Care Coordination Design and Impact:

What did we learn from the MNCARES study?

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Panelist
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Ambulatory Care Management Supervisor - Social Worker, M Health Fairview

Panelist
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Director of Ambulatory Care Management, M Health Fairview

Panelist
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Planner Principal, Minnesota Department of Health

MN Community MEASUREMENT

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Agenda

Brief introduction to MNCARES
(Steve)

Study background and origin
(David)

M Health Fairview experience
(Jenny and Lindsy)

MNCARES findings
(Steve)

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What is the MN Care Coordination Effectiveness Study?

- 4-year study started in 2020
- Funded by the Patient-Centered Outcomes Research Institute
- **Objective:** compare two approaches to care coordination used in primary care clinics across MN
- **Outcomes:** health care quality, utilization, and patient-reported measures

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A large collaborative research effort

Certified Health Care Home Clinics/Care Systems

CERTIFIED HEALTH CARE HOME — DEPARTMENT OF HEALTH — HealthPartners Institute — MN Community MEASUREMENT

Payor Organizations

Blue Cross Blue Shield of MN | Medica | MN Dept. Human Services | UCare | HealthPartners

Patients

Multiple national expert consultants

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MNCARES - Origin and Background

- Care coordination is key to Health Care Homes (HCH)
- Unanswered questions: How does it work? What is the best approach?
- HCH Director and HealthPartners
- Partnership and funding

DEPARTMENT OF HEALTH

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HEALTH FAIRVIEW

Ambulatory Care Management

Jenny Kolb RN, BSN, Director of Ambulatory Care Management

Lindsy Johnson, LSW, Supervisor Social Work Care Management

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MHFV Ambulatory Care Management

Model of Care

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Ambulatory Care Management Team

Who we are: The team is comprised of 5 distinct areas

Primary Care Care-Coordination	FPAN Care Coordination	Specialty SW	Connected Care Resource Center	Clinical Product Navigators
Team serves traditional MHFV Primary Care clinics (RN, SW, CHW, FRW)	Team serves independent and affiliate practices (SW only)	Team that serves BH, Adult and Pediatric Specialty Clinics (SW only)	Centralized members of the CM team (RN, SW, CHW, CTA) *Transitions of care for the system, Centralized TCU referral process, etc.	RN's who specialize in: • High Utilization patients • Monthly Payer Case Collaboration Review • Payer Focused Initiatives • Referral network navigation

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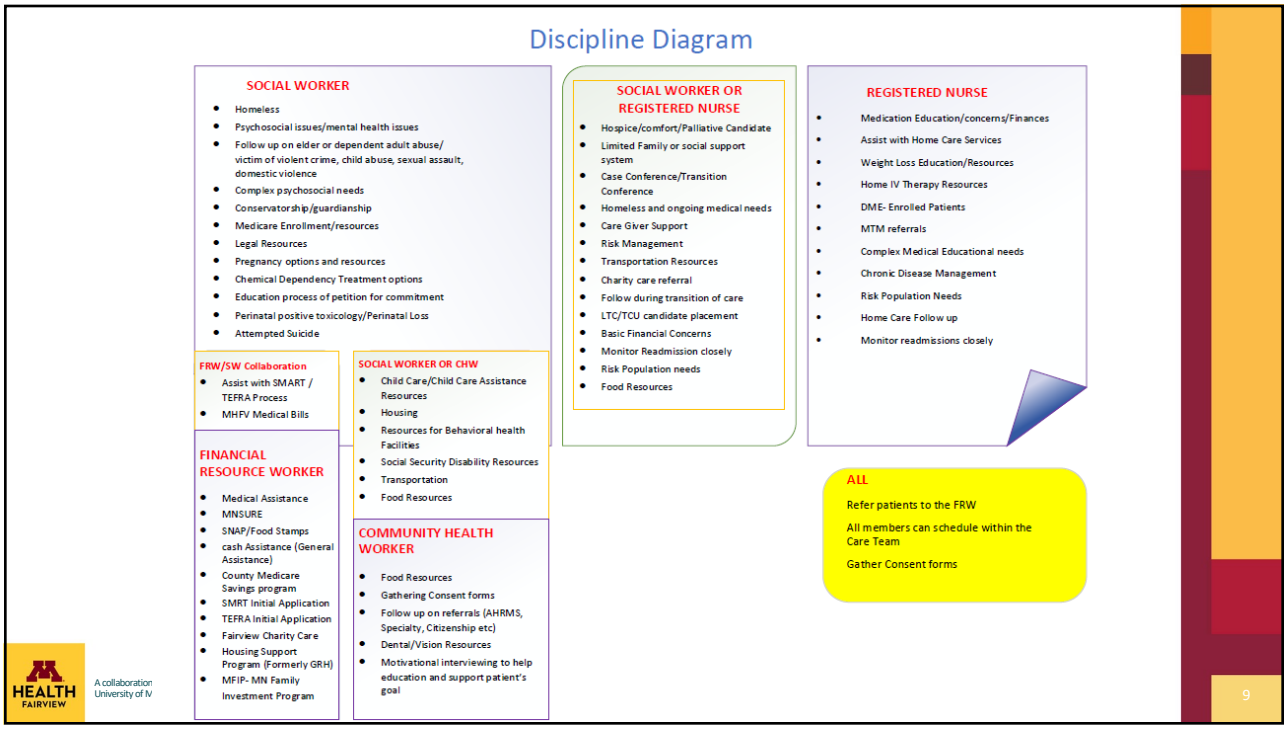

