Connecticut ACOs in Early Stages of Assisting Members with Complex Needs

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Accountable Care Organizations and PCMH Plus entities (collectively "ACOs") are relatively new healthcare delivery structures serving Connecticut residents. ACOs are voluntary groups of health care providers working together to provide high quality care to their members and spend scarce health care dollars more efficiently. In addition to fee-for-service payments for care provided, ACOs also share in savings on their members' total cost of care. Savings payments can be moderated by quality performance. **ACOs offer the potential to both improve the health of people with complex conditions and to control rising healthcare costs.**

The **Complex Care Committee of Connecticut's Medical Assistance Performance Oversight Council** is charged with advising the legislature and Medicaid programs about the needs of Medicaid members with complex conditions. Related prior work by the Committee includes underservice metrics for proposed health neighborhoods serving members with complex needs, care plan best practices and standards, a study of palliative care needs in Connecticut Medicaid, and advising DSS on a high-need member project sponsored by the National Governors Association. As part of their charge, the Committee requested a survey of all ACOs in Connecticut to collect best practices in serving members with complex needs. The CT Health Policy Project volunteered to conduct the survey.

As a small number of members in coverage pools are responsible for the majority of costs, **many ACOs have focused attention on providing effective care for members with complex conditions**. In national surveys a large majority of ACOs identify members with complex/costly conditions, but only 8 to 21% have fully implemented initiatives for those members. Most ACOs (86%) assess outcomes such as ED visits and readmissions, but few are able to identify which interventions are working.[1] It is crucial to evaluate which interventions are effective for health outcomes and savings; many promising initiatives do not work.[2] Monitoring and evaluation are even more important in ACOs that care for underserved populations, such as Medicaid members with complex needs, as they average lower quality outcomes and more problems achieving health equity.[3]

It is important to note that ACOs are not the only healthcare practices and systems that provide care to members with complex needs and best practices can be found both within and beyond ACOs and shared savings payment arrangements.

Promising practices for members with complex needs in early evidence from ACOs in other states include:

- Identification of members with complex medical needs[4]
- Targeting interventions to those who will benefit the most with individualized care plans and services[5]
- Listening to members' goals and needs in drafting care plans and in developing ACO services, policies and priorities[6]
- Team-based care[7]
- Integrating medical, social and behavioral healthcare[8]
- Robust, meaningful links to community and social services -- i.e. housing, food security, legal assistance, personal safety, transportation[9]
- Providing after-hours clinical response – i.e. 24/7 telephone, telehealth or in-person assistance[10]
- Intensive care management[11]
- Medication management[12]
- Home visits by ACO representatives with a holistic, integrated focus; as opposed to home visits by providers about their specific services or population[13]
- Care transition services[14]
- Patient engagement and education, member-focused website, individualized direct messaging to members[15]
- Scheduled medical clinics for hard-to-access services – i.e. vision screening for members with diabetes[16]
- Ensuring adequate workforce with robust recruitment, training and retention initiatives[17]

Methodology

Twenty-six ACOs serving Connecticut residents were invited to complete the survey. ACOs were identified from Medicaid, Medicare, and commercial payer lists. The online survey was open during June and July of 2019. Fourteen ACOs responded for a response rate of 54%. Not all ACOS responded to every question. Survey questions are attached.

Results

As for the rest of the nation, **most Connecticut ACOs identify members with complex needs**, most often using clinical data, emergency department or hospital utilization, and by specific medical conditions. ACOs vary in how much and what they know about their complex

populations. Most dedicate specific staff to engaging members with complex needs, most often by phone and at provider visits.

Eight of fourteen Connecticut ACOs have specific interventions for members with complex needs but strategies varied between ACOs. Most common interventions identified as best practices in literature include care transition services, intensive care management, medication management, and help accessing social services. Most specific interventions are provided by ACOs rather than by practices or consultants.

Most ACOs deliver team-based care for members with complex needs. Members of teams varied between ACOs. Most are not condition-specific. Details on care planning were sparse, but two use a patient-directed process and one relies on technology for care plans. ACOs' plans for evaluating their efforts varied significantly.

As for national ACOs, the greatest challenge identified by Connecticut ACOs was member engagement. Lessons learned included:

- The power of team-based care
- Resources for outreach
- Personal face-to-face contact
- Identifying high-risk members for "intensive attention" wherever they contact the system
- Using wellness visits as opportunities for care planning
- Integrated care meetings

Asked how state policymakers could help them, ACOs mentioned resources and supporting best practices.

