Appendices

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Appendix A: Integration Models

Special Needs Plans (SNPs)

Description

- Created through the Medicare Modernization Act, CMS was given the authority to designate certain Medicare Advantage Plans as SNPs targeting one of three high-need populations: (1) dual eligibles, (2) beneficiaries requiring institutional level care, or (3) beneficiaries with specific chronic conditions.
- SNPs (run through private companies) contract with Medicare to receive a risk-adjusted premium to cover a range of Medicare services.
- Integrated further through the Medicare Improvements for Patients and Providers Act of 2008 (enforced in 2010) which:
  1. Requires new or expanding plans to contract with states to provide at least some coordination with Medicaid benefits
  2. Establishes new standards in provision of care including evidence-based models, interdisciplinary care teams, and individual treatment plans

In Practice

States contract with SNPs in a variety of ways. The most popular options are described below in increasing order of complexity and integration with Medicaid.

- **Data Sharing:** Integrates all parties involved in the care for the dual eligible population to receive necessary information through data and information exchange. *Example:* Maryland
- **Medicare Cost-Share Only:** States contract with SNPs to provide for Medicare premiums and beneficiary cost sharing that Medicaid is required to pay for dual eligibles. *Example:* Texas
- **Medicare Cost-Share and Medicaid Wraparound Services:** States provide plans with a monthly capitation rate to cover Medicare cost-sharing responsibilities and contract with SNPs to provide Medicaid services not covered or only partially covered by Medicare (e.g., vision, dental, hearing, etc.) *Examples:* New York (Medicaid Advantage) and Minnesota (Special Needs Basic Care)
- **Medicaid Acute and Long-Term Support and Services:** States enter into agreements with SNPs for the provision of the full array of Medicare and Medicaid services. *Examples:* Arizona, Minnesota (MSHO), New Mexico, New York (Medicaid Advantage Plus), and Washington

Advantages

- Patient ease – they can utilize one health care plan and one provider group
- States choose level of integration that meets their population's needs and goals
- Greater budget predictability through use of capitated models
- Streamlining of some administrative processes (e.g., enrollment, marketing, and quality reports)
- Require a multidisciplinary care team to develop individual beneficiary care plans

Barriers to Implementation

- Enrollment does not guarantee coordinated care
- Medicare and Medicaid funding not always blended
- Different state requirements complicate plan development
- Without guaranteed integration, consumers continue to navigate two separate systems
- Not viable option for *all* states (e.g., those without Medicaid managed care) or *all* areas within a state (e.g., rural areas)
- Savings on acute care side from integration not realized by the states, reducing incentive
- Existing, nonexpanding plans not required to coordinate with Medicaid

Program for All-Inclusive Care for the Elderly (PACE)

Description

- Provides eligible beneficiaries with all necessary Medicare and Medicaid medical and supportive services
- Participants must fit the following eligibility requirements:
  - 55 years old
  - Certified by the state to need nursing home care
  - Ability to live safely in the community at time of enrollment
  - Reside in a PACE service area
- Follows standardized regulations that control requirements regarding eligibility, application procedures, program administration, services, payment, participant rights, quality assurance, and marketing
- Contract between CMS and the state Medicaid agency for the official operation of a PACE program when program requirements met
- Can be entity of a city, county, state, tribal government, or a private 501(c)(3) not-for-profit entity

In Practice

- Care is coordinated through a day health center. Beneficiaries are picked up and spend the majority of the day in these centers, where physician and administrative offices are both located.
- The PACE provider is reimbursed at a flat, per-member, per-month (PMPM) rate, and is responsible to pay for all medical and nonmedical services.
- The program's services (detailed in the Johns Hopkins ElderPlus case study) range from primary and specialty medical care to social supports such as groceries, durable medical equipment, and transportation.

