Care Management & Accountable Care: A Tale of Two Patients

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International Comparison of Spending on Health, 1980–2010

Average spending on health per capita ($US PPP)

Total health expenditures as percent of GDP

Notes: PPP = purchasing power parity; GDP = gross domestic product.
Source: Commonwealth Fund, based on OECD Health Data 2012.

“Triple Aim”
Accountable care depends on one key activity, more than any other:

Care Management
Why is care management the integral component of population health management?

What is Care Management?

- **A Definition**
  “Consistent processes - coordinated over time and among diverse service organizations and clinical practices by a centralized team - to identify and address patients’ comprehensive medical, behavioral health, and social needs.”

- **Another Definition**
  “Care management is patient and family-centered coordinated services and supports across the healthcare continuum of care: inpatient, outpatient, emergency care, and primary care. The goal of care management is to optimize the patient’s health and well-being by developing and implementing an integrated service and support plan in partnership with the patient, family and others who care so the patient’s quality of life is maximized, utilization of healthcare services is appropriate and services are provided in the community at the lowest level of care possible.”
A Simpler Definition

Care when, where, and how it is needed.

A Case Example:

A 54 year-old man has struggled with diabetes for many years. He now has moderate heart failure, has peripheral vascular disease with a poorly healing leg wound, and has developed mild renal insufficiency. Medication compliance is poor and the patient requires repeated emergency department visits. He has had multiple hospitalizations in the past year.

A Case Example:

A 54 year-old man has struggled with diabetes for many years. He now has moderate heart failure, has peripheral vascular disease with a poorly healing leg wound, and has developed mild renal insufficiency. Medication compliance is poor and the patient requires repeated hospitalizations and emergency department visits.

What do we really know about this man?
Suppose you learned that he:

- Moved to AZ two years from the east coast and has no family in the region
- Sleeps in the forest or at the community shelter
- Has a history of psychotic depression
- Has no health insurance
- Was prescribed 17 medications following his last hospitalization

*Do you view his “case” differently?*

**Another Patient Story:**

An 83 year-old woman was recently discharged from the hospital following hip replacement after a hip fracture. She had been previously healthy, without any chronic medical problems.

*Would additional information change her care after hospital discharge?*

**How does the additional information on these patients change care?**
Life context matters

Home location is important

"Care Traffic Control"

- Functioning as a "care traffic controller", a Care Manager coordinates service connections for each patient's diverse needs - over time - with an emphasis on what each patient needs to get and stay well.

99.989%
98.6%
How do we turn such a framework into consistent clinical processes?

**Assistance with Daily Needs**
- Transportation
- Child care services
- Grocery shopping

**Behavioral Health Needs**
- Depression & anxiety screening
- Access to timely behavioral health services
Structured Medical Care Processes

- Consistent approaches to care through Care Process Models are critical.
How is it possible to address all these “ABCS”?

Comprehensive assessment is the first step
Population Risk Stratification: 5 Tiers

1. Highest need patients
2. Chronic conditions, poorly controlled
3. Chronic conditions, stable/controlled
4. Abnormal biometrics, otherwise well
5. Well

Highest Need Patients

1. Shelter?
2. Food and safety?
3. Behavioral health needs?
4. Transportation?
5. Medication adherence?

Care Management Fundamental

Form new partnerships

New Partnerships
THRIVE
Translational Health Research Initiative

- Mission Statement
  - The THRIVE (Translational Health Research Initiative) partnership will encourage and support innovative population health research to improve health outcomes for all of the communities across Northern Arizona.

- THRIVE Objectives
  - Objective 1: THRIVE will support collaborative (outcome-oriented, evidence-based) research efforts that build a strong clinical, behavioral, and community health research hub in Northern Arizona;
  - Objective 2: The founding partners of THRIVE (NAU and NAH) will proactively seek additional partners that can contribute to the overall mission of the THRIVE initiative.

GOAL: To Anchor the Northern Arizona End of the Arizona Biosciences Corridor

THRIVE Projects

- Precision Medicine and Transitional Care for Cardiac Disease: Flinn Foundation
- Building Culturally Congruent Transitional Care Models for Anglo, Hispanic, and Native American Populations

- Shi’Hooghan (NAH Foundation)
  - This project will connect GIS data about Navajo patients’ home location with community and clinical resource information about primary care clinic location, Tribal and IHS outreach worker information, and other data that are key to successful care transitions for patients after hospital discharge.

