PATIENT-CENTERED MEDICAL HOME:

A NEW (BUT FAMILIAR) PATH TO VALUE-BASED CARE DELIVERY

APRIL 2016

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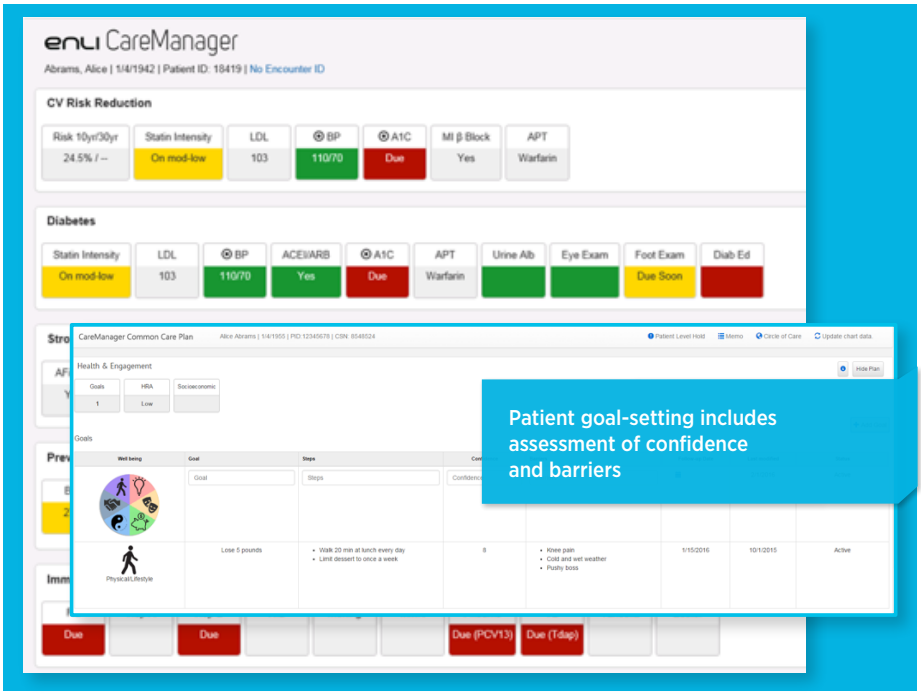
Health Intelligence

Emergency Room Follow-up

If a patient visits the emergency room, that information can easily be lost in traditional charts. CareManager uses risk stratification to capture information from many data sources to let the provider know which patients were seen in the emergency room and then populates a care-coordination tool for those patients.

CareManager can help the care team standardize a workflow for patients such as those at high risk for asthma. A critical element is to be able to set patient goals that can be shared across the care team, including the patient's confidence in setting the goal and barriers to his or her success. Finally, a customized action plan can be recorded into the EHR and a patient-facing action plan can be sent to the patient via mail or patient portal, based on the patient's preference.



Case Study: Practice Transformation at The Christ Hospital Health Network

The Organization:

The Christ Hospital Health Network (TCHHN) is a 555-bed acute-care hospital based in Cincinnati, OH that has 41 primary care locations and over 100 ambulatory sites. It is a recognized national leader in clinical excellence and patient experience. The organization is focused on improving the health of the community and creating patient value by providing exceptional outcomes, affordable care, and the finest experiences.

The Transition:

Like many organizations, TCHHN is making the transition from a traditional model that focuses on acute care with a one-to-one patient-physician approach, to a team-based approach that is focused on population health within the community. TCHHN recognizes that the patient-doctor visit is no longer the primary commodity in healthcare. Providers are now responsible for the population within the community they serve, and they need appropriate tools to accomplish that. PCMH helps standardize best practices across TCHHN and aligns delivery with emerging reimbursement models. PCMH pillars appear in all commercial payer contracts within the Christ Hospital community.

The Challenge:

The EHR is designed for data capture, not visualization or knowedge-transfer. TCHHN needed a more rigorous reporting structure and a more user-friendly format to help improve processes and quality, and to address rigorous NCQA requirements for PCMH or value-based programs such as CPCI and CCM.

