Will NC's System of Care Principles Survive Medicaid Transformation?

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Objectives

Review how one program is operationalizing system of care principles across healthcare populations and for those with complex needs

Describe the scope and range of system of care approaches used for Medicaid

Discuss the relationship between value based contracting and strengthening system of care

Identify and offer input into how managed care organizations can implement system of care principles within an integrated Medicaid program

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Pre-Work

Based on your experience with Systems of Care in North Carolina, as a

- Person participating in services, including family/circle of support
- Service provider
- Advocate
- Regulator
- Other stakeholder

What is working well?
What isn't working well?
Lessons learned
Actionable recommendations

Aetna's commitment to addressing social determinants

Mercy Maricopa Integrated Care

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Case Study: *Impact of System of Care Supports and Services for Individuals with Serious Mental Illness (SMI)*

Mercy Maricopa Integrated Care [MMIC]: Medicaid managed care plan serving Maricopa County, AZ since 2013

Over 900,000 members

Behavioral health services to

- Medicaid eligible children and adults diagnosed with a general mental health/substance use disorder
- Foster care youth
- People with IDD

Integrated behavioral health and physical health services to Medicaid eligible adults diagnosed with Serious Mental Illness (SMI): ~20,000 people

2017: National Opinion Research Center (NORC)* completed case study

* independent non-partisan social research organization at the University of Chicago

System of Care Supports and Services

Permanent Supportive Housing: *Housing First* **using SAMHSA Fidelity Model**

Supported Employment: *Zero Exclusion* **using SAMHSA Fidelity Model**

Metrics

- impact of the program on cost of care
- impact of the program on utilization-based quality measures

Design

- Measured differences in cost and quality of care before and after enrollment
- Compared the change in health care cost and quality of services for members enrolled in each program to the change for a comparison group of members on the waiting list

Methodology

- Data from Q2 2014 to Q2 2017
- At least one Quarter of data before and after enrollment in the program

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Permanent Supportive Housing Results

Pre-Post

Significant decreases in

    Total Cost of Care [BH & PH]: $4623 PMPQ

        Housing Subsidy $2427 PMPQ

        net +$2196 PMPQ

    BH Admits/K, Professional & Facility Costs

    Total [BH & PH] Facility Costs

No significant change in PH costs, ED visits or Pharmacy costs

Comparison Group: Waiting List

Significantly lower Total Cost of Care: $5002

    BH Professional Services

    Total Facility Costs [BH & PH]

    Pharmacy Costs

No significant difference in ED visits

Supportive Employment Results

Pre-Post

Total Cost of Care Increased $1293 PMPQ

- BH Professional Costs Increased: $864*
- PH Professional Costs Increased: $103
- Pharmacy Costs Increased: $444

Inpatient Admits Decreased

BH Admits: 9% decrease [N.S.]: consistent with literature and

expected to become significant with longer measurement

period

PH Admits: 35% decrease

Comparison Group: Waiting List

Significantly higher Total Costs of Care: $1090 PMPQ

Higher BH Professional Costs: $1138 PMPQ*

Lower BH Facility Costs: $742 PMPQ

*Mostly costs of Supported Employment services

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Lessons Learned

Be Person-Centered [Everyone]-- Collaborative partnering shown by shared decision-making about priorities, goals, and who's going to do what, when

Strengthen and Maintain Stakeholder Partnerships -- MOUs/SOWs clarify roles and responsibilities of all stakeholders: local and state government, providers and the local network of community-based organizations

Nurture and Sustain Good Communication – Change Management processes include all stakeholders, identifying and reconciling differences, getting to consensus and sharing accountability for results

Be Strategic with Resources: Make the best use of all available resources, including those that many stakeholders may not even be aware exist

References to Final Reports

https://news.aetna.com/2018/02/partnership-and-promise-improving-the-health-of-a-community/

The Aetna Foundation

Aetna's philanthropic commitment

Mission: to promote wellness, health, and access to high-quality health care for everyone, while supporting the communities we serve

Provides grants to community organizations and funds national partners to change lives by

Encouraging healthy lifestyles

Enhancing health care equity

Putting innovation to work to improve health among the underserved

Building Healthy Communities:
4 major national initiatives, $12M investment

Partnership with U.S. News & World Report to develop the Healthiest Communities Rankings and spur local action by health officials

Open RFP program that supports nonprofits working to create impact at the community level

Grants to support state and Community-based organizations in reversing prescription drug abuse by at-risk populations

Prize competition among 50 communities that will address the social determinants of health through cross-sector collaboration

