PRESBYTERIAN

Emergency Room Reduction Utilizing Peer Supports

Porfirio "Pilo" Bueno, Director of Recovery

JULY 24, 2017

Understanding ER Overutilization

- Identify members with 2 or more non-emergent ER visits in a 6 month period.
- Assign Certified Peer Support Specialists to each case (according to capacity).
- Analyze the cause(s) for the ER visit.
- Is substance abuse or violence contributing to the issue? What are the triggers? Is homelessness a cause? What can claims data tell us? What medications are currently prescribed to the member. Are prescriptions filled regularly?

Understanding ER Overutilization continued

- Does lack of transportation to PCPs lead to unnecessary ER visits?
- Is the member dissatisfied or fearful of their PCP?
- What educational efforts have been made in the past? And how was that information delivered?
- Is the member hoping for a prescription refill when they present to the ER?
- Does law enforcement take the member to the ER?

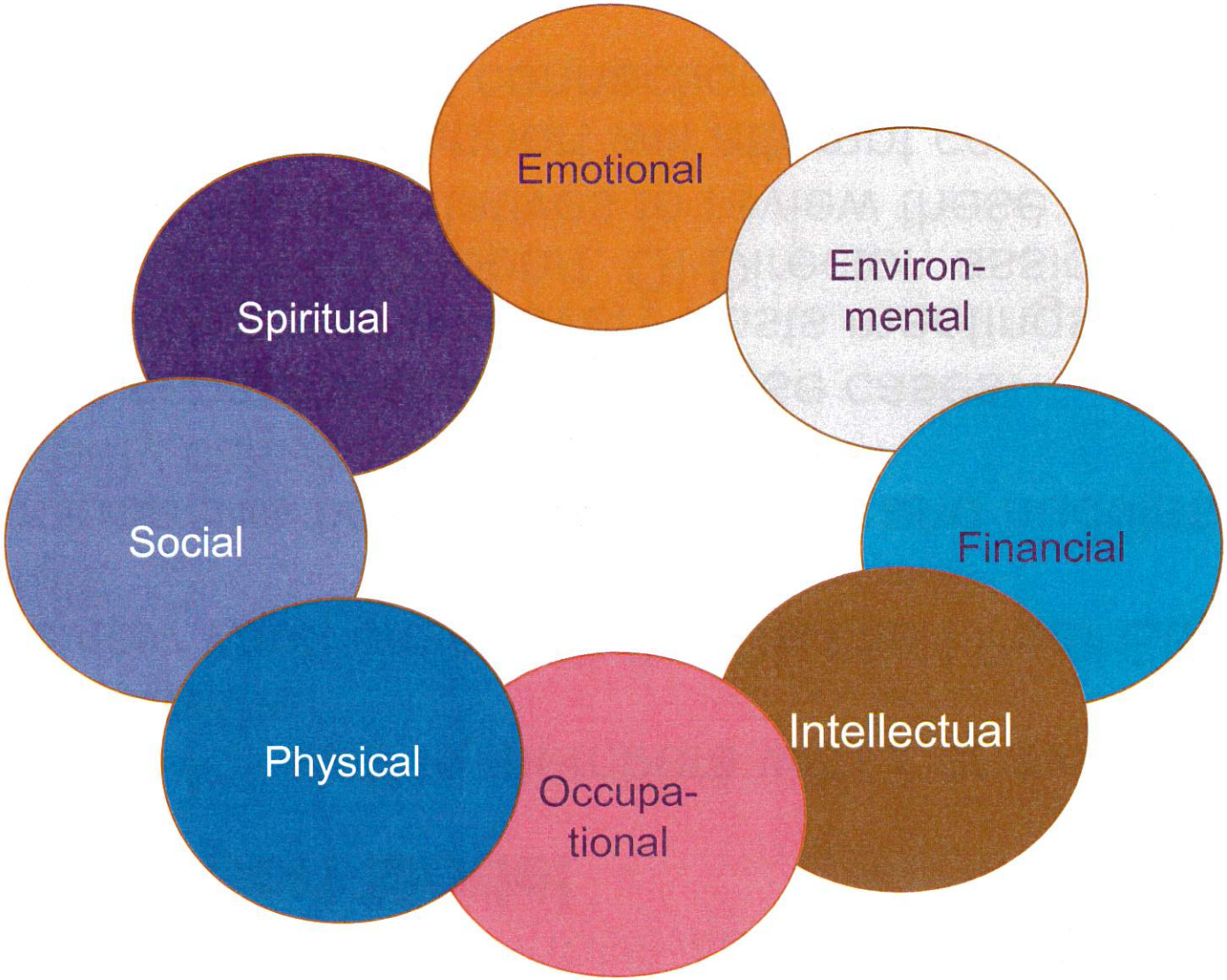
Additional Analysis

- Are members with high ER utilizing sobering centers when possible?
- Are CSAs or other BH providers aware of the problem (over utilization)?
- What are CC assigned to these members doing to change this pattern?
- Is medication management a factor?
- Have ER Navigators been utilized
- Do we know the demographics of these members (including language preferences & learning styles?
- Is there a Value Added Service which can mitigate use?

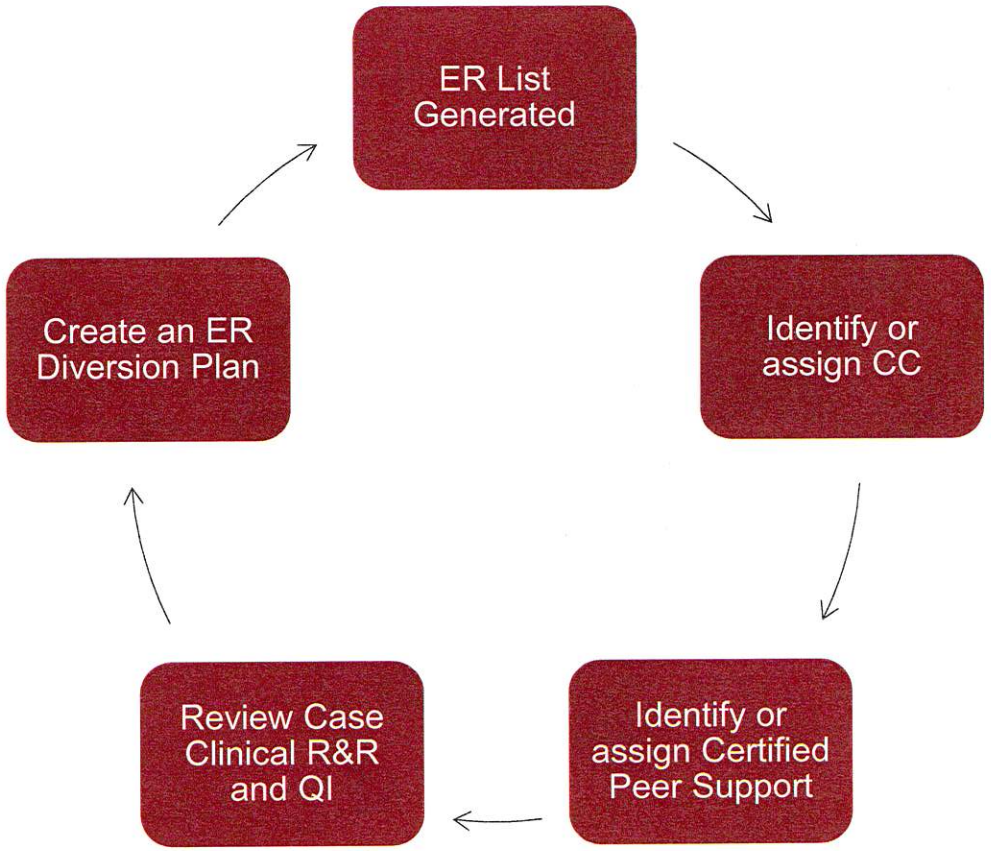
Peer Support Model

- Assign PS staff to members with 2 or more ER visits in 6 months.
- Review each case with the Certified Peer Support staff.
- Include this population in rounds and huddles as priority cases, and;
- Hold separate rounds for these cases.
- The Director of Recovery hosts meetings with Certified Peer Support, QI Director, assigned RN and Clinical representatives to review these cases.
- Certified Peer Support will attempt contact members twice weekly until connection is made.

