

Reduce Hospital Inpatient Admissions in a High Risk High Cost Medicaid Population Using Complex Care Coordination

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BACKGROUND:

The California Department of Health Care Services (DHCS) is responsible for providing and overseeing health care to a highly diverse, publicly funded population of individuals, who often have multiple chronic illnesses, may be seriously ill and near end-of-life. These individuals are economically disadvantaged and may be lacking access to health care providers — especially those who work in a coordinated system of care. DHCS contracted with APS Healthcare (APS) to provide a Coordinated Care Management Program (CCMP) to Fee-For-Service Medicaid (Medi-Cal) Seniors and Persons with Disabilities (SPD) who have chronic conditions or who may be seriously ill and/or near end-of-life.

The highest risk and highest cost individuals within in this population are of greatest interest for intervention for APS. Consistent with current research¹, engaging the top 5% (in cost and utilization) could provide the greatest opportunity for improvements in health outcomes. High risk patients — with combinations of conditions, or diseases that have been unmanaged — make up only 5% of a typical patient population but can account for up to 60% of resource utilization².

OBJECTIVES:

The goal of the program is to decrease the fragmentation of care, improve health outcomes and end-of-life decision making while decreasing the unnecessary utilization of health care. To this end the quality improvement initiative:

1. Analyzed utilization data to identify preventable admissions and gaps in care.
2. Identified those individuals within the eligible population who are most actionable.
3. Provided Care Coordination for individuals that was targeted to their specific behavioral health and medical needs.
4. Collaborated with health care facilities to ensure appropriate discharge planning; a predictor of readmissions^{3,4}.

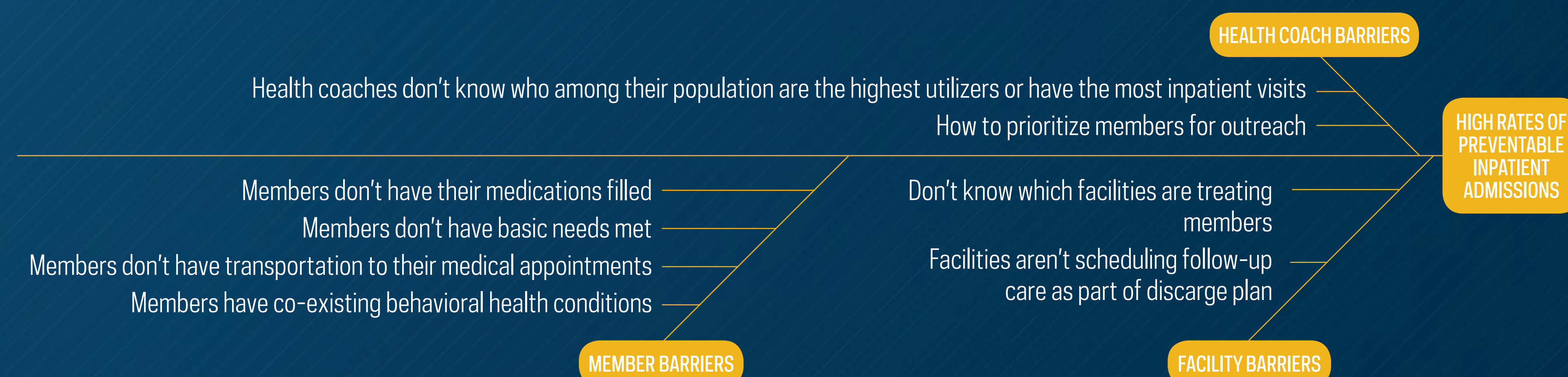
POPULATION:

The program serves Fee-For-Service Medi-Cal SPD individuals who have multiple chronic conditions or who may be seriously ill and/or near end-of-life. The population is low income — within the State and Federal qualifying thresholds — usually lacking education and resources that would result in better management of their health conditions.

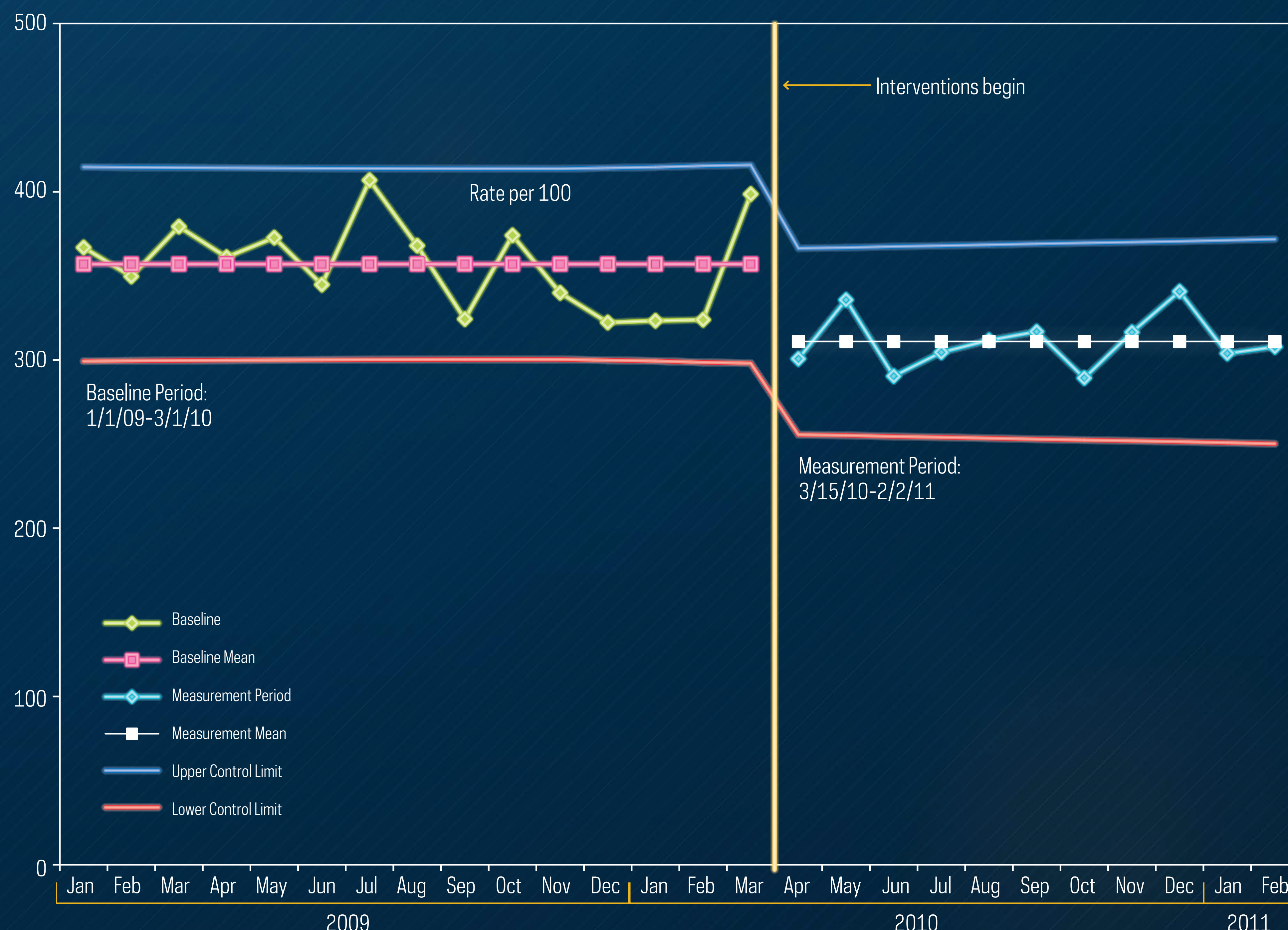
- The program has roughly 45,000 Medicaid eligible individuals and engages approximately 1,500 at any given time.
- 12,000 unduplicated individuals who were eligible for the entire intervention time period — 1/1/10-12/31/10 — were included in the analysis.
- The mean age for the engaged population is 55 years and 65% are female and 35% male.

QUALITATIVE CAUSAL ANALYSIS: REDUCING INPATIENT HOSPITAL ADMISSIONS

APS Healthcare conducted a qualitative causal analysis to determine the most significant barriers in reducing inpatient hospital admissions.



Medicaid Special Needs Population Inpatient Hospital Admissions per 1,000 Members: 2009-2010



METHODS:

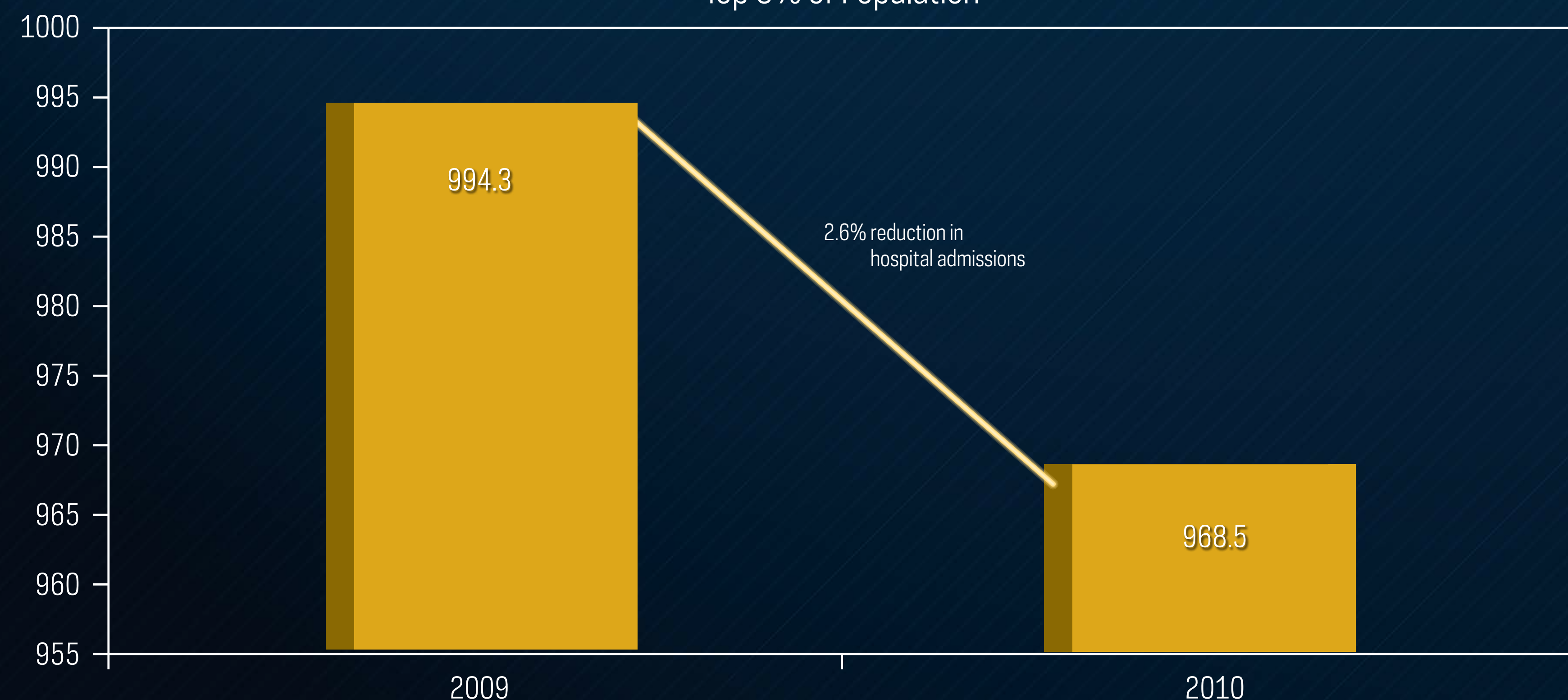
The outcome of this qualitative causal analysis was the development and implementation of four critical interventions aimed to influence inpatient admissions. The interventions included:

1. Utilized field-based care coordination — 1/1/10
 - The program hired licensed field-based care managers and ensured that each lived in the community they were serving.
 - The program used claims data to identify the facilities with the highest number of members' preventable inpatient and ER admissions that were targeted for outreach.
 - Members with Agency for Health Care Research (AHRQ) Prevention Quality Indicator (PQI)⁵ admissions were then organized by facility and field-based staff, and deployed to these facilities for collaboration with discharge planners.
2. Utilized a comprehensive assessment model — predicated on Maslow's Hierarchy of Needs⁶ philosophy — to ensure that psychosocial needs were addressed — 1/1/10
 - Program used a comprehensive assessment model to help ensure that members received support that is specific to their individual and immediate behavioral and medical needs.
 - Social Needs and Behavioral Risk Assessments guided staff in understanding the immediate physiological needs of their members.
3. Used IT tools and claims data to identify the most acute and actionable members for engagement — top 5% — 3/1/10
 - APS applied its proprietary stratification matrix to create a risk score and prioritize members. The stratification matrix integrated multiple sources of data including claims, encounter and pharmacy data to create a stratification methodology which factored in disease burden and complexity, behavior utilization patterns, gaps in care, statistical modeling of future costs, as well as age and gender.
4. Established responsibility for facility engagement — 9/1/10
 - The program created a new position entitled Provider Engagement Manager whose responsibilities included introducing and educating the facilities and providers about the benefits of the Complex Care Coordination program and how collaborative discharge planning can more effectively prevent readmissions.

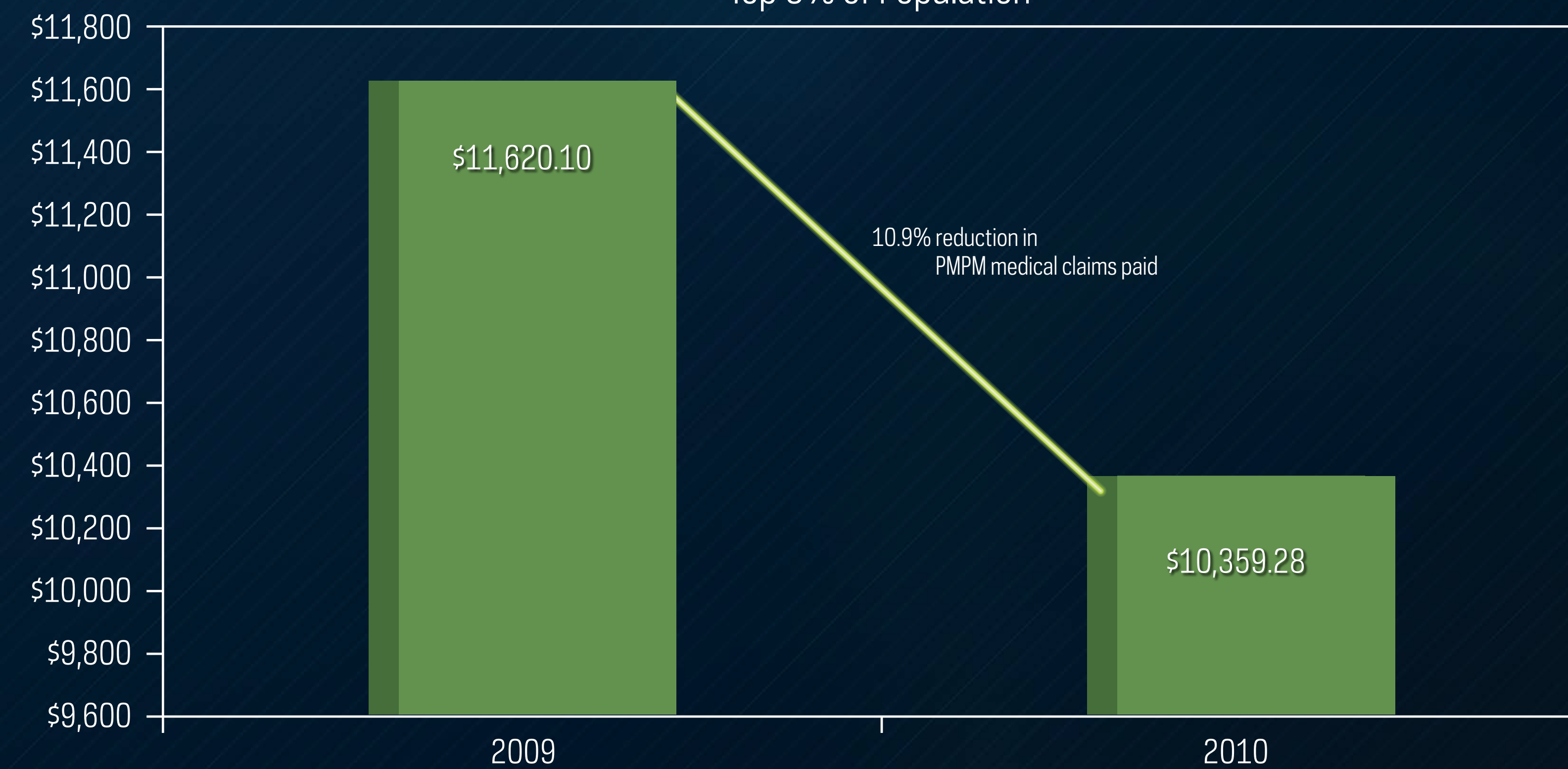
CONCLUSION:

Traditional methods of telephonic Care Coordination do not produce the same results in a marginalized Medicaid population. Meeting members where they are to conduct comprehensive care coordination can significantly influence follow up care. Additionally, targeting the highest risk and most actionable members in our population provided the greatest opportunity to impact the rate of IP admissions. Partnerships with hospitals and other health care facilities are imperative in the absence of authorization and census data. Lastly, information technology solutions play a vital role in identifying those most in need and actionable at the right time among a large population.

Hospital Readmissions per 1,000 Medicaid Members Top 5% of Population



Per Member Per Month (PMPM) Claims Paid Top 5% of Population



¹Eggett, G & Friedman, B (1988). The need for special interventions for multiple hospital admission patients. Health Care Financing Review, Dec, Spec No.57-67.

²Sanger, P. (2002). Health plans juggle precarious patients. Managed Healthcare Executive, 12(3), 38-38-40.

³Coleman EA, Berenson RA. (2004). Lost in transition: challenges and opportunities for improving the quality of transitional care. Ann Intern Med, 141:533-6.

⁴Jha, A, Orav, E, & Epstein, A. (2009). Public reporting of discharge planning and rates of readmissions. The New England Journal of Medicine, 361(12), 2637-45. doi:10.1056/NEJMe0904859

⁵http://www.qualityindicators.ahrq.gov/factsheets/pqi_resources.aspx

⁶Maslow, A. (1943). A theory of human motivation. Psychological Review, vol. 50, 1943, 370-96.