Caring for High-Need, High-Cost Patients In & Out of Primary Care

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County of Los Angeles Department of Health Services

IHE Innovation Forum XV
Edmonton, Alberta
June 22, 2016

Outline

- Opportunity for Delivery Transformation
- Overview of Population Health & Complex Care Management
- What complex care management looks like
- Moving towards widespread adoption

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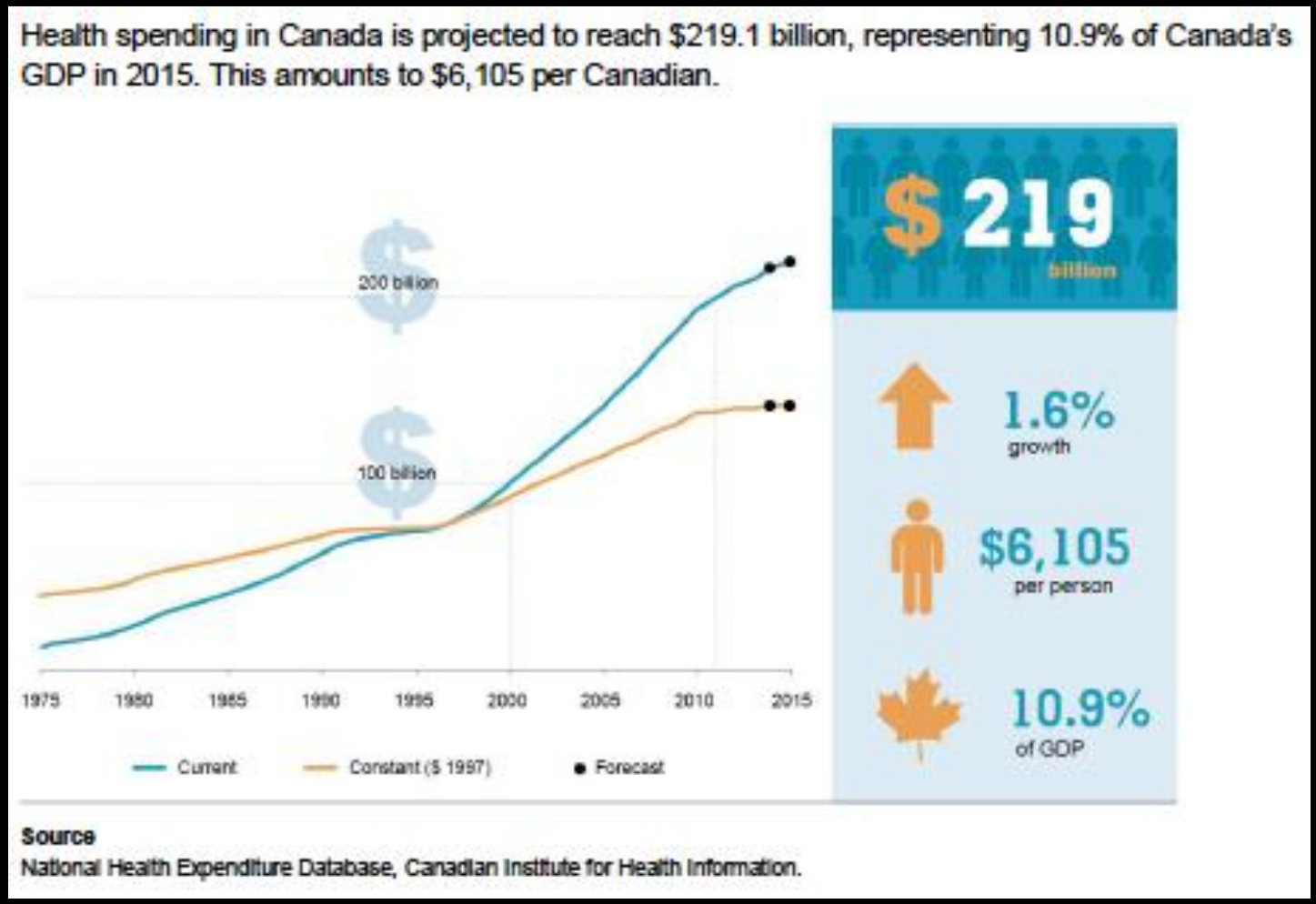
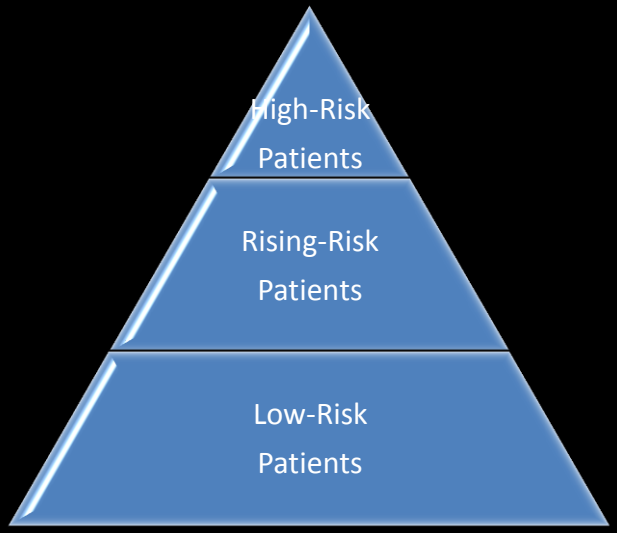
Pressure on government budgets pushing policy changes to address rising cost



Opportunity to Transform Health Delivery

- Move from
  - Units of care delivery to people & populations
  - Partial to whole person
  - Fragmented to integrated systems
  - Autonomous physicians to multidisciplinary teams
- Continuously improve
- Focus on things shown to improve value & support innovation
  - Improve by increments & leaps
- Engage the community
- Rapidly share learning

Population health management approaches are at the core of this delivery transformation effort



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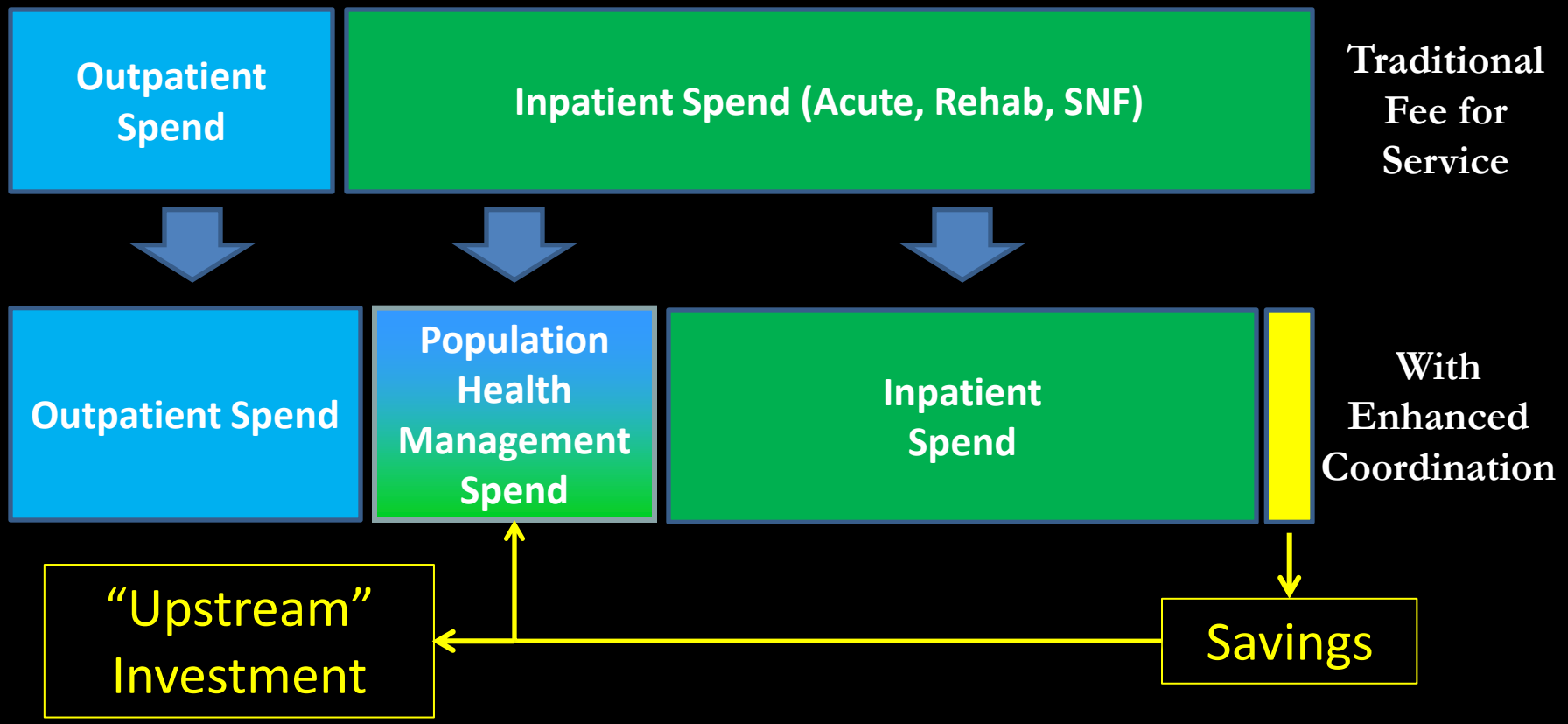
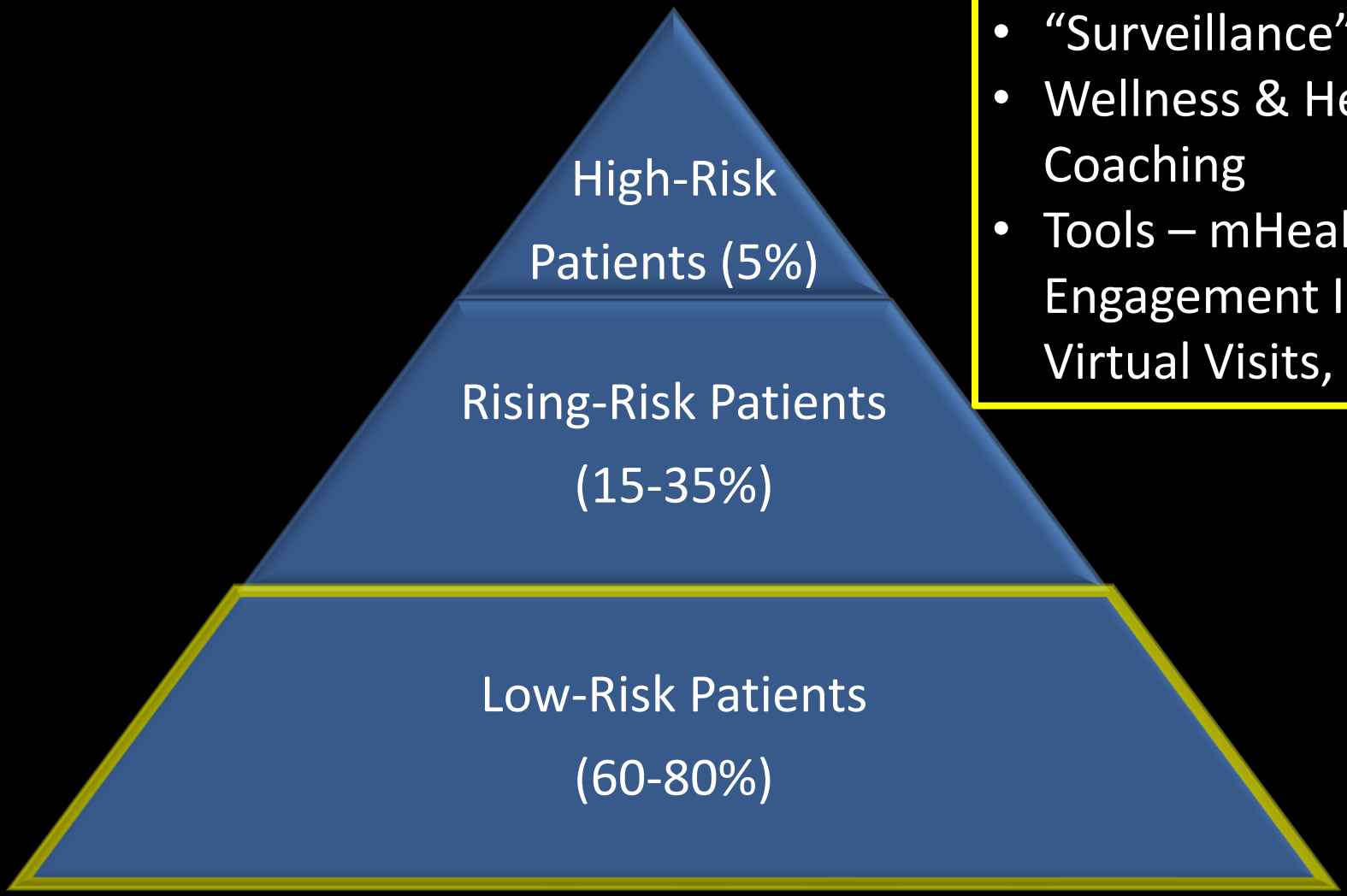
Conceptual Strategy for Population Health Management



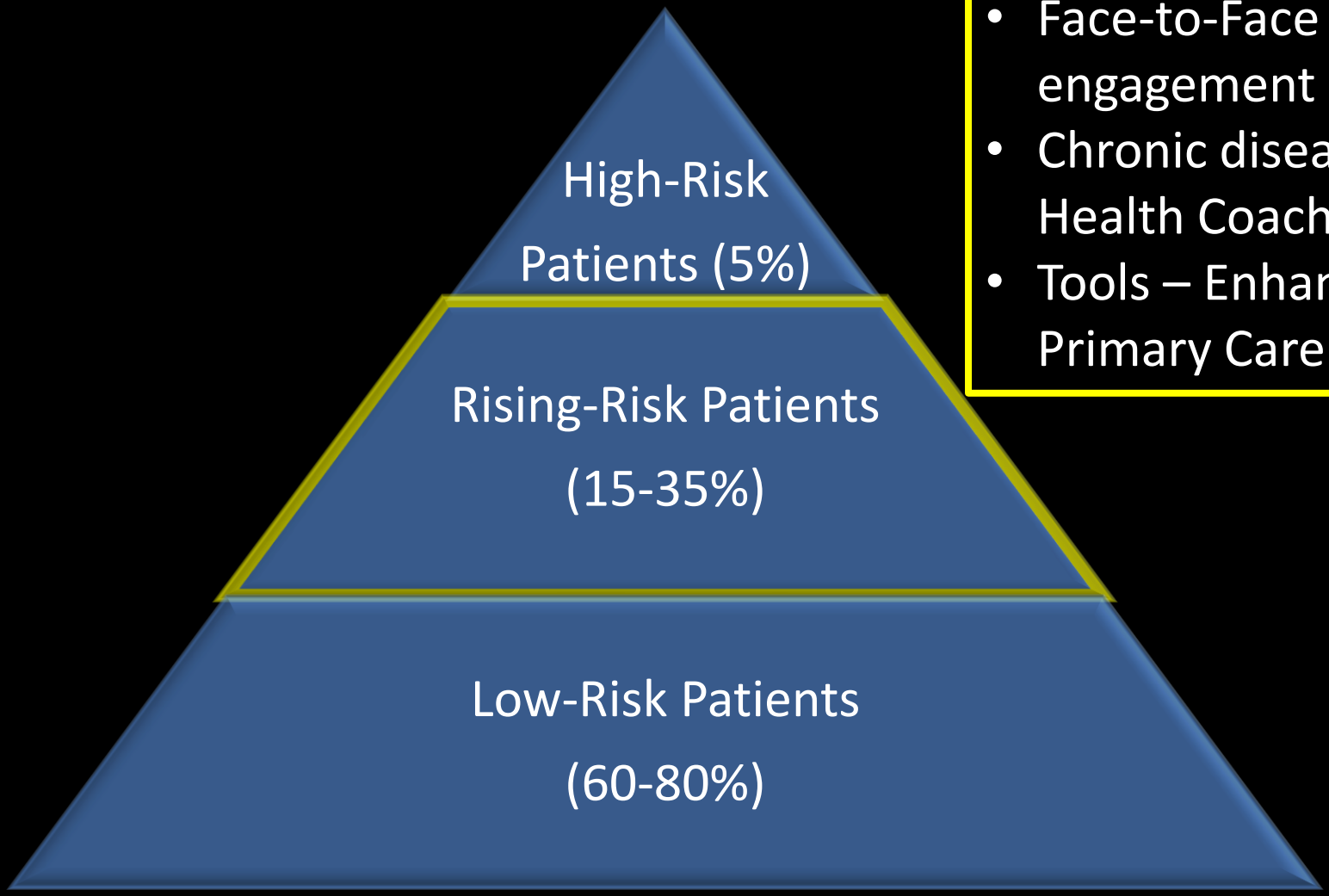
Three Population Foci



Low Touch/High Volume

- "Surveillance"
- Wellness & Health Coaching
- Tools – mHealth/Pt Engagement Industry, Virtual Visits, Health Ed

Three Population Foci



Med Touch/Med Volume

- Face-to-Face engagement
- Chronic disease & Health Coaching
- Tools – Enhanced Primary Care

