SUPER-UTILIZERS

USING DATA AND INNOVATION TO TREAT OUR MOST VULNERABLE; AN URBAN AND RURAL PERSPECTIVE

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American Hospital Association
Metro & Small or Rural Hospitals
Executive Engagement Series

American Hospital Association

The Impact of Super-Utilizers on Rural Hospital Emergency Rooms

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Lauderdale County, Mississippi

Demographics of Lauderdale County, Mississippi

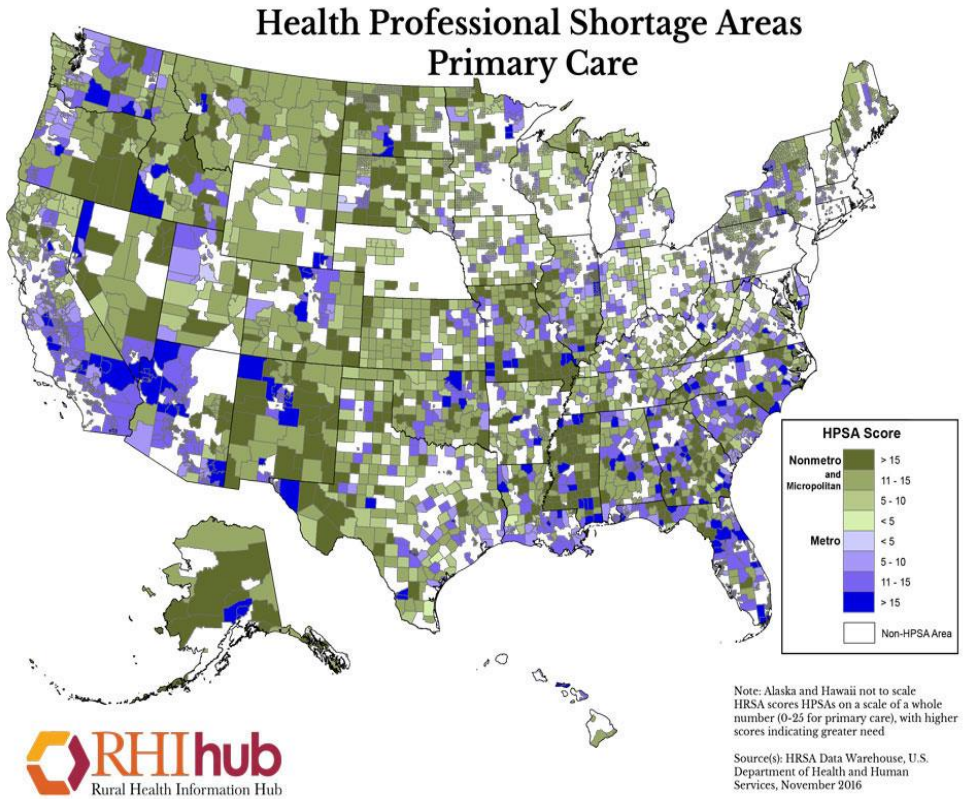
- Total Population Estimate in 2015: 77,755 (-3.1 % since 2010)
- White: 54% African American: 43% Hispanic or Latino 2.2%
- Female: 52% Male: 48%
- Per Capita Income: $21,525 Median Annual Income: $38,132
- Percentage Living in Poverty: 22%*
- Population Under 18 years old: 24%
- Population 65(+) years old: 15%

Employment: 1 out of every 5 jobs in Lauderdale County is related to the medical field. These are also among the highest paying jobs in the community.

Data from www.census.gov

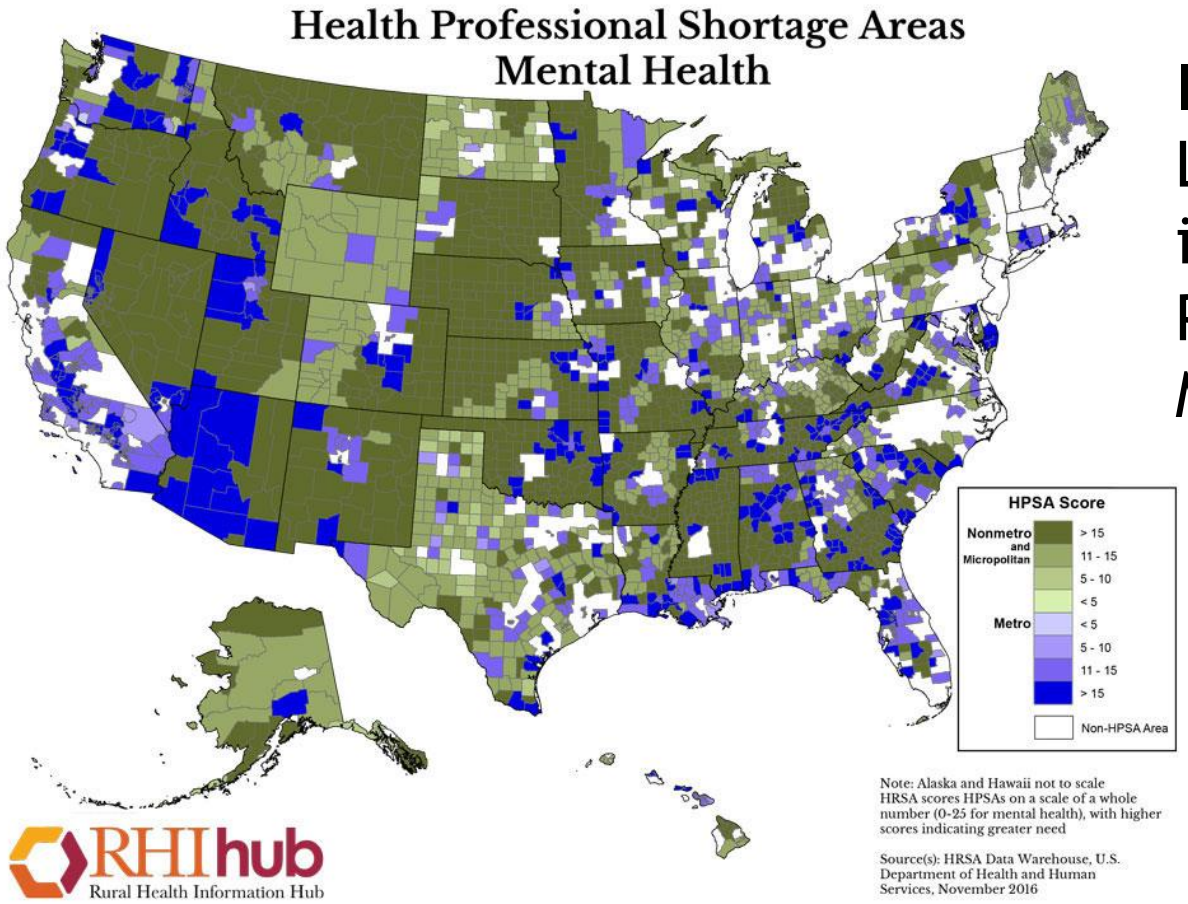
*Estimate based on a survey sample. Actual number may be higher.

