Integrated Case Management: Value-Based Assistance for Complex Medical and Behavioral Health Patients

Prepared for 14th Annual TCOM’s Conference
- Evidence and Transformation: Taking Person-Centered Care to Scale
October 3 – 5, 2018
Learning Objectives

• Understand the core components of the Value-Based Integrated (Medical / Behavioral Health) Case Management Model (VB-ICM)
• Understand how to implement the VB-ICM Model (from Current Case Management Model to VB-ICM)
• Learn the VB-ICM value on investment (Outcomes)
Agenda

- Overview
- Why VB-ICM?
- What is the VB-ICM Model?
- Implementing VB-ICM Model
- Outcomes
- Appendix
- References
Premera’s Focus
Premera’s Focus: Customer Obsessed Culture

- **Purpose** – Improving customers’ lives by making healthcare work better
- **Values** – The customer is at the center of all we do
  - Identify with the customer
  - Act with urgency
  - Be excellent
  - Challenge convention
  - Do the right thing
  - Work together
- **Customer Statement** – “You take great care of me and make it simple and easy.”
Premera is Addressing the Four Customer Problems

- Healthcare costs are too high – “It costs too much”
- There is inconsistent care and quality – “I don’t get what I need”
- Waste is everywhere – “I get what I don’t need”
- The experience is poor – “I don’t have the experience I want and deserve”
Why Value-Based Integrated Case Management?
The Problem

• Evidence supports a strong link between behavioral health conditions and chronic illness
  – 2 - 3 times more costly with chronic medical and behavioral health comorbid conditions
  – 4 - 5 times more likely to be hospitalized
  – More than half of all behavioral health treatment occurs in the general medical system
  – 70% of primary care visits are related to psychosocial issues
  – Estimated 9 - 17% of total healthcare expenditures could be eliminated with integration between medical and behavioral healthcare
The Problem: Cost

PMPM Costs for Patients with Diabetes Increases with Co-existing Behavioral Health Condition - Commercial Populations

- NoMH/SUD: $1,004
- Non-SPMI MH: $1,566
- SPMI: $2,036
- SUD: $2,117

Diabetes without Complications
Diabetes with Complications

MH: Mental Health
SPMI: Severe and Persistent Mental Illness
SUD: Substance Utilization Disorder

Milliman (2018)
The Problem: Quality

- Patients often do not get the care they need
  - Preventive care is underutilized
  - Chronic disease treatment lacks coordination and effective treatments such as drug therapies or self-management skill training and monitoring
- Patients receive unnecessary and even harmful care
  - Provider variation and lack of consistent adoption of evidenced-base care
The Problem: Experience

- Patient experience is focused on whether or not something that *should have happened* in a health care setting *actually did happen* or *how often* it happened such as
  - Easy access to information
  - Getting timely appointments
  - Good communication with health care providers
  - Provider coordination between different specialties and between levels of care
  - Receiving evidenced-based care
Value-Based Integrated Case Management Model
What is Value-Based Integrated Case Management?

- A case management model that utilizes a *relationship-based, interdisciplinary approach* to address *clinical and non-clinical barriers* to improved health outcomes
Targeting

- Value-Based Integrated Case Management (VB-ICM) targets members with health complexity, high utilization and functional impairment.

- Health complexity is defined as the interference with the achievement of expected or desired health and cost outcomes due to the interaction of biological, psychosocial (behavioral health), social, and health system factors when individuals are exposed to standard care delivered by their doctors.

Aina & Susman (2006); Anderson & Horvath (2004); Bayliss & Steiner (2003); CMSA, (2010); de Jonge et al. (2003); de Jonge et al. (2006); Egede (2004); Fischer et al. (2000); Hansen et al. (2001); Huyse et al. (2006); Kathol, RG, Knutson, KH, Dehnel PJ. (2016)
Targeting: Segmentation and Health Status

- Segmentation and health status target individuals with impactable needs
Targeting: Points of Intervention

- Focused is on preventing acute events, optimizing care and supporting the best long-term outcomes
Outreach and Engagement

- Leverage individual’s engageable moment when they call us, meeting individuals where they are and delivering value with each interaction
  - Customer service offers a of warm transfers of targeted individuals to our clinicians
  - Extended operation hours including evenings and weekends
  - Staff trained in evidenced-based engagement skills
    - Certified Motivational Interviewing National Trainers (MINT)
    - Extensive initial and ongoing training, call assessment and individualized coaching
  - State-of-the-art propriety tools that provide comprehensive individual view to assist clinicians in providing value with each interaction
Single Point of Contact

- Integrated approach between Utilization Management, Pharmacy and Clinical Programs with enterprise-wide “real time” support
Whole Person Assessment

• VB-ICM utilizes a narrative, relationship-based assessment approach

  – Know the individual as a person, not just their conditions
  
  – Identify and leverage the individual’s true motivators for change
  
  – Focus on identifying and eliminating the individual’s barriers in the following domains
    ▪ Biological
    ▪ Psychological
    ▪ Social
    ▪ Health System

• Staff are interdisciplinary trained to address all the members barriers
Guided Interview

- Address six content areas
  - General Life Situation
  - Physical Health
  - Emotional Health
  - Interaction with Treating Providers
  - Health System Issues
  - Sensitive Information

- Conversation supports scoring the VB-ICM-CAG
  - Allow the discussion to flow vs. prescribe course
  - Come back to questions as needed within the conversation flow

- Ends with identification of the individual’s goals and establish baseline measurements
Utilize VB-ICM-CAG to quantify barriers pre, during and post services

<table>
<thead>
<tr>
<th>9/15/XX</th>
<th>HEALTH RISKS AND HEALTH NEEDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lucinda</td>
<td>Historicial</td>
</tr>
<tr>
<td>Score = 34</td>
<td>Complexity Item</td>
</tr>
<tr>
<td>Biological Domain</td>
<td>Chronicity (HB1)</td>
</tr>
<tr>
<td></td>
<td>Diagnostic Dilemma (HB2)</td>
</tr>
<tr>
<td>Psychological Domain</td>
<td>Coping with Stress (HP1)</td>
</tr>
<tr>
<td></td>
<td>Behavioral Health History (HP2)</td>
</tr>
<tr>
<td>Social Domain</td>
<td>Job and Leisure (HS1)</td>
</tr>
<tr>
<td></td>
<td>Relationships (HS2)</td>
</tr>
<tr>
<td>Health System Domain</td>
<td>Access to Care (HHS1)</td>
</tr>
<tr>
<td></td>
<td>Treatment Experience (HHS2)</td>
</tr>
</tbody>
</table>

## Anchor Points: Example

<table>
<thead>
<tr>
<th>HP1</th>
<th>Coping with Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Ability to manage stresses/life and health circumstances, such as through support seeking or hobbies</td>
</tr>
<tr>
<td>1</td>
<td>Restricted coping/problem solving skills, such as a need for control, illness denial, or irritability</td>
</tr>
<tr>
<td>2</td>
<td>Impaired coping/problem solving skills, such as non-productive complaining or substance abuse but without serious impact on medical condition, BH, or social situation</td>
</tr>
<tr>
<td>3</td>
<td>Minimal coping/problem solving skills, manifest by destructive behaviors, such as substance dependence, BH illness, self-mutilation, or attempted suicide</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HP2</th>
<th>Behavioral Health History</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No history of behavioral health problems or conditions</td>
</tr>
<tr>
<td>1</td>
<td>Behavioral health problems or conditions, but resolved or without clear effects on daily function</td>
</tr>
<tr>
<td>2</td>
<td>Behavioral health conditions with clear effects on daily function, needing therapy, medication, day treatment, partial program, etc.</td>
</tr>
<tr>
<td>3</td>
<td>Behavioral health admissions and/or persistent effects on daily function</td>
</tr>
</tbody>
</table>
Member Centric Goals and Interventions

• Goals are focused on removing clinical and non-clinical barriers to health improvement identified in the VB-ICM CAG

• Clinicians
  – Establish agreed upon, prioritized goals
  – Focus on actively supporting individuals and collaborating with providers to address barriers to improved health outcomes
  – Elicit change talk to support individuals to improve self-management of their conditions and follow their provider’s treatment plan
Value-Based Integrated Case Consult

- Consultants include
  - Psychiatrist
  - Medical/Surgical Physician
  - Clinical Pharmacist
  - Case managers, team leads, managers and director
  - Other internal departments as applicable (e.g. Clinical Review, Provider Relations)
Implementing VB-ICM
Implementing VB-ICM Model

• Transition planning
  – Transitioning to VB-ICM model requires a strong change management strategy and agility

• Functional and structural reorganization
  – True integration is more than integrating teams, it includes changing the focus of how the case manager thinks about their work

• Process and system design to support automation and operational efficiencies
  – Documentation guides integrated thinking, promotes relationship-based approach and meets accreditation requirements

• Staff training focused on skill building with rapid response to emerging challenges
Lessons Learned

• Anticipate high staff anxiety regarding managing cross-specialty cases even with intensive training and support

• Key to supporting staff includes a rapid response to questions and challenges
  – Recommend weekly trainings and intensive individualized coaching

• Practice with timely, specific feedback supports case manager skill development and mastery

• With experience and regular feedback, case managers gain confidence and apply skills to new dilemmas as they rise
Outcomes
Outcomes: Operational

• Reach and engagement
  — Increased reach rate: 174%
  — Increased engagement rate: 69%
  — Increased active engagement rate: 91%

• Administrative cost and productivity
  — Decreased staffing: 28%
  — Increased productivity: 213%
  — Decreased cost per case: 66%
Outcomes: Clinical

• Health Plan
  — Reduction in depression symptoms: 34%
  — Reduction in anxiety symptoms: 32%
  — Post discharge follow-up appointments: 81% with average of 6 days

• Patient-Centered Medical Home
  — Reduction in emergency room visits: 51%
  — Reduction in hospitalizations: 53%
Outcomes: Quality, Satisfaction and Cost

- Quality
  - NCQA Complex Case Management 2013 and 2016 Audits: 100%

- Satisfaction
  - Overall: 96%
  - Net Promoter Score: 81

- Cost
  - Decrease inpatient costs PMPM: 46%
  - Decrease in total inpatient costs: 47%
Summary

- Significant opportunity to make healthcare work better by addressing both medical and behavioral health conditions
- VB-ICM focuses on removing the individual’s clinical and non-clinical barriers to health improvement in the biological, psychological, social and health system domains
- Implementation requires a strong change management strategy, agility and assisting staff to change how they think and do their work
- Outcomes support VB-ICM model is effective in addressing all four of the customer problems
Appendix
Appendix A: Contact Information

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1.888.704.2091 Fax

rachel.andrew@premera.com
Appendix B: Comparison: Current vs. VB-ICM Model

<table>
<thead>
<tr>
<th>Current Case Management</th>
<th>Value-Based Integrated Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness-Focused</td>
<td>Complexity-Focused</td>
</tr>
<tr>
<td>Problem-Based</td>
<td>Relationship-Based</td>
</tr>
<tr>
<td>Diverse Triggering Methods</td>
<td>Complexity-Based Triggering</td>
</tr>
<tr>
<td>Pediatric case management</td>
<td>Systematic pediatric complexity case management capabilities</td>
</tr>
<tr>
<td>- Based on child/youth manager experience</td>
<td></td>
</tr>
<tr>
<td>Specialty Case Managers (Hand offs)</td>
<td>Interdisciplinary Trained Case Managers</td>
</tr>
<tr>
<td>Initial Outreach Calls by Complex Case Managers</td>
<td>Initial Outreach calls by Engagement Team</td>
</tr>
<tr>
<td>Illness Targeted Assessments</td>
<td>Complexity, Multi-Domain Assessments</td>
</tr>
<tr>
<td>Measurement: Process (e.g. cases touched, calls)</td>
<td>Measurement: Health outcome (e.g. clinical, functional, fiscal, satisfaction, quality)</td>
</tr>
<tr>
<td>Case Load Dictated by Process Measurements</td>
<td>Case Load Dictated by Outcome Measures</td>
</tr>
</tbody>
</table>
Appendix C: Guidelines & Validated Assessment Tools

• Health Wise Knowledge Base
• Duke/UNC Functional Support Questionnaire
• Generalized Anxiety Score – 7
• Modified Morisky Scale
• Medication Adherence Survey
• Patient Health Questionnaire 2 and 9 (PHQ2/PHQ9)
• Patient-Centered VB-ICM Performance (e.g. Clinical, Functional and Economic Goals, Quality of Life, Satisfaction with Providers)
Appendix D: Example: PCIP (Patient Centered VB-ICM Performance)

<table>
<thead>
<tr>
<th>Name and Case #:</th>
<th>Alvarez, Lucinda</th>
<th>1234</th>
</tr>
</thead>
<tbody>
<tr>
<td>VB-ICM Manager Name &amp; Team Name</td>
<td>Maxwell, Ellen</td>
<td>Complex care Team</td>
</tr>
<tr>
<td>VB-ICM Program</td>
<td>Medicaid</td>
<td></td>
</tr>
<tr>
<td>Book of Business</td>
<td>State of New Mexico</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>BASELINE</th>
<th>FOLLOW-UP ASSESSMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Period</td>
<td>9/9/XX</td>
<td>10/25/XX</td>
</tr>
<tr>
<td>Individual's Measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Toe Surgery (ulcer diameter &amp; depth in mms)</td>
<td>12.5, 0.2</td>
<td>1, 0.1</td>
</tr>
<tr>
<td>Back to Work (days worked/week)</td>
<td>0</td>
<td>0.5 (for 1 week)</td>
</tr>
<tr>
<td>Satisfaction with Health (VAS 1 to 10)</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Days Feeling Healthy (days/last month)</td>
<td>0</td>
<td>15</td>
</tr>
</tbody>
</table>

| VB-ICM Manager’s Measures | | | | |
| VB-ICM-CAG Score | 34 | 19 | 16 | 14 |
| Clinical I--HbA1c (percent) | 9.2 | | | 7.8 |
| Clinical II--PHQ-9 (total score--0 to 27) | 19 | 12 | 10 | 9 |
| Functional I--attends child functions (#/month) | 0 | 3 | 8 | most |
| Functional II--knitting (hours/week) | 0 | 0 | 2 | 5 |
| Economic I--ER visits (visits/month) | 3 | 0 | 0 | 0 |
| Economic II--medication costs (out of pocket cost/last month) | $294 | $325 | $205 | $209 |

References
References


References
Continued


