VALUEPartnerships
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Blue Cross Blue Shield of Michigan

High Intensity Care Model

Self Study

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Objectives

- Define the High Intensity Care Model
- Identify patients appropriate for the HICM program
- Identify the key components of the HICM
- Apply the use of protocols to the development of the individualized plan of care

Program Overview

- Designed to address the needs and costs of the most complex Medicare Advantage (MA) patients; BCBSM MA PPO members

- Identifies at-risk BCBSM MA members in Michigan and provides them with intensive care management services to increase quality of life, increase their care cost-efficiency and increase BCBSM's ability to refine risk adjustment and address STARS gaps in care.

HICM Program History

- BCBS Program
  - Started October 2014
  - Most complex at risk Medicare Advantage patients
  - Provide intensive care management services to increase quality of life and independence
  - Increase care cost-efficiency, address gaps in care and refine risk adjustment
  - Based on GRACE* model, majority of services in the home, dedicated team including NP/RN, SW, pharmacists, nutritionist, LPN, medical director
  - Consistent with PCMH, PCMN, OSC principles

*Geriatric Resource for Assessment & Care of Elders

- Update BCBSM Information on
  - Patient targeting (chronic conditions*, high utilization of services, poor care management)
  - Performance requirements
  - Training requirements

*list of chronic conditions

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HICM Targeted Patients

Targeting method component 1: chronic disease comorbidity

- We determine the number of chronic conditions each member has from a list of 35 chronic diseases (see Appendix). We considered members to have a disease if they had ≥2 occurrences of its diagnosis codes in claims during a 2 year period.

Targeting method component 2: indicators of high utilization or poor care management

- Health and utilization indicators are also assessed for each member. The cut-points for these indicators were chosen because they were most predictive of 2014 costs using 2012-2013 data. The indicators are:
- Number of acute inpatient hospital stays in 12 months
- Number of emergency department visits in 12 months, 0-30 days after which ≥1 of the following occurred:
  - Another emergency department visit
  - An acute inpatient hospital stay
- Number of visits to a specialist (a physician, but neither a family practitioner nor an internist) in 12 months
- Number of distinct generic class numbers (GCNs) dispensed in 12 months
- Member responded ‘fair’ or ‘poor’ to “In general, would you say your health is:” on the most recent Medicare Advantage Health Assessment (MAHA)
- Member reported needing help with activities of daily living on the most recent MAHA
- Member reported losing weight without trying over 6 months on the most recent MAHA
- Facility + professional PMPM costs 24 months

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HICM Targeted Patients

Combining the two components to target patients for HICM

- The number of chronic conditions and the indicators above are combined to target members for HICM. Since some indicators are not available for all members (the number of distinct GCNs and the three MAHA questions), we categorize members into four groups based on the information available. Members with more chronic conditions or indicators within each group are prioritized in the targeting process. Compared with the original targeting method, the new method appears to target a ‘better’ group of members (i.e., people who can benefit from HICM, thereby reducing their costs) by including more chronic diseases and considering additional aspects of members’ health, utilization, and care management.

HICM Targeted Patients

- Solid tumor without metastasis
- Metastatic cancer
- Lymphoma
- Renal failure
- Depression
- Diabetes, uncomplicated
- Diabetes, complicated
- Cardiac arrhythmias
- Congestive heart failure
- Valvular disease
- Coronary heart disease
- Hypertension, uncomplicated
- Hypertension, complicated
- Peripheral vascular disorders
- Chronic pulmonary disease
- Pulmonary circulation disorders
- Liver Disease
- Dementia
- Cerebrovascular disease
- AIDS/HIV
- Alcohol abuse
- Blood loss anemia
- Coagulopathy
- Deficiency anemia
- Drug abuse
- Fluid and electrolyte disorders
- Hypothyroidism
- Neglect
- Obesity
- Other neurological disorders
- Paralysis
- Peptic ulcer disease excluding bleeding
- Psychoses
- Rheumatoid arthritis / collagen vascular diseases
- Weight loss

HICM Training Requirements

Non-physician training requirements

- All Core HICM Team members are required to attend the Complex Care Management Course (CCM) provided by Care Management Resource Center (CMRC)
  - Core HICM Team members include: nurse practitioners (CNP), licensed master degree social workers (LMSW), physician assistants (PA) and registered nurses (RNs) , pharmacists
- In addition to the CCM course HICM Core Team members are required to take the HICM self-study module and case study. It is suggested that these two modules are taken after attending the CCM course.
- HICM core team members will receive their GRACE program book on day three of the CCM course.