Health Statistics for Lauderdale County



In November of 2016, Lauderdale County was ranked as a Health Provider Shortage Area for Primary Care in rural areas (Rural Health Information).

Health Statistics for Lauderdale County



In November 2016, Lauderdale County was identified as a Health Provider Shortage Area for Mental Health Care.

Our Medical Community

Rush Foundation Hospital

- Founded in 1915 as an 18 bed facility
- 102 years later, it is a 215 bed facility

Anderson Regional Medical Center

- Founded in 1929 with 30 beds
- After acquisition of Riley Hospital, Anderson now has 400 beds.

Our Medical Community

Greater Meridian Health Clinic, FQHC

East Central HealthNet Residency Program and Primary Care Clinic

The Hospital Closure Crisis Nears: Who Will be Next?

- November 2015: 31 Mississippi hospitals identified at risk or generally at risk of closure. 20 of them are rural.
  - 3 Financial Indicators
    - Profitability
    - Uncompensated care
    - Medicaid shortfalls
- One third of Mississippi hospitals were at risk.
- In December 2015, Pioneer Community Hospital in nearby Newton closed.

Health Care Providers and Community Leaders on Alert

- Local hospital threatens to close its emergency room due to financial losses
  - Healthcare providers concerned that this influx of patients will overwhelm their facilities and put them financially at risk.
  - Chamber of commerce and business leaders concerned that this news would deter businesses from locating in our area.

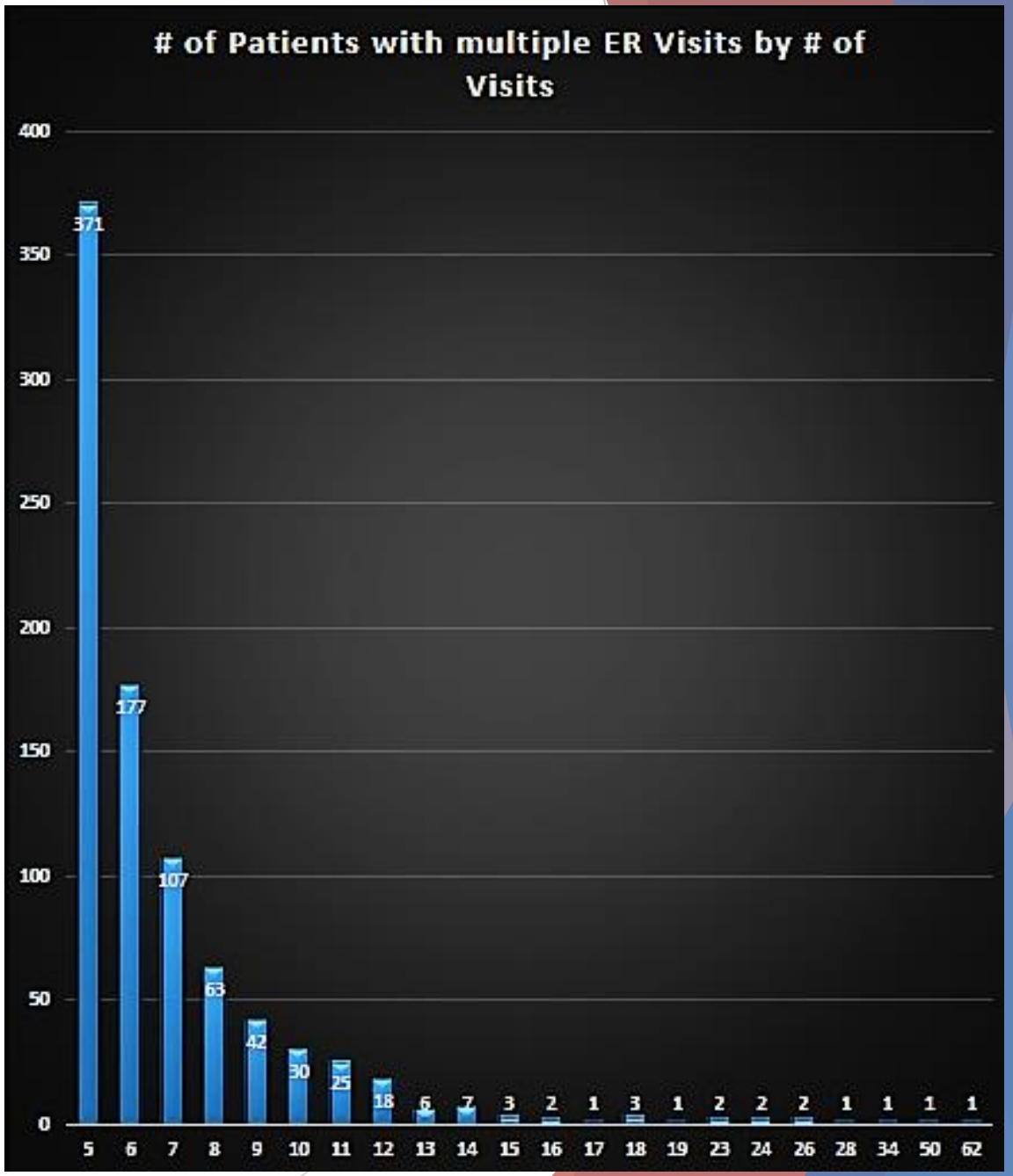
A Community's Response: The Formation of a Planning Team

Healthcare providers and community leaders

- Both acute care hospitals
- FQHC
- Residency program/primary care clinic
- University
- Philanthropic foundation
- Community college's nursing department
- Chamber of commerce
- Housing authority
- Community behavioral health clinic
- For-profit behavioral health hospital
- The Montgomery Institute staff

Rural Super-Utilizers

- 866 “super-utilizers,” individual patients who frequent the ER 5 or more times a year, accounted for 6,002 separate ER visits.
- One hospital reported that their super-utilizers’ combined visits equaled the total number of patients the ER saw in a month.
- Community surveys revealed that patients did not properly understand when a health problem warranted a visit to the emergency room.
- Other patients willfully misuse the ERs for a variety of personal reasons.



