

ABSTRACT: 2016 ELAM Institutional Action Project Symposium

Project Title: Transition to Population Health: Quality Improvement Through Outreach

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Background, Challenge or Opportunity: MetroHealth Medical Center's major managed care Medicaid contract has changed from fee for service reimbursement to a mixed model for reimbursement that includes per member per month payments with incentives for achieving HEDIS quality measures and some reimbursement for fee for service. HEDIS measures are calculated by Medicaid. Practically, this means that the medical system is responsible for the quality of care given to those who come in *and* the quality of care for those who are assigned to Metro but never call or seek care. Challenges in reaching patients who are not trying to come in include: inaccurate phone and contact information from the insurance company, a medical system call center that is set up to receive and not initiate calls, and patients who are reluctant to come in or have transportation barriers to receiving care.

Purpose/Objectives: Our objective is to reach out to patients assigned to the medical center by the insurance company who are overdue for care and have them successfully complete visits. Getting children in for well child visits was the first priority. Scalability to adult care if the program is successful is incorporated. The ultimate goal is to improve the health of the Medicaid population in Cleveland

Methods/Approach: A series of meetings were held between the primary care service line, the call center and the schedulers. Each have separate budgets and consensus was needed in order to put a business plan together. When agreement was reached that calling assigned patients without recent care was desirable and that outreach should be housed in the call center, a business plan was developed. The plan demonstrated that the costs of the personnel making calls would be more than covered by the quality bonus for achieving quality benchmarks. Next steps will involve: Getting permission to create an outreach unit from the CCO and COO, hire and train staff, create tracking systems to monitor number of calls made and number of appointments completed, continue to track HEDIS measures for improvement in well child care. If there is success in well child care, we will scale up to adult care for asthma, diabetes, and hypertension in 2017. If we are not successful, understanding why we failed will be important to finding a new strategy to achieve our goals.

Outcomes and Evaluation Strategy: HEDIS measures are calculated by managed Medicaid from claims data and sent to the medical center quarterly. Additionally, as a process measure of success, short of the final financial outcomes of payment for achieving the HEDIS benchmark, we will track the number of calls made, the number of appointments made, the no show rate, completely appointments. We anticipate the outreach call center being up in 3rd quarter 2016 and first outcomes to be available at the end of 4th quarter 2016.

Transition to Population Health: Quality Improvement Through Outreach



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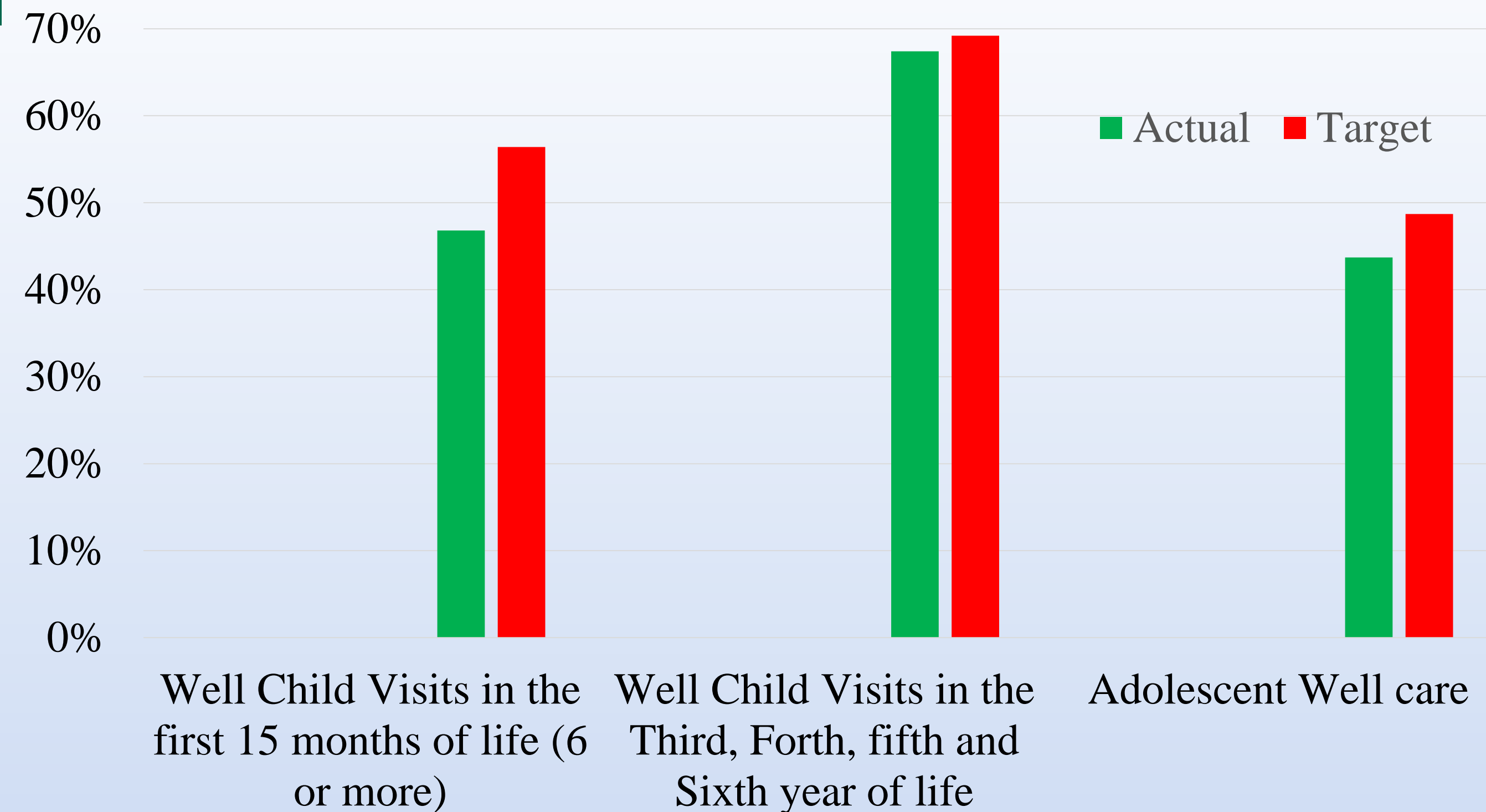
BACKGROUND

