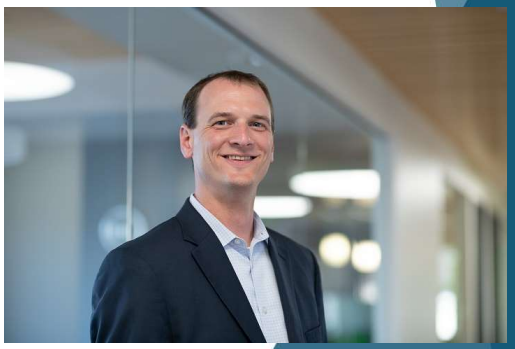
Complex Care Management

Establishing a Collaborative Approach

Speaker Background

- **Kristin Ward** has more than 26 years in the healthcare industry. She is a Registered Nurse with an extensive background in the acute hospital setting and Performance Improvement consulting. She is master's prepared with a focus in nursing leadership & administration. She is a member of ACMA & ACDIS and holds CMAC & ACM-RN certifications. The past several years of her healthcare career have been focused on leading project initiatives and project teams focused on providing financial and operational improvements across Care Management, Utilization Management, Clinical Documentation Improvement, Point of Care Charging Workflows, and other revenue transformation initiatives. Kristin is currently a Director with Eclipse Insights, LLC, an expert health care consulting firm.



- **Eric Wilberg** has more than 18 years of experience working with more than 50 hospitals and health systems, including large multi-facility systems, community and critical access hospitals, academic, and regional medical centers to improve net revenue and revenue cycle efficiency. Eric is a Certified Healthcare Financial Professional (CHFP), Executive of Healthcare Revenue Cycle (EHRC) and Fellow with the Healthcare Financial Management Association (FHFMA), serves as the current President-Elect for the Colorado Chapter, and holds additional specialist certifications in Business Intelligence and Physician Practice Management. Eric is currently a Managing Director with Eclipse Insights.

TODAY'S OBJECTIVES

01 | Industry Barriers & Challenges

02 | Priorities & Opportunities for Providers

03 | Collaborative Approach & Strategies

04 | Value & Results

Industry Barriers & Challenges

Challenges with Treating Highly Acute & Complex Patients

Nationwide Challenges

Increased costs and sustained demand

America's hospitals and health systems are facing a new existential challenge — sustained and significant increases in the costs required to care for patients and communities putting their financial stability at risk… **sustained demand for hospital care with patients coming to the hospital sicker and staying longer has exacerbated these challenges.**

Administrative burden and costs

Commercial health insurer policies like **unnecessary prior authorization requirements** and **improper claim denials** continue to add significant burden for hospital staff — **diverting staff time from caring for patients and contributing to clinician burnout**.

High cost, high need patients

It has been widely reported that about **5% of patients make up approximately 50% of health care spending**. These patients are typically **high utilizers of the health care system, have multiple chronic conditions, take multiple medications, and have complex social needs**.

Increasing complexity and social risks

A study found in patients with **complex medical comorbidities that social risks were associated with higher odds of inpatient admissions, emergency department visits, and mental health visits during a 1-year period.**

Multiple chronic conditions and comorbidities

An estimated **129 million people in the US have at least 1 major chronic disease (**e.g., heart disease, cancer, diabetes, obesity, hypertension) as defined by the US Department of Health and Human Services. ***Ninety percent of the nation's $4.5 trillion in annual health care expenditures are for people with chronic and mental health conditions.***

Defining Complex Care Patients

- High risk for hospitalization or rehospitalization
- High Emergency Room visits & utilization
- Clinically complex medication regimen (over 7 medications, poor adherence, etc.)
- Chronic conditions (diabetes, renal disease, heart failure, COPD, etc.)
- Social risk & vulnerability
- Other variables

Complex Care Management – Barriers & Challenges

Fragmented operational & technological workflows	***Identifying, managing, & monitoring chronic disease patients***	***Community resource gaps***	***Lack of holistic, preventive approach** including SDoH & Behavioral Health*
***Increasing clinical denials and administrative burden** for hospital readmissions*	***Lack of collaborative alignment with payors** & their care management teams*	***Inconsistent & fragmented care plans***	***Misalignment of KPIs & limited reporting capabilities***

Challenges with Managing Highly Acute and Complex Patients

Social Determinants of Health (SDoH)

- Many **complex cases are marked by social factors** that impact health outcomes. Patients who experience **unstable housing, food insecurity, limited income, or poor access to follow-up care** are more difficult to discharge safely & keep out of the hospital setting.

