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Suffolk Care Collaborative

Population Health, DSRIP and the role of Case Management/Care Coordination

CMSA Long Island

September 9, 2015

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"A Century of Change 1900-2000"

- Over the last 100 years our population has experienced increased longevity along with the accompanying burden of continued prevalence of chronic illness.
- Declines in fertility rates and increases in life expectancy contribute to the aging of our population, in contrast to high fertility and mortality a century ago.
- This change, combined with the number of aging Baby Boomers, will result in an increase in the number of persons over the age of 65 in the next 20 years.
- Life expectancy projected to increase from 76 to 77 for men and 81 to 82 for women by 2020. Effect of aging not only felt by the elderly but also by their families.
- Leading causes of death have transitioned in the 21st century from acute illness or such infection diseases as PNA and tuberculosis to chronic conditions and degenerative disease.
- In the early 21st century the focus on chronic conditions (especially those with MCC's) has become a high priority.

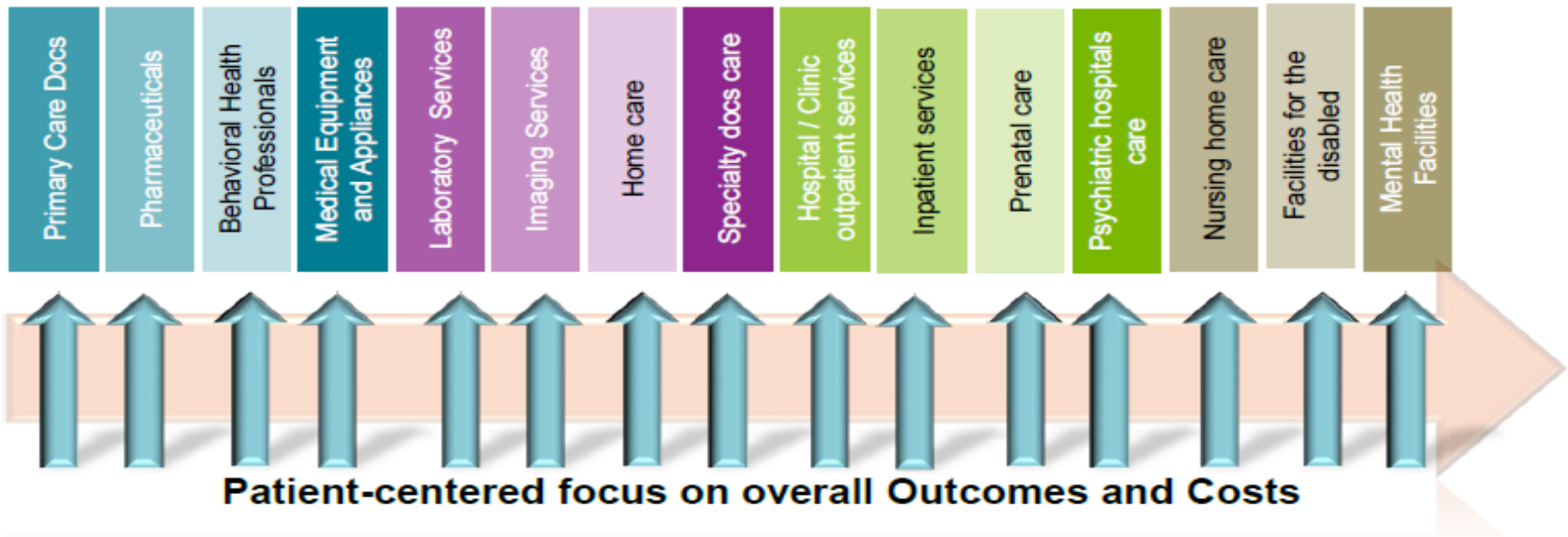
Key Trends and Facts

- In 2005, 133m Americans (45% of the population) were living with at least one chronic condition. By 2020 that number is expected to increase to 157m (48.3% of the population) with 81m having have more than one chronic condition (MCC).
- 80% of people over 65 have at lease one chronic condition and 50% have at lease two.
- More than 75% of healthcare costs are due to chronic conditions.
- 75% of hospital days, office visits and prescription drugs are attributes to those with chronic conditions.
- The health care needs of patients with MCCs are complex, requiring numerous providers and caregivers to be involved in their care often results in care that is fragmented, difficult to coordinate and leads to frequent hospitalizations.

As the the number of people with chronic conditions increases, health care costs, including long team and homecare expenditures, are also expected to increase

Current Fee For Service – deeply embedded, double fragmentation

FFS *and* Silo's

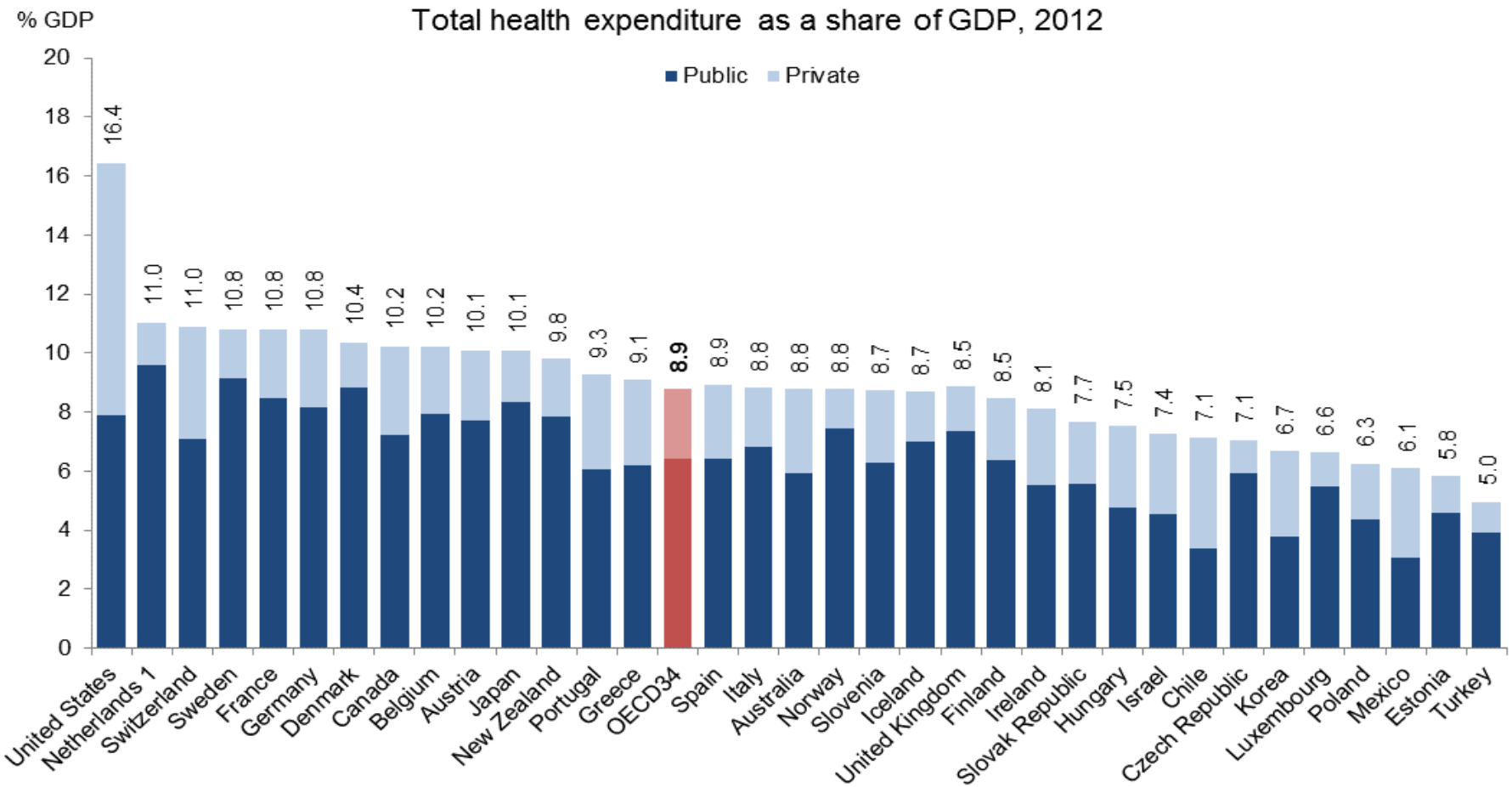


Challenge to change:

Providers, Payers and Governments have embedded this fragmentation in their culture, organization & systems

Currently our System Primarily Operates as Independent Siloes Which Sometimes Interconnect

