ACAP Care Coordination Survey Results

Prepared by: SNCS

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Outline

- Survey Overview
- Respondents' Enrollment Mix
- Care Coordination Staffing and Techniques
- Care Coordination Impacts
- Transitions of Care
- Health Risk Assessments
- Medical Homes

ACAP Care Coordination Survey

- The Association for Community Affiliated Plans surveyed its membership in August 2012 to achieve a common understanding of care management strategies.
- Of the 58 ACAP member plans the survey was disseminated to, 29 plans provided some care coordination data (response rate is 50%)
- Response rate varied by part of the survey – most respondents provided enrollment and care coordination staffing information

Survey Instrument Included 86 Questions

- Enrollment level and mix
- Number and mix of care management staff
- Type of care management conducted
- Case loads
- Care management software used
- ROI and other impacts
- Transitions of Care
- Health risk assessments
- Patient centered medical homes
- Wellness initiatives

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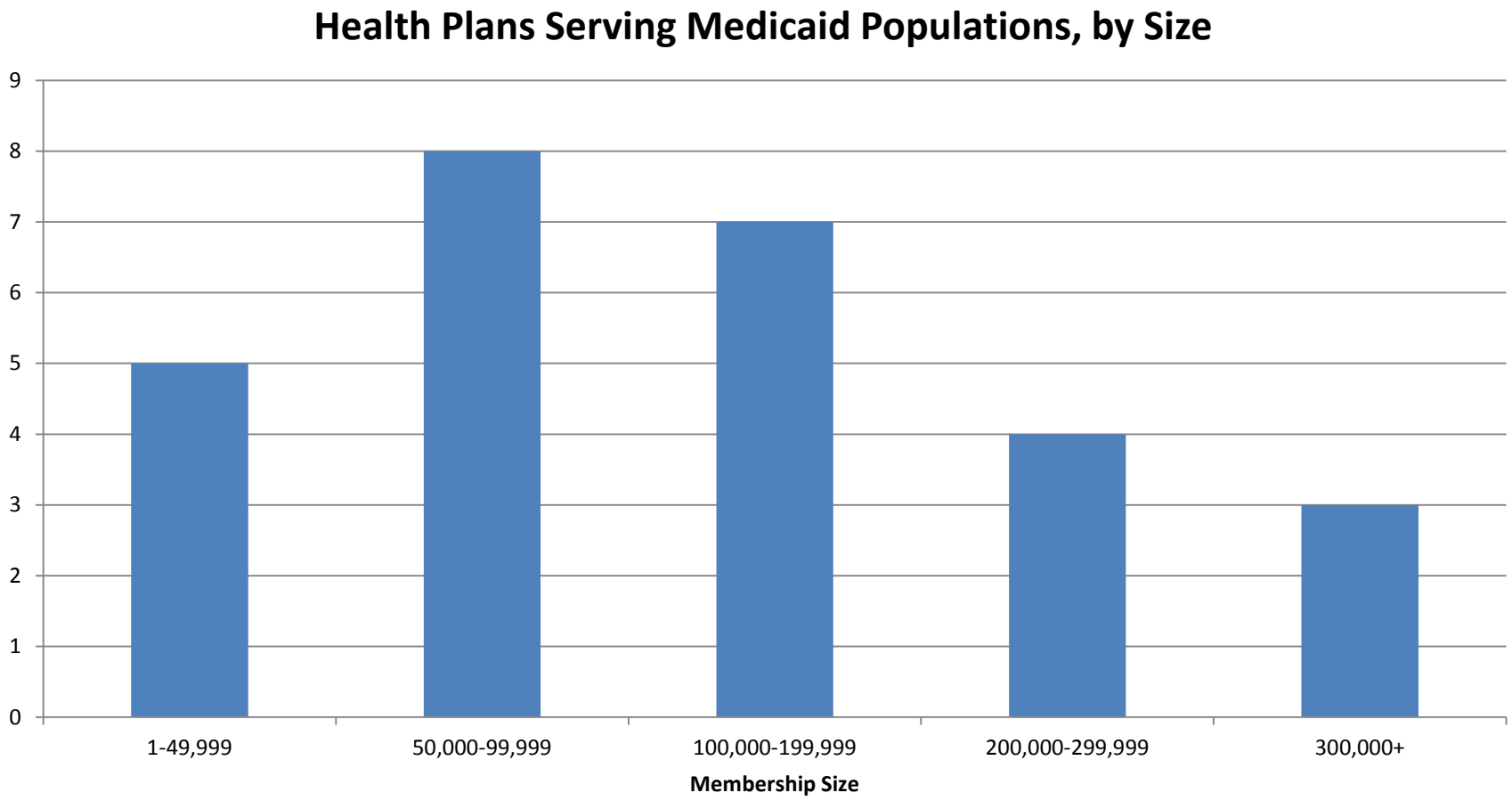
Respondents' Enrollment Mix

