



Tiger Team Meeting Materials

Tiger Team Members

- Christopher Colenda, M.D., West Virginia United Health System
- Karen Fitzpatrick, M.D., West Virginia United Health System
- Barbara McKee, Charleston Area Medical Center / Partners In Health Network
- Karen Yost, Presteria Center
- Craig Robinson, Cabin Creek Health Systems
- Vicky Gallaher, UniCare (Mitch Collins)
- CoventryCares TBD (Todd White)
- Highmark BCBS TBD (Fred Earley)
- Jon Cain, West Virginia Bureau for Medical Services (Medicaid)

Charge to the Tiger Team

We must operationalize the super-utilizer definition as approved by the SIM Task Force at the January meeting. That is, how will this definition work in practice? Most operationalizations use ED visits, hospitalizations and/or costs as a starting point. One major point to keep in mind is that we should be encompassing enough to incorporate a sufficient population to actually make an impact on costs and quality.

The SIM Task Force was presented with these operationalizations as starting points for discussion.

1. Partners In Health Network – Multi Visit Patient (MVP) Program

12 or greater ED visits in the previous 12 months.

2. Health Affairs Published Study (August 2015): Denver Health

Patients who had three or more hospitalizations in a rolling 12-month look-back period or had both a serious mental health diagnosis (using ICD-9 codes) and two or more hospitalizations in the look-back period.

3. West Virginia National Governors Association Medicaid Complex Care Program

A Medicaid member who accesses the ED 10 or more times or has more than 25 health care encounters in the previous 12 months.

4. Other Participants in the National Governors Association Medicaid Complex Care Program

Colorado – Six or more ED visits in 12 months and 30 or more prescription drugs in 12 months.

Wisconsin – Three or more ED visits in six months or Medicaid claims of \$100,000 or more in 12 months.

Super-Utilizer Definition Approved by the Task Force

Super-utilizers experience complex physical, behavioral and social determinants of health that are not well met through the current fragmented health care system. These individuals would receive better care at a lower cost if they were identified and provided coordinated care.

This definition is a combination of two definitions: one used by The Robert Wood Johnson Foundation / The Camden Coalition of Healthcare Providers and another used by the National Governors Association Medicaid Complex Care Program.

Questions to Answer Today

- 1. Is there another operationalization component that we are missing?**
- 2. How do / should payors-providers share their super-utilizer information / insights and predictive modeling technology to impact this population?**
- 3. What data points are needed to more effectively impact this super-utilizer population?**

De-identified Responses from Tiger Team Members (Pre-Meeting Task)

- 1. Does your organization have a definition of a super-utilizer? If yes, please provide that definition.**
 - ✓ Several Tiger Team members do not have a uniform definition of a super-utilizer across their organization. Instead, *ad hoc* definitions are often used to query data based on hospitalization or ED visit triggers during a set time period.
 - ✓ Several Tiger Team participants are members of the Partners In Health Network (PIHN) and use the definition / operationalization of super-utilizer as 12 or greater ED visits in the previous 12 months (and who uses the ED as a primary care provider).
- 2. If you answered yes to question 1: Does your organization believe that definition is compatible with the definition that has been approved by the SIM Task Force? If no, please explain.**
 - ✓ No Tiger Team member felt that their organization's definition of super-utilizer was incompatible with the definition that was approved by the SIM Task Force.
- 3. How does your organization operationalize (see examples on the first page) the definition of super-utilizer specifically? Please provide that operationalization.**
 - ✓ Most Tiger Team participants use a combination of ED visits and hospitalizations to operationalize their definition of super-utilizers. Costs and specific diagnoses do not figure into the operationalization of a super-utilizer definition exclusively; however, costs and diagnoses are included in certain predictive modeling software used by payors and providers.
 - One PIHN member uses the aforementioned definition but adds three or more hospitalizations to their specific organizational definition.
 - Recently, another PIHN member started using a care coordinator to determine whether there are appropriate ambulatory services that could substitute for hospital services in its super-utilizer population (Medicaid members only). The definition used

by this PIHN member is four (4) or more ED visits in the previous 12 months or more than three hospitalizations in 12 months. A medical assistant or social worker completes a medical record review and then contacts the patient to conduct an interview to determine the cause of hospital use.

- ✓ No Tiger Team member uses the “health care encounters” operationalization as in the Medicaid Complex Care Program.

4. Why does your organization use this particular operationalization?

- ✓ Many Tiger Team members use the operationalization as part of a larger organizational structure, such as the Partners In Health Network.
- ✓ Other Tiger Team members developed their definition based on existing data and resources, such as what is received in primary care clinic reports, to triage for appropriate care coordination.

--One respondent noted this clearly: “We know the obvious, that cost and utilization is not a good indicator of unnecessary use or of the value of additional care coordination. So we felt that the care coordinator’s job is to first assess whether care coordination would be useful and, if so, what specifically is needed.”

- ✓ Still, at least one Tiger Team member does not have a uniform operationalization of super-utilizer because there is no way to systematically coordinate care (and there has been little incentive for it from payors). As noted by this Tiger Team member, there is “[...] no way to recoup the costs of adding all of the case managers/social workers necessary to coordinate [super-utilizer] care” due to its large catchment and service area.

5. Of the components of the operationalization, which does your organization feel is the most important predictor of super-utilizer status (e.g. number of ED visits, number of hospitalizations, total health care costs, etc.)?

