Oak Street Health Inc - Independent Healthcare Consultant

Interview conducted on September 15, 2022

Topics
Super-utilizers, Care Management, Resource Allocation, Cost Reduction, Ambulatory intensive care, Clinical Pharmacists, Medicaid, Chronic Diseases

Summary
In a conversation between a Tegus Client and an Independent Healthcare Consultant, they discuss managing super-utilizer spend and reducing medical claims cost by targeting moderate COPD and congestive heart failure patients. The consultant suggests prioritizing care management for the rising risk group and using behavioral contracts and financial rewards to engage members. They also discuss the overlap between intensive ambulatory care practices and voluntary super-utilizers, and suggest education and open access to primary care to reduce emergency room use. The consultant recommends creating an intensive ambulatory program for super-utilizers with carefully selected providers and a team consisting of a doctor, nurse practitioner, social worker, and community health worker. The model could potentially work for Medicare and commercial groups, but the sweet spot is in the Medicaid and duals population.

Expert Details
Former Senior Director of Population Health and Innovation, National Medical Management, and Chief Medical Officer at Aetna, leaving in November 2021. Expert can speak to Medicaid duals, MA, marketplace, and 20+ years of decision-making around managing super utilizer medical claims cost.

Current Independent Consultant. The expert provides consultant services to health plans, hospital systems, and the overall healthcare industry in strategic and operational areas.

Former Senior Director of Population Health and Innovation, National Medical Management at Aetna Medicaid, leaving in November 2021. The expert was a senior executive responsible for the population health programs, including health equity and Social determinants supporting the plans that comprise Aetna Medicaid.

Prior to this role, the expert was the Chief Medical Officer at Aetna leaving in April 2020. They served as Chief Medical Officer for the Duals demonstration plan In Illinois and as creator and MD coordinator for the Medical management [Center of Excellence] of the three Great Lake area duals plans (Illinois, Ohio, Michigan).

The expert is focused on innovative population tools for enhancing this engagement including risk-adjusted information profiling and more recently telemedicine and other electronic tools.

Q: What populations do you primarily work with (Managed Medicaid, MA, etc.)?
A: Medicaid duals, MA, marketplace

Q: Are you involved in decision-making around managing super utilizer medical claims cost?
A: I was (for 20+ years) until I retired. I am now a consultant to plans so not a decision maker currently.

Tegus Client
Hello. Thank you so much for taking the time to speak with me today. So I'm looking in the space of managing super-utilizer spend and I would love to pick your brain and I have a number of questions. Some of them are more high level and some of them, you'll see get a little bit more into the weeds. But before we

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begin, I would love to learn about your background and experience with the super-utilizer population.

Independent Healthcare Consultant
Yes, absolutely. It's been part of my life for probably 35 years. I'm an Independent Consultant now, but most recently, I work for a large national health plan in the Medicaid state overseeing population health for all their Medicaid plans. And virtually, by definition, controlling cost and spend in Medicaid involves a huge amount of population planning for super-utilizers.

As I came to my large national plan, I did that for about the last two years. Before that, I was recruited in and I was the Chief Medical Officer for their duals MMP demonstration project. And almost, again, by definition, people who are duly eligible are, if they're not all super-utilizers, they are all potential super-utilizers. So working and we set up the center of clinical excellence to manage utilization for that duals population nationally.

And that involves lots of planning around super-utilizers. Prior to that, 10 years at a large set of health plans owned by a big academic system and one of the largest plan was a Medicaid plan. We also had a Medicare Advantage plan. We also had a commercial plan in the military dependent retire plan. I was Deputy Chief Medical Officer overseeing quality utilization management, case management, lots of planning and dealing with super-utilizers there as well.

Prior to that, Kaiser Permanente on the East Coast. And I did enough for 20 years. I did a number of jobs there, but a good part of my time there was spent overseeing regional utilization management on the East Coast. And then again, anybody oversee utilization management deals a lot with super-utilizers. So I've been dealing with them for decades.

Tegus Client
Great. How do you define a super-utilizer?

Independent Healthcare Consultant
Yes, that's actually a great question. I want to make sure we're talking about the same population. I divide and most people I know, divide super-utilizers into sort of two groups. One is people who are super utilizing and it's remediable. There's also within that group, some that are not remediable, people who are using a huge amount of resource costing the health plan a lot of money.

You have within that group, a lot of people say it's the top 5% of membership and a lot of health plans. It's probably more than that in Medicaid and certainly way more than that in duals. But when you break it down, the people who are super-utilizers in the top 5%, some of them, there's not a lot you can do with other than hold their hand and help them. People who are trauma victims are going to be super-utilizers, they're going to have huge bills. And there's not a lot you can do to remediate that. You just need to make sure they're getting the right care in the right place.

Tegus Client
Right. Which people who are victims, trauma?

Independent Healthcare Consultant
Trauma, sure. I mean once somebody runs you over with a truck, you've got to be a super-utilizer, and there's not a lot you can do about it as a health plan or as a health system. And remember, I'm coming at all this from the health plan. So we're paying the bills. The second group is folks with cancer. There are some things you can do about that. By definition, a lot of people with cancer become super-utilizers when you have drugs that cost $100,000 a month, you're going to be a super-utilizer, no matter what.

Some of that is remediable making sure it's the right drugs and so on. But in general, they're going to be super-utilizers, whether you like it or not. Then you get into the next group of folks, which historically, if you look at the population health care amid is the next 15% of members who are rising super-utilizers. Rise in chronics, people who may not be super-utilizers yet, but who are having signs of potentially becoming super-utilizers.