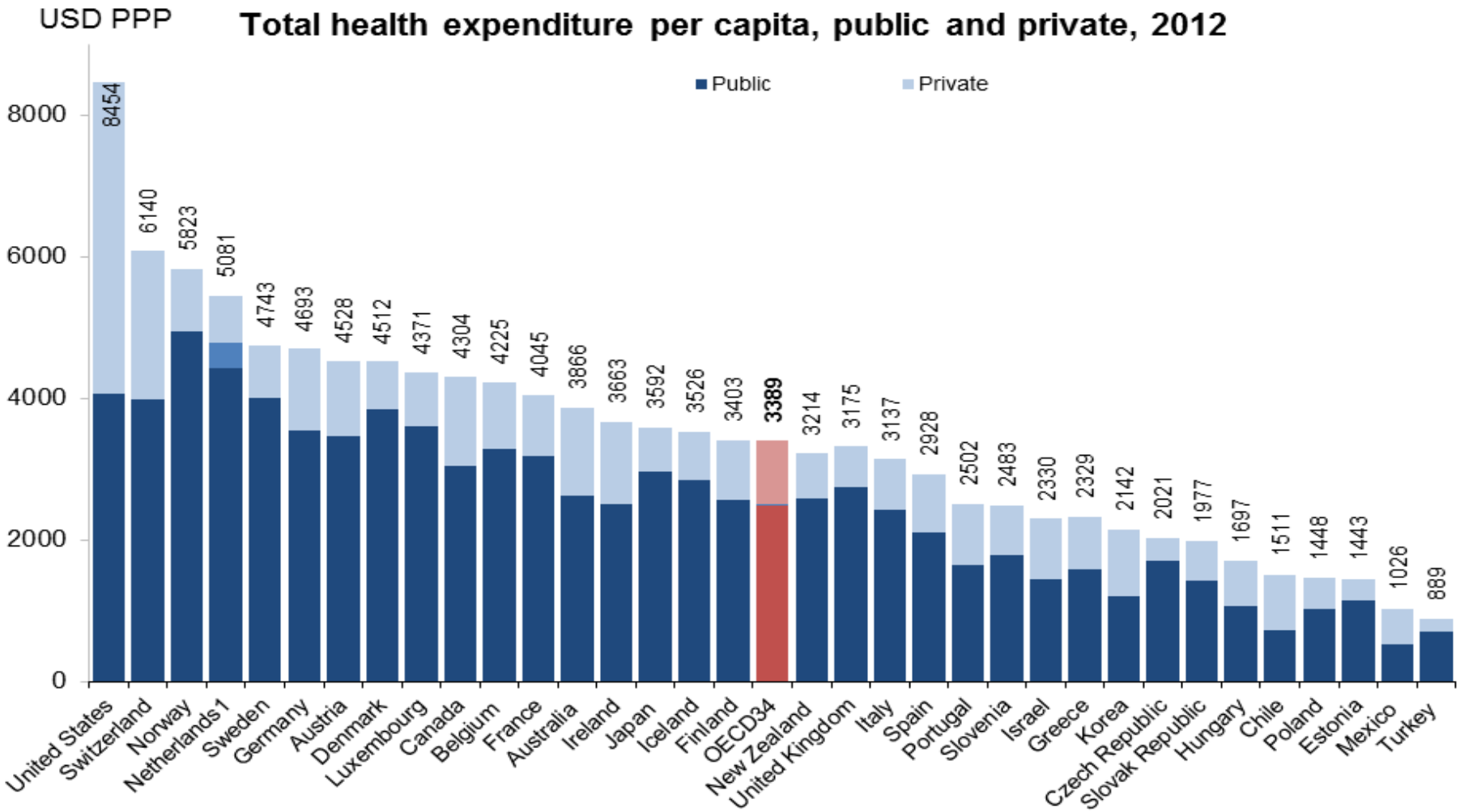
At 16.4% of GDP in 2012, US health spending is one and a half as much as any other country, and nearly twice the OECD average



1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.

Source: OECD Health Data 2015

US spends two-and-a-half times the OECD average



1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.

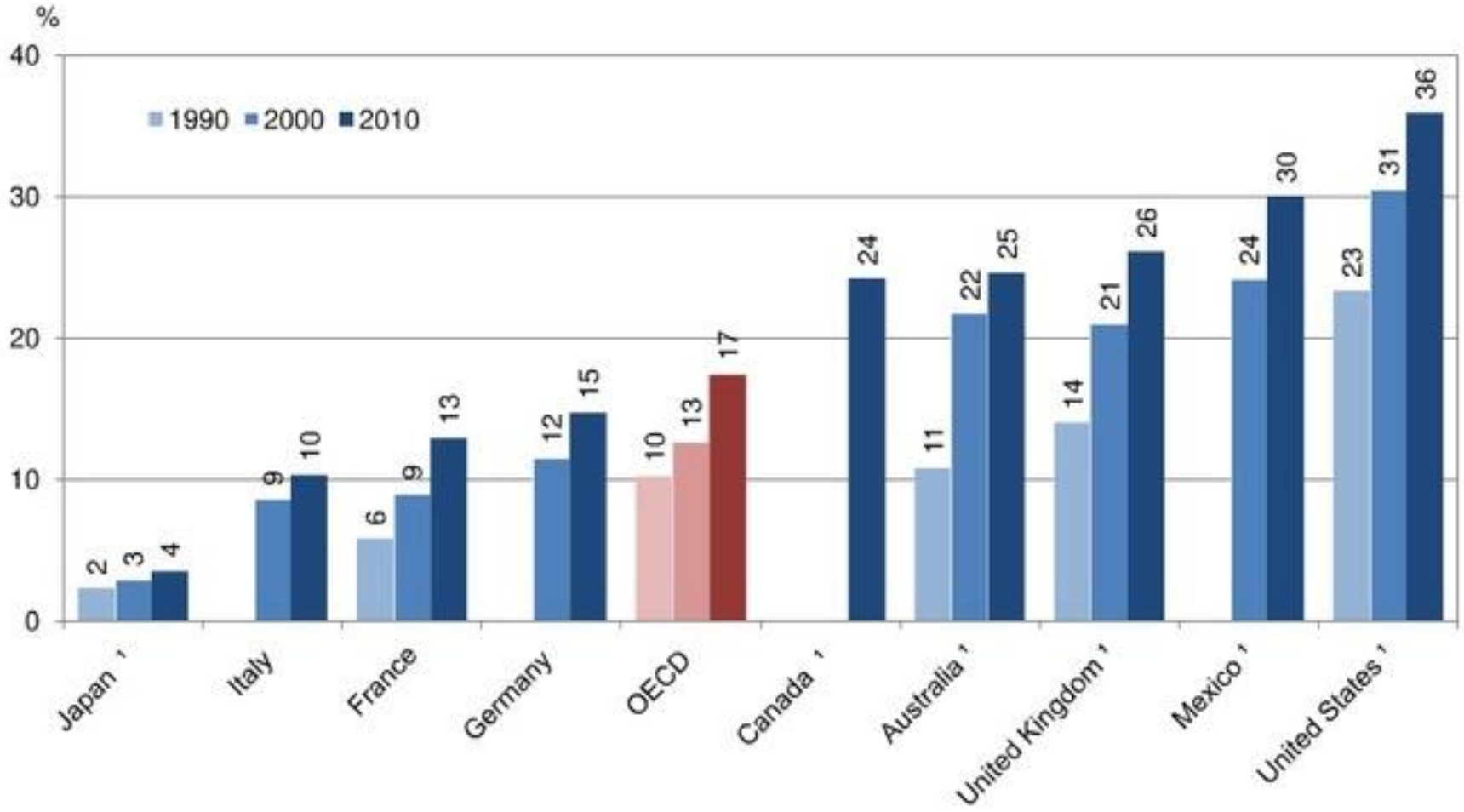
Source: OECD Health Data 2015

Where the United States health system does More than other countries in 2013

	United States	Rank compared with OECD countries	OECD average
MRI Units	35.5 per million population	1st	12.4 per million population
MRI Exams	106.9 per 1 000 population	2nd	51.0 per 1 000 population
CT Scanners	43.5 per million population	2nd	20.9 per million population
CT Exams	240.4 per 1 000 population	2nd	137.7 per 1 000 population
Pharmaceuticals and other medical non-durables (2012)	$1014 per capita	1st	$521 per capita

Source: OECD Health Data 2015

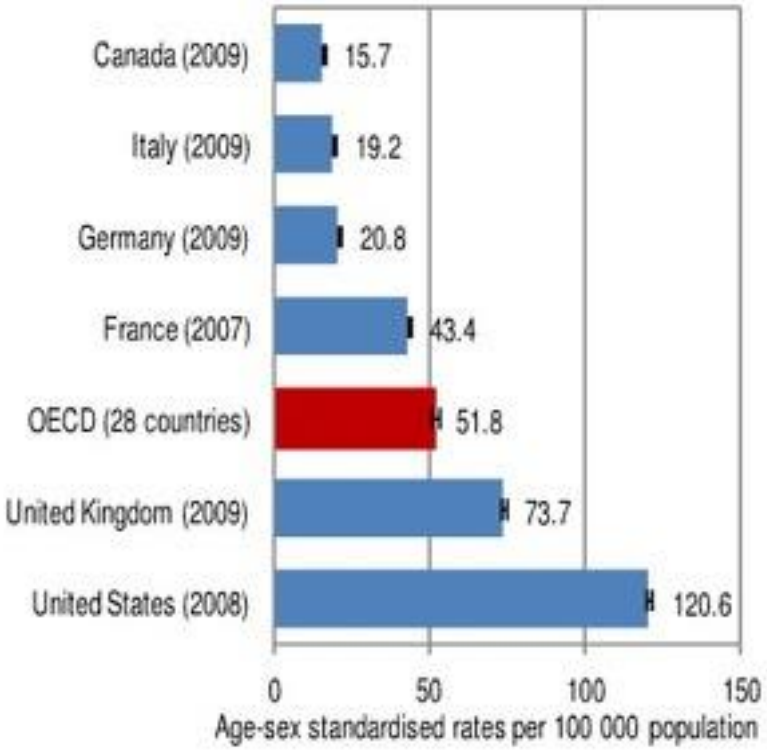
Obesity rates have increased substantially over the past 20 years and are highest in the US



