JANUARY 2016

Developing Safety-Net Care Management in California

An Opportunity for Whole-Person Care

ABOUT THIS BRIEF

Between July and November 2015, JSI, with the support of Blue Shield of California Foundation, reviewed national peer-reviewed and grey literature and conducted in-depth discussions with thought leaders involved in innovative approaches to managing the care of high-need safety-net populations. JSI qualitatively analyzed the literature and interviews to identify key themes and building blocks for successful care management initiatives to advance whole-person care in California. As part of this effort, the inventory tool in Appendix A was created with input from health leaders in California counties and staff at the California Health Care Safety Net Institute.

JSI RESEARCH & TRAINING INSTITUTE, INC.

JSI is a research and consulting organization dedicated to promoting and improving the health and well-being of underserved and vulnerable people and communities in the United States and across the globe. JSI works across a full range of public and community health areas, strengthening health systems to improve services and ultimately people's health.

AUTHORED BY:

JEREMY CANTOR, MPH
RACHEL TOBEY, MPA
ELIANA GREENBERG, BA

INTRODUCTION

Payers, providers, and policymakers—particularly within publicly financed health systems—are intently focused on new strategies to achieve the Triple Aim (reduced per capita cost, improved experience of care, and improved population health). In response to broad recognition that a small number of complex patients drive a disproportionate share of utilization and cost,[1] county and state health leaders across the country are developing initiatives to better manage and coordinate care for high-need populations.[2,3] With Blue Shield of California Foundation support, JSI Research & Training Institute, Inc. (JSI) and partners at the California Association of Public Hospitals and Health Systems (CAPH) and the Safety Net Institute (SNI) detailed a Whole-Person Care (WPC) framework to operationalize the Triple Aim by addressing vulnerable individuals' health, behavioral health, and social needs in concert rather than in isolation.[4,5,6,7] Subsequently, safety-net leaders requested a deeper inquiry into care management within the context of whole-person care. Furthermore, in California, two key policy initiatives—county-led Whole-Person Care Pilots under the 1115 Waiver, *Medi-Cal 2020*, and the state Health Homes for Patients with Complex Needs initiative—are poised to provide much-needed funding to create systems of care that better manage the whole-person needs of complex Medicaid and dually eligible individuals across selected counties.[8,9]

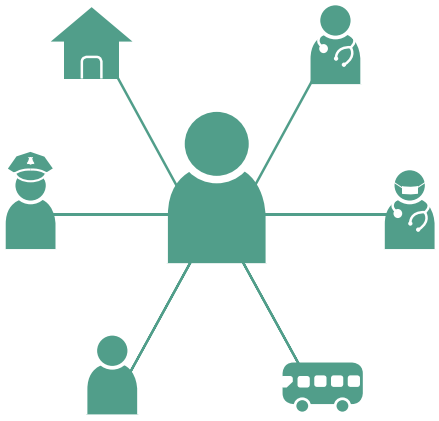
Most care management has been designed and delivered at an organizational level through either providers or payers. Developing approaches at a county level offers the potential to engage more partners and increases potential resources to respond to a wider range of patient needs. To support care-transformation efforts, this brief summarizes findings from state and national experience to answer the question: *What is necessary to develop effective county-level, safety-net care management initiatives?*

WHAT DOES CARE MANAGEMENT ENTAIL?

Care management involves a set of integrated activities that support patients in managing their medical, social, and behavioral health needs. In contrast to traditional telephonic and/or disease-centric case management programs, current care management approaches strive to address not only medical conditions but the multitude of factors that influence health outcomes, including mental health and substance abuse issues as well as factors such as housing, transportation, and food security.

Effective care management relies on a strong relationship between the patient and a multidisciplinary team that can respond to complex health, behavioral health, and social issues and is integrated into existing care-delivery systems. Effective care management also often involves a tailored plan of care and services that clearly documents roles and responsibilities for the patient and members of the care team.[10,11]

A county-level care management initiative would likely involve a variety of entities, including managed care organizations, various points of contact in the healthcare system, behavioral health providers, and social service agencies.



"Ten years ago or more, telephonic care management was the primary intervention in disease management programs. And that's not what we are talking about now. Now we are talking about something much more intensive, not for everybody, but instead focused on the highest-cost, highest-need, most receptive people—it is just a different level of rigor."

—Kathy Moses,
Center for Health Care Strategies

ARE CARE MANAGEMENT AND CARE COORDINATION DIFFERENT?

A review of the use of the terms "case management," "care management," "case coordination," and "care coordination" by governmental agencies and national organizations and in the academic and practice literature did not reveal a clear consensus on distinct meanings.[2,3,10,12] For example, Section 2703 of the Affordable Care Act lists care management and care coordination as two separate Health Home Services;[13] the Agency for Healthcare Research and Quality describes care management as a strategy under care coordination;[12] and the Chronic Care Model is described as a response to deficiencies in managing care of disease, and two of the model "themes" are care coordination and case management.[14]

Many thought leaders and those engaging in care transformation in the field, including a number of our key informants, emphasized that closely adhering to an externally prescribed, defined approach is not as important to success as identifying a measurable desired outcome (or set of outcomes), a relevant target population, a realistic timeframe, and adequate resources. In addition, within a given health and human services system, it is important to define terms to be internally clear and consistent regarding what an intervention entails and to assign points of accountability within the system.

It is worth noting that, while there is not consistent use or meaning of "care management" and "care coordination," there is a recognized distinction between direct patient engagement (e.g., care plan development, motivational

interviewing, assistance navigating systems, and accessing resources such as food and housing) and organizational systems and practices that support efficient, appropriate care (e.g., data sharing, cross-organization communication, staff training, and hiring of skilled staff). The distinction between patient-facing activities and systems-level supports is particularly useful in planning a county-level, multi-partner initiative in order to identify different funding streams and necessary capacity-building processes. Broad agreement also exists that both patient engagement and support and coordination between systems are foundational to an effective intervention.

