

## **Enhanced Care Management (ECM)**

In March 2006, the Central Plains Regional Health Care Foundation, a nonprofit affiliate of the Medical Society of Sedgwick County, opened the Enhanced Care Management (ECM) program. ECM extended care management services to Medicaid HealthConnect (fee-for-service) enrollees who resided in Sedgwick County. ECM was funded through a contract with the Kansas Health Policy Authority, which administers the Kansas Medicaid program.

The state purchased the ACG predictive modeling software program from Johns Hopkins University to identify patients, via claims data, who were at risk of becoming high utilizers of medical services over the following year. Those patients were referred to ECM by KHPA staff. Enrollment was voluntary. A significant outreach process was implemented to invite and welcome this highly marginalized population into the program. ECM patients experienced multiple chronic conditions and significant socio-economic challenges.

ECM was designed as a patient-centered care management service that partnered with the local health care community. The program infused standards of practice for a wide variety of disease states, culled from the Kansas City Quality Improvement Consortium. The program implemented a multi-disciplinary team approach:

- Nursing and social service professionals who worked in teams to provide home-based care management services for enrollees
- Contracted physician medical director
- Contracted community consultants (mental health experts, pain management/addiction specialists/evaluators, etc)

ECM was designed to improve enrollees' health outcomes while promoting more efficient and effective use of Medicaid services. The program incorporated elements of care coordination, case management, disease management and the Chronic Care model:

- Nurses educated patients on disease-specific self-management techniques, supported patient adherence to prescribed medication use and provider treatment plans, and accompanied patients to medical appointments when appropriate
- Nurses served as liaisons between patients and their providers to improve communication
- The contracted medical director had access to Medicaid claims data to review specific patients' utilization patterns and to identify previous treating providers

- Most ECM patients entering the program hadn't seen a primary care provider for more than a year, but claims data indicated they had a history of multiple chronic conditions including diabetes, congestive heart failure and asthma
- Care managers helped patients access blood pressure monitors, weight scales, medication planners, pedometers, exercise tools, shower chairs, canes, safe and affordable housing, food, utility and clothing assistance, mental health and substance abuse services, credit counseling, and legal aid.

**From March 1, 2006 to July 1, 2009:**

- 736 patients were served in the ECM program
- Average length of enrollment was **eight months**
- Internal evaluation process measured clinically significant improvement in patients' self-reported health status.

**Preliminary results of an external evaluation by Ruth Wetta-Hall, Ph.D., KUSM-W, Dept. of Preventive Medicine:**

- Analyzed two years of claims data on 140 randomly selected ECM enrollees (compared utilization of health care services two years prior to enrollment to two years post enrollment in ECM)
- Utilization costs were reduced from \$11 million to \$5.5 million over a 2-year period, measuring a cost reduction of 50% for those patients
- The KHPA's \$1,638,400 investment in the ECM program leveraged a \$5.5 million cost savings, just for those 140 Medicaid HealthConnect enrollees
- Dr. Wetta-Hall recently completed a comparison of ECM enrollees to a population of similar patients in Wyandotte County. Results are unknown, as this report is not yet available.

**Enhanced Care Management Database:**

A database was designed in-house by staff and a contracted software developer. It tracked:

- Detailed demographic information
- Contacts with patients and providers, and the amounts of time associated with those contacts in minutes (phone calls to and from, in-person meetings, collateral contacts, etc)
- Patients' medical histories (including prior providers)
- Lists of patients' medications compiled by nurse care managers
- Referrals made to other providers and social service agencies
- Detailed care plans and goal achievement
- Patients' responses to assessment survey instruments (the software automatically scored surveys)
- The ECM software program remains intact for potential future use.

January 2011