Planning for Success: Models for Community Health Improvement from Around the Country and What We Can Learn From Them

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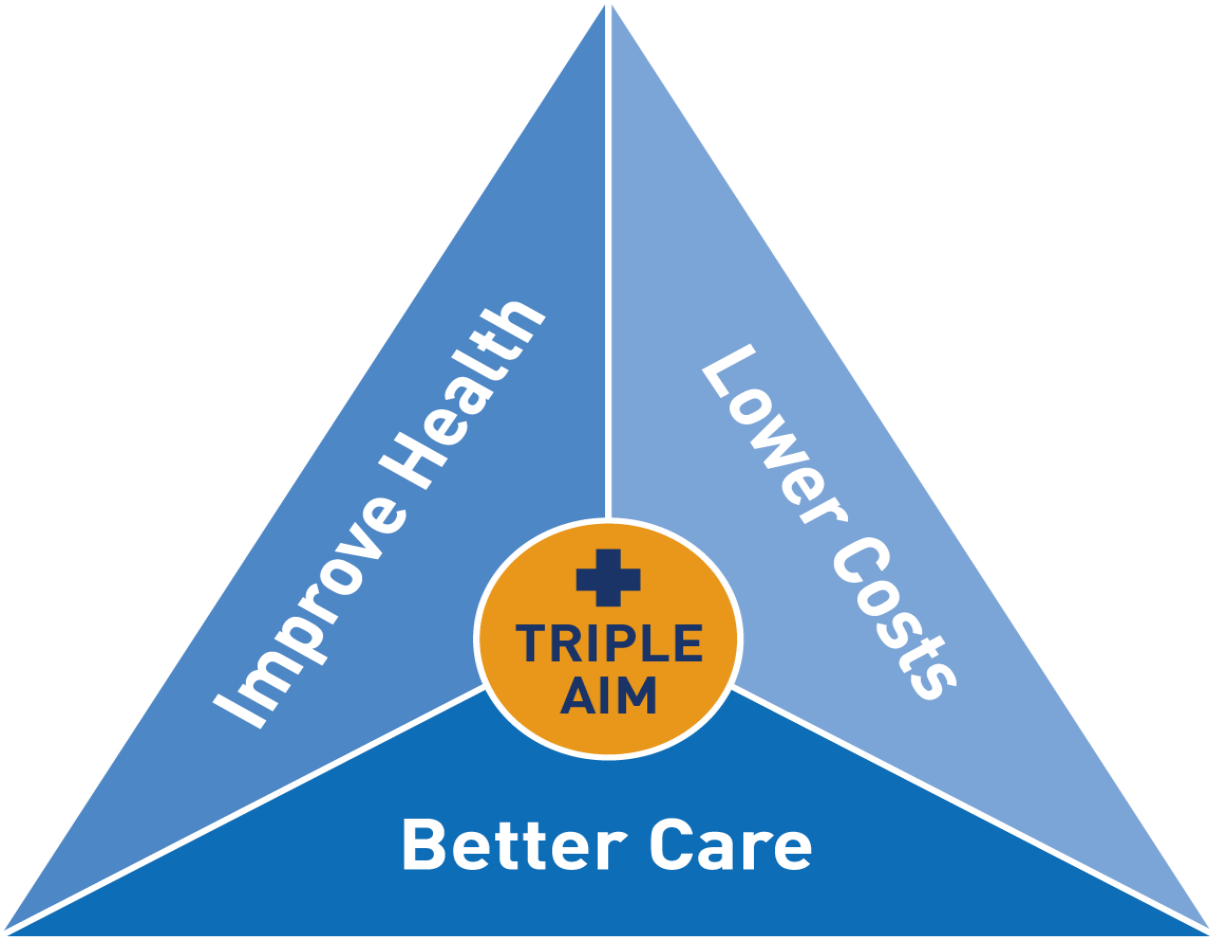
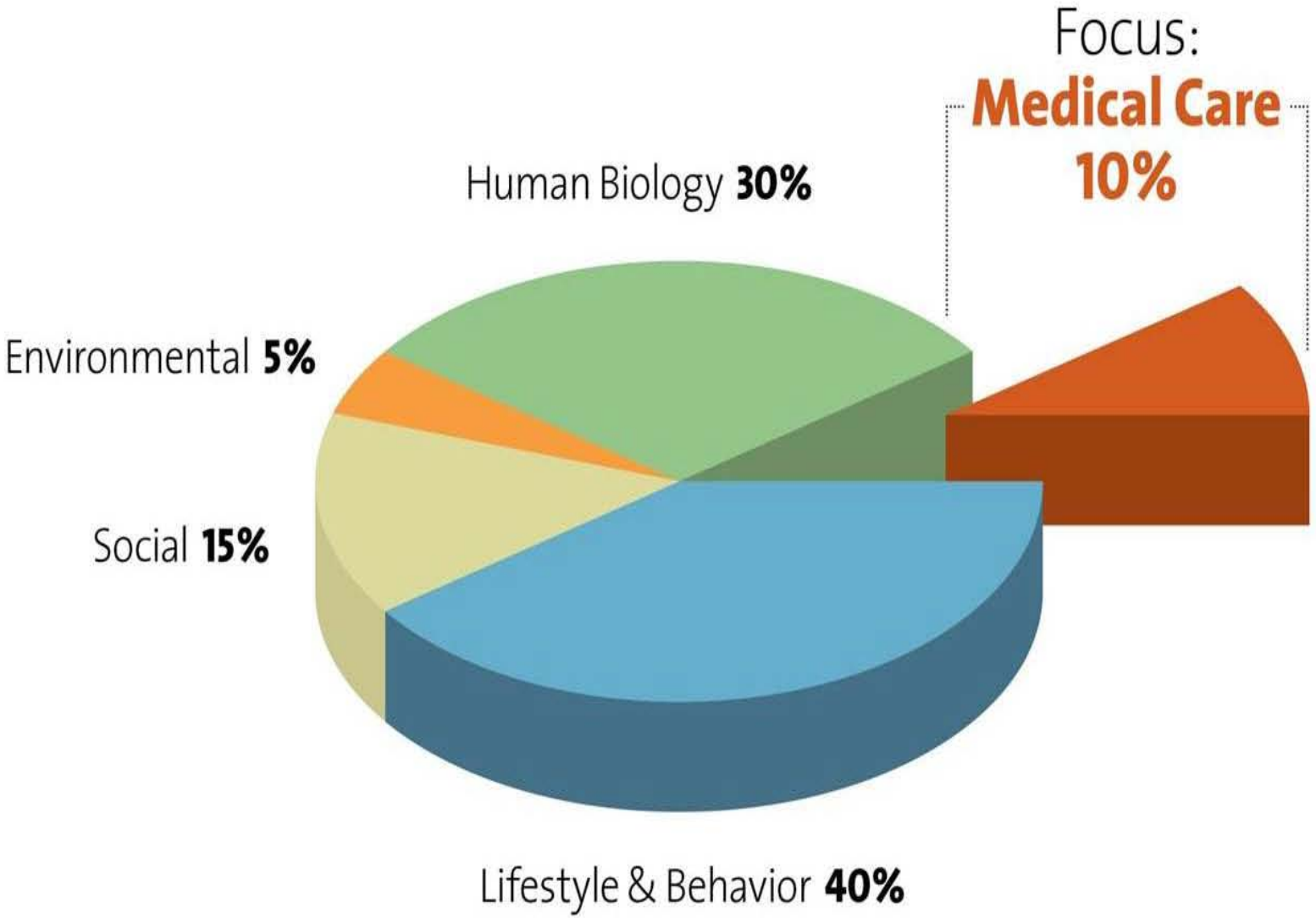
TODAY

