Innovations in Primary Care: Implementing Clinical Care Management in Primary Care Practices

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Objectives

1. Explain the role of the clinical care manager and name three challenges to implementation of clinical care management in primary care practices
2. Explain the components of a clinical care management system and associated processes/workflows
3. Measure the progress of clinical care management implementation and its effectiveness

Agenda

- Overview of MA Patient-Centered Medical Home Initiative
- Implementing Clinical Care Management (CCM) in Practices
- Measuring Progress
- Challenges, Lessons Learned and Next Steps

Overview of MA Patient-Centered Medical Home Initiative

MA Patient-Centered Medical Home Initiative

- Statewide Initiative
- Sponsored by MA EOHHS
- Multi-payer
- 46 Participating Practices
- 3 year Demonstration
- Start Date: March 29, 2011
- Partners: UMMS, Bailit Health Purchasing
- ***Vision: All MA primary care practices will be PCMHs by 2015***

MA PCMHI: Incentive Alignment/Payment Reform

- Payment streams:
  - Fee for service
  - Start-up infrastructure payments
  - Prospective Payments
    - Medical Home Activities
    - Clinical Care Management
  - Shared Savings

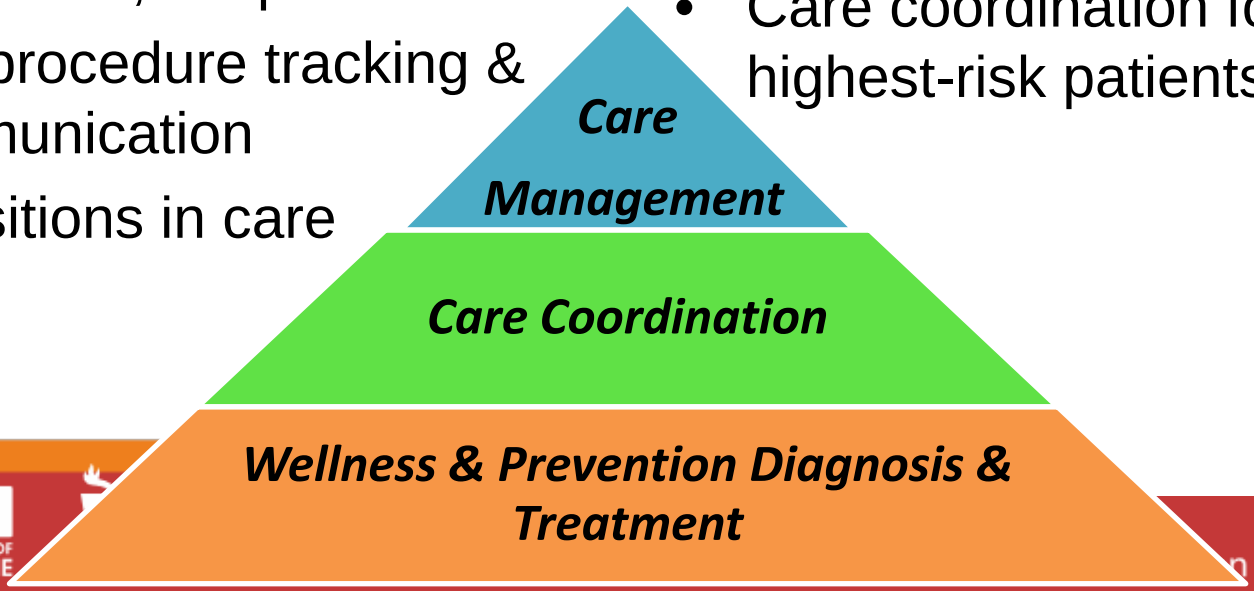
Care Coordination & Clinical Care Management

Care Coordination

- Arrange, track and coordinate with specialists, community resources, behavioral health
- Agreements with specialists, hospitals
- Test/procedure tracking & communication
- Transitions in care

Clinical Care Management

- Individualized, integrated care plan
- Manage/mitigate risk and improve outcomes
- Medication management
- Care coordination for highest-risk patients



Implementing Clinical Care Management (CCM) in Practices

Supporting Implementation of Clinical Care Management

Training:

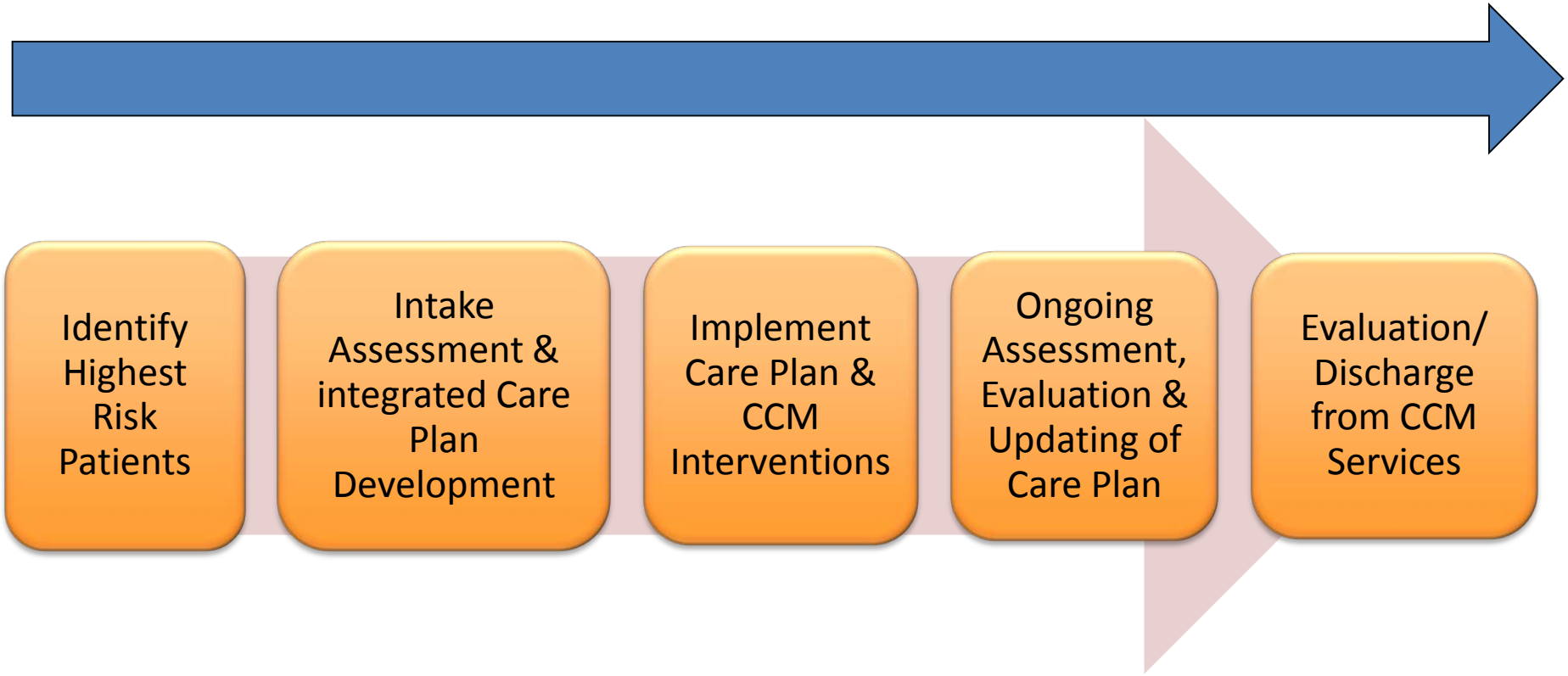
- Initial one day training of clinical care managers (CCMs)
- Focused sessions at 4 learning collaborative conferences
- Monthly Clinical Care Management webinars for CCMs

Curriculum:

- CCM “continuum of care”
  - CCM roles and responsibilities
- Clinical Care Management system components

CCM "Continuum of Care"

Communication with Care Team, Patient, External Providers & Community Resources spans the CCM Continuum of Care



CCM System Components

System for Identifying Highest Risk Patients:
Hospital & ED Visit Notifications, Provider/Team Referrals, Payer Data

