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Jennifer B. Valentine, MSPH

Medical Assistance Programs

**BETTER HEALTH, BETTER CARE  
& LOWER COSTS**  
BUILDING BRIDGES TO SUCCESS



**Oregon Medicare - Medicaid  
Alignment & Integration:  
CCO Duals Technical Assistance Tool**



# DUALS ALIGNMENT TOOL = A ROADMAP



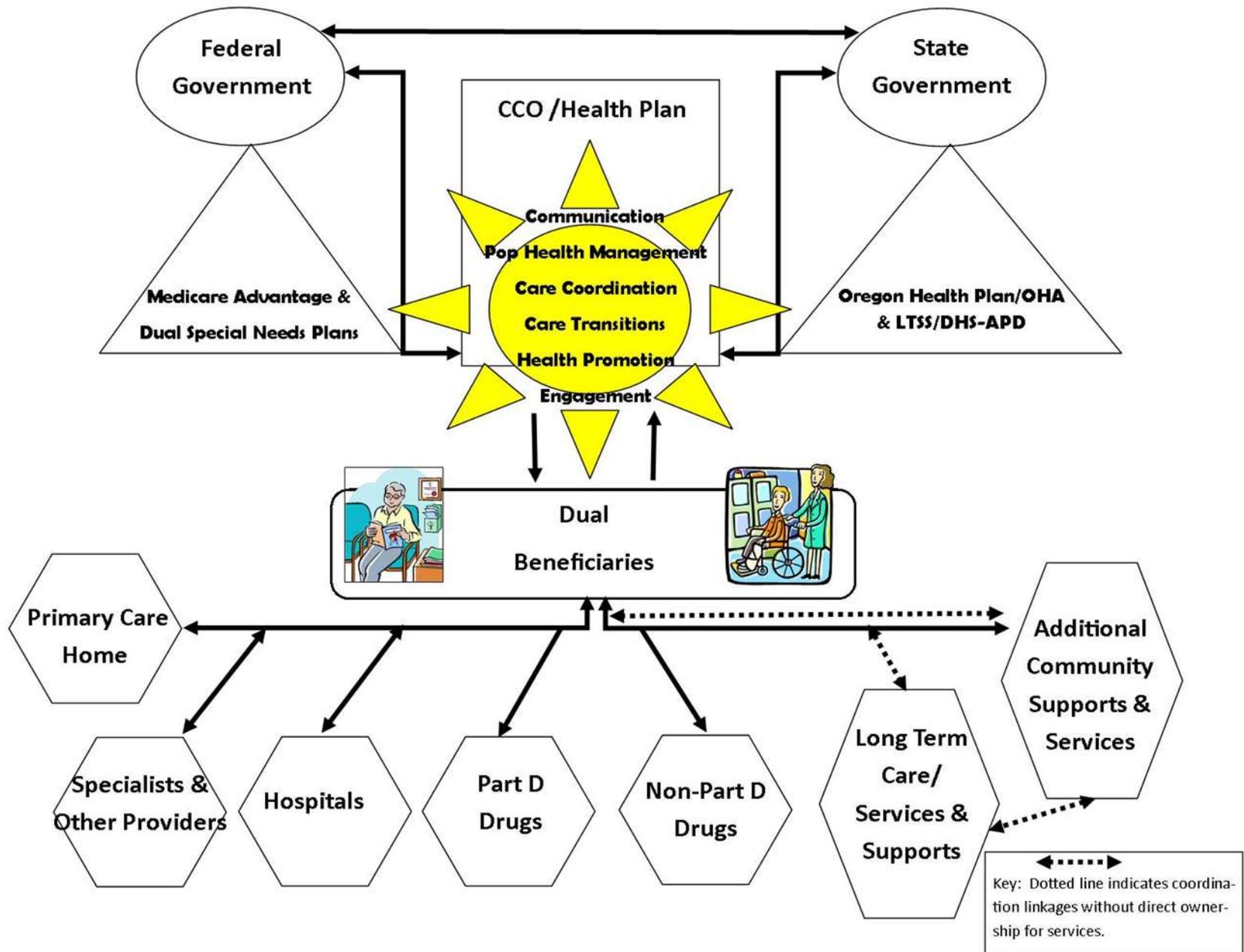
The journey of a thousand miles begins with a single step –Lao Tzo

## Figure 1: A Day in the Life of a Dual Eligible

Mattie is a 77-year-old woman eligible for both Medicare and Medicaid.<sup>6</sup> She has longstanding diabetes and hypertension, and has had several strokes, resulting in weakness on her left side. She needs care from many providers: a personal care attendant whose assistance allows her to live alone at home, a licensed social worker who helps address her depression, and a variety of specialists to whom she has trouble getting to because of her mobility problems. The below chart compares Mattie's health insurance benefits in an integrated system versus unintegrated care.

| Mattie's Health Insurance Coverage                                                                                          |                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| WITHOUT INTEGRATED CARE                                                                                                     | INTEGRATED CARE                                                                                                  |
| * Three ID cards: Medicare, Medicaid, and prescription drugs                                                                | ✓ One ID card                                                                                                    |
| * Three different sets of benefits                                                                                          | ✓ One set of comprehensive benefits: primary, acute, prescription drug, and long-term care supports and services |
| * Multiple providers who rarely communicate                                                                                 | ✓ Single and coordinated care team                                                                               |
| * Health care decisions uncoordinated and not made from the patient-centered perspective                                    | ✓ Health care decisions based on Mattie's needs and preferences                                                  |
| * Serious consideration for nursing home placement; Medicare/ Medicaid only pays for very limited home health aide services | ✓ Availability of flexible, non-medical benefits that help Mattie stay in her home                               |

<sup>6</sup> Case study from Robert J. Master, MD, Commonwealth Care Alliance, Massachusetts.



# GUIDING PRINCIPLES

**Oregon's Triple Aim: "Better Health, Better Health Care, Lower Cost"**

**ORS 410: "Choice, Dignity and Independence Values"**

**Long Term Care 3.0 "Right Services, Right Time, Right Place"**

FROM



TO



# IT'S BEEN A LOT OF STEPS...ARE WE AT THE TOP OF THE MOUNTAIN YET?



CCO's Formed,  
PCPCH Movement

ACA Expansion

Integration of Behavioral  
Health and Dental  
Health

In Oregon, we set our goals high!

# WHAT'S AHEAD & WITHIN OUR GRASP

- Improved Care Transitions, Reduced Care Fragmentation
- Increased Care Coordination results in improved outcomes, reduced cost, better health and quality of life
- Increased Communication and Use of Tools to Support Integrated Care Teams, Patients and Families
- Reduction of Health Disparities, improved health for communities at large
- Increased focus on prevention

What else do you see?



How do we scale innovations to full system implementation and sustainability?