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System Care Coordination Model

VISION: Empower customers to achieve their highest attainable level of health and wellbeing, supported by the optimal delivery of innovative and evidence-based best practices.

Patient enters the system

- Primary Care
- Specialty Care
- Acute
- Post-Acute

Standard Assessment

- Clinical and social risk factor assessment
- Risk stratification
- Drives for service level needs based on standards

Connected Care Resource Center (CCRC)

- Multidisciplinary team utilized to remove admin burden
- Remote monitoring (e.g., GetWell Loop, MyChart, etc)
- Set quality service level standards for outcomes, roles, functions and tools
- Monitor changes in patient conditions/risk that warrant higher level of service
- Support population health initiatives
- Scaled services

ACCOUNTABILITIES:

- Outreach for all care transitions (low-high risk)
- Discharge planning (i.e., referrals, transportation, home care, education, etc)
- Schedule post-discharge appointments proactively before discharge
- Facilitate telemedicine services
- Act as a final resource guides
- Complete pre-assessments

Plan of Care

ACUTE CARE COORDINATION

- Episodic new patient to system, not followed by specialty
- Consult-based service (some enrolled by risk)

PRIMARY CARE COORDINATION

- Follows patient across the care continuum
- SW & RN Care Coordinators

SPECIALTY CARE COORDINATION

- Follows patient across the care continuum
- Disease management
- SW and RN Care Coordinators

- Post-acute care coordination
- Homecare
- Patient education
- Etc.

Clinic RNs

SERVICE LINES

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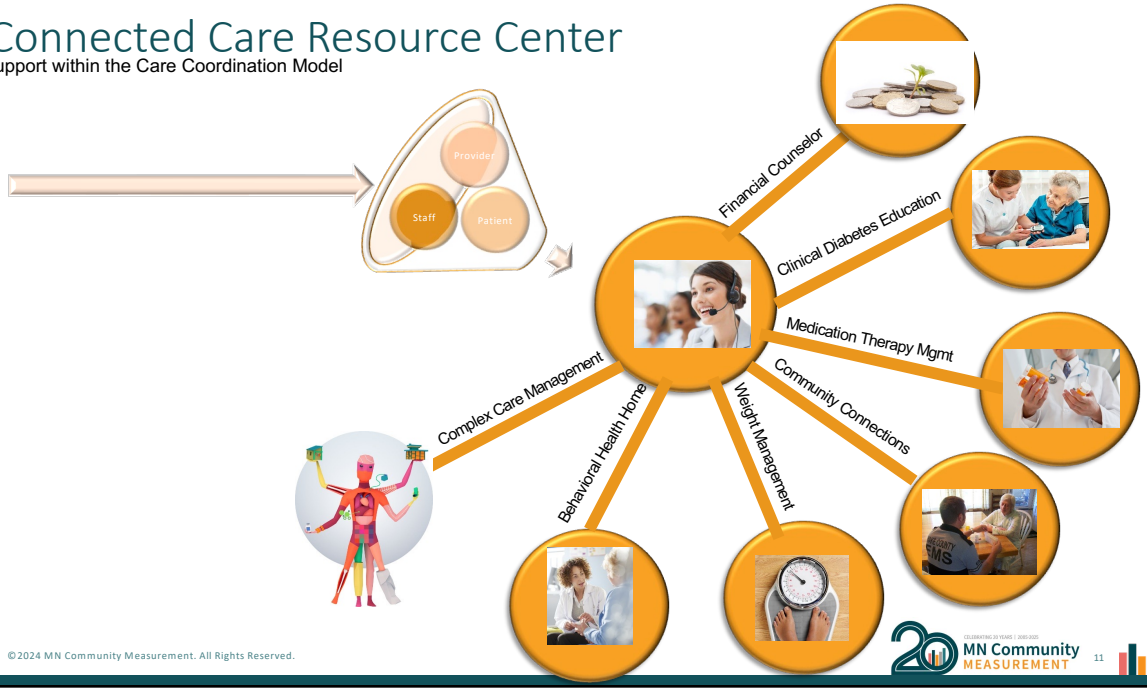
Connected Care Resource Center

