Chemung County Medical Home Strategy & Development

NYSAC 2011 Legislative Conference
Monday, February 7, 2011
3:45 – 5:00 PM
**Problem:**
Medicaid spending must be controlled and health outcomes improved.

**Premise:**
Any attempt at Medicaid reform must include strategies to change both patient and provider utilization patterns.

**Strategy:**
Create a Patient Centered Medical Home Model devoted to serving only the Medicaid population and a software solution that will provide tools necessary to:

- support the creation of non-traditional intervention strategies
- develop metrics necessary to evaluate the impact of the model on Medicaid costs and health outcomes
Process for Model Development in Chemung County

Community Engagement – County Executive Tom Santulli and Deputy County Executive Mike Krusen led an extensive process to engage key stakeholders in the community. A formal partnership was established between members of the medical community and the county for the creation of a patient centered medical home.

Site Preparation – Space in the Chemung County Human Resource building was renovated to house the new medical home, Priority Community Health Care (PCHC). Staffed with a physician and nurse practitioner, the practice is prepared to serve up to 4000 patients and opened on March 1, 2010. There are approximately 2500 currently enrolled patients.

Health Information System – Chemung County contracted with Salient Management Company to create a software solution that would integrate Medicaid paid claims data with electronic medical record data. The goal was to provide complete, timely and accurate data to the practice that would inform the development of non-traditional intervention strategies, and provide the framework for evaluation.
Partners and Roles

**Chemung County**
- Communicate value to community and state
- Facilitate managed care enrollment, referrals
- Facilitate community-based involvement with PCHC and foster linkages with county resources
- Provide access to Salient technology and resources for Medicaid and EMR data and integration
- Coordinate funding for PCHC accreditation
- Physical plant support

**Management Committee**
- Executive-level decision making
- Review and monitor goals
- Includes representation from each stakeholder organization
- Approves budget
- Reviews results of patient care

**Practice Management (Twin Tier Physician’s Management and Southern Tier Area Plan)**
- Manage day-to-day practice
- Provide Practice Administrator
- Provide office support staff
- Form Management Committee
- Monitor state-mandated QA

**Priority Community Health Care**
- Deliver services to an estimated 4,000 Medicaid enrollees on a partially capitated basis
- Facilitate managed care enrollment
- Employ best practice strategies for cost saving and outcome improvements
- Leverage EMR and Medicaid data for clinical decision support and monitoring
- Coordinate county resources and form community linkages for integrated patient care

**Arnot Medical Services**
- Provide clinicians
- Furnish Health Center
- Give EMR access to Health Center
- Provide EMR data to Salient

**Priority Healthcare**
- Serve as medical management company
- Provide member services with emphasis on patient education
- Provide on-site medical case management
- Receive pre-negotiated capitation
- Process capitations – reimburse practice
- Perform state-mandated QA
PCHC Goal and Strategies

Goal
• Improve health and reduce Medicaid spending for the Medicaid population eligible to be enrolled in Managed Care.
• Provide a “controlled” environment/dedicated primary care site.
• Develop a model with proven results that can be replicated.

Strategies
• Couple provision of medical care with targeted intensive care management, coordination with community service providers, and non-traditional interventions to improve engagement, compliance, and health outcomes.
• Target specific chronic disease states and develop and implement standards of care to improve outcomes and reduce costs.
• Actively monitor and change patient behavior to reduce costly or inappropriate health care utilization.
• Leverage EMR and Medicaid paid claims data and use ongoing evaluation strategies to learn and adjust.
True Medical Home Environment
Integrate, Organize, Correlate

- Clinical Data
- Managed Care Encounters
- Medicaid Claims
- Other Data Sources
- Enrollment Roster
- Whole Person Orientation
- Safety & Quality
- Care Coordination & Integration
- Personal Provider
- Enhanced Access
- Continuity of Care
- Capacity & Accountability
## Translating Vision to Data Elements

<table>
<thead>
<tr>
<th>Process</th>
<th>Activities</th>
<th>Indicators of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment, Admission and Engagement</td>
<td>Phone Calls</td>
<td>↑ Number of enrolled at PCHC</td>
</tr>
<tr>
<td>Community Linkages and Referral Coordination</td>
<td>Mailings</td>
<td>↑ Number of patients with organizing visit completed</td>
</tr>
<tr>
<td>Disease Management Strategies</td>
<td>Face-to-Face Contacts</td>
<td>↓ Number of no-shows/scheduled</td>
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<tr>
<td>Provision of Patient Care</td>
<td>EMR Data Entry</td>
<td>↓ Number of claims outside the clinic by type</td>
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<tr>
<td>Access to Care</td>
<td>Admitting Enrolled Patients</td>
<td>↓ Inappropriate ER, inpatient, and specialist use and cost</td>
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<tr>
<td></td>
<td></td>
<td>↑ Average length of enrollment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>↓ Number disenrolled by patient request</td>
</tr>
<tr>
<td></td>
<td></td>
<td>↓ Number disenrolled due to patient behavior</td>
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</table>
Examples of Operational Use of Data

Patient Profile

Users: Clinicians

— Track a patient as they access the healthcare system over time to understand utilization and medical needs and inform plan of care.

