

An Integrated Approach to Care Management

Introduction

Martin's Point Health Care strives to manage patients' health across the care continuum and to provide care that is accessible, comprehensive, integrated, and coordinated. As a part of an organization dedicated to the Medical Home Model of primary care, the Health Management Department applied the Medical Home **team-based approach** to care for its health plan members during a three month pilot. Aligned with the goals of Triple AIM, the integrated team pilot focused on the population experiencing transitions of care from home to hospital. The integrated team measured its' impact on hospital length of stay, cost of care, readmission rate, and patient satisfaction.

Methods:

Nurses across the Health Management Department, representing Utilization Management, Case Management, and Health Coaching/Wellness formed a team, focused on the same goal for the membership population. This approach kept the patient/member at the center of care coordination and conversations. A Project Manager led the pilot discussions, process improvement efforts, and project development. Medical Directors and Management provided support and guidance that accompanies change management and team formation (forming, storming, norming, performing).

The integrated team utilized Care management software with integrated guidelines; these guidelines for care drove pre-admission calls, concurrent admission reviews, and post-discharge follow-ups. With expectations and resources set prior to admission, the team found a drop in readmission rates and improved patient experience than a baseline group who did not receive the service. Post-discharge, those members who required ongoing assistance with a chronic or other condition, were offered chronic care management or case management support. Those who did not require such were offered wellness coaching, in order to more specifically focus on health maintenance or behavior change.

A total population of 120 health plan members were included in the pilot; 55 of those members were US Family Health Plan (TRICARE) participants. At the start of the pilot, baseline data was collected on patient experience (through survey), cost (cost/stay based on claims information), and quality (readmission rate [claims], length of stay deviation [from Milliman Care Guidelines]). Data was captured via the same means for the 90 day period within which the pilot was conducted.

Results:

Anecdotal results of patient satisfaction poured in throughout the pilot study. Members and caregivers called thanking our Nurses for their involvement in care, for the pre-planning, safety and resource consideration, quality of care, and general improved experience.

The change to placing the member/patient at the center of care conversations improved the coordination of care; members were viewed as individuals with different life events, rather than as individual events that happened to occur to the same person. With Nurses rooted in the same care guidelines and resources, they succeeded in setting expectations for members before hospitalization, which improved patient knowledge around the procedure and expected outcomes.

Data will be disseminated in December. Preliminary results as of this abstract are positive.

This initiative led to stronger, more structured internal communication among the different functions within Health Management. The pilot program resulted in Department-wide restructure into integrated teams.

Conclusion:

The transitions of care pilot transformed into “the way we do business”. All of Health Management is now working in an integrated team approach to patient-centered care.

Smaller, cross-functional teams will allow our Health Management Department to be more agile in meeting the needs of our membership. Small teams have the ability to test new processes, campaigns, and programs without impacting the entire Department or entire membership.