Advantages	Barriers to Implementation
▪ Fully integrates Medicare and Medicaid funding streams ▪ Keeps beneficiaries in their own homes ▪ Establishes a set of comprehensive quality measures, monitoring consumer outcomes and satisfaction ▪ States have the ability to serve as the PACE organization or provide PACE through specific Medicaid plans	▪ Demands significant capital upfront ▪ Administration is resource intensive for such a small population (depending on organization) ▪ Savings from integration not realized by all participating parties ▪ Limited provider networks in PACE organizations may require enrollees to change providers ▪ Age and level-of-care requirements hinders wider-scale PACE adoption

Medicaid Managed Care Models (MMCMs)

Description

- Medicaid reimbursement models in which either payers reimburse at set capitated rates, or providers receive a combination of fee-for-service (FFS) reimbursement plus a care coordination stipend PMPM. These models come in a variety of forms, and beneficiaries may be a part of one or more MMCMs:
  - Privately managed care organizations
  - Primary care management providers
  - Prepaid inpatient or ambulatory health plans

In Practice

Occur in two general models:

- Risk-based: health plans receive a capitated PMPM payment to provide all (covered) services.
- Enhanced FFS: primary care providers receive an extra set amount beyond FFS reimbursement to also coordinate specialty care.
- Additional, noncovered services are reimbursed on a FFS basis.

Advantages	Barriers to Implementation
▪ Improves care coordination above typical FFS arrangements ▪ Could be incremental step toward taking on more risk/ blending of funds ▪ With waivers, states are allowed to vary their plans for their needs and financial constraints.	▪ Beneficiary must separately enroll in Medicare. ▪ Medicare and Medicaid funding not fully blended, resulting in less flexibility for providers to tailor the benefits than with global capitated payment ▪ Limited risk for the state but also limited opportunity for the state to accrue savings ▪ Often does not include necessary behavioral and long-term care health services ▪ Must be designed for every set of purchaser/ payer/provider circumstances

Appendix B: Expanded Case Studies

Case Study: Hopkins ElderPlus, Johns Hopkins Health System *Baltimore, MD*

Who: The PACE program of Johns Hopkins Health System in Baltimore, MD.

What: Hopkins ElderPlus (HEP) follows PACE protocol and receives funding to provide comprehensive health services for eligible individuals over the age of 55. The program can serve up to 150 beneficiaries and includes primary and specialty medical care, nursing, social services, therapies (occupational, physical, speech, recreation, etc.), pharmaceuticals, day health center services, home care, health-related transportation, and any other services deemed necessary to maximize beneficiary health.

Results:

- Officials estimate that the cost of care for one dual eligible to the state through PACE averages $4,200 less per year than that of a similar person at home or in a nursing home.
- Patients average a longer median survival (4.2 years) versus Medicaid waiver (3.5 years), per national PACE estimate.

Core Elements		Description
1	**Complete Comprehensive Assessment and Reassessment**	• Upon admission to the program, an individualized care plan is designed collaboratively by the beneficiary, family members, and the clinical care team. • The plan is reviewed and updated annually to ensure the safety of the beneficiary is still preserved.
2	**Conduct Periodic Visits**	• Outreach coordinators are embedded into the program to meet with beneficiaries at the day care center and also within the home when necessary. • The majority of beneficiaries are in the day center at least twice a week, allowing for regular visits.
3	**Implement Protocol-Based Planning**	• The care team utilizes clinical protocols to ensure standards of care for this patient population.
4	**Incorporate Person-Centered Care Principles and Practices**	• A bimonthly newsletter with reminders and educational opportunities is distributed to patients. • Patients are transported to the day center and are observed throughout the day. All necessary medical and support visits are arranged.
5	**Utilize Team-Based Care Management Centered on Primary Care**	• HEP has an interdisciplinary team composed of key clinical providers: primary care physicians, nurses, therapists (physical, occupation, and recreational), dietitians, pharmacists, and social workers. • Visits are also arranged with part-time dentists, optometrists, psychiatrists, and podiatrists. • Nonclinical staff is also included in all care planning including home health aides, transportation coordinators, and outreach coordinators.
7	**Align Financial Incentives**	• Providers are reimbursed on a fixed PMPM rate.

