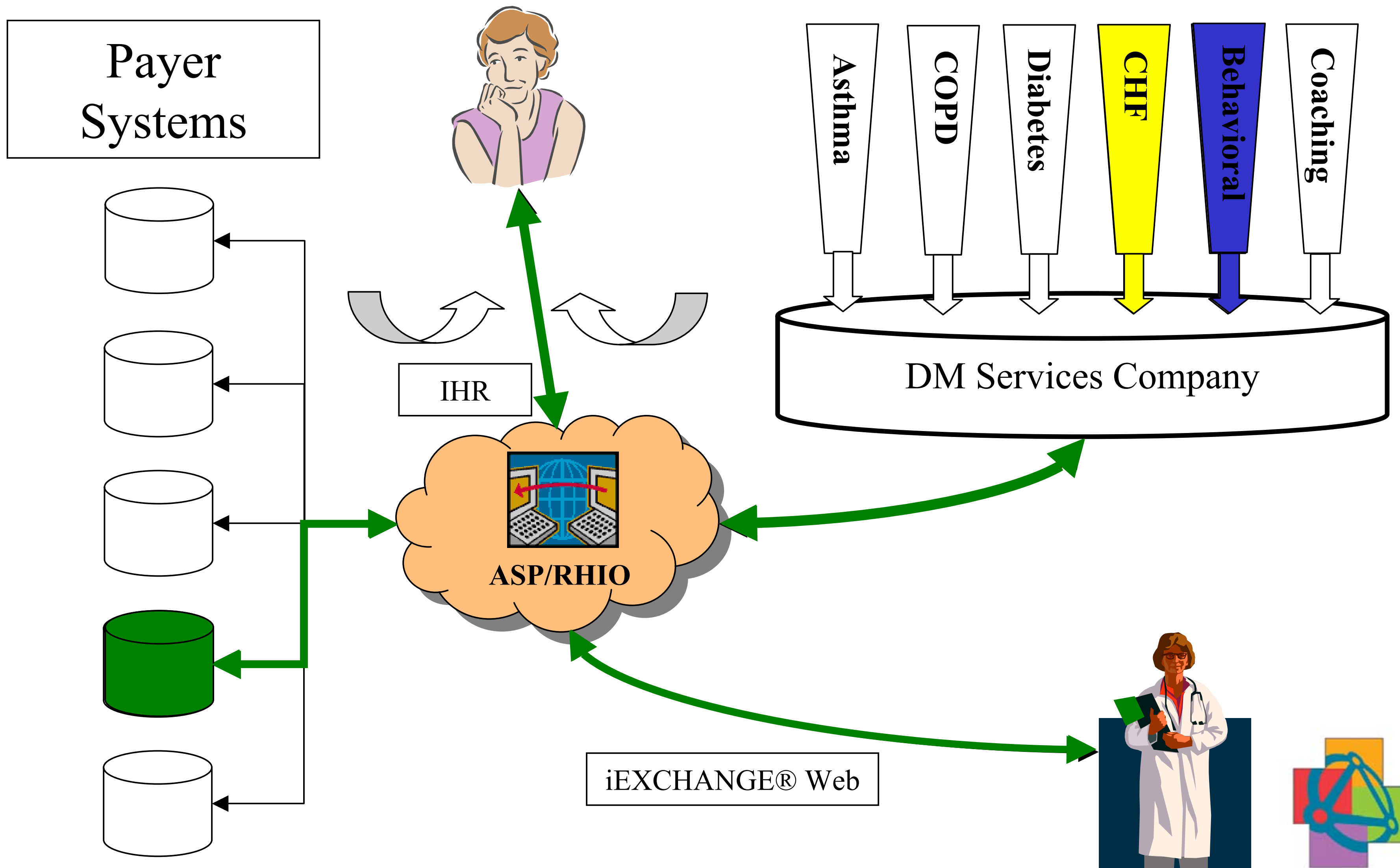
# Collaborative Care Mgmt.



# Value of the PCS Today

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- **Even as a uni-directional document (Payer to Provider), early retrospective reviews of records in Emergency Rooms have shown:**
  - Almost half of the ED records were missing relevant Rx info on Patients, meaning that Drug-Drug and Drug-Condition conflicts may have been missed.
  - Of the 60 case records reviewed, 4 cases led to hospital admissions and batteries of tests that likely would have been avoided had PCS data been present for the ED staff to review.
- **The economics are compelling: a PCS could be available today – for use by Patients and Providers over secure Internet connections – across a population for enhanced Disease Management.**
  - Costs represent less than one-tenth of one percent of premium costs.
  - Cost reductions due to increased quality of care are expected to be between 7.5% and 30% for the full-blown NHII.