Fragmented Operations

- Clinical teams and revenue cycle departments don't often get opportunities to communicate. When new processes are rolled out on the clinical side, it isn't always clear why those changes are important to patient care. Without a clear line of communication, it's **harder to enhance processes across the board, as a team — *especially in complex care management***.

Hospital Readmissions

- Frequent readmissions often lead to **denials and penalties** from Medicare and other payors. This becomes **costly to a hospital's bottom line**, resulting in **downstream financial losses** that can impact resources available for patient care across the hospital and care continuum.

Patient Experience

- Frequent readmissions or extended stays are frustrating and can be stressful to patients. Poorly-managed care transitions can **negatively impact their overall experience with the hospital, to the detriment of HCAHPS scores, hospital ratings, and reimbursement levels**. Keeping patients satisfied (and out of the hospital) requires a coordinated approach to care transitions.

Example: Disjointed Complex Care Management

01

Care Access

- Lack of PCP or PCP follow-up delays
- Transportation issues
- Lack of/limited community/care continuum resources

02

Care Coordination

- Improper care transitions
- Care gaps/planning issues
- Poor hand-offs
- Lack of resources

03

Financial

- Low income
- Un/underinsured
- Payor denials
- Readmission penalties
- Over-utilization of services

04

Fragmented Operations

- Silos – Rev Cycle/Clinical teams, care continuum, etc.
- Lack of payor relationships & accountability

05

Patient Experience

- Poor outcomes & quality of life
- Low quality care
- Increased financial burden
- Knowledge gaps/lack of advocacy

Priorities & Opportunities

Complex Care Management – Key Priorities & Opportunities

- The following are key focus areas that should be evaluated to identify gaps & opportunities in managing complex care patients & **improve your bottom line**.

Confirm your patients are receiving **care that is best suited to their needs, in the right setting, at the right time.**

Implement standardized documentation that accurately **tells the patient's story across the care continuum.**

Early identification & management of rising/high-risk patients that necessitate additional resources for disease prevention & improved chronic disease outcomes.

Improve collaborative efforts and communications with key stakeholders for **ongoing alignment & strategies.**

Gain a deeper understanding of the performance of Complex Care Management efforts and outcomes via clear & digestible reporting dashboards

Key Priorities & Opportunities continued…

- Build and implement optimal, sustainable processes that improve the management of Complex Care patients throughout the care continuum and **decrease overall costs of care**.

- Enhance operational workflows between all care managers (IP, TCM, CCM, service line navigators, payors), post acute providers/care continuum, & providers
- Build/enhance technical workflows to support the operational processes

Workflow Optimization

- Consistently document to **promote effective hand-offs & transition of care amongst care teams** (acute, post acute & payors)
- Utilize **high-risk screening tools** to identify complex patients timely
- Develop **longitudinal care plans**
- Effectively **document SDoH**

Standardized Documentation

- Prioritize identified at-risk patients
- Be proactive in care gap management
- Leverage community partnerships to align with patient centered needs/care planning
- Utilize evidence based, personalized patient centered care plans

Disease Prevention & Management

- **Align with internal & external stakeholders** (payors, care continuum) for complex care strategies & management
- **Include the patient** in decision making process
- Ensure that the patient has **access to care needs** (PCP, transportation, housing, meds, etc.)

Improved Collaboration

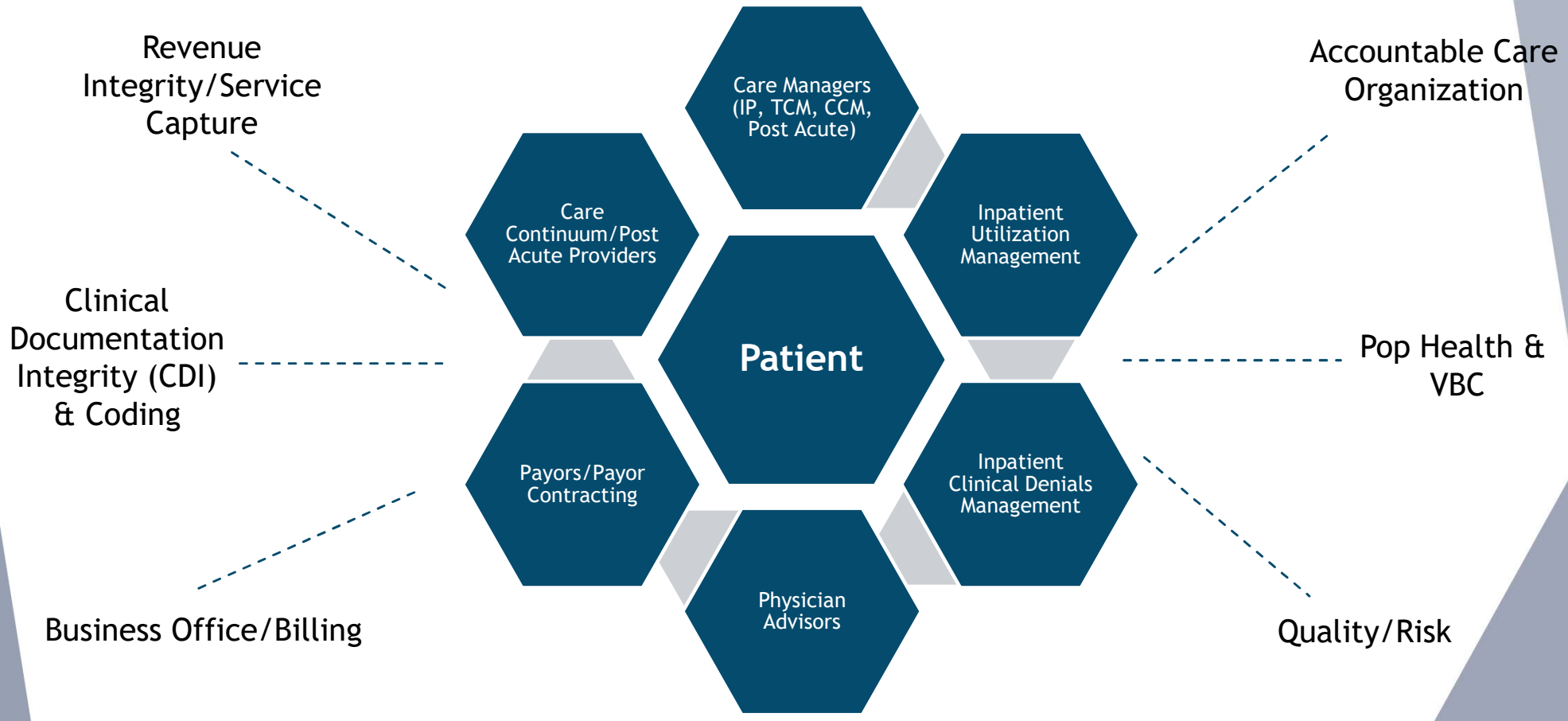
- **Establish KPIs & implement dashboards** to monitor performance & management of complex patients
- Use metrics to **identify ongoing issues/opportunities & focus areas**

KPIs, Data, & Reporting

Collaborative Approach & Strategies

3 Key Focus Areas

A **Collaborative** Approach - Managing Complex Care Patients



Align Internal Stakeholders

Start by getting key stakeholders on the same page. **Schedule regular meetings between Inpatient physicians, care coordinators, and utilization managers** to discuss complex cases in real time. These conversations can help your teams:

- Get complex care patients **appropriately resourced**
- Identify **opportunities in the discharge process**, including any post-acute provider barriers and challenges
- Identify **payor trends** to escalate to managed care/payor contracting leadership
- **Prevent unnecessary readmissions**

Communicate Proactively with Payors

Consider implementing standing meetings between Inpatient *utilization managers*, *care coordinators*, *and payors* on a more frequent basis (i.e., weekly). This enables your hospital to address significant needs as they emerge to:

- **Prevent denials**
- **Handle resourcing proactively**
- **Share accountability and responsibility with payors**

Lastly, **know & understand your payor contract terms** & hold them **accountable** to those terms.

Engage Physician Advisors for Appeals

To get readmission denials overturned and recoup payment, ***engage experienced physician advisors who can help you appeal the denial***.

Take the opportunity for an internal physician advisor or an outsourced vendor to initiate a peer-to-peer review. This can help your hospital ***overturn denials, keep revenue in-house, and ensure patients get the care they need***.

Value & Results

Driving Value for your Organization

Value:

- ↓ Costs of Care/Overutilization
- ↓ Readmission Denials/Penalties
- ↑ Quality & Value of Care
- ↑ Patient Experience
- ↑ Patient Outcomes
- ↑ Coordinated Care & Transitions

Example Metrics to Monitor Success

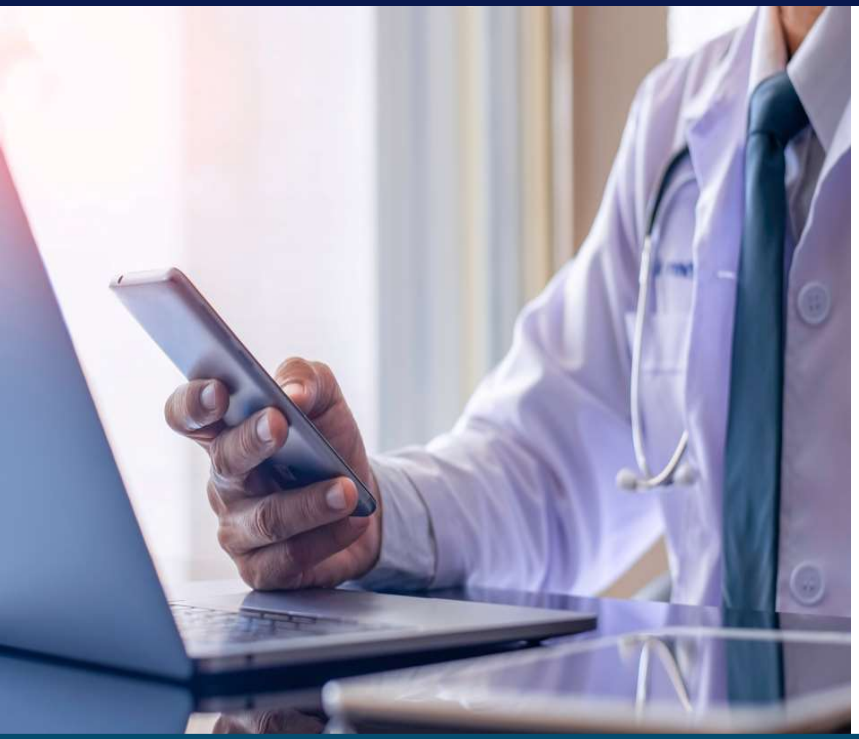
Quantitative:

- Overall Costs of Care
- Utilization of Services (over & under)
- ED Utilization & Visits
- Readmissions
- Write-offs & Denials
- LOS & Excess Hospital Days
- Avoidable Delay Days

Qualitative:

- Patient Engagement
- Patient Satisfaction
- Care Plan Usage/Gap Closure
- Care Quality & Outcomes for Chronic Conditions
- Coordination of Care Across the Continuum

CASE STUDY



SITUATION

- Community hospital with high volumes of socially complex patients, frequently readmitted for related & unrelated diagnoses
- Increasing payor denials & Medicare penalties for Readmissions
- Limited payor collaboration & support from internal payor contracting team

