



**Realizing the Potential:
Risk Management
Programs That Improve Population Health
Care Continuum Alliance Forum11**

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September 7, 2011

Agenda

- **Observations**
 - Fragmentation, Incoordination, Medical Errors, Costs > Inflation
 - IDNs Perform Better
- **Integrated Care is the Headline**
 - ACA
 - PCMH & ACO
 - Essential Elements of Clinical Systems
 - Registries
 - Patient Tracking
 - QI Culture
 - Access: Individual & Organizational
- **5% is the Problem & Solution**
 - Case Management & Care Coordination
- **Program Results**
- **Vignettes and Q & A**

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A National View of Care, A Problem of... Coordination and Integration

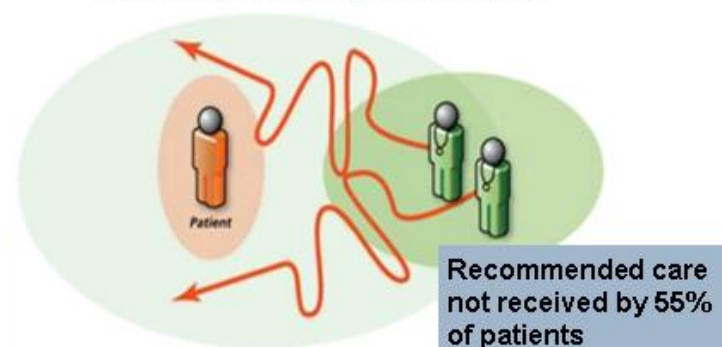
Care Coordination is Inadequate

Chronic patients see ≥ 6 providers per yr.



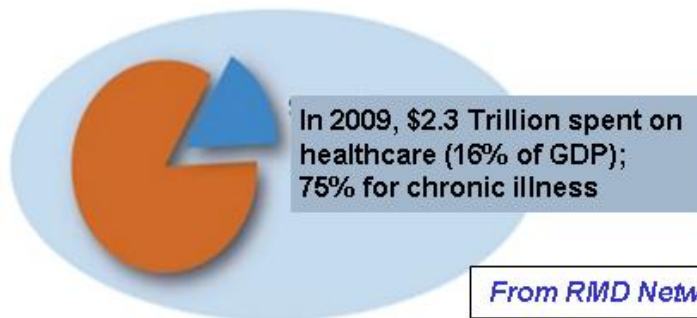
Care Coordination is Inadequate - Bodenheimer, T., M.D., "Coordinating Care - A Perilous Journey Through the Health Care System", NEJM, March 6, 2008

Recommended Care is Not Received



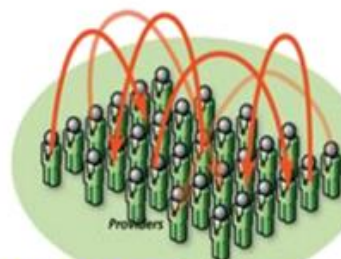
Recommended Care is Not Delivered - McGlynn, et. al., "The Quality of Health Care to Adults in the United States", NEJM, June 26, 2008

Costs are High



From RMD Networks, Geoff Hyatt

Obligation for Coordination is High



In a year, an average PCP coordinates with 229 other doctors in 117 practices, for FFS Medicare patients

Obligation for Coordination is High - Pham, Hoangmai, MD, MPH, et. al., "...The Scope of Care Coordination", Annals of Internal Medicine, February 17, 2009

IDNs Tend to Perform Better

Best Commercial Plans



Rank	Plan	State	Score
1	Harvard Pilgrim Health Care (HMO/POS)	Mass., Maine	91.1
2	Harvard Pilgrim Health Care of New England (HMO/POS)	N.H.	90.2
3	Tufts Associated Health Maintenance Organization (HMO/POS)	Mass., N.H., R.I.	89.9
4	Grand Valley Health Plan (HMO)	Mich.	89.4
5	Capital Health Plan (HMO)	Fla.	89.0
6	Geisinger Health Plan (HMO/POS)	Pa.	88.6
7	Fallon Community Health Plan (HMO/POS)	Mass.	88.0
8	Health New England (HMO/POS)	Conn., Mass.	87.9
9	CIGNA HealthCare of New Hampshire (HMO/POS)	N.H.	87.7
10	Group Health Cooperative of South Central Wisconsin (HMO)	Wis.	87.6

By Avery Comarow
Posted November 11, 2009

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National Trends: Integration of Care

▪ **ACA**

- Facilitates Dramatic Growth in Medicaid Lives
- Accountable Care Organizations (ACOs) will be created within and outside Medicare
- PCMH - Patient Centered Medical Home

▪ **Essential Features of Integrated Care Delivery**

- Patient Tracking (Use of Registries)
- Care Coordination (Inter-visit Contact/Coordination of Care)
- Enhanced Access (Same Day Appt or Levels of Care, Appropriate Use)
- Quality Improvement (Use of PDSA for QI Activities)

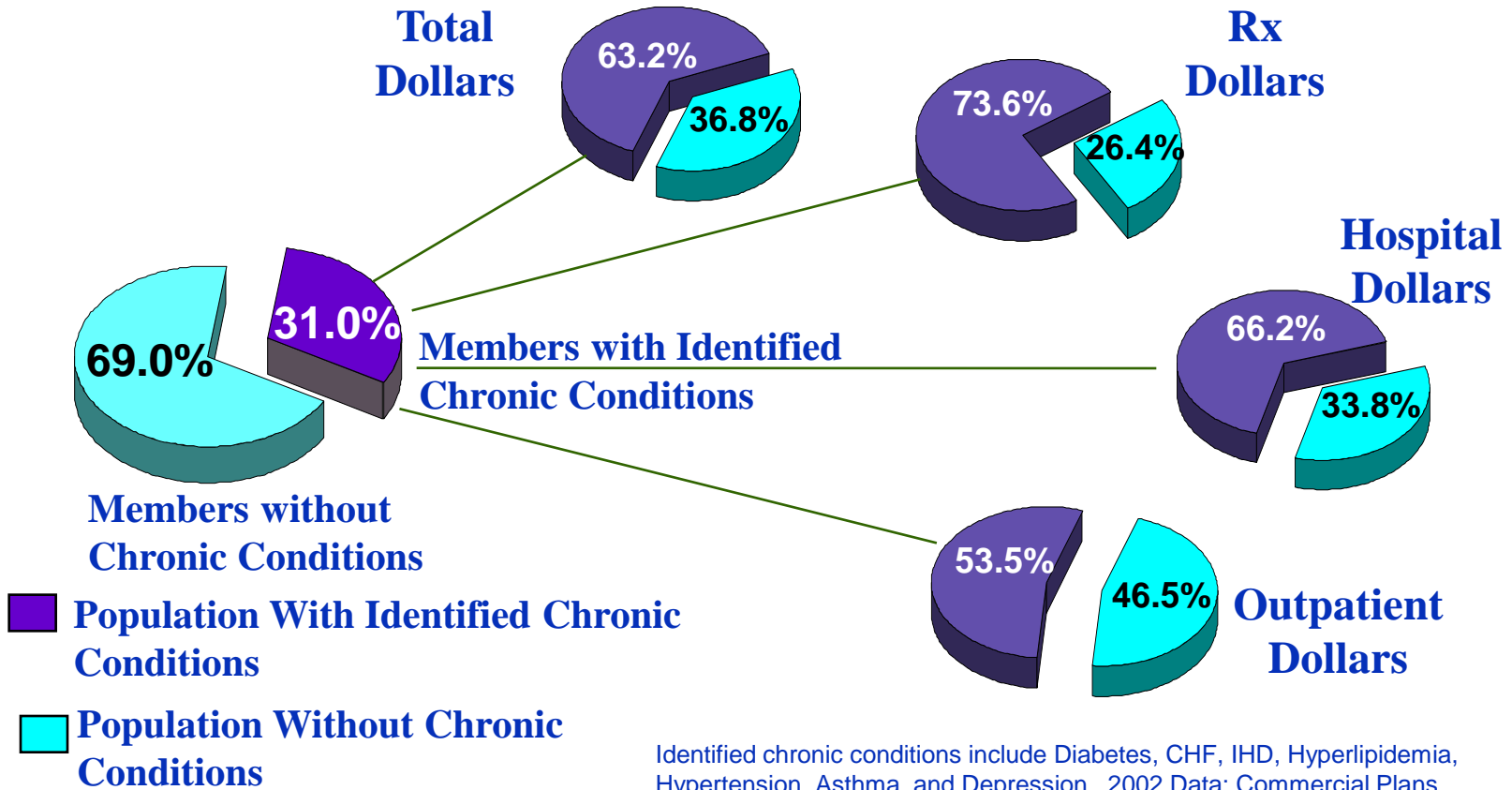
▪ **Medicaid & Medicare**

- Focus of Cost and Quality Initiatives: VBP, Meaningful Use, etc.
- High Levels of Fragmentation & Lack of Coordination: ACOs, etc.

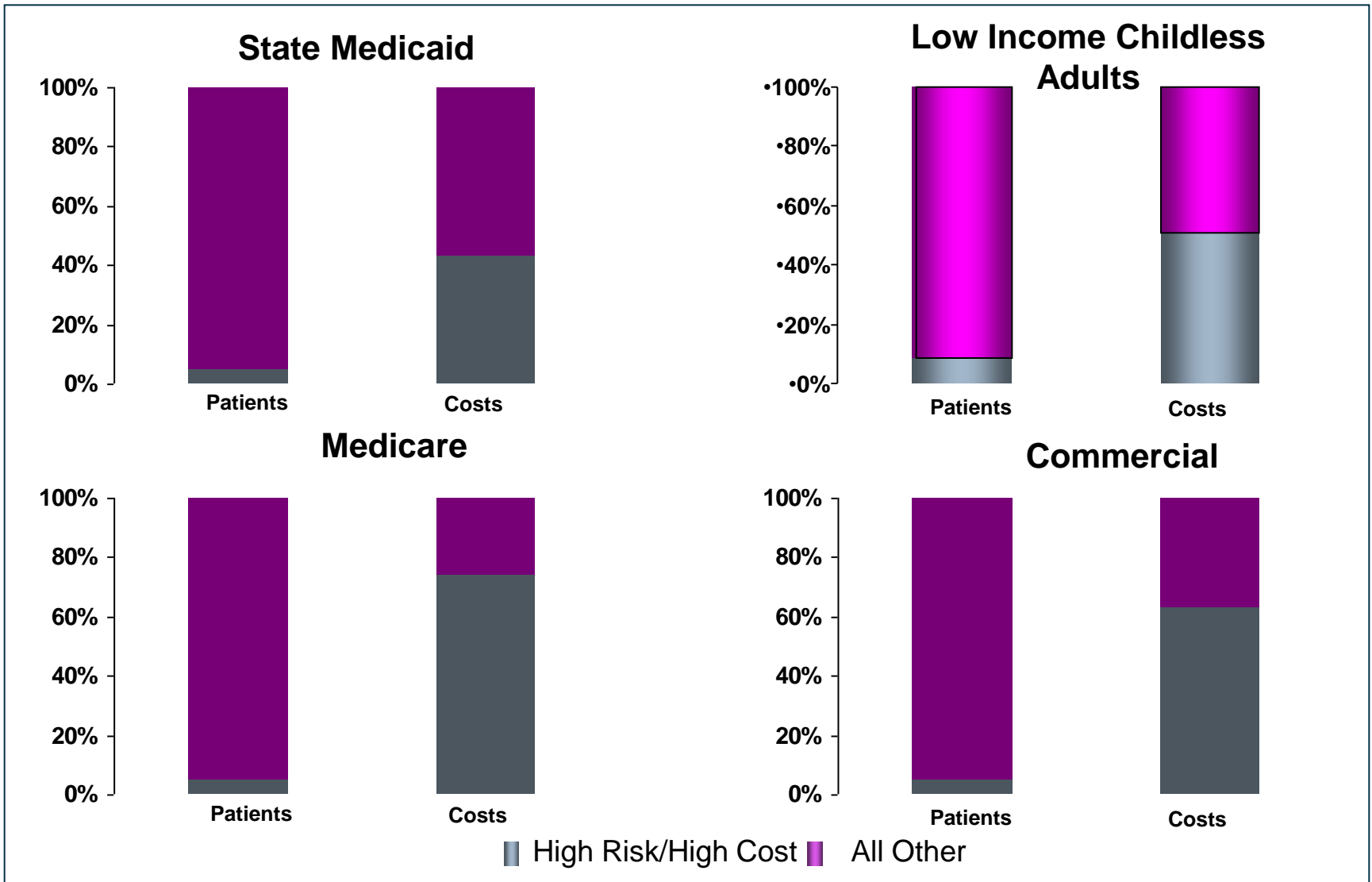
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Chr. Disease = Most of the Cost, Then, DM Programs



But, In All Populations, A Small Group → Poor Outcomes & Higher Costs

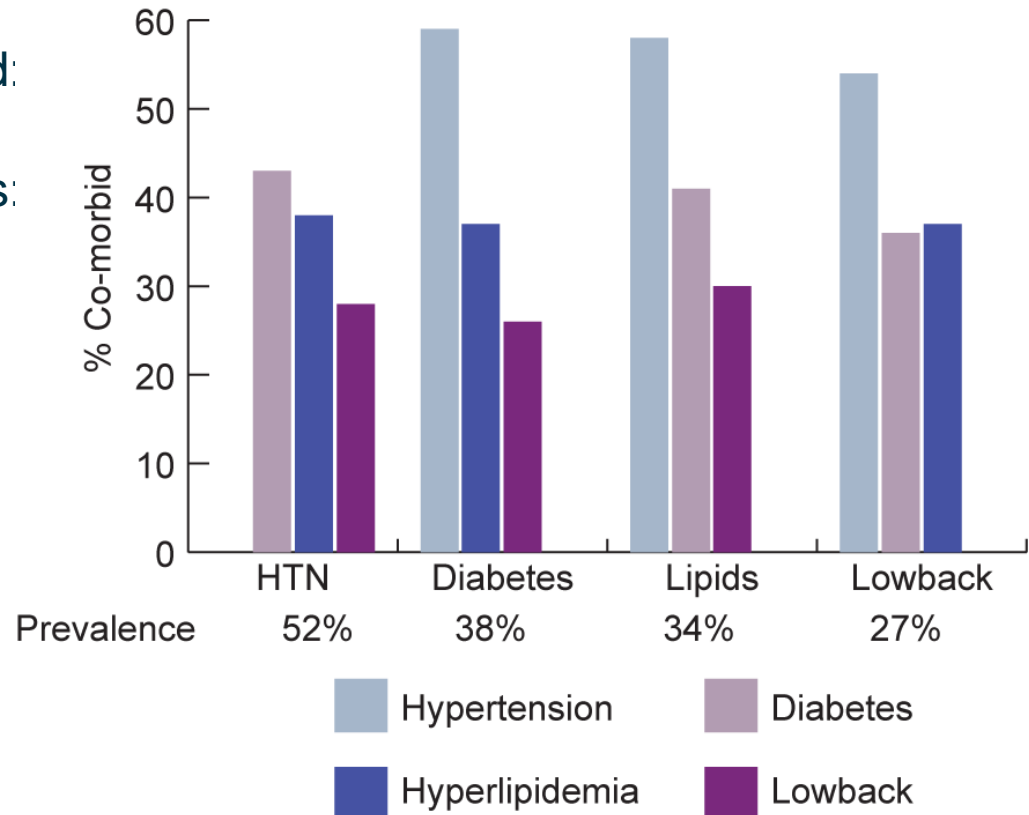


High Risk/High Cost Patients = 5% (Complex & Drive Utilization)

The Small Grp is the HR/HC Patients & compared to the Remaining Patients:

- Average Monthly Spend: **8 – 10 times higher**
- Emergency Room Visits: **3 – 5 times higher**
- Inpatient Admissions: **>20 times higher**
- Readmissions: **>80 times higher**

High Risk/High Cost Patients Have Significant Co-morbidities



Chr. Dis. Members & Odds Ratios of Being In The Top 5%

Odds Ratios	Stay Top 5 '05 and '06	Next 35 '05 to Top 5 '06	Bottom 60 '05 to Top 5 '06
Age	1.00*	1.01*	1.02*
Diabetes	1.92*	1.84*	1.17*
CAD	1.48*	1.70*	1.23*
CHF	2.83*	1.81*	1.51*
COPD	1.56*	1.72*	NS
Asthma	1.94*	2.0*	NS