# **DUALS ALIGNMENT TOOL: KEY AREAS COVERED**



**Communication**

**Population Health**

**Management (Using Data!)**

**Care Coordination**

**Care Transitions**

**Health Promotion/Chronic  
Disease Management**

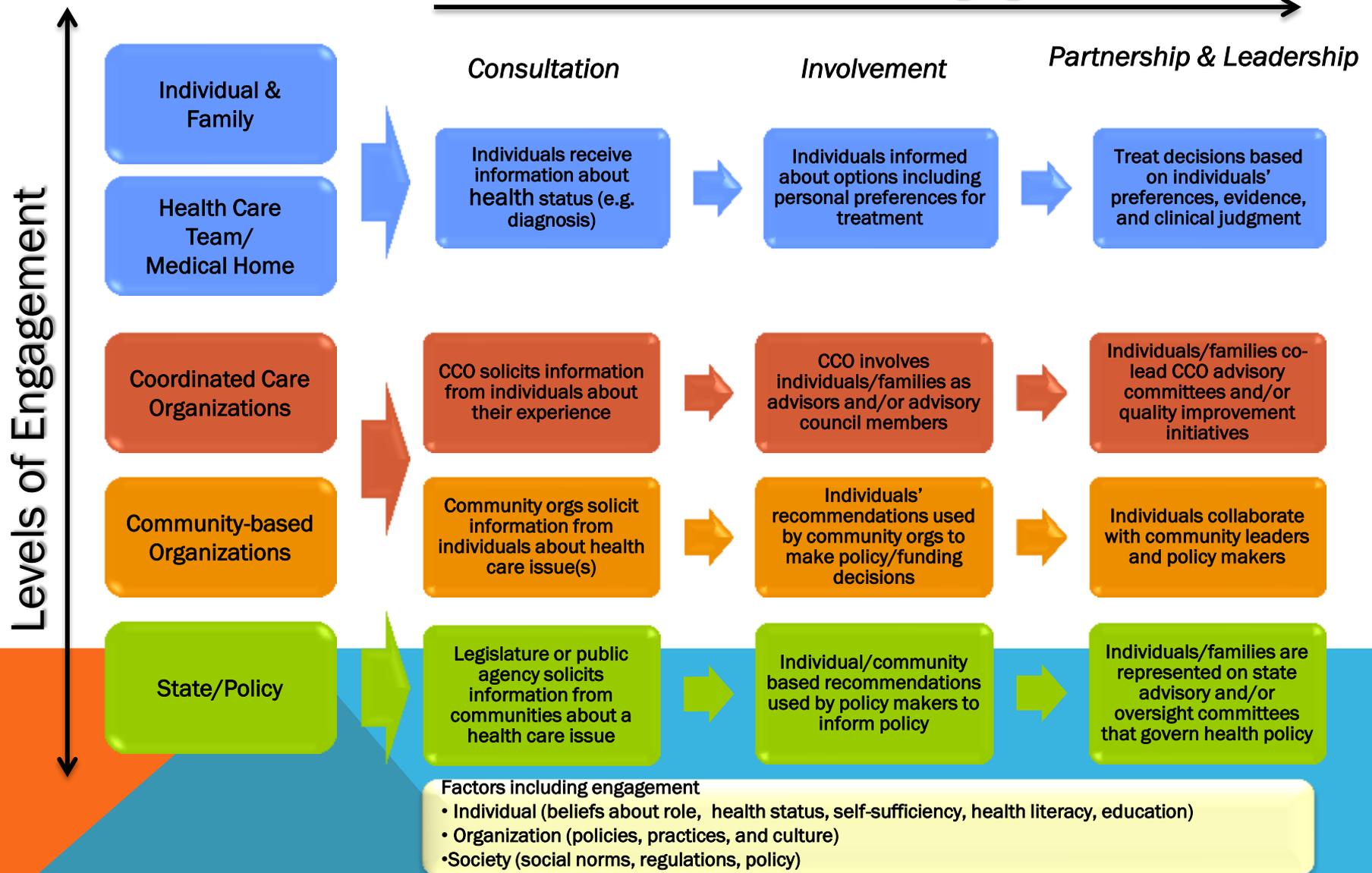
**Engagement**

**Health Equity (& Social  
Determinants of Health  
Lens)**

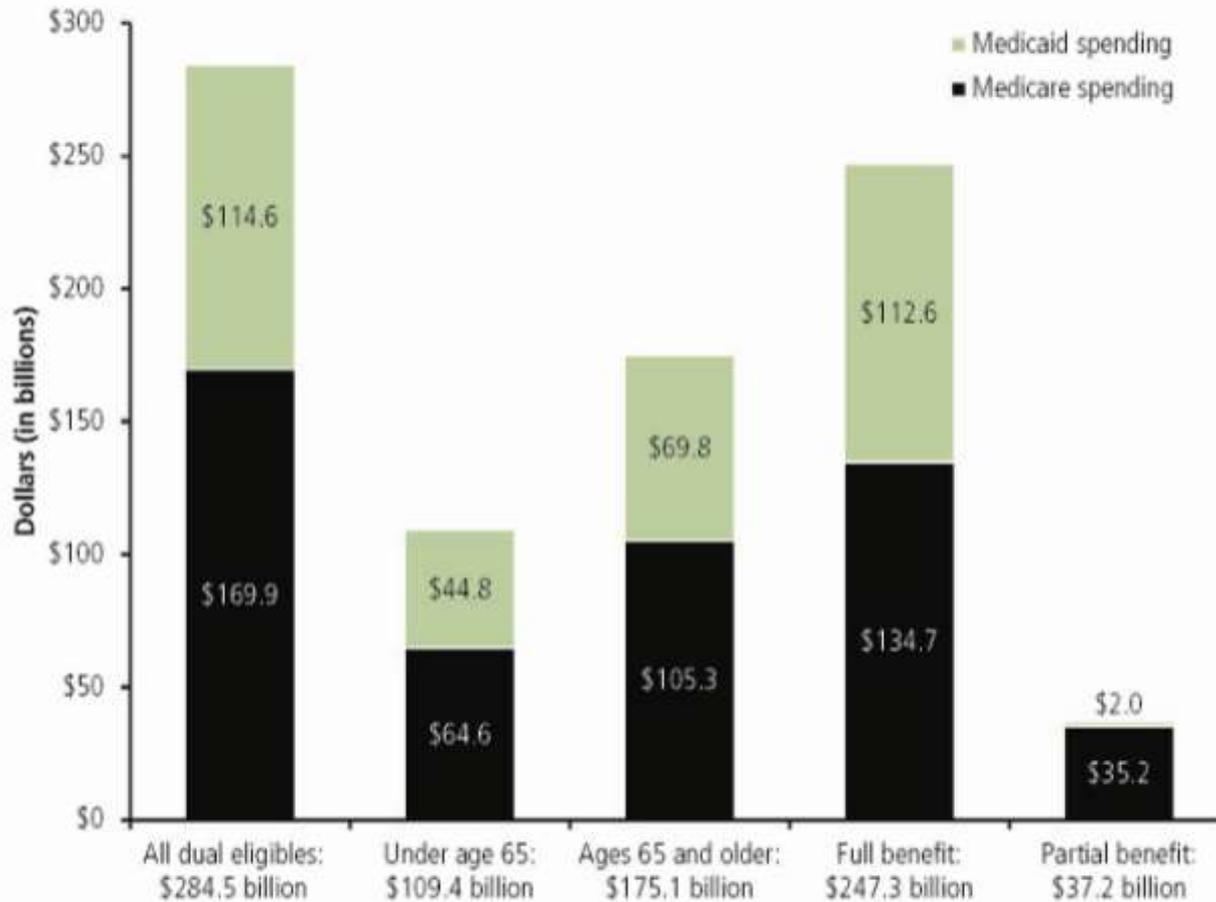
**Administrative Policy &  
Leadership**

# A Multidimensional Framework for Individual And Family Engagement In Oregon

## Continuum of Engagement



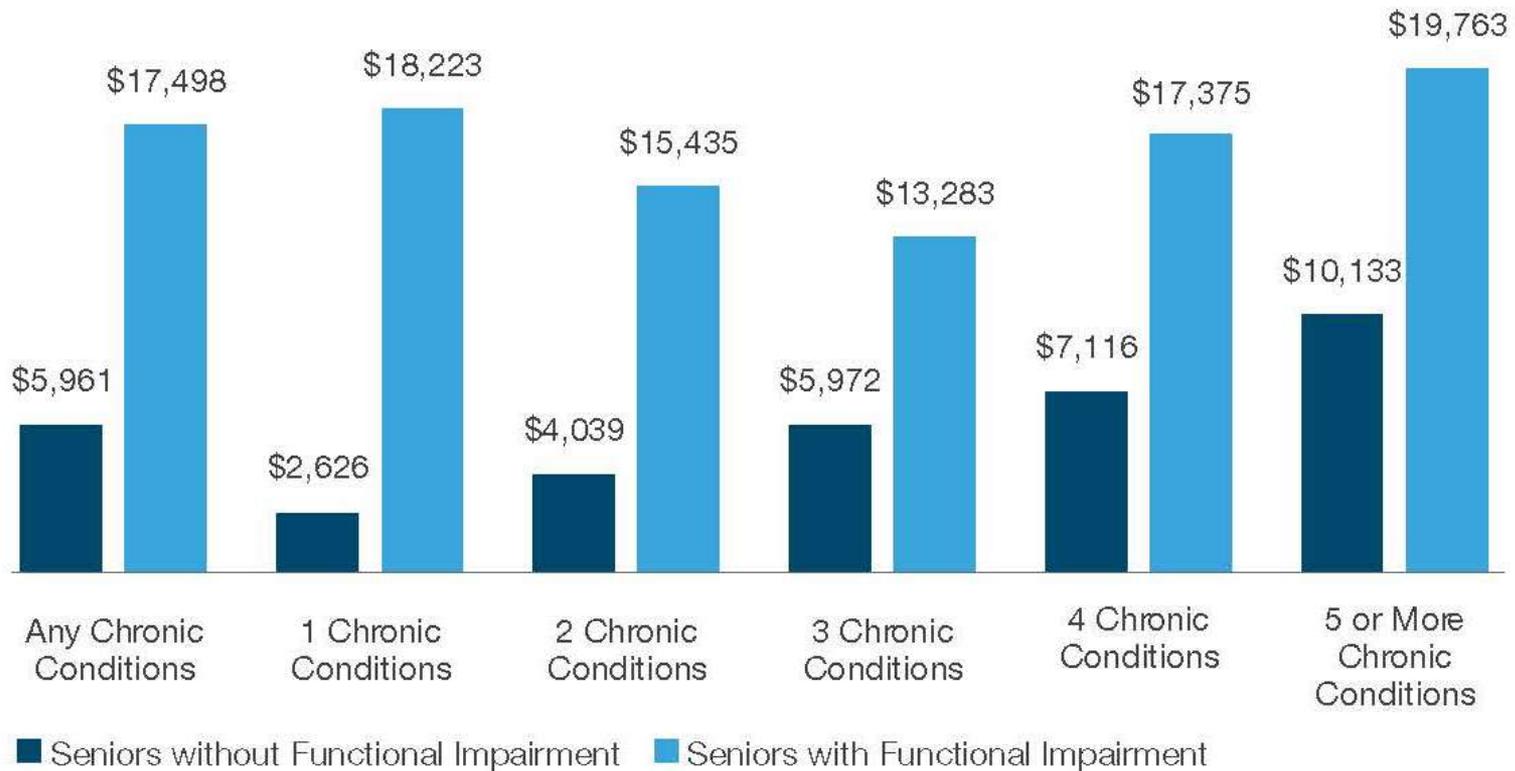
## Medicare and Medicaid spending on dual-eligible beneficiaries by age and type of benefit, CY 2010



Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission, Jan 2015

*Note:* CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Totals may not sum due to rounding. Exhibit excludes administrative spending.

**Figure 1: 2006 Per Capita Medicare Spending by Chronic Conditions and Functional Impairment**



Source: Avalere Health analysis of the 2006 Medicare Standard Analytic Files.

Source: Adapted from Stiefel M, Nolan KA. Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on [www.IHI.org](http://www.IHI.org))

Figure 4

Patient Profile



**Clinical Input**

- Forgetful
- No family in the area
- History of falls
- Bone loss

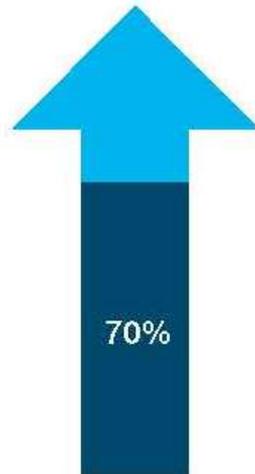
**HRA**

- Smoker (1 pack/day)
- Widowed / lives alone
- No exercise
- Improper nutrition

**Claims Data**

- Diabetes
- Age 91
- High Medicare spending in prior year

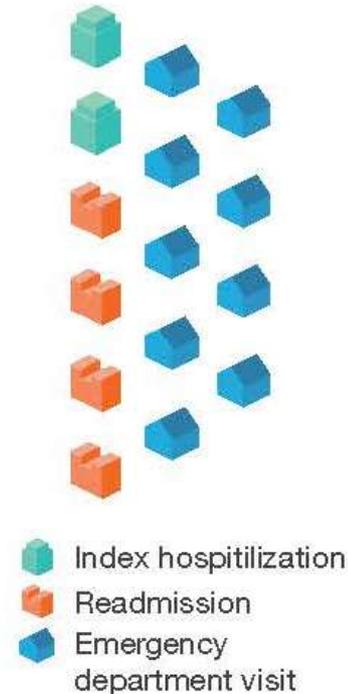
Likelihood of Being in Top 20% of Spending



