Data Summary Report: Top 50
Highest Utilization: Non-primary care encounters
March 27, 2017

ANTHEM BLUE CROSS

Indicator	**2015** ***Jan – Dec (12 months)***	**2016** ***Jan – Jun (6 months)***
Top Aid Codes:		
1. Disabled (60, 64, 6H)	90%	64%
2. Medi-Cal Expansion (M1, M3, L1)	4%	20%
3. Aged (10, 14, 1H)	6%	6%
4. Adult (30, 34, 3N)	0%	2%
Percentage of Medi/Medi	30%	12%
Percentage of enrollees no longer enrolled in subsequent year	25%	54%
Three or more ED visits	96% *64% had 10+*	62%
One Inpatient Stay	84% *70% had 2+*	100%
Indication of homelessness	14%	26%
Complex care management	30%	22%
County Mental Health Specialty Services (used County MHP List)	6%	10%
Behavioral Health diagnosis on a non-PCP claim (*exclude Dementia and SUDs.)*	90%	12%
Comorbid Conditions		
1. Physical/Behavioral	74%	78%
2. Diabetes/hypertension	60%	6%
3. Diabetes/SUD	38%	2%
4. 3 or more conditions	100%	72%
Chronic Conditions		
• Substance Use Disorder (SUD)	58%	66%
• Major Depressive Disorder	74%	46%
• Psychotic Disorder	12%	30%
• Bipolar Disorder	4%	2%
• Hypertension	98%	78%

• Diabetes	62%	6%
• Asthma	68%	20%
• COPD	84%	38%
• Congestive heart failure	96%	64%
• Coronary artery disease	82%	48%
• Chronic liver disease	40%	44%
• Dementia	10%	18%

Data Parameters:

Population **–** Each plan pulled data for the top 50 utilizers of non-primary care services.
Homelessness – defined differently by each plan.
Complex Care Management – indicates members participating at the time of the data pull.
Plan Mental Health Services – may be difficult to extract data due to imbedded services at some locations, provider training, etc.
County Mental Health Plan – sent plans point in time data on their respective members.

Strategies:

- Complex Discharge Planning Team – Focuses on transitions of care with SPD members and high utilizers.
- High Intensity Interval Team (HIIT) – Behavioral Health outreach to members with high ED utilization. Pilot program last year resulted in decreased ED visits. **– NEW**
- Safe Choice Program – Targets members with high ED/IP utilization and opiate prescriptions from different providers.
- Partnership – Collaboration with PMGs (primary partnership with River City Medical Group) on complex member needs and transitions of care.

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HEALTH NET

Indicator	**2015** ***Jan – Dec (12 months)***	**2016** ***Jan – Jun (6 months)***
Top Aid Codes:		
1. Disabled (60, 64, 6H)	56%	64%
2. Medi-Cal Expansion (M1, M3, L1)	34%	30%
3. Aged (10, 14, 1H)	0%	0%
4. Adult (30, 34, 3N)	10%	6%
Percentage of Medi/Medi	6%	0%
Percentage of enrollees no longer enrolled in subsequent year	26%	20%
Three or more ED visits	98% *96% had 10+*	98% *92% had 10+*
One Inpatient Stay	60% *42% had 2+*	56% *42% had 2+*
Indication of homelessness	16%	14%
Complex care management	6%	8%
County Mental Health Specialty Services (used County MHP List)	10%	16%
Behavioral Health diagnosis on a non-PCP claim (*exclude Dementia and SUDs.)*	30%	42%
Comorbid Conditions		
1. Physical/Behavioral	10%	2%
2. Diabetes/hypertension	0%	2%
3. Diabetes/SUD	6%	6%
4. 3 or more conditions	28%	20%
Chronic Conditions		
• Substance Use Disorder (SUD)	66%	52%
• Major Depressive Disorder	24%	10%
• Psychotic Disorder	20%	26%
• Bipolar Disorder	10%	6%
• Hypertension	14%	8%

• Diabetes	10%	12%
• Asthma	12%	12%
• COPD	16%	16%
• Congestive heart failure	8%	2%
• Coronary artery disease	4%	2%
• Chronic liver disease	2%	0%
• Dementia	0%	2%

Data Parameters:

Population **–** Each plan pulled data for the top 50 utilizers of non-primary care services.
Homelessness – defined differently by each plan.
Complex Care Management – indicates members participating at the time of the data pull.
Plan Mental Health Services – may be difficult to extract data due to imbedded services at some locations, provider training, etc.
County Mental Health Plan – sent plans point in time data on their respective members.

Health Net used a primary diagnosis only for chronic, comorbid, and behavioral health conditions.

