Developing and Measuring Care Coordination Outcome Goals and Objectives

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Cleveland Clinic Care Management
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Learning Objectives

1. Identify what tools and metrics are needed to monitor the effectiveness of the program

2. Identify progress goals and key stakeholders

3. Learn how to evaluate patient satisfaction
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Cleveland Clinic Overview

Cleveland Clinic

Our Mission
To provide better care of the sick, investigation into their problems, and further education of those who serve

Education  Patient Care  Research
Cleveland Clinic Overview

- Total patient visits – 3.6 Million
- Admissions – 211,649
- Surgical cases – 192,650
- System-wide beds – 4,450
  - Main campus beds – 1,400 beds
- Hospitals - 1 tertiary care, 9 community
- System wide employees – 43,000+

Source: Corporate Statistics Dashboard, 2014 and Facts & Figures

Clinical Institutes

- Anesthesia
- Arts and Medicine
- Cole Eye
- Dermatology and Plastic Surgery
- Digestive Disease
- Education
- Emergency Services
- Endocrinology and Metabolism
- Glickman Urological and Kidney
- Head and Neck
- Heart and Vascular
- Imaging
- Lerner Research
- Medicine
- Neurological
- Nursing
- OB/GYN and Women’s Health
- Orthopedic and Rheumatologic
- Pathology & Laboratory Medicine
- Pediatrics and Children's Hospital
- Regional Operations
- Respiratory
- Quality and Patient Safety
- Taussig Cancer
- Wellness

International Reach

One of the largest transport programs in US
Clinical Enterprise

- CEO
- Chief of Staff & Clinical Enterprise
- Physician Affairs
- Clinical Transformation
- Nursing Institute
- Institutes
- Medical Operations
- Regional Operations
- Florida

Clinical Transformation
- CCICM Design & Build
- Care Paths/Bundles
- Distance Health
- PCMH
- Population Health
- Quality & Patient Safety
- Patient Experience
- Continuous Improvement
- Analytics
- EHP Medical Management
- Quality Alliance
- Care Coordination
Institute for Healthcare Improvement
Triple Aim Initiative

Better Health for the Population
Better Care for Individuals
Lower Cost Through Improvement

Cleveland Clinic Integrated Care Model
A Value-Based Patient-Centered Model of Care

- Personalized
- Patient-focused
- Integrated
- Continuous
- Transcends time & physical location
- Right care, right place, right time
- Primary & specialty care

Care Coordination is a linchpin competency

Cleveland Clinic
Care Management

“Case Management in hospital and health care systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The Case Management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient’s right to self-determination.”

Approved by ACMA Membership, November 2002
Cleveland Clinic Care Coordination

- Network of nurses and other care team members who coordinate care across the continuum
  - Primary Care Coordinators
  - Specialty Care Coordinators
  - Transitional Care Coordinators
- Goal is to drive value: improve outcomes while reducing utilization (cost)
- Focus is on managing high risk patients
  - Unplanned health care encounters (high utilizers)

Cleveland Clinic Integrated Care Model: Patient-Centered, Integrated Model of Care: Components

Primary Care Coordination
Setting: Ambulatory
- Longitudinally follow high-risk patients for PCP team
- Main point of contact for the patient, family, and other care coordinators
- Targeted outreach, assessment and monitoring to ensure care goals are met

Specialty Care Coordination
Setting: Surgical & Procedural
- Follow high-risk patients through course of specialty care in medical or surgical setting
- Ensure patients continue to follow recommended CarePaths

Transitional Care Coordination
Settings: Hospital, ED, Post-Acute,
- Facilitate seamless care for high-risk patients transitioning across venues
- Follow the high-risk patient during the episode of care that is associated with the patient’s presence in a particular venue

Technology-Enabled to Ensure Required:
- Dynamic Risk Registry
- Integrated Documentation Toolset
- Care Coordination Flag
- Ongoing Management and Reporting

Care Management Quad Model

HRTCC
UM
SW
TCC
Key Stakeholders

- Patients, Patients, Patients
- Support Systems (family, friends, care advocates)
- Care Team (Physicians, Nurses, Ancillary Support teams)
- Centers for Medicare and Medicaid Services (CMS)
- Accountable Care Organization (ACO)
- Government Payors
- Commercial Insurance Payors

Implementing Care Coordination

- Information transparency across continuum
- Integration to care paths
- Successful ‘hand-offs’ across transitions
- Align job expectations & metrics for success
- Patient & Caregiver Engagement
High Risk Patients

Goal: Develop a strategy to identify, stratify, and manage high risk patients

- Define high risk
- Identification process & visualization (by all providers) of high risk patients, PCP
- Risk stratification of patients
- Single source of documentation for coordination of care, allowing for communication between patients, PCPs, specialty physicians & (eventually) payor

What makes the patient high risk?

