# TOWARD A HEALTHIER FUTURE FOR DUAL ELIGIBLES:
# A COMMUNITY CARE NETWORK

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**Submitted To:**

**CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES**

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# A COMMUNITY CARE NETWORK

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## I. OVERVIEW

The California Department of Health Care Services is soliciting ideas for how best to serve "dual eligible" beneficiaries who qualify for both Medi-Cal and Medicare. DHCS is interested in models of care to meet the needs of people who are younger and physically disabled and those who are older and chronically ill – as well as people who have intellectual and developmental disabilities and those who have serious mental illness.

At first blush, the disparate needs of this population would seem to require different models. Community Medical Centers believes, however, that a novel patient-centric approach will meet the needs of this population, improve quality, lower cost, and most importantly provide directed guidance to better health.

Our new model is a Community Care Network premised upon the notion that the daunting challenges of the dual-eligible populations all have a common cause. It was TS Elliott who made popular the phrase, "Hell Is The Place Where Nothing Connects." Nowhere is this more true than in the dual-eligible population. Whether it is fragmented medical care or fragmented social or behavioral care, what is missing is an effective patient-centric care management system. The model Community advocates is a rational approach that may be implemented across the broad spectrum of the dual-eligible population.

## II. QUESTIONS: PART 1

### 1. *Describe the model you would develop to deliver the components described above.*

Our proposed care model (referred to throughout as The Network) begins with a data management and informatics back end. This back end is built from multiple data sources including claims data, lab data, physiologic data, case management data, social service data, geospatial data, and externally produced quality and outcomes standards. The Community Care Network back end will allow all providers to see patients' care needs and health performance at any time. Moreover, the knowledge generated by this system can be shared across providers, programs, and caregivers. A sample data starting point from a comparable structure is reflected at the end of the questions.

Though this model is new to California, examples of success exist elsewhere: Community care models similar to our intended model exist in other parts of the country. In South Carolina a recent study compared quality and cost of care outcomes for their Medicaid population. The study showed that between a traditional fee for service model versus an HMO model versus a community care network model, that the community care network not only matched the HMO for quality outcomes (which greatly exceeded the traditional fee for service providers) but did so with lower overall costs of about $100 per member per month. Community care models in North Carolina and Alabama have repeatedly shown that when appropriate resources are brought to bear on behalf of the patient's quality and cost improve. In North Carolina asthma patients showed a 28% increase in flu immunizations, and 98% of the patients received the right medications. Similarly in Alabama by managing asthmatic patients to transparent quality standards, quality improved and overall cost went down by as much as 6.1%. North Carolina reported a reduction in pharmacy expenses by 22%, The Patient First model which was an early stage community care model in Alabama was able to distribute $4.5 million in shared savings to providers based upon improved quality measures and enhanced patient compliance with drug, diet and exercise recommendations. These improvements in physiologic measurements, quality metrics and cost reduction are the result of unique patient centric tools that create transparent, transactional knowledge driven capability at the bed side , office, and home. Another excellent example of our intended approach can be found in the January 24, 2011 New Yorker article by Dr. Atul Gawande on the work of Dr. Jeffrey Brenner in Camden New Jersey titled "Hot Spotters." The article highlights the impact of focused community efforts on the most complex patients. Our goals are similar and our structure will contain the following 5 tools:

1. A patient-centric, provider-accessible medical record to support all providers regardless of practice site or structure. For an example of this record please see the slide deck appended at the end of these questions.

2. Quality reminders pushed to the provider desktop to ensure compliance/performance with best practices for managing this population. For an example of the reminders, provided in the form of fusion charts/dashboard, please see the appended slide deck.

3. Enrollment of patients, where appropriate, in a case/care management structure.

4. Patient enrollment, where appropriate, in a low-cost, highly effective, interactive voice response system that allows patients to tell our network how they are doing at any time. For an example of this, please see Attachment A.

5. A proprietary Community Care Network management system that flattens out the reach, distribution and sharing of knowledge and information among all stakeholders -- clinical, behavioral, parents, partners and patients who are engaged in the care and well being of the individual. The hallmark of this network is that the tools are patient-centered, not provider centered, which means getting the right information to the right person at the right place at the right time.

