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Improving Care for Patients with Complex Care Needs

Northern California Convening

July 30, 2014

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Lessons from Bay Area Complex Care Pioneers

Dave Moskowitz, MD, MAS
Hope Center, Alameda Health System

Anna Robert, RN, MSN, DrPH and Fern Ebeling, RN, BSN
San Francisco Department of Public Health

Jason Cunningham, DO
West County Health Centers

Alameda Health System

- Public hospital authority for Alameda County
- 4 ambulatory clinics, acute care hospital and trauma center, psychiatric hospital, rehab hospital
- 2 more new hospital acquisitions
- Primary care clinics staffing and patients
  - 45 provider FTEs
  - approximately 320,000 visits per year
  - Patients: 37% Latino, 36% African American, 16% white, 10% Asian

Hope Center

- Launched January 2013
- Ambulatory-ICU model
- Patients engaged from inpatient at Highland
- 120 enrolled, about half active in case mgmt
- Team includes 2 RN case managers, LCSW, CHW, MA, PCP, as well as other supports
- Outcomes measures include annual admissions, bed days per year

San Francisco Health Network

- County system with 14 primary care clinics, hospital-based and community-based
- Approx. 91 provider FTEs
- 70,000 patients
  - 32% Hispanic, 24% Asian, 20% White, 19% Black, 4% other
  - Median age: 45
  - Insurance status: 64% public insurance, 35% uninsured

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Complex Care Management

- First program launched February 2012
- Recent merger of 3 programs into one
- Primary care embedded at 4 sites, plans for 5
- Population: 3 or more admissions in 12 mos
- Capacity/goals: 200-250 active, 200-250 graduates/year
- Outcomes measures include hospital days pre/post, ED visits pre/post, patient and provider satisfaction

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SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

West County Health Centers

Caring for our Communities

a california health+ center

- Western Sonoma County
- Non-profit FQHC with 7 clinic sites
- 13,000 patients
- Primary care, dental, mental health, wellness, teen, HIV
- Staff: 119 FTEs, 26 medical providers
- $1M+ uncompensated care, 2012
- 40% patients at or below FPL

Complex Care Management

- Primary care-embedded, no separate enrollment
- Team: provider, MA, coordinator, RN case manager, behavioral health, patient navigator
- Patients: high utilization, high total cost of care
- 5 – 10 patients per team in complex care services
- Intake includes a home visit
- Care includes acuity score, reassessed monthly
- Case conferences are important part of team's work to support patients

West County Health Centers
Caring for our Communities
a california health+ center

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Selecting and Risk-Stratifying Patients for Complex Care Management Programs

Clemens Hong, MD, MPH
Massachusetts General Hospital

Selecting and Risk Stratifying Patients for Complex Care Management: Lessons from Successful Programs

Clemens Hong MD, MPH

Improving Care for Patients with Complex Care Needs

Northern California Convening

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Acknowledgements

- Co-Authors: Timothy Ferris & Andrew Hwang
- All interviewees from 20 CCM Programs

- Funding:

- Program Officer: Giovanna Giuliani

*** No conflicts of interest to report ***

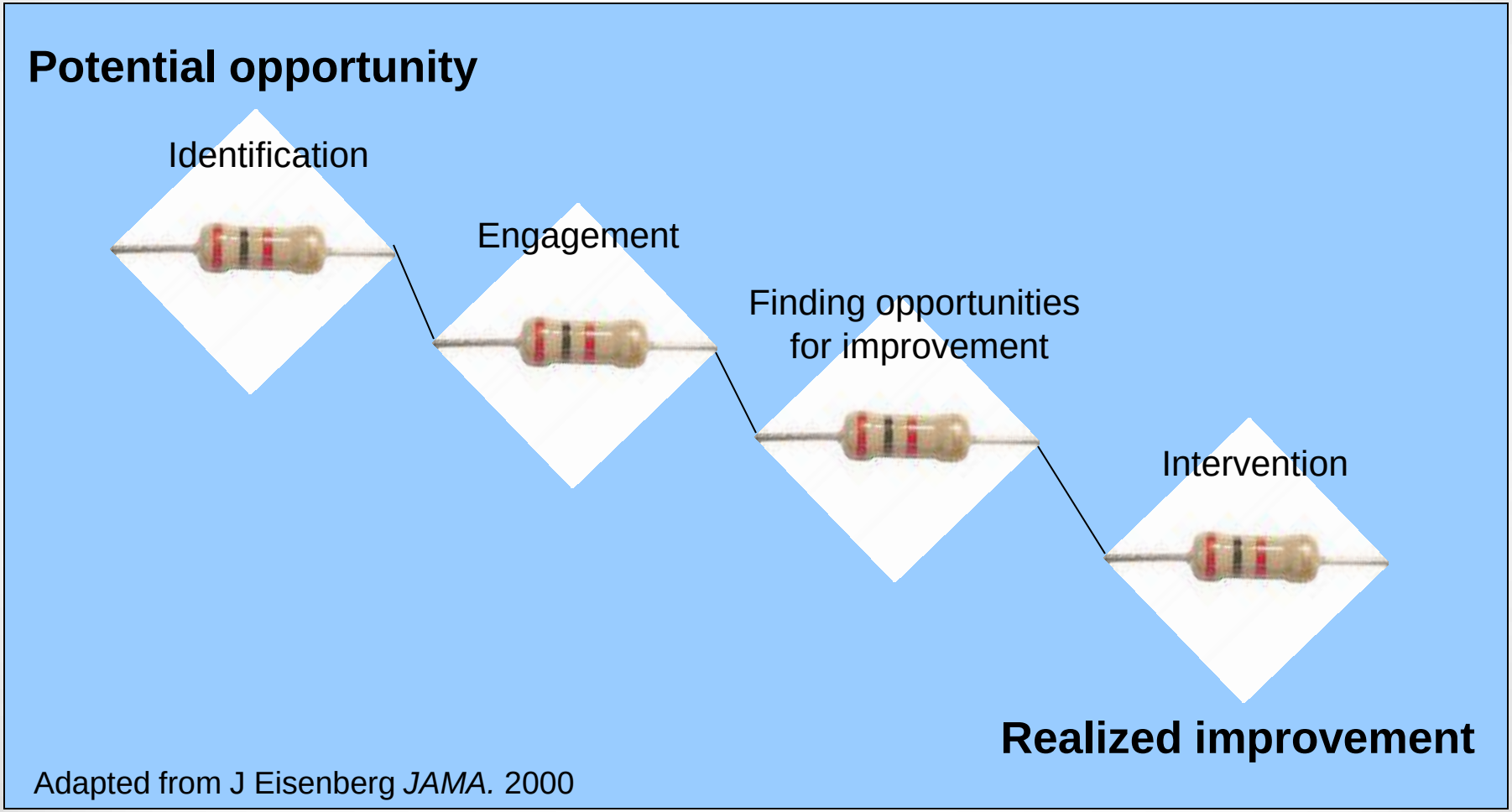
Who would you select for complex care management?

What information do you need to make a decision?

Key Questions for CCM Programs?

- What are our desired program outcomes?
- Over what time frame do we need to achieve them?
- What are the assets and gaps in the health delivery system in which we will embed the program?
- What tools will we pull together in our approach?
- What resources/data are available to identify high-risk patients?
- How will we approach risk-stratification within the population we select?
- How will we go about designing the initial patient selection approach?
- How will we improve our approach?

CCM Programs: Drops in Potential



Key Questions for CCM Programs?

- What are our desired program outcomes?
- Over what time frame do we need to achieve them?
- What are the assets and gaps in the health delivery system in which we will embed the program?

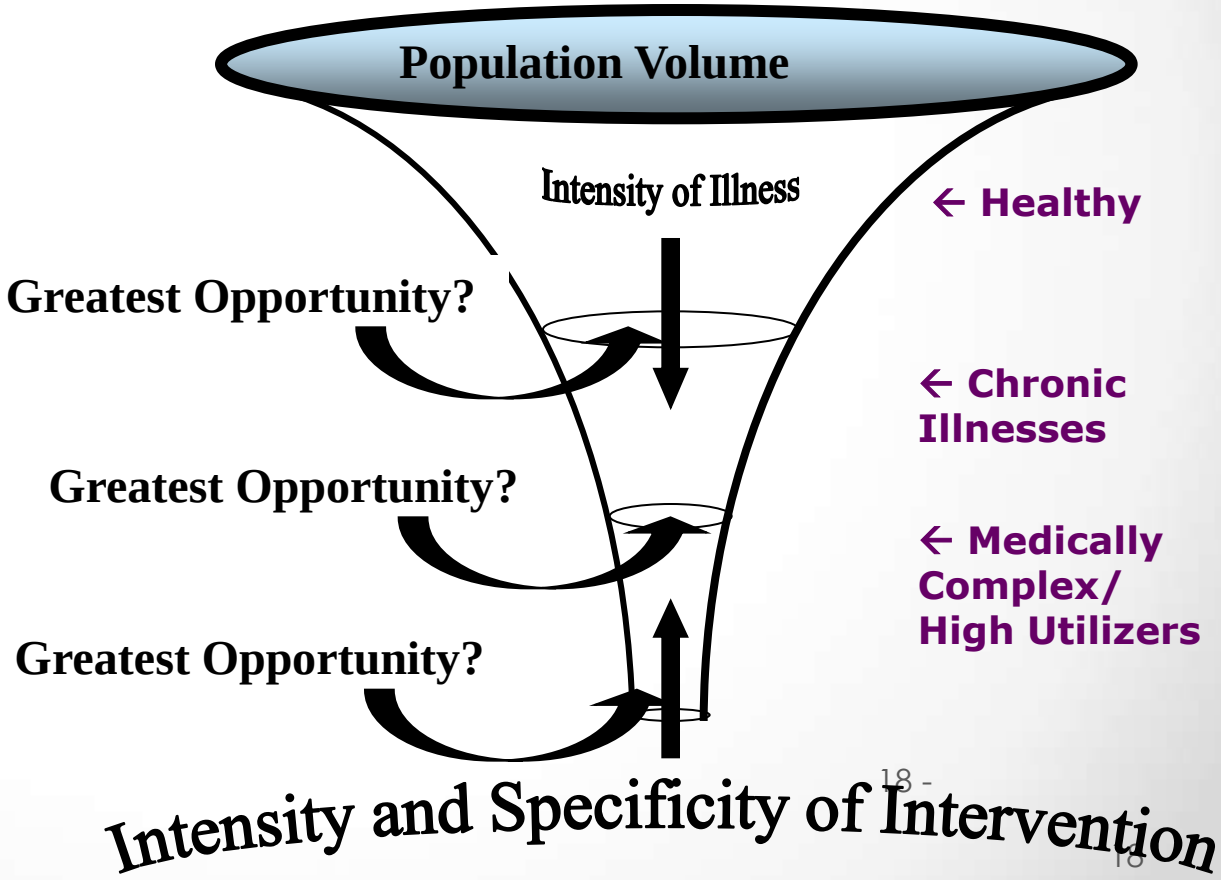
- **Goal: Align Population, Intervention, & Outcomes**
  - Prioritize and agree upon outcomes of interest
  - Agree upon the time in which outcomes should be achieved
  - Identify the population in which you hope to achieve these outcomes
  - Match the planned staffing/resources and interventions to the target population to achieve the desired outcomes

Patient Selection

- Search for the Holy Grail
  - Select a population at risk for future poor outcomes & costs for which planned CCM interventions can improve outcomes

Finding the Sweet Spot - Care Sensitivity

- No single approach – align population & intervention
- Identify windows of opportunity for intervention – utilization
- Identify care gaps that CCM can address – poor disease control
- Engage the patient



18

Key Questions for CCM Programs?

- What tools will we pull together in our approach?
- What resources/data are available to identify high-risk patients?

- **Goal: Apply best available tools to best available data to get started**

- **Tools**
  - **Quantitative**
  - **Qualitative**
  - **Hybrid**

- **Data Sources**
  - **Claims**
  - **Data Warehouses**
  - **Surveys**
  - **Clinicians**

Quantitative Approaches

- Claims-based risk prediction
- Acute Care Utilization focused
- High-risk condition or medication focused
- Multifactorial Risk Assessment

Qualitative Approaches

- Referral by clinician or care team
- Patient self-referral

Hybrid Approaches

- Quantitative with qualitative gate
- Qualitative with quantitative gate

- **Case Study: Cambridge Health Alliance Approach**

Iora Worry Score supports population health, focusing resources to have the most impact

Iora Worry Score 2.0

Our objectives

- A clinically meaningful stratification tool for **targeting patient recruitment and population health management**
- **Consistent** use across populations, practices, and processes
- **Multiple, independent data sources** (e.g. subjective; clinical, claims, patient-reported data) to lead to consistent scores
- Transparent, straightforward algorithm - **Not a black box**

Scores and Actions

Iora Worry Score	10	9	8	7	6	5	4	3	2	1
Patients with…	***Complex, chronic disease; Active acute event***	***Complex, chronic disease; High prob of acute event in next 30d***	***Complex, chronic disease; High prob of acute event in next 90d***	***Complex, chronic disease; Out of control***	***Complex, chronic disease; In control***	***Multiple clinical issues; Not at goal***	***Multiple clinical issues; At goal***	***Single clinical issue; Not at goal***	***Single clinical issue; At goal***	***General pop.; No active issues***
Target caring/ planning	Daily huddle/ Home or hospital visit	Biweekly huddle	Weekly huddle	Monthly huddle	Every six weeks huddle	Alternate month huddle	Quarterly huddle	Every 4 months huddle	Biannual huddle	Annual huddle

Key Questions for CCM Programs?

