Interagency Care Teams [ICT] for High-Risk Patients

Creating the Future of Aging
Area Agencies on Aging Association of Michigan
Annual Conference - May 19 & 20, 2016

Area Agency on Aging, Inc.
SPECIALISTS IN AGING

Offering Choices for Independent Lives
Health Care Partnerships in process…

1) **MI Health Link** – Aetna & Meridian contracts
   Examples: vendor management, monitoring, coordination, assessment

2) **Great At Any Age** – 4AM Mich. Health Endowment Fund
   Examples:  
   a) Medicare accredited nutrition classes/therapies
   b) Health Plan/local purchases – balance classes

3) **Interagency Care Team [ICT] for High-Risk Patients** – multiple state & local funders
   Examples: transition/health coaching; ongoing care management
Healthy Berrien Consortium

1998 – Mission
Healthy Berrien Consortium [HBC] adopted a conscious strategy of pursuing data-driven collaboration and integration to continuously improve the health and wellness of the entire community.

Membership
Area Agency on Aging
Berrien Cy Dept. of Human Services
Berrien Cty Health Department
Berrien Cty Medical Society
Cassopolis Family Clinic
Consortium for Community Dev.
Hospice At Home

InterCare Community Health Network
Lakeland Health
Riverwood Mental Health Authority
United Way
Assorted Community Leaders
Area Agency on Aging: Region IV
Health System: Lakeland Health
FQHC: InterCare, Cass Family Medical Clinic
Public Health: Berrien Co. Health Dept.
Behavioral Health: Riverwood, Woodlands
PCP Groups and Specialists
• **Long-Term Goal:** Develop a local model for effective management of chronic diseases that includes coordination of services from both healthcare agencies and social service agencies.

• **Short-Term Goal:** Develop a local model for the effective management of congestive heart failure (CHF) that minimizes the need for inpatient hospitalization and encompasses both healthcare and social services.
Purpose:

To link persons with multiple chronic health conditions requiring ongoing services and supports with flexible interagency care teams that promote self-direction and person-centered planning to achieve positive health outcomes.
Interagency Care Team [ICT] links care management/health coaching functions across agencies for high risk patients

Payment Structure:
Initially self-funded by partners: AAA, hospital, PCP groups, FQHCs, Health Dept., other

Foundation(s) - 4 local entities funding services, evaluation & payment model development for scalability

Planned – bundled payment for flexible team participation, FFS for desired carve outs

AAA Services:
Health coaching; care management
Value Expectations...

Interagency Care Team [ICT]
• Better health outcomes for targeted high risk patients/consumers
• Reduced hospitalizations
• Less duplication & fragmentation of effort
• Development of payment model for sustainability
Early discussion revealed numerous issues:

• Need to reduce frequent hospital readmissions and unnecessary ED visits

• Need for increased communication & access to services between different service entities (both clinical and non-clinical)

• Understanding specific barriers that patients face in seeking healthcare/other services or complying with a plan of a care
  Transportation
  Education
  Funding
  Caregiver support
  Etc.
Community Roadmap

1. A few activities happen just before discharge to help prepare patient for CHF management after their hospital stay. 2. At the time of discharge, patients will either go home (with or without family/friend caregivers) or go to a non-hospital healthcare facility. 3. Multiple agencies have staff that help guide patient’s through the process of managing CHF as an outpatient and these people become involved around the time of discharge. 4. Patients may go home following their stay in a non-hospital healthcare facility. 5. Outside of the hospital, the primary care provider (PCP) is likely to be providing a majority of the patient’s healthcare services. 6. There are numerous community resources that help deal with both the healthcare and social needs of CHF patients. Some of those resources tend to be focused primarily—although not exclusively—around education while others tend to be more focused on direct services—but likely also include an educational component. 7. There are multiple vehicles for accessing those resources, some of which provide opportunities for funding. 8. CHF patients face numerous barriers that impede their ability to take full advantage of all available resources.
ICT Steering Committee:
Maintains vision, values, assures collaborative efforts, outcome tracking, champions development across entities

ICT Selection/Operations Committee
Creates list of high risk patients with frequent use of hospital and/or ED services; refines ICT operations as needed to achieve goals
Target population

