Effective Care for High-Need, High-Cost Patients: How to Maximize Prevention and Population Health Efforts

May 9, 2018

Speakers

Jeff Micklos

Executive Director
HCTTF

Jeff has been the Executive Director of the Task Force since 2015. He was previous with the Federation of American Hospitals.

Kelly McCracken

National DPP Consultant
National Association of Chronic Disease Directors

Kelly is a consultant on the National Diabetes Prevention Program for the NACDD. She was previously with the Colorado Department of Health and Environment.

Michael Anderson-Nathe

Chief Equity and Engagement Officer
Health Share of Oregon

Michael is an executive with Health Share of Oregon. Michael has extensive experience with community engagement and equity work.

Jennifer Snow

Director of Accountable Communities
Greenville Health System

Jennifer is with SC-based Greenville Health System. She joined GHS in 2011, and previously worked for the Girl Scouts of South Carolina.

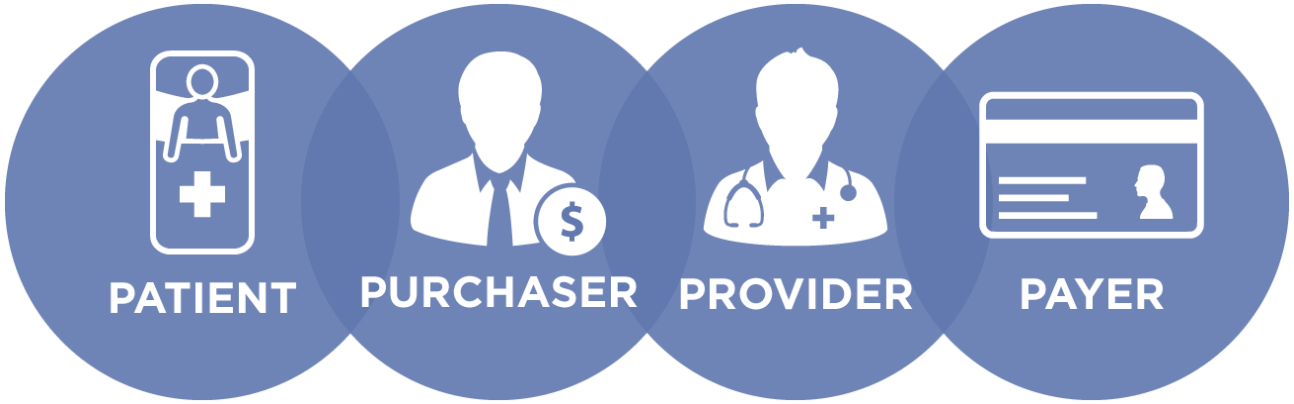
Agenda

- Introduction to the HCTTF and background on HNHC work
- Overview of the NACDD and the National DPP Medicaid Demonstration Project
- Health Share of Oregon's "Equity First" approach
- Greenville Health System's Accountable Communities model
- Upcoming Webinars

Who we are: Our mission to achieve results in value-based care

The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change, both for ourselves and our country.

We aspire to have 75% of our respective businesses operating under value-based payment arrangements by 2020.



Our Members: Patients, Payers, Providers and Purchasers committed to better value

Task Force activities: HNHC management and public health collaboration

- **Social service integration framework** to assist organizations in the integration of community resources within a population health model
- **White papers** on identification of high-need, high-cost individuals, development of care management programs, and sustainable financing for care management
- **Webinars** on social service integration and social service financing
- **Research** on contracting for the high-need, high-cost population
- **Forum participation** in public health/health care system collaboration efforts

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Medicaid Coverage for the National DPP Demonstration Project

Achieving Value Through Transformation Webinar Series

May 9, 2018

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS

Promoting Health. Preventing Disease.

NACDD Overview

- Strengthen state-based leadership & expertise
- Lead & influence to shape health landscape
- Capacity building, professional development, & advocacy
- Member-based, member-driven, member-led

