CivicHealth

Addressing the Emerging Challenges

Undercutting Hospital Profitability

A case study of how hospitals are using CivicHealth's solutions to:

- Reduce uncompensated care
- Improve post-discharge care coordination
- Manage volume and maximize profit in the ED

Even as hospitals recognize the need to implement new concepts and targeting programs, they are faced with a shortage of prior results or history, further complicating their decision process.

Feeling the Pain

Hospitals across America are faced with significant financial pressures as their payment model shifts to value-based reimbursement and bundled payments. This creates an increasingly urgent need to improve connectivity and collaboration between multiple providers, healthcare networks and organizations using disparate technology. Managing care pathways, including creation and collaboration within a specialty or narrow network, continues to challenge hospitals.

Whatever the strategy, program or initiative, the least common denominator centers around a care management strategy to reduce cost risk of certain patients within a population.

Among the initiatives that seem most likely to be needed and rewarded under both new payer models and the ACA are reducing uncompensated care, improving post-discharge care coordination and managing volume while maximizing profit in the ED.

Unlike untested offers that have sprung up in the last few years in an attempt to meet ACA and payer mandates, CivicHealth's systems have been used for over a decade to address these specific issues. The hosted, web-based software solutions offered by CivicHealth can help hospitals manage their efforts to tackle these tough imperatives and improve patient outcomes, as well as their bottom line.

CHALLENGE #1

Reducing Uncompensated Care Costs

Hospitals and physicians incur billions of dollars in self-pay bad debt or "uncompensated care" each year, according to the American College of Emergency Physicians (ACEP).[1] Fifty-five percent of emergency care goes uncompensated, according to the Centers for Medicare & Medicaid Services. Healthcare costs for both the full-year and part-year uninsured totaled $176 billion in 2013 - $86 billion of which was incurred when they were uninsured.

The current number of Emergency Department (ED) visits by uninsured populations is difficult to pinpoint, as it varies among states based upon their adoption of Medicaid, as well as ready access to other points of care. However, a 2015 Gallup poll found that the number of U.S. citizens without insurance has declined to 11.9%, but that's still almost 40 million people.

A 2013 study from Truven Health Analytics™ of patients with employer-sponsored insurance coverage sheds light on the use of the ED by those with non-emergent conditions. The study shows that nearly 3 out of 4 ED visits by insured patients could be treated by outpatient care.[2] According to the report, those with private insurance were just as likely to misuse the ED as those without insurance.

"The inappropriate use of ED services is growing, resulting in care that is more costly and lacks continuity," the report noted. The study was based on insurance claims data for more than 6.5 million ED visits made by commercially insured patients in 2010. Only 29 percent of those patients had emergent conditions.

Among the top reasons given for use of the ED for non-emergent care is lack of any other source of medical access. Also, consumers may be unaware of assistance they can receive when uninsured such as:

1) Providers who work with consumers on a sliding fee based on income
2) Government programs for which uninsured consumers may be eligible
3) Discounted pharmaceutical programs
4) Other community health and social services resources.

When the burden of care for non-emergent case is shifted from the ED, hospitals can achieve significant savings. CivicHealth provides a tool for helping to reduce non-emergent ER utilization that can result in better care for the patient and significant savings for the hospital. The CivicHealth system also automates the process of determining if uninsured patients qualify for health care programs such as Medicaid and Children's Insurance and can be used to coordinate and automate the patient enrollment process.

REDUCED ED VISITS = SAVINGS

CivicHealth conducted studies at three hospitals to determine reductions in non-emergent ED visits and resulting savings.

Pensacola, Florida (one year)
- 20% reduction in non-emergent ED visits
- $800,000 in ED cost avoidance savings

Cincinnati, Ohio (one year)
- 59% reduction in non-emergent ED visits
- $549,000 in ED savings

Minneapolis, Minnesota (six months)
- 55% reduction in non-emergent ED visits
- $500,000 in ED savings

CHALLENGE #2

Supporting Post-Discharge Care

As payers move towards value-based payment programs that require better care coordination, hospitals are being required to take on new tasks for which many are unprepared. They are assuming more risk for managing patient outcomes in order to maximize revenue from new value-based payment programs such as bundled payments, accountable care organizations, and value-based contracts with patient centered medical homes, health plans and self-insured businesses.

In order to provide better care coordination, hospitals must look outside their traditional four walls to ensure patients comply with their care plans. This may include identifying and managing non-clinical social needs such as transportation, nutrition, disease education, housing issues, home support and financial needs.

When these contextual issues are addressed by physicians and care providers, the resulting benefit for patient outcomes is remarkable. A study published in the April 16, 2013 issue of *Annals of Internal Medicine*[3] showed that in the 59% of cases in which physicians created a contextualized care plan, there was a good outcome 71 percent of the time. When context was not factored in, bad outcomes occurred in 54% of cases.

Patients aren't the only entities to benefit from a better care coordination model. When healthcare systems in Pensacola, Florida initiated a patient care program using CivicHealth's integrated system, they recognized a $2.06 financial return for every $1.00 invested in the program.

