Conference on Practice Improvement

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

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# Seminar Objectives

Participants will be able to:

- Explain the role of the clinical care manager
- Name at least three critical success factors for effective implementation of an integrated, interdisciplinary clinical care management (CCM) system in primary care practices
- Identify the 5 phases of clinical care management Continuum of Care
- Name and describe the 4 key components of an integrated interdisciplinary care plan
- List 3 strategies for successful interdisciplinary team collaboration

# Seminar Outline

1. MA Patient-Centered Medical Home Initiative
2. Overview of Clinical Care Management
3. The CCM Continuum of Care: A Patient Case Study
   - Activity #1: Identifying the highest risk patient
   - Activity #2: Intake Assessment and developing an integrated care plan
   - Discussion: Evaluating care plan effectiveness/discharging patients from clinical care management
4. Wrap-up

# The Patient-Centered Medical Home Represents a Paradigm Shift

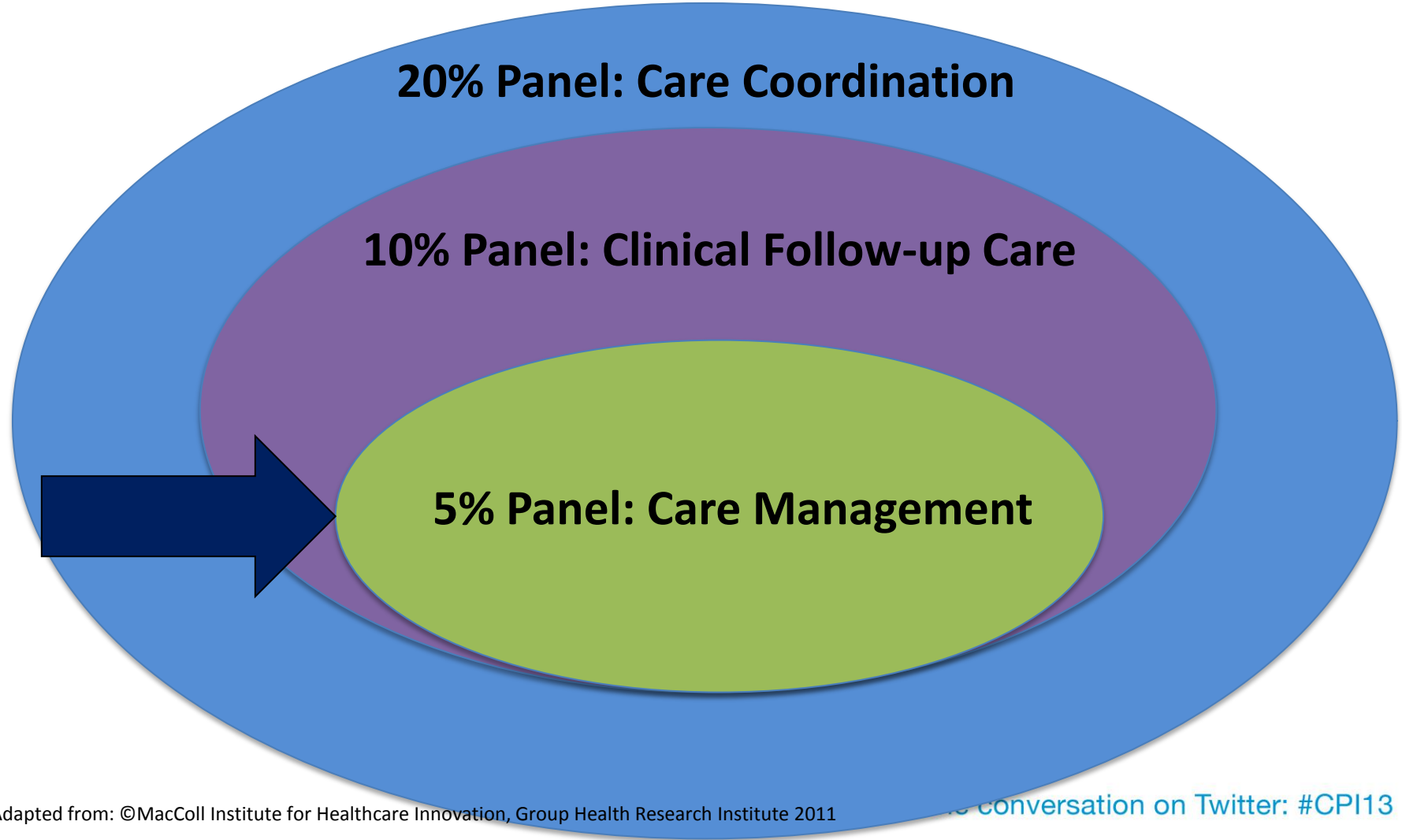
- From episodic, visit based care to a more proactive approach to care which is person-centered
- Shifting from a “sick-care” system to a “health-care” system
- Requires a team-based approach to care delivery
- Coordination and integration of care – important components

# MA Patient-Centered Medical Home Initiative

- Statewide initiative
- Sponsored by MA EOHHS
- Multi-payer
- 44 participating practices
- 3 year demonstration
- Start date: March 29, 2011
- ***Vision: All MA primary care practices will be PCMHs by 2015***

