



Curriculum Guide on Managing Care: A Systems-Based Approach

Version 1.1

**Sample Pages from the Instructional Materials
Provided in the Guide**

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Managed Care Opinion Survey

- Survey Instrument and Description

Forms

- Checklist for Course Director: Implementing the Rotation and the Sessions
- Teaching Site Profiles:
 - A Profile of the Managed Care Organization Participating in the Rotation
 - A Profile of the Community Practice Participating in the Rotation
- Evaluation Forms:
 - Resident Feedback Form: Session Evaluation Form
 - Resident Feedback Form: Overall Rotation Evaluation Form
 - Faculty Feedback Forms
 - Course Director Summary Form
- Confidentiality Agreement for Residents Regarding MCO Sessions

Part II. Session Instructional Materials

List of Sessions

Faculty Overview and Orientation

Community Practice sessions

Managed Care Organization sessions

Instructional Materials: Sessions in binder and on CD-ROM

- **Managed Care Organization Perspective Session:** Quality Assurance and Improvement
- **Community Practice Perspective Session:** Utilization Management in the Community Practice

Instructional Materials: Sessions on CD-ROM only:

Community Practice Perspective Sessions:

Population-Based Care and Patient Management

Referral Management

Patient Education / Health Education

Practice Management Systems and Operations

Managed Care Organization Perspective Sessions:

Utilization Management in the MCO

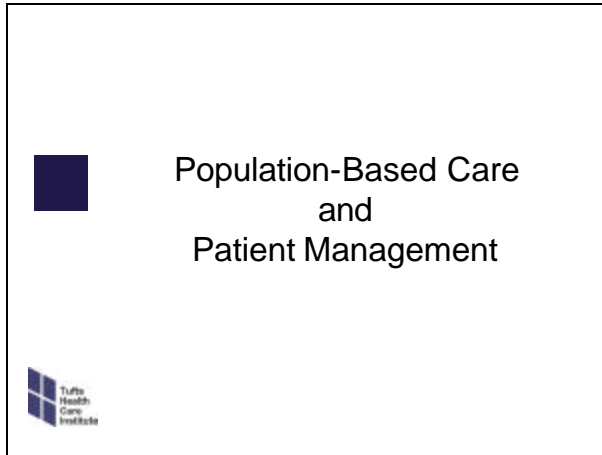
Provider Performance Reports

MCO-Physician Contracting

Case Management

Disease Management

Pharmacy Management

The slide has a dark blue square on the left. The title "Session Objectives" is centered at the top in a large, black, sans-serif font. Below the title is a horizontal line. Underneath the line, the text "After this session, the resident will be able to:" is followed by a bulleted list of five objectives. The Tufts Health Care Institute logo is in the bottom-left corner, and a small number "2" is in the bottom-right corner.

After this session, the resident will be able to:

- Discuss the effects of a population-based health care perspective on the clinical management of patients in the ambulatory setting
- Describe strategies and techniques for stratifying a patient panel by health risk and managing the care of each segment
- Illustrate the role of the primary care physician as coordinator of care
- Accept the benefits of disease management and practice guidelines when appropriately applied to individuals
- Explain the importance and application of patient-centered care and communications in clinical situations


The slide has a dark blue square on the left. The title "Overview of Discussion" is centered at the top in a large, black, sans-serif font. Below the title is a horizontal line. Underneath the line, there is a bulleted list of discussion topics. The Tufts Health Care Institute logo is in the bottom-left corner, and a small number "3" is in the bottom-right corner.

Overview of Discussion

- Overview: effects of managed care
- Population-based care
- Cost-effective care
- Panel management strategies and tools
 - Risk assessment
 - Demand management
 - Disease management
 - Practice guidelines
 - Care coordination
 - Patient-centered care
 - Practice management tools

Population-Based Care


What do you think of when you hear “population-based care”? What does this mean for medical practice?



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Views of Population-Based Care (1)


- “A population health perspective encompasses the ability to assess the health needs of a specific population; implement and evaluate interventions to improve the health of that population; and provide care for individual patients in the context of the culture, health status, and health needs of the populations of which that patient is a member.” *AAMC 1999*
- “Members with a particular disease must be prioritized so that disease management interventions are targeted toward those members most likely to cost-effectively benefit. This type of intervention is increasingly referred to as population health management.” *Zeich 1998*



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Population-Based Care

- “Population” refers to:
 - panels of health plan members, or
 - patients associated with a physician, practice or delivery system
- Individual patient can belong to multiple subpopulations within the practice’s panel
- Distinct from the community or public health perspective (i.e., population = all residents of a geographic community or region)




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Denominator Medicine (1)

Individual patients (numerator)
Populations to which they belong (denominator)


- Goals: treat individuals and improve collective outcomes.
- Denominators can be:
 - all health plan members
 - those enrolled with a provider network or physician
 - groups with similar demographics
 - people with the same disease state or clinical condition
- Numerators can be units of service (e.g., screenings, admissions) or costs or numbers of patients.



