



The Health Commons Grant: What Have We Learned About Transformation?

David Labby, Chief Medical Officer, Health Share of Oregon

**Oregon Innovation Café
Salem Convention Center**

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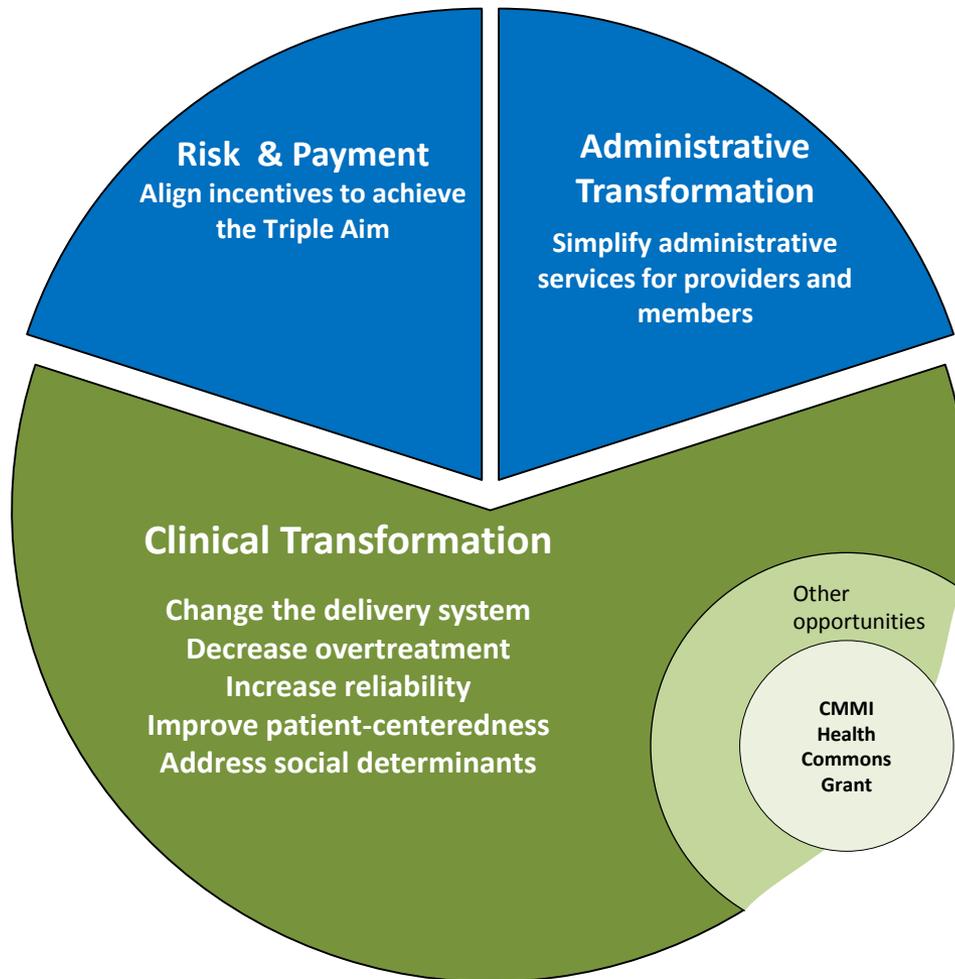
Health Share of Oregon

- **Largest CCO** – providers from tri county region (Clackamas, Multnomah, Washington Co)
 - 4 Medicaid Managed Care Plans
 - 3 County Based Medicaid Mental Health Organizations
 - 9 Dental Health Organizations
- **Inclusive Network**
 - All 6 Hospitals / Health systems;
>1600 providers
- **250,000 Medicaid members**



“Health Commons” Grant Award: July 2012

“A springboard for change”



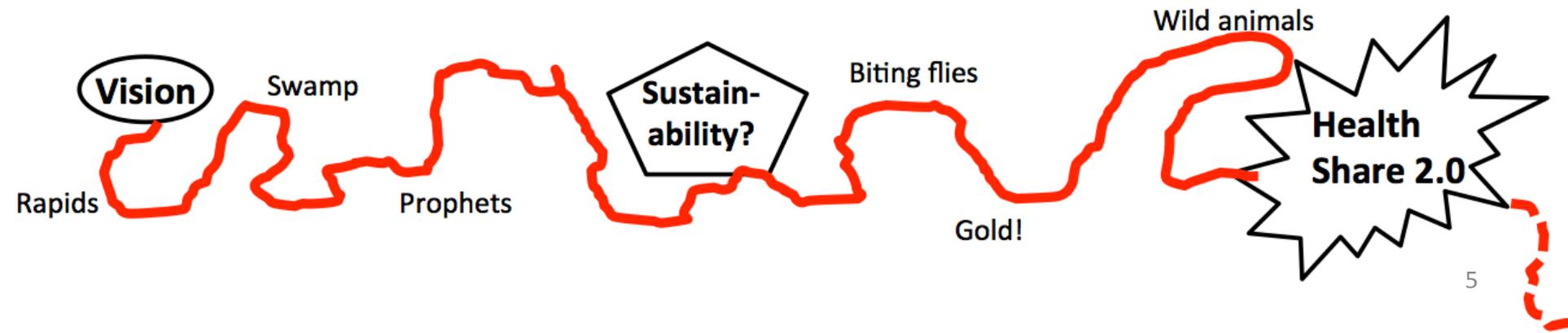
- \$17.7 M over 3 years
- Build a regional system of care for adult “high utilizers”
- Scale up current interventions at different high acuity touch points
- Build infrastructure: IT platform, common metrics, communication pathways
- Build common clinical leadership

What Have We Accomplished?

- **“Touched:” 13,600 individuals; 4000 in intensive management**
(March 2015)
- **Built a “High Needs” system of care that will continue and expand**
 - **Met complex needs of stakeholders for transformation... Does it:**
 - Save money?
 - Help the people we serve?
 - Build provider capacity
 - to do a better job?
 - to have better job satisfaction?
 - Change the relationship between the payers and their network?
 - Catalyze further changes we are interested in?
- **Details at: <http://www.healthcommonsgrant.org>**

Key questions from the journey...

