Welcome to the National Forum!
Session Objectives

- Contextualize recent strong market signals around addressing patients' social needs in the broader shift toward value-based care models
- Discuss methods and tools to identify the factors getting between people and optimal outcomes and creative ways to address them
- Draw lessons and strategies that can be applied to your own organization’s efforts

Rapid Fire Presenters

- Rocco Perla
  *President*
  Health Leads

- L. Gordon Moore
  *Senior Medical Director of Population and Provider Solutions*
  3M’s Health Information Systems

- Rose Englert
  *Sr. Business Leader, Community Health Innovation Programs*
  CareOregon

- Facilitator:
  Niñon Lewis, *Executive Director, Triple Aim for Populations Focus Area, IHI*
**Health and Health Care in Transition**

<table>
<thead>
<tr>
<th>Issues</th>
<th>Impact</th>
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<tbody>
<tr>
<td>Health is a priority</td>
<td>Health care moving beyond the walls to address health</td>
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<tr>
<td>Payment changes</td>
<td>issues upstream</td>
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<tr>
<td>Aging population,</td>
<td>Caught between two</td>
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<tr>
<td>growth of insured</td>
<td>business models</td>
</tr>
<tr>
<td>Variation in safety,</td>
<td>Access problems especially</td>
</tr>
<tr>
<td>reliability, and care</td>
<td>primary care</td>
</tr>
<tr>
<td>Chronic disease epidemic</td>
<td>Preventable harm and</td>
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<tr>
<td>Health care at 17% GDP</td>
<td>unjust disparities</td>
</tr>
<tr>
<td>Joy in work amidst</td>
<td>Unsustainable ineffective</td>
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<tr>
<td>increasing demands</td>
<td>care models</td>
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<tr>
<td></td>
<td>Lack resources to meet</td>
</tr>
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<td></td>
<td>other social needs</td>
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**IHI Triple Aim**

- A System design that is one aim with three dimensions:
  - Improving the health of the populations;
  - Improving the patient experience of care
  - Reducing the per capita cost of health care.
**Triple Aim Populations**

- **Defined Populations**: Triple Aim for a defined population that makes business sense (e.g. who pays, who provides)
- **Community-Wide Populations**: Solving a health problem within the community and creating a sustainable funding source

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**When we talk about population health...**

- From what we have seen through our work at IHI, population management as presently practiced is best conceptualized as population medicine.
- Population medicine, in this case, is the design, delivery, coordination, and payment of high-quality health care services to manage the Triple Aim for a population using the best resources we have available to us within the health care system.
- However, a true focus on population health addresses all of the determinants of health, beyond the resources of the health care delivery system.
When you don’t have the answers…

• Likely someone from your sector has solved the problem or a piece of it
• If not, likely someone from your sector is currently trying to solve the problem
• If not, likely someone from your sector has tried to solve the problem and has failed (and you can learn from them)
• If not, someone from an adjacent sector has worked to solve a similar problem
• If not, someone from a completely different sector has worked to solve a problem that could be helpful with the problem you are facing

ROCCO PERLA, HEALTH LEADS
Crossing the Quality Chasm

“Bringing state-of-the-art care to all Americans in every community will require a fundamental, sweeping redesign of the entire health system...merely making incremental improvements in current systems of care will not suffice.” – IOM, 2001

Mismatch Between Drivers of Health and Spending


Despite growing awareness, “don’t ask don’t tell” continues to be common refrain when it comes to patients’ social needs
“Historic” CMS Pilots

**Accountable Health Communities (AHC):**

- **Targeted implementation:**
  - $157 million/5 years; up to 44 awardees
  - Fees for screening for & navigation to social resources

- 3M+ patients screened annually

**Comprehensive Primary Care+ (CPC+):**

- **Scaled implementation:**
  - Up to 2,500 primary care practices
  - Alternative payment model incl. social needs screening & resource directory

- 12M+ patients screened annually

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**Fundamental Sweeping Redesign?**

- “No-intervention” control group for things like food insecurity in AHC

- No resource navigation requirement in CPC+

- New payment models are colliding

- No definitions of success for resource connections

- Focus is mostly on high cost / high need patients/members
“What is the role and responsibility of the healthcare system with respect to patients’ social needs?”

