Technology Driving Contemporary Care Management

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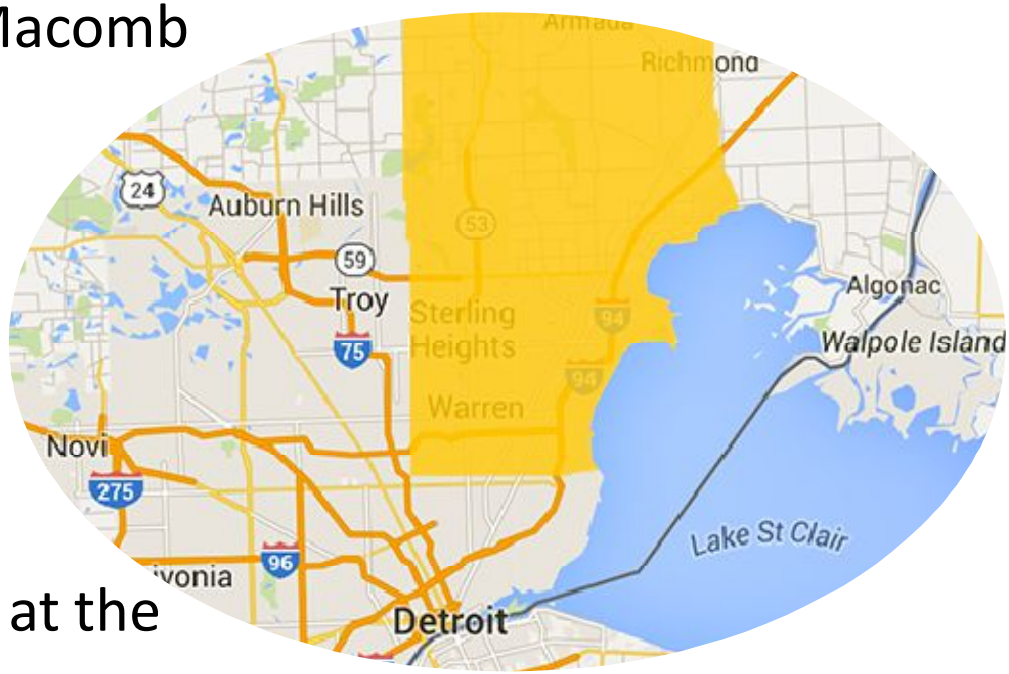
Alliance HEALTH

