Improving Care for High-Need Patients

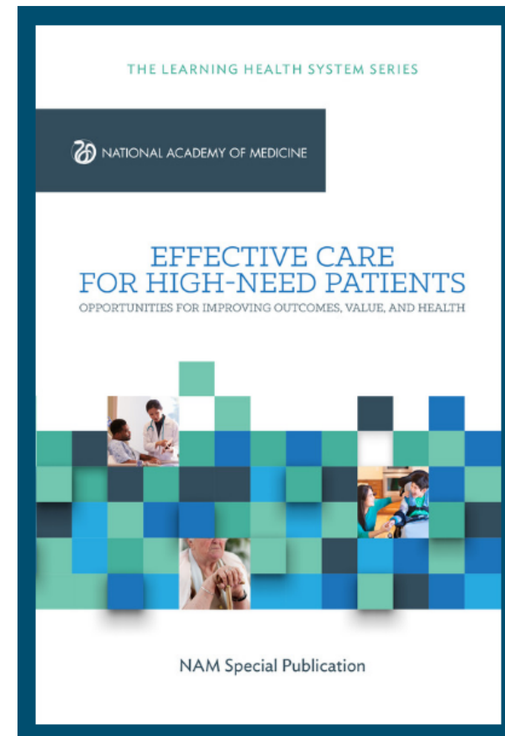
Featuring Commonwealth Care Alliance

Webinar Series

February 16, 2018 | 12:00 – 1:00PM ET

nam.edu/HighNeeds

Share your thoughts!



This webinar series is produced in partnership with the Peterson Center on Healthcare.

NATIONAL ACADEMY OF MEDICINE

Leadership • Innovation • Impact | *for a healthier future*

AGENDA

WELCOME & OVERVIEW OF PUBLICATION 12:00 – 12:05

Henrietta Awo Osei-Anto, National Academy of Medicine

Michael McGinnis, National Academy of Medicine

MODEL DEVELOPMENT 12:05 – 12:15

Malinda Ellwood, MassHealth
Design and Conception of the One Care Program

MODEL IMPLEMENTATION 12:15 – 12:45

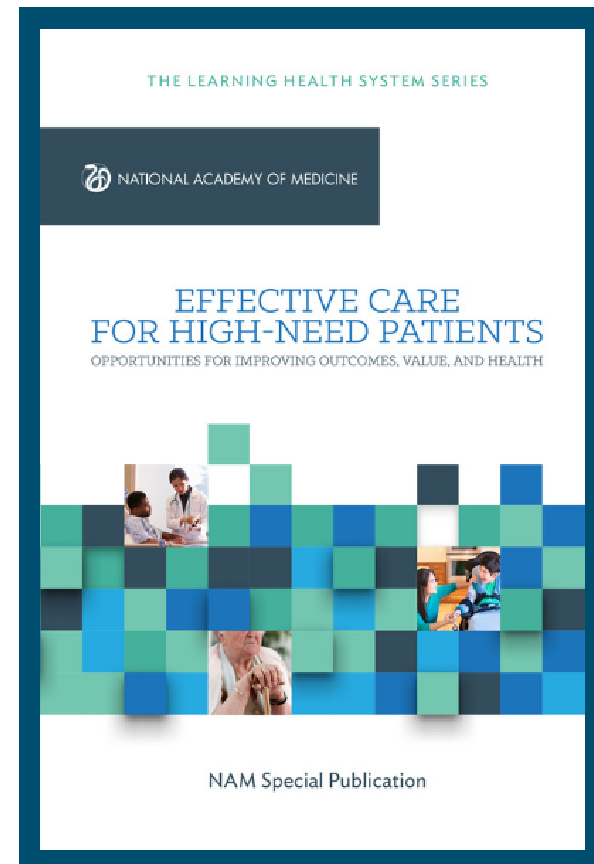
Lori Tishler, Commonwealth Care Alliance
Introduction to One Care at Commonwealth Care Alliance

John Loughnane, Commonwealth Care Alliance
Innovations for One Care members at Commonwealth Care Alliance

AUDIENCE Q&A 12:45 – 1:00

Welcome & Introduction

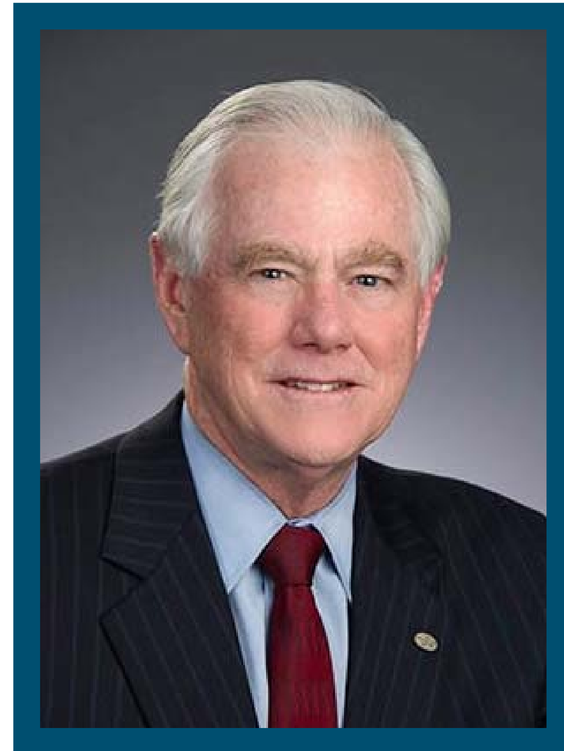
Henrietta Awo Osei-Anto
National Academy of Medicine



