New Approaches for Bending the Cost Curve Proven Models for Delivering Whole Person Care

OPTUM®

COUNTY OF SANTA CLARA
Health System

Agenda

1. **Background**
2. Whole Person Care (WPC) and CMS Grant
3. Understanding the Population
4. Infrastructure Development
5. WPC Approach and Design
6. Results
7. Key Takeaways

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About Santa Clara county

- 1.8 million residents with estimated day-time population of 2 million
- Part of the *San José-Oakland-San Francisco Combined Statistical Area* ranked as the 5th largest in the U.S. (8.6 million estimated as of 2014)
- The heart of Silicon Valley, with *San José* considered to be the "capital"

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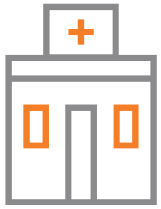
County of Santa Clara Health System

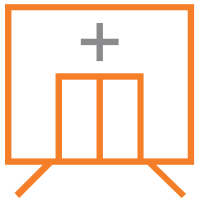


The 2nd largest public hospital system in CALIFORNIA

Integrated system since 1977

$2.1 billion safety net serving mainly MEDICAID patients

6,680
employed staff



The Santa Clara Valley Medical System is a LEVEL 1 TRAUMA CENTER with 574 beds

(trauma, burn and spinal cord and brain injury rehabilitation centers)

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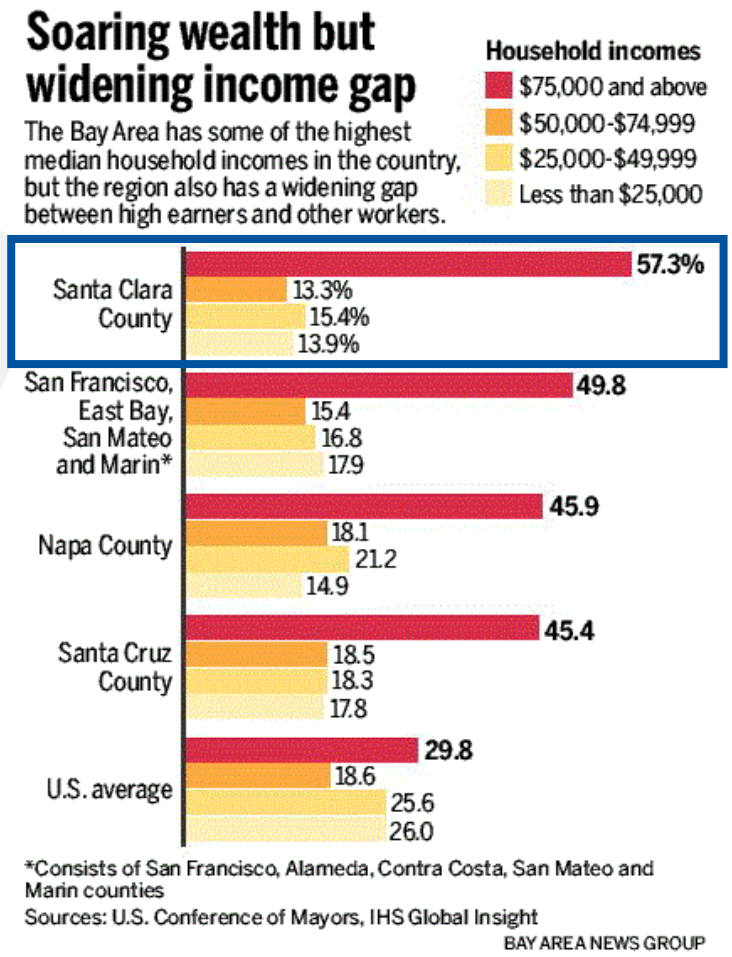
A safety net system in Silicon Valley

- San José 2012 median income: $76,000 (U.S. $51,000)
- 45% of Santa Clara County households make more than $100,000
- 33.5% of households in Santa Clara County earn below the living wage
- Fourth largest number of homeless individuals of all U.S. metro areas (6,681)



