Meeting Patients Where They Are:
The CareMore @ Home Program

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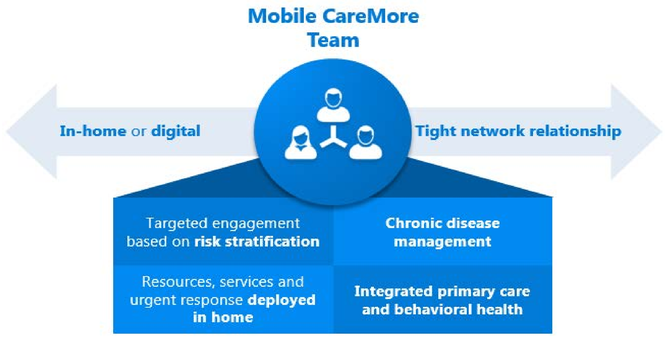
Project Description

CareMore @ Home is a program that provides clinical services in the field for patients who frequent the emergency room and hospital, but do not engage in coordinated outpatient care.

Problem Statement:

How can we get coordinated outpatient care to complex patients in Sacramento who do not go to clinic visits, but frequent the emergency room and hospital? There can be multiple reasons for these gaps in care, not limited to but including co-morbid behavioral health, social needs, or environmental barriers.

Discovery:



- I interviewed 35 Key Informants to garner recommendations for interventions that could best fill this gap in coordinated outpatient care for unengaged patients.
- Large range of ideas and recommendations, ranging from staff requirements to provider training to payment models.
- The scope of solutions often mirrored the area of healthcare of the Key Informant (ex: hospital exec, case management nurse, clinic CMO).
- Based on my interviews and research, I looked to combine several recommendations, instead of just choosing one.
- I led teams at Anthem and CareMore in designing a model of care that focused on a multi-disciplinary field team in Sacramento that would meet the patient outside of the clinic to engage in care.

Goal:

Engage complex patients in outpatient care in the field who have high rates of inappropriate use of emergency room and inpatient facilities, but low rates of outpatient clinic care.

Outcome-oriented Objectives:

- Increase engagement rate during outreach by 20%
- Decrease inappropriate ER use by 15%
- Decrease readmission rate for inappropriate inpatient use by 15%
- Engage up to 2000 complex patients in program (by 2021)
- Increase outpatient engagement (encounters) and connection to patient's medical home and behavioral health specialists
- Increase adherence to quality/HEDIS metrics

Results

Membership Outreach	As of July 5	As of Aug 2
Calls Made	1,756	2,714
Members Reached	352	550
Opt Out	180	213
Opt In	84	170

Encounters	As of July 5	As of Aug 2
Healthy Start/Initial Visits	71	116
Behavioral Health Visits	0	88
Other/Follow up in person	82	146
Telephonic	54	120
Engagements Kept	207	445

Appt. Show Rates as of Aug 2	
Healthy Start/Initial Visits	78%
Overall Show Rate	85%

Lessons Learned

- Multi-disciplinary solutions are needed, but it can be challenging to bring multiple entities together to execute.
- When working between multiple healthcare agencies, it is important to identify Information Technology (IT) solutions early.
- Keep goals patient-centric in order to keep new clinical collaborations moving forward. For patients, small interventions customized to them and consistent follow-through can make big differences in outcomes.

Next Steps:

- Continued patient outreach
- Tracking of encounters
- Tracking/Trending of patient utilization & clinical outcomes
- Shared savings add-on in 2020

Mission Model Canvas

Key Partners
- CareMore Health
- River City Medical Group (RCMG)
- WellSpace Health
- Halo Health Centers
- Collective Medical Technologies (CMT)

Key Activities
- Design mobile model of care for Sacramento population
- Contract creation/agreement
- Solidify funding
- Hire Sacramento team members
- Track metrics

Key Resources
- Funding from Anthem of up to $4M over 3 years
- Premanage access to inpatient an ER census data

Value Propositions
- Increase engagement rate during outreach by 20%
- Decrease inappropriate ER use by 15%
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Buy-in & Support
- CareMore Health
- Anthem Finance
- River City Medical Group

Deployment

CareMore mobile team will consist of MD, NP, SW, CHW and non-clinical coordinators who will provide outreach, engagement and follow-up care Interventions around the clock

Beneficiaries
- **Patients**: timely care and connection where care is most convenient for them
- **CareMore:** establishing a team in Sacramento for Medicaid helps expand out CareMore's model
- **River City Medical Group:** adding wrap-around services for providers
- **Sacramento County:** coordinated care in the field among multiple healthcare facilities and integration with county programs

Mission Budget/Cost

Anthem funding in tiered PMPM payments for up to 2000 program patients through 2021. $4M budget to cover full program needs including but not limited to mobile team staff, IT needs and service delivery.

Mission Achievement/Impact Factors

By adding a multi-disciplinary mobile team to engage and acutely stabilize complex patients, a decrease in ER and inpatient readmissions and an increase in outpatient engagement and adherence would indicate a successful model and program.