- The 29 respondents serve a wide range of enrollee populations
  - Nearly all respondents serve the TANF population, collectively serving 0.8 million TANF adults and 1.8 million TANF & CHIP children
  - Vast majority of respondents also serve SSI Medicaid-only enrollees, their collective SSI Medicaid-only enrollment is approximately 300,000 persons
  - 11 (38%) serve Medicare Advantage members; collective enrollment is roughly 300,000 MA members (vast majority of these members are dual eligibles)

Health Plans Serving Medicaid Populations, by Size



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Care Coordination Tabulation and Analyses Made Difficult by Several Factors

- Small number of respondents to several questions (e.g., only one MCO provided ROI statistics, 20 respondents provided caseload information)
- Plans vary widely in:
  - enrollment levels and mix
  - staffing levels and mix
  - use of providers' staff to support MCO's care coordination
  - criteria by which enrollees are assigned to care coordination program(s)
  - intensity and nature of care coordination occurring (frequency of contact, telephonic vs. face-to-face, etc.)
  - how staff (particularly non-clinically licensed personnel) are counted as supporting "care management"
- This section of report tabulates activity where possible/valid, but also conveys extensive descriptive information

Care Coordination Structure by Line of Business

- Of the 38 plans that responded to the survey, 12 serve Medicare and Medicaid populations.
- Of these plans, the majority (n=8) have integrated care management programs with staff serving all populations
- The other four MCOs have separate care management programs for their Medicare product(s).

In-House Care Management Structure

- Asked how their in-house care management is organized:
  - 11 MCOs have a single overall pool of staff that manage their members, regardless of member's age, disease(s), eligibility category, and cost/risk.
  - 5 plans group staff by line of business/eligibility category
  - 8 plans organize staff by member's disease category (or categories)
  - 3 plans organize staff by member age
  - 3 plans organize staff by member cost or risk
- Some plans organize staff by more than one of the groupings listed.
- Seven plans commented that their care managers are grouped by disease management and or complex case management acuity levels.
- 15 of the 24 plans responding to this part of survey indicated they have integrated disease management within their care management systems.

MCO-Specific Examples of Care Management Staffing – Plans with 100% TANF Membership

MCO	Population Served	Approximate Enrollment	Care Management FTEs	Enrollees Per FTE Care Manager	% Of Care Management Staff Not Clinically Licensed	Average Caseload for RN Care Managers
Plan A	100% TANF	51,000	49	1,000	51%	175
Plan B	100% TANF	58,000	10	6,000	20%	40 (for face to face interaction)
Plan C	100% TANF	73,000	9	8,000	22%	350

Note: Enrollees per FTE figures do not depict care managers' average caseloads in each MCO, as most enrollees are not "in care management"

MCO-Specific Examples of Care Management Staffing – Plans with TANF & SSI Members (but no Medicare enrollees)

