

# CIN Partners Share:

## Complex Care Programs

**Main Take Home:**  
Programs work—but patients/families have to understand and be a part of the care plan.

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' August 2011 meeting, which focused on complex chronic care and high-risk programs. Brief presentations from Humboldt-Del Norte Medical Foundation, HealthCare Partners, and Monarch HealthCare started the conversation.

### Humboldt-Del Norte Foundation for Medical Care

**Who:** Rural independent practice association (IPA) of primarily one- and two-physician practices.

**Intent:** Improve patient functional status/satisfaction and clinical quality, and reduce costs through care management for high-risk PPO<sup>1</sup> members. Priority Care program is a pilot partnership with an employer and health plan, with cost savings to be shared between the plan and IPA.

**Activities:** In preparation for program launch, Humboldt's design includes:

- Identification of target population through insurance claims—545 PPO members with multiple chronic conditions.
- Direct engagement with both patients and providers to: understand Priority Care and its implications and assist in patient recruitment.
- Emphasis on patient self-care, including the patient's support system, and using the Patient Activation Measure (PAM).
- "Shareable" care management software with: photos of patients, risk assessments, PAM scores, and shared action plans.
- Continual process improvement to: assess and risk-stratify patients; determine frequency and type of contact; develop individualized care plans; and use case conferences to modify them.

*"No matter how many times you've contacted a provider about your program, always start from the beginning."*

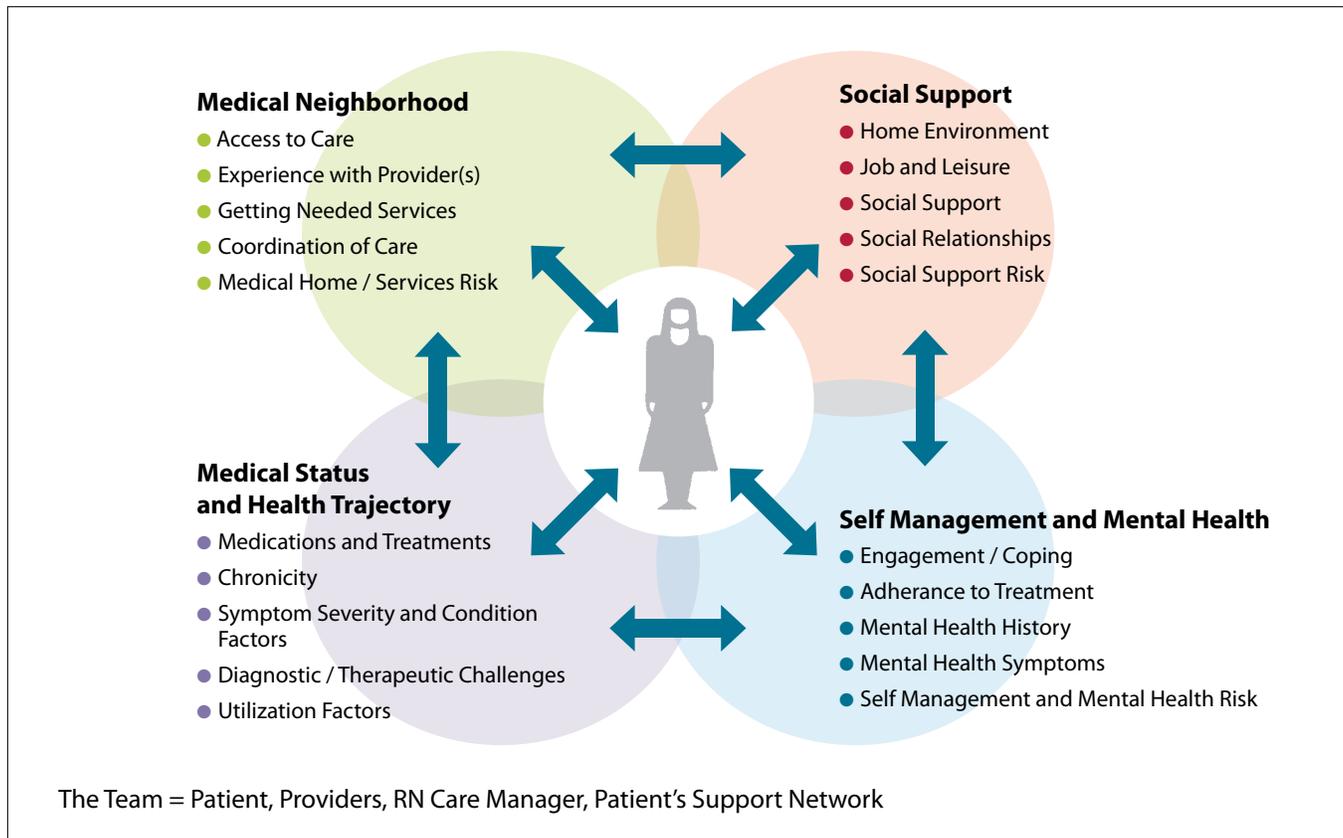
**Results:** The program recently launched, with 95% of recruited patients accepting so far. Important baseline data are collected, including patient experience, depression scoring (PHQ9), patient activation (PAM tool), and RN care manager risk assessment on four domains (see graph on page 2).

