Effective Strategies for Improving Care, Reducing Hospital Use: Lessons Learned

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Today

- Lessons learned from PCMH
- Lessons learned from Special Needs Plans
- Conclusions

PCMH EXPERIENCE

PCMH Transforms Practice Model for Population Health

Current View
30 Patients Per Day
14 have Chronic Conditions
Unknown Health Risks
Visits Too Short for Coaching

New Population View
2500 Patient Population
900 have Chronic Conditions
1100-1250 have Mod-High Health Risk
Care Teams Leveraged by HIT

Volume-Based/Episodic → **Value-Based/Continuous**

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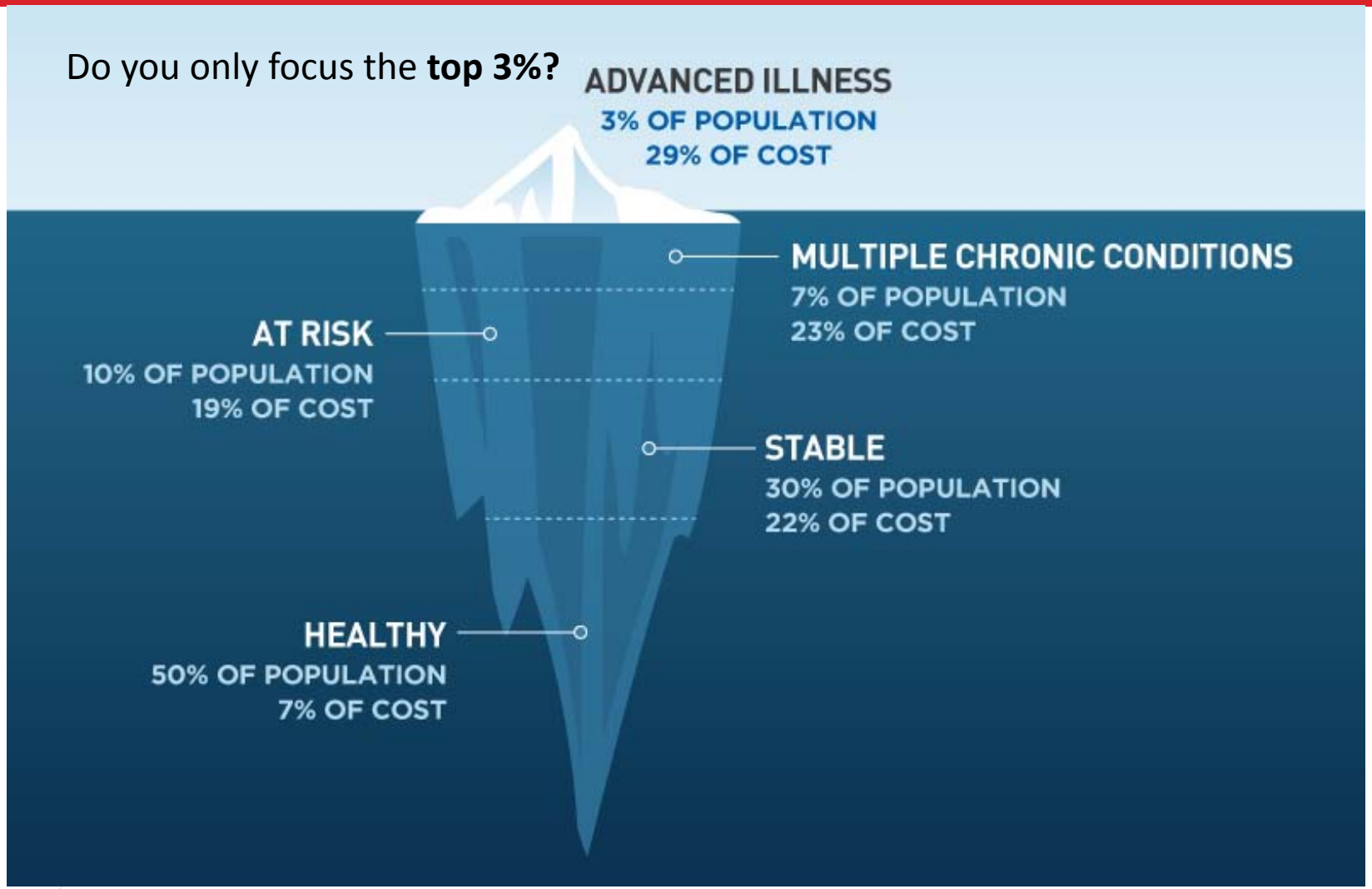
Care Management: Look Below the Waterline

Do you only focus the **top 3%?**



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Latest Research

PCMH studies continue to demonstrate impressive improvements across a broad range of categories including: cost, utilization, population health, prevention, access to care, and patient satisfaction, while a gap still exists in reporting impact on clinician satisfaction.

