Improving Care for High-Need Patients

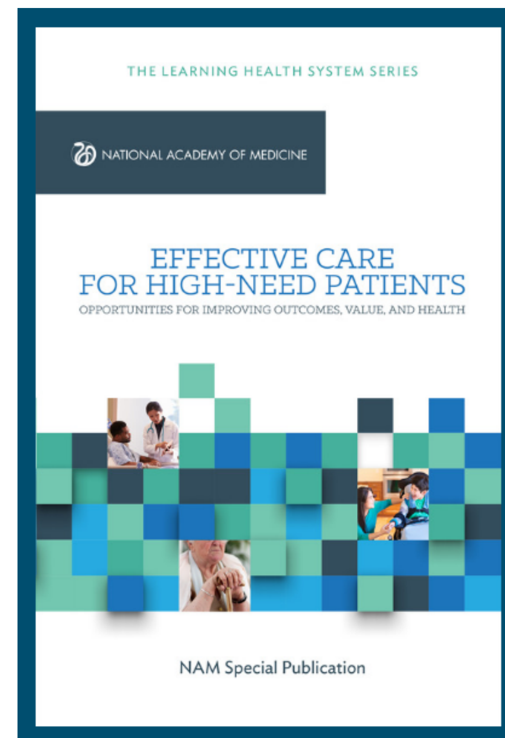
Featuring Health Share of Oregon

Webinar Series

April 25, 2018 | 2:00 – 3:00PM ET

nam.edu/HighNeeds

Share your thoughts!



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PETERSON CENTER ON HEALTHCARE