Three Population Foci

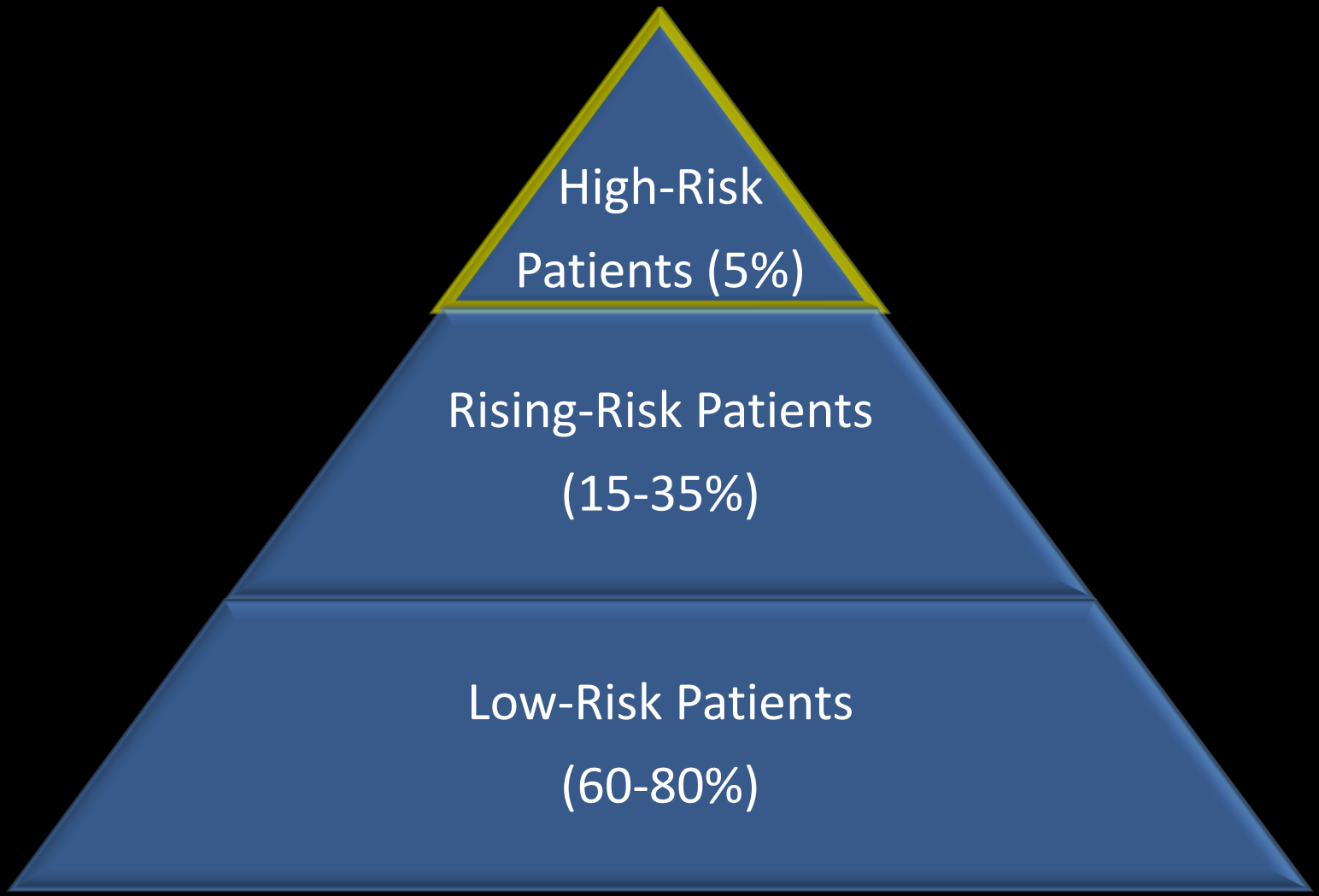
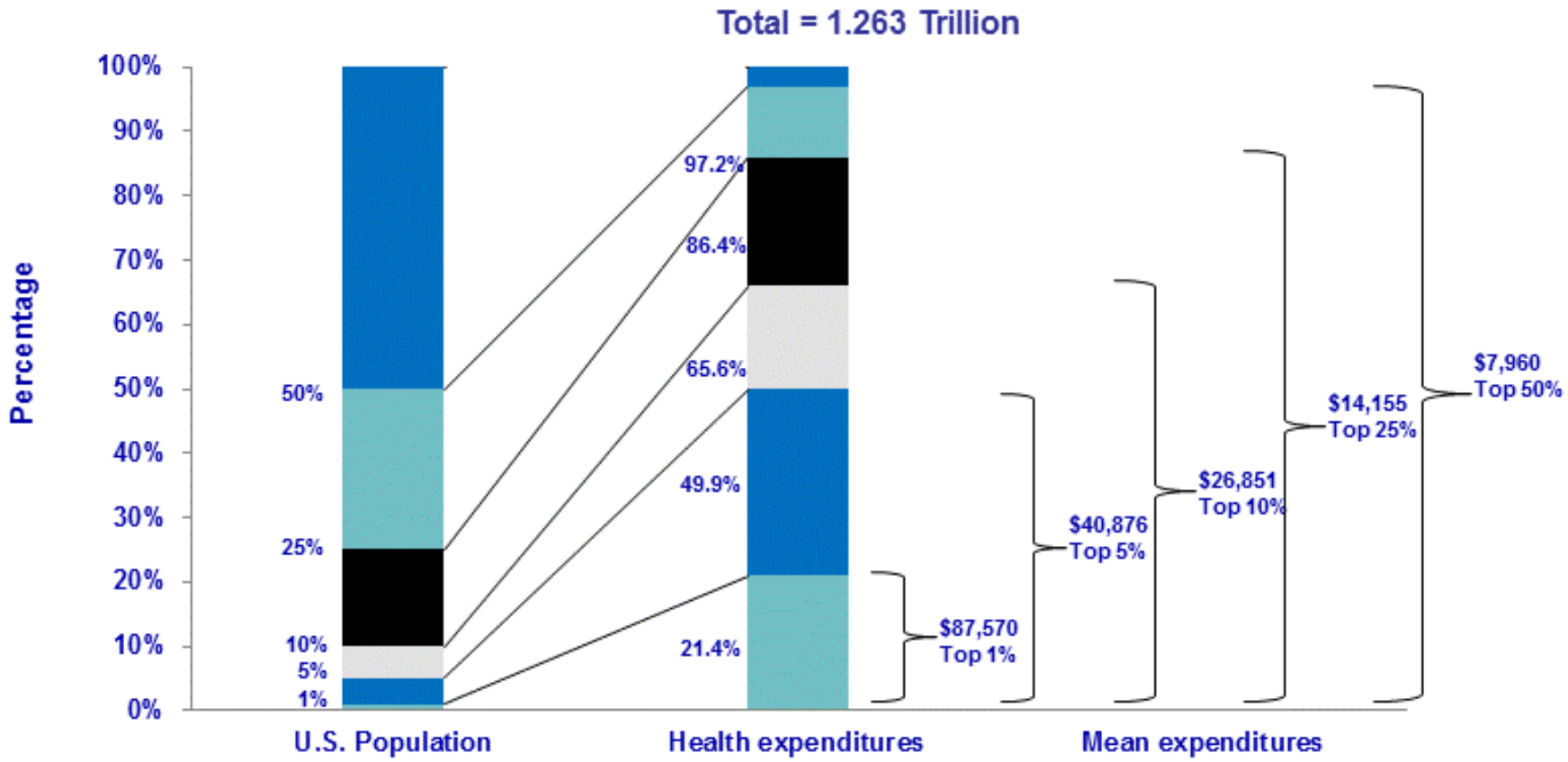


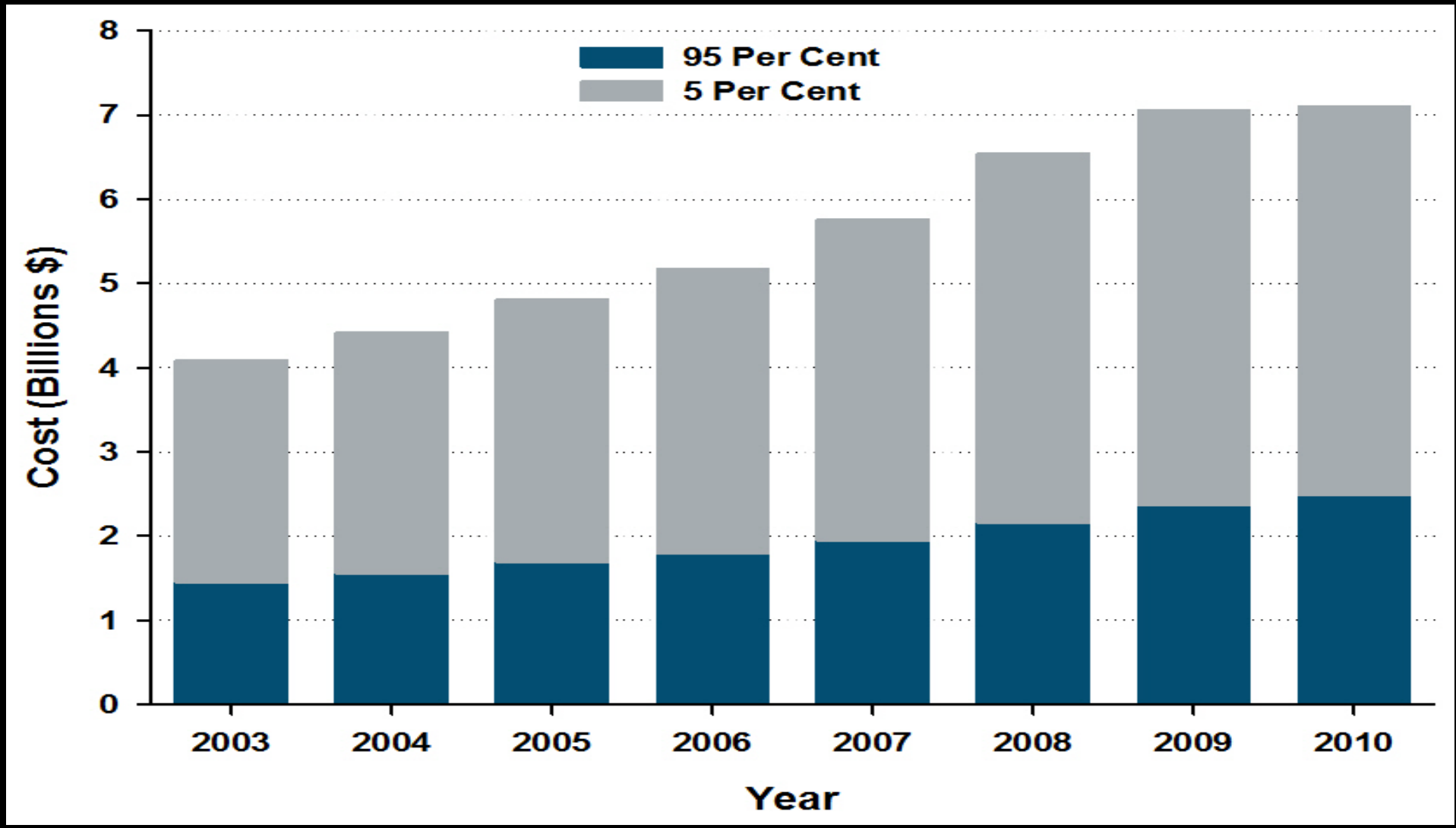
Figure 1. Distribution of health expenditures for the U.S. population by magnitude of expenditure and mean expenditures, 2010



Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2010

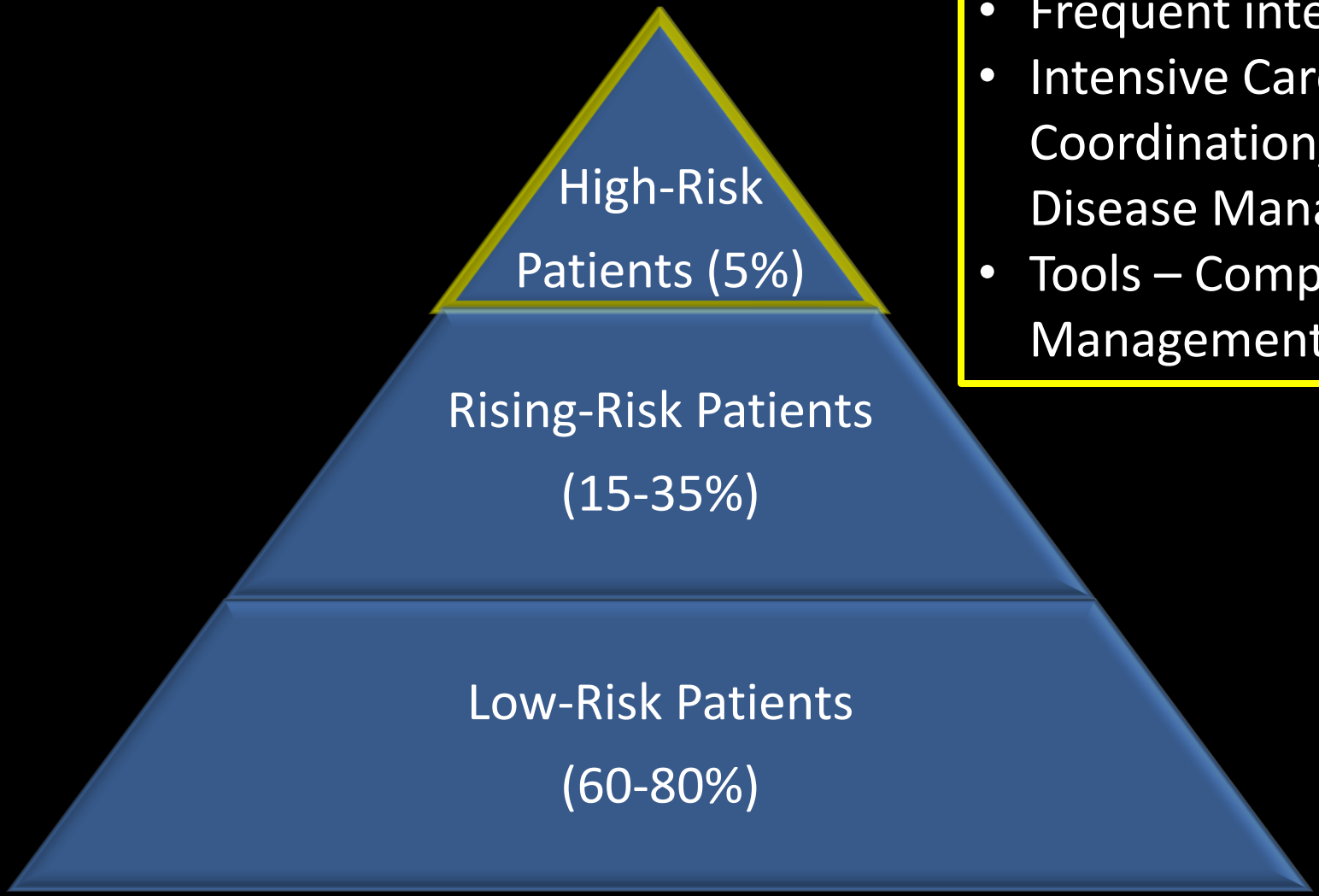
Sources: Cohen, Steven B. and Namrata Uberoi. 2013. "Differentials in the Concentration in the Level of Health Expenditures across Population subgroups in the U.S., 2010." Agency for Healthcare Research and Quality. http://meps.ahrq.gov/mepsweb/data_files/publications/st421/stat421.shtml.