Aetna Foundation in NC: 2018

Org Name	Grant	Project Title	City
Opportunities Industrialization Center Inc.	$50,000	Opportunities Industrialization Center - Certified Medical Assistant Prep Program	Rocky Mount
North Carolina Harm Reduction Coalition	$999,350	Rural Opioid Overdose Prevention Project	Raleigh
Mecklenburg County Health Department	$10,000	Village HeartBEAT	Charlotte
Davidson County Health Department	$10,000	Davidson County Healthy Communities	Lexington
Duke University	$10,000	North Carolina Healthiest Counties Initiative	Durham
Chatham County Public Health Department	$10,000	Leveraging Partnerships Built Through the Comprehensive Plan to Create a Sustainable, Data-Driven, Health-In-All-Policies Approach in Chatham County, NC	Pittsboro
Centralina Council of Governments	$50,000	Transportation Improvements are Popping Up in West Charlotte	Charlotte
Guilford Child Development	$50,002	Family Success Center (FSC) / Early Learning Center (ELC)	Greensboro
Bountiful Cities	$53,000	Community Food Education Collaborative	Asheville

Built Environment: Improved walkability, bike-ability, and use of public spaces in a community

Community Safety: Increased collaboration between local law enforcement and community members to proactively address immediate public safety issues, public health issues, or both

Environmental Exposures: Decreased exposure to air and water contaminants; increased understanding, monitoring, and reporting of local environmental hazards by residents

Healthy Behaviors: Increased consumption of fruits and vegetables; increased physical activity and stress reduction activities

Social/Economic Factors: Increased access to healthy foods through the development of new or enhanced retail options, including resident-owned businesses

Aetna Foundation Healthiest Cities and Counties Challenge

https://www.aetna-foundation.org/index.html

Information channels

North Carolina Center for Nonprofits

North Carolina Network of Grantmakers

Spectrum News

Aetna Foundation newsletter

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Scope and Range of a System of Care Approach to Serving People
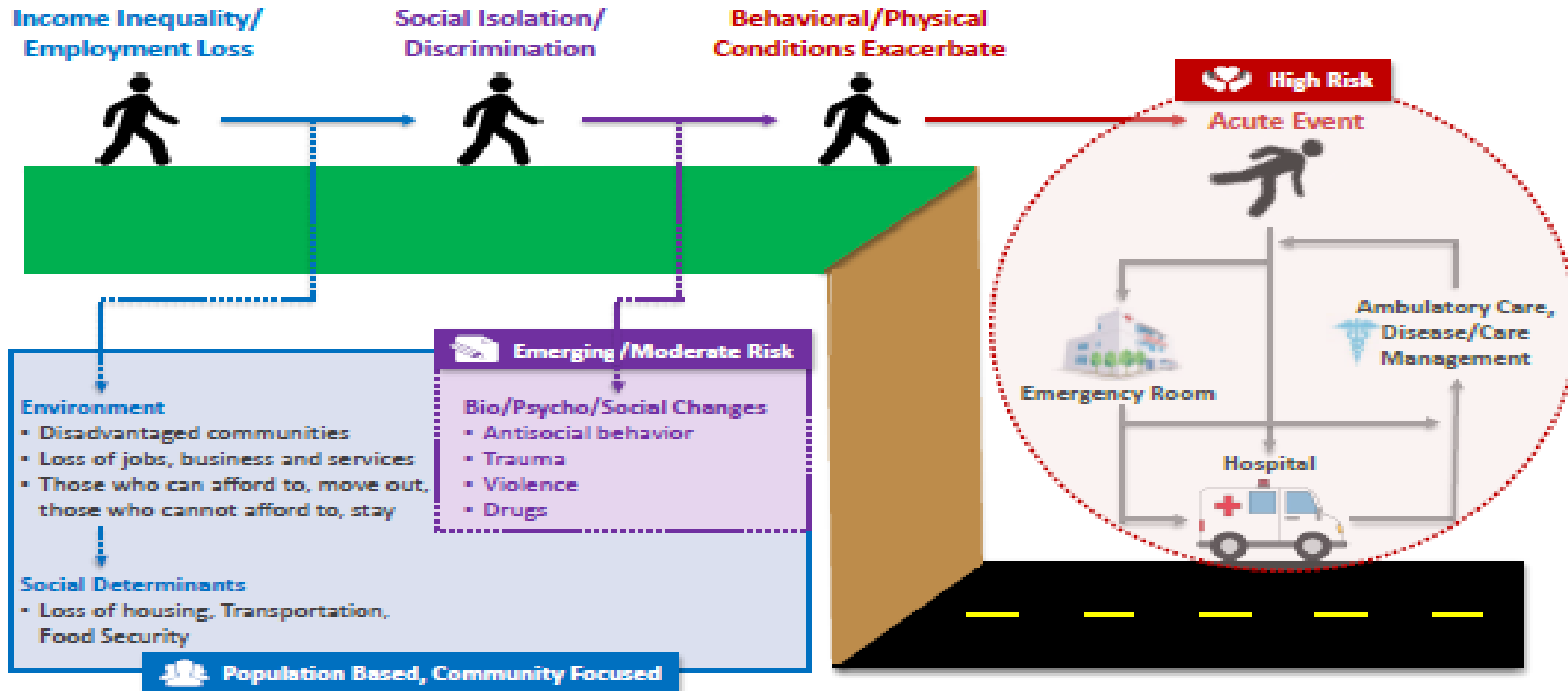
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System of Care Definition

A collection of integrated services and supports that help people achieve goals that are important to them. The integrated services and supports may include all forms of health services, as well as housing, employment, healthy food, transportation and other living supports to optimize resiliency and independence. The SoC is grounded in the demonstration of trauma informed care, culturally and linguistically appropriate services, and recovery principles.

