Care Coordination in Medicare Advantage

A Panel Discussion

Heather Kilbourne
Division of Policy, Analysis, and Planning, Medicare Drug and Health Plan Contract Administration Group, CMS

Donna Williamson
Division of Policy, Analysis and Planning, Medicare Drug and Health Plan Contract Administration Group, CMS

Denise Kress
Tufts Health Plan

Aelaf Worku
CareMore Health Plan

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Objectives

- **Define Care Coordination**
- **CMS 2016 Quality Strategy**
  - Mission & Goals
- **Care Coordination and Medicare Advantage**
- **Panel Discussion**
  - Tufts Health Plan: Denise Kress
    - Collaborative Care Model
  - CareMore Health Plan: Aelaf Worku
    - Clinical Model of Care

Definition of Care Coordination*

Care Coordination is:

- The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care
- Organizing care that involves the marshalling of personnel and other resources needed to carry out all required patient care activities
- Often managed by the exchange of information among participants responsible for different aspects of care

***Agency for Healthcare Research and Quality (AHRQ)**

CMS 2016 Quality Strategy Mission

Optimize health outcomes by leading clinical quality improvement and health system transformation.

CMS Quality Strategy Goals:

1. Make care safer by reducing harm caused in the delivery of care
2. Strengthen person and family engagement as partners in their care
3. Promote effective communication and care coordination
4. Promote effective prevention and treatment of chronic diseases
5. Work with communities to promote best practices of healthy living
6. Make care affordable

CMS Quality Strategy Goal #3

- Promote Effective Communication and Coordination of Care
- Objectives include:
  - Reduce admissions and readmissions
  - Embed best practices to enable successful transitions between all settings of care
  - Enable effective health care system navigation

CMS Quality Strategy Goal #3 (cont.)

CMS aims to achieve these objectives by:

- Promoting increased care coordination across the health care continuum
- Promoting a person-centered approach to coordination of care
- Recognizing the positive impact of having critical pieces of information communicated across all providers and settings of care

Care Coordination and Medicare Advantage

42 CFR § 422.112(b) Continuity of Care

MAOs offering coordinated care plans must:

- Ensure continuity of care and integration of services
- Have methods for coordinating services
- Provide each enrollee with a primary source of care
- Have programs for coordination of plan services, including community and social services
- Procedures to ensure that the MAO and provider networks have the necessary information for effective and continuous patient care and quality review

Panel Discussion

Denise Kress MS, GNP, BC, CHIE

Vice President,
Care Management Programs for Senior Products

Tufts Health Plan, Boston, MA

Aelaf Worku, MD

Regional Medical Officer, Clark County, NV

CareMore Health Plan

Tufts Health Plan: Who We Are

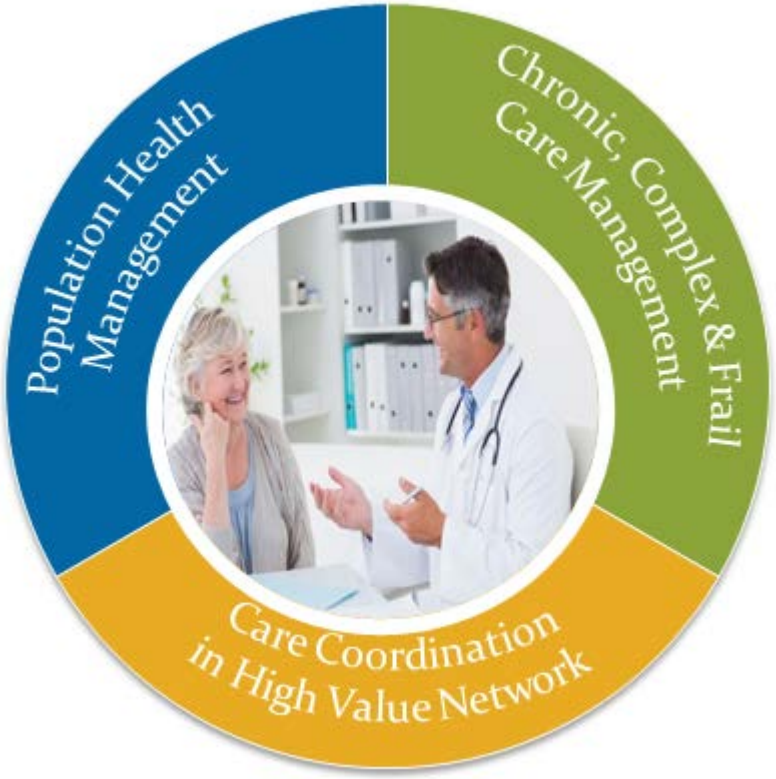
Mission: Improve the health and wellness of the diverse communities we serve