Support within the Care Coordination Model



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Model Advantages

Improves customer experience and patient outcomes

Decreases total cost of care by:
1) Improving ED & IP utilization
2) Providing services in alignment with standard risk stratification
3) Enabling care management staff to work at the top of their licensure

Easily adaptable to new landscapes and outreach capabilities (e.g. COVID-19)

Alleviate provider burden:
1) Ensuring complex patients are supported in between clinic visits/episodes of care with closed loop communication to provider
2)Proactive versus reactive care
3) Assurance Chronic Care Management is delivered based on best practice

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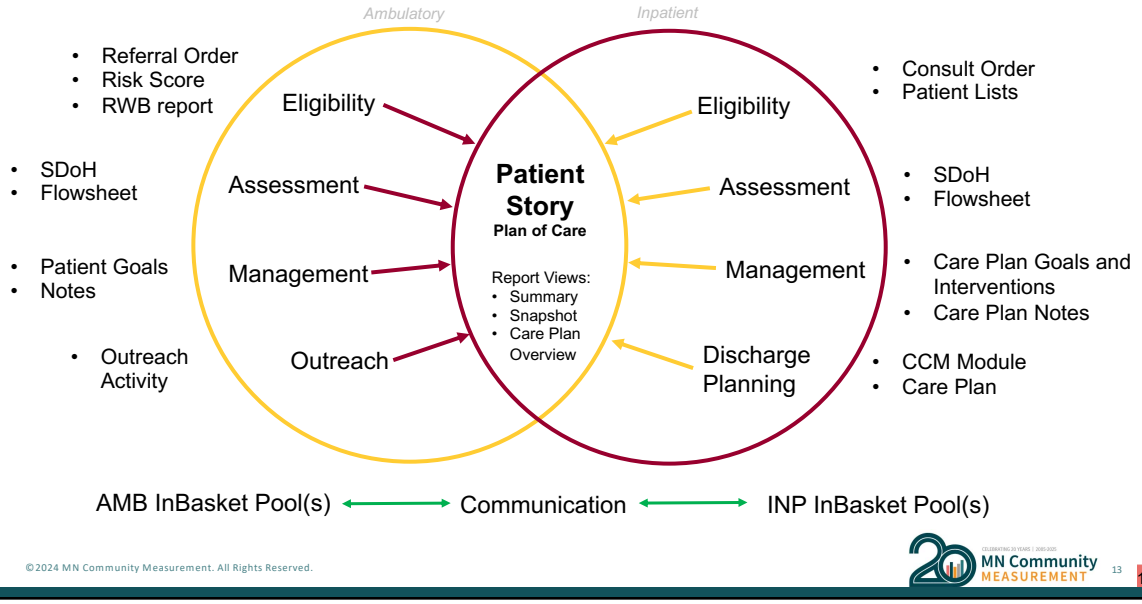
Capturing the patient story…is our goal!