Each of these five tools is supported by an ongoing infosystem of care unique to the Community Care Network. This infosystem comprises, among other things:

a) **A thoughtful review of claims data, and where available lab, pharmacy, encounter and patient self reported data in its analysis:** There are four keys to any review of information associated with health management. First is data acquisition. The patients in the selected population are potentially served by multiple programs, providers, other caregivers, and support services; hence heterogeneous data acquisition will have to be anticipated. The second key is data fusion or turning heterogeneous data to homogenous data. The third key is data analysis of the fused data. Finally the fourth is data visualization. Community combines each of these four keys by using the flexibility of open standards to connect to disparate data sources, analyze data from disparate data sources, and return information from disparate data sources to the end-user from a single access point.  Community also has the ability to examine non-medical social data to determine if there are externalities impacting the care challenges.

b) **Patient risk-scoring solutions and predictive modeling:** Using strong research and actuarial skills Community begins its scoring approach by using a risk severity index. This RI score is reflective of patients' conditions as known through claims data. Many patients have multiple co-morbidities which each must be managed. The RI scoring is then compared to an Adjusted Risk Index or quality score of the providers. This ARI presents a numeric value of the Providers response to the known conditions of the patients. Finally the patient may also be scored from a compliance formula. When combined, the Comprehensive Health Score (CHS) presents a base number of the patient's health status. Based upon actuarial review, reduction in the CHS reflects both an improvement in the health status of the patient and future out year cost savings, assuming the patient's health risk can either be stabilized or reduced.  This Risk Score becomes an important measurable outcome in the Community management of this population since there must be measurable objectives to evidence improvement based upon the Community Care Network approach.

c) **Geo-mapping solutions as a part of this response**: Community has the ability to use Geospatial technologies for multiple purposes. Our team, in conjunction with partners, has real depth in GIS applications for healthcare utilization. Geospatial technologies have evolved over the last 25 years from command-line, disconnected, software applications,

with peculiar data-ontologies, to connected, network-centric, database-driven applications providing computational analysis of spatial relationships. Our capability includes spatial and non-spatial, structured and non-structured harvesting via web services, including real time data feeds such as in Google Earth. Moreover we can provide management and processing and inter-operability into a consistent form for analysis and functional operations, such as the ability to identify clusters of like disease conditions or clusters of similar quality or compliance challenges. This GIS effort can be linked to our review work and our underlying data to produce the very data visualization referred to in item one above. By linking this data together with our GIS toolkit we can also make the system interactive and allow for real time or near real time data rendering. This capability allows the Community Care Network to "see" the opportunities together, thereby giving strong steerage to the program management. Examples of the GIS applications to be used by Community are attached in the power point.

d) **Peer to peer comparative clinical support data**: Using our back-end data analysis system, Community has the ability to evaluate clinical quality. In determining programmatic effectiveness there are generally three drivers of poor outcomes - payor requirements, which impact needed care, patient non-compliance, and provider quality opportunities. Our network will focus on each of these challenges, including a quality opportunity *missed* or *met* scorecard for certain chronic diseases.

The deployment of this network shall include:

a. A geographical area including all of the Fresno County and It should be noted that as much of the Community Care Network infosystem is virtual, distance between partners becomes less relevant.

b. Our initial focus will be on the 9,889 Medicare dual eligibles in Fresno County between the ages of 22 and 64. Community Care Network's enrollment strategies are anticipating the ability to reach all of these patients in year one and obtaining an enrollment of 5,000 during the first 12 months of operations. We are willing to expand the program to include the remaining 20,272 dual eligibles 65 and over given we have the opportunity to review and analyze current demographic and utilization data specific to this population.

c. The provider network today is comprised of existing Community physicians and ancillary providers. Over the next few months Community will be augmenting this network through a variety of strategies, which could include contracting with a Medical Foundation as well as with several Federally Qualified Health Centers in Fresno County. It should also be noted that a hallmark of the Community Care Network model is that it is not physician or hospital centric but rather patient centric. As such social workers, pre-school or school teachers, DTP workers, and behavioral experts are as much a partner in this system as medical providers.