MCO	Population Served	Approximate Enrollment	Care Management FTEs	Enrollees Per FTE Care Manager	% Of Care Management Staff Not Clinically Licensed	Average Caseload for RN Care Managers
Plan D	95% TANF; 5% SSI	55,000	33	2,000	9%	100
Plan E	93% TANF; 7% SSI	83,000	46	2,000	4%	not provided
Plan F	92% TANF; 8% SSI	100,000	17	6,000	53%	80
Plan G	88% TANF; 12% SSI	175,000	58	3,000	9%	35
Plan H	88% TANF; 12% SSI	165,000	33	5,000	48%	75 - 100
Plan I	85% TANF; 15% SSI	215,000	87	2,500	30%	65
Plan J	85% TANF; 15% SSI	32,000	3	11,000	33%	175
Plan K	80% TANF; 20% SSI	70,000	10	7,000	30%	75 - 100
Plan L	80% TANF; 20% SSI	185,000	30	6,000	47%	50 - 70
Plan M	45% TANF, 10% SSI, 45% Commercial	210,000	33	6,000	21%	100
Plan N	100% SSI (HIV Special Needs Plan)	6,000	30	200	27%	200

- In most of the above plans, the RN Care managers have a caseload between 50 and 100 members at a given point in time.
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- Half of the above plans have 5,000 – 7,000 enrollees per FTE care management employee.

MCO-Specific Examples of Care Management Staffing – Plans with TANF, SSI and Medicare Members

MCO	Population Served	Approximate Enrollment	Care Management FTEs	Enrollees Per FTE Care Manager	% Of Care Management Staff Not Clinically Licensed	Average Caseload for RN Care Managers
Plan O	89% TANF, 5% SSI, 6% Medicare	300,000	98	3,000	65%	35 (375 for prior authorizations)
Plan P	95% TANF; 10% SSI; 5% Medicare	185,000	33	6,000	33%	not provided
Plan Q	70% TANF; 15% SSI; 15% duals	110,000	16	7,000	19%	350
Plan R	75% TANF; 10% SSI; 15% Medicare	40,000	30	1,300	40%	30
Plan S	70% TANF; 10% SSI; 20% duals	215,000	24	9,000	17%	35
Plan T	70% TANF; 15% SSI; 15% duals	450,000	38	12,000	24%	50
Plan U	78% TANF; 14% SSI; 8% duals	170,000	32	5,000	28%	60
Plan V	75% TANF; 20% SSI; 5% duals	75,000	14	5,000	29%	62

- In most of the above plans, the RN Care managers have a caseload between 30 and 65 members at a given point in time.

- Half of the above plans have 5,000 – 7,000 enrollees per FTE care management employee.

Telephonic Versus Face-to-Face Care Management

- Case loads for telephonic care management range from 50 to 350 and 20 to 100 for face-to-face.
- MCOs' care management staff communicate with members/caregivers in the following ways (aggregated via straight average across 21 respondents):
  - Telephonic (65%)
  - Face-to-face (17%)
  - E-mail (5%)
  - Other (13%)
- Other forms of communication include faxing, texting, and internet applications

Volume of Care Coordination Interaction With Members (aggregated across 10 respondents)

Approach	Annual Volume
Outbound Calls (live voice)	390,160
Outbound Calls (computerized)	195,340
Face to Face Meetings	7,488
Health Fairs, Other Community Events	3,126

Distribution of Care Management Staff

Type of Staff	Number	Percent Distribution
Registered Nurses	428	46%
Advanced Practice Nurses	13	1%
Licensed Practical Nurses	27	3%
Bachelor's of Social Work	39	4%
Other Bachelor's Level Care Managers	18	2%
Community Peer Care Managers	96	10%
Other Licensed Care Managers	47	5%
Non-Licensed Support Staff	267	29%
Total	935	100%

Above data are aggregated across the 28 MCOs that responded to this portion of the survey.

Plans Vary in Degree to Which Non-Licensed Staff Are Used

- Survey asked for staff mix in seven clinical licensure categories plus non-licensed support staff
- 28 respondents provided the requested staff mix
  - 2 of the respondents (7%) had more non-licensed care coordination staff than licensed
  - 8 MCOs (29%) had 1 - 2 times as many licensed staff as non-licensed staff
  - 18 MCOs (64%) had at least twice as many licensed staff as non-licensed staff
- Support staff were predominantly responsible making housing and transportation arrangements, acting as a community liaison, entering data, and administrative support
  - Five plans reported using non-clinical support staff to conduct a moderate level of case management: complete HRAs, authorize LTC services and DME items, etc.

