Collaboration, coordination and care: Hudson Valley’s embedded case manager pilot unites payers, providers and the community to transform patient care

Advanced primary care practices using embedded RN case managers can increase quality outcomes and decrease costs in populations with chronic, complex medical conditions in an open community model of primary care.

That’s the premise underlying the latest Hudson Valley Initiative undertaking, the Advanced Primary Care & Care Coordination Project, managed by Taconic Health Information Network and Community (THINC) and operated in partnership with Taconic Independent Practice Association (TIPA).

The project, in the Hudson Valley area of New York, deploys RN case managers in primary care practices to coordinate care for those patients most in need. Eight primary care practices at 13 practice sites are participating in the pilot, which began in July 2011 and was fully implemented in January 2012.

Why it matters
Patient care, especially for those who most need attention, is often fragmented. Patients with chronic illness typically receive care from a multitude of providers. So not only must they cope with their conditions, but they must also keep track of disparate providers and an array of medications. Frequently, the challenge is overwhelming.

Moreover, a physician may have to work with several different health plans, each with its own case manager who works only with patients in that particular plan. When that happens, there is no one person—or even one practice—responsible for coordinating a patient’s care.

The lack of coordination leads to waste, duplication and medical errors.1

The Advanced Primary Care & Care Coordination Project advances a solution. The nurse case manager works in the practice as part of the team and across health plans. She becomes a resource for the practice, working with at-risk patients who may face both complex medical and psychosocial problems. The case manager supports these patients to keep their conditions from worsening—requiring acute care—and to help them find resources to resolve other issues, from transportation to literacy.

This approach represents a dramatic change. Generally, the services an embedded case manager provides are not reimbursable, either through Medicare, Medicaid or commercial health plans. As a result, those services are simply not available in most ambulatory care practices. But now, some health plans are showing a willingness to explore the possibility. Among them are the plans participating in the Hudson Valley pilot: Aetna,

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The pilot reaches residents of seven rural counties south of Albany, N.Y.: Westchester, Putnam, Dutchess, Orange, Sullivan, Ulster and Rockland. There is a broad spectrum of socioeconomic conditions represented within these counties, ranging from densely populated, impoverished inner cities to affluent suburban towns and villages, and sparsely populated, isolated rural areas. The average per capita income is roughly 25 percent lower than the statewide average. No single payer dominates the health insurance market. In the commercial market, there is no payer with more than 25 percent market share and eight commercial payers have a significant presence.

SOURCES: U.S. Census Bureau (2008); American FactFinder; New York State Department of Health (August 2009); County Health Assessment Indicators; and U.S. Department of Health and Human Services, Health Resources Services Administration. Find Shortage Areas: MUA/P by State and County

The case manager

The centerpiece of the program is the RN case manager who works with the primary care team to help manage high-risk patients and their care by actively coordinating with specialists, hospitals and long-term care providers; reconciling medications; coaching patients and families in management of the condition; and simply being available to answer questions. It’s a whole-person approach, and the case manager works with patients to identify clinical, financial and social resources and offer assistance as they navigate care transitions.

Each is an experienced RN case manager who has met rigorous selection criteria and undergone extensive training. Each is either board-certified or slated to take the Certified Case Manager exam.

The practices

The practices all participated in the THINC/TIPA medical home project in 2008-2009, and achieved National Committee for Quality Assurance Level 3 patient-centered medical home recognition. Beyond that, they were selected based on a willingness to participate in the pilot. They offer a diversity of size, geography and even EHR systems. They range from a sole practitioner to large, multi-specialty practices across New York’s Hudson Valley. (See sidebar for details on the region.) The practices are Hudson Valley Primary Care; Bridge Street Family Medicine; Imtiaz Malik, MD; Clarkstown Pediatrics; Crystal Run Healthcare; Mid Hudson Medical Group; Mount Kisco Medical Group; and Westchester Health Associates.

A better way

The effort represents a better way for practices to deal with their most complex patients, lifting a tremendous burden from both patient and practice. “Physicians can provide the kind of attention and care they want to give, and the primary care team can manage more complex patients within the practice,” said Susan Stuard, THINC’s executive director.

