Care Coordination: An Integrated Approach to Improve Delivery Systems

July 20th, 2016
Today’s Presentation

• List 3 benefits of system-wide care coordination
• Identify 3 components of an effective care coordination program
• Identify 4 data-sharing strategies that have been successfully used for care coordination

Reaching across Arizona to provide comprehensive quality health care for those in need
Group Discussion/Activity

• Break into 3 groups according to number assignment
• Decide on note taker and spokesperson
• Discuss assigned scenario:
  - What is needed to coordinate care for this member?
  - How would you share member data?
  - With whom would you share this member’s data?
  - What staff should be involved in coordinating care for this member?
  - How would you know if you successfully coordinated care for this member?
AIHP Member Scenario #1 (fictional)

- 59 year old male – has unstable housing, frequent medical crises, and does not routinely take meds as prescribed
- Medical history includes uncontrolled diabetes, advanced heart disease, and behavioral health issues related to chronic substance use
- Past 6 months:
  - 23 ED visits
  - 6 IP admissions in which 3 were 30 day re-admissions
  - Member has filled >30 prescriptions at IHS/638 facilities.
- Enrolled with the TRBHA, but has not yet accessed any services
AIHP Member Scenario #2 (fictional)

• 42 Male- Lives with his sister when he is in town, but often goes to see relatives and friends living in New Mexico
  • Data shows that he has had 23 ED Visits related to pain, including out of state visits to EDs, no IP claims for the past 6 months
  • Alcohol & Depression screening at least 5 times in different facilities
  • Multiple Rx’s led to current Rx assignment
  • Extremely transient, lack of housing, multiple incarcerations
  • Is enrolled with a TRBHA but has never accessed services
AIHP Member Scenario #3 (fictional)

• 39 AI Female-
  • Behavioral health and substance use issues, and meets SMI criteria, enrolled in RHBA but not compliant, her case manager lost contact with her, she is endanger of having her son placed with DCS
  • A review of her Rx data shows that she filled 330 Rx in the last year and at least 212 during the current year
  • History of medical non-compliance, limited mobility, hearing impaired
American Indian Health Program

- 120,000 Americans Enrolled in FFS – one-third of Arizona American Indian population
- $1 billion per year - $650 m to IHS/Tribal 638 providers
- Limited care management infrastructure – compared to MCO capacity – staffing and payment
- Vast geography – majority of members in 3 counties – Coconino – Apache – Navajo – 33,638 square miles – 2 MA and 1 Maryland
- Healthcare disparities – American Indians 4 times more likely to die from diabetes than non-American Indians AZ
Current System Limitations and Challenges

- Scale of fragmentation is significant given broad network that American Indians may access for services and the geography of Arizona
- Resource limitations of Indian Health Provider Organizations to share or receive actionable data
- Limited resources within AHCCCS to create more scale around care management platform
- Historical limitations of Medicaid and other payers to cover costs of care management infrastructure
Essential components for care coordination

- Persistence
- Buy in from leadership
- Strategies for data sharing

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AIHP Efforts to Date

Staff – added new resources including BH manager and physician

Relationships – Have traveled statewide to visit Tribal providers and stakeholders

Data – Sharing data with 14 different organizations on member utilization

Model – Have 130 members in active care management with providers
Data Sharing Strategies

• Privacy statement- guidance around when information can be shared
• How the data will be shared- care coordination for 25 vs. 500
• Notifications- 24/7 vs. adminstration
• Staff/Partners- Clarify who has access to different kinds of data
Check out the Announcements/Updates

- **Last Name, First Name - Every Member has been changed**
  - 2/25/2016 3:38 PM
- **Week of Jan 25-29th - Huddle Board Stats - Sample Demo**
  - 1/27/2016 10:04 AM
- **T/RBHA Phone List 01 26 16**
  - 1/26/2016 2:03 PM
- **Gila River site up...**
  - 9/16/2015 10:39 AM

Did you Check the Calendar?

