Care Managers and Care Management—the Lehigh Valley Experience

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Roadmap for today

1. PCMH at Lehigh Valley Health Network (LVHN)
2. Evaluating the Care Manager Role
   -qualitative
   -quantitative
3. Strategy moving forward
4. Discussion

The Lehigh Valley

PCMH at LVHN

- Seven LVHN practices participated in a state-wide multi-payer PCMH pilot: the PA Chronic Care Initiative
- All are now NCQA recognized
- PA selected for CMS Demo: practices may continue in pilot for another 2-3 years.

Care Manager in the PCMH

- Seven practices with mandate to implement Care Managers.
- Minimal requirements from PA around background of Care Manager or patient panel size
- LVHN gave autonomy to practices, and we studied what happened with this new role: We are now completing this *pilot within a pilot.*

Qualitative Data Collection

- Define role of care manager
- Who should be care manager?
- Time spent doing care management

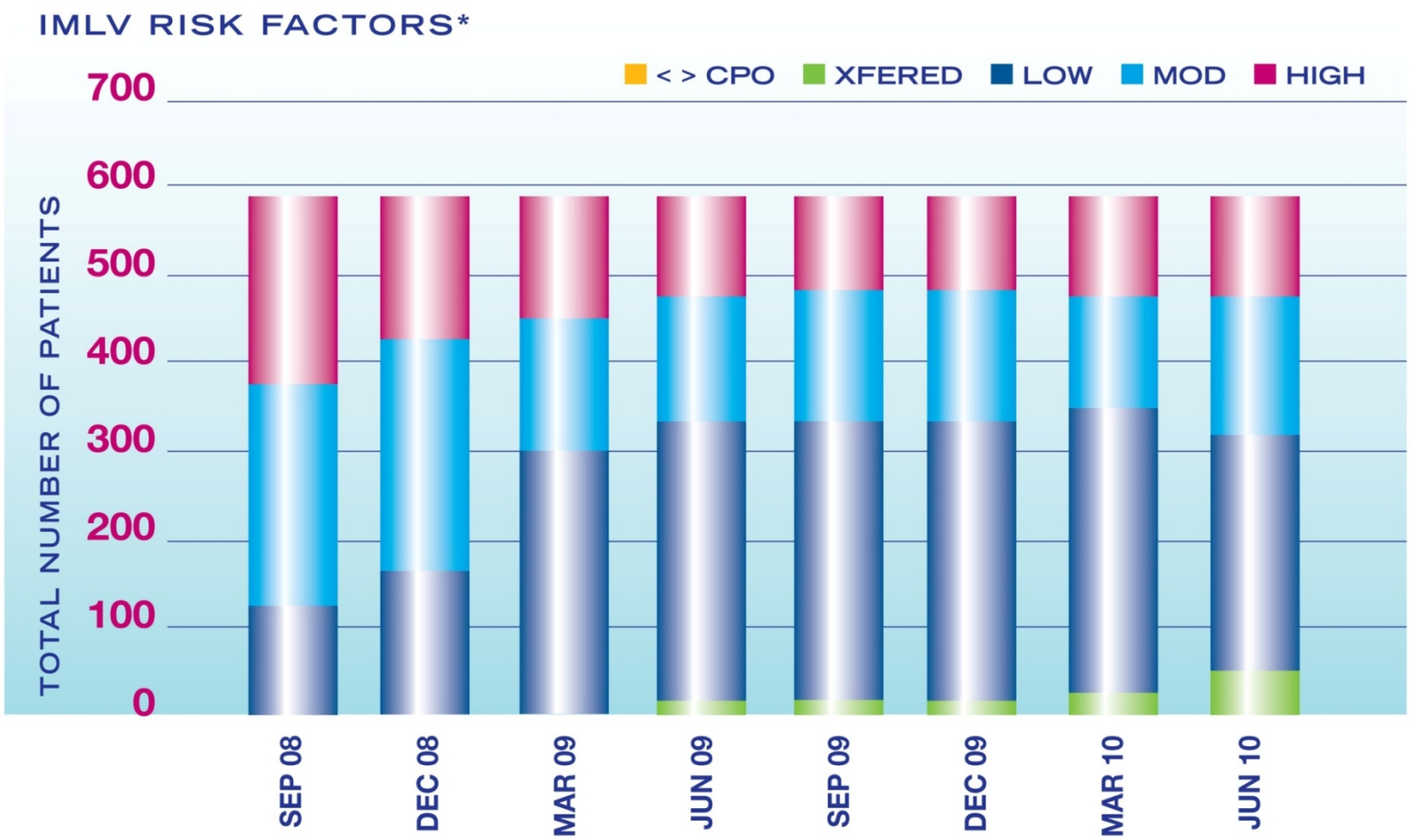
Qualitative Learnings

- “Care Management is constantly evolving”
- Definition of care management changed in practices over time, but identified *core features.*
- In spite funding, minimal dedicated care management : practice needs took priority
- Range of activities suggest it is not the job of one person, but of the practice as a whole.

