Capital Region Chronic Illness Demonstration Project

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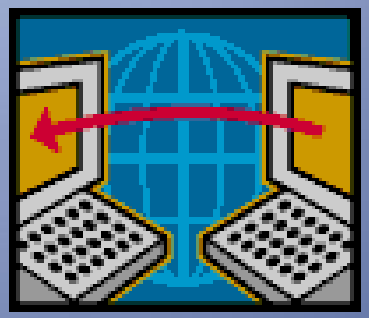
MISSION:
Improve Health Outcomes

- Enroll patient in a medical home
- Exchange information and coordinate care among multiple service providers
- Improve compliance with health treatment plans
- Reduce Emergency Room visits



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Improve health outcomes - Methods

- Conduct comprehensive assessment upon initial enrollment in the CIDP
- Involving patient in the development of their individualized care plan
- Providing intensive case management and linkages to health care and social services

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Improve health outcomes - Methods

- Utilizing technology to remind patients of appointments, Rx renewals, etc.
- Utilizing the 5 friends approach to remind patients to take medications and follow health protocols
- Conducting follow-up health and social assessments every six months or following a trigger event suggesting a significant change in health status.

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The Prospective Patients

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Demographic Characteristics

Patients with Risk Scores 50+

Data Element	All NYS	Albany MSA
N (2005/06)	33,363	799
N (Estimated 2008)	25,000	600
Age	45.1	44.4
Female	43.9%	50.2%
White	28.2%	52.9%
Black	40.7%	23.4%
Hispanic	15.0%	7.8%
Other/Unknown	16.1%	15.9%

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Prior Diagnostic History

Patients with Risk Scores 50+

Data Element	All NYS	Albany MSA
Cereb. Vasc. Dis.	4.9%	4.8%
AMI	6.2%	6.0%
Ischemic Heart Disease	22.5%	21.8%
Congestive Heart Failure	16.4%	18.6%
Hypertension	50.1%	49.1%
Asthma	34.8%	35.4%
COPD	23.5%	31.0%
Diabetes	28.8%	29.4%

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Prior Diagnostic History

Patients with Risk Scores 50+

Data Element	All NYS	Albany MSA
Renal Disease	6.1%	4.8%
Sickle Cell	2.6%	1.4%
Any Chronic Disease	75.9%	77.1%
Multiple Chronis Dis.	52.2%	54.3%
Cancer	14.0%	16.4%
HIV/AIDS	23.0%	13.0%

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Prior Diagnostic History

Patients with Risk Scores 50+

Data Element	All NYS	Albany MSA
Alcohol/Substance Abuse	73.0%	79.5%
Any Mental Illness	68.6%	74.1%
Schizophrenia	26.7%	23.0%
Psychosis	19.6%	12.8%
BiPoloar Disorder	39.0%	45.3%
MH or Substance Abuse	87.9%	90.9%
MH & Substance Abuse	53.7%	62.7%

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Average Medicaid Expenditures

Prior 12 months for Patients w/ Risk Scores 50+

Data Element	All NYS	Albany MSA
Inpatient	20,973	12,358
Emergency Dept.	306	420
Primary Care Visit	489	290
Specialty Care	80	33
Psychiatric Care Visit	810	920
Substance Abuse Vis	1,129	578
Other Ambulatory	1,989	1,247
Pharmacy	6,470	5,411

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Average Medicaid Expenditures

Prior 12 months for Patients w/ Risk Scores 50+

Data Element	All NYS	Albany MSA
Transportation	427	237
Community Rehab	109	511
Case Management	585	547
Personal Care	853	380
Home Care	875	558
LTHHC	49	60
All Other	2,388	1,486
Total Cost	37,530	25,038

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CIDP at a Glance

Chronic Care Model

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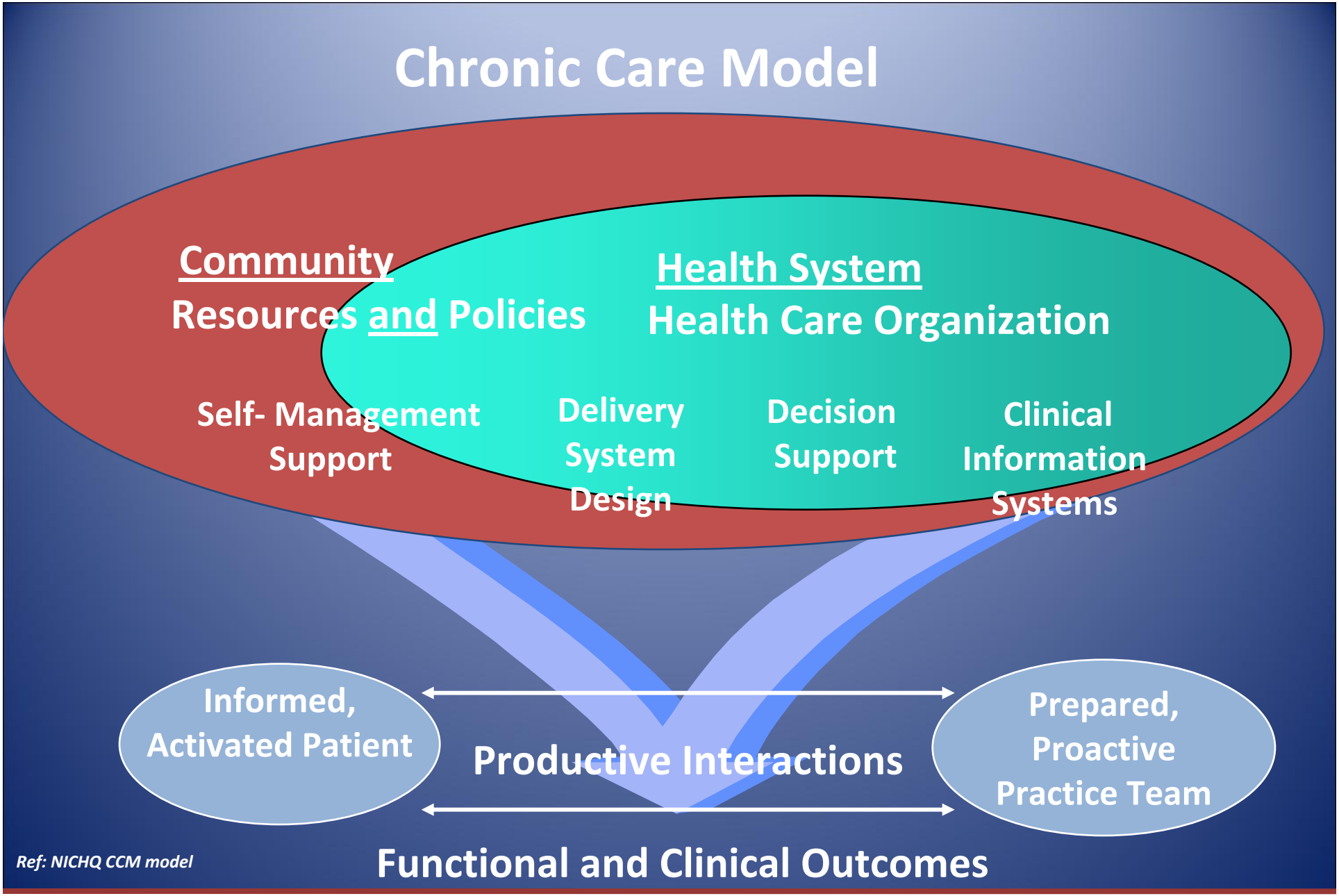

