ACO Accelerated Development Learning Session

Baltimore, MD
November 17–18, 2011

Module 2A: Care Delivery—Coordinating Care and Managing High-Risk, High-Cost Beneficiaries

November 17, 2011
3:45–5:45 p.m.

Barbara Spivak, MD, President
Mount Auburn Cambridge Independent Practice Association, Inc. (MACIPA)

Mount Auburn Cambridge IPA (MACIPA)

- Founded in 1985 to organize physicians and negotiate managed care contracts
- 513 physician members who admit to Mount Auburn Hospital or Cambridge Health Alliance
- MACIPA takes full risk capitation from three major local health plans since the mid-1990s
  - Blue Cross Blue Shield of MA
  - Tufts Health Plan and Tufts Medicare Preferred
  - Harvard Pilgrim Health Care
- 48 employees
- 40,000 capitated lives

Case Management

- In the book *Epidemic of Care,*[1] Kaiser Permanente CEO George Halvorson and coauthor George Isham showed how the use of health care resources is distributed among a health plan's members
  - The least expensive 70% of patients account for 10% of the expenditures
  - The most expensive 1% of patients account for 30% of expenditures

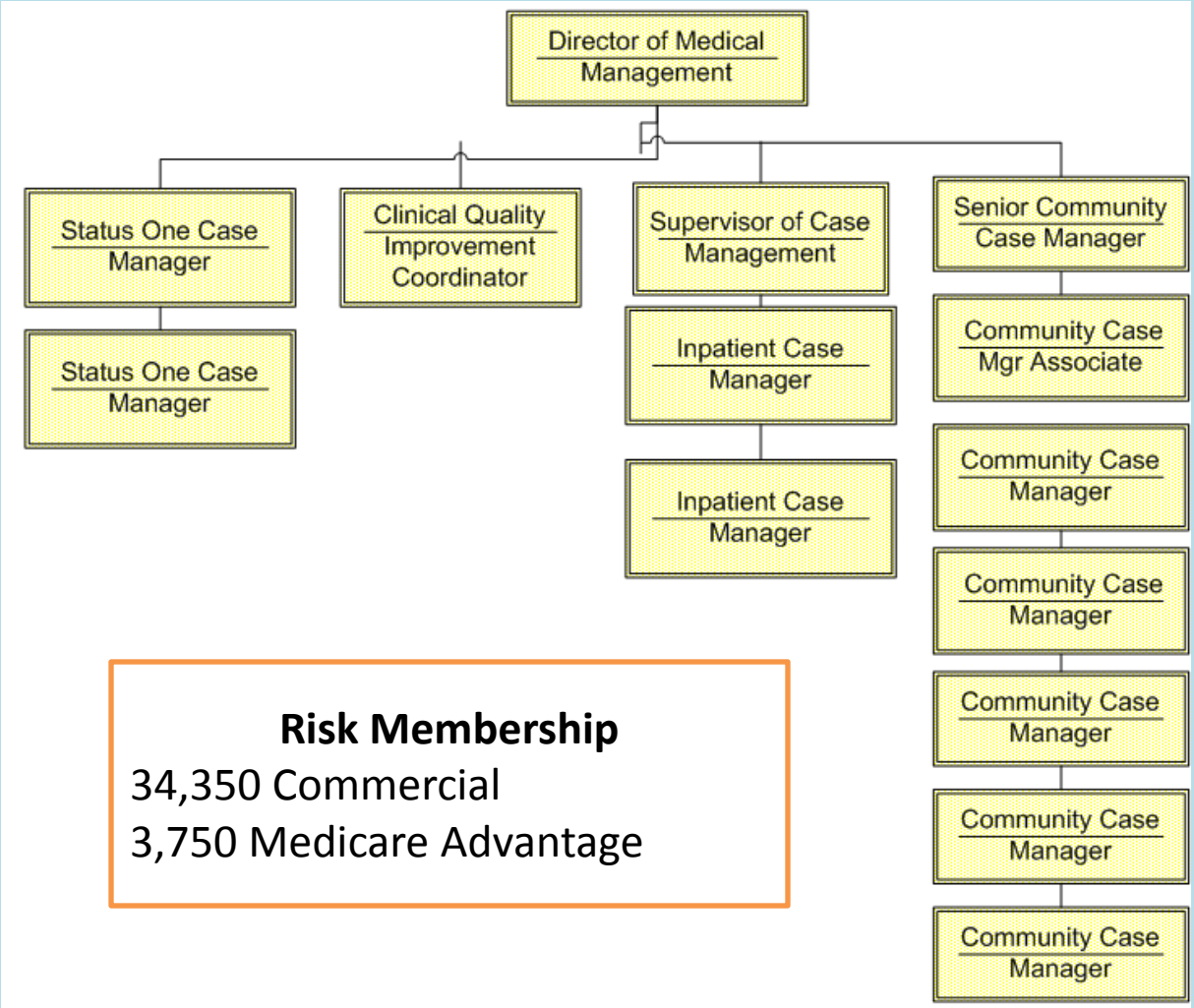
[1] Halvorson, G.C., and G.J. Isham. 2003. *Epidemic of Care: A Call for Safer, Better, and More Accountable Health Care*. San Francisco: Jossey-Bass.

Case Management

- Clearly, two different approaches are needed for managing the care of these two groups of patients
  - For the least expensive group, the health care system must deliver rapid and convenient access to care whenever and wherever it is wanted.
  - For the 1% of patients in the most expensive category, the health care system must efficiently deliver the care that is predictably needed and must successfully coordinate care when the unpredictable occurs.
  - This approach to care may be described as a disease management process, in which case management plays an important role. The impact of disease management on the health care system should be to use medical resources more efficiently and to eliminate expenses that do not produce positive clinical results.

Crooks, P. 2005. "Managing High-Risk, High-Cost Patients: The Southern California Kaiser Permanente Experience in the Medicare ESRD Demonstration Project." *The Permanente Journal* 9(2).

MACIPA
Case Management Department



Risk Membership

34,350 Commercial

3,750 Medicare Advantage

MACIPA
Case Management Department

- Staff 13.5 FTE
  - Director Case Management
  - Supervisor Case Management
  - Case Management Associate (administrative support)
  - 10.5 Case Managers

MACIPA
Case Management Ratios

- Complex/Chronic Patients
  - 1 Case Manager : 80 Patients
- This ratio supports active case management
  - Home visits for patient assessment
  - Onsite patient visits at SNFs
  - PCP office setting

Identifying High-risk, High-cost Patients

Monthly High-risk, High-cost Reports From Health Plans

- Reports are based on a rolling 12-month period and capture:
  - High-cost patients
  - Patients with multiple acute hospital admissions
  - Frequent ED visits
  - Claims with targeted diagnoses such as CHF, COPD, falls, and cancer
  - Patients age >75
  - Patients with >7 medications and a hospital readmission

Identifying High-risk, High-cost Patients

- Use of prospective modeling software
  - Software product identifies patients with an elevated Risk Index
- Ad hoc referrals from PCP, case manager, patients, and families
  - These are real-time referrals that occur during provider interactions with the patient
  - Patients who are identified as being at high risk can be referred directly into the care management program for further assessment, ongoing management, and support

Identifying High-risk, High-cost Patients

- Monthly review of utilization activity at PCP group meetings
  - PCP groups meet at least monthly to discuss and review performance, including our own real-time utilization data

Care Coordination

- Case management is an integral part of the PCP care team
  - There must be close collaboration between the PCP, case manager, and patient
  - The case manager must be skilled in geriatric conditions, chronic disease management, motivational interviewing, and behavioral change theory
  - Care coordination must be patient centered and reflect the wishes and values of the patient

Resources Required to Manage Care Transitions and Coordinate Care Across Providers

- A case management software system to document assessments, goals, care plans, and action plans while providing reports on progress and outcomes
- EMR system that supports transfer of clinical information between providers

Resources Required to Manage Care Transitions and Coordinate Care Across Providers

- Case management staff trained in "Transitions of Care" techniques and documented protocols that outline the process
  - Assessing patient and caregiver health literacy to ensure that health information is understandable
  - Medication review
  - Review of care instructions along with signs and symptoms to watch for
  - Using the "teach back" method of instruction
  - Timely follow-up with PCP
  - Postdischarge follow-up visits by phone or in person to ensure adherence with plan of care and assist where necessary

Resources Required to Manage Care Transitions and Coordinate Care Across Providers

- A community of providers who understand and are committed to providing high-quality transitions
  - Ongoing education and communication with area providers to set guidelines for what should be included in a care transition
  - Identify barriers to improved transitions
  - Share data and feedback with providers

Effects of Care Coordination on Quality, Utilization, and Expenditures

- Improved quality, as measured by an increase in patient satisfaction
- Improvement in screening and quality measures
- Would expect utilization to decrease because better coordination and management of chronic and complex diseases results in fewer unavoidable ED visits and hospitalizations
- Given the high cost of hospital care, expenditures for care should decline, and the cost of providing care coordination would be offset by the savings in patient care expenditures