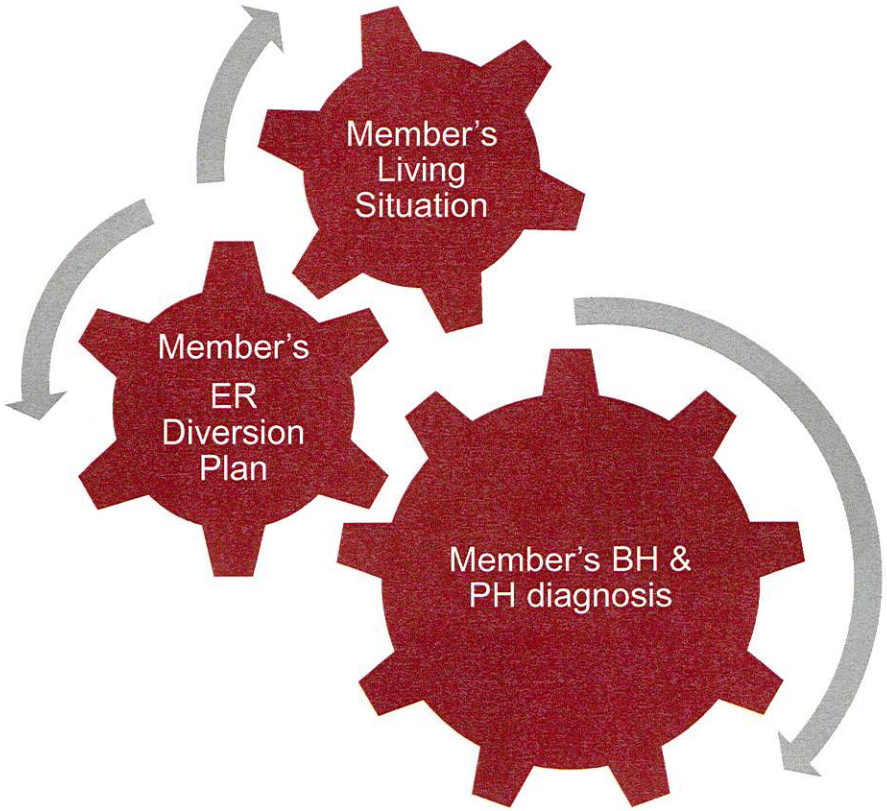
Eight Dimensions of Wellness



ER Diversion Workflow



An ER Diversion Plan



Getting Started

Making Contact

- Care Coordinator initiates or reinitiates contact
- Discuss the need for an ER Diversion Plan
- Collects additional data
- Offers Peer Support and or Community Health Workers
- Initiates ROIs with service providers

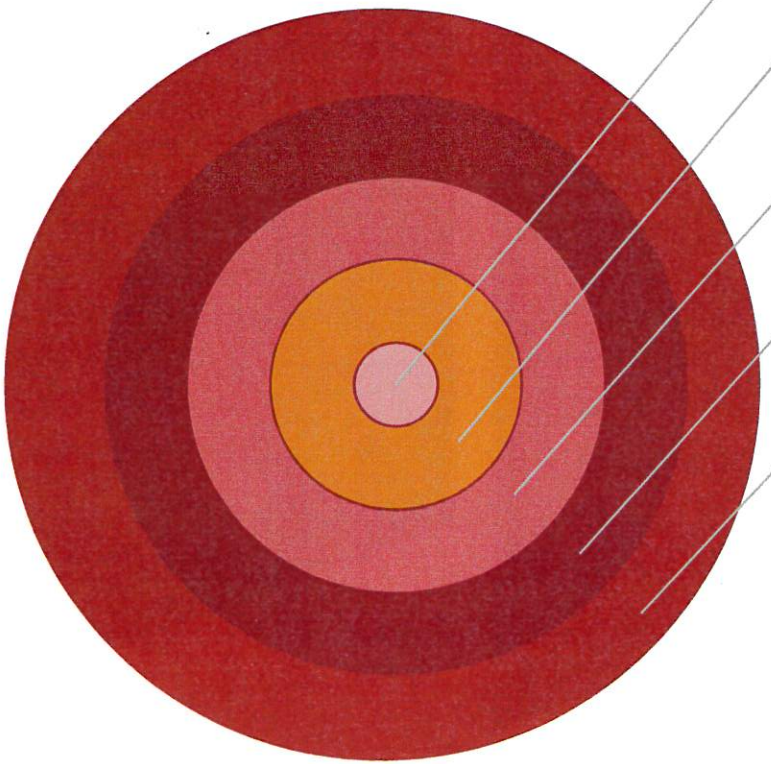
Developing a Plan

- Team meet to review data
- Identify educational materials needed for member
- Identify additional resources needed
- Identify any VAS ideas

Certified Peer Support Outreach

- Initial visit in person set up schedule with member and review plan
- Introduce the concept of recovery
  - Give personal experience
  - Discuss warm and hot lines
  - Provide ongoing support

External Partners



Member

Family & Social

Therapeutic (continuum)

Law Enforcement

Hot & Warm Lines

Food and Shelters, Parole Officers, Spiritual Leaders, Domestic Violence Programs, Nurse Line, Other supports.

Coordinated Multi-Disciplinary Teams

- Certified Peer Support
- Care Coordination
- Case Management
- Medication Management (including Methadone, Suboxone etc.)
- Counseling Services (including SA)
- Regular Health Care Services
- Parole, Probation or Law Enforcement

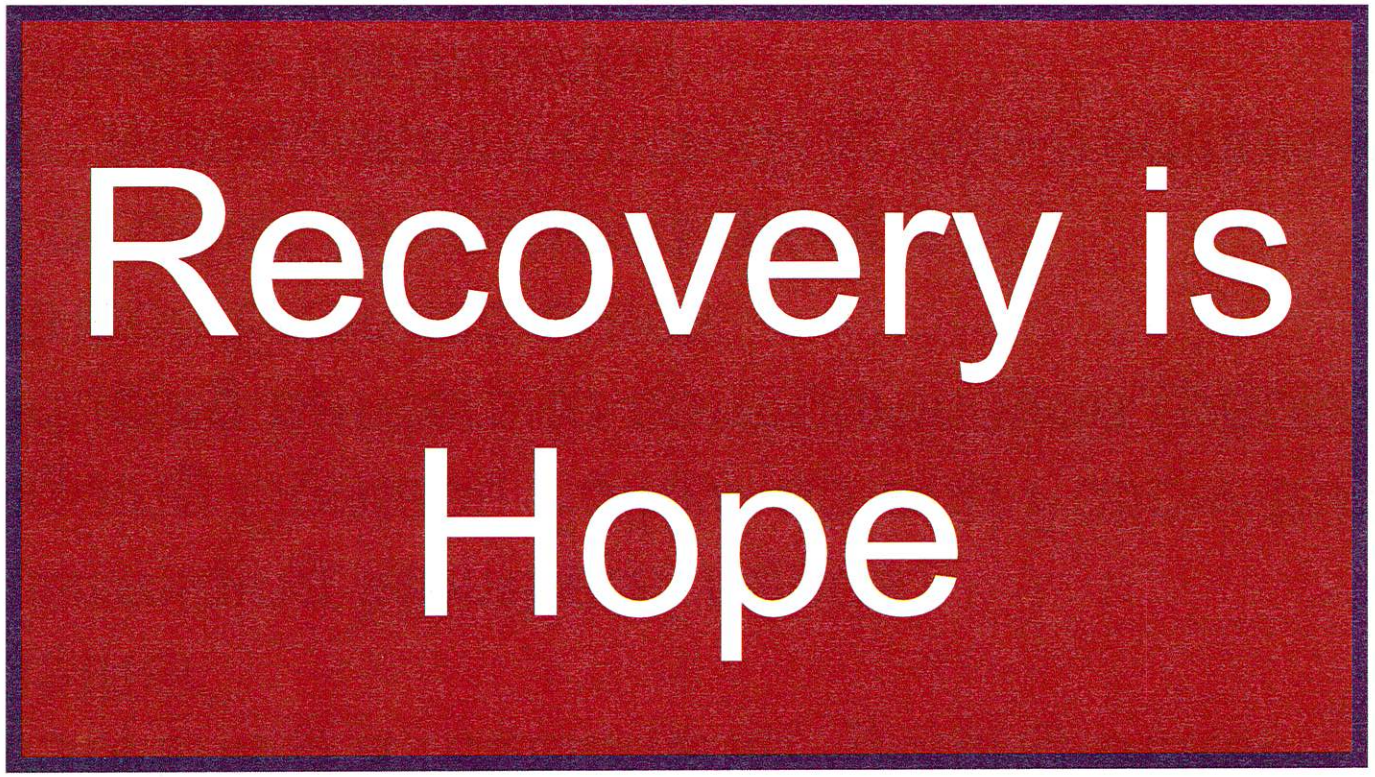
Auxiliary Needs

Clothes
Eyeglasses
Current Medications
Domestic Violence Needs
Bus Passes
Cell phones

Utilities
Rail Runner or other transportation
Dentistry
Job Training
Products such as Fact Sheets, Cards, Emergency numbers
etc.