Physician training requirements - *HICM Geriatrician/PCP Team Lead*

- HICM Geriatrician/PCP team lead (responsible for clinical supervision of the HICM team) – must review the HICM self-study module as well as attend the am billing session on day two of the CCM course

PCP training recommended – "other PCPs"

- Other PCPs (i.e. PCPs in a practice participating in the HICM program)
  - Introductory HICM one hour recorded webinar with CME (this is voluntary)
  - HICM self-study module (this is voluntary)

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HICM Program Key Differences

- **In-Home Assessment by RN/SW**
  - Safety
  - Nutrition
  - Medication management
  - Symptom management
  - Advance Care Planning
- **Interdisciplinary Team**
  - RN, NP, social worker, geriatrician, community liaison, and pharmacy
  - Integrates behavioral health, hospital, home health and community services
  - Team Conference weekly to review new patients and review case load
  - Care planning using problems/protocols
  - Caregiver support
- **Care Plan Focused on Protocols**
  - Health maintenance
  - Geriatric conditions
  - Condition management (Medications and symptoms)
  - Advance Care Planning
- **Frequent Follow-up and Longitudinal Care and Relationship**
  - Can be weekly at start
  - Specific monthly, quarterly and yearly reviews
  - Two years or more
  - High frequency at start, monitoring and frequency modulation with exacerbations and declining health

High Intensity Care Model

IN-HOME ASSESSMENT

In-Home Assessment*

Prior To Visit Review

- Medical record
- Medical history
- PCP notes
- Hospital & ED visit notes
- Specialty consult records

In-Home Assessment

- Review Program
- Obtain consent
- Provide Contact information
- Conduct assessment
- Establish goals

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*For a copy of the assessments **Click Here**

In-Home Assessment
NP/RN/SW

NP/RN

- Conducts medical history
- Conducts medication review and reconciliation
- Conducts brief physical exam, orthostatic vitals, hearing, gait, affect and mental status
- Nutritional assessment
- Develop problem list
- Identify protocols

SW

- Complete social history
- Functional assessment
- Depression screening
- Care giver assessment
- Home safety evaluation
- Develop problem list
- Identify protocols

HICM workflow Click Here

High Intensity Care Model

PROTOCOLS

GRACE PROTOCOLS

GRACE protocols identify and address common geriatric conditions and provide RN/SW with actions that could be initiated prior to the interdisciplinary team conference and physician order.

Protocols are reviewed annually and signed off by medical staff.

- Address common geriatric conditions
- Used to guide care to meet evidence based guidelines
- Used in building individualized plan of care

GRACE Protocols*

- Advance Planning
- Medication Management
- Difficulty Walking/Falls
- Depression
- Dementia
- Caregiver Burden
- Chronic Pain
- Malnutrition/Weight loss
- Urinary Incontinence
- Visual Impairment
- Hearing Loss
- Health Maintenance

*For a copy of the protocols **Click Here**

GRACE Protocol
Example: Difficulty Walking/Falls

Routine Team

- Monitor orthostatic
- Increase fluid intake
- Prescribe walking program
- Provide patient education on falls prevention

PCP Review

- Confirm diagnosis and update EMR
- Evaluate and treat causes of fall
- Order lab evaluation
- Optimize pain management
- Consult physical therapy

High Intensity Care Model

HICM INTERDISCIPLINARY TEAM

HICM Team

- NP/RN
- Social Worker
- Community Resource Liaison
- Geriatrician
- Mental Health Liaison
- Pharmacist
- Program Coordinator

