



## Care Coordination in Medicare Advantage – A Panel Discussion

*Heather Kilbourne, CM*

*Donna Williamson, CM*

*Denise Kress, Tufts Health Plan*

*Aelaf Worku, CareMore Health Plan*

Stacey Plizga: Our next session features a panel discussion with representatives from CMS who will provide an overview of care coordination and how it supports the CMS Quality Strategy goals. Additionally, representatives from Tufts Health Plan and CareMore Health Plan will discuss the Collaborative Care Model and how it is executed.

It is my pleasure to introduce Heather Kilbourne and Donna Williamson from CMS, and Denise Kress from Tufts Health Plan and Dr. Worku from CareMore Health Plan.

[Applause]

Heather Kilbourne: Good afternoon, everybody. My name is Heather Kilbourne; and I want to thank you all for joining us, especially after lunch and after the break. We'll try to be as exciting as possible.

Today our main objectives of this presentation is first to do a quick care coordination definition/overview; and then we're going to go over the CMS 2016 Quality Strategy, walk through the mission and the goals; and we'll go over what care coordination means to Medicare Advantage. Then we'll get into the good stuff and have our panel discussion start with two presentations and a quick discussion first by Tufts Health Plan with

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Denise Kress, and then Dr. Worku from CareMore Health Plan has joined us. So let's go ahead and get started and quickly define care coordination.

This definition we chose today is from AHRQ, but it's widely recognized in the industry. Care coordination is the deliberate organization of patient care activities between two or more participants that includes the patient. It's involved in a patient's care to facilitate the appropriate delivery of healthcare. Care coordination is also organizing care that involves the marshalling of personnel and other resources needed to carry out all patient care activities. Finally, care coordination is often managed by the exchange of information among participants responsible for different aspects of care; and I just want to emphasize that this always includes the patient.

Finally, we'll talk about the 2016 Quality Strategy mission. I know it says 2016 because we're always operating either a year ahead or a year behind in the government, but this is also current. The CMS strategy goals are, one, to make care safer by reducing harm caused in the delivery of care; two, to strengthen person and family engagement as partners in their care; and, three, which is what we're really going to emphasize today, is the promotion of effective communication and care coordination; four, our goal is promote effective prevention in treatment of chronic diseases; five, we want to work with communities to promote best practices of healthy living; and finally, make care affordable.

With that, I will give it over to my colleague, Donna, to talk about Goal No. 3, which is the care coordination aspect.

Donna Williamson: Thank you, Heather.

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As you can see, there is some natural overlap in the quality strategy goals. I'd like to draw your attention though, as Heather mentioned, to CMS Quality Strategy Goal No. 3, which is promote effective communication and coordination of care.

The objectives for this include reducing hospital readmissions, embedding best practices to enable successful transition between all settings of care, and enabling effective navigation of the healthcare system. CMS aims to achieve these objectives by promoting increased care coordination across the healthcare continuum, promoting a person-centered approach to coordinating care, and recognizing the positive impact of critical or essential pieces of information communicated across all providers and settings of care.

In the Medicare Advantage Program, MA plans offering coordinated care plans must ensure continuity of care and integration of services; provide each enroll with a primary source of care; have methods and/or programs in place for coordinating plan services, including community and social services; and ensuring that the MAO, as well as their contracted providers, have the information necessary for effective and continuous patient care, along with the data to drive quality review and quality improvement.

So what does it take to achieve effective care coordination? What is the right mix of activities or strategies within your organization?

We are extremely honored and very fortunate today to have Tufts Health Plan and CareMore Health Plan with us here to discuss their practices for care coordination. I want to thank both of you for traveling to the Baltimore area today and taking time out of your busy schedules. With that, I will hand the presentation over to our panel speakers.

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Denise Kress: Thank you very much; I appreciate the invitation to be here. My name is Denise Kress. I'm a geriatric nurse practitioner, and I've worked with Tufts Health Plan for 17 years. During that time, I've seen a lot of change in Medicare Advantage. I actually started with a physician practice when Medicare Advantage first came to the Boston area in 1994 and I think, like everybody, have continued to see evolution of that model.