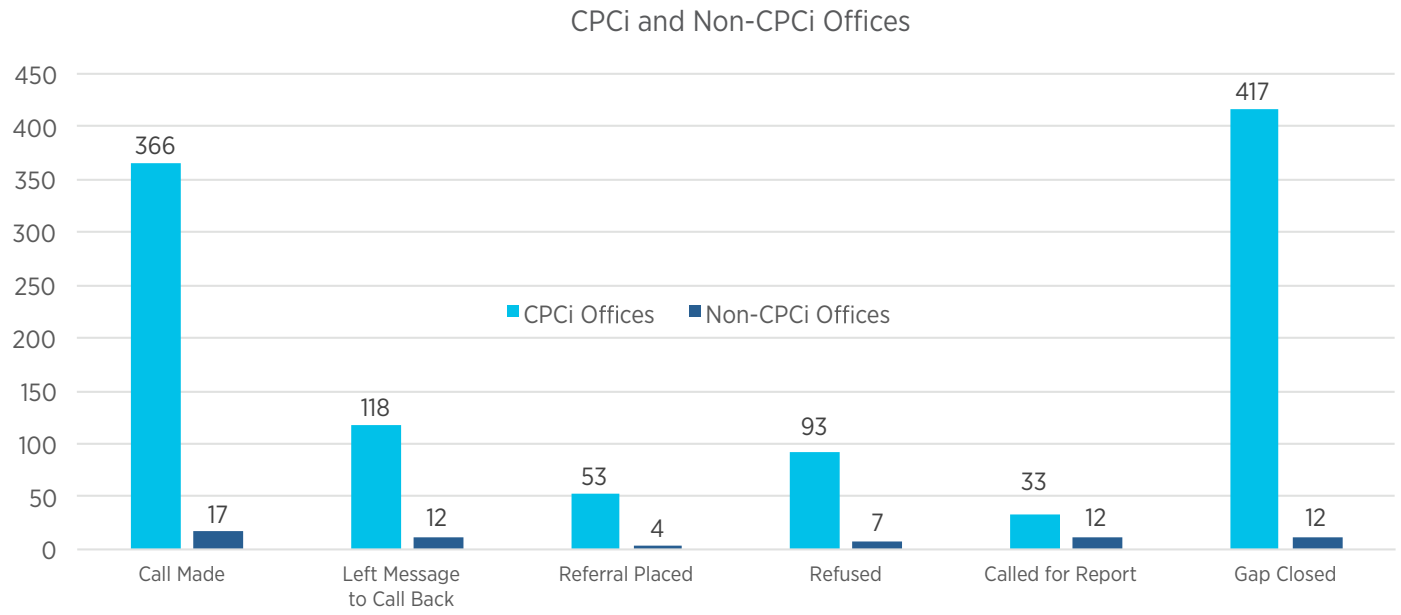
The Solution:

Working with Enli, TCHHN initially addressed its diabetic population, using CareManager for risk stratification and outreach. Because labor costs are a major driver of overall practice costs, TCHHN used CareManager to help ensure that practices were using care managers and care coordinators wisely and to the top of their licensure, and so that they could be more efficient and effective in their outreach.

The Results:

As part of its CPCI initiative, 16 of TCHHN's 34 practices were chosen to participate in the Medicare Advantage program. This provided a natural "control group" of 18 non-CPCI practices for the purposes of comparing results, and illustrates the dramatic difference in outreach and gaps closed for those practices utilizing CareManager.

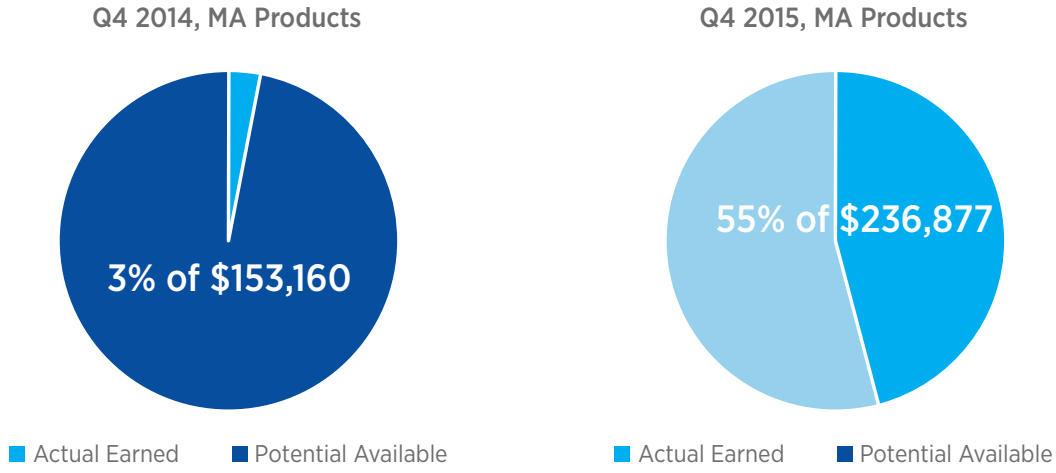
Work effort > Commercial Medicare Advantage



Closed care gaps in this population also significantly increased revenue in Medicare Advantage contracts over just one quarter.