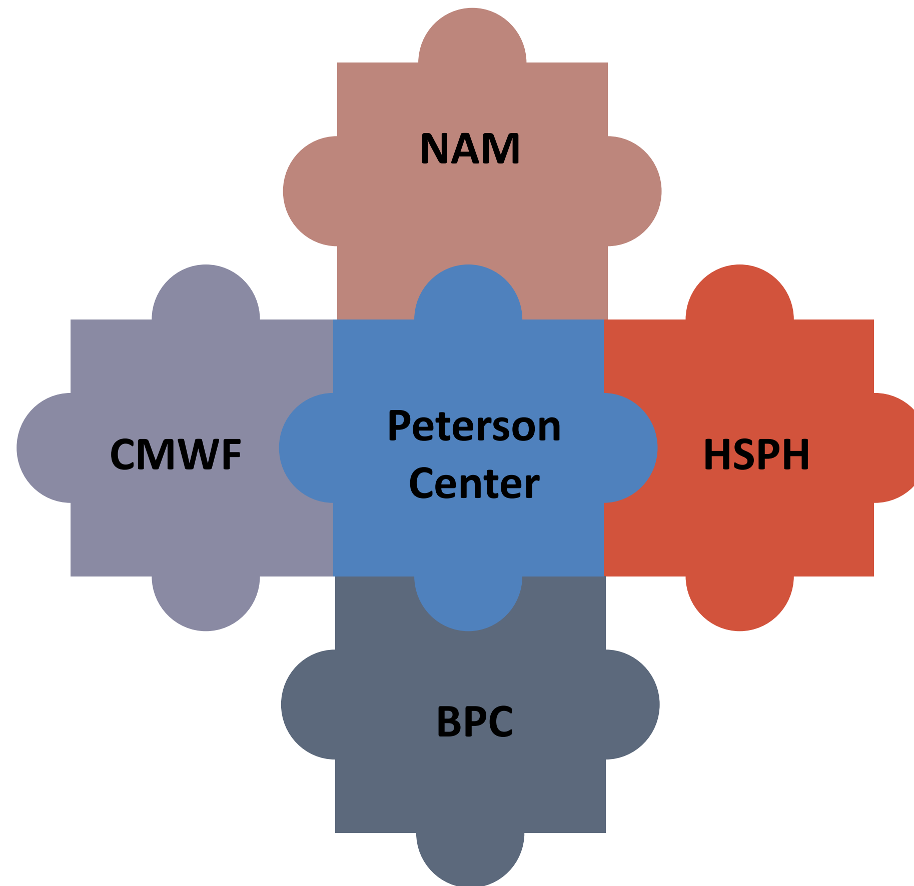
Overview of Special Publication

J. Michael McGinnis, MD, MPP

Leonard D. Schaeffer Executive Officer
National Academy of Medicine



Partners



Collective goal: Advance our understanding of how to better manage health of high-need patients through exploration of patient characteristics and groupings, promising care models and attributes, and policy solutions to sustain and scale care models.

Planning Committee

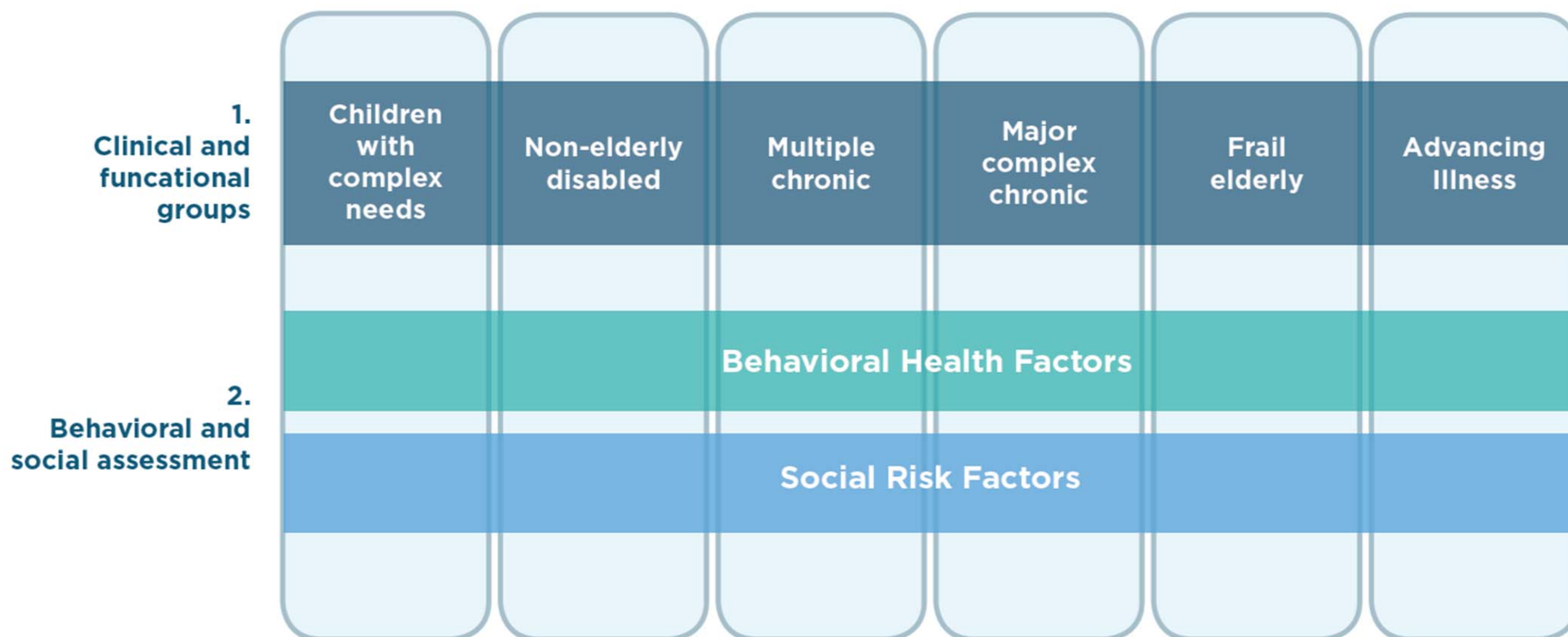
PETER V. LONG (*Chair*), President and Chief Executive Officer, Blue Shield of California Foundation
MELINDA K. ABRAMS, Vice President, Delivery System Reform, The Commonwealth Fund
GERARD F. ANDERSON, Director, Center for Hospital Finance and Management, Johns Hopkins Bloomberg School of Public Health
TIM ENGELHARDT, Acting Director, Federal Coordinated Health Care Office, Centers for Medicare & Medicaid Services
JOSE FIGUEROA, Instructor of Medicine, Harvard Medical School; Associate Physician, Brigham and Women's Hospital
KATHERINE HAYES, Director, Health Policy, Bipartisan Policy Center
FREDERICK ISASI, Executive Director, Families USA; former Health Division Director, National Governors Association
ASHISH K. JHA, K. T. Li Professor of International Health & Health Policy, Director, Harvard Global Health Institute, Harvard T.H. Chan School of Public Health
DAVID MEYERS, Chief Medical Officer, Agency for Healthcare Research and Quality
ARNOLD S. MILSTEIN, Professor of Medicine, Director, Clinical Excellence Research Center, Center for Advanced Study in the Behavioral Sciences; Stanford University
DIANE STEWART, Senior Director, Pacific Business Group on Health
SANDRA WILKNISS, Health Division Program Director, National Governors Association Center for Best Practices

Process

- Convened experts over the course of three workshops:
  - **Workshop 1:** Who are high-need patients, and what does successful care for these patients look like?
  - **Workshop 2:** What data exists on this population and what can it tell us? How do we segment high-need patients for best care?
  - **Workshop 3:** How can we match patient segments to the best fitting care? What are the policy barriers?
- Convened taxonomy and policy work groups

Characteristics of High-Need Patients

- High-need patients are diverse and have varying needs
- Variables that could form a basis for defining this patient population include:
  - Total accrued health care costs
  - Intensity of care utilized over a given time
  - Functional limitations
- The needs of this population often extend beyond their medical needs to social and behavioral services


Conceptual Model of a Starter Taxonomy for High-Need Patients
1.
Clinical and
funcational
groups
Children with complex needs
Non-elderly disabled
Multiple chronic
Major complex chronic
Frail elderly
Advancing Illness
2.
Behavioral and
social assessment
Behavioral Health Factors
Social Risk Factors
Note: For this taxonomy, functional impairments are intrinsically tied to the clinicial segments.