<table>
<thead>
<tr>
<th>Health</th>
<th>Social</th>
<th>Behavioral</th>
<th>Utilization</th>
<th>Cognitive / Functional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma / COPD</td>
<td>Inadequate caregiver support</td>
<td>Depression</td>
<td>Chronic uncontrolled condition</td>
<td>Cognitive impairment</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>Interpreter needed (patient or</td>
<td>Anxiety</td>
<td>2 or more admissions in last</td>
<td>Advanced age, with</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>caregiver)</td>
<td>High-risk behaviors includes</td>
<td>12 months and/or</td>
<td>frailty</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Financial concerns</td>
<td>substance abuse</td>
<td>2 or more ED/Urgent Care visits</td>
<td>Mobility/ADLs</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Inpatient (financial insurance</td>
<td></td>
<td>in last 6 months and/or</td>
<td>Environmental challenges in the home</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>status)</td>
<td></td>
<td>1 or more SNF episode in last</td>
<td></td>
</tr>
<tr>
<td>Asthma / COPD</td>
<td>Transportation needs</td>
<td></td>
<td>12 months</td>
<td></td>
</tr>
</tbody>
</table>

Note: These are risk categories to help stratify risk

Identification of High Risk Patient

Patient who has uncontrolled chronic medical condition and has increased utilization as defined by the following:

- 2 or more admissions (including observations) in the last 12 months and/or
- 2 or more ED/Urgent Care visits in the last 6 months and/or
- 1 or more SNF episodes in the last 12 months
**Domain Management Model**

**Medical/Surgical Issues**
- Medication Reconciliation
- F/U Appointment Scheduled
- Post-Acute Provider Communication
- Discharge Instructions provided to patient and Care Partner including Emergency Plan and Contact Information
  - + any disease specific criteria
  - + high risk patient action items
  - + no PCP action items

**Psych/Behavioral**
- (mental status, emotions, coping)
  - Assessment of patient/caregiver health literacy

**Physical Function**
- DME Ready

**Living Environment**
- Access to Medication Assessed
- Family / Care Partner Identified
- Discharge Transportation Ready

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**Care Coordination**

**Risk Assessment Tool** utilized across the Continuum

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**Implementing Care Coordination**

- Information transparency across continuum
- ID high risk patients
- Integration to care paths
- Successful ‘hand-offs’ across transitions
- Align job expectations & metrics for success
- Patient & Caregiver Engagement
Job Expectations & Metrics: Steps for Success

- Job titles and descriptions
- BSN requirement
- KJRs
- Certification
- Education/orientation
- Care coordination intranet site
- Affinity group
- Management structure and oversight
- Metric development and data review

Care Coordination Key Job Responsibilities (KJR)

- Identifies and contacts patients who can benefit from care coordination through utilization of risk assessment tools, patient lists, registries, specialty referrals, etc.
- Conducts comprehensive clinical assessments inclusive of disease specific, age specific, medical, behavioral, social, and end of life needs of each patient as appropriate. Identifies patients’ risk behaviors and discusses actions to promote health with patient/family/support member and the health care team.
- Assesses patient’s knowledge of health status, health literacy, and readiness to change. Uses the teach back method to assess knowledge.
- Collaborates with patient and health care teams to set a plan of care and monitor goals and interventions to maximize patient outcomes.
- Communicates with patient, family/support member, care coordinators and the healthcare team regarding the plan of care. Utilizes hand-off communication techniques with the health care team and care providers across different institutional facilities.
- Effectively involves the health care teams and community resources to meet the needs of the patient. Understands reimbursement and financial health care implications to the patient and organization when selecting resources that can assist the patient in achieving goals.
- Utilizes technology in the coordination of care process by accessing data/reports and documenting nursing care in the electronic medical record.