5% Account for 65% of Health System Costs Alberta



Specially trained multidisciplinary, complex care management teams

Three Population Foci



High Touch/High Volume

- Frequent interaction
- Intensive Care Coordination/Chronic Disease Management
- Tools – Complex Care Management Teams

Inconsistent Data on Utilization/Savings

- Medicare Coordinated Care Demo – Peikes NEJM 2009, HA 2012
  - 3/15 sites eventually showed net savings in high risk subsets

- Health Quality Partners – Coburn, 4th report to congress - 2011
  - In high risk subgroups (diagnosis-based)
    - 39% decreased admissions ($p<0.01$)
    - 37% decreased ED use ($p=0.05$)
    - $511 PMPM decreased Medicare expenditures (-36%, $p=0.01$) on $397 PMPM net expenditures (including program fees) ($p=0.05$)
    - 30% decrease mortality rate

Inconsistent Data on Utilization/Savings

- MGH Medicare Demonstration – Urato RTI Report 2013
  - 20% decreased admissions
  - 25% decreased ED visit rates by 25%
  - 4% decreased annual mortality
  - 7.1% annual net savings for enrolled patients
    - 15.1% annual net savings at MGH
    - 4% annual savings for total population
  - $2.65 ROI (per $1 spent)

- *All p-values <0.05

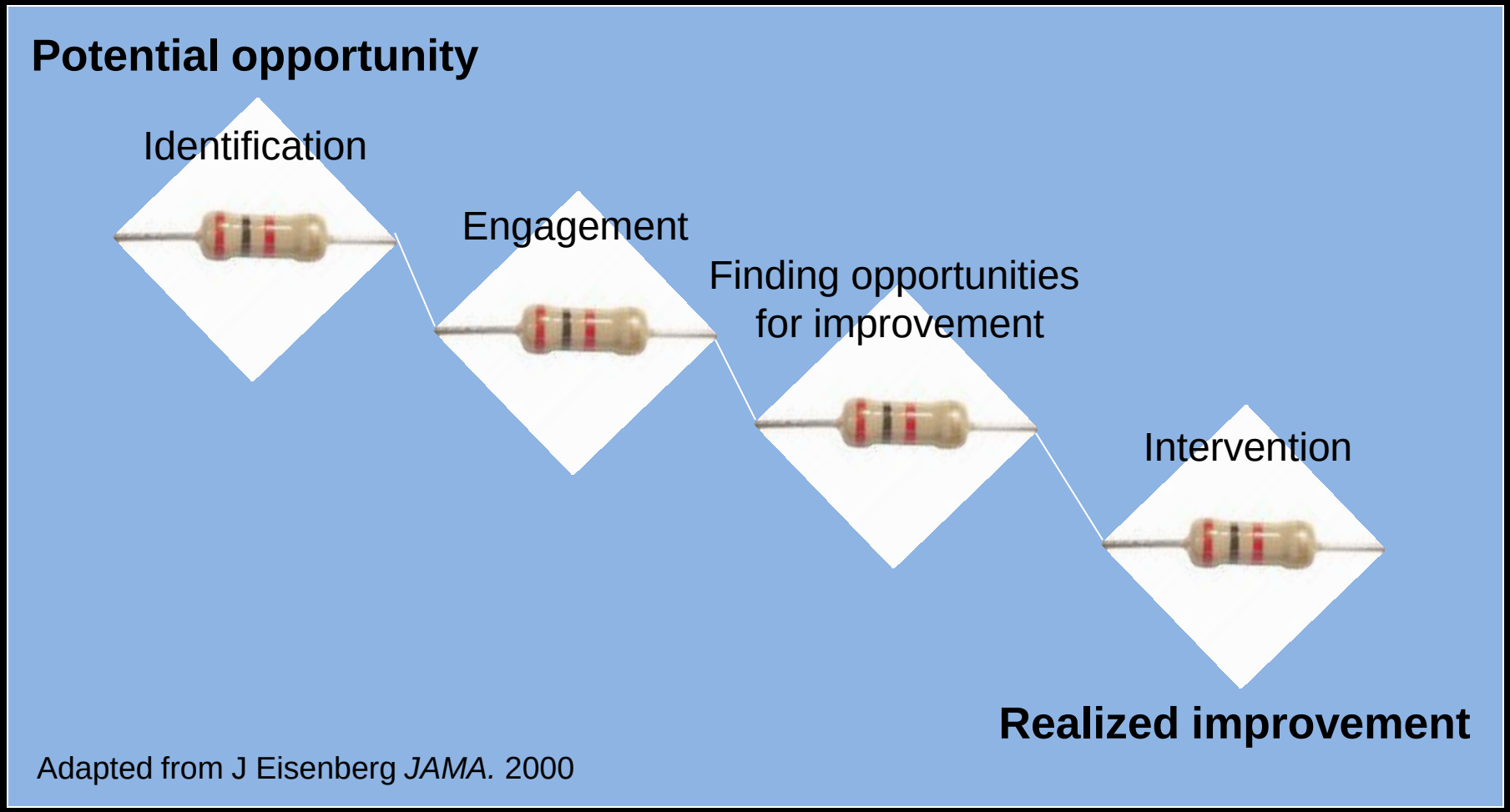
Inconsistent Data on Utilization/Savings

- System of Integrated Care for Older Persons – Beland
  - Decreased (-C$4270, $p<0.05$) institutional costs
  - 50% reduction in alternative level of care days
  - No difference in total overall cost or acute care utilization
  - Increased community care costs (+$C3394)

Inconsistent Data on Utilization/Savings

- GRACE – Counsell JAMA 2007, JAGS 2009
  - Decreased (-$1487, $p<0.001$) 3-year total medical expenditure in highest risk subgroups
  - Increased specialty, rehab, mental health expenditures
- King County Care Partners – Bell Report 2012
  - No change in total Medicaid costs
  - Decreased admissions & inpatient PMPM costs in patients with addiction
  - Increased prescription costs, in-home support service costs, use of chemical dependency treatment services

Challenges for CCM Programs: Drops in Potential



Real-world healthcare delivery models for complex patients

ISSUE BRIEF

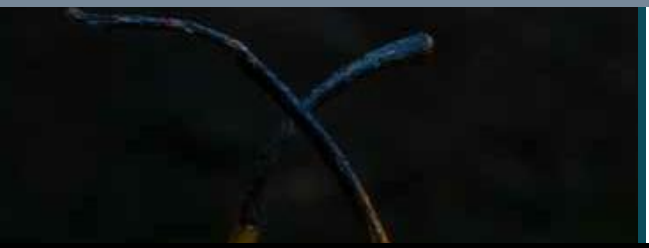
AUGUST 2014

The COMMONWEALTH FUND

Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?

CALIFORNIA HEALTHCARE FOUNDATION

March 2015



Finding a Match: How Successful Complex Care Programs Identify Patients

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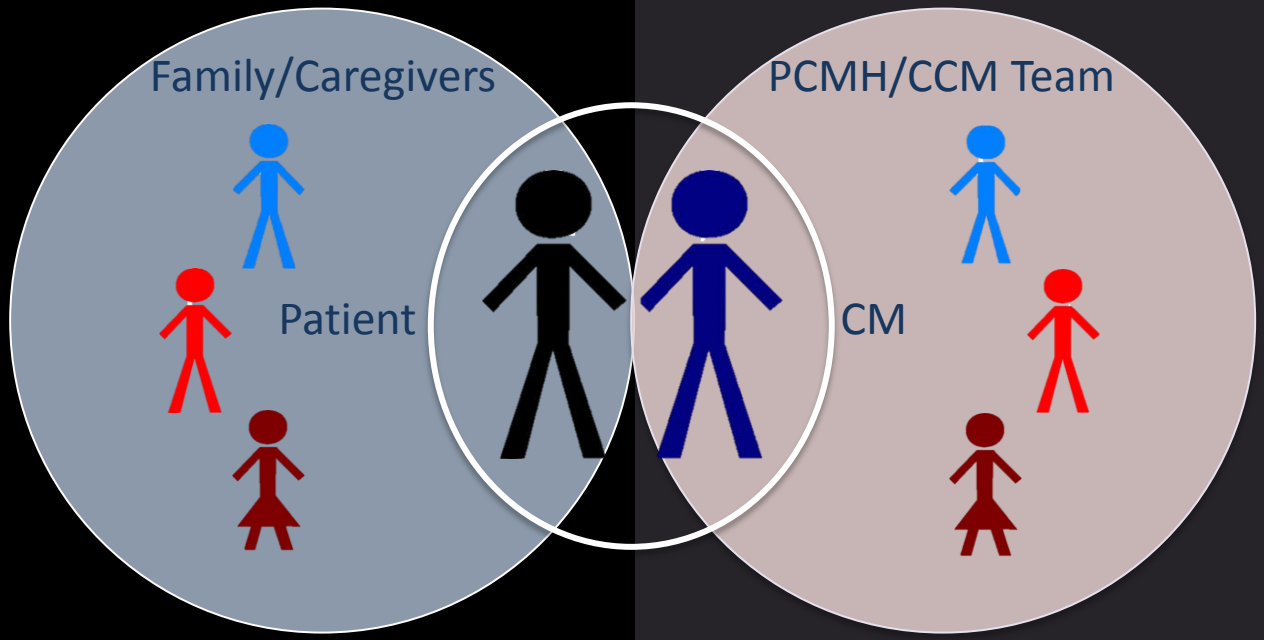
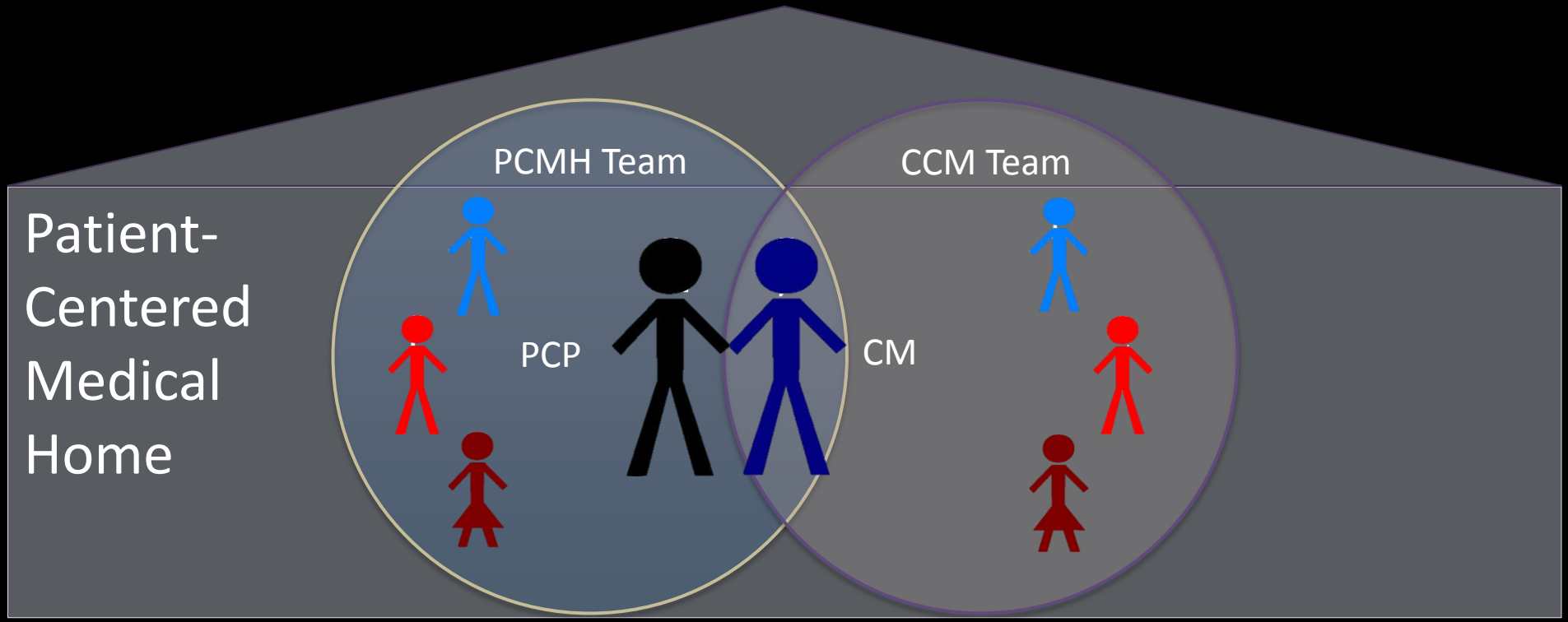
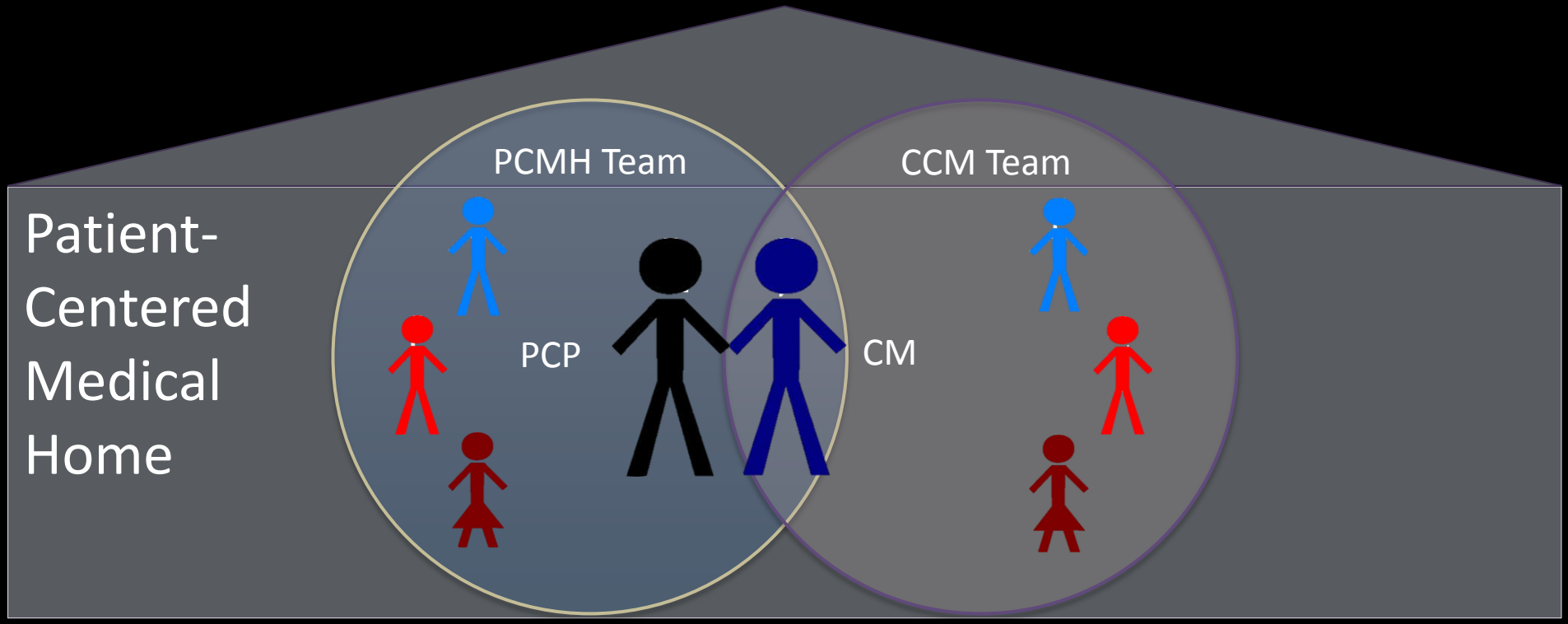
Trusting relationship between a patient & a proactive care team the foundation to care management





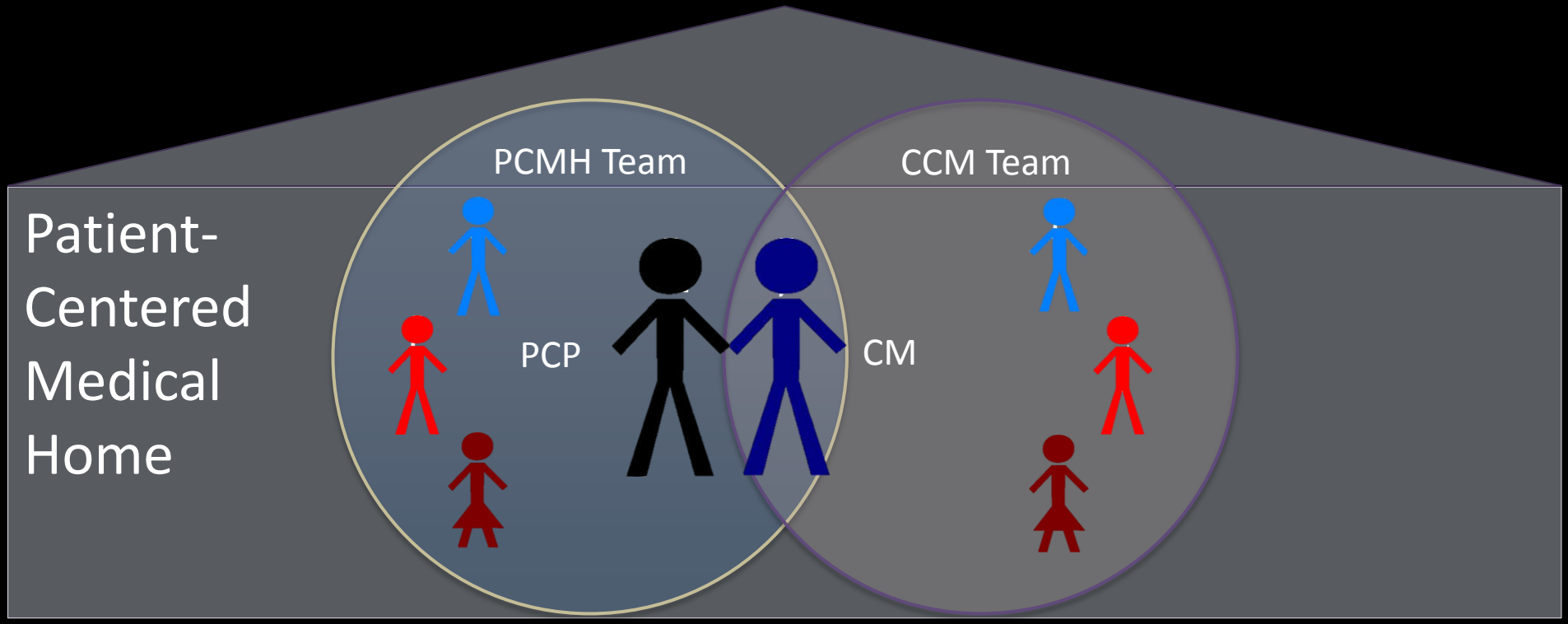
A strong relationship between care management & primary care teams critical for care management

As is a strong relationship between the care team & other health system and community partners

