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# Medical homes in primary care: policy implications from Care Management Plus

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# Case study

## Ms. Viera

a 75-year-old woman  
with diabetes,  
high blood pressure,  
mild congestive heart failure,  
joint pain and  
recently diagnosed dementia.



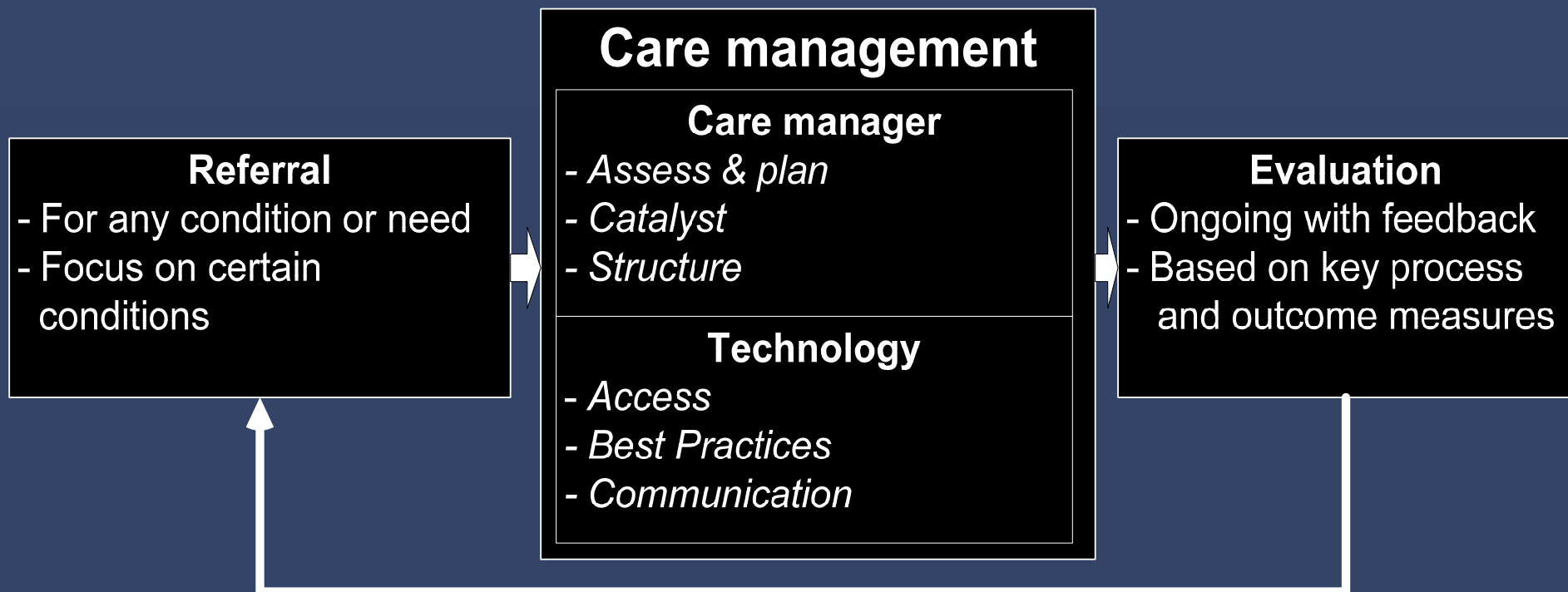
She sees 13 outpatient providers per year, fills 50 prescriptions per year, and patients like her represent ~50% of Medicare expenditures.

If her care is not coordinated across providers and transitions, she has an increased risk of hospitalizations and ED visits, increased risk of advancing disease, and high risk of functional decline.

How can Ms. Viera receive high quality, efficient care?