What has changed?

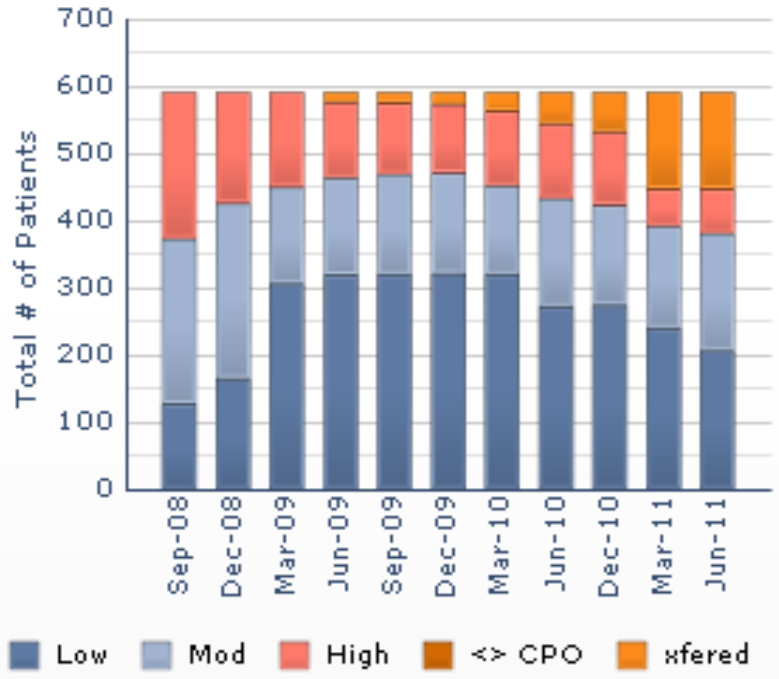
- Hospital follow up
  - Medication reconciliation/management
- Registries to identify high risk patients
  - Develop & implement patient care plans
- Increased perception of value of care management
  - Decrease ED utilization
  - Patient satisfaction with health

Table 3: Graph 1 Risk Stratification and utilization data for diabetic patients, quarterly data pre and post care manager implementation—sample from one "typical" practice

