Care Management for Medicaid Populations with Complex Needs

National Association of Medicaid Directors Conference
November 8, 2011

Carolyn Ingram
Senior Vice President, CHCS
CHCS Mission

To improve health care access and quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

► Our Priorities
  - Enhancing Access and Coverage to Services
  - Improving Quality and Reducing Racial and Ethnic Disparities
  - Integrating Care for People with Complex and Special Needs
  - Building Medicaid Leadership and Capacity
Agenda

• Define populations with complex needs
  ► Issues/considerations around their care

• Highlight state best practices
  ► New York
  ► Pennsylvania

• Discuss CHCS technical assistance initiatives
Defining Complex Populations

• Broadly defined as high-cost, high-need individuals with multiple chronic conditions and complex needs

• Needs cut across multiple systems of care
  ▶ Physical health care
  ▶ Behavioral health care
  ▶ Long-term care

• Face legal and social barriers that impede care
  ▶ Jail involvement leading to interruptions in eligibility
  ▶ Lack of stable housing
  ▶ Lack of family/support system
  ▶ Lack of knowledge/understanding and resources to navigate the health care system
Realities of Complex Needs

- Top 5% highest-cost beneficiaries account for 57% of $$
- Among the most expensive 1% Medicaid beneficiaries (acute care only), 80% have 3 or more chronic conditions
- 49% of those with disabilities also have psychiatric illness
- The presence of psychiatric illness increases spending and hospitalization rates by as much as 75%

Yet, most are in fragmented and disconnected physical & behavioral health delivery systems

What Ideal Care **CAN** Look Like:

<table>
<thead>
<tr>
<th>WITHOUT INTEGRATED CARE</th>
<th>INTEGRATED CARE</th>
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</thead>
<tbody>
<tr>
<td>✗ Multiple physical and behavioral health providers who rarely communicate</td>
<td>✓ Coordinated care team of providers</td>
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<tr>
<td>✗ Beneficiary confusion regarding how to access the care they need</td>
<td>✓ Dedicated care manager role to help patient navigation</td>
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<tr>
<td>✗ No centralized information sharing across providers</td>
<td>✓ Real-time, comprehensive data available across all providers</td>
</tr>
<tr>
<td>✗ Health care decisions uncoordinated and not made from the patient-centered perspective</td>
<td>✓ Health care decisions based on the individual’s needs and preferences</td>
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<tr>
<td>✗ Serious risk for emergency room use, hospitalization, and/or institutionalization</td>
<td>✓ Dedicated commitment across providers to reduce emergency room use and repeat hospitalizations</td>
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Complex Care Management: Critical Elements

System Level
- Integration (services, data, finances)
- Alignment of incentives
- Performance measurement and accountability
- Stratification and triage
- Team-based care and provider engagement
- Real-time information exchange
- Care transitions
- Medication management

Patient Level
- Patient and family-centered
- Primacy of psychosocial needs
- Prioritization of care
- Self-management and self-advocacy
- Eligibility maintenance
- Peer supports
- Incentives
- Leveraging technology
Examples of State Initiatives

• CHCS has worked with a number of states on “rethinking care” initiatives to create better systems of care for individuals with complex needs

• Initiatives include:
  ► Chronic Illness Demonstration Project (CIDP), NY
  ► Rethinking Care Pilots
    ▪ PA
    ▪ WA
    ▪ CO
Chronic Illness Demonstration Project Overview

- **Goal**: Demonstrate innovative and replicable approaches to effectively care for complex Medicaid populations

- **Target Population**: Complex (non-dual) Medicaid FFS identified through algorithm/predictive modeling

- **Financing Model**: CIDPs at risk in year 2 and 3; opportunity to share in savings

- **Key Project Elements**:
  - Enrollee assessment to develop care plan
  - Multi-disciplinary care team
  - Patient-provider relationship
  - Patient education and self-management
  - Focus on compliance to care/treatment plan
  - Social services and supports
Rethinking Care Pilots in Pennsylvania

• **Goal:** Test innovative care delivery models for individuals with co-occurring physical and behavioral health needs

• **Target Population:** Top 10% of non-dual beneficiaries with serious physical illness and SPMI diagnosis targeted

• **Financing Model:** MCO/PCCM and BHO partnership model with re-alignment of financial incentives

• **Key Project Elements:**
  - Enrollee assessment
  - PH/BH case management
  - Care manager
  - Members linked to medical home
  - Information exchange across providers
The Integrated Care Resource Center was recently established by CMS to help states develop and implement integrated care models for Medicaid beneficiaries with high-cost, chronic needs.

Technical assistance to help states integrate care for: (1) individuals who are dually eligible for Medicare and Medicaid; and (2) high-need, high-cost Medicaid populations via the Health Homes state plan option as well as other emerging models.

Coordinated by Mathematica Policy Research and CHCS.

Visit www.integratedcareresourcecenter.org to submit a TA request and/or download useful resources, including policy briefs, tools, state best practice resources, and the latest CMS guidance.
Health Homes Technical Assistance

- ICRC provides individual TA to multiple states
- TA focused on critical topics for states, including:
  - Defining target population
  - Identifying potential building blocks
  - Developing payment methodologies and maximizing the 90-10 match
  - Implementing in a managed care delivery system
  - Integrating physical health, behavioral health and LTSS
  - Care coordination
  - Overall SPA process
- Group TA will soon be provided through a learning collaborative and webinars
Duals Demo States Technical Assistance

- Duals demo design contracts awarded to 15 states to develop programs that integrate care across full range of acute, behavioral health and LTSS for Medicare-Medicaid eligible beneficiaries.

- CMS developed two financial alignment models to support integration of care:
  - Capitated model
  - Managed Fee-For-Service model

- 37 states (including 15 demo states) submitted LOIs to pursue one or both of the financial alignment models.
  - Programs to be designed and implemented by 1/1/2013.
Visit CHCS.org to …

• **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services

• **Subscribe** to CHCS e-mail Updates to learn about new programs and resources

• **Learn** about cutting-edge efforts to improve care for Medicaid’s highest-need, highest-cost beneficiaries

www.chcs.org
Hot Spots: Managing Complex Populations

Julian Harris, MD, MBA, MSc
Massachusetts Medicaid Director
Executive Office of Health & Human Services
Agenda

- Strategies with Results
  Atul Guwande “Hot Spotters”
- Leveraging MassHealth for Delivery System and Payment Reform
- Complex Populations in MassHealth
- Success and Challenges in Massachusetts
- Massachusetts’ Medical Home Foundation
- Integrated Care for Dual Eligible Adults
- Evolving to ICOs
Strategies with Results
Atul Guwande “Hot Spotters”

- **Camden Coalition - Camden, NJ**
  - 56% reduction in hospital bills
  - High utilizers highly concentrated geographically
  - Physician, nurse practitioner, social worker team – prevention and care coordination with high-cost patients

- **Verisk Health – Waltham, MA**
  - Reduction in preventive care can backfire
  - High utilizers can emerge in absence of primary care investment

- **Medicare Care Management Demonstration at Massachusetts General Hospital – Boston, MA**
  - 15% reduction in hospital stays and emergency room visits
  - Used a nurse at each of 19 primary care practices to improve care coordination for high-cost patients

- **Special Care Center - Atlantic City, NJ**
  - 40% reduction in emergency room visits and hospital admissions
  - Flat monthly fee for each patient; clinic exclusively designed to meet the needs of high cost patients
  - Daily team meeting: 2 physicians, 2 nurse practitioners, social worker, receptionist, 8 health coaches

Atul Guwande’s “Hot Spotters” article was published in The New Yorker on January 24, 2011
## Leveraging MassHealth for Delivery System and Payment Reform

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<thead>
<tr>
<th>MassHealth Members</th>
<th>FFS</th>
<th>MCO</th>
<th>PCC/PCCU</th>
<th>PACE</th>
<th>SCO</th>
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<td>SFY12 Average Members</td>
<td>480,000</td>
<td>494,000</td>
<td>325,000</td>
<td>3,000</td>
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- **Managed Care Organization (MCO) Plans**
  - Complex care management
  - Payer for MA PCMHI

- **Primary Care Clinical (PCC) Plan and Behavioral Health Carve-Out**
  - Creating stronger linkages between primary care and behavioral health care management
  - Payer for Massachusetts’ Primary Care Medical Home Initiative (PCMHI)