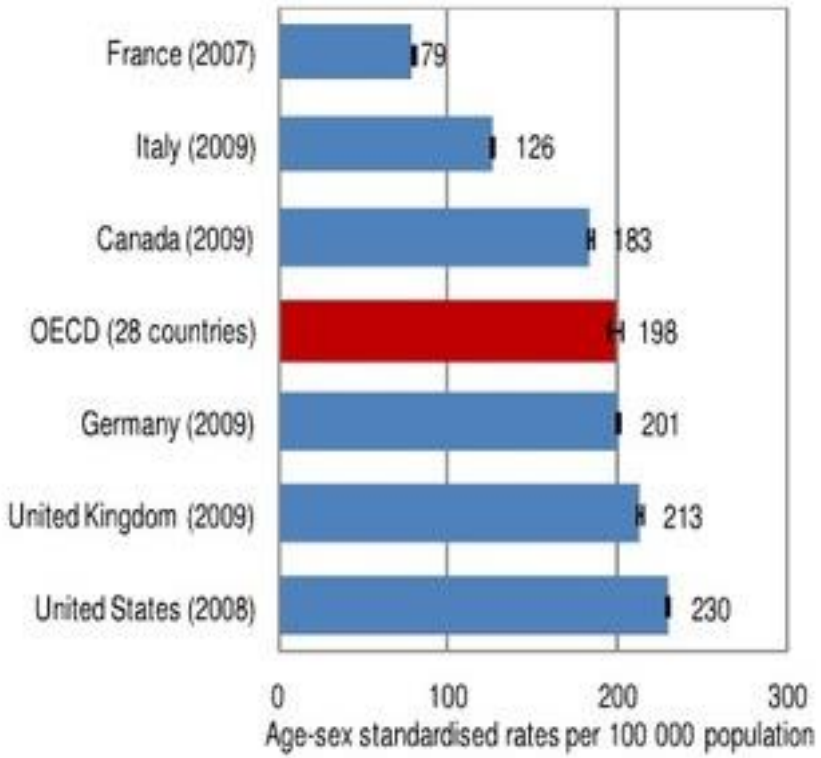
1. Data are based on measurements rather than self-reported height and weight.
Source: OECD Health Data 2012.

Primary care sector is not performing so well

Asthma hospital admission



COPD hospital admission



Note: 95% confidence intervals are represented by H.
Source: OECD Health Data 2012.

In a study by The Commonwealth Fund, the US ranks last among 11 industrialized countries in health care yet the cost of health care is the most expensive in the world

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*











	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

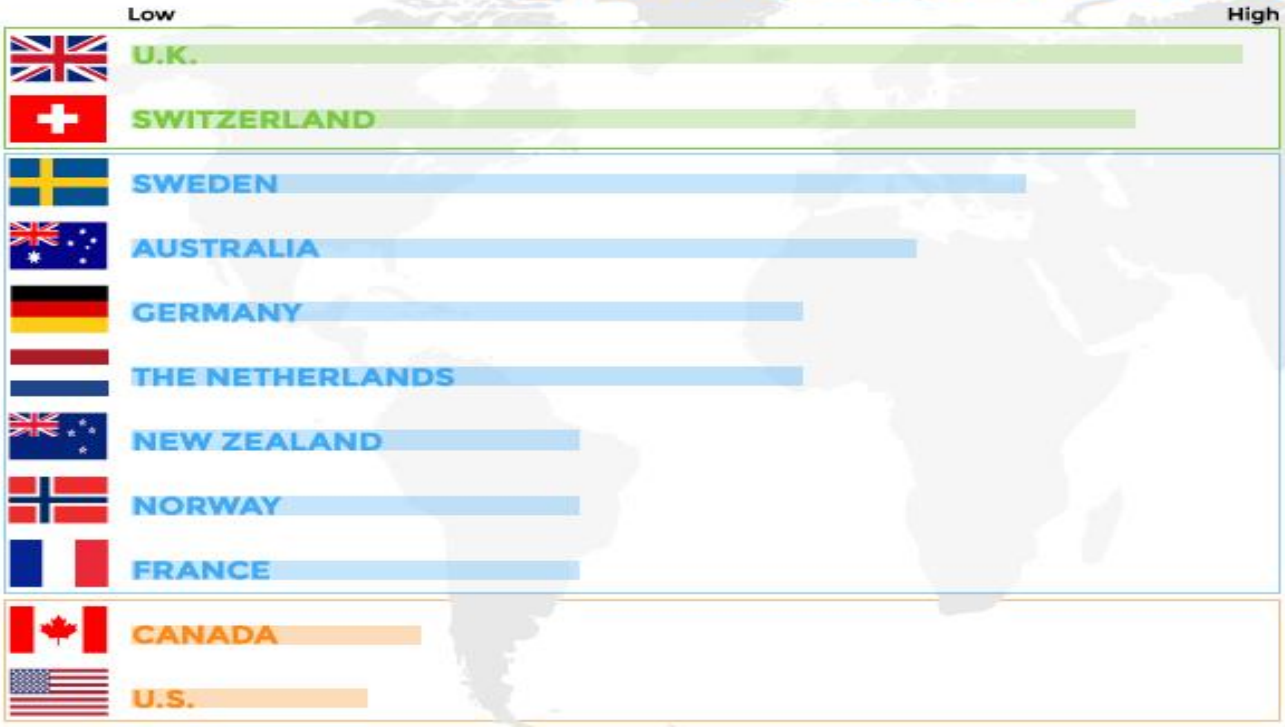
Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

U.S. HEALTH CARE RANKS LAST AMONG WEALTHY COUNTRIES

A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

Overall Health Care Ranking



Source: K. Davis, K. Stremikis, D. Squires, and C. Schoen, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2014 Update*, The Commonwealth Fund, June 2014.

The COMMONWEALTH FUND

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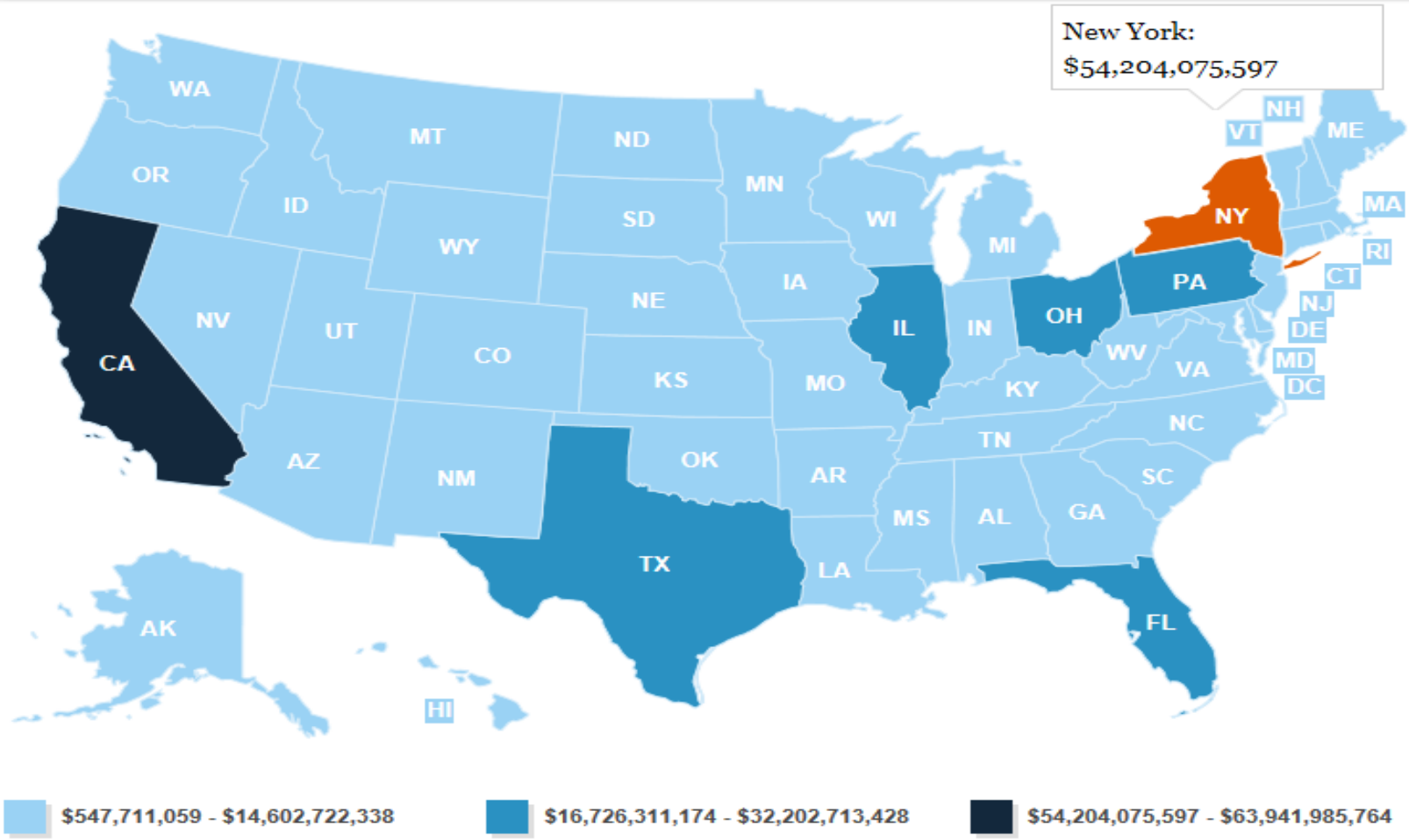
Total Medicaid Spending in the US



We're Amidst a Population Health Revolution

Cost

Quality

Demographics

Personalized Medicine

Consumer Expectations

Challenges We Face

We're Amidst a Population Health Revolution

How do we move from sick care to wellness?

How will we move from volume to value?

What works … and why?

What tools are needed for change?

Who will lead the change … and how?

DSRIP

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

- Sponsored by CMS
- Five-year population-based health management program; year one began in April 2015
- $8B in total available to NYS through DSRIP
- Funding must be earned by meeting performance and outcomes measures (*State wide performance matters*)
- Information technology (interconnectivity) and expanded care management are critical to the success of the program
- Key theme is collaboration! Communities of eligible providers are required to work together to develop DSRIP Project Plans

Goals:

- Regionalize healthcare throughout NYS improving the way care is delivered to Medicaid and uninsured patients
- Integrate providers
- Reduce avoidable hospitalizations and ED visits by 25% over five years
- Reduce the overall cost of care by focusing on prevention and primary care ultimately keeping people healthy
- Risk stratify patients to provide the right level of care to the patient at the right time, at the right cost

Core Requirements:

- Community needs assessment
- Governance
- Data sharing
- Budget and funds flow
- Cultural competency and health literacy
- Workforce plan
- Case Management/Care Coordination

- **Performing Provider System (PPS)** – a group of providers spanning the continuum of care that have agreed to work together in the DSRIP program as members of a regional network supporting one or more NYS counties

- **Regional Health Information Organization (RHIO)** - establishes a system of electronic interconnectivity permitting the sharing of clinical data among authorized, participating health care providers with a given network

- **Care Management** - applies systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively.

- **Safety Net Providers** – CMS and DOH have agreed to Medicaid patient volume thresholds by provider type for DSRIP that distinguish between high-volume Medicaid providers (‘safety net’) versus lower volume providers (‘non-safety net’).

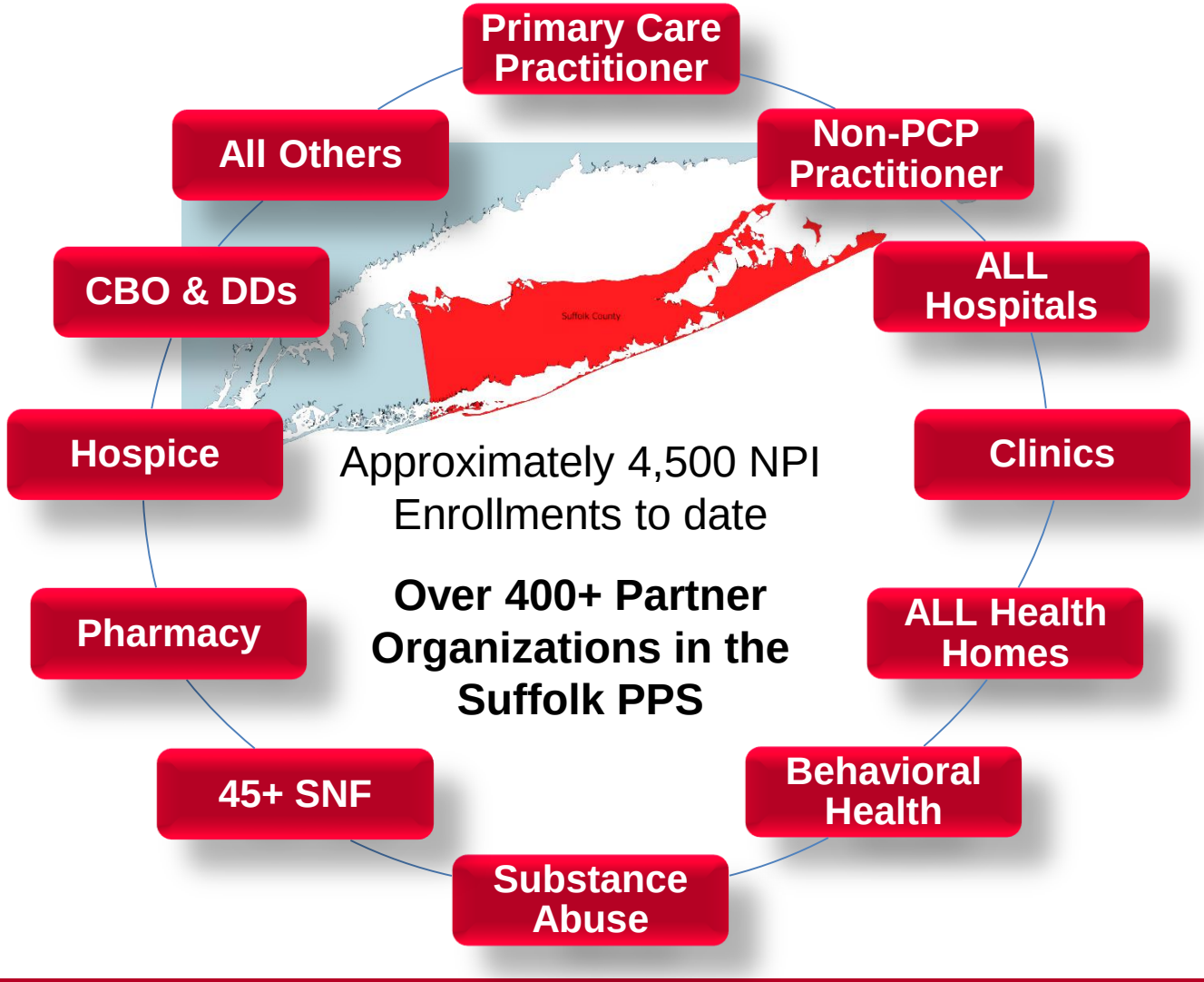
- **Projects** – PPS’ must select between 5-11 projects from a menu of projects that have been agreed upon by CMS and the NYSDOH; the selected projects must tie directly to the results of a comprehensive community needs assessment completed by the PPS

Our Population

Total Attributed Medicaid Beneficiaries	**269,278**
Non Utilizing (NU)	48,471
Low Utilizing (LU)	88,868
Utilizing	131,939
Total Uninsured	**168,618**
Total Suffolk PPS Attribution	**437,896**

A full copy of the Community Needs Assessment can be found online at www.suffolkcare.org

SCC Partner Composition



Brand Announcement

Our vision to become a highly effective, accountable, integrated, patient-centric delivery system has positioned us well to make an important contribution to the DSRIP program.

Some of the many goals will include the capacity to make the most of patients' self-care abilities, improve access to community-based resources, break down care silos and reduce avoidable hospital admissions and emergency room visits.

Project Number	Projects
2.a.i	Create Integrated Delivery Systems –focused on evidence-based medicine / pop health mgmt
2.b.iv	Care transitions intervention to reduce 30-day readmissions for chronic disease
2.b.vii	Implementing the INTERACT project
2.b.ix	Implementation of observational programs in hospitals
2.d.i	Implementation of patient activation activities to engage, educate and integrate the uninsured and low-utilizing Medicaid populations into community based care
3.a.i.	Integration of primary care services and behavioral health
3.b.i	Cardiovascular Health - Evidence-based strategies for disease management in high risk/affected populations (adults only)
3.c.i	Diabetes Care - Evidence-based strategies for disease management in high risk/affected populations (adults only)
3.d.ii	Expansion of asthma home-based self-management program
4.a.ii	Prevent substance abuse and other Mental Emotional Behavioral Disorders (MEB)
4.b.ii	Population-based health chronic disease prevention and management.

