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Bridging the Care Management Gap and Cutting Costs: A Systemwide Strategy

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Learning Objectives

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- Discuss an approach to map care management needs across a health system by defining patient populations and stratifying them by level of risk and areas of need.
- Describe one way to address barriers to institutional culture change that could help move toward systemwide care management.

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Defining the Problem: A Journey Beginning in 2020

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Our institution, as a large matrix academic center, aimed to improve: 1) the patient experience for complex patients and 2) our accountable care contract performance.

The CMO, CEO, and other key leadership requested for Population Health and Transitions of Care to review and create a systemwide mapping and approach to care management.

Challenges identified:

- taxonomy across the organization with varying meaning and scope
- lack of standardization in practice, scope, and workflow
- lack of alignment and communication standards resulting in process inefficiencies
- lack of risk stratification and standardized care model resulting in fragmented interventions

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A Systemwide Approach to Care Management

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Redesign Journey	Creation of an integrated model of care management and care coordination to bolster program development and emphasize quality and safety.
	Led the movement away from a medical or tertiary model approach involving episodic care focused upon acute health problems to a model that is designed for the continuum of care management and coordination services.
	With on-the-ground experience in care management and expertise in national care management models, we began with a systemwide mapping of care management functions and national best practices (including site visits).
	Co-defined the mission of our care management program.

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A Systemwide Approach to Care Management

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Patients with advanced disease or psycho-social needs require a higher level of support to maintain their quality of life, stay healthy at home and avoid unnecessary ED and hospital visits.

We prioritize high risk, high need patients (based on clinical condition, social-behavioral factors, etc) and those with chronic conditions.

We organize and partner with multidisciplinary, multispecialty teams to make systemwide improvements across our organization to provide more efficient, effective, aligned care and to keep these patients healthier at home.

These multi-modal interventions include an integrated care management approach and initiatives to meet patients' upstream and condition specific needs.

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Developed a Mission for our Care Management Program

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We partner with patients, providers, payers, and communities to provide measurable, efficient, equitable, high-quality care through results-driven care management, actionable data, tech-enabled tools, and evidence-based practice.

Population Health Approach to Intensive and Advanced Care Management

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Who are our high need, high risk populations? (segmentation)

- Look at overall population
- Look by chronic conditions: CKD, COPD/ asthma, heart failure, liver failure, cancer, CAD, stroke + DM, HTN, opiate use, etc.
- Look by other social behavioral factors: social determinants of health (SDOH), deprivation, vulnerability, etc.

Who are our high and rising risk subpopulations? (risk stratification of each population segment)

Risk Modeling

- Prospective risk of hospitalization or ED visit within the next 12 mos
- Risk of hospitalization or ED visit over next days

How do we develop tech-enabled, operational, and clinical care pathways?

- IT builds to streamline efficient workflows (bulk outreach, registries, telehealth, video visits, remote monitoring)
- Centralized intensive population health care management with proactive clinical and social decline pathways, coordination and navigation, community resources, home-based services, and more
- Local primary and specialty care team workflow integration to new tools and care management infrastructure

