

A Medical Director's Perspective

Care Management Demonstration Project for High-Risk Populations: Transition, Communication and Continuity

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In 2006, Massachusetts General Hospital (Mass General) in Boston, MA, began to explore opportunities to improve the overall care process for its high-risk Medicare patient population. After much deliberation, Mass General's physician leadership decided to participate in a three-year demonstration project through the Centers for Medicare and Medicaid Services (CMS) in order to re-design how the organization cares for its high-risk Medicare patients. Now in its second cycle, Mass General continues to work alongside CMS to develop and improve upon their initial successes with the Care Management Program.

DEFINING THE PROJECT

The project's management team includes: Mass General's Medical Director for the Care Management Program, Nurse Manager for Case Management and the Project Manager. The leadership team, who supported the program's design and development, continue to be an integral part of the project.

The project leadership team began the demonstration project process with a brainstorming session called the 'Capstone' meeting. The Capstone meeting was a collaborative effort, during which a cross-section of Mass General's inpatient and primary care leadership examined the needs of the high-risk Medicare patient population and discussed whether or not the resources necessary to care for this specific population were available and, if so, utilized.

Those involved in the Capstone meeting included: the social service department; primary care physicians; leadership from the physicians' organization; a number of specialists; case management leadership; and representation from Mass General's: hospice/palliative care; psychiatry and primary care geriatric practice.

The complexity of this patient population requires a different approach to care. The goal of the program is 'to improve patient outcomes through improved care management and care coordination for the most medically complex patients in our practices.' Therefore much of the focus of the brainstorming session centered on ensuring that a project designed to improve the care process took into account every possible factor which differentiates high-risk Medicare patients from the average patient.

DEVELOPING THE CASE

Once the direction and focus of the project had been established, the team began to develop the details of the initiative in order to create a proposal. Some of the factors outlined in the proposal included:

- Identification of high-risk patients/who the program would serve
- Percentage of the overall patient population
- The mission and operating principles
- Overall design of the program
- The cost of the initiative

Though the potential benefits of participating in a demonstration project are great, the project is still a risk model. This meant if the program was not successful; the organization must cover the cost of the initiative. CMS provides the participant with the funding to launch the project, and perhaps most importantly, the opportunity to work with a vested stakeholder, such as CMS, towards an ultimate goal. CMS emphasizes strong, successful outcomes in order to demonstrate solutions to many of the problems routinely faced by Medicare beneficiaries and their families.

With this in mind, proposing a project with such major financial implications to senior leadership can be considered a challenge. Therefore, continual reporting and transparency – both during the research and implementation phases as well as throughout the duration of the project – is a critical component in the formula for success.

Fortunately, Mass General's hospital and physician organization leadership – including the organization's CEO and the hospital's president – strongly supported the concept and gave their approval. Mass General's leadership felt that the initiative was well worth the risk. It would allow the organization to be a part of the solution; an active participant in determining which models of care are necessary to assure high quality care and strong health outcomes. Further, Mass General's leadership conveyed their confidence in the project by stating that in a 'worst case scenario' the initiative would have resulted in tremendous learning, and in a 'best case scenario' it would have delivered excellent care to patients and achieved exceptional savings.

Once the project leadership team had gained the support of the organization's executive management, the proposal was presented to CMS and subsequently approved.

IMPLEMENTATION

By definition the first six months of the program's life would be considered the implementation phase; however, in reality the implementation process is ongoing. During the first six months, patients selected by CMS based on a set of criteria were enrolled in the program. A comparison group was selected from other academic medical centers in Boston using the same set of criteria.

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Early in the implementation process, the project leadership team adopted a phrase that would serve as a form of slogan for the program: *'the way the program was at the start is not the way the program will be at the end.'* This was decided because throughout the demonstration project the organization's ultimate goal was to learn. Opportunities for error and mistakes increase substantially once learning ends and the process is no longer challenged.

The first step in the implementation process was to identify what type of case manager could best support these patients. The case manager's role requires a great amount of collaboration with the patient's primary care physician (PCP). At times it is necessary for a case manager to make recommendations to a PCP based on their knowledge of a patient as well as their observations during points of transition. In this regard, it is important that case managers possess extensive clinical and medical knowledge, and experience in order to work effectively with the PCP on issues such as medication reconciliation and alternative modes of care. With this consideration in mind, the decision was made to employ nurse case managers in the program in order to adequately meet these requirements.

Another pivotal component of the implementation process was operations meetings with full staff. These meetings focused on all the different areas necessary to successfully implement the program. Meetings addressed a variety of considerations such as necessary skill sets of the program's clinicians; the program's timeline; and the preferred type of computer system database collection. Initially, the care team dedicated a minimum of 20 hours per week to operations meetings. The program's design was developed and revised through these meetings. Each revision was presented to the hospital's leadership in order to gauge reactions and make any necessary adjustments before the program's launch.