Ray Baxter
Former Senior VP, Community Benefit, Research and Health Policy
Kaiser Permanente

Emerging Role of Healthcare: Coalition of Healthcare Leaders

Vision:
In partnership with communities, healthcare organizations should identify and address individuals’ most pressing basic human needs as an integral part of quality healthcare.

Role of Healthcare Delivery Organizations:
• Screen & document social needs
• Navigate
• Collaborate w/ community resources
• Measure & evaluate
Driver Diagram (Theory of Action)

Primary Drivers
- Systematic Screening Protocol
- Resource Referral and/or Navigation Services
- Dedicated Workforce
- Data Systems & Performance Improvement
- Leadership & Stakeholder Engagement

Secondary Drivers
- Screening tool
- Clinical integration
- Scope of service
- Community resource database
- Case management protocol & tool
- Quality patient interaction
- Roles & Capacity
- Training
- Management
- Technology platform
- Database infrastructure
- Reporting capability
- Clinic & Administrative Champions
- Strategic & Financial Commitment
- Patient engagement
- Physician, clinic staff engagement
- Community engagement

Social Needs Dashboard: Implementation Science

Program Impact: September, 2014 – August, 2015

Unique Clients 806 served

Resource Connections 750 made

Screening and Referral in August 60% of Clinic Screened

Top Presenting Needs
- Need
- Deaf
- Child-Rights
- Health
- Employment
- Utilities
- Adult Education
- Homelessness
- Housing

% of patients who...
- successfully accessed
- % connected
- 60%
- 40%
- 20%
- 10%

Results

Patient Experience
- Access
- Culture
- Coordination
- Efficiency
- Effectiveness

Advocates
- Staff
- Patients
- Community
- Providers

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Until People’s Basic Needs are Addressed

• Operationalize Equity
• Person-Centered Care
• Sustainable health reform
People can tell us stuff

- Unmasking and addressing non-medical factors improves outcomes
- This can be done systematically
- The results are interesting at several levels
  - Patient – unmask actionable issues
  - Physician – identify care team opportunities
  - System – needs assessment for population and delivery system
Healthcare system: What is the Matter?

Patients: What Matters to Me?

Clinician Patient Divide

Need Both

Clinical information System: registries

Patient experience measures, SMS tools

Based on 15+ Years of Empiric R&D with Health Assessments in office settings and communities

Over 200K adult users
25 Publications
Created by:
John H. Wasson, MD
Centers for Aging
Dartmouth Medical School
HowsYourHealth.com
Instrument utilizes branching logic. When the user reports a chronic condition, follow on questions are asked in order to provide an assessment as well as links to a wealth of informational materials relating to the condition. The above screen exhibits a follow-on question relating to a self-reported condition of high blood pressure.

Self-reported health confidence in a Medicaid population
0= least, 10= most  N=3,127
Patient-reported confidence (aka “activation”)—a strong indicator of risk

<table>
<thead>
<tr>
<th>Low confidence individuals also report the following:</th>
<th>Adjusted Odds Ratio*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization or ED for a chronic condition$^1$</td>
<td>1.552</td>
</tr>
<tr>
<td>More than one hospitalization or ED visit**</td>
<td>1.865</td>
</tr>
<tr>
<td>Hospitalization or ED use perhaps unnecessary**</td>
<td>1.609</td>
</tr>
<tr>
<td>Time lost from work due to emotional or physical problem</td>
<td>4.049</td>
</tr>
<tr>
<td>Medication for chronic illness maybe causing some illness$^1$</td>
<td>2.882</td>
</tr>
<tr>
<td>Do not have enough money to buy things for everyday life</td>
<td>2.787</td>
</tr>
<tr>
<td>Fair to poor info received from MD on chronic disease$^1$</td>
<td>2.566</td>
</tr>
</tbody>
</table>

All ORs were statistically significant
* Adjusted for Age, Sex, and 3M Clinical Risk Group (CRG) weight
$^1$ Based on a question asking about chronic conditions
** Based on a question asking about overnight hospital stays

Actionable issues

![Emotional Problems](chart_1)

![Pain Problems](chart_2)
Patient reported data

Use of Emergency Or Hospital During Past Year
(Uses Per Hundred for 9000 Adults (aged 35+) with at least One Chronic Disease)
Roadmap for the interaction

