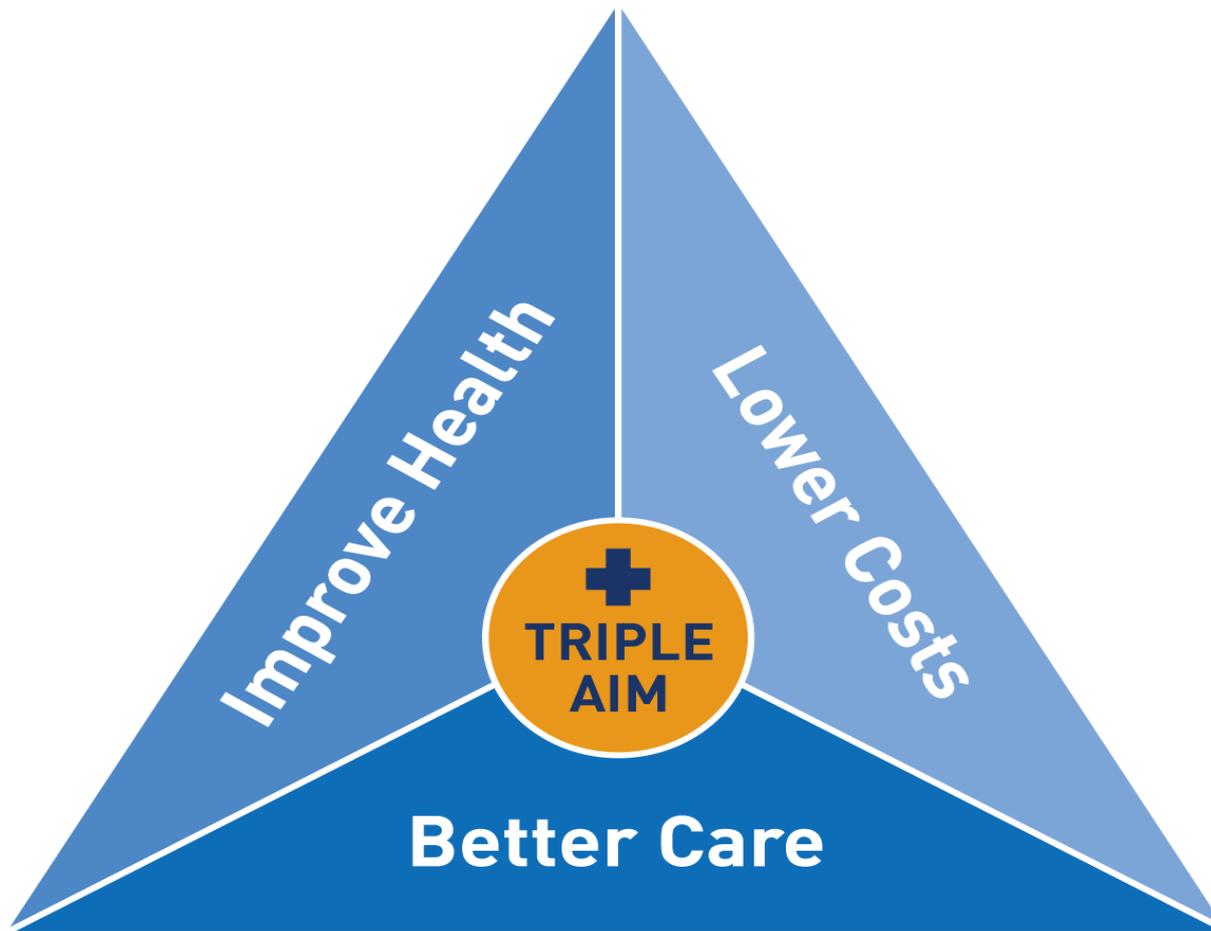


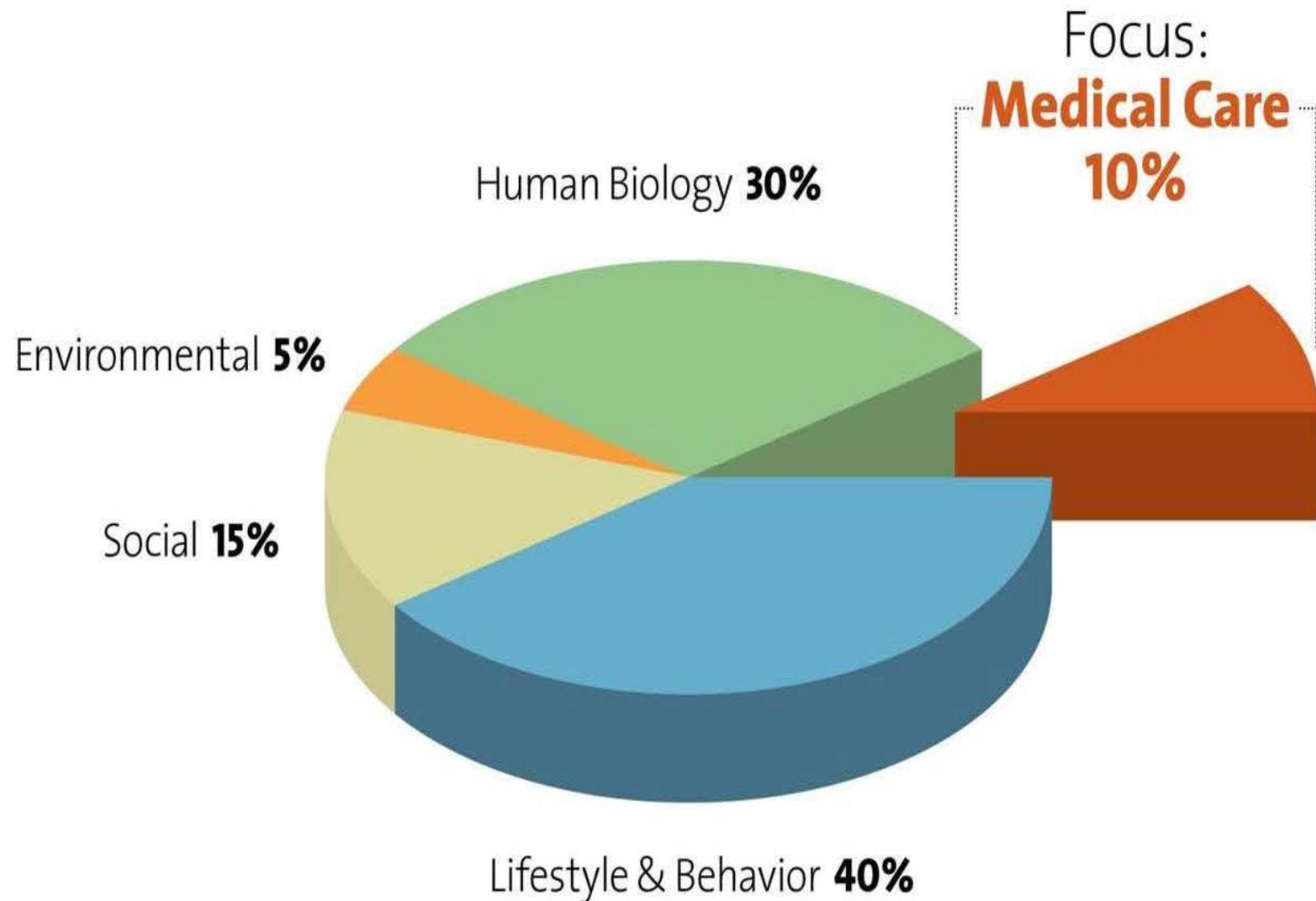
Planning for Success: Models for Community Health Improvement from Around the Country and What We Can Learn From Them