AGENDA

WELCOME & OVERVIEW OF PUBLICATION 12:00 – 12:05

Henrietta Awo Osei-Anto, National Academy of Medicine

Michael McGinnis, National Academy of Medicine

MODEL DEVELOPMENT & IMPLEMENTATION 12:05 – 12:45

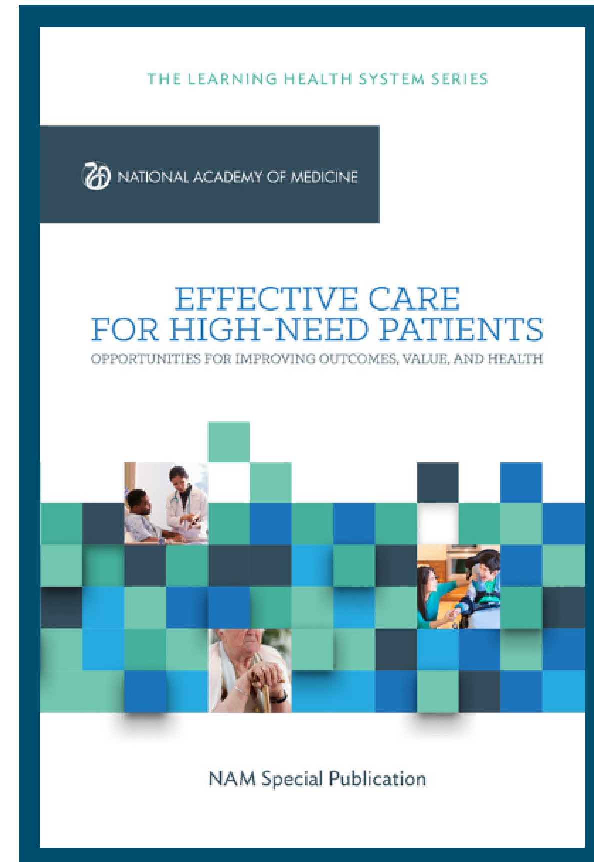
Helen Bellanca, Health Share of Oregon

Bobby Martin, Health Share of Oregon

AUDIENCE Q&A 12:45 – 1:00

Welcome & Introduction

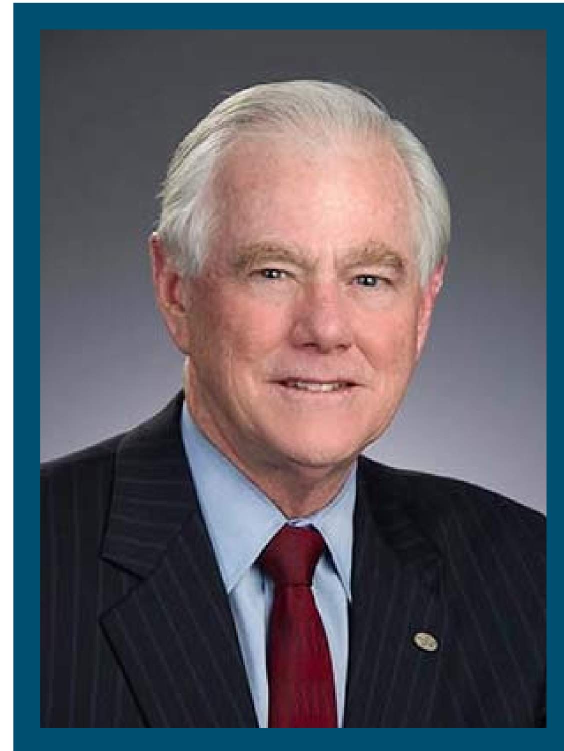
Henrietta Awo Osei-Anto
National Academy of Medicine



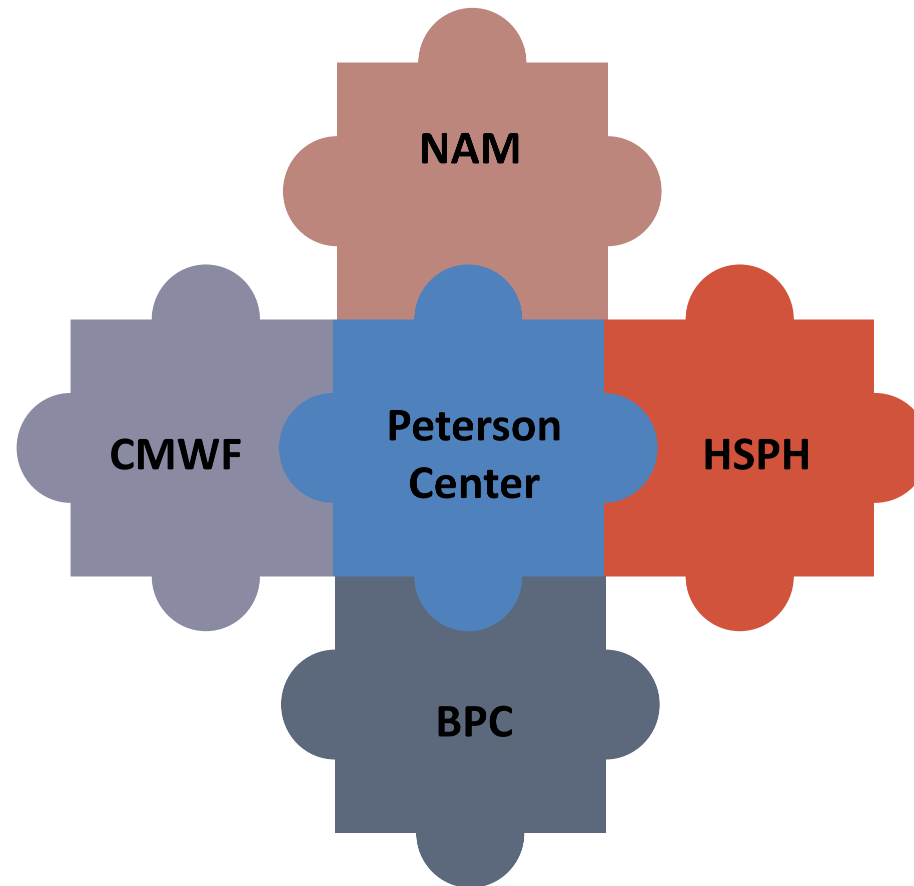
Overview of Special Publication

J. Michael McGinnis, MD, MPP

Leonard D. Schaeffer Executive Officer
National Academy of Medicine



Partners



Collective goal: Advance our understanding of how to better manage health of high-need patients through exploration of patient characteristics and groupings, promising care models and attributes, and policy solutions to sustain and scale care models.

