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Implementing Integrated Clinical Care Management in the Patient-Centered Medical Home

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INTRODUCTION

BACKGROUND

Clinical Care Management (CCM) of the highest risk, most complex and costly patients is a key element of the Massachusetts Patient-Centered Medical Home Initiative (MA PCMHI), and is a new service for most primary care practices. There is much confusion about the role of the Care Manager (CM), and a lack of awareness of key foundational elements critical to successful implementation of CCM.

AIMS

- Share approach to implementation of CCM in the MA PCMHI
- Use care management and care coordination clinical quality measures to monitor implementation progress
- Share lessons learned in implementation process

METHODS

DESIGN:

- **MA PCMHI:**
  - **Multi-payer, statewide initiative,** sponsored by MA Health & Human Services
  - **49 participating practice sites**
  - **3-year demonstration;** Start date: March 2011

INTERVENTION:

- Support for CCM implementation was provided by UMass Team through a learning collaborative, including monthly CCM Webinars and practice facilitation
- Developed CCM Implementation Model which includes the following domains:
  - Infrastructure and systems
  - CM role
  - Risk Stratification/ Population of Focus
  - Scope of service
  - Interdisciplinary team roles, responsibilities, processes and workflows

TEAM:

- UMass Facilitation and MA PCMHI Practice Teams

MEASURES:

- % Hospitalized patients with follow-up after discharge
- % Highest risk patients with care plans

CARE MANAGER ROLE

- Leading and coordinating the CCM process
- Identifying, tracking and managing care of "highest risk" patients
- Overseeing the development and implementation of an integrated patient care plan for each highest risk patient
- Ongoing clinical assessment, monitoring and follow-up of highest risk patients
- Behavioral patient activation interventions, including motivational interviewing and self management support
- Patient teaching
- Medication review, reconciliation and coordination with a licensed professional for medication adjustment
- Intense medical and medication management
- Intense transition management
- Ensuring care coordination of highest risk patients across the practice and healthcare system

DATA COLLECTION & ANALYSIS

- **Practices reported data monthly**
- **Linear Mixed Model Analysis**
- **Data were divided into three-month periods:** Time 1 (Sept-Nov 2011) to Time 9 (Sept-Nov 2013)
- **Change over time:** Time 1 vs. Time 9

CCM SYSTEM COMPONENTS

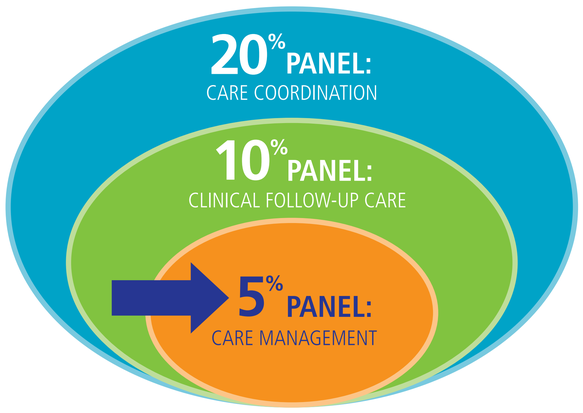
SYSTEM FOR IDENTIFYING HIGHEST RISK PATIENTS:
Hospital & ED Visit Notifications, Provider/Team Referrals, Payer Data

SYSTEM FOR TRACKING AND MANAGING CARE OF HIGHEST RISK PATIENTS:
Clinical Care Management Highest Risk Registry

SYSTEM FOR DELIVERY OF CLINICAL CARE MANAGEMENT SERVICES:
Workflows for interdisciplinary team communication and collaboration in the development, implementation and evaluation of the care plan

CARE COORDINATION AND REFERRAL SYSTEM:
Communication system with interdisciplinary care team, external providers & community resources; tracking of referrals and their completion

