Session Objectives

- Use an understanding of root causes to design services for a vulnerable population segment

- Build a sustainability plan using a portfolio of measures that demonstrate value to funders

- Activate partners to create a community-organized population health effort and mobilize a nontraditional health care workforce to meet social and behavioral needs
Oregon’s Health Care Transformation

“Coordinated Care Organizations” (HB3650)

- “CCOs” established for Medicaid with bipartisan support, June 2011
  - Response to 2008 Great Recession budget crisis / shortfall
  - Now cover 95% of Oregon Medicaid enrollees

- 16 Regional CCOs with Global Budgets – at risk for all Medicaid physical, behavioral and dental health costs
  - Must hold costs within low trend (3.4%)
  - Key “levers”
    - Governance by “all components of the health care system”
    - Care Integration across current silos
    - Payment reform / flexibility
    - Focus on “High Utilizers”
    - Coordination with community social services
  - P4P 3% withhold for quality, cost, patient experience measures

Health Share of Oregon

- Largest CCO – providers from tri county region around Portland
  - 4 Medicaid Managed Care Plans
  - 3 County Based Medicaid Mental Health Organizations
  - 8 Dental Health Organizations

- Network
  - Hospitals / Hospital systems; providers

- 240,000 Medicaid members
  - 53% increase in enrollment since ACA expansion (82k)
“Health Commons” Grant Award: July 2012
“A springboard for change”

- Build a regional system of care for adult “high utilizers”
- Leverage existing relationships
- Scale up current interventions at different high acuity touch points
- Build infrastructure: IT platform, common metrics, communication pathways
- Build common clinical leadership

What We Have Accomplished

- **Improving Hospital Discharge Handoffs:**
  - For Medical Admit / Primary Care
    - Redesigned D/C summary and Primary Care Follow Up
    - Spread high risk transition teams
  - For Psychiatric Admits
    - Spread intensive transition teams for those without established community mental health relationship
  - For Emergency Dept
    - Spread “ED Guide” program with increasing focus on Medicaid
What We Have Accomplished

• **Community Based Care**
  – Established a new out reach workforce to better connect high needs Medicaid enrollees with their providers and practices
    • Including a growing number of peer outreach workers from community based peer organizations
  – Established a Tri county 911 team for frequent users of the EMS system
  – Established an Emergency Dept Based team for frequent ED users with intensive behavioral health needs

What We Have Accomplished:

• **Created A Learning System based on data**
  – Built a “population management system,” PopIntel (CareOregon) to track work and integrate effort
  – Partnered with Center For Outcomes Research and Education (Providence CORE) for evaluation and reporting
    • Ongoing quantitative and qualitative feedback to identify “optimal impact” and refocus work

• **Created a regional “collective impact” structure:**
  – Collaborative effort of 6 Hospitals, 17 Clinics, 3 BH Organizations, 4 Community Organizations
  – Created 75 FTE (104 people)
  – “Touched:” 10,577; 3200 in intensive case management

What “High Needs / High Cost” Patients (aka “High Utilizers”) Have Taught Us

- It is not “What’s wrong with them”... but “What has happened to them:"
  - High prevalence of reported “Adverse Childhood Events”
    - ACE score >4 correlates with increased drug use including IVDU, mental illness / suicide, partner violence; >6, earlier death
  - Need to formally train staff on Trauma Informed Care

- Formal qualitative study of “Adverse Life Events”

“High Utilizers”: What We Knew...

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
What Did We Learn About The Prevalence of Adverse Life Experiences?

47% Suffered repeated physical, sexual or emotional abuse in childhood
23% Lived with an adult with a substance abuse issue
30% Were separated from parents
50% struggled in school
50% dropped out of school
33% Ran away or left home early
27% Became teen parents
37% Became homeless at some point
60% Became substance abusers
27% Were incarcerated at some point
90% Report job insecurity
30% Become unable to work at all
43% Were separated from their children

What the Numbers Tell Us

In short: program participants have led extraordinarily difficult lives

63% Struggle with mental health conditions
93% Describe struggling to get needed healthcare
33% Struggle to manage their medication
47% Describe being socially isolated

Health Resilience Program

Community Clinics and CareOregon Partner to Improve Care for Vulnerable Members

Health Resilience Specialist Mayela Torres and Client Brent Lamp
WHY the Health Resilience Program?

