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Achieving care integration from the patients' perspective: Results from a care management program

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1. Introduction

Integration of patient care has emerged as a priority for health care delivery, particularly for older, high-cost adults with multiple chronic conditions. As the number of older adults with chronic conditions grows,[1] attention has turned towards identifying ways to better integrate care delivery for these patients in an effort to improve quality and reduce health care expenditures. Care delivery for these patients is particularly expensive and challenging to manage because they often receive care from multiple providers, take many medications, and are frequently hospitalized. In the Medicare population, the average beneficiary sees seven different physicians and fills nearly 20 prescriptions in a year.[2] Within one year, the typical primary care physician coordinates care with 229 other physicians in 117 different practices.[3] The complexity of care delivery for these patients gives them a unique vantage on the totality of care they receive.

A large opportunity exists to improve care integration and delivery for patients with multiple chronic conditions. Some evidence links "integrated delivery systems," which we define as structurally integrated organizations capable of providing a continuum of health care services,[4,5] with better quality and efficiency of care delivery.[6,7] However, integration of organizations and their activities is conceptually distinct from integration of *care delivery* as perceived by patients.[8,9] Integrated organizational structures and processes may fail to produce integrated patient care from the patient's point of view. We define *integrated care* as care that is coordinated across professionals, facilities, and support systems; continuous over time and between visits; patient and family centered; and based on shared responsibility between patients, family members, and caregivers.[9] Our conceptualization of care integration distinguishes it from organizational integration and emphasizes the patients and family members' central roles as active participants in managing a patient's health.

Since the passage of the Affordable Care Act, many health reform programs have targeted care delivery for high cost patients. Health reform has facilitated the creation of programs such as Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs), meaningful use of electronic health records, and performance-based payment models that seek to integrate care. In January 2015, Medicare began paying physicians a care management fee intended to promote better care integration.[10] However, results of ongoing programs have so far been mixed, and none of these evaluations have considered whether patients are experiencing their care as more integrated as a result of these interventions.[11–15] Evaluating the patient's perspective on the extent of care integration could help providers to better understand the mechanisms through which patient outcomes improve and, importantly, the reasons why some interventions do not yield expected improvements.

To our knowledge, this study is the first to evaluate the achievement of integrated care by a care management demonstration program from the perspective of older patients with multiple chronic conditions. To assess patients' perceptions, we used a recently developed patient experience measure, the Patient Perceptions of Integrated Care (PPIC) survey.[16] We report findings

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Table 1
Multiple Dimensions of Integrated Care from the Patient's Perspective.

Dimension	Description	Sample Survey Item
Information flow to primary care provider	A patient's primary care provider stays up-to-date about the patient's medical condition and delivers consistent and informed care for the patient.	In the last 6 months, how often did you have to remind your primary care provider about care you received from specialists?
Information flow to specialist	A patient's specialist is up-to-date about the patient's medical condition and delivers consistent and informed care for the patient.	In the last 6 months, how often did the specialist seem to know the important information about your medical history?
Information flow to other providers in primary care provider's office	All providers in the primary care provider's office are up-to-date about the patient's medical condition and deliver consistent and informed care for the patient.	In the last 6 months, how often did other staff seem up-to-date about the care you were receiving from your primary care provider?
Information flow post hospitalization	After a patient's hospitalization, all care-team members (which may include clinicians, support staff, and other personnel who routinely work together to provide medical care for a specified group of patients) deliver consistent and informed patient care, regardless of the team member providing them.	After your most recent hospital stay, did anyone from your primary care provider's office contact you to ask about the condition you were in the hospital for?
Proactive action before visits	Care-team members reach out and remind patients of upcoming appointments and inform the patient about what to expect.	Before your most recent visit with your primary care provider, did you get a reminder from this provider's office about the appointment?
Post-visit information flow to the patient	Care-team members inform patients of test-results in a clear and timely manner after a patient's visit.	In the last 6 months, when your primary care provider ordered a blood test, x-ray, or other test for you, how often did anyone from this provider's office follow up to give you those results?
Responsiveness independent of visits	Care-team members reach out and respond to patients between visits; patients can access care and information 24/7.	In the last 6 months, how often has anyone from your primary care provider's office contacted you between visits to see how you were doing?
Continuous familiarity with patient over time	Care-team members are familiar with the patient's past medical condition and treatments.	When you see your primary care provider, how often do you have to repeat information you have already given to someone in your provider's office?
Coordination with home and community resources	Care teams consider and coordinate support for patients by other teams offered in the community (e.g., Meals on Wheels).	In the last 6 months, how often did anyone from your primary care provider's office ask if you needed more services at home to manage your health conditions?
Patient-centeredness	Care-team members design care to meet the needs and preferences of patients, family members and other informal caregivers.	In the last 6 months, how often did your primary care provider discuss whether you were getting the health care you wanted?
Shared responsibility	The patient, patient's family, and care team share responsibility for providing care and maintaining the patient's health; processes enhance patients' engagement in self-management.	When anyone from your primary care provider's office gave you instructions about how to manage your health conditions, how often were you able to follow these instructions?

from the survey and compare perceptions of care integration among patients enrolled and not enrolled in the program.

2. Methods

2.1. MGH care management program

The Massachusetts General Hospital's (MGH) care management program (CMP) was launched on August 1, 2006, as part of the Centers for Medicare and Medicaid Services' Care Management for High Cost Beneficiaries (CMHCB) Demonstration program. The principal objective of the CMHCB demonstration was to test a risk-based contracting model and primary care-based intervention strategies for Medicare fee-for-service beneficiaries who were high cost and/or had complex chronic conditions. The intention of the CMHCB demonstration was to reduce future costs, improve quality of care and quality of life, and improve beneficiary and provider satisfaction.

The CMP program featured care enhancements for MGH's highest-risk, highest-cost patient population. Patients were selected to participate in the CMP based on specific criteria for level of disease severity, based on the Centers for Medicare and Medicaid Services' Hierarchical Condition Categories (HCC) risk score, annual health care costs, and clinical linkage with MGH (at least two prior MGH visits within the prior 12 months, and at least 50% of hospital stays at MGH). Initially, 2619 patients, approximately 15% of the MGH Medicare population, were invited to participate in the CMP.[17]

Program goals included reducing health care costs through reductions of preventable hospitalizations and emergency room visits, and optimizing the role of nurse care managers. To achieve these goals, the CMP was structured to facilitate communication between patients and care managers, patients and physicians, care managers and physicians, and among care managers and other care management professionals. Patient care managers and their one-on-one relationship to CMP patients represent the core element of the MGH CMP. Care managers developed relationships with patients over time through in-person interactions during physician office visits, telephone calls, during hospitalizations, and occasional home visits. They continually assessed patient needs, collaborated with physicians to develop treatment plans, educated patients, and facilitated communication and delivery of patient among the patient's multidisciplinary care team. The MGH care management model emphasized maintaining contact with patients before and between doctor visits as well as connecting patients to home and community services via the "community resource specialist" role, whose specific task was to collate community resources/services (such as transportation to physician visits, setting up patients with Meals on Wheels or connecting them to local community and civic organizations) to support patients and work with care managers to appropriately deploy these resources.[18] The CMP team also included mental health providers, given the high burden of mental health issues present among the CMP population, and a pharmacist.

A formal evaluation of the MGH program and CMHCB conducted in 2010 indicated that the CMP reduced the rate of increase of acute care hospitalizations and Emergency Department visits (but not 90-day readmissions), reduced the mortality rate within the intervention group of beneficiaries, improved beneficiary reported satisfaction related to communication with providers, and achieved substantial, statistically significant cost savings. This

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