- The community at large

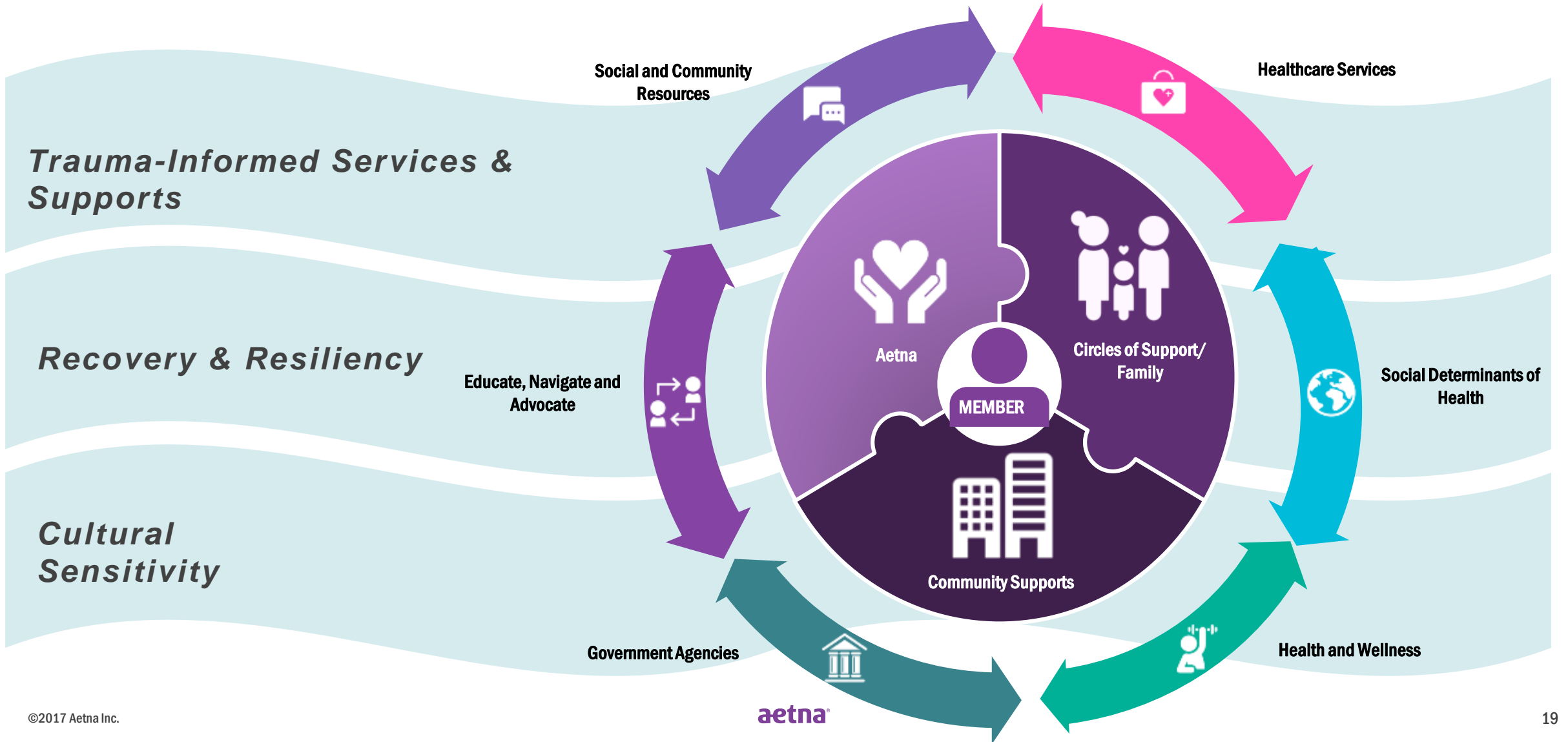- Populations of people with complex needs

