CARE MANAGEMENT COLLABORATIVE

Integrated Health Partners
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Care Management Collaborative – Act 1

- Identified need
- Assembled community care managers
- Held day long education and discussion session
- Developed cross-organizational teams
- Included 17 organizations, 27 individuals

Collaborative Structure

- Day long sessions every 3 months
- Discussion topics
  - ✓ Chronic Care Model
  - ✓ Self-Management Support
  - ✓ Model for Improvement
  - ✓ Depression
  - ✓ Cultural Competency
  - ✓ Transitions of Care Tools
- Monthly working luncheons

Collaborative Structure

- Developed aim statements
- Identified pilot population for each team (or not)
- Developed PDSA cycles
- Completed process mapping
- Tested and evaluated

Lessons Learned

- Aim statements are less beneficial than traditional collaborative
- Pilot population was difficult to ascertain
- Lack of continuity of the teams
- Deeper engagement is needed at the highest level of each organization
- Process mapping should have occurred earlier

Care Management Collaborative – Act 2

“Failure is the opportunity to begin again more intelligently”

Dove dark chocolate wrapper or probably originally Henry Ford

Care Management Collaborative – Act 2

- Overall Collaborative Aim Statements
  - ✓ Transitions of care
  - ✓ Emergency room visits
  - ✓ Self Management goal
  - ✓ Readmissions
- Targets will be set for the collaborative as a whole, with each team measuring their pilot population in those areas
- Allow more knowledge in focused areas for rapid spread and policy and procedure change for the community

Care Management Collaborative – Act 2

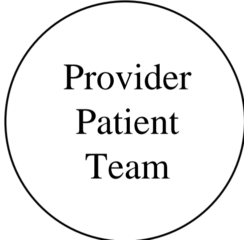
- Teams organized around practice
  - ✓ Will develop teams from practice with dynamic support system around physician patient teams
  - ✓ PDSAs will be "cross organizational" to break down the silos of care