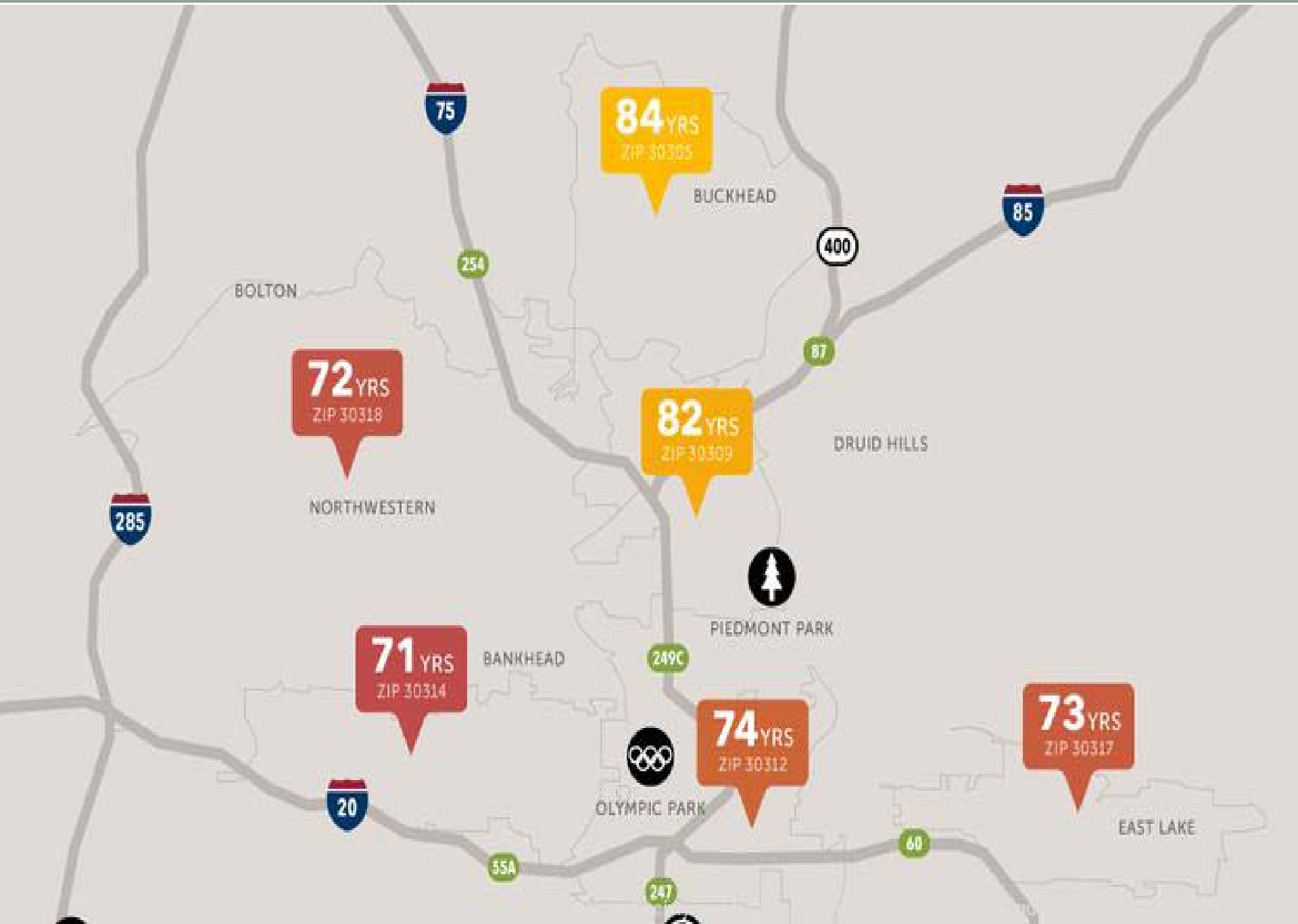
- Context for state health improvement efforts
- Show some examples from around the country
- Spend some time talking about lessons learned
- Discussion

