COPE HEALTH SOLUTIONS

Customized Care Coordination Strategies that Fill Workforce Gaps and put a Human Face on Health Systems

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Lisa B. is a 56-year-old African-American woman who lives in Kern County with her extended family. Lisa has diabetes, hypertension, shortness of breath and is overweight. Unable to afford her medications, she had several emergency visits two years ago for heart failure. Lisa was prioritized for enrollment in a new Care Navigator program to allow her to work with a non-clinically licensed coordinator under the supervision of a clinically-licensed case manager and primary care physician. Working with her Navigator and primary care physician through a host of issues related to medication, transportation and needed specialty care, Lisa had no emergency room visits last year and is now medically stable and enjoying life and family – and fun.

The value of better coordinating the fragmented pieces of patient care in a complex maze of systems has been well-proven. Studies on health care spending continue to find that a small percentage of individuals account for a large proportion of expenditures. In fact, the most expensive 5% of Medicaid beneficiaries accounted for nearly half of the program's spending from 2009 to 2011, according to a May 2015 report by the Government Accountability Office.[1]

Both nationally and particularly in California, risk-bearing medical groups have repeatedly verified that organized care with population health management and strong case management saves dollars but, most importantly, keeps people from enduring repeat painful procedures, risk of hospital-acquired injury, sleep deprivation, expense and fear.[2]

But one man's waste is another man's revenue and, until recently, hospitals and physicians simply did not have a financial incentive to implement a program for coordination of care. Most paradoxically remain financially penalized for keeping patients

[1] http://gao.gov/products/GAO-15-460

[2] *Coordinated Care Makes a Difference, Wells Shoemaker, M.D. 2011, citing CA utilization statistics, Managed Care Digest Series, 2010*

healthier and out of the hospital and emergency department. While illogical at a macro-level for “health” care, the business case is clear – a health system simply must have a sufficient concentration of risk-based or value payment contracts to financially and operationally support building the care coordination infrastructure that can sustainably move care outside the hospital and physician office walls.

With the implementation of the Affordable Care Act (ACA) and other health care reform programs, hospitals and health systems are now beginning to have aligned interests that sustain a system of coordinated care. The Centers for Medicare and Medicaid Services (CMS) has placed focus on alternative payment models that encourage decreased traditional hospital utilization and enhanced case management. In fact, CMS wants 50% of Medicare payments tied to ‘value’ by 2018. Accountable Care Organizations (ACOs), which have proven popular, currently serve eight million people as their numbers continue to grow. Under CMS initiatives and similar initiatives in the commercial market, proactively managing the care of at-risk patients can propel a fragmented fee-for-service system into a “Triple Aim” future.

COPE Health Solutions is strongly invested in this Triple Aim mission – with a particular passion for integrating systems of care for safety net patients and growing tomorrow’s future workforce from today’s diverse communities. Over the past 15 years, more than 24,000 diverse health scholars have participated in a credit course that affords them hands-on patient care experiences in hospitals and health systems. They develop a passion and empathy for vulnerable patients, enhance the patient experience and see the particular struggles that safety net patients experience in making sense of health care’s “un-system.”

In line with these values, in 2008, two years before the ACA, COPE Health Solutions partnered with Kern Medical Center in Bakersfield, California, a large public hospital and trauma center, to implement a care coordination program to reduce emergency department utilization and inpatient services by high utilizers of care. Hospitals across Los Angeles County also partnered to pilot the program.

A key strategy for the health system was a care management program for low-income adults identified as frequent users of hospital services.[3] Through the program, a care coordinator staffed the ED to make referrals, and a trained care manager was assigned to eligible patients.

The program in Kern County had measurable and documented successes,[4] including a significant drop in the likelihood of ED utilization. Among those patients who participated in the program, unadjusted ED costs per patient per year fell from $2,545 pre-enrollment to $1,874 post-enrollment. However, despite the success of Kern County's care coordination program, the financial incentives punished the system for "doing the right thing."

As a result, COPE Health Solutions was forced to put its care coordinator training and services on the back burner, pending changes to the financial incentives of the health care system. Now, with increasing "value-based" government and private payments, implementation of a care coordination program to reduce the use of high cost acute care services and enhance patient health and experience is now not only more financially sustainable, but a critical success factor for any hospital or health care system. "Bundled" or risk-based payments, especially combined with institutional risk, are differentiators among health systems; prospective payment means that the cost of case management staff and population oversight, along with sophisticated health Information technology, can be readily offset by savings.