# To help meet Ms. Viera's (and her family's) needs, we developed and tested a program called Care Management Plus.

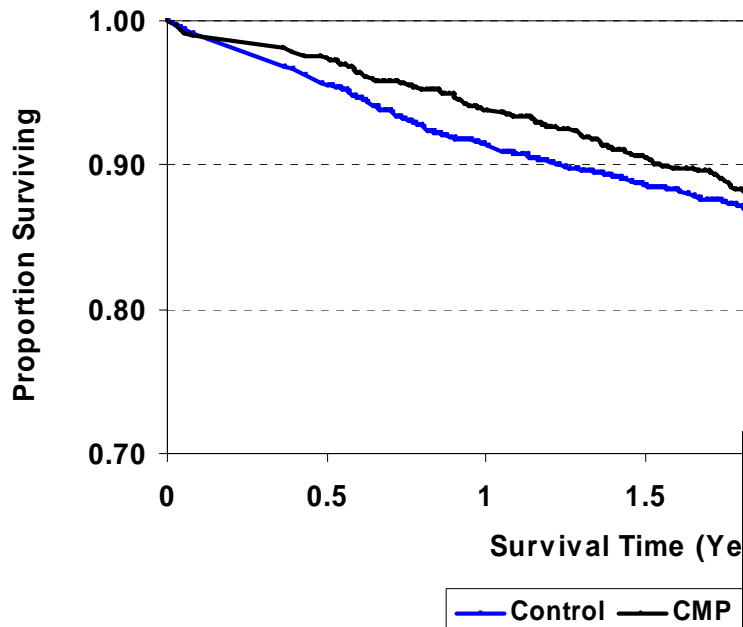
*In more than 40 primary care clinics in 4 states; started at Intermountain Healthcare in Utah and spread to OHSU, PeaceHealth, others ...*



This helps primary care clinics develop components common to a medical home.

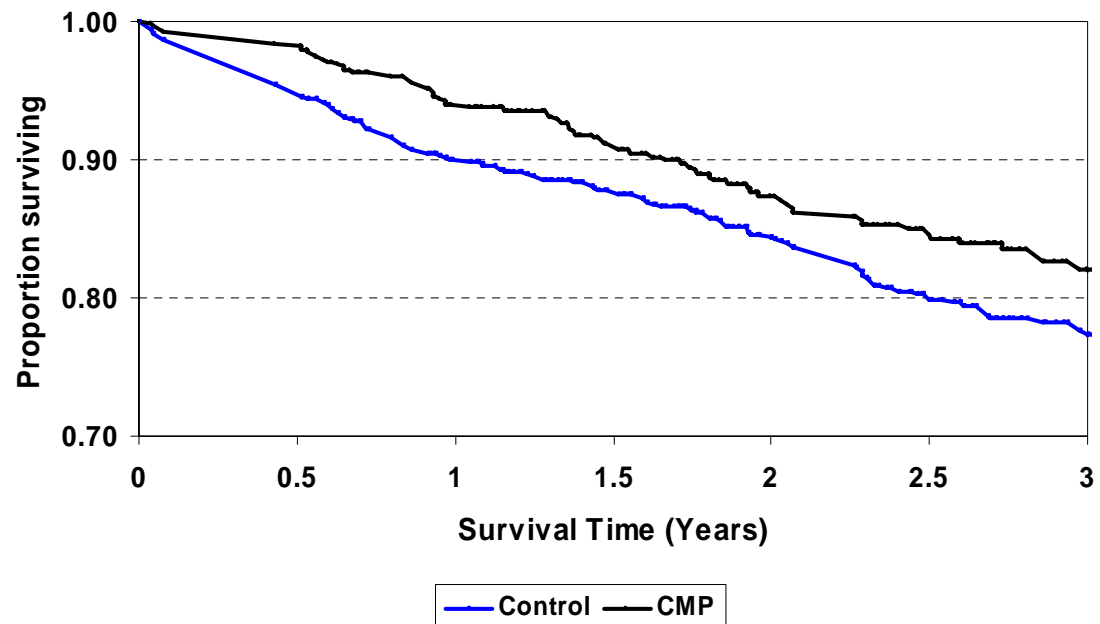
# Benefits from better primary care through our study ...

