Care Management Models: Managing Patient Complexity and Caseload Capacity

October 25, 2022
1 PM – 2 PM

Agenda

1. Housekeeping and Introductions
2. Presentations:
   - Maria Basso Lipani
   - Joann Sciandra
3. Audience Q&A and follow-up

Housekeeping

1. Speaker will present for around 50 minutes
2. Q&A will take the remainder of the time
    - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar, if you would like to ask your question verbally, please indicate that when submitting your question and we will unmute you during the appropriate time of the Q&A session.
    - When you are called on, if your unmute button does not work try *6
3. Webinar is being recorded
    - Slides and recording will be available on the NAACOS website within 24 hours. You will receive an email when they are available.

Speakers

Melody Danko-Holsomback, VP of Education, NAACOS

Melody Danko-Holsomback, MSN, CRNP is the Vice President of Education for NAACOS. She has over 11 years of population health experience and was the CAO and Director of Keystone ACO prior to her current role. She has over 28 years of experience in nursing, including positions in outpatient and inpatient care, as a CRNP healthcare provider and as an IT analysts and performance consultant.

Joann Sciandra MHA, BSN, RN, CCM is the Vice President of Care Coordination and Integration at Geisinger, one of the nation's largest health care organizations. In her role, Joann is accountable for the oversight of outpatient Care Management services, Proven Health Navigator® (PHN) (Medical Home), Special Needs Unit and the Staff Development Department. Joann is charged with managing medical trends, designing, implementing and administering best practice disease and case management programs, collaborating with Geisinger's Community Medicine and other provider groups in the clinical transformation. Prior to her promotion to Vice President, Joann held the role of Associate Vice President of Population Health .She earned her Master of Health Care Administration Degree from Grand Canyon University, and her Bachelor of Science in Nursing Degree from Wilkes University. She is also a Certified Case Manager. Joann has been a co-author for several publications and has presented nationally in Singapore regarding Medical Home and Case Management.

Speakers

Maria Basso-Lipana, LCSW, Vice President, Care Management for Population Health

As the Vice President, Care Management for Population Health, Maria leads a team of social workers, care coordinators and nurses who provide support to patients at risk for avoidable utilization. Maria is a licensed clinical social worker with 15 years of experience at Mount Sinai. In that time she has worked to design and deliver programs that improve the care of vulnerable populations including one for transitional care that received several years of outcomes-based funding from the Centers for Medicare and Medicaid Services. Maria has presented at numerous conferences and has co-authored several publications on this work. Prior to joining Mount Sinai, she worked at Kaiser Permanente in San Francisco.

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Joann Sciandra, MHA BSN RN CCM
Vice President, Care Coordination and Integration

Geisinger

About Geisinger:

Integrated health system with $7+ billion in combined revenues

Strategic priorities

One Geisinger:	Geisinger Clinical Enterprise	Geisinger Health Plan

We care for patients

- **10** hospital campuses
- **130** clinic sites
- **24,000** employees
- **1,800** employed physicians
- **Joint Venture** Inpatient Rehab Hospital
- **Addiction** Treatment Center