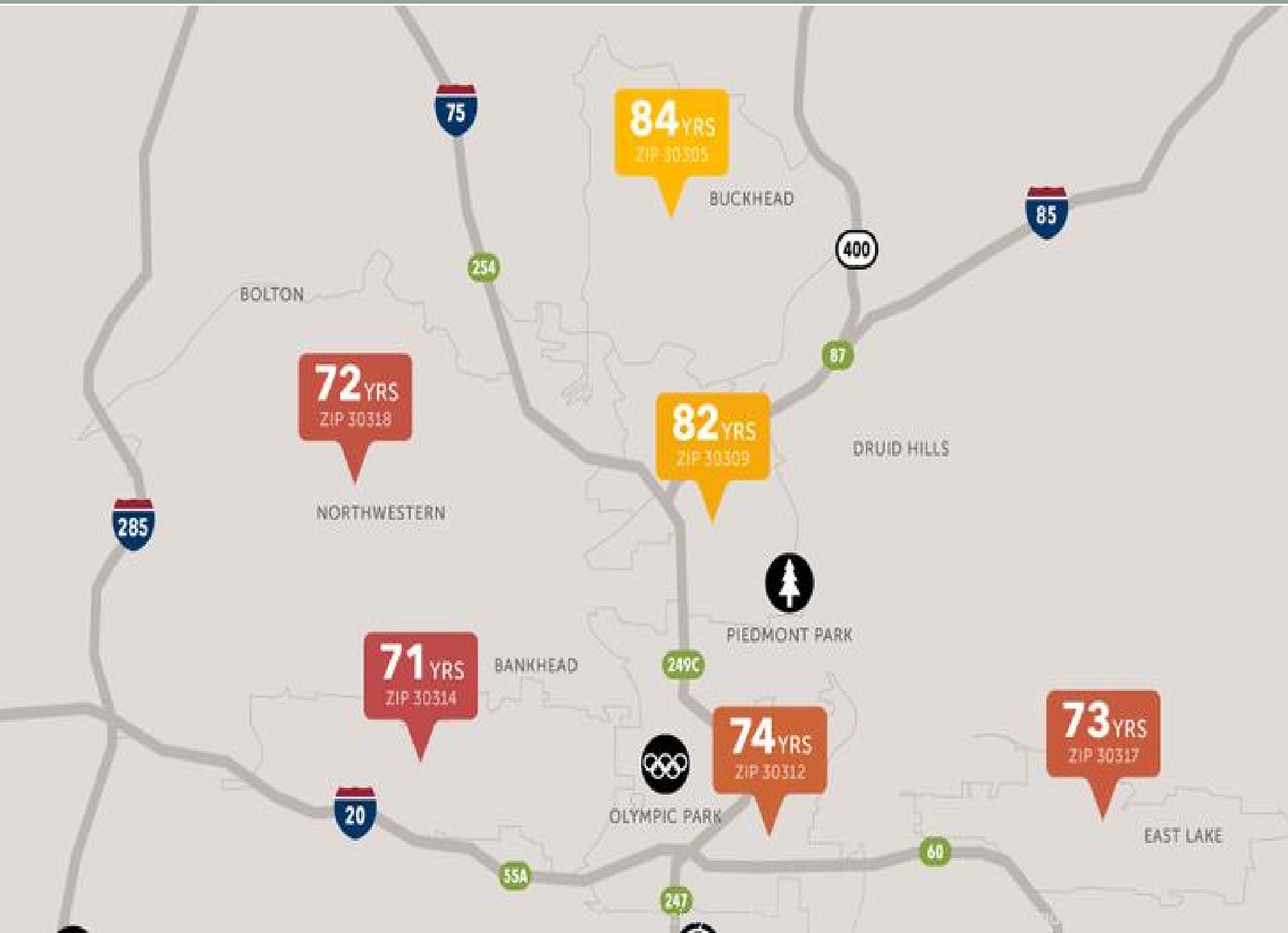
**Bruce Goldberg, MD
Cascade Pacific Health Alliance
November 10, 2016**

TODAY

- Context for state health improvement efforts
- Show some examples from around the country
- Spend some time talking about lessons learned
- Discussion







Opportunity Costs!