1. A preferred provider organization (PPO) is a health benefits plan that allows individuals to choose any provider without designating a primary care physician (PCP), but offers higher levels of coverage when participating or preferred physicians or hospitals are chosen (who are paid at pre-negotiated fees for specific services).

**Acknowledgments:** The August 2011 CIN meeting was hosted by Monarch HealthCare and the California Quality Collaborative.

## Humboldt-Del Norte Foundation for Medical Care

### RN Care Manager Assessment: The 4 Domains



### Humboldt-Del Norte Foundation for Medical Care

#### Lessons Learned and Surprises:

- Solicit feedback from patients about how to present new options; for example, Priority Care appeals more to patients when called a *service*, rather than a *program*.
- Use rapid cycle testing of patient recruitment. The protocol that is working best for Priority Care: an initial call from the physician office staff, followed by a physician letter, then an enrollment call from the care manager.
- Have office staff lead recruitment. Patients identify them with the practice (whom they trust) and are concerned when a physician calls.
- Stagger outreach to patients to "smooth" demand for intake and assessment.
- Identify one physician champion to pave the way with one-to-one discussions with providers. Be prepared with talking points for their concerns.

## Monarch HealthCare

**Who:** Orange County-based IPA with more than 150,000 members and a network of more than 1,300 providers. The organization bears risk for hospital and skilled nursing facility costs.

**Intent:** Improve care transitions to decrease avoidable hospital admissions, readmissions, and ED visits.

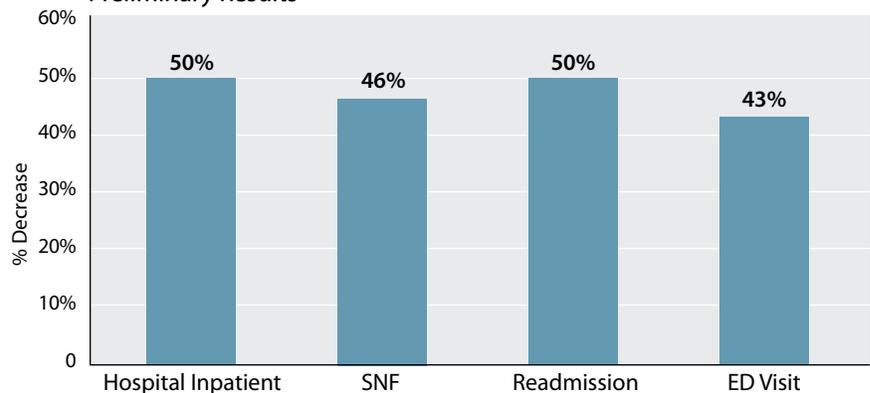
**Activities:** The IPA launched Monarch Cares Clinic in 2008 to provide post-discharge “bricks and mortar” care staffed by a geriatrician, nurse practitioner, and social worker. Patients who came to the clinic had improved outcomes, but most referred patients did not participate, opting to wait (sometimes too long) to see their own primary care provider (PCP). Therefore, in 2009 Monarch introduced and tested Senior Touch, a post-hospital home-visit program for seniors. Staffed by a geriatric nurse practitioner, social worker, and pharmacist, the program: reconciles medications, schedules a follow-up appointment with the PCP, provides a personal health record, discusses advanced care planning (including POLST), and reviews warning signs.