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# The Road to RHIO

# Collaborative Care Management

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- **Focus on a Payer's potential High-ROI situations first, then extend the programs on a marginal cost basis to receive marginal benefits.**
  - Emergency Room Visits are expensive and high-risk, with a limited number of technically sophisticated sites to connect;
  - Disease Management programs offer additional opportunities to collaborate to benefit patients with complex conditions, especially if specialty networks are involved;
  - Consider extending efforts to pull in other high-intensity programs (like Medicaid) for greater community impact and political support;
  - Finally, push for full adoption across the general population.



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# Collaborative Care Management

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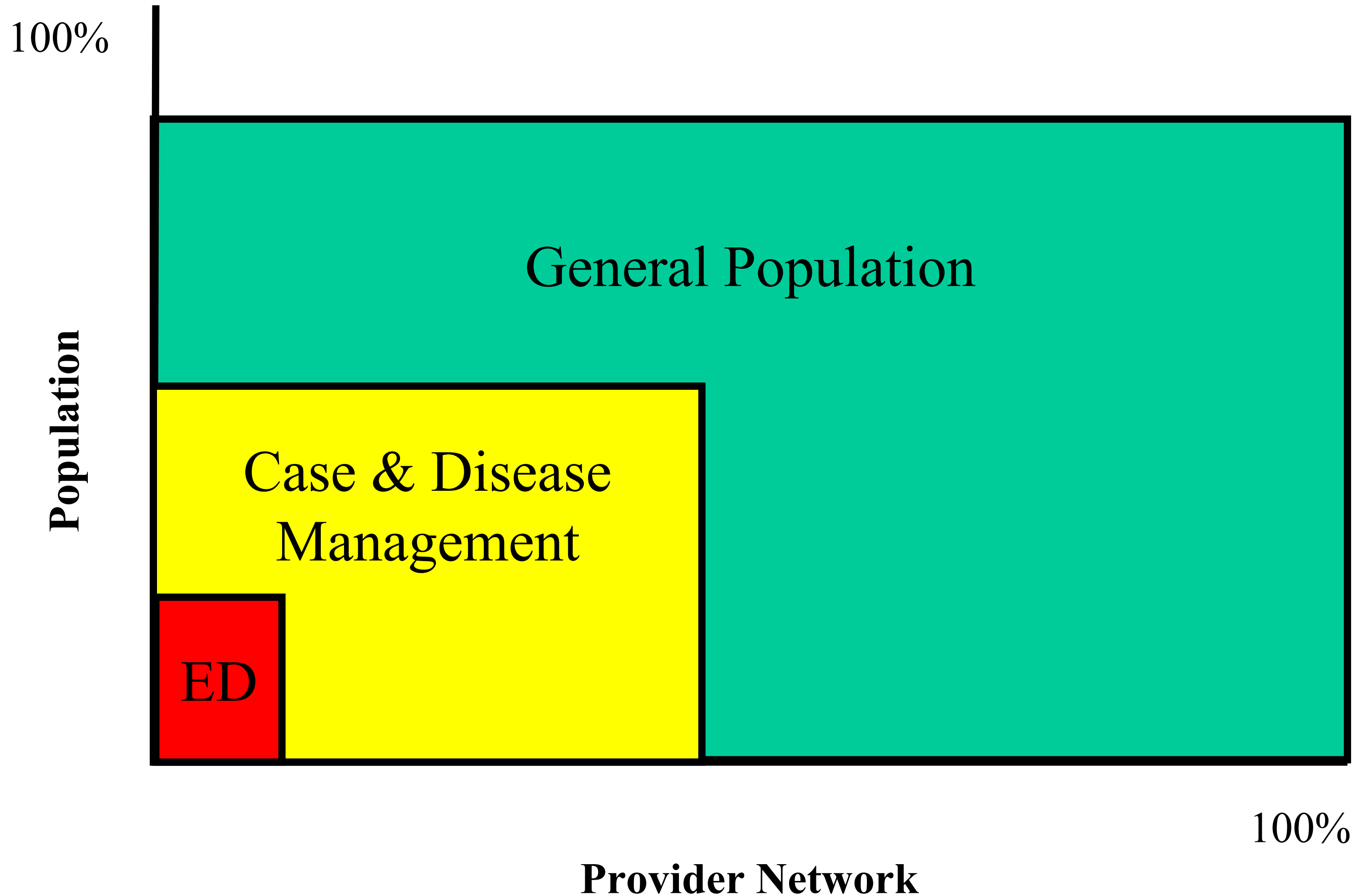




