Technology Driving Contemporary Care Management

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- Not-for-profit organization
- Affiliated with Henry Ford Macomb Hospital
- 524 physicians
  - 89 employees of hospital
  - 113 PCPs
  - 411 specialists
- 20 payer contracts
- Our core value...“The PCP is at the center of the care delivery continuum”
GM PHO Participation in Advanced Payment Models

- Risk (varying) contracts with 20 payers
- Majority of PHO PCPs participating in APM
- PCP compensation aligned with value based contracts
- Ongoing commitment to innovation and practice transformation (first care management program initiated in 2012)
Population Health Management: The Care Management Cycle

Which patients

Performance reporting

Increase frequency / decrease intensity

Care delivery model

Which providers
The Initial Care Management Paradigm

ONE SIZE FITS ALL
Care Management Cycle
the Initial Paradigm

- one-size stratification
- too many patients

- insufficient
delayed
historical data
unsure of effectiveness

- hire nurses
add’l costly resources

- wrong goals
one target for all physicians

- nurse calls
Templated
Fragmented care
PCP disconnected
**FACTS**

- Patients selected by payer(s)
- No two practice populations are the same
- Selection by a single criteria
- Costly resources
- CM excluded PCP
- No clear ROI

**ASSUMPTIONS**

- The PCP can personalize selection
- The PCP can individualize care model
- Cost targets are unique to population
- Leverage existing resources
- ID affordable CM plans
- Engage the physicians

**OBJECTIVES**

- Embed the PCP in CM
- Share best practices
- Show a ROI
Care Management Cycle Evolving Paradigm

- Predictive analytics
- PCP insight
- Manageable outreach group

- Monthly reporting
- Control group vs. outreach group

- Existing resources
- Support from PHO + peers

- Individualized cost of care goals for each population

- Unique by each physician for their population
Early Predictive Analytics Model Enabled Selection of the Following Patients for CM

... patients with a specific chronic condition
... those in existing programs
... younger, high-risk score patients
... those most motivated to manage goals
... the sickest
... not sure why
Diabetic Institute

- 142 patients enrolled
- HbA1c average at patient start date 8.70
- HbA1c average currently 7.33
- 631 lbs. total weight loss
- 91% on statins
- 93% on ACE/ARB
- 72% had eye exams
Promising Results But Not Without Challenges....

- Lack of real time updating of the selected high risk sub-population
- Just knowing the patient is “high risk” was not sufficient to drive effective care management interventions
- Physician led team based approach limited predominantly to in office care
- Difficulty with patient engagement
- Lack of resources to develop a true team based approach
Decision to Enhance Health Information Technology Capabilities to Support:

“The right care to the right people by the right providers at the right time for the right cost”
Care Management Cycle
The New Paradigm

- Triggers
- Predictive analytics
- PCP insight

Performance reporting
Which providers
Increase frequency / decrease intensity
Care delivery model
Triggers Driving Specific Care Management Interventions

• Risk Flags
  – Predictive flags – such as frailty, med compliance, care density, complexity, Risk of admission re admission or flag for polypharmacy

• Events
  – TOC- Inpatient, emergency room, skilled nursing facility, scheduled imaging or consult not performed, not seen in 12 months

• Diagnosis
  – Dementia, Malignancy, DM, COPD, CHF, multiple Dx’s, fall, poor diabetic control

• Screening
  – Gaps in care, mental health, dementia, ETOH, survey, genomics
Predictive Analytics
The New Paradigm

• Provide multi-sourced data, available in real time to the entire care team in order to risk stratify the overall population as well as subpopulations with specific conditions

• Identify and engage patients who are at high risk for poor outcomes and/or unnecessary utilization i.e. patients with triggers
Software Demo
Care Management Cycle
The New Paradigm

- Triggers
- Predictive analytics
- PCP insight

Performance reporting

Increase frequency / decrease intensity

Care delivery model

- Care team
- Existing resources
- PHO, outside vendors, community resources
The Care Team

• Meets at least weekly
• Available 24/7 with real time access to medical record
• Members
  – PCP, SCP, PA/NP, MA, Data analyst, Pharmacy, Mental health, Care givers, Urgent care, Social work, Medstar, family, community resources
Care Management Cycle
The New Paradigm

- Triggers
- predictive analytics
- PCP insight

- Care team
- existing resources
- PHO, outside vendors, community resources

- individualize care plans based on triggers

Performance reporting

Increase frequency / decrease intensity
The Care Plan

• Based on vulnerabilities
  – Frailty, Transportation, $ for meds,
• Based on EBC
  – Fill gaps, disease specific care algorithms like Diabetic Institute, pre-visit planning
• Based on need for contact
  – OV, MyChart, eVisit, phone visit, home care, technology
• Based on need to connect to community services
  – Government, private, faith based
The Care Delivery Model

• Monitor and manage the focus population using triggers
  – Ex. Discharged hospital patient with a positive frailty index
• Patients identified by triggers are matched to appropriate care plans
  – TOC
    • Visit scheduled within 2 days (site based on patient needs)
    • Phone medication reconciliation performed
  – Frailty
    • Home evaluation ordered to verify rails in bathrooms etc. and that patient has assistive devices as needed (walker)
    • Nutritional assessment
    • Medication review for meds predisposing to falls
• Care team resources mobilized based on these care plans
• At least weekly team meetings to discuss challenging patients and processes. PCP as team leader
Care Management Cycle
The New Paradigm

- Triggers
- Predictive analytics
- PCP insight

- Real time reporting
- Control group vs. outreach group

- Care team
- Existing resources
- PHO, outside vendors, community resources

- Individualized cost of care goals for each team
- Individualize care plans based on triggers
Technology Enabled Continuous Cycles of Tracking, Reporting and Improving

• Data collection
  – Multi-sourced data, EMR, HIE
  – Real time clinical data
  – Monthly claims feeds

• Tracking
  – Software platform
  – Organization and practice views with drill down to individual provider and patient

• Reporting
  – To providers
  – Extended care teams including community partners
  – To payers

• Improving
Thank you