The Tufts Health Plan is a large organization that has over a million members. We have commercial; we have public plans; and we have a Medicare Division. I'm going to focus today on the Medicare Advantage Plan. Within that, we have an HMO and we have what we call in Massachusetts a SCO, which is a FIDE SNP that specializes in the over-65 population of dual eligibles.

The first thing that we want to really talk about is the Collaborative Care Model. This is the very essence of what it is that we're trying to do...is to deliver the best care at the highest quality for the best outcomes for our members. Part of that Collaborative Care Model is really working in collaboration with the PCPs. In our particular model in our plan, the majority of our physicians share risk; and we find that having that aligned incentive really helps for everyone to be on the same page, focused on again member outcomes and quality, as well as a positive member experience.

The way that we focus first is like looking at population health. We have a standardized care model that goes across our entire network, and then we have a predictive model to look at not only who the highest risk members are but what we call rising risk...the people that have chronic conditions that we want to proactively identify and manage so that we can mitigate some of their risk factors.

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Some of the things when we look at that, that focus is really on being able to have members and their caregivers have the skills they need to be able to self-manage, as well as proactively identifying and managing geriatric conditions. I think everyone focuses on diseases, and we're trying to get away from disease focus because it's not often, in my experience as a clinician, that heart failure or their injection fraction is the thing that's going to make the difference on their success in staying the community and their personal goals for care.

Instead, it might be the social determinants; it might be depression, anxiety, cognition changes, functional changes. Those are the things that are really most important. So what we really do is make sure that we're on top of all those things and we're constantly screening for them. Part of that screening is also -- and the way we work with the physicians is to not only have the care managers screen for those conditions, but we actually then help the physician groups by providing tools for them so they know how to manage some of these geriatric conditions.

You might say, "Well, what are you doing that for? Don't all the physicians know how to manage these things?"

Like nurses, physicians in the same way...we were never really taught geriatrics. It just wasn't a specialty back then with Florence Nightingale. But I think that it's a specialty, just like pediatrics is. So we want to make sure that people understand the nuances of care for the older adult population. So we do things like there are geriatric evaluation and management tools that we access through the American Geriatric Society, which are really nice, standardized approaches to what things need to be done for people, say, that might have a cognitive change. It really goes through all the different steps and is evidence-based. So those are some of the tools that we use to bring out to the physicians.

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We also collaborate with them in the fact that we have medical directors meeting. So for each pod or group, they have a Medical Director that is assigned that is kind of responsible for the Medicare Advantage Program. We have a monthly medical directors meeting, either by webinar or in person; and we go over a variety of different things. A very small amount is really administrative; the rest of it is really clinical and quality. From feedback surveys that we've gotten from the physicians, those are the things they value the most...that we get into the specifics of care.

I was sharing with my colleague the idea that we had the Conversation Project which is, for those of you that aren't as familiar with it, Ellen Goodman is kind of the face of that. But it's really about getting people to have conversations about their care and what they want out of life that's meaningful. So we've actually had sessions with the medical directors on those conversations because you can't expect people to have conversations with patients unless they've kind of dealt with their own feelings about those things. So that's an example of how we engage the physicians.

The other thing that we do is have referral networks that we've identified, and we look at – we may be contracted with a lot of different providers in the SNF world, VNA, other types of providers, but we try and narrow that network; and the physician groups and pods may identify places or agencies that they're used to working with, but then we give them the data to look at those agencies' or providers' outcomes...like readmission rates and cost and utilization, efficiency. Then we also kind of grade them on their collaboration efforts. Are they willing to sit with us and really look at why did that person get readmitted? We all need to look at that as a failure of a community plan. It's nothing personal, but we need to figure it out.

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So that's just kind of an overview of how the physicians and the care kind of come together. I think that the critical success factors that we look at – I talked a little bit about predictive identification and intervention. But I think that many of us still have challenges in the predictive model because most predictive modes are claims-based. Without function and cognition and other types of information, like social determinants, we're really not getting all of the information that are often the drivers of cost and utilization in this population.

So I think that's a constant thing that we need to work on to improve...a multidisciplinary team that really is focused on *the* most complex members. So within our multidisciplinary team, we have our end care managers; we have care coordinators, some of which were kind of trying out the navigator role, that might be a lay person; advanced practice nurses with different specialties; a clinical pharmacist and a pharmacy tech to backstop that clinical pharmacist; a social worker, some that are social workers and others that focus more on behavioral health.

We have dementia care coordinators. We were one of the first health plans to partner with the Alzheimer's Association in Massachusetts and New Hampshire to kind of co-locate dementia care coordinators that actually work with our care managers. So when we identify people that have had changes with cognition or family caregivers that are stressing out that these care coordinators are able to intervene and help the families and members develop plans. Some of it is future planning; some of it is actual, like "what can you do now to manage a specific problem." We also have a geriatrician as part of that team.

As I mentioned, we try and integrate the chronic disease and geriatric management. We don't have separate silo disease management programs; instead, we treat people across and make those member-centric goals and really figure out what's going on with them. One of the



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questions that we'd like to ask the most is: What means the most to you? What is most important to you, and then let's try and figure out how to get it. You're not going to have a COPD patient change their smoking or their exercise or any of those things unless they have a reason to do so...so really trying to figure out what's important and then kind of move them along that road.

Effective transition obviously is key...for people that once they go into the hospital system, getting them back out to the community and trying to fill all those gaps and handoffs. We have transition programs that assist that member. So the care manager works across all those different settings, working with either a hospital case manager – we actually have "rounders" we call them in our skilled nursing facilities. So we'll have identified our designated physicians and advanced practice nurses that are working with care managers to help the member and the family, make sure that we're setting functional goals – not Olympus Day, just a functional goal. What is it that person needs to attain so that we know that they're going to be successful in the next level, and then move them to the home care or skilled services and community services. We talked about the referral circle and really look at data, and then a lot of different types of interventions to avoid ER hospital admissions, et cetera.

One of the most important things though I think is having metrics and constantly using that for performance management, whether that's at the group level or the provider level, and then being able to look at how that is playing out across a population and then bringing it down to a specific member level.

Then when we think about who is this population from a population segmentation viewpoint, we have what we call the "well older adult," somebody who has very little utilization. They don't really have chronic diseases; but it's about wellness and really focusing on getting that



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person to their annual wellness exam and putting a health plan in place, so to speak, a member action plan for what's important to them and how can they stay healthy. This is the population where want to really be able to see how we can better leverage technology. We haven't done a lot of that; but I think now that the population that's aging is more used to technology, we want to really have more proactive outreach so that it's a real-time access for that person that's looking for the information instead of having a nurse call them.

The other thing we've heard from older adults that are aging in is that they would like a source of truth besides Dr. Google and really be able to, if there were resources that were on the health plan site, that they would come and use that and feel more secure than the other ways that they're currently accessing information.

The next population is the low-risk that have some chronic illness. I think our focus here is really we try and leverage community-based programs, like the community CDSM (Chronic Disease Self-Management) Programs that are either in-person or telephonic and other community-based programs that might be in their area at hospitals or the local senior centers. This is where, again, we focus on fall prevention, even incontinence, brain health...all those kinds of things to make sure that people are healthy. Then we also try and see what we can do with brown-bag medication kinds of things so that we can work with that person to address their poly pharmacy and hope some deprescribing.

The next population is the high-risk chronic illness. These are people that not only do they have a chronic illness, but they have a functional or cognitive impairment in addition to that issue; or they may have some health disparities that need to be identified and addressed. These are people that we do a lot more assessment, and it's more of a continuous process that we go through. We do an in-depth assessment. Sometimes

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we use the comprehensive health assessments that are done by MPs, and then we work to develop a plan of care for that member; and, more importantly it's not our plan of care but a member action plan. What is it that's important to that member? What is it they want to work on? Then we give them that to support their needs.

Some of the things that the specialty team does is we actually have a geriatric consult team that is also available to our internal team, but the member and their family. This is an advanced practice nurse, behavioral health, geriatrician, pharmacist, dementia care coordinator...any combination of people that can work together. The nurse practitioner usually does an assessment in the member's home, sometimes in combination with the care manager; and then comes back and works with the multidisciplinary group to come up with a plan.