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KAISER

Indicator	**2015** ***Jan – Dec (12 months)***	**2016** ***Jan – Jun (6 months)***
Top Aid Codes:		
1. Disabled (60, 64, 6H)	32%	36%
2. Medi-Cal Expansion (M1, M3, L1)	24%	24%
3. Aged (10, 14, 1H)	10%	10%
4. Adult (30, 34, 3N)	34%	30%
Percentage of Medi/Medi	N/A	N/A
Percentage of enrollees no longer enrolled in subsequent year	14%	22%
Three or more ED visits	100%	100%
One Inpatient Stay	72%	54%
Indication of homelessness	None	4%
Complex care management	26%	90%
County Mental Health Specialty Services (used County MHP List)	N/A	N/A
Behavioral Health diagnosis on a non-PCP claim (*exclude Dementia and SUDs.)*	38%	28%
Comorbid Conditions		
1. Physical/Behavioral	38%	24%
2. Diabetes/hypertension	34%	38%
3. Diabetes/SUD	10%	20%
4. 3 or more conditions	66%	24%
Chronic Conditions		
• Substance Use Disorder (SUD)	22%	44%
• Major Depressive Disorder	44%	54%
• Psychotic Disorder	6%	10%
• Bipolar Disorder	8%	16%
• Hypertension	54%	52%

• Diabetes	50%	52%
• Asthma	38%	30%
• COPD	24%	11%
• Congestive heart failure	24%	30%
• Coronary artery disease	6%	4%
• Chronic liver disease	8%	16%
• Dementia	2%	0%

Data Parameters:

Population **–** Each plan pulled data for the top 50 utilizers of non-primary care services.
Homelessness – defined differently by each plan.
Complex Care Management – indicates members participating at the time of the data pull.
Plan Mental Health Services – may be difficult to extract data due to imbedded services at some locations, provider training, etc.
County Mental Health Plan – sent plans point in time data on their respective members.

Notes:
Medi/Medi – Kaiser GMC does not manage these members, therefore, no data included.
Homelessness – Identified by use of DHA P.O. Box, stated homeless, or by no address listed. Kaiser has a low percentage of homeless due to permit to enroll.
Mental Health Specialty – Carved in for Kaiser.

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MOLINA HEALTHCARE

Indicator	**2015** *Jan – Dec (12 months)*	**2016** *Jan – Jun (6 months)*
Top Aid Codes:		
1. Disabled (60, 64, 6H)	64%	64%
2. Medi-Cal Expansion (M1, M3, L1)	18%	30%
3. Aged (10, 14, 1H)	12%	4%
4. Adult (30, 34, 3N)	6%	2%
Percentage of Medi/Medi	12%	4%
Percentage of enrollees no longer enrolled in subsequent year	24%	40%
Three or more ED visits	64%	64%
One Inpatient Stay	88%	86%
Indication of homelessness	20%	26%
Complex care management	56%	82%
County Mental Health Specialty Services (used County MHP List)	4%	2%
Behavioral Health diagnosis on a non-PCP claim (*exclude Dementia and SUDs.)*	50%	68%
Comorbid Conditions		
1. Physical/Behavioral	50%	68%
2. Diabetes/hypertension	66%	44%
3. Diabetes/SUD	38%	26%
4. 3 or more conditions	86%	86%
Chronic Conditions		
• Substance Use Disorder (SUD)	52%	70%
• Major Depressive Disorder	48%	60%
• Psychotic Disorder	14%	22%
• Bipolar Disorder	14%	26%
• Hypertension	92%	90%

• Diabetes	68%	44%
• Asthma	46%	28%
• COPD	34%	40%
• Congestive heart failure	56%	44%
• Coronary artery disease	44%	42%
• Chronic liver disease	28%	54%
• Dementia	6%	14%

Data Parameters:

Population – Each plan pulled data for the top 50 utilizers of non-primary care services.
Homelessness – defined differently by each plan.
Complex Care Management – indicates members participating at the time of the data pull.
Plan Mental Health Services – may be difficult to extract data due to imbedded services at some locations, provider training, etc.
County Mental Health Plan – sent plans point in time data on their respective members.

Note: Molina provided revised 2015 data as of 3/21/17 for all diagnostics.

Strategies:

- Emergency Department Support Unit (EDSU), Transitions of Care, Complex Case Management, and Complexist Program. – Ongoing
- Reports – Gap in Care and HEDIS sent to providers monthly.
- Core teams – Track and develop interventions.
- Enhanced provider engagement.
- Care Model Alignment – Track and assign high utilizers and high risk members to Case Management.