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

Jeanne Z. Cohen

University of Massachusetts Medical School

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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 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

**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, 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

**CCM POPULATION OF FOCUS**

- **20% PANEL:** Care Coordination
- **10% PANEL:** Clinical Follow-up/Care
- **5% PANEL:** Care Management

**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)
  - Comorbidities, 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, measurable 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?

**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