*Aligning for Action*

# LAN SUMMIT

Health Care Payment Learning & Action Network

# Engaging Communities: Improving Population Health in Alternative Payment Models

# Welcome

**Alexander Billioux (CMS)**

*Director, Division of Population Health Incentives and Infrastructure at Center for Medicare and Medicaid Innovation*

# Today's Panel

**Andrew Renda**

*Director Bold Goal (Population Health), Office of the Chief Medical Officer*

**Antonio Beltran**

*Vice President, Safety Net*

**Sonia Sarkar**

*Chief Policy and Engagement Officer, Baltimore City Health Department*

HUMANA'S

# BOLD GOAL

## 20% HEALTHIER BY 2020

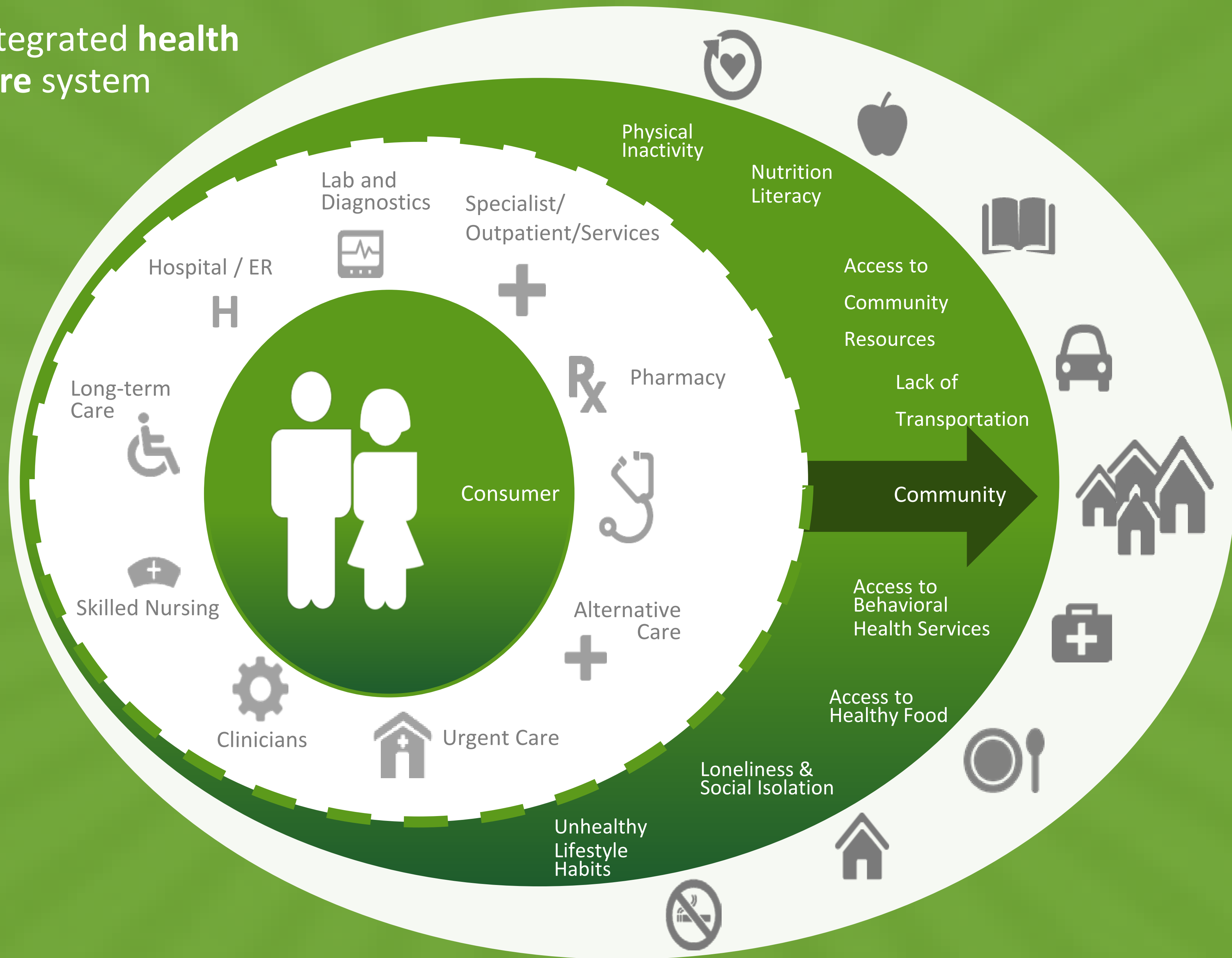
#MOREHEALTHYDAYS

Dr. Andrew Renda

BOLD GOAL | OFFICE OF THE CHIEF MEDICAL OFFICER

OCTOBER 2017

Humana.


Integrated health care system
Physical Inactivity
Nutrition Literacy
Lab and Diagnostics
Specialist/ Outpatient/Services
Hospital / ER
Access to Community Resources
Pharmacy
Long-term Care
Lack of Transportation
Consumer
Community
Skilled Nursing
Alternative Care
Access to Behavioral Health Services
Access to Healthy Food
Clinicians
Urgent Care
Loneliness & Social Isolation
Unhealthy Lifestyle Habits

# HUMANA HAS A BOLD GOAL

**Humana's goal for 2020 –** *A dream with a deadline*
The communities we serve will be ***20% healthier by 2020*** because we help make it easy for people to achieve their best health

