PHC Experience with Care Management Programs

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About Us

Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

Care Management Programs

- Intensive Outpatient Care Management (IOPCM)
- Transitions Program
- Whole Child Model (WCM)
- Support counties addressing homelessness
- Whole Person Care (WPC) Pilots

IOPCM

- Structure
- Enrollment
- Outcomes
- Lessons Learned

IOPCM Structure

- Goal: Reduce inpatient hospitalizations and ED visits through intensive care management.
- Contracted with 16 PCP organizations (mostly health centers)
- All sites had up-front grant funding to get program started
- Staffing: Nurse, social worker and navigator
- Accountability: Care plan submission and review

IOPCM Enrollment

- Adults only, no Medi-Care or other health coverage
- Combination of defined chronic conditions and high utilization
- Not included: Bipolar, Schizophrenia, Primary Methamphetamine Use Disorder
- Included: Homelessness, Opioid and Alcohol Use disorder
- May not be co-enrolled in another care management program (palliative care, hospice, renal dialysis case management, targeted case management)

IOPCM Outcomes

- PHC is a Learning Organization
- Started in 2012, many aspects of model tested
- Six analyses of ROI (two by external evaluators):
  - Range of ROI: 0.4 to 2.4 (breakeven ROI=0)
  - Average ROI: 1.2 ($2.2 saved for every $1 spent)
- Member satisfaction high
- Provider satisfaction with program high (burnout is issue)

IOPCM Lessons Learned

- Staffing Model
- Team Structures
- Matching Care Manager skill set
- PCP-care manager data exchange
- Evolving Payment Structure
- Accountability
- Staff turnover
- Organizational Capability

IOPCM Lessons

- Staffing Models
  - Embedded Model
    - Duplication of management and oversight functions
  - Health Plan Model
    - Disconnection with PCPs
    - Management of staff very different then traditional care coordination
  - Contracted Model
    - Preferred Model

IOPCM Lessons

- Models for Team Structure
  - Centralized care management (14 contactors)
    - One care management team manages patients from multiple PCP care teams
    - Less staff training
  - Decentralized care management (2 contractors)
    - Each PCP care team also provides intensive care management for small number of their patients requiring this
    - All care teams must be trained
    - Deliverables harder to gather together
    - Tightest coordination with PCP

IOPCM Lessons

- Matching Care Manager Skill Set with Needs of Enrolled Members
  - Teams were unsuccessful in engaging individuals with primary Methamphetamine-Stimulant Use Disorder
  - No cost decreases for those enrolled with bipolar disorder or schizophrenia
  - “Feeling good” about the relationship vs. reducing utilization

IOPCM Lessons

- PCP-Care Manager Data Exchange
  - Lack of shared information with PCP very inefficient
  - Made closing HEDIS gaps more challenging
  - Consider data exchange a foundation for care management

IOPCM Lessons

- Evolving Payment Structure
  - Started with 2 years of grants to jump start care management (like way WPC was structured)
  - Transitioned to payment depending on intensity of sevices provided
  - Added pay for performance, linking 25% of payment to no ED visits/hospitalizations in month.

IOPCM Lessons

- Care Management Team Accountability
  - Current reporting required on seven data elements, plus comprehensive care plan with patient directed goals of care
  - Much less than the 47 data elements required for HHP
  - Earlier versions of IOPCM with more data elements when testing different aspects of program

IOPCM Lessons

- Care Management Team Staff Turnover
  - Major impact on program ability to deliver services
  - Emotional stress caring for sick patients with high mortality rate
  - Ability to hire and retain care managers sets maximum capacity of IOPCM program

IOPCM Lessons

- CB-CME Organizational Capacity
  - Dedication to Intensive Care Management model
  - Willingness to move away from grant funding
  - Overall organizational leadership/management capability
  - Application process to vet interested CB-CMEs

Why PHC Declined to Transition IOPCM to Health Homes

- Enrollment criteria mismatch
- Burdensome reporting
- Enrollment projections not realistic
- Start-up costs for new sites
- HHP model didn’t work for smaller counties
- Health Plan oversight higher than HHP assumptions

Other Lessons Learned

- Transitions Clinic Model
- Whole Child Model
- County Support of Homeless
- Whole Person Care

Lessons Learned

Transitions Clinic Model

- Based on Model developed at San Quentin/UCSF, now spread nation-wide
- Many aspects of model in CalAIM!
- Three sites funded: Vallejo, Santa Rosa, Redding
- Grant-based funding
- High fidelity to existing evidence-based model: less detailed reporting needed
- Staffing: turnover an issue
- Specialization of Care Management

Lessons Learned

Whole Child Model (WCM)

- January 2019: PHC initiated WCM
- Sufficient case management infrastructure for children with CCS
- Additional case management counterproductive
- Issues should be addressed in existing infrastructure

Lessons Learned

County Support of Homelessness

- Homeless = PHC members or potential PHC members
- $25 million divided among all 14 counties
- Each county applied to use money based on local needs to fill gaps in other funding sources.
- Focused on highest utilizing homeless
- Housing-first model
- Leveraged $5 in local funding for every $1 in PHC funding
- Funding not linked to individual members, so ILOS model may not fit.

Lessons Learned

Whole Person Care

- Six PHC counties with WPC pilots: Solano, Sonoma, Shasta, Napa, Marin and Mendocino.
- Many counties focused on homeless population
- Data exchange is key challenge
- Reporting requirements challenging
- Each pilot is different (target population, staffing, ILOS, management, contracting, evaluation)
  - Some more successful
  - Others less so

Key Recommendations

- Los Angeles ≠ Modoc County:

- Minimum Reporting Needed to Assure Accountability

Contact Us

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