Transformation Support Webinar: Care Coordination

August 27, 2015
Webinar Agenda

 Speakers
- Nancy Jaeckels Kamp, Principal, HMA
- Greg Vachon, MD, Principal, HMA
- Art Jones, MD, Principal, HMA
- Gail Miller, HMA

 Agenda
- Introduction
- Transformation Plan Template
- Goals
- Critical components of care coordination
- Build or Buy
- Key considerations
Introduction

- Regional Partnerships are in the process of building care coordination functions. A critical element for success is effectively operationalizing these functions.
- Domains 4 and 5 of the Transformation Plan Template address care coordination operational plans.
## Risk Stratification, Health Risk Assessments, Care Profiles and Care Plans

Describe any plans for use of risk stratification, HRAs, care profiles, or care plans. Describe how these draw from or complement the standardized models being developed.

### For risk stratification
- Include the types of patients, risk levels, data sources, accountabilities (who is accountable for what?)

### For HRAs
- Include the types of screenings, who is accountable for completing, and where information is recorded.

### For care profiles and/or care plans
- Include the key elements that will be included, the systems through which they will be accessible, the people who will have access. Standardized care profiles are anticipated to be developed by the state-level integrated care coordination infrastructure.

Identify the training plan for any new tool identified in this section.
## Care Coordination

- **Describe any new care coordination capabilities that will be deployed by the regional partnership.**
- **Identify the types of patients that will be eligible for care coordination and how they will be identified and by whom.**
- **Define accountability of each person in the care coordination process.**
- **Describe staffing models, if applicable.**
- **Describe any patient engagement techniques that will be deployed.**
Care Coordination is an important step in the All-Payer Model

Care Coordination - a patient-centered approach and set of activities designed to assist patients and their support systems in managing medical, behavior, and social conditions more effectively.

Goals:
- Improve patients’ functional health status
- Prevent progression of chronic disease
- Enhance coordination of care (organizing hand-offs, clear communications with whole care team)
- Eliminate duplication of services
- Reduce the use of potentially avoidable medical services
Maryland’s initial focus is on the high need, high use Medicare patients

Rough Estimates of Scaling for Medicare in Maryland

<table>
<thead>
<tr>
<th>% of Beneficiaries</th>
<th># of Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>40k</td>
</tr>
<tr>
<td>30%</td>
<td>240k</td>
</tr>
<tr>
<td>30%</td>
<td>240k</td>
</tr>
<tr>
<td>35%</td>
<td>280k</td>
</tr>
</tbody>
</table>

- High need/use
- Chronically ill at risk of being high use
- Chronically ill but under control
- Healthy
Critical Components of Care Coordination

Systems and Workflows
- Risk Stratification
- Health Risk Assessments
- Systems to support:
  - Communications
  - Alerts
  - Tracking and follow up
  - Management of the program (processes and connection to outcomes)
- Care transitions and connectivity to hospital/ED admits and discharges

People/skills
- Multi-disciplinary care team working together (includes behavioral health, etc.)
- Care coordinators with relevant backgrounds for population’s needs
- Clear accountabilities
- Robust training with an emphasis on patient engagement and self-management
- Integration with primary care
## A Key Decision Point is Build or Buy: Buy

<table>
<thead>
<tr>
<th>Why Buy:</th>
<th>Key criteria for hiring a vendor:</th>
<th>Keys to success with vendors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially faster to ramp up and start</td>
<td>Proven track record for quality outcomes and ROI</td>
<td>Take responsibility to oversee and hold the vendor accountable</td>
</tr>
<tr>
<td>Could be a short-term solution while building your own program and infrastructure</td>
<td>Skills and approach match your goals for the population</td>
<td>Meet routinely with the vendor</td>
</tr>
<tr>
<td>Proven model and skillsets available immediately</td>
<td>Ready to begin and scale as needed</td>
<td>Ensure contract aligns with goals and population needs</td>
</tr>
<tr>
<td>Potentially more predictable cost structure</td>
<td>Experience and know-how to integrate into practice teams and hospital transition teams</td>
<td>Track and discuss performance measures with vendor</td>
</tr>
<tr>
<td></td>
<td>Cultural fit for the local environment</td>
<td>Set up processes for checking adherence to the model/approach</td>
</tr>
<tr>
<td></td>
<td>Performance goals built into contract</td>
<td>Collect feedback from key stakeholders; patients, PCPs, etc.</td>
</tr>
</tbody>
</table>

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9
A Key Decision Point is Build or Buy: **Build**