ABOUT US

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

D I A B E T E S

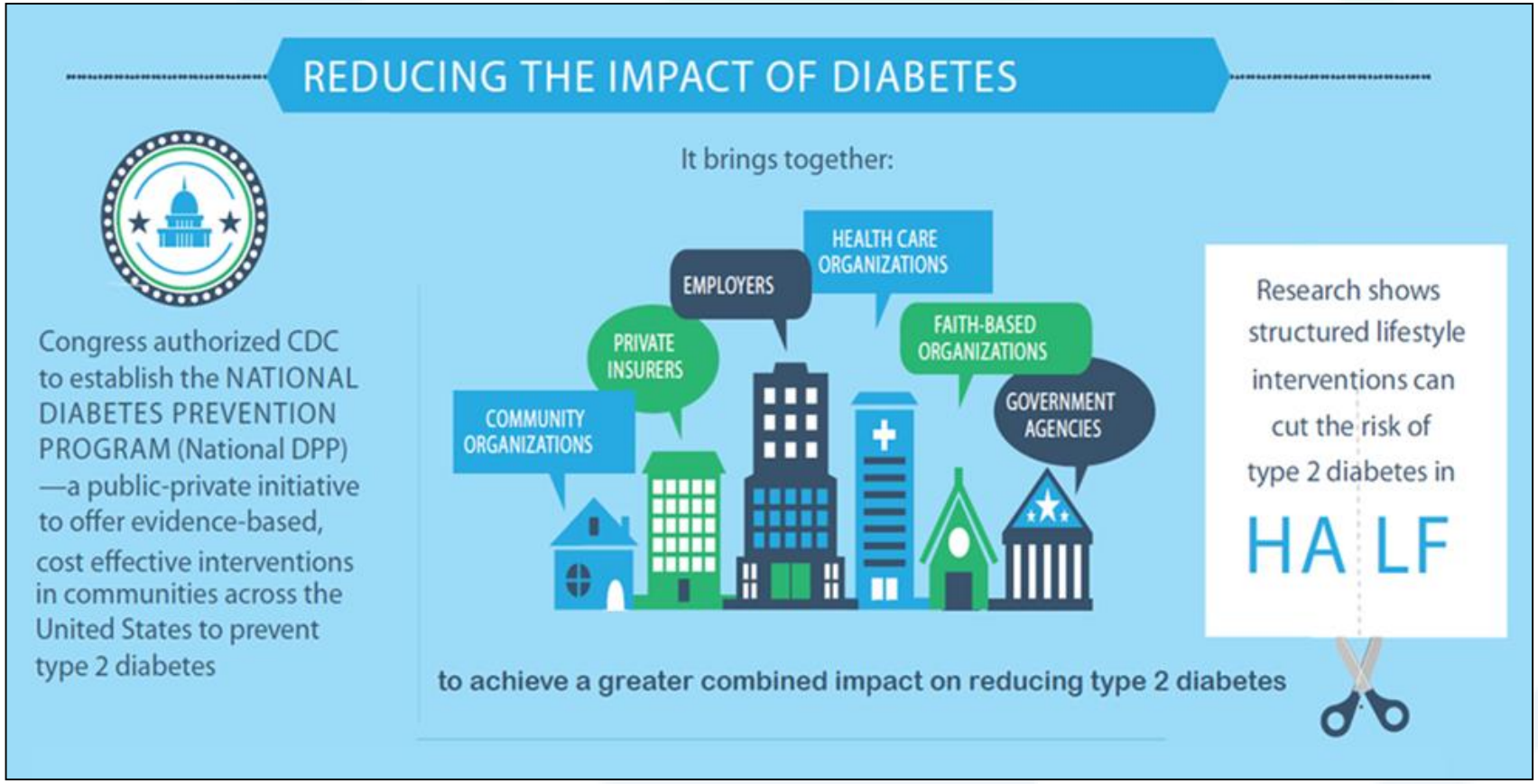
Strategic leadership

Coordinate action

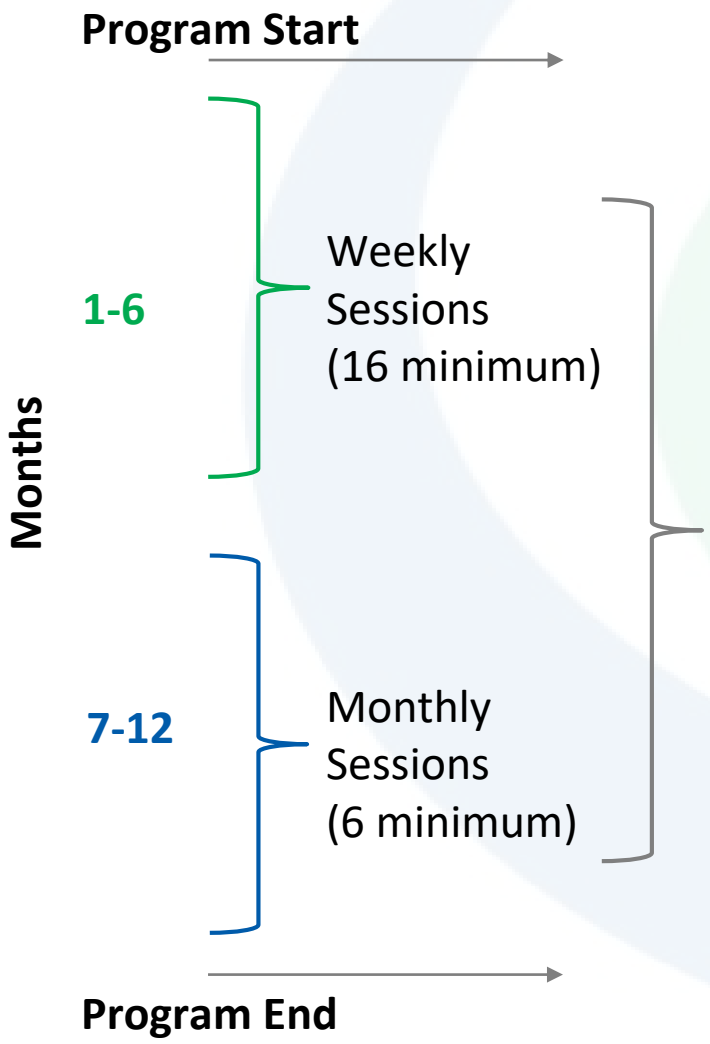
Expand & sustain
proven strategies

National Diabetes Prevention Program

A national effort to mobilize and bring effective lifestyle change programs to communities across the country



Elements of the National DPP Lifestyle Change Program



PROGRAM GOAL: Help participants make lasting behavior changes such as eating healthier, increasing physical activity, and improving problem-solving skills

Delivered by trained lifestyle coach

Example modules covered in core phase:

- Eat Well to Prevent T2
- Burn More Calories Than You Take In
- Manage Stress
- Keep Your Heart Healthy

Example modules covered in maintenance phase

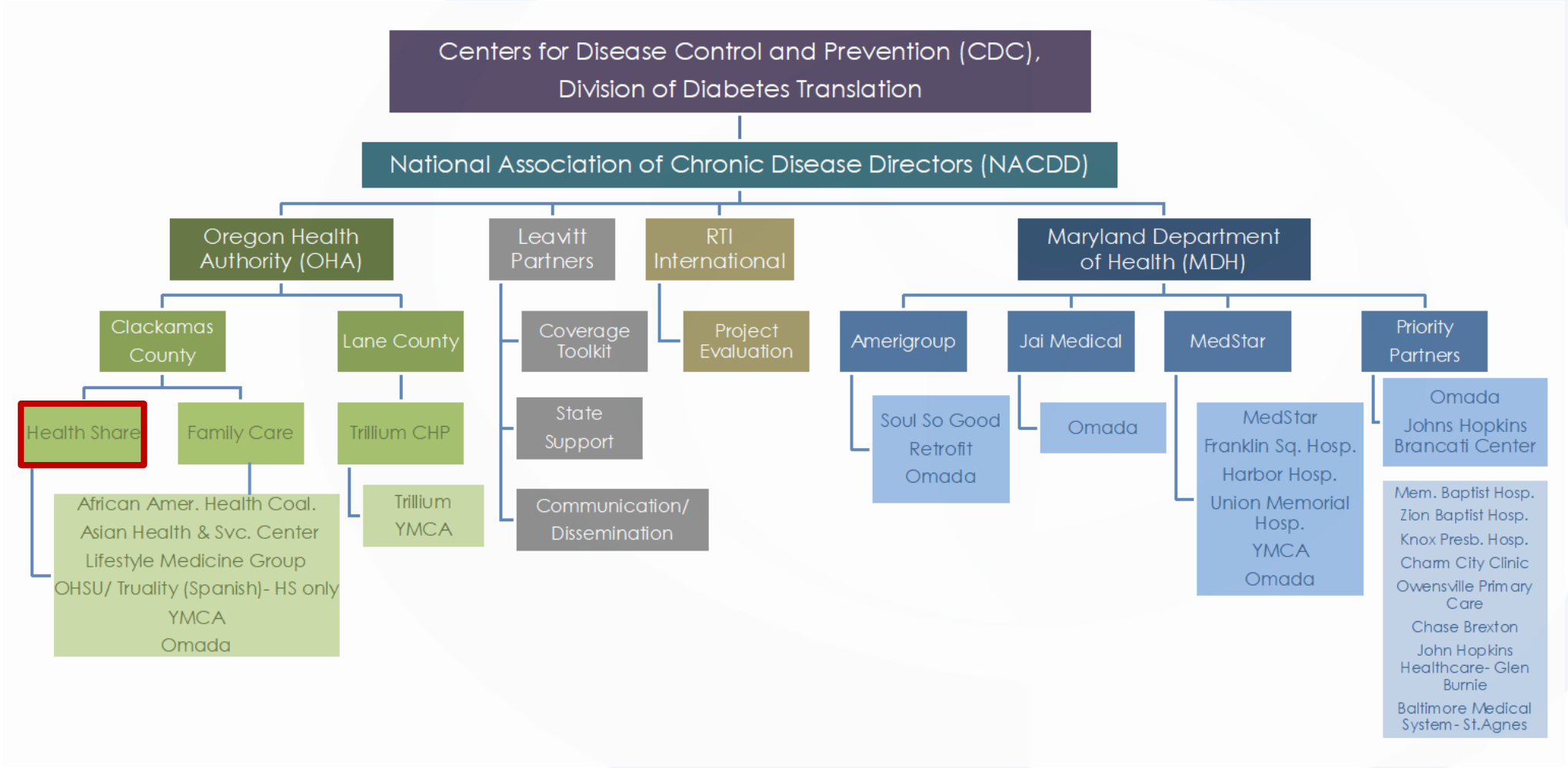
- When Weight Loss Stalls
- Stay Active Away from Home
- Get Enough Sleep

National DPP Medicaid Demonstration Project

- A three year project
  - Year 1: July 2015 – June 2016 – Planning year
  - Year 2: July 2016 – June 2017
  - Year 3: July 2017 – June 2018

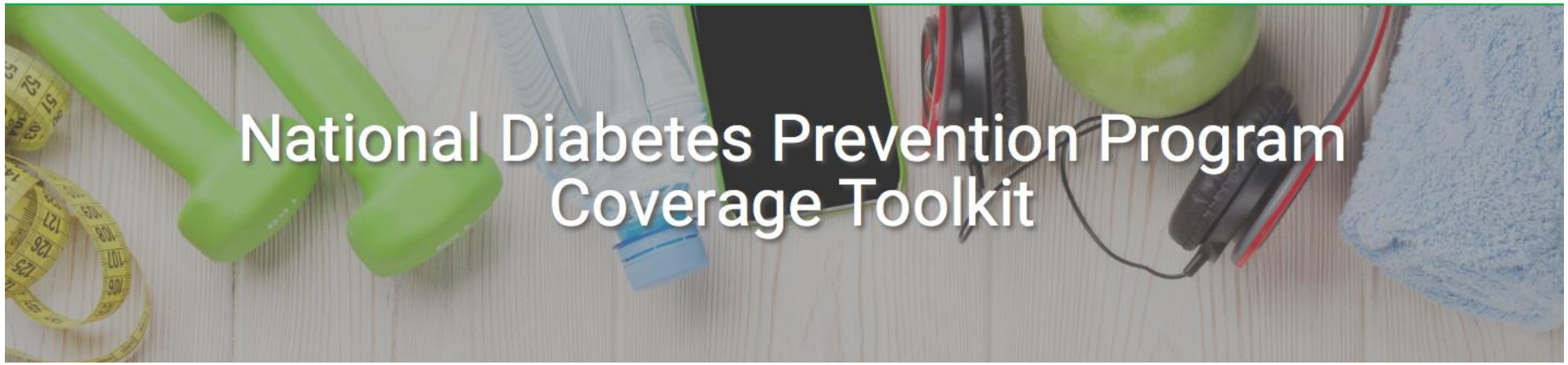
- The ultimate goal of this demonstration is to achieve sustainable coverage of the National DPP lifestyle change program for Medicaid beneficiaries under current Medicaid authorities

National DPP Medicaid Demonstration Project



Search

Home | The National DPP | Medicaid Agencies | Medicaid MCOs | Commercial Plans | Medicare



Medicaid Agencies

Learn More

https://coveragetoolkit.org/

Medicaid MCOs

Learn More

Medicare

Learn More

Quick Facts

- Online resource to support Medicaid, Medicare, and employer and commercial health plans who are considering covering or implementing the National DPP
- Covers topics such as contracting, delivery options, coding & billing, data & reporting
- Developed by the National Association of Chronic Disease Directors (NACDD) and Leavitt Partners
- Funded by the Centers for Disease Control and Prevention (CDC)
- Special sections on how to obtain Medicaid coverage and draw down federal funds

Commercial Plans

Learn More

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ACHIEVING VALUE THROUGH TRANSFORMATION

