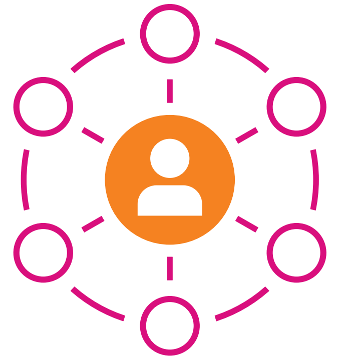
Success Story



Treating the Whole Person

Niagara Falls Memorial Medical Center Health Home

Reduced readmissions by 66%
Cost savings of $98K year-over-year for top 22 utilizers

The Niagara Falls Memorial Medical Center (NFMMC) Health Home is a Medicaid-funded coordinated care management program that provides services to at-risk adults and children in Niagara County, NY. The health home focuses on delivering an integrated and coordinated experience across the continuum of care, including among its services comprehensive care management, post-hospitalization follow-up, and working with community and social services to provide the additional support patients need to improve their health.

NFMMC uses Aerial™ Health Coordinator to document and manage all care coordination activities for health home members, including activities that take place at the hospital and with downstream providers.

The Challenge: Holistic Care for At-Risk Patients to Minimize Risk

NFMMC Health Home clients have high needs—eligibility requires a serious mental health diagnosis or a minimum of two qualifying chronic conditions, and many are homeless or displaced in the community. "As a health home in a poor, rural community, our clients often have more at-risk problems than seen at other health homes," said Tiffany Cook, Director of the Adult and Children Health Home at NFMMC. "We focus on getting them the right level of care and keeping them out of the ED."

For these patients, complex and overlapping social, economic, environmental, and societal issues can interfere with treatment plans and exacerbate chronic diseases. Treating the whole person by addressing behavioral and social determinants of health (SDOH) in addition to medical care not only helps this vulnerable population deal with all their issues so that they can become healthier, but also reduces the risk of high-cost emergency treatment.

"Without our health home, many of our clients would fall through the cracks," said Cook. "Our care managers do a phenomenal job of keeping their fingers on the pulse of their social needs as well as their health needs."

The Solution: Intensive Care Management

NFMMC uses Health Coordinator to enable care teams to identify and address medical, behavior, and social determinants of health in a single care plan and collaborate with the community to tackle those factors that prevent good outcomes. These capabilities enable NFMMC Health Home to personalize care to address each client's specific needs.

The platform supports identification of SDOH issues, information sharing, and collaboration across ambulatory and community-based settings, and universal care plans to track and coordinate issues, goals, and interventions, including social determinants. Custom assessments ask the right questions and can be electronically completed on-the-spot to identify issues and automatically add them to the care plan. Real-time alerts enable instant notification of critical problems. Information sharing with partners according to consent enables NFMMC Health Home to bring SDOH providers into care teams.

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"Seamless communication with real-time data that goes to everybody on the care team enables us to react and go to wherever the client presents—ED, PCP, or other ancillary services within the NFMMC campus," said Cook. "Being able to communicate and respond in real time is a big success for us, and enables us to provide the high-level support to prevent ED/inpatient admissions."

In a typical month, 4 of the top 5 issues the health home identifies and addresses—and nearly 50% of the total—are activities of daily living (ADLS), financial, housing, and mental health issues. Managing these non-medical issues—along with other behavioral and social determinants such as alcohol and drug use, transportation challenges, food security, education and health literacy, and more—are the core of NFMMC Health Home's care coordination work.

Hot Spotter Program Addresses Highest Utilizers

While all health home clients are high-risk, NFMMC Health Home collaborates with the community hospital on the "Hot Spotter" program, started in 2018, which identifies the top 22 patients who have had 10 or more ED visits in the previous 6 months and enrolls them in the most intensive care management program. Many of these high utilizers are homeless and struggling with substance abuse, and directing them to more appropriate levels of care can make a difference to NFMMC's bottom line.

"My main goal is to engage these clients so they call before making a decision to come to the ED," said Kofi Brenya, care manager and Hot Spotter program lead. "Building trust in our relationship means they will come see us when they need something, reducing the number of ED visits."

When a Hot Spotter does enter the ED, an alert with the client name and diagnosis is generated. Each Hot Spotter is connected on-the-spot to a hospital social worker to see if they can assess and meet the patient's needs without an ED registration. Encounter information is entered directly into the Health Coordinator system, immediately sharing information with the health home's care managers to keep the entire care team informed. In some cases, a simple conversation and sandwich is all that's needed to generate a successful encounter and prevent more expensive care, often care that would not have been fully reimbursed. "Our MCO noted a significant drop in ED registrations since our sandwich program started," said Cook.

Intensive care management with these patients follows a common care plan with the goal of helping them better manage their own health. It's a continual process of assessing these patients and working with them to act on something—getting a driver's license, going to the Medicaid office, arranging for a cab, and much more—while at the same time educating them so they develop the skills to complete these tasks themselves. When clients stay out of the ED for a full year, they graduate from the Hot Spotter program.

Results: Significantly Reduced ED Utilization

The Hot Spotter program has significantly reduced ED usage. For the clients who started the program in 2018, ED usage has gone down by **66%**. And, for the top 22 utilizers, ED usage has gone down by **64%** in the first 10 months of 2020 vs. 2019. At a typical cost of **$350** per ED visit, this savings translates to **$98,000** year over year.

But perhaps the most important impact is at the individual level. For those who have graduated from the program, **42 percent** have 0 ED visits since graduation, and **89 percent** have 3 or fewer—down from an average of 12 ED visits in the prior 12 months. For these high-risk individuals, NFMMC Health Home has truly made a difference.

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