Care Models that Deliver

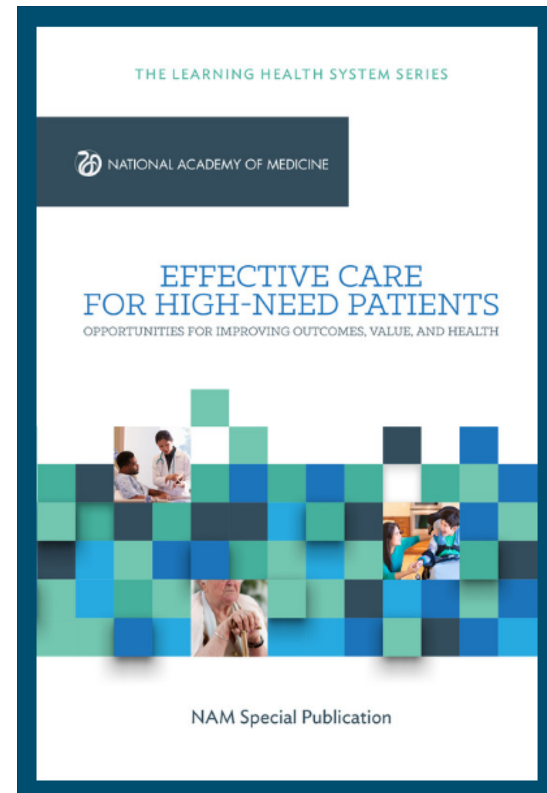
Delivery Features of Succesful Care Models

- **Teamwork.** Multidisciplinary care teams with a single, trained care coordinator as the communication hub and leader
- **Coordination.** Extensive outreach and interaction among patient, care coordinator, and care team, with an emphasis on face-to-face encounters among all parties and collocation of teams
- **Responsiveness.** Speedy provider responsiveness to patients and 24/7 availability
- **Feedback.** Timely clinician feedback and data for remote patient monitoring
- **Medication management.** Careful medication management and reconciliation, particularly in the home setting
- **Outreach.** The extension of care to the community and home
- **Integration.** Linkage to social services
- **Follow-up.** Prompt outpatient follow-up after hospital stays and the implementation of standard dis charge protocols

Today's Federal Program

One Care Program
Commonwealth Care Alliance
Commonwealth of Massachusetts

www.mass.gov/one-care
www.commonwealthcarealliance.org



Model Development

Malinda Ellwood

Health Programs Policy Analyst
MassHealth

One Care

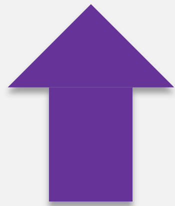
MassHealth+Medicare
Bringing your care together

MassHealth Presentation
National Academy of Medicine:
Improving Care for High Needs Patients Webinar Series
February 16, 2018

What is One Care?

One Care is a state-federal demonstration that allows people age 21-64 who are eligible for both MassHealth and Medicare (dual eligibles) to receive care as part of a single plan offering comprehensive benefits.

Goals of One Care



Improve Health & Functional Outcomes

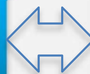
Person-Centered Coordinated Care

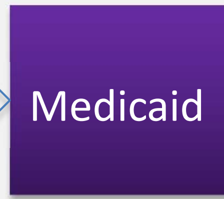
Fragmentation Of Care

Fee For Service Focus

Outcome Focus

Address Cost – Shifting between Programs





Target Unsustainable Cost Increases

What services are covered?

Medicare: All Part A, Part B, and Part D services

Medicaid State Plan Services

- including Long-Term Services and Supports (LTSS)

Integrated to Improve Quality and Reduce Unnecessary Costs

Behavioral Health Diversionary Services

Community Support Services

Flexible Services

Who are the populations being served in One Care?

Adults with physical disabilities

Adults with intellectual/ developmental disabilities

Adults with disabilities who are homeless

Adults with serious mental illness

Adults with multiple chronic illness or functional and cognitive limitations

Adults with substance use disorders

Care Model Development and Stakeholder Involvement

- Member advocates and other stakeholders worked collaboratively with MassHealth from the early planning stages, and their ideas have helped shape One Care into a high-quality person-centered model. Our stakeholders work with us to continually drive improvement and innovation in One Care.
- MassHealth worked with stakeholders during One Care's development to:
  - Identify gaps in services and care coordination
  - Build a care model that enables individuals with disabilities to live independently
  - Ensure care is person-centered, and that members' goals drive their services
  - Develop strong member protections
- MassHealth developed an Implementation Council to ensure an ongoing role for consumers and other stakeholders in implementation
  - Independent body required to be majority consumer members (and/or family members)
  - Also includes providers/trade organizations, unions, community-based organizations, and other advocates

Person-Centered Care

Health Care based on the goals and preferences of the individual being supported in the design and implementation of services

- Decides who will attend meetings and be involved in decisions
- Attends every meeting about his/her care
- His/her goals and preferences play an integral role in decision-making process
- All options are fully explored and discussed and choice is respected

Dignity

Respect

Self-determination

Purposeful Living

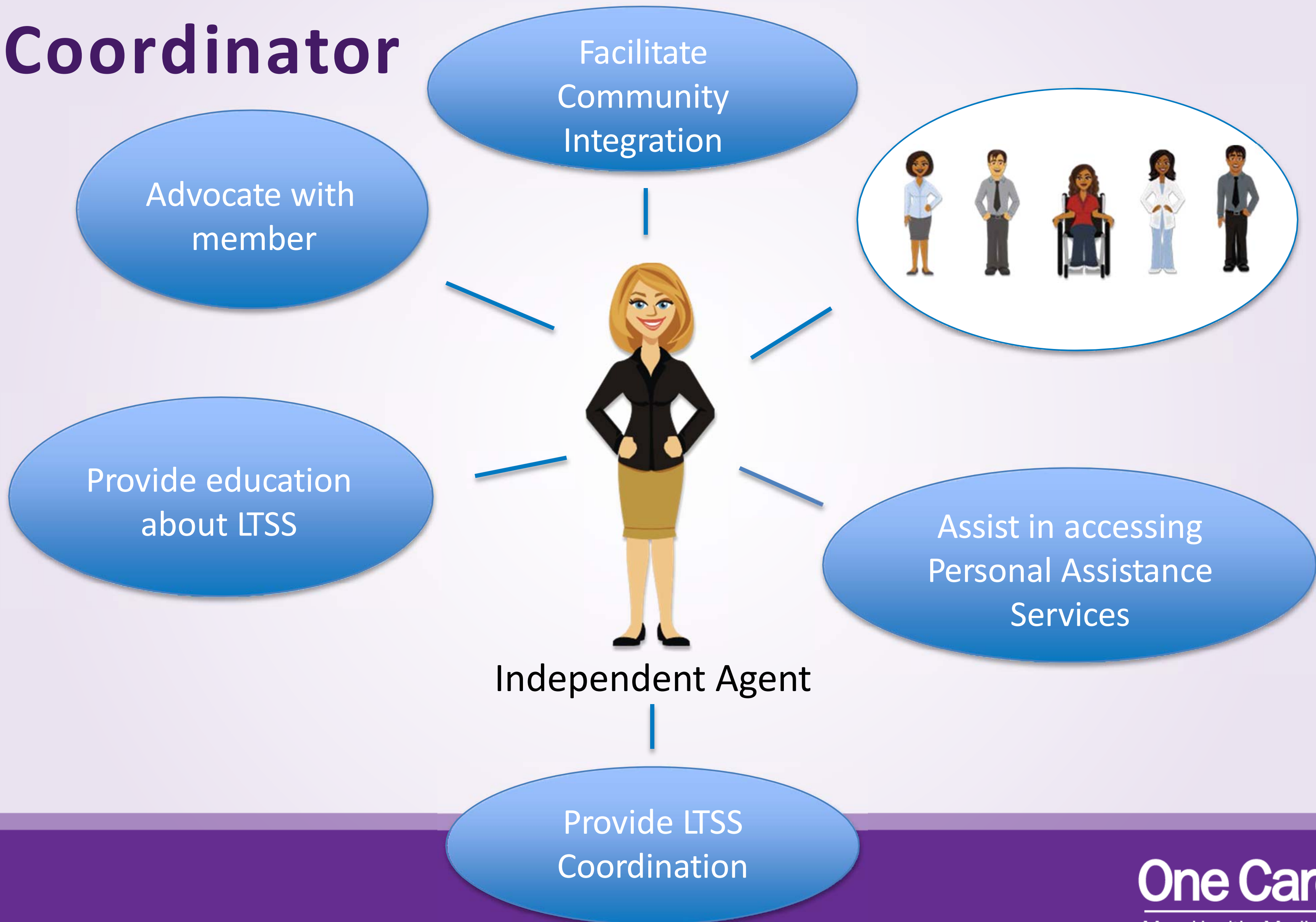
Delivery of Care

One Care Plans

Care delivered through Care Team and provider network

Integration of primary care, specialists, behavioral health and LTSS

Person-centered assessment, planning and service delivery using medical home or health home models as foundation


Long-Term Supports (LTS) Coordinator
Facilitate Community Integration
Advocate with member
Provide education about LTSS
Assist in accessing Personal Assistance Services
Independent Agent
Provide LTSS Coordination
One Care
MassHealth+Medicare

Personal Care Plan

Develops Personal Care Plan

- Informed by comprehensive in-person assessment
- Member directs Care Team and is involved every step of the way
- Covers the whole range of medical, functional, behavioral health, social and support needs
- If does not reflect his/her needs member has right to disagree or appeal

Transition into One Care

One Care plans must provide written notification if the Personal Care Plan proposes changes to authorized services

Clinician/ Provider can join One Care plan

One Care plans can create a single case agreement

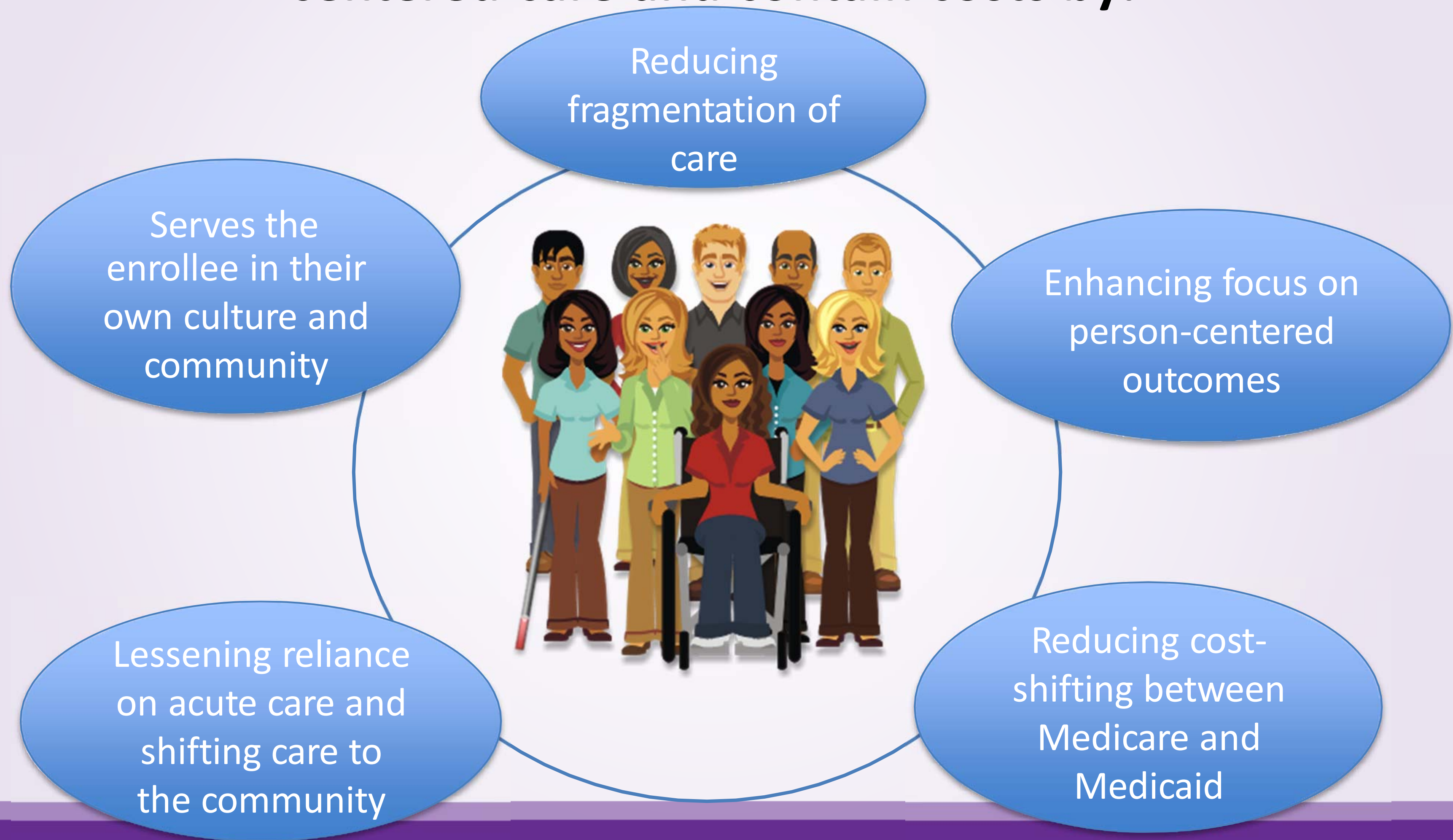
Care Team can help identify new Clinician/ Provider