NATIONAL CONTEXT

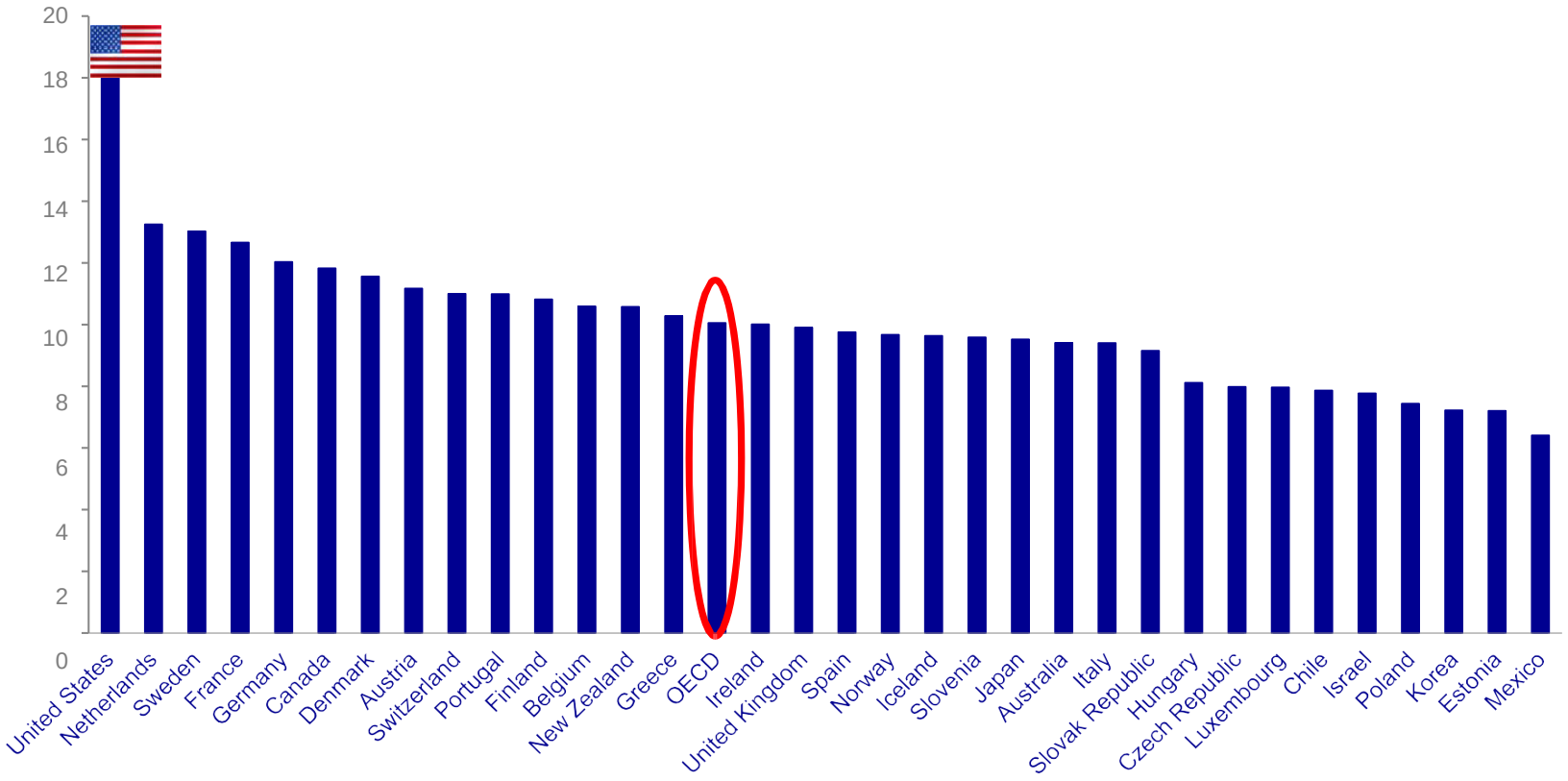
- Health care costs growing faster than other economic indicators
- Outcomes are varied and inconsistent
- National health reform efforts – SIM, Medicare, PCMH, CPC
- State health reform efforts – Medicaid, commercial market reforms
- Growing evidence of importance of social investments, care coordination, primary care


Improve Health
Lower Costs
TRIPLE AIM
Better Care


Focus:
Medical Care
10%
Human Biology 30%
Environmental 5%
Social 15%
Lifestyle & Behavior 40%

