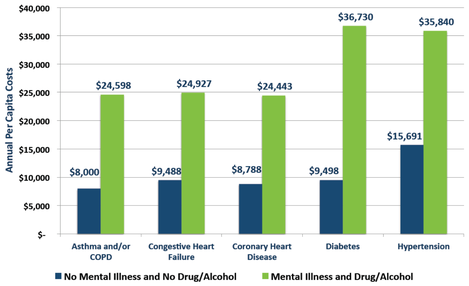
Excelling with the 5%: Advancing Wellness for Superutilizers

Christina VanRegenmorter, MSSW, PMP, Centerstone Research Institute; Claire R. Bohmann, BA, Centerstone Research Institute; Sai Motoru, PhD, Ginger.io; Maren Sheese, LCSW, Centerstone of Indiana; Mary Moran, LCSW, Centerstone of Tennessee; Mandi Hodges, RN, BS, Centerstone of Tennessee

WHY SUPERUTILIZERS?

- They are key for value based care success. For SSDI Medicaid adults, 5% = 60% of costs. Kronick RG, Bella M, Gilmer TP. (2009) *The faces of Medicaid III: Refining the portrait of people with multiple chronic conditions.* Center for Health Care Strategies, Inc.
- If they aren't your clients already, they should be. In a study of Missouri **5%** high utilizers, **85%** had a mental health diagnosis. The Lewin Group (2010, April 30). *Missouri Medicaid report on high cost beneficiaries.* Retrieved on July 16, 2013 from http://www.lewin.com/~/media/Lewin/Site_Sections/Publications/MOHealthDol_beneficiary-report2010apr30.pdf
- Mental health & addictions triple chronic health condition costs. California 1115 Waiver Behavioral Health Technical Work Group. (2010). Beneficiary risk management: Prioritizing high risk SMI patients for case management/coordination. Presentation by JEN Associates, Cambridge, MA.

Impact of Behavioral Health Co-Morbidities on Medicaid Costs



STEP 1: GAP ANALYSIS

See SuperUtilizer Care Gap Analysis

1. **Data Analytics Readiness.**
   - ✓ We know who our superutilizers are.
   - ✓ We get alerts <24 hrs for client hospital/ED visits.
2. **Technology Readiness.**
   - ✓ We have an E.H.R.
   - ✓ We have a data warehouse linked with HIEs and/or MCOs.
   - ✓ We can track passive & active data remotely for highest risk clients.
3. **Clinical Leadership Readiness.**
   - ✓ Our CEO has made superutilizer care a top priority.

STEP 2: ENGAGE FUNDERS

1. **Learn about what MCOs and States are doing already.**
   - Is there an existing superutilizer program you can join?
   - Are there funding streams already available?
2. **Share Data.**
   - Ask for Hospital & ER alerts for shared patients.
   - Ask for lists of high utilizers that you are already serving.
3. **Make the Ask.**
   1. Can you help fund a superutilizer pilot?
   2. If we self-fund & have effective results, will you fund later?

STEP 3: CHOOSE A CLINICAL MODEL

1. **Don't start from scratch.** Organizations who have been trying to solve this issue include:
   - Government agencies like the Centers for Medicaid & Medicare Services (CMS) and Agency for Research & Quality.
   - Kaiser Family Foundation & the Center for Healthcare Strategies.
   - Managed Care Organizations like Aetna, Kaiser Permanente, & United Healthcare.
   - States like New York, Oregon, Washington, & Oklahoma
   - Providers like Centerstone (TN/IN/), Group Health (Oregon) and Intermountain Healthcare (Utah).
   - Researchers and innovators like Dr. Jeffrey Brenner (Camden Coalition), Dr. Mary Naylor (University of Pennsylvania), and Dr. Tom Doub (Centerstone Research Institute).
2. **Use Others' Lessons Learned**. Look both at what DIDN'T work and what HAS worked for these organizations.

Lessons Learned: What **Not** To Do

- **Be 100% Remote with solely nurse call-in centers.**
  - This is fine for persons on Coumadin or other medications needing intermittent education/coaching. For high utilizers, it has a neutral or negative impact on results.
- **Ignore mental health and addictions.**
  - Many of the failed demonstrations explicitly excluded individuals with addictions and serious mental illness from their intervention. This then excluded their highest impactible utilizers.
- **Use staff that aren't culturally competent.**
  - Do not replace local health promotoras with external non-Spanish speaking nurses if 50% of your clients are Latino.
  - Do not hire staff afraid of cockroaches, dirt, blood, or smoking.
- **Have a goal that hurts your bottom line.**
  - If you are a hospital with 100% FFS payment for hospital days & ED visits, a superutilizer intervention may be in conflict with your performance engine & financial goals.

Lessons Learned: WHAT **TO** DO

- **Target *impactible* high utilizers**
  - Screen first. If they need Hospice, refer to Hospice.
  - If you have a lot of high utilizers and limited staffing, screen clients for Patient Activation when prioritizing who to enroll.
- **Go to clients' homes**
  - Check out the fridge & pillboxes (usually there are none).
  - Tackle Environmental wellness factors (mold, lead paint).
- **Tackle key social needs**
  - Food, housing, community, spirituality, safety.
- **Address medications**
  - Reduce total # of meds.
  - Conduct extra med. checks post hospital/ER visits.
- **Put frontline staff first**
  - Have 1:1 daily coaching calls for new staff to address issues.
  - Ensure THEY receive outcomes data first.
  - Seek their feedback often & follow-through on it.

STEP 4: PILOT TO PROVE EFFICACY

1. **Start Small**
   - Even if you are in a Pay-for Performance contract with 1 year to reduce total costs for a population, spend at least 3 months in pilot phase first.
   - If you are still in a FFS setting, stay small until you can figure out how to operationalize within your current payment structures.
2. **Use Project Management Principles**
   - Create a charter & project plan with communications and risk plan.
   - Transparently track outcomes.
   - Use lessons learned process monthly with key staff.
3. **Select Excellent Technology Partners**
   - Match partner to your gap analysis needs.
   - Choose partners that add the most value.
4. **Define your Eligibility Criteria**
   - Over $35,000 in annual expenses?
   - 3 hospitalizations in last 12 months? 3 months?
   - 10 ER visits in last 6 months?
5. **Define your Engagement Criteria**
   - How long will you try to engage a high utilizing client to enroll in your pilot? 4 weeks? 2? 1 phone call?
6. **Define your Target List**
   - Ensure pilot staff know **WHO** will be targeted for being served by the pilot.
   - Tip: Have 3 to 12 times as many clients on an engagement list as you need to enroll in the pilot to prove efficacy.
7. **Train Your Mangers**
   - Track Fidelity Requirements to Model.
   - Transparent outcomes tracking.
8. **Select Superb Staff**
   - Assertive, engaging, and funny.
   - Willing to get hands dirty.
   - Enjoy spending time with people with serious mental illnesses and addictions.
   - Believe they can empower clients to make positive change.
9. **Train your Staff**
   - Memorize Clinical Model Fidelity Requirements.
   - Behavioral activation & motivational interviewing.
   - Train in top 10 behavioral health & top 10 Physical Health conditions for clients on your list.
   - SuperUtilizer Care 101 w/ role playing.
10. **Monitor Fidelity & Outcomes Weekly**
11. **Have Fun!**

STEP 5: GET VBC CONTRACTS

- **Double Check your Outcomes with Payer Records.**
- **Calculate cost of project, cost savings, and expansion costs.**
- **Present Pilot Results to Payers.**
- **Negotiate & Obtain Value Based Care Contracts.**

Centerstone's High Utilizer Model

coactionHealth

- New clinical model
- Targets the 5% (3+ hosp/ED use)
- Analytics
- Technology-enabled care
- Wellness coaching with RN support
- Flexible funds

Technology Partners

- **CRI Centerstone Research Institute** →
  - Clinical Model Dev.
  - Analytics
  - Hospitalization & ER Alerting
  - Fidelity Tracking
- **Ginger.io** →
  - Passive Sensor & Active Data
  - Dashboard for health state
  - Alerts to Wellness Coaches
  - 83% of clients used app 2x or more each month
- **HipaaChat** →
  - Secure texting
  - Videochat
  - Audiomemo
  - Photochat
- **fitbit** →
  - Passive Movement Sensor

Centerstone's Provider Role

- **Inform Clinical Model**
  - Lessons Learned & Expertise
- **Mental Health & Nursing Leadership**
  - Health home integration, crisis response & consultation
  - Supervision, oversight, & continuous training.
- **Intensive Wellness Coaching**
  - Creative, prompt care for complex needs integrating on-site (i.e. blood pressure, CO monitor) & remote technology.
  - Focus on enhancing client's enjoyment of life & wellness.

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Centerstone Results

coactionHealth

Reduced Costs

Hospital Days: ↓ 51%

ED Days: ↓ 23%

$248,645 Estimated Savings

Increased Client Care Quality

- 84% Connected to Care Team.
- 75% Can Manage Health Condition.

Excellent Client Satisfaction

- 84% Satisfied with Ginger.io technology.
- Very high NPS Score of 43.
  - Healthcare best-in-class NPS is 40 (Kaiser Permanente).

Client Voices

"The surveys [Ginger.io]! They're encouraging me continually. [It] helps."

"[I'm helped by] the surveys [Ginger.io]. If I'm having a bad day, Landen will call and help me through it. If someone checks on you 5 minutes before killing yourself, it helps."

"It's helping me get better and exercise more, and helping my physical health. I wasn't exercising or drinking water at all. Everything's working out."

"I love the FitBit, tracking how many steps, how many calories I burn, how many miles. I've lost 10 pounds."

"I now have walking shoes and running shoes. It's my first new pair in my life."

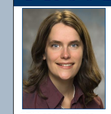
"My house was making me sick. My wellness coach helped get a safer place to stay."

"I bought me some walking shoes. Now I can walk outside."

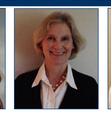
"I wasn't eating at all before Will. He gave me some food lists, and I've been able to eat now this week."

"I've seen my motivation level kind of go up a little bit from being down and not doing anything or being active to now it's gone up a lot."

PROJECT LEADERS



CRI Lead Christina VanRegenmoter, MSW, PMP: *We created this model to provide better care to those who need it the most.*



Centerstone TN Lead Mary Moran, LMHC: *Piloting coactionHealth in our Health Home has improved outcomes for our high utilizers.*

Centerstone IN Lead Maren Sheese, LCSW: *Combining health coaching, technology, and flexible funds was key for our success.*

CRI Centerstone Research Institute

For more Information

www.centerstonerseearch.org

christina.vanregenmorter@centerstone.org

615-463-6253

@vanregenmorter