HealthCatalyst
ignite outcomes improvement™

A Care Model to Support the Needs of Medically Complex Patients

Allina Health

Individuals with disabilities have complex health needs and face profound issues of access to basic health services. As such, this population is four times more likely to be hospitalized than the general population.[1] To strengthen care for high-risk patients of all abilities, Allina Health formed the Courage Kenny Rehabilitation Institute. As one of the largest non-profit rehabilitation programs in the country, it touches over 85,000 lives each year— including helping those with disabilities via a "primary care medical home" care model.

Established in 2010 through grant support and data sharing arrangements with the Minnesota Department of Human Services (state Medicaid agency), the Courage Kenny Advanced Primary Care Center (CKAPCC) is staffed by disability-knowledgeable professionals who stay focused on improving the health of those served. Because of its early success and innovative care model, the CKAPCC was awarded one of 107 Health Care Innovation Award grants by the Centers for Medicare and Medicaid Services (CMS) to further test and evaluate its model.

THE PRIMARY CARE MEDICAL HOME: AN EFFECTIVE CARE MANAGEMENT MODEL

The average individual served by the CKAPCC has seven to nine medical conditions in addition to his or her primary disability—making even basic care for this population a challenge. In the face of rising costs, and to prepare for an emerging pay-for-outcomes reimbursement model, CKAPCC identified several areas for improvement.

- Guide care to providers with knowledge and experience caring for medically complex patients
- Strengthen care coordination between traditionally "siloed" services, such as primary care and community support programs
- Integrate non-medical services into the care model to address social determinants of health
- Take a holistic approach to caring for people with greater emphasis on preventative care

CARE COORDINATION AND CENTRALIZED DATA IMPROVE CARE FOR PATIENTS WITH DISABILITIES

CKAPCC adopted several strategies to provide patients with an ideal primary care medical home that would improve their outcomes and keep them out of the hospital.

Care coordinators. CKAPCC assigned registered nurse care coordinators to meet patients' highly individualized health and social needs. Their work includes developing care plans, performing assessments and triage, and handling referrals, med refills, labs, immunizations and health education. They also assist with non-medical needs that, if left unaddressed, can hinder patients from keeping to their care plans. These encompass everything from housing to legal issues.

Heightened care coordination across the continuum. The program has employed several key actions to utilize

> "Having a single integrated clinic with all the necessary support services under one roof was a huge accomplishment. We saved money while achieving the Triple Aim.
>
> Kyle Grunder, Director of Provider Operations, CKRI, Allina Health

multi-disciplinary collaboration and partner care team members with patients and their families.

- Set goals that meet individual patient needs

- Maintain a concerted focus on early intervention techniques – including patient appointment scheduling, follow up, and arranging accessible transportation

- Provide a fully accessible facility and one-hour appointments to address complex care needs

- Provide services such as psychiatry and primary care under one roof

A single source of truth. Allina implemented an EDW and analytics platform from Health Catalyst® system-wide that combines claims data, medical records, state health care expense data, and other sources of data throughout the Allina system. This in turn enabled CKAPCC to take a number of actions:

- Identify, target and monitor populations for different initiatives

- Evaluate clinical processes and business operations

- Manage care and support across the continuum

- Measure patient outcomes

- Demonstrate improved outcomes for services provided

RESULTS

Allina's data-driven efforts to strengthen care of patients with disabilities has made a clear and meaningful impact on outcomes.

- **30 percent reduction in hospitalizations.** Pre-enrollment baseline was .74 hospitalizations per patient per year. Post-enrollment, this reduced to .52 hospitalizations per year per patient.

- **66 percent reduction in hospitalization days.** Pre-enrollment baseline was 10.2 hospital days per year. Post-enrollment, this reduced to 3.5 hospital days per year.

- **79 percent reduction in 30-day readmissions days.** Pre-enrollment baseline was 6.37 days in hospital associated with a 30-day readmission per member per year. Now reduced to 1.36 days in the hospital.

- **Significantly improved access to care through nurse care coordinators.** CKAPCC care coordinators have contact with 55% of their patients each week, spending an average of 52 minutes per patient per issue.

- **Saved $4.5 million over a one-year period.** Savings based on comparison with a three-year baseline of medical services use, with reduced or eliminated need for services that would otherwise have been required – such as emergency room visits, hospital admissions, and when admitted, reduced length of stay.

WHAT'S NEXT?

Allina's model for advanced primary care has proven to effectively manage a complex population. It also offers a template for shifting a portion of the healthcare system away from fee for service. If Allina Health is successful in gaining partners on the payment side of healthcare delivery to fund this program in a value based payment methodology, expanding the clinic to other geographies within Minneapolis and St. Paul will be explored. ◊

REFERENCES

1. Centers for Disease Control and Prevention, National Center for Health Statistics. (2011). Health, United States, 2011 – with special feature on socioeconomic status and health. Retrieved from http://1.usa.gov/22LtyPm

ABOUT HEALTH CATALYST®

Health Catalyst® is a mission-driven data warehousing, analytics, and outcomes improvement company that helps healthcare organizations of all sizes perform the clinical, financial, and operational reporting and analysis needed for population health and accountable care. Our proven enterprise data warehouse (EDW) and analytics platform helps improve quality, add efficiency and lower costs in support of more than 50 million patients for organizations ranging from the largest US health system to forward-thinking physician practices.

For more information, visit www.healthcatalyst.com, and follow us on Twitter, LinkedIn, and Facebook.