Total Payment

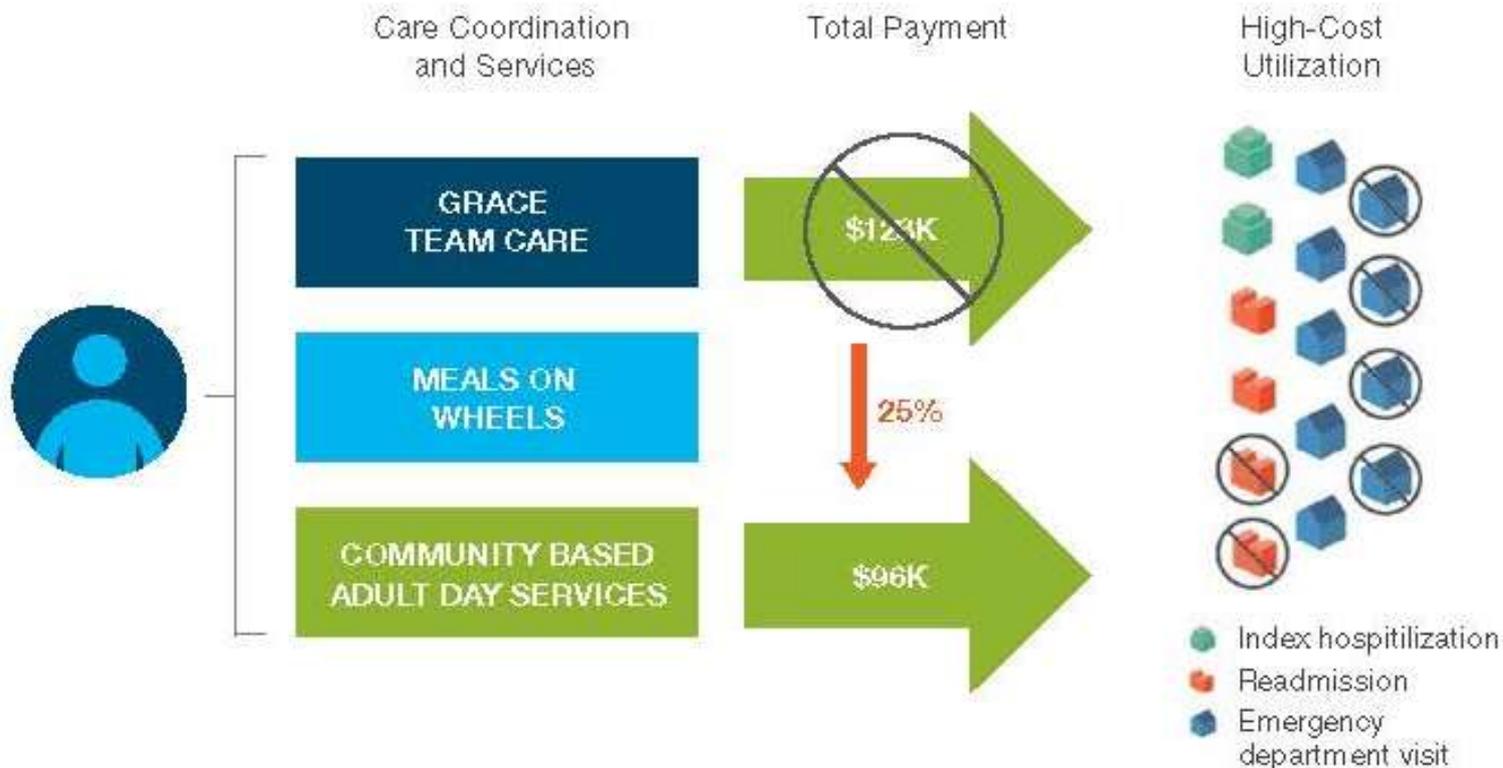


High-Cost Utilization



Source: Adapted from Stiefel M, Nolan KA. Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on [www.IHI.org](http://www.IHI.org))

Figure 5



Source: Adapted from Stiefel M, Nolan KA. Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on [www.IHI.org](http://www.IHI.org))

# SHARED ACCOUNTABILITY CCO BRIDGES WITH LTSS

**Memorandums of Understanding, Platform for Collaboration**

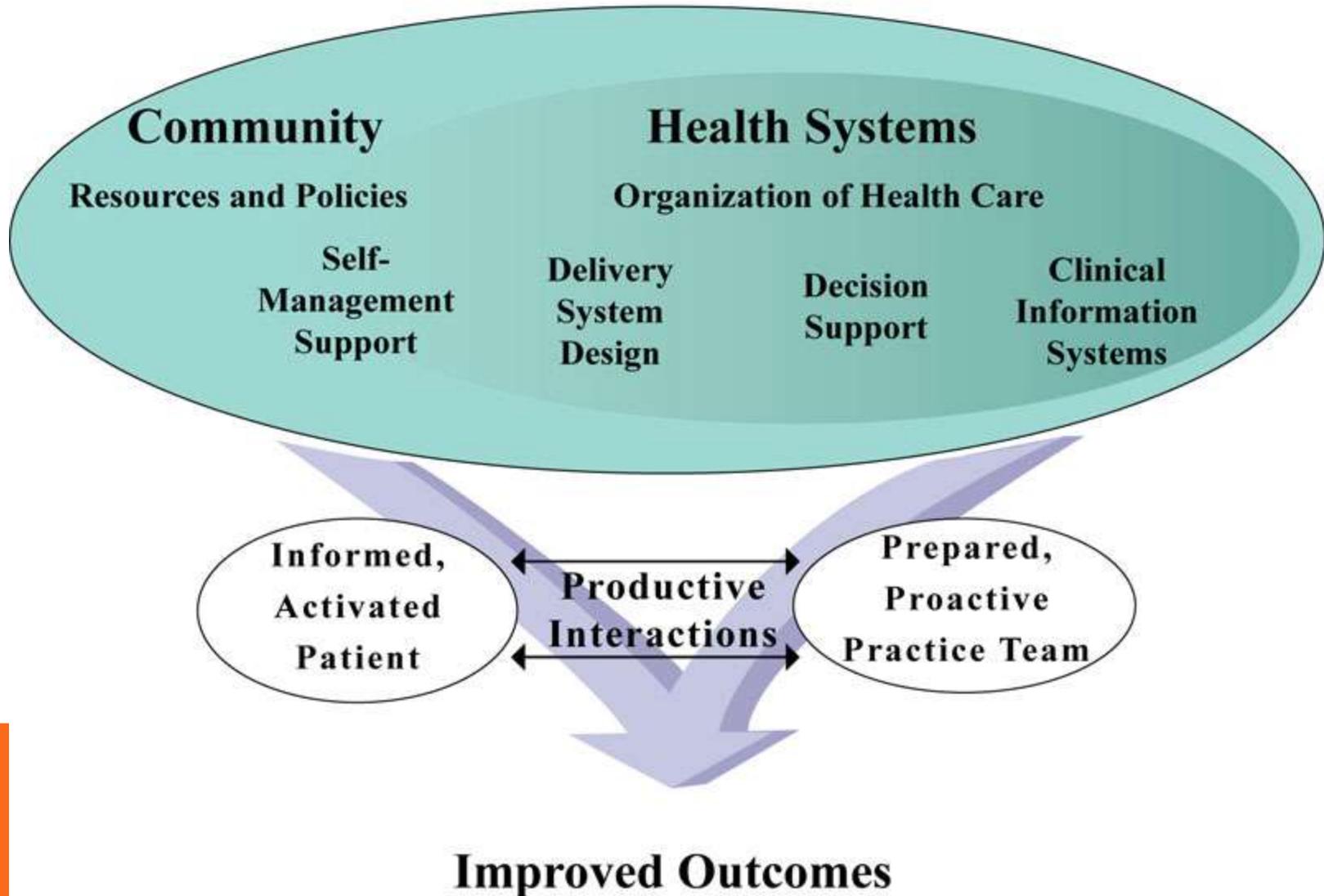
**Identification of High Risk Populations**

**Care Coordination, Care Planning, Care Transitions**

**Who Has What Information? Who Has What Services  
Available to Assist Patient and Family?**

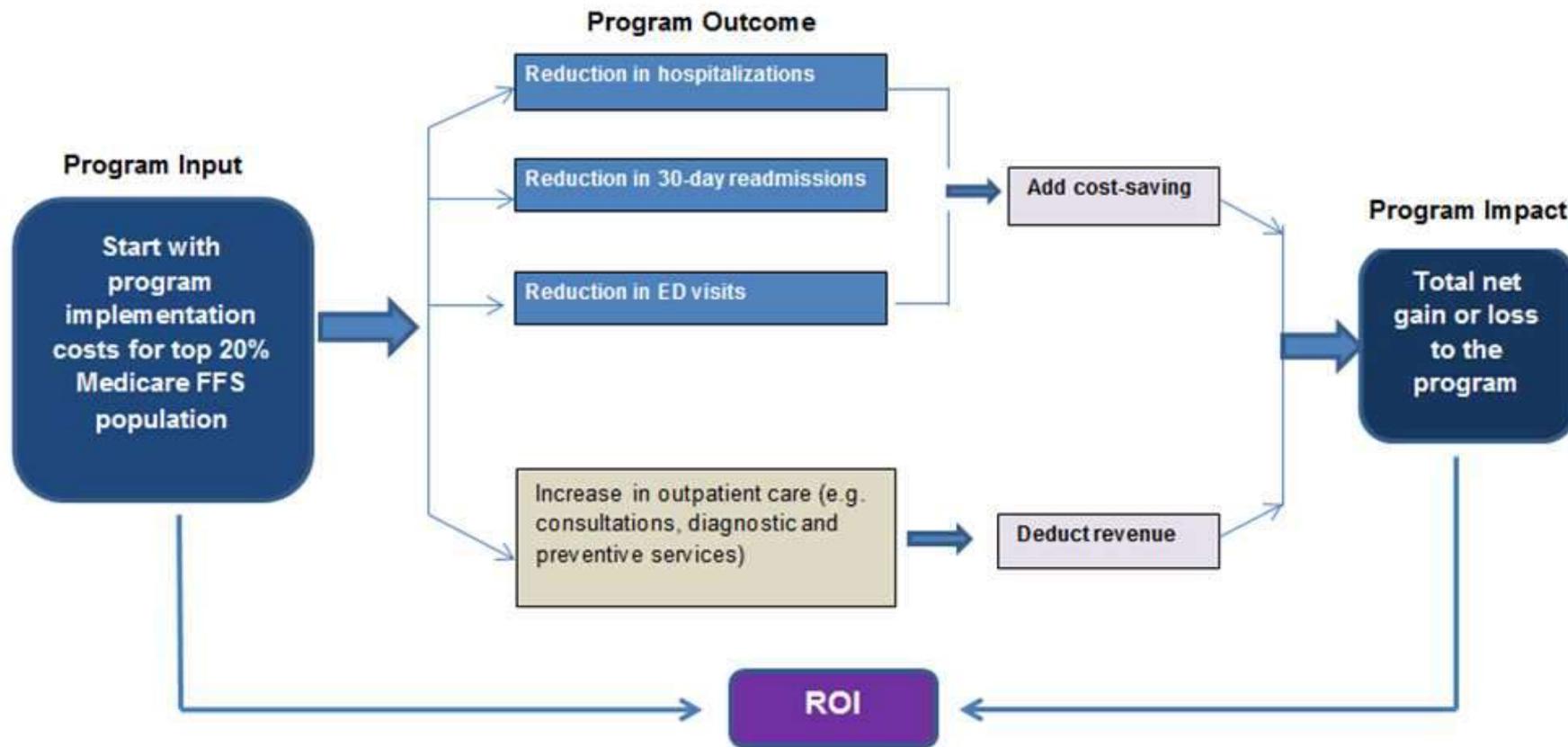


# The Chronic Care Model



**Care Coordination ROI CALCULATOR:** ROI is a standard measure used in both the public and private sector to gain a concise understanding of an investment's net benefit. The simplicity of the equation below allows for versatile use across all types of investment.

