The Cleveland Super-Utilizer Project: Red Carpet Care

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MetroHealth

- 750 bed facility includes rehab, SNF
- Link to Case Western Reserve School of Medicine
- 500 employed physicians
- Level I Trauma, burn center, spinal and rehab, regional LifeFlight, 100k visit-ED
- 53% of county’s uninsured/ Medicaid
Background
IMPROVE

- Statewide Medicaid effort to decrease avoidable ED visits-2010
- NEO: Non-mental health “ultra-utilizers”
- Care plans devised by MH Medical Director in cooperation with PCP, Case Managers at payor
- Care Plans in EMR (EPIC)
- Ready identification by ED

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IMPROVE

• Payor case managers
  – Assisted in making appointments
  – Appointment reminders
  – Arranged transportation
  – Educate about medications
  – Accompanied patients on visits
  – Offer free pre–programmed phones

• Monthly review of plans

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IMPROVE Outcomes

• Decrease in ED visits at MH by 44% in a year
• Increased communication with payor
• Effective education of patients
• Coordinated patient care
• Reduction in nonclinical work for provider
• Development of patient self-management and responsible behavior
• Program continues into 3rd year.
An Important Lesson

• In a FFS environment:
  – MetroHealth lost revenue due to decrease in ED visits and hospitalization
  – Medicaid plans saved

• Going forward:
  – Shared savings
  – PMPM
  – Payor-funded case managers
Methodology

- Partnered with:
  - Medical Mutual of Ohio - commercial plan
  - Buckeye Community Health Plan - Medicaid

- Innovative financial model:
  - Payor funded APNs
  - PMPM
  - Shared savings
Methodology

• Steering Committee
  – Data:
    • Chaired by Randy Cebul, MD, Metro
    • Epidemiologists from Metro
    • Finance representation from each plan
  – Intervention
    • Chaired by Alice Petrulis, MD, Metro
    • Representation from each health plan
      – Case managers- medical and behavioral health
Methodology-cont’d

• Lists of possible recruits
  – Criteria:
    • DM, HTN, HF
    • High cost due to ED and hospitalizations
  – Exclusion criteria
    • CA
    • ESRD
    • Pregnancy
  – Goal- 150 recruits
    • 75 from each plan
Focus Groups

• 2 sets of patients identified from prior IMPROVE project
• Lunch/transportation
• Results
  – Want to see same provider every time
  – Desire for provider to like them and want to take care of them
Methodology-cont’d

• APNs
  – Two
  – Prescriptive authority

• 2 different delivery models
  – One as PCP
  – One as case manager with other PCPs

• Sites
  – Main campus- FP
  – Urban satellite
Tools

• EMR: EPIC
• Registry
  – Reminders about next appt
  – Post discharge phone calls
• EMR alert if patient in ED or hospital
• Weekly meetings with CMs at plans
  – Avoid duplication
• Journals- patients and APNs
Community Resources

- West Side Catholic Center
- University Settlement
- Providers of food, housing support, notaries, clothing, counseling
Tools

- Surveys- experience of care
- Phones for APN
  - Avoid patient wait on call tree
- Phones for patients
  - Criteria
  - Relieved concern re minute limits
  - Ready ID of call from APN
  - Direct access to APN
Tools

- Notepad, pedometers, water bottles, pillboxes
- APN business cards
- Patient toolkit- bag, calendar with note pg
Activities of APNs

• Recruitment
  – Success of ED and hospital visits

• Intake form
  – Camden Coalition
  – Depression screening
  – Questions re education/literacy, legal issues
  – Mobility, Transportation needs, food, pain
  – Home visits

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Activities, cont’d

• Appt reminders
• Medication reconciliation
• Urgent phone calls
• Urgent visits
• Care plans in EPIC
Metrics

• Quality metrics
  – DM, blood pressure, lipids, CA screen, immunization
• ED visits and hospitalization reduction
• Show rates
• Medication refills
• Surveys
Success and Testimonials

- Home visit aborted ED visit
- Interaction in ED prevented readmission
  - Meds, shoes
- Cart
- Pulse oximeter
- Rehabilitated drug abuser
- Senior Advantage
Key to Success

- Collaboration with health plans
- Access to provider—same provider
- Integration of BH and nutrition
- Group clinic availability
- Identification of all patient needs
  - Housing
  - Transportation
  - Community resources
Thank you

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