Constant feedback and input from individuals throughout the continuum was also an important part of the implementation process. The program's development was truly a team effort. From community resource specialists to case managers; everyone played a vital part in the program's implementation. The management team communicated regularly with staff and other interested parties throughout the process to solicit advice and feedback, and identify opportunities for improvement.

ANATOMY OF THE PROGRAM

The program operates under the direction of the project leadership team and involves approximately 200 PCPs and 14 nurse case managers. The nurse case managers are assigned by and embedded within the physician practice either on or off campus at Mass General. Each case manager is assigned to the patients identified by CMS for the primary care practices. The average case load for the program's case managers is 200 patients.

As previously mentioned, the program's case managers are nurses with extensive clinical experience, who average more than 25 years experience. The program was designed so that case management's collaboration with the patient and coordination with the PCP sets the plan of care. The case manager essentially supports the plan of care, and the other specialists and individuals involved surround the case manager in order to provide additional support. Those who provide such support include:

- Community Resources - Provide assistance in situations such as:
 - Transporting to/from an appointment
 - Locating a resource within the community
 - Locating an individual willing to volunteer and assist the patient
 - Securing housing
 - Assisting financially
- Social Workers - A considerable percentage of the patient population is affected by mental health issues. The program utilizes three social workers who are also assigned by physician practice.
- Pharmacist - A part-time position, the pharmacist is involved with patients who have elaborate medication profiles as well as those who may require assistance with Medicare part D-related medications. The pharmacist also might help with medication reconciliation and recommendations to the PCP.

The program's case managers are positioned to perform some functions that reinforce the PCPs care plan including appointment follow-ups, creating smoother transitions from one level of care to the next and reviewing medication plans. All this is done as the case managers forge relationships with the patient and his or her family.

The case manager's first function when he or she receives a new panel of patients is to contact each of the patients to speak with them regarding enrollment in the program. Next, they perform a comprehensive assessment, which includes functional, medication, transportation and mental health assessment. This process allows the case manager to thoroughly examine all aspects and identify how they might be able to support the patient in meeting their goals of care.

CHALLENGES

As with any new initiative, a number of challenges were encountered during both the implementation and the day-to-day operation of the Care Management Program at Mass General.

Moreover, demonstration projects, by virtue of their research nature, present participants with some challenges. CMS outlines

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the structure for its demonstration projects as well as some restrictions. Perhaps the most challenging of these restrictions is that participating organizations are unable to share outcomes data until the first phase of the demonstration is complete. Therefore, Mass General's focus has been towards qualitative outcomes. Fortunately, as the organization's first priority is clinical care, Mass General has been able to demonstrate significant positive impacts in the management of patients and in the satisfaction of both physicians and staff.

In a like manner, another challenge was the cultural change associated with the program. The program was a new concept for Mass General and had not been experienced by its staff. Fundamentally this meant that the way in which PCPs delivered care was going to change to some degree. Thus, the program had to be introduced in a manner that could be embraced in a number of different practices by a variety of individuals who were not accustomed to such a system.

One of the greatest ongoing challenges in terms of the day-to-day management of the program is the large case loads. Each case manager is responsible for a case load comprised of cases that are both labor and time intensive. For any one of the patients in the program, a case manager could invest an entire day or sometimes an entire week. This presents a considerable challenge as the organization's case managers must work to balance the depth into which they work with each patient versus the breadth of all the patients in their case load.

Some challenges have arisen; however, they have been virtually offset by the amount of positive energy surrounding the program and the support it has received throughout the organization. Throughout the life of the program people have been excited about the project's potential to improve patient care and have been eager to offer input and suggestions.

KEY CONSIDERATIONS

One of the most important considerations in the implementation process was identifying the right people to provide support throughout the process. At Mass General, the Information Systems dept. (IS) provided invaluable services and support to the care team. For example, the case managers asked for weekly lists of their patients scheduled to visit the primary care practice. IS met the request and developed a solution – a database system that records where all the patients enrolled in the program are located within Mass General at any given time. Case managers receive an email from the system each Monday informing them of patients who have appointments scheduled that week. In addition, case managers receive an email and a page when a patient presents in the emergency department and an email when a patient is admitted and discharged from the hospital.

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Another key element for the program's continued success is to recognize opportunities for improvement and what solutions might help address these issues. At Mass General, the Care Management Program provides a platform for testing new models of care. The program depends on both qualitative and quantitative data to inform development. Staff, physicians and other care providers are a tremendous source of quality improvement ideas. This is coupled with the work of the Data Analytics Team who prepares monthly reports on utilization and performance measures, as well as custom reports to guide new initiatives.

Lastly, outreach has been a valuable tool for the Care Management Program. The management team has worked to ensure the project was promoted through the organization's newsletters and internal publications, in addition to numerous presentations to primary and specialty care practices and other care providers both in the hospital system and in the community. These public relations efforts incited many within the organization to offer their support in the effort.