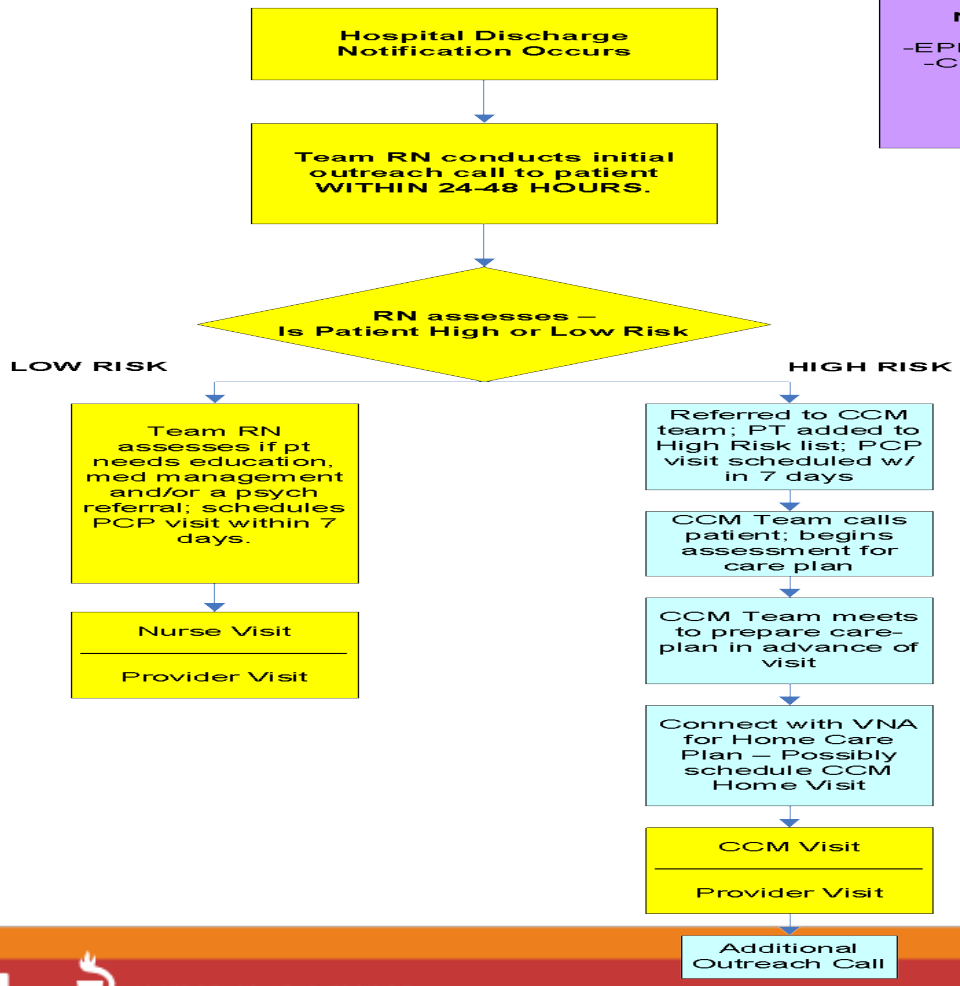
System for Tracking and Managing Care of Highest Risk Patients:
Clinical Care Management Highest Risk Registry

System for Delivery of Clinical Care Management Services:
Workflows for interdisciplinary team communication & collaboration in the development, implementation, & 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

Workflow Example – Hospital Discharge Follow-up

Hospital Discharge WorkFlow



Hospital Discharge Notification Sources:

-EPIC Hosp Discharge Pt List
-CHA Discharge Summary
-Payer-based
-MD in ER
-Fax notification
-Chartlinx

If patient needs education or med management, pt could meet with RN immediately before PCP visit.

Team RN will make a psych referral if needed.

CCM Care Plan will initially include:
1. VNA and/or PN/CCM home visit
2. Meeting with a member of the CCM team during/prior to the PCP visit
3. Psych referral if needed
4. Additional outreach call post PCP visit
5. Subsequent calls, visits and check-ins as needed and as indicated on the care plan.

Measuring Progress

Care Transitions and Care Management Clinical Quality Measures

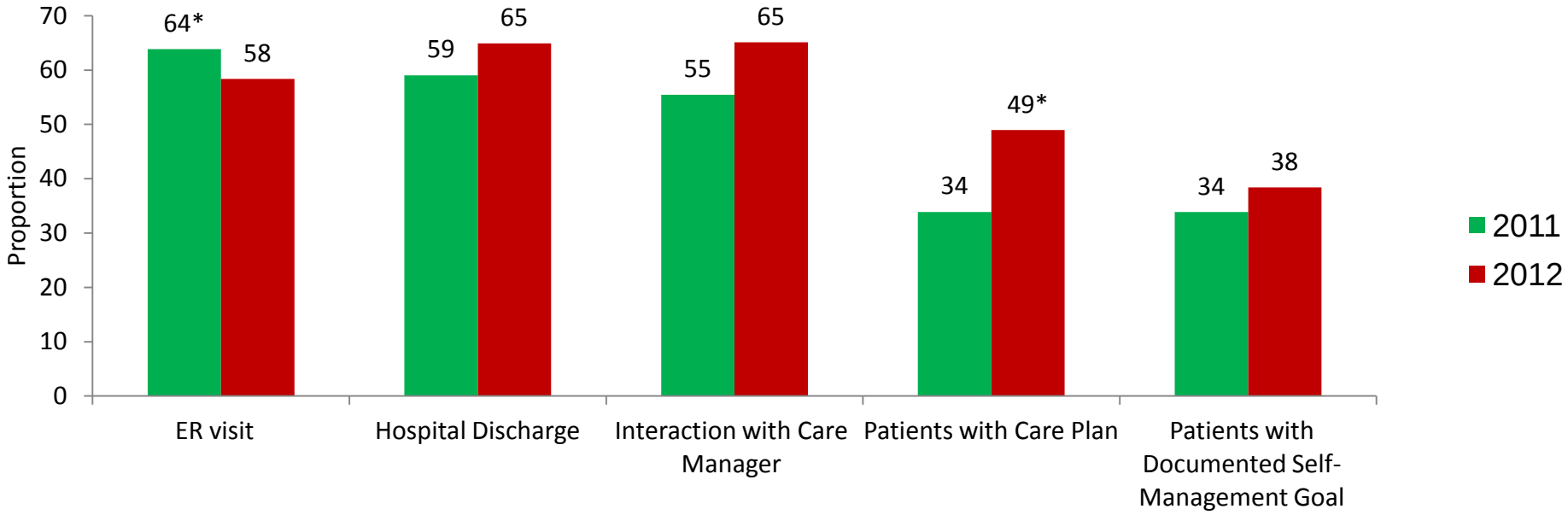
- Percentage of patients with follow-up documented:
  - After hospitalizations
  - After emergency room visits
- Percentage highest-risk patients with:
  - An interaction with care manager
  - A care plan
  - A documented self-management goal

Data Analysis

- Year: 2011 vs 2012
- Practice Type: Adult vs Pediatric
- Financial Support:
  - Technical Assistance Plus Payment Reform(TAP)
  - Technical Assistance Only(TAO)

Care Transitions & Care Management Measures 2011 vs 2012

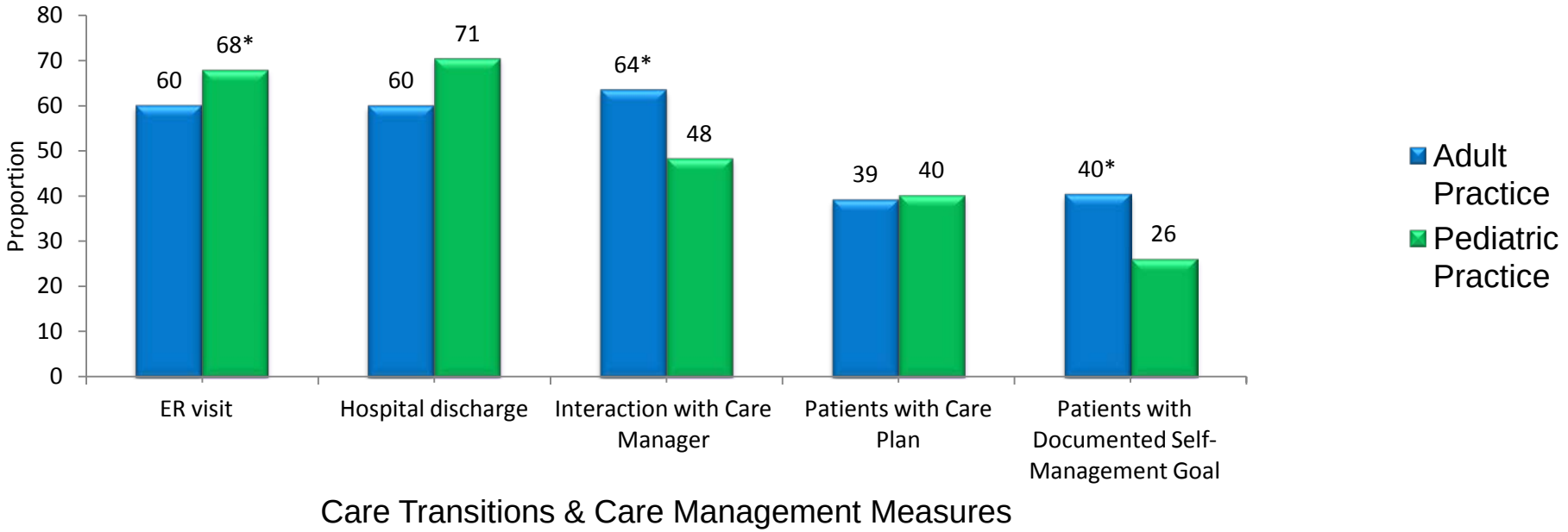
All measures increased over time except "Follow-up after ER visit"



