Mi-CCSI
Center for Clinical Systems Improvement

The Michigan Center for Clinical Systems Improvement welcomes you to our 3 part webinar series

- March 15 – Tom Bodenhemier MD
  - Maximizing Care Management; an emphasis on care/case management and health coaching
- May 3 – John Fox MD & Carol Robinson DNP
  - Advance Care Planning; why, how and the impact on Triple AIM
- June 6 – L Gordon Moore MD
  - Transforming PCMH Practices; new approaches involving measurement, accountability, and financing

Our speaker today

Thomas Bodenheimer MD, MPH is a general internist who received his medical degree at Harvard and completed his residency at UCSF.

He spent 32 years in full-time primary care practice in San Francisco's Mission District – 10 years in community health centers and 22 years in private practice.

He is currently Professor Emeritus of Family and Community Medicine at University of California, San Francisco and Founding Director of the Center for Excellence in Primary Care.

He is co-author of Understanding Health Policy, 7th Edition, 2016, and Improving Primary Care, 2006 (both McGraw-Hill). He has written numerous health policy articles in the *New England Journal of Medicine, JAMA, Annals of Family Medicine, and Health Affairs.*

Disclosure Statement of Financial Interest

- I, Thomas Bodenheimer MD, MPH

DO NOT have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.

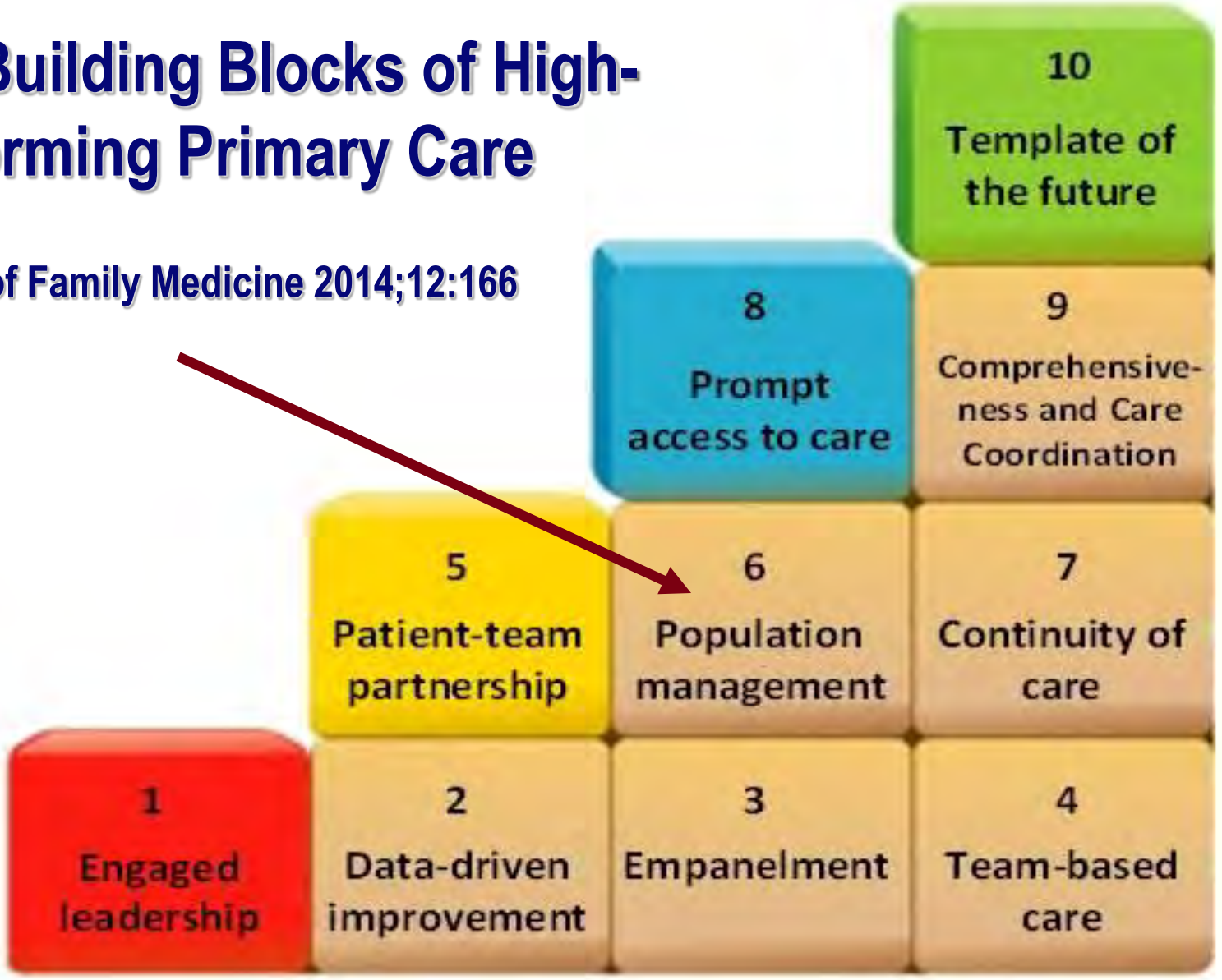
Care management of patients with complex healthcare needs

Thomas Bodenheimer MD
Center for Excellence in Primary Care
University of California, San Francisco