Some General Lessons Learned

- The care model must be flexible enough so that it can be adapted to meet the individual needs of members
- Plans had to develop creative strategies to engage members who they were unable to connect with through traditional means (i.e. those who did nor respond to phone calls or other attempts at contact)
- Building the infrastructure to support the care model takes time and resources (e.g. ability to create Central Enrollee Record (CER), share data among care team members as appropriate, track assessments, care plans, service authorizations, as well as ongoing updates and ultimately population health)
- It's important for plans to develop relationships with community-based organizations, and it takes time to establish roles, adapt to billing practices, and to develop trust
- Workforce development/capacity is also critical to consider
- It's important to manage quality and encounter data reporting at the plan and provider level to ensure consistent data that accurately captures experience
- Ongoing stakeholder collaboration and communication is key (e.g. ongoing work with the Implementation Council, plan consumer advisory boards, and other engagement):
  - To create buy-in and maintain trust among members and their communities
  - To ensure ongoing accessibility
  - To make care more effective
  - To inform successful practice transformation

Conclusion

One Care provides opportunities to enhance person-centered care and contain costs by:



One Care
MassHealth+Medicare

Visit us at: www.mass.gov/one-care

Email us at: OneCare@state.ma.us

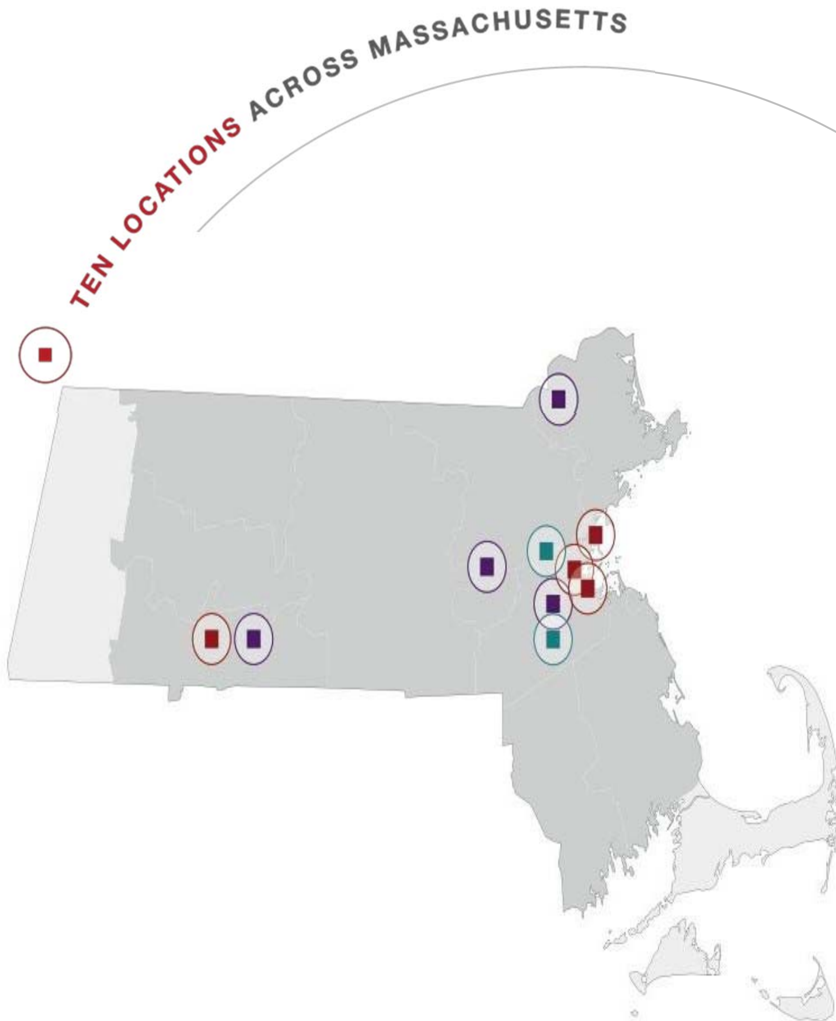
One Care Shared Learning:
https://onecarelearning.ehs.state.ma.us/

Implementation

Lori Tishler, MD, MPH

Vice President of Medical Affairs,
Commonwealth Care Alliance

CCA today



- Based in Massachusetts, CCA is a not-for-profit, community-based healthcare organization
- Dedicated to improving care for individuals dually-
- eligible for MassHealth (Medicaid) and Medicare
- Mission of providing the best possible care, individually tailored to the members and patients we serve
- Nationally recognized for innovative model of care that improves quality and health outcomes while reducing overall cost of care

Commonwealth Care Alliance offices (4)

Commonwealth Community Care clinics (4)
CCA's clinical affiliate; a specialized primary care practice offering comprehensive, disability-competent care

CCA Crisis Stabilization Units (2)
CCA's alternative to psychiatric hospitalization for members with acute behavioral health/substance use disorder needs

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CCA's care model

Primary Care

Community Behavioral Health

CCA Clinical Staff as part of the continuum

Acute Hospital Inpatient

Emergency Department

COMMUNITY BASED SERVICES

ACUTE CARE INTEGRATION

Care partners matched to member needs with appropriate intensity

Social determinants addressed to improve overall member health

What makes CCA different?

