



To have data from all multiple sources throughout the network in one place in structured tables makes analytics that much easier. The EDW allows everyone, across the system, to pull data from the same place.

Maryann Vienneau
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Our care managers are most proud of making a difference in patients' lives across the continuum over time.

Jennifer Wright, R.N.
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Meeting varied patients' needs

The list of candidates for the iCMP is reviewed by the PCP and nurse care manager, who assess each patient's needs and discuss additional qualitative information that may not be adequately represented within the claims data. Together, the PCP and nurse select patients who are appropriate for the iCMP.

While the care managers focus on ensuring availability of appropriate care for patients who may need additional community resources or mental health support, they also identify other, atypical areas where support is needed.

One example of this is a patient, who was being supported by an iCMP care manager, who had regular monthly appointments with her PCP to treat her venous stasis ulcers, a type of wound that develops as a result of decreased blood return to the heart. Each month, the PCP would direct the patient to wear her compression stockings, which are designed to help increase blood flow back to the heart. Unfortunately, this patient did not wear the stockings as directed, and each month the PCP would restate the importance of wearing the stockings, expressing concern about the patient's ulcers and sharing how the stockings would help improve the current ulcer and prevent additional ulcers from developing. The patient's ulcers were not going to get better unless she wore the compression stockings.

The care manager noticed that the patient only wore red clothing from head to toe. The care manager was certain that the reason the patient would not wear the compression stockings was because they were not red. Upon bringing this discovery to the PCP's attention, the care manager obtained red compression stockings. The patient immediately began wearing her new, red compression stockings and her problem with venous stasis ulcers was eliminated.

Data helps with strategic decision making

Through the EDW, analytics platform, and care managers who are skilled at assessing and meeting patient needs, Partners is able to gain valuable insight about patients who are candidates for the iCMP, as well as plan cost-effective care to best meet the patients' needs.

Analytics supports both strategic decision making and the operations of the iCMP. IT systems improve care coordination, leveraging real-time data from the EHR. For example, when an iCMP patient is registered in the EHR for care in the ED or for an inpatient bed, an automated page goes out to the patient's PCP and iCMP care manager for the patient. Additionally, flags noted in the EHR identify



We've made wonderful progress. We're very comfortable that we've created a product for this group of patients that is really quite effective and clinically meaningful and that our providers really like.

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iCMP patients, helping to ensure the care team is aware of the additional care team members involved in the patients' care who should be contacted when the patient presents to the ED or is admitted to the hospital.

RESULTS

The iCMP has provided positive clinical outcomes and financial benefits for at-risk contracts. Claims data from the EDW applied in the risk modeling software has resulted in the identification of more than 50,000 at-risk patients. Approximately 14,000 patients actively participate in the iCMP.

In its Pilot Phase as a Medicare Demonstration Project, when compared to a similarly selected control population, the program achieved the following results:

- 20 percent lower hospitalization rate per 1,000 patients.
- 13 percent lower rates of ED utilization.
- 25 percent relative difference in mortality (16 percent in iCMP patients vs. 20 percent among the comparison group).
- 12.1 percent gross savings.
- 7 percent in annual net savings after the management fee paid by CMS.
- Positive ROI—for every \$1 spent, the program saved at least \$2.65.

While the financial savings are impressive, communication among care team members has also increased, as have physician, staff, and patient satisfaction. Physicians have stated that they have better work-life balance and are satisfied they are able to focus on the most effective medical management of the patient, while other team members use their skills to help patients overcome social, behavioral, and informational barriers to care.

WHAT'S NEXT

As part of the broader population management strategy, Partners has expanded the iCMP systemwide and is broadening efforts, offering the program to pediatric patients

Partners is also considering enhancements to their care management model, moving to a triad model that expands leadership to include a social worker and community health worker who would each manage cohorts of patients that would benefit the most from their specific expertise.

Partners is also continuing to expand and improve population health and redesign primary care practices to make them more efficient and a better experience for patients and care team members. By the end of 2018, all Partners primary care practices will receive Patient-Centered Medical Home certification. 📌

REFERENCES

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2. Massachusetts Health Connector. (n.d.). *The top ten facts about Massachusetts health care reform*. Retrieved from <https://betterhealthconnector.com/wp-content/uploads/reports-and-publications/10FactsPoster.pdf>

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