Michigan Center for Clinical Systems Improvement
March 15, 2016

The Building Blocks of High-Performing Primary Care

Annals of Family Medicine 2014;12:166



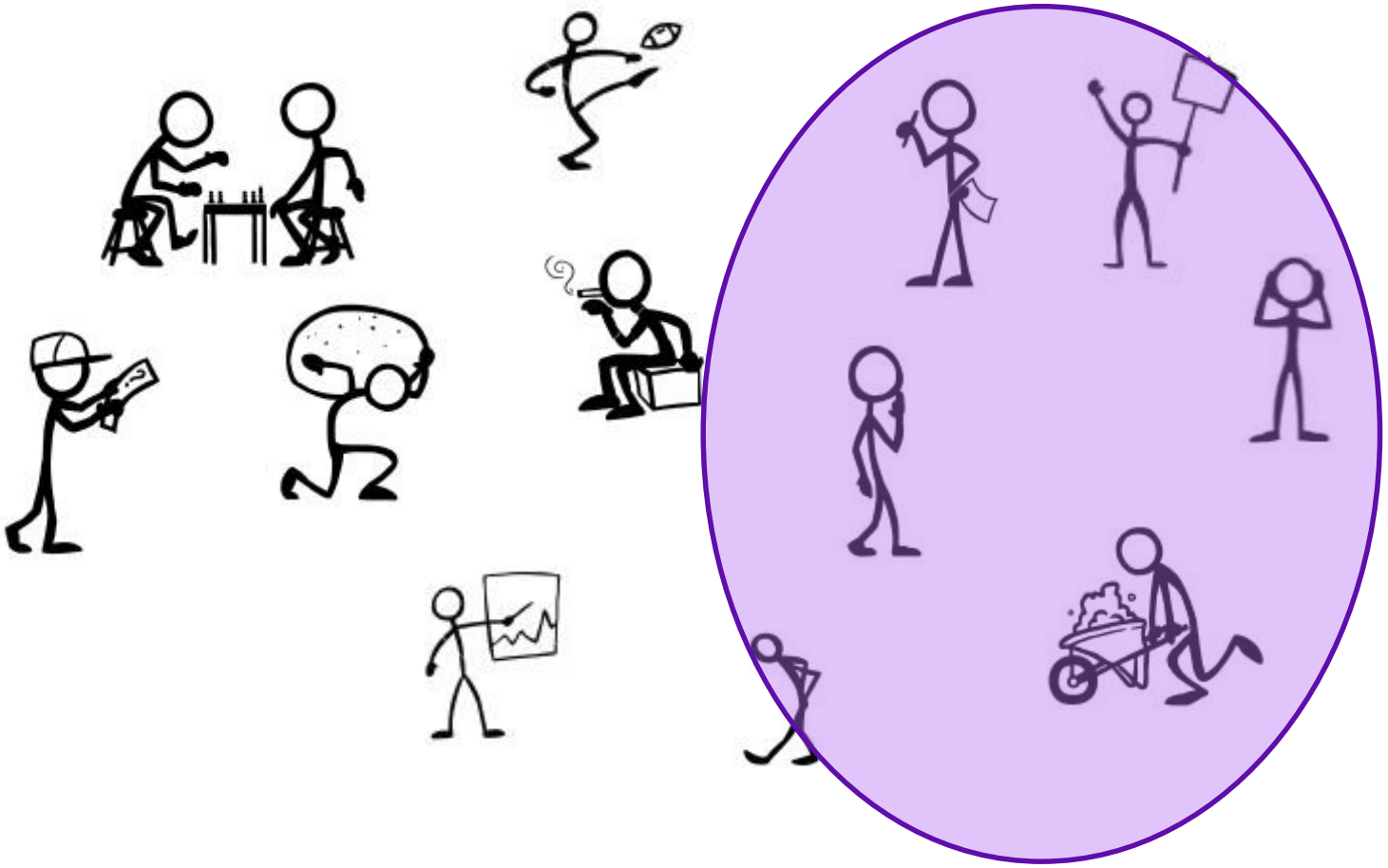
Building Block 6. Population management:
stratifying the panel

Panel Management:

Ensuring that ALL of the patients in our panel get recommended preventive and chronic care

Population management: stratifying the panel

Health Coaching: Helping patients with less complex chronic conditions to improve their self-management skills.

