Delivering Team-Based Chronic Care Management: Overcoming the Barriers

Findings, Recommendations, and Resources from the Primary Care Development Corporation's Integrated Care Planning Initiative

PRIMARY CARE DEVELOPMENT CORPORATION

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PRIMARY CARE DEVELOPMENT CORPORATION

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About PCDC

Founded in 1993, the Primary Care Development Corporation is a nationally recognized nonprofit organization that catalyzes excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity. To date, PCDC has helped over 1,000 primary care practices in 34 states to improve delivery of care by providing capital as well as training and technical assistance services. PCDC has also leveraged over $800 million in capital projects that enhance primary care capacity in low-income communities.

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EXECUTIVE SUMMARY

The United States spends more on health care than anywhere else in the developed world, and yet we have lower life expectancies and worse health outcomes than most industrialized countries.[1,2] A large portion of that spending is for a small group of high-risk, high-need patients. Often, these patients suffer from multiple medical and behavioral conditions, exacerbated by unmet social needs and an uncoordinated health care system focused largely on acute care, and not prevention.

In recent years, there has been increased adoption of chronic care management (CCM) programs across the country as a strategy to improve clinical outcomes, reduce costs, and provide better care for high-risk, high-need patients. CCM aims to address the medical and psychosocial issues that patients face, and is ideally delivered by a team where primary care, behavioral health providers, and care managers coordinate services. Integrated team-based care and the provision of CCM is a new approach to delivering health care that requires organizations to transform and therefore to embrace and support culture change.

Critical to the success of this approach is an organization's ability to engage in integrated care planning – a process through which a patient's care team, as well as the patient and their family/support system, come together on a regular basis to assess the patient's health issues and their priorities, and develop a coordinated plan to address them. The Primary Care Development Corporation (PCDC) believes that care management is a critical strategy for improving outcomes for high-risk, high-need patients, but in our experience it is rarely happening.

This is a report on the *Integrated Care Planning Initiative*, a PCDC led project begun in 2014 funded by the Altman Foundation and The Morton K. and Jane Blaustein Foundation to better address and overcome the challenges related to implementing and delivering CCM in a primary care setting. The initiative created a learning community where organizations providing both primary care and care management for Medicaid patients in New York State worked on developing solutions for their specific challenges, shared best practices, and learned from one another.

During this project, participating organizations made progress creating processes for updating members of the care team on issues regarding the patient, and increased their knowledge and understanding of the goals of integrated care planning and how to carry it out. All participants faced challenges as they tried to improve and spread team-based CCM across their organizations. These included both systemic issues, such as a largely unsupportive payment system, and organizational issues including non-interoperable electronic systems that did not support team-based collaborative care.

Over the course of the project, participants gained an in-depth understanding of how these challenges impact patient care. They designed solutions and approaches to address these challenges head-on, or to work around them. This report provides discussion and key findings from the project. It also includes organizational and policy level recommendations to support and inform stakeholders looking to implement effective team-based CCM. The Appendices contain a PCDC-developed roadmap, examples of workflows and tools developed by participants, findings from a literature review, and case studies of successful large scale care management programs across the country.

We hope that our work provides insight and ideas that will help support better health care for all, but in particular for high-risk, high-need individuals. The delivery of team-based chronic care management is a key strategy for improving health outcomes and lowering costs, but requires significant culture change and redesigning of systems. Health care organizations will need strong leadership, resources, and a commitment to provide better care for those most in need.

INTRODUCTION

The United States spends more on health care than anywhere else in the developed world, and yet we have lower life expectancies and worse health outcomes than most industrialized countries.[1,2] A large portion of that spending is for a small group of high-risk, high-need patients. 50% of Medicaid costs go towards care for 5% of its enrollees,[3] while 50% of Medicare costs go towards care for 10% of its enrollees.[4]

High-risk, high-need patients are defined as those who experience multiple chronic physical and/or mental health conditions and whose health care needs may be exacerbated by unmet social needs.[5,6] Often, these patients are challenged by disease self-management, escalate quickly to acute levels of care, and require hospital and long-term care more frequently. Many may not have access to culturally competent care, may feel untrusting of or unwelcome in the health care system, and therefore fall through the cracks. The effects of poverty, racism, unstable housing, mental health conditions, substance use, and other social determinants of health, coupled with an uncoordinated health care system focused largely on acute, rather than preventive care, all contribute to poor outcomes and high costs for these individuals.

In recent years, and particularly as a result of the Affordable Care Act (ACA), new strategies to improve clinical outcomes and reduce costs have focused on better care for high-risk, high-need patients. These efforts have taken numerous forms and have been implemented at the federal, state, and local levels, as well as by health plans and delivery systems.

One of these new strategies is care management, a set of activities designed to engage patients and their support systems in a collaborative process intended to assist them with managing medical conditions and related psychosocial problems more effectively.[7] Today, many primary care organizations and networks are adding care management programs to their service offerings, and the outcomes of care management are promising, demonstrating improved health outcomes while decreasing the overall cost of care.[8]

Care management includes comprehensive assessment of the patient's needs and care planning that addresses all of the issues that affect a patient's health, with a specific focus on his or her stated preferences and goals. It also includes patient education that incorporates health literacy best practices and the use of strategies such as health coaching and motivational interviewing to support patient engagement and self-management of their conditions.

Care management for high-risk, high-need patients, or those with chronic conditions, is often referred to as

Care Coordination vs. Care Management

The terms care coordination and care management are frequently used interchangeably in the field and in the literature. In this report we use both terms and discuss organizations that use both terms, but make the following distinction: All individuals who access health care services need coordinated care, but only those who have complex medical and/or social needs need care management.

chronic care management (CCM). Because CCM aims to address both the medical and psychosocial issues that patients face, it is ideally delivered by a team where primary care, behavioral health providers (mental health and substance use disorder providers), and care managers coordinate services. This team-based systematic coordination of primary and behavioral health care is known as integrated care, considered by many to be the most effective approach to caring for people with multiple health care needs.[9,10]

Integrated team-based care and the provision of CCM are not simply another set of activities that health care organizations can add to what they are already doing. They are a new approach to delivering health care. Key to the success of this approach is an organization's ability to embrace and support culture change. Integrated team-based care and the provision of CCM require a conscious move away from the care paradigm of the past.

To be successful, organizations must create new workflows both within their organizations and with other external organizations, clarify roles and responsibilities of team members, and provide training for staff. To avoid CCM becoming yet another task to add to practitioners' (doctors, nurse practitioners, and physician assistants) workloads, organizations need to think strategically about the bigger picture. A team-based, integrated approach to the delivery of CCM can translate into better outcomes for patients, and by sharing work with trained care team members, can also address practitioner burnout.

The Primary Care Development Corporation (PCDC) believes that care management is a critical strategy for improving outcomes for high-risk, high-need patients and aligns with our mission to catalyze excellence in primary care to achieve health equity. By focusing on the root causes of chronic conditions such as access to care and the social determinants of health, (safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and healthy environments[11]) care management is a powerful way to engage and care for patients that for too long has been missing from the U.S. health care system. As more health care providers and health plans pursue value-based payment arrangements, care management will be a critical tool for achieving improved health outcomes and reducing unnecessary costly hospital use, particularly among high-cost, high-need patients. In this new payment environment, care management should be offered in all primary care practices, especially those that care for high-cost, high-need patients, and should be reimbursed by payers.

In this paper, we report on the *Integrated Care Planning Initiative*, a PCDC-led project begun in 2014 and funded by the Altman Foundation and The Morton K. and Jane Blaustein Foundation to better address and overcome the challenges related to implementing and delivering CCM in a primary care setting. The initiative created a learning community where participating organizations could work on developing solutions for their specific challenges, share best practices, and learn from one another.

The Integrated Care Planning Initiative

- The Project: Why "Integrated Care Planning?"
- Project Participants
- Insights from the Literature Review
- Project Methodology and Goals
- Learning Sessions and Technical Assistance
- Data and Measurement
- Insights from our Expert Advisory Panel
- Key Findings from the Integrated Care Planning Initiative
- Organizational and Practice Recommendations
- Policy Recommendations

The Project: Why "Integrated Care Planning?"

A central component of delivering team-based CCM is engaging in integrated care planning — a process through which a patient's care team, as well as the patient and their family/support system, come together on a regular basis to comprehensively assess the patient's health issues and their priorities, and develop a coordinated plan to address them.

However, in our experience delivering technical assistance and training to a diverse array of health care organizations both in New York State and across the country, integrated care planning rarely occurs on an organizational or practice level.

Some organizations have hired care coordinators and care managers to work with high-risk patients, but the work they do is often siloed and separate from other health care providers in the organization, sometimes actually creating less coordinated services for patients. Many lack a roadmap or experience for how to collaborate between departments and across organizations – facing fragmented workflows, lack of processes, a culture that has not yet fully embraced team-based care, and a regulatory and payment environment that impedes change.

We chose the title "The Integrated Care Planning Initiative" for this project to reinforce two core ideas: 1) properly executed care planning is essential for patients, particularly those who are high-risk, and 2) delivering it in an integrated, team-based model is an approach that can address the social determinants of health and root causes of a patient's issues.

Project Participants

The Integrated Care Planning Initiative brought together five organizations that were providing primary care and care management for Medicaid patients. As participating organizations in the New York State Health Homes program, all of these organizations received a payment per patient per month (PMPM) to identify, enroll, and provide care management and care coordination for high-risk, high-need Medicaid patients.

All of the participating organizations were National Committee for Quality Assurance (NCQA)-recognized Patient-Centered Medical Homes, had functioning electronic health records (EHRs), and provided primary care, behavioral health, and care management services on site.

Project Participants

Organization	Location	Funding for Care Management	Primary Care Delivery Setting
BrightPoint Health	New York City	New York State Health Homes	Federally Qualified Health Center (FQHC)
Community Healthcare Network	New York City	New York State Health Homes	FQHC
Institute for Family Health	New York City and Westchester County	New York State Health Homes ACO Grant funding for care management for patients who don't qualify for Health Homes	FQHC with residency program
Mount Sinai Hospital System	New York City	New York State Health Homes Grant funding for care management for patients who don't qualify for Health Homes	Internal medicine clinic with residency program.
Upstate Cerebral Palsy-Central New York Health Home	Utica, NY	New York State Health Homes	One FQHC and multiple behavioral health and social service provider sites.

While each had different organizational structures and represented different geographic areas in New York State, these organizations all faced challenges delivering care management as an integrated team.

Insights from the Literature Review

To inform the design of the learning community, PCDC conducted a review of articles and studies on care management and care coordination carried out in the United States and published since 2006. In total, 61 program evaluations, white papers, case studies, issue briefs, and other publications from industry stakeholders were reviewed. (Appendix 2)

The search also included non-peer reviewed studies and relevant tools from reputable organizations in the field, such as the Center for Health Care Strategies, The Commonwealth Fund, the Institute for Healthcare Improvement, the Safety-Net Medical Initiative, Mathematica Policy Research, the Agency for Healthcare Research and Quality, the Robert Wood Johnson Foundation, the California Quality Collaborative, and the Milbank Memorial Fund.

Through the literature review, we sought to identify:

- Evidence supporting the effectiveness of CCM in the primary care setting
- Evidence supporting the effectiveness of integrated care planning and a team-based care delivery approach
- Successful models and approaches for delivering team-based CCM in a variety of settings
- Common attributes and best practices of successful CCM programs
- Challenges and solutions for the delivery of team-based CCM in primary care settings

Searches included key phrases and words such as:

- Care coordination + care management models
- Case conferencing + complex patients
- Chronic care management + complex care management
- Strategies for high-risk, high-need patients
- Team-based care + complex patients
- Integrated care planning + care planning
- Care coordination + hospitalization
- Transitions of care + care management
- Doctors + care management + team based care

Findings:

While drawing conclusions about cost savings and utilization reduction is complicated without following a cohort of patients for several years or doing a randomized controlled trial – few of which exist – there is an ever-increasing number of reviews of care management programs in the literature that demonstrate the benefits of CCM for high-risk, high-need patients. CCM programs appear to be particularly effective in reducing emergency department (ED) and inpatient admissions, and in reducing costs through reducing occurrence of those events.[12]

Some examples of the effectiveness of CCM programs include the following:

- Two academic medical centers and a managed care organization used multidisciplinary teams to improve provider communication, patient and family education, care transitions from the hospital, and follow-up ambulatory care. Results included:[5]
  - a lengthening in average time between hospital encounters among asthmatic children
  - a reduction in 30-day hospital readmission rates of 46% among elderly patients with heart failure
  - a reduction in 30-day hospital readmission rates of 21% among dually eligible Medicare and Medicaid beneficiaries with special needs
- Community Care of North Carolina (CCNC), a program for Medicaid patients, showed that compared to high-risk individuals not enrolled in CCNC, high-risk patients enrolled in CCNC had lower hospital admissions, ED visits, and total cost.

- Common attributes and best practices of successful CCM programs include:
  - using quantitative and qualitative data to identify target populations who need services[13]
  - comprehensively assessing patients' risks and needs[5,14]
  - care planning that includes goal setting and clear indication of an individual's preferences and wishes and incorporates patients and families in care decisions[15]
  - frequent care team contact
  - clear lines of communication between care team providers
  - a care team that works to create a common set of goals with which to direct patient care[16]
  - facilitation of transitions out of the hospital
  - linkages to housing, behavioral health services, and other community resources

Limitations:

While we found a large amount of literature on CCM and team-based care, fewer studies focus specifically on models of "integrated care planning." This may perhaps be because this term is not commonly used. Rather, information on this topic is found in articles and studies that more generally examine team-based care and care management models, or in descriptions of care planning processes.

It would appear that challenges exist for researchers because CCM covers such a broad array of patient types (complex conditions, mental health conditions, substance use disorders, elderly and frail, etc.), is delivered in multiple types of settings (primary care, hospital outpatient settings, large practices, small practices, etc.), and within differing payment models (Medicaid, Medicare, fee-for-service, payment per member per month).

While there are reviews of programs that provide CCM for high-risk, high-need patients and that analyze the effects of these programs, overall the evidence of impact of CCM as well as the evidence for a team-based delivery approach for care management is limited and illustrates the need for: 1) more evaluation of existing programs and 2) more examples of specific CCM models used in different types of settings that are most effective at improving health and reducing cost.

The Expert Advisory Panel

The project was guided by an expert advisory panel consisting of national safety-net provider organizations and leaders from the fields of medicine, nursing, behavioral health, care management, housing, and public policy. The expert advisory panel met three times between November 2014 and May 2016, providing insight into the systemic barriers organizations face in delivering team-based CCM, and sharing experiences addressing challenges in their own organizations. Their insights informed topics and approaches discussed in the learning community. (Insights on the project from the expert advisory panel appear on Page 14).

Project Methodology and Goals

The five participating organizations assembled multidisciplinary "change teams" composed of a primary care provider (PCP) and a care manager, as well as one representative from administration, behavioral health, nursing, and care management supervisory staff. This change team led the work to optimize and improve their site's integrated care planning process and delivery of team-based care management. PCDC created a **Roadmap** (Appendix 1) for the change teams that summarizes key drivers, related change ideas, and best practices in implementing and delivering team-based CCM. The roadmap lays out the following key steps:

1. Obtain organizational commitment for team-based chronic care management
2. Define care teams at the practice level
3. Engage high-risk, high-need patients into care management
4. Ensure clear, routine communication among care team members
5. Train care team members in how to operate as a team
6. Engage patients in the care planning process

As change teams worked over the course of the project, they created and tested solutions, and faced challenges in following the steps in the roadmap. We have cited useful new workflows and tools in the roadmap.

The following is an overview of the work that change teams did and how PCDC supported them as they turned their focus to each key step in the roadmap.

1. Obtain organizational commitment for team-based chronic care management.

At the beginning of the project, PCDC met with leadership at each organization to fully explain the time and resources needed and what an organization stood to gain from participation in this work.

Participating organizations expressed a desire to understand how to more effectively deliver care as a coordinated team for their high-risk, high-need patients. Improving in this area would help them across many other care coordination and value-based payment (VBP) models in which they were already deeply invested, including the New York State Delivery System Reform Incentive Payment program (DSRIP) and Accountable Care Organizations (ACOs).

Starting with the idea that an organization's culture must be supportive for change to succeed, PCDC created two surveys to assess whether clinical and administrative staff at each organization had "bought

into" the concept of an integrated, team-based delivery of CCM and how well they thought it worked.

Change teams and their colleagues filled out the **Team-Based Chronic Care Management Staff Survey** (Appendix 1: 1.1) to assess their CCM operations, staff understanding of their CCM program, and perceptions of how collaborative different departments were with one another when working with high-risk, high-need patients. The results of these surveys allowed each team to set their own individualized goals for the project work.

Because not all the change teams worked on the same goals, PCDC also created a standard **Project Survey** (Page 20) to assess progress on common goals and principles related to best practices in integrated care planning.

After the change teams completed these surveys, attended the first learning session, and participated in a coaching call, we asked them to identify three goals that they wanted to work toward, and we assisted them in designing measures of progress for those particular goals. All the goals that the change teams chose related to the roadmap principles.

2. Define care teams at the practice level.
As project participants thought about defining care teams at the practice level, they realized that empanelment – where the care of a group of patients is assigned to a specific care team – is a foundational component of team-based care delivery. For a team to deliver high-quality coordinated care, they need to know who their patients are, be familiar with their patients' issues, follow up with them between visits, and take full accountability for their care. With empanelment in place, setting up interdisciplinary case conferences and knowing which patients to focus on (the high-risk, high-need patients that your team is responsible for) becomes fairly easy. Without empanelment, it can be a challenge to know how to identify specific patients in particular need. While these change teams could not empanel patients for this project (as this involved change at a much larger scale), many of the organizations were in the process of moving their entire organizations to empaneling patients to specific care teams as part of larger quality improvement changes.

3. Engage eligible high-risk, high-need patients into care management.
Since all the participating organizations could receive a PMPM for each patient enrolled in the New York State Health Homes program, they were eager to use this project to improve their care management enrollment numbers. They knew that there were many patients eligible for care management that they provided primary care or behavioral health services for but who had not been enrolled. Change teams observed a variety of reasons that patients were not enrolled: they had been offered enrollment but declined; they had never been reached out to; or they were in the care of a PCP who was not consistently, or ever, referring eligible patients to care management.

The lack of integrated health information technology systems or processes that would support team communication often resulted in separate care plans created by each department (medical, behavioral health, and care management) for each patient.

4. Ensure clear, routine communication among care team members.
All the change teams chose to work on goals related to making improvement in this area, including:

- Establish regular case conferences with the interdisciplinary team to discuss shared complex, high-risk cases and create one unified care plan.

  When the project began, none of the participating change teams held interdisciplinary case conferences. The lack of integrated health information technology (HIT) systems or processes that would support team communication often resulted in separate care plans created by each department (medical, behavioral health, and care management) for each patient. These plans sometimes had competing patient goals. Teams worked to set aside a time to meet and discuss cases as a

team, test out best ways to run and organize these meetings, and create one integrated template for care planning that they could complete during or after the meeting and then share with the patient at a later time.

- Ensure that care team members' contact information is current, in one location in the EHR, and easily accessible to all PCPs and health care staff.

  Change teams observed that PCPs and other health care staff could not easily access contact information in one place in the EHR; this information was often difficult to access in the system and not kept up-to-date. This maintained the status quo of each department working in isolation and limited the ability of care team members to collaborate on patient care.

- Establish a coordinated approach among the care team for following up with patients after a critical event such as an unplanned hospitalization.

  At the beginning of the project, none of the organizations had a coordinated cross-departmental approach to follow-up on patients who had had an unplanned hospitalization. Many had processes for their own department (i.e., some PCPs were notified when their patient was discharged from the hospital and received a report), but there was generally no process for PCP's to notify behavioral health or care management that their shared patient had been discharged.

5. Train care team members in how to operate as a team.

Change teams learned from their baseline assessment and from discussion that practitioners rarely received information or training on how the care management program at their organization worked and were rarely solicited for their feedback on how it should work. This contributed to a lack of buy-in on the part of some practitioners as they were unfamiliar with what care managers did. Care managers received training on how to deliver services, but rarely received guidance on how to engage with practitioners or function as part of an interdisciplinary team.

6. Engage patients in the care planning process.

Since integrated care planning brings together the care team, the patient, and the patient's family/support system, change teams examined the degree to which patients were being included in the care planning process. While care managers were working with patients and their support systems on care plans, many change teams felt that training in best practices for assessment and care planning, as well as patient engagement strategies such as health literate education approaches and motivational interviewing, would be useful.

Learning Sessions and Technical Assistance

In each learning session, change teams participated in lectures and activities related to team-based CCM led by PCDC staff. Change teams reported to the rest of the group on the work they had been doing, answered questions, and shared successes and challenges. Guest speakers and panelists were invited to present as well.

For coaching calls, change teams met with their PCDC coach to apply the concepts presented in the learning sessions. This often took the form of discussing their organizational challenges, proposing solutions to those challenges, testing these solutions between coaching calls, and reporting back to the team. Processes that the team deemed successful or that produced desired results became recommendations that would be presented to their leadership and rolled out organization-wide.

Data and Measurement

Participating teams collected data throughout the project to track their progress toward meeting their project goals.

Since each organization worked on different sets of goals, not all quantitative process and outcome measures were tracked by all teams. Additionally, many teams had trouble collecting data and keeping up with reporting on processes developed and tested during the project.

Below are three measures that were tracked by three out of five teams:

1. Number of referrals from PCPs to care management
2. Number of new referrals that result in enrollment in care management
3. Number of cases discussed during interdisciplinary case conferences

Results of Referral to CCM and Conversion to Enrollment in CCM Data:

Most change teams were able to increase the number of referrals their PCPs were making to the CCM program. Some change teams worked with many PCPs, while others focused on one or two. This explains the variation in the number of referrals from PCPs across the sites. Some teams also tracked the number of referrals that resulted in enrollment. The number of referrals and the number of referrals resulting in enrollment are used to calculate the "conversion rate."

Site	Data tracked	Jan-March 2015	April-June 2015	July-Sept 2015	Oct-Dec 2015	Jan-Feb 2016
1	Referrals to CCM	34	40	69	73	11
	Enrolled in CCM	11	11	27	6	0
	Conversion rate	32%	28%	39%	8%	0%
2	Referrals to CCM	1	14	0	0	0
	Enrolled in CCM	0	9	0	0	0
	Conversion rate	0%	64%	0%	0%	0%
3	Referrals to CCM	13	13	106	49	26

Results of Cases Discussed During Interdisciplinary Case Conferences Data:

Teams seeking to establish routine interdisciplinary case conference meetings were also experimenting with the best way to run those meetings and determine how many patients should be reviewed. One of the key figures tracked was the number of cases discussed. It took several months to establish these meetings at the practices. Most teams settled on reviewing two to six high-risk cases per one-hour interdisciplinary case conference meeting. This number of cases provided sufficient time for discussion of the patients' issues and to plan next steps for the care team.

One of the five teams that did not track any data on this was never able to get an interdisciplinary team

Site	Data tracked	Jan-March 2015	April-June 2015	July-Sept 2015	Oct-Dec 2015	Jan-Feb 2016
1	Number of cases discussed at ICCs	0	5	3	0	1
2	Number of cases discussed at ICCs	0	0	0	11	6
3	Number of cases discussed at ICCs	0	0	5	13	7

that included practitioners to meet for these meetings. Their pilot site was a residency practice, and leadership was in the process of establishing clear teams with empaneled patients. These changes did not take effect until after the project ended, and the team found it impossible to schedule interdisciplinary case conferences with the necessary care team members in attendance without these structural changes.

Limitations Tracking Process Measures

PCDC worked with the change teams to establish their own measures that would determine if they were making progress towards their goals. However, understanding what to track proved challenging at times. For example, what is the best measure of success if the goal is to have case conferences? More case conferences are not necessarily better for team building and patient care. Rather, what is the measure of a productive case conference with an interdisciplinary team? While PCDC suggested measures, such as the number of care plans with evidence of medical, behavioral health, and care management input, most organizations lacked sufficient staff availability to track this.

One organization, however, was able to track the following:

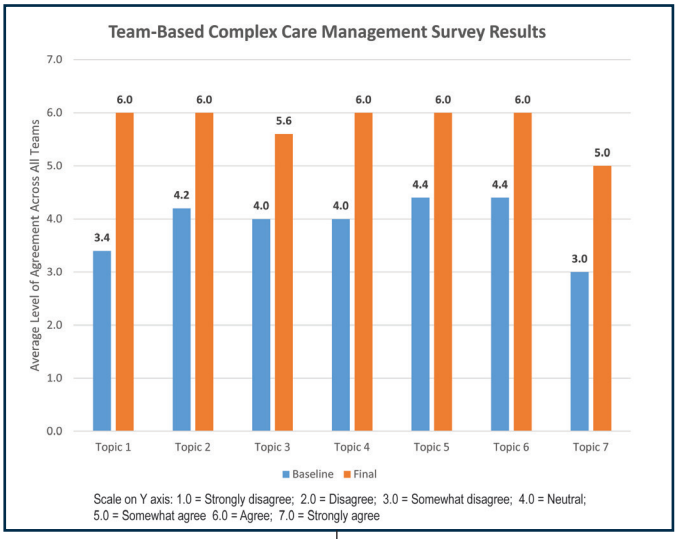
Site	Data tracked	Jan-March 2015	April-June 2015	July-Sept 2015	Oct-Dec 2015	Jan-Feb 2016
3	Number of care plans with evidence of contribution from medical, behavioral health, and care management	0	0	2	13	4

Outcome Measures

Outcome measures were difficult for all sites to track. For example, due to a lack of data sharing among health plans and hospitals and a lack of robust health information exchanges, none of the community health

center sites could effectively track hospital use by their patients.

Change in patient health status also was hard for care managers to report on as they were usually not tracking any clinical measures as part of their programs. Although clinical measures are reported on the practitioner side, teams found it difficult to identify a manageable number of clinical indicators to track improvement in health status across their care management patients. High-risk, high-need patients in these programs often suffered from multiple diseases and conditions and the care management programs had broad eligibility criteria. Data collection and reporting, like care delivery, was not coordinated between care management and primary care.



PCDC encouraged sites to track patient activation and engagement to determine if the new processes implemented during the project helped patients become more engaged in their care. Although the participating organizations agreed that this would be valuable information to have, none were collecting or reporting on this data. These measures are generally not required to be reported to any payer or government agency.

Despite our encouragement, sites decided that they were not ready, nor had the resources necessary, to meaningfully collect patient activation measures (such as building the questions into the EHR, training staff to discuss the questions with patients, having a staff person request that patients fill out a paper form, etc.). Many sites reported that they were having larger conversations at the leadership level about tracking patient activation and engagement measures in the future for their entire organization.

Alternatively, change teams found other ways to anecdotally report patient engagement. For example, one team tracked "no show" rates for primary care appointments among their patient population as a proxy measure for patient engagement; they subsequently reduced their "no show" rate for these patients from 45% to 25%. The team reported that this reflected more coordinated care through increased collaboration among the care team, which resulted in patients being more engaged in their care overall and thus more motivated to show-up for appointments.

Results of Project Surveys

A comparison of the baseline to end results of the Project Surveys revealed that all sites made progress in at least one of the seven topics, with most sites making progress in five to seven topics.

The change teams rated their agreement or disagreement with the following statements:

"Staff have an…"

Topic 1: Understanding of the integrated care planning process and its goals;

Topic 2: Awareness of patients' eligibility for chronic care management services;

Topic 3: Understanding of individual role in the integrated care planning process

Topic 4: Understanding of the other care team roles in the integrated care planning process

Topic 5: Awareness of who is primarily responsible for care planning with the patient

"Staff are…"

Topic 6: Engaged in the care planning process

Topic 7: Using a standard process for updating other care team members regarding patient issues

Teams made the most progress with creating a standard process for updating members of the care team on important issues regarding the patient over the course of this project (Topic 7). Understanding the integrated care planning process and its goals was another area where sites reported significant improvement (Topic 1).

The areas where the least progress was made included staff understanding their role in care planning (Topic 3). This likely reflects how difficult it was for staff from different disciplines to communicate well with one another, and the significant culture change involved in transitioning towards a coordinated team-based care delivery approach as opposed to a physician-led approach. However, over the course of the initiative, staff members from different disciplines who had little contact with each other prior to the project stated how valuable it was for the team to learn about each other's roles and contributions to patient care.

Exit Interview

An exit interview was done with each change team at the conclusion of the learning community. The exit interview focused on various topics, including how well the solutions designed addressed the challenges the team sought to tackle; the extent to which the solutions are implemented at the pilot site; challenges and barriers experienced by the team; the benefits and value of the new solutions to patients and staff; how sustainable these solutions are; and how to adopt them more broadly across the organization.

Exit Interview Common Themes

- There is now interdepartmental communication that did not previously exist at these organizations.
- PCPs and staff from different departments have a better understanding of how each contributes to patient care.
- PCPs and staff feel less isolated in their roles and know who they can contact at their organization to support patients with issues outside of their scope of practice.
- Setting aside staff and PCP time to create any new protocols and procedures, providing training to staff on new approaches, and designating staff to spearhead new initiatives (such as holding regular case conference meetings) were all critical to the implementation and sustainability of the new solutions.
- Many sites encountered leadership that had misconceptions about HIPAA and were hesitant to allow the sharing of patient information across providers even if consent forms were signed. (See policy recommendations for more on the ACA and this issue on Page 18).
- PCPs and staff gained different perspectives about their patients through these interdisciplinary discussions.
- Patients reported to the care managers that they felt their care was more coordinated and that their care providers appeared to be "on the same page" regarding their treatment.
- Having patient information located in multiple systems across departments within and across organizations (i.e., hospitals, managed care plans, primary care practices, care management providers, etc.) was a significant barrier to effective collaboration.

Insights from the Expert Advisory Panel

PCP engagement: It was generally agreed upon by the panel that PCP engagement in CCM programs was a challenge across many organizations. Many PCPs were not aware which of their patients were enrolled in a CCM program, and/or they did not know how to contact a care manager, and many organizations overlooked the need to include PCPs in the rollout of care management services.

It was also pointed out that CCM and a team-based approach was a "culture change," and that PCPs did not necessarily see the value in their being involved in care management activities. The panel recommended that organizations have a strategy and dedicate resources to getting buy-in from PCPs for their care management programs. They encouraged the participating organizations to make it easier for PCPs to know who is on the care team and how to contact them, as well as demonstrating how care managers can take work off the PCP's plate and not add to it.

Providing education and face-to-face meetings where PCPs can meet care managers and understand how care management could help them and their patients was suggested as an approach to build relationships between practitioners and care managers.

Other suggestions for PCP engagement included tying incentives to specific activities that relate to working with care managers or performing specific tasks. It was noted that PCP time spent working with care managers, or any other team members, is not billable and that many PCPs would have to add this activity on top of seeing patients.

Interdisciplinary Case Conferences: To emphasize the importance of a patient-centered approach for case conferences, the panel emphasized the importance of having the teams clarify the purpose of the meetings and what each person's role was before, during, and after the meeting.

Cross-Organizational Collaboration and Partnering with Community Organizations: Recognizing the challenges and changes inherent in this process, the panel emphasized the need for leadership and administration at the organizations to come together and agree on shared goals. They felt that providing stories, data, and ongoing feedback about contributions from the different organizations working together were ways to increase and improve this collaborative atmosphere.

Measures: Discussion about measures took place at every expert advisory panel meeting. While panel members agreed that change teams should be measuring and tracking their work, they also acknowledged that many organizations, including their own, are overwhelmed with reporting and measurement tracking and are also involved in numerous initiatives and projects that compete for staff attention and time.

Key Findings from the Integrated Care Planning Initiative

Interdisciplinary case conferencing is unfamiliar to many staff in primary care organizations, but was seen as extremely valuable for improving coordination of patient care, engaging patients, and improving staff morale.

Most care teams were used to holding "huddles" (frequent, short meetings to stay informed, review work, and make plans) as a means of organizing clinic teams to meet the immediate needs of patients on the day's schedule. Case conferencing is a different process that involves in-depth discussions among interdisciplinary staff about the overall direction of a patient's care, usually focusing on two or three patients at a time, chosen because of their particular immediate needs or acuity.

Scheduling interdisciplinary case conference meetings with the necessary care team members can be extremely difficult to accomplish without established teams that have a shared panel of patients. One team that could not implement established teams with empaneled patients designed a "liaison" model as a means of increasing coordination across medical, behavioral health, and care management departments. In this model, designated staff members at the primary care clinic with access to the EHR systems for each department communicated regularly with care managers and PCPs and updated the PCPs with any important patient information gathered. They also held regular case conferences with care managers so that they could be informed of any patient updates and new appointments or services they could assist their patients with completing. In the absence of established teams, this model helped to improve the coordination of care and communication of critical patient information to the providers and staff that make up an individual patient's care team.

Engaging PCPs in CCM, increased enrollment in CCM

As with many CCM programs around the country, New York State provides Health Home organizations with a list of Medicaid enrollees who are "high utilizers" and who qualify for CCM services. Project change teams reported that a "top down" approach to patient recruitment and engagement – in which outreach workers seek to enroll patients on the list, call them, or even

go to their homes – often yielded poor results and left significant numbers of eligible patients without those services. Many patients on these lists did not respond favorably to being approached or called by a stranger who had yet another program to offer them.

Health Home organizations and other care management providers also engage in "bottom up" enrollment, in which PCPs and care team staff identify eligible individuals who are known to them and who may benefit from the program. An effective relationship and strong communication between the patient, PCP, and care manager resulted in a greater likelihood that the patient would enroll in CCM. For example, patient enrollment increased when PCPs indicated on their CCM referrals the reason for the referral and care managers could explain to the patient why the PCPs thought CCM would be of help. The role of the PCP was seen as critical as patients tended to trust the PCP and take their recommendations.

To engage PCPs in CCM enrollment, care managers attended staff meetings with PCPs on a more regular basis. These meetings built trust so that PCPs knew to whom they were referring their patients and gained a better understanding of the work that care managers did. Care managers also provided in-service training to PCPs, explaining how CCM could help their patients, how they could access these services, and how care managers could assist PCPs with some of the workload related to complicated patients with high social service needs. Once PCPs understood these things, referrals started coming more readily.

Critical events such as hospitalizations can be opportunities to engage patients in care management.

"Warm hand-offs" (defined as when care team members introduced a patient to another care team member in person) made the enrollment process more seamless and made patients more likely to enroll. Some teams embedded a care manager onsite with the PCP to conduct intake assessments with patients referred to CCM on the same day the patient had a primary care or behavioral health visit. When this was not possible, medical assistants, nurses, and/or social workers were trained to meet with patients the same day as their primary care or behavioral health visit. Practitioners or trained practice staff could introduce the patient to the care management team member, show the patient that this was a trusted member of the team, and inform them that care management would be following up. This made enrollment in the program more convenient for the patient.

Most EHRs do not currently support team-based care

Finding the names and contact information of care team members in the EHR proved surprisingly and needlessly complicated. Most EHRs are not configured to enable this seemingly simple activity, and project change teams expressed the need to have care team contact information accessible in a common, easy-to-reach location. For example, PCPs who sought to notify care managers of critical patient updates often could not do so because they did not know which care manager was working with their patient and/or how to get in touch. Organizations using multiple outside agencies to provide CCM services, as is common in the Health Homes program, faced additional challenges in keeping contact information up-to-date since it was often documented in separate and unconnected HIT systems.

Four out of five of the organizations participating in the project did not have an electronic care plan where information from physical health, behavioral health, and care management could all be recorded in one place. One organization used a spreadsheet with tabs on the bottom for each department for its care plan.

A coordinated response to critical patient events such as unplanned hospitalizations requires clear direction from leadership and defined interdisciplinary care teams.

PCPs and care managers did not receive notifications consistently from hospitals or health plans after a critical event such as an admission or discharge.

Real-time notification was rare, was sent by different methods (e.g., electronic, fax, phone, or letter), or was sent to different offices or people in the organization (e.g., administration, finance, nursing, social work, or a general mail box). This lack of a system contributes to poor or no follow-up care for patients and missed opportunities to get CCM services to those who might benefit from them.

To effectively communicate with patients, care managers must be notified about critical events such as unplanned hospitalizations or new diagnoses as these can provide opportunities to engage patients in CCM services. For example, some PCPs participating in the project asked the care manager on their team to visit hospitalized patients to help coordinate discharge and engage them in CCM services. These care managers reported that patients were often more open to receiving CCM services during those times.

However, when interdisciplinary teams were not well established or were not accustomed to working together, responses to notifications regarding unplanned hospitalizations remained siloed, with each department conducting its own process or having no process to follow up with patients.

Organizational and Practice Recommendations

The following recommendations for organizations and practices seeking to implement and sustain team-based CCM are based on the key findings and work conducted through the project.

Empanel Patients Based on Interdisciplinary Teams

Empanelment is the foundation of high-functioning team-based care. Without a shared panel of patients, interdisciplinary team communication and case conference scheduling can suffer, as can team cohesion and a shared sense of responsibility for patient care.

Establish Protected Time and Payment for Regular Case Conferencing Involving all Care Team Members

A fee-for-service payment system generally does not support interdisciplinary case conferences – a factor that will hopefully change as health care moves toward an increasingly VBP environment. Although the Health Homes PMPM payment covers CCM and support staff to participate in case conferencing, it is often insufficient to fully cover PCPs' time for these activities. Most administrators want salaried practitioners to continue to maximize their time spent on billable activities and are reluctant to grant them protected time to participate in case conference meetings. As a result, case conferences involving care managers and PCPs either do not occur, or PCPs who see value in interdisciplinary case conferencing add them into their busy schedules, contributing to burnout and job dissatisfaction.

To establish regular case conference meetings, organizational leadership should provide protected time for PCPs and ensure that VBP arrangements support this work. Leadership should also designate a case conferencing "champion" – a clinician on the team with strong organizational capabilities who can ensure that meetings are scheduled and attended, content is prepared, and follow-up items are completed.

Embed Care Managers, Conduct "Warm Hand-Offs," and Train Practitioners to Increase CCM Enrollment

"Bottom up" referrals, in which PCPs refer eligible patients to CCM programs, can lead to higher enrollment rates than "top down" methods. This requires coordination between the CCM program and primary care, hospitals, behavioral health, and other social service providers where patients may obtain services. The "warm hand-off" from a patient's PCP yielded higher enrollment in the care management program in most cases in this project.

PCPs also need training and information about CCM programs. They need to be given opportunities to interact with care managers and become familiar with the services they provide. They must also understand how the CCM enrollment and consent process works.

Establish Coordinated, Integrated Follow-up after Critical Events/Unplanned Hospitalizations

If organizations are to move towards decreased

readmissions and ED use for their patients, all patients should be contacted after critical events, with one person or office coordinating with all the other departments or teams. A well-established process should include workflows to ensure that notifications are sent to the correct staff members and defined roles and responsibilities for the staff members involved in follow-up.

Given the myriad ways that information about critical events flows in and through organizations, organizational leadership must establish clear roles, responsibilities, and processes for responding to notifications about these events within the organization and with nearby hospitals, specialty facilities, and health plans.

Policy Recommendations

To support high-quality, integrated team-based CCM, many changes, such as those made during this project, can be made at the organizational and on-the-ground level. However, it became clear during the course of the Integrated Care Planning Initiative that many organizations seeking to move toward integrated, team-based delivery of CCM face challenges that can only be addressed through changes in policy, either at the federal, state, or payer level. The policy recommendations below are not comprehensive, but reflect specific issues that we identified during the course of this project.

Payment Models Must Support Team-Based Care
As health care financing moves from fee-for-service to VBP, it is critical that care management payments fully cover all costs related to care management, including time for PCPs and staff for case conferencing, collaborative care planning, and coordinated follow up to critical events. Whenever possible, organizations undertaking care management should be paid prospectively based on patient enrollment and acuity.

Ensure Health Information Technology Access and Interoperability
While considerable efforts are being made to foster health information exchange, the current state of HIT does not adequately support consistent real-time information sharing between and even within organizations. As was seen with the participating organizations in this project, rarely did medical, behavioral health, and care managers who care for the same patient receive the same notifications or information from hospitals or outside providers.

Additionally, even within an organization, as was the case with almost all of the project participants, it is common to have primary care, behavioral health, and care management programs operating in three completely different HIT systems or in three separate sections of an EHR. This substantially hampers collaboration between departments, can be unsafe for the patient as different information is located in different places in the EHR, and places a substantial burden on staff to find ways to share information about patients throughout the care team.

The organizations that participated in this project are not outliers. To provide context, only 30% of hospitals across the country routinely notify PCPs outside their system of an ED visit,[18] 37% of ambulatory care practitioners electronically share information with other providers, and 11% share information with behavioral health practitioners.[19] EHR vendors often charge substantial fees to connect their systems with others, health plans and health care organizations are often reluctant to share data with other entities, and state and regional-based health information exchanges do not capture information from all providers. Meanwhile, the number of health information exchange implementation efforts has been in decline.[20]

The Office of the National Coordinator has charted a roadmap for national interoperability by 2024[21] and is strengthening standards to achieve these goals. However, intermediate steps can be taken at the state level that can foster greater interoperability today.

- **Strengthen vendor standards for EHR systems, assist practices with interoperability, and validate practice level interoperability.** States should recommend that practitioners select EHRs that are fully functional for all health care and care management services, as well as fully interoperable with other systems.

- **Leverage federal HITECH matching funds to expand primary care and behavioral health integration.** CMS has recently released guidance that allows states to request 90% matching federal funds to facilitate and promote electronic connections amongst a wider range of Medicaid practitioners, including behavioral health professionals.[22] States are required to use these federal funds to support Medicaid practitioners' efforts to meet Meaningful Use objectives. This is a promising opportunity to improve and support collaboration between PCPs and behavioral health providers.

Facilitate Data Sharing Through Education and Policy Changes

In recent years, laws have enabled the appropriate sharing of health information among health care organizations involved in a patient's care to foster effective care coordination and care management. The ACA amended federal health care privacy laws (HIPAA) to allow the sharing of health information between primary care and behavioral health organizations for this purpose. States can have more stringent laws, and many do; patients can decline to have information shared between providers if they choose to do so. This issue was identified during this project as different providers discussed cases and tried to move towards sharing and coordinating care across departments. There was a hesitancy, or sometimes complete lack of ability, for staff to share appropriate health information between all those involved in a patients' care – even within a single organization. We believe this was due primarily to two factors: 1) misunderstanding of HIPAA laws, despite changes brought about from the ACA, and 2) administrative blocking of electronic access in some organizations to certain providers and staff to parts of a patient's EHR.

One organization believed that behavioral health providers and PCPs were not allowed to disclose information with each other about a patient they both provided care for, even when the patient had consented to have information shared. With information recorded in two separate HIT systems, one for behavioral health staff and another for primary care staff, very little information was shared, which impeded coordination of care. Other organizations were unclear about what could be disclosed, so their default action was not to share. Even organizational policies on information sharing were more conservative than required, suggesting that organizational leadership did not fully understand regulations governing data sharing for patient care.

- **Provide clear guidance to health care and administrative staff about federal and state confidentiality laws to facilitate data sharing.** States should issue guidance clarifying policies regarding the appropriate disclosure of information within and between health care provider organizations to effectuate care coordination and care management services.

- **Promote Integrated Care for Patients with a Substance Use Disorder.** Federal regulations on sharing information were promulgated in 1987 through 42 CFR Part 2 to provide essential confidentiality for people with substance use disorders (SUD), which, at the time, were critically needed to protect people and reduce stigma. An update to these regulations to manage the care of patients with SUD in the context of primary care is currently being proposed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and would enable the sharing of treatment information with organizations involved in population health management (e.g., ACOs, Health Homes, and managed care organizations). However, the proposed rule allows information to be shared with "the office or unit responsible for population health management in the organization," which may not apply to care managers or practitioners in a care team. SAMHSA should therefore clarify the rule to ensure that treating practitioners are covered; consider closer alignment with HIPAA standards; and include care coordination as a service qualified to participate in SUD information-sharing.

- **Allow Billing for Same-Day Physical and Behavioral Health Visits at FQHCs.** FQHCs are often major providers of primary care, behavioral

health, and care management services. However, five states (Iowa, Kentucky, Nevada, New York, and Utah) and the District of Columbia do not allow FQHCs to bill for a physical and behavioral health visit on the same day[25] under the FQHC Prospective Payment System (PPS), which creates a financial incentive for FQHCs to schedule patients for visits on multiple days. While VBP arrangements could also incentivize same-day care, the states would still need to enable FQHCs to bill for both visits to comply with PPS rules. Allowing same-day billing for a primary care and a behavioral health visit would support team-based care delivery centered on the real-time needs of patients. It would also ensure a more seamless hand-off between the PCP and the behavioral health provider that would better support patient engagement and eliminate the inconvenience of scheduling multiple visits on patients, staff, and practitioners.

- **Leverage Data Collection and Analysis for More Effective Patient Allocation.** One of the key lessons learned from the initiative is that PCPs can be overwhelmed by working with a large number of care coordination entities and care managers, and vice versa. While much of this can be addressed at the organizational level, states and health plans can encourage PCPs to work with a manageable number of care managers, and care managers to work with a manageable number of PCPs.

  When patients have no specific primary care or behavioral health provider identified, the states and health plans should use algorithms that identify patient loyalty and utilization patterns to assign patients to existing PCPs and care coordination services, consistent with the patient social and geographic relationships. Care management programs can use this data to inform patient assignments within their organizations to determine which provider is best positioned to provide services to a patient.

Conclusion

The effects of poverty, racism, unstable housing, mental health conditions, substance use, and/or aging, coupled with an uncoordinated health care system focused largely on acute care, and not prevention, all contribute to poor outcomes and high costs for high-risk, high-need individuals. Team-based CCM can help. Health care providers can improve patient care by implementing interdisciplinary case conferences to discuss patient cases, plan care, and solicit the preferences and concerns of patients and their families. They can strategize on how to ensure that all high-risk, high-need patients receive care management and that processes that involve coordination between team members such as after critical events are in place. These changes are not easy and involve culture change to succeed. However, as value-based payment becomes a reality for much of the health care system, interventions like CCM will be critical for achieving better health outcomes at lower costs for vulnerable populations. Health care organizations will need strong leadership, resources, and a commitment to provide better care for those most in need of it.

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APPENDIX 1

Integrated Care Planning Roadmap, Example Workflows and Tools

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B. Roadmap

C. Suggested Measures

D. Example of Workflows and Tools Table of Contents

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3.2. Increasing Patient Enrollment in Care Management: Using Clinic Support Staff in the Referral Process

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4.4.a. Example Workflow

APPENDIX 1A

How to use the Roadmap and Example Workflows and Tools from the Project

The workflows and tools created during the learning community and developed by the participating teams are included here. The Roadmap provides a summary of the key drivers and change ideas that were used to guide the work of the project teams and can be used by other organizations looking to implement similar changes. It also provides a list of corresponding tools and workflows, most of which were developed by the project participants.

Please note that the workflows and tools presented are examples of how project participants adopted the change ideas at their practices. They were developed with the individual organization's needs in mind and are not necessarily validated or widely tested approaches. They have been included as examples for other practices to review as they seek to adopt similar improvements in the coordination of care between primary care, behavioral health, and care management.

The following topics are included:

1. Obtaining organizational commitment for team-based chronic care management
2. Defining care teams at the practice level
3. Establishing clear, routine communication among care team members
4. Engaging high-risk, high-need patients into care management
5. Training care team members in how to operate as a team
6. Engaging patients in the care planning process

The workflows and tools developed as part of the project are found under specific approaches listed in the Roadmap under "Tools." Each approach contains a summary sheet that describes the purpose of the designed solution, the challenge(s) it seeks to address, and how it supports team-based chronic care management. This is followed by a list of best practices for leadership and staff to consider when implementing these solutions at their own practices.

Leaders and staff aiming to implement these solutions at their own practice should review the Roadmap for context and to understand how the workflows and tools presented address specific key drivers and change ideas that can impact the success of team-based chronic care management. It is important to consider how these approaches can support the needs of the individual practice and its patients and staff and where they may need to be modified. We recommend paying close attention to the best practices as they provide advice on how participating organizations addressed unanticipated challenges with implementing these solutions.

Following the Roadmap is a list of suggested process, outcome, and satisfaction measures that practices should consider tracking as they implement the solutions presented to support team-based chronic care management.

APPENDIX 1B

Primary Driver	Secondary Drivers	Change Ideas	Tools
1. Organizational commitment toTeam-Based Chronic Care Management	✔ Leadership is committed to the idea of involving practitioners in care management activities and understands how this can be of value to patients and staff ✔ Practitioners buy into and understand how chronic care management can help them achieve goals	• Engage senior leadership (of any organizations involved) in a discussion of the relationship between organizational goals, performance-based payment, and team- based chronic care management • Based on engagement of senior leadership, develop organizational goals and key performance indicators (KPIs) for team-based chronic care management	1.1 Assessing Your Team-Based Chronic Care Management 1.1. a. Team-Based Chronic Care Management Staff Experience Survey
2. Care teams are defined at the practice level	✔ Patients are empaneled to defined interdisciplinary teams ✔ Staff roles to coordinate care across disciplines are established	• Define teams of PCPs, behavioral health practitioners, and care managers based on their shared patients • For established patients who see practitioners on different teams, consider implementing processes to facilitate communication between these practitioners • Assign new patients to specific teams based on their needs and preferences • Regularly review and update panel assignments • Consider assigning care management staff to work with specific practitioners or teams of practitioners. As new patients enroll in the care management program assign them to care managers who work with their practitioners.	• Safety-Net Medical Home Initiative, Empanelment: http://www.safetynet-medicalhome.org/change-concepts/empanelment • Improving Chronic Illness Care, Group Health Research Institute: http://www.improvingchroniccare.org/downloads/empanelment.pdf

		• Embed nurses or care managers in the practice who can interface between departments and act as a point of contact for practitioners and care managers if care teams are not well established or do not share patient panels.	2.1. Liaison model between primary care, behavioral health, and care management
3. Practitioners and clinical staff engaging high-risk, high-need patients into care management services	✔ Practitioners are aware of the care management services available, how they can support their patients, and how to refer patients to the program ✔ Processes to manage referrals from practitioners to care management are clearly established	• Provide education during staff and team meetings on the care management program, the services it provides, patients served, and how to refer and connect with the program • Support practitioners in identifying patients on their panel who may benefit from but are not receiving care management services and establish a process for practitioners to refer patients into the program • Use clinical staff to assess patient interest and eligibility for care management services and to make referrals to the program • Encourage practitioners to offer care management services to patients not currently receiving them at visits following a hospitalization • Close the loop on referrals to care management by communicating the outcome to the referring practitioner	3.1. Increasing Patient Enrollment in Care Management: Practitioner Referrals 3.1.a. Example Workflow 3.1.b. Example of a Referral to Care Management with Useful Patient Information 3.2. Increasing Patient Enrollment in Care Management: Using Clinic Support Staff in the Referral Process 3.2.a. Example Workflow 3.3. Notifying Practitioners of their Patient's Participation in Care Management: 3.3.a. Example Communication from Care Management: Notification of Patient's Enrollment in Program 3.3.b. Example Communication from Care Management: Request for Input on Comprehensive Care Plan

4. Clear, routine communication occurs among team members	✔ Care team members routinely communicate about the needs of shared patients ✔ Shared care plans are visible to all team members involved in a patient's care ✔ Processes exist to engage patients in the care planning process ✔ Care team members have each other's up-to-date contact information	• Establish regular interdisciplinary case conference meetings to discuss high-risk, high-need patients shared between practitioners and care managers • Establish that care managers will follow-up with the patient after the interdisciplinary case conference discussion about any potential changes to the patient's care plan and input on action items for completing goals • Maintain up-to-date care team contact information in one location in the EHR • Discuss the patient again at the next interdisciplinary case conference meeting if the patient is in disagreement on goals on approach for the care plan • Create opportunities for communication between care management and clinicians in the course of routine care ■ Embed care managers at primary care sites ■ Include care management staff in daily clinic huddles ■ Use secure texting between care team members ■ Engage a clinical liaison -- such as a nurse -- to communicate information to clinicians and to other team members • Focus on engaging practitioners in care planning for a small group of high-risk patients with multiple, complex needs to design and test new care planning systems	4.1. Establishing Regular Interdisciplinary Case Conferences: 4.1.a. Example Workflow 4.1.b. Case Consult Form Example 1 4.1.c. Case Consult Form Example 2 4.2 Maintaining Accurate Care Team Member Contact Information 4.2.a. Example Workflow 4.2.b. Sample Monthly Update Report

	✔ Care team members receive notifications about critical events, such as patient hospitalizations	• Encourage practitioners to alert the care manager when one of their shared patients is in the hospital so that the care manager can support discharge planning and follow-up	4.3. Coordinated care team response to unplanned hospitalization 4.3.a. Example Workflow 4.4. Offering care management services to patients at post-discharge visit 4.4.a. Example Workflow
5. Train care team members in how to operate as a team		• Provide education during staff and team meetings on the care management program, the services it provides, patients served, and how to refer and connect with the program • Provide in-servicing to all staff and new staff including and especially practitioners on the CCM program	• PCDC's Care Management Fundamentals Training: www.pcdc.org • PCDC's Team-Based Care in the Patient Centered Medical Home Workshop: www.pcdc.org
6. Engage patients in the care planning process		• Provide training to all staff on patient engagement strategies, health literacy education approaches, motivational interviewing, the social determinants of health, and best practices in assessment and care planning	• PCDC's Care Management Fundamentals Training: www.pcdc.org

APPENDIX 1C

Process Measures:

- % of target population with integrated care plans
- % of patients who were seen by their PCP within 7 days of discharge from the hospital
- # of interdisciplinary case conferences held per month
- # of referrals from practitioners to chronic care management
- # of new referrals that result in enrollment in chronic care management program

Patient-focused:

- Healthy days: Centers for Disease Control and Prevention. Measuring Healthy Days. Atlanta, Georgia: CDC, November 2000. https://www.cdc.gov/hrqol/pdfs/mhd.pdf
- Patient activation: Insignia Health Patient Activation Measure: http://www.insigniahealth.com/products/pam-survey

Long-term outcomes:

- # of preventable admissions in target population
- # of hospital readmissions within 30 days in target population

Experience Surveys:

- Practitioner and staff experience with processes (see Assessing Your Team-Based Chronic Care Management: Staff Experience Survey)
- Patient experience with care management

APPENDIX 1D

Assessing Your Team-Based Chronic Care Management

For organizations looking to improve team functioning within their chronic care management program, it is important to understand staff perceptions of the care management program, the barriers they experience to collaboration with other team members, and what they need to feel supported in their role on the team.

This 16-question survey covers common challenges that staff experience working in a team-based chronic care management program and measures the extent to which these challenges are issues for them in their everyday work. It also provides a forum for staff to provide feedback about what is working well and what could be improved about the program. Staff should be instructed to fill out this survey anonymously. Answers gathered should be used as a starting point to facilitate discussions with staff to identify specific goals and choose approaches to improve team functioning and collaboration across staff from different disciplines.

1.1.a. Team-Based Chronic Care Management Staff Survey

1. What is your role? (Please check all that apply)
   - ☐ MD/DO
   - ☐ NP/PA
   - ☐ RN
   - ☐ LPN or MA
   - ☐ Nurse Care Manager
   - ☐ Care Manager or Care Coordinator
   - ☐ Outreach Worker or Patient Navigator
   - ☐ Behavioral Health Provider
   - ☐ Social Worker
   - ☐ Administrator or Project Manager
   - ☐ Pharmacist
   - ☐ Specialist Provider
   - ☐ Other (please specify)

2. I understand how to contact the other members of my patients' multidisciplinary care team who are participating in [name of care management program]. (Please indicate level of agreement).
   - ☐ Strongly disagree
   - ☐ Disagree
   - ☐ Somewhat disagree
   - ☐ Neither agree or disagree
   - ☐ Agree
   - ☐ Strongly Agree

   Comments:

   _____

3. How often are you able to contact other members of a patient's care team at your organization when you need to?

	Never	Rarely. In less than 10% of the chances when I should have	Occassionally. In about 30% of the chances when I should have	Sometimes. In about 50% of the chances when I should have	Frequently. In about 70% of the chances when I should have	Usually. In about 90% of the chances when I should have	Every time
Clinicians	☐	☐	☐	☐	☐	☐	☐
Nursing	☐	☐	☐	☐	☐	☐	☐
Behavioral health providers	☐	☐	☐	☐	☐	☐	☐
Social service providers	☐	☐	☐	☐	☐	☐	☐
Care management staff	☐	☐	☐	☐	☐	☐	☐

   Other relevant staff members (Please specify and indicate frequency)

4. Overall, how would you rate the communication among the care teams (including clinicians, behavioral health, social and care management staff) involved in [name of care management program]?
   - ☐ Poor
   - ☐ Fair
   - ☐ Good
   - ☐ Very good
   - ☐ Excellent

   Please provide any additional comments:_____

5. This care management program is a valuable resource for my patients (Please indicate your level of agreement).
   - ☐ Strongly disagree
   - ☐ Disagree
   - ☐ Somewhat disagree
   - ☐ Neither agree or disagree
   - ☐ Somewhat agree
   - ☐ Agree
   - ☐ Strongly agree

   Please provide any additional comments:_____

6. Among all the tasks you need to accomplish on a daily basis, how much do you consider integrated care planning activities a priority?

- ☐ Not a priority
- ☐ Low priority
- ☐ High priority
- ☐ Medium priority

Please provide any additional comments:

_____

7. Please indicate the level of influence the members of the patient's care team tend to have during the care planning process

	Not at all Influential	Slightly Influential	Somewhat Influential	Very Influential	Extremely Influential
Clinicians	☐	☐	☐	☐	☐
Nursing	☐	☐	☐	☐	☐
Behavioral health providers	☐	☐	☐	☐	☐
Social service providers	☐	☐	☐	☐	☐
Care management staff	☐	☐	☐	☐	☐

Please provide any additional comments:

_____

8. I am aware of what other members of the care team are working on with my patients participating in [name of care management program]

	Not at all aware	Slightly aware	Somewhat aware	Very aware	Extremely aware
Clinicians	☐	☐	☐	☐	☐
Nursing	☐	☐	☐	☐	☐
Behavioral health providers	☐	☐	☐	☐	☐
Social service providers	☐	☐	☐	☐	☐
Care management staff	☐	☐	☐	☐	☐

Please provide any additional comments:

_____

9. I understand my role in the care planning process for my patients participating in [name of care management program] (Please indicate level of agreement).

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Somewhat disagree
- ☐ Neither agree or disagree
- ☐ Somewhat agree
- ☐ Agree
- ☐ Strongly agree

Please provide any additional comments:

_____

10. I understand what the following roles do and how they can help my patients.

	Strongly Disagree	Disagree	Somewhat Agree	Neither Agree or Disagree	Somehat Agree	Agree	Strongly Agree
Clinicians	☐	☐	☐	☐	☐	☐	☐
Nursing	☐	☐	☐	☐	☐	☐	☐
Behavioral health providers	☐	☐	☐	☐	☐	☐	☐
Social service providers	☐	☐	☐	☐	☐	☐	☐
Care management staff	☐	☐	☐	☐	☐	☐	☐

Please provide any additional comments:

_____

11. I feel supported by the organization in my role to provide adequate care planning services to my patients (Please indicate your level of agreement).

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Somewhat disagree
- ☐ Neither disagree or agree
- ☐ Somewhat agree
- ☐ Agree
- ☐ Strongly agree

12. Do you have the resources you need in order to provide care planning services to your patients?

- ☐ Yes
- ☐ No

If no, please explain:

_____

13. I feel that other members of the care team see my role and knowledge as valuable (Please indicate level of agreement).

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Somewhat disagree
- ☐ Neither agree or disagree
- ☐ Somewhat agree
- ☐ Agree
- ☐ Strongly agree

Please provide any additional comments:

_____

14. What do you feel works well about the integrated care planning process for [name of care management program]?

_____

15. What do you feel could be improved about the integrated care planning process for [name of care management program]?

_____

_____

_____

_____

2.1. Liaison Model Primary Care, Behavioral Health and Care Management

For practices serving a high number of patients that also have a large care management program, such as those found in Health Homes programs, establishing consistent teams and facilitating routine communication among the patient's practitioners and care managers can be extremely challenging. The liaison model can help address this challenge by providing another point of contact at the practice for care managers to coordinate with. This approach addresses coordination issues associated with not having defined interdisciplinary teams that share a panel of patients.

In this model, clinical staff, such as a RN who serves as a care manager on the primary care team (Primary Care Manager) and a social worker (Care Manager) who provides chronic care management services, act as the intermediaries between the primary care and behavioral health practitioners and other care management staff. In this role, their key responsibilities include:

- Case conferencing with care managers regarding patients in care management who are also seen by practice clinicians.
- Organizing in-person interdisciplinary case consult meetings between medical, care management, and behavioral health.
- Notifying primary care practitioners (PCPs) of any new and significant issues affecting their patients identified by other care team members.
- Answering questions for care team members regarding medical, behavioral, or social issues affecting patients in the practice.
- Connecting patients referred by PCPs for care management services to those services.
- Communicating with care managers about urgent referrals needed for their patients so that care management can support the patient in completing the referral.
- Closing the loop with PCPs regarding significant tasks care managers completed for patients and completion of urgent referrals.

Best Practices:

- Designated staff in these liaison roles must be well versed in primary care and care management operations.
- Project management skills are critical for these roles as they are managing multiple demands, both involving patient care and administrative tasks.
- These staff members should be onsite at the primary care practice as much as possible. Too much field work will prevent them from carrying out their intermediary role.

3.1. Increasing Patient Enrollment in Care Management

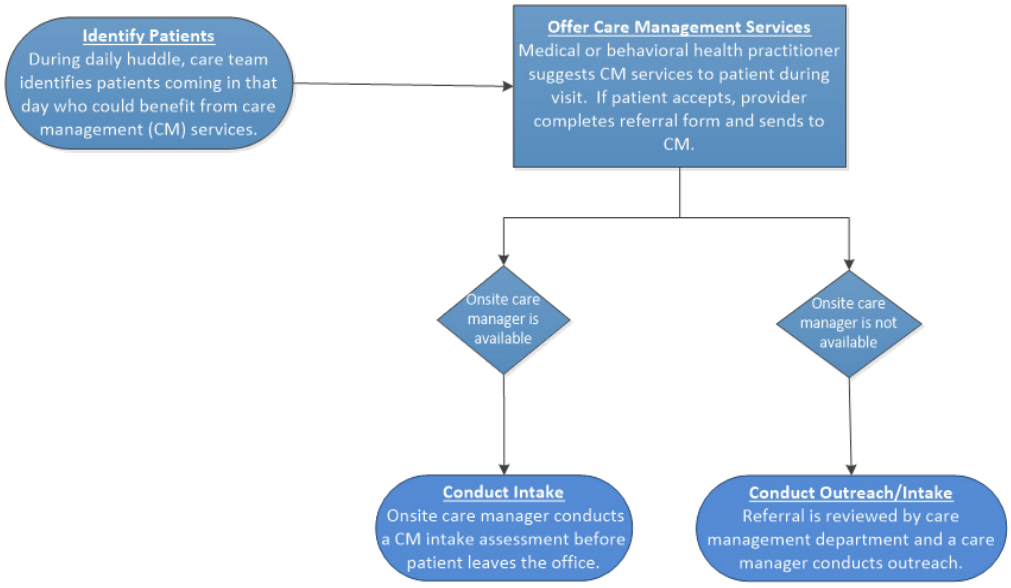
Primary care and behavioral health practitioners who identify and refer high-risk patients to care management services help patients receive the support they need to navigate complex health and psychosocial services in a timely manner. Care management services also give practitioners a resource to help their patients address social issues affecting their health.

Patients who could benefit from care management services may be more likely to engage in them if they are recommended by their practitioner that they trust as opposed to someone who is unknown, such as an outreach worker. Practices have experienced greater success at enrolling patients, particularly those who are hard to reach, into care management when they involve the practitioners in their practice.

Best practices:

- Ensure that practitioners are trained on and understand that a care management program exists, how it benefits patients, which patients are appropriate for services, and how to complete a referral.
- Provide a point of contact within the care management program for practitioners to contact with any questions or issues.
- Embed prompts in the EHR to remind practitioners to assess the patient for care management services during critical visits, such as after an unplanned hospitalization or emergency department visit (see Offering Care Management Services to Patients at Post-discharge Follow-up Visit).
- Encourage practitioners to link care management services to a specific need the patient is concerned about. This will help the patient understand how these services can meet their specific needs.
- Advise practitioners to include the reason for the referral in the referral document to care management. This helps the care manager or outreach worker engage the patient and show that there is coordination between care management and their primary care or behavioral health practitioner.
- If your organization has multiple care management programs, streamline the referral process by having all referrals for care management use the same referral form and process and have them go to a single role, such as a "triage social worker" who will determine which program is the best fit for the patient. This makes the referral process easier for practitioners as they do not need to keep track of the multiple care management services available at the organization.
- Notify the patient's practitioner of his or her enrollment in care management and what the care manager is working with the patient to improve (see Notifying Practitioners of their Patient's Participation in Care Management).

3.1.a. Example Workflow: Practitioner Referral to Care Management



3.1. b. Example of a Referral to Care Management with Useful Patient Information

Patient: Bill Smith **MRN:** 1234567

Referring Department: Primary Care **Date of Request:** 4/22/16

Problem List:

- Insulin-dependent Type 2 Diabetes Mellitus (HCC)
- Generalized Anxiety Disorder
- Severe Major Depressive Disorder
- Post-Traumatic Stress Disorder
- Osteoarthritis
- Opioid Addiction

Example of a well-documented referral that includes information that helps the care manager connect care management services to needs/ concerns of the patient.

Procedure Information: Bill needs intensive ongoing Care Management.

Reason for Referral: Patient has Diabetes II with an A1C level of 11 at last 3/15/16 visit.

Patient scored 21 on PHQ9 and 19 on GAD 7 at 3/15/16 visit.

Patient is red-banner and has not been to Mental Health since 3/7/16.

Patient has not responded to outreach attempts from Provider or MH Clinician. Most recent attempt on 4/11/16.

Services Needed: Patient is being referred to CM; patient needs transportation, a new wheelchair, VNS, and to be reengaged back to Mental Health. Possible Substance Abuse referral.

Additional Notes: Patient does not like to be called Billy-PTSD trigger. Patient also prefers women providers ONLY. Patient can be apathetic to care at times.

*Please notify PCP once contact is made at extension 1234

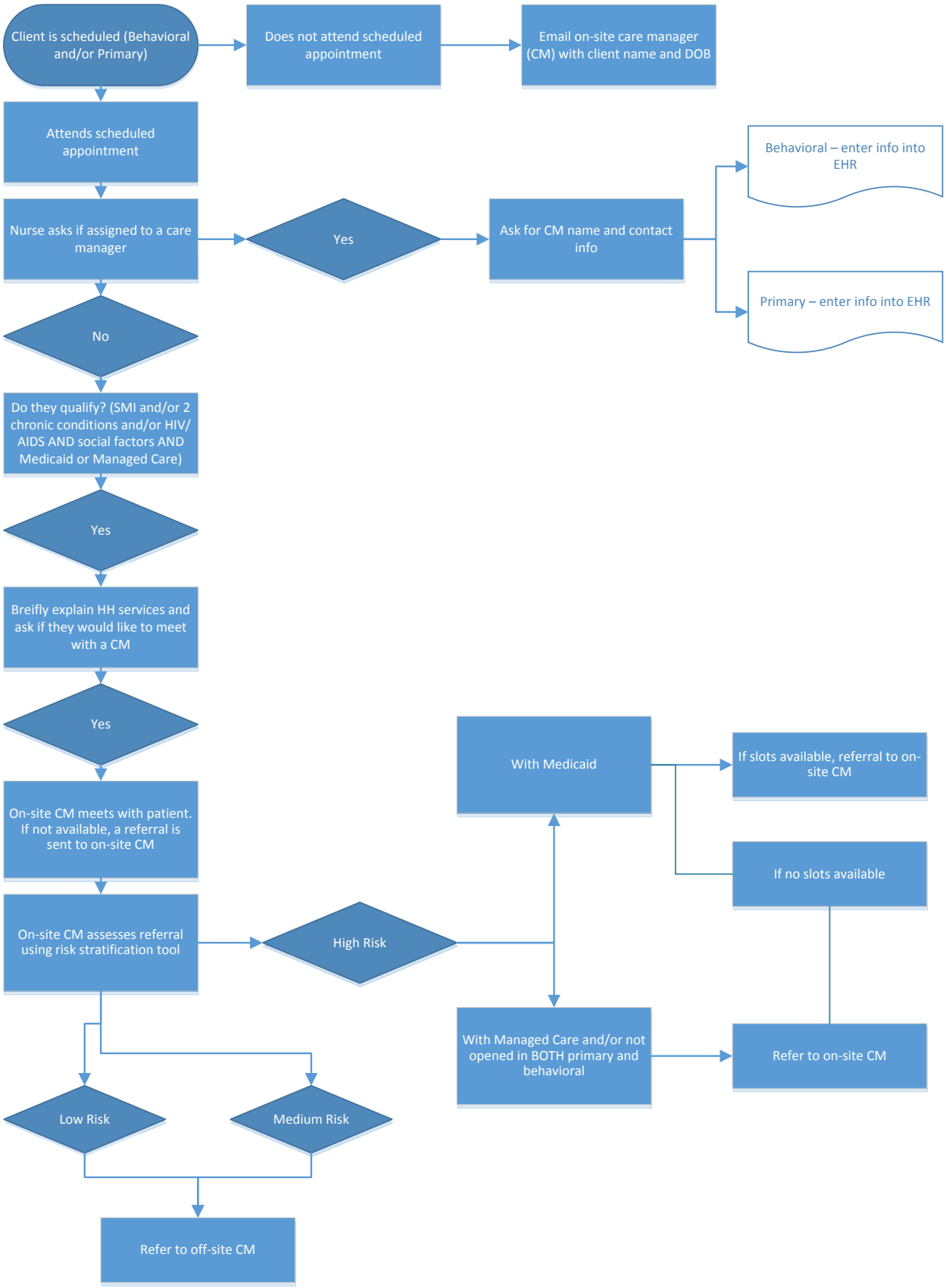
3.2. Increasing Patient Enrollment in Care Management: Using Clinical Support Staff in the Referral Process

While PCPs can play a key role in making direct patient referrals to care management services, a robust discussion of the care management program with the patient can be difficult to include during a 15-minute patient visit. Practices have been successful using clinical support staff such as nurses and onsite care managers to work with PCPs to identify patients who could benefit from care management services and engage these patients the same day as their visit with the practitioner. This strategy distributes the work across more members of the care team and allows for the care management intake assessment to be completed the same day as the referral.

Best Practices:

- Ensure that nurses or other care team members are trained on the care management program eligibility criteria, benefits, and services as well as on how to conduct intake assessments.
- Identify potentially eligible patients before the patient's appointment with the practitioner.
- Engage these patients while they are waiting to be seen by the practitioner.
- Have someone from care management onsite to meet with patients the same day as their visit with the clinician. This helps to reduce time spent on outreach and builds stronger relationships between care management, primary care, behavioral health, and patients at the clinic.
- Notify the patient's PCP of his or her enrollment in care management and what issues the care manager is currently working on with the patient (see Notifying Practitioners of their Patient's Participation in Care Management).

3.2. a. Example Workflow: Using Clinical Support Staff in the Referral Process



3.3. Notifying PCPs of their Patient's Participation in Care Management

Once a patient is enrolled in care management the patient's PCP and referring practitioner (if different) should be notified of the patient's participation in the care management program. This is an opportunity for the care manager to introduce his or herself, outline the role of the care manger in supporting the patient's care and how the practitioner can contact the care manager. The care manager may also ask the practitioner for input on care plan goals to discuss with the patient.

This approach is particularly helpful to PCPs if the health care organization employs many care managers and/or partners with multiple care management provider agencies. These organizations may also have several different care management programs that are targeted at specific patient populations. A large number of care managers and care management programs can be overwhelming for practitioners, especially if they do not routinely work with the same care managers. Taking the initiative to introduce oneself to the PCP and explaining how the care manager is helping the patient may increase the likelihood of PCPs referring patients to these programs and coordinating with the care manager on patient issues.

Best practices:

- Keep email correspondence short and to the point.
- Include key information such as the name and contact information of the care manager, the full name of the patient, what the care manager will be working on with the patient, and how the care manager can support the patient in maintaining their health.
- Educate PCPs about the care management services available and how care managers can help support patient care.
- Make PCPs aware that they may be contacted by care managers about their patients enrolling in care management.
- Encourage PCPs to collaborate with the care manager on the care plan and use them to support patient care as appropriate.

3.3. a. Introductory Email Template

Example email template for care managers to communicate with practitioners about patient enrollment into the care management program and how the care manager will support the patient.

Subject Line: Care Management Enrollment

Dear Dr. _____,

My name is _____ (phone = 212-555-1234), a social worker following your patient _____

(Name and MRN)_____ who is part of [organization's] care management program.

I recently met with _____and will be working as his/her ongoing to assess barriers to maintaining adherence with health care goals and create a Care Plan for the patient. He/she was referred by _____ and consented to the program on _____.

I am currently helping __ (patient name) __with _____. Please let me know if there are any goals you would like me to work on with the patient or any appointments you need coordinated. Please also let me know the most convenient way for us to collaborate (email, phone, in person).

Thank you for your time and support,

Social Worker Name
Phone Number
Email

3.3. b. Care Plan Email Template

Example email template for care managers to communicate with practitioners about the development of the patient's care plan. This is useful if a telephonic or in-person case conference is not possible.

Subject Line: Care Management Care Plan

Dear Dr. _____ ,

I am _____ (patient's name and MRN) _'s Care Coordinator (cell 212-555-1234). Based on _____ (patient's name)'s preferences, your note and feedback from _____ (patient's name)'s other specialists/providers, the following is a select summary of his individualized Care Plan:

- Return to clinic on 7/1 for blood work for hyperkalemia.
  We will facilitate transportation to this appointment.
- Reinforce with patient low potassium diet and medication adherence.
- Wheelchair clinic referral for wheelchair repair.
  Please place an order in Epic and we will facilitate appointment.

Please do not hesitate to contact me with any questions, updates, or changes in priority, either by phone or via email. I am also available to accompany the patient to an appointment or meet prior to an appointment if it would be helpful. Detailed documentation Re: care plan goals and interventions can be found in _____ (patient's name)_____ last care management note (Date).

Thank you,
Social Worker Name
Phone Number
Email Address

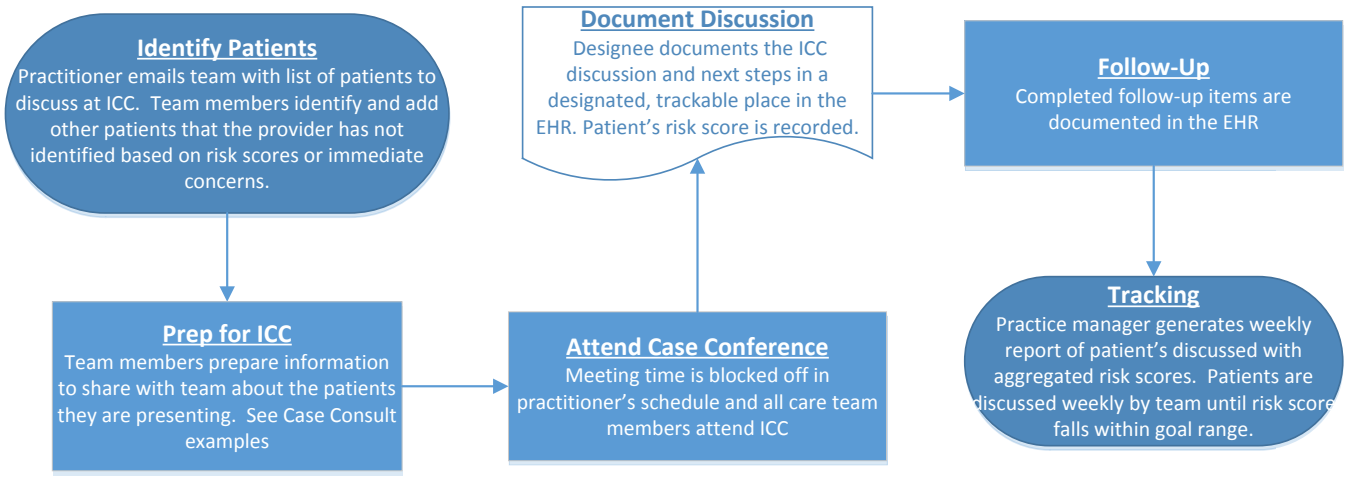
4.1. Establishing Regular Interdisciplinary Case Conferences between Medical, Behavioral Health, and Care Management Services

An interdisciplinary case conference serves as a platform for team members across different disciplines and departments to engage in a meaningful conversation regarding high-risk, high-need patients. It is an opportunity to discuss the patient's concerns, diagnoses, and social issues that may be pertinent to the care for that patient. It is also a time to identify and coordinate needed services amongst the care team.

Best Practices:

- Don't assume that simply co-locating services will lead to the delivery of integrated care or collaboration across departments who share patients. Leadership should provide protected time for teams to have these discussions that are not in addition to their everyday administrative and patient care responsibilities.
- Create assigned interdisciplinary teams to regularly meet to discuss high-risk, high-need patients who are shared by the practitioners on the team or are seen by at least one of the practitioners.
  - o High-risk, high-need patients who are cared for by some, but not all, clinicians on the team may also benefit from input from other disciplines regarding their care or needed services.
- Designate a staff member to ensure that meetings occur and are attended by team members.
- Engage all levels of staff in case conference meetings so that everyone is aware of and can take action to support the practice's high-risk, high-need patients.
- Use a risk stratification tool to monitor the status of patients of concern with the goal of reducing their risk level to the point of being considered stable.
- Rotate who leads meetings so that the PCP does not always lead case conferences. This will help ensure that meetings are not focused only on clinical care, but give equal focus to the perspectives of the behavioral health practitioners and care management staff.

4.1. a. Example Workflow: Interdisciplinary Case Conference (ICC)



4.1. b. Case Consult Form Example 1

This is a tool that clinical and social work staff use to prepare cases to be discussed during the interdisciplinary case conference with the care team. The information is collected from the various EHRs and systems that store patient information across disciplines at the practice. Having this information in one place helps to make the case conference discussion more efficient.

CASE CONSULT: Interdisciplinary Review of Patient

ID: [Name] is a ____ year-old patient.

CONDITION(S):

- _____
- _____
- _____

TREATMENTS:

- Current Treatments _____
- Medications _____
- Adherence Status _____

TREATMENT GOALS:

(1) _____

(2) _____

(3) _____

Relevant BASELINE & CURRENT CLINICAL MEASURES:

- Medical (e.g., A1C)
- Mental Health (e.g., PHQ-9 / GAD-7)
- Specific symptoms that are not improving

PSYCHOSOCIAL STRESSORS & BARRIERS:

- Substance Use _____
- Family / Relationships _____
- Educational / Vocational _____
- Social / Leisure _____
- Finances _____
- Legal _____
- ADLs _____

PATIENT STRENGTHS: (e.g., support network, insight/adherence):

- _____

PLAN OF ACTION: (Recommendations / Follow-up)

MD: _____ MH: _____

CM: _____ NUT: _____

SW: _____ HE: _____

Date of Case Consult: _____

Δ **Patient:** yes / no

Date of Follow-up Case Consult: _____

Current Risk Zone *(circle one)*: **Red** - **Yellow** - **Green**

4.1. c. Case Consult Form 2

This form is a suggested guide fopr staff on what patient information to have available for the case conference discussion

Case Consult Form

Integrated Case Conference Meetings

Client's Name: _____

Age: _____

Presenting Problems

Mental Health: _____

_____

_____

_____

Medical: _____

_____

_____

_____

Substance Abuse: _____

_____

_____

_____

Social (Housing, Budgeting, Food, Transportation, Legal, etc.): _____

_____

_____

_____

Current Services (Pending or Received): _____

_____

_____

_____

Additional Comments: _____

_____

_____

_____

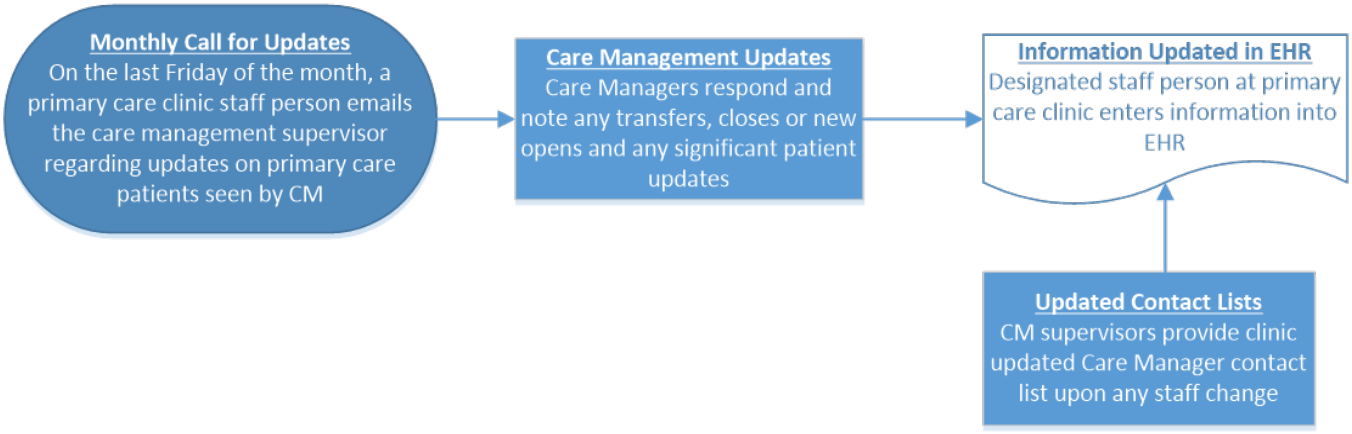
4.2. Maintaining Care Team Member Contact Information

One of the most basic yet important activities to support the coordination of patient care among the care team is to ensure that each care team member has accurate, up-to-date names and contact information of the other care team members. Without this information, members of the care team cannot easily communicate with or bring in other members of the care team to address critical issues affecting the patient. Keeping this information accurate and up-to-date is an activity that requires dedicated staff time to complete and maintain. Practitioner and care management staff assignments can change frequently, so this should be an ongoing effort.

Best practices:

- Dedicate specific staff roles in care management and at the practice who will be responsible for maintaining accurate records of care team member names and contact information.
- Identify an easy-to-access area of the patient record where care team members can find this information. If care team members operate in different systems, a location for care team contact information should be made available and maintained in all systems.
- Updating practitioner and care manager contact information can also be an opportunity to provide a quick update on the patient's status.

4.2. a. Example Workflow: Maintaining Care Team Member Contact Information



4.2. b. Sample Care Management Monthly Update Report:

Care managers fill out this form monthly for each client on their caseload who is also a patient at the primary care or behavioral health practice. The "patient status" should be brief (1-2 sentences in length) and summarize a significant change in the patient's status or indicate if there is no update for the month. The form is then shared with the patient's primary care practitioner.

[Name of Primary Care or Behavioral Health Practice]

PATIENT INFORMATION:

Patient Name: _____

DOB: _____

MR#: _____

Address: _____

Phone Number: _____

CARE MANAGER INFORMATION:

Care Manager Name: _____

Care Manager Agency: _____

Care Manager Contact Number: _____

MONTHLY VISIT/CONTACT:

Date/time of monthly visit/contact #1: _____

Location: _____

Patient Status: _____

Date/time of monthly visit/contact #2: _____

Location: _____

Patient Status: _____

Date/time of monthly visit/contact #3: _____

Location: _____

Patient Status: _____

4.3. Coordinated Care Team Response to an Unplanned Hospitalization

A coordinated response from the care team to a patient's unplanned hospitalization visit can help to ensure the patient is receiving the services and support he or she needs after they leave the hospital. It also alerts the care team to patients who may need more intensive care management and engagement. The patient's assigned care manager can be helpful at the hospital to support the discharge planning process and scheduling follow-up visits with the patient's practitioners. A critical event such as this should also trigger a discussion with the patient's care team to coordinate follow-up and identify next steps among all practitioners and staff working with the patient.

Best Practices:

- Have a process for ensuring that hospital notifications are sent to the correct staff to engage in follow-up with the patient. For patients in care management, this should be the assigned care manager.
- Ensure that the names and contact information of care team members for each patient are kept up-to-date in the EHR so that the care team can be notified of the hospitalization (see Maintaining Accurate Care Team Member Contact Information).
- Have the patient's assigned care manager meet with the patient while in the hospital to support the discharge planning process.
- Create a process where all team members are made aware of the hospitalization, follow-up tasks are assigned to appropriate team members, and completion of follow-up tasks is communicated to all team members.

4.3. a. Example Workflow: Coordinated Care Team Response to an Unplanned Hospitalization

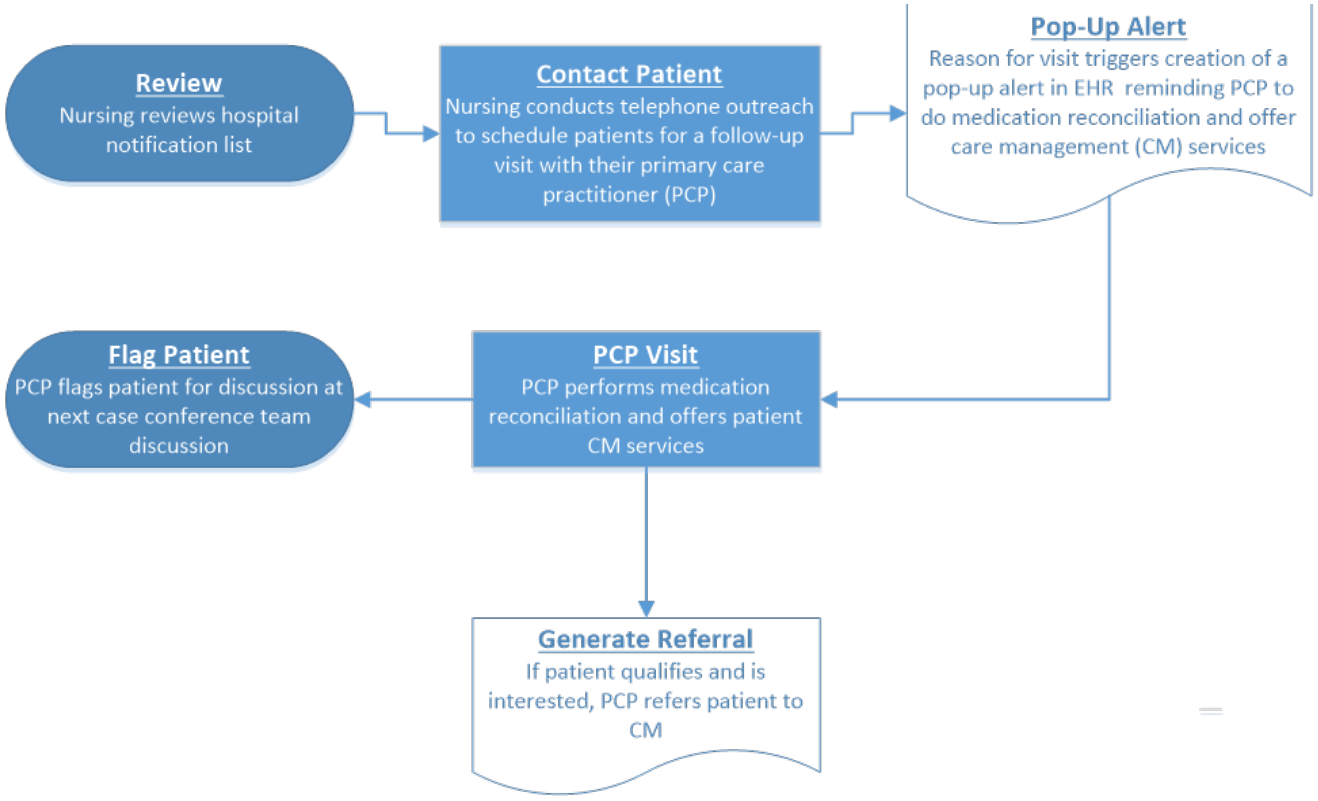
4.4. a. Offering Care Management Services to Patients at Post-discharge Follow-up Visit

A critical event such as an unplanned hospitalization or ED visit is a good time to offer care management services to patients not currently receiving them to support them through this difficult time and to help them take steps to improve their health overall. Some practices found that automated messages in the EHR help to remind practitioners to offer care management services at all post-hospitalization follow-up visits. The reminders helped practitioners who were new to working with care management or where care management was a recently added service at the organization.

Best Practices:

- One practice found that creating prompts in the EHR to remind practitioners to offer care management services to patients at their post-discharge follow-up visit increased referrals to care management.
- Ensure that there is a process (preferably automated) for referring patients to care management.

4.4. b. Example Workflow: Offering Care Management Services to Patients at Post-discharge Follow-up Visit



Integrated Care Planning Literature Review Guide					
Article	**Author**	**Date Published**	**Resource Type**	**Topic/Areas of Focus**	**Notes**
Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?	Hong C, Siegel A, Ferris T, The Commonwealth Fund	8/1/2014	Issue Brief Review of 18 complex care management programs	Best practices in CCM, Attributes of successful CM program, Team communication/coordination	Provider groups taking on risk for overall costs of care in ACOs are developing care management programs to improve care and thereby control costs. Many such programs target "high-need, high-cost" patients: those with multiple or complex conditions, often combined with behavioral health problems or socioeconomic challenges. In this study, 18 successful CCM programs are reviewed to offer guidance to providers, payers, and policymakers on best practices in CCM. Effective programs customize their approach to their local contexts and caseloads; use a combination of qualitative and quantitative methods to identify patients; consider care coordination one of their key roles; focus on building trusting relationships with patients as well as their PCPs; match team composition and interventions to patient needs; offer specialized training for team members; and use technology to bolster their efforts.
Beyond Fighting Fires and Chasing Tails? Chronic Illness Care Plans in Ontario, Canada	Russell G, Thille P, Hogg W, and Lemelin J. Annals of Family Med. Ann Fam Med 2008;6:146-153. DOI: 10.1370/afm.793.	2008	Qualitative evaluation following in RCT examining the effect of external facilitators in enhancing the delivery of chronic condition care planning in primary care.	Physicians' perceptions and experience with care planning	Outlined common barriers and beliefs held by physicians who tried collaborative care planning. Shared experiences of both enthusiasts and non-enthusiasts and implications for future work in this area.
National Coalition on Care Coordination Issue Brief	National Coalition on Care Coordination	unknown	Issue brief	Overview different care coordination models	Appendix A provides a useful overview of different types of care coordination/care management programs.
Framework for Measuring Nurses' Contributions to Care Coordination	American Nurses Association	10/1/2013	Proposed framework	Identifying and quantifying the aspects of care coordination driven by nurses	
Care Coordination: Reducing Care Fragmentation in Primary Care	Safety-Net Medical Home Initiative	4/1/2011	Implementation guide	Introduces several change concepts related to effective care coordination	
Frameworks for Integrated Care for the Elderly: A Systematic Review	MacAdam M, Canadian Policy Research Networks	4/1/2008	Literature review	Efforts to provide integrated care for the elderly	Reviews effectiveness and key features of different interventions. Much of the focus is on solutions tested in Europe and Australia.

Article	Author	Date Published	Resource Type	Topic/Areas of Focus	Notes
The Evaluation of the Medicare Coordinated Care Demonstration: Findings for the First Two Years	Mathematica Policy Research, Inc.	3/1/2007	Evaluation	Early results of the Medicare Coordinated Care Demonstration	Provides evidence about characteristics of an effective care management program.
Care Plans 2.0: Consumer Principles for Health and Care Planning in an Electronic Environment	Consumer Partnership for eHealth	11/1/2013	Recommend	Components of effective care plans and care planning	
Primary Care Providers' Experiences with an Integrated Healthcare Model	Westheimer J, Steinley-Bumgarer M, and Brownson C	8/1/2008	Evaluation	Examination of the experiences of PCPs participating in integrated health care services between mental health and primary care in a university health center.	Researchers found that a gap exists between what PCPs believe behavioral health can assist with and their frequency of referrals - this indicates the need for communication about how behavioral health providers can support the treatment of physical symptoms.
High-Intensity Primary Care: Lessons for Physician and Patient Engagement	National Institute for Health Care Reform	10/1/2012	Research brief	Outlines key factors for physician and patient engagement in high-intensity primary care programs based on a study by the Center for Studying Health System Change	Information about the hesitation of PCPs to effectively engage in care management.
Lessons From Medicare's Demonstration Projects on Disease Management and Care Coordination	Congressional Budget Office	1/1/2012	Summary of research/lessons learned	Shares results of CMS demonstration projects	Summary of findings relate mostly to costs; a deeper analysis as to the challenges and barriers is not provided.
Core Principles of Effective Team-Based Care	IOM	10/1/2012	Experts provide guidance on coordinated collaboration among health professionals	Provides case studies and recommendations on how to facilitate teams working together effectively	
Role Construction and Boundaries in Interprofessional Primary Health Care Teams: a Qualitative Study	BMC Health Service Research	2013	Qualitative study	Team dynamics in health care and how to improve them	

Article	Author	Date Published	Resource Type	Topic/Areas of Focus	Notes
Challenges of Change: A Qualitative Study of Chronic Care Model Implementation	Hroscikoski M et al.	7/1/2006	Qualitative study	Change management issues with transforming to CCM	
A Coalition Creates a Citywide Care Management System	Robert Wood Johnson Foundation	2012	Report on grantee program	Setting up a program to provide care manage-ment/ care coordination to high-risk patients in Camden, NJ	
CareOregon: Transforming the Role of a Medicaid Health Plan from Payer to Partner	The Commonwealth Fund	7/1/2010	Case study	Care management support model for high-risk Medicaid patients	Includes suggested metrics, examples of a care plan, and a patient assessment. Care managers are RNs with lay outreach workers.
Community Care of North Carolina Care Management	Community Care of North Carolina	2010	Summary of program	Roles and tasks of care managers/care planning/care coordination	Outlines key components of their care management approach/model. CCNC Care Managers are vital participants in the care team who empower patients to understand and access quality, coordinated, and effective health care. Utilization of an interdisciplinary team including network resources, community resources, and the care team at the medical home, especially involvement of the Primary Care Provider (PCP) provides the optimal benefit for the patient.

Article	Author	Date Published	Resource Type	Topic/Areas of Focus	Notes
Coordinating Care for Adults with Complex Care Needs in the PCMH: Challenges and Solutions	AHRQ	1/1/2012	White Paper	Common challenges and solutions in providing team-based complex care management	o Confirms challenges with engaging primary care clinicians and offers some solutions that have worked in other health systems and states. Several program leaders reported they judged the success of their case managers or care coordinators by the degree to which they are accepted and integrated into the PCP. o In most cases, programs serving patients with complex needs pay physicians to participate in care coordination activities. Payment helps both in the recruitment of PCPs and partially compensates the practice for the additional time and resources involved in team-based care. o Many program representatives stressed the importance of (1) directly engaging the primary care professionals and office staff in the practice and (2) providing sufficient flexibility to allow clinic teams to design the care coordination approach that works best for them. This point of view echoes a finding from research on what makes for effective case management and care coordination programs for patients with complex needs—substantial engagement with primary care practices appears to be key to program success. Both PCP engagement and flexibility appear to be critical for providing initial motivation to contemplate participation, as well as subsequent commitment to implement care coordination programs. CCA, for example, typically takes 3 months up front to develop a shared understanding of the clinical model and obtain support and cooperation from all clinicians and staff in the practice. o Many program leaders emphasized that engagement of clinical staff is critical, and that clinician leadership is also essential for practice transformation. It is vital that CCA requests the practice to identify a clinical “champion” and then reimburses the practice for that person’s time to develop the program. CCNC staff note that at the practice level, “innovation is facilitated by the physician leaders."
Evaluation of the Medicaid Value Program: Health Supports for Consumers with Chronic Conditions	Mathematica Policy Research, Inc.	8/1/2007	Evaluation	Chronic care management interventions conducted by State Medicaid programs	
Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients	CHCS	10/1/2013	Review of programs	Comparison of chronic care management program components	Contains key care management elements of various programs from around the country, including measures. Cost and utilization data are included on various care management programs across the country.

Article	Author	Date Published	Resource Type	Topic/Areas of Focus	Notes
Engaging Patients in Self Management Care Plans	AAFP	6/1/2013	Editorial	Lack of physician training in coaching patients to self manage conditions	
An Examination of New York State's Integrated Primary and Mental Health Care Services for Adults with SMI	Scharf DM et al. Funded by New York State Health Foundation	2014	Review/evaluation of programs	Review of 3 programs from both the policy and provider perspectives: SAMHSA's PBHCI, OMH's Medicaid Incentive, and Medicaid Health Homes	Provides substantial information about other similar integration initiatives from the substance abuse and mental health perspectives; many findings support our observations.
Partnering with Patients, Families, and Communities: An Urgent Imperative for Health Care	Josiah Macy, Jr. Foundation	4/1/2014	Conference report	Outlines changes needed to the medical education system	Describes how providers have not traditionally been taught how to work in teams.
Care Management of Patients with Complex Care Needs	Robert Wood Johnson Foundation	12/1/2009	Research synthesis report		Provides evidence to support key strategies for successful complex care management.
Vermont BluePrint for Health 2013 Report	Vermont Department of Health	2014	Program report/evaluation	Review of Vermont's efforts to reform its Medicaid program	Care management for high-risk Medicaid beneficiaries is part of the program, which uses nurses and social workers. Contains interesting information on how the program is structured.
Chronic Care Management Intervention: A Qualitative Analysis of Key Informant Accounts	University of Washington	6/1/2010	Evaluation	Qualitative review of Rethinking Care Project (supported by CHCS)	
Care Coordination in Accountable Care Organizations: Moving Beyond Structure and Incentives	Press MJ, Michelow MD, and MacPhail LH	12/1/2012	Editorial	How to support on the ground care coordination in an ACO	Argues that ACOs need to develop and support professional skills in the areas of collaboration, communication, and teamwork, and names tools to address these barriers.
Care Management in New York State Health Homes	Levy J	8/1/2014	White Paper	Best Practices and challenges with care management in Health Homes	Identifies some Best Practice techniques that Health Homes have used to engage providers and improve communication.
Complex Care Management Toolkit	California Quality Collaborative	4/1/2012	Toolkit	Provides ideas on how to improve an existing or new complex care management program	Comprehensive toolkit for implementation of complex care management.

Article	Author	Date Published	Resource Type	Topic/Areas of Focus	Notes
Integrating Primary Care into Behavioral Health Settings	Millbank Memorial Fund		Report	Identifying models and their evidence base; describing implementation efforts	Provides model frameworks and links to implementation resources.
The Future of the Medical and Mental Health Collaboration	Blout A	11/1/2011	Presentation	Overview of different models and lessons learned with integrating primary care and behavioral health	Contains helpful definitions and lessons learned with data to support them.
Integrated Treatment Tool	Center for Evidence-Based Practices-CWRU	2010	Toolkit	Evaluates the presence and extent that primary care and behavioral health services are integrated	A very detailed Toolkit is helpful in defining roles, responsibilities, and other functions.
Key Elements of Integrated Care for Persons Experiencing Homelessness	National Healthcare for the Homeless Council	6/1/2011	Report	Reviews models of behavioral health and primary care integration	Identifies key concepts and illustrates with many case studies.
Patients and Health Care Teams Forging Effective Partnerships	Okun S, Schoenbaum S, Andrews D et al., Institute of Medicine Roundtable	12/1/2014	Report	Explore the patients' view of their role in team-based care and what is needed to create high-functioning teams	Includes results of an interview study to assess opinions of team-based care from multiple stakeholders; also provides a literature review on team based care.
2015 Commonwealth Fund International Health Policy Survey of Primary Care Physicians	The Commonwealth Fund	12/1/2015	PPT	Statistics about primary care doctors and care management	Topics covered include practice preparedness to manage patients with complex needs; capacity to provide access and care management; communication and care coordination; health information technology; and system views and physician satisfaction.
Accountable Care in the Safety Net: A Case Study of the Cambridge Health Alliance	Hacker K, Mechanic R, and Santos P. The Commonwealth Fund	6/1/2014	Case study	Case Study of the Cambridge Health Alliance and how it transformed to become an Accountable Care Organization	Guidance on how an organization that cares for a large portion of vulnerable patients can transform.
Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs	Craig, C, Eby D, and Whittington J. Institute for Healthcare Improvement	2011	White Paper		For patients with multiple health and social needs, the care management team needs to have the capacity to effectively address mental health, medical frailty or complexity, and social instability or lack of social support.
CIN Partners Share: The Engine for Excellent Care: New Directions for Primary Care Teams	California Improvement Network	8/1/2016	Partner Meeting Report	New directions for primary Care Teams	Best Practices in establishing care teams in primary care, with examples.

Article	Author	Date Published	Resource Type	Topic/Areas of Focus	Notes
Cambridge Health Alliance Model of Team-Based Care Implementation Guide and Toolkit	Cambridge Health Alliance	2014	Toolkit	How to implement team based care for vulnerable populations	Argues that the current infrastructure for primary care is grossly insufficient to meet the population management needs of a primary care patient panel. It is critical to have a team-based model of care to sustainably meet the acute care, preventative care, and chronic care needs of safety net patient populations. This involves both creating an expanded primary care team and clearly defining roles, responsibilities, and workflows so that the care needs of the population can be met. The team model of care needs to facilitate the development of a trusted relationship between the consumer and key care team members. In the safety net patient population, given the incredibly high prevalence of mental health and social health issues as well as physical health issues, it is essential that we address mental, physical, and social issues together in an integrated way. Care management for both routine and complex patients who have needs in more than one of these areas therefore requires a team approach. Envisions care management as a dynamic interplay between the usual care team and the complex care team depending on the complexity of the patient at that moment.
Care Coordination in Case Study preliminary Findings	The Center for Health Workforce Studies	4/1/2014	Report		
Implementing Integrated Interdisciplinary Clinical Care Management in the PCMH	Cohen J, Steinberg C		PPT from Conference on Practice Improvement	Setting up CCM in a PCMH setting	
The Promise of Care Coordination-Transforming Healthcare Delivery	Families USA	2/13/2016	Issue Brief	Health System Reform	Provides results from Medicare Care Coordination demonstration projects as well as clear definitions of health homes, care management, ACOs, etc.

Article	Author	Date Published	Resource Type	Topic/Areas of Focus	Notes
Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations	Boyd C, Leff B, Weiss C, Wolff J, Hamblin A, and Martin L. Center for Health Care Strategies	12/1/2010	Issue Brief	Identifying Medicaid patients who are most likely to benefit from care management	Identifying Medicaid's highest need, highest cost beneficiaries who are most likely to benefit from care management is an ongoing conundrum for states. Previous Faces of Medicaid analyses from the Center for Health Care Strategies documented the high prevalence of comor-bidity among Medicaid beneficiaries with disabilities. This new analysis by researchers at Johns Hopkins University provides an even clearer picture. The findings identify: • High-priority patterns of multimorbidity based on hospitalization rates and costs • The impact of mental illness and substance abuse on per capita costs and hospitalization rates; • Significant opportunities for clinical interventions, including a companion online literature review that inventories promising care models for high-priority multimorbidity patterns. The brief also outlines how states can apply provisions within the Patient Protection and Affordable Care Act to develop more integrated models for beneficiaries with serious mental illness, chronic physical conditions, and substance disorders.
Redesigning the Care Team: The Critical Role of Frontline Workers and Models for Success	Patel K, Nadel J, West M. Hitachi and Brookings Institute	3/1/2014	Toolkit	Using frontline workers in care team delivery models	Examines different case studies that use frontline unlicensed workers as a critical component of primary care redesign.
Primary Care Physicians In Ten Countries Report Challenges Caring For Patients With Complex Health Needs	Osborn R, Moulds D, Schneider EC, Doty MM, et al. Health Affairs 34, no.12 (2015):2104-2112	7/8/2009	Journal Article	International survey about primary care doctors around coordinating care	This survey of primary care doctors in the United States and nine other countries reveals their concern about how well prepared their practices are to manage the care of patients with complex needs and their variable experiences in coordinating care and communicating with specialists, hospitals, home care, and social service providers. While electronic information exchange remains a challenge in most countries, a positive finding was the significant increase in the adoption of electronic health records by primary care doctors in the United States and Canada since 2012. In addition, feedback on job-related stress, perceptions of declining quality of care, and administrative burden signal the need to monitor frontline perspectives as health reforms are conceived and implemented.

Article	Author	Date Published	Resource Type	Topic/Areas of Focus	Notes
Health Centers and Payment Reform	National Association of Community Health Centers	7/6/2009	Primer	Community health centers and payment reform	Health centers are strongly positioned to achieve the Triple Aim – improved patient experience, improved population health, and reduced total health system costs per capita – within low-income and underserved popula-tions nationwide. Payment reform efforts can align payments to support innovation and important resources for health centers to achieve their mission and address social determinants of health in their communities. Furthermore, payment reform that strengthens and supports the role of patient-centered primary care is critical to achieving the Triple Aim. This paper describes a framework for health centers to understand the role of payment reform in achieving the Triple Aim. The framework is composed of three facets. The first facet provides for more flexibility of service delivery within current health center payment; the second provides the investments to support delivery system transformation (including health centers serving as Patient Centered Medical Homes and Integrators); and the third facet provides incentive payments for performance on Triple Aim outcomes.
Medicaid Coverage of Social Interventions	Bachrach D, Guyer J, Levin A. Manatt Health	7/9/2009	Issue Brief	Circumstances and legal authority under which states may use Medicaid to cover the costs of interventions that address the social determinants of health	
Improving Hospital Transitions and Care Coordination Using Automated Admission, Discharge and Transfer Alerts	Office of the National Coordinator for Health Information Technology	5/1/2013	Learning Guide	Promising IT-enabled interventions for transitions of care	
Primary Care Providers' Perceptions Of and Experiences With An Integrated Health Care Model	Journal of American College Health. vol 57 No 1	7/1/2009	Journal Article	Experiences of PCPs participating in an integrated health care service with mental health	Findings indicate a need for further communication in the role that mental health can play in the collaborative treatment of physical symptoms.

Article	Author	Date Published	Resource Type	Topic/Areas of Focus	Notes
Gaining Ground: Care Management Programs to Reduce Hospital Admissions and Readmissions Among Chronically Ill and Vulnerable Patients	McCarthy D, Cohen A, Johnson MB. Commonwealth Fund	1/1/2013	Issue Brief	Impact of care management on avoidable hospital admissions and readmissions	Preventable hospital admissions and readmissions are indicators of health system fragmentation associated with suboptimal patient outcomes and avoidable costs of care. Three case studies illustrate the potential of care management programs to address this problem by improving care coordination and transitions among high-risk patients. Study sites included two academic medical centers and a managed care organization owned by a home health agency. The sites employed bundles of interventions involving multidisciplinary teams to improve provider communication, patient and family education, care transitions from the hospital, and follow-up ambulatory care. Results include a lengthening in average time between hospital encounters among asthmatic children and relative reductions in 30-day readmission rates of 46 percent among elderly patients with heart failure and of 21 percent among dually eligible Medicare and Medicaid beneficiaries with special needs. Spreading such models will likely require supportive changes in payment policy or aligned incentives between payers and providers.
Better Health and Lower Costs for Patients with Complex Needs	Craig, C, Sevin C, Hassinger M. Institute for Healthcare Improvement	5/1/2015	Informational Call/PPT	Reviews the IHI Better Health and Lower Costs for Patients with Complex Needs Collaborative	Makes the case for focusing on patients with complex needs and high costs. Reviews different models of care management.
Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment	Bachrach D, Pfister H, Wallis K, and Lipson M. Manatt Health Solutions	5/1/2014	Report	Business case for providers addressing social determinants of health	Explores the impact of social factors on patient health and health care costs, and the growing relevance of such factors in today's health care environment. Informed by published research and interviews with more than 25 experts.
Putting the Accountability in Accountable Care Organizations: Payment and Quality Measurements	Families USA	7/5/2009	Report	Overview of how Accountable Care Organizations work and the role of advocates	Accountable Care Organizations must be more than just a new means of paying health care providers. Instead, they must encourage providers to change the way they deliver care by improving quality, by coordinating care, and by offering patient-centered care. Specifics include the importance and challenges of measuring patient and care giver experience.
Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide	AHRQ	7/1/2009	Guide	How to implement a care management program for Medicaid patients	Resource for those involved in designing and implementing a care management program.

Article	Author	Date Published	Resource Type	Topic/Areas of Focus	Notes
Can We Talk? Priorities for Patient Care Differed Among Health Care Providers	Evanoff B, Potter P. Wolf L. Grayson D. Dunagan C, Boxerman S.	2005	AHRQ study	Communication between different types of health care providers and staff	Specific focus on acute care settings. Describes how true collaboration builds consensus around the common goals that all members of the health care team must address, as well as the creation of a common set of goals with which to direct patient care.
What The Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Less Data On Costs	Health Affairs		PPT Slides	Various presenters on the topic of patient engagement	Multiple approaches and models that focus on patient engagement and data to support the effects of those approaches/models.
Using Lessons from Disease Management and Care Management in Building Integrated Care Programs	Integrated Care Resource Center	4/1/2014	Technical Assistance Brief	Best Practices in disease management/care management programs	Focuses on Medicare demonstration project results and lists Best Practices in care management programs as well as evidence for benefits of care management.
Information Exchange Among Physicians Caring for the Same Patient in the Community	Van Walraven C et al. Canadian Medical Journal	11/1/2008	Journal Article	Exchange of information between physicians/ continuity of care	
Complex Care Management Program Overview	California Improvement Network	7/1/2013	Guide	Review of over 15 CCM programs	Detailed description of programs across the country and their care delivery and staffing models.
Complex Case Conferences Associated with Reduced Hospital Admissions for High-Risk Patients with Multiple Comorbidities	Tuso P et al. Kaiser Permanente Journal	2014	Journal Article	Effects of person centered care and case conferences on reducing hospital admissions	Complex case conferences with disease-focused and person-focused interventions may be associated with reduced hospital admissions for patients with heart failure and multiple comorbidities.
Care Transition Bundle: Seven Essential Intervention Categories	National Transitions of Care Coalition	7/4/2009	White Paper	Seven Best Practices related to transitions of care	This is a bundle of essential care transition intervention strategies that any provider interested in implementing improvements in care transition can consider for use. This bundle is applicable to any type of care transition “exchange” and is categorized into main topics that are essential to any care transition with descriptive language and examples to aid the provider in adopting these strategies.

APPENDIX 3

Nationwide Approaches to Team-Based Care Coordination

Health Homes
19 states and the District of Columbia have fully implemented Medicaid health homes. More than 10 other states are in the process of seeking federal approval.[1]

Health Care Innovation Awards
A number of programs that won Centers for Medicare and Medicaid Innovation awards focused their projects on team-based care coordination. Sites include the Center for Health Care Services (TX), the Johns Hopkins Community Health Partnership (MD), Maimonides Medical Center (NY), and the Transitions Clinic (CA).[2]

State Innovation Model
Of the 38 states funded by CMS to transform health care delivery via SIM grants, at least 17 have included care coordination capacity building as part of their strategy.[3] CT, DE, IA, RI, and others have explicitly used the initiative to create community care teams for those with complex needs.[4]

State-Led Initiatives
States such as VT, NC, and CO have rolled out state-wide team-based care coordination programs targeting high-need populations in recent years.[5]

Accountable Care Organizations
A number of ACOs, including Hennepin Health (MN), OneCare Vermont, and ThedaCare (WI), are focused on generating shared savings through care coordination. This number is likely to grow as value-based purchasing strategies continue to gain traction nation-wide.

Managed Care Plans
Several states have added requirements to their managed care contracts to implement team-based care coordination programs, and a growing number of health plans throughout the country are investing in similar programs on their own.

December 2016

Developed by the Center for Health Care Strategies (CHCS) drawing from:

[1] CHCS. "Medicaid Health Homes: Implementation Updated." July 2016. Available at: http://www.chcs.org/resource/medicaid-health-homes-implementation-update/.

[2] The CMS Innovation Center (2016). "Health Care Innovation Awards." Available at: https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/.

[3] CHCS and State Health Access Data Assistance Center. "Community Care Teams: An Overview of State Approaches." March 2016. Available at: http://www.chcs.org/resource/community-care-teams-overview-state-approaches/.

[4] CHCS. "State Innovation Model Participants Map, 2015." Available at: http://www.chcs.org/project/technical-assistance-for-the-state-innovation-model-sim/.

[5] CHCS. "Programs Focusing on High-Need, High-Cost Populations." April 2016. Available at: http://www.chcs.org/resource/programs-focusing-high-need-high-cost-populations/.

Federal, State, and Local Care Management/Care Coordination Initiatives

Health Homes, SIM models, and ACOs

Currently, there are multiple federal and state initiatives that support the delivery of care management services. One prime example is that of Health Homes, a program created by the ACA to provide Medicaid reimbursement for care coordination services to individuals with complex needs. In its first two years, Health Homes provided a 90/10 federal/state financial share in the first two years. To date, 19 states and the District of Columbia have fully implemented Health Homes programs, with another dozen seeking federal approval.

State Innovation Models (SIM) is another federally funded, state-run effort spurring care coordination efforts. Through SIM and the Center for Medicare and Medicaid Innovation (CMMI), 38 states are working to broadly transform their health care delivery systems, with at least 17 SIM states focused specifically on building care coordination capacity.[1]

Several states, including Connecticut, Delaware, Iowa, and Rhode Island, have used the SIM initiative to create community care teams that are focused on providing team-based care to individuals with complex medical and behavioral health issues. Similarly, a number of CMMI Health Care Innovation Awardees have focused their projects on providing team-based care coordination services to Medicaid beneficiaries. Other state-led team-based care coordination programs have been implemented, including Vermont's Blueprint for Health, Community Care of North Carolina, and Colorado's Regional Care Collaborative Organizations.

States are also increasingly utilizing managed care plans as key partners in efforts to increase team-based care for complex patients. For example, both Pennsylvania and New Jersey now require managed care plans to support community-based care coordination programs for complex Medicaid beneficiaries. Other health plans throughout the country have invested in similar programs, including the San Francisco Health Plan, CareOregon, and Commonwealth Care Alliance in Massachusetts.

At the local and regional level, accountable care organizations (ACOs) such as Hennepin Health in Minnesota, ThedaCare in Wisconsin, and OneCare Vermont have invested in team-based care management programs of their own. The continued spread of ACOs and other value-based purchasing strategies encourage entities to provide efficient and cost-effective care, which often translates into providing care management for high-cost and medically complex patients.

The New York State Health Homes Program

In 2012, New York became one of the first states to implement a Health Homes program. New York's Health Homes are configured around 31 designated lead entities, each of which has created a network of health care practitioners and community-based organizations (CBOs). These network ("downstream") partners are frequently subcontracted by the lead Health Homes to provide care coordination or facilitate connections to needed services. New York Health Homes currently serve more than 230,000 Medicaid enrollees.[1]

The goals of the Health Homes program are also aligned with New York State's Delivery System Reform Incentive Payment (DSRIP) Program, an $8 billion initiative launched in 2014 to foster collaboration and health system reform with the goal of achieving a 25 percent reduction in avoidable hospital use over five years. New York State has encouraged close integration of health home networks within 25 DSRIP "Performing Provider Systems" to drive reductions in avoidable hospital use by high-risk, high-need patients.

While the Health Homes care delivery model presents the promise of better care for complex patients, implementation faces considerable challenges. These challenges are related to fundamental changes in care delivery, poor communication within and between organizations delivering services, inadequate health information technology, and insufficient payment, particularly as care delivery shifts toward producing high-value care and away from high-volume care. According to a recent evaluation of the program, "the Health Home model's whole-person approach,

encompassing comprehensive care management and coordination, integration of physical and mental/behavioral care, and links to nonclinical supports…has the potential to improve the overall health and quality of life for some of the most vulnerable Medicaid beneficiaries. Whether the potential is realized depends on the ability of the providers who, in some cases, have to make large changes in the way they deliver care to meet the model's requirements."

CareOregon Health Resilience™ Program

CareOregon is Oregon's nonprofit health plan that funds and implements the Health Resilience™ Program, a care management program for Medicaid and Medicare-Medicaid beneficiaries with complex health and psychosocial needs. As part of the Health Resilience Program, care coordinators with a master's degree and behavioral health expertise are embedded in selected primary care clinics in the CareOregon network. The care coordinators, also known as Health Resilience Specialists, provide patient-centered care management services to patients and facilitate regular interdisciplinary care team meetings with practice staff. Teams comprise physicians, nurses, social workers, behavioral health specialists, pharmacists, and care managers. The Health Resilience Program has demonstrated an annual 19 percent decrease in inpatient hospital utilization, a 22 percent decrease in emergency department visits, and a 28 percent increase in PCP visits over a 12-month period through the following approaches:

Coordinated Care Organizations: CareOregon is a member of HealthShare of Oregon, one of sixteen Coordinated Care Organizations (CCOs) within the state. CCOs are networks of practitioners and payers who coordinate physical, behavioral, and oral health benefits and services, and who have collective financial responsibility for patient outcomes. CCOs specifically focus on reducing costs in Medicaid beneficiaries through global budgets, support for non-traditional health workers, and an emphasis on preventive and other factors not always considered directly related to health (e.g., housing and transportation). CareOregon receives capitated payments from HealthShare of Oregon, which it uses to support its full range of services, including the Health Resilience Program. Oregon's CCO structure supports Health Resilience Program's holistic approach to wellness by providing a financial incentive to align value-based payment models and disparate health and social service systems.

Predictive Modeling to Allocate Patients: Clinics must serve a minimum of 125 high-risk patients to be included in the program. Patients are assigned to clinics, not to specific practitioners, and are then assigned to Health Resilience Specialists using an algorithm that tracks utilization and clinic loyalty patterns. While patients tend to consistently see the same PCP, this structure accommodates the possibility that patients may receive care from many different clinicians. The patient allocation process accommodates the patients' utilization patterns, supports clinic alignment with Health Resilience Specialist caseloads, and ensures that CareOregon sends payments to the practice that provides services to the patient. In instances in which a Health Resilience Program patient needs to switch to another clinic or PCP, the Health Resilience Specialist facilitates the transition to either another Health Resilience Program clinic or to another practice via a "warm hand-off."

Incentives for Participation: To ensure practice buy-in and the full integration of Health Resilience Specialists, clinics self-select to join the Health Resilience Program and make an up-front commitment to fully integrate the Health Resilience Specialists into the clinic. Each practice then appoints a full-time medical PCP as a program champion. The champion's role is specifically to advocate for and participate in integrated care team activities. To support this aspect of the model, CareOregon offers a stipend of 10 percent of the champion's salary to cover time spent meeting with the care team, as these meetings are not a billable service under Medicaid. Through these incentives, Health Resilience Program found that clinics with previously-established team-based care models tend to integrate Health Resilience Specialists more successfully.

In a practitioner satisfaction survey conducted by CareOregon, practitioners reported feeling more supported when Health Resilience Specialists work with complex patients and more confident in those patients' health outcomes. Practitioners recognize the program's value, and their buy-in is a key component of the how the model gains traction in practices. CareOregon is also considering whether to develop incentive metrics related to reducing emergency department and inpatient hospital utilization, which would further incentivize clinics and health systems to work with initiatives such as the Health Resilience Program to reduce acute health care utilization.

Practitioner Education: CareOregon has dedicated significant resources to educating participating practitioners and practices about the Health Resilience Program and the role of the Health Resilience Specialist. The organization developed a team-based care curriculum and a Patient-Centered Primary Care Home toolkit, a job description for the champion role, and a mechanism for evaluating champions. CareOregon has also provided participating clinics with a document that delineates best practices in primary care and established a learning collaborative for participating clinics that supports team-based care practices.

Maine's Community Care Team

The Maine Community Care Team (CCT) program was developed in 2012 to support the Maine Patient-Centered Medical Home (PCMH) Pilot. This program is a multi-payer effort including the state Medicaid agency (MaineCare), Medicare, other government stakeholders, commercial payers, the employer payer collaborative Maine Health Management Coalition, and Maine Quality Counts (the regional health care improvement collaborative). CCTs consist of regionally-based interdisciplinary care teams that partner with multiple practices to provide short-term services and supports to high-utilizing patients for up to six months. Administratively supported by Maine Quality Counts, the CCT program has leveraged funding from the multi-payer stakeholder group and private foundations to pay for program planning and start-up costs, and to provide a PMPM payment structure for CCT teams.

CCTs partner with medical practitioners involved in a variety of statewide delivery system reform programs, such as MaineCare Health Homes and the PCMH demonstration, as well as practices unaffiliated with these initiatives. While CCTs are required to employ an RN care manager and social workers, teams may consist of staff from both the CCTs and the practices to ensure continuity of care and effective cross-team communication, and regular patient monitoring by the PCPs. Other team members may include health coaches and community health workers to provide self-management support, pharmacists and psychiatrists to provide consultations when needed, and nursing, medical, social work, and pharmacy students as well. There are several factors that are essential to the collaborative nature of the CCT program:

Patient Allocation Strategies: Through the practices' EHR systems, the state's health information exchange, and Medicaid/Medicare claims data portals, CCTs analyze each practice's patients to determine eligibility and appropriateness for the program. Eligibility criteria for patient participation include ED utilization, hospital admission criteria, and payer or practitioner identification of high-risk or high-cost patients. Patients can also be directly referred to CCTs by PCPs, payers, and hospitals. CCTs may then use patients' diagnoses or conditions as a way to prioritize participants for enrollment based on practices' patient population, including those with multiple chronic conditions or social service needs that hinder treatment, or those who have not yet met previously set treatment goals. Through this combination of data analysis and adaptability, CCTs are able to target high-risk patients for the program while also being responsive to practices' needs. In addition, since the patients are enrolled into the program through an existing practitioner relationship, the medical practice is automatically tied to the patient's care team and the CCT intervention process.

Supporting the CCT/Practitioner Relationship: A close, integrated relationship between CCTs and partnering practitioners is essential to the program's collaborative care model. CCTs exist throughout the state and are encouraged to include team members who are familiar with the region they serve. This local

connection encourages strong relationships between CCTs and area practices. Partnerships between the CCT teams and practices must be mutually accepted, and practices are required to identify staff champions to lead collaboration efforts. To further strengthen the connection between the two entities, CCT staff identify themselves to patients as working directly with practitioners' offices. Multidisciplinary case conferences with CCT and practice staff occur at least monthly, either in person or via video or phone conference. Additionally, Maine Quality Counts has established a learning collaborative for the CCTs and partnering practices to support quality improvement, interagency collaboration, and best practices. The learning collaborative consists of three all-day learning sessions per year, regional forums, monthly webinars, and an annual "super-utilizer" summit. These aspects of the program support CCTs in their efforts to fully integrate into the culture and workflow of the medical practices and deliver care that is both coordinated and sustainable.

Commonwealth Care Alliance

The Commonwealth Care Alliance (CCA) is a Massachusetts nonprofit health care system that serves the most complex and highest cost Medicare and Medicaid beneficiaries, including lower-income older adults and people with disabilities. The organization's care delivery and care management structure is built around an interdisciplinary team-based model that focuses on providing care in community settings. The model leverages payments from both Medicaid and Medicare to provide a robust range of services to members. Interdisciplinary team meetings are held frequently (weekly or more), with additional ad hoc case conferences to discuss specific high-priority patients. Several factors support the success of CCA's team-based approach, including:

Risk-adjusted global payments: CCA's payment structure is key to the flexibility of the organization's care model. As a fully integrated plan for individuals who are dually eligible for Medicare and Medicaid, CCA receives premium payments that are risk-adjusted to ensure that the payments account for the populations' complexity. This financing model supports the broad range of practitioners and team members that beneficiaries may require. It also enables CCA to self-determine how to best to deploy its resources. For example, having a CCA nurse practitioner and behavioral health practitioner conduct a joint home visit can enable highly effective collaboration and improved patient care; however, such a joint visit would not be reimbursed under traditional fee-for-service payment models. CCA's risk-adjusted global payment model allows it to finance this innovative way of delivering care.

Co-location of behavioral and physical health services: Medical and behavioral health care providers are co-located in many of CCA's care delivery sites. This physical proximity allows for both formal and informal case-conferencing opportunities among physicians, nurse practitioners, social support coordinators, and behavioral health clinicians, and other team members.

Team model: From its inception, CCA's interdisciplinary care team has been at the core of its model. PCPs serve as the hub of the patient's care, and other team members may include long term services and supports coordinators, behavioral health practitioners, geriatric specialists, and community health workers. Teams also often include advanced practitioners, social workers, and nurses. Additionally, social service organizations are frequently integrated into the care teams as staff and model extenders, collaborating extensively to support patients' non-medical needs such as housing and food stability.

Access to member data: CCA has the benefit of being both a health plan and a delivery system, which means it has access to a robust set of member data. This access has helped staff understand who should be involved in interdisciplinary care team meetings and how to assign patients to teams. The organization uses data to track its patient and financial outcomes, and has been able to highlight opportunities for improvement for CCA members. CCA has found that sharing this data helps outside practitioners, clinics, and practices understand the concrete benefits of care management, and has been critical to getting buy-in for the integrated care team approach.

APPENDIX 3 CITATIONS

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