Making it Work

- Establishing a relationship "getting better together"
- Determining Members' needs.
- Ongoing Contact, Follow-up and Follow-through.
- Reducing barriers to communication (phones).
- Nutrition/Exercise plans.
- AA or other SA support groups.
- Pain Management (including non-traditional or alternative treatments)
- Stress Reduction


Recovery is
Hope

Molina Healthcare of New Mexico

Tina Rigler, Vice President, Government Contracts
Amir Wodajo, Director of Case Management/Behavioral Health

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Overview

NM ER for Emergencies Steering Committee

- Chaired by Darcie Robran-Marquez and Beth Landon
- Includes representation from the Medicaid MCO's, New Mexico Hospital Association, Emergency room physicians, Collective Medical Technologies, and provider groups (i.e. First Choice, PMS)

EDIE: Emergency Department Information Exchange

- Connects to an electronic medical record and provides alerts to ER Provider if patient meets criteria

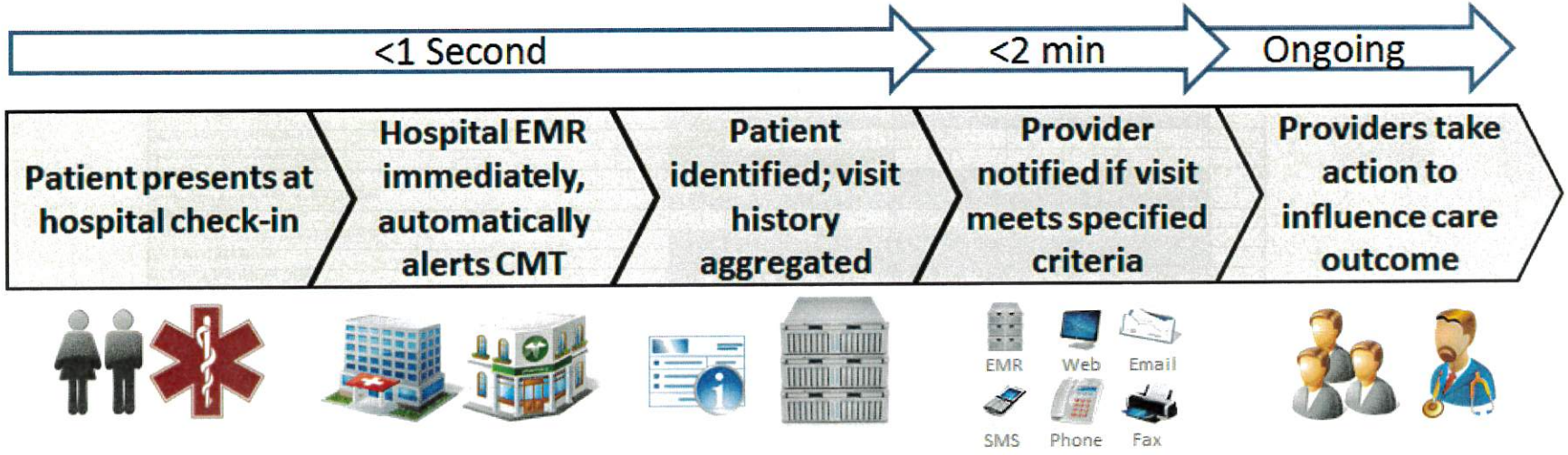
PreManage

- Provides alerts to MCO's or provider groups on cohorts they have identified

CMT: Collective Medical Technologies, vendor for EDIE/PreManage

EDIE/PreManage

Typical workflow: Real-time situational awareness



Source: Collective Medical Technologies

NM ER for Emergencies Dashboard

Hospital	Clinical Overview	IT Overview	Official "Yes" Decision	Contract Redlines - In Process	Contract Signed	IT Planning	IT Implement ation Work In Process	Clinical Training	Go Live [estimate/target]	Region
New Mexico ER is for Emergencies										
Heart Hospital of New Mexico at Lovelace Medical Center									Live	1
Lovelace Medical Center									Live	1
Lovelace Westside Hospital									Live	1
Lovelace Women's Hospital									Live	1
Presbyterian Hospital									Live	1
Presbyterian Kaseman Hospital									Live	1
Presbyterian Plains Regional Medical Center									Live	1
Presbyterian Rust Medical Center									Live	1
University of New Mexico									Live	1
University of New Mexico Sandoval Regional Medical Center									Live	1
Veterans Hospital										1
Christus Saint Vincent Regional Medical Center									Live	2
Cibola General Hospital									Live	2
Eastern New Mexico Medical Center										2
Gallup Indian Medical Center (pilot)										2
Guadalupe County Hospital									Live	2
Holy Cross Hospital									Live	2
Los Alamos Medical Center										2
Lovelace Regional Hospital- Roswell									Live	2
Miner's Colfax Medical Center										2
Presbyterian Dr. Dan C. Trigg Hospital									Live	2
Presbyterian Socorro General Hospital									Live	2
Presbyterian Espanola Hospital									Live	2
Quorum-Alta Vista Regional Hospital										2
Rehoboth McKinley Medical Center									Live	2
San Juan Regional Medical Center									Live	2
Union County General Hospital										2
Artesia General Hospital									Live	3
Carlsbad Medical Center										3
Gerald Champion Regional Medical Center									Live	3
Gila Regional Medical Center										3
Lea Regional Medical Center										3
Lifepoint-Memorial Medical Center										3
Mountain View Regional Medical Center										3
Nor Lea General									Live	3
Presbyterian Lincoln County Medical Center									Live	3
Quorum-Mimbres Memorial Hospital										3
Roosevelt General Hospital									Live	3
Sierra Vista Hospital										3

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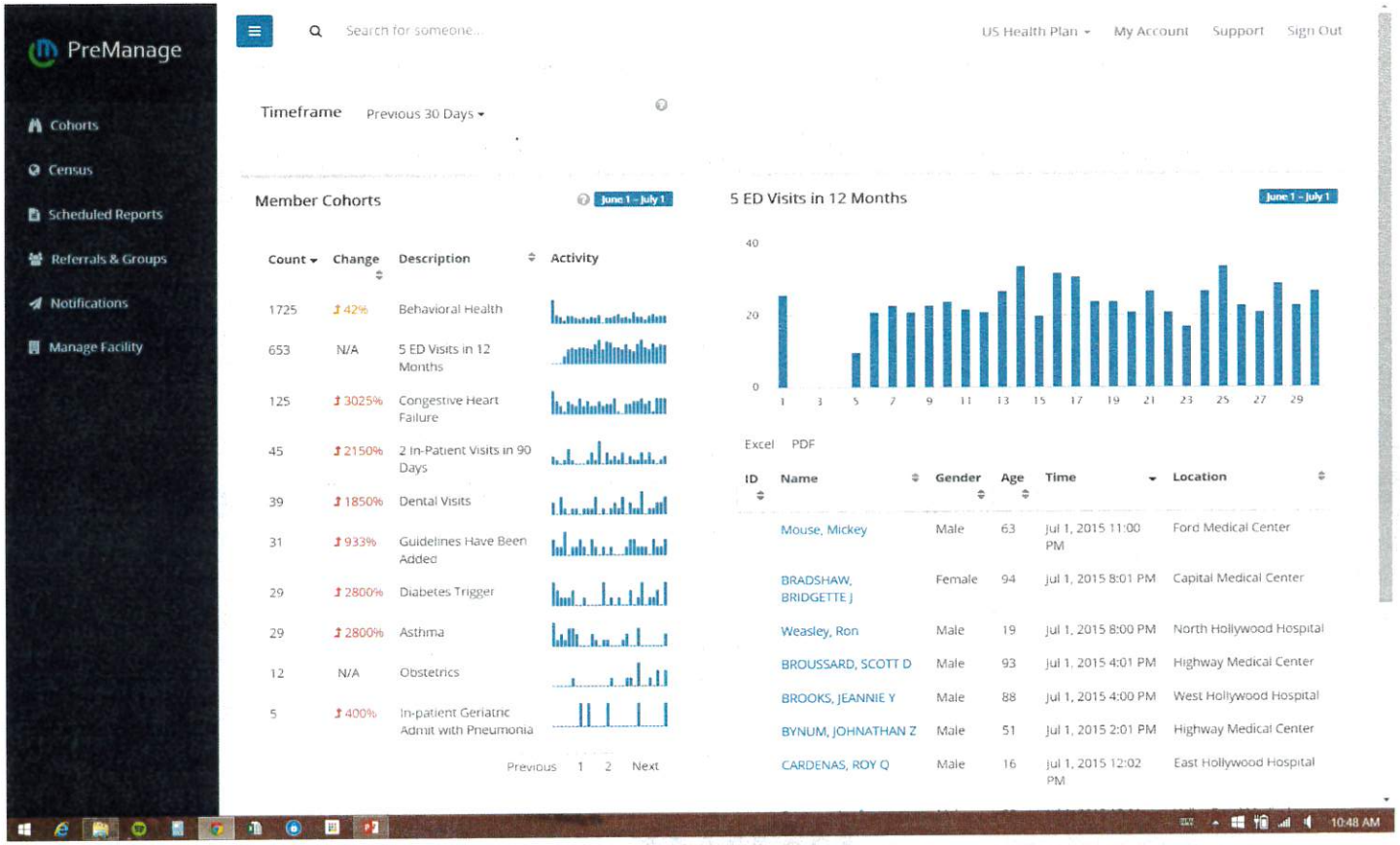
Example: PreManage MCO/ Provider Alert



