Innovative Coordinated Care Models

Rachel Post, LCSW
Policy Director
Central City Concern

Rachel Solotaroff, MD, MCR
Medical Director
Central City Concern

CENTRAL CITY concern

May 2014

Central City Concern: Who we are

Providing comprehensive solutions to ending homelessness and achieving self-sufficiency.

Serving approximately 13,000 individuals yearly.

CENTRAL CITY concern

Four Dimensions to Mission

Housing – 1,600 units

Integrated Care – 159,360 visits

Peer Support – 42,700 hours of service

Employment – 500 jobs

History: healthcare transformation in Oregon

Governor Kitzhaber
Old Town Clinic – Feb 2011

Governor Kitzhaber
Old Town Recovery Center– May 2012

CENTRAL CITY concern

$1.9 Billion Federal Support for CCOs!

- 5 year Investment
  - Cut cost growth by 1% pts after 2 years, then 2%
  - Measurably improve quality and access
    - 17 P4P metrics, 2% global budget bonus at risk
- 6 Key Transformation "Levers"
  - Focus on "those with multiple or complex conditions"
  - Alternative payment methods focused on outcomes
  - Integrated physical, behavioral, oral models of care
  - Administrative simplification / new models of care
  - "Flexible services"
  - Learning systems for accelerating innovation spread

Health Share of Oregon Board of Directors

Founding Members

Hospital Systems:
- Adventist Health
- Kaiser Permanente
- Legacy Health
- Oregon Health & Science University
- Providence Health & Services
- Tuality Healthcare

Counties
- Clackamas County
- Multnomah County
- Washington County

Other

CareOregon (MCO)
Central City Concern

Elected Board members
- -Primary Care Provider physician
- -Specialist physician
- -Nurse Practitioner
- -Mental Health Treatment Provider
- -Addiction Treatment Provider
- -Dentist
- -Community-at-Large – two members
- -Chair of Community Advisory Council

CENTRAL CITY concern

Central City Concern role in CCO

- Founding member
- Strategic education around homelessness
- Tri-County Community Behavioral Healthcare Network
- Vice Chair of Finance Committee
- Clinical Work Groups
- Supportive Housing Work Group

