CA Health Homes: Relationship-Centered Care and the Role of the Health Action Plan

Practice Transformation Series Webinar #2

Speakers
Alan Glaseroff, MD, Stanford Coordinated Care
Lisa Payne Simon, MPH, PBGH/CQC
Today’s discussion

- CA Health Homes Program: Relationship centered care and the Health Action Plan
  - Lisa Payne Simon, MPH, PBGH/CQC

- Building Trust by Design
  - Alan Glaseroff, MD, MPH, Stanford Coordinated Care
Background: HHP Target Population = Medi-Cal Patients with Complex Needs

- ACA Section 2703: State-optional Health Homes Medicaid benefit = intensive care coordination and services for people with chronic conditions
  - Highest-risk 3% of Medi-Cal members
  - Specific target populations: frequent utilizers, patients with multiple co-morbidities, those experiencing homelessness
- Program goals:
  - Coordination, management and integration of services
  - Improved patient health outcomes
  - Lower cost of care
Health Home Network

**MANAGED CARE PLANS (MCPs)**

**Mandatory:** MCP and Medicare-Medicaid plans in target HHP counties  
**Optional:** MHP and county integrated Mental Health/Substance Use Disorder plans in target HHP counties

**COMMUNITY BASED CARE MANAGEMENT ENTITIES (CB-CMEs)**

Qualifying organizations include: Community health centers, community mental health centers, hospitals, local health departments, primary care or specialist physicians or groups, SUD treatment providers, providers serving individuals experiencing homelessness, or other organizations who meet CB-CME requirements and are selected by the MCP

**COMMUNITY AND SOCIAL SUPPORT SERVICES**

Sample organizations could include supportive housing providers, food banks, employment assistance, social services
In HHP, comprehensive care management = care that is:
- Based on assessment of patient’s health and social service needs
- Coordinated and continuous
- Integrated among all care and service providers
- Culturally appropriate & meets health literacy standards

Comprehensive care management also involves:
- Engaging members to participate in HHP
- Collaborating with HHP members and their family/support persons to develop a comprehensive, individualized, person-centered Health Action Plan (care plan)

Based on the needs and desires of the member, the HAP will be reassessed based on progress or changes in member’s needs; the HAP will also track referrals.

HHP Concept Paper
http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx
HHP will assess member needs, provide care/service in these areas…

- Physical health
- Behavioral health
- SUD
- Community-based Long Term Supportive Services
- Palliative care
- Trauma-informed care
- Social supports (nutrition, transportation to appointments, employment counseling, child care, other needs)
- Housing: short-term, transition services, tenancy supports
- Health education & health promotion

In HHP, CB-CMEs must complete a comprehensive health risk assessment to identify member’s range of needs, and develop (with the member) a customized HAP based on identified needs, health status and goals.

HHP care coordination services begin once the HAP is completed.
Health Homes: What is Different about this Benefit? One CB-CME’s view...

- Increase coordination between medical and behavioral health services/systems
- Address homelessness/unstable housing of eligible members
- HHP requires additional care management and care coordination services above currently contracted services
  - Member outreach
  - Health Action Plan completed
  - Medication Reconciliation with every transition
  - Notification of providers of ER/IP/SNF visits
  - Reporting (to MCP)
HAP Sample – template & instructions

- Washington State Department of Social and Health Services / Washington State Health Care Authority (under Forms – Health Action Plan)


  ➢ [http://www.hca.wa.gov/medicaid/health_homes/Pages/index.aspx](http://www.hca.wa.gov/medicaid/health_homes/Pages/index.aspx)
Building Trust by Design

Alan Glaseroff, MD, MPH
Stanford Coordinated Care
Determinants of Health and Their Contribution to Premature Death

Schroeder, NEJM 357; 12

- Social: 15%
- Environmental: 5%
- Medical: 10%
- Behavioral: 40%
- Genetic: 30%
Positive and Negative Outliers
5 Key Behaviors to Increase Activation

Emphasizing patient ownership
Partnering with patients
Identifying small steps
Scheduling frequent follow-up visits to cheer successes, problem solve, or both
Showing caring and concern for patients

Pretty obvious list. What gets in the way?

