Taking Better Care: Supporting Well-Being for an Aging Population

Alliance of Community Health Plans (ACHP)

Coalition to Transform Advanced Care (C-TAC)

Tuesday, May 12th, 2015

430 Dirksen Senate Office Building

10:00am – 11:15am
Today’s Speakers

• **Sarika Aggarwal, MD** *(Executive Vice President and Chief Medical Officer, Fallon Health)*
• **Jay LaBine, MD** *(Chief Medical Officer, Priority Health)*
• **David Longnecker, MD** *(Chief Clinical Innovations Officer, C-TAC)*
• **Mary Beth Quaranta Morrissey, PhD, MPH, JD** *(American Heart Association)*
• **Bill Novelli** *(Co-Chair, C-TAC)*
• **Patricia Smith** *(President and CEO, ACHP)*
• **Janet Tomcavage** *(Senior Vice President and Chief, Value-Based Care Initiatives, Geisinger Health Plan)*
The Challenge of Advanced Illness Today

The Issue:
- Rapidly aging population
- Health system ill-equipped to provide care

The Results:
- Greater risk for hospitalizations and unwanted treatment
- Conflicting medical advice
- Higher cost of care to families and the nation
What is Advanced Illness?

**Advanced Illness** occurs when one or more conditions become serious enough that general health and functioning decline, curative treatment begins to lose its effect, and quality of life increasingly becomes the focus of care -- a process that continues to the end of life.
Care Continuum

- **Advance Directive**
  - PHASE 1: Healthy or with reversible illness
  - PHASE 2: Early onset, chronic conditions
  - PHASE 3: Progressive, frequent complications
  - PHASE 4: Hospice eligible

- **Disease Progression**
  - Chronic and Curative Care
  - Palliative Care
  - Hospice
### The Big Gap...

<table>
<thead>
<tr>
<th>What People Want</th>
<th>What They Get</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Be at home with family, friends</td>
<td>Recycled through the hospital</td>
</tr>
<tr>
<td>2. Have pain managed</td>
<td>Often unwanted, ineffective treatment</td>
</tr>
<tr>
<td>3. Have spiritual needs addressed</td>
<td>Often die in hospital, in pain and isolation</td>
</tr>
<tr>
<td>4. Avoid impoverishing families</td>
<td>At great cost to families and the nation.</td>
</tr>
</tbody>
</table>
About C-TAC

National, non-partisan, non-profit coalition of 120+ organizations and leaders

A catalyst and voice to support the growing movement across America to transform advanced illness/end of life care
C-TAC’s Goal

“All Americans with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person-and family-centered care that is consistent with their goals and values and honors their dignity.”
The Advanced Care Project

A national collaboration among clinicians, community-based groups and other stakeholders, to identify, analyze and implement best practice clinical models that improve care for patients and families living with advanced illness.

- Person-Centered
- Team-Based
- Home-Based
Foundational Elements

➢ Community Engagement
➢ Provider Engagement
➢ Shared Decision-Making
The C-TAC Approach

- **Clinical Interventions** (e.g., symptom management)
- **Patient/Family Decision-Making** with coordinated input from clinicians and trusted advisors
- **Community and Social Support** (e.g., respite care for caregiver)
- **Improved Shared Outcomes** (e.g., person-centered care; reduced unwanted hospitalizations)

Policy Advocacy

Public Engagement
Guiding Principles

- Defined Eligible Population
- Personal Values Drive Care Decisions
- Care Management Integrated Across Units
- Operational Design Supports Workforce Efficiency
Continuous Quality Improvement

1. **Plan:** Develop* consensus-based frameworks (e.g.,) Clinical Framework

2. **Do:** Implement frameworks & provide training for pilot

3. **Check:** Pilot data collected & barriers (e.g., policy) identified

4. **Act:** C-TAC Workgroups evaluate & disseminate findings (e.g., National Summit)
Results

- 60% Decrease in Hospitalizations
- 67% Decrease in ICU days
- ~$8,000 Decrease in Cost of Care
Current Barriers to Success

- Silos of Payer, Provider and Policy regulations
- Piecemeal Payment Systems
- Fragmented Entity and Employer Rules
Policies to Support High-Quality Advanced Care

1. **Coverage that Supports Patient Voice in Care Plan.** Improve access to planning and coordination services that align care with individual goals, values, and preferences.
   - Coverage for robust advance care planning over time.
   - Coverage for inter-professional team-based, home-based care.
   - Increase awareness of care planning services and programs.

