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

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Keywords
Patient-centered medical home, Medicaid, practice transformation, care coordination, clinical management, training, Massachusetts

Comments
Presented at the 15th Annual International Summit on Improving Patient Care in the Office Practice and the Community.
Implementing Integrated Clinical Care Management in the Patient-Centered Medical Home

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, Paper 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 SCOPE OF SERVICE
- Tracking, coordinating & managing care of highest risk patients across the “continuum”

CCM POPULATION OF FOCUS
- 20% Panel: Care Coordination
- 10% Panel: Clinical Follow-up Care
- 5% Panel: Care Management

CCM INTERDISCIPLINARY TEAM WORKFLOW
- Implementation & evaluation/updating of care plan:
  - By care manager with team input
- Develop care plan for each Highest Risk patient to include:
  - Patient Assessment
  - Problem List (Risk Drivers)
  - Goals & Interventions

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

LEARNING 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

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

METHODS

DESIGN:
- MA PCMH:
  - 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 PCMH 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

CLINICAL QUALITY MEASURES: Change Over Time
- Care Coordination: Follow-Up After Hospital Discharge
- Management of Highest Risk Patient: Developing Care Plan