Older, Poorer, and Sicker:

Perspectives on Transforming Care for the Most Vulnerable of the Dual Eligibles - A View from the Trenches

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AltaMed-Facts

- One of nation's largest FQHC's, with wrap-around IPA
- PCMH certified by TJC and NCQA
- 73% earn less than $44,700/year for a family of four
- Take all insurance types; 27% have no insurance
- 81% of our patients are Latino
- 1,900 employees across 43 sites
- 125,000 patients served; 930,000 annual visits
- 140 providers, mid-level practitioners
- 600 contracted specialists

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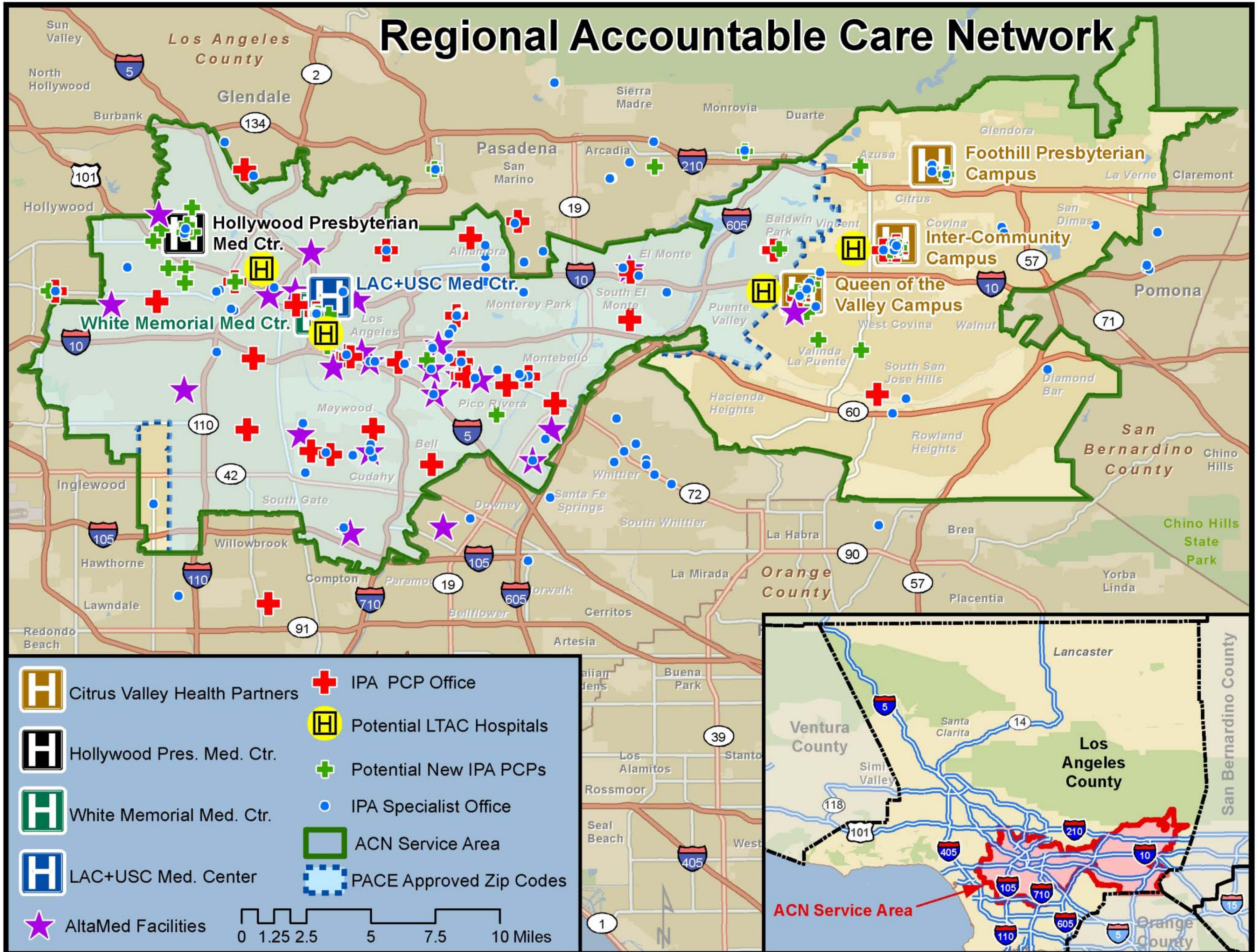

Regional Accountable Care Network
Hollywood Presbyterian Med Ctr.
LAC+USC Med Ctr.
White Memorial Med Ctr.
Foothill Presbyterian Campus
Inter-Community Campus
Queen of the Valley Campus
Los Angeles County
San Bernardino County
Orange County
Citrus Valley Health Partners
Hollywood Pres. Med. Ctr.
White Memorial Med. Ctr.
LAC+USC Med. Center
AltaMed Facilities
IPA PCP Office
Potential LTAC Hospitals
Potential New IPA PCPs
IPA Specialist Office
ACN Service Area
PACE Approved Zip Codes
0 1.25 2.5 5 7.5 10 Miles
Ventura County
Los Angeles County
San Bernardino County
Lancaster
ACN Service Area

What we learned from the SPD's

- Medical management resources had to be grown quickly
- HRA's can be done by the group faster and more accurately
- Group case management can reduce utilization more than by health plan
    - Less confusion of patient
    - Better communication, access to EHR
- SPD utilization is 120% of Medicare HMO

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Our Medical Management Model

- Strive for full delegation
- All patients get HRA and tiering
- Central team
- Clinic team
- Hospital team
- ACN team
- Transitions of care model

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Case Management: Case Study

- 64 yr old male
- Muscular Dystrophy
- Hepatitis C
- HTN
- DM
- Chronic Pain
- Symptomatic BPH
- Lumbago
- Pressure Ulcer
- Generalized Weakness
- Dental Caries

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Psychosocial Issues

- Depression
- Unstable Living Arrangement
- Insomnia
- History of IV Drug Abuse
- Pain Medication Seeking Behavior

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Overall utilization

- 4-23-10: ER admit for Syncope
- 4-26-10: ER admit for Syncope
- 5-13-10: ER admit for OD/Suicide Attempt
- 5-17-10: ER admit for Suicidal ideation
- 5-21-10: Admit for Drug Withdrawal Sx
- 6-10-10: Admit for Diabetic complications/neuropathy
- 7-9-10 to 9-21-10: Multiple USC specialty follow-up evals with GI/Neurology
- Needs GT for dysphagia/weight loss/generalized weakness but patient refused

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8-10-10 starts Complex Case Management

- Care Coordination with Specialists/PCP
- Patient Education
- Lifestyle Modification
- Social Services
- Continuous Patient Education
- Routine Calls to Patient and Patient's Family for continuous support
- Interdisciplinary Team Meetings

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Positive outcomes

- Patient moved out of Garage with no bathroom to a Residential Facility
- GT placement 8-2011
- Improved Family Social Support
- Methadone Treatment Program
- Compliance with Medications, PCP and Specialist Follow- ups
- 2 ER visits: 11-29-11 & 7-9-12

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Case Management: Results

	PRE - CM	POST - CM
Outpatient Care	$12,000	$5,000
Hospitalizations	3	2
ER Visits	5	2
Hospital Days	9	7
Professional Fees	$3,500	$1,500
Cost of Care (Per Month)	$8,375	$932
Cost of Case Management (Per Month)	-	$351
Cost of improved Quality of Life	-	Priceless

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Success Factors

- Small panel size
- Interdisciplinary teams
- Fully integrated care
- More services at point of care
- More personal “touches”
- Intense Medical Management
- Transportation
- Social Services
- Extended Hours
- Aligned financial incentives-role of contracting

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Workforce Challenges

- Duals are currently cared for by providers that are not in managed care and are not board certified
- Spanish-speaking health workers, especially behavioral health, are scarce
- Will there be enough PCP's?

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Resource Challenges

- Long term care facilities
- Skilled nursing facilities
- Adequate funding?

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Patient Challenges

- Patients will be sicker, with more psychosocial needs
- Obtaining patient input in process design
- Obtaining patient engagement and compliance
- Different payers require different processes

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Contracting Challenges

- Do we understand cost/risk of the Duals
  - What is the cost/opportunity of LTC?
  - Is there enough money after everyone takes their margin?
- Full delegation of medical management?
- Uniform DOFR?

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Hospital/Medical Group Challenges

- Hospitals see their revenue and influence decreasing
- Want to:
  - Increase market share
  - Redefine their role
    - "Employ" providers
    - Be integrators of care
    - Be owners, not vendors
- Hospitals need to safely change financial models

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Other System Challenges

- Retail pharmacies are not adequately integrated into the system
- CHC collaboration
- Safety-net coordination

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Technology Challenges

- The value of technology grows exponentially with the # of external inputs – so does the complexity and cost
- HIPAA
- Master Patient Index
- Cost/ROI

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What it feels like...

Where We Need to Invest

- Standardization
  - Benefit design
  - DOFR
- Workforce
  - Evaluation of providers, especially non-board certified
  - Training of culturally sensitive, bilingual staff, especially behavioral health
- Best methods of patient input and engagement
- Patient education regarding palliative and hospice care
- Design all inclusive systems of care
- Alternative payment models that go beyond PCMH to include all care settings
- Medication reconciliation with retail pharmacies
- Technology
  - Master Patient Index
  - Health Information Exchange

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Summary

- **The lines are blurring between "traditional" and "safety net" providers –** how do we best care for new populations entering managed care?
- **Patients:**
  - Will be sicker
  - Have greater psychosocial needs
- **Providers:**
  - Need enhanced medical management capabilities
  - Need enhanced IT
    - Recordkeeping – EHR
    - Communication – portals, HIE, MPI
    - Analytics

We need to get it right!

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