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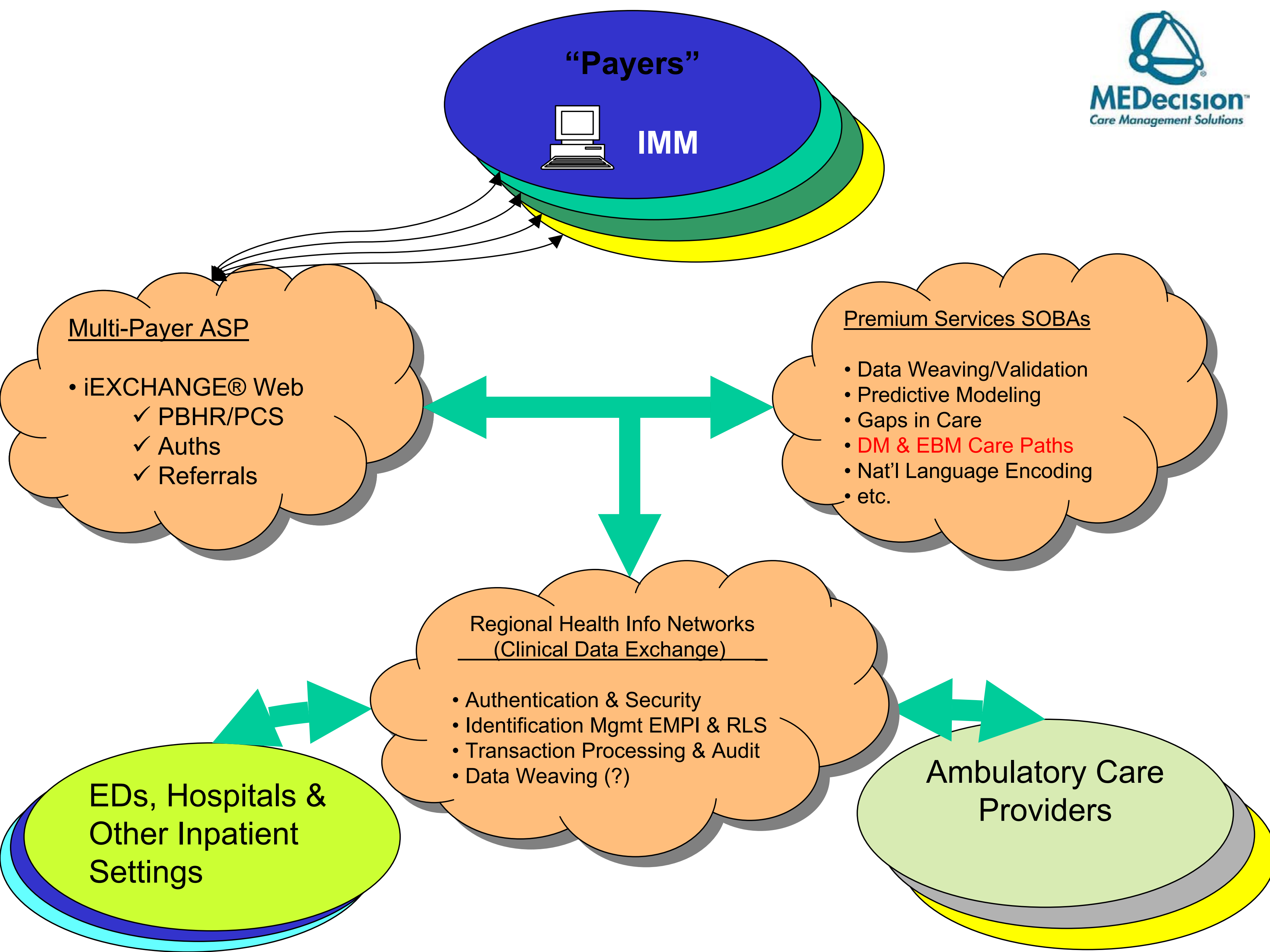
"Payers"
IMM
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Multi-Payer ASP
• iEXCHANGE® Web
✓ PBHR/PCS
✓ Auths
✓ Referrals
Premium Services SOBAs
• Data Weaving/Validation
• Predictive Modeling
• Gaps in Care
• DM & EBM Care Paths
• Nat'l Language Encoding
• etc.
Regional Health Info Networks
(Clinical Data Exchange)
• Authentication & Security
• Identification Mgmt EMPI & RLS
• Transaction Processing & Audit
• Data Weaving (?)
EDs, Hospitals & Other Inpatient Settings
Ambulatory Care Providers

