icw®
Technology for Health

ICW Care Management

Care Pathways across all Venues

connect. manage. personalize.

Proactive Patient centered Care Management

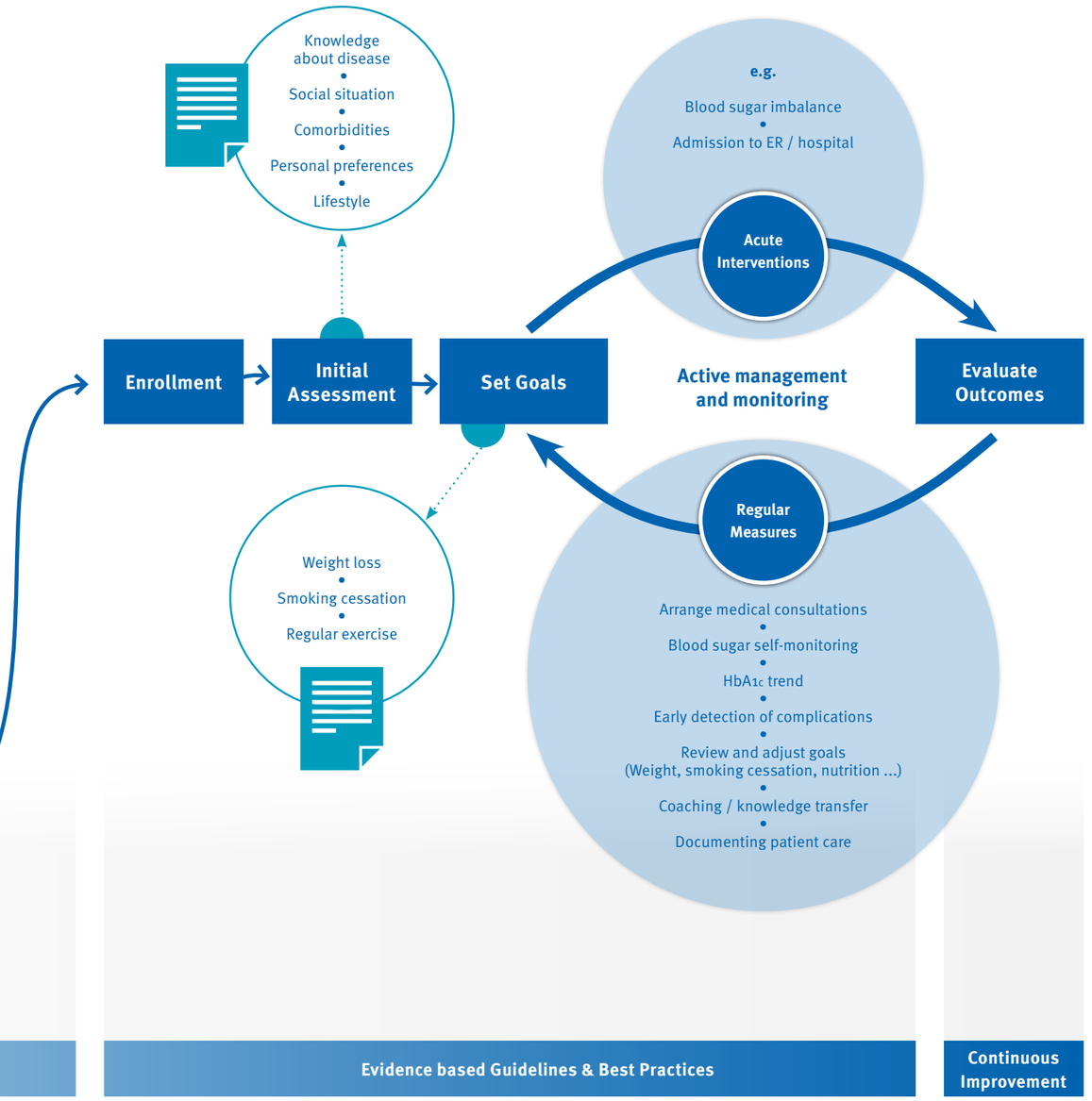
Recent experience has shown that a significant level of care coordination is required for the long-term success of ACOs and other healthcare organizations participating in value-based reimbursement programs. This burden should not be placed directly on the physicians, especially not on the PCPs, who are already faced with a substantial volume of work that is not directly related to the treatment of their patients. As a consequence, a growing number of healthcare organizations have started to rely on nurse care managers to increase their care management workforce. While PCPs continue to be the patients‘ first point of contact for face-to-face visits, diagnostic tests or prescriptions, care managers stay in touch with patients between office visits, follow up with them about physician instructions and care plans, help with medication adherence, organize care transitions, address the patients‘ psycho-social needs or work with them on improving their health literacy. Offering these services reduces total cost of care for patients with chronic diseases and comorbidities in addition to improving their health.