Where will these competent and helpful hands come from? Must they be clinically-licensed or are there roles for non-clinically licensed but highly

[3] *Frequent users defined as having four or more ED visits or admissions; three or more admissions; or two or more admissions and one ED visit within a 12-month period*

[4]:http://journals.lww.com/lww-medicalcare/Abstract/2011/02000/Evaluation_of_Care_Management_for_the_Uninsured.9.aspx)

trained navigators? Should they reside in the health plan or in the health systems or physician's office?

For all the talk about systems, finance and technology, closely managing and coordinating the care of a vulnerable patient or member is fundamentally an expression of human concern through well-trained, caring hands. Further, the prevalence of chronic disease and co-morbidities creates an imperative for a new approach to organizing health care delivery. Increasingly, the role of a care navigator becomes paramount – to meet a patient where they are and walk side-by-side with them on the path to better health. The role requires empathy, native language and cultural understanding, strong communication and problem-solving.

There is no substitute for skilled clinicians. Team-based care requires the participation of an inter-disciplinary care team shaped around the clinical, social and behavioral needs of the patient. These roles include primary and specialty care physicians, nurses and other clinical, social and behavioral health professionals.

However, many of the critical roles in care coordination and population health management are "middle-skill" jobs that do not require clinical licensure – freeing clinicians to work at the top of their licenses. Further, in a community setting, clinicians or mid-levels may not be the appropriate provider type to address non-clinical tasks that can be performed by individuals who have received appropriate training. These responsibilities can be supported by specially-educated, trained, culturally-competent, non-clinically licensed staff.

The Care Navigators in Kern County were non-clinically licensed individuals with prior experience as case workers or medical office assistants, who also received training and education on social and community resources, communication and health topics. They helped their patients with assessing physical and social barriers, goal creation and achievement, care navigation, access to support services, transitions of care, and served as liaisons during provider visits.

These Care Navigators were able to perform a variety of crucial non-clinical tasks that helped their patients access care, navigate the system and participate in their own wellness. They freed up the licensed professionals to concentrate on the tasks which truly required their experience and advanced licensure.

The question of where Care Navigators should reside is controversial. Increasingly, health plans are assuming accountability for this function and are the optimal location for some aspects of population health management. However, given the primacy of the provider's role and accountability, it is very important that the primary care physician and health system staff maintain oversight and ultimate control of Care Navigators. The provider's central control minimizes the increasing perception of multiple coordinators from the insurer and providers tripping over themselves and confusing patients.[5]

With the challenge in mind of filling this pressing need for non-licensed Care Navigators, COPE Health Solutions has developed a certification program for non-clinically licensed individuals (as well as licensed) to allow them to provide care coordination and patient ambassador services under clinical staff supervision. Standard training elements include the development of competencies for professional conduct; basic health promotion; the elimination of barriers to care; identification and understanding of high risk populations; and facilitation of communication and connection to resources.

The Care Coordination certification offers our health system clients a carefully developed training curriculum, standardized processes and a "turn-key" operation. The training is carefully customized to the client through an organizational assessment, interviews with site staff and meetings with labor representatives.

[5] *The Tangle of Coordinated Care*, NY Times, 4/14/15 http://mobile.nytimes.com/2015/04/14/health/the-tangle-of-coordinated-health-care.html?_r=4&referrer=

Further, our experienced consulting team is available to support health systems with wrap-around services to ensure sustainable success with a new Care Coordination program. Wrap-around consulting services embed the care coordination program into an overall integrated care delivery system, including ambulatory network development, clinical workflow redesign and development of financial incentive models, such as independent physician associations, ACOs and licensed health plans.

Health care has changed. The clunky, misaligned systems that served a narrower range of patients in the past are highly inadequate to meet the new demands of an expanded, sicker and more diverse patient population. In such an environment, a customized care coordination strategy that incorporates workforce planning is required in order to achieve the most touted goals of Triple Aim.

Learn more about us and how we can help you in the changing market at:

www.copehealthsolutions.org

Our Vision: Our clients are leaders in adding value for consumers through innovations in population health management, talent development and alignment of financial incentives.

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