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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.



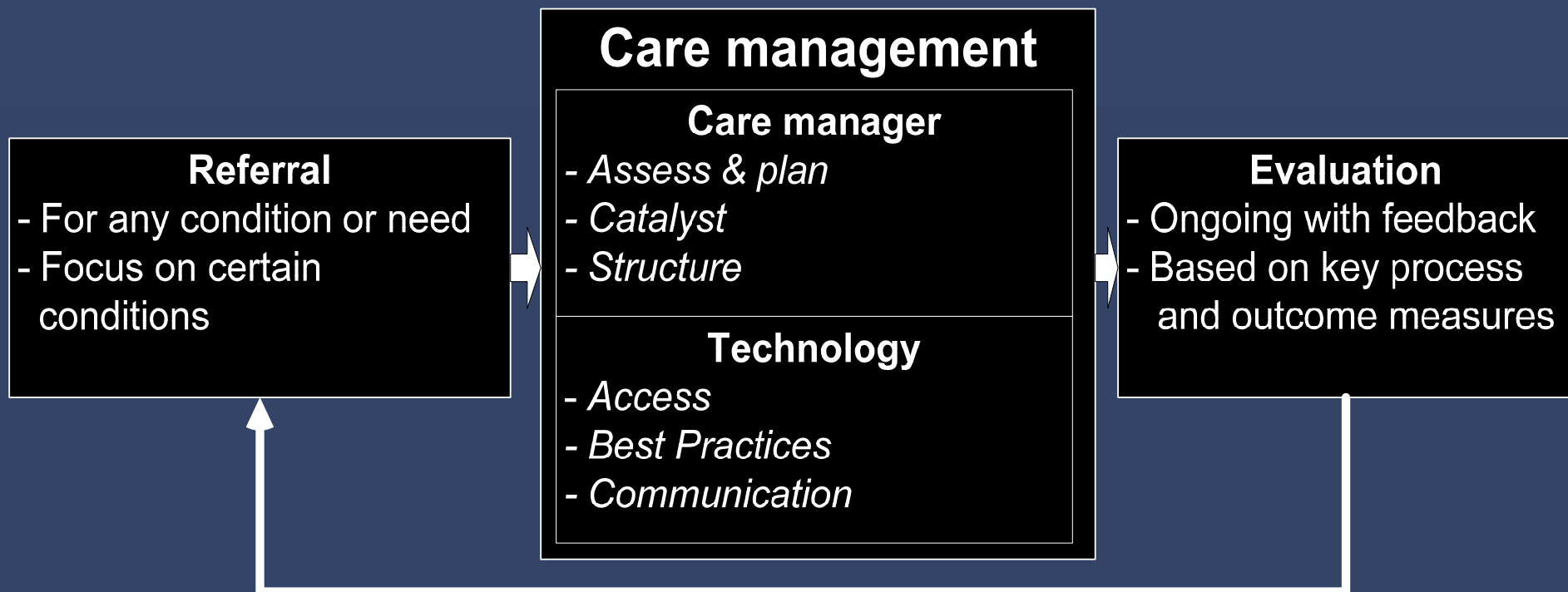
She sees 13 outpatient providers per year, fills 50 prescriptions per year, and patients like her represent ~50% of Medicare expenditures.

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.