GREATER MACOMB PHO
Affiliated with Henry Ford Macomb Hospitals

Greater Macomb PHO

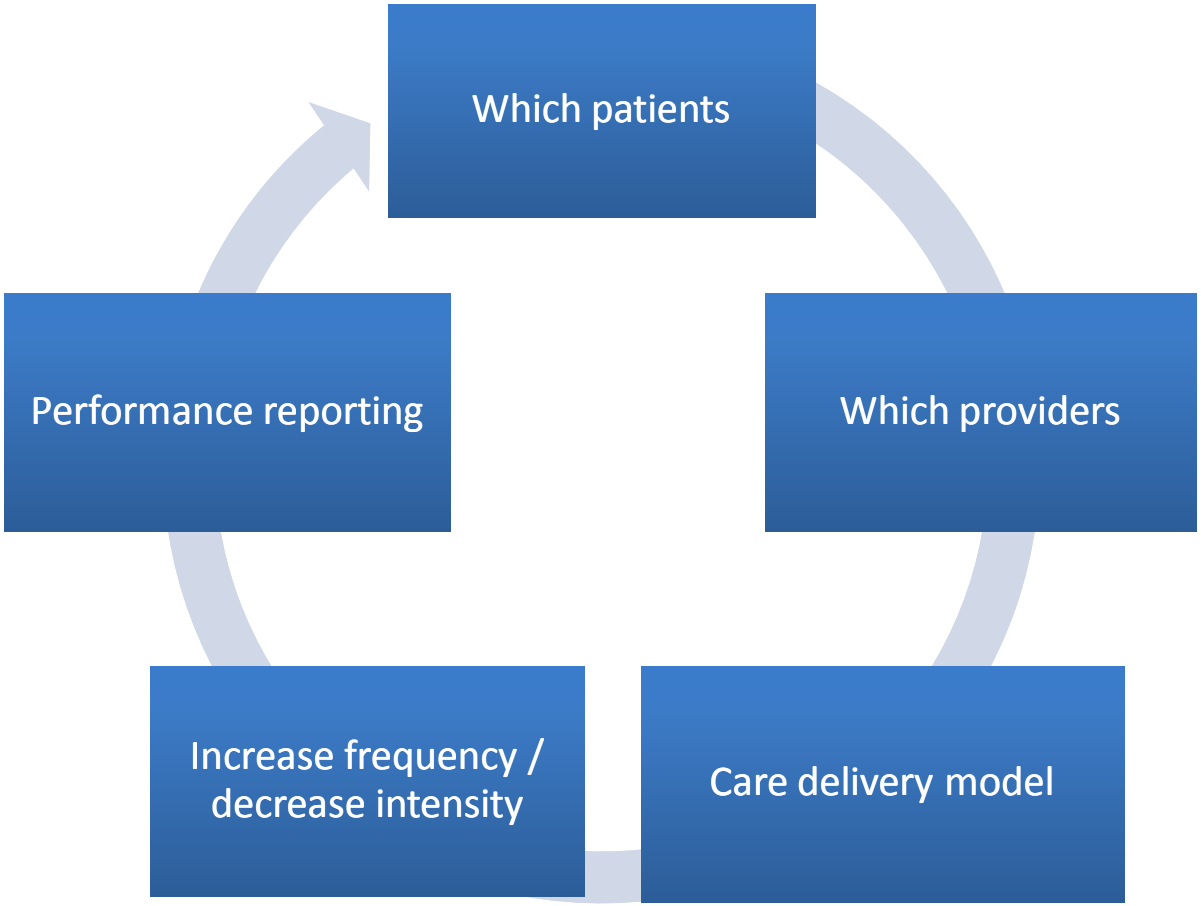
- Not-for-profit organization
- Affiliated with Henry Ford Macomb Hospital
- 524 physicians
  - 89 employees of hospital
  - 113 PCPs
  - 411 specialists
- 20 payer contracts
- Our core value…"The PCP is at the center of the care delivery continuum"



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



The Initial Care Management Paradigm

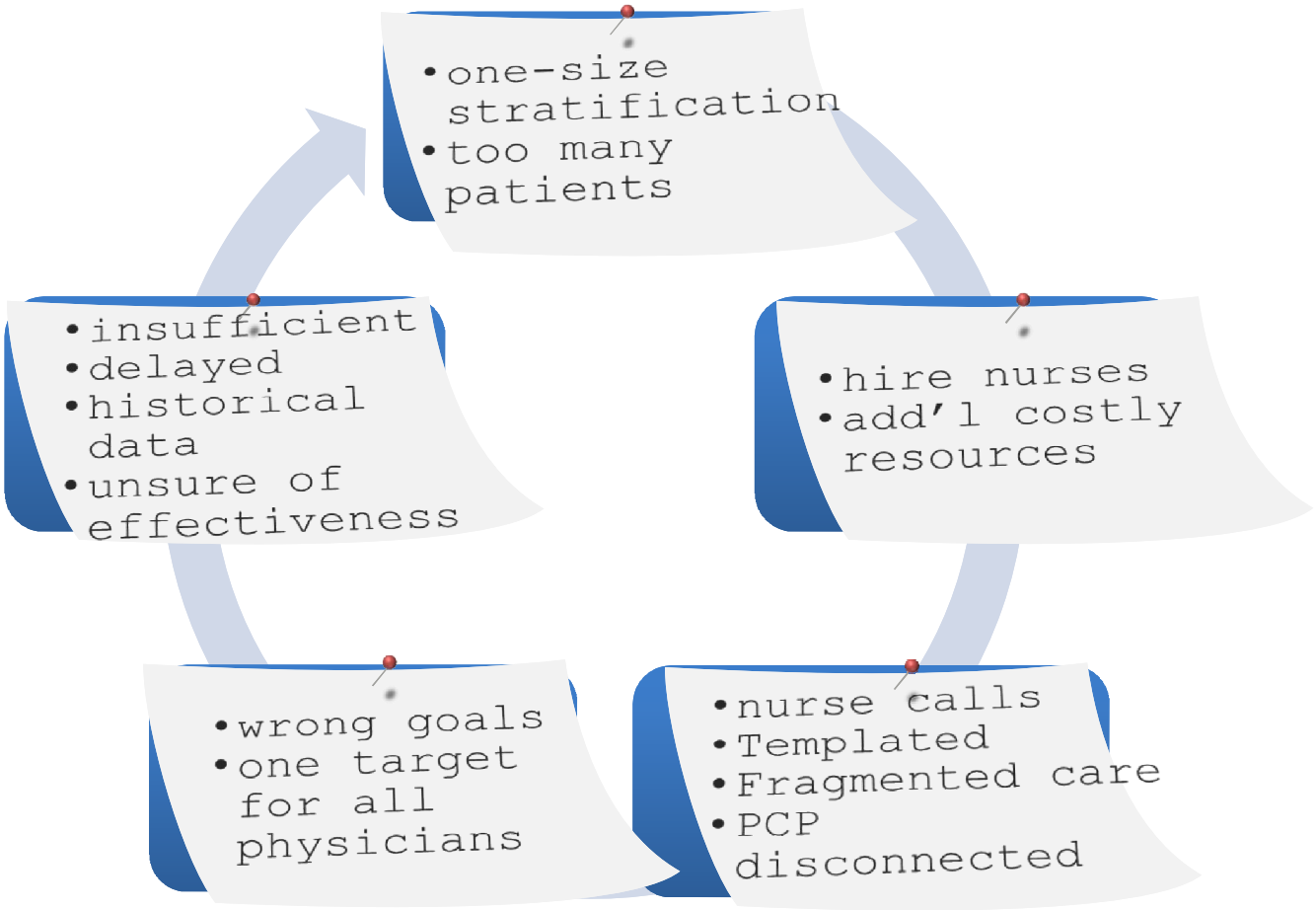
ONE

SIZE

FITS

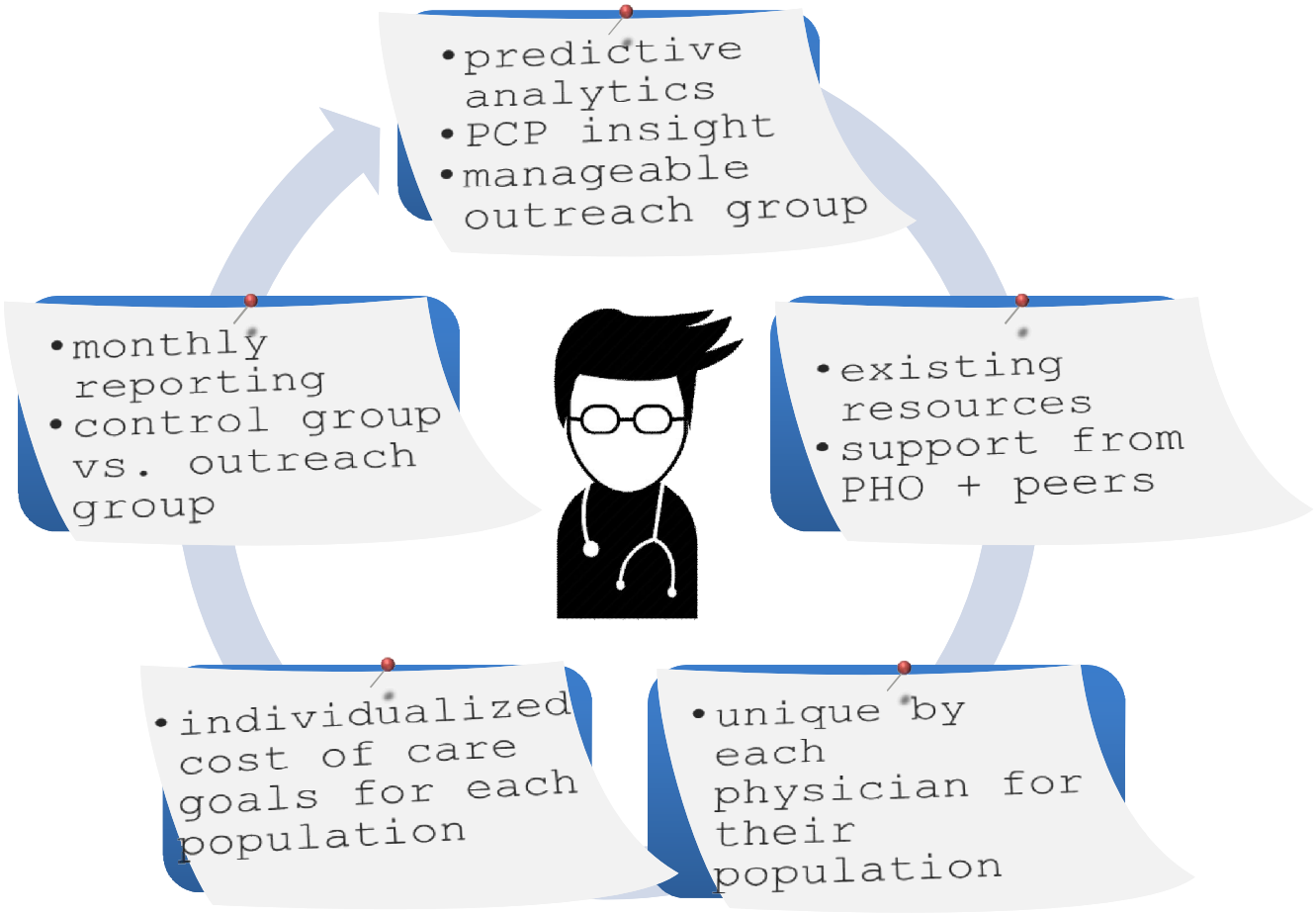
A L L

Care Management Cycle
the Initial Paradigm



FACTS	ASSUMPTIONS	OBJECTIVES
		
Patients selected by payer(s)	No two practice populations are the same	Engage the physicians
Selection by a single criteria	The PCP can personalize selection	Embed the PCP in CM
