Integrated Acuity-based Care Model Design and Implementation for Vulnerable Populations

BUILDING A SUSTAINABLE CARE MODEL THAT MEETS THE QUADRUPLE AIM

A successful care model is the underpinning of effective care management that drives toward value. Care management is a core competency of any organization that seeks to be sustainable under value-based payment models and consistently provide high-quality, efficient care to its patient population.

THE CHALLENGE

- Upward trend on inpatient utilization
- Downward trend in PCP follow-up
- Population with unique and complex needs
- Need to define a clear path to manage utilization trends without compromising quality

THE OPPORTUNITY

1) GOALS
- Financial sustainability
- Program planning
- Successful procurement

2) TARGETED OPPORTUNITIES
- High performing network that meets population needs
- PCP engagement and incentive alignment
- Data-driven and evidence-based care model redesign

3) DATA-DRIVEN AND EVIDENCE-BASED CARE MODEL REDESIGN
- Amplify team-based care model
- Provide clinical infrastructure
- Relieve burden of work on CMs
- Deploy resources based on acuity
- Ensure skill-task alignment
- Design member-centric processes
- Drive greater accountability at all levels
- Define and leverage metrics

REDESIGNING THE CARE MODEL

STEP 1: ASSESS CURRENT STATE CARE MODEL

DATA ANALYSIS

COPE Health Solutions partnered with Tufts Health Plan to:

- Perform accelerated claims and social determinants of health (SDOH) data analyses
- Examine utilization characteristics to identify predictors of avoidable spend

AREA OF IMPACT

Reduce inpatient utilization including:

- Avoidable inpatient admissions
- 30-day readmissions
- Shifting single-day admissions to observations
- Shifting inpatient behavioral health to outpatient programs

Reduce PCA utilization and duplicative services

Shift hospital-based outpatient surgery to ambulatory surgery centers

RESULTS

- 5% of expenses included in the medical claims extract (members with at least 10 months of eligibility) were from potentially avoidable or preventable inpatient or ED events
- 18% of inpatient admissions included in the medical claims extract were from potentially avoidable inpatient events
- One-half of the potentially avoidable expenses were from 16% of the total members - those in top quartile of PMPM costs and 3 or more chronic conditions

INTERVENTION

- Care Transitions
- Care Management
- Data Analytics & Access
- Utilization Management
- Network Development

STEP 2: DESIGN FUTURE STATE CARE MODEL

CURRENT STATE

RN Care "Team"	BH Care "Team"
Nurse Care Manager	BH Care Manager
Members w/ primary medical diagnosis	Members w/ primary BH diagnosis

Care managers responsible for relationship management, assessments, transitions of care, PCP coordination, connection to services and all clinical management

- Outreach / Scheduling Team
- CHWs
- LTSS Program Coordinators
- MDS Nurses
- Assessment Team [Pilot Only]

FUTURE STATE CARE MODEL

CARE TEAM 1	CARE TEAM 2
Accountable Nurse Care Manager (Lead)	Accountable Nurse Care Manager (Lead)
• BH Care Manager	• BH Care Manager
• Care Coordinator	• Care Coordinator
• CHW	• CHW
• Peer Specialist	• Peer Specialist
Sub-Specialties based on Population	*Sub-Specialties based on Population*

- Enrollment Team
- Assessment Team
- Care Transitions Team
- Clinical Pharmacy Team

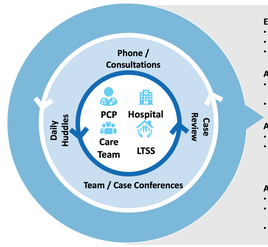
1. CARE MODEL STAFFING AND ROLE DEFINITION

Care team composition is fundamental to care model redesign. The care team of the future is multidisciplinary, interdisciplinary and interprofessional, allowing for top-of-license care provision. The new care team was diversified to meet these needs, but in a manner that was cost neutral to the original team composition. This allowed for an expanded and more tailored approach to care management.

CRITICAL SUCCESS FACTORS

- **Understanding the job market:** Ensure that newly defined roles are consistent with available skillsets in the market place (Scopes of Practice, Job Descriptions)
- **Defining roles and responsibilities:** Accountability is key and is enabled by clearly defined roles and responsibilities with the care team
- **Training the staff on new roles:** Each staff member was trained on the model and on their individual role to foster understanding of daily tasks and responsibilities as well as how they fit into the larger picture of the model of care

CARE TEAM ROLES



Enrollment Specialist
- Welcome Calls
- Brief Health Risk Screen
- Scheduling Assessment

Assessment RN
- Comprehensive, MDS, & LTSS Assessments
- Reassessments

Attribution Manager
- Risk level determination
- ICT assessment, case load management, regional management