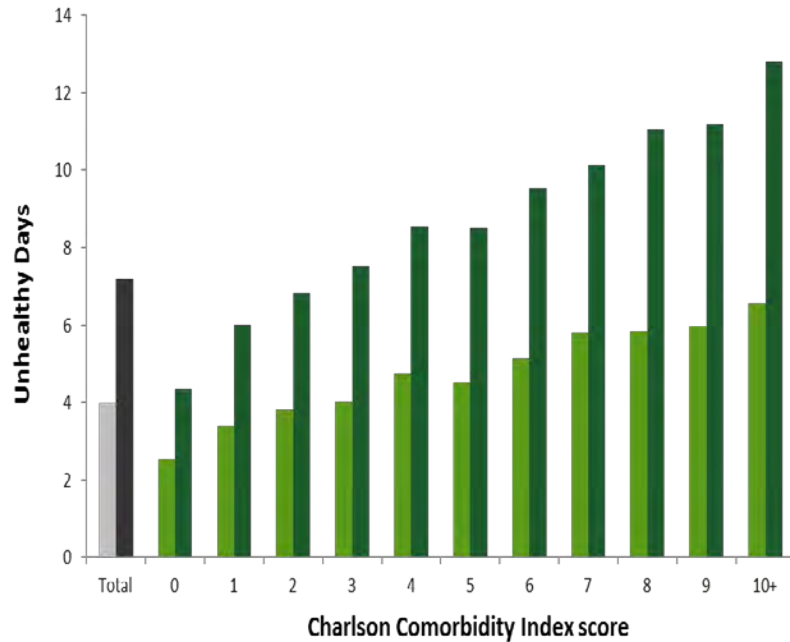
## Healthy Days

+

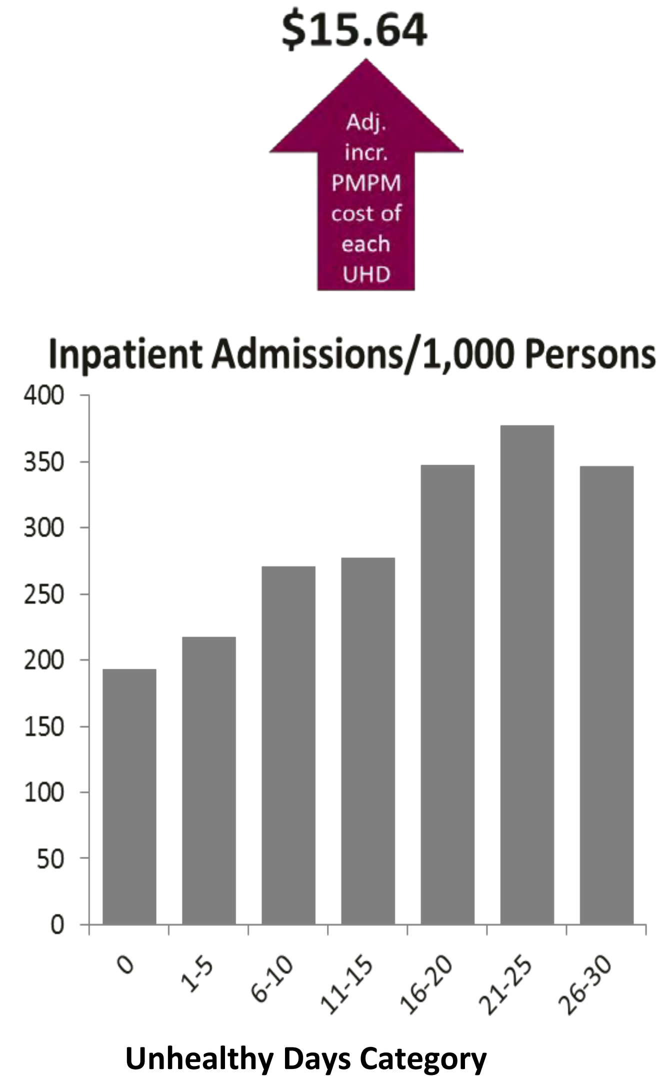
=

# Healthy Days are associated with outcomes and costs

## Disease Progression

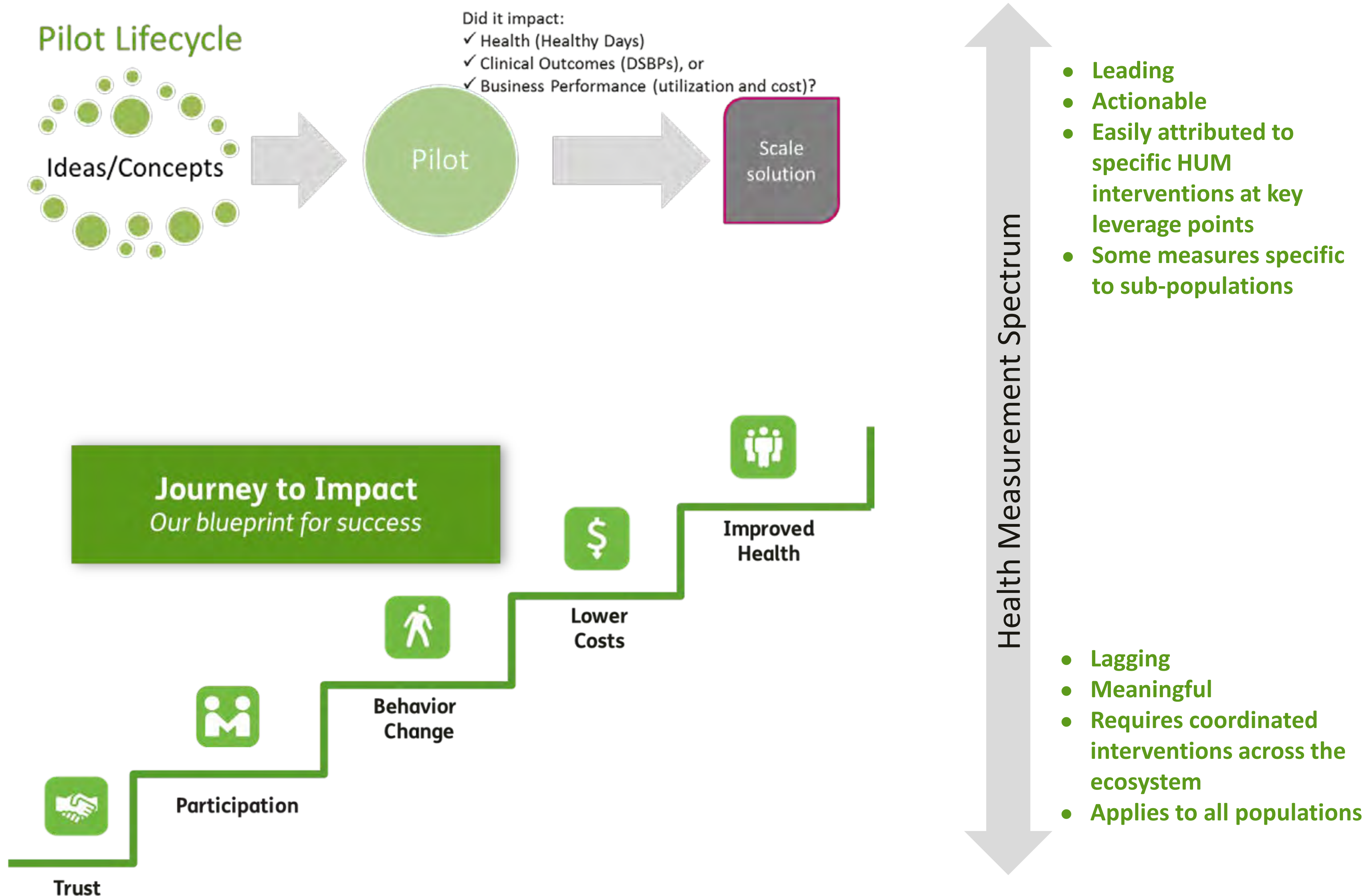



## Utilization and Cost




Human

# Healthy Days as a leading and lagging health indicator

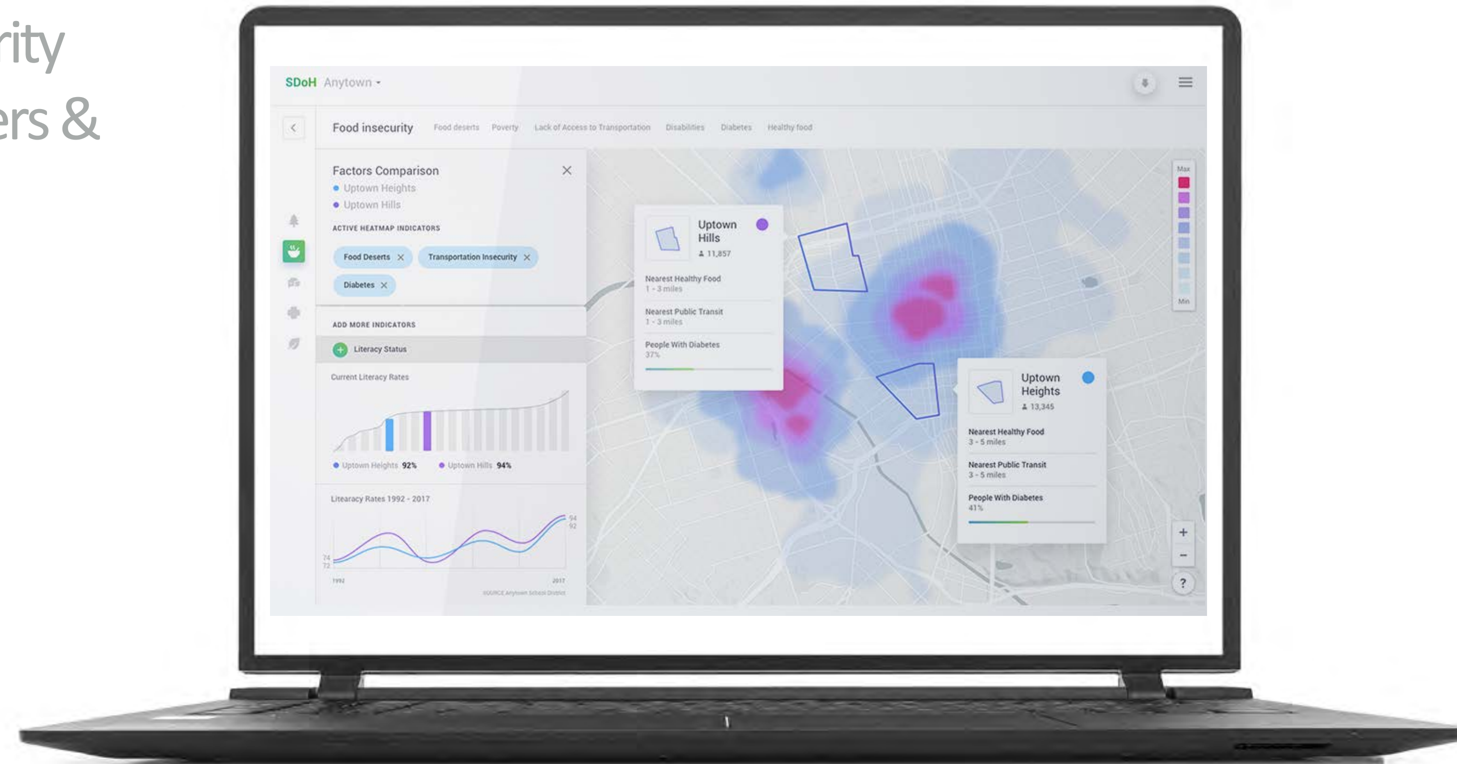



- Leading
- Actionable
- Easily attributed to specific HUM interventions at key leverage points
- Some measures specific to sub-populations

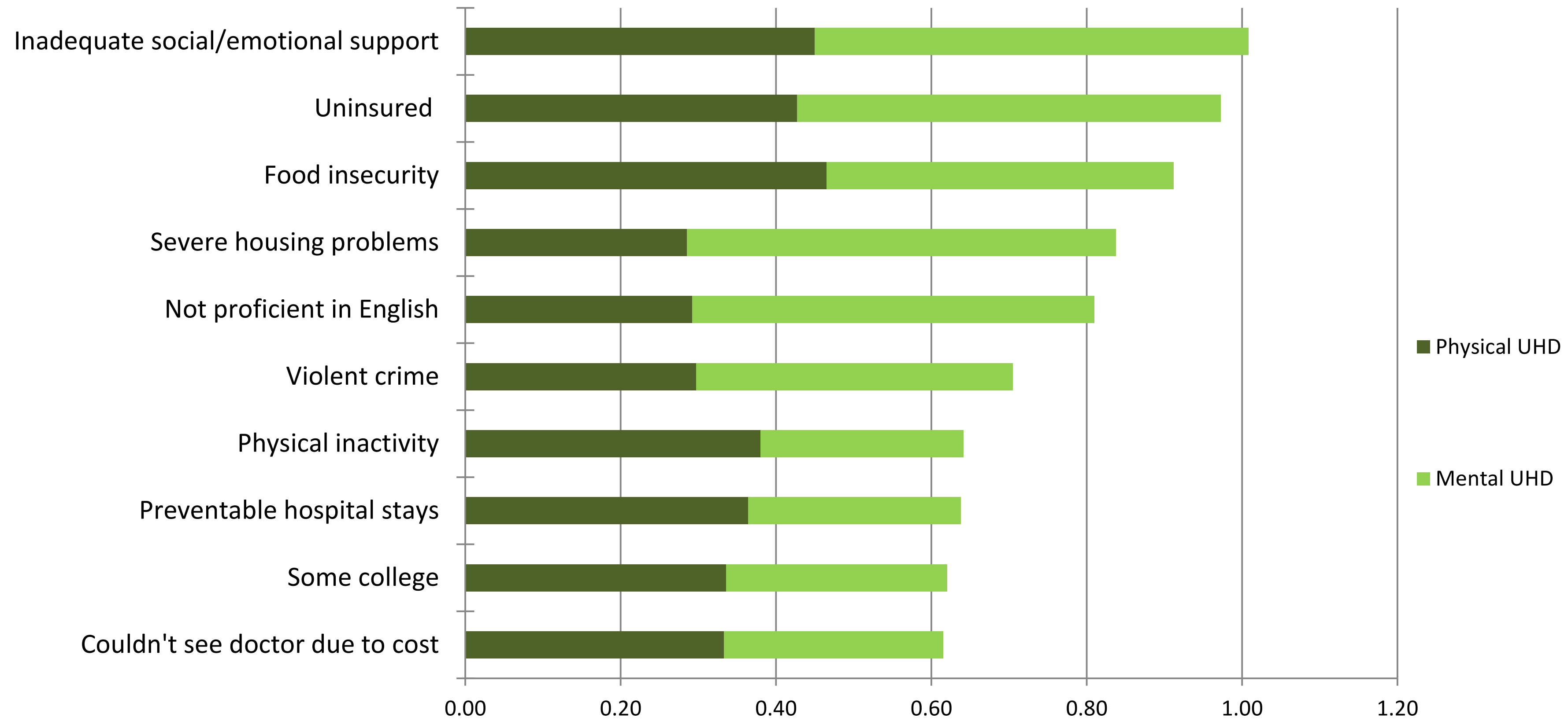
- Lagging
- Meaningful
- Requires coordinated interventions across the ecosystem
- Applies to all populations

# **Leveraging data & listening** to the community

Identify priority health barriers & conditions



# Social Determinants of Health and Healthy Days



# FOOD INSECURITY

- **1 in 8 Americans**
- **$121.92 billion was spent on direct related costs tied to food insecurity in 2014**
- **2x as many Unhealthy Days**

Sources: Feeding America, Feeding Tampa Bay, Hungerreport.org, Clinical Analytics, Humana

## Comprehensive Food Insecurity Intervention and Randomized Control Trial

**BROWARD COUNTY, FLORIDA**

**1) Screen**

- Train clinical staff
- Screen all patients via EMR

**2) Refer**

- Patients with positive screening referred to food bank staff
- Patients complete informed consent and randomized into treatment, control groups

**3) Intervention (12 months)**

- Treatment (n= 1,000): "Case management" approach, with weekly access to healthy food via community programs
- Control (n = 400): Information about food resources, assistance programs (SNAP, WIC)

**4) Outcomes**

- Measure improvements in health, clinical outcomes, business metrics

# LONELINESS AND SOCIAL ISOLATION

- **7% increased likelihood of diabetes**
- **3.4 times more likely to suffer depression**
- **Double risk of Alzheimer’s**
- **1 Unhealthy Day**

Source: American Association of Retired Persons, Clinical Analytics, Humana

## Loneliness Toolkit

### How to use your toolkit

This toolkit is designed to help you on your journey to feeling connected and healthy, with vital information, tools, and resources you need right at your fingertips.

Here, you'll find six sections organized with worksheets, useful tips, and resources that may help make your life easier. Remember, this communication doesn't guarantee benefits and doesn't indicate all services received will be covered by your plan. Please refer to your Evidence of Coverage or call Customer Service at the number on the back of your Humana ID card to confirm that the service will be covered by your plan.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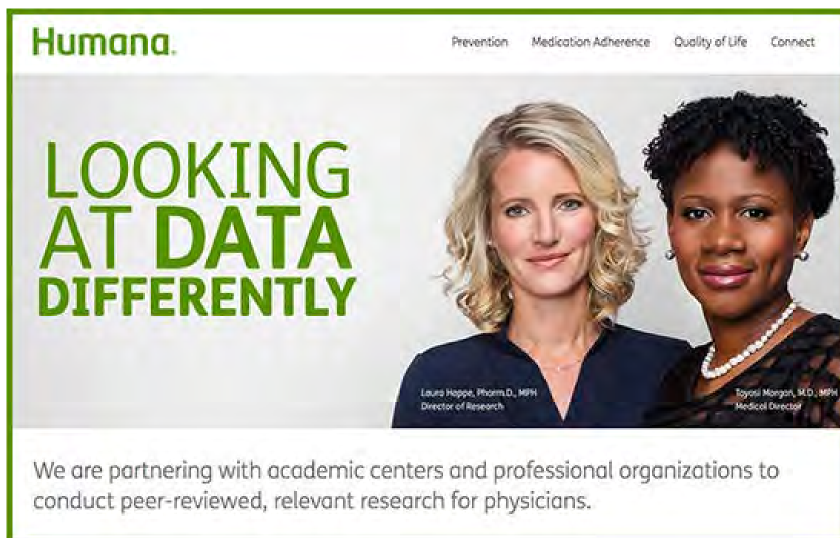
# Research validates the impact of addressing social determinants




www.humana.com/research

www.humana.com/researchlibrary

Havens et al. **Are there differences in Healthy Days based on compliance to preventive health screening measures?** Poster Presentation at: ACPM Preventive Medicine Conference. February 2015; Atlanta, GA USA.

Chiguluri et al. **Relationship between diabetes complications and health related quality of life among an elderly population in the United States.** Poster Presentation at: ADA 75th Scientific Sessions. June 2015; Boston MA USA.

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Fang X, Peña J, Cordier T, Slabaugh SL et al. **Factors associated with worsening health-related quality of life among a Medicare Advantage population.** Presented at the American Public Health Association Annual Meeting, Chicago, IL. October 31-November 4, 2015.

Casebeer A, Drzayich Jankus D, Hopson S, et al. **Is there a relationship between self-reported healthy days and comorbidity medication adherence among oncology patients?** Poster Presentation at: American Society of Clinical Oncologists (ASCO) Quality Care Symposium. February 26-27, 2016; Phoenix, AZ.

Cordier T, Slabuagh L, Young P, Havens, E, Gopal V, Prewitt T. **Do people who are adherent to their medications have fewer unhealthy days?** Podium presentation at: Preventive Medicine. February 27, 2016; Washington DC.

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Slabaugh et al. **Leveraging Health-Related Quality of Life in Population Health Management: The Case for Healthy Days.** Population Health Management. 2017 Feb;20(1):13-22.

Cordier et al. **A health plan's investigation of Healthy Days and chronic conditions.** American Journal of Managed Care. November 2017 (planned)

*Aligning for Action*

# LAN SUMMIT

Health Care Payment Learning & Action Network

## Addressing SDoH with Community Health Workers

**Tony Beltran**
**VP, Safety Net Transformation**
**Trinity Health**

# Our integrated people-centered health system improves the health of individuals, populations and communities

**Better Health • Better Care • Lower Costs**

**Episodic Health Care Management for Individuals**

Efficient & effective episode delivery initiatives

**Population Health Management**

Efficient & effective care management initiatives

**Community Health & Well-Being**

Serving those who are poor, other populations, and impacting the social determinants of health

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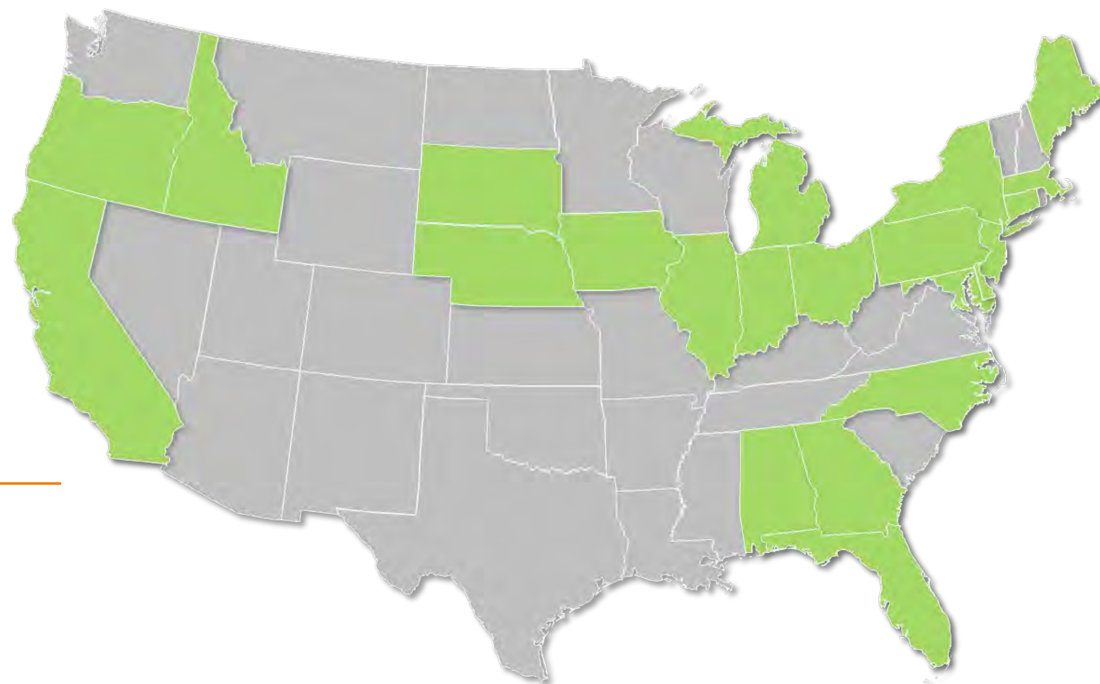
# Trinity Health's 22-state diversified system today



