



Health Plan Innovations in Patient-Centered Care

Care Management



Health Plan Innovations in Patient-Centered Care:

Care Management

A publication of the Alliance of Community Health Plans

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Letter from ACHP's CEO

Dear Colleagues,

I am delighted to introduce the first publication in ACHP's series on Health Plan Innovations in Patient-Centered Care. This series, which focuses on work being done by our member plans to achieve the goals of improved population health, enhanced patient experience and more affordable costs, adds to the increasingly urgent discussion on how to deliver high-value care while bending down the health care cost curve.

Care management is an appropriate first topic for this series. Complex, chronically ill patients have traditionally been the most expensive and difficult to treat; almost half of all health care spending in the United States goes to only five percent of patients, many of whom have multiple health conditions as well as social, environmental or financial barriers to good health. Such patients often need and benefit from personalized care, tailored to their individual needs; care management nurses, many of whom work in partnership with social workers, nutritionists, pharmacists and other staff, can step in to supplement the care patients are receiving at their physicians' offices.

Such programs are offered by ACHP plans as a resource to both patients and providers. Patients get one-on-one time with a specially trained nurse who takes a holistic approach to care, rather than focusing on specific conditions. Primary care physicians, who are overworked and rarely have the time necessary to devote to helping these complex patients, appreciate the assistance that the health plans offer in improving patients' health and quality of life.

The 22 not-for-profit, community-based plans and provider groups that make up ACHP have years of experience offering care management services to their members. Their traditionally close partnerships with the physicians and provider groups who take care of their members, strong knowledge of their communities, and commitment to investing in the health of these communities have put ACHP plans at the forefront of innovations and successes in the realm of care management.

This report highlights best practices that our plans have developed, as well as challenges they face each day in their efforts to improve care and the experience of patients and their families. We hope that this honest look at care management models among ACHP plans provides a starting point for a nationwide discussion on the critical role that health plans and their provider partners can play in achieving better health and better health care, as well as a more affordable health care system.

Patricia Smith



President & CEO
Alliance of Community Health Plans

Executive Summary

In 2008, the United States spent more than \$2.3 trillion on health care; an estimated 75 percent of this spending was related to treatment of patients with chronic diseases and complex needs. Left unchecked, this spending will continue to grow as a result of an aging population and a fragmented delivery system.

In the past, health plans relied on disease management programs to improve health outcomes of patients with chronic diseases such as diabetes, heart failure or COPD. Over the past decade, however, there has been a growing recognition that patients with multiple chronic illnesses and complex needs – such as financial, behavioral or environmental barriers to good health – need more personalized, targeted interventions. Care management, which is the coordination of care for patients with complex health care needs, has emerged as a way of improving quality of care for these patients while reducing health care costs.

There are a variety of activities that care management nurses perform, including patient self-management education; medication reconciliation; environmental assessments of members' homes; referrals to community agencies, providers, and wellness resources; and coordination of care among a patient's multiple physicians. Such activities benefit both patients and their physicians as patients get personalized, one-on-one care and attention, leaving physicians free to work at the top of their license.

Successful care management programs involve face-to-face interaction with patients, close relationships with physicians, and knowledge of both community resources and environmental barriers to good health. The 22 not-for-profit, community-based health plans and provider organizations that make up the Alliance of Community Health Plans (ACHP) can provide the highest standards of care management to patients because of their close alignment with physicians and provider groups as well as their familiarity with and involvement in local communities. Health plans working closely with providers can coordinate care more effectively; care management nurses physically located in practices can work closely with physicians, complementing each other's skill sets. Regional health plans are well equipped to refer patients to local community resources and can understand region-specific cultural, linguistic and religious needs.

This handbook provides examples of ACHP member plan initiatives and best practices across a variety of care management-related topics including:

- how plans partner with practices and physicians to optimize patient care;
- innovative use of technology and software to support care management activities;
- financial assistance to practices that engage in care management;
- stratification of patients into varying levels of intervention; and
- a focus on measuring outcomes and the value of evidence-guided innovation, among others.

We believe that the lessons and practices in this handbook can be spread and applied to a variety of delivery models and health plan types. It is our hope that this handbook can serve as a resource for plans already engaged in care management, as well as those beginning work in this area.

I. Introduction

Sections

Background

About ACHP

About the Publication Series

Introduction to Care Management

BACKGROUND

In 2008, the United States spent more than \$2.3 trillion on health care.¹ Some of the causes of this spending are well known, such as advanced technology, high administrative costs and expensive pharmaceutical drugs. However, it has been estimated that 75 percent of total health care spending comes from services related to the treatment of chronic diseases such as diabetes or heart disease.² An aging population with increasing needs for medicine, monitoring and support will drive even more spending in the coming years.

While aging and illness are inevitable, expensive and inefficient health care is not. Research has shown that although the United States spends more than any other country on health care, it misallocates resources in the delivery system.³ The Patient Protection and Affordable Care Act (PPACA), enacted by Congress in 2010, includes among its provisions reforms that are aimed at improving health care delivery, including care management and coordination. These provisions of the law draw upon a decade of work from quality-improvement organizations such as the Institute of Medicine, the National Quality Forum, and the Institute for Healthcare Improvement. The collaborative approach these groups have taken in their work has enabled many communities around the country to build or remodel their health care delivery and payment systems. ACHP and its member organizations have adopted this model of community-based health care improvement, based on the goals of improving patients' clinical experience, the affordability of care, and the health of the population as a whole.

Measurement-driven improvement principles have guided several models into the mainstream of U.S. health care delivery. Over the last decade,

the patient-centered medical home (PCMH) model has been widely adopted as an upgrade from the patchwork of office visits, lab tests, and hospital admissions that continues to define many patients' health care. The accountable care organization (ACO) is an emerging model that builds on clinical reform efforts by incentivizing hospitals, medical centers, health plans, and entire health care communities to share responsibility for patients' outcomes at a target budget. Care management is a crucial element of both PCMH and ACO models, and will likely continue to spread as a standard health plan practice. Therefore, it is important to examine existing care management models and review best practices to form a foundation for future development of the model.

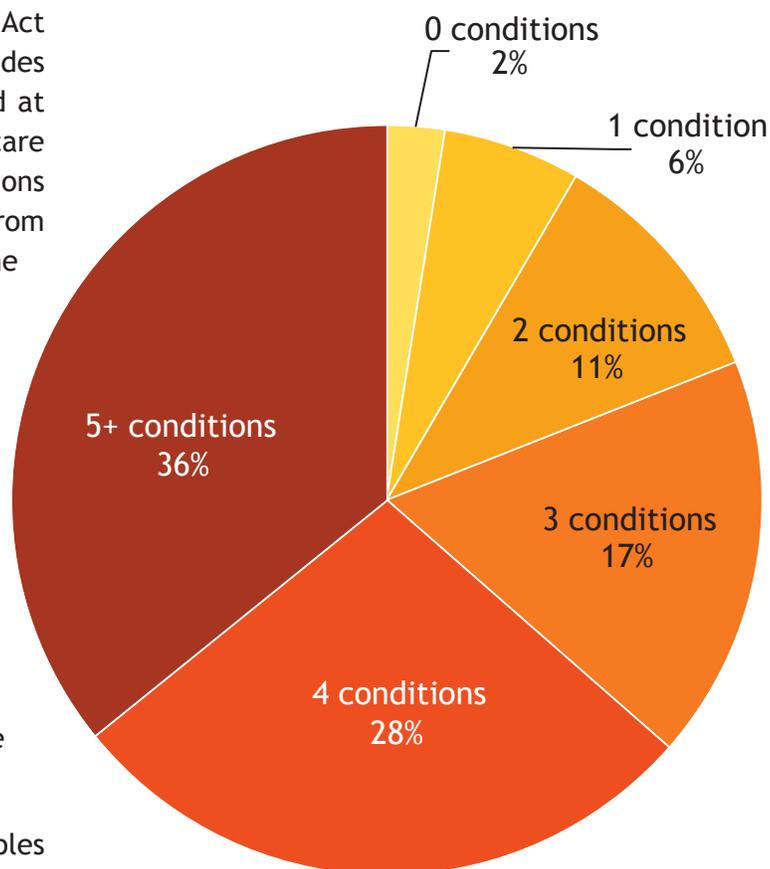


Figure 1: Percentage of per capita spending for patients with 0-5+ chronic conditions⁴

I. Introduction

This handbook is a cross-section of several approaches to care management that represent a diverse set of geographies, network arrangements, and populations among ACHP plans. Each plan has customized the basic principles and components of care management to fit the needs of its community. The various approaches and programs outlined here are

not simple solutions, nor is setting up a care management program enough to transform a primary care practice. Nonetheless, the plans featured in this handbook have much to contribute to the care management discussion based on their many years of experience setting up, implementing, and evaluating their programs.

ABOUT ACHP

The Alliance of Community Health Plans (ACHP) is a national leadership organization founded in 1984 that brings together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care in their communities. The 22 community-based and regional health plans and provider organizations that belong to ACHP improve the health of the communities they serve and are on the leading edge of patient care coordination, patient-centered medical homes, accountable health care delivery, information technology use, and other innovations that aim to improve affordability and the quality of care that patients receive.

ACHP members are:

- Not-for-profit health plans or subsidiaries of not-for-profit health systems, or provider groups associated with health plans. Member organizations are located primarily in mid-sized and smaller markets and have deep roots in their communities.
- National leaders in health care quality that annually rank among the top-performing health plans in the nation.

- Innovators in delivering affordable, coordinated, multidisciplinary care, and pioneers in the use of electronic health records.
- Role models for other health plans in innovating to achieve the industry's aim of better health and better care at a lower cost.

The plans profiled in this handbook represent a variety of delivery models, geographical areas, and member populations. At Group Health Cooperative, which serves more than 670,000 members in Washington and Idaho, almost 60 percent of members are aligned with plan-affiliated primary care physicians. Fallon Community Health Plan in western Massachusetts, on the other hand, has 170,000 members and an entirely contracted network relationship with independent physicians.

In spite of their differences, ACHP plans share a commitment to their patients and their communities that is reflected in the design of their care management models as described in Part II, which starts on page 12.

ABOUT THE PUBLICATION SERIES

The *Health Plan Innovations in Patient-Centered Care* series aims to profile the role health plans can play in advancing care. In particular, this series examines how community-based health plans can partner with medical practices and community-based organizations to deliver high-value care, serving as valuable resources to patients and physicians.

This first publication, on care management and the role of the care management nurse, examines the exceptional work being done by ACHP plans to manage care of high-risk, chronically ill patients with complex needs.

The second publication will discuss transitions of care from acute care to post-acute care settings. ACHP members have been leading the health care industry in developing care transitions programs that improve delivery system quality

and overall health of patients, and address costs for beneficiaries and their surrounding markets. To highlight these innovative programs, ACHP has commissioned Avalere Health to perform research, analysis and compilation of findings.

The third study will focus on patient-centered medical homes, primary care transformation, and the ACHP Primary Care Innovation Collaborative, formed in 2008. Members of this collaborative developed four PCMH standards specifically for community health plans, which focus on patient-centeredness and coordination, support of system integration, outcomes measurement, and value-based practice reimbursement. ACHP is partnering with Michigan State University in writing about the collaborative and progress its members have made in achieving the PCMH standards.

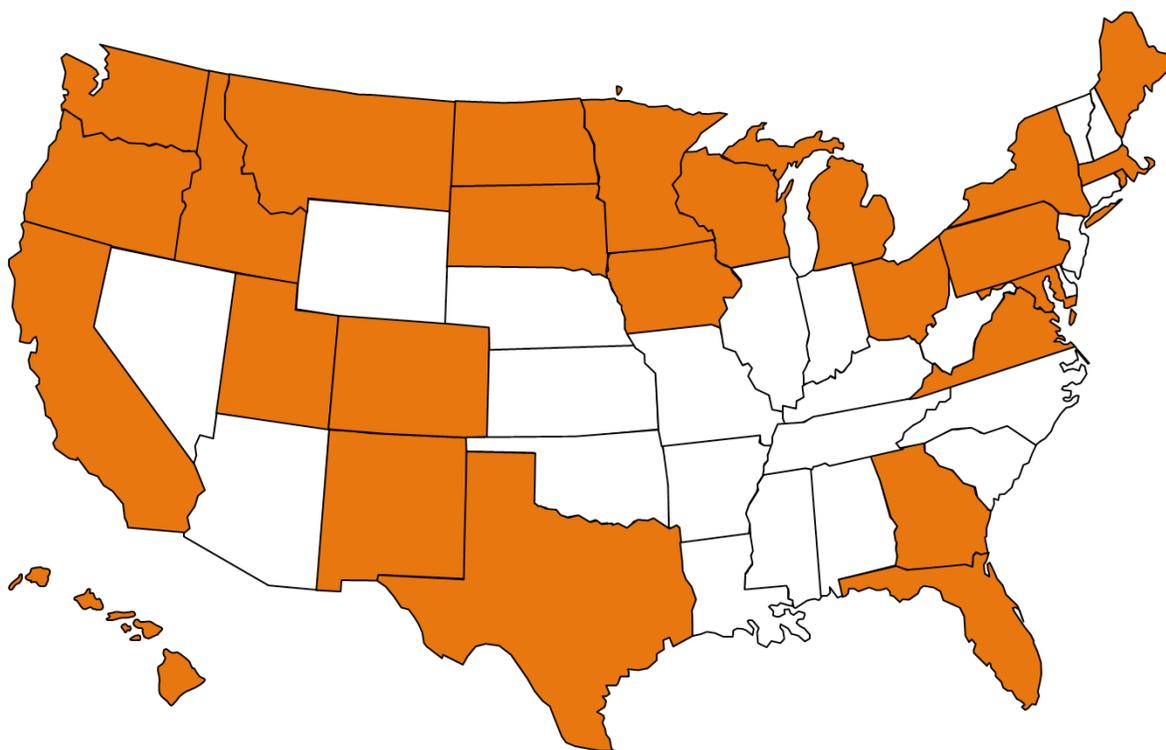


Figure 2: States containing at least one ACHP plan

INTRODUCTION TO CARE MANAGEMENT

Definitions

According to the National Committee on Quality Assurance, complex case management is:

the coordination of care and services provided to members who have experienced a critical event or diagnosis requiring the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. The goal of complex case management is to help members regain optimum health or improved functional capability, in the right settings and in a cost-effective manner.⁵

Activities generally seen as falling under the realm of care management are those that:

- Help patients and caregivers manage medical conditions and psychosocial problems more effectively, with the goal of improving their health;
- Coordinate care and reduce duplication of services; and
- Reduce the need for expensive medical services.⁶

This handbook uses the phrases *care management* and *case management* interchangeably, in reference to the above types of activities. Care management, as it is used here, involves a number of functions, which may include identification of members who could benefit the most from a program; patient/family education; care coordination among multiple providers; discharge support when members leave a hospital or other facility; medication management; patient engagement; linking patients to community services and other resources; ensuring that follow-up appointments are scheduled on time; and communicating with a patient's primary care physician. These functions are described in detail on page 26.

