C28: Life in a Global Medicaid Budget: One Year Later

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These presenters have nothing to disclose.

Objectives

- Learn how community partners support engagement with providers to support the Triple Aim
- Understand the care and feeding of community partnerships
- Learn how the economic model encourages engagement and supports outcomes
- Explore how the person-centered medical home supports population health
- Leverage our first year experiences to guide your journey
Poverty with a view

150 miles north to south

250,000 residents, expected to grow to 300,000 by 2019

Approximately $275 million coming into the community through the Coordinated Care Organization

53,000 Medicaid (Oregon Health Plan) beneficiaries in Deschutes, Jefferson, Crook and part of Northern Klamath and Lake counties

More than 50% are children

Top 5% account for most of the spend—primarily complex adults

Primary industries are tourism and healthcare

Largest number of breweries per capita in the US

Central Oregon Health Council

Creating America’s healthiest community, together.
Vision: the Triple Aim

Creating America’s healthiest community, together.

Development of the COHC

Transforming health in Central Oregon

Creating America’s healthiest community, together.
Central Oregon Health Council

The COHC is the governance body of the CCO.
The councils of the COHC report to the COHC and are advisory to the CCO.

Economic overview

Global Budget from State to CCO
(CCO is Insurance Company guided by COHC)

CCO – 8.5% Admin Fee
Provider contracts - 5 key domains for remaining 91.5%

Hospital Capitation  PCP Capitation  Specialist FFS  Dental  Mental Health

Contract Surplus – 50% providers / 50% returned to COHC
Hospital performance metrics

SOURCE OF FUNDS: 20% WITHOLD ON HOSPITAL SERVICES

50% TO HOSPITALS

PERFORMANCE METRICS

50% utilization measures
- 5% Length of stay
- 15% Readmissions
- 15% ED visits
- 15% ED follow up with PCP

50% process development
- 10% SBIRT
- 10% Narcotic “to-go” packs
- 10% C-Section
- 10% C-Diff
- 10% Mental Health follow up after ED

50% TO PHYSICIANS

Contract negotiation considerations

- What is economic comparison to assess performance?
- When does FFS-equivalency mindset change? Should it?
- Hospital and providers – negotiate together (or not) with CCO?
- What is included in capitation rate? Is stop-loss needed?
- Do rate increases drive access?
- Does it take a village to establish performance metrics?
Readmission risk assessment
• RN case management evaluates every Medicaid inpatient admission and conducts readmission risk assessment; high/moderate risk assessments are faxed to RNCC at the appropriate clinic, and a phone call is made to RNCC for a formal hand off; high risk assessments for SCMG patients are also faxed to Adult High Risk Nurse Navigator

Clinic referral
• Referral by any member of care team working with patient who identifies a need that another member may be able to address (CHW, RNCC, Nurse Navigator); testing validity and usefulness of high Truven score list, patients are referred to CHW’s for follow up and continuity of care

ED utilization
• EDIE identification (6 visits within 6 months); early identification via utilization risk assessment prior to 6 visits/6 months

Identifying our care model

Our model: Primary Care Wrap-Around
• We have primary care services with RNCCs and Providers, but we also have CHWs that go out into the community, we have Nurse Navigators that also work out in the community and outpatient, and we are going to pull away from offering so much support to Bridges (which is the Ambulatory ICU)

Models From Change Package:
• A: Ambulatory Care ICU
• B: Primary Care Wrap-Around
• C: Community Collective Impact Approach
St. Charles Family Care

Development of Medical Home
All sites approved by OHA as Tier 3 MH
RN Care Coordinators
Embedded Behavioral Health Providers (Psychologists)
Community Health Workers
Pharmacy support
Many support staff now directed to helping with the OHP population and risk contract-link between ED and clinic
ED diversion and CHW (big cost in some communities)

Would like to add:

Social Workers
Exercise/Trainers
PT/OT
Health coaches
Integrated EMR
Best Risk Prediction Tool integrated into EMR
(Milliman? Truven? Etc.)
For our 10,000 integrated lives/SCMG population:

Medical Management of OHP list and access

Fastidious review of referral and covered conditions

Had to develop our own chart review and workflow for referrals and special testing (MRI)

Informed chart review according to regional patterns

Highest rates of back/neck surgery and interventions in Dartmouth Atlas—so look in the places where the $$$ are greatest and poor ROI

Informed patient care management

<table>
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<th>Region</th>
<th>Inpatient Back Surgery per 1,000 Medicare Enrollees, by Gender</th>
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Robin’s learnings from the community perspective

Move the money closer to the patient—including the decisions about how we spend it

Don’t let perfection be the enemy of good

In order for experiments to scale, align incentives and outcomes—follow the money

Mind and body are connected, and teeth are in the mouth

Change is personal—and it’s hard—and it has to happen

Jenn’s economic and contract learnings

• Need understanding of COHC expectation for surplus to reinvest
• Rate setting and how rate increases and decreases need to be associated with quality and outcomes
• Change mindset off of fee for service
• Longer term tie to the Triple Aim and CHNA view of the metrics for continuity and building
• Continuity of improvement efforts and metrics is important
Rob’s medical home/care provision learnings

- Link clinical outcomes to the individual provider level-and incentivize them
- Educate care teams on what is and isn’t covered
- Importance of behavioral health and the social determinants of health
- Limit metrics and align them between payers-let providers determine the metrics
- Physician and provider engagement is CRITICAL early and often
- Contracting should integrate physical and mental health: carve-outs are for Turkeys, not health care

Why is community important?

What Determines Health?

- Genetics, 30%
- Social & Environment, 20%
- Health Care, 10%
- Behavior, 40%
Don Berwick’s charge: The moral test

- Put the patient first
- Among patient’s, put the poor and disadvantaged first—those at the beginning, the end and the shadows of life
- Start at scale—flood the zone
- Return the money
- Act locally

MAKE WHAT IS POSSIBLE REAL

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Resources

Community Health Improvement Plan
www.cohealthcouncil.org

Central Oregon Healthy Communities
www.healthiercentraloregon.org/

Collaborative Family Healthcare Association
www.cfha.net

Patient Centered Primary Care Collaborative
www.pcpcc.net

St. Charles Health System
www.StCharlesHealthCare.org

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