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That's a group you want to spend a lot of time on because you may be able to prevent them. And the way people index into that group is in a number of ways. They have multiple chronic diagnosis that are likely to become more and more resource-intensive unless you do something about it. The classic patient is the obese patient with diabetes, early congestive heart failure and maybe they were smoker and they have COPD.

They may not be a super-utilizer today but given a little bit of time, they've got to be one. So you want to concentrate on that group of people. You also have sort of what I would call the voluntary super-utilizer group, which every health plan has a way to flag this, people who make multiple ED visits, people who are using the emergency department as their source of care. They don't have a PCP or they have one, but they don't use them.

And different plans have sort of different flags on that. 6 visits in 6 months, 12 visits in a year, 6 visits in a year sometimes. Now financially, they're not huge super-utilizers, but they have the potential to become it because of their habits. So that's a group you want to concentrate on. The other group in the top 5% that you can't do a lot about, but that I will mention besides cancer and trauma is NICU babies.

Once a baby is born prematurely, 28 weeks, they're going to be in the NICU for 3.5 months, they're going to have $1 million bill. Well, that's a super-utilizer. Now, can you do a whole bunch about the baby once they're born, you can do some stuff about it, but you can't put them back inside the mom and then prevent them from being a super-utilizer. But you can concentrate on high-risk pregnancies to prevent the birth of the NICU baby, to prevent the birth of the super-utilizer.

So that you can identify the high-risk pregnancy. You can provide extra care and case management for the high-risk mother. And so instead of having a 28-week birth, she has a 36-week birth. And the difference there is probably about $0.5 million. So that's another group that is remediable to some degree. So I've said a lot. Let me stop and see if you have any questions on what I had to say or any follow-ups on that.

Tegus Client
Yes. So I'm more focused on the group that you can affect change. And in your view, that's multiple chronic conditions and folks that are not navigating the system correctly.

Independent Healthcare Consultant
And high-risk pregnancies. Yes. And multiple chronic conditions, and if you're looking at the Medicaid space, people with a co-diagnosis in the behavioral health space, those are historically very high utilizers. Somebody who's schizophrenic, manic depressive, clinically depressed and also has a chronic condition. Those are potential.

Tegus Client
They are fine utilizers of inpatient care or emergency rooms, all of the above?

Independent Healthcare Consultant
All of the above. And again, the group that you're focusing on, which makes perfect sense, that's where people should be focused. The analogy, they're rising risk, which what a lot of health plans call them but identify them early and remediate early. So you need to be able to identify that group before they become high utilizers, frankly, or before they become very high utilizers and there's not anything you can do about it. So I agree. That is the question to concentrate.

Tegus Client
How do you know that someone within this multiple chronic diagnosis group has become such a high utilizer that there's nothing you can do to impact change on medical claims cost?

Independent Healthcare Consultant
It's a tough and I will tell you a quick anecdote. A cardiologist friend of mine used to say the people who are up in that top 5%, and he said this was a little straight face. He said, “A lot of them are in God's waiting

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room, and you basically need to help them be comfortable, but you're probably not going to get them out of that waiting room," meaning there are people whose conditions are such that medically or socially, frankly.

But medically more so than anything else, you're not going to be able to do much to remediate their conditions. And their conditions are probably going to be fatal within a few years. I'm sad to say that. But it's a medical judgment. And I'm sure someone somewhere maybe one of your potential clients has written some AI software that helps do that.

In fact, I'm pretty sure people have. But that it's not easy to identify those folks, but it's like an experienced managed care professionals like myself, who've done a lot of utilization, know the when they see them. And that's an awful thing to say, but it's true. So that's my answer to that.

Tegus Client
When you say you know them when you see them, what are some of the tell-tale signs?

Independent Healthcare Consultant
So one of the signs is a co-diagnosis in the behavioral health sphere. Where their medical condition is continuing to deteriorate and the medical care just cannot do it. Their diabetes is getting worse. Their congestive heart failure is getting worse despite maximum medications. Their behavior, it's almost like they've given up. They have bad diabetes, but they won't manage their weight because we know it's hard to do. But the real answer is their medical conditions despite maximum treatment are still getting worse. Most diabetics actually die of heart failure. That's what kills, but not the diabetes. And where their congestive heart failure has become, this classification of congestive heart failure has become four, there's one, two, three and four, they become four. Their renal failure, they're on dialysis and not doing well. All of the above.

I'm using diabetes as an index, but it is relatively common to be running through all of this. But patients with respiratory diseases are the same way. Their COPD is so bad. COPD is Chronic Obstructive Pulmonary Disease, mostly in smokers, but in other people as well. At some point it becomes impossible to treat. People on oxygen at home, people in and out of the ER all the time, and there's not much you can do about it. I don't know if that answers your question, but it's on turn to answer your question.

Tegus Client
No, that's helpful. Do you give these people care managers?

Independent Healthcare Consultant
Yes. They need care managers.

Tegus Client
Does that move the needle on their cost of care?

Independent Healthcare Consultant
It can. But again, when you're care managing these people, half of what you do in care management is you want them to be comfortable with where they are. You want to still try, if they're not losing weight, the care manager wants to work on that. If they're not making their medical appointments, the care manager wants to work on that. If they're not taking their behavioral health books, the care manager wants to work on that. So yes, it can help.