Costly resources	Leverage existing resources	ID affordable CM plans
CM excluded PCP	PCP can individualize care model	Share best practices
No clear ROI	Cost targets are unique to population	Show an ROI

Care Management Cycle
Evolving Paradigm



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

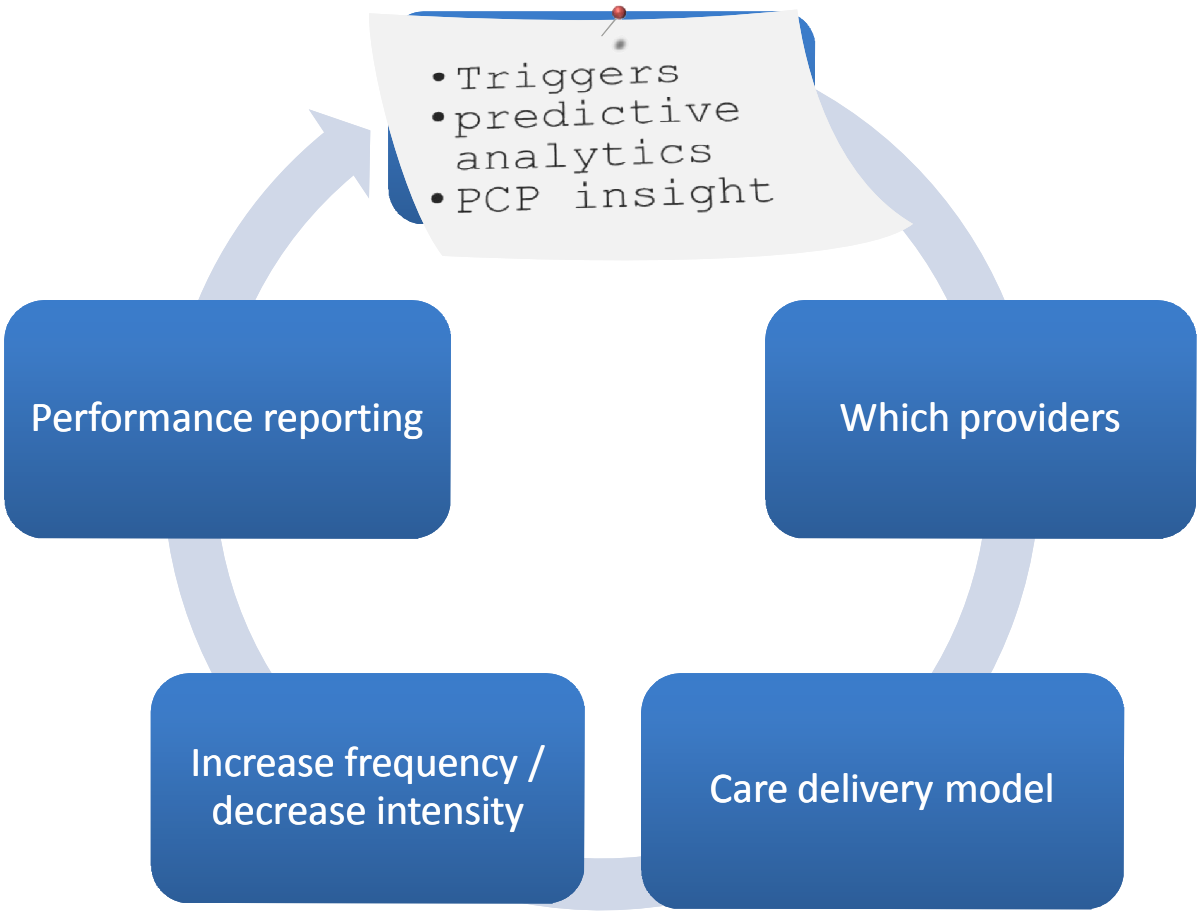
Promising Results But Not Without Challenges….