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2024 System Priorities

Initiatives and accomplishments

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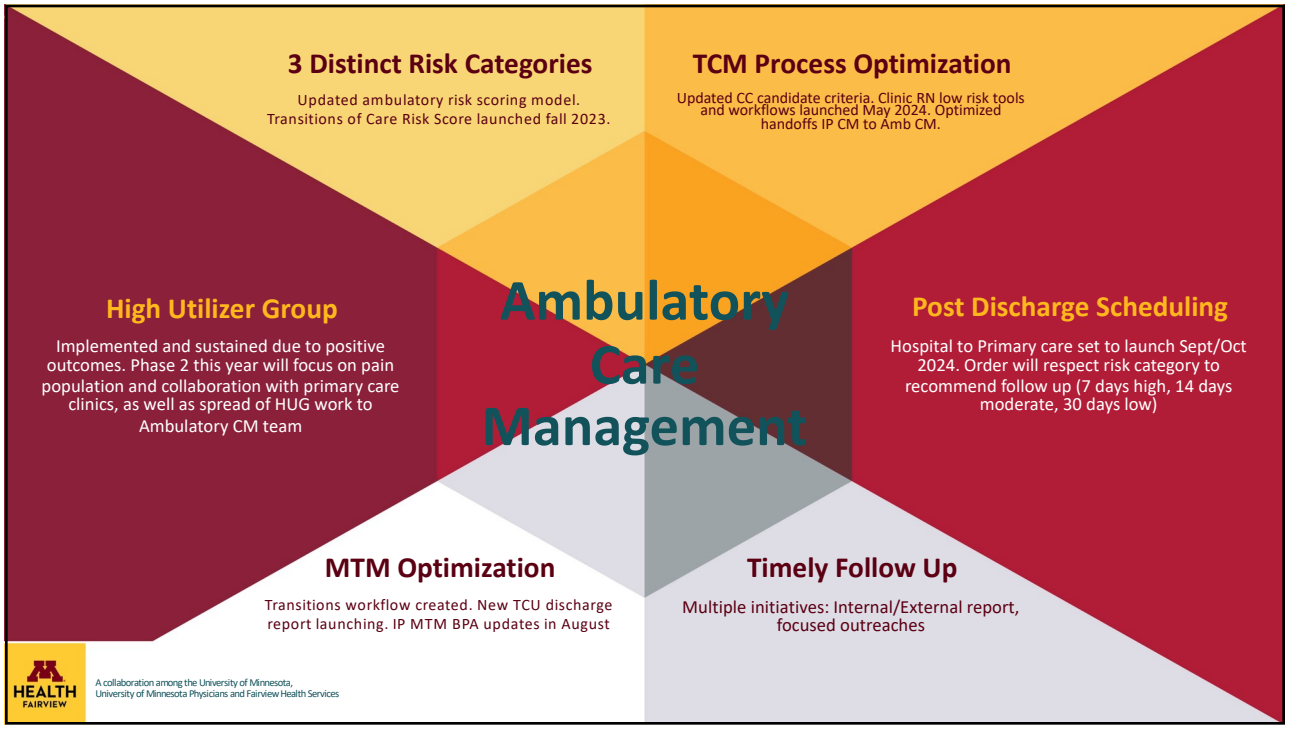

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Project Highlights

HIGH UTILIZER GROUP

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What is the HUG care model?

Highly coordinated care across the continuum, involving multiple care providers, in partnership with patient and family.

Personalized complex care planning to provide best care, direct patient to lowest cost site of care whenever appropriate (PC, ADS, BH), and make plan of care visible in Epic to internal and external care providers

Focused on reducing overall recidivism, rather than only addressing the current situation

RNs deep dive into patient medical, behavioral, psychosocial situation; develop recommendations

Multidisciplinary physician leader team reviews, consults, enhances or endorses RN recommendations

Team develops care plan that includes new referrals and connections to existing care team and community partners

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Pain Management: Reduction in MME's (morphine milligram equivalent)

Pre-HUG MME	Post-HUG Intervention MME (as Feb 2024)	MME Reduction
180	54	-126
233	109	-124
90	30	-60
>900	270	-630

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As someone who sees complex pain patients routinely on the Inpatient Pain Service, I am often struck by the repeated hospitalizations and prolonged length of stays of certain individuals. Since joining the HUG and referring some of these patients, I have remarked on not being consulted on many of them for >1 year now. **I truly believe that through intense work and multidisciplinary conferences that our group has been able to create complex and effective plans that have led to better patient outcomes.** This has translated to less frequent hospitalizations and potentially shorter length of stays. I just want to say what an honor it is to work with such dedicated people and thank you for the opportunity.

Service Line Medical Director, Pain Management

HEALTH FAIRVIEW

A collaboration among the University of Minnesota, University of Minnesota Physicians and Fairview Health Services

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Centralized TCU Referral Process - CCRC
(MHFV Community Hospital sites)

- Patient flow within our hospitals is critical and securing a SNF placement requires a huge amount of time for follow up. CCRC team helps in the follow up of these referrals offsetting Acute Care Managements time to operate to the top of their licensure.
- With a robust dashboard, we have a system view of referrals sent, accepted, and declined rates which can help us to continue improving the discharge process- giving patients a more positive experience and improving patient flow for hospitals.
- The CCRC team has worked with SNF community to streamline referral process:
  - Encourage SNF Epic Care Link access (ease of referral review)
  - IT partnership to clean up epic place of service
  - Build relationships/partnerships with SNF admissions teams

