LG Health Care Connections

Population Health Colloquium

Post Conference: Developing Super-Utilizer Programs

John C Wood MD, FAAFP
Chairman, Family and Community Medicine
Medical Director, Care Connections

Lancaster General Health
Choose well. Be well.

Lancaster, PA

Lancaster General Health
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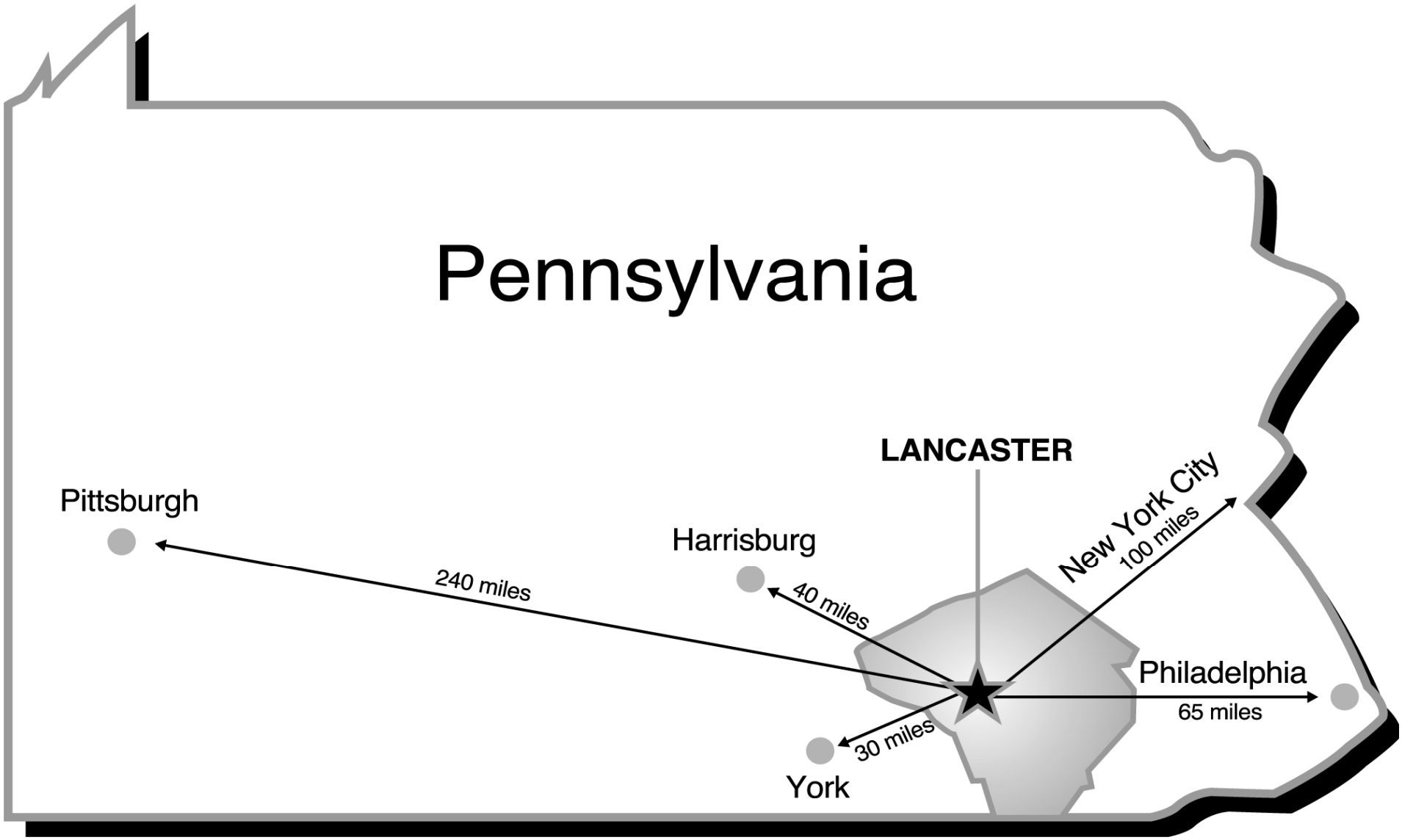
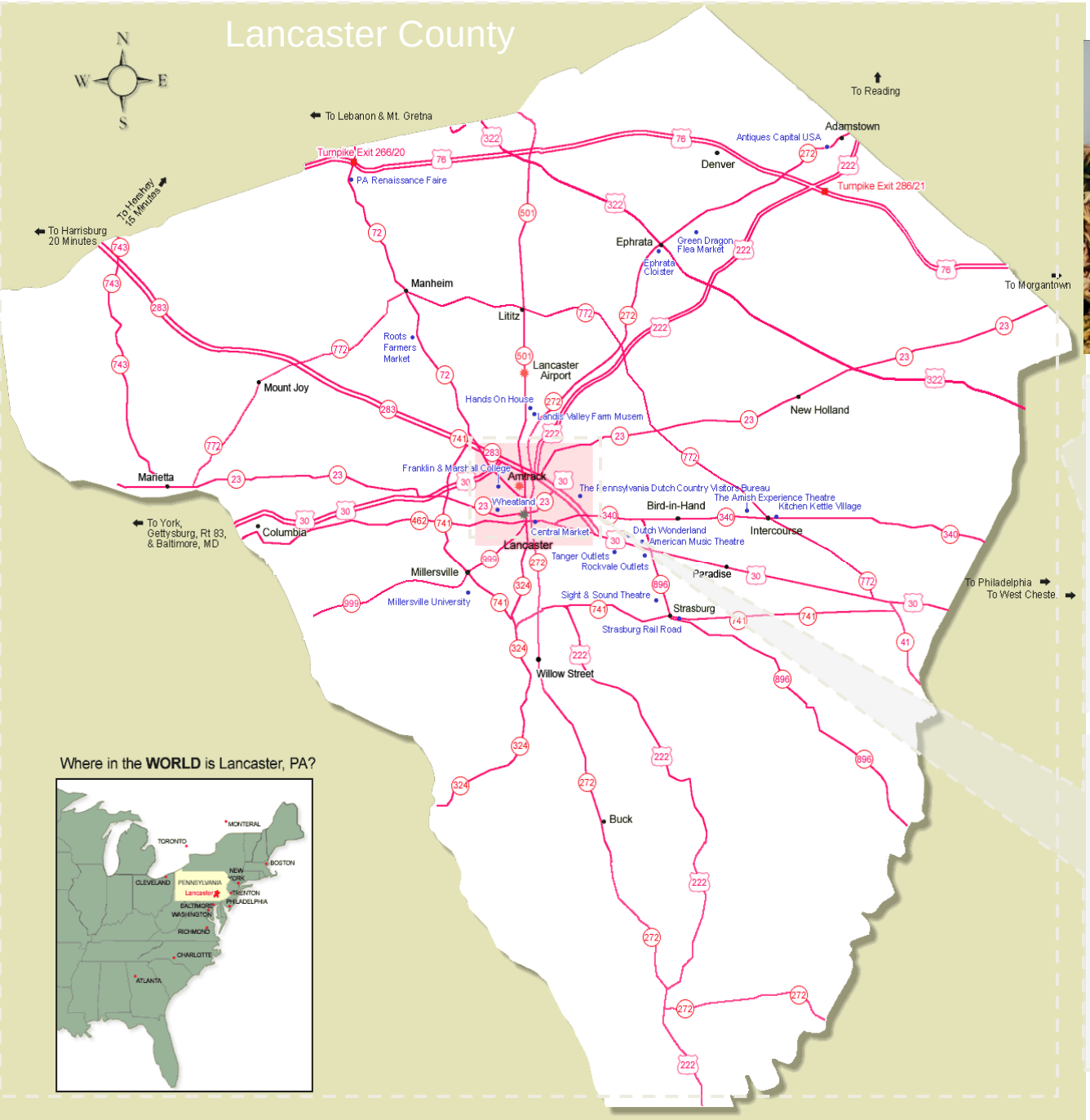




