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Comments Prepared for Senate Finance Medicaid Reform Subcommittee
Presented by: Dr. Douglas Eby, Vice President of Medical Services, Southcentral Foundation

Emergency Room and Hospital Super-Utilization

I. Reducing Emergency Department (ED) Visits - There is a large body of evidence and experience from Alaska, the US, and many other countries that repeatedly show that any system providing highly capable Primary Care that includes good Case Management/Care Coordination will result in significant reductions in ED and Hospital use, resulting in large reductions in total cost, lab and radiology use, and overuse of medications. Consistently shown as well are improvements in a long list of quality measures.

   a. At Southcentral Foundation (SCF) we showed a reduction of over 50% when SCF first made the dramatic system changes over 15 years ago (although we started from an admittedly bad baseline) and we have been able to show an additional 25% reduction in the past ten years.
   b. Barbara Starfield has published many articles for many years showing data across many systems nationally and internationally supporting similar findings – the stronger the Primary Care, the less costs and better outcomes.
   c. These results are found most impressively with strongly capable Primary Care – level III National Committee Quality Assurance (NCQA) or more rigorous levels of ability. Too much primary care has been reduced to simple care and 'triage', sending anything the least bit complicated to specialists. This approach will still reduce ED use, but will not as significantly impact cost or quality.
   d. There are many results – CareOregon, Blue Cross/Blue Shield of Michigan, the Vermont Blueprint for Health, and others – where a significant part of the improvement in Primary Care capability was directly funded by the payer – MCAID, MCAID Intermediary, or Insurance Company. These investments include extensive training in expanded Primary Care, case management capability, putting the mind and body back together in Primary Care, creating highly capable population health data management, and Primary Care workforce development.
      i. SCF has created the Nuka Institute in the past two years and how has the capability to work as a consulting firm to provide any and all of the above training and capability development – and would be happy to be a contractor who knows Alaska well for these capacity building services.
      ii. If not purchased from SCF, it will still be wise to contract with entities with proven track records of capability and accomplishment such as some who have presented this week.

e. Additional articles, data, results can be found in the following locations:
    i. Commonwealth Fund – webpage and publications
    ii. Health Affairs Magazine/website
    iii. Kellogg Family Foundation
    iv. CMS – Innovation Center – and AHRQ
f. CMMI Innovation Grants – about 4 years ago CMS, through their Innovation Center, provided up to $30 million per contracted site to try out innovative care models – many aimed at the highest cost individuals. These results are becoming available – and are showing similar things across many locations – that effective personal, trusting, care coordination – usually by a clinical person – and optimally connected with a Primary Care Practice – reduce significantly the costs and improve the outcomes – with the largest savings found among the highest cost individuals.