

IMPROVING CARE COORDINATION BY WORKING WITH SUPER-UTILIZERS

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Opening Thoughts

Think about a patient that has:

- Been in/out of the hospital and ED many times in a six month period
- Multiple chronic conditions (diabetes, CHF, COPD, mental illness, etc.) but not degenerative disease like end stage renal failure
- Not reached end of life

List the barriers to better healthcare for this patient on paper



Who We Are

- Mountain-Pacific Quality Health is the **Quality Innovation Network-Quality Improvement Organization (QIN-QIO)** for four states and three territories
 - **Montana**
 - **Wyoming**
 - **Alaska**
 - **Hawaii**
 - **Guam**
 - **American Samoa**
 - **The Commonwealth of the Northern Mariana Islands**

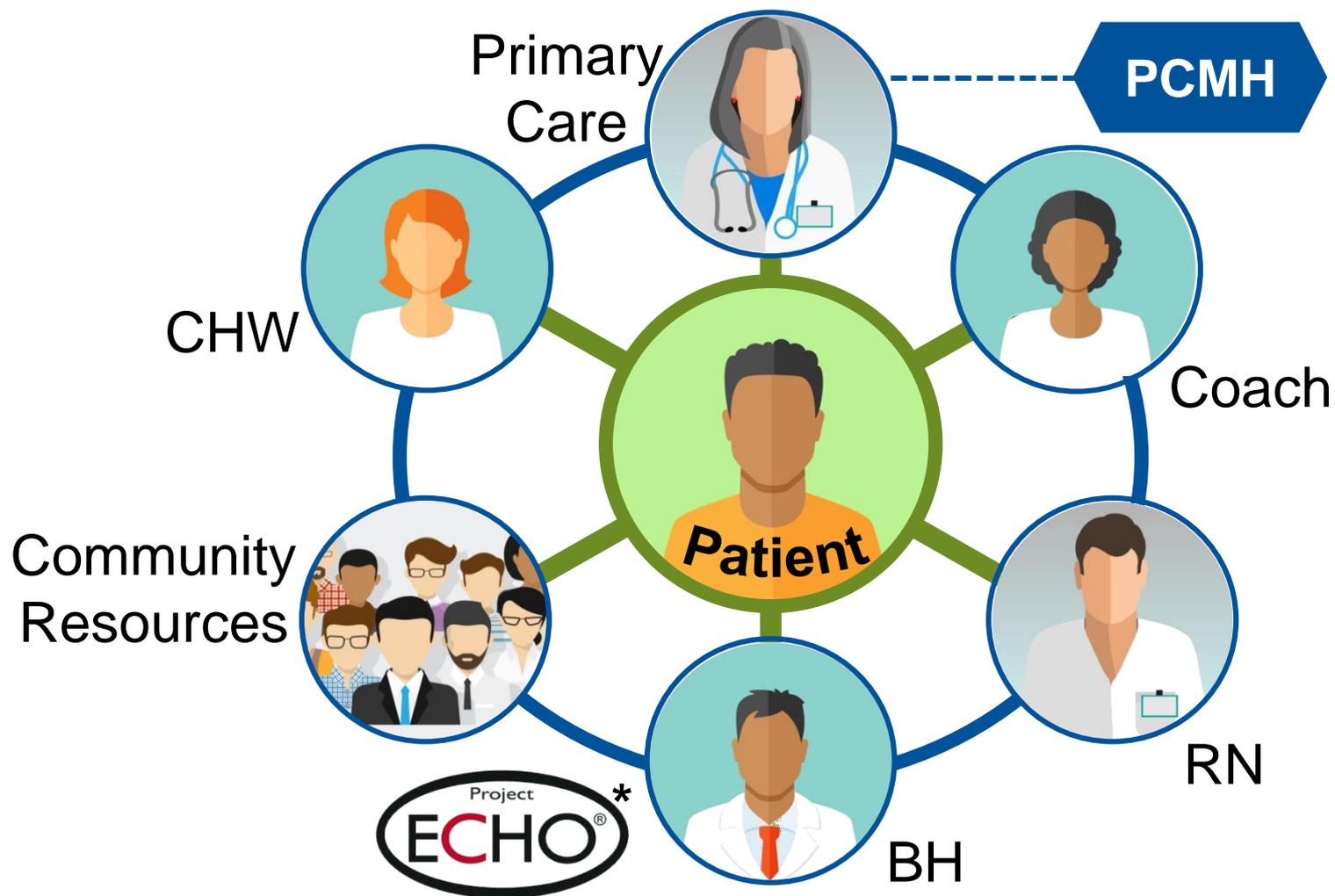


New “Hotspotting” Project

- Apply nationally renowned Camden Coalition of Healthcare and Transitional Care models to rural setting
- Test, fund and deploy ReSource Teams, functioning as community outreach teams.
- Test, fund and deploy cellular-enabled tablets to work with patients remotely via video chat
- Spread best practices through training and education