CENTRAL CITY concern

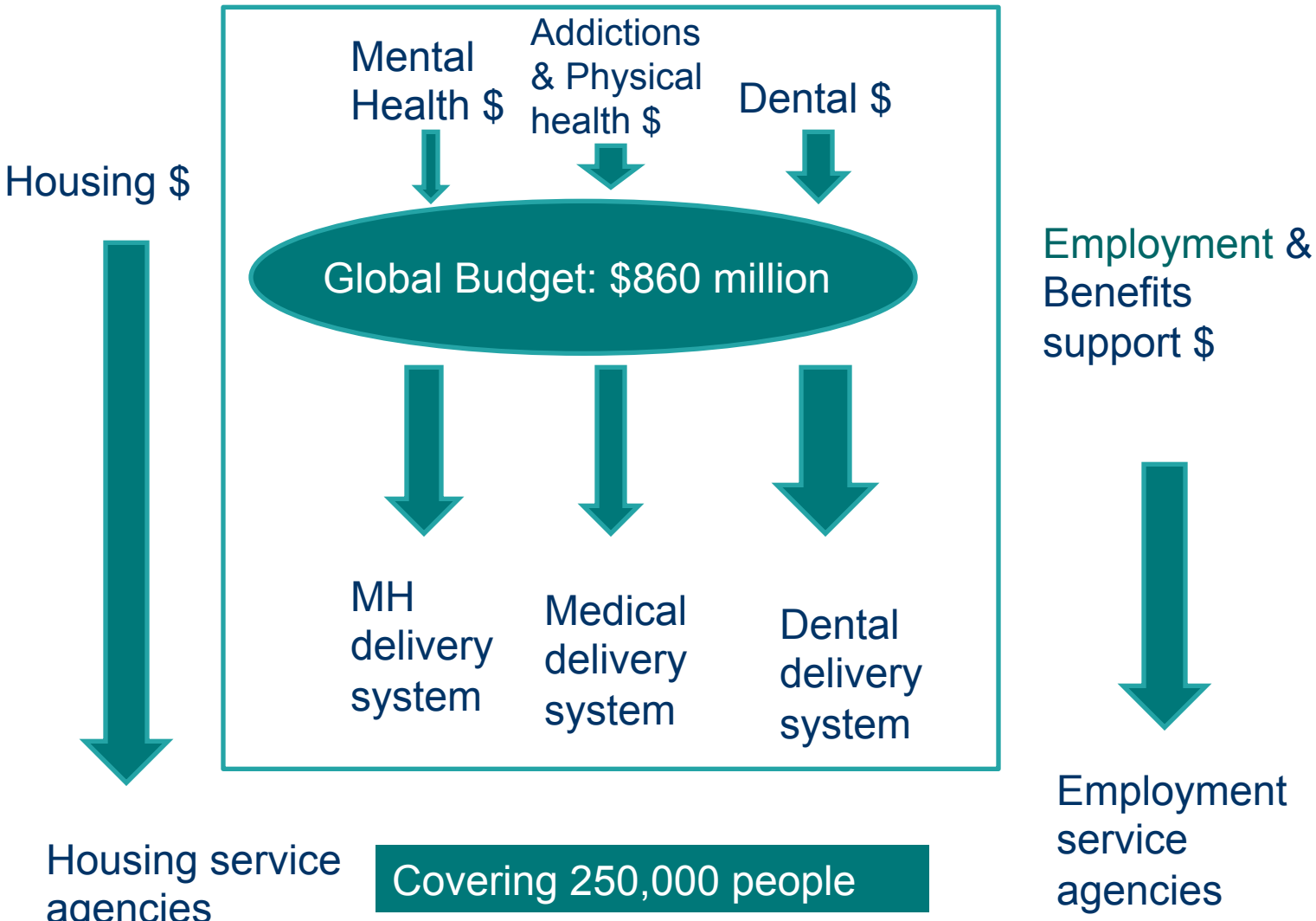
CCO Criteria

- ✓ Operate within a global budget
- ✓ Manage financial risk, establish financial reserves, meet minimum financial requirements
- ✓ Coordinate physical, mental health and chemical dependency services, oral health care
- ✓ Encourage prevention and health through alternative payments to providers
- ✓ Engage community member/health care providers in improving health of community
- ✓ Address regional, cultural, socioeconomic and racial disparities in health care

www.health.oregon.gov

CENTRAL CITY concern

CCO Model – Health Share of Oregon



Medicaid Enrollment in Oregon

Total new OHP = 316,000

Total new OHP members projected for 2014= 240,800

Total new OHP assisted by Central City Concern= 1,750

CENTRAL CITY concern

DEVELOPING NEW CLINICAL MODELS IN THE CCO

- Health Commons Grant
- Pay for Performance
- Clinical Innovation

CENTRAL CITY concern

Overarching Aim: To create a regionally integrated patient-centered system to improve care coordination, care quality and health status for high cost/high acuity adult patients in the Medicaid & Dual-Eligible target population

TriCounty Health Commons

Level 1 strategies

Unified, integrated processes:

A. Yield **small** per member savings across large number of patients

B. Function as screening and capture points for referring high acuity pts to Level 2 intensive services

PRIMARY CARE Medical Homes
Co-located Behavioral Health ; Integrated w/ Level 2 services

COMMUNITY-WIDE Registry
Real time ED & Inpt admit alerts; Program 'touches' viewable by all providers

EMERGENCY DEPT Navigators
Divert non-urgent cases; support pts to establish PCMH

STANDARDIZED Hospital Discharge
Uniform discharge standards & processes between hospitals and PCMH

Level 2 strategies

Integrated community-based supports:

A. Yield **large** per member savings across small number of (high cost) patients

B. Provide individualized intensive multi-disciplinary support to high acuity patients

INTERDISCIPLINARY COMMUNITY CARE Teams

Integrated physical & mental health community-based teams comprised of traditional & non-traditional workforce

- Geographically-based high acuity patient outreach
- Aligned with Primary Care & Specialist practices
- Integrated with Mental Health & Addictions Srvs
- Home, community & telephonic supports
- Address psycho-social challenges to health

INTENSIVE HOSPITAL-to-COMMUNITY Programs

C-Train: high risk medical inpt-to-community transitions
Intensive Transition Team: psychiatric inpt-to-community transition

- Enhanced discharge planning & patient supports
- Rx reconciliation & adherence coaching
- Home visit & telephonic post-discharge supports
- Prompt follow up & care coordination with PCMH / specialists / mental hlth services / ICCT

CENTRAL CITY concern

From The Health Commons Grant Team

CCC's Role in the Health Commons

CHIPS:

Central City Concern

Health

Improvement

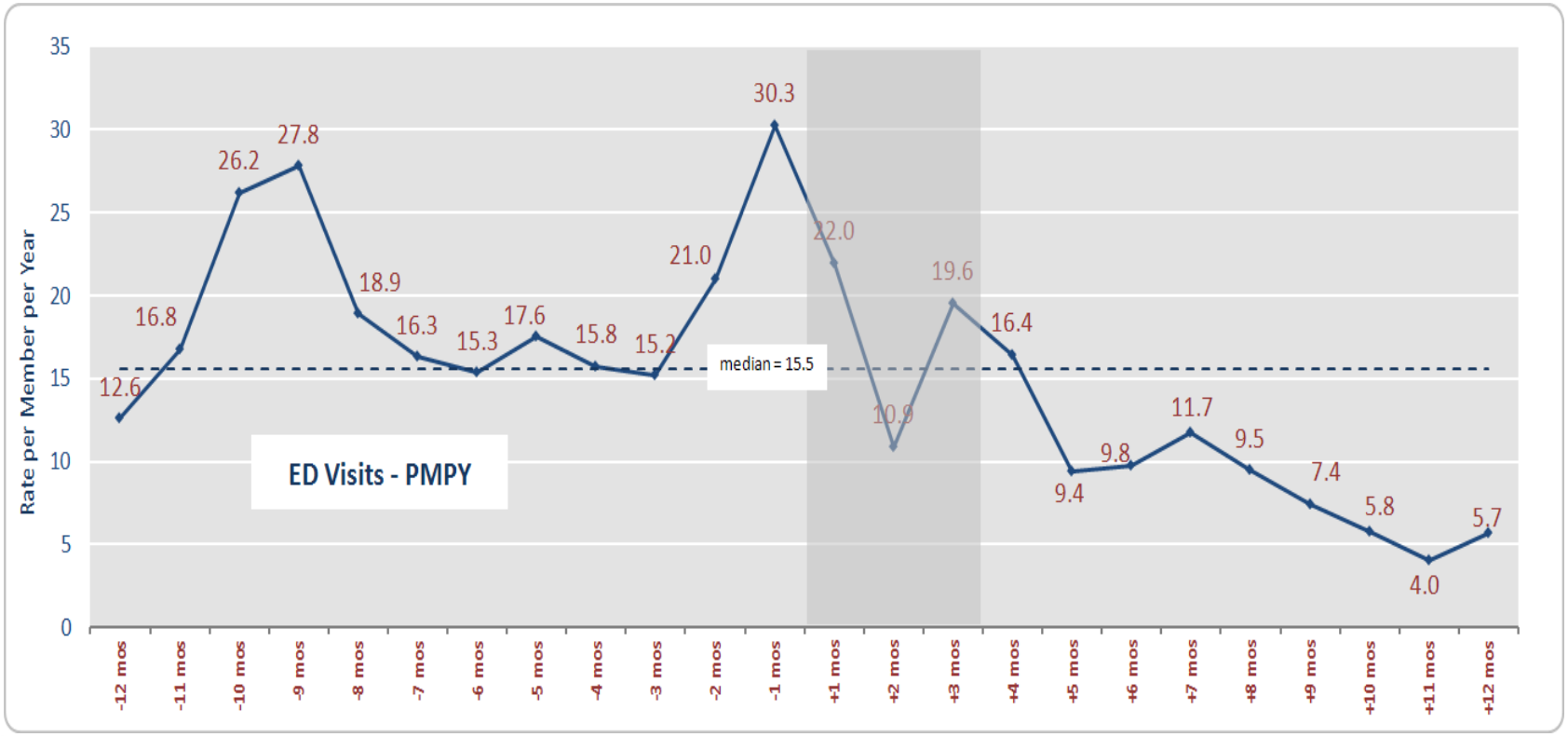
Project**S**

This program employs five outreach workers, including 2 recovery specialists, a registered nurse, and a mental health professional who are embedded in Old Town Clinic.