- We deliver high-quality health care to more than 1,100,000 members in Massachusetts, Rhode Island, and New Hampshire.

Products

- Medicare Advantage
- Medicaid
- Commercial

Collaborative Care Model



The model supports PCPs in focusing on care for the majority of the population while a multidisciplinary team provides specialized care management for multi-morbid, frail and complex members.

Collaborative Care Model (cont.)

Critical Success Factors

- Predictive identification & intervention with high and rising-risk members
- Multidisciplinary team approach to the management of the most complex and frail members across the continuum
- Integrated chronic disease and geriatric condition management;
- Effective management of transitions of care
- Preferred referral circles with quality and outcome(s) management
- Programs to address avoidable ER visits, acute hospital admissions, and long-term care placement

Care Model: Population Segmentation

Population Segmentation Characteristics

“Well”

- No/low disease burden
- No chronic disease and low utilization
- Focus on prevention and education
  - Coaching programs around weight control and nutrition, smoking & stress
  - Prevention education on how to stay healthy (e.g., flu shots)
  - Annual Wellness Exam

Care Model: Population Segmentation (cont.)

Population Segmentation Characteristics

“Low-risk Chronic”

- Disease burden increases
- 1+ chronic condition with minimal functional impact and low utilization
- All Well processes, plus:
  - Focus on education to improve self-management skills
  - Chronic disease and geriatric condition management
  - Evidence-based protocols to mitigate risk factors (e.g., exacerbations, hospitalizations)

Care Model: Population Segmentation (cont.)

Population Segmentation Characteristics

“High-Risk Chronic”

- Disease burden increases significantly
- 1+ chronic conditions with functional/cognitive impairment, health disparities and/or high utilization
- All Low-Risk Chronic processes, plus:
  - Episodic care management for lower end of the spectrum
  - Intensive care management for higher end of the spectrum
  - Consults by specialty team
  - Medication review, reconciliation and adherence

Care Model: Population Segmentation (cont.)