- 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 Driving Specific Care Management Interventions

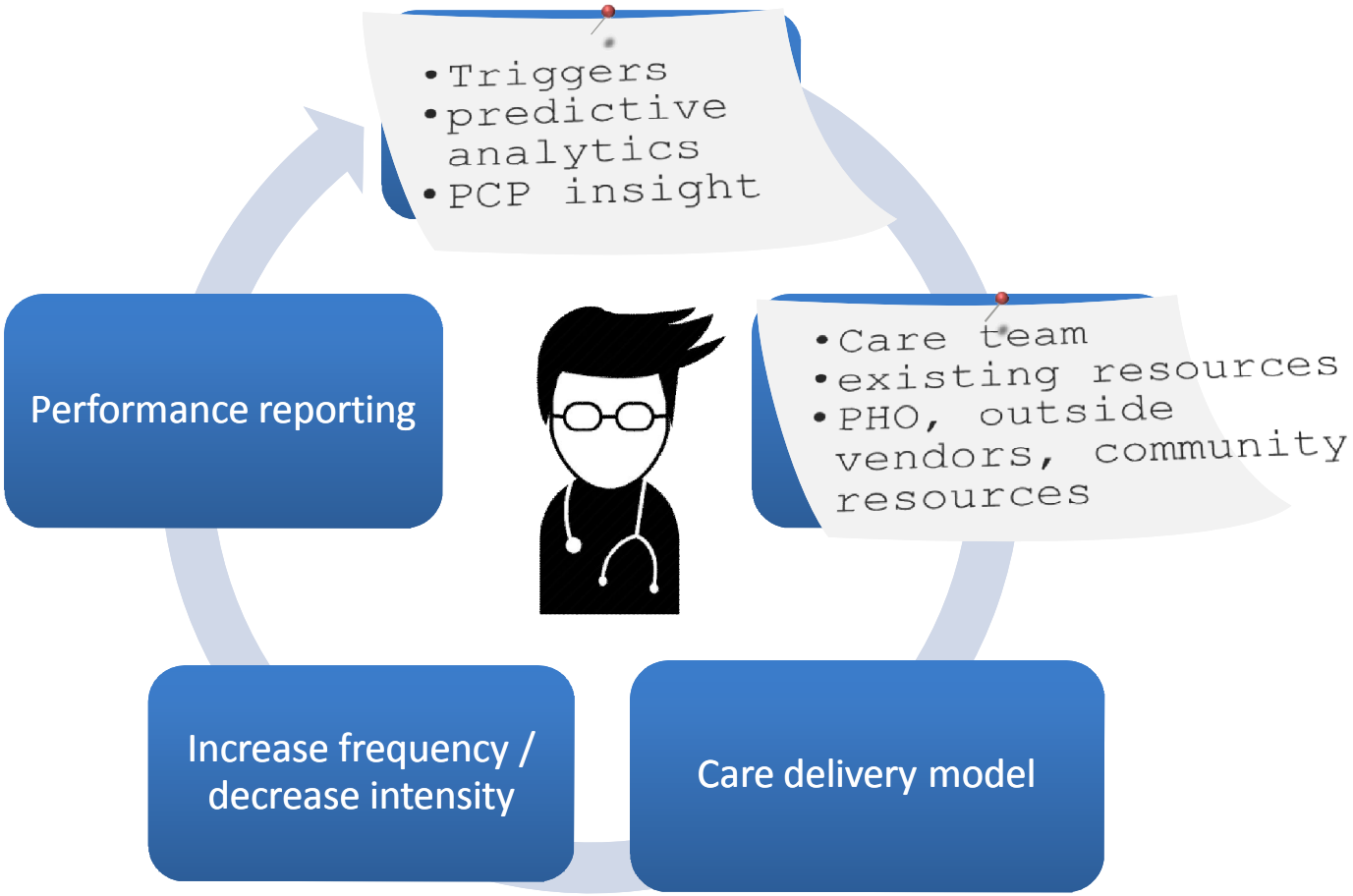
- Risk Flags
  - Predictive flags – such as frailty, med compliance, care density, complexity, Risk of admission re admission or flag for polypharmacy
- Events
  - TOC- Inpatient, emergency room, skilled nursing facility, scheduled imaging or consult not performed, not seen in 12 months
- Diagnosis
  - 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