# The Future of Analytics

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- **Analytics processes for care management and care delivery will lose "ownership" of underlying data sources:**
  - Collaborative relationships will promote sharing - but not control - of data.
  - Federal NHII initiative is predicated on a "federated" model for clinical data.
- **Continued emphasis will be on Patient-centric analyses and interventions, but will increasingly encompass interactions with the members and the treating physicians and other professionals.**
  - Goal: To increase the quality of the sources and uses of data.
- **Improved quality of clinical and member HRA data will allow for better predictions and high-risk/high-value case identifications with fewer false positives and false negatives.**

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# The Value of Perfection
# The Cost of Perfection

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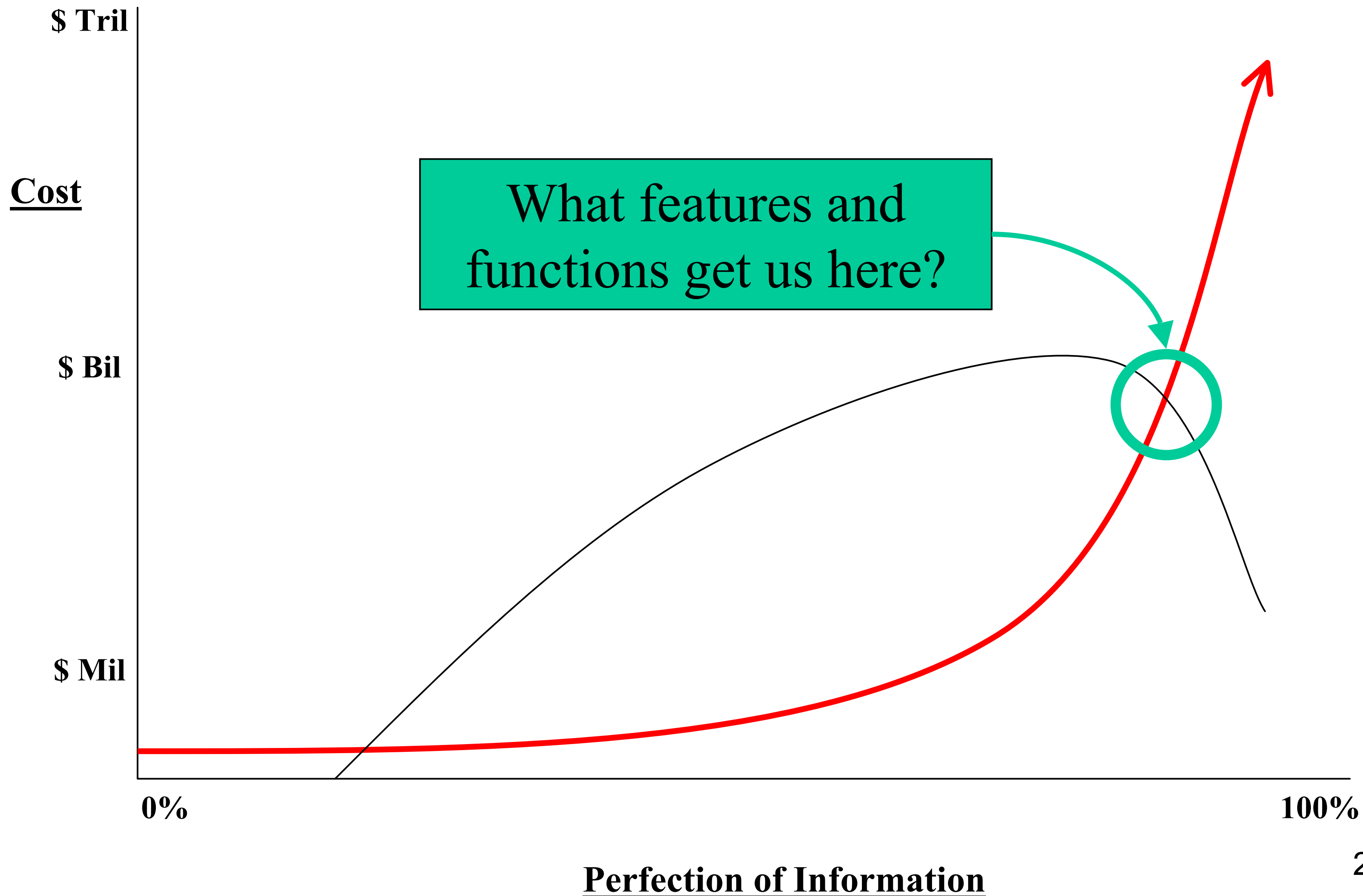




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# Questions?

# Thank You!

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