- How will we approach risk-stratification within the population we select?

- **Goal: Prioritize and direct effort towards the highest risk, most care sensitive patients**

- Risk Stratification
  - Clinical assessment
    - Informal
    - Qualitative Tiering
  - Automated
    - **Case Study: Iora Health Worry Score**

Key Questions for CCM Programs?

- How will we go about designing the initial patient selection approach?
- How will we improve our approach?

- **Goal: Use a process that engages stakeholders early & often and continuously improve it**

- Who?
  - Delivery system & program leaders
  - Primary care & CCM teams
  - Analysts
- **Case Study: Denver Health**

Who would you select for complex care management?

Questions?

Thank you!

Contact: cshong@partners.org

Key Questions for CCM Programs?

- What are our desired program outcomes?
- Over what time frame do we need to achieve them?
- What are the assets and gaps in the health delivery system in which we will embed the program?
- What tools will we pull together in our approach?
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Identifying Patient Needs Through Ethnographic Research

Suneel Ratan, MPP and Melissa Marshall, MD

Community Health Center Network of Alameda County

Ethnographic Research as Foundation of Program Design

Suneel Ratan, MPP
Melissa Marshall, MD
Community Health Center Network

Community Health Center Network
Setting the standard for Community Health Care

Ethnographic research definition and purpose

- Wikipedia: Conducting research from the 'point of view of the subject of the study'
- Our goal: Get 360-degree view of high-utilizer patients – preferably in home settings – to inform program design

Overall approach

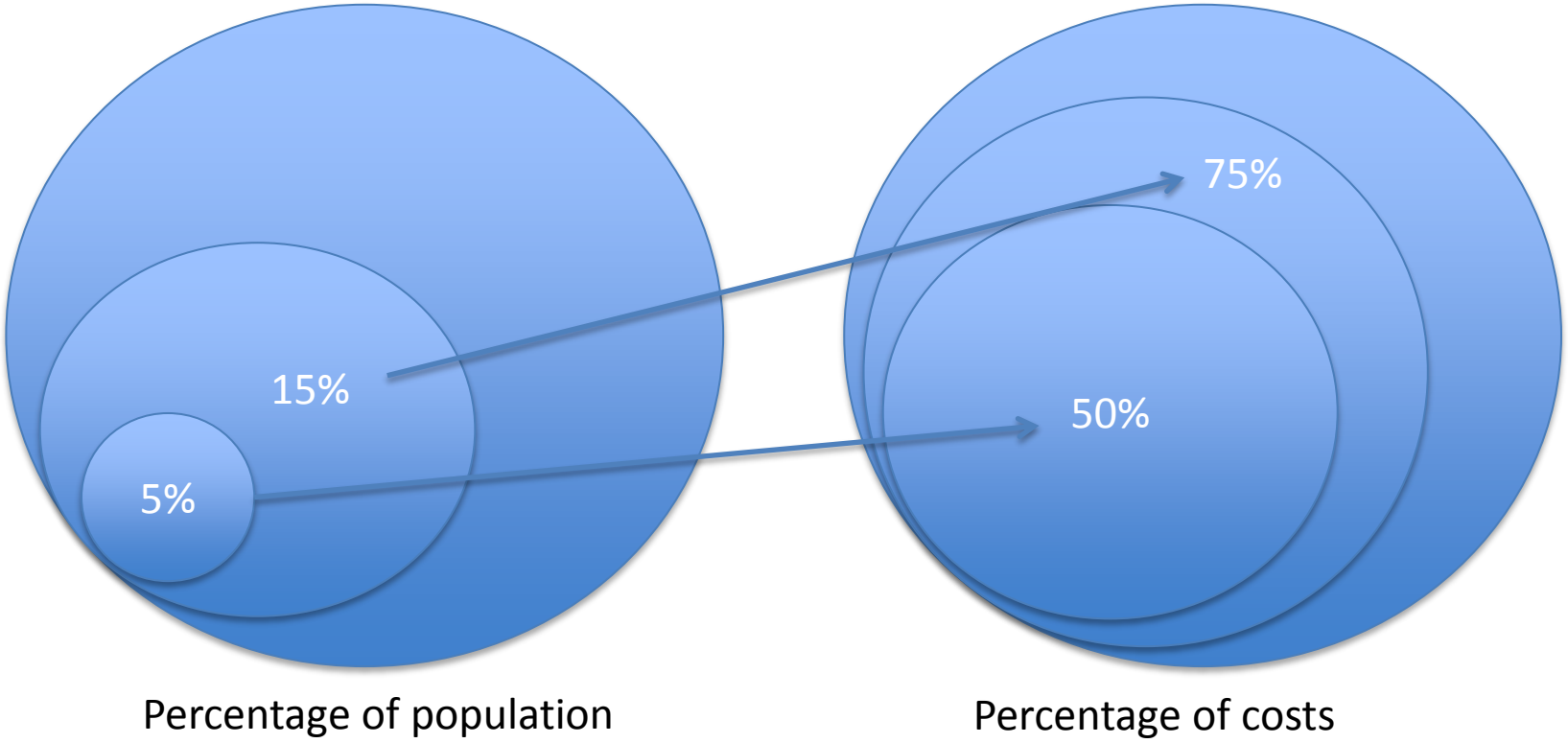
- Interview at least 30 high-utilizer patients
- Preference toward home interviews to understand home environment
- Interviews of 90 minutes to two hours
- Personnel: Variety of skill sets, primarily one LCSW and one doctor of public health

Key Steps

- **Define** patient population
- **Draw** sample
- **Develop** interview protocol and tools
- **Conduct** interviews
- **Tabulate** responses
- **Step back** to draw inferences, establish personas

Patient population definition

Started with top 15 percent – then narrowed to top 5 percent / high hospitalization risk



Getting total cost of care data from health plans is critical

Tools

- Questionnaire / interview guide
  - Tension between impressionistic story telling and quantitative data gathering
- Environmental assessment
- Photo release
- Livescribe pen and notebook
- Qualtrics-based post-interview questionnaire
- $50 grocery store gift cards as incentive

The interview: Teasing out stories

Life story dimension	Key characteristics
Story of your childhood	Family of origin stability, childhood trauma, poverty status, education, language, literacy, immigrant / native
Story of your life today	Housing, nutrition, transportation, substance use / abuse, functional limitations, social connectedness, technology use, life goals
Story of your health	Conditions, medications, experience of health care system

Conducting the interviews

- Conducted 32 interviews between April and June 2014
  - Those successfully contacted generally responsive, except for some in throes of crisis
  - Key characteristics of individuals not successfully contacted
    - Homeless / housing insecure
    - Severely mentally ill
- Interviews conducted in English, Spanish, Cantonese, Mandarin

Selected Statistics n=30

84%

Grew up in poverty

85%

Experienced childhood trauma

37%

Express being lonely

19%

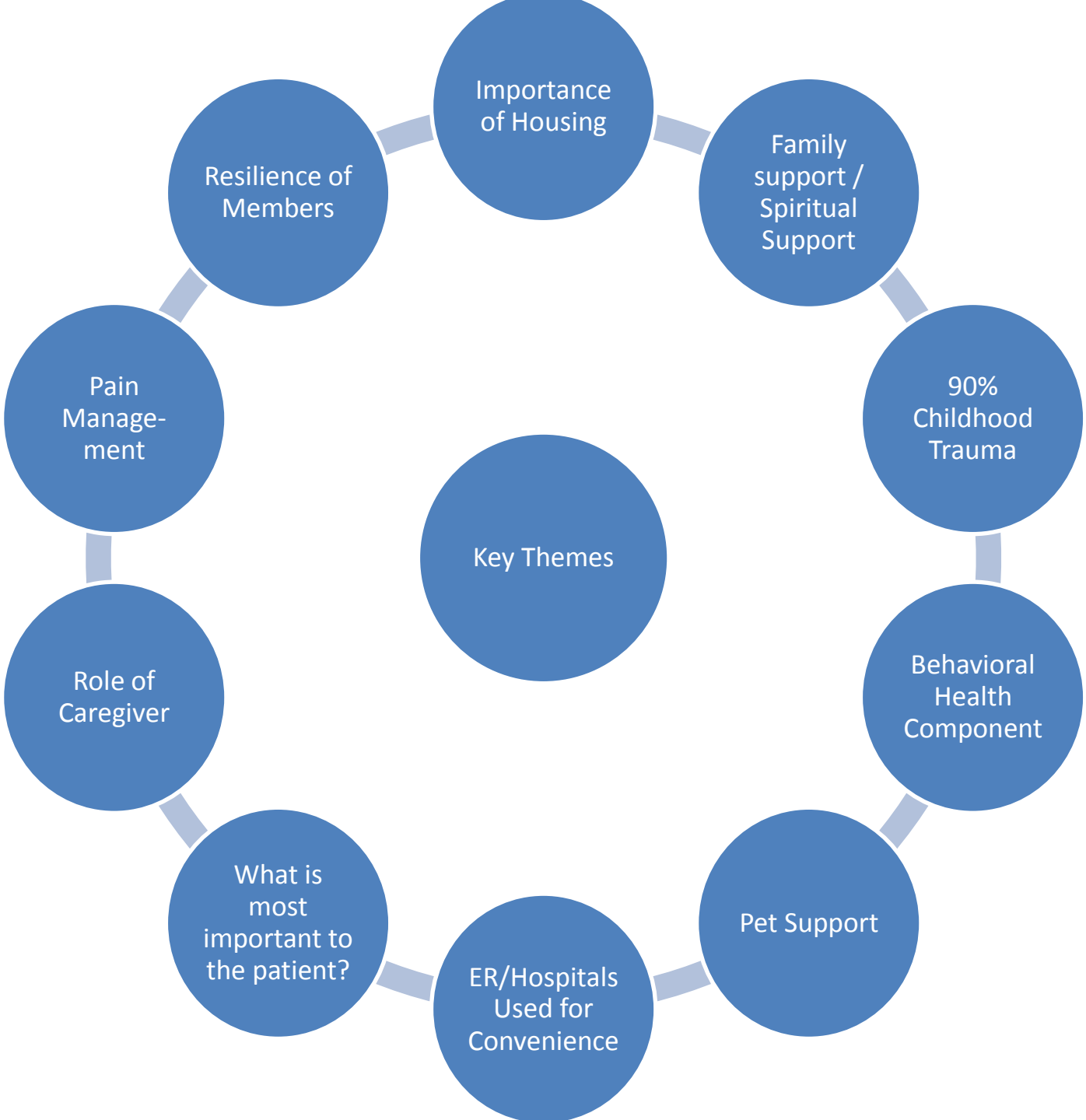
Feel healthy

65%

Have functional limitations that limit his/her ability to perform the activities of daily living

63%

Talked about stress in their lives


Key Themes
Importance of Housing
Family support / Spiritual Support
90% Childhood Trauma
Behavioral Health Component
Pet Support
ER/Hospitals Used for Convenience
What is most important to the patient?
Role of Caregiver
Pain Manage-ment
Resilience of Members

Contact information

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Community Health Center Network

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Approaches to Patient Engagement and Outreach

Rachel Davis, MPA
Center for Health Care Strategies (CHCS)

Maria Raven, MD, MPH, MSc
San Francisco Health Plan, Complex Care Innovation Lab

CHCS Center for Health Care Strategies, Inc.

Advancing access, quality, and cost-effectiveness in publicly financed health care

Outreach and Engagement of Complex Medicaid Populations: *Lessons Learned from the New York Health Home Experience*

Northern California Regional Convening:
Improving Care for Patients with Complex Care Needs

Oakland, California

July 30, 2014

Rachel Davis
Senior Program Officer, Center for Health Care Strategies

CHCS
Center for Health Care Strategies, Inc.

A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care

- **Priorities**: (1) enhancing access to coverage and services; (2) integrating care for people with complex needs; (3) advancing quality and delivery system reform; and (4) building Medicaid leadership and capacity.
- **Provides:** technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.
- **Funding:** philanthropy and the U.S. Department of Health and Human Services.