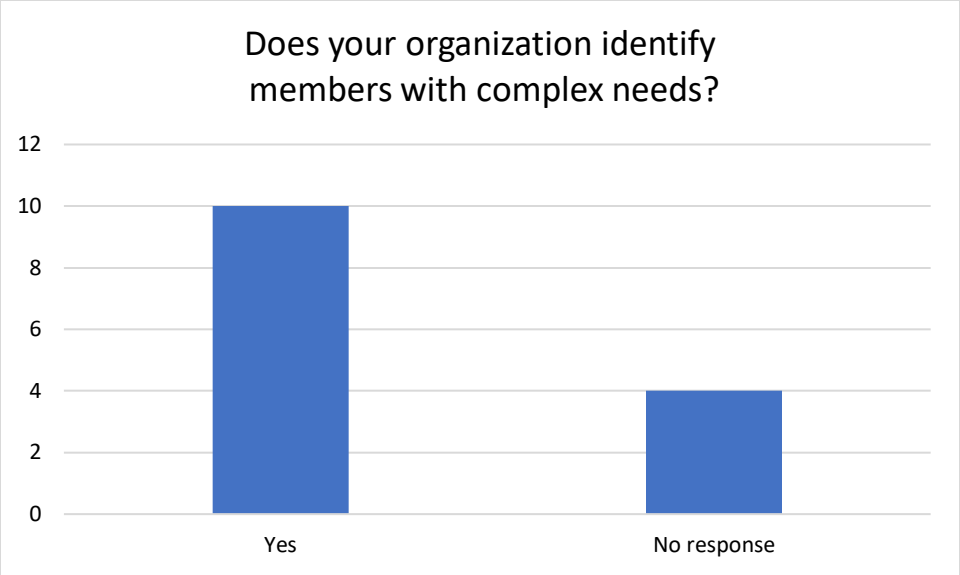
Conclusion

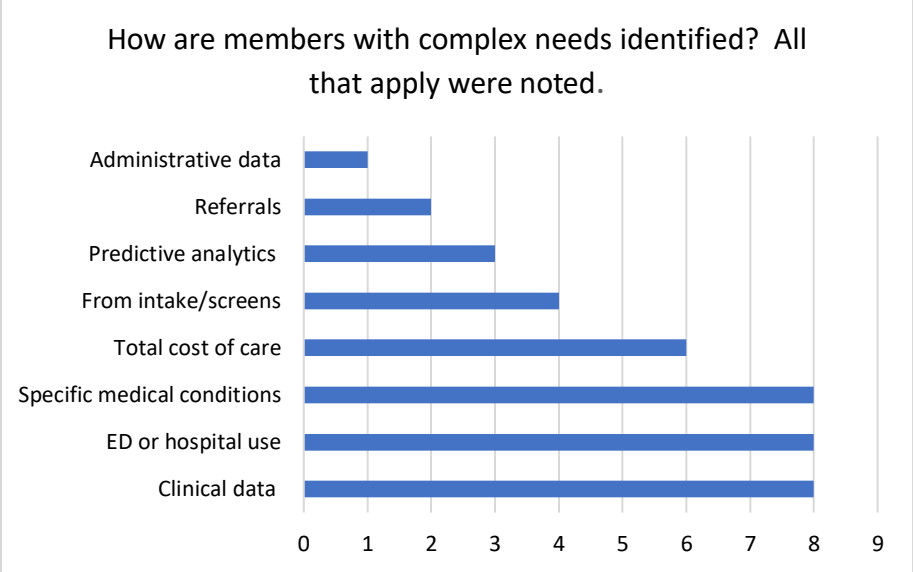
Connecticut's ACOs are interested and working to address the needs of complex patients. Many are using best practices identified across the nation. It is early and they need help from the state to continue making progress.

Results in detail

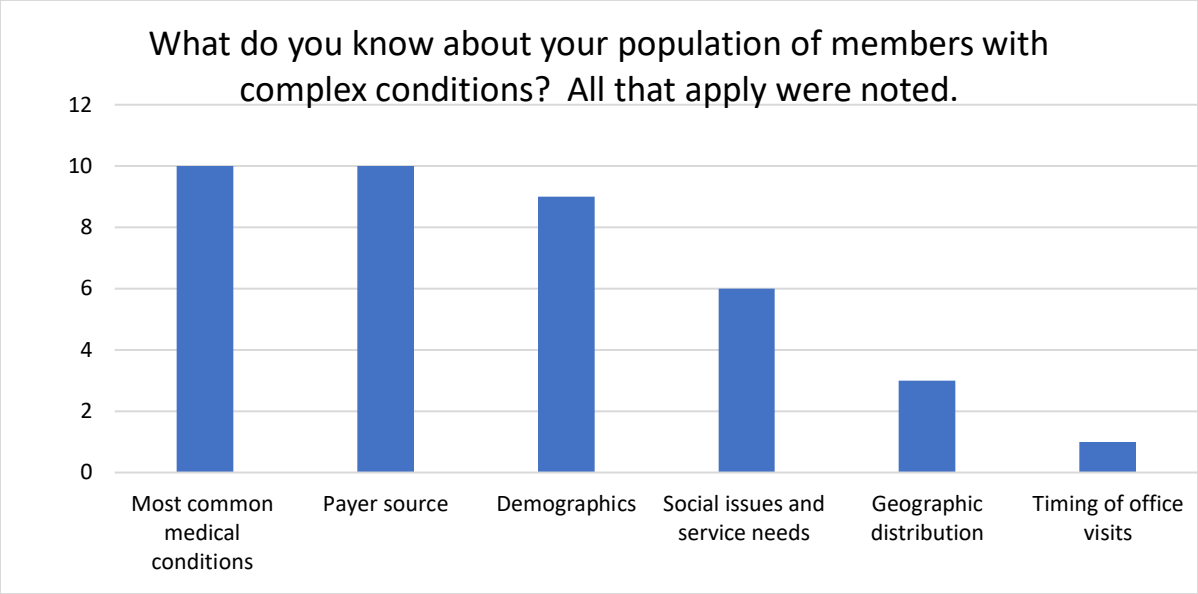
I. <u>Identification of members with complex needs</u>.

Ten ACOs indicate that they identified members with complex needs.



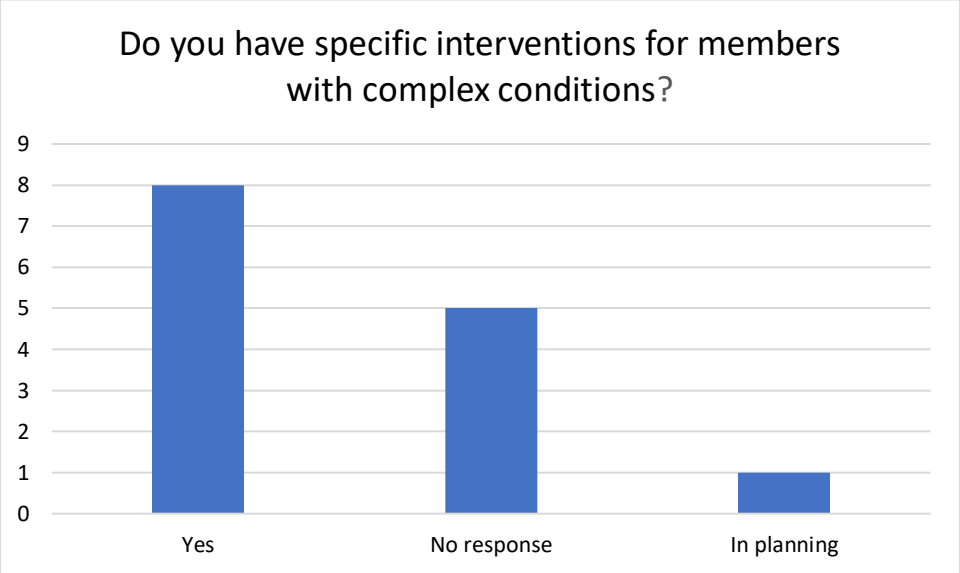


Other identifiers include: co-morbid behavioral health and medical issues; risk scores; and providers and their care teams can identify someone as high complexity based on their expert knowledge of the individual.



Other responses include: total costs, total predicted costs next year (helpful in identifying people for whom some resolution of their complex problems is expected to occur) and knowing who is on the member's care team (e.g. specialists).

II. Interventions for members with complex needs.



III. How do you engage members with complex needs?

- Care coordinators reach out via telephone to engage and offer an in-person visit for identified patients.

- Dedicated Nurse Practitioner by site

- We have congestive heart failure, COPD, and diabetes protocols outlining frequency of telephonic outreach and questions to be reviewed. Complex care patients are enrolled for nurse outreach and can "graduate" from the program for reaching milestones or goals as discussed with patient, although care can always be restarted or patient can decline at any time.

- Telephonic outreach, post-acute transitions of care, face-to-face encounters at hospital, special needs facility, office, community centers, and community agencies.

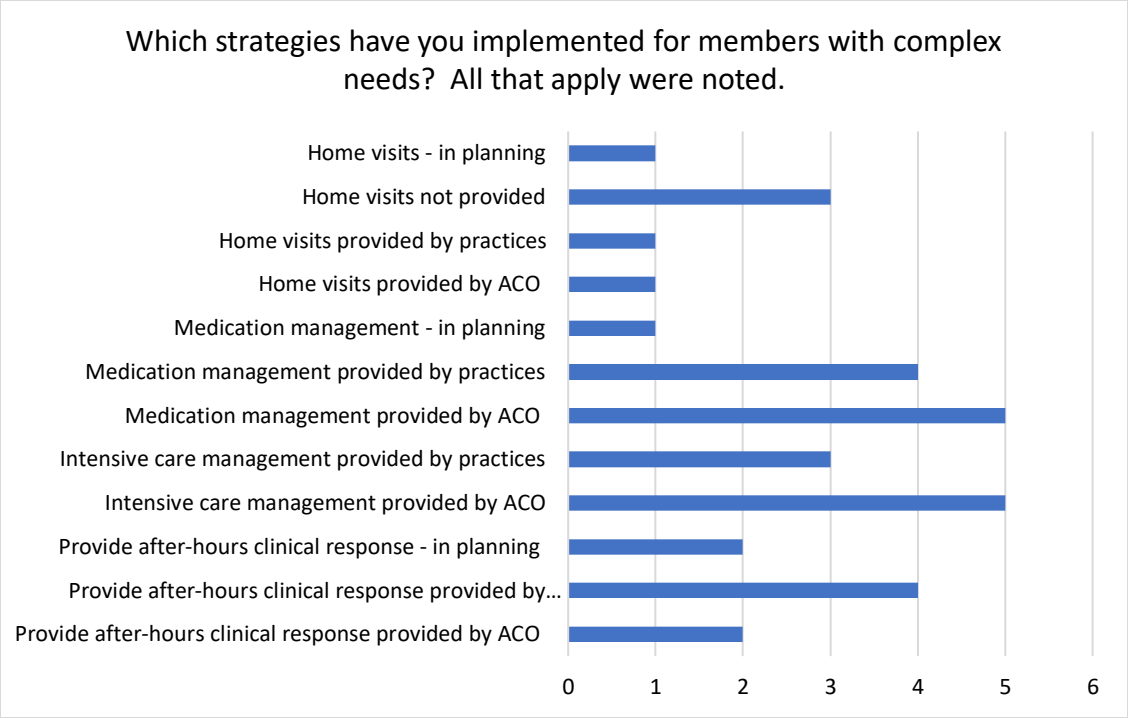
- Extended Care Coordinators

- Chronic Care Management visits within attributed TIN (Taxpayer Identification Number) participant practices (within the clinically integrated network).

- Primary care nurses engage them in complex management; they are also "flagged" to be discussed in integrated care meetings to look for any gaps in care/other needs. Access to care and primary care registered nurses prioritize for screening for adverse social determinants of health.

- We inform them of our services.