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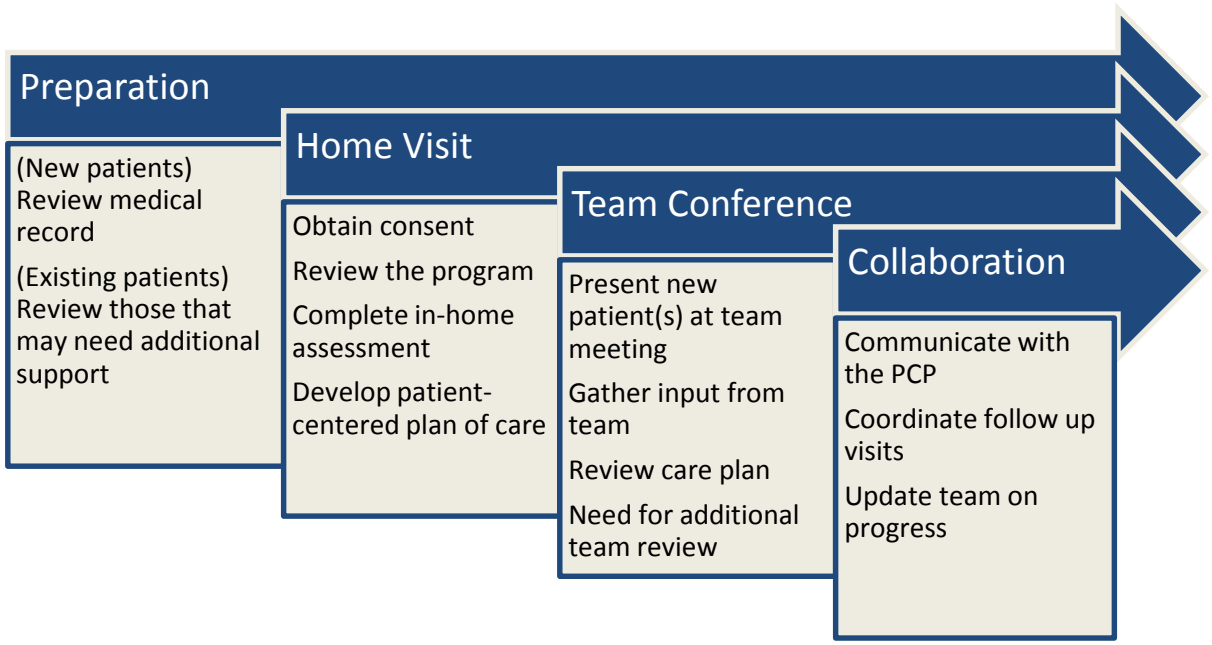
Interdisciplinary Team Conference

