WakeMed

WakeMed Health & Hospitals

Care Management Case Study

WakeMed Key Community Care's Complex Care Program with Evolent Health

Located in the competitive health care market of Raleigh, North Carolina, WakeMed Key Community Care (WKCC) is an ACO formed by WakeMed Health & Hospitals and Key Physicians in 2013. With both commercial and Medicare contracts, WKCC is focused on enhancing the quality and coordination of care for patients, especially the chronically ill, in the Triangle area.

Background

In addition to WakeMed Key Community Care's ACO network of more than 220 independent primary care physicians and a leading health system with another 500 providers, WKCC's efforts are supported by Evolent Health, a partner for providers transitioning to value-based care and a member of the HCTTF. Evolent Health is a key partner in the ACO and supports WKCC's clinical, operational, and financial accountable care efforts. In collaboration with Evolent, WKCC developed an initiative to achieve higher value for high-risk patients called the Complex Care Program, which is central to their ACO strategy.

Program Description

WKCC's Complex Care Program is an initiative meant to identify and manage high-need, high-cost patients that require more extensive care coordination needs. The Complex Care Program is supported by the ACO's organizational and operational model. The model serves to align financial, clinical, and executive leadership both from strategic and operational perspectives to successfully deliver financial return and improved clinical outcomes under a value-based care paradigm. This model has demonstrated a high degree of replicability of its governance and its physician alignment approach in diverse environments among other partner health systems.

A critical component to the model's success is the information system's ability to assure that data from clinical (e.g. EMRs, lab, pharmacy) and administrative (e.g. claims) sources integrate across the care continuum. Integration initiatives that optimize multiple electronic medical records systems are the highest information systems development priority at WKCC.

Care Management Strategies

WKCC's Complex Care Program uses an innovative approach for targeting high-risk patients with more extensive care coordination needs, including predictive modeling and advanced stratification methods to identify chronic patients (e.g., diabetes, coronary artery disease, congestive heart failure, COPD, asthma) with the highest likelihood of having an avoidable acute event in the 12 months following identification.

Central to the program is the care advisor who regularly engages with the primary care team on-site regarding services needed for the patients. Physician engagement, clinical guidance, and patient feedback are the keys to successfully managing chronic conditions, along with collaboration among the care advisor, the dietitian, the pharmacist, and behavioral health providers.

The program is focused on behavior change and motivation, engaging patients in setting their own goals and graduating them when they achieve their goals. A patient-centered, whole-person view is emphasized to address not only the diseases in question but also other drivers of poor outcomes such as behavioral health issues, psychosocial factors, finances, and living situation.

Patients participate in the Complex Care Program for less than six months on average. The program emphasizes a short timeframe, driving to measurable results quickly while tracking the process measures, including: (1) Initial care planning within 30 and 60 days of identification; (2) Care planning visits with the primary care physician; (3) Extended care visits which include those with a pharmacist, social worker, or nutrition educator; and (4) Engagement as measured by number of telephone or in-person contacts per month. WKCC considers continued tracking to be a high priority in order to further understand the relationship between the process measures and the outcomes measures of per member per month spend and inpatient utilization.

Findings

A case-control study of WKCC's Complex Care Program for the ACO's MSSP beneficiaries showed a 35%reduction in acute inpatient days per thousand and a concurrent 25% reduction in acute inpatient spend ($p<0.05$), key indicators of improvement in quality of life for WKCC's patients. Outpatient utilization did not decrease in terms of emergency department (ED) visits, primary care visits, and specialist visits.

WKCC's organizational and operational model has had the broader impact of reinforcing the structure of the MSSP ACO model to benefit both Key Physicians and WakeMed through the sharing of technology, infrastructure, people, and processes. These structural configurations have resulted in the physician engagement, and the formation of information systems and best practices that have been crucial for the Complex Care Program to achieve favorable results.

In addition to a significant reduction in acute inpatient cost and utilization, a quantitative analysis shows favorable trends for graduates of the WKCC MSSP Chronic Care Program compared to a control group matched on age, gender, comorbidities, months of health plan eligibility, and a propensity score based on 12 months of historical health care costs and utilization.

These trends include:

- A 18% reduction in total (acute and sub-acute) inpatient admissions with a concurrent 22% reduction in total inpatient spend;
- A 11% increase in PCP visits paired with a 18% increase in PCP spend; and
- A 9% reduction in total medical spend.

The qualitative case studies of patients in the Complex Care Program reinforce the successful cost and utilization outcomes. For example, a patient was identified for high ED utilization (nine visits 2014, seven in 2015 prior to May). The diagnoses were hypertension Irritable Bowel Syndrome (IBS), atrial fibrillation, dementia, and acid reflux. The PCP indicated this was one of his most challenging Medicare beneficiaries. The patient was compliant with every three month PCP visits; however, despite the counsel to call the PCP prior to going to the ED, the patient repeatedly used emergency services for non-urgent complaints. The care advisor met with the patient in the PCP office and helped schedule monthly PCP visits and frequent telephonic check-ins to reinforce the importance of consistent PCP services. After beginning this intervention, the patient called the PCP prior to seeking emergency care and he has not utilized the ED since May 2015. The care patterns in this case study are representative of the overall effectiveness of the Complex Care Program.