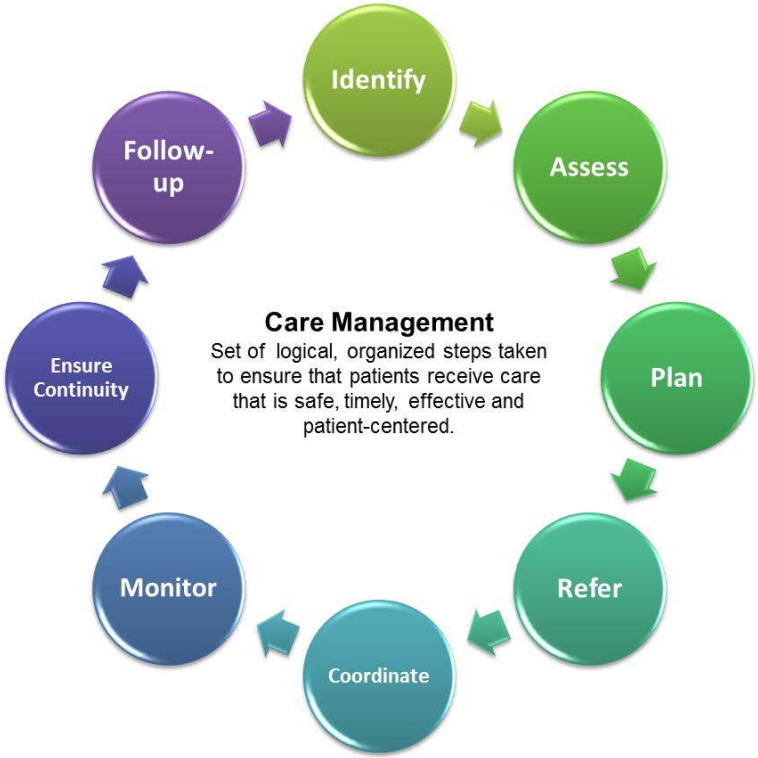
- Decreases in the cost of care, such as per member per month costs, return on investment, and total cost of care (61% of peer-reviewed and 57% of industry-generated studies)
- Reductions in the use of unnecessary or avoidable services, such as emergency department or urgent care visits (61% of peer-reviewed and 57% of industry-generated studies), in patient admissions (31% of peer-reviewed and 57% of industry-generated studies), and hospital readmissions (13% of peer-reviewed and 29% of industry-generated studies)

Latest Research (continued)

- Improvements in population health and increases in preventive services, such as better controlled HBA1C, blood pressure and LDL levels (31% of peer-reviewed and 29% of industry-generated studies) and increases in screening and/or immunization rates (31% of peer-reviewed and 29% of industry-generated studies)
- Improvements in access to care, such as overall access to primary care physicians as well as non-face-to-face visits (31% of peer-reviewed and 29% of industry-generated studies)
- Improvements in patient satisfaction, such as overall satisfaction, recommending the practice to family and friends, and satisfaction with provider communications (23% of peer-reviewed and 14% of industry-generated studies)

Patient-Centered Primary Care Collaborative, Patient-Centered Medical Home's Impact on Cost and Quality, An Annual Update of the Evidence, 2012-2013, January 2014.