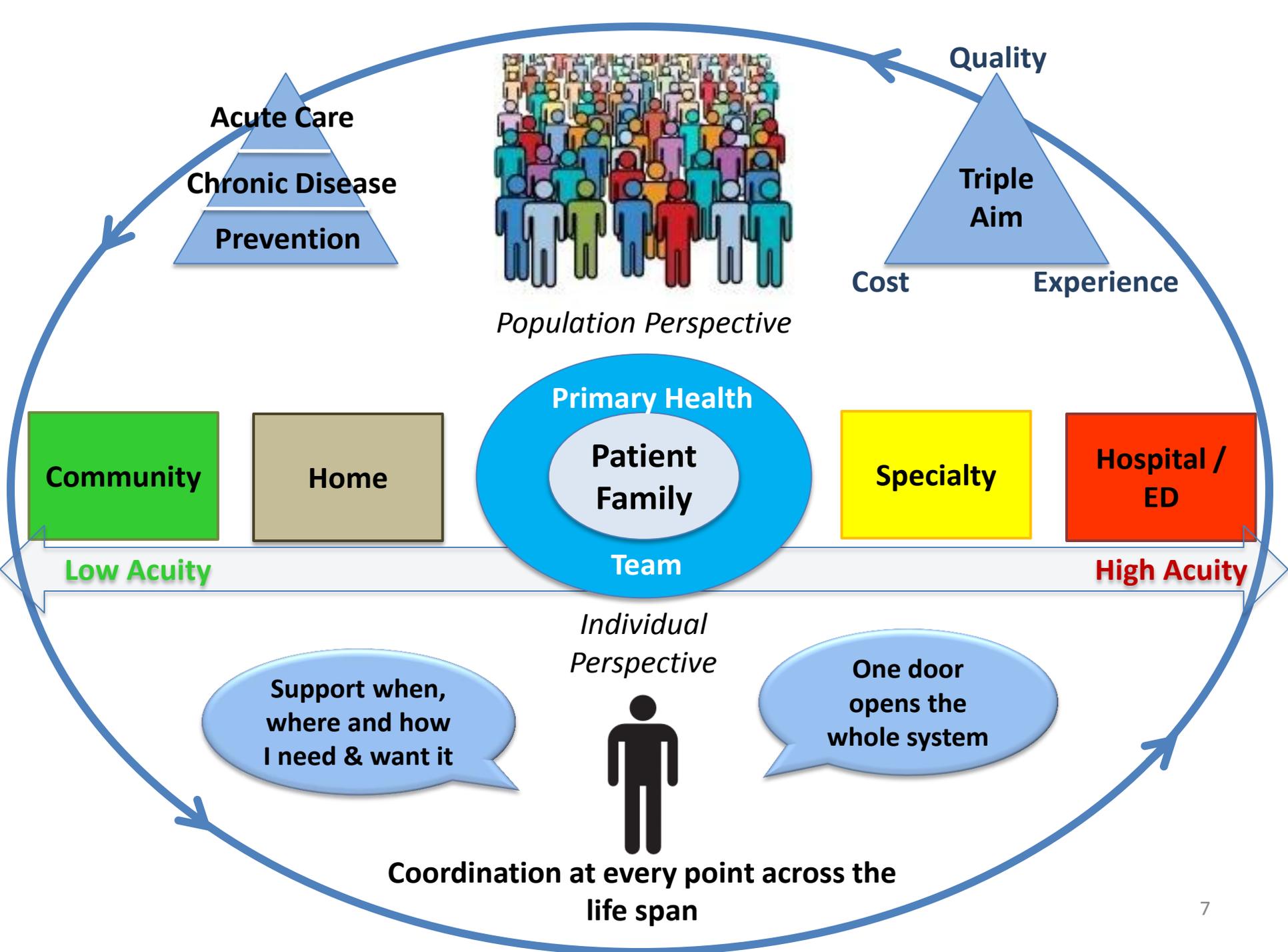
1. What kind of care system are we trying to build?
2. What population specific problem are we trying to solve?
3. How do we best organize ourselves to accomplish our goals?
4. How do we learn rapidly to catalyze further transformation efforts?





What kind of care system are we trying to build?

**TCMC: What is the “Model of Care” that best meets the need of the Health Share population?
(Do we have a clear “vision?”)**





**What population specific problem
are we trying to solve?**

**“A Regional System of Care For
Medicaid Adult High Utilizers”
(Do we have a clear goal / mission?)**

2011 Data Exploration to Define Regional “high utilization” Criteria

All CareOregon Medicaid
Adults (19yrs+) living in TriCounty Area

MCHD NE Clinic CareOregon Medicaid
Adults (19yrs+) Assigned to MCHD NE

Claims Data for 12 Month Period

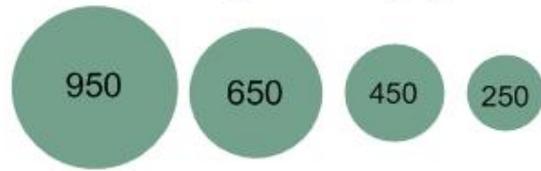
Utilizer Type Groups	% mbrs	% Paid TOTAL Paid Cost, 12mos
No inpt / 0-1 ED	70%	30%
No inpt / 2 - 5 ED visits	13%	11%
No inpt / 6+ ED visits	3%	5%
1+ OB inpt ONLY	5%	7%
1 nonOB inpt / 0 - 5 ED visits	6%	18%
2+ nonOB inpt <u>OR</u> 1 nonOB inpt/6+ ER visits	4%	29%
	100%	100%