- Work with payers to develop sustainable community health teams
- Save \$\$\$\$\$

Delivery System Models: Building on the PCMH Foundation

Hot-Spotting with community ReSource Teams



Readmissions

Inpatient Hospital 30-Day Readmissions of Medicare Fee-for-Service Patients Billings Community – 4/01/14 to 9/30/14

Category	Value	Billings Community Residents		Rest of MT Residents		P-Values ≤ 0.10
		# of Discharges	% 30-day Re-admissions (# Readmits)	# of Discharges	% 30-day Re-admissions	
Total	Live Discharges	2938	14.30% (420)	13069	13.01%	P=0.0661
Race, ethnicity	White	2597	13.40% (348)	11917	12.80%	
	Black	≤10		30	26.67%	
	Other	38	31.58% (12)	88	11.36%	P=0.0098
	Asian	≤10		27	11.11%	
	Hispanic	≤10		28	25.00%	
	North Am. Native	263	21.29% (56)	884	15.16%	P=0.0231
Location discharge status	Home self-care	1925	14.44% (278)	8105	12.97%	P=0.0924
	SNF, swing-bed	620	14.68% (91)	2795	13.56%	
	Home Health Care	103	23.30% (24)	932	14.48%	P=0.0295
	Hospice	88	1.14% (1)	315	1.59%	
	Other Institution	179	11.17% (20)	825	12.73%	

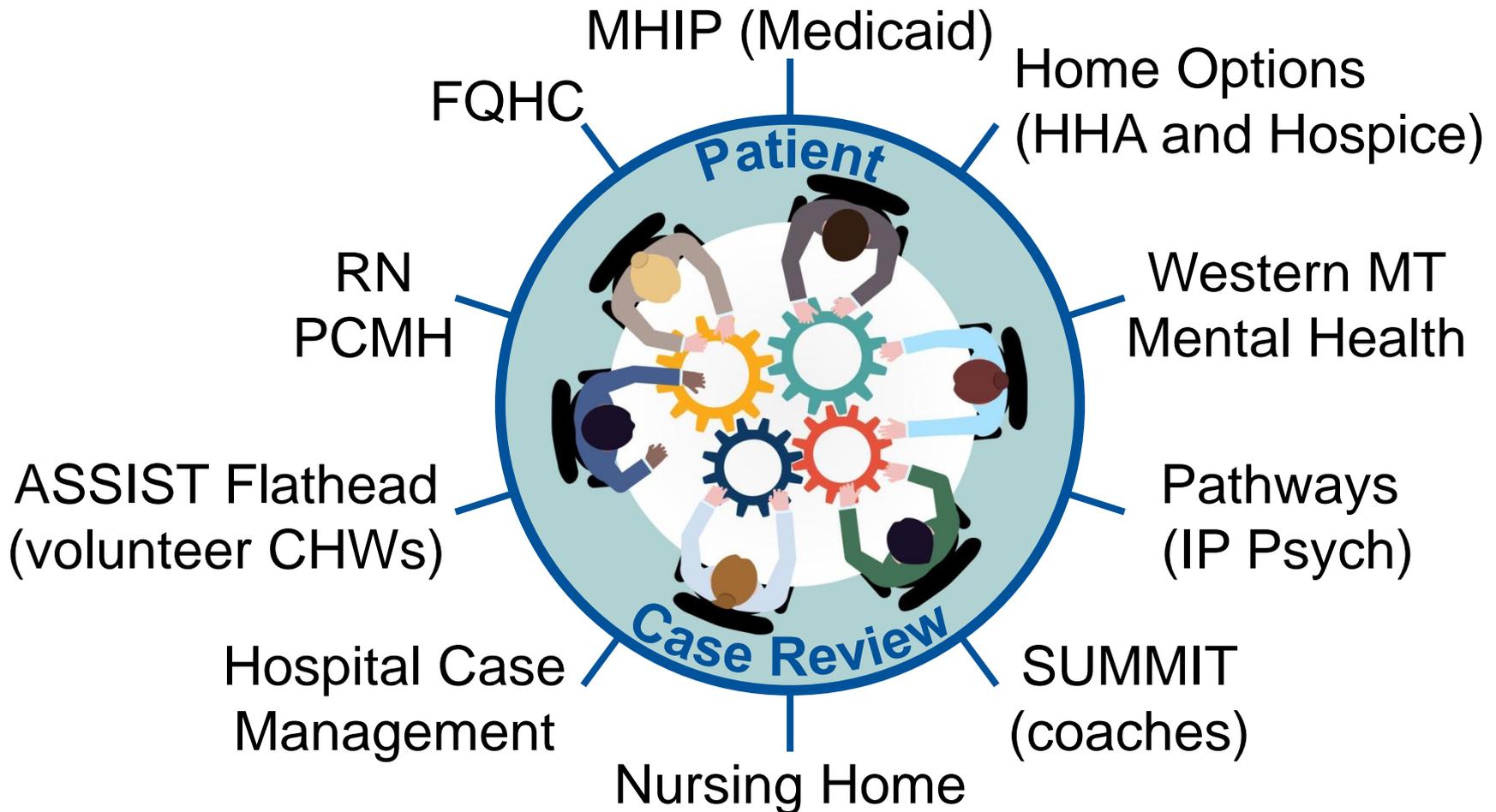
Note: Ethnicity for Other and AI ▪ Home Self-Care and Home Health

