

CIN Partners Share:

Care Models for Complex (and Costly) Populations

Main Take Home:
Identify the highest need patients, engage them in their own care, and prevent unnecessary hospitalizations.

The California Improvement Network partners — public and private health care organizations actively engaged in improving chronic disease care at the clinical practice level — meet quarterly to share experiences. Following are highlights from the partners' May 2012 meeting, which focused on care models for complex (and costly) populations. Brief presentations from CareMore and Health Care Partners started the conversation.

CareMore www.caremore.com

Who: CareMore is a Medicare Advantage Plan HMO with a clinical model that promotes wellness, has expertise in multiple chronic disease management, and uses a reimbursement model that includes pay for performance incentives. Their membership numbers 65,000 in California, Arizona, and Nevada, and about half of their members have annual incomes of less than \$30,000. Because of its ability to replicate successfully in geographically and demographically disparate communities, CareMore was acquired by WellPoint in August 2011 with the vision of bringing the CareMore model to WellPoint's 70 million members in 14 states.

"We've shown that taking better care of patients equates to lower health care costs."

Intent: Focus on the frail and ill (the 20% who drive most of the costs). Address the complex problems of aging through innovative health care approaches. Protect the precious financial resources of seniors and the Medicare program by managing chronic disease, frailty, and end-of-life care.

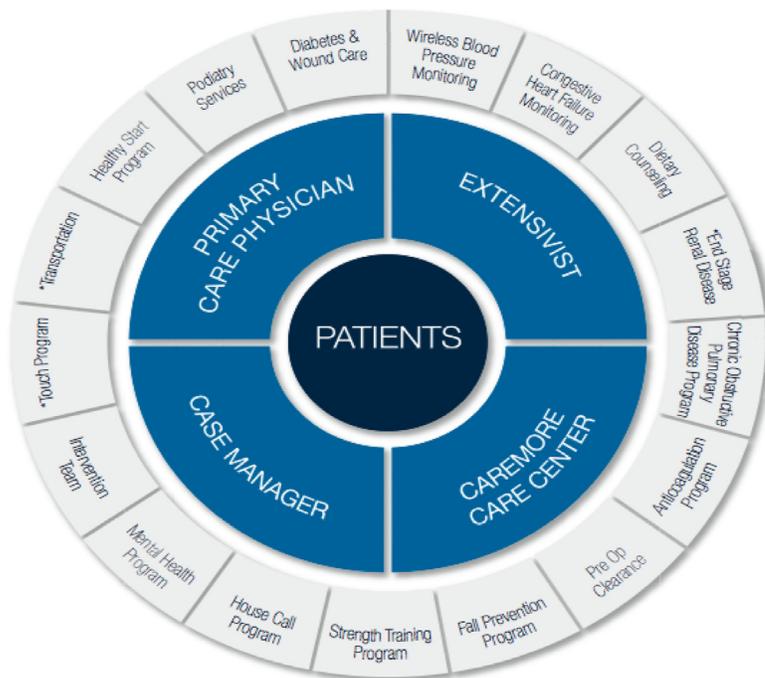
Activities: The model revolves around the CareMore Care Center, a one-stop shop for members. Member engagement begins with an initial visit with an RN designed to identify complex patients. This visit includes a physical exam, full range of assessments (e.g., depression screening, functional status), and advance directive review. CareMore members are encouraged to maintain relationships with their primary care providers (PCPs), with the Care Center providing enhanced wrap-around care when needed. The CareMore staff team includes RNs, medical assistants, social workers, and podiatrists. At some sites, the team also includes behavioral health professionals and MD 'extensivists' who visit members in the hospital but also provide pre-operative and post-hospital care. In addition, extensivists provide ongoing support for members with complex chronic conditions that require frequent evaluation and follow-up from a multidisciplinary team. CareMore provides members with a wide range of health management programs. A customized electronic health record system with dashboard clinical summaries simplifies communication between CareMore team members and community PCPs.