Any successful patient-centered care management service must be backed by a sustainable IT strategy. Traditional EHRs put their focus on episodic care delivered by individual providers and therefore quickly reach their limits when trying to address the specific needs of managing care across all venues on a community. The ICW Care Management (ICW CM) solution was developed to precisely meet the needs of organizations who are introducing community-wide care management services. It is an efficient web based solution for team-oriented, cross-organizational care management. The dynamic work processes within the community can be represented flexibly according to an organization’s individual requirements.

ICW Care Management puts a community-wide electronic care plan at the center of a care manager‘s daily work. This care plan is focused on physical, mental, cognitive, psychosocial, functional and environmental assessments and an inventory of resources. As such, it provides an overview of all relevant problems, medications and planned interventions. To make the care plan accessible for the whole community, it can be easily shared with all of the patient’s providers, family or caregivers. Additional key components of include a comprehensive patient record, a context-aware rules and workflow engine, electronic forms technology and a growing care pathway library.

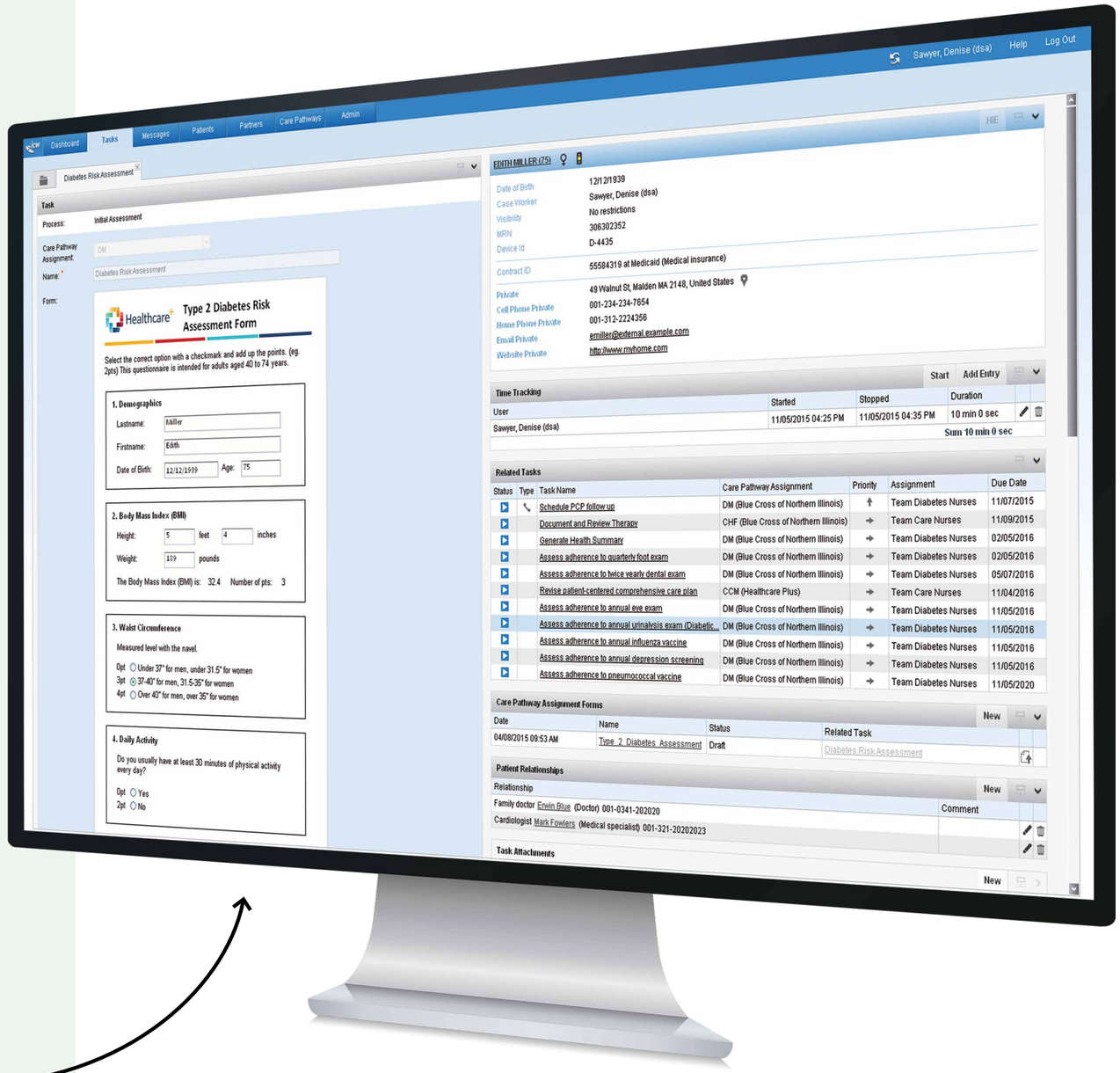
ICW Care Management allows cross-institutional care processes to be efficiently managed and monitored. As a result, all patients receive care that is ideally suited to their needs.

