Managing the Care Managers

Future Possibilities for Patient-Centered Care Coordination

Reducing the Cost of Health Care:
Current Innovations and Future Possibilities

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September 20, 2017
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Care Management in the Post-ACA Landscape

- Payers and providers continue to invest in care management and care coordination to improve patient outcomes at reduced cost
  - The coordination movement has been **catalyzed by new value-based financial incentives, increased focus patient-centered care, and ongoing health system concentration**
  - Existing models employ a **wide range of styles and expertise** in care managers/coordinators, from nurses, social workers, and community health workers
  - Efforts are underway to better assess who needs care management and what kind of care management is appropriate

"Everybody's trying to help, but is everyone doing it in the most efficient and effective way for the consumer and the family? Or are we just confusing the issue?"

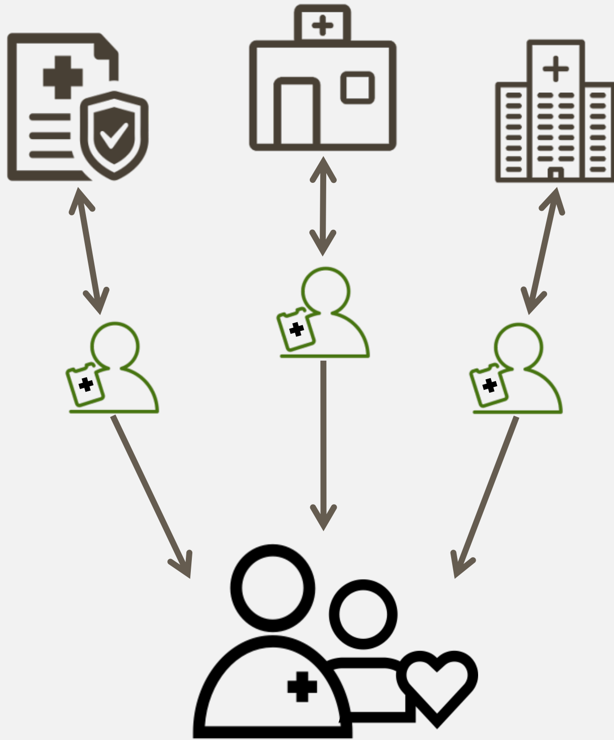
-Cheri Lattimer, Former Executive Director of Case Management Society of America

- The Case Management Society of America has grown to more than 37,000 certified members, an **85% increase** between 2010-2015
- Cost-saving results vary, and more research is needed to identify the long-term impact of comprehensive care management, but **reducing waste and duplication-- and counterproductive efforts-- in the care coordination system will improve documented cost-savings**

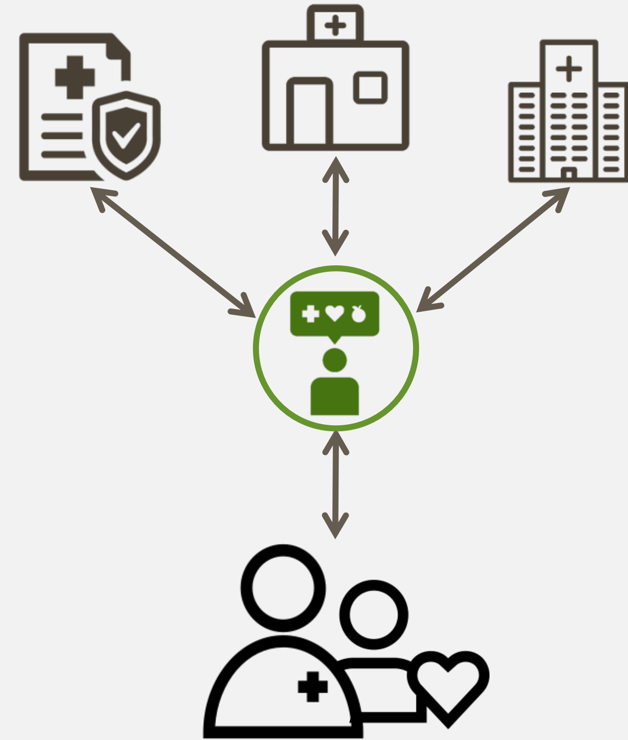
Sources: https://www.nytimes.com/2015/04/14/health/the-tangle-of-coordinated-health-care.html?_r=0; https://www.ahrq.gov/sites/default/files/publications/files/caremgmt-brief.pdf; http://www.modernhealthcare.com/article/20150328/MAGAZINE/303289980

