Breaking Down Silos of Care: Integration of Social Support Services with Health Care Delivery

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California

- Nearly 500,000 commercial and over 100,000 senior members in Metro LA. 525 employed physicians in 66 locations and over 4,100 under contract.

Florida

- Over 48,000 senior members and 4,000 commercial members in central and South Florida. 60 employed physicians in 41 locations and over 2,800 under contract.

Nevada

- 36,000 senior and 37,000 commercial members under global or partial capitation in Metro LV. 130 employed physicians in 52 locations and 1,400 under contract.

New Mexico

- 180,000 patients including 26,000 managed Medicare members.
Why: Five Percent Rule

- **Cause 55% of all Hospitalizations/year**
- **Older population with multiple medical conditions**
- **Complicated psychosocial circumstances**

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<tr>
<th># chronic</th>
<th>Admit Rate</th>
<th>Next year admit</th>
<th>DDH</th>
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<tbody>
<tr>
<td>0</td>
<td>5%</td>
<td>10%</td>
<td>10%</td>
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<tr>
<td>1</td>
<td>12%</td>
<td>15%</td>
<td>8%</td>
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<tr>
<td>2</td>
<td>19%</td>
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<tr>
<td>3</td>
<td>31%</td>
<td>29%</td>
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<tr>
<td>4</td>
<td>44%</td>
<td>36%</td>
<td>17%</td>
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<tr>
<td>5</td>
<td>57%</td>
<td>43%</td>
<td>20%</td>
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<tr>
<td>6</td>
<td>66%</td>
<td>43%</td>
<td>26%</td>
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Key Concepts – 4 A’s

- **Accountability** of individual and team
- **Ability to scale** to needs of the organization
- **Affordable model** of care that is replicable
- **Appropriate patient selection**
Key Concepts

• **Accountability** - Each team member needs to accountable to the population for which they are assigned.

• **Scalability** – Must be flexible to meet market needs and adaptable for all products: HMO, PPO, Dual Eligible

• **Affordability** – Everyone needs to work at the top of their scope of practice. Determine who best to do the intervention.

• **Patient Selection** – Is the patient at risk of admission? Is there an intervention that can positively impact the course of care? What support does patient need to self manage?
Solution
Site Based Care Management

• Team Based Care – MD, CM, Patient Coach and Social Worker support

• Focus on supporting a panel of patients vs. “case load” - Introduction of true “accountability”

• Level of support and interventions tailored to the acuity of the patient
New Care Delivery Team

- Leverage PCP
- Improve efficiencies
- Maximize team performance
- Create team alignment
- Deliver patient focused care
New Care Delivery Team

• Expanded the care team
  • Everyone on team needs to understand their role
  • Each team member works to maximize their scope of practice
  • Team needs to “practice” team dynamics

• Increased utilization of Nurses, SW’s, MA’s with supervision of highly engaged clinician

• Focused on patient self management
  • Involve both patient and family in care
Care Management Model: Information Flow

Core Care Management Team:
RN Care Manager
Patient Coach
Social Worker

Health Ed Disease Mgmt
PCP Specialist
UM Compliance
High Risk Programs
Health plans/payors
IT/Technology
Home Health/SNF/DME
Inpatient/SNF Inpt Central
OOA Transplant Referral

Inpatient/SNF
Central
Training for Care Management Team

Structured Training for all team members, including patient/family focused modules:

- DM – COPD, CHF, Diabetes,
- Complex Care Management
- End of Life Care – Tools: POLST, Advanced Directives, 5 Wishes

Motivational Interviewing (MI)
- Focus on alignment of patients needs and drivers

Development of protocol driven care
- Non – Adherence
- Dementia, Falls
- Medication Management, Life Care Planning,
Patient Focused Guiding Principles

• Facilitate self care through advocacy, shared decision-making, and education
  • Develop shared agenda
  • Use of Motivational Interviewing
  • Use of Health Educators for comprehensive training
Patient Focused Guiding Principles

Promote the use of evidenced-based care
Geriatric Resources for Assessment and Care of Elders (GRACE)*

- Difficulty Walking/Falls
- Depression
- Advance Planning
- Medication Management
- Caregiver Burden

*Steven Counsell – Indiana University
http://medicine.iupui.edu/IUCAR/research/grace.aspx
Patient Focused Guiding Principles

• Practice cultural competence with awareness and respect for diversity

• Promote optimal patient safety
  • Provide assistance with “transitions of care” between hospital and home.
  • Identify barriers that prevent patients from achieving their goals
Addressing Psychosocial Needs

Majority of patients with complex medical needs have social needs that contribute to high utilization

- **Social Workers are in all care settings:**
  - Home Care
  - Comprehensive Care Centers
  - Primary Care Clinics
  - Acute/SNF facilities

- **Perform psychosocial evaluations to assess members needs:** Placement, Resources, Financial

- **Assist in locating state based and community resources:** Medi-Cal, Meals on Wheels, Transportation, California Children Services
Metrics

• Focus on Key Metrics – where can we make impact:
  ▪ Readmission Rates
    • Focus on admission prevention
  ▪ ER Utilization
    • Identifying signs and symptoms before they are acute
  ▪ Patient Satisfaction
    • Patients engaged with their care team, increased compliance and retention
## Initial Outcomes

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<tr>
<th>Metric</th>
<th>HealthCare Partners Model of Care</th>
<th>National Benchmarks</th>
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<tr>
<td>Senior Acute to Acute Readmission Rates</td>
<td>13.66%</td>
<td>19.6%</td>
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<td>Source: NEJM –”Rehospitalizations among Patients in the Medicare FFS Program” Jencks, MD, William, MD et al., 4/2009</td>
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<td>Patient Satisfaction “Completely Satisfied”</td>
<td>52.4%</td>
<td>N/A</td>
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<td>Senior Outpatient ER Visit Rate PTMPY</td>
<td>308</td>
<td>411 per 1000 (2010)</td>
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REFERENCES

1. the role of care management with the review of the literature by Robert Wood Johnson
   http://www.rwjf.org/pr/product.jsp?id=52372
2. the guided care model for outpatient interventions developed by Chad Boult of Hopkins
   http://www.guidedcare.org/
3. care transitions with Eric Coleman, who is probably the leading spokesman in this country
   http://www.caretransitions.org/
4. an interesting high level review on chronic care model developed by Ed Wagner
   http://www.improvingchroniccare.org/