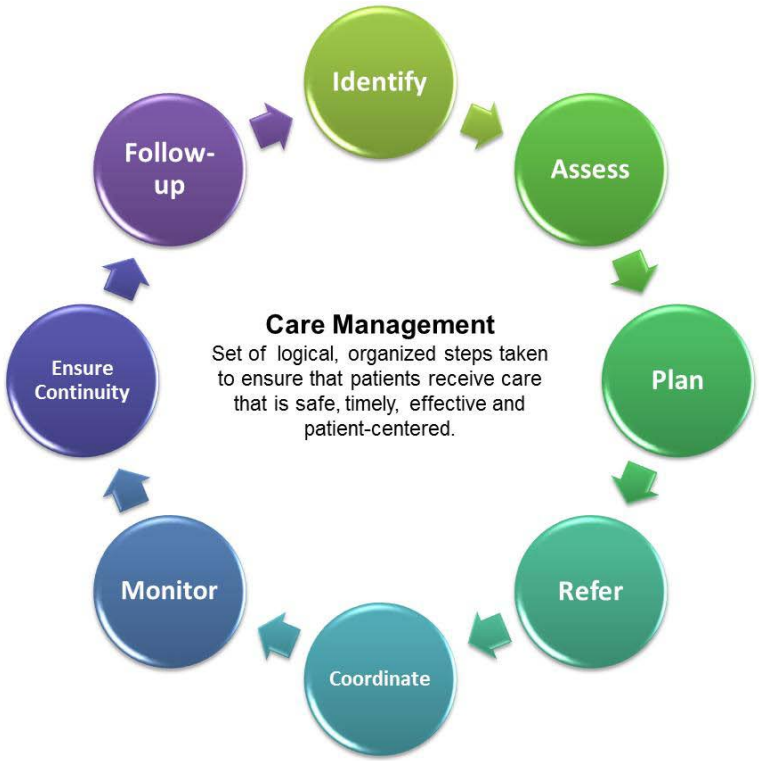
NCQA PCMH Standards



Identify | Assess | Plan

- **PCMH 2:**
  - Capture patient info and clinical history
  - Perform comprehensive health assessment
- **PCMH 3:**
  - Using EB guidelines to plan care
  - Develop individual care plans
  - Identify high-risk/complex patients
- **PCMH 4:**
  - Provide referrals to community resources

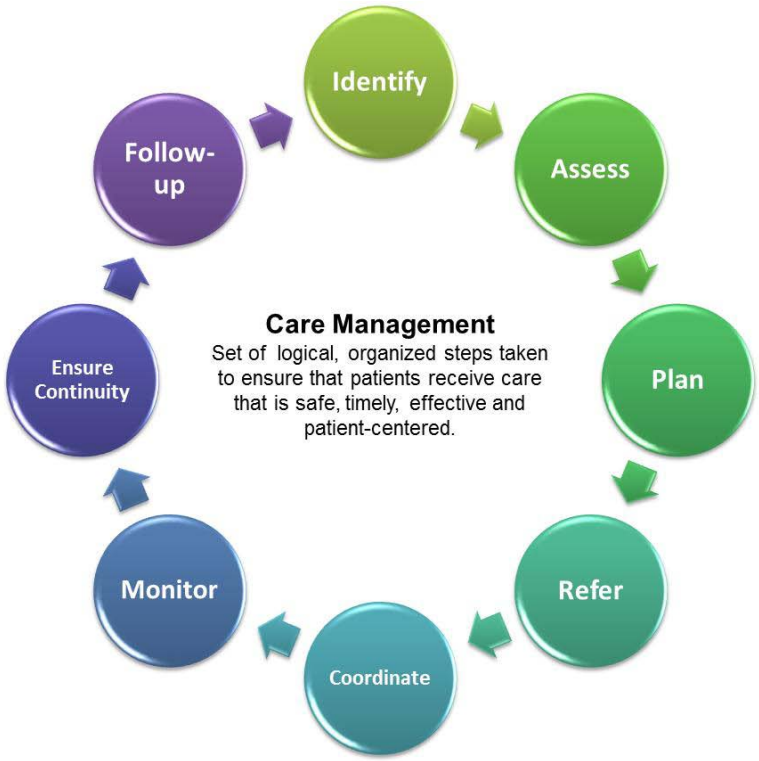
NCQA PCMH Standards (continued)



Refer | Coordinate | Monitor

- **PCMH 3:**
  - Assess/address barriers when goals not met
  - Manage medications
- **PCMH 4:**
  - Provide referrals to community resources
- **PCMH 5:**
  - Tracks & communicates test/lab results
  - Tracks & follows-up on specialist referrals
  - Provide education on self-management
  - Systematically coordinates with facilities during care transitions

NCQA PCMH Standards (continued)



Ensure Continuity | **Follow-Up**

- **PCMH 1:**
  - Ensure same day & after-hours access
  - Continuity of care team
- **PCMH 3:**
  - Follows-up with patients that missed appointments

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Challenges

- **Most challenging elements that practices "must pass" to become recognized:**
  1. ***Using data to support population health***: Generating lists, proactively reminding patients about needed services (2D)
  2. ***Care management***: Carrying out functions such as pre-visit preparation, providing written care plans (3C)
  3. ***Referral tracking and follow up***: Giving the receiving site reason for the referral, providing electronic summaries of care, tracking referral status (5B)