Population Health Delivery Model

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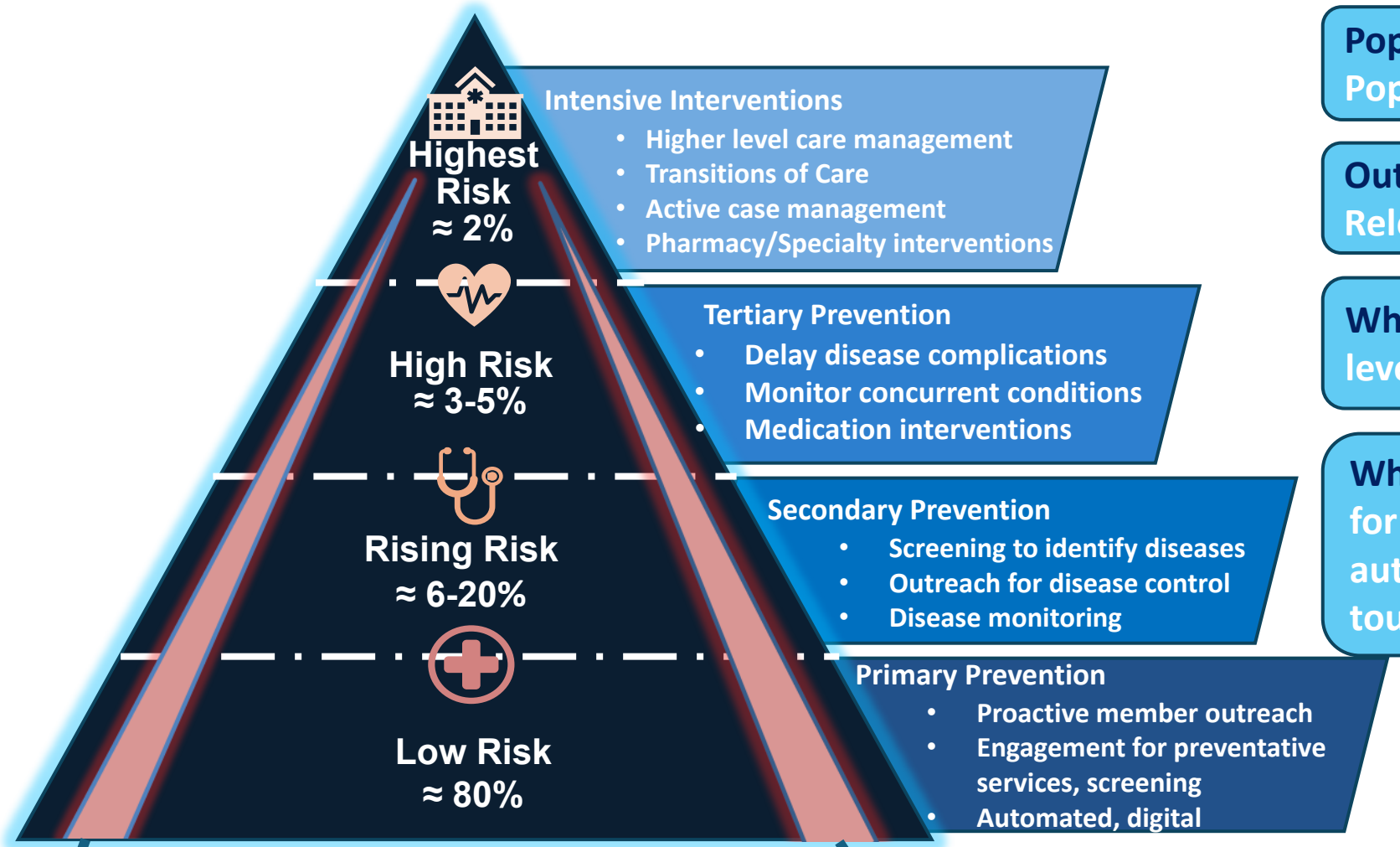

Intensive Interventions
- Higher level care management
- Transitions of Care
- Active case management
- Pharmacy/Specialty interventions

Tertiary Prevention
- Delay disease complications
- Monitor concurrent conditions
- Medication interventions

Secondary Prevention
- Screening to identify diseases
- Outreach for disease control
- Disease monitoring

Primary Prevention
- Proactive member outreach
- Engagement for preventative services, screening
- Automated, digital

Population: UC Davis Active Patient, Population Health Patient Registry

Outcome: Hospitalizations, ED visits, Relevant care gap closure

Why?: To prevent poor outcomes at all levels of risk

What? Tailored proactive interventions for each risk level, leveraging automation, digital health, with high touch efforts focused toward top tiers

