REDWOOD HEALTH COMMUNITY COALITION

Serving Sonoma, Napa, Marin & Yolo Counties

# Track 2: Using Technology for Complex Care Management

## Additional Activities:

**10:45 AM – 1:30 PM**

*Help Squad – one-on-one PCMH and Meaningful Use Support (Innovation Room)

*Promising Practices Gallery Walk Raffle (Inside perimeter of the office)

**1:00 PM**

*Promising Practices Raffle (Training Room)

*See the back of your agenda to participate*

# Partnership HealthPlan of CA Care Management and Care Planning

James Cotter, MD MPH

November 2017

# Why do Care Management?

- Most expensive 1% of patients spend 20% of our national health expenditures

- Complex chronic conditions often have:
  - Poor coordination
  - Unnecessary utilization
  - Poor outcomes

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Optimizing Care Management

- **Practice based**
  - Care managers are co-located where patients receive their care
  - Documented reduction in health expenditures of 7% (Medicare)

- **Payer Catalyzed**
  - Payment models that facilitate and encourage care management
  - PMPM payments that allow flexibility
  - Coordinated strategy between payer and providers

Powers, B et al. Optimizing High Risk Care Management. JAMA, Jan 2015

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Is Care Management Effective?

- CHF, DM, CAD – yes
  - Health management skills and health knowledge changed health behaviors

    (Vasc Health Risk Manage. 2010; 6:297-305)
- Depression – yes

  (JAMA 2002;288(2):2836-2845)
- Hospital readmission – yes

  (Social Work. 2015;60(3):248-255)
- Frail Elderly – yes

  (J Am Geriatric Soc. 2014;62(12):2369-2376)
- Dementia – no
  - No good evidence on health expenditures or hospitalizations

    (J Nutr Health Aging. 2010;14(8):669-676)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# What Interventions Are Most Effective?

- Medication reconciliation
  - Especially if you give the patient a pill organizer
- Transportation
  - The new state benefit has been very helpful
- One number to call to get help
  - Appointments, questions, messages
- Motivational Interviewing
  - Engaging the patient in his or her own care

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Finding Patients

- Claims data with quantitative risk and prediction tools
  - A backwards look at costs
  - May miss patients with complex psychosocial needs
- High risk conditions
  - Patients with a high risk condition are not always high risk
- Frequent acute utilization
  - Prior utilization is not always predictive of future use
- Referral by clinician
  - Challenging patients may not always "care manage" well
- Patient self referral
  - Patients who need the most help may not have the motivation or ability to seek help

CHCH, Finding a Match, March 2015

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Key Assessments: How much do you need to know?

- HRA: Health Risk Assessment
  - Medical history, hospital and ED utilization
  - Behavioral and mental health, functional capacity, housing stability
- SHA: Staying Healthy Assessment
  - Assesses acute, chronic and preventive needs
  - Nutrition, activity, safety, dental, mental, sexual health
- AUDIT-C, DAST-10: Assess substance abuse risk
- PHQ 2/9: Depression score
- PAM: Patient Activation Measure

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# What Else Would You Want to Know?

- Mental illness assessment
- Trauma history and adverse childhood experiences
- Cultural and linguistic barriers to care
- Memory and cognitive assessment
- Frailty score
- Hospital admission risk score
- Functional (ADL) assessment: vision, hearing, ambulation
- DME needs
- Home safety and fall risk assessment
- Caregiver support, long term support service needs
- Advanced directive and goals of care

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# The Care Plan in IOPCM

- **Medical History**:
  - Current problems and medications, allergies, hospitalizations
- **Physical Health**:
  - Functional assessment and DME needs, nutritional issues, dental
- **Review of Assessments**:
  - HRA, SHA. PHQ2/9, AUDIT-C, PAM level
- **Psychosocial challenges:**
  - substance abuse, cognitive assessment
- **Self-Management skills**:
  - medication adherence, patient activation, physical activity
- **Summary Acuity Score**
  - How much time will it take to care for the patient?

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Engaging Patients

- Engaging patients
  - Influencing individual decisions
  - Sometimes one decision at a time
- Patient Activation Measure
  - Tier 1 – dependency
  - Tier 2 – starting to pay attention, learning
  - Tier 3 – building confidence and taking action
  - Tier 4 – maintaining health behaviors
- Motivational Interviewing

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Motivational Interviewing

- Developed to treat problem drinkers by William Miller in 1983 and later enhanced by Miller and Stephen Rollnick in 1991.
- Explore and resolve ambivalence
- Client centered – non judgmental
- Goal oriented
- Engage, Focus, Evoke, Plan
- Envision a better future and change behavior to achieve it

- Some people are naturally talented at this, but it really is a learned skill that takes practice.

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Shared Action Plans

- Given to the patient at a face to face visit
- Includes Care Manager contact number and PCP's name
- Current Medications:
  - Highlighting any **recent changes**
- Follow-up: PCP appointments, labs or imaging needed
- Treatment:
  - Referrals given
  - Specific things the **patient agrees to do**
- Keep it simple and hand it to the member

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Health Homes Program Evolution

- 1992, AAP: **Medical home** for care of infants, children and adolescents
- 2002, AAP: The Medical Home
- 2004, AAFP: Future of Family Medicine
- 2006, ACP: The Advanced Medical Home
- 2007: Joint Principals of the **Patient Centered Medical Home**
  (AAFP, ACP, AAP, AOA)
- 2008: DHHS Medical Home Workgroup
- 2009: SAMHSA
- 2010: ACA section 2703: **Health Homes Program**

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Health Homes for Patients with Complex Needs

**CMS Guiding Principles:**

- Improve care coordination
- Integrate palliative care into primary care delivery
- Improve health outcomes for people with high risk chronic diseases
- Strengthen team based care using community health workers
- Strengthen community linkages
- Reportable net cost avoidance within 2 years

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Health Homes for Patients with Complex Needs

**DHCS Objectives:**

- Ensure providers serve members experiencing homelessness
- Increase integration of physical and behavioral health
- Increase care coordination close to the point of care delivery
- Referral to community and social support services
- Enhance the use of health information technology

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# The Care Plan IOPCM2 and Health Homes

- **Physical Health**
  - Acute and chronic problems
  - Diet and nutritional needs
  - Palliative care and advanced care planning needs
- **Psychosocial Health**
  - Mental and behavioral issues
  - Substance abuse
  - Trauma informed care
- **Social Support**
  - Long term support services needs
  - Housing stability/homelessness
- **Self Management skills**

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Trauma Informed Care

- Higher disease rates
- More substance use disorder
- Mores behavioral health issues
- Poorer health outcomes
- Social and emotional impairment
- Cognitive impairment
- Maladaptive coping strategies

http://developingchild.harvard.edu/resources/multimedia/videos/three_core_concepts/toxic_stress

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# DHS HHP Reporting Draft

- **Enrollment**
  - Enrolled, Not Eligible, Unsuccessful, Duplicate Program, Dis-enrolled
  - Number of care managers (RN ratio to member enrollees)
- **Member Activity**
  - Housing stability, referrals, received supportive housing
  - HAP completed within 90 days
- **Network Capacity**
- **Engagement** percentage within 6 months
- **Blood Pressure** control by age group (32 data fields)
  - CMS required health measure

All of this reported on an excel spreadsheet

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# HHP Reporting Requirements

**The current world:**

- Excel spreadsheets with specific data elements
- Document who is enrolled and dis-enrolled
- Documenting health assessment dates
- Documenting the care plan
- Auditing shared action plans

**The future?**

- How much can we extract directly from your EMR?