The New York Health Home Experience

- Live since January 2012
- Currently targeting high-needs, high-cost Medicaid patients
- First health home program in US to include direct payment for outreach activities
- Over 35 distinct entities designated as health homes
- CHCS interviewed 12 for best practices
- Issue brief available at www.chcs.org

Challenges

- Lack of adequate contact information
- Limited upfront data on member needs
- Cultural and linguistic barriers
- Traveling inefficiencies
- Lack of awareness of programs

Staffing Structure

- Dedicated outreach staff seem most effective
- Skill sets are more important than credentials
  - Ability to think creatively
  - Strong people skills
  - Multi-lingual
  - Independent
- Staff should have familiarity with the community's culture, needs, geography and resources

Data

- Go beyond claims data:
  - Electronic health records
  - Managed care organizations
  - On-line search engines
  - Inmate lookup services
  - Returned mail
  - Facebook
  - Health Information Exchanges

- Seek out data-matching opportunities with a variety of partners
- Real-time access is key
- Comprehensive and centralized IT structure is a plus

Developing Relationships with Partners

- Data Exchange Application and Agreements and Business Associates Agreements for as much data-sharing and collaboration as possible
- Explore possibilities to co-locate outreach staff in community-based locations
- Coordinate closely with relevant hospital departments (e.g., psychiatry, chemical dependency)
- Referrals and warm-hand offs
- Possible cross-training opportunities

The Sales Pitch

- Develop a strategy
  - Which method of outreach should you use to convey what time of information?
- Invest in promotional materials
- Aim for enrollment in the first conversation
- Tailor the pitch to your audience

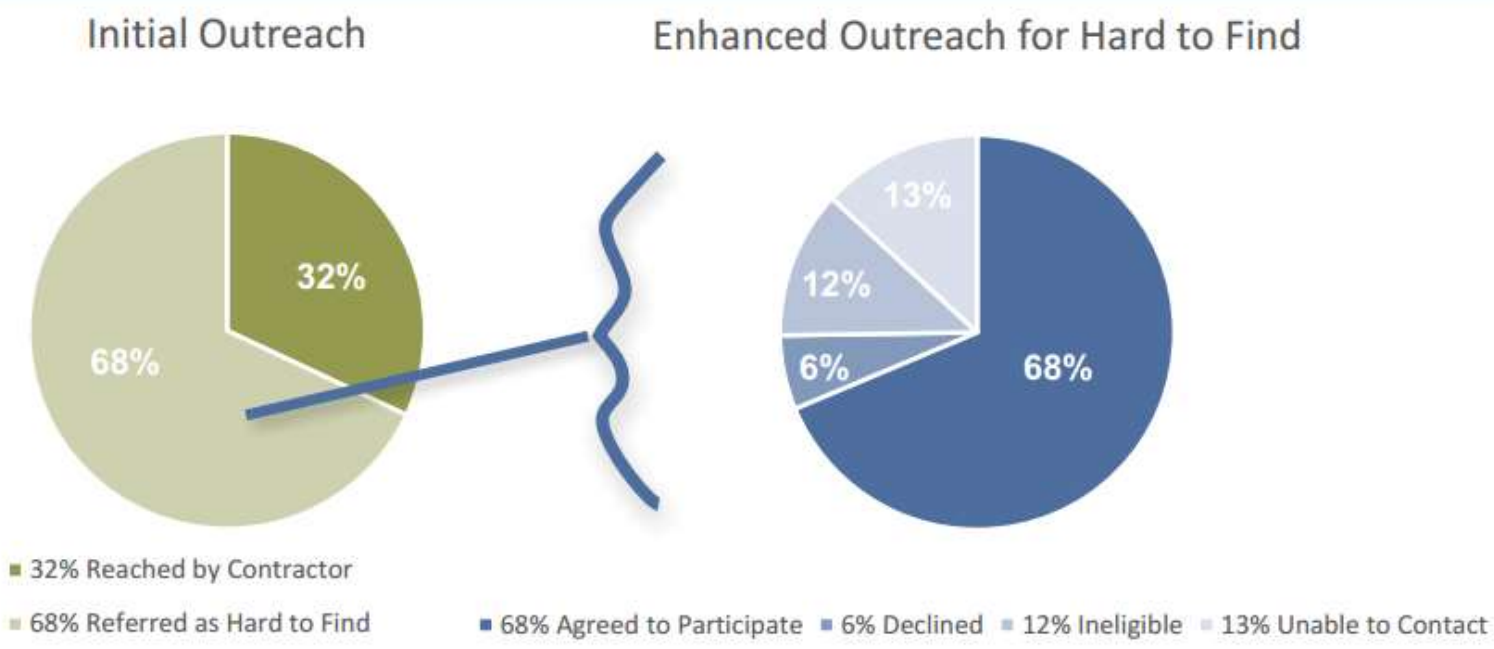
CASE STUDY

The Washington State Mailing Campaign Experience

- Mail on a Tuesday
- Brightly colored stickers to distinguish from bills
- Emphasis on white space and simple language
- Signed in blue ink by MD in cursive
- Offer incentives
- Hand-written follow-up notes
- Self-addressed, stamped mail-back forms

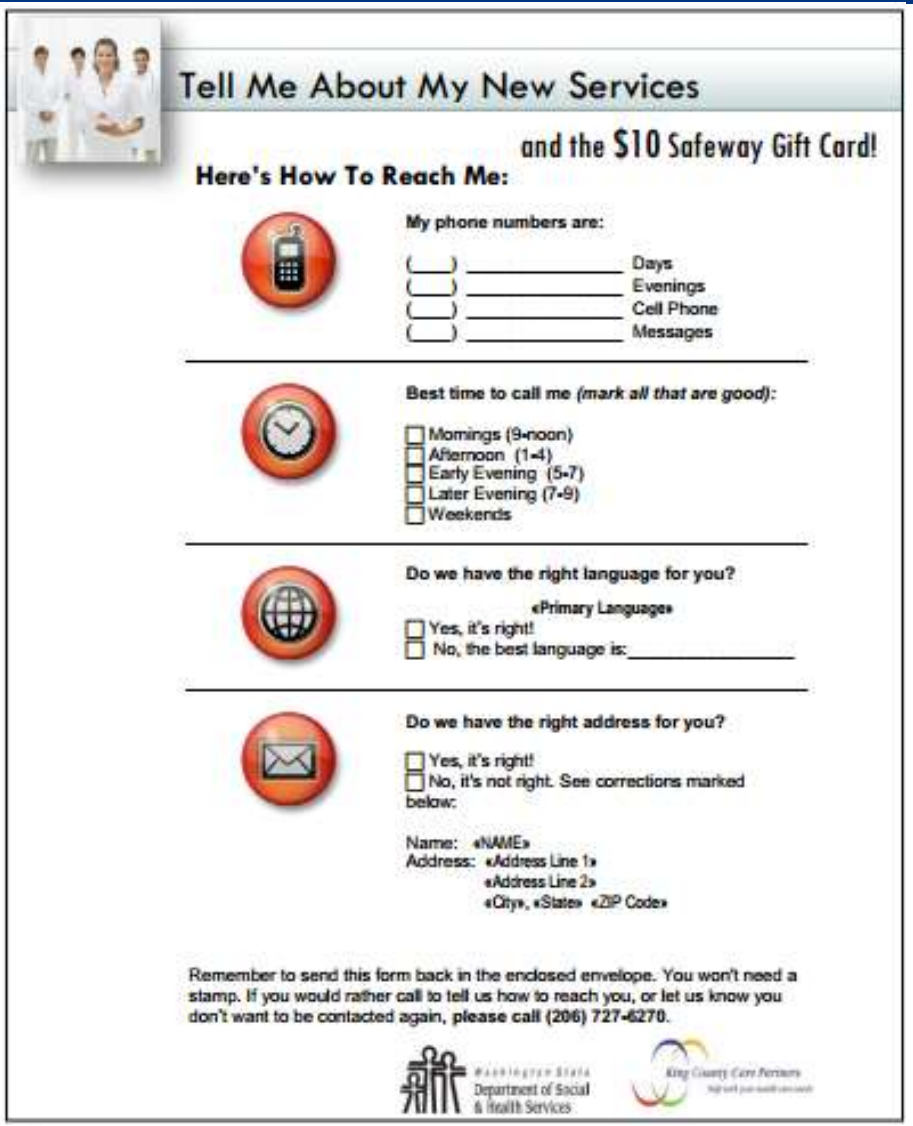
Washington State Mailing Campaign Results

Exhibit B1. Engagement of Hard-to-Find Members Before and After Enhanced Engagement Strategy



Source: Washington Department of Social and Health Services, October 2010. Full presentation available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261169.

Washington State Sample Mail-Back Form



Tell Me About My New Services

and the $10 Safeway Gift Card!

Here's How To Reach Me:

My phone numbers are:

(___) _____ Days
(___) _____ Evenings
(___) _____ Cell Phone
(___) _____ Messages

Best time to call me *(mark all that are good)*:

☐ Mornings (9-noon)
☐ Afternoon (1-4)
☐ Early Evening (5-7)
☐ Later Evening (7-9)
☐ Weekends

Do we have the right language for you?

«Primary Language»
☐ Yes, it's right!
☐ No, the best language is:_____

Do we have the right address for you?

☐ Yes, it's right!
☐ No, it's not right. See corrections marked below:

Name: «NAME»
Address: «Address Line 1»
«Address Line 2»
«City», «State» «ZIP Code»

Remember to send this form back in the enclosed envelope. You won't need a stamp. If you would rather call to tell us how to reach you, or let us know you don't want to be contacted again, **please call (206) 727-6270.**

Washington State Department of Social & Health Services

King County Care Partners

Engaging and outreaching to vulnerable populations

Maria Raven, MD, MPH, MSc
Assistant Professor of Emergency Medicine
University of California, San Francisco

July 30, 2014

Housing affects health care

- Housing is a social determinant of health[1]
- Homeless individuals have been shown to have higher mortality rates and use of acute care services[2]
- Conversely, for certain segments of the homeless population, the cost of housing provision is likely offset by concomitant reductions in health care spending[3]

1. World Health Organization, Commission on Social Determinants of Health. Closing the Gap in a Generation: Health equity through action on the social determinants of health. Available from: http://www.who.int/social_determinants/en
2. http://home2.nyc.gov/html/doh/downloads/pdf/epi/epi-homeless-200512.pdf
3. Burt MR et al. Medicaid and permanent supportive housing for chronically homeless individuals: literature synthesis and environmental scan. Washington, DC: Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, 2011 (http://aspe.hhs.gov/daltcp/reports/2011/ChrHomlr.pdf).

Program 1: New York State Medicaid

- Chronic Illness Demonstration Project (CIDP)
  - Funded by New York State Department of Health Medicaid Services to address high cost of fee-for-service Medicaid beneficiaries
  - Implemented within large public hospital system: New York City Health and Hospitals Corporation
  - PMPM on top of standard FFS reimbursements

Program 2: San Francisco Health Plan CareSupport

- CareSupport
  - Implemented in response to large influx of seniors and people with disabilities (SPDs) in FY 11-12
  - Funding from SFHP and grant from California Healthcare Facilities Finance Administration to expand program and rigorously evaluate

Homelessness, Medicaid, and health plans

- Currently, many homeless individuals are Medicaid eligible, but remain un-enrolled or have high “churn rates”
- Change projected with ACA implementation[1]
- SFHP is anticipating this change
  - Provision in current grant for transitional units
  - Staff experience, training and field work
  - Assessment questions

1. Kaiser Commission on Medicaid and the Uninsured: Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion

Program model

- Teams of BA-level care managers supervised by social workers
- Rather than create parallel system of care, attempt to maximize connections to existing health and social services
- High-touch, patient-centered, holistic approach
- Encourage care managers to be accountable across systems of care

What might influence health plans to be housing stakeholders

- Payer mix
  - Commercial vs. Medicare vs. Medicaid
- Risk arrangements
  - Risk is financial responsibility
  - More risk may mean more incentive to affect factors such as housing
- Concentrations of of vulnerable members in specific areas/housing units

Outreach to vulnerable populations

- Telephonic outreach and management does not work, especially for homeless populations
- Difficult to find, keep in contact with
- Studies show mobile phones more common than landlines
  - Mobile phone possession and service can be intermittent

Outreach to vulnerable populations

- Don’t make assumptions: OK to ask “do you have a place to stay right now” or “where are you currently staying?”
- Get information about current living situation, and in past 1-2 years
  - Can consider validated question set
- Additional information: doubled up/couch surfing, has a place today but won’t tomorrow, or living in an unsafe environment?
- Location, location, location
- Collateral contacts

Outreach to vulnerable populations

- Consider that non licensed staff may be more willing and more effective in some situations
- Experience counts
- Interview candidates carefully
- Train staff appropriately
  - Local resources
  - Housing question set
  - Motivational interviewing
  - Trauma informed care
- Assure staff have adequate supervisory support

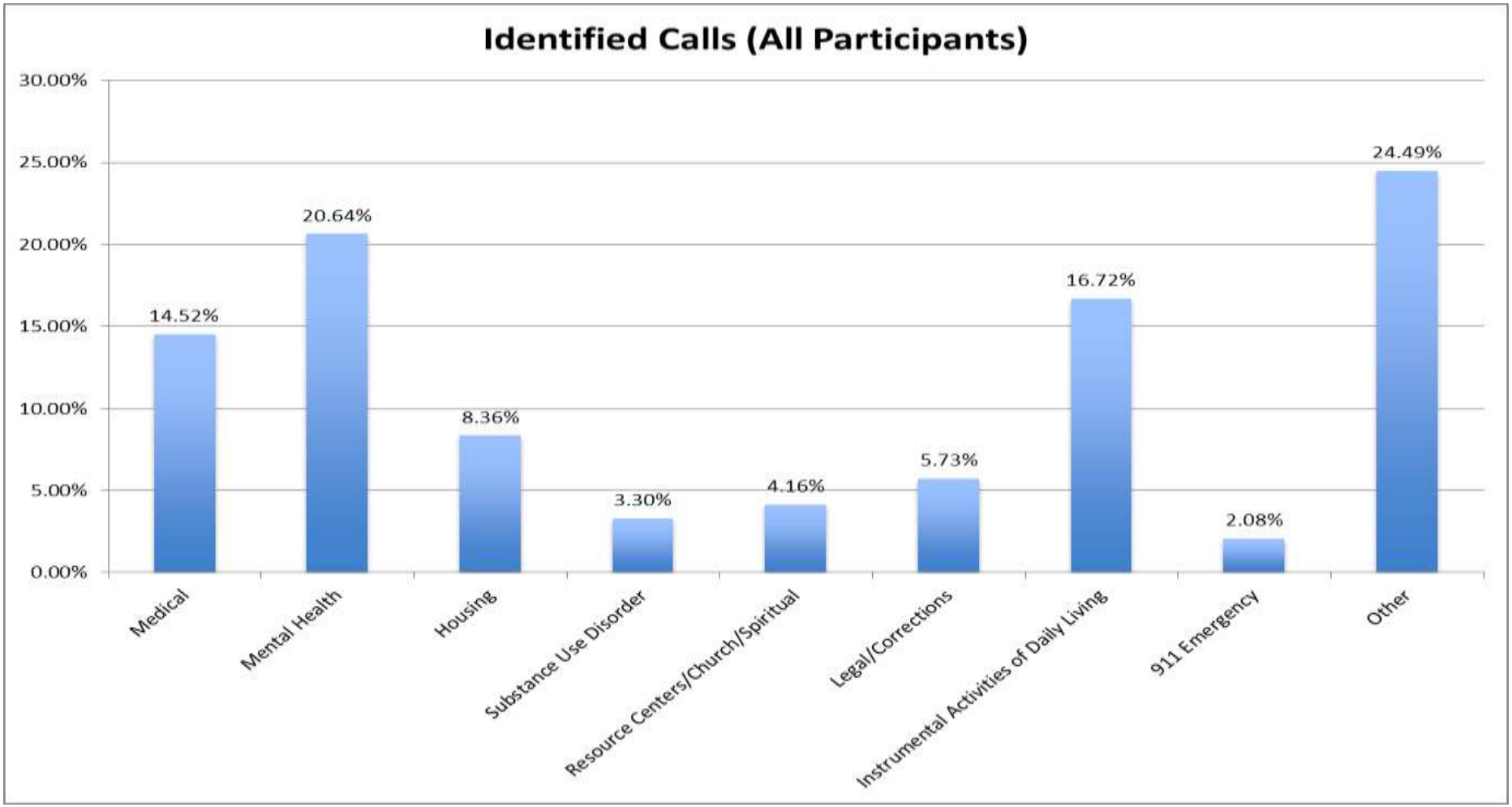
Program interventions that can benefit the homeless

- Face to face visits: corner, coffee shop, hospital/ED
- Mobile phone technology
- Aggressive facilitation of housing applications
- Partnerships with substance use and mental health
- Formal partnerships with housing organizations:
  - **Bi-directional data sharing** with patient consent/assent
  - **Patient tracking** before and after housing placement
  - Patient **co-management** (what can we take off your plate that makes sense?)
  - **Group meetings** for difficult cases

SFHP partnership with CSH and TNDC

- As part of SIF grant, 50 units in the newly renovated Kelly Cullen Community (KCC) building set aside for 50 highest cost homeless SFHP members
- Extensive outreach and work beyond “standard” job description of CareSupport team
- All 50 units filled!
- Ongoing data sharing for evaluation

Mobile phone project



Health system-housing partnerships are key to ongoing outreach, engagement

- Health system is entry (and underused intervention point) for homeless
  - Many have spent more time in health care settings than realized
- Partnerships improve communication, reduce care fragmentation
- Un-housed patients may delay getting care they need
  - Consideration for care planning and also analysis

Conclusions

- Expect increasing attention from State Medicaid programs and other payers regarding the homeless population
- Figure out who partnerships make sense for from a financial standpoint bearing in mind
  - Who is paying for which services
  - High cost portion of population
  - Cost of intervention or services
  - Whether needed services can be billed for
- ACA implementation may bring additional homeless individuals into coverage, increasing incentives for partnerships with housing

Thank you

- Questions?
- maria.raven@emergency.ucsf.edu

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Lessons from Implementation of the Intensive Outpatient Care Program (IOCP)

Lisa Mangiante, MPP, MPH
Pacific Business Group on Health

Marcus Zachary, DO
Brown & Toland

Michael Kern, MD
John Muir Health

Health Care Innovation Challenge

Intensive Outpatient Care Program

Lisa Mangiante, MPP, MPH
Director
July 30, 2014

The project described is supported by Grant Number 1C1CMS331047 – 01 – 00 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

The contents of this presentation are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

What is IOCP?

- $19 million HCIA award to PBGH to support care re-design for high-risk, medically complex patients
  - Chronic conditions where hospital use can be reduced through care coordination, self-management and provision of ambulatory care
- Built on successful pilots in commercially-insured population: Boeing (Everett Clinic), PG&E and CalPERS (Humboldt-Del Norte IPA)
- Initially Medicare--now Medi-Cal and Dual Eligible
- Goal -- demonstrate it's possible to improve care, demonstrate scalability, and meet cost, clinical and patient experience metrics

INTENSIVE OUTPATIENT CARE PROGRAM
PACIFIC BUSINESS GROUP ON HEALTH

Wave 1 & Wave 2 Partners

Wave 1 Partners

1. Brown & Toland
2. Cigna Medical Group (AZ)
3. John Muir Health
4. Partnership HealthPlan of CA
5. St. Joseph Heritage Health
6. Sharp Community Medical Group
7. Sharp Rees-Stealy
8. Sutter
    1. Sutter Medical Foundation
    2. Sutter Gould Medical Foundation
    3. Sutter Pacific Medical Foundation
    4. Palo Alto Medical Foundation (W2)

Wave 2 Partners

1. Arizona Care Network (AZ)
2. Dignity Health Medical Group – Dominican
3. Dignity Health Medical Foundation – Mercy Medical Group
4. EPIC Management, L.P.
5. Greater Newport Physicians
6. Presbyterian Intercommunity Hospital
7. Santa Clara County IPA
8. Scottsdale Health Partners (AZ)
9. Southern California Integrated Care Network – San Bernardino
10. Southern California Integrated Care Network – Ventura
11. St. Luke's Health System (ID)
12. St. Rose Quality Care Network (NV)
13. The Polyclinic (WA)
14. Community Health Center Network

IOCP By the Numbers

- **$29.6** million: projected savings over 3 years (total cost of care)
- **27,000**: number of patients committed in HCIA award
- **15,000**: goal by 6/30/2015 (absent no-cost extension)
- **6,800**: number of patients enrolled since May 1, 2013
- **23**: participating partners
- **26-250**: monthly enrollment by group
- **5**: states represented (CA, AZ, ID, NV and WA)
- **3** Year Metrics
  - 5% reduction in hospital use and ED visits
  - 4% improvement in clinical outcomes
  - 2% - 4% improvement in patient experience

Intensive Outpatient Care Program
Pacific Business Group on Health

IOCP "Guardrails" to Engage Patients

- Care coordinators maintain longitudinal 1:1 relationship and as needed provide warm handoff to relevant support services (e.g., home health, DME, behavioral health, transportation, community care, Area Agencies on Aging)
    - In IOCP, common mental health issues are depression and anxiety

- At minimum, two way communication (phone, email or in person) between care coordinator and patient at least once per month during acute phase, with intensity decreasing as patients reach stability

- Care coordinators complete a face-to-face "supervisit" within 1 month of enrollment
    - Assessment with PAM, PHQ-2, and VR-12 tools; also medication reconciliation
        - gathered through motivational interviewing.
    - Support patients' Shared Action Plan (not a care plan), and work towards at least one goal per year

- 24/7 access, with communication to care coordinator next business day

Key Learnings

- Executive and clinical champion support necessary
- Enlist support for the program and to take an active role in patient engagement
  - Outreach by Medical Director engagement big factor in success
  - Engage office staff as well
- Model works well when integrated into entire population strategy for high risk patients
- Challenging in dispersed provider environment (e.g., IPA vs. Foundation)
- More patients than expected need assistance with Rx and visit co-pays, as well as connection to Meals on Wheels (transportation was expected)
- Strong project management is critical

Key Learnings

- Staff recruitment can be a challenge
  - Geography
  - Culture shift to a different kind of nursing
    - Takes time for coordinators to be comfortable with new approach
    - Attributes: empathy, listening, value longitudinal relationships with patients
    - For some, this approach simply not in comfort zone
- Big impact on enrollment when there is staff transition, vacation or leave

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BROWN & TOLAND PHYSICIANS

Physician/Patient Engagement

Help me help you

Dr. Marcus Zachary
Senior Medical Director at Brown and Toland Medical Group.
July 30, 2014

Brown and Toland Medical Group

Brown & Toland's 1,700 primary care and specialist physicians care for more than 300,000 HMO and PPO patients, in the San Francisco Bay Area. (As of 8/1/11, Alta Bates Medical Group from East Bay is now part of Brown & Toland.)

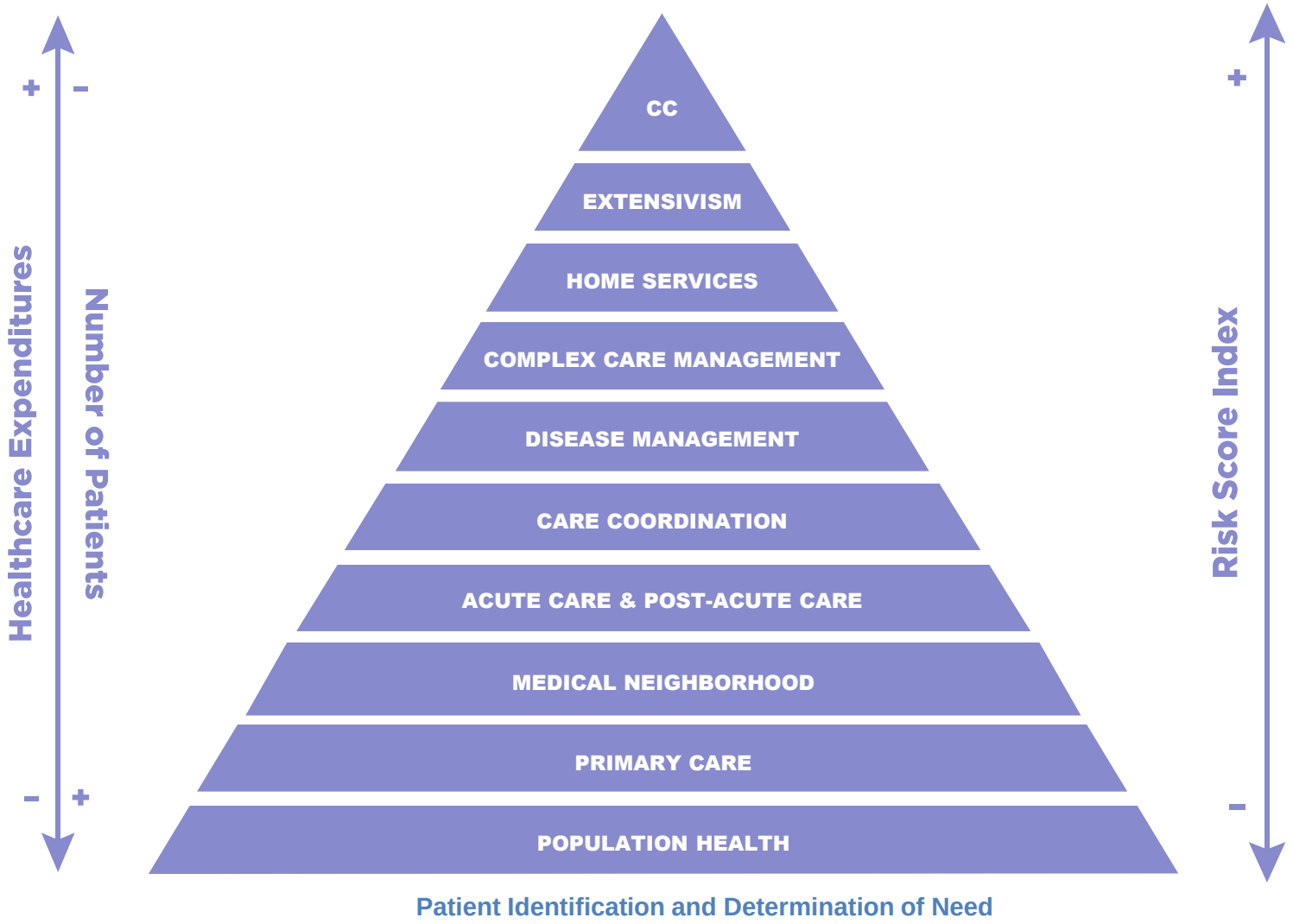
- Using the latest technology, Brown & Toland has connected independent physicians and hospitals to improve health care quality and reduce costs.
- Brown & Toland first to demonstrate to FTC as a clinically integrated IPA model (can do HMO and PPO contracts for our providers)

BROWN & TOLAND PHYSICIANS

How did we get here ?