- High Cost Mbrs with Chronic Conditions Tend to Stay High Cost
- Mid-range Cost Mbrs with Diabetes or Asthma Most Likely Move to High Cost
- Low Cost Mbrs with Diabetes, CAD or CHF Most Likely Move to High Cost
- Gender Not Significantly Related to likelihood of Between Group Movement

❖ Commercial & Medicare Population,

D. Taira & R. Chung, Unpublished

The Top 5% = Complicated Members

- **A small group of members drive a large portion of cost**
 - ~5% of members → ~50% of cost of care
- **Typical profiles**
 - Chronic diseases, multiple co-morbidities, co-morbid SMI/SA
- **Members not utilizing care efficiently**
 - Multiple providers, settings, and levels of care
 - Healthcare is uncoordinated - medical home not existent or not effective
 - Unnecessary ER use, hospitalizations/readmissions
- **Poly-pharmacy**
 - Poor engagement with conventional DM
- **Reducing uncoordinated care reduces costs, improves quality**

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Case Management Model – Based on Functions (APS Healthcare)

Minimal Model	<i>Coordination Model</i>	Comprehensive Model
<p>Outreach Client Assessment Case Planning Referral to Service Providers</p>	<p><i>Outreach</i> <i>Client Assessment</i> <i>Case Planning</i> <i>Referral to Service Providers</i> <i>Advocacy for Client</i> <i>Coordination of Services</i> <i>Developing Natural Support Systems</i> <i>Monitors Quality</i> <i>Reassessment</i></p>	<p>Outreach Client Assessment Case Planning Referral to Service Providers Advocacy for Client Coord. of Services Developing Natural Support Systems Reassessment Advocacy for Resource Develop. Monitors Quality Public Education Crisis Intervention</p>

From: The Impact of Managed Behavioral Healthcare on Individuals with a Dual Diagnosis, a Dissertation presented to Honolulu University, Joyce Ingram-Chinn, 2000

APS Healthcare Case Management Model – Based on Organizational Structure

Generalist Model	Distinct Model	Team Model
<p>The Case Manager is also the primary care giver.</p>	<p>Case Managers have job descriptions that are distinct to case manager functions</p>	<p>Case management (field-based) is a separate organizational unit that functions as an integrated team.</p> <p>Each team member has a specialty, e.g.</p> <ul style="list-style-type: none"> – Social Work, – Nurse Care Mgr, – Care Coordinator, – Community Care Worker, – Lay person, etc.

From: The Impact of Managed Behavioral Healthcare on Individuals with a Dual Diagnosis, a Dissertation presented to Honolulu University, Joyce Ingram-Chinn, 2000

The APS Approach: Next Generation - Total Population Management

- **Focus on the 5% who drive 50% of cost: 5% Solution**
- **High Touch, “Feet on the Street”**
- **Technology-driven**
 - **Percolator: the “secret sauce”**
 - **Care Connection® Platform: linked to Percolator™, shapes work**
- **Essential Features**
 - **Patient Tracking (Use of Registries)**
 - **Care Coordination (Inter-visit Contact/Coordination of Care)**
 - **Enhanced Access (Same Day Appt or Levels of Care, Appropriate Use)**
 - **Quality Improvement (Use of PDSA for QI Activities)**

Total Population Management Characteristics (APS)

- **Healthcare is Local, and So Are We**
 - Community-based operations
- **Focus on Patients with Complex Conditions**
 - Priority to those at greatest risk for poor clinical outcomes
 - High touch/ High Impact → vital for complex population
- **Technology-Enabled, Clinical Best Practice Care**
 - Dynamic “Percolator” stratification/prioritization methodology linked with workflow management tools → Web-based integrated plans of care
- **Provider Partnership/Collaboration**
 - Emphasis on effective patient-centered medical homes