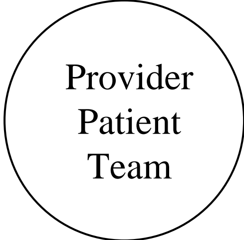
Core Practice Teams

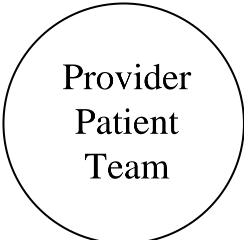
Emergency
Department

Hospitalist

Extended
Care Facility





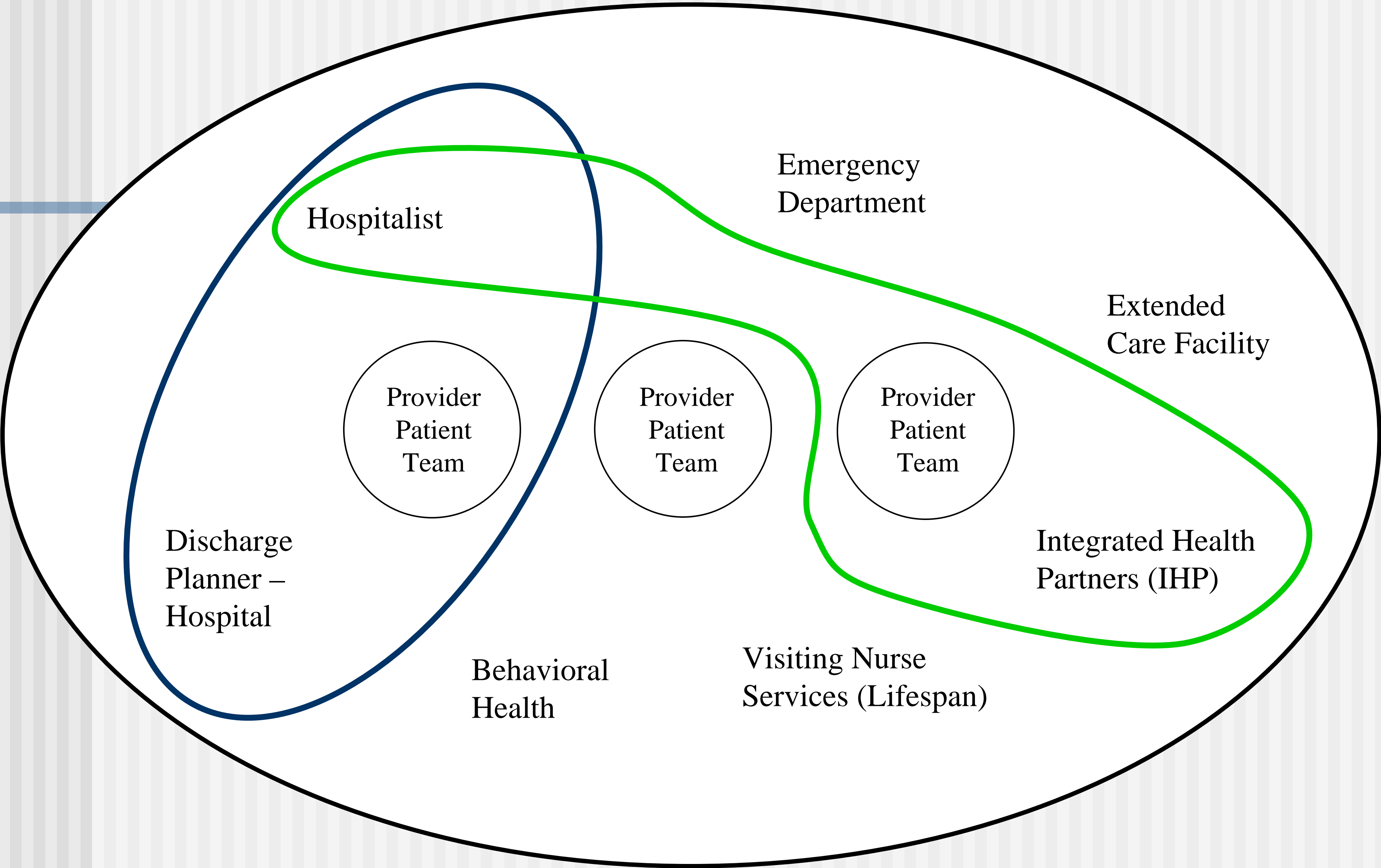


Discharge
Planner –
Hospital

Integrated Health
Partners (IHP)

Behavioral
Health

Visiting Nurse
Services (Lifespan)


Emergency
Department
Hospitalist
Extended
Care Facility
Provider
Patient
Team
Provider
Patient
Team
Provider
Patient
Team
Discharge
Planner –
Hospital
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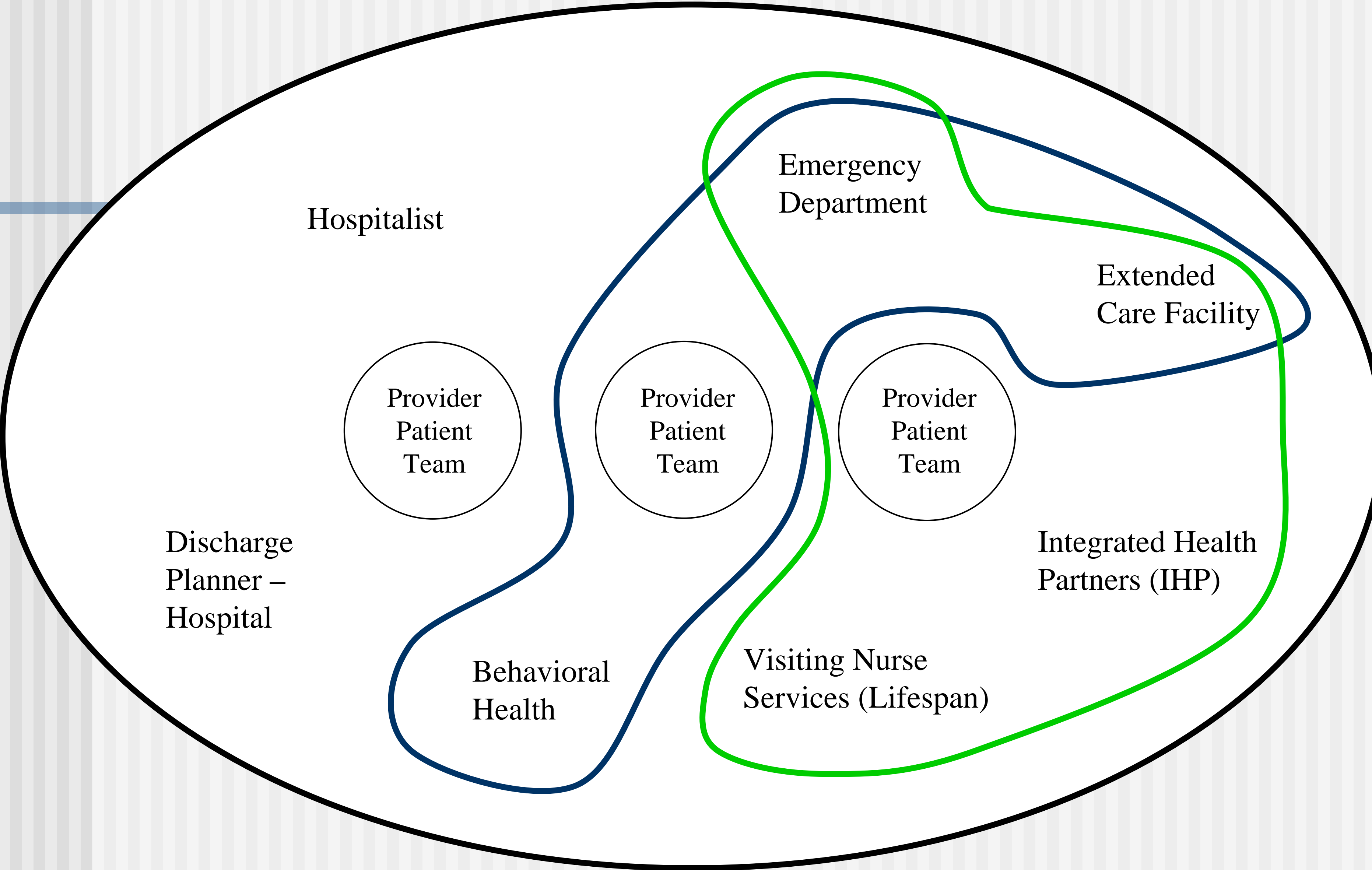
Hospitalist
Emergency Department
Extended Care Facility
Provider Patient Team
Provider Patient Team
Provider Patient Team
Discharge Planner – Hospital
Integrated Health Partners (IHP)
Behavioral Health
Visiting Nurse Services (Lifespan)