- 3 years ago BTMG went into total cost of care with CMMI/CMS via its Pioneer program. Our first ACO program.
- Since have expanded into commercial HMO and PPO ACO
- Marketplace shifting (again) away from FFS back to total cost however financials tied to outcomes/quality
- Participation in these programs requires prospective identification of patients and broad partnerships

Coordinated Care Across the Continuum



Assemblage of Scalable Infrastructure

Reorganizing a network

- Initial approach prospective pursuit of high risk patients
- Physician agnostic
- Moving towards a “pod” approach which essentially creates network concentration of resources without physical co-location
- Providers have complete care teams comprised of: their physician services rep, an outreach coordinator, social worker, inpatient and outpatient care managers, utilization nurse

Now what ?

Patient Identification

- Suite of applications geared towards the analysis of patients in context with the primary care providers including predictive logic
- Inpatient care managers meeting patients at hospitals and other inpatient facilities
- For HMO, can use authorizations
- Monitor utilization patterns particularly hospital and ER usage
- Disease management programs
- But most important is our provider network, the physicians

What we did first…

- Used applications to identify high risk patients to create pursuit lists
- Nurse/care managers cold called the patients
- Many of the contact numbers were bad (from plans) so time wasted
- Patients did not understand why we (BTMG) were calling; “why is the health plan calling me?” “How did you get this information?”
- A not insignificant amount of these patients had passed away

What we did next…

- The nurse and/or coordinator called the physician's office
- Main objective was to verify the contact number, get some medical history on the patient, and ideally have the doctor validate that the person was appropriate to contact
- Oh, verify the patient still alive
- In addition, a nurse practitioner reviewed the electronic medical chart
- Time consuming and often times unsuccessful getting all the information we needed
- Level of successful patient engagement did not improve

And then…

- After attending one of the IOCP/PBGH meetings, we incorporated some of the shared strategies and things got better!!!!

Current Approach

- Start with the identified patient population submitted to IOCP/PBGH
- Ranked the providers purely on volume of those patients in their practice
- Each provider's panel risk stratified
- Medical Director (me) email's provider with introduction and the "ask"
- Send the list
- Follow up in 2-3 weeks and set up meeting
- Meet the provider in their office and bring my team, usually a nurse practitioner, social worker, and physician service rep
- Get what you can from the provider
- Distribute to the wider complex care management team
- Close the communication loop with the provider

Results????

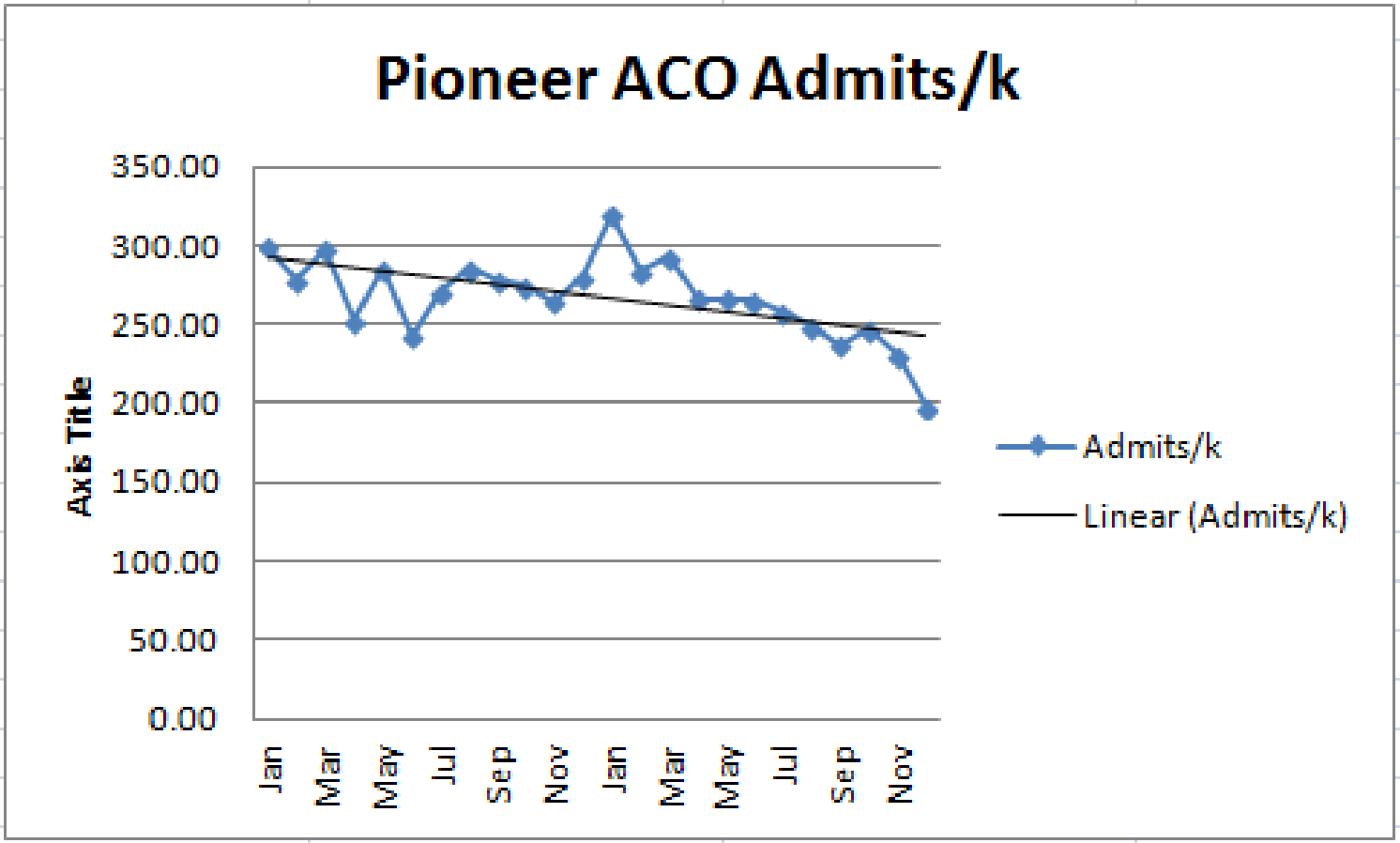
- Averaging 90 % successful patient engagement rate!!!!

Hints on how to make the provider “ask”

- The first email is simply a cry for help
- Keep the expectations low. The provider can get overwhelmed if 100s of patients so say can you give me just 30 names
- Be very specific regarding the criteria of the patients you seek
- MUST get clinical information too
- Use the face to face meeting to educate the provider about all the services available and who you are looking for
- Give them easy way to contact you
- Train the whole team to always loop back with the provider. Its not about the short term but the long term

Evolving processes

- Providers identify patients for us and “task” care management via the enterprise platform (self sustaining referrals)
- Quarterly “rounds” with engaged providers to both report out and reload
- Integrated pods/teams will include referral nurse, clinical nurse, physician service reps, social worker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Intensive Outpatient Care Program and the John Muir Medical Home

Mike Kern, MD
Medical Director

JOHN MUIR HEALTH

John Muir Medical Home

Contra Costa Market Context

- John Muir Health: two general hospitals, a psychiatric hospital, and a foundation model physician organization
- Approximately 1000 MD's in private practice, with a 140 doctor primary care group, including hospitalists
- Large managed care and CMS ACO populations served by foundation
- Medical Home (MH) pilot to improve service quality, and provide integrated care planning and interventions for complex patients at high risk for adverse health outcomes, high service use, and high costs
- MH Case Manager based in primary care practice, for the purpose of assisting the physician and healthcare team

Our Embedded Medical Home Model

- Concord site chosen with 14 PCP's practicing in single office, with about 25,000 patients
  - MH opened in 2010
  - Subsequently replicated at Rossmoor, Brentwood, and Walnut Creek sites
  - Different sites, different demographics, similar outcomes
- Physician leadership strongly supportive of the MH model
- Patient mix includes large Medicare ACO and Medicare Advantage populations
- RN Case manager and Healthcare Coordinator embedded into practice
  - Facilitates face-to-face engagement with patients, physicians, and practice staff to implement MH concepts
- Standardized training for MH staff using the Johns Hopkins "Guided Care" model

Our Central Medical Home Model

-Three RN/LVN teams provide Care Coordination services for 70 smaller practices

-Monthly face to face meetings

-Clinical pharmacist and social workers support the teams

-Four Disease Management Associates who provide clerical and logistical support for all the MH teams

JOHN MUIR HEALTH

IOCP and the MH model

- John Muir Health joined Wave 1 of the collaborative in 2012
- IOCP brought more rigor into our patient engagement process
- Emphasis on social issues, depression screening, patient activation measurement
- Data submissions to Milliman expected to provide more insight into what we are doing intuitively

The Future of the MH model

- MH enhancements
  - Palliative Care: ambulatory palliative care, palliative care 101 for the practicing physician, and palliative care in the SNF
  - Behavioral health: co-location of psychiatric NP's in the Outpatient Care Centers, leading to integration of BH within the PCP practices
  - Pharmacy: anticoagulation, poly-pharmacy, diabetes care
  - Specialists: key SP to move the MH model to a Medical Neighborhood concept

Concerns for the Future Model

- Can a virtual multispecialty group model succeed as a MN without financial integration?
- How can we best make use of big data, risk adjustment, and other analytics?
- Can we provide near real time measurement of interventions on key clinical outcomes, and emphasize the interventions that work best?
- Can we pay our physicians for the value they create, and not just for the services they provide?

Results to date: Change in Utilization

- MH enrollees experience a dramatic drop in inpatient utilization

	Medical Home Group	Medical Home vs. Control Group
	% Change Pre vs. Post Enrollment	% Utilization Change
Discharges	**-38%**	**-20%**
Observation	-59%	-31%
Outpatient	-13%	-8%

In 2013, 1730 hospital admissions were avoided in the MH population

Challenges and Lessons Learned

- Engaging physicians is key
  - About half the doctors using services regularly; others referring patients less often
- Appropriate patient selection difficult and engagement requires effort
  - Behavioral or social problems can be a barrier
  - Only 2-5% of patients are sick enough to warrant this level of management
  - Need to identify “rising risk” patients and manage them in a less costly yet effective way
- Coordination with inpatient team is a work in progress
  - Care transitions are a vulnerable phase for the frail patient
  - Readmission reduction is crucial to success

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Approaches to Trauma-Informed Care

Rachel Davis, MPA
Center for Health Care Strategies

Laurie Lockert, MS, LPC
CareOregon

Northern California Regional Convening: Improving Care for Patients with Complex Needs

July 30th, 2014
Oakland, California

Approaches to Trauma Informed Care

Presenters:
Rachel Davis, Center for Health Care Strategies
Laurie Lockert, CareOregon

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

Hx of suicidal ideation

Bipolar disease, manic

Drug-seeking behavior

Hand fracture

Panic disorder

PTSD (post-traumatic stress disorder)

What Lisa learned from Jake…
…outside of Jake's Medical Record

Passions and Interests

- He loves dogs and likes to help elderly people
- He is meticulous in grooming and keeping his surroundings clean
- He enjoys landscaping and yard work
- He would ask to walk on the street side of Lisa so she would not be splashed
- He insisted on opening doors for her "my mom taught me to be respectful"

Life Experiences

- Joined white supremacy group which provided a place where he could belong
- DX of borderline intellectual functioning in elementary school
- Acknowledged substance abuse to address mental health symptoms
- He and his mother were physically & verbally abused by an alcoholic father – he requested a female provider due to this abuse ("it is hard not to freak out when guys touch me")
- Easily overwhelmed by loud voices, large numbers of people and language that is "over my head"

What Happened?

Built trust : listened, transparency, client's pace

Identified goals: new PCP and stable housing

Plan ahead: communicate future steps

check for understanding

CHCS Center for Health Care Strategies, Inc.

