Lessons Learned: Integration Looking through a Care Management Lens – ICMP and PBCM

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Lessons Learned and Best Practices

- Integrated care management does make a difference.
- Don’t always feel you need to reinvent the wheel.
- Work very hard to connect existing ‘DOTS.’
- Be open to criticism, it can often improve outcomes.
- Devote resources to ‘front’ and ‘back’ ends of your infrastructure/system.
- Pediatric care management is not simply a ‘smaller’ version of adult care management.
- Be flexible.

Integration Focus (historical)

- PCMHI (Patient-Centered Medical Home Initiative)
- PCPRI (Primary Care Payment Reform Initiative)
- ICMP (Integrated Care Management Program)
- PBCM (Practice-Based Care Management)

Content Review

- ICMP
  - Mental health and physical health focus from the start
  - Plan-based
  - RNs and MH/BH staff working side-by-side as teams in five regional offices
  - Member-focused goals, addressing mental and physical health issues within the same care plans
- PBCM
  - Mental health and physical health focus from the start
  - Community-based
  - Worked with community-based practices ‘where they were at’
  - Six pilots focused on PCC work. Over the past few years it has grown to 18, including three BH providers.

PCBM Site Map

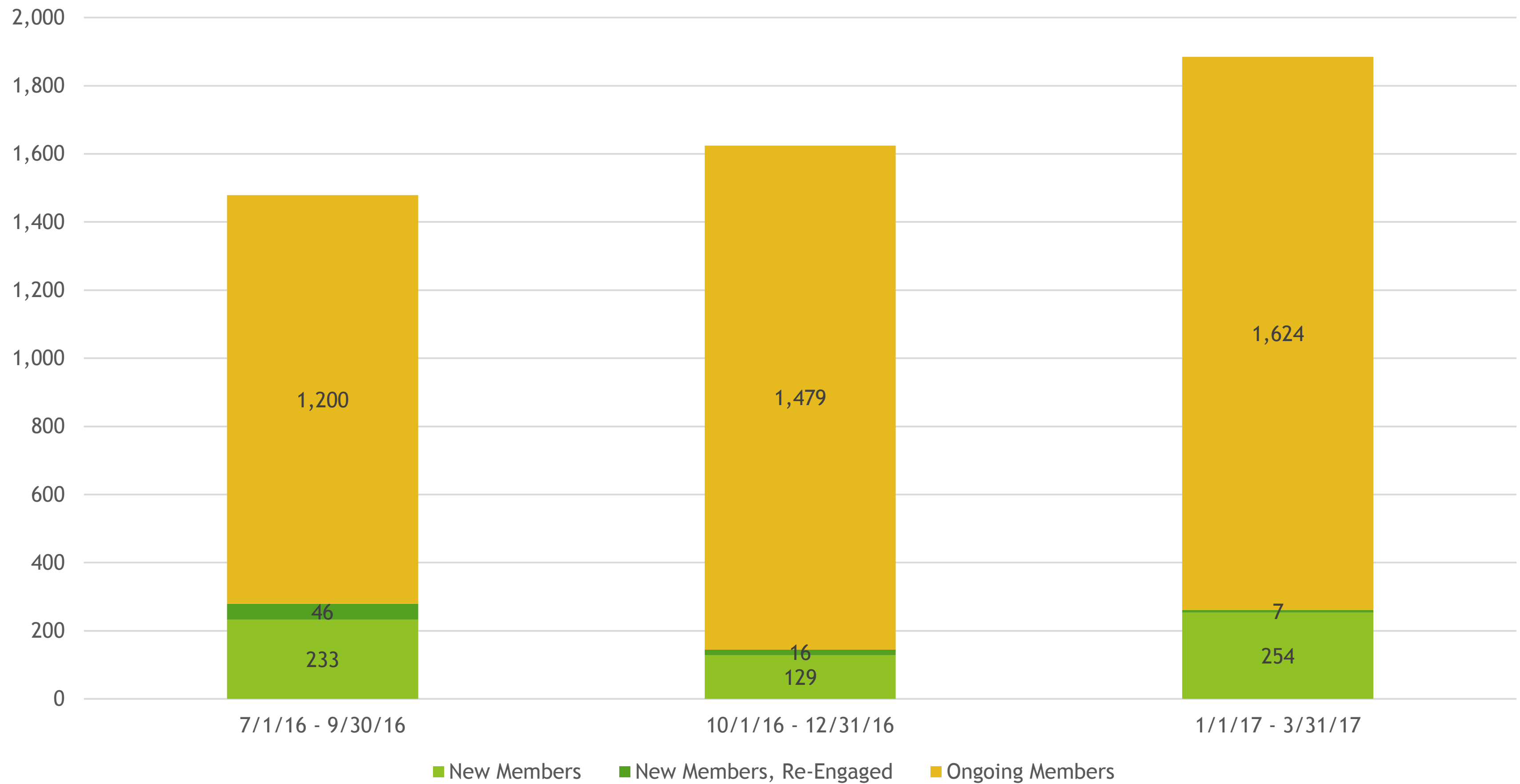
PBCM Site Map 2017

- Reliant Medical Group
- Berkshire Faculty Services
- Behavioral Health Network
- Greater Lawrence Family Health Center
- Manet Community Health Center
- South Middlesex Opportunity Council
- Caring Health Center
- North Shore Community Health
- Charles River Community Health
- U Mass Memorial Medical Group
- Advocates Community Counseling
- Brockton Neighborhood Health Center
- Duffy Health Center
- HealthFirst Family Care Center
- Stanley Street Treatment and Resources
- The Bridge of Central Massachusetts, Inc.
- Tural Pediatrics
- Whittier Street Health Center