Source: Collective Medical Technologies

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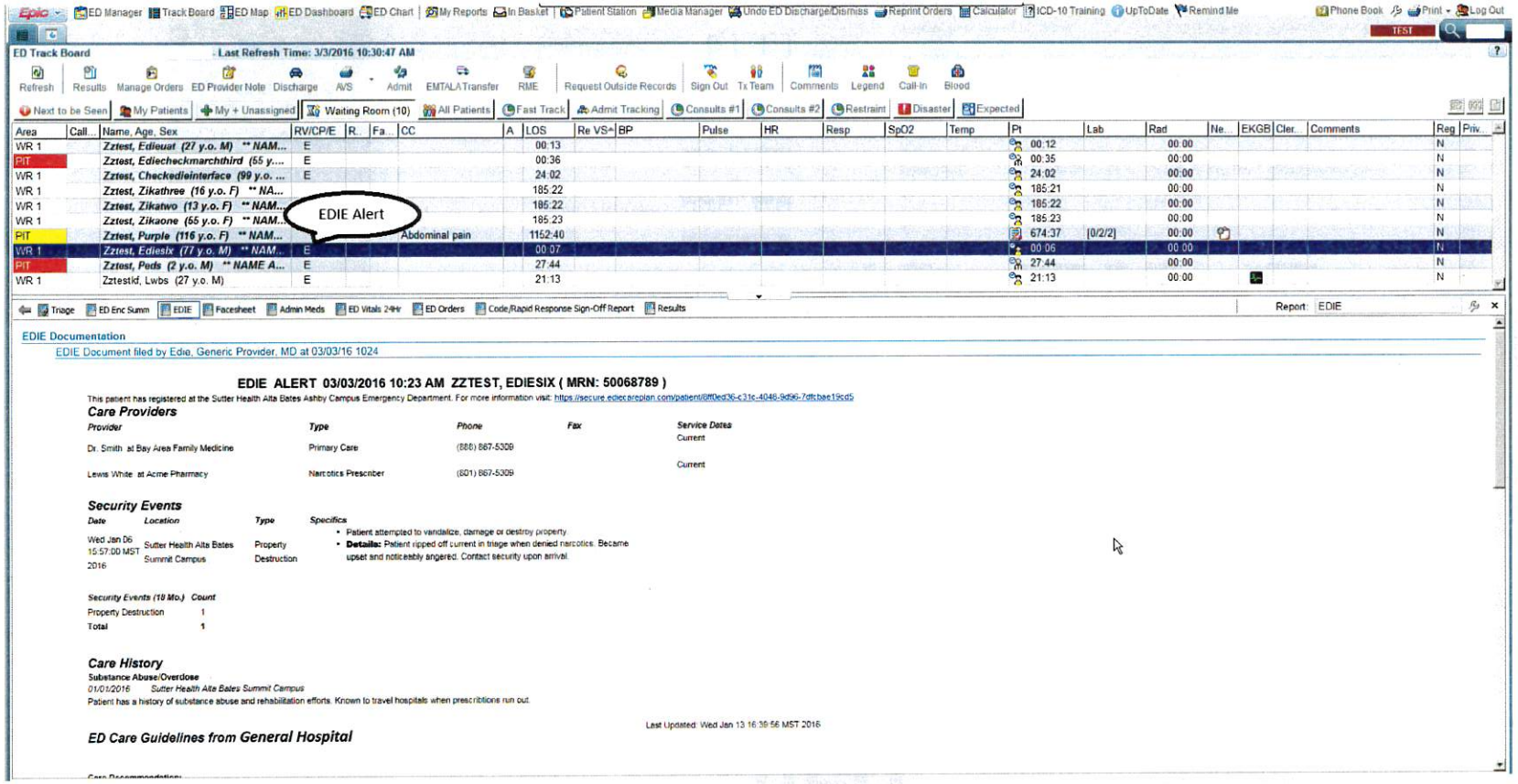
Example: EDIE Emergency Room Notification



Source: Collective Medical Technologies

In Progress

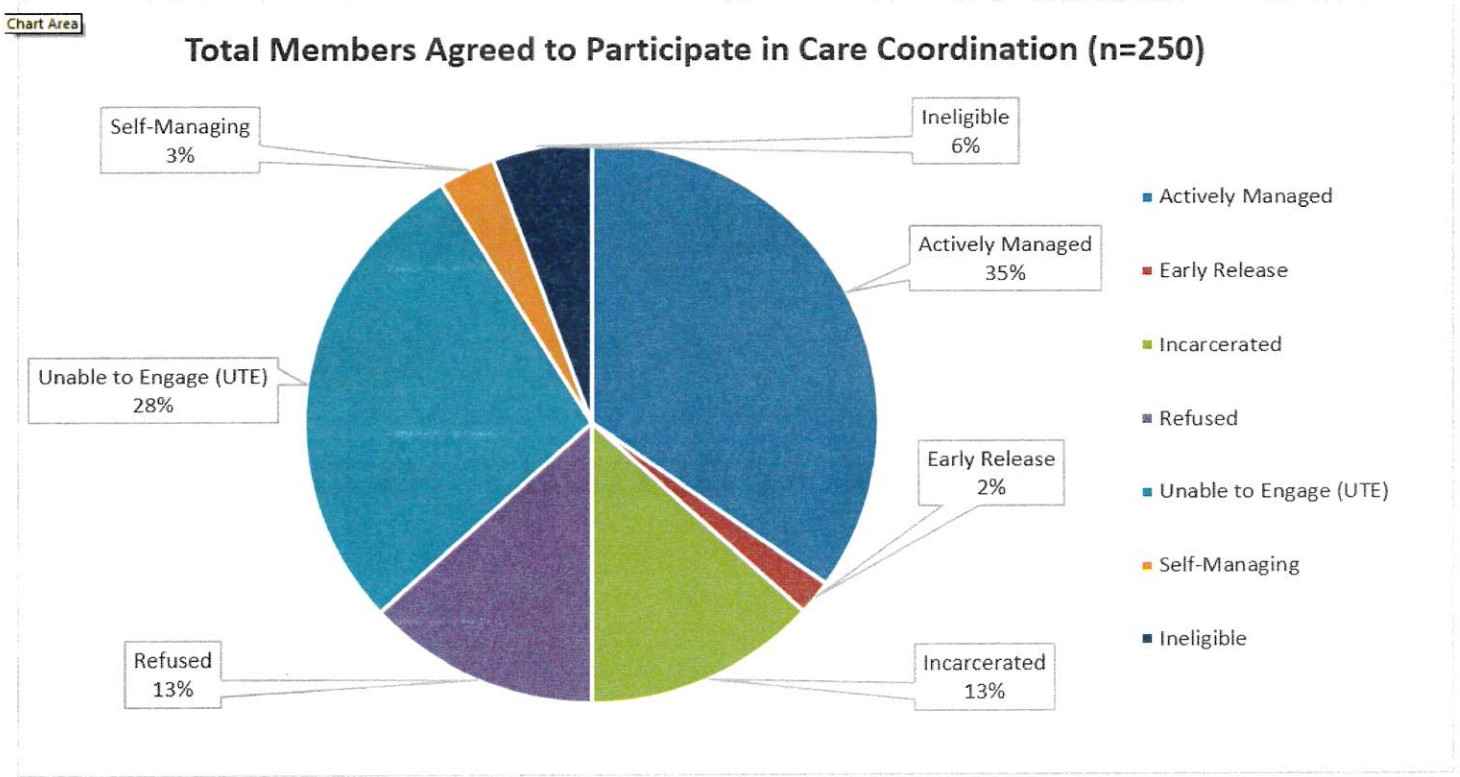
- NM Board of Pharmacy Integration
- IHS Facilities
- Clinical Consensus Committee