Example of workflow-based diabetes management with ICW Care Management



The advantages at a glance

- **The right care to the right patient at the right time:** Implementation and monitoring of evidence-based guidelines and individual best practices as care pathways
- **Reduced risk of a worsening patient health status:** Prompt rule-based alerting in the event of acute incidents
- **Time savings:** Prioritized task list with planned care tasks ensure the optimal allocation of the resources
- **Improved patient outcomes:** Comprehensive, unified single view of patient record through Integration with Health Information Exchange support better clinical decision-making and risk analysis
- **Timely care:** Quick intervention through actionable notifications created in the event of acute incidents derived from inbound data and documents, or from professionals maintaining or extending data
- **Increased effectiveness of care processes:** Planning, execution and monitoring of cross-institutional care processes with care providers of different specialties and in multiple settings
- **Improved communication:** Build-in messaging functionality enables communication between care team members and patient



Example of form-based risk assessment for type 2 diabetes

The right IT strategy

An innovative and future-safe tool is needed that can do more than the established IT systems in health care. ICW CM was developed precisely to meet these requirements.

The whole process starts with the patient's enrollment into Care Management. This is usually triggered by certain transitions of care – such as discharge from the hospital – or via registration through an ACO's beneficiaries' lists. It is also possible to register patients via enrollment lists generated by ambulatory or hospital EHR systems or by healthcare analytics applications.

Community-wide shared Care Plan

After a patient's initial enrollment into CM a care plan for that patient is created. The care plan represents the overall care strategy for a patient and ultimately drives the desired outcomes. To achieve this, it covers all relevant facets of patient centered care: Current problems, diagnoses, medications, allergies or recent lab results, planned and ongoing interventions, referrals, care goals and barriers to meeting the goals. Each patient has a unique care plan that fits his or her individual needs. The care plan helps managing long-term chronic care as well as short-term care transitions such as discharge from hospital. The care plan is a multidisciplinary tool receiving frequent updates and revisions based upon the patients' health status and care needs.