• Highest cost members were not getting needs met with previous approaches
  – Telephonic case management
  – PCR & PC3 – clinic-based care management

• Because they contribute as much as 60% to our annual health care expense, largely driven by ED and Hospital admissions, some of which are avoidable

• Social values

Curtis Peterson, Health Resilience Specialist
Gordon Rasmussen, Client

Data Exploration to Define Regional “high utilization” Criteria

All CareOregon Medicaid Adults (19yrs+) living in TriCounty Area

<table>
<thead>
<tr>
<th>Utilizer Type Groups</th>
<th>% Mbrs</th>
<th>% Paid TOTAL Paid Cost</th>
<th>12mos</th>
</tr>
</thead>
<tbody>
<tr>
<td>No inpt / 0 - 3 ED</td>
<td>70%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>No inpt / 2 - 5 ED visits</td>
<td>13%</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>No inpt / 6+ ED visits</td>
<td>3%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>1+ OB inpt ONLY</td>
<td>5%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>1 nonOB inpt / 0 - 5 ED visits</td>
<td>6%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>2+ nonOB inpt / 1 nonOB inpt / 6+ ER visits</td>
<td>4%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13% of CareOregon members (6178) = 52% of paid cost

MCHD NE Clinic CareOregon Medicaid Adults (19yrs+) Assigned to MCHD NE

<table>
<thead>
<tr>
<th>Population Segment</th>
<th># Mbrs</th>
<th>% Mbrs</th>
<th>% Paid Cost/12 mos</th>
</tr>
</thead>
<tbody>
<tr>
<td>No inpt / 0 - 3 ED</td>
<td>81</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>1 nonOB inpt &amp; 0 - 5 ED visits</td>
<td>97</td>
<td>4%</td>
<td>14%</td>
</tr>
<tr>
<td>2+ nonOB inpt OR 1 nonOB inpt &amp; 6+ ER visits</td>
<td>71</td>
<td>3%</td>
<td>32%</td>
</tr>
<tr>
<td>249</td>
<td>10%</td>
<td>51%</td>
<td></td>
</tr>
</tbody>
</table>

10% of CareOregon members (249) = 51% of paid cost
New Primary Care Workforce and New Clinical Models

Health Resilience Specialists (Master’s level Social Workers) are embedded with primary health homes and specialty practices to enhance the practices’ ability to provide community-oriented individualized ‘high touch’ support to high risk/high cost patients

- Basic Needs: food, shelter, safety, ADLs
- Supportive relationships
- Trauma recovery
- Hope & Purpose
- Integrated with Primary Care Team
- Care Coordination with Specialists & MH providers
- Health risk behaviors
- Cognitive / coping skills
- Health literacy

Who is Jake?

- 30 yr old male
- New to health plan
- At time of engagement:
  - Homeless (July 2013)
  - 19 ER visits since April 1
  - EMR Note stating “Aggressive Behavior”
Jake’s “Problem List”

Alcohol dependence in remission
  Self-injurious behavior    Hand Pain
Renal calculi            Cannabis abuse
  Antisocial personality disorder
Vaccine refused by patient
  ICH    Benzodiazepine abuse, continuous
  GAD (generalized anxiety disorder)
Noncompliance with medication treatment due to overuse of medication
  Acute bronchitis
  Bipolar disease, manic
Drug-seeking behavior    Hand fracture    Panic disorder
  PTSD (post-traumatic stress disorder)

Health Resilience Specialist Competencies

- Extensive outreach experience
- Mental health & SUD knowledge and comfort
- Understanding of trauma and trauma informed care
- Social justice values; compassion and empathy
- Culturally competent
- Exceptional advocacy and interpersonal skills
- Ability to set professional boundaries with compassion
- Training: MSW, LCSW, LPC
- High Motivational Interviewing aptitude
Human-Centered Program Learning

