Are We There Yet?
Evaluating Care Coordination Systems

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Network for Regional Healthcare Improvement (NRHI)

- National organization representing over 30 member Regional Health Improvement Collaboratives (RHICs)
  - Non-profit, non-governmental agency
  - Based in Portland, Maine
- Fostering collaboration across all healthcare stakeholders
  - Providers
  - Employers
  - Payers
  - Patients
Regional Health Improvement Collaboratives

- NRHI has over 30 members who collectively serve more than 40% of all Americans
Regional Health Improvement Collaboratives

- Aligning Forces for Quality – South Central PA
- Alliance for Health
- Better Health Greater Cleveland
- California Quality Collaborative
- Center for Clinical Systems Improvement
- Center for Improving Value in Health Care (Colorado)
- Common Table Health Alliance
- Finger Lakes Health Systems Agency
- Greater Detroit Area Health Council
- Health-e Connections
- HealthInsight Nevada
- HealthInsight New Mexico
- HealthInsight Utah
- The Health Collaborative (Greater Cincinnati)
- The Healthcare Collaborative of Greater Columbus
- Institute for Clinical Systems Improvement
- Kansas City Quality Improvement Consortium
- Louisiana Health Care Quality Forum
- Maine Health Management Coalition
- Maine Quality Counts
- Massachusetts Health Quality Partners
- Midwest Health Initiative
- Minnesota Community Measurement
- North Texas Accountable Healthcare Partnership (NTAHP)
- Oregon Health Care Quality Corporation
- P^2 Collaborative of Western New York
- Pacific Business Group on Health (PBGH)
- Pittsburgh Regional Health Initiative
- Washington Health Alliance
- Wisconsin Health Information Organization
- Wisconsin Collaborative for Healthcare Quality
Components of Better Coordinated, More Integrated Care

<table>
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<th>Term</th>
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| Care management              | Additional outreach and support to people with special needs  
|                              | • Frail elderly, uncontrolled diabetics                                                                                                                                 |
| Care coordination            | Coordination of care across settings  
|                              | • Discharge from inpatient to home care; skilled nursing facility to home                                                                                                                                 |
| Super utilizer/hot spotting  | Often mix of care management and care coordination  
|                              | • Frequent fliers in ED                                                                                                                                 |
| Integrated care systems      | Integration across traditional providers  
|                              | • Medical homes, health homes, ACOs, etc.                                                                                                                                 |
| Population health            | Health of an attributed population  
|                              | • Attributed to my practice, my ACO                                                                                                                                 |
| Health of community          | Incorporates and addresses needs of community  
|                              | • Jobs, housing, food, education, etc.                                                                                                                                 |
Where the Industry is Headed

- Plan-based
- Telephonic
- Disease management
- Traditional care managers
- Uniform approach
- Negligible impact on quality, cost of care, or patient’s life

- Provider-based
- In-person, community
- Stratified/targeted
- Team-based with non-traditional providers
- Tailored to changing needs of patient
- “Secret sauce” to impact avoidable re-admits, ED use, etc.
Federal Activity Supporting Better Coordinated, More Integrated Care

- Key investments:
  - Comprehensive Primary Care initiative, Multi-payer Advanced Primary Care Practice
  - Pioneer and Medicare Shared Savings Programs
  - Innovation Awards
  - State Innovation Model – Rounds 1 and 2
  - Transforming Clinical Practice Initiative
- Medicare Transitional Care Management code
- Congressional efforts as well
  - Primary Care Parity/PCP Bump extension
- And others…
Public Purchaser Activity Supporting Better Coordinated, More Integrated Care

• Continuing expansion of Medicaid managed care
  – Including more populations and integrating more services

• Extensive investment in the delivery system
  – 43 states with medical home initiatives ¹
  – 15 states have 24 health home programs (Section 2703) ²
  – Requiring plans to move provider networks towards greater value in part through integration
  – Expansion of regional care coordination entities
  – Design and implementation of ACOs

• State agencies beginning to converge strategies

¹ http://www.nashp.org/med-home-map
Private Sector Activity Supporting Better Coordinated, More Integrated Care

- Employers under intense pressure to manage costs
  - But reluctant to constrain employee choice
- Commercial plans testing new models
  - Abundance of activity around value-based purchasing
  - Concerns about too-narrow networks
  - Careful assessments of provider ability to accept risk
  - Reducing investments in disease management for investments care coordination/management
  - Significant jump in plans’ reporting of value-oriented payments to in-network physicians and hospitals