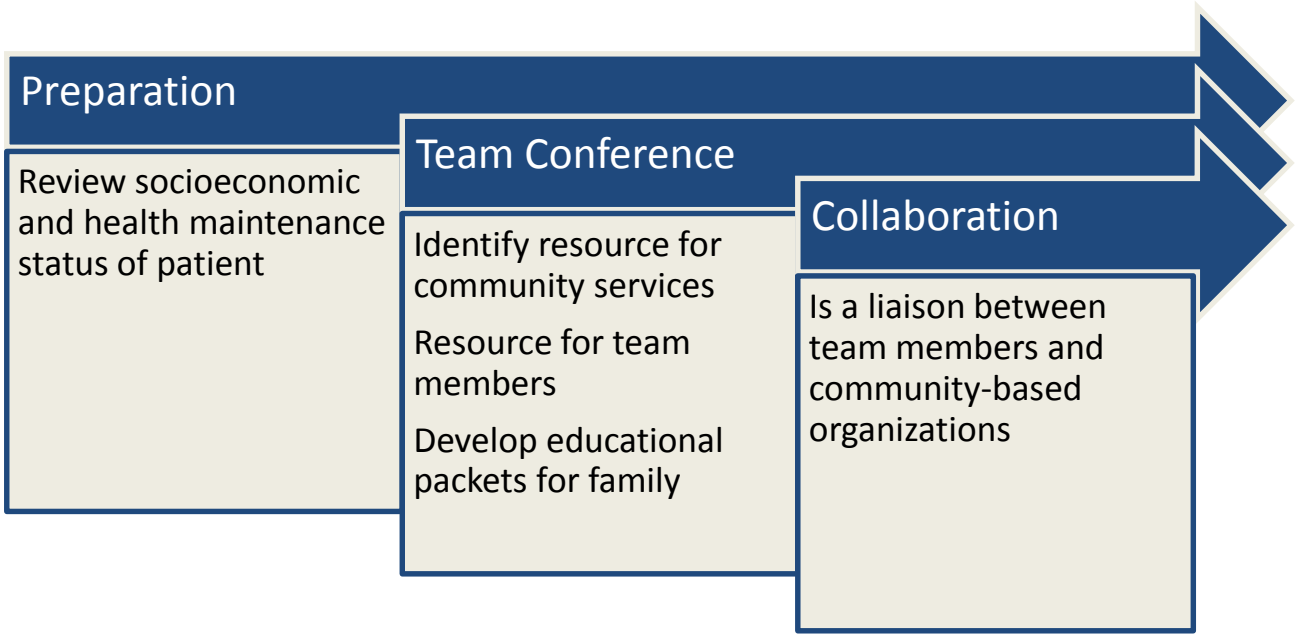
- Held weekly
- Reviews new patients assessment, plan of care and team based interventions
- Reviews current case load patient with changes
- Quarterly check in Annual re-review