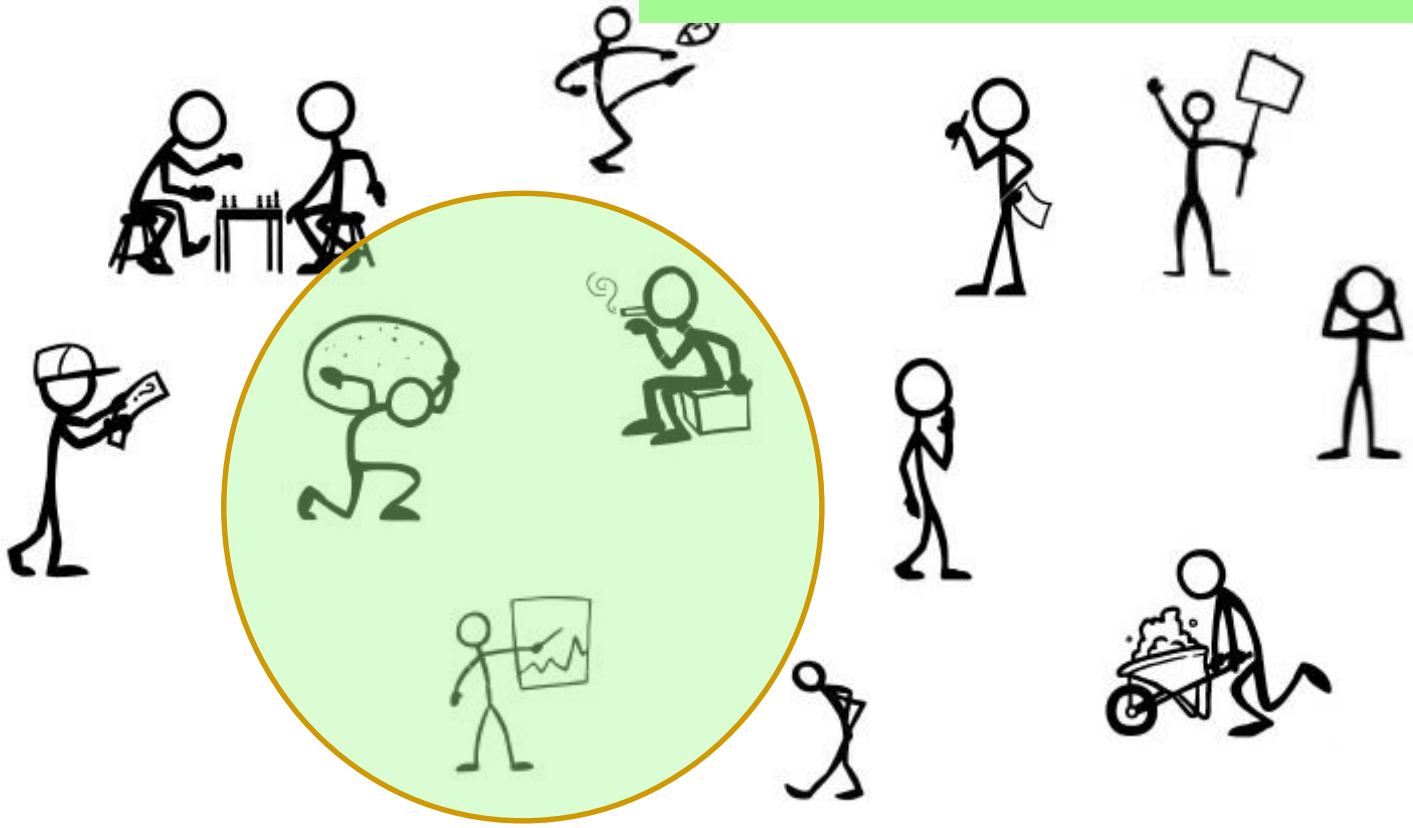


Population management:

Stratifying the panel

Complex Care Management:

Targeted, team-based management for patients with complex healthcare needs



Care coordination and care management

Care coordination ensures that

- Specialists, hospitals, labs, pharmacies, home care agencies – the medical neighborhood -- are available to primary care patients, and
- Primary care and the medical neighborhood share information in a timely manner
- Mainly done by non-licensed personnel

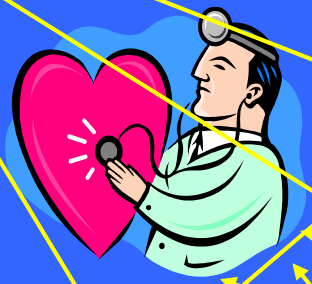
Care management assists patients/families to live with their chronic conditions through patient education, health coaching, medication management

- Requires licensed personnel

Complex care management is team-based care management for complex patients to 1) improve health and 2) reduce the need for expensive services.

Care coordination is an important part of complex care management: making sure patients can navigate the confusing health system

The confusing health system



Care coordination or care management?

Referral coordinator in primary care practice checks with a health plan to see if it has approved a CT scan for a patient

A social worker has a discussion with a high-utilizing patient about alternatives to calling 911

Spanish-speaking MA goes to specialist visit with Latino patient to translate

RN discusses alternatives to using opioids for a chronic pain patient and offers substance use referrals

MA uses a referral log to contact specialists who have not returned consultation reports to see if the patient attended the appointment and to get the report

MA health coach engages a patient to discuss medication adherence

Care management for patients with 1 – 2 chronic conditions

Systematic review of 41 studies of patients with diabetes: planned visits with nurse care manager was associated with improved outcomes[1]

Meta-analysis of 66 studies of quality improvement strategies for patients with diabetes

The most effective strategies

- Team-based care
- Planned visits by nurses or pharmacists
- The planned visits provide health coaching (self-management support)
- Best results when RN or pharmacist (using standing orders) makes medication adjustments without awaiting physician authorization[2]

- 1. Renders et al. *Diabetes Care* 2001;24:1821.
- 2. Shojania, *JAMA* 2006;296:427.

Health Coaching: Engaging Patients and Families in Their Care

What is health coaching

Paradigm shift:

From: Doctor (or nurse) tells patient what to do and calls them non-compliant if they don't do it

To: Engaging patients to learn their goals and what they are willing and able to do; meeting them half-way

Health coaching assists patients to gain the knowledge, skills, and confidence to become informed, active participants in managing their chronic condition [Ghorob, Fam Pract Management, May/June 2013]

The 2 key components of care management are health coaching and medication management

Health coaching is:

1. A function everyone should do
2. A job that a few people should be trained in and have time for

Health Coaching Evidence

RCT: patients with diabetes, hypertension and/or hyperlipidemia with medical assistants trained as health coaches had significantly improved A1c and LDL-cholesterol compared with non-coached patients[1]

In a RCT of low-income patients with poorly controlled diabetes, patients with peer health coaches (other patients with diabetes) had significantly improved A1c levels compared with controls[2]

1) Willard-Grace, Ann Fam Med 2015;13:130; 2) Thom et al, Ann Fam Med 2013:11:137.

Health coaching skills and evidence

Curriculum, tools, videos at cepc.ucsf.edu

Ask-tell-ask	• Engaging patients by asking what they think and what are their goals is associated with better outcomes than telling patients what to do[1]
Know your numbers	• Diabetic patients who know their A1c and their A1c goal have better control than a control group[2]
Close the loop (teachback)	• 50% of patients leave the medical visit without understanding their care plan. Diabetic patients whose care team closes the loop have better A1c levels[3]
Counseling on medication adherence	• The more actively a patient is involved, the better the adherence[4]

1) Heisler et al, *JGIM* 2002;17:243. 2) Levetan et al, *Diabetes Care* 2002;25:2. 3) Schillinger et al, *Arch Intern Med* 2003:163:83. 4) Osterberg, Blaschke, *NEJM* 2005;353:487.

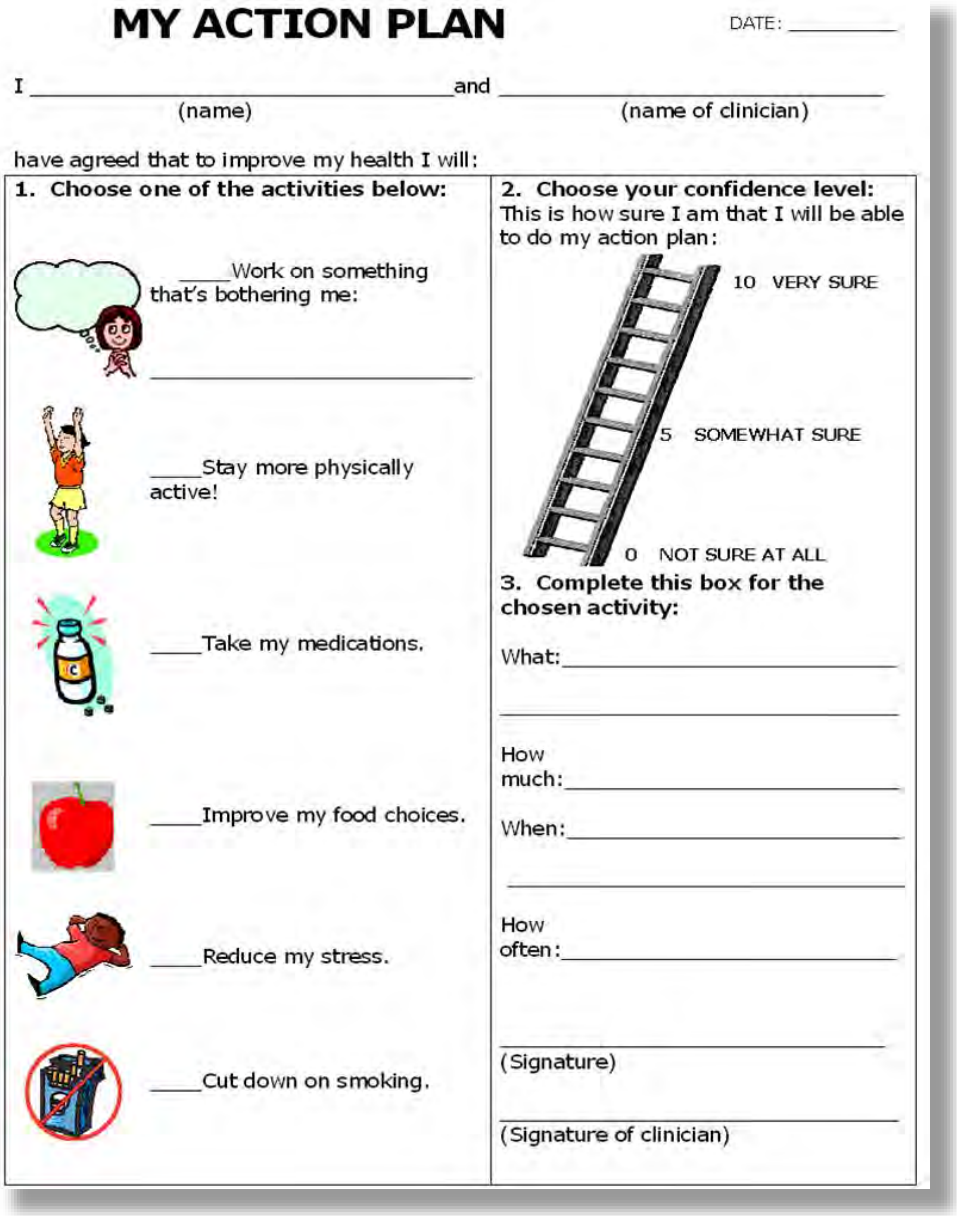
Health coaching skills and evidence: action plans

Action plans are agreements between a health coach and patient specifying a behavior change that the patient has chosen to make