**ROI = (Benefit from Investment – Cost of Investment) Divided by (Cost of Investment)**



# CREATION OF A COLLABORATIVE, PERSONALIZED, AND PRO-ACTIVE CARE PLAN TO ADDRESS THE PATIENT'S NEEDS.

## Risk-Stratified Care Management and Coordination

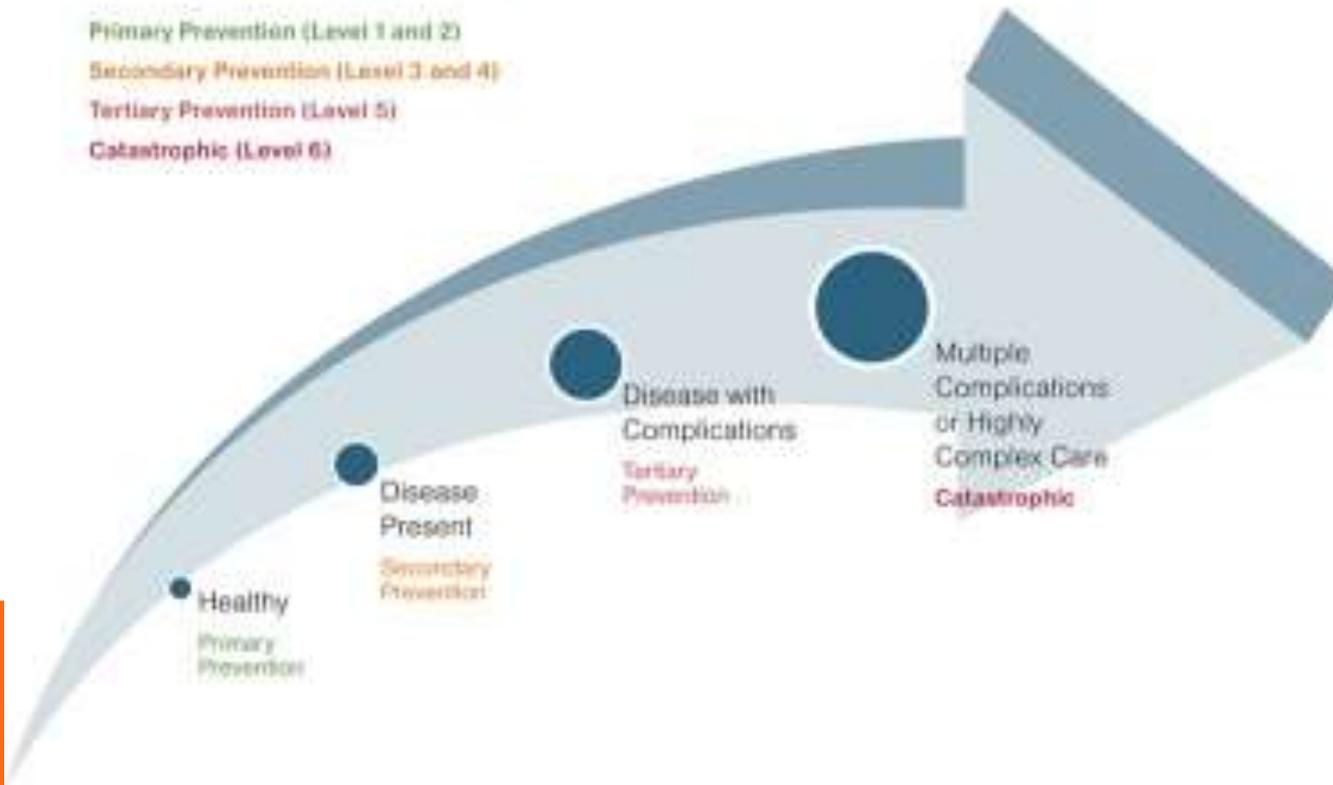
### Health Risk Categories

Primary Prevention (Level 1 and 2)

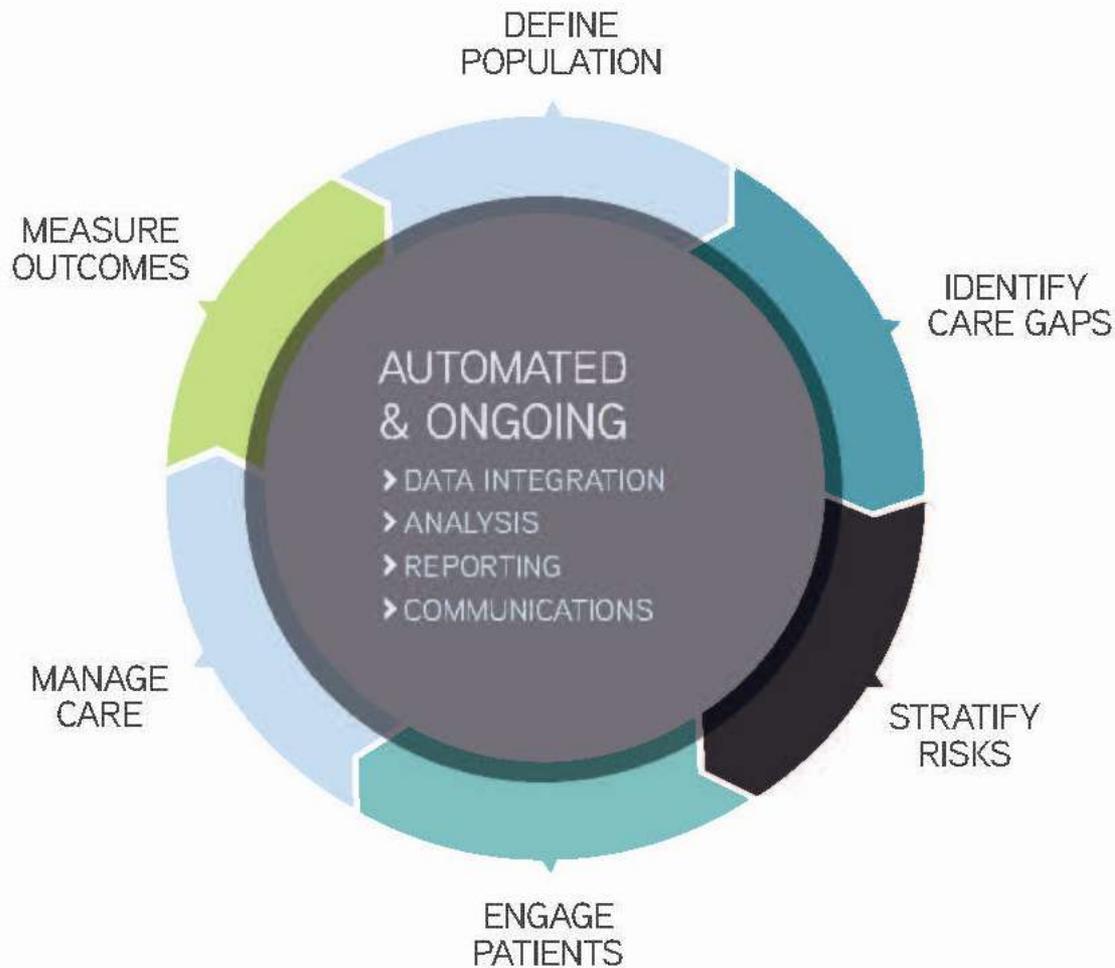
Secondary Prevention (Level 3 and 4)

Tertiary Prevention (Level 5)

Catastrophic (Level 6)



## Population Health & Risk Stratification: Integrating Data



**New Tools  
Being  
Implemented  
Across Oregon  
at Practice and  
CCO Level**

Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Healthcare Technology Transformation, 2012

# Evidence indicates care management can improve outcomes for certain people with chronic conditions by:

- Improving provider-enrollee communication;
- Increasing beneficiaries' adherence to recommended medication and self-care regimens;
- Facilitating greater communication between physicians and other care providers; and
- Encouraging greater use of evidence-based care.



Using Lessons from Disease Management and Care Management in Building Integrated Care Programs , J. Libersky and M. Au, Mathematica Policy Research, and A. Hamblin, Center for Health Care Strategies, April 2014

# Basic Components of Care Management Programs

Targeting efforts to those most likely to benefit. (risk identification/stratification)

Conducting (or compiling) comprehensive assessments to identify needed services and develop a care plan. (care plan)

Ensuring in-person contact between beneficiaries and care managers. (relationships)

Using appropriately trained care managers. (training)

Requiring care management team composition that meets enrollee needs.

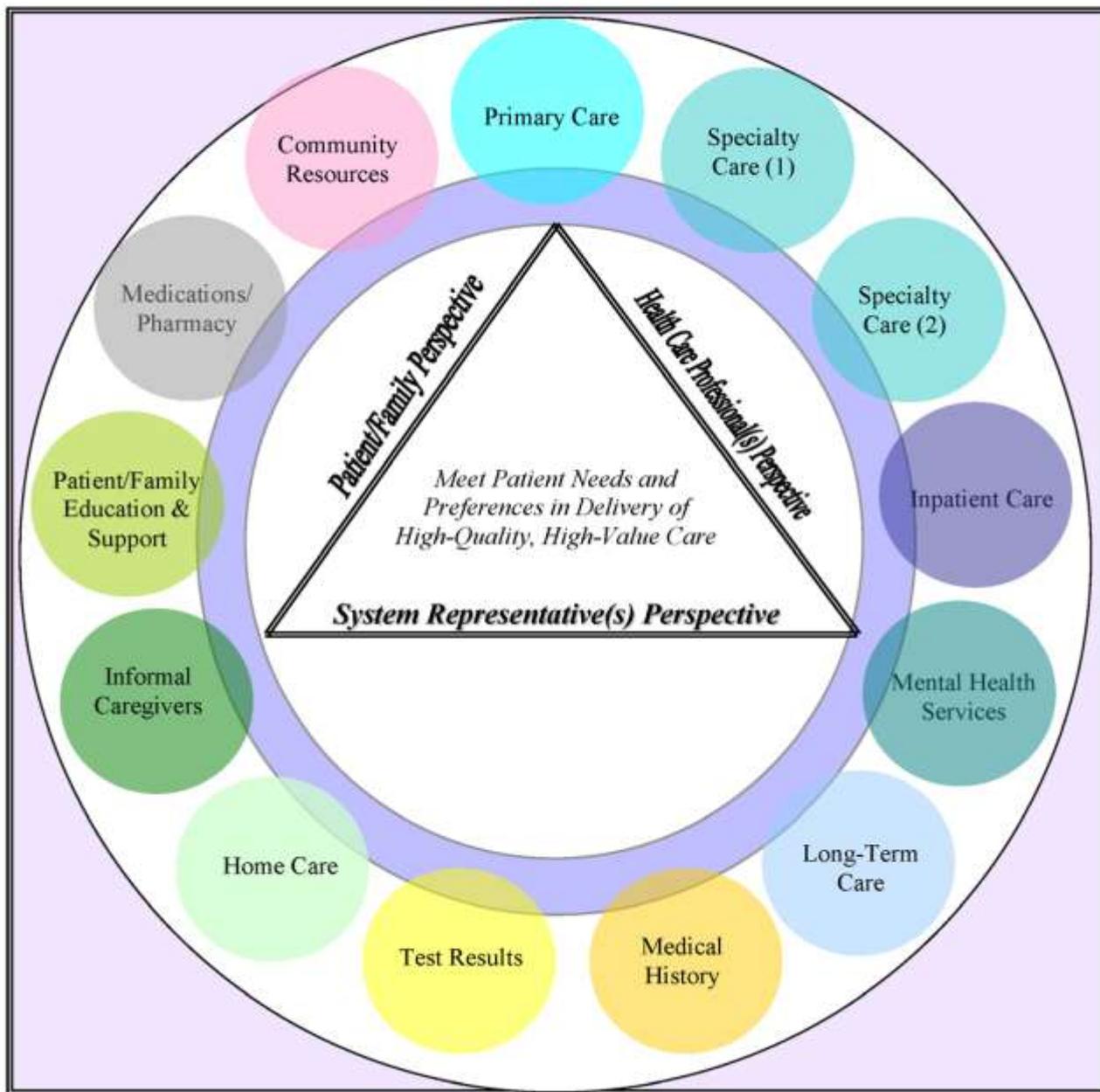
Facilitating timely communication of changes in health status and service use. (implementing tools like Care Accord, PreManage or other HIE)

Fostering interaction among care managers and providers. (relationships)

Promoting self-management. (patient activation)

Using evidence-based tools and protocols. (system-wide care guidelines)

# Care Planning & Care Teams: Are We Getting Everyone Who Is Needed Involved ?



# Care Transitions: Opportunities Abound

## “Poorly managed transitions can diminish health and increase costs.” –Health Affairs, Sept. 2012

**\$12 billion**

Preventable readmission costs  
[Potentially preventable 30-day hospital readmissions cost Medicare about \$12 billion annually.]