Population Segmentation Characteristics

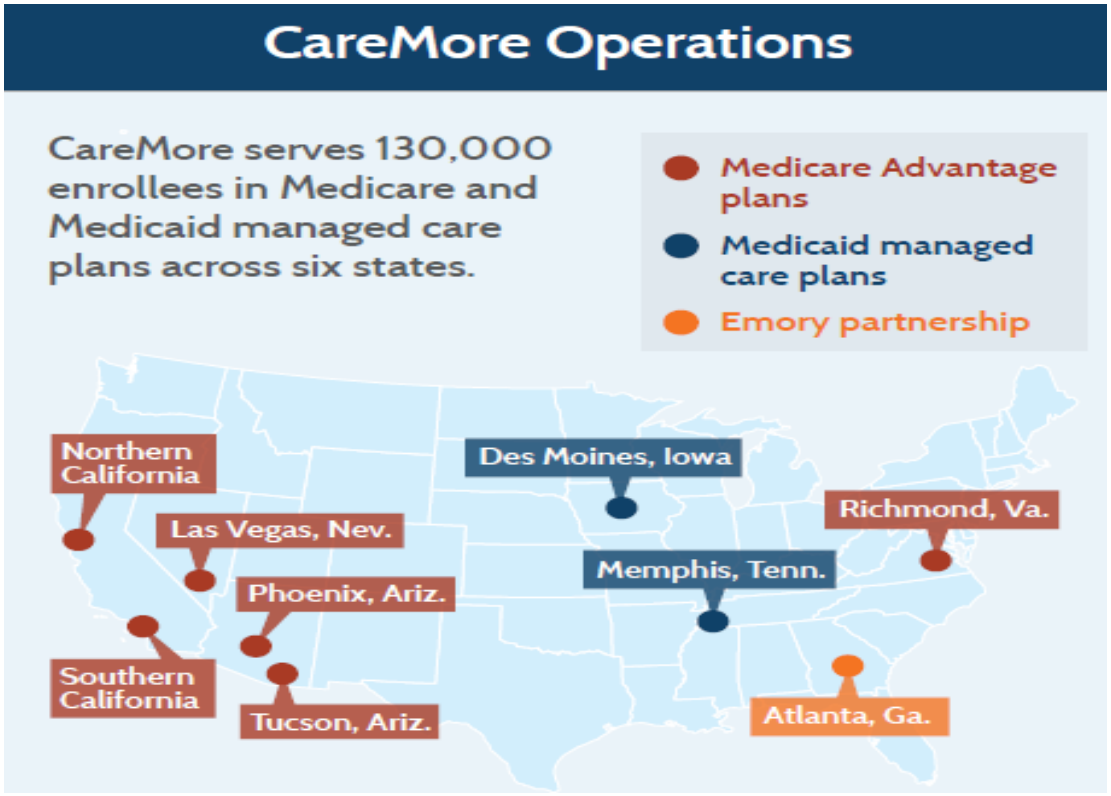
“Frail and Complex”

- High disease burden
- Top utilizers or those with significant impairment
- All High-Risk Chronic processes, plus:
  - Highly specialized team in all settings including hospitals and SNFs
  - Close monitoring
  - Home visits with ability to “treat in place”
  - Advanced illness management
  - Caregiver support