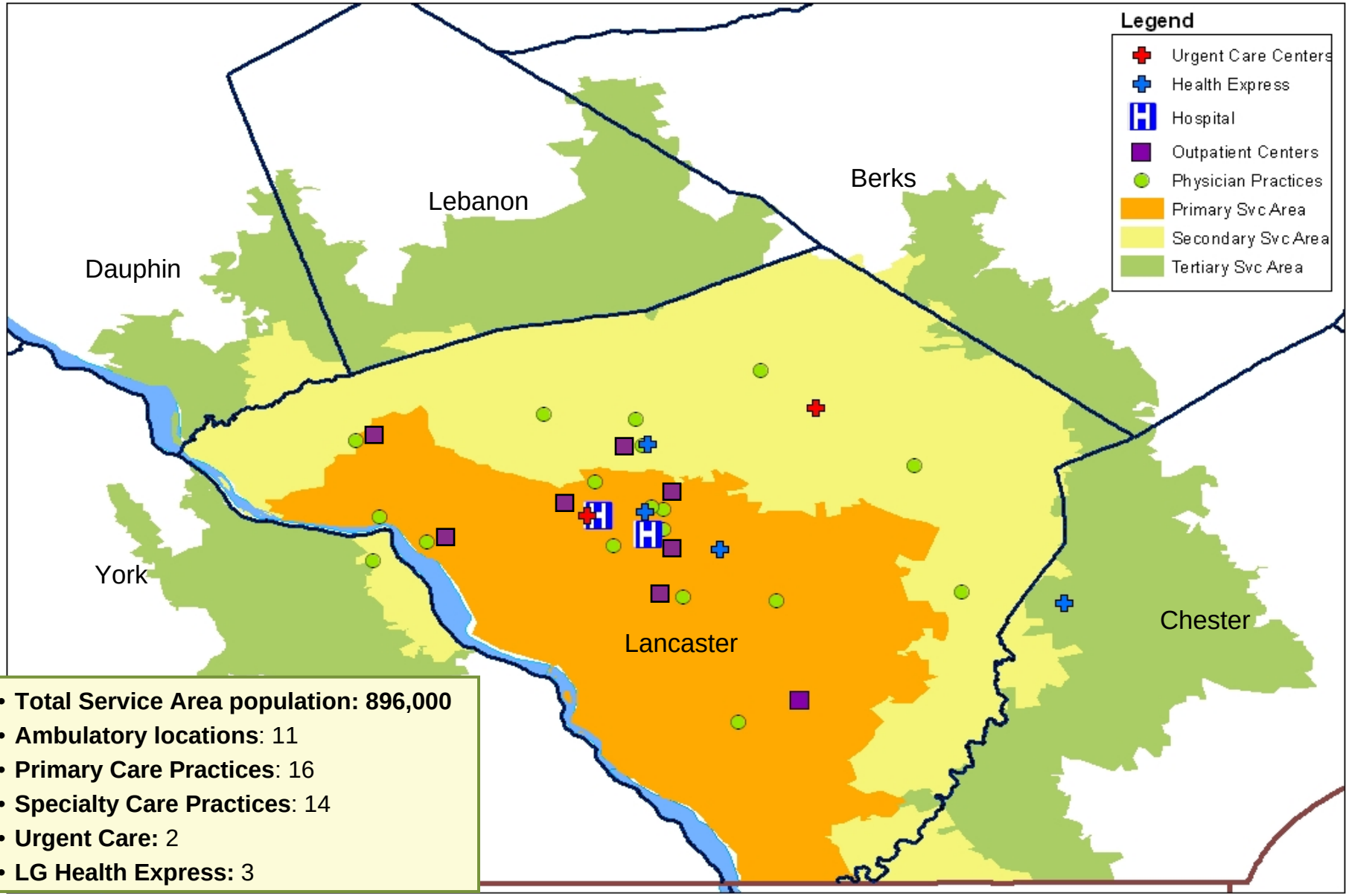
Lancaster County

Census: 528,329
White: 87.9%
Hispanic: 9.4%
African-American: 3.8%
< Poverty: 7%
Age ≥ 65: 15.6%

Lancaster City

Census: 60,191
White: 53.7%
Hispanic: 41.2%
African-American: 16.4%
< Poverty: 25%

Lancaster General Health – Locations



- **Total Service Area population: 896,000**
- **Ambulatory locations**: 11
- **Primary Care Practices**: 16
- **Specialty Care Practices**: 14
- **Urgent Care:** 2
- **LG Health Express:** 3

Core Issue

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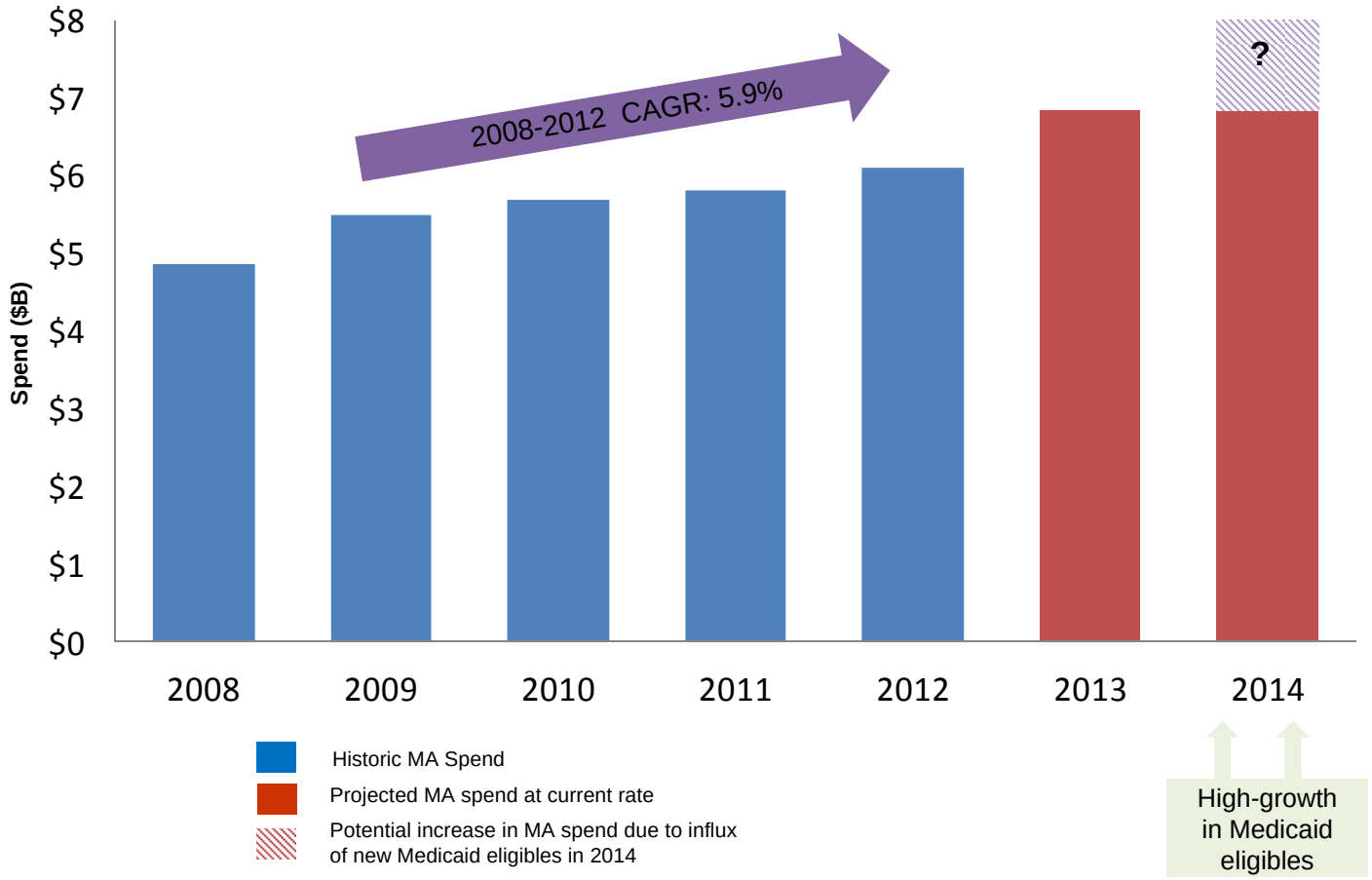
- Approximately 80,000 Medicaid beneficiaries in Lancaster County
- Annual inflation, eligibility expansion and continued demand of charity care

