Reducing Medicaid Readmissions

Webinar 3: High Impact Medicaid-Specific Strategies

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AHRQ Reducing Medicaid Readmissions Project
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Overview: Updating Your Strategy for 2015

1. Data/root causes: write it down, make it known, use it
2. Know who is doing what within hospital & community
3. Design a portfolio of efforts: improved processes, strategic collaborations, new services
4. Model the expected impact of portfolio of efforts

➢ Deliver “enhanced services” if standard care will not suffice
Objectives

- Health systems around the US are providing enhanced services to high-risk populations in order to reduce avoidable utilization.

- Policy and payment expectations are that providers understand and address the social and behavioral health drivers of utilization.

- Identify 3 ways other hospitals are delivering “enhanced services” that are applicable to your hospital.
Hospital Guide to Reducing Medicaid Readmissions
Table of Contents

- Introduction
- Why focus on Medicaid Readmissions?
- How to Use This Guide
- Roadmap of Tools
- Know Your Data
- Inventory Readmission Efforts
- Develop a Portfolio of Strategies
- Improve Hospital-based Processes
- Collaborate with Cross Setting Partners

- Provide Enhanced Services

http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/
Tools
1. Readmission Data Analysis
2. Readmission Interview
3. Data Analysis Synthesis
4. Hospital Inventory
5. Cross-Continuum Team Inventory
6. Conditions of Participation Checklist
7. Portfolio Design
8. Readmission Reduction Impact
9. Readmission Risk
10. Whole-Person Assessment
11. Discharge Information Checklist
12. Forming a Cross-Continuum Team
13. Community Resource Guide

http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/
“There’s always going to be a group of folks that’s going to need somebody to help them. That’s never going to change.”

~ Social Worker, North Philadelphia
Deploying Enhanced Services

- Enhanced services = services that go beyond the standard transitional care delivered to all patients at your hospital

- Enhanced services = redeploy existing staff, reallocate existing resources or investing new resources into new services

- Includes contracting for enhanced services (same concept: paying for, providing services that otherwise are not available)

- *Differentiate from coordinating with / linking to existing services (chapter 5 of the Guide; webinar 2 of series)*
Matrix of Enhanced Services

- On-time home follow up by Pharmacist
- Bedside delivery
- Transportation
- Follow up phone calls
- New facility (sickle cell clinic, crisis stabilization, sobering center)
- Complex Care Team
- Social Worker
- Community Health Worker

Resource Intensity ($)

Shorter

Time horizon (days, weeks, month(s))

Less

More
MINNEAPOLIS — Jerome Pate, a homeless alcoholic, went to the emergency room when he was cold. He went when he needed a safe place to sleep. He went when he was hungry, or drunk, or suicidal.

“I’d go sometimes just to have a place to be,” he said.

He made 17 emergency room visits in just four months last year, a costly spree that landed him in the middle of an experiment to reinvent health care for the hardest-to-help patients here in Hennepin County.

More than 11 million Americans have joined the Medicaid rolls since the major provisions of the Affordable Care Act went into effect, and health officials are searching for ways to contain the costs of caring for them. Some of the most expensive patients have medical conditions that are costly no matter what. But a significant share of them — so-called super utilizers like Mr. Pate — rack up costs for avoidable reasons. Many are afflicted with some combination of poverty, homelessness, mental illness, addiction and past trauma.
Enhanced Services for Patients with High Utilization

**CHCS March 2015 National Scan of Programs**

<table>
<thead>
<tr>
<th>STATE/PROGRAM</th>
<th>KEY PROGRAM DETAILS</th>
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<tbody>
<tr>
<td><strong>ALASKA</strong></td>
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<tr>
<td>- Southcentral Foundation</td>
<td>• Serves Alaska Natives and American Indians in urban and rural areas; provides comprehensive medical, behavioral health, dental, case management, and advocacy services through its Nuka System of Care.</td>
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<tr>
<td><strong>ARIZONA</strong></td>
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<td>- Maricopa Crisis Response Network (Phoenix)</td>
<td>• Serves individuals with excessive emergency department (ED) use, poly-pharmacy, and serious mental illness; includes focus on care coordination, crisis intervention, connections to housing, and collaboration with law enforcement.</td>
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<td><strong>CALIFORNIA</strong></td>
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<td>- Patient Health Improvement Initiative (San Diego)</td>
<td>• Focuses on reducing inpatient and ED admissions through hot-spotting and care team visits; associated with the Multicultural Health Foundation.</td>
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<td>- San Francisco Health Plan</td>
<td>• Provides comprehensive, community-based care coordination services for the plan’s highest-cost beneficiaries.</td>
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<td>- Stanford Coordinated Care (Palo Alto)</td>
<td>• Serves high-cost employees of Stanford University using an ambulatory-intensive care unit (ICU) model with a focus on patient activation to reduce costs/improve outcomes.</td>
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<td>- Alameda Health System (Oakland)</td>
<td>• Serves high-utilizing patients using an ambulatory-ICU approach to coordinate medical and social care within the safety net hospital system.</td>
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<td>- West County Health Centers and Santa Rosa Community Health Centers’ Complex Care Management Project</td>
<td>• Serves the most expensive Medicaid patients, using a medical care team, nurse, and patient navigators to coordinate care with a focus on home care.</td>
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<tr>
<td>- San Francisco Health Network’s Complex Care Management Program</td>
<td>• Serves high-risk, high-cost patients in an integrated delivery system; links patients with a nurse, health coach, and medical management team.</td>
</tr>
<tr>
<td>- Los Angeles Department of Health Services’ Care Connections Program</td>
<td>• Links individuals with complex needs with community health workers.</td>
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*Source: [www.chcs.org](http://www.chcs.org)*
Insights about “Super Utilizer” Programs

- Data is “oxygen for our program”
- Broadly define “risks” – and reassess individuals over time
- Regardless of who “employs” the team, the team is field-based
- Medication management must be done in the home
- Priority placed on frequent contact and in-person
- Focus on engagement, outreach, addressing all needs

http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf407990
$8B Medicaid Transformation Effort: NY DSRIP

Care coordination and transitional care programs:
- Ambulatory intensive care units
- Co-located primary care services in Emergency Departments
- Care transition intervention model
- Care transition intervention model for SNF residents
- Transitional supportive housing

Connecting settings
- Community base health navigation services
- Telemedicine to increase access to services

Behavioral Health
- Community crisis stabilization services
- Community based withdrawal management

http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf
Examples of hospital-provided enhanced services
In Practice: Temple University Hospital

Community health workers connect with patients
Temple University Hospital started a CHW program to augment their efforts to reduce readmissions among heart failure and other high-risk patients. The hospital assigns a CHW to all patients with three or more readmissions in the past year. The CHWs meet with patients as early as possible during the hospitalization and try to meet with the patient multiple times before discharge. This connection while in the hospital makes it much easier to continue the relationship in the post-hospital setting. By design, CHWs meet with patients independently of doctors and nurses. CHWs have noted that patients feel more comfortable telling them about psychosocial and economic problems that may prevent them from adhering to their care plan, such as being unable to afford heat in their home or not understanding what the doctor said.
Addison Gilbert Hospital, Gloucester MA

- Complex care team
- SW, Pharmacist, outreach/coordinator (non-clinician)
- Added pharm tech
- Added NP
- Program manager

Average 47 contacts per patient
Alameda Health System, Oakland CA

- 8 FTE -member transitional care team
- Pharmacist, CHF RN, COPD RN, Social Worker, 2 community health outreach workers (CHOW)
- CHOW came from background of detox center workers
- Program manager, data analyst
- CHOW screen inpatient units for patients with HF, COPD, HIV
- Establish rapport in-house, arrange for follow up quickly
- “Acknowledge reality” of marginal housing, poverty, instability
- Specifically inquire about and discuss substance use
- Accompany, support, touch base, follow up
- RN hold “group visits” as “drop in” in outpatient conference room
- All members of team do home visits

Courtesy of Maia White, Highland Hospital
Target population: most expensive Medicare FFS pts at MGH

Opportunity: Identify in ED, intervene to avoid hospitalization

Intervention: Flag in record to identify patient by registration in ED
  - Patients’ full care team (SW, PCP, specialists) paged
  - Expectation clinicians will go to ED and avert admission

Impact: for every $1 spent, $2.65 was saved

Lessons learned:
  - May not stop patients from behavior of going to ED
  - These patients always “look bad” (physically, or labs)
  - Clinicians who know the patient know what baseline is
  - Partner with ED doc to reassure no substantial change is presents and to assure that close follow up will occur

http://www.massgeneral.org/News/assets/pdf/CMS_project_phase1FactSheet.pdf
In Practice: Successful sickle cell clinics

Johns Hopkins Hospital and two Medicaid managed care plans established a sickle cell clinic. The clinic can respond urgently and efficiently to patients experiencing acute pain crises, keep patients out of the hospital, and provide more expert management. The clinic has reduced total hospital utilization, readmissions, and ED visits and has been recognized as an innovation by the Maryland Department of Health and Mental Hygiene. The Sickle Cell Center for Adults at Johns Hopkins uses an interdisciplinary approach to care, integrating primary care, hematology, social work, home visits, and nonclinical support services such as transportation for their patients.