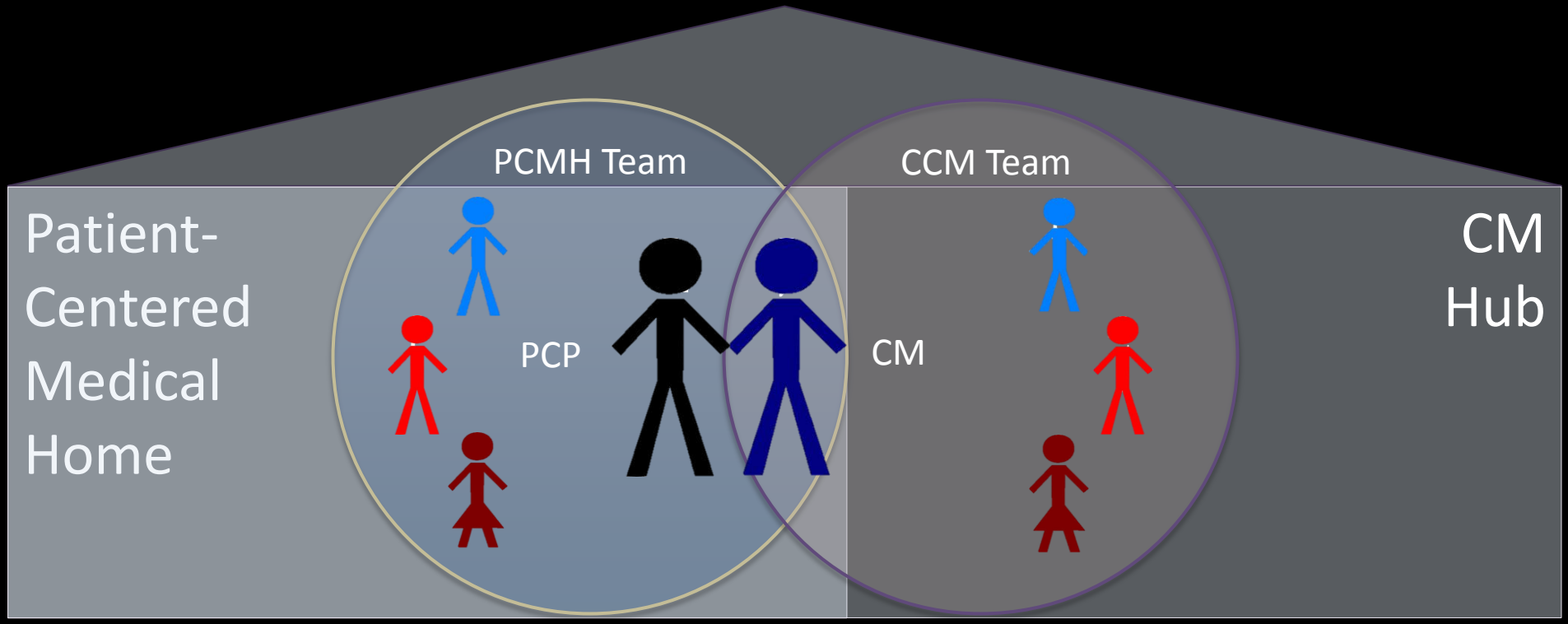


Health Delivery System

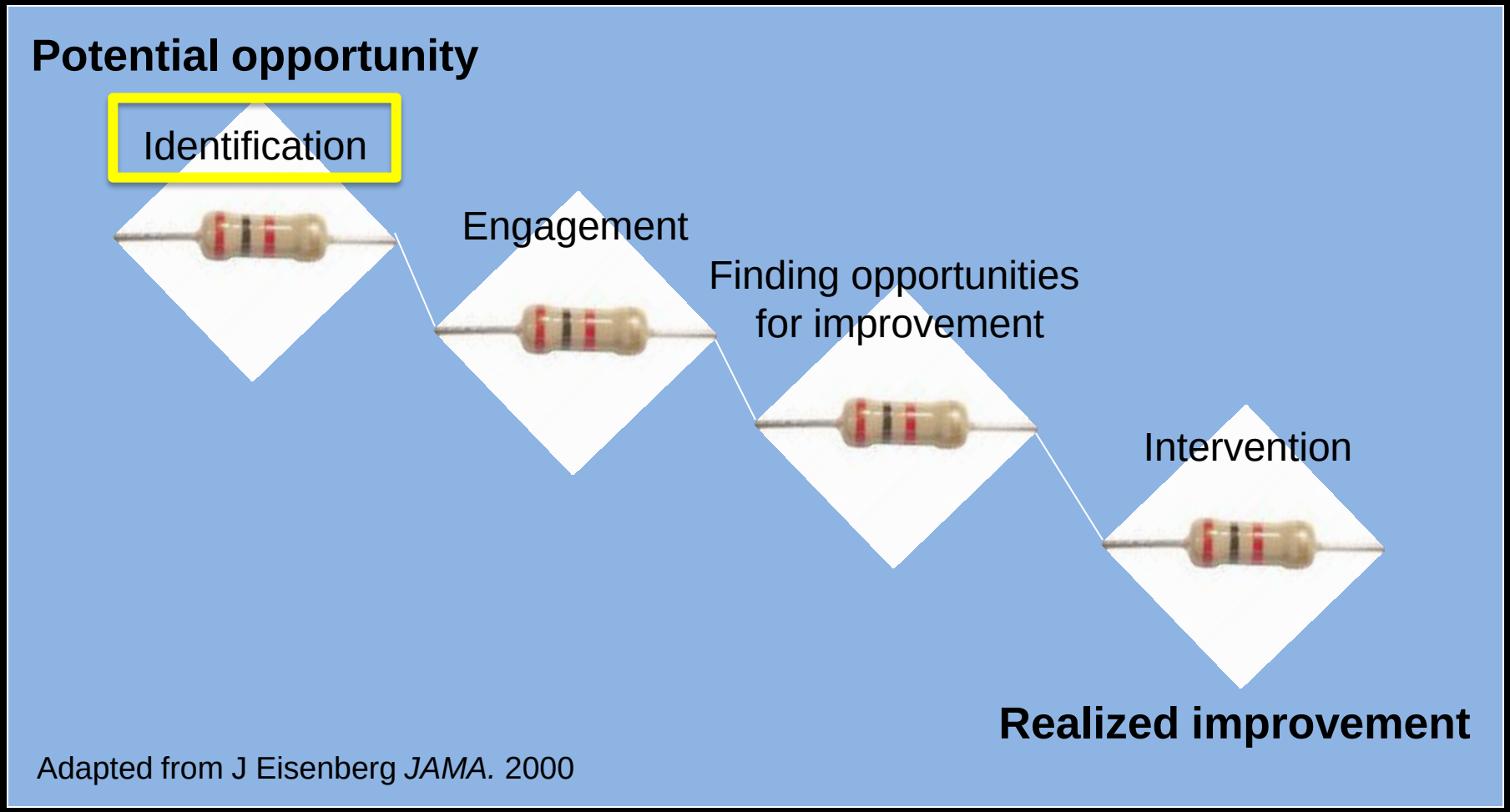
Care Management Structure



Care Management Structure



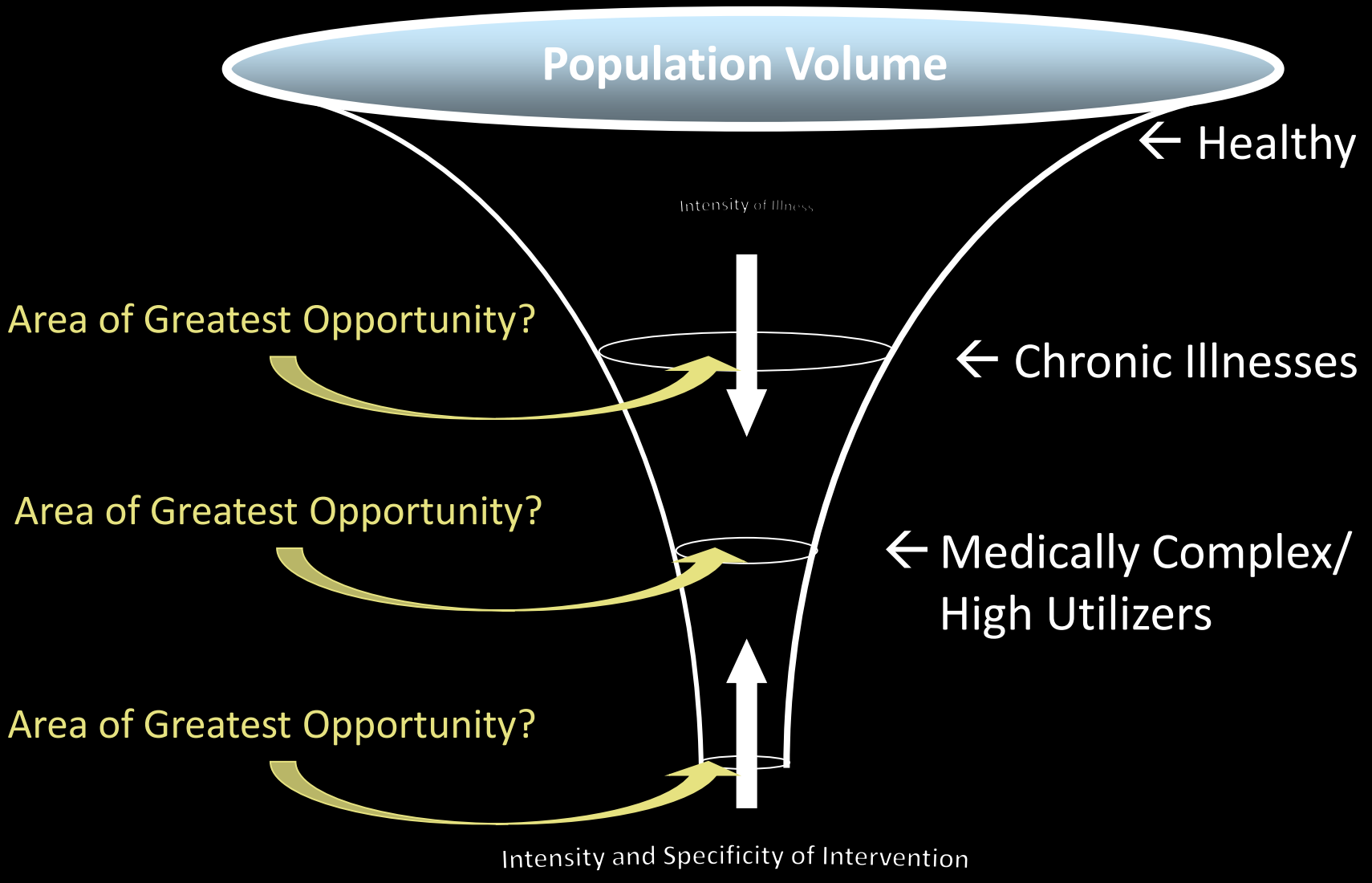
Challenges for CCM Programs: Drops in Potential



Goal of Patient Selection

- To align population, intervention, & outcomes
- Select a population at risk for future poor outcomes & costs for which planned CCM interventions can improve outcomes
- Key Challenges
  - Dynamic nature of risk
  - Lack of full picture
  - Care sensitivity is patient & program dependent

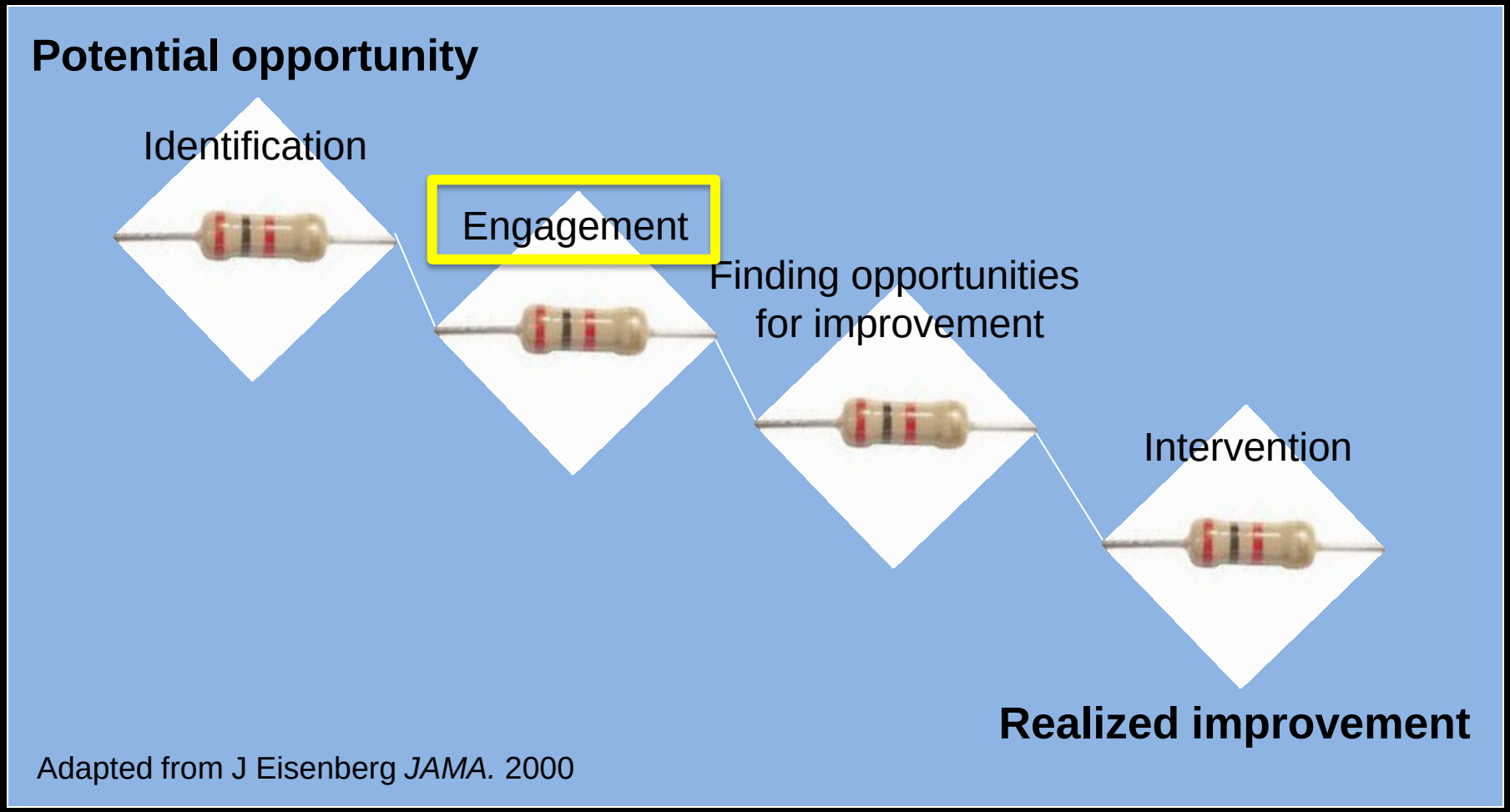
Effective Targeting of Care Management



Patient Selection Approaches

1. Quantitative
   - Applying risk prediction software to claims data
   - Acute care utilization focused
   - High risk condition focused
2. Qualitative
   - Referral – Physician/Staff or Patient
3. Hybrid approaches

Challenges for CCM Programs: Drops in Potential



Impact of Changes to Washington University Demo

EXHIBIT 3

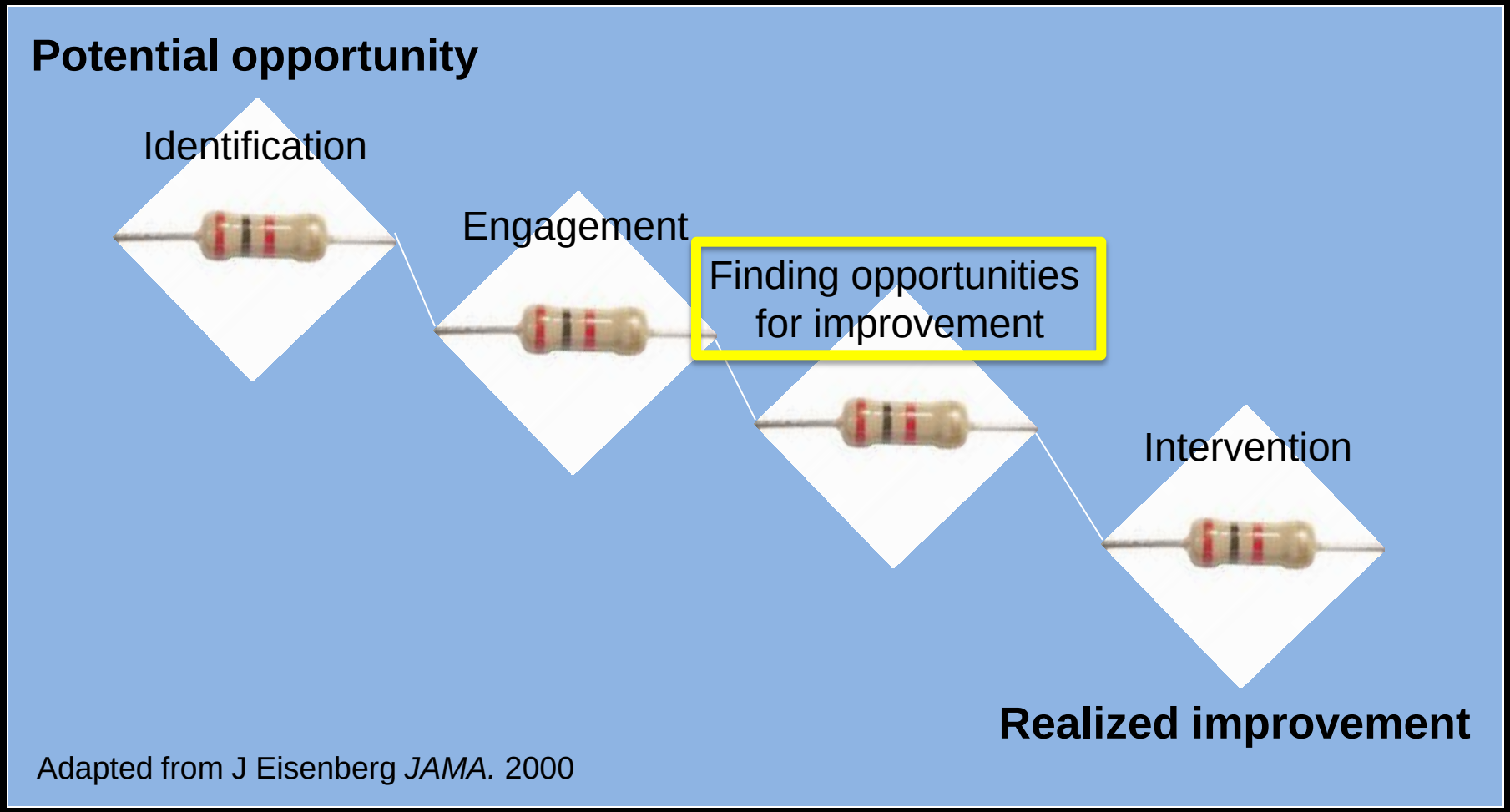
Impact Of The Washington University Care Management Demonstration On Medicare Spending, Before And After Program Redesign