8	**Develop Network and Community Partnerships**	• Based in a day center, social workers cooperate with a variety of community and social services to cover transportation, grocery shopping, and prescription pick-up.
9	**Provide Non-Health Care Services**	• Home health aides may help with light housekeeping and other chores. • HEP staff also conducts home inspection for safety hazards upon admission into the program.
10	**Offer Home-Based Care**	• While the majority of care is provided from the day center, the care can extend to home under acute situations. • Physicians and nurse practitioners may make home visits. • Home health aides are a standard part of every program. • Meals are provided if necessary.
11	**Organize Center-Based Day Care**	• The majority of medical and nonmedical services are centered within the day center. Clinical provider offices, social and rehabilitation services, and administrative offices are all located within these centers. • Depending on individualized care plan, beneficiaries may attend the centers rarely to every day. The average member is present about two days per week. • Participants receive a meal and other snacks.
12	**Incorporate Cultural Competency and Equity of Care Standards**	• All eligible patients can participate in the plan regardless of race, ethnicity, religion, language, etc.

Case Study: Geriatric Resources for Assessment and Care of Elders, Wishard Health Services, *Indianapolis, IN*

Who: Geriatric Resources for Assessment and Care of Elders (GRACE), through Wishard Health Services, operate in conjunction with the Indiana University Department of Geriatrics.

What: GRACE is a comprehensive primary care provider plan (through a pilot program and clinical trial) for low-income seniors. The plan serves to improve the diagnosis of geriatric syndromes and improve the quality of care that can be provided.

Why: Older people with multiple chronic illnesses and common geriatric conditions often do not receive the intensity of care necessary for good outcomes, and these patients account for a disproportionate share of spending. Coordinating care and transitions between sites of care can significantly impact outcomes.

Results:

- A randomized control trial found improved performance on ACOVE quality indicators (for both general health care and common geriatric conditions).
- The same trial also found enhanced quality of life based on the SF-36, a survey that notes general health, vitality, social function, and mental health characteristics.
- A second intervention study found that GRACE participants exhibited fewer ED visits, decreased hospital admissions (370 per 1000 as compared to 615 per 1000 in year three), and lower high-risk readmission rates (5% as compared to 19% after 7 days and 28% as compared to 47% after 90 days).

- The reduced hospital costs offset program costs and exhibited potential for cost savings ($5,100 per patient per year as compared with $6,600 in year three).

Core Elements		Description
1	**Complete Comprehensive Assessment and Reassessment**	• When admitted to the program, all patients receive an in-home assessment with a geriatric nurse practitioner (NP) and social worker (SW) who evaluate all medical and social needs.
2	**Conduct Periodic Visits**	• Post discharge from an acute or post-acute inpatient stay, the NP relays information to the primary care physician (PCP) and also schedules an at-home follow-up visit.
3	**Implement Protocol-Based Planning**	• Staff receives training in the use of care protocols for evaluating and managing common geriatric conditions. The program has protocols developed in advanced care planning, common health maintenance, medical management and adherence, fall monitoring, chronic pain management, urinary incontinence, depression, vision loss, hearing loss, dementia, and caregiver burden.
4	**Incorporate Person-Centered Care Principles and Practices**	• Interdisciplinary teams discuss each patient and his or her respective needs. This team typically includes a geriatrician, pharmacist, physical therapist, mental health case manager, and a community resource expert. • Included within the assessments is a discussion with a caregiver/ family member to ensure that needs are met for the patient's entire circle.
5	**Utilize Team-Based Care Management Centered on Primary Care**	• The assigned NP and SW meet with the patient's PCP to finalize and implement an individualized care plan. With all parties on the same track, the team is able to ensure continued care management and coordinated transitions. • When planning a care transition to the patient's home, the clinical team provides social support, reconciles a list of all necessary medications, and makes certain all care planning is coordinated.
6	**Facilitate Data Sharing and Integrated Information Systems**	• All clinical and social information is documented in the EMR. • GRACE utilizes a web-based care management tracking tool.
7	**Align Financial Incentives**	• The program currently reimburses on a FFS schedule, and they received public and private funding for the pilot program and trial.
8	**Develop Network and Community Partnerships**	• The team integrates their primary care services with affiliated pharmacy, mental health, hospital, home health, and other community-based services.
10	**Offer Home-Based Care**	• All patients receive their initial evaluation, regularly-scheduled assessments, and post-discharge consultations in their own home.

12	**Incorporate Cultural Competency and Equity of Care Standards**	• All patients are selected for the pilot program and clinical trial based solely on need, and they are treated individually to their unique cultural characteristics.

Case Study: Holy Cross Hospital Geriatric Emergency Department *Silver Spring, MD*

Who: Holy Cross Hospital is a 450-bed, not-for-profit, teaching hospital located immediately north of Washington, DC. It is part of Trinity Health, headquartered in Michigan.

What: In 2008, the hospital opened the first senior emergency department (SED) nationwide for patients 65 and older who are experiencing acute but not life-threatening illnesses. In 2009, the 8-bed SED saw an average of 450 unique patients per month.

Why: The over-65 population is growing rapidly and constitutes a high rate of ED visits in the area. Seniors often find the ED overwhelming, and the ED offers little follow up to coordinate visits. The majority of senior ED visits in the area were based on acute issues for chronic conditions.

Results:

- In a survey of over 1,000 patients treated in the SED, 98 percent rated their experience as excellent.
- SEDs are planned to open in 19 hospitals throughout Trinity Health by 2013.
- Among patients treated in the SED, 50 percent are taking five or more medications; upon review by pharmacists in the polypharmacy program, 20 percent were identified as taking an inappropriate medication or dosage.

Core Elements		Description
1	**Complete Comprehensive Assessment and Reassessment**	• Once the patient is stable, nurses screen for cognitive loss, depression, and alcohol and drug use in addition to risk assessments for falls, neglect, or abuse. • After discharge from the ED: » A geriatric social worker follows up with high-risk patients within 24 hours to answer any questions and arrange necessary care. » An administrative assistant follows up with all patients approximately two days later to help address any challenges they are facing and coordinate any necessary follow-up care.
3	**Implement Protocol-Based Planning**	• The organized, process includes the assessment of commonly faced geriatric issues, as described above. When a senior patient is noted to be on five or more medications (including both over-the-counter and prescription medications), nurses are trained to institute polypharmacy referral – that is, the pharmacist reviews and identifies drug doses that are inappropriate for older adults.

4	**Incorporate Person-Centered Care Principles and Practices**	• Each staff member receives training to care for the unique characteristics of this population. • Environmental physical enhancements to make the area more welcoming include: » Larger, private rooms with better beds and room for a family members, » Comfortable beds to prevent skin breakdown and pressure ulcers; large clocks and phones for easier use, » Warm-colored painted walls, and » Safety features such as wall railings.
5	**Utilize Team-Based Care Management Centered on Primary Care**	• The geriatric ED is staffed primarily by the main ED staff who completed a 12-hour geriatric training program within the hospital. Training includes information on common health problems facing seniors and on strategies for providing compassionate care to this population. • To further coordinate care, a nurse practitioner and a geriatric social worker are employed to work exclusively with patients.

Holy Cross Hospital also offers a senior surgery center and an ACE unit to coordinate specialized care for seniors throughout the entire inpatient stay.

Case Study: BOOST Program at SSM Saint Mary's Health Center *Saint Louis, MO*

Who: SSM St. Mary's Health Center, is a 582-bed community teaching hospital in Saint Louis, affiliated with the Saint Louis University School of Medicine, and a member of SSM Health Care.

What: SSM St. Mary's implemented Project BOOST (Better Outcomes for Older adults through Safe Transitions) within a 30-bed hospitalist unit for patients with specific diagnoses, taking multiple medications, or having other certain high-risk conditions. BOOST is a quality-improvement toolkit developed by the Society of Hospital Medicine to enhance the care of patients transitioning from the hospital to home.

Why: Discharge is a variable process at most hospitals, and older adults are statistically most likely to be readmitted. Many of these readmissions are avoidable, and Medicare payment is scheduled to eliminate payments for unnecessary readmissions.

Results: Within three months the unit:

- Decreased 30-day readmissions from 12 percent to 7 percent
- Increased patient satisfaction from 52 percent to 68 percent

Core Elements		Description
1	**Complete Comprehensive Assessment and Reassessment**	• Patients are identified to be "BOOSTed" at team meetings. • Follow-up calls by the team's nursing leader are made to patients within 72 hours of discharge to see how they are doing, check on medication compliance, and ensure that follow-up doctor appointments have been made.

3	**Implement Protocol-Based Planning**	• BOOST utilizes common risk factors to identify patients, such as the lack of home-based support, poor health literacy, or the necessity to take multiple medications regularly (more than six). • Patients who meet specific characteristics are "BOOSTed," and the patient's chart is flagged. Additionally, the name is added to a white board on the unit so all team members can track the care. • The discharge process is designed around education-based, joint physician-nurse rounds. The patient has to describe important steps of their care back to the providers to ensure a smooth home transition.
4	**Incorporate Person-Centered Care Principles and Practices**	• With the team approach to discharge, nurses spend more time at the patient's bedside and more time to work closely with patients and family members throughout the stay. • The education process includes helping patients and family members better understand diagnoses, medical safety, and the importance of following up with their doctors after discharge. • At discharge, all important points are captured on a patient-friendly, one-page "Patient Pass," to ensure a successful transition from hospital to home. This includes a listing of all tests received, main diagnosis, doctor contact information, the prescribed medication regimen and scheduled follow-up appointments.
5	**Utilize Team-Based Care Management Centered on Primary Care**	• Utilize hospitalists and pharmacists on the units. • There are daily 9:00 a.m. handoff meetings between doctors, nurse practitioners, nursing team leader, unit care manager, and social worker. These meetings identify the specific patients to be BOOSTed. • All team members are brought together for twice-a-week staff meetings to review patient progress.
6	**Facilitate Data Sharing and Integrated Information Systems**	• Data collection and analysis tools are supplied through BOOST to improve and benchmark performance.

Case Study: AtlantiCare Special Care Center *Atlantic City, NJ*

Who: AtlantiCare is an integrated delivery network located in New Jersey.

What: The health system opened the Special Care Center in Egg Harbor Township during 2008, which is a specialized primary care center for patients with a chronic illness such as heart disease, diabetes, hypertension, obesity, asthma, or emphysema.

Why: Facing a population with low socioeconomic status and multiple chronic conditions, the team was motivated to find a way to increase patients' involvement in their own care.

Results:

- According to analysis conducted between 2008 and 2009, patients experienced 41 percent fewer inpatient admissions and 48 percent fewer emergency visits. Surgical procedures also were reduced by 25 percent.
- Improved outcomes in pharmaceutical compliance, quality indicators, and generic use.
- Earliest SCC outcomes indicate that spending on primary care visits, prescription drugs, labs, and testing has increased because SCC patients are now more compliant with their care protocol.
- Patient satisfaction has increased significantly, with numbers indicating that over 90 percent of patients believe their physicians seemed more informed and understood necessary care processes better.

Core Elements		Description
1	**Complete Comprehensive Assessment and Reassessment**	• First appointment with the physician is one full hour in length. • All patients who make a sick visit receive a follow-up call within 24 hours.
2	**Conduct Periodic Visits**	Health coaches see their patients at least once every two weeks to assess progress toward chronic care management and address barriers.
3	**Implement Protocol-Based Planning**	• The program relies on behavioral health care to address stress and other barriers affecting chronic conditions. • The team discusses best practices at the daily meetings and implements those procedures across the group.

4	**Incorporate Person-Centered Care Principles and Practices**	• A health coach, assigned to a panel of patients, works one-on-one on health issues, assists each patient in proactively managing care, and helps with navigating the health system • Physicians reserve a one-hour appointment for new patients and a 30-minute appointment for existing patients. • The entire care team shares 24/7 call coverage, allowing patients to contact them at any time with problems. The on-call providers can bring up the patient's chart from home and refer to the ED if necessary. • Patients are guaranteed same-day sick visits, which are triaged by the nursing staff before referring to the physician.
5	**Utilize Team-Based Care Management Centered on Primary Care**	• The overall care team includes physicians, nurse practitioners, pharmacists, health coaches, and clerical and administrative staff. • To provide care to the 1,200 patients within the practice, there are two full-time physicians, two nurse practitioners, seven health coaches, two administrative assistants, one part-time nutritionist, and one social worker. • Health coaches coordinate care directly with the patient. • The entire team meets each morning to discuss patient progress.
6	**Facilitate Data Sharing and Integrated Information Systems**	• All clinical notes are in the IT system, and each clinical team member uses the chart during the daily team meeting. • Providers encourage filling prescriptions on-site to improve monitoring of patient compliance.
7	**Align Financial Incentives**	• With no copayments for appointments or for prescriptions filled on-site, barriers to care are reduced. • Physicians are reimbursed with a flat monthly fee for each patient.
9	**Provide Non-Health Care Services**	• Health coaches also aid in any social support necessary for patients.
12	**Incorporate Cultural Competency and Equity of Care Standards**	• Overall, the staff speaks seven languages: Spanish, Chinese, Cantonese, French, Creole, Gujarati, Hindi, and Vietnamese.