Planning Committee

PETER V. LONG (*Chair*), President and Chief Executive Officer, Blue Shield of California Foundation
MELINDA K. ABRAMS, Vice President, Delivery System Reform, The Commonwealth Fund
GERARD F. ANDERSON, Director, Center for Hospital Finance and Management, Johns Hopkins Bloomberg School of Public Health
TIM ENGELHARDT, Acting Director, Federal Coordinated Health Care Office, Centers for Medicare & Medicaid Services
JOSE FIGUEROA, Instructor of Medicine, Harvard Medical School; Associate Physician, Brigham and Women's Hospital
KATHERINE HAYES, Director, Health Policy, Bipartisan Policy Center
FREDERICK ISASI, Executive Director, Families USA; former Health Division Director, National Governors Association
ASHISH K. JHA, K. T. Li Professor of International Health & Health Policy, Director, Harvard Global Health Institute, Harvard T.H. Chan School of Public Health
DAVID MEYERS, Chief Medical Officer, Agency for Healthcare Research and Quality
ARNOLD S. MILSTEIN, Professor of Medicine, Director, Clinical Excellence Research Center, Center for Advanced Study in the Behavioral Sciences; Stanford University
DIANE STEWART, Senior Director, Pacific Business Group on Health
SANDRA WILKNISS, Health Division Program Director, National Governors Association Center for Best Practices

Process

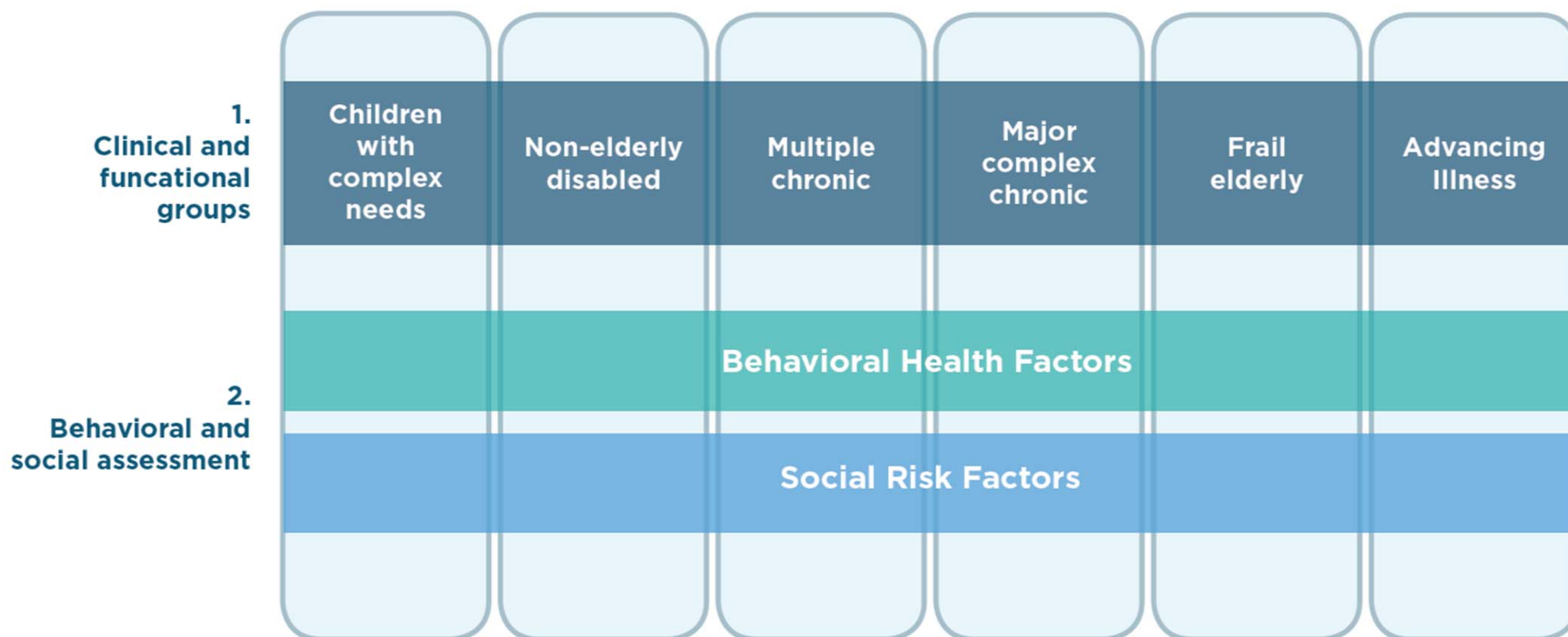
- Convened experts over the course of three workshops:

  - **Workshop 1:** Who are high-need patients, and what does successful care for these patients look like?
  - **Workshop 2:** What data exists on this population and what can it tell us? How do we segment high-need patients for best care?
  - **Workshop 3:** How can we match patient segments to the best fitting care? What are the policy barriers?