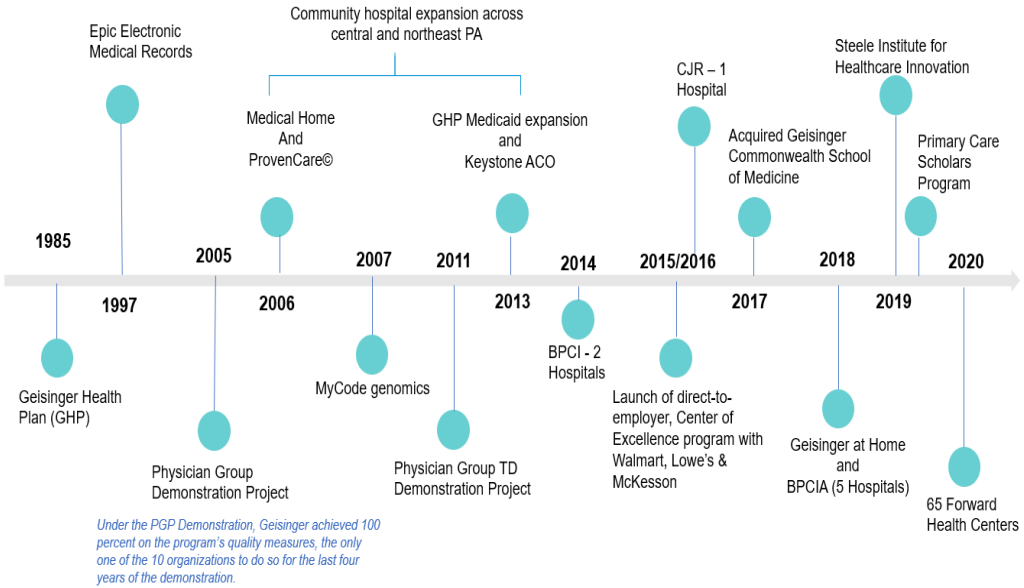
We care for GHP members

- **More than 600,000** risk lives managed
- **48,000** contracted providers in network

We teach, research and innovate

- **600** MBS/MD students at GCSOM
- **50+** students in School of Nursing, **2,300+** other nursing students
- **570** residents/fellows
- **1,000+** active research projects

Geisinger: 35 years of innovation

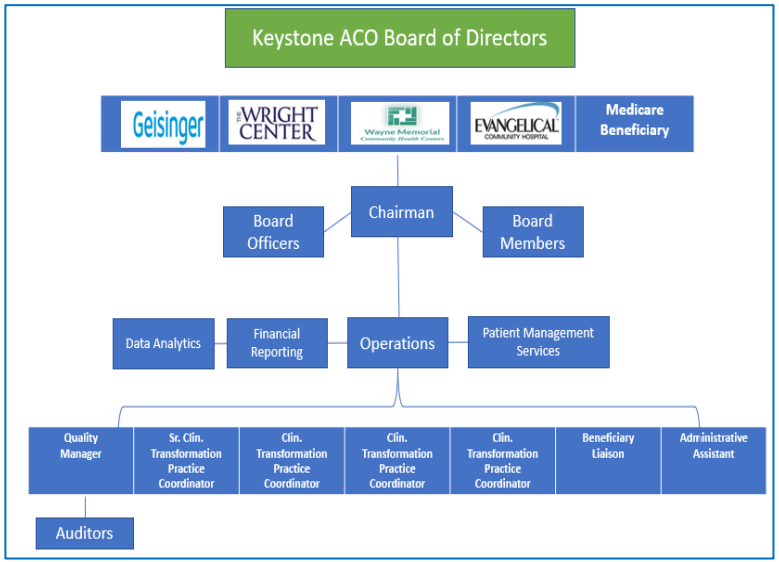


Under the PGP Demonstration, Geisinger achieved 100 percent on the program's quality measures, the only one of the 10 organizations to do so for the last four years of the demonstration.

Vision: Making better health easy	**Values:**				
	Kindness	Excellence	Safety	Learning	Innovation

About KACO:

Small administrative overhead spanning over 25 counties in PA



Additonal Keystone ACO Member Supported Positions			
Role	Partner Member	FTE	Status
MTDM Pharmacist	Wayne	0.5	Contract under review
MTDM Pharmacist	Evangelical	0.5	Operational-ongoing
Emergency Medical Tech	Evangelical	1.0	Operational-ongoing
At-Home Model-Midlevel	All	1.0	Started in Notheast- scaling
At-Home- CMA Support	Geisinger North East	1.0	Planning- to support Mid Level
Medication Affordability	Geisinger	2.0	Vacant --Under review
MIH Paramedic	Northeast	1.0	Vacant- Under review
Paramedic Coordinator	Northeast	1.0	Vacant- Under review
Case Managers CHA/CMA	All	variable	Operational- Ongoing-