2. **Increased Support for Caregivers.** Ensure that caregivers have access to a full array of resources and tools to support their emotional, physical, and psychological needs as well as those they serve.

3. **Enhanced Quality Measurement.** Support further development of quality metrics (process, outcomes, and patient & family experience) to ensure that advanced illness care delivery meets both quality and personal expectations.

4. **Advanced Illness Model(s) Development in Medicare/Medicaid.** Support further development and implementation of innovative advanced illness care delivery models via CMS/CMMI based on best practices.
Learn More About C-TAC...

Visit [www.thectac.org](http://www.thectac.org)
Caring for an Aging Population
Case Studies in Improving Care for the Frail Elderly

May 12, 2015
About ACHP

- 23 health plans; 28 states
- Community/regionally based
- 18 million enrollees
- ~10% of US health care market
- ~15% of private Medicare Advantage/health plan market
- Prominent names, but not typically national
- Models for reform
ACHP Member Plans

- CDPHP
- Capital Health Plan
- CareOregon
- Dean Health Plan
- Fallon Health
- Geisinger Health Plan
- Group Health Cooperative
- HealthPartners
- Independent Health
- Kaiser Permanente
- Martin's Point HealthCare
- New West Health Services
- Presbyterian
- Priority Health
- UPMC Health Plan
- Scott & White Health Plan
- Security Health Plan
- SelectHealth
- Tufts Health Plan
- U Care
- Supporting seniors beyond clinical care in all aspects of their life
- Keeping seniors out of the hospital and where they are most comfortable, so their final years may be independent and fulfilling.
- Lowering costs so health care can be more affordable.
Medically-Complex Medical Home

Janet Tomcavage RN, MSN
SVP and Chief, Value Based Care Strategic Initiatives
May 2015
Geisinger Health System
An Integrated Health Service Organization

Provider Facilities $1,854M
- Geisinger Medical Center and its Shamokin Hospital Campus
- Geisinger Wyoming Valley Medical and its South Wilkes-Barre Campus
- Geisinger Community Medical Center. Scranton, PA
- Geisinger-Bloomsburg Hospital
- Geisinger-Lewistown Hospital
- Marworth Alcohol & Chemical Dependency Treatment Center
- 2 Nursing Homes
- >87K admissions/OBS & SORUs
- 1,746 licensed inpatient beds

Physician Practice Group $825M
- Multispecialty group
- ~1040 physician FTEs
- ~710 advanced practitioners
- 83 primary & specialty clinic sites (49 community practice)
- 2 outpatient surgery centers
- ~2.5 million outpatient visits
- ~410 resident & fellow FTEs
- ~270 medical students

Managed Care Companies $2,093M
- ~502,800 members (including ~85,000 Medicare Advantage members and 145,000 Medicaid members)
- Diversified products
- ~37,000 contracted providers/facilities
- 43 PA counties
- Offered on public & private exchanges
- Members in 5 states

Moody’s Investors Service, Aa2/Stable
Standard & Poor’s, AA/Stable
Problem Identified

- Subset population of very complex, frail elderly
- Frequent acute care utilization
- Uncoordinated hospital-based resources
- Limited in-home resources
Solution – Pilot with Redesigned Care Team

• Implemented **Redesigned Care Team** at 5 Medical Home practices managing 75 medically-complex patients
  ✓ Case Manager
  ✓ Social Worker
  ✓ New Community Health Assistant

• Implemented integrated Care Coordination service across continuum

• Implemented new patient-specific Support & Action Plan to help guide patient / family when condition(s) change / exacerbate

• Leverage new non-licensed role to expand impact of CM teams
Outcomes

- Significant reduction in ED and hospital admissions and total cost of care
- Demonstrated value of new non-licensed working
- Supporting the elderly requires services beyond clinical care
  - Must move care to home
  - Frailty of these patients must be considered
  - Intensity of service is big
  - Requires different model
Advanced Chronically Ill

Jay P. LaBine, M.D.

