Patient-Centered Medical Care: Vision to Reality

Implementing Care Management for Complex Patients in Primary Care

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Health Care Transformed: Better Delivery for Those Most in Need

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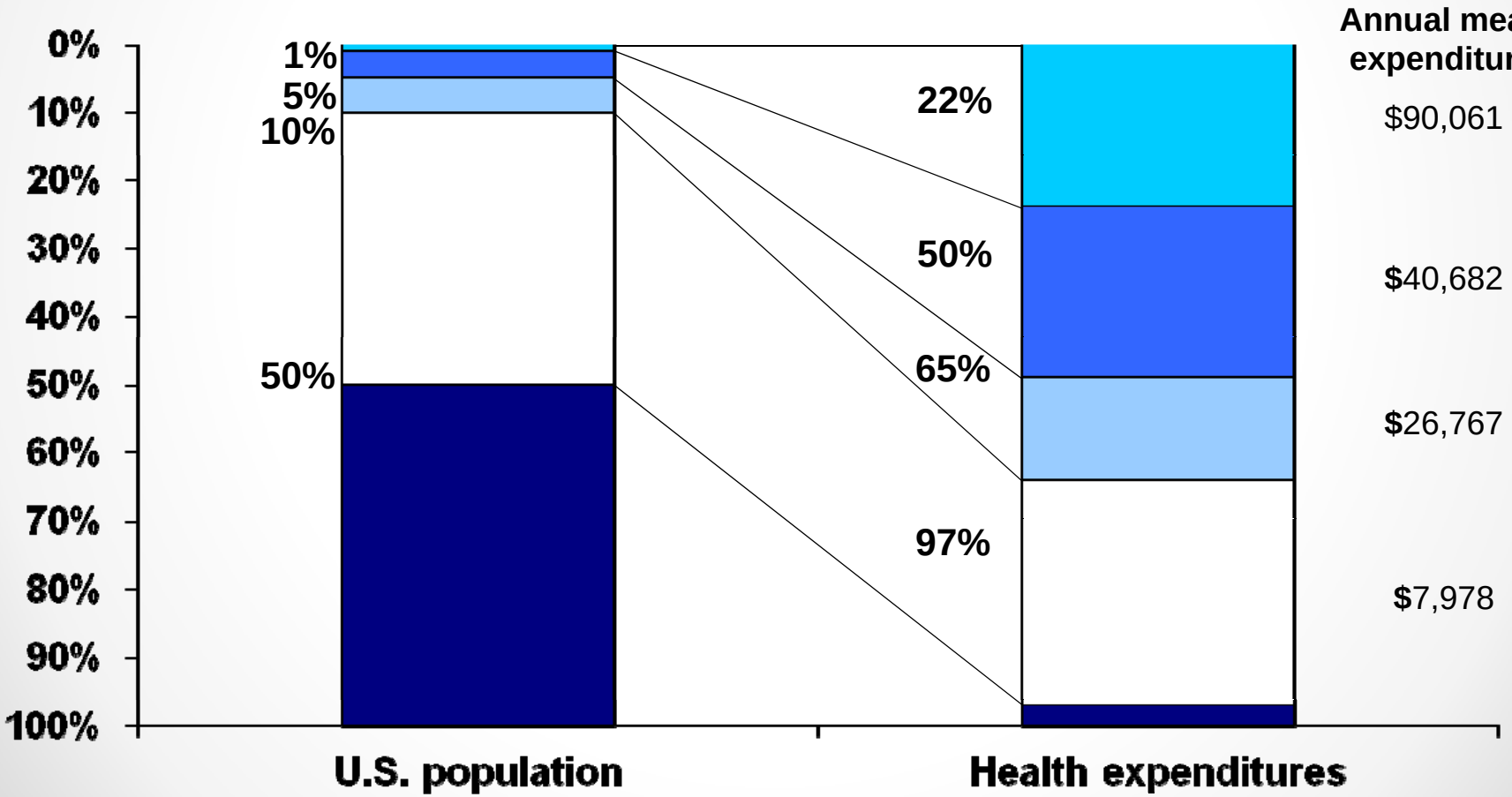
Outline

- Overview of complex care management (CCM) and its relationship to primary care
- Review core features of CCM programs
- Recommendations to help spread CCM programs