SDOH: Food, transportation, housing

Health Equity: Race, gender, age

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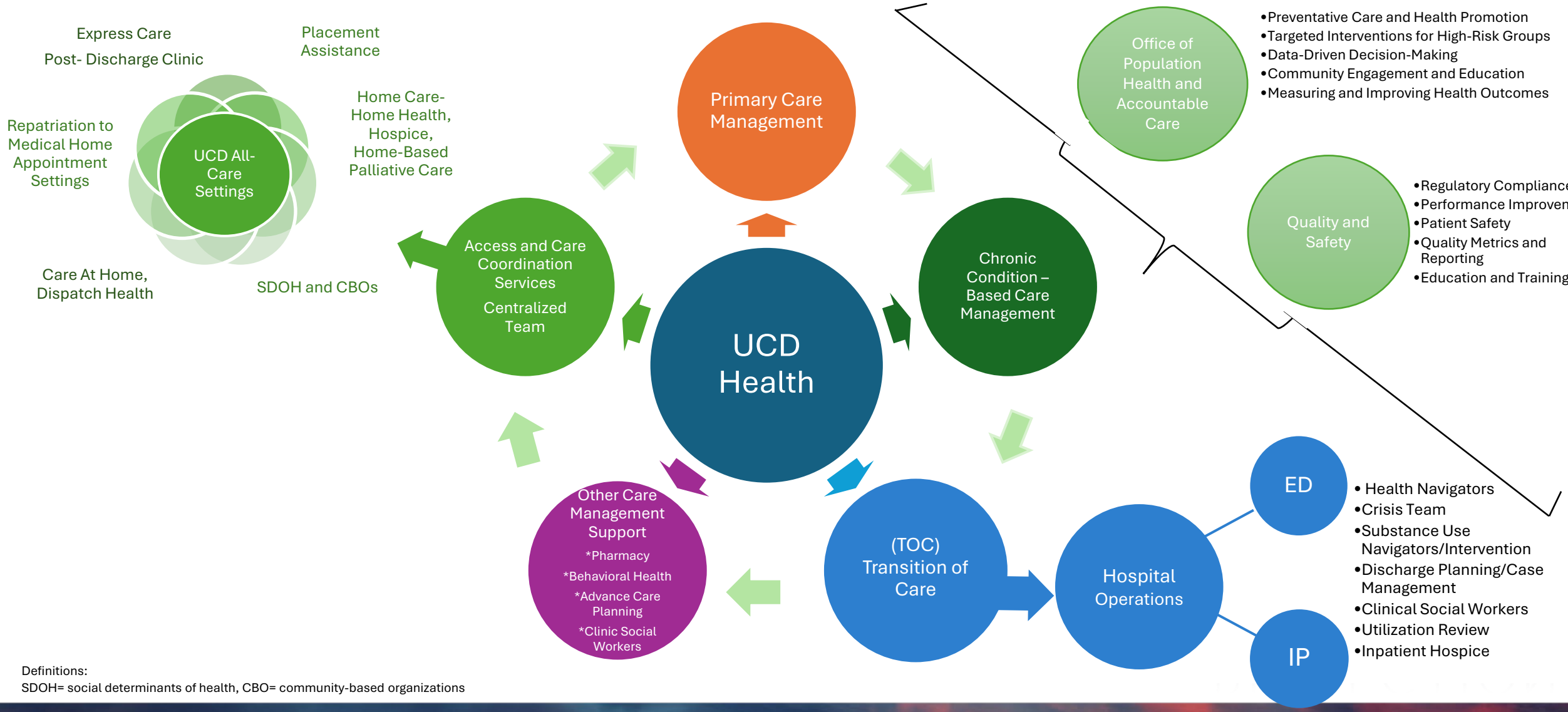
