SOUTH CENTRAL PENNSYLVANIA HIGH-UTILIZER LEARNING COLLABORATIVE:

Implementing strategies to improve patient outcomes and reduce overutilization
Goals

- Improved patient health
- Integrated, more efficient services (physical, behavioral, and social)
- Cost savings due to reduced inappropriate utilization and reduced readmissions
- A new relationship with community resources
- Share our learning – CHANGE the system
Super-Utilizer Programs in SCPA

- Family Medicine Educational Consortium facilitated initial meetings

- Crozer-Keystone Health System (Delaware County)
- Lancaster General Health (Lancaster)
- Neighborhood Health Centers of the Lehigh Valley (Allentown)
- PinnacleHealth (Harrisburg)
- WellSpan Health (York/Adams/Lancaster)
Lancaster General Health
Innovative Solutions Inc.

Lancaster General Health Care Connections
Lancaster General Health Care Connections

Launched August 2013
As of March 2014, 75 patients enrolled, 13 graduated

Primary care program for the high risk population
  Transitional (3-6 months)
  High Intensity
  Interdisciplinary
  Focus on continuity

Innovation learning lab
  (translating learning to PCMH)

Funding:
  Health System Self Funded
  State Earmark 2013-14
  Working with payers
Care Connections

Care Connections Team
- Extensivist, or clinical leader and "quarterback" for the member’s care
- Advanced Practice Provider (NP)
- Navigators
  - Clinical & Lay Health Worker
  - Community Paramedics
- Social worker/
- Case manager
- Clinical pharmacist
- County Social Services Liaison

The core care team is responsible for coordination (gets what is needed, when it is needed, where it is needed)
Bridges to Health

- Medical Director (PT)
- Physician
- Program Supervisor
- RN Care Manager (1:50)
- Health Coach (LPN)
- Medical Assistant
- Psychology Intern
- PT/OT attending care plan meetings and pts in office
- Access to through co-located practice
  - Dietician
  - Pharmacist
  - Financial case worker
- Piloting College Intern (nursing first then psych/sw/pre-med)
Relationship of Bridges to Health and PCMHs

- WellSpan Bridges to Health
- % Total Healthcare Spend
- % of Members

- Those who are well or think they are well
- Those with chronic illness
- Those with severe, acute illness or injuries
- PCMHs
Bridges to Health to Date

• Recruited since 9/17/12 = 72
• Deceased = 4
• Transitioned back to PCMH = 22
  ➢ Tracking outcomes
• Left Practice without organized transition = 4
• Current enrolled = 42

Chris Echterling MD     cechterling@wellspan.org
Pinnacle SuperUtilizer Program

Hotspotted in Harrisburg

3 Sites
• Internal Medicine residency clinic
• Sr. Independent living complex clinic
• Emergency department

Nadine Srouji, MD, FACP
nsrouji@pinnaclehealth.org
Common Elements to All Programs

- Key: Community Navigation team that coordinates care in patient-centered manner where the patients reside or frequent
  - Broadens focus on "Transitions of Care" which is often limited to mean hospital to office-based settings
  - Home visits, community visits
  - High touch, high frequency—intensive care management
  - Utilization of our Community Life Team as part of Paramedical Program (Medication Reconciliation and Safety Evaluation foci)

- Single Care Plan

- Identify patients in the hospital and see in the hospital

- Multidisciplinary teams

- Medication Reconciliation-- in the home, in the medicine cabinet
Residential Living Center Clinics

- Working with multiple independent senior living facilities
  - These centers were identified as “hotspots” of utilization
  - Approach has been to improve access to care for all of its residents, not just high utilization residents

- Elements:
  - Navigation with an RN and a LSW
  - Physician clinic half day: patients seen in their apartments
  - Contact with hospital team and follow up after discharge; coordinate with PCP and subspecialists
  - Medication reconciliation after discharge
    - Checking that medications filled
    - Reconciling medications in their medicine cabinet with what their discharge medication list shows as well as what they were on before admission
Lehigh Valley
Superutilizer Partnership