The practices understand this, and view the case manager as a crucial member who supports the whole team. “The primary care teams took to it immediately, for the most part,” said Stuard. While some took a little longer, “now, more than six months into the pilot, the practice doctors would revolt if we tried to take this away.”

The evidence confirms their commitment: Care coordination enhances value; research shows that the patient-centered medical home and embedded care managers can both enhance quality and improve costs.3,4


The patient

Each RN case manager works with a panel of up to 125 patients. Using multiple sources of information from EMRs, hospitals and payers (such as diagnosis codes, admission and discharge reports and predictive modeling), the sickest and most costly cases are identified and enrolled with the case managers.

Reviewing the data is important, but so is listening to the practice staff, who notice missed appointments, changes in health status, or even if the patient just doesn’t sound “good” on the telephone, said Annette C. Watson, RN-BC, CCM, senior vice president of TIPA’s Community Transformation Department and immediate past chair of the Commission for Case Manager Certification. Watson is in charge of implementation and operations for the pilot.

The care team makes the encounter with the case manager an organic part of the practice. If a patient appears to be a good candidate to work with a case manager, a member of the practice staff such as a nurse, physician or physician assistant will mention the case manager and offer to introduce him or her while in the office. For the patient recently discharged from the hospital, the case manager reaches out with a friendly phone call and introduces him- or herself as part of the practice, explaining that the call is to make sure the patient’s transition from hospital to home is going smoothly.

The exact nature of the encounter varies, but it’s never framed as dealing with something that’s “wrong” with the patient—or doing something “to” him or her. The case managers engage the patients as partners.

Drawing from the best

Care coordination projects are not novel; they have been deployed successfully in integrated care systems—that is, where hospitals and primary care practices are all owned by the same entity, Stuard explained. Often, integrated delivery systems include their own health plans; such is the case with Geisinger Health System.

What’s innovative is how THINC and TIPA addressed the challenge of care coordination outside of that context. The Hudson Valley pilot design drew from elements of some of the programs that had evidence of success, including the Geisinger ProvenHealth® Navigator program, and Massachusetts General Hospital Medicare Demonstration Project for Care Management.

“We ended up creating a model for the Hudson Valley that took some of the elements of these programs and some elements of traditional case management—and then embedded the RN case managers as part and parcel of the practices,” Watson explained.

Importantly, although they are embedded in the individual practices, the case managers are deployed from a centralized organization, TIPA. This helps ensure consistency and high quality. In other words, the model involves a centralized case management department that decentralizes staff by embedding them into physician practices. It’s the best of both worlds, said Watson. “We provide the training, the oversight and the ongoing activities not only to successfully embed case managers in practices, but to also help practices with additional transformation work, to continue to build on those foundational activities.”

As part of this pilot, TIPA has created processes to take the practices from the base line as Level 3 medical homes, and help them transform to advanced primary care practices. The TIPA Medical Council, which was instrumental in the success of the medical home initiative, plays a key leadership role for the pilot. It meets monthly with TIPA’s administrative and executive staff. In addition, monthly meetings with practices allow for practice-specific support. So TIPA
is able to offer strategic, system-level leadership as well as tactical support at the practice level, Watson said.

**Beyond competition: the payers**

This extraordinary level of coordination and collaboration extends beyond the clinical level.

The shared vision among competing health plans—to work side-by-side to improve care—makes this project unique. For care coordination to be completely successful, case managers, and the entire care team, need cooperation from payers. In the Hudson Valley, they are getting it. Each participating health plan—Aetna, CDPHP and MVP—contracted individually for per-member, per-month payments. THINC manages the payment process.

It nevertheless took considerable conversation to make this multi-payer model operational, and including the payers involved a tradeoff, she acknowledged. The project could have moved ahead much more quickly without the payers at the table, but it wouldn’t have held the promise of sustainability. “We made a choice; the care management project was just too critical not to plan it collaboratively,” Stuard said. “It took twice as long as expected, but it was worth doing.”

Aligning payment with care is crucial, Stuard explained. Payment policies have not kept up with some of these new models of care. Just look at the PCMH transformation and the level of engagement being fostered in the Hudson Valley, she noted. For that to happen, the payment models have to change. Fee-for-service models are not aligned with this approach to care. That’s why the multi-payer approach is so important.