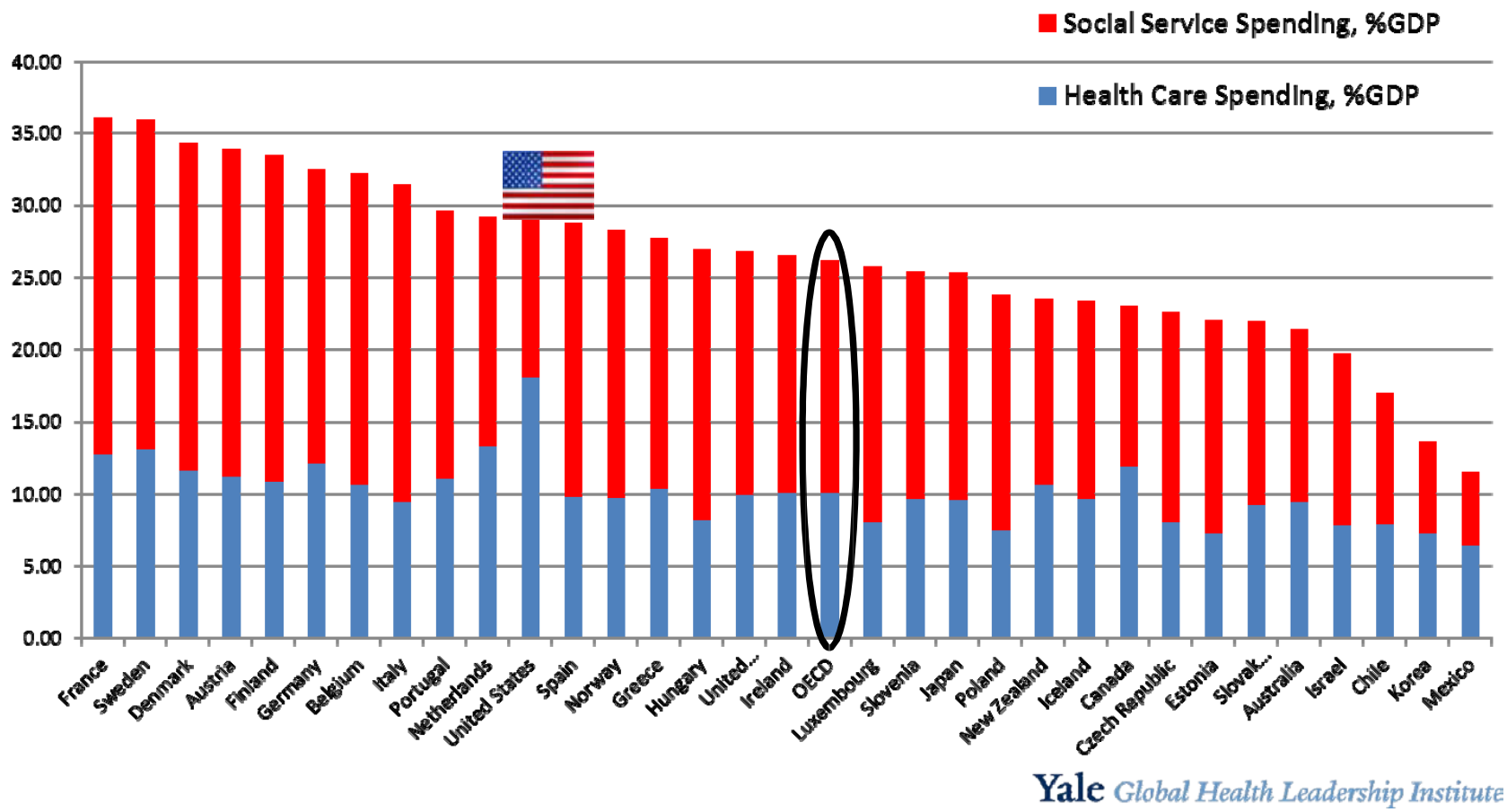

84 YRS
ZIP 30305
BUCKHEAD
72 YRS
ZIP 30318
NORTHWESTERN
82 YRS
ZIP 30309
DRUID HILLS
71 YRS
ZIP 30314
BANKHEAD
74 YRS
ZIP 30312
OLYMPIC PARK
73 YRS
ZIP 30317
EAST LAKE
PIEDMONT PARK
BOLTON
75
85
400
285
20
254
87
249C
55A
247
60

Health Expenditures as % of GDP, 2009



Yale *Global Health Leadership Institute*

Total Investment in Health as % of GDP



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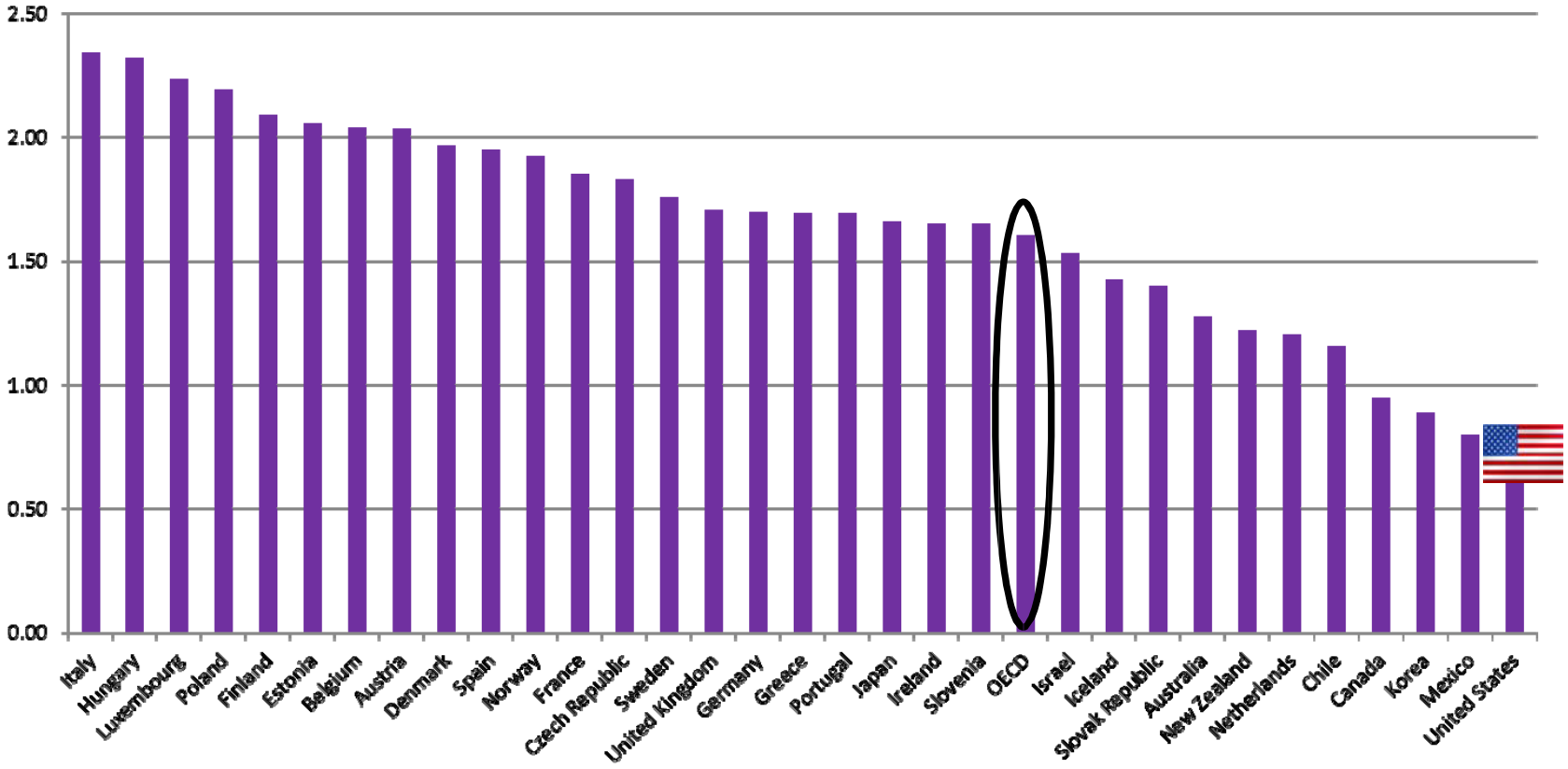
Ratio of Social Service to Health Care Spending



*Switzerland and Turkey are missing data for 2009

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Opportunity Costs!

- 1 ED Visit = 1 months rent
- 2 hospitalizations = 1 year of child care
- 20 MRIs = 1 social worker per year
- 60 echocardiograms = 1 public school teacher per year

SGIM Presidential Speech, Dr. Moran, 2015

STATE EFFORTS TO IMPROVE HEALTH
&
INCREASE INVESTMENTS IN SOCIAL SPENDING

- Foster better value and efficiency in health delivery systems through payment reforms, value based purchasing and delivery system changes
- Invest some of those savings into social enterprises that improve health
- Increased partnerships across health and social service endeavors
- Creating coordinating/integrating organizations