Patients with diabetes randomly assigned to traditional patient education or goal-setting with action plans

The group doing action plans had significant reduction in HbA1c compared with the patient education group, whose A1c did not change

Naik et al, Arch Intern Med 2011;171:453



MY ACTION PLAN

DATE: _____

I _____ and _____
(name) (name of clinician)

have agreed that to improve my health I will:

1. Choose one of the activities below:

_____Work on something that's bothering me:

_____

_____Stay more physically active!

_____Take my medications.

_____Improve my food choices.

_____Reduce my stress.

_____Cut down on smoking.

2. Choose your confidence level:
This is how sure I am that I will be able to do my action plan:

10 VERY SURE

5 SOMEWHAT SURE

0 NOT SURE AT ALL

3. Complete this box for the chosen activity:

What: _____

_____

How much: _____

When: _____

_____

How often: _____

_____
(Signature)

_____
(Signature of clinician)

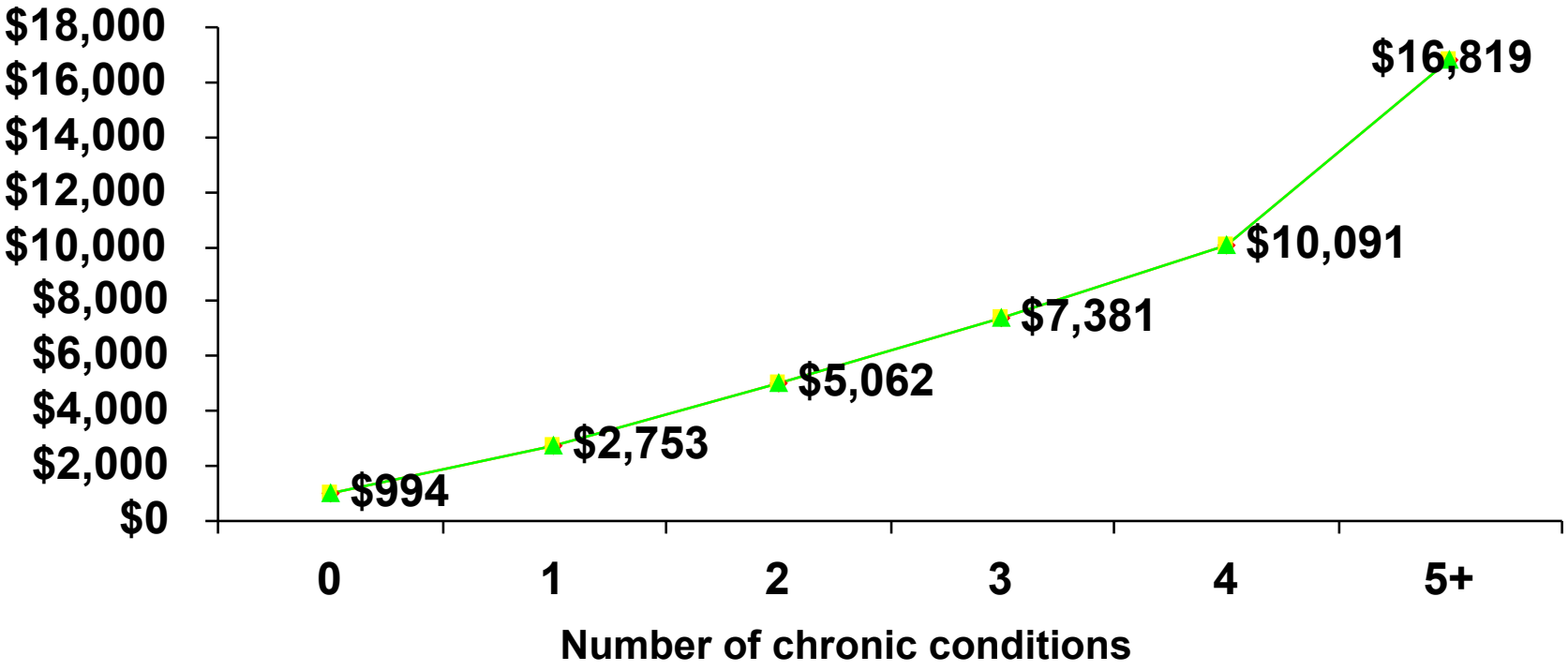
Wisdom from Kate Lorig RN, PhD

The founder of evidence-based health coaching

Stanford Patient Education Research Center

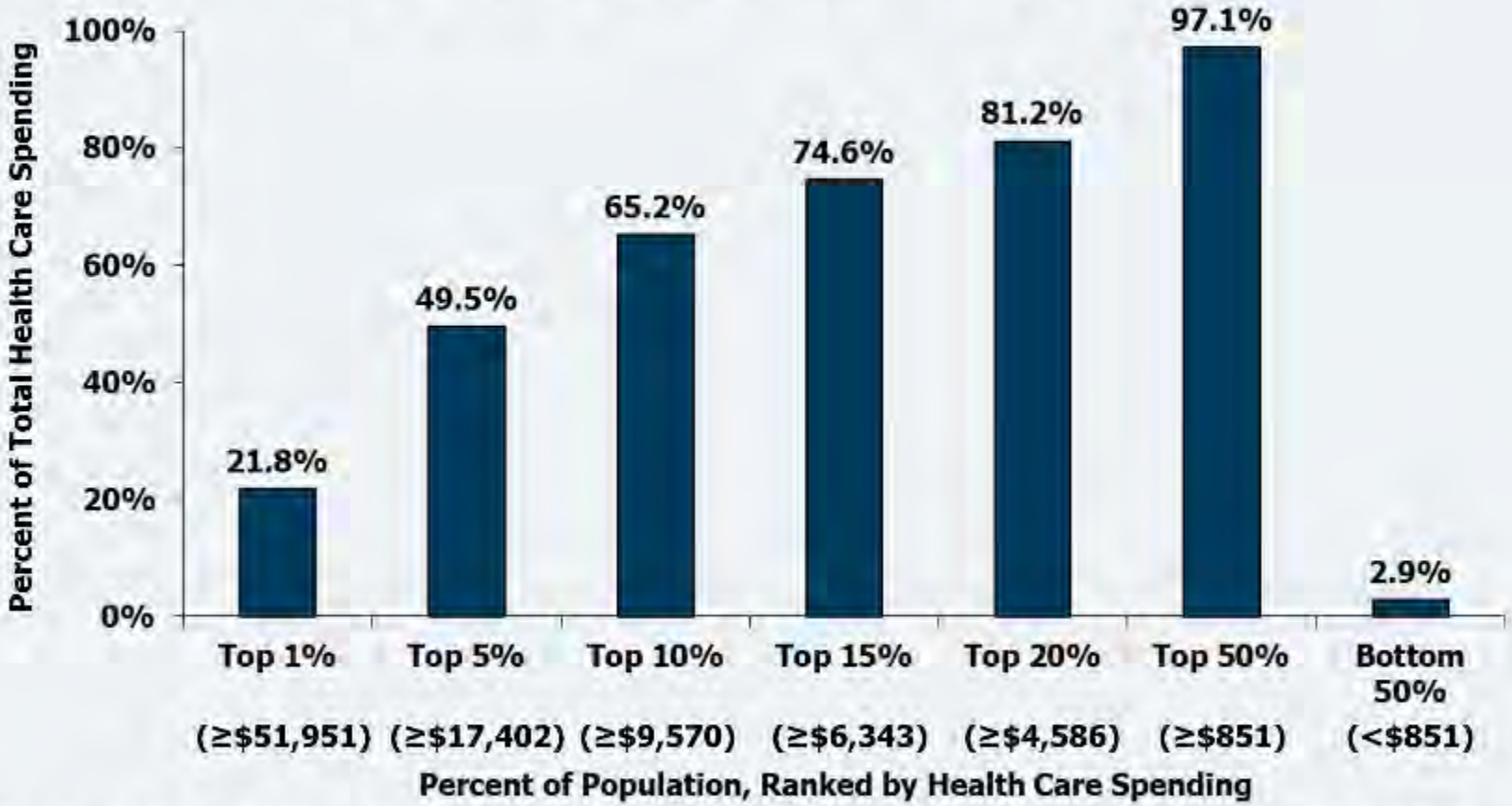
"If you are confident you can do something, you probably can do it. If you are not confident, you probably can't."

Average per capita spending by number of chronic conditions (2004)



Anderson, "Chronic conditions" Johns Hopkins, 2007

Concentration of Health Care Spending in the U.S. Population, 2009



Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), Household Component, 2009.

Complex care management

Care management for patients with complex health care needs

What are the goals?	• Reducing total costs • Improving health and quality of life
Who does complex care management?	• Team of RN, SW, pharmacist, health coach/patient navigator
What are the case loads?	• RN or SW alone, about 50 • RN + SW + health coach/patient navigator, perhaps 200

Because it takes a lot of resources, who are the best patients to target?

What does the team do?

What are some complex care management models?

Who needs CCM?

Most are patients with

- Multiple chronic conditions