Care coordination is a separate activity that may be distinct from or part of a care management program. In this handbook, care coordination is defined as the coordination of care between and among multiple providers – such as primary care physicians, specialists, and physical therapists – and sites of care – such as clinics, hospitals, skilled nursing facilities, and patients' homes.

Disease management is defined as “a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.”⁷ This handbook considers disease management interventions to be population-based and focused on a single condition, such as diabetes or asthma; care management, on the other hand, focuses on the total person and managing multiple co-morbidities as well as psychosocial issues and environmental determinants of health. Interaction between disease management and care management at the plan level is described on pages 30 to 32.

Successful Care Management Programs

According to the Robert Wood Johnson Foundation, successful care management programs that have been shown to improve quality and reduce costs have the following characteristics:

- Appropriate patient selection
- Person-to-person encounters
- Specially trained care managers with low caseloads
- Multidisciplinary teams, including physicians
- Presence of informal family caregivers
- Use of coaching techniques⁸

ACHP programs, because of their close alignment with providers and commitment to patients, have incorporated elements of all of the above characteristics into their care management programs.

Case Studies

Care management holds the potential to increase the quality of life for people with multiple chronic conditions while decreasing costs. Many studies have highlighted the cost savings from reduced hospital and emergency room admissions as a result of effective, targeted and coordinated care,⁹ although there are difficulties in measuring outcomes outside of the research setting. The benefits to quality are more clear.

The following case studies, as well as those on pages 16, 27, and 34, illustrate the benefits of personalized care management.

Mrs. D

Mrs. D, a 79-year-old member of Capital District Physicians' Health Plan (CDPHP) in New York, was referred by her physician to a CDPHP case manager embedded in her physician's office due to an elevated HbA1C of 9% and fasting sugars above 150. She had a history of COPD as well as difficulty maintaining energy conservation, and her physician reported that she had poor adherence to blood sugar testing. In addition, Mrs. D was unsure how to use her new glucose monitor.

The CDPHP case manager sat down with Mrs. D at the clinic to assess her situation and come up with self-management goals. The case manager provided Mrs. D with names of CDPHP-participating diabetic educators as well as educational literature on COPD, a self-care handbook on living with diabetes, and information on portion control and nutrition. She also trained Mrs. D on COPD management, purse-lipped breathing techniques, energy conservation techniques, and how to clear her lungs. The case manager also taught Mrs. D how to do her daily blood sugar monitoring.

In addition, the nurse reviewed with Mrs. D potential dangerous symptoms of COPD as well as situations when she should notify her doctor immediately.

Thanks to this personalized education and face-to-face time, Mrs. D's blood sugar decreased and she reported dietary changes. She began testing finger sticks as prescribed by her physician and began attending diabetic education classes at a local hospital.



Mr. H

Mr. H was a Special Needs Plan member of UPMC Health Plan in western Pennsylvania, facing significant behavioral and mental health challenges. He was a high emergency room utilizer and had been admitted to the hospital many times before a practice-based care manager identified and engaged him. Mr. H was given his care manager's phone number and met with her one-on-one every time he visited his doctor. If he started panicking or having an anxiety attack, he called his care manager before going to the emergency room.

Mr. H's care manager spent hours with him, teaching him how to manage his pain medications, eat well, and manage his stress. Today, his inpatient utilization has dropped; he has gone from being one of the most frequent ER users at the plan to almost never having to go into the emergency department. Mr. H is happier because he has access to a clinician who is familiar with him and who he feels cares about him.

II. Care Management Models

Sections

The Plan-Provider Relationship

Use of Technology

Organization of Care Management
Systems

Funding and Payment Incentives

There are many common features of care management programs among ACHP member plans. Some of these are related to the NCQA complex case management criteria (QI 7)*; for example, all plans allow for a variety of referral methods, including self-referral or referral from caregivers, physicians, specialists, a utilization management department, or other people or organizations.

However, there also are significant differences in model designs across ACHP member plans due to a variety of factors, including geography, membership, and alignment with providers. Models range from fully centralized (where all care management is telephonic from a central location) to fully embedded (where health plan nurses work out of provider offices) to provider-owned (where the health plan assists provider-employed care managers). Caseloads may vary from 35 to 150 patients, and although some plans offer financial incentives to providers, others do not.

The populations targeted may include commercial populations as well as members of Medicare Advantage, Medicaid, CHIP, or Special Needs Plans. The types of sites in which health plans embed nurses are mostly primary care clinics (including both single- and multiple-practitioner

sites), but also include Federally Qualified Health Centers (FQHC), hospitals, specialist sites, and pediatric clinics. Sites chosen are generally those that give care managers access to populations that would most benefit from care management, including high-risk members.

Care management models also evolved in different ways and at different paces across ACHP plans. At Capital District Physicians' Health Plan, the case management program was fully formed when it was offered to physicians, due to providers' relative inexperience with such models. The model at Group Health Cooperative was developed in-house with advice from both their group practice and their network physicians. The model at Independent Health in western New York evolved together with the practices and began as a voluntary opt-in for high-functioning sites. Geisinger Health Plan had a strong centralized case management model but found it could enhance the effectiveness of its program by deploying its case managers directly into the practices.

The following sections – which focus on the provider-plan relationship, use of technology, organization of case management programs, and funding/payment incentives – highlight the variety, as well as best practices, among ACHP plans in each of these areas.

* 2011 NCQA Health Plan Accreditation Requirements; Quality Management and Improvement (QI) section 7, "Complex Case Management"

THE PLAN-PROVIDER RELATIONSHIP

One of the most salient characteristics of ACHP plans' care management models is the level to which the health plan works and interacts with both providers and patients. Although many health plans offer care management to their members, a significant proportion of this work in the United States is done telephonically, by a third-party vendor hired by a health plan. Such care management programs have failed to conclusively prove effectiveness on cost and quality measures and, according to health care researcher Soeren Mattke of the RAND Corporation, "payers and policy makers should remain skeptical about vendor claims" of cost savings.¹⁰

Embedding health plan nurses in a provider office allows the nurse to be seen as an extension of the physician rather than an extension of the health plan, which improves the patient's experience of truly coordinated care.

ACHP member plans go above and beyond the national standard when it comes to patient-provider-plan interaction by embedding care management nurses in provider practices and engaging with patients face-to-face. Such close contact between health plan nurses and providers has been shown to be an essential element of care management models.

Embedding nurses in practices allows for greater coordination of care between health plan nurses and patients' physicians; when a nurse works in the same office as a physician, they can meet on a regular basis to consult about patients, exchange notes, and discuss treatment plans. Arranging face-to-face visits with patients is

easier when a nurse works out of a physician's office, as patients can arrange to see the nurse before or after their appointment and clarify any instructions from the physician. In addition, as the director of care management at Group Health Cooperative said, embedding nurses "allows the nurse to be seen as an extension of the physician rather than an extension of the health plan," which improves the patient's experience of truly coordinated care.

When health plan-employed care managers are embedded in a practice, all of that practice's patients potentially benefit. When care managers assist physicians with care for the most complex patients, who often require significant one-on-one guidance, physicians are free to work at the top of their license and devote more time to treating all practice members. Physicians can also share best practices with care managers and learn from those managers' experiences.

Face-to-face visits are valuable for both patients and nurses, and especially so for vulnerable populations such as the frail elderly and those with special behavioral or other needs. Face-to-face visits at a physician's office allow a nurse to re-emphasize points that a doctor has made and confirm that patients understand everything their physician told them. Home visits made by a nurse or social worker allow the care manager to assess a patient's home situation and level of caregiver support, check for dangers in the house, and confirm with the patient, for example, which medications they take and how they are stored.

Embedded case managers can be a resource to providers as well as patients. Practices are often overwhelmed with large populations of complex patients,¹¹ and the direct presence of a health plan employee can go a long way toward building stronger relationships between insurers and

providers of care, while unlocking efficiencies in the way practice staff spend their time.

The following pages examine how care management programs at ACHP plans utilize the plans' close relationships with providers and communities to benefit patients.

Embedding Nurses in Plan-Affiliated Practices

ACHP plans are uniquely positioned for greater provider-plan cooperation due to their delivery models, which involve close relationships with physicians and provider groups. Group Health Cooperative (GHC) and Presbyterian Health Plan (PHP), for example, embed care management nurses in physicians' offices in the group practices with which they have contracted.

Group Health Cooperative is a consumer-governed health plan located in Washington State and Idaho, serving 580,000 members. It is a mixed-model network health plan that contracts with a large multispecialty medical group as well as with independent physicians in private practices. As part of its patient-centered medical home initiative, GHC has embedded nurse case managers in 32 primary care and specialty sites to provide assistance to the sickest one or two percent of members with complex chronic illnesses and multiple co-morbidities. Although case managers work out of the practices, their salaries are paid by GHC. These case managers meet with patients in clinics and communicate with them over the phone for education, to monitor their progress as well as any risk factors, track admissions and discharges to hospitals and emergency rooms, and coordinate care among primary care physicians, specialists, social workers, home health workers, and other specialists. Each clinic has a care manager embedded for at least four days a week. In larger clinics, GHC embeds one full-time nurse for every 14,000 members.

A clinic of 30,000 members, for example, would have two nurses working five days a week.

For GHC's contracted network practices, the nurse case managers live in the local areas and visit physicians on a regular basis. Each nurse has an assigned population of providers and manages patients referred by those physicians. Because patients are assigned to care management by providers, the nurses are seen as an extension of the physician or practice rather than as an extension of the health plan. Nurses working in the network frequently see patients face-to-face, and they are viewed as a local resource; the communities they work in are typically small, so they are aware of the character of the community and know many of their patients firsthand even before they enter care management.

In this Section:

Embedded Care Management Models

- Capital District Physicians Health Plan
- CareOregon
- Geisinger Health Plan
- Group Health Cooperative
- Independent Health
- Presbyterian Health Plan
- Priority Health
- UPMC Health Plan

Presbyterian Health Plan, headquartered in Albuquerque, New Mexico, has two categories of case managers: delivery system case managers who are embedded in practices and who work mainly with the Medicare Advantage population, and health plan case managers who work with commercial and Medicaid populations. The embedded case managers treat only PHP patients and do face-to-face and telephonic

CASE STUDY: MR. L

Mr. L, a 77-year-old Hmong male with a history of mental health problems and gout, lived with his daughter and son-in-law. They reported concern about Mr. L's mental health status as well as concern that he would get lost when he left home to go on walks.

He received Elderly Waiver (EW) services that included assistive devices he needed for recurrences of gout. Mr. L had a history of suicidal thoughts, alcohol abuse, and hallucinations. At the time of his assessment, he reported nightmares, nighttime auditory hallucinations and screaming out. He had been evaluated by a psychiatrist, who prescribed medication for depression. However, Mr. L did not fill the prescription because of questions about insurance coverage.

The UCare Minnesota Senior Health Options (MSHO)[†] Care Coordinator helped to identify cultural barriers that were limiting utilization of psychiatric and primary health care, including attendance at appointments. She also provided support to the family members involved with caregiving and obtained additional EW services for Mr. L that included Lifeline (an emergency response system) and assistive equipment for him to use during episodes of gout.

As a result of the work of the MSHO Care Coordinator and the Hmong clinical liaison, Mr. L is now taking his medications and is emotionally stable. The UCare clinical liaison is a key partner with the care coordinator in identifying and implementing culturally acceptable interventions that promote utilization of health care services and resources. Mr. L has indicated a willingness to consider adult day care in the future. The clinical liaison educated Mr. L's family about how to access and utilize health services, and his family members are now actively involved in arranging his health appointments. The care coordinator also arranged for him to wear an identification bracelet and Lifeline, which gives the family peace of mind regarding Mr. L's safety when he is alone.

[†] *Minnesota Senior Health Options (MSHO) is a Medicare Advantage Special Needs Plan offered by UCare that combines Medicare and Medicaid financing and services for seniors age 65 and over who are eligible for Medicaid, with or without Medicare.*

case management, as well as home visits. Some large practices have one or two case managers embedded full time at the clinic, five days a week. Other clinics share case managers; a case manager might cover two or three clinics, spending the morning at one and the afternoon in another, or a few days in one clinic and a few in another. Health plan case managers, on the other hand, are not embedded in clinics because of the vast geographical distances they cover, although they do go to physicians' offices or meet with members who are located nearby. Whereas the group practice is located in Albuquerque, which has a high population of PHP members, network physicians are stretched across the state, making it impractical for the health plan to embed a case manager in every clinic.

Embedding Nurses in Network Practices

Geisinger Health Plan (GHP) in Pennsylvania embeds care management nurses both in Geisinger practices and in their contracted network as part of their medical home model, called ProvenHealth Navigator® (PHN). GHP has developed criteria for how many of their plan's patients must be members of a particular clinic to support an embedded care management model. For example, the practice ideally must have at least 600 of the plan's Medicare patients, 5000 commercial patients, or a combination of the above; if a practice doesn't meet these criteria, GHP can split a nurse's time between two sites. The health plan has found that splitting a nurse case manager among sites adds complexity, but they have demonstrated that an impact can nonetheless be achieved.

Nurse case managers at GHP use a combination of face-to-face and telephonic interactions in their care management program, with about 50 percent of a nurse's time spent working telephonically and the other half in the provider's office, seeing patients face-to-face. Nurses see patients in person when patients

first enter case management, when patients come into the office to see a provider, when there is an exacerbation of their condition, upon discharge, and in other situations as needed. PHN sites rely on case managers to identify patients while they are in the hospital or during acute exacerbations. This information helps "activate" the teams to provide additional resources to patients when they are most needed. For example, if a member is in the hospital and needs to transition to a skilled nursing facility (SNF), the PHN case manager can help direct that member to a SNF where the patient's primary care physician provides care.

