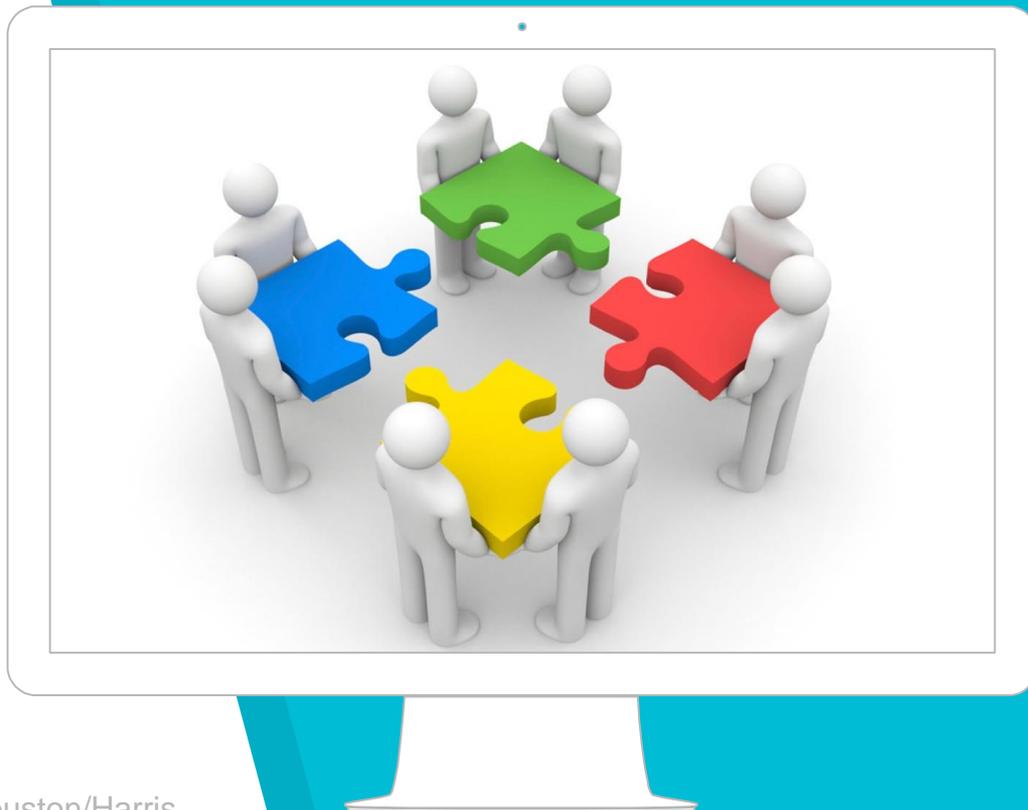




HOUSTON/HARRIS COUNTY SUPER-UTILIZER PROGRAM

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?

CURTIS'S STORY (BEFORE)

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."*



CURTIS'S STORY (AFTER)

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 utilizer problem

HEALTHCARE SPENDING

- ▶ **\$2.8 trillion** in U.S.
Potential cost avoidance **\$168B**
- ▶ **\$280 billion** in TX
Potential cost avoidance **\$17.6B**

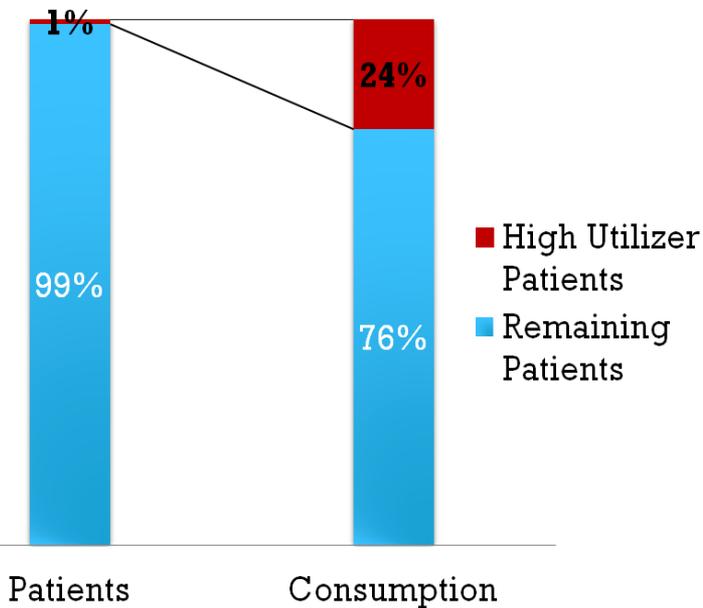
Assumptions:

Potential savings/cost reduction 30%

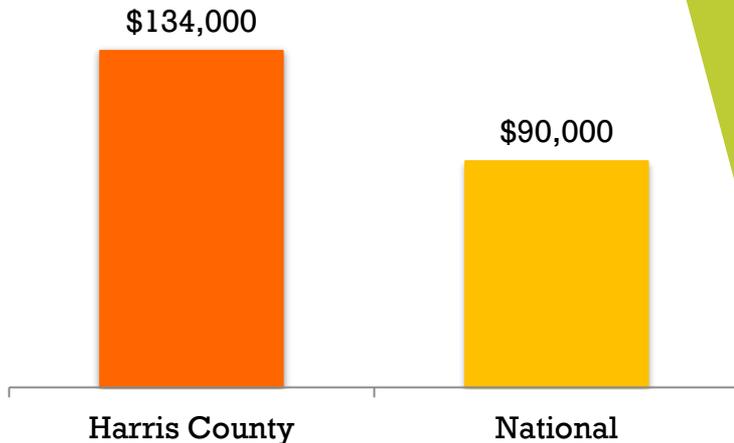
Top 1% responsible for 24% of cost



SUPER UTILIZERS IN TEXAS



Average cost per patient annually

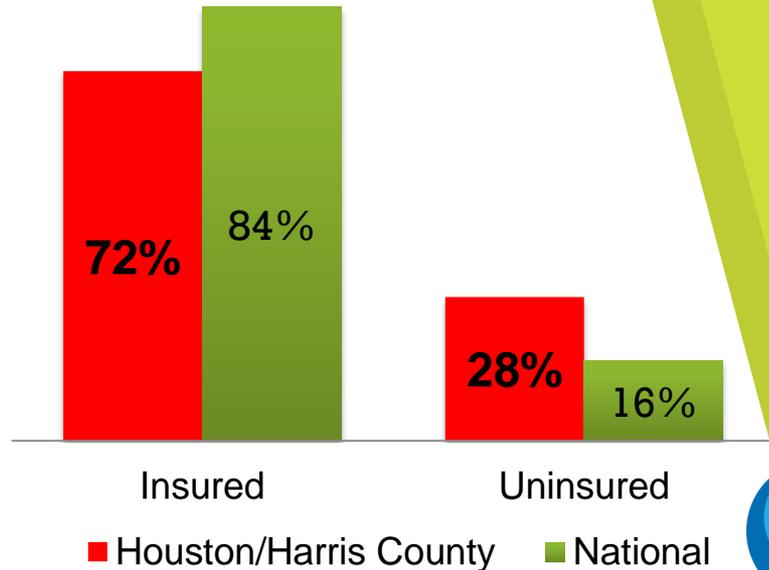
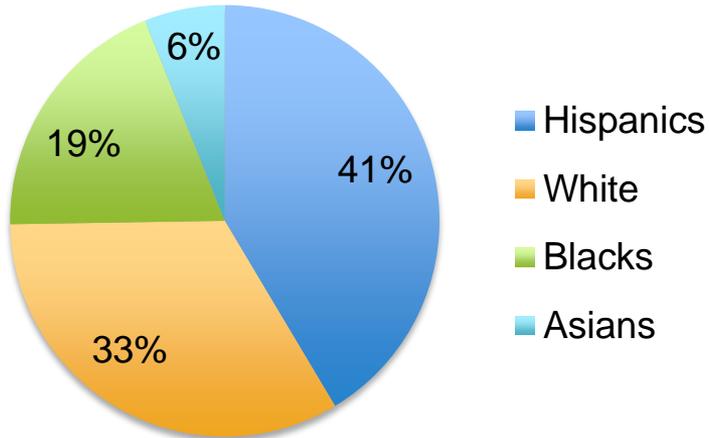