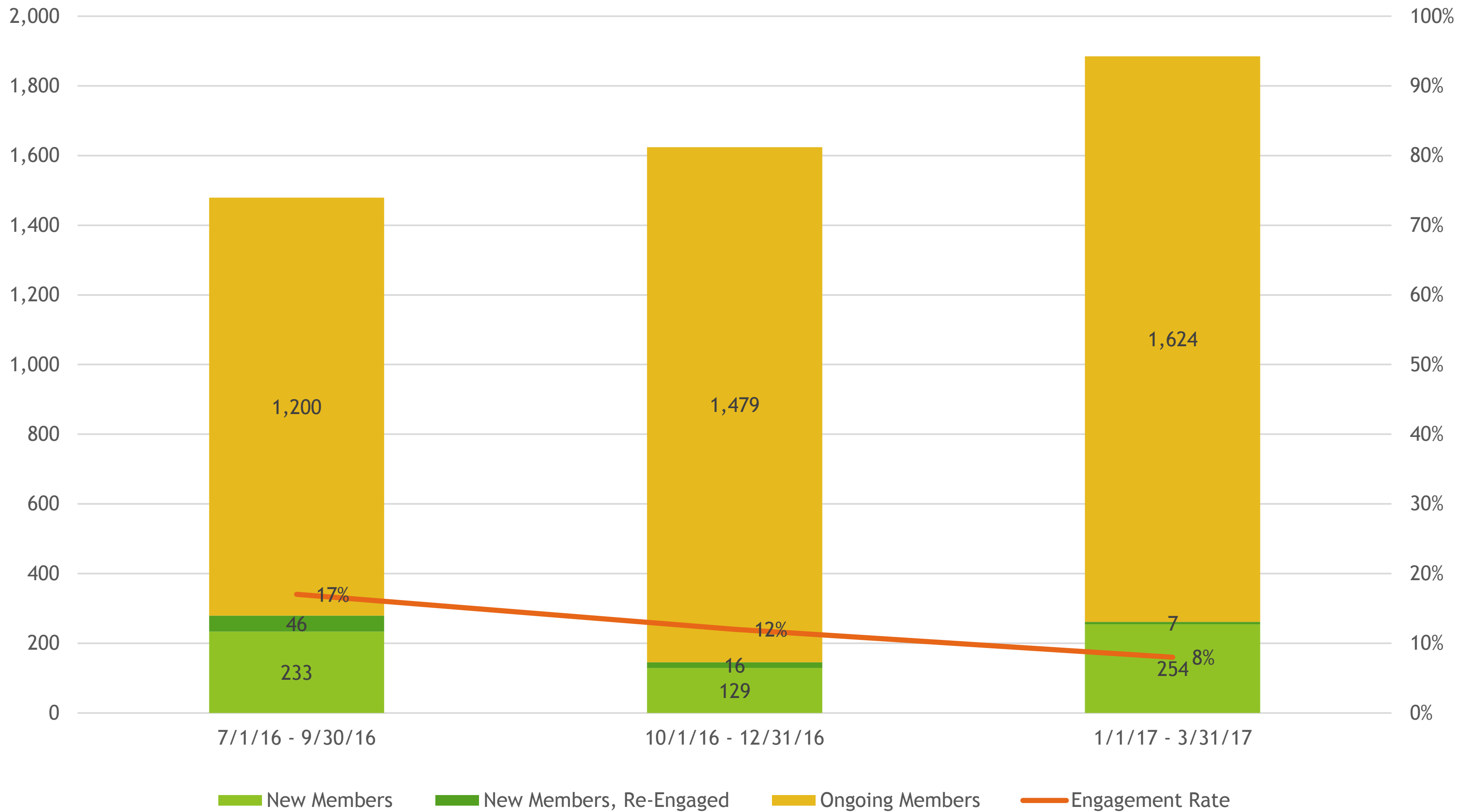
Challenges

- Outreach and Engagement
- Resources (staff, staff, staff!)
  - Lack of onsite social workers, MH providers
  - Lack of diversified team
- Communication
  - Health literacy issues
  - Connecting to community supports (housing, transportation)