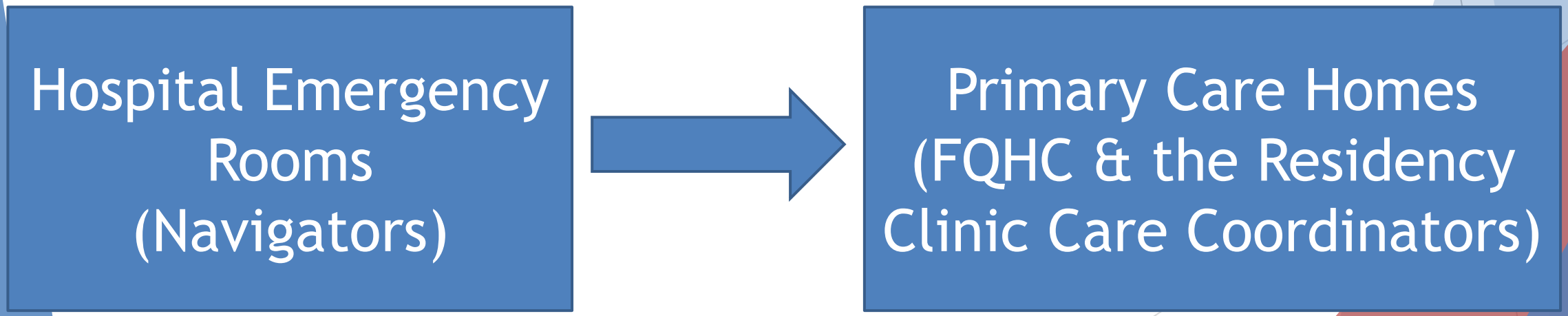
Community Health Needs Assessment: Focus-Emergency Rooms

Key Findings:

- **Misuse of the ER**
  - Perception of “Free” Care
  - Lack of Transportation
  - Convenience
  - Psychological Issues
  - Lack of Compliance with Doctor’s Orders
  - Lack of Family Support/Encouragement

Our Community Response: A Strategic Plan to Improve Healthcare

- Following a model partnership between Jackson-Hinds Community Health Clinic (FQHC) and The University of Mississippi Medical Center, the team created a pathway to move non-urgent patients out of the emergency rooms.



Looking Forward

- Implement our strategic plan to improve access to primary care and reduce ER visits
- Educate citizens
- Find solutions to the lack of access to mental health specialists
- Find funding for the residency program and clinic and the FQHC

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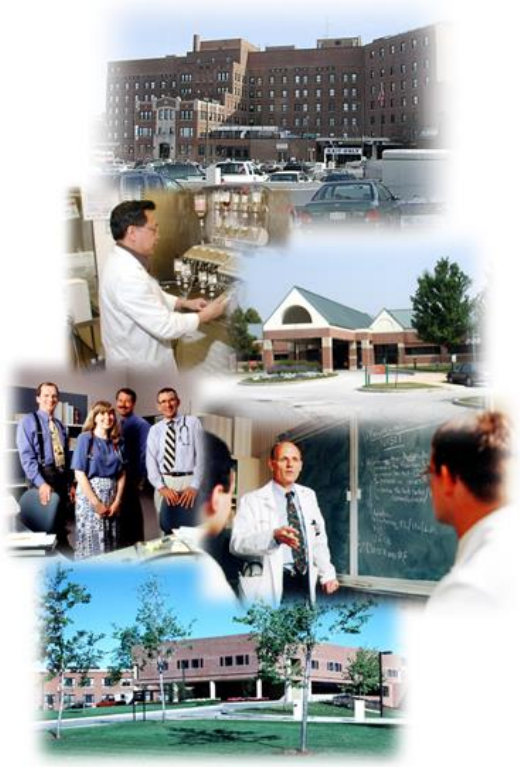
WellSpan® Medical Group

BRIDGES TO HEALTH

Chris Echterling MD
Medical Director – Vulnerable Populations
WellSpan Health

AHA Webinar
June 8, 2017

What is WellSpan Health?



- A community-owned, not-for-profit $1.8 billion annual revenue health system in south central PA with 12,000 employees working in 90 sites of care
- WellSpan Medical Group
  - Over 850+ employed specialty and primary care providers
  - over 1.5 million total visits per year
- 6 Hospitals
  - *Ephrata Community Hospital – 130 beds*
  - *Gettysburg Hospital – 76 bed community hospital*
  - *Good Samaritan Hospital – 172 beds*
  - *WellSpan Surgery & Rehabilitation Hospital – 73 beds*
  - *York Hospital – 572 bed Level I Trauma Center*
  - *Philhaven Hospital - 14th largest behavioral health in US*
- Teaching System- 10 residencies & 4 fellowship programs
- We are NOT a hospital-based system (we do not think of ourselves that way, and less than 40% of revenue is from hospital inpatient activities)

Bridges to Health (SuperUtilizer AICU) History

- Fall 2010 - Charity Care Program leadership looks at spending resources wisely, IHI on-line learning community, 5% → 50%
- Feb 2011 - Jeff Brenner, MD ("HotSpotters") visits York to help kick off pilot
- March – August 2011 – Monthly Superutilizer pilot
  - 12 patients
  - Monthly Community Meetings
    - ED staff, hospitalists, Area Agency on Aging, County Human Service, VNA
- September 2012 – WellSpan Bridges to Health opens
- Redeployment of Inpt. Case Managers (from unit-based to practice-based) and Health Coaches as part of PCMH efforts (Care Coordination Teams)
- Summer 2014 – York County Commissioners agree to embed Case Manager in Bridges to Health
  - Census: 50 patients currently enrolled in the program and 183 patients total enrollment since inception of program.

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Program Basics

Patient recruitment criteria:

- 18 or older
- Par Insurances/uninsured
- PCP WS, FFH or none
- >$50,000 across at least 3 occurrences (admits, Obs or ED)
- Within 25 min drive of office
- EHR clinical review
- Agreement from PCP