Jail Involved Care Coordination Pilot

Pilot between Molina Healthcare began on June 1, 2016 with Metropolitan Detention Center (MDC)

Year to Date Referrals

- 250 members agreed to participate in this project
- 20 Refused with MDC; 13 refused with the Care Coordinator



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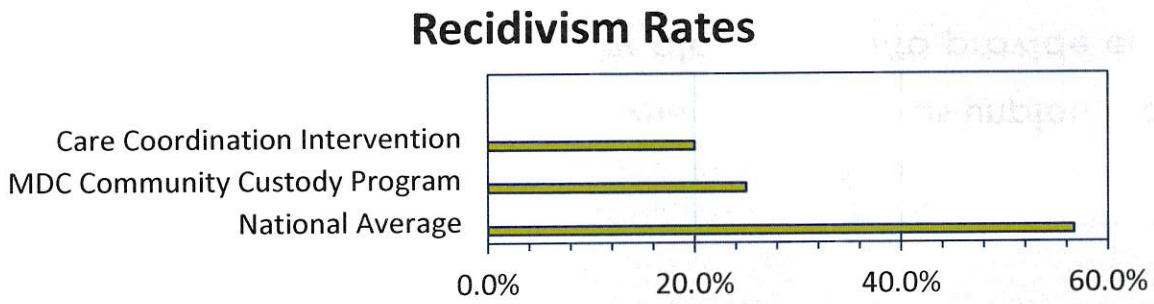
Jail Involved Care Coordination Pilot cont.

Successes

- Data illustrates:
  - ✓ A significant decrease in ED use upon initiation of Care Coordination.
  - ✓ Higher utilization of BH services among members engaged.
  - ✓ Higher utilization of PH services among members engaged.
  - ✓ Decrease in Pharmacy claims/Improved Medication Adherence
    - Attributed to overall increase in health, increase in access to appropriate primary care services and 90 day Rx fills.
- Recidivism rates
  - ✓ Per the National Institute of Justice (NIJ), more than half (56.7%) of inmates who are released are reincarcerated within 1 year of release.
  - ✓ Individuals involved in the Community Custody Program (ankle monitoring) show a rate of 25%.
  - ✓ Members that received the Care Coordination Intervention show a rate of 20%.



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Jail Involved Care Coordination Pilot cont.

Opportunities

- Release Dates
  - ✓ Timely notification
  - ✓ Engaging prior to release date when release was unplanned
  - ✓ MDC will be implementing a new alert system to provide email notification on member release, real-time.
- Continued efforts on obtaining HRAs on missed/early released members
- Re-approaching those members that are reincarcerated
- Collaborate with MDC on discharge planning and treatment team meetings
- Medicaid benefit suspension and reinstatement
- Continued data and claims analysis

Jail Involved Care Coordination Pilot cont.

Success Stories

Care Coordination in Action

On a visit to the Metropolitan Detention Center, MHNM met a man who was incarcerated for burglary, aggravated battery, and possession of narcotics, among other infractions. He agreed to complete a Health Risk and Comprehensive Needs Assessments at MDC. While undergoing the assessments, this man shared that he had used illegal drugs for 20 years and contracted HIV and Hepatitis C. Up to that point, he had received only sporadic medical care. Upon his release, an MHNM CC helped the man establish contact with an Intensive Outpatient Program (IOP) for substance abuse. The CC also assisted him in reestablishing a relationship with a medical provider for treatment of HIV and Hepatitis C. The member has continued ask his MHNM CC questions about his health and about community resources. As of March 2017, he graduated from his IOP program and continues attending behavioral health and physical health appointments regularly. The man also happily reports that he recently found employment.

The way back to hope: A True Molina Story.

Michelle—After addiction, crime and incarceration, a fresh start.

In her mid-30s with two children, Michelle found herself in a violent marriage. She got involved in an assault case and missed her court date. It kicked off a demoralizing cycle of incarceration, substance abuse, crime and homelessness—and led her to lose custody of her kids. But the worst was yet to come.

A few weeks from her jail release date, Michelle got the news that her son had died. Completely shattered, she decided to try heroin when she got out, "so I could die."

But just before she was to leave Bernalillo County Metropolitan Detention Center (MDC), Michelle got a call from Richard, a Molina Healthcare Case Manager. Through a Molina and MDC partnership program, Michelle could get care coordination, medical and behavioral treatment and recovery services. "It never crossed my mind that I could go into recovery," says Michelle. Desperate to change her life, she jumped at the chance.

At Molina, Richard teamed up with Donald, Michelle's Peer Support Supervisor, and Lisa, her Community Connector, to secure housing, counseling, medical care, recovery education and much more for her.

Moved and motivated by all she's received, Michelle has worked hard on her recovery. Her Molina team feels richly compensated by Michelle's amazing progress, and the light in her eyes as she lives with more accountability, and a future full of possibilities—including restored custody of her daughter.

"Just to know someone was there who cared about me—it meant everything."

MOLINA® HEALTHCARE

UnitedHealthcare Community Plan Innovations

- SBHC Grants
- Respite for UHC members experiencing homelessness
- Remote Home Monitoring for CHF

UnitedHealthcare®
COMMUNITY & STATE

Improving Adolescent Behavioral Health in New Mexico

Community Grants Program meeting for School Based Health Centers

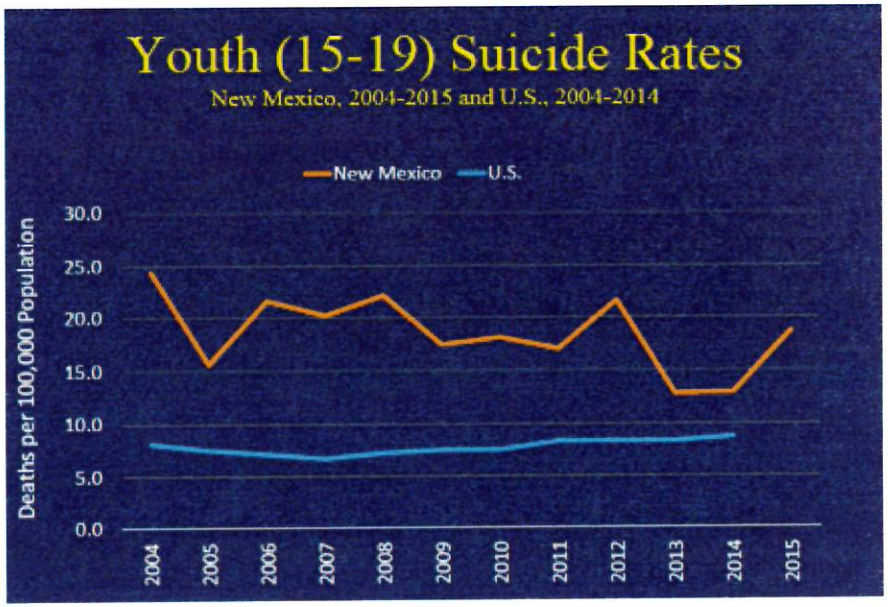
UnitedHealthcare®
Community Plan

What Is the Extent of the Problem?

UnitedHealthcare Community Plan

In 2015, 11% of adolescents had a major depressive disorder and 20% intentionally hurt themselves

In 2015, the suicide rate for young adults was 72% higher in NM than the U.S. and has been above the U.S. average for more than a decade



In 2015, 15% of high school students reported they had 5 or more drinks of alcohol in a row within a couple of hours in the past 30 days

NM Dept. of Health and Office of Adolescent Health

Working Together

UnitedHealthcare Community Plan

UnitedHealthcare's goal is to improve the health of adolescents in New Mexico. We believe the best way to accomplish this is to work collaboratively with community organizations.

We plan to use the information gathered in the August meeting to offer a grant opportunity open to school based health centers.

We anticipate awarding 1-3 program or project grants ranging from $10,000-$15,000 for projects up to 12 months.

Respite for UHC members experiencing homelessness

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Hospital Aftercare Respite

UnitedHealthcare COMMUNITY & STATE

- There are approximately 1,200 UHC members identified as experiencing homelessness being served by United Healthcare throughout the state.
- In Bernalillo County the total numbers are 326 members who had inpatient and/or ER claims in 2016: 186 male and 140 female.
- Some of the members do not meet acute SNF criteria but have illnesses that require transitional management/treatment in a safe place.

