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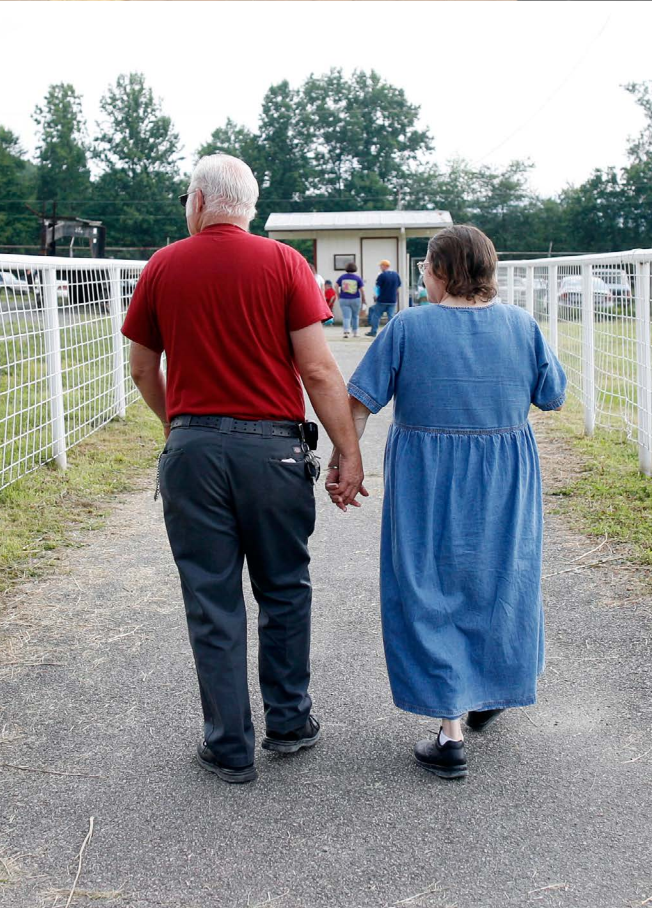

WISCONSIN

Improving Complex Disease Management through Multi-Specialty Care Teams

Thedacare Accountable Care Organization

Center for Health Policy at BROOKINGS

EDITORS

Mark B. McClellan
Senior Fellow
Director, Health Care Innovation and Value Initiative
The Brookings Institution

Gregory Long
Chief Medical Officer and Senior Vice President, Systems of Care
ThedaCare

CONTRIBUTING AUTHORS

Elise Presser
Research Assistant, Center for Health Policy at Brookings

Margaret Darling
Research Assistant, Center for Health Policy at Brookings

Kate Samuels
Project Manager, Center for Health Policy at Brookings

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Improving Complex Disease Management through Multi-Specialty Care Teams

ThedaCare, Wisconsin
Provider Type: Accountable Care Organization
Patients Served Annually: Ambulatory patients-220,000 (~500,000 visits); Inpatient—28,000 discharges
Program Name: Complex Patient Care Model Redesign

EXECUTIVE SUMMARY

ThedaCare, a Wisconsin-based accountable care organization (ACO), is piloting a team-based care model for improved management of their most complex, high-risk patients, including those with diabetes. The Complex Patient Care Model Redesign aims to dramatically improve quality and cost of care as well as patient and physician experience through a more robust, holistic approach to health that integrates all aspects of patient care. Multispecialty teams include clinical pharmacists and behaviorists in addition to physicians, nurses, advanced practice clinicians, and care coordinators. The program focuses on improving care coordination and navigation, patient engagement, mental health recognition and management, community resource connection, environmental and socioeconomic barriers, and medication management. The team-based care model is intended for patients at high risk being in the top 5 percent of spending, as identified through a risk-stratification tool. A comprehensive intake visit introduces patients to the program and the multidisciplinary care team. The team develops a patient care plan, which is updated and revised regularly. In addition to regular patient contact, the team utilizes new technology like remote bariatric monitoring to assist patients in managing their condition between office visits.

