Strengthening Care Management with Health Information Technology

Learning Guide Executive Summary

By unleashing the power of health IT to support care management, Beacon Communities\(^1\) were able to expand, enhance and improve the quality of a range of care management services in order to improve care transitions and chronic disease management, and better engage patients.

This Learning Guide mobilizes knowledge and lessons learned from five federally-funded communities\(^2\) that undertook and implemented IT-enabled care management strategies. These communities demonstrated the central role that health IT can play in strengthening care management to improve patient and population health.

Inside the Learning Guide

Setting the Stage for Success. The Learning Guide begins with a review of foundational elements that can accelerate successful community deployment of health IT enabled care management functions. These elements include the presence of existing collaborative partnerships, the commitment of key stakeholder leadership to advancing care management, the presence or establishment of common goals that strong care management can facilitate, and local experience with collaboration across institutional walls. The Learning Guide is designed for communities that are:

- Interested in using health IT to support the integrated and comprehensive delivery of care management services.
- Leaders in bringing together stakeholders to develop a vision for a highly functioning care management system.

\(^1\) The Department of Health and Human Services, Office of the National Coordinator for Health IT (ONC) provided $250 million over three years (2010-2013) to 17 selected communities throughout the United States to build and strengthen health IT infrastructure, test innovative approaches, and make strides toward better care, better health, and lower costs.

\(^2\) The five communities that provided in depth information about their experiences for this Learning Guide are: Bangor Beacon Community (Maine), Greater Cincinnati Beacon Collaboration (Ohio), Keystone Beacon Community (Pennsylvania), Southeast Minnesota Beacon Community, and Southern Piedmont Beacon Community (North Carolina).
Reorganizing their health care delivery system to incorporate new models of outcome-oriented, value-based care in which care management plays a vital role, for example, Patient-Centered Medical Home (PCMH) models and Accountable Care Organizations (ACO).

Lessons from the Beacon Community Experience. The communities that contributed to this Learning Guide exist in a wide range of markets, from highly integrated health care delivery to those with little connection between systems. The learnings from these communities are organized into five Strategic Objectives that reflect the key components of deploying IT-enabled care management within a community. The Strategic Objectives are as follows:

1. **Build collaboration, consensus, and commitments among key stakeholders around shared goals for IT-enabled care management.**

The experiences of these Beacon Communities consistently demonstrated that buy-in, a feeling of ownership, and commitment of the leadership of each stakeholder organization are critical for successful deployment of IT-enabled care management services. This section of the Learning Guide also discusses the importance of clarity around the technological and financial feasibility for each stakeholder organization, and how the Beacons achieved this.

2. **Identify and select health IT tools to drive care management goals.**

There are several steps involved in identifying and selecting health IT tools to drive care management goals. In identifying and selecting their health IT tools, communities looked at how tools aligned with various care management functions, considered which care management models would benefit most from the deployment of health IT tools, and determined how their chosen approach would be measured and evaluated. This portion of the Learning Guide includes a discussion of the tools each of the five contributing communities used to support care management functions.

3. **Identify data elements and data sources, and establish DUAs necessary to support care management.**

Capturing key data elements is required both to implement and evaluate the efforts. As part of the third Strategic Objective, the Learning Guide summarizes the ways in which communities can identify required data elements and their sources, and collect, aggregate and feed the data into the selected care management tools. This section also discusses the process for establishing Data Use Agreements (DUAs), which are necessary for the secure exchange of health information across providers and other stakeholders within a community.
4. Support physician practices in implementing the technology and care management approach, including revised clinical workflows and change management.

This section of the Learning Guide covers business process considerations for clinical practices, including testing and refining the technology, clarifying the roles of each care team member, redesigning clinical and administrative workflows, and training users for changes in workflow and technology adoption. While addressing technical and data implementation needs for deploying health IT to support care management, it is vital for communities to look at the implications for clinical staff responsibilities and workflows.

5. Empower patients to take control of their own health through education and self-management.

A primary aim of care management is to empower patients to become self-activated, better manage their own care, and work with their care teams as partners in health. This section discusses the Beacon communities’ learnings around bolstering care management with patient-facing health IT tools that provide secure patient-provider communication, that facilitate access to their health history, that increase health literacy, that enable self-monitoring, and that facilitate interactive tracking of progress toward health goals.

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