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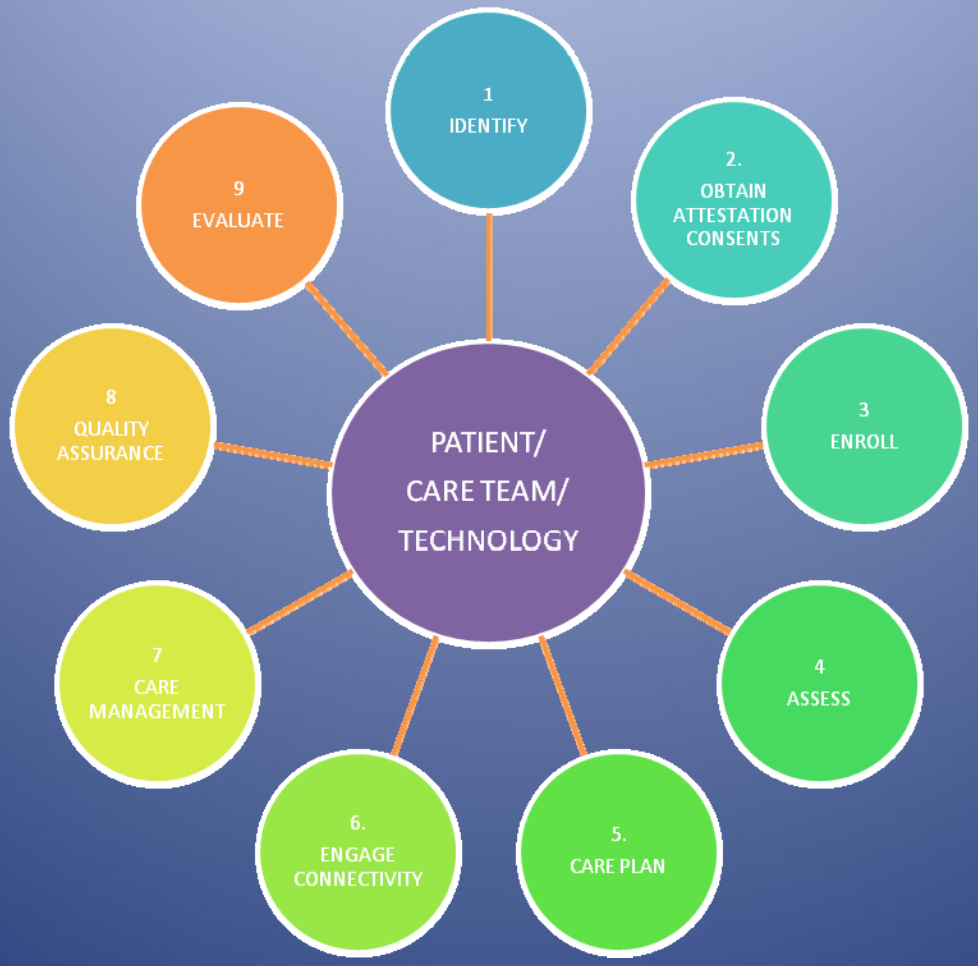
CIDP at a Glance



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Outreach

- Hire and train CIDP staff
- Demographic data analysis to determine how best to reach target population
- Reach out to WMY Health Programs, key community programs and health care providers

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Outreach

- Initial outreach will be extended to potential enrollees who are already known to WMY Health Services
- Plans for reaching out to non-WMY Health will be individualized

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Patient Enrollment

- Program explained
- Obtain all required consents and information releases
- 5 Friends Identification
- Demographic information collected

  (at home or WMY Health)

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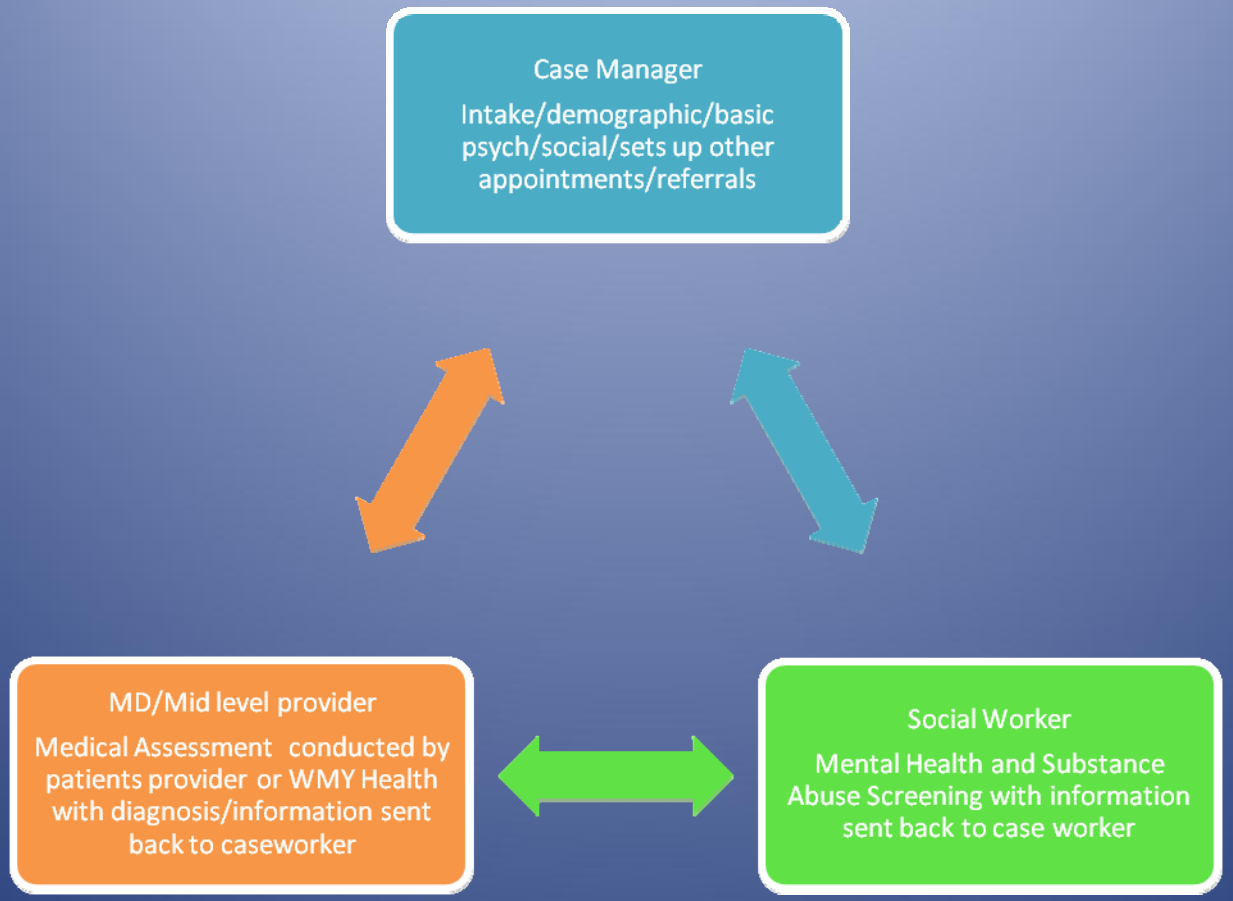
Patient Enrollment



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Health Assessments – 8 Components

- Physical Health
- Mental Health
  - Substance Abuse or Chemical Dependency
- Quality of Life/functional Status
- Social Supports

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Health Assessments – 8 Components

- Life control
- Engagement with the System
- Care Satisfaction
- Readiness for change

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Care Plan Development
Self Management Goals

- Patient
- Clinicians (MD, NP, PA, Pharmacist, Nutritionist)
- RN –Health Educator
- Social Worker
- Case Manager
- Friends
- Other services/specialists

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Interventions

- Medical interventions
- Social interventions
- Personal health record creation
- 5 Friends

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Cell Phones for the Enrollees

- Break Down Barriers
  - Enhance the communication between the community healthcare coordinators and the enrollees
  - Connects enrollee's "5 Friends" for support
- Provide Incentive
  - Incentive to enroll in the program and actively stay engaged throughout
- Risk Management Considerations
  - We need help with strategies for loss prevention and retrieval of the phones

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Equipping the WMY Staff Members

