Bridges to Care

A MULTIDISCIPLINARY CARE COORDINATION DEVELOPED TO IMPROVE THE HEALTH OF HIGH UTILIZERS IN AURORA, COLORADO.

SCHOOL OF MEDICINE
Department of Emergency Medicine
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

University of Colorado Hospital
UNIVERSITY OF COLORADO HEALTH

MCPN
METRO COMMUNITY PROVIDER NETWORK

Aurora Mental Health Center

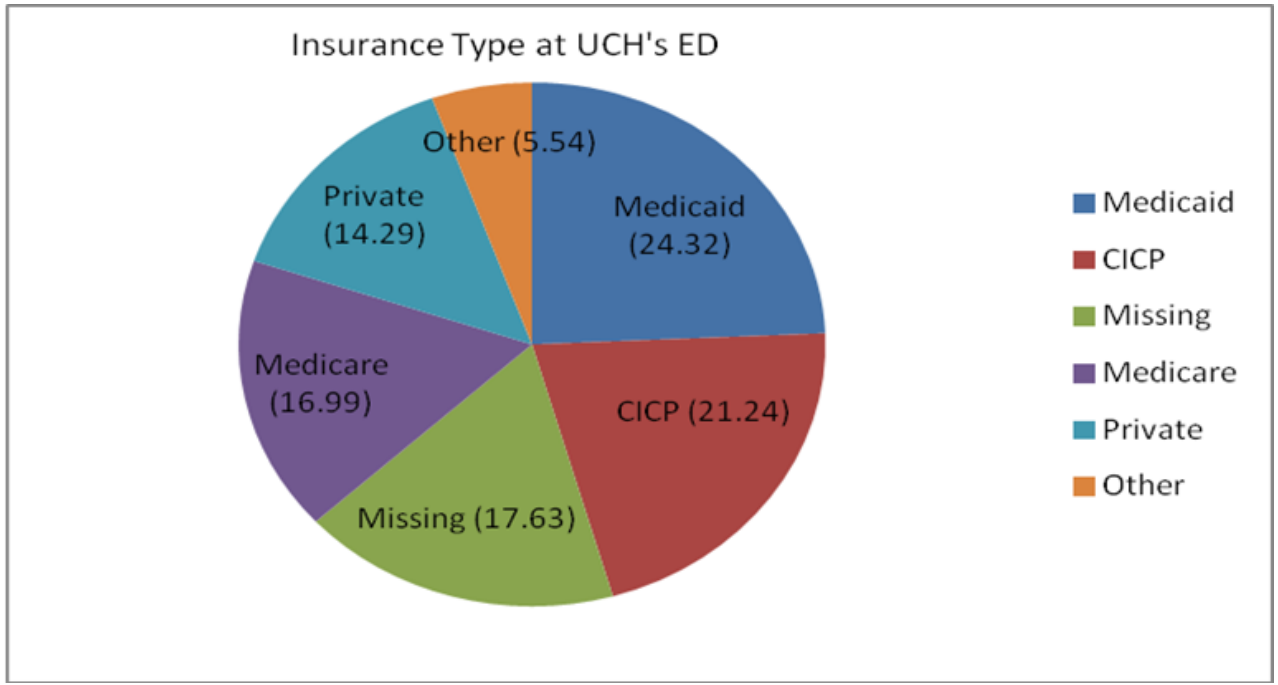
TOGETHER COLORADO

University of Colorado

SCHOOL OF MEDICINE
Department of Emergency Medicine
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

University of Colorado Hospital
UNIVERSITY OF COLORADO HEALTH

UCH Emergency Department



THE NEW YORKER

MEDICAL REPORT

THE HOTSPOTTERS

Can we lower medical costs by giving the neediest patients better care?

by Atul Gawande JANUARY 24, 2011

Hot Spotters

3 or more ED visits in 1 year

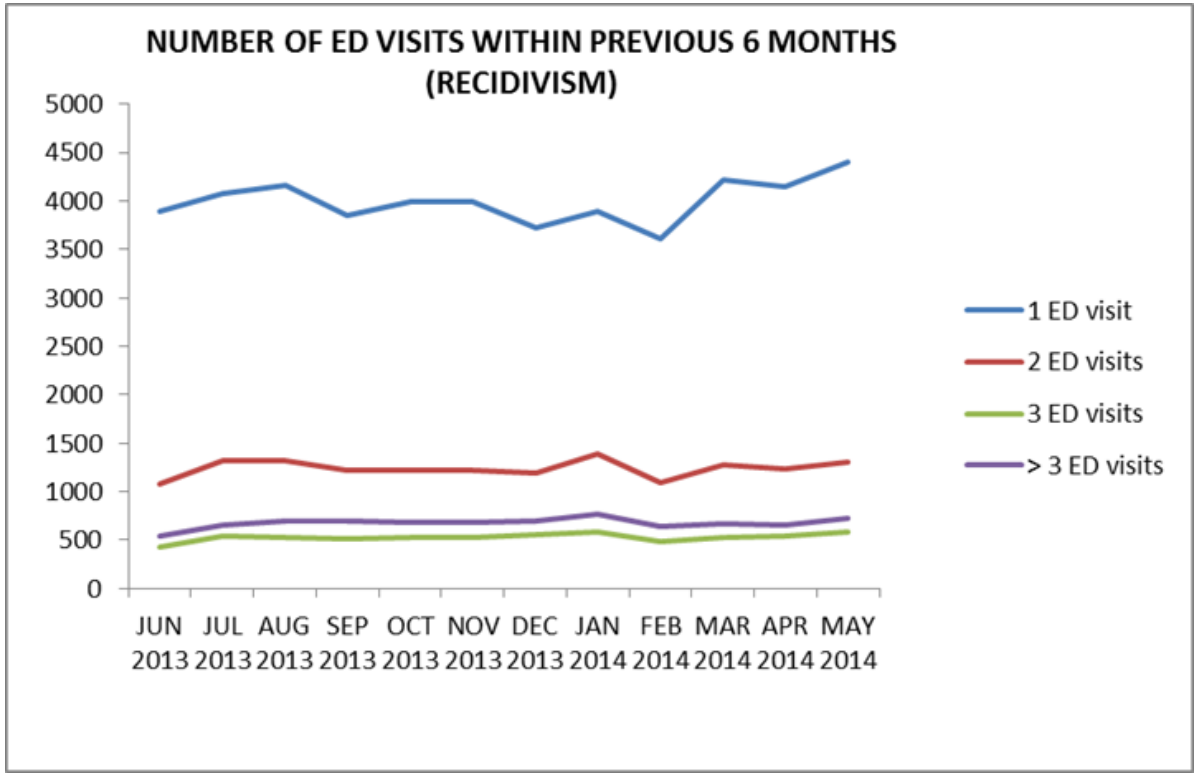
10% of population = 70% of health care expenditures

Medicaid: 2x rate of ED use than insured

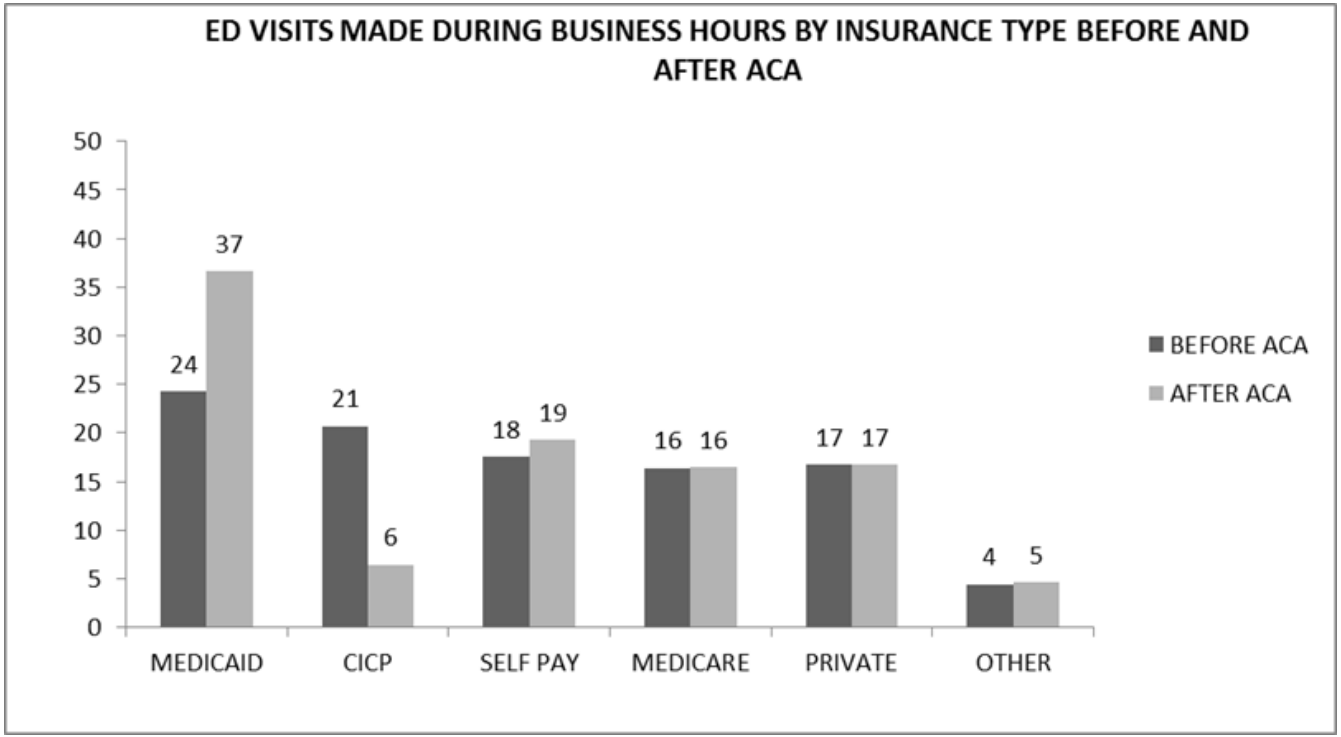
New Yorker, 1/24/11: Dr. Jeff Brenner; Camden, N.J.

- 1% of 100,000 residents use medical services → 30% of total costs
- 2 high-rise apartments: high numbers of costly care
- “ED visits and hospitalization = failures of health system”

New patients or loyal customers?



Emergency Department (ED) Outcomes



Bridges to Care Goals

900 patients by June 2015

Demonstrate cost savings w/ ↓ ER & Inpatient use

Increase Medicaid enrollment

Decrease Illness Burden

Transition patients from home visits to clinic

Establish medical homes for patients

Demonstrate and develop sustainability plan

B2C Collaboration

Community organizations, primary care clinics, mental health clinics and UCH

Intensive care coordination services from multidisciplinary team for 60d

- Health coach - promote healthy behavior lifestyle changes
- PCP - promote preventive care and visits to the clinic
- Care coordinator - connects clients with community resources
- Community organizer – health advocacy training to promote better delivery of health care services
- Behavioral health assessment & interventions/referrals

Recruited in ED by a community health worker

Enrolled in Program

Adults with 3 or more visits to the ED in 6 months

Exclude patients with chief complaints related to acute mental health and substance abuse conditions, end stage chronic disease, and pregnant.

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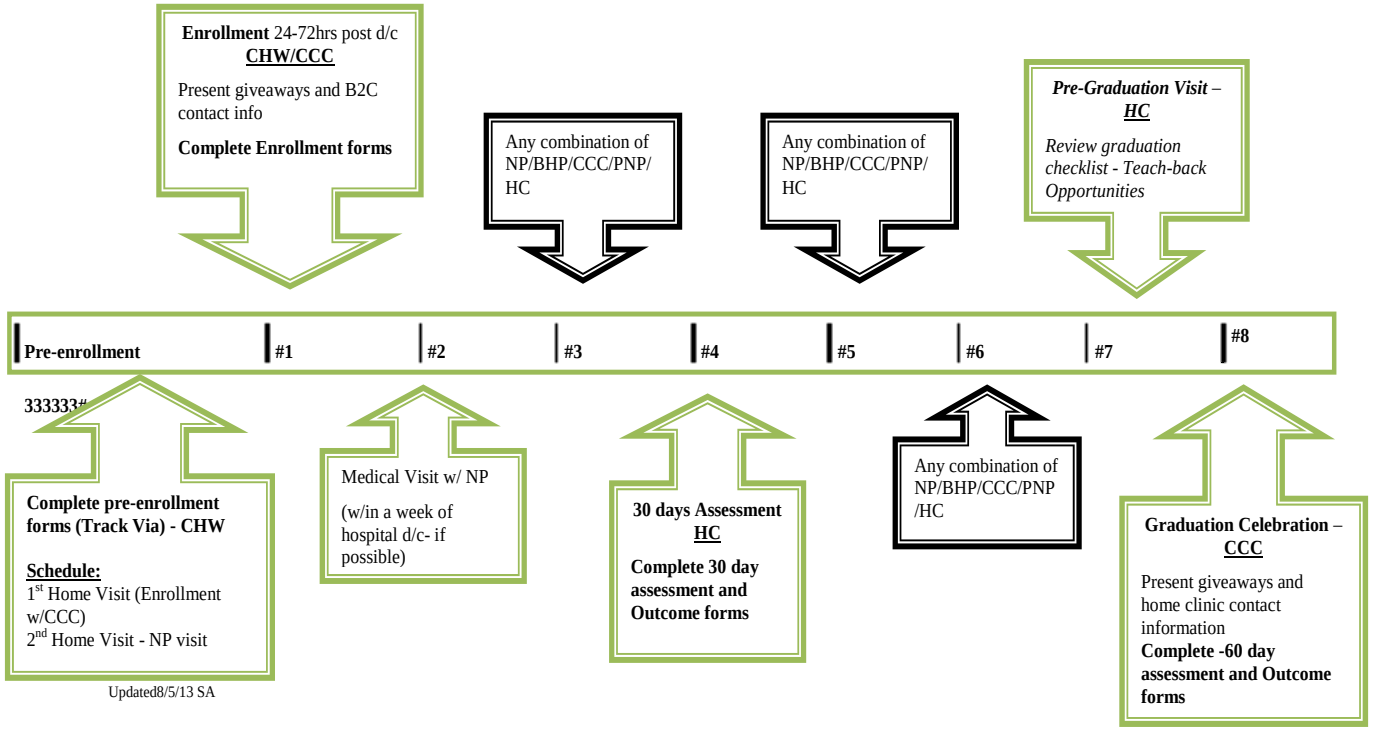
B2C Home Visit Timeline

THIS IS TO BE USED AS AN TOOL

NOT ALL PATIENTS WILL FOLLOW THIS TIMELINE EXACTLY.

60 day model (Minimum of 8 visits)

More home visits may be needed to graduate the patient from the program



Updated8/5/13 SA

How was it funded?

$4.2M CMMI funded 3 year program 2011-2014, as part of multi-site study:

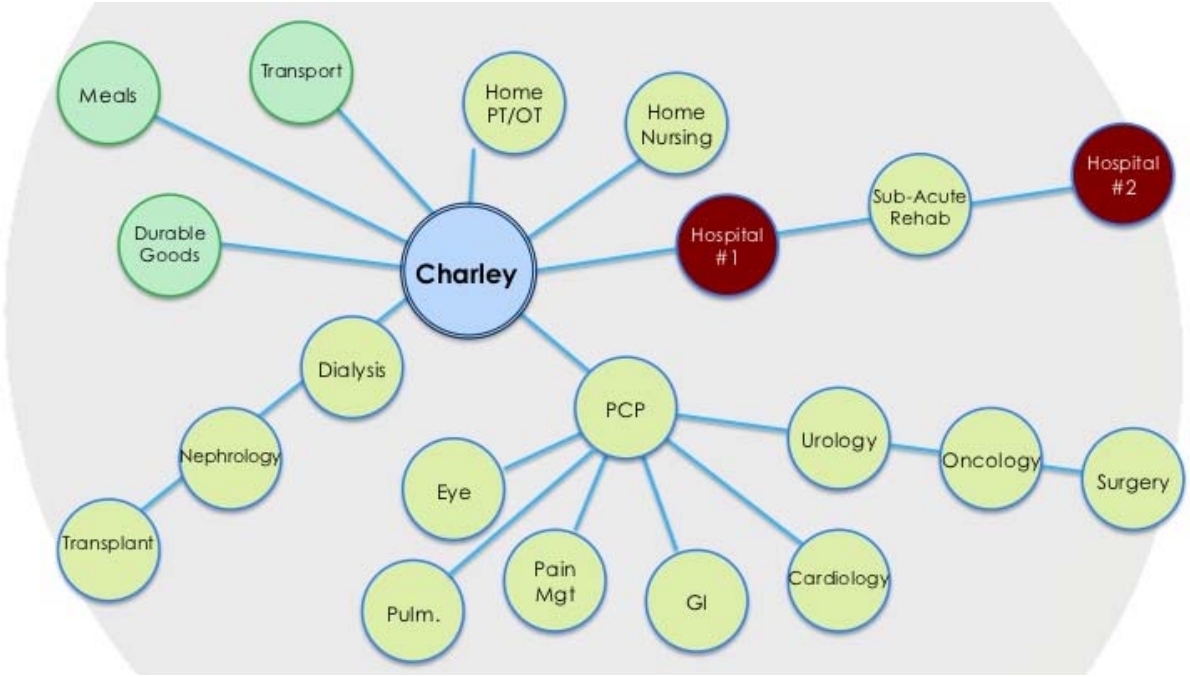
- Allentown, PA
- Aurora, CO
- Kansas city, MO
- San Diego, CA
- Camden, NJ

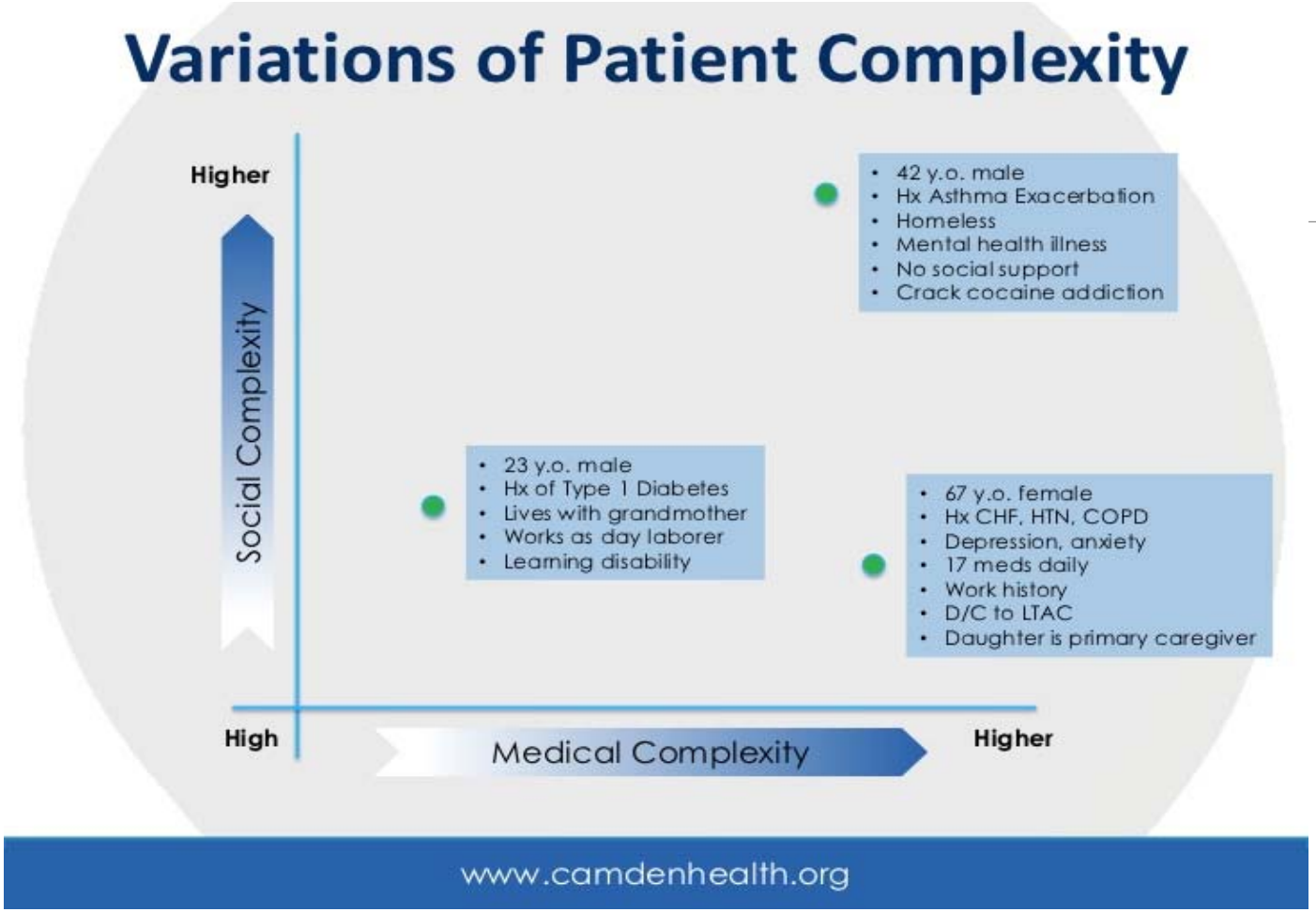
Each site had its own care coordination team, ranging from having a care coordinator to a multidisciplinary team doing home visits

The Colorado site was the only site to integrate behavioral health services into the program, where all clients were screened and treated for behavioral health diagnosis

Findings

Typical Patient





B2C created customized care plans for patients

Barriers to Participation in Program

Enrollment:

Barriers to Care

Financial Instability: unable to afford copays/meds, uninsured, period of unemployment, medical debt)

Lack of Transportation (47%)

Lack of Timely appointments (61%)

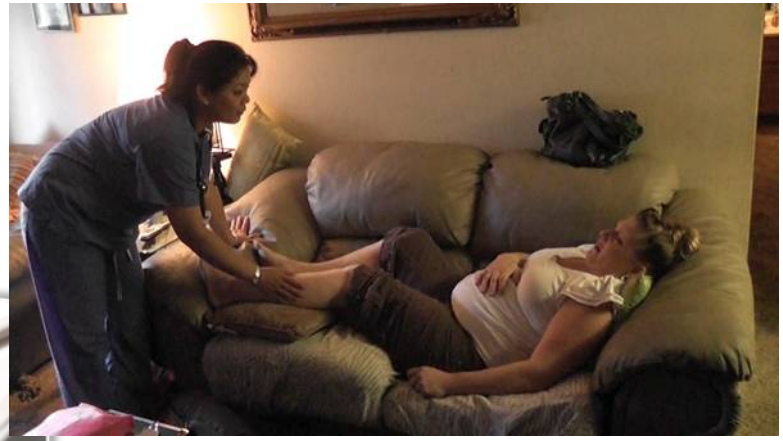
No Primary Care Provider (55%)

Lack Specialty care access (insurance status, ability to pay) (38%)

Current system does not pay for ED and outpatient collaboration

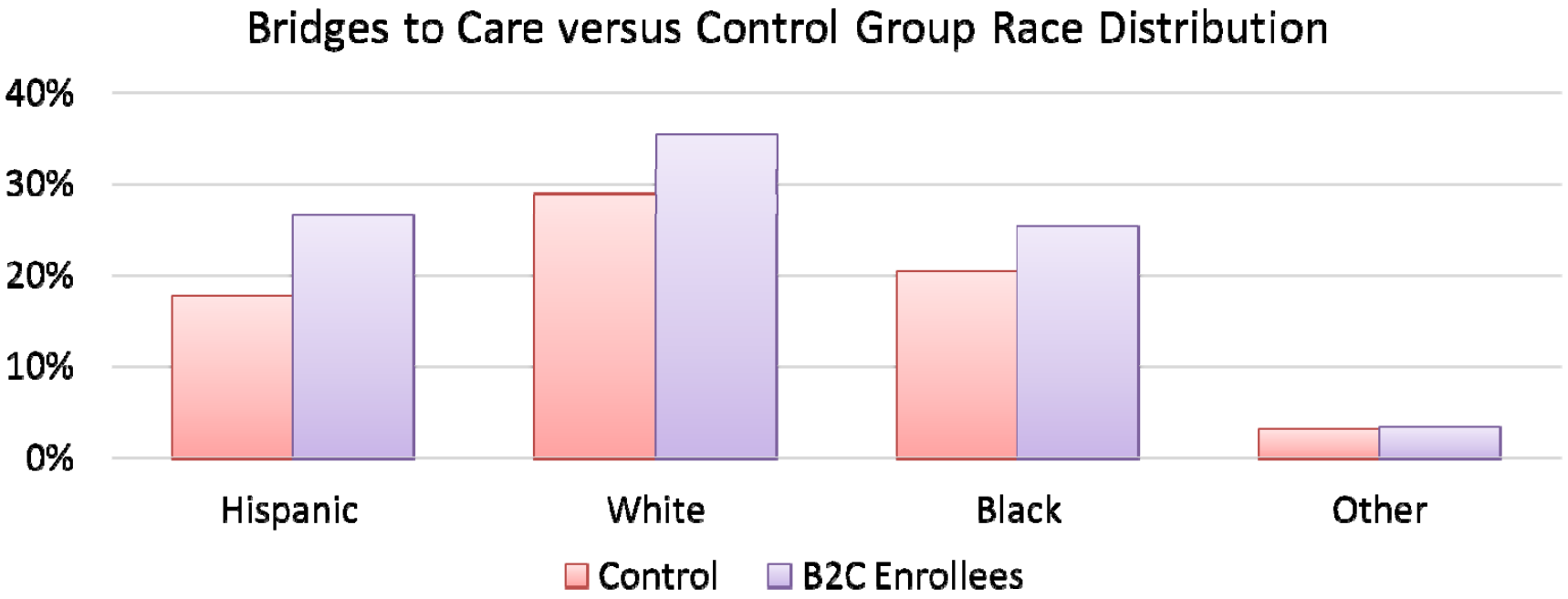
Current system does not have for home visits

Home Based Initial Intervention

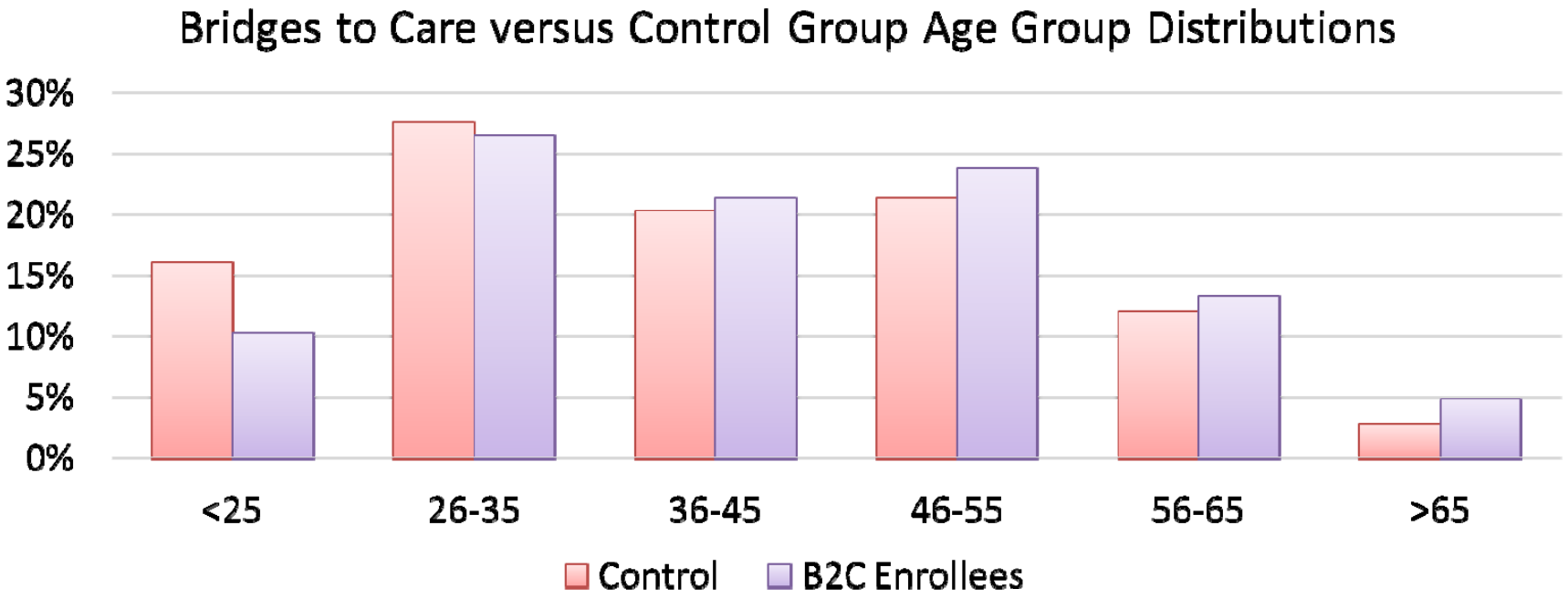


Results

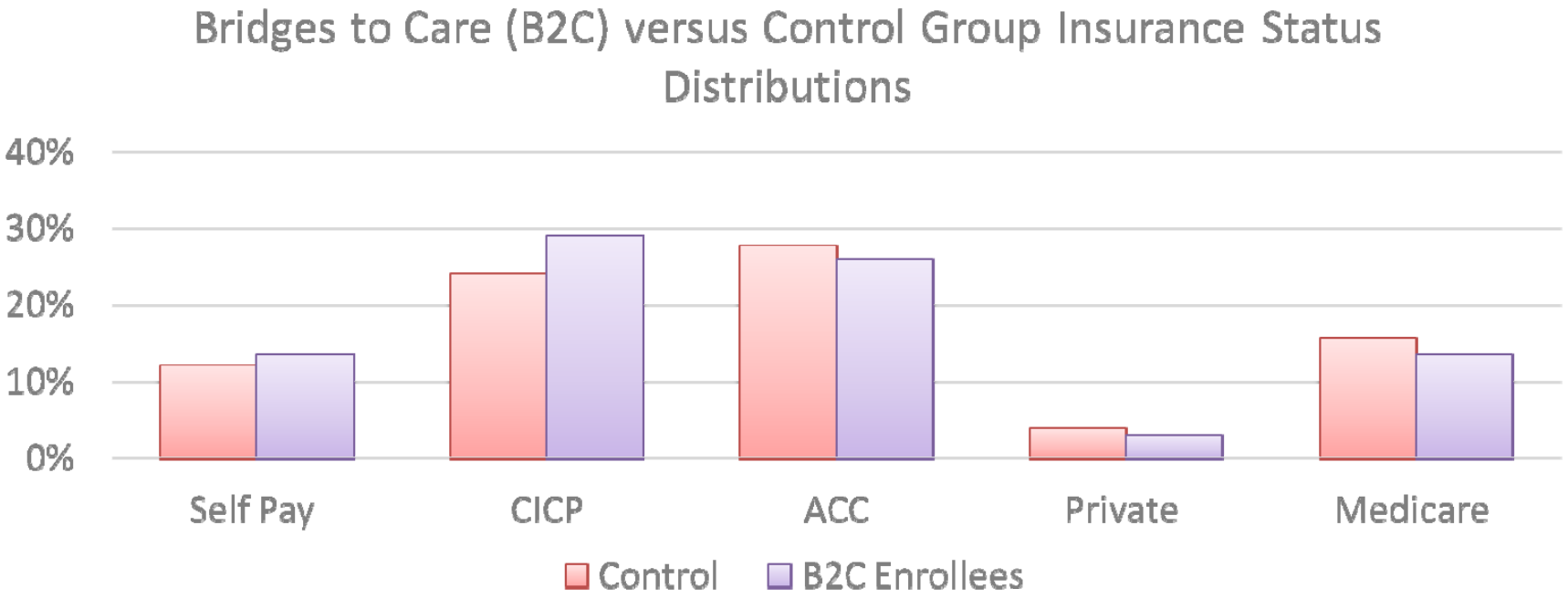
Most Are White or Hispanic



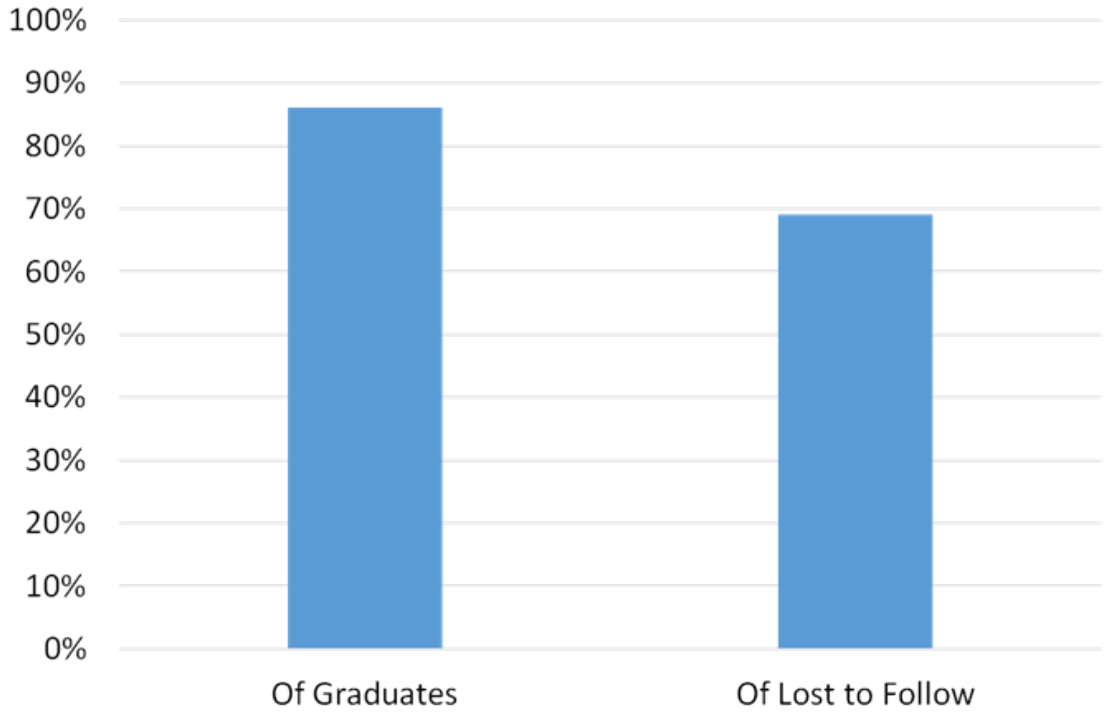
Hotspotters are Surprisingly Young



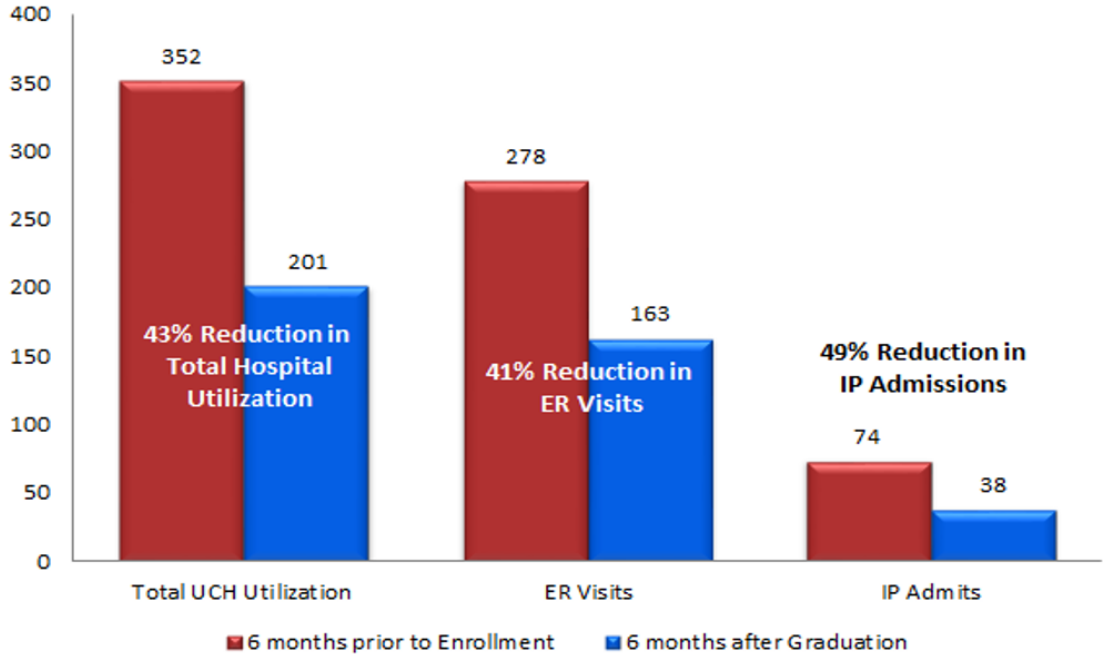
Mostly Medicaid Patients



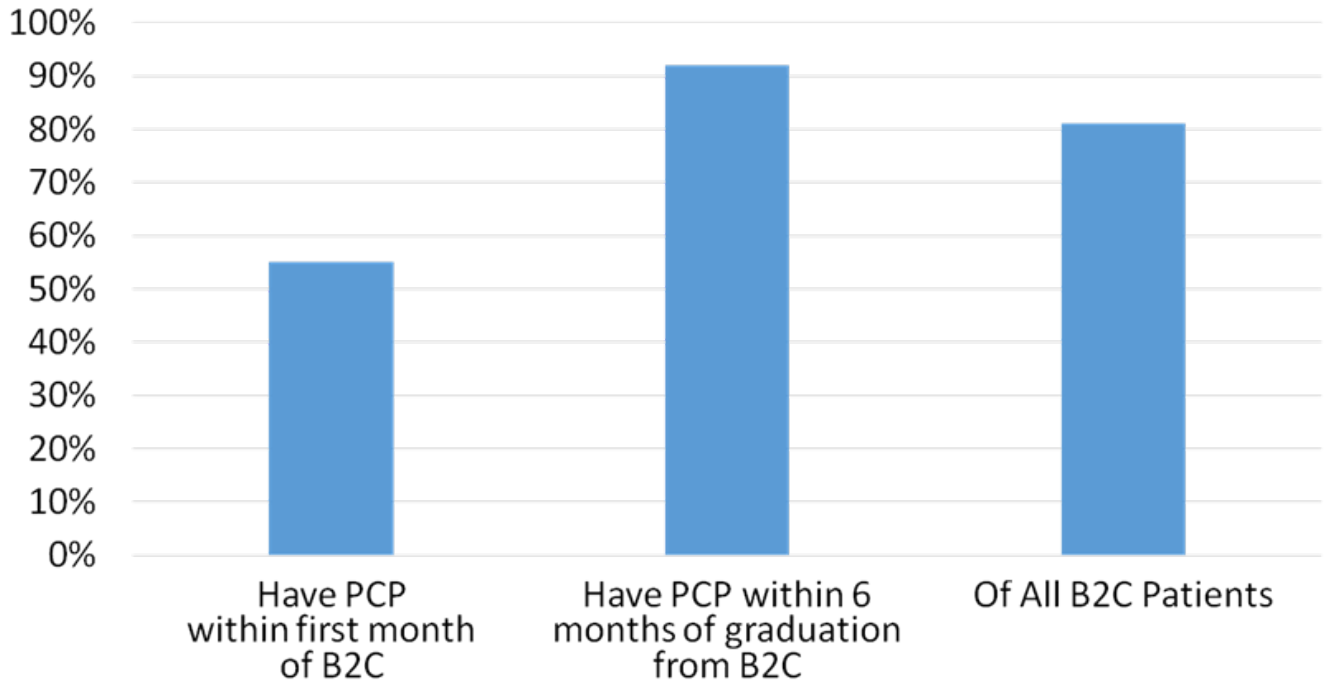
Many Have Behavioral Health Issues



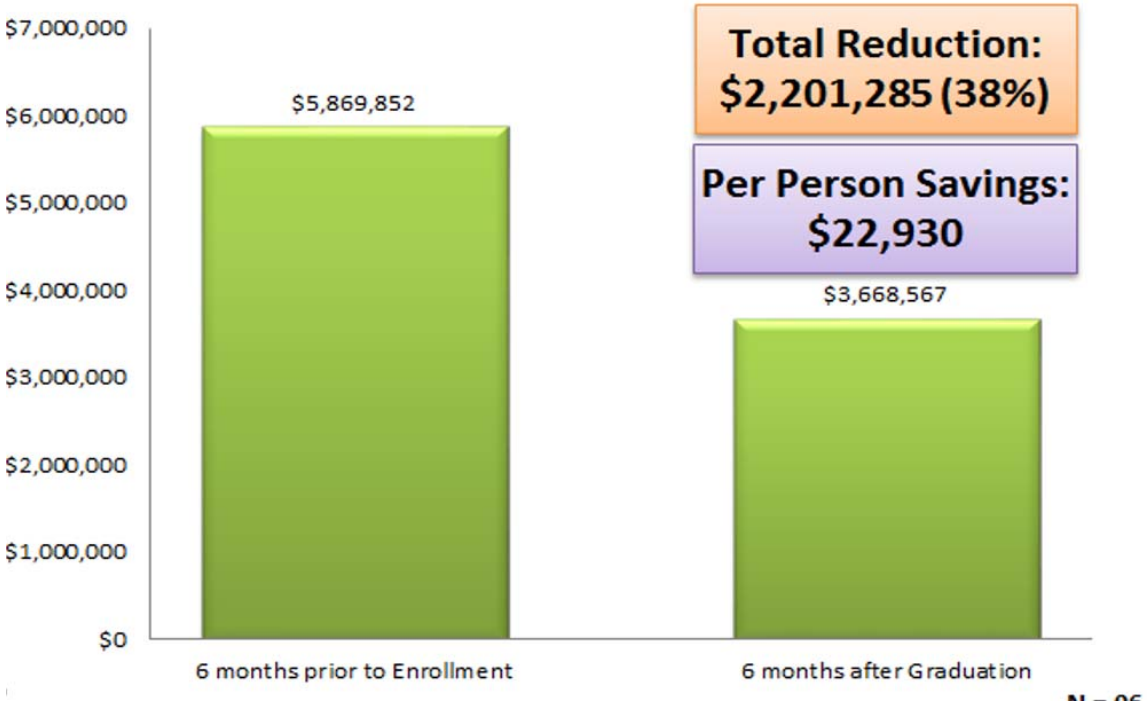
Decreased High Cost Utilization



Graduates Established Medical Home

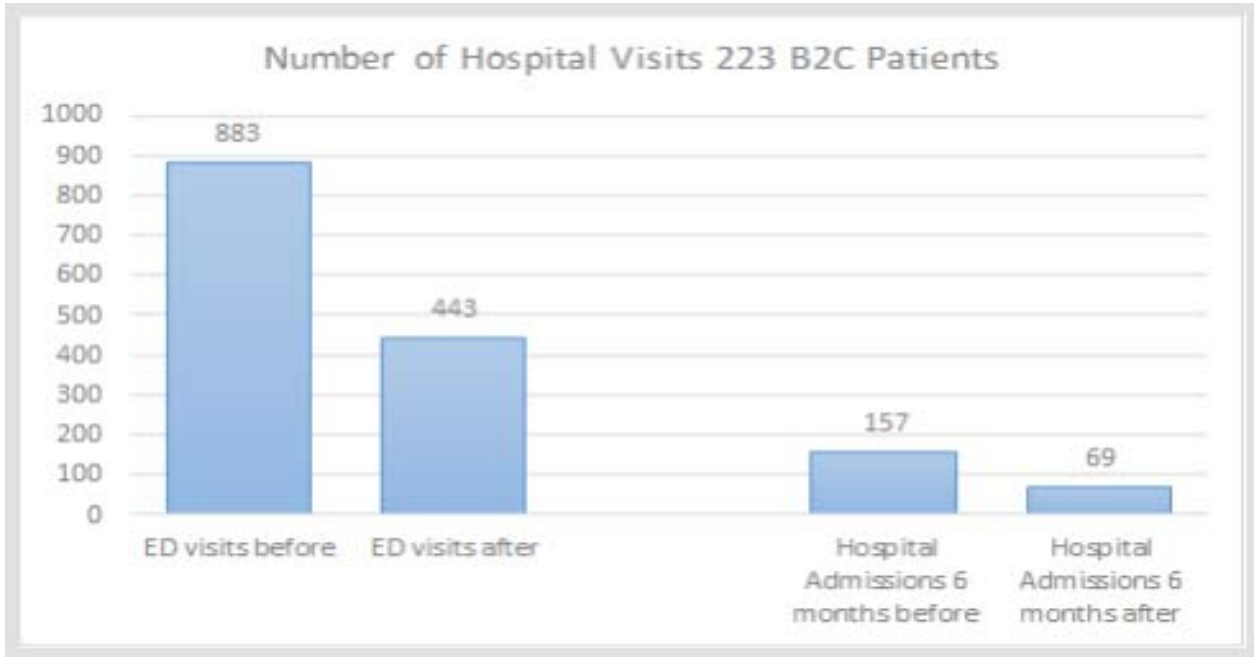


System Cost Decreased > 50%



Total site cost $1.2M
Total saved $13.5 M

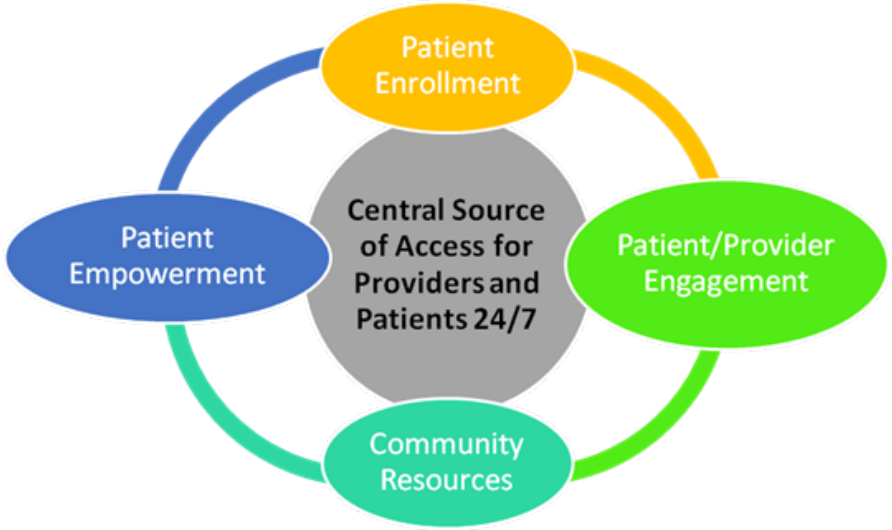
Hospitalization Decreased 50%



Patient Stories

“B2C helped me be more confident in living with and managing my health condition.”
“ It was more well-rounded care. The counseling aspect was very helpful.”
“They helped me regain my health and also helped with mental/emotional and family issues.”

Sustainability Plan for Intensive CM Programs



Physician Focused APM for EM…TBD

FFS +

- Case management CPT codes

Episode payment

- Short episode (ED visit trigger)

Public utility (PMPM)

Risk with outpatient provider as a bundle

Condition based payment

Global budget to manage population

American College of Emergency Physicians®

Lessons Learned

Improving population health requires community collaboration. Must include primary care+ mental health services.

Care coordination reduces ED use for high utilizers (“hard to reach” populations) -B2C model works

We need to stop blaming the patients and build shared incentives for patients, community resources and providers.

Need to creating sustainable programs.

Require community engagement aligned incentives to be successful

Require financial investment upfront before ROI

- To build a team
- To build partnerships
- To recruit clients where they show up “in the ED

BRIDGES TO CARE

Thank You

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Roberta Capp MD, MPH

Greg Misky MD

University of Colorado Hospital physicians (left to right) Jennifer Wiler, Greg Misky, and Roberta Capp have helped to facilitate the B2C program. Photo: CU School of Medicine Clinical Affairs Department