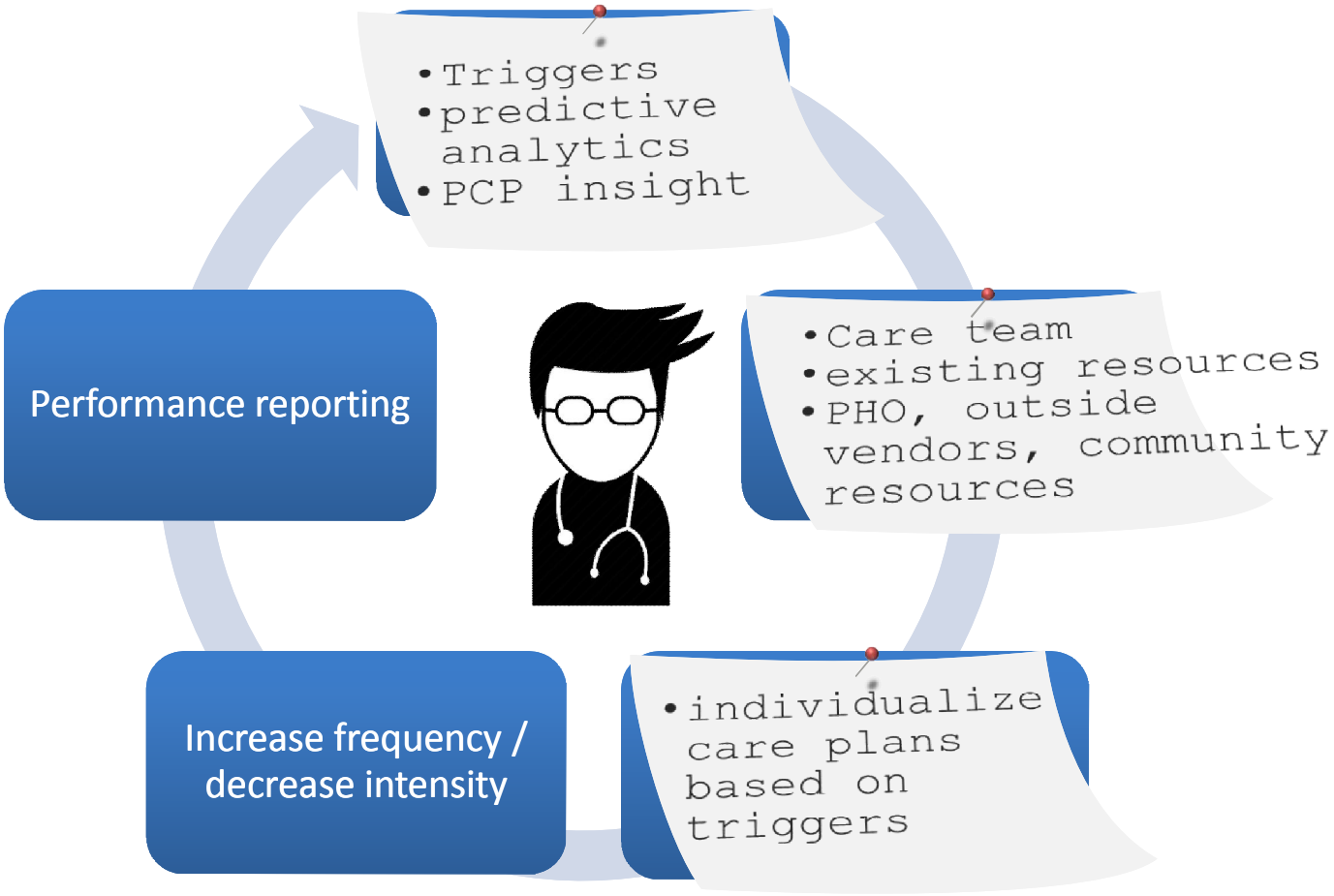
Care Management Cycle
The New Paradigm



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