Challenges (continued)

- **Elements where less than half of practices achieved full credit:**
  1. ***Electronic access:*** Providing patients with electronic access to their health information; e.g., test results, medication lists (PCMH 1C)
  2. ***Referrals:*** Providing referrals to community resources (PCMH 4B)
  3. ***Agreements:*** Establishing and documenting agreements with specialists if co-management needed (PCMH 5B)

Areas of High Performance

- **More than 80% of practices achieved full credit on the following:**
  1. ***Continuity:*** Ensuring the patients have a consistent care team (PCMH 1D)
  2. ***Care Management:*** Implementing evidence-based guidelines through point of care reminders (PCMH 3A)
  3. ***Care Management:*** Managing medications including (PCMH 3D):
     - Reconciliation during care transitions
     - Assessing patient response to medications and barriers to adherence
     - Documenting over the counter medication and supplements

Lessons from Level 3 Medical Homes:
Health Information Technology

"We had already had an electronic medical record system for a couple years, and we were sort of doing internal improvements and tracking, but when we decided to do this it became really apparent that there were other functionalities of this program that we could really utilize…care management functionality that was innate in the electronic medical records program that we had, but we just hadn't really branched out to do yet…."

- NCQA Recognized Patient-Centered Medical Home

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Lessons from Level 3 medical homes:
Team Based Care

- **Utilizing staff to the maximum potential of their license (e.g. standing orders)**
  - Gives physician more time to address patient concerns
  - Empowers staff
  - Improves relationships between physician and staff
- **Information and skills training to clinicians and staff**

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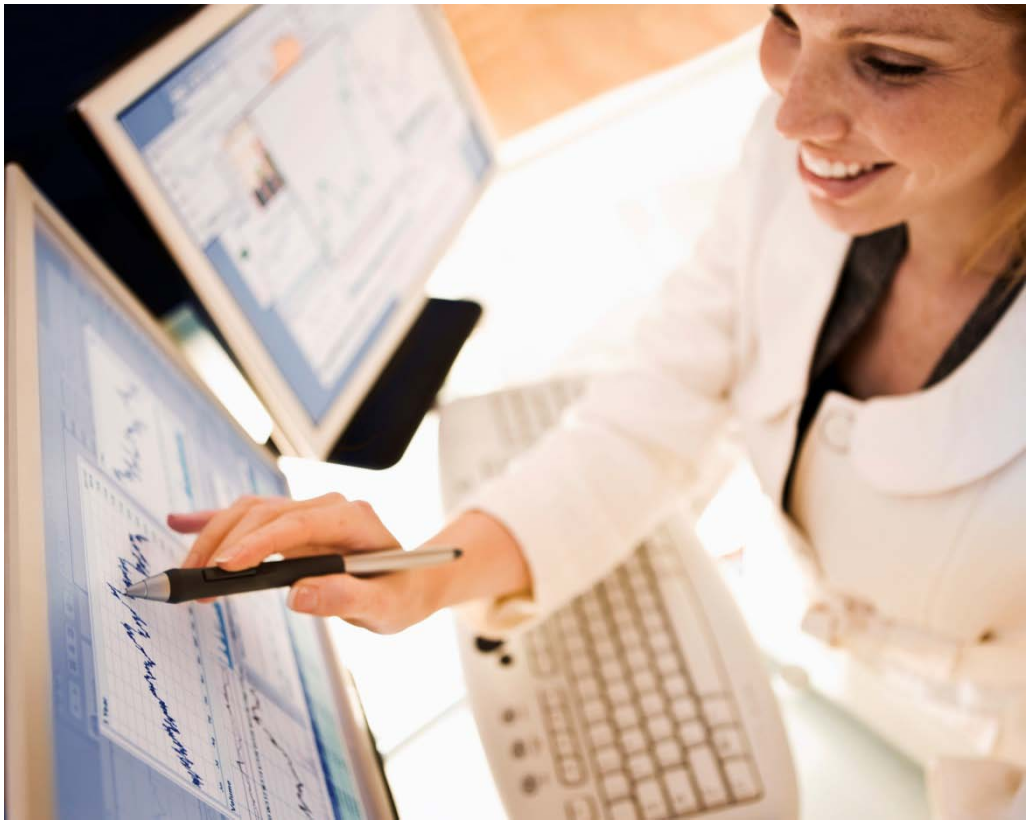
Lessons from Level 3 Medical Homes:
Resources

- **Participation in a demonstration/pilot project**
- **Payment for being a PCMH**
  - Incentives allowed practices to hire dedicated population health staff:
    - Medical home assistant
    - Care coordinator
    - Phone nurse

Lessons from Level 3 Medical Homes:
Formal Approach to Quality Improvement

- **Level 3 practices tended to use the following strategies:**
  - Piloting changes before implementing them practice-wide
  - Performance feedback to physicians



What makes a successful PCMH?