CCM POPULATION OF FOCUS



CARE PLAN COMPONENTS

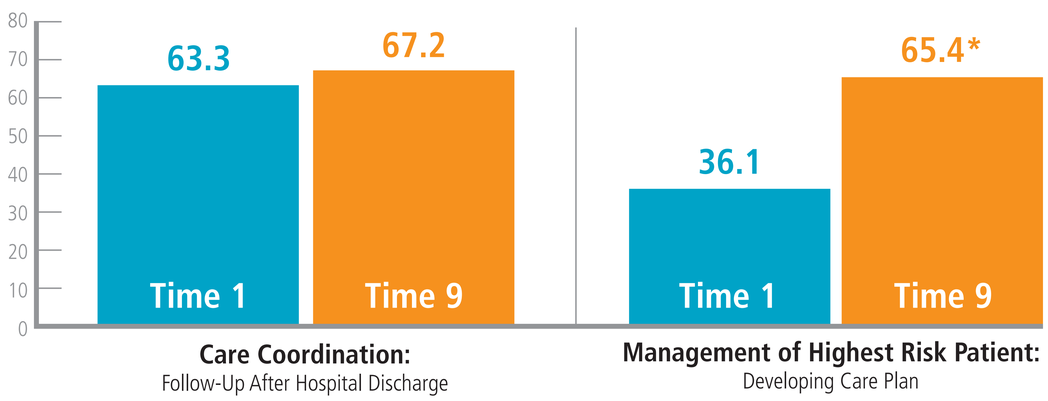
Intake Assessment	• **To inform the plan of care; identify problems, risk drivers and barriers to care**
Problem List	• **"Risk Drivers"** ("drivers" or root causes that led to the patient being identified as Highest Risk) • **Co-morbidities, barriers to care**
Goals	• **Set short & long term goals with patient** to mitigate "risk drivers," address problems, needs and barriers to care • **Goals should be specific, measureable and meaningful to patient**
Intervention Plan	• **Interventions to mitigate risk, achieve goals, address barriers to care and meet patient's needs** • **The Care Team,** including the patient/family, **should have input**
Evaluation of the Plan; Discharge	• **Has the patient's risk been mitigated/decreased?** Needs met? Goals achieved? If not, why not? • **Barriers to care addressed?** If not, what are the barriers and how might they best be addressed?

CCM SCOPE OF SERVICE

TRACKING, COORDINATING & MANAGING CARE OF HIGHEST RISK PATIENTS ACROSS THE "CONTINUUM"

IDENTIFY HIGHEST RISK PATIENTS → INTAKE ASSESSMENT & INTEGRATED CARE PLAN DEVELOPMENT → IMPLEMENT CARE PLAN & CCM INTERVENTIONS → ONGOING ASSESSMENT, EVALUATION & UPDATING OF CARE PLAN → EVALUATION/ DISCHARGE FROM CCM SERVICES

CLINICAL QUALITY MEASURES: Change Over Time



Care Coordination: Follow-Up After Hospital Discharge

Management of Highest Risk Patient: Developing Care Plan

CCM INTERDISCIPLINARY TEAM WORKFLOW

Bi-weekly CCM Interdisciplinary Team Meetings:
- Identify HR patients/validate HR list
- Review/discuss patients
- Develop/update/evaluate care plans

Develop care plan for each Highest Risk patient to include:
- Patient Assessment
- Problem List (Risk Drivers)
- Goals & Interventions

Determine team member responsibilities:
Care plan implementation

Care Manager (CM) finalizes care plan with patient

Implementation & evaluation/ updating of care plan:
- By care manager with team input

RESULTS

In the first 27 months of the MA PCMHI, participating practices have significantly improved CCM by more consistently developing care plans for highest risk patients (*$p < .0001$).

LESSONS LEARNED

- Infrastructure and systems are critical foundational elements for effective CCM implementation
- Care coordination, clinical follow-up and CCM focus on different populations and include different services; team members need to be assigned to these functions and roles defined
- Identifying the population of focus for CCM through a standardized risk stratification method is the first step to ensuring effective and efficient CCM
- CCM requires an interdisciplinary team with clearly defined roles, scope of service and workflows, and the patient is a vital member of the team
- The CM oversees the development and implementation of an integrated care plan, assesses effectiveness and revises appropriately to meet goals, mitigate risk, and improve outcomes