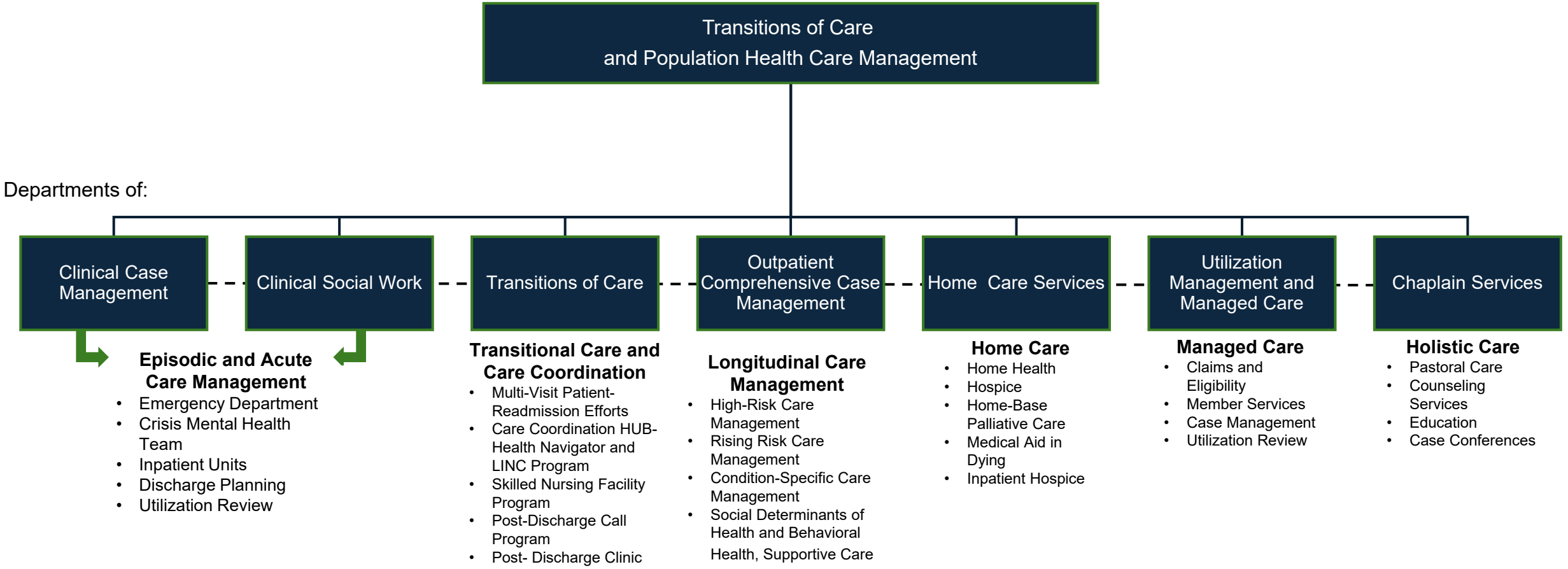
Integrated Services in Care Management, Transitional Care, and Population Health for Comprehensive Organizational Impact