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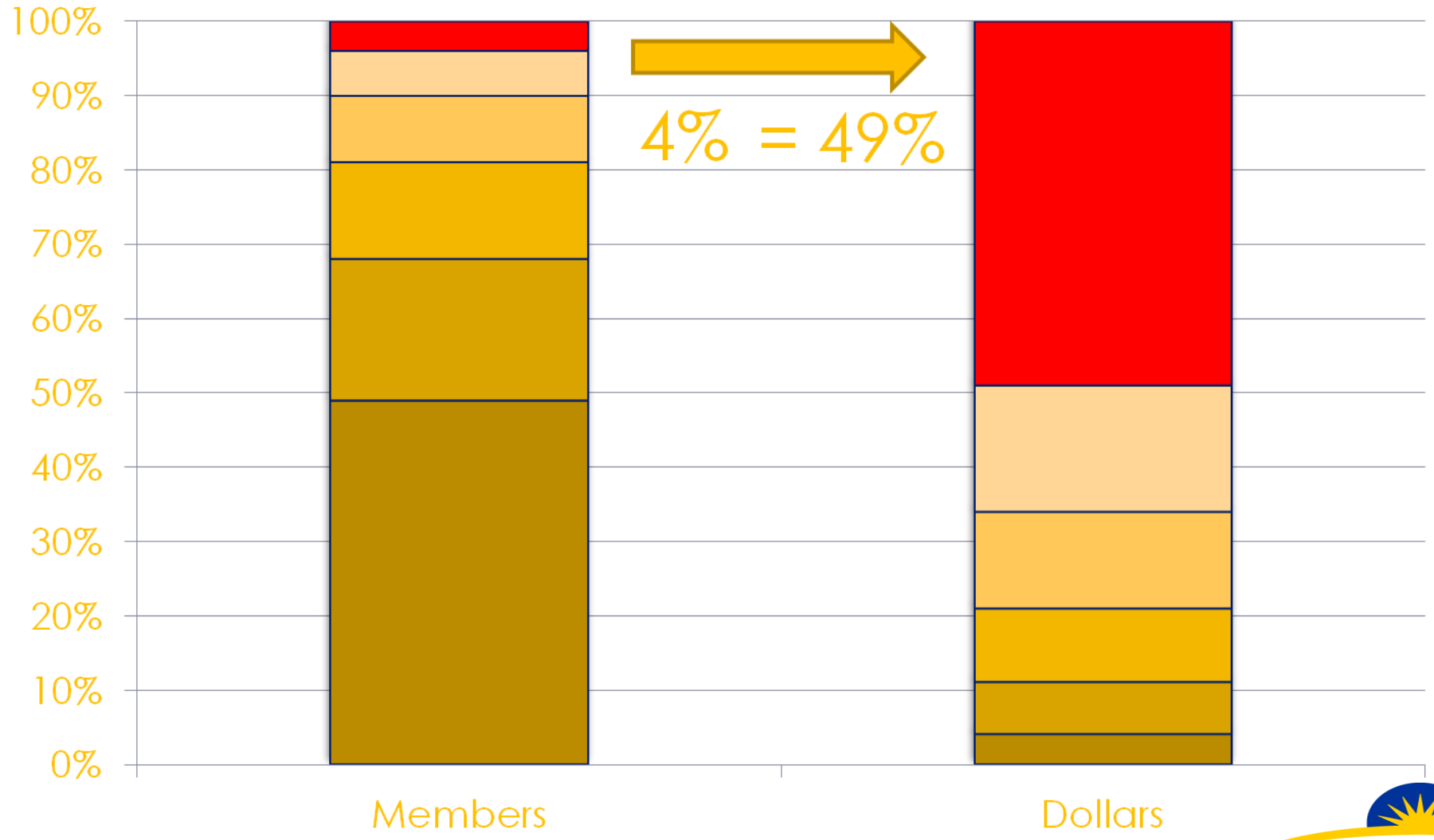
WellSpan Health Claims Paid
(1/1/10-12/31/10 by members and dollars)
Our Data



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Bridges to Health Staffing

- Medical Director (PT)
- Physician (FT)
- Program Supervisor
- RN Case Manager (FT)
- Social Worker
- Embedded County Behavioral Health Navigator
- Medical Assistant
- Psychology pre-doctoral Intern (“Behaviorist”)
- PT/OT attends Team Huddles weekly
- Access to through co-located practice
  - Dietician, Pharmacist, Financial case worker, Smoking Cessation
- Center for Mind Body Health Collaboration

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Patient Assessment

- Bridges to Health Team forms care plan based on:
  - Initial Roundtable discussion (patient and entire team)
    - Discussion on patient and team recommended goals/action steps to better their overall medical health and address psychosocial needs
  - Thorough review of the EHR
  - Clinical assessment (in office by physician with complete med rec)
  - RN case manager assessment (in home with complete med rec, home safety eval ,DME assessment, etc.)
  - Psychosocial assessment (home) by social worker /county worker
  - Ongoing Assessment including periodic Roundtable discussions of shared goals with the team and patient
- Daily Care Team Huddles
- Transition of care visits (within 7 days of hospital discharge) .
- Communication with inpatient team/case managers

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Provided Services

- Scheduled and acute walk-in appointments available (8-4:30PM daily)
- Physician on call 24/7
- Accompanied ”Navigation” visits with patient to key specialist’s visits
- Transition of care visits (within 7 days of hospital discharge) .
  - Team is in constant communication with inpatient team/case managers regarding details of the case and discharge status.
- Interdisciplinary team "huddles” daily - refining care plans on existing patients

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Five Core Element Aims

- **Bridges to Health strives toward these 5 core elements:**
  - **Intensive team-based and relationship-centered care**
  - **Outreach** (home visits, Comprehensive and holistic assessment)
  - **Coordination** (Shared Care Plan, accompanied visits, 24/7 access)
  - **Foundation in high quality, shared data** (patient selection and outcome measurement)
  - **Community Engagement (ACEs, spreading learning – community care coordination meetings)**

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Meet Julia

31 year-old female

Medical Diagnosis:

- Type 1 Diabetes
- Gastroparesis/history of Sepsis
- Chronic kidney disease
- C. Difficile
- Factitious Disorder, Anxiety, and Depression

Julia began with Bridges on 10/16/12

Julia's Utilization: (Payer-United Medicaid)

2012	$1,228,402
2013	$529,198
2014	$310,215
2015 (annualized)	$99,330

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Patient Characteristics

Percent of SU Patients with each Diagnosis

Behavioral Health (Axis 1/11)	89%
Chronic Pain	52%
COPD	40%
Diabetes	54%
Substance Use	57%
ERSD w Dialysis	9%
Frail Elderly	2%
Heart Disease	52%
HIV/AIDS	0.80%
Hospice	3%
Intellectual Disabilities/ Cognitive Impairment	25%
Renal Disease	37%

Percent of SU Patients with each social determinants of utilization

Childhood Trauma	58%
Domestic Violence	40%
Financial Issues	90%
Food Insecurity	61%
Functional Illiteracy	40%
Housing	48%
Language	26%
Transportation	62%

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South Central Pennsylvania High Utilizer Collaborative Partners