*Values meet the study's definition for a trend ($p<.05$) and are significantly different across the groups

Adult vs Pediatric Practices

Pediatric practices have higher rates of follow up after Hospital & ER visits
Adult practices have higher proportions of highest risk patients with interaction with care manager and documented self-management goal



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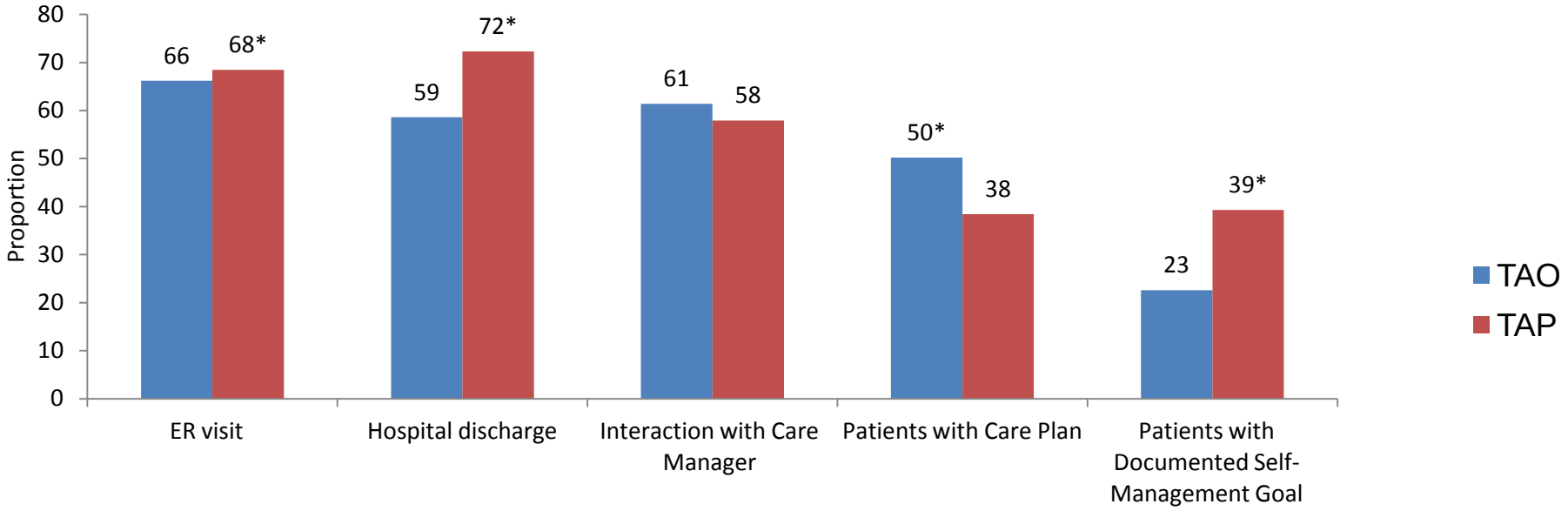
Financial Assistance Status

Practices with payment reform have higher rates of follow up after hospitalizations & ER visits and higher proportions of highest risk patients with documented self-management goal



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TAO-Technical Assistance Only, TAP-Technical Assistance Plus and SNMHI-Safety Net Medical Home Initiative

Challenges, Lessons Learned & Next Steps

Challenges

- Notification systems for hospitalizations and ER visits
- Establishment of risk stratification criteria for identifying highest risk patients to be managed by the CCM
- Clarity of CCM role and workflows
- Resource constraints
- EMR/registry functionality –Data capture/reporting, care plan development & tracking
- Coordinating payer- and practice-based care management

Lessons Learned

- Engaged leadership is critical for successful implementation of CCM
- Risk stratification is the key to identifying the population served by the clinical care manager
- It is important to clarify what is meant by care management, care coordination & planned care
- EMR functionality for the CCM service requires further development

Next Steps

- Analyze Transformation Status Reports re: CCM implementation
  - Practice monthly self-assessment on progress towards implementing PCMH
- Complete and analyze CCM Payer-Practice pilots:
  - Understand the intersection & coordination of payer- and practice-based CCM
- Implement leadership engagement strategy
- Implement EMR user groups

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