<table>
<thead>
<tr>
<th>Why Build:</th>
<th>Key considerations to build:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment towards long-term structure</td>
<td>Affordability of opportunity costs</td>
</tr>
<tr>
<td>Control of the program</td>
<td>People with the right skills are available internally</td>
</tr>
<tr>
<td>Operations</td>
<td>Talent is available to hire if needed</td>
</tr>
<tr>
<td>Refinement and evolution of the model over time</td>
<td>HIT needs including connectivity can be met internally or purchased</td>
</tr>
<tr>
<td>Staffing considerations</td>
<td></td>
</tr>
<tr>
<td>More flexibility to ramp up or modify speed of implementation</td>
<td></td>
</tr>
<tr>
<td>Organizational learning can be used for development of programs for</td>
<td></td>
</tr>
<tr>
<td>additional populations</td>
<td></td>
</tr>
<tr>
<td>Easier to identify emerging problems and mitigate</td>
<td></td>
</tr>
</tbody>
</table>
Key Considerations for Operational Planning

- **Risk Stratification**
  - How will state-level risk stratification be used?
  - How and what types of data do you have access to?
  - How will you define risk levels in your care coordination model?

- **Health Risk Assessments**
  - Determine screening HRA and in-depth assessments
  - Determine who and how they will be completed
  - How will information impact risk stratification
Key Considerations for Operational Planning

- **Care Planning Technology**
  - How will state-level care profiles be used?
  - What application will be used to organize data, create care plans, and document care coordination activities?
  - Ensure connectivity and ED/admission alerts

- **Care Coordination Staffing**
  - Define teams and staffing ratios
  - Setup processes and accountabilities
  - How do the risk levels correlate to care coordination levels of staffing and efforts?

- **Other Care Coordination Infrastructure**
  - Determine population need for call center, home visits, etc.
  - Define quality assurance and performance monitoring programs
  - How will patients be engaged through PCPs, hospitals, and community-based organizations
Stories from the Field
Gail Miller, HMA
Healthcare Ecosystem – Progression to Scaled System

Traditional Healthcare System

Integrated Care Delivery


Individualized. Proactive. Connected
Scaled Model - Care Management Model

Operating Principles
• Care Management for Life
• Holistic Care Model
• Integrated Care
• Driven by data
• Utilization Management is a subset of Care Management
• Right staff for the complexity level
• Relationship with patient is KEY to success
Patient Identification

- New Member Survey
- Two years claims data
- Diagnosis codes
- Claims volume or site of treatment triggers
- Referrals from
  - Physician
  - UM team
  - Sales force, family member etc.

Percentage of total costs:

- Sickest 20%
- 5% 41%
- 15% 34%
- 30% 18%
- 30% 6%
- 20% 1%
- 1%
Stratification Identification

• “Enrollment Process in Care Management”
  • Explanation of service
  • Verification of need
  • Agreement to participate
  • Functional assessment

• Help members continue to live at home
• In-home and telephonic support
• Anticipate members’ needs and problems
• Encourage preventive care
• Prevent costly interventions
## Intervention Levels

### Chronic Care Program

<table>
<thead>
<tr>
<th>Health Challenged</th>
<th>High Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Members: 25%</strong></td>
<td><strong>Members: 10%</strong></td>
</tr>
<tr>
<td>• Telephonic Care Coordination</td>
<td>• In-Home Care Management</td>
</tr>
<tr>
<td>• Field Visit if needed</td>
<td>• In-Home Care Giving</td>
</tr>
<tr>
<td>• Biometric Monitoring</td>
<td>• Video visits and PERS alerts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At Risk</th>
<th>Functionally Challenged</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Members: 40%</strong></td>
<td><strong>Members: 25%</strong></td>
</tr>
<tr>
<td>• Telephonic Health Coaching</td>
<td>• Telephonic Care Management</td>
</tr>
<tr>
<td>• IVR monitoring</td>
<td>• In-Home Support</td>
</tr>
</tbody>
</table>

### Transitions Program

#### High Risk

- Hospitalized members at high-risk of readmission within 30 days post discharge
  - In-Home Care Management for 30 days post discharge
    1) Hospital visit prior to discharge
    2) Home visit within 48 hours post discharge
    3) Coordination of PCP visit within 1 week
    4) Home visit post PCP visit
    5) Ongoing follow up during first 30 days
    6) Integrated with HCCP after day 30

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- All staff trained on motivational interviewing
- Care managers work on the same system
- Notes shared across teams
- Alerts are used to get immediate attention
- Appointments system included
Intervention Levels

Low Intervention - Health Educator or Coach (60%)

• Health education, monitoring practices, nutritional counseling, drug review, safety assessments, community services bridge