Pennsylvania Medical Assistance Spending (State Funds) 2008-2014



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Key Principles for High Risk Program Development

- Promote **individual's engagement** in their health and emphasize **provider accountability.**

- Develop a **value-based model** that aligns incentives and resources while bending the cost trend.

- **Use innovative solutions and best practices** (care design, decision support tools, advanced technologies).

- Develop **integrated partnerships** and **affiliations with the local county and community agencies** and MCO(s) for **the advancement of new care delivery solutions.**

- Focus on **continuous improvement and quality.**

Patient Perspectives

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About Care Connections

Launched August 2013

Primary care program for the high risk population
- Transitional
- High Intensity
- Interdisciplinary

Innovation learning lab

Funding:
- Health System Self Funded
- State Earmark 2013-14

Connection to the PCMH

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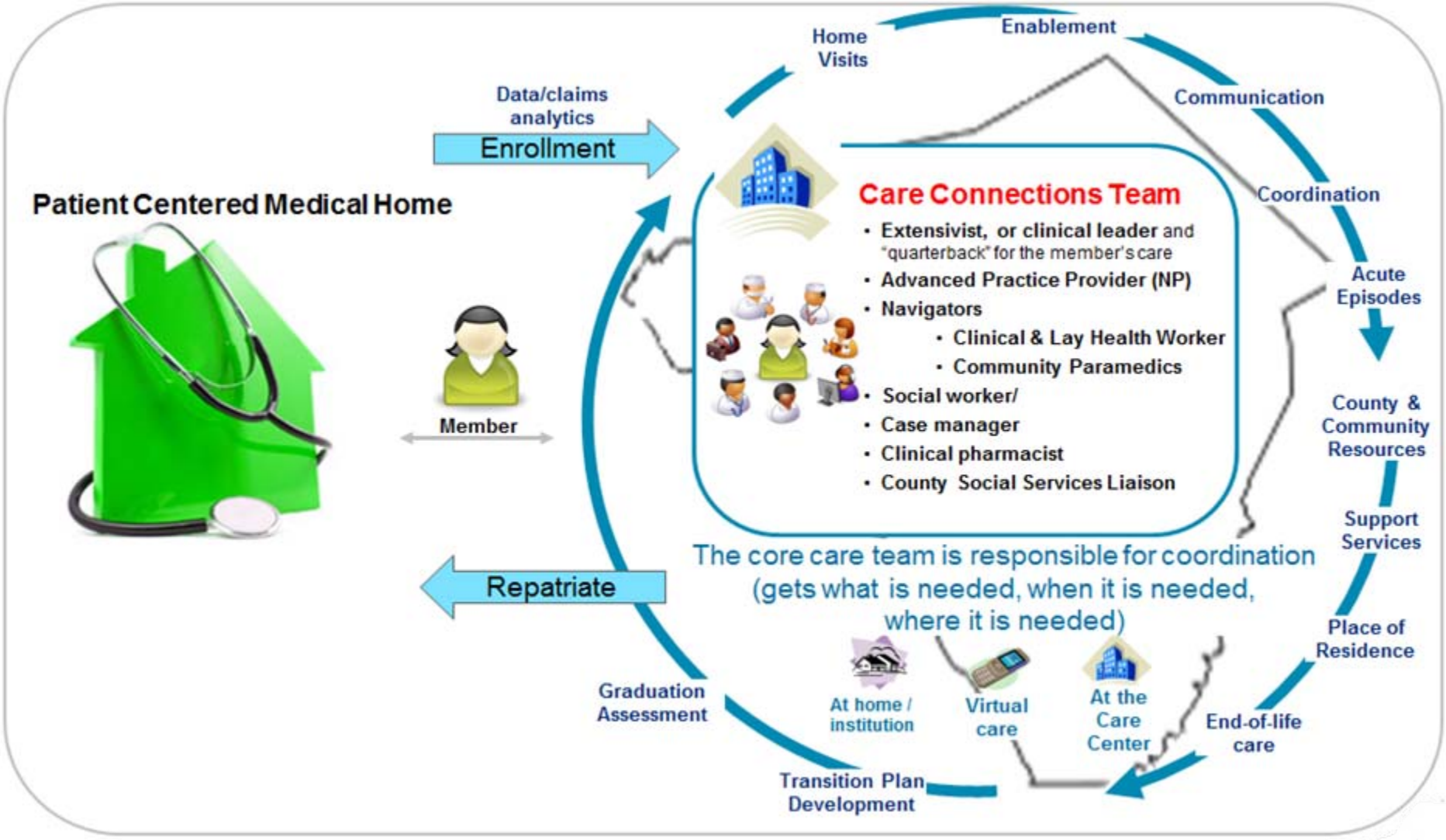