Flinn Foundation Project

Precision Population Health Management: Integrated Paired Proposals for Personalized Transitional Medicine for Native American, Hispanic, and Anglo Populations in Northern Arizona

Collaborations for Native American Health
2nd Quarter Meeting - April 10th, 2014
AHCCCS COLLABORATION

- Improved care management
  - For adult members of the American Indian Health Plan with high need, high cost conditions
  - Through collaboration with key partners in behavioral health, primary care, and community-based services
Innovation is vital

Mobile Technology Fact Sheet

Highlights of the Pew Internet Project’s research related to mobile technology.
(Note: This page will be updated whenever new data is available.)

As of January 2014:

- 90% of American adults have a cell phone
- 58% of American adults have a smartphone
- 32% of American adults own an e-reader
- 40% of American adults own a tablet computer
“Real-Time Telehealth”

- Videoconferencing-based services
Opportunities:

- There are many ways that innovation can support care management service delivery
- And there are many examples of how such innovation has already been used in health care
“It’s just feeling that backbone there to have support. You know it does touch you emotionally because who else is watching out for you?”

Care Beyond Walls and Wires

Measure

ENT Consultation

• Statewide experience in Alaska
• Consultation extended in 2006 to eastern Washington
  – “Expert triage” model

FMC Readmission Reduction

![Figure 13: HF 30-Day Readmission Rates](image)
Note: Percentages may not add to 100% due to multiple outcomes per case.

About 73% of the patients seen needed something done (meds, surgery, ongoing monitoring) and 27% needed to be screened out.

Alaska ENT Outcomes (n=897)

- 27% Unnecessary & cases were archived without sending
- 22% Referred for monitoring
- 19% Meds started
- 19% Referred to regional ENT clinic
- 23% Surgery or testing recommended at ANMC
- 5% Refer to other specialty

What does the horizon look like?

AHCCCS Care Coordination Development Work Session

“Care Traffic Control”

- Functioning as a “care traffic controller”, a Care Manager coordinates service connections for each patient’s diverse needs - over time - with an emphasis on what each patient needs to get and stay well.
Care Management
Fundamental

It's about relationships.

IPC Care Model

Community

Health Care Organization

Decision Support

Clinical Information Systems

Self-Management Support

Delivery System Design

Prepared, Proactive Community Partners

Prepared, Proactive Care Team

Safe

Efficient

Patient-Centered

Effective

Timely

EFFECTIVE RELATIONSHIPS

Improved health and wellness for American Indian and Alaska Native individuals, families, and communities

Activated Family and Community

Informed Activated Patient

“Protective Factors”

Conclusions
The influence of social relationships on risk for mortality is comparable with well-established risk factors for mortality.
Let’s return to the 2 patient stories …

54 year-old gentleman:

- Many medical problems
- Lives in the forest or at the community shelter
- Feels overwhelmed by all his medications
- Likes Flagstaff and wants to stay

*How can care management help?*

Housing is healthcare.
The Outcome

- The patient is eligible for housing in a 30 unit complex newly established in the community.
- Daily home-based services are provided through a care management aide
  - supervised by a local care management nurse
  - using telemedicine
  - working in association with the wrap-around services available at the complex.
- The patient’s need for emergency department visits and hospitalizations significantly decreases

83 year-old elder:

- Recent hip fracture while herding sheep
- Lives with family on the Navajo Nation
- Does not have running water at home
- Is teaching her grandchildren Navajo

How can care management help?
The Outcome

• The patient stays an extra day in the hospital while transitional care services are arranged.
• Relatives in the community near the hospital care for her over the first week following discharge
  — A care management aide visits every day
• The patient returns home
  — A Tribal CHR visits daily, and then weekly
  — Daily smartphone video sessions occur
• She continues to herd sheep and teaches her grandchildren Navajo

Thank you

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In beauty may I walk.
All day long may I walk.
Through the returning seasons may I walk.
On the trial marked with pollen may I walk.
With grasshoppers about my feet may I walk.
With beauty may I walk.
With beauty before me may I walk.
With beauty behind me may I walk.
With beauty above me may I walk.
With beauty all around me may I walk.
In old age wandering on a trail of beauty, lively, may I walk.
In old age wandering on a trail of beauty, living again, may I walk.
If it finished in beauty,
It is finished in beauty.

DINE’ PRAYER