SOLUTION

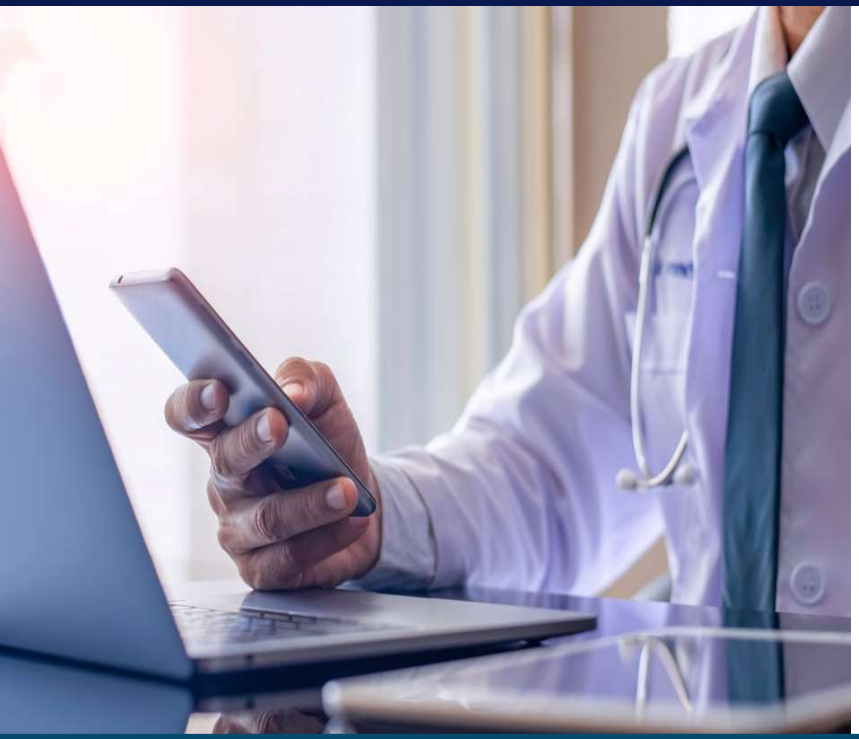
- Established weekly collaborative meetings with Utilization Management, Care Management, & problematic payors to get ahead of denials & create shared responsibility for the patient/member
- Educated internal Physician Advisors & clinical denials team on appeal language for concurrent & retrospective appeals
- Resurfaced internal Readmission Committee; Created & delivered training materials for Care Coordination of High-Risk Readmissions & Transition Planning reference tools

RESULTS

INCREASE in overturn rates for Readmission denials, resulting in **~$285K in annual net write-off reduction**

IMPROVED Payor/provider collaboration

CASE STUDY



SITUATION

- 2 hospital system with high volumes of socially complex patients, frequently readmitted for related & unrelated diagnoses; Inconsistent Care Management processes across the system
- Increasing payor denials for Readmissions; Low pursuance of appeals and/or overturn rates with internal Physician Advisors (PA) for 1 hospital. The other hospital had successful overturn rates with external vendor PA's.

SOLUTION

- Established weekly collaborative meetings with Utilization Management & problematic payors
- Engaged payor care managers to come into the hospital to round on their members & collaborate on transition plans
- Implemented internal weekly collaborative Complex Case Review meeting
- Referred high dollar Readmission denials to external Physician Advisor for appeals

RESULTS

INCREASE in pursuance of & overturn rates for Readmission denials, resulting in ~$500K in annual net write-off reduction

IMPROVED Collaboration, care transitions, LOS/throughput

Next Steps

Is Your Complex Care Management approach in need of Re-Visioning?

Potential signs this is the time for focus:

- ❑ Increased Readmission penalties from Medicare
- ❑ Increasing payor denials for Readmissions
- ❑ Poor peer to peer or retrospective appeal overturn rates for clinical/readmission denials
- ❑ High ED utilization & rehospitalization/readmission rates
- ❑ Increasing LOS & excess/avoidable days
- ❑ Declining quality scores/metrics
- ❑ Patient experience scores/rating are falling

ECLIPSE INSIGHTS

Thank you

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Appendix

References

- Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area
- Fast Facts: Health and Economic Costs of Chronic Conditions | Chronic Disease | CDC
- 2023 Costs of Caring | AHA
- Hospitals Face Financial Pressures as Costs of Caring Continue to Surge | AHA News
- Delivering Care to High-Cost High-Need Patients: Lessons Learned in the Development of a Complex Care Primary Care Team - PMC
- Waste in the US Health Care System: Estimated Costs and Potential for Savings - PubMed