Equity First & Diabetes Prevention

An approach to tackling health disparities and improving patient health

Michael Anderson-Nathe
Chief Equity & Engagement Officer
May 9, 2018

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Health Share of Oregon

Coordinated Care Organization

Integration focus

- Physical
- Behavioral
- Dental
- NEMT

Regional approach

- Coverage area
- Local governance
- Community investments

Financial management

- Global budget
- Value based payment
- Bending cost curve

Quality focus

- Incentive metrics
- Transformation Quality Strategy

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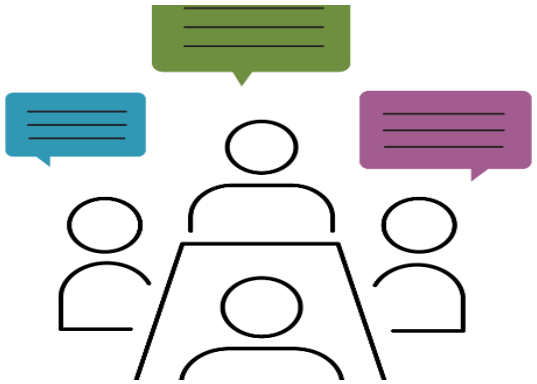
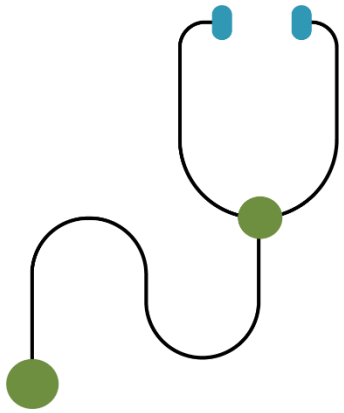
Health Share of Oregon



- 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 focus on systems level transformation and community investments



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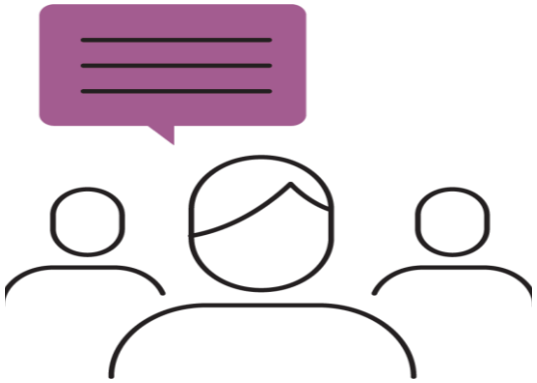
Equity at Health Share

Equity is foundational to the work we do at Health Share.

- It is in our mission and values
    - We believe health equity is **achievable** and requires **deliberate action** on our part
- Invested in staffing
- Infused in our strategic priorities using an equity first approach



We partner with communities to achieve ongoing transformation, health equity and the best possible health for each individual.

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Why an equity first approach?

- Tackles health and health care disparities
- Creates system change
- Fosters a member-centric approach
- Brings intentionality to services
- Integrates equity throughout

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Food for thought

“high-need” and “high-cost”

Who is centered here when we use this language?

What messages do we send to our members?

Equity work is an iterative process

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Equity First Approach

Commit to it

Commit to addressing health and health care disparities from the start.

Use Data to drive it

Stratify your data. Ask yourself, “who bears the burden?” Look at additional sources of data to complete your picture.

Engage impacted communities

“Nothing about us without us.” Data only indicates something is going on. Partner with impacted communities to make meaning.

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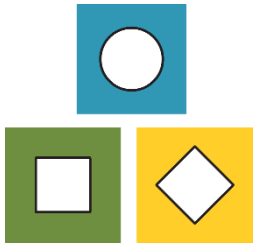
Equity First Approach contin.

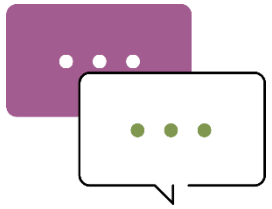


Build it into your program

It should inform: priority population; strategies, goals and tactics; resource allocations and metrics

Resource it

Achieving equity requires the *unequal* distribution of resources.



Be accountable

Follow through with community partners. Measure and share your progress.

Acknowledge past failures.

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Case Study

Medicaid Demonstration for the National Diabetes Prevention Program (DPP)

Foo

Equity First Approach

Commit to it

- Internal champions at Health Share and FamilyCare
- Stated organizational commitment
- Created buy in among funders and partners
- Assembled teams with necessary expertise and skills
- Applied equity approach throughout the process
- Tireless advocates

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Equity First Approach

Use Data to drive it

- DART (Disparities, Analytics and Reporting Team)
  - Stratified by Race, Ethnicity and Language (REaL)
- Local public health data
- Community health assessments

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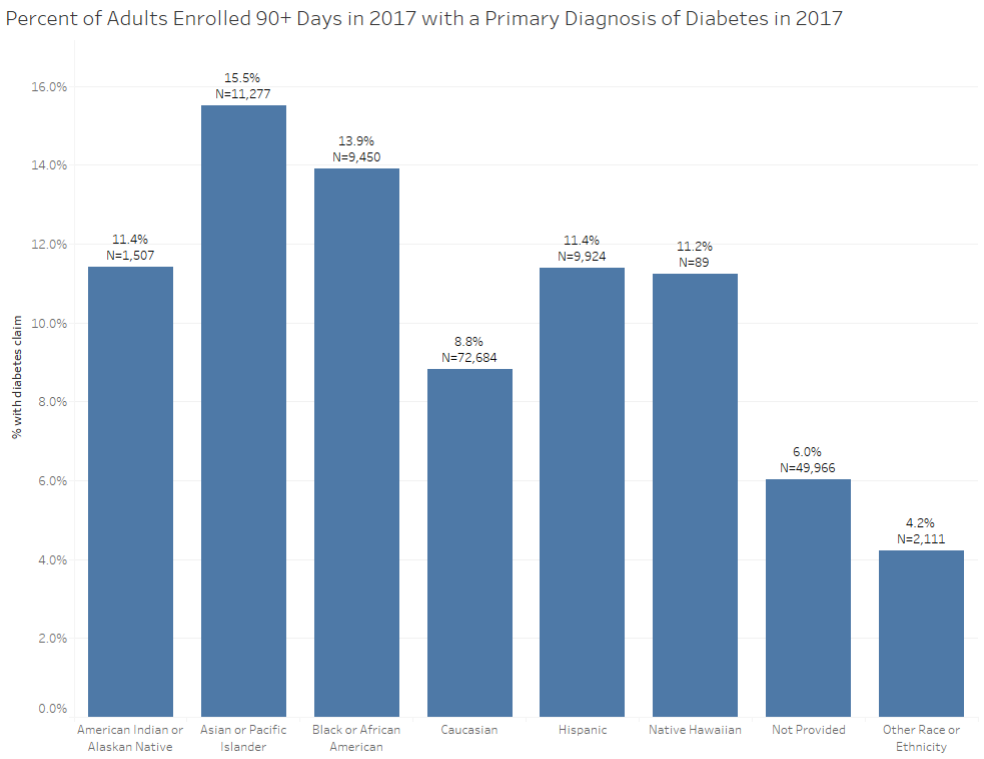
Using Data to Inform

Clear disparities among our members



Our members from communities of color had higher rates of diabetes than our white members.

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Equity First Approach

Engage impacted communities

This is about making meaning out of disparities and leads to:

- Partnering in different ways with different players
  - Contracts with community based organizations
    - Including culturally specific organizations
- Letting them influence and inform the program
  - Payment models
  - Contracting
  - Participant recruitment and retention

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Equity First Approach

Build it into your program

- Focused our priority population and recruitment
- Informed who we contracted with
- Shaped our payment model:
  - Capacity payments
  - Grant based versus fee for service
  - Incentive structure
  - Value-based dependent on retention not weight loss

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Equity First Approach

Resource it

- Capacity payment to community-based organizations
- Incentive structure and overall cost
- Internal staff to support partners
    - Contracts and data sharing TA
    - Programmatic and financial issues
    - Learning collaboratives

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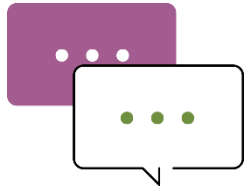
Equity First Approach



Be accountable

- Take time to listen and build relationships
- Acknowledge historical trauma and exclusion AND change your behavior
- Advocate for equity at every opportunity
- Assess/evaluate and make improvements
- Share your results with stakeholders

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Key takeaways

Remember, taking an equity first approach means we have to operate differently

- Commit to equity from the start
- Relationships matter
- Listen to the community and be flexible
- Invest in infrastructure
- This takes time

"We can change the world and make it a better place. It is in your hands to make a difference."

Nelson Mandela

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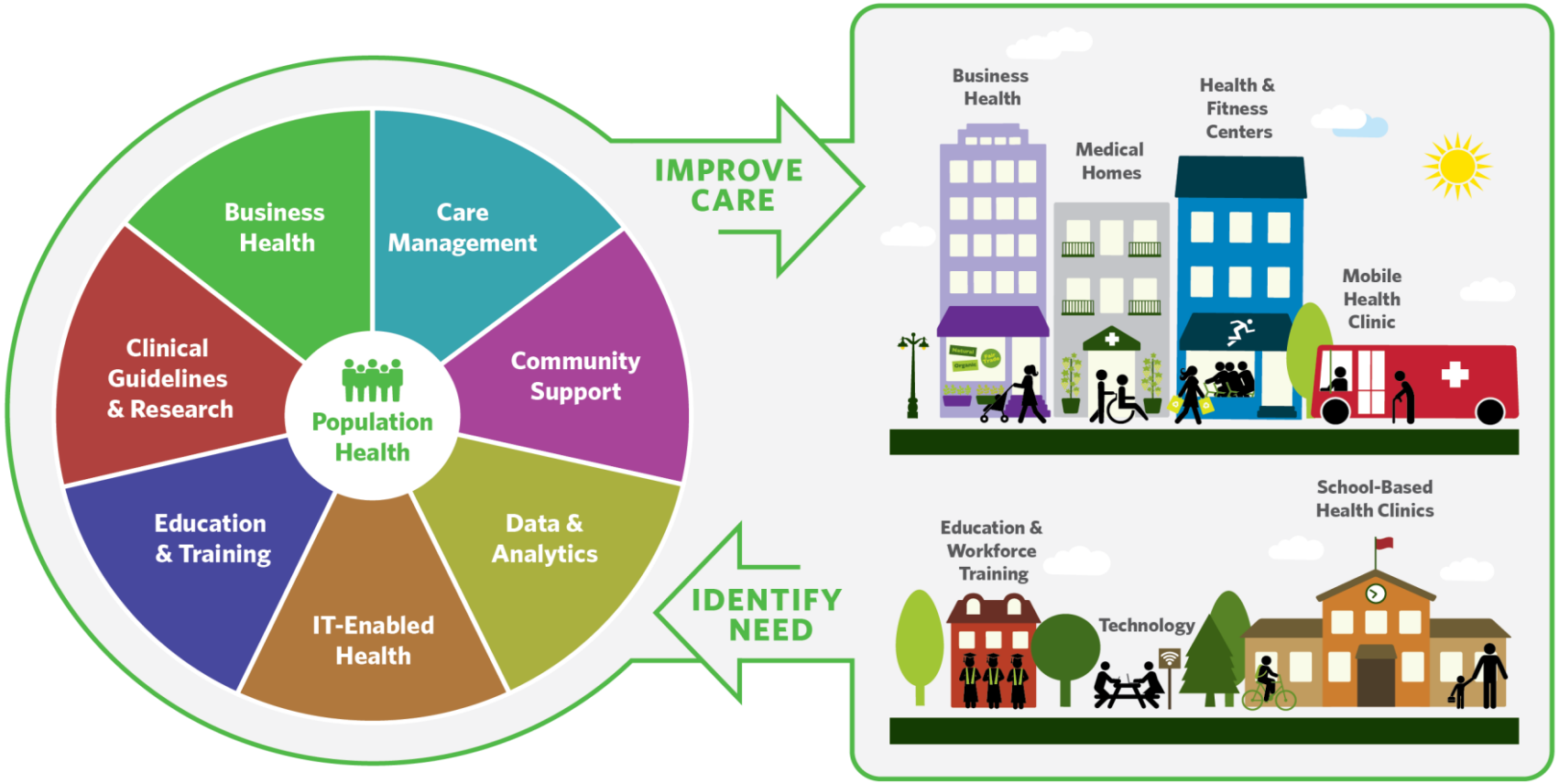
GREENVILLE HEALTH SYSTEM

