Session Objectives

- Apply segmentation strategies to the identification of high-risk, high-cost patients.
- Develop action-plans to better understand the needs of these patients from a person-centered viewpoint.
- Use “change concepts” that can be applied to this patient population to design the first set of tests to be implemented in a care redesign process.
Guiding Principles

1. Identification of individuals at high risk for future cost
2. Impactability of the identified individuals
3. Cost effectiveness of your intervention or redesign – have to understand the cost drivers in your population/region
4. Potential interventions or redesign – what we are currently doing isn’t working, so how can we change it?

Percent of Total Health Care Expenses Incurred by Different Percentiles of U.S. Population: 2002

Sources: Statistical Brief #73, March 2005, Agency for Healthcare Research and Quality
Persistence In Spending

Figure 1. Persistence in the level of health care expenditures, U.S. civilian noninstitutionalized population, 2008 to 2009

Figure 3. Impact of Behavioral Health Comorbidities on Per Capita Costs among Medicaid-Only Beneficiaries with Disabilities

Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations
Cynthia Boyd, Bruce Leff, Carlos Weiss, Jennifer Wolff, Allison Hamblin, and Lorie Martin CHCS DECEMBER 2010

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July 30-31, 2012
5 Step Process for HR HC Patients

Based on our change package and our experience working with teams to re-design care for HR/HC patients we have developed the following 4 step process:

- Step One: Segment & Identify Your HR HC population.
- Step Two: Understand Needs and Root Causes. How do you delve into peoples’ stories’?
- Step Three: Co-create and Execute a Care plan with 5 People. What did you learn about their capabilities?
- Step Four: Scale to 25
- Step Five: Build to Full-Scale

Segmentation
Our Vision: Healthy Oregonians regardless of their income or social circumstances.

- Publically financed health plan for low-income citizens
  - Medicaid: Mom’s and Children, Disabled/Chronically Ill
  - Medicaid/Medicare “Special Needs” Plan
- 180,000 Members
- Not for Profit
- Contracted network
  - 50% Safety Net PCPs
  - Diverse Private practice PCPs
  - Major metro and rural hospitals
- Began building population programs for complex members in 2003
- Participant in IHI Triple Aim Initiative since May 2007

CareOregon Population Segments

- Members who are in the top five or ten percent of health care expenditures
- Members who are served within a regional Coordinated Care Organization (CCO)
- Members who are also receiving regular mental health services from a community mental health agency
- Members who receive primary care from one of 30 practices engaged in the implementation of PCPCH

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Step One: Segment & Identify Your High Risk Population

Identification Methods:
(1) Population-Level
   - Using Claims
   - Using Clinical Data
   - Using Predictive Modeling
   - GIS Mapping

(2) Individual-Level
   - Using Utilization Event Notification
   - Using Clinical Knowledge
   - Using Patient Input
Utilization Threshold Criteria Using Claims Data