	Average monthly care management fee paid[a] ($)	Expenditures[b] without care management fees ($)	Program impact, without fees		Program impact, with fees	
			Dollars	Percent	Dollars	Percent
All enrollees before redesign	167	1,917	69	3.6	236	12.3**
All enrollees after redesign	151	2,256	-217	-9.6*	-66	-2.9
Higher-risk enrollees[c] before redesign	165	2,443	36	1.5	201	8.2
Higher-risk enrollees[c] after redesign	149	2,933	-435	-14.8**	-286	-9.7*

Changes that led to ROI

- Telephonic -> Face-to-face – St. Louis based Care Managers
- Stronger Transitional Care & Medication management support
- Added Social Worker
- More comprehensive assessment & streamlined care plan process

Challenges for CCM Programs: Drops in Potential

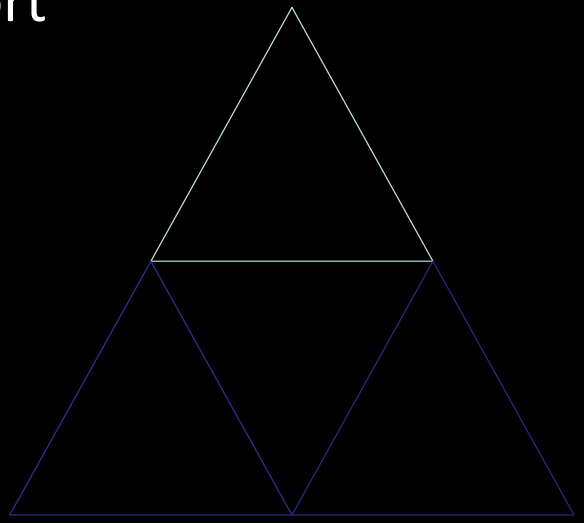


Scope of Work & Key Tasks

Central Task

- To build strong relationships with patients, primary care teams, hospitals/specialists & other community care partners

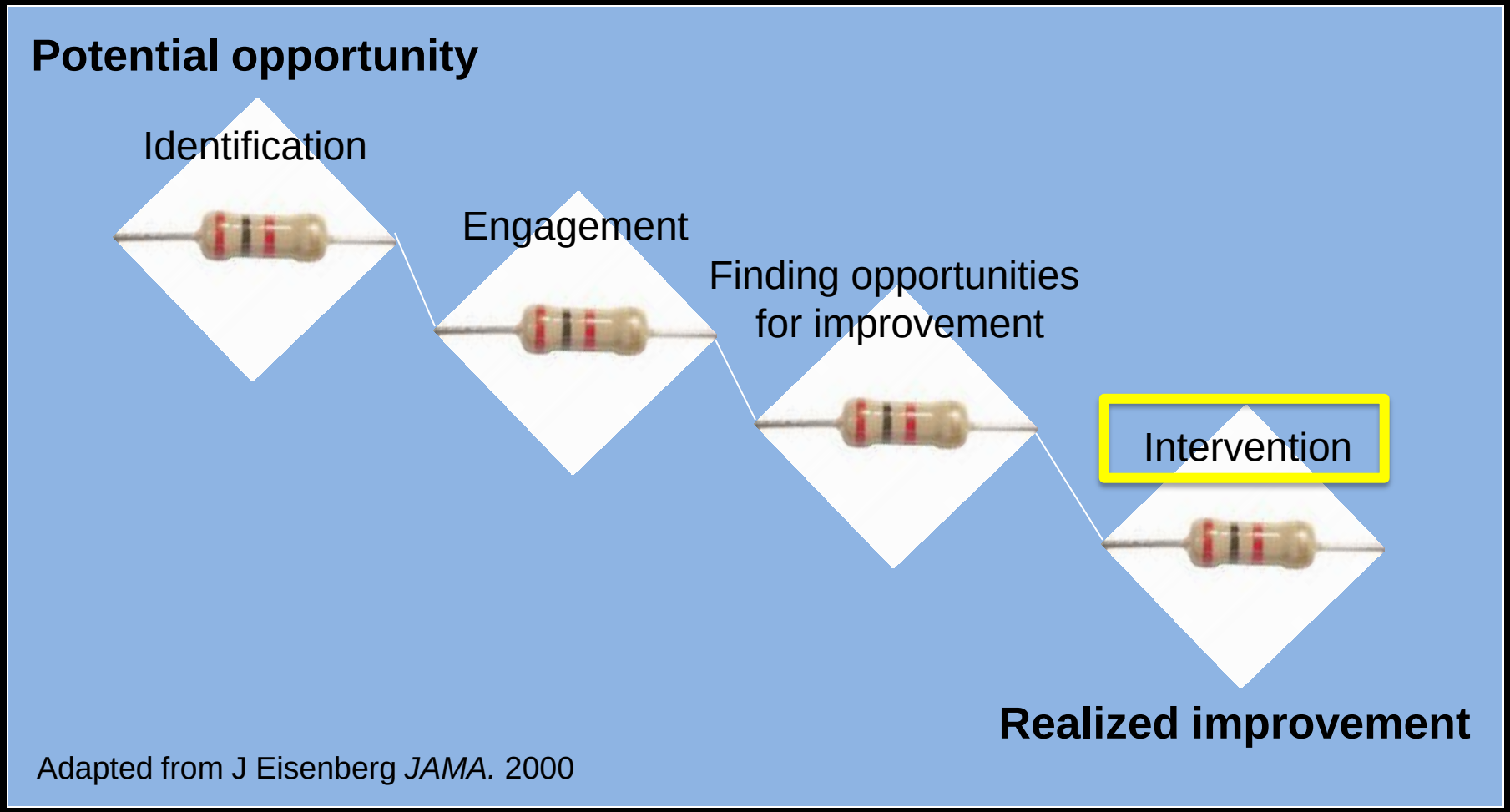
- Comprehensive assessment & creation of care plans
  - Address barriers to access/care & biopsychosocial needs
- Care coordination – focus on high-risk times
- Health coaching/self-management support
  - Medication management
- Advanced illness management support



Engaging Other Critical Partners

- Inpatient facilities/EDs/Skilled Nursing Facilities (SNF)
  - Coordinated transitions from hospital/ED/SNF to home
  - Breaking down communication & information silos
- Ties to Specialists
  - Seeking high value relationships
- Ties to community-based agencies
  - Close partnership with entities that can help between encounters

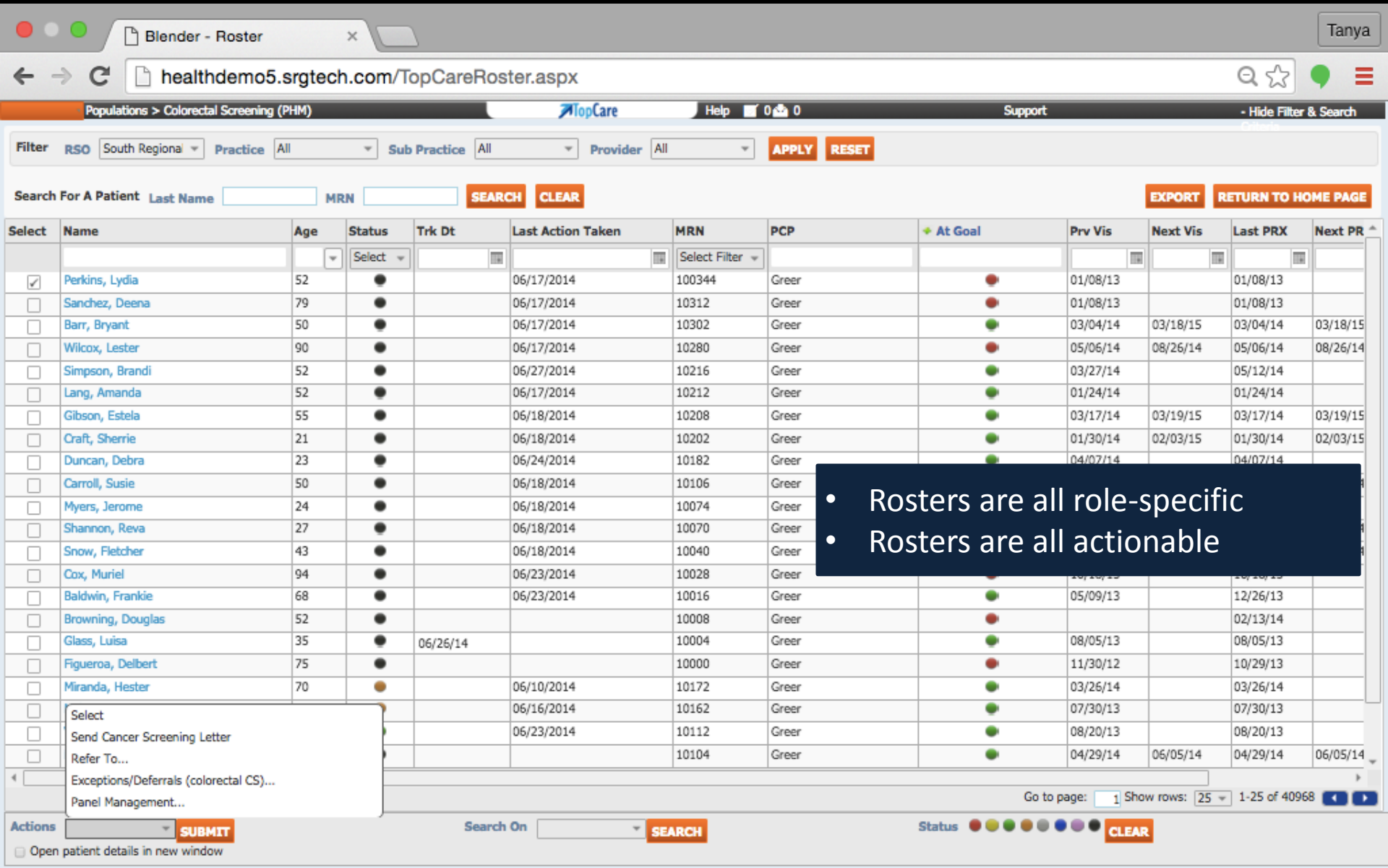
Challenges for CCM Programs: Drops in Potential



Continuous data-driven improvement & high-functioning Care Management IT tools important

- Design + Implementation = Effectiveness

- Care Management IT tools
  - Support operations, program management & quality improvement
  - Front end user interface enables team-based care delivery
  - Embedded, advanced analytics


Blender - Roster
Tanya
healthdemo5.srgtech.com/TopCareRoster.aspx
Populations > Colorectal Screening (PHM)
TopCare
Help
Support
- Hide Filter & Search
Filter
RSO
South Regiona
Practice
All
Sub Practice
All
Provider
All
APPLY
RESET
Search For A Patient
Last Name
MRN
SEARCH
CLEAR
EXPORT
RETURN TO HOME PAGE
Select
Name
Age
Status
Trk Dt
Last Action Taken
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PCP
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Perkins, Lydia 52 06/17/2014 100344 Greer 01/08/13 01/08/13
Sanchez, Deena 79 06/17/2014 10312 Greer 01/08/13 01/08/13
Barr, Bryant 50 06/17/2014 10302 Greer 03/04/14 03/18/15 03/04/14 03/18/15
Wilcox, Lester 90 06/17/2014 10280 Greer 05/06/14 08/26/14 05/06/14 08/26/14
Simpson, Brandi 52 06/27/2014 10216 Greer 03/27/14 05/12/14
Lang, Amanda 52 06/17/2014 10212 Greer 01/24/14 01/24/14
Gibson, Estela 55 06/18/2014 10208 Greer 03/17/14 03/19/15 03/17/14 03/19/15
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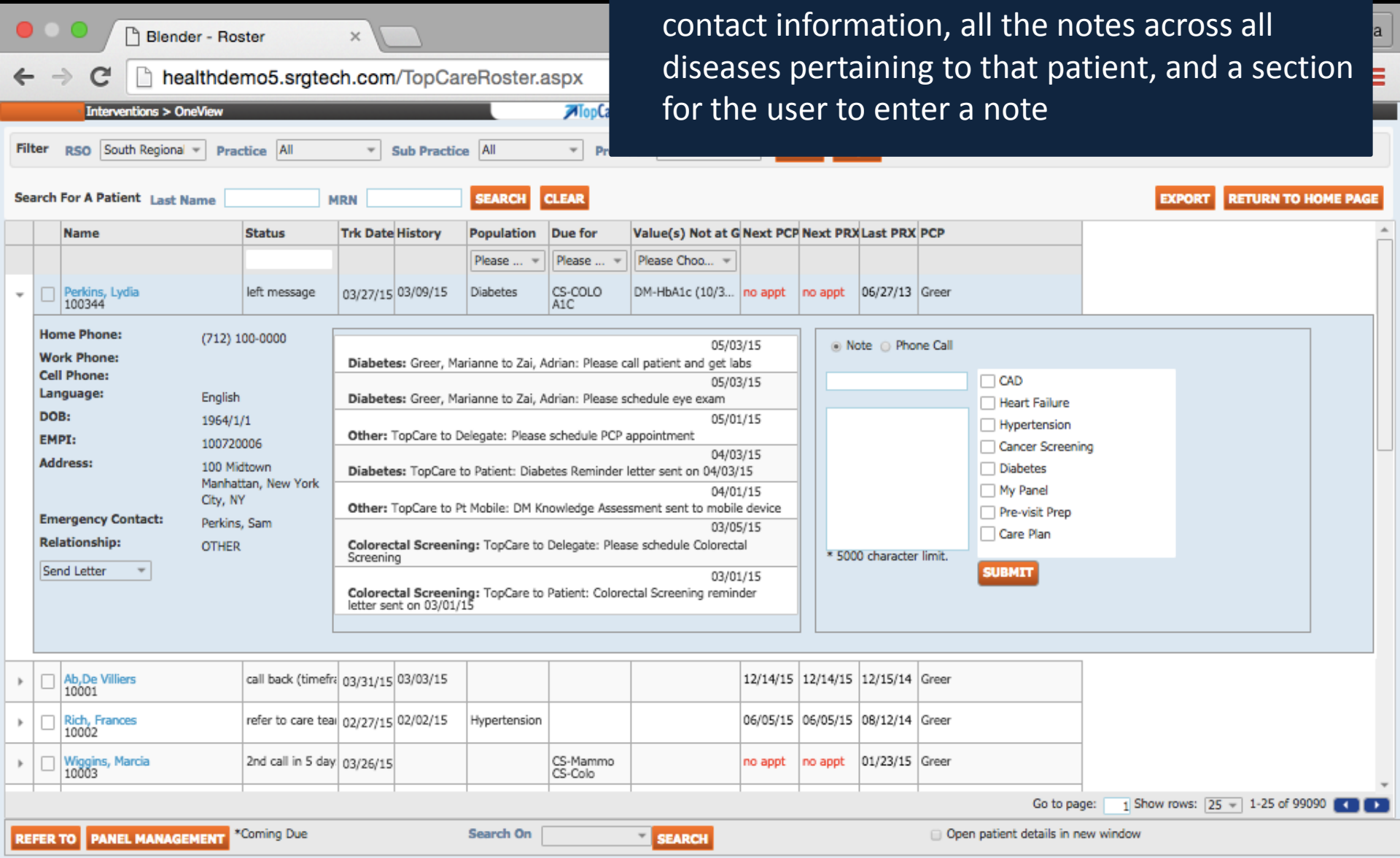
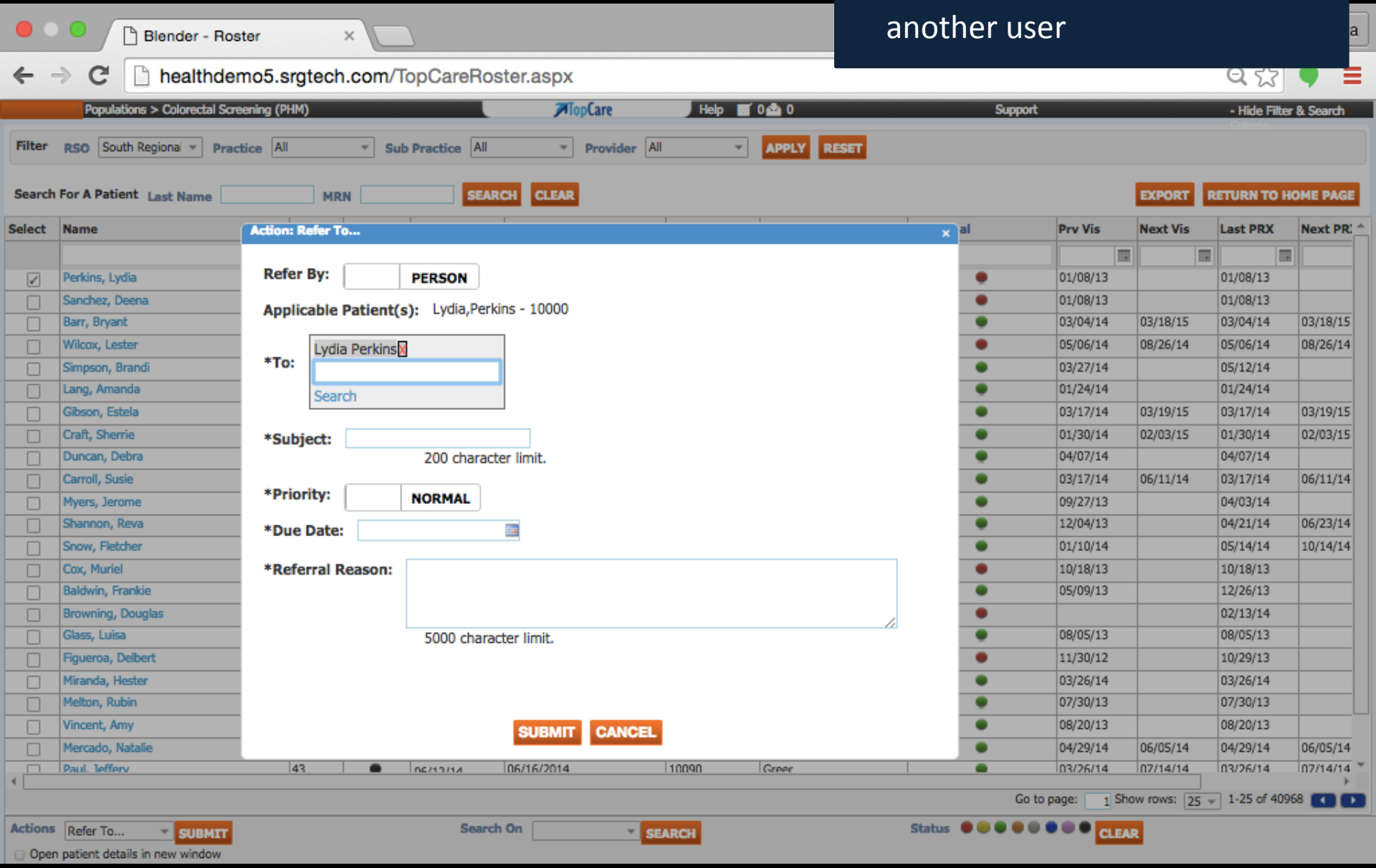
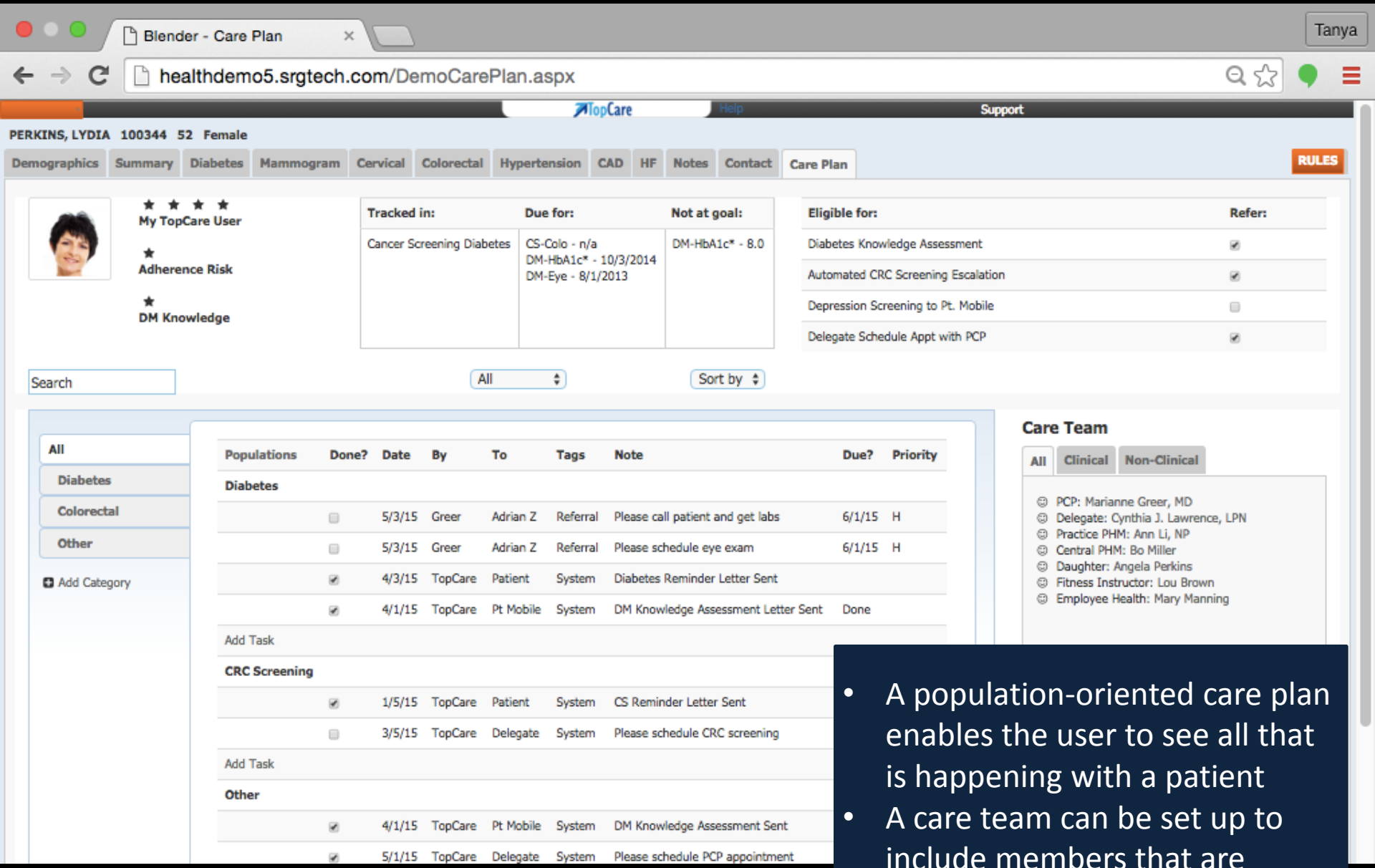
Duncan, Debra 23 06/24/2014 10182 Greer
Carroll, Susie 50 06/18/2014 10106 Greer
Myers, Jerome 24 06/18/2014 10074 Greer
Shannon, Reva 27 06/18/2014 10070 Greer
Snow, Fletcher 43 06/18/2014 10040 Greer
Cox, Muriel 94 06/23/2014 10028 Greer
Baldwin, Frankie 68 06/23/2014 10016 Greer 05/09/13 12/26/13
Browning, Douglas 52 10008 Greer 02/13/14
Glass, Luisa 35 06/26/14 10004 Greer 08/05/13 08/05/13
Figueroa, Delbert 75 10000 Greer 11/30/12 10/29/13
Miranda, Hester 70 06/10/2014 10172 Greer 03/26/14 03/26/14
06/16/2014 10162 Greer 07/30/13 07/30/13
06/23/2014 10112 Greer 08/20/13 08/20/13
10104 Greer 04/29/14 06/05/14 04/29/14 06/05/14
Select
Send Cancer Screening Letter
Refer To...
Exceptions/Deferrals (colorectal CS)...
Panel Management...
Go to page: 1 Show rows: 25 1-25 of 40968
Actions
SUBMIT
Search On
SEARCH
Status
CLEAR
Open patient details in new window
• Rosters are all role-specific
• Rosters are all actionable