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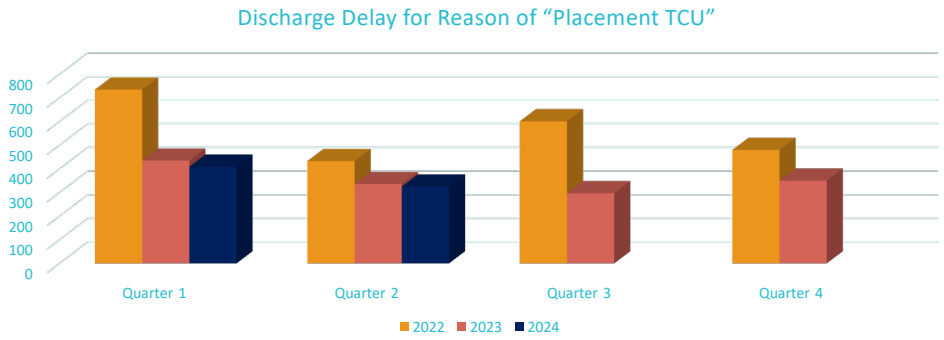
CCRC Centralized TCU Process-Outcomes



Consistent trend throughout 2023 showing decreased discharge delays for TCU placement

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Some findings from MNCARES

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Who is in the study?

415 HCH-certified clinics
72 care systems

→ **98 clinics** Ineligible/declined

317 included clinics (83% of eligible)
42 care systems (64% of eligible)

Medical/Nursing Model
178 clinics (56%)
34 care systems

Medical/Social Model
139 clinics (44%)
22 care systems

care systems are not mutually exclusive

12,711 patients
starting care coordination in 2021

3571 patients (28%)
152 clinics (54%)

9140 patients (72%)
132 clinics (46%)

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Who are the patients in the study?

12,711 patients

Median age: 66 years

62% female

60% White
17% Asian
11% Black or African American

4% Hispanic or Latino

Insurance: 44% state-sponsored

CC visits: 5 (median)

Median per patient: 6 chronic conditions

90% have 2+ chronic conditions

Top 6 diagnosis codes by overall prevalence:
Hypertension 58%, Hyperlipidemia 53%, Diabetes 46%, Depression 42%, Anxiety 39%, Low back pain 30%, Osteoarthritis 30%

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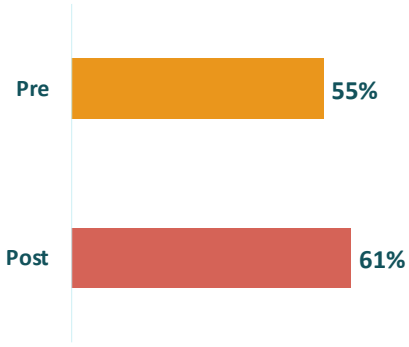
Key takeaway 1

Overall, patients' care quality outcomes improved
in the year following care coordination compared to the year prior to care coordination.

Goal achievement for care quality measures was **6% higher** for patients in the 12 months after starting care coordination



Composite outcome includes: A1c control, asthma control, aspirin use, blood pressure control, cancer screening, depression control, tobacco use, and statin use

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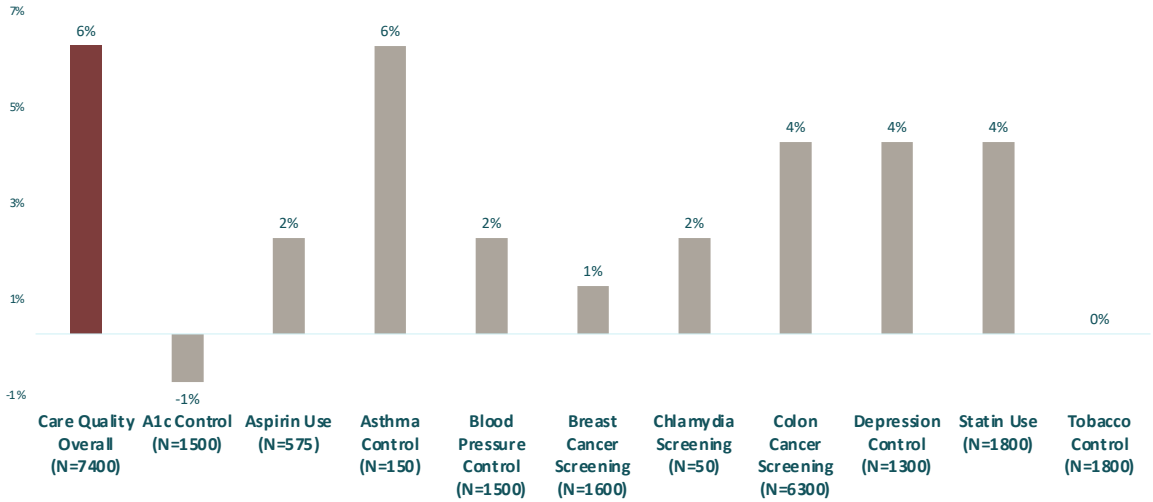
Change with Care Coordination by Measure