Results: CareMore has lower hospital readmission rates (13.6% vs. 20%) and 15% lower per capita spending compared to the overall Medicare population. CareMore's lower rate of spending is partly due to their patients having fewer hospital bed days and skilled nursing facility bed days — 63% and 67% less than the overall Medicare population, respectively. In addition, 97% of members surveyed in 2011 said they were "somewhat" to "very" satisfied with their CareMore experience.

The CareMore Model

Goals:

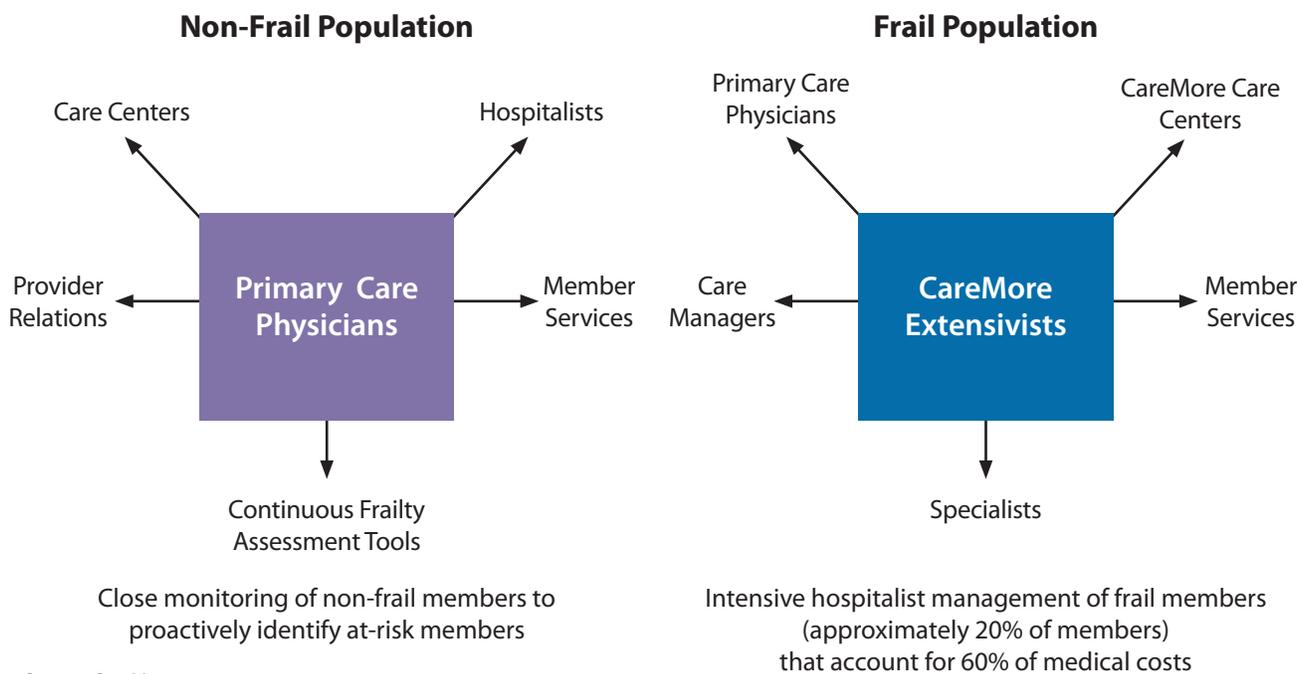
- Provide support system for PCPs
- Chronic & frail seniors receive all the services necessary to live an active & independent lifestyle
- Avoid hospitalizations & other unnecessary acute episodes



Source: CareMore

* Only in markets offered

The CareMore Care Model



Source: CareMore

CareMore

Lessons Learned and Surprises:

CareMore has high rates of initial and annual follow-up visits. Eighty percent of members participate in an initial Healthy Start visit; the percentage is slightly lower for annual follow-up Healthy Journey visits. Members appreciate that Care Centers are in their neighborhoods — often in a local mall — and that a person takes the time to sit down with them to take a full history and physical.