Regional Activity Supporting Better Coordinated, More Integrated Care

• Growth of multi-payer, multi-stakeholder regional collaboratives
• Trusted, third-party conveners in the region, state
• Foster local solutions – given regional markets – for advances in delivery system and payment
• Heavy reliance on state or regional data analytics to identify regional opportunities for better care
• Partners for states seeking engagement from other purchasers (e.g., employers), from payers, and from consumers
California

• **Pacific Business Group on Health**
  – Intensive Outpatient Care Program - $19M CMMI Innovation award for medically complex patients
  – Goal: Improve clinical outcomes and patient experience; reduce preventable hospital use
  – PBGH role: recruited medical groups, built infrastructure, provided training, monitoring progress and metrics
    • 23 partners; 512 practices; 9K Medicare, Medicaid, duals
  – Care coordinators in longitudinal 1:1 relationship with patients
    • Face-to-face “super visit” within 1 month of enrolling
    • 24/7 access with communication to care coordinator
    • Phone, email, or in-person visit each month
Colorado

• Proliferation of care management/coordination initiatives
  – Ground zero: Alamosa-San Luis Valley
  – How to align care transition initiatives across state?

• Healthy Transitions Colorado
  – Medicare, commercial payers, Medicaid, and full spectrum of providers – medical and non-medical - required to improve care
  – Center for Improving Value in Health (CIVHC)
    • Using APCD to calculate care transitions metrics for community
    • Shining light on duplication of care coordination programs/efforts
    • Fostering local connections between service providers
  – Impact: Medicare readmits trending downward
  – Challenge: Who should/will fund this important work?
Maine

- **Maine Quality Counts** set strong foundation for advanced primary care through MAPCP initiative
  - Supported addition of two Medicaid health home programs
- Working directly with providers on care transitions
  - Educating and setting expectations with practices around readmits
  - Leveraging/promoting Health Information Exchange (HIE) and getting practices to use it
  - Convening learning collaboratives that build relationships between practices, skilled nursing facilities, hospitals
Ohio

• Red Carpet Care - multi-payer initiative targeting highest cost, most complex, impactable patients

• Better Health Greater Cleveland obtained grant funding and is convening parties
  • Funding care coordinators to manage patients – 75 commercial, 75 Medicaid – and hired advanced practice nurses with prescribing privileges
    – Supporting practices through individual coaching and learning collaborative

• Impact on commercial side: $400 PMPM decrease

• Medicaid results out soon
What Are We Seeing?

- Expansion of medical homes, patients, payment\(^1\)
- Mixed/inconclusive results for impact on quality and cost
- Increases in NCQA PCMH certification
- Some evidence of improvements in care
  - Rhode Island’s Multi-payer Chronic Care Sustainability Initiative\(^2\) – ↓ in ambulatory care sensitive ED visits
  - Oregon’s Coordinated Care Organizations Year 1 Results\(^3\)
    - ED visits ↓ 17%, ED costs ↓ 19%, admits ↓
    - Outpatient primary care ↑ 11%, primary care spend ↑ 20%

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1 Samuel T. Edwards, Asaf Bitton, Johan Hong and Bruce E. Landon. Patient-Centered Medical Home Initiatives Expanded In 2009−13: Providers, Patients, And Payment Incentives Increased Health Affairs, 33, no.10 (2014):1823-1831
2 Meredith B. Rosenthal, PhD1; Mark W. Friedberg, MD, MPP2,3,4; Sara J. Singer, MBA, PhD1,4,5; Diana Eastman, BA1; Zhonghe Li, MS1; Eric C. Schneider, MD, Effect of a Multipayer Patient-Centered Medical Home on Health Care Utilization and Quality - The Rhode Island Chronic Care Sustainability Initiative Pilot Program, JAMA Intern Med. 2013;173(20):1907-1913.
3 Presentation by Jeanene Smith, MD, Oregon Health Authority; October 15, 2014, State Health Policy Academy
What Are We Seeing? (Cont’d)

• Many levers to pull, but change in services rendered, in referrals made, in managing the patient’s care happens locally, at the point of care

• Providers manage their whole patient panel - Medicaid is just one part

• Therefore, better coordinated, more integrated care needs to be a multi-payer, multi-stakeholder, and local approach
A Few Considerations

- Lots going on - how to align efforts so we don’t perpetuate chaos, fragmentation?
- Which specific interventions are impacting specific outcomes? Do we care?
- If not paying for volume, *then what*?
- How to effectively engage specialists and hospitals in this effort?
- Could there be too much integration? What happens then?
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