Managing Medicaid to Improve Outcomes

Providence Alaska's coordinated care demonstration project

Providence Health & Services Alaska has set the standard for modern health care in Alaska since 1902. Today, Providence Alaska is the state's largest private employer, with nearly 5,000 caregivers. Providence Alaska is a part of the larger Providence St. Joseph Health, the nation's third-largest non-profit health system. Several Providence regions have partnered with their respective state governments to transform Medicaid. Providence Alaska is uniquely situated to draw upon this expertise and learn from the experience in other states, while remaining deeply rooted in Alaska.

What is Coordinated Care?

Coordinated care is a patient-centered approach to delivering care through a collaborative and coordinated patient care team. The goal is to provide the right level of care in the right care setting by wrapping supportive services around the patient in order to improve health outcomes and reduce costs.

Outside of tribal care, the current health care environment is fractured and it is largely the patient's responsibility to manage their own health care needs. This fractured environment increases costs and stresses the already fragile health care and EMS safety nets. Through the direction of Senate Bill 74 (2016), Providence Alaska partnered with the State of Alaska by contracting for a 36-month coordinated care demonstration project through the Providence Family Medicine Center. The project cohort includes 5,000 Medicaid and dual-eligible beneficiaries.

The cornerstone of this coordinated care project is the Patient-Centered Medical Home model of care. This model creates a patient care team --also called an Integrated Direct Care Team-- comprised of behavioral health, social work, nurse case management, health navigation, home visits, and pharmacy services. This team coordinates with the patient's primary care physician to increase access while identifying the most appropriate delivery of care needed to improve patient outcomes at a lower cost.

The Providence coordinated care demonstration project is also a step toward the necessary transformation to value-based health care payment models. The project blends the existing fee-for-service payment model for physician services with a capitated per-member per-month (PMPM) fee to provide the financial support for the care team services that are not currently billable but are essential to patient care and improved outcomes.

Providence Alaska and the Alaska Department of Health & Social Services are not only partnering on this project to reduce overall costs, but to rethink how we define our desired community health care outcomes.

Moving away from costly emergency department care

Emergency departments are widely understood to be the most-expensive form of health care. In communities across the country, there is a small group of high-utilizers who may visit the emergency department multiple times per year. National statistics show that those top 10% of health care users account for nearly 70% of the costs. This high-risk group often have multiple complex and serious health conditions while lacking the supportive environment to ensure ongoing treatment. In addition, patients who lack access to primary care may arrive in the emergency department with preventable and potentially avoidable conditions that have escalated to a more serious condition.

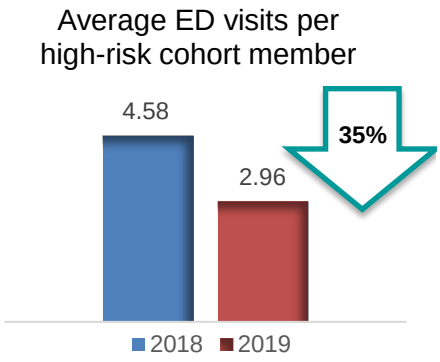
For information about our advocacy issues, please contact Emily Ford at 907-360-2131 (cell) or emily.ford@providence.org

First-year outcomes

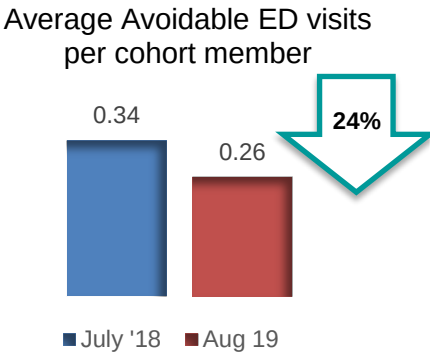
Meaningful and effective transformation projects are built upon the fundamentals of the Quadruple Aim: better health outcomes; improved patient experience; better cost of care; and improved provider experience. Initial steps are to encourage treatment in appropriate care settings and preventative care to improve health outcomes while reducing costs.

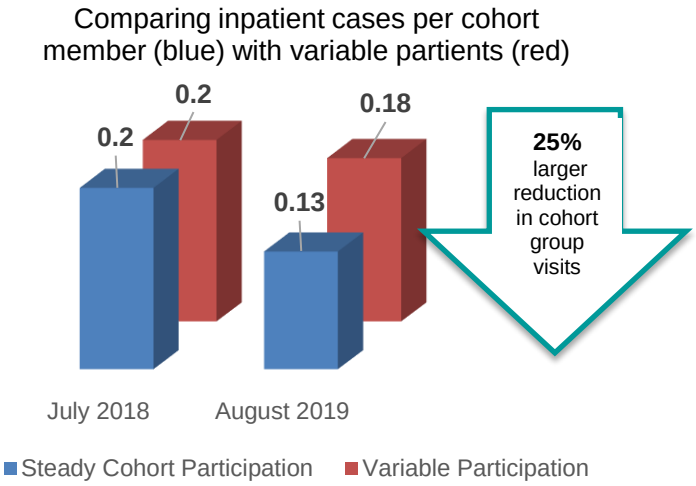
After roughly one year, the Providence Alaska coordinated care demonstration project is showing a reduction in both emergency department visits and inpatient stays at Providence Alaska Medical Center. Instances of avoidable visits also decreased (avoidable visits usually do not require any diagnostic or screening services, procedures or medications). Perhaps most impressive is the reduction in the high-risk groups who engage with their care team.

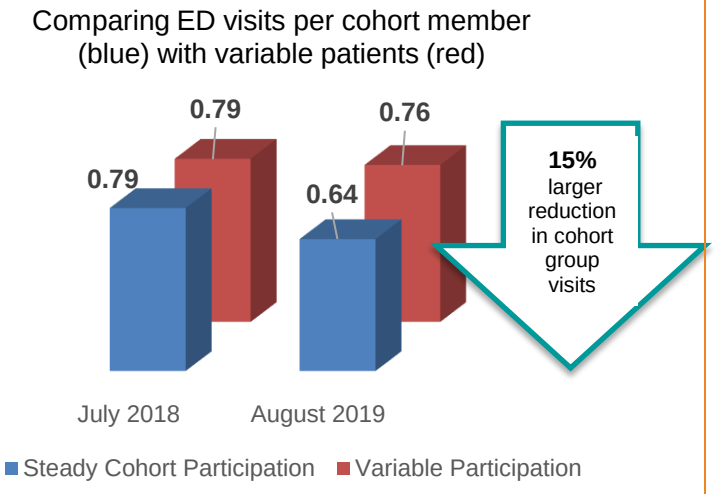
The charts below compare average visits in July 2018 versus August 2019 for patients who stayed in the cohort for the full-year; the high-risk/high-utilizer cohort population; and from Medicaid-eligible patients who did not consistently engage with the care team (variable participation). The data is based on a rolling 12-month average per 1,000 patients.



Fewer people are using the ED, with the largest percentage decrease within the high-risk group and in avoidable ED visits.







Patients who stayed in the cohort for the full year are not using the emergency department for their primary care as frequently, and are receiving the wrap-around services that improve health outcomes.

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