Advancing access, quality, and cost-effectiveness in publicly financed health care

Trauma Informed Care:
Overview and National Case Studies

Northern California Regional Convening:
Improving Care for Patients with Complex Care Needs

Oakland, California

July 30, 2014

Rachel Davis
Senior Program Officer, Center for Health Care Strategies

What is Trauma Informed Care?

- Instead of asking “What’s wrong with you?” asks: “What happened to you?”
- Recognizes that trauma has effects on physical health outcomes, behavior patterns, and the physiological ways that information gets processed
- Acknowledges that many “problem” behaviors survivors exhibit are actually coping mechanisms
- Guides systems in how to avoid re-traumatizing individuals

Trauma Informed Care vs. Trauma Treatment

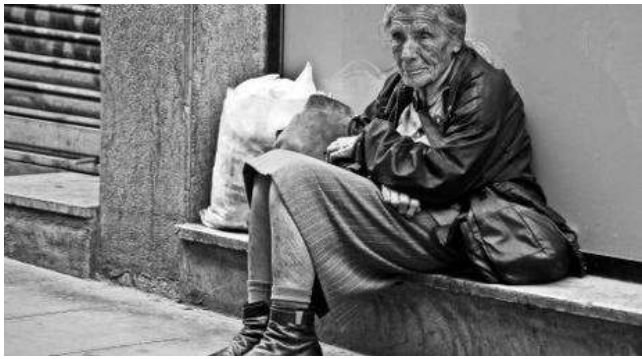
- **Trauma informed care** is a lens that organizations or staff can adopt to better understand their members' behaviors and work more skillfully with them
- **Trauma treatments** are actual clinical approaches utilized by trained professionals to treat the symptoms of trauma
- Can you have one without the other…?

Trauma Treatments

Treatment	Features	Results
Eye Movement Desensitization and Reprocessing (EMDR)	Uses bilateral stimulation (moving eyes back and forth) to rewire the way that traumatic memories are processed	RCT found that 84-100% of single trauma victims were PTSD-free after 3 sessions
Prolonged Exposure (PE) Therapy	Desensitizes individuals to trauma by repeatedly revisiting the memory	Average PE patient had better outcomes than 86% of counterparts in control group
Seeking Safety	Integrated approach to treating PTSD and substance use, focuses on creating sense of safety	Positive outcomes for multiple populations
Sanctuary Model	Framework for treating organizational trauma by creating a healing environment	Designated a “promising practice” by the California Evidence-Based Clearinghouse for Child Welfare

Trauma and Complex Populations

- The experience of trauma crosses gender, socio-economic, ethnic, and racial lines, but…
- Many "complex" Medicaid beneficiaries display symptoms associated with trauma:
  - Higher disease rates
  - Higher rates of substance use and behavioral health disorders
  - Poorer social outcomes
- TIC as a different way to successfully engage them?



CASE STUDY

Southcentral Foundation (SCF)

- Alaska Native-owned non-profit health care organization serving 60,000+ Alaska Native and American Indian people throughout Alaska, including 60 rural villages
- Native Alaskans display effects of “historical trauma”
- Family Wellness Warriors Initiative: training and modeling
- SCF pays for all staff to attend first week of training

CASE STUDY

Camden Coalition of Healthcare Providers

- Seeks to improve the quality of care provided Camden, NJ residents
- Interviews with program enrollees revealed high degree of childhood trauma
- Engaged the broader Camden community in discussions with 2013 city-wide trauma summit
- The Healing 10: ten organizations in Camden seeking “Sanctuary Certification” in Sanctuary Model (three year certification process)

CASE STUDY

Commonwealth Care Alliance

- A non-profit care delivery system for Medicaid and Medicare beneficiaries with complex needs in and around Boston, MA
- Piloted TIC intervention for patients with history of trauma
- LCSW joined daily rounds to bring TIC perspective to discussions
- Clinicians gained insight into how they interacted with patients, increased emphasis on patient history
- Next steps: TIC or trauma treatment?

Food for Thought

- Buy-in from leadership is critical
- Should be a systems-wide approach: “in the water” so that all staff in an organization understand and support its importance
- Staff should receive comprehensive and on-going training
- Educating clinicians and community partners about trauma, its effects, and how to incorporate a trauma informed care lens in their work is a challenge, but also valuable
- More data is needed for complex populations

CHCF Northern California

Complex Care Workshop

July 30, 2014

Developing a Trauma Informed Workforce

Laurie Lockert MS, LPC

Manager Health Resilience Program, CareOregon

PHASE I

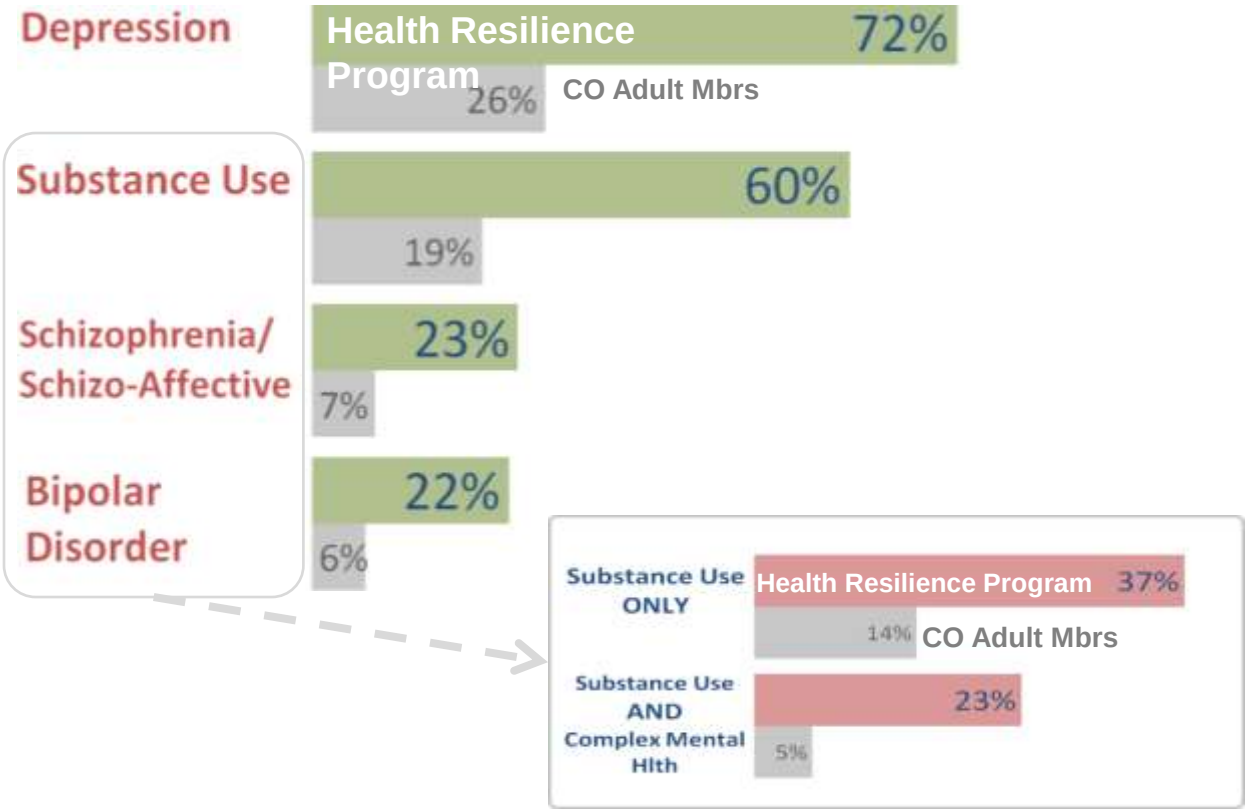
In the Beginning…

History Trainings **Hiring** **Critical**

PHASE I

Seeking out High Acuity Members

Compared to the overall CareOregonadult Medicaid and Dual member population…
Members enrolled in the Health Resilience program
are *more likely* to experience
high disease burden and psycho-social challenges



PHASE II

Learning from 'Huddles'

Gathering the stories

PHASE III

New Understandings

Client Level:

Capturing not *just any* "high utilizer" but a Population with Extensive Trauma Histories



Staff Level:

Master's training: prepared to work with trauma behaviors & safety issues

PHASE III

Sustaining Our Culture

Fostering a Learning organization

TIC Leadership

Tell the stories

Transparent Management style

Incorporate **meditation&gratitudes**

Changing Course, Asking Questions

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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Measuring the Impact of Our Work

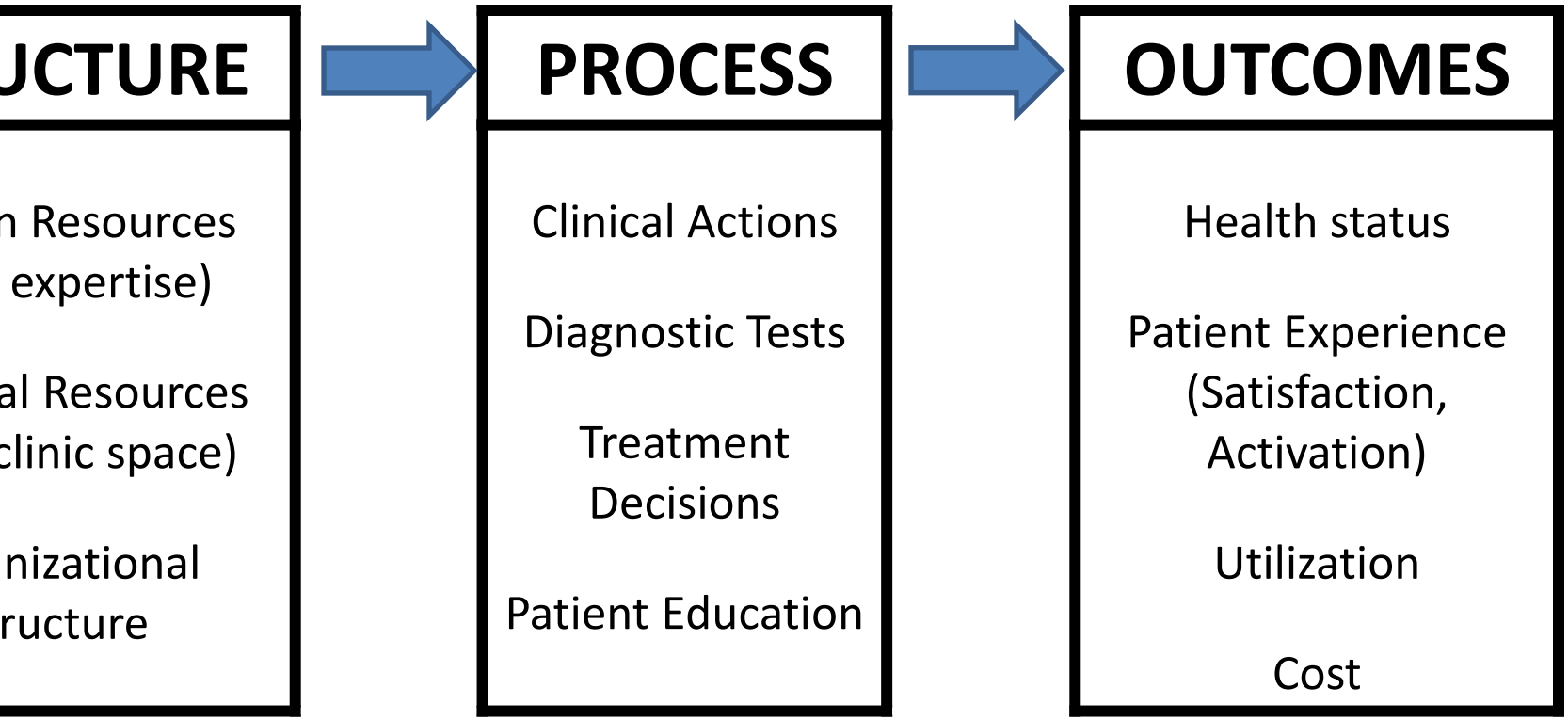
Donna Zulman, MD, MS

VA Palo Alto Health Care System
Stanford Clinical Excellence Research Center

Measuring the Impact of Complex Care Interventions

July 30, 2014
CHCF Northern California Complex Care Workshop

Donna M. Zulman, MD, MS
Division of General Medical Disciplines, Stanford University
Center for Innovation to Implementation, VA Palo Alto