Use of Employee Care Coordinators Versus Outside Contractors

- 30 respondents indicated the degree to which outside contractors are used for care coordination
  - 22 reported conducting all care management in-house
  - 7 reported 90-99% of care management occurring in-house
  - In one MCO, 75% of care management is contracted out to at-risk provider groups
- External contractors used include
  - Maternal Health: Baby Love, Alere
  - Behavioral Health: Beacon Health, PsycHealth

How Care Management Staff Time is Spent

Rank	Care Coordination Staff Activity	Percentage of Time
1	Care continuity/transition management	17.6%
2	Developing Treatment Plans	15.9%
3	Patient/family education & advocacy	12.9%
4	Logistics management (e.g., transportation, scheduling of appointments)	10.2%
5	Health coaching	8.9%
6	Patient counseling	7.6%
7	Conduct HRA	6.7%
8	Utilization management	6.5%
9	Motivational interviewing	6.4%
10	Discharge planning	3.3%
11	Crisis intervention (including ER diversion)	2.5%
12	Quality improvement	1.4%
	TOTAL	100.0%

17 MCOs responded to this portion of the survey. Above table presents a straight average across these responses.

Monthly Case Load per Type of Case Manager

- Registered Nurses
  - 20 respondents reported using RNs
  - Average monthly caseload of 100
  - Caseload range of 35 - 375
- Advanced Practice Nurse
  - 4 respondents reported using Advanced Practice Nurses
  - Average monthly caseload of 70
  - Caseload range of 60 - 100
- Licensed Practical Nurse
  - 4 respondents reported using Licensed Practical Nurses
  - Average monthly caseload of 105
  - Caseload range of 45 - 350
- Bachelor's of Social Work
  - 4 respondents reported using BSWs
  - Average monthly caseload of 84
  - Caseload range of 30 - 200

20 MCOs responded to this portion of the survey.

Monthly Case Load per Type of Case Manager (continued)

- Master's of Social Work
  - 12 respondents reported using MSWs
  - Average monthly caseload of 47
  - Caseload range of 20 - 100
- Bachelor's of Health Science/Community Health
  - 3 respondents reported using BHS staff
  - Average monthly caseload of 59
  - Caseload range of 25 - 110
- Community Peers
  - 3 respondents reported using Community Peers
  - Average monthly caseload of 53
  - Caseload range of 20 - 80
- Other Licensed Staff
  - 7 respondents reported using some other licensed staff
  - Includes MBAs, LCSWs

20 MCOs responded to this portion of the survey.

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Tracking Care Management Impacts

	Yes	No
Do you calculate the return on investment (ROI) on your care management programs?	8	14
Do you capture member satisfaction information about your care management programs?	15	4

Specific ROI Examples

- Care transitions: 2.2
- Complex CM: 3.8
- Home visiting nurse practitioner: 3.8

Qualitative Questions Yielded Key Summary Information

- Survey questions invited respondents to share what approaches have been most successful, what their key lessons learned are, what they are most proud of, and what they are planning to change
- Plans mostly gave non-conflicting but different answers to these questions
  - Detailed responses are provided in Appendix at end of this slide presentation
  - Next two slides summarize key themes

Key Themes from the "Big Picture" Questions

- Building and maintaining effective relationships with providers, enrollees, caregivers, etc. is critical
- Effective teamwork within the MCO's personnel also essential
- Plans are experiencing success moving care coordination out of MCO's office
  - Embedding MCO staff at certain provider sites
  - achieving stronger connection to members/caregivers at the home
  - early face-to-face assessments important for many high-need persons
- More care coordination resources are needed going forward
  - particularly staff increases
- No single approach fits all – each member is a "sample of one"

Themes from "Big Picture" Questions (continued)

- Care coordination is evolving – plans are experimenting and learning in many areas
  - e.g., risk stratification mechanisms, techniques to achieve member engagement, use of para-professionals to augment clinically licensed staff
- Well-integrated approaches needed for the many enrollees who have both physical health and behavioral health conditions
  - effective staff training is important component in this area
- Transitions of care initiatives/innovations are emerging rapidly
  - e.g., sooner and stronger assistance to enrollees post-discharge from a hospitalization

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Inpatient Transitions of Care -- Program Models Used

Transitions of Care Model Used	Number of Repondents	Percent of Repondents
None	4	19%
Coleman Model	7	33%
Guided Care (Johns Hopkins)	2	10%
Plan-Developed Model	4	19%
Other Model	5	24%
Total Respondents (note one MCO uses multiple models)	**21**	**100%**

Regarding staffing of their transitions of care programs, eight respondent MCOs employ a dedicated, separate transitions of care team; ten MCOs reported that their case management staff perform transitions of care services in addition to their other duties.