Aetna Better Health Community Care: The "Cliff Analogy"
Address "Cliff Analogy" by solving root cause issues upstream before member becomes acute
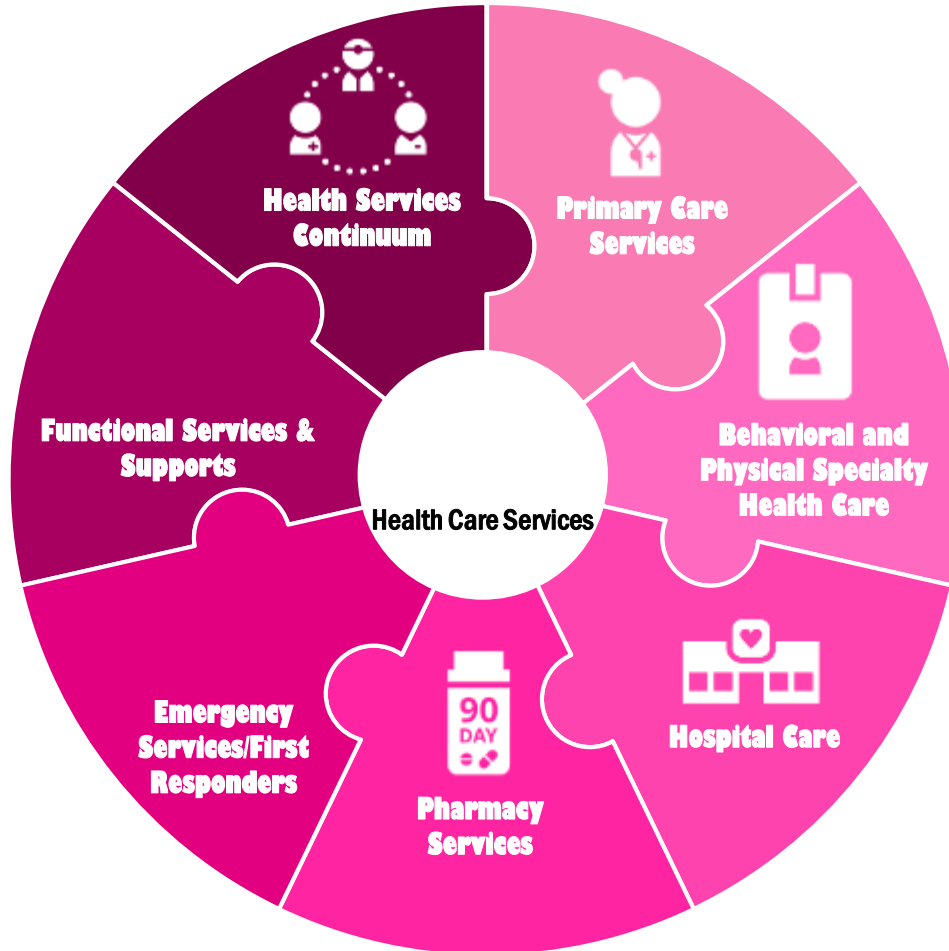
The "Cliff Analogy," developed by Dr. Camara Phyllis Jones at the CDC, aims to emphasize the fact that non-health interventions are needed to improve health outcomes and achieve Health Equity...

Income Inequality/ Employment Loss

Social Isolation/ Discrimination

Behavioral/Physical Conditions Exacerbate

High Risk

Acute Event

Emerging/Moderate Risk

Environment
- Disadvantaged communities
- Loss of jobs, business and services
- Those who can afford to, move out, those who cannot afford to, stay

Bio/Psycho/Social Changes
- Antisocial behavior
- Trauma
- Violence
- Drugs

Ambulatory Care, Disease/Care Management

Emergency Room

Hospital

Social Determinants
- Loss of housing, Transportation, Food Security

Population Based, Community Focused

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System of Care

Trauma-Informed Services & Supports

Recovery & Resiliency

Cultural Sensitivity

Social and Community Resources

Healthcare Services

Educate, Navigate and Advocate

Social Determinants of Health

Government Agencies

Health and Wellness

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Circles of Support/ Family

MEMBER

Community Supports

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Healthcare Services Managed by the Health Plan

Health Care Services (center)

- Health Services Continuum
- Primary Care Services
- Behavioral and Physical Specialty Health Care
- Hospital Care
- Pharmacy Services
- Emergency Services/First Responders
- Functional Services & Supports

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Health and Wellness

- Healthy Diet/Weight
- Smoking Cessation
- Health Maintenance and Prevention
- Physical Health Exercise
- Alternative Health/Mindfulness
- Personal Activation Tools

Health and Wellness

Educate, Navigate and Advocate

Social Determinants of Health

Government Agencies

Government Services

- Health/Public Health
- Emergency Services
- Youth Serving Agencies
- Law Enforcement & Corrections
- Entitlement Programs
- Behavioral Health Departments
- Employment and Housing Services

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Social and Community Resources

Social and Community Resources

- Centers for Independent Living
- Habilitative Services
- Area Agencies on Aging
- Consumer and Peer to Peer Agencies
- Advocacy Organizations
- Volunteer Organizations
- Faith-Based Organizations