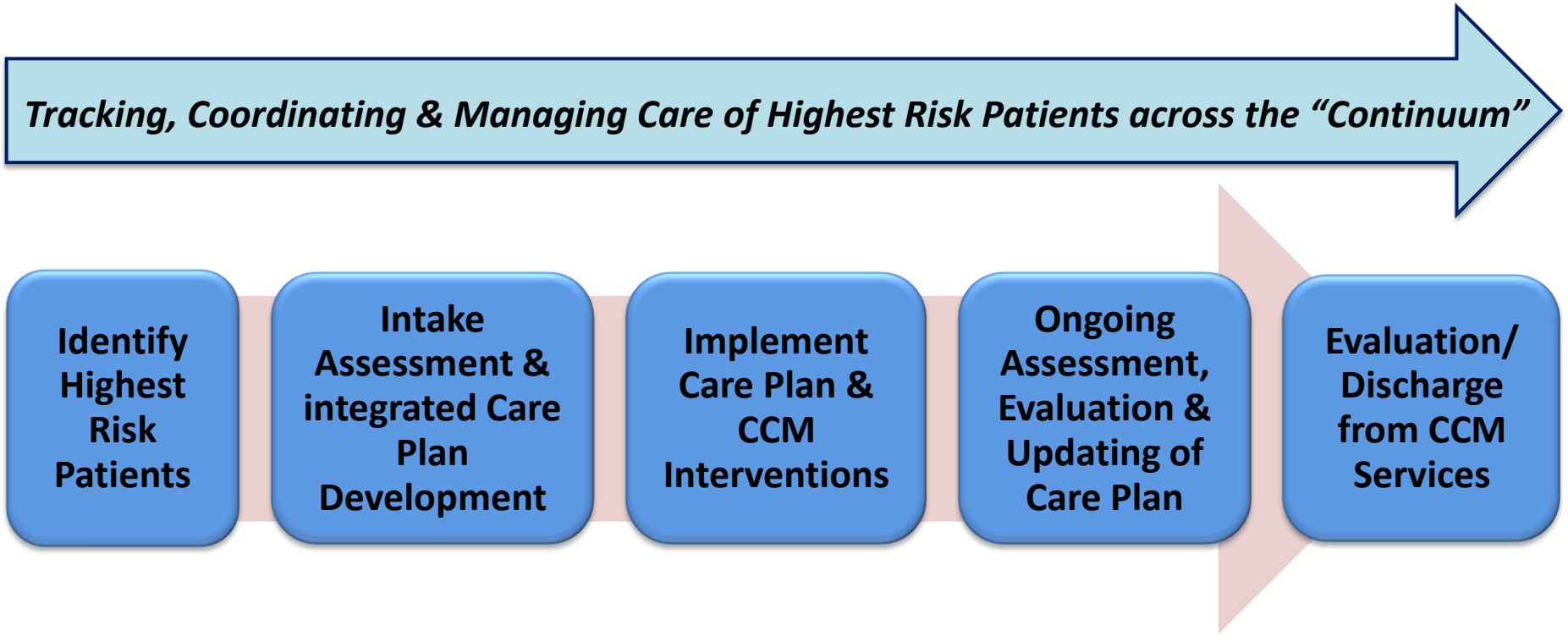
MASSACHUSETTS PCMHI
Patient-Centered Medical Home Initiative

# Care Coordination…….Care Management: Populations of Focus




Adapted from: ©MacColl Institute for Healthcare Innovation, Group Health Research Institute 2011