Population Assessment

Users: Management Committee, Practice Administrator

— Understand the demographic and clinical characteristic and utilization patterns of the population of patients enrolled in PCHC for targeting, engagement, and resource strategies.

Enrollment and Engagement

Users: Case Manager, Office Manager, Nurse

— Track patient engagement with PCHC and utilization of services outside of PCHC, and identify high priority patients for outreach.

Disease Management Strategies

Users: Practice Administrator, Clinicians

— Use data to target cohorts or disease states for disease management strategies.
Community Awareness

• Met with community based organizations.
• Oriented audience to focus of PCHC as a Medical Home Model.
• Invited CBO “active” involvement/ collaboration.
• Adopted a community wide release of information.
• Secured commitment to enhanced care coordination.
Using Data to Drive Interventions and Achieve Results

- Improve Patient Engagement
  - Understand our Enrolled Population
- Develop Targeted Outreach Strategies
  - Cohorts of patients
  - Individualized efforts
- Coordinate with Providers
  - High ER Users: A Case Study
  - Create “real” deflection strategies
- Intervene by Disease State
  - Hypertensive Cohort Study
- Compare Cost and Utilization - Pre and Post Enrollment

Let’s see some examples...
Improve Patient Engagement

The view on the left shows the number of people enrolled in PCHC by month in pink, and the number of people coming in for visits in blue. The view on the right shows the cumulative number of people who have been seen at PCHC since it opened. This information can be used to set visit goals for the practice and to learn more about patients with no visits to implement outreach strategies.
This view gives a breakout of the population enrolled and the percentage of visits according to age group. Notice that 45-64 year olds have a disproportionate share of the visits, while the 0-4 and 5-14 year old population are underrepresented in terms of visits. Use the solution to investigate further to determine the reason for the disproportionate share of visits.
Targeted Outreach

This Scattergram shows PCHC enrollees according to the number of ER visits they had and the total cost of these ER visits. Use this information to measure the results of interventions aimed at reducing the number of enrollees with multiple ER visits.
Targeted Outreach

In this view we can focus on individuals with the highest ER use. Here you can see that one patient had 30 ER visits in 10 months. Views like this allow the medical home to identify outliers in any area of interest and then determine appropriate interventions.
Coordination with Providers

This shows all services received by our highest ER user: 160 total service claims at a cost of about $20,000. We can see that the patient is receiving services from a number of mental health providers, prompting the medical home to coordinate a plan of care with those providers and the patient.
Coordination with Providers

Still focused on our highest ER user, this view shows a daily trend of ER visits on the top and PCHC visits on the bottom. We can see that as this patient became more engaged with primary care, ER visit frequency begins to slow down.

In addition, we have found that delays in being seen by a “referred to” provider can cause a patient to seek care in the ER. This information can be used to explore with specialty providers possible solutions to delays in appointment times.
**Targeted Intervention by Disease State**

This is a study of patients enrolled at PCHC with hypertension. Going back through 5 years of claims data, we found 59 patients with this diagnosis. We can examine the latest blood pressure readings for those who have been seen at PCHC. The view below shows how many patients have filled prescriptions for hypertension.
Targeted Intervention by Disease State

Here we see patients who have been seen at PCHC and whose hypertension is not being managed with medication. This view displays the latest blood pressure results, using color to highlight patients who are above the safe range.

This information can be used to attempt to engage those patients not seen, identify patients with drugs prescribed by other providers, and to further investigate the patient in the danger zone, but not being managed with medication. These collections can be created for any disease state.
Impact on Medicaid Spending

Here we see a detailed breakout of cost for a group of 393 patients who have been enrolled in PCHC since enrollment began last year, and who were also enrolled in Medicaid for 10 months the year prior. We can see that compared to last year, there has been a decrease in total spending for this population. Although it is premature to draw conclusions, and additional analyses are required, the preliminary view is very encouraging.

<table>
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<tr>
<th>Total Billed Provider Type: 19</th>
<th>MA Total Paid</th>
<th>MA Avg Svc $ / Patient</th>
<th>MA Avg Drug $ / Patient</th>
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<tbody>
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<td>This</td>
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Totals  
$1,248,108.40   $1,270,833.81   ($22,725.41)  -1.79  $2,283.45  $2,935.95  -22.22  $1,279.97  $980.81  30.53
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Linda was the Commissioner of Human Services for Chemung County and worked closely with the County Executive’s Office on the Medical Home project. She recently joined Salient as a Principal Advisor.

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Jed is the CEO of CNYMSS and is a consultant to Chemung County and Salient, providing patient centered medical home/enhanced care coordination development support.