REPRINT APRIL 2013

hfm
healthcare financial management association hfma.org

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financial planning on a comprehensive scale

Making the necessary investments for comprehensive care management can support more cost-effective and efficient care delivery for multiple populations across the continuum of care.

AT A GLANCE

Hospitals and health systems that wish to explore the shift to comprehensive care management should:

- Assess the investments in infrastructure necessary to support comprehensive care management
- Gauge the financial implications and set quality and financial goals
- Monitor performance using metrics such as patient satisfaction, avoidable admissions, out-of-group referrals, and average length of stay

As the healthcare industry gradually shifts from volume- to value-based business models, care delivery approaches also are changing to become more patient-centered, with a change in emphasis from hospital care to primary care. Patient-centered care is at the heart of a care delivery system that emphasizes a more comprehensive approach to care through population health management.

A comprehensive care management program focuses on meeting patient needs by coordinating services, data, and processes across the care continuum, from the first appointment in a physician's office through treatment, follow-up visits, and home healthcare visits. The overall goal is to diagnose and treat conditions earlier for an entire patient population, such as those living with diabetes or heart disease, thereby managing care more effectively and cost efficiently.

For patients, the value of comprehensive care management lies in receiving better coordinated, higher-quality care that more fully meets their needs. For payers, comprehensive care management has the potential to reduce the cost of treatment and avoid inpatient admissions or readmissions. And for hospitals and health systems, a well-designed and well-executed comprehensive care management program serves as a foundation from which they can earn quality-based payment incentives and protect against penalties for poor outcomes—particularly as these organizations become responsible for managing financial outcomes of physician groups.

Developing a comprehensive care management program first requires thoroughly assessing existing and required infrastructure, then gauging the financial implications of various implementations and choosing which best fits the specific situation. Managing the chosen program then entails monitoring a series of operational and financial metrics to gauge progress and success in meeting the goals of the initiative.

Assessing for Core Components

The shift to patient-centered care changes how care is delivered, where it takes place, who participates in the care process, the amount of communication and data passing among providers and payers, and how that information is transmitted. To make this shift, a hospital or health system should assess and adjust its existing infrastructure to incorporate the core components of comprehensive care management. This assessment should include a careful look at the clinical staffing, technology, and facilities needed to support comprehensive care management.

Patient-centered care. According to the Agency for Healthcare Research and Quality, a patient-centered medical home (PCMH) is characterized by care that is comprehensive, patient-centered, coordinated, accessible, and continually improved upon (see "Defining the PCMH" at pcmh.ahrq.gov). Care teams consist of physicians and specially designated staff who work together to coordinate care for patients in the physician's office and beyond. For example, a PCMH care team with a patient panel consisting of 4,000 members would generally include one midlevel clinician, such as a physician assistant or nurse practitioner; one registered nurse; one licensed practical nurse; and two to three certified medical assistants (one per each physician or clinician on the care team). This example would apply to both capitated and non-capitated models. In some instances, patient service representatives could be assigned to care teams so that they can play a more hands-on role in improving the patient experience.

In addition, the cornerstone of the comprehensive care management is the *embedded care manager*, who coordinates patient care with providers that are not part of the PCMH, but are part of the patient's continuum of care. The embedded care manager could be employed by the medical group or hospital-owned physician office, or be funded by payers. In the case of the hospital-owned physician office, the employer is predominantly the hospital.

A PCMH requires one embedded care manager for every 3,000 Medicare members, 6,000 Medicaid members, and 9,000 commercial insurance members. Additional staffing requirements include a behavioral health specialist, a nutritionist, and a diabetic educator for every three medical home care teams.

Hospitalists. These primary care physicians work on-site at hospitals, facilitating and coordinating inpatient care and ensuring that discharged patients receive the appropriate follow-up care in the right settings. The number of hospitalists employed by a given facility varies according to patient volume.

Electronic health records (EHRs). In general, the better the technology, the fewer the challenges in implementing a comprehensive care management program and achieving quality and financial goals, thus speeding the transition. Such technology should allow clinical, patient account, and financial data to flow among providers and payers across the care continuum. EHRs are critical to care coordination because they enable providers to more efficiently track a patient's medical history throughout the care continuum. EHRs should be robust enough to interface with other care-related and financial systems, such as evidence-based decision support, quality management, and outcomes reporting systems. The ability of an EHR to interface with external systems is another critical component of comprehensive care management.