PrimeMed MEDICAL GROUP

Geisinger

EVANGELICAL COMMUNITY HOSPITAL

FAMILY PRACTICE CENTER, PC

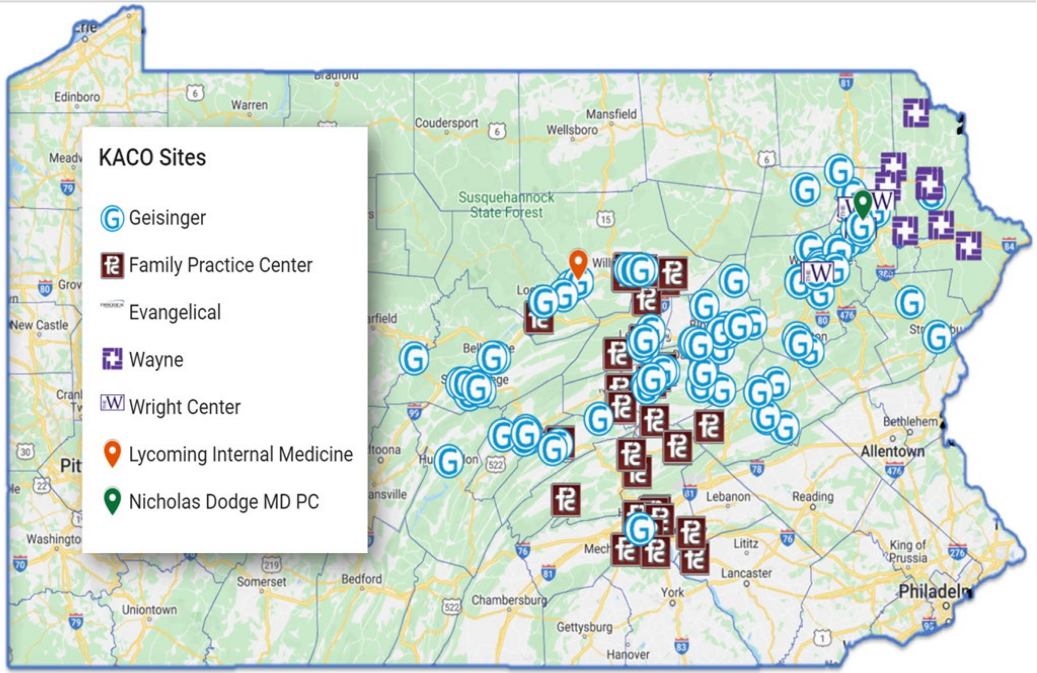
Dr. Nicholas Dodge, MD

THE WRIGHT CENTER

Wayne Memorial Community Health Centers

CommunityCare

Lycoming Internal Medicine



Creating a Care Model in our Communities

Supporting those with serious & significant health conditions


Home


Embedded


Telephonic

Coordinated Medical Care

- Comprehensive assessment
- Condition optimization & management
- Close coordination with PCP/SCPs

Integrated Social & BH

- Social determinants of health
- Behavioral health

Acute Care

- Mobile paramedics
- Case Management
- Home Health

Advanced Illness

- Plan of care
- Symptom management
- Palliative care
- Timely transition to hospice

Care Management

Remote Telephonic	Primary Care	Technology - Assisted	Specialty	Home Based
- Telephonic based RNs, Behavioral Health Case Managers and Community Health Assistants (CHA)	- Embedded RN CMs (Medical Home) - Behavioral Health Case Managers - Community Health Assistant - Seen as part of the practice care team	- Blue tooth scales for pulse oximetry, BP and blood glucose monitoring - 24-hour monitoring - Interactive Voice Response (IVR) for TOC -In-home video connectivity	- High risk OB - High Risk Pediatrics - "Transitions" for high risk children - COPD, HF, and ICU embedded RN CMs	- Complex patients - Provider lead - Interdisciplinary Team - Telehealth/Telemonitoring

Ambulatory Care Team

- Social Determinants of Health
- Benefit Management
- Chronic Condition Management
- Transitions Of Care

Risk Segmentation Model & Staffing Model

Care Management Model

- Care management is defined at six distinct levels, each level with unique FTEs, criteria, and processes
- The processes at each level will be performed with minimal variation across all lines of businesses