All practices that take part in the PHN model are rewarded with payment and reimbursement incentives, as described on page 33.



Capital District Physicians' Health Plan (CDPHP), based in Albany, New York, also embeds nurse care managers in network practices; each nurse manages two practices and spends two days a week at each practice, plus one day a week at the CDPHP office. The nurses' schedules depend on the needs and desires of each practice. For example, some federally qualified health centers (FQHCs) have a high number of OB/GYN patients, and the case manager is embedded on OB days so that he or she can see those patients face-to-face. In other practices, physicians ask patients to see case managers on non-physician days so that patients can avoid the co-pays

II. Care Management Models

affiliated with seeing the physician. During the one day a week when the nurses are at the CDPHP office, they continue doing telephonic outreach to patients but also use this time to expand on their experience by sharing lessons learned and best practices with other case managers.

Like Geisinger Health Plan, CDPHP must consider geography and patient numbers when deciding where to embed case managers. It would be unsustainable to embed a nurse in a practice that has only 400 CDPHP members; the plan needs to ensure that enough patients would benefit from the program before establishing care management at that site. CDPHP is currently spreading its care management model and is trying to expand to practices where nurses can have the most face-to-face contact with high-risk populations, especially Medicare members.

CDPHP credits its success with embedding nurses in network practices to its traditionally strong relationship with physicians. CDPHP has a primarily physician-run board and has established a core group of staff dedicated to communication with physicians around the issue of medical homes, as described in greater detail on page 23. In addition, CDPHP communicated care management from the outset as a strategic relationship for the physicians, to help them improve quality and efficiency.

Independent Health, which serves more than 350,000 members in western New York, has an almost entirely network relationship with its physicians, which made embedding nurse case managers a challenge. The time that each nurse spends at the practice depends on the receptiveness of the practice, although the goal is for a nurse to spend about 75 percent of his or her time outside the health plan. Like Group Health Cooperative, Independent Health believes that if the case management call comes from the physician's office and if the close relationship between plan and provider

is apparent, it in turn helps the relationship between the care manager and the patient. Action plans developed by case managers are practice-specific and based around cost and quality opportunities present at each site; some case managers may want to improve diabetic scores at a site, while others focus on patients with congestive heart failure. Ultimately, one goal of case management at Independent Health is for the practices to develop care management competencies and build them into their normal workflow.

Independent Health case managers are a resource provided to physicians, and the relationship works most seamlessly where the practice sees the case manager as a peer working toward the same goals, rather than a separate health plan employee. As Molly Fachko, the assistant director of care management at Independent Health said, care management is the most successful “where the practice truly sees [the nurses] as peers working on the same goals, not as someone who's separate and distinct coming in; where they see them almost as another employee.”

The UPMC Health Plan patient-centered medical home (PCMH) model embeds practice-based care managers (PBCMs) in both UPMC system practices and other contracted network practices. Embedded care managers, who are employed by UPMC Health Plan, function as part of a physician's team at each practice; their primary role is to support physicians in managing their UPMC Health Plan members. PBCMs focus on patients who could benefit from greater intensity of care and interaction, including those with complex needs, those recently discharged from a hospital or diagnosed with a chronic condition, those who require self-management education or medication reconciliation, or those who have frequent admissions.

PBCMs are assigned to one or more primary care practices and are in turn responsible for the entire UPMC Health Plan population assigned to

those primary care offices. PBCMs have access to physicians' schedules, so they help schedule appointments for members, help them prepare for those appointments, and provide education during their visits. Most of a PBCM's time is spent seeing patients face-to-face.

Centralized Models

Thanks to technological advances such as electronic health records, telemonitoring and video/mobile communication, many care management activities can be performed remotely. A "centralized" approach to care management refers to an arrangement where trained nurses or care management professionals support practices virtually from an off-site location such as a health plan office. This approach carries advantages for serving populations in rural locations, where plan penetration may be lower and health plan staff may be limited in how many members they are able to engage.

Some plans using a centralized care management approach combine traditional disease management tools with more comprehensive global care planning processes to support their practices in managing members with chronic disease. For example, SelectHealth, a 530,000 member health plan integrated with the Intermountain Healthcare system in Utah, uses a team of plan-based care managers to work closely with the staff in the delivery system. These health plan employees identify patients with diabetes, asthma, COPD, hepatitis, and heart failure; stratify these cases by complexity; and then coordinate with the appropriate office staff from across the Intermountain Healthcare system to ensure the delivery of appropriate and timely care.

Geisinger Health Plan deploys a centralized case management model for patients not in PHN sites that focuses on transitions of care and management of patients with targeted

conditions such as COPD, heart failure, end-stage renal diseases, or complex diabetes. The centralized case manager relies on telemonitoring data and Health Information Exchanges (HIEs) to assist with access to the up-to-date clinical information he or she needs to help patients. While communication with the primary care provider is not as effective as in its embedded model, case managers nonetheless provide valuable navigation services to members.

Health plans with centralized care management models are often supplementing the care coordination and clinical management already in place at practice sites. In addition, some plans with centralized care management programs, such as Capital Health Plan, an HMO based in Tallahassee, Florida, still manage to arrange for face-to-face visits with members, usually at the health plan office or in a third-party location. Other plans rely on their extensive knowledge of local communities to connect members to resources with community-based organizations and local groups. For example, Fallon Community Health Plan, based in Worcester, Massachusetts, employs social workers who are very connected to their communities and who assist patients in accessing resources (see page 28 for more information).

One option available to plans that cannot do home visits is telemonitoring, whereby the care management nurse installs a device in a patient's home that, for example, measures blood sugar levels, weight or blood pressure, and automatically transmits that data to the nurse. Security Health Plan, a physician-sponsored nonprofit HMO in Wisconsin, has had success with a telemonitoring system which is installed in patients' homes and connected to their phones. The system, with which members can self-measure blood pressure and weight, is installed and monitored by a contracting nursing agency; data are transmitted to Security Health Plan case managers, allowing nurses to better track patients' health changes, facilitate

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provider communication, monitor medication adjustment needs, and prevent ER visits and hospitalizations.

UCare also refers patients with heart failure to its telemonitoring program. All members in UCare's Minnesota Senior Health Options program who have been diagnosed with heart failure receive telemonitoring equipment in their homes, while members in other UCare products are referred if they have had an inpatient stay for heart failure. Members weigh themselves on a regular basis and answer a series of questions. Results are transmitted to the care manager; the nurse then follows the protocols and parameters set by the patient's primary care physician to respond to any changes. UCare care managers contact patients' physicians, when necessary, to discuss adjustments to treatment plans.

Practice-Employed Care Managers

All approaches to care management require extensive transformation of practices, including adequate training for staff, development of infrastructure, and changes in culture. The extent to which salaried health plan employees contribute to patient care varies by plan. In some arrangements, however, health plans take the approach of "teaching the provider groups to fish," through training, funding, and other forms of support, to help practices develop effective care management systems.

From the health plan perspective, it may seem that this would limit the level of engagement between plan and practice; however, if done correctly, this approach carries several advantages. It spreads best practices beyond specific health plan membership and into local communities where continuity of care expands to entire populations. It is more sustainable, since practices learn how to manage patients on their own without external support. Finally, it fosters a learning environment, where the resource is not a person to be employed but rather a concept to be adopted, improved, and shared. CareOregon and Priority Health both have such initiatives in place.

CareOregon, which was created in 1993 by a partnership of safety-net providers, is a nonprofit health plan serving Medicaid and Medicare recipients in Oregon. With 950 primary care providers, CareOregon serves more than 160,000 members throughout the state. In 2007, CareOregon started its Primary Care Renewal (PCR) initiative, and incorporated care management functions in 2009.

CareOregon's care management system is a "virtual all-payer" system; although nurses receive training from the health plan, the care managers are clinic employees and can see both CareOregon members and patients



Figure 3: A CareOregon-sponsored Care Management Learning Collaborative from 2009

who are members of other health plans. In addition to funding training of clinic case managers, CareOregon funds its own health plan case managers, who assist the clinic nurses in managing CareOregon patients. Plan case managers work telephonically from a central location; they work with high-cost CareOregon patients who need centralized care coordination that the health plan can provide through its access to multiple data systems. While CareOregon case managers focus more on repeat hospital and ER visitors, clinic care managers focus on patients with unstable chronic illnesses. Plan and clinic care managers collaborate and share information; for example, if a clinic care manager needs assistance with utilization or medication patterns, CareOregon shares that data. Clinic care managers sometimes refer patients back to the plan case manager. Since the health plan does not have the busy, chaotic environment of a primary care clinic, plan nurses often have more time to organize and coordinate care for the most complex patients than do physicians at the practices.

Some PCR sites target all patients, while some target only CareOregon members. The health plan, from the outset, let clinics decide individually if they had adequate resources to make capacity-building part of their core infrastructure for all patients, or if they wanted to initially focus only on CareOregon patients. Many providers chose to undergo a comprehensive practice transformation so that they could offer care management to all of their patients. As care management is increasingly recognized as a critical part of any well-functioning medical home, practices are taking more initiative in funding such programs; currently, CareOregon pays approximately 60 percent of the clinical transformation costs, while the practices carry the remaining 40 percent. CareOregon's payment model includes a fee-for-service base with additional money available based on process and outcome measures as well as on meeting certain entry-level criteria.

The decision-making process at CareOregon is fully collaborative. No decisions are made unilaterally by either the health plan or the clinic, and the plan and providers have been able to reach consensus on almost every issue that has been brought up. CareOregon credits this ability to reach consensus on the flexibility that is built into the collaboration. For example, when the health plan created its payment model, clinics were given many options to choose from regarding which quality metrics they would report on. One clinic, for example, serves primarily women and children, while another serves homeless adults, most of whom are men. Each clinic takes the PCR model and decides how it is going to be executed, as well as what its own organizational and clinical standards will look like. Measurement and evaluation metrics are co-designed with clinics by a subcommittee to ensure that any data collected is meaningful to both the health plan and the providers.

Priority Health, like CareOregon, has instituted an all-payer model for the clinics involved in its patient-centered medical home initiative; this model, like CareOregon's, includes embedded practice case managers partnering with health plan case managers. Priority Health provided the initial funds and resources for development of care management initiatives at the practices, including funds for hiring RN staff, staff training, infrastructure development, access to systems, and competency training.

The role of care managers within primary care practices has not widely existed in the areas of Michigan serviced by Priority Health, so as part of its PCMH pilot program, funding was provided to a set number of practices to build this capacity. The practice care managers initially focused mainly on diabetes, while Priority Health case managers remained focused on diseases across the entire continuum of care, including all chronic and many acute episodes of care that may require care management or care coordination. The goal was for the practice-

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based care managers to see patients across the universe of conditions, but that process is occurring at different speeds depending on the practice. Some clinics that used funding from the pilot to employ a care manager may not have had a Priority Health case manager on site. In these instances, a Priority Health case manager works with plan patients telephonically and provides the practice-based care manager with access to the health records or with updates on interventions so that they can work as clinical co-leads with those patients in the pilots who have Priority Health insurance. Outside of the pilot, Priority Health case managers reach out to those members in need and then communicate with that patient's primary care office or their practice-based care manager, requesting him or her to work with the patient on self-management education or to reinforce certain messages.

In a separate PROMETHEUS Payment® model initiative, Priority Health has been training practice-based case managers and building their capacity in order to phase out plan-based care managers from those practices.

Priority Health took a different approach in a separate PCMH pilot which began in the fall of 2009. Rather than dictating specific steps practices had to take or requiring conformation with a preexisting PCMH model, Priority Health provided practices with up-front grant dollars and three broad focal areas toward which the money could be applied: access to care, care coordination, and/or patient engagement. Practices were free to choose how to spend their grant dollars as long as they did so in alignment with one of these focus areas. This allowed practices to adopt primary care innovations in alignment with their own priorities, goals, and needs.

Of the 15 practices in the pilot, 12 chose to use their funds to hire and train care managers who would function as part of the care team and assist physicians in managing patients with

complex needs. These care managers facilitated broader practice transformation in addition to being a valuable resource for physicians and other clinical staff. That 80 percent of practices chose to spend limited funds on care management activities speaks to the perceived value to physician practices of care management nurses and other resources to help manage the care of complex patients.

ACHP plans pride themselves on their close partnerships with providers, and their care management models – which include close cooperation and partnership with physicians and clinics – are no exception.

Communication with Providers

ACHP plans pride themselves on their close partnerships with providers, and their care management models – which include close cooperation and partnership with physicians and clinics – are no exception. Frequent meetings between providers and plans can improve on a plan's care management model and facilitate cooperation between physicians and the health plan.

At Group Health Cooperative group practices, the embedded case managers hold weekly “chronic disease huddles” with team RNs and doctors for patients who have diabetes, heart failure, asthma, COPD or hypertension/coronary artery disease. At these huddles, the physicians and nurses discuss each patient's progress, as well as the responsibilities of each team member.

Capital District Physicians' Health Plan put together a team to communicate with physicians. This Strategic Engagement Team (SET) includes a core group of staff who meet quarterly with practices and have a phone line dedicated to engagement with practices. SET hosts collaboratives with practices, including workshops on primary care transformation; movement toward medical homes; aligning goals; and improving cost, quality, and Triple Aim measures. CDPHP has also hired a Supervisor of Case Management who visits practices on an ongoing basis and is available to troubleshoot and answer questions between meetings.

CareOregon's care management program is run by a Primary Care Renewal Steering Committee, which includes representatives from the health plan and each of the five PCR sites. This committee espouses co-ownership and co-development of the care management program between plan and clinics.

Geisinger Health Plan provides every medical home site – both in its group practice and in its network – with a monthly packet of utilization and cost data from the health plan, as well as proactive quality reports on a monthly or quarterly basis, depending on how often a site wishes to receive them. GHP also requires practices participating in its ProvenHealth Navigator® model to conduct monthly medical home site meetings to review practice redesign opportunities, case studies, and performance feedback.

As part of UPMC Health Plan's PCMH model, the plan regularly provides physician practices with data, including claims information related to services members have received, pharmacy data about member prescriptions, population-level information showing the overall health status of a physician's patients, and reports containing actionable data on which each physician may intervene. Physician account executives (PAEs) coordinate activities between UPMC Health Plan and the practices. These PAEs

meet with key stakeholders in each practice to discuss specifics of the PCMH model and update them on any new initiatives. UPMC Health Plan hosts monthly and quarterly meetings for PCMH practices; PAEs also meet individually with office managers and physicians to suggest areas for practice improvement. PAEs work with provider advocates, who facilitate communication between the plan and practices with regard to issues such as claims, credentialing, billing, or access to the UPMC Health Plan secure Website. Provider advocates are assigned to individual physicians.

Priority Health has hosted biannual learning collaboratives in partnership with TransforMED, featuring keynote speakers such as physician experts or other professionals. In addition, the practices that employ a care manager are invited to participate in care management learning sessions and often visit other practices to see how they are implementing the care management role.

It is important, when deciding on a method of communication with providers, to consider physicians' preferences. Independent Health, for example, had a PCMH website, but found that such a medium did not suit the busy schedules of its physicians, who had to remember to access the website regularly. Instead, Independent Health now sends out a biweekly PCMH update newsletter, which contains information about upcoming meetings and events, new programs, trainings available through the plan, and other information. Independent Health also holds monthly collaborative meetings with representatives from practices as well as the health plan. The goal of these collaboratives is to share best practices and promote community relationship-building. Communication, said Molly Fachko, the assistant director of case management at Independent Health, should be regular and involve multiple media to make sure that messages get across to providers.

USE OF TECHNOLOGY

In addition to the telemonitoring software described on pages 19-20, ACHP member plans utilize many different types of technology in innovative ways to identify patients who are most likely to benefit from care management, better engage patients, and manage their health. Such technology can increase communication between plans and providers, assist health plans in carrying out care management activities, or serve as a resource for patients. For example, a number of ACHP plans, including Geisinger Health Plan, Group Health Cooperative, and Presbyterian Health Plan, use Epic software to communicate and share information with practices. Priority Health created a patient registry more than 10 years ago and shares this tool with all network providers, highlighting care opportunities.

Sharing of electronic health records (EHR) between physicians and the health plan can be an excellent resource for care managers. Claims data takes 30 days before it is available to health plans, whereas EHR can be instantly transmitted to a care manager to let him or her know what occurred at a patient's medical appointment, as well as any medications that were prescribed. When EHR are integrated and shared across a medical system, all of a patient's providers – a primary care physician, specialists, care managers, and others – can access the comprehensive set of information about a patient, avoid duplication of services, and decrease reliance on accurate patient recall.

Fallon Community Health Plan (FCHP) has implemented a system of shared EHR with a local group practice, Fallon Clinic. This system is especially valuable for senior members enrolled in the FCHP Home Run Program, which targets frail Medicare Advantage members with Fallon Clinic physicians. FCHP has read-only access to

Fallon Clinic's central enrollee record, and for members in the Home Run Program, information is shared among the primary care physician, specialists, and case managers. Contracted visiting nurse association (VNA) nurses can also export clinical information from their tracking system into the central enrollee record, which contains medical as well as psychosocial information on patients.

Independent Health worked with practices that were concerned about sharing of protected health information (PHI). In larger practices, the health plan worked with the clinic's IT department to make EHR for Independent Health members available to case managers in a responsible manner. Independent Health helped other practices transition the practices from paper to electronic medical records as part of their NCQA accreditation process.

Where sharing of EHR is not possible (for example, because a clinic does not yet use EHR or because of HIPAA concerns), an alternative that some plans – such as Group Health Cooperative and Presbyterian Health Plan – use is sharing of providers' patient schedules so that embedded care managers can see when patients they are managing have appointments at the clinic. This allows care managers to schedule meetings with patients or follow up with them telephonically immediately after a doctor visit.

Most of the ACHP plans involved in care management utilize predictive modeling as a tool to identify patients who should be targeted for case management. Predictive modeling is a statistical tool used to identify, based on clinical and administrative data, which patients are most at risk for hospitalization or rehospitalization, future adverse health outcomes, or high-cost procedures. Plans use predictive modeling software to seek out patients who could

benefit the most from care management by targeting those who are ill enough to require coordination, but not so ill as to be unable to benefit from self-management education or personalized care. Geisinger Health Plan, for example, utilizes MEDai, a predictive modeling tool created by Elsevier, to identify high-risk patients. Members with a “risk rank” of 4 or 5 are reviewed and screened for eligibility in the case management program. Ninety percent of members referred for case management are enrolled.

Other plans offer electronic resources for patients engaged in care management. Independent Health, for example, offers Emmi® Educational Videos to its members to help them understand conditions and treatment options. These videos provide information and function as decision aids in helping patients make choices about their treatment and future. Security Health Plan uses the StayWell/HealthMedia library – which includes podcasts and digital coaching opportunities – to offer targeted educational resources to members engaged in care management.

Software can be valuable to health plan case managers by helping them organize care for patients. Capital Health Plan, for example, has developed an internal population management application in collaboration with its information systems department. This software streamlines case management documentation by housing assessments, care plans, evidence-based guidelines, interactions, follow-up care and other resources in one place. Once a patient is identified as a suitable candidate for care management and agrees to take part, a chronic condition assessment automatically loads into their case, which contains information about evidence-based guidelines and care plans for each condition the patient might have. The care plans are customizable for individual patients. By the end of 2011, Capital Health Plan will be utilizing recently updated EHR systems to grant staff practices access to this information

for their patients in case management; once physicians open an EHR for a patient, they can see that the patient is in case management as well as what is being done with that patient.



Care managers at UPMC Health Plan utilize HealthPlaNET, a clinical data management tool developed at the health plan to organize and coordinate care. This software provides a member-centric view of everything that occurs with each patient and includes data from care managers, claims, self-reported health risk assessments, and responses to standardized questionnaires, laboratory results, and other sources. For each member, UPMC Health Plan care managers can view previous outreach attempts to patients, caregivers, or providers; clinical assessments to identify barriers to care; problems, goals, and interventions attempted; and case goals and care plans. Care managers can quickly view inpatient cases or other requests for services that also need to be approved, an overview of the patient’s health state, and member-specific problems.

The member-specific problems identified in HealthPlaNET may be transportation issues, difficulties with access to care, or other clinical, infrastructural, financial or social issues that have a direct impact on a member’s ability to get care. These are hard-coded in the system,

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allowing staff to make associations among inputted information and to track outcomes. For example, the software can easily determine how many members have transportation problems, and the health plan can analyze trends in that figure over time given a range of interventions.

Work that care managers do is often guided by HealthPlaNET worklist items, which are tasks

that a care manager could engage in, triggered by events such as recent diagnoses, gaps in care, hospitalizations or overdue screenings. Depending on the type of trigger or event, worklist items have different due dates and priorities; for automated processes and claims, for example, due dates are assigned by the software. Care managers can also input worklist items manually and assign custom due dates.

ORGANIZATION OF CARE MANAGEMENT SYSTEMS

The design of the care management models themselves differs from plan to plan depending on plan resources and member needs. These differences are reflected in varied roles of the care management nurse as well as the organization of care management within a health plan.

Roles of a Care Management Nurse

There is a basic set of core tasks that care management nurses at ACHP member plans perform. Due to the emphasis of care management models on prevention of disease-related complications, improvement of outcomes, and reduction in admissions and readmissions, care management nurses spend a significant amount of their time on patient education, especially as it relates to self-management, prevention, and monitoring of symptoms.

It is in both the care managers' and patients' best interests to ensure that patients can recognize warning signs of their conditions and act on those signs before they become more serious. Disease-specific education ensures that patients are aware of signs and triggers that could be indications of an exacerbation of

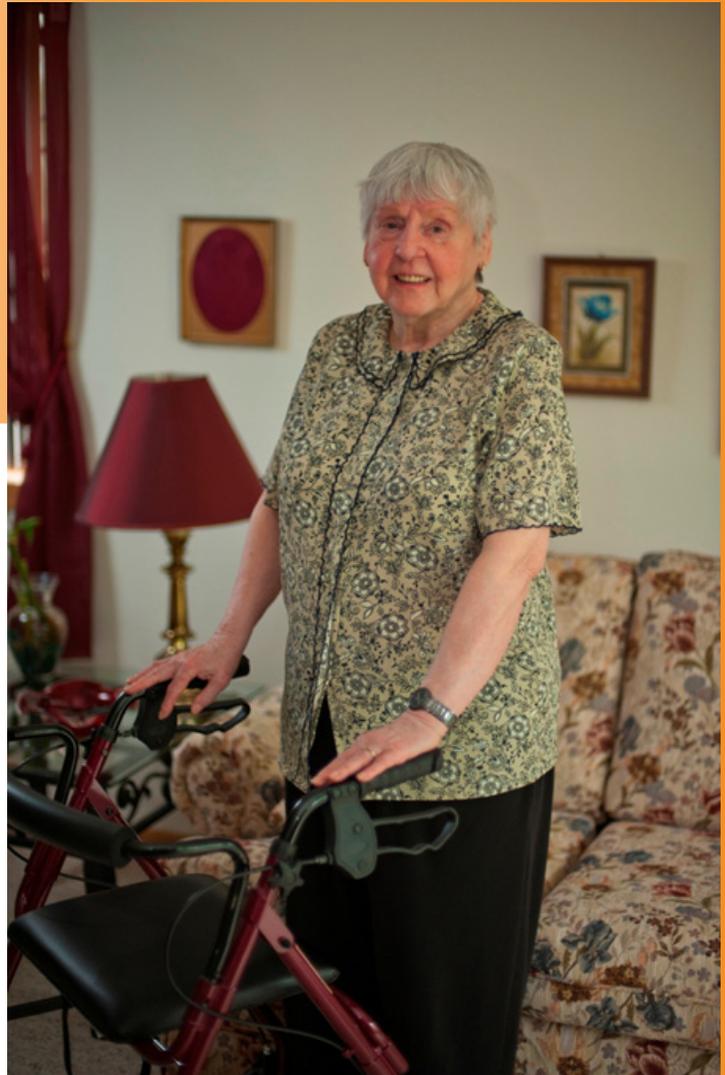
their condition, in order to prevent unnecessary clinical outcomes and admissions. Care managers also ensure, after discharge or after physicians' appointments, that patients understand their discharge instructions, as well as instructions for and side effects of any medications that they are prescribed and the potential for interactions with other medications or substances.

Although in many health plans medication management and medication reconciliation take place in separate departments, care managers do have a role in managing patients' use of prescription and non-prescription drugs. Home visits are especially helpful for care management nurses in this regard, as nurses can personally confirm and inspect the medications that patients take, check for expired drugs, and check for potential interactions between prescription and over-the-counter or herbal medications.

Many care management nurses take an active role in monitoring patients' progress toward wellness goals or clinical progression. In this role, nurses either assess patients' progress in person, over the telephone, or through the use of telemonitoring or telehealth software. For example, a case manager might chart a patient's blood pressure, weight, or asthma score over time, and offer personalized health coaching based on the patient's outcomes.

CASE STUDY: PAULINE

“I don’t know what would have happened to me without Margie,” says Pauline Whitehead of her Security Health Plan nurse care manager, Margie Straka. “She turned my life around.” Pauline, who had retired to Minocqua, Wisconsin, had been embarrassed to leave her apartment, as her noisy walker was upsetting other residents of her senior community.



Margie helped put Pauline in contact with a durable medical equipment company that sent her another walker at no cost and put her back on her feet. Margie continues in a care management role with Pauline, calling to provide care advice and offer practical suggestions to help Pauline keep on top of her health needs.

“She’s so understanding,” Pauline says about Margie. “Her instructions are easy to follow, and the results are amazing. She tells me to be sure to call her if I need to, and she’s always there.”

Photo and case study courtesy of Security Health Plan

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All of the care management nurses employed by ACHP member plans mentioned in this handbook help patients with referrals, both to providers and to community-based organizations. As employees of health plans, nurses have access to information about each patient's benefits, coverage, and network of physicians, allowing them to help patients access specialists, nutritionists, physical therapists, and other providers. Care managers also can facilitate sharing of information between physicians; at Capital Health Plan, for example, care managers share medical information between specialists and primary care physicians upon referral and/or discharge.

Some case managers, such as those at Presbyterian Health Plan, also focus on care transitions; these health plan case managers are embedded in hospitals and ensure that patients are familiar with discharge instructions. The member's understanding of discharge is validated through a face-to-face visit with the case manager, and a follow-up call is conducted within 72 hours of discharge to ensure implementation of the discharge plan (which includes initiation of home health care, medication reconciliation and fills, equipment delivery, and ensuring that a follow-up appointment with a provider has been scheduled).

Due to unique rural geographic opportunities, Security Health Plan in Wisconsin has developed a network of hospital care managers who collaborate with plan care managers to facilitate a one-month post-hospitalization transition program for members with targeted needs.

At Geisinger Health Plan, practice-based case managers reach out to hospital discharge planners to coordinate services needed after discharge. Upon discharge, these case managers contact patients within 24 to 48 hours and focus on medication reconciliation, patient safety, provider follow up, and development of a patient-activated action plan in case of an emergency.

At UCare, care management activities and responsibilities vary by product line. All members enrolled in its Minnesota Senior Health Options (MSHO) product, most of whom are frail elderly, are care managed; members receive face-to-face assessments conducted in their own home upon enrollment, annual reassessments, and personalized care plans developed in partnership with care managers. Care managers communicate with a member's primary care physician when the care plan is developed, upon a change in the member's condition, or to update the physician on unmet needs or overdue care, such as preventive screening or vaccinations. Care managers in the MSHO program also do discharge and transitions management.

In the UCare Connect product, Health Plan Navigators help patients interact with their health care system by ensuring that members are satisfied with their primary care physicians, contacting them with reminders about preventive screenings, and doing surveillance and monitoring of claims systems to refer patients to disease management or health promotion departments at the plan. Case management is provided to UCare Connect members based on health care need and gaps in service. Respite care is available for caregivers of members in both the MSHO and UCare Connect programs.

For the UCare for Seniors and UCare Prepaid Medical Assistance Plan (PMAP) products, nurses work telephonically to help patients manage their own care and refer them to community resources

Multidisciplinary Teams

According to the Robert Wood Johnson Foundation, "successful care management programs have care managers as part of multidisciplinary teams that involve physicians."¹² As discussed on pages 15-19, ACHP plans embed care managers in physician practices to increase communication and partnership with physicians. ACHP plans also

employ social workers, geriatricians, and other staff and providers who can deliver tailored, effective care to their members. At CareOregon medical home sites, for example, all patients from all payers are impaneled to a particular primary care team, which includes providers, physicians, and care managers.

Plans such as Fallon Community Health Plan, Group Health Cooperative, Presbyterian Health Plan, Security Health Plan, and UPMC Health Plan have social workers on staff to work with specific patients. These plan-employed social workers work closely with care managers to assist patients with special behavioral and other needs to manage their conditions and overcome environmental barriers to good health. They ensure that patients have adequate resources to manage their conditions; offer caregiver support and training; help with financing and transportation; and connect patients to community organizations. Social workers can work remotely from a health plan's office or may be embedded in clinics alongside care managers.

At UPMC Health Plan PCMH practices, practice-based care managers (PBCMs) are supported by a multidisciplinary clinic support team. This team includes social workers, health-plan-based specialty care managers, pharmacists, lifestyle health coaches, nonclinical outreach staff, discharge planners, and member services staff. If a member has questions about claims, copayments or specific benefits, for example, the PBCM can refer him or her to a staff member from member services. PBCMs can request assistance from plan-based care managers in providing disease-specific education and identifying resources for members; outreach staff contact members who require preventive services and do home visits if members are noncompliant or have transportation barriers.

At Group Health Cooperative, social workers and care managers work together in physicians' practices. Group Health schedules its caseloads so that there is always at least one care manager

or social worker in the clinic at all times. Social workers help families transition to long-term care, manage the financial burdens of health care, find alternate sources for medications, and deal with difficulties such as abuse, homelessness or domestic violence. Social workers are embedded in all urgent care centers, as well as the hospital birthing unit and in high-intensity specialty departments like oncology and nephrology. The social workers focus on counseling for caretakers and transitions to assisted living or long-term care centers as well as financial planning for high-cost diseases.



Group Health Cooperative also employs a number of specialized care managers. Its complex care managers perform most care management roles among Group Health's network physicians, but in the Puget Sound area, where two-thirds of its members are located, the plan has additional specialist care managers on staff. These include compassionate care managers, who help elderly patients make difficult decisions about their future care at their own pace and assist them in transitioning from the pre-hospice stage; pediatric high-risk case managers; high-risk heart failure care managers; transplant care managers; and bariatric surgery care managers. Group Health also employs care managers who work with hospitalized patients during their hospital stay and post-discharge.

Fallon Community Health Plan (FCHP) partners with Fallon Clinic and utilizes a geriatrician for its Home Run Program, which is described in greater detail on page 32. FCHP also employs social workers who meet with patients in person and communicate with them telephonically. These social workers assist with financial issues and refer patients to agencies within the area, such as elder services or other community resources. A FCHP social worker is involved in the Home Run Program and facilitates Home Run Club meetings every month, the social component of the program. Transportation is provided, light meals are served, and education and social activities are offered.

The care management team at Independent Health includes a practice care coordinator (PCC) who conducts the main patient interaction and care management activities; a practice management consultant (PMC) who works on operational issues such as setting up policies and procedures; and a pharmacist. This team, known as the POD, is assigned to individual practices and meets regularly to coordinate activities. For example, when Independent Health rolled out its Emmi[®] health management video library, the PMCs went out to practices and provided logistical support, creating usernames and passwords and training staff to use the system. The PCCs, on the other hand, worked with the practices on how to use the tool appropriately and on how to identify patients who could benefit most from the videos.

Capital District Physicians' Health Plan (CDPHP) also employs a pharmacist to work with patients in care management as part of its Medication Therapy Management program. CDPHP embeds pharmacists in high-volume medical homes, working closely with care managers and physicians to conduct medication reconciliation.

Levels of Care Management

Different levels of care management help customize care for patients at different stages of disease and/or with different health care needs. For example, disease management programs in ACHP member plans generally focus on patients with a single condition, with various levels of severity, while care management programs often deal with patients who have multiple co-morbidities, complex chronic illnesses, and who need assistance navigating treatment for several conditions as well as care coordination services. Disease management is usually condition-specific and is generally offered for conditions such as diabetes, congestive heart failure, coronary artery disease, depression, COPD, obesity, cancer, and hypertension. Care management, on the other hand, is rarely limited to specific diseases; eligibility criteria generally span a number of conditions and risk factors.

Capital Health Plan (CHP) has successfully integrated disease management with case management, stratifying patients on multiple levels to ensure that they get appropriate interventions, and maintaining constant communication with patients and physicians. The opt-out disease management program focuses on diabetes, cardiovascular disease, COPD, depression, and ADHD. Patients are identified monthly based on HEDIS measure criteria and, once they are invited into the program, receive a variety of interventions. Outreach takes the form of newsletters, website updates, communication with physicians, and phone calls to individual patients to ensure that they remember to, for example, set up appointments for an annual lab visit or take their medications regularly. CHP sends lab slips to other members, along with letters, to remind them to complete their annual testing. Every month, CHP posts – on a secure Web portal that physicians can access as needed – lists of patients who are due for certain services, such as mammographies, PAP smears, or A1c checks.

There is a dedicated phone line for patients in CHP's disease management program, which patients are encouraged to call if they have any social, financial, or other concerns. Often, patients are referred to case management as a result of such conversations when they are believed to require additional services. In addition, patients discharged from case management can be referred to disease management if they need continued follow-up to make sure they are meeting HEDIS guidelines. The care management and disease management departments at Capital Health Plan have access to each other's databases, facilitating sharing of information between the two programs.

There also are varying levels of care management at CHP. The Level 1 intervention patients are those who need just a single intervention, such as help with arranging transportation to and from a clinic. Time spent in Level 1 case management is usually one or two days. Level 2 interventions are with those members who don't necessarily fit the criteria for complex case management, but who need assistance with multiple issues. Level 2 interventions might include getting a member in touch with help for social needs; the average duration of Level 2 case management is three weeks to a month. Level 3 is complex case management for patients who are very ill with multiple conditions or who have suffered a life-altering event. The average length of stay in complex case management is approximately six months, but can be longer if needed.

In addition to the above disease management and care management initiatives, Capital Health Plan has created a Center for Chronic Care (CCC) to centralize care for high-risk patients and give them greater access to primary care physicians, with the goal of reducing hospitalizations and ER visits. CHP patients are stratified by risk and invited to join the CCC. Two staff physicians oversee 500 to 600 patients at a time, which enables them to see patients as frequently as needed and for much longer office visits than in a traditional primary care setting. Nurses at the

clinic coordinate care needs for the patients.

CareOregon and Presbyterian Health Plan also have three tiers of care management into which they segment patients. Two of Presbyterian's care management tiers involve care coordination, such as helping connect patients with new providers and resources in the community. One level requires the help of a nurse; the second level utilizes a tech-level individual to help coordinate care; the third tier is complex case management. Presbyterian Health Plan also has a disease management program for patients with diabetes and coronary artery disease.

Levels of Care Management Intervention at Capital Health Plan

1. Patients who require a single intervention, such as help arranging transportation (one day)
2. Members who need assistance with multiple issues, such as social needs (three weeks to a month)
3. Complex case management for patients with multiple conditions (six months or longer)

At Geisinger Health Plan, disease management targets low- and moderate-risk patients with conditions such as hypertension, asthma, coronary artery disease, and diabetes for self-management education, medication optimization, surveillance, and prevention. A core component of Geisinger's disease management program is a self-management action plan, which is a plan of care defining what a patient should do if he or she experiences defined symptoms. For example, if a patient has diabetes and gets sick, the action plan addresses steps to take to monitor his or her blood glucose,

II. Care Management Models

replace carbohydrates, and adjust his or her medications to avoid unnecessary trips to the emergency department. Disease management nurses work with physicians to optimize therapies and medications for their patients. Patients who have complex co-morbid conditions requiring more intense services and/or coordination of services are steered to care management.

The disease management program at Fallon Community Health Plan, which focuses on coronary artery disease, congestive heart failure, asthma, and diabetes, is population-based and stratified into low-risk, moderate-risk and high-risk. The low-risk group receives quarterly mailings. The medium-risk group gets outreach calls from health educators, and the high-risk cases are transferred to the nurses who do complex case management. The Home Run Program is a small program within care management, aimed at frail elderly, many of whom have had a status change, such as onset of an illness or a fall. Many of the patients in the Home Run Program are homebound, so nurse practitioners or the geriatrician do house calls with these patients, assess a patient's environment, proactively identify potential problems, and institute interventions to reduce admissions and ER visits.

Referrals to Community Agencies

Due to the regional, community-based structure of ACHP plans, as well as their familiarity with local systems of health and care, health plan nurses are in a unique position to refer patients to community-based organizations and resources. Such resources may include, for example, local Meals on Wheels services, nonprofit organizations or centers, Area Agencies on Aging, home health agencies with which the plan has special contracts or arrangements, or HUD (U.S. Department of Housing and Urban Development) resources for homeless patients.

Geisinger Health Plan has developed a “Medical Neighborhood” as part of its ProvenHealth Navigator® model, whereby care managers direct patients to services in communities that deliver the highest value; for example, case managers and practices identify home health agencies that are willing to provide services at a moment's notice. GHP has also started a “kitchen table” medication review program with a local home health agency for patients recently discharged from the hospital. In this program, a case manager might, for example, identify pharmacies that prefill medication boxes or provide home deliveries. Finally, forging relationships with local nursing homes has been a core focus of Geisinger's “SNFist” program, which is an advanced medical management model for patients in skilled or long term care.

Due to the regional, community-based structure of ACHP plans, as well as their familiarity with local systems of health and care, health plan nurses are in a unique position to refer patients to community-based organizations and resources.

Security Health Plan started a Nurse On-Call program in coordination with local home health agencies in order to give care managers more objective information about what was going on in members' homes. Due to geographical constraints, it is not feasible for the nurse case managers to do home visits and conduct assessments in members' houses; in addition, many of the members about whom they wanted such information are not homebound and are therefore ineligible for the Medicare home health benefit. The home health agency conducts assessments, such as environmental, safety fall prevention, asthma and physical therapy assessments to identify members' needs

and to assist care managers in developing action plans for members. This one-time home visit information is transitioned to the care managers for ongoing care management interventions.

A Focus on Innovation

An important part of a care management program is flexibility and willingness to adapt to meet changing needs of populations. Security Health Plan, for example, reacted to an increase in utilization needs for cancer care by adding a strong emphasis for care management for cancer patients in 2010. The plan added a COPD program upon seeing that patients with COPD had frequent readmissions; it also modified its tobacco cessation program and started a weight management initiative.

To reduce unnecessary ER utilization at a large hospital in Presbyterian Health Plan's network, the plan created the ER Navigator program. A non-clinical person is embedded in the emergency

department, and patients who are determined by physicians to be non-emergent may choose either to be seen and treated at the ER (for which they must pay up front), or be seen within the next 24 hours by a more appropriate provider. If the patient chooses to be seen by another provider, the navigator connects the patient to a primary care physician or to urgent care. With the success of its ER Navigator program, Presbyterian Health Plan has also initiated a Community Coach program for newly insured Medicaid members who need a basic introduction to the health care system, including how and when to arrange pediatric and adult physician visits and in which situations patients should call either the ER or their primary care physician. There are financial incentives for participation in these programs; if patients visit their primary care physician within 90 days of joining Presbyterian's Medicaid plan, they receive a \$50 gift card. If at the end of the year they have used the emergency room appropriately, members receive another \$50 gift card.

FUNDING AND PAYMENT INCENTIVES

Several ACHP plans introduced funding, payment, and/or reimbursement incentives to physicians as part of their care management or PCMH initiatives. Payment incentives can be significant factors in the success of care management programs by encouraging hospitals and providers to partner in their implementation. Hospitals in particular have a disincentive to implement or support care management, as their income streams are tied to frequency of admission and provision of costly services, both of which care management aims to decrease. Primary care physicians, on the other hand, are often overworked and find it difficult to contribute time to efforts such as care management. Practices paid on a fee-for-service basis are

uncompensated for any additional work they do as part of a care management program. Payment incentives, therefore, relieve some of the burden on physicians, particularly on primary care providers, and are tangible proof of a health plan's confidence in and commitment to a model.

Provider reimbursement is a critical component of Tufts Health Plan's Coordinated Care Model (see figure 4 on page 35). The health plan, which serves almost 750,000 members in Massachusetts and Rhode Island, created its Coordinated Care Model with the goal of improving the quality of care while reducing costs. Providers are paid with value-based contracts, depending on

CASE STUDY: MRS. X

Mrs. X was an 80-year-old Vietnamese woman with multiple medical problems. She had been a UCare member for more than five years. Prior to her enrollment in MSHO[†] in 2006, she was on Prepaid Medical Assistance and her Elderly Waiver services were managed by a county caseworker.

Mrs. X's medical conditions included congestive heart failure, chronic obstructive pulmonary disease, hypertension, insulin dependent diabetes with unstable blood glucose, renal problems, leg ulcers, and other medical conditions. She had previous hospitalizations for blood glucose instability, pneumonia, triple bypass surgery, and falls. In addition, she was legally blind and spoke minimal English. She lived with her son, daughter-in-law, and grandchildren, and was alone for most of the day. Because she was unable to unlock the outside door, the Meals on Wheels volunteer couldn't deliver meals.

At the time Mrs. X enrolled in MSHO, her care coordinator arranged a number of services, including skilled nursing visits and home health aide services; Glucerna (diabetes diet management); Lifeline (emergency response system); and Meals on Wheels. Although the need for personal care assistant (PCA) services had been identified, the county caseworker had been unable to locate an agency with a Vietnamese-speaking PCA. The UCare MSHO care coordinator located a PCA agency that could provide Vietnamese-speaking PCA staff.

The MSHO care coordinator worked closely with the family, home care agency staff, the PCA, the supervisor, and the physician to coordinate services that would add continuity to the skilled nursing and home health aid services, which had a positive effect on Mrs. X's health conditions. As a result, her blood glucose stabilized and her wound care became less complicated. Today, her leg ulcers have healed, she receives regular daily attention to her wounds, and she has had no hospitalizations since a fall in 2006 that required an SNF admission.