For the purposes of simplicity in this brief, the term *care management* will be used to encompass both the patient-service and systems components of interventions focused on managing and coordinating care for complex, high-need patient populations.

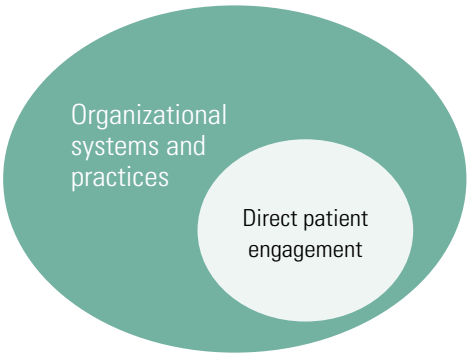


Figure 1. Effective care management initiatives build two complementary sets of capacities

DOES THE EVIDENCE SUPPORT THE EFFECTIVENESS OF CARE MANAGEMENT?

Care management is a fast-evolving area of implementation and study as many states, counties, and payers continue to pursue and refine initiatives. Some studies and reviews indicate significant cost and quality improvements associated with care management,[15,16] while others show a more mixed picture.[17]

Three states have released reports indicating significant savings from care management initiatives:

- The long-running care management program of Community Care of North Carolina (CCNC) has demonstrated significant reductions in utilization and cost: among the CCNC target population of Medicaid beneficiaries living with multiple chronic conditions, rates of hospital admission declined by 10% and rates of readmission by 16% between 2008 and 2014.[18] A 2014 evaluation of the CCNC initiative documented total cost avoidance of $389 million.[19]
- The Missouri Patient-Centered Health Homes (PCHH) demonstration under Section 2703 of the Affordable Care Act estimated annual savings of 1.89% per patient per month.[20] Since the program was established in 2012, the Missouri Health Home has saved the state an estimated $36 million.[21]
- Minnesota Health Care Home clinics reported 9.2% annual Medicaid savings under a PCHH demonstration that included the whole state Medicaid population.[20,22]

However, because initiatives vary significantly in terms of populations, resources, and strategies, an important effort is underway to tease out specific conditions, principles, and components of success.[23,24] Two notable findings from recent research include:

- "High-risk care management programs are most effective when they are anchored in the practices where patients receive their care."[25]
- Health and cost outcomes resulting from care management may take a number of years to emerge as quality improvement processes lead to reshaped, more effective approaches.[26]

Many states and health systems continue to refine approaches to care management. With numerous initiatives underway, the evidence on the effectiveness of care management is likely to become increasingly robust. As these initiatives roll out, it will be equally important to document and understand unsuccessful approaches as it will be to identify the factors of success for initiatives that are able to demonstrate positive cost and quality outcomes.

HOW DOES CARE MANAGEMENT RELATE TO WHOLE-PERSON CARE?

In prior work, we defined whole-person care as "the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources."[4]

The WPC framework can provide a helpful lens for county leaders interested in designing effective care management initiatives. In addition, pursuing a county-level care management initiative holds promise for building capacity and systems across the six WPC dimensions, thereby strengthening key building blocks for other initiatives and other populations.

Figure 2. Dimensions of whole-person care

FINDINGS: IMPLEMENTING CARE MANAGEMENT IN THE CALIFORNIA SAFETY NET

The findings from our research process closely align with the WPC framework and are organized based on the WPC dimensions in the following discussion. The WPC framework and these findings are intended to be seen as interdependent rather than sequential elements and to provide a comprehensive structure for planning and implementing an effective care management initiative.

COLLABORATIVE LEADERSHIP: DELINEATE PURPOSE, ASSEMBLE RESOURCES, AND PROBLEM SOLVE

Collaborative leadership from health, behavioral health, and social service providers and payers is essential for developing a county-level approach with the necessary systems, aligned resources, and commitment from stakeholders. Multiple key informants cautioned that a poorly conceived or implemented approach can result in a failure to achieve intended outcomes and can undermine trust and willingness to innovate in the future. Specific steps toward successful collaborative leadership include:

- Engage leaders early in the process, agree on purpose, and use data to build a shared understanding of the need for better care management. For example, a number of counties, including San Francisco and Sonoma, have brought together multiple sectors, including health, behavioral health, and criminal justice, to review lists of high-need individuals to identify patterns of high utilization of multiple systems and to plan to coordinate care across sectors more effectively.
- Identify key individuals who will have responsibility and resources for managing the change effort associated with a county-level

care management initiative. Successful initiatives nationally and in California counties, including Los Angeles and San Francisco, have designated specific staff to guide care management across the dimensions discussed in this brief.

> Develop a process for on-going engagement and problem solving. Leaders can serve to break down existing siloes and cultural norms, support coordination across agencies, and implement strategies that facilitate project implementation. For example, in Los Angeles County, when reviewing lists of patients for entry into the care management program was identified as an administrative burden, medical directors began providing physicians with clinical time to do so.

TARGET POPULATION: IDENTIFY PATIENTS WHO ARE LIKELY TO RESPOND TO INTERVENTION

It is critical to develop an approach to identify patients who are most likely to respond to the care management intervention in a manner that achieves the desired outcome(s) in the desired timeframe. Data analysts and program developers in counties and states have discovered that simply selecting the highest-cost patients based on past utilization is not an effective approach because the majority of the highest-cost patients are experiencing acute health crises: the intensive treatment they are receiving is necessary and appropriate, and many are in end-of-life scenarios. A number of counties in California, including San Francisco and Santa Clara, have developed data warehouses to facilitate aggregation of data from multiple systems and identification of high-utilizers of those systems. However, defining "high-utilizers" can be complicated. For example, rather than treating all encounters as equal regardless of setting and length of stay, Santa Clara has developed a point system to more accurately capture the range and intensity of utilization across the county.[27]

"Know your target population. Get a sense of what their needs are. Then start thinking about the type of individuals you would need to be care managers, to be part of the health care team, and how you are going to build patient relationships. You need good training materials on what you are trying to accomplish, the goals of the program, how you are going to measure it, and what steps you are going to take."