Targeting criteria:

• persons dually eligible for Medicare and Medicaid,
• co-morbidities of 3-4 chronic diseases or conditions
• consideration of the involvement of a Primary Care Physician
• persons seen as likely to benefit from the intervention
• frequency and volume of hospitalization and/or ED visits
### ICT Project Key Elements

<table>
<thead>
<tr>
<th>Patients &amp; Caregivers</th>
<th>Providers (Health and Social Services)</th>
<th>Resources</th>
<th>Technology</th>
<th>Process</th>
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</thead>
<tbody>
<tr>
<td>In-Home Assessment, Health Benefits Counseling &amp; Health Coach visits</td>
<td>Aligned objectives</td>
<td>Interagency Care Team including CM functions across health and social service sectors</td>
<td>Web-based Care Management communication tool</td>
<td>Improved Care Coordination</td>
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<tr>
<td>Chronic Disease Self-Management Training</td>
<td>Access to timely data/information sharing across health and social services sectors</td>
<td>Community Roadmap of full array of health and social services and supports</td>
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<td>Chronic Disease Management</td>
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<td>Caregiver education and support</td>
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<td>Barrier identification/home stabilization</td>
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<td>Improved population health</td>
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<td>Coordinated care management/increased monitoring to reduce unnecessary care and utilization of appropriate setting of care</td>
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<td>Reduced cost</td>
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ICT Intervention Phases

- Enrollment
- Intensive
- Maintenance
- Monitoring
Interagency Care Team [ICT] Evaluation Design

Berrien County Health Department - oversight & management

Evaluation Components

1) Patient Surveys – pre and post (every 6 mo.)

2) Systemic Changes
   a) Process changes within ICT member agencies
   b) Common patient education tools: CHF, Diabetes, COPD

3) Patient Outcomes
   a) specific health markers
   b) evidence of self-management/stabilization

4) Cost Reduction
Committee Roles - Meeting frequency

**ICT Steering Committee**: Meets monthly to monitor project implementation, provide oversight, champion development across entities and troubleshoot any barriers to project success.

**ICT Selection/Operations Committee**: Meets monthly to refine project operations, achieve workplan objectives and identify/select patients for participation.

**IT committee**: Key IT personnel from partner organizations meet as needed to identify solutions to project communication tool needs.

**Care Team Huddle**: Weekly telephonic care conferences to address most pressing care coordination needs of pts.
ICT – Care Team Roles

Care Team Lead:
- Serve as patient’s Single Point of Contact
- Actively manage care/coordinate services
- Gather info/data
- Develop plan of care to include self-management goals
- Reach out to team members – provide updates
- Initiate Care Conferences as needed
- Update on-line communication w/patient encounter info

Care Team Members:
- Update on-line communication tool w/patient encounter info
- Participate in care conferences as needed
- Share info/data - Provide updates
- Weekly telephonic care conferences/team huddle
Online HIPA-compliant Communication Tool:
Resource Connection

- Team members populate encounter information/patient data/comments and upload files
- All team members receive email alert when new patient information is added. Coded low, medium or high priority

Phone:

- Direct dial info shared for CMs across participating agencies for streamlined access to phone care conferencing.

In Person:

- As appropriate, team members meet with patient together to do a warm handoff. E.g. AAA Coach introduced at PCP visit or in Hospital.
Key Communication Themes

- ICT members’ work has been impacted by broader understanding of how the patient interfaces with the system
- A firm hand-off that includes confirmation of the information received is more efficient and leads to better care
- Working together allows education to move into the realm of reiteration of new “collaborative” goals
  - Joint-issued education materials
  - Reiterating discharge instructions
  - Consistent patient goals with each agency
  - Reinforcing the message that patient received last week from different provider
  - Consistent metrics to know about (2lb vs 5lb)
Progress toward goals: Patients

Goal #1: Improve health outcomes and reduce costs

6 months post ICT intervention Patient survey results:
• Pts indicate “I know who to call if I am getting worse or feeling bad” (86%)
• Pts indicate that rather than immediately presenting to the ER, he/she would telephone a known contact for advice first. (86%)
• Only one patient thought they would definitely be going to the ER or hospital in the next 30 days

Reduced utilization example:

Patient had 8 ED visits and one hospitalization in the 12 mos previous to ICT enrollment.

