Medicaid Waiver Project: Health Connections Program Proposal

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Project Title	Health Connections

Rationale for the Project

Problem Statement:

Health Connection Programs: Care Navigation for Vulnerable Populations will provide comprehensive care to targeted patients identified as "super-utilizers" (people with chronic medical conditions, low income & health literacy and, high healthcare use). A care team will collaborate with each patient's PCP and others to ensure optimal outcomes and a smooth transition to the community setting. The program's purpose is to improve healthcare outcomes for these vulnerable patients, reduce the overall health care costs of caring for them, and improve the overall health of the community. HHC will bridge the gaps in systems and connect patients to services and resources for better health. The program's purpose is to improve healthcare outcomes for these vulnerable patients, reduce the overall health care costs of caring for them, and improve the overall health of the community.

Supporting Research:

Despite efforts across the United States to reduce or eliminate disparities in healthcare, significant inequalities, including risk factors, access to healthcare, morbidity, and mortality continue in vulnerable populations. For example, studies find that Americans living in poverty are much more likely to be in fair or poor health, have disabling conditions, are less likely to have used many types of healthcare[1], and are almost twice as likely to have made at least one visit to the emergency room visits in the past year.[2]

Vulnerable populations include the economically disadvantaged, racial and ethnic minorities, the uninsured, low-income children, the elderly, the homeless, those with HIV, and those with other chronic health conditions, including severe mental illness and substance use disorders. The vulnerability of these individuals is enhanced by race, ethnicity, age, sex, and factors such as income, insurance coverage (or lack thereof), and absence of a usual source of care. Their health and healthcare problems intersect with various social factors, including housing, poverty, and inadequate education.

All too often these vulnerable populations, especially those with chronic medical conditions, become "super-utilizers" of healthcare resources and responsible for a disproportionate share of the nation's healthcare spending. For example, during a two-year period at CHI Franciscan Highline Medical Center, just 1,109 patients accounted for more than 117,500 billing episodes – an average of 106 episodes per patient. A recent analysis of national healthcare spending[3] shows that:

- Five % of the population accounts for almost half (49%) of total healthcare expenses. Among this group, annual medical expenses (exclusive of health insurance premiums) equaled or exceeded $11,487 per person.
- The 15most expensive health conditions account for 44% of total healthcare expenses.
- Patients with multiple chronic conditions cost up to seven times as much as patients with only one chronic condition.
- The five most expensive health conditions were heart disease, cancer, trauma, mental disorders, and pulmonary conditions.

Providing healthcare to those on the margins of society is challenging at best. Many of these patients health care is compensated by Medicaid programs which are economically undesirable for healthcare providers. Compensation for Medicaid patients is significantly below cost which leads to some healthcare providers not to provide care to these patients which leads to higher cost care in the ER or Hospital setting. While this creates the incentive for lower utilization of unnecessary healthcare services (and therefore costs), it can also have the undesirable side effect of creating an economic incentive not to provide needed early stage treatments for patients with chronic conditions, resulting in much greater treatment costs when these patients' chronic conditions worsen.

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[1] National Center for Health Statistics. Health, United States. Washington, DC: US Department of Health and Human Services; 2005. Available at http://www.cdc.gov/nchs/products/pubs/pub d/hus/state.htm

[2] National Center for Health Statistics. Health, United States, 2013: In Brief, Hyattsville, MD, 2014, p. 14, http://www.cdc.gov/nchs/data/hus/hus13_InBrief.pdf.

[3] Mark W. Stanton, "The High Concentration of U.S. Health Care Expenditures," AHRQ, Research in Action, Issue 19, http://www.ahrq.gov/research/findings/factsheets/costs/expriach/index.html#diff4

Nevertheless, opportunities exist for systemic change to this challenging context. Recently, several programs across the country[4] have shown that focusing on the underlying issues of "super-utilizers" can achieve materially better outcomes for patients at significantly lower costs for the providers and payers. However, although the needs of these medically vulnerable populations are serious, are often debilitating or life-threatening, and require extensive and intensive medical and nonmedical services, their needs tend to be underestimated – and those in greatest need of care coordination are often the least likely to receive it.[5]

This program addresses the needs identified in the State of Washington's five-year Health Care Innovation Plan[6] which was developed by a wide variety of stakeholders around the state (including leaders from state and local government, public health, delivery systems, business, health plans, consumer groups, labor, tribal entities, providers and community organizations). The plan calls for "caring for the state's most vulnerable; engaging individuals in their own health; addressing the needs of rural and underserved communities; and preventing illness, injury, and disease," as well as a transformed health care system, with several aspects that align directly with the goals of the *this program*:

- The integration of physical and behavioral health care services
- Health systems positioned to address prevention and social determinants of health as part of the broader community of health
- Support at the state and local levels for practice transformation that emphasizes team-based care
- An emphasis on regionally responsive payment and delivery systems, driven by integrated purchasing of physical and behavioral health care
- A transparent system of accountability, allowing purchasers, consumers, providers, and plans to make informed choices

Project Description

Which Medicaid Transformation Goals[i] are supported by this project/intervention? Check box(es)

xReduce avoidable use of intensive services
xImprove population health, focused on prevention
xAccelerate transition to value-based payment
xEnsure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

xHealth Systems Capacity Building
xCare Delivery Redesign
xPopulation Health Improvement – prevention activities

Description: *Health Connections* consists of a care team (Registered Nurse, Social Worker, Registered Dietician, and Community Health Worker) who collaborate with the patient's primary care provider and other providers and services to ensure optimal outcomes and a smooth transition to the community setting. The team will address each patient's needs (medical, mental health, substance abuse, social services, housing, transportation, food, low healthcare literacy, etc.) in an integrated, holistic manner. This care transitions program will link the most vulnerable, underserved populations to evidence-based, cost-efficient care and support, with the goals of connecting patients to appropriate levels of healthcare and community services and/or resources, coaching and supporting patients in achieving personal health goals, and reducing overutilization.

Goals:

- Achieve demonstrated improvements in all three Triple Aim dimensions (Better Health, Better Patient Experience, and Lower Costs per Capita) for enrolled patients
- Increase access to support services, community resources, and primary care for enrolled patients
- Create a replicable model that can be scaled across the health care system and sustained through demonstrated cost savings and improved patient outcomes

Project Description

[4] Atul Gawande, "The Hot Spotters: Can we lower medical costs by giving the neediest patients better care?" *The New Yorker*, January 24, 2011.
[5] National Healthcare Quality Report, 2013, Chapter 7. Care Coordination, http://www.ahrq.gov/research/findings/nhqrdr/nhqr13/chap7.html
[6] http://www.hca.wa.gov/hw/documents/shcip_innovationplan.pdf

A key success factor in improving the health status of this high-risk vulnerable population within the Highline Community will be to engage patients, their families, and their significant others in this process and coach them in how to utilize the healthcare system and community resources to achieve a better health status at lower costs. Participants will be involved in setting health goals and the program will support the goal achievement and graduation from the program.

Current collaborative partners:

- Global to Local on mobile phone-based diabetes management and plans for other program initiatives (see below for details)
- TAVHealth for documentation, outcome tracking, and reports (see below for details)
- Qualis (Quality Review Organization) on providing comparative reports (e.g., statewide 30-day readmission rates vs. Highline's PSA vs. enrolled patients)
- Alliance for Healthy Communities for community training and resources, including behavioral health issues and depression screening, as well as appropriate interventions
- Project Access, a nonprofit that coordinates specialty medical care (i.e., orthopedic surgery) for low-income uninsured people regardless of legal residency status

***Future Collaborations planned**:*

- *NAVOS (mental health, case management, and residential services),*
- *Local Fire Dept and Parish Nurse Group*

Core Investment Components

The budget is based on a pilot project that is grant funded and is based on serving 2 Hospitals. As we expand to more Hospitals or Health Systems then we would need approximately 1-2 teams per hospital. (Each team is able to serve at least 100 pts per year.) If it is a larger hospital then 3 teams maybe required to meet the need. It depends on number of Medicaid enrollees in that specific Hospital or Health Care System. Currently with this pilot program, we are seeing major reduction in costs and utilization as well as improvement in health care for the patients enrolled in this program. We are able to provide further outcome data on a Grant Report including outcomes that will be completed by mid-February. We project that it would take about 6 months to expand and develop the program in a new area based on current experience. The projected cost for one year will be approximately $930,000.

Project Metrics

The following evidence-based and other methods to measure outcomes:

- Better Health: Care team members will use the following evidence-based tools to assess improved health for each enrolled patient: Self-Efficacy For Managing Chronic Disease (Stanford), Personal Health Questionnaire Depression Scale, LACE Index Scoring Tool to assess risk of Readmission, SMART Goal, Hospital Re-Admission Analysis.
- Increased Access: We will use the Client Perception of Coordination Questionnaire and Participant Satisfaction Tool to assess the patients' perception of increased access to community and social services.
- Better Patient Experience: We will use the Client Perception of Coordination Questionnaire and Participant Satisfaction Tool to assess the patients' perception of improvement in their care due to participation in *Health Connections*
- Lower Costs: We will measure the cost-savings realized in overall cost of care for participants as evidenced by reduced hospitalizations and emergency department (ED) visits.

[i].