L8: Care Management for Complex Patients: Strategies, Tools and Outcomes

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Objectives

- Describe methods to identify and understand the needs of their own complex, high-cost population segments
- Work with other individuals to create action-plans for learning successful interventions based on a person-centered point of view
- Review outcome data and program development activities that maximize progress toward Triple Aim goals

These presenters have nothing to disclose.
We will discuss:

1. The difference between Complex and Complicated populations
2. High cost vs. avoidable costs
3. The financial conditions conducive to delivery-system strategies for care management
4. How our system has responded given our specific situation
5. The domains a tool should include to identify patients who would be helped by our approach.

We will Deliver: the tool we use to help us decide on which patients to address and the format for a universal care plan.

BHLC Roadmap

Choose your macro population and learn its segments
Identify individuals who are good candidates for your enhanced care design
Develop a care model to fit the needs and strengths of the target population
Recruit people into care
Engage people in care
Partner within and outside of your organization
Managing Services for a Population

- Community, Family and Individual Resources
- Needs Assessment for Segment
- Population Segmentation
- Goals
- Service Design
- Coordination
- Delivery of Services at Scale
- Population Outcomes
- Feedback Loops
- Integrator

Healthy CHÅ
Domains of Improvement

- **PEOC**: Care Management is grounded in a patient-centered relationship that assists patients to optimize the health-system while accessing community-based resources to improve health.

- **Financial Sustainability**: Optimizing care reduces over-utilization and under-utilization that ultimately leads to poor health outcomes. Care management helps eliminate wasteful spending.

- **Workforce**: Care managers help take care of the most complex patients so that primary care teams have more time and energy to care for everyone else.

- **Strategy and Growth**: Care Management delivers on the Triple Aim – Strengthening quality, improving patient and family experience with the healthcare system and enhancing value for our highest risk patients.
What is Care Management?

ACO strategy aimed at identifying and engaging patients whose complex and complicated care needs cannot be addressed by the health care system as currently designed.

Symptoms of poor coordination:
- Under, over-utilization, or mis-utilization (both within and outside of our delivery system)
- Frequent ED visits, inpatient stays, and readmissions
- Poor health outcomes
- Unengaged/Unsatisfactory relationships with providers and staff
- Poor self-management of co-morbidities
- Low “Value” care

Complex vs. Complicated…

vs.
Value vs. Avoidable Cost...

Is the entire population equally likely to need high-cost care?

Poor Value: World's most expensive bicycle (pedal-powered vehicle) - $1.6 million

Avoiding avoidable Cost: World's least expensive form of brain protection.

The 90/10 Rule in the Literature

Focusing on the Highest Spenders
A Sweet Spot for Cost Control?
What financial conditions are most conducive for investing in delivery-system-based care management programs?

The financial model affects strategy

Financial Models related to investment strategies in CCM by the delivery system

Less Conducive

- Fee for Service
- Pay for Performance: Bonuses for Quality
- Shared Risk between Providers and Payers: Cost, quality, pay-backs
- Global Budget: fixed maximum expenditures for defined set of services or payback $ over budget
- Accountable Care Organization: Provider takes full financial accountability for enrolled patients

More Conducive

Management Strategies:

- Payer and Delivery centralized strategy with duplication
- Delivery system on point
- Embedded in primary care

Payer telephonic auth/denial, central RN CM function
The delivery system affects strategy

Your Strategy Must be Tailored to your Capabilities and Network:

Private Practice or Health Center

- Connect with local payers and hospital
- Case managers to discuss complex cases with your nursing or care team.
- Develop triage tools and patient-centered care plans
- Develop and use a “worry list” for patients
- Assign a “point” person who knows community resources if any

Large, Integrated Hospital System

- Integrate inpatient case management with outpatient care management
- Integrate Claims and Clinical Data to assist triage
- Claims and EMR to develop
- Gain input from stakeholders regarding standard documentation of plans and goals
- Establish network affiliations

As the delivery system grows more complex tactics change

Our Specific Conditions

- **General:** An academic public health safety net system within walking distance of Boston Hospitals
- **Care Delivery:** 10 medium-sized community health centers, 3 school-based clinics, 2 hospitals, 3 Emergency Departments, 3 community specialty clinics, specialty clinics – 70 primary care doctor FTE’s
- **Population:** Take care of 105,000-130,000 underserved patients, >60% of whom speak a primary language other than English
- **Finances:** 60% are in a financial risk arrangement, 40% are fee-for-service
- **IT:** Epic both outpatient and inpatient, access to claims data on 40% of our patients
- **Payer Mix:** 82% public payers
Our Observations and Response

Drivers of Cost
- Acute Illness
- Chronic Disease
- Under-use of PCP
- Over/Mis-use of ED/inpatient
- Social disconnection
- Substance Abuse
- Mental Health
- Disabilities
- Poverty

Care Management Staff Model – Top 5%

*Community Health Worker

Role Differentiation

Social Work Care Manager
- Care Plan development
- Integrate care among various providers, especially BH providers
- Assess substance abuse and mental health needs and pt readiness to change
- Address anxiety and trust issues
- Coach re: behavior change

Community Health Worker
- Meet with patient during hospitalization
- Arrange for post-acute home visit and other home visits as needed
- Appointment reminders
- Arrange transportation
- Arrange entitlements
- Link to community resources
- Teach patients self monitoring strategies

Nurse Care Manager
- Care Plan Development
- Integrate care among various providers
- Assess degree of support req’d – diabetes, COPD, etc…
- Arrange for nutrition consults pulmonary, etc…
- Coach patients re: med adherence and self care strategies
- Arrange for VNA services
Primary Care Site-based
Mobile to “navigate” to appointments
Connected to Inpatient Case Management
Depends on analytics of both claims and EMR data about use and appts.
Has “trust” in system

• Improve Quality, Safety, Efficiency, and Coordination
• Strengthen Patient/Family Experience
• Connect patients to primary and specialty care; support optimal engagement
• Improve Value (Cost/Care)
• Reduce Hospitalizations, Readmissions, and ED visits through education, navigation, and “patient activation” and health coaching.
**Selection and Drivers**

- **PCP & Care Team Referral**
- **Hospitalists and Specialists**
- **Hospital to Home Staff**
- **Inpatient Case Mgmt & Social Workers**
- **Payer High Risk Lists**
- **High ED Use Lists**
- **Authorization and D/C Lists**
- **Disease Registries**
- **Readmission Reports**

**Effectiveness for FY ‘14**

- **14,440 pts** • Total 1st Payer Cohort
  - **468 pts** • Analytics – The top 3% by utilization, high ED and Inpatient activity
    - 9 patients enrolled in CHA care management
    - 28 patients deceased, moved, or not CHA PC
    - 243 patients were not "validated" by PCP or Triage process
  - **190 pts** • Appropriate (validated) for Care Management
  - **78 pts** • Declined, Unable to Reach
  - **112 pts** • Enrolled in Care Management
    - 47 Patients enrolled during SFY 2013 efforts
    - 65 Newly enrolled patients from SFY 2014 efforts
  - **77 pts** • Evaluated for Cost Avoidance
    - 43 Patients enrolled during SFY 2013 efforts
    - 34 Newly enrolled patients from SFY 2014 efforts
    - At least 6 months of pre/post claims data
  - **$809,645** • Annualized Cost Avoided
    - 62 patients enrolled in SFY 2013 with actual costs avoided of $895,960
    - 34 patients enrolled early in SFY 2014 with estimated costs avoided of $210,670

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Patient Selection

Which Patients Will Benefit?:

Traditional Delivery System Methods:
- Demographics
- Diagnoses
- Utilization visible to clinician (minimal)
- Clinician “gut instinct”

Traditional Payor Methods:
- Utilization visible through claims
- Cost
- Diagnoses
- Authorization requests for hospitalizations, medications, DME, home services, VNA, SNF, LTAC, Rehab, psychiatric services.