IV. Which strategies have you implemented for members with complex needs?


Which strategies have you implemented for members with complex needs? All that apply were noted.
Home visits - in planning
Home visits not provided
Home visits provided by practices
Home visits provided by ACO
Medication management - in planning
Medication management provided by practices
Medication management provided by ACO
Intensive care management provided by practices
Intensive care management provided by ACO
Provide after-hours clinical response - in planning
Provide after-hours clinical response provided by…
Provide after-hours clinical response provided by ACO
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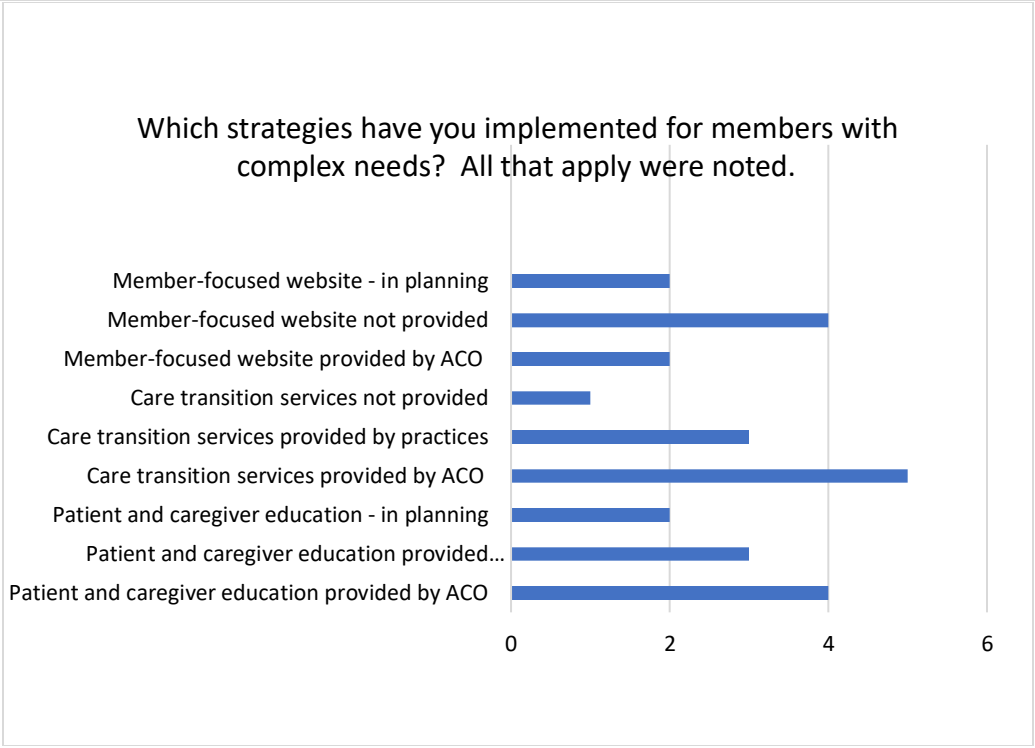
Which strategies have you implemented for members with complex needs? All that apply were noted.
Member-focused website - in planning
Member-focused website not provided
Member-focused website provided by ACO
Care transition services not provided
Care transition services provided by practices
Care transition services provided by ACO
Patient and caregiver education - in planning