Penn Medicine Lancaster General Health

Crozer-Keystone Health System

WellSpan Bridges to Health

PinnacleHealth

NHCLV

It Takes a Neighborhood To Build a Healthy Community

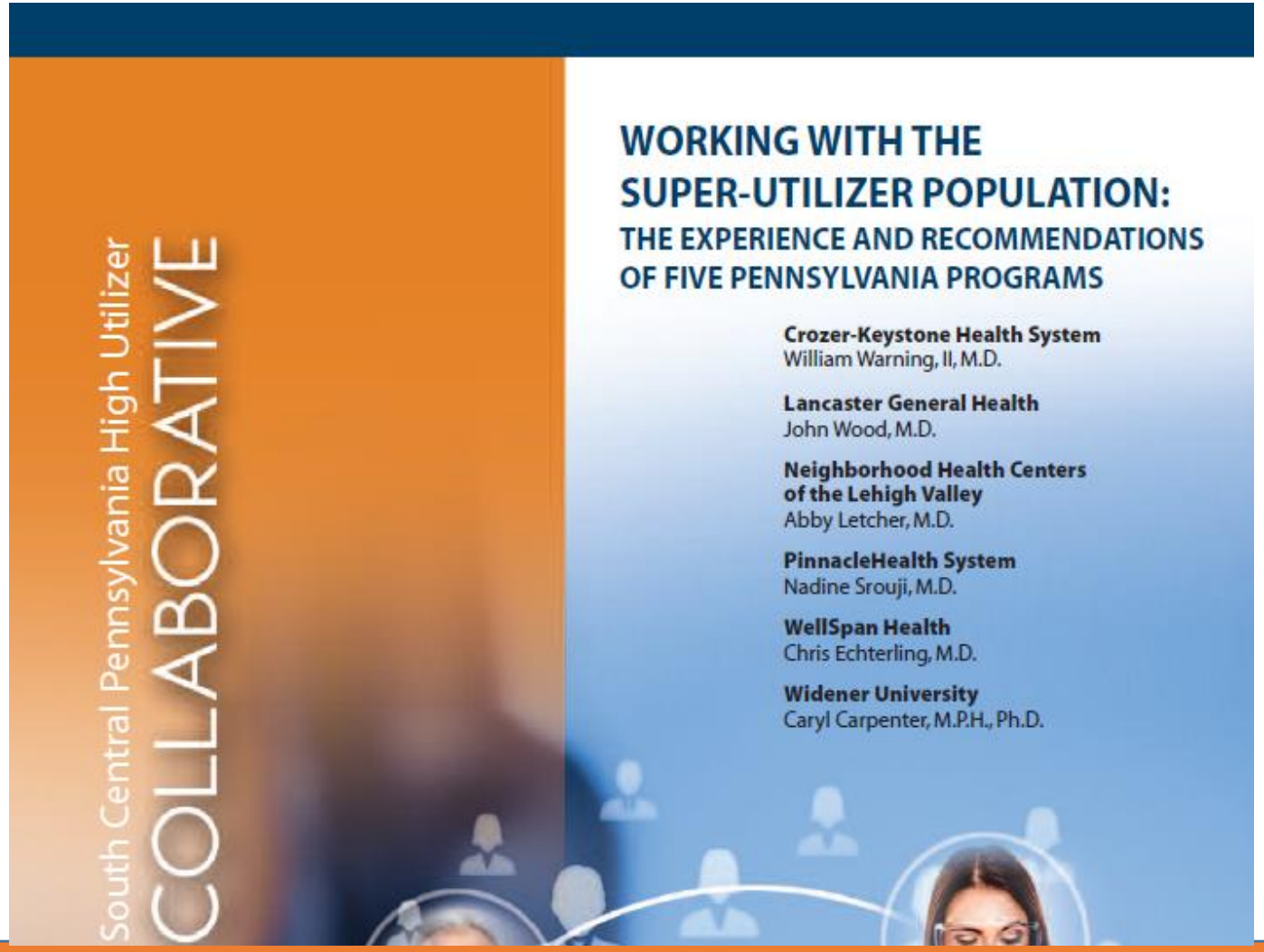
AF4Q

Aligning Forces for Quality

Improving Health & Health Care in Communities Across South Central Pennsylvania

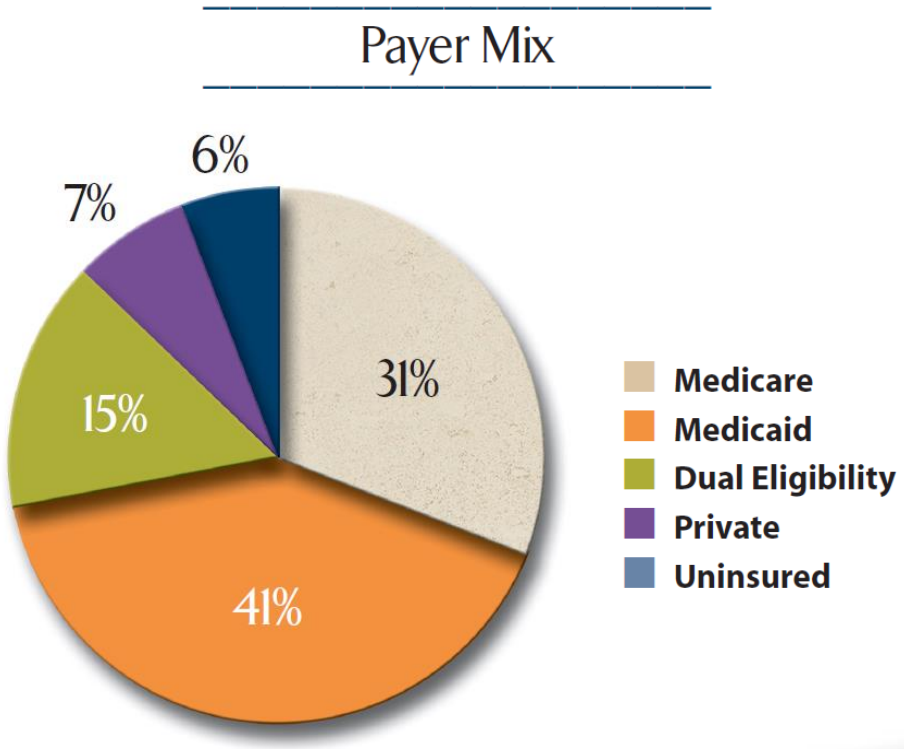
WellSpan Health

White Paper Available @ www.aligning4healthpa.org/

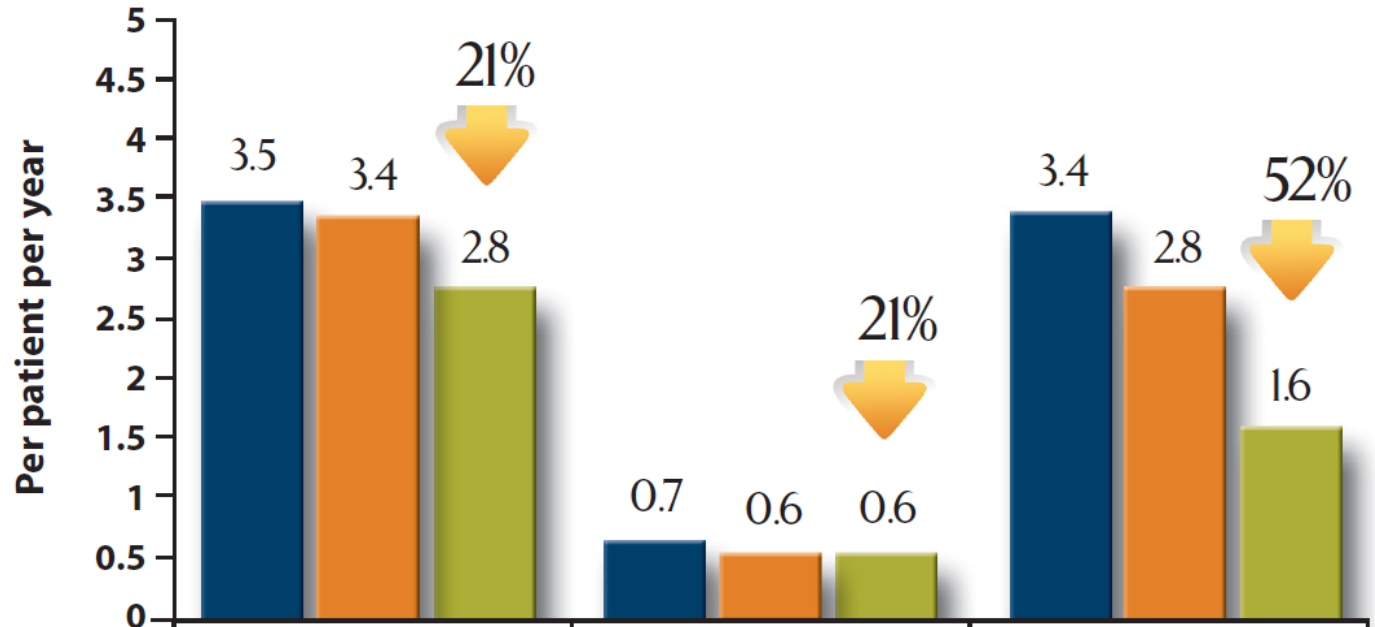


Southcentral PA High-Utilizer Collaborative - OUTCOMES

- As of December 31, 2014, Crozer-Keystone, Lehigh Valley, LGHealth, and WellSpan had seen **446 patients**, average age of 56 years.



Utilization



	ED Visits	Observation	Inpatient
Before	3.5	0.7	3.4
During	3.4	0.6	2.8
After*	2.8	0.6	1.6

* After data includes only those patients who are no longer active in program.

Benefits of “SuperUtilizer” programs beyond better care, lower costs

- “Learning Labs”
  - New approaches
  - Identifying system gaps
- Teaching – Residents, Med Students, Nursing Students
- Public Relations – stories and donations
- Benefit to PCMHs
  - Somewhere to go for advice
  - Possibly transition of pts