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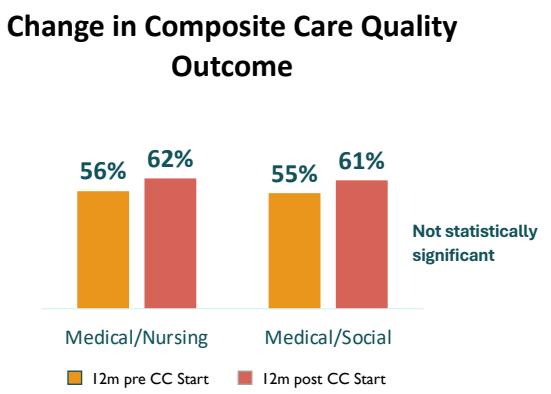
Key takeaway 2

The improvement in care quality outcomes was not different between patients in **Medical/Nursing** compared to **Medical/Social** model clinics.



Increase in percent reflects improvement in care quality outcomes

Patients in both models experienced improvement in outcomes

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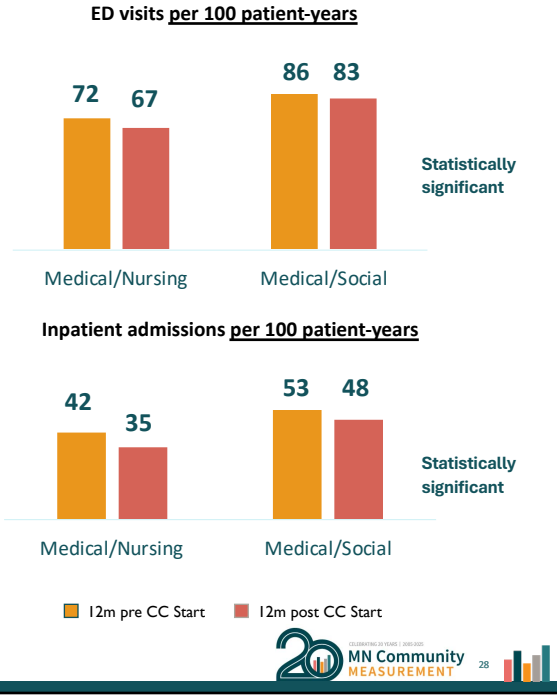
Key takeaway 3

Patients in both care models had fewer ED visits and hospitalizations in the year after starting care coordination, and that reduction was larger in Medical/Nursing compared to Medical/Social model clinics.



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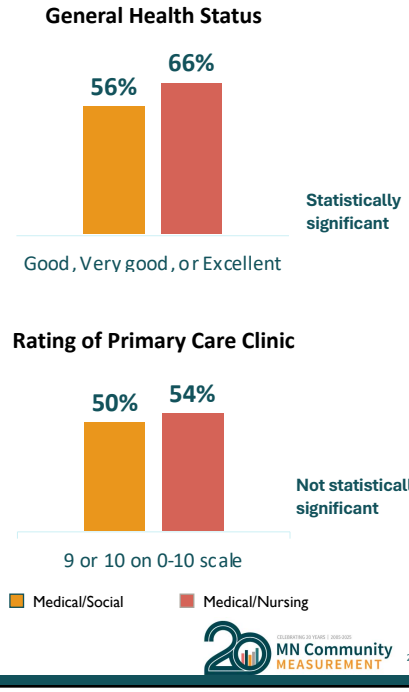
Key takeaway 4

Care coordination patients in **Medical/Nursing** clinics reported better health status and rated their clinics better than those in **Medical/Social** clinics.



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Key takeaway 5

The two care models we compared in the study overlap with each other in practice.

Using the survey of care coordinators, we identified four distinct "types" of care models being used in practice, suggesting a new way to look at models and compare outcomes.