- **Individualized** assessments and interdisciplinary care plans
- **Team-based** access to full complement of licensed and supportive clinicians
- **Coordination** across the continuum of care
- **Consumer Directed** respect for the member's autonomy, dignity, and voice
- **Community** Ready Resource Teams, Mobile Integrated Health and Advanced Practice Clinicians seamlessly keep members in the community

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CCA MassHealth programs

- Medicare-Medicaid Plan (MMP)
- Dual Eligible only
- Eligible population: Age 21-64
- CCA service area: 8 counties and 1 partial
- Where applicable, assign care management responsibilities to certain provider sites ("Health Homes")
- Variety of care management models tailored to diverse population needs

- HMO/Special Needs Plan
- Dual Eligible or MassHealth Standard only
- Eligible population: Age 65+
- CCA service area: 7 counties and 3 partial
- Delegated and non-delegated arrangements with primary care sites for primary care and care management
- Variety of care management models tailored to diverse population needs

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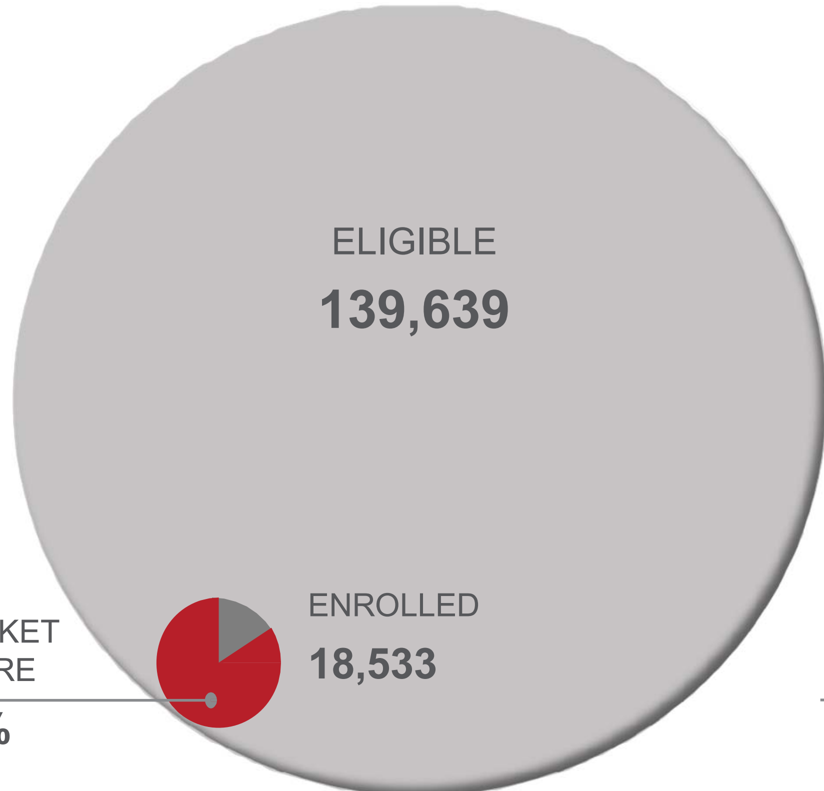
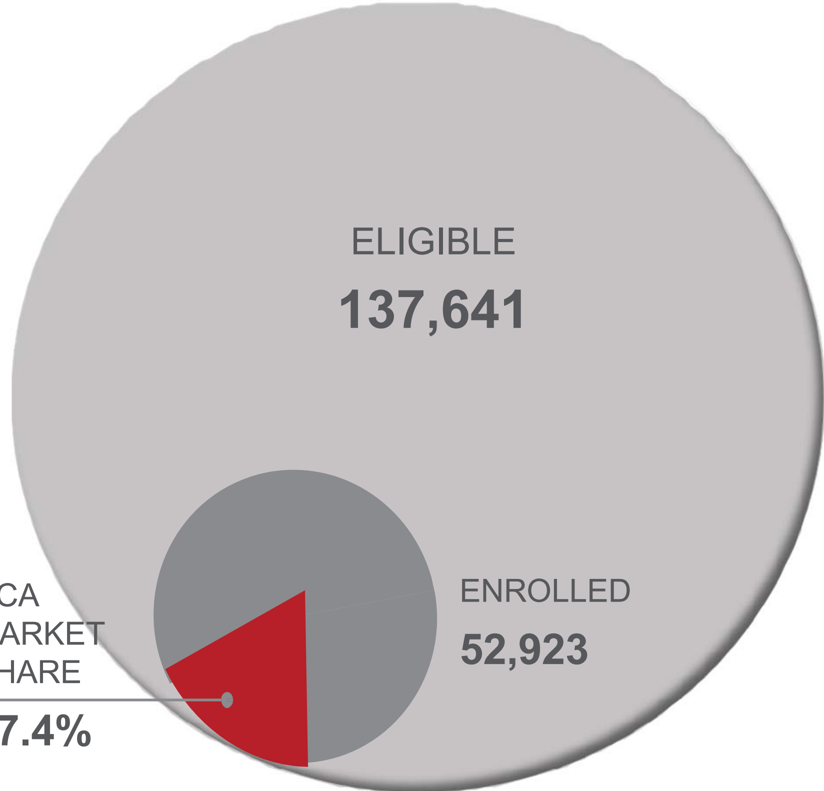
Massachusetts landscape

One Care



Senior Care Options



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Source: MassHealth, as of Dec. 1, 2017 Effectives

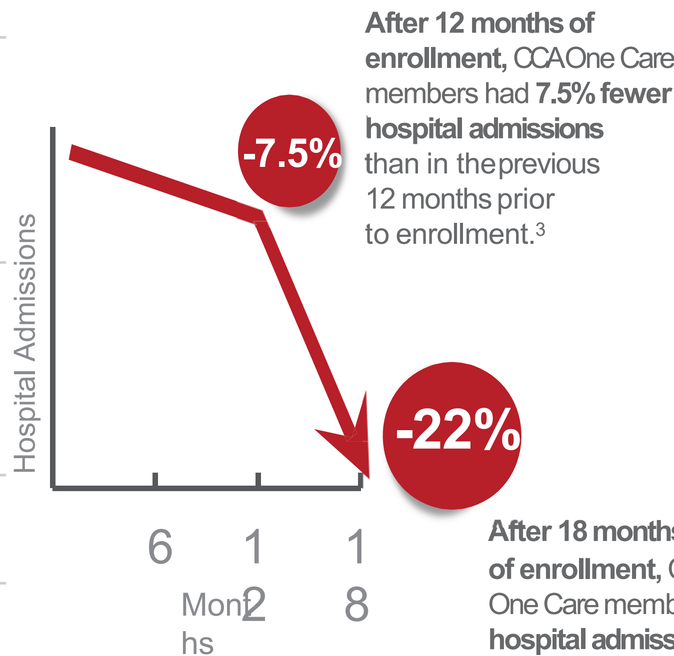
CCA One Care

- Top-rated Medicare-Medicaid Plan in the country for two consecutive years (2016-2017)[1]
- 2017 Membership: 15,529[2]

Key Statistics*

50	**average age**
10x	**cost of caring** for One Care-eligible population averages to about $2,000 per member per month, 10 times the average for general population
76%	**have a serious mental illness** such as schizophrenia, bipolar disorder, severe depression or substance use disorders
60%	**have four or more chronic conditions**
4.5%	**are homeless**

Results



After 12 months of enrollment, CCA One Care members had **7.5% fewer hospital admissions** than in the previous 12 months prior to enrollment.[3]

After 18 months of enrollment, CCA One Care members' **hospital admissions dropped by 22%** on average.