[†] *Minnesota Senior Health Options (MSHO) is a Medicare Advantage Special Needs Plan offered by UCare that combines Medicare and Medicaid financing and services for seniors age 65 and over who are eligible for Medicaid, with or without Medicare.*

their ability to manage care and risk. Almost 40 percent of Tufts Health Plan’s HMO membership is served by providers who have value-based contracts, saving hundreds of thousands of dollars by reducing inappropriate referrals to tertiary hospitals, high-cost labs, and surgical facilities. Tufts Health Plan has also invested significantly in care management consultation with physicians, providing comparative data, identifying potential gaps in care, and sharing information on best practices in order to improve outcomes and the quality of care. This collaboration helps ensure providers’ success in a value-based contract arrangement. The third part of Tufts Health Plan’s model addresses member behavior through product design that motivates patients to seek care at lower cost from high-quality providers (such as tiered networks) while also providing incentives to stay healthy.

CareOregon and Priority Health both provided grant money and other resources to practices that wanted to start all-payer care management programs. CareOregon used such money to support structural transformations and tied reimbursement to the development of tangible care enhancements. Initially, CareOregon provided quality-improvement grant money focused on capacity building for care management. The plan also has incentives in place in its medical home payment model, which includes a fee-for-service base and additional money available based on process and outcome measures as well as on meeting certain entry-level criteria.

Priority Health provided up-front funding for its PCMH sites. At sites that employed care managers with the funds,

Priority Health provided training, infrastructure support for those who had external facilitation, access to stratification reports, and other non-monetary resources. Payment incentives came in two phases; the first phase was grant money, while the second phase consisted of both grant money and per member per month (PMPM) payments. In addition to a care management PMPM, Priority Health currently has an additional Medical Home Uplift incentive program focused on clinical outcomes and HEDIS measures.

Geisinger Health Plan, Independent Health, Presbyterian Health Plan and UPMC Health Plan all have financial incentives as part of their PCMH initiatives. One component of Geisinger’s ProvenHealth Navigator® medical home model is value-based reimbursement, which includes a continuation of existing fee-for-service and pay-for-performance payments. In addition, practices receive monthly stipends to cover the up-front infrastructure PHN® costs for the first year. Geisinger also uses a quality-gated shared savings model based on reaching predefined quality and efficiency targets.

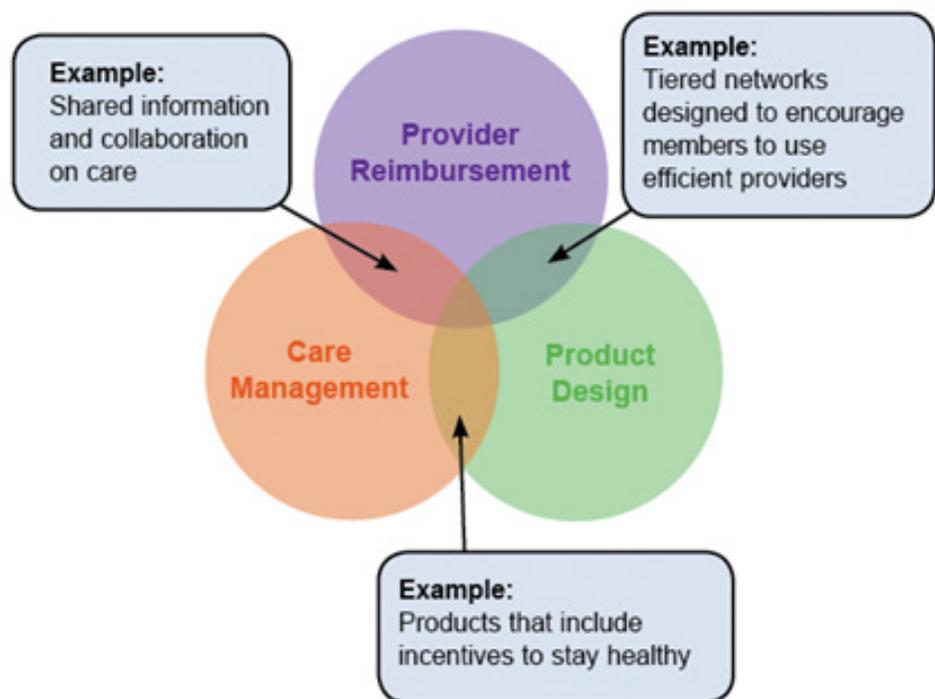


Figure 4: Tufts Health Plan’s Coordinated Care Model, courtesy of Tufts Health Plan

III. Outcomes and Evaluations

Sections

Cost Savings

Health Outcomes

Patient and Provider Satisfaction

The plans described in this handbook have conducted a number of outcomes evaluations of their care management programs. Results of any care management evaluations should take into consideration that case management is often just one of multiple interventions that are happening at a plan, and effects of care management are difficult to differentiate from effects of other programs happening simultaneously. For example, when care management is one aspect

of a patient-centered medical home model, positive cost and quality outcomes may signify a successful case management program, a good PCMH model, or neither. As many researchers have found, studying care management programs in a real-world environment is challenging.

What follow are select outcomes assessments conducted by ACHP plans and outside sources, according to the best data available.

COST SAVINGS

Group Health Cooperative in Seattle evaluates its care management program in a number of ways, including patient satisfaction, nurse-captured financial savings, percentage of patients who met their goals upon discharge from the program, and seven-day readmissions rates. The nurse-captured financial savings measure is calculated by comparing a patient’s ER and hospital admissions trends before and after entry in case management. Between January and July of 2011, nurses and GHC financial analysts reported total cost savings of \$2,524,604 for their 8,224 patients in complex case management and 1,831 patients in regular case management. Figure 5 shows these cost savings on a month-by-month basis for January through July 2011.

Month (2011)	Savings
January	\$363,822
February	\$294,901
March	\$339,739
April	\$298,005
May	\$343,595
June	\$289,046
July	\$595,496
First seven months	\$2,524,604

Figure 5: Nurse-captured financial savings at Group Health Cooperative in 2011

Activity at Tufts Health Plan	Money saved, per dollar spent
Proactive telephonic management of complex patients	\$1.90
Obstetrical case management	\$4.50
Reviews of hospital utilization	\$4.80

Figure 6: Return on investment at Tufts Health Plan for care management activities

Tufts Health Plan in Massachusetts and Rhode Island has seen significant cost savings from its care management program. ROI calculated from 2005 to 2008 shows that proactive telephonic management of complex patients saved \$1.90 for every \$1 spent; obstetrical case management for women at high risk for preterm delivery saved \$4.50 for every dollar spent; and on-site and telephonic review of hospital utilization saved \$4.80 per dollar spent.

III. Outcomes and Evaluations

Fallon Community Health Plan has calculated a high return on investment as well as lower per member per month (PMPM) expenses for members enrolled in its Home Run Program. Preliminary results from an evaluation conducted of data collected from March 2007 to February 2011 – on a total of 222 Home Run Club members – show clear cost trends in spite of a small sample size.

The Home Run Program is estimated to have saved Fallon Community Health Plan approximately two million dollars from March 2009 to February 2010 alone. Excluding pharmacy costs, for the 222 members enrolled in that time period, as measured for each individual prior to and after enrollment, PMPM costs decreased from \$2,883 to \$1,905; at a cost of \$406,000 and with gross savings of \$2.41 million, the program has shown a ROI of 4.94, saving almost \$5 for every dollar spent. Including pharmacy costs, PMPM decreased from \$2,943 to \$1,991, creating net savings of \$2.35 million and saving \$4.78 for every dollar spent.

Figure 7 shows how PMPM costs decreased for Fallon Community Health Plan patients who enrolled in the Home Run Program from 2009 to 2011 (dark blue), while PMPM costs for patients who were targeted but did not enroll in the program remained constant (orange). Patients targeted for the Home Run Program are frail elderly with higher than average medical costs and needs, which is why their monthly expenses are higher than the average among all

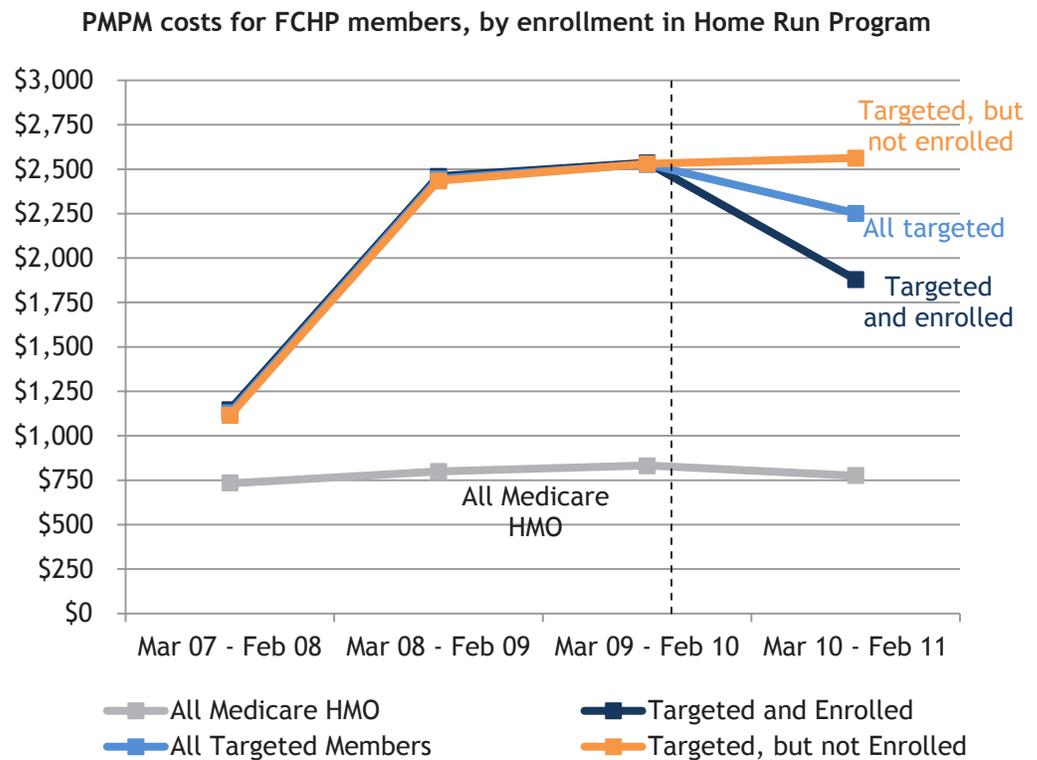


Figure 7: PMPM costs for Fallon Community Health Plan members, by category

Fallon Community Health Plan Medicare HMO members (light blue, versus grey). The 222-person “Targeted and enrolled” sample includes members who enrolled at any point between March 2009 and March 2010; cost savings from the Home Run Program, therefore, become apparent after March 2010, once enough members have had interaction with the program.

PMPM costs for four groups of members - those enrolled in the Home Run Program for three, six, nine, or twelve months, steadily increased prior to enrollment in the program, then decreased after enrollment, as seen in Figure 8 on the following page. PMPM costs continued decreasing even after patients left the program; on average, among this population, members who stayed in the program for only three months still saw declines in PMPM costs 24 months post-enrollment.

Security Health Plan has calculated cost savings from case manager interventions for two Above and Beyond services, which are additional services/benefits provided to members engaged in case management outside of their contracted benefits. The Nurse-On Call initiative, which provides a one-time RN home visit to assess a member’s home maintenance management, safety and psychosocial needs, is estimated to have saved over a million dollars in 2010 (see Figure 9). The plan’s Telemonitor Program, which provides in-home biometric management of congestive heart failure symptoms, saved \$39,010 in avoided ER visits and hospitalizations in 2010.

PMPM costs for members in FCHP’s Home Run Program, by duration of stay in the program

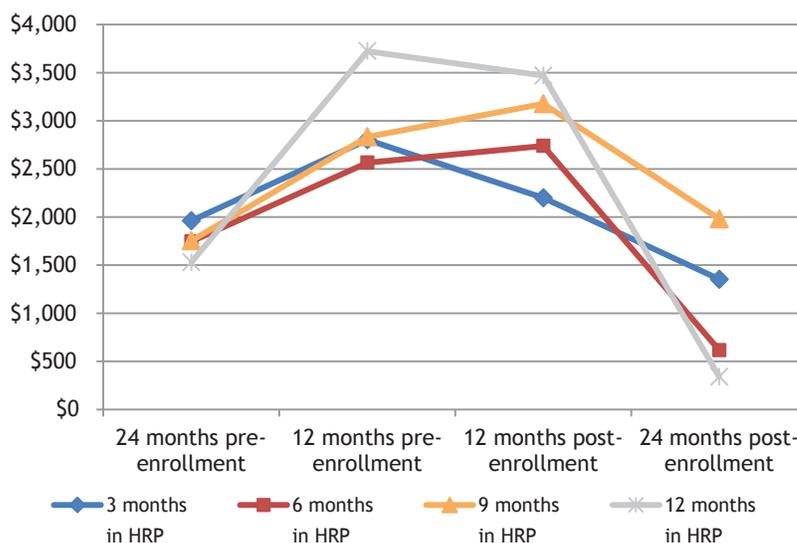


Figure 8: PMPM costs for Fallon Community Health Plan members in the Home Run Program, by length of enrollment in the program

Program	2010 Utilization	2010 Estimated Cost Savings
Nurse On-Call Program	223 visits	\$1,044,864.55
Telemonitor Program	5 cases	\$39,010.43

Figure 9: Cost savings from Security Health Plan’s Above and Beyond Services

HEALTH OUTCOMES

Capital Health Plan has calculated a number of outcomes related directly to its care management program. Thirty-eight percent of case managed patients had fewer ER visits in the first six months of case management, compared to the six months prior to enrollment in case management. In addition, 50 percent of members showed a decrease in the number of hospital admissions in the first six months of case management, compared with the six months prior to enrollment.

Capital Health Plan also computes Duke Health Profile scores, which measures functional health status and health-related quality of life, for patients upon entry into and discharge from case management. Sixty-seven percent of members involved in Capital Health Plan’s case management program showed an improvement in their perception of health status compared with when they entered case management, and 80 percent of members showed improvement in their general health summary score.

Geisinger Health Plan has done extensive analyses of its Proven-Health Navigator® medical home model. A study in the *American Journal of Managed Care* from August 2010 found significant reductions in admissions (amounting to 56 avoided admissions per 1000 members per year) and readmissions (21 fewer readmissions per 1000 members per year). While this result did not reach significance ($p=0.21$), analysis found that the PHN model reduced cumulative spending by 7 percent. A forthcoming publication will demonstrate the continued impact of the PHN model on reducing costs.

