C9: Building Enhanced Primary Care Teams For High Needs Patients

David Labby – Chief Medical Officer, Health Share of Oregon
Rebecca Ramsay – Director of Community Care Programs, CareOregon

IHI Summit
Tuesday, March 17
9:30-10:45

Session Objectives

- Design services for a vulnerable population segment based on understanding the root cause of risk
- Mobilize a nontraditional health care workforce to meet social and behavioral needs
- Build a portfolio of measures and evidence that demonstrates sustainable value to stakeholders and funders
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)
Clinical Transformation
Change the delivery system
Decrease overtreatment
Increase reliability
Improve patient-centeredness
Address social determinants

Administrative Transformation
Align incentives to achieve the Triple Aim
Simplify administrative services for providers and members

Risk & Payment
Align incentives to achieve the Triple Aim

“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

- **Community Based Care**
  - Established a new “out reach” workforce to better connect high needs Medicaid enrollees with their providers and practices
    - Mainly based in primary care practices as part of new PCPCH high needs teams
    - Includes a growing number of peer outreach workers from community based peer organizations
    - Includes a Tricounty 911 team for frequent users of the EMS system

• Community Based Care

"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 People with High Needs (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

• Formal qualitative study of “Adverse Life Events”
“High Utilizers:” What We Knew...

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 0-6 yo
50% struggled in school

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

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 30+ yo
47% Describe being socially isolated

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
Adverse Life Events: Cumulative Burden Across Life Span

- Abuse: Emotional, Physical, Sexual
- Substance Use: Drugs, Alcohol
- Abandonment
- Traumatic Loss
- School Failure
- Job Failure
- Homelessness
- Incarceration

Self reported life events from 30 Medicaid "High Utilizers" enrolled in intensive management program

Age Greater Than 30

<table>
<thead>
<tr>
<th>Age Greater Than 30</th>
<th>0-4</th>
<th>5-12</th>
<th>13-19</th>
<th>20-30</th>
<th>30+</th>
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<tbody>
<tr>
<td>0-4 AHA</td>
<td>Abuse (4)</td>
<td>Maltreatment (3)</td>
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Adverse Life Events: Cumulative Burden Across Life Span

- Abuse: Emotional, Physical, Sexual: 70%
- Substance Use: Drugs, Alcohol
- Abandonment
- Traumatic Loss
- School Failure
- Job Failure
- Homelessness
- Incarceration

Self reported life events from 30 Medicaid "High Utilizers" enrolled in intensive management program

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Self reported life events from 30 Medicaid "High Utilizers" enrolled in intensive management program
### Adverse Life Events: Cumulative Burden Across Life Span

- **Abuse:** Emotional, Physical, Sexual: 70%
- **Substance Use:** Drugs, Alcohol: 60%
- **School Failure:** 60% do not graduate HS; 1 College Grad
- **Job Failure:** none fully employed
- **Homelessness:** 23%
- **Incarceration:** 30% in jail/prison; 17% “been arrested”

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Self-reported life events from 30 Medicaid “High Utilizers” enrolled in intensive management program

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### Health Resilience Program

Community Clinics and CareOregon Partner to Improve Care for Vulnerable Members

Health Resilience Specialist Mayela Torres and Client Brent Lampa
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

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/12 mos</th>
</tr>
</thead>
<tbody>
<tr>
<td>No inpt / 0-1 ED</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>No inpt / 2 - 5 ED visits</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>No inpt / 6+ ED visits</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>1+ OB inpt ONLY</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>1 nonOB inpt / 0 - 5 ED visits</td>
<td>6%</td>
<td>18%</td>
</tr>
<tr>
<td>2+ nonOB inpt OR 1 nonOB inpt/6+ ER visits</td>
<td>4%</td>
<td>29%</td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
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</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 / 6+ ER visits</td>
<td>81</td>
<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>1 nonOB inpt &amp; 0-5 ED visits</td>
<td>97</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>2+ nonOB inpt OR 1 nonOB inpt/6+ ER visits</td>
<td>71</td>
<td>3%</td>
<td>32%</td>
</tr>
<tr>
<td>249</td>
<td>10%</td>
<td>51%</td>
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</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)

What Happened?

