COST CONTAINMENT INITIATIVES REPORT

AN OUTCOME REPORT
ON 5 HEALTH CARE COST
CONTAINMENT INITIATIVES

FUNDED BY THE HEALTH CARE
FOUNDATION OF GREATER KANSAS CITY

Health Care Foundation
OF GREATER KANSAS CITY

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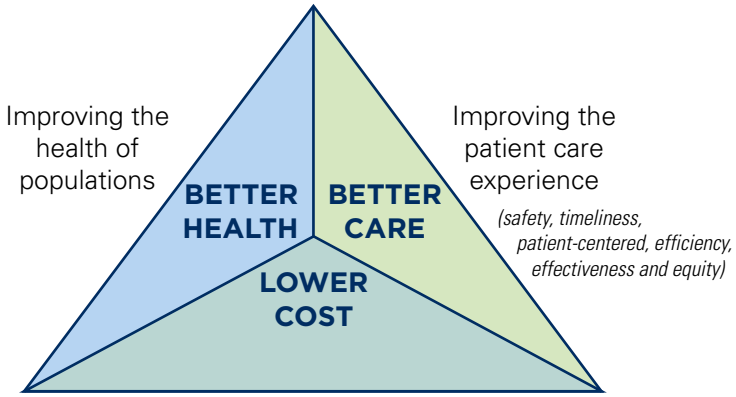
REPORT SUMMARY

Between 2009 and 2015, the Health Care Foundation of Greater Kansas City (HCF) provided about $3 million to fund five triple aim[1] initiatives.

THE GOAL OF THIS REPORT IS TO ANALYZE THE OUTCOMES OF THE INITIATIVES TO HELP GUIDE MEDICAID AND HEALTH SYSTEM DISCUSSIONS IN BOTH KANSAS AND MISSOURI.

The three aims of the initiatives included:

- Improve patients' health care experience
- Improve health outcomes and access to care
- Lower the cost of care per person



Funded initiatives

The five initiatives provided medical homes and care management to about 2,500 people[2] in the greater Kansas City region who were:

- Low income
- At risk of hospital readmission
- At risk of unnecessary emergency department (ED) use

Grantees' strategies included:

- Intensive outreach and engagement
- Person-centered care management
- Use of medical homes to provide:
  - Access to appropriate care
  - Skills to self-manage conditions and to navigate the health care system
  - Access to community resources to address social determinants of health

Outcomes

Grantees reported positive outcomes for each of the triple aim goals. HCF funding helped grantees develop and implement strong approaches to improving health system efficiency. HCF also helped identify ways to continue providing these interventions, including relationships with managed care entities and health care providers.

Lessons learned

- **Keys to success:** Building relationships between providers and community agencies was key to the success of these projects. Grantees also noted the importance of learning from clients and developing trust to learn their needs and accurately address them.
- **Sources of sustainability:** These projects are patching together funding across philanthropic grants and government funding. They are exploring the opportunity to offer such services to Medicaid managed care organizations and also contracting directly with hospitals.
- **Challenges:** Data collection posed an ongoing challenge, particularly obtaining hospital data to inform clinical decision making and training staff to use data systems. Staff training was another recurring challenge, especially because of high turnover.

[1] Health Affairs 27.3 (2008): 759-69. Web. 15 Feb. 2015. <http://content.healthaffairs.org/content/27/3/759.full.pdf html>.

[2] This number excludes the medical homes initiative and year three of the guided chronic care initiative. This is not an unduplicated number as the care coordination initiative duplicated clients counts served in multiple grant years.

INTRODUCTION

This report describes five initiatives that received $3 million of funding from the Health Care Foundation of Greater Kansas City (HCF) from 2009-2015. The triple aim goals of the initiatives included:

1. Improve patient's health care experience
2. Improve health outcomes and access to care
3. Lower the cost of care per person

The goal of this report is to analyze the outcomes of the initiatives to help guide Medicaid and health system discussions in both Kansas and Missouri.

Interventions and outcome measures

All five initiatives used evidence-based interventions to increase access to care, improve the experience of care, and improve health outcomes, while also reducing costs.

- Four of the initiatives provided care management:

Care coordination initiative provided patients with a community health worker to help them navigate and access care.

Hospital diversion initiative offered enhanced behavioral health care and services for uninsured and underinsured people with psychiatric conditions, substance abuse, or more than one condition.

Community-centered care initiative used a care team to provide care coordination, outreach, client assessment, and education.