The APS Healthcare Model: Differentiated

Conventional DM	The APS Total Population Health Model
<ul style="list-style-type: none"> ▪ Medical / Clinical Education 	<ul style="list-style-type: none"> ▪ Access to care, public health approach
<ul style="list-style-type: none"> ▪ Gateway Disease Focus 	<ul style="list-style-type: none"> ▪ Data driven case identification
<ul style="list-style-type: none"> ▪ Stratify 	<ul style="list-style-type: none"> ▪ Stratify + “Percolate” (prioritize interventions and daily workflow)
<ul style="list-style-type: none"> ▪ High Risk / Cost by conditions 	<ul style="list-style-type: none"> ▪ High Risk / Cost + Impactable risk
<ul style="list-style-type: none"> ▪ Interventions = Education & Support 	<ul style="list-style-type: none"> ▪ Interventions = Case Finding, Coordination, Self-Management + establish and support effective health, home
<ul style="list-style-type: none"> ▪ Staffing & Delivery model: Nurse delivering remote telephonic disease education 	<ul style="list-style-type: none"> ▪ Staffing & Delivery model = Local multidisciplinary team (Nurse, SW, Care Coordinators...) for F2F & Telephonic engagement, social support, linkage to Providers & Health Home / ACO
<ul style="list-style-type: none"> ▪ Multiple systems 	<ul style="list-style-type: none"> ▪ Single technology system that integrates data, drives workflow and delivers reports

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Pilot Program – Preliminary Results

- **Population**

- ABD population: chronically ill patients with multiple medical co-morbidities and social deprivation
- Geographically dispersed; four counties

- **Services**

- Intensive APS Model → 5% Highest Risk
- Moderate Intensity → 15% Moderate Risk

- **Assessment Time Frame**

- 3 Years Eligibility
- 12 Month Impact Assessment
- Baseline Established

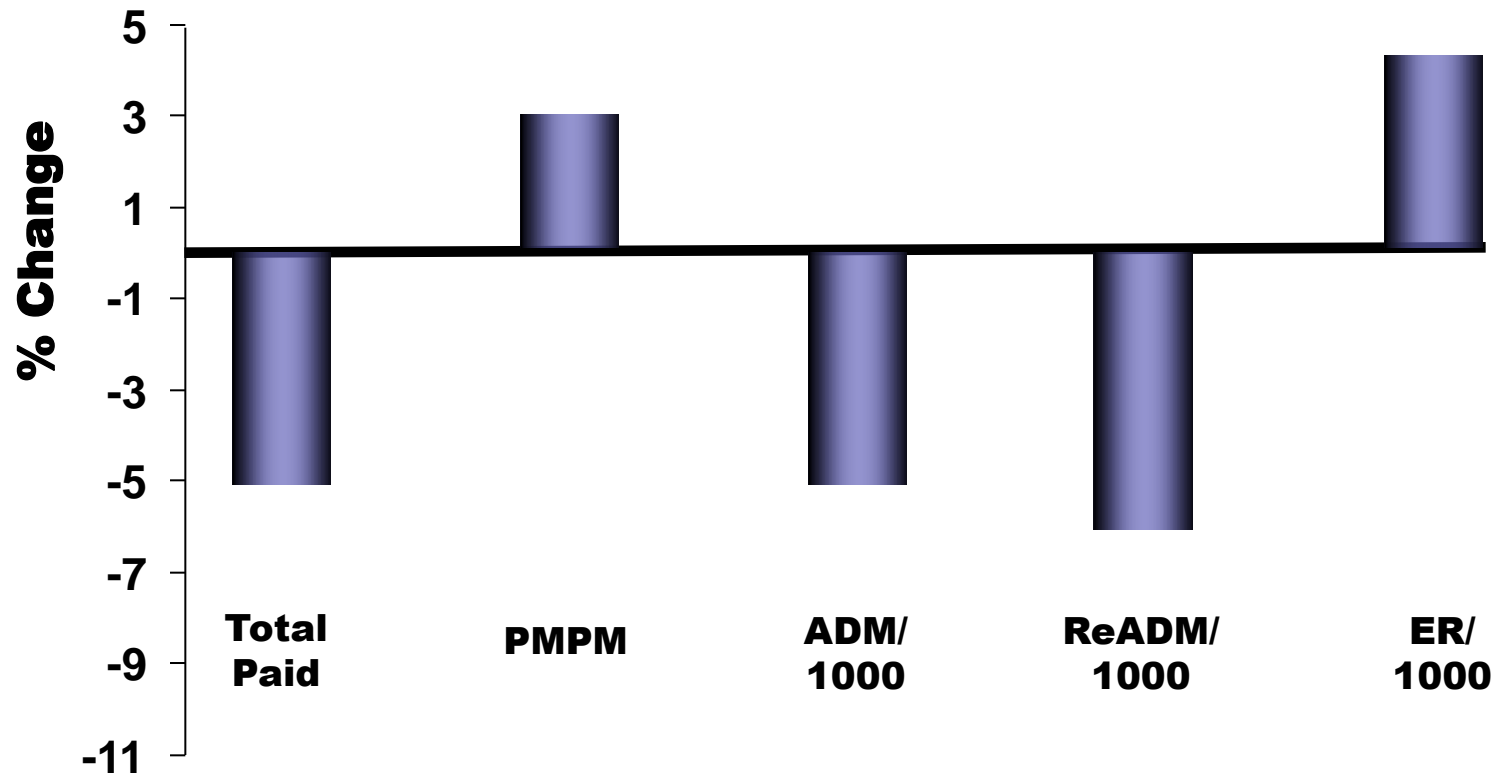
Pilot Program: Population Baseline - Revised