Population Segments and Cases Managed within Each Level

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Home-Based, Highest Cost, and Predictive Risk	**Complex Case Mgmt.** **Complex Predictive Risk**	**Specialty Care Mgmt.** **Special Needs Unit Peds** **Women's Health** **SNP**	**Behavioral Health**	**Transitions of Care (TOC)**	**Condition Management (to be addressed by CDMCC)**
• Highest utilization/cost members requiring predominantly In-Home Care, such as patients at end of life, with severe progressive illness, and/or truly are homebound • Complex post-discharge member needing in-home support	• Advanced/critical illness/ complex co-morbidities, requiring intensive interventions but expecting progression • Stabilized exacerbation(s), but still requiring intervention • Early identification, and is at risk for future utilization	• Qualifying conditions requiring specialized interventions which fall within an established administered program (e.g., Nephrology, Cardiology, Pulmonary, 65 Forward) • High risk/ complexity to stabilized SNU/Peds patients requiring interventions or Shift Care advanced interventions • Medicaid high, moderate, or low risk Women's Health patient with current pregnancy or post-partum • Dual-eligible SNP	• Primary behavioral health diagnosis, requiring intervention and SDOH needs • Stabilized behavioral health exacerbation(s), but still requiring intervention • Early identification of primary behavioral health driver, and are at risk for future utilization (e.g., unnecessary ED visits, etc.)	• TOC cases are members recently discharged from inpatient stays with 1-2 conditions and high readmission risk, needing short-term care of 30-45 days, with routine discharge protocol • Cases are screened and triaged upon intake to determine if it meets criteria for TOC, and if not, then are referred to Complex CM or Geisinger at Home • Significant population including Non-Geisinger GHP members	• Members requiring education or training to self-manage chronic conditions and/or high-risk health behaviors

Addressing Population Management:

Problem

- Increased need for Care Management (CM) services
- 50% of pts enrolled with an RN CM >9mo
- Capacity in the extended care team
- Sub-optimal use of tele-monitoring services
- No reliable way to report dosing and interventions
- Lacked a model to support patients that needed monitoring outside of a licensed individual

Plan

- Development of a playbook with defined dosing, intervention and length of enrollment
- The Extended Care Team defined roles to support the playbook
- Expansion of telemonitoring with set criteria
- Formation of a command center to support patients upon graduation from CM
- Enhancement of risk stratification model
- Staff education and validation
- Built the playbook within our documentation platform

Risk Stratification – Complex Case Management

Intensity Tier 1

- 2 weeks; longer if unstable

Week 1: Minimum of 3 patient contacts per week
- All 3 contacts licensed: Minimum of 1 OV, HV, or TM (BYOD)
- First contact within 24 hours, to include bottle-out med review and 3 red flags (licensed-driven Telephonic)

Weeks 2+: Minimum of 3 patient contacts per week
- Minimum of 2 licensed contacts: OV, TM, Telephonic, HV or CHA-assisted HV if needed)

Provider (PCP/Specialist) contact within 1st week; thereafter, every 2 weeks while in Tier 1 if no progression to Tier 2
- TM visit (BYOD)
- Provider visits count as licensed visits above

Questions?

Geisinger

Mount Sinai Health Partners (MSHP) Care Management: Patient Segmentation & Stratification

Maria Basso Lipani, LCSW

Vice President, Care Management for Population Health

Mount Sinai Health System

October 25, 2022

Mount Sinai Health Partners

Intentions for today

1. Provide a high-level overview of our Care Management model

2. Review our approach to patient identification (segmentation and stratification)
   - Highlights our partnership with our internal Analytics team
   - Leverages our technology
   - Maximizing our interdisciplinary team