We did this for a group last fall and identified a number of members who were being followed by their PCP; but because of their incredibly complex needs, they're not being met in a 15-minute office visit. It's not possible. Also, there's something about somebody that's that complex in their own home environment, it's a different dynamic; and you start finding out all different things that you can really start to address...a lot of social determinants, a lot of medication issues. So that we found was a very, very helpful thing.

The other thing about geriatric consult team though is you need to make sure that there's a way to close the loop...because you can make the recommendations back to the PCP, but you have somebody make sure that somebody is really acting on those recommendations. Otherwise, you had a nice meeting; you came up with great ideas, but they're not going to be executed fully. Then the member and their family are going to be disappointed and left still kind of at their wits end of what to do.

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The other piece that we really do is close collaboration with the VNAs and skilled nursing facilities. So not only do we have a preferred network, but we set expectations; and we almost have service level agreements with them about how we collaborate. We tried to take out all of the administrative burden of a prior off, on visits, all that sort of stuff; that is just an administrative nightmare for everyone. Instead, it's like you go do the assessment; let's have a conversation and make sure we're all on the same page about what the issues are; and then you tell me how many visits that's going to take to do, and we have a continuous conversation. But in the end, what we know is this is the end result that this member or their caregiver needs; and that's what we need to work on and to get to.

The next population is the frail/complex. So all these things we're doing – and we kind of just keep adding on the things. This is the population where we probably spend the most time and effort. Our care managers are not insurance care managers, which kind of have a bad name. It's like going to the dark side when you first move to an insurance company to have a job because people say, "Oh, you're not a real nurse anymore."

But actually our care managers go to the house. They're in the practices with the physicians. So if somebody is coming in for a conversation, they may meet with a member prior to the time they spend with the PCP or follow up after. Specifically, things like advanced illness, schools for care...really understanding what the conversation was that just happened or making sure that the member still thinks about what is it I need to ask the doctor? What is that one thing that I want to make sure I walk out of this visit with? So we do that in, as I said, home visits for this really complex group of patients.

We also use a team approach. We have used facetime to do virtual med reviews. It's actually kind of cool because the members like it. Some of the members put lipstick on and fix their hair because like they were on

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TV talking to the pharmacist and going through their meds. So they're engaging well. I don't mean to say that in a derogatory way. They just were really engaged in that process of going through their meds and very open to the suggestions that were being made, and then the pharmacist followed up with the PCP and got the changes put in place.

I think I mentioned the advanced illness structure. We're doing a lot with our care managers to educate them on the basics about having the conversations and goals for care, but we're doing a lot with the work from (inaudible) and advanced illness projects specifically on the advanced illness conversations, and really training the care managers and other providers on how to have the serious illness conversations and the fact that these things need to be revisited every time somebody has a hospitalization or a change in condition. I think that what we're finding is that the people that are invested in this find it extremely rewarding.

We're also then building in the business diversity part. So we're doing a lot of work on unconscious bias and really trying to get people to understand cultural and ethnic diversity in all of these types of issues.

The last slide is really about the functions that go across the population so that we manage the members across all levels of care...so acute inpatient, whether they're at the community hospital or not, skilled nursing, and also long-term care facilities. Many of our long-term members that transition into long-term care, we have nurse practitioners and physicians that manage those members and try and, again, constantly assess them to preemptively try and get access to Part B services or other things so that they won't lose function, that we're making sure that they're not having weight loss...all those kinds of things...and, again, talking to them and their caregivers about their needs and how they may continue to change.

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I talked about the specialized clinical programs and some member-centric capabilities that we continue to look at, about same-day appointment availability, annual help risk assessments, and comprehensive health assessments and how we can leverage that. But I think that we're really looking at a little bit more technology to see how we can engage more people.

Donna Williamson: Great, thank you so much, Denise.

Next, Dr. Worku.

Aelaf Worku: Thanks for having me. I am the Regional Medical Officer for CareMore Health System in Nevada. That basically means I am the medical leader for the community for the plan, and we're located in Las Vegas at this time...so at Clark County, but largely Las Vegas. We're another MA plan. We were founded in 1993, so we're coming up on 25 years in terms of managed care delivery in general. We've expanded from being just in Southern California to several states, as well as cities.