- Clinical vs. Care Management
- Eligibility
- Data Management and Reporting
  - Incorporating CM into EHR (tracking and reporting in system)

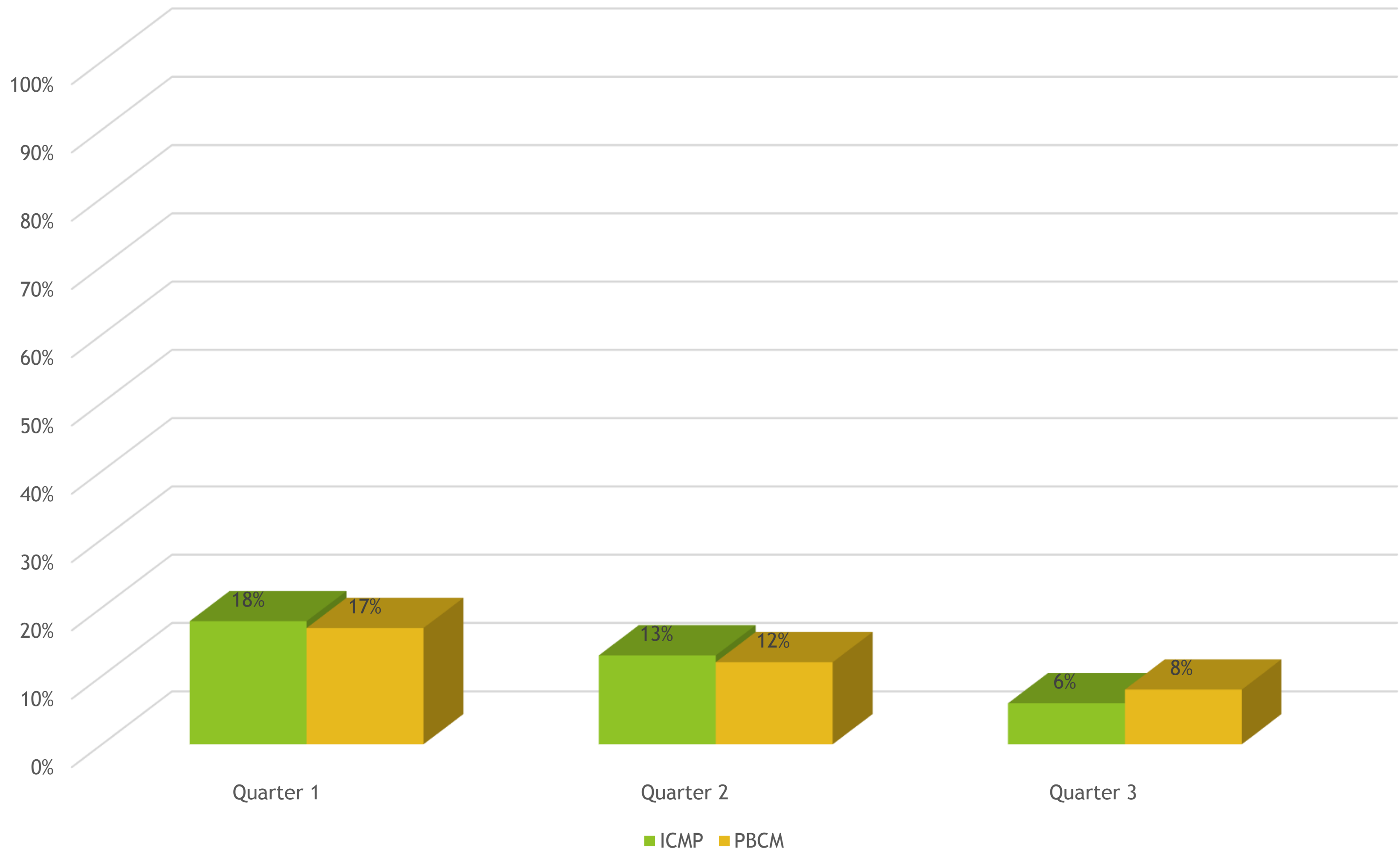
Quarterly Member Engagement September 2016 – March 2017