Neighborhood Partnerships to Improve the Health of Communities

Jennifer Snow, MBA
Director of Accountable Communities

GREENVILLE HEALTH SYSTEM

IMPROVING THE HEALTH OF POPULATIONS



Beyond the Medical Home

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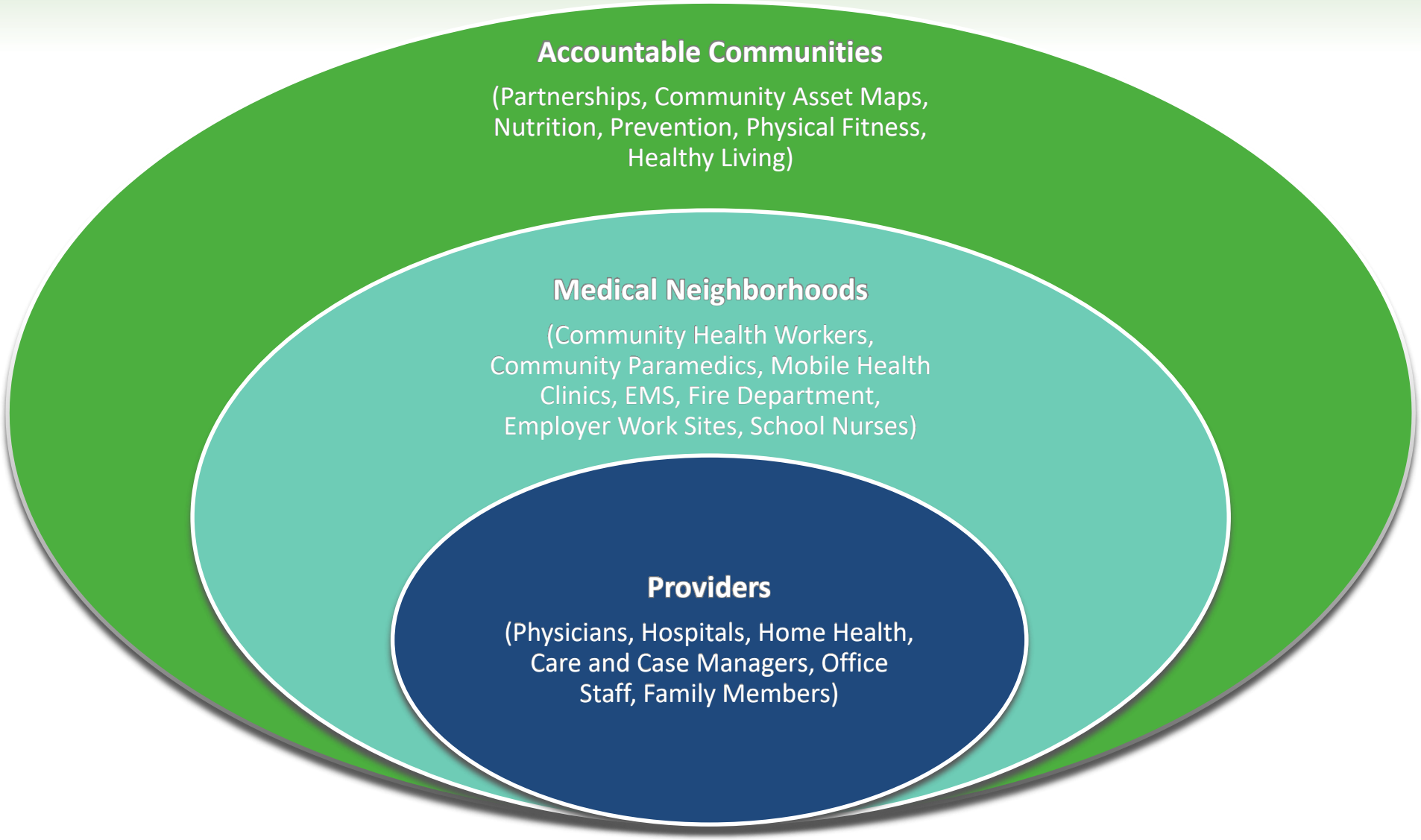


Medical Neighborhoods

GREENVILLE HEALTH SYSTEM

- Health system and safety-net collaboration
- Providing access to care within communities
- Community Paramedic and Health Worker Models
- Home Health
- Mobile Health Clinic
- Care Management
- Care Coordination