We primarily started in the Medicare Advantage space; but in the last few years, we've also started dabbling in Medicaid Managed Care. We even have something called "Health Essentials," where we collaborate with institutions – for instance, Emory in Atlanta, Georgia -- and actually instruct kind of like-minded health systems in some of the components of the CareMore system and care delivery, which we're going to go into next.

As was alluded to earlier, what is a challenge in care delivery?

There are a lot; but in the scheme of things, you have a primary care office and it's really, really challenging, particularly when people with chronic disease...as mentioned, 15 minutes...15 minutes of getting

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someone in, getting them relaxed and taking their blood pressure, decloaking them, doing a physical exam, doing your history, making sure you do any med refills. That doesn't leave much time in terms of teaching, instruction, root cause evaluation of what their chronic disease causes are and what are their barriers to care delivery as recognized early on.

Moving out from the PCPs office instead to the CareMore Care Centers, the CCCs, which is the middle figure, that is where the secret sauce is; or that's where the magic happens. So what that is a collection of several agents that are involved in interdisciplinary care. You have the physicians that saw a patient in a hospital and potentially in a rehab facility, also see them in this space where they address post discharge needs.

As many of the PCPs in the audience or people that work with PCPs know, there's a big disconnect between what happens in the hospital and what happens outside of the hospital. There's a lot of information that's really hard to track down, to be accurate. If you're that primary care provider and you're trying to reconcile all this information, it will take you a long time; and you still may not get all the nuances. Whereas if it's the provider that saw you in the hospital, that is a lot easier...much, much easier because you know the trajectory of the patient. You're comfortable with the trajectory of their recovery from their acute illness, as well as any of the issues that came up that might be potential barriers. Once they're stabilized, you discharge them from the care center home.

So the philosophy behind that is we think it reduces readmissions to the hospital. We think it actually kind of tucks patients in before they're discharged back to their PCPs. But that's not all, because that's revolved around physicians; and for some of you familiar with the hospital medicine literature, you'll be aware that physicians – all these hospital medicine

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docs – spend on average roughly what, 10% of their time, 15% of their time, directly with patients. Nurses spend three to four times as much time with the patients. So you know that the contact with the patient still isn't that much; and so the time for teaching is also very limited.

So what we also offer in those care centers are nurse practitioners that actually are instructed in chronic disease management programs. They're versed in it. They manage it extremely well, extremely efficiently. They have up to 45 minutes with these patients, can identify the challenges to care delivery, identify maybe some educational deficits, technique issues, COPD. I mean, a significant percentage, not a majority, but well over 20% of COPD exacerbations are attributable just too bad need with inhalation alone, right? So you actually take that time, where you have a medical assistant actually teaching you how to use your inhalation device properly, that's a simple intervention, right? It doesn't cost a lot, but it makes a difference; and that's not something that's typically done in your primary care office.

A third essential element in those comprehensive – I keep saying comprehensive care centers because that's where I trained, University of Chicago, so forgive me for the slip of the tongue. But what makes the CareMore Care Centers really successful in my eyes is also the training of the medical assistant staffs who actually – we call them clinical partners because they're involved more than the average medical assistant. They give you a lot of leverage in terms of connecting with patients. They actually know our patients better than the nurse practitioners and the physicians...a lot of time on the phone with them, a lot of labor-intensive conversations, a lot of reinforcement.

I come from a background of research. I've certainly dabbled in research and big data analysis. A lot of care delivery is really local, is really granular; it's just labor-intensive. And so these care centers are that



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space in which that granularity occurs and is allowed to occur. So our philosophy is you do what you do well outside the hospital; but kind of the position between the PCP and the hospital, that intermediate space, that's where the care centers get involved, where we have specialists that see patients as needed and are well-integrated into the rest of the care delivery team. Our case managers are located in those facilities, and it's essentially how the care model succeeds; and we're going to go a little bit into the details.

In terms of delivering quality and lower costs, again, it's an interdisciplinary team. You have the extensivists. You may or may not have heard of this term before. It essentially means extensive hospitalist. So you see the patient in the hospital; you see them in the SNF, if they need it; you see them in the care center afterwards. So you see them in three different settings. That longitude in the relationship is actually understatedly important...developing that trust with caregivers, developing that rapport and communication with patients.