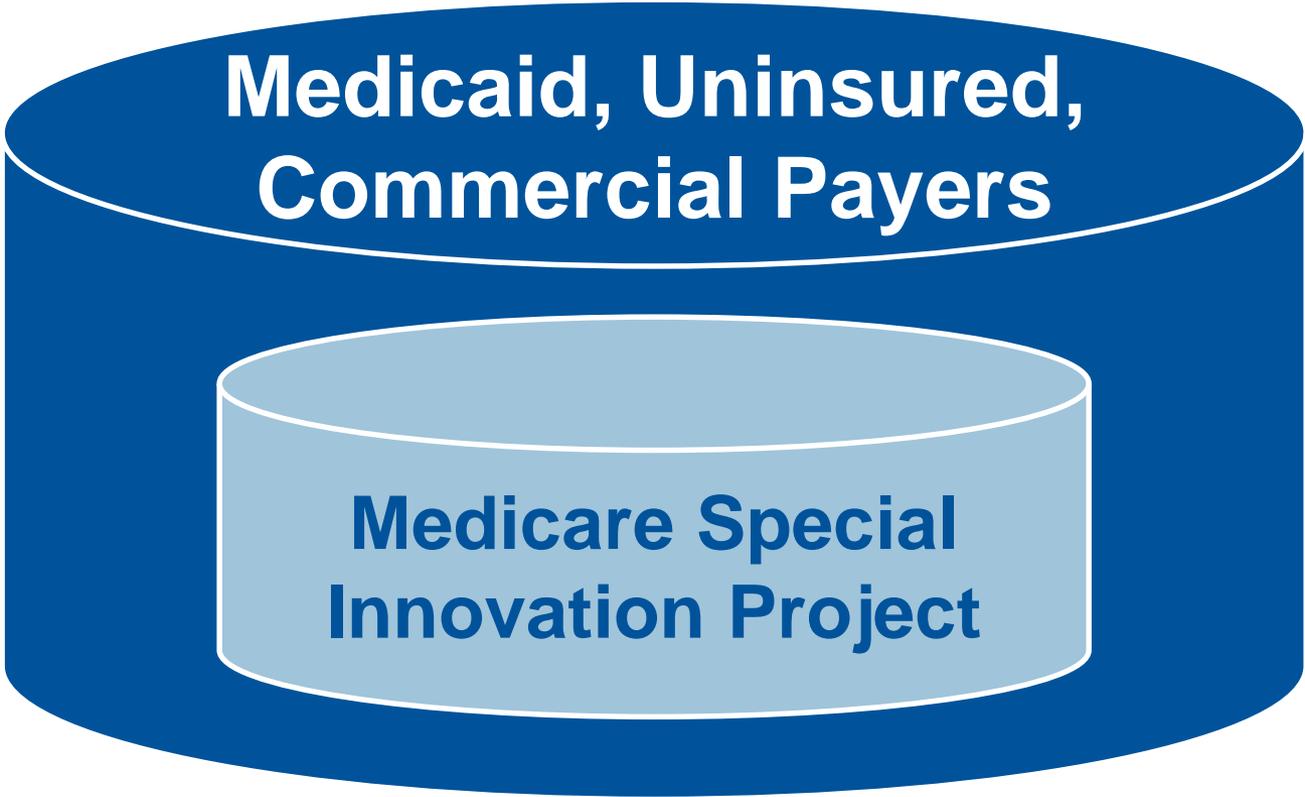
(Discharges are live discharges of Medicare FFS beneficiaries, not IP hospital transfers. Readmissions are inpatient hospital admissions within 30 days of discharge, including IP transfers that do not occur on the same day as the discharge.)