Guided chronic care initiative integrated social and health care for patients with heart failure.

- Medical home initiative gave technical help to primary care practices and community mental health centers in the HCF region to transform their practices into medical homes. Medical homes help clients access and coordinate care across services. They provide team-based care, population management, and use of evidence-based practice guidelines.

Cost containment initiatives lowered the cost of care, while improving health outcomes and experience of care. HCF measured a lower cost of care by looking at:

- Preventable hospitalizations
- Unnecessary emergency department (ED) visits

Target population[3]

The grantees served about 2,500 low-income people, who are more at risk of hospital readmission or unnecessary ED use. These populations may also benefit from interventions to help them use the health system efficiently.

Many of the people served had chronic conditions or behavioral health needs.

- About 2 percent were children
- About 14 percent were over age 55

The most common conditions in the population included:

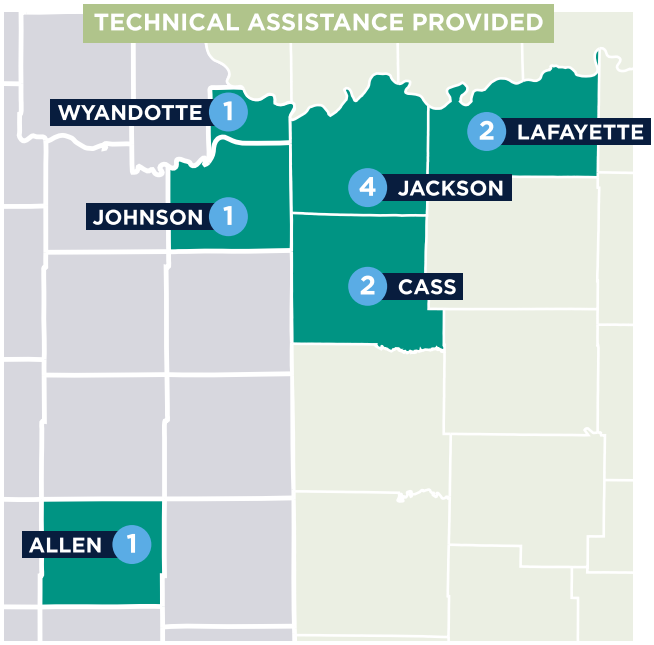
- Behavioral health needs
- Diabetes
- Heart conditions[4]

This tracks closely to conditions linked to hospital readmissions nationally. In a 2011 report, the top three causes of hospital readmissions among adult Medicaid recipients were mood disorders, schizophrenia, and diabetes; and among the uninsured were mood disorders, alcohol-related disorders, and diabetes.[5]

Geography

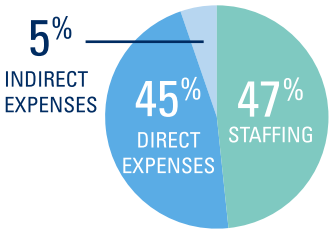
The Missouri Medical Homes Collaborative offered technical assistance to organizations that provide services throughout the HCF service area. The remaining four initiatives serve the following geographies:

Jackson County (4 grantees)
Johnson County (1 grantee)
Wyandotte County (1 grantee)
Cass County (2 grantees)
Allen County (1 grantee)
Lafayette County (2 grantees)



Budget allocations

Between 2009-2015, HCF provided about $3 million in grant funding for the five cost containment initiatives.

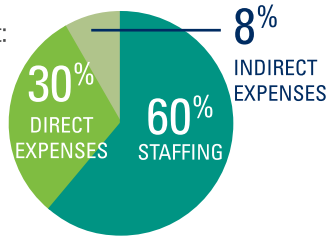


- About 47 percent was spent on staffing
- About 45 percent was spent on direct expenses and services for the uninsured
- More than 5 percent was spent on indirect expenses, such as allocated overhead costs

Among the four initiatives that provided direct services, grantees spent:

- Almost 60 percent on staffing
- About 30 percent on direct expenses
- About 8 percent on indirect expenses

The other initiative spent 100 percent of the grant funds on consultants for technical assistance services.[6]



[3] This information is estimated based on grantee proposals, grantee interim and final grant reports, and grantee interviews.
[4] This information is based on HCF funding reports, grantee interim and final grant reports, and grantee interviews.
[5] *Healthcare Cost and Utilization Project, Statistical Brief* 172 (2014). Print.
[6] These percentages are based on grantees' interim and final reports and grantee interviews.