1.a All Patients



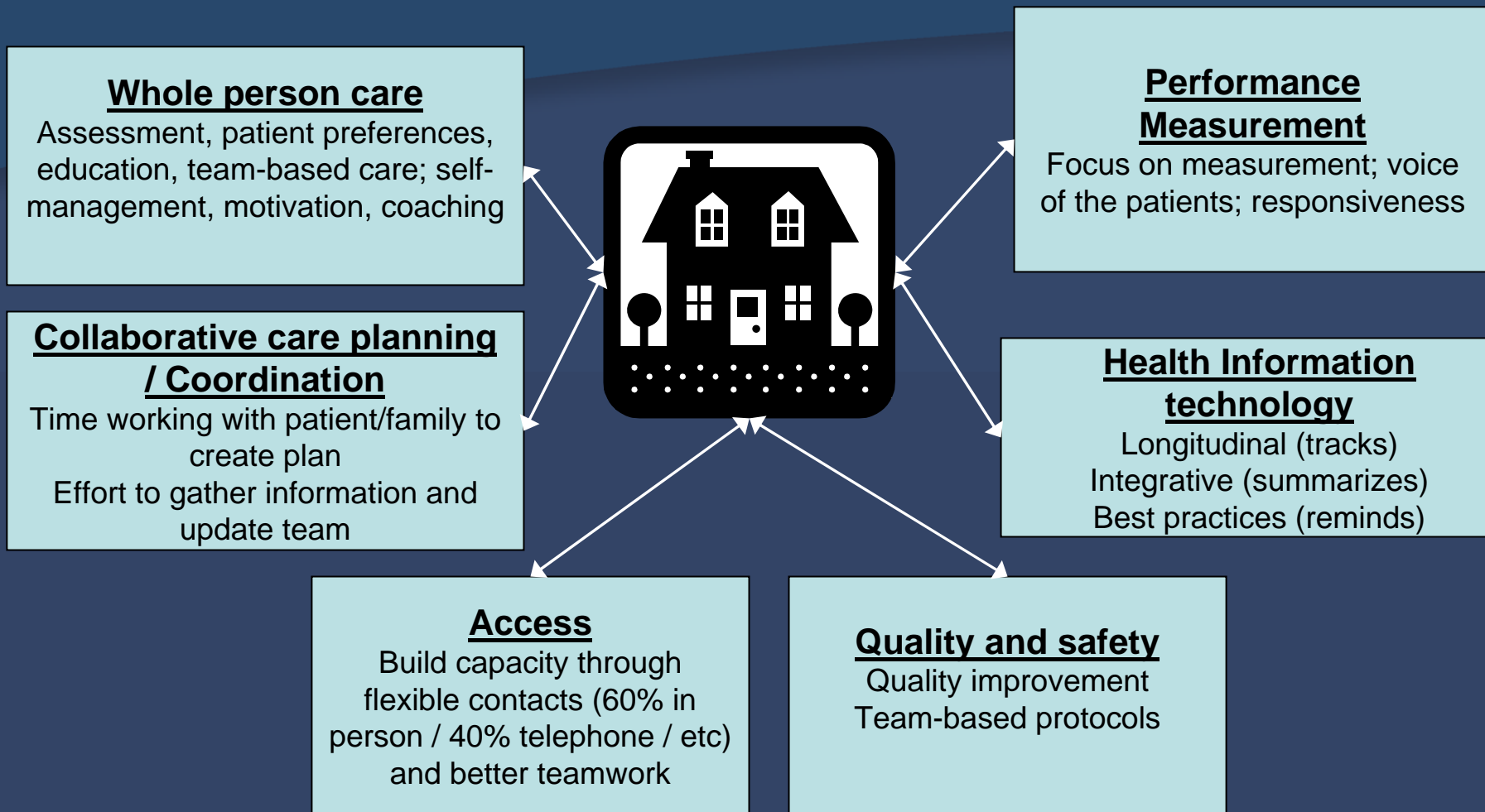
Diseases under better control  
Patients / primary care team  
more satisfied  
Teamwork brought efficiency  
gains of 8-12%  
Cost savings for insurers up  
to \$250,000 per clinic  
Cost savings for clinic -  
limited

1.b Patients with diabetes



Dorr, AcademyHealth, 2006  
Dorr et al, HSR, 2005  
Dorr et al, DM, 2006  
Wilcox, The CMJ, 2007  
Dorr, AJMC, 2007