Risk Stratification

Risk Stratification

	Self Management Goal		Readmission	
	Yes (1)	No (2)	With SM Goal	Without SM Goal
Healthy (1)	1	2	2	4
> 1 Significant acute (2)	2	4	4	8
1 Minor Chronic disease (3)	3	6	6	12
Multiple Minor Chronic (4)	4	8	8	16
1 Significant Chronic Disease (5)	5	10	10	20
2 Significant Chronic Diseases (6)	6	12	12	24
3 or more Significant Chronic Diseases (7)	7	14	14	28
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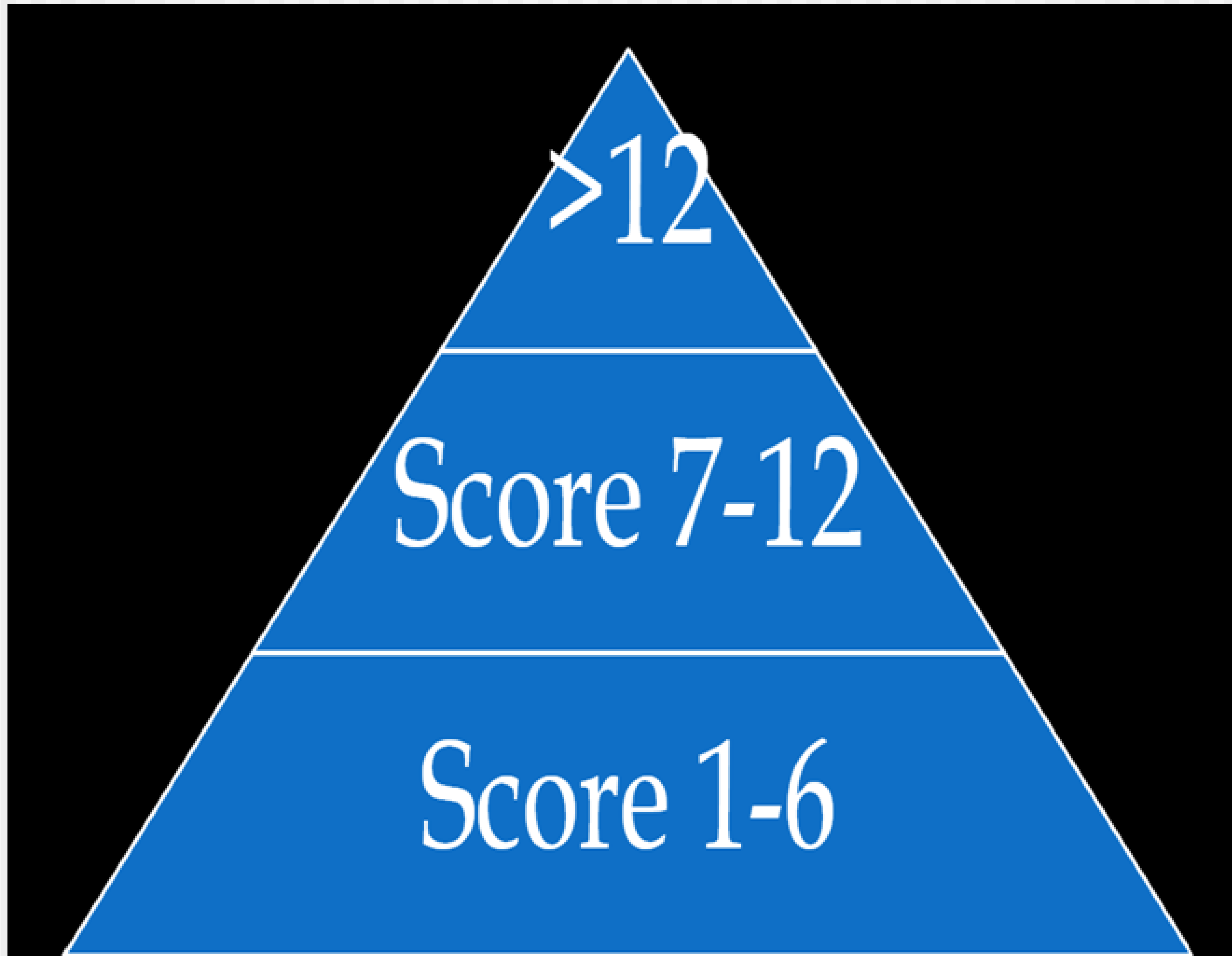
Risk Stratification