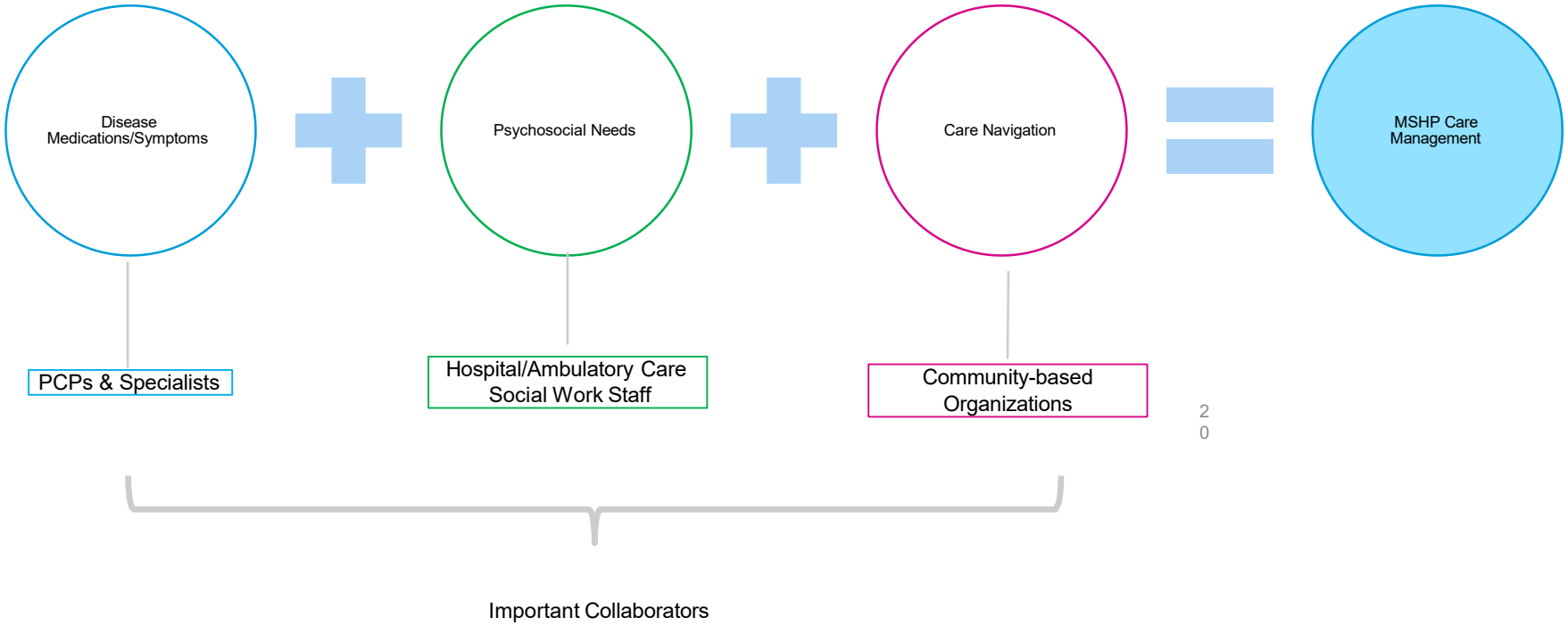
Mount Sinai Health Partners Care Management Model

Fives Key Areas of Impact

What are the biggest drivers of financial performance?

1. Risk Adjustment
2. Inpatient Stays
3. Emergency Room utilization
4. Post Acute Stays
5. Specialty Care

MSHP Care Management Model of Care



MSHS Social Care Ecosystem: A Continuum of Care to Meet Patients' Needs

Patient Target Group Level of Risk/Complexity

Community Health Worker

- Light touch support for a broader group of lower risk patients with clear, simple needs OR…
- More intense, specialized support for a narrowly defined pt group (ex: COPD) or social care domain ex: housing)

Practice Embedded*

- Short term targeted interventions related to primary and behavioral health care access, self-management of illness, transportation and caregiving

MSHP Care Management

- Short or long term high touch, complex social care for high risk medically and/or socially complex patients in high value contracts

High Intensity Primary Care*

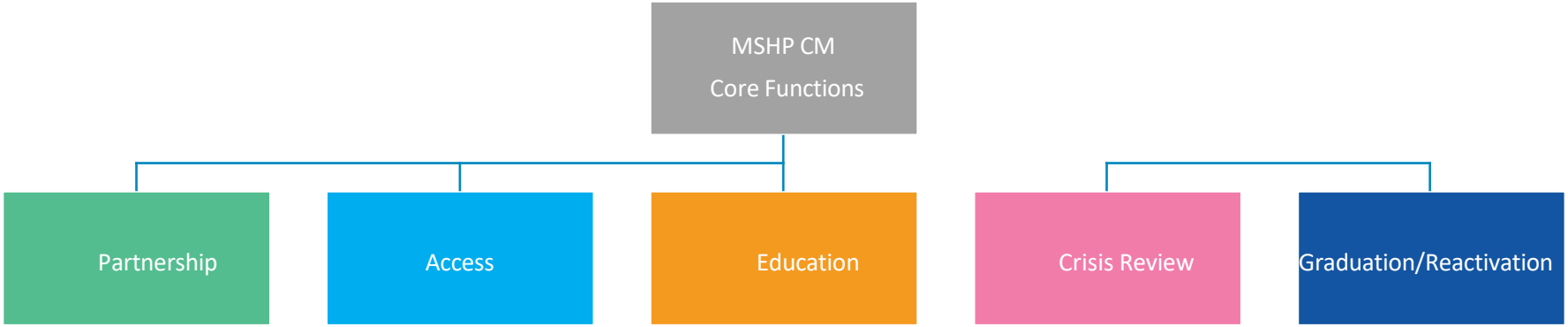
- Short or long-term intensive practice-based support around social needs in close collaboration with primary medical team