Pre-visit activation/planning

Provider agenda → Patient agenda

Assess Importance

Advise

Agree

Assess Confidence

Assist

Arrange

Collaboration

develop mutual understanding

Medical

Social/Roles

Emotional

Information

Problem solving
action plan, goals

Tailoring interventions and modalities to wants and needs

Follow-up

Neil Baker M.D., 2007

Schematic of the Planned (Chronic) Care Model

Adapted from Wasson et al., Jt. Comm J Qual Safe 29(5), 227 – 237, May 2003

CM = Clinical Microsystems
Personal Action Plan

1. Something you WANT to do: Lose weight
2. Describe
   - How dect. snacks
   - Where Home
   - What no snacks
   - Frequency 6 days this week
   - When after dinner
3. Barriers Forget
4. Plans to overcome barriers Put a note by chair
5. Confidence rating (1-10) 7
6. Follow-Up plan Phyllis will call me next week

Lorig et al 2001

Finding people who might benefit:

How convinced are you that this is the right work for you?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Very convinced

How confident are you now that you can manage and control health problems or concerns?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Very confident

Lorig et al. Outcome Measures for Health Education and other Health Care Interventions, SAGE Publications, 1996
SRH measures provide a promising way to prospectively profile Medicaid-eligible adults by likely health care needs.

Using Self-Reported Health Measures to Predict High-Need Cases among Medicaid-Eligible Adults

Laura R. Wherry, Marguerite E. Burns, and Lindsey Jeanne Leininger

Rate of identified need

- violence or abuse
- sexual issues or birth control
- AIDS or STDs
- how to make the health care system work better for you
- substance abuse
- nutrition and exercise
- preventing injury or accidents
- preventing heart disease and cancer
- Ear, Eye, or mouth issues
Good Collaborative Care Makes a Difference

Study of 25,000 Americans 19-69

<table>
<thead>
<tr>
<th>Past treatment has made:</th>
<th>Good collaborative care</th>
<th>Poor collaborative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>pain much better</td>
<td>34.7%</td>
<td>9.6%</td>
</tr>
<tr>
<td>emotional problems much better</td>
<td>34.8%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Pts with HTN, CAD, DM report their systolic BP&lt;140</td>
<td>74.8%</td>
<td>64.6%</td>
</tr>
<tr>
<td>Reports of problems from their medications</td>
<td>8.6%</td>
<td>20.1%</td>
</tr>
<tr>
<td>Spent at least one day at home because of illness in past 3 months</td>
<td>26.9%</td>
<td>31.6%</td>
</tr>
<tr>
<td>Physical or emotional problems limiting capacity to work in past 2 weeks</td>
<td>18.0%</td>
<td>33.4%</td>
</tr>
<tr>
<td>Hospitalized in past year with common chronic diseases</td>
<td>12.3%</td>
<td>14.2%</td>
</tr>
</tbody>
</table>


When you visit your doctor’s office, how often is it well organized, efficient, and does not waste your time?

PATIENT EFFICIENCY DATA

DATA FROM HOWSYOURHEALTH SURVEY
### The Joint Commission Journal on Quality and Patient Safety

**Clinical Microsystems Series**

**Clinical Microsystems, Part 2. Learning from Micro Practices About Providing Patients the Care They Want and Need**


### Article-at-a-Glance

**Background:** Usual medical care in the United States is frequently not a satisfying experience for either patients or primary care physicians. For example, only a minority of patients agree that their doctors’ offices are clean, that the care they want and need is there, whereas many primary care physicians are leaving primary care or not entering primary care at all. Whether primary care can be sustained and its quality improved is a subject of national concern. In this context, an increasing number of physicians are using micro-systems principles to radically redesign their practices. The transformation is motivated both by physicians’ well-being and chronic interest for the sake of their patients.

These problems confront health systems when they try to improve the quality of office practices. Note, these in the problem of the weak link in the chain. From the patient’s perspective, the value of care in a health system can be no better than the services garnered by the small clinical unit—our micro-system—of which it is composed. When some of these micro-systems are weak links, essential services of the health system will back up, break down, or fail in inefficient and costly workarounds.