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# A PHC New Care Management Program:

# Intensive Home-based Palliative Care

## PHC intensive care management program

- January 1- a new benefit for all PHC members
- Four Covered Diagnoses:
  - Cancer: stage 3 and 4
  - CHF with low LVEF
  - COPD dependent on oxygen
  - End-stage Liver Disease
- Life expectancy of 12 months

PARTNERSHIP HEALTHPLAN of CALIFORNIA

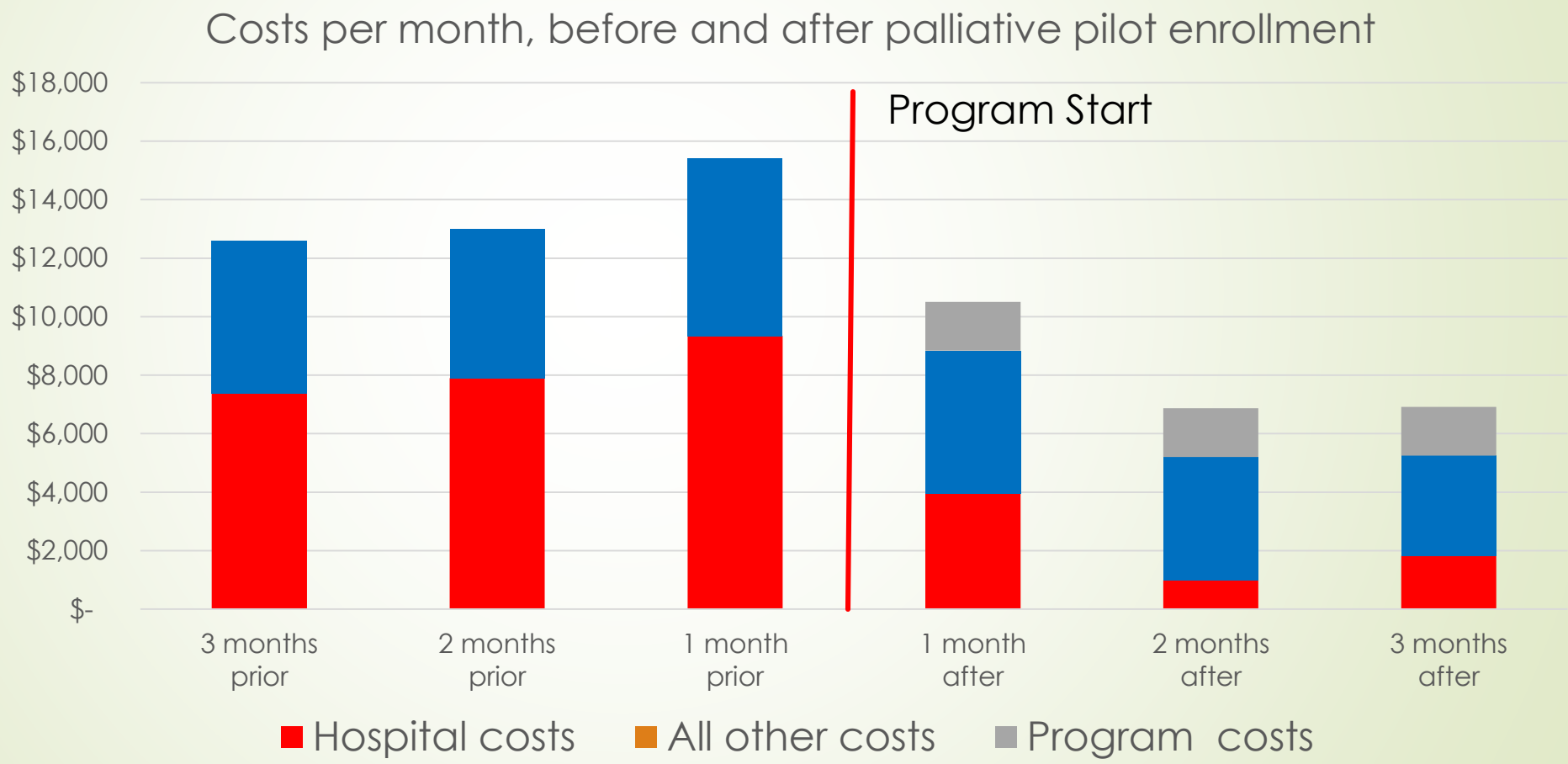
# UCSF Safety Net Study 2010 - 2013

- 403 Patients:
  - Hospitalized in last 6 months of life 76%
  - Hospitalized in the last month of life 45%
  - Multiple admissions in last month of life 21%
  - Died in the hospital 33%

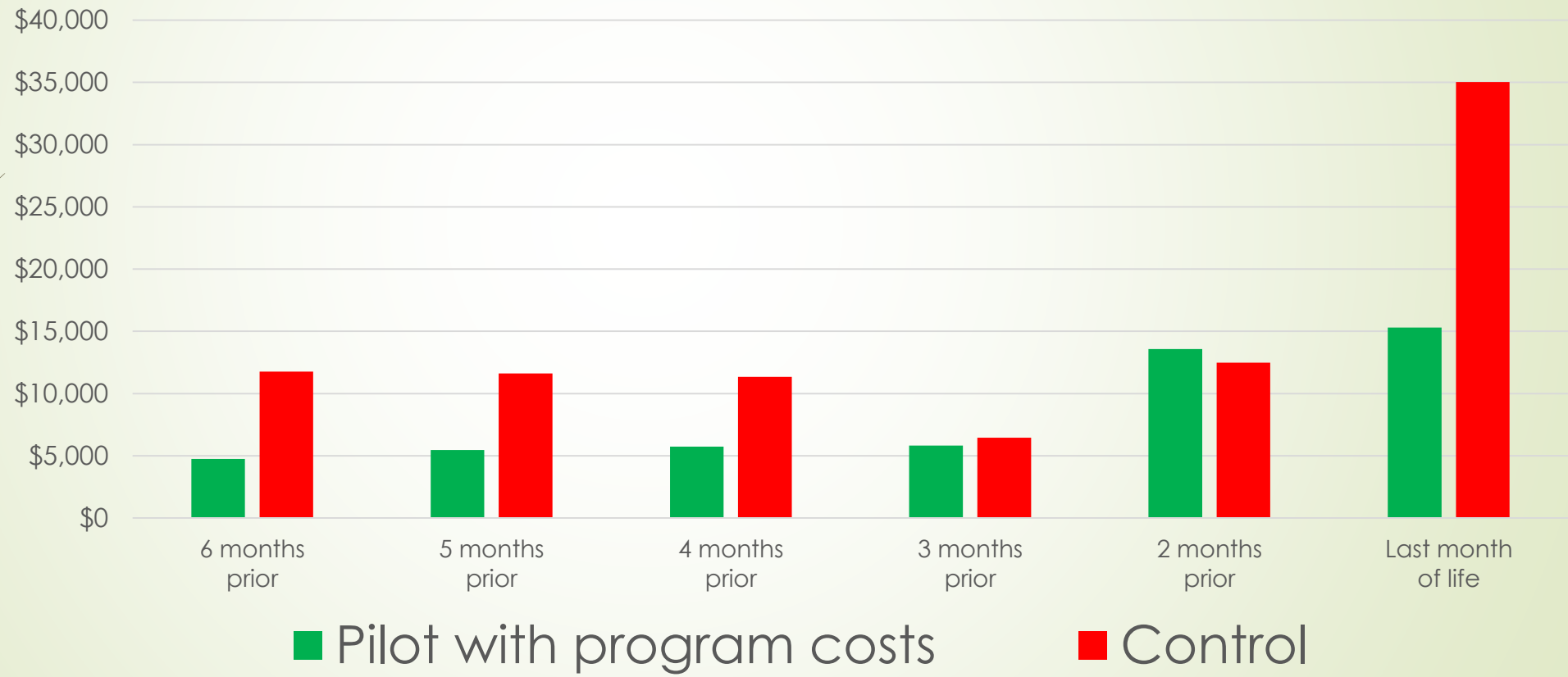
- Hospitalization is common at the end of life

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Pre and Post Enrollment Costs



# Hospital Costs in Last 6 Months of Life



# Triple Aim

Better Outcomes

Higher Satisfaction

Lower Costs

Palliative care achieves the triple aim:

- providing comprehensive end of life care with
- high patient satisfaction
- without an increase in health care costs

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# HHP and Palliative Care Comparison

## IOPCM

- Two or more chronic conditions
- Inpatient stay or ED visits
- Chronic condition risk score
- Homelessness
- Intermittent contact

## Palliative Care

- Four covered diagnoses
- Inpatient stay or ED visits
- 12 month life expectancy
- Willing to have home care
- Needs 24/7 support

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Consider Home Based Palliative Care

- Cancer, Advanced Liver Disease, CHF, COPD
- Using the ED or hospital for symptom management
- Declining functional status
- Death within 12 months would not be unexpected
- Willing to be managed at home for their symptom control
- Need 24/7 support for end of life care

PARTNERSHIP HEALTHPLAN of CALIFORNIA

# USING TECHNOLOGY FOR CARE PLANNING/COMPLEX CARE MANAGEMENT

Marin City Health and Wellness Center

November 2017

# WHY CCMR?


ParkRx

# HEALTH EDUCATION

- MCHWC utilizes eCWs CCMR (PHM) for health education and the Park Prescription program
- Health educator develops problem-based care plans for each patient in their initial meeting
- Updates are done as needed, at least every 6 months
- Most common conditions: diabetes, hypertension, obesity, depression
  - HE works with closely with providers by assigning care plans to providers to look over
  - HE develops tangible Action Plans that patients can walk away with which include information on how to contact their providers, their circle of care, etc.