Patient and caregiver education provided…
Patient and caregiver education provided by ACO
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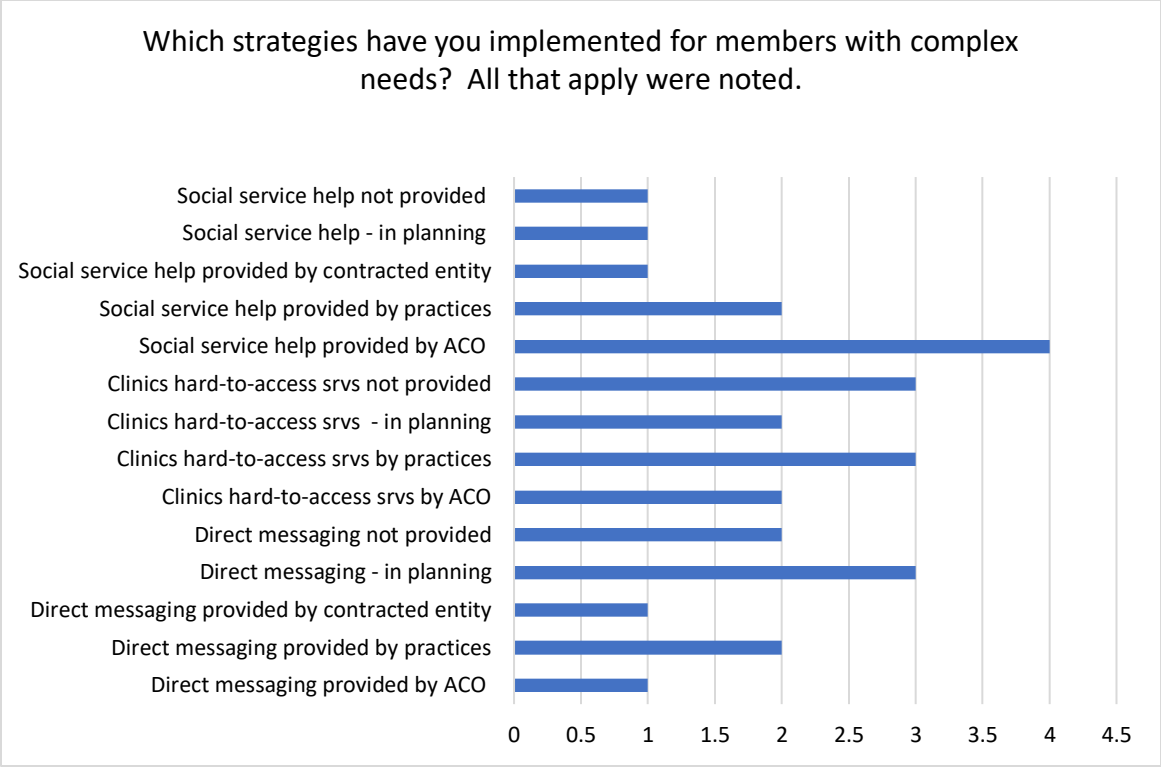
Which strategies have you implemented for members with complex needs? All that apply were noted.
Social service help not provided
Social service help - in planning
Social service help provided by contracted entity
Social service help provided by practices
Social service help provided by ACO
Clinics hard-to-access srvs not provided
Clinics hard-to-access srvs - in planning
Clinics hard-to-access srvs by practices
Clinics hard-to-access srvs by ACO
Direct messaging not provided
Direct messaging - in planning
Direct messaging provided by contracted entity
Direct messaging provided by practices
Direct messaging provided by ACO
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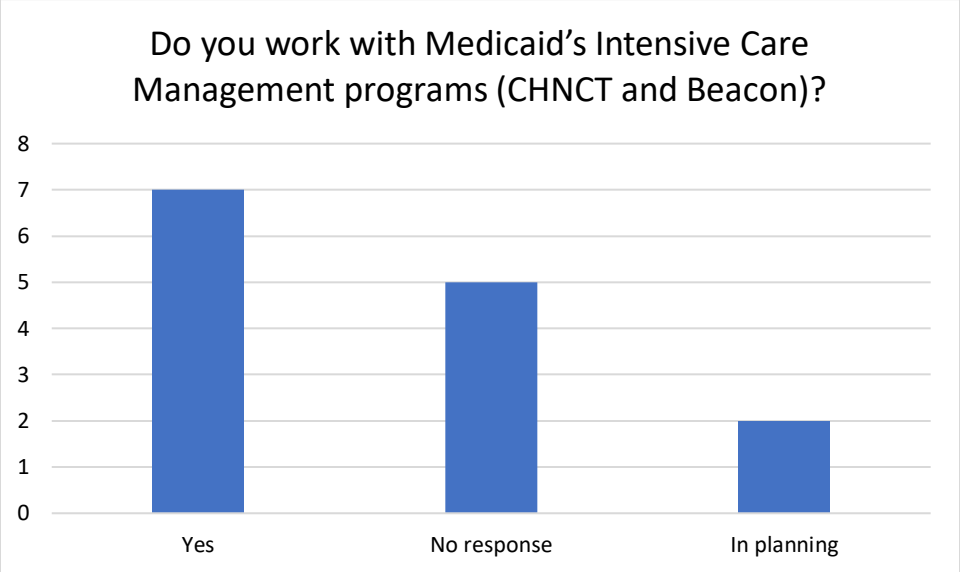
Do you work with Medicaid's Intensive Care Management programs (CHNCT and Beacon)?
8
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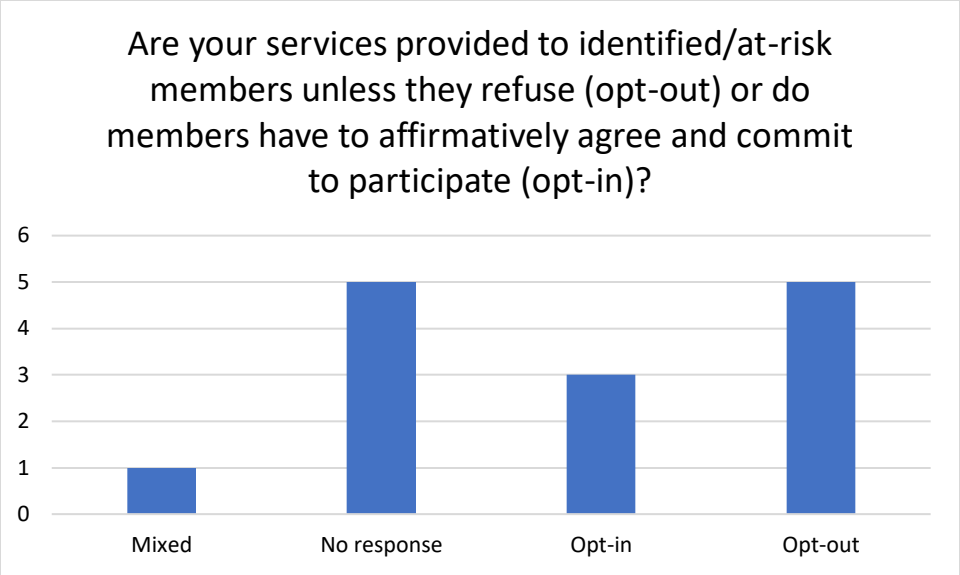
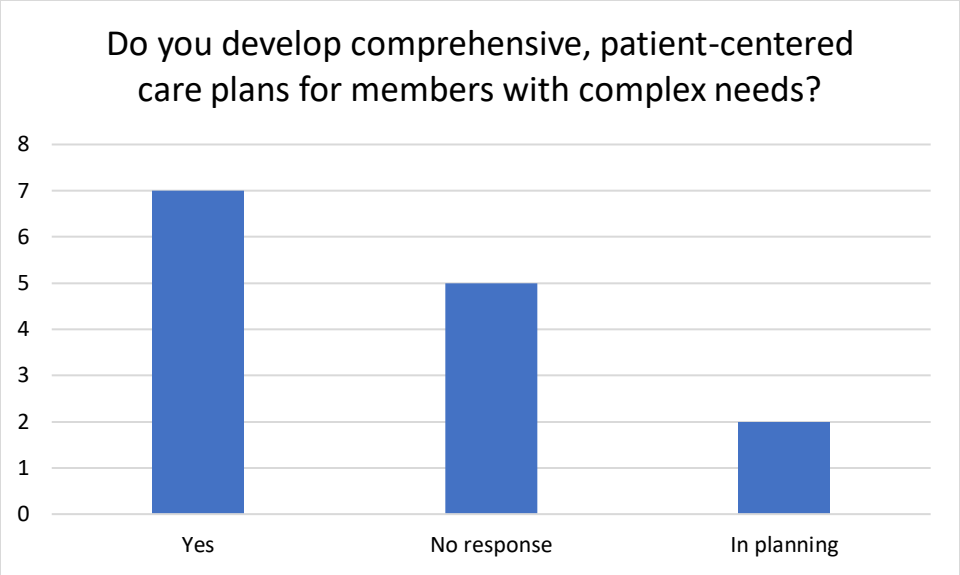
Yes
No response
In planning