Team Roles and Interdisciplinary Team SW/NP/RN



Team Roles and Interdisciplinary Team

Community Resource Liaison



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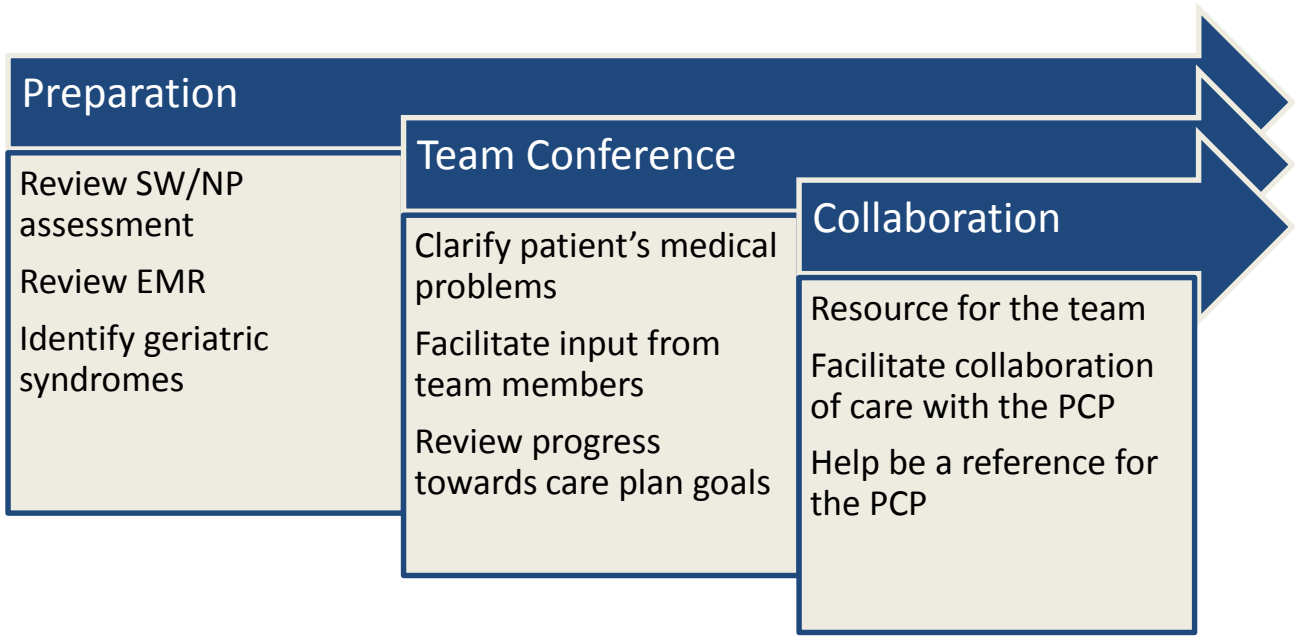
Team Roles and Interdisciplinary Team