- Laptops with built-in broadband cards

- Cell phones with internet and text messaging capabilities

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Equipping the Patients

- Cell phones with internet and text messaging capabilities

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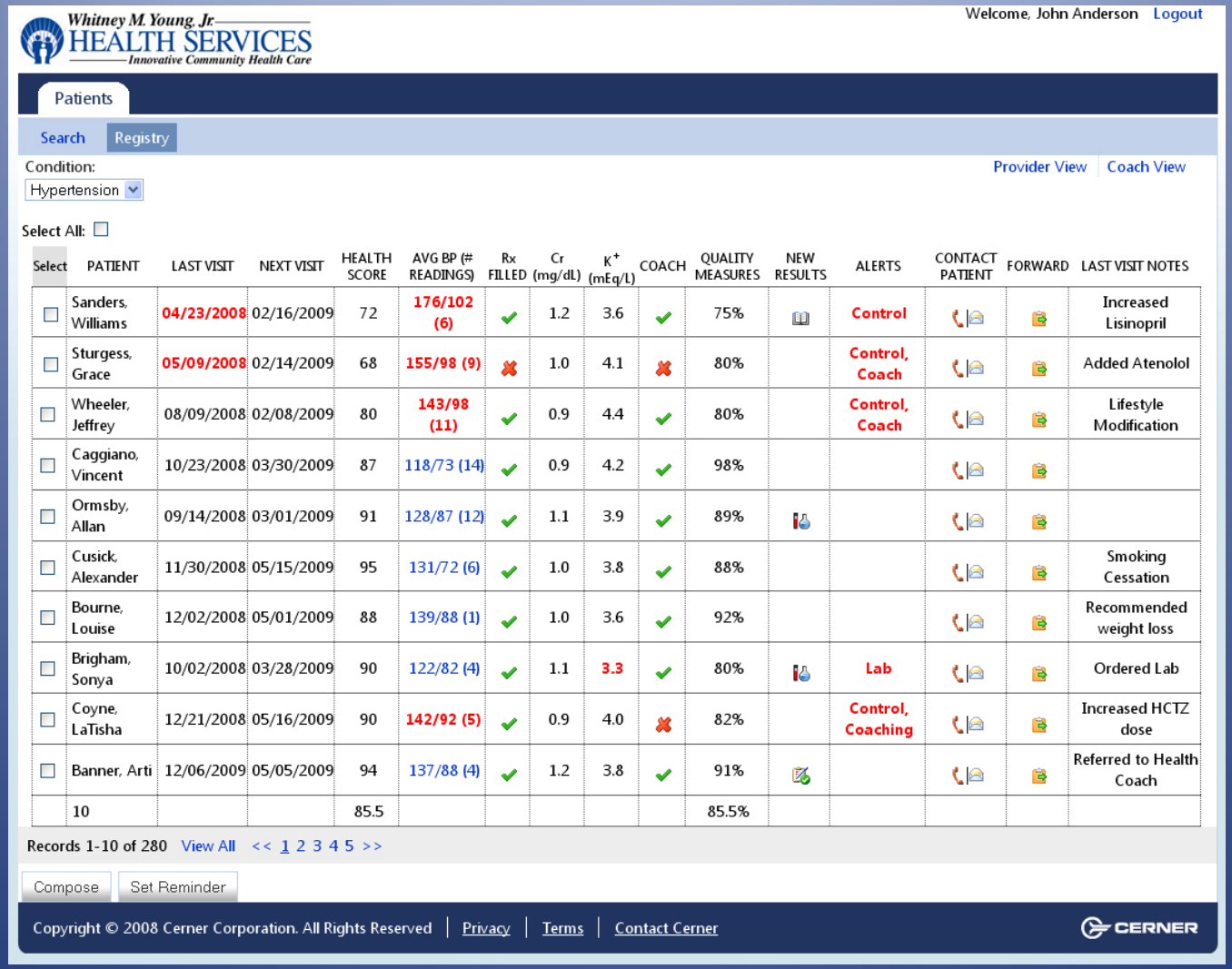
Patient Registry



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Welcome, John Anderson Logout

Patients

Search | Registry

Condition: Hypertension

Provider View | Coach View

Select All:

Select	PATIENT	LAST VISIT	NEXT VISIT	HEALTH SCORE	AVG BP (# READINGS)	Rx FILLED	Cr (mg/dL)	K+ (mEq/L)	COACH	QUALITY MEASURES	NEW RESULTS	ALERTS	CONTACT PATIENT	FORWARD	LAST VISIT NOTES
☐	Sanders, Williams	04/23/2008	02/16/2009	72	176/102 (6)	✔	1.2	3.6	✔	75%		Control			Increased Lisinopril
☐	Sturgess, Grace	05/09/2008	02/14/2009	68	155/98 (9)	✘	1.0	4.1	✘	80%		Control, Coach			Added Atenolol
☐	Wheeler, Jeffrey	08/09/2008	02/08/2009	80	143/98 (11)	✔	0.9	4.4	✔	80%		Control, Coach			Lifestyle Modification
☐	Caggiano, Vincent	10/23/2008	03/30/2009	87	118/73 (14)	✔	0.9	4.2	✔	98%					
☐	Ormsby, Allan	09/14/2008	03/01/2009	91	128/87 (12)	✔	1.1	3.9	✔	89%					
☐	Cusick, Alexander	11/30/2008	05/15/2009	95	131/72 (6)	✔	1.0	3.8	✔	88%					Smoking Cessation
☐	Bourne, Louise	12/02/2008	05/01/2009	88	139/88 (1)	✔	1.0	3.6	✔	92%					Recommended weight loss
☐	Brigham, Sonya	10/02/2008	03/28/2009	90	122/82 (4)	✔	1.1	3.3	✔	80%		Lab			Ordered Lab
☐	Coyne, LaTisha	12/21/2008	05/16/2009	90	142/92 (5)	✔	0.9	4.0	✘	82%		Control, Coaching			Increased HCTZ dose
☐	Banner, Arti	12/06/2009	05/05/2009	94	137/88 (4)	✔	1.2	3.8	✔	91%					Referred to Health Coach
	10			85.5						85.5%					

Records 1-10 of 280 View All << 1 2 3 4 5 >>

Compose | Set Reminder

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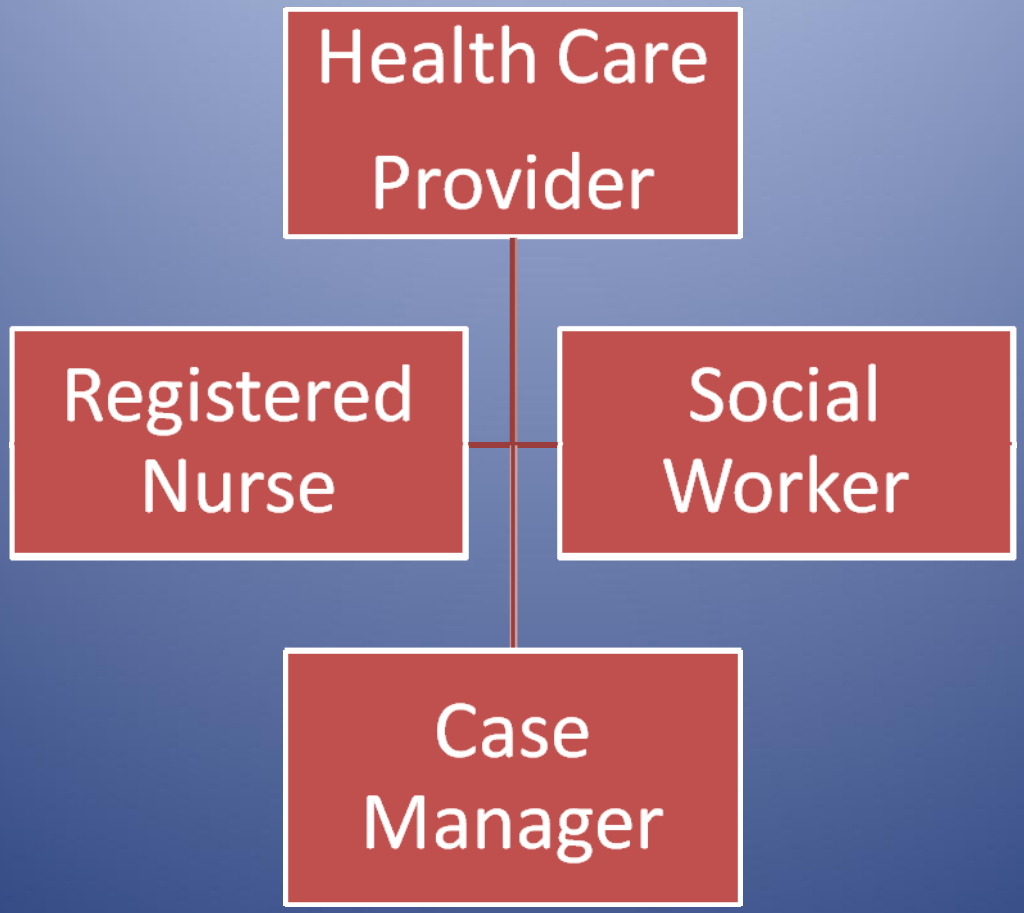
Functional View of Care Management



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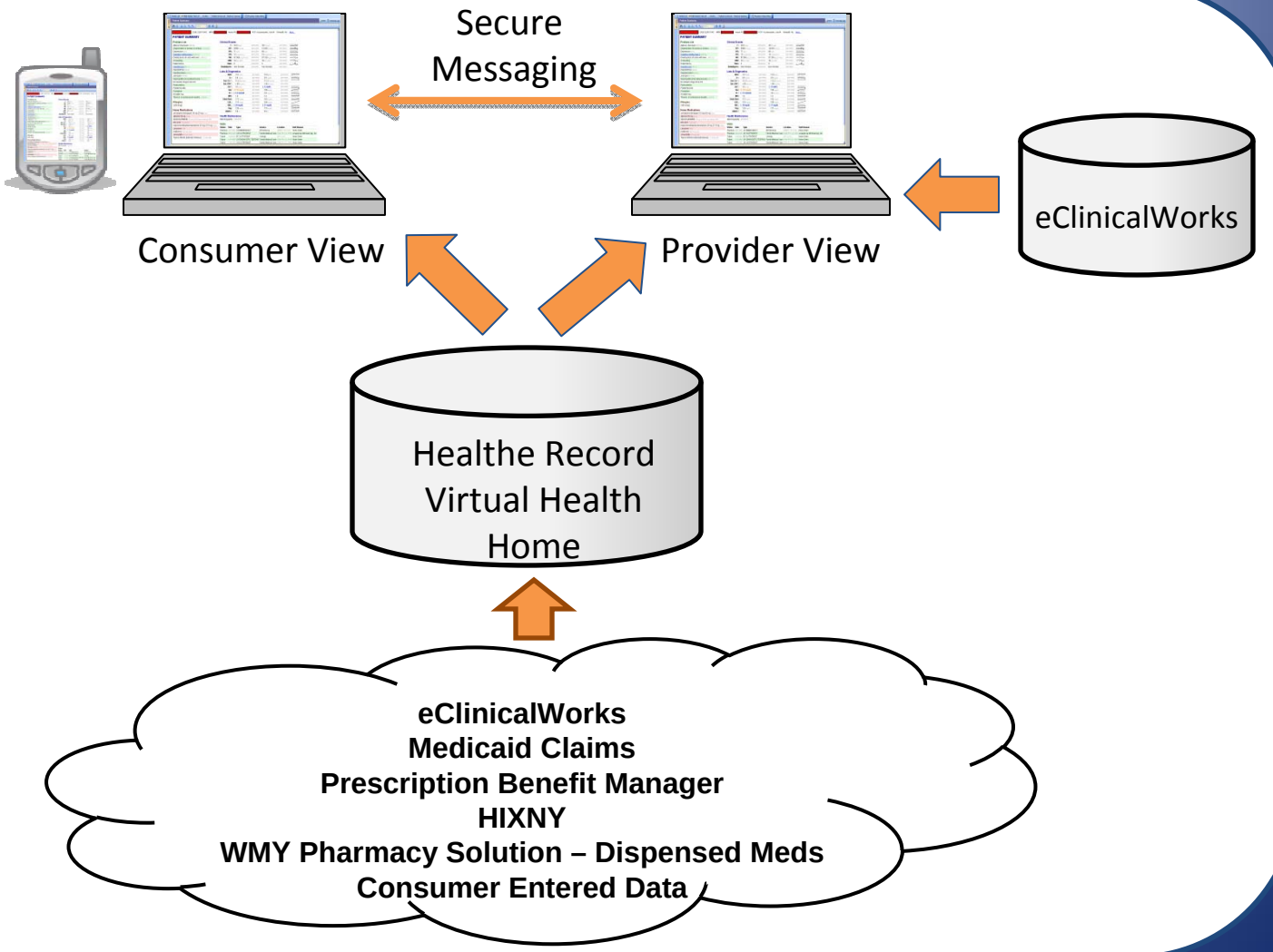
Healthe Record Interfaces