Care management initiatives

The four care management initiatives identified a target population and their needs, and provided person-centered care management activities. They shared many of the same strategies, including:

- Client engagement
- Person-centered care
- Social determinants of health
- Data analysis

Client engagement

Grantees report ongoing client engagement as key to the intervention.

Each initiative chose places where they could identify clients for care management as an access point. Access points included:

- Hospital emergency departments
- Safety net clinics
- Public housing complexes
- Hospital inpatient
- Primary and specialty care offices

In each access point, initiatives had a contact person who worked to develop trust and engagement with the client, using everything from phone calls to home visits. Contact people could include:

- Community health workers
- Community service providers
- Members of the care team
- Nurses
- Social workers
- Outreach coordinators
- Clinical nurse leaders

Person-centered care

All initiatives employed person-centered approaches to care management. This means they targeted interventions to individual needs and included the client at the center of care.

The initiatives largely used teams of providers, social workers, pharmacists, and others based on the individual need.

These were the most common activities:

Care coordination

- Developing and maintaining individual care plans, including helping clients schedule and keep provider appointments and connect and engage with a medical home
- Coordinating care across medical, dental, behavioral health, and community-based services, including clinical information and individual care plans

Self-management training

- Using medicines correctly
- Understanding which food to consume or avoid
- Making good health care decisions
- Getting ready for provider appointments

Medicine management

- Getting the correct dose of prescription medicines
- Understanding how and why to take medicine
- Finding pharmacies or helping apply for pharmacy assistance programs

Health education: Health education of chronic conditions was in all four of the initiatives. Community-centered care initiative used it the most, including during health fairs and smoking cessation classes.

Flexible services: The hospital diversion initiative and the guided chronic care initiative used flexible services to increase access to care and ultimately improve health and reduce cost, such as:

- An extra day in a detox facility to help secure stable housing before release
- Same-day appointments
- In-home supports

Social determinants of health

Social determinants of health are social and economic challenges that cause difficulty navigating the system and staying healthy, such as low literacy or unstable housing. The care team and contact person worked to eliminate barriers and improve access to care, including:

- Coordinating with community resources
- Assuring transportation to appointments
- Securing stable housing
- Applying for Medicaid and other assistance programs
- Reconnecting with families and developing social supports
- Accessing job training programs

Data analysis

Initiatives collected and analyzed client data to:

- Monitor and update client interventions
- Evaluate initiative performance
- Measure cost savings

Practice transformation initiative

The medical homes initiative provided coaching and technical assistance to primary care providers and community mental health centers working to become medical homes. Medical homes provide care management, such as:

- Care coordination
- Self-management training
- Health education

The practice sites received technical assistance on the primary medical home requirements:

- Using a team-based approach to deliver care
- Accountability for coordinating care
- Offering clients better access to providers and services
- Using data to monitor critical health indicators, perform population management, and inform clinical decision-making

OUTCOMES

HCF initiatives made great strides toward attainment of the triple aim. Several of the cost containment initiatives report:

- Lower costs
- Improved health outcomes and access
- Improved experience of care

HCF grantees lowered costs

All five initiatives have long-term goals to lower cost, including having fewer hospitalizations and ED visits. Initiatives have identified trends in lower costs and ED use.

Hospital diversion initiative

After the first three years, the average number of visits to the ED in 90 days went from 3.5 visits to 0.9 visits. This saved $13.7 million dollars for the health care system[7]

Guided chronic care initiative

Found lower ED use, hospitalizations, and patient costs over time[8]

Missouri health homes

After 18 months, reported savings in Missouri of $23.1 million overall[9]

Community-centered care initiative

Saw a 58-percent decrease in ED usage[10]

HCF grantees improved health outcomes and access to care

All grantees used measures to assess quality of care. Measures included:

- Assessment of clinical health indicators
- Access to care measures, such as engagement with a medical home after an ED visit

Guided chronic care initiative

- Helped establish the best dose of medicine for each patient, a critical component for health maintenance among heart-failure clients
- 91 percent of clients got targeted doses for their condition within a year of starting the program[11]

Medical home initiative

- Improved outcomes for diabetes at the community mental health centers
- More children with body mass index assessments and counseling where appropriate
- Better primary care follow-up after a hospitalization

Care coordination initiative

- 100 percent of clients who scheduled a medical home visit after an ED visit attended the appointment[12]

HCF grantees improved experience of care

All five initiatives had a long-term goal of improving patients' care experience. The aim is that better experiences will lead to better engagement in care, and therefore, better health outcomes and lower cost. The hospital diversion initiative — the longest running grant in this cluster — reported a significant client satisfaction rate of 98 percent at one-year follow-up.[13]

[7] FY09-1329 final grant report.