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Denominator Medicine (2)


- Any combination of numerator and denominator can be standardized, e.g., screening rates per 1000 or per member per month (PMPM) (e.g, children in the age range receiving vaccinations).
- Track data to measure and compare service patterns for populations.
- Use findings to identify under-utilization and over-utilization, and positive and negative outcomes.



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Cost-Effective Care (1)

- Essential in a cost-constrained environment
- Getting the most “bang for the buck”
- Obtaining a good outcome, but at a reduced cost
- Operating cost-effectively to conserve resources for the next patient(s)

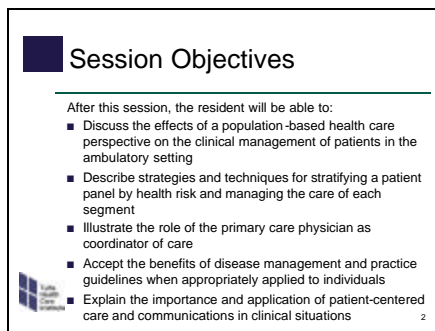
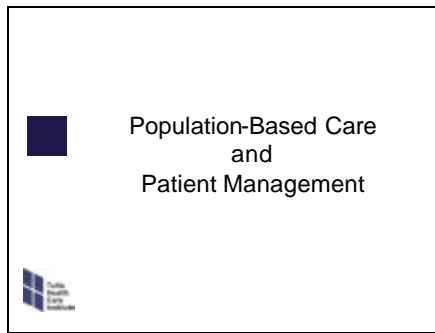


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Curriculum Guide on Managing Care, V. 1.1
Population-Based Care and Patient Management
Orientation / Slides / Notes

Faculty Notes for Slides


These slides should be clear enough for your discussion with the residents. Here are some additional background notes for certain slides.




Curriculum Guide on Managing Care, V. 1.1
Population-Based Care and Patient Management
Orientation / Slides / Notes


 **Overview of Discussion**

- Overview: effects of managed care
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 - Risk assessment
 - Demand management
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 - Practice guidelines
 - Care coordination
 - Patient-centered care
 - Practice management tools


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 **Effects of Managed Care**


- Increased access to primary care physician services
- Need to educate patients about managed care systems and processes
- Increased importance of patient satisfaction
- Heightened attention to risks and risk stratification of patients, particularly as they relate to utilization of resources
- Proactive management of your panel as a population

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Managed care has spurred physicians who provide clinical services to:
improve access to care for their patients
educate their patients about managed care systems and processes
satisfy their patients regarding wait times and communication styles
understand the risk status of their patients regarding utilization of resources
be proactive about the management of their patient panel rather than waiting for patients to come into the office with their illnesses. As a rule, intervening early in a particular illness episode will ensure a better outcome with lower utilization of resources.

 **Population-Based Care**


What do you think of when you hear “population-based care”? What does this mean for medical practice?

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Learners can say what population-based care means to them. The slides that follow cite several factors.

Curriculum Guide on Managing Care, V. 1.1
Population-Based Care and Patient Management

Orientation / Slides / Notes

 **Views of Population-Based Care (1)**

- "A population health perspective encompasses the ability to assess the health needs of a specific population; implement and evaluate interventions to improve the health of that population; and provide care for individual patients in the context of the culture, health status, and health needs of the populations of which that patient is a member." *AAMC 1999*
- "Members with a particular disease must be prioritized so that disease management interventions are targeted toward those members most likely to cost-effectively benefit. This type of intervention is increasingly referred to as population health management." *Zeich 1998*

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References:

Association of American Medical Colleges (AAMC), Medical Informatics Panel and the Population Health Perspective Panel.

Contemporary issues in medicine: medical informatics and population health: report II of the Medical School Objectives Project.


Acad Med. 1999; 74:130-141. Association of American Medical Colleges (AAMC).

Abstract: www.academicmedicine.org


Related AAMC Press Release, AAMC Stresses Value of Population Health In Medical Education, May 28, 1998.