When entering a new market, staff spend significant time and attention introducing local physicians to the CareMore model. PCPs are paid their capitation rate for patients being followed at the Care Center, and some receive fees for patient visits. Once familiar with the model, physicians generally appreciate the enhanced services CareMore provides to their patients (up to daily visits if needed) that they are often unable to provide themselves. It can take 18 months of working with the program and/or 50 CareMore patients in their practice for physicians to fully understand and work well with the model.

CareMore makes it easy for members to be active in their own health maintenance. CareMore's Nifty After Fifty fitness centers are senior-friendly and easy to access. Members with chronic conditions have no or low copayments for their key medications.

Services and programs are customized based on member needs. These services include: home visits from nurse practitioners in certain markets (CareMore has found that their scope of practice enables them to better manage complex patients at home), wound care, and programs for patients with chronic lung disease, cardiovascular disease, diabetes, and end stage renal disease (ESRD).

HealthCare Partners www.healthcarepartners.com

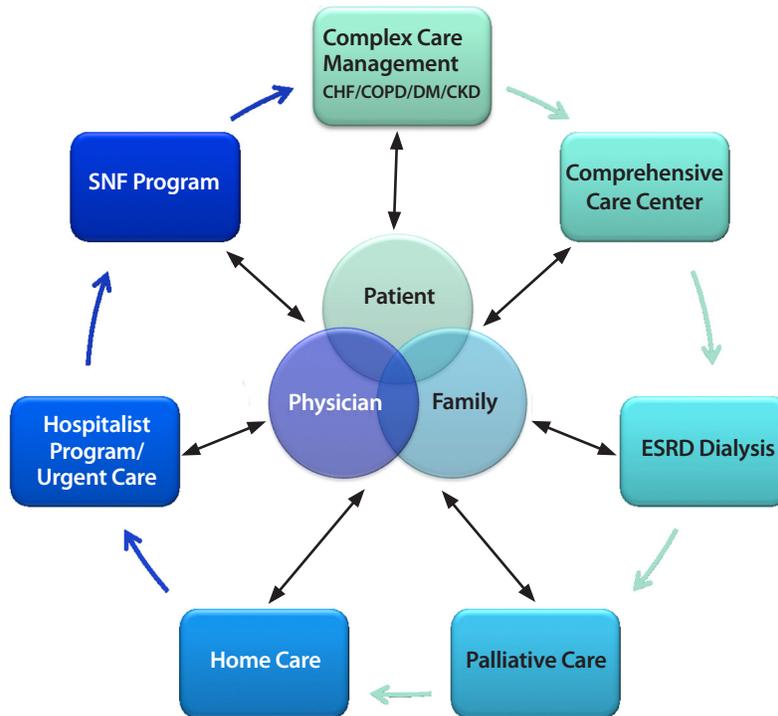
Who: HealthCare Partners (HCP) is a Los Angeles-based medical group with both employed and independent practice physicians. HCP is one of the largest multispecialty provider organizations in California, with more than 50 staff model clinics, 750 employed full-time primary and specialty care physicians, and a network of collaborating Independent Practice Association (IPA) physicians. Throughout California, HCP staff and IPA physicians care for more than 500,000 commercial members and more than 102,000 senior Medicare Advantage members, in addition to many other Medicare and PPO patients. HCP has just been bought by DaVita, a leading provider of dialysis services.

"It's not the one thing you do, it's all the things you do."

Intent: In Southern California, HCP's wide array of programs and disease-specific services provide members with "no wrong door" to care (see care model). HCP places priority on assuring that there is designated responsibility for individual patients to provide clear care plans and smooth handoffs.