Outcome measures/reporting tools. Under value-based payment models, providers are paid based upon quality outcomes or adherence to evidence-based care protocols. Payers generally determine the quality targets and the measures used in incentive programs. One set of performance measures, developed by the National Committee for Quality Assurance and used by the Centers for Medicare & Medicaid Services (CMS), is the Healthcare Effectiveness Data and Information Set (HEDIS), which measures performance on eight domains of care using 75 specific measures. Qualifying for incentives requires the use of tools, often employed through the EHR, to capture and report on data related to specific quality measures.

Facilities. Within the comprehensive care management program, service is often provided in an ambulatory care setting, such as a physician office. The physician office should be designed to optimize patient access and throughput, with two to three exam rooms per clinician. When evaluating office locations, a healthcare provider should consider the location's convenience to the patient population, the geographic spread between locations and between other care facilities and support sources, and the physician and care management coverage across multiple locations.

Gauging the Financial Implications

Depending on a provider's existing resources, the infrastructure needed to implement a comprehensive care management program can require substantial investment. However, the financial implications of a program implemented successfully can be substantial as well.

Providers achieve ROI from comprehensive care management programs by meeting quality targets tied to financial incentives. Quality metrics may include hospital admissions per 1,000 patients. The goal of comprehensive care management is to reduce the cost of care by treating patients before their conditions worsen, and in the least expensive setting.

A large independent medical practice in the Northeast realized an ROI of about $10 for every dollar spent on a comprehensive care management program. The medical practice, consisting of 300 primary and specialty physicians, had the potential to earn $18 million in incentives by reducing its rate of admissions per 1,000 patients. The practice's net revenue for the year was approximately $250 million. Before initiating a comprehensive care management program, the medical group failed to meet the requirements to earn financial incentives under its agreement with a payer. In undertaking a comprehensive care management initiative, the medical group added about 27 nurses to act as embedded care managers at a cost of about $150,000 per nurse, including wages and benefits. By reducing its admissions-per-1,000-patients rate, the group earned $10 million in incentives during 2012, the first year in which the program was implemented, and is expected to earn $12 million in 2013.

However, most physicians in the United States work in solo or small to medium group practices. They lack the resources necessary to invest in IT or in hiring care coordination and care management resources. Small practices also typically lack the ability to obtain data to compare their performance with that of other practices or benchmarks. One successful strategy to enhance the capacity of small practices to care for patients is to share resources with other physicians and the community. Small practices may not have the financial capacity to have full-time clinical-care nurses, care coordinators, case managers, urgent-care providers, or nutritional counselors. They could, however, augment existing staff and clinical services by sharing these healthcare personnel through a regional or community-based pool.

For example, a model of care developed by a small Michigan healthcare practice partners with 150 community-based primary care physicians and deploys a shared pool of health navigators. The health navigators reinforce the physician's recommendations related to healthy lifestyles, medication adherence, and self-monitoring, as well as link the patient to community resources, to prevent and manage chronic disease.

Many health plans use the HEDIS performance-measurement tool. Based on a provider's compliance rate for each of the 75 quality measures, a payer will determine which measures qualify the provider for incentives. For example, a provider at 60 percent of the threshold for mammography screenings for its patient population will have an incentive to increase the rate to a target rate of, say, 70 percent.

In working with payers to establish the parameters for financial incentives, providers should first identify areas of opportunity for improvement—such as improving compliance with mammography screenings—and then work with the payers in setting goals based on those opportunities. Such performance goals can then be tied into the organization's overall financial and strategic planning processes.

Hospitals should look for ways to employ utilization and disease management to reduce the amount of resources used in treatment and proactively treat patients before expenses escalate. By employing utilization and disease management programs, the same independent medical practice in the Northeast realized claims savings of about 10 percent.

Providers also can decrease operating expenses by enhancing efficiency of care processes. A fully mature comprehensive care management program has defined protocols and clearly delineated roles and responsibilities for caregivers. During a medical exam, for example, physicians should not ask the patient the same questions a nurse asks during an initial screening. Defined workflows reduce redundancy and improve productivity, which in turn reduce overhead costs as economies of scale are improved.