—Denise Levis Hewson, Community Care of North Carolina

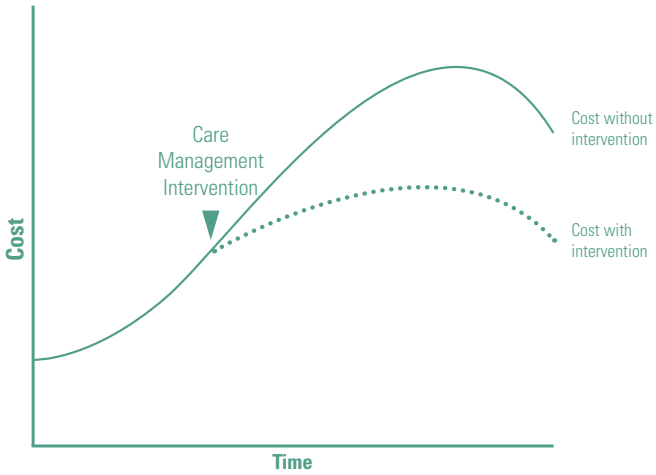


Figure 3. Potential benefit of identifying rising risk

Picking potential care management participants based on high-utilization in the past can lead to another pitfall: selecting many patients at the peak of their utilization curve. Due to factors such as the waxing and waning of disease severity, temporary changes in social circumstances, and even death, a cohort of participants selected because they are in the top tier of utilization are likely to regress toward the mean without intervention.[28] This means that if a county care management initiative simply selects the highest utilizing patients and does nothing but track their utilization and cost over time, they are likely to see reductions in both. As a result, an initiative might look like a success in spite of not actively having an impact on cost, quality, or population health from a county-wide perspective.

Thus, a key success factor for effective care management approaches is to identify patients on the upswing in their utilization trajectory, what has been termed "rising risk" (see Figure 3). Health systems with robust data platforms and analytic capacity may decide to employ one of the many available predictive modeling software instruments.[29,30] Alternately, analysis of cross-system utilization may also reveal patient profiles (demographics, diagnoses, utilization, social conditions such as housing status) that indicate likely high future levels of utilization. For example, Santa Clara County Center for Population Health Improvement found that 80 of the 100 highest utilizers within the county system used both mental health and physical health services.[27] This corroborates reports from other counties and research indicating that individuals with multiple physical and behavioral health comorbidities are likely to be high-utilizers, and to experience uncoordinated care across multiple systems.[4]

The reality in many geographies is that the quality of data and data exchange is limited. As a result, many county leaders and others developing care management initiatives are adopting a hybrid quantitative and qualitative approach wherein lists of potential participants are generated based on basic criteria (such as utilization within one or two systems) and then reviewed by program staff/clinicians. In Los Angeles County, a list of such patients is reviewed by a provider who has ideally seen the patient and who has been trained to evaluate suitability for care management.

This task of reviewing lists for suitability for care management could also be performed by a trained care manager or program administrator. California's Department of Health Care Services (DHCS) lays out such a hybrid approach in their most recent concept paper for the State's Health Homes for Patients with Complex Needs initiative. DHCS's paper states that a Target Engagement List developed through diagnosis code analysis will be reviewed by plan and provider staff in order to "identify the highest-risk three-to-five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services."[8]

SCREENING FOR AND CAPTURING SOCIAL DETERMINANTS OF HEALTH

One of the potential distinguishing features of care management approached from a WPC perspective is screening for social, economic, and behavioral risk factors and linking to resources to address those factors. Screening of the patient population for social factors can facilitate effective care planning, connection to important resources, and identification of priority risk factors such as homelessness or domestic violence. To that end, the National Association of Community Health Centers and partners are developing the PRAPARE tool to allow providers to screen for social determinants of health.[31] The Center for Medicare and Medicaid Innovation also recognizes the importance of such screening: a January 2016 funding announcement made $157 million available to support local Accountable Health Community initiatives that screen for social risk factors and create responsive links to social services.[32]

ICD-10, the latest revision of international medical classification codes, presents an opportunity for providers and systems to capture social determinants in a standardized fashion that can facilitate future risk-stratification, performance measurement, and payment. Examples of ICD-10 "factors influencing health status and contact with health services" Z-code categories that capture non-medical "diagnoses" include: education; literacy; employment; occupational risk factors; physical environment; housing and economic circumstances; social environment; negative life events in childhood; unwanted pregnancy; imprisonment, incarceration, and other violence.[33]

SHARED DATA:
COLLECTIVELY AGREE UPON DESIRED OUTCOMES

In order to be successful, care management programs can use data to appropriately align intended outcomes, a defined target population, a designated timeframe, and resources necessary to carry out the initiative. Figure 4 depicts the notion that alignment of these elements is critical to unlock the maximum impact of a care management initiative.

Alignment will likely need to be approached as an iterative process. If, for instance, an initiative's cost-saving goals for homeless patients are dependent upon access to transitional or permanent supportive housing units that do not exist, either those resources need to be developed or the outcomes and population need to be revisited. If, after reviewing data and evidence, an initiative's leaders decide that their expectations for short-term cost savings from better managing individuals with significant physical and behavioral health comorbidities are unrealistic, they may decide to extend the timeframe, increase resources (e.g., increase behavioral health integration in hospitals and primary care), or narrow the target population (e.g., to those who are eligible for certain services).