Because fee-for-service payment provides very limited support for the team-based care model, it is currently supported by a grant, with the pilot being used to provide a better assessment of its impact on cost and thus the extent of payment reform needed to sustain it. Currently, the ACO shares in savings or losses in care costs above certain benchmark but the ThedaCare leadership believes that more significant payment shifts toward partial or full capitation would be helpful for sustainability.

Approximately 1800 patients have been identified as high-risk in the pilot sites, 54% of whom are diagnosed with diabetes. So far, during the initial pilot phase, almost 100 of these patients have been enrolled in the program. While the Complex Patient Care Model Redesign is a new program, it builds from numerous successful strategies employed by the ACO in the past, and limited early results look promising.

PART 1: BACKGROUND

State Profile

Wisconsin has an estimated population over 5.7 million,[1] approximately 17% of which is enrolled in Medicare.[2] Statewide, the annual per capita spending for Medicare beneficiaries is $8,908, almost $1,500 less than the national average.[2] Part of this lower cost may result from fewer beneficiaries who are dually eligible for Medicare and Medicaid. In Wisconsin, only 18% of Medicare beneficiaries are dual eligible compared to 21% nationally. [2] Of Wisconsin's 72 counties, ThedaCare has a 12-county service area that includes the 6th and 72nd ranked counties on overall health outcomes.

Chronic diseases are an important cause of morbidity and mortality in Wisconsin, as well as in the U.S. overall. According to the Centers for Disease Control and Prevention (CDC), 7.5% of the population in Wisconsin is diagnosed as diabetic. In 2012, the mortality rate due to diabetes was 22 per 100,000 people, making the disease the 7th leading cause of death in the state.[3]

ThedaCare's Payment Model

ThedaCare is a community health system serving 235,000 patients over 12 counties in Northeast Wisconsin and the ThedaCare system includes seven hospitals and 35 clinics.

ThedaCare has partnered with Bellin Health, an integrated health care delivery system in Eastern Wisconsin, to form Bellin-ThedaCare Healthcare Partners (BTHP), an Accountable Care Organization (ACO) under the Pioneer ACO Model program in the Center for Medicare and Medicaid Innovation (CMMI).[3] The BTHP ACO consists of two hospital systems, a network of primary care providers, and over 300 affiliated specialist providers in Northeast Wisconsin. Looking forward, ThedaCare intends to transition to an ACO that is exclusive to ThedaCare, which will be a part of the Medicare Shared Savings Program (MSSP).

Under both programs, ThedaCare's providers are reimbursed on a fee-for-service basis and the ACO can share in savings or losses in care costs above certain benchmarks for a defined patient population. Shared savings can offset reductions in hospital and physician revenues from patients having fewer overall services and complications, and can provide some resources to support delivery reforms that improve patient care but are not feasible under fee-for-service (FFS). To date, BTHP have met all quality and cost benchmarks and have received shared savings. They have used 40% of their savings garnered to reinvest in infrastructure to support programs like the Complex Patient Care Model Redesign, and distributes the remaining 60% to primary care providers (20%), specialists (30%), and hospitals (50%).

Becoming an independent Medicare ACO is a step in ThedaCare's strategy to move away from FFS toward value-based reimbursement with all payers. To achieve this goal as quickly as possible, ThedaCare is working to contract with their commercial payers in risk arrangements. Currently, however, BTHP ACO is ThedaCare's only reimbursement contract in which it benefits from overall spending reductions for high-quality care provision and could be required to pay back losses should expenditures exceed benchmarks.

PART 2: INNOVATIONS IN CARE

ThedaCare's Complex Patient Care Model Redesign

While ThedaCare performs well on ambulatory chronic care and preventative health measures compared to State and National benchmarks, improvement had stagnated. In addition, high rates of health service utilization have persisted and adoption of clinical best practices has remained low. Specifically, in the first two years of the BTHP ACO, the number of patients with three or more qualified ED visits in six months and hospital readmission rates both increased.