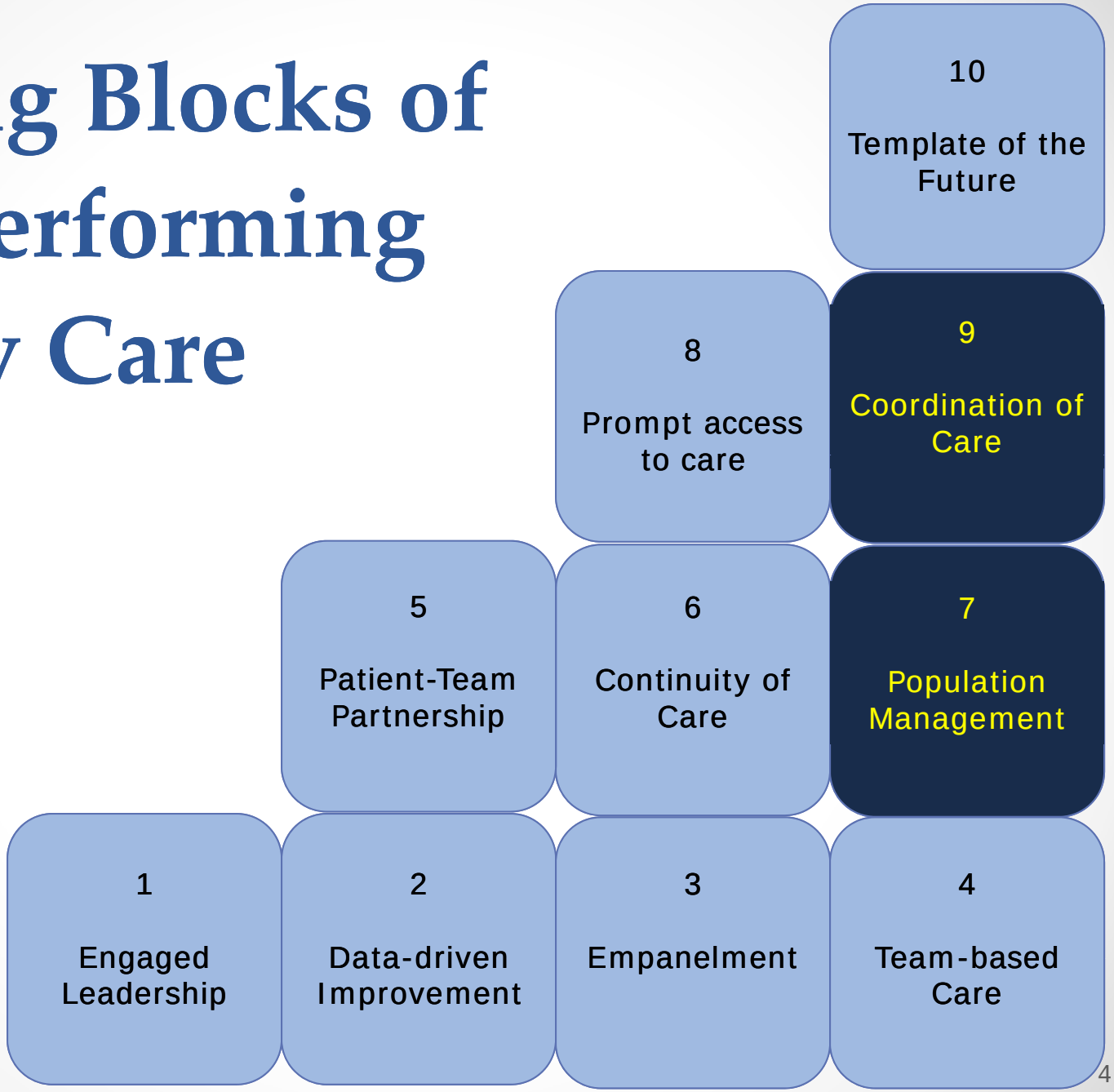
Health Care Costs Concentrated in Sick Few—Sickest 10 Percent Account for 65 Percent of Expenses

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 2009



Source: Agency for Healthcare Research and Quality analysis of 2009 Medical Expenditure Panel Survey.

Building Blocks of High-Performing Primary Care



Willard & Bodenheimer The Building Blocks of High-Performing Primary Care: Lessons from the Field, April 2012 (www.chcf.org)

Complex Care Management Defined

Complex Care Management (CCM) is the organized delivery of care to address the complex needs of high risk, community dwelling patients

Research Questions

- What are the core, operational attributes of successful CCM programs?
- How do these programs customize for specific populations or contexts?

Methods

- Site selection: literature review, expert steering committee, & snowball sampling
  - Inclusion criteria:
    - Primary care-aligned CCM program
    - Existing data on performance
    - Ongoing operation
- Data collection: 3+ Interviews/site
- Analysis: 2 independent reviewers identified themes

Domains of Study

1. **Team structure**
2. **Patient selection**
3. **Patient engagement**
4. **Integration with primary care & other providers**
5. **Scope of work & key tasks**
6. Integration of information technology
7. Care manager (CM) training
8. **Outcomes**

CCM Program Characteristics

- 18 programs from 14+ States
  - 5 were part of a primary care transformation initiative
  - 12 urban, 3 rural, 3 mixed
- Program payer mix
  - 8 multi-payer
  - 8 Medicaid/uninsured, 10 Medicare, 8 private
- Program “ownership”
  - 7 payer, 8 delivery system, 2 payer/delivery System, 4 regional CM partnerships

1. Team Structure

- Most lead Care Managers (CMs) are nurses (RNs)
- "Tight vs loose" team structure
  - Integrated multidisciplinary team → Independent CM
- Multidisciplinary teams address different needs:
  - Administrative support staff
  - Pharmacists
  - Resource specialists/social workers
  - Behavioral health specialists
  - Health coaches
  - Community health workers (CHWs)

More common in Medicaid

2. Patient Selection:
Three Common Approaches

1. Quantitative
    - Claims-based risk prediction (harder for Medicaid)
    - Event-triggered: post-discharge, high-utilizer tracking
2. Qualitative – Referral
3. Combined

The issue of mutability:

- Post-event
- Motivation/readiness
- Behavioral health

Key issue in Medicaid

3. Patient Engagement

- Connection to primary care
- Face-to-face interaction
- Longitudinal relationships
- Traits of CM team members
  - Detective skills & creative problem solving
  - Ability to build trust
  - Cultural concordance – CHWs
- Motivational interviewing
  - Sell it to patients & ensure early success
- Mobile workforce & technology

Key Strategies in Medicaid

4. Primary Care Integration

- "Tight vs loose" integration
  - Embedded, high touch → off-site, low touch
- Approaches to enhancing integration
  - Co-location
  - Face-to-face interaction: accompaniment, meetings
  - Data/EMR Access
  - Early successes/Trust building
  - Education on CM role/benefits

5. Scope of Work & Key Tasks

- **Central task:** to build relationships with patients, primary care teams & hospital/community partners
- Touches
  - Twice weekly to monthly
  - Telephonic, office, in-home
- Patient case load: 50-300 patients per CM
  - Depends on training, resources, & intensity of intervention
  - Use of teams, risk stratification & IT enable larger case loads

5. Scope of Work & Key Tasks

- Comprehensive assessment & creation of care plans
- Care coordination
  - With Hospitals/EDs, SNFs, Specialists, VNA, behavioral health & community-based resources
  - Focus on Transitions of Care
- Health coaching/self-management support
- Address behavioral health needs
- Address barriers to access/care
- Address social service needs
- Patient advocacy/activation

Key Strategies in Medicaid

8. Outcomes

	Mortality	Quality of Care	Admit/ Readmit	ED Utilization	Total Cost of Care	Provider Experience	Patient Experience	QOL/ Functional Status
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What's Needed?

- **Financial**
  - Incentives that reduce unnecessary utilization and accelerate interoperable HIT
  - Up-front investment in CCM infrastructure & programs
  - Reimbursement for uninsured post-ACA
- **Organizational/Technical**
  - Stronger primary care
  - Accelerated adoption of interoperable HIT
  - Multi-payer alignment to promote provider integration
  - Technical Assistance
  - Regional CM structures to help smaller/rural practices
  - Workforce development (professional & paraprofessional)

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  - Joanne Sciandra
  - Annette Watson

Questions?

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6. Integration of IT

- Little advanced care management IT infrastructure
- Limited:
  - Data availability
  - Support for care plans
  - Decision Support or task assignment ability
  - Population management functionality
  - QI functionality
  - Referral tracking

MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION

7. CM Training

- Most pair classroom didactics with on-the-job training (shadowing/mentorship)
- Motivational Interviewing – most important skill