• Onboarding process, contact every three months telephonically

• Case load- 600 patients with minimum contact every three months, 70% contact
Intervention Levels

Moderate Intervention – Social Worker or Registered Nurse (30%)

- Health education, symptom management, drug review and education, coordinate medical services, community services bridge, in-home visit if needed, address functional impairments
- Minimum contact – once a month telephonically
- Case load- 200 patients with minimum contact once a month, 70% contact
Intervention Levels

High Severity – Social Worker or Registered Nurse (10%)

• Higher intensity of need, health education, symptom management, drug review and education, coordinate medical services, community services bridge, address functional impairments, advanced care planning

• Weekly contact, in home visits supplemented by telephonic depending on patient need

• Case load - 30 patients with minimum contact once per week, 95% contact
Initial Outcomes

Chronic Care Program Averts Hospitalizations (ongoing)

- Expected: 883
- Actual: 509
- 42% Fewer

Transition Program Reduces Hospital Readmissions (30-day program)

- Expected: 25%
- Actual: 11%
- 56% Fewer
Stories from the Field
Art Jones, MD, HMA
Introduction *The MHN ACO Approach to Practice Transformation*

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**Excerpt from the MHN ACO Care Management Plan**

Care Management will be delivered at the primary care practice site

- *Builds trust* among the member, provider and care manager
- *Allows* the care manager to be a member of the actual *patient centered* medical home team
- *Facilitates free flow* of timely information and warm handoffs when indicated

Patient is at the center while providers work in a coordinated and integrated manner

- *Recognize and respect* different responsibilities that they each bring to the delivery of health care to the patient
- *Collectively* enrollee patients are informed about their health, and coordinated resources and expertise are provided to them

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A well-defined and appropriately executed program providing incentives that reinforce the tenets of this plan can help drive adoption
MHN Model of Care: *Integrated Delivery Across the Continuum*
Care Management Connect: Tracking Quality Assessments & Indicators
Care Management Connect: 
Managing Health Risk At the Practice Level
## HRA Results  As of August 18, 2015

<table>
<thead>
<tr>
<th>Site</th>
<th>Population</th>
<th>HRAs Completed</th>
<th>HRA Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alivio</td>
<td>5,439</td>
<td>3,927</td>
<td>72.2%</td>
</tr>
<tr>
<td>Aunt Martha’s</td>
<td>4,697</td>
<td>3,543</td>
<td>75.4%</td>
</tr>
<tr>
<td>CFHC</td>
<td>11,354</td>
<td>7,107</td>
<td>62.6%</td>
</tr>
<tr>
<td>Erie</td>
<td>6,747</td>
<td>4,748</td>
<td>70.4%</td>
</tr>
<tr>
<td>Esperanza</td>
<td>3,832</td>
<td>2,564</td>
<td>66.9%</td>
</tr>
<tr>
<td>Friend Family</td>
<td>14,797</td>
<td>11,003</td>
<td>74.4%</td>
</tr>
<tr>
<td>Lawndale*</td>
<td>8,415</td>
<td>5,894</td>
<td>70.0%</td>
</tr>
<tr>
<td>PCC Wellness</td>
<td>6,426</td>
<td>4,577</td>
<td>71.2%</td>
</tr>
<tr>
<td>PrimeCare</td>
<td>3,909</td>
<td>2,518</td>
<td>64.4%</td>
</tr>
<tr>
<td>La Rabida</td>
<td>181</td>
<td>142</td>
<td>78.5%</td>
</tr>
<tr>
<td>RUMG</td>
<td>14,763</td>
<td>11,499</td>
<td>77.9%</td>
</tr>
<tr>
<td>SMG</td>
<td>3,129</td>
<td>1,470</td>
<td>47.0%</td>
</tr>
<tr>
<td><strong>Overall ACO</strong></td>
<td><strong>83,689</strong></td>
<td><strong>58,992</strong></td>
<td><strong>70.5%</strong></td>
</tr>
</tbody>
</table>

### HRA Count

<table>
<thead>
<tr>
<th>Completion Rate of All New HRAs Completed After August 1, 2015 Eligibility Start Date</th>
<th>HRA Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>757</td>
</tr>
<tr>
<td>26.2%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Completion Rate of All New HRAs Completed 60 days After June 1, 2015 Eligibility Start Date</th>
<th>HRA Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5,564</td>
</tr>
<tr>
<td>73.4%</td>
<td></td>
</tr>
</tbody>
</table>
# CRA and Care Plan Results