Regional Target Population – Three Counties

Cost / Counts Profiles Clinic Assignment - Oregon MCO, as of Nov 2012

<table>
<thead>
<tr>
<th>Utilizer Type Groups</th>
<th># members</th>
<th>% members</th>
<th>Mean Total Paid Per 12 mos</th>
<th>Mean Acute Paid per 12 mos</th>
<th>Mean SS Paid per 12 mos</th>
<th>Total Paid, $ by Utilizers</th>
<th>% Paid Cost, $ by Utilizers</th>
<th>Exp. Per 30 days</th>
<th>Patients, 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non/No/12</td>
<td>11,421</td>
<td>79%</td>
<td>$2,586</td>
<td>$0</td>
<td>$303</td>
<td>$7,356,454</td>
<td>30%</td>
<td>6,239</td>
<td>-</td>
</tr>
<tr>
<td>Non/No/1-5 (takers)</td>
<td>2,543</td>
<td>19%</td>
<td>$5,916</td>
<td>$0</td>
<td>$902</td>
<td>$15,373,141</td>
<td>11%</td>
<td>16,778</td>
<td>-</td>
</tr>
<tr>
<td>Non/No/6+ (takers)</td>
<td>1,421</td>
<td>10%</td>
<td>$10,187</td>
<td>$0</td>
<td>$3,045</td>
<td>$14,100,175</td>
<td>5%</td>
<td>14,707</td>
<td>-</td>
</tr>
<tr>
<td>1-18 month (takers)</td>
<td>214</td>
<td>4%</td>
<td>$9,578</td>
<td>$4,181</td>
<td>$389</td>
<td>$10,415,177</td>
<td>7%</td>
<td>2,764</td>
<td>2,160</td>
</tr>
<tr>
<td>18-59 month (takers)</td>
<td>1,994</td>
<td>45%</td>
<td>$12,905</td>
<td>$7,215</td>
<td>$695</td>
<td>$51,106,911</td>
<td>18%</td>
<td>3,053</td>
<td>2,910</td>
</tr>
<tr>
<td>60+ month (takers)</td>
<td>1,451</td>
<td>4%</td>
<td>$13,126</td>
<td>$7,573</td>
<td>$3,072</td>
<td>$19,448,206</td>
<td>9%</td>
<td>12,234</td>
<td>5,445</td>
</tr>
<tr>
<td>mean age = 41 yrs</td>
<td>47,219</td>
<td>100%</td>
<td>$6,666</td>
<td>$1,326</td>
<td>$429</td>
<td>$285,208,483</td>
<td>100%</td>
<td>$7,115</td>
<td>8,463</td>
</tr>
<tr>
<td>mean AG Per 12 = 31.1%</td>
<td>47,219</td>
<td>100%</td>
<td>$6,666</td>
<td>$1,326</td>
<td>$429</td>
<td>$285,208,483</td>
<td>100%</td>
<td>$7,115</td>
<td>8,463</td>
</tr>
</tbody>
</table>

6178 high cost members/12 mos

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Clinic View of Target Population

Multiple High Volume Complex Patient Clinics

Multnomah County Health Department-NE Clinic Population

<table>
<thead>
<tr>
<th>Population Segment</th>
<th># Members</th>
<th>% Members</th>
<th>Avg Total Paid Cost per Member/12 mos</th>
<th>% Paid Cost/12 mos. of Segment</th>
<th># ED visits</th>
<th># IP Admits</th>
</tr>
</thead>
<tbody>
<tr>
<td>No inpatient/6+ ED visits</td>
<td>81</td>
<td>3%</td>
<td>$8743</td>
<td>5%</td>
<td>786</td>
<td>0</td>
</tr>
<tr>
<td>1 Non-OB inpatient and 0-5 ED visits</td>
<td>97</td>
<td>4%</td>
<td>$18,767</td>
<td>14%</td>
<td>147</td>
<td>97</td>
</tr>
<tr>
<td>2+ Non-OB inpatient OR 1 Non-OB inpatient AND 6+ ED visits</td>
<td>71</td>
<td>3%</td>
<td>$59,440</td>
<td>32%</td>
<td>383</td>
<td>189</td>
</tr>
</tbody>
</table>

10% members = 51% Total Paid Cost/12 mos.

249 high cost members/12 mos.

Using Real-Time Event Notification Instead of Claims Data

The threshold criteria stays the same but the method of identification improves.

- Patient is admitted to ER
- ER posts admission info to FTP site
- CareOregon pulls member data off FTP site
- CareOregon creates daily report of ED admissions and IP admissions
- Patient is admitted to Inpatient Hospital Unit
- Hospital contacts CareOregon for inpatient authorization
- CareOregon processes inpatient authorizations
Using Real-Time Event Notification Instead of Claims Data

CareOregon creates daily report of ED admissions and IP admissions

Reports are sent to providers based on clinic assignment

Reports are sent to HR/HC panel manager at CO who triages and sends to program staff

HR/HC program workflows:
- New participant identification
- Existing program participant f/u

Reports bounce off program registry and auto alerts are sent to program staff for actively enrolled patients

Transition workflows occur in clinics

Using Clinical Knowledge for Identification

Question: How can we use clinical knowledge to target the HR/HC individuals who are more likely to have persistent high costs?

More Likely to Be Persistent
- Admissions related to chronic conditions and co-morbidities
- Acuity and utilization pattern increasing over time
- Knowledge of social & behavioral risk overlay
- Cognitive impairments
- Others??

Less Likely to Be Persistent
- Admissions related to acute conditions
- Good social support and minimal medical and social co-morbidities
- Enrolled in palliative care or hospice
- Others??
Relying on Providers’ Clinical Intuition

Providers/Care Teams as predictive models:

- Who is on a steady health decline trajectory?
- Who, without more intensive assistance NOW, is going end up in the ED or the hospital?
- Who keeps you up at night?
- For whom do you need some extra intel? Eyes and ears in the home?

