Collaborative Care for Enrollees With Multiple Conditions: A Triple Aim Strategy

Author: Howard Springer, Vice President

Our current health care system has become financially unsustainable with gaps in care, silos and duplication in care delivery, and lacks bridges to critical support services necessary for improving health outcomes. One challenge is that overall population health is determined by factors and social determinants outside the health care delivery system. Per the Healthy People 2020 vision, "Determinants of health reach beyond the boundaries of traditional health care and public health sectors; sectors such as education, housing, transportation, agriculture, and environment can be important allies in improving population health."[1]

Enrollees with multiple chronic health conditions typically comprise 20% of the population but consume 80% of the resources (80/20 rule). These enrollees are considered high risk as a result of poor disease management and a FFS volume-based health system with gaps in care. Average costs for enrollees with multiple chronic health conditions range from $1200 PMPM (commercial) to $5000 PMPM (Medicare) as a result. Addressing inefficiencies within the care delivery (reducing waste, rework, and redundancies) can reduce unnecessary health care expenses that provide no benefit to the enrollee. Improving outcomes and value is a longer-term strategy.

Successful transformative strategies require not only addressing the costliness of the top 20% (rising risk) through more effective delivery of health care services, but also building operational linkages to the non-health sectors that address "social determinants of health" through specific investments in new, multidisciplinary workforce capacity, delivery system reform and population health improvement. While Medicaid transformation demonstrations are strategies to transform health care for government programs they are relevant to commercial and self-funded employer groups as solutions.

COPE Health Solutions can provide an assessment of your current effectiveness for addressing your high-risk/rising risk population and strategies to improve access, improve care, reduce cost of care and improve provider and enrollee satisfaction (Quadruple Aim).

Collaborative care for high-risk enrollees with multiple health conditions require interventions beyond the primary care visit, and can best be achieved by providing resources within the primary care setting to address many of the concomitant stressors affecting the enrollee. Behavioral patterns and social circumstances, such as mental health, substance abuse, social/economic stressors, and adverse childhood experiences (ACEs) [2]

are more than 60% of the determinants to health, and result in 23% avoidable Emergency Department (ED) visits and a 70% higher readmit rate over baseline for discharges from inpatient facilities. For Medicaid enrollees, behavioral patterns and social/economic stressors result in increased homelessness, morbidity and mortality of health. Providers have inadequate resources to meet the complex needs of their patient population due to gaps, silos and lack of alignment of funding (especially in a fee-for-service environment). Collaborative care with a systematic case review (treat to target) integrates best practices within primary care, and is high-touch/high communication with enrollees suffering from multiple chronic conditions. Collaborative care transitions practices to value-based care by focusing on quality (HEDIS/Stars), outcomes and satisfaction.

Studies have shown that in primary care settings, providing access to and addressing behavior patterns/social economic factors of enrollees suffering from multiple health conditions reduces avoidable ED visits and 30-day readmissions, improves HEDIS bundled metrics for chronic illness, reduces depressive symptoms (PHQ 9) and improves satisfaction of the enrollee and provider. Collaborative care interventions are more effective than usual care for depression, anxiety disorders and co-morbid medical conditions such as heart disease, diabetes and cancer.[3] Implementation has resulted in lower total cost of care and has also lowered the following health indicators: HBA1c, BP, HDL, and PHQ 9 scores.

As compared with usual care, an intervention involving trained staff who provide guideline-based, patient-centered care management of chronic disease while monitoring depression, significantly improves control of medical disease and depression for enrollees.[4] This program increases primary care access and capacity and addresses the federal objectives for Medicaid enrollees.

Collaborative care is a low-risk, evidence-driven turnkey solution for providers to effectively take risk for chronically ill patients by improving measurable outcomes and quality metrics while reducing medical expenses.[5] Additionally, providers can bill for some collaborative care services through CPT code 99490 for care management services. These revenues offset some of the startup costs during the transition from volume-based to value-based reimbursement.

The financial return for commercial and Medicare populations has been greater than 200-300%. Locally, a more than 120% ROI for staffing costs was realized by targeting the top 20% of utilizing enrollees with multiple diagnosis by just reducing unnecessary ED and imaging expenses. Savings began within three months of enrollment into the program by reducing unnecessary utilization including: $117 PMPM ED savings and $15 PMPM imaging savings. Additional savings accrued from reduced pharmacy expenses and re-hospitalizations over time. HEDIS quality indicators and health status improves as well. An additional $41.98 PMPM revenue from CPT 99490 is available for care management for eligible enrollees.

This type of transformation enables practices to transition to value-based care and increase their capability for taking medical risk for enrollees in a sustainable manner using both CPT codes for care management and shared savings.

About COPE Health Solutions

This is one example of a strategy to implement Quadruple Aim. COPE Health Solutions provides expertise and resources to help regional delivery systems implement Delivery System Reform and Innovation Programs (DSRIP) Medicaid waiver projects in California, Texas, and New York and Washington. Successful projects have:

- Reduced avoidable use of intensive services in settings such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional long term services and supports (LTSS), and jails.

- Improved population health, with a focus on prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders, and oral health that is coordinated and whole-person centered.
- Accelerated the transition to value-based payment, while ensuring access to specialty and community services.
- Ensured that Medicaid per-capita cost growth is below baseline trends.

COPE Health Solutions' mission is to help our clients achieve visionary, market-relevant health care solutions. Check out our website: https://copehealthsolutions.org/.

References:

[1]http://www.healthypeople.gov/2020/topics-objectives/topic/vision

[2]http://www.cdc.gov/violenceprevention/acestudy/about.html

[3]Collaborative Care for Patients with Depression and Chronic Illnesses, Katon,W., New England Journal of Medicine, 2010;363. (http://www.nejm.org/doi/pdf/10.1056/NEJMoa1003955; 27 December 30, 2010);27 December 30, 2010)

[4]Systematic Case Review: Improving Treatment for Complex Mental and Medical Conditions, Trevis, J.

[5]http://www.samepage.samepagehealth.com/home/outcomes