Starting with "outcomes" makes sense because it requires answering the primary questions:

- What are we trying to effect?
- What is our timeframe?
- How will we measure if we are successful?

The underlying question is, "What is the 'pain point' that warrants this effort?" Frequent pain points include health system costs, poor health outcomes, and lack of patient engagement and satisfaction. Clinical leaders have also described care management as a staff satisfaction and retention strategy as it provides resources and strategies for successfully caring for challenging patients.

> *"A good starting point is a stakeholder analysis to look for win-wins. Where are the pain points? Where do you need the most support?"*
>
> *—Clemens Hong, Los Angeles County Department of Health Services; Anansi Health; Massachusetts General Hospital*

Including outcomes from other sectors such as housing and criminal justice can serve to engage cross-sector partners and make a broader cost and utilization case. Once agreement on collective outcomes is established, an effective care management program will establish a mechanism for sharing data on progress toward outcomes on a regular basis with all key stakeholders.

In the past, efforts to share data have been hampered by fear of violating privacy regulations. However, there is emerging guidance on the legal framework for information sharing in California and the significant leeway granted for data sharing for "treatment, payment, and health care operations."[34,35]

Figure 4. Strategically planning and adjusting care management approaches is critical to unlocking impact

PATIENT-CENTERED CARE: BUILD THE NECESSARY WORKFORCE AND EXPERTISE

Care management should be approached as a distinct discipline requiring special skills. Effective care management leverages existing strong patient-provider relationships wherever they exist. This could include trusting relationships with a behavioral health provider, a social worker, or a community health worker. Care management teams comprised of such team members are key to building relationships with patients, many of whom have developed a distrust of the health system.

Care management teams must also have the skills and capacity to coordinate care with multiple providers, manage transitions, and respond to patients' non-clinical social needs by securing resources and coordinating with non-clinical organizations. Such capacity often requires a significant investment in training of existing staff to ensure that the necessary skills, cultural competency, and communication and support systems are in place. To provide effective care management, some systems may need to hire additional staff who have specific skills in relationship building with patients and navigating and making connections across multiple safety-net systems.

"Replicating complex care management programs is challenging. Even if you borrow a model that is working really well somewhere else, you can't deploy it in the same way. So you need to take lessons learned elsewhere, put a team on the ground to develop and implement the model, and use data to drive continuous improvement. The biggest caveats are that you need to have the right skills on the team and the level of leadership engagement to ensure that the design and implementation teams have dedicated time to do this."

—Clemens Hong, Los Angeles County Department of Health Services; Anansi Health; Massachusetts General Hospital

"You've got to prove follow-through. We had one of our social workers convene a meeting of our initial clients after about six months. One of the things people said was, 'I like you guys because you came through for me. You did what you said you were going to do.' These are folks that have been burned multiple times, and you've got to prove that you're going to do what you say you are going to do, and do it with good heart."

—Dr. Laura Miller, Community Health Center Network

Interviewees also advised that a care management initiative should have multiple doors of entry that allow patients in need to enter care management through whichever "door" they currently use in the health system. Similarly, an effective county-level initiative will support staff in multiple settings to provide care management services. With staffing in multiple settings, coordination and oversight are paramount; as many have expressed, a manager of the care managers may be necessary to hold an initiative together.

Finally, while developing an effective care management approach requires significant organizational capacity and staffing shifts, it is important that patients experience minimal disruption in care. California's Coordinated Care Initiative provides a cautionary tale of an attempt to streamline and improve care for a priority population (individuals dually eligible for Medicare and Medi-Cal) that has experienced numerous challenges due to confusing notification and enrollment processes and significant transitions in care.[36]

COORDINATE ACROSS SECTORS: ENGAGE HEALTH AND NON-HEALTH LEADERS IN A PLANNING PROCESS

Most care management has been done in isolated programs either at the health plan or provider level. Building a care management approach as part of a county approach to whole-person care creates the opportunity to build partnerships and systems across payers, providers, community organizations, and other county health and human service agencies.

Conducting a care management planning process that involves understanding and analyzing current activity can help to identify existing assets and strengths. Highlighting strengths can help stakeholders identify tasks that collaborating entities could most effectively accomplish, and where capacities are needed at the county level. A planning exercise is also an opportunity to engage with health plans, a critical stakeholder that often already conducts some type of care management. As such, health plans can be instrumental partners in setting up an initiative and achieving long-term success.

Three key steps of a county-level care management planning process might include:

A) UNDERSTAND CURRENT ACTIVITY

Care management is not a new idea: in virtually every county, there are numerous existing efforts within multiple agencies. However, existing efforts are likely uncoordinated with one another. In order to understand existing resources and build on existing strengths, county leaders have expressed that a useful first step in an effective care management initiative is to ask key questions such as: What is being done? For whom? By whom? With what funding?

Based on the answers, stakeholders can identify opportunities for collaboration (e.g., multiple programs focused on the same population) as well as service and infrastructure gaps (e.g., lack of engagement at time of discharge). Appendix A includes a simple inventory tool and synthesis guidance that JSI developed in collaboration with county leaders to guide collection of countywide care management information.

"Successful complex care programs require collaboration between health plans and community health centers. Community health centers have the ability to engage patients and develop a relationship with patients, are the patients' primary care medical home, and have an understanding of local community resources. Health plans can support with funding, technical training and assistance, identifying high risk patients, and outcomes analysis."