Nature and Volume of Transitions of Care Support

Transitions of Care Support Activity	Number of Respondents	% of Non-Maternity Admissions Where This Type of Support Occurs	Response Range
Visit(s) in hospital during inpatient stay	8	18%	0% - 100%
Phone call(s) during hospitalization	6	4%	0% - 15%
Phone call(s) post discharge	10	57%	6% - 100%
Home visit post discharge (by plan staff)	7	8%	0% - 20%
Home visit post discharge (by home health agency)	7	11%	0% - 25%
Medication reconciliation	8	44%	9% - 100%
Assisting in scheduling follow-up appointments	10	36%	10% - 100%
Assuring appointment compliance	9	40%	6% - 100%
Patient education and coaching	9	40%	2% - 100%

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Health Risk Assessment Experiences

- 14 respondents indicated that they use direct mail to conduct HRA for at least some of their enrollees
  - Four of these MCOs view the approach to be ineffective (it is used because it is a contract requirement)
  - 75% of enrollees in these 14 MCOs receive an HRA via direct mail
- 11 respondents indicated that they conduct some or all of their HRA information gathering through phone calls to members
  - 47% of enrollees in these 11 MCOs receive a telephonic HRA
- One MCO conducts 75% of its HRAs via face-to-face meetings
  - No other MCO indicated that they conduct HRAs face-to-face

Top 10 Top Enrollee Paths Into Care Management

(across 21 respondents' own rankings)

1	Claims/utilization data
2	Provider referral
3	HRA
4	Predictive modeling
5	Member services
6	Chart review
7	Social service agency
8	Risk adjustment
9	Caregiver referral
10	Biometric screening

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Patient Centered Medical Home (PCMH) Activity Overview

- 12 MCOs indicated that they currently contract with at least one PCMH
- Collectively, these MCOs have contracted with 113 PCMH sites
- Six MCOs pay enhanced rates to their PCMH providers
  - In four of these MCOs, enhanced rates are based on participation
- Four of the MCOs require the PCMH to secure NCQA recognition/designation

APPENDIX

DETAILED RESPONSES TO VARIOUS OPEN-ENDED QUESTIONS:

- What Care Management Initiative Has Been Most Successful?
- What are Key Lessons Learned?
- What Are You Most Proud Of?
- What Changes are You Planning to Make?

What Care Management Initiative Has Been Most Successful?

- Prenatal High Risk, Complex CM
- Point of contact and on-site presence in Integrated Delivery Team (IDT) meetings
- Care Transitions, Complex CM, and the Home Visiting Nurse Practitioner (in combination -- one would not work as well without the others)
- Post discharge calls. Out of this effort, we have identified many areas to improve the transition from hospital/home to reduce rates of readmission
- ESRD, Pregnant Women programs result in cost savings and improved health
- SNP model of care; coordination of care among treating providers and members
- HRA's which focus more on psychosocial barriers to receiving care but also capture diagnoses

What Care Management Initiative Has Been Most Successful? (continued)

- The integrated care management model is the most successful initiative that we have undertaken. The face to face assessment fosters better outcomes.
- Asthma, Diabetes, CAD DM programs are easier to produce results in utilization, reduced ER and quality measures.
- Partnered with a hospital-based program for in-home education for asthmatic members. Significant increases seen in enrollee knowledge of asthma and treatment; significant decrease in ER & urgent care visits.
- Stratification of case mgmt levels and integration of BH and medical.
- Improving the amount of time taken to outreach and engage members (from 30-45 days to 3 weeks). This, plus changing the process from having the non clinical staff engage members in care management to the Nurse Care Managers has doubled the engagement rate.
- Foster care initiative provides a designated liaison to the foster family.

What are Key Lessons Learned?