d. The Community Care Network is a patient-centric model; hence its reach is built from the patient out. Experience has told us that to optimize care you must have an ability to push and pull information to all parties. As a result the patient has the ability to see and view their record. The patient has the ability to receive and review text message reminders of their own self care. Patients have the ability to use the web or phone to report their own

care management to their patient record. The patient is provided with a case/care manager or a life care nurse or coach. If the patient is already living in a group home or facility then the Community Care Network, works with the facility nursing manager to identify appropriate partners to optimize the patient experience and to connect up with other providers. Moreover, the Community Care Network is designed to connect the patient not with just a medical provider but with the right provider of the right services from a broad reach of community services. For example, in developmentally disabled populations living in group homes, the Network can assist in developing an electronic patient record to follow the patients. Many patients both move throughout the group home system and also are hospitalized periodically and then returned to the group homes. Because group homes are often challenged to maintain funding the Network can provide valued tools and resources to optimize quality care, manage medications and reminders and coordinate care during and between hospitalizations.

e. Assessment and planning is done in a collaborative case management style with the support of a robust online tool and supported by the data warehouse and informatics back end. For an example of the planned Community Care Network tool please see the slide deck appended at the end of these questions.

f. Care management approach across all settings: Again it is important to note that this is a Community Care Network, which is patient centric. The data, the knowledge, the quality recommendations, the risk scoring, the care management recommendations follow the patient throughout their care settings.

g. Financial structure: A Knox Keene health maintenance organization licensed and approved to take risk will support the Community Care Network. The HMO will seek the advice of leading professionals on risk retention, risk transfer and risk management. The working intent is for the HMO in turn to explore a blend of relationships with all providers along the lines of either capitation or shared risk together with a quality and outcomes driven shared savings plan. The hallmark of community care networks in other settings is to both meet quality expectations and reduce overall cost. Community believes these outcomes will be achievable here.

## 2. *How would the model meet the needs of all dual eligibles?*

The Community Care Network is designed to reach all dual eligibles. Because it is patient centric not provider centric, the Network begins with the question of what is needed to improve outcomes for this patient. The model is neutral initially as to disease state, location of the patient, principal caregivers or patient self-capability. Running behind the model are a set of robust analytics tools from leading data companies and a unique data search accelerator. As a result because the Network is patient centric, provider neutral and disease neutral we can develop guidance, recommendations and approaches to optimize care across a wide range of conditions and capabilities. In fact over time the data engine can search to find best practices of care for specific condition subgroups and share these with all providers.

## 3. *How would integrated model change beneficiaries a) behavior such as self management of chronic illness etc and b) use of services?*

This is a diverse population, but where self management is possible, particularly in the area of chronic illness, the Network begins with a presumption that merely having a relationship with a doctor is insufficient to promote effective care. The Network uses the scoring system described above to find patients who are clearly having difficulties navigating their burden of illness. Once identified, those patients are given a care manager who provides self-management instructions to the patient. Where appropriate the patient is provided with physiologic monitoring tools such as blood pressure cuff, scales or glucometers. The patients are then enrolled in a home health interactive voice response system. The patients then call this system on a regular basis and report their conditions. The care managers use these reports for timely care intervention. As a result compliance is improved, avoidable emergency room visits are eliminated and the patient becomes a better partner in their own care. In addition the patients' information whether self generated or entered by the care manager goes into the patient record for viewing by all providers (as appropriate). We also use the data to prompt reminders to physicians so they support the patients' efforts.

**4. *How would an integrated model change provider behavior or service use to produce cost savings that could be used to enhance care and services? For instance how would your model improve access to HCBS and decrease reliance on institutional care?***

The Network approach begins with the belief that there is a need for a strong primary provider relationship between the patient and a primary care giver. As stated above, our model believes that strong provider quality and connectivity drive outcomes. Sharing quality reminders and best practices with the providers incent them to meet standards of care, which are demonstrated to improve outcomes and lower costs. Moreover by providing the primary care provider with a full patient centric view of the care received by the patient a number of things beyond just avoiding ED visits occur. For instance compliance with testing such as HgA1C occurs more frequently. Medication clashes occurring because of multiple hospitalizations are resolved. Patients when hospitalized enjoy a lower length of stay. Our Network is marketed to providers as a "force multiplier" not a competitor to allow them to drive better over-all outcomes. Examples of outcomes from other similar Community Care Networks are found in the power point attached with this submission.

