Role of Technology in Improving Care for Complex Patients

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Technical Current State

- EMR
  - Manages individuals - treatment plan
- Registry
  - Population health - gaps in care
- HIE
  - Gateway enabler - ER, inpatient, labs, radiology

Technology Gaps

- EMR
  - Limited to single system/or those using same tool
- Registry
  - Not fully functional or integrated into EMR
- HIE
  - All functions not fully deployed

Making it Real

Using technology to help complex patients

- Current State
- Future State

Laura

The person

- 68
- Married 45 years to Andy
- 4 children, 12 grand children
- Seamstress, homemaker, gardener
- Safety risk due to short-term memory loss
- Withdrawn and little interest in her hobbies

Laura

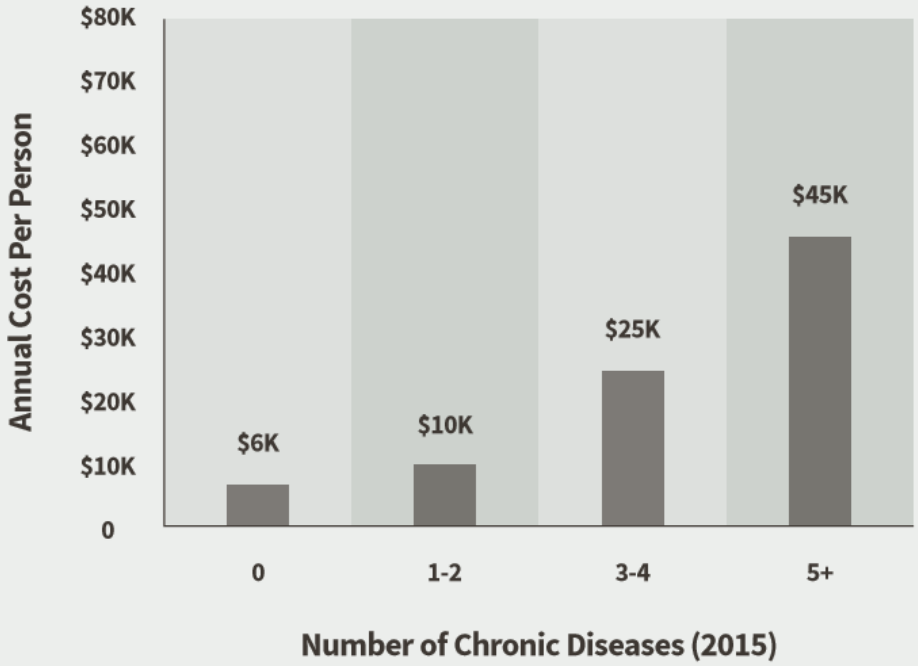
Clinical Presentation

- Diabetes, high blood pressure, depression
- Multiple ER visits
- Lack of control for one or more conditions
- Financial challenges
- Has family support
- Advanced directive completed and on file

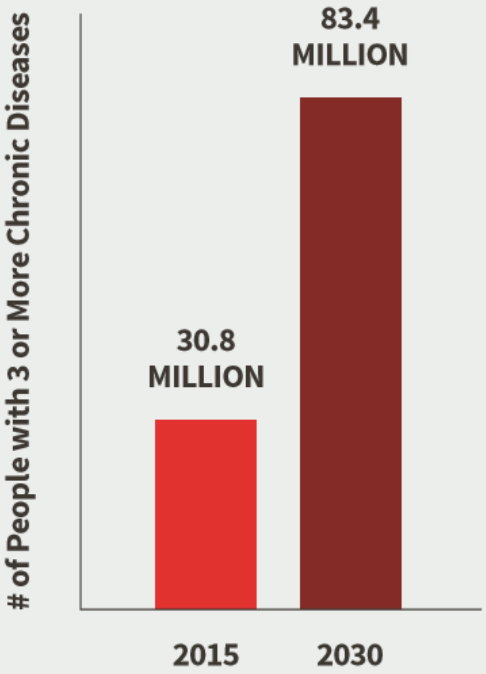
Why We Care about Laura

5% OF PEOPLE ACCOUNT FOR 50% OF HEALTH CARE SPENDING [1] IN AMERICA...

HEALTH CARE COSTS ARE CONCENTRATED AMONG THOSE WITH MULTIPLE CHRONIC DISEASES



NUMBER OF PEOPLE WITH 3+ CHRONIC DISEASES IS GROWING



[1] SB Cohen, "The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2012- 2013." Statistical Brief #481. AHRQ, Sept. 2015. http://meps.ahrq.gov/mepsweb/data_files/publications/st481/stat481.pdf

Improving Care for Laura

Technology critical to enable care management support of the key functions:

- Select - Who
- Assess - What
- Manage – Getting to goal

Select

Risk Management Criteria

- Diagnosis: Multiple Chronic Conditions
- Data: Access and depth
  - Payer, EMR/Registry, Inpatient facilities, other (labs, treatments, procedures, radiology, path)
- Patient centered: Desire - Ability