- Built trust: listened, transparency, client’s pace
- Identified goals: new PCP and stable housing
- Plan ahead: communicate future steps
- Check for understanding
Health Resilience Specialist Competencies

- Extensive outreach exp
- Mental health & SUD knowledge and comfort
- Understanding of trauma and trauma informed care
- Social justice values; compassion and empathy
- 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

Co-Designed Hub & Spoke Model

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

Primary Care Clinic

Primary Care Clinic

Primary Care Clinic

Primary Care Clinic

Health Resilience Clients

Clinical Assessment at Intake  N=275

Active MH Condition
- MH Condition
  - PTSD Yes 64% 31%
  - Anxiety Yes 51%
  - Depression Yes 75%

Chronic Pain
- Yes 42%
- No 58%

Hx of Trauma
- Unknown 42%
- No 3%

Active Trauma
- Unknown 16%
- No 30%
- Yes 54%
## Health Resilience Program

% of Clients Outreached to who Successfully Engaged

<table>
<thead>
<tr>
<th>Date</th>
<th>Unique Clients with 1+ Outreach Attempts</th>
<th>Engaged</th>
<th>Engaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/31/2013</td>
<td>385</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>6/30/2013</td>
<td>680</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td>9/30/2013</td>
<td>952</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td>12/31/2013</td>
<td>1,140</td>
<td>68%</td>
<td></td>
</tr>
<tr>
<td>3/31/2014</td>
<td>1,300</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>6/30/2014</td>
<td>1,493</td>
<td>70%</td>
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</tbody>
</table>

- **Launch of Online Registry** = More reliable data collection

## Utilization Rates for HRP cohort

### ED Visits - PMPY

<table>
<thead>
<tr>
<th>Date</th>
<th>Utilization Rate</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 mos PRE</td>
<td>4.9 PMPY</td>
<td>-</td>
</tr>
<tr>
<td>6 mos POST</td>
<td>4.8 PMPY</td>
<td>+34%</td>
</tr>
</tbody>
</table>

### non-OB Inpt Stays PMPY

<table>
<thead>
<tr>
<th>Date</th>
<th>Utilization Rate</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 mos PRE</td>
<td>1.6 PMPY</td>
<td>-</td>
</tr>
<tr>
<td>6 mos POST</td>
<td>1.1 PMPY</td>
<td>+35%</td>
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</table>
Primary Care / Behavioral Health Visit Rates

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?

Number of VALID respondents

| TOTAL | 117 | 9.1 |

Average Rating on 0 - 10 scale
0 = No value at all; 10 = Absolutely Essential
**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**
  - Improve transitions btw acute care settings and primary care: Disagree 33%, Neutral 59%, Agree 25%
  - Increase our capacity to coordinate care on behalf of these patients: Disagree 25%, Neutral 69%, Agree 30%
  - Reduce appointment 'No Shows': Disagree 30%, Neutral 48%, Agree 26%
  - Foster a deeper understanding of these patients' needs: Disagree 26%, Neutral 68%, Agree 30%

**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**
  - Reduce time required to care for these patients: Disagree 24%, Neutral 49%, Agree 25%
  - Reduce the stress or burden associated w/ care for these patients: Disagree 19%, Neutral 65%, Agree 23%
  - Improve the efficiency of our clinical teams when caring for these patients: Disagree 23%, Neutral 61%, Agree 23%
  - Increase the overall job satisfactions among our clinic staff: Disagree 29%, Neutral 57%, Agree 23%
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>
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<tbody>
<tr>
<td>Manage chronic health</td>
<td>36%</td>
<td></td>
<td>52%</td>
<td></td>
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<tr>
<td>conditions more effectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Become more involved in their own health and care</td>
<td>33%</td>
<td></td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>Increase level of social connectedness</td>
<td>31%</td>
<td></td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>Improve their functional status and quality of life</td>
<td>36%</td>
<td></td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Maintain and/or work toward sobriety</td>
<td>32%</td>
<td></td>
<td>48%</td>
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“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?

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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

“Bio psychosocial model”
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.
  - 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 and finding ways to enhance social services will be critical
  - How do we create truly bio psychosocial “coordinated care?”

Thank You!
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www.healthshareoregon.org
www.healthcommonsgrant.org