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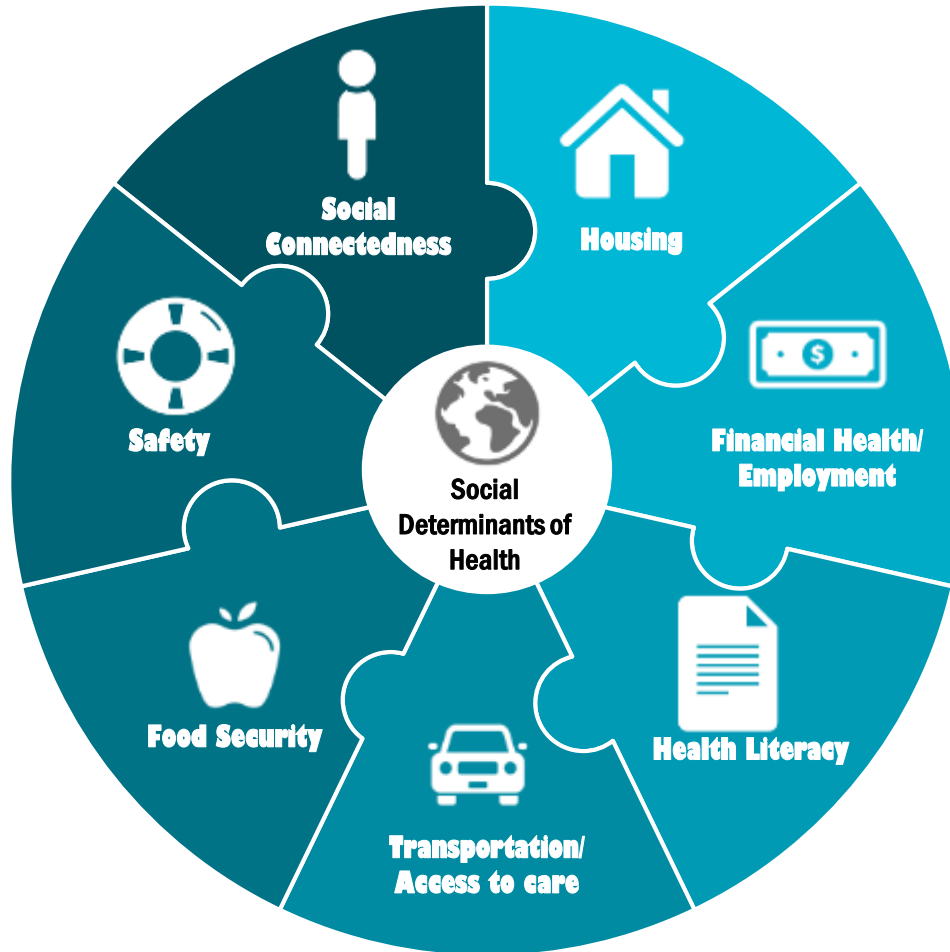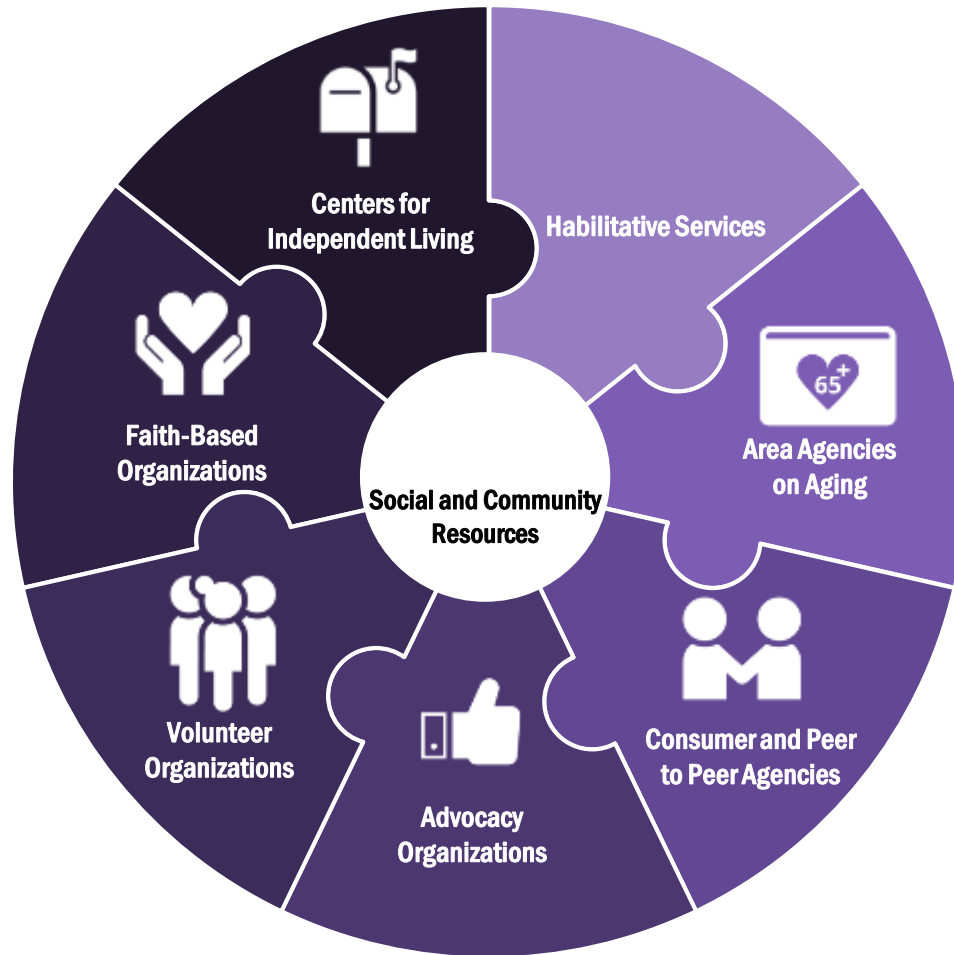
