Helping Practices to Help Patients

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Vision and Key Principles

• Strong primary care is foundational to high performing healthcare systems
• Timely data is essential to success
• Clinicians who are expected to improve care must have ownership of the improvement process
• Healthcare is local – collaboration at the community level is key
• Savings can be achieved through better quality care
Primary Goals of Community Care

• Improve the care of the enrolled population while controlling costs

• A “medical home” for patients, emphasizing primary care, patient centered and team based care

• Community networks capable of managing beneficiary care

• Local systems that improve management of chronic illness in both rural and urban settings

• Develop and support high functioning delivery systems able to achieve the Triple Aims
CCNC Footprint Statewide

All 100 NC Counties

- 6,000 primary care providers
- 1,800 Practices
- 90% of PCPs in NC participate

14 Networks

Each network averages:
- 1.4 Medical Directors
- **52 Local Case Managers**
- 1.8 Pharmacists
- 1.0 Psychiatrist

1.3 million Medicaid Patients
300,000 Aged, Blind, Disabled
150,000 Dually Eligible
CCNC Medical Home in the Medical Neighborhood

Population mgmt: Stratify population, choose targets

Data to inform decisions & focus efforts

Primary Care Foundation

Multi-disciplinary team: RX, Behavioral, Care Manager

Community supports and resources
Patient-Centered Continuum

THE MEDICAL NEIGHBORHOOD

- HOSPITAL
- SPECIALIST
- PHARMACY
- SKILLED NURSING FACILITY
- CARE MANAGER
- PCP
- PATIENT
- PATIENT’S FRIENDS & FAMILY

- LONG-TERM CARE
- COMMUNITY-BASED RESOURCES
- REHABILITATION
- HOME HEALTH
How does CCNC Work?

• Medical homes with local clinical leadership and community based solutions

• Care Management Model
  o Use of analytics to target highest yield patients and care settings
  o Care managers are integrated with practices, hospitals and communities
  o Interdisciplinary team approach

• Engaged provider network that participates in care improvement and cost effectiveness strategies

• Practices and hospitals as a unit of intervention
Key elements of our model

• Medical Home and Provider Engagement
• Population stratification
• Care and disease management of complex patients

• Provider and patient engagement
• Practice support / PCMH certification
• Data, analytics and reporting
• HIE connectivity
• Transitional care

• Medication management
• Wellness management of low risk population
Features of High Performing Systems of Care

• Use data and analytics to stratify and manage patients – population stratification / predictive modeling

• Organize delivery system for
  o a) preventative care
  o b) chronic conditions and self-management
  o c) complex and high-risk care coordination

• Use interdisciplinary health care teams to manage patient panels

• Improve access to care through innovation (same day visits, 24/7 nurse advice, group visits, etc.)

• Identify and close gaps in care
Features of High Performing Systems of Care, cont.

• Dedicate care coordinators to improve continuity of acute and post-acute care transitions

• Establish communication workflows with specialists and community providers

• Supply resources to organize and support high performance

• Engage patients and caregivers

• Strengthen population management through practice processes and tools

• Improved patient experience and satisfaction
Features of High Performing Systems of Care, cont.

• Consider social determinants of health
• Patient-centered care plans for high risk patients
• Impact health outcomes through evidence-based interventions
• Extend the health care team into a medical neighborhood
• Provide patient education, self-management skills training
• Provide end-of-life and palliative care
• Integrate with behavioral health
CCNC Care Management – Supporting Practices to Target the Right Patients
CCNC Care Management Evolution

Disease Management → Care of Complex Patients

Focus on High Cost/High Risk → Focus on Most “Impactable”

One Size Fits All → Right sizing of intervention to maximize ROI
Technology-enabled Care Management

Plan-Do-Study-Act

1. Identifying Patients for Care Management
2. Tracking Patient Information
3. Supporting Care Coordination and Collaboration
4. Engaging Patients
5. Reporting on Impact
Where are the Opportunities?