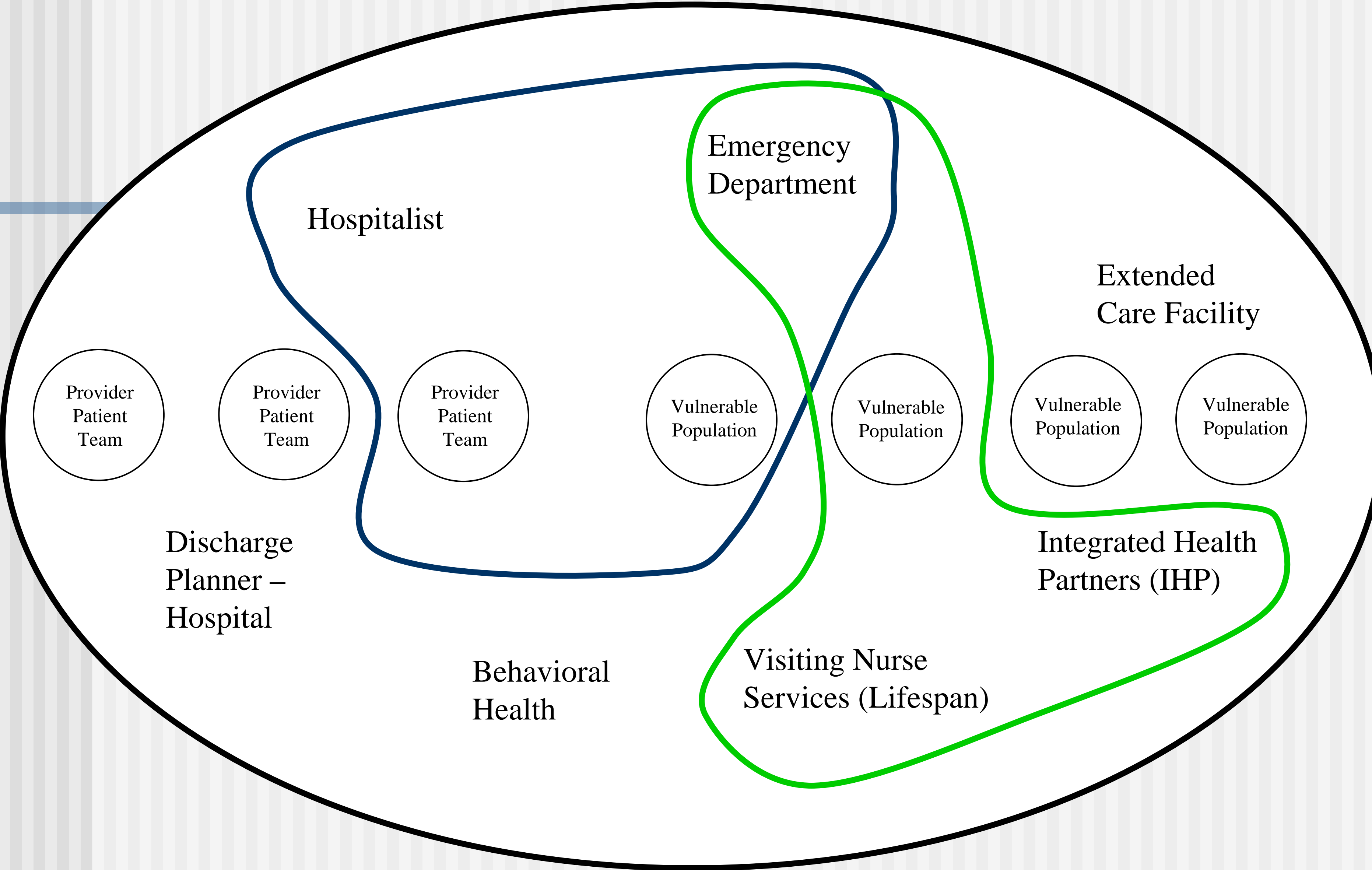


Issues with Ethnic Disparities

- Improvement in care may not reach the most vulnerable of our population, actually worsening our disparities gap
- Apply the Chronic Care Model to the social determinants of health in vulnerable populations using the learning collaborative framework to address ethnic disparities
- Incorporate marginalized populations to community improvement
  - ✓ Issues with access to care
  - ✓ Issues related to culture and loci of care