Case Study: The Acute Care for Elders Tracker at Aurora Health Care *Milwaukee, WI*

Who: Aurora Health Care, is a not-for-profit, integrated delivery system, consisting of 15 hospitals, 155 clinics, and 1,600 employed physicians in eastern Wisconsin.

What: Acute Care for Elders Tracker, a computerized data tool to improve care for hospitalized elderly and critical patients, expands on the Acute Care for Elders (ACE) unit design that originally opened in the same facility in 1995. It provides teams with real-time information on each patient's health risks and allows teams to customize treatment plans. E-geriatrician makes geriatricians available through teleconferencing to consult with clinical staff at organizations without consulting geriatric specialists.

Why: The data tool identifies and proactively treats elderly hospital patients at risk for common geriatric problems such as delirium, falls, pressure ulcers, adverse drug reactions, and functional decline, as many of these problems can be prevented or slowed, depending on the situation. Because it was not possible to establish ACE units at each facility, Aurora created a virtual model using its IT system.

Results:

- The share of patients receiving urinary catheters decreased to 20.1 percent from 26.2 percent.
- The share of patients receiving consultations for physical therapy increased from 27 percent to 39.1 percent, displaying enhanced protocol adherence.

Core Elements		Description
1	**Complete Comprehensive Assessment and Reassessment**	• The data reports are published for every older patient. • The data report is updated every 15 minutes, listing individual risk factors that can be monitored in real time.
3	**Implement Protocol-Based Planning**	• The reports list individual risk factors for functional decline or poor outcomes. • Follows ACE guidebook, with developed guidelines for optimal medical care for older patients. • From the almost-daily multidisciplinary meetings, best practices are shared, aiding in the development of protocols and guidelines for common geriatric conditions such as falls.
4	**Incorporate Person-Centered Care Principles and Practices**	• ACE units were remodeled (handrails, chairs, flooring, lighting) to accommodate seniors who have visual and other disabilities. • Uses Individualized care plans.
5	**Utilize Team-Based Care Management Centered on Primary Care**	• A multidisciplinary team of clinical nurse specialists, social workers, pharmacists, and physical and occupational therapists meets for 30 minutes a day, five days a week, to review the ACE tracker report and develop personalized plans for each patient. • If geriatricians are in-house, they attend the meetings twice a week. • If the facility does not have a geriatrician, a geriatrician from another hospital within the system participates by teleconference twice a week.

6	**Facilitate Data Sharing and Integrated Information Systems**	• Team works with Aurora's IT specialist. • Computer system automatically produces the ACE tracker report on each older patient daily, regardless of location within the hospital, and it is updated every 15 minutes. Report lists age, history of dementia, number of medications, history of falls, functional status, and more. • E-geriatrician is used for virtual consults twice a week.
7	**Align Financial Incentives**	• The e-geriatrician is reimbursed hourly for remote program participation.

Case Study: Commonwealth Care Alliance *Massachusetts*

Who: Commonwealth Care Alliance (CCA) is a state-wide, not-for-profit program that acts as a prepaid care delivery system.

Why: Beginning as a demonstration program in 2004, CCA serves the most complex and critical patients throughout the state.