Activities: To improve care management, services are localized to geographic regions called pods. Each pod consists of a hospital and a staff model clinic and is surrounded by IPA physicians. Within each area, approaches range from disease and care management programs to home-based palliative care visits by advanced practice nurses (APNs). HCP employs its own hospitalists; 125 FTE hospitalists work in California alone. IPA physicians are paid their capitated rate even when their patients are in an HCP program (Level 3 or above); for some patients, such as ESRD patients on dialysis, their medical home becomes the dialysis unit. HCP is facing the challenges of addressing patients' mental health issues by embedding behavioral specialists into interdisciplinary teams. One pilot is using psychiatric technicians as outreach workers to manage a small panel of approximately 75 patients. HCP makes extensive use of MAs within their staff model primary care practices, with two to three MAs per physician and an even higher ratio for high risk patients. For HCP, "everything is traded for a bed day."

The HealthCare Partners Care Model



Source: HealthCare Partners

Stratifying Patients into the Appropriate Clinical Program

Hospice/Palliative Care

Home Care Management

Provides in-home medical and palliative care management by specialized physicians, nurse care managers, and social workers for chronically frail seniors that have physical, mental, social, and financial limitations that limit access to outpatient care, forcing unnecessary hospital use.

High Risk Clinics and Care Management

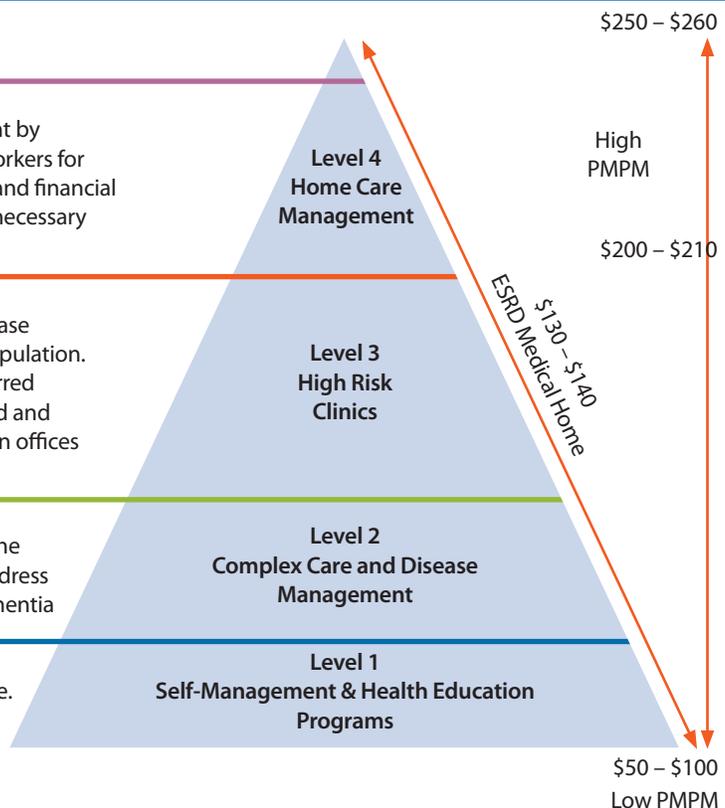
Intensive one-on-one physician /nurse patient care and case management for the highest risk, most complex of the population. As the risk for hospitalization is reduced, patient is transferred to Level 2. Physicians and care managers are highly trained and closely integrated into community resources and physician offices or clinics.

Complex Care and Disease Management

Provides long-term whole person care enhancement for the population using a multidisciplinary team approach to address conditions like diabetes, COPD, CHF, CKD, depression, dementia

Self Management, PCP

Provides self-management for people with chronic disease.



Source: HealthCare Partners

Results: In spite of high quality ratings (both clinical quality and patient satisfaction) and relatively low rates of hospitalization, HCP continues to find pockets of patients with high rates of hospital use. Current areas of emphasis include managing patients with serious mental illness and enhancing palliative care services.

Health Care Partners

Lessons Learned and Surprises:

Every program for high-risk patients is on a path of continual evolution; none look the same as they did several years ago. Approaches are constantly re-engineered and evaluated as to how they interrelate. The best outcomes are seen when a full complement of programs is implemented all at the same time and not rolled out piecemeal, one or two programs at a time. For example, a hospitalist program and an ESRD program will each provide some savings but a comprehensive care program will maximize savings. A comprehensive approach that includes palliative care, programs for heart failure and chronic lung disease, diabetes classes, and post discharge care will ensure that the patient is being cared for at every stage of the disease process. HCP lessens the severity of the disease process by providing early identification, education, and treatment, and by empowering the patient.