Geriatrician



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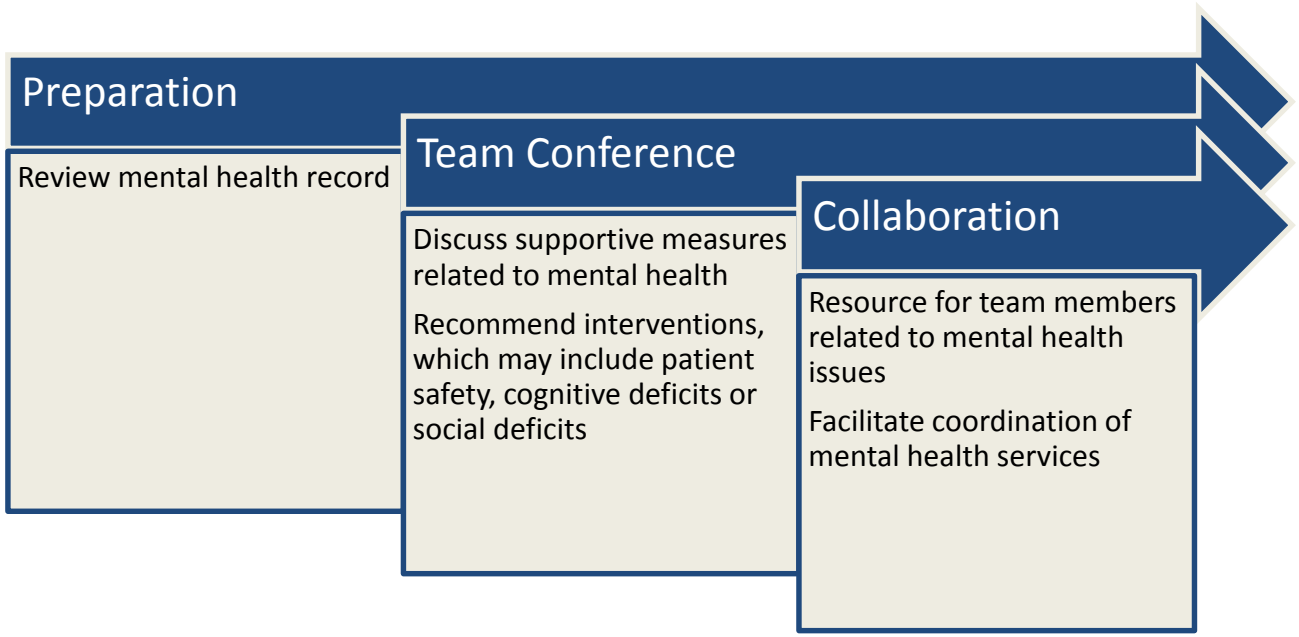
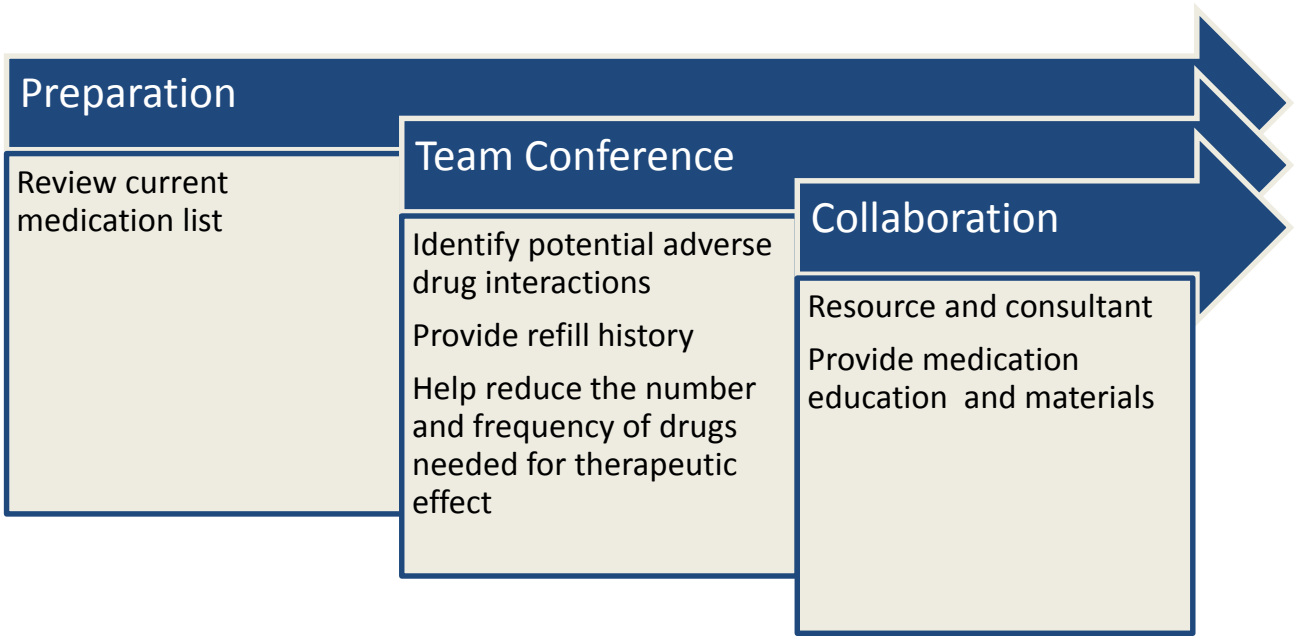
Team Roles and Interdisciplinary Team