Results:

- CCA nursing home certifiable (NHC) beneficiaries (the most complex) account for 332 risk-adjusted hospital admissions per year, as compared to 671 for beneficiaries facing the Medicare dual eligible FFS experience.
- CCA NHC patients exhibited a 46 percent reduction in long-term nursing home stays, better than a comparable Medicare FFS population.
- CCA NHC patients had an average of 20 multidisciplinary PCP/NP/SW team visits per enrollee per year as compared to 3.7 visits for traditional dual eligibles.

Core Elements		• Description
1	**Complete Comprehensive Assessment and Reassessment**	• Upon admission to CCA, each patient receives a comprehensive assessment in their own home to evaluate medical, behavioral, equipment, and social supports that will be necessary.
2	**Conduct Periodic Visits**	• Visits are conducted regularly, managed by a NP, to ensure continuity of care.
3	**Implement Protocol-Based Planning**	• Depending on specific patient issues, there are medical, behavioral health and durable medical equipment protocols that are followed in order to provide necessary resources without a delay.
4	**Incorporate Person-Centered Care Principles and Practices**	• Care and resource allocation plans are developed for each individual patient's needs, combining primary health care, behavioral health, and any necessary durable medical equipment. • CCA performs their own medical equipment assessment to provide patients with necessary equipment faster. Clinicians are available 24 hours a day, seven days a week

5	**Utilize Team-Based Care Management Centered on Primary Care**	• CCA completely redesigns the care delivery strategy to focus money and time on primary care.
6	**Facilitate Data Sharing and Integrated Information Systems**	• The EMR supports informed triage decisions and facilitates improved data transfer between affiliated providers.
7	**Align Financial Incentives**	• CCA operates as a fully integrated dual eligible SNP and depends on Medicare and Medicaid risk-adjustment premiums, which allow them to redesign care delivery to focus on primary care. • CCA had a $16.9 million increase in primary care expenditures over the traditional FFS model in 2010.
8	**Develop Network and Community Partnerships**	• CCA works in collaboration with community physicians, health systems, community centers, and other available social supports to cover each patient's wide range of needs.
9	**Provide Non-Health Care Services**	• Premiums cover durable medical equipment, behavioral health services, and other social assistance programs.
10	**Offer Home-Based Care**	• CCA funds over 500 full-time in-home personal care assistants as necessary for its patient population. • A NP responds and visits the patient's house to assess and manage new problems as they arise.

Case Study: CMO, The Care Management Company, Montefiore Medical Center *Bronx, NY*

Who: CMO, The Care Management Company is a subsidiary of Montefiore Medical Center.

What: Caring for a vulnerable Bronx population of approximately 140,000 enrollees, CMO handles medical and behavioral care management as well as other administrative functions commonly managed by health plans.

Why: CMO data analysis and care planning allows patients to remain at home and out of the hospital, which improves their quality of life and lowers costs.

Results: CMO has proven to keep patients out of the ED and hospital, holding down the overall cost of care and improving primary care outcomes.

Core Elements		Description
1	**Complete Comprehensive Assessment and Reassessment**	• Utilizing a population health strategy, CMO mines data continuously to bucket patients into care plans that fit their needs and complexity. • More complex patients are provided with personal assessments to arrange necessary care.
3	**Implement Protocol-Based Planning**	• Implements plans first based on population need. • Employs evidence-based models for treatment of depression and alcohol abuse with chronic medical conditions.

4	**Incorporate Person-Centered Care Principles and Practices**	• CMO patients are flagged upon admission to hospital or ED visit to notify care team. • More complex patients have individualized care plans focused on their needs, including self-management tools, case management, and transitional care management. • Individualized care plans are developed by an accountable care manager who utilizes information in the system as well as patient-reported information.
5	**Utilize Team-Based Care Management Centered on Primary Care**	• The accountable care manager develops a personalized care plan that can involve any or all clinical team members across the care continuum. • Mental health and substance abuse expertise is included within all interdisciplinary care management teams.
6	**Facilitate Data Sharing and Integrated Information Systems**	• CMO is in the unique position to mine both provider claims and cost data to understand where care can be improved. • All patients have access to an online personal health record to monitor their own care progress. • For more complex patients, caregivers have permission to access information from the personal health record.
7	**Align Financial Incentives**	• Insurance companies make capitated payments to the Montefiore IPA, which allocates money to necessary care. Potential for savings is realized throughout the delivery system.
8	**Develop Network and Community Partnerships**	• CMO partners with other providers and agencies within the communities to create more integrated comprehensive care plans that include social benefits in addition to medical necessities. • CMO provides more than 25,000 visits at homeless shelters and through mobile clinics. • The company also works with schools to institute clinics and other public health measures to fight obesity.
10	**Offer Home-Based Care**	• Care plans for complex patients include house calls and in-home comprehensive primary care.