Step-Down as Patient Stabilizes

Escalate Based on Complexity

Draft: 6/12/22

MSHP Care Management Model of Care: Core Functions



Patient's perspective

What matters to them

What gets in the way of self-management

Alignment toward their goals

Strive for right care at the right time

PCP, specialists, home care, community supports

Linkage to our interdisciplinary team

What information would be helpful and could inform decision-making, and/or better support self-management of illness

Learning from every unplanned admission

Use learnings to strengthen our assessments and care plans

Apply to all patients

Instilling confidence in lessons learned/skills developed during intervention

Ensuring they know they can call us back

MSHP Care Management Model: Strengths

- Emphasizes meaningful engagement of patient/family as a crucial first step
- Interdisciplinary team
- Approach is to do *with* not *to* people
- Leverages technology at every turn
- Continuously endeavors to deepen our partnerships toward greater effectiveness & efficiency (hospitals, practices, payers, CBOs)

MSHP Care Management: Target Patient Groups

TOCs
(Transitions of Care)

NHHRs
(Non-hospitalized, high risk)

Direct Referrals
(Sent from providers)

Today's high risk discharges

"Tomorrow's admissions"

"Eyes & ears"

Our Approach to Patient Identification

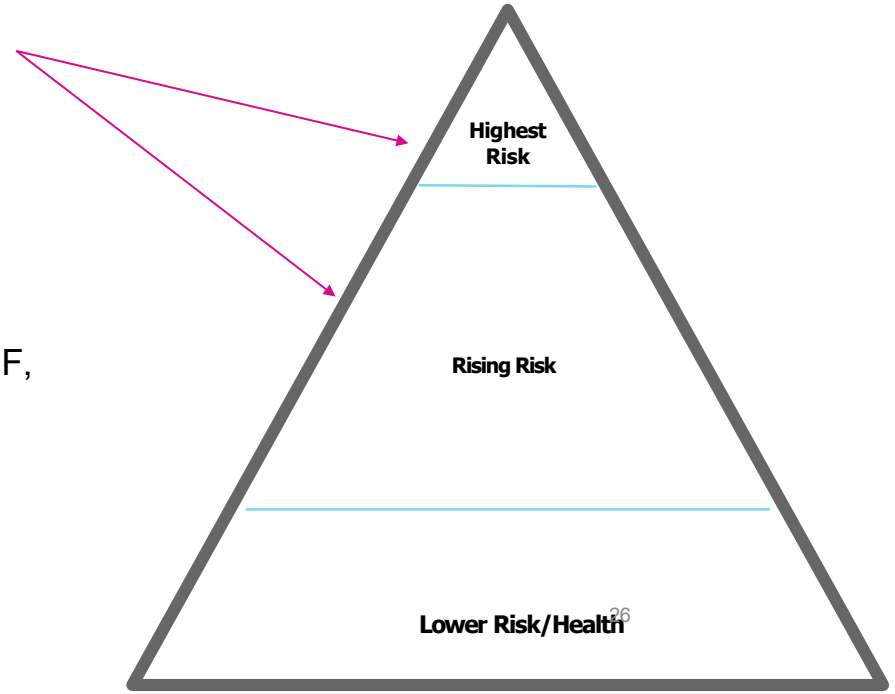
MSHP Care Management Target Patients and Initial Segmentation

1. **Chose a group of lives to target**
   - Today's discharges
   - Tomorrow's admissions

2. **Segment them by discipline**

Nurses: Focus is on patients with CHF, COPD, DM; those discharging from SAR

Social Workers/Care Coordinators: Focus is on other illnesses



* Our practices focus on a separate group; our quality team, another group – divide and conquer in every direction