[1] CMS Medicare Advantage Prescription Drug Plan CAHPS Survey
[2] CCA membership as of Dec. 1, 2017
[3] The Commonwealth Fund, Vol. 41, Dec. 2016, "The 'One Care' Program at Commonwealth Care Alliance: Partnering with Medicare and Medicaid to Improve Care for Nonelderly Dual Eligibles."
*CCA Business Intelligence; statistics as of Sept. 1, 2017

One Care member benefits

- Members get the same benefits provided by MassHealth Standard and Medicare, plus more—all at no cost

$0 monthly premiums*

$0 copays

$0 dental services, including dentures

$0 prescription and over-the-counter drugs

$0 transportation to appointments

$0 eyeglasses and hearing aids

$0 personal care assistance

$0 medical equipment

$0 mental health services and supports

"Before I found CCA, I was always going from one doctor to the next or going to the emergency room whenever my health got bad. I couldn't believe with CCA, they send people to your home to check up on you, they have somebody always looking out for you."

P. Joiner,
CCA One Care member

*CommonHealth members who pay a premium to MassHealth must continue to pay their MassHealth premium if they switch to Commonwealth Care Alliance.

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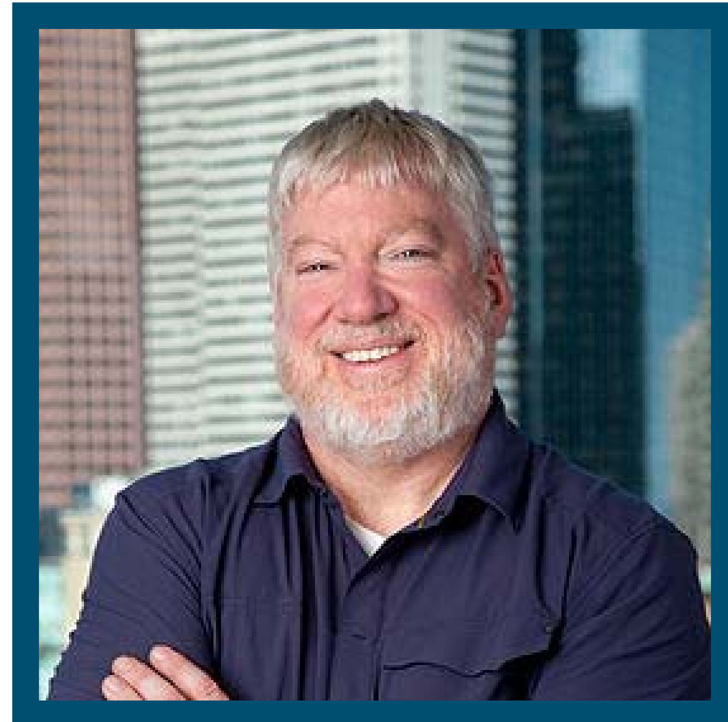
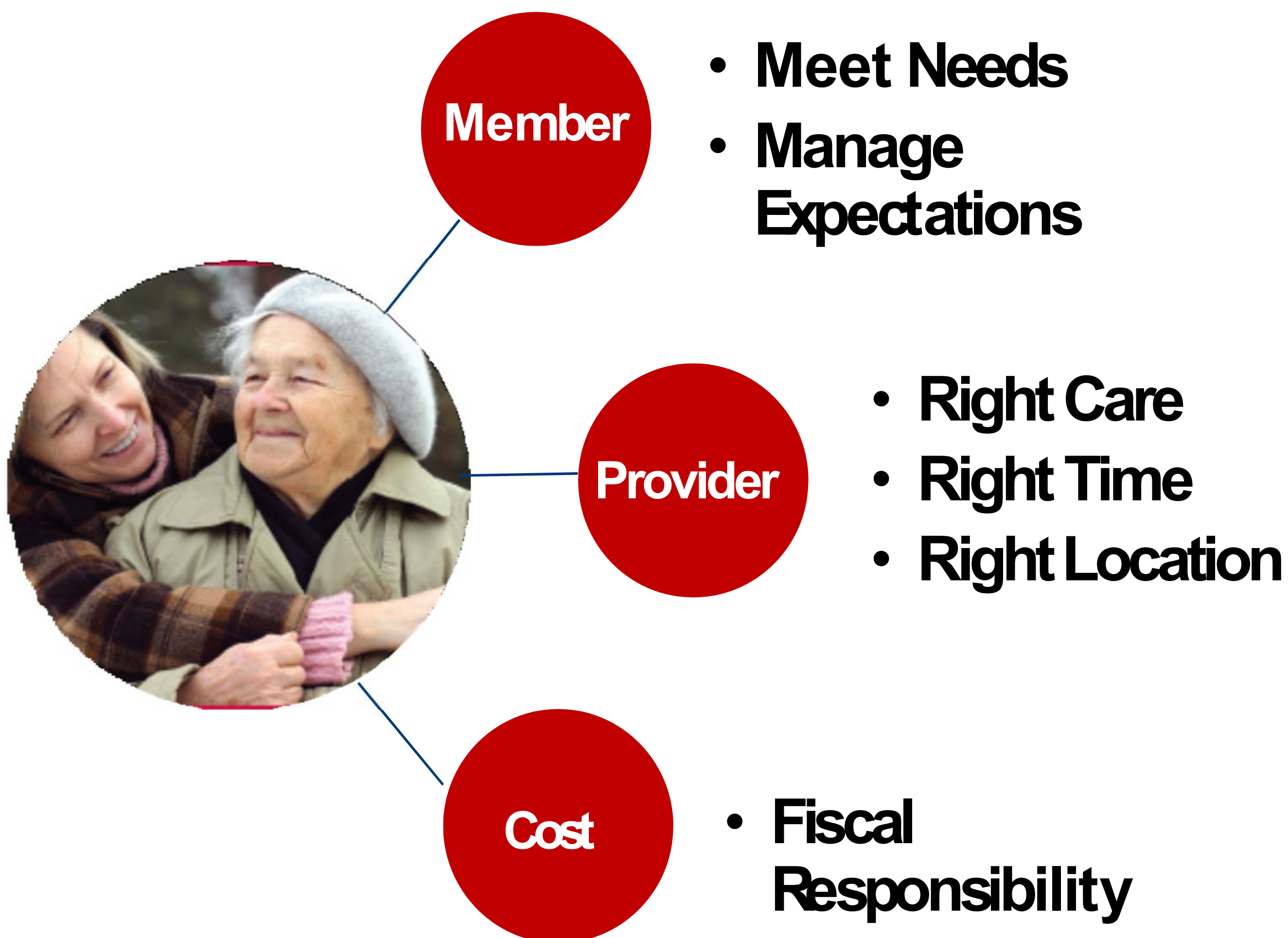
John Loughnane, MD

Chief Innovation Officer,
Commonwealth Care Alliance



Community Paramedicine



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Early KPIs | Exceptional experience & ED diversion

The NEW ENGLAND JOURNAL of MEDICINE

PERSPECTIVE COMMUNITY PARAMEDICINE

Community Paramedicine — Addressing Questions as Programs Expand

Lisa I. Iezzoni, M.D., Stephen C. Dorner, M.Sc., and Toyin Ajayi, M.B., B.S.

