



Primary Care Case Management (PCCM) Program Description:

The Rhode Island Department of Human Services (DHS), Center for Adult Health has designed and implemented a system of managed health care delivery through a Primary Care Case Management (PCCM) model called The Connect Care Choice Program. This managed care / health care network of primary care practices was assembled from existing “best practices” who have adopted the “chronic care model” and provide a “patient-centered medical home.”

The Connect Care Choice Program requires that these practices meet a higher standard of performance, provide evidenced-based chronic disease management, a patient-centered medical home, nurse care management, primary and preventive care while encouraging self management supports and education. The design of this program of health delivery is quality focused, holistic in its approach to achieve and maintain wellness as well as to improve access to primary and specialty care.

Goal:

The goal is to have adult Medicaid members achieve independence in the community with the necessary medical and social supports. The program is designed to reduce costly and avoidable acute and institutional stays in support of the rebalancing efforts of the Global Waiver.

Vision:

All adult Medicaid beneficiaries will have choice and access to quality health care services and remain well and independent in the community.

Mission:

Adult Medicaid beneficiaries will have access to enhanced primary care through established Primary Care/ Nurse Case Management Networks.

Program Components:

The Connect Care Choice model of delivery is a Primary Care / Nurse Case Management (PCCM) program and includes the following components:

- Advanced Patient-Centered Medical Home as defined by the American College of Physicians
- Nurse case management on-site within the practice and community
- Improved access to primary and preventive care
- Self-management supports and disease education
- Use of health care technology and Electronic Health Records

Eligible Population

The eligible population includes adults, 21 years and older, living in the community and eligible for Medicaid only. This high acuity population includes Aged, Blind and Disabled and are at high risk for repeat hospitalizations.

Strategy for PCCM Network Development & Practice Participation Criteria

The provider networks for the Connect Care Choice Program model are based on practices in a variety of settings that have adopted the chronic care model through participation in the Rhode Island Chronic Care Collaboratives – a Robert Wood Johnson funded initiative partnering with the Rhode Island Department of Health’s Diabetes Prevention & Control program and facilitated by Quality Partners of Rhode Island. The state has also targeted practices that are part of the Allied Advocacy for Integrated Behavioral Health with Primary Care. These practices include all settings of care; private group practices, community health centers and hospital-based ambulatory clinics.

The Advanced Medical Home Standards (developed by the American College of Physicians) have been adopted by the Connect Care Choice program to serve as guidelines for physician participation.

Population Characteristics

Connect Care Choice members are characteristically high risk patients with frequent Emergency Room use and hospitalizations who have been risk-stratified utilizing the Connect Care Choice predictive modeling tool. There is a high incidence and prevalence of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Depression, with 60% of the members having co-occurring behavioral health conditions.

Added Practice Supports - Nurse Case Managers

The Nurse Case Managers are an integral part of the Connect Care Choice program and provide the following:

- Located on-site at the practice and integrated into the practice team
- Patient needs assessment, case management, care coordination, and transportation
- Nursing interventions for a caseload of 150-200 high risk patients
- Promote disease management education and self-management supports
- Collect, monitor and provide patient clinical and performance outcome measures

Program Statistics

Implementation of the Connect Care Choice program began in September 2007. To date, the program has achieved statewide participation of over 17 practice sites and 2300 members.

Practice model / number of physicians	Members
6 Private Group Practice-Statewide (83 Physicians)	318
5 Hospital Based Primary Care Clinics	489
6 Community Health Centers	1093
17 Practice Sites Statewide	1900 Members(current)

Utilization Data

The following utilization findings based on MMIS Claims data compare Pre-Program to First Year results.

- Rebalancing efforts and improved access to services for the Connect Care Choice Program have resulted in reduced institutionalizations. In the first year there has been an increase of 10.5% in the utilization of Behavioral Health services and an increase of 17.2% in the utilization of Home and Community Based Services.
- Improved access to Primary Care Physicians coupled with an increase of 2.6% in the utilization of Outpatient Services has resulted in a **decrease of 16.7%** in the utilization of Emergency Room services.
- While appropriate Acute Inpatient Hospitalization increased by 21% for this medically complex population, it is anticipated that greater access to Primary Care and the Nurse Case Manager “Hospital to Home Transitions Project” will avoid acute readmissions, and provide a decrease of 20-25% over the next several years.

Clinical Measures / Outcomes

*based on first year 2010 data (2,300 members)

Diagnosis	Goal	Member Success Rate
Diabetes		
⇒ HgbA1C	<7	¹ 43%
⇒ Blood Pressure	<130/80	² 53%
⇒ LDL (Cholesterol)	<100	³ 40%
Coronary Artery Disease (CAD)	Pt. on Beta Blocker	⁴ 55%
Depression	Pt. on Antidepressant	^{5, 6} 64%
Smoking Cessation	100% of smokers are educated on smoking cessation	⁷ 67%
Self-Management Goals	100% of high risk pts will achieve self-mgmt goals	⁸ 45%

With the Connect Care Choice Program’s emphasis on chronic care management and self-management goals, Rhode Island’s adult Medicaid members can achieve wellness and slow the progression and incidence of co-morbid chronic conditions over time. This will positively impact utilization of expensive acute care and long-term care services and produce significant cost savings.

Our members will stay well, in their homes and in the community.

¹ Source: Pt. Primary Care physician’s practice medical record

² Source: Pt. Primary Care physician’s practice medical record

³ Source: Pt. Primary Care physician’s practice medical record

⁴ RI Medicaid Drug Utilization Review (DUR) Board data

⁵ RI Medicaid Drug Utilization Review (DUR) Board data

⁶ 64% compares favorably with national statistics based in information provided by Paul Block, PhD – Director of Psychological Centers

⁷ NCM Intervention Report

⁸ NCM Intervention Report