Care Pathways and Task-driven Work Model

Providing effective and cost-efficient care is crucial for the success of any healthcare organization in value based contracts. Evidence based care pathways help care managers to plan the right interventions at the right time depending on the patients' individual conditions. A care pathway usually represents clinical best practices for the treatment of a specific condition (such as diabetes, COPD or CHF). However, it is not limited to providing guidance about interventions and assessments, but also about their timely sequence or the appropriate venues. The Care Management solution can reference a standard pathway library that is focused on protocols for ambulatory and community-based care and can be customized to a care delivery organization's specific needs. In addition to the clinical decision support, customer-specific pathways can also be used to drive administrative processes and workflows such as discharge planning or referral coordination. Technically, care pathways are realized using the solution's integrated rules and workflow engine.

By automating repeating tasks – such as sending out reminders to patients or scheduling follow-up phone calls – the administrative workload for care managers can be significantly reduced, freeing time to spend with patients. The efficiency is further increased by the ability to check off tasks automatically based on changes of the patient's clinical record.

Events that require the care manager's attention – e.g. a visit to the ER – are shown as alerts. Task lists are used to present a care team's or an individual care manager's upcoming work items. Team managers can change task assignments and task due dates. This approach enables care teams to efficiently plan the tasks to be addressed in a given time frame and to balance the work load according to the team's resource availability.

Patient Record

Timely access to comprehensive and up-to-date clinical information is essential for effective care management. The built-in patient record provides a wide range of structured clinical data including problems, diagnoses, medications, procedures, immunizations and labs. In this context the ability to connect to existing primary sources ensures that the patient record is constantly kept up to date with data from facilities across the community.

Electronic Forms

For ongoing clinical documentation intelligent electronic forms are integrated, which can be designed intuitively and comfortably with ICW FormDesigner. Electronic forms can be used to fulfill client/project specific documentation needs such as capturing additional (e.g. non clinical) information from patients or service providers and make the data available for evaluation.

Integration with EMRs and HIEs

ICW CM provides all interfaces required for deep integration with existing applications. Supporting IHE profiles CM can be connected to Health Information Exchange (HIE) and Master Patient Index (MPI) solutions. By relying on open standards like CCD and HL7 customers can avoid vendor lock-in and reduce integration costs. Additionally we provide extensive APIs to also integrate within non-standard environments.

With the ICW Care Management, managed care organizations get the ideal solution for meeting the requirements of modern care management — patient care is manageable, the care teams are perfectly coordinated, and the results are transparent.

Example:

The care plan can specif y that a patient with diabetes should visit an eye specialist every six months. ICW Care Management notifies the care team in advance to make an appointment. The solution then automatically checks in the background that a repor t by the eye specialist appears in the patient's clinical record within two weeks, and then closes the task without fur ther manual interaction. If the repor t does not appear, a reminder task is created.

The ICW CM components

- **Community-wide care plan with all relevant patient-centered information ready to be shared with all members of the care team, e.g. family members, patient and providers**
- **Comprehensive patient record for administrative, claims, clinical, and nursing information**
- **A context-aware workflow and rules engine for individual modeling and control of treatment and care processes and individual goals**
- **Task-oriented display of all processes: allocation of tasks to teams or individuals, and rule- and Event-controlled creation of tasks and status changes**
- **Alerting: Configurable notifications about acute events in real time, such as hospitalization or laboratory values that are outside normal limits**
- **Innovative electronic forms technology: flexible and intelligent forms to meet client/project specific documentation needs – such as patient questionnaires or organization-specific documentation, support of dynamic form content including calculations, structured data storage, access to form content by the workflow engine, and the possibility to evaluate form content**
- **Integrated e-mail client to be used in secure e-mail communication environments**
- **Extensive Interfaces for deep integration with existing applications based on HL7, IHE integration profiles and CCDA documents including the option to integrate via proprietary formats (for example device data and configurable batch import) and API**
- **Extensive service and support for defining and implementing care pathways and forms, including user support when the system is introduced and later on**

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Download an electronic copy of this brochure here.

Do you have further questions? Then give us a call!

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