May 12, 2015
Tandem365
Community Collaborative

- Priority Health
- LifeEMS
- Porter Hills
- Clark Retirement Community
- Holland Home
- Sunset Retirement Communities & Services
Tandem365 Model

- Care Team: Nurse Navigator, Social Worker, Volunteers
- Paramedic Check-ins & Rapid Response
- Medical Oversight
- Care Coordination with Primary Care and PH Care Management
## Tandem365 Outcomes

Members enrolled prior to November 30, 2014

<table>
<thead>
<tr>
<th>Total Members*</th>
<th>96</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Gross Allowed Amt Savings</td>
<td>$1,062,090</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Pre(^1)</th>
<th>Post(^2)</th>
<th>Difference</th>
<th>% inc / (dec)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowed Amt PMPM</td>
<td>$4,264</td>
<td>$2,785</td>
<td>$1,479</td>
<td>(34.7%)</td>
</tr>
<tr>
<td>Acute IP Stays / 1,000 Mbr Mos</td>
<td>98</td>
<td>61</td>
<td>37</td>
<td>(37.7%)</td>
</tr>
<tr>
<td>ER Visits / 1,000 Mbr Mos</td>
<td>273</td>
<td>131</td>
<td>143</td>
<td>(52.1%)</td>
</tr>
<tr>
<td>Specialty Visits / 1,000 Mbr Mos</td>
<td>2,449</td>
<td>1,318</td>
<td>1,131</td>
<td>(46.2%)</td>
</tr>
<tr>
<td>SNF Stays / 1,000 Mbr Mos</td>
<td>28</td>
<td>17</td>
<td>11</td>
<td>(39.7%)</td>
</tr>
</tbody>
</table>

* Includes all members who enrolled prior to 11/30/2014, for the duration of their enrollment, regardless of current enrollment status

1 “Pre” includes 14 mos. up to 2 mos. before starting Tandem365
2 “Post” includes all enrolled mos. after starting Tandem365, services through 1/31/2015 and paid through 3/31/2015
# PH Advanced Chronically Ill

13 County Region

<table>
<thead>
<tr>
<th>Business Category</th>
<th>Member Count</th>
<th>Prior Cost PMPY (Avg)</th>
<th>Prior Total Cost Annualized</th>
<th>Future Cost PMPY (Avg)</th>
<th>Future Cost Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>881</td>
<td>$78,870</td>
<td>$69,484,215</td>
<td>$49,936</td>
<td>$43,993,700</td>
</tr>
<tr>
<td>Medicare</td>
<td>2,670</td>
<td>$55,714</td>
<td>$148,755,416</td>
<td>$50,057</td>
<td>$133,650,950</td>
</tr>
<tr>
<td>Medicaid</td>
<td>409</td>
<td>$53,434</td>
<td>$21,854,500</td>
<td>$58,339</td>
<td>$23,860,820</td>
</tr>
<tr>
<td>Total</td>
<td>3,960</td>
<td>$60,630</td>
<td>$240,094,131</td>
<td>$50,885</td>
<td>$201,505,470</td>
</tr>
</tbody>
</table>
Fallon Health
Senior Dual Programs

Sarika Aggarwal, MD
EVP and Chief Medical Officer
Fallon Health
Sarika.Aggarwal@fchp.org

“Making our communities healthy”
We are much more than a health plan.
Fallon’s Dual Programs for Seniors: The Belief

- Older adults with chronic care needs are better served by living at home and in their communities when possible.

