HOUSTON/HARRIS COUNTY
SUPER-UTILIZER PROGRAM

Presentation at the Texas HHSC webinar on the Houston/Harris County super-utilizer program, our progress, and partner stories
1. CURTIS’S STORY

How many of you have met a super utilizer?
Weekly visits to ER for unmanaged diabetes

Unmet mental health challenges

No primary care provider

Referred to PCIC after amputation and multiple admissions

“I still have the problems here and there, but not as severe... sometimes being a patient is just a number and strictly about money... but you all really care.”
Reduced ER visits

Coordinated care with Primary Care Provider and specialists

Approved benefits and housing

Reconnected with family and enhanced social resources

“I still have the problems here and there, but not as severe... sometimes being a patient is just a number and strictly about money... but you all really care.”
AGENDA

Super Utilizers
PCIC – Mission, workflow & collaborations
Data sharing and analysis
Intervention
CHC partnership
Lessons learned, barriers and possible solutions
Q&A (15 minutes)
2. SUPER UTILIZERS

An introduction to the super utilizor problem
HEALTHCARE SPENDING

- **$2.8 trillion** in U.S.
  Potential cost avoidance $168B

- **$280 billion** in TX
  Potential cost avoidance $17.6B

Assumptions:
Potential savings/cost reduction 30%
Top 1% responsible for 24% of cost
SUPER UTILIZERS IN TEXAS

Medicaid expenditure 2011 = $806 Million in Harris County

Average cost per patient annually

- High Utilizer Patients
- Remaining Patients

99% 1%
76% 24%

$134,000
$90,000

Harris County
National
HOUSTON/HARRIS COUNTY

- **Largest city** in Texas
- 4th largest city in the US
- Harris County - 3rd most populous county with a population of 6 million people
WHO ARE SUPER UTILIZERS

Individuals whose complex physical, behavioral, and social needs are not well met through the current fragmented health care system. As a result, these individuals often bounce from emergency department to emergency department, from inpatient admission to readmission or institutionalization—all costly, chaotic, and ineffective ways to provide care and improve patient outcomes.

- RWJ Foundation
SUPER UTILIZER CHARACTERISTICS

‘Legs’ of a super-utilizer chair:

1. Chronic conditions (including pain)
2. Mental illness
3. Substance Abuse
4. Social factors

A chair can have a broken leg and still stay upright. Each new damaged leg lowers stability. If all four fail, so does the chair.

Focusing on one leg won’t get it upright.
3. Mission, workflow and collaborations
To improve quality and reduce cost through coordination of care for the most costly and vulnerable in our health care system.
MEET THE CLIENT
At hospital:
Engage and enroll
- ID root causes of high utilization
- Goals to modify causes of SU
- Plan steps and goals for CHW
- Define trigger events that will help track progress

Prepare a coordination plan

RN
MSW
HFD/EMS
Clinical Coordination
PCP Specialty care Pharmacy
Social Coordination Housing Food Job/Income

Monitor usage alert

Assessment and Evaluation

Dashboards
- Provider level
- System level

End-Points & Outcomes

Measures every 30 days
↓ Admissions
↓ ER visits
↑ QOL
↓ Cost

Warm Hand-Off to PCP
OR
Re-enrollment

Identify potential policy changes and make recommendations at a system level
SUSTAINABILITY MODEL

- Grant funding
- SU management contract - CHC
  (Pay for performance Yr. 1 vs. Yr. 2 cost savings shared)
- SU management contract – Hospital Plan
  (“Pay per visit” + Yr. 1 vs. Yr. 2 cost savings shared)
- IT data infrastructure & dashboard development
A look at the process and flow of data in identifying super utilizers and the coordination of care
PROCESS FLOW

Data Dump

Pre/Post Analysis & Follow up

Data Cleanup

Data Blending

Intervention Tracking

Client Selection & Enrollment

Client Eligibility & Identification

Referral Program

Data sharing and analytics
INTERVENTION TRACKING

- History
- Care Plan
- DLA-20
- ACE
- Root Cause Analysis
- EcoMap

Data sharing and analytics
DASHBOARDS

Data sharing and analytics

Community

Institution

Provider

Client
Data sharing and analytics

PATIENT SELECTION DASHBOARDS

- Geographic Distribution of Patients
- Age Distribution
- Total Billed per Patient
- Diagnosis
- Admit & ER Billed per Patient
Data sharing and analytics