# PARK PRESCRIPTION PROGRAM

- The Health Educator uses the care management program extensively to document biometric data as well as qualitative data for the Park RX program.
  - All participants are enrolled in the Park RX program and assigned problems based on their conditions
  - Biometric data is tracked and vitals show up in the visit progress note alongside the care plans
  - Action plans are completed with patient and printed at the end of each session

# PATIENT CENTERED MEDICAL HOME

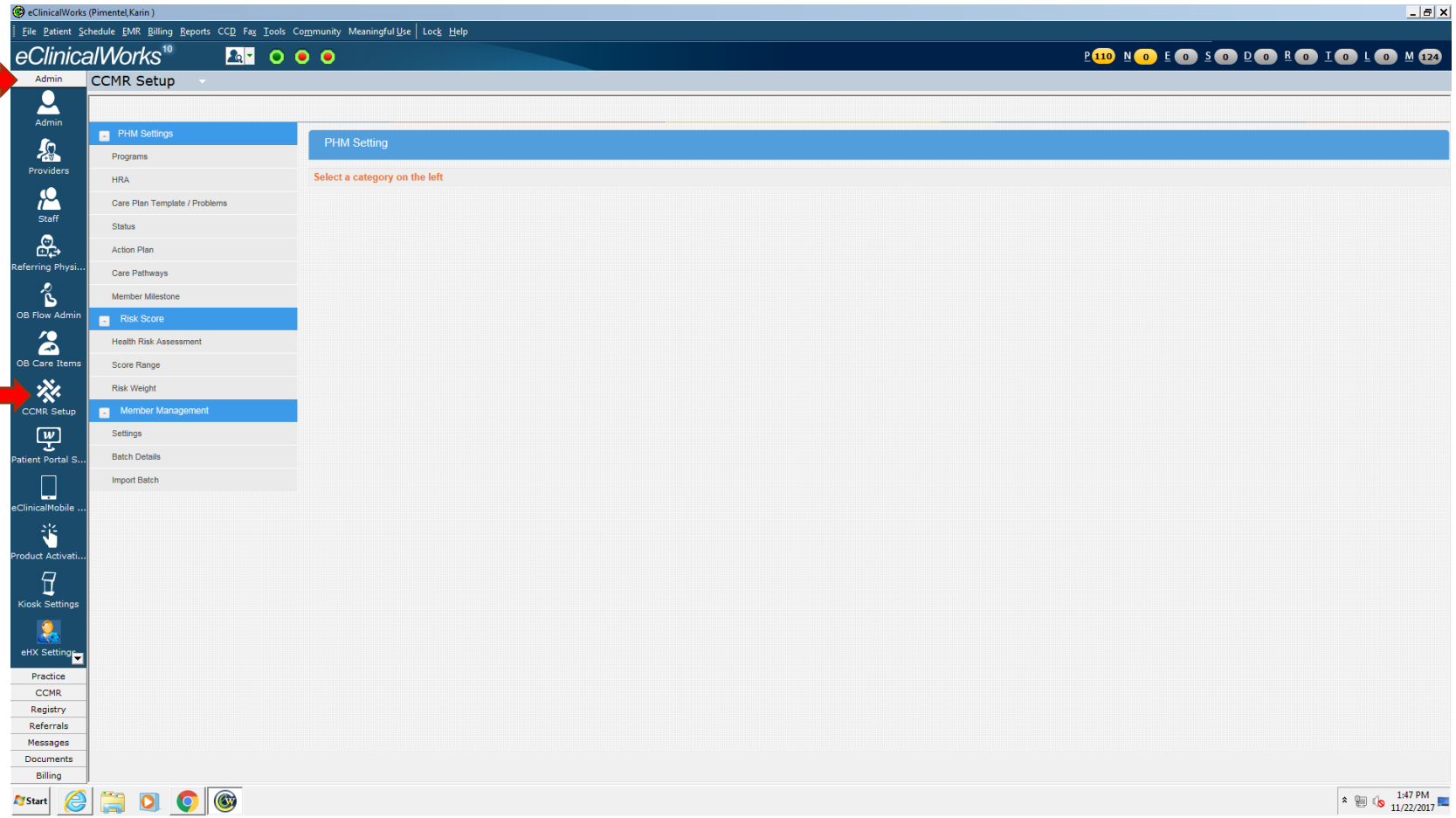
- MCHWC achieved PCMH recognition in 2017 and used CCMR to conduct and document care planning
  - A component of achieving this status was our work in care planning, specifically our depression and diabetes care plans
  - Depression care plans are conducted by behavioral health providers
  - Diabetes care plans are conducted by the Health Educator
  - These patients are tracked and followed up with at regular intervals

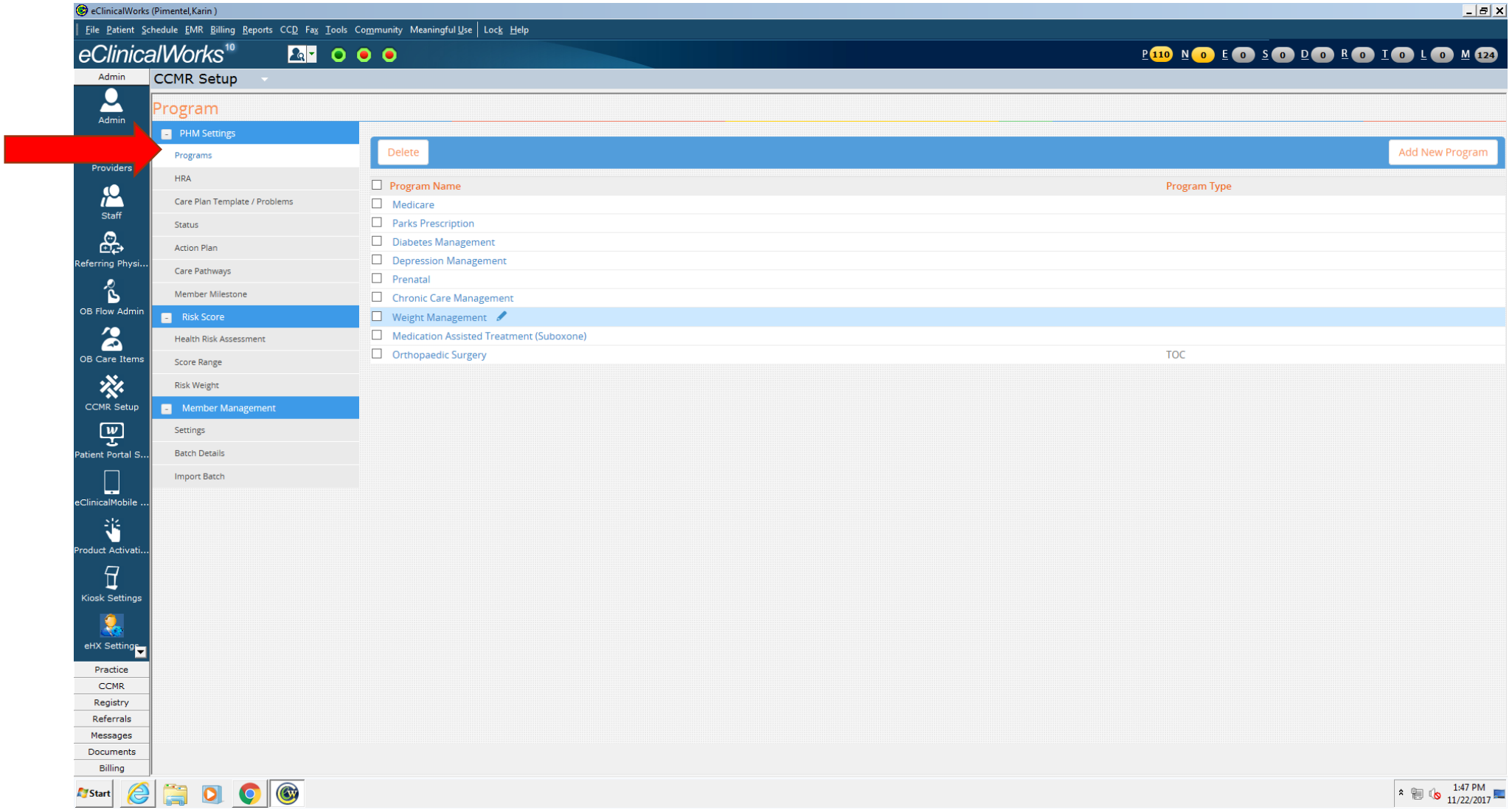
# LIVING HEALTHY PROGRAM

- Marin City Health and Wellness Center's Health Homes Program
- All participants in LHP work with an LCSW and Care Manager to develop a care plan and regular action plans
- Care Planning module allows for vitals and PHQ9 to be attached to care planning progress notes