But if you look at populations care managers, the rising risk folks are really who are care managers leverage. You can leverage your care managers and really prevent the risk for rising. Because the people that we're just talking about, their risk has already risen. Let's get to say, and they're already high utilizers as a high risk. And yes, you can ameliorate some of it, but they're going to be high utilizers no matter what. So yes, you can make the number a little bit, but you're not going to arrest the high utilization.

Tegus Client
So if I wanted to really move the needle financially in terms of reducing medical claims cost, should I be

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going after the moderate COPD and moderate congestive heart failure?

Independent Healthcare Consultant
Yes. I mean you still have to care manage the other people. But Wayne Gretzky once asked what makes you the world's greatest hockey player. He said, "Because I skate to where the puck is going to be, not where the puck is." And that's what's happening with this. You want to care manage people, you want to care manage where the puck is going to be. You want the rising risk. So if I had limited resources for care management at a health plan, I would provide, and this is a mistake a lot of health plans make, they throw all their care management into the top 5%. And it helps and it's the right thing to do from a humanistic point of view, but it doesn't bend the cost curve as much as one would hope.

I would have way more resources into the next 15% into the rising risk group. And that's a mistake not only the health plans make but states make as well. In Medicaid, states say, you must care manage the top X percent of your members in terms of spend. And that's not necessarily the best use of care management. Do you need to do something for those members? Absolutely, no question about it. But if I had 10 care managers, I put 2 of them on that group and the other 8 on the rising risk group.

Tegus Client
Got it. So here's a question. Let's say you have two folks with congestive heart failure better in the top 5% of spenders and are extremely ill. One has anxiety, one doesn't. Do you expect to see within the patient or the member with anxiety a lot more utilization?

Independent Healthcare Consultant
Yes, probably some more because every time something happens, they're going to be in the ED and the one who's a little bit more comfortable with their disorder is not going to be in the emergency room very often. The big one was COPD. Anxiety and COPD are really a tough combination. I've seen some people they have oxygen at home. They do okay. They get their checkups. Occasionally, they go to the ED. But you got to somebody with high-level COPD who is anxious, they may be in the emergency room twice a week.

Tegus Client
How you manage the person with high levels of COPD and is anxious?

Independent Healthcare Consultant
Lots and lots of contact. You want the care manager. This is somebody that , a lot of care managers, how you ask them how often do you talk with your members and they say, once a month, maybe twice a month. This is somebody you want to talk to twice a week. This is somebody you want to give them resources.

You want to give them if they're amenable to digital help, you want to give them something that's an avatar that's base that helps them there. There was a big pilot in Pittsburgh, I think, and it's been replicated in a couple of other places where plan contracted with the EMS system, which, believe it or not, the paramedics of the EMS folks have a lot of downtime.

It's not predictable downtime, but they contracted with them for the EMS paramedics to do home care, home health drop-ins on some of these people. And drop in twice a week and see how they were just for 20 minutes, see how they were doing, and it had some profound effects. The way you deal with anxiety is to hold the hand. It's not medical, it's behavioral. So that's the way you try to deal with that.

Tegus Client
Were these drop-ins for every high-utilizing COPD patients? Or were these with the high-utilizing COPD patients with anxiety?

Independent Healthcare Consultant
With anxiety. I mean if you're going to stratify your targets, it would be nice to drop in on everybody, but you'd start with the ones with anxiety. Similarly, people with congestive heart failure, folks with anxiety or profound depression, you prioritize those ahead of the others. A lot of dealing with high utilizers because you

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don't know health plan or health system has the resources to handle everybody, but some got to prioritize.

I will give you an example of my time at the large academic health system where I work. We set up something called ambulatory intensive care. And this is from the delivery system side, but set up by the health plan. If you look at high utilizers and ones who might be amenable to not be so high utilizers. If you look at the primary care panel, it's 1,800, 2,000 patients.

But the physician or a provider in that panel can't spend a lot of time with anybody. So what we did is we set up a practice of ambulatory intensive care. And those providers, first of all, we added other people to the health care team. We had social work. We actually added clinical pharmacy to the team. And each provider there had a panel of 200, not sort of concierge care for a high-utilizer group.

So they were able to give much more attention to these folks up to and including if somebody had bad congestive heart failure had a cardiology appointment, their primary care provider might go with them for the cardiology appointments. Now, was it costly to pay providers, primary care providers, staffs and nurse practitioners to have such small panels?

Absolutely. But the health plan actually pay them an extra $500 per member per month to provide those services on top of the fees for the service. It sounds like a lot, but the ROI hit 2:1 within the first 12 months because their high utilizer spends went down. So net of the very expensive primary care costs, it still had a pretty good ROI. So that's another example.

Tegus Client
Yes. I mean every health plan in the country is dealing with these high-utilizer populations.

Independent Healthcare Consultant
Health systems that are carrying risk now.

Tegus Client
But there aren't too many ambulatory intensive care practices. Why is that?

Independent Healthcare Consultant
No, there aren't. There's one company out of Georgia that does it, I think. I'm trying to remember who they are. I think they did crack the Baltimore market eventually, but we had one ourselves, we set it up ourselves. So yes, I think ambulatory intensive care. And are you familiar with the camp in New Jersey stuff?

Yes. I mean the geo mapping and the setting of the clinics in the right place, that's sort of another version of ambulatory intensive care. I think if this is your client or somebody in this space or thinking about this space is your client, I think it's a giant opportunity. And when you say to the CFO of your health plan, I want $500 a month extra for these members.

First thing the CFO will do is have you thrown out of the office and probably dropped in the nearest body of water. But then a year later, you can prove on a pilot that the ROI is at least 2:1, then the CFO is happy with you. But $500 forever per month, essentially care management fee, which is really what it looks like to a primary practice is, it's a lot of money.

Tegus Client
How do you engage the members to participate with this ambulatory intensive care practice?

Independent Healthcare Consultant
That's a tough one because some of them are unengageable. You don't spend a huge amount of time. If they don't want to work with you, then you sort of put them in that list of you can't remediate it, good luck. So what we use is we use the contract. There are two ways to do it. Ours was just a behavioral contract.

The member was asked to come in for a meeting, was told that they would have 24/7 access, not just to an advice line, but a provider on the phone, not always their own provider but somebody from the team, 24

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hours a day. People like that. Do you need your primary care provider to go to your specialty visit with you? People like that. So what was signed was the behavioral contract. I do know of one place and this was through a union welfare fund at West that a doc set up one of these.

And not only was it a behavioral contract, but the members got some financial reward for playing nice in the system. So if you have two appointments a month with your PCP. And at the end of the year, you've only missed 2 out of the 24 appointments, you're going to get a Walmart gift card for $200 or $300. So I'm making up that reward, but they put financial rewards for their members into the behavioral contract. And that was evident relatively successful.

Tegus Client
All right. And then let's talk so that's the group that are six super-utilizers and then you have the voluntary super-utilizers. No?

Independent Healthcare Consultant
Yes, they overlap.

Tegus Client
Yes, I was going to ask how much do they overlap? And for these intensive ambulatory care practices, do they also touch the voluntary super-utilizers?

Independent Healthcare Consultant
Yes. Less so, only because of the resources. I'll give you an example, going way back to my Kaiser time. The voluntary super-utilizers tend not to be as expensive as the six super-utilizers. And the voluntary super-utilizers are mostly using emergency rooms and things. And even at an average of $1,200 a visit to emergency rooms a month. It adds up, but it doesn't add up to $50,000. It doesn't add up to multiple hospitalizations.

We had two different demographic groups in Kaiser Mid-Atlantic based on geography, and they both had high utilization. But one had high utilization. One was sort of a upper-middle class and they were folks who just like to go to the doctor and they like to go to the emergency room. Every time somebody stubbed their toe, they were in the emergency room. So it adds up. But that's a very different dynamic. And the other group was also middle class, but it was a much lower socioeconomic middle class, a lot more chronic disease, a lot more hypertension.

And they were also super-utilizers, but they were super-utilizers who were much more complicated. So the approach has ended up being different. The fully voluntary super-utilizers that aren't getting hospitalized, you can try to deal with them. And there's probably more of them than there are of the others. But on a unit cost basis, they are much less costly. They may add up to the same because they're more of them.

Tegus Client
Are these two used to address this population? Which strategies do you use to address the voluntary super-utilizer population?

Independent Healthcare Consultant
Education to some degree. I will tell you the biggest thing that we did, and this is something that hasn't fully cut on around the country. It's a closed system. It's a closed panel system. We went to what's called advanced open access for our primary care. Meaning if somebody wanted an appointment today, they can have an appointment today. And what that did is that cut off a lot of the emergency room use. Our cost of delivering an internal appointment was a fraction of an emergency room visit. So what we did is we played into what they wanted. We played into.

They wanted access and we knew they were going to get it one way or the other, education helps a little bit. Advice nurses helps a little bit. Telehealth helps a little bit. But what we did is we find other ways to meet their needs. They were way less expensive. So the easy went way down. When we went to open access,

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meaning if they called into the Kaiser Permanente medical center and they said, "I wanted to be seen today," they got seen today. And that was open access for everybody, not just that group.

That was a change in our approach to the world. Telehealth helps there because you can meet some of their needs by televisits. It's hard to change their habit. So you try to figure out how to hit them in the middle is I think the best way I would say that. But the whole concept of open access has not gone on outside of a few big groups like Kaiser and Geisinger and Sutter and some others. Most private practices are scared to death of open access. They shouldn't be, but they are.

Tegus Client
So if I were to create an intensive ambulatory program for super-utilizers, do you think I would need that to be open 24/7?

Independent Healthcare Consultant
It needs to be available 24/7. But the way we did was they weren't open 24/7. They were open until about eight and nine. Is one of the providers in the practice carrying a cell phone then they actually changed their off every day. So there was one cell phone number that was available. And it wasn't an advice nurse. It was an actual provider. It was either a doctor or nurse practitioner. So that's how we got 24/7 access to them.

And it even happened that after the conversation at 2:00 in the morning, the provider said, well, this number really needs to be seen and the provider would actually go and meet the member in the emergency room and shepherd them through the system. So it's very hands-on. I mean, ideally, if you had a big enough patient population or enough of these folks, you might keep a center open 24 hours. Kaiser has many centers open 24 hours now.

They have a couple in each market that are open 24 hours, even in the nonhospital markets, Mid-Atlantic now has, I think, 4 of that are open 24 hours a day that meet the needs of these members, but really meet the needs of these members. But there are ways to do it short of being open 24 hours a day, I think.

Tegus Client
So what was the role of the pharmacist in this practice?

Independent Healthcare Consultant
Drug, drug, drug. Parsing out drugs, making sure a lot of these people, particularly the multiple clients are on 7, 8, 9, 10, 11, 12 drugs. And they have interactions. So these are clinical pharmacists. They're not the people who package pills and pass it across the table. And Kaiser has hundreds of these folks.