The Alphabet Soup of Approaches

- ACO
- CCO
- ACC
- ACH
- RCCO
- MCO
- PCMH

Funding Approaches

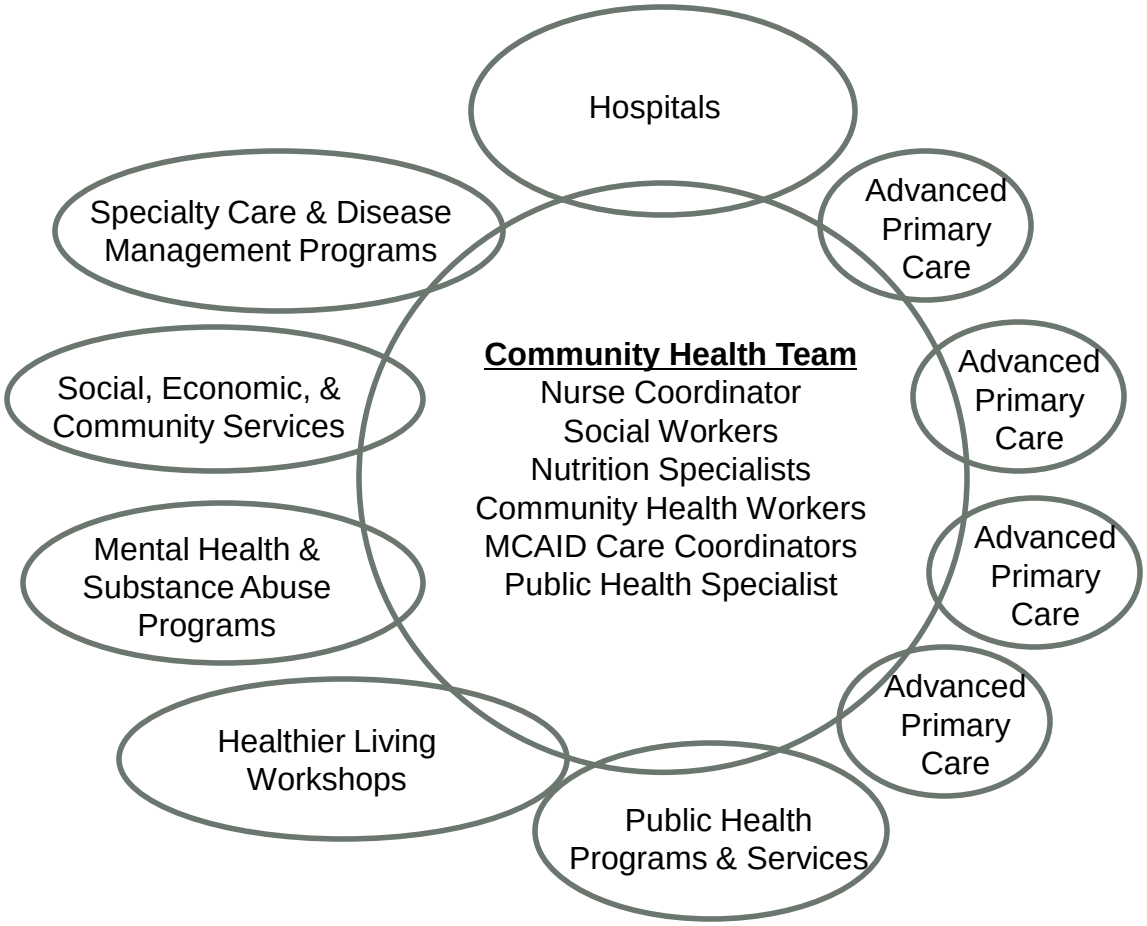
- State, Federal $
- Medicaid $
- Commercial Insurance $
- Medicare $
- Philanthropy
- Hospital Community Benefit
- State Trusts
- Social Impact Bonds
- Combination of the above

VERMONT

Vermont Blueprint

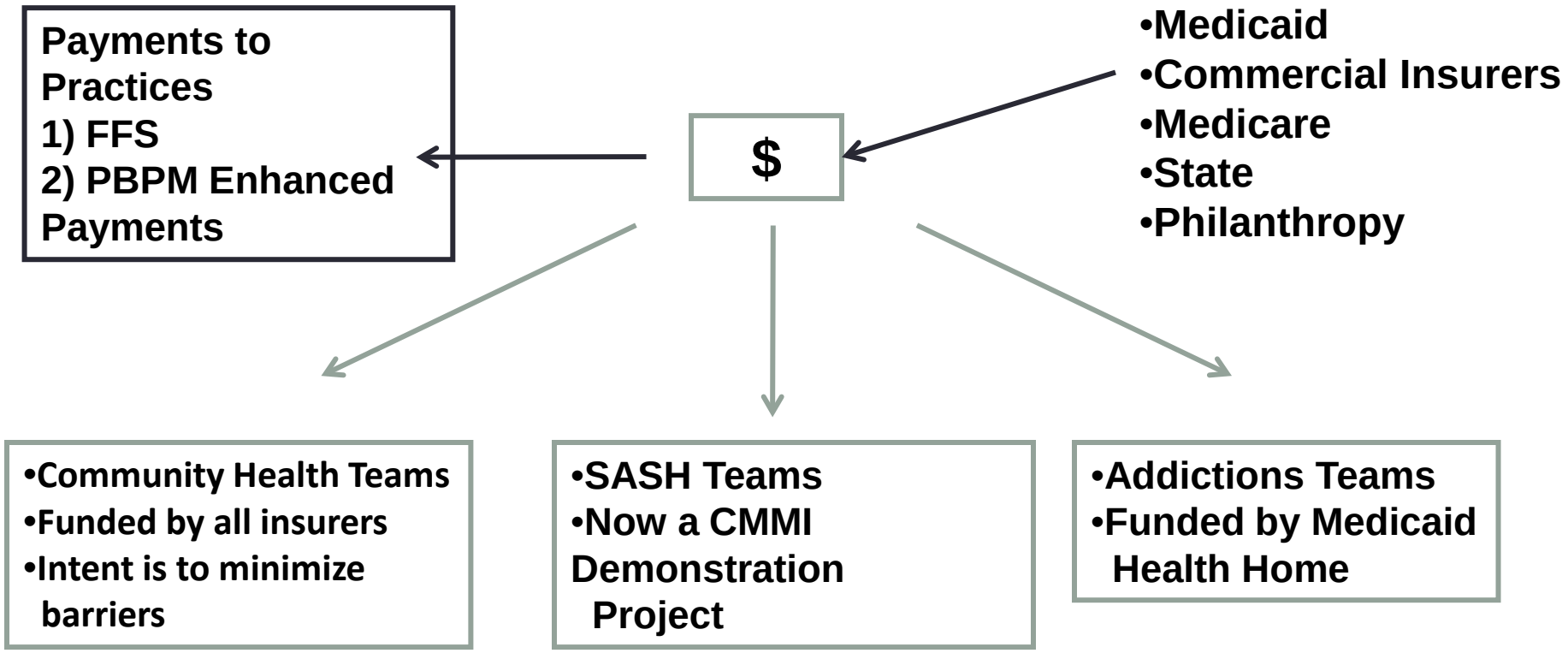
Vermont Blueprint

- Statewide initiative with local leadership and implementation
- 14 Health Service Areas – each have an administrative entity and Community Health Team (CHT)
- Work includes:
  - Staffing CHT's
  - Local project management
  - Financial management
  - Support for Patient Centered Medical Homes
- CHT's
  - Care coordination
  - Population health and disease management
  - Counseling
  - Linking patients to social services



- A foundation of medical homes and community health teams that can support coordinated care and linkages with a broad range of services
- Multi Insurer Payment Reform that supports a foundation of medical homes and community health teams
- A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry
- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact

Blueprint Funding Flow



VERMONT Blueprint for Health

Smart choices. Powerful tools.