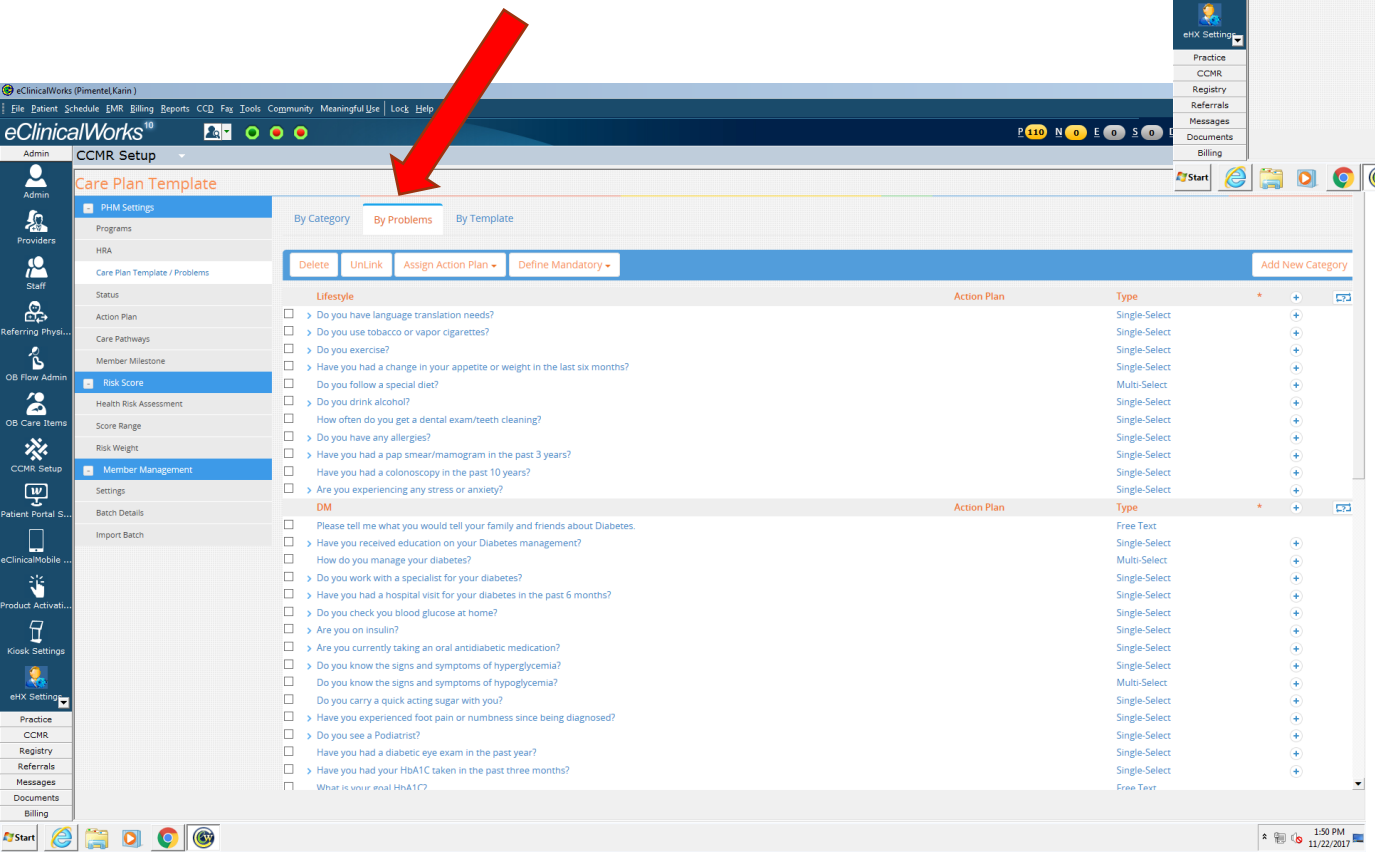
# IMPLEMENTATION

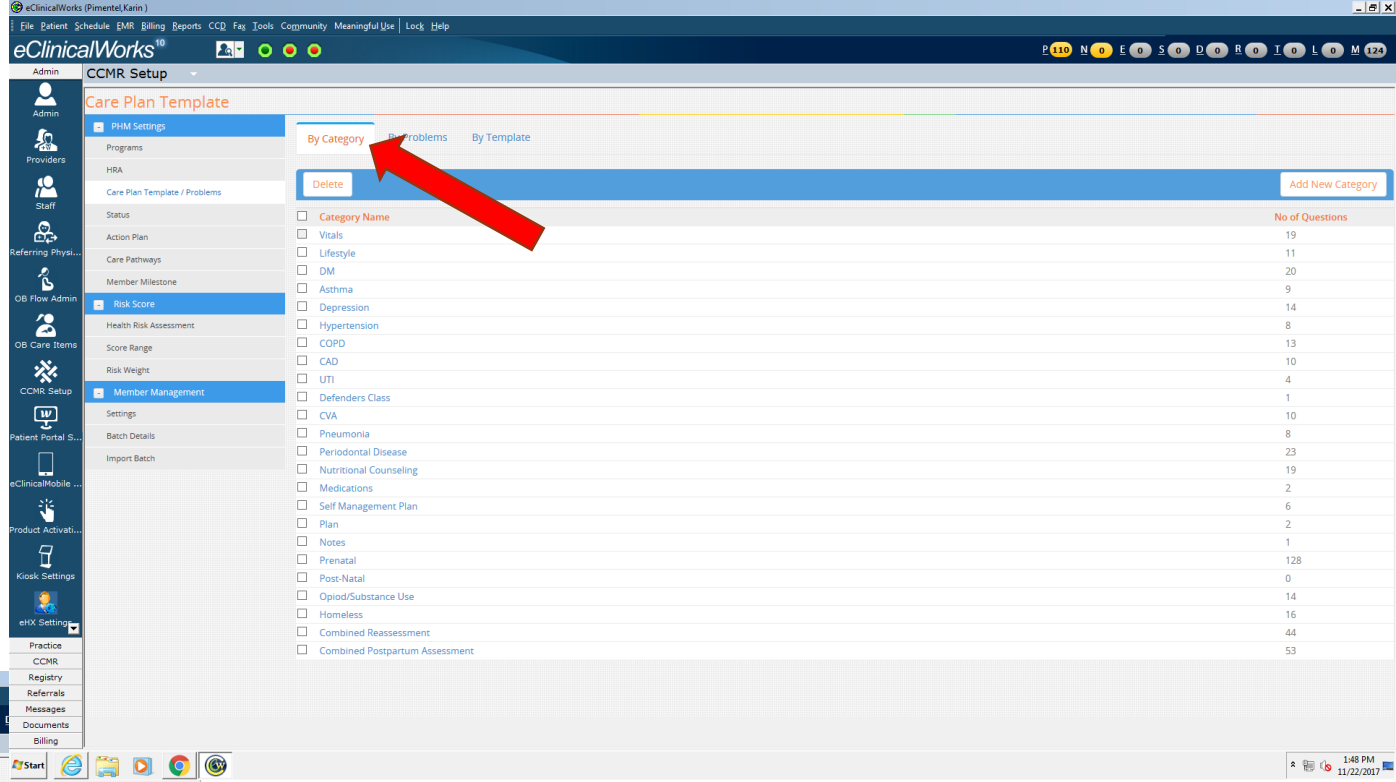
- Activation – eCW
- Training – eCW
- Choosing "problems" and "programs" – MCHWC
- Creating care plans - MCHWC