*As of August 18, 2015*

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of High and Medium Risk</th>
<th>CRAs Completed</th>
<th>CRA Rate*</th>
<th>Care Plans Completed</th>
<th>Care Plan Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alivio</td>
<td>160</td>
<td>59</td>
<td>36.9%</td>
<td>18</td>
<td>11.3%</td>
</tr>
<tr>
<td>Aunt Martha’s</td>
<td>604</td>
<td>197</td>
<td>32.6%</td>
<td>179</td>
<td>29.6%</td>
</tr>
<tr>
<td>CFHC</td>
<td>1,483</td>
<td>51</td>
<td>3.4%</td>
<td>49</td>
<td>3.3%</td>
</tr>
<tr>
<td>Erie</td>
<td>491</td>
<td>274</td>
<td>55.8%</td>
<td>269</td>
<td>54.8%</td>
</tr>
<tr>
<td>Esperanza</td>
<td>244</td>
<td>75</td>
<td>30.7%</td>
<td>47</td>
<td>30.3%</td>
</tr>
<tr>
<td>Friend Family</td>
<td>1,453</td>
<td>656</td>
<td>45.1%</td>
<td>663</td>
<td>45.6%</td>
</tr>
<tr>
<td>La Rabida</td>
<td>41</td>
<td>7</td>
<td>17.7%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Lawndale</td>
<td>1,133</td>
<td>258</td>
<td>22.8%</td>
<td>213</td>
<td>18.8%</td>
</tr>
<tr>
<td>PCC Wellness</td>
<td>1,217</td>
<td>127</td>
<td>10.4%</td>
<td>54</td>
<td>4.4%</td>
</tr>
<tr>
<td>PrimeCare</td>
<td>306</td>
<td>79</td>
<td>25.8%</td>
<td>77</td>
<td>25.2%</td>
</tr>
<tr>
<td>RUMG</td>
<td>1,557</td>
<td>305</td>
<td>19.6%</td>
<td>28</td>
<td>14.7%</td>
</tr>
<tr>
<td>SMG</td>
<td>250</td>
<td>89</td>
<td>35.6%</td>
<td>73</td>
<td>29.2%</td>
</tr>
<tr>
<td><strong>Overall ACO</strong></td>
<td><strong>8,939</strong></td>
<td><strong>2,177</strong></td>
<td><strong>24.4%</strong></td>
<td><strong>1,884</strong></td>
<td><strong>21.4%</strong></td>
</tr>
</tbody>
</table>

*Rate of Completion on High and Medium Risk Patients*
**Daily Inpatient Discharge Report**

**ER Discharge Date:** 03/01/2014  
**PCP Organization:** Organization X  
**Medical Home(s):** All

In preparing this report, we relied on data and information provided by third-party sources. We attempt to ensure the integrity, completeness, and accuracy of all data analytics and reports we provide, but we have not independently tested or confirmed the validity of the underlying information used to prepare these reports.

Discharges are only based on MHNConnect hospital information.

*Empiricant may vary due to retroactivity.

*Readmissions calculation may be underrepresented due to timing of received underlying information.

**Report last run:** 3/2/2014 7:49 AM

**Total Inpatient Events for Members:** 30

<table>
<thead>
<tr>
<th>Medical Home Assignment</th>
<th>Member ID</th>
<th>Member First Name</th>
<th>Member Last Name</th>
<th>Member Date of Birth</th>
<th>Member Telephone Number</th>
<th>Source Hospital Name</th>
<th>Admit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Home 1</td>
<td>#12345678</td>
<td>John</td>
<td>Smith</td>
<td>01/01/1980</td>
<td>555-123-4567</td>
<td>X Hospital</td>
<td>03/01/14</td>
</tr>
<tr>
<td>Medical Home 2</td>
<td>#23456789</td>
<td>Jane</td>
<td>Johnson</td>
<td>02/02/1981</td>
<td>666-234-5678</td>
<td>Y Hospital</td>
<td>03/01/14</td>
</tr>
<tr>
<td>Medical Home 3</td>
<td>#34567890</td>
<td>Mark</td>
<td>Taylor</td>
<td>03/03/1982</td>
<td>777-345-6789</td>
<td>Z Hospital</td>
<td>03/01/14</td>
</tr>
<tr>
<td>Medical Home 4</td>
<td>#45678901</td>
<td>Sarah</td>
<td>Brown</td>
<td>04/04/1983</td>
<td>888-456-7890</td>
<td>X Hospital</td>
<td>03/01/14</td>
</tr>
</tbody>
</table>

**Inpatient Average Length of Stay:** 6.2 Days

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**Real-time inpatient discharge monitoring and member healthcare activity.**

The Daily Inpatient Discharge Report allows clinics to view which of their members had an inpatient facility discharge the previous day. The report combines real-time hospital activity with historical claims and clinical information in order to enhance informed patient outreach efforts. The report can serve as a tool to reduce inpatient readmissions through enhanced care coordination follow-up activities and targeted patient education efforts. Reduced readmissions can lead to improved healthcare outcomes, enriched patient quality, and reduced costs.

