UCHealth CENTRAL INSIDER

UNIVERSITY of COLORADO HEALTH

Volume 8 | Issue 17 | March 17, 2015

Signs of success as grant nears end

"Bridges to Care" Supporters Ponder Next Steps

By Tyler Smith

Nearly two years of data has yielded strong signs that the federally funded "Bridges to Care" program has lived up to its name. Now supporters at University of Colorado Hospital and Metro Community Provider Network (MCPN) are looking for ways to build on the success.

Members of the Metro Community Provider Network Bridges to Care team. Heather Logan, director of accountable care, is far left.
Photo credit: Metro Community Provider Network.

The initiative, dubbed B2C, is the product of a three-year, $4.2 million grant to MCPN from the Centers for Medicare and Medicaid Innovation that targets frequent users of emergency department and hospital services. Patients in the program work for at least eight weeks with MCPN clinical care coordinators who identify their needs and barriers to care, provide health care coaching, and link them to medical and mental health services in their communities.

Providers in UCH's Emergency Department assist by identifying patients who meet the criteria for enrollment in the B2C program.

The short-term goal is to decrease utilization and save money. More fundamentally, however, B2C aims to guide underserved patients to the services they need to help them manage their own health and avoid preventable emergency care and hospitalizations.

While the grant ends in June, the groups are considering ways to sustain the concept, said Jennifer Wiler, MD, MBA, associate professor and vice chair of clinical quality, patient safety, and process improvement with the Department of Emergency Medicine at the University of Colorado School of Medicine.

Bridges and inroads. The MCPN and UCH team is buoyed by an analysis of 228 patients who completed the B2C program. They're still crunching the numbers, but the results are promising. For example, patients visited the ED only about half as often during the six months after program completion than they had in the six months before they entered B2C. In addition, the number of ED visits for "ambulatory care sensitive conditions" (ACSC) – those for which good outpatient care can many times prevent hospitalizations or disease complications – fell by 43 percent in the same group *(see table)*.

An additional preliminary review of gross hospital charges for B2C enrollees in the eight months before and after graduation from the program showed savings of nearly $9 million, said Roberta Capp, MD, assistant professor of Emergency Medicine at CU.

Capp said UCH's involvement with B2C has provided a lift for the program by flagging potential enrollees when they come through the door of the ED.

"We're getting patients in the right time and place," Capp said. "It's easier to make a connection with the patient in the ED. We found that a phone call after the visit didn't work as well."

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A hand up. Controlling utilization and costs is an important aim of B2C, but the program has larger aims, said Heather Logan, director of accountable care for MCPN.

"We're looking not only to impact patients' health care, but also to effect behavioral change," Logan said. "It's not just did they not return to the hospital; it's whether they were able to access primary care."

Here, too, there are signs of success. Among patients who are at least one year out from completing the B2C program, 73 percent continue to see a primary care physician, Logan said.

Left to right: Roberta Capp, Greg Misky and Jennifer Wiler helped build UCH's connection to the Bridges to Care program.

Logan noted that B2C is unique among the organizations that received grants in 2012 in that it emphasized mental health services, with Aurora Mental Health being one of the key partners in the B2C initiative.

A staggering 86 percent of B2C graduates have a mental health diagnosis, Logan said. As Greg Misky, MD, a hospitalist at UCH noted, mental and behavioral health issues can be a formidable barrier for patients also dealing with medical problems.

"It may often be more than a matter of giving an asthmatic patient an inhaler or getting a patient to stop smoking," Misky said. "These health issues may be part of unaddressed depression or other causes."

To measure the effect of the B2C program on mental health status, MCPN asked patients to report the number of days they felt "mentally unstable or unhealthy" at 30, 60, and 180 days after completing the program, Logan said. At the 180-day mark, the number of mentally unhealthy days decreased for 59 percent of the patients, she said.

Now MCPN is working on the follow-up: corroborating the possible relationship between mentally unhealthy and physically unhealthy days and breaking down that information by medical diagnosis. That information could be available in May, Logan said.

On to the next. The signs of B2C success have translated into a renewed partnership between UCH and MCPN to maintain momentum after the grant ends. The two organizations have created a new position for a community health liaison to be based at UCH. The person will work with MCPN patients who need a primary care physician or additional services and link those who consent to a clinical care coordinator with MCPN, Logan said.

The "end game," Misky said, is to continue to connect underserved patients to "medical homes" staffed by MCPN providers who help them knit together a coherent system of care that meets their individual needs. The medical home concept isn't new, but the incentive to make it work is more urgent as the state continues to enroll tens of thousands of new Medicaid patients, many of them with significant health care needs.

"Interest in sustaining the Bridges to Care model is huge," Misky said. Without an innovative approach to meeting additional demand, UCH and other hospitals likely will face continued patient throughput problems, while the state will bear additional cost, he noted.

"We have to find creative ways to manage these new patients and coordinate their care differently than we do now," Misky said.

The stakes for UCH, Children's Hospital Colorado, and University Physicians, Inc. are heightened by their sponsorship of Colorado Access, a nonprofit health plan that is part of the state's Accountable Care Collaborative – an initiative to coordinate primary care and services for Medicaid patients.

Under the program, the state's Health Care Policy and Finance Department pays per-member-per-month fees to Colorado Access and other collaborative care organizations and to primary care providers at UCH, Children's Hospital Colorado, and others to manage the care of Medicaid patients. The organizations and providers can earn additional payments based on their management of 30-day hospital readmissions, emergency visits, and high-cost imaging services.

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"Colorado Access is incented to manage population health and costs," Wiler said. "UCH and UCHealth leadership have been supportive of Bridges to Care and welcoming to new ideas. We now have a wonderful opportunity to look at other health care providers and payers to improve patient population management and talk about sustainability of the Bridges to Care concept."

Finding fixes. With the end of the B2C grant approaching, UCH and MCPN leaders are also mulling ways to overcome the barriers they've seen patients encounter. Lack of transportation has been a "huge issue," Capp said. Another is connecting patients with chronic conditions to specialty care, Logan said. Clinical care coordinators also had to work closely with Aurora Mental Health providers to help patients find creative ways to deal with stress and behavioral issues in a system strained by scarce resources, Logan said.

The B2C experience revealed that changing a system that has mostly been broken for people with limited resources can only happen if providers take the time to listen to the people they care for, Misky said.

"The program touches patients and families beyond their health care needs," he said. "They are not always high utilizers because of their diseases. There are other layers to their lives and they need to be heard if we are to identify the issues. Physicians can't tell patients what their problems are. They have to ask them."

At the same time, Logan added, a workable alternative to fragmented, costly, and inefficient care also relies on the willingness of patients to take control of their own health.

"It's a challenging system to navigate if you have chronic conditions and you [need] a lot of specialists," she said. "I think at some point some of these patients have kind of thrown in the towel on their health. For us, the question is, how do we get them back on track and be their biggest cheerleaders, but also hold them accountable. We look for patients who are ready to become engaged and ready for change."

Utilization Data for Bridges to Care Graduates*

	Six months before intervention	Six months after intervention	% Change
Number of ED visits	917	460	49.8364231
Number of Hospital Admissions	165	75	54.5454545
Number of ACSC ED visits	265	152	42.6415094
Number of ED for patients with MHD	191	127	33.5078534
Number of ED visits for patients with chronic pain	39	22	43.5897436

*Data from 228 patients who enrolled in and completed the program. Source: Metro Care Provider Network and CU Department of Emergency Medicine.