5 Step Process

- Step One: Identify Your High Risk population.
- Step Two: Understand Needs and Root Causes. How do you delve into peoples’ stories’?
- Step Three: Co-create and Execute a Care plan with 5 People What did you learn about their capabilities?
- Step Four: Scale to 25
- Step Five: Build to Full Scale
Step Two: Understand Needs and Root Causes

- Using data systems
- Using clinic personnel
- Using patient interviews
- Using third party data to understand personal behavioral and economic issues
- Consider GIS mapping

Understanding Root Causes for Risk and Cost
Where is the $$$ going?
% of Total Billed Charges by Service

(State of Oregon Medicaid Data)

2009 Total Billed Charges = $1,630,851,673

Hospitalizations and ER admits amount to 43% of Billed Charges

* Outpatient Behavioral includes mental health services and ER and non-ER chemical dependency services

Very High Prevalence of Mental Health and Addictions
(State of Oregon Medicaid Data)

CareOregon Tri County Claims Data: 21% or 13,440 Adults have 1+ chronic condition PLUS substance abuse or schizophrenia; 3% or 1920 have both.
Understanding Hospital Admissions

CareOregon Non-Dual Hospital Admissions -
Total Paid by Type

- Potentially Avoidable
- Admissions thru the ED
- Elective Admissions
- OB-related Admissions

Effect of Substance Use and Mental Illness on Cost/Utilization

Average 12 mos TOTAL cost, ED and Hosp utilization by group

<table>
<thead>
<tr>
<th>Adults with Diabetes</th>
<th>DM and Substance Use</th>
<th>$18,511</th>
<th>ED visits: 3.9</th>
<th>IP stays: 1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM w/o Substance Use</td>
<td>$8,064</td>
<td></td>
<td>ED visits: 1.3</td>
<td>IP stays: .39</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults with CHF</th>
<th>CHF and Complex Mental Health</th>
<th>$40,651</th>
<th>ED visits: 4.0</th>
<th>IP stays: 2.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF w/o Complex Mental Health</td>
<td>$27,302</td>
<td></td>
<td>ED visits: 1.6</td>
<td>IP stays: 1.4</td>
</tr>
</tbody>
</table>
Understanding Root Causes for Risk and Cost

Understanding the Root Causes: Ask the Care Team

Count of Qualitative Themes from PCP Notes
PCP's were asked: What is driving this patients non-Primary Care utilization?
Understanding Root Causes for Risk and Cost

- Data
- Root Cause
- Care Team
- Patient

Understanding Root Causes: Ask the Patients

15 Case Review Method

1. Identify 15 patients that meet your high risk – high cost criteria
2. Use a semi-structured set of questions to gain insight into patient perspectives
3. Identify similarities, differences, and common themes
4. Come together as a design team/leadership team to discuss what was learned
5. Build next steps based on what you learn

“Act for the Individual to LEARN for the population”
What Did CareOregon Learn About Root Causes?

- High prevalence of childhood and life trauma (relevance of the ACE study); often translates into distrust of health care providers
- Most clients have had an overwhelmingly negative experience with the healthcare system; most clients primarily identify as ill and as a patient
- Prevalence of SA and mental health conditions; mild cognitive deficits common
- Lack of timely access to psychiatric assessment and mental health respite services
- Care coordination needs extensive (particularly between sites of care)
- Many can't afford or do not have access to non-medical items or services critical to optimal health and self-management (i.e., transportation, stable housing, healthy food, medications, place to exercise, etc)

Using root cause analysis to design effective interventions

<table>
<thead>
<tr>
<th>Root Cause</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Not picking up medications vs. taking meds inconsistently or inaccurately</td>
<td>2. Address pharmacy barriers vs. offering coordinated fills, bubble packing, and self-management support</td>
</tr>
<tr>
<td>3. Daily substance use vs. low health literacy</td>
<td>3. Engage in CD treatment vs. health education at appropriate literacy level</td>
</tr>
</tbody>
</table>
Step 2 - In Summary, With Your Identified High Risk Population:

1. Review claims data to see trends and issues
2. Talk to care team who are managing high risk patients
3. Interview high risk patients
4. The goal is to get a better understanding
5. This may cause you to segment the population further

5 Step Process

- Step One: Identify Your High Risk population. Who did you reach?
- Step Two: Understand Needs and Root Causes. How did you delve into peoples’ stories’?
- Step Three: Co-create and Execute a Care plan with 5 People. What did you learn about their capabilities?
- Step Four: Scale to 25
- Step Five: Build to Full Scale

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Step Three: Co-create and Execute a Care plan with People

- Start with what matters to the person
- Include an identified family member or friend in planning discussion if preferred
- Identify the person’s life and health goals together
- Identify the person’s care preferences together
- If the goal is big, start by outlining steps and doing the first step

---

D.T.

COPD
Chronic Heart Failure
Cognitive Impairment
Depression
Type 2 Diabetes

54 year old man who has had multiple hospital admissions for exacerbations of CHF
Who is D.T.?

- Lives alone in a single room apartment, has daughters and an ex-wife who live in other states. Doesn't have a lot of social interaction but has two cats that he adores.
- Cardiology NP refers him to our outreach worker upon discharge. NP goal: no 30-day readmission.
- Everywhere in his chart it is written that D.T. is usually belligerent, uncooperative, non-compliant, and verbally abusive.

Case Study: D.T.

**Resources and Capabilities**
- Good Medicaid insurance coverage
- Committed care team with timely, reliable access
- Stable living situation
- State-sponsored caregiver who D.T. trusts

**Socially Determined Risk Factors**
- Living in poverty
- Low health literacy
- Demonstrates challenging interpersonal behaviors (from care team perspective)
- Demonstrates inability to effectively advocate for himself
- Demonstrates difficulty with basic planning and problem solving (cognitive impairment?)
Case Study: D.T.

<table>
<thead>
<tr>
<th>Patient Goals and Preferences</th>
<th>System Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not like to be hospitalized or referred to the ED</td>
<td>Care providers do not treat him with respect or offer him privacy</td>
</tr>
<tr>
<td>Wants to live alone with his cats</td>
<td>Has not been able to get an appropriate wheelchair</td>
</tr>
<tr>
<td>Likes to be able to get out of his apartment and “move around outside”</td>
<td>Care providers don’t talk to one another</td>
</tr>
<tr>
<td>Desires privacy and respect from care providers</td>
<td></td>
</tr>
<tr>
<td>Wants to be in touch with daughters more frequently</td>
<td></td>
</tr>
</tbody>
</table>

D.T.: Co-Created Care Plan (Part 1)

Plan for D.T.

- With permission, go through D.T.’s cupboards and refrigerator to assess daily diet habits
- Go grocery shopping with D.T. and his caregiver; teach about sodium and fluid related to CHF and connect to his desire to stay out of the hospital; teach about daily weights, offer scale and self management tools
- Role model advocacy with visiting care providers (home health, case worker) by setting up regular visiting times based on D.T.’s preferences; also requiring a phone call prior
- Accompany D.T. to medical appointments to provide care coordination and opportunity to role model “respectful” communication on both sides
- Work with health plan and DME provider to replace wheelchair
- Teach D.T. how to use Facebook to connect with daughters
D.T.: Co-Created Care Plan (Part 2)

- Set ideal dry weight
- Develop Lasix sliding scale protocol – outreach worker to reinforce teaching and appropriate PCP communication
- Refer to outpatient palliative care team
- Develop End-of-Life plan

Acting with the Individual to Learn for the Population

- Building trust/rapport is paramount
- Engaging around what matters to the individual
- Think outside the “medical services” box – what are the socially or behaviorally determined risk factors?
- Who else can help? Recognize that what the individual might need most might be something you are not in the position (or trained) trained to provide
- Don’t forget about the influence of health literacy, esp related to medication management
- Try to step into the shoes of your patient
5 Step Process for High Risk Population

- Step One: Choose a High Risk population.
- Step Two: Understand Needs and Root Causes of that same population.
- Step Three: Co-create and Execute a Care plan with 5 People to learn from them.
- Step Four: Design a system to care for 25 based on learning from working with 5.
- Step Five: Build to Scale

5X Scale-up – Reduce cost and improve care for socially complex

<table>
<thead>
<tr>
<th>Number of people</th>
<th>System issues to address</th>
</tr>
</thead>
</table>
| 5                | 1. ID common system barriers  
                  | 2. Form a team of volunteers  
                  | 3. Find people through referrals |
| 25               | 1. Full time team  
                  | 2. Redesign of practice  
                  | 3. Cooperation of hospitals for data  
                  | 4. Assess outcomes |
| 125              | 1. Grant funding for operations  
                  | 2. Consistent population outcomes |
| 625              | 1. ?? |
| 3125             | 1. ?? |
| 15,625           | 1. ???
Step Four: Scale to 25

- Take the learning from working with 5 individuals and see if you can scale it up to 25. At this point you are now going to have to think about larger programmatic issues. If you haven’t already done it, you should be deciding how many people are in this high risk population that you will ultimately want to impact. Knowing this long-term goal is very important as you start to scale up.

Support Elements as you Scale Up

- 1. Non-traditional Health Care Workers
- 2. Case Managers who are often RN’s
- 3. Pharmacy Support
- 4. EMR as tool for communication and coordination
- 5. Primary Care Access
- 6. Retraining of any of the above
- 7. Community and Social Service resources
- 8. Integration of the support team
- 9. The family and individuals role in this work
Scale-Up Issues

- Staffing/Resourcing the work
- Beginning to standardize some of the work
- Understanding and learning about the work (How do I know a change is an improvement?)

Staffing and Resourcing

- At 25x, it will take more than just part of someone’s regular FTE
- At 25x, you should think about this as a true pilot; an opportunity to demonstrate an effective new model
- Consider reallocating an existing employee for a period of time, borrowing or collaborating with staff from a partner agency or another department
- Communicate to leadership that this is a demonstration project worthy of resourcing for a temporary period of time
Beginning to Standardize

- In order to evaluate results, some standardization is necessary so that you know what you are evaluating
- Examples:
  - Enrollment/eligibility criteria
  - Intervention timespan
  - Care planning elements
  - Documentation/tracking strategy

Example of Early Standardization

<table>
<thead>
<tr>
<th>Community Care Program: Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>One non-obstetric hospital admission or 6+ ED visits within past 12 months</td>
</tr>
<tr>
<td>Must be receiving primary care from a participating clinic</td>
</tr>
</tbody>
</table>
Example of Later Standardization

<table>
<thead>
<tr>
<th>PRIMARY ACTIVITIES of ENCOUNTER (Select all that Apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Gathering</td>
</tr>
</tbody>
</table>
| This happens in encounters including Consultation or ongoing client interactions. This does not include the Assessment process (as there is no interaction during that time), but focuses on the stages of Outreach and Engaged.
| Periodic Check-In with Client                          |
| This refers to meetings to touch base, check-in, or otherwise meet with client to find out what is going on in their lives.
| Skills / Problem Solving Training                      |
| This includes skills regarding their specific health conditions, self-management skills, problem solving skills, and training for other skills.
| Motivational Interviewing                              |
| Mark when used as a primary activity                   |
| Life-Enriching / Health Promotion Activity             |
| Both activities for life enriching (bobby-based activity, social integration, etc.) and activities supporting their health (walking, swimming, signing up for gym, beyond Dr. appt).
| ADL Support                                            |
| Supporting their Activities of Daily Living (walking, bathroom activities, removing lice, housing needs, etc.)
| Medication Management                                  |
| Mid reconciliations, reviewing information about meds, what meds to take/when, setting up or sorting out bubble packs, etc.
| Physical Assessment                                    |
| Outreach RN, as appropriate per client’s clinical condition
| Multidisciplinary Assessment                           |
| Getting people together in one room – step beyond Care Coordination
| Health Education / Health Literacy                     |
| Talking to the client about their health, helping them read an EMR, disease-specific information and training (e.g., how to administer insulin), disease management skills, taking vitals and weight, etc.
| Community Resources Education                          |
| Educating client on how to navigate various systems: housing, SSI, Aging and Disabilities, etc.
| Insurance Education                                    |
| Educating client on their CareOregon insurance benefits and options.
| External Advocacy                                      |
| Housing, A&D, etc.                                     |

Measurement and Learning

- At 25x-125x you cant create “peer-reviewed” results BUT you can demonstrate a clear improvement trend that may influence future resourcing and practice.
- Must have a measurement and learning strategy BEFORE you start.