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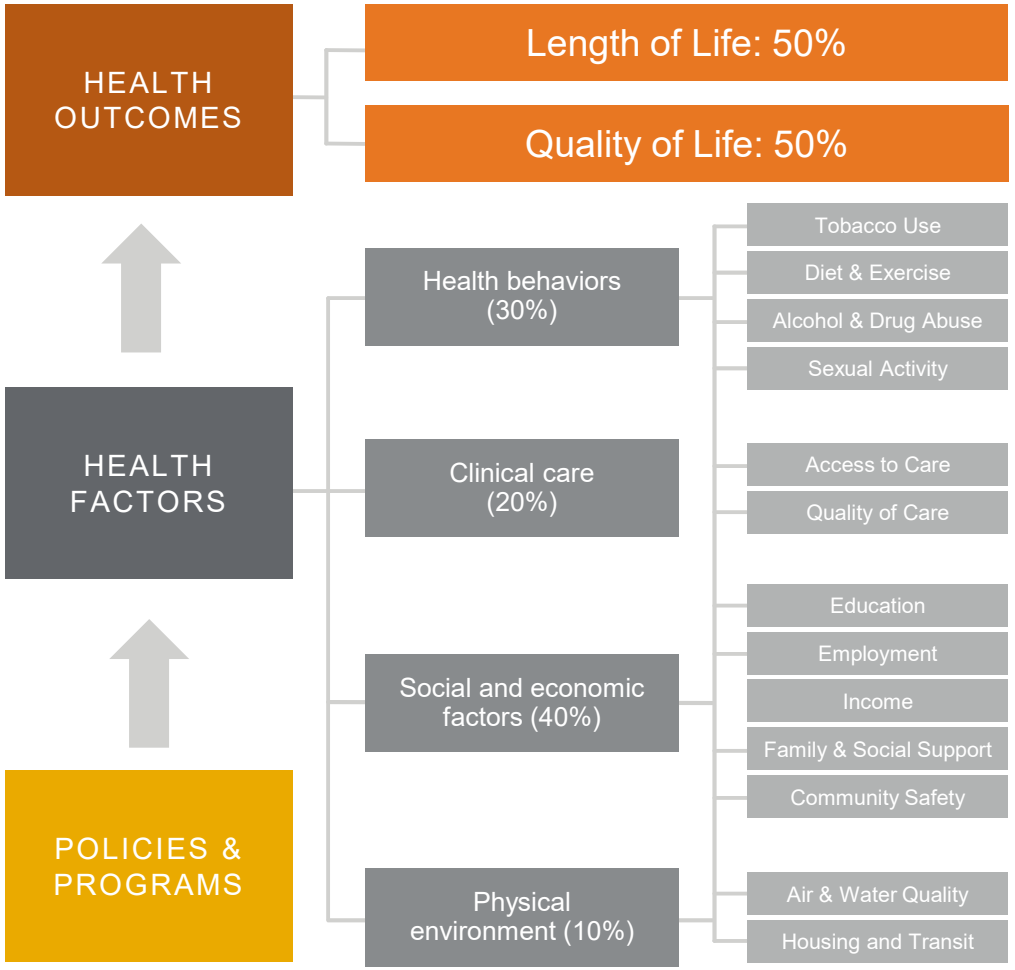
Key drivers

80% of factors that impact health are non-clinical



County health rankings model ©2014 UWPHI

Source: "The Relative Contribution of Multiple Determinants to Health Outcomes", Laura McGovern et al., Health Affairs, Health Policy Brief, 2014

POPULATION HEALTH INSTITUTE
Translating Research for Policy and Practice

Publication: Different Perspectives for assigning weights to determinants of health.

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Whole Person Care (WPC)

Overarching goals

- Coordination of health, behavioral health, and social services
- Comprehensive coordinated care for the beneficiary resulting in better health outcomes

24 pilots selected through competitive process (two application rounds)

$1.5 billion total federal funds over five (5) years

Required partners:

- Medi-Cal managed care health plan
- Health services agency
- Specialty mental health agency
- Public agency
- Community partners

Partners work together to:

- Identify target population (common high utilizers)
- Share data
- Coordinate care in real time
- Evaluate individual and population progress

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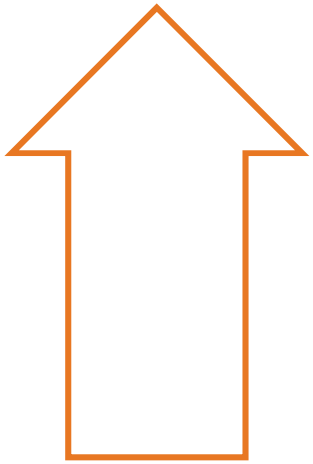
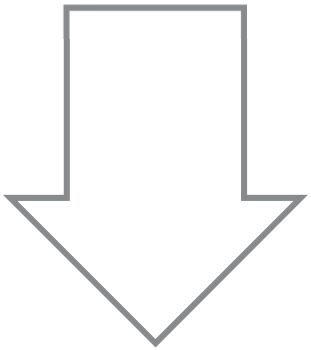
Goals and strategies



- Integration and coordination among county agencies, health plans, and community partners
- Health outcomes for the WPC population

- Data sharing among local partners
- Access to housing and supportive services
- Infrastructure that will ensure local collaboration over the long term