Teresa's Story
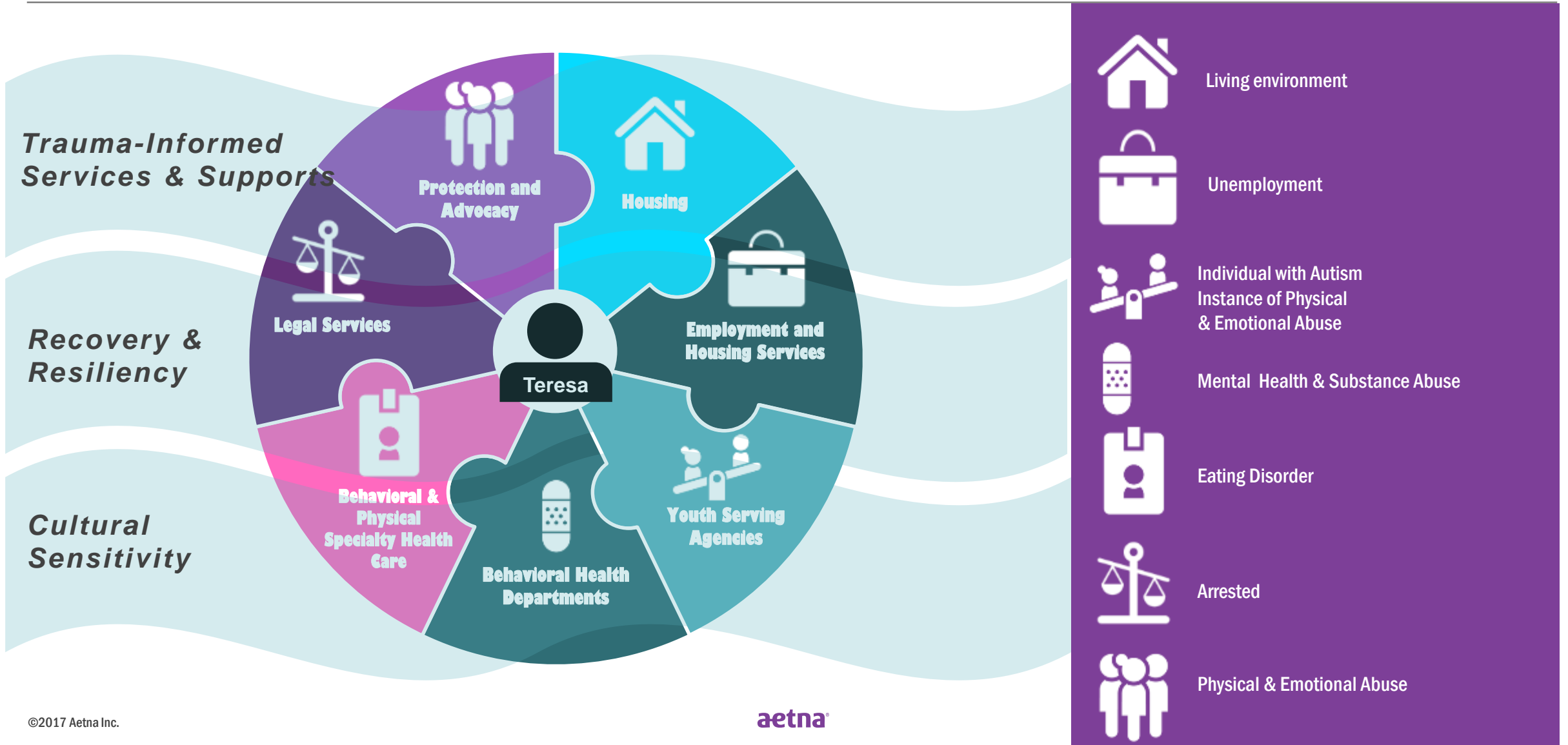
How to Operationalize SOC Principles