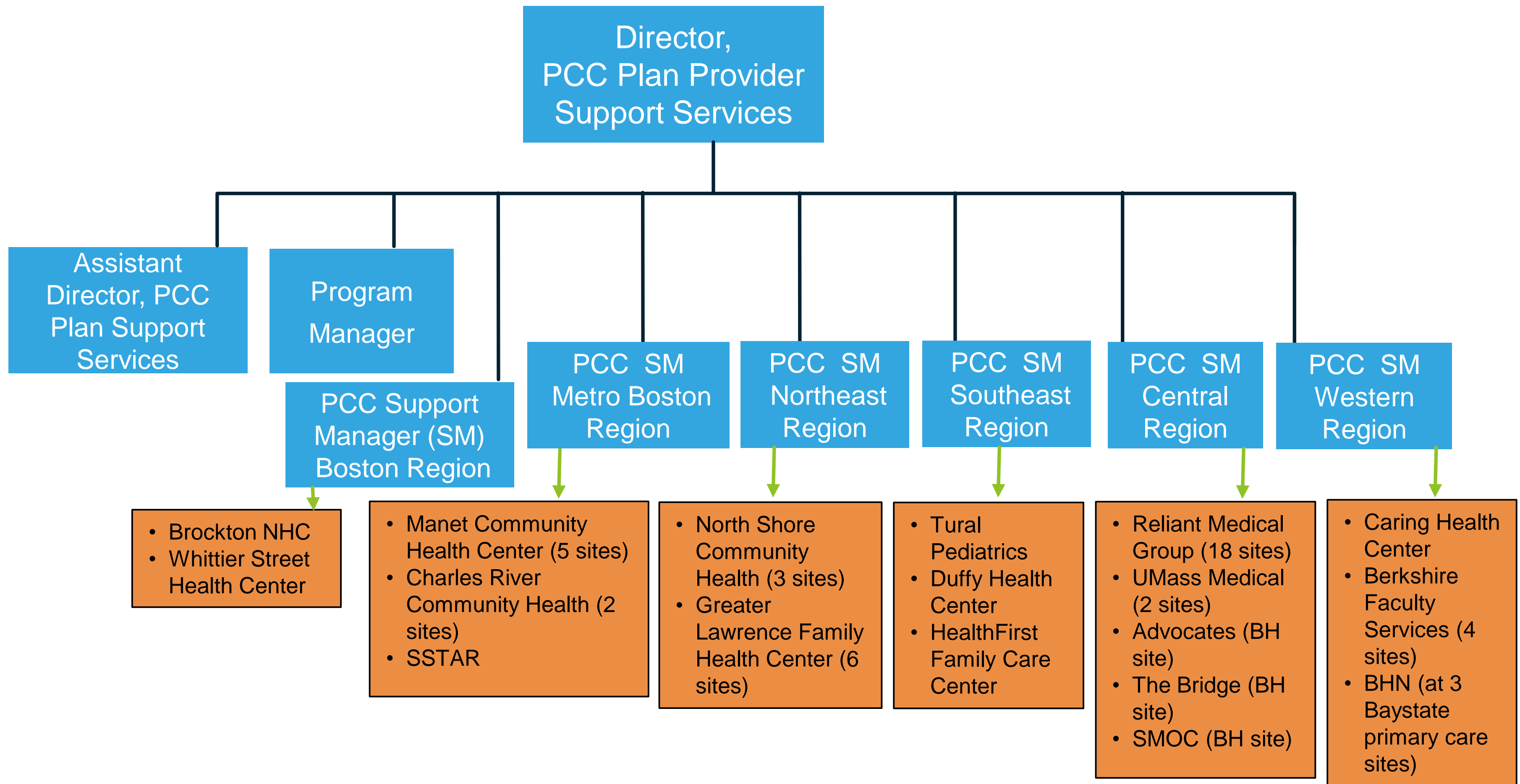
Member Engagement Totals and Engagement Rate September 2016 – March 2017