- Convened taxonomy and policy work groups

Characteristics of High-Need Patients

- High-need patients are diverse and have varying needs
- Variables that could form a basis for defining this patient population include:
  - Total accrued health care costs
  - Intensity of care utilized over a given time
  - Functional limitations
- The needs of this population often extend beyond their medical needs to social and behavioral services


Conceptual Model of a Starter Taxonomy for High-Need Patients
1. Clinical and funcational groups
Children with complex needs
Non-elderly disabled
Multiple chronic
Major complex chronic
Frail elderly
Advancing Illness
2. Behavioral and social assessment
Behavioral Health Factors
Social Risk Factors
Note: For this taxonomy, functional impairments are intrinsically tied to the clinicial segments.

Care Models that Deliver

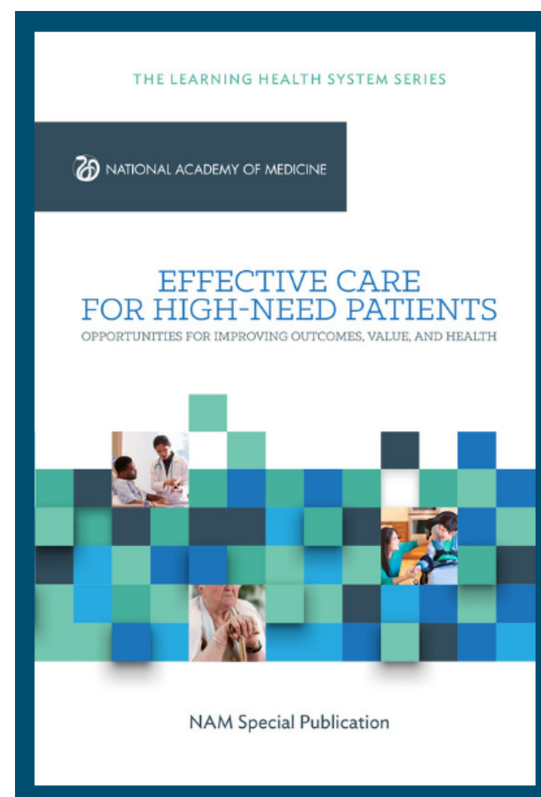
Delivery Features of Succesful Care Models

- **Teamwork.** Multidisciplinary care teams with a single, trained care coordinator as the communication hub and leader
- **Coordination.** Extensive outreach and interaction among patient, care coordinator, and care team, with an emphasis on face-to-face encounters among all parties and collocation of teams
- **Responsiveness.** Speedy provider responsiveness to patients and 24/7 availability
- **Feedback.** Timely clinician feedback and data for remote patient monitoring
- **Medication management.** Careful medication management and reconciliation, particularly in the home setting
- **Outreach.** The extension of care to the community and home
- **Integration.** Linkage to social services
- **Follow-up.** Prompt outpatient follow-up after hospital stays and the implementation of standard dis charge protocols

Today's Featured Program

Coordinated Care Model
Health Share of Oregon

http://www.healthshareoregon.org/



Model Development & Implementation

Helen Bellanca, MD, MPH

Associate Medical Director
Health Share of Oregon

COMPLEX CARE WEBINAR SERIES

From Metrics to Meaningful Change

Experience with improving child health from Oregon's Coordinated Care Model

Helen Bellanca, MD, MPH

Associate Medical Director

April 2018

Background

Oregon’s Coordinated Care Organization Model

CCOs 101

- Accountable Care for the Medicaid population
- Launched in 2012
- Global budget for physical health, behavioral health and dental health
- Build on Primary Care Medical Home model
- Focus on integration of care

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CCOs 101

- Required to maintain a 3.4% cap on growth in per capita spending
- Use pay-for-performance metrics to monitor performance --assurance that we are not degrading quality

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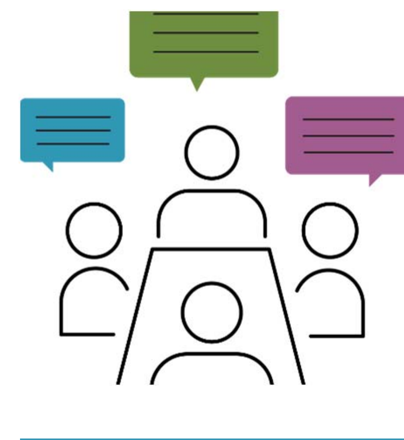
BACKGROUND

Health Share of Oregon

Health Share of Oregon

- Largest CCO in the state, with more than 323,000 members
- 16 different risk-accepting entities (4 physical health, 3 behavioral health and 9 dental health plans)
- We keep less than 1% of the Medicaid dollars for operations and pass down the rest
- We negotiate with partners to keep a portion of the earned dollars from the metrics quality pool



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All Together, All for You.