SASH – Support and Services at Home

- Helps Vermont's seniors and individuals with special needs access the care and support they need to stay healthy while living comfortably and safely at home

- SASH is a care management model harnessing the combined strength of social service agencies, community health providers and non-profit housing organizations to support approximately 5,000 Vermonters in aging safely and healthfully at home. www.sashvt.org

- SASH participants demonstrated statistically significant lower growth in expenditure across categories including total Medicare expenditures, emergency room visits, hospital outpatient department visits, and primary care/specialist physician visits.

- **Against a comparison group, SASH participants in the most experienced panels show growth in Medicare expenses was lower by an estimated $1,536 per beneficiary per year**.

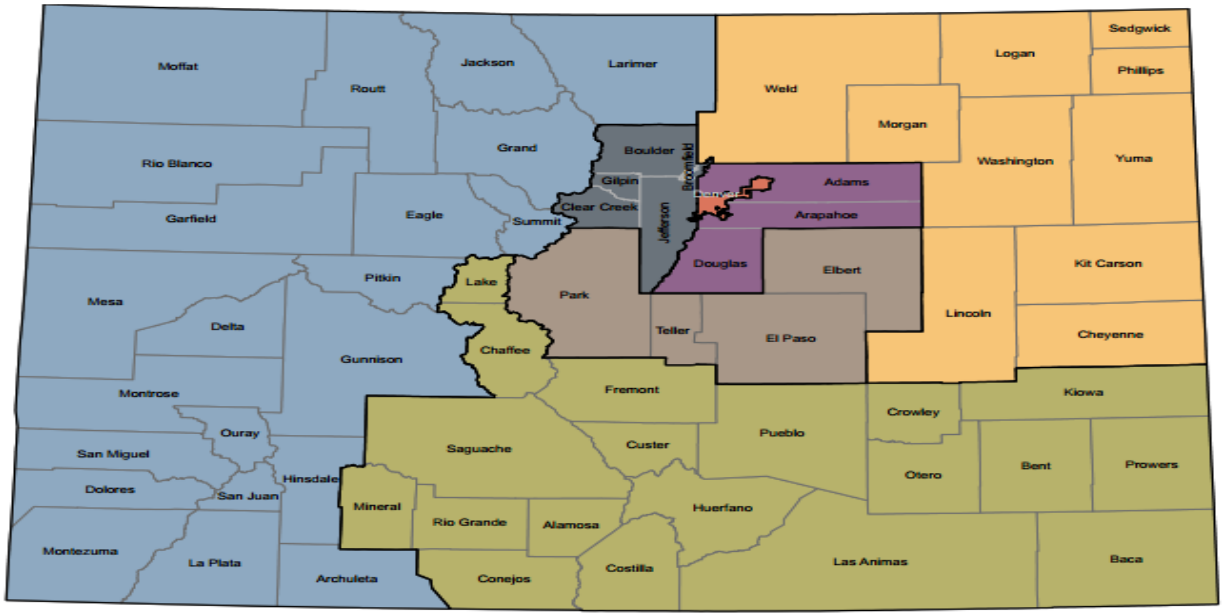
VERMONT Blueprint for Health

Smart choices. Powerful tools.

COLORADO

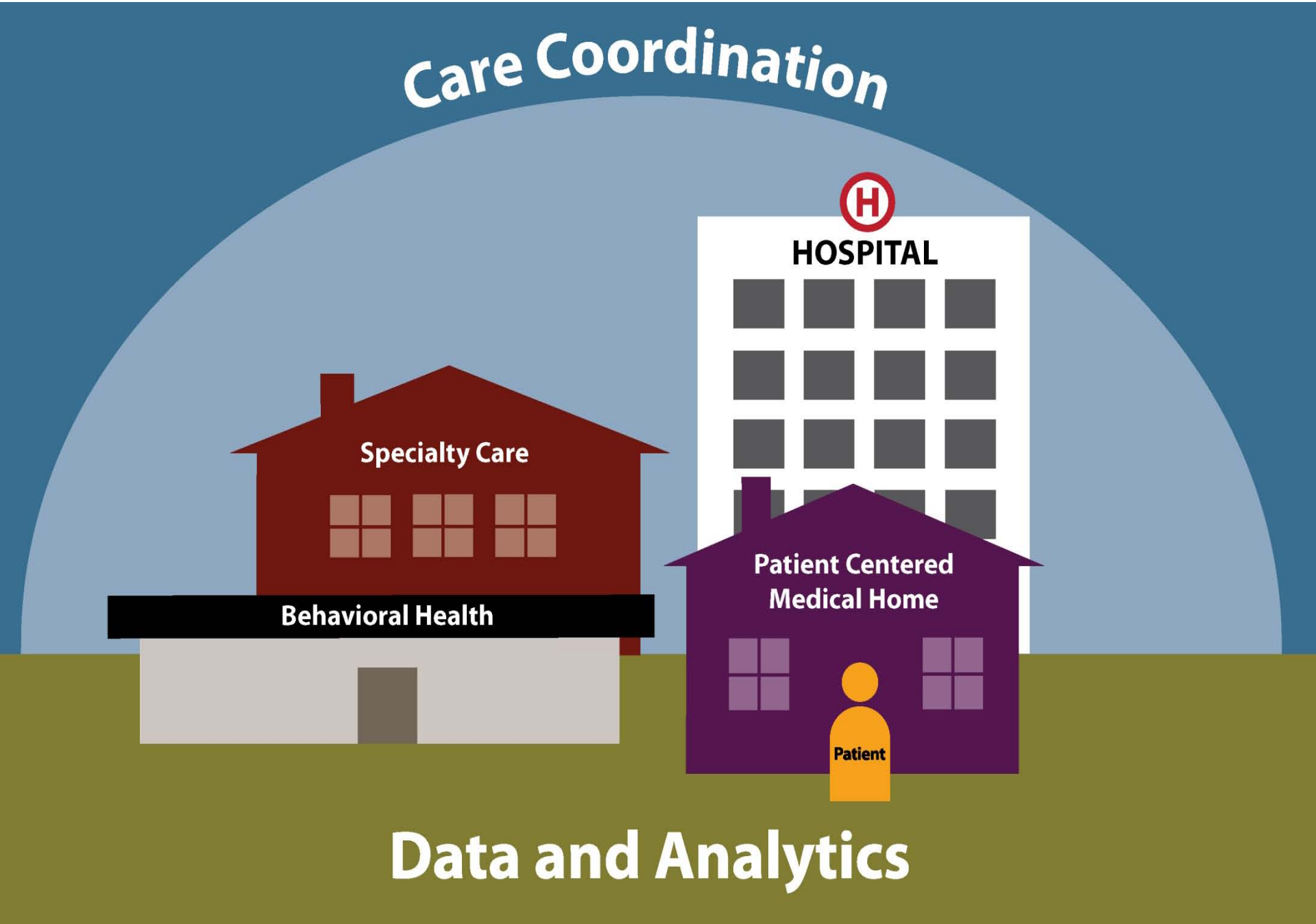
Regional Care Collaborative Organizations

