TEAM BASED APPROACH

Chronic Care Management

CHAD VAWTER
DEPUTY CEO
FAMILY HEALTHCARE NETWORK

FamilyHealthCare NETWORK

Care Coordination

The California Department of Health Care Services (DHCS) has been focusing on care coordination programs to help patients navigate health care system.

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Patient Centered Medical Home

2012

- Providing services for high risk patients based on medical diagnosis or social determinants of health using a care team structure

Healthy Homes Program

2019-2021

- Focused on patients with chronic health conditions and social determinants of health
- Monthly/biweekly touch points between Care Coordinator and patient to ensure progress

Cal-AIM and Enhanced Care Management

2021

- Focuses on social determinants of health + chronic health condition
- Similar to HHP, ECM allows payment to community support providers (CS)

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Cal-AIM Goals

One

Identify and manage comprehensive needs through whole person care approaches and social drivers of health.

Two

Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.

Three

Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.

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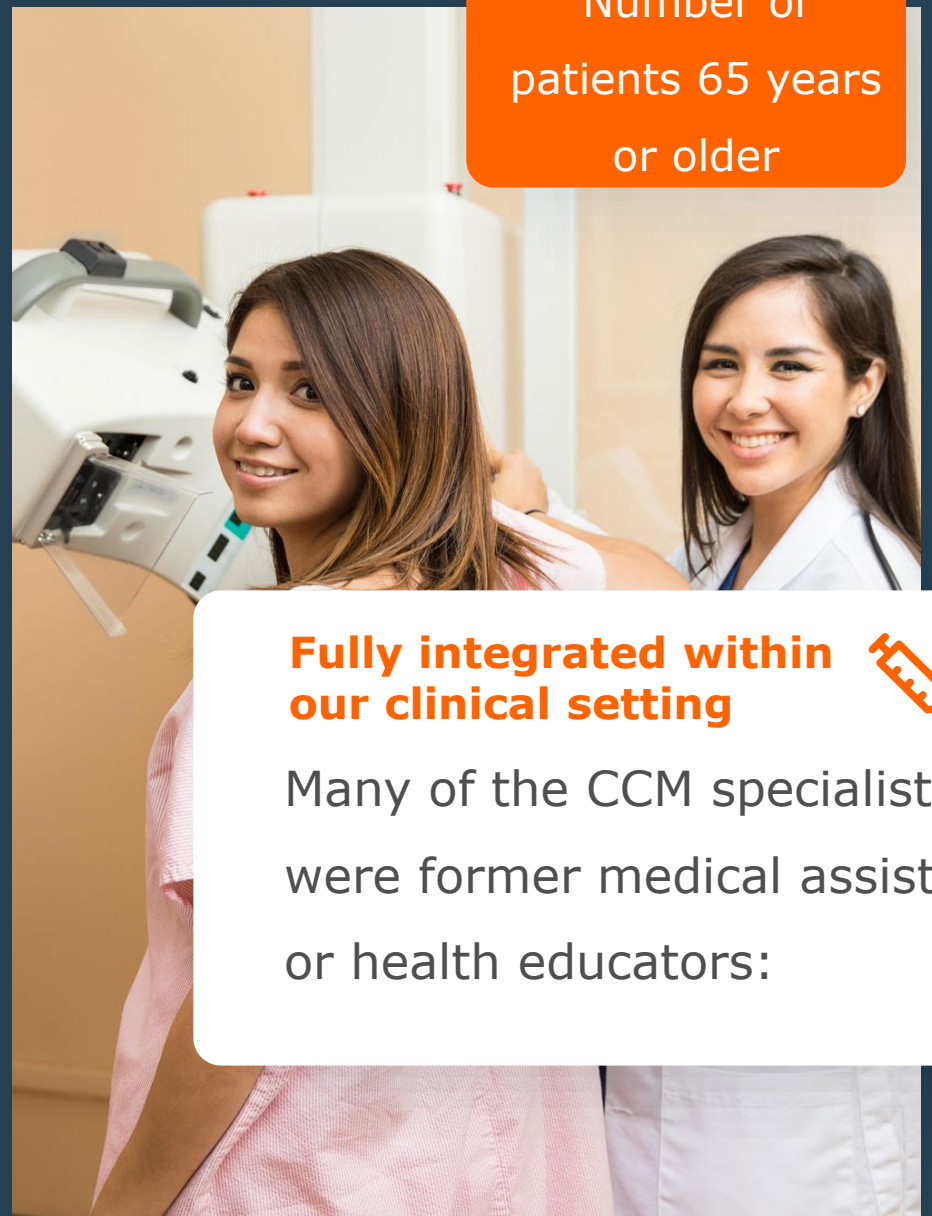
15,800
Number of patients 65 years or older



TRANSITION TO

Chronic Care Management Specialists

Fully integrated within our clinical setting

Many of the CCM specialists were former medical assistants or health educators:

Medicine That Touches The World

- They live in the community and understand barriers to care and are aware of local resources.

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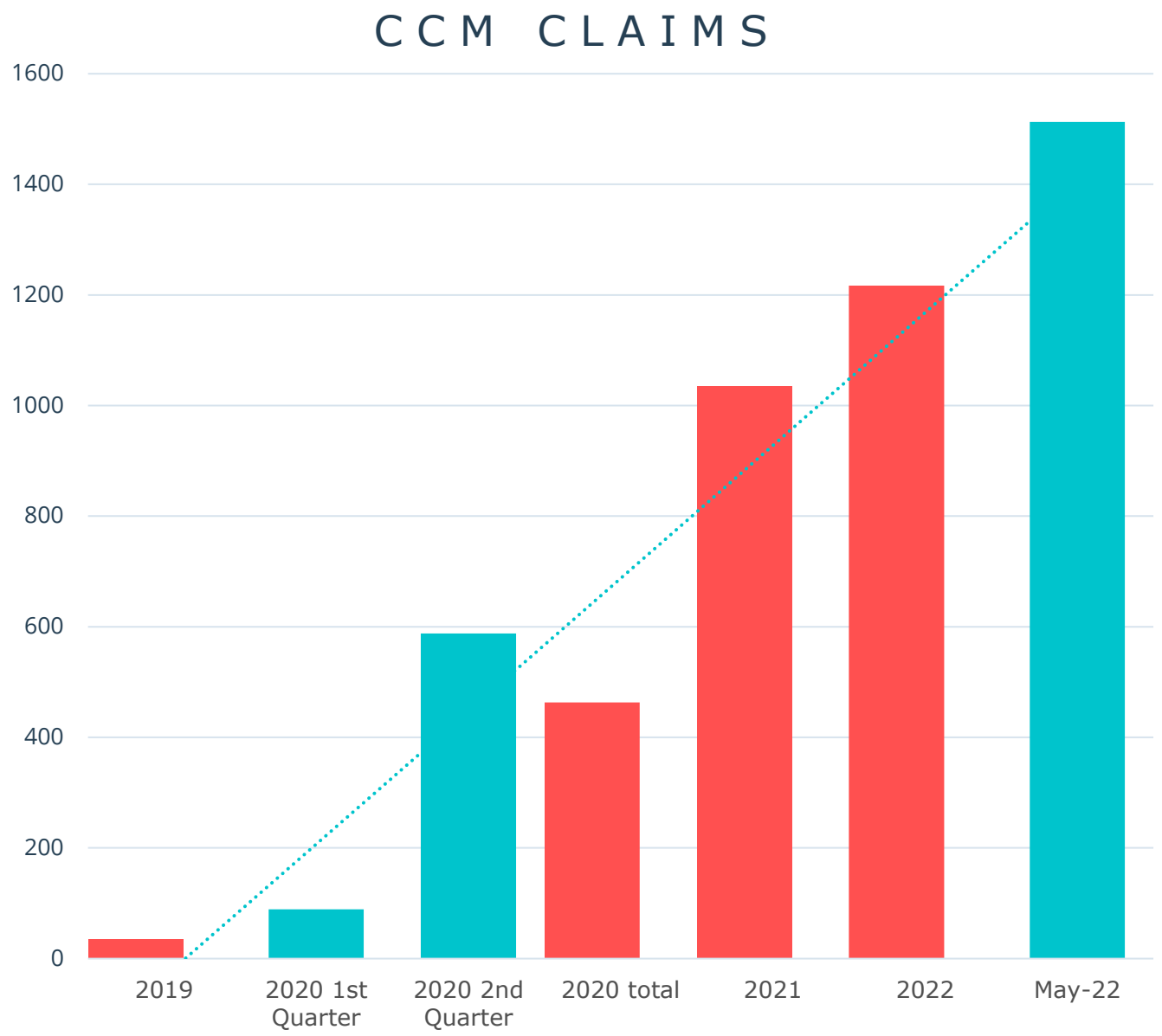
CCM CLAIMS