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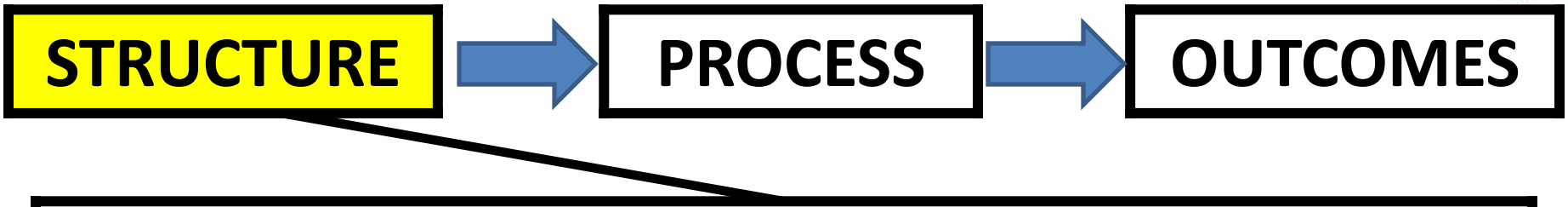


Human Resources	Multidisciplinary team
Material Resources	Patient tracker
Organizational Structure	Co-location with primary care Integration with primary care medical home

STRUCTURE → **PROCESS** → **OUTCOMES**

Comprehensive Intake	% of intake completed
Frequent Contact	# inpatient/phone contacts per patient
After-Hours Access	# after-hours calls (and reasons for calls)
Chronic Condition Management	% patients who received motivational interviewing, % who had goals assessed
Primary/Specialty Care Coordination	% of specialty care visits attended, % with pre-visit plan completed; # contacts with specialty care providers
Transition Support	% patients contacted during/after hospitalization
Social/Community Resources	Assessment of services received/utilized

STRUCTURE → **PROCESS** → **OUTCOMES**

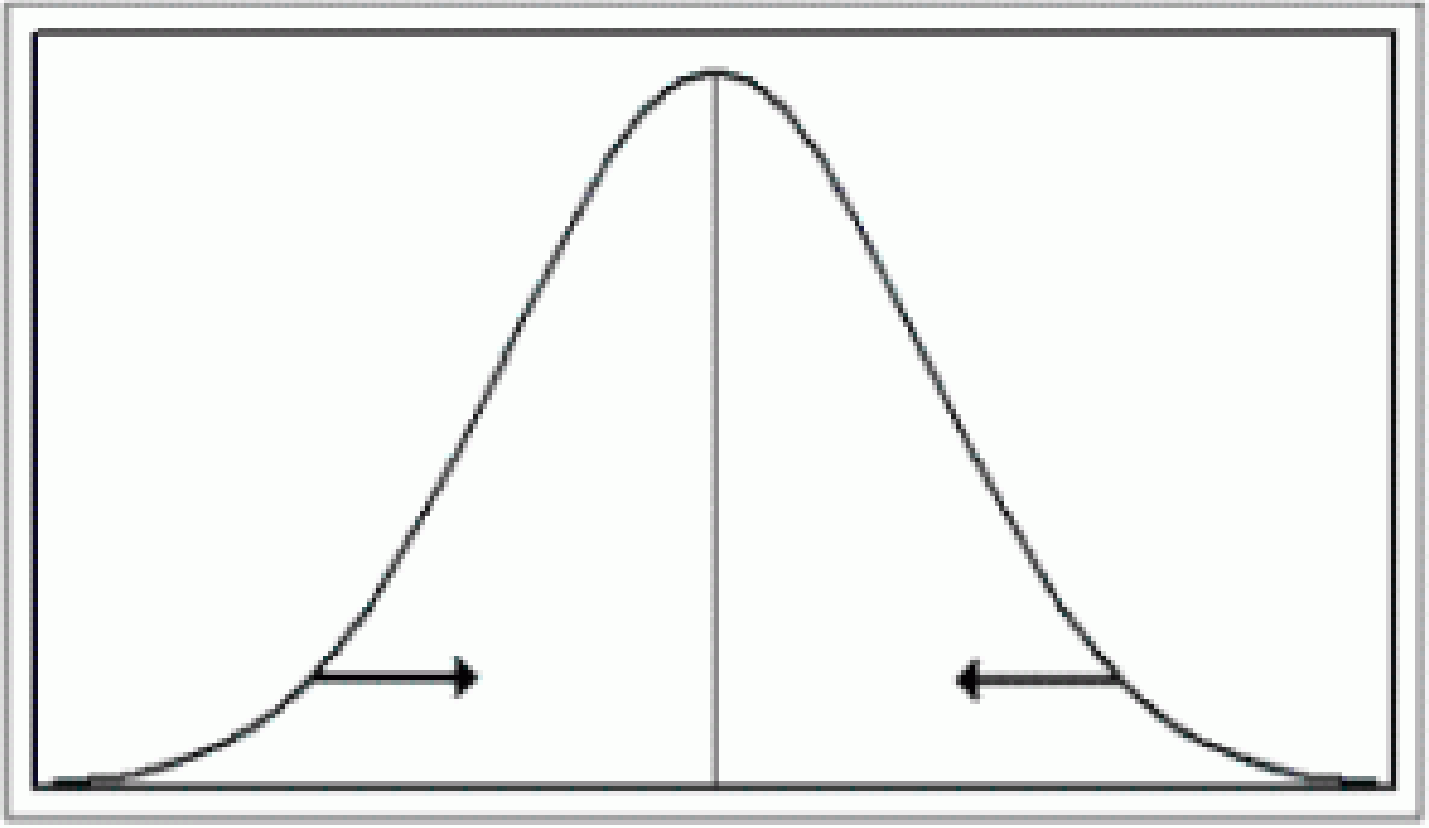
Patient Experience	Satisfaction with ImPACT and with VA care Activation (PAM-6)
Clinical Outcomes	Symptom burden (fatigue, pain, stress, sleep) Functional status
Quality of Care	Access to ImPACT or primary care after discharge Location of patient deaths (home vs. acute setting)
Utilization	# Hospitalizations and ER visits (total ACSCs) Length of stay in inpatient settings # Visits to primary, mental health, specialty care
Costs	Total Costs of specific inpatient/outpatient services
Organizational Outcomes	Provider satisfaction/burn-out Access for other patients

A Couple of Evaluation Lessons Learned…

Operations-research collaborations are a win-win

Design & Implementation	Evaluation
Determine program objectives and timeline	Develop study design, outcome metrics, and analysis plan
Identify the target population	Identify patients for intervention and comparison groups
Determine clinical team and intervention components	Complete pre-implementation needs assessment
Begin program implementation	Collect and analyze baseline data
Iteratively assess and improve program	Collect and analyze process and implementation data
Collect follow-up information about patients	Evaluate program success and implementation

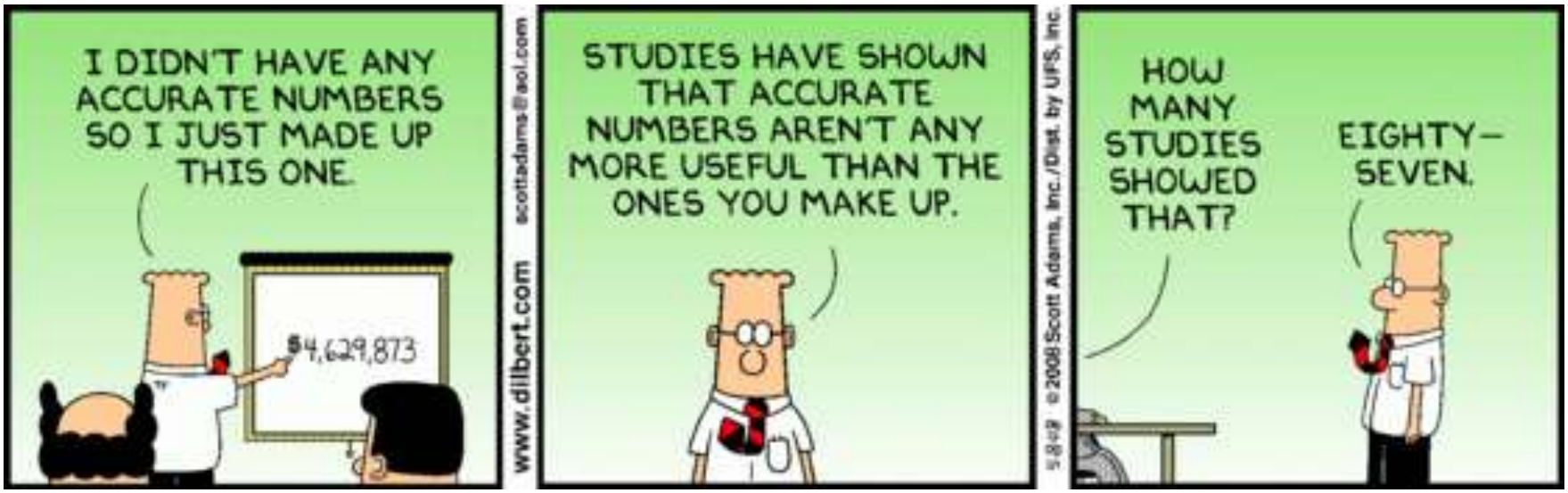
Regression to the Mean is a Powerful Force (or… “most people are average”)



Subgroup analyses provide valuable insight

"Data don't make any sense,
we will have to resort to statistics."

Data Validation is Critical



Examples of Data Quirks:

- Encounters with cost = $0
- Overlapping admissions
- Admissions with cost = $0 (until patient is discharged)
- Patient with change in SSN
- 1 day admissions that were handled in ER
- Costs after patient had died

Summary:
Tips for Complex Care Program Evaluations

- **Structure-Process-Outcome framework** can guide evaluation
- **Consider measuring program's impact on a range of measures** Patient experience, clinical outcomes, quality of care, utilization, costs, organizational change
- **Operations-research collaborations** are a win-win
- **Regression to the mean is a powerful force**- include a comparison group when possible
- **Subgroup analyses provide valuable insight**- identify subgroups in advanced based on clinical program's focus and expected effects
- **Data validation is critical**- "garbage in, garbage out"

Thank You

ImPACT Team (VA Palo Alto)
VA Office of Specialty Care Transformation
VA Office of Primary Care
VA Health Services Research & Development

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Policy and Innovation Funding Landscape

Giovanna Giuliani, MBA, MPH
California HealthCare Foundation

Cari Jarbouai, MPH, MSW
California State Innovation Model (CalSIM) Project Manager, Health Homes for Patients with Complex Needs

Creating Health Homes for Patients with Complex Needs

Cari Jarbouai, MSW, MPH
Project Manager
California State Innovation Model (CalSIM) Initiative

CHHS
California Health & Human Services Agency

Presentation Roadmap

- California State Innovation Plan
- ACA Section 2703 Health Home Option
- CMMI Testing Grant Next Steps
- Q&A

California State Health Care Innovation Plan

The California Innovation Plan includes four initiatives and six building blocks, which are collectively designed to achieve savings within three years, as well as to catalyze longer term transformations of the health care delivery system. The Innovation Plan brings together leadership from California's public and private sectors to work together to implement these initiatives and building blocks.

The Innovation Plan has three overarching goals designed to advance the Triple Aim:

1. Reduce health care expenditures regionally and statewide.
2. Increase value-based contracts that reward performance and reduce pure fee-for-service reimbursement.
3. Demonstrate significant progress on the Let's Get Healthy California dashboard.

TRIPLE AIM

Lower Costs	Better Health Care	Better Health

Let's Get Healthy California (LGHC) is the foundation for the Innovation Plan. LGHC identifies six goals to achieve health and create health equity: Healthy Beginnings, Living Well, End of Life, Redesigning the Health System, Creating Healthy Communities, and Lowering the Cost of Care.

INITIATIVES

MATERNITY CARE

ISSUE C-sections are more costly than vaginal deliveries and can lead to adverse maternal outcomes. C-sections have increased from 22% to 33% from 1998-2008.

GOAL Reduce elected early deliveries, reduce C-sections, increase Vaginal Birth After Delivery.

HEALTH HOMES FOR COMPLEX PATIENTS (HHCP)

ISSUE 14 million CA adults have 1 or more chronic conditions. 5% of CA population accounts for over 50% of health care expenditures.

GOAL Expand HHCP model to provide high-risk patients with better coordinated care.

= 50%

PALLIATIVE CARE

ISSUE 70% of Californians report preference to die in their homes; only 32% do.

70%

GOAL Better align care with patient preferences with new benefit and payment approaches.

ACCOUNTABLE CARE COMMUNITIES (ACC)

ISSUE More than 75% of health care costs are due to chronic diseases, which are highly preventable, and in which significant racial and ethnic disparities exist.

GOAL Pilot ACCs to improve the health of the entire community by linking community prevention activities with health care.