- Health information technology
  - Functional and integrated EHR/registry
  - Inter-operability with local hospitals and other providers
- Leadership
  - Motivation to change
- Practice Culture
  - “team” and “patient-centered” mentality
  - Change process capability
  - Resistance (barrier)

What makes a successful PCMH? (continued)

- Formal Approach to Quality improvement
  - Quality of care indicators, patient experience
  - PDSA and other methods to make change
  - Feedback to providers
- Team-based care
  - Training
  - Delegation (e.g. standing orders)
  - Utilizing staff to the maximum potential of license
- Resources
  - Financial
  - Technical assistance for application

LESSONS FROM SPECIAL NEEDS PLANS

What Do SCAN Special Needs Plans Provide?

A variety of benefits/services depending on where members are in the continuum of aging

HEALTHIER SENIORS	CHRONICALLY ILL	FRAIL or END OF LIFE
▪ Preventive care ▪ Fitness benefits ▪ Wellness communications ▪ Care Navigators ▪ Population Health & Monitoring	▪ Transportation ▪ Low (no) cost meds ▪ Affordable Dr. visits ▪ Complex Care Management/ Disease Management ▪ Care Navigators	▪ In-home services to assist with ADLs (FIDE SNP only) ▪ Care manager ▪ Caregiver referrals ▪ Advanced Illness Management

"Be there when I need you"

"Help me stay healthy and navigate the system"

"Help me stay at home"

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Programs

AIM: Palliative Care	Members with end-of-life care needs
Complex Care Management	Members at high-risk for poor health outcomes and hospitalizations
Disease Management	Members with CHF or COPD
Care Coordination	Members needing assistance with access, services, or transitions
Population Health Management	Members requiring health outreach efforts based on continuous data mining, predictive modeling algorithms and risk stratification

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Better Practices- Staffing

PAL Unit

- **Dedicated Bi-lingual customer service**
- **Specialize in Medicaid benefits/eligibility**
- **Welcome calls**

Care Navigators (new 2013)

- **Educational Calls**
- **Care Coordination**

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Better Practices- HRA

MAIL

IVR

CALLS

IN-PERSON

Better Practices- Care Transitions

Telephonic Model	→	Home visits for some high utilizers or members hard-of-hearing
Empowered Members to make follow-up MD appointments	→	Conference call with MD office to make follow up appointment
Assessment asks if members understand meds & dc instructions	→	More comprehensive probing and medication reconciliation
Care Transitions coaches struggling with complex End of Life issues	→	Referrals to Advanced Illness Management Program

Better Practices- Behavioral Health

IMPACT

Improving Mood -- Promoting Access to Collaborative Treatment

- Evidence-Based Model for reducing depression and improving clinical outcomes
- Trained, embedded Care Manager with PCPs
- Collaboration with Psychiatrist
- Identifying Provider Partners

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Better Practices- Information Sharing

No standard platform for sharing information with providers

SFTP SITE

(Secure File Transfer Protocol)

- SNP Membership Reports
- Care Mgmt Trigger Reports
- Copies of HRA's & Care Plans

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Conclusions

- Case management—hands-on case manager/care coordinator who works with members and conducts regular assessments
  - Helps prevent exacerbations and head off issues
  - Manageable caseloads
- Good patient education and self-management
  - Unnecessary hospitalizations are reduced If patients better understand their conditions and know when to call a doctor, case manager rather than going to ER
- Medication therapy management programs and medication reconciliation after a transition
- Benefit flexibility
  - The ability to order grab bars, transportation, physical therapy, meal assistance or other actions that will help keep a person at home; usually goes hand-in-hand with a strong case management program
- Tiered CM programs where the highest risk patients get the most interventions and hands-on attention
- Better coordination between the PCP, hospitals and the plan, including follow-up after a hospitalization to have member see PCP