—Kristian Lau,
Community Health Center Network

"Effective care management is less about individual incentives, and much more about the systems we build to make the right thing the easier thing to do. It's not about paying me to administer PHQ-9 screens for depression; it is about having a system where my patients are screened, the information is provided to me, and I have a behavioral health person to whom I can say 'let's talk to this patient together.' That's a system of integrated behavioral health that allows me to treat the whole person."

—Sophia Chang,
California HealthCare Foundation

B) ANALYZE GAPS AND ASSETS

A critical review of current activity from a countywide perspective can reveal important gaps, overlaps, and assets. For example, discovering that individuals are being care managed by multiple systems may present an opportunity to eliminate redundancy, and may also indicate a gap in coordination across systems.

C) USE PLANNING PROCESS FOR CROSS-SECTOR RELATIONSHIP BUILDING

The inventory process can provide an opportunity for sectors that have not collaborated effectively to develop important relationships and rapport. Ongoing, nuanced communication between systems is instrumental to achieving successful patient care and transitions. For example, one clinician characterized transitions for high-need patients as "not warm handoffs, but burning hot handoffs," requiring very active communication among all service providers involved in the patient's care.

FINANCIAL FLEXIBILITY: STRATEGICALLY USE EXISTING AND NEW RESOURCES

In order to create the funding and flexibility necessary to implement a successful care management initiative, counties will need to strategically use current resources, potentially reallocate existing funds, and take advantage of multiple payment reform opportunities that will become available in the coming years. In terms of existing resources, capitated budgets, whether at the plan or county provider level, create opportunities and flexibility to use existing funds in the health system for care management.

Additionally, existing care management may be deployed more efficiently. As mentioned above, many patients receive care management from multiple entities, creating potential duplication and confusion. Opportunities may also exist to more effectively distribute care management roles within organizations. For example, when one public hospital inventoried their care management activity, they found that their Intensive Care Management and Homeless Referral programs had the equivalent of one full-time staff member while their pharmacy had over four full-time employees working on securing medications not covered by insurance and communicating about medication management with patients and clinicians. They saw an obvious opportunity to create better linkage between the programs and to identify ways the pharmacy staff could support the objectives of the other programs.

In addition to existing resources, new funding streams are becoming available that can support care management. However, to avoid duplication of spending, it may be necessary to braid funding sources to serve discrete purposes in a care management initiative. Braiding funding refers to aligning funding streams to pay for services, projects, or infrastructure that could not be supported by any single stream while maintaining separate accounting for spending and outcomes by stream. For instance, Table 1 details how a county that plans to participate in the Health Homes for Patients with Complex Needs initiative, the proposed 1115 Waiver WPC pilot, and the FQHC Payment Reform pilot might braid funds for care management:

Provider systems have to have shared financial understanding and accountability to undertake management of a defined population. When those constraints are put in place, what I've seen is that the "shopping around for best practices" starts to go away pretty quickly and people get practical, roll up their sleeves, and say 'OK, we only have X number of dollars and we've got to take care of these needs: What can we do?'

—Sophia Chang, California HealthCare Foundation

THE CARE MANAGEMENT BUSINESS CASE FOR HOSPITALS

Depending on specific payment model and market context, participation in a county-level care management initiative can help a hospital to:

- Strategically reposition itself as a health system that helps patients get the right care, in the right place, at the right time
- Avoid readmission penalties
- Improve its payer mix by replacing lower-reimbursement patients with higher-reimbursement patients
- Perform under a global capitation contract
- Leverage existing care management investments

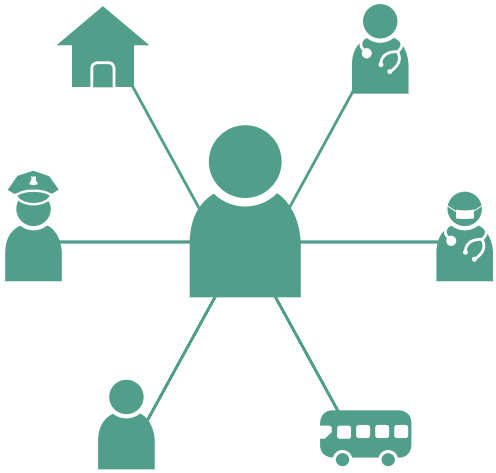
Table 1. Braiding potential resources for care management

Source	Potential Uses	Limitations
Health Homes for Patients with Complex Needs initiative (Section 2703)[8]	Funding staff that deliver care management services, including clinical care management, coordination with other systems, and patient outreach.	Funds are limited to services for certain Medi-Cal and dually eligible members.
1115 Waiver Whole-Person Care pilots[37]	Support infrastructure and value-based performance payments for better care and outcomes for high utilizers of multiple systems. A portion of WPC funding might be designated for secure infrastructure for sharing health information and another portion for incentive payments for achieving outcomes. Such incentive payments might be repurposed by a county for further investment in care management innovations going forward.	Funds will only be available in counties that are selected as pilot sites.
FQHC payment reform pilots (Senate Bill 147)[38]	Per-visit payments will be transformed to per-member-per-month (PMPM) equivalent payments for all members assigned to the FQHC, allowing for the use of existing resources in more patient-centered ways, including some aspects of care management. For example, to fund a full-time behaviorist who serves all patients, these funds could supplement Health Home funds that support the portion of an FTE spent with patients eligible for Health Home services.	PMPM payments are only for assigned managed care Medi-Cal members at selected pilot sites. PMPM payments will need to be paired with additional funds since per-visit FQHC payments historically did not cover the full cost of care management.
New Medicare care management funding for FQHCs/RHCs[39]	Beginning January 2016, FQHCs and RHCs can bill Medicare for monthly care management (approximately $40 PMPM) as long as certain conditions are met. Medicare patients must have multiple chronic conditions to be eligible, and FQHCs/RHCs must meet scope of service requirements including comprehensive initial visit, continuity of care with a designated practitioner, creation of a comprehensive care plan, and management of care transitions within the health care system.	This option is limited to Medicare patients served at FQHCs and RHCs that meet certain requirements.
Other	Additional resources from sources such as foundations, hospital and health plan community benefits, and Center for Medicare and Medicaid Innovation grants could serve to fill gaps and provide additional flexibility, especially for testing innovative approaches to care management.	The request processes are competitive and often come with reporting and administrative requirements.