Additional benefits include:

- 74% of consumers are receiving services for which they were referred
- 12% of persons with diabetes reached HbA1c control of ≤ 7.0%
- 36% reduction in depressive symptoms among consumers diagnosed with a depressive disorder
- 20% reduction in ED visits with $800,000 in ED cost avoidance savings
- $300,000 in Medicaid net revenue recovery

The CivicHealth system allows program staff to redirect and refer uninsured ED consumers to alternative healthcare providers within the community, and assists consumers in determining eligibility for financial assistance programs and Medicaid. Participating partners are able to substantially decrease the number of uninsured consumers who cycle through the ED, decrease the bad debt of affiliated hospitals, increase charity care reimbursements, and help patients connect with permanent medical homes to receive coordinated quality healthcare that is affordable.

To document the benefits of the Pensacola program, area hospitals collected emergency room data on low-income uninsured adults presenting to the ED for non-emergent care with diagnoses of diabetes, cardiovascular disease, and/or a positive depression screen for a one-year period prior to the use of CivicHealth's software and a one year period after the use of CivicHealth's software.

CivicHealth's comprehensive technology system, which has been used successfully to improve care for the uninsured in more than 30 communities across the country, is now being adopted by hospitals to help them maximize reimbursement through improved care coordination.

CHALLENGE #3

Establising Successful ED Redirection Programs

It's been well proven that ED care is one of the most costly venues for care delivery, yet hospitals struggle to change from the old mentality of volume-based reimbursements to the new model of value-based care. The ED can still serve as a source for profitable inpatient services, with a redirection program helping to reduce costly unnecessary readmissions and direct non-emergent cases to more appropriate resources.

The CivicHealth system was used in a pilot program sponsored by the State of Minnesota in the Minneapolis/St. Paul area to redirect consumers frequenting the ED for non-emergent care to primary care homes using a care transition model. The system provided the hosted software tool for primary and specialty care appointment scheduling and making referrals between the ED and participating provider clinics.

As part of this pilot program, data was collected on emergency department utilization for six months prior to the implementation of the CivicHealth system and six months after implementation of the system. The study population included low-income Medicaid and uninsured adults presenting to the ED for non-emergent care. Results from the study showed a 55% reduction in non-emergent ED visit utilization and $500,000 in ED savings.

The CivicHealth system is also being used in a Cincinnati hospital to support an ED Care Coordination Pathway program that connects uninsured patients who have no regular source of medical or dental care to a medical home. ED physicians refer a patient in "real time" to community health workers who schedule appointments across 18 community, medical and dental practices.

The program supports:

(1) Better health outcomes and chronic disease management
(2) Organizational, patient and community engagement
(3) Improved performance tracking
(4) Decreased use of expensive hospital resources
(5) Reduced uncompensated care

In addition, use of the CivicHealth system qualifies as a billable item in the new Medicare billing codes (as of Jan. 1, 2013) for managing at risk Medicare patients for 30 days after discharge. These new billing codes apply to discharged Medicare patients with medium or high complexity and can also cover the use of information systems as part of the care transition process. Medicare payments of up to $292 per discharge may be realized on these new billing codes.

The CivicHealth system is ideally suited for automating transitional care programs designed to reduce avoidable readmissions (such as Project RED, BOOST, Naylor, Guided Care and Coleman Care Transition Intervention). The automated steps help enforce consistency with the programs and maximize the productivity of the care transition workers.

About CivicHealth

CivicHealth's comprehensive technology solutions are used to coordinate care pathways across multiple organizations, including human services. CivicHealth streamlines and centralizes data from EHRs and other disparate IT systems, integrating clinical and non-clinical resources to lower costs, increase efficiency and improve patient care.

CivicHealth connects a wide range of clinical and non-clinical organizations to create networks that enable cost-effective care coordination and strategic resource management. CivicHealth's software platform is used by hospitals, accountable care organizations and patient-centered medical homes; post-acute and long-term care networks; health plans; and community and public health organizations to manage risk, coordinate care and evaluate individual outcomes and population health. The company's proven technology has been in use for over a decade in more than 30 communities across the country.

CivicHealth's robust platform offers the interoperability, workflow and reporting required in today's healthcare environment. The solutions facilitate collaboration within a specialty or narrow network.

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[1] http://www.acep.org/News-Media-top-banner/The-Uninsured--Access-To-Medical-Care/, accessed 5/31/13

[2] http://www.truvenhealth.com/news_and_events/press_releases/april252013.aspx, accessed 5/31/13

[3] Saul J. Weiner, Alan Schwartz, Gunjan Sharma, Amy Binns-Calvey, Naomi Ashley, Brendan Kelly, Amit Dayal, Sonal Patel, Frances M. Weaver, Ilene Harris; Patient-Centered Decision Making and Health Care Outcomes, An Observational Study. Annals of Internal Medicine. 2013 Apr;158(8):573-579.