Cross-Continuum Care Management Staff Deployment Models

Population Health Advisor

Refining Cross-Continuum Care Management Model

Define Care Management Strategy

Care Management Leadership

Care Management Goals

Care Team Composition

Care Team Deployment

Today's Focus

Implement Care Management Program

Patient Enrollment

Patient Management

Care Coordination

Performance Management

For more information on this project or the Population Health Advisor team, please contact your Dedicated Advisor or Becky Tyrrell at TyrrellR@advisory.com.

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Multiple Options to Deploy Care Management Teams

Overview of Common Complex Care Model Types

	Embedded in Primary Care Practice	*Dedicated Complex Care Clinic*	*Centralized within Administrative Office*	*Mobile or Community-Based*
				
Team Placement	Care managers work in primary care offices alongside office staff; may spend all of their time in one office or split their time between up to 3 offices each, depending on patient volumes	Complex care management services consolidated to single clinic location; patient contact may be face-to-face or telephonic.	Care managers work from a central administrative office; patient contact is typically telephonic with patients assigned to care management teams by primary care provider	Care managers work remotely, dividing time between patient homes, assigned offices, and the hospital setting
Advantages	Achieves greatest level of integration with primary care team, allowing for faster care management buy-in from office staff and improved coordination of care (e.g., facilitates warm handoffs, care conferences)	Care managers work with broader clinical team, offering support with patient management; easier to standardize processes and monitor program progress towards goals	Remote patient management reduces travel time and enables larger patient caseloads	Allows for care manager to get full picture of patient's condition across the care continuum and to meet regularly with all involved care teams; increased patient convenience
Common Challenges	Office staff may try to "co-opt" care managers to perform administrative or clinical tasks unrelated to their care management role Requires additional forums to promote team cohesion and collaboration among care managers	Patients may be reluctant to change their primary care provider, travel to a different office location Requires increased coordination with primary care staff and specialists working at other locations	Requires effective and routine communication about the program to ensure buy-in from primary care and specialized providers Face-to-face patient contact more difficult to arrange, whether in a practice or in the community	Lack of dedicated office/work space may pose challenges to workflow Requires increased oversight of patient management processes to ensure care standardization Requires additional forums to promote team cohesion and collaboration among care managers

Source: Population Health Advisor interviews and analysis.

Balance Practice Resources and Patient Needs when Selecting Model Type

Factors Influencing Positioning of Care Management Staff within the System

Factors	Diagnostic Questions
Provider engagement	*Are PCPs at advanced stages of medical home deployment and comfortable with multidisciplinary team-based care delivery?*
Physical space/infrastructure	*Is there sufficient space/infrastructure to dedicate exclusively to co-locate care management services or establish a new clinic?*
Patient Access	*Are transportation and health care access are major barriers across high-risk populations?*
Target population volumes	*Do patient volumes justify a dedicated complex care clinic or triage line?*
Risk-based contracts/payment	*Is the organization quickly moving toward broad risk assumption across multiple payer populations?*
IT and data-sharing capabilities	*Is information-sharing across care settings a major hurdle?*
Staff availability	*Do you have existing staff resources to leverage? What are their credentials?*
Geographic proximity	*Are primary care practices located in close proximity or would it be challenging for a care manager to regularly travel between sites?*

Source: Population Health Advisor interviews and analysis.

Profiled Care Management Programs

Model Type	Organization	Organization/Model Description	Services Provided
Embedded in Primary Care Practice	Massachusetts General, Partners HealthCare	Massachusetts General is a 900-bed academic medical center and part of Partners HealthCare, an integrated health system, located in Boston, Massachusetts. As part of the six-year CMS Medicare Care Management for High Cost Beneficiaries Demonstration, Massachusetts General embedded high-risk care managers in primary care clinics to support the top five percent high-risk, chronically ill, medically complex patients.	Care plan development and navigation across care sites, referral management, patient education and self-management support, patient monitoring and follow-up.
Dedicated Complex Care Clinic	Iora Health	Iora Health is a primary care company headquartered in Cambridge, Massachusetts that contracts directly with self-funded employers to operate new clinics for the top ten percent highest risk patients with multiple comorbidities.	Disease management education and support, face-to-face patient care, coordination of holistic patient needs, progress monitoring and follow-up.
Centralized within Administrative Office	New West Physicians	New West Physicians is a 68-physician group located in Denver, Colorado, that leverages medical assistants and nurses at an administrative office to fill prevention care gaps for commercial ACO patients.	Targeted outreach for prevention screening, plus some additional education and support for more complex patients.
Mobile- or Community-Based	Molina Healthcare	Molina Healthcare is a managed care company headquartered in Long Beach, CA, that implemented a community health worker intervention for high-utilizer Medicaid managed care patients.	Navigation, access, disease management, and health literacy services.

Source: Population Health Advisor interviews and analysis.

On-Site Support Facilitates Relationship-Building with Patients and Care Team

Care Manager Collaborates with Clinicians to Set Care Plan and Monitor Progress

Nurse Care Manager

- 20+ years experienced RN, comfortable managing complex care needs of high-risk patients
- Central point of contact for care coordination, patient activation
- Embedded in PCP office, but may float between clinics lacking sufficient high-risk patient volumes
- RN-to-patient ratio of 1:200-250

Designs Care Plan with Primary Care Physician

PCP

- RN viewed as indispensable, trusted care team partner
- RN works with maximum of three clinics to preserve MD-RN relationship
- Frequent discussions in person, via IT workflow system

Coordinates with Additional Team Members

- Social Worker
- Pharmacist
- Medical Director[1]
- Community Resource Specialist

Case in Brief: Massachusetts General Hospital, Partners HealthCare

- 900-bed academic medical center; integrated health system, teaching affiliate of Harvard Medical School, located in Boston, Massachusetts.
- Part of the six-year CMS Medicare Care Management for High Cost Beneficiaries Demonstration
- Multidisciplinary team provides comprehensive clinical care, non-clinical support to top five percent high-risk, chronically ill, medically complex patients[2]
- Currently expanding program to serve Pioneer ACO patients, other populations under risk

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1) Part of management team that includes Project Manager and Team Leader for Case Management.
2) CMS Demonstration covered top 10% high-risk, high-cost Medicare patients; current top 5% population includes medically complex who would benefit from care management (multimorbid chronic, one severe chronic , mental health /behavioral health/ substance abuse, lack of socioeconomic resources to manage illness); excludes medically complex, i.e., complicated obstetrics, trauma.

Source: Care Management Program, available at: http://www2.massgeneral.org/caremanagement/, accessed February 1, 2015; Population Health Advisor interviews and analysis.

Care Manager is Central Point of Contact and Accountability

Primary Responsibilities Navigating and Activing Patients Across the Continuum

Navigation

Coordinates Across Sites
- Facilitates access to services
- Develops care plan with physician, embedded in PCP practices

Manages Referrals
- To disease management
- To specialists
- To medication management support
- To psychosocial support

Tracks Patient Activity
- IT system alerts care manager to inpatient, ED utilization
- EMR “icon” alerts system physicians when patient is assigned to a care manager

Activation

Provides Education
- Coaches patients on disease management goals[1], monitors progress, offers encouragement
- Supports symptom management

Supports Patient Self-Management
- Encourages adherence to care plan, improvement through patient-centric goal setting
- Fosters patient and caregiver activation, offers education

Encourages Frequent Communication
- Promotes open communication through consistent monitoring, feedback, and follow-up
- Forges one-on-one relationship with patient to promote two-way communication

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Source: Care Management Program, available at: http://www2.massgeneral.org/caremanagement/, accessed February 1, 2015; Population Health Advisor interviews and analysis.

Freestanding Clinic Model Ensures Dedicated Focus on Highest-Risk Patients

Iora Leverages Clinical and Non-clinical Roles for Management

Iora Care Team Member Duties

Nurse (NP, RN)

- Oversees clinic based case and disease management program
- Assists physician in developing patient care plan
- Ensures care plan progression in coordination with health coach

Health Coach (non-clinical)

- Primary point of contact for coordinating patient needs
- Assists patient with understanding care, impacting clinical change
- Health coach to patient ratio approximately 1:200[1]

12.3% Decrease in total spending for patients enrolled in 2009[2]

48% Decrease in ED visits for patients enrolled in 2009[2]

Case in Brief: Iora Health

- Primary care clinics located in New Hampshire, Nevada, and New York, Massachusetts, Arizona, and Washington
- Contracts directly with self funded employers to operate new clinics for top ten percent highest risk patients with multiple comorbidities
- Multidisciplinary care team (PCP, RN, health coach) oversees patient management; specialists available by consult
- Team supported by robust analytics including real-time pharmacy data, lab, remote monitoring, inpatient admission, ED visit alerts

1) AtlantiCare Special Care Center ratios: 1,200 patients, 2 MDs, 1 NP, 6 health coaches and administrative support.
2) Relative to control group created using propensity matching; gross spending dropped 18%.

Source: Fernandopulle R, "Creating Truly Accountable Care: Creating a New Entrant for Primary Care Delivery," June 2011; Dartmouth Now, "Dartmouth to Offer New Primary Care Practice," available at: http://now.dartmouth.edu/2011/11/dartmouth-to-open-new-primary-care-medical-practice; Valley News, "College Tries Alternative Health Scheme," available at: http://www.vnews.com/11242011/ 8180506.htm; Fernandopulle R, "Implementing a Medical Home for Patients with Complex Chronic Disease," available at: http://www.pcpcc.net/files/pep-report.pdf; Population Health Advisor interviews and analysis.

“Tag-Team” Approach Ensures All Care Management Needs Met

Comprehensive Approach to Managing High-Risk Patients

	Education	Coordination	Communication	Accountability
				
Nurse	Educates patient on disease management, ensures understanding of necessary skills	Manage teams of health coaches, oversee disease education	Provides face-to-face patient care in practice, addresses clinical concerns; available 24/7	Ensures resolution of bottlenecks in patient care, brings critical concerns to PCP
Health Coach	Meets with patient before, after physician visit to explain care plan components	Participates in daily team huddle to discuss patients, workflow priorities	Manages progress via phone, email contact, group visits; available 24/7	Coordinates holistic patient needs, follow-up, medication regimen adherence

Building Patient Relationships to Transform Care

“We recruit our coaches for attitude and train for skill. This kind of care requires a different mind-set from usual care. Coaches may have medical training, but it isn't necessary. The real job of the health coach is to get involved with the patient, blocking and tackling, helping them manage their health the best they can.”

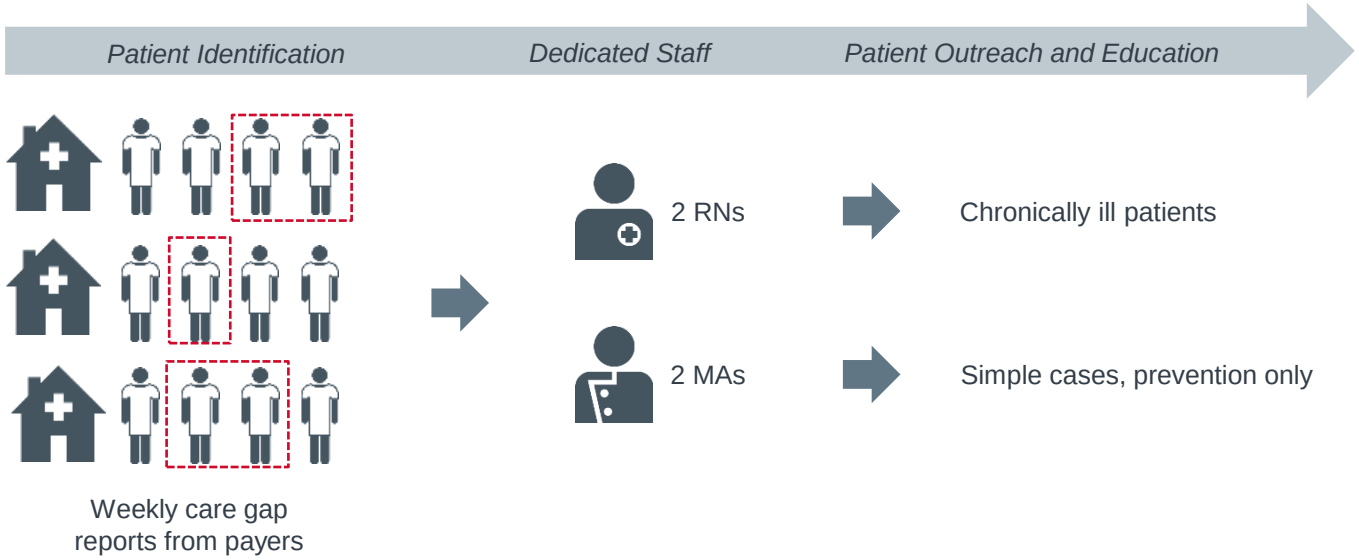
Rushika Fernandopulle, MD
President

Source: Fernandopulle R, “Creating Truly Accountable Care: Creating a New Entrant for Primary Care Delivery,” June 2011; Dartmouth Now, “Dartmouth to Offer New Primary Care Practice,” available at: http://now.dartmouth.edu/2011/11/dartmouth-to-open-new-primary-care-medical-practice; Valley News, “College Tries Alternative Health Scheme,” available at: http://www.vnews.com/11242011/ 8180506.htm; Fernandopulle R, “Implementing a Medical Home for Patients with Complex Chronic Disease,” available at: http://www.pcpcc.net/files/pep-report.pdf; Population Health Advisor interviews and analysis.

Leveraging System-Level Resources Enhances Program Reach

Begin to Separate Face-to-Face and Virtual Care Steps

Targeted Outreach for Prevention Screening



Case in Brief: New West Physicians

- 68-physician group located in Denver, Colorado
- Hired two medical assistants and two nurses at administrative office dedicated to filling prevention care gaps for 37,000 commercial ACO patients
- Reduced time spent by physicians, nursing staff within offices in performing patient outreach

Community-Based Approach Meets Patients Where They Are

Continuity Across Settings Builds Trust and Enhances Coordination

Case in Brief: Molina Healthcare

- Managed care company headquartered in Long Beach, CA, offering health plans, medical clinics, and a health information management solution
- Molina Healthcare of New Mexico**,** in partnership with the University of New Mexico and Hidalgo Medical Services, implemented a community health worker intervention for high utilizer Medicaid managed care patients
- Community Connectors provide navigation, access, disease management, and health literacy services for patients
- Enrolled patients showed reduced ED, inpatient, and prescription drug costs; program has now expanded to 11 states where Molina operates health plans

Assess immediate personal needs

- Food and water
- Housing and housing adaptations
- Transportation arrangements

Listen to provider treatment recommendations

- Disease management training
- Appointment scheduling, reminders, and follow up
- Pharmacy discounts

Ensure access to appropriate resources

- Durable medical equipment ordering
- Income support, SSI[1] application assistance
- Collaboration with family and social support agencies

Source: Johnson D, et al., "Community Health Workers and Medicaid Managed Care in New Mexico," *J Community Health, 37, no. 3 (2012), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3343233/?tool=pmcentrez*

1) Supplemental Security Income .

The Advisory Board Company

2445 M Street NW | Washington DC 20037
P 202.266.5600 | F 202.266.5700

advisory.com