They work with members on multiple drugs to optimize their drug treatment. And optimization also means something called therapeutic substitution. There's a difference between generic substitution, which is automatic and happens. If I write a prescription for you for a brand name drug, and I don't say, "dispense as written." And the pharmacist is going to fill it with a generic, which is an absolute equivalent drug.

But there's such a thing as therapeutic substitution, which the drugs are therapeutically equivalent but not chemically equivalent. And a pharmacists, other than, I think, two states now, pharmacists provide to make that substitution. But in most places, pharmacists do not make that substitution. But what can happen when a new patient comes in on 12 drugs, a clinical pharmacist spends an hour going through their drugs with them. This is particularly true with older patients.

The pharmacists they can't make the substitution, but they can go back to the prescribing physician and say, "Did you know that you've got Mrs. Smith on this cardiac drug that costs $900 a month, and there's this cardiac drug that has very similar therapeutic endpoints that's also available through generic that cost $40 a month. May I change your member?" And we discovered in Kaiser, and it's been replicated in a lot of places that clinical pharmacists embedded in these teams returned at least 200% to 300% of their salary and savings.

Tegus Client

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Helpful. So let's say I were to make an intensive ambulatory super utilizer practice that was at full risk, right? So I want to manage Medicaid plans, and I said, "Okay, I've made this practice. I embed social workers. I embed me help these on. I have primary care doctors that are trained to deal with this population". Do you think that would be of interest?

Independent Healthcare Consultant
Yes, absolutely. I will give you another little story. One of the things I left out of my history is I spent about two years in the Midwest with a small Medicaid health plan, trying to get them. They're not in existence anymore. And I was out there for about two years as a Chief Medical Officer. And before we had to shut down because the state was broken and not paying Medicaid health plans.

I spent a huge number of hours in conference and in meetings with a university, a medical center, and the department of family practice helping them. They never got there because the health plan went away, the Chairman of family practice retired but we were well on our way to building one of these things in a metro Midwest area. It never happened for various reasons.

I left, plan went out of business, Chairman retired. But yes, I think there would be lots of interest. Again, to justify one of these things. The staffing costs were heavy. The benchmark, I'll give you, it costs about $500 a month extra to put members in one of these practices. Could you do it for 4, yes. Could it cost more than $500, yes.

But the initial approach, you got to get members to have a track record to demonstrate success on it's sort of a circular argument, but you've got to continue to health plan to give you the money to start with to get the experience and to improve the ROI. But it's there. I mean, I will tell you, it's absolutely there.

Tegus Client
When you say $500 a month extra, how are you thinking about this?

Independent Healthcare Consultant
Okay. Let me say, fully capitated. $500 a month care management costs and costs of the special panels. What we did is we also paid fee for service for the visits and the encounters. So we paid $500 on top of the fee-for-service and the encounters. On the other hand, you could look at your members and turn their fee-for-service history into a capitation and then just throw on top of that $500. That's sort of loose-goose, but that's kind of the way I would look at it.

So you're going to end up with these members being per member per year capitated what $500 times 12 is already $6,000, you can throw on top of that maybe another $6,000 or $7,000 of direct medical costs, just for the primary care. And then you going to throw on top of that, if you're talking full capitation, full risk, including hospitalization, you've got to figure that one out as well. So I mean, these are very expensive numbers, but there's money to be saved by doing it, right. You have to get an actuary with a very smart pencil, very, very smart pencil.

Tegus Client
Got it. In terms of the members that do best in this sort of arrangement, what would the sort of profiles look like? And I'll give you some examples. Would that be a frail diabetic? Would that be someone that's living under a bridge and going to the emergency room for housing?

Independent Healthcare Consultant
Yes. I think some sort of measurement of wanting to change becomes important. And some frail diabetics, from a medical point of view, they're ideal. Frail diabetic with vascular disease and congestive heart failure, early kidney disease. That's an ideal person for this, but they also have to want to change. They have to want to take care of themselves. The person under the bridge, who probably is schizophrenic, some of them want to change as well.

There are measures. There are instruments that measure willingness to change for hospice one of them. I've forgotten what university he came out of, but it's a well-known change readiness instrument. And you

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probably want to use some instrument like that looking at your members because when you've seen one person, you've seen one person. If there's no desire to change at all it's a waste of time, frankly.

Tegus Client
Yes. No, that does make sense. And then so how did you do it at your academic medical center? Did you give people quizzes or behavioral interviews to gauge their desire?

Independent Healthcare Consultant
Yes, exactly. You heard me say they had to sign a behavioral contract. And the behavioral contract said, I mean, they weren't financially rewarded for it, but the behavioral contract was worked out with a site social worker. And there were people who either would have signed or that was very clear they were signed just because, and they would take them on, but they get fired from the practice relatively quickly.

It is part of the contract said, "You will be compliant if you will make your visits, you will take your medications, you will refill your medications." And it was monitored. I mean, you're spending a huge amount of resources on these folks. And if they're not benefiting. That's one of the, I won't call it a failure.

But one of the weaknesses of the way a lot of case management has done is people are unwilling to declare failure and open up that space for someone who really can utilize it. Case managers tend to hang on to their caseloads forever. And there are people who sadly aren't benefiting and you need to open that capacity for someone who will benefit. So yes, it's very behavioral, that's the approach.