Care Management Structure

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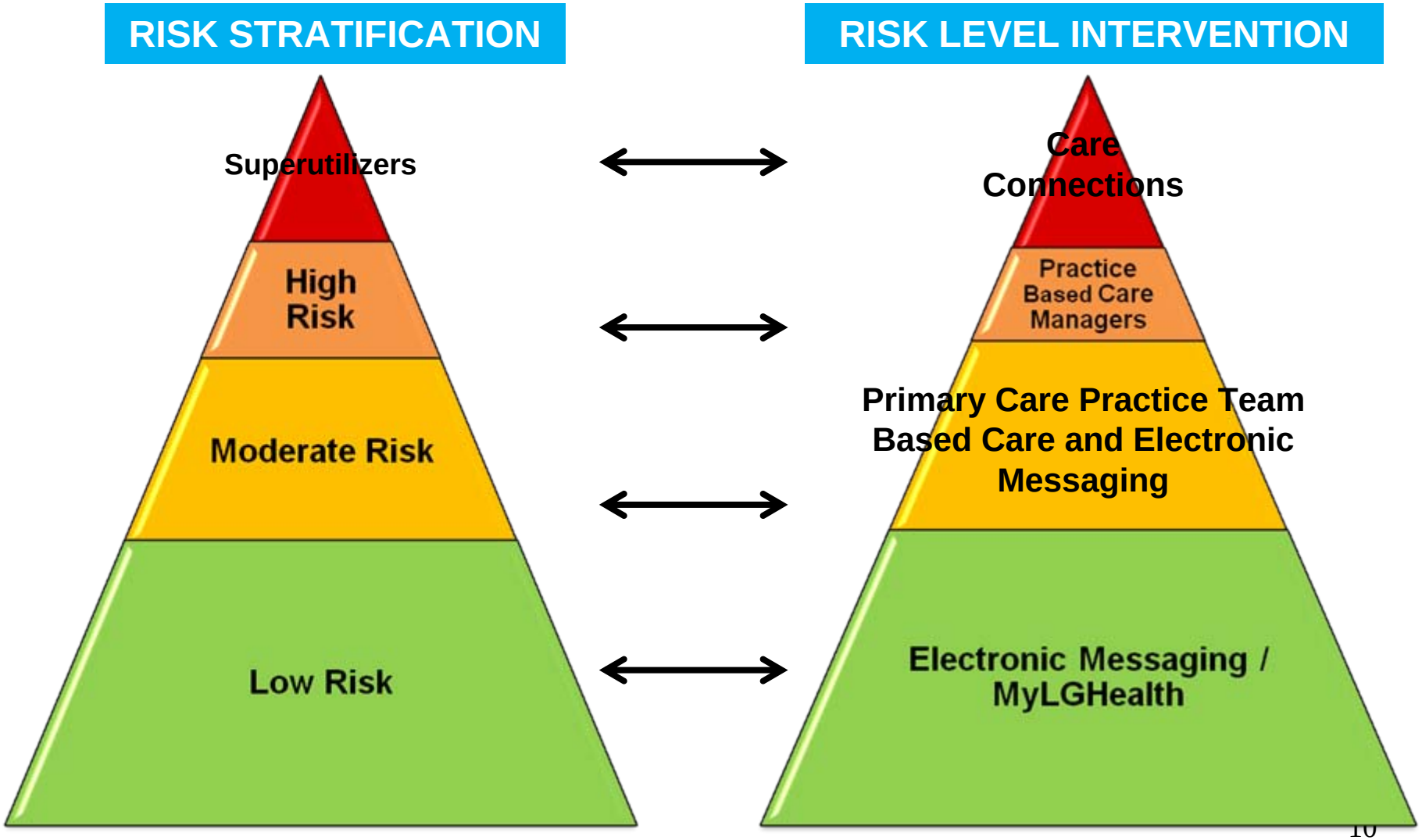
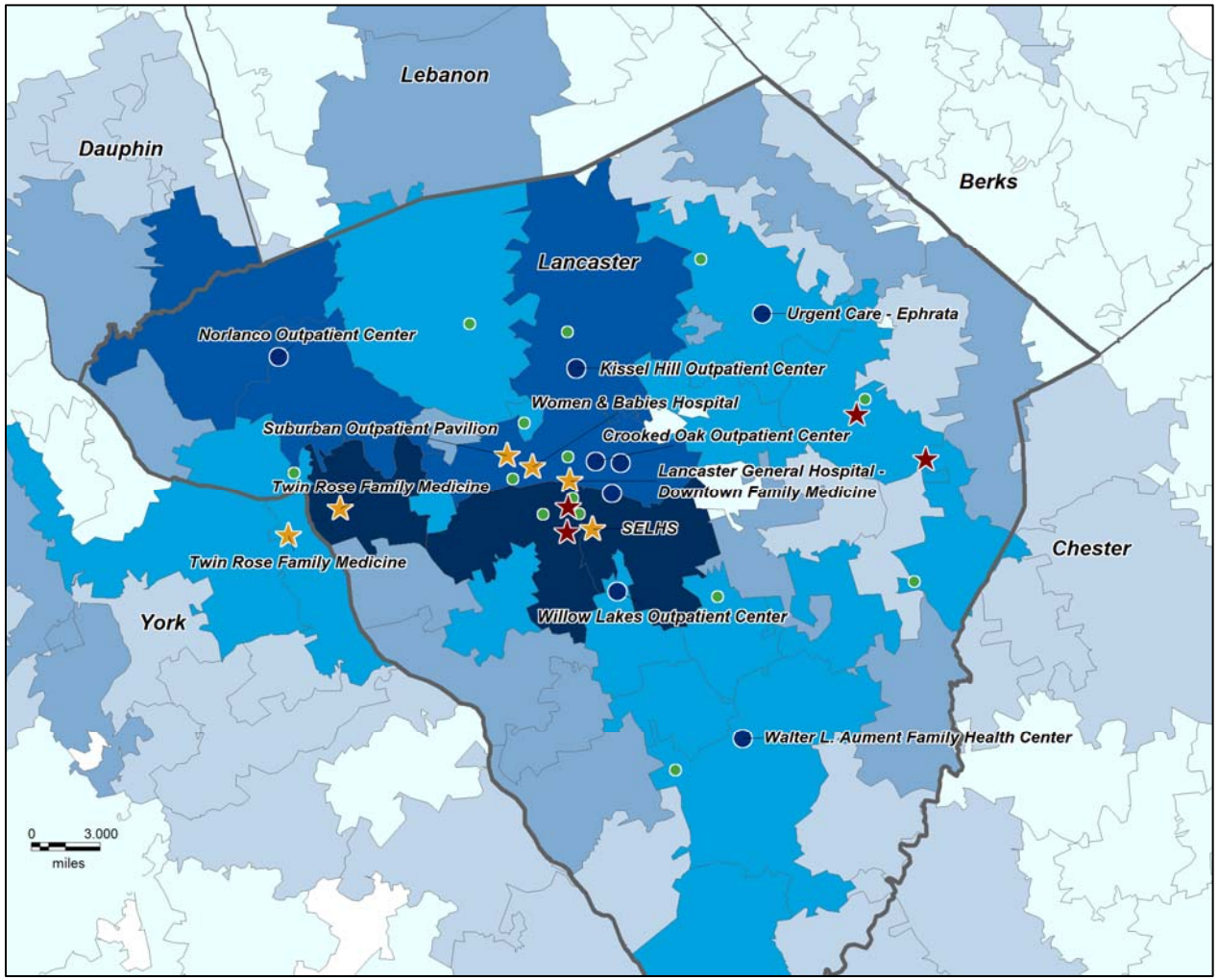


Where Medicaid Recipients Reside*

Lancaster General Health
Choose well. Be well.



Zip level patient count	
	<10
	10 - 49
	50 - 99
	100 - 499
	500 – 1,000
	1,000+

Provider locations	
★	LG Hospital, Downtown Family Medicine, Twin Rose, Suburban Outpatient Pavilion
★	Secondary locations (FQHCs)
●	Outpatient
●	Other

* Note: heatmap shows density of Medicaid recipients that accessed care at LG Health in 2011