# *Clinical Care Management (CCM) Scope of Service… The CCM "Continuum of Care"*



# Clinical Care Management 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

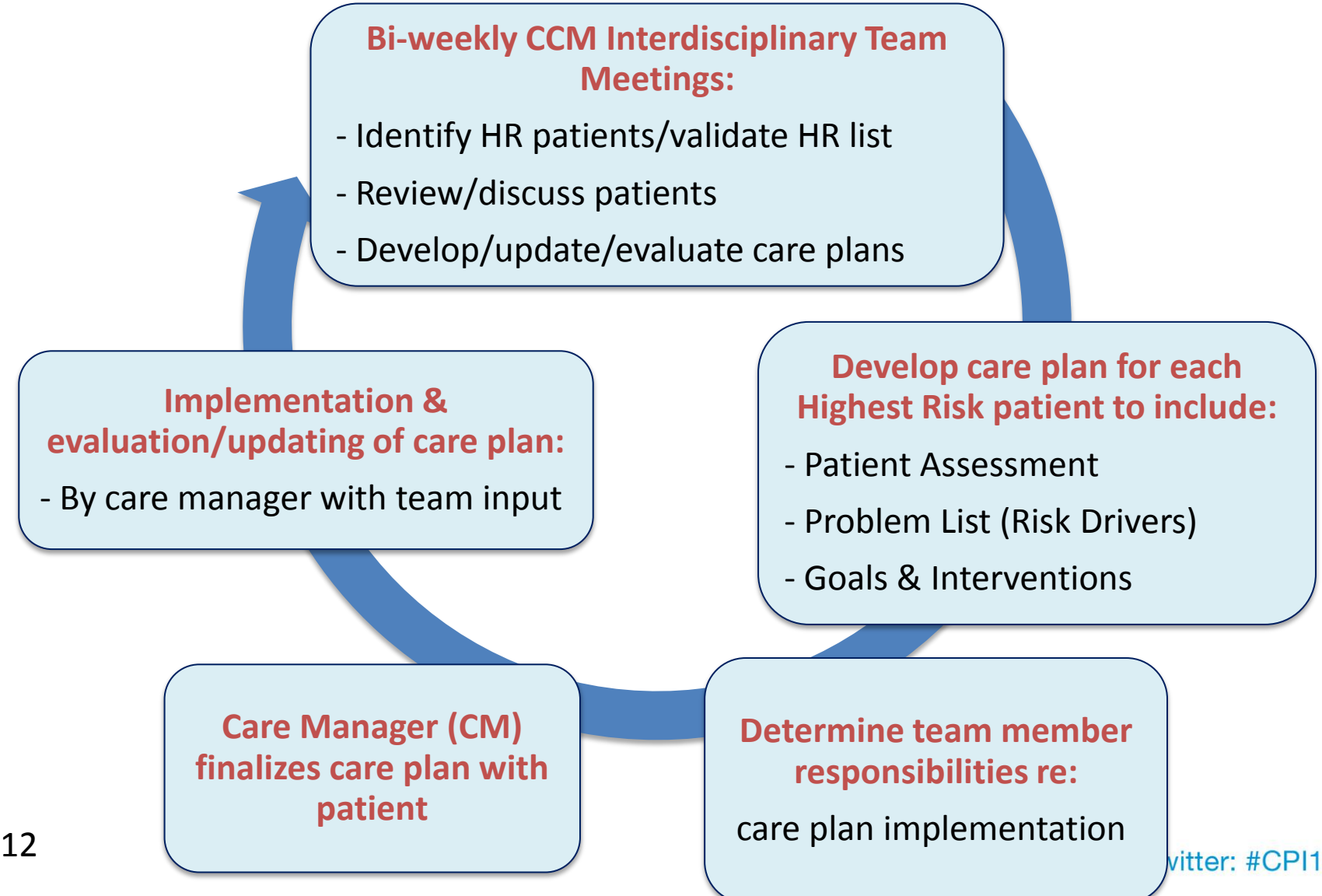
# Care Manager's Role

- Leading and coordinating the Clinical Care Management process
- Identifying, tracking and managing care of "highest risk" patients
- Overseeing the development of an individualized and integrated (medical and behavioral health) patient care plan
- Overseeing the Implementation of the integrated care plan
- Ongoing clinical assessment, monitoring and follow-up of highest risk patients

# Care Manager's Role, cont'd

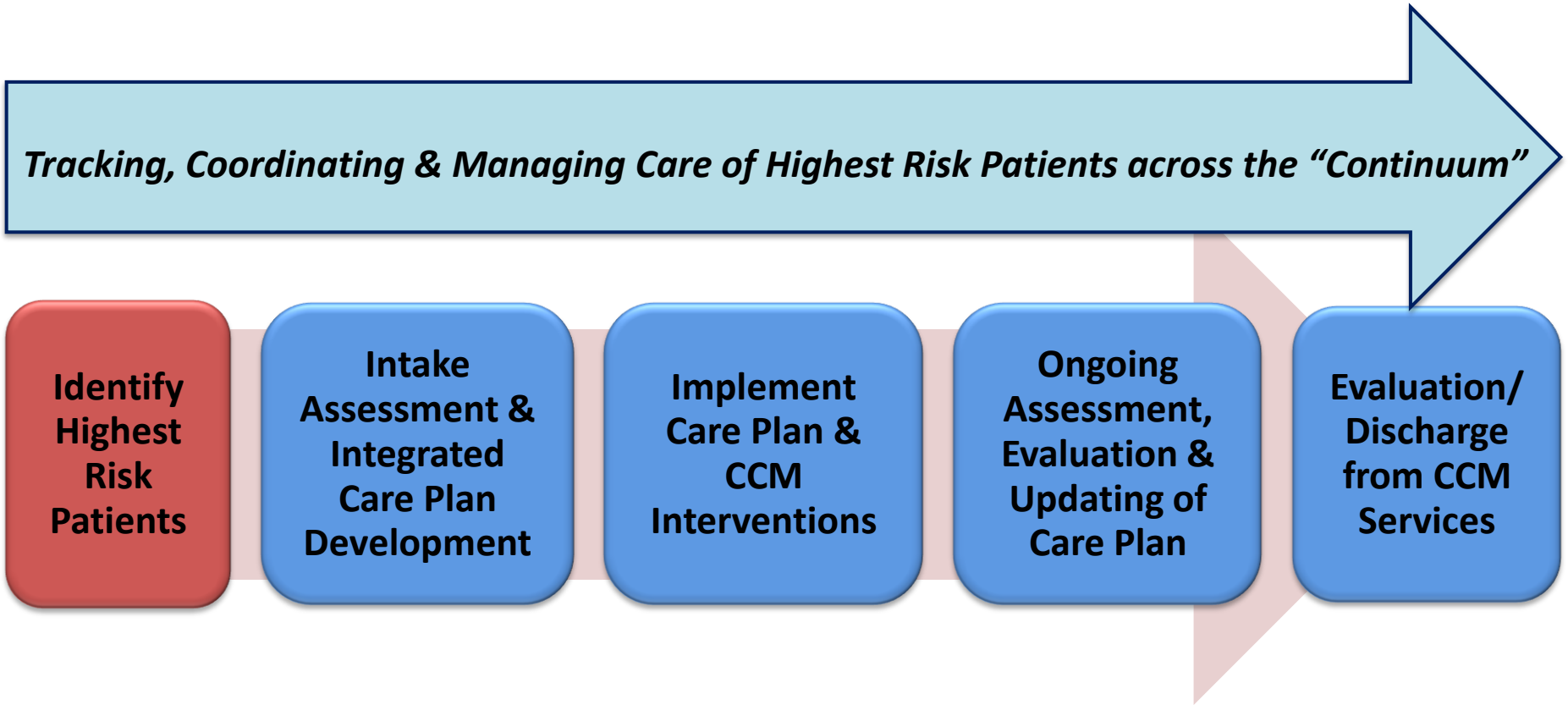
- Behavioral patient activation interventions, including motivational interviewing and self management support
- Patient teaching
- Medication review, reconciliation and coordination with a licensed professional for medication adjustment
- Intense medical and medication management
- Intense transition management
- Ensuring care coordination of highest risk patients across the practice & healthcare system

# Interdisciplinary Team Workflow for Clinical Care Management (CCM)



# The Clinical Care Management "Continuum of Care"
# A Patient Case Study

# *The Clinical Care Management (CCM) "Continuum of Care" …..*



# Our Patient

***60 y/o male referred to care manager per office-based provider referral:***

- 3 ED visits past 6 months
  - Most recent, 2 weeks ago w/chest pain resulting in inpatient admission to r/o MI (negative)
- **Dx**: morbid obesity, hypertension, CAD, asthma/COPD, dementia, major depressive disorder, hyperlipidemia, chronic pain
- **Medications**: metoprolol, NTG, ASA, lisinopril, simvastatin, cholestyramine, warfarin, morphine, memantine, aripiprazole, citalopram, amytriptiline, montelukast, budesonide/formoterol, albuterol

# Our Patient, cont'd

- **Physical/Functional/Cognitive Impairments**:
  - Self care deficit
  - Knowledge deficit
  - Memory loss
- **Behavioral Health Concerns**: depression, high stress level
- **Safety**: bleeding risk 2˚ warfarin therapy, cognitive impairment
- **Socioeconomic**: financial barriers
- **Support Systems**: considerable family responsibility for grandchildren; few available supports

# Is Our Patient "Highest Risk?"

- Why? Why not?
- How would we determine if he *is* or *is not* appropriate for referral to Clinical Care Management Services?

# *Activity #1:*

# *Risk Stratification & Discussion of Risk Drivers*

# Identifying Highest Risk Patients/Risk Assessment

## Complex Care Management Triage Tool

v9_11_13 Cambridge Health Alliance Complex Care Management

Patient Name: _____ MRN#: _____

Referred by: _____ Referral Date: _____ DOB: _____ Age: ___

Triaged by: _____ Triage Date: _____ Clinic: _____

Patient Activation: Patient willing to engage in CM: Yes/ No Patient knows of referral: Yes/ No

### Higher Risk Drivers (3 Points Each)

| Points | |
|---|---|
| | Utilization:<br>o Inpatient admission in past 30 days OR<br>o 2+ Inpatient admissions in past 6 months OR<br>o 2+ ED visits in past 6 months (medical or psych) OR<br>o 30-day Readmission in past year |
| | High Risk of:<br>o Inpatient admission/ ED visits in next 6 months<br>o Decline in functional status/ need for long term care in next 6 months |

### Moderate Risk Drivers (2 Points Each)

| | |
|---|---|
| | Chronic Disease(s): High Risk- poorly controlled (2 Points Each) __CAD __CHF __Diabetes __COPD __Chronic Pain __End stage disease:_____ |
| | RX Meds: 10+ active prescriptions OR recent change in high risk meds (anticoagulant, insulin, etc) |
| | Disengagement: significant, chronic condition(s) and (2 Points Total)<br>o inadequate follow-up with PCP, or<br>o not following care plan, or<br>o specialty care without coordination |
| | Disability: significant Physical/ Mental/ Learning disability which impacts reasons for referral |
| | Psycho-Social risk factors which prevent adequate mgmt of high risk diseases (2 Points Each)<br>(examples: language/literacy, safety, homelessness, poor supports, etc.) |
| | Substance Abuse: Actively using, newly sober, motivated to change (2 Points Total) |
| | Mental Health Diagnosis that is severe, persistent, and uncontrolled: (2 Points Total)<br>(examples: Major Depression, Bipolar, Schizophrenia, Debilitating Anxiety, etc. |

### Fundamental Risk Drivers (1 Point Each)

| | |
|---|---|
| | Chronic Disease/ Comorbidities – not well controlled /and not noted above (1 Point Each) |
| | Functional Impairments – Fall risk, impaired ADLs, impaired ambulation, impaired judgment, difficulty getting to appts, unable to follow med regimen (1 Point Each) |
| = **Total Score** | **15 or greater = Highest Risk** – offer Care Management<br>< 15 = Does not meet criteria for Care Management |

# Activity #1

1. Break up into groups
2. Complete Triage Tool utilizing the patient case provided
3. Answer these questions:
   - Are these the right criteria?
   - Who in your practice would complete this assessment?
   - How would you implement this assessment and communicate across your practice?

3. Reconvene for debrief/discussion

# Is Our Patient Highest Risk?

## Complex Care Management Triage Tool

u9.11.13 Cambridge Health Alliance Complex Care Management

Patient Name: _____ MRN#: _____

Referred by: _____ **Referral** Date: _____ DOB: _____ Age: __

Triaged by: _____ **Triage** Date: _____ Clinic: _____

Patient Activation: Pt willing to engage in CM: Yes/ No Patient knows of referral: Yes/ No

### Higher Risk Drivers (3 Points Each)

| Points | |
|---|---|
| 6 | **Utilization:**<br>o Inpatient admission in past 30 days OR<br>o 2+ inpatient admissions in past 6 months OR<br>o 2+ ED visits in past 6 months (medical or psych) OR<br>o 30-day Readmission in past year |
| 3 | **High Risk** of:<br>o Inpatient admission/ ED visits in next 6 months<br>o Decline in functional status/ need for long term care in next 6 months |

### Moderate Risk Drivers (2 Points Each)

| | |
|---|---|
| 6 | **Chronic Disease** – High Risk- poorly controlled (2 Points Each) _X_CAD __CHF __Diabetes _X_COPD _X_Chronic Pain __End stage disease :_____ |
| 2 | **RX Meds:** 10+ active prescriptions OR recent change in high risk meds (anticoagulant, insulin, etc) |
| 2 | **Disengagement:** significant, chronic condition(s) and (2 Points Total)<br>o inadequate follow-up with PCP, or<br>o not following care plan, or<br>o specialty care without coordination |
| 2 | **Disability:** significant Physical/ Mental/ Learning disability which impacts reasons for referral |
| 4 | **Psycho-Social risk factors** which prevent adequate mgmt of high risk diseases (2 Points Each)<br>(examples: language/literacy, safety, homeless, poor supports, etc.) |
| | **Substance Abuse:** Actively using, newly sober, motivated to change (2 Points Total) |
| 2 | **Mental Health DX** that is severe, persistent, and uncontrolled: (2 Points Total)<br>Major Depression, Bipolar, Schizophrenia, Debilitating Anxiety, etc. |

### Fundamental Risk Drivers (1 Point Each)

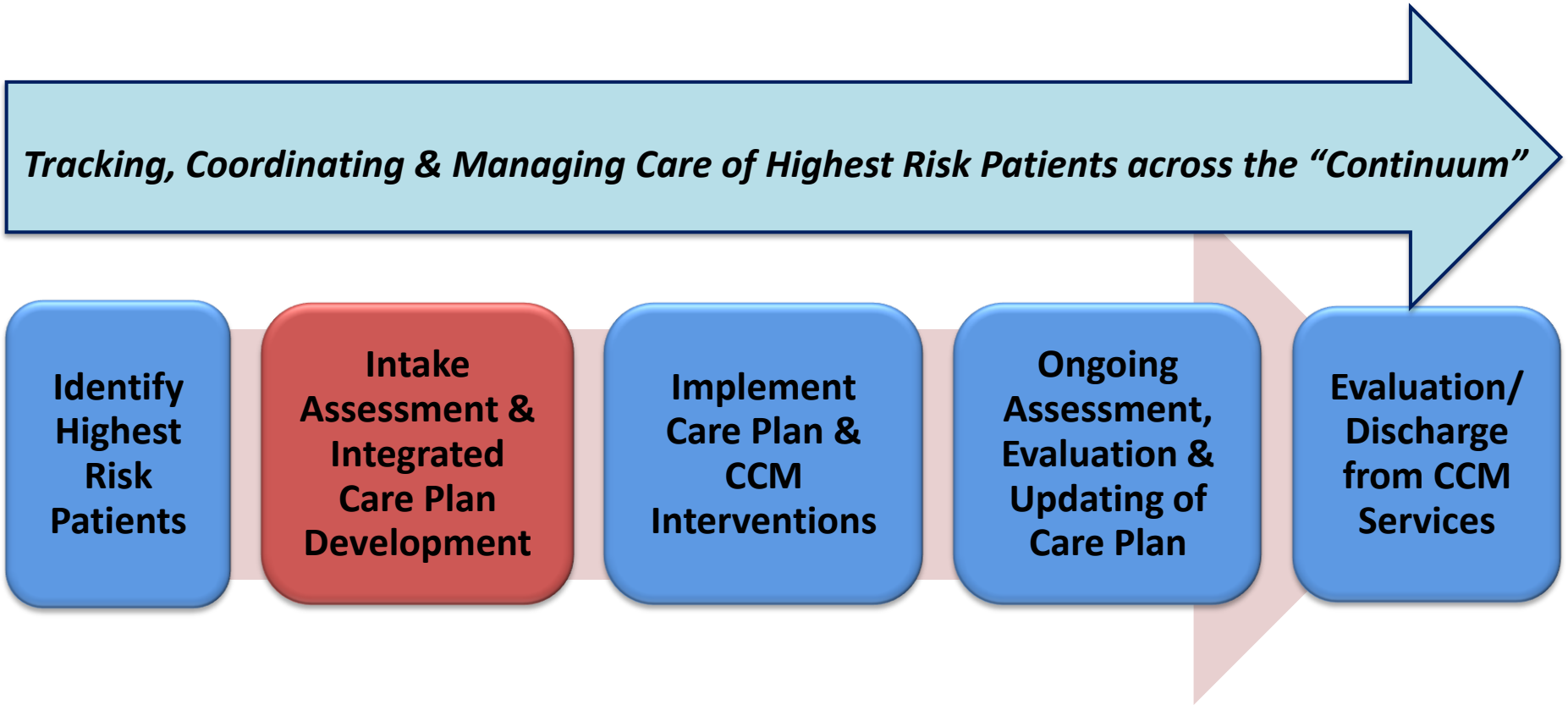
| | |
|---|---|
| | **Chronic Disease/ Comorbidities** – not well controlled/ not noted above (1 Point Each) |
| 1 | **Functional Impairments** – Fall risk, impaired ADLs, impaired ambulation, impaired judgment, difficulty getting to appointments, unable to follow med regimen (1 Point Each) |

28 = Total Score

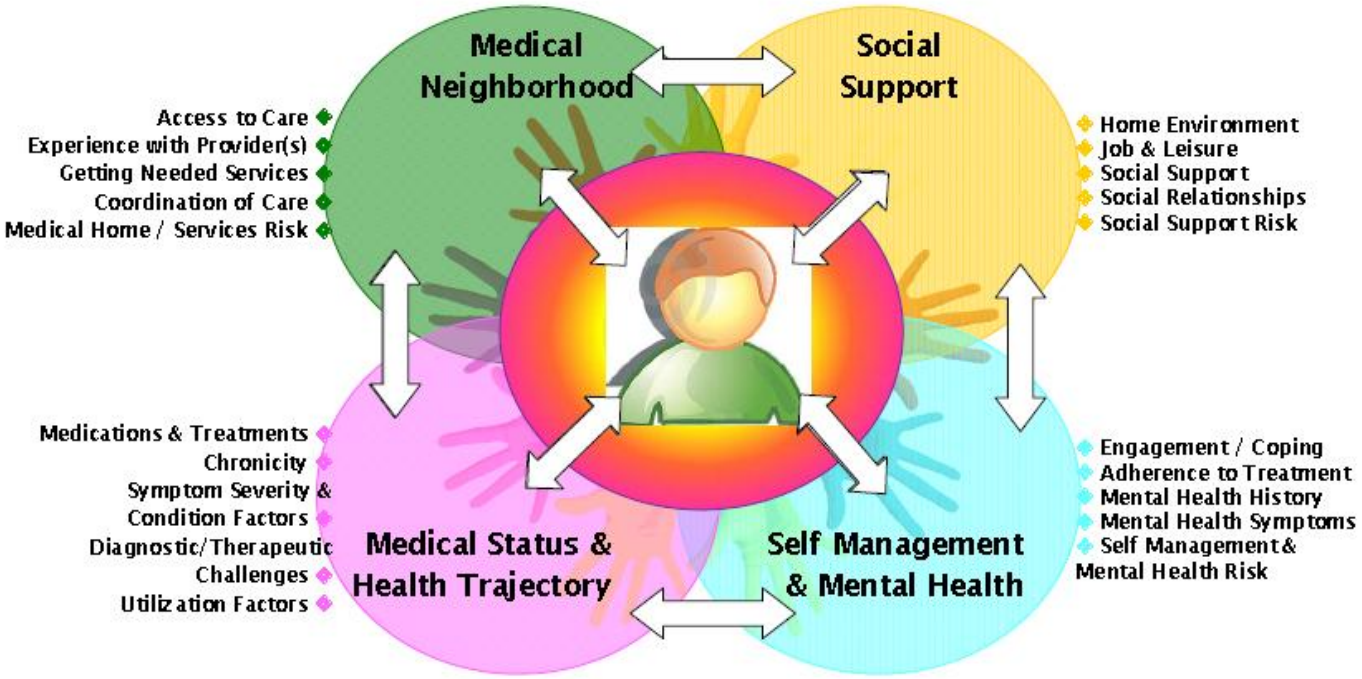
15 or greater = Highest Risk – offer Complex CM

< 15 = Does not meet criteria for Complex CM

# *The Clinical Care Management (CCM) "Continuum of Care" …..*



# Intake Assessment: The 4 Domains




The Team = Patient, Providers, RN Care Manager, patient's support network

Humboldt IPA PRIORITY CARE Domain Assessment Adapted from Care Oregon The 5 Domains and INTERMED Complexity Grid LAN02/2011

# Intake Assessment Template

**Intake Assessment**

[Date]

Patient's Name: _____ DOB: __/__/__ Code Status: Insurance Info:

| | | |
|---|---|---|
| Demographic/Family Information:<br><br>Insurance/Financial/Socioeconomic issues:<br><br>Patient/Family Strengths: | ADLs/Mobility:<br><br>Safety Concerns:<br><br>Sleep Concerns:<br><br>Special Needs: | Medications/ Reconciliation issues:<br><br>Current Medication List:<br><br>Risks:<br><br>Adherence: |
| Hospital Admissions:<br><br>ER Visits: | Current Community & Social Services (i.e. VNA, ASAP/ Elder Services, "Meals on Wheels", Community Support Worker etc.):<br><br>Current Rehabilitation Therapies &Treatments (i.e. OT/PT/ST/RT, Cardiac/Pulmonary Rehab, Chemo etc.): | Behavioral Health Concerns:<br><br>Other Barriers to Care: |
| Diagnosis(es)/ Medical Hx:<br><br>Surgical Hx: | Current Specialty Care:<br><br>Current DME/Assistive Devices: | Risk Drivers: |

