



**Department
of Health**

**Medicaid
Redesign Team**

Improving Care for Super Utilizers

It is possible! Insights from a national perspective and the MAX experience

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Agenda

- Who are Super Utilizers?
- What can be done to improve care and reduce utilization?
- How have NY DSRIP teams done this?
- What can you do to improve care for super utilizers?

Objectives

1. Understand why improving care for super utilizers is clinically, operationally and strategically important to achieve DSRIP goals
2. Understand the core concepts: view recurrent utilization as a *symptom* of an unmet need, and identify the “*driver of utilization*”
3. Identify 3 ways you can improve care for super utilizers

Who are Super Utilizers?

A working definition and key stats

Definitions

- Super Utilizer
- = High Utilizer
- ≠ High Cost
- ? Complex

Key Stats

4+

7% – 25% – 60%

85%

52% v. 8%

CHIA Hospital-wide All Payer Readmissions in Massachusetts June 2016

AHRQ HCUP Statistical Brief #184 November 2014

AHRQ HCUP Statistical Brief #190 May 2015



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Top Diagnoses

- Acute medical: sepsis, UTI, pneumonia, cellulitis
- Chronic medical: CHF, COPD, diabetes, sickle cell
- Behavioral health: mood disorders, schizophrenia, ETOH

➤ *Combination of medical, behavioral health and social needs*

61 man with 8 hospitalizations for shortness of breath.

“Oh honey, I’m in here every couple of weeks and it always takes about 5 days to tune me up”

32M with lifetime of uncontrolled diabetes.

“I need housing, not a shelter. I need someone to help make sure I take my medicines. In a shelter they don't do that and they kick you out every morning. I need a stable residence and no one is able to help with that.”

What can be done?

Identify the “driver(s) of utilization;” do not over-medicalize

Identify Root Causes; the “Driver of Utilization”

- Ask “why”
- Identify the drivers of utilization
- Listen for all the factors that lead to acute care utilization
- Assess for clinical – behavioral – social needs
- Don’t over-medicalize recurrent utilization

“It doesn’t matter what SU population you identify – the needs are determined by the psychosocial and behavioral health issues”

Identify and Engage in Real-Time

- Patient is here, now
- Prioritize engagement
- Understand patient's priorities, needs, concerns
- Establish a trusting, helpful relationship based on the patient's needs and priorities and not leading with a medicalized agenda

“Do something different”

- Arrange for
- Coordinate
- Follow up
- Navigate
- Advocate
- Check in
- Reassure

“Management starts with the hospital based team – not just assessing and referring, but **initiating** and for some amount of time, **providing** the active **follow up and support** with the goal of **definitively linking** the patient to the services and supports required to reduce utilization.”

Collaborate

- Identify and engage providers, agencies, payers
- Coordinate
- Collaborate
- Align
- Leverage each others' efforts
 - Case conference
 - Create, use care plans

“The multidisciplinary team is needed to do this....we need to rely on other expertise”

Work to achieve stability

- Management and follow up are iterative
- Occur back and forth across settings and over time

“The ultimate outcome of this [collaborative, cross-setting] process is to bring someone from an unstable cycle of high utilization to increased stability and lower utilization”

“

We have gone from a hospital that was dealing with patients and crises in the moment to one where we know the patient....

We are more **collaborative and work better together**...all of our departments are closer and this has **extended to the community as well.**

”

How have teams done it?

Teams from the MAX Series: Improving Care for Super Utilizers



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St. Luke's Cornwall Hospital

Montefiore Hudson Valley Collaborative PPS

*Kathy Sheehan, Director of Emergency Services, Trauma & Respiratory,
St. Luke's Cornwall Hospital*

St. Luke's Cornwall Hospital: Overview

Target population:

Patients with **6+ ED** visits and **3+ IP** admissions in a 12 month period



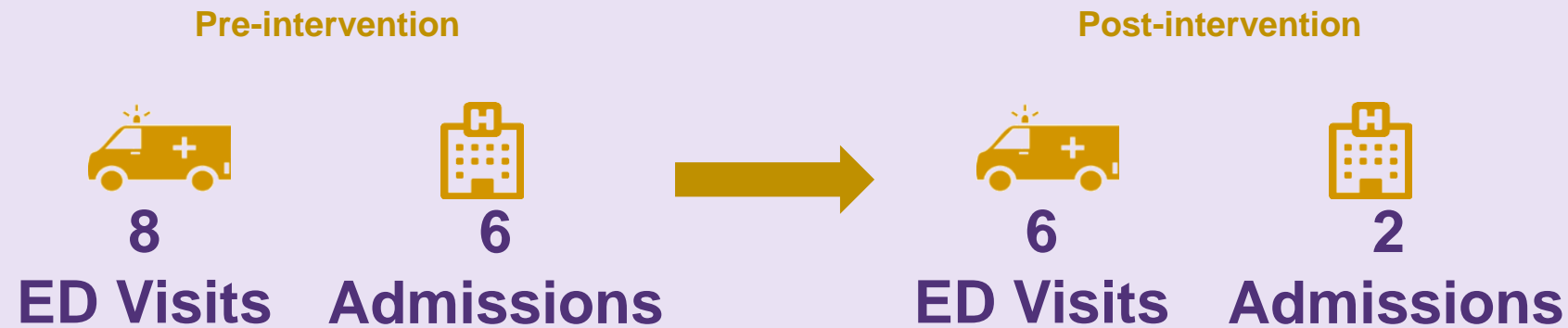
Action Team:

IT Analyst, Hospital Director of Case Management, Hospital Care Transitions Nurses, ED Nurse Administrator, ED Physician, PPS Administrator, PCMH Administrator, Behavioral Health Clinic Administrator

Process Changes:



24 year old woman with chronic health care issues



Impact

(Mar. '16 – Sep. '16)

62 Patients presented



47 Patients engaged

“Quarterbacks” identified for
89 of 91 Patients

33 Patients connected to services

Hospital Utilization

Note: Only includes patients with an Index visit and at least 90 post-index visit data

	Before 3 mo. Pre-Index Visit	After 3 mo. Post-Index Visit	%Δ
 ED Visits	118	119	1%
 IP Admissions	43	12	-72%

Lessons Learned

1. **A data analyst / IT is an essential member** of the Super Utilizer team
2. **Identify a care management point-person (“Quarterback”)** to provide frequent, high touch engagement to address the their medical, behavioral, and social needs
3. **Collaborative management between the hospital and the “Quarterback”** is essential to engage the patient and more effectively assess and address their drivers of utilization



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Champlain Valley Physicians Hospital

Adirondack Health Institute PPS

*Ken Thayer, ED Nursing Director,
Champlain Valley Physicians Hospital*

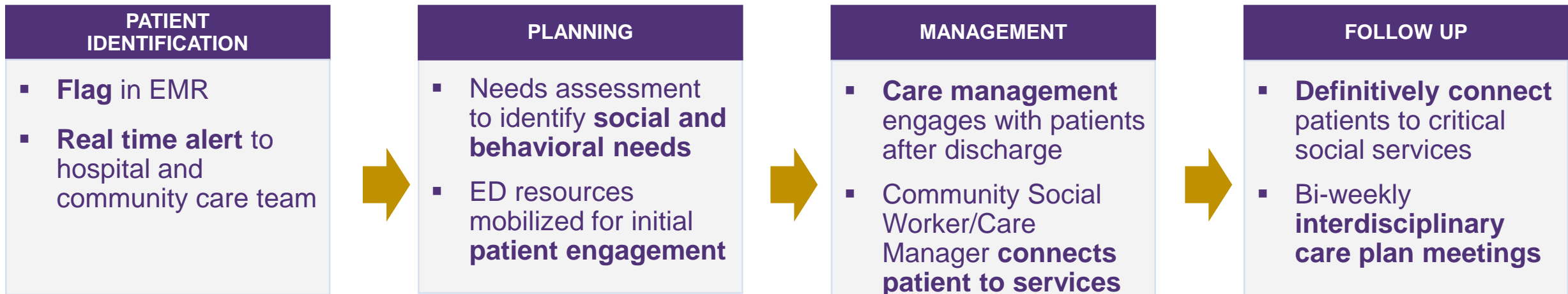
Champlain Valley Physicians Hospital: Overview

Target population: Patients with **10+ ED** visits in a 12 month period



Action Team role types: ED Leadership, Administrative Leaders, Data Analyst, ED Physician, ED Care Manager, ED Nurse, Care Management Leader, Social Services representative, Behavioral Health Services representative, Substance Abuse representative, Medical Home

Process improvements:



Champlain Valley Physicians Hospital: Impact

39 year old man with a high number of ED visits each month. He has significant financial issues, limited access to transportation, poor coping skills, social stressors, and is primary caregiver to his disabled wife. Primary reason for ED visits was anxiety and panic attacks. His long-term counselor recently left and he has been without services for over 4 months.