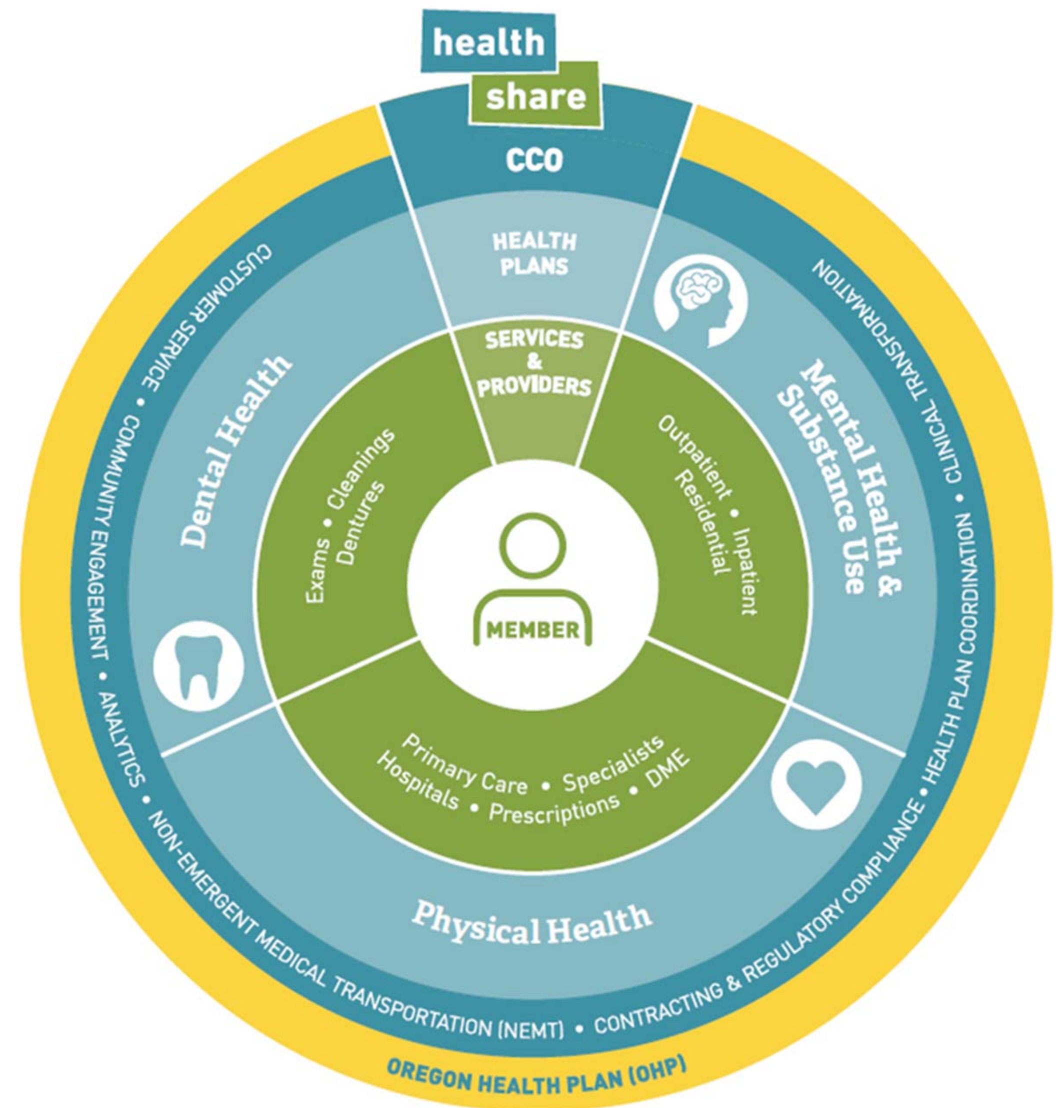
Health Share of Oregon

323,000 members

130,000 children 0-17

5,000 children currently in foster care

~30,000 children and adults with a history of foster care placement



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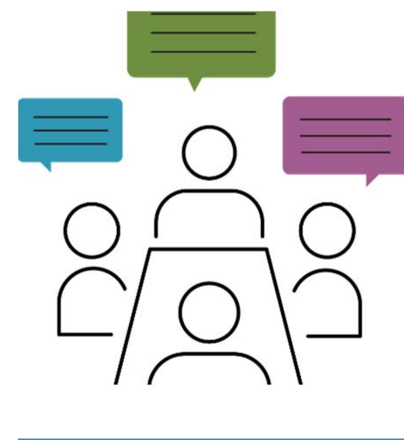
Health Share of Oregon



How we transform the system:

- Use incentive metrics to draw attention to key areas of care
- Convene plans, providers and community stakeholders around common goals
- Share data
- Fund pilots of new ideas
- Host learning collaboratives
- Work with providers and plans to negotiate new payment arrangements

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Background

CCO Incentive Metrics Program

CCO Incentive Metrics Program

- Metric set is negotiated between CMS and Oregon Health Authority
- **4.25% of Medicaid budget** is available to each CCOs to earn through performance on metrics
- To earn the full amount, CCOs must meet either their **improvement target** or the absolute **benchmark** for 12 of 16 measures, and must achieve a PCPCH enrollment score of 0.6 or higher
- Benchmark is statewide goal and is the same for all CCOs. Yearly improvement targets are CCO-specific, based on last year's performance
- Any money not earned by CCOs goes back into a pot for **second round** based on 3-4 priority measures

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Metric	Description
Adolescent Well Care Visits	12-21 years old, preventive visit
ED utilization	Visits per member month
Assessments for Children in DHS custody	Physical, mental and dental health assessment done within 60 days
CAHPS composite: Access to care	Got care as soon as you needed it, adult and child
Child immunization status	Required vaccines by age 2
Cigarette smoking prevalence	Proportion of population with smoking status recorded, +smoker, +tobacco use
Colorectal cancer screenings	Adults 51-75 with FOBT, Flex Sig or Colonoscopy in prior year(s)
Controlling hypertension	Adults 18-85 with hypertension diagnosis with most recent measurement <140/90
Dental sealants on permanent molars for children	Children 6-9 and 10-14 who received sealant in measurement year
Depression screening and follow-up	Patients 12 and older with a visit who were screened, and have a follow up plan if screen in postitive
Developmental Screening	Children 0-3 with a validated screen for development
Diabetes: HbA1c poor control	Adults 18-75 with diabetes with HbA1c >9%
ED use among members with mental illness	ED visits per 1000 member months among adults identified as having a mental illness
Effective Contraception Use	Women ages 15-50 with claims for Tier 1 or 2 contraceptive method (procedure, prescription or surveillance)
Patient-Centered Primary Care Home enrollment	((# in Tier 1*1) + (# in Tier 2*2) + (# in Tier 3*3) + (# in Tier 4*4) + (5 STAR members *5))/(Total # of members enrolled in the CCO)*5 ≥ 0.6
Timeliness of prenatal care	For live births, a prenatal visit in the first 14 w or within 42 days of enrollment
Weight Assessment and counseling in children and adolescents	Children 3-17 with BMI, nutrition counseling and exercise counseling

Challenge Pool Measures

Challenge Pool Measures	2013	2014	2015	2016	2017	2018
Alcohol or other substance misuse screening (SBIRT)	x	x	x	x		
Assessments for children in DHS custody						x
Childhood immunization status						x
Developmental screenings			x	x	x	x
Depression screening and follow-up plan	x	x	x	x	x	
Diabetes HbA1c poor control	x	x	x	x		
Effective Contraceptive Use					x	
Patient centered primary care home (PCPCH) enrollment	x	x				
Timeliness of prenatal care						x

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CASE STUDY

Foster Care Metric

Foster Care Metric

Percentage of children with physical health, behavioral health and dental health assessments within 60 days of entering DHS custody.

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Children in Foster Care

Maternal and Child Health Bureau Definition of Children and Youth with Special Health Care Needs (CHSHCN):

> "Children who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

American Academy of Pediatrics considers children in foster care to be CYSHCN

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83% of youth in foster care received at least one mental health diagnosis

Adults who have been in Foster Care suffer PTSD rates at twice the rate of US Combat Veterans.