Claims Data for 12 Month Period

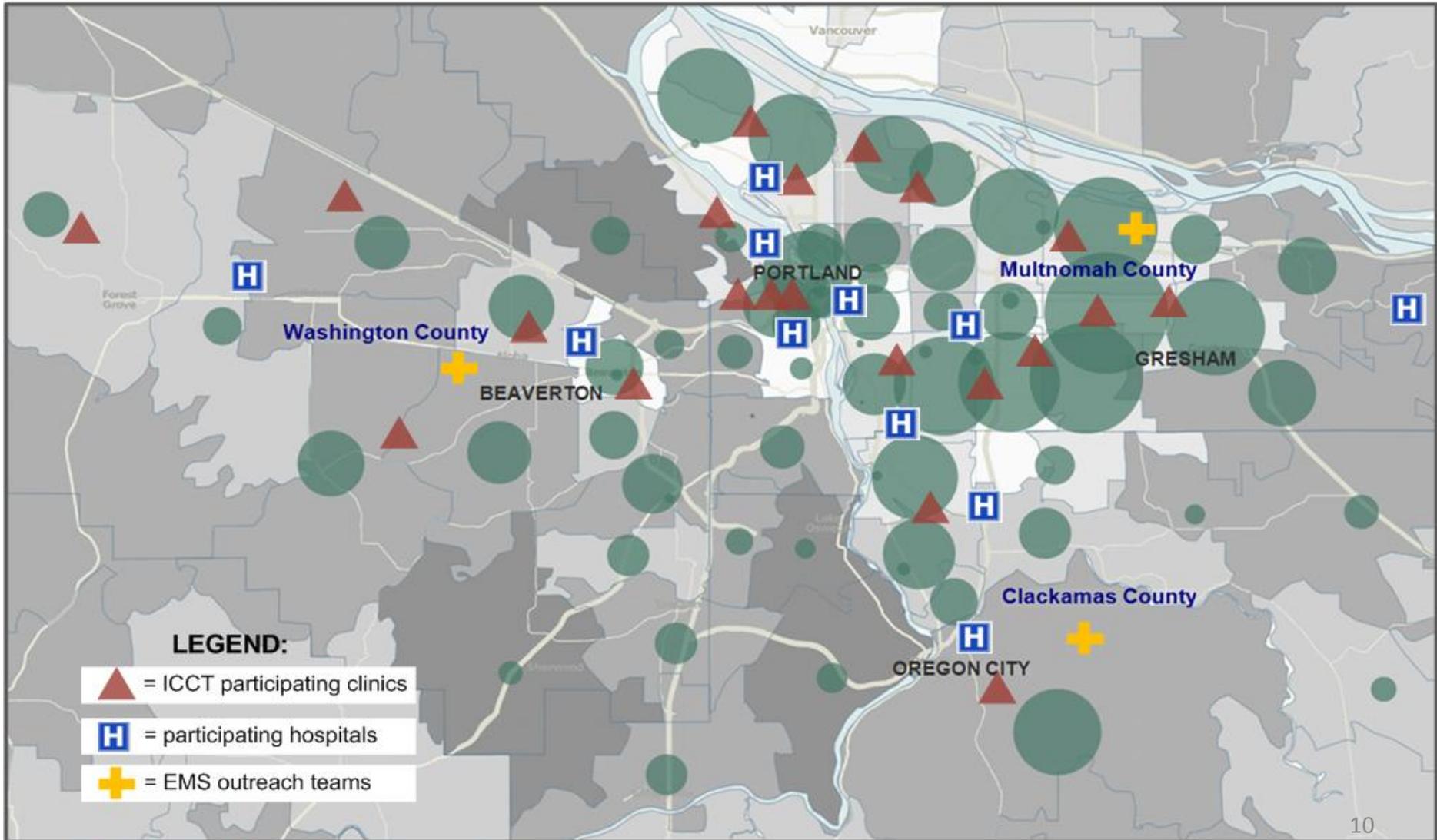
Population Segment	# Mbrs	% Mbrs	% Paid Cost/ 12 mos
No inpt / 6+ ER visits	81	3%	5%
1 nonOB inpt & 0-5 ED visits	97	4%	14%
2+ nonOB inpt OR 1 nonOB inpt & 6+ ER visits	71	3%	32%
	249	10%	51%

13% of CareOregon members (6178)
= 52% of paid cost

Number of High Cost/High Risk*
Medicaid & Dual Eligible Adults by ZipCode



2009 Median Household Income, by ZipCode



* High Cost / High Risk = meet Level 1 or Level 2 criteria

Relationship Between Social Determinants of Health and Hospital Admissions

Community Need Index (CNI)

Figure 3

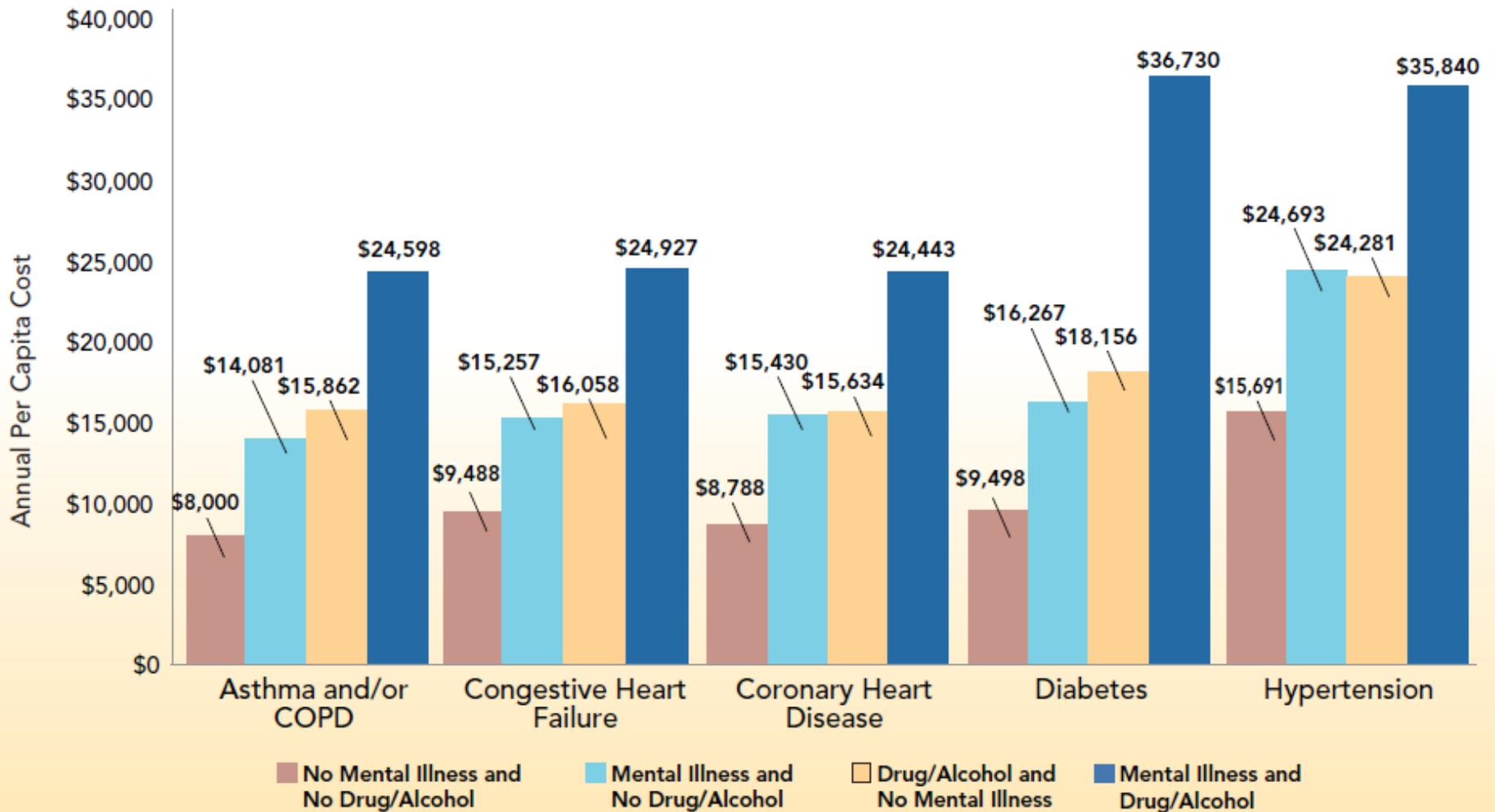
Annual Admission Rate per 1000 Population by CNI Score
Ambulatory vs. Marker Conditions