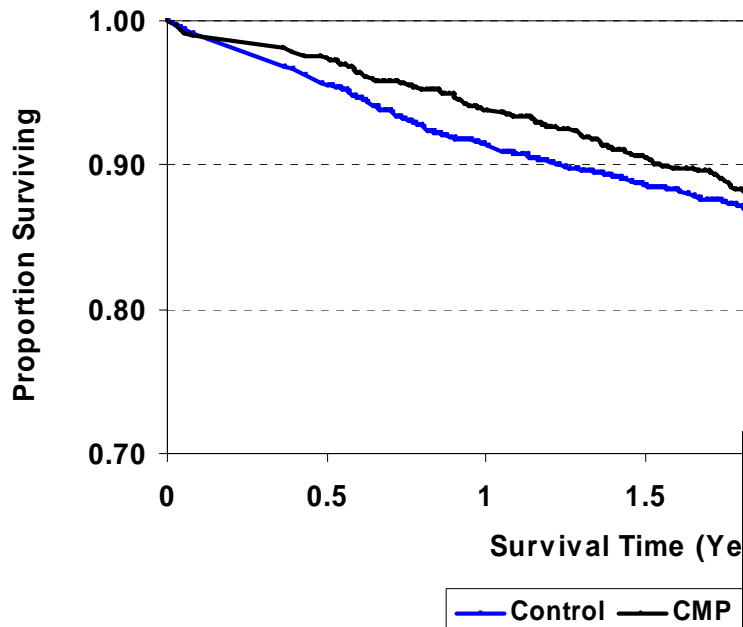
In more than 40 primary care clinics in 4 states; started at Intermountain Healthcare in Utah and spread to OHSU, PeaceHealth, others ...



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

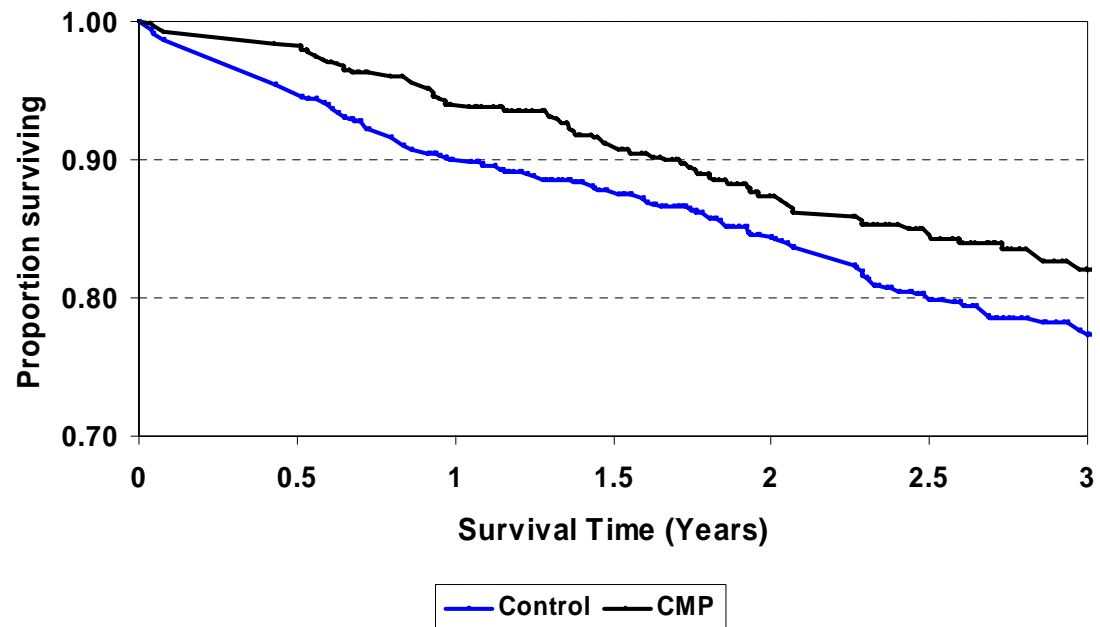
Benefits from better primary care through our study ...