5. ***How would your specific use of blended Medicare and Med-Cal funds support the objectives outlined in the proposal above.***

While a more detailed analysis of this is required, a simple starting point begins with the premise that a risk-based premium is established. Ideally, an HMO or another risk bearing organization would manage that premium. From that premium the Network receives a per-member per-month (pmpm) fee to provide Network services as outlined above. The services include the provision of a patient centric record, all data and knowledge management services, the Community Care Network web services for all patient management functions, the interactive voice response system and text messaging for self management and administrative services. The Network does not manage provider payments but is responsible for producing quality scorecards and assisting in calculating shared savings bonus payments. Though the pmpm for these Network services has not been established it is estimated for our budget purposes to be between $75 and $125 pmpm.

6. *Do you have support for implementing a duals pilot among local providers and stakeholders?*

Although discussions are preliminary, there appears to be support among the medical provider community. Discussions will be ongoing with the non medical community, but our system has a long and strong record of community support. There are a number of structures involved in this activity. Mentioned above is the role of the Knox Keene plan and a future Medical Foundation. The Community Care Network may also be a free-standing not-for-profit. If so, it will contain strong stakeholder representation from throughout the entire dual eligible patient and care giver enterprise.

7. *What data would you need in advance of preparing a response to a future Request for Proposals?*

Access to claims for the impacted population will greatly assist. In addition, a matrix of current providers, patient sites and community resources receiving funding for these patients including group homes, intermediate care facilities, step down units, independent living, assisted living, memory disorder units, residential mental health facilities would be of value. As DHCS continues its work on its own evaluation measures and reporting requirements these should be shared as well.

8. *What questions would need to be answered prior to responding to a future RFP? What support in enrollment will DHCS provide? What rules, restrictions or program governance will be created for this program?*

It is crucial that we ultimately have access to both state and federal data pertaining to the dual eligible population in Fresno County prior to responding to the RFP. In addition, it will be very helpful to understand the State's anticipated direction with regards to marketing rules and regulations that with pertain to the pilots. For example, will patients be assigned to the program? Will enrollees have the option to opt-in and opt-out of the program? Also, what, if any, requirements will DHCS have regarding the composition of local pilot governing boards?

9. *Do you consider the proposed timeline to be adequate to create a model that responds to the goals described in this RFI?*

Yes. Community is prepared to make the requisite investment in creating both the external and internal structures needed to develop a successful Network. Community may develop this structure for other purposes in advance of the RFP but regardless all dates and timelines are fully capable of being met.

## III. QUESTIONS: PART 2 – RELEVANT TO COMMUNITY

### 1. *What is the best enrollment model for this program?*

Because this is a Community Network, we believe enrollment begins with the imputed caregiver for the patients. For the dually eligible who are managed by a primary care physician, enrollment begins by "enrolling" the primary care physician who in turns refers the patient to us. As outlined in questions above, we assert that our Network model is a force multiplier for primary care physicians. We assist in the management of the patients, provide ongoing compliance advice, supply a patient-centric health record, and connect the patient to community resources. These actions assist the medical provider in meeting quality goals and participating in shared savings bonus distributions. The Network also solicits providers for their advice on goal setting and meeting and in the design of services. For patients who are managed in group-care settings such as group homes, mental health facilities, and memory disorder centers, the enrollment process begins with the team leaders at these facilities. The Network goal is to provide access to additional resources, promote more effective outcomes, create enhanced communication with medical resources and smooth the transition and follow-up care between hospitalizations and the group care settings.

### 2. *Which long term supports and services (Medi-Cal and non Medi-Cal funded) are essential to include in an integrated model?*

As a general rule, dual-eligible patients represent the edge of complexity when dealing with their disease and life style burdens. The missing ingredient is not so much a service or additional funding as it is steerage on a patient-centric basis for the right care and treatment goals for these patients. We are entering new territory for some of these patients. Historically, many physically and emotionally developmentally disabled patients died in the early childhood or teenage years. Now because of the care and compassion provided by group homes and other settings, they are living well into full adulthood. The same is true for many chronically ill patients or Alzheimer patients. In addition, many of the causes or incidents resulting from their disability such as abuse add to the complexity of self-management or effective clinical management. There are two real services that the Network can bring to this population. The first is a robust database containing both structured and unstructured data with leading search and analytics tools to constantly explore the right care recommendations for these patients. At the edge of complexity we operate beyond the standard HEDIS goals and quality measures. We must, and will, explore the right course. Community Medical Centers is fortunate to have a strong affiliation with UCSF, a leading research institution. The Network's research platform makes it unique among traditional provider/care management approaches. Moreover, the second feature is the DNA of the Network itself, which is to match the patient with the right provider regardless of job title or location. For instance, for some patients the most effective provider of support and care may be a school nurse, or a caring child or sibling. The Network is not constructed to support the inpatient medical industrial approach but rather is to truly match the patient with the right community care resource no matter how distributed. Some of this distribution may be well outside the traditional reimbursement scheme but effective nonetheless. An example is in order.

A few months ago, a patient at a group home began to experience deep depression and was withdrawing from any interaction or social services. Upon investigation, it was found that her closest living relative, an aunt, had just moved away to another town. Wise caregivers found the aunt and offered to buy her post cards if she would just write and mail them to the patient. She did and the patient returned to her former health quickly. The Network must constantly support the right "patient as a person" experience where appropriate drawing on clinical experience and where appropriate drawing on life experiences.

**3.** *How should behavioral health services be included in the integrated model?*

This RFP deals with a wide range of patient needs, but Community would suggest that behavioral health should be incorporated among the continuum. Since the closure of the Crisis Intervention Center by the County last year, mental health has reached crisis levels in Fresno County. Those patients categorized as 5150s are flooding area hospital emergency departments that were never designed to handle complex, and at times dangerous, psychiatric patients. As such, the Network will seek to expand mental and behavioral health throughout the dual eligible population. A case management based program with a day treatment facility will be considered, as these types of programs have shown promising results elsewhere in the state. Also, from a group home or residential care setting the opportunity exists as suggested above to use our data base and patient centric view to optimize the impact of the behavioral health professionals when dealing with complex patients.

**4.** *How would an integrated model change provider behavior or service use in order to produce cost savings that could be used to enhance care and service*

The most fundamental position taken by Community in this model is that in many cases a hospital admission – and most certainly an emergency room visit – is a failure. The DNA of a community care network is wellness-centric not illness-centric. As such, the quality measures, transparent communication, broad incorporation of the entire care team in assisting the patient and indeed enrolling the patient as a partner in his own care is a fundamentally different approach to the current state of fragmented fee-for-service or poorly designed capitated risk based reimbursement. The Community Care Network begins, as outlined above, with a view of the patient as a risk score. The risk score highlights patients who are not navigating their collective burdens of illness and disability as well as might be hoped. This gives us a starting point, a benchmark and a goal to ascertain not just the why of the patient's condition but how we can work together to achieve a maximal health for this patient. From there a care plan can be reviewed or developed including a focus on what can the patient do to be a better partner in their care. In many cases obese patients become incented to lose weight, chronically ill patients become more compliant with medication use, and when the right help and coaching is provided to coordinate care, patients migrate to a healthier state. In Alabama for instance, a high risk pregnancy community care program monitors expectant mothers for over 70 quality/risk indicators, with the care team focused on bending the curve on smoking, drug, alcohol use or poor diet patterns. The provider incentives for our network will be based upon risk score reduction not utilization. Since risk scores are made up of quality, cost and patient centric metrics such as physiologic benchmark improvement including reduction in Blood Pressure, loss

of weight or reduction in HgA1C- the health of the patient forms the basis for the development of a provider bonus pool.

It may sound incredibly basic, but experience has shown that meeting the right quality metrics (note: not all quality measures actually improve care or reduce costs), stabilizing physiologic measures, providing mid-level care coaching, case management, and life style assistance reduce the cost of inpatient care.

