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

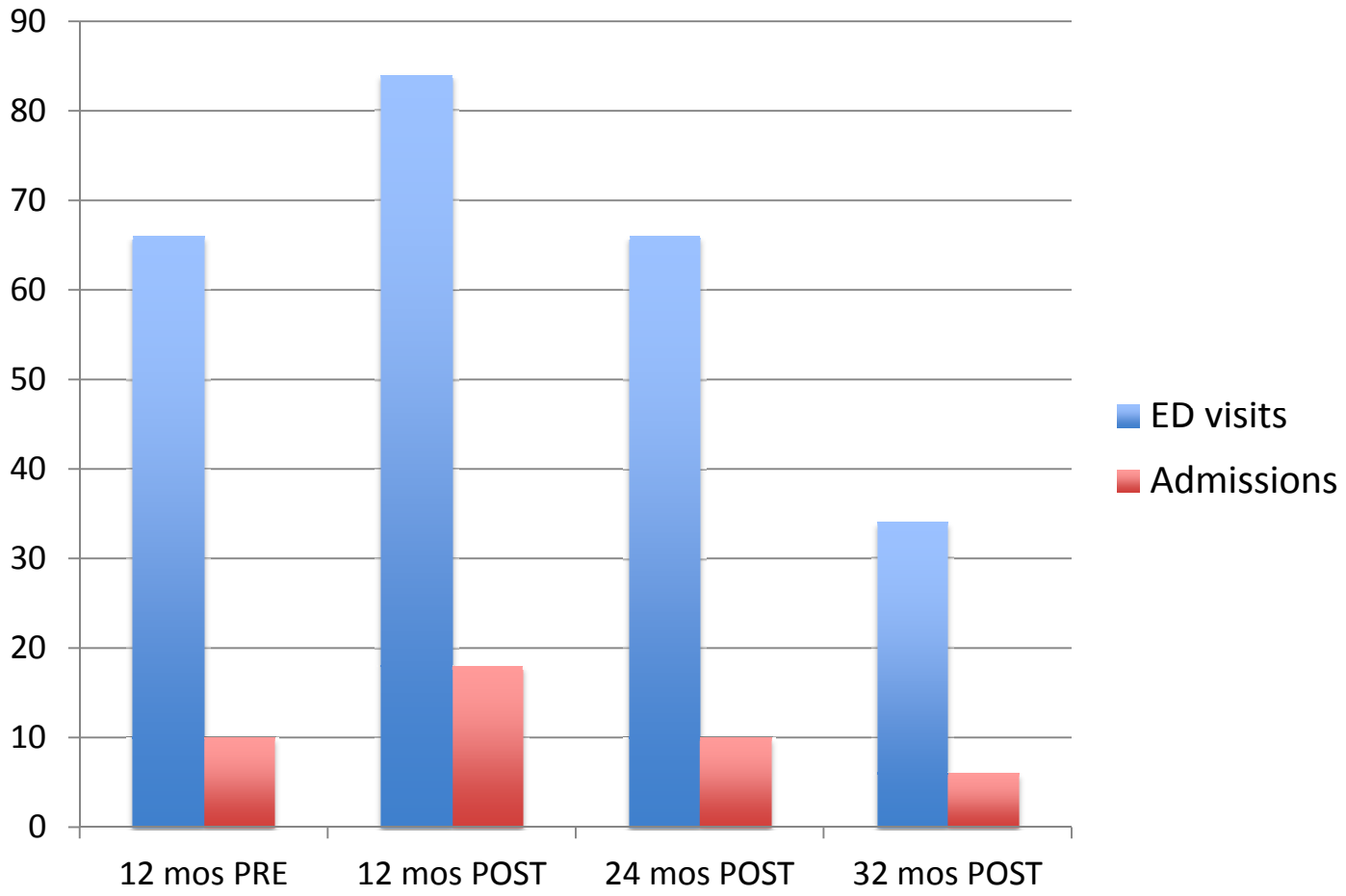
Coordinating with other providers

- 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



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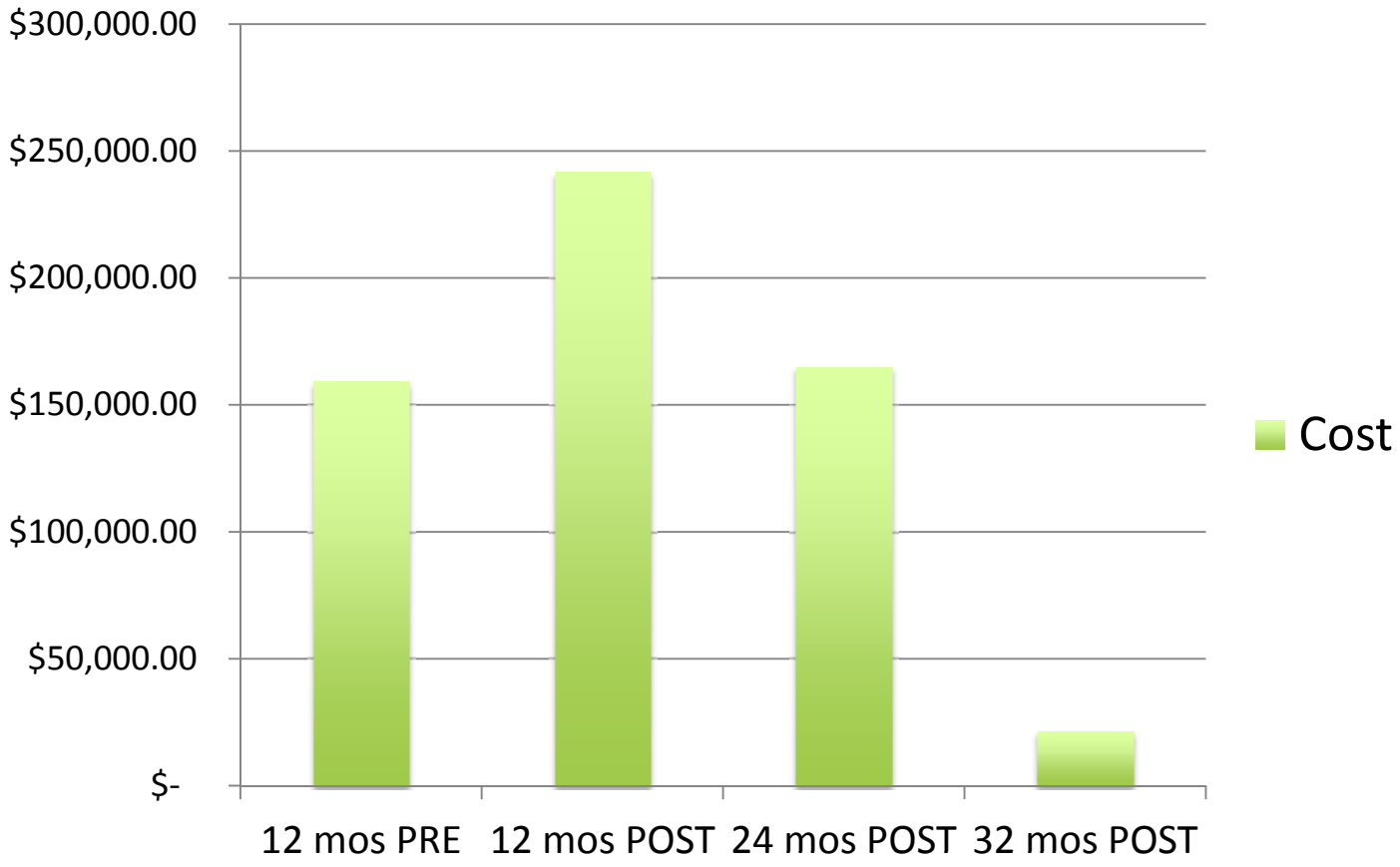
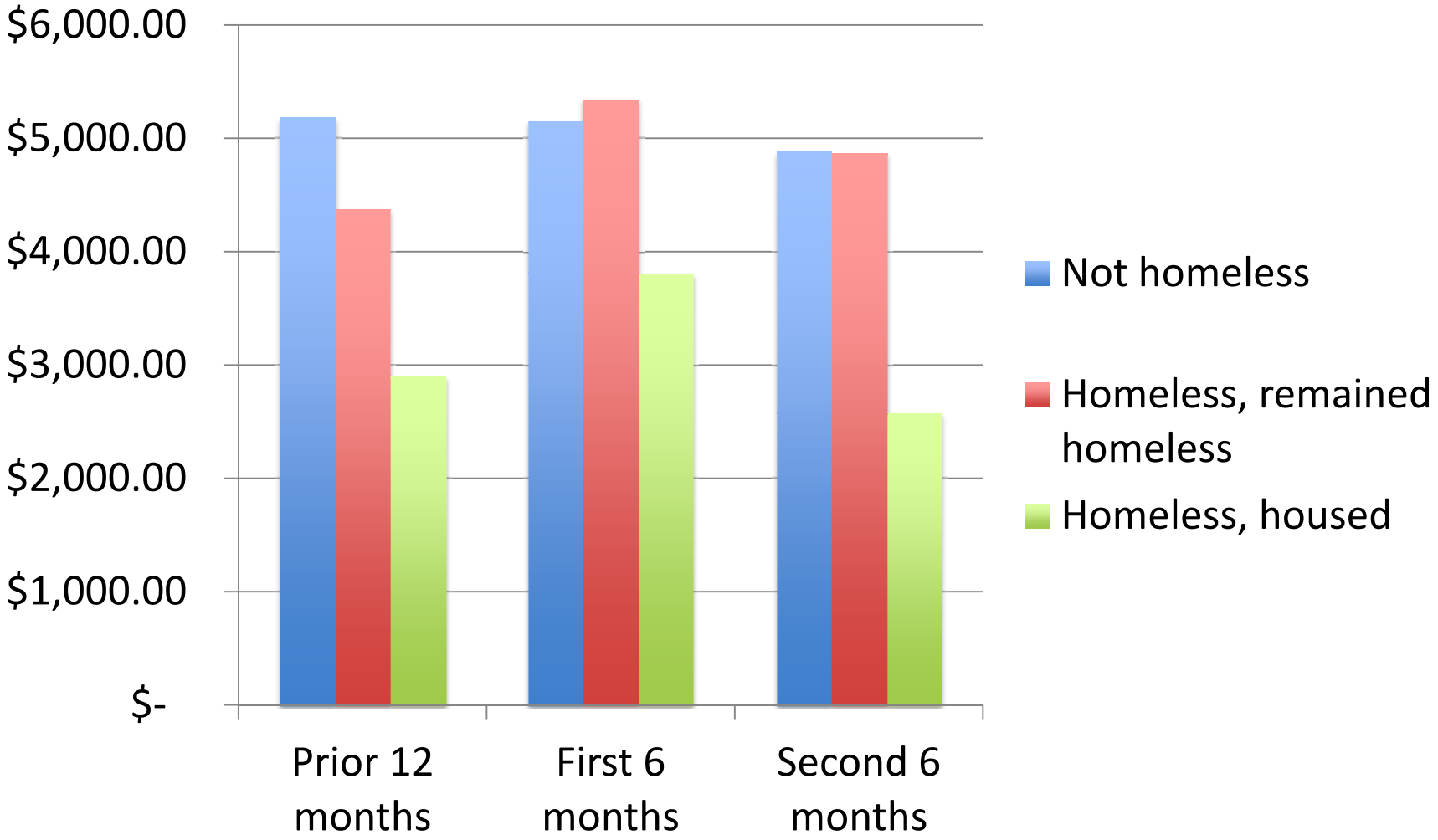


Analysis

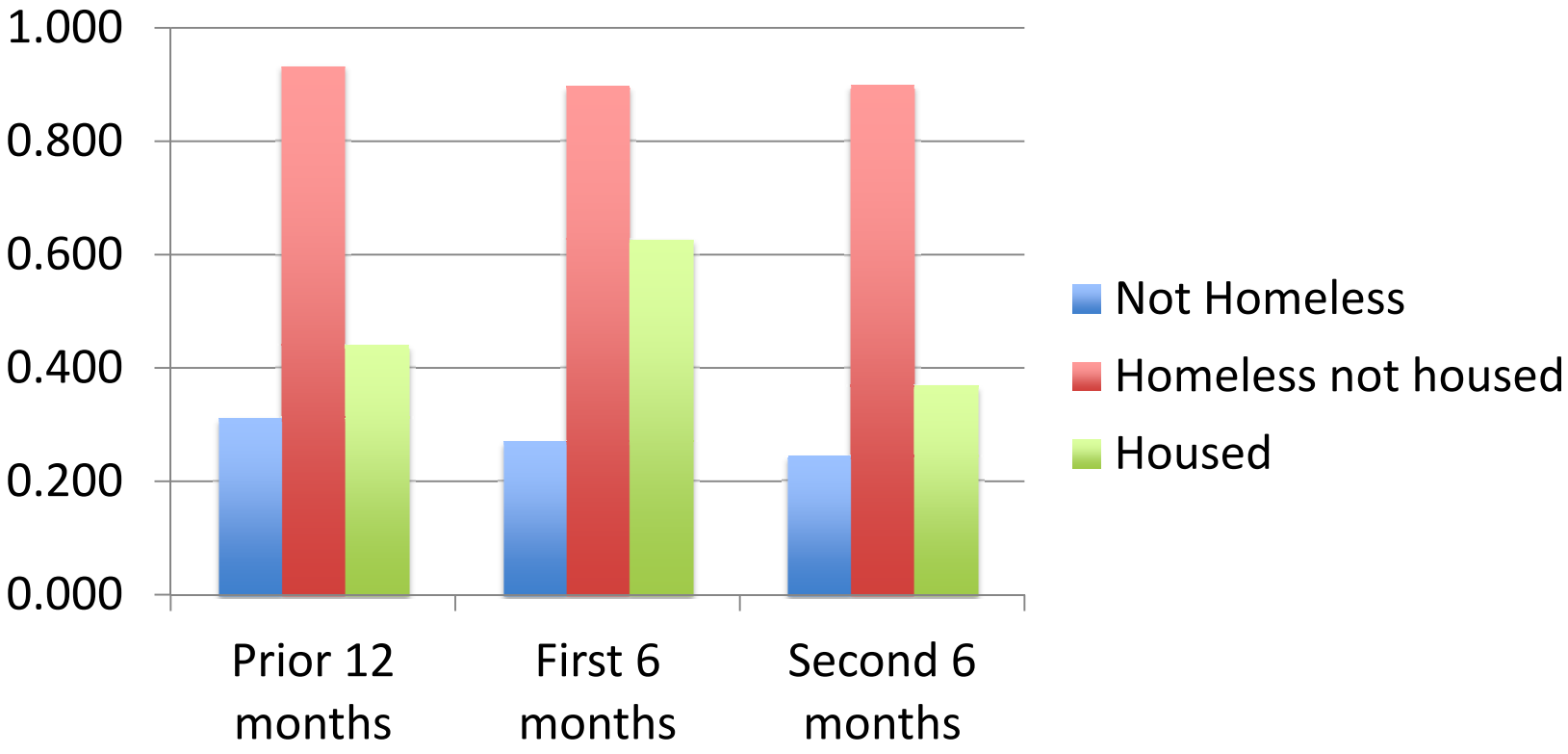
- Pre-post analysis comparing 12 months pre-enrollment to 12 months post enrollment
- Patients enrolled for a minimum of 12 months, never disenrolled/reenrolled
- Entire cohort examined in addition to homeless subset
  - Patients classified as homeless if referred to Housing Coordinator and confirmed street or shelter homeless at enrollment

Average monthly Medicaid costs

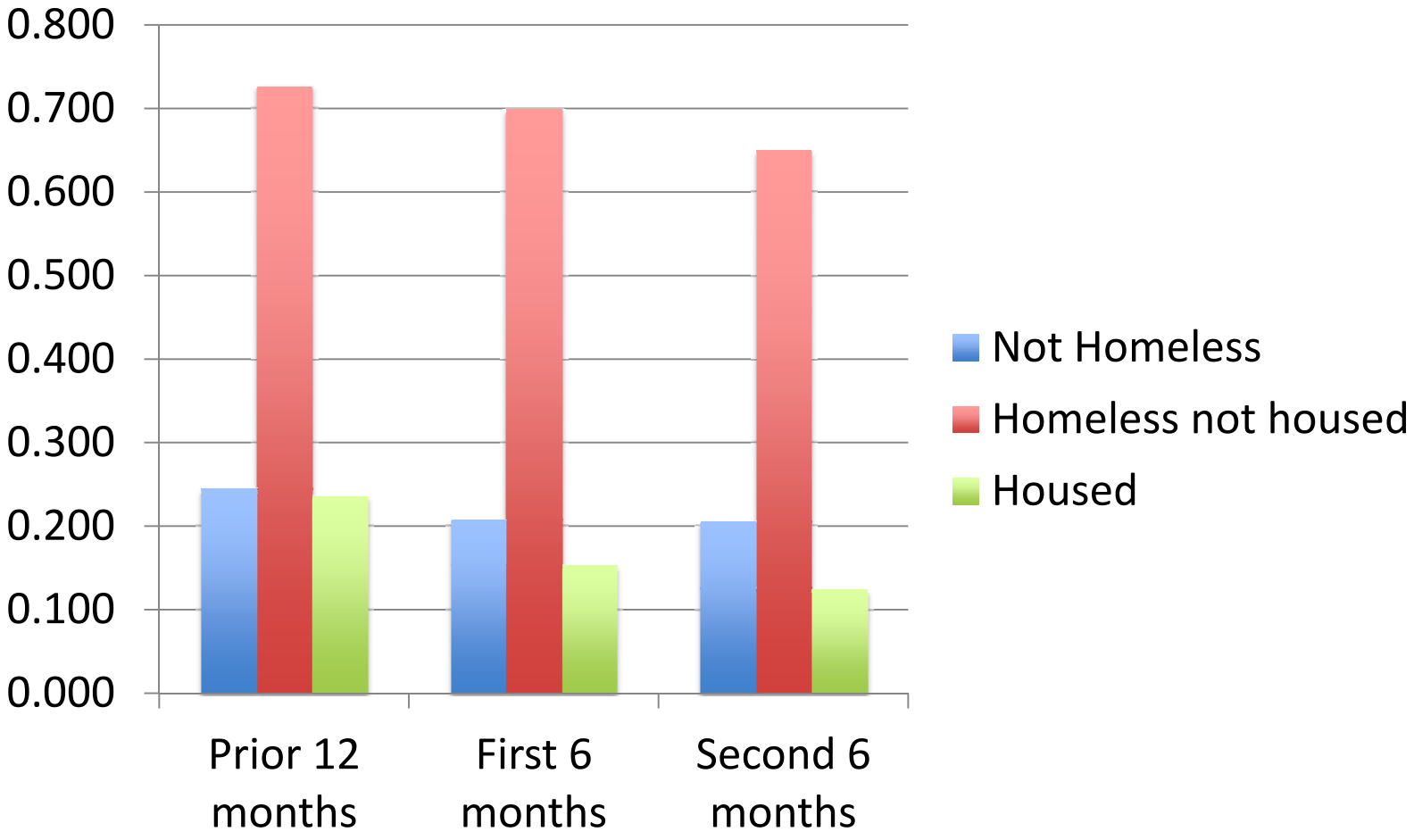
(program costs included in post period)