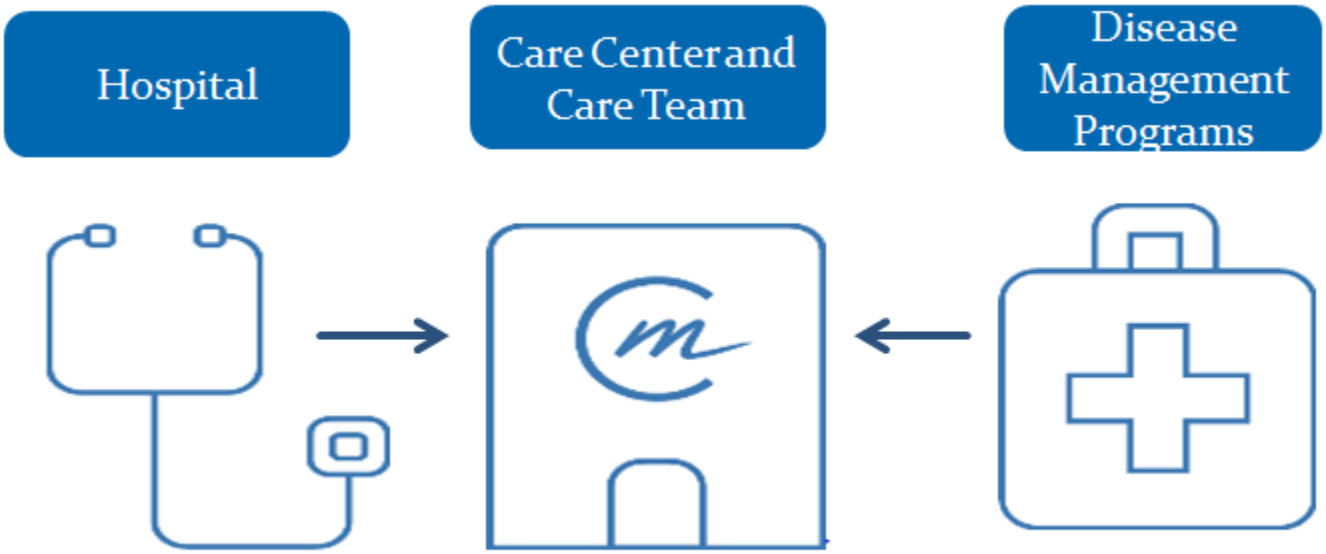
Functions Applied Across the Population

- **Management in All Care Settings**
  - Community, Hospital, SNF, Rehab, Long-term care facility
- **Management of Transitions of Care**
- **Specialized Clinical Programs**
  - Geriatric Consult, Pharmacy, Dementia Care, Behavioral Health, Advanced Illness
- **Member-Centric Capabilities**
  - Nurse Triage, Same-day Appointment Availability, and Annual Health Risk Assessment (HRA)

CareMore's National Presence



CareMore's Model



CareMore's Model (cont.)

How do the Care Centers Succeed in Delivering Both Quality and Lower Costs?

Interdisciplinary Clinical Management

- Extensivists
- Nurse Practitioners
- Specialists
- Case Management
- Dieticians & Pharmacists

64 Free Clinical Programs and Services, including:

- Diabetes
- Congestive Heart Failure
- COPD
- Wound Care
- Chronic Kidney Disease
- Behavioral Health

Hospital Outcomes

STRONG ACUTE MANAGEMENT and WELL-COORDINATED CARE TRANSITIONS

Interdisciplinary Team

- Extensivist Physicians
- Case Managers
- Primary Care Provider

Results: CareMore vs. Medicare Average

- 20% fewer admits
- 28% lower length of stay
- 37% lower bed days
- 19% fewer readmissions

Judicious Use of Skilled Nursing Facilities

Interdisciplinary Team

- Extensivist Physicians
- Case Managers
- Disease Management Programs

Results: CareMore vs. Medicare Average

- 26% more admits
- 43% lower bed days
- 54% lower length of stay

Effective Diabetes Management

Diabetes Program

- Nurse Practitioners
- Registered Dietitians
- Point of Care HbA1c labs
- Insulin and blood sugar testing management
- Self-Care Education

Results

Individuals referred to the Diabetes Management Program for A1c poor control > 9 experienced better blood sugar control.

- 13.8% with excellent control < 7
- 35.3% with good control < 8
- 59.8% under control <= 9

Comprehensive Diabetes Care

Diabetic Program Clinical Compliance

- Protocols in CareMore's EHR for prompt annual diabetes care compliance
- ACE/ARB and statin medication management
- Appointment scheduling for retinopathy screening via CareMore Outreach

Comprehensive Diabetes Care (cont.)

Results for Program Participants

- **BP Control**
  - 2% better control
- **Cholesterol Control**
  - 7% better control
- **Eye Exam**
  - 10% more exams

Successful Congestive Heart Failure (CHF) Monitoring

CHF Weight Program

- Wireless scale for weight monitoring at home provided to members with CHF
- Alerts CareMore Nurse Practitioner to contact member for rapid weight increase
- Same-day appointment at the CareMore Care Center if needed

Results for Program Participants

- 48% fewer hospital days
- 36% fewer admissions
- 23% fewer readmissions

Proactive Chronic Obstructive Pulmonary Disease (COPD) Management

COPD Program

- COPD Management and Self-Care Education with Nurse Practitioners and Dietitians
- Medication Management – routine and rescue meds
- Smoking Cessation Class for all smokers interested in quitting

Results for Program Participants

- 38% fewer admissions
- 48% fewer hospital days

Comprehensive End-Stage Renal Disease (ESRD) Program

ESRD Program

- ESRD management NPs and dedicated case manager
- Dialysis access line inspection and cleaning
- Close collaboration with nephrologist and dialysis center

Results for Program Participants vs. Medicare ESRD

- 41% fewer admissions
- 60% fewer hospital days