Independent Health has documented a decrease in ER utilization at PCMH pilot practices from 2008-2011. Emergency room use at practices not involved in the pilot increased by 19% from 2008 to 2010; at the same time, ER utilization at PCMH pilot practices decreased by almost 38 percent, as seen in Figure 10.

ER utilization per thousand, for PCMH practices and non-PCMH practices at Independent Health

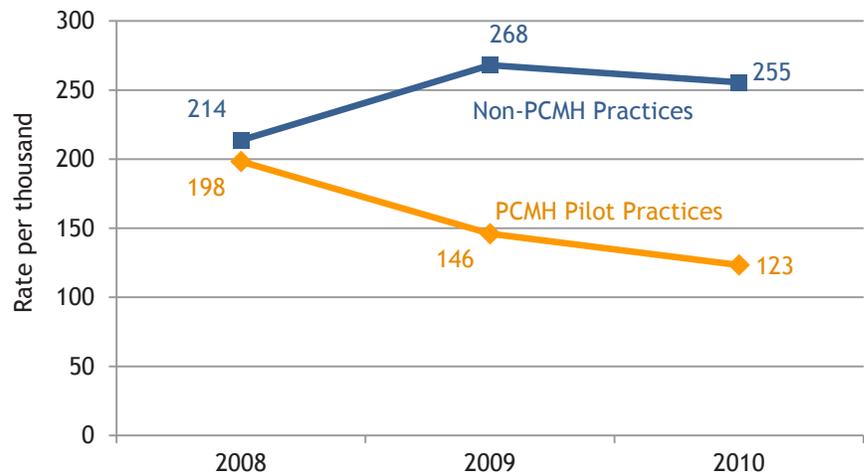


Figure 10: ER Utilization at Independent Health PCMH pilot practices

Preliminary results from Priority Health’s telemonitoring program for heart failure members at risk for hospitalization show decreases in hospitalizations as well as ER visits. Inpatient days (days that a member spent admitted to a hospital) per member year decreased by 37 percent, and visits to the ER decreased by 20.2 percent when comparing the year prior to telemonitoring to the two years following implementation of the program. These reductions in ER and hospital visits had large cost effects; total costs (which includes ER and hospital admission costs) decreased from \$40,103[‡] per member per year to \$26,186 (which includes ER and hospital admissions, as well as costs associated with the telemonitoring program), for a total reduction of 34.7 percent.

Preliminary results from evaluation of telemonitoring program at Priority Health

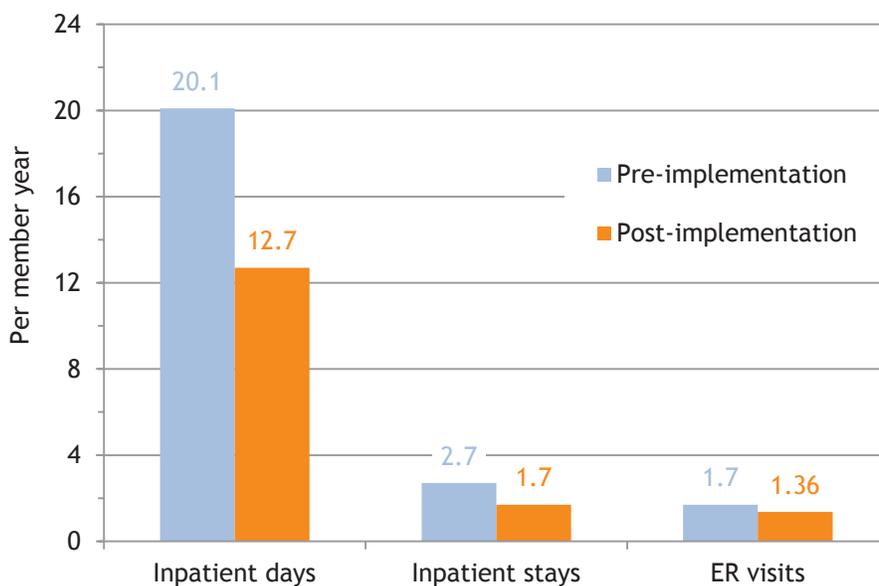


Figure 11: Reductions in inpatient days, inpatient stays, and ER visits pre- and post-implementation of a telemonitoring program at Priority Health

‡ All cost values for Priority Health’s telemonitoring program are calculated on the allowed amount; costs are calculated as the reimbursed amount with all applicable discounts, rather than the billed amount.

The Priority Health study represents a preliminary evaluation of the program; the analysis only includes the pre-post experience for members participating in telemonitoring, as it compares members before and after starting the program. Members engaged in telemonitoring may have been more likely to have higher severity or higher cost events prior to the program. An ongoing evaluation will compare results using matched controls with similar risks and histories to establish a more precise evaluation of the program.

Capital District Physicians' Health Plan has seen, as a result of its Enhanced Primary Care pilot, reductions in ER visits of 9 percent, advanced imaging of 7 percent, and hospital admissions of 15 percent; all these findings are statistically significant at $p < 0.1$.

CareOregon saw a statistically significant ($p < 0.001$) reduction in ER visits at clinics involved in its Primary Care Renewal (PCR) initiative. The mean number of ER visits per 1,000 members per year declined by 208 at the PCR clinics after implementation of the initiative, from 1,110 to 902; the high initial numbers are due to CareOregon member demographics, which include low-income and disabled Medicaid members. CareOregon's overall, all-cause inpatient utilization rate has decreased at its PCR sites as compared to non-PCR clinics. Between January 2007 and May 2010, the number of inpatient stays per 1000 members per year stayed steady at an average of 240.5 in the non-PCR sites. During this same period, the number of inpatient stays at PCR sites has decreased, from an average of 287.7 stays before PCR implementation to an average of 226.7 afterwards.

PATIENT AND PROVIDER SATISFACTION

A 2010 survey of providers indicated a positive assessment of the impact of Geisinger Health Plan's ProvenHealth Navigator® on the practice. Eighty-five percent of providers agreed or strongly agreed that management and monitoring of patients had improved across all care sites; 90 percent agreed that communication with patients had improved; 97 percent agreed that they would recommend the PHN to their patients; and 93 percent would recommend it to other primary care providers.

In a 2010 survey of almost 400 Geisinger Health Plan members, 99 percent of members involved in case management rated their case manager as "very good" or "good," with 79 percent rating the effectiveness of the case manager in working with patients as "very good."

Member satisfaction remains high at Capital Health Plan – all patients who responded to a survey rated their satisfaction with case management at a score of 8, 9, or 10 out of 10.

IV. Reflections

Sections

Challenges

Next Steps

Conclusion

CHALLENGES

Establishing successful care management programs at ACHP plans was neither effortless nor without challenges. Many of the largest challenges that plans faced were related to their relationships with physicians. Although embedded care management models are more effective than purely telephonic models, they are also more difficult to set up, especially for network physicians; initiating such programs is a long process that involves mutual development of the models, agreement on resource sharing, and constant cooperation and sensitivity to other parties' needs.

Ultimately, the goal of establishing a case management program is not to hire a case manager but to reach certain goals that are important to the plan and its members.

A few plans described the challenges they faced working with, and communicating their goals and mission to, physicians and practices. At one plan, the physicians originally viewed the role of a case manager as essentially “transactional” in nature; although the case managers were embedded in practices as a resource to both patients and physicians, the physicians thought that the primary role of the nurses was to provide them links to authorizations and to streamline the time they could spend with patients. The health plan, on the other hand, wanted the care managers to focus their time and energy on tasks such as patient education, medication reconciliation, referrals to community organizations and resources, and other forms of support. The case managers initially referred physicians to the appropriate departments at

the plan that dealt with authorizations, and over time the physicians came to understand the role of the care managers in their offices.

Two plans mentioned that they were too focused on the process when they were setting up care management programs, instead of maintaining focus on outcomes and the bigger picture. There was a sense of complacency and satisfaction around incremental changes, such as the hiring of a care manager; such outcomes were seen as end goals, instead of high-level outcomes such as changes in hospitalization rates or quality of care. Ultimately, the goal of establishing a case management program is not to hire a case manager but to reach certain goals that are important to the plan and its members. By focusing on the bigger picture – increased quality of patient care, lower costs for members – plans can avoid “settling” for short-term successes and can push themselves and affiliated organizations to continue innovating and improving.

At a number of practices, case managers had to define boundaries in order to avoid “turf issues” with physicians. There was initial apprehension at certain practices with embedded case managers that the nurses would be attempting to control or influence a physician’s care, instead of supplementing it. There was also concern from physicians that the primary role of the nurses would be to ration care. Such concerns were overcome through frequent communication, education and building trust over time. Physicians were reassured that the nurses were not there to take over their responsibilities but instead to act as an additional resource to physicians and patients. One plan succeeded in overcoming such concerns by creating standard roles for medical assistants, practice RNs, and nurse case managers.

IV. Final Thoughts

Several nurses discussed initial resistance by providers and physicians to embedding health plan case managers at their practices, due to skepticism as well as resource and time constraints. At one plan, the care management program was seen as “one more thing to do” by practices. As an employee of that plan explained, “[physicians] were thinking it was yet another ruse.” There have been many trends in the health care industry over the years, and physicians initially approached care management as simply one more passing fad. Plans and case managers overcame this skepticism by demonstrating the effectiveness of the programs through pilots and by providing funding support to prove their own support of the programs. There also were concerns about resource use by case managers, in particular with regard to space. Embedded case managers require a separate office where they can set up a computer and meet with patients, and providing this space was a challenge in certain practices; however, this concern was overcome by demonstrating the worth to each practice of embedded care managers.

Limitations of delivery models caused a number of challenges for health plans and providers. Some plans that include both staff and network physicians had initial difficulties because of different relationships with each group as well as variation between the groups’ case management models. Practices, too, have struggled to find ways to provide care management services to all their patients. At Capital District Physicians’ Health Plan and Geisinger Health Plan, physicians occasionally ask embedded case managers for advice about their patients from other plans; to comply with HIPAA, the physicians keep their patients entirely anonymous, and both plans have developed non-branded educational materials and tools that physicians can share with members of other plans. Many providers wish that such services were offered to all their patients. The Independent Health assistant director of case management discussed this issue as an area of opportunity, and said that an alternative option would be helping practices hire their own plan-agnostic care managers in a self-sustaining way; as she said, “practices would like to see the resource available to all patients, and it would be nice if all plans provided the same resource.”

NEXT STEPS

Payment reform is a crucial missing piece of the care management equation.

Fee-for-service reimbursement generally is not conducive to care management programs. Such reimbursement incentivizes high utilization, which in turn increases health care costs. Care management can decrease the use of high-cost services such as ER and hospital admissions, which in turn may create a disincentive to use care management programs in an environment where reimbursement is structured around utilization.

A number of ACHP plans already give payment incentives to providers and practices for engaging actively with plan-employed, embedded care managers. Kaiser Permanente and Group Health Cooperative were among the first organizations to use care management for high-cost patients. Value-based reimbursement is a component of Geisinger Health Plan’s ProvenHealth Navigator® medical home model, which includes pay-for-performance based on quality measures, and shared savings for meeting quality and efficiency targets. Such payment incentives have been

effective in building lasting partnerships with providers and encouraging plans and providers to strive for higher quality of care with lower costs. However, without broader payment reform, embedded, face-to-face care management services are likely to be offered to a limited number of patients.

A number of options have been proposed for payment reforms to move away from fee-for-service, including global or bundled payments and separate reimbursement for care management. A global payment approach to hospital, ER, and ambulatory care could incentivize providers to lower utilization, admissions, and readmissions through programs such as care management. This approach is being tested by the Centers for

Medicare and Medicaid Services in its bundled payments demonstration project, which would reform payment structures to encourage patient-centered care, and its Comprehensive Primary Care initiative, which includes a monthly care management fee. Alternatively, a separate reimbursement could be created for RN case managers under the fee-for-service system; currently, providers who wish to hire case managers must do so without being reimbursed for those services.

Expanded care management programs hold the promise of increasing the quality of life of many patients without access to these services and bringing plans and providers closer to achieving the goals of better care, enhanced patient experience and reduced costs of care.

CONCLUSION

The challenges posed by a growing population of chronically ill patients have become clear. Illness and disease are compounded by the financial burden of paying for services, social and environmental barriers to accessing care, and organizational barriers to delivering effective care. As these issues become more pressing due to an aging population and rising health care costs, a set of solutions are being tested, implemented and spread. ACHP plans have been at the forefront of innovations that improve population health, increase patient satisfaction and lower costs, and their experiences in care management can serve as valuable starting points for the broader implementation of effective, patient-centered care.

There are many approaches to complex case management that include creative use of employees, time, technologies, and other resources. While the various approaches outlined here have yielded some measure of success

for the organizations that tried them, they are neither one-size-fits-all models nor prescriptive solutions. Nor is care management sufficient to transform primary care or to establish a patient-centered medical home; care management, like electronic health records, is just one aspect of patient-centered care.

Whichever care management model health plans or providers choose, the enablers of success will be the same: a commitment to closing gaps in communication and knowledge that leave patients stranded when they most need support; a dedication to working as teams across organizational boundaries despite resistance or physical barriers; and visionary leadership at all levels to guide organizations through the process of transforming medical practices.

The second and third studies in this series will examine these issues in greater detail through the lenses of care transitions and primary care transformation.

V. Appendices

Sections

About ACHP

ACHP Member Organizations

Care Management Programs by
Plan: Basic Information

Contact ACHP

Acknowledgments

References

ABOUT ACHP

ACHP is a national leadership organization that brings together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care in their communities. The 22 community-based and regional health plans and provider organizations that belong to ACHP improve the health of the communities they serve and are on the leading edge of patient care coordination, patient-centered medical homes, accountable health care delivery, information technology use and other innovations that aim to improve affordability and the quality of care that patients receive.

Our Mission

ACHP and its members improve the health of the communities we serve and actively lead the transformation of health care to promote high-quality, affordable care and superior consumer experience.

We realize our mission by:

- Providing a forum to solve our members' most pressing challenges
- Advocating for better health and health care
- Developing quantitative and qualitative tools to improve performance and meet marketplace challenges
- Building the evidence base for health care improvement

ACHP Members Are

- Not-for-profit health plans or subsidiaries of not-for-profit health systems, or provider groups associated with health plans. Member organizations are located primarily in mid-sized and smaller markets and have deep roots in their communities
- National leaders in health care quality that annually rank among the top-performing health plans in the nation
- Innovators in delivering affordable, coordinated, multidisciplinary care, and pioneers in the use of electronic health records.
- Role models for other health plans in innovating to achieve the industry's Triple Aim – better health, better care, at a lower cost

Our History

The Alliance of Community Health Plans was founded in 1984 as The HMO Group to help independent health maintenance organizations identify and share best practices. The group changed its name, appointed new leadership and moved from New Jersey to Washington, DC, in 2001. ACHP continues to help high-performing health plans and provider groups improve coverage and care and to advocate for policies that improve health and health care quality and affordability.