Tegus Client
What doesn't work when you're creating an intensive ambulatory practice? Is there anything that counterintuitively doesn't work well?

Independent Healthcare Consultant
I've never been asked that. That's a great question. What doesn't work well. Let me turn it around a little bit. You've got to pick your providers carefully. At my academic medical center, the director of the practice was somebody got a passion for it. That was great. But when they started meeting new providers, it sort of looked around their group practice.

It was a group practice of about 600. And they said, "Okay, who's new and doesn't have a lot of patients yet? Who can we pull off?" That was a bad way to select your providers. This is hard work. This is brain taxing work, not medically brand taxing, behaviorally for the providers. There needs to be a passion. Tt's incredibly got to be fine work when you succeed, but you're not going to succeed all the time.

So what doesn't work is not picking your providers carefully. And by providers, I mean your docs, your nurse practitioners, your social workers, your pharmacists or whatevers, your community health workers, important to this. Are you mentioned it? Now I really mentioned, they're important. Well, so that's what doesn't work. It's not selecting the right providers.

Tegus Client
What data or population health statistics can you be providing your team in order to help prepare them for success?

Independent Healthcare Consultant
You want to provide good risk stratification. By definition, these people are high risk. But if you can sub-stratify them, that would help. And then you have the nonmedical determinants of health. And some people suggest, particularly in Medicaid, which seems to where you're concentrating that the ultimate determinants of health really are more social determinants rather than medical determinants. It's about food. It's about housing. It's about job. It's about safety and violence.

And there are a number of companies out there that are stratifying people on the social determinants of health. So it's a relatively new industry. There's a company called, Socially Determined, it does that. They

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provide risk scores. That data is important. When we did this seven years ago, we didn't have that data. The social workers would get it in the history, but we didn't have that data formally. That data is incredibly important to address.

Tegus Client
Do you think you could have driven higher ROI with that data?

Independent Healthcare Consultant
Yes, you absolutely can. You can get a better ROI with that data or identifying that somehow. I mean the experience that Geisinger had a number of years ago, David Feinberg published it by providing food as medicine with their diabetic population, just by identifying who needed food and who needed healthy food and providing food had a huge ROI. Yes, that's a very important piece of this.

Tegus Client
Got it. And when you did the intensive ambulatory practice, did you look at those folks that were sort of super utilizes to the emergency room?

Independent Healthcare Consultant
We did. We did not put a lot of them in that practice, if that's all they were doing. There were a few of them. I mean, I'm going to go back to Kaiser for a minute. When we went to advance open access, we had one very famous member who get ready, hold onto your socks, at 257 emergency room visits in the previous 12 months. That's an outlier, but that kind of member gets special attention. Think about it, 257 visits.

Tegus Client
That's crazy. Would you put them in a program like this?

Independent Healthcare Consultant
Yes, I might put somebody like that in a program. Is somebody was your classic ED over-utilizer, 6 or 12 or something, I would put them in regular case management first and get them locked into a primary care doc and get their needs met in other ways. But if you've got a what I would call an ultra-super-utilizer in the ED space, I might put one of them in a program like this.

Again, you got to remember, there's got to be an ROI. So if the spend isn't big enough to have an ROI with an intensive program, it doesn't make any sense. So it's sort of an actuarial patient selection process, I guess, and thought of it that way, but that's what it really is.

Tegus Client
What are the most straightforward ways that cost savings can be derived by having a program like this?

Independent Healthcare Consultant
Keeping them out of the hospital. The most expensive thing is keeping them out of the hospital. The biggest expense is hospital. Now, ED is connected to that because people get to an emergency room and the first thing the emergency room wants to do, besides take care of them, of course, get them out of their emergency room.

There are only two ways to get people out of an emergency room, send them home or send them upstairs. So emergency room tends to lead to hospitalization, which is why there's some concentration on emergency room. But the single most important thing is stabilize on medication, stabilize on complex specialty care.

The other thing is a lot of these people have an average of five or six specialists they see. And guess what, specialists don't coordinate. That leads to problems as well. You want to keep them out of the hospital, that's the biggie. You want to maximize the right medicines and make sure they're adhering to taking their medicines. Those were the things to do.

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Tegus Client
What about the behavioral health component?

Independent Healthcare Consultant
Yes. I mean that flows throughout the whole thing. Because a lot of this is behavior modification. So yes, that's important as well. I agree.

Tegus Client
What are the FTEs that are need to make a practice like this? What's the ideal care team here? How about that? Is it a physician, a case manager, a community worker, social worker, pharmacists, behavioral health therapies?

Independent Healthcare Consultant
And to set up one team and one clinic with one team doesn't make a lot of sense because you don't need a clinical pharmacist for just one team, a clinic. Let's say your index is your provider and the provider is a doc. The doc has, I'm making this up, but it's ballpark correct. The doc is going to have a panel of 200 patients.

You add a nurse practitioner and then their joint panel becomes 300 or maybe even 350. That panel probably does need a full-time social worker, but doesn't need a full-time clinical pharmacists. Clinical pharmacists can support 2 or maybe even 3 of these panels.

Tegus Client
Can we just put this to patients? So a social worker can due a doctor in this type of arrangement to 200 patients, a nurse practitioner can bring that to 300, social worker can bring 300, pharmacists can see a 1,000?

Independent Healthcare Consultant
Yes. Let's call it 2 panels, 600?

Tegus Client
Pharmacists to 600?

Independent Healthcare Consultant
Clinic ,Community health workers are cheap. So you would probably have a community health worker for every panels, maybe even 1.5 for every panel. That's your core group.