- Focus on improving quality of life for the participant and caregivers leads to effective and efficient care.
Fallon Dual Special Needs and PACE Plans in Massachusetts

- Fallon’s Medicare Advantage Special Needs Plan (D-SNP) and Senior Care Options (SCO) Program
  - Began January 2010
  - Ages 65 and up
  - May be community dwelling or long-term care facility residents
  - Maybe Duals or MassHealth Standard only

- Fallon’s PACE program was established in 1995, has 5 sites and is nation’s 7th largest
  - Only health plan in MA and 1-of-2 US plans to sponsor a PACE
  - Ages 55 and up
  - All elders are nursing home eligible
  - Maybe Duals or MassHealth Standard only or private pay

Fallon has a D-SNP and PACE plan in upstate New York in collaboration with Weinberg
Models of Care of Fallon Senior Dual Plans

Fallon PACE

- Insurance, medical care and social support—all in one package
- Comprehensive medical coverage
- Interdisciplinary team approach
- Individualized care plan
- Specific assessments integrated into an interdisciplinary plan of care
- Team led by Geriatrician on site
- Adult day care services on site
- Home-based model of coordinated care
- Alternative to nursing home placement

Fallon D-SNP

- Insurance, medical care and social support—all in one package
- Comprehensive medical coverage
- Interdisciplinary team approach
- Individualized care plan
- Home based assessments integrated into an interdisciplinary plan of care
- ‘Virtual model’ led by PCP and ‘Navigator’
- Adult day care contracts
- Home-based model of coordinated care
- Maintain quality of life in the least restrictive setting

All members considered ‘High Risk’ and managed
The Navigator...

- Acts as the primary contact for PCP, office staff, enrollee, and family members.
- Ensures coordination of care implementation of services.
- Facilitates Primary Care Team meetings, M.D. appointments, referrals.
- Makes in-home visits to establish relationships with both the enrollee and the family.

Reach and engage
Home visit assessment
Plan of care development
ICT meeting
Plan of care implementation
## Challenges to Expanding Senior Dual Programs

<table>
<thead>
<tr>
<th>PACE</th>
<th>D SNP</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Capital Investment</td>
<td>- State and Federal budget constraints</td>
</tr>
<tr>
<td>- State and Federal budget constraints</td>
<td>- D SNP integration with Medicaid benefits</td>
</tr>
<tr>
<td>- Provider shortage</td>
<td>- Align Medicare and Medicaid appeals and grievances</td>
</tr>
<tr>
<td>- Limited Operational Flexibility</td>
<td>- D SNP performance on quality measures compared to MA (Star Rating)</td>
</tr>
<tr>
<td>- Increase Barriers to start up</td>
<td>- Provider shortage</td>
</tr>
<tr>
<td>- Part D premiums for Medicare only are not competitive</td>
<td>- New programs require Medicaid support</td>
</tr>
</tbody>
</table>
Positive Outcomes Of Fallon Senior Dual Programs

Fallon D-SNP

- 98% enrollee satisfaction 4 years running
- Acute admissions/1,000 are lower by 13%
- SNF admits/1,000 are lower by 13.4%
- SNF days/1,000 are lower by 28.2%
- PMPM cost savings are estimated at $ 128.20
- Our LTC admission rate is: 5.14%, with 65% eligible for LTC
- 2014 30-day readmission rate was 17.8% compared to Medicare 18.4%

Fallon PACE

- 100% of participants willing to recommend program to others
- 100% members have Advanced Directives
- 85% members have Advance Care Planning
- Successful in keeping 85.6% of our participants in the community
- 2014 30-day readmission rate is 15.7% compared to Medicare readmission rate of 18.4%

*Compared to the Centers for Medicare and Medicaid Services, 5% Worcester County sample dual eligible 65+ weighted for Fallon Health mix of institutional/non-institutional and adjusted for utilization and intensity.

Mor V, et al Health Aff 2010;29:57-64
HEDIS Outcome Measures for Fallon D-SNP

![Care of Older Adults Chart]

- Advanced Care Planning
- Medication review
- Functional Status assessment
- Pain Screening

Legend:
- HEDIS 11
- HEDIS 12
- HEDIS 13
- H13 90th Percentile
QUESTION
AND
ANSWER