- Frequent hospitalizations, high costs
- Many prescription medications
- Many care providers, requiring care coordination
- Limitations of ADL

CCM is intensive, costly process requiring highly skilled personnel

It shouldn't be offered to patients who are

- Too healthy (i.e., low risk for hospitalization and excessive costs)
- Too sick to benefit

How select patients for CCM?

Health plan high-risk lists (e.g. those with 2 or more hospital admits in past year, or high risk score)

Hx of costs over 2-3 years, number of dx's, number of rx's, depression, self-mgm skills, social isolation

Opinion of PCP and primary care team

Need both; they are never the same

After identifying patients, RN discusses with patient/family to see if they agree to engage

Hong C et al. Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program? Commonwealth Fund, August 2014

Key components of complex care management (CCM)

Team assesses what the patient needs

Team develops care plan with patient, family, physicians

Team teaches patient/family about diseases, symptoms

Team uses health coaching techniques

- Close the loop
- Know your numbers
- Medication adherence counseling
- Action plans

Team coaches patient/family on yellow flags, red flags

Team tracks how patient is doing over time, revises care plan as needed

Payment for complex care management

The dysfunction of fee-for-service	• Pays face-to-face visits with physicians, NPs, PAs • Teams are an expense, not a revenue source
Fee-for-service add-ons	• PCMH payments • Pay-for-performance
Alternative payment models	• Capitation • Global budget, usually in an ACO • Shared savings from reducing hospitalizations in an ACO

Payment for complex care management: Medicare's new care management fee

CPT code 99490: physicians, NPs, PAs, clinical nurse specialists

Eligible patients: 2 or more chronic conditions that increase risk of death, exacerbation, or functional decline

Care plan: problem list, goals, symptom management, medication management, care coordination

Provider/team accessible 24/7

Lots of work, fee about $45 once a month

Complex care manager, 100 patients/month: $54,000.