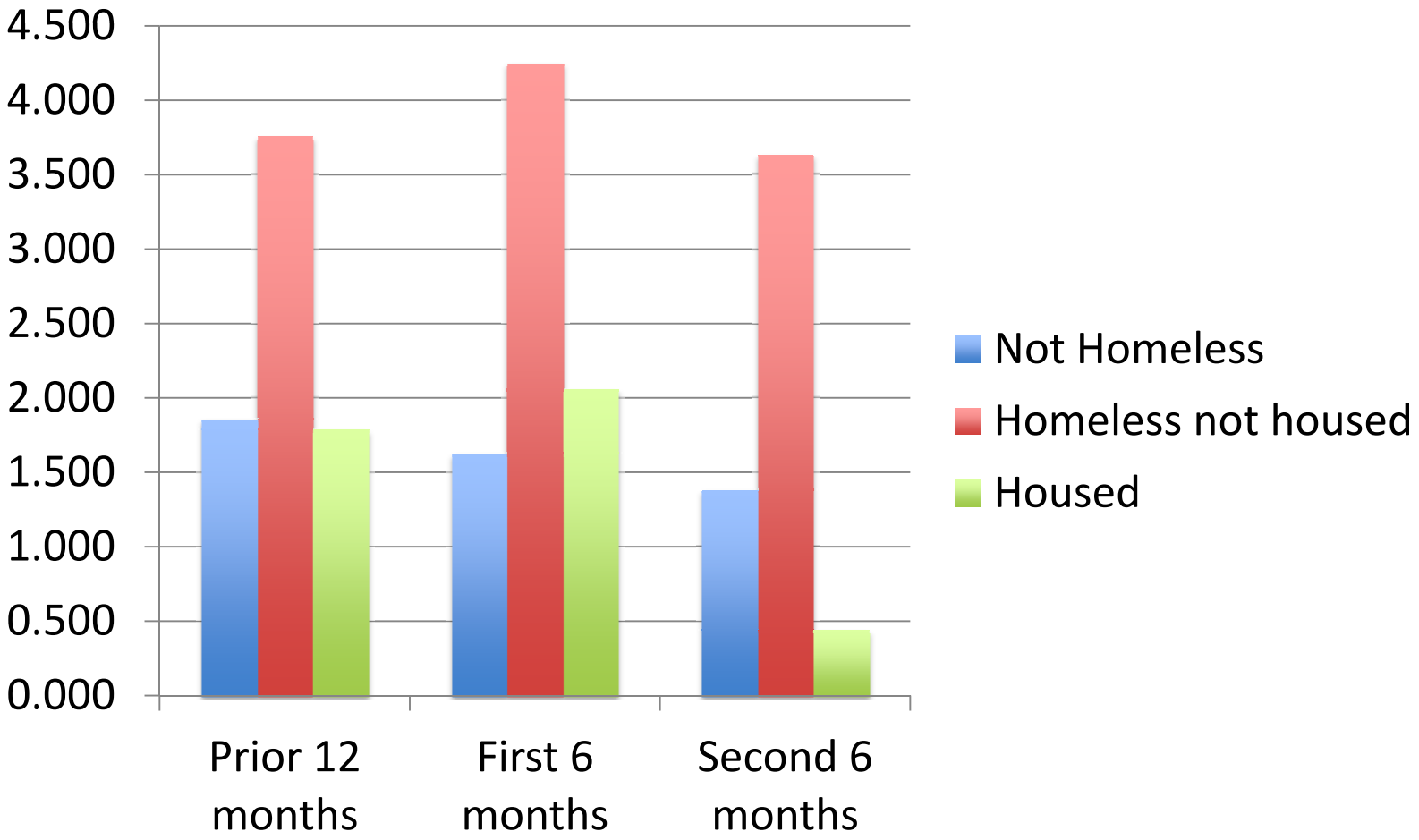
Average Emergency Department visits per month



Average Inpatient visits per month



Average Inpatient days per month



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