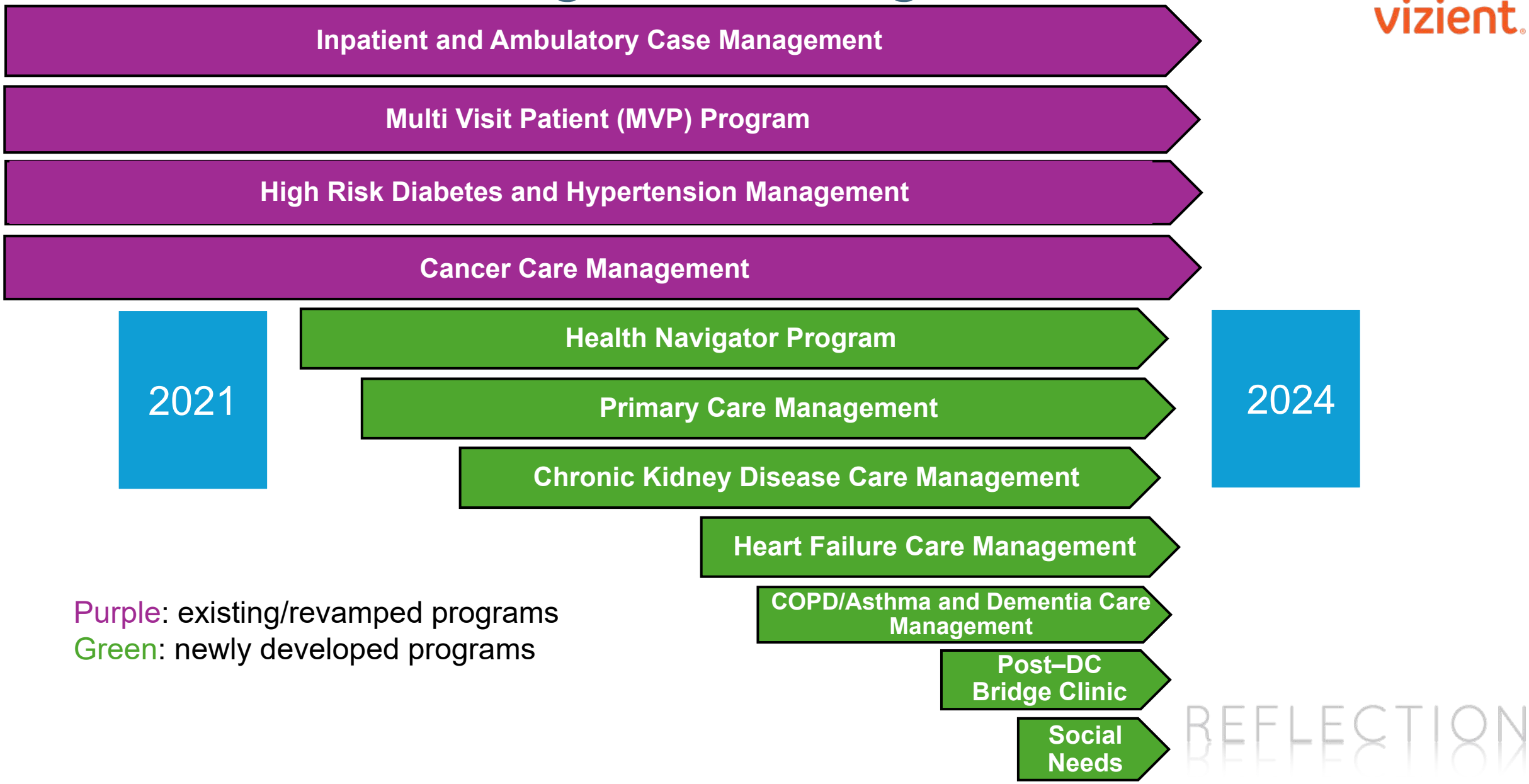


Definitions:
SDOH= social determinants of health, CBO= community-based organizations

Organizational Structure

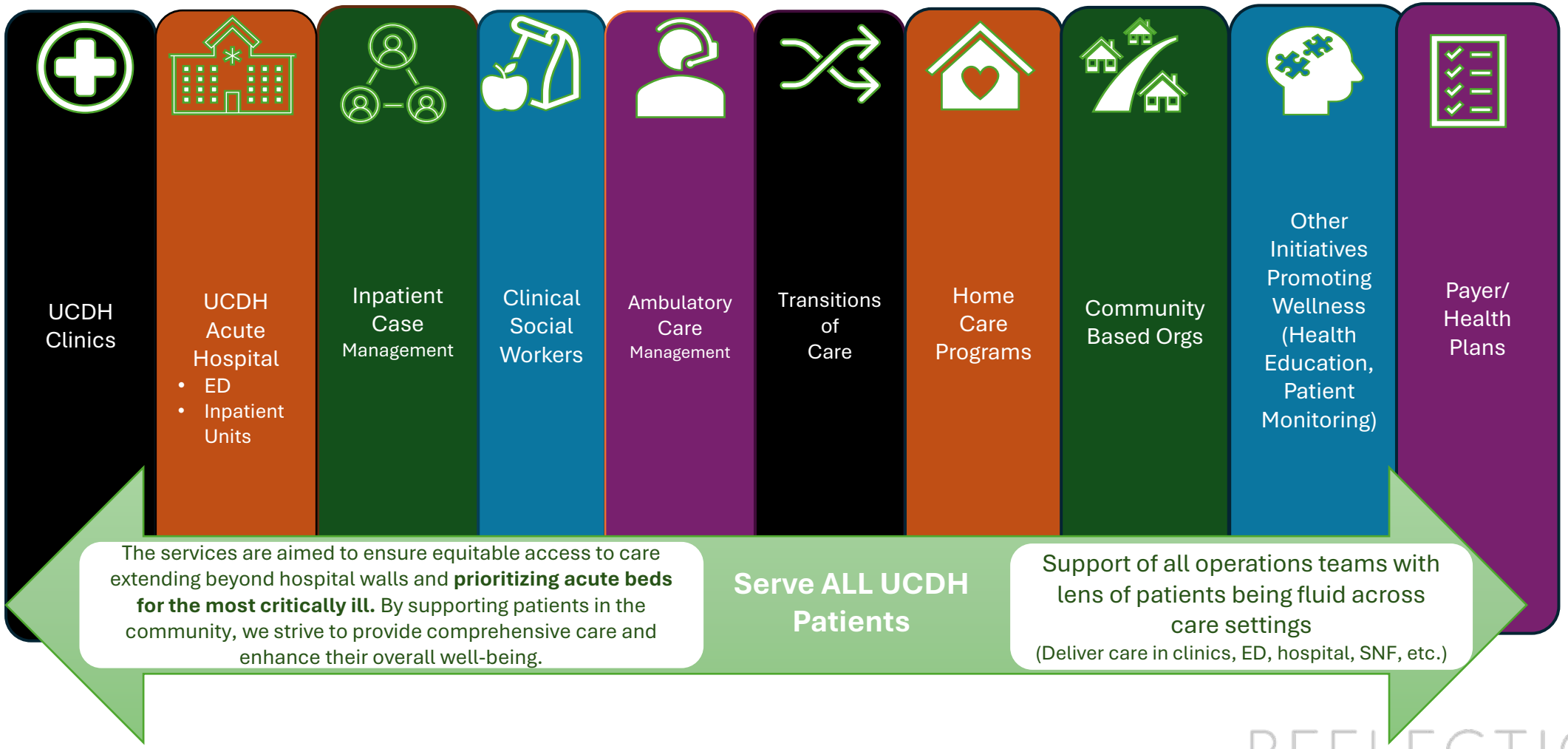


Timeline of Care Management Redesign



Purple: existing/revamped programs
Green: newly developed programs

Population Health Collaboration



Care Management Framework Based on Clinical Acuity, Risk of Future Acute Care Utilization

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	Acute Care Needs	Chronic Care Needs
Lower Intensity Care Management	**Phenotypes 1:** • A low to moderate risk patient for future hospitalization/ ED visits by risk model • E.g., Just discharged from the hospital or ED	**Phenotypes 3:** • Rising risk patient (i.e., moderate risk patient for future hospitalization/ ED visits by risk model) • Needs additional chronic condition management or education • E.g., Chronic diabetes or hypertension management
High Intensity Care Management	**Phenotypes 2:** • Maybe not be identified as high risk for future hospitalization/ ED visit by risk model; however, had an acute event for a short period making high risk for readmission or ED visit • Multiple complex care management and acute coordination needs • E.g., Post-surgical patient with complex medical and care coordination needs	**Phenotypes 4:** • High or very risk patient for future hospitalization/ ED visit (by risk model) • Multiple complex care management and coordination needs on an on-going basis • E.g., Late-stage chronic kidney disease, COPD, diabetes, mental health condition, unhoused status

Prepared by Vanessa McElroy, TOC and Dr. Reshma Gupta, OPHAC

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Primary Care Management (low to high intensity, chronic > acute)

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Population

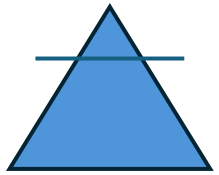
- Adult UCDH primary care patients with an ED or hospital visit in the past year, and who are at 60% or greater risk of being seen in the hospital or the ED again within the next year

Focus

- Managing acute clinical or social decline
- Care coordination, chronic condition self-management education and support, proactive outreach, and monitoring of patient needs
- Coaching, monitoring, follow-up, and providing timely connections with the right resources
- Linking to other appropriate care managers across health system including pharmacy

Staffing/Reach

- 12 LVNs and 5 RNs who provide intensive care management
- 3500 eligible patients



Results

- Following enrollment in the PCM program, patients have:
  - 17% lower ED visit rates
  - 28% lower hospitalization rates
  - 13% fewer ICU days compared to their baseline utilization

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Chronic Condition Care Management (high intensity, chronic > acute)

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Population

- Adult UCDH patients with chronic kidney disease, COPD/ asthma, heart failure, dementia and cancer, ED or hospital visit in the past year, and 60% or greater risk of being seen in the hospital or the ED again

Focus

- Helping patients meet unique condition-specific care management and coordination needs in alignment with primary care management services
- Condition-specific care plans (e.g. renal replacement therapy for CKD), self-management education, care coordination, timely referrals to specialty care, outreach for patients experiencing acute clinical decline

Staffing/Reach

- 1-2 RNs/RTs per condition, longitudinal intensive care management and coordinate with related CM staff across care venues
- Goal is 80-100/FTE