Enrollment Rate at Quarter End September 2016 – March 2017



PCC Support Managers (SMs)



PCC SM Site Visit Support

PCC SMs meet with sites approximately once a month on-site, focusing on:

- Sharing reports showing enrollment trends
- Working on key operational issues, such as:
  - Identifying opportunities to improve communication within the practice about the care management program
  - Working with sites to strengthen outreach and engagement
- Conducting record reviews to assess how site is conducting care management under the PBCM model and identifying needed areas of improvement
- Ensuring that PBCM site is aware of full range of BH services available to PCC Plan Members and strengthening referral pathways with BH providers

Training/Education

- Quarterly Learning Collaboratives
- MBHP webinars on integration related topics, e.g., SUD services, risky drinking, health literacy
- PBCM practices were introduced to the resources available through the Southern New England Practice Transformation Network (SNE-PTN), a collaboration between UMass Medical School and UConn Health Center. SNE-PTN provides technical assistance, training, coaching, and resources to primary and specialty care clinicians to help support them in the transformation needed for success under alternative payment models

Examples of Care Management Support Tools

MASSHEALTH ACO PRIMER: INVESTMENT IN HEALTH-RELATED SOCIAL NEEDS

With its MassHealth ACO opportunity, the Bay State is rewarding the integration of health-related social needs into clinical care. While crucial to the success of this new integrated model, many providers lack the insight to design high-impact, cost-effective interventions. This free guide--based on over 20 years of experience implementing social needs programs--shares key methods for testing and maximizing health while decreasing total cost of care, ensuring the long-term success of your model.

READ MORE >

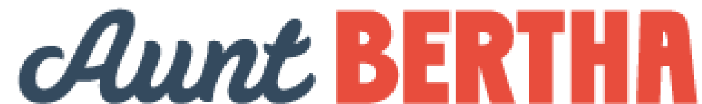
HEALTH LEADS SCREENING TOOLKIT

The Health Leads Screening Toolkit is the first to combine **20 years of experience** implementing social needs programs with a **patient-centered approach** and **well-researched, clinically-validated guidelines** from sector authorities like the Institute of Medicine, Centers for Medicare and Medicaid Services and the Centers for Disease Control -- all in one place.

READ MORE >

Examples of Care Management Support Tools (cont.)

Health Leads Reach™



- Web-based resource tools
- Shared platform
- Up-to-date local information re: resources
- Social determinants of health focus

Best Practices

- We now consider engagement as a crucial part of the assessment. We begin a simple conversation, drawing the person toward telling ‘his/her story’ about his/her current medical/behavioral health/general life concerns. We use empathy, validation, compassion, and reflective listening skills before we even begin to tell him/her about the program.
- Team members frequently ‘pop-in’ after a PCP visit in order to check in with their patient.
- Joint visits - often the RN and CHW will do a joint home visit in order to work together.

Best Practices (cont.)

- Support with transportation and other social determinants that can be a barrier to care
- Leveraging the knowledgebase and expertise offered by our PCC Support Manager to resolve issues impacting the program
- Education regarding same-day visits at health center vs ED use

Resources

- https://www.auntbertha.com/
- https://healthleadsusa.org/
  - https://healthleadsusa.org/solutions/tools/
- https://www.healthify.us/
- http://www.sneptn.org/

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Thank you