MANAGED CARE ROLES IN CARING FOR HIGH-RISK AND HIGH-NEED MEMBERS

Seiji Hayashi, MD, MPH

Lead Medical Director, Government Programs

CARE MANAGEMENT SOCIETY OF AMERICA- CHESAPEAKE CHAPTER

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Overview

- Whole Person Care
- Role of Managed Care
- Stress & Burnout
- Value of Care Management

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About CareFirst BlueCross BlueShield

86 Years
86 years of doing business and investing in care solutions

3.5 Million Members
One of the largest not-for-profit healthcare organizations in the country

9,500 Employees
9,500+ employees and contractors across the mid-Atlantic region

1.7 Million Providers
Access to 1.7 million providers across the United States

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CareFirst BlueCross BlueShield Government Programs

Medicaid
- CareFirst Community Health Plan Maryland

Medicare
- Medicare Advantage- Individual Plans
- Medicare Advantage- Group Plans
- Medicare Advantage- DualPrime- Special Needs Plans (DSNP)

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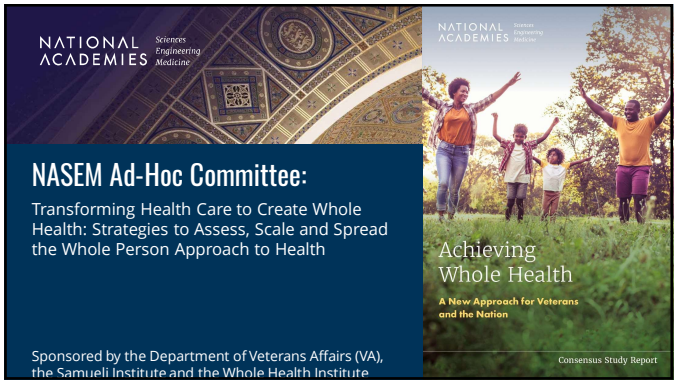

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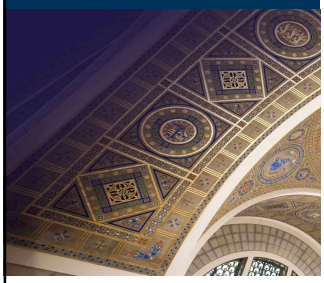
Study Statement of Task



1. Where is Whole Health currently being implemented?
2. What does Whole Health accomplish for the VA and in other systems?
3. How can effective Whole Health strategies spread?
4. What other factors affect the performance of Whole Health?

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Committee Definition of Whole Health & Whole Healthcare

"Whole health is physical, behavioral, spiritual and socioeconomic well-being as defined by individuals, families and communities. To achieve this, whole healthcare is an interprofessional, team-based approach anchored in trusted longitudinal relationships to promote resilience, prevent disease and restore health. It aligns with a person's life mission, aspiration and purpose."

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ACHIEVING WHOLE HEALTH

Five foundational elements of whole health that are necessary for an effective whole health care system.

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Examples of Practices & Systems with Whole Health Characteristics

- **Department of Veterans Affairs**: Whole Health System
- **FQHCs**: Southcentral Foundation: Nuka System of Care, Mary's Center
- **Mental Health Clinics**: Kitsap Mental Health Services "Race to Health!" Program
- **PACE Programs**: Advanced Care for the Elderly (ACE) Program
- **Statewide Initiatives**: Vermont Blueprint for Health
- **Department of Defense**: National Intrepid Center of Excellence (NICoE)
- **International Programs**: New Zealand, Australia, Spain, Germany, Costa Rica

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Assessing Congruence with Whole Health

Foundational Elements:

1. People-Centered
2. Comprehensive and Holistic
3. Upstream-Focused
4. Equitable and Accountable
5. Team Well-Being

TABLE 4-2 Congruence of the SCF/Nuka System of Care with the Foundational Elements of Whole Health

Foundational Elements	Components that Address the Foundational Elements	Nuka Indicators
People-centered	Achieving a sense of purpose through longitudinal, relationship-based care	☑
	People/families/communities direct goals of care	☑
	Care delivered in social and cultural context of people/family/community	☑
Comprehensive and holistic	Address all domains that affect health—acute care, chronic care, prevention, dental, vision, hearing, promoting healthy behaviors, addressing mental health, integrative medicine, social care, and spiritual care	☑
	Attend to the entirety of a person/family/community's state of being	☑
	Components and team members are integrated and coordinated	☑
Upstream-focused	Multisectoral, integrated, and coordinated approach to identifying and addressing root causes of poor health	☑
	Address the structures and conditions of daily life to make them more conducive to whole health	☑
Equitable and accountable	Whole health systems need to be accountable for the health and well-being of people/families/communities	☑
	Care needs to be accessible to all	☑
Team well-being	The health of the care delivery team is supported	—

NASEM, Achieving Whole Health: A New Approach for Veterans and the Nation, Page 133

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The Evidence for Whole Health

- Improved patient experience and reported outcomes
- Increased access, reduced ED usage, fewer hospitalizations
- Improved quality metrics
- Improved outcomes for specific conditions (pain management, mental health, TBI, healthy aging)
- Reduced maternal and infant mortality
- Improved equity, promotion of team well-being, some cost reductions

NASEM, Achieving Whole Health: A New Approach for Veterans and the Nation, Page 157-217

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CareFirst

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Role of Managed Care in Facilitating Whole Healthcare

1. Design benefits to cover Whole Healthcare, including social services
2. Include practices in our network with Whole Healthcare characteristics.
3. Support Whole Health Transformation at healthcare facilities.
4. Support coordination and integration of services by providers, social services agencies and government entities.
5. Support development of new entities that support Whole Healthcare.

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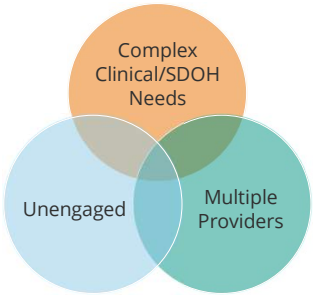
MCO Roles in Care Management & Coordination



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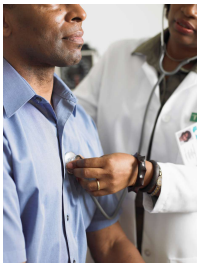
DSNP Member Focus: Top 250 by Cost

Member Characteristics

- **Average age**: 67
- **Geography**: 50% live in Baltimore
- **Cost:** $34,580,350; Avg: $139,437
  - IP Admissions: 746 (Hosp, ARF, SNF, Psych)
  - ED Visits: 478
- **Complex Health Issues**:
  - Cancer, ESRD, CHF, DM, COPD, SUD, SMI, etc..
  - Average Risk Score: 3.0
- **Exclusions**
  - 13 members expired
  - 9 members disenrolled
  - 20 members attributed to VBC Partner



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Logic Model for Improving Quality while Lowering Cost

Resources/ Inputs	Activities	Output	Outcome
• Data • CareFirst • Provider Network • CF Contractors • Community Resources	• Engage Members • Connect to Care • Support Adherence • Address SDOH	• Care Gaps Closed • Reduced ED visits • Reduced inpatient admissions & length of stay	• Higher Quality • Lower Cost
Measures	% Engaged % PCP/Specialist % Needs met	HEDIS, IP Days, #ED/LANE	STARS $$$

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DSNP Daily Rounds

- **Daily Rounds** (30 minutes)
- **Case Discussions**
  - New and F/U prioritized by CMs
  - Prioritized by complexity & urgency
- **Discussion of needs**
  - Medical
  - BH
  - Pharmacy
  - SDOH
- **Identify most impactful intervention(s) and develop next steps**
- **Follow up**

- **DSNP Rounds Team**:
  - Medical Director
  - Care Managers
  - Social Worker
  - Pharmacists
  - Utilization Management nurses
  - Community Health Navigators
  - Project Manager

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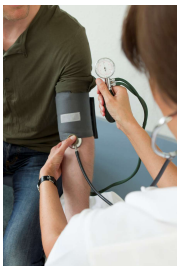
DSNP Member Case Study

45-year-old member with heart failure and chronic kidney disease

Member has 12 ED visits and five inpatient admissions; unable to reach after discharge from hospitals until he is admitted again.

With at-home outreach by a Community Health Navigator:

- Accepted engagement by Navigator
- New PCP established
- Appointment with cardiologist made
- No new ED visits since engagement



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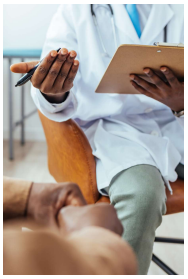
DSNP Member Case Study

72-year-old member with severe COPD on chronic oxygen

Member has been missing medical appointments and not refilling medicines; has been getting small oxygen tanks that last only 30 minutes and needs three tanks to go for a medical visit.

With Case Manager outreach:

- Connected with pulmonologist and ordered a portable oxygen concentrator
- Immediately approved by Utilization Management



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DSNP Rounds: Learnings

Coordinate provider visits
- Prioritize appointment types

Prioritize those we can reach
- Willing members
- IP, ED, SNF, or recently discharged
- Use CHWs
- Don't give up!

DME and supplies are difficult to obtain
- Oxygen
- Wheelchair
- Home safety

Support placement in appropriate levels of care
- LTC Referrals
- SNF vs. Home Health

Support treatment adherence
- Chronic disease medications
- Dialysis
- Diet

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CARE FOR YOURSELF...

SO THAT YOU CAN CARE FOR OTHERS

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Our Aims

Better Care, Better Health, Lower Cost

Workforce Wellness

Health Equity

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Why We Do What We Do

3M's: Meaning, Mastery, Membership

Rosabeth Moss Kantor. Three Things that Actually Motivate Employees. Harvard Business Review. October 23, 2013

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Causes of Stress & Burnout in Healthcare

- Intensely stressful and emotional situations in caring for those who are sick
- Exposure to human suffering and death
- Working conditions with ongoing risk for hazardous exposures
- Long and often unpredictably scheduled hours of work related
- Unstable and unpredictable work lives, and financial strain
- High administrative burdens and little control over schedules

https://www.cdc.gov/niosh/healthcare/risk-factors/stress-burnout.html

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Job Satisfaction

"…autonomy, complexity, and a connection between effort and reward…"

Malcolm Gladwell

Gladwell, Malcolm. Outliers: The Story of Success. New York: Little, Brown and Company, 2008.

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Value of Care Management in the Medical Neighborhood

Schluter. *et al.* Impact of integrated health system changes, accelerated due to an earthquake, on emergency department attendances and acute admissions: a Bayesian change-point analysis. *BMJ Open* 2016;**6**

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Value of Care Management

Better Access, Quality, Equity, Lower Cost, and Patient Experience in care.

Care Management is the **RIGHT THING** to do.

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THANK YOU

SEIJI HAYASHI, MD, MPH, FAAFP
SEIJI.HAYASHI@CAREFIRST.COM
LINKEDIN.COM/IN/SEIJIHAYASHI

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