The Center partnered with two managed care organizations (MCOs), Amerigroup and Priority Partners, to establish a per member per month fee to cover the services beyond direct health care, such as care coordination and case management. With the MCOs supporting the Center’s integrated approach to care, the Center achieved a readmission rate of 24 percent compared with a range of 30.3 to 50.5 percent for comparison hospitals in the University Health System Consortium.

Similarly, the Medical University of South Carolina (MUSC) noted that sickle cell patients made up about 10 percent of admissions and 30 percent of readmissions, most of which were due to a small number of patients. MUSC began offering ED-like services in their university internal medicine clinic (e.g., IV hydration, pain management). A list of frequent utilizing sickle cell patients was given to the ED so that those patients could be sent directly to the clinic. Each patient would receive individualized care plans for acute and chronic care based in the internal medicine clinic instead of the ED.

- 30% of all readmissions
- IV hydration
- IV pain
- Standard, urgent plan
- Several hours LOS
“It’s always been about social work fundamentals: meeting the patient where they are, counseling, teaching, educating. To expect people who are already working and living at a deficit to be able to readily navigate these systems is just unrealistic.”

~ Care Transitions Program Manager
Observations about “Complex Care Teams”

- Deploy a multi-disciplinary team
  - Navigator/outreach/CHW, social work w BH skills, pharmacist

- Address full complement of medical, social, logistical needs
  - Basic Needs: affordable medications, transportation, housing, legal, benefits
  - Social and Behavioral Support: psychotherapeutic support, harm reduction
  - Navigating and Advocating: problem-solving orientation

- Identify using combination of clinical and non-clinical criteria
  - History of high utilization, no PCP, numerous prescribers, numerous meds, behavioral health comorbidities, homeless….not “just” chronic disease

- Don’t over medicalize – whole person, psychosocial
  - Start with the person’s priorities
  - Understand this is about stabilization, shifting patterns of care-seeking
Is it affordable?
“Enhanced services” currently gravitate to the 2 ends of spectrum:
- short-term, low resource intensity (follow up phone calls, transportation) or
- longer-term high resource intensity (complex care team)

- Short term, lower resource – deploy to more at-risk patients
  - E.g.: all patients with any risk factor for readmission

- Longer term, higher resource – deploy to highest risk patients
  - Eg. Super utilizers, active SUD, homeless, etc
Modeling Impact / Cost Efficiency

1. How many discharges in “target population”
   - All patients with any-risk: 75% of all discharges
   - Patients with highest risk: 10% of all discharges (not people = fewer people)

2. What is the expected impact of the enhanced service?
   - Lower intensity service has lower expected impact, eg 5%
   - Higher intensity services has higher expected impact, eg 40%

3. What’s the cost of the service?
   - Lower intensity service is lower cost
   - Higher intensity is higher cost
   - Estimate best-possible (FTE, per-episode)
## Examples

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<tr>
<th>Service</th>
<th># Discharges</th>
<th>RA Rate Pop</th>
<th>Impact</th>
<th>$ Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone call</td>
<td>75% = 3750</td>
<td>16% (600)</td>
<td>5% (30)</td>
<td>$300,000</td>
</tr>
<tr>
<td>Complex Team</td>
<td>10% = 500</td>
<td>40% (200)</td>
<td>40% (80)</td>
<td>$800,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
<th>Net</th>
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<tbody>
<tr>
<td>Phone call</td>
<td>$30/call = $112,500</td>
<td>$187,500 saved</td>
</tr>
<tr>
<td>Complex Care Team</td>
<td>Pharm+SW+CHW = $250,000</td>
<td>$550,000 saved</td>
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In a GBR world, “enhanced services” are high-value investments and are what is needed to meet needs of complex individuals.
Upcoming Meeting & Resource Library

In-Person Learning Session:
- April 1, Turf Valley
- Register here: https://www.surveymonkey.com/r/April1Readmissions

Resources on MHA *Transitions: Handle With Care*
- Slides from today
Thank you!

We welcome your feedback on the webinars and Guide/Tools!

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