Growing increasingly short of breath late one night, Ms. E. called her health care provider's urgent care line, anticipating that the on-call nurse practitioner would have her transported to the emergency department (ED). Over the past 6 months, Ms. E. had made many ED visits. She is 83 years old and poor, lives alone, and has multiple health problems, including heart failure, advanced kidney disease, hepatitis C with liver cirrhosis, diabetes, and hypertension. In the ED, she generally endures long waits, must repeatedly recite her lengthy medical history, and feels vulnerable and helpless. She was therefore relieved when, instead of dialing 911, the nurse practitioner dispatched a specially trained and equipped paramedic to her home. care and community paramedicine programs aim to address critical problems in local delivery systems, such as insufficient primary and chronic care resources, overburdened EDs, and costly, fragmented emergency and urgent care networks.[1] Despite growing enthusiasm for these programs,[2] however, their performance has rarely been rigorously evaluated, and they raise important questions about training, oversight, care coordination, and value.

EMS systems were established in the United States in the 1950s and expanded, using federal funding, in the 1970s to create 911 response networks nationwide. Operating EMS systems around the clock requires trained workers with diverse skills. In 1975, the American Medical Association departments provide roughly half of today's emergency medical services. Almost all 911 calls result in transportation to an ED because of state regulations and payment policies: insurers, including Medicare, typically reimburse EMS providers only for transporting patients. At the receiving end, many EDs face escalating demand and soaring costs, as more people seek attention for nonurgent acute and chronic conditions — in part because they lack regular sources of primary and chronic disease care. One estimate suggests that about 15% of persons transported by ambulance to EDs could safely receive care in non–urgent care settings, potentially saving the system hundreds of millions of dollars each year.[2]

~1,750 encounters in pilot program

CCA members surveyed after paramedic visits voiced high approval rates:

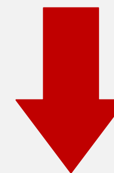
- **95%** Agreed the visit was as good or better than an Emergency Room visit
- **85%** Reported that the visit averted a visit to an emergency room
- **93%** Reported that the visit enabled them to see a provider sooner

> Absolutely fabulous program. This truly saved me from another trip to the emergency room.
> -CCA Member

To date, the program has:

Enhanced Member Care

Decreased Hospitalizations



Improved Clinical Outcomes

Early KPIs | Reducing per episode cost

Estimated Savings Disaggregation

EMS Transport to the ED → **$ 350**

ED visit without admission → **$ 1,200**

Observation admission → **$ 2,600**

Average cost of an inpatient admission → **$ 12,000**

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Thank you!

Questions or comments?

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John Loughnane

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Q & A

- Please type your questions in the Q & A box at the lower right-hand corner.
- Provide your name and organization.
- If possible, please specify who you are directing your question to.

Register for March 29 Webinar

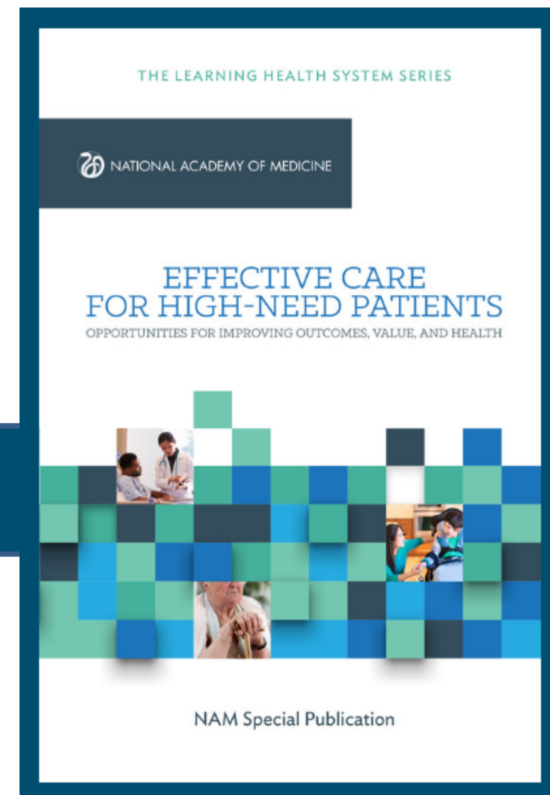
Improving Care for High-Need Patients

Featuring

Health Quality Partners

March 29, 2018 | 2:00 – 3:00 PM ET

Register at NAM.edu/HighNeeds



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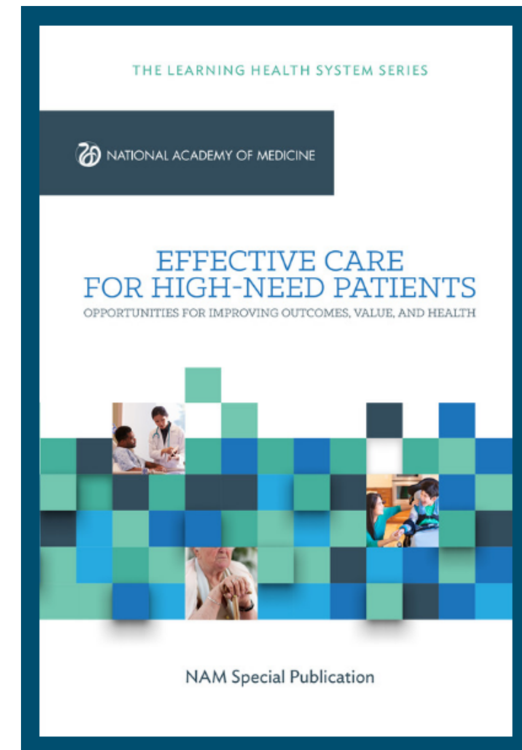
NATIONAL ACADEMY OF MEDICINE

Thank you for joining!

A recording of today's webinar will be posted online at nam.edu/HighNeeds.

For more information about the National Academy of Medicine's initiative on high-need patients, please visit:

nam.edu/HighNeeds



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