ACHP MEMBER ORGANIZATIONS

Capital District Physicians' Health Plan

Albany, New York | www.cdphp.com

Capital District Physicians' Health Plan was founded in 1984 as a not-for-profit IPA model HMO in Albany, New York. Since then, Capital District and its affiliates have grown to serve more than 400,000 people in 29 counties throughout New York state and seven counties in Vermont.

Capital Health Plan

Tallahassee, Florida | www.chp.org

Created in 1982, Capital Health is a not-for-profit health plan serving more than 118,000 members in the six-county area of Tallahassee, Florida. Capital Health Plan is a mixed model HMO that owns two health center complexes where physicians, nurses and allied health care professionals are directly contracted with Capital Health and provide coordinated care to members.

CareOregon

Portland, Oregon | www.careoregon.org

CareOregon is a not-for-profit organization serving low-income and vulnerable residents of Oregon. The organization was created in 1993 by a partnership of the state's safety-net providers. With 950 primary care providers, CareOregon serves more than 155,000 members in 20 counties throughout the state.

Fallon Community Health Plan

Worcester, Massachusetts | www.fchp.org

Founded in 1977, Fallon Community Health Plan is a locally integrated health plan serving more than 160,000 and providing its members with access to physicians and hospitals throughout Massachusetts. Fallon is the only health plan in Massachusetts that is both an insurer and provider of care, providing group and non-group health plan options, including HMO, POS and PPO, as well as Medicaid and Medicare Advantage plans.

Geisinger Health Plan

Danville, Pennsylvania | www.thehealthplan.com

Geisinger Health Plan is a not-for-profit health plan serving 250,000 members in 42 counties throughout central and northeastern Pennsylvania. Founded in 1985, Geisinger provides HMO, PPO and TPA plans for businesses, individuals and families, and Medicare beneficiaries and children enrolled in the Children's Health Insurance Program (CHIP).

Group Health Cooperative

Seattle, Washington | www.ghc.org

Founded in 1947, Group Health Cooperative is a consumer-governed, nonprofit health care system that integrates care and coverage. Along with its subsidiaries, Group Health Options, Inc., and KPS Health Plans, Group Health serves more than 670,000 members in Washington and Idaho. It employs more than 9,000 staff and operates medical centers, a charitable foundation and a research center.

Group Health Cooperative of South Central Wisconsin

Madison, Wisconsin | www.ghc-hmo.com

Group Health Cooperative of South Central Wisconsin is a nonprofit, managed health care organization serving more than 64,000 members. Group Health's five primary care clinics integrate with its insurance arm to provide primary care and health insurance products and, through its partnership with the University of Wisconsin, specialty and tertiary care to its members.

HealthPartners

Minneapolis, Minnesota | www.healthpartners.com

Founded in 1957 as a cooperative, HealthPartners is the nation's largest consumer-governed, nonprofit health care organization. It serves more than 1 million members, including a large population of residents in the Minneapolis/St. Paul area. HealthPartners is a pioneer in developing programs that measure health care quality and reward providers that meet high clinical standards of care.

Independent Health

Buffalo, New York | www.independenthealth.com

Independent Health began in 1980 as one of western New York's first HMOs. Independent Health covers more than 280,000 members in New York and across the country with more than 100 plans, services and products. Among other programs, Independent Health is leading a multifaceted program to redesign physician offices to be more patient-centric.

Kaiser Permanente

Oakland, California | www.kaiserpermanente.org

Founded in 1945, Kaiser Permanente is a health care provider and not-for-profit health plan serving more than 8.9 million members in nine states and the District of Columbia. Kaiser Permanente comprises Kaiser Foundation Health Plans, Kaiser Foundation Hospitals and the Permanente Medical Groups.

Martin's Point Health Care

Portland, Maine | www.martinspoint.org

Martin's Point is a not-for-profit health care organization based in Portland, Maine. Through health care centers, health plans and employer wellness services, Martin's Point serves more than 38,000 members throughout northern New England and New York.

New West Health Services

Helena, Montana | www.newwesthealth.com

Founded in 1998, New West Health Services is a provider-sponsored health plan serving residents of Montana. With headquarters in Helena, operations center in Kalispell, and regional offices in Billings and Missoula, New West has partnerships with more than 4,600 medical providers and serves more than 40,000 members and 700 employer groups.

Presbyterian Health Plan

Albuquerque, New Mexico | www.phs.org

Presbyterian Health Plan and Presbyterian Insurance Company, Inc., are owned by Presbyterian Healthcare Services, New Mexico's largest locally owned health care system, serving more than 400,000 members. Based in Albuquerque, Presbyterian Health Plan offers a statewide health care delivery system and has more than 25 years of experience in managed care.

Priority Health

Grand Rapids, Michigan | www.priorityhealth.com

Priority Health is a nonprofit health plan serving more than 609,000 members in 65 counties in lower Michigan. More than 12,000 employers offer Priority Health coverage to their employees, and more than 14,000 health care providers participate in its network. Priority Health offers products for employer groups, individuals, and Medicare and Medicaid patients.

Rocky Mountain Health Plans

Grand Junction, Colorado | www.rmhp.org

Rocky Mountain Health Plans (RMHP), founded in Grand Junction, Colorado in 1974, is a locally-owned, not-for-profit organization that serves more than 173,000 members. RMHP is the only health plan in Colorado serving every market segment including employers, individuals, Medicare, Medicaid and Child Health Plan Plus beneficiaries.

Scott & White Health Plan

Temple, Texas | www.swhp.org

Scott & White Health Plan began operations in 1982 as Centroplex Health Plan, a not-for-profit HMO covering two central Texas counties. Scott & White has grown to more than 194,000 members in 50 counties and offers a variety of insurance plans for members and employers, including a child-only plan, statewide self-insured plan and a Medicare prescription plan.

Security Health Plan

Marshfield, Wisconsin | www.securityhealth.org

Security Health Plan is a physician-sponsored, not-for-profit HMO founded in 1986 as an outgrowth of the Greater Marshfield Community Health Plan. Security Health Plan has a membership of more than 187,000 people in 32 counties in northern, western and central Wisconsin, and a network that includes more than 4,350 affiliated physicians, 40 affiliated hospitals and over 55,000 pharmacies nationwide.

SelectHealth

Murray, Utah | www.selecthealth.org

SelectHealth is a non-profit health insurance organization serving more than 538,000 members in Utah and southern Idaho. As a subsidiary of Intermountain Healthcare, SelectHealth is committed to health improvement, superior service, and providing access to high-quality care. In addition to medical plans, SelectHealth offers dental, vision, and life and disability coverage to its members. SelectHealth also administers several government health plans including both state and federal high risk pools and the Children's Health Insurance Program.

Tufts Health Plan

Watertown, Massachusetts | www.tufts-health.com

Founded in 1979 as a not-for-profit HMO, Tufts Health Plan offers health care coverage to individuals and through employer groups in Massachusetts and Rhode Island. Serving more than 743,000 members through a network of 90 hospitals and over 250,000 providers, Tufts has the highest enrollment in consumer-driven health plans in New England.

UCare

Minneapolis, Minnesota | www.ucare.org

Founded in 1984, UCare is an independent, nonprofit health plan serving more than 195,000 members in Minnesota and western Wisconsin. UCare provides health care programs sponsored by the state of Minnesota and Medicare through a network of health care providers, including 16,000 physicians at nearly 5,000 locations.

UPMC Health Plan

Pittsburgh, Pennsylvania | www.upmchealthplan.com

UPMC Health Plan is owned by the University of Pittsburgh Medical Center (UPMC). UPMC serves more than 1.1 million members. As part of an integrated health care delivery system, UPMC Health Plan partners with the medical center and a community network of more than 80 hospitals and 7,600 physicians to serve residents in a 29-county region of western Pennsylvania.

CARE MANAGEMENT PROGRAMS BY PLAN: BASIC INFORMATION

	Capital District Physicians' Health Plan	Capital Health Plan	CareOregon	Fallon Community Health Plan		Geisinger Health Plan
Name of program	PCMH Embedded Case Management Model	Complex Case Management	Primary Care Renewal	Case Management	Home Run Program	ProvenHealth Navigator®
Type of model	Embedded	Centralized	Provider-employed CMs are embedded Health plan CMs work telephonically	Centralized case managers working from home. Future plan is to have designated case managers work on site in provider practices	NPs perform health assessments in the home for members who meet program criteria	Embedded in all practices (both plan-affiliated and network)
Who employs care managers	Health plan	Health plan	Practice and plan both employ CMs	Health plan	Plan employs nurse practitioner and CM	Health plan
Number and types of sites care managers work in	9 primary care and FQHC sites, expanding to 12	One administration site housed within the Care Coordination Department	5 primary care clinics	N/A	N/A	44 Medical Homes
Which members/products are services available for?		Commercial and Medicare		Medicare Advantage, commercial, Medicaid	Medicare Advantage	Commercial and Medicare
Payment/reimbursement incentives available for physicians?	As part of PCMH model, provide PMPM practice transformation payments, performance bonuses, and risk adjustment		Structural transformation supported by grant money, tied to development of tangible care enhancements; Payment model for FFS clinics for quality targets and improvement	N/A	N/A	Significant value-based incentives through medical home model; hybrid of FFS payments, P4P, practice transformation stipends

Group Health Cooperative	Independent Health	Presbyterian Health Plan	Priority Health	Security Health Plan	UCare	UPMC Health Plan
Complex Case Management	Case Management	Presbyterian's Integrated Care Solutions Program	PCMH Pilot	Care management	Care management	UPMC Partners in Excellence
Embedded in group practice Centralized for network	Embedded	Embedded in group practice In network, most work is telephonic	Embedded plan CM alongside practice CM	Centralized	Centralized	Embedded
Health plan	Health plan	Health plan, group practices, and hospital all employ CMs	Practice and plan each employ CMs	Health plan	Health plan	Health plan
28 Primary Care sites, 4 specialty sites, and 3 centralized telephonic sites	18 primary care (including pediatric sites) with 3 PCCs assigned to cover all sites; PCCs are not embedded in all sites	11 provider clinics	15 primary care practices	2 office sites	N/A	49 internal medicine and family practice sites
Commercial, Medicare, Medicaid	All products	All products	All products	All products	Dual eligibles, SNP members with disabilities, Medicare, and Medicaid	All products
Currently developing Provider incentive programs based on a range of quality outcomes	Financial incentives around cost and quality outcomes		Upfront grant funding Ongoing PMPM for CM support, incentive program for PCMH recognition			Standard P4P; case management fee currently to one large physician group; gain sharing currently with a physician health organization

	Capital District Physicians' Health Plan	Capital Health Plan	CareOregon	Fallon Community Health Plan		Geisinger Health Plan
Care manager caseload		10-15 complex case management patients per CM		Target is 60 per case manager	1.5 FTE manage 150 participants	130-150 per CM
Frequency of CMs meeting with providers / communication with providers	Frequent communication through SEC team Quarterly meetings	Face-to-face meetings are arranged on an as-needed basis. CHP has a Network Newsletter for sharing general information with all providers. Messages can also be posted on CHPConnect and on the CHP website	Frequent meetings of PCR Steering Committee; fully collaborative decision-making	As needed to coordinate services, clarify or convey clinical information	NP and geriatrician close, ongoing interaction	Formal monthly meetings are held at all PHN sites to review workflow and office redesign, case studies, and performance feedback including quality, utilization and cost data supplied by the health plan
Social workers and others on multi-disciplinary team?		Contract with social worker		2 FTE social workers at this time	Team includes geriatrician, NPs, case manager, social worker and Program Support Coordinator	Pharmacist for high risk medication assistance as well as medication adherence reporting

Group Health Cooperative	Independent Health	Presbyterian Health Plan	Priority Health	Security Health Plan	UCare	UPMC Health Plan
50 per CM along with other duties such as post hospital phone calls	5-7 practices each; CM caseload of ~50 complex CM cases	35-40 patients per CM		40-60 patients per CM	MSHO: 75-100; UCare Connect: 50-75; UCare for Seniors: 50-80; PMAP: ~200	Most PBCMs have between 80-200 members on their work list
Weekly chronic disease huddles in group practice Regular communication at beginning and end of case management, and as needed during case management	Conference with doctors on complex patients, but primarily work with members Monthly collaborative meetings PCCs define roles based on needs of practice Electronic PCMH updates	Monthly and as needed	Monthly / quarterly care management collaborative meetings + “go-sees” Health plan case managers meet monthly with POC CM in “huddles” to discuss PH members in CM	Send initial notification to PCPs Additional ongoing contact during engagement as appropriate	Initial communication plus as-needed	Monthly meetings at outset transition into quarterly meetings once the PBCMs have been established PBCMs meet together weekly
Social workers embedded in group practice. In network, SWs live in local areas Compassionate CMs; High-risk CMs; High-risk heart failure CMs; Transplant CMs; Geriatric surgery CMs	Team includes PCC (Practice Care Coordinator), PMC (Practice Management Consultant) and a Pharmacist Meetings include physicians, nurses, and front office staff from the practice as well as the CM and health plan leadership	ED navigator program Community coach Employ social worker	Plan-employed social workers, respiratory therapists, RN’s and many other qualified health professionals as well as those who are familiar with government program requirements	Social workers are employed by plan. All care managers have Chronic Care Professional certification – specialized training in motivational interviewing and health coaching	Social workers employed by plan Support staff for Care Managers – Associate care managers Pharmacist participates in case reviews Medical directors consult on complex cases	Virtual support team of interdisciplinary staff includes: Outreach Staff; Social Workers; Pharmacists; Lifestyle / Health Coaches; Mobile Staff; Utilization Management; Discharge Planners; Member Services; Provider Advocates

CONTACT ACHP

For more information about care management efforts at ACHP plans or the Health Plan Innovations in Patient-Centered Care series, email innovations@achp.org.

General questions about ACHP can be directed to info@achp.org. More information can also be found at our website at www.achp.org.

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