- Deep knowledge about these patient’s lives helps us know where to focus our attention (on the root causes):
  - Recognize and address trauma hx, social isolation, and anxiety/depression/chronic pain
  - Build addiction recovery pathways & connect with peer support specialists who have had “lived experiences”
  - Address unstable housing
- Treat them with compassion and cultural competence, to include a deep understanding of the effects of intergenerational poverty
  - Debunk the myths about high utilizers:
    - They are free loaders
    - They don’t take responsibility for their care
    - They are emotionally dependent on the ED
- Honor them as survivors and resilient

Current Program Structure

- Centralized Payer Infrastructure
  - Staff are employed by Payer
  - "Community of Practice" – local and national
  - Learning System and Peer Support
  - Clinical & program supervision
  - Data and Evaluation
  - Program Development
  - Onboarding, orientation and workforce development
    - Triage
    - Health plan liaison
    - Population view
- Primary Care Clinic
  - Staff are deployed into clinics
  - Medical Oversight
  - Integration with primary care team & services (multidisciplinary village)
  - Continuity of relationship
  - Delivery system view
  - Hub for patients
  - Critical referral sources
- Hooper Detox
- Specialty Clinic

Co-Designed Hub & Spoke Model
Health Resilience Clients
Clinical Assessment at Intake  N=275

- Active MH Condition
  - Yes: 64%
  - No: 36%

- MH Condition
  - PTSD: 31%
  - Anxiety: 51%
  - Depression: 75%

- Chronic Pain
  - Yes: 42%
  - No: 58%

- Hx of Trauma
  - Unknown: 42%
  - Yes: 55%
  - No: 3%

- Active Trauma
  - Unknown: 16%
  - Yes: 54%
  - No: 30%

- Depression
  - Yes: 55%
  - No: 4%

- Anxiety
  - Yes: 31%
  - No: 7%

- PTSD
  - Yes: 17%
  - No: 20%

Health Resilience Program
% of Clients Outreached to who Successfully Engaged

- Cumulative # Unique Clients with 1+ Outreach Attempts
  - As of Mar 31, 2013: 385 (77% Engaged)
  - As of Jun 30, 2013: 680 (67% Engaged)
  - As of Sept 30, 2013: 952 (66% Engaged)
  - As of Dec 31, 2013: 1,140 (68% Engaged)
  - As of Mar 31, 2014: 1,300 (70% Engaged)
  - As of Jun 30, 2014: 1,493 (70% Engaged)

Launch of Online Registry – More reliable data collection
Utilization Rates for HRP cohort

Primary Care Visit Rates for HRP
Outpatient Behavioral Health Visit Rates for HRP (excludes Medicare)

Provider & Care Team Survey

Overall Rating of Value

What number would you use to rate the VALUE of having a Health Resilience Specialist in your clinic to work with patients who have complex medical and/or psychosocial issues?

Average Rating on 0 - 10 scale
0 = No value at all; 10 = Absolutely Essential

Number of VALID respondents

| TOTAL | 117 | 9.1 |

n= 424 clients engaged in program on or before 9/1/13
### Improved Care Processes

Having a Health Resilience Specialist in our clinic working with patients who have complex medical and/or psychosocial issues has helped to . . .

\[ n = 117 \]

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improve transitions</strong> btw acute care settings and primary care</td>
<td>33%</td>
<td></td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td>Increase our <strong>capacity to coordinate care</strong> on behalf of these patients</td>
<td>25%</td>
<td></td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td><strong>Reduce appointment ‘No Shows’</strong></td>
<td>30%</td>
<td></td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td><strong>Foster a deeper understanding</strong> of these patients' needs</td>
<td>26%</td>
<td></td>
<td>68%</td>
<td></td>
</tr>
</tbody>
</table>

### Improved Efficiency & Lower Clinic Stress

Having a Health Resilience Specialist in our clinic working with patients who have complex medical and/or psychosocial issues has helped to . . .

\[ n = 117 \]

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduce time</strong> required to care for these patients</td>
<td>24%</td>
<td></td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td><strong>Reduce the stress or burden</strong> associated w/ care for these patients</td>
<td>19%</td>
<td></td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td><strong>Improve the efficiency</strong> of our clinical teams when caring for these patients</td>
<td>23%</td>
<td></td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td><strong>Increase the overall job satisfactions among our clinic staff</strong></td>
<td>29%</td>
<td></td>
<td>57%</td>
<td></td>
</tr>
</tbody>
</table>
**Improved Health Related QOL**

The Health Resilience Specialist(s) work with patients in our clinic has helped those with complex medical and/or psychosocial issues to . . .