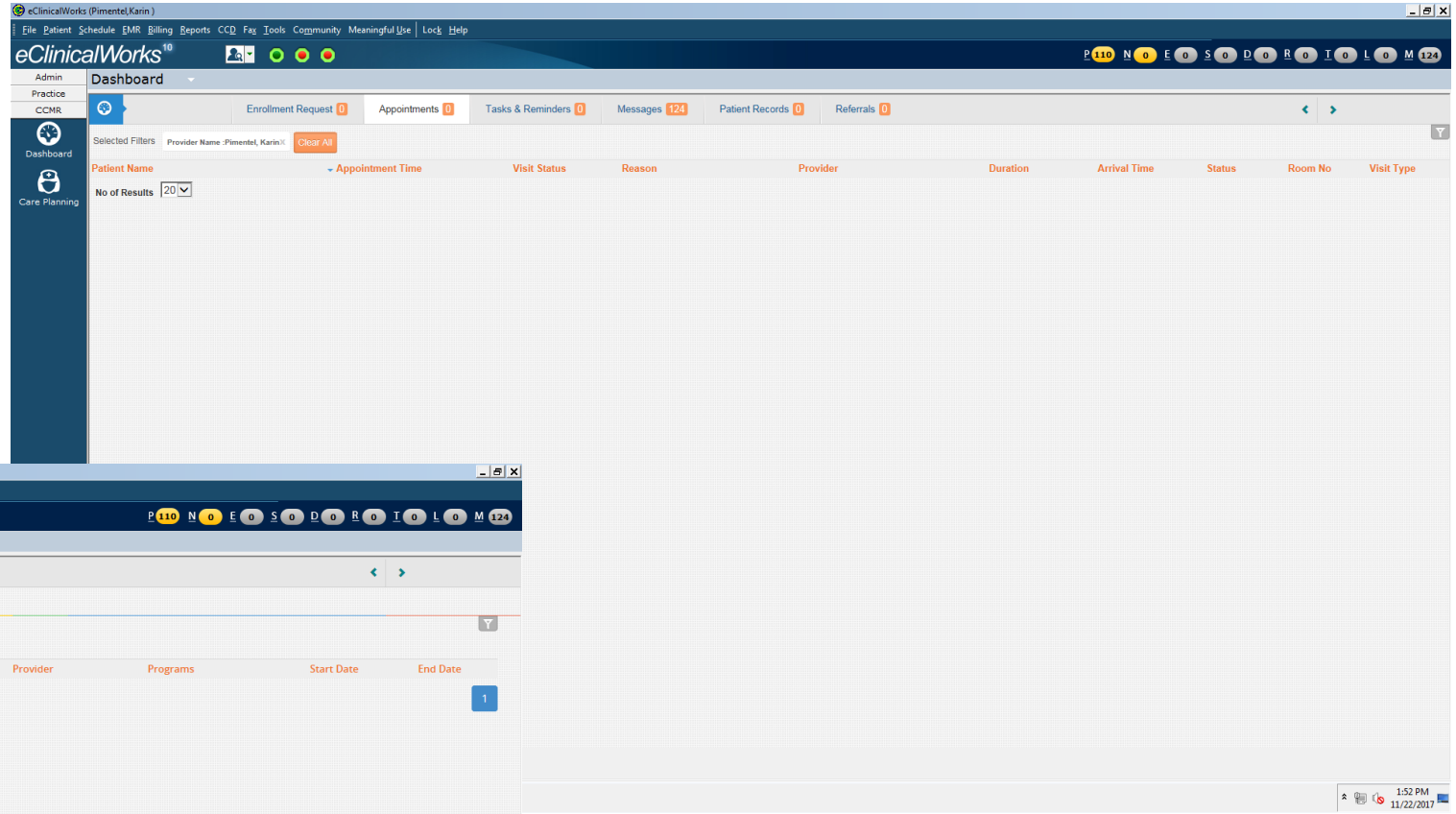

eClinicalWorks (Pimentel,Karin )
File Patient Schedule EMR Billing Reports CCD Fax Tools Community Meaningful Use Lock Help
eClinicalWorks 10
P 110 N 0 E 0 S 0 D 0 R 0 T 0 L 0 M 124
Admin
CCMR Setup
Admin
Providers
Staff
Referring Physi...
OB Flow Admin
OB Care Items
CCMR Setup
Patient Portal S...
eClinicalMobile ...
Product Activati...
Kiosk Settings
eHX Settings
Practice
CCMR
Registry
Referrals
Messages
Documents
Billing
Program
PHM Settings
Programs
HRA
Care Plan Template / Problems
Status
Action Plan
Care Pathways
Member Milestone
Risk Score
Health Risk Assessment
Score Range
Risk Weight
Member Management
Settings
Batch Details
Import Batch
Delete
Add New Program
Program Name
Program Type
Medicare
Parks Prescription
Diabetes Management
Depression Management
Prenatal
Chronic Care Management
Weight Management
Medication Assisted Treatment (Suboxone)
Orthopaedic Surgery
TOC
Start
1:47 PM
11/22/2017

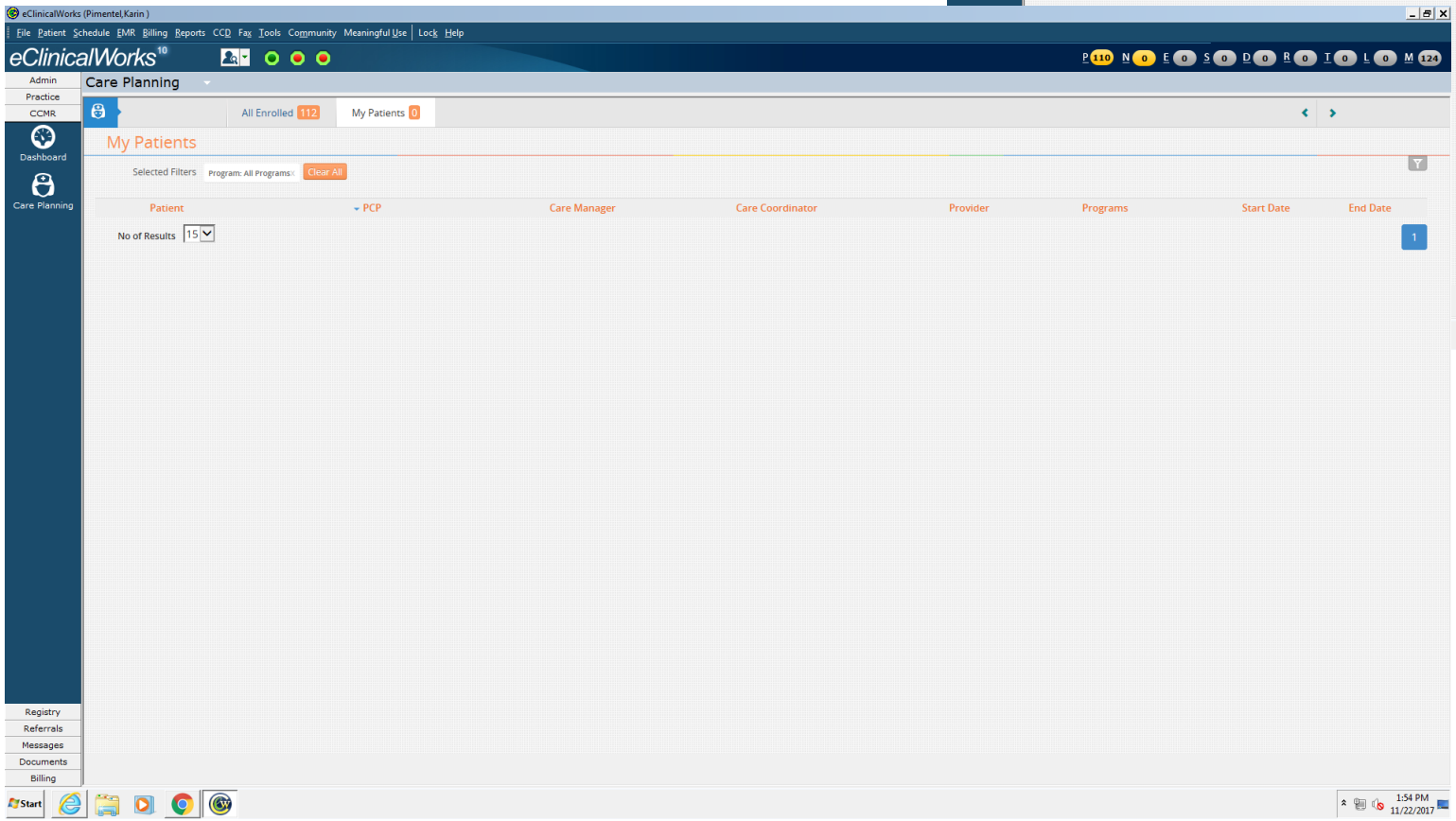
# IMPLEMENTATION



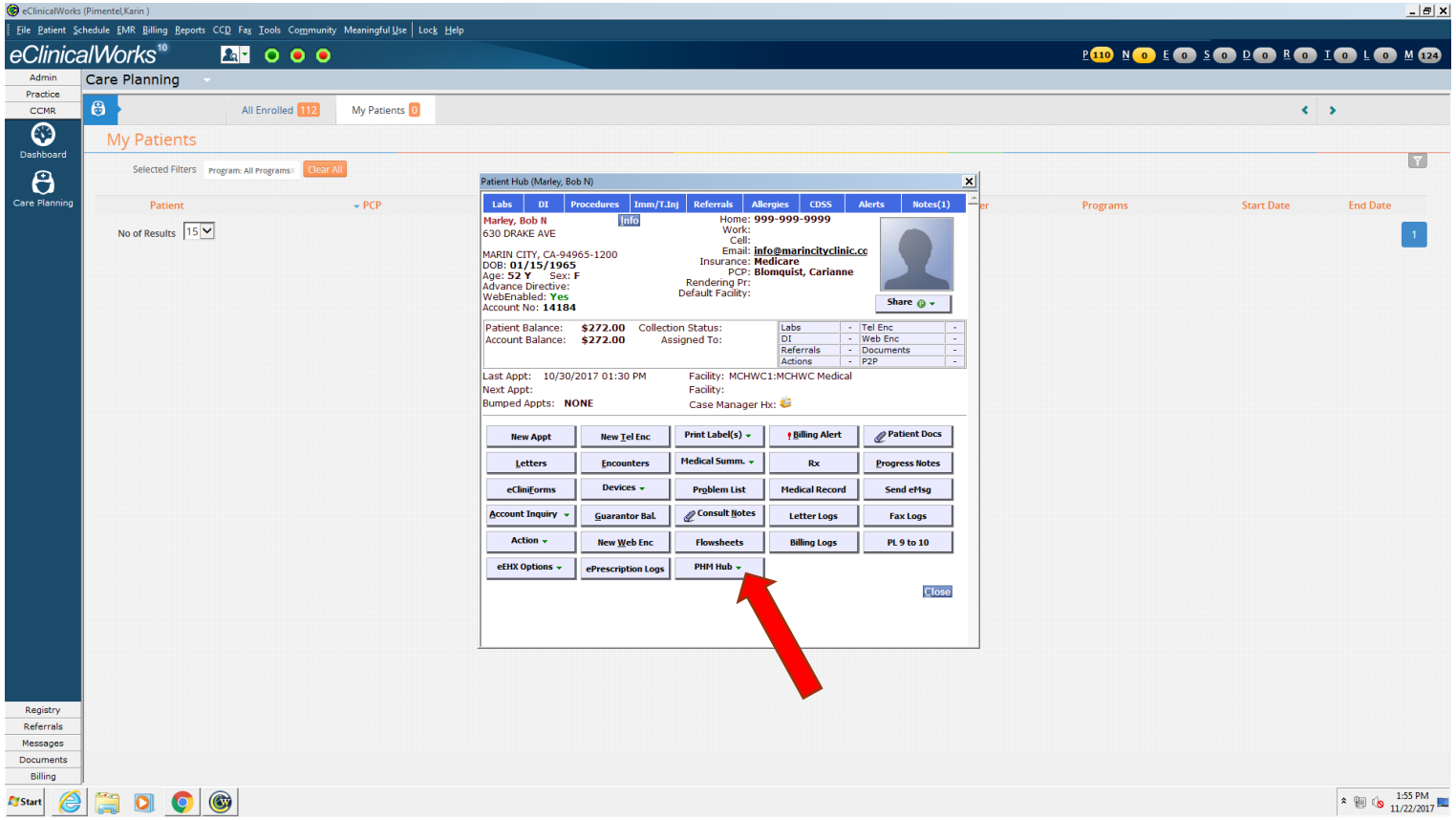
# DASHBOARD/ ENROLLED PATIENTS



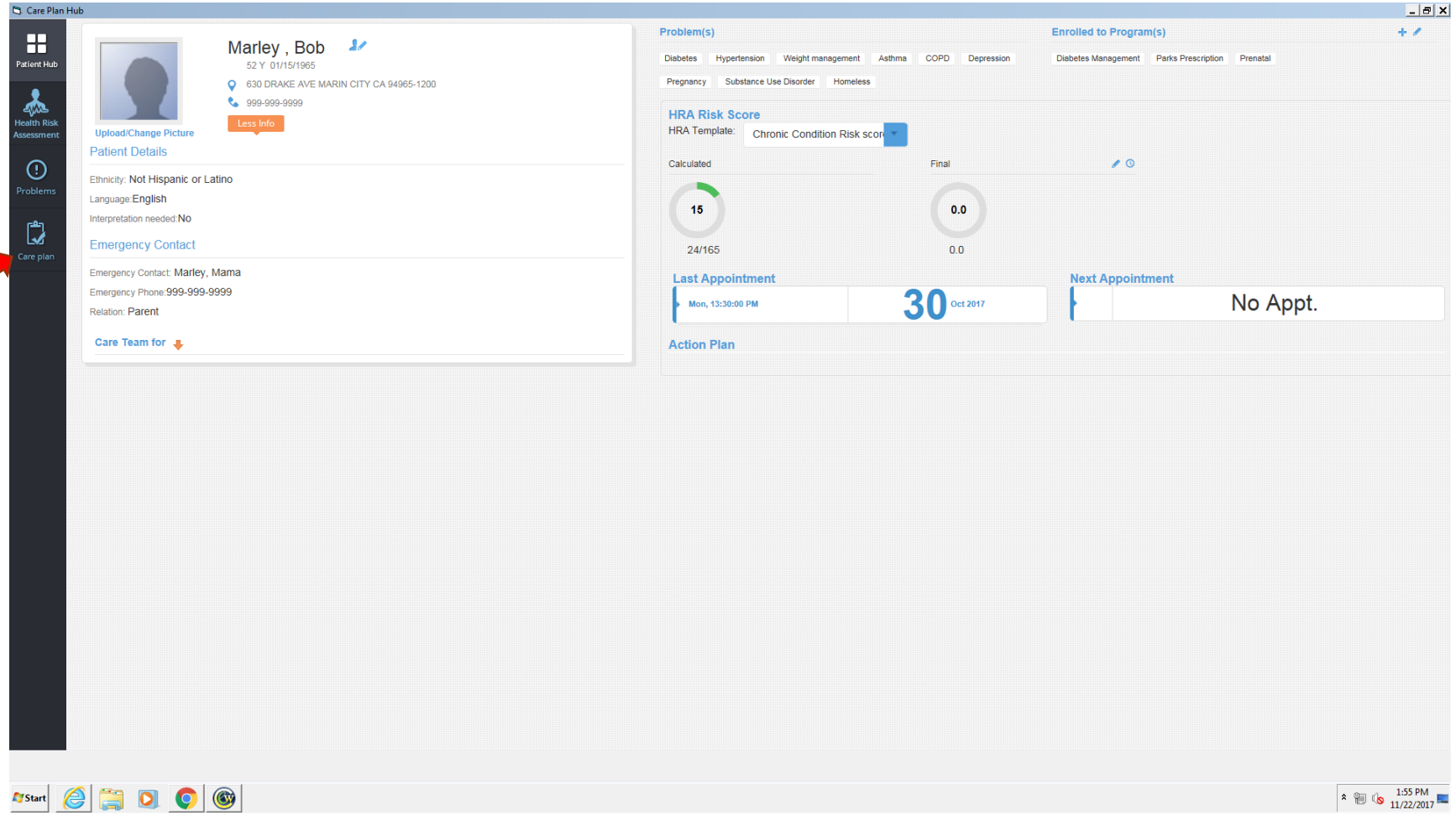



# CCMR/PHM HUB

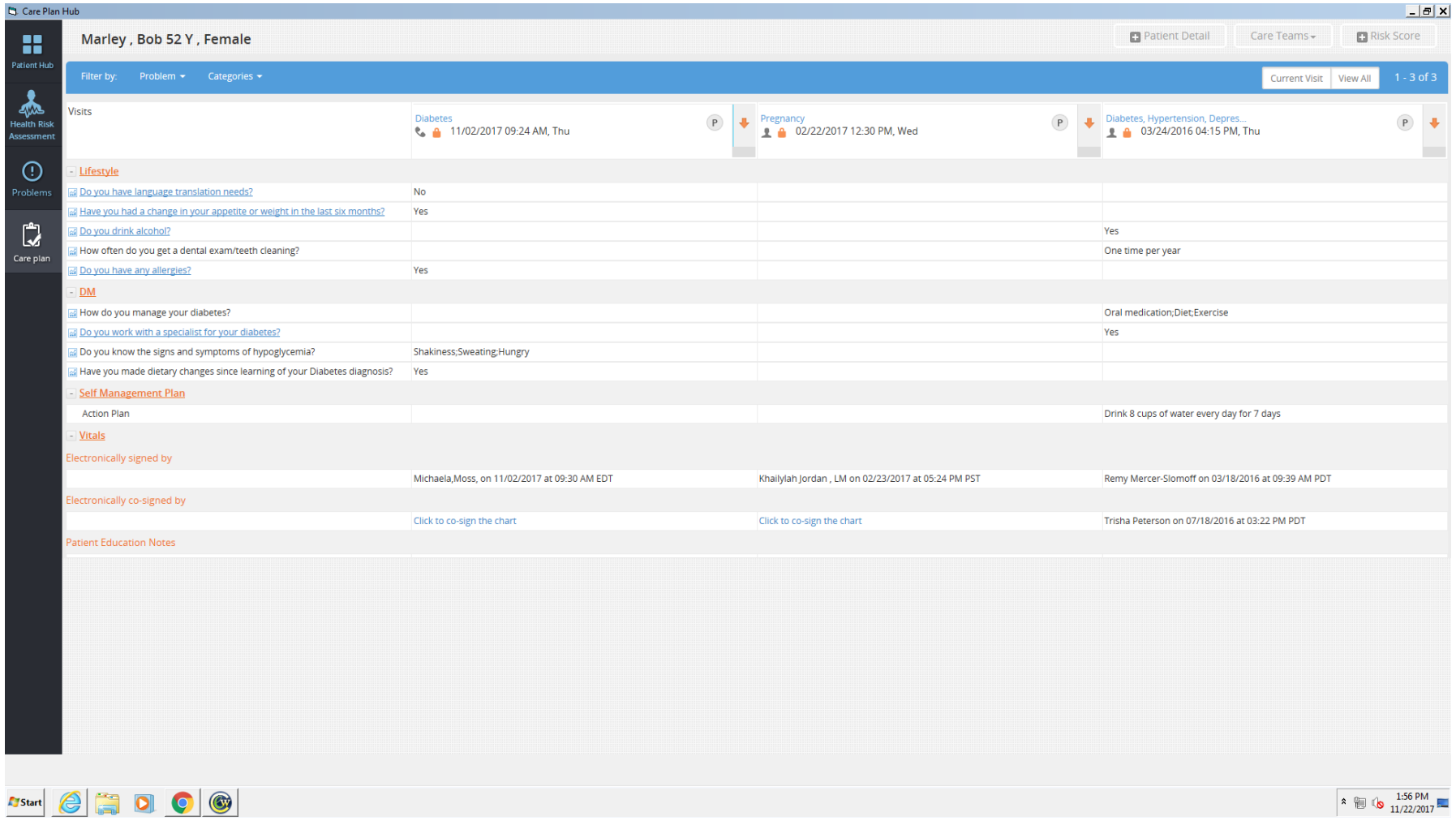
- Go through eCW hub to look at past care plans or virtual visit
- Do not use for new care plan if the patient is on the schedule
- Recommended: patient on schedule, go through progress note



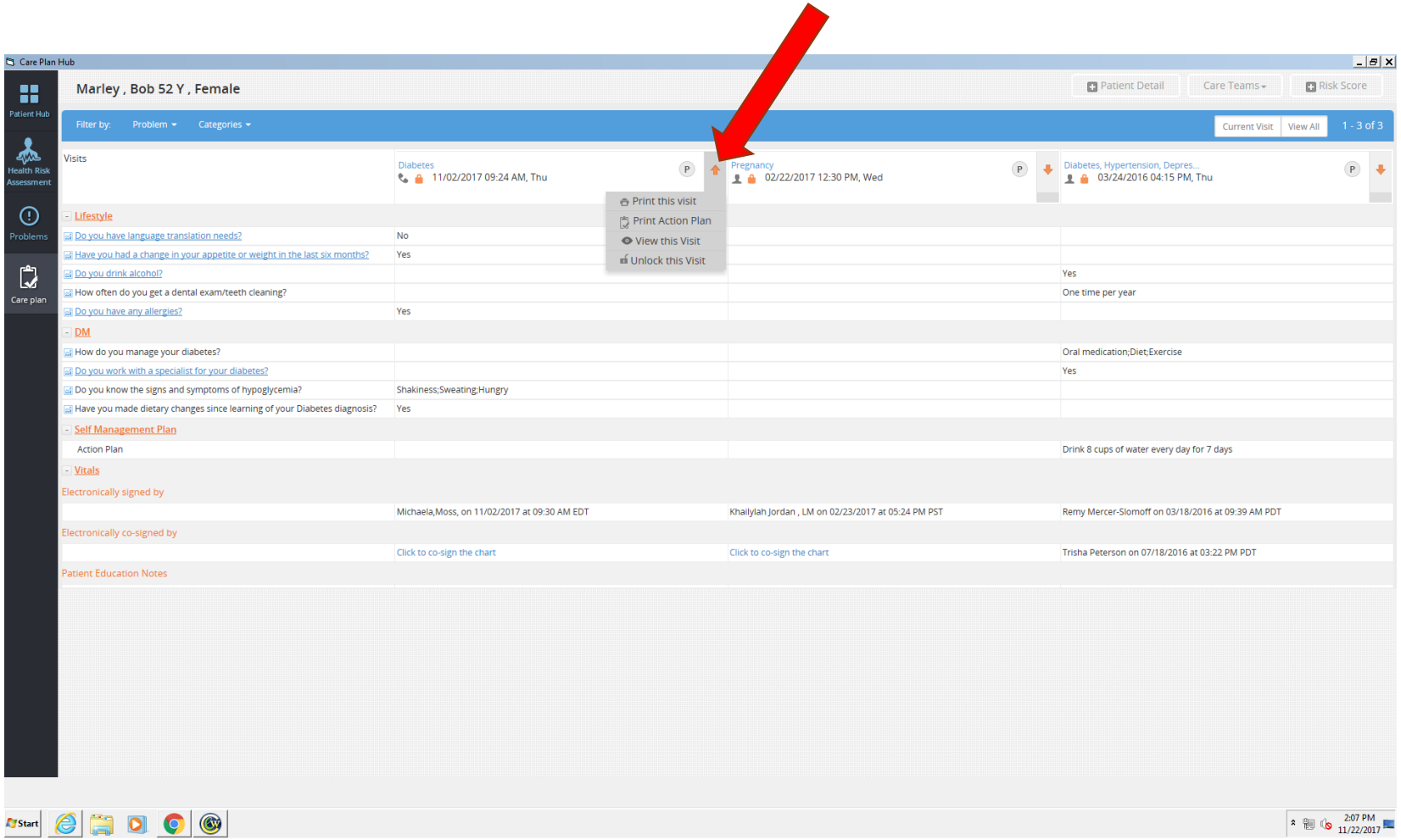
# CCMR/PHM HUB


Care Plan Hub
Patient Hub
Health Risk Assessment
Problems
Care plan
Marley , Bob
52 Y 01/15/1965
630 DRAKE AVE MARIN CITY CA 94965-1200
999-999-9999
Less Info
Upload/Change Picture
Patient Details
Ethnicity: Not Hispanic or Latino
Language:English
Interpretation needed:No
Emergency Contact
Emergency Contact: Marley, Mama
Emergency Phone:999-999-9999
Relation: Parent
Care Team for
Problem(s)
Diabetes
Hypertension
Weight management
Asthma
COPD
Depression
Pregnancy
Substance Use Disorder
Homeless
Enrolled to Program(s)
Diabetes Management
Parks Prescription
Prenatal
HRA Risk Score
HRA Template:
Chronic Condition Risk scor
Calculated
15
24/165
Final
0.0
0.0
Last Appointment
Mon, 13:30:00 PM
30
Oct 2017
Next Appointment
No Appt.
Action Plan
Start
1:55 PM
11/22/2017

