Delegated Care Management Effectiveness

January 2020

Background

- BCBSRI has invested heavily in the PCMH model over the past 10 years.
- BCBSRI delegates Care Management (CM) activities to practice-assigned care managers when the practice site is compliant with the National Patient Centered Medical Home (PCMH) Recognition Standards set forth by NCQA, and has a practice-based NCM/CC.
- Although BCBSRI does not actively provide care management to members attributed to a delegated PCMH site that is in good standing, it is still our responsibility to ensure care management is being delivered appropriately.

Program Goals

- Educate practices, systems of care, and internal associates
- Ensure visibility
- Measure areas of utilization impacted by effective case management
- Collaboratively manage improvement plans
- Improve performance of delegated high-risk care management
- Provide support for ongoing development

Performance Evaluation Methodology Overview

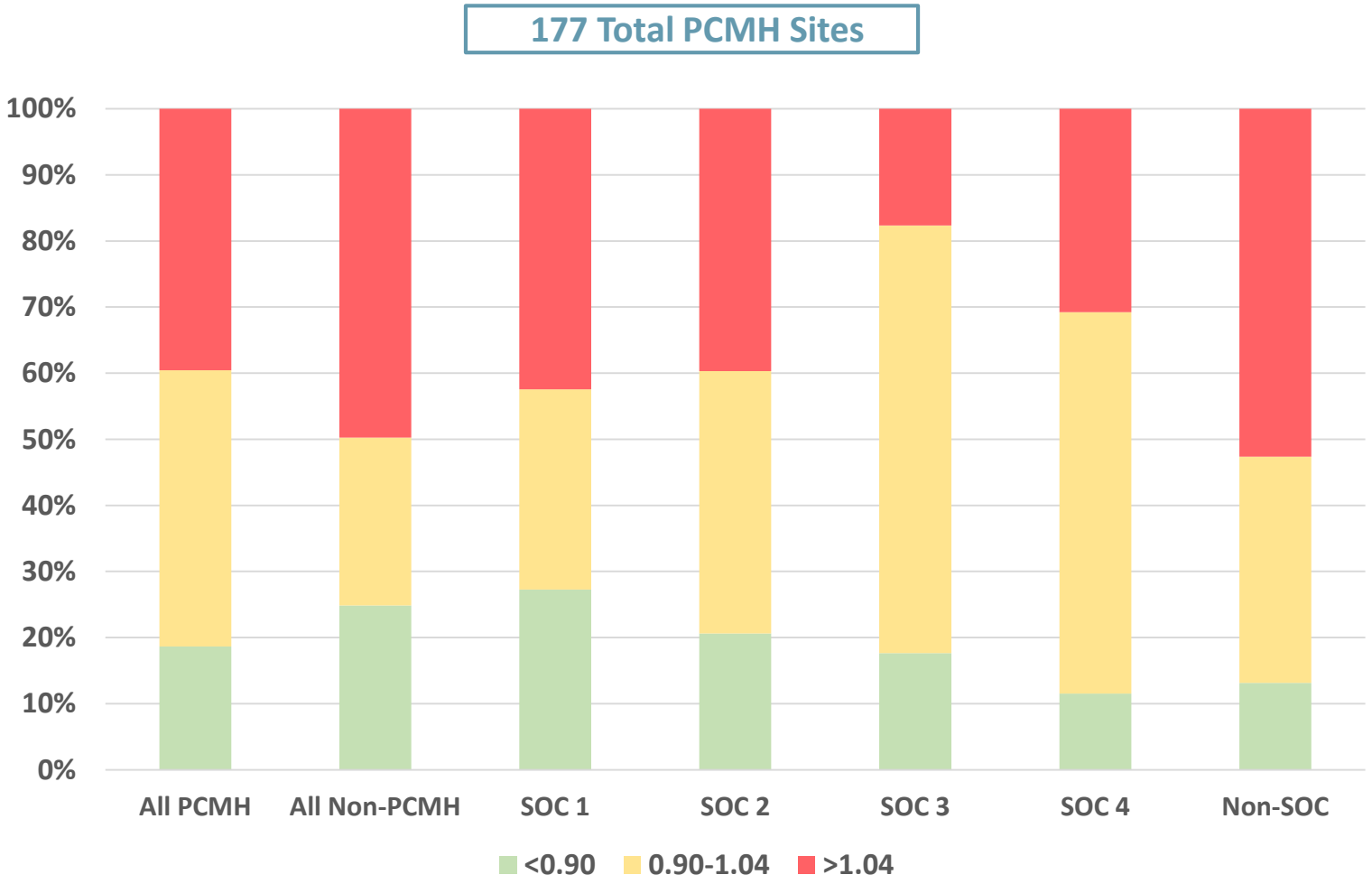
- PCMH sites with delegated care management should demonstrate differentiated cost-efficiencies and care quality
- To assess differentiation between all PCP sites, an analysis utilized aggregated data from January 2018 – December 2018. Sites with <20 members and/or <200 member months were omitted due to small sample size.
- This analysis included utilization measures, PCP/Specialist visit ratios, PMPM costs, and risk-adjusted performance index values across various lines of business.
- Performance Index values were calculated based upon average cost efficiency for all primary care sites (PCMH and non-PCMH). A Performance Index value of 1.00 indicates that the risk adjusted PMPM is equivalent to the average risk adjusted PMPM for all PCP practices.
- Sites with delegated care management were assessed in comparison to those who are not delegated the responsibility of care management.