**1%**

Hospital payment penalty  
Starting October 1, 2012, Centers for Medicare and Medicaid Services can reduce payments by 1 percent to hospitals whose readmission rates for patients with certain conditions exceed a particular target.

**30%**

Reduction in readmissions  
[A care transitions intervention reduced 30-day hospital readmissions by 30 percent in a large integrated delivery system in Colorado.]

**39%**

Reduction in patient costs  
[A care transitions intervention reduced readmission costs by 39 percent per patient in six hospitals in Philadelphia.]

# Health Affairs: “The prevailing financial incentive for hospitals is to not expend resources on improving care transitions.”

Incentives in new metrics & reporting –CMS Compare, CCO Metrics

Incentives in new payment models –1% payments –carrots and sticks for hospitals (is it enough?)

Other policy approaches:

Pay physicians for care transition services

Track whether hospitals transmit records to physicians

Strengthen hospital do-not-pay policies

Incorporate tools for real-time hospitalization & care transitions information



“Primary care physicians often have little or no information about their patients’ hospitalizations.”

Health Affairs Health Policy Brief, Improving Care Transitions. Better coordination of patient transfers among care sites and the community could save money and improve the quality of care, Sept. 2012

Emergency  
Department  
Discharge  
Process  
Environmental  
Scan Report,  
AHRQ, Oct.  
2014

Figure 1.  
Map of  
barriers  
that hinder  
effective ED  
discharge



## Risk Factors for Discharge Failure

A host of social and medical problems put patients at risk for ED discharge failure.

### Social factors include:

- Lack of insurance or inadequate insurance,
- Homelessness,
- Low income,
- Lack of a primary care provider (PCP),
- Poor comprehension or health literacy, and
- Race/ethnicity.

### Medical factors include:

- Alcohol dependence,
- Drug use,
- Psychiatric illness,
- Physical or cognitive impairment,
- Various medical conditions and chief complaints,
- Advanced or young age, and
- Male sex.

# Creating an Ideal Transition Home

## I. Perform Enhanced Admission Assessment for Post-Hospital Needs

- A. Include family caregivers and community providers as full partners in completing standardized assessments, planning discharge, and predicting home-going needs.
- B. Reconcile medications upon admission.
- C. Initiate a standard plan of care based on the results of the assessment.

## II. Provide Effective Teaching and Enhanced Learning

- A. Identify all learners on admission.
- B. Customize the patient education process for patients, family caregivers, and providers in community settings.
- C. Use “Teach Back” daily in the hospital and during follow-up phone calls to assess the patient’s and family caregivers’ understanding of discharge instructions and ability to perform self-care.

## III. Conduct Real-Time Patient and Family-Centered Handoff Communication

- A. Reconcile medications at discharge.
- B. Provide customized, real-time critical information to the next care provider(s).

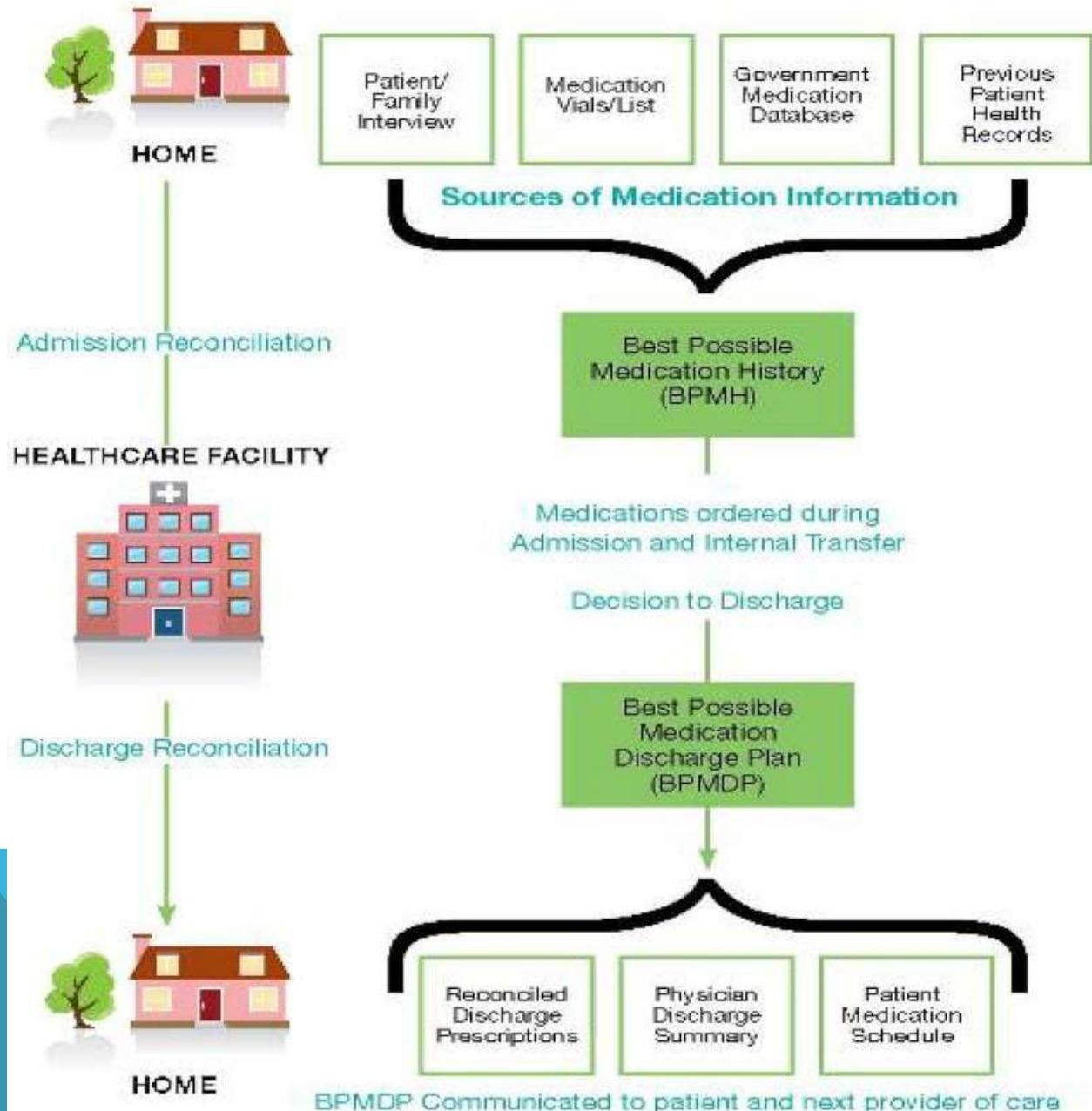
## IV. Ensure Post-Hospital Care Follow-Up

- A. High-risk patients: Prior to discharge, schedule a face-to-face follow-up visit (home care visit, care coordination visit, or physician office visit) to occur within 48 hours after discharge.
- B. Moderate-risk patients: Prior to discharge, schedule a follow-up phone call within 48 hours and schedule a physician office visit within five days.

# Overview of medication reconciliation.

Adapted from Pharmacy Practice 2009;25(6):26

Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices. Chapter 25 Medication Reconciliation Supported by Clinical Pharmacists (NEW), L. Lo, J. Kwan, O. A. Fernandes, and K. G. Shojania, Evidence Reports/Technology Assessments, No. 211. Agency for Healthcare Research and Quality (US); March 2013



# **NEW ROLES THAT ARE POTENTIAL CHALLENGES TO SUCCESS**

**Consumer & Family Engagement**

**Partnership Models**

**Culture, Language and Relationships of Agencies**

**Goals for Health Equity**

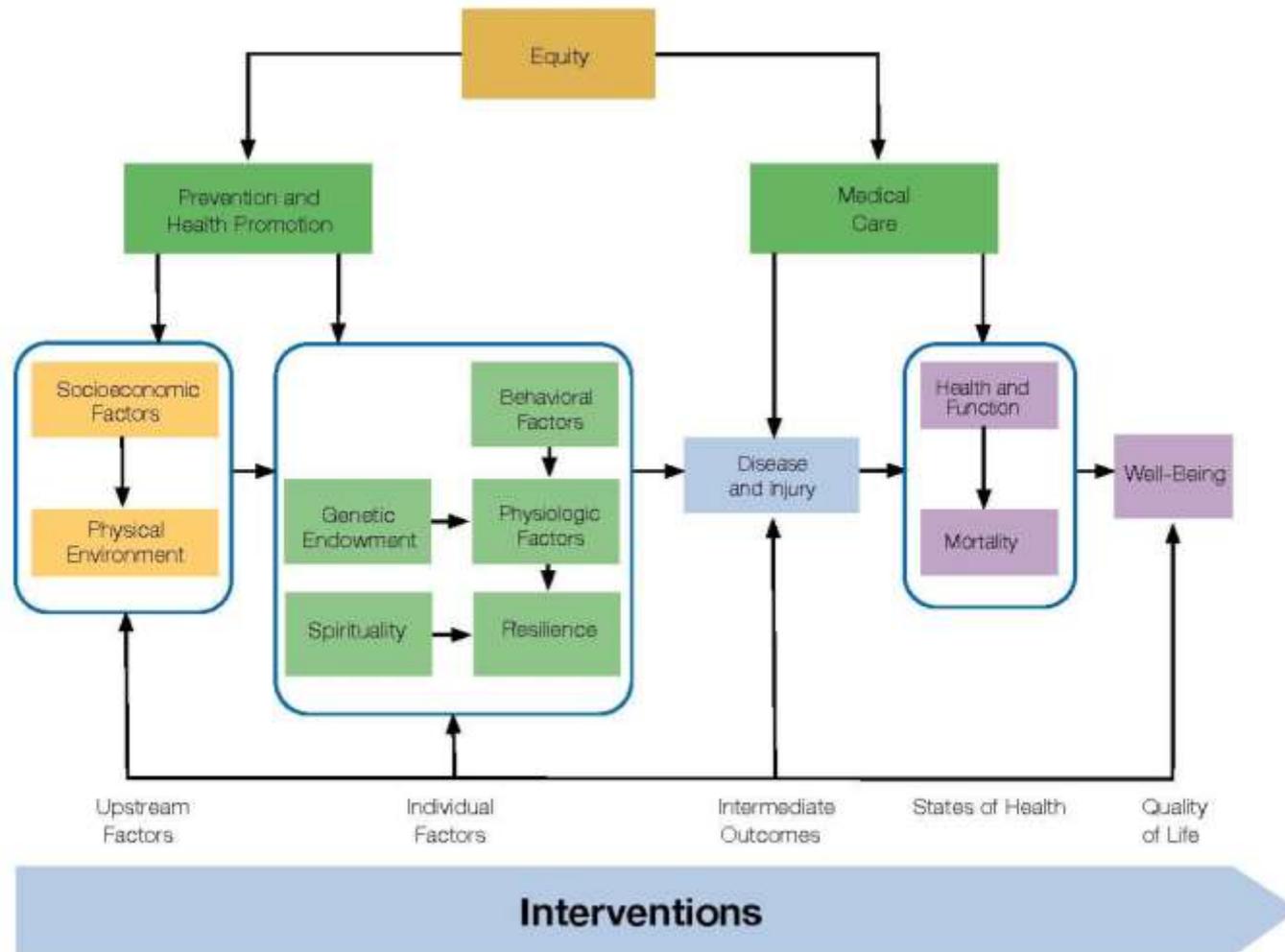
**Workforce Readiness for New Roles, Integrating Roles  
Successfully**