# Care Plan Components

| | |
|---|---|
| **Intake Assessment** | • To inform Plan of Care; determine problems, risk drivers & barriers to care |
| **Problem List** | • "Risk Drivers?" ("drivers" that led to the patient being identified as Highest Risk)<br>• Co-morbidities, barriers to care |
| **Goals** | • Short & long term goals, to mitigate "risk drivers", address problems and barriers to care<br>• Set goals with patient (specific, measurable, meaningful to patient) |
| **Intervention Plan** | • Interventions to mitigate risk., achieve goals, address barriers to care and meet patient's needs<br>• 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?<br>• Barriers to care addressed? If not, what are the barriers and how might they best be addressed? |

# Root Cause Analysis: The 5 Whys

## *"DRIVERS of the DRIVER"*

1. Why was the patient's risk score so high?
   - ED Visits/inpatient admission & 3 chronic conditions (poorly controlled)
2. Why was the patient admitted to the hospital?
   - Rule out MI
3. Why was the patient admitted for rule out MI?
   - ED visit with chest pain
4. Why did the patient develop chest pain?
   - Medication non-adherence ……*RISK DRIVER*
5. Why did the patient have difficulty with med adherence?
   - Knowledge and cognitive deficits
   - Med regime complexity
   - Financial barriers?

# *Activity #2:*

# *Care Plan Development & Discussion*

# Care Plan Template

**Patient's Name:** XXXXX **DOB**: XX / XX / XX **Code Status:** XXXXXXX **Insurance Info**: XXXXXXX

❑***New Care Plan***: I have actively participated in the development of my Care Plan with my Care Manager/Team.
•I have a copy and will actively partner with my Team to follow this Care Plan.
Patient's Name: _____ Patient's Signature: _____ Date: ____/____/____

❑***Care Plan Update/Change(s):*** I have actively participated in the development of my Care Plan with my Care Manager/Team.
• I have a copy and will actively partner with my Team to follow this Care Plan.
Patient's Name: _____ Patient's Signature: _____ Date: ____/____/____

| Date | Problem(s) | Goals/Target Date | Intervention Plan | Responsible Party | Evaluation & Follow-Up |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

# Activity #2: Care Plan Development

1. Break up into groups
2. For each Risk Driver/Root Cause (Problem) identified in the "5 Whys":
   - set a goal
   - create a plan to reach the goal
   - identify responsible party(ies) for implementation
3. Reconvene to discuss the plans developed by each group

# The Integrated Care Plan

**Patient's Name:** XXXXX **DOB:** XX / XX / XX **Code Status:** XXXXXXX **Insurance Info:** XXXXXXX

| Date | Problem(s) ("Risk Drivers" – factor or factors that led to the patient being identified as Highest Risk) | Goal(s) (Goal relative to "Risk Driver", specific, measurable & meaningful to the patient) | Intervention Plan (The plan to meet goals, service needs and mitigate risk) | Responsible Parties: (Who is responsible for implementing the plan?) | Evaluation & Follow-Up |
|---|---|---|---|---|---|
| | **Medication non-adherence 2° to:**<br>▪ knowledge deficit<br>▪ complexity of medication regime<br>▪ cognitive impairment | Medical:<br>1. Patient will accurately verbalize the name of each of his medications, reason for use, possible side effects, and administration schedule.<br>2. Family will support patient's achievement of medication adherence.<br>Patient:<br>1. To be healthy to be able to do more w/grandchildren. | **Minimize Complexity:**<br>Explore w/ provider, possible opportunities to decrease complexity of med regime (i.e. reduce dose frequency by switching to long acting forms where possible, identify combination meds that could replace two separate prescriptions, etc.)<br>**Patient Education & Support:**<br>▪ Assess/identify "knowledge gaps"<br>▪ Provide teaching where gaps exist (verbal and written instructions)<br>▪ Confirm patient's understanding<br>▪ Reminder strategies (pill organizer, calendar, phone reminders)<br>▪ F/u assessment/reinforcement<br>▪ Involve family supports | ▪ Care Manager<br>▪ Provider<br>▪ Patient & Family | |