BIKE ROUTE

BUILDING BLOCKS

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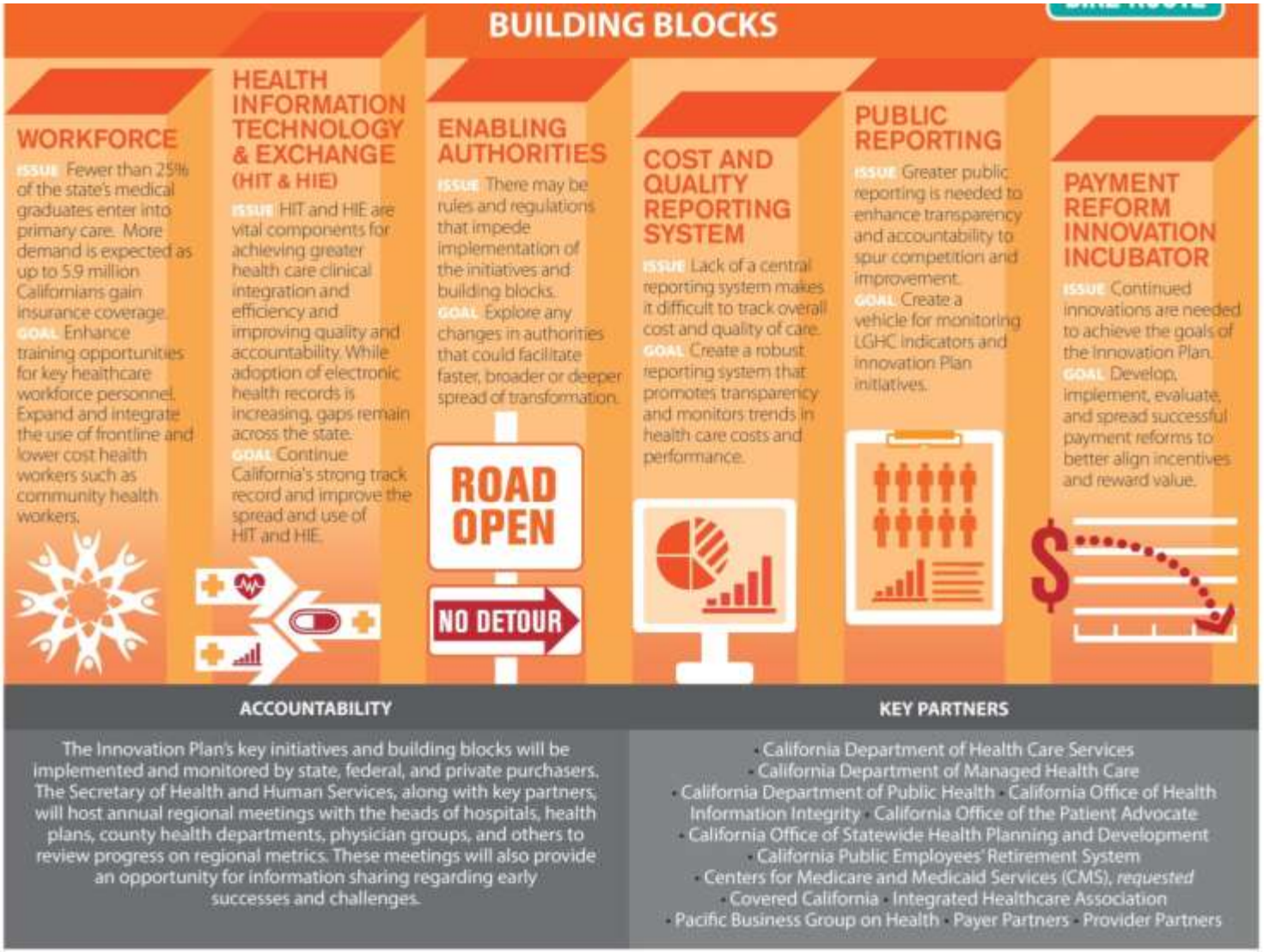

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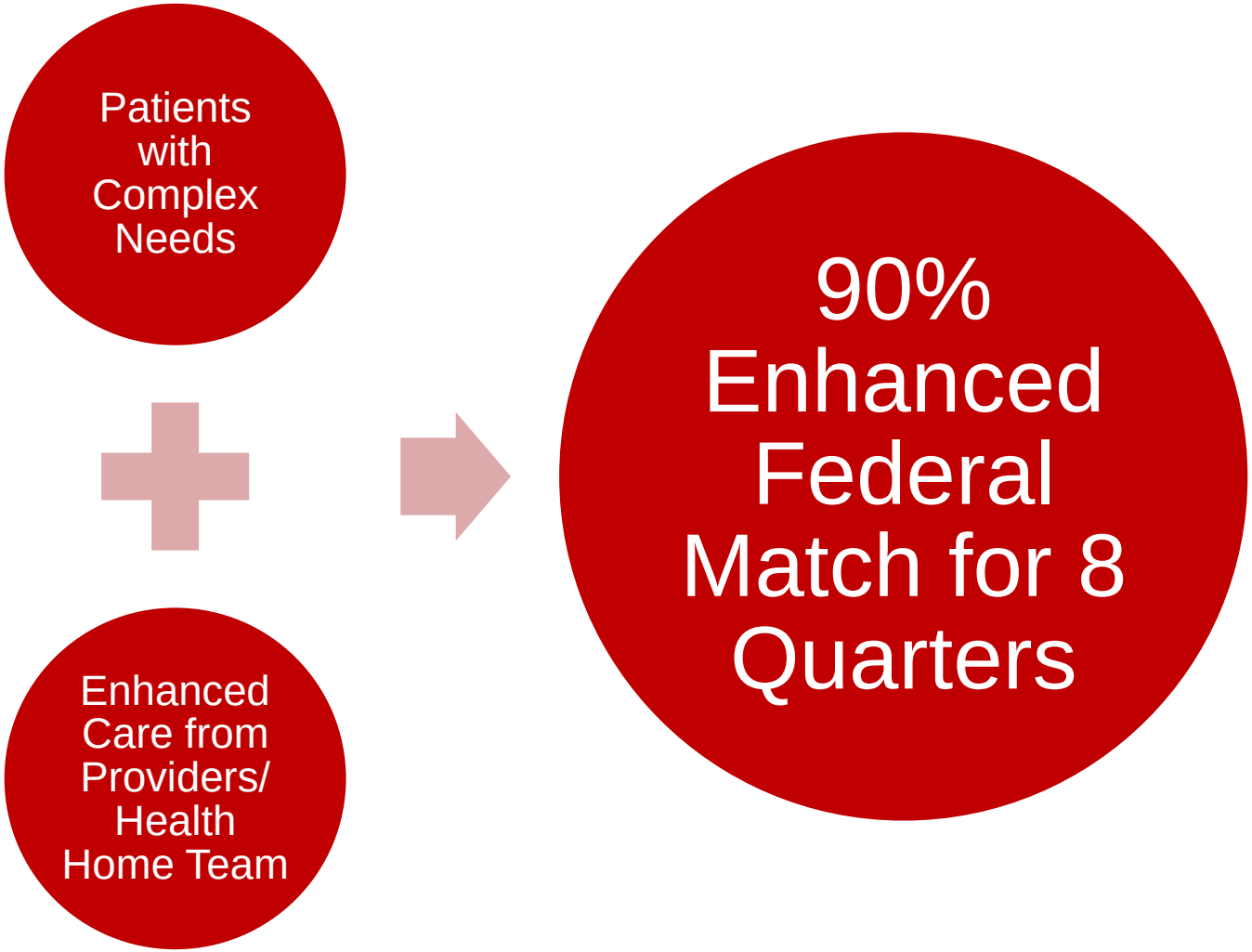
Section 2703 Overview (Medi-Cal)



Section 2703: Patient Population

- Medicaid Eligible Individuals having:
  - Two or more chronic conditions*
  - One chronic condition* and the risk of developing another
  - At least one serious and persistent mental health condition

*Chronic conditions include: a mental health condition, a substance abuse disorder asthma, diabetes, heart disease and BMI >25. States may add other chronic conditions for review and approval.

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Section 2703: Provider Requirements

- Health home providers must offer 6 broadly defined health home services:
  - Comprehensive Care Management;
  - Care coordination;
  - Health promotion;
  - Comprehensive transitional care from inpatient to other settings;
  - Individual and family support;
  - Referral to community and social support services

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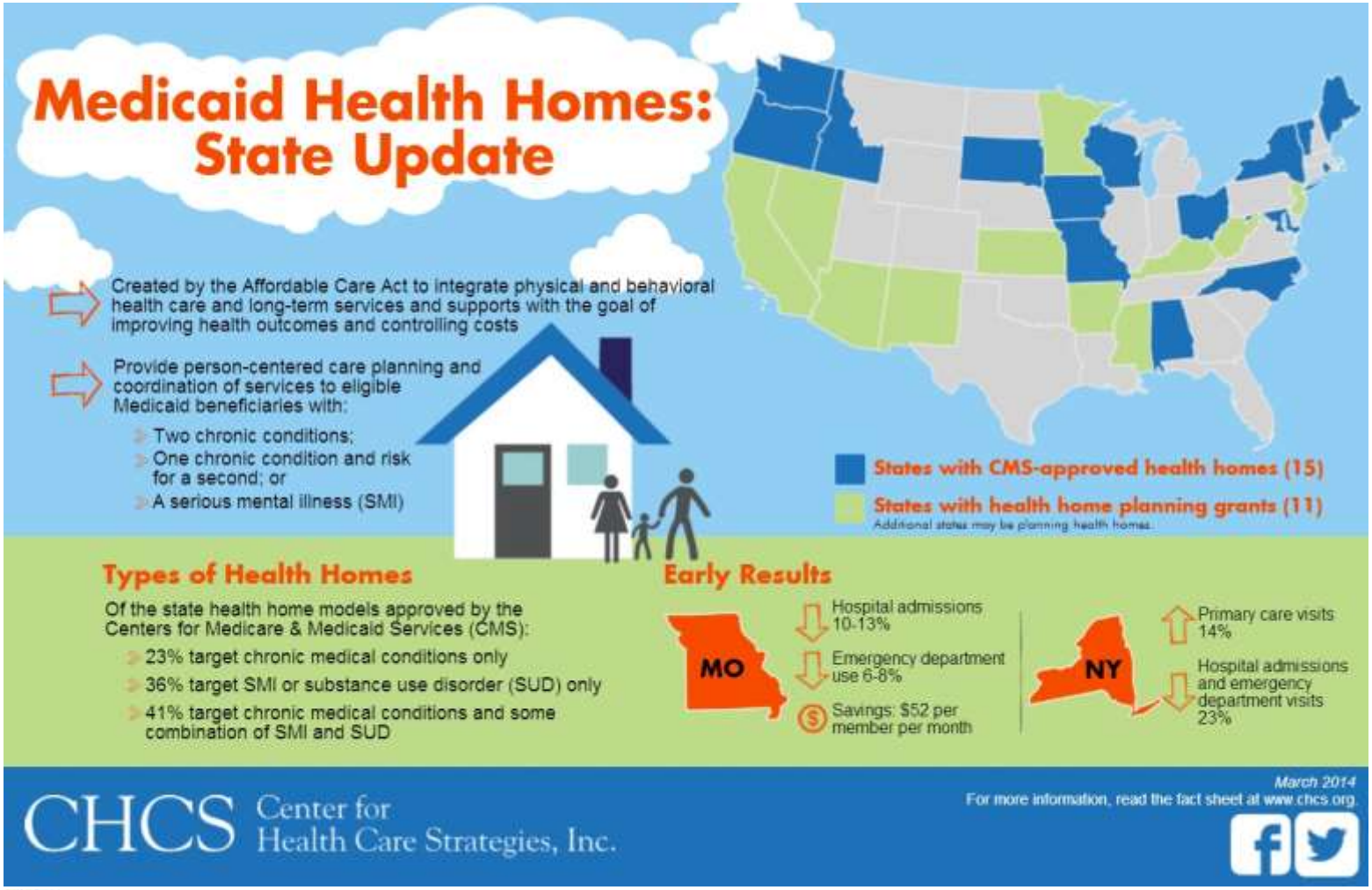
Section 2703: Current Landscape



Section 2703: SPA Considerations

- **Geographic region** – Target specific geographic areas for health homes, or implement statewide.
- **Priority Populations** –Given federal grant as well as program requirements, California is focusing on populations with high levels of avoidable health care costs.
- **Tiering** – Prioritize to serve patients by acuity or target all patients with a named condition.
- **Provider Qualification** - Define the required infrastructure and related qualifications for providers to be designated as health homes.

Section 2703: Spread care models

- Determine key components and functionality, including palliative care capacity, community linkages
- Test payment methodology and rates
- Support inclusion of community health workers
- Provide technical assistance and support for implementation
- Submit State Plan Amendment; once approved - 8 quarters of enhanced federal match for health home activities

CalSIM Grant Next Steps

- CMMI Testing Grant submitted July 2014
- Awards announced in November 2014
- Jan 2015 – December 2018 grant period (unless feds delay)
- Aug-Dec 2014 continued planning, including target populations, structure of provider technical assistance
- Year One to include planning/CMS approvals/provider readiness

Three years for health home implementationo

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Questions and Comments

For more information see: http://www.chhs.ca.gov/pages/pritab.aspx
Email any questions or comments to: innovate@chhs.ca.gov

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Thank you!

Improving Care for Patients with Complex Care Needs

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