Medicaid expenditure 2011 = **\$806 Million** in Harris County



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.



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.

PCIC

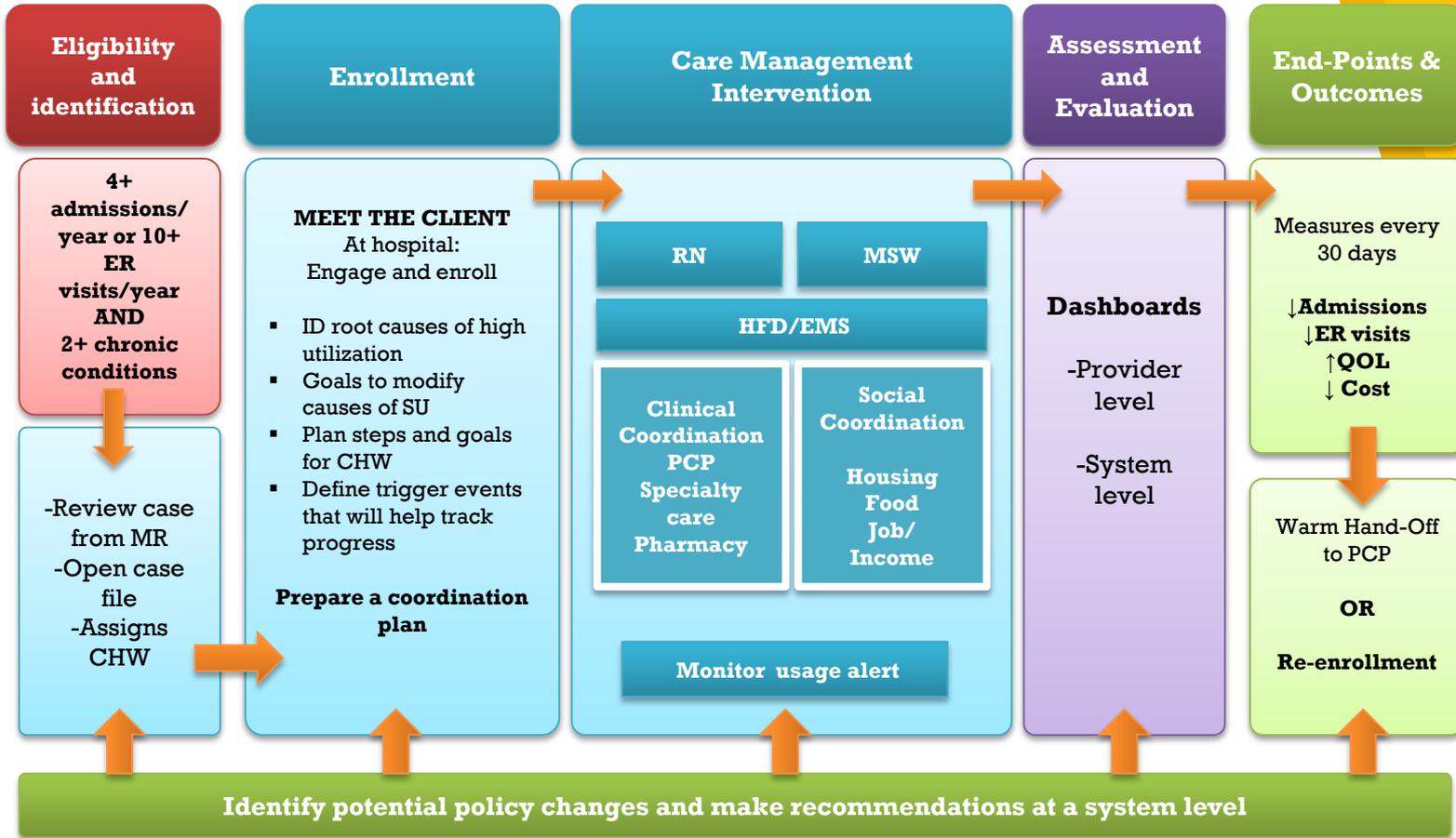
Mission, workflow and
collaborations

PCIC MISSION

To **improve quality** and **reduce cost** through **coordination of care** for the most costly and vulnerable in our health care system.



WORKFLOW



STAKEHOLDERS



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



4.

DATA SHARING AND ANALYTICS

A look at the process and flow of data in identifying super utilizers and the coordination of care

DATA OBTAINED

Houston Police Dept.

HPD

1,053,606
crime records

454,625
arrest records

37,312
juvenile arrest records

Houston Methodist Hospital

HMH

9,618
patients

27,534
visits

Harris Health System

HHS

28,511
patients

130,051
visits

Homeless Mgmt. Information System

HMIS

324,498
HMIS
"service provided"

854 users

Community Health Choice

CHC

1,833
claims data

58 patients

Houston Fire Dept.