Many practices find the amount of work to be greater than the amount of payment

Some complex care management models

Health Plan Model:	Health plan employs CCM team, mainly telephonic
Hospital Discharge Model:	Transition from inpatient to home
Primary Care Model:	CCM team embedded in one or more primary care practices
aICU Model:	All care provided by separate high-risk clinic or high-risk team, patient leaves PCP
ED Model:	Emergency Department-embedded team provides CCM
Home Care Model:	Care entirely in patient's home
Housing First Model:	Homeless or precariously housed people receive stable housing with social services
Community-Based Model:	Care provided where patients are

Bodenheimer T, Berry-Millett R. Care Management for Patients with Complex Healthcare Needs, Robert Wood Johnson Foundation, 2009; Bodenheimer T. Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients: Reflections on Pioneering Programs. Center for Health Care Strategies, October 2013.

Health plan model:

CareOregon Medicaid managed care plan

Health resilience specialists are hired by the health plan and embedded in primary care practices

- Masters degree in social work or psychology
- Experience in community work and addiction

Most patients have 3 issues

- Physical disease (COPD, CHF, HBP, diabetes
- Mental health issues
- Addiction, mostly opioids and alcohol

Patients seen in clinic, at home, in community settings; are accompanied to specialist and community referral sites. Not just telephonic care management

In addition to building trust, the health resilience specialists

- Help navigate health and social service systems
- Motivational interviewing
- Health literacy education
- Self-management skill development

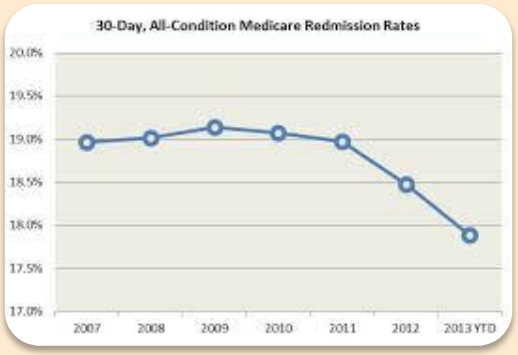
Supervised by RN, behaviorist, pharmacist

- All meet weekly for to discuss difficult cases

Hospital discharge model:

Care Transitions Intervention

Coleman et al, Arch Intern Med 2006;166:1822



RNs trained as "transition coaches" to teach patients/families skills to care for themselves

1 hospital visit, 1 home visit post-discharge, 3 post-discharge phone calls

Significantly lower readmission rates and lower hospital costs compared with controls

Primary care model: patients stay with PCP

Geriatric Resources for Assessment and Care of Elders (GRACE)

Counsell et al, JAMA 2007;298:2623

NP/SW care management team working with PCPs and geriatrician

In-clinic, home and phone contacts

Extensive training of care management team

Small case load for care management team

Higher-risk subgroup: lower ED/hospitalization rates year 2, lower total costs year 3 compared with controls

Ambulatory intensive caring unit (aICU) model

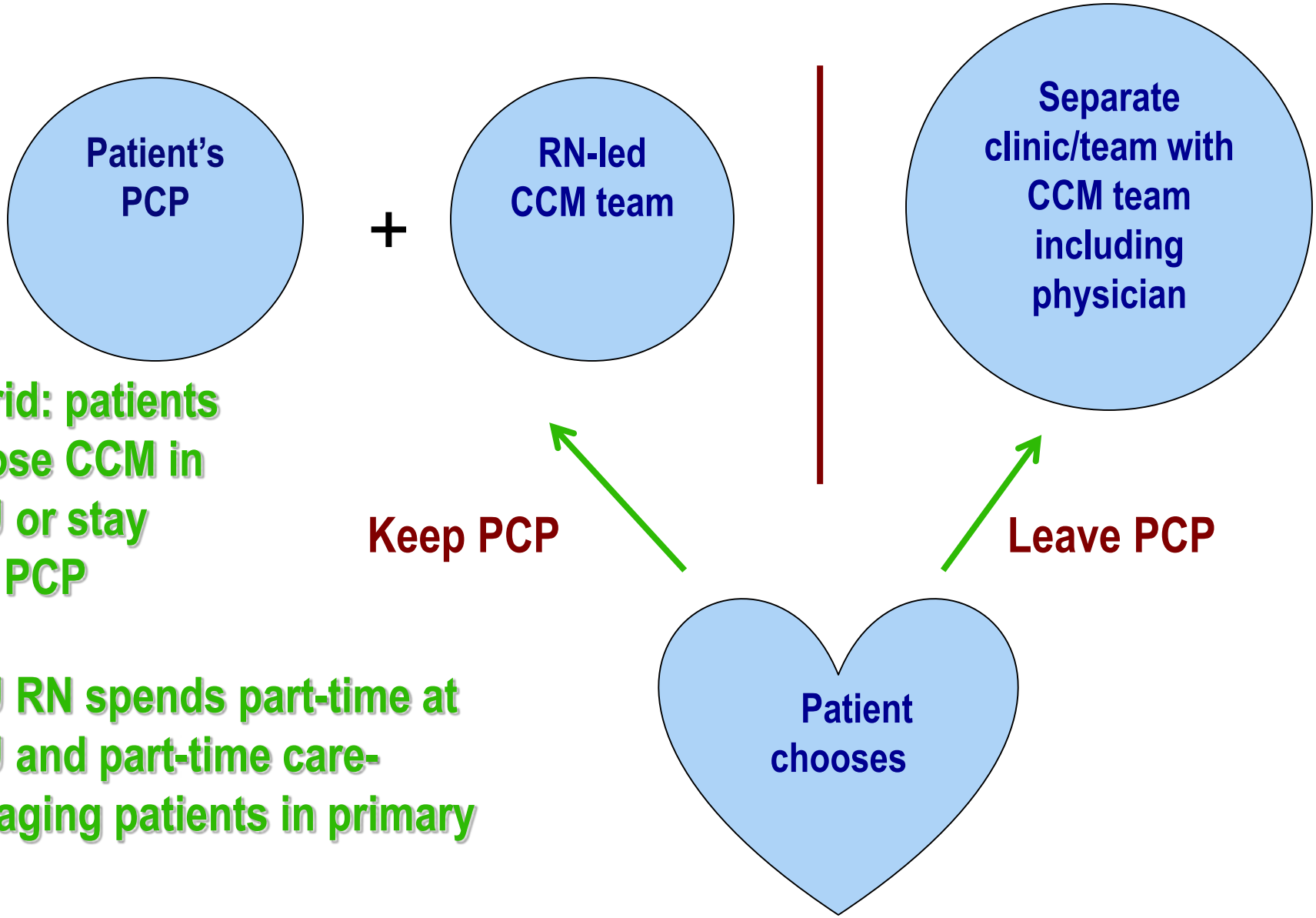
Complex patients cared for by separate high-risk clinic (aICU) with a team of physician, RN, SW, perhaps pharmacist, health coaches