**Meaningful Use of Metrics, Population Health Tools**

**Engaging Public Health & Health Non-Profits at Community  
Level**



**Figure 1. IHI Population Health Composite Model**



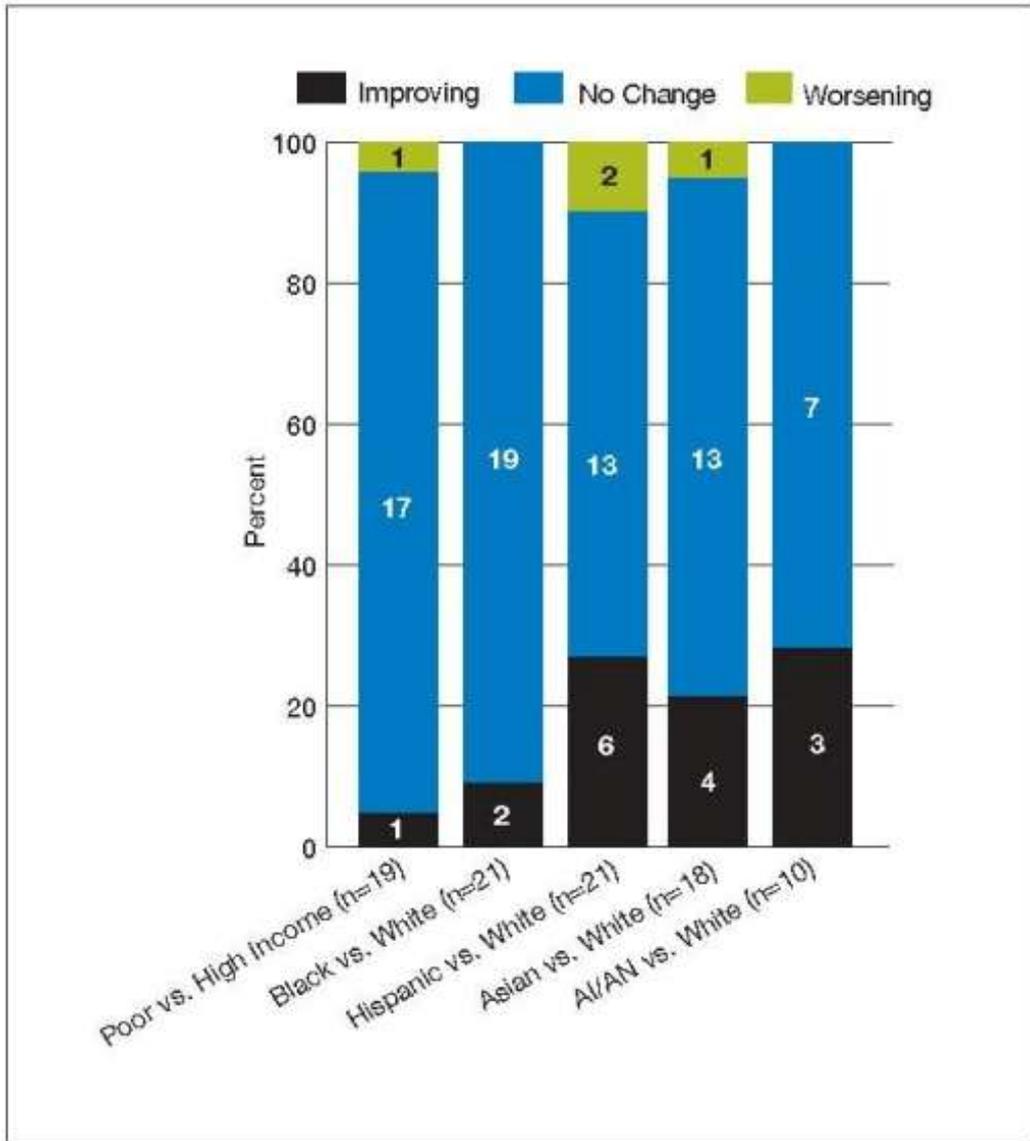
Source: Adapted from Stiefel M, Nolan KA. Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on [www.ihl.org](http://www.ihl.org))

## ACCESS DISPARITIES:

Through 2012, across a broad spectrum of access measures, some disparities were reduced but most did not improve.

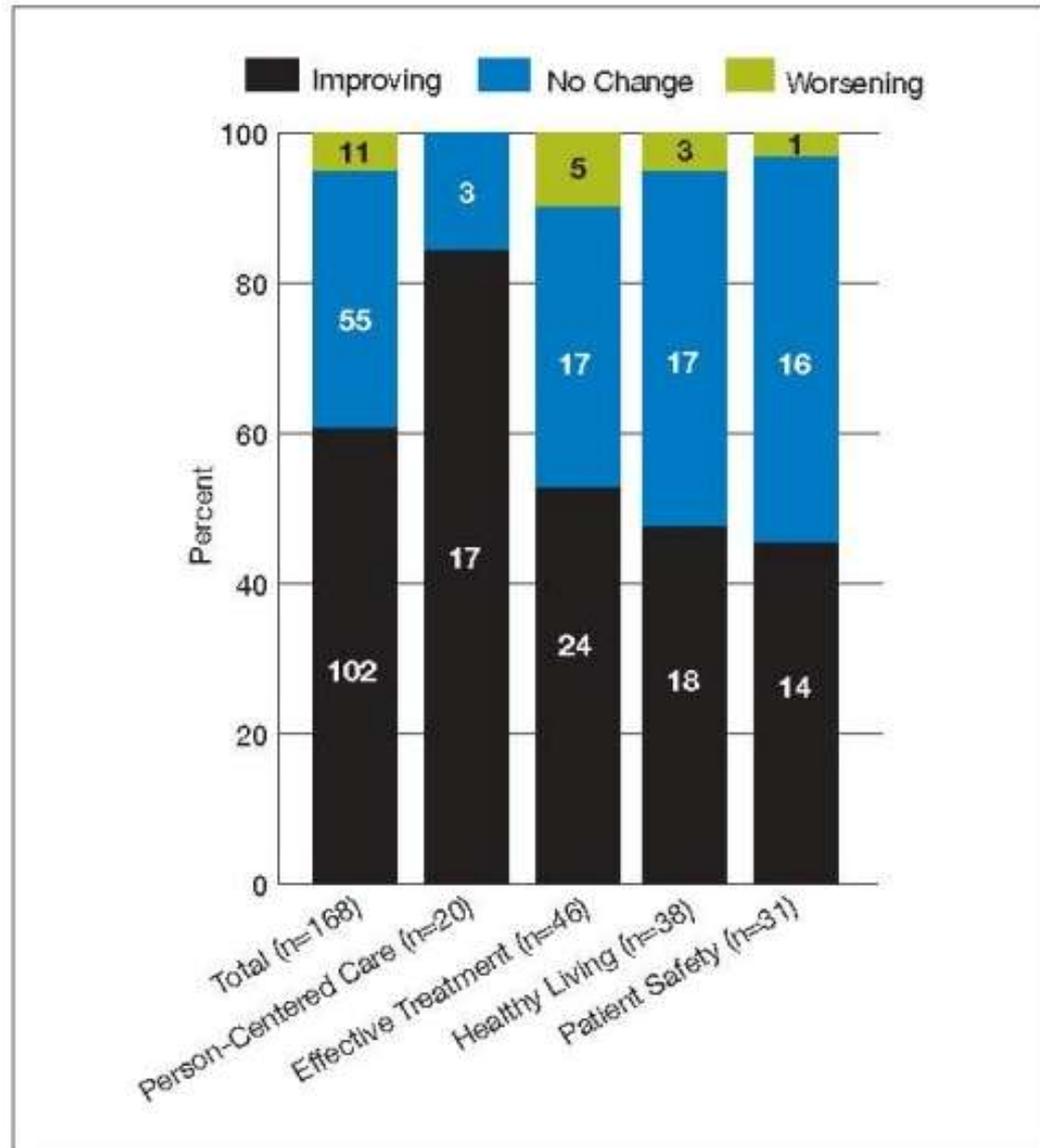
### Change in Disparities:

Number and percentage of all access measures for which disparities related to race, ethnicity, and income were improving, not changing, or worsening, through 2012



**QUALITY:** Quality of health care improved generally through 2012, but the pace of improvement varied by measure.

Number and percentage of all quality measures that are improving, not changing, or worsening through 2012, overall and by NQS priority

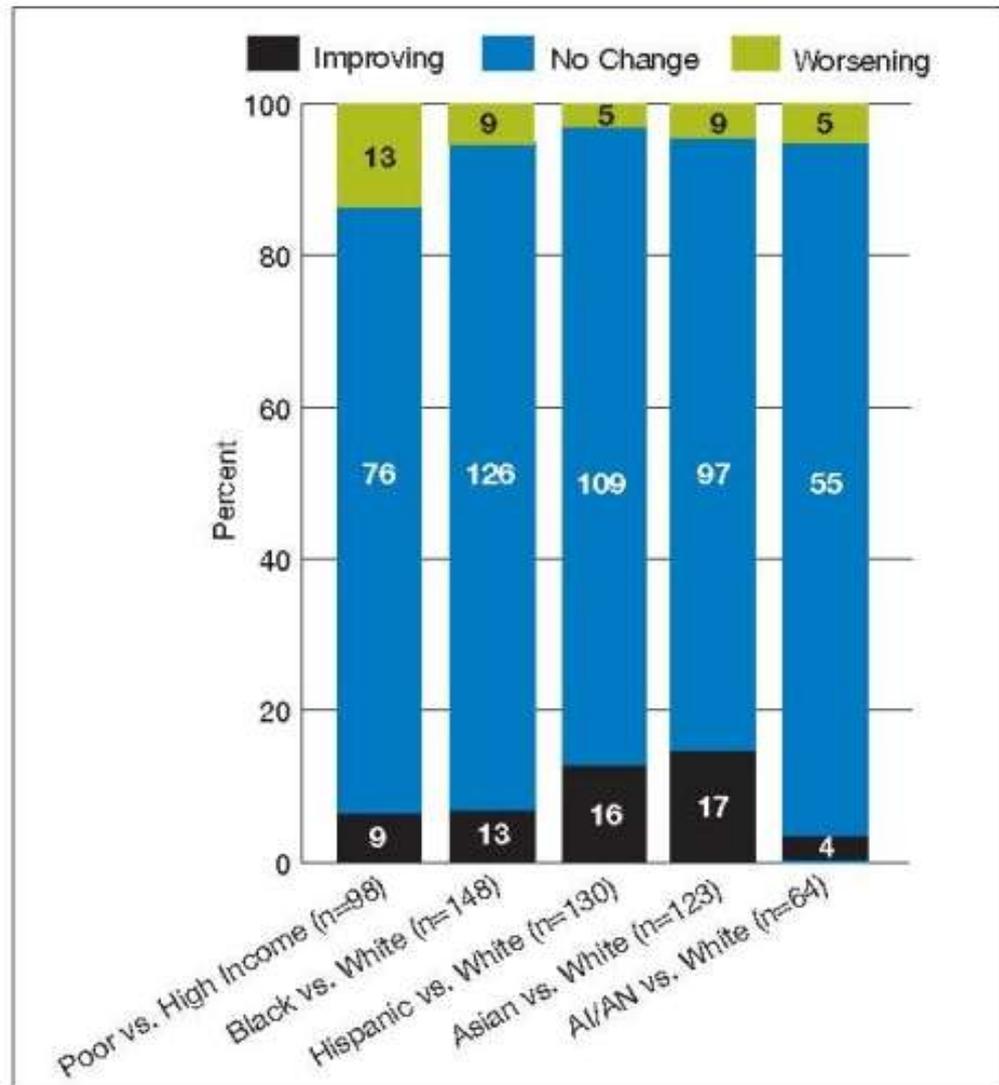


## QUALITY DISPARITIES:

Through 2012, some disparities were getting smaller but most were not improving across a broad spectrum of quality measures.

### Change in Disparities:

Number and percentage of quality measures for which disparities related to race, ethnicity, and income were improving, not changing, or worsening, through 2012



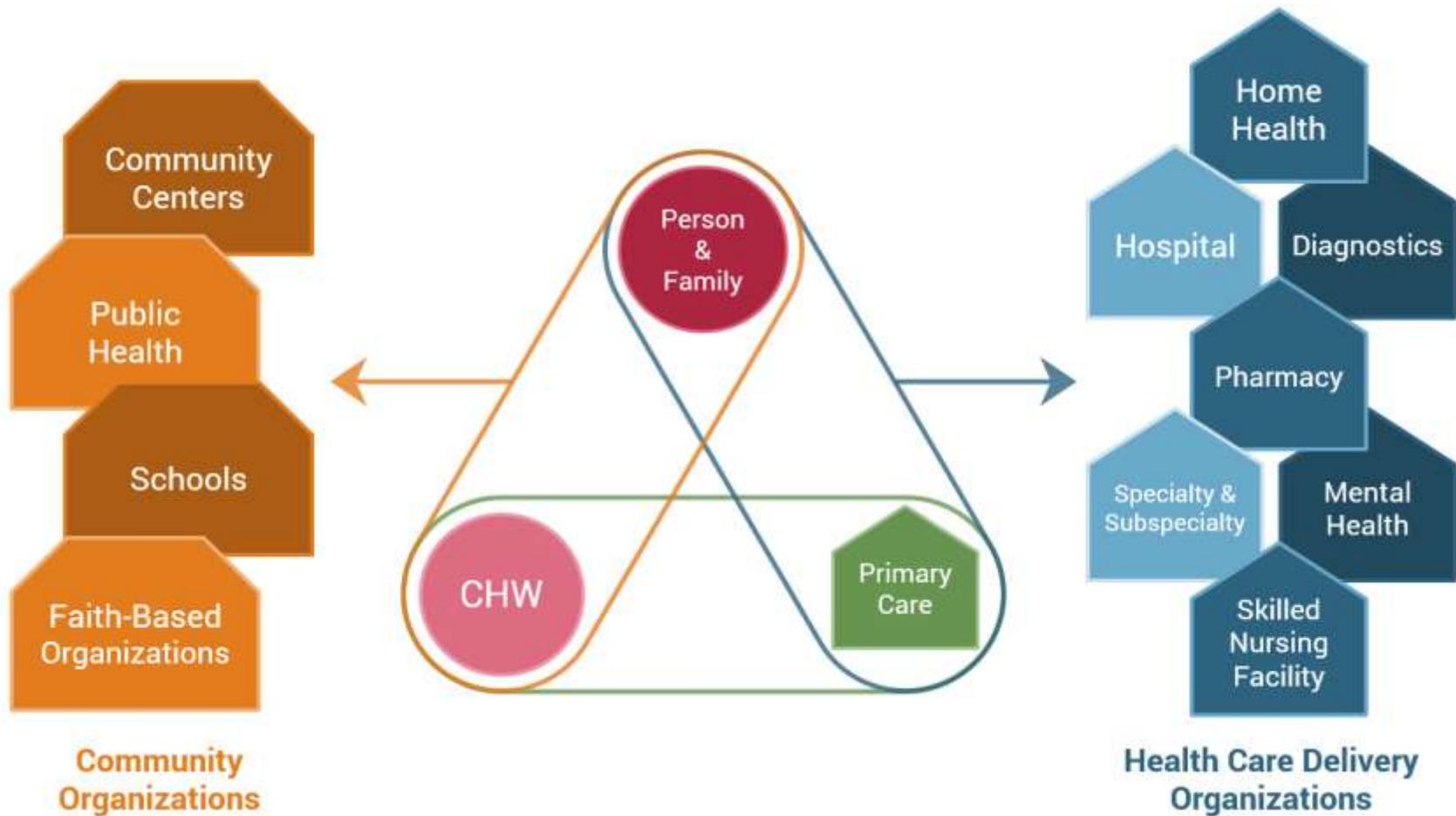
# NEW WORKFORCE ROLES ARE HELPING

1. Outreach and Mobilization
2. Community and Cultural Liaising
3. Case Management, Care Coordination and System Navigation
4. Health Promotion and Coaching

Figure 3.1: Phases of a Social Determinants of Health Initiative



Figure adapted from Brownson et al, 2003 and Green et al, 1991.<sup>51-52</sup>



Peer Support in the Patient - Centered Medical Home and Primary Care Conference Report, 2015, American Academy of Family Physicians Foundation, the Patient-Centered Primary Care Collaborative (PCPCC), National Council of La Raza (NCLR)

# **GAINING ENGAGEMENT & TRUST OF MEMBERS**

**Make clear that clients receive same benefits with increased coordination**

**Highlight that care delivery and services likely to be less confusing for clients and families**

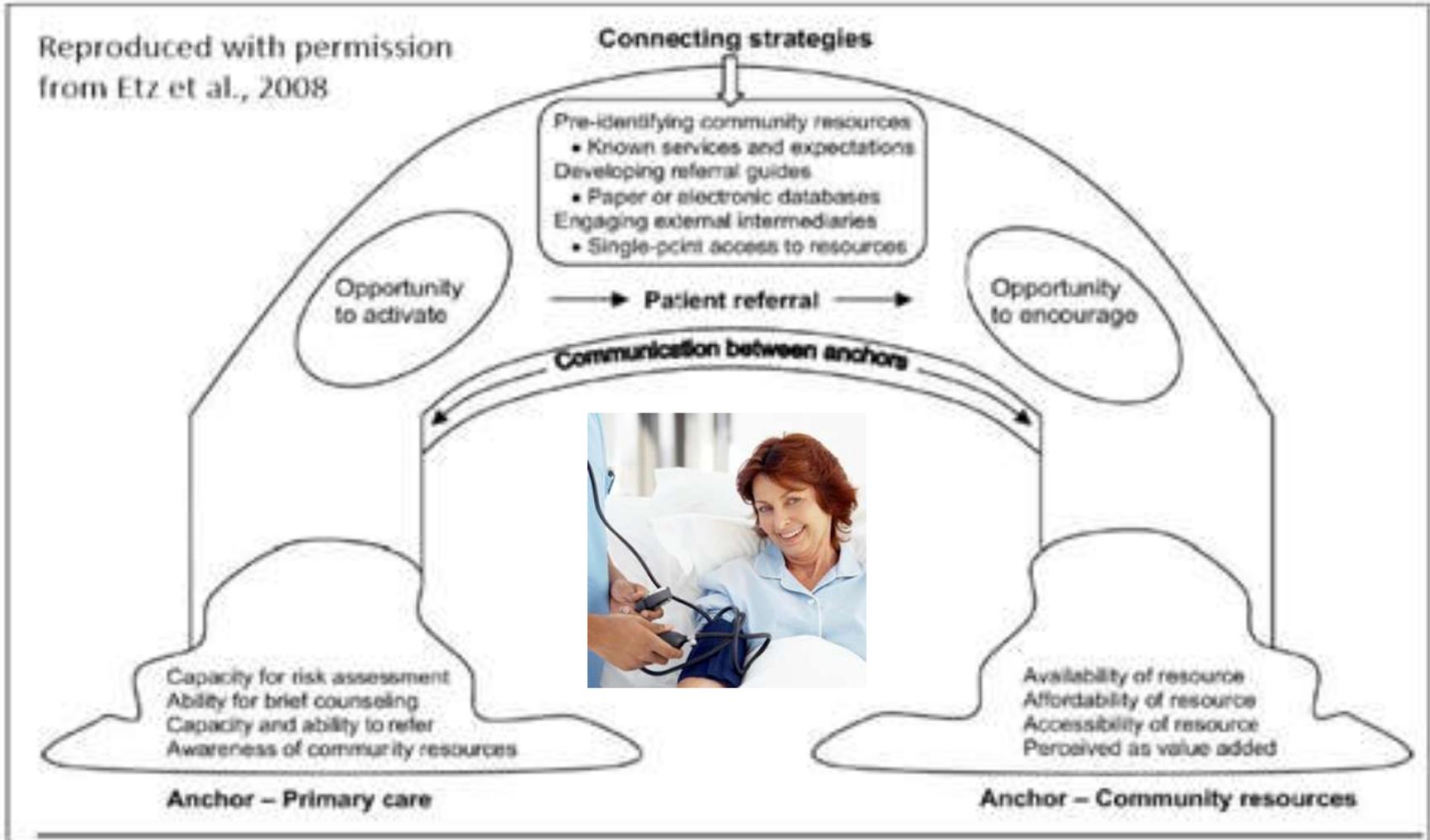
**One contact to answer questions about benefits, problem-solve issues**

**Assistance to consumers to better understand new system, resources and processes**

**Local people who know resources in your community will be leading care delivery**



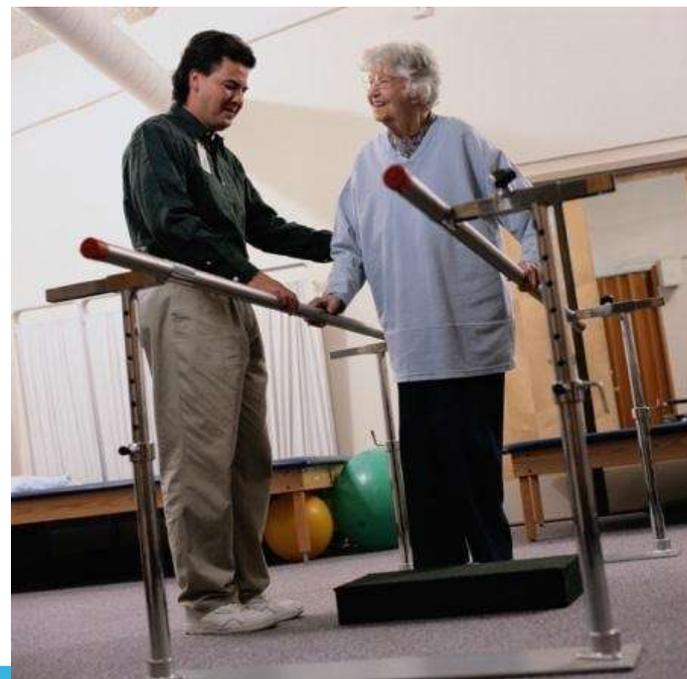
# CONNECTING PRIMARY CARE & COMMUNITY



## Increased Focus on Prevention for Duals

The highest strength of evidence for an increased risk in functional status decline (defined as disability or physical function limitation) was found for (in alphabetical order):

- cognitive impairment
- depression
- disease burden
- increased and decreased body mass index
- lower extremity functional limitation
- low frequency of social contacts
- low level of physical activity
- no alcohol use compared to moderate use
- poor self-perceived health
- smoking
- vision impairment



*What are the main risk factors for disability in old age and how can disability be prevented?*

WHO Regional Office for Europe's Health Evidence Network (HEN), September 2003



# **PRIMARY CARE, HEALTH REFORM AND PUBLIC HEALTH: Exploring Increased Integration to Improve Population Health**

**Why Stronger Linkages Are Needed According to the Institute of Medicine's Report Brief, March 2012.**

- 1. Multiple actors contribute to population health—including social and environmental determinants of health & impact of primary prevention**
- 2. Substantial, lasting improvements require concerted efforts**
- 3. Integration can enhance capacity of primary care and public health to carry out missions**
- 4. Health reform provides opportunity for change**

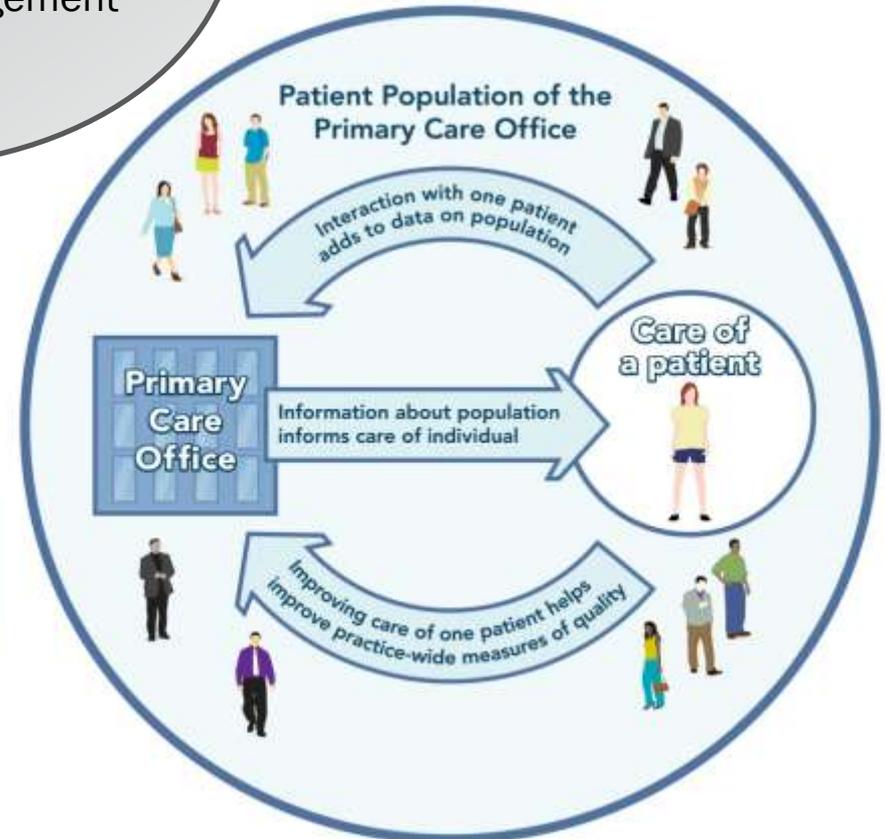
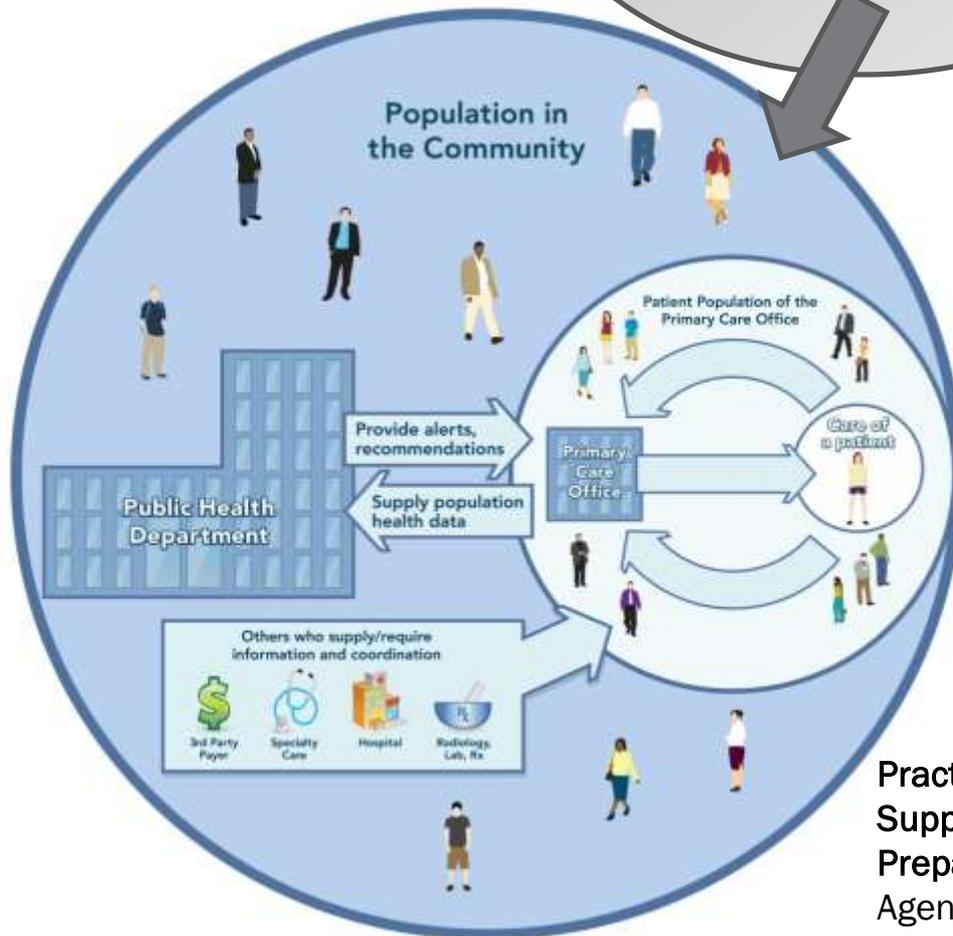


# Understanding Population Health

## The Built Environment For Health

- \*Infrastructure (Physical, Social, Service)
- \*Multi-sector Engagement
- \*Policies

Sources: Health and the Built Environment: A Review; RWJ Where We Live Matters for Our Health: Neighborhoods and Health



Practice-Based Population Health: Information Technology to Support Transformation to Proactive Primary Care  
Prepared for:  
Agency for Healthcare Research and Quality , 2010

## **TRANSFORMATION CENTER**

**Learning Collaboratives**

**Council of Clinical Innovators**

**CCO Innovator Agents**

**CCO Summits/Innovation Cafes'**



**Oregon**  
**Health**  
Authority

## **PATIENT CENTERED PRIMARY CARE HOME INSTITUTE**

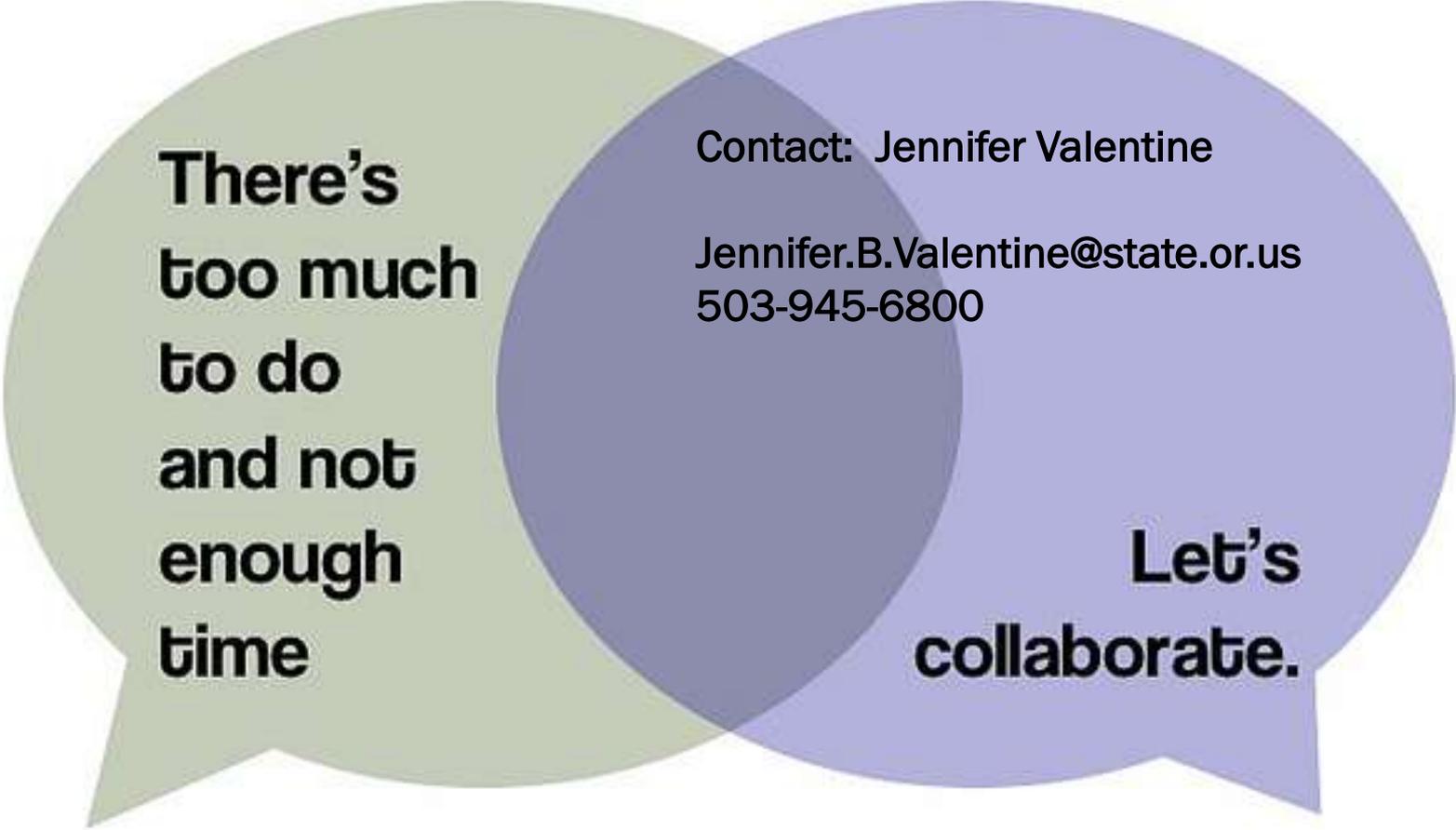
**Webinars**

**Guides, Resources**

## **AGING & DISABILITY SERVICES:**

**LTSS (Long-Term Services & Supports) Innovator Agents**

**Community Health Promotion/Chronic Disease Management  
and Care Transitions Programs**



**There's  
too much  
to do  
and not  
enough  
time**

Contact: Jennifer Valentine

Jennifer.B.Valentine@state.or.us  
503-945-6800

**Let's  
collaborate.**

**let's collaborate**