HFD

55,457
transport records

Houston Jail

JAIL

41,753
incarceration records

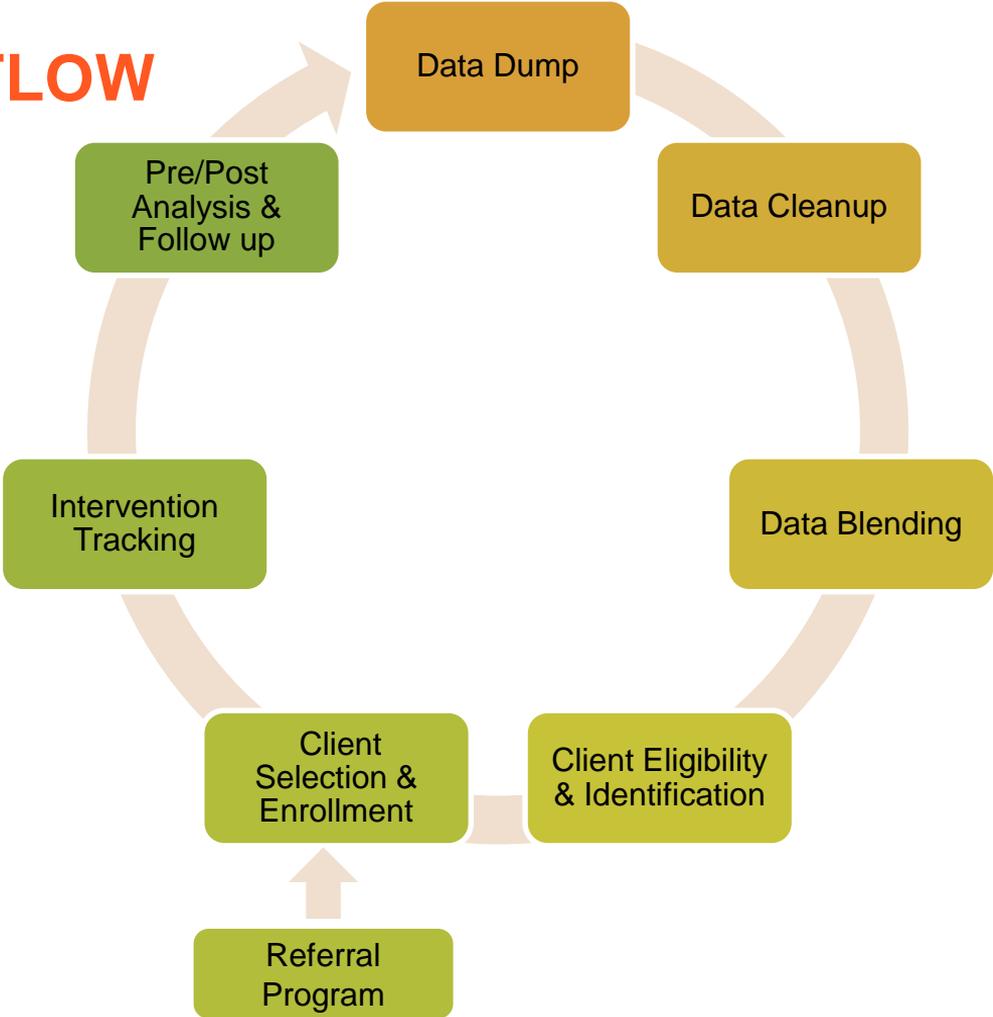
Houston Recovery Center

HRC

428
frequent user records



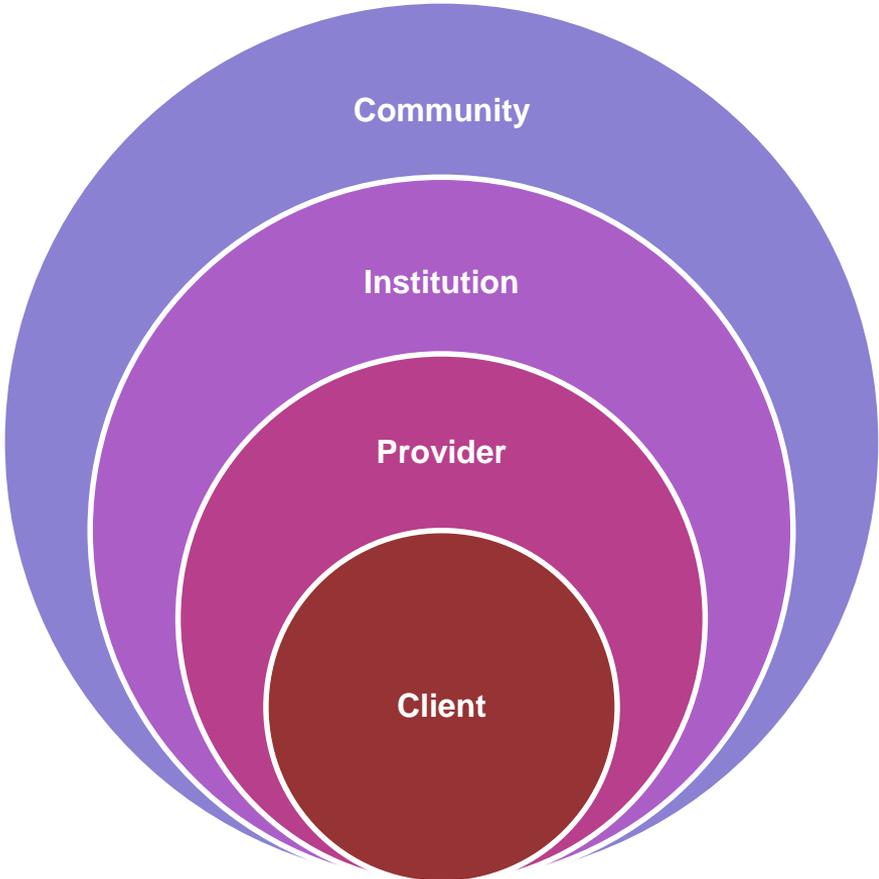
PROCESS FLOW



INTERVENTION TRACKING



DASHBOARDS

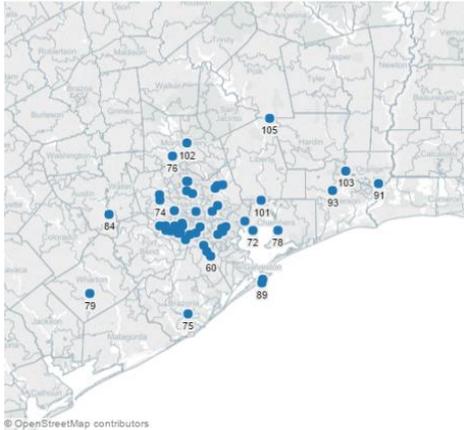


PATIENT SELECTION DASHBOARDS

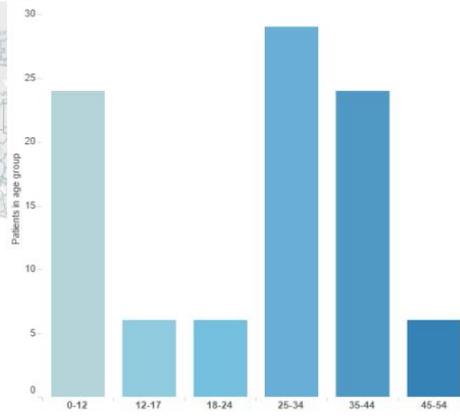
County Filter: (All) City Filter: (All) Chc Pseudo Member Id: (All)

Total Billed Filter: 12,800 to 4,820,740

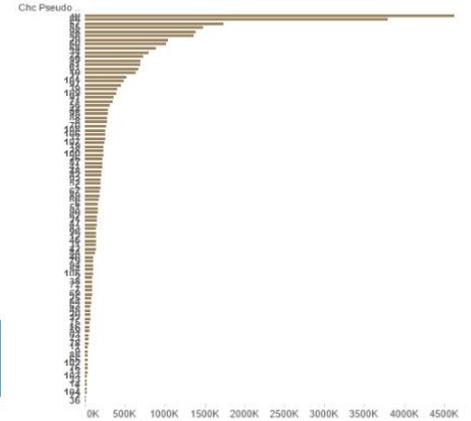
Geographic Distribution of Patients



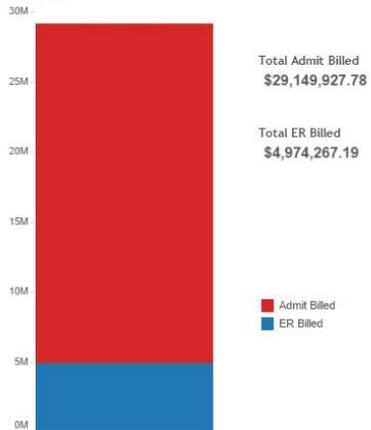
Age Distribution



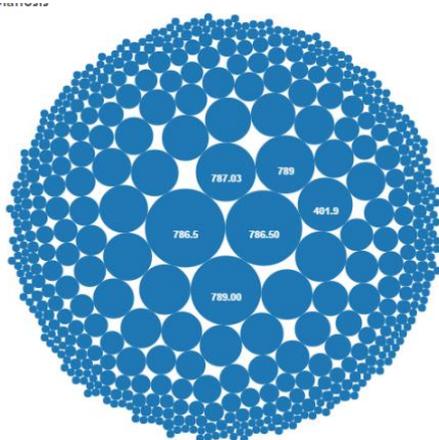
Total Billed per Patient



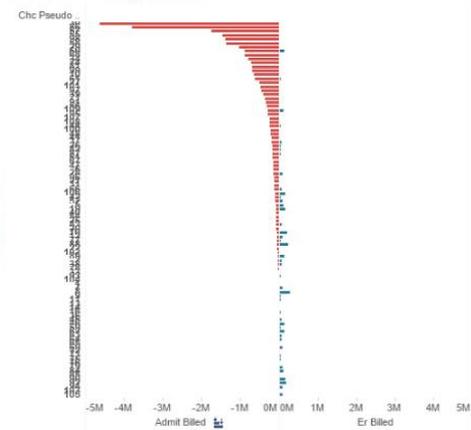
Total Billed



Diagnosis



Admit & ER Billed per Patient



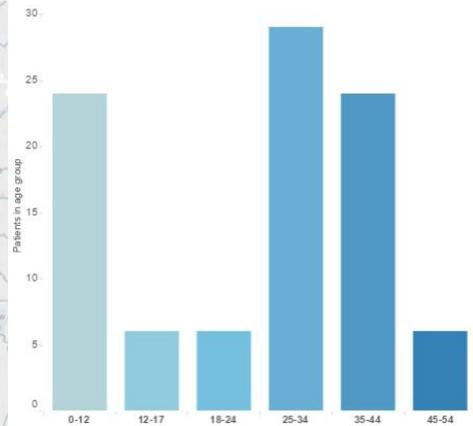
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Total Billed Filter: 12,899 - 4,629,740

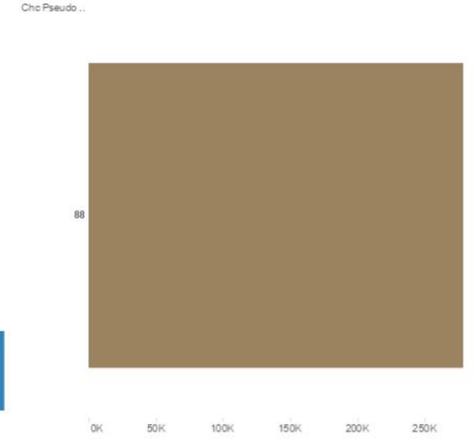
Geographic Distribution of Patients



Age Distribution



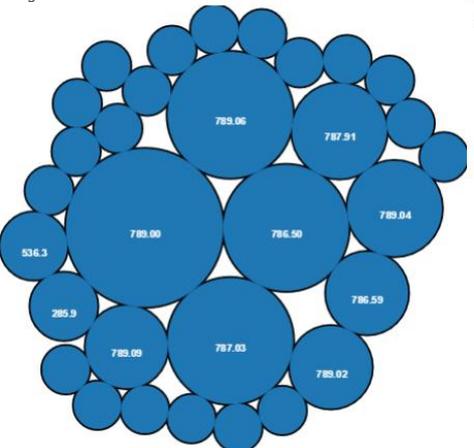
Total Billed per Patient



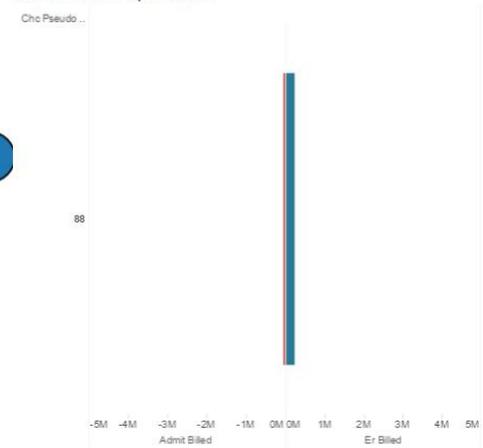
Total Billed



Diagnosis



Admit & ER Billed per Patient



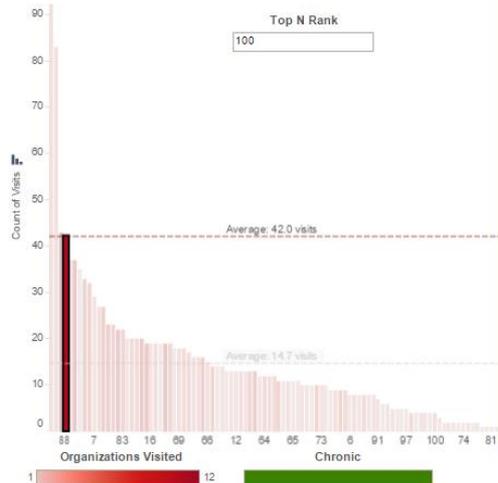
Count Visits Filter

1 92

Visit Date Filter

1/3/2014 9/29/2015

Visits(Size) & Institutions(Color) Per Patient

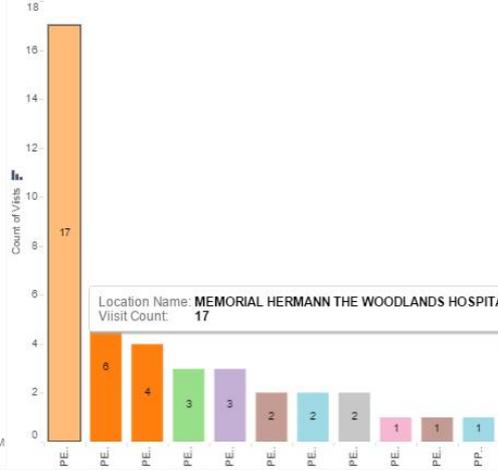


Visits (Size) & Chronics (Color) Per Patient

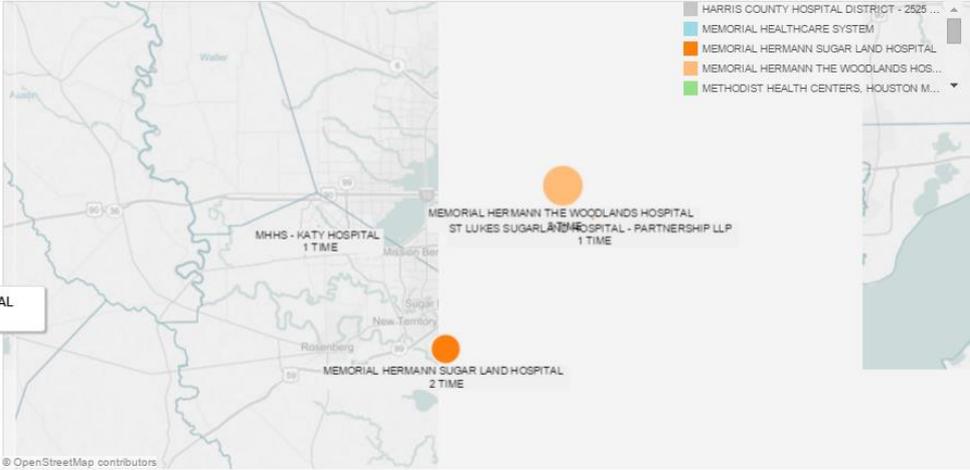


October 2014 Show History

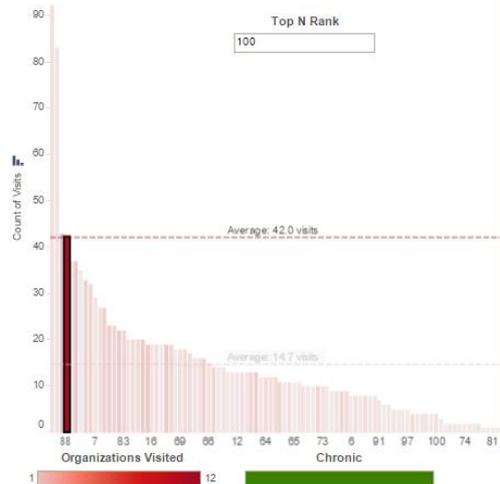
Visits per Institution



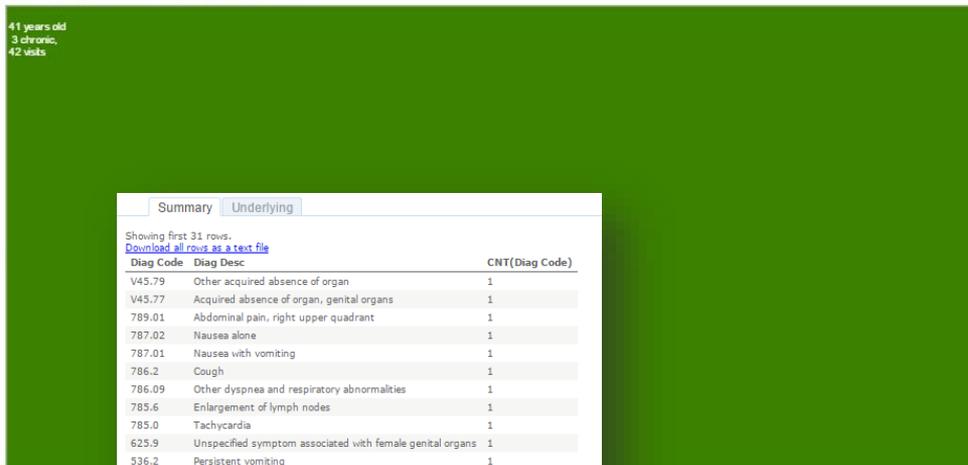
Institution Utilization Over Time



Visits(Size) & Institutions(Color) Per Patient



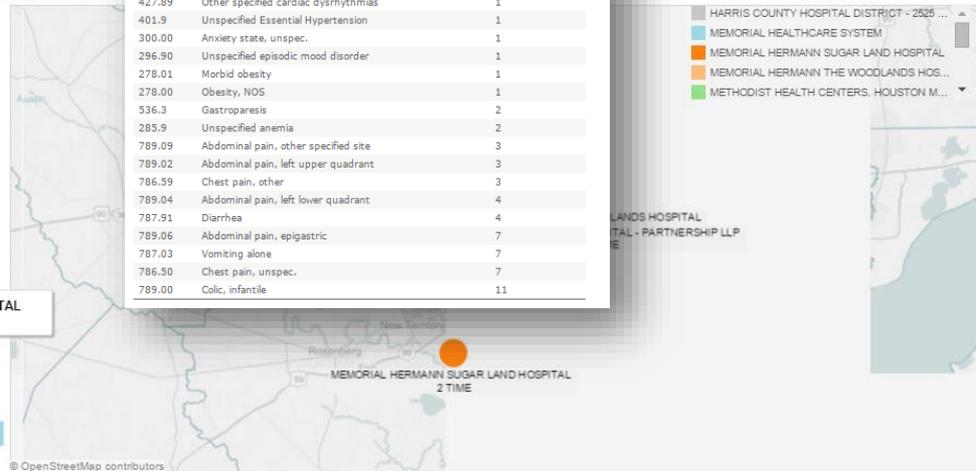
Visits (Size) & Chronics (Color) Per Patient



Visits per Institution



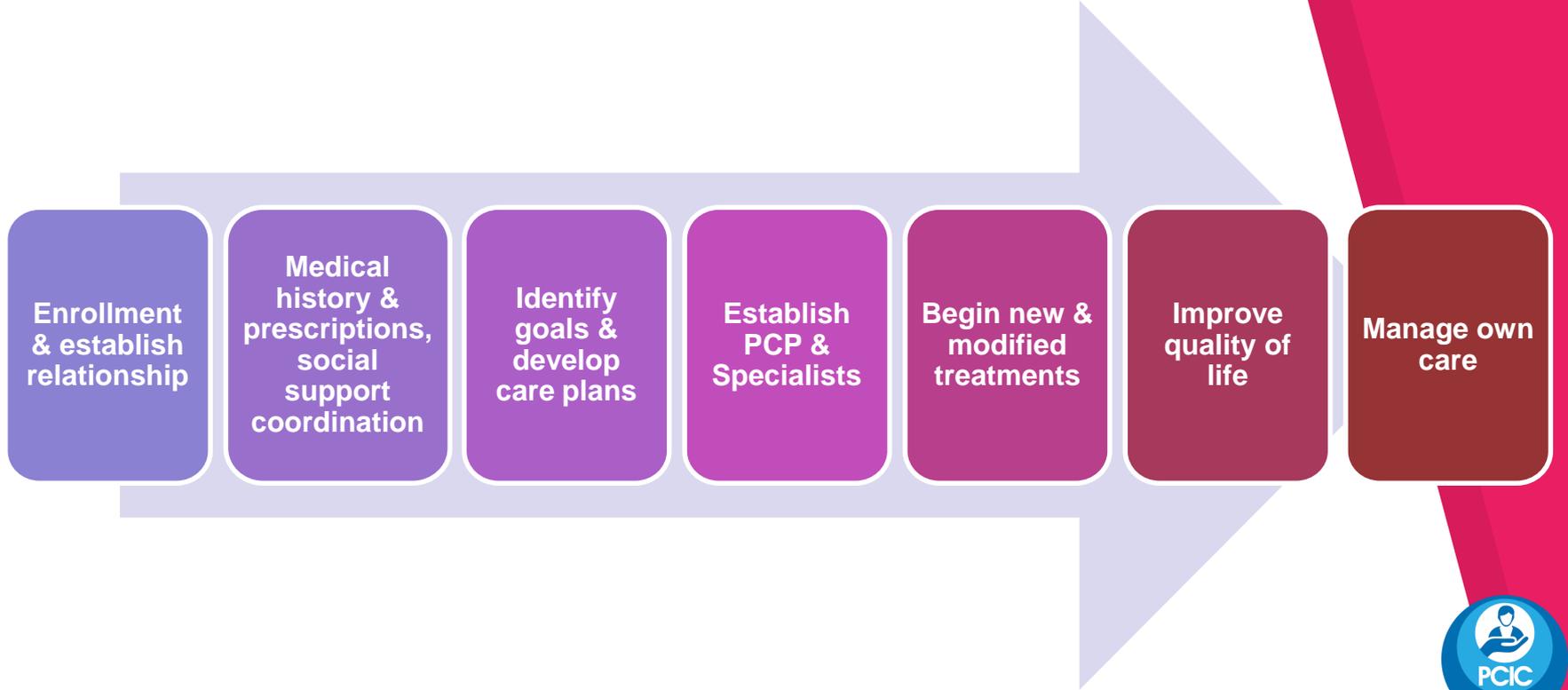
Institution Utili:



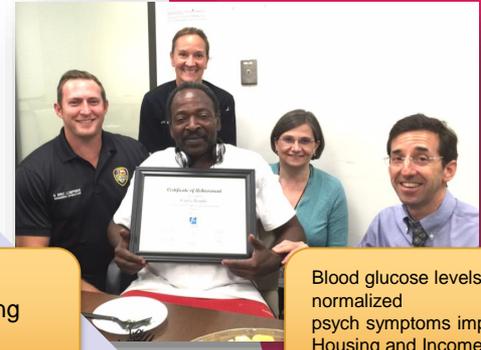
5. INTERVENTION

PCIC's care
coordination
intervention program

PATH TO GRADUATION



PATH TO GRADUATION (FOR CURTIS)



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

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

EcoMap
ACE
DLA-20
Medication reconciliation

PCP
Endocrinologist
Psychiatrist

DLA improved by 39%
SSI approved



PHASE 2 RESULTS (SOCIAL FACTORS)

28 Total clients enrolled



13 Clients successfully managed



Housing

4 Homeless

9 Housed

Insurance Status

6 Medicare/Medicaid

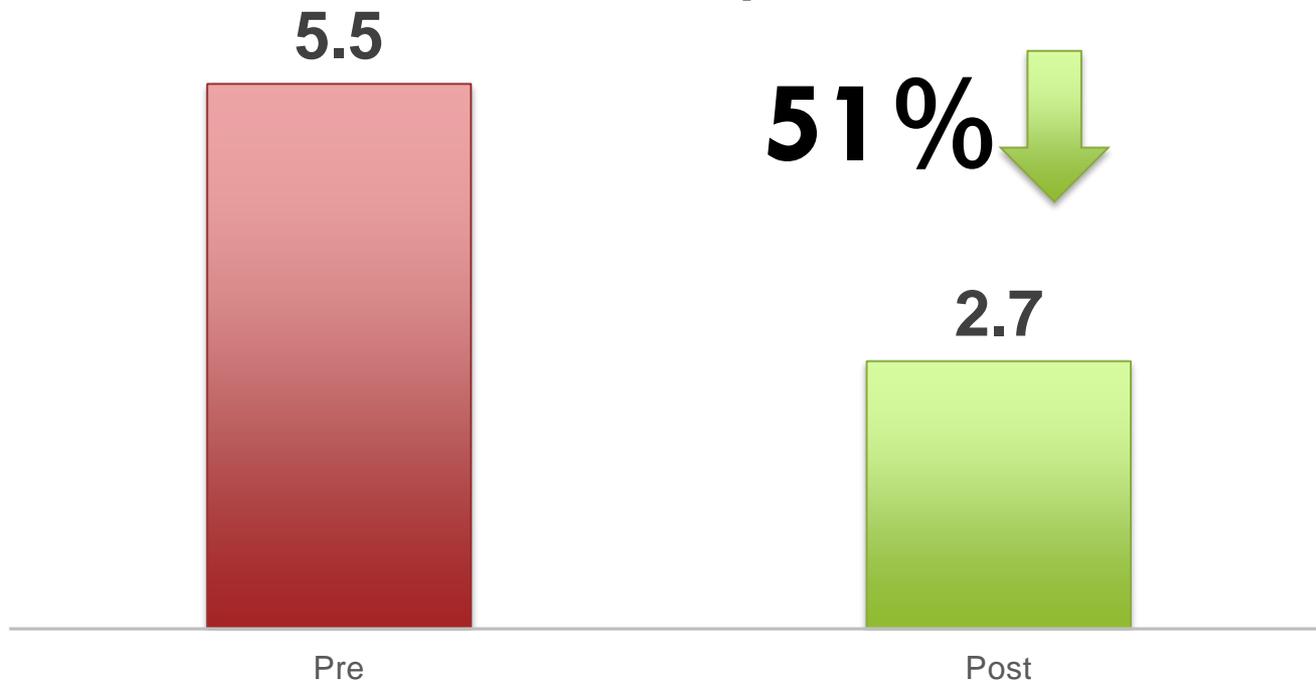
2 Private Insurance

5 Uninsured



PHASE 2 RESULTS

3 months pre & post intervention
EMS transports



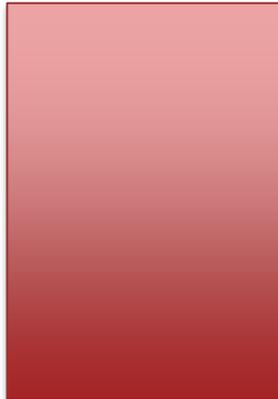
PHASE 2 RESULTS

Improved function (DLA-20)

34%

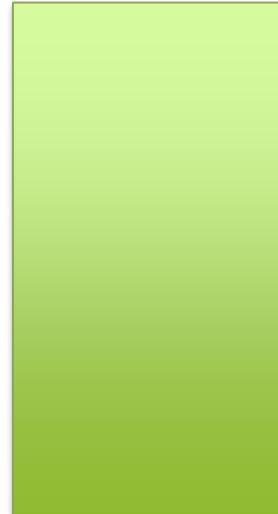


44.4



Entrance

57.3



Exit



PHASE 2 RESULTS

HHS cost – 6 months pre and post intervention

52% 

	6 MONTHS PRE ENROLLMENT		6 MONTHS POST ENROLLMENT	
PATIENT TYPE	CASES	CHARGES	CASES	CHARGES
IP ADMISSIONS	5	\$77,723	0	\$0
EC VISITS	41	\$110,651	22	\$54,934
OP VISITS	84	\$31,165	75	\$49,965
GRAND TOTAL	130	\$219,539	97	\$104,899



COMMUNITY HEALTH CHOICE PARTNERSHIP



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



COMMUNITY HEALTH CHOICE PARTNERSHIP



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



COMMUNITY HEALTH CHOICE PARTNERSHIP



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



COMMUNITY HEALTH CHOICE PARTNERSHIP



“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



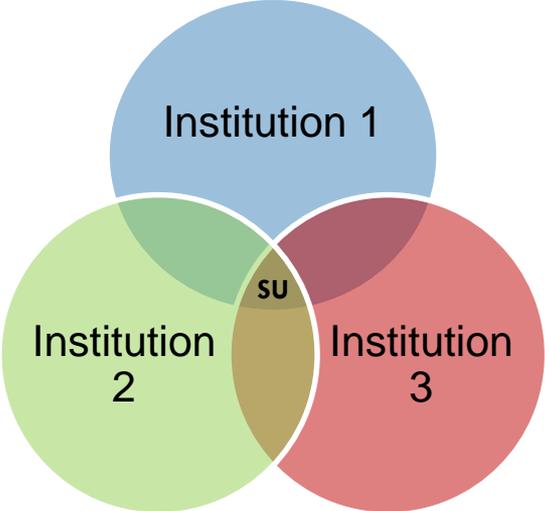
6.