Geographic Distribution of Patients

Age Distribution

Total Billed

Diagnosis

Admit & ER Billed per Patient

Data sharing and analytics
Data sharing and analytics
5. INTERVENTION

PCIC’s care coordination intervention program
Enrollment & establish relationship

Medical history & prescriptions, social support coordination

Identify goals & develop care plans

Establish PCP & Specialists

Begin new & modified treatments

Improve quality of life

Manage own care

PATH TO GRADUATION
Enrollment & establish relationship

Medical history & prescriptions, social support coordination

Identify goals & develop care plans

Establish PCP & Specialists

Begin new & modified treatments

Improve quality of life

Manage own care

Curtis referred by HHH to PCIC

Control DM
Stable housing
Secure Income (SSI)

Close DM monitoring
SSI application

Blood glucose levels normalized
Psych symptoms improved
Housing and Income secured
in home provider

EcoMap
ACE
DLA-20
Medication reconciliation

PCP
Endocrinologist
Psychiatrist

DLA improved by 39%
SSI approved

PATH TO GRADUATION (FOR CURTIS)
PHASE 2 RESULTS (SOCIAL FACTORS)

28 Total clients enrolled

13 Clients successfully managed

Housing

4 Homeless
9 Housed

Insurance Status

6 Medicare/Medicaid
2 Private Insurance
5 Uninsured
PHASE 2 RESULTS

3 months pre & post intervention
EMS transports

Pre: 5.5
Post: 2.7

51% decrease
PHASE 2 RESULTS

Improved function (DLA-20)

34% ↑

44.4

57.3

Entrance
Exit

Intervention
## PHASE 2 RESULTS

HHS cost – 6 months pre and post intervention

![52%](image)

<table>
<thead>
<tr>
<th>PATIENT TYPE</th>
<th>6 MONTHS PRE ENROLLMENT</th>
<th>6 MONTHS POST ENROLLMENT</th>
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<tr>
<td></td>
<td>CASES</td>
<td>CHARGES</td>
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<td>EC VISITS</td>
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<td>OP VISITS</td>
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<td>GRAND TOTAL</td>
<td>130</td>
<td>$219,539</td>
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HHS cost – 6 months pre and post intervention

52%
What motivated CHC to join the effort with PCIC?

- Important in achieving Community’s overarching goals
- Engage members & providers in improving individual & Community health
- Participate in the community through collaboration
- Improve access to healthcare for low-income families
- Improve cost-effectiveness of care
- Promote health through Effective and Efficient Resource utilization
What have we developed together so far?

Selecting the right people for the program

Client selection dashboards

Client identification – 7 selected (Criteria)
- 25+ years old living in Houston area
- 2 or more chronic conditions
- Large number of ED & IP visits
- Specific amount of claim dollars spent
- Will not be terming with us any time soon

Client recruitment & enrollment – 2 clients
What outcomes does CHC hope to achieve from this collaboration?

- Appropriate use of health care services
- Positive self-management of the client’s chronic conditions
- Identify enablers and scale to larger population
“PCIC's comprehensive coordination of care model provides patients with better outcomes through root cause analysis, frequent contacts and social supports. The service cost per patient is lower than ER cost and the ROI can be reasonably calculated. Community Health Choice is excited to partner with PCIC on the Medicaid population and may consider other lines of business.”

Richard Lee, CFO
Community Health Choice
6. LESSONS LEARNED

Barriers and enablers
DATA SHARING IS KEY

Overlap Analysis

Institution 1

Institution 2

Institution 3

Hot Spots

Data driven intervention

Better Care

Lower Cost
### BARRIERS

#### CLIENT
- Communication challenges
- Transportation challenges
- No PCP
- Limited/unreliable transportation
- No support network
- Low education
- LONELINESS

#### SYSTEM
- Provider not accepting Medicaid
- No appointments available
- Too many referrals
- No accountability
- No coordination among institutions
ROOT CAUSE ANALYSIS

JUST THE TIP OF THE ICEBERG

Lessons learned
ECOMAP - ON ENROLLMENT

- SSI
- Healthcare System
- Prison
- Brother-in-Law
- Mother
- Children
- Neighbor
- Food Stamps
- Sister
- Housing Homelessness

J.S.
ECOMAP – PROJECTED AFTER INTERVENTION
THANK YOU