- Embedded care managers fostered positive relationships with PCP's, members, and staff.
- CM is about relationships both with members, providers and the community. To positively influence behavior, a therapeutic relationship with a health care professional is needed.
- No "one program fits all". Programs need to be structured in such a way as to allow flexibility and continuity in each "program" being aware of what the others can provide and how each can be supportive of the other.
- Having nurses embedded in sites and navigators in the community has been very helpful in improving member engagement and assisting in reducing ER visits
- Para-professions (patient navigators and case manager associate) compliment clinical staff. They are able to support care management efforts and allow clinicians to implement/provide and sustain services necessary to meet members needs. Hiring and training a specific team of support staff has increased capacity to do more.
- Needs to be a broad model that includes medical and psychosocial factors. Since it does not include UM functions, the work does not need to be structured by product line.
- Strong push for care managers in the field, working one-on-one with members. Plans reported using such peer support specialist is key. Also, collaboration with behavioral health vendors and other ancillary providers/vendors are important to assist with network, knowledge and referrals.
- Proper training for the staff is critical for an integrated model.

What are Key Lessons Learned? (continued)

- It is difficult to keep members engaged even with an incentive program - we are planning a group face to face case management program
- Providers are where the care is delivered and where there are opportunities for additional collaboration results
- Case management is very time consuming and resource intensive.
- The ability to manage an enrollee through the continuum of care, starting from an acute level of care to our transition of care program to ensure a safe transition home up to more complex care management services.
- Better stratification, daily communication of the levels, and improved DM/CM hand-offs
- Non clinical staff attempting to engage a complex population does not yield a high engagement rate or necessarily the right members being engaged.
- Found it important to define case management acuity in three levels: Complex Case Management, Care Coordination and Service Coordination.
- Psycho-social issues and behavioral health issues that are barriers to healthy outcomes are easily identified when the care manager meets the client in person. In person observation is key to establishing a relationship. Motivational interviewing is also key to client engagement. The use of ICM-CAG tool which covers 4 domains including physical health, behavioral health, psycho-social and healthcare navigation is an effective tool for the care managers.

What Are You Most Proud Of?

- High member satisfaction rates with all of our care management programs.
- Knowing our providers prefer us for their patients' case management services.
- Excellent member satisfaction with care management services and improved quality of life secondary to CM services. Consistent year to year decreases in AD/k, BD/K, decreases in ALOS, decreases in ED utilization.
- We have many testimonials about how our programs have improved members' lives and health outcomes. Member satisfaction is high.
- We received a score of 100% for our complex case management program from NCQA. We have a highly skilled cadre of clinical case managers. We have developed a robust population health approach for our pregnant population.
- Commitment and dedication of staff in serving members & supporting our mission
- Restructuring and defining 'care management' for our system and for our population is what we're most proud of. Staff are specialized/trained better based on the program they work within. Enhancing our use of 'para professionals' has helped tremendously. We are proud of our use of patient navigators and how well their efforts integrate with clinical efforts to maximize outcomes.

What Are You Most Proud Of? (continued)

- TEAM WORK!! We have RNs, LVNs, MSWs, LCSWs, Member Services Counselors, and authorization reps that all work collaboratively for the good of the client. No hierarchy within the team
- We are proud of our positive outcomes with the use of the ICM-CAG tool. The program worked well with the most complex Medicaid "fee for service" clients and we made an impact on the health of our clients and became recognized as a positive force at the community and state level. We have replicated this model within our other care management programs.
- Face to face program for pregnant women
- Great success stories from our case managers where they have gone above and beyond to help members
- Integrated team process
- Outcomes of CM since stratification
- Implementation of Interdisciplinary team meetings specific to Member's needs.

What Changes are You Planning to Make?

- ACAP plans are clearly investing in more care coordination; several MCOs indicated that they are hiring additional staff
  - A general/overall increase in case managers
  - Increase number of peer outreach staff
  - Expand staffing structures
  - Increase staffing (clinical and navigator level) due to their high acuity needs.
- Implement a dedicated model and staff to serve dual eligibles
- Shift more CM staff into sites/provider offices versus telecommuting
- Integrate advanced practice nurses, MSW, BSW and other disciplines within the team

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