Financial impact > Commercial Medicare Results

Intentional investment on focused resources leads to significant improvements



"We understand that PCMH is a new way of doing business and a new method of delivery, and to lean into that is critically important for the success not only for our systems and medical offices, but also for our patients."

- Dr. Amy Mechley
  Medical Director
  Wellness Division I The Christ Hospital Health Network

TCHHN has also shown significantly higher clinical quality in almost all measures when compared to CPC performance within its region.

Financial impact > Commercial Medicare Results

Clinical Quality Measure	TCHHN Performance	All CPC Region Performance
Tobacco Use Assessment and Cessation Intervention	94%	70%
Colorectal Screening	60%	42%
Breast Cancer Screening	64%	41%
Diabetes Hemoglobin A1c Poor Control (low % desirable)	11%	12%
Diabetes LDL Control (Patients screened for LDL test)	80%	62%
Diabetes LDL Control (Patients LDL < 100)	46%	42%
Blood Pressure Control	73%	68%
Ischemic Vascular Disease (Patients Screened for LDL test)	75%	58%
Ischemic Vascular Disease (LDL controlled)	50%	42%
Influenza Immunization	*24%	37%

**TCHHN was not using Enli CareManager to identify and target patients for influenza immunization during the performance period, the only clinical quality measure that did not demonstrate improvement.*

WHAT'S NEXT:

Looking forward, TCHHN has committed to invest further in CareManager, upgrading to incorporate additional clinical evidence to address at-risk populations. TCHHN is installing CareManager Central Worklist to support care teams engaged in PCMH outreach. And TCHHN is continuing to augment its technology platform and delivery model with creative strategies focused on patient engagement.

WHERE DO YOU GO FROM HERE?

Find more information on PCMH and how to get there.

- The National Committee for Quality Assurance (NCQA) provides the standard approach to PCMH recognition and certification (other certifications and accreditations are also available that follow similar guidelines). http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh
- The Institute for Healthcare Improvement provides reports and educational videos on PCMH. http://www.ihi.org/
- The Health Care Payment Learning & Action Network provides extensive resources to support the adoption of value-based and alternative payment models. https://hcp-lan.org/

>>> Contact Enli Health Intelligence for more information about CareManager and how it can help you transform your practice.

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ABOUT ENLI

Enli Health Intelligence™ is the market leader in population health management technology. Enli enables care teams to perform to their full potential by integrating healthcare data with evidence-based guidelines embedded in provider workflows across the population and at the point of care.

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i Patient-Centered Primary Care Collaborative (PCPCC), "The Patient-Centered Medical Home's Impact on Cost and Quality: Annual Review of Evidence 2014-2015." https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-2014-2015

ii PCPCC, "Patient-Centered Medical Home's Impact on Cost and Quality..."

iii The Institute for Healthcare Improvement (IHI), "The IHI Triple Aim." http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.

iv PCPCC, "Patient-Centered Medical Home's Impact on Cost and Quality..."

v Journal of the American Board of Family Medicine. Jan – Feb, 2016. Rosenthal. Are We Learning More About Patient-Centered Medical Homes (PCMHs), or Learning About Primary Care?

vi Health Leaders Media. January 2016. Letourneau. PCMH Model Soaring, Despite Funding Challenges

vii PCPCC, "Patient-Centered Medical Home's Impact on Cost and Quality..."

viii PCPCC, "Patient-Centered Medical Home's Impact on Cost and Quality..."

ix Institute for Healthcare Improvement (IHI), Triple Aim Initiative. http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx

x Based on a 2014 Medical Group Management Association survey of data collected from 2,518 medical groups. https://www.pcpcc.org/2014/10/01/patient-centered-medical-homes-spend-more-earn-more

xi CMS Blog, "Comments of CMS Acting Administrator Andy Slavitt at the J.P. Morgan Annual Health Care Conference, Jan. 11, 2016." https://blog.cms.gov/2016/01/12/comments-of-cms-acting-administrator-andy-slavitt-at-the-j-p-morgan-annual-health-care-conference-jan-11-2016/

xii Data from a survey by PerfectServe, conducted by Nielsen from nearly 1,000 clinicians, case managers and practice administrators. http://hitconsultant.net/2015/04/07/ehrs-not-sufficient-care-coordination/