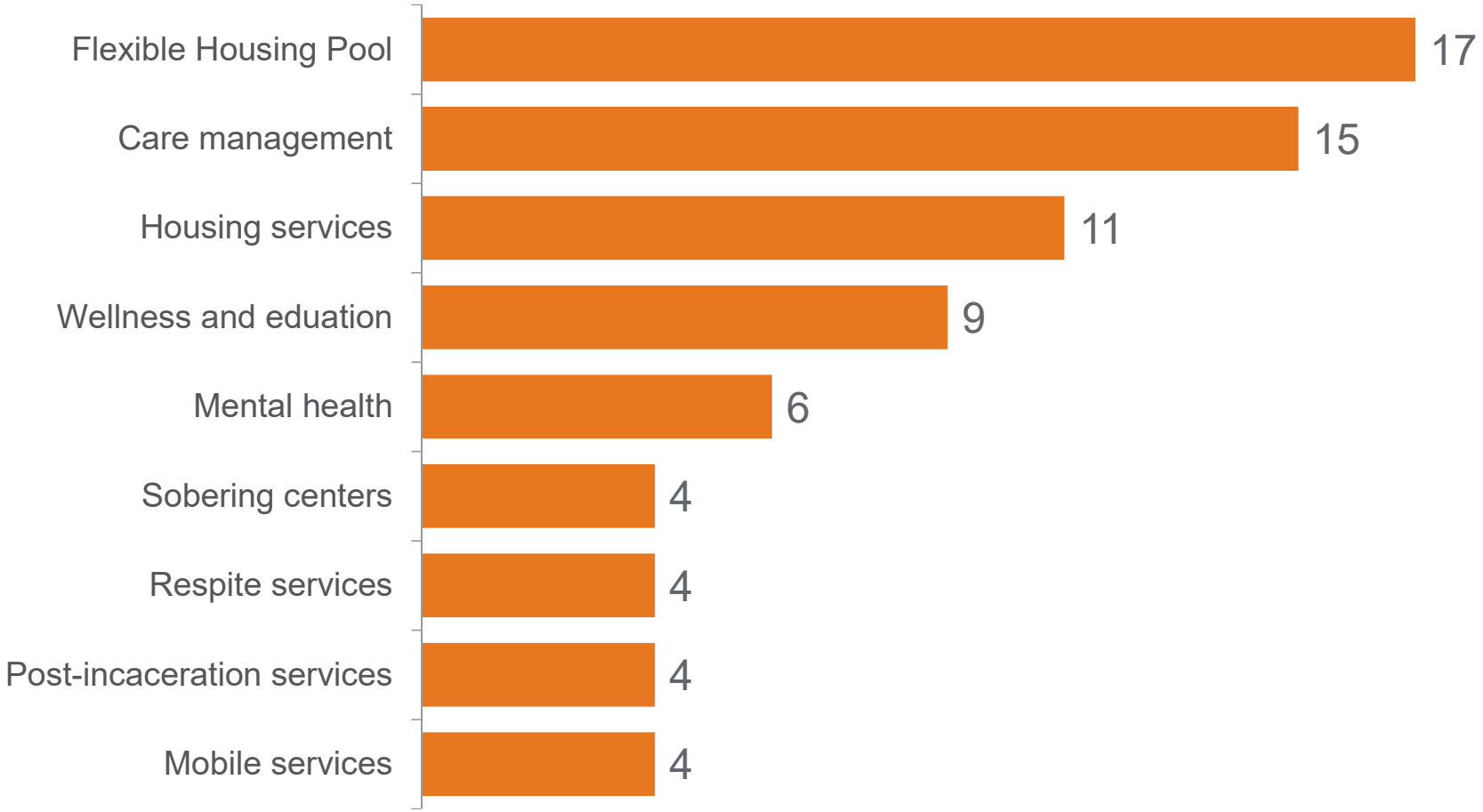


Inappropriate emergency department and inpatient utilization

Statewide target population

Criteria	# of pilots
High utilizers with repeated incidents of avoidable ED use, hospital admissions or nursing facility placement	15
High utilizers with two or more chronic conditions	3
Individuals with mental health and/or substance use disorder conditions	8
Individuals who are homeless/at-risk for homelessness	14
Individuals recently released from institutions (i.e., hospital, county jail, IMD, skilled nursing facility)	7

Statewide services and interventions



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High Users of Multiple Systems (HUMS)

- Engages in multiple systems (medical, mental health, substance abuse) = fractured care
- Relies on urgent/emergent services — ED, PES, inpatient, urgent care, mobile crisis, ambulance
- Is less visible because not usually highest user of a single system
- Suffers from multiple disorders (serious medical, psych, addiction)
- History of poor medication adherence
- Bears a higher burden of chronic diseases and premature death rates
- Is often homeless (shelter-seeking) and difficult to engage

Listening session methods

Quantitative

Population: Medi-Cal patients ages 18−64, no dementia, HUMS score of 9+ in 2016

Data source: HealthLink and VHP claims

Qualitative (listening sessions)

45 listening sessions (39 SCC, 6 external), 99 participants

Inclusion criteria: programs or clinics serving HUMS or other patients with complex needs

Program identification: existing inventory, referral

Literature review

Peer-reviewed and gray literature on care/case management programs and high utilization

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Point system for HUMS

The point system evaluates the number of clinical events for each patient and assigns a number of points for each event

EVENT TYPE (NUMBER OF POINTS)	EXAMPLE	POINTS
1. Inpatient stay (1 point/day)	5 day stay in defined timeframe	5
2. ED admission (3 points/event)	1 ED event in defined timeframe	3
3. Emergency Psych Admission [EPS] (3 points/event)	1 EPS event in defined timeframe	3
4. Acute psych care facility (BAP) (1 point/day)	2 day stay at BAP in a defined timeframe	2
5. Urgent/express care (1 point per event)	5 urgent care events in a defined timeframe	5
		16