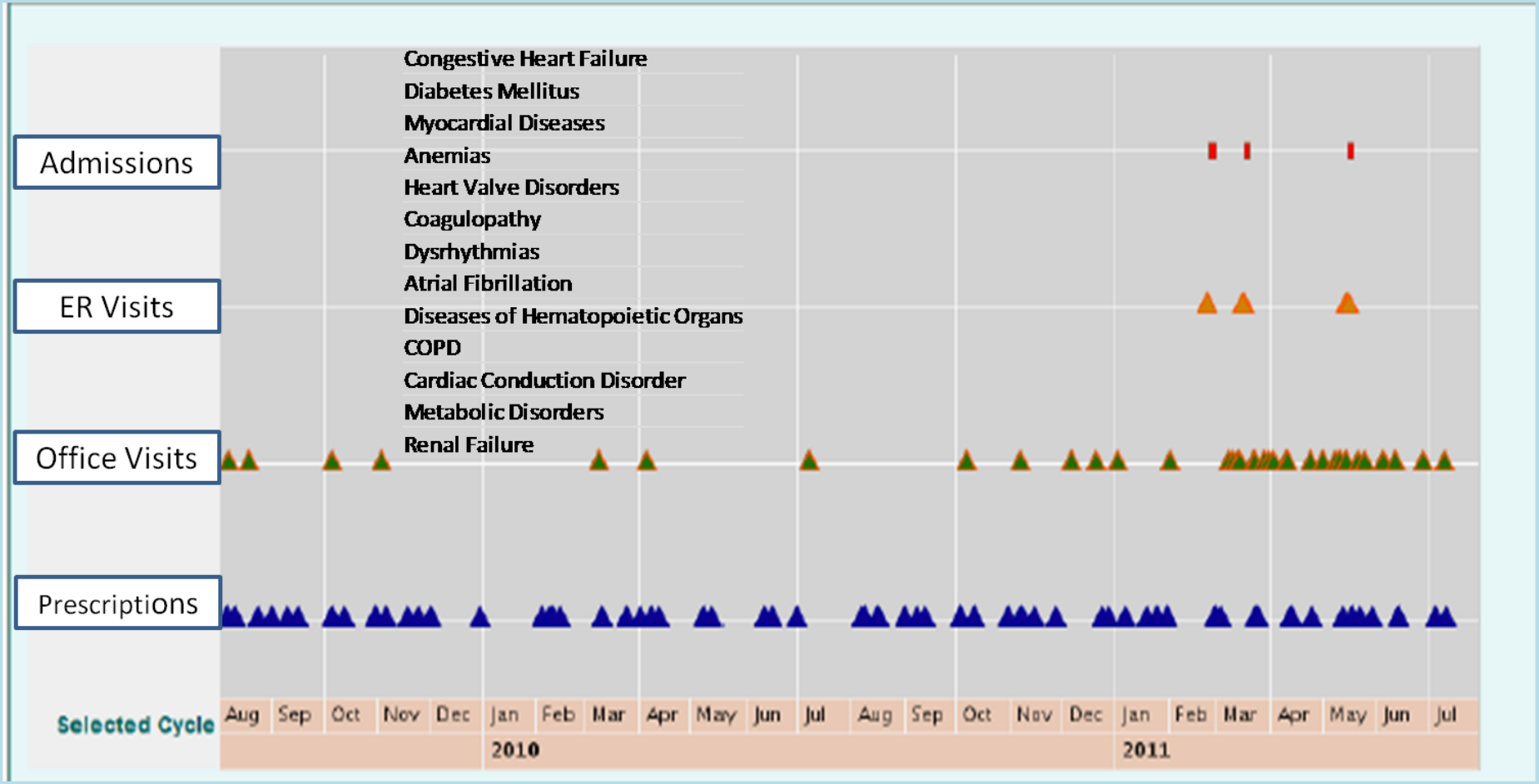
MACIPA Adjunct Programs

- Other programs that support patient care
  - MACIPA COPD, CHF, and diabetes disease management programs
  - Registries—cancer screening and disease management
  - Pharmacy program
  - Data—our own data—give us access to faster and “cleaner” reporting

Why We Are Successful

- We don’t rely on health plan case managers
- We hire our own case managers
- Case management is integrated into the lives of our physicians and patients
- We outsource what makes sense financially

