Presbyterian Medical Services VBP Update

Presentation to MAC
April 23, 2018
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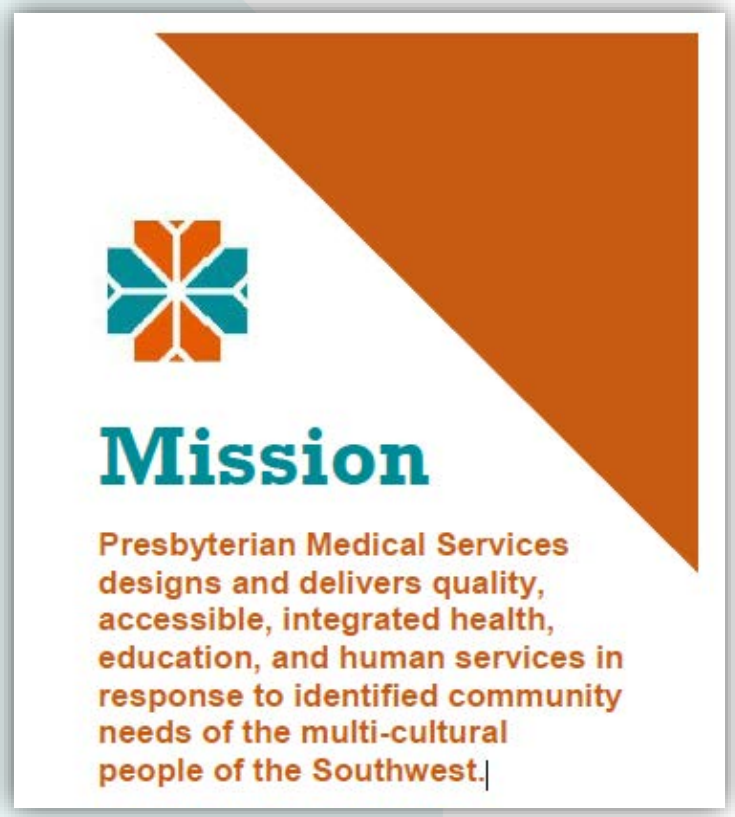
CORPORATE COMMITMENT

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



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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

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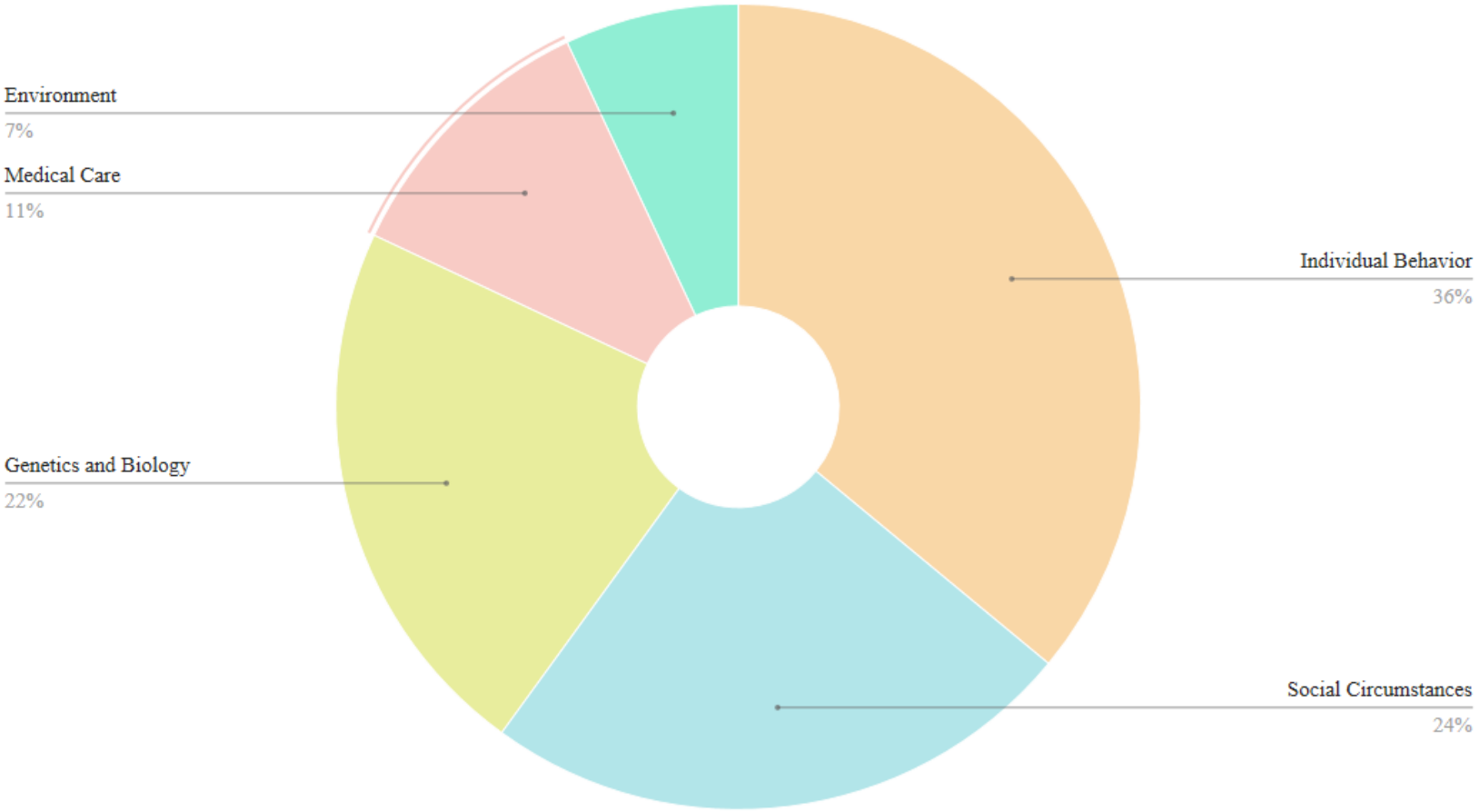
DETERMINANTS OF HEALTH



https://www.goinvo.com/features/determinants-of-health/

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High-Risk, High-Cost Group is First Priority

Pyramid of Risk

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 efforst? **(Care Team Insights)**

First priority

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 ares for improvement at the clinical program level to drive systematic improvement? **(Clinical and Operational Apps)**
- Are you able to identify the greatest areas fo inappropriate utilization? **(Paitent Harm)**

Required for LT sustainability

https://www.healthcatalyst.com/healthcare-total-cost-care-analysis-vital-tool

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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

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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

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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

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CONTINUED….

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

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LESSONS LEARNED

Challenges

Significant up-front investment/ Capital Intensive

- Technology
- Workflow modifications/disruption
- Human Resources

Partnerships

- Communication lines
- Data sharing
- IT systems

Complexity of agreements/Organizational Sophistication

Human Element

- Patient engagement
- Patient treatment compliance

Feet in Two Worlds

- Managing FFS and APM

Successes

Numerous success stories such as Mary's.

Increased organization's resources

Improved care team communication/patient engagement

Improved Clinical Quality

Positive financial results

Improved relationship with MCOs/successful partnership moving Care Coordination closer to the point of care

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