CENTRAL CITY concern

CHIPS Outcomes

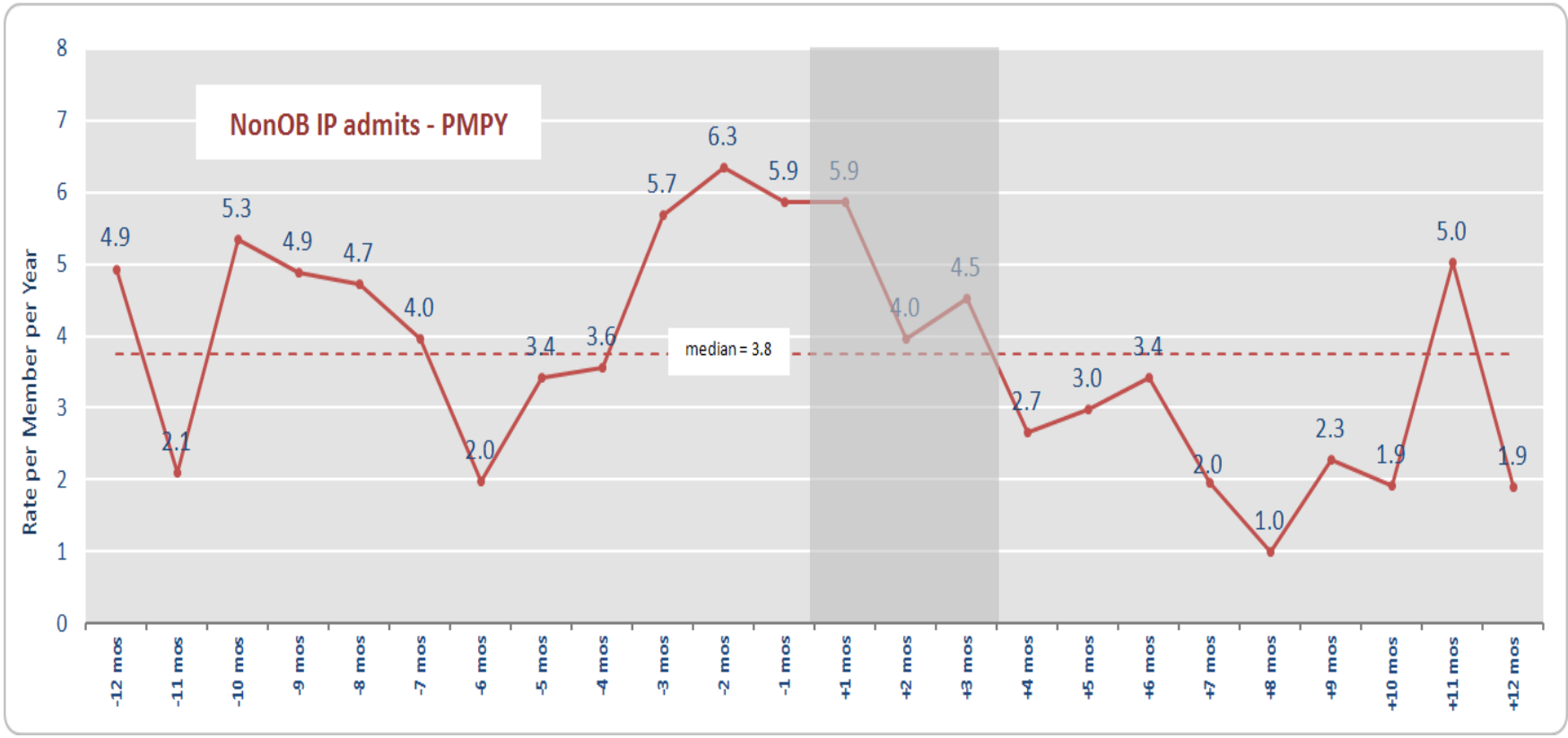
Decreased ED visits



CENTRAL CITY concern

