THE COMMUNITY CARE ALLIANCE OF CHICAGO

Overview Presentation
Outline

1. Who is the Community Care Alliance of Chicago?
2. CCAC Funding
3. Family Health Network: Fiduciary and Operational Support
4. CCAC Governance Structure
5. CCAC Clinical Model of Care
WHO IS THE COMMUNITY CARE ALLIANCE OF CHICAGO?
The Health & Medicine Mission is to promote social justice and challenge inequities in health and health care. We are a 30-year old independent policy center that conducts research, educates and collaborates with other groups to advocate policies and impact health systems to improve the health status of all people.
Access Living

Chicago’s Center for Independent Living, fostering an inclusive society and programs that empower people with disabilities to live independent and self-directed lives, including having consumer controlled and fully accessible health care options.

Advice and consultation on:
- Provider Education
- Consumer Education
- Durable Medical Equipment
- Facility, programmatic and equipment access
- Peer Support
- Possible board recruitment
- Possible consumer outreach
Sinai Health Systems and Schwab Rehabilitation Hospital

Located on the west side of Chicago, Sinai Health System is recognized as a national model for urban health care delivery.

Sinai will provide:

- Clinical expertise.
- Development of the CCAC clinical model of care.
- Advanced rehabilitation facilities and programs.
- Outreach and collaboration with community providers.
- Development and funding strategy
• The only not-for-profit managed care community network serving Chicago and Cook County.
• Will serve as CCAC Fiduciary Agent and will offer operational support.
• Is connected to a network of safety-net hospitals and community providers.
CCAC FUNDING
Innovations Project (state-level)

- Illinois Department of Healthcare and Family Services
- RFP to be released January or February 2012
- Funding expected to begin Fall 2012
- Not grant funding, but a Medicaid contract to provide care/share risk
Center for Medicare and Medicaid Innovation (federal-level)

- Innovations Challenge Grant
- Proposals DUE January 27th, 2012
- Funding expected Spring 2012
- Large grant opportunity: $1 Million to $30 Million awards
Family Health Network (FHN)

- FHN able to provide financial and operational support for the development of CCAC in the beginning stages, until CCAC is able to function on its own
FAMILY HEALTH NETWORK (FHN)

CCAC Fiduciary Agent and Operational Support
Family Health Network Overview

- FHN provides access to cost effective quality health care for people who could not otherwise afford it through enrollment in our health plan and the support FHN provides Safety Net Providers.

- Family Health Network (FHN) is contracted with HFS to participate in the Medicaid Managed Care Program. Founded in 1995, FHN is a not-for-profit corporation directed by local “Safety Net” health care providers with all operations located in Illinois.

- Operational for 15 years, FHN is the only surviving Managed Care Community Network (MCCN) in Illinois. Approximately 15 MCCNs and HMOs have come and gone.

- FHN’s model has been successful because it aligns provider incentives and results in quality care for enrollees. Providers, including hospitals, are rewarded for efficiencies and quality outcomes.
Family Health Network Overview continued

• **Low administrative expense.** General and Administrative (Excl. Marketing) expenses less than 7%. Consistently one of the best performing plans in the country.

• December 1, 2011 enrollment was 69,256 up 29% over the past year.

• **Capitation payment and enrollee list on the first of each month.** Easier to manage patient panel and cash flow. All clean claims paid within 30 days of receipt.

• Provider/Member services unit ranked as one of the best in the country.

• Continuous and significant Quality Improvement.
Starting in 2010, Family Health Network embarked on a multi-year, multi-million dollar strategy to:

1. **Expand access to care** through growth in FHN’s contracted primary, specialty, behavioral health, and hospital network.

2. **Enhance care coordination capabilities** through implementation of the McKesson Clinical Care Management System and a more robust patient centered Care Coordination Model.

3. **Make FHN “scalable” and improve overall health plan performance** through migration to the industry leading* information system platform and participating in the Metro Chicago Health Information Exchange.

*TriZetto’s QNXT system as rated by Gartner Group and Forrester Research
Care Coordination requires…
access to the quality health care services your members need

**Primary Care Physicians**
Start: 568  
Now: 796 (40%)  
+Pipeline: 1,111 (96%)

**Specialists**
Start: 1,565  
Now: 1,797 (15%)  
+Pipeline: 2,551 (63%)

**Behavioral Health**
Start: 271  
Now: 298 (10%)  
+Pipeline: 352 (30%)

**Hospitals**
Start: 28  
Now: 37 (32%)  
+Pipeline: 40 (43%)

Free Transportation/Member & Provider Services/Care Coordinator
Financial Integration... provides the incentive alignment to initiate and sustain care integration

*FHN PFQ program funded out of Admin Pool and HFS withhold/bonus

**Illustrative: Hybrid Global Cap**

- **Hospital Services Pool, 35.5%**
- **Medical Services Pool, 45.0%**
- **Outreach, Education, Enrollment, 5.0%**
- **Med. Mgt, PFQ*, Add’l Member Incentives, Admin., 7.0%**
- **OOA, Burns, Transplants, Reinsurance, Solvency Contribution, 7.5%**

**FHN’s model is designed to:**

- Compensate providers fairly and reward excellence by allowing top performers to earn more
- Offers direct and powerful incentives for providers to drive efficiency and better outcomes
- Encourages medical providers to work in teams and take collective responsibility for a patient’s health
- Provides a realistic framework to transform a fragmented and inefficient system into one that is integrated, accountable, and focused on creating healthy communities
**Managed Care Community Network**

**One Definition:** A provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall cost and quality of care for a defined Medicaid population and regulated by HFS.

**If Provider wanted to participate in Medicaid Managed Care as an MCCN?**

- Risk Management (Insurance Risk), Capital, Financial Integration, Treasury, Accounting, Claims Payment, Capitation Payment, Premium Reconciliation

- Federal and State Regulatory Compliance, Contract Compliance, Legal

- Care Management to include Health Risk Assessment, Risk Stratification, Care Plan Development, Chronic Care Management, Disease Management, Case Management, Utilization Management, Transition of Care, Quality Assurance, PIPs, HEDIS, and Member tracking, reporting, outreach and education

- Member Services, Network Development, Provider Services, and Provider relations, outreach, education and enrollment

- Information Technology, Encounter Data collection and reporting…
CCAC CLINICAL MODEL OF CARE
Definitions

- **Patient**: Medical term referring to a person receiving medical treatment.

- **Consumer**: Term used by disability and other advocates to refer to a person who is expert in his/her own health care needs and is empowered to make choices about medical treatment and to partner with health care providers.

- **Person, client**: Alternative terms that combine concepts of “patient” and “consumer.”

- **Member**: An individual covered by a health plan; payer perspective.

- **Stakeholder**: Any person or organization with an interest in the State’s Innovations Project and, in particular, the CCAC initiative.
CCAC’s Mission is

- to provide high quality, cost-effective, and person-directed services to persons with complex health needs covered under Medicaid.
Underlying philosophy of CCAC

Higher quality care, improved patient satisfaction and cost savings achieved by:

• Decreasing ER visits,
• Decreasing hospitalization rates, and
• Preventing secondary complications through care coordination
Underlying philosophy of CCAC

• Community based services
  • Including in-home care services
• Primary and preventive care services
• Accessible wellness services
• Minimization of all access barriers
• Timely acquisition of all care needs
  • DME
  • Personal Assistance Services
• 24/7 availability of care team who have access to medical records, with development of electronic health records system
CCAC and the Commonwealth Care Alliance

• CCAC model is based on the Commonwealth Care Alliance’s Boston Community Medical Group model of care

• Dr. Robert Master (Commonwealth Care Alliance’s President and CEO) was a featured speaker at an event CCAC hosted in August, 2011
Target Population

Medicaid insured individuals with Disabilities
(subject to modification pending data from HFS)

- Spinal Cord Injury (SCI)
- Traumatic Brain Injury (TBI)
- Cerebrovascular Accident (CVA, or Stroke)
- Neuromuscular diseases including those on home ventilation
- Cerebral Palsy
- Spina bifida
- Multiple Sclerosis
- +/- Intellectual/Developmental disabilities and behavioral health
HFS Medicaid innovations project 3 phases

- Seniors and adults with disabilities
- Children with complex medical needs (with emphasis on transition care services)
- Persons eligible for Medicaid and Medicare (Duals)

*Note that our focus will be on people living in Chicago/Cook County, and in the community (not nursing home population)*
Salient features of clinical care model

- Non-profit
- Person-centered care plan
- Comprehensive care coordination across all levels of care
- Stakeholder (including consumer) representation throughout
- Prepaid, risk adjusted premium
- Wrap around, “all-in” care
- Integration of medical and long-term care services
- Focus on prevention, health and wellness
- Specialized primary care networks:
  - Disability accessible, knowledgeable
CCAC Clinical Model of Care: Birds Eye View

- Consumer/Patient
- CCAC Primary Care Team
- CCAC Wrap-Around Services
What do we mean by “person centered”?

• Care plan is created in a collaborative partnership between primary care coordinator, patient and relevant family/ support people

• Services provided based upon best medical evidence and practice, and informed by consumer/ stakeholder representatives and values

• Care plan goals ultimately driven by principles of patient self-determination and individual health values.
CCAC Clinical Model of Care: “All-In”

CCAC’s clinical care model is based upon a bio-psycho-ecological model of care, encompassing wrap-around, ‘all-in’ care. **CCAC is the intersection of these 3 fields.**
Medical/ Rehabilitation

- Hospitalization (acute, IRF, SNF, LTAC)
- Outpatient primary care and specialty care medical services
- Physical/ Occupational/Speech Therapy services
- **Durable medical equipment**
- Medical Supplies
- Pharmaceuticals
- Medical tests- radiology, labs, etc
- Wound care
- Dietician
- Home Health and personal assistance services
- IV infusion therapy, nutrition, chronic/ community ventilator care
- Orthotics/ prosthetics
- Podiatry
- Ophthalmology
- Hearing aides/ devices
- Dental
- Advance directives/ advance care planning
Behavioral/ Mental health

• Full range of mental health providers (including peer workers?)
• Drug/ alcohol abuse treatment
• Stress management interventions
• Domestic violence and abuse services
• Violence prevention
• Wellness programs (diet, exercise, etc)
• Prevention of secondary complications
• Peer support
• Community Health Workers
• Vocational options
• Respite services
• Disability rights and advocacy resources
Environmental/ Ecological

- Home modifications
- Equipment needs (lifts, shower chairs, ramps, etc)
- Transportation
- Access to entitlement programs for accessible housing, safe neighborhoods, educational programs
- Personal assistance services
- Community mapping of current resources/ and development of needed resources
- Social/ community integration
- Assistive technology
Specialized Primary Care Team Members

- Nurse Practitioners
  - Physiatrists
  - Peer Support Counselors
  - Family Practice Physicians
  - Social Workers
  - Internal Medicine Physicians
  - Registered Nurses
  - Mental Health Professionals
  - Pediatricians
  - Physical Therapists
  - Occupational Therapists
  - Allied Health Providers

Every patient has an assigned nurse practitioner

- Care Team lead = Nurse Practitioner
- Team members employed by CCAC if not employed through Medical Home
Nurse Practitioner: Care Team Leader

• First-line primary care and care coordination
• Communicate with all team members plan of care
• Teaches patient’s identified caregivers needed care functions as needed
• **Weekly** presents patient to disability specific team after admission (team meetings)
• **Monthly** follow ups if no triggers
• **Annually** performs an update of care plan
CCAC Wrap-Around Services

- Provided as deemed necessary by Primary Care Team assessment, and consumer direction
- Wrap-around service providers are contracted partners with CCAC
- Knowledgeable about disability specific issues
Contractual/networked services

Medical specialists knowledgeable about disability specific issues

- Orthopedics
- Neurosurgery
- Urology
- Neurology
- Pulmonary
- Cardiology
- Rheumatology
- Anesthesia
- Psychiatrist
- ENT
- Ophthalmology
- Dental
- Endocrinology
- Plastics surgery
- Gastroenterology
- Respiratory therapy
- Women’s health
- Dermatology
Contractual/ networked services

- Hospital services (academic, community, rehabilitation, LTAC)
- Emergency care
- Outpatient and Day rehabilitation therapy
- Home Health for nursing, wound care, respiratory/ vent care, infusion therapy

- DME providers
- Medical supply companies
- Pharmaceutical providers
- SNF for short term stays
- Orthotics/ prosthetics
- Medical labs/radiology services
Anchor sites

- Dedicated to and knowledgeable about serving the defined CCAC population
- Fully accessible- e.g., sites/ offices/ exam tables/ bathrooms/ medical equipment/ w/c accessible scales/ scheduling/ communication
- Networked with care management tools, EMR, health information technology, and quality metrics
Anchor Sites and CCAC Nurse Practitioners

- Anchor sites will employ CCAC Nurse Practitioners, with funding through CCAC
- The CCAC nurse practitioner will be ‘embedded’ into the Anchor Site
Disability specific and chronic disease management care pathways

• Primary care/ prevention independent of disability: e.g., HTN, DM, cancer screening, diet/ exercise, immunizations

• Disability specific pathways: disability- specific clinical protocols with attention to secondary prevention, disability specific health and wellness recommendations, and quality outcome metrics

• Traditional chronic disease management pathways (e.g., diabetes, asthma, congestive heart failure)
McKesson Care Management Tool

- The McKesson Care Management tool (already in use at Family Health Network, FHN) is a shell.
  - Disease specific prompts/triggers can be built into the system. If we know that certain diseases require attention paid to specific appointments, procedures, etc., we can build this into the McKesson tool to trigger these important clinical procedures.

- McKesson can be tailored to each individual patient
  - We will be able to build disease specific protocols that enable nurse practitioners/other providers to update client’s goals, record communication between provider and patient, and more.
Summary: Special features of CCAC

- Specialized primary care coordinated services
- “All in”, wrap around care
- Focus on community/home-based care
- Consumer/stakeholder representation
- Consumer-driven PA services
- Anchor sites: fully accessible
- Ongoing education about disability specific issues (with CE credit if possible)
- Member newsletter? Articles on health and wellness, disability advocacy, community resources