Implementing Care Coordination

Patient & Caregiver Engagement

- Information transparency across continuum
- Integration to care paths
- High risk patients
- Align job expectations & metrics for success
- Hand-offs across providers

Terms

- ID: Identifies
- Align: Aligns
- Success: Successes
Care Coordination Key Goals

Integrated Care Model: Ensure infrastructure support for care coordination across the enterprise

Readmissions and Quality: Improve all-cause readmissions and close gaps in care by improved hand-offs

Risk Contracting: Build competency around population management in order to execute on Per Member Per Month (PMPM) and shared savings agreements

Patients First and Enhance Patient Throughput:
• Increase access
• Reduce the cost per unit of service with increased access and smaller cost base

Successful Hand-offs Across Venues

Goal: Implement elements that will enable effective Care Coordination as patients transition across the continuum of care.

• A standardized assessment of patient transitional care needs
• Seamless 'handoffs' between care teams involved in transitioning patients across settings (including private practice)
• Engaging patients in their care during difficult transitions

High Risk Patient Care is Coordinated Across Venues of Care
**Framework & Workflow**

- **Primary Care Coordinator (PCC)**
  - Family Health Center
  - Hospital/Comprehensive Care
  - Inpatient Care

- **Operational Care Coordinator (OCC)**

- **Quality Care Coordinator (QCC)**

**Consistent Patient Identification**

**EPIC Care Team Tab**

All Care Coordinators sign-in to declare themselves as part of the care team:

- Include/verify Care Coordinator (CC) contact information in the comments field.
- Select notification of admission, if applicable.

**Screenshot of Care Team Tab**
Care Path Integration

Goal: Implement a clear, step-by-step process for incorporating care coordination into care path guide development, review and implementation

- Define integration with care path teams
- Ensure care goals are met
- Care path education process for external partners

Care Paths

A key component of our value-based care initiative, care paths are multidisciplinary plans of care used to optimize clinical outcomes and the cost of care.

They are intended to minimize unnecessary practice variation by following principles of evidence- or experience-based medicine.

What does that mean for patient care?

By following a care path, providers base treatment on documented evidence or shared experience to deliver the best outcome and value for a patient or population of patients. But a care path is not always a single approach — expected practice allows provider judgment, and some clinical activities will not apply.

Cleveland Clinic currently has 51 Care paths developed and in use.

Standardized Care Paths
Implementing Care Coordination

- Information transparency across continuum
- ID high risk patients
- Alignment to care paths
- Successful ‘hand-offs’ across transitions
- Patient & Caregiver Engagement

Utilization Metrics

- Payor based and internal data
- ED visits/Urgent Care
- Admissions
- Case Mix Adjusted Length of Stay (CMALOS)
- All cause readmissions
  - 8 day
  - 30 day

Payor Metrics

- Per Member Per Month (PMPM) Spend
- Medicare Spend Per Beneficiary (MSPB)
- Post Acute Facility utilization
- Diagnostic Specific cost and utilization metrics (example Diabetes)
- Predictive modeling to identify and address rising risk
Quality Metrics

- Hand Off percentage
- Follow Up Appointment percentage
- Percentage of Patients with a Care Coordinator
- Patient Activation Metrics

ACO Quality Metrics

- Patient/caregiver experience
- Care Coordination/patient safety
- At risk population
- Preventive Care

Domain: Patient/Caregiver Experience

- Timely care, appointments, and information
- Provider communication
- Patient’s rating of provider
- Access to specialist
- Health promotion and education
- Shared decision making
- Health status/functional status
### Domain: Care Coordination/ Patient Safety

- Risk standardized all cause readmissions
- Diagnosis sensitive conditions: Chronic Obstructive Pulmonary Disease (COPD), Asthma and Heart Failure (HF)
- Medication reconciliation
- Falls: screening for future fall risk

### Domain: Preventive Care

- Breast cancer screening
- Colorectal cancer screening
- Influenza immunization
- Pneumonia vaccination
- Body mass index screening and follow-up
- Tobacco use: screening and cessation intervention
- Screening for high blood pressure and follow-up documented
- Screening for clinical depression and follow-up plan

### Domain: At Risk Population

- Diabetes
- Hypertension
- Ischemic Vascular Disease
- Heart Failure
- Coronary Artery Disease
Metrics: Patient Experience Surveys

- CG-CAHPS 12 Month Adult Primary Care
- CG-CAHPS 12 Month Pediatric Care
- CG-CAHPS Adult Visit
- H-CAHPS - Discharge Domain

Analytics and Outcomes

Thank You!

Questions?