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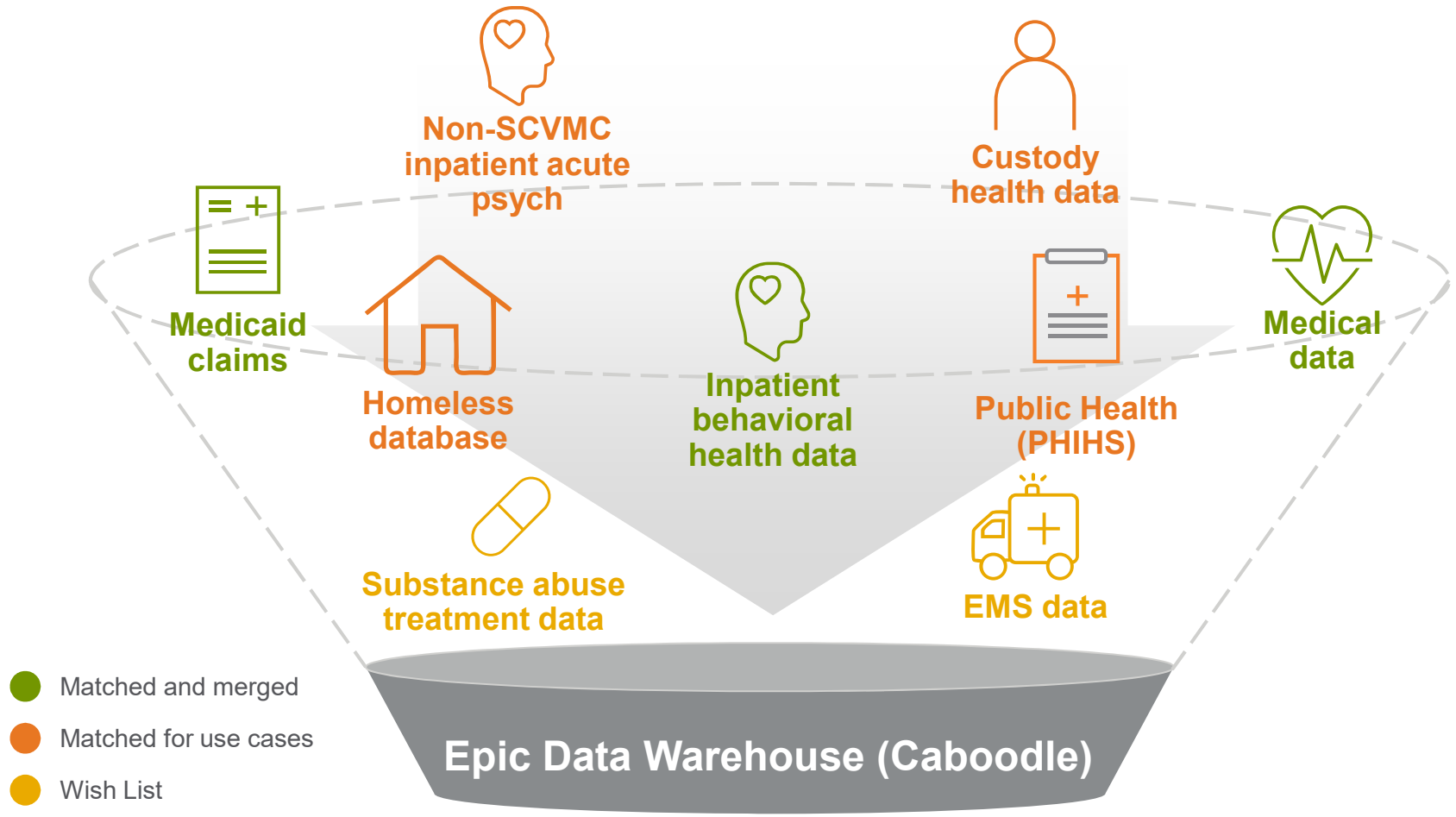
Data aggregation in Epic data warehouse



Lessons learned

- Lack of Social Determinants of Health (SDOH) Integration - Data exchange infrastructure investments industrywide have focused more on clinical data than mental health, social and behavioral data
- Completion of Data Use Agreements (DUA) - Tipping point for confidence to connect to the Trust Exchange was the completion of DUA's which required considerable investment and lift by the Lead Entity (LE)
- Silver bullet "*products*" don't exist – Control by the LE over strategy related to connectivity, aggregation of data and Business Intelligence (BI) allowed success
- Crawl, Walk, Run – Baseline not only your patient population, but also your operations and evaluate how to engage the patient population meaningfully with the data and operational models you have
- Streamline engagement with partners

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DESIGN PRINCIPLES FOR WPC CONCEPTUAL MODEL

A number of design principles were used to develop the Whole Person Care Conceptual Model and are anchored in the state's objectives and the system's unique capabilities; in sum, these principles drive the model toward the desired outcomes

DESIGN PRINCIPLES

Drive consumer centricity through single point of contact and deep patient insights, addressing cultural and linguistic needs

Use of multi-disciplinary, integrated care team

Engaged **clinical and admin NGM6 leadership** to align enterprise and drive delivery excellence

Engagement of extended care team, including family, caregivers, and social support

Use of multi-channel reach, finding patients where they are, across the continuum

Develop sustainable model that achieves outcomes to allow program to exist beyond funding

Integrate and align with programs, services and the care delivery network

Data-driven and collaborate innovation and performance management

Integrated Care Center to house integrated team and enabling technology

DESIRED OUTCOMES

- Total cost of care
- Utilization
- Quality
- Patient experience
- Provider effectiveness
- Compliance