Community Exchange: Janelle Zelko, Kathy Perlow
CUNA: Josh Chisolm, Jewel Davis
NHCLV: Manuel Ayala, Abby Letcher
Parish Nursing Coalition: Deb Gilbert, Lisa Cordero
Superutilizer Project
Center for Medicare & Medicaid Innovation (CMMI)
Health Care Innovation Award

• Collaborative Leadership:
  – NHCLV,
  – Congregations United for Neighborhood Action,
  – Community Exchange,
  – Parish Nursing Coalition

• Partnership: Camden Coalition, 3 other sites nationally, Rutgers and CHCS

• Goals: to establish Outreach Teams to support superutilizers in our community, reduce unnecessary utilization and build community support for health

• 3 years funding
Crozer-Keystone Super-Utilizer Programs

- Camden-Cooper-Crozer Hot-Spotting and Super-Utilizer Fellowship
- Residency Health Center-Based Super-Utilizer Program (learning lab for fellows, residents, and students from psychology, pharmacy and social work, as well as Center staff)
- Independence Blue Cross Medicare Advantage Program—Crozer-Keystone Health System-wide, IBC-sponsored proof of concept study to decrease utilization and costs of frail elderly patients
Fellowship Overview
2 days each week with the Camden Coalition for Healthcare Providers

Mentorship from Dr. Jeffrey Brenner
- Business models
- Primary care redesign
- Payment reform
- Leadership training

Northgate II, Camden city hotspot
- Dual-eligible, elderly population
- Fellowship roles:
  - Create new care transitions/coordination program
  - Process improvement

Abigail House, Camden city hotspot
- Nursing home/Sub-acute facility
- Fellowship roles:
  - Interpret utilization data from hospital transfers to drive improved outcomes
  - Advocate for universal advance directive discussion
Fellowship Overview

1-2 day with Crozer-Keystone Family Medicine residency program

- Medicare Advantage pilot program (Independence Blue Cross)
  - Data mining for patient selection and outcome measurement
  - Project/workflow development
  - Staff hiring

- Residency program-based superutilizer project
  - Restructure superutilizer project at all levels
  - Direct participation in home visits, care coordination, and team based care

1-2 days providing outpatient primary care

William Warning MD
williamwarning@crozer.org
Who are the super-utilizers?

- Patient who has frequent, preventable hospital admissions and ER visits
  - What is a super-utilizer?
  - Examples of criteria used by Camden and PA programs for inclusion

- Why are they super-utilizers?
  - System failures
  - Consumer decisions

- Patient profiles from Collaborative programs
  - Demographics
  - Medical issues
  - Behavioral health issues
  - Social service needs
Spaghetti Maps: Visual Care Coordination
Why do patients over-utilize inpatient and ED services?

Most common reasons related to people:

- No strong relationship with a primary care provider
- Have one or more mental health issues (including previous trauma)
- Don’t know how to navigate system
- Don’t know how to manage chronic conditions outside the hospital
- Are uninsured, underinsured or otherwise lack financial access to care

South Central PA High Utilizer Collaborative
How Does our Health Care “Systems” Contribute to the Problem?

- Fragmented care
- Poor communication
- Dysfunctional incentives
- Lack of data
- Lack of recognition of patient barriers and preferences
Neither How we Use Data, Nor Our Payment Model, Makes Sense

- Data not used to maximize better patient health.
- Even with EHR’s, there are major firewalls and obstacles that prevent patients from getting the best possible care.
- A hospital emergency department physician (whose job it is to save lives) has no way of knowing when an incoming patient with chest pains last filled his prescriptions... or when he last got imaging scans or blood work done at another hospital.
This Fractured System Results In

- Unnecessary utilization of services and testing
- Increased preventable and avoidable readmissions
- Care linkage deficiencies — especially in patients with complex medical needs
- Poor patient outcomes
- Much higher cost across the system — and our communities
True to a Greater Degree in the Medicaid Patient Population

- More likely to have greater medical complexities, multiple co-morbidities and therefore seen by multiple providers including behavioral health, drug and alcohol, etc.
- Less likely to have a strong family / social safety net.
- More likely not to be educated about their diagnoses or treatment.
- More barriers to follow through with recommended care.
- The “Balloon” Analogy.
Hospital superutilizers are often the same individuals that are DPW, county human services superutilizers.