It takes almost one year to stabilize dually eligible patients with complex care needs. Patient retention is key to developing a return on investment for complex patients — time is required to put the right services into place to avoid downstream hospitalizations.

HCP sees a need to better integrate palliative care throughout its programs and is seeking to add residential hospice care to its spectrum of services — hospice is viewed as a cost, not revenue, center. Bringing care to the home as patients become more frail can be highly cost-effective, and most importantly, aligns with patient preferences. Physician care is being replaced by visits from APNs who are supported by a geriatric specialist.

Quick Takes

- **It's all about the patient experience;** positive experiences drive retention. As patients have positive experiences with new care models, they become the most effective ambassadors for the program in the community.
- **Clinical staff members should not spend their time doing paperwork;** let doctors spend their time with patients. Non-clinical staff can handle paperwork and schedule appropriate follow-up, and nurse practitioners can do home visits and adjust patient medications as appropriate. In the staff model, budget two to three MAs per MD, ideally, if you are focused on complex patients. Care is provided by a team.
- **With any new care model, the first step is to establish communications and relationships with PCPs.** Electronic medical records and good analytics are useful tools but do not make the system of care.
- **Health care is always delivered locally.** Programs need to be tailored to fit local dynamics.
- **Targeting the right patients with the appropriate care is critical.** Not all patients need everything.
- **When given an informed choice,** patients and families generally choose the least costly services.

Asked and Answered !

How do you manage the changes required for these care models?

CareMore — We go where the seniors are, and we keep local (usually at the sub-county level). Scale has been a challenge, but we have worked to simplify and standardize the basic model, then tailor it as needed to each locality — building local relationships with PCPs and hospitals. What helps in the buy-in: making the evidence-based protocols transparent to local physicians so that they can gain confidence in the care provided at the Care Center and supported by the APNs.

HCP — There is often a tension between “big bang” and incremental changes, but the bottom line is to create a culture that makes it OK to fail. A key to our success is keeping everyone in the organization focused on why their work is important to people’s lives through storytelling and treating everyone like a family member; everyone wants to make a positive difference. We provide ongoing performance feedback to all of our providers — using a bit of peer-pressure and competitiveness to encourage performance improvement.

How do you work with non-employed primary care providers?

Both programs — We contract with independent physicians and provide both capitation rates and fee-for-service payment for the care they provide. Incentives are aligned to encourage PCPs to see their patients as often as they’d like — to help decrease specialty care services and avoid unnecessary hospitalizations. Consistent communication with the patient’s PCP, through a dashboard or other means, is key. In addition, PCPs receive quality bonuses for better patient outcomes, and many, with encouragement, realize that the care management models help them meet that goal.

How do you make these programs work financially?

Both programs — Avoiding unnecessary hospitalizations provides significant financial room for innovation and better care. Don’t get distracted by the occasional outlier, high-cost patient — they can be managed individually. Investment in coordinated care, especially for seniors, pays off. To think “system,” focus on the top 15% of your population that is the most costly, and assess how they can be engaged through consistent programming — much of this happens at the direct care level. As a health plan, not as a direct provider, there are then opportunities to better manage the next population level (15%-25%) who incur avoidable high-cost care.

Online Resources

Physicians in Supporting Roles in Chronic Disease Care: The CareMore Model. David B. Reuben, MD, *Journal of the American Geriatrics Society* January 2011. <http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2010.03237.x/abstract>

Predictive Modeling And Team Care For High-Need Patients At HealthCare Partners. J. Lester Feder, *Health Affairs* March 2011. <http://content.healthaffairs.org/content/30/3/416.full?ijkey=axZAVjAyPVrcM&keytype=ref&siteid=healthaff>

California Improvement Network Resources

<http://www.chcf.org/california-improvement-network/resources>

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