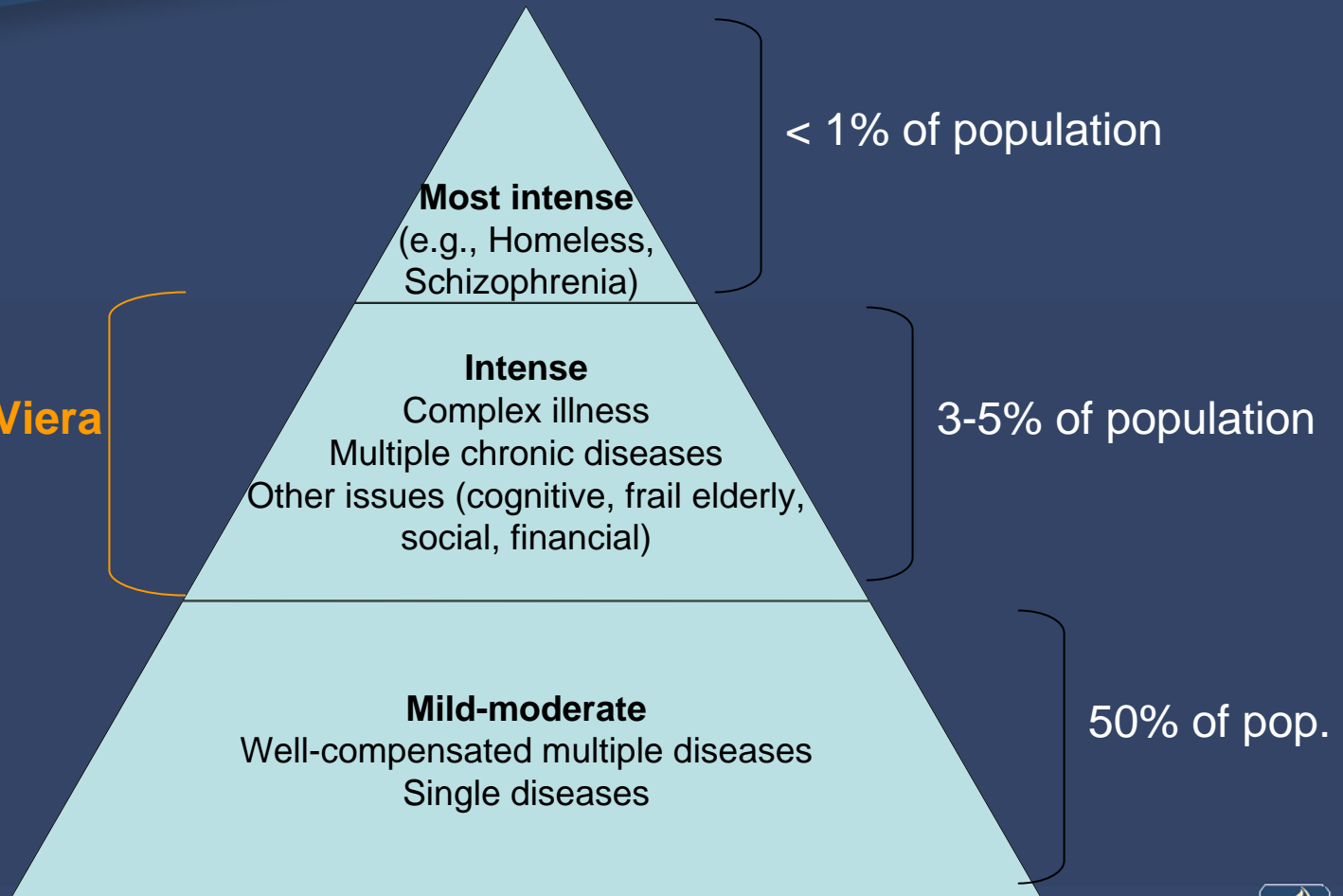
# Primary Care Medical Home



(Dorr, JGIM, 2007)

# Care coordination varies by intensity and function for different populations and needs.

Patients like Ms. Viera



## Challenges in creating Medical Homes from our work

Area	Our experience	Next Steps
1. Reimbursement	Misaligned incentives	Thoughtful reform
2. Capacity	Negatively perceived environment; change attractive	(re)Train; redesign; but mostly incent
3. Reliability	Variation in clinics and implementation	Metrics (e.g., revised NCQA PPC); demonstrations
4. Costs	Not a one year, zero sum game.	Demonstration with high need patients

# The Care Management Plus Team

- OHSU
  - David Dorr, MD, MS
  - K. John McConnell, PhD
  - Kelli Radican
- Intermountain Healthcare
  - Cherie Brunker, MD
- Columbia University
  - Adam Wilcox, PhD

## Advisory board

- Tom Bodenheimer
- Larry Casalino
- Eric Coleman
- Cheryl Schraeder
- Heather Young

(additional slides)

# Redesigning metrics – National Committee on Quality Assurance Physician Practice Connection

- Access and Communication
- Tracking (registry use)
- Care Management
- Patient self-management support
- Performance reporting and improvement

# PP3: Care Management (e.g.)

- Element D.1-11. For the three clinically important conditions, the physician and nonphysician staff use the following components of care management support:
  - Conducting pre-visit planning with clinician reminders
  - **Setting individualized care plans**
  - **Setting individualized treatment goals**
  - **Assessing patient progress toward goals**
  - Reviewing medication lists with patients
  - **Reviewing self-monitoring results and incorporating them into the medical record at each visit**
  - **Assessing barriers when patients have not met treatment goals**
  - **Assessing barriers when patients have not filled, refilled or taken prescribed medications**
  - **Following up when patients have not kept important appointments**
  - **Reviewing longitudinal representation of patient's historical or targeted clinical measurements**
  - **Completing after-visit follow-up**