If patients have PCP, they leave PCP; most are satisfied because the aICU provides much more care and is accessible

Primary care physicians often happy that complex patients leave for the aICU because these patients take a lot of time

Rather than a separate aICU there might be a high-risk team in the primary care practice; patients leave their PCP to be on that team

aICU hybrid



Hybrid: patients choose CCM in aICU or stay with PCP

aICU RN spends part-time at aICU and part-time care-managing patients in primary care

aICU hybrid model:
Stanford Coordinated Care

Separate clinic only for complex patients

Patients can choose to stay with PCP or leave PCP and receive all care at Stanford Coordinated Care

aICU team is 3 MDs, RN, LCSW, pharmacist, physical therapist/chronic pain expert, 3 care coordinators

RN goes to practices of patients keeping their PCP

Care coordinators are health coaches, join visit as scribe, post-visit and between-visit to ensure understanding, set goals, teach yellow/red flags, help patients navigate the system, go with patients to specialists

aICU hybrid model: Stanford Coordinated Care

Multiple clinical measures (like A1c, BP), functional measures (ADLs), utilization measures (ED visits, admits), and patient experience measures

Metrics on big wall chart with red/yellow/green dots (red=bad, green=good). Goal: "get the red out"

CCM team meets to discuss patients, see if improvement or not on the red/yellow/green wall chart

Early data: ED visits down 39%, hospital admits down 25%. Patient and staff satisfaction 99%, HEDIS quality measures 99th percentile

Across all these programs, what works?

Most critical is health coaching: teaching patients/families/caregivers how to self-manage their conditions

Health coaching for complex patients

Coaching of complex patients is both similar and different from coaching of less complicated patients

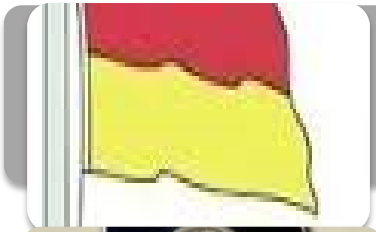
When you separate out the problems of a complex patients, each problem is not so complicated; complexity is the interaction of multiple problems. A care plan and action plan can be created for each of the separate problems

Example:

- Diabetes: care plan is lifestyle change and titrating medications
- Osteoarthritis: care plan is physical therapy, exercise program, anti-inflammatory medications
- Domestic violence: meet with social worker to make definitive care plan

Health coaching for complex patients

Reducing hospitalizations is both a cost outcome and a quality outcome



Best way to reduce hospitalizations is teaching yellow and red flags. Example CHF: increased shortness of breath, edema, or 3 pound weight gain are yellow flags. Coaching teaches

1) weigh yourself daily and if weight up 3 pounds, call care team or take extra furosemide

2) Reduce salt intake

3) Take medications faithfully

Take-home messages

Population-based care includes

- Panel management
- Health coaching
- Complex care management

Care management includes patient education, health coaching and medication management

Health coaching assists patients to gain the knowledge, skills, and confidence to become informed, active participants in their care

Health coaching is essential for all patients with chronic conditions

- Patients with 1 or 2 conditions
- Patients with multiple conditions and complex healthcare needs

Gradually, we are learning from experience how to care for patients with high costs and complex healthcare needs

Thank you for improving health care for the people of Michigan

Reminder

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  - To obtain your continued education credits please complete and return the evaluation form emailed to you
  - Include your name in the attestation request on the form
  - Return the form to Kristen.gildner@miccsi.org or fax to 616.608.4058
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