**$17.6B**
In Revenue

**$1.1B**
Community Benefit Ministry

**1.3M**
Attributed Lives

**131K**
Colleagues

**7.5K**
PNO Physician & Clinicians

**25.6K**
Affiliated Physicians

**93**
Hospitals* in 22 states

**22**
Clinically Integrated Networks

**15**
PACE Center Locations

**111**
Continuing Care Facilities

*Owned, managed or in JOAs or JVs.

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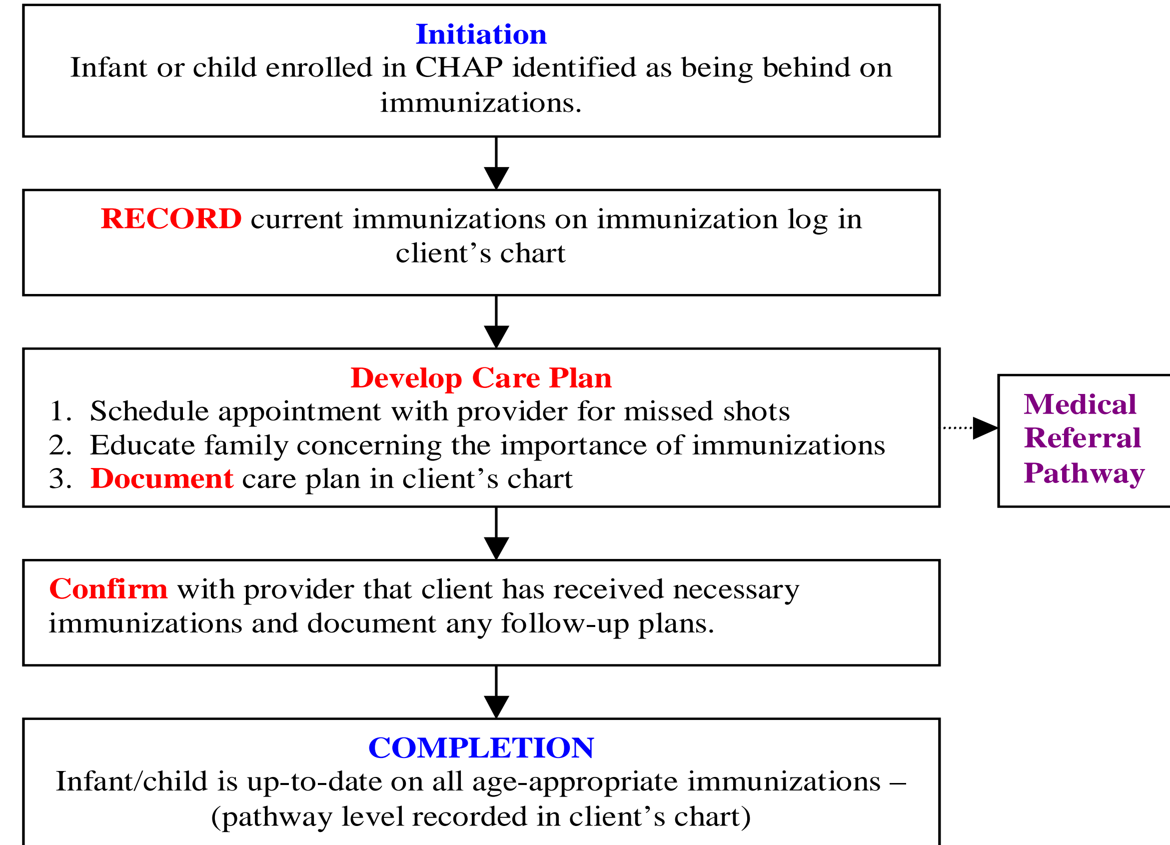
# Community Health Workers

- Mercy Health Project in Muskegon, MI
  - Developed an innovative model for Community Health Workers (CHWs)
  - Started as a CMMI Grant
  - Goal: Reducing cost and improving overall care through assisting individuals in accessing community services
- Developed a community HUB based on AHRQ model
- Utilized the Care Coordination Systems' Pathways tool for care management for CHWs
  - Care coordination and linkage to care
  - Specific pathways to address social determinants of health (SDoH)

# Mercy Health Project- CHW

- Developing Four Pathways
  - **Pathways for Better Health**- individuals with complex or urgent medical needs
  - **Pathways to  a Healthy Pregnancy**- expectant mothers
  - **Pathways to Re-Entry**- individuals being released from incarceration
  - **Pathways to a Healthy Future**-Youth 12-18 and their families
- Funded through community benefit dollars from the hospitals and met the needs of the Community Health Needs Assessment (CHNA)
- Tremendous impact on individual patients but limited by community benefit funding available

# Pathways Example





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# FY-2017 CHWB Program

## Direct Service Programs

| Average Cost per Patient Reduction<br>n = 3,586 | | |
|---|---|---|
| Emergency Department | 30%<br>($519ea) | $557,925 |
| Inpatient Admissions | 13%<br>($1,937) | $902,642 |
| Urgent Care | 21%<br>($34) | $25,602 |

| Average Visit Reduction per Patient | | |
|---|---|---|
| Emergency Department | 14% | 227 Visits |
| Inpatient Admissions | 10% | 41 Stays |
| Urgent Care | 14% | 76 Visits |

## Pathways Programs

| MPHI Analysis – Muskegon Subset<br>n = 2,726 |
|---|
| ED visits dropped after 6 months in program for all patients (Medicare, Medicaid, Dual) |
| Hospitalizations decreased after 9 months in program for Duals. |
| All three groups showed sharp declines in readmission after 3-6 months in program. Only Medicare patients maintained that trend beyond six months. |

# Scaling the Model

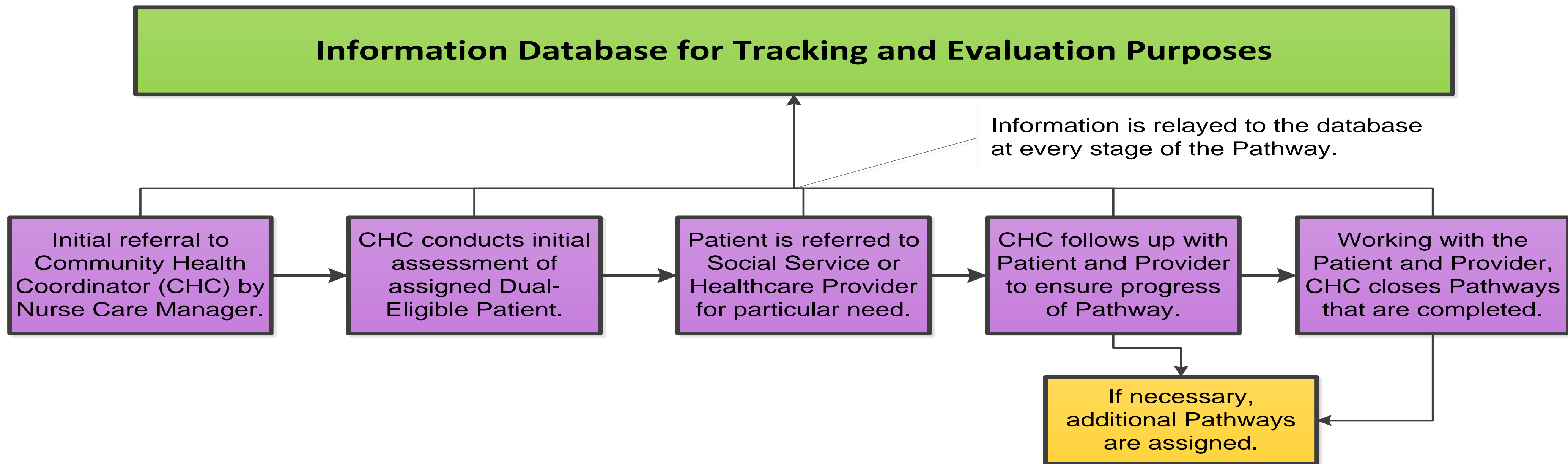
- Trinity Health focused on scaling the model to 9 Regional Health Ministries (hospitals) within Trinity Health
- Trinity Health's Community Health Institute provide over $1M in funding
- Collaborated with AmeriCorps to hire  up to 50 Community Health Coordinators
- Focus on addressing SDoH for patients in Alternate Payments Model/ACO

# Community Health Coordinators (CHCs) will have multiple focus areas

- Dually enrolled—top 5% risk
- Nurse care manager reviews cases and assigns to CHC versus referrals from the community
- CHC works with patient to deliver Pathways:
  1. Medical Home pathway
  2. Medical Referral pathway
  3. Medication Assessment pathway
  4. Medication Management pathway
  5. Social Service Referral pathway
  6. Smoking Cessation pathway
- Pathways reach and outcomes captured in CCS software
- Nurse care manager serves as resource for needs outside the CHCs' scope of work

# The pathways process provides a framework for CHCs

The Pathways model provides a framework through which CHCs can address the health needs of the most vulnerable populations in our communities.




Within the Pathways model, a "pathway" refers to a regimented referral process evidence based protocol for a particular need.
Each CHC receives 40 hours of training on the protocols and scope of work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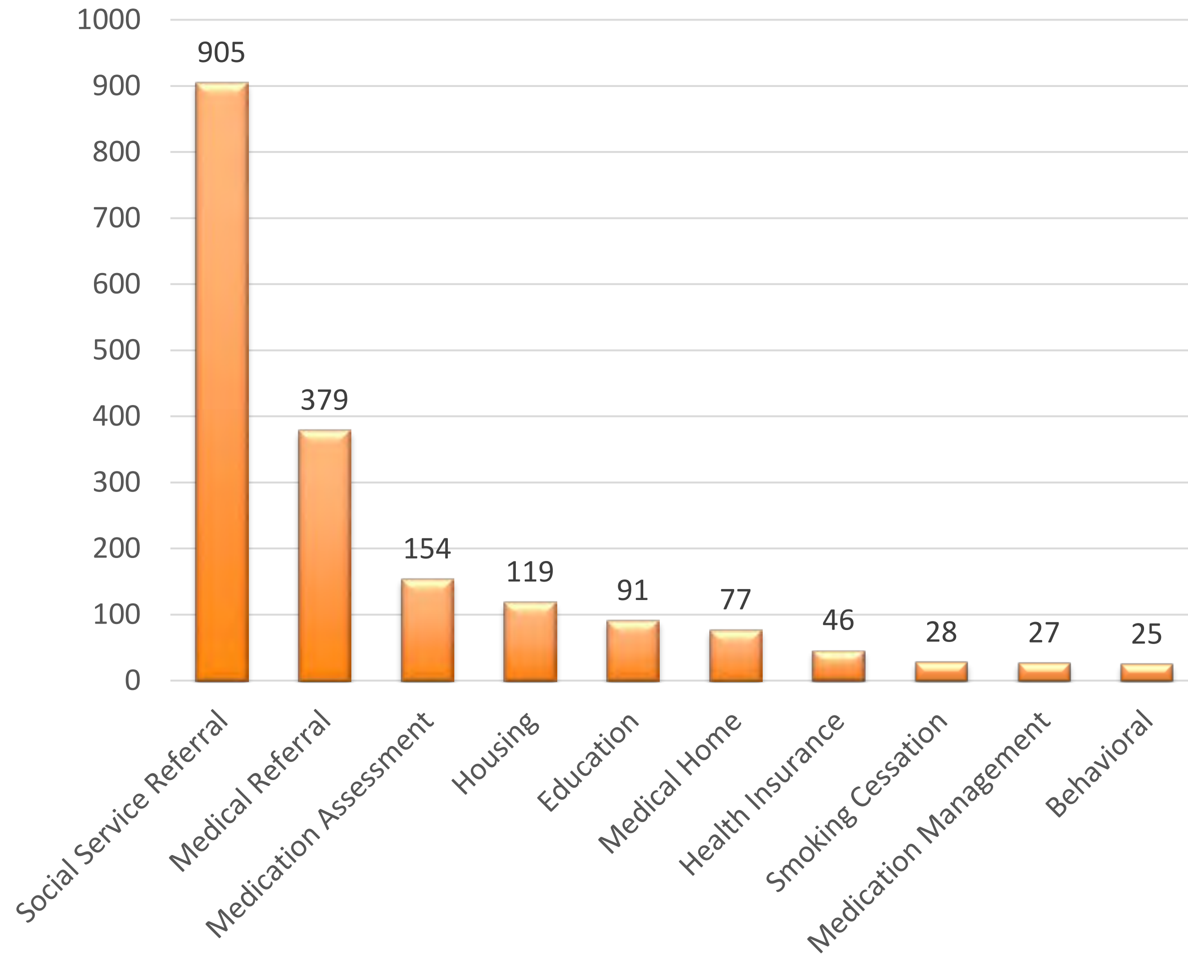
# Significant Social Service Referral Need




- Program First 10 Months
- About 30 CHCs hired
- 1,869 Pathways have been opened for 682 Patients
- 20% are finished incomplete for lack of community resources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# Transition to Traditional Grant to Pilot

- Program was successful but had a few stops and starts
- Administrative challenge (for AmeriCorps, RHMs and the System Office)
- Lack of clear accountability framework for members
- Poor compatibility between standard AmeriCorps practices/procedures and the needs of the program
- Little flexibility around deployment and management of members

# New Grant

- Purpose
  - Extend Trinity Health's ability to effectively and efficiently achieve Triple Aim outcomes for vulnerable and poor populations, particularly those in which we bear risk (Medicare/Medicaid and Medicare attributed lives) by expanding the use and practice of Community Health Workers to address the social determinants of health in Trinity Health communities.
- Goals
  - Standardize CHW role across enterprise (job description, scope of practice, competencies)
  - Integrate CHWs into the clinical teams
  - Support CHW recruitment with grant funding opportunities
  - Demonstrate CHW impact on the cost of care, quality and experience outcomes (not just programmatic measures)
  - Create a financially sustainable model for CHWs
  - Replicate Community Pathways HUB through operational support
- Scope
  - Total 18 CHWs; two CHWs in 9 RHMs
  - $1.35M in funding for 18 months

# Target Population

- The target population of the initiative is high-risk attributed lives served by the local RHM through an ACO or BPCI program.
- Funding will not be provided to support care navigation among other populations at this time.
- The Initiative will utilize the Trinity Health ambulatory care management evidence-based criteria:
  - Sort population by medical spend and include patients in the top 5% of medical spend
  - Stratify Top Spenders using Evidence-based Criteria
    - 2 or more Inpatient Admits within 12 months OR
    - 2 or more Readmissions within 12 months OR
    - 2 or more ED visits within 12 months OR
    - 2 or more Diagnoses of Chronic Conditions (Heart Failure, Hypertension, Diabetes, CAD, COPD, Asthma or Behavioral Health)

# Performance Measures

Progress will be achieved against the following measures

- ACO Measures
  - Medical Cost of Care PMPM
  - Acute Inpatient Admits
  - ED visits/1000
  - All Cause 30-Day Readmits/1,000Target Population
- Care Coordination Measures
  - Number of active beneficiaries with current open pathways
  - Number of beneficiaries discharged from Good Samaritan Initiative
- CHW Measures
  - Total number of pathways completed and finished incomplete
- RiskQ Score before and after intervention

# Future State

- Develop a self-sustaining model for CHWs in an APM structure
- Scaling the successful pilots at the original 9 RHMs and at new RHMs without reliance on grant or community benefit funding
- Use aggregate RHM data to determine community need such as housing, food, transportation, etc.
- Opportunity to address the Community SDoH need through Community Benefit Dollars or Socially Responsible Investing

## Contact Information

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**Trinity Health**
**Antonio.beltran@trinity-health.org**

# LAN Resources

https://hcp-lan.org/resources/

# Contact Us

We want to hear from you!

www.hcp-lan.org

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PaymentNetwork@mitre.org

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