Metrohealth Medical Center is a public hospital located in the inner city of Cleveland, OH. MetroHealth Medical Center's major managed care Medicaid contract has changed from fee for service reimbursement to a mixed model for reimbursement that includes per member per month payments with incentives for achieving HEDIS quality measures and some reimbursement for fee for service. HEDIS measures are calculated by Medicaid. Practically, this means that the medical system is responsible for the quality of care given to those who come in *and* the quality of care for those who are assigned to Metro but never call or seek care. Challenges in reaching patients who are not trying to come in include: inaccurate phone and contact information from the insurance company, a medical system call center that is set up to receive and not initiate calls, and patients who are reluctant to come in or have transportation barriers to receiving care.

OBJECTIVE

Our objective is to reach out to patients assigned to the medical center by the insurance company who are overdue for care and have them successfully complete visits. Getting children in for well child visits was the first priority. Scalability to adult care if the program is successful is incorporated. The ultimate goal is to improve the health of the Medicaid population in Cleveland

Hedis measures actual vs target quarter 3 2015



METHODS

A series of meetings were held between the primary care service line, the call center and the schedulers. Each have separate budgets and consensus was needed in order to put a business plan together. When agreement was reached that calling assigned patients without recent care was desirable and that outreach should be housed in the call center, a business plan was developed. The plan demonstrated that the costs of the personnel making calls to over 15,000 patients would be more than covered by the quality bonus for achieving quality benchmarks. Next steps will involve: Getting permission to create an outreach unit from the CCO and COO, hire and train staff, create tracking systems to monitor number of calls made and number of appointments completed, continue to track HEDIS measures for improvement in well child care. If there is success in well-child care, we will scale up to adult care for asthma, diabetes, and hypertension in 2017. If we are not successful, understanding why we failed will be important to finding a new strategy to achieve our goals.

OUTCOMES

Baseline HEDIS measures for well-child care are shown on graph and compared to targets. All measures are below desired outcomes. After implementation of the outreach intervention, it is hoped that actual rates will exceed targets. HEDIS measures are calculated by the Medicaid managed care company and sent quarterly. Because MetroHealth Medical Center does not collect or analyze the data and the Medicaid company does not have any influence over the intervention, the risk of measurement bias is minimized.

DISCUSSION

Quality of care is evolving from good care and outcomes for the patients seen by a health care institution, to defining a population for whom the medical center is responsible and ensuring that all patients have maximized their health, whether or not the patient initiate a health care encounter. This is the concept of population health. While public health hospitals have always taken care of the poor and underserved, what it means to take care of someone is changing. Public hospitals must balance their "rescue mission" (trauma care, acute hospitalizations for illness) with one of primary and preventative care to keep people out of the hospital. Prevention is in the financial interest of the tax payer and new reimbursement models that reward keeping people healthy make good public health sense. How the organization and personnel of a hospital should be rearranged to maximize population health needs further study. Our proposed intervention is one such exploration

SUMMARY

Hospitals must adapt their systems to evolving notions of quality. Systematically studying methods of reaching unengaged patients will help understand how to organize the health system to best serve all it's patients and not just the ones that seek care on their own.