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Where could we get started?

- Where are your risks?
  - Value based contracts/ACOs
  - Your own employees and dependents
  - Uninsured/charity
- Where are your practices/providers all ready thinking about social determinants?
- Great Resources out there…

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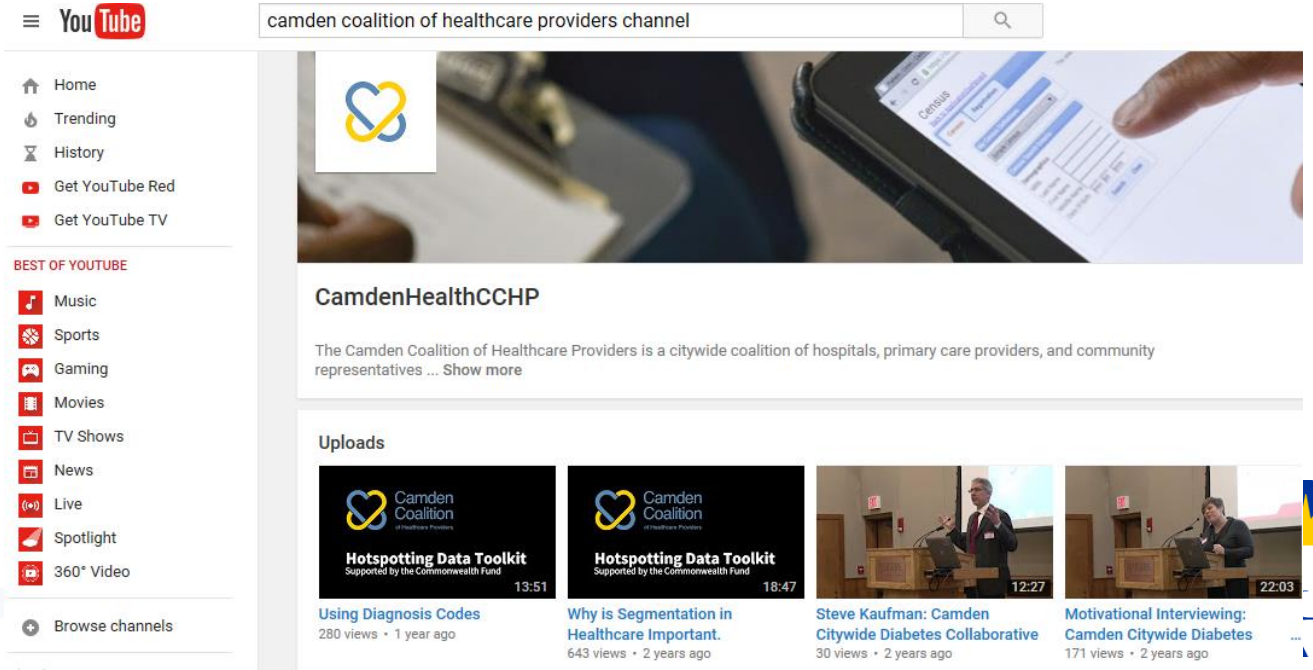
Resources – Camden



National Center for Complex Health and Social Needs

Helping communities to improve care for patients with complex needs

The National Center for Complex Health and Social Needs, launched in 2016, aims to improve wellbeing for individuals with complex medical, psychological, and social needs. It works to coalesce a new field of health care by bringing together a broad range of clinicians, researchers, policymakers, and consumers who are developing, testing, and scaling new models of team-based, integrated care. The Center and its staff collaborate with other experts across the nation to develop best practices, inform policy, and foster an engaged and accessible community to develop this work and teach it to others.