Quantifying Achievement of DSRIP Goal of 25% Reduction in Avoidable Hospital Readmissions Over 5 Years

Reduction Bucket	Potentially Avoidable	25% Reduction	Denominator	Denominator Definition
Prevention Quality Indicators (PQIs)	*3,651*	*913*	35,540	Suffolk County **Medicaid** admissions age greater than 18
Pediatric Quality Indicators (PDIs)	*432*	*108*	3,837	Suffolk County **Medicaid** admissions age less than 18; excluding newborns
Reduction Bucket	**Potentially Avoidable**	**25% Reduction**	**Denominator**	**Denominator Definition**
Avoidable ED (PPV)	86,435	21,609	112,902	Emergency department volume by Suffolk County **Medicaid** members
Avoidable Readmissions (PPR)	1,612	403	26,714	At risk admissions defined by 3M at Suffolk County hospitals

Source

PQIs and PDIs are computed from the 2013 limited SPARCS data

All other measures are based on CY 2012 data

GOAL OF 90% PAY FOR PERFORMANCE BY DY 5

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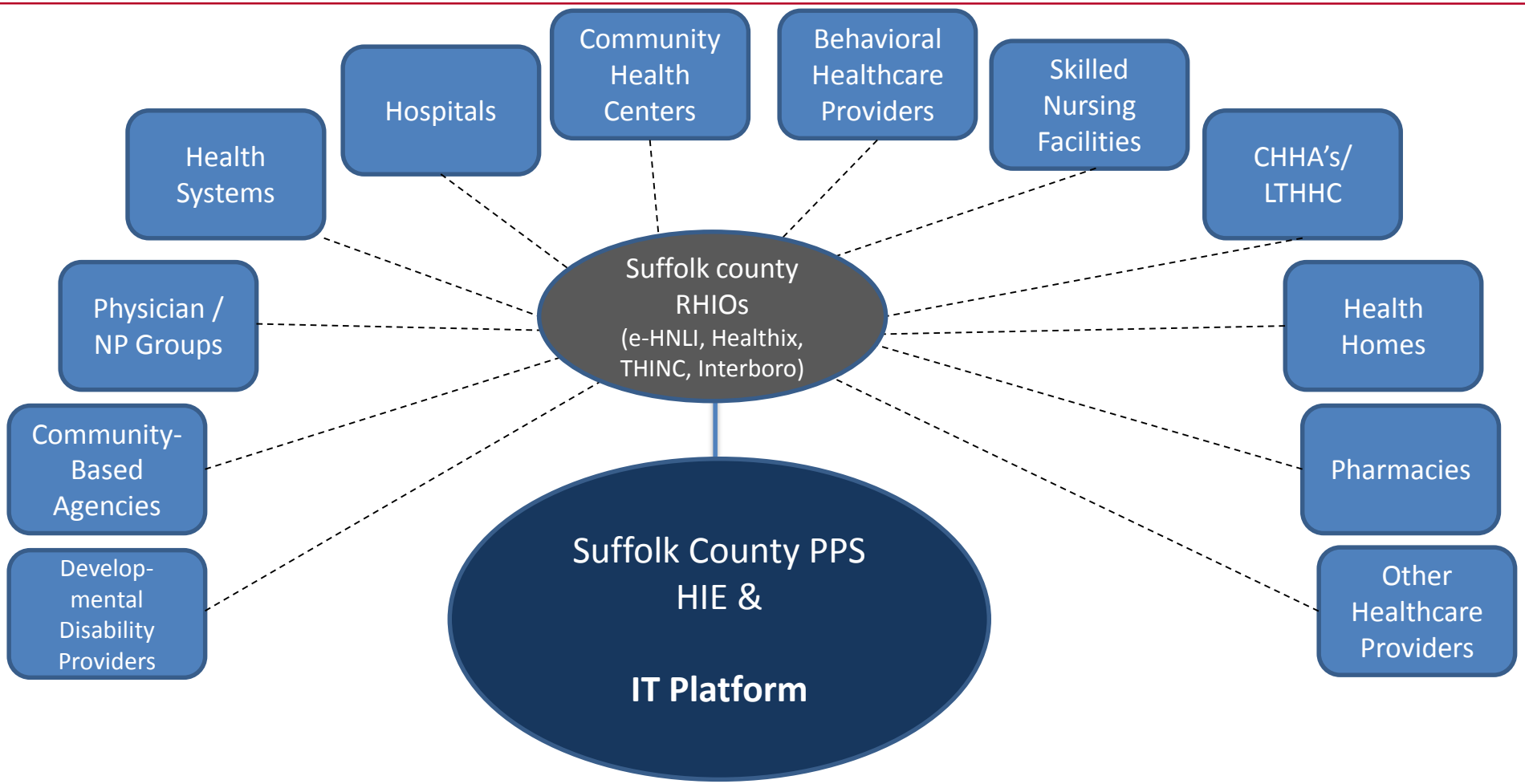
Connecting the Partners



SUFFOLK CARE COLLABORATIVE GOALS

1. Establish a solid foundation of team-based care across medical, behavioral, and social service.
2. Assure that patients get the right care at the right time, while avoiding unnecessary services.
3. Develop a robust data infrastructure and advanced analytical capabilities.
4. Improve access to care, for Medicaid members and uninsured populations.
5. Improve chronic condition management, particularly for those with chronic disease.
6. Support provider practice transformation by transitioning from the traditional fee-for-service payment and toward value based payment.
7. Eliminate health disparities in Suffolk County.
8. Transform the PPS into a highly efficient integrated delivery system.

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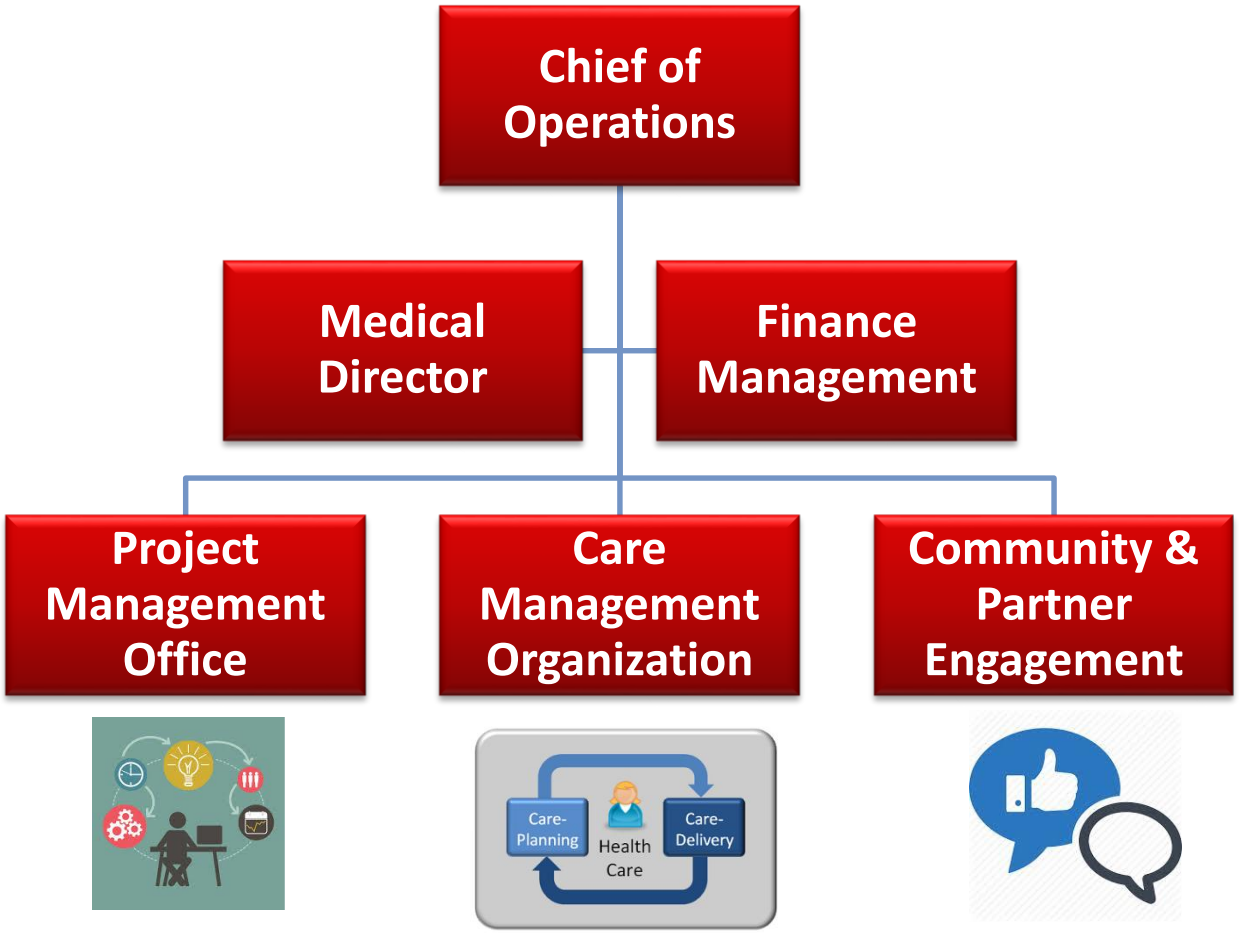
Governance

The SCC Central Service Organization



BENEFITS:

- Help for providers with managing some of their most complex, high need, and high cost patients through expanded care management services
- Expanded access for providers to information about patients' care throughout the continuum of care, with the patient's consent
- Expanded access to behavioral health care, primary care and specialty care for Medicaid and uninsured patients
- An opportunity to participate with the other 400+ partner organizations of the PPS in Medicaid managed care contracts

Population Health Management

"the technical field of endeavor which utilizes a variety of individual, organizational and cultural interventions to help improve patient self-care, morbidity patterns (i.e., the illness and injury burden) and the health care use behavior of defined populations."

"the coordination of care delivery across a population, by providers and support services, to improve clinical and financial outcomes, through disease management, case management and demand management."

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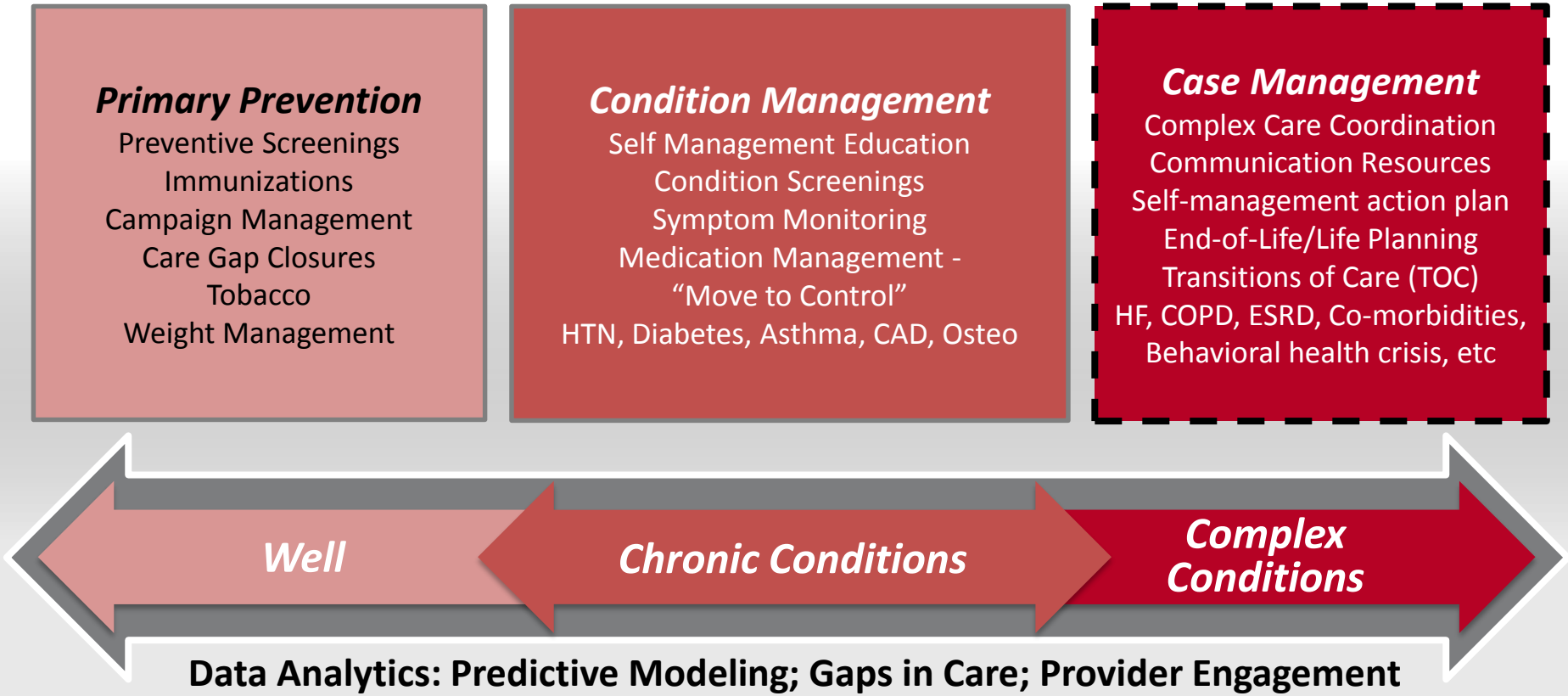
Population Health spans the entire care spectrum – the nature of the care management intervention depends on where the patient falls on that spectrum

Population Health Management Spectrum:



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Today, care management is primarily delivered in inpatient settings, health homes and MCOs

Health Home

Focuses on patients with 2+ chronic conditions, BH issues etc.

Hospital

Traditionally, IP CM has emphasized discharge planning, UM and reducing LOS

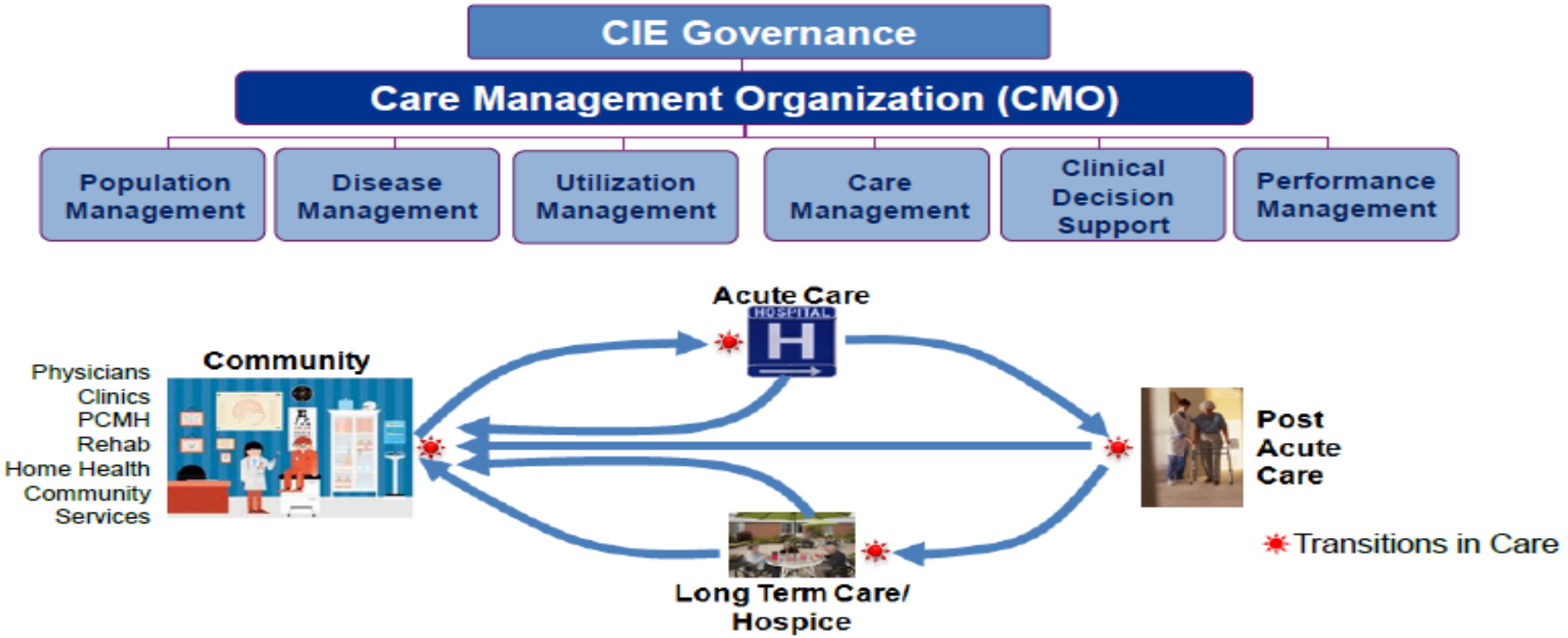
Insurance

Payers have emphasized UM, managing complex OON benefits etc.

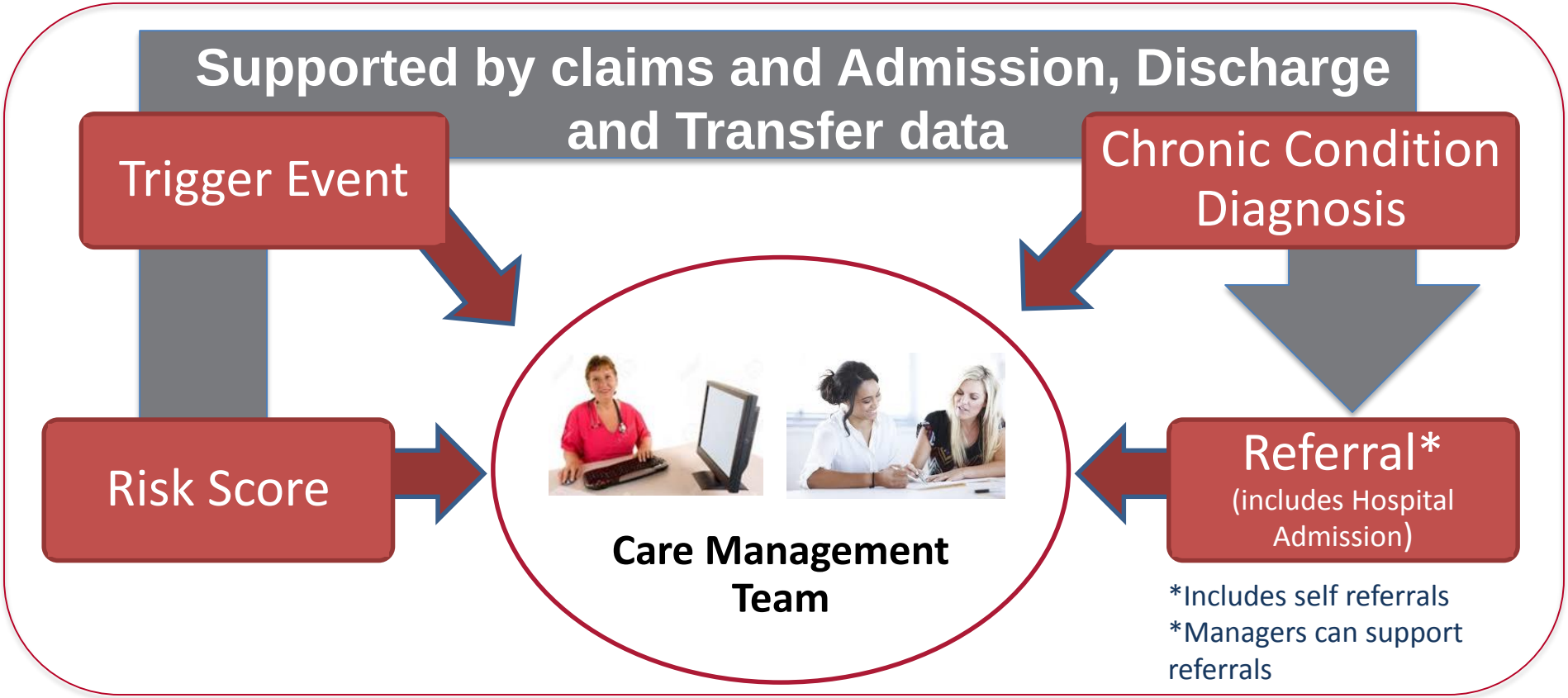
How should a "next generation" CM system address the barriers within the existing system?