MSHP CM Segmentation Strategy: Leverages Unique Qualifications by Discipline

Nurse Clinical Coordinators:

Focus is on patients with CHF, COPD, DM; those discharging from SAR

- Med Rec post-discharge (TOC)
- PCP appointment in 7 days (TOC)
- Disease Management (TOC & NHHR)
- Connectivity to social work as appropriate (TOC & NHHR)

Social Workers & Care Coordinators:

Focus is on other illnesses

- Identify & address non-medical drivers of avoidable utilization (TOC & NHHR)
- Ensure access to primary, specialty care (TOC & NHHR)
- Preparation for program graduation – patient self-referral for rising risk (TOC & NHHR)
- Connectivity to nursing, pharmacy, mental health as needed (TOC & NHHR)

MSHP CM Stratification Strategy:
Leverages our Analytics Tools & Provider Relationships

Today's high risk discharges

Use of Risk of Unplanned Readmission Epic Score (RoUR)

High/Very High

LACE+ for external admissions

Tomorrow's admissions

Use of Johns Hopkins ACG Tool

Risk of Unplanned Admission

No shows

Missed Rx fills

Race

Eyes and ears

Provider Concern

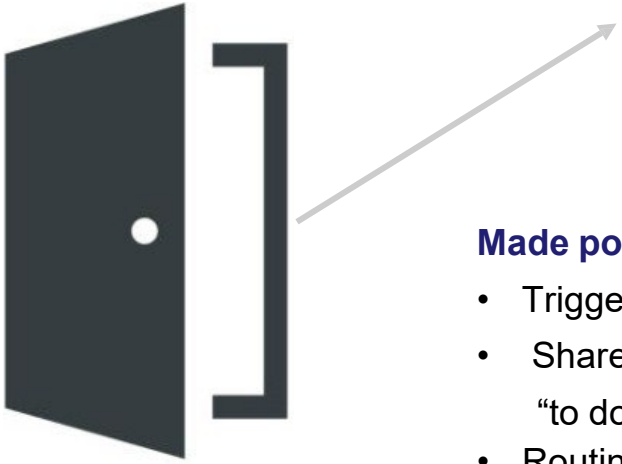
- Direct Referrals

Priority practices

Risk for unplanned admission

MSHP CM Stratification Strategy: Leverages Available Technology

One Front Door to Care Management…



Access to a multidisciplinary team… (Social Workers, Nurses, Care Coordinators, Pharmacists, Behavioral Health Therapists, Community-ParaMedicine, etc.)

Made possible by our Epic tools:

- Trigger questions
- Shared assessment content that autopopulates "to do" tasks
- Routing capabilities with urgency prompts on the landing page
- Patients lists that facilitate CM team huddles

Evaluating Effectiveness

MSHP Care Management: Evaluating Performance

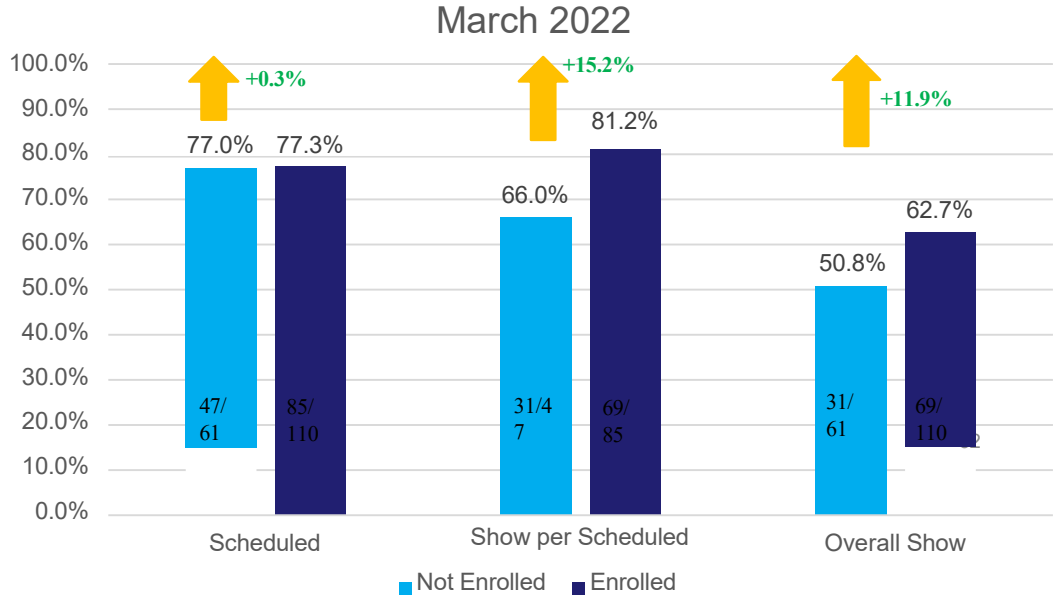
KPI	Care	Caid
Conversion Rate (Avg. Jan./Apr.)	57%	32%
Show Rates for Appointments at Tier 1 Practices (Q2 focus)	79.3% show rate	n/a
Show Rates for Appointments at Tier 2 Practices (Q2 focus)	74.4% show rate	n/a