By teaming to improve care for the same population, we have potential to reduce utilization of DPW / County human services.

Providers have begun conversations with payers who are looking for a partner – Commercial insurance often is an easier partner -- cannot gain access to the government / Medicaid / public payer data.
Payment Reform For all Involved -- Too Risky Without the Data

- To decrease utilization, need to know:
  - Who to focus on – candidate selection
  - Understand the utilization (Where? When? What?)
  - Baseline and follow-up to judge effectiveness

- Health systems face “de-construction” transformation, workforce retraining and redeployment:
  - Need to understand – how much, what type?
  - Plan for costs/changes
  - In order to understand and plan → need the data
AF4Q SCPA HighUtilizer Collaborative Work to Date

- Started with FMEC
- Learning Collaborative – monthly meetings (webinar – in person Quarterly)
- Facilitate statewide meeting
- Advocate for data sharing/funding pilots with Dept Public Welfare
- Highmark Foundation Grant – THANK YOU!
- Aligning Forces for Quality-South Central Pennsylvania
- White Paper – Combined Data, Core Concepts, Recommendations
## Comparison Table of Programs

<table>
<thead>
<tr>
<th>Structure</th>
<th>Crozer</th>
<th>Lehigh Valley</th>
<th>Lancaster General</th>
<th>Pinnacle</th>
<th>WellSpan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you affiliated with a hospital system?</td>
<td>Crozer-Keystone Health System. (Delaware County, PA)</td>
<td>Lead is FQHC. Pursuing formal agreements with all three major area health networks. (Allentown, PA.)</td>
<td>Lancaster General Health, (Lancaster PA)</td>
<td>PinnacleHealth (Harrisburg, PA)</td>
<td>WellSpan, (York, PA)</td>
</tr>
<tr>
<td>1. Are you affiliated with a FQHC?</td>
<td>Not as part of the SU Program. The residency program staffs a FQHC. One fellow sees patients there as part of the fellowship, but no SU patients there.</td>
<td>Neighborhood Health Centers of the Lehigh Valley.</td>
<td>Informally with Southeast Lancaster Health Services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>1. What are the types of providers and other staff on your team? FTEs?</td>
<td>2 physician fellows (.33 each); .12 psychologist, .12 nurse case manager, .25 MSW student, .08 PsyD student, 10 clinical pharmacist, .05 supervising physician. (Full-time RN case manager with IBC grant.)</td>
<td>1 Parish Nurse, 1 MSW, 1 LPN and hiring a second, 2 community health workers, contracted time of a community organizer, Timebank liaison, 0.2 physician, part-time project manager.</td>
<td>1.5 MD, 1 NP, 4 care navigators, 2 front staff, 2 patient support reps (MA), 1 RN Case Manager, ISW, 5 pharmacist, 2 psychologist, county social service liaison (funded by County Social Services). All co-located in hospital.</td>
<td>0.5 FTE RN, 0.5 SW, 0.5 MD = STAFF AT SITES - social service liaison in living facilities is full time.</td>
<td>1 PCP (internist, FT), 0.3 medical director, plus RN case manager, clinical SW, health coach (LPN), medical assistant, program supervisor (all full-time)</td>
</tr>
</tbody>
</table>
Intensive inter-disciplinary team-based and relationship-centered care

- Integrates behavioral, community and physical health through healing relationships based in trust and empowerment

- Multidisciplinary meetings to create a shared care plan directed by patient goals.