Care Management in the Post-ACA Landscape

Current State



Ideal State



"Despite the rapid and widespread adoption of CM, questions remain about the best way to optimize and pay for the mix of staff and services involved in its delivery."

-Agency of Healthcare Research and Quality

Sources: https://www.ahrq.gov/sites/default/files/publications/files/caremgmt-brief.pdf

Case Study: Rocky Mountain Health Plans (RMHP)

A Colorado insurance provider offering innovative care coordination/management tools that serve as a payer-led model for active payer-provider-community collaboration

- Offers commercial (including the Marketplace), Medicaid and Medicare plans
- Leads Medicaid Accountable Care Collaborative (ACC) and Regional Care Collaborative Organization (RCCO) for the Western Slope region of Colorado
  - The collaborative serves 22 countries through **community-embedded interdisciplinary care teams**, including nurses, social workers, and community health workers
  - Care teams are funded by RMHP through **community delegation agreements** using pooled state and private grant funding
  - Provider leadership teams hire and **share care managers through co-management agreements**
- Utilizes a **Medical Neighborhood** model to foster connections and coordinate care across all levels of the health system, include specialists, hospitals, other providers and health plans
- RMHP also offers financial incentives for providers to developed care coordination for high-need individuals and engage with other providers across the medical neighborhood

Note: Rocky Mountain Health Plans was acquired by UnitedHealthcare in March 2017

Sources: https://www.rmhpcommunity.org/providers/faq; https://pcmh.ahrq.gov/page/coordinating-care-medical-neighborhood-critical-components-and-available-mechanisms; https://www.rmhpcommunity.org/sites/default/files/resource/Agreement%20Principles.pdf; http://www.commonwealthfund.org/~/media/files/publications/casestudy/2013/mar/1666_rodin_medicaid_colorado_case_study_final_v2.pdf

Case Study: Johns Hopkins Guided Care

Originally developed in 2001, the Guided Care model uses specially-trained nurses to coordinate care across in-home, primary care, and hospital services to avoid duplication and improve health outcomes

- Designed **as long-term assistance for patients with multiple chronic conditions**, but the model is customizable to each health systems' population needs
- Guided Care Nurses provide **patient-centered need assessment, motivational interviewing, patient and caregiver-friendly plan development, liaise between health care professionals, and refer patients to social services**
  - Recommended caseload of 50-60 patients/nurse
- Offers coordination services via **in-home coaching and telephonic follow-up**
- Nurses participate in a six-week **online certification program** and health systems pay a licensing fee to Johns Hopkins for technical support
  - The program can be fully implemented in six-to-nine months

Outcomes

Eight large health systems and plans are utilizing the model nationwide, including Harvard Vanguard Medical Associates, and Kaiser Health Plan of the Mid-Atlantic

A 32-month randomized trial found:

- 29% reduction in the need for home health care services
- 49% reduction in hospital readmissions when part of an integrated delivery team, compared to 13% reduction in a non-integrated delivery system
- Improved patient perception of care quality from the Guided Care nurse and their caregivers

Sources: http://www.guidedcare.org/program-history-results.asp; https://www.ncbi.nlm.nih.gov/pubmed/21403043; https://www.jhsph.edu/research/centers-and-institutes/roger-c-lipitz-center-for-integrated-health-care/Guided_Care/index.html; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3631081/

Key Questions for Discussion

- How do we ensure care management/coordination is accountable to patient needs vs. institutional needs?
- Should we accommodate multiple care managers through an intermediary, or work for structural change?
- Can we align financial incentives and accountability for truly integrated patient-centered care management/coordination?

Thank You!

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