- A row expands, and opens a pane displaying contact information, all the notes across all diseases pertaining to that patient, and a section for the user to enter a note



- A user can send a task to another user





- A population-oriented care plan enables the user to see all that is happening with a patient
- A care team can be set up to include members that are typically not part of a care team

Important concepts for program planning

- **Build strong relationships**

- No perfect model
  - Start with the best approach for the context/population
  - Then use continuous quality improvement to improve

Important concepts for program planning

- Keys to efficient complex care management
  - Work in multi-disciplinary teams
  - Complement existing services
  - Allocate resources to high-yield activities & high-risk patients at high-risk times
  - Focus on mutable issues (know your system's assets)
  - Use HIT/data integration to enhance CM efficiency

Outline

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What's needed for widespread adoption?

- Address Financial Barriers
  - Incentives to reduce unnecessary utilization & accelerate interoperable HIT development
    - Global Payment
    - Care management fees (at risk)
  - Up-front investment in CCM infrastructure & programs

What's Needed for widespread adoption?

- Address Organizational/Technical Barriers
  - Stronger primary care
  - Accelerate adoption of interoperable HIT
  - Multi-payer & multi-sector alignment to promote provider integration
  - Regional CM structures to help smaller/rural practices
  - Technical Assistance to address implementation challenges
  - Workforce development (professional & paraprofessional)

Thank you!
Questions?

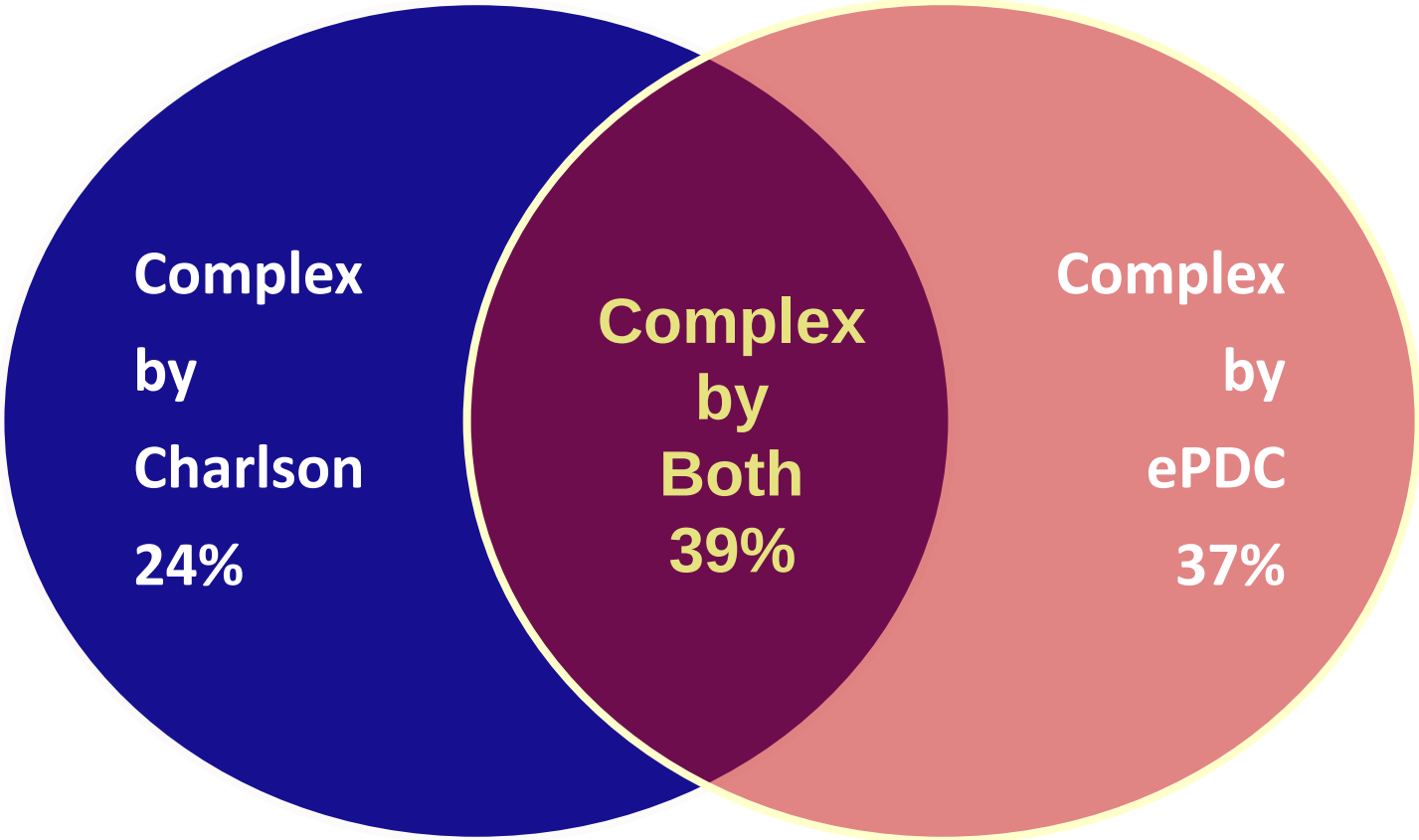
Contact:
chong@dhs.lacounty.gov
@Clemenshong

Patient engagement

- Connection to primary care
  - Face-to-face interaction
  - Longitudinal relationships
- Traits of team matters
- Motivational interviewing
  - Sell it to patients
  - Ensure early successes
- Mobile workforce & technology

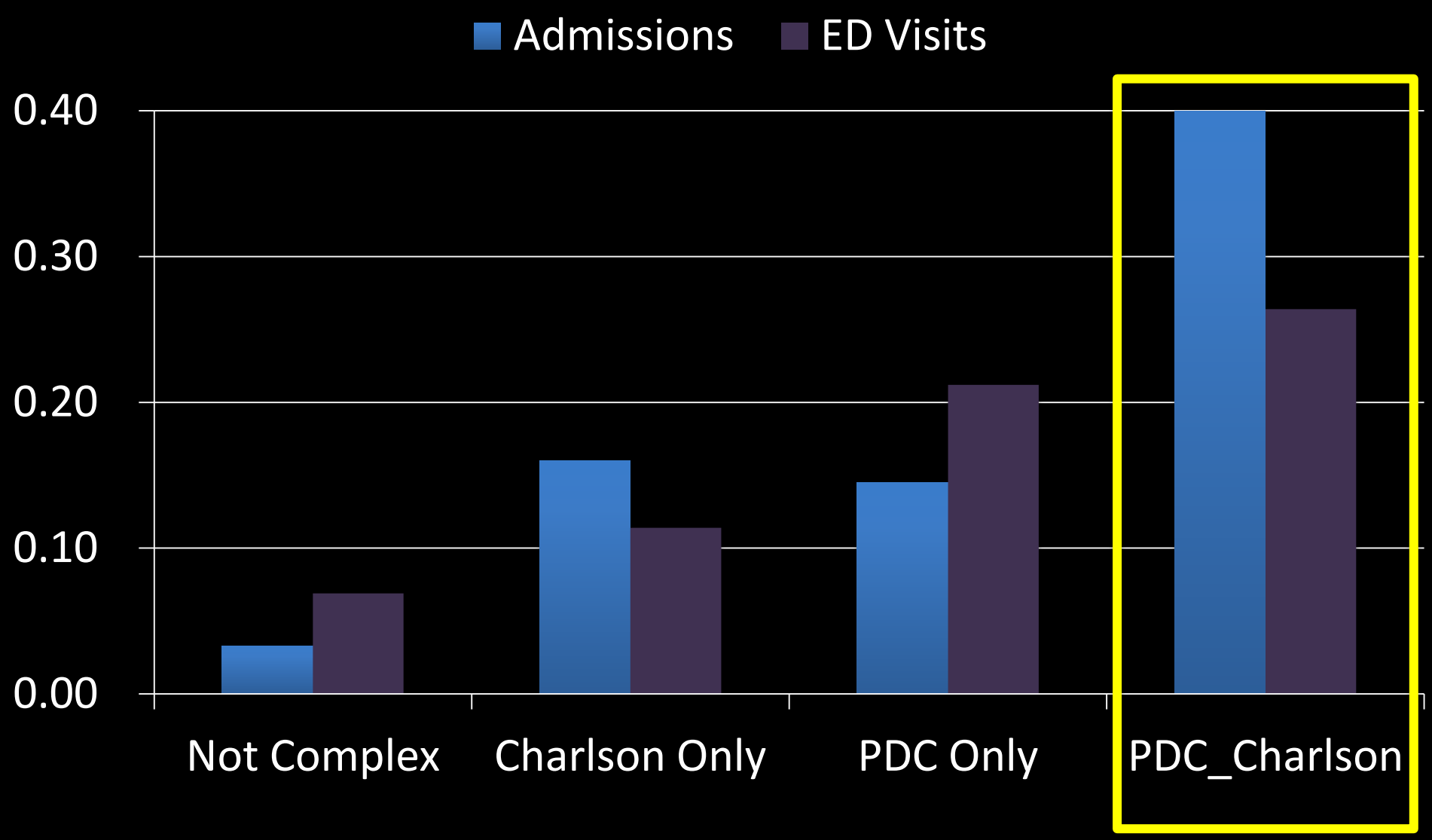
Making the right pitch to patients is important
Tailored approach at Camden 1. Reach out to patients during hospitalization or ED visit 2. Personalized introduction 3. Open-ended questions to identify patients' needs 4. Use understanding of needs to tailor presentation of services

Complexity defined by Charlson & estimated Physician-defined Complexity (ePDC)