- High frequency of encounters determined by patient needs and goals, often multiple times a week

Outreach – including Home visits ("priceless")

Coordination/Access to Team

- Accompanied visits to hospital, specialist and primary care to support increasing self-advocacy

- Access to "the plan" 24/7

Foundation in high quality, shared data

Shared learning and advocacy - health system and community

Community engagement
The PRELIMINARY Data
Overall Statistics

Total Patients 333 (as of 12/31/13)
Average Age 52.2 years

Payer Class

- Medicare: 59%
- Medicaid: 10%
- Dual: 8%
- Private: 19%
- Uninsured: 4%

South Central PA High Utilizer Collaborative
33% are no longer active with the programs

Reasons:
- 68% Graduation
- 14% Expired
- 8% Patient Choice
- 6% Program Choice
- 4% Lost to Follow Up

South Central PA High Utilizer Collaborative
## Medical Diagnoses

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health (Axis I/II)</td>
<td>89%</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>57%</td>
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<tr>
<td>Diabetes Mellitus</td>
<td>54%</td>
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<tr>
<td>Heart Disease</td>
<td>52%</td>
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<tr>
<td>Chronic Pain</td>
<td>52%</td>
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<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>40%</td>
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<tr>
<td>Renal Disease</td>
<td>37%</td>
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<tr>
<td>Intellectual Disability/Cognitive Impairment</td>
<td>25%</td>
</tr>
<tr>
<td>End Stage Renal Disease with Dialysis</td>
<td>9%</td>
</tr>
<tr>
<td>Hospice</td>
<td>3%</td>
</tr>
<tr>
<td>Frail Elderly</td>
<td>2%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>0.80%</td>
</tr>
</tbody>
</table>
## Social Determinants of Utilization

<table>
<thead>
<tr>
<th>Social Determinant</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Issues</td>
<td>90%</td>
</tr>
<tr>
<td>Transportation Difficulties</td>
<td>62%</td>
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<tr>
<td>Food Insecurity</td>
<td>61%</td>
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<tr>
<td>Adverse Childhood Event</td>
<td>58%</td>
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<tr>
<td>Housing</td>
<td>48%</td>
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<tr>
<td>Functional Illiteracy</td>
<td>40%</td>
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<tr>
<td>Domestic Violence</td>
<td>40%</td>
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<tr>
<td>Language Barriers</td>
<td>26%</td>
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</tbody>
</table>
Exclusion - pregnancy, trauma, cancer, mental health only

Enrollees = at least 1 month with program

Utilization (ED, Observation, Inpatient) for our home systems only (except NHCLV)

“Before Enrollment” = 18 months prior to enrollment in program – then we determine “per month”

“After Enrollment” = utilization since enrollment divided by months of enrollment (includes graduated and currently enrolled)
## Utilization

<table>
<thead>
<tr>
<th>Rate (per enrollee/month)</th>
<th>Before Enrollment</th>
<th>After Enrollment</th>
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</thead>
<tbody>
<tr>
<td><strong>ED Visits</strong></td>
<td>0.26</td>
<td>0.29</td>
</tr>
<tr>
<td><strong>Observation Visits</strong></td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td><strong>Inpatient Visits</strong></td>
<td>0.29</td>
<td>0.19</td>
</tr>
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- **Utilization Rate (per enrollee/month)**: 12%
- **Utilization Rate (per enrollee/month)**: 34%
- **No Change**
Giving patients ‘life’ days outside the hospital

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Before Enrollment</th>
<th>After Enrollment</th>
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<tbody>
<tr>
<td>1.35</td>
<td></td>
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<td>1.40</td>
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<td>1.45</td>
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<td>1.50</td>
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<td>1.60</td>
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<td>1.70</td>
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<td>1.75</td>
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<td>1.80</td>
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<td>1.85</td>
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<tr>
<td>1.90</td>
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16%
Meet Carol

- Link to Carol (WellSpan) video (WITF)


https://www.youtube.com/watch?v=NgfYNPvV30k
Where Do We Go Next?

- Data Use Agreement
- REDCap – combining de-identified but individual patient data
- We need Payer data to “get the whole picture”
- We need to segment the population
  - What works for whom?
- Complete our White Paper
- Continue to learn from each other
Ways to become involved

- Family Medicine Education Consortium (FMEC)
  - [www.fmec.net/](http://www.fmec.net/)
- Camden Coalition of Healthcare Providers
  - [www.camdenhealth.org/](http://www.camdenhealth.org/)
- SCPA HU Learning Collaborative
  - Contact Sam Obeck DNP, Project Coordinator at [sobeck@wellspan.org](mailto:sobeck@wellspan.org)