CONCLUSION

Care management is becoming increasingly established as an approach for improving care and outcomes for complex, high-need patients and controlling health-systems costs. Developing and implementing care management at a systems level is challenging but also creates the opportunity to design an approach that builds on a broad pool of resources and more fully responds to the health, behavioral health, and social needs of the patient population.

Given the challenges of simultaneously building capacity across whole-person care dimensions and changing organizational culture(s), care management initiative development requires dedicated time for skilled staff and the backing and engagement of multi-sector leadership. In addition to achieving important short- and mid-term outcomes for defined priority populations, effective care management implementation can serve as a critical step toward broader system transformation and whole-person care.



SUMMARY OF FINDINGS

Collaborative Leadership

- Secure buy-in from relevant leaders
- Get agreement on who will lead change effort
- Create a process and venue for ongoing engagement and problem solving

Patient-Centered Care

- Leverage existing patient–provider relationships
- Define members of care team including "manager of care managers"
- Develop training for existing staff and hire new staff as necessary

Target Population

- Avoid selecting participants based solely on cost/utilization
- Develop methodology for identifying "rising risk" participants
- Track social determinants of health

Coordination Across Sectors

- Inventory current activity
- Engage relevant sectors in analyzing gaps and assets
- Build cross-sector relationships, communications channels, and expectations

Shared Data

- Select outcomes that relate to shared pain points
- Align outcomes with resources, timeframe, and population
- Develop mechanism for sharing progress

Flexible Financing

- Potentially reallocate existing health care funds
- Increase efficiency in use of existing resources
- Take advantage of new funding opportunities as they become available

APPENDIX A: CARE MANAGEMENT INVENTORY

INSTRUCTIONS

The purpose of this tool is to gather as much relevant information as possible in order to form a countywide picture of care management. The goal of this information gathering is to lead to analysis and discussion of patterns and opportunities. The term "care management" is used as an umbrella term to include activity that may be labeled care/case coordination as well. Here are a few tips for filling out the inventory:

- If your organization or agency has more than one care management program, fill out a separate inventory for each one.
- There will likely be questions that are not answerable in a check box. In that case, use the "notes" section to explain the nuance and detail, and do not hesitate to expand the boxes as necessary.
- If there is not a formal program name, you may leave that field blank. However, if there is a term used to describe the program internally, even if informal, include it.
- The questions about program cost may be hard to determine or may require an estimate. It depends largely on how formal the program is and what payment structures (capitation, etc.) are in place. In many cases the best estimate may be derived by identifying costs (largely staff time) per month.
- Include both specific and general comments in response to the open-ended questions; this information will help shape follow-up conversations.

CARE MANAGEMENT INVENTORY: PAGE 1 OF 3

General Information	
County	
Lead Organization	
Program Name	
Contact Person/Coordinator	
Number of Participants (Patients)	

How is the target population identified/defined?	Check all that apply	Specify criteria, if possible
Insurance status: Medi-Cal, Duals, etc.		
Utilization pattern		
Specific health condition(s)		
Through referral/recommendation		
Defined by risk assessment tool/process		
Other criteria (please specify)		

Who pays for the program?	Percentage of costs	Notes
Health Plan		
State (including MHSA)		
Behavioral Health		
County health funds		
Other county funds (social service, etc.)		
Other (please specify)		

What are the monthly care management revenue and/or expenses?	Estimated $ amount	Notes
Revenue:		
Per member per month capitated fee		
Billable encounters		
Expense:		
Organizational budget (staffing costs)		
Service fee to external partner(s)		
Other (please specify)		

CARE MANAGEMENT INVENTORY: PAGE 2 OF 3

Who is delivering services?	Check all that apply	Notes
Health Plan staff		
Provider in existing public hospital, FQHC		
Behavioral health staff		
Provider at social service agency		
Contracted external organization		
Other (please specify)		

Who makes up the care management team?	Check all that apply	Number of staff	Notes
Nurses (RN and NP)			
Physicians			
Behavioral health practitioner			
Social worker			
Medical assistant			
Community health worker/promotora			
Other (please specify)			

How is data tracked and stored?	Check all that apply	Check if shareable	Notes
Electronic health records			
Internal data system			
Data warehouse			
Customized database			
Other (please specify)			

What services are being provided?	Check all that apply	Notes
Disease management		
Motivational interviewing		
Comprehensive transitional care		
Individual and family support		
Medication management		
Obtaining benefits		
Referrals to community/social services		
Health Information Technology to link services		
Other (please specify)		

CARE MANAGEMENT INVENTORY: PAGE 3 OF 3

Have outcomes been observed?	Check all that apply	Specify data point and collection method
Utilization (readmissions/in-patient days/ ED visits)		
Total cost of care		
Improved health status		
Achieving quality metrics		
Decreased costs in other sectors		
Patient satisfaction		
Attaining housing or benefits		
Other (please specify)		

With whom does the program partner/communicate with or refer to regularly?	Check all that apply	Notes
Primary care providers		
Behavioral health providers		
Social services		
Housing agency/organizations		
Criminal justice (courts, sheriff)		
Other (please specify)		

Open-ended questions	
Where do you see gaps both in terms of: a. populations that are not receiving support? b. program capacity and operations?	
Where are there unnecessary overlaps with other organizations and programs?	
Other comments or ideas?	