The Conceptual ROI

Community	Number of Patients Addressed		CMS- Estimated Cost per Re-admission	Min. of 2 admissions per 6 Months = 2x Admission Cost	Year 1 Estimated ED Visit Reductions = 1 Less Visit per Patient	Year 2 Estimated ED Visit Reductions = 1 Less Visit per Patient	AHRQ Estimated Cost per ED Visit	Total Estimated ED Savings	Assumes 75% Medicare, Medicaid and/or Indian Health Services		
	Year 1 (Training and Scaling Up)	Year 2							Federal Year 1 Cost Savings	Federal Year 2 Cost Savings	
Billings	0	50	\$10,286	\$20,572	0	50	\$1,390	\$69,500	-	\$823,575	
Helena	15	30			15	30		\$62,550	\$329,430	\$494,145	
Kalispell	15	40			20	40		\$83,400	\$336,380	\$658,860	
	30	120							\$665,810	\$1,976,580	
									CMS SIP Investment	(\$490,858)	(\$645,863)
									Net	\$174,952	\$1,330,717
									ROI	36%	206%

Coming to the Table as a Community





**Medicaid, Uninsured,
Commercial Payers**

**Medicare Special
Innovation Project**

A Place to Start

“Let’s start with building this and have an eye to building something much larger.”

Mary Sterham, RN, VP of Quality North Valley Hospital

WORKING WITH PAYERS





Defining the Target Population: Payer Data Recap

- At Governor's Council meeting (March), payers presented data about high cost/high need populations – potential areas of focus:
 - Behavioral health, esp. depression, substance abuse
 - Chronic disease, esp. diabetes, heart disease, kidney disease
 - Low birth weight babies
 - Cancer
 - Musculoskeletal conditions
- Collaborative Care and Community Resource Team = good way to build on existing reforms (e.g., PCMHs) and target people with above conditions, esp. those with access barriers and disparities

Data as a neutral starting point

Payer Collaboration Process

Define objectives and target population(s)

- Reviewed Data Workgroup findings
- Discussed common target populations across payers

Consider potential impacts of delivery reform models

- Reviewed evidence for delivery models

Define core elements of delivery models

- Agreed team-based care should be central
- Collaborative care and community resource team models build on PCMH foundation
- Project ECHO can extend a delivery model's reach/impact

Develop supportive payment models

- Discussed mechanisms for payers to support delivery models within FFS
- Agreed to pursue short-term funding to launch regional pilots