**Results:** With promising preliminary results from the Senior Touch project (see graph), Monarch is expanding the patient population, geographic reach, and staffing (adding social work interns). The program is now named the High Risk Touch Team.

*“After our first attempt, what we did right was to start small and simple, then layer on.”*

### Monarch Senior Touch Project: Utilization Decreases

Preliminary Results



Comparing 3 months prior to the April 2009 pilot and 3 months after being in the pilot. N=58.

### Monarch HealthCare

#### Lessons Learned and Surprises:

- A stand-alone high-risk clinic may not work well in an IPA setting, where the providers are “strangers” to the patients as well as to their PCPs.
- Maximize the clinical potential of nurse practitioners. Rather than simply managing and communicating care plans with PCPs, the NPs now conduct senior annual assessments and proactively identify gaps in care.
- Having one dedicated medical director working with a number of NP/PA and RN teams assures consistent high quality and is more scalable than having a series of part-time physicians per team.
- Start small with a pilot approach; measure effectiveness; then make a decision about spread.
- Physician Orders for Life Sustaining Treatment (POLST) and the conversation it initiates, is a helpful tool to assist patients and families articulate their goals/wishes.

## HealthCare Partners

**Who:** A physician-owned integrated medical group and IPA serving greater Los Angeles and Orange Counties with 600,000+ members.

**Intent:** Offer a host of interventions targeted to the needs of the 5% of patients who generate 55% of all hospitalizations.

**Activities:** Four programs for high-risk patients:

- **Ambulatory Care Management:** a telephone-based program that uses motivational interviewing techniques to help patients understand and manage their condition(s). Social worker support helps patient/family with social needs.
- **Site-Based Care Management:** team-based care (physician, care manager, patient coach, social worker) that supports care planning for a panel of patients at the physician office with follow-up calls.
- **Home Care:** home visits by an interdisciplinary team, for complex patients with barriers to seeing their PCPs. Patients have access to their team 24 hours a day.
- **Comprehensive Care Centers:** “bricks and mortar” clinics with an interdisciplinary team—MD/NP/PA, nurses, care managers, social workers, and medical assistants—offer longer comprehensive visits and take on the role of primary provider.

*“We know that 5% of our patients are the most costly. The challenge is that it’s a different 5% every year.”*

**Results:** Hospital utilization trends for the HomeCare and Comprehensive Care Center programs show a downward trend pre- and post- enrollment. See table.

### HealthCare Partners Hospital Utilization Change

Hospital days per 1,000	12 months prior to program	Enrolled in program*	Change	Hospital days per 1,000	12 months prior to program	Enrolled in program*	Change
HomeCare	6,353	4,592	-26.7%	HomeCare	1,435	1,140	-21%
CCC	5,973	4,820	-18.3%	CCC	1,633	1,232	-24.5%

\*Data based on member months ranging from 1 to 24 months. Average length of time in programs approximately 7-10 months.

### HealthCare Partners

#### Lessons Learned and Surprises:

- The high-risk population is dynamic. Over 25% of people served by these programs disenroll, transfer to hospice care, or die annually. Palliative care and advanced care planning are critical components of all high-risk programs.
- Referral of post-discharge patients is not 100% accurate. Therefore, the programs use a “no wrong door” approach so that staff can move patients into the program that best suits their needs.
- Adequate primary care capacity must be bolstered (in this case, via site-based care management) so patients can “graduate” out of intensive high-risk programs; otherwise, programs become saturated.
- Standard assessment tools (such as the GRACE cardiac risk assessment tool), used longitudinally, help in managing complex chronic patients and provide consistency in the setting of individually tailored treatment plans.
- Some 20%-50% of patients may decline “bricks and mortar” clinics; therefore it is preferable to bring care to the patient/family, or to their regular site of care.