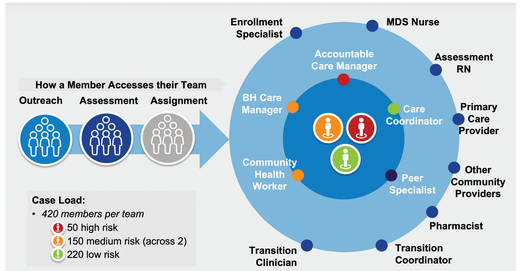
Accountable Care Manager
- Care team oversight
- High-risk member management
- Clinical escalation

BH Care Manager
- BH, SUD consult & Support
- BH-primary member management

Care Coordinator
- Low risk member management
- Scheduling support
- Care team interface
- SDOH support

Community Health Worker
- Moderate-risk member management
- Community-based resource referral
- Face-to-face support

Peer Specialist
- Consult on principles of recovery
- Member advocate



SCOPE OF PRACTICE OVERVIEW

Community Health Worker Scope of Practice

For Illustrative Purposes Only

Task Level	Definition
Approved	Task is approved for your role without explicit approval.
Licensed Approval Required	Task requires explicit approval from a licensed care team member for your role (necessary licensure specified in task).
Restricted	Task is restricted based on licensure requirements, and hand-off to a licensed care team member is required.

Level	#	Task
Approved	1	Outreach to members either in-person or telephonically.
	2	Connect members with emergencies to 911 and escalate to relationship lead, ACM, and PCP.
	3	Escalate members with risks to relationship lead and ACM for care plan adjustment.
	4	Collaborate with members and the care team to eliminate duplication of services.
	5	Schedule appointments and conduct reminders/follow-ups with members.
	6	Support members in obtaining/picking up medications.
	7	Reinforce education provided by care managers and relationship leads.
	8	Contribute thoughts and insights to inform care plan updates.
	9	Document interventions and interactions in CCMS.
	10	Maintain care plans for moderate-risk members.
	11	Outline preliminary care plans for moderate-risk members.
	12	Update care plans for moderate-risk members.
	13	Participate in case reviews and care team huddles.
	14	Attend appointments with members.
Licensed Approval Required	15	Request support for medication reconciliation and ensure completion.
	16	Support members in adhering to treatment regimes, as specified by care plan
Restricted	17	Complete comprehensive assessments.
	18	Administer medications.
	19	Complete medication reconciliation.
	20	Make diagnoses.
	21	Provide clinical recommendations or advice on medical, BH-related, or medication items.
	22	Assign or reassign members to a care team
	23	Approve or finalize care plans.

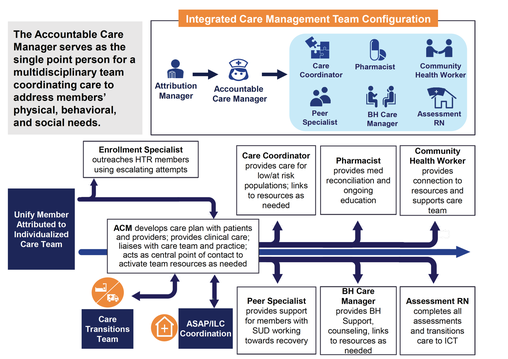
2. WORKFLOW AND PROCESS DEFINITION

Having the right team is the first step. Leveraging them in the most impactful manner requires clear processes and protocols. Staff are educated on tools and processes, and ongoing high-touch support was provided to ensure process adherence.

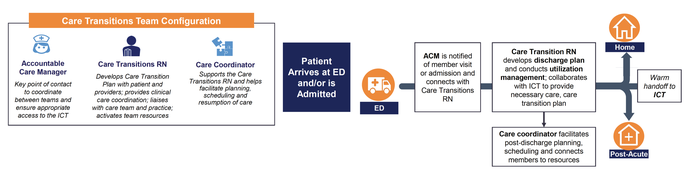
CRITICAL SUCCESS FACTORS

- **Health Risk Assessments Early in Patient Engagement:** This allowed the right care team to convene around the patient and the deployment of resources in alignment with urgency of needs
- **Daily Huddles and Timely Intervention:** Care teams collaborated to review cases and resolve issues allowing for timely identification and resolution of patient needs
- **Data-Driven Care Management:** Documentation during care model processes allows for monitoring of the process and allows timely access to information and provision of dynamic, in-the-moment care

The Accountable Care Manager serves as the single point person for a multidisciplinary team coordinating care to address members' physical, behavioral, and social needs.



A single, unit-based workforce performs discharge planning, utilization review, and social work functions in an integrated and coordinated workflow



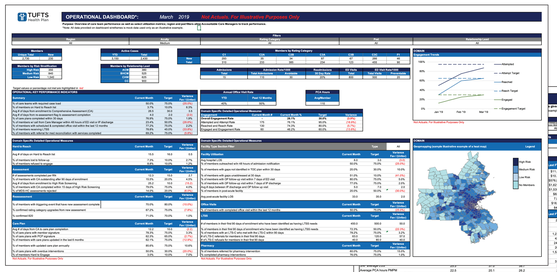
3. MONITORING AND PERFORMANCE MANAGEMENT

It is imperative that performance indicators be monitored for process adherence and efficacy. This involved establishing data analysis and reporting processes that fed both operational and executive dashboards.

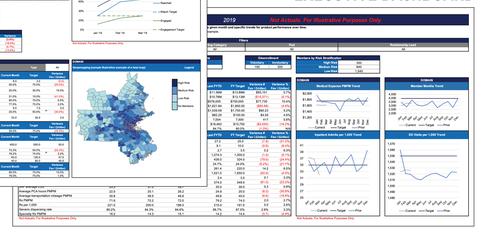
CRITICAL SUCCESS FACTORS

- **Selecting the right KPIs:** Using a menu of evidence based Key Performance Indicators (KPIs), selected those that monitor key aspects of the care model
- **Reporting and Review Cadence:** Establish process in collaboration with the data and analytics team to process data and generate reports and dashboards for timely review
- **Action Orientation and Authority:** In monitoring trends and rates, leadership can identify anomalies and drill down further into the data. Available information allows leadership to not just understand what is wrong but learn why

OPERATIONAL DASHBOARD



EXECUTIVE DASHBOARD



4. POST IMPLEMENTATION

CARE MODEL IN ACTION: PATIENT VIGNETTES

ACCELERATED COMPREHENSIVE ASSESSMENT PREVENTS UNNECESSARY ED VISITS

Detect / Escalate	Engage Team & Solution	Resolve
• During the initial Health Risk Assessment (HRA) the member informed the Enrollment Specialist (ES) that she was in severe pain and assigned to new MD • ES immediately schedules the member for their assessment and signals ACM	• Accountable Care Manager reviews HRA and assigns member to CC • CC outreaches member and MD provides immediate treatment and the member secures an appointment	• Member's pain was resolved in real time, avoiding an ED visit • Her assessment and care plan were completed • Positive member experience

MEMBER ACTIVATES TEAM INSTEAD OF VISIT TO ED

Detect / Escalate	Engage Team & Solution	Resolve
• Upon initial outreach to a newly assigned member, the CC helped the member get an appointment with his GI specialist • Subsequently, the member called to report increasing abdominal pain and need to go to the ED	• The CC alerted the ACM who called the member to further evaluate his pain • The ACM followed up with the GI specialist who saw the member on that day and initiated treatment	• Member's pain was resolved in real time, avoiding an ED visit • Her assessment and care plan were revised • The team huddled on this member until his condition stabilized • Positive member experience

SECURING HOUSING PRIOR TO SNF DISCHARGE

Detect / Escalate	Engage Team & Solution	Resolve
• During rounds between UM and CM, a member's status in a SNF was discussed with the team • Member was approaching discharge (complex, with multiple chronic conditions ESRD) • Member lived on the 4th floor with a non functional elevator; Housing was the top priority for discharge	• The TOC RN engaged with member's son and SNF team to activate CHW to identify housing options in advance of planned discharge • The team huddled on this member to stay informed of progress and position to remove any barriers to plan	• The CHW and TOC RN found housing for this member • The member was discharged with services on schedule • The UM/CM/TOC interface was organized and the team was proactive and prevented avoidable SNF days • Positive member experience

DATA DRIVEN CARE MODEL: RAPID CYCLE IMPROVEMENT

KPI DATA COLLECTION REFINED FOR CARE PLAN UPDATE METRIC

Monitor	Examine	Refine
• In revie operational dashboards and reports, noticed care plan update rates were lower than expected • Leadership reviewed a sample of cases to explore the issue • This seemed incongruent to other findings including lower case loads and higher touch patient care	• Further examination of cases and discussions with team revealed that care plan updates were made appropriately • Many members reviewed did not require an update to their care plan. These were counted in the denominator but not the numerator of the rate	• Working t additional drop down options to refine data collection • Adding options to indicate "no update required" allows recognition that cases were reviewed and a deliberate decision was made • Increased precision in KPI reporting

KPI EXCLUSION CRITERIA REFINED FOR OUTREACH METRIC

Monitor	Examine	Refine
• In revie operational dashboards and reports, noticed a low attempt rate for member follow up within 48 hours of discharge • Data, clinical and front line team members convened to discuss the results to identify the root cause	• Discussion with the care management team revealed that follow up attempts were made when members were discharged home, but not when discharged to another inpatient setting • Together they distinguished between data and operational root causes	• Working with the data team to refine the exclusion criteria in the logic producing the reports • By removing the discharges to SNF, leadership will have a more accurate view of performance • Refined logic for more accurate and actionable KPI

CONTACT INFORMATION

For more information on how we can help you with your care model, please email info@copehealthsolutions.com.