

ISSUE

To improve chronic illness care for Californians through

- Partnering of community stakeholders (purchaser, provider, health plan, technology provider) to make connections that are meaningful for patients across the span of health management
- Patient and family involvement in their care via enabling, participatory, technology (Health 2.0)

FOCUS

This Pilot is one of three emphases within the 2008 Strategic Plan for Patient Access:

- By 2010, 20% of patients with chronic illness in California will have access to an understandable version of their clinical information/data
- “California Healthcare Foudnation will be a catalyst and partner for patient engagement

CURRENT CONDITION

- 30 % of Californians have hypertension, 35 % with adequate control
- Hypertension is the costliest chronic illness for employers: \$392/employee/year (\$44,448 wage base)



Stakeholder engagement in portions of the care cycle

- EMC (Massachussets), Intel, IBM (& Paitient Centered Primary Care Collaborative), Google, Microsoft, other technology providers supporting community/participation

PROBLEM ANALYSIS

Gaps in Chronic Illness Care • “harm is only seen in the aggregate; responsibility is diffuse”

- Physician recognition of mildly elevated (typically systolic) blood pressure is variable
- Limitations of office vs. home based monitoring of blood pressure
 - Overtreatment of white coat / undertreatment of masked hypertension
- Limited perception of cost for any single stakeholder (patient, provider, employer, payer)
 - Unlike most chronic conditions, indirect costs are greater for hypertension relative to medical expenses

Gaps in Technology Use

- Majority of providers are not interacting with patients between visits to manage high blood pressure
 - Few role models outside of integrated care systems to spur adoption across the medical community
- Consumers with with electronic access cannot consolidate clinical data across providers / platforms
- Current solutions have not been tied together to demonstrate value to patients and payers
 - Example: home blood pressure monitoring with automatics uploading, secure e-mail, lab test result review, plan design and incentives
- Many concepts are theoretical and haven't been tested yet
 - Example, robust home blood pressure monitoring program tied to employer and/or provider engagement to manage hypertension

TARGET CONDITION

Infrastructure and capability: A functioning consumer connectivity solution to engage patients and stakeholders in the care of around chronic conditions (applicable across conditions)

Test Case: Hypertension (applicable to one condition).

ACTION PLAN

Activity	A	M	J	J	A	S	O	N	D
CASE BASED REVIEW									
CASE: EMPLOYER/PURCHASER CENTRIC	█	█							
CASE: PROVIDER CENTRIC		█							
CASE: CONSUMER CENTRIC		█							
DETERMINATION OF BEST FEATURES AND PILOT FOCUS		█	█						
IDENTIFICATION OF PARTNERS / ROLES		█	█	█	█				
POTENTIAL PARTNER MINI-SUMMIT AT CHCF			█	█					
APPROVAL BY BOARD						█			
AGREEMENTS IN PLACE							█	█	
BEGIN ACTIVITY (2009)									

COST-BENEFIT / WASTE REDUCTION

- Component connectivity - monitors, portal, workflow
- Reduced unnecessary visits for routine blood pressure monitoring
- Increased necessary office visits for uncontrolled or masked hypertension (if seen < 1 time in last 12 months)
- Reduced expenditure on 2nd or 3rd line agents
- Potential integration with P4P incentives - demonstration along with new measure

FOLLOWUP/UNRESOLVED ISSUES

Measures of success

- Ongoing measurement of patient access/engagement - PBGH Survey In Development
- Clarification of P4P and HEDIS hypertension measures in 2009
- Clarification of measurement of productivity loss / presenteeism case - Retain Clinical Champion
- Partnerships and interest alignment - Due diligence on business models
- Availability of technology solutions by 2009 - Work with CHCF consultant to evaluate capabilities
- Eliciting patient engagement - Site visits to employers and recruitment of patient advisors to assist