A Small Portion of Beneficiaries Are Responsible for a Disproportionate Share of Costs
“Big Data never cured a case of cancer, it is the people on the ground that improve health”
Anonymous
Fragmented Care

• Patients are admitted and discharged from hospitals without communication to medical home
  ✓ Need effective and timely communication with hospitalists / discharge planners
  ✓ Need to ensure follow-up with PCP and/or specialist AND medication reconciliation
• Patients see multiple specialists without effective communication to medical home
• Patients have multiple prescribers
• Information systems do not talk with each other
Identifying the Right Patients

Targeted Approach to population management

• Analytics team identifies most ‘impactable’ patient population

• CCNC Priority Population
  o Readmission Risk
  o Above expected hospital costs
  o ED super utilizers
  o Dual Eligible Priority
  o Behavioral Health Priority

• Methodology:
  • Population stratified by clinical risk groups and then by disease severity/control
... Providing the Right Care

CCNC Care Management Team
• Care Managers (RN, BSW, MSW)
• OB Care Managers
• Behavioral health providers
• Pharmacists
• Lay health advisors, educators, etc.

Care Management Model
  o Patient engagement through motivational interviewing
  o Assessment, care planning and goal setting
  o Interdisciplinary team linked by informatics platform
  o Integration with medical home and other care settings
At the Right Time

Care Management Model Targets Opportunities in “Real Time”

• Transitional Care Priority: Patients with disease profile that benefit most from transitional care

• Admission Discharge Transfer Feeds: ADT feeds with 56 hospitals identify patients every 8 hours that are in hospital or ED

• Point of Care Referrals: Physician, Hospital, ED, BH/MCO

• Synchronize care alerts with medical home visits, such as
  – Patients with gaps in care
  – Patients with drug therapy problems
Care Management Interventions for High Risk Patients

- Medical home linkage
- Medication Management
- Goal setting and care plan development
- Health education
- Self management coaching
- Motivational interviewing
- Preparation for provider visits
- Linkage to community resources
The Traditional Approach of Patient Targeting

Traditional approaches focus on highest cost/highest risk patients for savings. With this approach, care management interventions may have little or no impact on the trajectory of health care costs for many patients.

● = Individual patient health care cost
Because their utilization is higher than others in the same cohort, these patients would likely benefit from Targeted Care Management. Under conventional flagging methodology, they would have been missed.

Every patient in the population is assigned to a clinical risk cohort according to a hierarchical model using standard claims data—including inpatient, outpatient, physician, and pharmacy data history.

Each dot represents an individual’s healthcare spending pattern, focusing on potentially preventable hospitalizations or emergency room visits.

Under conventional flagging methodology, all of these people might have been flagged; care management would likely have had minimal impact for most of them.
Population Profiling: CareTriage and Impactability

By identifying individuals at higher risk, with higher impactability, care providers can focus interventions on patients that have the largest change in cost trajectory.

CareTriage measures the probability of an event or outcome.

Impactability predicts how much change can be expected when intervened.
Impactability Concept

Using this **impactability** concept, intervening with the outlier in Peer Group #1 would result in a larger actual-to-expected cost difference then using conventional methodology and choosing to design an intervention targeting the higher cost individuals in Peer Group #2.

The **impactability** score represents the PMPM dollar savings likely to be yielded if the patient were managed (Multiply the score by 6 months to calculate the true savings, e.g., someone with a score of 350, really translates to a likely savings of 350*6 = $2,100).
Priority Patient List

...data-driven identification of individuals who are most likely to benefit from care management outreach.
Transitional Care

- Real-time notification of hospital admission.
- Priority flagging based on overall risk profile using historical claims.
Components of Transitional Care

- Face-to-Face Patient Encounters
- Patient Education
- Medication Management
- Timely Follow-up with Outpatient Providers
Each dot represents the home address of a client who received transitional care services between July 2011 and June 2012. As of December 2014, we are providing transitional care management for approximately 4700 patients per month.
Which Patients Benefit the Most from Transitional Care Management?

