Health System Transformation and Modern Day Chronic Care
NAMD, November 2013

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Modern Day Chronic Care: Holistic, Person-Centered, Team Based, Population Health

- Background on Oregon’s Health System Transformation
- Examples of “New” Chronic Care models:
  - Practice Change:
    - Specialized “one-stop clinics” & Co-location
      - Integration of Mental Health, A&D and oral health
    - Team-based care – Care coordination
    - Patient Centered Primary Care Homes
  - Population Health / “Person Focused”
    - Use of “Traditional” Health Care Workers
    - “Super-utilizers” and Hot-spotting
    - Person/patient Engagement
- Early lessons and results
Oregon Medicaid Health Systems Transformation and Coordinated Care Organizations

- Recognition that health care costs are unsustainable and that we do not get the health outcomes for the amount of money that we spend

- Implemented major health system transformation and reform efforts with Triple Aim goals of:

  Better Health, Better Care, Lower Costs
Key Health System Transformation Components

• Coordinated Care Organizations
  – Community level accountability and flexibility
  – New models of integrated care: patient centered and team-focused; integrated physical, behavioral and oral health
  – Governance by a partnership of providers of care, community members and stakeholders in the health system who have financial responsibility and risk
  – A global budget that grows at a sustainable, fixed rate with payment alternatives that incent positive health outcomes
Chronic Care – Practice change
Examples from CCOs

– CCOs building on one-stop shop clinics
  • Western Oregon Advantage Health (WOAH) for foster children
    – All assessments within 30 days, all in one visit
  • Umpqua Health Alliance – single clinic
    – Oral health; Mental health; Physical health
    – Receptionist to Psychiatric Nurse Practitioner to Doc to RX coordinator
  • Many CCOs using co-location of behavioral health providers in medical clinics; a couple have placed medical providers like nurse practitioners in MH clinics
Practice Change: Patient Centered Primary Care Homes
Practice Change: PCPCH

• Implementation
  – 450 PCPCHs
  – In a survey of PCPCHs about half needed to add new services in order to implement the model

• Achieving the Triple Aim
  – PCPCH model is helping them improve the individual experience of care; increase access to services; increase the quality of care and improve population health management

• Improving outcomes
  – PCPCH clinics demonstrated significantly higher mean scores than non-PCPCH clinics for diabetes eye exams, kidney disease monitoring in diabetics, appropriate use of antibiotics for children with pharyngitis, and well-child visits for children ages three to six years

*Information for a Healthy Oregon. The Quality Corporation, August 2013.*
Chronic Care – Population health & Person-centered approaches: Examples

– Columbia Pacific using metrics to analyze where need to focus efforts and designing interventions/focus areas to address

– Eastern Oregon CCO – use of telemedicine and getting specialized care on the “other end of the line”.

– PacificSource - Care coordination teams focus on highest utilizers of ED
Chronic Care – Two In-depth Examples

• Trillium: Community Health Workers in Care Coordination
• Health Share of Oregon: implementation of “Health Resilience Model” or Trauma based care
Example:
Trillium Community Health Care Model

Provider/TCHP identifies patient as having complex needs.

External Provider makes referral of patient to Trillium Care Coordination.

Trillium Care Coordination triages patient referral to determine if CHW is needed.
- Trillium Care Coordination Team identified to work with CHW and patient

Referrals

Internal
- Hot Spot List
- Risk Stratification
- Hospital Readmissions
- CC/UM Identification

LUCC receives triaged CHW referrals
- Care Plan issues for CHW to assist patient with are identified on referral

Trillium Care Coordination Team meets every 2 weeks with LUCC CHWs
- Ongoing training
- Complex Case Review
- Updates on patients referred
- Continued ongoing communication
Trillium: Why do we have a Community Health Workers Program??

- The Program is part of the patient-centered, team-focused concept that is the basis for the Coordinated Care Organization
- To assist the member’s network of providers:
  - Improve overall health
  - Work directly with high-needs patients
  - Fill in gap of needs not met elsewhere
Trillium: Case Presentation

- 40 year old female with chronic pain; numbness; frequent UTI’s; fluctuating body weight secondary to medication; and frequent ED usage
- Client has been described as having a rude, foul, and uninhibited manner, which has lead to her being fired from Urgent Care and a local hospital
- She is a survivor of a long history of physical and sexual abuse
- Her mental health diagnoses include bipolar disorder, anxiety disorder, history of alcohol and methamphetamine abuse, and has histrionic, borderline and antisocial personality traits
Trillium: Client Interview

- What was going on in your life before you started working with your CHW?
  - “My back. And I was going to the ER all the time.”

- What did you work on with your CHW?
  - “Laughing.”

- What are the positive aspects of working with your CHW?
  - “I have not blown off my head.”

- Are there negative aspects of working with your CHW?
  - “No, we’re funny.”

Positive Outcome...
ER visits went from 15-20/year since 2009 to 5 in the last 12 months
“62 year old with multiple hospital admissions”

Moving from: “What is wrong with him...”
To: “What has happened to him...”
62 Year Old Caucasian Man

Admitted to the hospital for almost a month for acute complications of his Chronic Heart Failure. Had a previous 25 day admission 5 months earlier.

Health Share of Oregon: Trauma & Resilience

William’s “Problem List”

- Chronic Heart Failure
- History of Addiction to IV Drugs and Alcohol
- COPD
- Schizoaffective Disorder
- Intermittent Homelessness
- Developmental Disorder
- Hepatitis C
- Type 2 Diabetes
Health Share of Oregon: Trauma & Resilience

As Often Viewed By Others / Providers...

- **Irritable**
- **Hostile**
- **Cannot give clear health history**
- **Extremely needy / demanding**
- **Chronic relationship problems**
- **Problems with pain / pain tolerance**
- **Chronic poor self care**
- **Intermittent job history**
- **Stoic, reluctant to admit health problems**
We got to know William, and others like him, we have found:

- Poor health literacy
- Prevalence of SA and mental health conditions but lack of access to services
- Mild to moderate cognitive deficits
- Homelessness and food insecurity; chaotic lives burdened with cumbersome eligibility requirements for social programs
- Inability to access basic resources such transportation, healthy food, medications, place to exercise, etc
- Extensive care coordination needs, particularly between sites of care
- Very high prevalence of adverse life events, trauma, and toxic stress: childhood trauma, school failure, job instability, relationship failure, self medication with substance use, high risk behaviors, poor decision making skills...
Obvious conclusion

- “Usual medical care” – even really really good usual medical care – will not be enough for the high acuity population.
  - New forms of “Trauma Informed” care management / case management are needed
  - Access to mental health and addictions resources is critical
  - Socially determined risks cannot be ignored or assumed outside of “health care”
  - New (and less costly) approaches will be required for success
Health Share of Oregon: Trauma & Resilience
“Health Resilience Program”

• Building a Trauma Informed Care System for high needs Medicaid members

• Key elements: Safety, Empowerment, Trust, Collaboration, Choice
  – Comprehends the impact of violence
  – Provides service in ways that do not re traumatize

• Health Resilience Specialists
Lessons Learned: Themes

• ENGAGEMENT
  – Listening and learning

• COORDINATION; INTEGRATION; BREAKING DOWN SILOES
  – Putting people in the center
  – Holistic focus on whole person, especially MH and other social determinants

• PUTTING IT ALL TOGETHER
  – Data & analytics; changing the practice of medicine – practice of health

• What NOW?
  – Need Different Education system for Traditional health workers; for Team based care; for Patient Engagement
  – Metrics and incentives
  – Information systems – telemedicine & Health Information Exchange
  – Analytics tools
  – Build on and expand on best practices – evaluation and spread
Questions?

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Modern Day Chronic Care Management

Margaret E. O’Kane
President, National Committee for Quality Assurance
November 13, 2013
We’re working toward high-value health care

Measurement, transparency and accountability move health care toward greater value
NCQA has been working on chronic care management for years

1. Built chronic care management into Accreditation standards and HEDIS measures
2. Developed Patient-Centered Medical Home (PCMH) Recognition, ACO Accreditation
3. Developed Patient-Centered Specialty Practice (PCSP) Recognition
4. Our next frontiers: behavioral health, long term care
What is a medical home?

PCMH 2011 standards

• Care access and continuity
• Identify and manage a population
• Treatment planning and care management
• Provide self-care support and community resources
• Track and coordinate
• Measure to improve performance
• More emphasis on team-based care
• Focused care management on high-need populations
• Higher bar, alignment of QI activities with triple aim
• Alignment with Stage 2 Meaningful Use
Patient-Centered Specialty Practice (PCSP) Recognition

- Builds on success of PCMH
- Recognizes specialists for exemplary care coordination, communication
- Can be a component of an ACO, network or payment strategy
Model for evaluating quality

- Screening and Assessment
- Individualized Shared Care Plan
- Coordinated Service Delivery
- Beneficiary Engagement and Rights
- Population Management and Health Information Technology
- Quality Improvement Systems

Healthy People Healthy Communities
Better Care
Affordable Care
Types of quality measures

Structure
Do plans have systems to support good care?

Process
Do patients receive recommended care?

Outcomes
Are outcomes improved? Is care patient-centered?

Accreditation Standards
SNP Structure and Process Measures

HEDIS
CAHPS, Health Outcomes Survey
Vermont and North Carolina build on NCQA programs to build accountable care systems
What’s the same?

- Support for PCMH & PCSPs
  - New complex care management code tied to PCMH / PCSP
  - Added in clinical practice improvement activities section
- Expansion of QE program

What’s different?

- 2017 start, bonus program instead of update changes
- Builds off existing programs (e.g. measures in PQRS), emphasizes resource use, meaningful use, CPIA
- Potential for larger bonuses, cuts
SoonerCare Health Management Program (HMP)
Development of the Health Management Program

48th: Diabetes deaths*
48th: Stroke deaths*
49th: Heart disease deaths*

2006 Legislative mandate
- Focus on chronic disease
- Reduce cost
- Increase quality

*Number of deaths due to disease per 100,000

SoonerCare HMP Principles

- Focus in on the person—not the disease
- Teach the member how to self-manage — rather than do it for them
- Providers must be included
- Redesigning practice to support team-based care
The Chronic Care Model

Community
Resources and Policies
- Self-Management Support

Health Systems
Organization of Health Care
- Delivery System Design
- Decision Support
- Clinical Information Systems

Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team

Improved Outcomes

Developed by The MacColl Institute
© ACP-ASIM Journals and Books
SoonerCare HMP Design

**Arm 1**
- Focuses on the high risk patients

  Nurse Care Management

**Arm 2**
- Focuses on assisting providers (physicians)

  Practice Facilitation
Focus on self-management supports

- Tier 1 - Face to Face
- Tier 2 - Telephonic

Serves highest risk SoonerCare Members

- Vast Majority have at least 2 chronic conditions
- 78% over 21 years

Behavioral Health

- 40% have both physical and behavioral health conditions
- Diabetes and Psychosis most common diagnosis
Practice Facilitation

• Serves SoonerCare Choice Patient-Centered Medical Homes with high chronic disease incidence on member panel

• Core Functions of Practice Facilitators
  • Develop a practice team with well defined roles
  • Assist provider in making their encounter with the patient productive and efficient
  • Empower team members with the utilization of standing orders and educational tools
  • Implement a user friendly and functional information system (REGISTRY)
  • Create a “new culture” within the practice, focused on quality
HMP Evaluation

Performed by external, independent evaluator: Pacific Health Policy Group (PHPG)

4 Outcomes Examined

- Quality of Care
- Satisfaction
- Utilization and Expenditure Trends
- Cost Effectiveness
NCM Outcomes

- Improved quality of care
- Reduced risk scores and care gaps
- High member satisfaction scores
- Utilization and savings trends
  - Overall per member per month savings in medical expenditures runs a 32.81 deficit in the 1st 12 months but results in savings of $410.36 after 13 months
  - Reduction in inpatient days and ER visits from forecasted
  - Total savings (cost avoidance) to date: $93.1 million
Satisfaction

Participants in the HMP at least 6 months reported:

- Overall program satisfaction
  - Very Satisfied: 88%
  - Somewhat Satisfied: 10%
  - Dissatisfied: 2%

- Perceived changes in health
  - Reported being in better health: 27%
  - Reported the HMP contributed to their improved health: 92%
Inpatient Trends

65% Reduction

57% Reduction

SoonerCare HMP 4th Annual Report, Page 174
Emergency Room Trends

SoonerCare HMP 4th Annual Report, Page 174
88 practices served (through present day)

Serving approximately 115K members

Improved Quality of Care Measures over the course of SFY12; significant increase in compliance rates for chronic obstructive pulmonary disease and several coronary artery disease measures.

Generally higher compliance rates in PF practices compared to overall SoonerCare population
### Practice Facilitation Outcomes

#### 88 Practices Served
- Serving approximately 115,000+ SoonerCare members

#### Quality of Care
- Improvement on 51% of disease-specific clinical measures
- Most improvement on asthma and diabetes

#### Satisfaction
- 87% credit the program with improving care to patients with chronic conditions
- 91% would recommend the program to a colleague
• Medical Costs reduced for both:
  • Patients with chronic conditions (Asthma, Diabetes, Hypertension, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Coronary Artery Disease)
  • Overall Patient Panel

• $74.91 PMPM saved by PF services

• $46.1 million aggregate savings (cost avoidance)
## Cost Avoidance/ ROI

<table>
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<tr>
<th>Component</th>
<th>Administrative Costs</th>
<th>Medical Savings</th>
<th>Net Savings</th>
<th>Return on Investment</th>
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<tbody>
<tr>
<td>NCM (All)</td>
<td>($16,811,912)</td>
<td>$109,924,559</td>
<td>$93,112,647</td>
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<tr>
<td>NCM Tier 1</td>
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<td>$34,541,997</td>
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<td>Practice Facilitation</td>
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<td>$55,863,530</td>
<td>$46,111,582</td>
<td>473%</td>
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<td><strong>TOTAL Program</strong></td>
<td><strong>($26,563,861)</strong></td>
<td><strong>$165,788,090</strong></td>
<td><strong>$139,224,229</strong></td>
<td><strong>524%</strong></td>
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Moving forward

Health Coaches
Improve process and provider involvement by moving Nurse Care Management into the Practice site. Direct work with member to incorporate teaching and behavior modification principles at the time of the provider visit.

Resource Center
Provide additional support and services to the Health Coaches to allow Health Coach to focus on behavior change.

Practice Facilitation
Continue to work with practices to focus on process improvement and improving Chronic Disease Care.
Contact Information

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