### Patient Experience vs. Trust, by Country

#### Attitudes about Doctors, by Country.*

<table>
<thead>
<tr>
<th>Country</th>
<th>All Things Considered, Doctors in Your Country Can Be Trusted (Strongly Agree or Agree)</th>
<th>Satisfaction with the Treatment You Received When You Last Visited a Doctor (Completely or Very Satisfied)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>rank</strong></td>
<td><strong>% (95% CI)</strong></td>
</tr>
<tr>
<td>Switzerland</td>
<td>1</td>
<td>83 (81–85)</td>
</tr>
<tr>
<td>Denmark</td>
<td>2</td>
<td>79 (77–81)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>3</td>
<td>78 (75–80)</td>
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<td>Britain</td>
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<td>Finland</td>
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<td>75 (73–78)</td>
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<td>75 (73–77)</td>
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<td>Belgium</td>
<td>8</td>
<td>74 (71–76)</td>
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<td>Sweden</td>
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<td>Australia</td>
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<td>73 (71–75)</td>
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<tr>
<td>Norway</td>
<td>12</td>
<td>72 (70–74)</td>
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<td>Taiwan</td>
<td>12</td>
<td>72 (70–74)</td>
</tr>
<tr>
<td>Slovenia</td>
<td>14</td>
<td>70 (68–73)</td>
</tr>
<tr>
<td>South Africa</td>
<td>14</td>
<td>70 (68–72)</td>
</tr>
<tr>
<td>Portugal</td>
<td>16</td>
<td>69 (66–72)</td>
</tr>
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<td>Philippines</td>
<td>17</td>
<td>68 (65–71)</td>
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<td>Israel</td>
<td>18</td>
<td>67 (64–70)</td>
</tr>
<tr>
<td>Germany</td>
<td>19</td>
<td>66 (64–68)</td>
</tr>
<tr>
<td>Slovakia</td>
<td>20</td>
<td>62 (59–66)</td>
</tr>
<tr>
<td>South Korea</td>
<td>20</td>
<td>62 (60–65)</td>
</tr>
<tr>
<td>Lithuania</td>
<td>22</td>
<td>61 (58–64)</td>
</tr>
<tr>
<td>Japan</td>
<td>23</td>
<td>60 (57–63)</td>
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<tr>
<td>Croatia</td>
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<td>58 (56–61)</td>
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<td>United States</td>
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<td>Chile</td>
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<td>56 (52–59)</td>
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<td>Bulgaria</td>
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<td>46 (43–49)</td>
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<tr>
<td>Russia</td>
<td>28</td>
<td>45 (42–48)</td>
</tr>
<tr>
<td>Poland</td>
<td>29</td>
<td>43 (40–46)</td>
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</table>

* Respondents who answered the satisfaction question “does not apply” were not included in the denominator. Countries are rank-ordered according to the percentage of respondents who said they strongly agreed or agreed that “All things considered, doctors in [your country] can be trusted.” Countries with the same rank were tied on that measure. CI denotes confidence interval. Data are from the International Social Survey Programme, 2011–2013.

Trust Gap: US 3<sup>rd</sup> in experience 24<sup>th</sup> in trust

“Why wouldn’t a person with a chronic condition do everything in their power to live long and feel well?”

Stop overeating, stop drinking, stop staying out late, stop fighting, stop worrying, stop eating sweets, stop gambling...

What did the doctor say? I don’t know... I stopped listening.
“Cup Runneth Over”...

Provider

Medical Assistant/Care Coordinator

Nurse

Behavioral Health

Clinical Pharmacist

Physical Therapist
Design Thinking Serves as a Structured Problem-Solving Process
<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling alone and suspicious</td>
<td>Becoming an empowered patient</td>
</tr>
<tr>
<td>Forced to be the organizer</td>
<td>Supported and confident</td>
</tr>
<tr>
<td>Feeling studied</td>
<td>Feeling listened to</td>
</tr>
<tr>
<td>Facts</td>
<td>Hands-on action</td>
</tr>
<tr>
<td>Passed between providers</td>
<td>Creating personal relationships</td>
</tr>
<tr>
<td>Stalled</td>
<td>Thriving</td>
</tr>
<tr>
<td>Resource intensive</td>
<td>Streamlined</td>
</tr>
</tbody>
</table>
“The source of energy at work is not in control, it is in connection to purpose.”
How to Deliver the 5 Behaviors?
SCC Approach: “The Activation Model”

• From:
  “What bothers you the most?

• To:
  “Where do you want to be in a year?”
Patient Variation – What the Patient Faces

Domains

- Medical Neighborhood
  - Access to Care
  - Experience with Provider(s)
  - Getting Needed Services
  - Coordination of Care
  - Medical Home / Services Risk

- Social Support
  - Home Environment
  - Job & Leisure
  - Social Support
  - Social Relationships
  - Social Support Risk

- Medical Status & Health Trajectory
  - Medications & Treatments
  - Chronicity
  - Symptom Severity & Condition Factors
  - Diagnostic/Therapeutic Challenges
  - Utilization Factors

- Self Management & