PraCMan

Hausarztpraxis-basiertes Case Management

UniversitätsKlinikum Heidelberg

Hausarztpraxis-basiertes Case Management bei multimorbide Patienten im höheren Lebensalter

MDK Nord Kompetenzzentrum Geriatrie
Expertenforum Hamburg 2017
„Neue Möglichkeiten der ambulanten geriatrischen Versorgung – Konzepte und innovative Praxisbeispiele “

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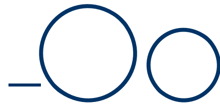
Weltweite Zunahme des Anteils (mehrfach) chronisch erkrankter Patienten (WHO 2008, GEK 2010)

Multimorbidität in der Hausarztpraxis „Regel statt Ausnahme“
(Fortin *Ann Fam Med* 2005, Glynn *Fam Pract* 2011)

Multimorbidität nicht *nur* bei Patienten über 65 Jahren (Laux *BMC Health Serv Res* 2008, Holden *Popul Health Metr* 2011)

Das Problem

- Steigende Zahl von Arzneimittelverschreibungen und Konsultationen im ambulanten Bereich
  (Laux 2008, Glynn 2011)
- Steigende Versorgungskosten insgesamt
  (Glynn 2011, Wolff 2002)
- Vermehrte Zahl von (potentiell vermeidbaren) Krankenhausaufenthalten (Wolff *Arch Intern Med* 2002)



Strategies for Reducing Potentially Avoidable Hospitalizations for Ambulatory Care–Sensitive Conditions

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ABSTRACT

PURPOSE Hospitalizations for ambulatory care–sensitive conditions (ACSCs) are seen as potentially avoidable with optimal primary care. Little is known, however, about how primary care physicians rate these hospitalizations and whether and how they could be avoided. This study explores the complex causality of such hospitalizations from the perspective of primary care physicians.

METHODS We conducted semistructured interviews with 12 primary care physicians from 10 primary care clinics in Germany regarding 104 hospitalizations of 81 patients with ACSCs at high risk of rehospitalization.

RESULTS Participating physicians rated 43 (41%) of the 104 hospitalizations to be potentially avoidable. During the interviews the cause of hospitalization fell into 5 principal categories: system related (eg, unavailability of ambulatory services), physician related (eg, suboptimal monitoring), medical (eg, medication side effects), patient related (eg, delayed help-seeking), and social (eg, lack of social support). Subcategories frequently associated with physicians' rating of hospitalizations for ACSCs as potentially avoidable were after-hours absence of the treating physician, failure to use ambulatory services, suboptimal monitoring, patients' fearfulness, cultural background and insufficient language skills of patients, medication errors, medication nonadherence, and overprotective caregivers. Comorbidities and medical emergencies were frequent causes attributed to ACSC-based hospitalizations that were rated as being unavoidable.

CONCLUSIONS Primary care physicians rated a significant proportion of hospitalizations for ACSCs to be potentially avoidable. Strategies to avoid these hospitalizations may target after-hours care, optimal use of ambulatory services, intensified monitoring of high-risk patients, and initiatives to improve patients' willingness and ability to seek timely help, as well as patients' medication adherence.

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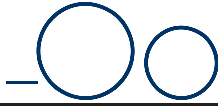
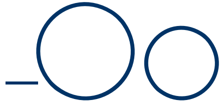


Attributed Causes[a]	Potentially Avoidable No. (%)	Not Avoidable No. (%)
Total	43 (41)	61 (59)
System level	19 (63)	11 (37)
Absence of treating physician	7 (70)	3 (30)
Unavailability of ambulatory services	5 (50)	5 (50)
Failure to utilize ambulatory services	7 (88)	3 (12)
Physician level	12 (38)	20 (62)
Diagnostic uncertainty	2 (25)	6 (75)
Ambulatory treatment failure	4 (24)	13 (76)
Suboptimal monitoring	6 (86)	1 (14)
Medical	19 (19)	82 (81)
Medication side effects	1 (17)	5 (83)
Medical emergency	0 (0)	33 (100)
Somatic comorbidity	9 (24)	29 (76)
Psychiatric comorbidity	3 (33)	6 (67)
Substance abuse	2 (33)	4 (67)
Fall	4 (44)	5 (56)
Patient level	45 (54)	38 (46)
Fearfulness	7 (64)	4 (37)
Cultural background	5 (56)	4 (45)
Insufficient language skills	6 (67)	3 (33)
Delayed help seeking	5 (71)	2 (29)
Medication error	4 (100)	0
Medication nonadherence	11 (52)	10 (48)
Nonmedication nonadherence	6 (38)	10 (63)
Cognitive impairment	1 (17)	5 (83)
Social level	9 (45)	11(55)
Lack of social support	5 (46)	6 (55)
Overprotective caregiver	3 (75)	1 (25)
Overstrained caregiver	1 (20)	4 (80)

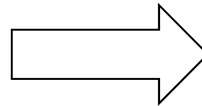
[a] Multiple causes could be attributed to each ambulatory care–sensitive hospitalization.

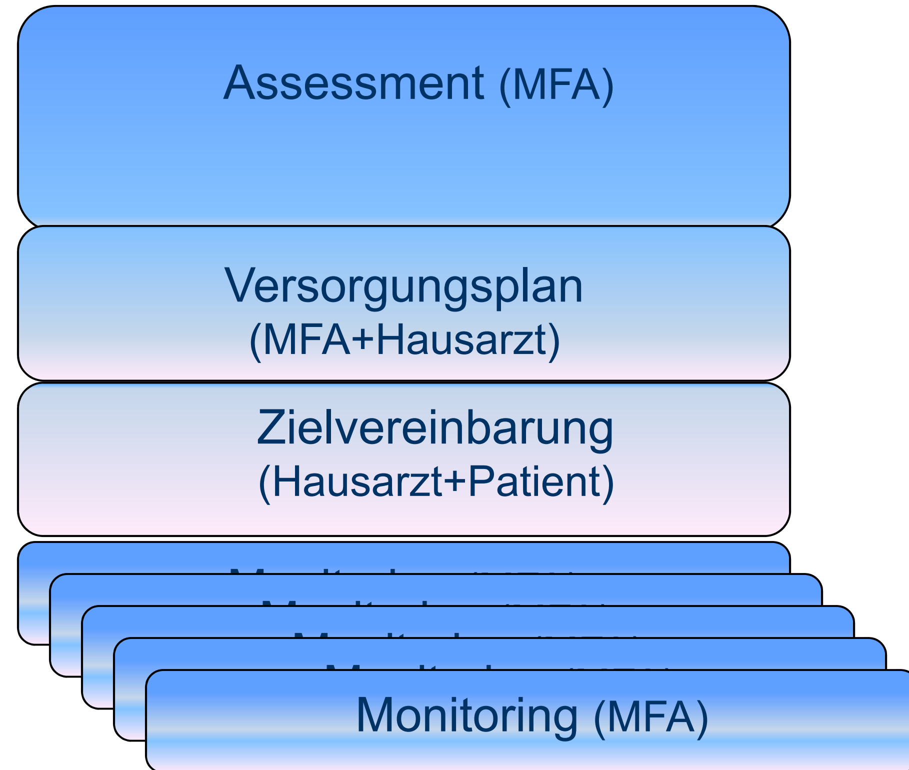
43/104 „vermeidbare Hospitalisierungen“(41%)

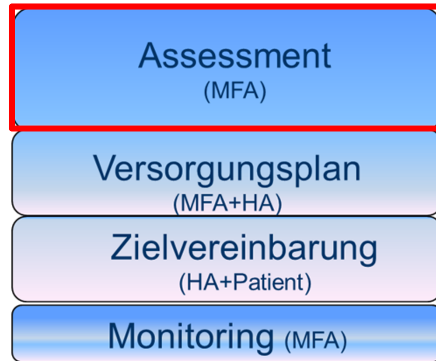
- Systemebene (63%)
- Arztebene (38%)
- Medizinisch (19%)
- Patient (54%)
- Soziales (45%)



Patienten mit statistisch hohem KH-Einweisungsrisiko

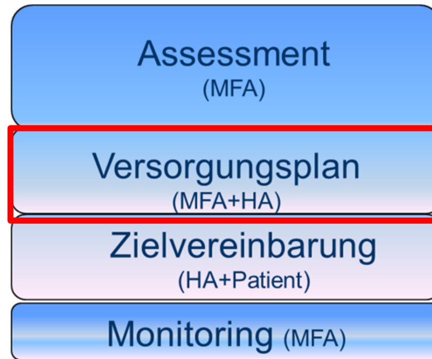






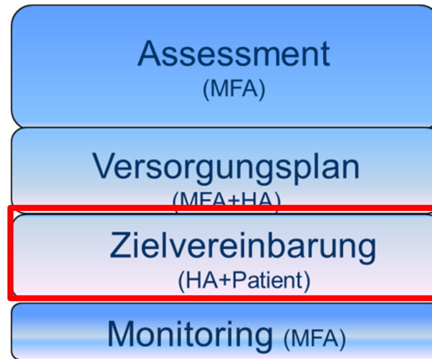
Assessment

- Geschulte MFA
- Praxis od. Hausbesuch (10%)
- Dauer: ø 35 min (MFA)
- Inhalt:
  - Allergien/Impfstatus
  - Medikamente (incl. Adhärenz, „brown-bag-review“)
  - Depressionsscreening
  - …



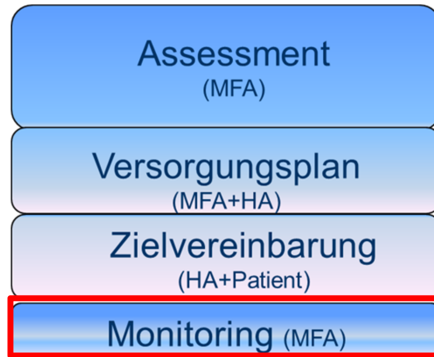
Versorgungsplan

- Übergabe Assessmentergebnisse an den Arzt
- „Ideenspeicher“ für weitere Planung
- Softwarebasierte Dokumentation
- Dauer: ⌀ 14 min
  (MFA-Arzt)



Zielvereinbarung

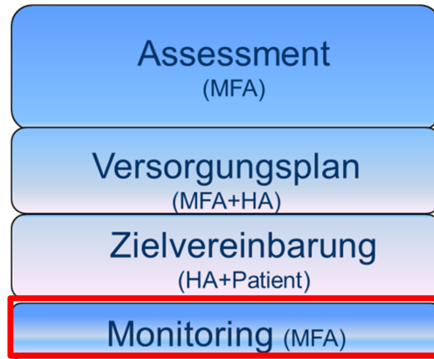
- Priorisierung der Patientenziele
- Shared-Decision-Making
- Einbezug von Angehörigen
- Patiententagebuch



Monitoring

- Individualisierte Inhalte:
  - Allgemeines Modul
  - Diabetes-, COPD-, Herzinsuffizienz- und Depressionsmodul
  - **Coaching**
- Angepasste Frequenz:
  - alle 1-6 Wochen

  Dauer: Ø 12 + 5 min



Ampelschema

Gefahr – sofort Arztkontakt

Unauffällig

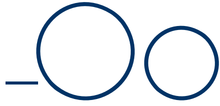
A1 **Haben Sie NEU aufgetretene Brustschmerzen oder ein NEU aufgetretenes Engegefühl in der Brust (Angina Pectoris)?**

(•) Ja ( ) Nein

Wie lange haben Sie diese Schmerzen / dieses Engegefühl schon?

( ) Seit heute
( ) Seit Tagen
(•) Seit mehreren Wochen oder länger

Baldige Aktion: Termin innerhalb von 24 h/ Bericht



Evaluation PraCMan

Cluster randomisierte Studie in Baden-Württemberg (D)
115 Praxen mit 132 Teams (2.076 Patienten)

Intervention:	Hausarztzentrierte Versorgung + CM
Kontrolle:	Hausarztzentrierte Versorgung
Population:	DM Typ II, COPD, Herzinsuffizienz
	≥ 75. Perzentile KH-Aufnahme-wahrscheinlichkeit
	Alter ≥ 18 Jahre
Dauer:	24 Mon. Intervention
Prim. Endpunkt:	KH-Aufenthalte in den ersten 12 Monaten

(Freund et al. *Trials* 2011)

Annals of Internal Medicine

ORIGINAL RESEARCH

Medical Assistant–Based Care Management for High-Risk Patients in Small Primary Care Practices

A Cluster Randomized Clinical Trial

Tobias Freund, MD; Frank Peters-Klimm, MD; Cynthia M. Boyd, MD; Cornelia Mahler, MA; Jochen Gensichen, MD; Antje Erler, MD; Martin Beyer, MA; Matthias Gondan, PhD; Justine Rochon, MSc; Ferdinand M. Gerlach, MD; and Joachim Szecsenyi, MD

Background: Patients with multiple chronic conditions are at high risk for potentially avoidable hospitalizations, which may be reduced by care coordination and self-management support. Medical assistants are an increasingly available resource for patient care in primary care practices.

Objective: To determine whether protocol-based care management delivered by medical assistants improves care in patients at high risk for future hospitalization in primary care.

Design: Two-year cluster randomized clinical trial. (Current Controlled Trials: ISRCTN56104508)

Setting: 115 primary care practices in Germany.

Patients: 2076 patients with type 2 diabetes, chronic obstructive pulmonary disease, or chronic heart failure and a likelihood of hospitalization in the upper quartile of the population, as predicted by an analysis of insurance data.

Intervention: Protocol-based care management, including structured assessment, action planning, and monitoring delivered by medical assistants, compared with usual care.

Measurements: All-cause hospitalizations at 12 months (primary outcome) and quality-of-life scores (12-Item Short Form Health Survey [SF-12] and EuroQol instrument [EQ-5D]).

Results: Included patients had an average of 4 co-occurring chronic conditions. All-cause hospitalizations did not differ between groups at 12 months (risk ratio [RR], 1.01 [95% CI, 0.87 to 1.18]) and 24 months (RR, 0.98 [CI, 0.85 to 1.12]). Quality of life (differences, 1.16 [CI, 0.24 to 2.08] on SF-12 physical component and 1.68 [CI, 0.60 to 2.77] on SF-12 mental component) and general health (difference on EQ-5D, 0.03 [CI, 0.00 to 0.05]) improved significantly at 24 months. Intervention costs totaled $10 per patient per month.

Limitation: Small number of primary care practices and low intensity of intervention.

Conclusion: This low-intensity intervention did not reduce all-cause hospitalizations but showed positive effects on quality of life at reasonable costs in high-risk multimorbid patients.

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For author affiliations, see end of text.
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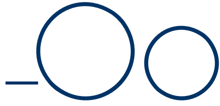
	Case Management (n=1.093)	Kontrollgruppe (n=983)
Alter	72 Jahre	72 Jahre
Spannweite	29-94 Jahre	22-96 Jahre
Pat < 65 Jahre	235 (22%)	192 (20%)
Geschlecht weiblich	569 (52%)	514 (52%)
Vorhergesagte KH-Aufnahmewahrscheinlichkeit (LOH)	34%	34%
Anzahl Komorbiditităten	4 (1-15)	4 (1-12)

Ergebnisse

- ✓ **Verbesserte Lebensqualität**
  - ✓ Psychische und physische Lebensqualität (SF12)
  - ✓ Gesundheitsstatus (EQ5D)
- ✓ **Verbessertes Überleben**
  - ✓ 52% längere Überlebenszeit in 12 Monaten

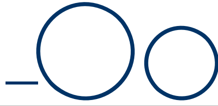


Krankenhausaufenthalte nach Entlassdiagnose (2 Jahre)

	Case Management	Kontrolle
Typ II DM	0,06	0,09
COPD	0,14	0,26
Herzinsuffizienz	0,21	0,26

Breitenimplementierung

- AOK Baden-Württemberg bietet das Modell seit Juli 2014 allen geeigneten Versicherten im Rahmen des Vertrages zur Hausarztzentrierten Versorgung an
- Versorgungsmanagement in den Praxen wird unterstützt durch eigene Software
  (PraCMan Cockpit)
- Im 1. Quartal 2017 waren mehr als 13.900 Versicherte in ~ 600 Praxen eingeschrieben
- Verhandlungen mit weiteren Kassen laufen



PraCMan-Cockpit

Hausarztpraxis-basiertes Case Management

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Das Versorgungsmodell PraCMan

Hausarztpraxis-basiertes Case Management für chronisch kranke Patienten

Einleitung

Was ist PraCMan?

PraCMan steht für ein praxisorien
die speziell auf ausgewählte chro

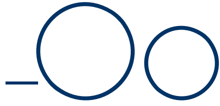
- Praxisnahe Prozesssteuerung
- Vereinfachte Dokumentation
- Datensicherheit

Welche Ziele hat PraCMan?

- Verbesserung der Versorgung chronisch kranker Patienten durch eine engmaschige Betreuung
- Verringerung von (vermeidbaren) Krankenhausaufenthalten

Über das System

Hier finden Sie ein Flussdiagramm, welches Ihnen den Ablauf des Casemanagement mittels PraCMan aufzeigt:



Vielen Dank für Ihre Aufmerksamkeit!

Kontakt

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