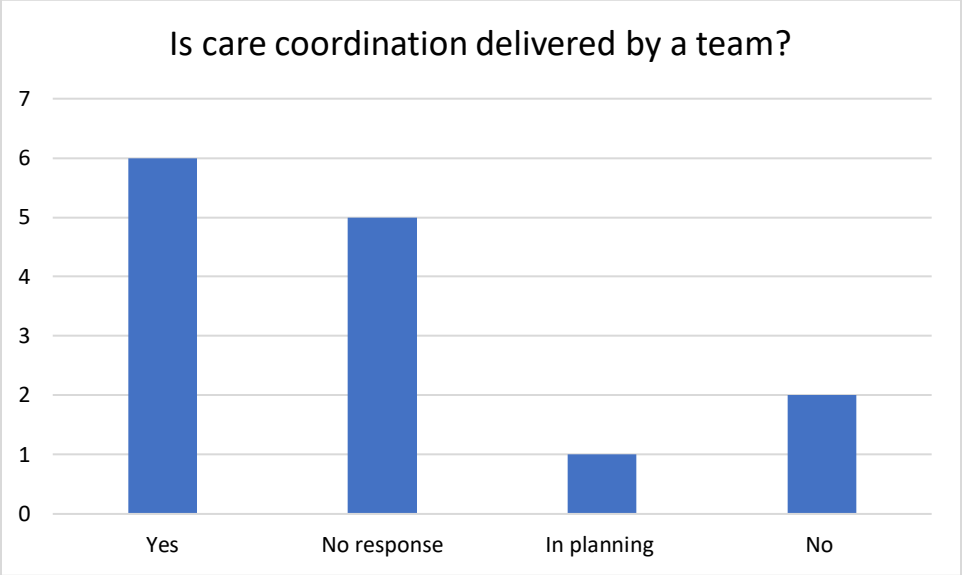


V. Care Coordination

Please describe your care planning process.

- Care plans are developed collaboratively with the patient and the care coordinators during the first visit(s).
- Patients are evaluated while hospitalized, referred from MD offices, outreached based on high risk diagnoses and high utilization of services.
- Comprehensive assessment and creation of care plan.
- Bilingual Extended Care Coordinators contact patients who either self-identify, are referred by providers, or are identified through reports.
- Use of Epic Care Management module for documenting all transitions of care and chronic care management interventions.
- It is quite challenging using the established tools and we aren't satisfied with our work in this area, but have invested a great deal of effort and will continue to do so.

