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Informing Care Coordination Strategies

Summary of Preliminary Findings

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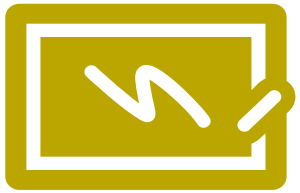
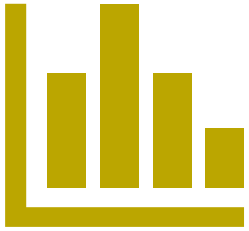
Today's topics



MNCARES Study Overview



Results: A First Look

Small group discussions

Acknowledgement: The research reported in this presentation was funded through a Patient-Centered Outcomes Research Institute® award (IHS-2019C1-15625).

- Project origin - Health Care Homes
- Extensive literature but no best way
- National Academy of Medicine committee
- Fit funder (PCORI) priorities
- Collaborative development of proposal

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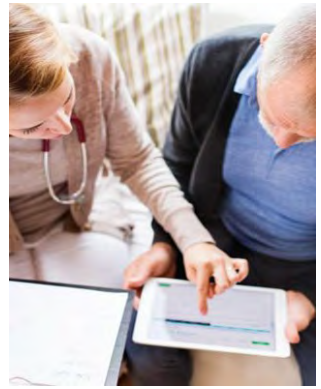

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COLLABORATING PARTNERS

Certified Health Care Home Clinics/Care Systems

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MN Community MEASUREMENT

Payor Organizations

- Blue Cross Blue Shield of MN
- Medica
- MN Dept. Human Services
- UCare
- HealthPartners

Patients

Multiple national expert consultants

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What did we want to learn?

Aim 1. How do patient outcomes compare between Medical/Social vs. Medical/Nursing models?

Aim 2. What are the key components of both models that are associated with better outcomes?

Aim 3. What other organizational, community, care process, and patient factors explain differences in outcomes?

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What patient outcomes did we measure?

Health Care Quality

Composite measure of overall care quality – MN CM

12 months pre/post CC start

Health Care Utilization

Emergency dept. visits & Hospital admissions - payors

12 months pre/post CC start

Patient-Reported Outcomes

General health rating & Clinic rating – patient survey

6-18 months post CC start

What were the compared care models?

The 4 criteria of the **Medical/Social model:**

- ✓ There is ≥1 social worker (licensed or not) who is a part of the care team at the clinic, and
- ✓ The social worker is responsible for assessing and coordinating social services for care coordination patients at the clinic, and
- ✓ The social worker routinely interacts with clinicians at the clinic, and
- ✓ The social worker routinely interacts with care coordinated patients at the clinic

Both care models may still vary in many features

Clinics not meeting all 4 criteria are classified as **Medical/Nursing**

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Who is in the study?

Clinic inclusion criteria

- Adult primary care clinics, Health Care Home certified
- ≥10 adults receiving care coordination
- Agreement to participate fully in study activities

Patient inclusion criteria

- Age 18 or older
- Started care coordination in participating clinics in 2021

For claims-based outcomes only: Insured by MN DHS, Blue Cross Blue Shield, UCare, Medica, or HealthPartners

Who is in the study?

415 HCH-certified clinics
72 care systems

98 clinics Ineligible/declined

317 included clinics (83% of eligible)
42 care systems (64% of eligible)

Medical/Nursing Model
178 clinics (56%)
34 care systems

Medical/Social Model
139 clinics (44%)
22 care systems

care systems are not mutually exclusive

12,711 patients
starting care coordination in 2021

3571 patients (28%)
152 clinics (54%)

9140 patients (72%)
132 clinics (46%)

Who is in the study?

12,711 patients

- **Median age:** 66 years
  - **62%** female
- **60%** White
  17% Asian
  11% Black or African American
  - **4%** Hispanic or Latino
- **Insurance:** 44% state-sponsored
  - **CC visits:** 5 (median)
- **Median per patient:** 6 chronic conditions
  - **90%** have 2+ chronic conditions

Top 6 diagnosis codes by overall prevalence:
Hypertension 58%, Hyperlipidemia 53%, Diabetes 46%, Depression 42%, Anxiety 39%, Low back pain 30%, Osteoarthritis 30%

What have we learned?

A first look at 5 early key takeaways

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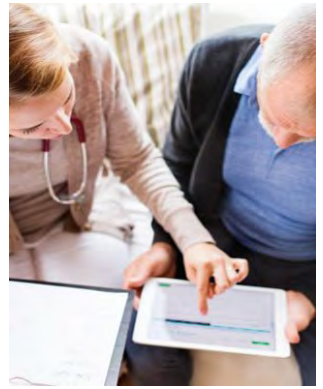

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The following content will be available for viewing during Learning Days 2024. Please reach out to mncares@healthpartners.com with questions.

Thank you!

Contact us *at MNCARES@HealthPartners.com*

HealthPartners Institute: *Leif Solberg and Steven Dehmer*
Health Care Homes: *Dave Kurtzon and Joan Kindt*

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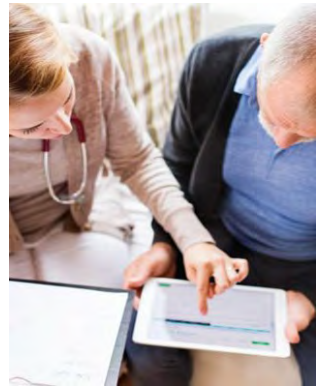

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