Race (Black or Hispanic)	45.9%	75.2%
No Life Partner	64.1%	71.1%

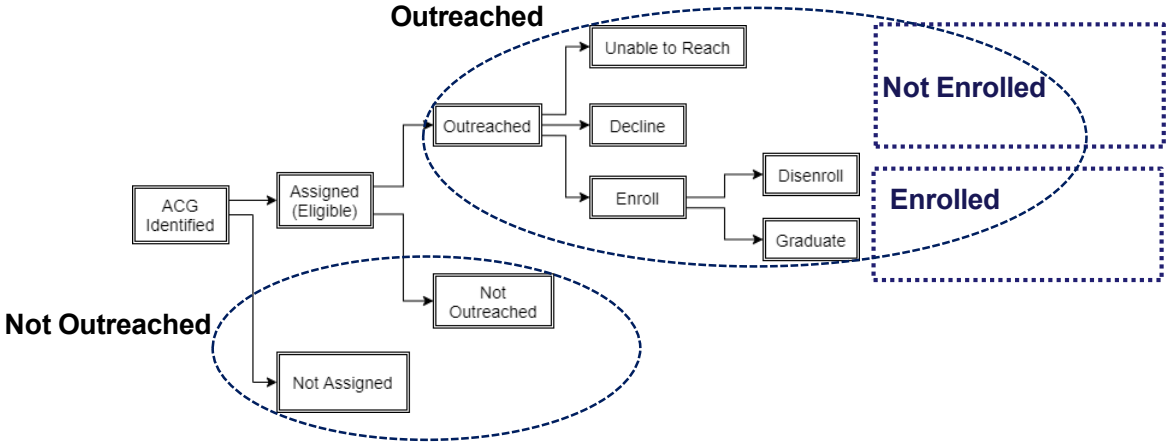
Show Rates TOCs in March - MSSP Only – Sample Analysis

Scheduled f/u visits and attendance are higher among CM enrolled

- CM “enrolled” are compared to those “eligible for CM but not enrolled”
- **Eligible TOCs = 171: Enrolled = 110 (64%), Not Enrolled = 61 (36%)**



MSHP CM Performance Overview: Comparison Groups 2023



Patient Satisfaction

MSHP CM Patient Experience

"Thank you for **treating me with dignity** despite all you've read in my chart."

MSHP CM Patient Experience

"You have helped me in ways no one has. **I feel empowered** and ready to meet all challenges because of how you have helped me. **You have taught me valuable things**."

MSHP CM Patient Experience

"Thanks for helping us understand the complexity of my child's chronic illness. Living with illness and adapting to illness has not been an easy journey for him."

Thank you!

Questions ?

Upcoming Events

Virtual Affinity Groups starting Thursday

- Operations Affinity Group: October 27, 2022, and January 26, 2023, from 3–4:00 pm ET
- Quality Affinity Group: November 3, 2022, and February 2, 2023, from 3–4:00 pm ET
- Data and Analytics Affinity Group: November 9, 2022, and February 16, 2023, from 3–4:00 pm ET
- Executive Affinity Group: November 17, 2022, and February 23, 2023, from 3–4:00 pm ET
- Clinical Affinity Group: December 1, 2022, and March 2, 2023, from 3–4:00 pm ET

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Contacts

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NAACOS general question: https://www.naacos.com/contact-us