Mental health Liaison



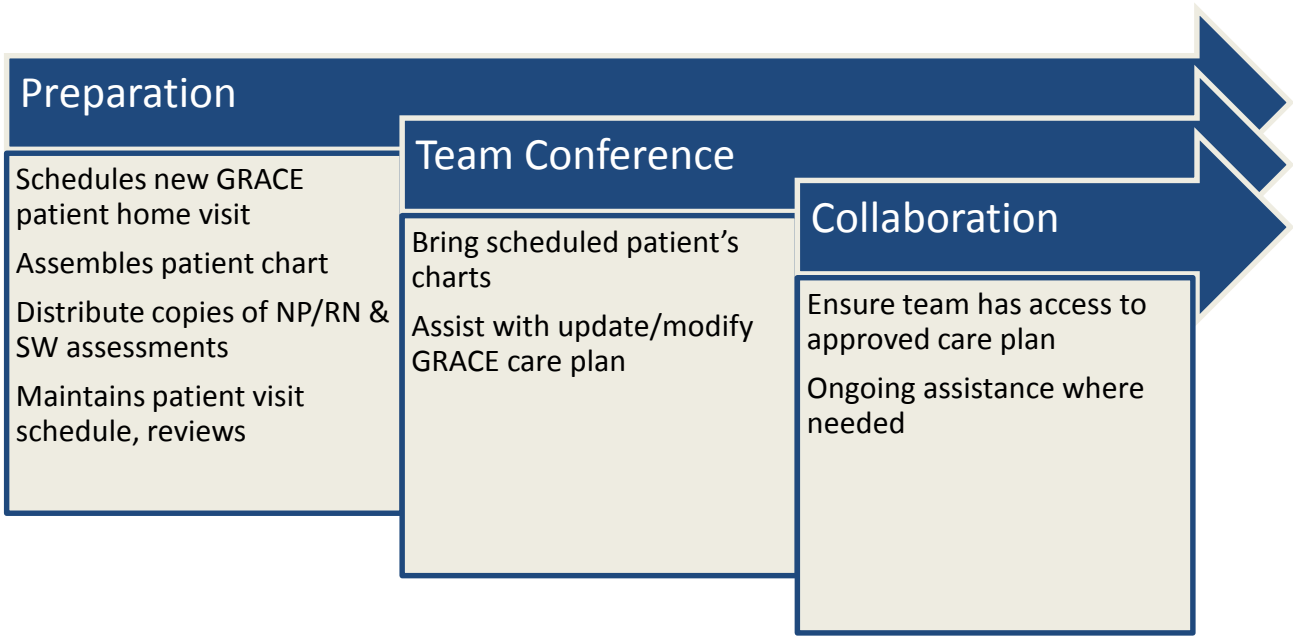
Team Roles and Interdisciplinary Team

Pharmacist



Team Roles and Interdisciplinary Team

Program Coordinator



Follow up

- Planned frequency of follow up:
  - Weekly
  - Monthly
- Quarterly
- Annual reassessment
- Click Here for link to visit requirements

High Intensity Care Model

PATIENT EXAMPLE

Patient Story

Ms. D is an 80 year old female who was recently hospitalized for acute renal failure. During her hospitalization, Ms. D was referred to the HICM program. The hospital staff was concerned about Ms. D as she was unsteady on her feet and did not seem to understand when staff gave her directions.

Ms. D's primary care physician, was notified and agreed to have the HICM program see her. Ms. D saw her primary care physician the day after her hospitalization and seemed to be medically stable again.

During the physician visit she agrees to the program and for the NP and SW to make a home visit.

Patient Story

Assessment

During the home assessment the following information was documented:

- Current medications: Simvastatin, metoprolol, aspirin,
- Medical history: diabetes, osteoarthritis, HTN, ARF
- NP: Blurred vision in left eye, decreased hearing bilaterally, urge incontinence with depends, constipation, recent fall getting out of car, occasional dizziness when bending over, current diabetic monitor not working
- SW: Lives with her sister and brother, unable to write a sentence, completed 8th grade, provided educational material on advance directives, receives $700 per month SS and SSI, has Medicare and Medicaid. Patient would like a med box, embarrassed to leave the house due to urinary incontinence

Patient Story
Plan of Care

Problems:
- Possible fall risk
- Short-term memory issues
- Has fallen
- Non-working glucometer
- Financial constraints
- Urinary incontinence

Protocols:
- Medication Management
- Cognitive Impairment
- Difficulty Walking/Falls
- Health Maintenance

Interventions:
- Provide education/materials on memory loss and/or dementia to patient and family
- Contact pharmacy to assist with blister packing
- Instruct in pelvic exercises
- Caffeine reduction

High Intensity Care Model

DISCHARGE

Discharge

Case Closure

- Patient expires
- Hospice admit
- Palliative care
- No-show for three scheduled visits
- High threshold for non-compliance
- Relocation outside service area
- Patient improves/patient request

Discharge
Team Steps

- Discuss discharge at team meeting
- Notify PCP
- GRACE team to provide smooth transition to new provider
- Contact patient, provide any resources patient may require
- Discharge care plan protocols