Performance Index Categories

Rating	Description
Green	Sites delegated the role of care management with performance index values <0.90* scored better than at least 75% of non-PCMHs and are categorized as a “Green” site.
Yellow	Those with performance index values < 1.04* scored better than at least 50% of non-PCMHs and are categorized as a “Yellow” site.
Red	Sites with performance index values > 1.04* scored worse than at least 50% of sites that are not delegated the role of care management and are categorized as a “Red” site.

*Cutoff ranges for Green, Yellow, and Red vary slightly with lines of business, however these are the ranges for overall performance index values

Distribution of Delegated Care Management Sites by Overall Performance Index Scores



*Sites with less than 20 members and/or less than 200 member months were excluded

On-Site Care Management Assessments

Methodology for Care Management Assessments

- Delegation oversight calls for review of the Care Management being delivered at the delegated practices, thus care management assessments are being performed at each site.

- Assessment tool was developed, and is aligned with:
  - NCQA PCMH Requirements
  - CMSA and ACMA Standards
  - BCBSRI CM Policies
  - OHIC PCMH Standards

- Charts were identified for review based upon
  - RUB score (RUB 4 and RUB 5)
  - Highest utilization of:
    - ED visits
    - Inpatient stays
    - High cost indicators

Care Management Assessment Goals

- Assess the ability of each PCMH practice to deliver effective care management that aligns with the delegated PCMH care model
  - Utilize:
    - Care Management sites' survey results
    - On-site assessment results, and
    - Cost efficiency analysis to guide assessment approach
- Understand the barriers to success that are currently being encountered by the PCMHs and nurse care managers
- Create improvement plans that address specific care management opportunities identified in the site assessments
- Support the implementation of targeted interventions to improve care management delivery and effectiveness

Care Management Assessment Findings

Care Management Program Policies, Procedures, and Work Plans

- Care Management staff are not consistently able to verbalize an understanding of, or locate:
  - Department policies;
  - CM department success measures;
  - Current care-load; and
  - Criteria for appropriate discharge from care management

This workflow should be outlined in program/policy expectations and there should be care management procedures in place.

Identification for Care Management

- Care Management staff are not consistently able to verbalize an understanding of:
  - How their patients are identified for CM;
  - Which patients are experiencing transitions; and
  - Which high risk patients are currently unengaged.

- Most practices rely solely on the high risk patients lists they receive from insurance companies for Care Management targeting
  - Care Managers are focusing on engaging the “top few” on the high-risk lists and are not consistently providing outreach to the entire list

Care Coordination and Care Transitions

TOC procedures appear to be a growing area of focus, but there is still room for improvement.

- Many practices lack processes that ensure NCMs are promptly notified if their patient has an ED visit or is admitted to the hospital
- Med Recs appear to be done often, but many times not within 48 hours of an inpatient discharge
- TOC visits are not always occurring within 7 days of an inpatient discharge
- Lack of consistent coordination and warm handoffs when other care teams are involved
- Lack of engagement with patients in a long term care facility
- No clear definition of roles and workflows

Initial Assessment and Health Status

- Most practices do not have known Care Management onboarding procedures
- Many NCMs are not aware of the proper components of an initial assessment
- An explanation of why the patient was identified for Care Management is often not included in the initial assessment
- Patients are rarely assessed for appropriate discharge from Care Management when their condition stabilizes

Assessment of Behavioral Health Status

- PHQ-9 assessments are not consistently administered after a positive PHQ-2 assessment
- Most practices do not have standardized next interventions and follow-up procedures based upon PHQ-9 findings
- Inconsistent documentation and/or screening for SUD
- NCMs lack a thorough understanding of the BH community resources available

Assessment for Social Determinants of Health

- Documentation is inconsistent, making it difficult to find information related to SDOH
- Charting by exception is very common, which makes it difficult to know if screenings have taken place
- Most NCMs are unaware of the specific benefits their patients are entitled to based upon their insurance plan

Development of Care Plans

- Lack of care plan in place for some members engaged in care management
- Most care plans that do exist are unstructured
- Absence of specific SMART goals is common
- Care plans are not always shared with the patient **AND** the provider
- Inconsistent adherence to care plans with updates on goal completion or readiness for discharge
- Patients are very rarely given explicit self-management responsibilities

Documentation

- Documentation is not standardized, making it difficult for NCMs to locate key information when they need it
- Many NCMs seem unaware of what information should be documented for each patient encounter
- Charting by exception is extremely common
- Providers sometimes do not have access to NCM notes/assessments/care plans, which hinders the impact care management can have on the patient's ongoing care

How Can We Make Meaningful Change?

- Ensure NCMs are provided the **tools for success**, such as:
  - Structured templates for initial assessments, care plans, etc.
  - Clear definition of their roles and responsibilities
  - Documentation systems that are integrated into the MD workflow
  - Access to policies and procedures for expectations of care management

- Create awareness of the deficiencies that exist

- Educate new NCMs, current NCMs, providers, and systems of care about best practices