Implementing Care Management for Complex Patients in Primary Care – Best Practices from Successful Programs

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Using complex care management teams to improve care & reduce costs

One proposed solution to address healthcare cost problem

Specially trained multidisciplinary, complex care management teams
<table>
<thead>
<tr>
<th>Program/Population</th>
<th>Utilization/Cost</th>
<th>Quality</th>
<th>Patient Experience/QOL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Admit / Readmit</td>
<td>ED Use</td>
<td>Cost</td>
</tr>
<tr>
<td>GENERAL TREND</td>
<td>↓</td>
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Source: Hong CS, Ferris TG. CMWF Brief 2014 (Pending Publication)
Challenges for CCM Programs: Drops in Potential Engagement

Potential opportunity

Identification

Engagement Finding opportunities for improvement

Intervention

Realized improvement

Adapted from J Eisenberg *JAMA*. 2000
Health Delivery System

Social Service Agencies

Government Service Agencies

Acute & Post-acute Facilities

Specialty Care Providers

Family/Caregivers

Patient

CCM Team

CM

Payers & Purchasers

Public Health Agencies

Behavioral Health

Home Health & VNA

Public Health Agencies
Scope of Work & Key Tasks

• Central task
  • to build relationships with patients, primary care teams & hospital/community partners

• Touches
  • Twice weekly to monthly
  • Telephonic, office, in-home

• Patient case load:
  • Depends on training, resources, & intensity of intervention
  • Use of teams, risk stratification & IT enable larger case loads
Scope of Work & Key Tasks

• Comprehensive assessment & creation of care plans
  – Address behavioral health & social service needs
  – Address barriers to access/care
• Care coordination – focus on transitions of care
• Health coaching/self-management support
  – Medication Management support
• Advanced illness management support
• Patient advocacy & activation
• Facilitate Practice Change
Patient Selection

1. Quantitative
   - Applying risk prediction software to claims data
   - Acute care utilization focused
   - High risk condition focused

2. Qualitative
   - Referral – Physician/Staff or Patient

3. Hybrid approaches
Effective Targeting of Care Management

Population Volume

Intensity of Illness

Healthy

Chronic Illnesses

Medically Complex/High Utilizers

Area of Greatest Opportunity?

Intensity and Specificity of Intervention
Patient engagement

• Connection to primary care
  • Face-to-face interaction
  • Longitudinal relationships
  • Traits of team matters
  • Motivational interviewing
  • Sell it to patients
  • Ensure early successes

• Mobile workforce & technology

Making the right pitch to patients is important

<table>
<thead>
<tr>
<th>Tailored approach at Camden</th>
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<tbody>
<tr>
<td>1. Reach out to patients during hospitalization or ED visit</td>
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<td>2. Personalized introduction</td>
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<td>3. Open-ended questions to identify patients’ needs</td>
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<tr>
<td>4. Use understanding of needs to tailor presentation of services</td>
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</tbody>
</table>
Primary care integration

Co-location

Face-to-face interactions

Education on CM role/benefits

Champions

Data/EMR Access

Enhancing integration

Early successes/Trust building
Engaging Other Critical Partners

• Ties to inpatient facilities/EDs
  – Communication with inpatient CMs
  – Communication with skilled nursing facilities
  – CM team members embedded at hospital sites

• Ties to community-based agencies
  – Home health agencies
  – Hospice
  – Elder Resource Centers
  – Community Centers
  – Social Service Agencies
Important concepts for ensuring efficient CCM

• Build strong relationships with patients, primary care teams, hospitals/specialists and other community care partners

• “A good CM doesn’t do everything”
  – Allocate CM resource to high-yield activities
  – Complement existing services
  – Focus on mutable issues
  – Work in multi-disciplinary teams
  – Use HIT infrastructure to enhance CM efficiency
Important concepts for ensuring efficient CCM

• No perfect model
  – Start with the best approach for the context/population
  – Then use continuous quality improvement to improve

• CCM is evolving rapidly so we will need to continue to share learning and evaluate different approaches
Los Angeles County
Department of Health Services
Care Connections Program

Health Services
Los Angeles County

Anansi Health
Serving 5-10% of LAC DHS’s Patients

CCM Panel within a Panel

- Complex biopsychosocial needs
- Hard to engage
- High utilization of health care
- High cost of care

19,000-38,000 out of 380,000 primary care patients

15-30X growth possible
Aims

- Admit/ED
- CCP
Patient Engagement

Social Support

Comprehensive Assessment & Care Planning

Health System Navigation

Care Transition Support

Advanced Illness management support

Chronic Disease Support & Health Coaching

CHW Role
66 year old man

h/o Stroke X4 – left sided paralysis & seizures

Heart Disease - planned bypass surgery

Prescribed 15 pills daily - trouble affording

Smoker – wants to quit with hypnosis

Wheelchair – transportation issues

Has caregiver – personal care attendant

Admits for rectal bleeding & stroke in past year

Frequent ED Visits for pain management

Multiple specialists – 4 appointments/week

Depression – evaluated for self-neglect
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Questions?

Thank you!

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Tiering

• Tiering the Total Population
  – Quantitative approaches

• Tiering High-Risk Patients
  – Clinical Tiering by CMs
    • Care Gaps, Chronic Conditions, Utilization trigger-based
  – Individualized Care Plan
  – Automated Tiering
    • Risk score, time in program, health risk assessment or utilization trigger-based
    • Iora health’s “Worry Score”