Finally, providers can analyze the ways in which providing higher-quality care can affect payments within fee-for-service contracts. For example, PCMHs are rated by independent healthcare agencies based on the level of care they provide. Under CMS's value-based purchasing program, providers with higher-ranked PCMHs are paid a higher monthly capitated fee. Providers that meet CMS's criteria for incentives then should use their success in care management to negotiate for higher rates with managed care payers whose members receive care in the same PCMH, because these members are receiving a higher level of care as well. For example, a provider may negotiate for an additional $10 per encounter for each fee-for-service patient who is able to secure an appointment within three days of the initial contact.

Monitoring Metrics for Progress

Once the infrastructure has been assessed and quality and financial goals have been set, providers that choose to implement a comprehensive care management program should monitor both operational and financial metrics to gauge progress.

Various metrics can be used to measure performance at both the medical group level and the hospital level. Medical groups should monitor performance against metrics monthly. Hospitals and physician practices should conduct monthly performance reviews to discuss key metrics and identify opportunities and action steps for improvement.

A sample of measures that hospitals and medical groups should monitor regularly includes patient satisfaction, admissions per 1,000 patients, avoidable admissions, out-of-group referrals, average length of stay/readmission, and claims expenditures.

Patient satisfaction/Consumer Assessment of Healthcare Providers and Systems Survey. Access is an important aspect of patient satisfaction because patients want to make physician appointments at convenient times. Payment under a PCMH can be based in part on the amount of time it takes for a patient to be seen by a physician after the patient's initial contact to set up an appointment. According to CMS guidelines, the goal should be three business days from time of contact for patients to be seen by a primary care physician and seven to 10 business days for a specialist visit.

Inpatient and emergency department (ED) admissions per 1,000 panel members. A high number of admissions may indicate that a physician is inefficiently managing patients within the PCMH, causing patients to rely on the ED when symptoms appear, for example, rather than seeking preventive or maintenance care, which can reduce costs.

Avoidable admissions. Commonly referred to as ambulatory-sensitive conditions or soft admissions, avoidable admissions are inpatient admissions that could have been avoided if the condition had been managed on an outpatient basis or within the patient's skilled nursing facility. Such admissions increase costs and jeopardize incentives.

Out-of-group referrals. Patients who see out-of-network specialists can increase costs in a capitated payment model because the provider has only a fixed amount of money to manage the cost of care for each patient.

Average length of stay (LOS) and readmission rates. Successful comprehensive care management programs should drive down LOS and readmission rates. Often, payment incentives are based on reducing LOS and readmission rates.

Claims expenditures. In a capitated payment model, a claim results when costs exceed those

covered under the health plan. Excess claims expenditures signal that patient care is not being managed effectively and patients are seeking excessive care or care from specialists outside the network.

Additional metrics that both hospitals and physician groups commonly track include coding compliance rates, collections percentages, days in accounts receivable, and per-member-per-month referral cost per specialty. Hospitals also commonly track cost per admission, cost per bed days, cost per readmission per each line of business (Medicare, Medicaid, commercial), cost per case, cost per DRG, and bed occupancy rate.

A more sophisticated comprehensive care management program will track both activity- and resource-based costs. A *cost per care management activity* places a cost on every activity, such as managing a referral or making a follow-up phone call to a patient for medication compliance. A *cost per care management resource* tracks costs on resources, such as mobile devices used to monitor patient compliance.

As a health system's comprehensive care management program evolves, more detailed annual or semiannual reviews should be conducted to determine overall performance relative to the changes that have taken place in the care environment. Reviews should focus on the top three to five areas where gaps in care are hampering quality outcomes and the necessary resources to make improvements in these areas.

Setting the Stage

Fundamentally, a successful comprehensive care management program rests on a strong foundation of resources and relies on the ability to both implement and manage the program effectively. Appropriate infrastructure means that technology is robust enough to communicate with other information systems and can track, monitor, and report on patient progress and outcomes; staffing is at the right amount and level; and staff roles and responsibilities are clearly defined and their workflows streamlined. As with any multifaceted performance initiative, managing progress of such a program requires monitoring core metrics that will gauge progress at the hospital and medical group level.

Ensuring that this foundation of resources is present from the start of a comprehensive care management initiative will drive the financial benefits of comprehensive care management and help hospitals and health systems achieve the main tenets of the new value-based directive in health care: better care at a lower cost. ●

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