- 1 ED Visit = 1 months rent
- 2 hospitalizations = 1 year of child care
- 20 MRIs = 1 social worker per year
- 60 echocardiograms = 1 public school teacher per year

STATE EFFORTS TO IMPROVE HEALTH & INCREASE INVESTMENTS IN SOCIAL SPENDING

- Foster better value and efficiency in health delivery systems through payment reforms, value based purchasing and delivery system changes
- Invest some of those savings into social enterprises that improve health
- Increased partnerships across health and social service endeavors
- Creating coordinating/integrating organizations

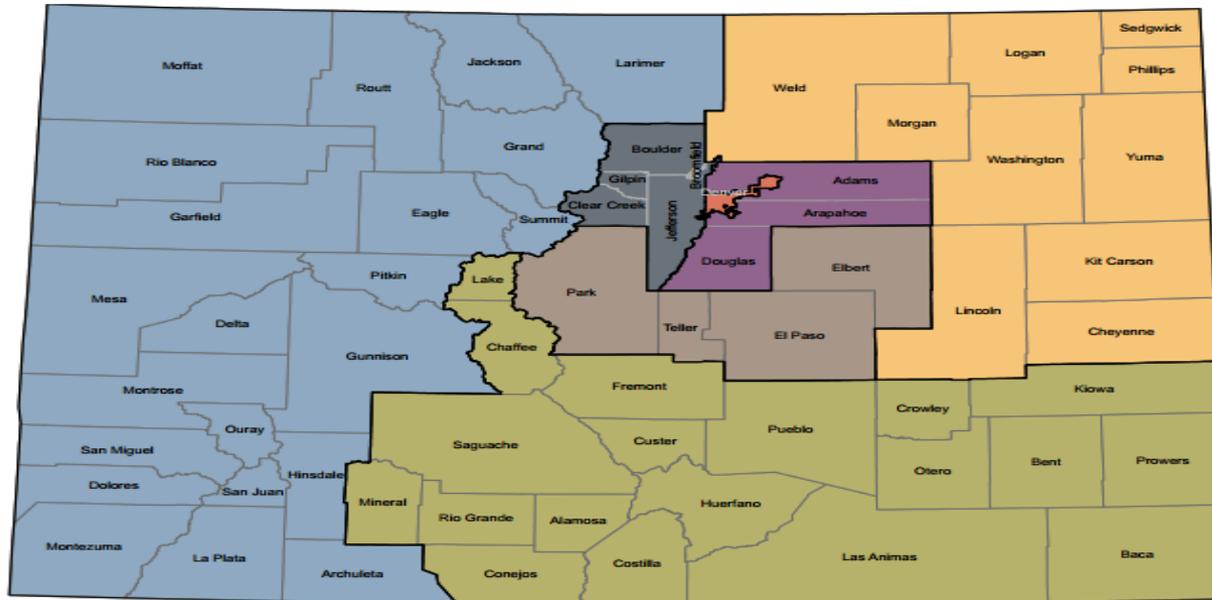
The Alphabet Soup of Approaches

- ACO
- CCO
- ACC
- ACH
- RCCO
- MCO
- PCMH

COLORADO

Regional Care Collaborative Organizations

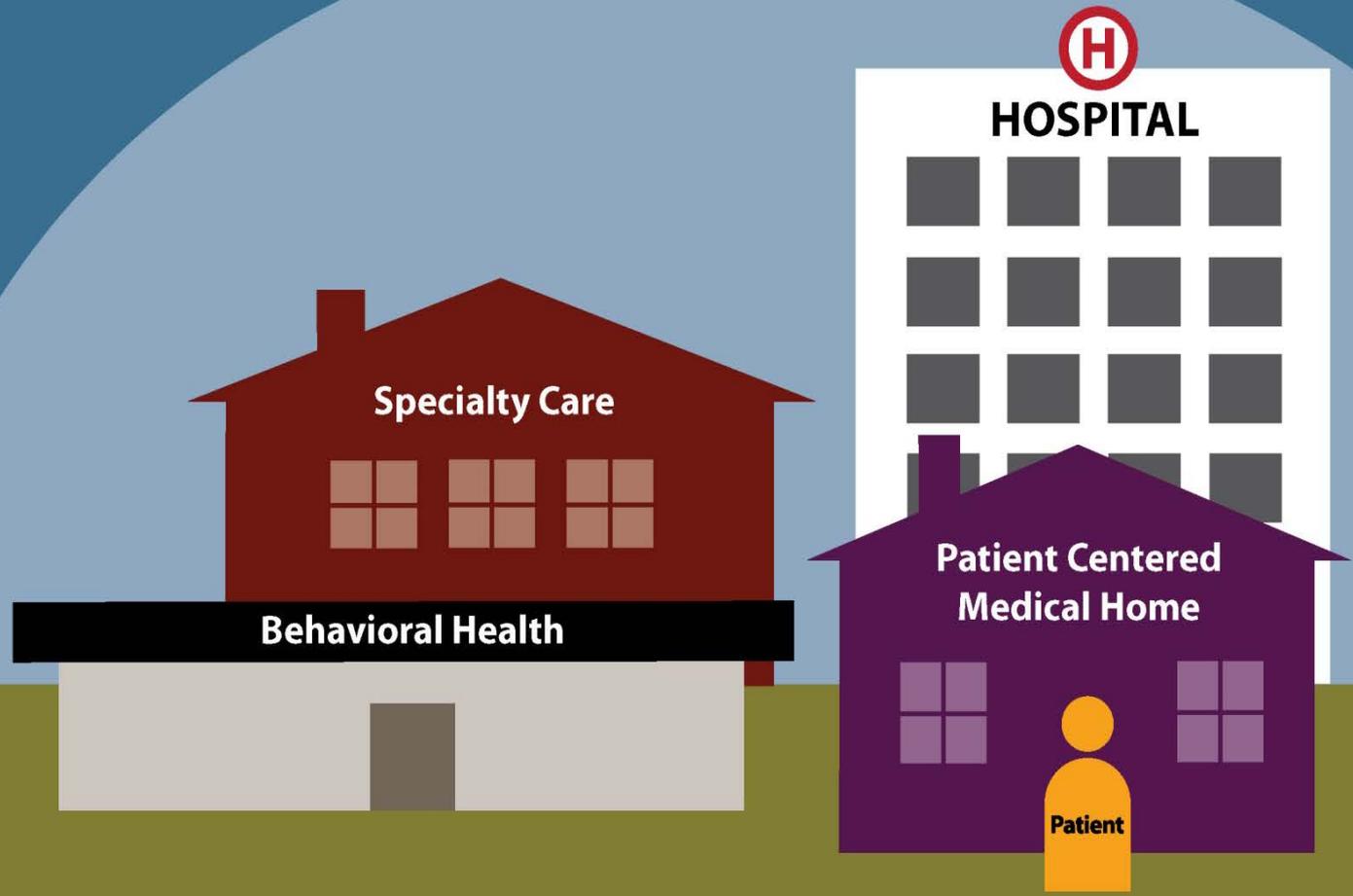
Map 1: Colorado's Accountable Care Collaborative Regional Care Collaborative Organizations



Region, RCCO Name	ACC Enrollment as of June 2014
Region 1: Rocky Mountain Health Plans	84,459
Region 2: Colorado Access	52,171
Region 3: Colorado Access	172,336
Region 4: Integrated Community Health Partners	74,755
Region 5: Colorado Access	49,118
Region 6: Colorado Community Health Alliance	82,954
Region 7: Community Care of Central Colorado	97,189

Source: Colorado Department of Health Care Policy and Financing

Care Coordination



Data and Analytics

Regional Care Collaborative Organizations (RCCO)

- Develop network of providers
- Support providers with coaching and information
- Manage and coordinate member care
- Connect members with non-medical services
- Report on costs, utilization and outcomes and work to improve them.

Regional Care Collaborative Organizations (RCCO)

- Connects Medicaid clients to Medicaid providers and also helps Medicaid clients find community resources and social services in their area.
- Assist Medicaid clients get the right care when they are returning home from the hospital or a nursing facility.
- Assists with other care transitions, like moving from children's health services to adult health services, or moving from a hospital to nursing care.