Aftercare Respite-current UHC data on homelessness 2016

UnitedHealthcare COMMUNITY & STATE

Age/Gender:

	# Unique indiv	Avg Age	# & %<18	# & %18-64	# & %>64	DSNP	# wInpt stay(s)*	Avg # Inpt PP	# wER visits**	Avg # ER visits PP
F:	140	38.5 yrs	14 (10%)	114 (81%)	12 (9%)	9 (6%)	34 (24%)	2.2	66 (47%)	2.6
M:	186	39.6 yrs	10 (5%)	170 (91%)	6 (3%)	12 (6%)	38 (20%)	2.9	112 (60%)	2.9
Total:	326	39 yrs	24 (7%)	284 (87%)	18 (5%)	21 (6%)	72 (22%)	2.5	178 (55%)	2.8

*72 patients had a total of 184 Inpatient stays, with the total number ranging from 1-14

**178 patients had 492 total ER visits, with the total number ranging from 1-17

Top Diagnoses

All:	Ill-defined and unknown cause of mortality	21.2%
	Alcohol abuse with intoxication, unspecified	16.3%
	Illness, unspecified	15.6%
	Essential (primary) hypertension	14.1%
	Chest pain, unspecified	12.3%
	Type 2 diabetes mellitus without complications	11.7%
	Headache	11.3%
	Alcohol abuse with intoxication, uncomplicated	10.1%

(denonminator=326 mbrs)

Heading Home and Hospital Aftercare Respite

UnitedHealthcare COMMUNITY & STATE

- Heading Home's Mission is to make experiences of homelessness ***rare, short-lived, and non-recurring.***
- Heading Home started Respite Care in 2015 to address men experiencing homelessness who were too sick to go back on the street but no longer needed to be in an acute care hospital.
- 20 medical beds currently contracted to the three of the four major hospitals in Albuquerque: UNM, Presbyterian, Lovelace and the VA Hospital.
- UHC's Community Plan has contracted for 1 bed with Heading Home starting June 1, 2017.
- Currently talking with Barrett House Foundation for female respite bed

Heading Home Respite Care Facility Services

- 24- Hour Shelter
- 3 Diabetic Approved Meals each day
- Staff Controlled Medication Management
- Case Management
- Transportation to local medical appointments:
  - Monday - Friday (9:00 a.m. to 3:00 p.m.)
- Onsite private Medical Exam Rooms for weekly UNM student clinic, home health care, insurance case workers, hospital liaisons, also includes the ability for United Care Coordinators to visit members at Medical Respite Facility.

Heading Home Respite Care Facility Eligibility

- Male 18 years and older
- Currently experiencing homelessness
- Currently suffering for acute medical/psychiatric condition
- Ambulatory and capable of performing ADLs
- Have no airborne communicable disease
- Medically stabilized
- Referred to AOC Campus by Presbyterian, UNM, Lovelace, or VA Medical Center in conjunction with UHC.

(No onsite medical staff, is first aid/CPR certified only, is *not* an LTC, and is *not* a drug/alcohol detox facility)

Cost and Benefits

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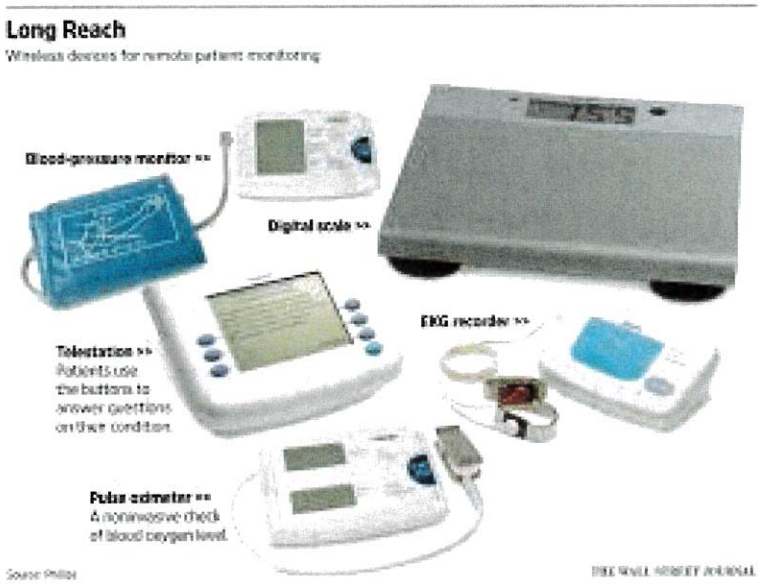
- Contracting one bed per month with Heading Home Respite we anticipate reducing 2 ER visits at an average cost of $1,500 per ER visit and 1 admission per month at an average cost of $4,000: $3,000 + $4,000 = $7,000 per month – monthly cost for respite of $4,500 = $2,500 per month savings with a total savings of $30,000 per year per member.
- Benefits: decrease readmission and ER visits among UHC members experiencing homelessness.
- Benefit is the unique service this offers to our members experiencing homelessness who have ongoing needs. This also addresses the social determinants of health to mitigate overall medical costs for a member.



Remote Home Monitoring for CHF

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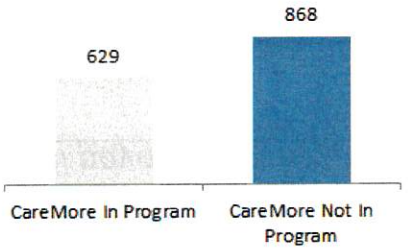
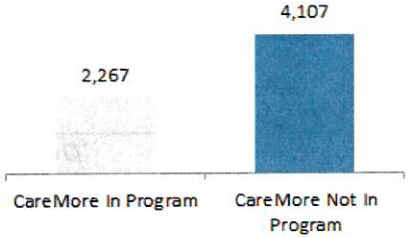
Congestive Heart Failure (CHF) Program Outcomes

CAREMORE
It's what we do.

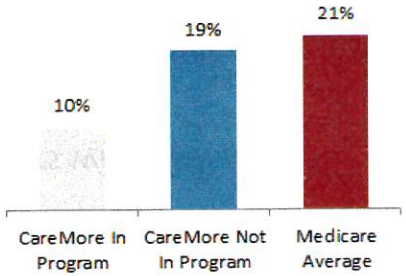
CHF Hospital Admits per 1,000



CHF Hospital Days per 1,000



CHF Readmissions



Compared to non-participants, CareMore CHF program patients experience

- ***45% fewer admits***
- ***27% lower hospital days***
- ***47% fewer readmits***

The CareMore CHF Program includes

- ***Wireless scale for weight monitoring at home, which alerts CareMore Nurse Practitioner to contact member immediately upon rapid weight increase***
- ***Same-day appointment at the CareMore Care Center if/when needed***

97% of Program Participants regularly use their remote monitoring scales to record daily weights

Notes
CareMore 2013 health metrics. Based on program participants with diagnosis of CHF who received Ideal Life Wireless Scale (In Program) and individuals who did not (Not in Program).

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# Uniq claims with CHF Diag:	*10317*
# Uniq DSNP Members with CHF Diag:	*1069*

Avg of 2.2 Diagnoses per member claim, where at least 1 of 5 was CHF

Avg of 9.65 claims of any type for each mbr with CHF - inpt, outpt, physician, DME, etc.

Claims payment:	
Sum of all payable claims CHF-related:	*$6,321,630*
Avg payable claims amount per member:	*$6,009*
Avg payable amount per claim:	*$612.75*

Member Breakdown by County of Residence (or responsible party)

COUNTY	# Members	%
BERNALILLO	367	34.3%
DONA ANA	381	35.6%

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- Pilot Project with IdeaLife- Home Monitoring of DSNP members discharged from Acute Inpatient Facility with primary diagnosis of CHF for 90 days and then 90 follow up – goal is reduce readmissions for CHF and improve member self- management of CHF.
- Includes Scale for daily weighing, BP Cuff, and remote Pod to monitor member - this is monitored remotely by IdeaLife.
- Equipment mailed to member home with set-up performed by Care Coordinator or CHW.
- Education of member on CHF and self management.
- Parameters on BP and weight sent to IdeaLife.
- Outreach to cardiologists on members enrolled in pilot for engagement.