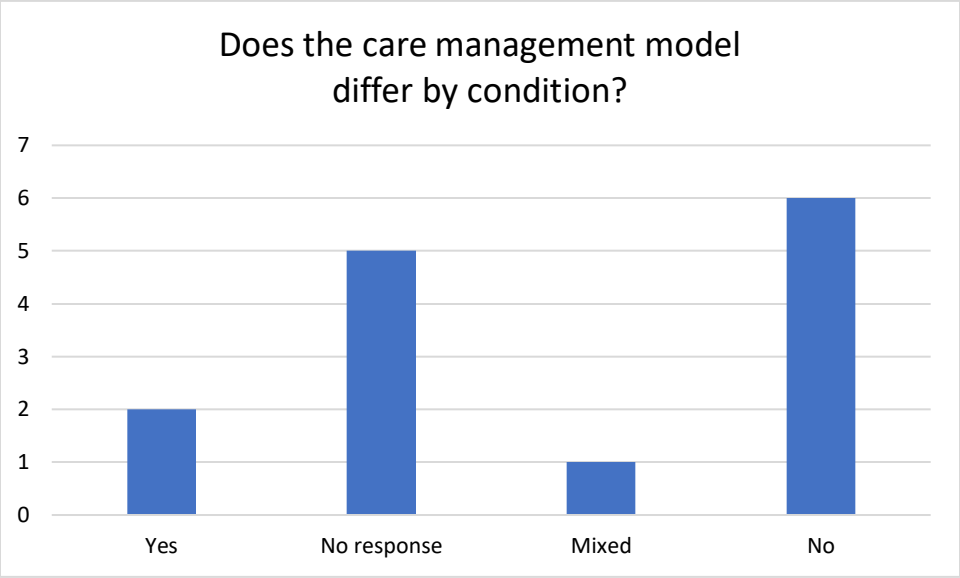




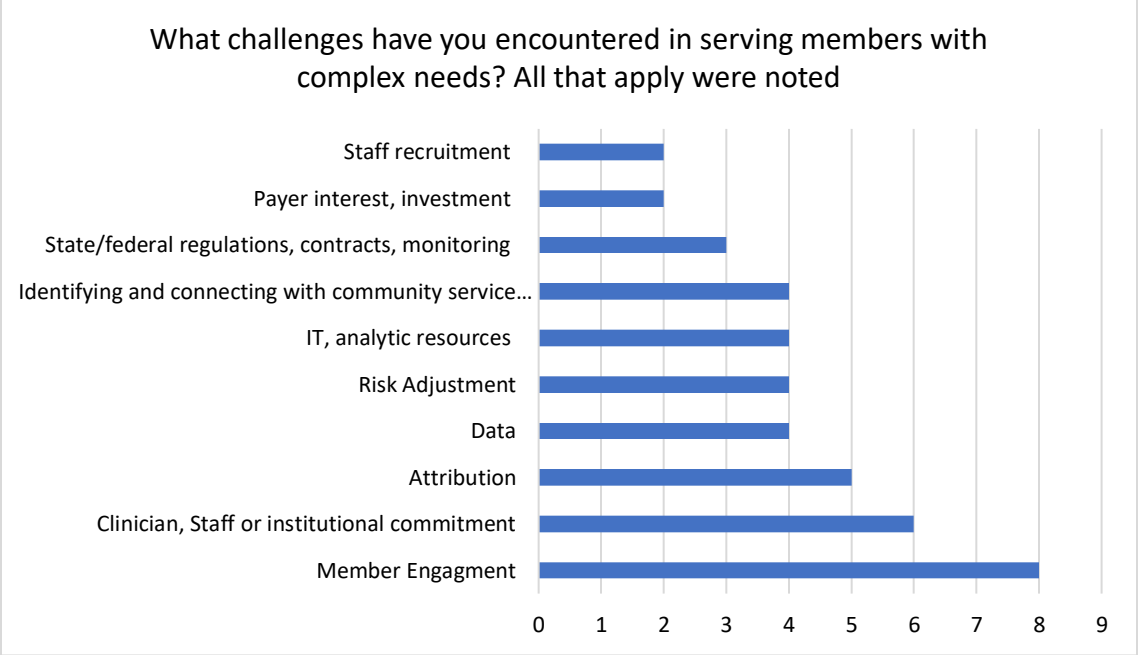
If care coordination is delivered by a team, which professionals are typically on the team?

- Nurses, social workers, pharmacists, care coordinators, and community health workers
- Nurses, social workers, physicians, advanced practice registered nurses, medical assistants
- Providers, nurses, Extended Care Coordinators, referral coordinators
- Registered nurses, social workers, providers

- Primary care RNs, medical assistants, sometimes PCPs and behavioral health clinicians
- Nurses, doc, social worker, case manager/coordinator



VI. Challenges



Other: "We are a large practice, not an ACO, and are trying to do all of this in house--close to where the patients are. We are still relatively early on in this process (a few years) and building some of the systems as we go. I imagine the ACOs are much more sophisticated, but not sure they are as close to the patients."

VII. Lessons Learned

Which strategies have been most successful in caring for members with complex needs?

- Team members working at top of license capabilities for medical management and education, with non-licensed staff providing supportive follow-up and frequent outreaches, creating and driving self-management and health efficacy.
- Having enough resources to provide outreach and follow up to patients in a proactive way versus reactive.
- Personal face-to-face contact.
- Standard work--connecting members to resources via all applicable venues.
- Identifying high risk / complexity patients so we can flag them in system for more intensive attention and recognition that they are complex patients whenever they contact the system. We utilize our primary care registered nurses for complex care management. We are working to make our Medicare annual wellness visits a good opportunity for care planning and have found that integrated care meetings (created under our PCMH_ program) have become a very useful strategy.

How do you evaluate the impact of your interventions for members with complex needs?

- Utilization but too early to tell
- All patients are followed for 1 year with minimal of monthly check backs
- Re-evaluation of risk scores, health outcomes
- Data review, patient comments
- Outcomes and performance measures

- We look at readmissions, ER utilization, control of chronic illnesses, care gaps. We would like more of a patient reported outcome measurement and are piloting that in behavioral health but don't have one, really, to assess patient response other than through patient surveys today.

Do you have any outcomes you can share, especially reductions in total costs, ED visits or hospitalizations?

- We manage a performance indicator dashboard that tracks high risk patient re-admissions, team outreaches and engagement rates.

- ED utilization and hospitalizations have reduced year over year in our Medicare Shared Savings Program ACO population.

- We do for our members overall, but not specifically for this population--we have not broken it out at this time.

How can state policymakers help you serve your members with complex needs?

- Create special reimbursement for duals to invest in these kinds of programs, similar to Delivery System Reform Incentive Payment Program in New York.

- Require standardized health screenings as part of the eligibility process for assistance programs.

- Continue to support the per member per month add on payments to allow for additional non-billable support staff to provide care coordination.

- Reimbursement for services, advising Medicaid patients.

- Reimbursement improvement for dual eligible members.

- I am following the "Primary Care First" and “Primary Care First Serious Illness Population" models. I see Connecticut is not on the list to participate. But I think that is a good model to keep an eye on and think about replicating. Also, the Medicare ACOs are taking advantage of adding the Medicare approved services of transportation, food, and housing support. These are all important services for these patients.

Attachment -- Complex Need Member ACO Survey tool

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[11] J Niles, et. al., 2019; LT Das, et. al., 2019

[12] K Edwards, et. al., 2019; P Long, et. al., 2017; J Niles, et. al., 2019

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[14] J Niles, et. al., 2019; TK Fraze et. al., 2019; OIG 2019; P Long, et. al., 2017

[15] K Edwards, et. al., 2019; P Long, et. al., 2017

[16] Matt Katz, CT State Medical Society, personal communication

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