[8] FY11-2178 final grant report.

[9] PowerPoint presentation: Missouri Practice Coaching: Lessons from the Field. MO Primacy Care Association. MO Association of Community Mental Health Centers.

[10] FY14-3873 final grant report.

[11] FY11-2178 final grant report.

[12] FY13-3396 interim report.

[13] FY09-1329 final grant report.

Collaboration

Building relationships among provider types and community agencies is integral to the success of all the initiatives, including locating and engaging clients, accessing community resources, employing a community-wide treatment plan, or obtaining client data.

Care coordination initiative

Multi-sector collaboration was key to engaging hard-to-reach clients and creating a system that connected social service and health care organizations.

Hospital diversion initiative

Because of collaboration and relationship-building, hospitals or detox centers kept clients one to two days longer, allowing coordinators to locate stable housing options prior to discharge — a requirement for keeping clients engaged.

Medical homes initiative

The medical home developing and strengthening partnerships with hospitals, specialty providers, or community-based organizations is essential to delivering holistic care to clients.

Learning from the client

Four initiatives credited engaging and developing trust with the client as a key to success.

Community-centered care initiative

The grantee had staff on-site in the housing complex and maintained a constant presence. This helped build trusting relationships with clients and learn what services they need. For example, at the request of the clients, the community-centered care initiative developed a youth sex-education program.

Guided chronic care initiative

- Client trust helped identify client needs that weren't accurately measured by screening tools. For example, they recognized a need for help with medicines in their heart-failure patients based on client conversations, even though the measurement tool didn't originally identify it. They then developed a medicine clinic to address the problem.
- Clients' preferences vary for self-management materials and created materials at the appropriate literacy level with video options.

Multiple initiatives

Four grantees found that clients needed assistance completing Medicaid applications and other paperwork for assistance programs, and they worked to address that need.

[16] FY12-2948 final report.

[17] CSI Solutions, LLC. Missouri Medical Home Collaborative, Final report. August 2013.

Leadership engagement

Two grantees identified buy-in from organizational leaders as a key to success.

Hospital diversion initiative

Top-down support was key to ensure hospital staff provided data and reinforced the community-wide treatment plan.

Medical home initiative

Building collaborative relationships is difficult and must be supported by senior leadership at the state and organizational level.

- Organizational leadership support was necessary for:
  - Setting a vision for the medical home
  - Ensuring its support
  - Monitoring progress and setting expectations
  - Ensuring physician participation
- Practices without engaged leadership did not show progress in any clinical measures.[14]

Sources of sustainability

Grant funding

Two grantees reported securing, or working to secure, additional grant funding.

Government funding

The hospital diversion initiative received government funding from the Missouri Department of Mental Health for community service coordinator salaries and flexible services.

Managed care

The hospital diversion initiative is expanding to at-risk youth covered by their parents' commercial managed care organizations (MCOs). A next step would be to offer hospital diversion services to Medicaid MCOs.

The guided chronic care initiative is exploring contracting with MCOs to provide care management services for high-risk clients.[15]

Health providers

The care coordination grantee is exploring contracting directly with hospitals to procure its community health worker and care coordination services.

Data collection

Three of the five initiatives identified data collection as a challenge, including:

- Obtaining hospital data for use in clinical decision making and measuring outcomes
- Training staff on how to enter data and how to get the data they needed from the system

Hospital data collection

Three grantees noted that getting data from hospitals was difficult. The hospital diversion initiative grantee noted that hospitals incorrectly cited HIPAA concerns as a barrier to sharing data, but once hospital staff had been educated and hospital leadership identified a point person for data collection, the process was much smoother. Getting this data is critical to estimating the savings of such efforts.

Staff data collection training

In the medical homes initiative, data infrastructure was fundamental to success, including:

- Selecting and populating a registry
- Mapping workflows
- Training staff to input, extract, and interpret data

The data collection and validation process took much longer than anticipated, including the time to train staff. Behavioral health data was not available until 12 months from the launch, which stopped participants from employing a population management perspective sooner. The grantee noted that it might have been helpful to include its staff as core members of the implementation team from the beginning.

Educating and training staff

Staff education and training posed a constant challenge. Staff training took time and was often continual due to turnover.