- Whole person approach: biological, psychological, and social interventions
- Shared platforms across all stakeholders
- Safe transitions in care
- Behavioral and physical health integration
- More cohesive communication and coordination – avoid duplication of effort

As the Industry Continues to Converge, the Clinically Integrated Entity (CIE) will be the Dominant Model



An effective CM system needs powerful data. "Data feeds" to identify patients in need of care management … a "no wrong door" approach to enrolling patients



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"How it all Works" – Sample 'use case' for how the care manager will work in the future state

New patients are populated into the CM tool daily or are referred from any source

Administrative support screens patient for program eligibility before sending to CM specific queue

Care manager receives the list of patients in his/her queue - Urgent cases are flagged for action

Care manager outreaches to patient and documents - letter sent to patient if unable to reach via phone

Within 28 days of a patient being placed "in process" the case is either enrolled or closed

Care Manager enrolls patient into the Care Management system

Care Manager conducts appropriate assessments based upon the program the patient is enrolled in

Care Manager provides ongoing support for patient and closes gaps in care as necessary, coordinates with PCP and BH as needed

When a patient has met their goals or has had their needs met, the case will be closed with a reason for closure documented in CM tool

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ILLUSTRATIVE

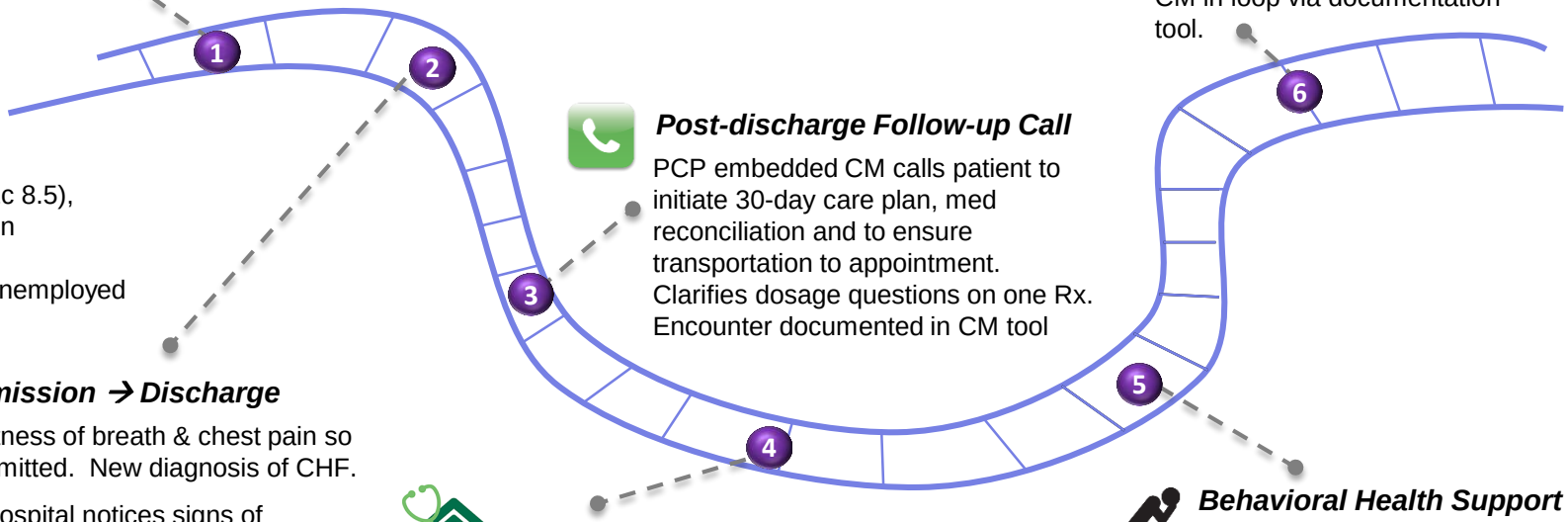
Jointly we hope to create a seamless patient journey in our future state

Care Manager relationship

Trusted relationship with care team in PCP site; Referred to Certified Diabetes Educator for diet suggestions and County Services for housing/ finance issues. Encounter documented in CM tool.

Jane Doe

- 58 years
- Diabetic (a1c 8.5), Hypertension
- Depression
- Divorced, Unemployed
- Medicaid



ER Visit → Admission → Discharge

Experiences shortness of breath & chest pain so visited ER and admitted. New diagnosis of CHF.

Social worker at hospital notices signs of depression; advises on OP resources

IP CM documents high risk of readmission (severity of medical issues, poly Rx, poor housing). Communication between the IP and OP CM

Post-discharge Follow-up Call

PCP embedded CM calls patient to initiate 30-day care plan, med reconciliation and to ensure transportation to appointment. Clarifies dosage questions on one Rx. Encounter documented in CM tool

Post-discharge Visit

PCP assesses patient and Rx prescriptions are filled. Patient admits to suicidal thoughts, substance abuse. Case Manager part of visit and initiates a PHQ-2 / IMPACT screening. Warm handoff to BH practitioner via 'tele-health' meeting. Encounter documented in CM tool.

Health Home Visits

HH CM agency coordinates home visits and follow-ups; Bluetooth scales capture abnormal weight gain. PCP and CM in loop via documentation tool.

Behavioral Health Support

For next 2 months, collaborative treatment plan by BH provider, PCP and CM. CM notices that patient might qualify for Health Home. Encounter documented in CM tool.

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Best practice CM roles – the type of staff needed to get the best patient results. "Hiring right" is very important in filling these roles in a CM organization

Care Management Nurses:

- Embedded or remote locations
- Daily notifications of admissions
- Support post-discharge provider appointments
- Targeted post acute assessment
  - Help patient answer:
    - What is my main problem?
    - What do I need to do?
    - Why is it important for me **to do this?**
- Follow-up for 30 days

Health Management Nurses:

- Promote self care and self management
- Patient activation and engagement
- Condition and Risk Screenings
- Support preventive services
- Symptom Monitoring
- Medication Adherence support
- Close gaps in care
- Provide evidence based care

Core Competencies of Care Manager:

Required Skills and Abilities:

- Demonstrates customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community agencies, patients, and families with diverse opinions, values, and religious and cultural ideals.
- Reveals ability to work autonomously and be directly accountable for results.
- Incorporates excellent written, verbal, and listening communication skills, positive relationship building skills, and critical analysis skills into care management practice.

Education And/Or Experience:

- RN License and Certification in Care Management required within two years of hire and maintained throughout employment.
- BSN or comparable Bachelor's degree required.
- Demonstrated working knowledge of New York Medicaid guidelines required.
- Minimum of three years recent experience to match responsibilities above such as acute care, home health or skilled nursing facility.
- Experience as a Care Manager PCMH preferred.
- Experience with IT solutions such as electronic health record, learning management or disease/care management systems a plus.

Core Competencies of Health Manager:

Required Skills and Abilities:

- Demonstrates customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community agencies, patients, and families with diverse opinions, values, and religious and cultural ideals.
- Experience in motivational interviewing and teaching patients self care and self management skills
- Incorporates excellent written, verbal, and listening communication skills, positive relationship building skills, and critical analysis skills into care management practice.
- Demonstrates flexibility and ability to adapt to evolving requirements of DSRIP program

Education And/Or Experience:

- Requires Registered Nurse with current license.
- BSN or comparable Bachelor's degree required. CDE preferred.
- Minimum of three years recent experience to match responsibilities above such as acute care, home health or skilled nursing facility.
- Patient health education experience required
- Demonstrated working knowledge of New York Medicaid guidelines required.
- Experience as a Health/Disease or Care Manager PCMH preferred.
- Experience with IT solutions such as electronic health record, learning management or disease/care management systems a plus.