# CARE PLANS


Care Plan Hub
Patient Hub
Health Risk Assessment
Problems
Care plan
Marley , Bob 52 Y , Female
Patient Detail
Care Teams
Risk Score
Filter by:
Problem
Categories
Current Visit
View All
1 - 3 of 3
Visits
Diabetes
11/02/2017 09:24 AM, Thu
Pregnancy
02/22/2017 12:30 PM, Wed
Diabetes, Hypertension, Depres...
03/24/2016 04:15 PM, Thu
Lifestyle
Do you have language translation needs?
No
Have you had a change in your appetite or weight in the last six months?
Yes
Do you drink alcohol?
Yes
How often do you get a dental exam/teeth cleaning?
One time per year
Do you have any allergies?
Yes
DM
How do you manage your diabetes?
Oral medication;Diet;Exercise
Do you work with a specialist for your diabetes?
Yes
Do you know the signs and symptoms of hypoglycemia?
Shakiness;Sweating;Hungry
Have you made dietary changes since learning of your Diabetes diagnosis?
Yes
Self Management Plan
Action Plan
Drink 8 cups of water every day for 7 days
Vitals
Electronically signed by
Michaela,Moss, on 11/02/2017 at 09:30 AM EDT
Khailylah Jordan , LM on 02/23/2017 at 05:24 PM PST
Remy Mercer-Slomoff on 03/18/2016 at 09:39 AM PDT
Electronically co-signed by
Click to co-sign the chart
Click to co-sign the chart
Trisha Peterson on 07/18/2016 at 03:22 PM PDT
Patient Education Notes
Start
1:56 PM
11/22/2017

# PRINT ACTION PLANS



# SUCCESSES/CHALLENGES

- Goals and action plans keep providers as well as patients on track
- Tangible plan for patients to walk away with
- Assign to shared providers – circle of care
- Track quantitative and qualitative metrics at once
- Challenges
  - CP loading time on the front end
  - Training all providers to access and utilize CP
  - Tracking and running reports

REDWOOD COMMUNITY HEALTH COALITION

# *Care Planning. . . What Next?*

## RCHC Symposium on the Future of Complex Care

November 28, 2017

# Comprehensive Care Plan

- **Data elements**
- **Programs:**
  - IOPCM
  - 2703: Health Homes
  - Whole Person Care
- **Next Steps**
  - Clinical Advisory Group to refine and pilot test

**Care Plan: Meets criteria for PHP IOPCM program and Health Homes Program**

The care plan may be implemented as a documentation template in any health record or it may be implemented in case management software or add-on such as CCMR.

| Item | Type | Options | Structure Flag |
|---|---|---|---|
| Reason for enrollment or general notes | Free Text | | |
| Patient's reported history | Free Text | | |
| Specialists | Free Text | | |
| Chronic conditions | Multiselect | Diabetes | X |
| Chronic conditions | Multiselect | Congestive Heart Failure | X |
| Chronic conditions | Multiselect | COPD | X |
| Chronic conditions | Multiselect | Asthma | X |
| Chronic conditions | Multiselect | Traumatic Brain Injury | X |
| Chronic conditions | Multiselect | Chronic Liver Disease | X |
| Chronic conditions | Multiselect | Dementia | X |
| Chronic conditions | Multiselect | Substance Use Disorder | X |
| Chronic conditions | Multiselect | Hypertension | X |
| Chronic conditions | Multiselect | Major Depression | X |
| Chronic conditions | Multiselect | Bipolar Disorder | X |
| Chronic conditions | Multiselect | Psychotic Disorder | X |
| Chronic conditions | Multiselect | Obesity | X |
| Hospitalizations in the last 6 months | Number | | X |
| ED Visits in the last 6 months | Number | | X |
| Advanced Care Plan | Multiselect | Code Status Assigned | X |
| Advanced Care Plan | Multiselect | Paperwork completed with pt - | X |
| Advanced Care Plan | Multiselect | POLST Completed | X |
| Advanced Care Plan | Multiselect | Full advance directive on chart | X |
| HRA Done | Date | | X |
| SHA | Date | | X |
| Audit-C | Date | | X |
| Health Concerns | Multiselect | Physical Health | X |
| Health Concerns | Multiselect | Mental and Behavioral Health | X |
| Health Concerns | Multiselect | Substance Use Disorder | X |
| Health Concerns | Multiselect | Community Based Support Ser | X |
| Health Concerns | Multiselect | Palliative Care, Adv. Care Plann | X |
| Health Concerns | Multiselect | History of Trauma | X |
| Health Concerns | Multiselect | Housing Security | X |
| Health Concerns | Multiselect | Social Support Needs | X |
| Health Concerns | Multiselect | Medication Compliance | X |
| Health Concerns | Multiselect | Transportation Barriers | X |
| PHQ2 | Number | | X |
| PHQ9 | Number | | X |
| Today's BP | Free Text | | |
| Homeless | Select | Yes | X |
| Homeless | Select | No | X |

# Health Action Plan

**Health Action Plan: Meets criteria for PHP IOPCM program and Health Homes Program**

The health action plan may be implemented as a documentation template in any health record or it may be implemented in case management software or add-on such as CCMR.

| Item | Type | Options | Assoc Action (CCMR only) | Structure Flag |
|---|---|---|---|---|
| Medication list reviewed with case manager today | Select | Yes | | X |
| Medication list reviewed with case manager today | Select | No | | X |
| Current Problems | Free Text | | | |
| Personal Health Goals | Free Text | | Targets | |
| Activities to keep me well (diet) | Free Text | | Nutrition/diet | |
| Activities to keep me well (physical activity) | Free Text | | Physical activity | |
| Other prevention and wellness activities | Free Text | | Prevention | |
| Red flags - when to call my case manager | Free Text | | Red flags | |
| Next appointment with case manager | Date | | Upcoming Appointment | X |
| Next appointment with PCP | Date | | Upcoming Appointment | X |
| Take medications as directed. Bring all of your medications to your next appoin | Select | Yes | Recommendations | X |
| Take medications as directed. Bring all of your medications to your next appoin | Select | No | Recommendations | X |
| IOPCM Tier (or Case Management Tier) | Number | | | X |

# Health Risk Assessment

**Health Risk Assessment: Meets criteria for PHP IOPCM program and Health Homes Program**

The health risk assessment may be implemented as a documentation template in any health record or it may be implemented in case management software or add-on such as CCMR.

| Item | Type | Options | Structure Flag |
|---|---|---|---|
| In general how would you describe your health over the last 6 months? | Single Select | Excellent | X |
| In general how would you describe your health over the last 6 months? | Single Select | Very good | X |
| In general how would you describe your health over the last 6 months? | Single Select | Fair | X |
| In general how would you describe your health over the last 6 months? | Single Select | Poor | X |
| Do you have a PCP at ___ Health Center | Single Select | Yes | X |
| Do you have a PCP at ___ Health Center | Single Select | No | X |
| Do you have a Specialist (a doctor that specializes in certain health conditions, li | Single Select | Yes | X |
| Do you have a Specialist (a doctor that specializes in certain health conditions, li | Single Select | No | X |
| In the last 12 months, did you have trouble paying for your utility bill? | Single Select | Yes | X |
| In the last 12 months, did you have trouble paying for your utility bill? | Single Select | No | X |
| In the last 12 months, have you been unable to buy food for yourself? | Single Select | Yes | X |
| In the last 12 months, have you been unable to buy food for yourself? | Single Select | No | X |
| Can you get a ride to the doctor's office or clinic if needed? | Single Select | Yes | X |
| Can you get a ride to the doctor's office or clinic if needed? | Single Select | No | X |
| Can you get a ride to the doctor's office or clinic if needed? | Single Select | Unsure | X |
| Which of the following statements best describes your current living situation? | Single Select | I live alone | X |
| Which of the following statements best describes your current living situation? | Single Select | I live with my spouse c | X |
| Which of the following statements best describes your current living situation? | Single Select | I live with family or fri | X |
| Which of the following statements best describes your current living situation? | Single Select | Other - describe: | X |
| Do you have concerns about your current living situation, like housing condition | Single Select | Yes | X |
| Do you have concerns about your current living situation, like housing condition | Single Select | No | X |
| Have you ever talked with your doctor about your wishes for care as you get ne | Single Select | Yes | X |
| Have you ever talked with your doctor about your wishes for care as you get ne | Single Select | No | X |
| Have you ever filled out a form called an Advance Directive? It puts your end of | Single Select | Yes | X |
| Have you ever filled out a form called an Advance Directive? It puts your end of | Single Select | No | X |
| Have you been involved in or exposed to: | Multi Select | A natural disaster such | X |
| Have you been involved in or exposed to: | Multi Select | Combat or warzone | X |
| Have you been involved in or exposed to: | Multi Select | Physical or emotional | X |
| Have you been involved in or exposed to: | Multi Select | Sexual abuse or assau | X |
| Have you been involved in or exposed to: | Multi Select | Sudden violent death | X |
| Have you been involved in or exposed to: | Multi Select | Serious harm, injury o | X |
| Have you been involved in or exposed to: | Multi Select | None of the above | X |
| Have you been diagnosed with any of the following conditions? | Multi Select | Heart problems | X |

*Image incomplete

# thank you

Partnership HealthPlan of California

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# Questions?

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