2017 Behavioral Health Facility Liaisons

MAC Meeting Presentation

Leading the Way to Improved Behavioral Health Engagement and Outcomes

Lisa Mortensen, LCSW/LISW

Director

Clinical Programs/Behavioral Health

BlueCross BlueShield

BlueCross BlueShield

HCSC

Facility Liaison Program

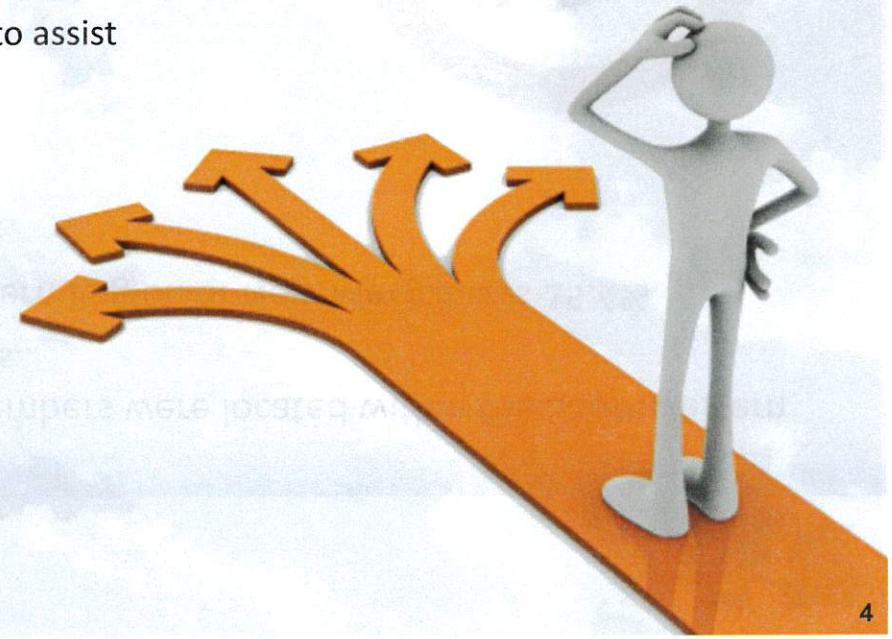
Defining the Problem

- Analysis of the data revealed that 17 of the top readmission members were located within the Southwestern Region of New Mexico were accounting for **70%** of readmissions.
- The readmission rate for the identified facility in the Southwestern Region of New Mexico was **15.4%.**
- Chart analysis discovered a trend in common barriers including:
  - Homelessness
  - Inaccurate Contact Information
  - Chemical Dependency/Substance Abuse
  - Isolation
  - Lack of Outpatient Follow Up Post Discharge
  - Difficult to Engage in Care Coordination
  - Medication Adherence
  - Fragmented Landscape of Needed Services

Addressing Barriers

- **Homelessness** – Lack of Transitional Housing or Transition Living services
- **Member Contact** – Unable to locate members or inability to engage
- **Pharmacy and Provider Follow-up** – Unable to get medications and did not know about their follow appointments post discharge
- **Community Resources** – Members unfamiliar with resources to assist them in community engagement

To address these common barriers we had to think outside the box to ensure members needs are being addressed appropriately.

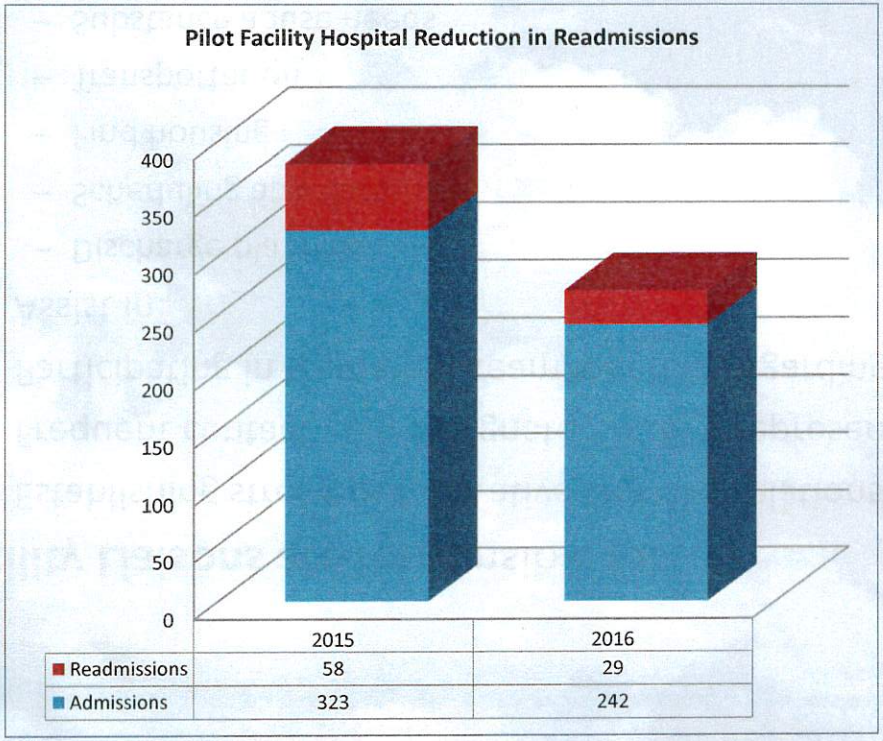


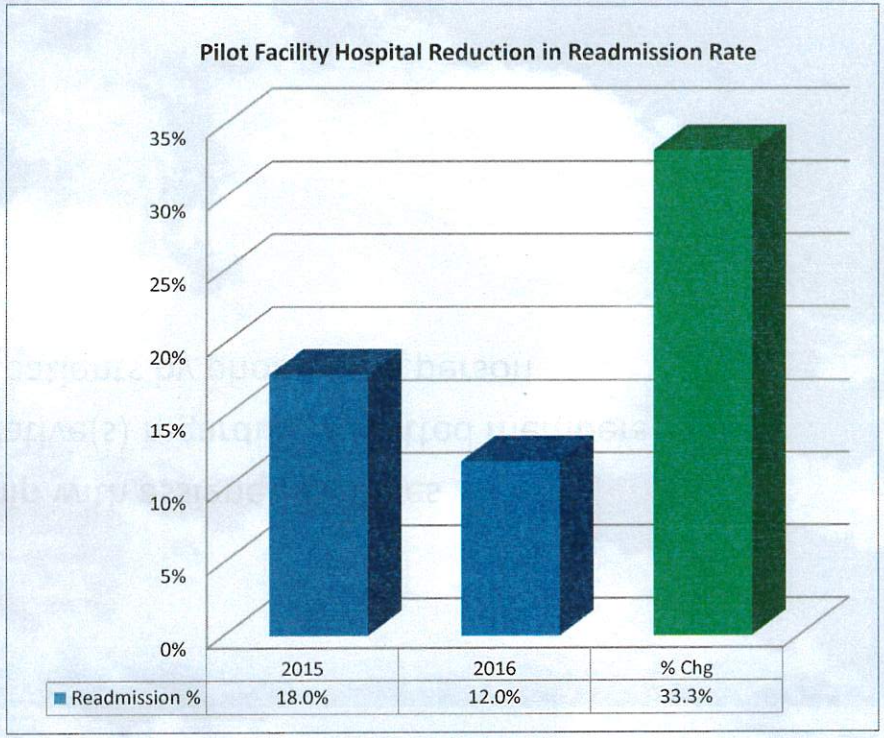
Facility Liaison Program

Facility Liaisons are responsible for:

- Establishing strong collaborative working relationship with assigned facilities
- Frequent contact with designated facility representative(s) regarding admitted members
- Participating in treatment team meeting regarding patients by phone or in person
- Assist in:
  - Discharge planning
  - Scheduling appointments
  - Find housing
  - Transportation
  - Substance abuse needs
  - Finding community resources for food or bills
- Ensuring member knows of their benefit for Care Coordination and offer to enroll member if not already enrolled. If member is enrolled, coordinate contact with existing BH and/or PH Care Coordinator.