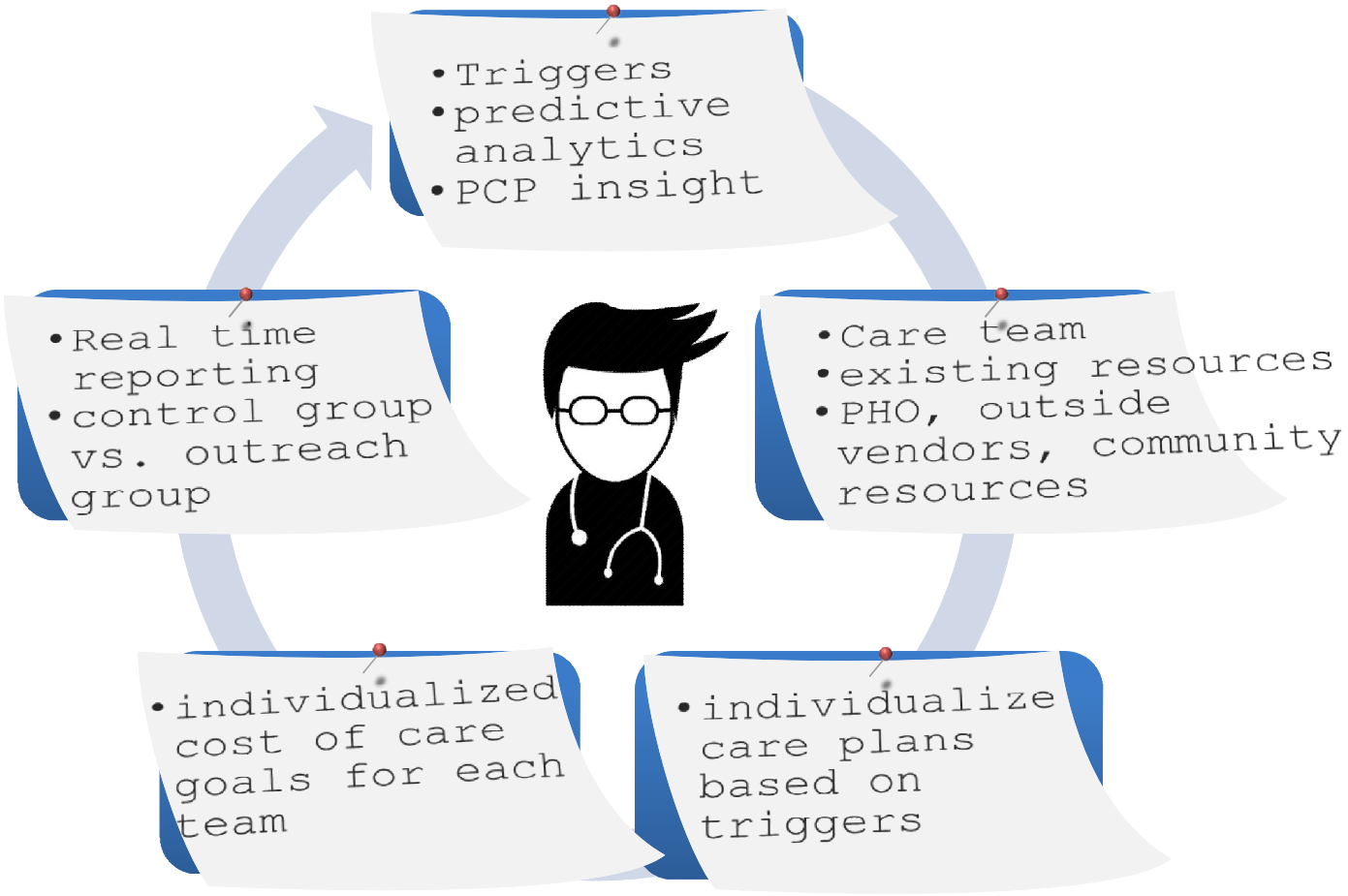
The Care Plan

- 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



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