Case Study: The Care Coordination Network at Summa Health System *Akron, OH*

Who: Summa Health System is a regional health network serving a five-county region in Northeast Ohio, compromised of six community and teaching hospitals, four outpatient health centers, and a 240-plus physician-hospital organization.

What: Summa created the Care Coordination Network (CCN) to improve care organization and patient transition between inpatient facilities and locations providing post-acute care.

Why: Facing limits on the number of available beds throughout Summa hospitals, there was a desire to improve access to post-acute care beds, improve communication between the two categories of providers, and optimize the knowledge of both areas to achieve improved clinical outcomes. Additionally, Summa Health System was facing financial pressure to ensure more timely patient discharges to post-acute care centers without compromising the quality of patient care being provided.

Results:

- Summa's 31-day readmissions rate for patients discharged to skilled nursing facilities (SNF) dropped from 26 percent in 2003 to 21.8 percent in 2010.
- The average length of stay for the patients discharged to SNFs annually fell from 7.4 to 7.1 days between 2003 and the end of 2006. This slight difference enabled hospitals throughout the system to admit an additional 130 patients each year without the addition of staff or resources. The number of hospital surgeries and tests canceled due to incomplete paperwork has decreased for patients transferred from SNFs.

Core Elements		Description
3	**Implement Protocol-Based Planning**	• CCN developed a standardized nursing facility referral process, including guidelines for determining patients' post-acute care needs and a quick reference manual for discussing these decisions with patients. • The transfer form reduces the chances of miscommunication, standardizing data such as patient demographics, care orders, treatments received, and other issues that the providers should understand. • Local ambulance services that transfer patients from SNFs to hospitals for surgery or tests also collaborate with CCN to ensure patient consent forms and other relevant paperwork are complete and that requirements are met before the patient is transferred. • Organizations continue to update protocols, led by the senior services division and nursing representatives, to guide patient assessment and reporting of the patient's condition to the nursing home's attending physician.

5	**Utilize Team-Based Care Management Centered on Primary Care**	• CCN educates hospital and nursing facility staff about the network and its efforts to improve the patient transition process. An annual education fair helps increase hospital discharge planners' and social workers' awareness of the nursing facilities available for referrals. • The area's agency on aging case managers have been successfully integrated into the SNFs, and they work with Summa patients and consumers to offer additional long-term care options.
6	**Facilitate Data Sharing and Integrated Information Systems**	• The CCN developed outcome measures to monitor member and network performance, ultimately establishing best practice protocols to sustain and encourage quality improvement. • CCN implemented electronic referrals using the Extended Care Information Network Software, allowing member facilities to question each other about available beds, patient needs, and other transition issues. • Complete patient information also enables facilities to classify patients in appropriate resource utilization group payment categories. • Summa's quality office collects data on all patients transitioning to and from network SNFs. They share facility-specific performance data with network members every six months to identify best practices, target improvement efforts, and recognize outstanding performance.
7	**Align Financial Incentives**	• Appropriate inpatient stays at both facilities achieves better financial health.
8	**Develop Network and Community Partnerships**	• The CCN is composed of representatives from Summa and participating post-acute care providers, including approximately 40 skilled nursing facilities that have satisfaction and performance scores of 90 percent or better and demonstrate a commitment to implementing the policies and procedures established. • CCN is affiliated with local EMS/ambulance services in addition to the local agency on aging. • The team emphasizes improving communication and addressing barriers within the partnerships. SNFs can call a hotline, which is staffed by a Summa geriatric coordinator, when they face transition problems. • Regular meetings with the network steering committee members occur quarterly, and specific subcommittees meet monthly.