For some dually eligibles who have complex mental and physical developmental disability, this network offers a unique opportunity to more closely tie the behavioral health work in places such as group homes to medical providers to set patients goals, enhance quality and improve the often disconnected state between group homes and hospitals. Because provider incentive is tied to the maximal health state of the patient, it is our hope that all caregivers will feel more comfortable leveraging a broad spectrum of community resources and to feel empowered to lean forward into exploring new approaches to improve care.

### 5. *Which services do you consider to be essential to a model of integrated care for duals?*

In addition to the services outlined above, there are a number of essential services, the first is good quality care and outcomes goals so that all providers have an understanding of where the patient is in his current disease burden. The second is a strong primary care network. Of course, depending on the patient's conditions, the primary care physician may not always be a traditional family practice or internal medicine provider but may be the imputed health care professional most often responsible for the care decisions of this patient. In a group home setting for instance that may be the nurse or team leader. Third, there must be robust home-health support including home health care/case management services etc. Fourth, the patient where able must be given his own tools of self management, either through the interactive voice response system referenced above or through text messaging or emails or other Network to patient support for compliance management.

### 6. *What education and outreach for providers, beneficiaries and stakeholders would you consider necessary prior to implementation?*

The Network is truly designed to be an all-inclusive, participatory community resource, built from the patient's needs out not the provider's needs in. The Network does not erode the current relationship between most providers and the patients; rather it enhances that relationship. A good approach to this is to create a learning journey experience. A learning journey is a facilitated session (or sessions) among all stakeholders. We commonly begin with a challenge to imagine the default state of this population if no changes occur. We then ask the attendees to create the ideal care state imagining that they or a loved one was the patient. What comes from the learning journeys are comments such as we want a more compassionate system of care, or a more effective system of care, or a more connected system of care. Learning journey participants are then asked to define the goals of such a system. How will its success be measured, how will care be improved, how will stakeholders contributions be recognized? What the process does is self create many of the component pieces of the Network. Samples of learning journeys or more detail can be provided.

**7. *What questions would you want a potential contractor to address in response to a Request for Proposals?***

Not Applicable

**8. *Which requirements should DHCS hold contractors to for this population? Which standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility?***

Because the Network is patient centric, it's important that any system be built through the eyes of the patient. That means that the language of the patient is the language of the education and assistance provided. It means that for many patients a land line is not a given so web tools must be mobile web centric. It means that many communications devices are shared and so security concerns must be addressed. It means that in many cases the care manager is a son or a daughter who often feel ill equipped to understand how best to navigate the complex system of both care and financing of care. For those in group homes who are developmentally challenged web tools must be designed to maximize their ability to communicate based upon functional capability.

**9. *If not a potential contractor, what are you able to contribute to the success of any pilot in your local area?***

Not Applicable

**10. *What concerns would need to be addressed prior to implementation?***

Community Medical Centers is committed to improving the overall health status of the population we serve, and we will hold to that core principle regardless of whether or not we are selected as one of the pilot programs. With that being said, our primary concern is that we be given a fair opportunity to continue our mission, and that any new programs that are introduced by DHCS continue to focus resources on the patients and providers, and that the funding for those programs is adequate.

**11. *How should the success of these pilots be evaluated and over what time frame?***

Community would suggest that the evaluation measures begin with the risk scores and migration of these risk scores (risk rising over time). The risk score is a comparative measure to determine the migration of disease burden. A goal of this program will be to improve the migration of the risk score and the risk score for the population itself. Because the risk score is an algorithm of cost and quality any improvement of the risk score will be reflective of quality improvement and cost reduction. We would suggest measurements be done over at least 3 years. For the beginning non-compliant population, it may well be that some cost goes up as medications are filled and taken. That rise will be offset over time by reduction in emergency room visits and length of stays but those may occur in year 2. Moreover medication reconciliation, care management resources, home based services may all initially be new dollars expended on this population

which may create a rise in cost in year 1. Hopefully this program will always be cost neutral as in patient services are left behind and other services become more effective.

**12.** *What potential financial arrangements for sharing risk and rate-setting are appropriate for this population and the goals of this project?*

All financial arrangements that serve to align the clinical and financial incentives of the patient and providers would be acceptable. Community Medical Centers would certainly consider risk arrangements after a complete actuarial assessment and legal review.