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National Child Traumatic Stress Network

55% of young children entering the foster care system have 2 or more chronic conditions

25% have 3 or more chronic conditions

Most Common: skin conditions, asthma, anemia, malnutrition, manifestations of abuse

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35% of children enter foster care with significant dental and oral health problems

Dental problems lead to poor nutrition, missed school days, behavior problems, future health complications

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Health care challenges

- Foster Children enter care with multiple unmet health care needs, health histories and records are often incomplete or unknown
- Access to care is hindered by rule, policy, and practice, and foster children experience multiple changes in providers and caregivers (5 different placements is average in Portland area)
- Clinics and providers struggle to identify which children are in foster care
- Caregivers have limited support or training around the complex health needs, and there is diffused authority between foster parents, court, DHS, bio-parent
- Prioritized care often dependent on crisis
- Coordination of health care needs is critical but frequently absent

CAN A METRIC CHANGE THIS SITUATION?

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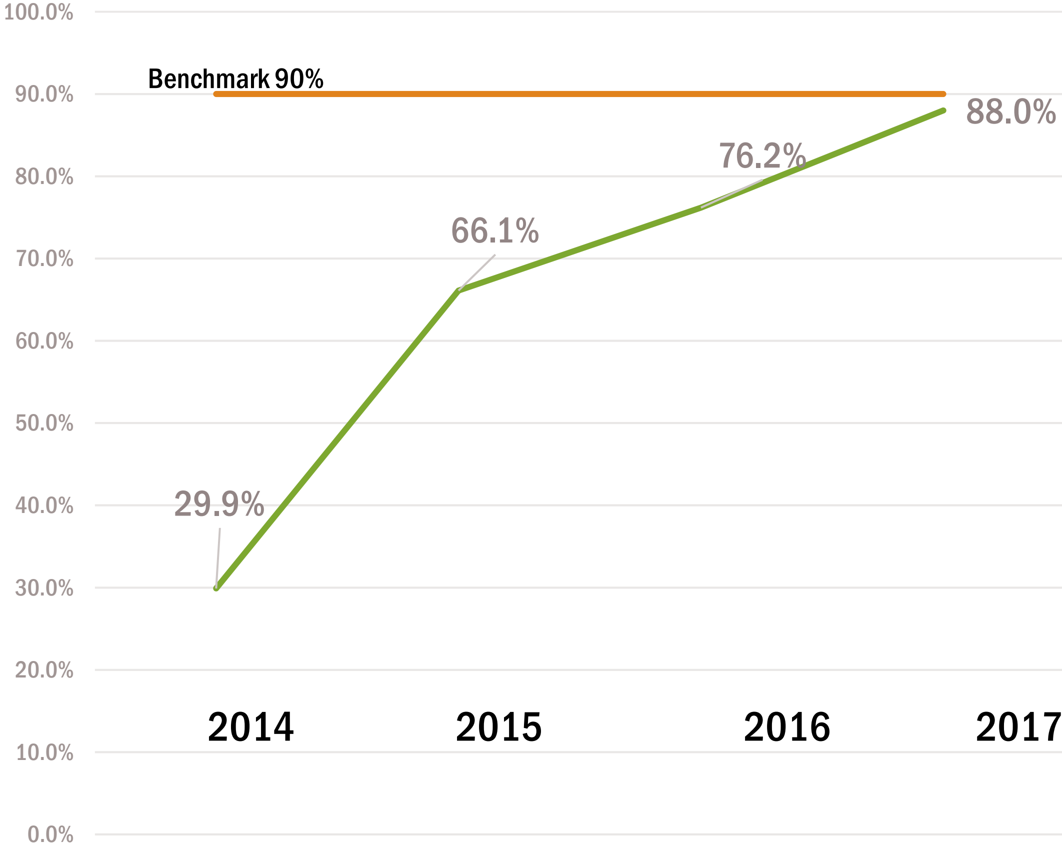
Foster care metric performance

Case study

Health Share's performance on the foster care metric 2014-2017



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Strategies for performance improvement

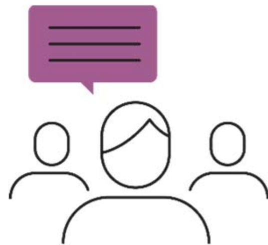
SHARING DATA

Who are the foster kids in your clinic? How can you better track their care? Who is getting their assessments done? How are others doing it?

CROSS-SECTOR MEETINGS

Coordinate the care coordinators!

