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Care Management Operating Model

Suffolk Care Collaborative PAC Meeting

March 26, 2015

Objectives

- Share emerging thoughts on Care Mgmt. Operating Model, with focus on:

  1. Care Management Solution Vision
  2. Organization Structure for Patient Accountability
  3. Ideal Patient Journey

- Address questions on how the model will work in Suffolk County (Panel Discussion)

High-level Solution Vision for Suffolk County

Our vision is to augment existing CM resources with PPS-staffed CMs embedded (remote, and hybrid) across Suffolk County … while training existing staff

Existing CM Resources in Suffolk County

Health Homes

CM Agencies

Coordination

Coordination

5 X MCO CM
(Telephonic)

Existing Health Systems (e.g., NSLIJ, CHS-LI)

Suffolk Care Collaborative

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

Regional Pods

- Special Needs Units (Remote Centers)

PCMH/ Practice/ Clinics

- Embedded CM (high volume practices)
- Community Health Workers

Hospitals

- TOC CMs
- ER CMs

Embedded CM/CHW (PPS resource)

Provision of staffing, standards, and technology

Coordination only

CM – Governance Structure

The Clinical Governance Committee provides the CM leadership & vision – operational details and programs are developed by CM Operating Workgroup

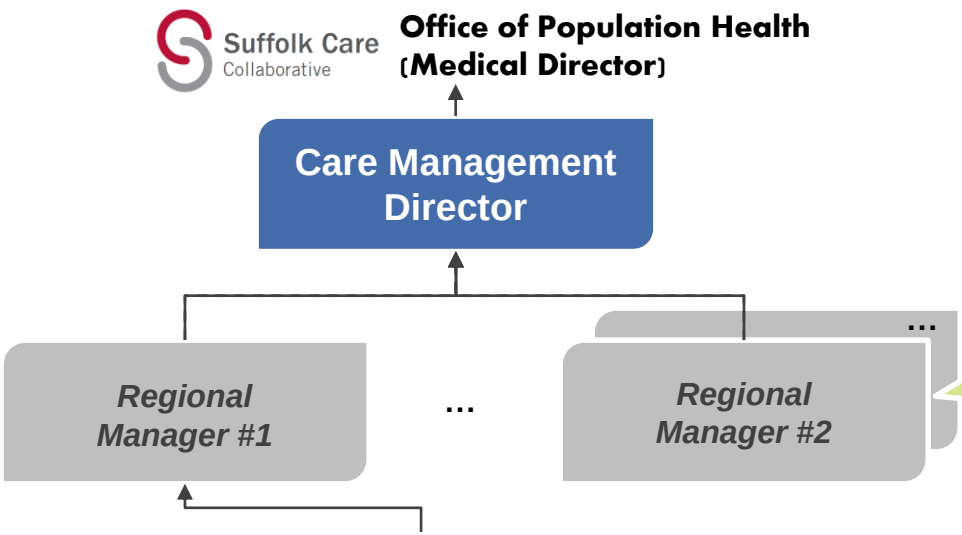
ILLUSTRATIVE

Representatives from …	Participate in …	Focus Areas
▪ Physician group reps and BH providers ▪ Health Homes ▪ Care Management Agencies ▪ IP hospitals and SNFs, NHs ▪ Home Health, Social Work, Hospice, Pharmacy, Other PPS providers ▪ Community Based Organizations ▪ Managed Care Organizations (ad-hoc as needed)	 **Suffolk Care Collaborative Clinical Governance Committee**	▪ Setting CM vision and strategy ▪ Clinical oversight and monitoring of progress ▪ Signoff on clinical protocols, standards, metrics ▪ Approve technology related to clinical interventions ▪ …
▪ All PPS provider organizations that provide a case management function that supports the PPS projects and patient engagement requirements ▪ (SCC care management team, HUB CM teams, Health Homes, Community CM agencies, and BH providers)	 **Suffolk Care Collaborative Population Health Operating Workgroup**	• Ensure effective operational implementation of the care management program • Ensure collaborative development of operational polices and standards required to meet DSRIP project requirements • Collaboratively share knowledge and resources around case management best practices • Identify risks, Troubleshoot challenges • Monitor results and key metrics • May spin-off subgroups on IT/Analytics, Communications

CM – Organization Structure

Regional Managers will lead CM pods; Each CM pod will have both "Co-located" and "Remote" CM centers that are comprised of RNs, SWs, CHWs, Coaches, etc.

ILLUSTRATIVE



NOTE:

- Regional managers are generally RNs (CCM preferred)
- Matrixed to SCC and Practices
- Accountable for execution of CM model in region

Regional CM Pod #1

A. Co-located in Provider Setting

Comprises: RN CMs

Locations: High volume PCP offices, EDs, Hospitals, FQHCs

Focus:

1. Provide CM services to high risk/at-risk patients
2. Leverages services from "Remote" CM centers for social work, health coaching, lay worker (CA), CHW etc.

B. Remote CM Centers (Non Co-located)

Comprises: Social workers, RN CMs, Health coaches, Asthma CHWs[1], TOC and Care Associates

Locations: Remote centers, with option to travel

Focus:

1. Provide CM services to support patients not attributed to an embedded (high volume) practice

2. Provide non-CM services to support co-located practices

Note: Some CMs, SWs may be sourced through Schools of Nursing, Social Work in Suffolk County

Organizing for Patient Accountability

Who is the patient's quarterback across various care settings/ transitions?