Initial Program Measures

- Emergency Department Visits:
- Inpatient Readmissions Within 30 Days:
- High Cost Imaging:
- Well Child visits
- Postpartum Care

Transformation Activities

- Evaluate changes in data monthly (improvements, setbacks)
- Modify care coordination and data management practices
- Engage staff in cycles of rapid improvement (PDSAs)
- Spread Best Practices
- Special projects driven by local need – investing in social determinants and moving upstream

FUNDING

- \$3 PMPM payments for all attributed patients
- Incentive payments for performance on Key Performance Indicators (KPIs)
- Delegated Care Management
 - \$3.50 PMPM
 - Varies by Region

Regional Care Collaborative Organizations (RCCO)

- 2015- generated \$37 million in net savings (\$121 million in savings - \$84 million in administrative costs)
- Lowered ED visits, high cost imaging and readmissions
- Increased well child visits, postpartum care

**EASTERN
OREGON
CCO**

Quick facts about EOCCO

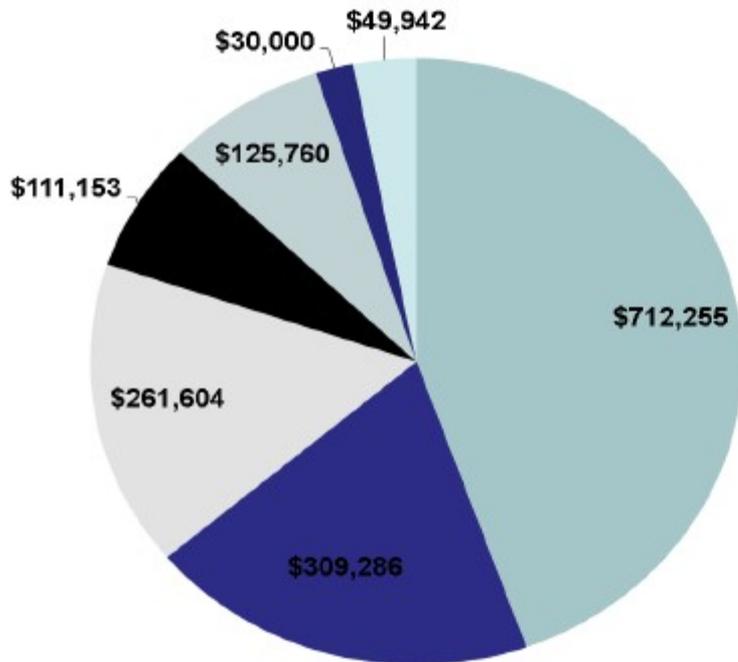
- **EOCCO serves 12 rural and frontier counties**
 - › Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler
 - › 6 of 12 were primarily FFS/Open Card counties prior to CCOs
- **Land Area: approximately 50,000 sq. miles**
 - › 52% of land area of State of Oregon
 - › Equal to the size of NY
 - › Larger than land area of 19 states
- **Population: 194,592**
 - › 5% of Oregon's population
 - › 1/3 the population of WY (least populous State)
 - › Equivalent to the combined populations of Salem, Lake Oswego and Lebanon

Fundamental changes to healthcare and financing

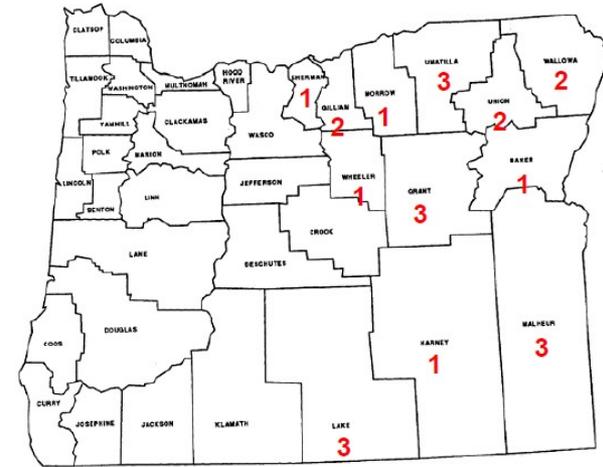
- Improved relationships among "health" workforce
- Shared Savings/APMs
- Investments in Community Health Workers
- Community Advisory Council funding/projects
- Integration of services (Physical, Behavioral, Dental, NEMT)
- Improved quality measures
- Health Integrated