Build a shared care coordination platform



LEARNING COLLABORATIVES

Established Foster care medical home became a model for others to develop in the community

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Core elements of a foster care medical home

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- ✓Identification, Tracking, Monitoring of kids in foster care
- ✓Specialized Care Coordination
- ✓Parent/Provider Education
- ✓Care aligned with AAP Guidelines
- ✓Connected to Community Resources and Referral Options
- ✓Integrated Mental Health and Oral Health
- ✓Transition Support

How a foster care medical home works

- Provides stability in midst of many transitions
- Use trauma-informed approach to care
- Care navigation for physical health, mental/behavioral health, dental health
- Family therapist on the team
- Track key screenings and assessments
- Coordination of records
- Close follow up with referrals
- Communication with the family and care team providers
- Transitional support into adult medicine and into other family settings

"…One system that sticks with the kid no matter where they go…"

- Foster parent

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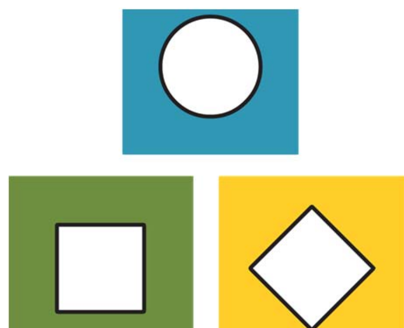
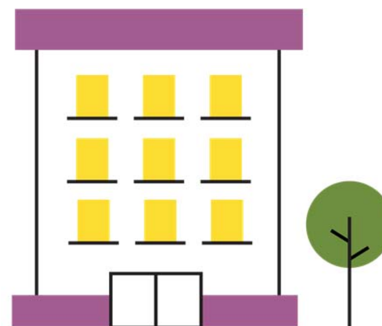
- https://youtu.be/W6sPJszA_LMealth

What the metric work led to



THREE ADVANCED PRIMARY CARE MEDICAL HOMES FOR KIDS IN FOSTER CARE
Centers of excellence in community, sustainable, trauma-infomed

RECOGNITION OF FOSTER CARE AS A HEALTH DISPARITY
We need to disaggregate our data to understand needs



MEDICAL LIAISON POSITION AT DHS AGENCY
Attention to health and health care by child welfare partners

LINKS TO PREVENTION
Treat parents with substance use disorders, screen for risk of abuse and neglect, support all parents

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Power of metrics

- Shine light on key areas of care needing quality improvement
- Draw focus to small, high needs, complex populations
- Money helps
- Sharing data helps more!
- When metrics work well, they catalyze system transformation
- If you want meaningful metrics that lead to meaningful change, don't be afraid to grow your own!

"Measure what is measurable and make measurable what is not so."

– Galileo

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Helen Bellanca, MD, MPH
Associate Medical Director
helen@healthshareoregon.org

Q & A

- Please type your questions in the Q & A box at the lower right-hand corner.
- Provide your name and organization.

Effective Care for High-Need Patients

Opportunities for Stakeholder Action

nam.edu/EffectiveCareAction

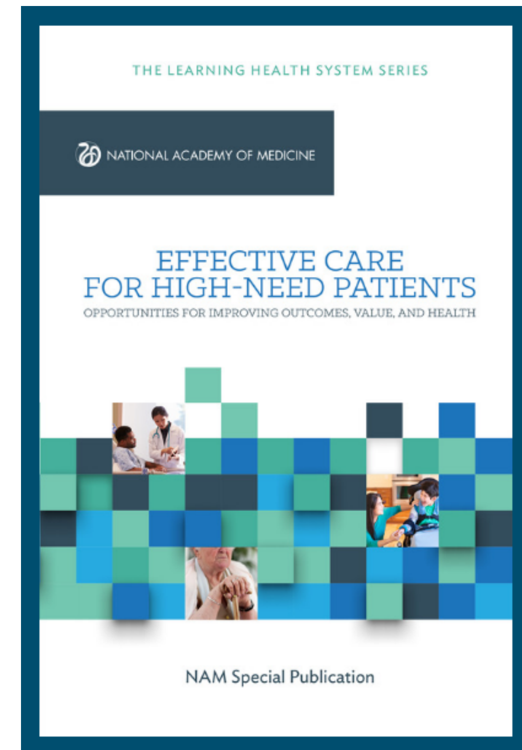
#HighNeeds

Thank you for joining!

A recording of today's webinar will be posted online at nam.edu/HighNeeds.

For more information about the National Academy of Medicine's initiative on high-need patients, please visit:

nam.edu/HighNeeds



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