The National Center's founding sponsors are **AARP**, **The Atlantic Philanthropies**, and the **Robert Wood Johnson Foundation**, and it is hosted by the Camden Coalition.

Putting Care at the Center, the annual National Center conference, will be taking place November 15-17 in California.

The National Center website will launch in Fall of 2017, and will serve as a virtual home for the Center and the community it serves. For more information, follow the National Center on Twitter at **@NatlComplexCare**, visit **Complex.Care**, or contact **nationalcenter@camdenhealth.org**.

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RUTGERS
Center for State Health Policy

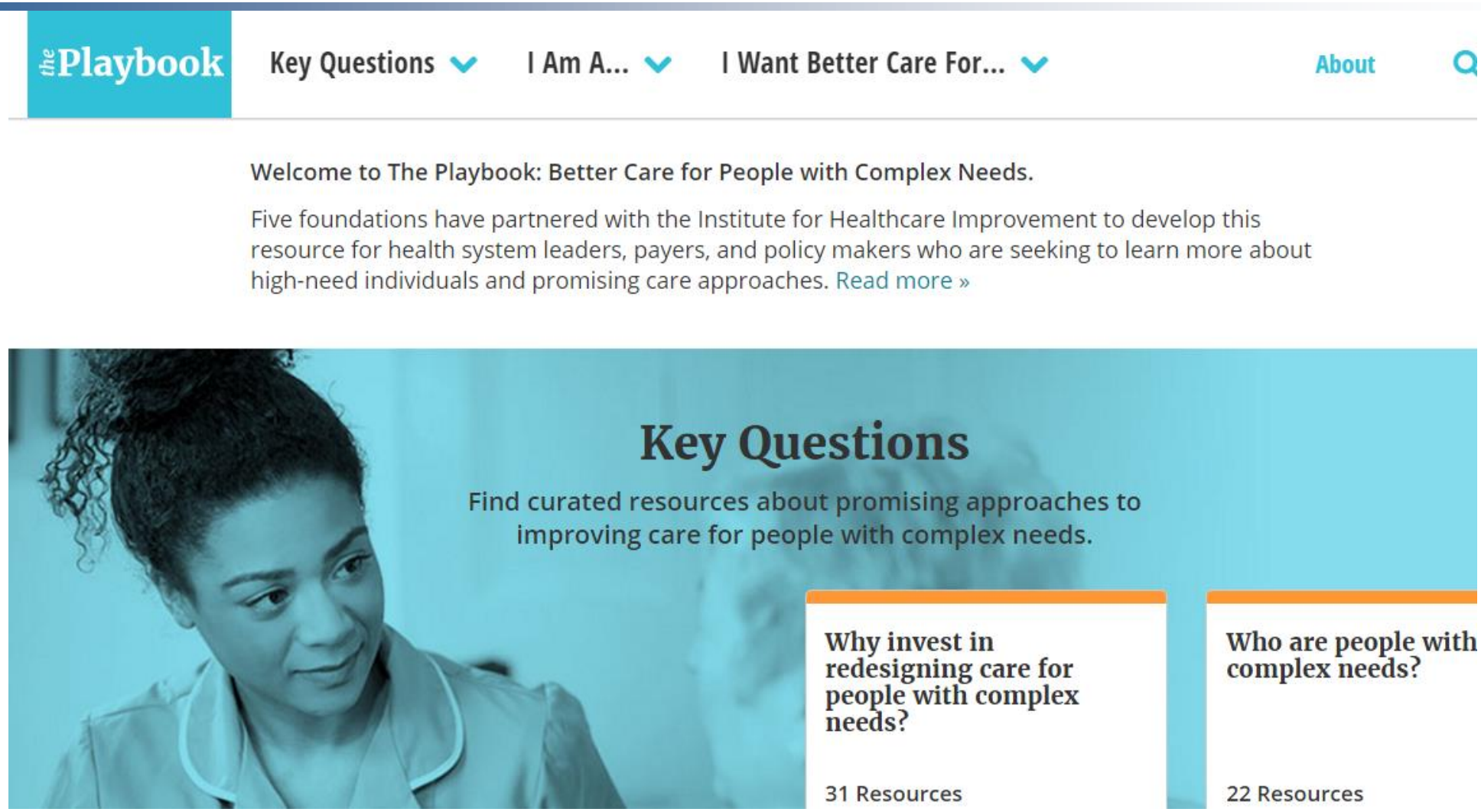
Improving Care for Complex Patients:
Stories from Four Super-Utilizer Pilot Programs

July 2016

Super-utilizer pilot programs at a glance

Program name	Organization and location	Jan 2013 – Jun 2015 Enrolled	Jan 2013 – Jun 2015 Graduated
Lehigh Valley Super-Utilizer Partnership (LVSUP)	Neighborhood Health Centers of the Lehigh Valley (NHCLV), Allentown, PA	111	84
Guided Chronic Care (GCC)	Truman Medical Centers (TMC), Kansas City, MO	265	150
Bridges to Care (B2C)	Metro Community Provider Network (MCPN), Aurora, CO	489	360
Patient Health Improvement Initiative (PHII)	MultiCultural Independent Physicians Association (IPA), San Diego, CA	154	102