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage their chronic health conditions more effectively</td>
<td>36%</td>
<td>52%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Become more involved in their own health and health care</td>
<td>33%</td>
<td>56%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase their level of social connectedness</td>
<td>31%</td>
<td>57%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve their functional status and quality of life</td>
<td>36%</td>
<td>55%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain and/or work toward sobriety</td>
<td>32%</td>
<td>48%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**“Advanced Primary Care”**

- Dedicated team coordinating efforts around “high needs” patients pioneered by OHSU Family Medicine at Richmond.
  - Centralized team with MD Clinical Champion, Health Resilience specialists, behaviorist, RN care coordinator, panel manager
  - Serves as resource to all other clinic teams for identified high needs “REaCH” patients
  - Central coordination point for hospital and ED coordination and follow up
  - Provider new specialized services: DBT and Seeking Safety Groups

- “Advanced Primary Care” Collaborative follows
  - CareOregon and Health Share partner to support multiple primary care practices in building similar dedicated “high needs” teams
Asking Questions, Changing Course

**Target Population**
Recent program evaluation: We have the most success with the very highest utilizers...why?

**Reviewing Data**
Who were we most successful engaging?
Who were we not successful with?
What did we miss?

**Expanding Peer Services**
How do we build a long-term “Recovery Pathway?”

**Strengthening Coordination**
Who else needs to be along the pathway?

**Engaging the System**
How do we integrate more addictions training & better system coordination?

---

The sustainability equation

- The CO Board cared most about how the health system and network viewed the program
- They also cared a lot about how the program was changing lives
- Finally, they were assured that the program is paying for itself and is touching a significant number of members
What Does This Mean For Improving Medicaid Health Outcomes?

Is a Medicaid “high utilizer” program really a “trauma recovery” program?

- Adding a “case manager” to the best medical home team is likely not enough
- “Advanced primary care:” specialized teams with clinicians, behaviorists, Health Resilience Specialists, RN care managers, Peer Support Specialists…
  - Dialectical Behavioral Therapy (DBT) groups; Seeking Safety Groups; EMDR
- Other? Other community models (eg Native American…)

“Population Centered Design”
Not all “high utilizer” groups are the same

Determinants of Health Outcomes:

- Medical System Determinants
  - Access
  - Quality
  - Safety
  - Integration
  - Patient Centricity
  - Proactivity

- Social Environmental Determinants
  - Adequacy of basic supports (food, shelter)
  - Supportive relationships

- Individual Behavioral Determinants
  - Health risk behaviors
  - Cognitive / coping skills
  - Health conditions
The Challenge for Medicaid (at least)...

While the US spends the most for health care services, it spends less on social services than most developed countries. (Bradley, The American Health Care Paradox)

- US spends less than 10% of GDP on social services vs France, Sweden, Austria, Switzerland, Germany, Italy all of whom spend about 20% (OECD av17%)
  - Total health care and social service GDP expenditure is also less in US than these countries
- Forging alliances with social services will be critical
- Finding ways to enhance social services will be critical
- How do we create truly bio psychosocial “coordinated care?”

Population Centered Design: Medicaid

- Patients with few resources to deal with health issues
- Usually complex physical, mental health and/or addictions issues

- May lack basics for self care (food/housing)
- Unsafe communities; Stressed families
- Poor social supports

- High prevalence of risk behaviors
- Learned distrust of “systems” being marginalized, vulnerable; easily triggered, over reactive
- Self medication for chronic stress with street drugs
- Low sense of self worth, efficacy
- Low health literacy
Population Centered Design: Commercial

- Patients with complex medical conditions
- Usually with adequate social / personal resources

- Major cost driver is medical system dysfunction:
  - Uncoordinated care across silos
  - Volume based payment
    - Redundancy
    - Over Medicalization
  - Failure to orient to patient goals
  - Discontinuous transitions
  - Access barriers

- Patient activation
- Self management for chronic conditions
- Wellness behaviors

The Challenge for Medicaid (at least)...

- While the US spends the most for health care services, it spends less on social services than most developed countries.
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Thank You!

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