<http://www.aamc.org/newsroom/pressrel/980528.htm>

Zeich R. Patient identification as a key to population health management. *New Medicine*. 1998;2:109-116.

 **Views of Population-Based Care (2)**

- "Population-based care involves a new way of seeing the masses of individuals seeking health care. It is a way of looking at patients not just as individuals but as members of groups with shared health care needs. This approach does not detract from individuality but rather adds another dimension, as individuals benefit from the guidelines developed for the populations to which they belong." *Boland 1996*
- "When caring for a population, you should measure outcomes for all your patients with the targeted condition, not just those who come to your office. This is largely what differentiates population-based care from traditional, individual-centered care." *Rivo 1998*

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References:


Boland P, editor. Redesigning Healthcare Delivery. Boland Healthcare, Berkeley, 1996. pp. 159-163.

Rivo M. It's Time to Start Practicing Population-Based Health Care. *Family Practice Management*. June 1998;5(6). <http://www.aafp.org/fpm/980600fm/popbas.ed.html>

Curriculum Guide on Managing Care, V. 1.1
Population-Based Care and Patient Management
Orientation / Slides / Notes

Fundamentals of Population-Based Care

- Assess the health needs of a specific population; implement and evaluate interventions to reduce risk of disease and its complications within that population.
- Measure outcomes for all your patients with a targeted condition, not just those who come to your office.
- Approach patients not just as individuals but as members of groups with shared health care needs; individuals can benefit from the guidelines developed for the populations to which they belong.
- Provide care for individual patients in the context of the culture, health status, and health needs of the populations of which that patient is a member.




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Denominator Medicine (1)

Individual patients (numerator)
Populations to which they belong (denominator)

- Goals: treat individuals and improve collective outcomes.
- Denominators can be:
 - all health plan members
 - those enrolled with a provider network or physician
 - groups with similar demographics
 - people with the same disease state or clinical condition
- Numerators can be units of service (e.g., screenings, admissions) or costs or numbers of patients.




13

Any combination of numerator and denominator can be standardized, e.g., screening rates per 1000 or per member per month (PMPM) (e.g. children in the age range receiving vaccinations). Our ability to track these data with ever-improving information systems allows us to seek out quality metrics or patterns of under-utilization as well as over-utilization, and to measure and compare how well patients and populations are being served. Without the reinforcement of population-based measures, it is hard to recognize successes and improvements, i.e., true health care improvement (outcomes).

Denominator Medicine (2)

- Any combination of numerator and denominator can be standardized, e.g., screening rates per 1000 or per member per month (PMPM) (e.g. children in the age range receiving vaccinations).
- Track data to measure and compare service patterns for populations.
- Use findings to identify under -utilization and over-utilization, and positive and negative outcomes.



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Curriculum Guide on Managing Care, V. 1.1
Population-Based Care and Patient Management
Cases

Cases for Discussion

Instructions: Please read the following case vignettes and answer the discussion questions for each case.

Case #1

Your seven-person primary care group practice has recently joined a hospital-based IPA, which has accepted a managed Medicare contract. The IPA sends out risk assessment instruments to all managed Medicare patients and has just forwarded to you the results of your first three patients, indicating that one is high risk. The patient's high-risk status was established based on the patient being on multiple medications, having multiple illnesses, and being homebound with few social supports.

Questions:

1. Before you have just waited until your patients come into your office to receive care. Would you do anything differently in this case?
2. The two patients at low risk readily agree to have an appointment with you within the month for a complete physical exam; however, the high risk patient refuses, saying he doesn't need your help. Would you drop the issue at that point in time?
3. A visiting nurse visits the patient and finds numerous risk factors for falls, an unkempt apartment, with little food in the refrigerator. What would you do now?
4. The case manager arranges for an occupational therapist to visit the apartment of your high-risk patient to make recommendations regarding reducing fall risk, arranges Meals-on-Wheels for nutritional support, and begins to work with the patient around getting the patient to enroll in an adult day health program. The visiting nurses recommend some medication adjustment, which you willingly make. Even though you still haven't seen the patient, you are happy to learn from the occupational therapist that at least he has made some improvements in his living situation to reduce fall risks. Since you haven't seen the patient yet, would you make a home visit?

Curriculum Guide on Managing Care, V. 1.1
Population-Based Care and Patient Management
Cases / Notes

Answers to Cases for Discussion – Faculty Guide
(Do not distribute to trainees)

Instructions: Please read the following case vignettes and answer the discussion questions for each case.