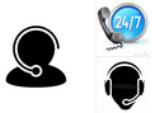
ILLUSTRATIVE

1 Medicaid Health Home & CM Agencies

- Primary responsibility for all Health Home patients
- Collaborate with PPS Care management Team

2 PPS Care Management

2A. PCP Co-located



2B. Remote Center

- Primary responsibility for all other patients (applies to PPS and PPS Hubs)
- For high volume PCP sites, CM co-located … otherwise remote center CM
- High vol. ED, Hospitals have TOC Care Manager – resp. for handoff to OP CM
- CM leverages:
  - ❑ care team resources (social workers, care associates, asthma CHWs, CDEs, etc.)
  - ❑ community resources (churches, food banks, agencies …)

3 MCO Care Management

UnitedHealthcare · EmblemHealth · healthfirst · Affinity Health Plan · Fidelis Care · …

- Primary responsibility for all Utilization and Benefits Management
- Handle all complex benefit exceptions for out of network, transplants etc.
- Collaborate with PPS Care Management Team

Illustrative Patient Journey in Ideal State

Whole person care model. Fewer dropped handoffs. Connection to services. Availability of access slots.

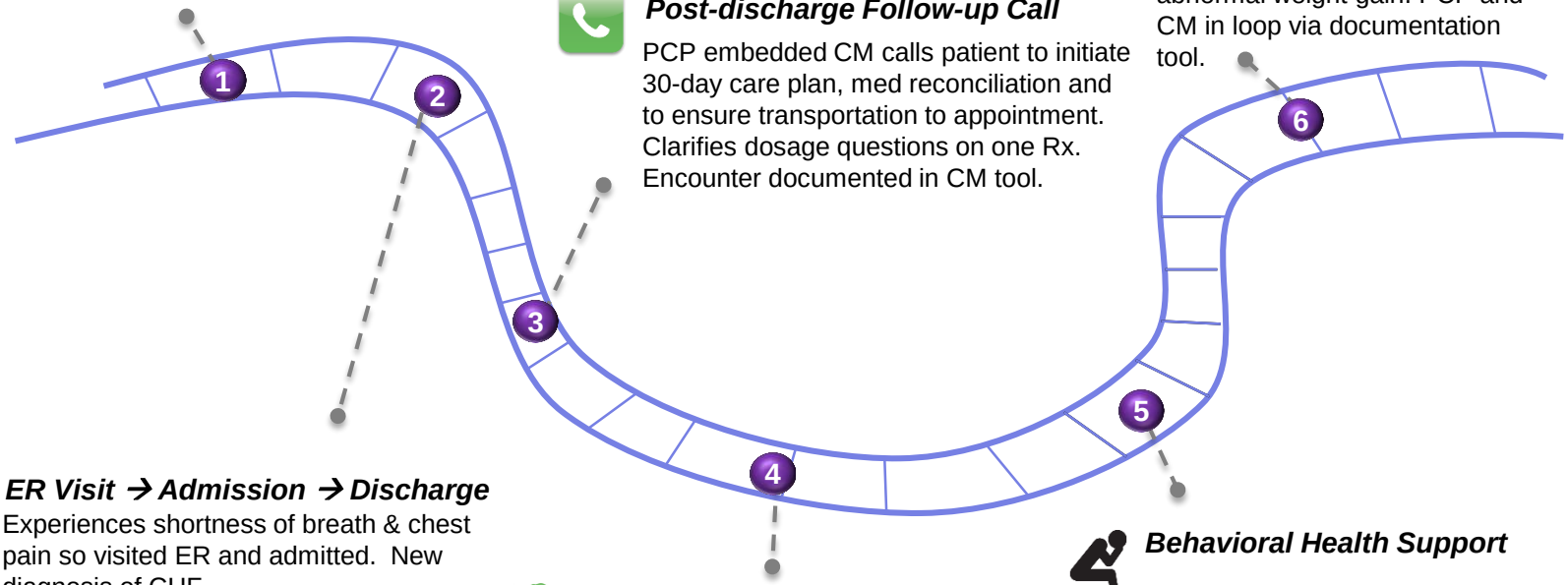
ILLUSTRATIVE

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
- Divorced, Unemployed
- Medicaid



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.

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.

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 with OP CM via IP EMR to CM documentation tool

Post-discharge Visit

PCP confirms patient is getting better 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.

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.

Panel Discussion

25 minutes of Care Management Q&A

Dr. Kris Smith (NSLIJ)

VP and Medical Director Care Solutions (the NSLIJ Care Management Organization)

Dr. Chuck Baumgart (xG Health)

Sr. Medical Director at Geisinger and xG Health, responsible for standing up the Medicaid insurance line at Geisinger

Dr. Roni DeKoning (Assn. for MH&W)

Deputy Director for the Association of Mental Health & Wellness. Deeply involved in the Medicaid Health Home initiative.

Joann Sciandra, RN BSM CCM

VP Population Health at Geisinger Health Plan responsible for CM, DM, Wellness and medical home strategy and implementation

Dr. Susmita Pati (SB)

Chief of Primary Care Pediatrics at Stony Brook Children's. Leads the Keeping Families Healthy program for pediatric asthma

Samir D'Sa

Sr. Director at xG Health responsible for NY DSRIP services