7) Integrated Care Management Program (iCMP)- Care Management for Adult and Pediatric High Risk Patients – FINALIST

Partners HealthCare Population Health Management

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PROJECT DESCRIPTION

The Integrated Care Management Program (iCMP) is a primary care embedded, longitudinal care management program led by a nurse care manager working collaboratively with the primary care physician (PCP) and care team.

The care team includes nurse care managers, social workers, pharmacists, and community resource specialists and, when appropriate, community health workers.

Key elements of the program include:
- Access to specialized resources including mental health, community resources expertise, pharmacy, palliative care
- Involvement through continuum of care with home visits, telemonitoring, integration with post-acute and specialty services
- Patient self-management with health coaching and shared decision making
- IT enabled systems to improve care coordination leveraging real-time, automatic notification of admissions/discharges and electronic medical record flags identifying iCMP patients
- Data driven analytics to support strategic decision-making and operations
- Intensive, on-going support and training for teams and staff

iCMP focuses on subset of patients who are chronically ill, medically complex and would benefit from a care management intervention. These patients are identified using a proprietary algorithm and clinical review by the primary care physician.

Characteristics of these patients include:
- Multiple medical conditions
- One chronic, severe medical condition
- Mental health, behavioral health, or substance abuse complicating medical condition
- Lack of socioeconomic resources to manage illnesses
- High utilization of services

As of July 2015, 12,000 adult patients and 1,500 pediatric patients are enrolled in the iCMP program.

OUTCOMES ACHIEVED

- Scaled the high risk program to all adult and pediatric primary care physicians across the system
- Identified and reviewed 40,000 patients and actively managing 13,500 patients
- Hired and trained 100 FTE care team members
- Increased communication and collaboration among the inpatient case managers and high risk care managers to improve patient care management post the acute admission
- Improved rates of patient/provider touches after the acute admission
- Reduced total medical expense (TME) trend for a cohort of patients that have been enrolled for the greatest length of time since baseline (See Figure 1)
- Reduced the medical admits per 1000 trend over last 2 years for patients enrolled for the greatest length of time

LESSONS LEARNED

- Allowing primary care physicians and care teams to make the final decision as to which patients should enroll in iCMP is a critical success factor
- Governance of program should include central oversight and guidance, but locally led by each organization in the network.
- Impact on cost and utilization can be seen when the care team engages with patients for at least 18 months and grouping patients enrolled in the program based on length of time in the program is an effective way to look at program impact on cost as well as mitigate the impact of regression to the mean.