LESSONS LEARNED

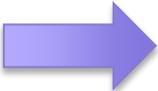
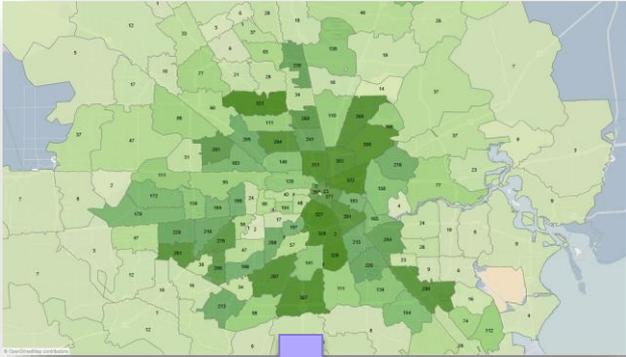
Barriers and enablers

DATA SHARING IS KEY

Overlap Analysis



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

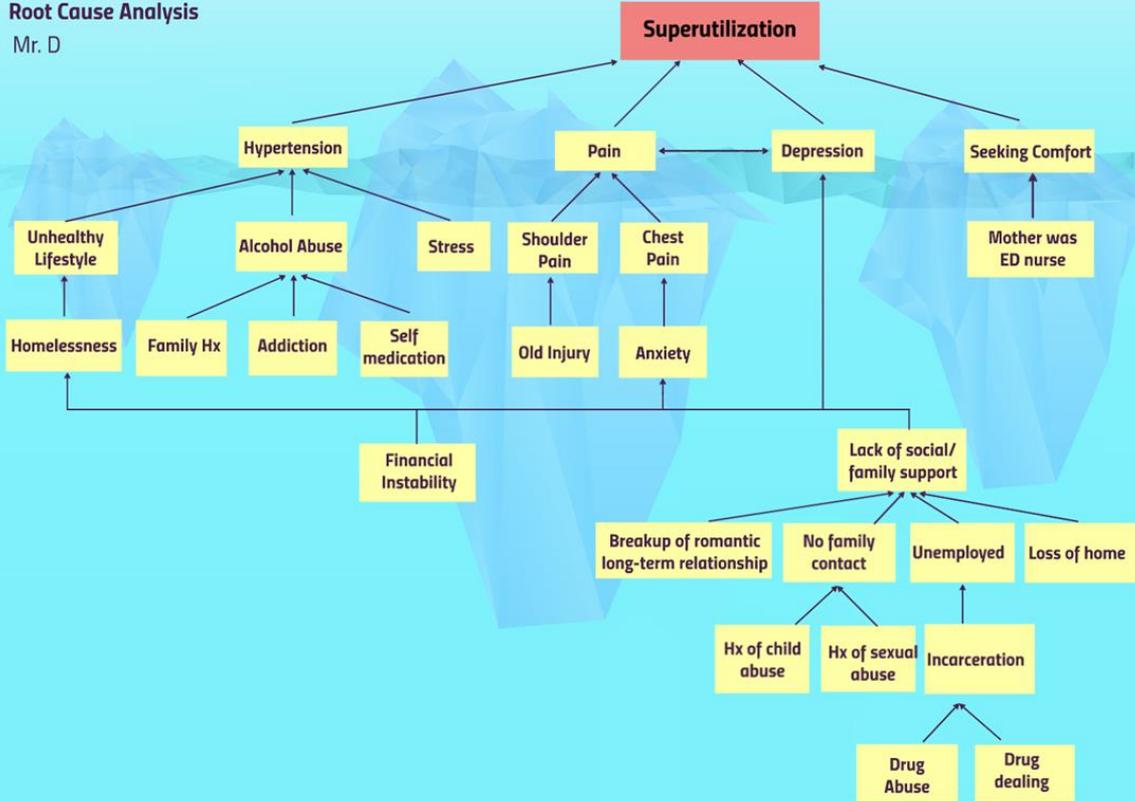
No coordination among institutions



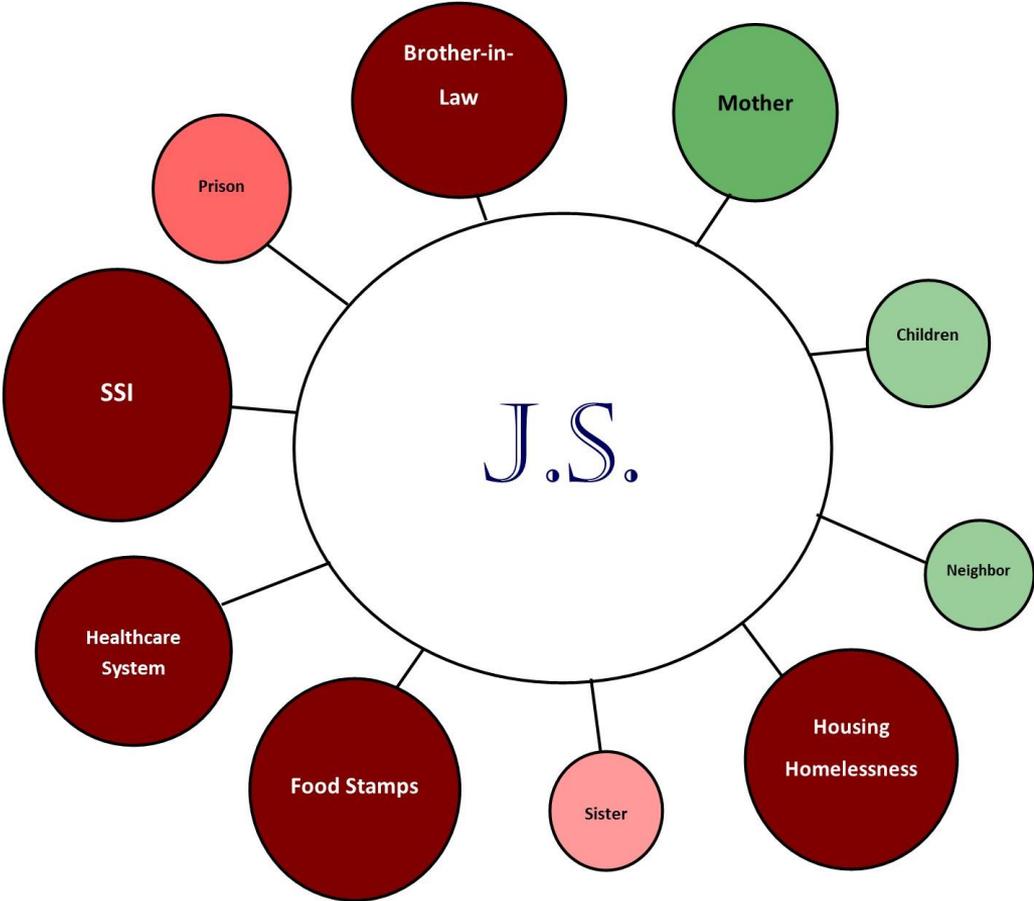
ROOT CAUSE ANALYSIS

JUST THE TIP OF THE ICEBERG

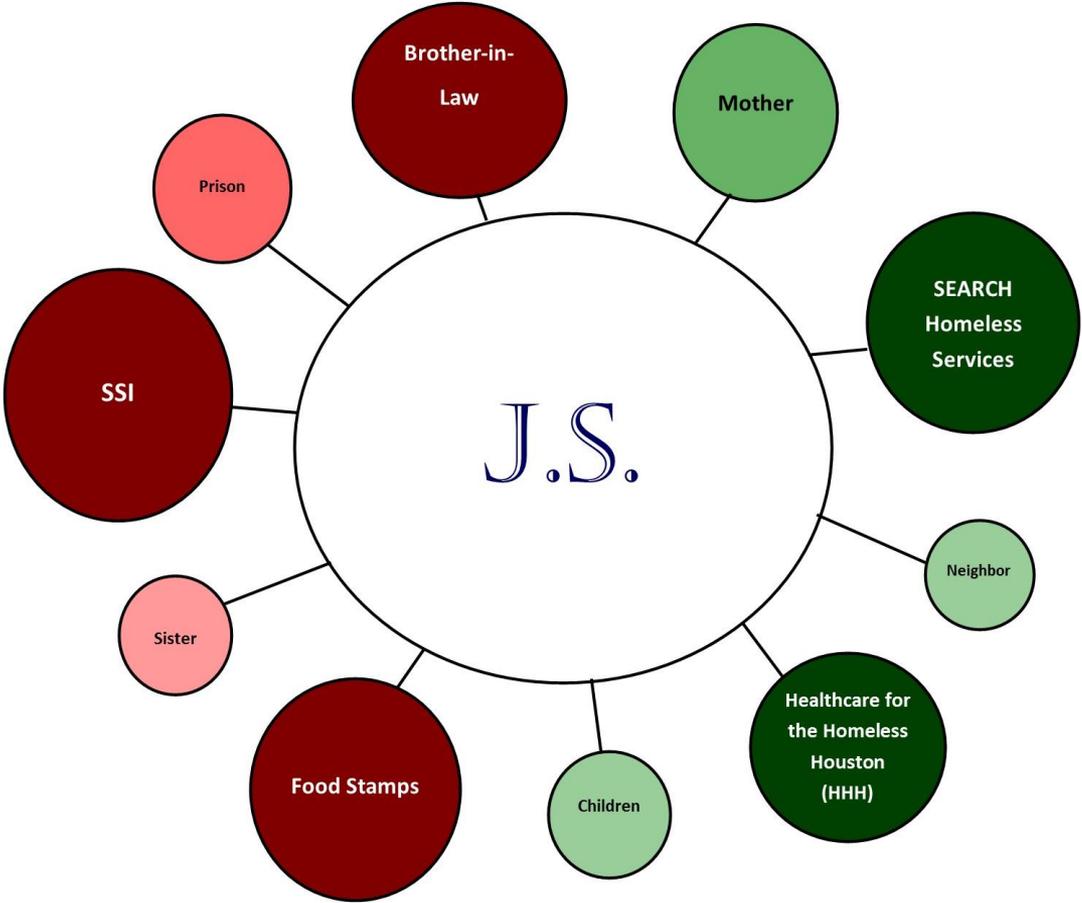
Root Cause Analysis
Mr. D



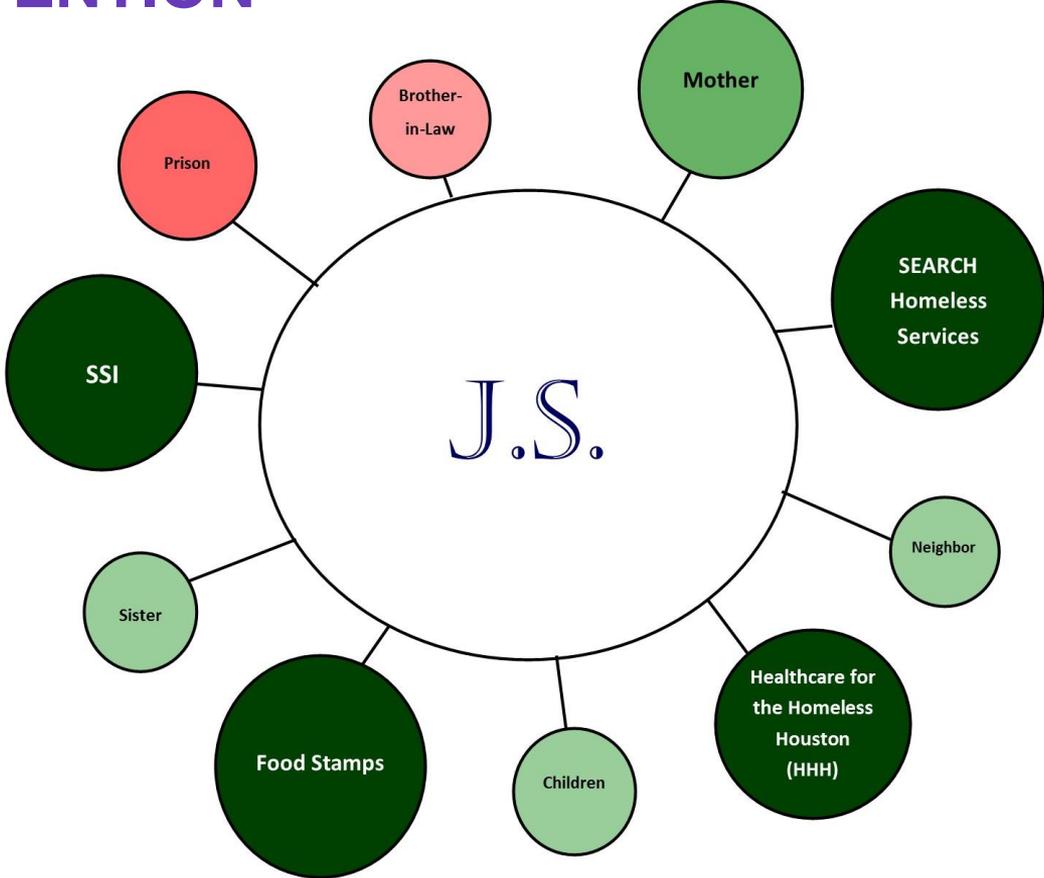
ECOMAP - ON ENROLLMENT



ECOMAP – DURING INTERVENTION



ECOMAP – PROJECTED AFTER INTERVENTION



Q&A



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THANK YOU