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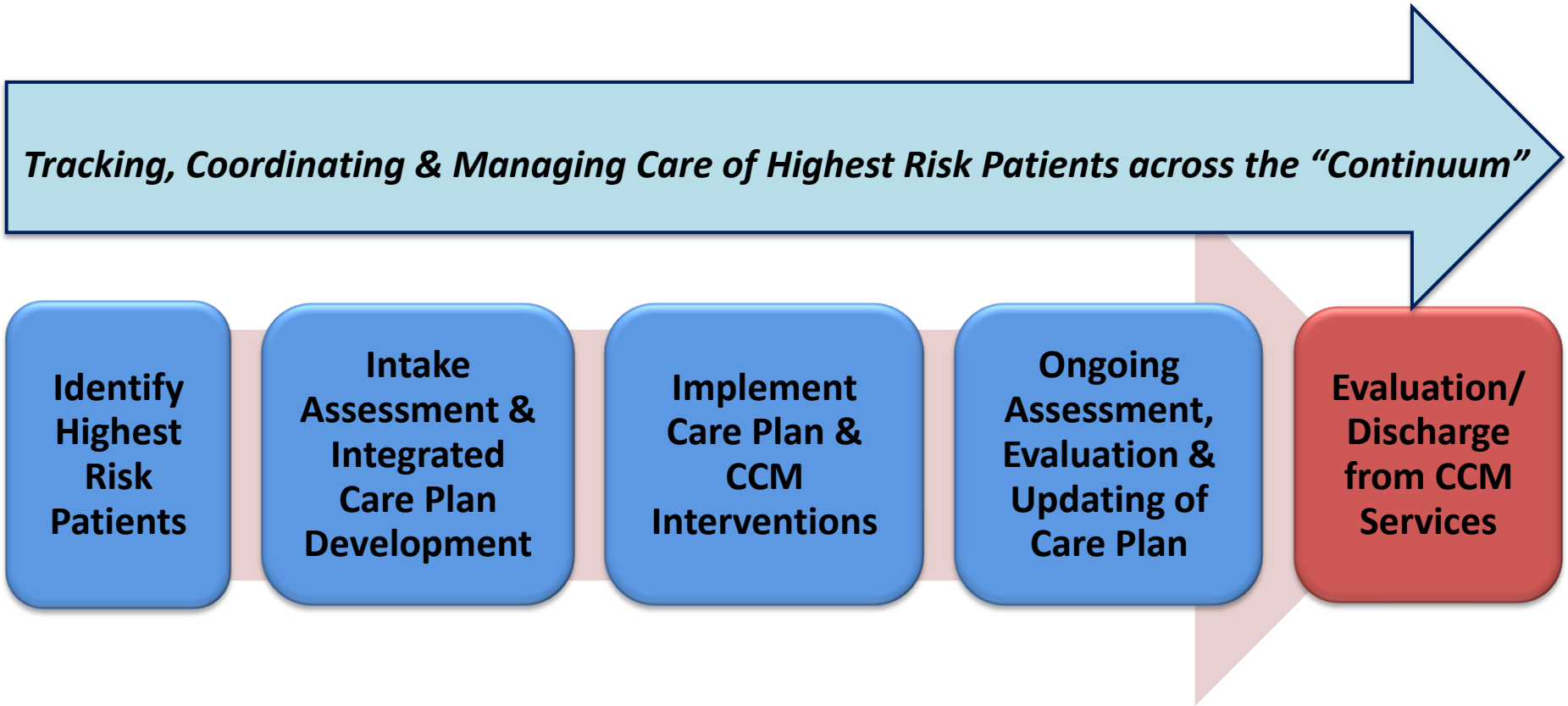
# *The Clinical Care Management (CCM) "Continuum of Care" …..*



# Discussion:

## Is Our Patient Ready for Discharge from the Clinical Care Management Service?

# Our Patient Post CCM Interventions

***After implementation of the care plan, interventions were effective in reaching goals ….our patient is now med-adherent and appropriately engaging in his treatment plan***

- Last ED visit/inpatient admission 6 months ago
- Taking medications as prescribed, BP under control, no incidences of chest pain
- Stress level manageable
  - has decreased childcare responsibilities
- Safety is still an issue that continues to be monitored:
  - bleeding risk (2˚ to warfarin therapy)
  - cognitive impairment

# CCM Discharge Criteria Categories

1. CCM goals have been met/service needs addressed
2. Patient referred for CCM and has not responded to outreach (Unengaged Referral)
3. Patient enrolled in CCM and has stopped responding to outreach
4. Patient is in communication with care manager but is not addressing significant health goals

Source: Cambridge Health Alliance Complex Care Management 2013

# Discharge/ Transition Process

- Care Manager & patient review Care Plan to assess what, if any, health goals remain
- Care Manager discusses with Care team, indications for ending CCM
  - Risk Assessment Tool can be used to validate risk reduction or assess for residual CCM needs
- Care Manager works with patient to:
  - Titrate the relationship
  - Review patient's successes, new skills/ supports
  - Develop plan to address potential future set-backs

# Wrap-up

- Clinical care management focuses on highest risk patients
- Care Manager leads an interdisciplinary team to develop and implement an integrated care plan
- Risk stratification tools are helpful to identify the highest risk patients in your practice
- The integrated care plan addresses risk drivers and goals developed with the patient
- Guidelines and criteria for discharge from CCM help to keep the highest risk registry dynamic

# Clinical Care Management Tools & Resources

- Complex Care Management "Toolkit" (CA Quality Collaborative)
- CCM Triage/Risk Assessment Tool (Cambridge Health Alliance)
- Intake Assessment & Care Plan Template (UMass Medical School)
- CCM Intake Assessment 4 Domains & Scoring Levels (Humboldt)
- Adult Meducation (www.AdultMeducation.com )
- Medication Reconciliation Toolkit (AHRQ)
- Post-Discharge Follow-Up (AHRQ)
- Highest Risk Registry (Excel)
- Discharge Follow-up Tracker (Excel)
- Risk Stratification Tools

# Acknowledgements

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