Best Practices in Managing Patients with Multiple Chronic Conditions (MPMCC) Learning Collaborative Group Overview Webinar

Thursday, February 16, 2012
3:00 PM– 4:30 PM EST

The Polyclinic

The Polyclinic/Regence Intensive Outpatient Care Program

Sponsored by AMGA and Merck & Co., Inc.
Organizational Profile

- The Polyclinic was established in 1917
- 18 sites
- 179 physicians
- 29 specialties along with Internal Medicine, Family Medicine and Pediatrics
- In 2011 The Polyclinic had 139,404 outpatient visits and 31,513 new patients
- The EMR that The Polyclinic is using is EPIC
- Independent physician owned organization
Goals and Objectives

- The Polyclinic intends on using the Intensive Outpatient Care Program (IOCP) pilot as a way to rollout a global solution that will help to manage high cost/high risk patients.
- This pilot should help the Polyclinic understand the type of infrastructure that is needed to help support chronic care patients.
- The goals are to:
  - Improve the physician and patient relationship
  - Improve the health status of the patient
  - Improve the clinical outcomes
  - Improve patient satisfaction
  - Decrease the total cost of care
The Big Picture

- The IOCP project allows the Polyclinic to extend this methodology and engage commercial payers. Our strategic plan is to provide value:

  \[ \text{Value} = \text{Quality} + \text{Satisfaction} \]

  \[ \text{Cost} \]

- The Polyclinic is developing practice standards that will help address the value proposition and move from volume to value.

- We are seeking incentive payments from commercial payers when we can demonstrate our value.

- The next steps have started and include embedding Enhanced Care RNs to support our Primary Care Providers.
Population and Intervention

- Polyclinic/Regence Intensive Outpatient Care Program
  - 1064 Potential enrollees identified by health plan
  - HP assigned risk using DCG type predictive model, target population with a 2.5 risk of having higher utilization than baseline population
  - Limited distribution to First Hill and Downtown patients
  - Combination of Internal Medicine, Family Medicine, Endocrinologists and Nephrologists
  - Number currently enrolled 172 patients
Population and Intervention

- Create Registry
- Case Management – RN HealthCare Navigator
  - Shared Care Plan
    - Work on 3 goals at a time, 1 goal chosen by patient
  - RN Triages Care Needs
    - Streamlines access to PCP, specialists
    - ER and Hospitalization avoidance
Patient/Caregiver Experience Survey
  ◦ Baseline and every six months Survey of case management patient satisfaction at enrollment and then every 6 months

Cost/Resources
  ◦ Admits/1000
  ◦ Readmissions/1000
  ◦ ED Visits/1000
  ◦ Bed days/1000
  ◦ Cost avoidance of admission or ED visit
  ◦ Total cost of care if available from the health plan
  ◦ Trend all of the above over time

Improving Health/Quality Functional status (see above, baseline and every 6 months)
Challenges

- Valid data from the Health Plan
- Correct attribution
- Enrollment attrition due to Health Plan increases in premiums
- PCP support and buy-in
Questions to Group

- Does anyone have a total cost of care model that they can share? We would like to be able to validate any Health Plan data.