www.bettercareplaybook.org



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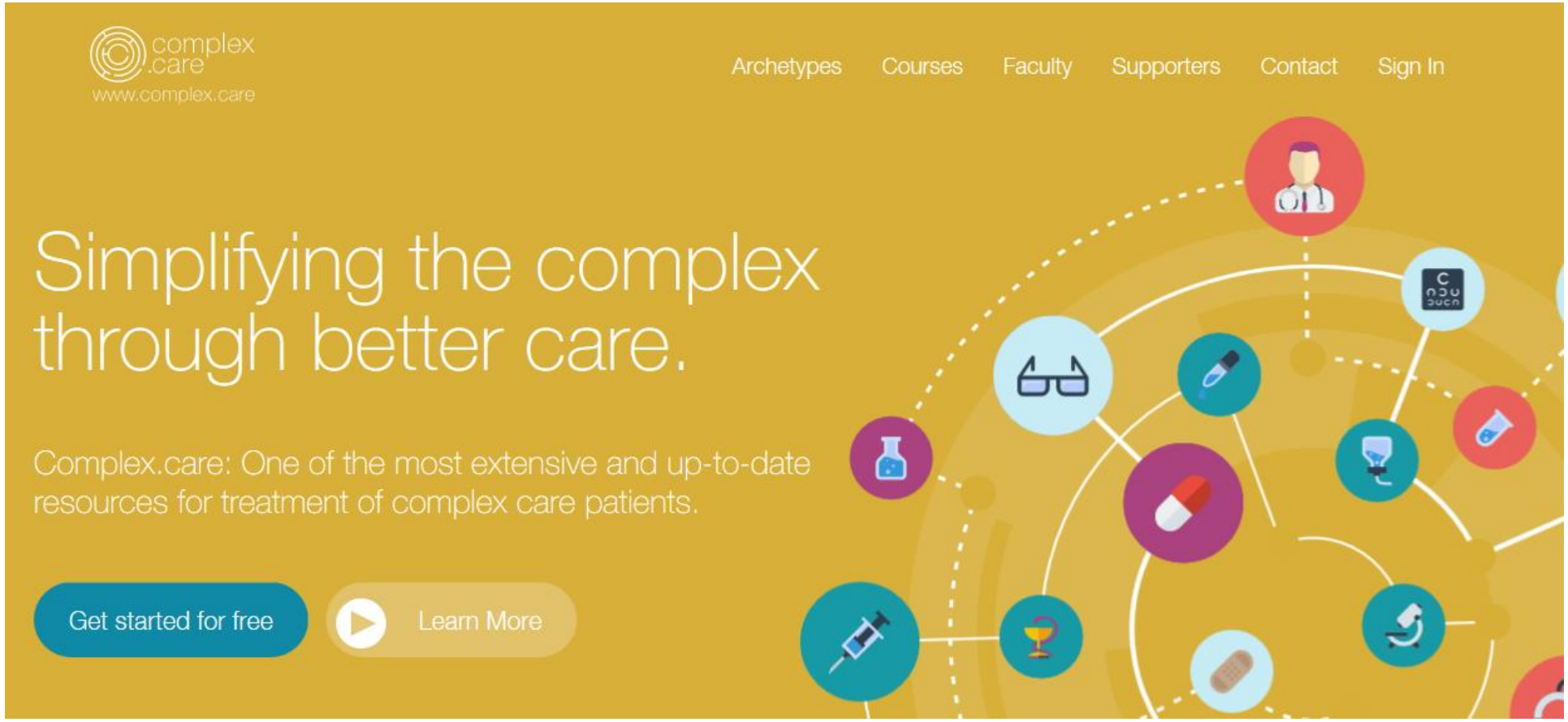
www.complex.care



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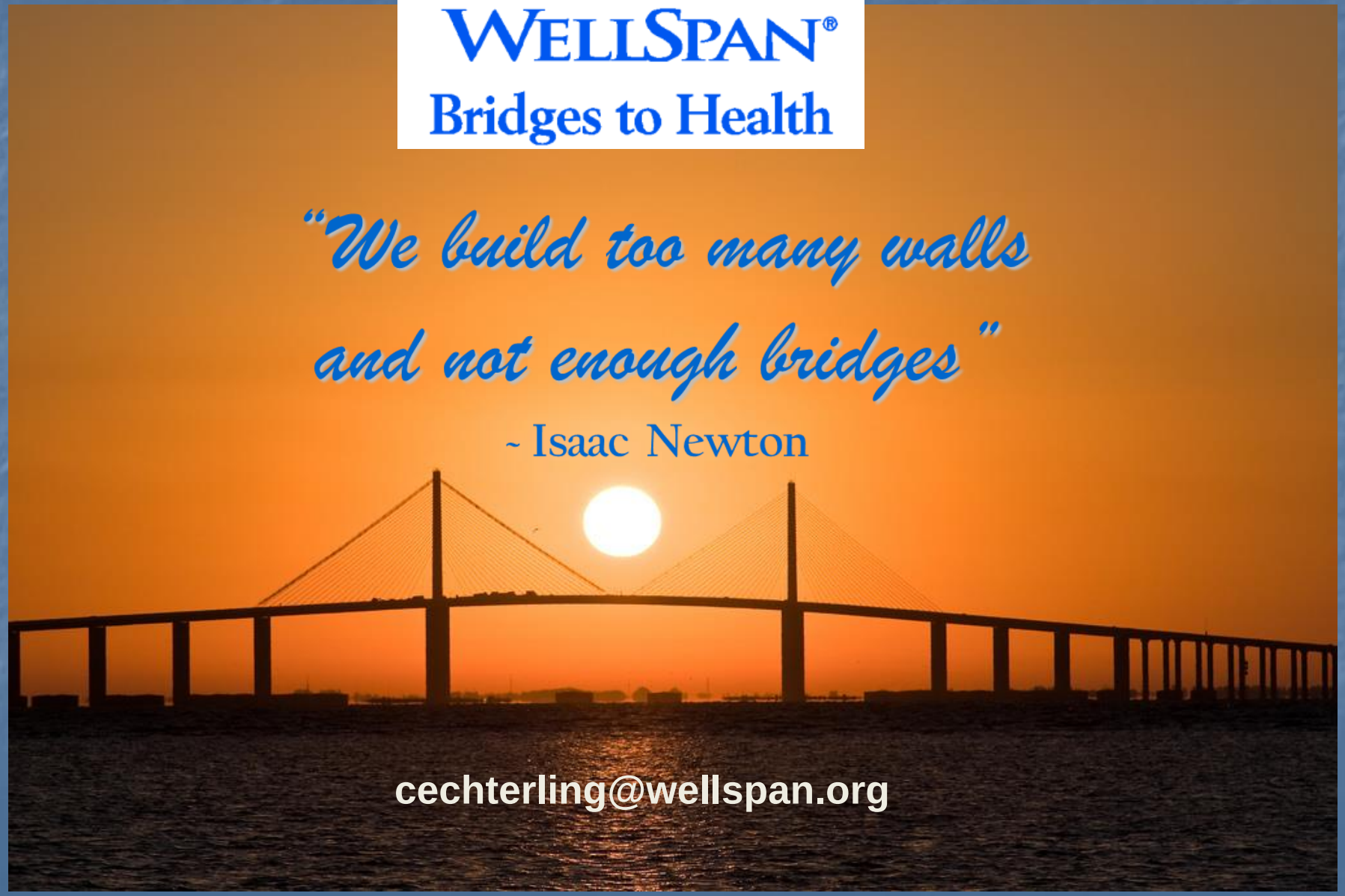
Bridges to Health



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Discussion

We invite your questions and comments.

HEALTH
rong Communities

American Hospital Association