CORPORATE COMMITMENT

Support and empower PMS care teams to improve our patients’ experiences with the health care system and their health outcomes as well as reduce per capita cost of care

Align with our MCO partners- working together to improve care
THE THEORY

• A “small” portion of patients account for a disproportionate share of costs

• Employ a methodology to identify these and other high-risk patients

• Develop a care management program to manage the care of these patients and address Determinants of Health

• Align PMS care teams to goals of program while concurrently adjusting existing workflow

• Relentless focus on Quality Measures
High-Risk, High-Cost Group is First Priority

Developing a Comprehensive Strategy

Ensuring the sickest, most costly patients are well managed
- Are you able to identify high cost/high need and risking risk patients? (Patient Stratification)
- Do you have point-of-care tools to steward team member workflow (CM workflow tools)
- Can you monitor the return on your engagement effort? (Care Team Insights)

Leveraging analytics to support a comprehensive primary care strategy
- Are analytics meaningfully underpinning your PCMH work by providing support for the management of broad quality requirements? (Community Care)
- Do you have tools to easily segment and monitor patients based on clinical condition or other variables for focused campaigns? (Precise Patient Registries)
- Do you have tools to engage and manage your employees health? (Catalyst4Health)

Using data to unearth opportunities for systematic improvements
- Do you have the ability to identify variability and areas for improvement at the clinical program level to drive systematic improvement? (Clinical and Operational Apps)
- Are you able to identify the greatest areas for inappropriate utilization? (Patient Harm)

CARE COORDINATION MODELS- WHAT WORKS?

Successful VBP demonstration projects*:

- Embedded Care Coordinators
- Robust HIT
- Target populations with modifiable risk
- In-person contact with patients
- Close coordination between care coordinator and PCP
- Timely information on hospital and ED admissions
- Coordination of care transitions and close follow up
- Patient self-management support and activation, including medication education
- Social support

*Multiple Sources- AHRQ, Commonwealth Fund, National Coalition on Care Coordination

** Success: wide variation 3-30% decrease in cost
PMS MODEL: HYBRID WITH CARE TEAMS

Our care teams are comprised of:

- Patients and families
- Primary Care Providers
- Primary care clinical support staff
  - Nurses (RN, LPN) and Medical Assistants
  - Community Health Workers- Embedded
  - Care Coordinator I- Embedded
  - Peer Support Workers
  - Customer Access Representatives
  - Outreach Specialists
  - Clinic Administrators
- Centralized Care Coordinators
- Behavioral Health Professionals
- Dental Professionals
- Pharmacists
- HIT staff- Centralized
THE TANGIBLE

Patient Background
- Mary, a 56 year old with diabetes in Eddy County living in a homeless shelter
- CC was informed by shelter staff that Mary was a difficult woman and hard to work with
- Mary was previously living with a partner who abused drugs and was verbally and physically abusive
- Mary was admitted to a BH hospital stating she, “finally broke and wanted to die.” She says she really didn’t mean it, but didn’t know any other way out.

Identified Problems
- Homelessness
- Trauma
- Unmanaged diabetes

Care Coordination Interventions
- Met with Mary at the shelter and established a trusting relationship, having called her and updated her regularly on the research the CC was doing to help Mary find housing
- Called and visited many local rental low income housing apartments, real estate agencies, and assistance programs obtaining information and applications
- Discussed basic diabetes management and provided educational materials; CC will continue visiting and helping Mary manage her diabetes
- Taught Mary the importance of and how to maintain a Personal Health Record and encouraged her to see healthcare providers
- NextGen PTA sent to provider for a new glucometer and supplies since Mary left all her diabetes supplies when she left her abusive living situation
Outcomes

• Mary has a BH appointment with PMS for an assessment and with a PMS PCP for diabetes assessment

• CC facilitated Mary moving to the Women's Battered Shelter until another more permanent home is found

• Mary is beginning to fill out her apartment application forms

• Mary loves her Personal Health Record (PHR), totes it around with her, and keeps it updated to improve interdisciplinary caregiver communication

• Mary expressed being very grateful for the help of her CC in finding more appropriate housing and for caring for Mary’s health and social needs
# LESSONS LEARNED

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<td>Significant up-front investment/ Capital Intensive</td>
<td>Numerous success stories such as Mary’s.</td>
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<tr>
<td>• Technology</td>
<td>Increased organization’s resources</td>
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<td>• Workflow modifications/disruption</td>
<td>Improved care team communication/patient engagement</td>
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<td>Partnerships</td>
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<td>• Communication lines</td>
<td>Improved relationship with MCOs/successful partnership moving Care Coordination closer to the point of care</td>
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<td>• Patient engagement</td>
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