Chronic Disease Management and Care Coordination

Question 1

1. Which of the following characteristics should not be expected of a registry?
   
   A. Ease of use
   B. Organized by patient; not disease
   C. Contain data relevant to clinical practice
   D. Easy to update from other automated data sources
   E. Require an advanced training to operate and maintain
Question 2

2. Please choose whether the characteristic – Individual patient based, Legal patient record – applies to:
   
   A. Electronic Health Record
   B. Chronic Disease Management System

Question 3

3. Please choose whether the characteristic – Requires customization for population management – applies to:
   
   A. Electronic Health Record
   B. Chronic Disease Management System
Question 4

4. Please choose whether the characteristic – Data usually focused on identifying medical conditions – applies to:

A. Electronic Health Record
B. Chronic Disease Management System

Question 5

5. Please choose whether the characteristic – Can be integrated with practice management systems and support billing – applies to:

A. Electronic Health Record
B. Chronic Disease Management System
Question 6

6. Please choose whether the characteristic – Simpler technology requiring less support services – applies to:
   A. Electronic Health Record
   B. Chronic Disease Management System

Question 7

7. Please choose whether the characteristic – Significantly more training for physicians and staff and greater computer literacy – applies to:
   A. Electronic Health Record
   B. Chronic Disease Management System
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Chronic Disease Care

• 133 million people, or almost half of all Americans, live with a chronic condition and this number is projected to increase by more than 1% per year by 2030 resulting in an estimated chronically ill population of 171 million
• Almost half of all people with chronic illness have multiple co-morbidities, such as diabetes, heart disease, depression, asthma and others
• As a result, many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of diseases
• Those deficiencies include:
  • Rushed practitioners not following established practice guidelines
  • Lack of care coordination
  • Lack of active follow-up to ensure the best outcomes
  • Patients inadequately trained to manage their illnesses

Partnership for Solutions. Johns Hopkins University, Baltimore, MD for The Robert Wood Johnson Foundation (September 2004 Update), "Chronic Conditions: Making the Case for Ongoing Care".


The Chronic Care Model

- The Chronic Care Model, which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels.

What is a registry?

- A registry or chronic disease management system is a list of patients and their relevant clinical data that can be sorted by a condition or set of conditions in order to improve and monitor the care of the population.

What to look for:
- Fast implementation
- Ease of use
- Organized by patient; not disease
- Contain data relevant to clinical practice
- Simple and efficient data entry
- Easy to update from other automated data sources
- Assist with internal and external performance reporting
- Guide clinical care first, measurement second

What it should not be:
- Try to emulate data load & functionality of an EMR
- Require an advanced training to operate and maintain
- Not become the “obsession” of practice activity

www.improvingchronicillness.com
Registry Report Types

- **Printed patient reports** at the point of care provide information on specific conditions and prompt provider teams to conduct appropriate assessments, deliver recommended interventions, and capture information to update patient records.

- **Registry generated exception** reports identify patients who are overdue for care or are not meeting management goals, and include important patient information to develop an appropriate outreach strategy for each patient.

- **Aggregate reports** provide information about how well individual care teams and the overall provider organization are doing in delivering recommended care to the patient population.

Registry: Point of Care

- Electronic patient information is entered into the registry, in the physician practice or by a program manager at another location.
- The registry provides reports or displays.
- For use at the point of care.
- To use in identifying patients who may need follow-up care.

- To provide status reports on the care program:
  - As feedback to physicians about their performance.
  - To track programs with population management.
Registry: Outreach to Patients

On a regular basis, the registry is updated with information about patients who need additional care. It is then used to contact those patients. The registry is also used to determine appropriate follow-up strategies for each patient.

Registry: Population Reporting

On a regular basis, reports are generated from the registry displaying aggregate information about the population being managed. Physicians receive feedback about how well they are doing in delivering chronic care in comparison with results for peers or for the population overall. Population results are discussed at medical staff and practice meetings. Reports serve other purposes: KOPA reporting, patient lists for chart audit, performance dashboard. Information on progress in population management stimulates ongoing improvements in care.
Registry: Differentiating Factors

- Source of Registry applications
  - Where software developed? locally, purchased from a vendor or from a free public domain
- Sponsorship
  - Local medical group, medical practice, state, government etc
- Technology Hosting
  - PC or network solution
- Single or Multiple condition
- Stand alone or integrated into an EMR
- Source (s) of patient information
  - Data entered manually or fed electronically from another source
- Configurability


Registry: Technology

Literature demonstrates that clinically relevant prompts and reminders at the point of care significantly reduce medication errors, overuse of labs and other tests and ensure increased rates of preventive measures.

Information systems:
- prompt providers with reminders to perform or order labs or exams allowing providers to assess how they are doing with process and outcome measures
- identify relevant patient subgroups for proactive care (i.e. notify all the smokers of a new cessation program, invite patients to a group meeting, or alter medications if some new therapy is shown to be beneficial.)
- store care plans and can be adjusted as patient changes their routine and care is adjusted
- provide a platform for sharing information as feedback to patients on how they are managing their condition as plans.
- produce performance reports that facilitate improvements in population management

Care Coordination Overview

- Use of care management tools—such as group visits or patient registries—varies widely among primary care physicians whose practices care for patients with four common chronic conditions—asthma, diabetes, congestive heart failure and depression—according to a new national study by the Center for Studying Health System Change (HSC).

- Results showed:
  - less than a third of these primary care physicians in 2008 reported their practices use nurse managers to coordinate care, and only four in 10 were in practices using registries to keep track of patients with chronic conditions.
  - Physicians also used care management tools for patients with some chronic conditions but not others.
  - Practice size and setting were strongly related to the likelihood that physicians used care management tools, with solo and smaller group practices least likely to use care management tools.
  - The findings suggest that, along with experimenting with financial incentives for primary care physicians to adopt care management tools, policy makers might consider developing community-level care management resources, such as nurse managers, that could be shared among smaller physician practices.

Harris Interactive Results

This 2008 snapshot, by Harris Interactive, takes a close look at chronic illness through the perspectives and experiences of those living with one or more chronic conditions in California. Among the findings:

- Respondents who reported having a primary care provider felt more in control of their health, were happier with their health care benefits, and were less likely to neglect their health.
- Many respondents reported that in the prior year they failed to get the health care they needed (such as medical tests, prescriptions, or care for a specific problem). Those who neglected care due to cost were more likely to end up in the emergency room.
- Although more than half of respondents reported that they had not received basic care management services or preventive care follow-up reminders, respondents with Kaiser Providers were much more likely to report receiving care management services and faster access to care.
- Nearly 30% of all respondents who saw multiple doctors reported receiving conflicting advice.
- Of respondents who rated their doctors’ collaboration as fair or poor, 46% were seen in the emergency room within the prior two years as compared to 34% who rated their doctors’ collaboration as very good/excellent.
Resources

- www.improvingchronicillnesscare.com
- http://www.ihe.net/pcc/committees/index.cfm
- http://www.chcf.org/publications/

References

- Partnership for Solutions: Johns Hopkins University, Baltimore, MD for The Robert Wood Johnson Foundation (September 2004 Update). "Chronic Conditions: Making the Case for Ongoing Care”.
- Kilbridge, Peter. “Crossing the Quality Chasm with Information Technology.” California Healthcare Foundation Ihealth Reports, July 2002.