- ✓ A few Tiger Team members supported prioritizing operationalizations with the number of ED visits first followed by the number of hospitalizations.
- ✓ Other Tiger Team members agreed with the above approach but also wanted to add more demographic data and social determinants of health to align with certain types of proprietary software that can conduct super-utilizer predictive modeling.

6. Does your organization engage in any predictive modeling that helps determine which patients might become super-utilizers?

- ✓ Several Tiger Team members utilize predictive modeling software, including at least two payor members and one provider. This software helps with determining who could become / is a super-utilizer, and it allows payors / providers to allocate care management resources more efficiently and appropriately.

State Innovation Model Tiger Team Webinar
February 9, 2016, 3 p.m. to 4 p.m.
Joshua Austin, SIM Project Coordinator and Facilitator

Participants

- David Campbell, West Virginia Health Improvement Institute
- Karen Fitzpatrick, M.D., West Virginia United Health System (For Dr. Christopher Colenda)
- Barbara McKee, Charleston Area Medical Center / Partners In Health Network
- Karen Yost, Pretera Center
- Craig Robinson, Cabin Creek Health Systems
- Vicky Gallaher, UniCare
- Mitch Collins, UniCare
- Garrett Moran, Weststat
- Fred Earley, Highmark BCBS

Unable to Participate

- CoventryCares TBD (Todd White)
- Jon Cain, West Virginia Bureau for Medical Services (Medicaid)

Barbara McKee: Partners In Health Network (PIHN)

- We should include adult age (18-64) as an objective measure. PIHN changed its super-utilizer definition to 21-64. The rationale for 21 is that it narrows the focus for an IRB proposal that is pending for PIHN's work. Everyone who participates in PIHN's super-utilizer initiative is a Medicaid MCO or FFS member.

Question: Is there a difference in super-utilizer populations between children, adult and elderly? This question was not ultimately answered by the Tiger Team.

Karen Yost: Pretera Center

- Mrs. Yost expressed concern about changing the age from 18 to 21. The 18 to 21 age range can be problematic fitting into any type of health system, but this population should not be excluded from super-utilizer interventions.
- Pretera Center, in the Medicaid Health Home, relies heavily on the clinical pharmacist to meet with the patient and do a review of medications. Additionally, wellness staff are looped in frequently (for smoking cessation, etc.). This happens in a team-based setting. The Medicaid Health Home population includes individuals with Bi-Polar Disorder and Hepatitis B or C (or are at risk of contracting either disease).

Dr. Karen Fitzpatrick: West Virginia United Health System (WVUHS)

- Some operationalizations factor in a behavioral health/mental health diagnosis, which is difficult to determine from primary care data.
- Dr. Fitzpatrick is supportive of an operationalization that is multi-factorial and that will be applicable to a variety of needs.

Question: What do the payors need to see from the PCP to better address the needs of super-utilizers?

Fred Earley: Highmark BCBS: In post-discharge, we have coordination to prevent recidivism (i.e., catch the patient before they are re-admitted); however, we are lacking care coordination transition and attachment to a PCP / PCMH. This cannot be addressed in real-time via claims data. More focused on preventing unneeded ED visits (no prior authorization) than hospitalizations. Care alerting (real-time) can assist with this in a PCP / PCMH setting.

Mitch Collins: UniCare: How utilization review functions at a provider and payor site is very different. There still seems to be reluctance to have a utilization review specialist embedded (e.g., difference of priorities). Providers and payors, sometimes, do not coordinate discharge planning as well as they should.

Mitch Collins: UniCare

- We should start bucketing, as health plans, and determine how we might address super-utilizers specifically. If we utilize an algorithm / predictive modeling, the health plans will start finding commonality. That commonality will help drive future interventions and targeting of populations.

Fred Earley: Highmark BCBS

- The super-utilizer definition should not be overly specific. We are really trying to drive toward what types of outreach/protocols are needed for the super-utilizer population.

Craig Robinson: Cabin Creek Health Systems (CCHS)

- CCHS, as a PCP, has been putting a lot of effort into the super-utilizer population. There seem to be three basic intervention steps:
 1. A close review of the patient's medical record;
 2. Next a guided interview by a health coach or care coordinator (What does the utilization look from their point of view?) and
 3. Developing an assessment and plan for that patient that takes into account their medical situation and barriers to accessing the health care system.
- When we try to operationalize super-utilizers, the above interventions seem to be the arena that we are in. The definition is just a rough screening tool; we do not know the cause of super-utilizer status until the above steps are taken.

Suggestions for Next Steps

- Dr. Karen Fitzpatrick: Investigate what Tiger Team members are doing in terms of care coordination for super-utilizer populations.
- Dr. Garrett Moran: It is critically important to look at the individual patient / assessment (e.g., be eye-balled).
- David Campbell: Claims data review (historical information) is the current norm for determining super-utilizers. Moving forward in a value-based system, predictive modeling will become even more important. We should explore where the data gaps are to help facilitate payors, providers and community-based organizations in addressing social determinants of health.

- Craig Robinson: Project ECHO enables specialist help to be leveraged by rural providers via a teleconferencing system. The Project ECHO model includes a specialist team who have a network of associated rural practices—meeting weekly or every two weeks—that present cases and develops collaborative care plans and action steps. An approach such as this might help us come to a better understanding about what super-utilizers need (by incorporating experts/specialists, PCPs and community partners). In essence, we would be hosting a peer to peer network, engaging in collaborative learning and sharing best practices regarding super-utilizer populations (in a “Grand Rounds” teleconferencing fashion).