2014 TRANSFORMATION GRANTS

- 23 selected



- Care Coordination
- Co-Located Services
- Health Promotion/Screening
- IT/Telemedicine/EMRs
- Mental Health Services/Training
- PCPCH
- Transportation



Umatilla County

- The “ConneXions” project developed a workforce of CHWs to meet behavioral health needs of patients in physical health care settings and to coordinate across agencies
- Outcomes:
 - Return ED visits reduced 8%
 - Multi-organization care team established, bedside assessments in ED, universal community referral process created
 - 900 referrals
 - Active caseload of over 500 patients
 - Received “Excellence in Innovation Award” from the Federal Office of Rural Health Policy

Project is expanding, savings now sustaining CHW's

Malheur County

- Embedded a nurse care coordinator and behavioral health specialist in hospital and primary care clinic for patients with complex conditions and behavioral health needs to reduce ED use and improve access to care
- Outcomes:
 - Connected 550 patients to resources (mental health, primary care, housing, medication assistance, and educational services)
 - For 183 patients targeted for ED care coordination intervention saw 63% decline in ED visits and 50% decline in inpatient visits

Project is expanding in 2016 by adding a Qualified Mental Health Professional to the ED, savings helping with community supports

TUESDAYS WITH MORRIE

Lessons Learned

- **COMMON VISION**

- Common vision for reforms/changes/interventions amongst partners is critical
- Leadership (legislative, executive, stakeholder) commitment to the goals and deliverables
- Engaging stakeholders around that common vision is critical – CEO's, consumers, CMS

- **COORDINATION**

- A strong coordinating mechanism is needed to work effectively across parties
- “Care coordination” across the spectrum is how many achieve their goals and find the resources for sustainability

- **GOVERNANCE**

- Pay careful attention how projects are governed – governance is critical for engagement
- How are decisions made, do you have the right people governing?
- Getting organizations to participate and having a role in governance go hand in hand

Lessons Learned (cont'd)

- **DATA**

- Have reliable data and information. Good data and information is needed now - to chart your course, and later - to monitor progress. Participants need to be involved with assuring validity.
- Data is key to your sustainability!
- Data is vitally important to address issues of equity
- Hold each other accountable with data
 - Financial
 - Outcomes

- **ACCOUNTABILITY**

- Be clear on what everyone is accountable for
- Have good data to back that up

- **STAGE YOUR WORK AND BUILD ON SUCCESS**

- Begin with a pilot, develop competency, expand
- Demonstrate ROI

Lessons Learned (cont'd)

- **SUSTAINABILITY**

- Plan for it!
- Projects should not be "one offs", rather they should help to sustain your organization and your future work

- **Community Engagement**

- Authenticity
- Broad community support and involvement is critical

- **Broad Disparities in Care and Outcomes Exist**

- Make addressing them part of the core mission

- Communicate early, often and in multiple modalities and then communicate again

- Financial support helps the transition from old system to new.

Lessons Learned (cont'd)

- **Payment reform is critical – don't expect new ways of doing business with old methods of payment**
 - Payment needs to help drive efficiency
 - Payment/financing needs to reward effective collaborations
 - Payment/financing must foster accountability to outcomes
 - Payment must drive the new transformation
- Multi-payer initiatives can accelerate change in delivery systems
- Payment and structures need to increase community accountability for population health outcomes that reflect physical, mental, social well being

Lessons Learned (cont'd)

- Need to recognize and help health care institutions transition and plan for new business models!
- Workforce –
 - Don't expect new methods of care with same workforce
 - Help to develop workforce that meets the goals of reforms
 - Provider engagement and training are critical
- Change is hard and takes time, but Don't slow down!
- Don't underestimate the investment needed in change management and technical support

Lessons Learned (cont'd)

- There is no perfect structure
- Be clear about goals – especially as it relates to improving health vs. improving the health system, access, quality, costs.
- On the journey to improve health, be careful not to “medicalize” social institutions.



**The future belongs to those
who create it.**