ICT Team able to coordinate care/stabilize health. nIN 2015 pt had:
– zero (0) ED visits and
– zero (0) hospitalizations.
Progress toward goals: Patients – Eliminate Barriers

Goal #2: Facilitate access to services, community resources and other supports to reduce barriers

Barriers Identified

- Supplies needed
- Confusion w/care instruct
- Med management/compliance
- Home care/social support
- Med cost
- Transportation
- Med rec discrepancies
- Experiencing symptoms
- Cost of care
- Home modification
- Behavioral health
- Caregiving
- Dental care
- Food costs
- Housing
- Utility bills
- Vision Care

Conf what to do when experiencing symptoms

Other

Communication (phone disc etc.)
Progress toward goals: Patients

Goal #2: Facilitate access to services, community resources and other supports to reduce barriers

Six month BHP report results (Apr-Sept 2015):

41 service/supports connections were made to reduce barriers and achieve patient health goals.

91% of barriers were resolved through coordination of care and connection to community resources, services and supports.
**Progress toward goals: Sustainability**

**Goal #3:** Provision of a cost-benefit analysis design and potential payment model to be used for project expansion, sustainability and replicability.

### Study – Plan – Test
- Body of evidence demonstrates need
- Broad coalition develops solution
- One-year beta test showed solution effective

### Implementation
- Implementation funding secured
  - **Berrien Health Plan**
  - (2015)

### Gaps identified
- **Project Coordinator / Project Evaluator**
- Salary Support
- Payment Model Consultant
- IT product refinement
- **Pharmacy consultations**
- **Nutrition Education**

### Sustainable Service
- Funding Secured for ongoing services through December 2017

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**Healthy Berrien Consortium**
- Berrien County Health Dept.
- Area Agency on Aging
- Lakeland Health
- InterCare (FQHC)

**Berrien Health Plan**
- Healthy Berrien Consortium
- Berrien County Health Dept.
- Area Agency on Aging
- Lakeland Health
- InterCare (FQHC)
- Riverwood (CMH)
**Progress toward goals: Sustainability**

**Goal #3:** Provision of a cost-benefit analysis design and potential payment model to be used for project expansion, sustainability and replicability.

### Interagency Care Team Project

<table>
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<tr>
<th>Study – Plan – Test</th>
<th>Implementation</th>
<th>Gap funding secured</th>
<th>Sustainable Service</th>
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<tbody>
<tr>
<td>Body of evidence demonstrates need</td>
<td>Implementation funding secured</td>
<td>United Way SWMI (2015-2017)</td>
<td>Funding Secured for on-going services through December 2017</td>
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- Healthy Berrien Consortium
- Berrien County Health Dept.
- Area Agency on Aging
- Lakeland Health
- InterCare
- Riverwood

- Berrien Health Plan
- Healthy Berrien Consortium
- Berrien County Health Dept.
- Area Agency on Aging
- Lakeland Health
- InterCare
- Riverwood

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**Key outcome:** Development and implementation of payment model
ICT – Payment Model Development timeline:

<table>
<thead>
<tr>
<th>Development of a payment structure for project sustainability through 1) a bundled payment channeled through an entity created by Healthy Berrien Consortium; 2) development of fee for service (ffs) contracting mechanisms between key partners.</th>
<th>2016</th>
<th>2017</th>
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<tbody>
<tr>
<td>Analyze costing models and use patterns of varied services to establish a bundled payment system</td>
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<tr>
<td>Development of fee for service (ffs) and/or PMPM contracting mechanisms between key ICT partners</td>
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<tr>
<td>Establish entity following HBC/BHP model to receive a bundled payment with capability of paying varied ICT partners</td>
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<tr>
<td>Implementation and testing of bundled payment and/or FFS model(s)</td>
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Stabilized Health for Seniors with Multiple Chronic Diseases

Increased Caregiver and Social Support

Reduced Hospitalization/ED visits
Increased Primary Care

Sustainability through Establishment of Payment Model
Questions?

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