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Consumer View of Healthe Record – Medication Claims

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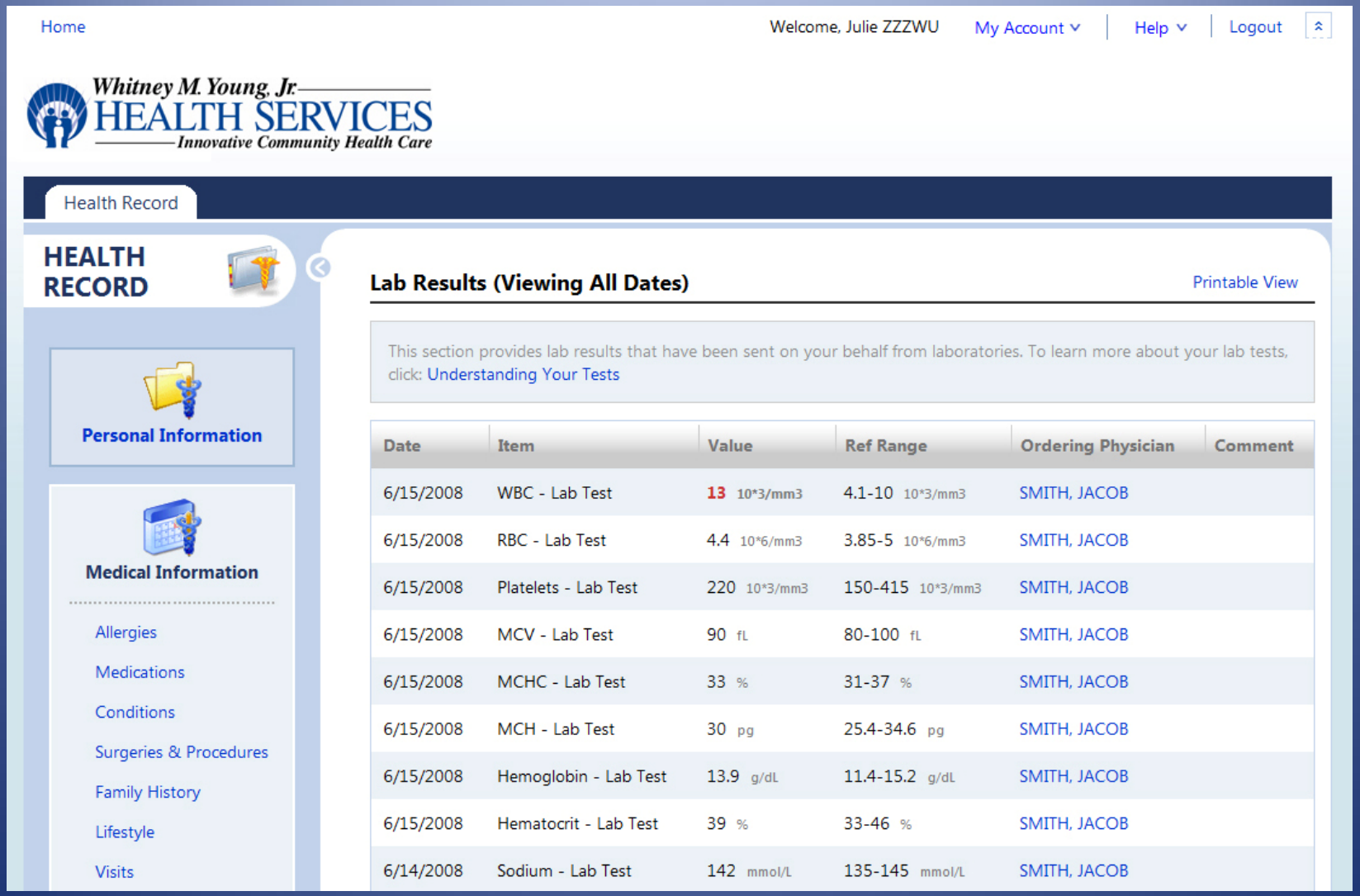
Consumer View of Healthe Record – Lab Results