**April, 2016**

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Look Here! Informative Web Links

- **Super-Utilizer Summit Review 2013**

Getting Started
- Share this site
- Change site theme
- Set a site icon
Indian Health System - Improving Patient Care (IPC) Model

Community

Health Care Organization
- Self-Management Support
- Delivery System Design
- Decision Support
- Clinical Information Systems

Safe > Efficient > Patient-Centered > Effective > Timely

Equitable

Activated Family and Community
Informed, Activated Patient

Prepared, Proactive Community Partners
Prepared, Proactive Care Team

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

AHCCCS
Arizona Health Care Cost Containment System
Evaluate progress, identify markers of analyses

- Analyze member activity before and after care coordination efforts.
Care Coordination Lessons Learned

- Member utilization data drives the interventions that are developed.
- Consider a member’s basic needs in offering effective treatment/services (Housing, food, safety).
- Develop an individual care plan with the member, based on the member’s presenting issues.
- Use natural resources and observe/adjust when there’s a lack thereof.
- Remain strength based while being very honest.
System Benefits

- Improve population health
- Enhance experience and outcomes
- Reduce cost of care
Transformation Strategies

• Behavioral-Physical Health Integration
  o Care Management for members with complex needs
  o Health Information Exchange
  o Value Based Payments

• Justice System Transitions

• American Indian Care Management capacity
What is DSRIP?

- Federal funds administered by the Centers for Medicare & Medicaid Services (CMS)
- DSRIP initiatives provide states with funding that can be used to support providers in changing how they provide care to Medicaid beneficiaries
- DSRIP initiatives are part of broader Section 1115 Waiver programs
DSRIP Initiatives

Figure 2
States are using DSRIP waivers to help achieve larger health system and Medicaid goals for delivery system reforms.

Delivery System Reforms

Improve Population Health

Enhance Experience and Outcomes for Patients

Triple Aim of DSRIP and Delivery System Reforms

Reduce Costs of Care
DSRIP Initiatives (cont’)

• DSRIP is an incentive program where payment incentives are distributed for meeting performance outcome requirements

• Providers can use funds to develop systems, infrastructure, and/or processes
DSRIP Focus on Four Main Areas

- Infrastructure Development (Process)
- System Redesign (Process)
- Clinical Outcome Improvement (Outcomes)
- Population Focused Improvement (Outcomes)
Safety Network Med Home Initiative

- Engaged Leadership
- Quality Improvement Strategy
- Empanelment
- Continuous and Team-Based Healing Relationships
- Organized, Evidence-Based Care
- Patient-Centered Interactions
- Enhanced Access
- Care Coordination
- Reducing Barriers to Care

AHCCCS
Arizona Health Care Cost Containment System

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Medical Home Waiver

- The AZ 1115 waiver proposal includes an American Indian Medical Home waiver which would pay a PMPM to qualifying facilities
- IHS/Tribal 638 workgroup finalized the medical home waiver proposal in early June
- CMC project 4 has been proposed to align with the medical home waiver
CMC Development: (fictional)

- Member lives in Chinle but presents to FMC ED @ 10PM on Saturday
  - Regional care management is notified by a real-time 24 hour notification (via HIE) that the member is in the ED
- Regional on-call care manager contacts the FMC ED and supports the evaluation and disposition
- BH evaluation/support occurs real-time in the ED
  - Temporary housing, peer support, & BH follow-up are arranged
  - Admission is avoided secondary to access to care plan & post-discharge supports
- Follow-up appointments are scheduled, including transportation, and the member is safely discharged from the FMC ED
  - Care mgmt closely monitors– with CHR/PHN visits - to help with diabetes care and assure understanding of the treatment plan
- Chinle medical home engages member & outcomes gradually improve
CMS Preliminary Feedback (cont’)

• CMS indicated that support for IHS/Tribal 638 organizations may need to be structured as payments for services rather than payments for projects:
  o IHS/Tribal 638 provider organizations would be eligible for care management and medical home service payments, with expectations similar to previously-designed project core components
  o These services would be separate from those services currently eligible for the all-inclusive-rate (AIR) & payments would occur separate from existing AIR payments for services
Arizona DSRIP-Additional Information

• https://www.azahcccs.gov/AHCCCS/Initiatives/DSRIP/
• https://www.azahcccs.gov/shared/fiveyear.html
Contact Information

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Questions?

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Thank You