Why it works...I think we all would have theories about that; but it just allows for a more organic connection and for things to come up in terms of identifying barriers or exacerbates of chronic diseases. The nurse practitioners aforementioned, who are instructed in our chronic disease models and have much more time for communication; the specialists as aforementioned – cardiologists, pulmonologists, podiatrists even – because as some of you may know in the chronic disease models, between diabetes, CHF, hypertension, wounds are a big deal and wounds of the feet in particular are a big deal. It's a no-brainer to have podiatrists involved in care in the care centers.

Case management – again, intermingled in there, they see post-discharge patients. They make sure to address needs...not just calling people at discharge and making sure they get ahold of them. But once

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we actually get them in the care center, reemphasizing their availability, what are the DME needs, what are the other identified barriers at home. Dietitians as well because we know a lot of our chronic diseases are exacerbated by not having appropriate dietary involvement. Even something – whether it's cancer, COPD, obviously diabetes and CHF, but even lesser-thought-about processes really benefit from a dietitian, as well as pharmacists at the aforementioned medicine reconciliations.

I can't emphasize enough how challenging appropriate intake of medications is. We know the literature about CHF exacerbations and poor adherence to medications. When you're dealing with people with multiple comorbidities, they just can't get it right sometimes; and they need that reinforcement and assessment of what are the causes of admission. So that space I was talking about earlier...that CCC, that CareMore Care Center...we have 64 programs in all – all free.

So when you think about Medicare Advantage, one of the things that comes up is how many people choose it and are actually low-income. A significant percentage of them are low-income, and they're looking for value-added services with no additional costs. And me being based in Vegas, sometimes I feel like I'm overwhelmed by the buffet mentality. People want to pay one thing and just get everything; and this, in a lot of ways, meets the needs of our members.

As far as the hospital outcomes, how it works well is, again, we have our own in-house case management and our interaction with the PCPs both at admissions and discharge and these intensivists as physicians, again, hospitalists that kind of longitudinally follow the patient throughout their care delivery experience.

So the reason I came to CareMore, the first thing I saw that struck me was the engagement of case management. We've all had our

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interactions with case management in hospitals; they try really hard, but these are just faces to them. They churn through so many people. To have case managers who are not only involved with the logistical details of needs in the outpatient setting but really know the patients, know their families, that makes a difference; and that's part of the secret sauce that we all here are trying to pursue.

In terms of the results, what it results in – and when you're comparing to average Medicare Advantage data: fewer readmissions, shorter length of stay, lower bed days, and a much lower return to acute statistic.

In terms of using skilled nursing facilities, it's the same basic team in terms of the intensivists and the case managers trying to coordinate their needs. We do the disease management program in an extended fashion because when you're in a rehab facility, you don't have the nurse practitioners there typically. There are some exceptions in the CareMore model, but we try to continue it in the outpatient spectrum, outpatient basis, but in the SNF. We all have had patients who are challenged in terms of even when you give them instructions, they don't quite get it; and you need to observe them in a different setting that is not quite the acute care setting to address the logistics and underlying barriers.

Our data is relatively robust compared to the Medicare average, in terms of length of stay and bed days. We do have slightly more admissions. Why?

If you think about it, a patient is in the hospital for antibiotics; and they're just getting antibiotics hung every so often...six hours, eight hours, maybe once a day. The acuity of those patients doesn't necessarily justify them being in the hospital. By having intensivists that are actually very good about following patients longitudinally, you can actually take those lower acuity diagnoses and you can shift them out to a more cost-effective

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setting. It is not something that we do lightly; by no means are we putting money in front of patients. But I can't tell you how many patients are bored to tears in the hospital and feel neglected and don't feel their needs being addressed traditionally. And they can get the equivalent amount of care in an additional setting, and that's something that allows for Medicare Advantage to be more sustainable.