Small Group Exercise #1

Exercise to develop patient validation tool:

1. Each small group will be given a “Delivery System Subtype.”

2. The goal of the group’s effort is to design a “Triage Tool” which is simple to use and considers:
   - The unique needs of your population
   - Your delivery system’s capabilities
   - High, medium, and low-risk drivers for utilization and avoidable care
     Examples would be: chronic diseases, age, substance abuse, mental health issues, etc.
   - How you would get the buy-in and validation from the clinical care team (providers?)
### Delivery System Subtype 1

- **General:** A Federally Qualified Health Center in a low-income neighborhood
- **Care Delivery:** 2 FTE of PCP, 3 NPs. Single site. ADDED: grant for RN and Community Health Worker
- **Population:** Take care of 30,000 underserved patients. Primarily non-English speaking
- **Finances:** 50% are in risk arrangements with the state.
- **IT:** Good outpatient EMR with reporting capabilities by diagnosis and provider.
- **Payer Mix:** 90% public payers

How and who would you choose to help with Complex Care Management?
How would you engage the care team in the process?

### Delivery System Subtype 2

- **General:** An affiliated group of 10 clinics and a hospital which are privately owned and operated
- **Care Delivery:** 40 PCP’s, full cadre of specialists but no CV surgery or neurosurgery.
- **Population:** 100,000 patients almost all employed
- **Finances:** 80% risk arrangements from total risk to simply pay-for-performance
- **IT:** Good outpatient EMR with reporting capabilities by diagnosis and provider, excellent claims data
- **Payer Mix:** The health centers have their own insurance product and negotiate with employers

How and who would you choose to help with Complex Care Management?
How would you engage the care team in the process?
Delivery System Subtype 3

• General: Large Hospital system providing high-tech quaternary care.

• Care Delivery: 300 subspecialists paid fee-for-service, affiliates with contracting entity for 1000 PCP’s at 20 locations admitting to 5 affiliate community hospitals

• Population: 300,000 patients

• Finances: 70% risk arrangements from total risk to simply pay-for-performance

• IT: Excellent EMR with reporting capabilities as well as access to claims data

• Payer Mix: 50% public, 50% private

How and who would you choose to help with Complex Care Management? How would you engage the care team in the process?

Commence Exercise:

Exercise to develop patient validation tool:

The goal of the group’s effort is to design a “Triage Tool” which is simple to use and considers:

• The unique needs of your population

• Your delivery system’s capabilities and funding sources

• High, medium, and low-risk drivers for utilization and avoidable care
  Examples would be: chronic diseases, age, substance abuse, mental health issues, etc.

• How you would get the buy-in and validation from the clinical care team (providers?)
Commence Exercise:

Our Bi-Directional Validation Process

PCPs validate data driven referrals

1) “Would you be surprised if this patient is hospitalized or has ED visit in next 6 mo?”

2) Will this patient engage with care manager?

3) What is the focal area for care management intervention?

Care Managers validate PCP referrals
Developing a standardized response

Transition back to care team:
- Achieved Goals
- Disengaged
- CCM provides little to no added value to triple aim goals

Evaluation and Re-assessment

Validation and Triage

Identification/Referral

High Risk Stratification/Payer Lists
PCP Referral
Inpatient Referrals

Assessment and Care Plan

Engagement and Outreach

30 Minutes

TIME FOR A BREAK
Once a patient has been identified by your validation tool:

- What’s next?
- How might you engage a patient?
- Who’s responsible for engaging them?

Once a patient has been identified, validated, and engaged in care management:

- Who (clinically and others) is the care plan for?
- What are key elements for a Care Management care plan?
- When would a care plan be created and with whom?
- Where would the care plan reside?
- Who else might have access to and change the care plan?
Small Group Exercise #2

What’s in a care plan?

1. What information is important for any provider/care team member to know about your newly identified high risk patient?