Source: Hong CS JGIM 2015

Acute Care Utilization (per person year) Over 4 Years

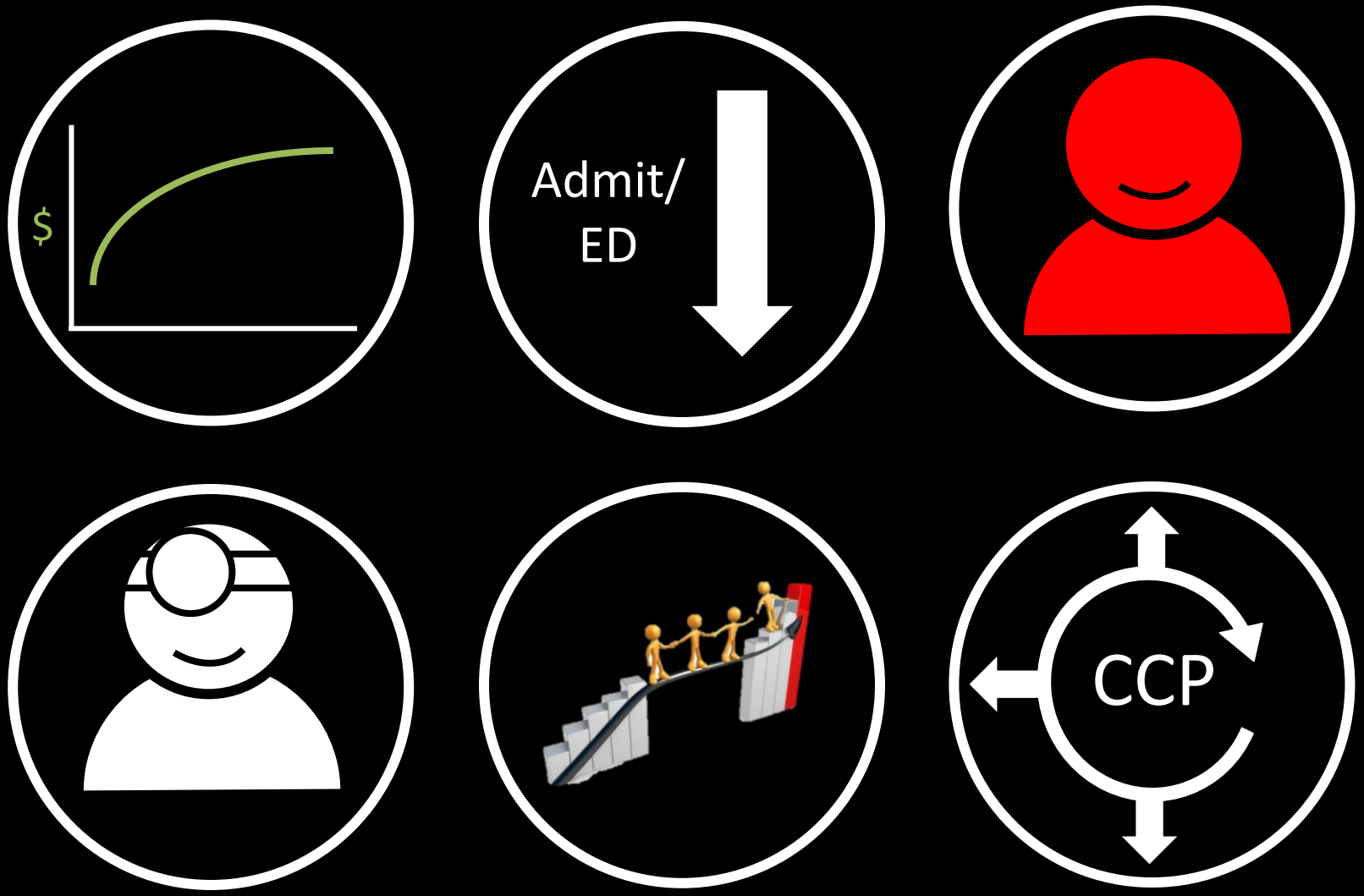


*All p-values <0.05

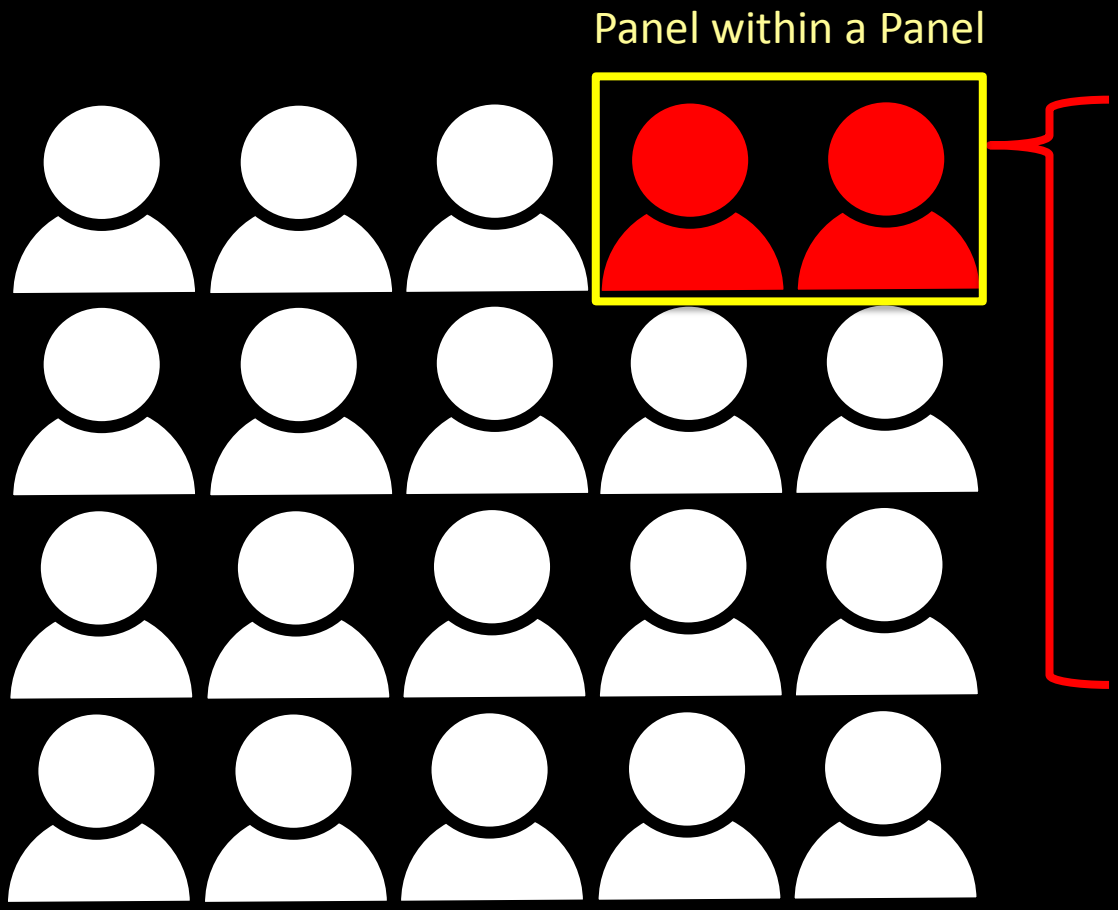
Source: Hong CS JGIM 2015

Los Angeles County
Department of Health Services
Care Connections Program

Care Connections Program (CCP) Aims



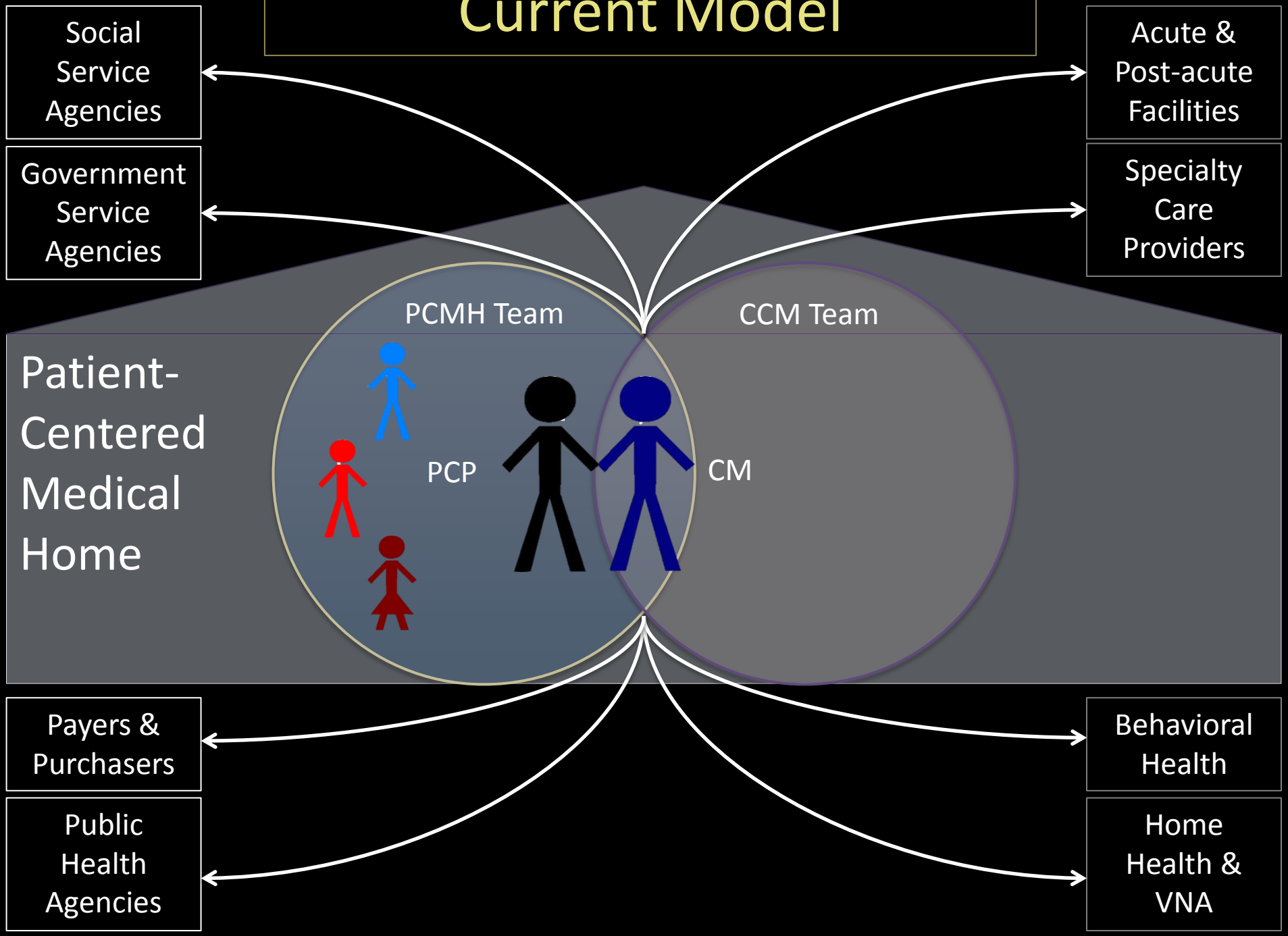
Serving ≈5% of LAC DHS's Patients



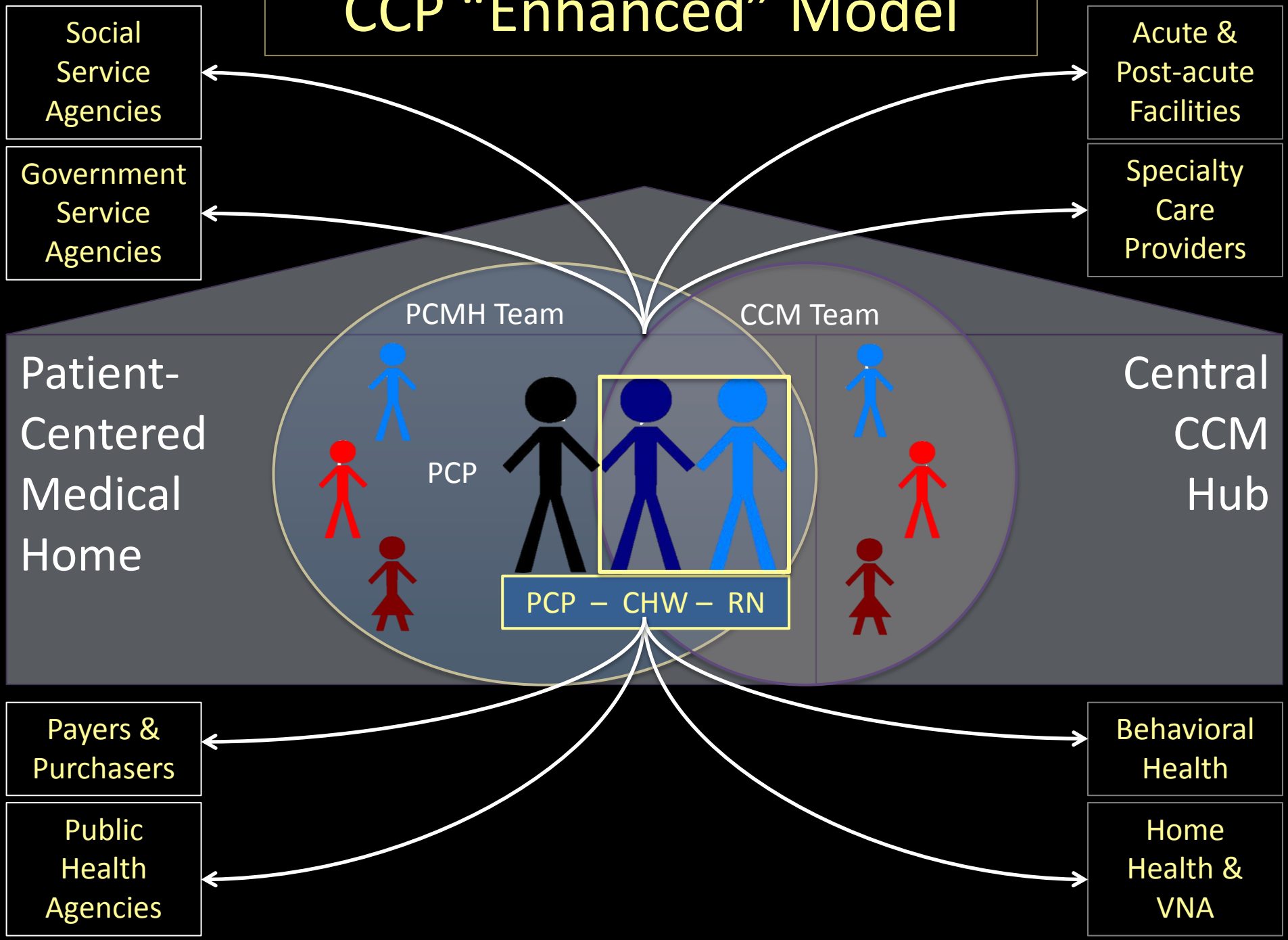
- Complex biopsychosocial needs
- Hard to engage
- High utilization of health care
- High cost of care