Watson elaborated on this, explaining that embedding a case manager in a practice, across multiple payers, is preferable to multiple case managers from multiple payers. The latter model is simply too fragmented.

In the TIPA model, the case manager can be payer-agnostic and deal with every sick patient regardless of payer, Watson explained. TIPA’s payer-agnostic protocols and standards will be the same across practices thus achieving efficiency and effectiveness across settings and payers. “The ability of the case manager to be consistent across payers is one key to the effectiveness that the pilot is designed to demonstrate,” Watson said.

**THINC: convener and collaboration central**

The task of bringing everyone to the table fell to THINC, which serves as the community convener, coordinating all elements of an advanced primary care pilot in a multi-payer environment. THINC creates a neutral setting that allows health plans to collaborate without regard to competitive issues, explained Stuard. There’s precedent: The three health plans have been engaged with THINC and TIPA since 2008, providing support for patient-centered medical home efforts.

The plans have also committed to provide the data needed for predictive modeling and selection of patients, and to share their expertise. “The payers are an incredibly important partner in this work,” Stuard said. Health plans have been doing case management for years. “They know a great deal about this, and they played an important role in program design. They bring to the table tremendous intellectual capital and experience vis-à-vis case management and chronic disease management.”

And, of course, their financial support is critical. It helps ensure sustainability, setting the stage to move from pilot to full implementation, she said.
have worked together to address transformation issues and learn from each other. “The Medical Council leadership and the IPA leadership have been key to leading the change,” Watson said.

Conceptually, it was important for the health plans to know there was independent oversight of what the care managers were doing, Stuard explained. “You need to find a way to give plans confidence you will be doing the things you say you will do,” she said. “There’s not always perfect trust between providers and health plans—even with our good relationships.”

TIPA’s operational oversight provides the assurance the plans need, and it prevents “mission creep.” The RN is a dedicated case manager, and cannot be pulled away from her case management responsibilities to fill in for an absent nurse or to handle a routine nursing task. The program was designed with the case managers as a resource for one specific purpose, Stuard explained. “The attitude was, let’s not let it get cannibalized—and practice teams honored that commitment.”

**Measuring success**

THINC is managing the research and evaluation aspect and will measure how the program performs against a control group of patients. THINC’s multi-payer database, developed to support the medical home project, will provide data to evaluate quality measures and utilization.

Plans are preparing ongoing monthly and quarterly reports on quality and utilization. Patient experience data using the CAHPS Patient-Centered Medical Home Item Set will be provided to practices on an ongoing basis through TIPA.

The goals are simple: to determine whether the program will improve health outcomes and lower total costs. The evaluation will also assess satisfaction with the new model from providers, payers and patients.

“I would say patient/team experience is absolutely critical. It’s hard to get past square one if you aren’t doing what you need to do on that front,” Stuard said. So far, feedback from patients and practices has been tremendous, so she’s confident the experience will be positive.

The next question, said Stuard, is “How do you move the needle on quality in an objective way?” Along those lines, she expects to see some real shifts in utilization—shifts that lead to reductions in costs. After all, the project is designed to keep patients out of the acute setting, except when necessary. However, that doesn’t mean she expects—or even wants—overall utilization to drop.

“We expect more planned, more mindful utilization. That means more primary care and more use of other resources—for example, home health services or behavioral health. Such shifts improve the quality of care and reduce costs overall.”

The pilot will run for 18 months, and Stuard anticipates the positive quality and cost outcomes that will give the program ongoing sustainability.

**Scalability and sustainability**

If successful, the program can be both sustainable and replicable. The design, unique to the Hudson Valley, can
be readily adopted by independent practices around the country, Stuard said.

“This pilot is not huge, but you have to start somewhere. And as word has spread, we’ve been approached to help train nurse care managers who could be deployed elsewhere in the Hudson Valley,” she said.

“Lessons Learned

1. Allow more time than you anticipate. Getting everyone to the table—and then agreeing how to move forward—took longer than anticipated, Stuard said. It was worth the extra time, and if she had to do it over, she wouldn’t change the approach, except to build in more time.