The second problem is the need to get many processes and handoffs right. For example, there seems to be at least nine ambulances of successful micro-systems within an otherwise health system. Imagine that your health system can reliably

### Table: Percentage of patients who say...

<table>
<thead>
<tr>
<th>Statement</th>
<th>Usual practices</th>
<th>Ideal medical practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>I receive exactly the care I want and need.</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>My care is perfect.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>My doctor’s office is efficient, well organized and does not waste my time.</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>It is very easy to get care when I need it.</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>My doctor’s office provides excellent education on my condition (respiratory disease).</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>My doctor’s office provides excellent education on my condition (cardiac disease).</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>My doctor is aware of my emotional issues.</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
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Healthy Behaviors Program

- 1115 Waiver
- Implemented Spring 2014
- Member benefit for completing healthy behaviors
- Provider benefit for achieving targets

People can tell us stuff

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- This can be done systematically
- The results are interesting at several levels
  - Patient – unmask actionable issues
  - Physician – identify care team opportunities
  - System – needs assessment for population and delivery system
WHAT IS A HEALTH PLAN’S ROLE IN SOCIAL DETERMINANTS?
CareOregon’s
Community Health Innovation Programs

• Housing
  – Case Management
  – On-site health services
  – Community Partnerships
    • Joint Office on Homelessness
    • HUD Continuum of Care
  – Capital investments

• Social Isolation
  – Give2Get
  – Neighborhood building
  – Coping and Coffee

CareOregon’s
Community Health Innovation Programs

• Food/Nutrition
  – Curative Nutrition Protocols
  – Prenatal nutrition education
  – Insecurity resources

• Transportation
  – Non-Emergent Medical Transportation
  – Ancillary transportation

• Medicaid “Flex” spending
APPLY CLINICAL CRITERIA TO PROGRAMS

LINK HEALTH & SERVICE NEEDS

Health Plan Alignment

Goals
- Decrease hospital
- Increase quality metrics (HEDIS, STARS)
- Increase member & provider satisfaction

Data driven
- Health Risk Assessment
- Claims
- HEDIS
- Medicaid incentives
Focus on Acute Cases

Community Service Provider Network Size

High Acuity

Disease state segmentation

Preventative & Upstream

Capacity

Health Plan Alignment

- Community Service Provider Network “CSPN”
  - Analog to clinical provider network
  - Contractual relationship
  - Data sharing arrangements (Closed-loop referral)
  - Output/Outcome expectations
Capacity Building Approach

Partner with Community Providers
- No cost to health plan for services
- Warm-handoff placement
- Data sharing

Pay for External Services
- Build capacity using health plan & grant resources
- Expand community offerings

Design Specific Interventions
- Health Plan staff, partner & grant resources
- Targeted to specific, limited conditions

Meets MOW Criteria:
Meets Clinical Insecurity Criteria: Meals on Wheels + Case Rate Billed to CO Limited Duration

Meets Curative Nutrition Criteria: Food Rx Wound Care Protocol
SDoH Root Cause Analysis

**Diagnosis**
- High HbA1C
  - “Noncompliant” with insulin regimen
- Misses appointments
- Multiple hospital encounters

**Root Cause**
- Unstable housing
  - No refrigeration for insulin
- Transportation challenges
- Poor medical literacy for diabetes-friendly diet

*Treatment Plan:*
*Housing case management, transportation plan, nutrition counseling*

Medical Respite Programs Decrease Hospital Readmissions

<table>
<thead>
<tr>
<th>Central City Concern, Recuperative Care Program</th>
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<tbody>
<tr>
<td>Stays Discharged from October 1, 2014 to September 31, 2015**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Readmission Within X Days of RCP Discharge</th>
<th>30</th>
<th>60</th>
<th>90</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Admissions</td>
<td>94%</td>
<td>86%</td>
<td>80%</td>
</tr>
<tr>
<td>1 Admission</td>
<td>6%</td>
<td>14%</td>
<td>16%</td>
</tr>
<tr>
<td>2+ Admissions</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
</tr>
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**NOTE: Many studies have demonstrated that a typical readmission rate for individuals experiencing homelessness is 50%.**
Case Study: R.P.

- Wound diagnosed 6/10/14
- 153 Wound Care Clinic visits through 07/22/15
- Clinic cost = $29,767
- 13 Inpatient days
- 2 ED Visits

$114,767 in Claims for Wound Care

R.P. Wound Nutrition Protocol

- Food and protein supplement delivery began 5/11/15
- 3 meals a day delivered with protein bars and shakes
- Delivery ended 6/12/15

$1,050 in food & supplement costs

NO ADDITIONAL WOUND CARE encountered after discharge in July 2015
Questions?

When you come upon a wall, throw your hat over it, and then go get your hat.

— Irish Proverb
Thank You for Joining Us!

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