≈20,000 out of
400,000 primary care patients

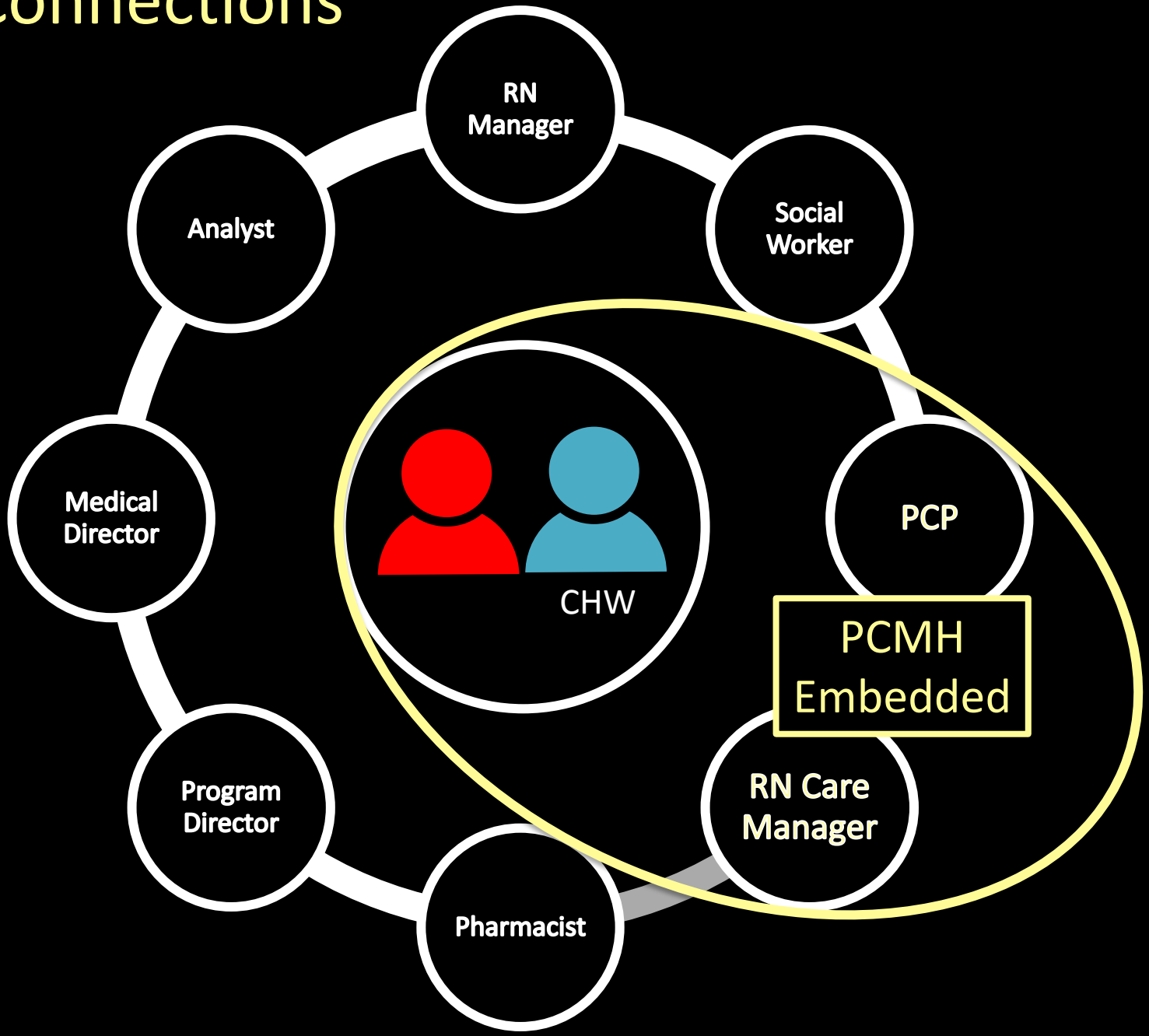
Current Model



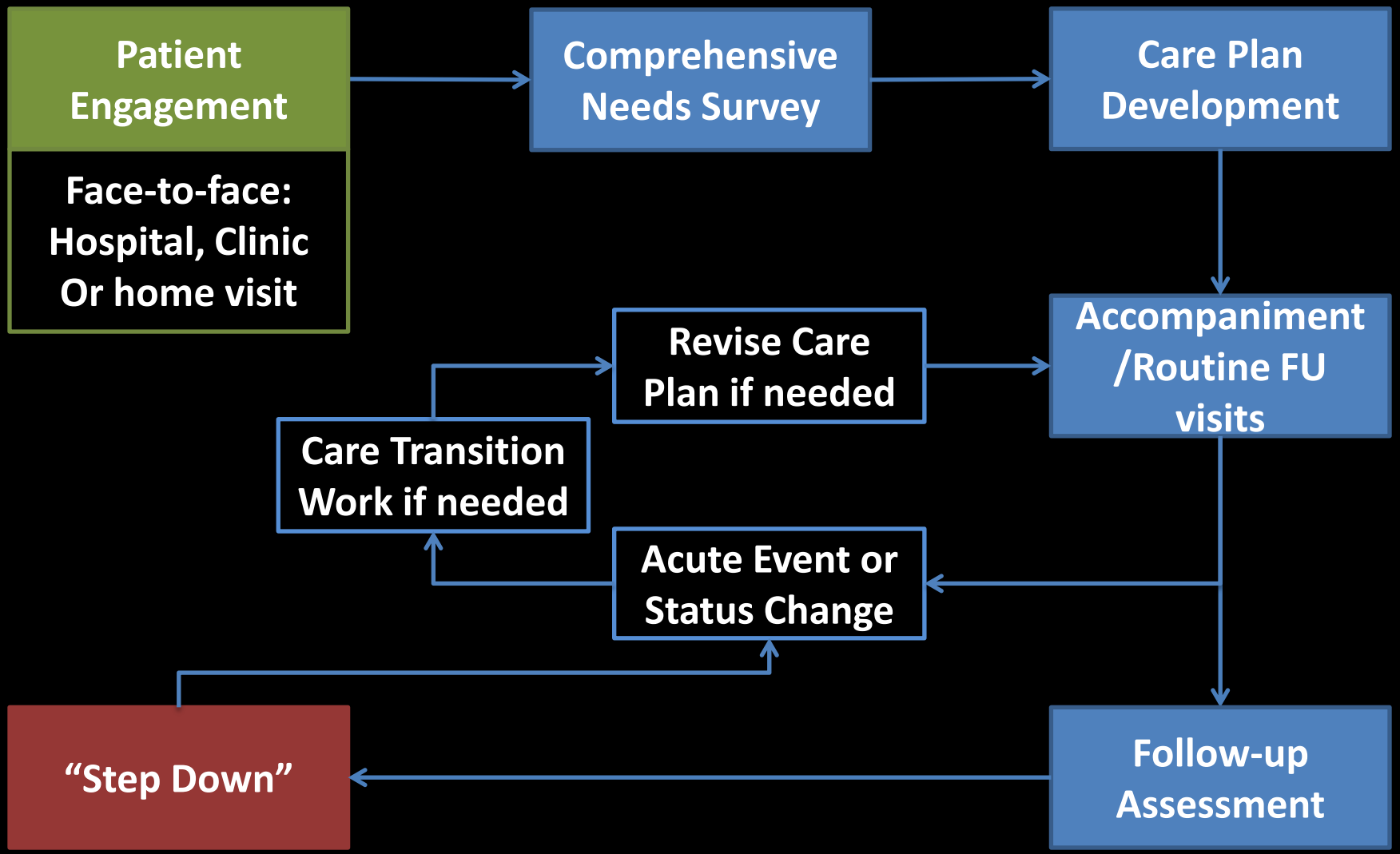
CCP "Enhanced" Model



Care Connections Team



CCP Program Overview



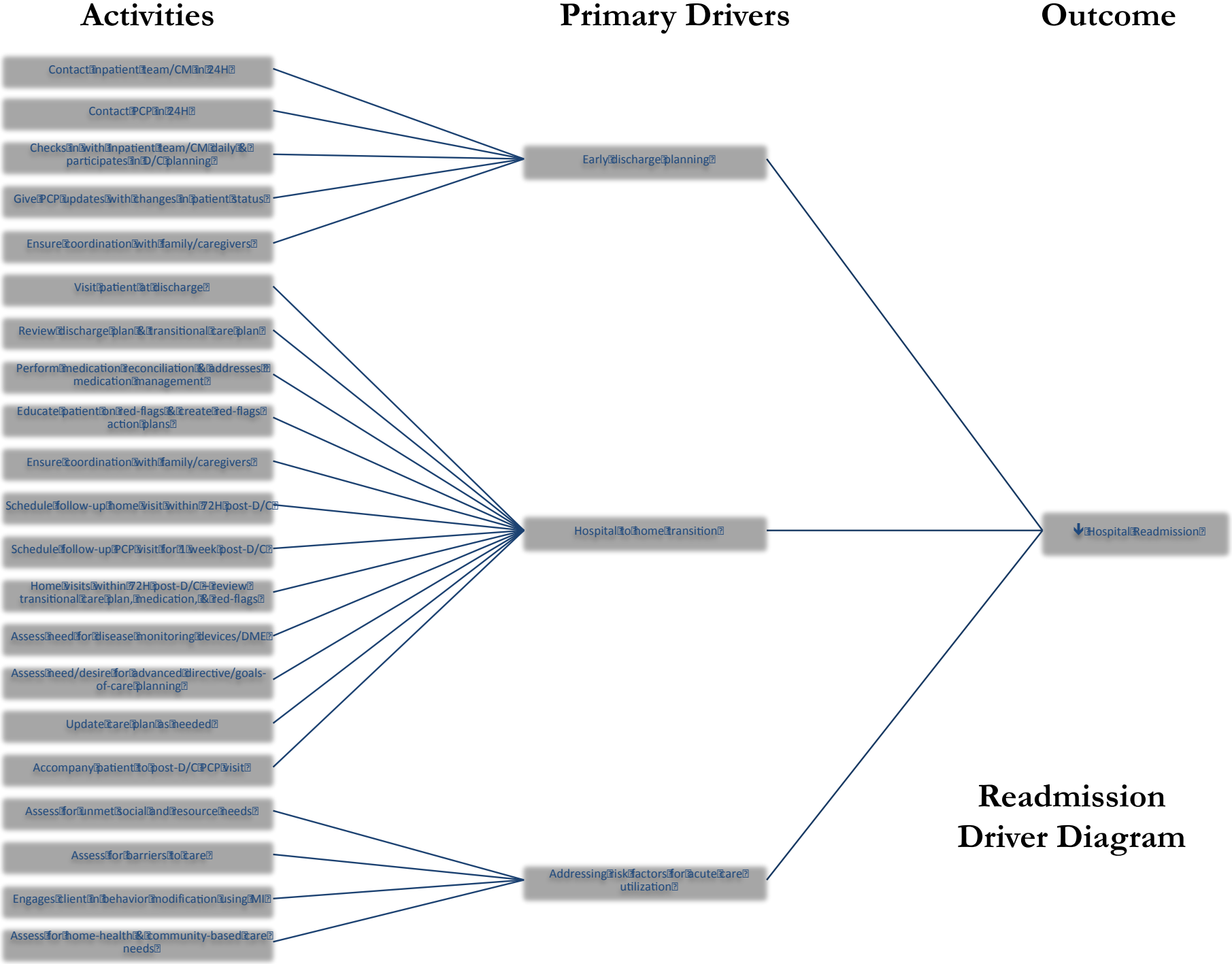
Patient Engagement

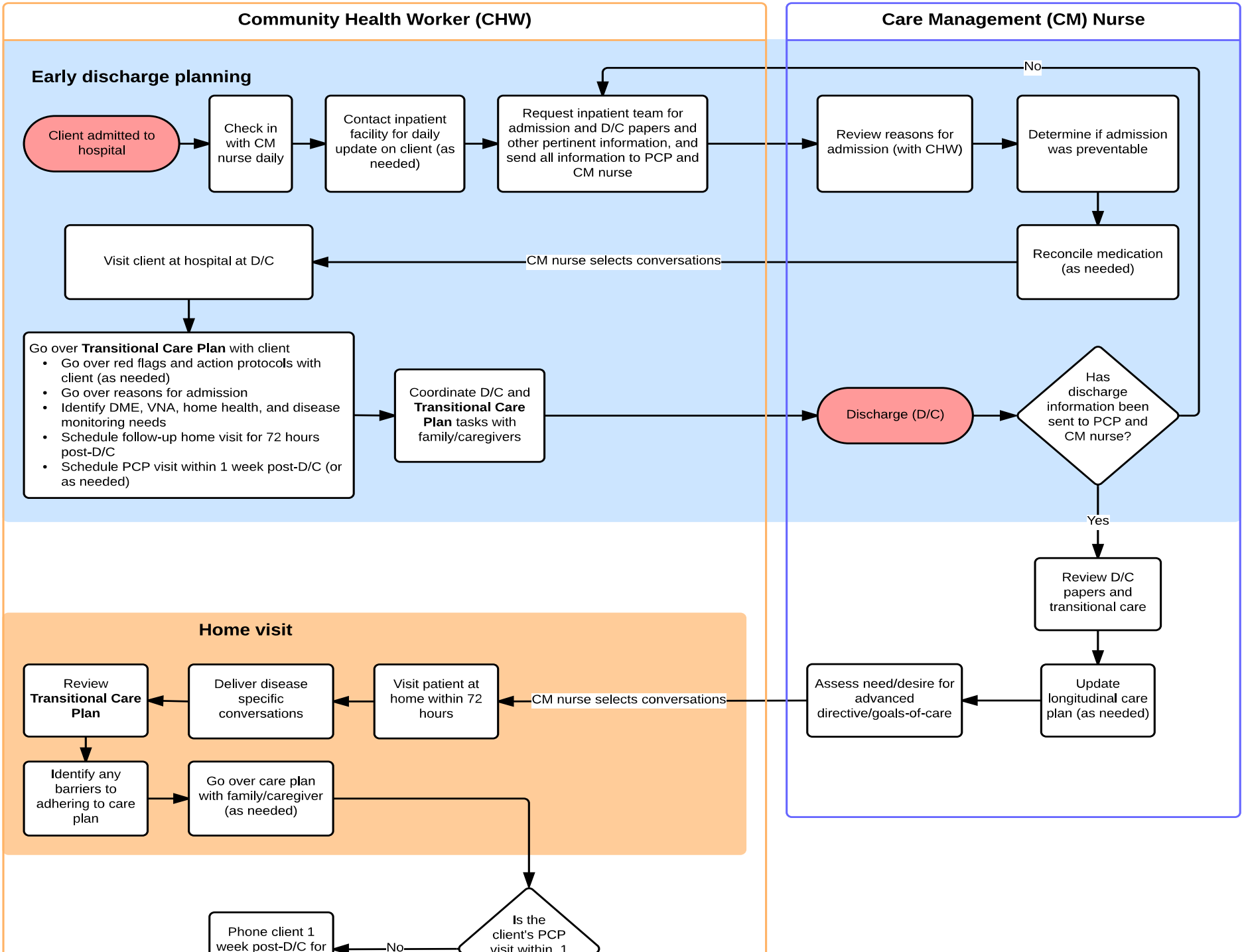
Social Support

Comprehensive Assessment & Care Planning

Health System Navigation

Care Transition Support


Activities
Primary Drivers
Outcome
Contact inpatient team/CM in 24H
Contact PCP in 24H
Checks in with inpatient team/CM daily & participates in D/C planning
Give PCP updates with changes in patient status
Ensure coordination with family/caregivers
Visit patient at discharge
Review discharge plan & transitional care plan
Perform medication reconciliation & addresses medication management
Educate patient on red-flags & create red-flags action plans
Ensure coordination with family/caregivers
Schedule follow-up home visit within 72H post-D/C
Schedule follow-up PCP visit for 1-2 week post-D/C
Home visits within 72H post-D/C - review transitional care plan, medication, & red-flags
Assess need for disease monitoring devices/DME
Assess need/desire for advanced directive/goals-of-care planning
Update care plan as needed
Accompany patient to post-D/C PCP visit
Assess for unmet social and resource needs
Assess for barriers to care
Engages client in behavior modification using MI
Assess for home-health & community-based care needs
Early discharge planning
Hospital to home transition
Addressing risk factors for acute care utilization
Hospital Readmission
Readmission
Driver Diagram


Community Health Worker (CHW)
Care Management (CM) Nurse
Early discharge planning
Client admitted to hospital
Check in with CM nurse daily
Contact inpatient facility for daily update on client (as needed)
Request inpatient team for admission and D/C papers and other pertinent information, and send all information to PCP and CM nurse
Review reasons for admission (with CHW)
Determine if admission was preventable
No
Reconcile medication (as needed)
CM nurse selects conversations
Visit client at hospital at D/C
Go over Transitional Care Plan with client
Go over red flags and action protocols with client (as needed)
Go over reasons for admission
Identify DME, VNA, home health, and disease monitoring needs
Schedule follow-up home visit for 72 hours post-D/C
Schedule PCP visit within 1 week post-D/C (or as needed)
Coordinate D/C and Transitional Care Plan tasks with family/caregivers
Discharge (D/C)
Has discharge information been sent to PCP and CM nurse?
Yes
Review D/C papers and transitional care
Update longitudinal care plan (as needed)
Assess need/desire for advanced directive/goals-of-care
CM nurse selects conversations
Home visit
Visit patient at home within 72 hours
Deliver disease specific conversations
Review Transitional Care Plan
Identify any barriers to adhering to care plan
Go over care plan with family/caregiver (as needed)
Is the client's PCP visit within 1
No
Phone client 1 week post-D/C for

Patient Engagement

Social Support

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Chronic Disease Support & Health Coaching

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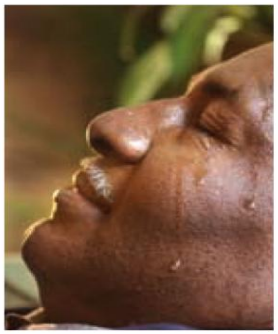
Care Transition Support

What to Do About Low Blood Sugar (Hypoglycemia)

Blood Sugar Reading 70 or below

Warning Signs

Dizziness



Sweating

Headache

Fainting

What to Do

1. Eat sugar.
Examples:

* Sugar tablets
* ½ cup fruit juice or regular soda
* 5-6 pieces hard candy
* 1 cookie
* 1 tablespoon of sugar or honey

2. Wait 15 minutes, then check your blood sugar again.
If it is still below 70, eat or drink something sugary again.

3. Wait 15 minutes, then check your blood sugar again.
If it is still below 70, drink more juice and go to the doctor or emergency room.

Patient Engagement

Social Support

Advanced Illness management support

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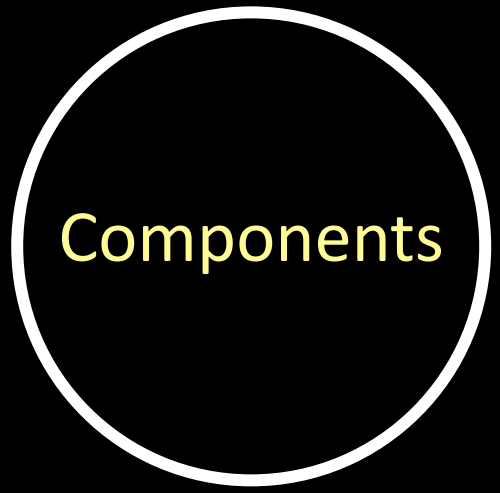
A Multi-faceted Program



Community Health Workers

Care Without Walls

Pharmacy Intervention

Community Engagement

Advanced Illness Management

Social Needs Navigation

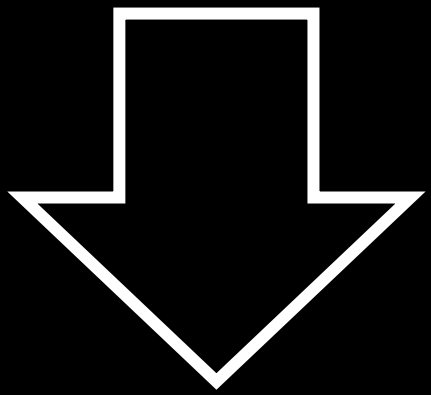
Data-driven Improvement

Care Transition & Acute Care Planning

Chronic Disease Management

Phase 1: Demonstration

March/April 2015 – March 2017	5 DHS primary care practices in South and East LA	Hire 25 CHWs	CHW training by WERC & Anansi Health	1,250 patients



Phase 2: Expansion

Up to 15X expansion possible

Apply lessons from Phase 1	Replicate model across LAC DHS

Challenges

- Poor baseline health system infrastructure
  - Data Integration & real-time data access
- Implementation
  - Front-line provider engagement & patient selection
  - Poor understanding of intervention & CHW role
  - Perception of program as “External”
  - Consistent delivery of intervention
- Culture “Clash”
  - Innovation vs “production engine”

Primary care integration

Co-location

Face-to-face interactions

Enhancing integration

Champions

Education on CM role/benefits

Data/ EMR Access

Early successes/Trust building

CHW Training/Supervision

- Training Topics
  - Motivational Interviewing/Harm Reduction/Trauma-Informed Care
  - Chronic disease self-management support – health coaching
  - Goal Setting/Care Planning
  - Program protocols – emergency, medication review
  - Disease specific topics
  - Other core competencies – boundary setting, safety
- CHW Supervision
  - Programmatic – CQI meetings, performance evaluation
  - Clinical – Weekly one-on-one, Monthly group, case conferences
- Clinical Support – Primary care team