Population Health 360
A COMPREHENSIVE LOOK

Round Table Discussion Notes

Care Management and Care Models

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Bluethorn 8

Round Table Facilitators

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(Multi layered Question) How can we advance that agenda for improvement of practice? (And) What will the partnership between payers and providers, what does that care model team look like? Who should govern? Who has the right resources? Tools? Managing dynamic between provider and payer?	• Some organizations have clinically integrated networks that has practice transformation and medical groups. Provide in-house care coordinators, so does the payer, conversation around resources that you have and what we have: findings: patients are being coordinated by multiple coordinators. Developed process to fix engagement, transfer to community health worker team, mapping out different resources we have and capacity. - Engaging Spanish speaking patients, with Spanish speaking nurses - Going to provider first, proactively • Our organization − if doing care coordination, it's going to be done by us as the provider; we have the relationship skillset and ability to deliver. It is interesting because we still have dynamics going back and forth with the finance end, which leads me to ask, how do we let payers in? What do they do when they are in there? Deny us more and withhold revenue? Will they start employing AI technology that can go against the organization? The fact we are not providing discreet data electronically is slowing down info transfer and operations. • We need a trust factor, right now there's an "us and them" tone. This lack of trust makes it impossible to build collaboration. We are building CIN and assessing capabilities between us and other providers in CIN. My sense is there's a sweet spot − need to develop the infrastructure to support direction. • Our network is over 200 practices, not all on one EMR − maybe they have clinical pharmacist and allow in office visits to leverage their resources, and if they do, we leverage them. Look at populations and identify what they can and cannot do, design roles and responsibilities around that piece. • We have care management and care coordination, and what we call navigators. We are all doing some type of clinical care coordination.

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	Some have care coordinators with health plans and then some from housing programs or social service agencies, so now suddenly one person can have 8 people. It's costly and terribly confusing, and takes up time – looking at a regional health reorganizations. We have so many different types of care coordinators, no one can understand the level of care per role. At some point we thought that kind of service was enabling (back in the day) and now we're making up for that. We try to lower cost and brought in people who are helpful but not efficient. Need scope and competencies. Navigator here and a navigator here have different roles − inconsistent and fragmenting our services.
Mental health infrastructure – there was hope that by moving these patients and uprooted the system to now what we call health homes. How do we standardize it across populations?	• Dawn: I remember doing chronic care improvement program. How do you take a FFS population and try disease management to coordinate their care? Attribute to hospitals, wrap services around so they don't receive multiple services and various medications etc. • Now the driver is looking at health plan, can you manage spending of members and who are you now providing wrap around services? And everyone is overlapping around a patient; how do we peel back those layers and who is responsible? Who is accountable, so it is less confusing for person in the middle? When you drive innovation you can tend to create chaos, and the chaos always seems to rest with the most vulnerable person. • Internal processes, standardization of roles are critical to reduce variation
How do we teach patients their own health literacy to learn how to escalate their own needs?	• Our organization works in provider space and plan space: when you think about case, care management we all interpret differently. But as a health plan, some market plans do it all, boots on the ground, managing members A-Z; some markets don't have it so they welcome it (variance) • NCQA / CMS requires highly regulated and documented, states Medicaid, audit: care plan! Goals and engagement – did you track outcomes? Very few provider orgs can do that. Some regulations are not tightened up. For Ex: provider with 500 thousand members. Can you take delegation for case management back? Have to have resources, have to have interdisciplinary team members, and have to have a system documentation. Look at it from a requirement lens, and infrastructure to support cause. • Transparency is not there. Large organizations feel they're being told what to do. • Everything we do we are starting to get saturated with maximum requirements for achieving outcomes. If you follow all steps you'll get to core elements you can't negotiate on and most meaningful. • Accountability − parameters need to be redefined • Effective use of huddles in providers, can we follow that and provide info to the ROI? • What are key outcome metrics we all agree are important? Huddles need to be data driven? What are measures? Have weekly feedback loop, intervention. Working or not? Who are you reviewing in the huddle and why?

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	• Care coordination, you need something or someone to coordinate, who is the individual to assess where's there risk? What do they need and what do they want? Then determine do I need to stabilize? I have under-duals, and then on other side I have ACO model and risk 1115. • On dual side: I can't get a Doctor to call me back. On ACO side: hands off they're ours! Once you delegate and you've got a practice that is accepting that responsibility, they come back to us and say that's really hard, did you know your patient has been in hospital in last three months? What they're learning is you need the feet on the street. • No infrastructure where food pantries are etc., coming along, half health plan says give it to them and other half says "yes" but they need our help. Coming from morning sessions on collaboration. Dual side practices don't really want these folks because they are hard to manage.
How do you share the person?	• We're rounding − nothing new and innovative, but how do we hand off the members with their assessment and their care plan and give me a go to person. If you're working on integrated care plan it tends to fall in place. We have an interdisciplinary team, nurses, MH care coordination. • COPE Health Solutions is assisting our health plan, and we brought them in to do a care model and to make a recommendation on managing cost and get better at demonstrating outcomes: RN care owner of care plans and accountable to oversee interventions. Aligns incentives, and can hold folks accountable, and support them. • Role clarity! Working at highest point of licensure. Make sure you're not using resources you don't need. If person is in community, I need the community health worker to problem solve • Model rolled out for patients with cog impairment, and we used CHWs that managed a panel of 200 and gave them screening tools for: Medical Director/ RN, SW Team, CHW • Tools and model worked well, (publications) because it was a cog imp and beh. health it showed results for caregiver. Now how do we scale that up with other populations? Scaling of a model requires minimum core elements. • How are you using your data? People get PIP projects need to be disciplined about how we look at our population, not everyone requires minimum touch. And workforce development! Organizational commitment around segmentation and what it takes to develop that workforce/ Solid workforce models to hire for the right traits. • Regional hospital admin, 3 of us then 3 leaders of medical group, we met every week, then health plan brought us the problem list so we developed plans, fragmented to putting together large groups. Medicare benefit. We gave responsibility to health plan office and that failed us. We redesigned program and now it's back to physician leaders / ownerships some time to get providers to take • Look at Cuban model, community worker program to be deployed. We need strategic alignment.

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Who is doing what? How do we minimize confusion?	• Community health literacy/ how to access care? • How to understand primary care and when to use? • How can we orient patients and our clients to services in communities?