High Risk Medicaid Population – Initial Target

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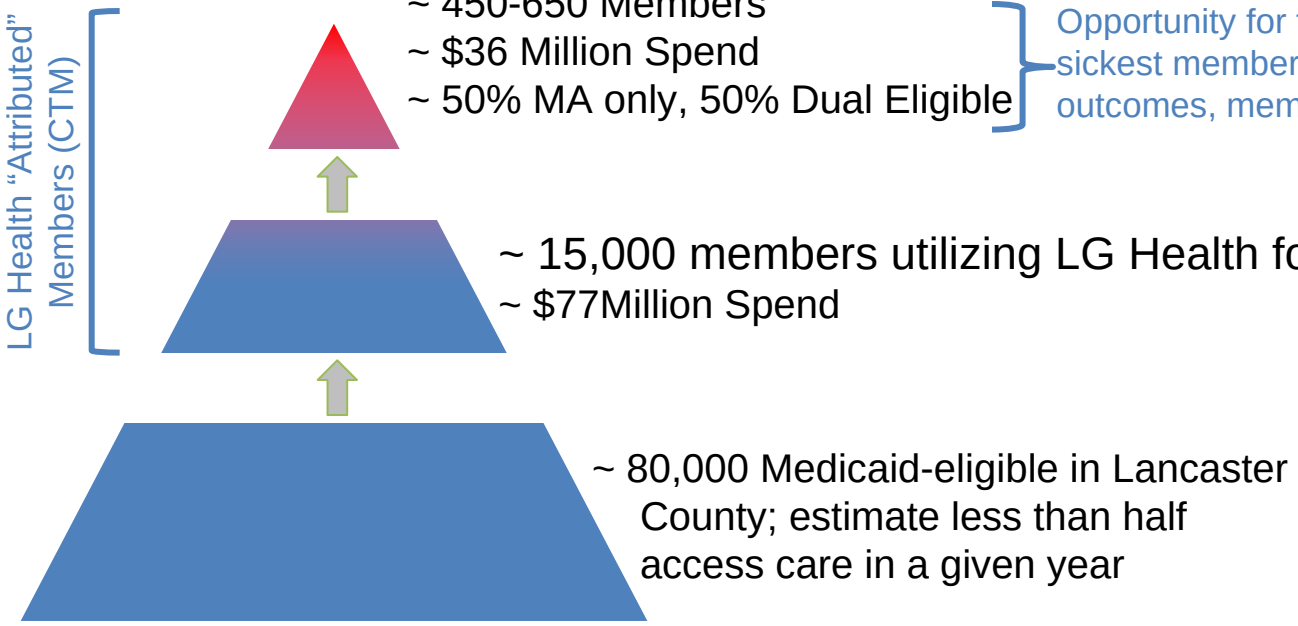
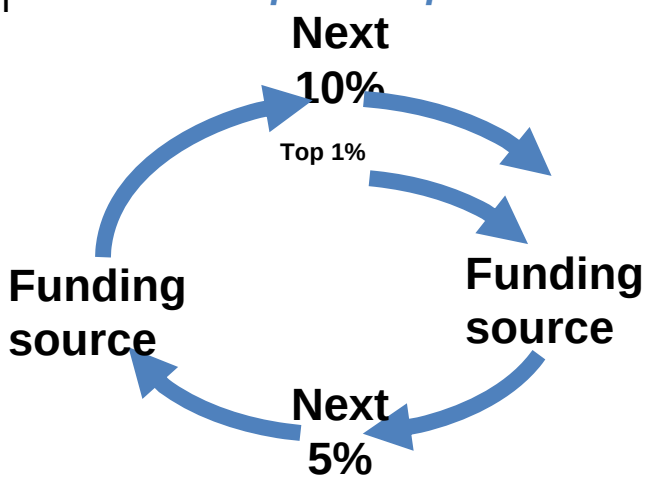
About 3% of the Attributed Members account of 50% of the spend



The Upward Spiral



Source: DPW data; LG Health internal data; Oliver Wyman analysis

Population Modeling

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- LG Health attributed lives
  - Brief screening
    - Number of inpatient admissions
    - Number of medications
    - Lack of social support structures

- Results
  - 1600 moderate high risk individuals (PCMH)
  - >400 high risk individuals (Care Connections)

LGH Utilization Typology

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<table>
<tr><th rowspan="2">ED Visits per Year 2011-2012</th><th colspan="5">Inpatient Visits per Year 2011-2012</th></tr>
<tr><th>0</th><th>1</th><th>2</th><th>3 to 4</th><th>5+</th></tr>
<tr><td>0</td><td colspan="2" rowspan="3">109,132 (95.5%) Patients</td><td rowspan="3">2,238 (2.0%) Patients</td><td colspan="2" rowspan="3">316 (0.3%) Patients</td></tr>
<tr><td>1</td></tr>
<tr><td>2 to 3</td></tr>
<tr><td>4 to 5</td><td rowspan="3">1,102 (1.0%) Patients</td><td rowspan="3">729 (0.6%) Patients</td><td rowspan="3">313 (0.3%) Patients</td><td colspan="2" rowspan="3">353 (0.3%) Patients</td></tr>
<tr><td>6 to 7</td></tr>
<tr><td>8 to 9</td></tr>
<tr><td>10+</td><td></td><td></td><td></td><td colspan="2"></td></tr>
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Visits are 2 year totals.

Care Connections Process

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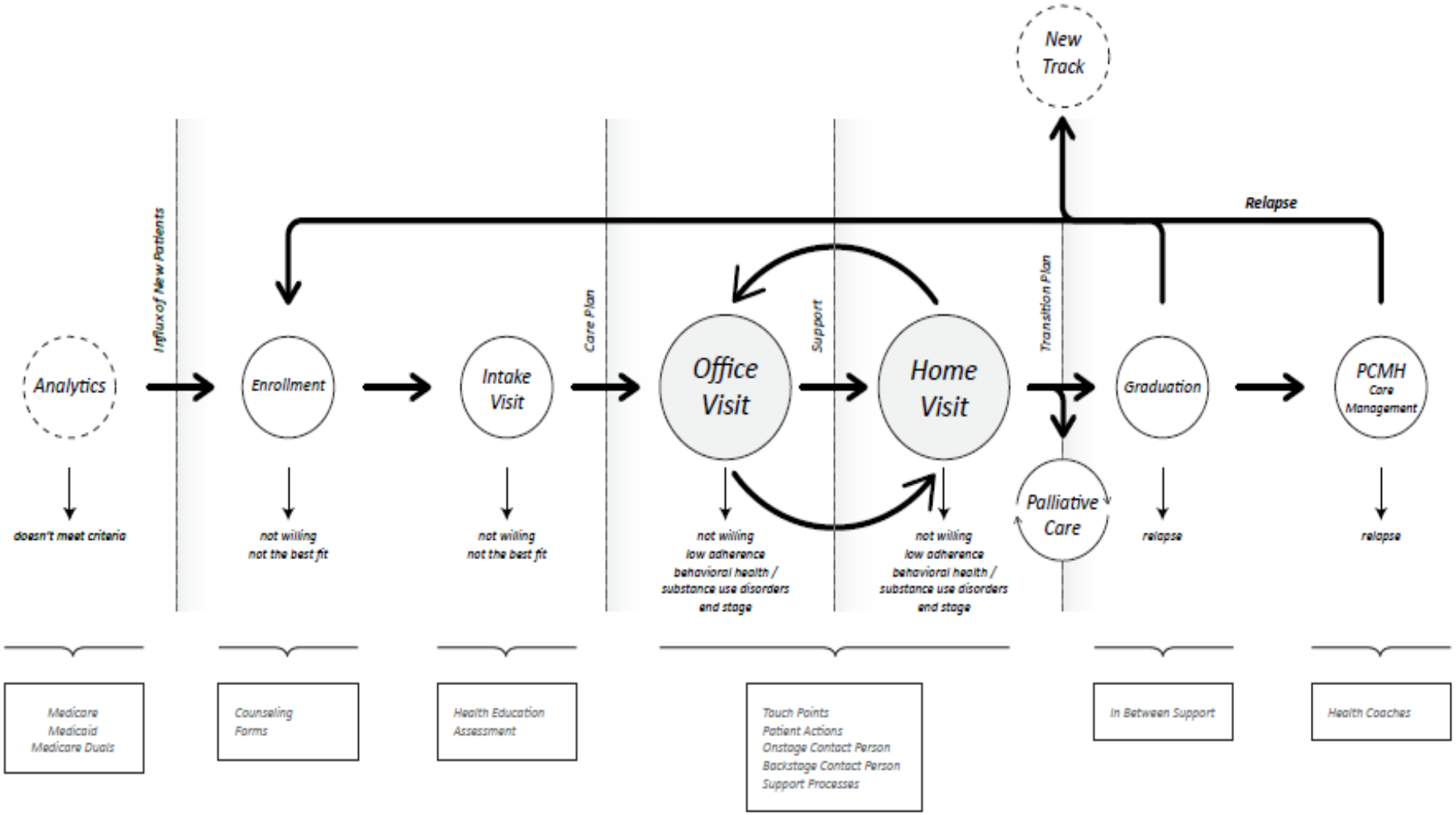
Choose well. Be well.



Data Driven Enrollment Process

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LG Health Attributed PCP Lives
(based on population)

Population Risk Stratification

- **Total Cost (inpatient, pharmaceutical, etc)**
- **Chronic Conditions (physical and behavioral)**

HIV, Primary Oncology Dx, or Major Catastrophic Event

Brief Psychosocial Risk Stratification Score Applied

Care Connections

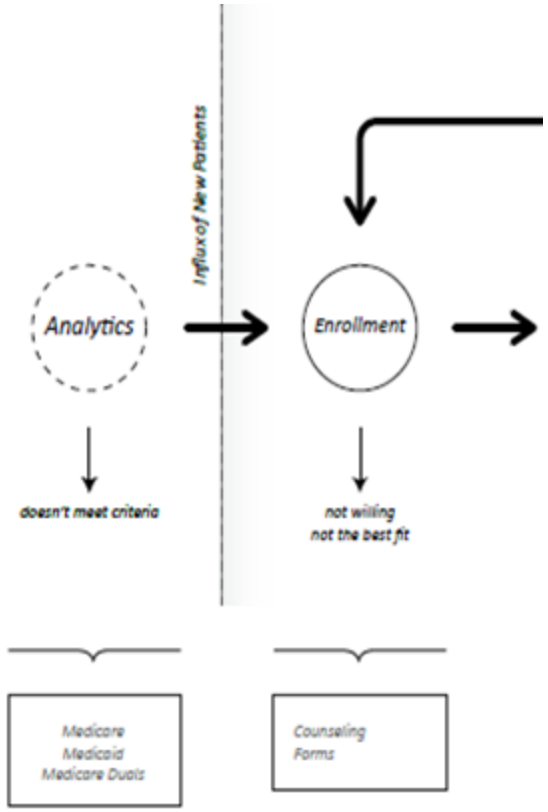
High or Very High Risk

Crossover

Low or Moderate Risk

PCMH Care Management

Identification/Screening Referral



Brief Screening

- Housing status
- Social Supports
- Hx of high risk medications
- Hx of Substance Use D/O

The Valued Member

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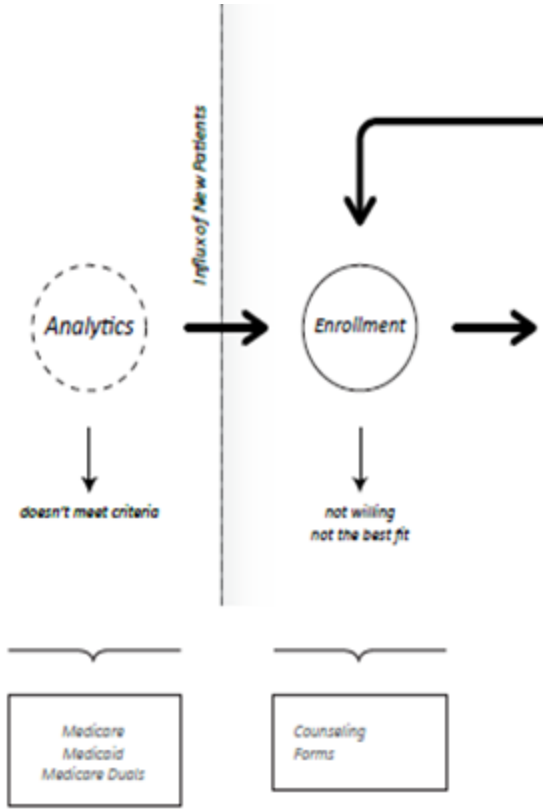
Engagement



We have 2 customers:

PCPs in Community
- Direct calls
- Letter via EMR

Patients
- Entry
- Call from PCP w/ warm handoff
- Hospital Engagement
- Cold calls

Intake and process

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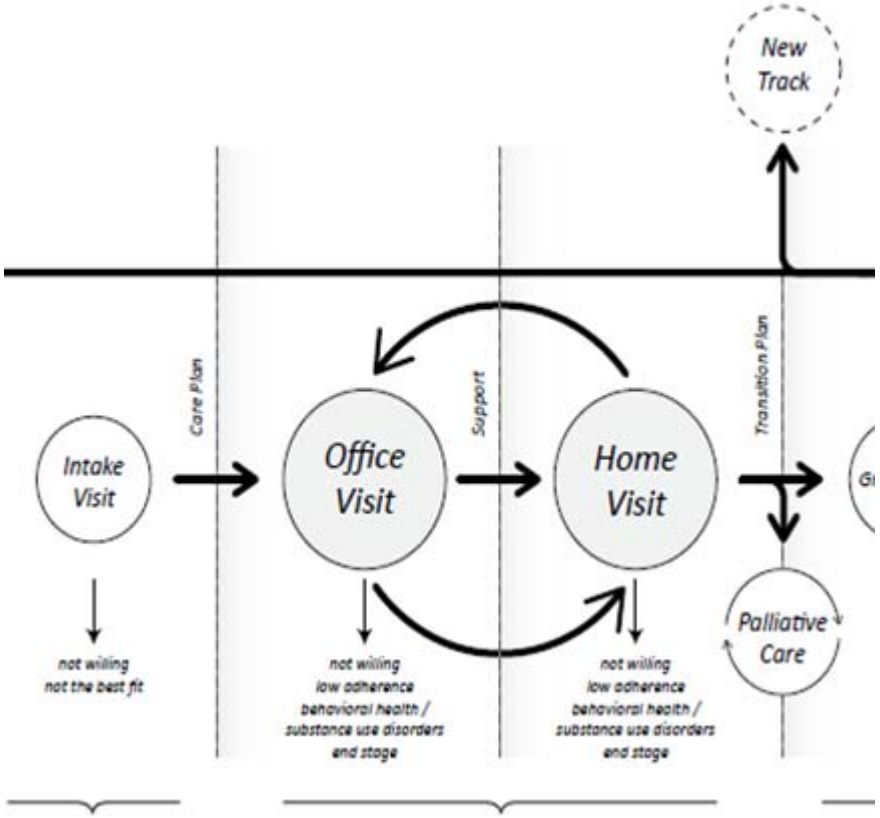

Intake Visit for Transition

Social Work/Navigator	Clinical Pharmacy & Provider Visit

Team Huddle for Treatment Plan

Ongoing Evaluation by Team	Preparation for transition back to PCMH/PCP

ON boarding process

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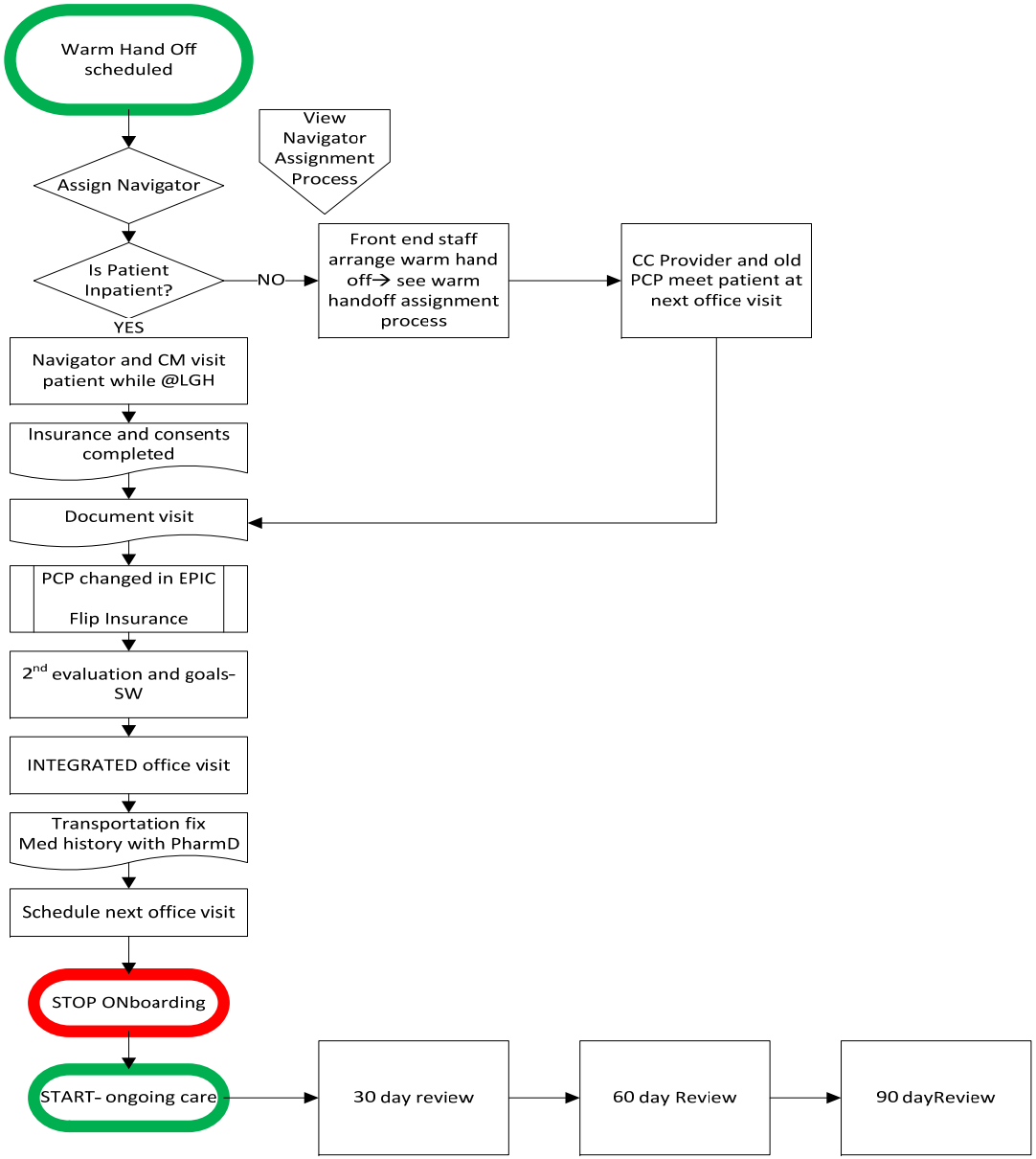

Intake Measures

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- Intake Interview (home)
  - MOCA
  - Realm-SF Literacy
  - Barriers
  - Strengths
  - Social Support/Eco-map/Genogram
  - Timeline of Events
  - Patient Self-Sufficiency Matrix
  - Psycho/Social Assessment
  - Medication Adherence

The Empowered Provider

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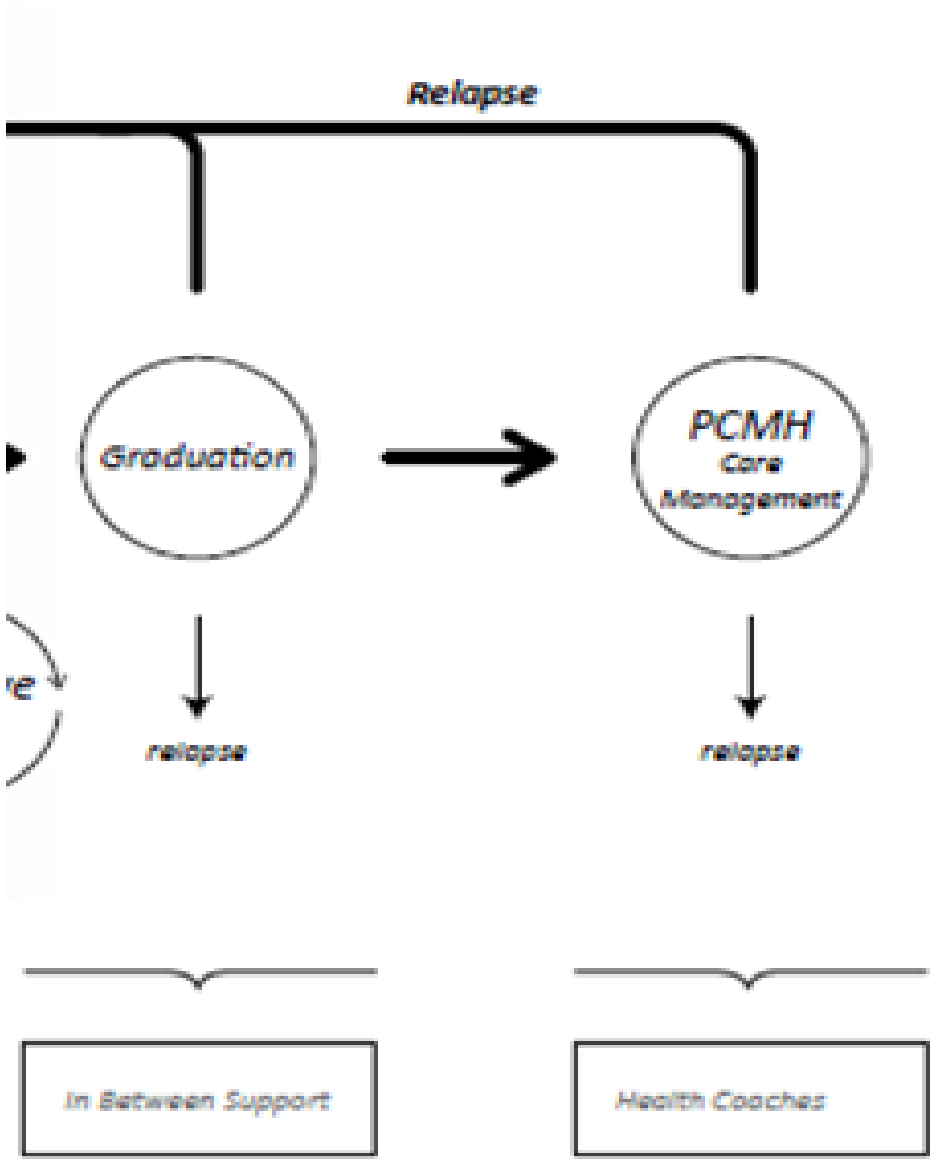
Choose well. Be well.

Innovative Solutions

Graduation: PCMH reintegration



The Connected Community

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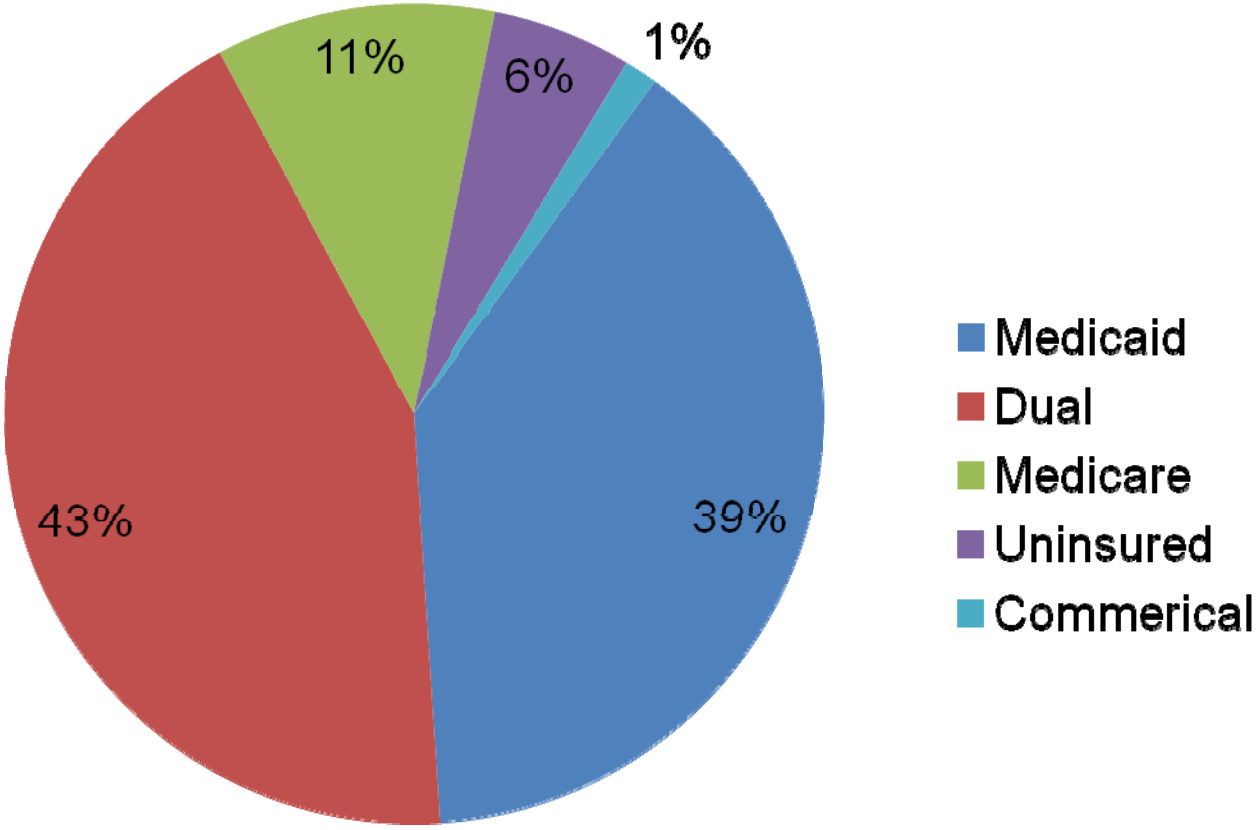
Innovative Solutions

Payer Mix



Utilization Outcomes*

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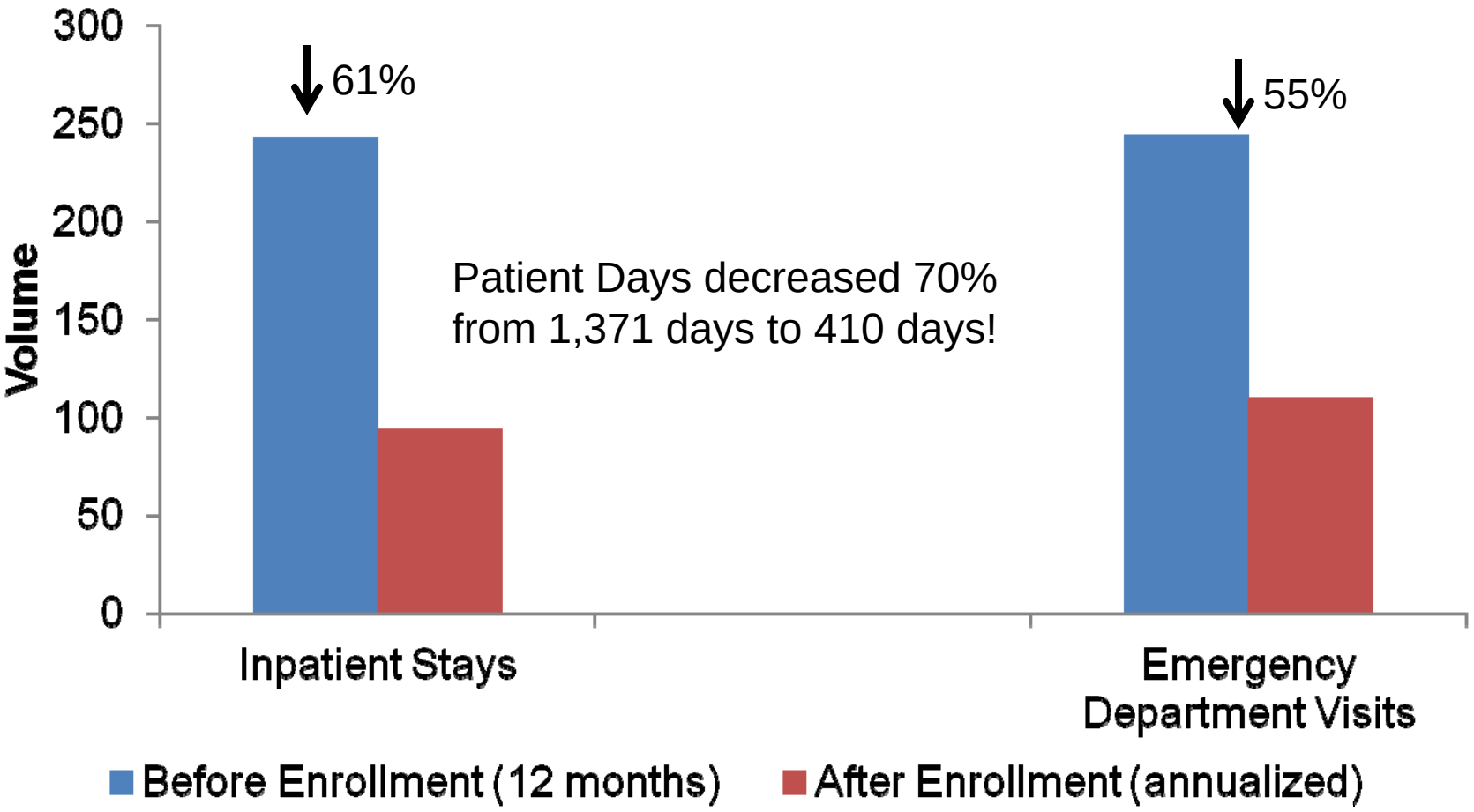

*based on 55 initial patients

Quality Outcomes

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8.5% improvement in A1C*

17% improvement in LDL *

78% improvement blood pressure control*

174% increase in provider visits

*based on 24 patients with enrollment of 90 days or greater

Financial Outcomes*

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Choose well. Be well.

Limitations in analysis due to only having access to LG Health data stream

Continuing to work with payers regarding payment for navigator, case management, and social work interventions

*based on 55 initial patients

Sharing our experience

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Imperative to define the problem/population up front

Innovation is hard, messy work
–Empower the team and the patients
–Connect the community
–“Feet to the street” to get the real story

High risk model development
–Integrate with health system activities
–7-8 care management activities per provider “touch”
–Intake visits >4 hrs per patient for team
–1:40 caseload for navigators
–Patient incentives/penalties aligned with healthcare needs (ex. CDAs)

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www.lghealth.org/careconnections

careconnections@lghealth.org