Issues with Ethnic Disparities

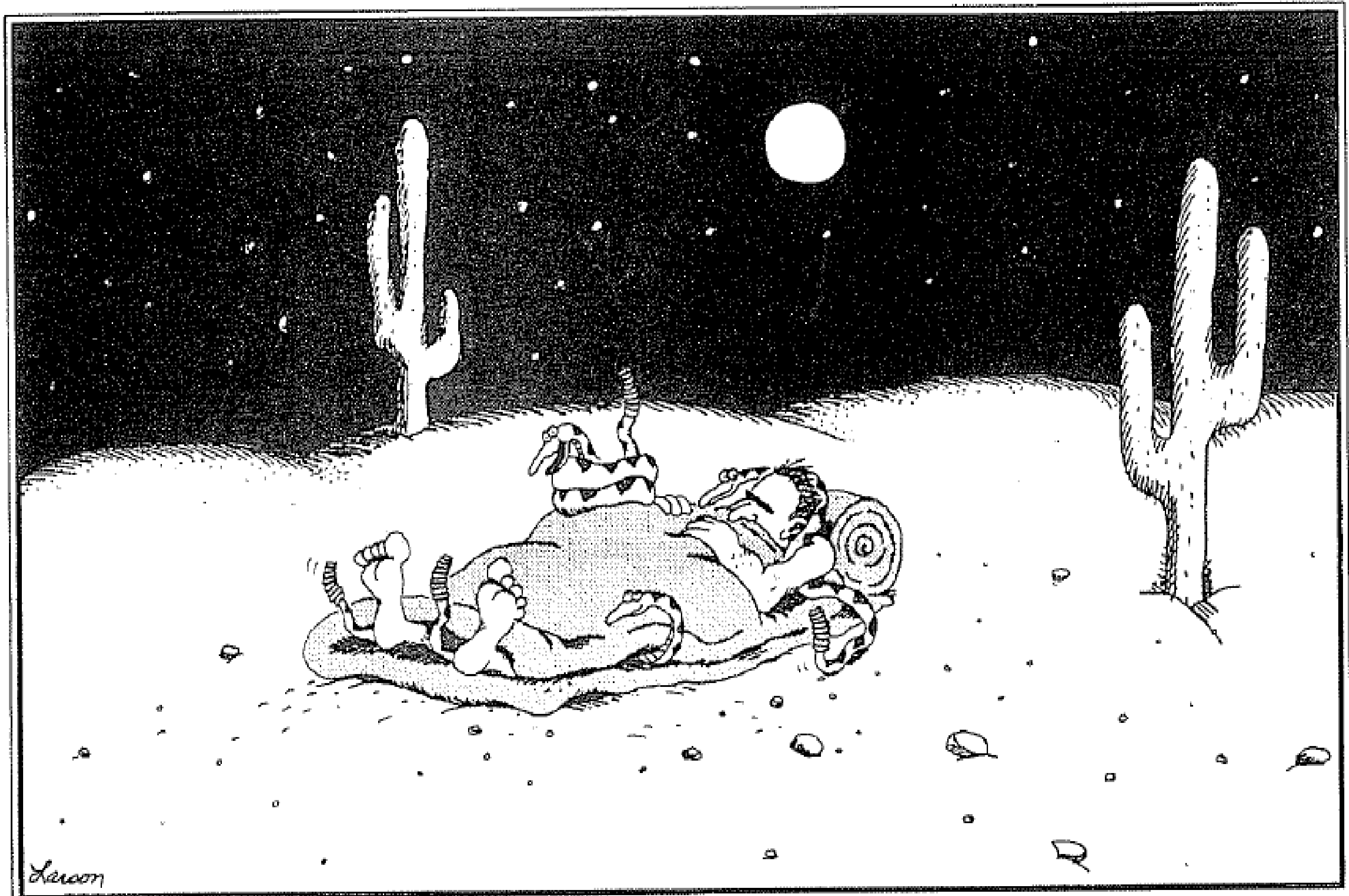
- Engage and empower minority leadership to develop initiatives that address health disparities within their spheres of influence (PGIP to the community level)
- Focus on the social determinants of health
- Measurements
  - ✓ Self management goal
  - ✓ Measures of patient engagement
  - ✓ Percentage of patients that can name their PCP
  - ✓ Active engagement in initiative
  - ✓ Health Outcomes – glucose, HbA1c


Emergency
Department
Hospitalist
Extended
Care Facility
Provider
Patient
Team
Provider
Patient
Team
Provider
Patient
Team
Vulnerable
Population
Vulnerable
Population
Vulnerable
Population
Vulnerable
Population
Discharge
Planner –
Hospital
Integrated Health
Partners (IHP)
Behavioral
Health
Visiting Nurse
Services (Lifespan)

Care Management – Calhoun County Collaborative Way

- Using existing resources, allow for efficient utilization of existing services, improving the likelihood of sustainability and improving integration of existing services
- Allowing common language for change across care continuum – (i.e. collaborative PDSA measurement used in different care sectors) driving for community cultural change
- Process mapping across the care continuum
- Taking lessons learned from Care Management Collaborative #1 on the individual experience of care management, and bringing it to a population level care management

True Collaboration Brings the Best Results



"Okay . . . On the count of three everybody rattles."

Thank You!

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