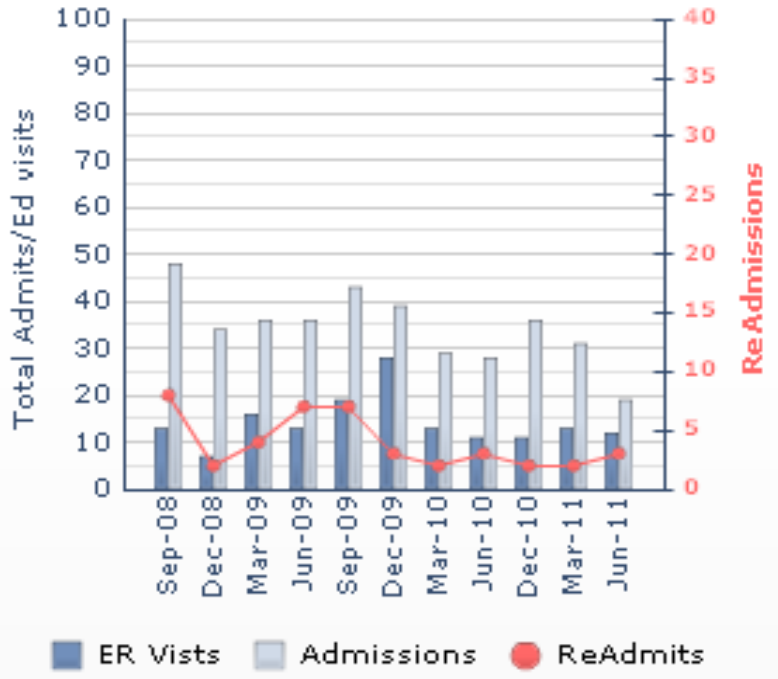


PA State Collaborative (Medical Home)
Cohort Diabetic Population

Practice I
Cohort by Risk Factors*

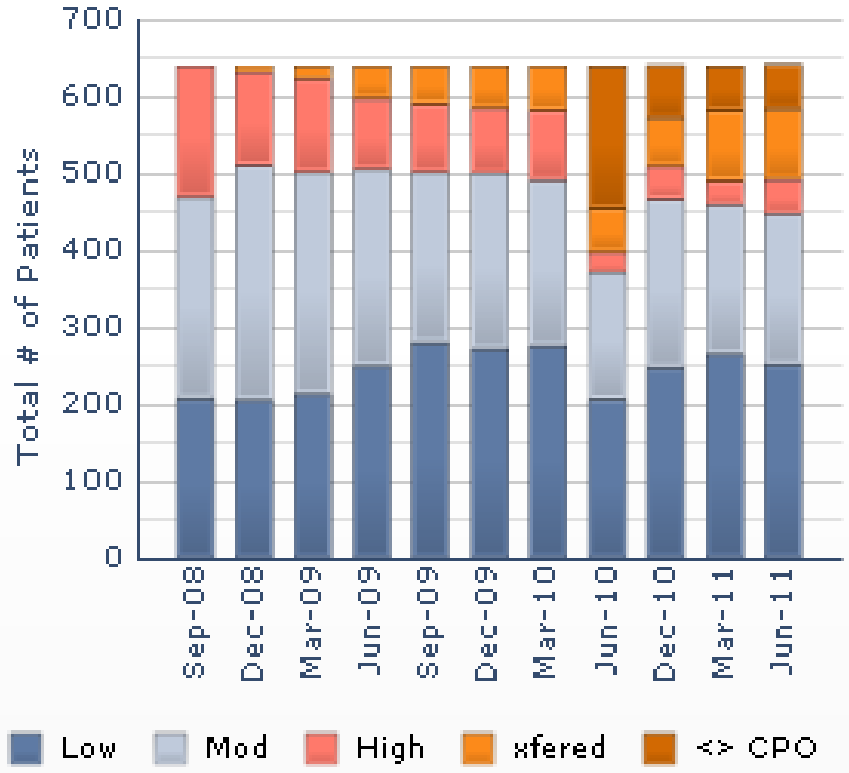


Practice I
Cohort per Quarter

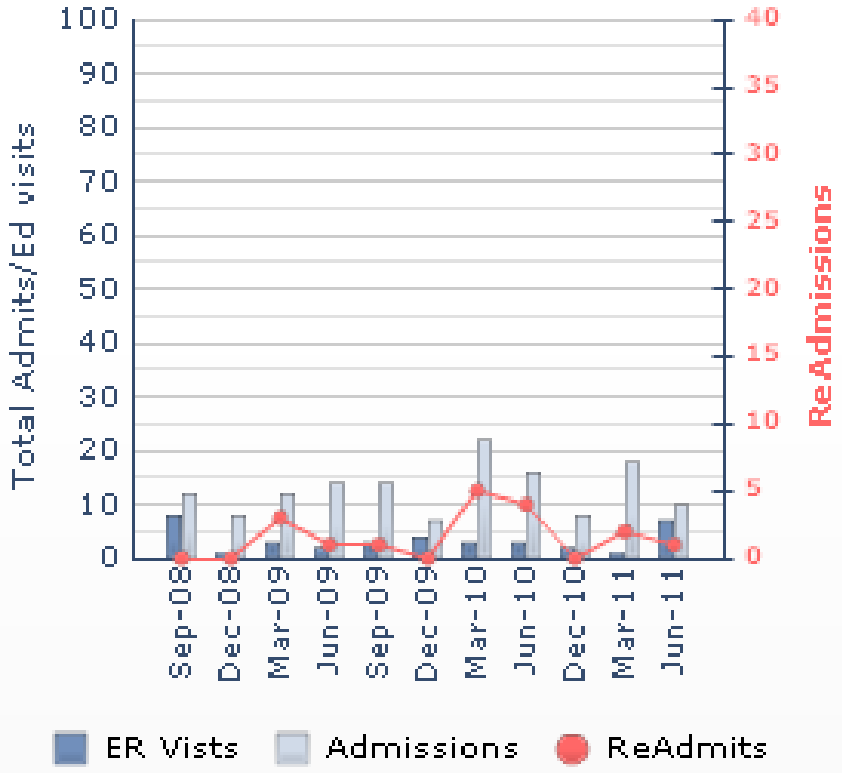


PA State Collaborative (Medical Home)
Cohort Diabetic Population

Practice H
Cohort by Risk Factors*

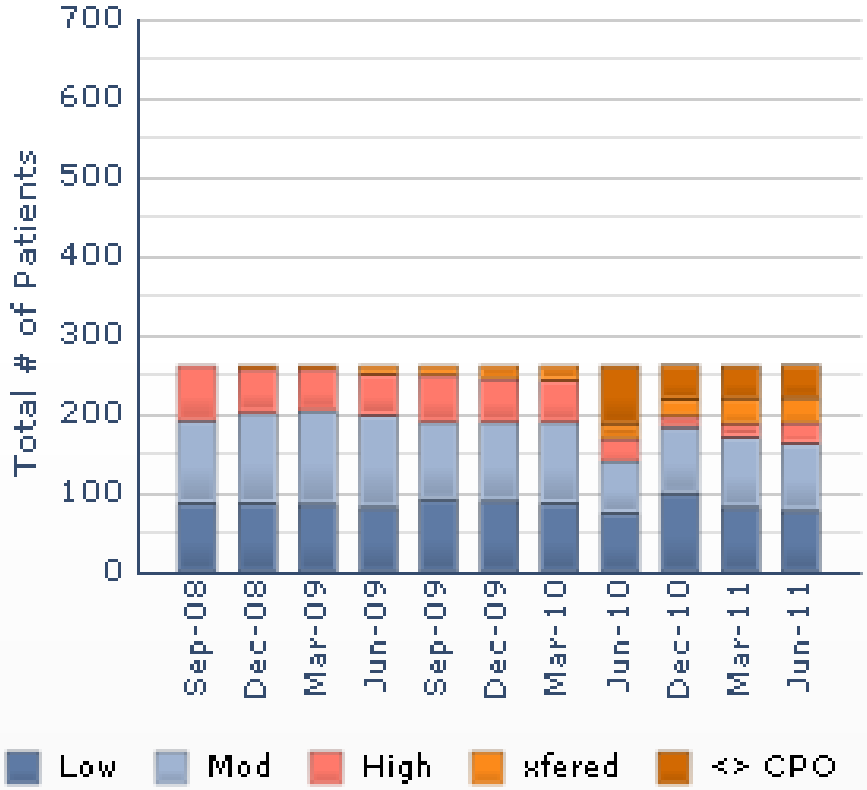


Practice H
Cohort per Quarter

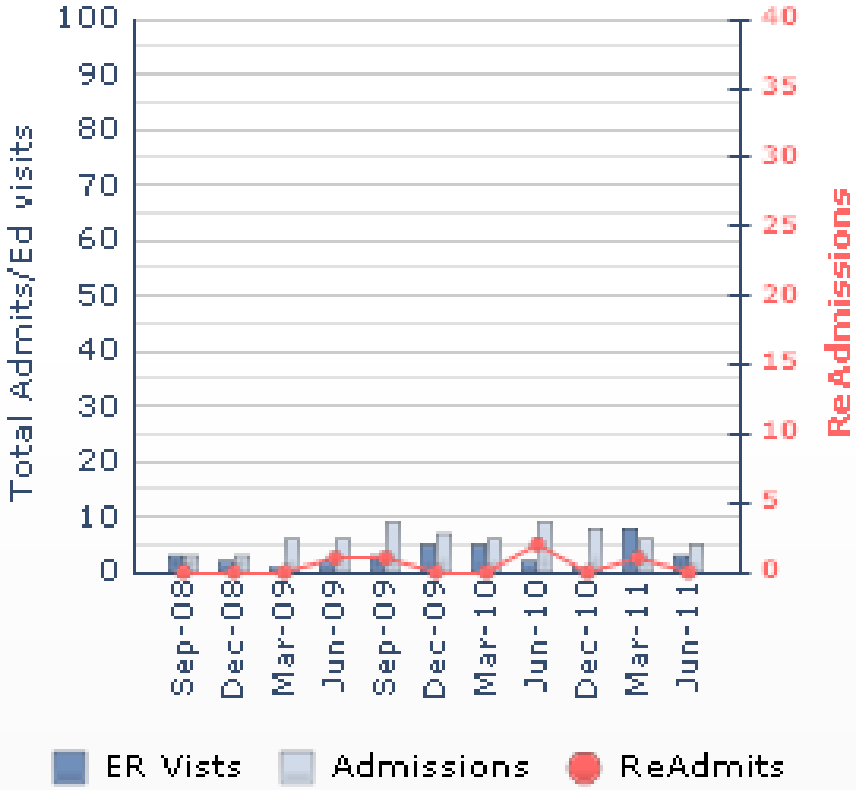