SYNTHESIS GUIDANCE

This inventory is likely a first step in a more extensive effort to improve care management activities. A qualitative synthesis of the results can be used to engage leaders in discussion of gaps, opportunities, overarching goals, and outcomes. Based on our experience, the suggestions and questions below may prove useful as the initiator/collector of the inventories works to synthesize and share results. For a copy of this inventory in Microsoft Word or to discuss the inventory and synthesis process, contact Jeremy Cantor at JSI: jeremy_cantor@jsi.com.

SUGGESTIONS

- Consider having two people review the completed inventories—possibly one person who is very familiar with the county system and one person who has limited to no exposure to the county—and then compare observations.
- Begin with a "strengths-based" perspective: It is easy to get overwhelmed with the challenges. Focusing on what already exists and where things are working can provide a counterweight and increase momentum.
- Put observations in a memo or other shareable format and convene cross-organization leaders to review and provide comments. Pay particular attention to shared "pain points", defining next steps, and potential action items.
- If a large number of inventories were completed (>10-15), it may be helpful to transfer the responses to an excel worksheet to more easily review and see patterns.
- In order to both understand each program and compare across programs, review each inventory from start to finish and then review the responses to each question across inventories.

REFLECTIVE QUESTIONS

- Are there specific strengths that stand out in particular programs (e.g., significant staffing, robust data management, etc.) or across programs (e.g., solid evidence of success, consistent emphasis on communication with other providers, etc.)?
- Are there resources within one program that might serve a countywide initiative?
- Do obvious redundancies exist across programs?
- Are there themes that emerge from the answers to the open-ended questions?
- Does it appear that any of the typical players in care management (health plan, primary care, ED, pharmacy, behavioral health, social service agencies, etc.) are not engaged?
- Is there any consistency in terms of outcomes, data approaches, or funding sources?
- Are there any obvious gaps in terms of services provided, care team, or population focus?

ACKNOWLEDGEMENTS

We are grateful to Blue Shield of California Foundation for supporting this work, staff at the California Association of Public Hospitals and Health Systems and the California Health Care Safety Net Institute for their guidance throughout, and the key informants listed here who were generous with their time and wisdom.

KEY INFORMANTS

> Sophia Chang, MD, MPH, Vice President of Programs, California HealthCare Foundation

> Clemens Hong, MD, MPH, Interim Medical Director – Complex Care Demonstration, Los Angeles County Department of Health Services; Co-Founder, Chief Science & Innovation Officer, Anansi Health; Primary Care Physician and Researcher, Massachusetts General Hospital

> Kristian Lau, MPH, MBA, Manager, Strategic Initiatives, Community Health Center Network

> Denise Levis Hewson, RN, BSN, MSPH, Senior Vice President for Network Development and State Programs, Community Care of North Carolina

> Laura Miller, MD, Chief Medical Officer, Community Health Center Network

> Kathy Moses, MPH, Senior Program Officer, Center for Health Care Strategies

> Leah Kory, MD, Medical Director Utilization Review, Ventura County Medical Center

> Patrick Oh, MSIS, Senior Analyst for Strategic Initiatives, San Francisco Health Network

REFERENCES

1. National Institute for Health Care Management. The Concentration of Health Care Spending: NIHCM Foundation Data Brief. July 2012. http://www.nihcm.org/pdf/DataBrief3%20Final.pdf

2. Hong C, Siegel A, Ferris T. Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program? The Commonwealth Fund. August 2014. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/aug/1764_hong_caring_for_high_need_high_cost_patients_ccm_ib.pdf

3. Farrell T, Tomoaia-Cotisel A, et al. Care Management: Implications for Medical Practice, Health Policy, and Health Services Research. (Prepared by Econometrica, Inc. under Contract No. HHSA2902007 TO No. 5.) AHRQ Publication No. 15-0018-EF. Agency for Healthcare Research and Quality. February 2015. http://www.ahrq.gov/sites/default/files/publications/files/caremgmt-brief.pdf

4. Maxwell J, Tobey R, Barron C, Bateman C, Ward M. National Approaches to Whole-Person Care in the Safety Net. JSI Research & Training Institute, Inc. March 2014. http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=14261&thisSection=Resources.

5. Maxwell J, Tobey R, Bateman C, Barron C. Opportunities for Whole-Person Care in California. JSI Research & Training Institute, Inc. September 2014. http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=14817&thisSection=Resources

6. Cantor J, Tobey R, Greenberg E. Integrating Housing Strategies with Health: An Opportunity to Advance Whole-Person Care in California. JSI Research & Training Institute, Inc. June 2015. http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=15757&thisSection=Resources

7. Tobey R, Maxwell J, Cantor J. California's 1115 Waiver: An Opportunity to Move from Coverage to Whole-Person Care. JSI Research & Training Institute, Inc. January 2015. http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15346&lid=3

8. California Department of Health Care Services. Health Homes for Patients with Complex Needs California Concept Paper Version 3.0. December 14, 2015. Available at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

9. California Association of Public Hospitals and Health Systems. Member Directory. http://caph.org/caphmemberhospitals/%20memberdirectory/. Accessed December 17, 2015.

10. Center for Health Care Strategies. Inc. Care Management Definition and Framework. 2007. http://www.chcs.org/media/Care_Management_Framework.pdf. Accessed November 9, 2015.

11. DOQ-IT University. Care Management Definition. http://www.ddcmultimedia.com/doqit/Care_Management/CM_Overview/index.html. Accessed November 14, 2015.

12. Agency for Healthcare Research and Quality. Care Coordination. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html. Accessed November 9, 2015.

