Integrated Care Management in the Age of Population Health: What does that mean?!?

Integrated Care Management Conference
September 21 and 22, 2016
Dot Verbrugge, MD
Medical Director of Integrated Care Management
Perspective – Case-by-Case vs Big Picture

What is this???
Perspective – Case-by-Case vs Big Picture
Did ya’ get it?!?
Perspective – Case-by-Case vs Big Picture

What is this???
Perspective – Case-by-Case vs Big Picture

Did ya’ get it?!?
Managing the Population
The BIG Picture
Population Health Financial Model

SelectHealth “Shared Accountability” since 2013

Intermountain is “At Risk” for all Medical costs

- What does that mean?!?
  - Payer
    - Manage Revenue (Premiums)
    - Pay Claims
    - Sales / Marketing
    - Compliance
  - Intermountain (Delivery System)
    - Medical Management
    - ALL MEDICAL EXPENSES!
But what does this mean for me as a Care Manager?!?

Right Care
at the
Right Time
in the
Right Place
What is different now?

Six Ideas:

1. **No More Silos!**
   - Think beyond YOUR setting ... And the next one!
   - Transitions (not “Discharges”)

2. **Identify and Address Risk Early**
   - Longitudinal Care Management initiative

3. **Understand Payments and Penalties**
   - Payments / Costs
     - Inpatient
     - Clinic
     - Medications
   - Penalties from CMS for poor quality and value

4. **Influence Utilization in all settings**
   - Appropriate Use Criteria

5. **Documentation Precision**
   - Demonstrate Measurable Value of Care Management
   - Patient risk factors and comorbidities

6. **Communicate, Communicate, Communicate**
   - PCP informed across the Spectrum
   - Patient Education
   - Share Care Plans
1) No more silos!

Think beyond your setting ... and the next one!

TOTAL Care matters, not just what happens in your setting

- **TRANSITION** Care (Don’t just “discharge!”)
- “What could have been done previously to avoid this problem?”
- “Where will this patient be in
  - 30 days? 60 days? 120 Days?”
- Does this patient have what s/he needs to successfully transition?
  - Medical Needs Assessments and plan
  - Psychosocial Needs Assessments and plan
- Intermountain “**Transition in Care Model**” under development
- **COMMUNICATION** with patient, caregivers, and providers
2) Identify and Address Risk Early

Risk Stratification Process and Patient Lists

Intermountain Risk Screening and Assessment Process

• Highest Risk patients identified based on
  • Utilization
  • Quality (Gaps in Care)
  • Cost

• Top 1% of patients with LONGITUDINAL Care Plans by
  • Medical Group Care Managers (if Medical Group PCP)
  • SelectHealth Care Managers (if SelectHealth and affiliated PCP)

• TRANSITION care between settings
• COMMUNICATION with patient and providers

• Medical Group NCQA Certification dependent on success of this program!
3) Understand Payments and Penalties
Inpatient Payments / Costs

Medicare Example:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Per Day</th>
<th>How It Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care</td>
<td>$190</td>
<td>60-Day Bundle</td>
</tr>
<tr>
<td>SNF</td>
<td>$300 - $516</td>
<td>Per Day RUG Rate</td>
</tr>
<tr>
<td>Rehab</td>
<td>$1098 - $1122</td>
<td>DRG Bundle</td>
</tr>
<tr>
<td>LTAC</td>
<td>$1746</td>
<td>30-Day DRG Bundle</td>
</tr>
<tr>
<td>Medical Hospital</td>
<td>$2105 - $2948</td>
<td>DRG Bundle</td>
</tr>
</tbody>
</table>

Management Strategies:

- Post-Acute Care Screening Tool
- Palliative / Hospice referrals
- Post Discharge Follow-Up Calls (Call Center)
- TRANSITION care between settings
- COMMUNICATION with patient and providers
3) Understand Payments and Penalties
Outpatient Payments / Costs

Medicare Example:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Per Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$101</td>
</tr>
<tr>
<td>Specialist</td>
<td>$97 - 229</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$107</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>$586 - $825</td>
</tr>
</tbody>
</table>

Management Strategies:

- Access to PCP Care
- Patient Education on cost-effective care
- Preventive Care
- TRANSITION care between settings
- COMMUNICATION with patient and providers
3) Understand Payments and Penalties
Medication Payments / Costs

Medicare Example:

<table>
<thead>
<tr>
<th></th>
<th>Cost per Script</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$34</td>
</tr>
<tr>
<td>Formulary Brand</td>
<td>$122</td>
</tr>
<tr>
<td>Non-Formulary Brand</td>
<td>$646</td>
</tr>
<tr>
<td>Specialty</td>
<td>$436</td>
</tr>
</tbody>
</table>

Management Strategies:

- Generic Preferred
- Formulary Preferred
- TRANSITION with medications
- COMMUNICATION with patient and providers
3) Understand CMS Payments and Penalties
“As goes Medicare, so goes Health Care”

Examples of Penalties:

- **Readmissions**
  - 3% withheld from ALL Admissions
- **Hospital Acquired Conditions**
  - “Never Events”
  - 1% withheld from ALL Admissions
- **Value Based Purchasing Program**
  - Patient Safety Indicators (PSI)
  - Clinical Process and Outcomes
  - Patient Experience
  - **1-2% withheld from ALL Admissions**

Initiatives:

- Readmission Risk Score and automated tasks in iCentra
- Patient follow-up calls (Call Center)
- Protocols and Standards (CPM’s) built into work flows
- Compliance measurement and feedback
- **TRANSITION** care between settings
- **COMMUNICATION** with patient and providers

Measurements are Adjusted for Case Mix Index based on Physician Documentation & Coding!
4) Influence Utilization in all settings

Appropriate Use Criteria

Procedures at Intermountain that significantly exceed national benchmarks:

- Hip Replacement
- Knee Replacement
- Spinal Fusion
- Hysterectomies
- Tonsilectomy

Appropriate use criteria implementation in all Health Care settings
5) Documentation Precision

Standardized documentation for accurate reporting

Accurate Documentation and reporting:

• Demonstrates Measureable Value of Care Management
• Patient registries for disease management
• Comorbidity adjustments for CMS penalties
• Impacts decisions about best practices
• COMMUNICATION between Care Managers and providers
• Address all TRANSITION needs

Example areas of concern:

• Completion of screening and assessments
  • Comorbidities
• Completion of psychosocial assessments
  • Social Determinants of Health
• Completion of Care Plan
• Advance Directives
• Transition Plan and completion of tasks
• Post-Acute Care disposition screening and decision
6) Do what you do best

Communicate, Communicate, Communicate!!!

Care Plan Development with the patient
- What is the patient’s goals?
- Involve caregiver when possible

TRANSITION Planning
- Follow-Up plan with PCP
- Referral completion
- Medication Reconciliation and Information
  *Top area of concern on follow-up calls*
- Community links to resources

Additional Education Available on
- Motivational interviewing
- Talk back
- Behavioral Change Model
Case Example
Care Management transformation in the age of population health

66-year-old female at Dixie Regional Medical Center

Chief Complaint
• Explosive diarrhea and increasing joint pain

Medical History
• Bilateral Total Knee Replacements
• Polymyalgia rheumatica

Pertinent Findings
• BP 102/50, HR 87, RR 31, RA Sats 86%, afebrile
• Gen: Cognitively intact
• Resp: Rales and ronchi, infiltrates on CXR
• MS: Red swollen knee

Diagnosis
• Septic knee with MRSA
• Pneumonia

Plan:
• IV Abx
• To OR for cleanout of infected prosthetic

Post Op course:
• Sepsis controlled on Abx
• Increasing confusion and not coherent after OR
  • MRI showed evolving bilateral infarct involving cerebrum and cerebellum.
  • Evolved to no spontaneous movement
    • Tone decreased. External rotation LE
    • Absent deep tendon reflexes
• Unable to extubate

New Diagnoses:
• Stroke with encephalopathy, prognosis unknown
• Vent dependent, Trach placed
Case Example – “Discharge” Plan
Before Population Health

Plan:
LTAC Utah Specialty Hospital in Provo
• Vent weaning (expecting 2 weeks)
• Transport by Life Flight to Provo
• “Discharge” to SNF when vent weaned

Advantages to “Discharging” to LTAC:
• Patient needs can be met at LTAC
• Transport costs will be covered by Medicare (+$5000*)
• LTAC costs will be covered by Medicare under 30-day DRG (+$52,380*)
• Hospital avoids cost of caring for patient that will not be paid under Inpatient DRG payment from CMS
  ($18,000 =[$300/day x 14 days])

*But patient cost share applies!

Post-Acute Care Cost: $57,380
Case Example – Transition Plan
The Age of Population Health

Plan:
Maintain patient at Dixie Regional
• Vent weaning (expecting 2 weeks)
• “Transition” to SNF when vent weaned

Advantages to Continuity at Dixie:
• Patient needs will be met without transport
• Continuity of Care for within facility
• Patient remains in home town by family

• Patient avoids costs of additional admission (LTAC) (Inpatient co-pay)
• Intermountain avoids costs of additional medical services
  • LTAC 30-day DRG cost avoided ($52,380)
  • Transport cost avoided ($5000)
  • Intermountain incurs cost of 14 days IP stay (+$18,000)

Post-Acute Care Cost: $18,000 AND Better Care!
What Care Managers Do Best:

Coordinate the
Right Care
at the
Right Time
in the
Right Place