2. Recognize that transformation must be ongoing. Watson noted that at the outset, some practices that achieved NCQA Level 3 PCMH recognition thought “they were entirely transformed” and adding a case manager for their high-risk patients would be easy. They weren’t, and it wasn’t. The practices are learning: Transformation never stops. “It’s a journey, not a destination,” Watson said, an ongoing process of quality improvement and pursuit of excellence and transformation.

3. Meet the practices where they are. "As practices become more advanced, they want to advance even further. Everyone is marching to the same drum, but each practice is marching at a different pace," depending on its culture and use of technology, Watson said. “Be prepared for those variations and be able to support each practice at its own level.” Stuard concurred. “A couple of the participating practices are pursuing ACO/ACO-like arrangements,” she said. “It is very much our intent that what happens as part of this pilot is aligned with what the ACO is trying to do.” It is essential to align with what provider and payer organizations need to be doing to move ahead with accountable care arrangements, she added.

4. Invest in training. Taconic IPA identified exceptional case managers and then invested in rigorous training, both on its own and with Geisinger. Watson emphasized the importance of training the practices, too. The TIPA Medical Council helps provides ongoing support in this area.

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—SUSAN STUARD, THINC’S EXECUTIVE DIRECTOR

“This is a multi-stakeholder collaborative project. It’s not characterized by one large integrated delivery network. Instead, it is a collaboration among a disparate set of provider groups, health plans and allied health care organizations.” That aspect is important, Stuard added. “There are only so many integrated delivery systems. Throughout the country, primary care more often happens in the small and mid-size practices—just as in the Hudson Valley.” And that may be the real take-away from this project, Stuard said. “If we are successful here, a project like this can be done almost anywhere.”

The changes made and the concepts tested will resonate widely. “What we are doing here helps set the stage for fundamental transformation—improved quality, safety and efficiency of health care, not just for the patients in our practices, not just in our community, but across the country,” Stuard said.
Annette C. Watson, RN-BC, CCM, MBA, senior vice president, TIPA’s Community Transformation Department

Watson is the Commission for Case Manager Certification’s immediate past-chair and serves as senior vice president, Community Transformation for Taconic IPA, a 4,000-member strong physician association optimizing the quality and value of medical services in New York’s Hudson Valley region. She is also founder and principal of Watson International Consulting. Previously, she served as managing director of global emerging business for CARF International, and before that as senior vice president at URAC. Watson has served as a CCMC Commissioner since 2007. She is a long-term member of the Case Management Society of America and was a founding member of the New England chapter.

Susan Stuard, MBA, executive director, THINC

Stuard leads the not-for-profit convening organization that establishes research-based criteria to enhance health care quality and value in the Hudson Valley. Prior to THINC, Stuard was the director for technology policy development at the New York Presbyterian Hospital. She was also the vice president of regulatory affairs for the Greater New York Hospital Association (GNYHA) where she led GNYHA’s efforts with respect to clinical information technology and the HIPAA privacy and security rules. She holds a Master’s of Business Administration from the Yale School of Management and a bachelor’s degree from Hamilton College.

About the Hudson Valley Initiative Each of the organizations behind the Hudson Valley Initiative plays a fundamental role in transforming health care delivery and promoting advanced primary care.

TIPA’s medical home transformation work has been an essential building block for care coordination. TIPA, a nearly 4,000-physician IPA, was part of the effort to help more than 300 Hudson Valley primary care providers become recognized by NCQA as Level 3 patient-centered medical homes—one of the highest concentrations in the nation.

MedAllies is the health information services provider that facilitates physician practice redesign to improve efficiency and effectiveness of health care through health information technology, and operates the technical backbone for health information exchange. Its expertise has been essential to creating the virtual integration necessary in a community that lacks a large integrated delivery network. Since 2007, more than 700 Hudson Valley physicians have implemented EHRs.

THiNC fosters collaboration and encourages transparency. It brings together providers and payers in a neutral forum that leaves individual concerns at the door. Building on an accountable finance model, it has partnered with six health plans and a major employer (IBM) in a value-based purchasing program to reward physician practices for reaching quality and care coordination benchmarks.