Care coordination initiative

Continual training of front desk staff due to frequent turnover was critical for screening and referral to the initiative.[16]

Hospital diversion initiative

They needed to continually train ED staff to adhere to the community-wide treatment plan and implement consistent intervention strategies. This was a challenge because ED staff frequently change shifts, resulting in many different personnel interacting with clients.

Medical homes initiative

Physician input is essential. Competing priorities and productivity requirements made it difficult for physicians to fully participate. Organization leaders must free physician time for educating and training on medical home requirements.[17]

RECOMMENDATIONS

These initiatives highlight the potential for collaborative, patient-centered efforts to reduce unnecessary emergency department use and preventable hospitalizations. They are worthy of consideration as our lawmakers explore strategies to reduce health care costs.

Initiatives such as these are also time- and resource-intensive. To be successful, any such initiatives will require adequate financing, ample time to demonstrate results, and new approaches to sharing data across the health care system.

APPENDIX

INITIATIVES DETAILS

	Who	What	Where
Care coordination initiative **Total grant award: $347,835**	Initiative employs community health workers (CHWs) to perform intervention services, including: • Patient assessment • Care coordination • Health education • Advocacy • Coaching • Support CHWs work with clients to: • Access medicines • Improve health literacy • Engage with a medical home • Lower emergency department use	Served about 1500 uninsured and underinsured low-income adults: • 92% uninsured at enrollment • Primary chronic conditions: • Mental health (24%) • Diabetes (24%)	Service area was primarily in Jackson, Johnson, and Wyandotte counties and included: • KC Care Clinic • Swope Health Services • Johnson County Health Partnership • Sojourner Free Health Clinic • St. Luke's Emergency Department
Hospital diversion initiative **Total grant award: $1,153,234**	Initiative uses behavioral health service coordinators to perform short- and long-term interventions for individuals with psychiatric disorders and co-morbid disease. They aim to lower ED use and hospital admissions. Services include immediate action to hospitals' requests for service, including: • Short-term, intensive response - Stabilization - Respite care - Intensive case management • Longer-term supports that promote self-sufficiency - Disease management - Recovery - Aftercare planning - Housing - Transportation Evidence-based approaches used: • Assertive community treatment • Motivational interviewing • Housing first • Stages of change	Served 824 uninsured and underinsured low-income adults with psychiatric conditions, substance abuse, or co-occurring conditions: • 55% Medicaid insured at enrollment • Average age: 39 • Primary conditions: - Psychiatric (90%) • Depression (22%) • Bipolar (23%) • Schizophrenia spectrum (15%) • Substance use (21%) • PTSD (7%) - Substance abuse (56%) - Homeless/unstable housing (37%)	Service area was primarily in Jackson County and the collaboration included: • Five hospital systems • Behavioral health providers from six community mental health centers • Police personnel from nine law enforcement municipalities • Representatives from the Missouri Department of Mental Health

	Who	What	Where
Community-centered care initiative **Total grant award: $430,000**	Initiative uses a comprehensive, team-based approach to improve health and reduce unnecessary ED and hospital use. The team provides: • Care coordination • Outreach • Client assessment • Education	Served about 400 uninsured and underinsured low-income adults and children who reported: • Frequent ED use • Disproportionate levels of chronic disease, including: - Diabetes - Asthma - High blood pressure - Mental health needs	Service area was primarily in Jackson County and included: • Samuel U. Rodgers Health Center • Truman Medical Centers • Housing Authority of Kansas City, MO
Guided chronic care initiative **Total grant award: $687,859**	The initiative tests a new model — guided chronic care — based on based on the Wagner chronic care model and modified to address social determinants of health. The model uses an interdisciplinary team, supported by integrated, electronic health records to coordinate care; work with clients and their families to address family and social support issues; and counsel clients regarding self-management of their condition.	Served 79 high-cost clients with heart failure: • 51.9% male • 84.8% African American • 43% Medicaid insured at the time of enrollment • 31.7% dual eligible • Average age: 54.5	Served the Kansas City urban area and included: • Truman Medical Centers • Partnership with the University of Missouri at Kansas City School of Medicine
Missouri medical homes collaborative initiative **Total grant award: $598,000**	The initiative funded a series of training activities and materials to assist primary care practices and community mental health centers to transform their practices into medical homes. Activities included learning sessions and practice coaching focused on practice transformation concepts including: • Population health • Team-based and patient-centered care • Quality improvement • Enhanced access • Care coordination • Evidence-based care	Served four primary care practices and five community mental health centers	Worked in the Health Care Foundation service area

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