- **Program of All-Inclusive Care for the Elderly (PACE) & Senior Care Options (SCO)**
  - Comprehensive care for elders (55+/65+)
  - Lessons for integrated care product development

- **Fee-For-Service (FFS)**
  - Most duals, elders, and people with other insurance
Complex Populations in MassHealth

- Dual Eligibles (Medicaid and Medicare)

- Dual Diagnosis
  - (Mental Health and Substance Use Disorder)

- Multiple Chronic or Disabling Conditions
Complex Populations in MassHealth

- Dual Eligibles (Medicaid and Medicare)
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  - (Mental Health and Substance Use Disorder)
- Multiple Chronic or Disabling Conditions
MassHealth Members Eligible for Medicare (Dual Eligibles)

18% of MassHealth members are Dual eligibles

- account for **39%** of Medicaid spending

- Dual eligibles ages 21-64 ~6% of members
  - 3+ hospitalizations in 2008
  - 32% of Medicare spending
  - 79% with a Serious Mental Illness (SMI) or substance use disorder
Duals with Diagnoses in Two or More Major Diagnostic Areas (Physical, Behavioral, Development) Accounted for More than 80% of Spending (21-64 yrs)

Graph from “Dual Eligibles in Massachusetts: A Profile of Health Care Services and Spending for Non-Elderly Adults Enrolled in Both Medicare and Medicaid,” Massachusetts Medicaid Policy Institute, September 2011.
Spending on duals by service type

- 35% of combined Medicaid & Medicare spending for LTSS
- 22% of combined Medicaid & Medicare spending with to hospital care
- Pharmacy spending represented 13% of combined spending
  - 40% had 5 or more prescriptions
Complex Populations in MassHealth

- Dual Eligibles (Medicaid and Medicare)

- Dual Diagnosis
  - (Mental Health and Substance Use Disorder)

- Multiple Chronic or Disabling Conditions
MassHealth Members with SMI and Substance Use Disorder

- People with a Dual Diagnosis
  - Mental Health
  - Substance Use Disorder

- PCC Plan in FY2010
  - 40% of top 5% most expensive members had dual diagnosis

- Dual eligibles ages 21-64, community non-waiver, 2008
  - 35% had a serious mental illness
  - 30% had a substance use disorder
  - 15% dual diagnosis
  - Spending 78% higher for dual diagnosis community non-waiver members

- Mental health service utilization predicts future high health spending
  - (Colleen Barry, October 2011)

- McGuire and Sinaiko study on costs for different self-reported mental health statuses:
  - $2,077 average total health care costs – excellent, very good, or good
  - $5,370 average total health care costs – fair or poor
Complex Populations in MassHealth

- Dual Eligibles (Medicaid and Medicare)

- Dual Diagnosis
  - (Mental Health and Substance Use Disorder)

- Multiple Chronic or Disabling Conditions
Higher percentage of non-elderly adults with disabilities in MA vs. national average

ADULTS AND NON-ELDERLY PEOPLE WITH DISABILITIES

MASSACHUSETTS, 2009

- Non-Disabled Children: 29%
- Non-Disabled Adults: 40%
- Adults & Children with Disabilities: 11%
- Seniors: 10%

U.S., 2007

- Non-Disabled Children: 25%
- Non-Disabled Adults: 49%
- Adults & Children with Disabilities: 15%
- Seniors: 10%

People with disabilities comprise a larger share of Medicaid membership in Massachusetts than nationally. MassHealth CommonHealth provides opportunity for more people with disabilities to get coverage. Seniors make up about the same portion of Medicaid enrollment in Massachusetts and the nation.

Sources: MassHealth Budget Unit, “EHS Results” www.mass.gov/hum/ehsresult; Kaiser Commission on Medicaid and the Uninsured.
MassHealth Members with Multiple Chronic or Disabling Conditions

- Care management for multiple chronic or disabling conditions

- 13% of PCC Plan with a chronic medical condition common among Medicaid and a BH condition (FY2010)
  - 37% of PCC Plan costs
  - Half of the most expensive top 5% of PCC Plan members

- Duals 21-64
  - 16% had both a chronic physical and serious mental health condition
  - 24% of high utilizers resided in long term care facilities; 76% in community
What can we do?
Primary Care and Care Management

We can intervene with these complex populations by changing the way we think about primary care and care management:

- Comprehensive multidisciplinary assessments, ideally in an individual’s own environment
- Individualized care plans, and flexible resourcing for care plans across care settings
- Clinical team empowerment to “order and authorize” all services
- RNPs can often assess and manage problems that develop at home, in lieu of emergency responses
- DME assessment and management is part of the care planning process
- Behavioral Health assessments and services are integrated into the care planning process
- 24/7 clinical availability and continuity management
- Web based EMR support
Successes and Challenges in Massachusetts

■ Re-orient to paying for outcomes
  – SCO data strongly indicate a reduction in nursing facility use, and ability of SCO to maintain frailer elders in the community longer
  – Medical Homes provides a foundation
  – Shift to environment of paying for outcomes we (and our members) want
    • Fewer preventable hospitalizations and emergency room visits
    • More practical application of prevention and wellness strategies

■ Accountability through Quality Measurement and Data
  – Quality measurement and data as a tool to find and prevent high utilization
  – New approaches for on the ground interventions and effective care management
Massachusetts’ Medical Home Foundation

- **Primary Care Medical Home Initiative (PCMHI)**
  - Key recommendation of MA’s Special Commission on the Health Care Payment System
  - 46 practices, 3-year multi-payer demonstration
  - Primary Care Medical Home is the foundation of delivery system transformation

- **Reframe the role of the primary care practice**
  - Care coordination
  - Care management for most complex patients
  - Integrated behavioral health
  - Enhanced access
  - Team-based care and planned visits
  - Patient-centerededness and patient engagement

- **Challenges to overcome**
  - Integrating payer-based and practice-based care management
  - Sharing information across settings
  - Move from FFS-based payment model
Integrated Care for Dual Eligible Adults

- Dual eligible adults ages 21-64 are a highly complex population
  - Nearly 60 percent have diagnoses in two or more of three major diagnostic categories (physical, behavioral and developmental)
  - Two in three have a behavioral health diagnosis
  - Vast majority live in the community

- MassHealth developing a demonstration to integrate care for dual eligible adults ages 21-64
  - Medicaid and Medicare benefits, plus additional behavioral health diversionary services and community support services
  - Integrated care management
  - Global payment to integrated care organizations (ICO) with the foundation of PCMHs
  - Measurement of ICO performance in key domains, including person-centered care and care coordination

- Key objectives
  - Improve quality of care for members
  - Improve accountability for members’ health outcomes
  - Improve members’ care experience and quality of life
  - Create cost efficiencies for Medicare, Medicaid and providers
Evolving to ICOs (a.k.a. ACOs)

- Principles of medical homes, shared accountability

- Realign incentives to reward care coordination, primary care foundation, behavioral health integration, paying for outcomes

- Care management will encompass a broader range of services

- ICOs can embrace care coordination interventions for high utilizers, and can target their resources where their patients need them

- Policy questions for public payers – different flavors of ICOs for disabled and elder populations?
Medicaid Managed Care: Caring For Complex Populations

Meg Murray
CEO
Association for Community Affiliated Plans
Methods

- Identifying individuals at risk and addressing complex medical and social issues through robust case management
- Integration of physical and behavioral health
- Using plan care managers at the practice site
- Using HIT to improve access to more streamlined specialty care
Congratulations to Shashana Herron: ACAP’s 2011 Scholarship Winner

Participated through Denver Medicaid Choice Plan
An Alternative To Emergency Room Care

Presented to the
National Association of Medicaid Directors
November 8, 2011
BCHN Overview

Eleanor Larrier, MPA
Chief Executive Officer
ABOUT BCHN

- Community-based, not-for-profit organization
- Federally qualified health center (FQHC)
- “Health Center without walls”
- Network of community health centers
OUR MISSION

• Provide access to affordable, quality health care especially for uninsured persons

• Obtain financial and other resources to support programs and services

• Promote disease prevention, early treatment and healthful lifestyles

• Improve the health status of medically underserved communities

Comprehensive, coordinated services
Health care barriers removed
Continuity of care
Elimination of health disparities
Integrated Public Health Systems
Culturally competent environment
Fiscal responsibility
BCHN CONTRACTORS

• Montefiore Medical Center
  - 5 community health centers (FQHCs)
  - 3 school-based health centers
  - Ryan White Early Intervention Services (5 FQHCs and 5 health centers)

• Promesa Systems, Inc.
  - 2 community health centers (FQHCs)
BCHN PATIENT DEMOGRAPHICS (2010)

- 83,402 patients
- 329,247 visits
- 53% Hispanic / Latino
- 30% Black/African American
- 12.8% Medicaid FFS; 44.1% Medicaid Managed Care
- 62.5% Below 200% Poverty Level
EXPANDING MEDICAL CAPACITY IN COMMUNITY HEALTH CENTERS

2006- HRSA BPHC Medical Capacity Expansion Grant

GOALS

• Expand access to affordable, comprehensive care for uninsured and other at-risk populations

• Facilitate community access to public health insurance

• Reduce use of the ED for primary care services

• Promote healthy behaviors

• Link community to local resources
EXPANDING MEDICAL CAPACITY IN COMMUNITY HEALTH CENTERS

- Objective: Recruit and enroll 5,000 new CHC patients by 2008

- Strategies:
  - Recruit, train, deploy patient navigators in target communities
  - Locate a patient liaison in a hospital Emergency Department
BCHN
Emergency Room Patient Liaison/ Patient Navigation Program

Goals:
•↓ ER Visits
•Link people with no Insurance/PCP to care

Follow Up

ER LIAISON

Patient Navigators

Follow Up

ER Patients
•Identify people with no Insurance/PCP

Patient Service Rep.

Medicaid Interviewer

Community
•Identify people with no Insurance/PCP

BCHN Health Centers
•Access to PCP
•Screening for Medicaid
WHO ARE PATIENT NAVIGATORS?

- Ethnically diverse community residents with great interpersonal and communication skills
- Outgoing, friendly, compassionate individuals
- Community advocates familiar with the day-to-day conflicts
- Part-time employees, $10/hr, max. of 9 hrs/week
- High school diploma or GED
PATIENT NAVIGATOR ROLE

- Identify community residents without a PCP or health insurance
- Provide information about our health centers and public health insurance options
- Provide information to promote healthy behaviors
- Reduce cultural, language and literacy barriers
- Prepare utilization reports
ED LIAISON ROLE

- Identify ED patients without a PCP and/or health insurance
- Accept referrals from our Patient Navigators
- Provide information about our health centers and public health insurance options
- Make appointments; facilitate access to health center services
- Prepare utilization reports
COLLABORATION & PLANNING

- Get buy-in from ED & Health Center leadership
- Recruit the ED liaison
- Review ED utilization data
- Establish roles, responsibilities & reporting process
- Logistics: space, orientation, access to information systems, training, feedback
- Establish referral process
Establishing Referral Process

- Review previous and/or current referral efforts
- Identify current ED and health center referral processes
- Document revised processes and get agreement
- Discuss “what ifs?”
- Establish contacts at the health centers to facilitate appointments and resolve issues
PROGRAM IMPLEMENTATION

- Staff Orientation
- Monitoring
- Data collection & analysis
- Feedback
- Corrective actions
CHANGES IMPLEMENTED

- Redesigned patient primary care referral form
- All ED providers notified of the referral procedure
- Additional associate contacts at health centers
- Patient Liaison trained and provided access to make electronic appointments
DATA MANAGER ROLE

• Redesign data reporting form
• Refine referral forms
• Data consolidation
• Data analysis and reporting
<table>
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<th>DATA ELEMENTS COLLECTED</th>
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<td><strong>Non-MMC/MMG/BCHN Referral?</strong></td>
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<td><strong>Referral to Patient Liaison</strong></td>
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<td><strong>New or Repeat Contact</strong></td>
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STUDY METHODOLOGY

• Interventions took place in 2009 and 2010

• ED and Health center visits collected from 7/1/2008 – 6/30/2011

• Visits used for study included all ED and health center visits within the six months prior to and following the intervention date per individual
  • E.g.: Intervention on 1/2/2010 = ED & HC Visits 7/1/2009 – 6/30/2010

• Visit data obtained from both billing and encounter data systems
Patient Liaison Activity:

- 5002 Patients Seen (2009 & 2010)
- Less 34 patients without Medical record number
- Less 1481 patients given information only (no intervention)
- 3487 (70%) patients with interventions:
  - 1967 referred for CHC medical appointments (56%)
  - 132 referred for eligibility appointment at CHC (4%)
  - 1388 referred for both medical appointment & eligibility appointment (40%)
Patient Demographics