Map 1: Colorado's Accountable Care Collaborative Regional Care Collaborative Organizations



	Region, RCCO Name	ACC Enrollment as of June 2014
	Region 1: Rocky Mountain Health Plans	84,459
	Region 2: Colorado Access	52,171
	Region 3: Colorado Access	172,336
	Region 4: Integrated Community Health Partners	74,755
	Region 5: Colorado Access	49,118
	Region 6: Colorado Community Health Alliance	82,954
	Region 7: Community Care of Central Colorado	97,189

Source: Colorado Department of Health Care Policy and Financing


Care Coordination
HOSPITAL
Specialty Care
Behavioral Health
Patient Centered
Medical Home
Patient
Data and Analytics

Regional Care Collaborative Organizations (RCCO)

- Develop network of providers
- Support providers with coaching and information
- Manage and coordinate member care
- Connect members with non-medical services
- Report on costs, utilization and outcomes and work to improve them.

Regional Care Collaborative Organizations (RCCO)

- Connects Medicaid clients to Medicaid providers and also helps Medicaid clients find community resources and social services in their area.
- Assist Medicaid clients get the right care when they are returning home from the hospital or a nursing facility.
- Assists with other care transitions, like moving from children's health services to adult health services, or moving from a hospital to nursing care.

Initial Program Measures

- Emergency Department Visits:
- Inpatient Readmissions Within 30 Days:
- High Cost Imaging:
- Well Child visits
- Postpartum Care

Transformation Activities

- Evaluate changes in data monthly (improvements, set-backs)
- Modify care coordination and data management practices
- Engage staff in cycles of rapid improvement (PDSAs)
- Spread Best Practices
- Special projects driven by local need

FUNDING

- $3 PMPM payments for all attributed patients
- Incentive payments for performance on Key Performance Indicators (KPIs)
- Delegated Care Management
  - $3.50 PMPM
  - Varies by Region

Regional Care Collaborative Organizations (RCCO)

- 2015- generated $37 million in net savings ($121 million in savings - $84 million in administrative costs)
- Lowered ED visits, high cost imaging and readmissions
- Increased well child visits, postpartum care

EOCCO

Quick facts about EOCCO

- **EOCCO serves 12 rural and frontier counties**
  - Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler
  - 6 of 12 were primarily FFS/Open Card counties prior to CCOs

- **Land Area: approximately 50,000 sq. miles**
  - 52% of land area of State of Oregon
  - Equal to the size of NY
  - Larger than land area of 19 states

- **Population: 194,592**
  - 5% of Oregon's population
  - 1/3 the population of WY (least populous State)
  - Equivalent to the combined populations of Salem, Lake Oswego and Lebanon

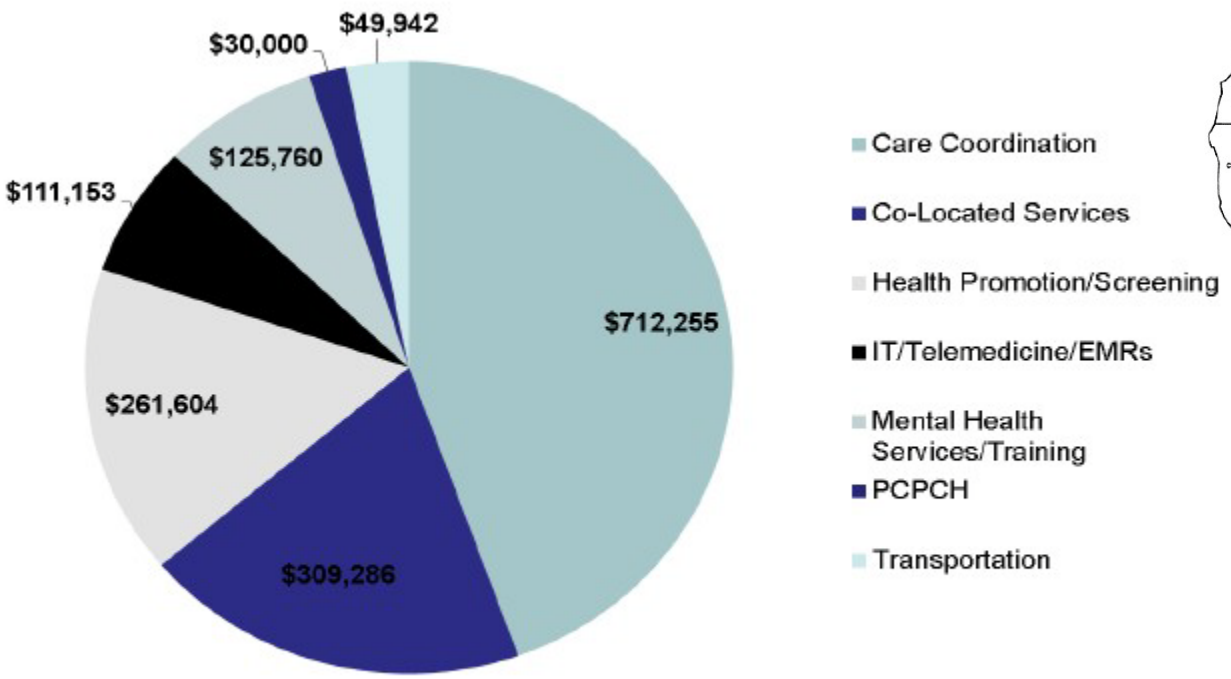
EOCCO Service Area and Common Cities and Towns

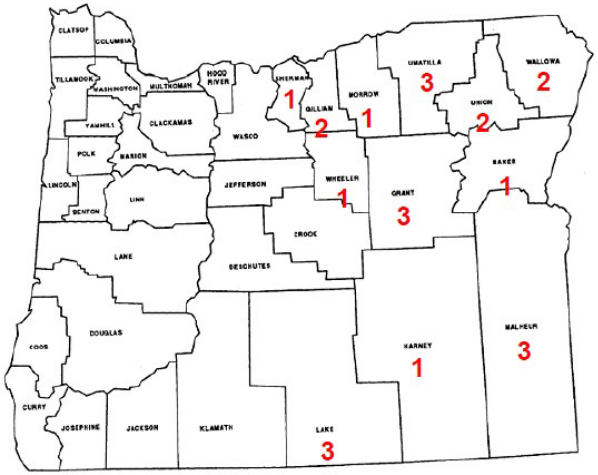
Fundamental changes to healthcare and financing

- **Relationships**
- **Shared Savings / APMs**
- **Community Health Workers**
- **LCAC funding**
- **Integration of services (Physical, Behavioral, Dental, NEMT)**
- **Quality measures**
- **Health Integrated**

2014 TRANSFORMATION GRANTS

- 23 selected





Umatilla County

- The “ConneXions” project developed a workforce of CHWs to meet behavioral health needs of patients in physical health care settings and to coordinate across agencies

- Outcomes:
  - Return ED visits reduced 8%
  - Multi-organization care team established, bedside assessments in ED, universal community referral process created
  - 900 referrals
  - Active caseload of over 500 patients
  - Received “Excellence in Innovation Award” from the Federal Office of Rural Health Policy

Project is expanding, savings now sustaining CHW’s

Malheur County

- Embedded a nurse care coordinator and behavioral health specialist in hospital and primary care clinic for patients with complex conditions and behavioral health needs to reduce ED use and improve access to care

- Outcomes:
  - Connected 550 patients to resources (mental health, primary care, housing, medication assistance, and educational services)
  - For 183 patients targeted for ED care coordination intervention saw 63% decline in ED visits and 50% decline in inpatient visits

Project is expanding in 2016 by adding a Qualified Mental Health Professional to the ED, savings helping with community supports

Public Health and LCAC, Morrow County

- Developed the “CARE” inter-agency team (including public health, LCAC, law enforcement, behavioral health, human services, education and dental providers. Developed inter-agency processes to coordinate care for at-risk residents age 18 and under and their families.

- Outcome: Developed care plans and referrals for 149 families to address health care and social determinants of health needs.

Project is expanding in 2016 by adding a care coordinator to work across three primary care clinics, a nurse care coordinator to assist with meeting EOCCO prevention targets, CHW training for the entire CARE team and a countywide inter-agency care coordination data tool.

Union County

- Created dispatch service to enable patients to get to same day medical appointments and worked with primary care, dialysis and other settings to encourage transportation planning with patients at time of appointments

- Outcomes:
  - Same day medical trips increased 340% from 250 to 850 over the year (goal 25% increase)
  - Overall rides for medical appointments increased 80% from 6,000 to 11,000 over the year.

Project is continuing in 2016. Working on same-day rides from ED to urgent care.

TUESDAYS WITH MORRIE

Lessons Learned

- **COMMON VISION**
  - Common vision for reforms/changes/interventions amongst partners is critical
  - Leadership (legislative, executive, stakeholder) commitment to the goals and deliverables
  - Engaging stakeholders around that common vision is critical – CEO's, consumers, CMS

- **COORDINATION**
  - A strong coordinating mechanism is needed to work effectively across parties
  - "Care coordination" across the spectrum is how many achieve their goals and find the resources for sustainability

- **GOVERNANCE**
  - Pay careful attention how projects are governed – governance is critical for engagement
  - How are decisions made, do you have the right people governing?
  - Getting organizations to participate and having a role in governance go hand in hand

Lessons Learned (cont'd)

- **DATA**
  - Have reliable data and information. Good data and information is needed now - to chart your course, and later - to monitor progress. Participants need to be involved with assuring validity.
  - Data is key to your sustainability!
  - Hold each other accountable with data
    - Financial
    - Outcomes
- **ACCOUNTABILITY**
  - Be clear on what everyone is accountable for
  - Have good data to back that up
- **STAGE YOUR WORK AND BUILD ON SUCCESS**
  - Begin with a pilot, develop competency, expand
  - Demonstrate ROI

Lessons Learned (cont'd)

- **SUSTAINABILITY**
  - Plan for it!
  - Projects should not be "one offs", rather they should help to sustain your organization and your future work
- Pay attention to geography – all health care is local
- "It takes a village" – broad community support and involvement is critical.
- Communicate early, often and in multiple modalities and then communicate again
- Financial support helps the transition from old system to new.

Lessons Learned (cont'd)

- **Payment reform is critical – don't expect new ways of doing business with old methods of payment**
  - Payment needs to help drive efficiency
  - Payment/financing needs to reward effective collaborations
  - Payment/financing must foster accountability to outcomes
- Multi-payer initiatives can accelerate change in delivery systems
- Payment and structures need to increase community accountability for population health outcomes that reflect physical, mental, social well being

Lessons Learned (cont'd)

- Need to recognize and help health care institutions transition and plan for new business models!

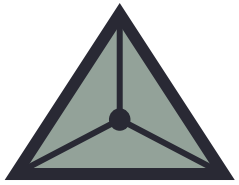
- **Workforce**
  - Don't expect new methods of care with same workforce
  - Help to develop workforce that meets the goals of reforms
  - Provider engagement and training are critical

- Change is hard and takes time, but …. Don't slow down!

- Don't underestimate the investment needed in change management and technical support

Lessons Learned (cont'd)

- There is no perfect structure
- Be clear about goals – especially as it relates to improving health vs. improving the health system, access, quality, costs.
- On the journey to improve health, be careful not to "medicalize" social institutions.



The future belongs to those who create it.