Select: Technology Support

- Demographics
- Quality metrics
- Risk screening/assessment
- Utilization/Cost of care
- Predictive modeling/risk score (payer reports)

Select
Use of Technology: Current State

Pre-screening and Patient Selection Approaches

- Admission Discharge
  - Some are limited to own systems
  - Alerted
  - Alerted with key information (with access to VIPR)
- Referrals (Specialist and Community Resources)
  - Some limited to those with a shared EMR
  - Ability to send referrals and notice of referral completion
- Care Team
  - Own EMR
  - If interfaces access to treatments/labs/radiology EMR and or HIE)
  - Limited payer data (multiple payers – multiple data to interpret)

Ideal State

Patient record with full transparency

- Multiple Inputs
  - Patient
  - Provider(s)
  - Facilities
- A single collaborative plan for managing and optimizing health outcomes and meeting the goals of the patient

Select: Best Practice Approach

1. Review medical and behavioral quality metrics – based on specific criteria
    1. Uncontrolled diabetes, high blood pressure, moderate depression
2. Obtain agreement
    1. Patient
    2. Primary Care Provider
3. Prep for the assessment
    1. CM gathers pre-screening data,
    2. Conducts a comprehensive assessment
    3. Reviews the case with a multi-disciplinary team

Select: Behavioral Medical Integration

Start with data (key member of the team)

- Determining eligibility conditions/diagnosis
- Determine eligibility criteria
- Review the EMR and registry to confirm criteria dates are within evidence base timelines
- Note and mark start date of CM enrollment + interventions

Care team input

- Review data with PCP
- Review program with patient (capture ability and desire)
- Define and establish the roles and responsibilities of the multi-disciplinary team
- Brainstorming an effective care plan with inputs from the multi-disciplinary team

Assess

Key to risk management

- Identify barriers to care
  - Medical – behavioral – social
- Framework for the care plan
- Establish patient agreement
  - Desire and ability

Assess: Care Planning

Assessment findings frame the care plan

- Data inputs
- Care team inputs
- Patient/support inputs

Establish goals that incorporate treat-to-target measures

- Behavioral
- Medical
- Social

Assess: Outputs

- Team approach in determining patients appropriate for high cost intervention of care management – based on population served and management of risk and barriers
- Multi-discipline problem-solving and priority setting for the care plan
- Defined measures to monitor and determine impact of the intervention/service

Getting There from Here

Category	Current State	Future State
Quality Metrics	Registry/Registry like EMR	Integrated
Cost Data	Payers (claims)	Health systems
Notifications of services	Payers (Prior authorized) HIE to system/practice	Integrated Health system notification
Patient Input	During the visit CM support between visits	Live and frequent input via portals Patient vs. medical record

Getting There From Here

Sharing of processes in-place or understood to be in-place

- https://www.youtube.com/watch?v=k0xgjUhEG3U

Instructions:

- Make friends – share patient identification processes within your system/practice/organization.
  1. What data feeds would be essential to determine eligibility for high cost interventions such as care management services?
     1. Using a scale of 1-10 how would you rate your practice/system today?
  2. What data measures will be critical to determine success of high cost interventions?
     1. Using the same scale how would you rate this today?
  3. What would shared data that is fully transparent look like to a high functioning system?

Manage: Result goals

- What is needed?
  - Claims
  - RX use/fill rates/cost
  - Utilization
  - Patient response to treatment – the secret sauce

Manage: Monitoring and Follow Up

Patient-centeredness approach

- Challenges/barriers to incorporating the plan of care into living life
  - Supports, cost, change management

Impact

PCMH (PGIP, MiHealth, NCQA, URAC)

SIM

CPC+

- Focused approach resolves clinical inertia
  - More rapid quality improvement
  - matching interventions with treat-to-target approach provides structure & team accountability

Supportive Research

10. Katon W, Unützer J. **Consultation psychiatry in the medical home and accountable care organizations: achieving the triple aim.** *Gen Hosp Psychiatry.* 2011;33(4):305-10.

We are in a time of increasing concern about unsustainable increases in health care costs to Medicare, Medicaid, employers and individuals. At the same time, more than half of patients with mental health needs do not receive care in any given year [1], and untreated mental disorders can be important drivers of high health care costs. As in the rest of health care, we are challenged with achieving the "triple aim" of improving access to care while at the same time improving quality and outcomes of care and reducing total health care costs [2]. To achieve this triple aim, psychiatrists of the future will have to shift professional roles. In addition to traditional consultation liaison activities focused on individual patients in outpatient clinics or hospital settings, psychiatrists should have important roles in monitoring behavioral health needs, treatments and treatment outcomes for defined populations of patients and providing supervision and guidance to interdisciplinary teams of primary care and behavioral health providers caring for a defined panel of patients.

Laura

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Now

- Select: Use of data
- Assess: Enrolled
- Manage: Regular monitoring of data
- Results: To goal
- Diabetes: In control
- Blood pressure: In control

Many Thanks

- Questions
- Input and ideas