Patient Example

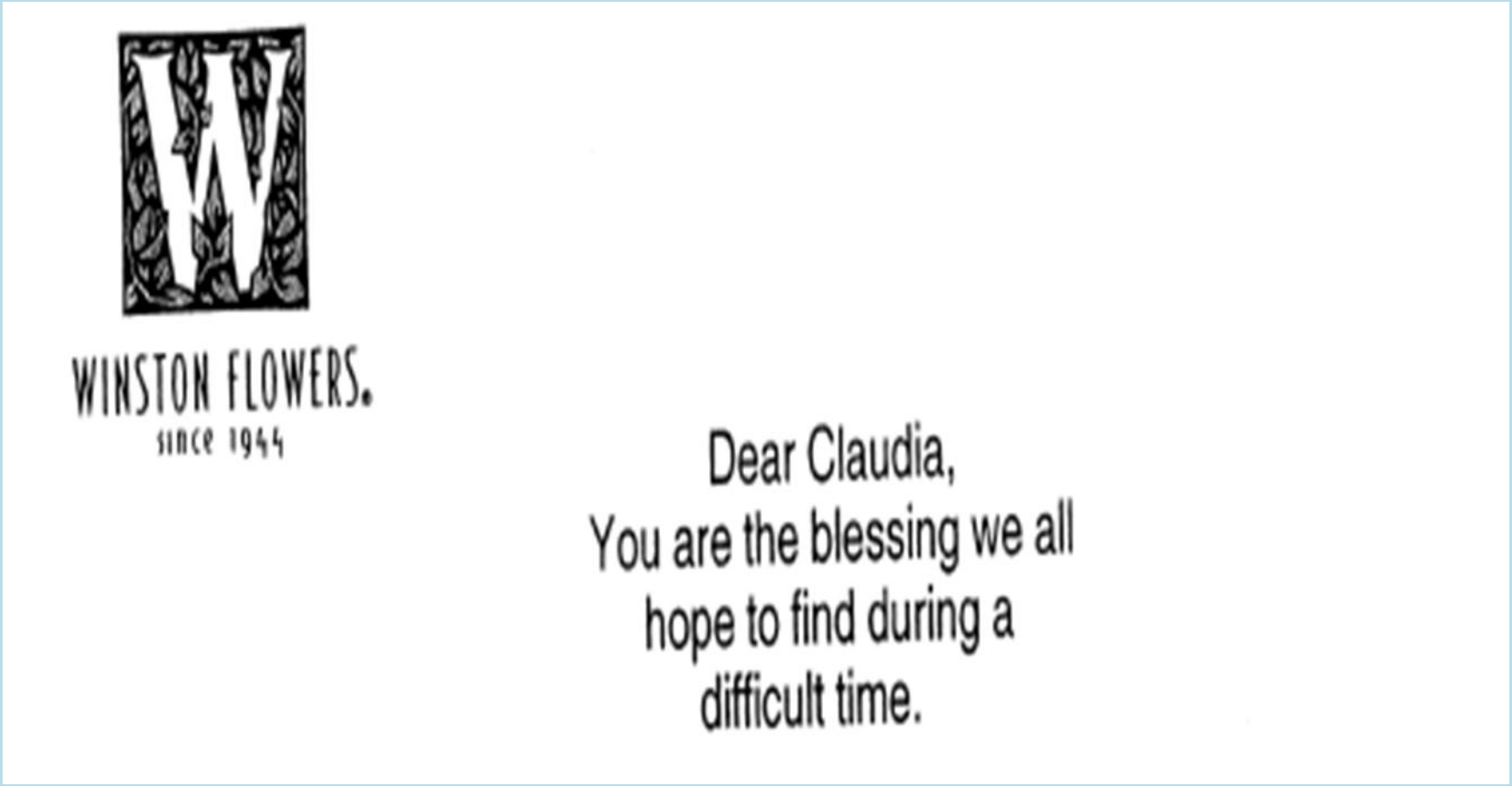


Patient Example

Full Cycle: August 2009 through July 2011

Total Paid	$39,686.23	# of ER Visits	4
Medical Paid	$35,210.08	# of Admissions	3
Pharmacy Paid	$4,476.15	# of Office Visits	39
Age/Gender	86/M	ALOS	3.3 days
RI/CGI	47/7		

Patient Appreciation for Case Manager



Points for Discussion

- Does your organization know who the high-risk, high-cost patients are now? If so, do you think you have a reliable method of identifying this subpopulation? If not, what steps will you consider to identify and understand this subpopulation?
- What are the interventions that would most support your high-risk, high-cost patient population? Does your ACO have the resources to support the implementation of these interventions? If not, what types of staff, devices, facilities, and other resources would you need?
- Do you have the relationships across hospitals, long-term care, primary, and specialty care to support the care coordination interventions you would like to implement or expand upon?

Points for Discussion

- What are the critical barriers to care coordination in your community and how could you overcome them?
- Are EHRs, registries, health information exchange, or data analytics in place to support these activities?
- What specific goals will you establish for the next 12 months for building capacity to better coordinate care? How will you identify and manage high-risk, high-cost patients? What tools will you rely on to identify and manage high-risk, high-cost patients and when will they be available? Who will be responsible for achieving these goals? How will you monitor?

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