In terms of effective diabetes management, again, it revolves the same teams. We do some things that I actually think are pretty cool...besides doing our point-of-care testing in clinic, demonstration of insulin injection techniques/adjustments, and self-care education, we even do the digital retinal exams in the care centers themselves. Remember I told you about those medical assistants we call clinical partners? This is part of the job description. They shoot the images; we use telemedicine, and we send those images over to ophthalmologists to interpret for us. So it's kind of one-stop shopping; and it has allowed us to really be more comprehensive in our care for our diabetic members. Our threshold is an A1C of 9; and in terms of our data, we have many people with better control, particularly those as high as 9. Even for the people that we've engaged who are below 9, we go back and forth. We save this program for people who have uncontrolled diabetes or diabetes at large; we've shown better outcomes across the spectrum.

Our protocol with respect to diabetes is important, and I'm going to highlight it for one reason. We are largely a SNF-driven program at CareMore; 50% of our members are in a SNF of some sort. Diabetics in my market make up nearly one-third of all our members. So it's not like we're risk-pooling, taking a bunch of healthy people and using it to cover everybody else; we have to get it right the first time. So when you're talking about how we approach it, besides those studies I mentioned that we do in-house, we have a lot of roust protocols for both HEDUS

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measure adherence and care delivery and education that help us achieve those better outcomes.

In terms of other elements, there is better blood pressure control, cholesterol control, and aforementioned eye exams that we actually have more done. I have to say that 10% is for CareMore wide. In my market in Clark, we're actually leading the way; and we're actually approaching 40% more exams done, just by virtue of like really well-trained clinical partners and collaboration with our local vendor.

A couple of other programs I want to mention...one is our congestive heart failure weight program. We use remote monitoring. We've talked about this in 2017; we should actually start applying some of these things. We know weight gain is a helpful way of detecting who is in acute heart failure. So we have monitoring devices...basically a scale with a remote setup. In my market, unfortunately, there's a significant indigent population...a lot of people who don't necessarily have Internet at home. We have a way set up for them to not have to actually pay for it and still be able to transmit this information.

They get contacted; it's 24/7, called, notified of a patient, what's going on, doing an evaluation of what might be exacerbating the congestive heart failure episode, and refer them to our Care Centers where they get a free transport to get their needs addressed. It has shown robust data in terms of hospital bed days, admissions, and readmissions.

Our COPD Program...again, same thing...driven largely through our nurse practitioners, dietitians. Not mentioned here are the clinical partners. The medication management is essential. COPD is challenging.

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One plug I will put in that we didn't really address – we kind of hinted at – is there are behavioral health components. I know that was a question earlier from this audience. In terms of integrating behavioral health, we know with certain diseases – in particular, CHF, coronary artery disease, history of strokes, COPD – there are depression/anxiety elements associated with that that lead to exacerbation. It's the medication management, as well as screening for other things, that help us succeed in addition to offering our smoking cessation class. Our results, as demonstrated, result in fewer hospital bed days and few admissions.

A quick story related to this was the second thing that struck me about CareMore when I was on my interview trail, for those of us who have had COPD patients, we know it's the top five killer in the United States. People last on average five to seven years when they have a frank diagnosis, and I was seeing people living 18 years with COPD. At first I questioned whether that was actually possible; and you realized that the level of engagement and early monitoring and addressing of symptoms and reduction of risk factors actually allowed them to succeed...striking but true.

The last program I want to mention is our End-Stage Renal Disease Program. This is largely focused out of Southern California, where out of our 1,800 end-stage renal patients 1,600 are. But we have nurse practitioners; dedicated case managers; we have an in-house nephrologist; even to dialysis access line inspection and cleaning. It's pretty thorough. In terms of how it's allowed us to address end-stage renal disease: fewer admissions, fewer hospital days, even progression. We're revising our data now because our last flash in terms of progression to end-stage renal is a little bit outdated; but even in terms of length to progressing to Stage 5 to Stage 3 is prolonged in our program, largely because of this responsiveness of our plan.

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Long story short...CareMore indulges in labor-intensive elements of care delivery that allow for improved outcomes.

Stacey Plizga: Thank you to our panelist speakers for providing an understanding of care coordination and sharing your experiences with the model. Thank you.

[Applause]

Stacey Plizga: If you would like to evaluate the session, go ahead and select "A," follow the links.

We do have our last session coming up before the open Q&A Session that we will host at the very end of the day, where we will bring up the speakers from all of the sessions throughout the day to answer any questions that are still outstanding.