CHIPS Outcomes

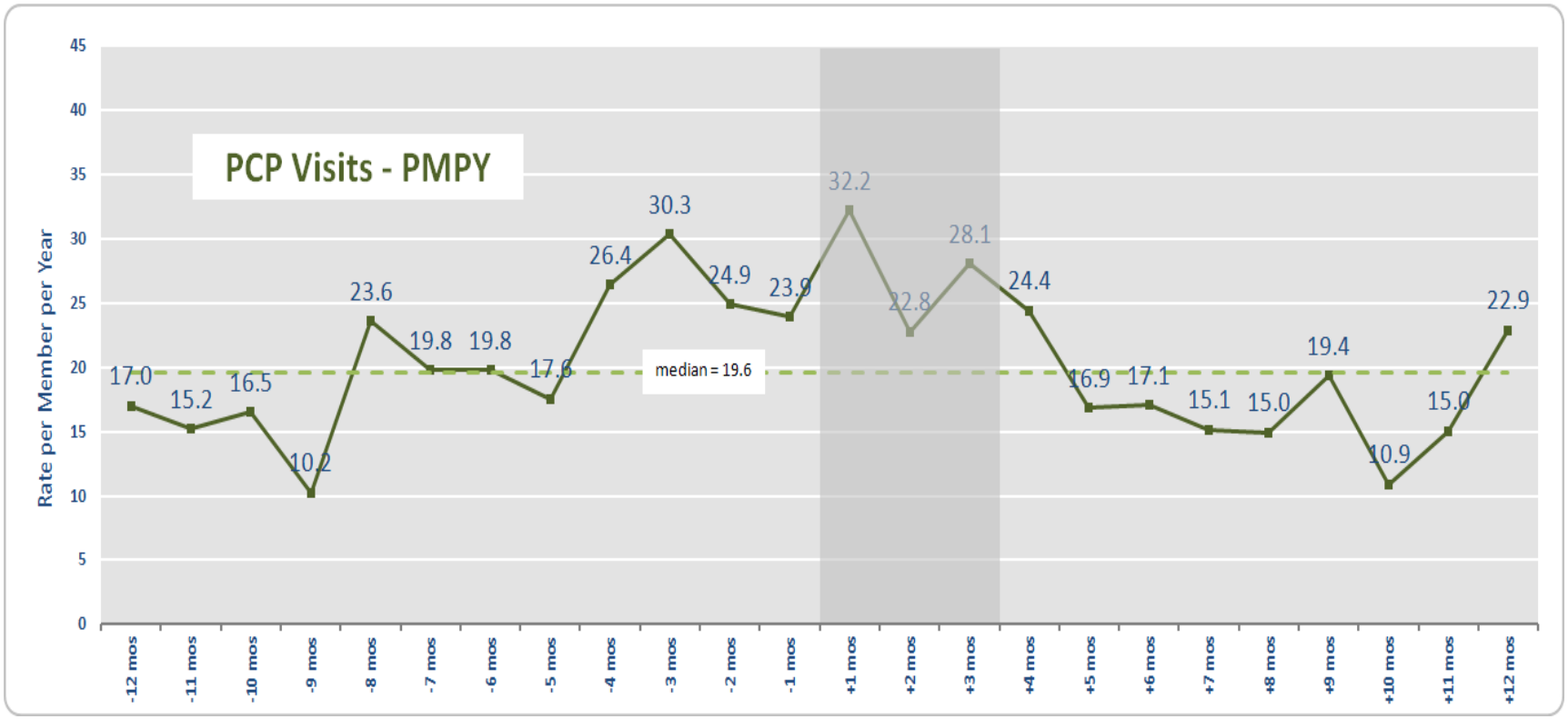
Equivocal decrease in IP visits (potential skew at end of study period)