**Allows care coordinators to prioritize their daily workflow.**

Daily Inpatient Discharge Report identifies:
- Complex members by length of stay & member chronic condition history, whether member was a readmit, etc.
- New members to a clinic that have not yet been contacted or seen by CountyCare PCP.
- Post-discharge sites of care (e.g., home or other healthcare facility).
Bridging Connections Across the Continuum of Care: *MHN In Action*

**Three steps to better care coordination:**

1. **Receive Alert**
   - Care Coordinators in the clinic receive a real-time email alert when a patient presents in the hospital/ED

2. **Interact via MHNConnect & Analytics**
   - Care Coordinators assess patient utilization and health history by using the data integrated in MHNConnect and Consilink analytics

3. **Patient-centered Care Management**
   - Care Coordinators proactively reach out to patients resulting in data-informed population health management & increased access to care
### Care Transitions Measure

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Name</th>
<th>RIN:</th>
<th>Medical Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELIZABETH BROWN</td>
<td>015223829</td>
<td>Alvio-Cicero 4842 W Cermak Rd, Cicero IL 60804</td>
</tr>
<tr>
<td>Plan: CC</td>
<td>Gender: F</td>
<td>Mon, Tues, Thurs, Fri (8:30 am - 5:00 pm)</td>
</tr>
<tr>
<td>Address: 4154 W 21ST PL APT 1, CHICAGO, IL 60623</td>
<td>DOB: 09/22/1967</td>
<td>Wed (1:00 pm - 8:00 pm) Sat (9:00 am-1:00 pm)</td>
</tr>
<tr>
<td>Phone: 773-826-1072</td>
<td>Main Line: 773-254-1400</td>
<td>After Hrs Line: 773-579-2669</td>
</tr>
</tbody>
</table>

#### 1. The hospital staff took my preference and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.
- [ ] Strongly Disagree
- [ ] Disagree
- [ ] Agree
- [ ] Strongly Agree
- [ ] Don't Know/Don't Remember/Not applicable

#### 2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
- [ ] Strongly Disagree
- [ ] Disagree
- [ ] Agree
- [ ] Strongly Agree
- [ ] Don't Know/Don't Remember/Not applicable

#### 3. When I left the hospital, I clearly understood the purpose for taking each of my medications.
- [ ] Strongly Disagree
- [ ] Disagree
- [ ] Agree
- [ ] Strongly Agree
- [ ] Don't Know/Don't Remember/Not applicable

[Save] [Close]
Medical Home Network: Driving Effective Population Health

MHN judges effective care management by its ability to lower patient risk.
Growth in Total Cost of Care: MHN vs. non MHN
Matched Cohort Trend

In Year 2, MHN risk-adjusted PMPM growth in total cost of care is 5% lower than non-MHN.
Improvements in Patient Engagement and Care

- 71.4% of 80,000 members have completed Health Risk Assessment
- July 2014 – May 2015
  - 34% reduction in bed days/1000*
  - 13.9% reduction in ED visits/1000*
  - 35% reduction in readmission rates*
  - Reduction in global care of care results pending claims run out

* Reflects the reduction achieved by MHN PCPs as compared to non-MHN PCPs in the CountyCare program; MHN has 48% of the ~180,000 CountyCare member population. CountyCare is a no-cost publicly funded managed care health plan in Cook County, Illinois.
Why did MHN Build Instead of Buy?

- Centralized and even embedded externally employed care managers didn’t integrate in the past
- Forced providers to be actively engaged in designing the care management model
- Employee status facilitated ability to piggyback on established PCP credibility with the patient
- Eliminated accountability finger pointing
- Complete alignment of care manager and PCP incentives
- One less hand in the cookie jar
Questions and Discussion
Next Steps/Updates

- Learning Collaborative for Regional Partnerships – 9/3 from 1-3pm, with optional lunch and networking from Noon – 1pm at Maryland Hospital Association
- September 10 webinar – Consumer Engagement
- September 24 webinar – Behavioral Health Integration
- October 1 – Learning Collaborative conference call (all hospitals)

- The Implementation RFP response, the Transformation Plan Final Report and the Hospital Strategic Transformation Plan are now all due on December 7th. This has been extended one week due to the holiday.