13. Medicaid.Gov. Health Homes. Centers for Medicare & Medicaid Services. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html. Accessed November 16, 2015.

14. Improving Chronic Illness Care. The Chronic Care Model. http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18. Accessed November 16, 2015.

15. Patient Centered Primary Care Collaborative. The Patient-Centered Medical Home's Impact on Cot and Quality: Annual Review of Evidence, 2013-2014. January 2015. https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality

16. Schilling B. Boeing's Nurse Case Managers Cut Per Capita Costs by 20 Percent. The Commonwealth Fund, March 25, 2011. http://www.commonwealthfund.org/publications/newsletters/purchasing-high-performance/2011/march-29-2011/case-study/boeings-nurse-case-managers

17. Peikes D, Chen A, et al. Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures among Medicare Beneficiaries: 15 Randomized Trials. *JAMA;* 2009 Feb 11;301(6):603-18. http://www.ncbi.nlm.nih.gov/pubmed/19211468

18. Bodenheimer T. Strategies to Reduce costs and Improve Care for High-Utilizing Medicaid Patients: Reflections on Pioneering Programs. Center for Health Care Strategies, Inc. October 2013. http://www.chcs.org/media/HighUtilizerReport_102413_Final3.pdf

19. DuBard A, Jackson C. Hospitalization Trend in North Carolina Medicaid. Community Care of North Carolina. August 6. 2015.

20. California Primary Care Association. Community Clinics and Health Centers in the California Section 2703 Demonstration. http://www.cpca.org/cpca2013/assets/File/Policy-and-Advocacy/Active-Policy-Issues/Payment-Reform/2014-DefiningSection2703-PMPM-PPS.pdf

21. Smith R. Missouri Health Home Program Wins American Psychiatric Association Award. KBIA Mid-Missouri Public Radio, October 7, 2015. http://kbia.org/post/missouri-health-home-program-wins-american-psychiatric-association-award

22. Wholey D, Finch M, et al. Evaluation of the State of Minnesota's Health Care Home Initiative: Evaluation Report for Years 2010-2012. Minnesota Department of Public Health. January 2014. http://www.health.state.mn.us/divs/opa/2014hchevalrpt.pdf

23. Abrams M, Schneider E. Fostering a High-Performance Health System that Serves our Nation's Sickest and Frailest. The Commonwealth Fund Blog. October 29, 2015. http://www.commonwealthfund.org/publications/blog/2015/oct/fostering-a-high-performance-health-system-sickest-and-frailest

24. Anderson G, Ballreich J, et al. Attributes Common to Programs That Successfully Treat High-Need, High-Cost Individuals. *American Journal of Managed Care*, published online Nov. 10, 2015. http://www.ajmc.com/journals/issue/2015/2015-vol21-n11/Attributes-Common-to-Programs-That-Successfully-Treat-High-Need-High-Cost-Individuals

25. Powers B, Chaguturu S, Ferris T. Optimizing High-Risk Care Management. *JAMA;* 2015; 313(8):795-796.

26. Friedberg M, Rosenthal M, et al. Effects of a Medical Home and Shared Savings Intervention onf Quality and Utilization of Care. *JAMA Intern Med,* 2015;175(8):1362-1368. http://archinte.jamanetwork.com/article.aspx?articleid=2296117

27. Schlefer M, Marocco D. Better Health for All. Santa Clara Valley Health & Hospital System. PowerPoint presentation available at: http://www.cbhda.org/wp-content/uploads/2014/12/Santa-Clara-HUMS-10132015.pptx

28. Linden A. Assessing Regression to the Mean Effects in Health Care Initiatives. *BMC Medical Research Methodology* 2013, 13:119.

29. Haas L, Takahashi P, et al. Risk-Stratification Methods for Identifying Patients for Care Coordination. *American Journal of Managed Care*; September 17, 2013. http://www.ajmc.com/journals/issue/2013/2013-1-vol19-n9/risk-stratification-methods-for-identifying-patients-for-care-coordination

30. Community Care of North Carolina. Highlights of Treo Solutions Report. Treo Solutions. https://www.communitycarenc.org/elements/media/related-downloads/treo-analysis-of-ccnc-performance.pdf

31. National Association of Community Health Centers, Inc. PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences. Paper version of PRAPARE for Implementation in 2015 As of April 15, 2015. https://www.nachc.com/client//PRAPARE_4_15_15.pdf

32. Centers for Medicare and Medicaid Services. Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm/. Accessed January 7, 2016.

33. International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)-2015-WHO Version for 2015. http://apps.who.int/classifications/icd10/browse/2015/en#/XXI. Accessed December 17, 2015.

34. Bernstein W, Belfort R, Ingargiola S. Integrating Physical and Behavioral Health: Strategies for Overcoming Legal Barriers to Health Information Exchange. Manatt. February 25, 2014. https://www.manatt.com/ThreeColumn.aspx?pageid=167991&id=570555#Article1

35. California HealthCare Foundation. Fine Print: Rules for Exchanging Behavioral Health Information in California. July 2015. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20F/PDF%20FinePrintExchangingBehavioral.pdf

36. California Department of Health Care Services. California's Coordinated Care Initiative: Implementation and Response to Evaluation Efforts in 2015. October 27, 2015. http://www.thescanfoundation.org/sites/default/files/sarah_brooks_cas_coordinated_care_initiative_implementation_and_response_to_evaluation_efforts.pdf

37. California Department of Health Care Services. Medi-Cal 2020 Waiver. http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx. Accessed January 7, 2015.

38. California Senate Bill 147, Hernandez. Federally Qualified Health Centers. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB147

39. Department of Health and Human Services. Centers for Medicare and Medicaid. Federal Register, Vo. 80 No. 220. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rule. November 16, 2015. https://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf