The Cleveland Super-Utilizer Project: Red Carpet Care

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

Background

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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.

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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

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Methodology

- Partnered with:
  - Medical Mutual of Ohio- commercial plan
  - Buckeye Community Health Plan- Medicaid
- Innovative financial model:
  - Payor funded APNs
  - PMPM
  - Shared savings

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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

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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

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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

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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

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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

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Community Resources

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

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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

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Tools

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

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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

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Metrics

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

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Success and Testimonials

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

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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

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Questions

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Thank you

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