1.a All Patients



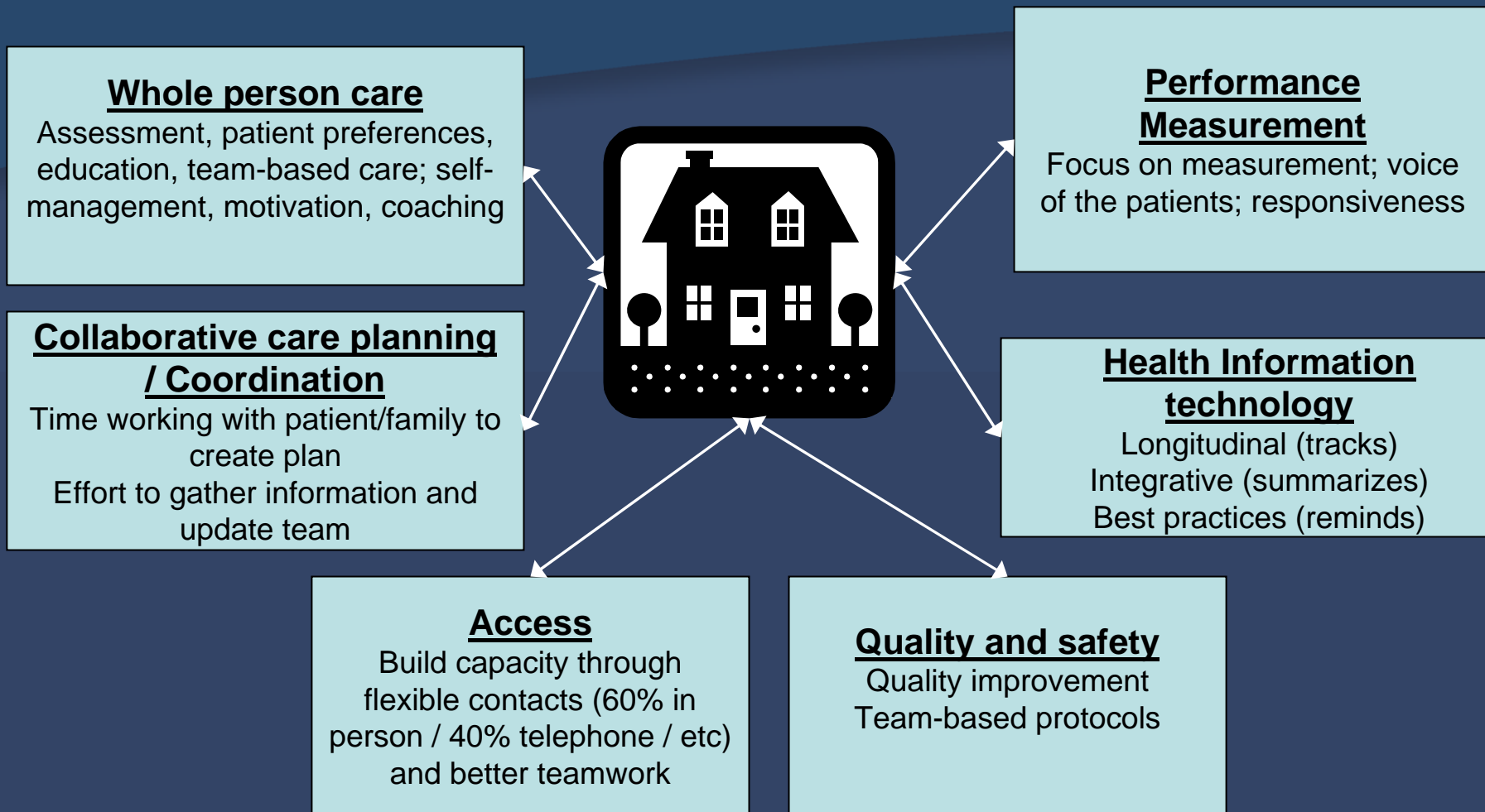
Diseases under better control
Patients / primary care team
more satisfied
Teamwork brought efficiency
gains of 8-12%
Cost savings for insurers up
to \$250,000 per clinic
Cost savings for clinic -
limited

