Center for Health Care Strategies
Super Utilizer Summit
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The Issue

- Small percentage of patients account for disproportionate share of health care use and costs
- Heterogeneous population: wide range of medical, behavioral, and social issues contribute
  - No “one size fits all” solution
Approach

• Intervention is intervention
• Payer may alter the way its carried out
• 2 experiences:
  – New York State Medicaid (state agency)
  – San Francisco Health Plan (managed care)
Hospital to Home (H2H)

- SDOH-sponsored Chronic Illness Demonstration Project
  - One of six State Department of Health contracts
- Intensive care management and coordination for fee-for-service Medicaid patients at high risk for frequent hospitalization
- August of 2009-March 2012
  - 540 patients enrolled cumulatively across 3 NYC public hospitals
- Now codified as part of federal Health Homes initiative
Hospital to Home’s task

• Find and enroll SDOH identified high-risk, high-cost fee-for-service Medicaid recipients
  – Predictive modeling

• Goals
  – Reduce Medicaid expenditures (read: hospital admissions)
  – Improve health and social outcomes

• All for $291.50 per patient, per month

• “Supportive housing without the housing”*
  *John Billings
Care team composition/locus

• Staffing Structure:
  • Social Workers supervise Community Based Care Managers (1:25 patient ratio), full-time housing coordinator, some dedicated primary care

• Care Managers required to have high school degree and relevant experience

• Offices (available for patient drop-ins) within 3 HHC hospitals, LOTS of field work
Frequency of contact

• State required minimum of 2 contacts per month, one face-to-face per quarter

• In reality, teams had extensive patient contact, much more than required unless unable to find
Coordinating with other providers

• Extensive in-reach (within HHC) and outreach to community organizations
• MOUs in place for data sharing
• Consents included multiple organizations
• 24 hour on call system
• For some, embedded primary care
Use of technology

- Predictive modeling helped target the “right” patients from the start
- Patient Alert system: automated email alerts to Care Managers
- Provision of cell phones for patients in need
- Program built own database, separate from the EHR: double data entry at times
Complexity of very high cost patients: Enrollee #1
Complexity of very high cost patients: Enrollee #1

<table>
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<th>Time Period</th>
<th>Cost 12 mos PRE</th>
<th>Cost 12 mos POST</th>
<th>Cost 24 mos POST</th>
<th>Cost 32 mos POST</th>
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</thead>
<tbody>
<tr>
<td>12 mos PRE</td>
<td>$150,000.00</td>
<td>$300,000.00</td>
<td>$300,000.00</td>
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<td>$600,000.00</td>
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<td>24 mos POST</td>
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Analysis

• Pre-post analysis comparing 12 months pre-enrollment to 12 months post enrollment
• Patients enrolled for a minimum of 12 months, never disenrolled/reenrolled
• Entire cohort examined in addition to homeless subset
  – Patients classified as homeless if referred to Housing Coordinator and confirmed street or shelter homeless at enrollment
Average monthly Medicaid costs
(program costs included in post period)

- Prior 12 months:
  - Not homeless: $6,000.00
  - Homeless, remained homeless: $3,000.00
  - Homeless, housed: $4,000.00

- First 6 months:
  - Not homeless: $5,000.00
  - Homeless, remained homeless: $2,000.00
  - Homeless, housed: $1,000.00

- Second 6 months:
  - Not homeless: $5,000.00
  - Homeless, remained homeless: $2,000.00
  - Homeless, housed: $1,000.00
Average Emergency Department visits per month

- Prior 12 months
- First 6 months
- Second 6 months

- Not Homeless
- Homeless not housed
- Housed
Average Inpatient visits per month

- Prior 12 months:
  - Not Homeless: 0.200
  - Homeless not housed: 0.700
  - Housed: 0.100

- First 6 months:
  - Not Homeless: 0.200
  - Homeless not housed: 0.700
  - Housed: 0.100

- Second 6 months:
  - Not Homeless: 0.200
  - Homeless not housed: 0.700
  - Housed: 0.100
Average Inpatient days per month

<table>
<thead>
<tr>
<th></th>
<th>Prior 12 months</th>
<th>First 6 months</th>
<th>Second 6 months</th>
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<tbody>
<tr>
<td>Not Homeless</td>
<td>2000</td>
<td>2500</td>
<td>3000</td>
</tr>
<tr>
<td>Homeless not housed</td>
<td></td>
<td>4000</td>
<td></td>
</tr>
<tr>
<td>Housed</td>
<td></td>
<td>2000</td>
<td>2500</td>
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</table>

Legend:
- Not Homeless
- Homeless not housed
- Housed
Critical components

• Hire (and train) the right people
  – Team members act as champions for program, see themselves as accountable for patient outcomes

• Obtain comprehensive, accurate data in advance
  – Outreach and evaluation purposes

• Partner with community based organizations, get consent for or agreement to share information

• Technology
  – Cell phones, patient alert system
Adapting program for a Health Plan

• San Francisco Health Plan absorbed tens of thousands of SPDs due to mandatory enrollment FY 2011-2012
• Limited experience managing complex patient population
  – Behavioral health is carved out
• In Feb 2011, began to help expand and restructure care management program
• SFHP has vast advantages re: cross-system encounter data
Adapting program for a Health Plan

• Prior
  – Phone based brief management of members identified as “high risk” based on HRA phone survey
  – 2 coordinators, 1 RNs, one MSW

• Current
  – Patients identified based on prior utilization and referrals from within SFHP
  – 4 care managers, 2 social workers, 1 RN
  – Expanding presence in community/homes/health care settings, outreach to community partners