SCC Care Management Strategy:

- Effective Care Management is the necessary foundation for population health efforts to create a reliable impact on patient quality, satisfaction, utilization and cost outcomes
- Leveraging the “know-how” of existing community CM providers and effectively collaborating with them is a key to creating better outcomes
- Leveraging the experience of an organization who has extensive care management expertise will also make the SCC CM organization more successful – xG Health/Geisinger

All CM processes optimized through years of learnings within Geisinger’s CM model including:

- Best practice training of staff
- Optimized and efficient patient assessment and intervention processes
- Collaborative relationships with the PCP
- Access to the patient EHR
- Effective integration with BH providers/services

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Our vision is to build a collaborative CM organization

Existing CM Resources in Suffolk County:

Health Homes

CM Agencies

Coordination

Coordination

MCO CM
(Telephonic)

Coordination

Catholic Health Services of Long Island

North Shore LIJ

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- Clinical Governance
- CM Staffing, Training
- CM Standards, Protocols
- On call coverage
- Physician Leadership

CMs cover Regional Pods

- Special Needs Units

Hospitals

- TOC CMs
- ER CMs

PCMH/ Practice/ Clinics

- Embedded CM (high volume practices)
- Additional CM resources (e.g., Care Associates)

 Embedded CM resources

Collaborate on staffing, standards, and technology

Coordination only

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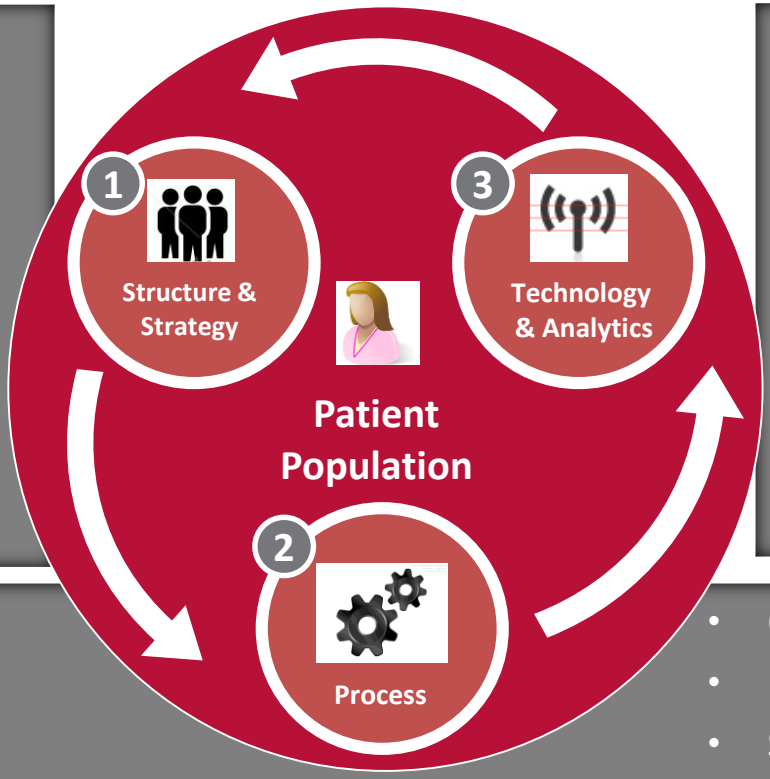
Our CM Model will comprise organization, process and technology building blocks

1) Structure and Strategy

- Delivery methods
  - Embedded
  - Remote
- Process
  - Core Workflows
  - Care Paths
  - Policies and Procedures
- Staff onboarding and development
- Staff Performance monitoring



3) Technology and Population Health Analytics

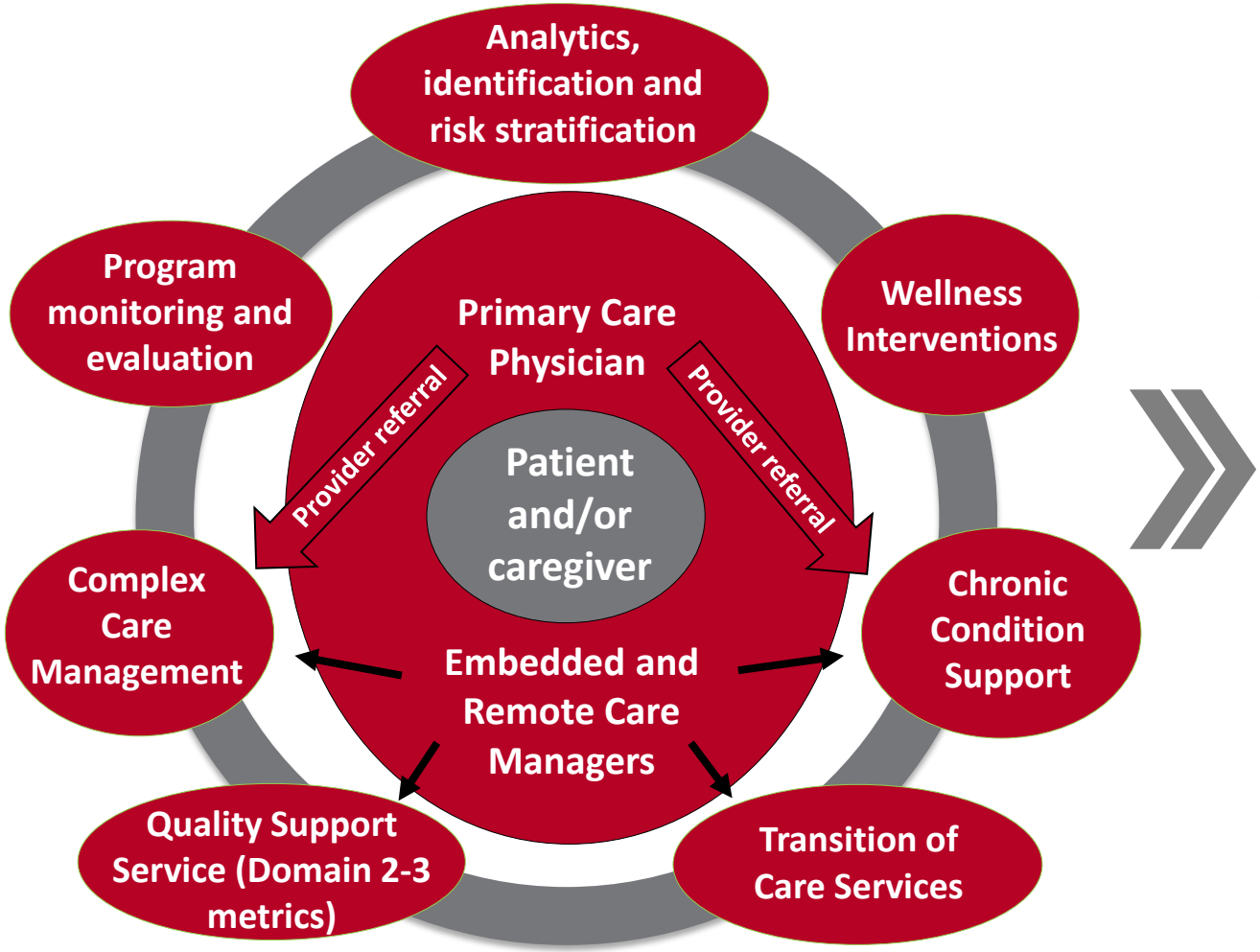
- Care Management Platform
- Informatics & Analytics
  - Performance Monitoring
  - Care Gaps
  - Program Impact
- Patient Engagement
- Tele-monitoring
- EHR leverage

2) Process

- Delivery methods
  - Embedded
  - Remote
  - Hospital based
- Population segmentation & risk stratification

- Core workflows
- Policies and Procedures
- Staff onboarding and development
- Staff Performance monitoring management and evaluation

Embedded and Remote Care Managers amplify the impact of PCPs



Care Managers are able to support PCPs/other Providers and assist with:

- Managing the most complex and highest need patients
- Working to address the social determinants of health – housing, transportation, finances
- Improving patient access to behavioral health services

Recent Headlines Illustrate the Transformation that is underway

U.S. Government unveils goal to move Medicare away from fee-for-service *January, 2015 | Reuters*

U.S. Government releases draft plan for electronic health data
January, 2015 | Reuters

Two Ways Big Data is Reshaping Health Care
September, 2014 | Wall Street Journal

(Connecticut) House nearing deal on massive health care bill
May, 2015 | CT Mirror

The Big Idea: How to Solve the Cost Crisis in Health Care.
September, 2011 | Harvard Business Review

A Strategy for Medicare Payment Reform – Improving ACOs While Expanding Bundled Payments
June, 2015 | Center for American Progress

In conclusion

- Advances in medical technology, Americans can expect to live longer
- The models for financing and delivering care in response to the rapid increase in chronic disease is occurring at a much slower rate.
- New models that focus on disease prevention and chronic disease management are critical.
- Health Policy and Regulatory Reforms of the past decade has set the stage for a paradigm shift in how care is delivered across the spectrum of care settings.
- Is our current System up for the challenge?... We must change the way we do things!

FOR MORE INFORMATION:

General NYS DSRIP Information:

New York State Department of Health DSRIP website:
https://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm

Suffolk Care Collaborative:

www.SuffolkCare.org

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