Managing Complex Care for High-Risk/High-Cost Populations

Cindy Hupke, BSN, MBA
Director, IHI
Background

- There are many ways to define the high risk high cost patients. For the sake of discussion we will focus on the US population and what we know about the patients who spend 50% of the money but generally represent 5%-10% of the population.
- What do we know about this population?
Percent of Total Health Care Expenses Incurred by Different Percentiles of U.S. Population: 2002

Sources: Statistical Brief #73. March 2005. Agency for Healthcare Research and Quality
## Persistence in Table Form

<table>
<thead>
<tr>
<th></th>
<th>Total Spent ($)</th>
<th>Share of Total Spending</th>
<th>Average Per Capita ($)</th>
<th>Number of people</th>
<th>Persistence in Spending Level (2008-2009)</th>
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<td>Bottom 50%</td>
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<td>236</td>
<td>150,000,000</td>
<td>73.9%</td>
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</table>
Interventions
Enhanced Primary Care Support Systems for HR/HC Patients

- A high cost intensive model that is supported by nurse care management (among other resources) along with primary care that often limits their work to a relatively small panel of patients. (Ambulatory ICU)

- A model that primarily focuses on the redesign and retraining of the primary care team. (Southcentral Foundation)

- A model that enhances really good primary care with a new skillset – non-traditional health care workers that take their assistance into the community for HR/HC patients. (CareOregon)
Elements of the Care System

1. Non-traditional Health Care Workers
2. Case Managers who are often RN’s
3. Pharmacy Support
4. Data at three levels: strategic, mezzanine, frontline
5. Primary Care
6. Behavioral Health
7. Community and Social Service resources
8. Integration of the support team
9. The family and individuals role in this work
Change Ideas

ASSESS AND SEGMENT THE POPULATION
- Identify high-risk/high-cost patients using a variety of methods
- Understand cost drivers within segments
- Assess patient resources and capabilities and their socially-determined risk

ENGAGE AND ACTIVATE THE POPULATION
- Understand patient goals and preferences
- Understand system barriers from patient perspective
- Co-create holistic approaches that impact peoples’ health

CARE FOR THE POPULATION
- Identify patient “archetypes” and design care platforms that encompass multi-sector partners
- Move care as close to the patient as possible
- Involve non-traditional health care workforce

ESTABLISH a CROSS-COMMUNITY SYSTEM of CARE:
- Invest (develop payment mechanisms) in social determinants of health
- Build coalitions including patients and families to identify and advocate for policies that support the needs of this population
### 1. Assess and Segment

#### Assess and Segment the Population

<table>
<thead>
<tr>
<th>Change Concept</th>
<th>Ideas To Try</th>
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</table>
| 1. Identify high-risk/high-cost patients using a variety of methods | - Define what “high risk/high cost” means for your system and your environment.  
- Develop a logical method for identifying a target population of high-risk/high-cost patients.  
Potential inputs to this method could include:  
  o Claims and/or utilization data (retrospective information)  
  o Real-time event notifications, e.g. hospital alerts of ED and admissions  
  o Exclusion of patients with short term acute episodes, e.g. obstetrical, traumatic injury  
  o Information such as diagnoses, mental health services, mix of services provided  
  o *Note: Predictive modeling methods may have a limited role in identifying high-cost populations at the level of specificity needed.* |
| 2. Understand cost drivers within segments | - Understand the root cause of the cost drivers within your high risk/high cost population  
  o Review high risk/high cost patients in a single clinic or site to understand utilization patterns  
  o Choose a small number 5-15 patients to examine more deeply including home visit or other interview  
  o Bring multi-disciplinary providers together to provide multiple perspectives on root causes of small number of patients.  
  o Interview frequent emergency department users:  
    - When did you first notice you were having a problem?  
    - When did you realize you might need medical assistance?  
    - When did you decide you needed to go to the ED?  
- Describe broad “types” of high risk/high utilization  
- Do routine, ongoing review of the most challenging patients with multi-disciplinary team |
| 3. Assess patient resources and capabilities and their socially-determined risk factors | - At time of encounter, include key questions such as home stability, psychological triggers, trauma, etc.  
- At time of encounter use HARMS-8 or Outcomes Star (developed in UK for homeless population) tools to develop a multi-factorial view of patient risk. |
Overall Approach: High-Risk, High-Cost Populations
Guiding Principles

1. Identification of individuals at high risk for future cost
2. Impactability of the identified individuals
3. Cost effectiveness of your intervention or redesign – have to understand the cost drivers in your population/region
4. Potential interventions or redesign – what we are currently doing isn’t working, so how can we change it?
4 Step Process for High Risk Patients

Based on our change package and our experience working with teams to re-design care for HR/HC patients we have developed the following 4 step process:

- Step One: Identify (segment) Your High Risk population.
- Step Two: Understand Needs and Root Causes. How do you delve into peoples’ stories’?
- Step Three: Co-create and Execute a Care plan with 5 People. What did you learn about their capabilities?
- Step Four: Scale to 25
Step One: Identify/Segment Your High Risk population

- Threshold approach
- Clinical knowledge
- Predictive modeling
## HR/HC Threshold Criteria

**Approach = Who has high cost utilization now?**
**Primary ID Method = Current Claims Experience + Primary Care Assignment**

### Multnomah County Health Department-NE Clinic Population

<table>
<thead>
<tr>
<th>Population Segment</th>
<th># Members</th>
<th>% Members</th>
<th>Avg Total Paid Cost per Member/12 mos</th>
<th>% Paid Cost of Segment/12 mos</th>
<th># ED visits</th>
<th># IP Admits</th>
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<tbody>
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<td>81</td>
<td>3%</td>
<td>$8743</td>
<td>5%</td>
<td>786</td>
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<td>1 Non-OB inpatient and 0-5 ED visits</td>
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<td>14%</td>
<td>147</td>
<td>97</td>
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<td>3%</td>
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<td>189</td>
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<td>Output</td>
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<tr>
<td>Health Dialog</td>
<td>PARR algorithm</td>
<td>• Patient demographics • Inpatient data • Hospital utilization</td>
<td>Risk score on a scale of 0 to 1.0</td>
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<tr>
<td></td>
<td>PARR1, PARR2, PARR++</td>
<td>• Primary Diagnosis • Secondary Diagnoses (up to 5) • Diagnostic Cost Groups-</td>
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<td>Hierarchical Condition Category (DCG-HCC)</td>
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<tr>
<td></td>
<td></td>
<td>• Community characteristics • Data on hospital of current admission</td>
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<tr>
<td>Health Dialog</td>
<td>Combined Predictive Model</td>
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<tr>
<td></td>
<td></td>
<td>• General Practitioner • Community characteristics</td>
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</tr>
<tr>
<td>Johns Hopkins</td>
<td>Adjusted Clinical Groups (ACG) Case Mix</td>
<td>• Age • Gender • Diagnostic (ICD) only • Pharmacy (NDC) only • ICD + NDC</td>
<td>Risk score on a scale of 0 to 1.0</td>
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<tr>
<td></td>
<td>System</td>
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</tbody>
</table>
Relying on Providers’ Clinical Intuition

Providers/Care Teams as predictive models:

- Who is on a steady health decline trajectory?
- Who, without more intensive assistance NOW, is going end up in the ED or the hospital?
- Who keeps you up at night?
- For whom do you need some extra intel? Eyes and ears in the home?
Step #1 Identify Your HR/HC Population

Chat in

- What population did you decide on as your high risk/high cost segment?
- How did you choose them: threshold, clinical, risk prediction or other? What criteria are you using?
- Why are you focused on this population?
4 Step Process

- Step One: Identify Your High Risk population.
- Step Two: Understand Needs and Root Causes. How do you delve into peoples’ stories’?
- Step Three: Co-create and Execute a Care plan with 5 People. What did you learn about their capabilities?
- Step Four: Scale to 25
Step Two: Understand Needs and Root Causes

- Using data systems
- Using clinic personnel
- Using patient interviews
- Using third party data to understand personal behavioral and economic issues
- Consider GIS mapping
Understanding Root Causes for Risk and Cost

Root Cause

Data

Care Team

Patient
Understanding Hospital Admissions

CareOregon Non-Dual Hospital Admissions - Total Paid by Type

- $33,425,473 Admissions thru the ED
- $36,926,106 OB-related Admissions
- $37,018,675 Elective Admissions

Potentially Avoidable
## Effect of Substance Use and Mental Illness on Cost/Utilization

Average 12 mos TOTAL cost, ED and Hosp utilization by group

### Adults with Diabetes

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<thead>
<tr>
<th>Condition</th>
<th>Cost</th>
<th>ED Visits</th>
<th>IP Stays</th>
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</thead>
<tbody>
<tr>
<td>DM and Substance Use</td>
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<td>DM w/o Substance Use</td>
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<td>.39</td>
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### Adults with CHF

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<th>Cost</th>
<th>ED Visits</th>
<th>IP Stays</th>
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</thead>
<tbody>
<tr>
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<td>CHF w/o Complex Mental Health</td>
<td>$27,302</td>
<td>1.6</td>
<td>1.4</td>
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</table>
Understanding Root Causes for Risk and Cost

Root Cause Data

Care Team

Patient
Understanding the Root Causes: Ask the Care Team

Count of Qualitative Themes from PCP Notes

PCP's were asked: What is driving this patient's non-Primary Care utilization?
Understanding Root Causes for Risk and Cost
Understanding Root Causes: Ask the Patients

15 Case Review Method

1. Identify 15 patients that meet your high risk – high cost criteria
2. Use a semi-structured set of questions to gain insight into patient perspectives
3. Identify similarities, differences, and common themes
4. Come together as a design team/leadership team to discuss what was learned
5. Build next steps based on what you learn

“Act for the Individual to LEARN for the population”
Add the Patient Voice

Harms-8

1) In general, how would you rate your current health?
   - Excellent
   - Very Good
   - Fair
   - Poor

2) How many prescription medications are you currently taking every day?
   - None (SKIP to question 3)
   - 1 - 2
   - 3 - 4
   - 5 or more

2_a) During the past WEEK, how often did you forget to take or decide not to take one or more of these medications?
   - Never
   - Sometimes
   - Usually
   - Always

2_b) How sure are you that you understand the reason you are taking each of these medications?
   - Very sure
   - Somewhat sure
   - Not very sure

3) Think about your usual daily activities, such as bathing, toileting, dressing, grooming, feeding, housework, family or leisure activities. Which of the following best describes your situation in the last MONTH:
   - I have no problems with performing my usual activities.
   - I have some problems with performing my usual activities without assistance.
   - I am unable to perform my usual activities without assistance.

4) In the last MONTH, how often did you have trouble with remembering or thinking clearly?
   - Never
   - Sometimes
   - Usually
   - Always

5) If you needed immediate help for a health problem, how many friends or relatives do you feel close to such that you could call on them for help?
   - None
   - 1
   - 2
   - 3 or 4
   - 5 or more

5_a) Who are they?
   Enter comments here:

5_b) How often do you communicate with them?
   Enter comments here:
Examples of understanding cost drivers and system/patient barriers

- Using the HARMS-8 (modified) Chinle identified knowledge deficits, medication refill barriers, and lack of home health assistance as cost drivers.
- CareOregon identified cognitive deficits, substance use, and unstable mental health conditions as cost drivers.
What Did We Learn About Root Causes?

- High prevalence of childhood and life trauma (relevance of the ACE study); often translates into distrust of health care providers

- Most clients have had an overwhelmingly negative experience with the healthcare system; most clients primarily identify as ill and as a patient

- Prevalence of SA and mental health conditions; mild cognitive deficits common

- Lack of timely access to psychiatric assessment and mental health respite services

- Care coordination needs extensive (particularly between sites of care)

- Many can’t afford or do not have access to non-medical items or services critical to optimal health and self management (i.e. transportation, stable housing, healthy food, medications, place to exercise, etc)
Mental Health Issues
Resource on Behavioral Health Integration
5 Levels of Integration

- **Level 1 – Minimal Collaboration:** Mental health and other healthcare providers work in separate facilities, have separate systems, and rarely communicate about cases.

- **Level 2 – Basic Collaboration at a Distance:** Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. Providers view each other as resources.

- **Level 3 – Basic Collaboration Onsite:** Mental health and other healthcare professionals have separate systems, but share facilities. Proximity supports at least occasional face-to-face meetings and communication improves and is more regular.

- **Level 4 – Close Collaboration in a Partly Integrated System:** Mental health and other healthcare providers share the same sites and have some systems in common such as scheduling or charting. There are regular face-to-face interactions among primary care and behavioral health providers, coordinated treatment plans for difficult patients, and a basic understanding of each other’s roles and cultures.

- **Level 5 – Close Collaboration in a Fully Integrated System:** Mental health and other healthcare professionals share the same sites, vision, and systems. All providers are on the same team and have developed an in-depth understanding of each other’s roles and areas of expertise.

Evolution and New Version

- Three main categories: coordination, co-location, integration
- Six levels of collaboration/integration
- Helps evaluate your current level and determine what next steps are needed to enhance the integration initiatives.
Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
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<tbody>
<tr>
<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
<td>KEY ELEMENT: PRACTICE CHANGE</td>
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<tr>
<td>LEVEL 1 Minimal Collaboration</td>
<td>LEVEL 3 Close Collaboration Onsite</td>
<td>LEVEL 5 Close Collaboration Approaching an Integrated Practice</td>
</tr>
<tr>
<td>LEVEL 2 Basic Collaboration at a Distance</td>
<td>LEVEL 4 Close Collaboration Onsite with Some System Integration</td>
<td>LEVEL 6 Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>

Behavioral health, primary care and other healthcare providers work:

- In separate facilities, where they:
  - Have separate systems
  - Communicate about cases only rarely and under compelling circumstances
  - Communicate, driven by provider need
  - May never meet in person
  - Have limited understanding of each other’s roles

- In separate facilities, where they:
  - Have separate systems
  - Communicate periodically about shared patients
  - Communicate, driven by specific patient issues
  - May meet as part of larger community
  - Appreciate each other’s roles as resources

- In same facility not necessarily same offices, where they:
  - Have separate systems
  - Communicate regularly about shared patients, by phone or e-mail
  - Collaborate, driven by need for each other’s services and more reliable referral
  - Meet occasionally to discuss cases due to close proximity
  - Feel part of a larger yet ill-defined team

- In same facility, where they:
  - Share some systems, like scheduling or medical records
  - Communicate in person as needed
  - Collaborate, driven by need for consultation and coordinated plans for difficult patients
  - Have regular face-to-face interactions about some patients
  - Have a basic understanding of roles and culture

- In same space within the same facility (some shared space), where they:
  - Actively seek system solutions together or develop work-a-rounds
  - Communicate frequently in person
  - Collaborate, driven by desire to be a member of the care team
  - Have regular team meetings to discuss overall patient care and specific patient issues
  - Have an in-depth understanding of roles and culture

- In same space within the same facility, sharing all practice space, where they:
  - Have resolved most or all system issues, functioning as one integrated system
  - Communicate consistently at the system, team and individual levels
  - Collaborate, driven by shared concept of team care
  - Have formal and informal meetings to support integrated model of care
  - Have roles and cultures that blur or blend

Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
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<tbody>
<tr>
<td>LEVEL 1</td>
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</tr>
</tbody>
</table>

**Key Differentiator: Clinical Delivery**

- LEVEL 1: Screening and assessment done according to separate practice models.
  - Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges.
  - Separate treatment plans.
  - Evidenced-based practices (EBP) implemented separately.
- LEVEL 2: May agree on a specific screening or other criteria for more effective in-house referral.
  - May agree on a specific screening, based on ability to respond to results.
  - Collaborative treatment planning for all shared patients.
- LEVEL 3: Some shared knowledge of each other’s EBPs, especially for high utilizers.
  - Some shared knowledge of each other’s EBPs, especially for high utilizers.
  - Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place.
- LEVEL 4: Consistent set of agreed upon screenings across disciplines, which guide treatment interventions.
  - Collaborative treatment planning for all shared patients.
  - EBPs shared across system with some joint monitoring of health conditions for some patients.
- LEVEL 5: One treatment plan for all patients.
  - EBPs are team selected, trained and implemented across disciplines as standard practice.
- LEVEL 6: Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place.

**Key Differentiator: Patient Experience**

- LEVEL 1: Patient physical and behavioral health needs are treated as separate issues.
  - Patient health needs are treated separately, but records are shared, promoting better provider knowledge.
  - Patients may be referred, but a variety of barriers prevent many patients from accessing care.
  - Patients experience a seamless response to all healthcare needs as they present, in a unified practice.
- LEVEL 2: Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider.
  - Close proximity allows warm hand-offs to other treatment providers.
  - Care is responsive to identified patient needs by a team of providers as needed, which feels like a one-stop shop.
- LEVEL 3: Patient needs are treated separately at the same site. Collaboration might include warm hand-offs to other treatment providers.
  - Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others.
- LEVEL 4: Patient needs are treated separately at the same site. Collaboration might include warm hand-offs to other treatment providers.
  - Care is responsive to identified patient needs by a team of providers as needed, which feels like a one-stop shop.
- LEVEL 5: Patient needs are treated for all patients by a team, who function effectively together.
  - Patients experience a seamless response to all healthcare needs as they present, in a unified practice.
- LEVEL 6: Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place.
  - One treatment plan for all patients.
  - EBPs are team selected, trained and implemented across disciplines as standard practice.
### Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

<table>
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<tbody>
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#### Key Differentiator: Practice/Organization
- No coordination or management of collaborative efforts
- Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow
- Some practice leadership in more systematic information sharing
- Some provider buy-in collaboration and value placed on having needed information
- Organization leaders supportive but often colocation is viewed as a project or program
- Provider buy-in to making referrals work and appreciation of onsite availability
- Organization leaders support integration through mutual problem-solving of some system barriers
- More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components
- Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced
- Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers
- Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development
- Integrated care and all components embraced by all providers and active involvement in practice change

#### Key Differentiator: Business Model
- Separate funding
- No sharing of resources
- Separate billing practices
- Separate funding
- May share resources for single projects
- Separate billing practices
- Separate funding
- May share facility expenses
- Separate billing practices
- Separate funding, but may share grants
- May share office expenses, staffing costs, or infrastructure
- Separate billing due to system barriers
- Blended funding based on contracts, grants or agreements
- Variety of ways to structure the sharing of all expenses
- Billing function combined or agreed upon process
- Integrated funding, based on multiple sources of revenue
- Resources shared and allocated across whole practice
- Billing maximized for integrated model and single billing structure

<table>
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<th>Physical Proximity</th>
<th>Practice Change</th>
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<tr>
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<td>Basic Collaboration Onsite</td>
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<td><strong>Beginning Integration</strong></td>
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<tr>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
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<tr>
<td><strong>LEVEL 5</strong></td>
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<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
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**Advantages**

- Frequency and Type:
  - Each practice can make timely and autonomous decisions about care.
  - Readily understood as a practice model by patients and providers.

- Physical Proximity:
  - Maintains each practice’s basic operating structure, so change is not a disruptive factor.
  - Provides some coordination and information-sharing that is helpful to both patients and providers.
  - Colocation allows for more direct interaction and communication among professionals to impact patient care.
  - Referrals more successful due to proximity.
  - Opportunity to develop closer professional relationships.

- Practice Change:
  - Removal of some system barriers, like separate records, allows closer collaboration to occur.
  - Both behavioral health and medical providers can become more well-informed about what each can provide.
  - Patients are viewed as shared which facilitates more complete treatment plans.
  - High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans.

**Weaknesses**

- Frequency and Type:
  - Services may overlap, be duplicated or even work against each other.
  - Important aspects of care may not be addressed or take a long time to be diagnosed.

- Physical Proximity:
  - Sharing of information may not be systematic enough to effect overall patient care.
  - No guarantee that information will change plan or strategy of each provider.
  - Proximity may not lead to greater collaboration, limiting value.
  - Effort is required to develop relationships.

- Practice Change:
  - System issues may limit collaboration.
  - Potential for tension and conflicting agendas among providers as practice boundaries loosen.
  - Practice changes may create lack of fit for some established providers.

- Level 1:
  - Opportunity to truly treat whole person.

- Level 5:
  - All or almost all system barriers resolved, allowing providers to practice as high functioning team.

- Level 6:
  - All patient needs addressed as they occur.
  - Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue.
Step 2 With Your Identified High Risk Population:

- Review claims data to see trends and issues
- Talk to care team who are managing high risk patients
- Interview high risk patients
- The goal is to get a better understanding
- This may cause you to segment the population further
4 Step Process

- Step One: Identify Your High Risk population. Who did you reach?
- Step Two: Understand Needs and Root Causes. How did you delve into peoples’ stories’?
- Step Three: Co-create and Execute a Care plan with 5 People What did you learn about their capabilities?
- Step Four: Scale to 25
Step Three: Co-create and Execute a Care plan with 5 People

- Start with what matters to the person
- Include an identified family member or friend in planning discussion if preferred
- Identify the person’s life and health goals together
- Identify the person’s care preferences together
- If the goal is big, start by outlining steps and doing the first step
54 year old man who has had multiple hospital admissions for exacerbations of CHF
Who is D.T.?

- Lives alone in a single room apartment, has daughters and an ex-wife who live in other states. Doesn’t have a lot of social interaction but has two cats that he adores.

- Cardiology NP refers him to our outreach worker upon discharge. NP goal: no 30-day readmission.

- Everywhere in his chart it is written that D.T. is usually belligerent, uncooperative, non-compliant, and verbally abusive.
## Case Study: D.T.

### Resources and Capabilities
- Good Medicaid insurance coverage
- Committed care team with timely, reliable access
- Stable living situation
- State-sponsored caregiver who D.T. trusts

### Socially Determined Risk Factors
- Living in poverty
- Low health literacy
- Demonstrates challenging interpersonal behaviors (from care team perspective)
- Demonstrates inability to effectively advocate for himself
- Demonstrates difficulty with basic planning and problem solving (cognitive impairment?)
Case Study: D.T.

**Patient Goals and Preferences**

- Does not like to be hospitalized or referred to the ED
- Wants to live alone with his cats
- Likes to be able to get out of his apartment and “move around outside”
- Desires privacy and respect from care providers
- Wants to be in touch with daughters more frequently

**System Barriers**

- Care providers do not treat him with respect or offer him privacy
- Has not been able to get an appropriate wheelchair
- Care providers don’t talk to one another
Case Study: D.T.

Plan for D.T.

- With permission, go through D.T.’s cupboards and refrigerator to assess daily diet habits
- Go grocery shopping with D.T. and his caregiver; teach about sodium and fluid related to CHF and connect to his desire to stay out of the hospital
- Role model advocacy with visiting care providers (home health, case worker) by setting up regular visiting times based on D.T.’s preferences; also requiring a phone call prior
- Accompany D.T. to medical appointments to provide care coordination and opportunity to role model “respectful” communication on both sides
- Work with health plan and DME provider to replace wheelchair
- Teach D.T. how to use Facebook to connect with daughters
Next Steps for You

- Choose a High Risk population. Everyone needs to do this if you are going to work on a high risk population.
- Understand Needs and Root Causes of that same population. In the next month you should work on this.
- Step Three: Co-create and Execute a Care plan with 5 People to learn from them. In the next two months you should work with 5 individuals
  - Start with what matters to the person
  - Include an identified family member or friend in planning discussion if preferred
  - Identify the person’s life and health goals together
  - Identify the person’s care preferences together
  - If the goal is big, start by outlining steps and doing the first step
Spread, Scale-Up, and Sustainability
For the Parking Lot.....

- Determine full scale at project setup and the milestones to reach full scale
- You will start with a small target population (5), but should be thinking about full scale at the start of this work.
- Within 3 months, a plan should be developed to create a supportive infrastructure to sustain the changes.
What is Full Scale?

- 850,000 = Medicaid beneficiaries in Oregon (15 Community Care Organizations, largest approximately 160,000 beneficiaries)
  - 5% high risk/high cost = 42,500 (largest CCO = 8,000)
  - top 1% = 8,500 (largest CCO = 1,600)

- Estimating frail older adults in a community of 100,000
  >65yrs of age = 13,000 (100,000 x 13% over 65 years of age)
  # of frail older adults = 650 to 1300 (13,000 x (5 to 10%))
The Key Sustainability Question:

- Who will derive financial benefit if your interventions succeed?
  - From a decrease in medical expenditures for the population served
  - From an increase in efficiency which allows more production and thus revenue
  - From an improvement in quality which is financially incentivized
  - From a decrease in financial withhold related to errors (readmissions)
  - From an increase in revenue related to more services
  - Others?
The Key Sustainability Question – Oregon Example

Who will derive financial benefit if our interventions are successful?

1) **Medicaid health plans** if overall cost decreases due primarily to a reduction in ER and hospital admissions
2) **Hospitals** if Medicare readmissions certain types are reduced
3) **Primary care clinics** if outreach workers create more time for providers to increase panel sizes
4) **Primary care clinics** if interventions improve P4P metrics
5) **Substance abuse providers** if more patients are successfully referred
Sustainability Planning Tips

- The more expensive the intervention the more robust the cost savings must be to create a return on the investment
  - Lay or Peer Community Health Workers versus Behavioral Health Specialists
- Identify what matters most to (potential) funders as early as possible
- Determine the average cost of an ED visit and/or hospital visit for your target population (do this soon) – how many would you need to avoid to pay the salary of any new workforce?
- Always pay attention to throughput, and make sure you are measuring it – this can be as important as scale
- Look for economy of scale opportunities – are there infrastructure elements that can be centralized or spread across multiple sites or staff?