Implement



Next Focus

BRAIDING FUNDING FOR SUCCESS AND SPREAD

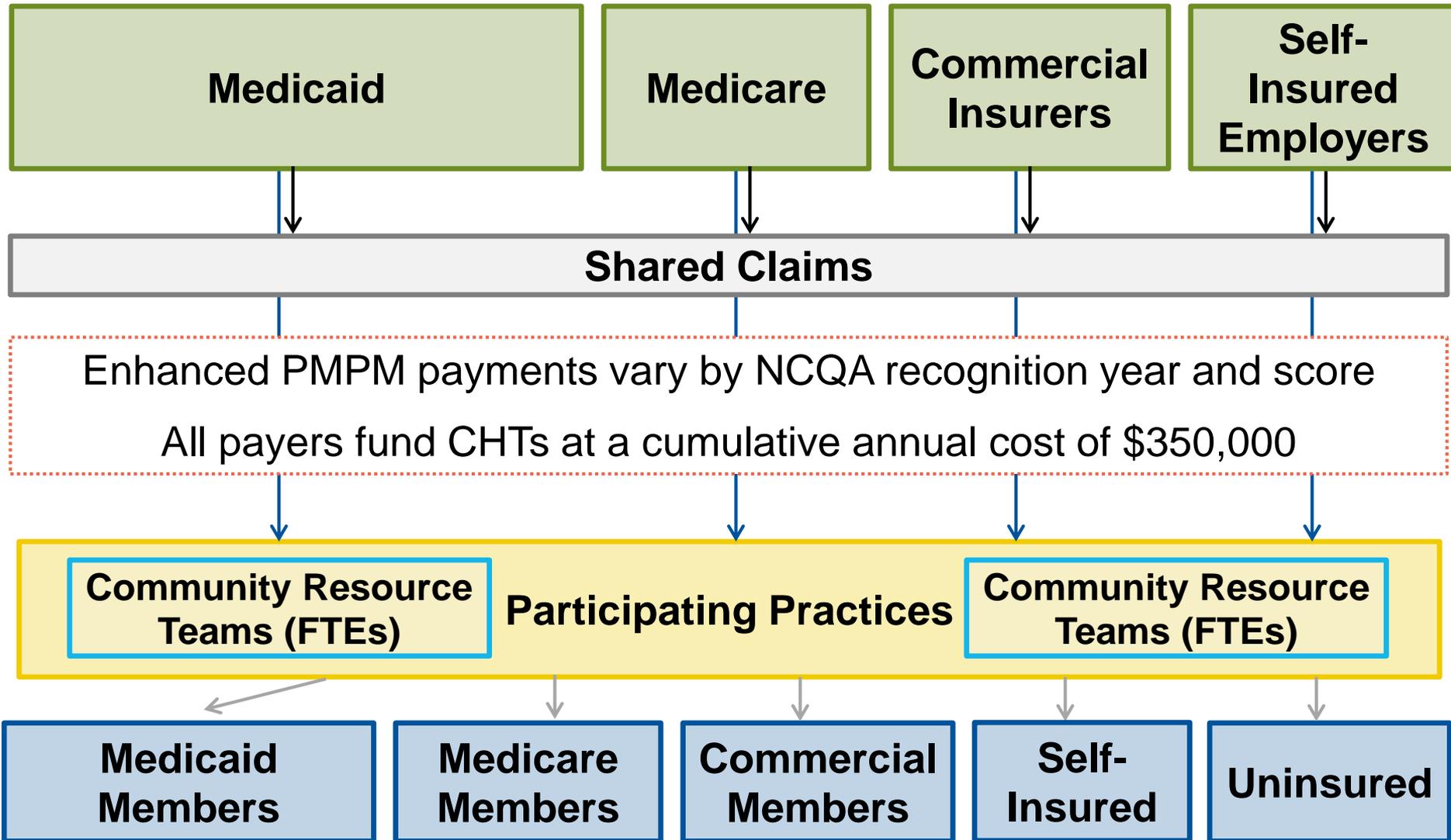




Funding Sources for Pilots

- CMS Special Innovation Project
- Robert Wood Johnson Foundation
- Montana Healthcare Foundation
 - Same criteria but looking beyond Medicare to Medicaid, uninsured, commercial patients
 - Funding would allow teams to work with all applicable patients
- Multi-payer funding

Patient Attribution Model (Example ONLY)



CPC+ Track One (Example ONLY)

	Care Management Fee (PMPM)	Performance-Based Incentive Payment	Underlying Payment Structure
Medicare	\$15 avg	\$2.50 opportunity	Standard FFS
Medicaid	\$10 avg	\$2.00	Standard FFS
Commercial	\$19	\$5.00	Standard FFS



QUESTIONS AND COMMENTS

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