Case #1

Your seven-person primary care group practice has recently joined a hospital-based IPA, which has accepted a managed Medicare contract. The IPA sends out risk assessment instruments to all managed Medicare patients and has just forwarded to you the results of your first three patients, indicating that one is high risk. The patient's high-risk status was established based on the patient being on multiple medications, having multiple illnesses, and being homebound with few social supports.

Questions and Answers:

1. Before you have just waited until your patients come into your office to receive care. Would you do anything differently in this case?
 - A. **In this case it would be critical to intervene in some fashion with the patient who is at high risk, otherwise that patient may develop a high cost episode of illness, such as a hip fracture if they fall, which would utilize much more resources than a preventive intervention. For example, the provider may want to invite the high risk patient in for a general physical exam to assess their risk status and adjust medications and/or the provider may want to refer to a case manager to ensure that proper supports in the community are present so the patient can exist independently at home.**

2. The two patients at low risk readily agree to have an appointment with you within the month for a complete physical exam; however, the high risk patient refuses, saying he doesn't need your help. Would you drop the issue at that point in time?
 - A. **It would be very important not to drop the issue, but to continue discussions to come up with a more acceptable intervention with the high-risk patient. Perhaps this high-risk patient would be willing to have a case manager or visiting nurse visit them in their home to assess risk status.**

Further Instructional Opportunities

Note to Faculty: Please select one or more of the following activities or discussion topics to continue instructing the trainees in how this content applies to actual settings and practical situations.

1. Panel Management. Describe how your practice keeps track of your patients and their insurance coverage, including people who have identified your practice as their provider site but have not presented as patients. Show any forms or reports that you use to segment your patient population. Indicate what non-clinical information is attached to the patient's record when an appointment is scheduled or begun, and how the physician uses this information.
2. Risk Assessment. Discuss your tools and techniques for assessing the health status of your patients, including new patients who appear on a health plan's list of enrollees who have chosen your primary care physicians. Provide copies of questionnaires and assessment forms. If you receive information on health status or prior utilization from the health plans, show this to the residents. Then, discuss how you use this information to care for your patients as a group and individually, e.g., initiating and scheduling appointments, sending appropriate education materials, identifying disease management programs, etc. Describe pro-active techniques for managing patients at various levels of risk to prevent onset of illness, exacerbation of symptoms, or expensive episodes of care.
3. Care and Treatment Decisions. Provide illustrations of how your decisions and recommendations are impacted by a range of considerations at the point of care: the patient's insurance coverage and ability to pay for services that are not covered at all or require copayments; the formularies, disease management programs, clinical guidelines, referral networks, case managers, or other medical management tools applied by the health plans or your delivery system; the patient's psycho-social characteristics as they impact the course of action you select and its likely effectiveness; and the costs of alternative actions, e.g., diagnostic tests, pharmaceuticals, procedures, home vs. hospital, etc. Show the residents examples of any job aids you utilize in making these decisions.
4. Care Coordination. Describe your methods of coordinating care and how you stay involved in the care of your patients, even if they are principally managed by other health care professionals. Show referral forms that you complete for specialists, case managers or others. Also show copies of reports that you receive and the action steps that you take depending on the information.

Curriculum Guide on Managing Care, V. 1.1
Population-Based Care and Patient Management
Questions

Post-Test Questions

1. In population-based care, which of the following constitute a population?
 - A. All the patients in your practice
 - B. All the patients from HMO X in your care
 - C. All healthy adult males ages 20-50
 - D. All patients diagnosed with diabetes

2. Giving your patients a chart showing which age/sex groups should receive immunizations at what intervals is an example of:
 - A. Disease management
 - B. Clinical guidelines
 - C. Demand management
 - D. Case management

Post-Test Questions
(Faculty Guide with Answers)

1. In population-based care, which of the following constitute a population?
 - A. All the patients in your practice
 - B. All the patients from HMO X in your care
 - C. All healthy adult males ages 20-50
 - D. All patients diagnosed with diabetes

Answer: All of the above.

A population can be defined in different ways for different purposes. You may need to track utilization for one health plan's enrollees in a special way. You may wish to track screenings and immunizations for healthy adult males ages 20-50. You may participate in a disease management program for diabetics. You may want to involve local schools and service organizations in a health campaign that will impact all your patients.

2. Giving your patients a chart showing which age/sex groups should receive immunizations at what intervals is an example of:
 - A. Disease management
 - B. Clinical guidelines
 - C. Demand management
 - D. Case management

Answer: C.

Demand management is a package of programs and processes targeted at the patient population, to improve health via self-care, empower patients with information, and educate patients about managed care systems and processes.