Pre-intervention



7 ED visits per month



Post-intervention






2 ED visits per month

Impact (Mar. '16 – Sep. '16)



Hospital Utilization

Note: Only includes patients with an Index visit and at least 90 days of post-index visit data

	Before 3 mo. Pre-Index Visit	After 3 mo. Post-Index Visit	%Δ
 ED Visits	53	12	-77%
 IP Admissions	3	1	-67%
 Total	56	13	-77%

*Self reported data

Lessons Learned

1. **Leveraging community resources** is critical to connecting Super Utilizers to social and behavioral health resources
2. **There is no single solution for the Super Utilizer population**; need to take an individualized approach and build a trusting relationship with the patient
3. **Data provides insights** for further process improvement opportunities
4. **Commitment to improve the health** of the population
5. **Hospital-based Care Manager made initial connection** and referrals to community agencies



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Ellenville Regional Hospital and The Institute for Family Health

Westchester Medical Center PPS

Steve Kelley, President and CEO, Ellenville Regional Hospital

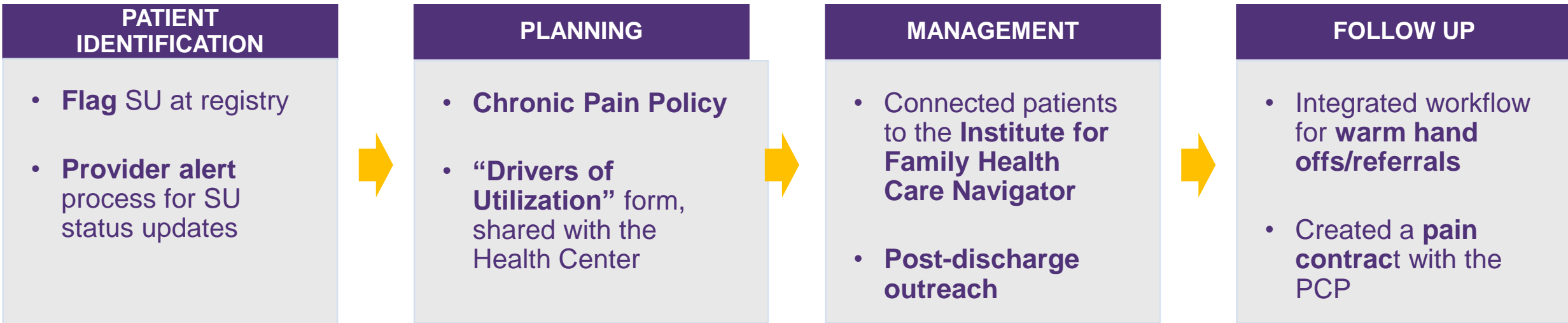
Ellenville Regional Hospital and The Institute for Family Health:

Target population: Patients with **5+ ED** visits for **chronic pain**





Action team role types: Hospital providers, Health Center Administrators, Patient Navigators

Process improvements:



Impact

(May '15 – Jul '16)

	Before (May'15 - Oct'15)	After (Nov'15 – Jul '16)	%Δ
 ED Visits	70/month	38/month	- 45%
 Opioid Orders	63/month	19/month	- 70%

Lessons Learned

- **Establishing standardized practice guidelines** through the Chronic Pain Policy and gaining the support of medical staff, leadership, and community providers through education helped sustain the effort
- **Begin with the largest partners first** to establish protocols and processes, and then expand
- **Care Navigation** services offered 24/7 to provide a “warm hand-off” for this population to assist them with their medical, social and behavioral needs
- **Ongoing, open communication** between ERH, IFH, and the Care Navigator helped identify solutions for meeting patient needs

“...changing the trajectory of human lives”

Jason Helgerson, MAX Improving Care for Super Utilizer Workshop, 2016

Thank you

Join us at the MAX Poster Session

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