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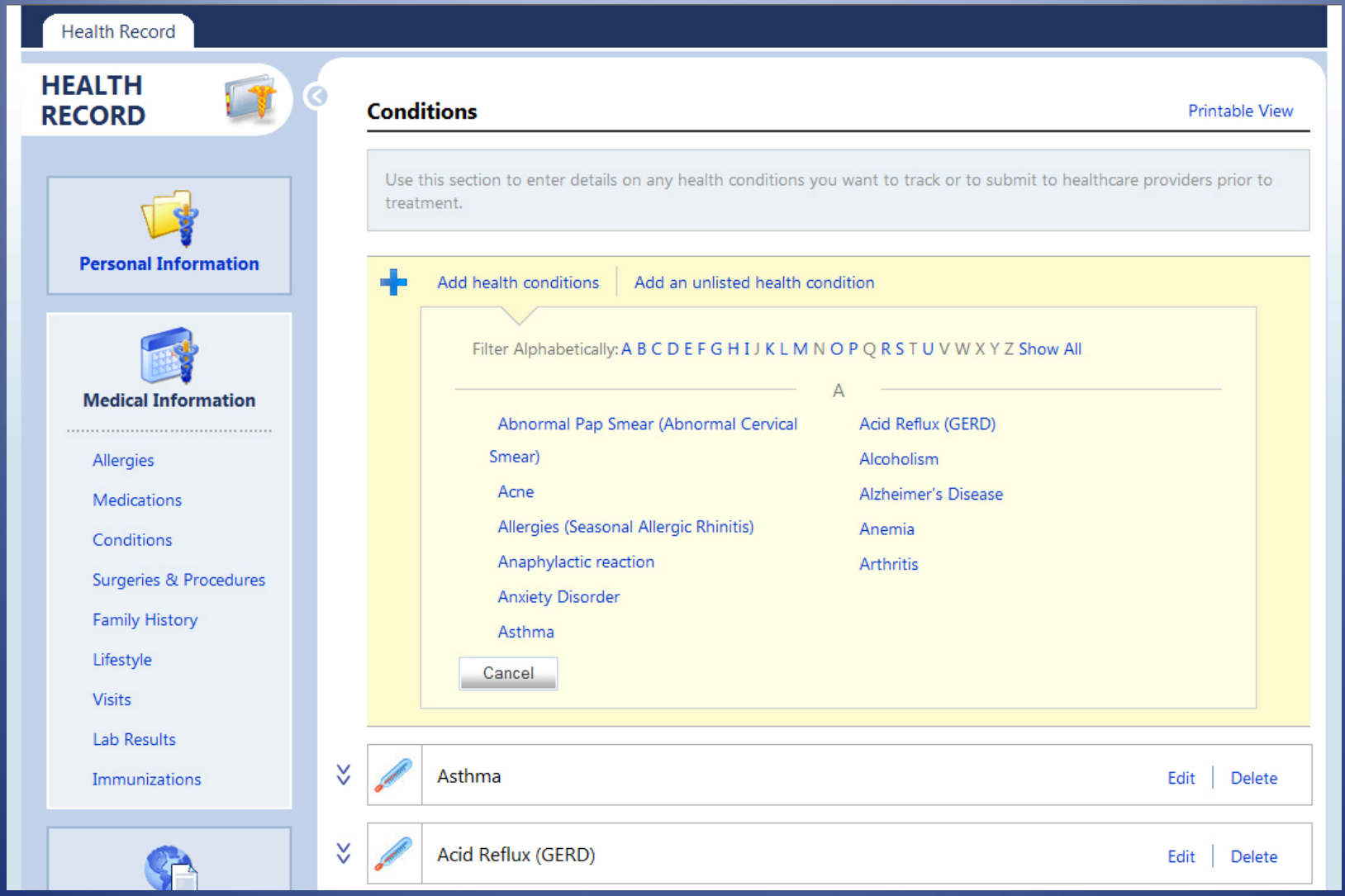
Consumer View of Healthe Record – Conditions



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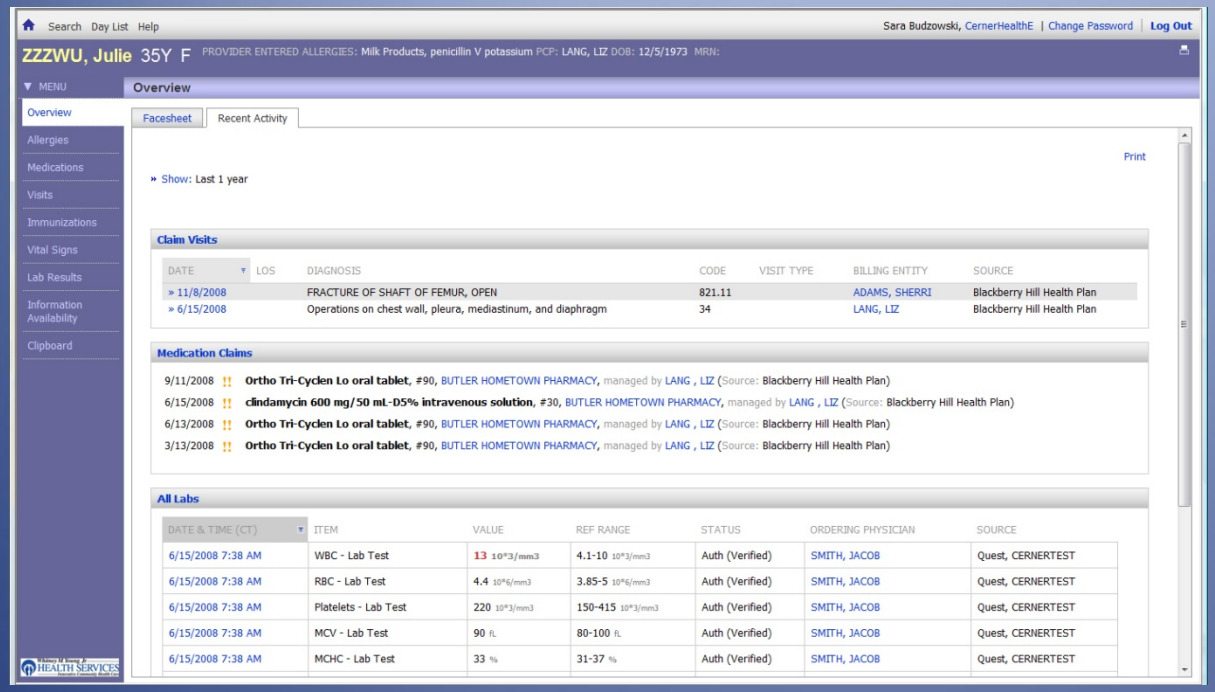
Provider View of the Healthe Record



- **Provides a secure, longitudinal view of health information to improve care coordination, reduce errors, and eliminate waste**
- **Accessed via a Web browser**
- **Monitor prescription compliance**
- **Providers have the ability to view:**
  - **Medications**
  - **Visit History**
  - **Lab Results**
  - **Immunizations**
  - **Allergies**
  - **Vital Signs**
- **View consumer entered "clipboard" information**

