Integrated Care Coordination: A 10-Year Journey of Care Management Across a Health System

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SUMMARY

In 2012, Lehigh Valley Health Network (LVHN) launched its first ambulatory care management program with multidisciplinary Community Care Teams (CCTs), comprised of RN Care Managers, Clinical Pharmacists, Behavioral Health Specialists, and Social Workers. Over the last ten years, this program has grown, redesigned, and evolved to meet the increasing demands of transitions of care, care management, and value-based population health. Come along as we review ten years of programmatic models and milestones; and how we leverage data, analytics, and outcomes to continue to "make the business case" for comprehensive, multidisciplinary, patient-centered care coordination.

LVHN continues to focus on the role of social determinants of health (SDOH) in the quality and cost of care. Utilizing a standardized screener, primary care practices assess patient risk for SDOH domains. For patients who are at risk for a SDOH, community-based resources are provided utilizing FindHelp. For patients at high risk for a SDOH, a referral to care management is made for further assessment and intervention. LVHN is also partnering with payers and community-based organizations to address and fund SDOH resources through value-based reimbursement (VBR) arrangements. In the future, LVHN is actively working to incorporate SDOH data into their predictive analytics and risk models to better improve targeted outreach efforts.

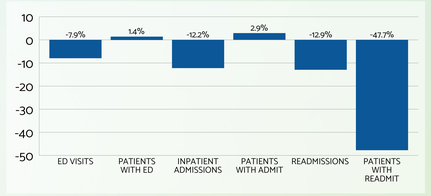

Figure 2. Adjusted Change 2018 compared to 2019 for CCT only. Those patients managed by CCTs, compared to the control group, saw reductions in ED visits by 7.9%, admissions by 12.2%, readmissions by 12.9%, and over $1.8 million in cost avoidance.

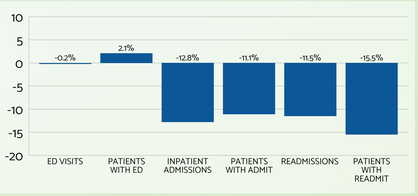

Figure 3. Adjusted Change 2018 compared to 2019 for TOC only. Those patients who received a TOC call (but were not managed by CCT), compared to the control group, saw reductions in ED visits by 7 0.2%, admissions by 12.8%, readmissions by 11.5%, and almost $3.5 million in cost avoidance.

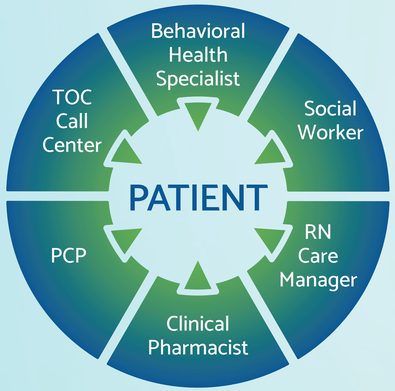

Figure 1. Population Health Model

2012-2014
- CCTs are launched in select PCP sites
- CCTs expand to additional PCP sites
- CCTs supported high-risk patients in 24 primary care practices and had some measurable outcomes to support the model

2015
- Transition of Care (TOC) calls centralized under the TOC Call Center

2017
- Increased interactions with payers and formal VBR arrangements required dedicated resources

2018-2019
- Dedicated care management resources focusing on commercial value-based arrangements launched
- CCTs redesigned into a geographically based HUB and spoke model, expanding their coverage to over 50 primary and specialty practices
- Inpatient CM integration
- Care Navigation/BPCI launch

2020
- All things COVID
- 17th Street practices transition to a FQHC Look-A-Like

2021
- Integration of RPM
- TOC-P, a virtual transition of care practice, launched
- SDOH standardized screening and resource directory launched in primary care

2022
- Increased prioritization of VBR populations as network takes on more financial risk and works to improve quality of care

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