Type 1:
Social & Medical,
More integrated, More resourced

Type 2:
Social & Medical, Less integrated,
More resourced

Type 3:
Medical, More resourced

Type 4:
Medical, Less resourced

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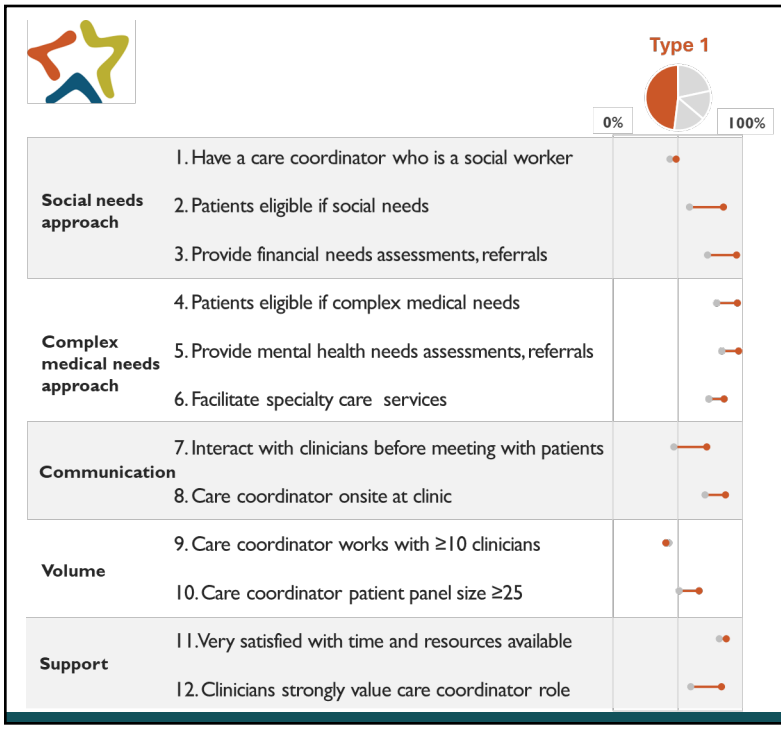

Type 1: Social & Medical, More integrated, More resourced

Type 1 was **the largest** - about half of care coordination programs.

The programs had both a **social** and **medical** focus, were well **integrated** into primary care, and perceived as well **resourced**.

This type was associated with the **largest drop in emergency department** visits and lower overall health status for patients.

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Findings from stakeholder engagement

Spring meetings

Study Steering Committee
Study care group liaisons
Clinician and clinic leaders
Study patients
HCH Learning Days

3 key takeaways

1) It usually takes longer than 12 months for the full impacts of care coordination to be realized (especially for those with high social needs).

2) In the absence of longer-term outcomes, it is hard to act decisively on study findings thus far.

3) It is critical to understand whether care coordination models differ in addressing patients' social needs.

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What is next for MNCARES?

- Several manuscripts and final report are in process
- Still learning from study data with additional analyses
- Additional stakeholder dissemination planned

In early September, we submitted a proposal for a long-term follow-up study of MNCARES to PCORI to address key feedback from stakeholders

- 35 of 39 care systems and 5 of 5 payor partners expressed interest in participating in the long-term follow-up study (reflecting potential to study long-term follow-up on 98% of original study patients)
- Merit review in November 2024
- Funding announcements in April 2025
- Earliest start date in August 2025

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Additional Data

CARE MANAGEMENT IMPACT

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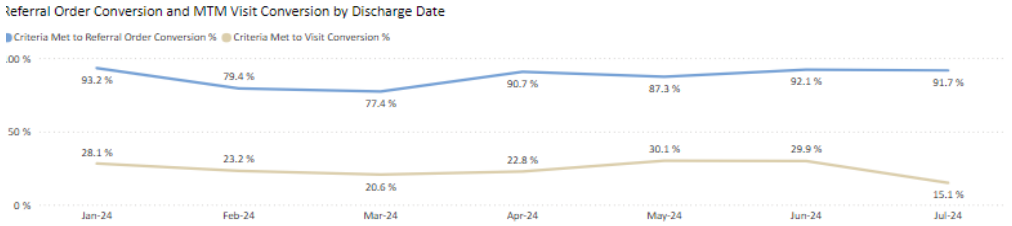
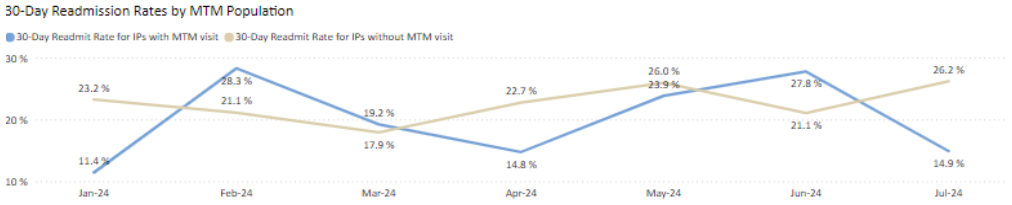
Average conversion to visit rate prior to June 2023 go live of project: 14%

Medication Therapy Management Transitions

MTM Criteria Met	Criteria Met to Referral Order Conversion	MTM Referral Order	Criteria Met to Visit Conversion	MTM Visit
1,842	87.3 %	1,608	23.7 %	437





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Connected Care: ED & IP Utilization for Patients Enrolled in Ambulatory CC

"Empowering patients to achieve their highest attainable health and wellbeing"

Metric	IP Utilization			
	Quarter 1 - 2023	Quarter 2 - 2023	Quarter 3 – 2023	Quarter 4 – 2023
Total enrolled patients (new)	2984	3023	3386	3878
Patients having ED pre-enrollment (>0 visits)	41.2% (1230 / 2984)	43.1% (1302 / 3023)	45.9% (1554 / 3386)	46.1% (1786 / 3878)
Patients having ED post-enrollment (>0 visits)	24.8% (740 / 2984)	27.3% (825 / 3023)	28.9% (980 / 3386)	29.2% (1132 / 3878)
	p < 0.000001	p < 0.000001	p < 0.000001	p < 0.000001
	Raw #s - # of patients with IP/ED *Ratio - # of patients with IP/ED / total #*			

- There was a statistically significant decrease in the number of patients who had any IP Utilization in the 6 months before enrollment compared to the 6 months after enrollment for all quarters.

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Connected Care: ED & IP Utilization for Patients Enrolled in Ambulatory CC

"Empowering patients to achieve their highest attainable health and wellbeing"

Metric	ED Utilization			
	Quarter 1 - 2023	Quarter 2 - 2023	Quarter 3 – 2023	Quarter 4 - 2023
Total enrolled patients (new)	2984	3023	3386	3878
Patients having ED pre-enrollment (>0 visits)	61.1% (1822 / 2984)	61.0% (1843 / 3023)	63.8% (2161 / 3386)	63.7% (2470 / 3878)
Patients having ED post-enrollment (>0 visits)	45.0% (1342 / 2984)	46.5% (1405 / 3023)	48.8% (1652 / 3386)	47.9% (1858 / 3878)
	p < 0.000001	p < 0.000001	p < 0.000001	p < 0.000001
	Raw #s - # of patients with IP/ED *Ratio - # of patients with IP/ED / total #*			

- There was a statistically significant decrease in the number of patients who had any ED Utilization in the 6 months before enrollment compared to the 6 months after enrollment for all quarters.

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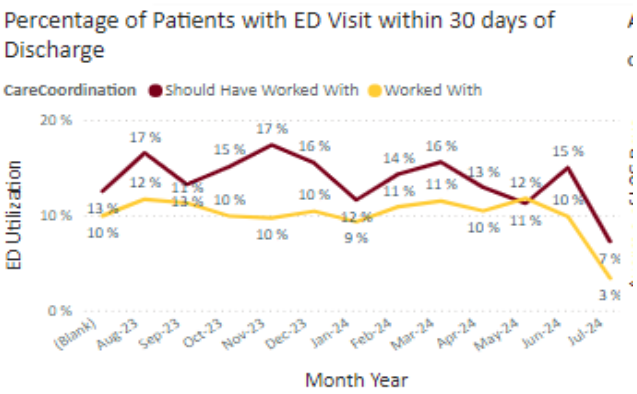
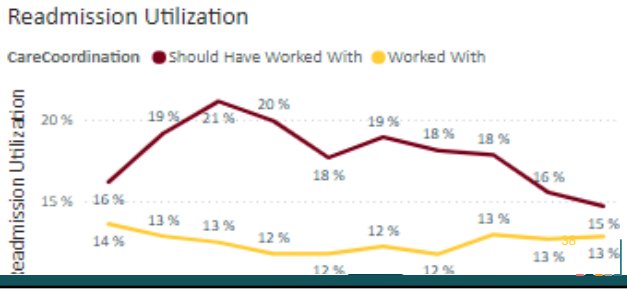
Inpatient Care Management Impact

- **Population**= All patients with a "risk of unplanned readmission" score of 20% or above
- Those that receive an IP CM consult show **reduced ED Utilization and readmission rates post discharge**





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Questions?

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