To meet these challenges, and as an attempt to create a sustainable care model that would meet the expectations of future risk payment contracts, ThedaCare initiated the Complex Patient Care Model Redesign program in 2014. The model aims to dramatically improve quality, cost, and patient experience for complex patients while reducing stress and burnout in physicians. The model focuses on improving 1) Care coordination and navigation, 2) Patient engagement, 3) Mental health recognition and management as a primary diagnosis and a co-chronic condition, 4) Community resource connection, 5) Environmental and socioeconomic assessment and connection with disease state, and 6) Poly pharmacy and reduction in medication adverse events. This model is centered on team-based care that includes primary care physicians (PCPs), advanced practice clinicians, registered nurses (RNs), nurse practitioners (NPs), pharmacists, care coordinators, and behavioral health clinicians (BHs). ThedaCare believes that by including less typical 'team-

members' such as pharmacists and behaviorists, this program will provide the robust, holistic view necessary to improve care for particularly complex patients.

The first phase of the program includes an initial 90-minute intake with the patient and members of the care team. When the patient checks-in, they are provided with medical and behavioral questionnaires. Once completed, these forms are entered into the e-record by a NP and BH, respectively. While these are being entered, the care coordinator does introductions and a psychological/social review. Then, the RN completes a medical review, a registered pharmacist completes a comprehensive medication review, and a BH completes a general wellness assessment. Each care team member documents their individual patient instructions and provides the patient with needed resources. The care coordinator helps develop goals, prints an after visit summary for the patient, verbally reviews any instructions, and closes the visit. A NP meets with the patient and updates the PCP regarding the patient and the visit.

Once enrolled in the program, the care team is responsible for follow-up and maintenance outlined in the care plan. The care team uses a variety of communication tools and new technology such as remote biometric monitoring to assist patients in following their care plan. One week after the intake visit, the care team reaches out to assess how successfully patients are engaging with their care plans and indicated goals. Regular patient contacts are directed, and often completed, by a care coordinator at least once a month depending on the acuity of the patient. After each contact, the multidisciplinary plan of care is updated and a printed version is shared with the patient.

Patient contacts include office or home visits, phone calls, and e-visits through email, instant messaging and video conferencing. Contact frequency is determined by risk level; more high-risk patients receiving more frequent contact. Patients are invited to bring family members/caregivers to appointments and the care coordinator may reach out to family members as needed and agreed upon by the patients. In addition, care coordinators may accompany a patient to specialist visits to help with communication and continuity of care. If a patient has been hospitalized, the care coordinator reaches out after discharge to arrange a face-to-face ambulatory evaluation within five days. This ambulatory evaluation is conducted by the physician or nurse practitioner and other members of the care team depending on the reason for hospitalization. For high inpatient utilizers, the care coordinator and NP may visit the patient in the hospital and be part of the discharge process.

This program is aided by the use of health information technology (HIT). This new technology includes the use of remote biometric monitoring and adequate technology for the patient to connect remotely to the care team. Patient information is documented by the care team into an EHR developed and, using the tools provided within the system, care coordinators can identify and monitor the high-risk patients needing follow-up on a given day including communicating test results.

PART 3: CHARACTERIZATION OF ACCOUNTABLE CARE AT THEDACARE

This case study applies the five pillars of the Global Accountable Care Framework to ThedaCare's Complex Patient Care Model Redesign. The Framework pillars, outlined in Table 1, include: population, performance, continuous improvement, payments and incentives, and care coordination.

Table 1: The Five Pillars of Accountable Care and Key Innovations in ThedaCare

Conceptual Pillar	Definition	Key Potential Success Factor at ThedaCare
Population	Identifying a defined group of patients for which providers are responsible	Patients identified as high-risk for top spending via algorithm
Performance Measures	Defining a set of targeted performance measures that ensure patient-centered outcomes are met	Utilization measures and diabetes-focused clinical outcomes such as Hemoglobin A1c control.
Continuous Improvement	Evaluating performance through learning and continuous improvement feedback loops	Ongoing analysis of performance measures by key leadership team with information given to practices on a regular basis
Payments and Incentives	Establishing aligned payments, non-financial incentives and rewards to outcomes that matter to patients	Currently grant funded, but as part of the Pioneer ACO program, part of any reduction in cost resulting from this program are recovered as shared savings
Care Coordination and Transformation	Implementing delivery and care transformation reforms that improve low-cost, high-impact, or high-value, care coordination including team-based structures, better decision support systems and enriched IT and analytics	Multidisciplinary team-based approach to care that has a single point of patient contact to help with continuity of care

Population: What population group is included in the model?

The Complex Patient Care Model Redesign is being piloted in two of ThedaCare's primary care practices, TCP Appleton Internal Medicine and TCP Shawano and focuses on the most high-risk, complex patients in these practices. Using a homegrown risk-stratification algorithm, ThedaCare identifies the top 5% of patients who account for approximately 60% of spending. This risk stratification tool assesses patients using a diverse pool of metrics, including number of chronic conditions, uncontrolled chronic conditions, utilization ED/inpatient services, behavioral/mental health diagnoses, number of medications, socioeconomic status, patient engagement, and provider intuition, along with data from registries held within the EHR.

Through their algorithm, ThedaCare has identified approximately 1,800 high-risk patients in these two clinic sites. Of these, approximately 54% have a diagnosis of diabetes. In these diabetics, 11.9% have an HbA1c above nine so are considered "uncontrolled." Once complex care patients were identified, including those with diabetes, ThedaCare reached out to an initial subset of these patients with a letter of invitation to participate in the intake process. Following the letter, a phone contact was made with over 90% patient contact rate. Of those targeted, nearly 40% of patients set an intake appointment. To test the program before implementing it across ThedaCare, the Complex Patient Care Redesign program is currently pilot testing at 2 clinical sites and randomly selected 100 of Internal Medicine patients to be enrolled in the program as the first cohort. The testing will then be expanded to include a second cohort of an additional 200 randomly selected patients from the original 1800 from the same Internal Medicine clinic.

Performance Measures: What are the types of measures that are used in the model?

ThedaCare was a founding member of the Wisconsin Collaborative for Healthcare Quality and has submitted data for ambulatory patients with chronic conditions and preventative categories for the last 12 years. For the last three years ThedaCare has also monitored the 33 Pioneer ACO measures required as part of the involvement in this CMMI program. For the Pioneer program, ThedaCare currently reports on the following measures specific to the care of diabetes patients:

- ACO 22: Hemoglobin A1c Control (HbA1c) < 8 percent
- ACO 23: Low Density Lipoprotein <100mg/dL
- ACO 24: Blood pressure < 140/90
- ACO 25: Tobacco Non-Use
- ACO 26: Aspirin use in the case of concomitant ischemic vascular disease

- ACO 27: Hemoglobin A1c Poor Control (HbA1c) >9 percent

In addition to the above measures, ThedaCare tracks over 200 other ambulatory and hospital measures, many of which are publically reported.

Continuous Improvement: What system is in place for performance improvement?

For the Complex Patient Care Model Redesign program ThedaCare will monitor all the aforementioned measures but is particularly interested in tracking the uncontrolled diabetic measure as an important clinical outcome. The results of the outcomes measures are monitored by the core leadership team and shared with the clinical care team weekly to monthly. The care team will continue to follow-up with patients not at target and adjust the care plan accordingly, including addressing patient engagement and mental health barriers. The remaining collected performance measures are monitored by the clinic leadership team and shared with the physicians at monthly intervals. In addition, qualitative patient experiences are collected and shared at a monthly Strategy Deployment Review meeting with the senior leadership team.

ThedaCare's program utilizes best practices. For example, pharmacy clinical best practice guidelines for patients with diabetes as well as ThedaCare developed pathways for 17 different disease entities to be embedded into the work flow for providers and the care team. In addition, the care coordinators will be able to guide patients through conversations on advanced care planning using a standard practice process developed at the Gundersen Clinic in LaCrosse, Wisconsin, and adopted by the Wisconsin Medical Society under the Honoring Choices Initiative.[4]

Payment and Incentives: How are financial and non-financial incentives used in the model?

ThedaCare believes that the Complex Patient Care Model Redesign program will significantly improve quality and cost of care for this patient population, leading to shared savings. However, because of their already-low costs, ThedaCare is concerned that the current construct of the Medicare ACO reimbursement formulas provides relatively limited room to support care redesign. A ThedaCare Foundations Grant of $432,000 provided the initial funding to develop the Complex Patient Care Model Redesign program. This grant covers an innovation consulting fee that helped to develop the program model ($150,000) as well as a portion of the salaries for an initial seven additional clinical staff members (approximately $490,000 in salary and benefits).

ThedaCare is working with payers to help them understand the complex care model in hopes of experimenting with risk adjusted partially or fully capitated reimbursement. Risk in their current Pioneer ACO is partially shared between the ThedaCare organization and its providers. This is done through a compensation scheme for PCPs that roughly breaks down to 70% RVU production, 15% financial, and 10% quality, which also includes production from all sources, not just the Pioneer program.

Care Coordination and Transformation: What types of changes in practice are used to achieve care transformation?

The care team collaborates with the PCP to develop a plan of care that is coordinated across providers. The initial intake is aided through forms within the EHR. Each member of the care team is assisted through a navigator with workflow. Upon completion of documentation and recommendations, each member clicks the 'ready to close' button for their role.

In addition, care coordinators become the patients' one point-of-contact for phone calls, messages, follow-up, results, etc. Given the complex nature of care for this patient population, the one point-of-contact allows patients to build a personal, longitudinal relationship with their care coordinator who can address any concerns. The care coordinator is responsible for connecting a patient to another staff member where appropriate. Because the care team is together in one location, immediate answers can often be provided to patients.

ThedaCare Results

The Complex Patient Care Model Redesign program began in December of 2014, and thus has limited results so far. However, preliminary results from the first three months of the program, shown in Table 2 are promising.

Table 2: Preliminary Results for Initial Patient Cohort

	Baseline		**Results**
	All High Risk across ThedaCare Family and Internal Medicine Clinics	Cohort 1: High risk enrolled in program at pilot site	**Cohort 1: High risk enrolled in program at pilot site**
Diabetes: Nephropathy Screening Completed	55% N=3697	60% N=58	64% N=58
Diabetes Uncontrolled: HbA1c >9.0%	13% N=3697	12% N=58	6.9% N=58
Diabetes Controlled: HbA1c <8.0%	76% N=3697	74% N=58	79% N=58
Hypertension Controlled: BP<140	85% N=8420	89% N=85	82% N=85
>3 ED Visits in Prior 6 Months	2.5% N=8420	11.8% N=85	8.2% N=85

The one backsliding measure resulted from ThedaCare's standard protocol for elevated blood pressure not being followed for this cohort for the first two months of the program. Following the identification of this issue, remedial action was put in place and it is expected that this measure will be back on track by the end of the next reporting period. In addition to these results, the pharmacy team has identified multiple opportunities for decreasing costs, reducing the number of medications, and avoiding medication errors through the program.

PART 4: THE FUTURE OF ACCOUNTABLE CARE AT THEDACARE

ThedaCare's goal is to improve management of the most complex, high-risk patients, including those with diabetes, through a team-based care model. The model aims to dramatically improve value-centered outcomes including quality and costs in a sustainable manner. Achieving a dramatic shift will be challenging, however. Some of the main difficulties include:

- Financial support
- Technical and analytic support
- Physician acceptance
- Patient acceptance

Challenges and Policy Solutions

Challenge 1: Financial Support

The current alternative payment models currently supported through CMS and private payers do not provide strong support for transformational ambulatory care redesign. In particular, shared savings and limited shared risk models provide only a limited shift from fee-for-service payment, especially with ThedaCare's relatively low baseline spending benchmark in Medicare. Leaders of the Complex Patient Care Model Redesign program believe that a partial capitation or full risk-adjusted capitation model would be more in line with this type of care model long term. With only a limited shift in payment, getting organizational

support for an extensive shift toward integrated team-based care has been challenging, since the program is still in the proof-of-concept phase and has required new technology and additional staffing.

Challenge 2: Technical and Analytic Support
ThedaCare has invested significantly in data collection and analytics to support better care for high-risk patients. Despite this investment, the program does not yet have the capacity to provide much real-time information back to the care team immediately to guide further action. For example, if a patient from the high-risk panel goes to the ED, her ambulance or registration data would be connected back to the appropriate care coordinator to enable him to engage in the patient's care planning process even before they are evaluated in the ED. However, the program team is providing ongoing outcomes data to the ThedaCare system leadership team to continue to garner support. In addition, the program team is modeling different financial scenarios to understand how the new care model could operationally 'break-even.'

Challenge 3: Physician Acceptance
The team-based care model is a new paradigm for clinicians (physicians, advanced practice providers, nurses, pharmacist, and behaviorist). As a result, getting clinician buy-in can be difficult as this approach is integrated into practice. Concerns among some physicians could include loss of autonomy and control of "their" patients, lack of trust or unfamiliarity of others managing their patients, and fear of not possessing the skills or competency in leading a team of care givers versus handling everything themselves. Fear of the unknown in this new paradigm of care possibly sums it up best. On the positive side, many physicians see this as reinforcement in greater resources to help manage a very complex, time consuming population of patients. The team based care approach will likely have both a short term and long term impact on filling a primary physician gap due to impending shortages. With the appropriate team resources, any given primary care physician should be able to double the number of patients managed in their panel, i.e., managing 4000 patients versus 2000.

Challenge 4: Patient Acceptance
ThedaCare has found the patients were initially skeptical that this program would cost them more or require them to change PCPs. Continual patient education on the value of this model of care is expected to help alleviate patient anxiety and misconceptions. The patient experiences thus far have been very positive once they have completed the initial evaluation. The original fears have not been realized.

Policy Implications
Because Medicare-only shared savings provides only limited resources for care transformation, the program team is seeking to develop more sustainable funding models. Multi-payer, mixed payment model environments can complicate the implementation and scalability of transformations like this one. Early and close communications with payers can help communicate the value of these transformations and ensure their sustainability. The team hopes to use the new ThedaCare ACO Medical Director's knowledge and relationships in the payer arena to help . The team is inviting leaders from commercial payers to see first-hand the innovative redesign work and early evidence of improved outcomes.

Next Steps

- Through June 2015, the new delivery model "prototype" refinement will be fully implemented for the first 300 high-risk patient in one clinic site
- At this "toll gate" review in June 2015, ThedaCare System Leadership Team will determine if the Complex Patient Care Model Redesign program is a viable product with which to proceed with full implementation to all complex patients at the two pilot sites, totaling nearly 1800 patients.
- In summer of 2015, assuming viability, ThedaCare will evaluate how to redesign care for the remaining 95% of the patient population at these two clinic sites that had not been identified as

complex care patients, rounding out a complete redesigned care model for all patients that is customized to each segment of that clinic population.

- Ongoing financial analysis of this new care delivery model will be required to understand what it will take to make this financially sustainable long term – likely requiring more substantial payment reforms like partial or full capitation.
- In the meantime, the program team hopes to secure additional grant funding to help offset cost increases to implement this new model, providing time and resources to prove this total care redesign process and implement more transformative payment reforms.

ENDNOTES

[1] US Census Bureau: State and County QuickFacts. US Department of Commerce, 2015.

[2] The Kaiser Family Foundation State Health Facts. Source: CMS State/County Market Penetration file, March 2012: The Henry J. Kaiser Family Foundation, 2015.

[3] CMS. Pioneer ACO Model. Available online at, and accessed March 20, 2015: http://innovation.cms.gov/initiatives/Pioneer-aco-model/.

[4] Wisconsin Medical Society. Honoring Choices Wisconsin. Available online at: https://www.wisconsinmedicalsociety.org/professional/hcw/.