Example to follow
Learning as we go…

**Community Care Program**
*Multidisciplinary Case Rounds*

- Once per week, all outreach workers assemble to discuss 2-3 challenging client cases
- Staffed with program managers/supervisors, peer mentors, and clinical consultants (psychiatrist, pharmacists, nursing)
- Multiple perspectives are discussed, clinical guidance is offered
- Peer outreach workers share their own emergent best practices and give each other support
- Patterns begin to emerge that can be applied to a broader segment of the population…...*client typologies and best practices*

**Other Learning System Ideas**

- Track progress using sticky notes & visual management system
- Create an excel database
- Interview providers and patients to learn about impact
- Get project staff together once per week to review data Conduct intentional PDSA cycles – document results
- Learn from individual patients – pay attention to themes
Learn From Individual Cases: William

- Chronic Heart Failure
- History of Addiction to IV Drugs and Alcohol
- COPD
- Developmental Disorder
- Schizoaffective Disorder
- Hepatitis C
- Intermittent Homelessness
- Type 2 Diabetes

October 2011: Admitted to the hospital for almost a month for acute complications of his Chronic Heart Failure. Had a previous 25 day admission 5 months earlier.

66 Year Old African American Man

What did we learn from William?

- Social isolation is a huge risk factor for our population
- Pay attention to the outliers – usual CHF hospitalization is 5.4 days, but William was in for almost a month. Why?
- Sometimes it takes focused advocacy to get an appropriate level of state and county assistance – William had benefits due to his DD that were not being provided; he slipped through the cracks
- Housing = health care (duh!); hard to expect anyone to be adherent on medications if they have unstable housing
Earliest Measurement System

Became this...

<table>
<thead>
<tr>
<th>Data</th>
<th>Indicators Type</th>
<th>Pre-IDU Data</th>
<th>Post-IDU Data</th>
<th>Pre-IDU Trends</th>
<th>Post-IDU Trends</th>
<th>E</th>
<th>Post-IDU Periods</th>
<th>Pre-IDU Periods</th>
<th>Pre-IDU Periods</th>
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<tbody>
<tr>
<td>A</td>
<td>Hospital</td>
<td>0</td>
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Institute for Healthcare Improvement
Innovation College
July 30-31, 2012
Step #5: Scale to 125, or Build to Full Scale

- At this point you have a program that will need a care design, consistent funding source, dedicated staffing, and an evaluation plan
- Determine full scale at project setup and the milestones to reach full scale

What is Full Scale?

- 850,000 = Medicaid beneficiaries in Oregon (15 Community Care Organizations, largest approximately 160,00 beneficiaries)
  - 5% high risk/high cost = 42,500 (largest CCO = 8,000)
  - top 1% = 8,500 (largest CCO = 1,600)

- Estimating frail older adults in a community of 100,000
  >65yrs of age = 13,000 (100,000 x 13% over 65 years of age)
  # of frail older adults = 650 to 1300 (13,000 x (5 to 10%))

What is your best estimate of full scale?
Enhanced Primary Care Support Systems for HR/HC Patients

- A high cost intensive model that is supported by nurse care management (among other resources) along with primary care that often limits their work to a relatively small panel of patients. (Ambulatory ICU)
- A model that primarily focuses on the redesign and retraining of the primary care team. (Southcentral Foundation)
- A model that enhances really good primary care with a new skillset – non-traditional health care workers that take their assistance into the community for HR/HC patients. (CareOregon)

Community outreach workers are paired with primary health homes and specialty practices to enhance the practices’ ability to provide individualized ‘high touch’ support to patients with exceptional utilization

- Staff are hired for engagement skills, compassion, non-judgmental attitude, outreach experience
- Focus is on the social determinants that drive high-cost medical utilization
- Outreach worker is incorporated as part of the practice team, but also has identity with a larger community of practice

- High PCP/Specialist involvement
- Documentation occurs in the practice’s EMR; population view and process metrics stored in a community care registry
- Voluntary Program
Major Change Areas for HRHC

- Patient Identification/recruitment
- Patient Engagement
- Caring for Patients
- Community Support

Structural Issues

- Information technology
- Human resources (i.e. workforce organization and capabilities)
- Financial
- Learning system
- Physical (e.g. space, equipment, capacity)
## System Perspective

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