CENTRAL CITY concern

CHIPS Outcomes

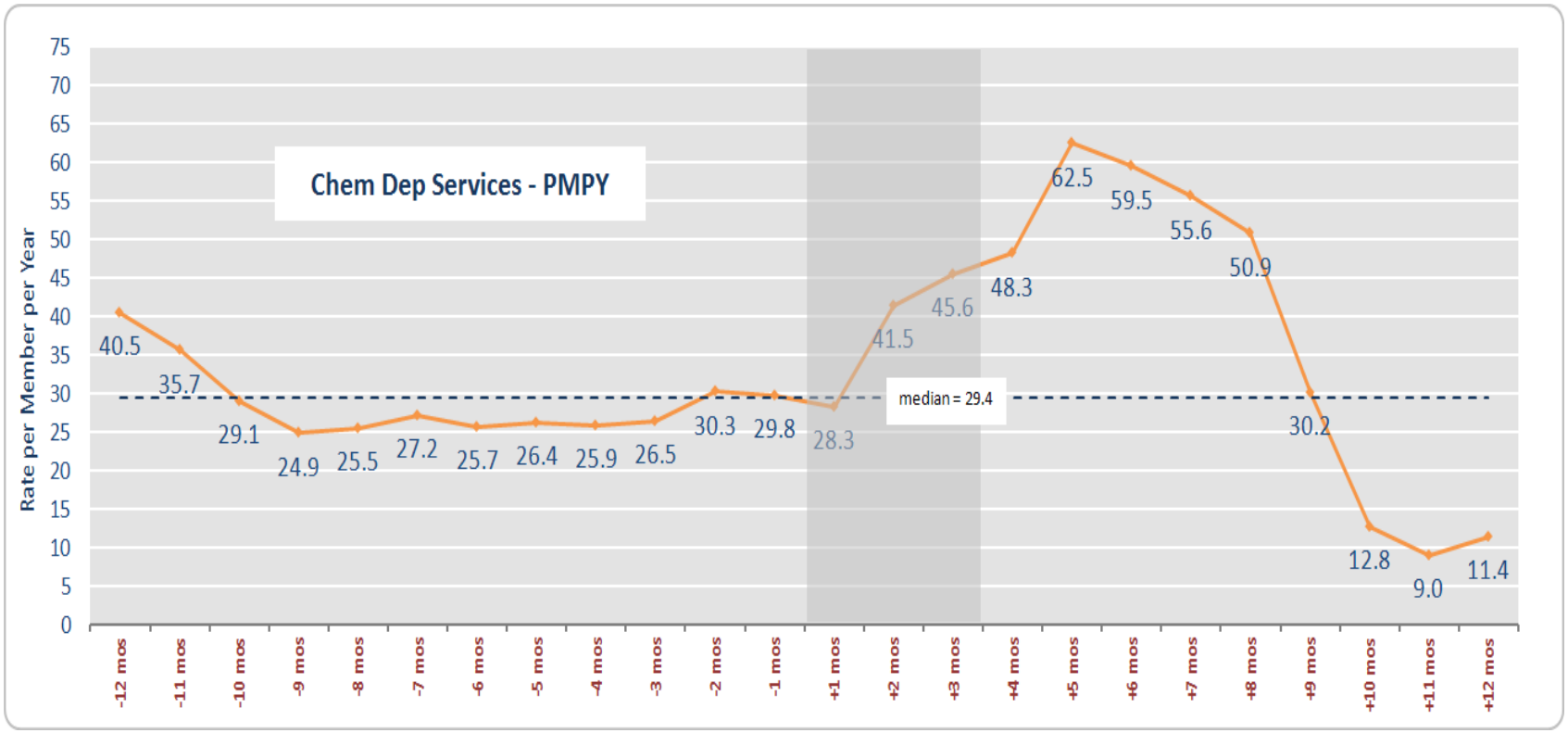
No Overall Change in PCP visits



CENTRAL CITY concern

CHIPS Outcomes

Initial increase in CD Treatment visits



CENTRAL CITY concern

CCO Incentive Measures

Quality and Access Data

Incentive Measure	Oregon 2011 Baseline	2013 Improvement Target	Benchmark
Focus Area: Behavioral Health Coordination			
Screening, Brief Intervention and Referral to Treatment (SBIRT)	0.1%	3.0%	13.0%
7-day Follow-up after hospitalization for Mental Illness	57.6%	67.6%	68.0%
Screening for Clinical Depression and Follow-Up Plan	Proof of concept	Proof of concept	Proof of concept
Focus Area: Maternal and Child Health			
Follow-up care for children prescribed ADHD Medication	52.3%	57.5%	51.%
Timeliness of Prenatal Care	67.5%	In development	89%
Elective Delivery before 39 weeks	In development	In development	In development
Mental and Physical Health Assessment within 60 days for children in DHS custody	51.4%	55.3%	90%
Developmental Screening in first 36 months of life	19.3%	22.4%	50%
Adolescent Well Care Visits	31.2%	34.2%	**53.2%**

CENTRAL CITY concern

CCO Incentive Measures (continued)

Incentive Measure	Oregon 2011 Baseline	Improvement Target	Benchmark
Focus Area: Chronic Conditions			
Colorectal Cancer Screening	12.5/1000	12.9/1000	21.9/1000
Controlled High Blood Pressure	Proof of concept	Proof of concept	Proof of concept