*Size of bubble reflects the size of the patient population.*
Return on Investment

• Number of patients needing to receive transitional care in order to avert 1 hospital admission in the coming year:
  
  o Complex, chronic patients = 6
    ✓ non-mental health discharges = 5.6
    ✓ mental health discharges = 7.2
  
  o Healthier patients = 133
Peer-reviewed research

Cutting Hospital Readmissions

• 20% reduction in readmissions for patients with multiple chronic conditions

• Benefit persists far beyond the first 30 days

• For every six interventions, one hospital readmission avoided – strong ROI
We analyzed time to 30-day readmission for patients getting outpatient follow-up within different lengths of time, and stratified by underlying clinical risk.

All CCNC enrolled at discharge; inpatient discharges during the period 4/1/12-3/31/13, excluding deliveries, newborns, discharges to another facility and members dually enrolled at discharge.
And observed that as patients’ clinical risk increased, the more likely they were to benefit from timelier outpatient follow-up.

All CCNC enrolled at discharge: inpatient discharges during the period 4/1/12-3/31/13, excluding deliveries, newborns, discharges to another facility and members dually enrolled at discharge.
Key Insights: Timeliness of Outpatient Follow-Up Office Visit

- High-risk MCC patients benefit from outpatient follow-up within 7 days of discharge.
- Evidence of benefit is much weaker for low-risk patients.
- Current outpatient resources are mismatched – for every patient getting a 7-day follow-up who doesn’t need it, there is a patient who would have benefitted from 7-day follow-up who did not get it.
How to Intervene in a Timely Manner?

• Local Hospital Relationship
• Real-Time ED and Inpatient Notifications
• Provider Referrals (PCP, ED, LME, Community Partners)
• Provider Portal
• Call Center Referrals
Motivational Interviewing

- Engage, Educate, Empower
- Consumers/patients become part of the workforce
- CCNC plan:
  o Train case managers in motivational interviewing (MI)
  o Provide coaching and technical assistance
  o Interact with patients who interact with physicians
  o Train physicians and their practices
Key Components for Effective Care Management / Coordination

• Inter-disciplinary team approach
• Standardized orientation, training and expectations
  – Standardized care management plan
  – Ensuring patients and families involved in care planning
• Documentation of care management activities is uniform, readily accessible and up-to-date
• Matching patient needs to team members and to interventions
• Align care management efforts to support practice transformation and payment reform efforts – self sustainability
Inter-disciplinary Health Care Team

Includes, for example:

• Patients and their family members / caregivers / support system
• Primary care provider – “leads the health care team”
• Other providers as appropriate (e.g. nurse practitioners, nutritionists, school nurses)
• Behavioral health and specialty providers
• Care Managers
  – Nurses, social workers, health educators, “promotores”, lay health advisors, etc.
• Community agencies (e.g. public health, social services)
• Community organizations (e.g. churches, advocacy groups)
Pearls…..

• Establish formal roles and responsibilities among the team and with the patient and the family / support system

• Communicate across all systems, both clinical and non-clinical

• Collaborate with all team members and providers

• Transitional care brings evidence-based ROI

• Assess needs and establish clear goals with the patient, family, health care team and system

• Ensure the plan of care is sensitive to the patient’s language, values, and culture

• Support self-management goals and aim for a “graduation day”
Pearls, continued…..

• Link and collaborate with community resources and partners
• Ensure data and analytics can support care management activities
  ✓ Stratify populations, identify potentially “impactful” patients, etc.
  ✓ Produce actionable reporting
  ✓ Develop a longitudinal analysis over time to determine effect of interventions, quality improvement, and cost containment
  ✓ How and what “story do we want to tell about our program” and will we have the data to do so
Questions?