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

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The Impact of Super-Utilizers on Rural Hospital Emergency Rooms

John Anderson, FACHE
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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](http://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).
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.

Hospital Emergency Rooms (Navigators) → Primary Care Homes (FQHC & the Residency Clinic Care Coordinators)
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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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.
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
WellSpan Health Claims Paid
(1/1/10-12/31/10 by members and dollars)

Our Data

4% = 49%
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
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
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
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)
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’s Utilization: (Payer-United Medicaid)

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost</th>
</tr>
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<tbody>
<tr>
<td>2012</td>
<td>$1,228,402</td>
</tr>
<tr>
<td>2013</td>
<td>$529,198</td>
</tr>
<tr>
<td>2014</td>
<td>$310,215</td>
</tr>
<tr>
<td>2015 (annualized)</td>
<td>$99,330</td>
</tr>
</tbody>
</table>

Julia began with Bridges on 10/16/12
### Patient Characteristics

#### Percent of SU Patients with each Diagnosis

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

#### Percent of SU Patients with each social determinant of utilization

<table>
<thead>
<tr>
<th>Social Determinant</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Trauma</td>
<td>58%</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>40%</td>
</tr>
<tr>
<td>Financial Issues</td>
<td>90%</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>61%</td>
</tr>
<tr>
<td>Functional Illiteracy</td>
<td>40%</td>
</tr>
<tr>
<td>Housing</td>
<td>48%</td>
</tr>
<tr>
<td>Language</td>
<td>26%</td>
</tr>
<tr>
<td>Transportation</td>
<td>62%</td>
</tr>
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South Central Pennsylvania High Utilizer Collaborative Partners
White Paper Available @
www.aligning4healthpa.org/
As of December 31, 2014, Crozer-Keystone, Lehigh Valley, LGHealth, and WellSpan had seen 446 patients, average age of 56 years.

Payer Mix

- Medicare: 41%
- Medicaid: 31%
- Dual Eligibility: 15%
- Private: 6%
- Uninsured: 7%
The graph shows utilization rates per patient per year for ED Visits, Observation, and Inpatient care.

- **ED Visits**
  - Before: 3.5
  - During: 3.4
  - After*: 2.8
  - Decrease: 21%

- **Observation**
  - Before: 0.7
  - During: 0.6
  - After*: 0.6
  - Decrease: 21%

- **Inpatient**
  - Before: 3.4
  - During: 2.8
  - After*: 1.6
  - Decrease: 52%

*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
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...
Resources – Camden
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 ComplexCare, or contact nationalcenter@camdenhealth.org.
Improving Care for Complex Patients: Stories from Four Super-Utilizer Pilot Programs

July 2016

Super-utilizer pilot programs at a glance

<table>
<thead>
<tr>
<th>Program name</th>
<th>Organization and location</th>
<th>Jan 2013 Enrolled</th>
<th>Jan 2015 Graduated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lehigh Valley Super-Utilizer Partnership (LVSUP)</td>
<td>Neighborhood Health Centers of the Lehigh Valley (NHCLV), Allentown, PA</td>
<td>111</td>
<td>84</td>
</tr>
<tr>
<td>Guided Chronic Care (GCC)</td>
<td>Truman Medical Centers (TMC), Kansas City, MO</td>
<td>265</td>
<td>150</td>
</tr>
<tr>
<td>Bridges to Care (B2C)</td>
<td>Metro Community Provider Network (MCPN), Aurora, CO</td>
<td>489</td>
<td>360</td>
</tr>
<tr>
<td>Patient Health Improvement Initiative (PHII)</td>
<td>MultiCultural Independent Physicians Association (IPA), San Diego, CA</td>
<td>154</td>
<td>102</td>
</tr>
</tbody>
</table>
Welcome to The Playbook: Better Care for People with Complex Needs.

Five foundations have partnered with the Institute for Healthcare Improvement to develop this resource for health system leaders, payers, and policy makers who are seeking to learn more about high-need individuals and promising care approaches. Read more »

Key Questions
Find curated resources about promising approaches to improving care for people with complex needs.

Why invest in redesigning care for people with complex needs?
31 Resources

Who are people with complex needs?
22 Resources
Simplifying the complex through better care.

Complex.care: One of the most extensive and up-to-date resources for treatment of complex care patients.

Get started for free  Learn More
“We build too many walls and not enough bridges”

- Isaac Newton

cechterling@wellspan.org
We invite your questions and comments.