Transforming Healthcare

2019-2022

Average CCM claims/month within each calendar year.

In 2019-2020, you will see the before and after look at claims from Health Education to CCM Specialist.



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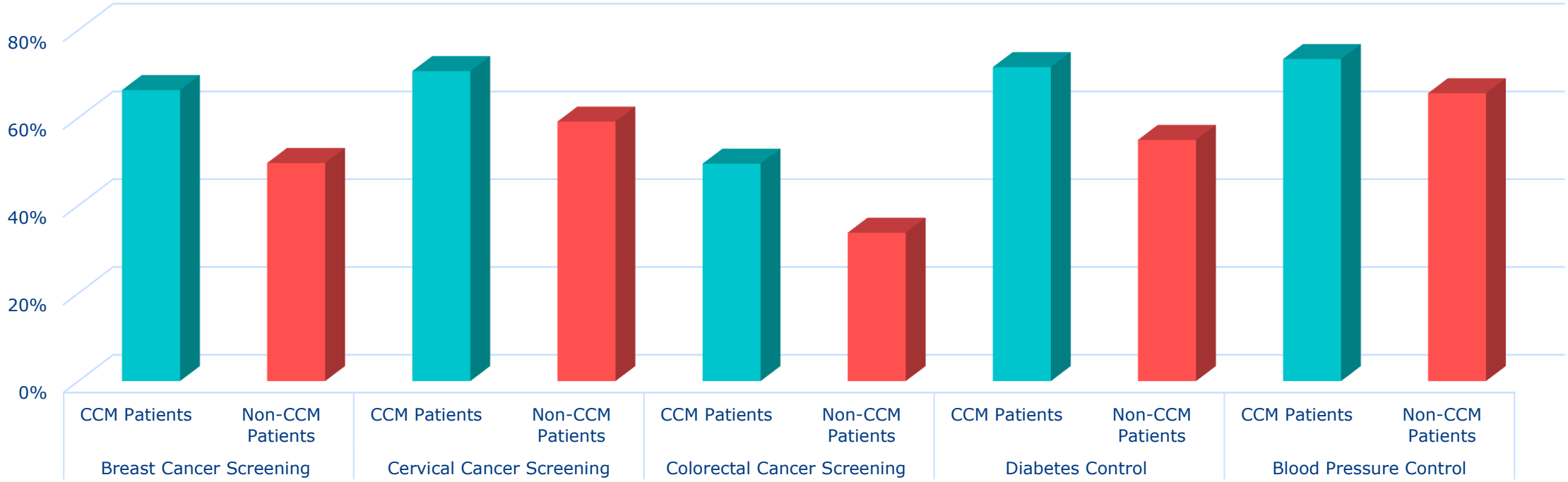
Chosen for Excellence

CCM patients were more likely to have completed a routine screening and have improved control over chronic health conditions, such as diabetes:

Quality Metrics: CCM vs. Non-CCM



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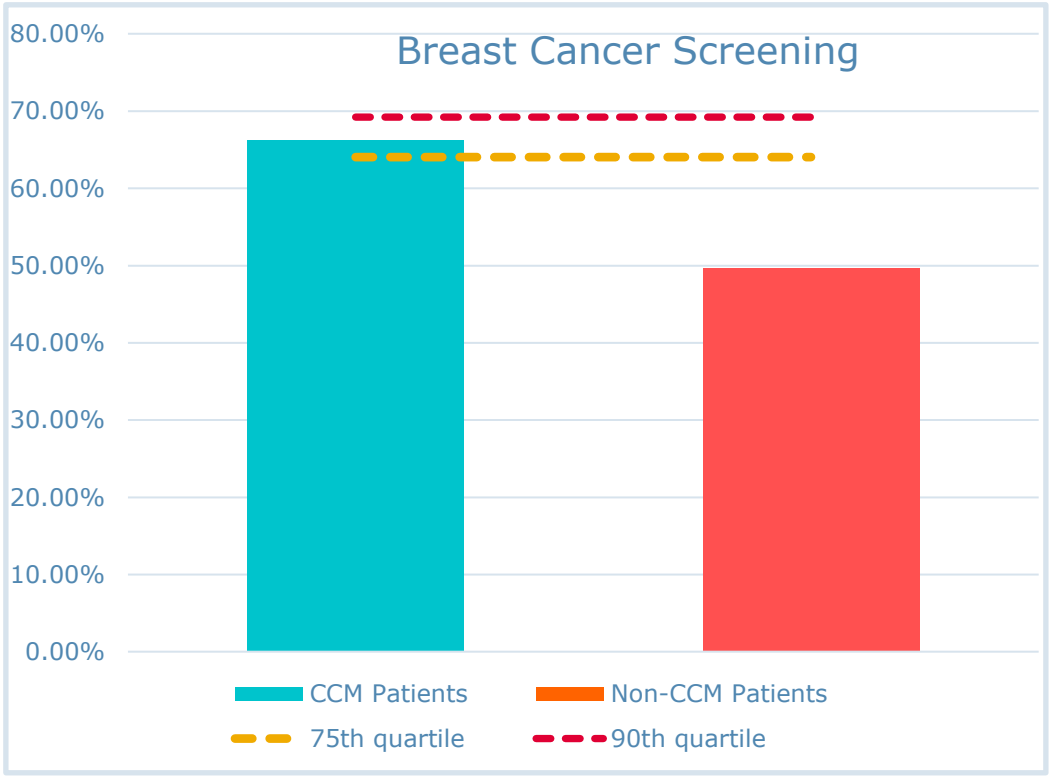
Breast Cancer Screening



33%

More likely to have completed a Breast Cancer Screening then non-CCM patients

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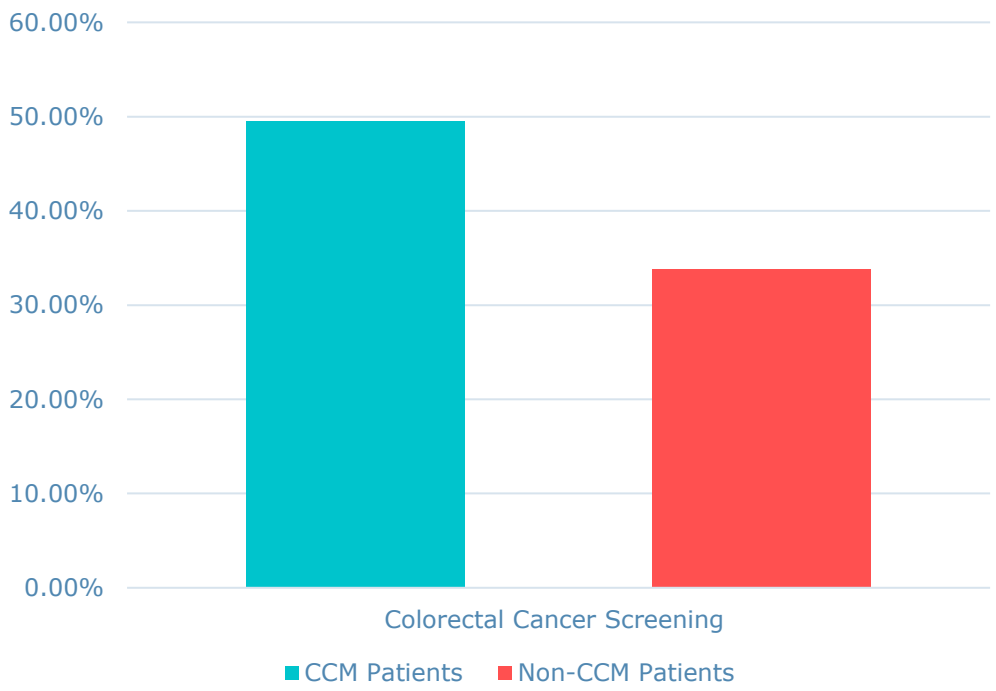
Colorectal Cancer Screening



47%

More likely to have completed a Colorectal Cancer Screening then non-CCM patients

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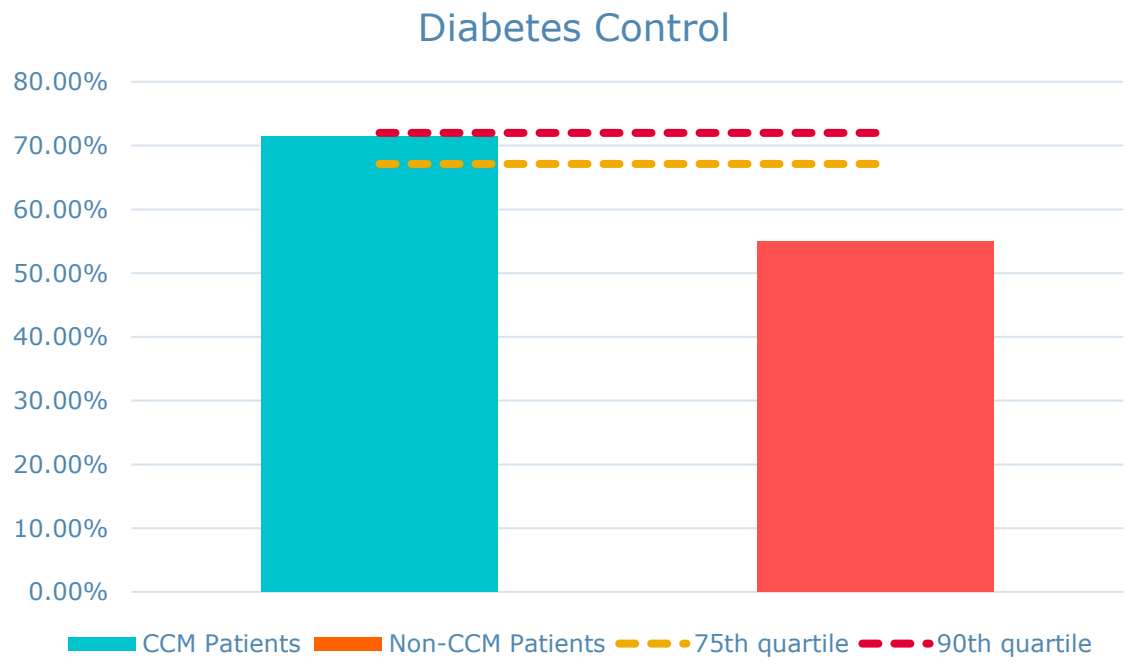
Diabetes Control



30%

More likely to have improved Hemoglobin A1c levels, reflecting improved Diabetes control then non-CCM patients

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ANNUAL WELLNESS VISITS

CCM Specialists assisted with AWVs leading to an:

- **Increase in completed Annual Wellness Visits**
- **Improvement in patient and provider satisfaction with the visits**
- **Completion of Comprehensive Care Plans with the Annual Wellness Visit**

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Next Steps

- Currently, we have a pilot to involve dispensary and referrals to utilize the “clock” to track time for CCM patients.
  - Once the pilot is complete, we will expand this to all staff across the network in a phased approach to include:
    - Dispensary
    - Referral Department
    - Medical Assistants
- Expand our Principal Care Management and Complex CCM program to eligible patients

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Inspiring Better Health

In summary, the choice to hire and train Chronic Care Managers within our model may have meant more upfront time and costs, but was the foundation for more success in the future.

This model is better suited for our patient population and goals of increasing quality care.

Care Coordination, access to care, warm hand-offs to internal services, and completion of Annual Wellness Visits would likely not be as seamless if we had outsourced.