Diabetes: HbA1c Poor Control	Proof of concept	Proof of concept	Proof of concept
Focus Area: Reducing Preventable and Costly Utilization			
Ambulatory Care utilization: outpatient	363/1000	370.6/1000	439/1000
Emergency Department utilization	64.6/1000	62.6/1000	44.4/1000
Focus Area: Member Experience			
CAHPS – Access to Care, Getting Care Quickly	83.0%	85.0%	87.0%
CAHPS – Satisfaction with Care	80.0%	82.0%	84.0%
Focus Area: Improving Primary Care			
Patient-Centered Primary Care Home Enrollment	50.3%	n/a	100% (tier 3)
EHR Adoption	32.0%	0.0%	>49.2%

CCO Incentive Measures – our focus

Focus on areas of need in our population:

- SBIRT:
  - Only clinic to meet this metric
  - Provide TA to other sites
- Decreased ED utilization

Less focus on:

- CRC screening (to be added this year)
- Maternal/child health

CENTRAL CITY concern

SBIRT Data: Year to Date

Internal Metric I: Screening Metric

$$\frac{\text{Total unique patients screened}}{\text{Total unique patients with visits within the past year}}$$

Goal: 90%

Outcome:83.7%

Internal Metric II: Intervention Metric

$$\frac{\text{Total interventions}}{\text{Total positive screens in unique patients with visits within the past year}}$$

Goal: 36%

Outcome: 48.3%

Internal Metric III: CCO Metric

$$\frac{\text{Total interventions}}{\text{Total unique patients with visits within the past year}}$$