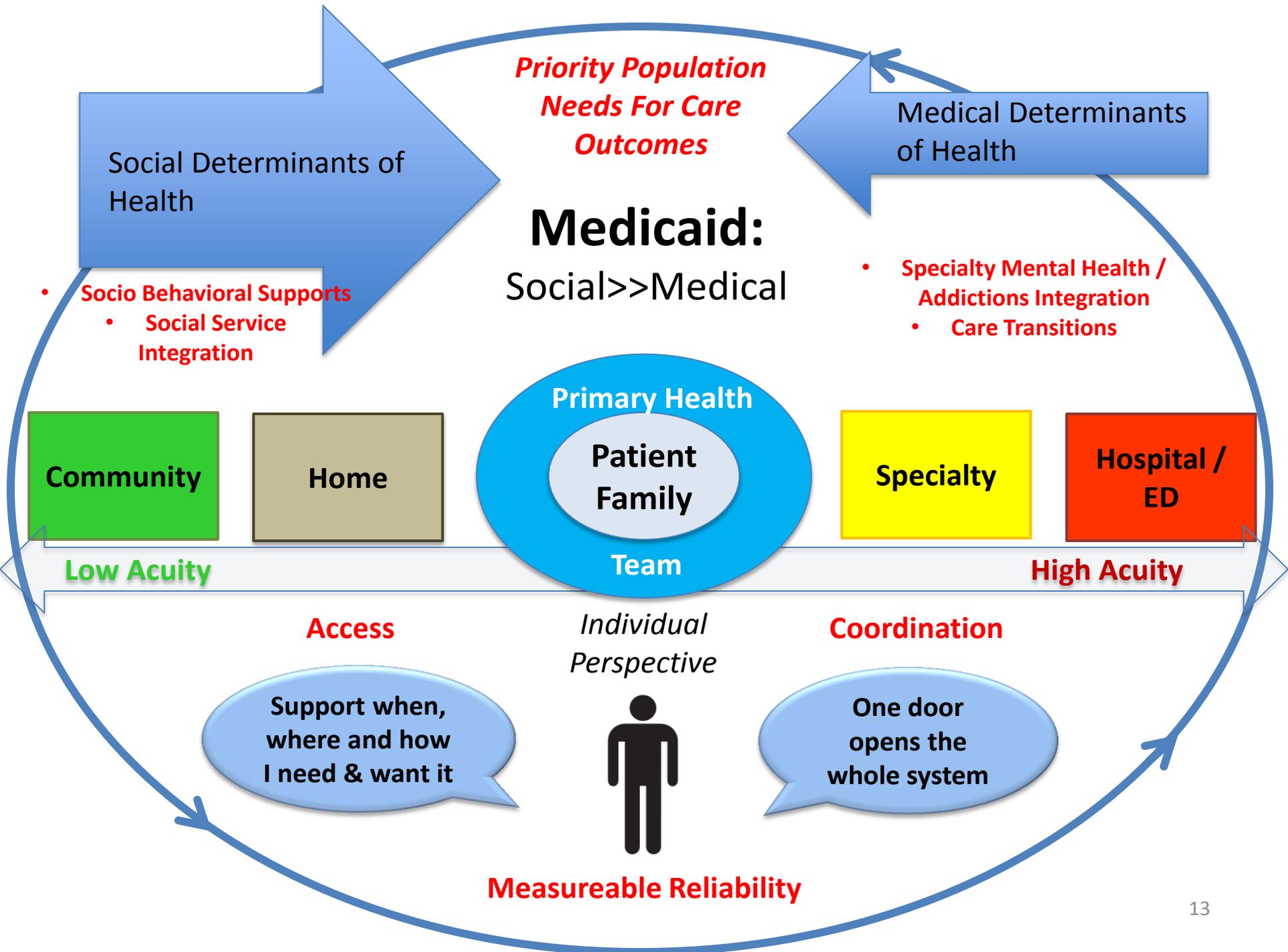


CNI Elements:

- Income Barriers
- Cultural/ Language Barriers
- Educational Barriers
- Insurance Barriers
- Housing Barriers

Figure 3 | Impact of Behavioral Health Comorbidities on Per Capita Costs among Medicaid-Only Beneficiaries with Disabilities





What We Have Accomplished

- **Improving Hospital Discharge Handoffs:**

- For Medical Admit / Primary Care

- Redesigned D/C summary and Primary Care Follow Up
- Spread high risk transition teams (CTraIn)
- Going forward:
 - New community standard for discharge / transitions process
 - Teams sustained by hospitals and plans

- For Psychiatric Admits

- Spread intensive transition teams for those without established community mental health relationship
- Going forward: teams sustained by County Mental Health Orgs

- For Emergency Dept

- Spread “ED Guide” program with increasing focus on Medicaid
- Going forward: sustained by Providence



What We Have Accomplished

- **Intensive Community Care Teams**

- Established a new primary care workforce / teams for high needs members
 - Health Resilience Program “outreach” specialists, with peer outreach workers from community based organizations
 - Going forward: supported by CareOregon / Prov and expanding from 16 to 25 clinics
 - Bud Clark Commons Skin Care Clinic
 - Sustained through integration with Central City Concern
- Established a Tricounty 911 team for frequent users of the EMS system
 - Sustainability plan as “community utility” through Health Share
- Established an Emergency Dept Based OHSU “New Directions” team for frequent ED users with intensive behavioral health needs
 - Sustained through Hospital and plan support





How Do We Best Organize Ourselves?

Creating A Regional Collective Impact Structure

How do we organize ourselves?

- **Coming Together Around A Common Agenda:**
 - Collaborative effort of 6 Hospitals, 17 Clinics, 3 BH Organizations, 4 Community Organizations
 - Clinical Leaders empowered for each intervention, including support by Project Managers
 - Each intervention resourced with new workforce: created 75 FTE (104 people)
 - Multiple Sub Contracts, intervention accountability
 - “Bottom Up, Top Enabled”

- **“Backbone”**
 - Inclusive Grant Oversight team to guide efforts
 - All Intervention, Evaluation Leads
 - Encouraged “self organization”
 - Regular Intervention Team Meetings
 - “Intersections meetings”
 - Project Management Office



How do we organize ourselves?

- **Created A “Mutually Reinforcing” Learning System**
 - Partnered with Providence Center For Outcomes Research and Education (CORE)
 - Real time feedback
 - Built technology, PopIntel (CareOregon), to track work and integrate effort
 - Trained Project Managers in Lean and QI
 - Regularly tracked progress on Visual Road Maps
 - Held learning collaboratives
 - Created communications strategy, website
- **Measured progress and adjusted metrics to be meaningful**
 - ① Start up – are we hiring and launching on schedule?
 - ② Implement – are we doing it right?
 - ③ Adjust – are we doing the right thing to get the outcome we want? Are we getting outcomes that stakeholders want?
 - ④ What does this tell us about further transformation efforts?

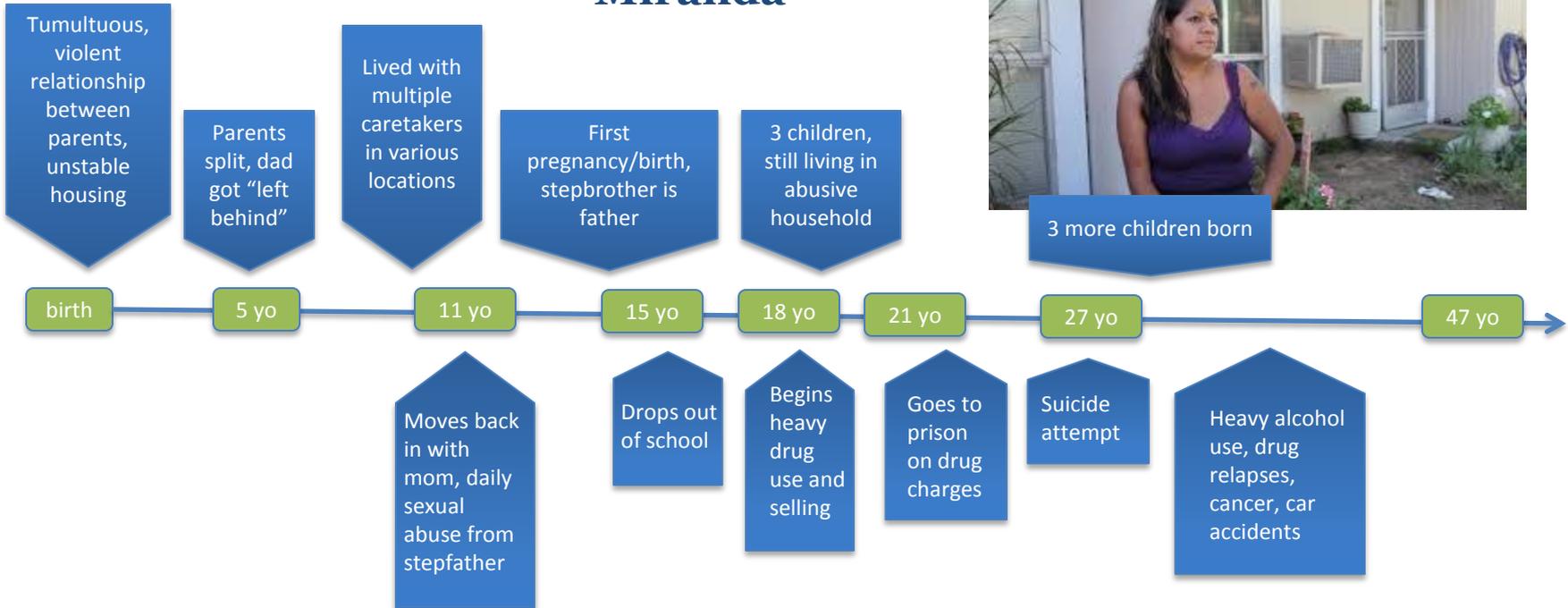
What “High Needs / High Cost” Patients (aka “High Utilizers”) Have Taught Us

- It is not “What’s wrong with them”... but “What has happened to them:”
 - High prevalence of reported “Adverse Childhood Events”
 - ACE Study Categories : Substance Abuse, Parental Separation, Mental Illness, Domestic Violence, Criminal Behavior, Abuse, Neglect (Felitti, Anda. Amer J Prev Med 1998)
 - ACE score >4 correlates with increased drug use including IVDU, mental illness / suicide, partner violence; ACE score >6, earlier death
- **Formal qualitative study of “Adverse Life Events”**
 - Health Resilience participant “open ended” interviews
 - Trained qualitative research staff; narratives coded, themes analyzed
 - Survey now being sent to 9000 Health Share members based on identified themes; oversampling “high utilizers,” African Americans
 - Can we identify common pathways to “high utilization?”



What we learned: Life stories with chain reactions of adversity

Miranda



Age 47

6 children age 15-32

No GED/diploma, no employment

In recovery from severe substance use

Chronic pain, cancer, multiple surgeries, no teeth or dentures

Multiple psychiatric medications

0-6 yo

30% Suffered repeated physical, sexual or emotional abuse in early childhood

47% Neglect

17% Had unmet basic needs (food, clothing)

13% Lived with an adult with a substance use issue

17% Were separated from parents



The Prevalence of Adverse Life Experiences

7-19 yo

54% struggled in school
50% dropped out of school

28% Ran away or left home early

30% Became teen parents

15% Became homeless at some point

46% Were substance users



19-30 yo

30% Were arrested or incarcerated at some point

52% Were substance users

26% Were homeless

74% Report job insecurity or become unable to work at all

28% Were separated from their children



What the Numbers Tell Us

Before Age 19:

63% experienced some form of abuse;
52% experienced extended maltreatment

30+ yo

40% Struggle with mental health

70% Describe struggling to get needed healthcare

30% Struggle to manage their medication

NONE able to work

30% Describe being socially isolated

Lauren Broffman, Center for Outcomes Research and Education (CORE)

Age Greater Than 30

Age/Gen Race	0-5	6-12	13-19	20-30	30+
48 F AA	Abuse (e)	Abuse (e)	Drugs/ Alc, Loss, DV, Sex work	Sex Work, Drugs, Arrest	DV, Drugs
57 M AA	Parent SU	Rape, Drugs	Aband, Quit Sch, Abus, Drugs, Loss	Jobless	Drugs, Arrest
68 F	Abuse (e)	In State Home for Dev Delay	Abuse (P)	Unable to work	Disabled
34 M	Parent SU	Loss	Leaves Home, Expelled	Drugs	Drugs
35 F AA	Adopted	Abuse (p)	Drugs, Quit School	Drugs, DV	Alc
51 F	Sibling SU	Drugs/ Alch	Drugs, Quit Sch, Homeless	Drugs, Arrests	Drugs, Suicide At
44 M	Parent SU, Abuse (p/e)	Abuse (p/e)	Abuse (s), Alc, Quit School, Homeless	Jail, Suicide At	Probabtion
36 F	Parent SU	Abuse (s), Run Away, Homeless	Quit Sch (8), Foster care, Drugs, Dentition Home	Drugs, Homeless	Jobless
52 F	Abuse (p/v)	Abuse (s)	Abuse (s), Drugs, Alc, Quite School (9), jail	Drugs, Alc, Homeless, DV	Alc
73 F AA	Parent SU, DV		Quit School	Loss	Suicide At
55 F	Abuse (p/v)		Alc, Drugs	Sex Work, Abuse (s) DV, Drugs, Alc	Suicide At
35 M	Abuse (p)		Homeless	Prison	Homeless
62 M AA	Abuse (v)	Major trauma		Jail	Drugs, Alc
46 F		Abuse (s)	Quit Sch (8) Drugs	Drugs, Prison, A. Suicide At	Drugs
56 M AA		Quit Sch (8)	Drugs, Alc, Abuser	Drugs, Alc, Prison, Homeless	Drugs, Alc
55 F		Abuse (s)	Bullied	Loss, Suicide At	Loss
71 F AA		Abuse (s)	Quit School		Disabled
50 M AA			Drugs, expelled	Drugs, prison	Drugs, Prison x2
44 M AA			Abuse (e/p) Alc, drugs	Alc, Drugs, Sex Offender, Pris, Abuser	Prison
40 M	Parental SU	Abuse (s)	Burglary, Dentition Home, Foster Care (many)	Drug, jail	
36 F	FAS, Abuse (s/p), Foster care (12)	Adopted		Evicted, Foster Care	
31 M AA		Abuse (e), Neglect, Race	Drugs, Alc, Arrest		
50 F H			Abuse (e)		Loss, Disabled
40 F AA				Injury; unable to work	
62 M AA	Parental SU				
41 M AA					Arrest
31 F				Rape, Homeless	

Adverse Life Events In “High Utilizers:” *Cumulative Burden Across Life Span*

- ✓ Abuse: Emotional, Physical, Sexual
- ✓ Substance Use: Drugs, Alcohol
- ✓ Abandonment
- ✓ Traumatic Loss
- ✓ School Failure
- ✓ Job Failure
- ✓ Homelessness
- ✓ Incarceration

Age Less Than 30

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29 F	Parental conflicts; family chaos	Parental conflicts; family chaos	Runaway; Traumatic Brain Injury; Quit school; Drugs	Unable to work; self harm
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Self reported life events from 30 Medicaid “High Utilizers” enrolled in intensive management program

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Adverse Life Events In “High Utilizers:” *Cumulative Burden Across Life Span*

✓ Abuse: Emotional, Physical, Sexual: 70%

✓ Substance Use: Drugs, Alcohol: 60%

- ✓ School Failure: 60% do not graduate HS; 1 College Grad
- ✓ Job Failure: none fully employed
- ✓ Homelessness: 23%
- ✓ Incarceration: 30% in jail / prison; 17% “been arrested”

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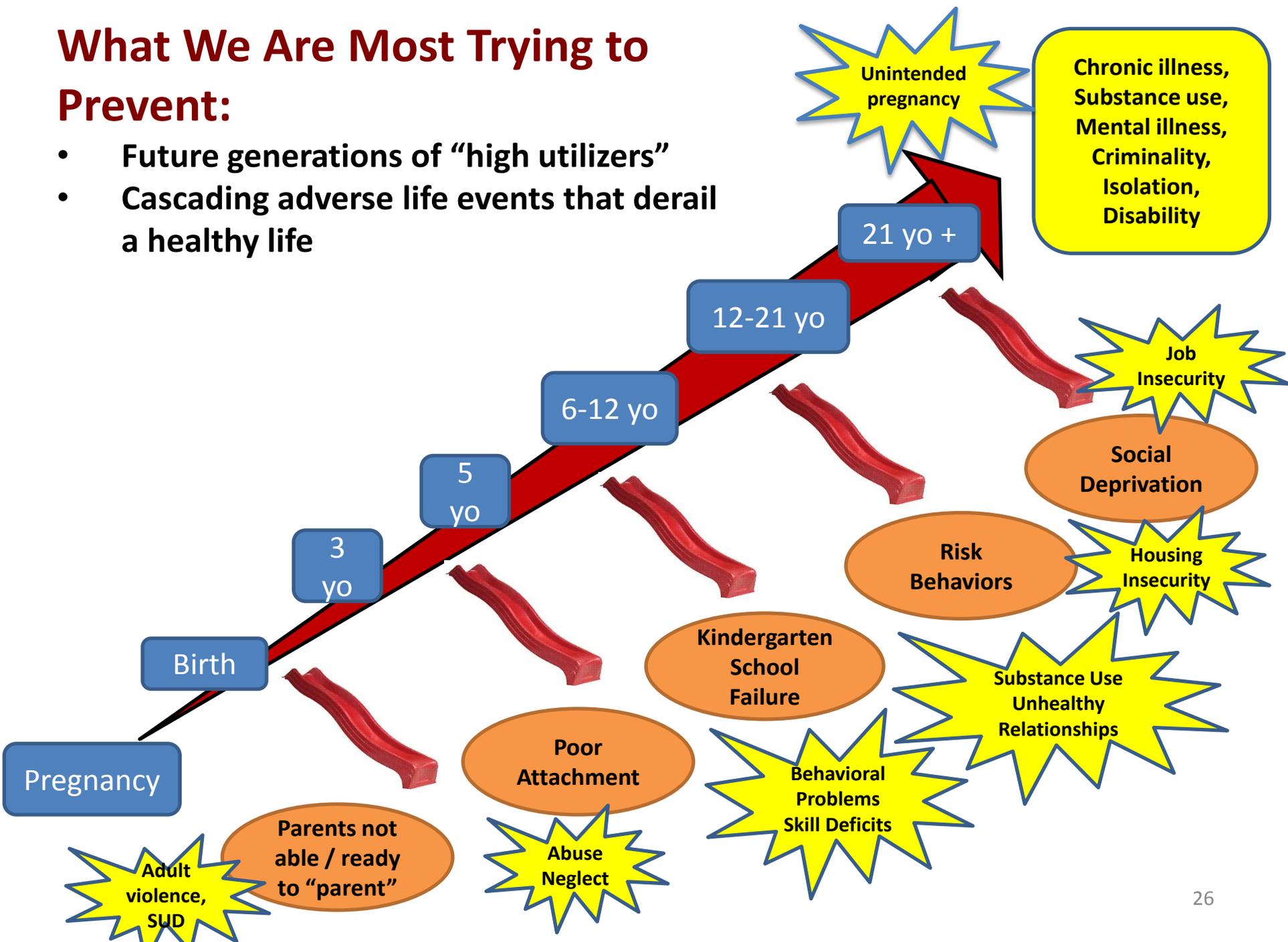


What Does This Mean For CCO “Population Health” Strategy?

Children in low SES households have 5 times the rate of maltreatment than other children: 3 times more likely to be abused, 7 times more likely to be neglected (NIS 2006)

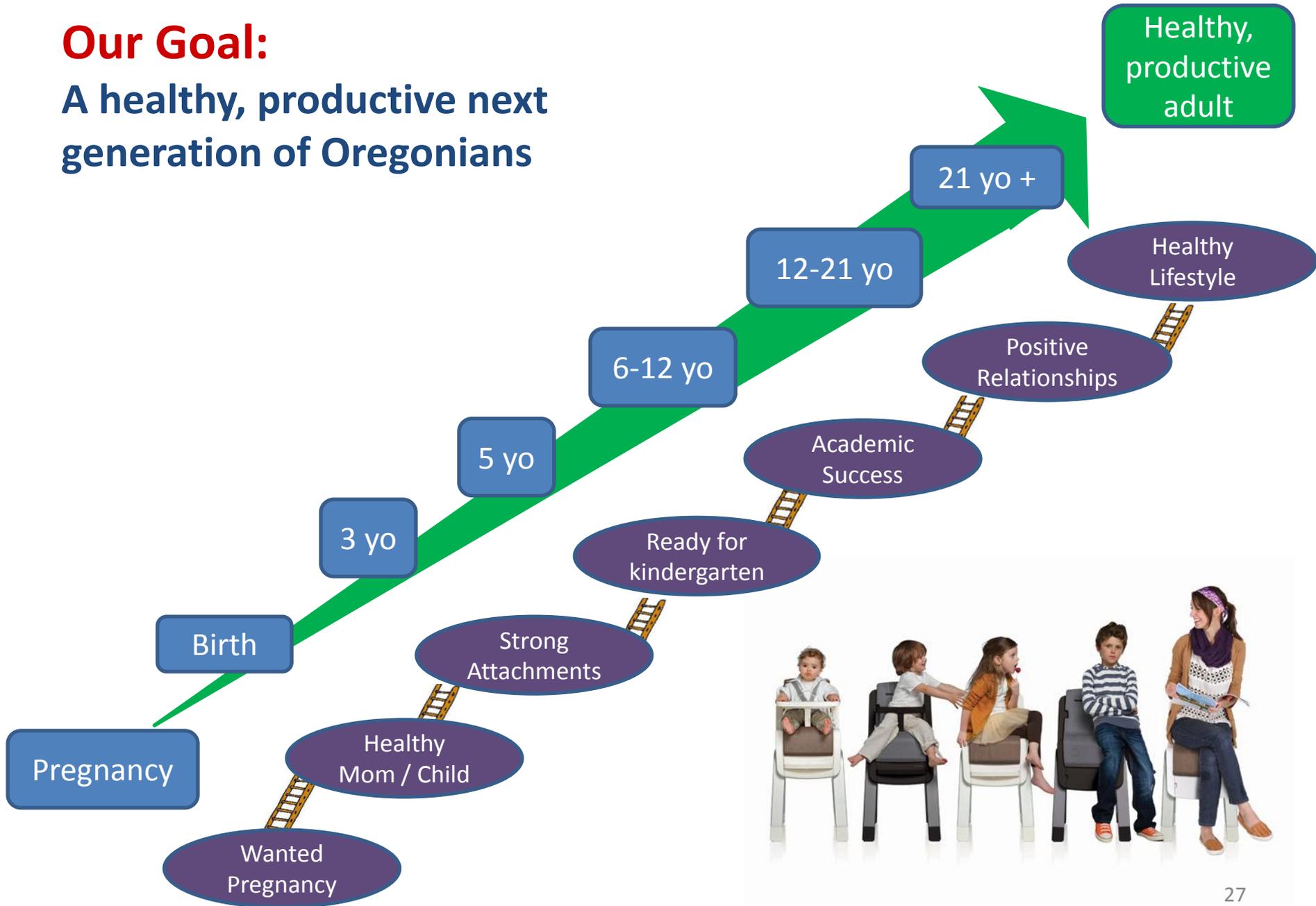
What We Are Most Trying to Prevent:

- Future generations of “high utilizers”
- Cascading adverse life events that derail a healthy life



Our Goal:

A healthy, productive next generation of Oregonians



What does this mean for a CCO prevention strategy?

- **Identify key touch points in the care delivery system where we can provide meaningful support:**
 - Promote stable families with healthy early attachments
 - Current: CCO P4P metric on effective contraception = desired pregnancy
 - Ensure that at risk families get the mental health, SUD treatment and social services they need to prevent adverse outcomes
 - Current: CCO charge to integrate care
 - Focus on highest risk children (Foster care)
 - Current: CCO metric on physical / behavioral / dental assessments
 - Help children be ready for kindergarten by age 5 to increase the likelihood of school success
 - Current: CCO P4P metric on developmental screening

What does this mean for a CCO Population Health strategy?

- Before entering school, the Health Care System is the social institution with the most contact with young children and their families (Bright Futures: 12 WCC before 3 yo)

	INFANCY								EARLY CHILDHOOD						
AGE ¹	Prenatal ²	Newborn ³	3-5 d ⁴	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●			
Weight for Length		●	●	●	●	●	●	●	●	●	●				
Body Mass Index ⁵												●	●	●	●
Blood Pressure ⁶		★	★	★	★	★	★	★	★	★	★	★	★	●	●

- Can we help make a difference for early families at risk?

Can CCOs Help Make A Difference?

Developmental Disabilities

- Children on Medicaid have 1.7 x the rate of “any developmental disability” than children with commercial insurance and 1.8 x the rate of “learning disabilities”
 - Do we need more developmental pediatricians? Or earlier interventions?

Condition	Health Insurance Coverage,%		
	Private	Medicaid or CHIP	Uninsured
Any developmental disability	12.10	20.28 ^k	11.61
ADHD	6.01	9.55 ^k	4.97 ^l
Autism	0.45	0.67	0.19
Blind/unable to see at all	0.10	0.17	0.17
Cerebral palsy ^a	0.61	0.60	0.33
Moderate to profound hearing loss	0.34	0.77	0.44
Learning disabilities	5.94	10.87 ^k	6.16 ^l
Intellectual disabilities ^b	0.44	1.68 ^k	0.38 ^l
Seizures in the past 12 months	0.49	1.31 ^k	0.46 ^l

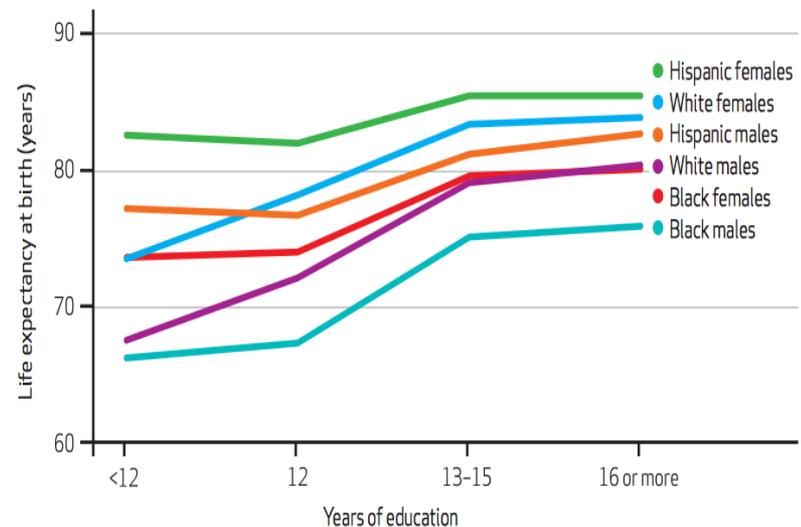
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Can CCOs Help Make A Difference?

Ensuring Early (and Later) Life Success

- School readiness: kindergarten is the first step into larger society.
 - Starting out poorly increases the likelihood of school failure and social failure
 - 15% of children with 2+ Adverse Childhood Experiences repeated a grade vs 5.65 with no ACE (Bethell C Health Affairs Dec 2014)
 - From our study: school struggles / lack of high school graduation appear to correlate with social marginalization and unmet health needs
- Not graduating high school highly correlates with poor health outcomes and shorter life: (Olshansky et al. Health Affairs Aug 2012)
 - Decrease in life expectancy with less than 12 years of education vs with 16 or more:
 - Black men – 9.7 years shorter
 - Black women – 6.5 years
 - White men – 12.9 years
 - White women – 10.4 years
 - Hispanic men – 5.5 years
 - Hispanic women – 2.9 years
 - Blacks and Hispanics with 16 or more years of education live 7.5 years and 13.6 years longer than whites with less than 12 years of education

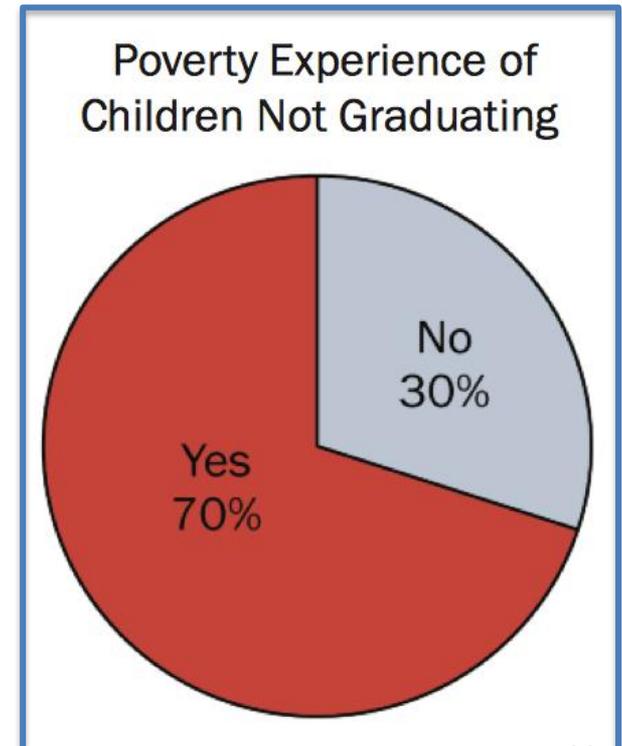
Life Expectancy At Birth, By Years Of Education At Age 25, By Race And Sex, 2008



Can CCOs Help Make A Difference?

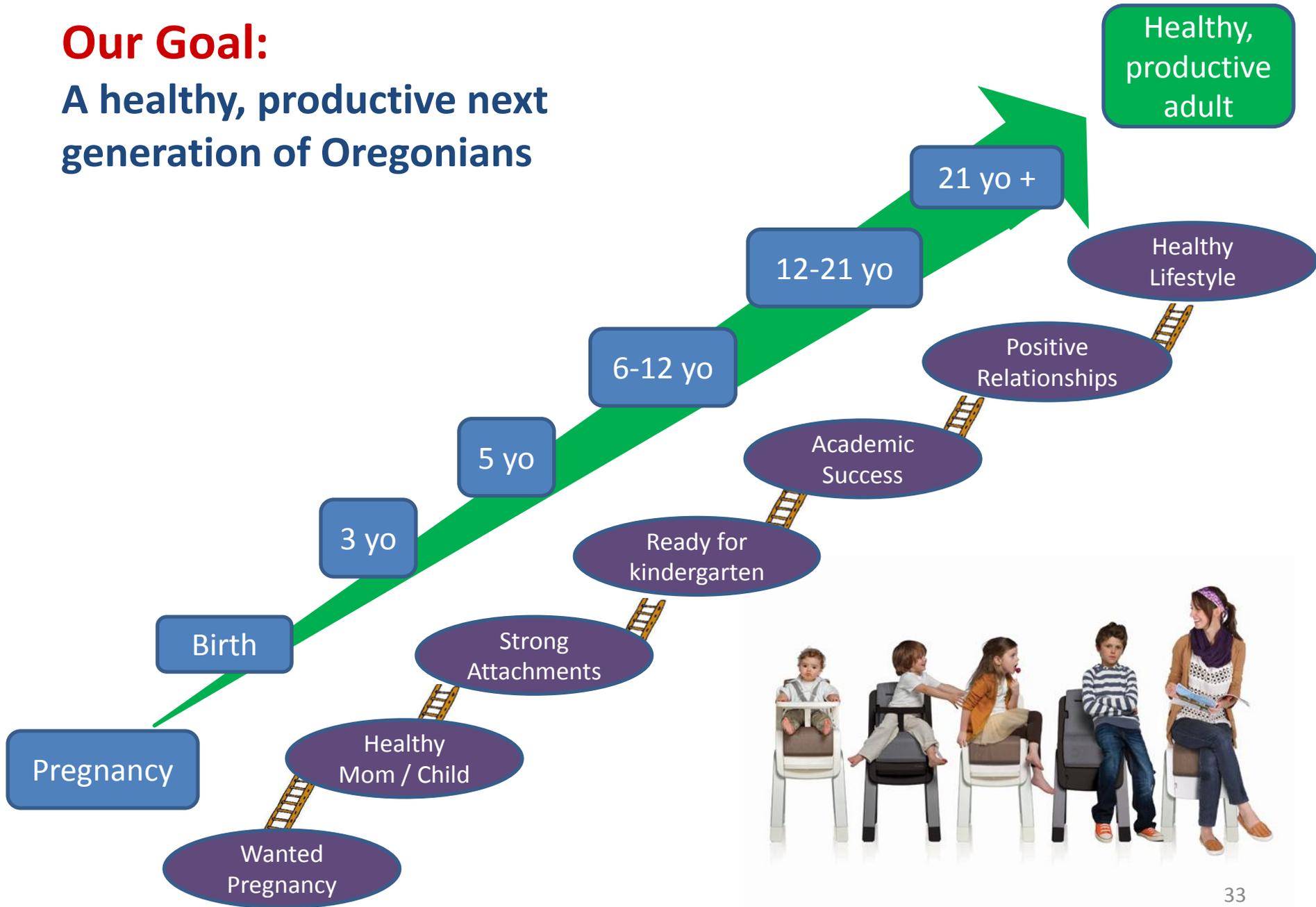
“Kindergarten Readiness”

- 80% of children from low income families failed to reach a “proficient” reading level in by the end of third grade (Annie E Casey Foundation 2010)
 - Through 3rd grade students “learn to read;” after third grade they have to “read to learn”
- 35% of children from poor neighborhoods not reading proficiently at third grade do not graduate High School
- For those not reading proficiently but have never been poor it is 9% (~4x)
 - For children reading proficiently, this drops to 11% for with any poverty, and 2% for those without. Percentages for minorities are worse.



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A healthy, productive next generation of Oregonians





Thank You!

david@healthshareoregon.org
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