Innovations Managing High Risk Patients: Intensive Outpatient Care Program

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PBGH Mission: To be a change agent creating increased value in the healthcare system through purchaser collaboration, innovation, and action, and through the spread of best practices.
Test & Learn: Intensive Outpatient Care Program

- **Boeing in Seattle**
  - IOCP in 2 self-funded commercial purchasers
  - Case management fee plus FFS for specialized MD-led teams within 3 Medical Groups
  - 18%-20% net reduction per capita spending vs. propensity matched controls

- **PBGH Pilot with Humboldt IPA with CalPERS and Utility Company**
  - Distributed rural county model within a distinguished IPA providing RN care managers into 25 private practices, with behavioral health/social worker support
  - Case management fee to IPA for care managers, FFS payments to providers
  - 16% savings in first year

- **$19 million CMMI HCIA award to PBGH to support care re-design for high-risk, medically complex patients**
  - 15,000 patients enrolled over three-year period
  - 23 participating care delivery systems in 5 states (CA, AZ, AZ, NV, WA)

- **California State Innovation Model (SIM) will include model for Medicaid health homes**
Strawman Identification Criteria

1. Predictive Risk Scoring OR

2. Utilization criteria AND
   - 2 + admissions, in last year, with one in last 6 months
   - 6 or more ED visits in last year

Other stratification criteria:
   - 5+ medications
   - 3 or more active specialists
   - Behavioral health diagnosis
   - 3 or more chronic conditions

3. Clinical Review/Referral
IOCP Guardrails

- Longitudinal 1:1 relationship between care coordinator and patient
- Warm handoff to relevant support services
- Two way communication (phone, email or in person) at least once per month during acute phase, with intensity decreasing as patients reach stability
- Care coordinators complete a face-to-face “supervisit” within 1 month of enrollment
  - Assessment with PAM, PHQ-2, and VR-12 tools; also medication reconciliation
  - Use of motivational interviewing to gather information
  - Support patients’ shared action plan & work toward at least one goal per year
- 24/7 access, with communication to care coordinator next business day
• Serves as a link to primary, specialty and ancillary services.
• Guides patients through the development of a shared action plan (what the patient wants to work on).
• Provides referrals to behavioral, psychosocial and community services.
• Care coordinators work closely with patients, build trust and coach them in self-management skills and behavior change.
• Team huddles to tier case load, manage and monitor program, ensure workforce engagement.
Early Results*

- Opt-in Enrollment rate = 76%
- PAM scores
  - 37% increase
  - 45% same
  - 11% decrease
- VR-12 scores improved
  - Physical health by 3.3%
  - Mental health by 4.2%
- PHQ scores improved by 31%
- Reduced Emergency Department visits and readmissions: estimated 21% savings**

*The research presented here was conducted by IOCP
**Milliman longitudinal analysis of 18-month continuously eligible beneficiaries
Key Learnings

- Psychosocial elements are key for engagement and support
- Opportunities for payer alignment
- Challenge in FFS environment
  - Care coordination code helps, but doesn’t offset all cost
  - Medical neighborhood reimbursement needed