Tegus Client
How many panels per clinic?

Independent Healthcare Consultant
To make it practical, minimum of two, ideally three. It depends upon what the catchment area, it depends on how many patients are available. The reason to some extent, you want at least two is because of the 24/7 coverage, 24/7 coverage. And the coverage has to be a clinical person, which means the coverage has to be the doctor, the nurse practitioner.

And if you only have one doc and one nurse practitioner in a panel, it's going to be hard to keep your staff if they're going to have to be on call every other 24 hours. So you want to get at least four providers into that and ideally maybe six providers into that rotation. So yes, I mean, there are different ways to design this, but we're talking directionally correct here.

Tegus Client
What about behavioral health workers?

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Independent Healthcare Consultant
Well, that's your social workers. I mean, there are two kinds of social workers. And there are social workers who do, I'm going to get your food. There are social workers who are, I'm going to get your brain straight. And you probably want a mix, but a lot of the psych social workers will also do the other stuff that need be. So when I say a social worker, I'm talking as much as psych social worker as I am a resource social worker, if that makes sense.

Tegus Client
Yes. And what about like the true psychiatrists or psychologist?

Independent Healthcare Consultant
They need to be available for backup. I don't think they need to be on the panel. But if your primary behavioral health practitioner in these panels as a social worker, they need to have a psychology, a doctoral level person to back them up. But it's a relatively less, particularly back them up on medication stuff. Although the docs on the panel will do that as well with their advice to the social workers. So yes, there needs to be somebody affiliated, but they're tangential to the panel.

Tegus Client
Okay. So let's say I had 2,000 patients and a bunch of pods, so 20 pods, do you think I would hire psychiatrists at that point?

Independent Healthcare Consultant
Absolutely, that's enough. The tangential becomes full-time work. But the pods don't have to be in one clinic. I mean the psychiatrist can tell it in the Medicare space, there are a couple of big provider organizations like Oak Street Health, and they started hires, but their psychiatrist cover seven or eight clinics, and they do it all by tele.

Tegus Client
And then what about diet nutritionist?

Independent Healthcare Consultant
Nutrition, yes. Again, nice to have as a consultant. If you had 20 panels, you probably have worked for a nutritionist or two. Again, they can be tele. A lot of the adjunct stuff can be done by telehealth. You don't want them internal through the panels. But you recall what I said early on, one of the reasons you keep the panel small is that if there's a specialty coordination that needs to be done, it's done by the primary care doc or and/or nurse practitioner. And if necessary, they will go to a specialty appointment with the member to help sort things out.

And nowadays, that can be done by telehealth. It was not done when we started. Very little telehealth when we started this, but they could do this by tele as well that it wouldn't have to get in the car and drive to the specialty hospital. On the other hand, that might assured that the patient goes. So now we might add medical specialists to these panels.

Tegus Client
What is the day in the life of a doctor with 200 of these super-utilizer patients look like?

Independent Healthcare Consultant
Some appointments usually an hour long seeing patients. Some supervision of the rest of the group of nurse practitioner, maybe a trip to the cardiology office with one of their patients. Very, very varied. It's not turning through patients. I mean one of the keys to this is you don't turn through people and your visits are an hour long.

Tegus Client

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Why need an hour?

Independent Healthcare Consultant
Got to have the connection. You've got a lot of this is for that personal connection. And it's hard to have personal connection in a 15-minute visit. Maybe there's some half-hour visits. But these are pretty intensive visits. I'll give you an example that's not high utilizing at all. There's a company called QuadMed. Have you ever heard of that?

Tegus Client
Yes, I'm familiar with QuadMed.

Independent Healthcare Consultant
You are. I mean, set up the on-site clinics required graphics. And QuadMed's visits are an hour long. And everybody, when they looked at Ray Zastrow, who used to be the Chief Medical Officer, he's gone now. Ray would say, I give my providers an hour and everybody go you're out of your mind. And you'd say, "Yes, but hey, it's because basically, by viewing our on primary care visits, we're able to obviate the need for emergency room visits and a lot of specialty visits". It works. So again, there's no single formula, but you want to have longer visits.

Tegus Client
What about education materials around the proper utilization of emergency rooms, et cetera? Do you think that would be helpful here?

Independent Healthcare Consultant
Yes, absolutely. I mean, proper use of emergency rooms, proper use of medications, proper use of specialists. There's a lot of education materials that can go with us. No question about it. And some of them exist out there, they just need to be bundled correctly and they need to be written at a level that works for most. If you're doing Medicaid, they need to be remediated grade level. They need to be written in the relevant languages for your patient population, all of the above. But yes, educational materials are useful for sure.

Tegus Client
What is the profile of a doctor that excels at a practice like this?

Independent Healthcare Consultant
Frequently, their family practitioners because they view the world, adults now we're talking about. They view their world a little bit more holistically than internists. They may be somebody has a master's degree in public health because they're interested in sort of broader health, public health than they are in treating unusual conditions. So I would say family practitioner ideally, interest in public health and population health either shown through training or just straight out interest.

Probably there's a behavioral interview to pick these people as well, very high EQ, very empathetic folks. I'll give you the example of doctors who don't work well in this is emergency room doctors who are great physicians, but they want bing bang and episodic care in and out, and they tend not to be tremendously empathetic.