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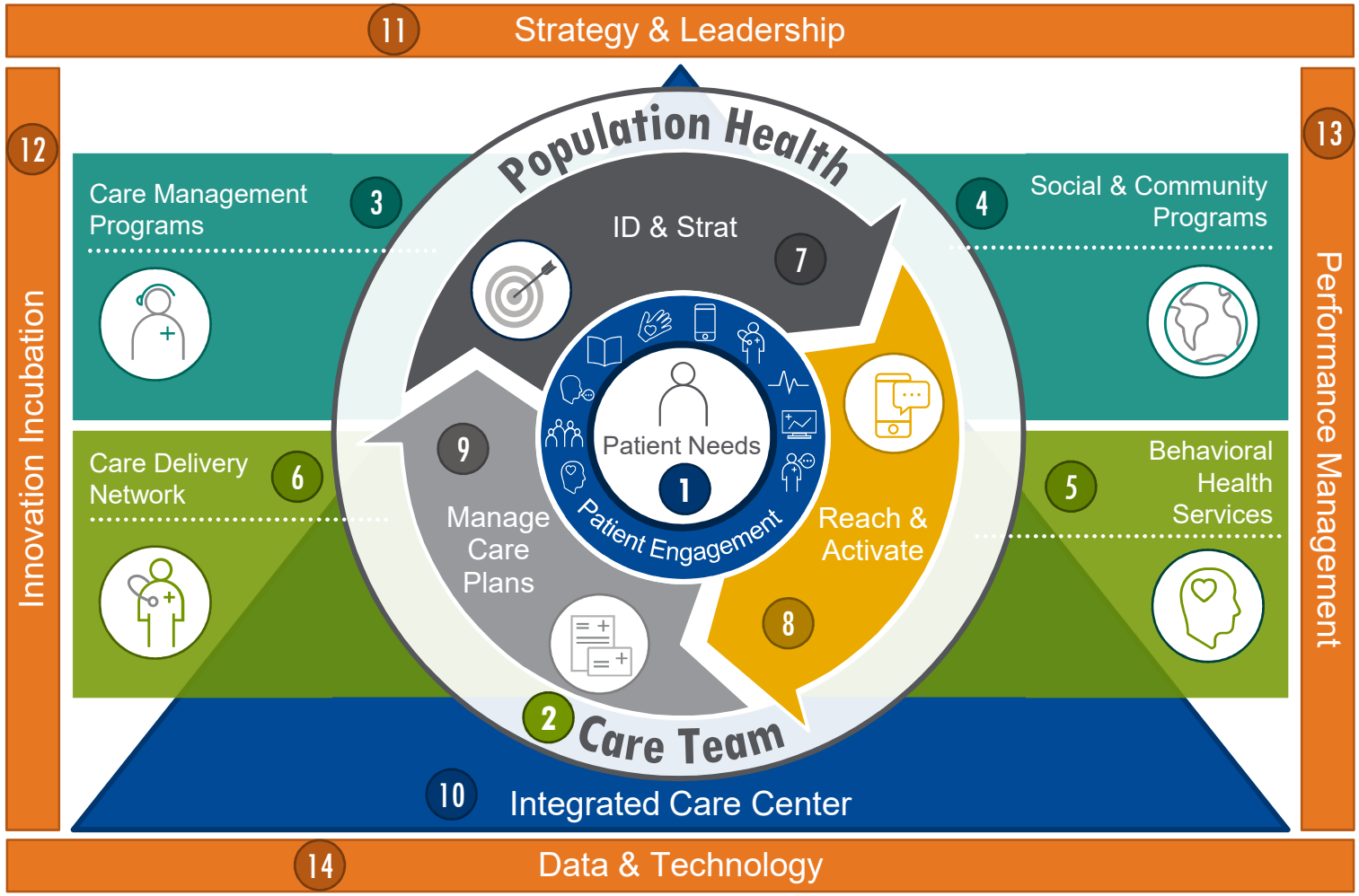
Slide 20

NGM6 check the bold statement for consistency in red as the other highlighted areas
Niles, Gisselle M, 3/8/2018

WHOLE PERSON CARE CONCEPTUAL MODEL

The Whole Person Care Model has a number of key components that, with effective management and execution, will enable success of the program



PATIENT NEEDS

1

The medical, behavioral, and social needs of the population are diverse and complex; understanding each patient's unique needs is critical to effective engagement

Medical

Frequent contact with care partner
Prevention and wellness
Coordination of services
Timeliness of care
Complexity of care
Access to care
Pharmacy

Behavioral

Frequent contact with care partner
Mental illness management
Stigmatized by diagnoses
Substance use treatment
Inappropriate use of ER
Access to care
Disability care
Pharmacy

Social

Family
Homeless support
Unstable housing
Food assistance
Transportation

Lack of trust
Medicaid churn
Assistive devices
Access to care
Financial/legal

Poverty and disenfranchisement
Coordination of services

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POPULATION HEALTH CARE TEAM

Build a strong, resourceful and well-coordinated interdisciplinary team acting as a trusted patient advocate to focus on delivering integrated, multidimensional care and services in traditional and non-traditional settings

Case Manager

Single point of contact to lead complex care management. Acts as the "quarterback" to develop personalized care plans with all care stakeholders.

Care Partner

Collaborates with Case Manager to help patient navigate non-clinical care and support. Culturally and regionally similar to patient. Primarily a community-based resource.

Complex Case Management ***Transition Management*** ***Condition Management*** ***Care Coordination***

ICC

Care Delivery

Multidisciplinary Integrated Care Team. Coordinates with Case Manager.

Behavioral	**Medical**
Psychiatrist	PCP
Psychologist	Specialist Provider
	Long-term Care

Extended Support

Family, Caregiver, and Social Support

Family / Friends / Caregiver
Community / Social
Home Aides
Translators

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CARE MANAGEMENT PROGRAMS

The Population Health Care Team will integrate with core programs and services to collaborate across service providers to effectively and efficiently administer the patient's care plan

Care Management

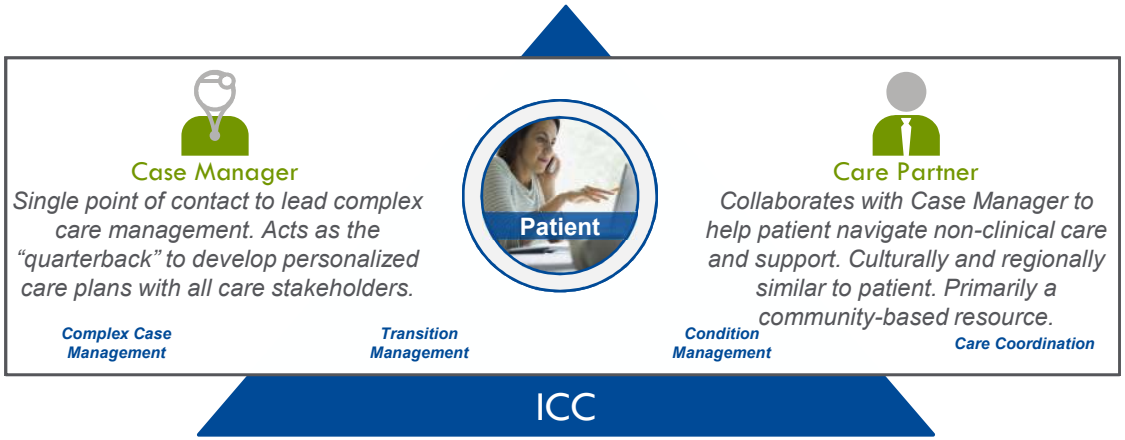
VHP CCM / DM Programs
PRIME
VHHP (Inc. Backpack Program)

Specialty Case Management

Ryan White HIV/AIDS Program
Positive Connections (HIV+)
Community Living Connection (IOA)
Nursing Home Transition and Diversion Program (IOA)
Tuberculosis Case Management (Public Health)

Behavioral Health

BH Care Management
Full Service Partnership
CCTP (Care Coordination and Transitions Program)



Utilization Management

Prior Authorization
Referral Management
Concurrent Review
Discharge Planning

Patient-Centered Medical Home Integration

Physician-Led Programs

Wellness

Preventive
Nutrition
PRIME

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SOCIAL AND COMMUNITY PROGRAMS

The Population Health Care Team will address social determinants of health by collaborating with social and community programs

Food

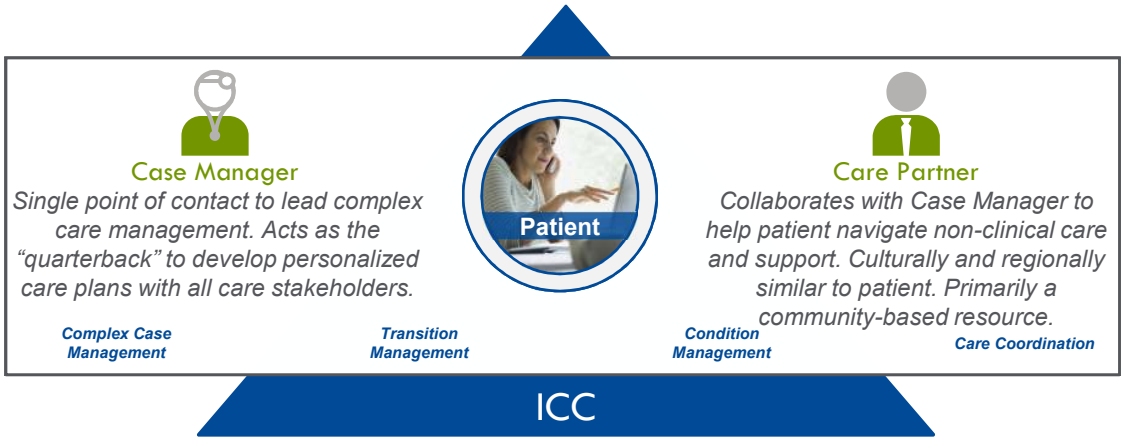
Emergency food assistance
Food banks
Healthy options

Housing

Temporary Housing
Permanent Housing
Care Coordination Project (includes New Directions)

Transportation

Non-emergent medical
Non-medical



Assisted /Supportive Living

Medical Respite
Board and Care Facilities
Custodial Placement

Other Social Support

Legal and Financial Services
Eligibility and Benefits
Advocacy

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BEHAVIORAL HEALTH SERVICES

The Population Health Care Team will integrate behavioral health services along with clinical and social programs to address the significant needs of the target population

Substance Use Services

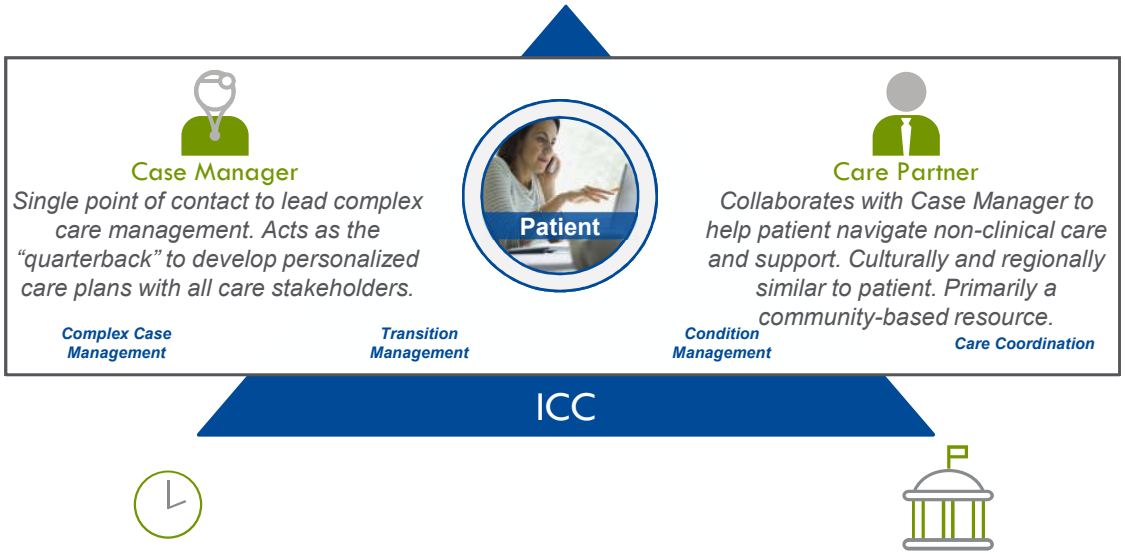
Mobile Treatment
Substance Use Treatment Services (SUTS)
Vivitrol Program
Sobering Station

Medical / Behavioral Integration

Integrated Care Delivery

Specialty Facilities

Medical Respite
Post-Acute Skilled Care / Placement
Nursing Home Placement



Psychiatric Day Services

Structured Daytime Activates

Custody Services

Integrated Services for Mentally Ill Parolees
Offender Treatment Program

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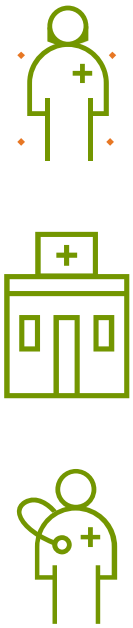
CARE DELIVERY NETWORK

There are a number of key elements that are required to enable and align the care delivery network with WPC

Care delivery providers

- BH providers
- CHP clinics
- Custody health
- Partner hospitals
- Valley Medical Center
- Valley Medical Center ambulatory care
- Other contractors



Key elements

Network strategy

- Adequacy◆
- Growth
- Partnerships◆
- Value-based care

Contracting

- Incentives◆
- Terms◆
- Legal support

Operations

- Credentials
- Data management
- Payment◆

Enablement

- Community/engagement
- Integration◆
- Tools◆

Measurement and analytics

- Growth
- Provider performance◆

◆ Higher Priority Elements

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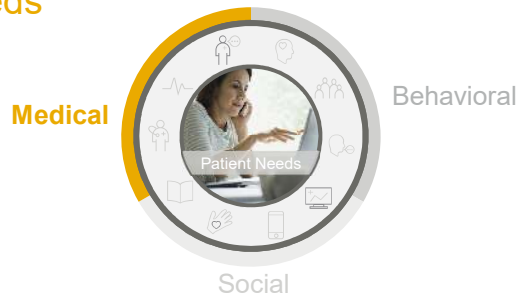
IDENTIFICATION & STRATIFICATION

Guided by the enterprise's strategic goals, identify and stratify patients, using a robust set of data and analytic methods, and incorporated into operational workflows

Business strategy/goals

- Total cost of care
- Utilization
- Compliance
- Quality
- Patient experience
- Provider effectiveness

Patient needs



Data types		Data enrichments	Model inputs	Rules prioritization	Ops integration
Typical	**WPC/social**				
• Behavioral◆ • Claims • Clinical◆ • CM/DM/UM activity◆ • Consumer • Demographics • HRA◆ • Labs◆ • Medical◆ • Membership • Rx◆	• Custody data • Eviction records • Homeless shelter staff surveys◆ • Homeless shelter status◆ • OSH data◆ • Probation records • Social services data◆	• Gap weights • Gaps in care◆ • Episode groupers◆ • Predictive models◆ • Provider performance measures◆ • Service indicators/ flags◆	• Conditions • Consumer attributes • Gaps in care –Clinical/HEDIS –HCC/risk –Network (OON/efficiency) • Risk (cost/utilization) • Social determinants • Social isolation –Patient preferences –Program participation	• Customer goals • Feedback loop from analytics◆ • Modalities • Programs hierarchy◆ • Regulatory◆ • Suppression logic◆ • Timing of value • Volume	

◆Higher Priority Elements

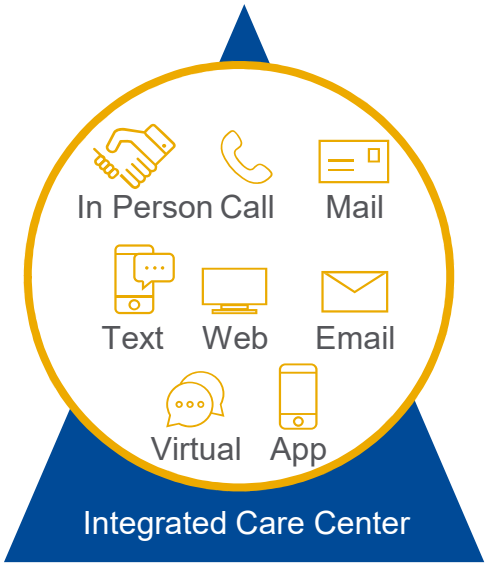
REACH & ACTIVATE

Employ multichannel capabilities to reach the most vulnerable individuals and engage them in a standardized assessment process geared to develop a plan addressing their goals across continuum of care

"Meet the Patient Where They Are" across the Care Continuum

ED | Inpatient | Urgent Care | LTAC/ Rehab/SNF | Home | Community Partners | PCP | Specialist | Custody Health | FQHCs | Homeless Shelters

Multi-Channel Reach



Activate

Via motivational interviewing and active listening

- Standard WPC Assessments (Needs & Risk Assessment)
- Patient Goals
- Multi-Disciplinary Care Plan Collaboration

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MANAGE CARE PLANS

The WPC future state model will develop one individualized care plan for each life that holistically addresses the patient's needs

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Two pilot projects

Gardner Health Services (GHS)

- Study population
  - 570 HUMS dual eligible patients assigned by Valley Health Plan (VHP)
  - 87 with at least one ED visit at San Jose Regional past year
- Study period – 8 months
- Goal – Reduce ED visits
- Interventions – Engage, enroll and provide care coordination services
- Methodology – Iterative Plan-Do-Study-Act (PDSA) cycles

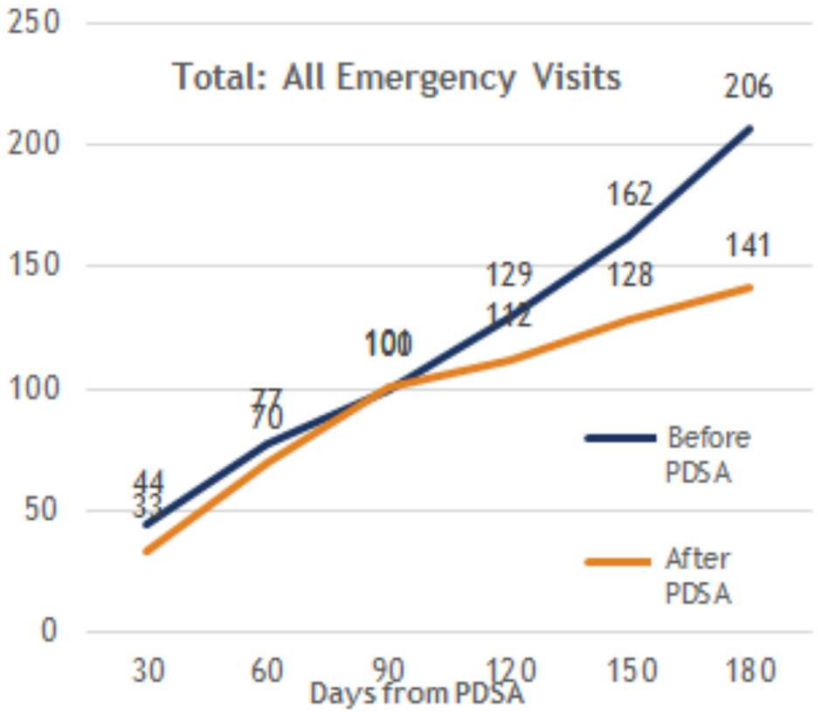
Roots Clinic

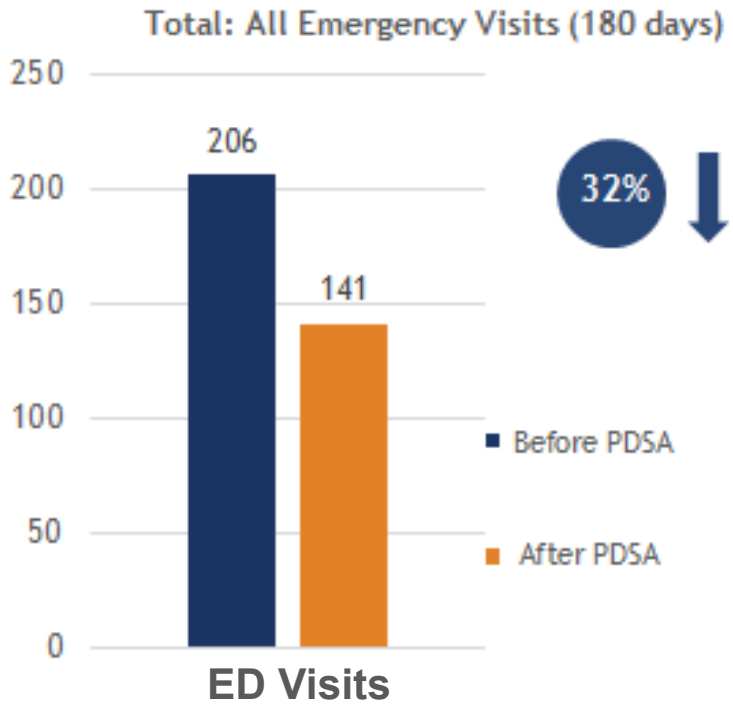
- 183 HUMS dual eligible patients assigned by VHP

WPC Case Study - Roots Clinic

- 60 year old AA woman walked into clinic Oct 2017
- Major depressive disorder on SSRI and TCA, 2+ chronic medical conditions, at risk for homelessness
- Received 10 medical and behavioral health visits, 14 F2F meetings w peer navigators, medical record review, case conference re care plan
- Re-diagnosed – Mania associated with depression, complicated by side effects of chronic medication management
- Referrals – carotid US, neuro-psych testing, DME (cane), DDS, local CBOs for housing counselling, legal aid, and emergency assistance
- Update – living situation stable, ongoing mental health services, no longer visits ED

Gardner Health Services pilot





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Challenges

Engaging the homeless population

Housing shortage in Santa Clara County

Immediate availability of mental health resources

PCP availability (appointments are scheduled months in advance)

Transportation resources needed

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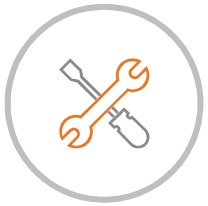
Current state of implementation



- First two years of WPC focused largely on building communication infrastructure especially between the hospital and the FQHCs.

- County is now beginning to test more innovative strategies to enroll, engage, and treat patients following a similar model of “whatever it takes.”

- Electronic tools such as Epic Healthy Planet, Epic risk scoring / outreach, and Johns Hopkins ACG will help better identify patients combined with provider referral.

Integrated Care Coordination across the continuum

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Key lessons

- WPC may be analogous to outpatient intensive care
- Texting, calls, letters may not be enough – highest yield with Face-to-face enrollment
- Many attempts to initially engage patients may be needed
- Electronic case management not enough
- Patients may be more motivated during acute event
- Individual patient complexity probably requires weekly multi-disciplinary case conferences
- Need “step-down” and “step back up” services for high acuity HUMS
- Retrospective utilization score are just the beginning
- Field-based staff vital to locate and engage patients
- Need more temporary and permanent housing options

Thank you.

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