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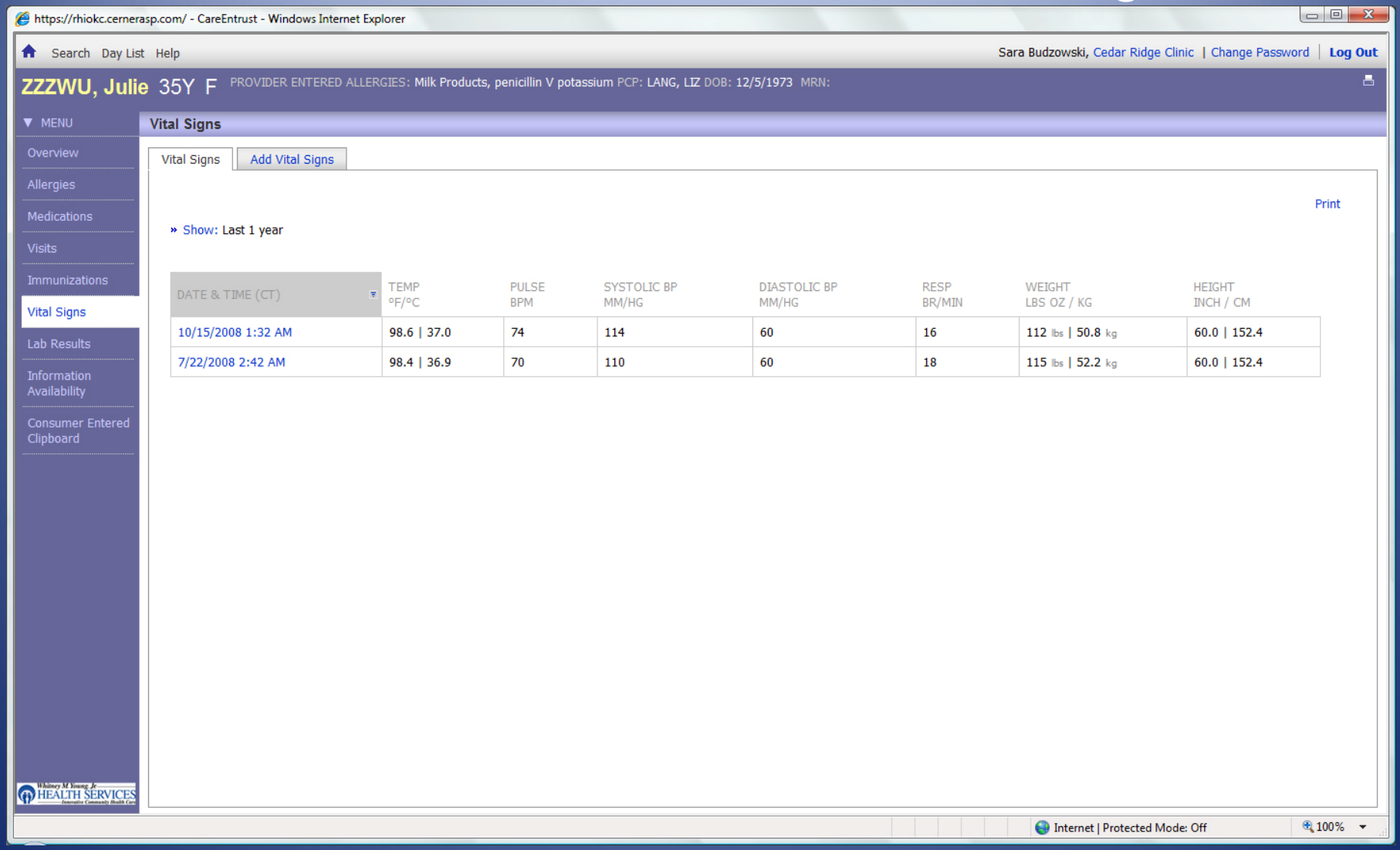
Provider View of Healthe Record – Vital Signs



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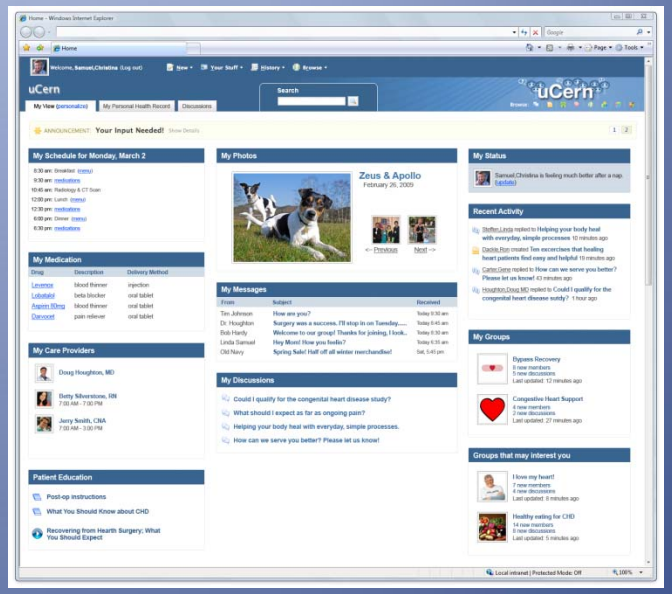
Social Networking Site

- Used to connect enrollees, friends of the enrollees, and clinicians to share information and help others learn from their knowledge and experiences.



- Helpful information for managing health:
  - Informational Videos
  - Patient Education Information
  - Calendar of Events
  - RSS Feeds – timely updates from favored websites
  - Nutrition Information
  - Blog/Patient Diary

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