2. What is important for the patient to know about their involvement in care management?

3. How would you communicate this across your system of care?

4. Is it possible to develop a tool that is more than just a documentation exercise?

5. Can it serve as a motivational tool for the patient and their care team?

20 Minutes

Commence Exercise:
Developing a Standard Response
My Care Plan - Handout

1. My Goals to Improve my Health
2. My Medical Team’s Goals
3. Challenges to Meeting my Goals
4. My Strengths and Supports to Meet my Goals
5. My Healthcare Team
6. My Action Plan
7. My confidence that I can Follow My Action Plan is:

Developing a standardized response

How we use our Care Plans:

Key Elements: It’s the patient’s care plan and the patient gets a copy

Who completes this? The patient and the care manager

How are changes made? Very simply – add a provider, change a goal, identify a new support

When and by whom? Anyone can add to the care plan at any time

…. just make sure that patient’s on board with changes and gets a copy
Developing a Standardized Response
Is this a Complex Care Patient?

How we identify patients in CCM (so go looking for the care plan!)

<table>
<thead>
<tr>
<th>Problem List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Coordination Note</td>
</tr>
<tr>
<td>“Complex Care Management Primary Care Visit”</td>
</tr>
<tr>
<td>Overview</td>
</tr>
<tr>
<td>See Patient Care Coordination Note</td>
</tr>
</tbody>
</table>

- Abnormal menstruation
  - Overview: Edited: Laura Niew, APRN, 11/18/2014
  - 11/18/2014 LMP 3 months ago, pelvis pain reported. 7 POCS, work-up initiated

- Complex type J DM with prediabetes or retinopathy
  - Overview: Edited: Laura Niew, APRN, 7/16/2013
  - STARTED ON ACE INHIBITOR

- Major depression, single episode
  - Overview: Edited: Amanda Fazzio, 11/18/2013
  - Childhood onset, pm albuterol

- Moderately persistent asthma
  - Overview: Edited: Amanda Fazzio, 11/18/2013
  - Childhood onset, pm albuterol
Developing a Standardized Response
Where our care plan resides

My Care Plan:

1. My goals to improve my health: To know my new PCP. Dr. Lesty. I want to make sure she understands what I need and my history. I follow up with all medical appointments and recommendations — especially work on colon-pump removal procedure which seems to be preventing success in other areas of my health. I consider mental health care therapy and psychiatry in the same place (Dari Community Health Alliance) to improve my mental health.


3. My strengths and supports to meet my goals: I am supported most by my son, who is also my PCA at this time.

4. Challenges to meeting my goals: I struggle with severe anxiety and often feel overwhelmed by my medical condition. I worry that my medical teams won’t fully understand my needs because I have many of them.

5. My healthcare team: Dr. Lesty (Lianerdian) (PCP); Dr. Shekar (surgery); Dr. Ahn (neurology); Alexandra Hammer, LCSW (781-485-8257, aharn@chaelson.org) (Care Manager)

6. My Action Plan: Follow up as needed; help facilitate connection to new PCP; help Sasha organize her medical appointments and goals; help Sasha connect to mental health care

7. My confidence that I can follow my Action Plan: I feel that Sasha is resilient, able to advocate for self, supported by her son/PCA who is also a good advocate for Sasha.
Key Take Aways

- Broadened your understanding of complex patients and complicated patients and the idea that your care management program needs to target patients who are impactable.

- Shape your program around avoidable cost not just high cost, again with an eye on which patients are impactable for Triple Aim goals

- Understand your unique healthcare system and design what is appropriate for what your system and what your patients need

- Give your care management program structure and form, developing useful tools that support your care management teams to educate others in your health system.
Resources and Contacts

• WIHI: When Everyone Knows Your Name: Identifying Patients with Complex Needs
• IHI White Paper: Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs
• Better Health and Lower Costs for Patients with Complex Needs: An IHI Triple Aim, 12 month Collaborative beginning July 2015

• For more information:
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