Advanced Medical Homes: Bending the Trend

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“Hot Spotting” in Employed Populations

1. Humboldt County, CA: “Priority Care”
   • Partnered with CalPERS, PG&E and PBGH (Anthem as ASO);
     – Disseminated rural county model within a distinguished IPA inserting RN care managers into 25 private practices
     – Enrolled patients starting July 2010
     – 20% savings in first year, net of investment
     – Expanding for local employers and Blue Shield HMO members

2. Stanford University: “Stanford Coordinated Care”
   • Pilot for University & Hospital Employees + Dependents enrolled in self-insured plan.
     – Clinic site staffed a team of medical professionals and health coaches who help people with chronic illnesses lead a healthy life and smoothly navigate their healthcare.”
     – Enrolled first patients starting xxx
     – Something about early savings/cases
A new approach to thriving in a complex health care system. Priority Care Nurses working with patients, their doctors and health care practitioners to better meet the patient’s needs.

Participants:
• Cal-PERS, PG&E
• Anthem as ASO
• IPA as care management
• Providers
• Members
Paying for Value: Intensive Outpatient Care Program with Embedded Case Managers

<table>
<thead>
<tr>
<th>Measure compared to baseline</th>
<th>Result</th>
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<tbody>
<tr>
<td>Health care costs of pilot participants versus control group</td>
<td>-20.0%</td>
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<tr>
<td>Hospital admissions</td>
<td>-28%</td>
</tr>
<tr>
<td>Improvement in mental functioning of pilot participants</td>
<td>+16.1%</td>
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<tr>
<td>Participants feeling that care was “received as soon as needed”</td>
<td>+17.6%</td>
</tr>
<tr>
<td>Average number of patient-reported workdays missed, 6 months</td>
<td>-56.5%</td>
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- Improve care coordination for predicted highest cost 5-20% of member
- Sites implemented shared care plans, increased access, proactively managed care
- Sites were paid a case rate pmpm to cover non-traditional services
- Model being expanded nationally – CalPERS/PGE/Boeing in California (with gainsharing); “hot-spotters” in New Jersey; Boeing in St. Louis

Source: http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/
A little background information:

- Ambulatory ICU concept applied to commercial PPO population – discussions began early 2010
- Identifying patients from claims and assigning a DxCG risk score
- Perhaps 700+ patients eligible (list refreshed x 1)
- Utilizing community PCPs to recruit and follow patients
  - Little push-back…but hard to coordinate
- Enrollment began July 2011
Humboldt-Del Norte IPA  Priority Care

Priority Care RECRUITMENT & ENROLLMENT PROCESS

**Humboldt IPA**

- Physician Outreach & Office Staff Preparation

**Anthem**

- Priority Care Patient Identification:
  - Member Eligibility (Anthem/CAL Pers/PG&E)
  - DxCG score > 2.5
  - Attributed PCP
  - ETG - Episode Treatment Group
  - Pharmacy Data
  - Home address in IPA network area with claims from same area

**1st Outreach Call from PCP / Office Staff & Letter #1**

- Member Recruited:
  - Consent signed
  - Information entered into database
  - Initial Visit Scheduled

**2nd Outreach Follow-up call from CM**

**3rd Outreach Letter #2 from RN Care Manager**

**4th Outreach Call from RN Care Manager**

- Patient Opt Out; Evaluate Reason

**Priority Care Process Begins**

**TRACK & TREND**

- # Enrolled
- # of attempts for enrollment
- Enrollment Outreach yielding greatest # of patients enrolled
- Opt out reasons
RN Assessment Tools

Performed on initial visit and repeated when indicated. Provide valuable information related to functional health, physical and mental well-being, abilities for self management and utilization of services.

- SF-12
- PHQ-9
- PAM
- Domain

Leads to patient centered goals, interventions and Action Plans.
4 Domains – what the patient is facing

The Team = Patient, Providers, RN Care Manager, patient’s support network
The Patient Activation Measure® (PAM®) assessment gauges the knowledge, skills and confidence essential to managing one’s own health and healthcare.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting to take a role.</td>
<td>Building knowledge and confidence</td>
<td>Taking action</td>
<td>Maintaining behaviors</td>
</tr>
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</table>
In an analysis of 33,163 patients of Fairview Health Services, a large health care delivery system in Minnesota, we found that patients with the lowest activation levels had predicted average costs that were 8 percent higher in the base year and 21 percent higher in the first half of the next year than the costs of patients with the highest activation levels, both significant differences.