PA State Collaborative (Medical Home)
Cohort Diabetic Population

Practice P
Cohort by Risk Factors*

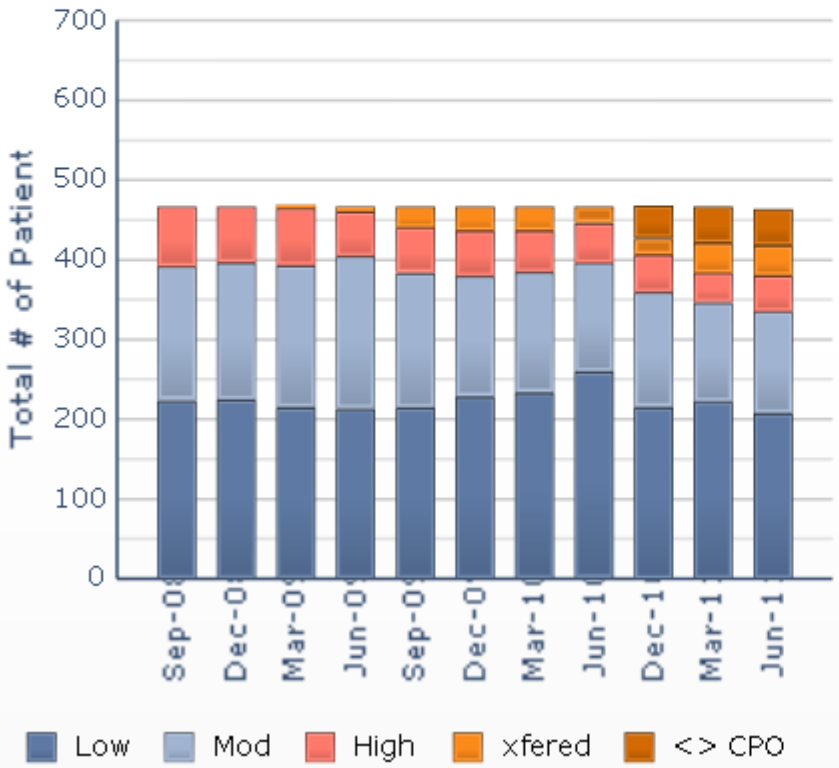


Practice P
Cohort per Quarter

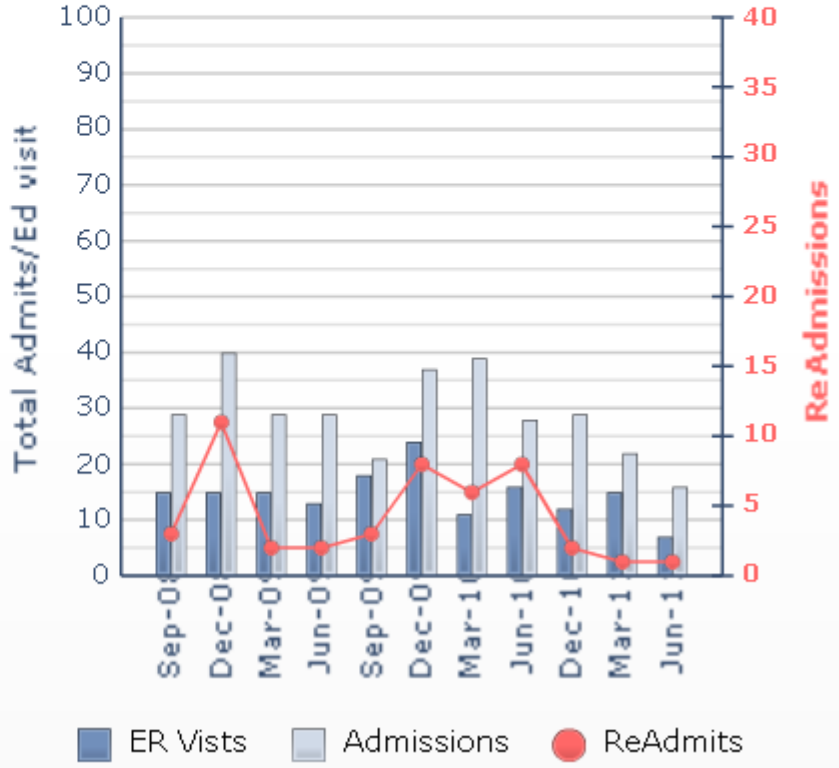


PA State Collaborative (Medical Home)
Cohort Diabetic Population

3600
Cohort by Risk Factors*



3600
Cohort per Quarter



Quantitative Learnings

- Risk profiles improved for most practices but timing of changes suggests it was PCMH—not care manager that “caused” change.
- No clear trends in utilization
- No clear relationship between education/background of care manager and outcomes

Strategy Moving Forward

- Using core features, assess all network practices for care management function.
- Gap analysis at practice level
- Centralized approach to meeting practice level needs (e.g. trainings, Centralized resources)
- Link to inpatient and transitions activities

Discussion

For more discussion, contact:

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