May , 2018

System of Care Operational Requirements

Person centered

Trauma-informed

Recovery & resiliency focused

Culturally sensitive

Complexity capable

Equitable access

Collaborative governance

Performance accountability

Sustainable business model

Person Centered

Engage each person in a collaborative conversation to plan the work

- Each person is an expert about their own life: their values, beliefs and preferences, their goals and priorities, their strengths and resources, and the people whom they trust and want to be part of their care team

- Each person is recognized and respected for their uniqueness: race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, and others

- People differ in how ready they are to make meaningful changes in how they live their lives and their level of activation

- People with multiple competing demands on their time and energy may become overwhelmed when treatments and services are burdensome and disruptive

- People living with trauma and its consequences need to describe what happened to them, after they trust you and feel safe. They need you to listen and hear their story, and need to be understood

Trauma-Informed

Universal Precautions

Trauma-Informed Care [TIC]: an overarching framework that emphasizes the impact of trauma and that guides the general organization and behavior of an entire system.

Becoming trauma-informed is a long-term commitment to change the culture of the organization

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Trauma-Specific Services [TSS]: interventions that are designed to directly address the impact of trauma, with the goals of decreasing symptoms and facilitating recovery

Recovery & Resiliency Focused

Dimensions of Recovery

Health: Learning to overcome, manage, or more successfully live with symptoms and functional limitations, and making healthy choices that support one's physical and emotional wellbeing

Home: A stable and safe place to live

Purpose: Meaningful daily activities, such as a job, school, volunteer work, or creative endeavors; increased ability to lead a self-directed life; and meaningful engagement in society

Community: Relationships and social networks that provide support, friendship, love, and hope

Resiliency: an individual's ability to cope with adversity and adapt to challenges or change. Resiliency develops over time and gives an individual the capacity not only to cope with life's challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resiliency and the process of recovery.

Culturally Sensitive

Cultural Competency

A skill set
Knowledge
Skills
Expertise
Proficiency
Capability

Cultural Sensitivity

An attitude and a way of relating with another
person
Humility
Curiosity
Responsiveness
Awareness
Respect
Openness

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Complexity Capable

Complexity is an expectation, not an exception

People with complex needs may have

An acute event such as a stroke or devastating medical illness or injury with meaningful risk of long-term disability and needing a continuum of rehabilitation services

One or more persisting and potentially disabling physical and/or behavioral health conditions

One or more psychosocial risk factors [SDoH]

Limited protective factors

Integration of healthcare services with services & supports to address social determinants creates "seamless" experience for individuals & families, and for providers

Medicaid covered services managed by the health plan

Medicaid covered services not managed by the health plan

Services not covered by Medicaid but available through other state and local agencies and other funding streams

Services available locally from community-based organizations

Equitable Access

Demographic differences
- Different age groups
- Different regions or service areas
- Different cultural, racial & ethnic communities

Populations of people with complex needs
- Serious mental illness/severe and persisting mental illness
- Disabling substance use disorder
- Severe emotional disturbance
- Intellectual and/or developmental disability
- Traumatic brain Injury
- Disabling physical health conditions: stroke, spinal cord injury, chronic progressive illnesses
- Children and youth in foster care
- People residing in long-term institutional settings
- People who are homeless and/or suffer residential instability
- People living in "hot spots" of poor health outcomes, poverty, hunger and violence

Collaborative Governance

How the system of care is organized, leadership and governance are addressed locally because of differences in available resources and community needs

Clear understanding of mutual roles and responsibilities & well-defined process for escalating and resolving differences among all participants

Shared governance structure improves the ability of the system of care to function in the most cost-effective and efficient way; for example:

Matches each person with the services that best meet their needs, regardless of the source or origin of those services, eliminating duplication and service gaps

Creates a single integrated care and services plan for each person that satisfies the requirements of each state agency and funding stream

Aligns and coordinates case managers from multiple agencies, simplifying each person working with multiple case managers

Performance Accountability

The whole process is data driven

Improve the health status of well-defined populations

Maintain and/or improve the health & well-being of individuals

Enable people to function better at home, in school, in the community, and throughout life

Each major element of the system of care, as well as the entire system as defined by local/regional factors, should

Develop consensus process and outcome measures for each component and for the system as a whole

Implement at least two meaningful quality improvement projects annually that will result in improved processes of care or outcomes

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Sustainable Business Model

Value-based business models align financial and non-financial incentives with:

- Improved clinical and functional outcomes
- Community-wide population health and healthcare equity
- Sustained improvement in health related quality of life

Full risk value-based contracts reward models of care that:

- Integrate preferred evidence-informed and promising physical, behavioral and oral health practices with services and supports that address the social determinants of health, illness and disability.
- Are trauma informed and include trauma specific services
- Expand capacity of preferred outpatient, home and community-based treatments, services and supports to prevent the need for Emergency Department, inpatient, residential and institutional utilization

Benefits of Value-Based Contracting to Strengthen the System of Care

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Systems of Care Solve for...