Summary

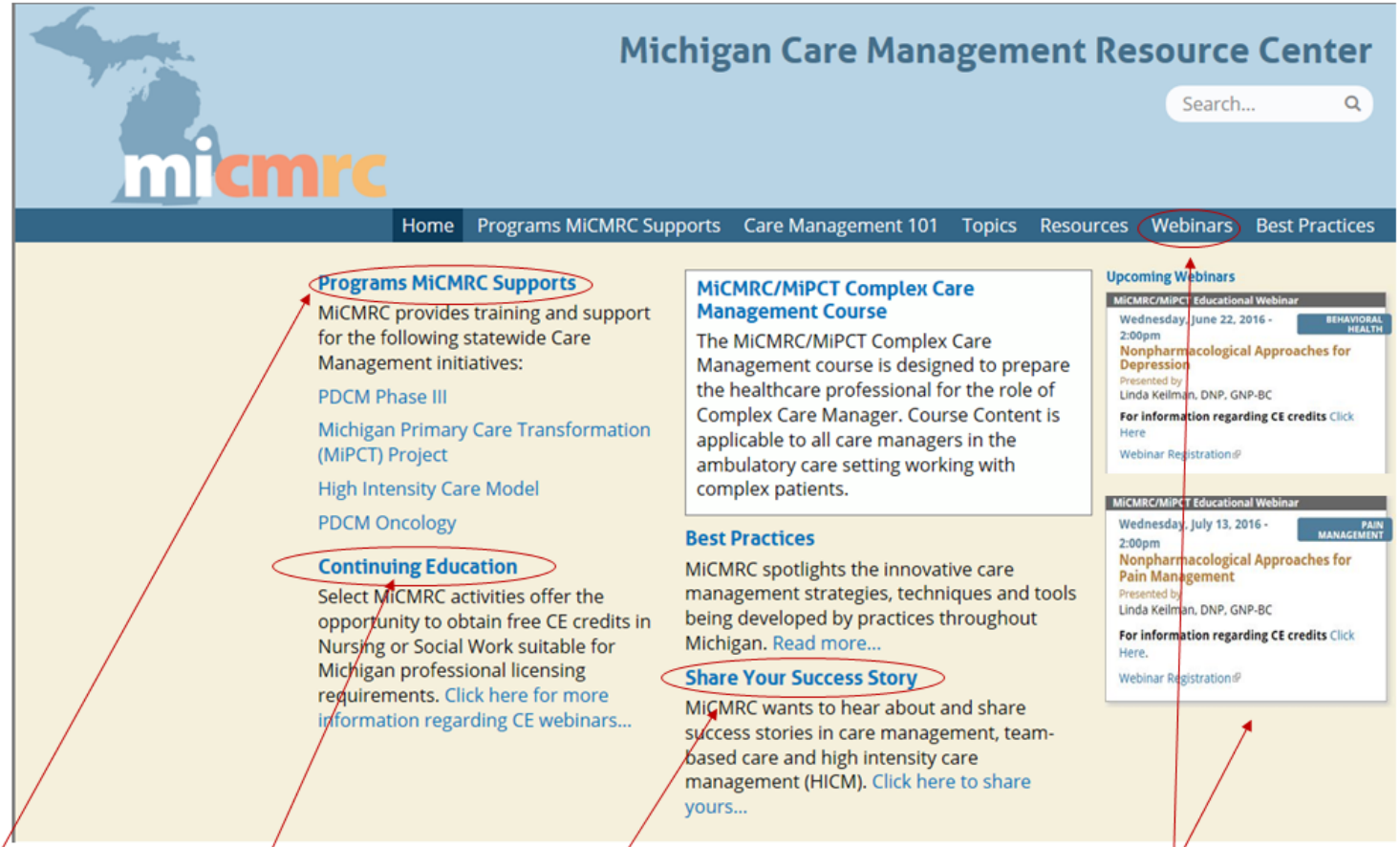
- The High Intensity Care Model is designed to provide Care Management services to complex patients within their own home.
- In-home assessments by a nurse and social worker
- Utilizes protocols based on geriatric conditions
- Care is provided by an interdisciplinary team
- Create an individualized plan of care
- Frequent follow-ups

To access the case study **Click Here**

MICMRC Website Resources

- Highlight HICM page with resources
  - Scripts
  - Letters
  - orientation Checklist – NP/SW
  - Care giver assessment
  - Grace Care Team Assessment
  - HICM Tracking worksheet
  - IDT Education on Clinical Geriatrics
  - HICM Workflow
  - **Click Here** for additional HICM resources

www.micmrc.org



Access your specific course information

View CE approved Webinars

Share your success as a CM

View multiple webinars on various topics

Additional Resources

If you have additional questions or concerns you can contact the Michigan Care Management Resource @ http://micmrc.org/contact-us

For additional HICM resources Click Here

For billing inquiries you can send your questions to **ValuePartnerships@bcbsm.com**