OUTCOMES

Though CMS restrictions and data use agreements limit the amount of data that can be released publicly until the project and its evaluation is complete, there are a number of positive outcomes and effects that can be shared and remain powerful despite a lack of specific detail.

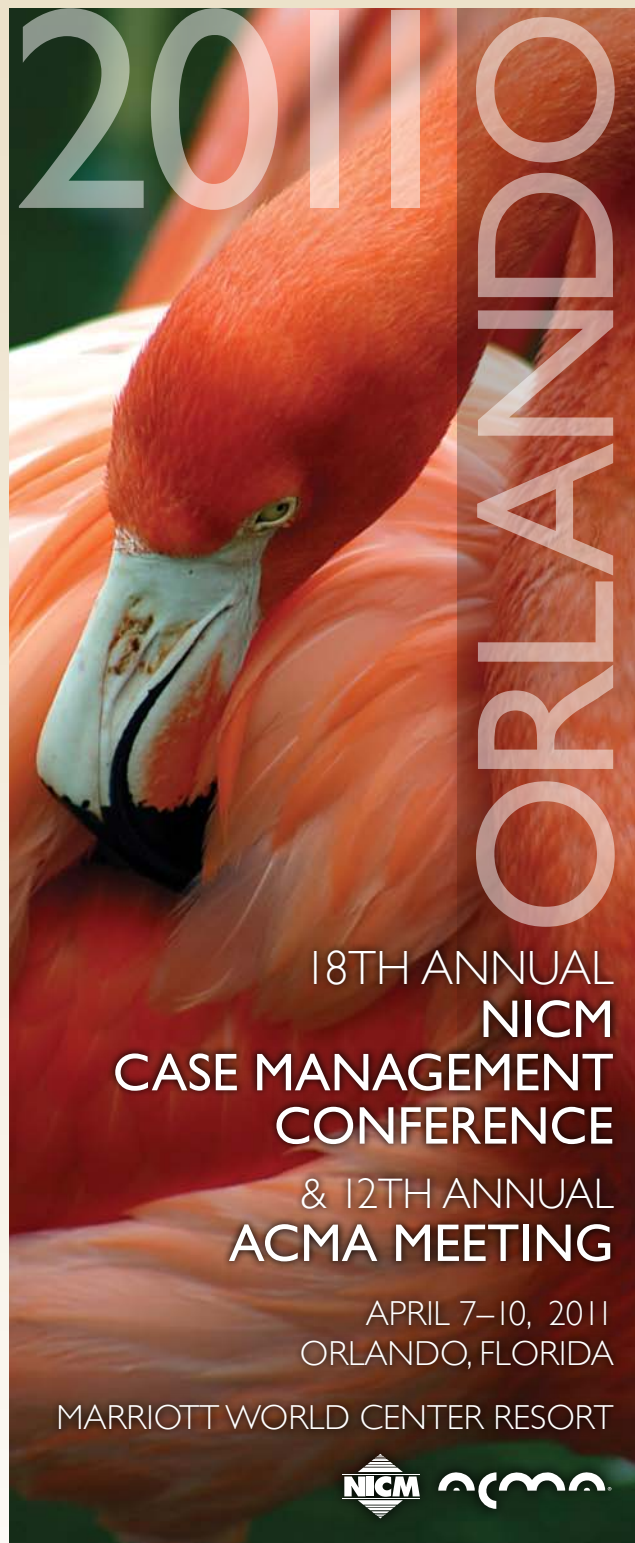
The program is projected to do well and may see a savings relative to a control population selected by similar criteria. This led Mass General and CMS to explore if the model can be replicated. In early 2010, the project expanded to Brigham and Women's Hospital and North Shore Medical Center to test replication.

Perhaps most importantly, the program has produced noticeable improvements in the quality of life for many of the hospital's patients. The case managers actively engage patients in a conversation about their goals of care. For many, this is a conversation that

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happens over time and addresses and includes a discussion of the patient's wishes at end of life. These conversations are now taking place when the patient will best benefit.

Additionally, patients are scheduling appointments with their PCP more readily, which aids the program's case managers in effectively managing the patient – their medications, symptoms, etc.

Finally, the program has also substantially impacted same day visits. Access to primary care practices allows case managers to triage a patient when he or she calls with issues so that they can be seen by their PCP rather than unnecessarily admitting in the ED. From a utilization standpoint, this has helped to reduce ED use and readmissions to the hospital.

The Care Management Program at Mass General continues with great success. The program's team leadership slogan, *'the way the program was at the start is not the way the program will be at the end,'* holds true. Mass General continues to learn from and improve their model in order to reach their ultimate goal – to further impact the way in which care is delivered while producing positive outcomes for the patient, care providers and the organization as a whole.

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