Results

- Following enrollment in chronic condition CM programs, compared to their baseline utilization, patients have:
  - COPD/Asthma
    - 30% lower ED visit rates
    - 47% lower hospitalization rates
    - 33% fewer ICU days
    - 1.2 days reduction in LOS
  - CKD:
    - 7% lower hospitalization rates
    - 1 day reduction in LOS

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Health Navigator Program (low to high intensity, acute)

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Population

- IP & ED Discharges (Health Navigators):
  - Patients discharged home needing follow-up care (establish PCP, coordinate PCP/specialty)
- Ambulatory Care Coordination (LINC)
  - Comprehensive Care Coordination around SDOH
  - Current: Ambulatory Case Management, Rheumatology, Endocrinology, Heart Failure, ED RNs, Sickle Cell Disease, Chronic Kidney Disease
  - Future: All primary & specialty patients

Focus

- Tailored care plans addressing medical, social, and psychological needs of high utilizers
- Remove discharge barriers for SNF placement and enhance quality and continuum of care with UCDH MDs, NPs, coordinators, and pharmacists providing direct care
- Prevent unnecessary ED or IP rehospitalizations by addressing post-discharge concerns

Staffing/Reach

- 18 Navigators, 2 Supervisors
- 23,000+ patients offered care coordination support
- Health Navigators provide care coordination support to 58% of ED patients and 42% of inpatients.

Results

- Clinical team no longer performing care coordination tasks
- Navigators integrated as part of the standard care delivery
- Achieved top Vizient benchmark for 7-day follow-up for high-risk patients
- ~60% of Care Coordination post ED/IP are with external facilities

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Multi-Visit Patient (MVP) Program (high intensity, acute > chronic)

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Population

- Patients with 4 or more ED encounters in the last 90 days
- Patients with 4 or more hospital admissions in the last 12 months

Focus

- Improve patient care and experience
- Tailored care plans to address medical, social, and psychological aspects of the high utilizer patient
- Foster collaboration among multidisciplinary team; leverage community resources
- Reduce unnecessary readmissions, decrease inefficiencies and health care costs

Staffing/Reach

- 2 RNs
- 140 Individual Care Plans published
- Daily review of re-admitted patients, prior 24hrs
- Daily recommendation for care management and care coordination interventions
- RN engagement with MVP while in-house to help with discharge and transitional care planning support

Results

- 69% of patients with an individualized care plan created had reduced visits
- Estimated 3,824 visits avoided
- Reductions were sustained beyond 12 months

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Post-Discharge Clinic (PDC) (high intensity, acute)

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Population

- High-risk patients needing 7-day follow-up care post-IP or ED visits
- 2 or more ED visits or inpatient hospitalization in last 12 months
- Primary Care Patient needing Same-Day Appt (Scheduled by Nurse Triage Team)

Focus

- Ensure high-risk patients have 7-day follow-up post ED/IP visits (& SNF Colab Partners)
- Enhanced Continuum of Care
- Address SDOH by providing free transportation to appointments and linkage to community resources
- Transition patients back to own medical home after 1-2 visits

Staffing/Reach

- 1 NP, 1 LVN
- 5-days, 70 clinic slots, 30 minutes each
- >9k patients meet criteria per year

Results

- 27.0% lower 30-day ED revisits (26.8% for patients who completed PDC visits vs. 53.8% for no f/up target patients)
- 24.2% lower 30-days Inpatient rehospitalization (22.6% for patients who completed PDC visits vs. 46.8)
- 34.6% of PDC visits are telemedicine (compare to 18.2% across our health system
- 73.1% target population are non-UCD affiliated

Lessons Learned

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- Having a unified reporting structure is helpful to implement care management across teams and achieve alignment in documentation, intake processes, shared information and workflows, and stewardship of resources.
- A strong physician-nursing-operations triad is vital for planning and implementation of a systemwide care management program.
- Evaluation of care management programs should begin with a measurement of baseline performance and be updated regularly to clearly measure success.

Key Takeaways

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- Be willing to imagine your health system structure as if you could build up care management from scratch with a lens of stewardship
- Map out silos and where this work is being done, even if not called care management
- Be open to making mistakes and walking into the politics of breaking down silos – this sometimes requires leadership change
- Deep investment in quality assurance to make sure staff is consistently executing on workflows

Questions?

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