Population n=11,208	Top 5% HR/HC	Next 15%	All Other 80%
% Of Total Costs	41%	32%	27%
Average Age	53	53	55
% Male	43%	39%	41%
PMPM	\$6,371	\$2,542	\$602
Months of Eligibility	12.0	12.0	11.9
Average Risk Score*	12.1	6.0	2.5
Number of Chronic Conditions	6.0	4.4	1.9
ER Visits / 1000	5,779	2,629	892
Inpatient Admits / 1000	2,714	835	158
Readmits / 1000	968	154	21

- All patients have 3 yr. continuous enrollment
- All patients have at least once chronic disease and are classified as disabled
- Excludes: patients eligible for other insurance, pregnancy/neonates, long term care facility charges

Pilot Program: Revised Results

- All Individuals in Pilot Have Severe Illnesses
- Reductions From Baseline (Not Trend) Seen Across Key Metrics



Pilot Program Results

- Program Contract Focused on is a Sub-set of the Whole
- Savings Accrued for Entire Program, Driven by Targeted Group Savings
- Greater Savings Likely if Non-targeted Group Included

	Impact on Total Population	Impact on Targeted Top 5%	Impact on Next 15%	Impact on Lowest 80%
	Intervention	F2F + CC + DM	CC + DM ± F2F	DM
Total Spend	- 5%	- 19%	- 7%	+ 5%
PMPM	+ 3%	- 10%	-1%	+ 15%
Admits/1000	- 5%	- 10%	- 8%	+ 2%
Readmits/1000	- 6%	- 6%	- 5%	-7%
ER/1000	+ 4%	+5%	+4%	+3%

*Same ABD members measured in the same risk group from baseline to impact year

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Case Vignettes

Correct Meds → Less ER & Inpatient Visits

Member ID 8998828: Mr. B of Sacramento County is a 22 year old male with diabetes and gastroparesis who was having difficulties with his medications since Medi-Cal would only pay for a limited amount and he could not afford to pay the rest.

The Care Manager worked with the PCP, Dr. R from DHCS and we were able to educate the PCP on the member medication approval process.

Lack of the appropriate medications had landed this member in the ER numerous times; ER 33 times in 2010 and the claims currently show no ER visits in 2011. Claims also show he was hospitalized 14 times in 2010 and again no claims for hospitalization for 2011.

Case Vignettes

▪ Potential Leg Amputation

Member Id: 8992690. Mr. R of Sacramento County: 53 year old man with multiple chronic conditions: diabetes, hypertension, cirrhosis of the liver, cancer, schizophrenia, and severe leg wounds.

In March 2011, the most urgent issue was severe leg wounds; had been dealing with the wounds since 2007.

They had limited access to transportation. The Care Manager arranged for transportation & prepared the application for Paratransit service.

The Care Manager arranged for a next day appt. with a new PCP at the M & M Clinic; He was admitted directly to the hospital after his appointment.

The Care Manager worked with the hospital discharge coordinator to continue IV antibiotics and transfer to a SNF, but did not want to go to a SNF. Home health nursing was arranged he was & his wife was taught to assist; there was eventual healing w/o Cx.