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

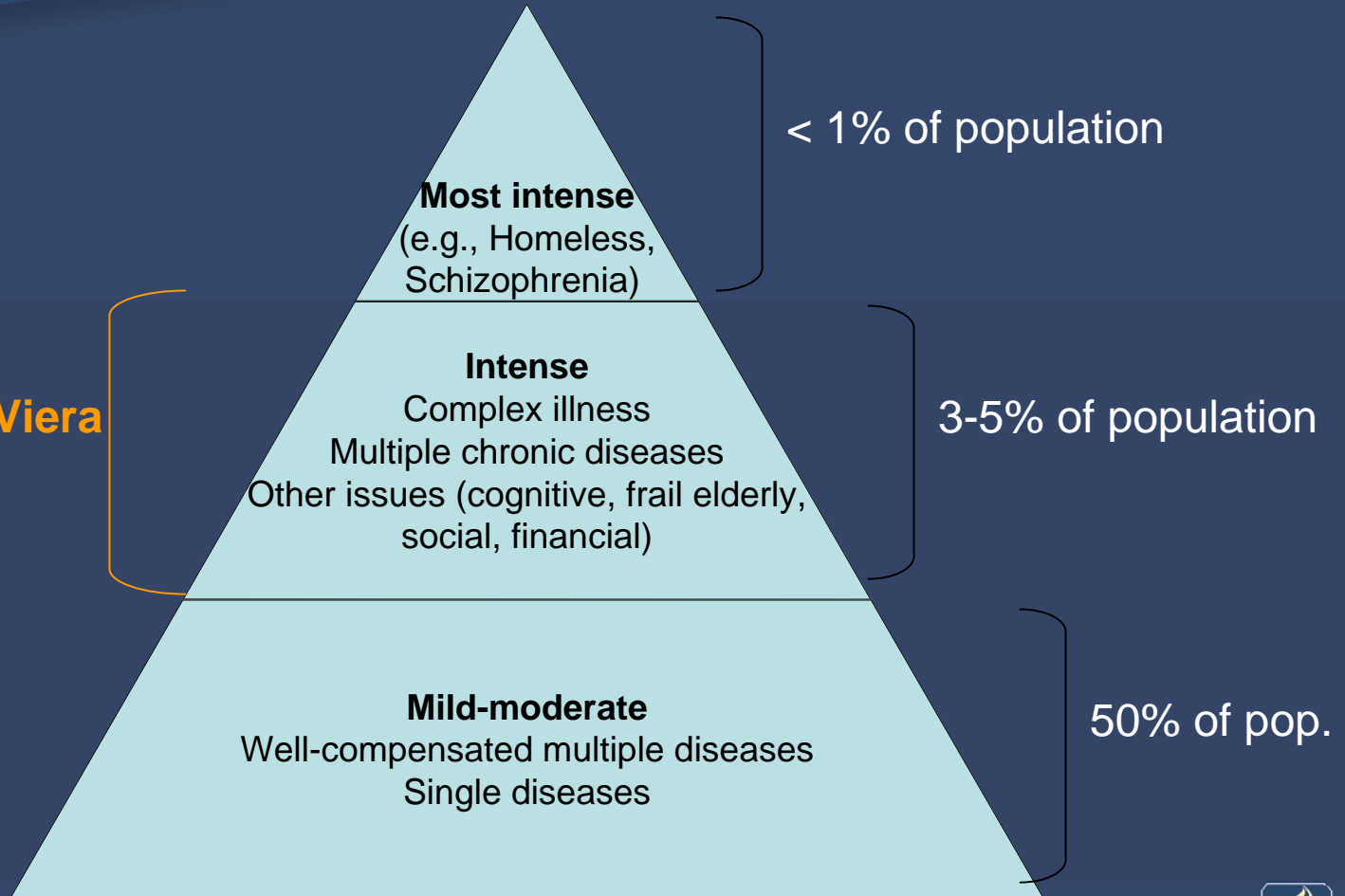
Primary Care Medical Home



(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**