Montefiore

Care Management Case Study

Montefiore Health System's Care Management

Located in the Bronx and Hudson Valley, New York, Montefiore Health System (MHS) serves one of the poorest and most disproportionately disease-burdened counties in the nation with nearly 80% of the payer mix from Medicare and Medicaid. The integrated delivery system includes 10 hospitals and nearly 200 primary care, school-based, and other specialty care sites.

Background

Montefiore has been a leader in payment and delivery reform pursuing value-based reimbursement in both the public and private sectors. Montefiore operates one of the most financially successful Pioneer ACOs in the nation, and provides population health and care management services to approximately 400,000 patients through full-risk and shared savings arrangements.

Program Description

The Montefiore Integrated Provider Association (MIPA) is an organization of more than 3,900 MHS-employed and community-based providers. The Montefiore Care Management Organization (CMO) is a robust health care management company that delivers care management services to patients with complex illnesses, coordinating seamlessly with on-site care delivered in acute and post-acute settings. The CMO also supports its network by providing patient education, provider relations, credentialing services, community health programs, data analysis and reporting, financial and customer services.

Care Management Strategies

The CMO identifies high-need, high-cost patients within the managed population through data mining, self-referral, and provider referral. Once identified, Montefiore staff contacts these individuals to arrange a comprehensive biopsychosocial assessment. An Accountable Care Manager (ACM), who is either a nurse or social worker, administers the assessment using motivational interviewing techniques. The assessment evaluates issues related to aging, cognitive and functional status, psychosocial stressors, caregiver supports, behavioral, and end of life planning needs.

Upon completion of the assessment, care managers compile a list of patient needs linked to specific interventions, which becomes the basis for a personalized care plan. The ACM reviews the personalized care plan with the patient and/or caregiver to obtain input and establish realistic goals. Interventions are then tracked within the CMO's automated care management system to ensure follow-through. The patient's primary care provider receives a summary of the issues identified upon completion of the assessment, along with a set of recommendations and actions to be taken by the ACM and patient or caregiver. There is regular communication between the care guidance team, patient/caregiver, and physician for as long as the patient requires care management.

Interventions and resources available to the ACM include:

- ***Chronic care management programs for diabetes, heart failure, asthma/chronic obstructive pulmonary disease:*** The CMO's comprehensive chronic care management programs use patient identification algorithms and

stratification criteria that permit targeting of interventions to individuals based on the severity of their disease. CMO physicians, ACMs, certified diabetic educators, and pharmacists work closely with providers to reinforce the use of evidence-based guidelines to create optimal treatment plans and promote patient adherence with the treatment plan. Interventions include regular telephonic contact with the care guidance team, tele-monitoring, educational mailings, and in-person individual and/or group education sessions.

- ***Tele-monitoring:*** The CMO utilizes tele-monitoring with individuals in its chronic care management programs for heart failure and diabetes and in other high-risk cohorts, including a small cohort of at-risk, frail, community-dwelling elderly.

- ***Medication reconciliation, adherence and optimization:*** The CMO employs pharmacists who work closely with ACMs, PCMH teams, inpatient and specialty providers, and patients/caregivers to review and resolve medication-related issues and provide patient education. Interventions include: assisting in attaining target dose levels of key medications for conditions such as heart failure and depression; recommending strategies to achieve better levels of medication adherence; reviewing regimens involving polypharmacy; and assisting patients facing financial barriers to adherence.

- ***Linkage to community support services and entitlement programs:*** Based on identified patient need, referrals are made for services/programs such as adult day care, Meals on Wheels, transportation, caregiver support, and senior centers. In addition, screening is conducted to determine eligibility for entitlement programs, such as Medicaid, and support is provided to facilitate the application process.

- ***Behavioral health management:*** The assessment process screens for depression, at-risk drinking, and history of other behavioral health disorders. ACMs work with PCPs to incorporate treatment of these issues into the patient's care plan, including assisting with the coordination of referrals for treatment and/or community-based services when appropriate.

- ***Life care planning and advanced illness management:*** The assessment process screens for the appropriateness of palliative care for pain and symptom management and/or hospice for end of life care. The majority of CMO clinical staff have received certification through the End of Life Nursing Education Consortium (ELNEC).

- ***Inpatient care monitoring:*** At Montefiore, hospital-based case managers are automatically alerted when a patient covered by a capitated or shared savings contract is admitted. The hospital-based case manager works closely with the interdisciplinary inpatient team to identify the root causes of admission and readmission, participate in patient and caregiver education, facilitate discharge planning, and communicate with the PCP and the CMO-based ACM.

- ***Caregiver support:*** In cases where the ACM is working with a caregiver, interventions to help reduce and avoid caregiver "burn-out" are enacted. This can include having a care manager interact with the caregiver on a regular basis, helping to arrange for respite services, and referring caregivers to support groups.

Findings

Montefiore's Pioneer ACO is one of the most successful across the country. It has generated an average annual savings of approximately 6% from benchmark and was the most financially successful Pioneer ACO in Performance Years 1 and 2, saving 7% and 7.1%, respectively.

Montefiore has also been successful in managing complex patients who are commercially insured. For example, it reduced the diabetes admission rate for one commercial insurer from 343 per 1,000 to 299 per 1,000 from 2009 to 2014.