Patient Hotspotting

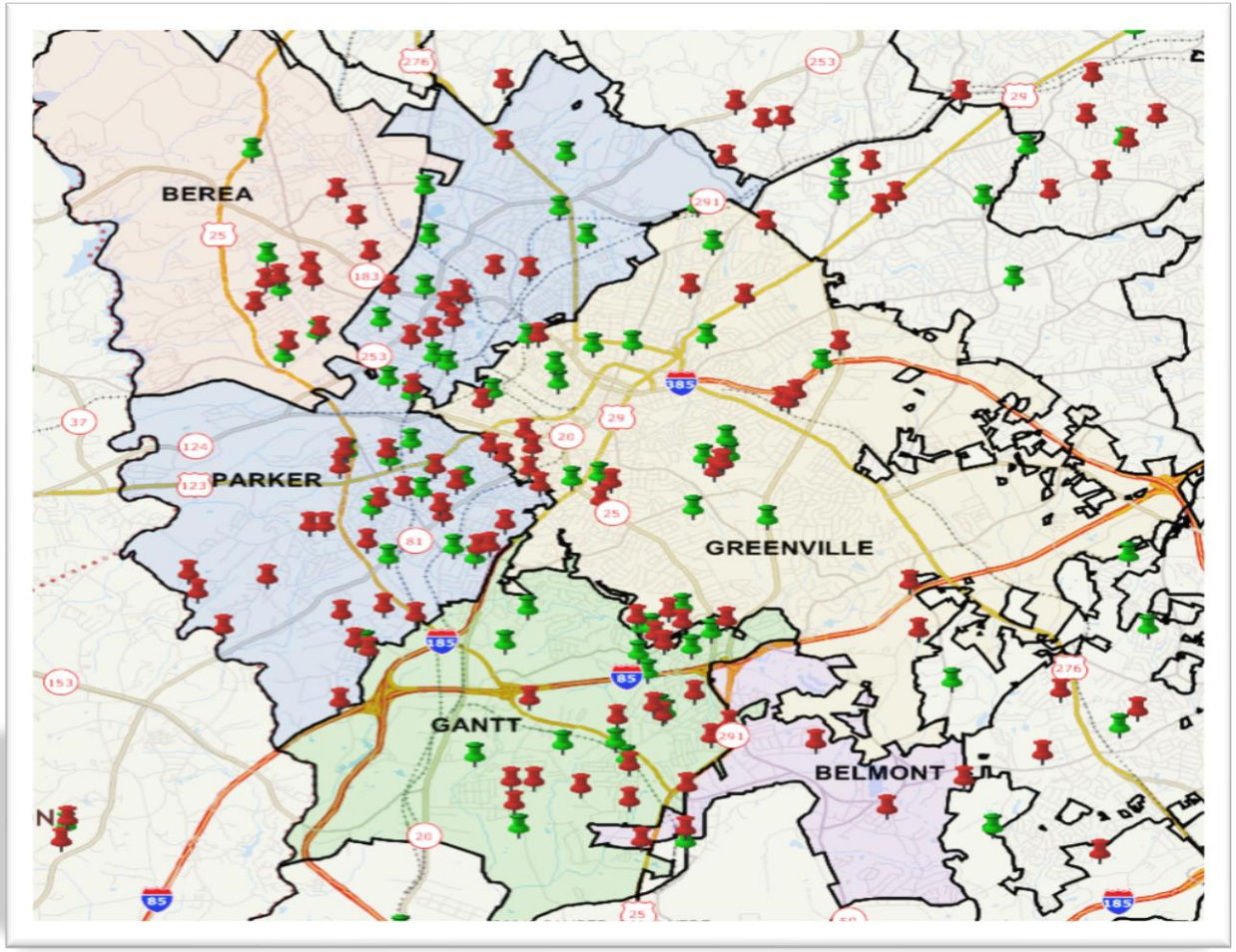
GREENVILLE HEALTH SYSTEM

Data Driven Process Through:

- Claims and EMR Data Analysis
- Risk Stratification
- Access to Care

Possible Focus Areas:

- ED and EMS Utilization
- Admissions
- Patient Populations
- Chronic Disease Prevalence
- Gaps in Care



Neighborhood Health Partners Community Paramedic

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GHS Utilization

- Overall cases **increased by 1.5%**
- Total costs **decreased by $467,921 ($4,774 per patient)**
- Hospital admissions **decreased by 19%**
- Average length of stay **decreased by 1.86 days**
- Emergency room visits **decreased by 25.3%**
- Primary care visits were **increased by 55.3%**
- Specialist care visits were **decreased by 28.4%**

EMS Utilization

- EMS responses **decreased by 44%**
- Total costs **decreased by $100,320**

Total Program Costs Saved: $568,241

Neighborhood Health Partners Community Health Worker

GREENVILLE HEALTH SYSTEM

GHS Utilization:

- Overall cases increased by 6.4% (mainly due to increase in primary care visits)
- Inpatient discharges decreased by 44.4%
- Outpatient ED visits decreased by 15.4%
- Primary Care visits increased by 49.7%

Neighborhood Health Partners Mobile Health Clinic

GREENVILLE HEALTH SYSTEM

- Go-live Feb. 17, 2016
- 2,198 patients encounters to-date
- (392 community clinic days at 9 sites
- 1670 uninsured patients referred to AccessHealth
- Payor:
  - 76% Uninsured
  - 9% Medicaid
  - 4% Medicare
  - 5% Dual
  - 5% Private
  - 1% Tricare

HEALTH | FEB 25, 2016 | BY MELINDA YOUNG

'Healthy and at home'

Local health systems offer solutions to treating chronically ill and uninsured

10 4

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SHARE LINES

ACA has pushed health care industry toward keeping people healthy and out of hospitals

Bon Secours St. Francis and Greenville Health System focus on prevention, neighborhood health

Home visits and hands-on case management keep patients out of the ER

Gone are the days when health systems competed for patients and championed new technology to fill hospital beds. The Affordable Care Act (ACA) has pushed the nation's health care industry into a new direction: keeping people healthy and **out** of the hospital.

According to the Congressional Budget Office, health care costs tripled in real terms between 1985 and 2005. Since the ACA became law, health care spending slowed to the lowest average rate of growth on record since 1965, according to a 2013 presidential report.

Since most health care organizations accept government-funded Medicare and Medicaid patients, the ACA can influence change by setting financial mandates and incentives within those two systems. One such

RELATED

HEALTH | FEB 25, 2016
Who gives poor, uninsured patients primary care services?

HEALTH | FEB 25, 2016
Case study: How home visits

Addressing Socioeconomic & Psychosocial Barriers

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- Transportation
- Health and Insurance Literacy
- Medication Assistance and Literacy
- Caregiver Education
- Care Navigation
- Trusting Relationships
- Plans of Care
- Connection to Resources

Integrating the Care Team

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Physicians - Primary Care & Specialists

Digital Health

Outpatient Clinical Staff

Community - Based Resources

Hospitalists / SNFists

Home Health & Ambulatory Services

Traditional & Non-Traditional Care Management

Behavioral Health

Care Team Expansion and Integration into Care Model

GREENVILLE HEALTH SYSTEM

- BlueChoice Medicaid Pilot – using CPs to manage uncontrolled asthmatics
  - Partnership with Bradshaw Institute and Clemson University
- Closing Gaps in Care
- Adding CHWs to supplement ambulatory care coordination
- Go-live on Caradigm enables interdisciplinary care model
- CHWs & Diabetes Prevention Program (DPP)

Accountable Communities

GREENVILLE HEALTH SYSTEM

Community-led innovation

- Community asset maps
- Safety-net providers (free clinics and FQHCs)
- Community resources (faith-based organizations, schools, EMS, police and fire districts)
- Community volunteer programs
- Food deserts and community gardens

Partnerships to improve health

- AccessHealth
- Clemson Health Extension Pilot
- PASOs
- Swamp Rabbit Trail
- YMCA

Greenville County imap

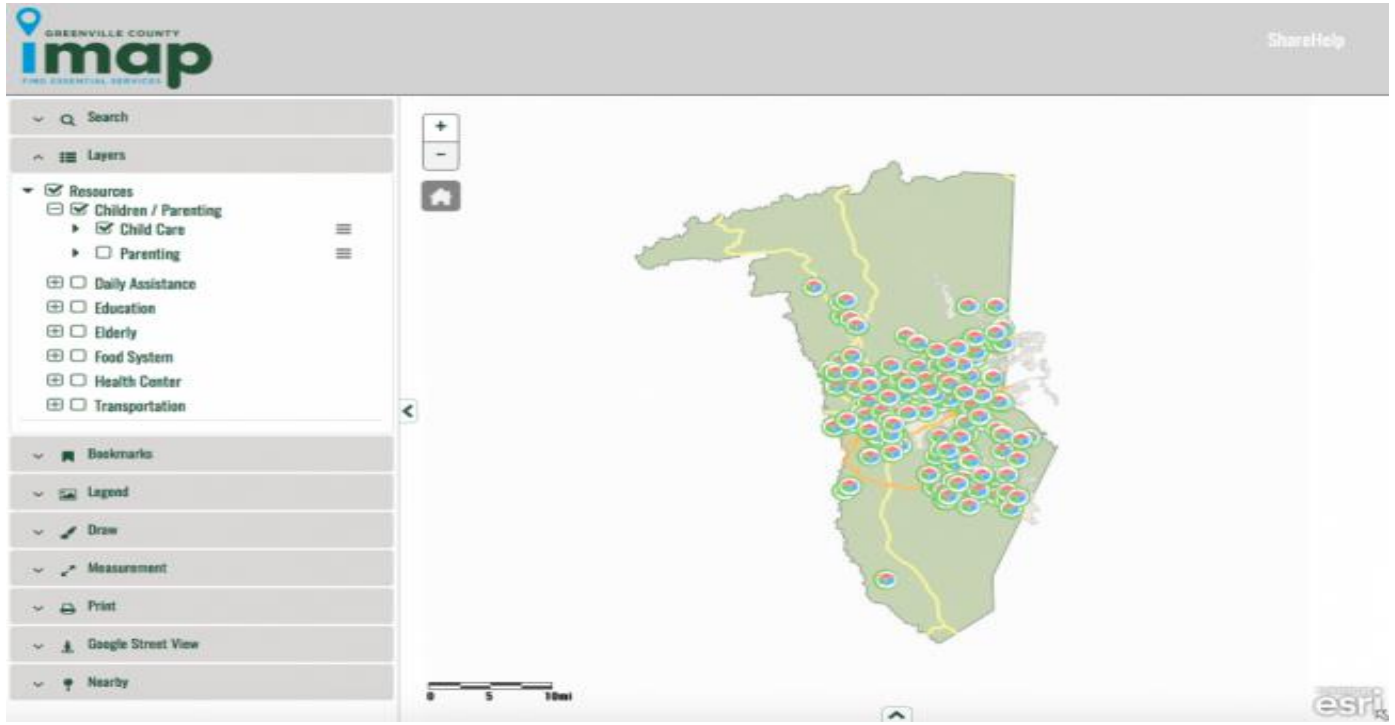
GREENVILLE HEALTH SYSTEM

Interactive map that provides a visual look at essential services in Greenville County

GREENVILLE COUNTY imap FIND ESSENTIAL SERVICES

Some assets include:

- Bus stops
- Parks
- Educational institutions
- Affordable housing
- Health centers
- Quality childcare
- Food assistance
- Recreation centers
- Shelters
- Community gardens
- Farmers markets
- Employment assistance, etc.



The New Healthcare Worker

GREENVILLE HEALTH SYSTEM

Nontraditional healthcare roles

Population health education and training needs:

- Physician engagement and training
- Resident and medical students
- Care transitions and management
- Social determinants of health
- Patient engagement and motivational interviewing
- Risk stratification
- Claims analysis and actuarial services

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Upcoming Webinars

May

Innovations in Primary Care

(May 23, 3:30 – 4:30pm ET)

This webinar is second in a two-part series on new value-based primary care models that advance value-based payment and care delivery. Featuring Gaurov Dayal of ChenMed and Laura Sessums of the Center for Medicare and Medicaid Innovation.

June

Consumer Engagement in Health Care Governance: Progress and Opportunity

(June 20, 2:30 – 4pm ET)

Consumer engagement is increasingly recognized as a critical component to achieving person-centered care, particularly for people with complex health and social needs. Featuring Kathy Brieger from HRHCare and Melinda Karp from Commonwealth Care Alliance will share their organizations' industry-leading approaches to consumer engagement.

To sign up for invitations to our webinar series, please visit: http://hcttf.org/sign-up