Expanding "Hot Spotting" to New Communities

What we're learning about coordinating health care for high-utilizers

THE CHALLENGE

Experts agree that reducing costs while increasing quality is at the crux of America's health care challenge. Knowing which approaches to improving patients' care work best – and who to target them at – is a matter of significant debate.

A relatively small number of patients account for the bulk of the nation's health care spending. Analysis by the Agency for Healthcare Research and Quality shows that the sickest 5 percent of U.S. patients account for over half of U.S. health care costs. If care for these 'high-utilizer' patients was more effective and efficient, costs would be reduced.

Patients who use the most health care services typically suffer from multiple chronic conditions, requiring frequent care provided by a number of different doctors. Many also have complicated social situations that directly impact their ability to get and stay well. Too often, high-utilizer patients experience inefficient, poorly coordinated care that results in multiple trips to emergency rooms and costly hospital admissions. Rarely do they receive coordinated, comprehensive care that addresses the complex medical and social issues they face.

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IDENTIFYING "HOT SPOTS"

The Camden Coalition of Healthcare Providers developed a model for identifying high-utilizer patients and providing them with highly coordinated care. Beginning in 2005, the Robert Wood Johnson Foundation (RWJF) funded the Camden Coalition to develop a community-based approach to identifying high-utilizer patients and providing them with coordinated medical and social services. The nonprofit Camden Coalition began 'hot spotting' in 2002 – collecting and using data from public and private insurance claims to identify which kind of patients were using the most expensive services and mapping where they live. They also coordinated with social service providers to ensure that the patients received the support they needed (such as transportation to medical appointments) to allow them to manage their medical conditions, as well as clear discharge plans so they did not fall through the cracks after hospital stays and end up back in the emergency room. This idea of hot spotting – or identifying where patients who utilized the most health care in a given region lived, or what characteristics they shared – provided clues about what the health care system needed to do to keep them healthy and out of emergency rooms and hospital beds.

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LESSONS FOR IMPROVING CARE

The result of fully implementing the model is better care at lower cost. By providing high-utilizer, high-cost patients with the right combination of health care and social services, the Camden Coalition kept people out of the emergency room and hospital, which are the hot spots of cost. The model holds potential for dramatic savings and improvement in care on a national scale.

RWJF understands that while poor quality of care is a national issue, solutions will happen locally. To find out what works best, RWJF is now testing the Camden Coalition method in select communities across the country. Pilots are underway in Maine and South Central Pennsylvania. These pilot sites, along with six other *Aligning Forces for Quality* (AF4Q) communities to be named soon, will adapt the model to their local resources and needs to create a range of very different, but very replicable, local approaches.

Aligning Forces for Quality communities include:

- Albuquerque, NM
- Cincinnati, OH
- Cleveland, OH
- Detroit, MI
- Greater Boston
- Humboldt County, CA
- Kansas City, MO
- Maine
- Memphis, TN
- Minnesota
- Oregon
- Puget Sound, WA
- South Central Pennsylvania
- West Michigan
- Western New York
- Wisconsin

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EARLY FINDINGS

- **Care coordination reduces the overall cost of care for people who have complex, chronic conditions.** This has implications for Medicare and Medicaid, which pay for the bulk of this group's health expenses.

- **Hot spotting turbocharges our ability to improve the health of certain populations** by showing where and how to apply tested public health approaches to quality improvement – and ultimately reduce costs.

- **Addressing high-utilizer patients' social needs is as important as addressing their medical needs.** Most patients require assistance to set up crucial supports such as meal delivery, accessible housing, transportation to appointments, and follow-up care once they leave the hospital.

- **The way providers are paid for care must change** to better reward and incentivize care coordination, which leads to better quality and reduced costs.