Gender, \( n = 3487 \)

- Male, 1260, 36%
- Female, 2227, 64%
Patient Demographics

Age, n= 3487

- 70 and Over (4%): 140
- 65 - 69 (2%): 82
- 45 - 64 (24%): 816
- 30 - 44 (30%): 1049
- 20 - 29 (33%): 1156
- 15 - 19 (5%): 149
- Under 15 (3%): 95
Patient Demographics

Race, $n = 3487$

- Black or African American, $1046, 30\%$
- White, $336, 9\%$
- Multiracial:Other Combination, $1178, 34\%$
- Asian, $63, 2\%$
- Unknown or declined, $831, 24\%$
- Other, $33, 1\%$
Patient Demographics

Ethnicity, $n = 3487$

- Hispanic or Latino, 2006, 58%
- Not Hispanic or Latino, 1202, 34%
- Unknown or declined, 279, 8%
Total ED and Health Center Visits Pre- and Post- Intervention $n = 15,184$

ED Visits, $n = 8058$
- Pre-Interv, 5480, 68%
- Post-Interv, 2578, 32%

Health Center Visits, $n = 7126$
- Pre-Interv, 1030, 14%
- Post-Interv, 6096, 86%
Study Outcomes

Patients were categorized by their continued contact with the ED and health centers

**Active Patients (62%)**: received care at either the ED and/or the health centers in both the Pre- and Post- Intervention periods.

**New Patients (2%)**: started care at the ED and/or health center in the Post-intervention period.

**Lost in Study Patients (34%)**: did not present for care at any study location in the Post-Intervention period. (Included in “No after care” Group)

**Non-Patients (2%)**: did not present for care in either the Pre- nor Post- Intervention periods (Included in “No after care” Group)
Study Outcomes

The frequency of ED and health center visits were compared Pre- and Post-Intervention.

**Positive Outcomes (53%)**: A decrease in the use of the ED and/or an increase in the use of or start of care in the health center

**Negative Outcomes (10%)**: An increase in the use of the ED and either a decrease or absence of use of the health center

**No After Care (37%)**: Individuals not presenting for care at either the ED or health center in the Post-Intervention period (includes those who never received care Pre- or Post-intervention period).
To further examine our intervention results, we looked at both Non-OB and OB Patients.
The percent positive change in pregnancy patients is 87% (278 patients) and in non-pregnant patients is 49% (1583 patients).
Trimester Entry Into Prenatal Care

Trimester Entry into Care FY 2010
n=1187

First, 697, 49%
Second, 535, 37%
Third, 194, 14%
CONCLUSIONS

- Out of the 3487 patients with interventions, 1271 (36%) did not utilize services at the ED or one of the five FQHCs after the intervention.
- Of the remaining 2216 patients:
  - 16% (355 patients) had a negative behavior change.
  - 84% (1861 patients) had some type of positive behavior change.
    - 50% (1118 patients) both reduced ED utilization and increased or started obtaining services at one of the five FQHCs.
    - 12% (269 patients) decreased or stopped using the ED, although their health center utilization did not improve.
    - 21% (474 patients) increased or started obtaining services at the FQHCs, although their ED utilization did not improve.
- Of the 320 pregnant patients, 278 (87%) had positive outcomes. Of the 3167 non pregnant patients, 1583 (49%) had positive outcomes.
LESSONS LEARNED

- Patients can be re-directed from inappropriate ER use
- ED Patient Liaison Model of Care Coordination can be a key factor in the success of new care models: Patient Centered Medical Home; Health Homes; Accountable Care Organizations
- Coordination and follow-up at all levels is key to successful referrals
- Patient Liaison familiarity with both ED & health center processes is essential
- Utilizing the Patient Navigators community knowledge to conduct grassroots outreach is essential
- Recruitment of the right people and team work are crucial
NEXT STEPS

• Develop a follow-up process for Lost to Study Patients

• Survey this group to determine the reasons for not continuing in care

• Fine tune cost savings

• Hire two additional Patient Liaisons in 2012 for wider reach

• Repeat this study in 2012

• Review the data for trimester entry into care for OB patients
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