## Asked and Answered !

### *How do we improve enrollment?*

Telephonic approaches may be effective when combined with another way of engaging patients, such as an initial home visit or a face-to-face visit in primary care. When a personal introduction to the program is made at hospital discharge, or recommended by the primary care provider, rates of enrollment—and trust in the program—markedly increase. Whenever services can be brought to the patient/family in ways they are familiar with, the more likely they are to participate.

### *What works best to promote patient behavior change?*

Reinforce patient self-management, especially through motivational interviewing.<sup>2</sup> Make sure that patients/families are a part of the plan of care and that they understand what to expect in terms of health improvement, holding steady, or palliation.

### *How do we know if we are successful?*

All high-risk programs struggle to find the appropriate metrics. One strategy to measure effectiveness is to track total cost of care for your entire patient population; this holds you to a higher bar and avoids the mistake of taking credit for regression to the mean.<sup>3</sup>

### *Implementation tips:*

- You will need to train teams on how to function effectively, including facilitation and communication skills. Clarify roles, use scenarios and case-based learning. Think about how to best support peers/medical assistants to be their most effective (rather than just taking tasks off doctors' "to do" lists).
- Have clinical leadership oversee and support case review and triage. They can help assure program consistency/quality and maintain the larger view of how care management fits for your population.
- Get continual feedback from patients. Ask them to help design/improve what you do, whether one-on-one, through ongoing surveys, or focus groups. Train patients to be a part of team meetings—cynicism leaves the room when patients are present.
- Remember that care management has to manage both the patient/family and the physician/team. Have clear, consistent, and user-friendly ways to share care manager discussions with PCPs and assure that patients are truly on board with the care plan.
- Don't underestimate the staff fatigue factor. Be sure to provide support for your staff, just as you provide care to your patients and their caregivers.

2. Motivational interviewing is based on four general principles: Understand the patients' perspective; help them appreciate the value of change; accept reluctance to change as natural rather than pathological; and support self-efficacy (successfully and confidently moving toward change).

3. "Regression to the mean" is a probability term meaning that, left to themselves, things tend to return to normal. In the case of complex patients, some will normally improve, especially if the most extreme (highest cost) cases are sampled. It is easy to attribute "improvement" in this population to a particular intervention, when in fact it is an artifact of sampling.

## Quick Takes

- **Complex patients need complex care.** High-risk or complex patient programs work best when there is a known/identified population and when there are simpler disease-specific approaches (e.g., diabetes coaching and support) already in place.
- **Continually refine your approach.** Don't wait for the "perfect." For example, rather than getting stuck deciding which high-risk identification tool to use, instead select a starting point, such as PCP or post-discharge referrals, a basic set of (multiple) diagnoses, utilization indicators, and/or risk scores. Improve and refine using a good triage, assessment, and intake process to engage patients at the appropriate level of intervention. Continually evaluate whether patients are in the right level of care.
- **Be clear about the role of primary care.** A care management "silo" does not work as well as models that integrate care management and primary care upfront, such as co-location of care managers at the physician office. Even the best primary care does not have the resources to adequately intensify care for complex patients without additional support.

## Online Resources

Robert Wood Johnson Foundation Synthesis Project—Care Management of Patients with Complex Health Care Needs.  
<http://www.rwjf.org/pr/product.jsp?id=52372>

IHI White Paper: Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs.  
<http://www.ihl.org/knowledge/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx> (free, but registration on ihi.org is required)

"American Medical Home Runs" by Arnold Milstein and Elizabeth Gilbertson, *Health Affairs*, Sept-Oct 2009.  
<http://content.healthaffairs.org/content/28/5/1317.short>

"The Hot Spotters" by Atul Gawande, *The New Yorker*, January 24, 2011.  
[http://www.newyorker.com/reporting/2011/01/24/110124fa\\_fact\\_gawande](http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande)



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