Facility Liaison Program





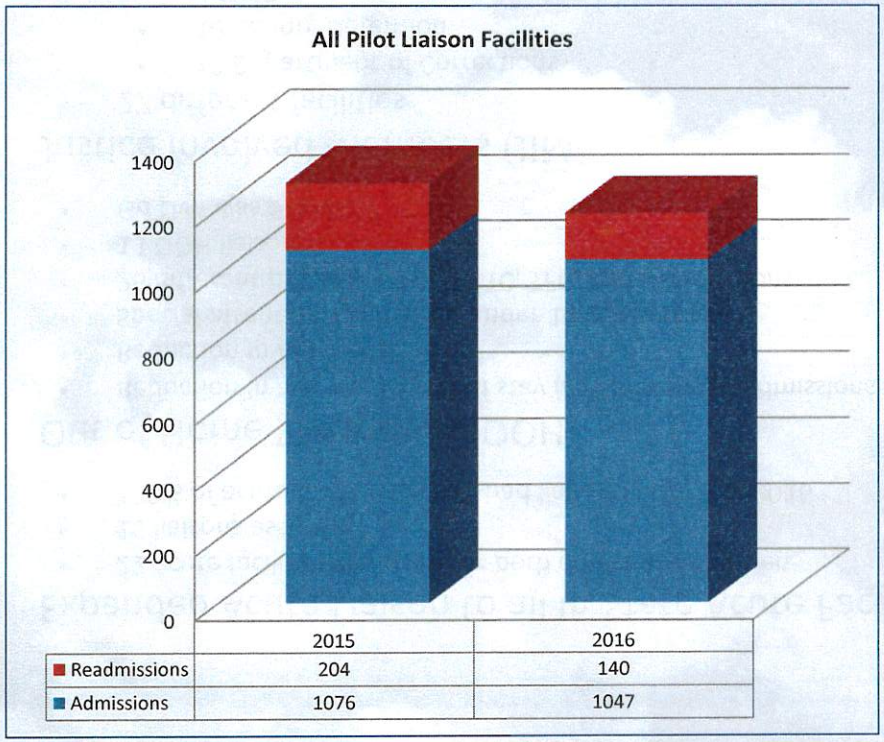
$160,000 savings from decrease in readmissions

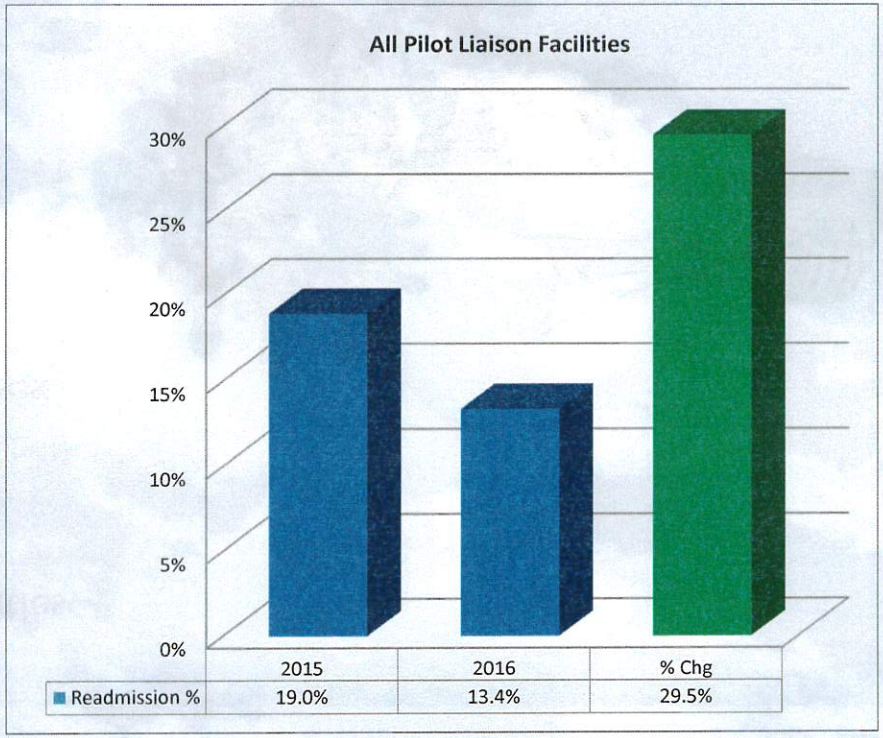
Facility Liaison Expansion

- Expanded Acute Liaison to all In-State Acute Facilities
  - 22 acute facilities that care for both adults and children
  - 16 liaisons assigned
  - 100% of acute facilities in NM had liaisons as of 7/1/2016
- Out of Home Placement (OOH)
  - Reduction in average length of stay (ALOS) for new admissions =<3%
  - Reduction in ALOS =<10%
  - Special attention to children under 10 years of age
  - 26 different providers for all RTC, TFC, and GH locations
  - 13 OOH liaisons
  - Go Live was 6/1/2017
- Justice Involved Members (JIM)
  - 27 different facilities
    - 12 Department of Corrections
    - 10 County Detention
    - 4 CYFD
    - 1 State
  - Go Live Date 6/1/2017
    - Started on 2/1/2016 at the Santa Fe Detention facility

Facility Liaison Program Expansion

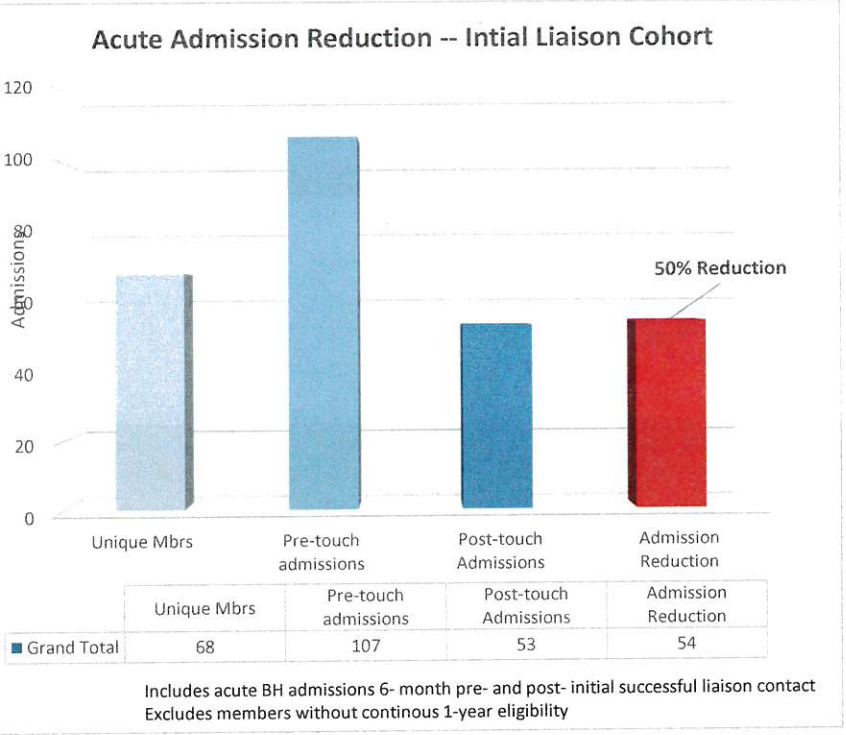
Expansion to 7 Acute Psychiatric Facilities





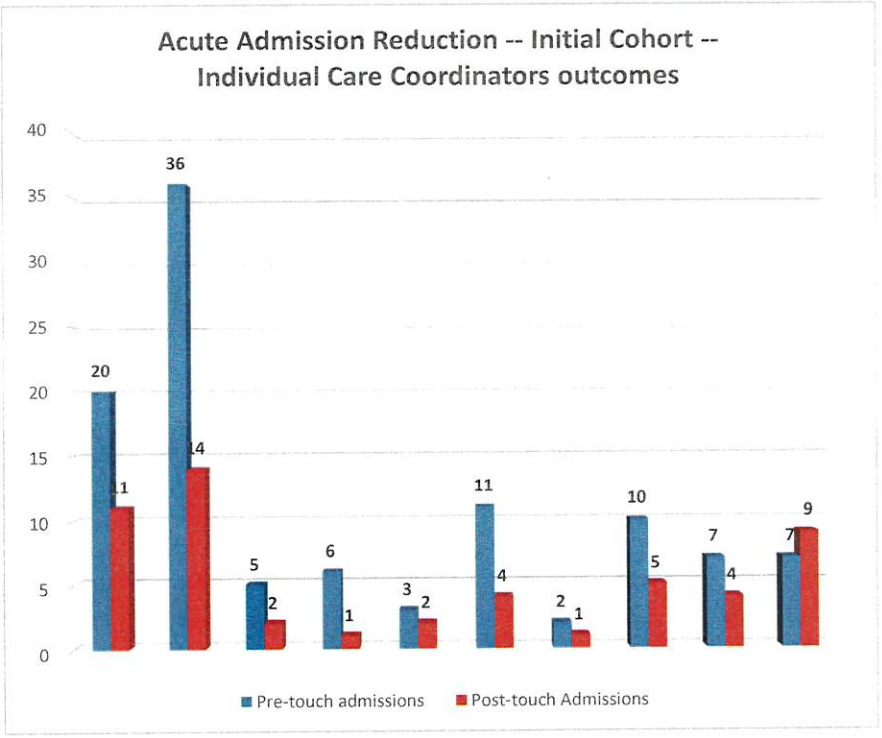
$352,000 savings from decrease in readmissions

Member Outcomes



	Unique Mbrs	Pre-touch admissions	Post-touch Admissions	Admission Reduction
Grand Total	68	107	53	54

Includes acute BH admissions 6- month pre- and post- initial successful liaison contact
Excludes members without continous 1-year eligibility



Discussion