Fragmentation
- Within and among health care services
- Within and among human services & supports
- Between health care and other human services & supports

Science-to-service gaps in care: evidence-informed best practices
- Absence [15 to 20 year lag]
- Inadequate capacity

Waste: Not making optimal use of the full range of resources available to help a person achieve goals important to them

Value-Based Payment Models

Align financial and non-financial incentives with preferred, evidence-informed practices

Reward high-performing organizations

Change practice patterns
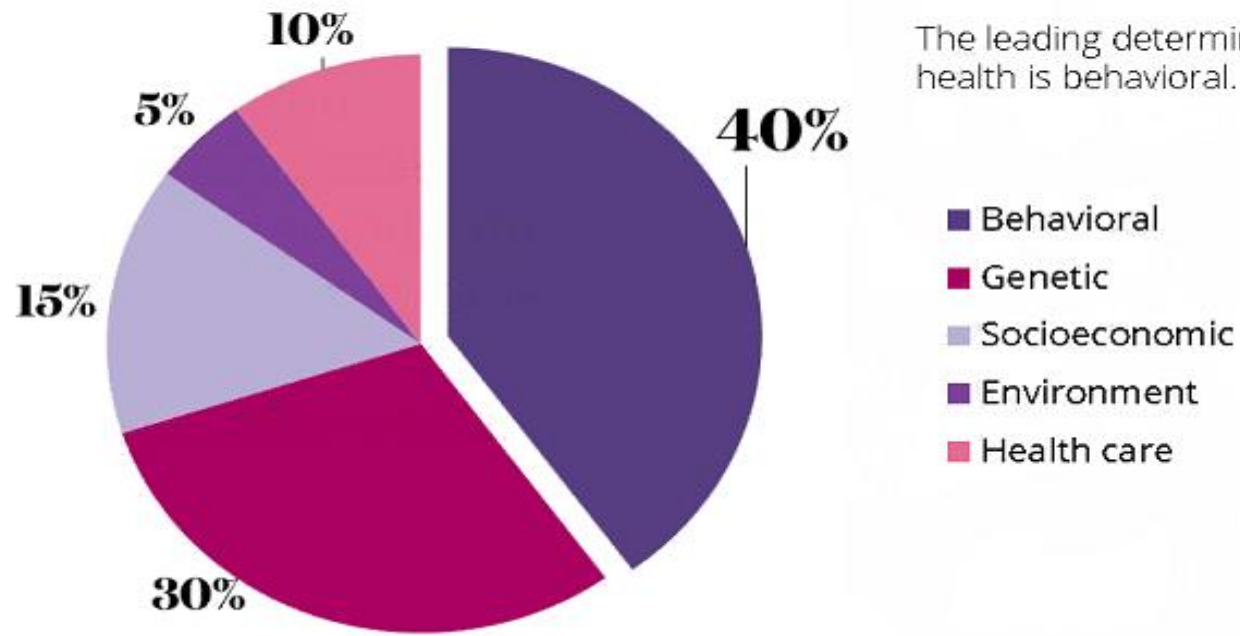
Close the science-to-service gap

Drive development of systems of care

Drive transformation of how health and human services and supports
- Improve the health of populations
- Enhance the experience of people participating in the system of care
- Reduce the cost of health care

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What drives health outcomes?

Social determinants of health

10%

5%

15%

40%

30%

The leading determinant of overall health is behavioral.

- ■ Behavioral
- ■ Genetic
- ■ Socioeconomic
- ■ Environment
- ■ Health care

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Medicaid Accountable Care Organization (ACO): full financial risk
- Hennepin County Medical Center
- NorthPoint Health and Wellness Center
- Metropolitan Health Plan
- Human Services and Public Health Department of Hennepin County

Offers medical, behavioral health and social services

Goal: increase the use of preventive care and reduce preventable hospital admissions and emergency department visits by addressing beneficiaries' other needs alongside their healthcare needs

Hennepin County: Commonwealth Fund Study

- Initial investment: $1.6 million to build the infrastructure
- Shared savings with each partner based on their respective involvement in members' care and completion of performance benchmarks
- After distribution, over 2013, 2014, and 2015, the organization had about $3 million left to reinvest into the program to build capacity
- Medical costs have decreased by roughly 11% per year since 2012
- ED visits decreased by 9.1% between 2012 and 2013, and outpatient visits increased by 3.3%
- Members who had been placed in housing were admitted to a hospital 16% less often, visited the ED 35% less often, visited the psychiatric ED 18% less often, and received outpatient clinic visits 21% more often between 2012 and mid-2014

Our Shared Goal: Personalized Health

Every person leads a meaningful and rewarding life as part of a larger community, pursuing goals that are most important to them, by marshalling their personal strengths and community resources to

- **Meet the challenges related to their health conditions and functional limitations**

- **Achieve and sustain their personal optimal health and well-being**

- **Thrive and flourish**

Discussion

Review Pre-Work

Based on your experience with Systems of Care in North Carolina

- *What is working well?*
- *What isn't working well?*
- *Lessons learned*
- *Actionable recommendations*

Discussion

How will we work together to assure that NC's System of Care Principles not only Survive Medicaid Transformation, but also Thrive and Flourish?

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Thank you!