Hibbard, J et al Health Aff February 2013 vol. 32 no. 2 216-222

<table>
<thead>
<tr>
<th>PAM</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td><strong>Domains</strong></td>
<td><strong>Social</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>Access</strong></td>
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<tr>
<td></td>
<td><strong>Behavioral</strong></td>
<td></td>
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<td></td>
<td><strong>Medical Trajectory</strong></td>
<td></td>
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</tbody>
</table>

Workflows based on patient variation
Member Comments

Collaboration
RN, Member, Provider

RN interventions, comments

Provider comments
“Hello Jane, this is Mary, I just got back from my doctor visit – I’m scared; my breast biopsy is positive for breast cancer....”

The shared decision making process begins: The RN clarifies what the patient heard; they discuss treatment options described by her PCP; and they develop an Action Plan for how to proceed.

“I am so happy that you are dedicated to helping me to understand the ‘big picture,’ and are available to talk whenever I need to call.”

Referrals to Surgeon, specializing in breast cancer and Radiation Oncologist made. Jane accompanies Mary to each of these visits.

Both specialists comment, “This is so great to have your nurse come to these appointments. She offers you support and can clarify the information presented!”
“Lab tests, lab tests, lab tests…
“My PCP wants this test, the specialist orders more tests. I go to the lab 2 or 3 different times and I wonder what tests are being ordered and why do I need so many.”

The RN speaks with the PCP and the specialist and determines that they are both ordering some of the exact same lab tests just a few days apart.

She assists them in combining their lab requests. This eliminates redundant testing and ensures that all of the baseline tests are done once for all providers.

Care coordination reduces duplication of testing saving costs and member time.

All providers have the information they need.

The member learns about his health.

“Thanks, for helping me to understand why all the lab work is ordered and now I only have to go once.”
During his intake visit, Rex, who is 41, tells Cynthia that he is frustrated by his diabetes and its complications. His A1c remains high (10.5), he has chronic foot pain from neuropathy and skin ulcers on his toe and is currently unable to work because of the pain. He is divorced, lives alone and pays child support for his 3 children.

Rex has had diabetes for 20 years. He monitors his blood sugar (BG) several times a day, they are always high. Consulting with Rex and his PCP the goal is to adjust his insulin in an attempt to bring his sugars down.

Collaboration with the PCP, the HEA RN diabetic educator, Rex and Cynthia yields an Action Plan: Increase insulin slowly over several days; monitor BGs; Cynthia will facilitate Rex getting the correct syringes and they will check-in by phone each day to discuss how the Action Plan and BG’s are doing – Goal = BG below 150 in the mornings.

“I am afraid of any drastic changes - - they don’t always turn out too well”

All of this took place over the course of 7 days – we will keep you posted on his progress.
Humboldt-Del Norte IPA Priority Care

Patient history:
A 64 year old, with multiple chronic conditions, some related to a radical urological surgery for cancer. He takes nine (9) different prescription medications. He is very well connected with his PCP and he has a supportive family. He has been searching for “the magic bullet” to help him…
“They (Priority Care nurses) are there to help you problem solve, give you things to try... The ER just gives you a pain pill and tells you to call your doctor on Monday.”

Our Care Management Interventions

- Assessment: Medical Neighborhood, Social Support, Self Management, Mental Health and Medical & Health Trajectory form the basis for an Action Plan
- Home Visit and Shared visit with the PCP
- Coordination of care with providers
- Mental health provider referral
- Regular and frequent patient contact from the RN Care Manager
Before  
02/2010 – 06/02/2011

- 6 ER visits
- 1 Inpatient Admission
- 1 Planned Surgery
- 1 PCP and 5 Specialists
- Depression Score 20

$41,639.00 (billed charges)
$2,947.00/month

After  
06/02/2011 – 10/04/11

- No ER visits
- No Inpatient stays
- No Surgeries
- 1 PCP and 2 Specialists
- Depression Score 12

$2,560.00 (billed charges)
$640.00/month
## Findings: Priority Care Total Utilization Metrics

<table>
<thead>
<tr>
<th>Exclusion Method</th>
<th>Number of Members Excluded (n=259)</th>
<th>Inpatient Days</th>
<th>Inpatient Admissions</th>
<th>Outpatient Visits</th>
<th>Professional Visits</th>
<th>ER Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> = All Members and Claim Lines Included</td>
<td>0</td>
<td>-63%</td>
<td>-51%</td>
<td>-17%</td>
<td>-11%</td>
<td>-25%</td>
</tr>
<tr>
<td><strong>B</strong> = All Members Included; Claim Lines over $250,000 Excluded</td>
<td>0</td>
<td>-59%</td>
<td>-50%</td>
<td>-17%</td>
<td>-11%</td>
<td>-25%</td>
</tr>
<tr>
<td><strong>C</strong> = Members with Total Allowed Amount over $250,000 Excluded</td>
<td>4</td>
<td>-52%</td>
<td>-54%</td>
<td>-15%</td>
<td>-11%</td>
<td>-26%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Utilization Change from Period 1 to Period 2</th>
</tr>
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<tbody>
<tr>
<td><strong>Inpatient Days</strong></td>
</tr>
<tr>
<td><strong>Utilization Change from Period 1 to Period 2</strong></td>
</tr>
<tr>
<td><strong>A</strong></td>
</tr>
<tr>
<td>-102</td>
</tr>
<tr>
<td>-120</td>
</tr>
<tr>
<td>-88</td>
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<tr>
<td>-66</td>
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<tr>
<td>-40</td>
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<tr>
<td>-20</td>
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<tr>
<td>-10</td>
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<table>
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<th>Utilization Change from Period 1 to Period 2</th>
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<tbody>
<tr>
<td><strong>Outpatient Visits</strong></td>
</tr>
<tr>
<td><strong>Utilization Change from Period 1 to Period 2</strong></td>
</tr>
<tr>
<td><strong>A</strong></td>
</tr>
<tr>
<td>-208</td>
</tr>
<tr>
<td>-601</td>
</tr>
</tbody>
</table>
## Findings: Priority Care Total Cost Metrics

<table>
<thead>
<tr>
<th>Exclusion Method</th>
<th>Number of Members Excluded (n=259)</th>
<th>Total Allowed Amount</th>
<th>ER Surgeries &amp; Visits Allowed Amount</th>
<th>% Change from Period 1 to Period 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A = All Members and Claim Lines Included</td>
<td>0</td>
<td>-23%</td>
<td>-16%</td>
<td></td>
</tr>
<tr>
<td>B = All Members Included; Claim Lines over $250,000 Excluded</td>
<td>0</td>
<td>-13%</td>
<td>-16%</td>
<td></td>
</tr>
<tr>
<td>C = Members with Total Allowed Amount over $250,000 Excluded</td>
<td>4</td>
<td>-29%</td>
<td>-19%</td>
<td></td>
</tr>
</tbody>
</table>

![Graph showing total allowed amount change from Period 1 to Period 2 for A, B, and C categories.](image1)

![Graph showing ER surgeries & visits allowed amount change from Period 1 to Period 2 for A, B, and C categories.](image2)
Adapting an Innovation for a Unique User Group
Where is the health spend for Stanford Employees?

• Target patient profile
  – High medical usage .... Those in the top 10% of employer population
  – $33K in average annual spending for medical & Rx *

<table>
<thead>
<tr>
<th>Medical Usage by Category</th>
<th>% of Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist w. Ancillaries</td>
<td>50%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>31%</td>
</tr>
<tr>
<td>Rx</td>
<td>13%</td>
</tr>
<tr>
<td>ED</td>
<td>3%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>3%</td>
</tr>
</tbody>
</table>

* Data based on Stanford Hospital & Clinics and LPCH PPO & partial HMO plan- 2010-11
Benefit to Enroll in Primary Care Plus

**Benefit Overview:**
- $0 co-pay at Stanford Coordinated Care to see your provider and care team*
  *If you are a member of the High Deductible PPO Plan, there will be a contribution to your Health Savings Account (HSA) for the initial months of participation
- 24/7 direct access to a member of your care team- via phone and e-mail
- Same day and next day appointments available
- A Care Coordinator with the time to listen and plan your health needs with you
- Free access to Stanford’s *Better Choices, Better Health*, internationally-recognized chronic disease self-management program
- Pharmacist review of your medications
- Coordination of your complex care

Some examples of ongoing conditions that may qualify you are:
- Diabetes, heart failure, asthma/chronic lung disease, chronic pain
- Also, anyone taking 5 or more prescription medications
Where Do Savings Come From?

• “Support the patients, manage the specialists”
• Reduce ED visits and avoidable admissions
• Better self-management
• Point-of-Care services
• Generics
• Facility charge reductions – ambulatory surgery centers
• Pricing: lab and imaging
SCC – “We’ve Got Your Back!”

• Tools
  – Benefit design
  – Patient selection and recruitment ("carrots only")
  – Measurement strategies – *Triple Aim*
  – IT decision support – knowing who is “on fire, smoldering, or kindling” and how/where to intervene
  – Protocols to enable team-based care
  – Clinic design
SCC – “We’ve Got Your Back!”

• Teams
  – Data drives team composition
  – Patient advisors guiding process
  – Health coaches, care coordinators, PT, behavioral health and primary care, pharmacist at point-of-care
  – Links to campus wellness program, occupational health
  – CDSMP embedded in wellness
SCC – “We’ve Got Your Back!”

- Training
  - On-site training by prototype
  - Specific skills workshops
    - Motivational interviewing
    - Active listening
    - Hiring the right team
    - Developing team-based protocols and workflows