Goal: 13%

Outcome: 13.6%

Clinical Innovation

- Clinical workgroup comprised of medical directors of all health systems in our RAE (risk-accepting entity, a subset of our CCO)
  - Struggle to get behavioral health at table
  - Finally added operational directors as well
- Took 2 years to norm as a group and get traction
- Now have workplans, projects, and some investment
- CCC is only HCH program at the table

CENTRAL CITY concern

Care Oregon RAE Clinical Workplan DRAFT

		Short (6 mo)	Medium (1 year)	Long (> 1 year)	
Community Care		***To be developed***			
Primary Care	***Improve Access***	Define capacity and do scan of RAE	Supply/demand matching Align incentives to maximize patient engagement		**Comprehensive Primary Care Initiative PCPCH Enrollment**
	Core F'ns of primary care	Proactive planning (prev care) Patient activation/self mgmt Care mgmt/care coordination Medication management Maximize capacity/access Team models	Create accountabilities and align incentives to maximize core competencies of primary care		
	Manage High Risk Popns	Spread NICH to Legacy Initiate pilots for managing high utilizing patients in primary care (Advanced Primary Care)	Determine best practices, align incentives, and spread to other clinics in RAE		
	Behavioral Health Integrat'n	Key projects in chronic pain/ addiction Key pilots in BH in primary care	Increase capacity for Suboxone Spread successful pilots Align payment	Develop Trauma-informed systems	
	HIT infrastructure: ***Develop Care Coordination/Information exchange and Data/ Analytics***				
Secondary Care		***To be developed.*** *Ideas- hub for specialty access, ED diversion programs, Specialist/ Primary care shared standards*			
Tertiary Care		***To be developed***			

Integration of Addictions and Primary Care

Convened stakeholders from primary care, specialty addictions, public health, payers and public health who defined following work:

- Expand evidence-based treatment for chronic pain (with and without concurrent addiction)
- Building capacity for buprenorphine prescribing in Primary Care through PCP/addictions partnerships
- Improve provider knowledge, skills and understanding of addiction (“Addictions 101”)
- Create addictions “hub” for consultation and service referrals
- Improve bi-directional communication between addictions and primary care providers
- Align and engage payers in all of the above

CENTRAL CITY concern

Clinical Vignette

Meet Catherine:

- 54 year old Native American female
- Longstanding history of alcohol dependence, tobacco dependence, severe COPD requiring oxygen, PTSD, panic disorder, homelessness
- Multiple ED visits/hospitalizations for COPD exacerbations, alcohol withdrawal, falls while intoxicated
- Unable to complete inpatient EtOH treatment (patient's stated request) due to complex medical issues
- Unable to participate in pulmonary rehab due to ongoing EtOH, related to untreated PTSD and panic
- Multiple admissions to our respite program without resolution of underlying issues
- Multiple agencies involved including primary care, Aging and Disabilities, Adult Protective Services, Tri-County 911 Outreach team

CENTRAL CITY concern

Clinical Vignette (continued)

- Overwhelmed primary care team placed CHIPS referral in June 2013
- Interventions of CHIPS team:
  - Identified patient goal of stable supportive housing and to cut back, but not quit alcohol
  - Collaboration with CHIPS RN and primary care team to improve respiratory and physical status while in respite care
  - Coordinated all agencies to provide support for transfer to care facility with managed alcohol program
  - Coaching with patient to tolerate facility, continue rehab until congregate housing option could be achieved
  - Patient currently in process of transport to congregate housing and transfer to ICM team
  - One ED visit, one hospitalization (from jail) since CHIPS engagement

Lessons Learned

- In performance measures, it's okay to be selective as long as you perform well in chosen area
- Utilize expertise of partners in other disciplines (especially behavioral health) for "hot spot" programs
- Difficult to get seat at the table, but the value of HCH expertise is evident in Triple Aim
- Promise of CCO still in question when we continue with FFS payment models

CENTRAL CITY concern

THANK YOU!

rachel.post@ccconcern.org
rachel.solotaroff@ccconcern.org

CENTRAL CITY concern