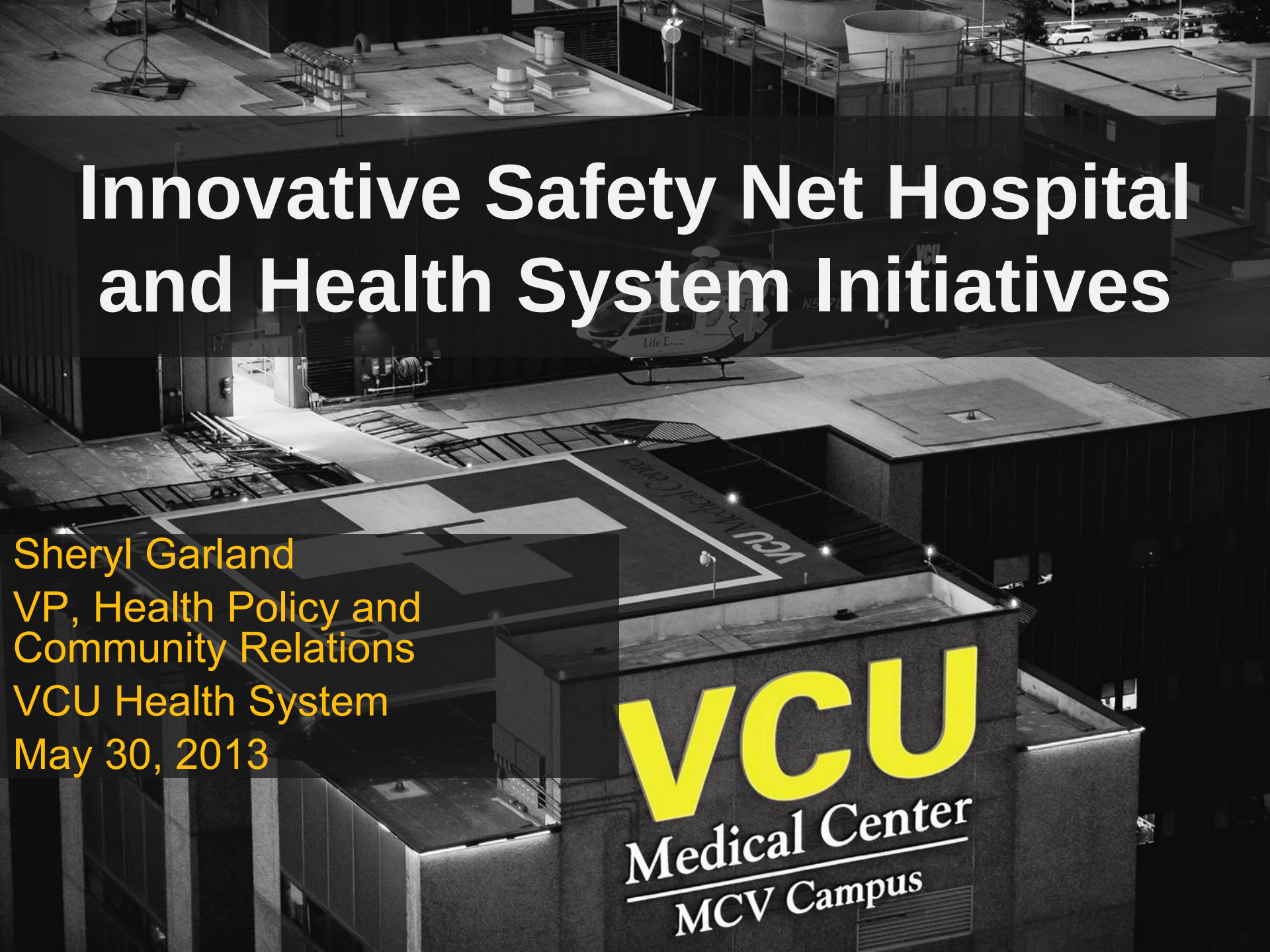
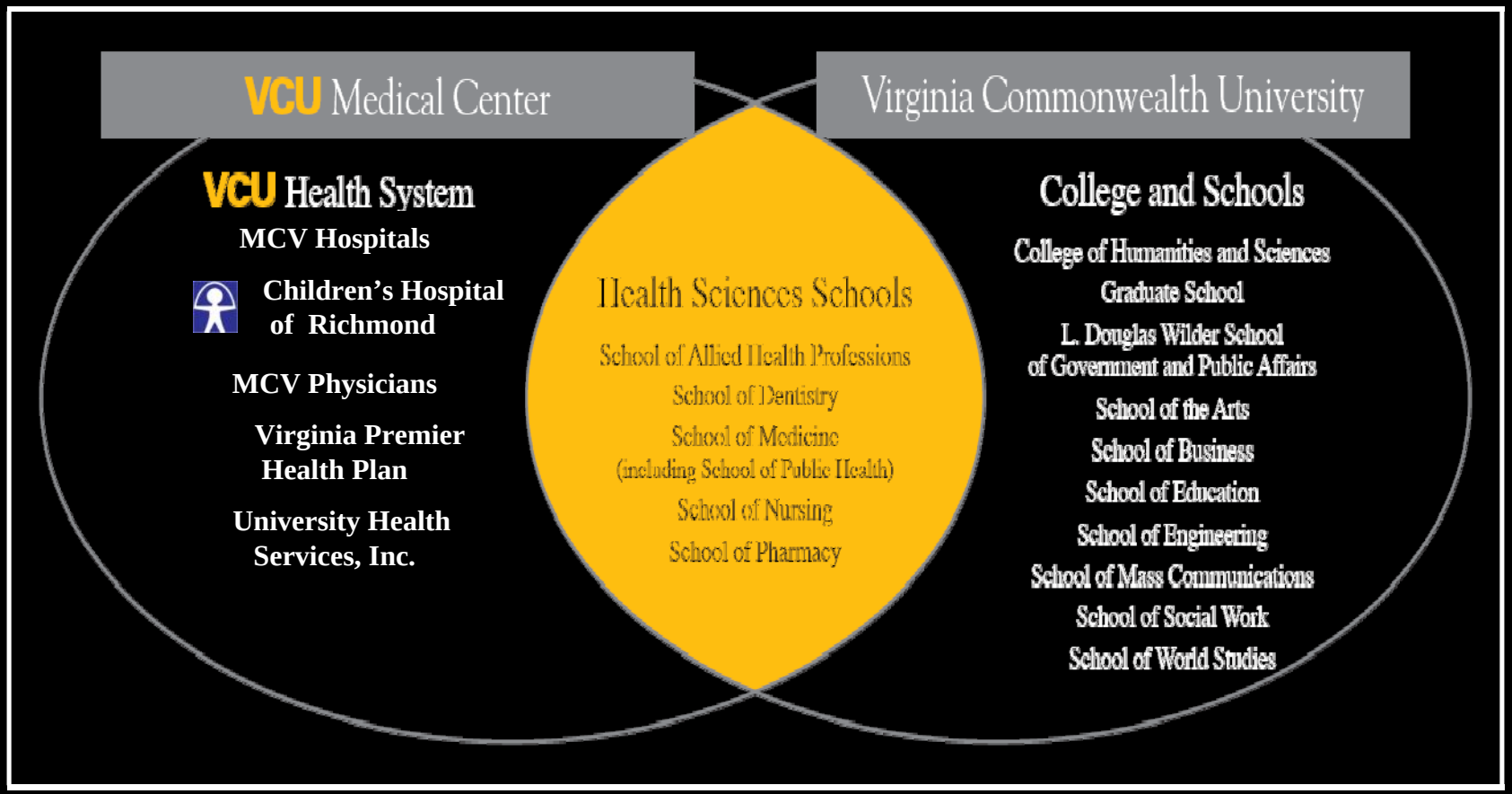
Innovative Safety Net Hospital and Health System Initiatives



Sheryl Garland
VP, Health Policy and Community Relations
VCU Health System
May 30, 2013

The VCU Medical Center

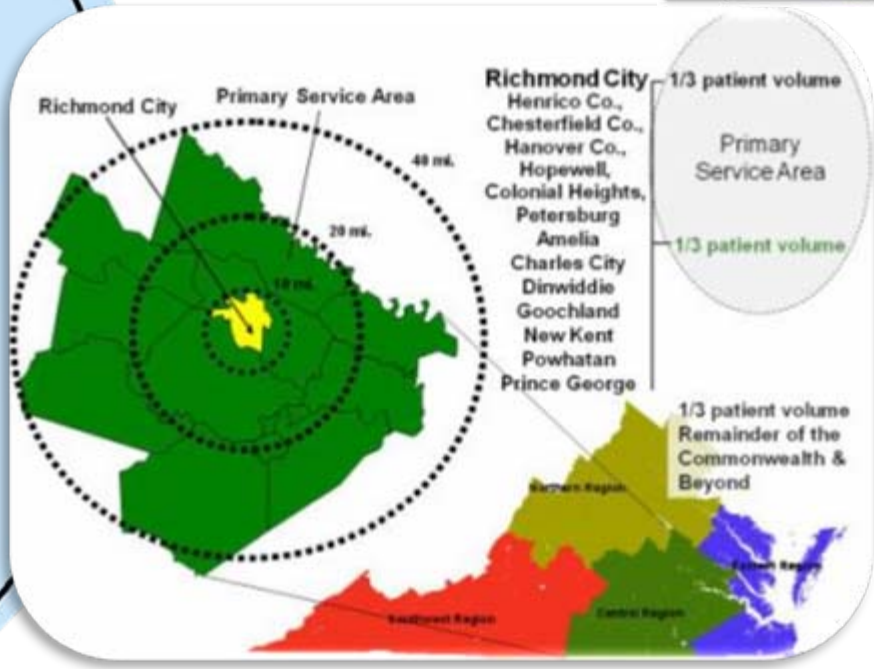


VCU Health System (VCUHS)

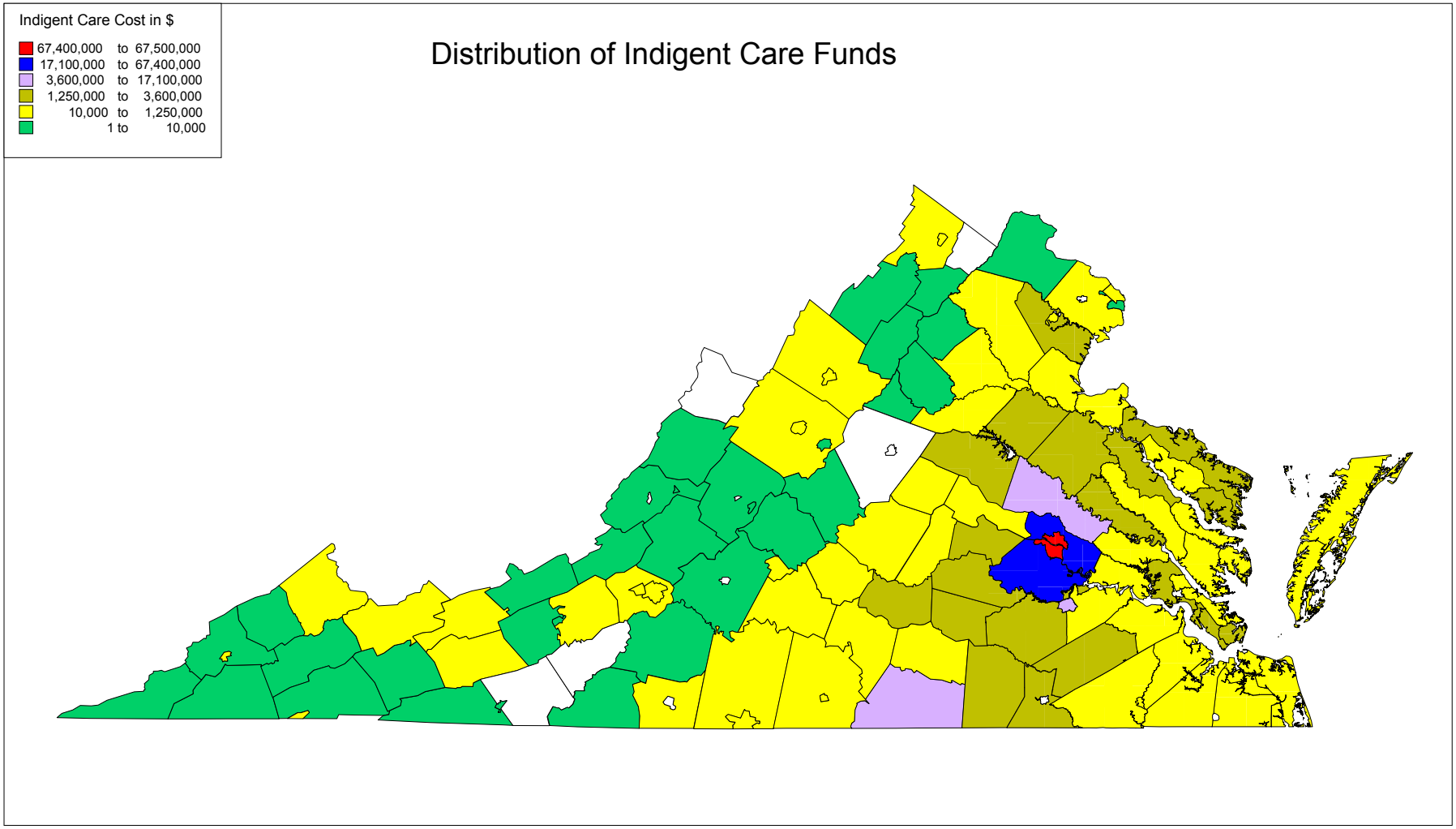
- MCV Hospital and Clinics
  - 779-bed teaching hospital
  - 80,000 Emergency Room visits
  - Over 550,000 ambulatory visits
  - Region's only Level I Trauma Center
- Children's Hospital of Richmond (CHoR)
  - Over 40 Pediatric medical/surgical specialties
  - 40-bed Private Room NICU
  - Only Level1 PICU in Central Virginia
- MCV Physicians
  - Over 600 physicians and NP's in the faculty practice plan
  - 100 specialty and sub-specialty service areas
- Virginia Premier Health Plan, Inc. (VPHP)
  - 172,000 member Medicaid HMO
  - Top-Ranked Medicaid Managed Care Organization in Virginia in 2011-2012*

*NCQA's Medicaid Health Insurance Plan Rankings, 2011-2012

The VCU Health System is a Major Regional Referral Center for Virginia and the mid-Atlantic



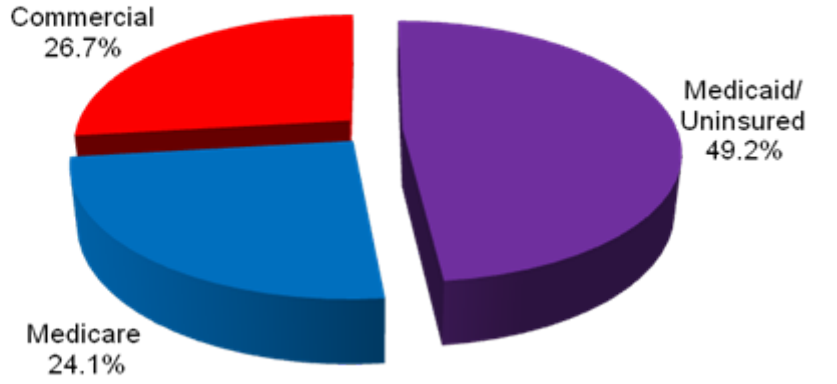
VCUHS' Medicaid and uninsured patients come from all corners of the state



Concerns for VCUHS

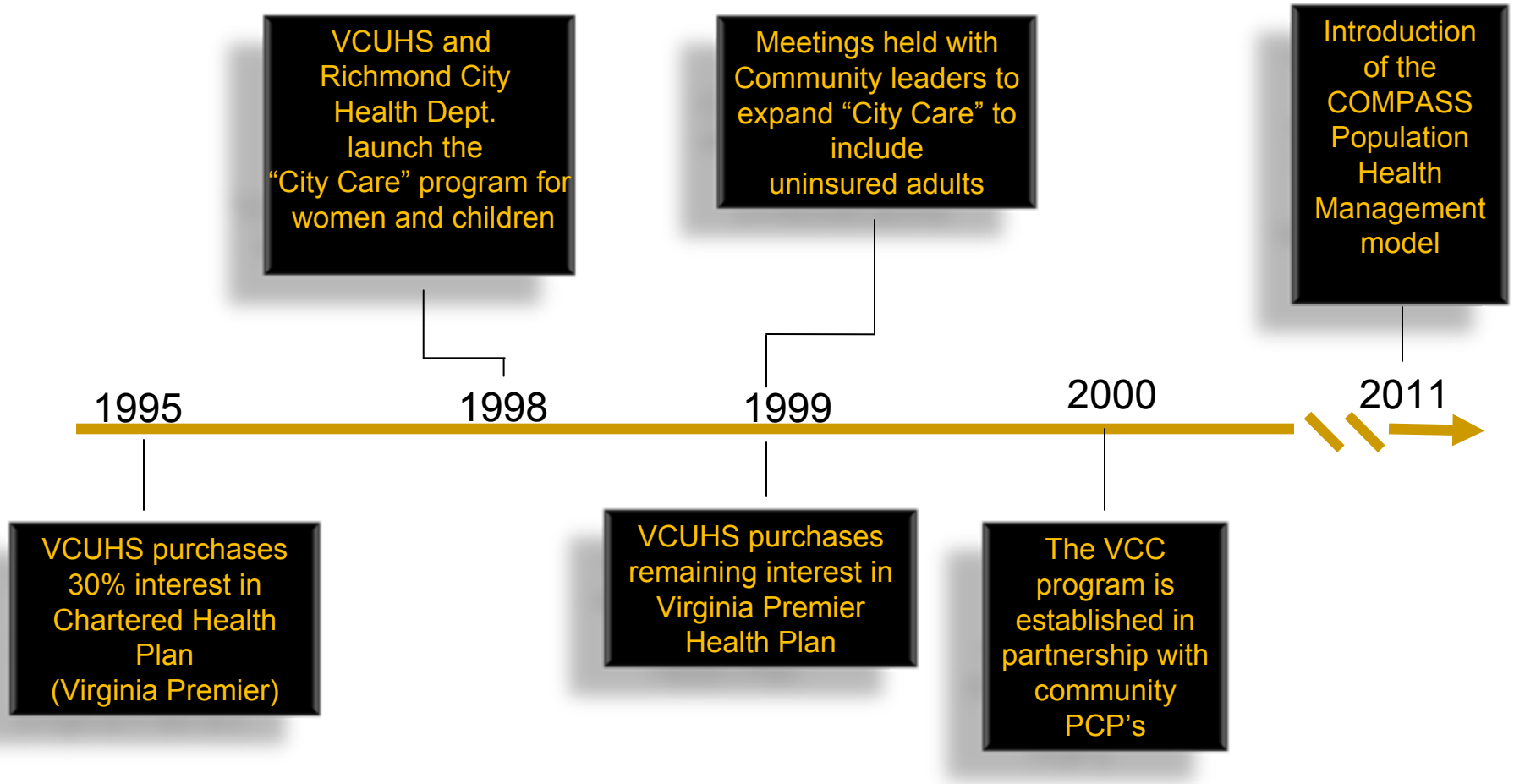
- Vulnerability of funding from governmental payers (i.e., DSH, Medicaid, and Medicare)
- Increasing need to address “Social Determinants of Health” that impact health outcomes
- Disproportionate percentage of uninsured and underinsured patients served

Source of Patients by Payer
Based upon FY12 Adjusted Discharges



Over 73% uninsured or government sponsored

VCUHS Programs Have Been Leveraged to Create Innovative Models

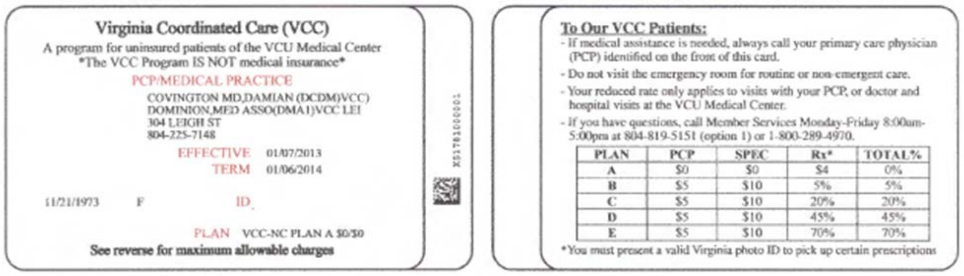


Virginia Coordinated Care (VCC) Program

- Established in 2000 to coordinate care for uninsured in Central Virginia
- Provides “medical homes” to over 27,000 patients who qualify for the VCU Health System’s Indigent Care program (below 200% FPL)
- VCUHS partners with 50 community-based physicians to improve access to care
  - Patients receive case management and navigation support
- Recognized as a model for managing care for uninsured patients

VCC Operations

- Virginia Premier Health Plan serves as the program's Third Party Administrator
- VCUHS Financial Counseling staff conduct financial screening for the program
- VCC Care Coordination staff conduct a health assessment for qualified patients
- Patients are enrolled for a 12-month period and assigned a medical home
- VCU faculty and staff assist with data analysis and evaluation of the program



VCC Program has demonstrated utilization reductions

COVERAGE ISSUES

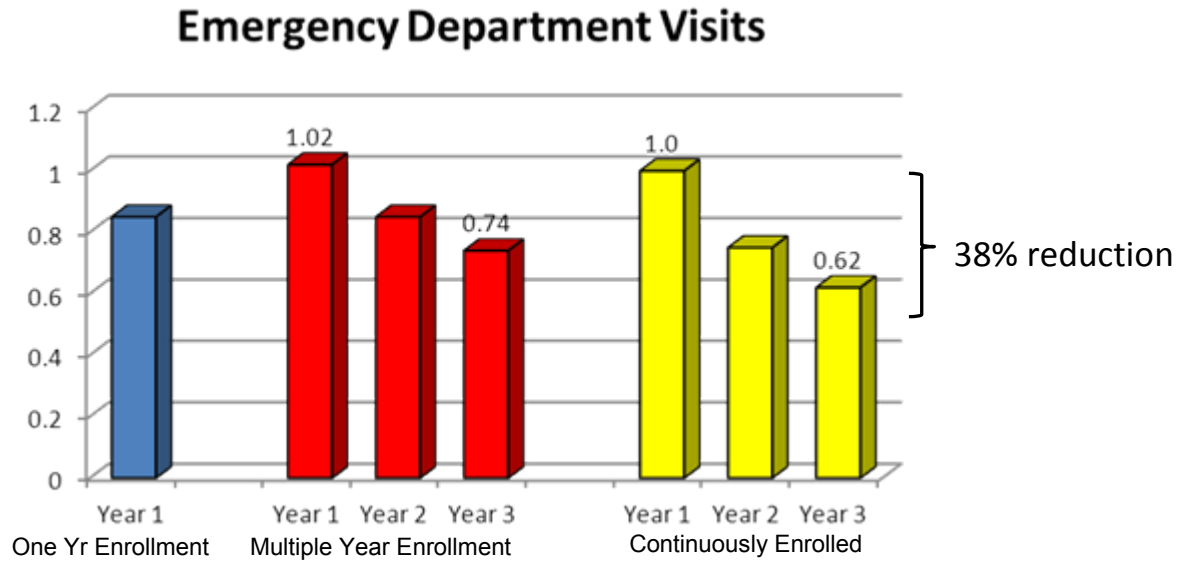
By Cathy J. Bradley, Sabina Dhir Gandhi, David Neumark, Sheryl Garland, and Sheldon M. Retchin

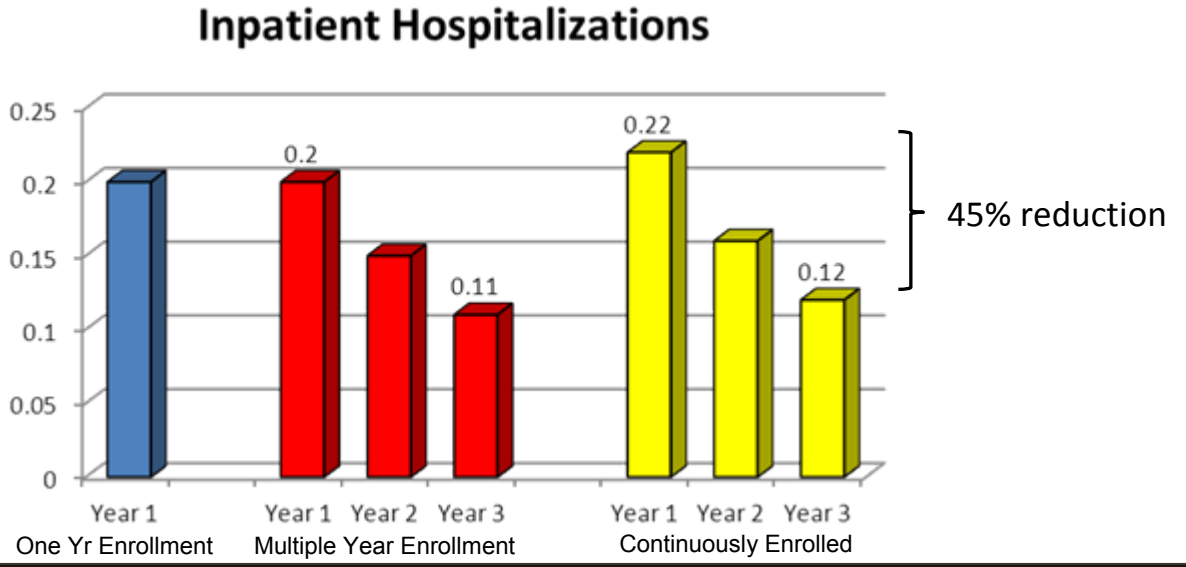
Lessons For Coverage Expansion: A Virginia Primary Care Program For The Uninsured Reduced Utilization And Cut Costs

ABSTRACT The Affordable Care Act will expand health insurance coverage for an estimated thirty-two million uninsured Americans. Increased access to care is intended to reduce the unnecessary use of services such as emergency department visits and to achieve substantial cost savings. However, there is little evidence for such claims. To determine how the uninsured might respond once coverage becomes available, we studied uninsured low-income adults enrolled in a community-based primary care program at Virginia Commonwealth University Medical Center. For people continuously enrolled in the program, emergency department visits and inpatient admissions declined, while primary care visits increased during the study period. Inpatient costs fell each year for this group. Over three years of enrollment, average total costs per year per enrollee fell from $8,899 to $4,369—a savings of almost 50 percent. We conclude that previously uninsured people may have fewer emergency department visits and lower costs after receiving coverage but that it may take several years of coverage for substantive health care savings to occur.

There is compelling evidence that people without health care coverage make inappropriate use of health care services,[1] such as excessive use of the emergency department[2] and avoidable hospitalizations.[3] The ef- emergency department use under Medicaid managed care programs,[4] especially those that use coordinated primary care. However, the evidence from studies of Medicaid managed care on cost reductions, increased access, and quality is inconclusive.[5,6]

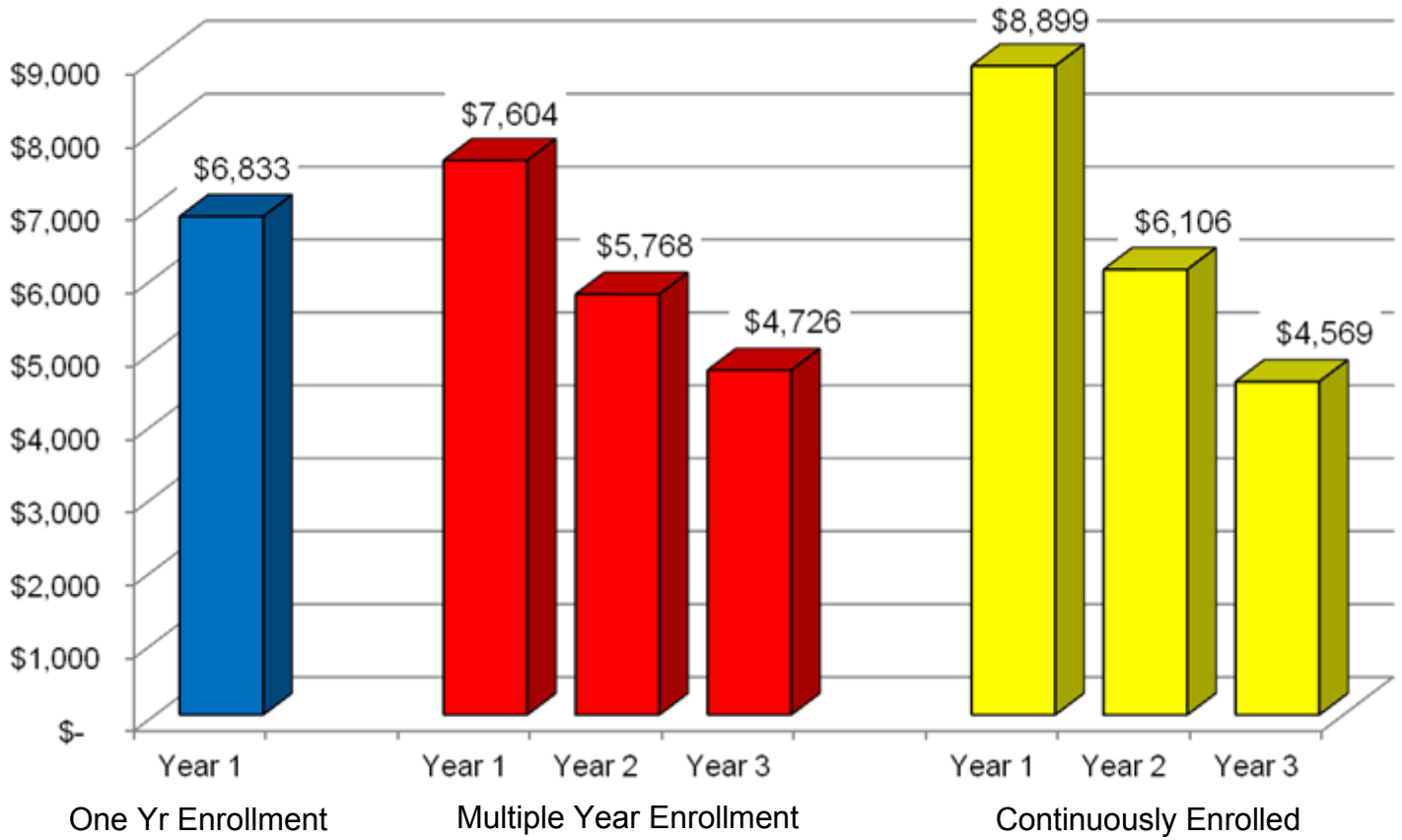
Bradley, C, Gandhi, S, Neumark, D, Garland, S, Retchin, S, Lessons For Coverage Expansion: A Virginia Primary Care Program For the Uninsured Reduced Utilization And Cut Costs, *Health Affairs* 31, No. 2 (2012): 355





VCC Program has also demonstrated reductions in costs

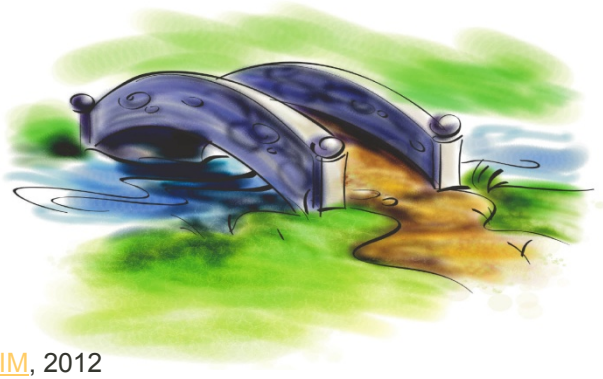
VCC Population
Average Cost/Year
(2000 – 2007)



Bradley, C, Gandhi, S, Neumark, D, Garland, S, Retchin, S, Lessons For Coverage Expansion: A Virginia Primary Care Program For the Uninsured Reduced Utilization And Cut Costs, *Health Affairs* 31, No. 2 (2012): 350-359

VCC is a “Bridge” to Health Reform

- Enrollees will be eligible for Medicaid or Health Insurance Exchanges beginning in 2014
  - >80% of the population is below 133% FPL
- VCC community providers may play a critical role in addressing access issues for the “newly insured”
- VCUHS Launched a **Population Health Management** initiative that focuses on the Institute of Healthcare Improvement’s “Triple Aim”:
  - **Improve the patient experience of care;**
  - **Improve the health of the population; and**
  - **Reduce, or at least control, the per capita cost of care***

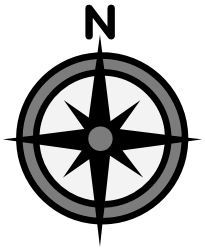


*IHI Triple Aim Initiative, Institute for Healthcare Improvement, www.ihi.org/offerings/Initiatives/TripleAIM, 2012

VCUHS Population Health Management Model

COMPASS

(Coordinated Care Options to Manage Patient Access to Systems and Services)



Medical Neighborhood

Care Coordination/Case Management

Community Partnerships

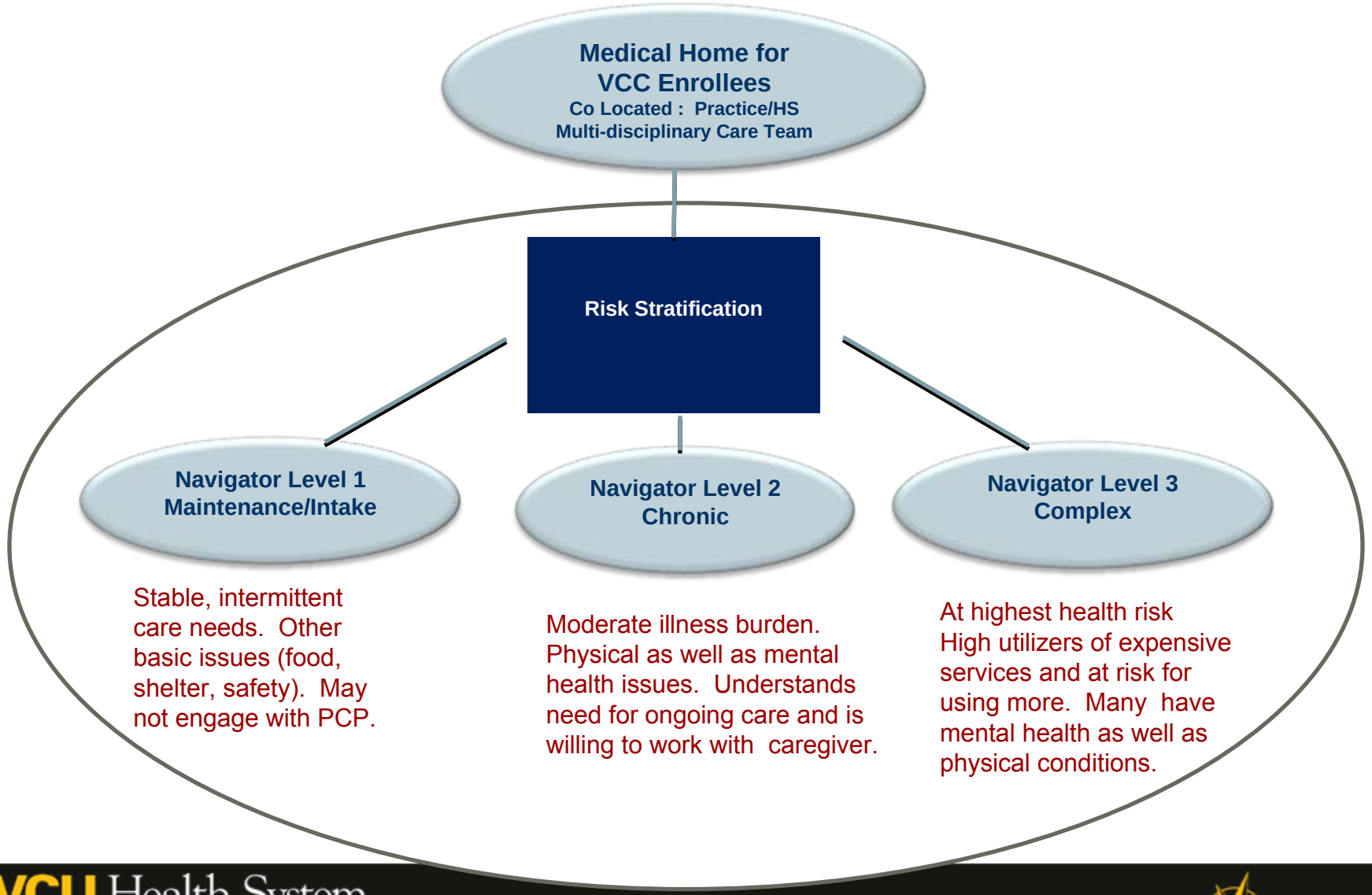
Payment Reform

Information Exchange and Data Analytics

Populations
Uninsured/VCC
Employees
Medicare
Medicaid
Commercial

Results:
- Improve Care for Patients
- Improve the Health of the Population
- Reduce per capita costs

VCC Population Risk Stratification



Interventions focus on populations with highest risk and costs

FY10 Allocation of VCC Hospital Costs

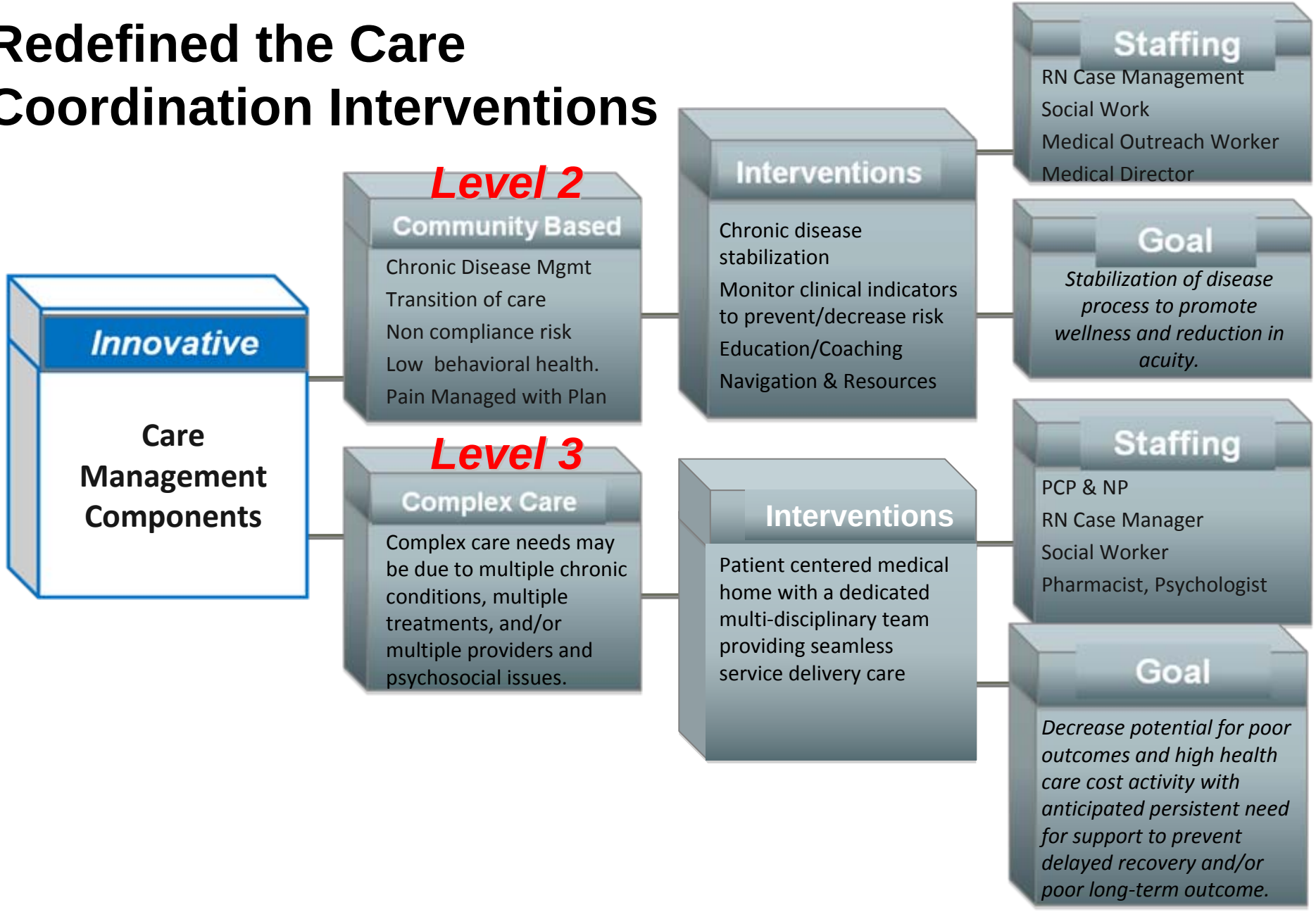
Risk Stratification	Population*	Hospital Costs**
Level 1	61%	20%
Level 2	15%	24%
Level 3	6%	56%

80% of Costs

*8% of the population did not use hospital services

**Based upon FY10 hospital costs of $56 million excluding Outpatient Pharmacy and physician services

Redefined the Care Coordination Interventions

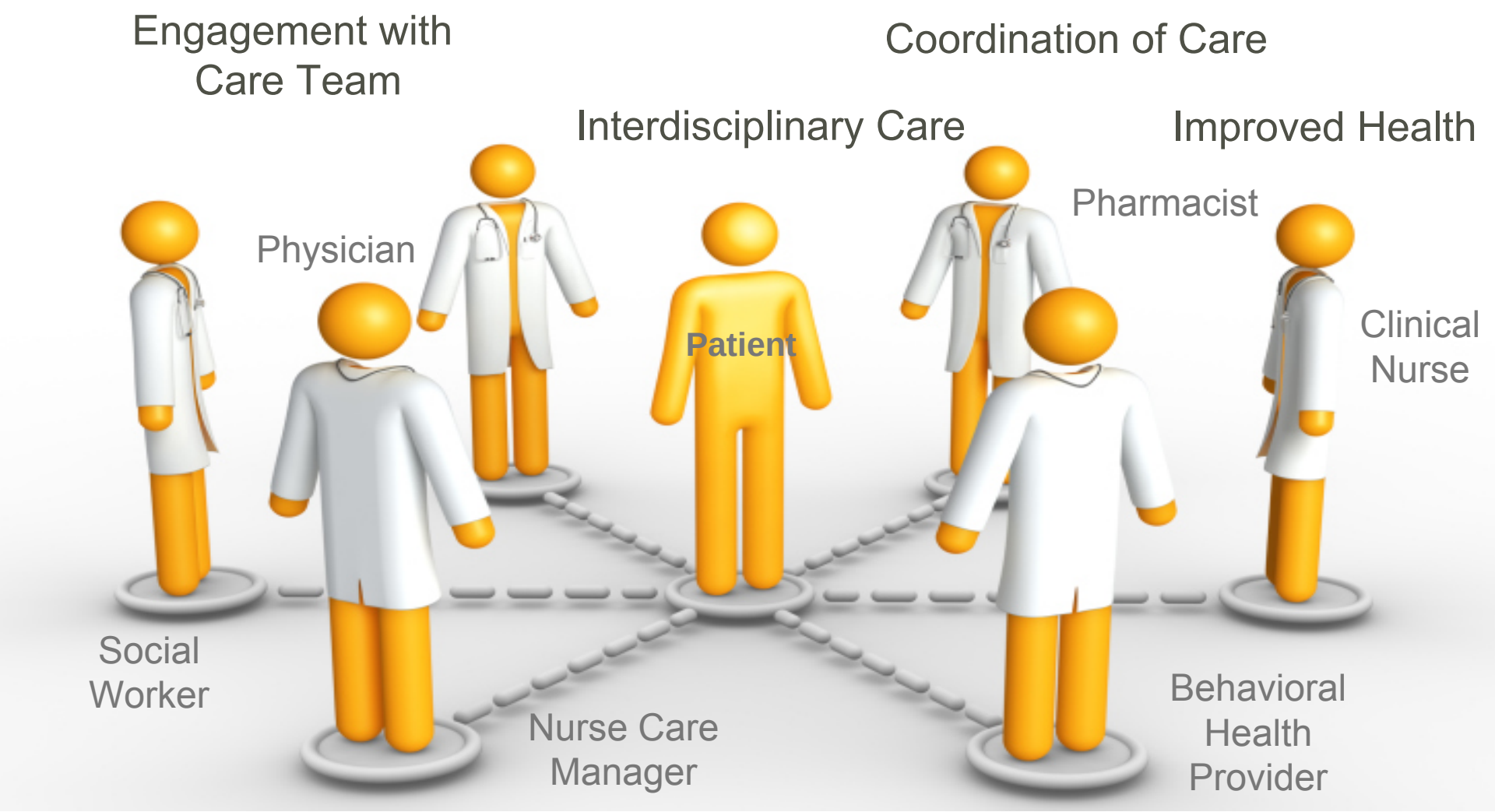


Medical Neighborhood Includes a Complex Care Clinic for High Risk Patients

- Established a VCUHS clinic supported by an interdisciplinary team in November 2011
  - Physician
  - Nurse Practitioner
  - RN Case Manager
  - Social Worker
  - Behavioral Health Specialist
  - Pharmacist
- Focused on patients with the highest cost and utilization
  - VCC enrollees with 3 or more chronic conditions
  - Most prevalent conditions were hypertension, behavioral health, and diabetes
  - Over 500 patients enrolled as of April 2013

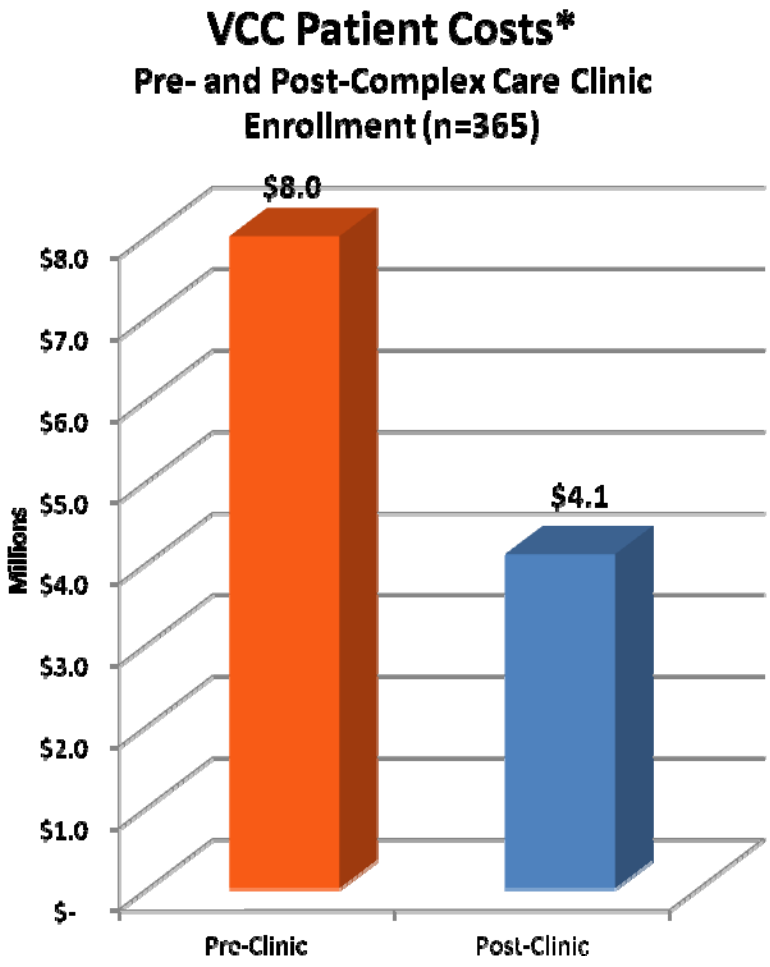
Patient Experience *Without* the Complex Care Clinic

Patient Experience *With* the Complex Care Clinic



Pre- and Post- Clinic Utilization Study

- Evaluated patients with at least one clinic visit between Nov. 2011 and Oct. 2012
- Cost of care for the population was reduced by approximately **49%**
- Inpatient utilization dropped **44%**
- Emergency Department use fell **38%**



*Includes Hospital inpatient, outpatient and ED costs

Population Experienced Improved Clinical Outcomes

- Percent of patients with hemoglobin A1c under control (HbA1c <7%) increased from **35% to 47%**
- Percent of patients with cholesterol under control (LDL-C <100 mg/dL) increased from **39% to 50%**
- Percent of patients with blood pressure under control (< 140/90 mmHg) increased from **39% to 58%**

Lessons Learned

- Establishing partnerships (not just contracts) with providers has improved program outcomes
- Stratification of the population allows for more effective alignment of resources
- Building care coordination models that incorporate community-based partners strengthens the ability to address social determinants of health
- Interdisciplinary care models strengthen the medical home for patients with multiple chronic conditions
- Providing accurate and timely data to providers is critical to achieve improved outcomes