Again, the receptors, clearly, but that's not somebody you want in one of these practices. And I saw one that somebody tried to set up, and they tried to set it up, and they tried to defer expenses by also running their center as an urgent care center. And I understand why they did that, but then they then populated it with ED and urgent care train docs, big mistake, want people to do this kind of ambulatory intensive care.

Tegus Client
Got it. So I see why that could be frustrating. My hunch would also be to make it an urgent care as well. Is the reason it doesn't work because of the difference in physician training and philosophy between family

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practitioners.

Independent Healthcare Consultant
Yes. I mean I think you could co-locate it with an emerger. If you're going to build bricks and mortar and you need to defer your capital cost, you can certainly have urgent care as part of this. But I think the doctors you want doing it are different.

Tegus Client
Yes. So let's say we have a patient panel of 200 patients per doctor. Can we walk through what that looks like? How many of them, it's going to depend on geography, but maybe just at a really illustrative level, how many of them are CHF, how many of them are COPD, et cetera?

Independent Healthcare Consultant
Yes. I would say, let's look at the chronic diseases, CHF, COPD, bad diabetes, or maybe some other pulmonary, maybe some severe asthma. I'd say diabetes is going to be #1, but that never swims alone. That swims with CHF. You're going to have some that are just CHF.

But you're going to have a lot of diabetics whose their real illness is CHF. You going to have a lot of COPD. It may have a lot where their primary diagnosis is actually mental health is schizophrenia. And then they have other minor chronic diseases underneath it. But I would say, diabetes, COPD and CHF is going to be the majority of your patients.

Tegus Client
Do you think I should have home visit capabilities with this organization?

Independent Healthcare Consultant
Yes, absolutely. I mean certainly home visit community health workers, but also home visit. I didn't mention it, but that's the other part of the day for our providers. They may go out and do a home visit. Absolutely, you need home visit capability.

Tegus Client
When you built this practice or when you were working with this practice, is there anything that you wish you had done differently? Or anything you would add?

Independent Healthcare Consultant
I built it and paid the bills, but I didn't work out it. I'm a pediatrician. We started with one panel and I think that was a mistake. I think we probably sort of started with two. We added a second one about four months in, but we started with only one panel and they had growing times. They struggled. And yes, I think that's the one thing I would have done differently. I would have identified more patients.

And I will tell you, when we recruited patients for it to recruit the original 200 patients, we actually triage through close to 500 patients, and with some of the patients rejected us and we rejected some of the patients. So if you're going to build two panels, you're probably going to have to triage to a couple of thousand patients to get your two panels.

Tegus Client
Got it. And then would you recommend doing this model for risk?

Independent Healthcare Consultant
Not at the beginning.

Tegus Client
Could that be the aspiration?

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Independent Healthcare Consultant
Yes, that would absolutely be the aspiration. I would phase it in. I would take risk for the professional care, not only at the panel, but also specialty professional care. I would take that risk to begin with, I would probably throw pharmacy on relatively quickly and maybe emergency room in the first group, but then hospitalization, I would leave for later.

So, yes, aspirationally, I think full risk. But maybe a few outliers, cancer drugs, maybe not. I know in my health plan when we negotiated with Oak Street for a group of elderly people, they dearly wanted to keep, they took full risk. They dearly wanted to keep cancer drugs and out of the panel.

Tegus Client
Yes. And then do you think Oak Street is sort of already here?

Independent Healthcare Consultant
They're hearing a way. They don't have ambulatory intensive care, but they have a very different model. They have a capitated model. They have a model. They don't really do much in Medicaid. They take a little bit of Medicaid, but their sweet spot is Medicare because there's a lot more money available in Medicare.

Tegus Client
So does it make sense to focus on duals efforts or on Medicaid super-utilizers?

Independent Healthcare Consultant
I think duals is a good place to start, but you don't get a huge concentration of duals anywhere to maybe make this work. I would start with duals and Medicaid. If you have a city with a lot of duals you might start with duals. But you're going to have to get into regular Medicaid pretty quickly. The thing is the margin in regular Medicaid is smaller. So the investment available is smaller. Margin in Medicare is much bigger. So that's why Oak Street and GenCare and others are in the Medicare space. That's why VillageMD with Walgreens will take all comers, but what they really want is Medicare, bigger margin.

Tegus Client
Does this intensive model work in the Medicare space?

Independent Healthcare Consultant
It probably can. I mean, Oak Street's version of it. And to my knowledge, they don't have an intensive model, but they have some of the elements of this model in their regular panels. They do have some social workers. They do have some clinical pharmacists. They've hired a psychiatrist to cover multiple sites. They have big community rooms in their clinics where Medicare members who are just in need of. Their anxiety being addressed can come in for community meetings and they provide transportation, which is another key to one of these models is provide transportation, somehow. So they have elements of this model.

And if they get big enough and they have sick enough people like I could see them going into this for a Medicare population. I mean I think the sweet spot is the Medicaid population, frankly, in the duals population. But I could see it being done for Medicare. Probably not for commercial, although you never know. I mean, the one that I alluded to that was set up by a Union Trust Fund, that's a commercial health plan.

But if you look at all of the people in this happened to the hotel and food workers. So they're a commercial group, and they're employed. But if you look at their demographics and you look at how they behave, they kind of look more like a Medicaid group than they do, this is not the CEO of MGM. This is the bus way in the restaurant at MGM. So it is a commercial group. So I can't say that it wouldn't work for commercial.

Tegus Client
Got it. Well, thank you so much for chatting with me today. I really appreciate the time and your clarity. Have a great day.

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