Managing care: At the Camden Coalition’s offices in Camden, New Jersey, a care management team composed of nurses, community health workers, and case managers meets regularly to coordinate care and manage the needs of their most complex patients. From left to right: Jeneen Skinner, Ebony Hailey, Gladys Antelo, Sharine Eliza, and Jessica Cordero.

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For Super-Utilizers, Integrated Care Offers A New Path

Many health systems continue to experiment with the best way to care for those patients who end up in the hospital most frequently.

BY BARA VAIDA

In December 2016 hundreds of health care professionals and consumers came to Philadelphia, Pennsylvania, to launch a nascent but growing national effort to fundamentally change how the United States cares for the most vulnerable and chronically sick Americans.

Spearheaded by Jeffrey Brenner, the founder of the Camden Coalition of Healthcare Providers, the gathering represented the first health care industry-wide discussion on best strategies for treating people who, for a variety of reasons including mental health and socioeconomic challenges, end up in the hospital or the emergency department (ED) multiple times in a year. These superutilizers of health care are among the 5 percent of patients that account for more than half of U.S. health care spending, according to the 2012 Medical Expenditure Panel Survey.1

“What we are learning is that we can take better care of these individuals, but it takes new and more proactive strategies,” Brenner said as he announced the creation of the National Center for Complex Health and Social Needs, which aims to be a clearinghouse for ideas and training. “It demands a new paradigm of care.”

Brenner’s coalition model, made famous among health policy leaders by a January 2011 New Yorker article titled “The Hot Spotters,”2 is one of the dozens that health systems, payers, and states are testing around the country. The strategies have mushroomed as Medicare, the federal health program for those older than age sixty-five, and Medicaid, the federal and state health program for low-income individuals, have embraced new payment strategies tying dollars to better patient outcomes. State budget constraints are also driving governors to look for new ways to rein in health care costs.

Many models are showing promise, but which strategies are the most effective for addressing super-utilizers remains unclear. In general, all of the models involve expanding a patient’s care from a single provider to an integrated health team that includes access to behavioral health and social services such as food, housing, and transportation. Often the care team will then follow up with patients repeatedly to make sure they get the care they need.

“This is about realizing that people’s health can benefit by addressing social isolation,” said Christina Milano, a family physician and an associate professor at Oregon Health and Science University.

Social Determinants Of Health

At their core, the models rely on recent research demonstrating that far more
than medical care determines health. Studies have shown that genetics influences about 20 percent of health and medical intervention another 20 percent, according to the Yale Global Health Leadership Institute. Social, environmental, and behavioral factors can affect as much as 60 percent of health.

“There is now wide acceptance of the social determinants of health,” said Seth Berkowitz, an internist at Massachusetts General Hospital who led a December 2016 study that found that the blood pressure and cholesterol level of many of his patients improved if they were directed to and made use of social services supports. “But no one has figured out yet how best to address these social determinants,” he said.

At this time, many versions of an integrated care model are being tested throughout the US health care system. In one pilot, an insurer is calling customers, asking if they need help with social services and, if so, linking them to someone who can help. Some providers are testing whether expanding resources in their primary care practices to connect patients to social services makes a difference.

Hospitals are analyzing whether the creation of a specific clinic for super-utilizers reduces overuse of the system; other hospitals are focused on improving the discharge and transition process to home. Still other hospitals are measuring whether expanding their ED teams to include social workers and behavioral health specialists and to help with housing is effective. Some health systems have built outpatient teams with community organizations to see patients at home. Most of the efforts have been in place for a decade or less, and evidence of which scenario works best is sparse.

“I think that we will need twenty to thirty models targeted at subsets of patients, based on evidence so that we can train staff and design workflows to help these different patients,” said Brenner. “Right now, though, we don’t have the ability to do that—to say, ‘if you deploy this model you can expect this outcome.’ We don’t have the data and understanding of the population yet, unlike, if we have a patient with heart disease, we have many evidence-based approaches that I can pull off the shelf.”

The most successful strategies have relied extensively on building connections to local community organizations that understand the needs of their residents, said Melinda Abrams, head of the Commonwealth Fund’s health care delivery reform program.

“I think what is going to be found is that you have to choose a model based on how you define your population,” said Abrams, whose organization in December 2016, published “The Playbook,” an extensive analysis of what is known about the evidence connected to super-utilizer models. “The proportion of proven outcomes is tiny, but what is there is promising.”

Early Promise

Health leaders repeatedly mentioned two systems’ work as aspirational: Brenner’s Camden Coalition and the Southcentral Foundation’s Nuka System based in Anchorage, Alaska. After a lot of work and time, both have produced some data showing that intensive outreach and long-term engagement in the local community can lead to better health outcomes and a reduction in ED use and hospital admissions.

Brenner, a primary care physician, built the Camden Coalition by piecing together support between hospitals and community organizations. Through grants from foundations, hospital systems, the state, and the federal government, he has built a team of ninety-five people, including nurse practitioners, medical assistants, health coaches, and social workers. Members of the team visit people’s homes to try to keep them out of the hospital.

The coalition also has data specialists who monitor electronic health record (EHR) information from four local hospitals, and they have begun to gather information from police departments and schools to try to predict where health problems might arise in the future. Currently, the coalition is one of three organizations that are managing Medicaid accountable care organization pilots in New Jersey.

Among its first thirty-six super-utilizer patients, the Camden Coalition’s efforts cut ED visits by 41 percent and hospital bills in half within the first year of its intervention launch in 2007, according to a 2010 study published in Perspectives in Health Information Management.

More recent data on Camden’s impact isn’t available because the organization is participating in a randomized control trial of its work. The study, conducted by the Abdul Latif Jameel Poverty Action Lab, is expected to yield results by the end of 2018.

Health policy leaders hope the results will provide more clarity on which strategies are the most effective with super-utilizers and how to scale the work for other communities.

“Dr. Brenner’s [latest] study will hopefully be a beacon of light for all of us,” said Rebecca Ramsay, director of community care at CareOregon, a non-profit Medicaid health plan.

In January 2017 Brenner announced he would be leaving the coalition to join the health insurer UnitedHealthcare as senior vice president of integrated health and human services. There, he will be running a new business unit developing new models of care for patients. UnitedHealthcare also said it will invest $15 million in the Camden Coalition.

Meanwhile, the Southcentral Foundation, a primary care provider for 65,000 people—10,000 of whom are located in fifty-five small remote Alaskan villages—is one of the oldest models of care in the United States that combines medical and community services.

The foundation has its roots in community leadership because the region’s Alaska Native economic development entity owns the organization. Unhappy with services provided by the Indian Health Service (IHS), tribal leaders in 1998 exercised their right under the Indian Self-Determination and Education Assistance Act of 1975 to take control of their health services delivery. Ultimately, the leaders gave the region’s IHS-funded primary care, pediatric, and obstetric practices to Southcentral. In 1999 tribal leaders asked Southcentral to also comanage the Alaska Native Medical Center, a 150-bed hospital that serves the state’s 148,000 Native Americans.

During the following decade, Southcentral completely transformed its system to create one of the most integrated primary care practices in the country. It also seamlessly included dozens of community services into its care plans for
people and its governance structure, so that its “customer-owners” would feel like Southcentral was like a family and would have a say in their care. “We don’t use the term ‘patient’ because we want to emphasize that people own their bodies, and they are the ones that know what they need physically,” said Katherine Gottlieb, Southcentral’s president and CEO. “They are walking in tandem, in a relationship with experts, which is us the providers, and we have shared responsibility.”

Between 2000 and 2015, ED visits dropped 45 percent, and hospital admissions fell 53 percent. Annual health spending on customers, which includes medical services, drugs, dental, optometry, and audiology services is about $8,000 annually, according to Doug Eby, Southcentral’s vice president of medical services. In comparison, Medicaid spent $9,474 per beneficiary in Alaska in fiscal year 2011, according to the Henry J. Kaiser Family Foundation.10

Eby cautioned that as a comparison, Medicaid’s figure doesn’t include drugs, dental, optometry, and audiology services. “We are heavy on personnel costs—about double the cost of humans for primary care,” said Eby. “But we do way less labs, x-rays, drugs, and specialist visits, so we end up with lower total health care costs.”

Southcentral has multiple primary care teams, each responsible for about 1,100 customers and a rural village or two. Each team includes a doctor, nurse case manager, a medical assistant, and pharmacist. The team members sit near one another and share responsibilities. Doctors focus on the most complex cases, while nurses handle more routine care.

The foundation expanded its capacity by building new care facilities on land it owns in downtown Anchorage. All of the primary care teams are located in one building. Dentists, optometrists, audiologists, behavioral health specialists, home health providers, dietitians, physical therapists, pain management specialists, midwives, and health coaches all work in other buildings near the primary care center. Dozens of community support program meetings take place in Southcentral’s buildings—everything from domestic violence support to living well with HIV.

Undergirding the providers’ work is an EHR system that enables Southcentral’s leaders to analyze its customers’ health data and determine whether providers are meeting Healthcare Effectiveness Data and Information Set benchmarks and track customer-owners who might be using the system excessively.

In 1999 Southcentral and the Alaska Native Tribal Health Consortium, a nonprofit that provides hospital and specialty care, agreed to jointly manage the Alaska Native Medical Center, located near Southcentral’s medical offices. Through the comanagement agreement, Southcentral and the Alaska Native Medical Center receive funding from Medicare, Medicaid, private insurance, and donations. Other funding is derived from contracts with the IHS, the Department of Veterans Affairs, and federally qualified community health centers. The integrated Southcentral and Alaska Native Medical Center staff are paid a salary through the comanagement agreement.9

“Part of what really distinguishes [Southcentral] is its sense of deference to the Native community and its willingness to go beyond the traditional boundaries of care and health benefits,” said Donald Berwick, former head of the Centers for Medicare and Medicaid Services (CMS) during the Barack Obama administration. “Can this be done elsewhere? Yes, and it should be.”

Investing In Social Services

Now, nearly two decades since the earliest integrated care models launched, a handful of larger entities—including about a dozen states—have begun their own experiments. Many are working on using some elements of the Camden and Southcentral models, such as expanding primary care teams and fortifying relationships with community outreach groups to retool their Medicaid programs. Their work could serve to accelerate health system efforts to provide more social services to people.

Traditionally, social services have been administered through separate agencies, disconnected from health. Health systems and insurers, therefore, don’t have billing mechanisms for food, housing, and transportation. Medicaid and Medicare leaders have also been reluctant to shift money from medical services to “non-medical” supports.

The Affordable Care Act (ACA), however, gave Medicare and Medicaid more leeway for testing new models, and in 2016 CMS announced it would be doling out as much as $157 million to health care systems in 201711 to pilot the best ways to address people’s social needs. Whether the repeal of the ACA, expected under President Donald Trump, will be an end to the initiative is uncertain.

In 2013 the National Governors Association convened a “complex care population” initiative12 to try and help states better assess and manage super-utilizers using Medicaid services. Governors from ten states—Alaska, Colorado, Connecticut, Kentucky, Michigan, New Mexico, Rhode Island, West Virginia, Wisconsin, and Wyoming—and one territory, Puerto Rico, joined the effort.

Wisconsin’s experience shows how hard and time-consuming it is to actually implement such an approach. The state decided to focus on reducing unnecessary ED visits among its Milwaukee-area Medicaid beneficiaries. Beginning in 2013, the state began convening meetings with community groups, more than a dozen Medicaid managed care plans, and health systems to build a consensus on how to identify its highest-needs patients, how to integrate teams, how to pay for the services, and how to keep providers accountable for care. After developing an initial plan in 2015, providers, insurers, and state leaders decided that the state’s efforts should be more comprehensive than focusing on super-utilizers. The state doesn’t expect to fully launch its complex care management program until 2018.

“We have been working on this for four years, and it feels like it’s been a snail’s pace, but I think it’s been a great success in that we are still moving in the same direction and we are getting major changes off the ground,” said Rebecca

At their core, the models rely on recent research demonstrating that far more than medical care determines health.
McAtee, director of the Bureau of Enrollment Policy and Systems at the Wisconsin Department of Health Services.

McAtee noted that among the challenging aspects of the state’s work is changing the culture of the current health system. Traditionally, insurers, providers, and social workers aren’t used to working together, “and it has taken a lot of time” to shift people’s thinking about their roles.

Oregon began its efforts before the NGA initiative and is farther along. In 2012 the state overhauled its Medicaid delivery system and enrolled most beneficiaries into one of sixteen coordinated care organizations (CCOs)—each was a kind of accountable care organization.13 CareOregon is a plan in one of those CCOs. Inspired by the Camden Coalition and Southcentral, CareOregon’s Ramsay was part of a group already working to change the structure of its primary care teams at Portland clinics. Changes included adding behavioral health support to some of its clinics.

CareOregon received an innovation award from CMS to add a community outreach component because “it became clear that for really complex patients, we couldn’t expect that all their needs would be taken care of in the clinic,” said Ramsay.

CareOregon built relationships with community groups and hired trained social workers, peer leaders with experience in addiction, health coaches, and behavioral health specialists, called “health resilience advisers.” Outreach staff act like patients’ family members, joining them for doctor’s appointments, monitoring their health, getting them social services supports, and alerting the primary care team when there is a problem. Adding that health resilience component led to a 22 percent drop in ED visits and 28 percent increase in primary care use, saving CareOregon about $1.6 million between September 2012 and January 2015.14 Throughout Oregon, CCOs have reduced Medicaid costs. Between 2012 and 2014 there was a 7 percent relative decline in statewide services expenditures, largely because of reduced hospital use.13

“The thing with all these models is they can’t be sustained if patients don’t ‘graduate’ to needing less care,” said Ramsay. “And the only way to do that is to build a community of support around them, and that is something that we are still working on.”

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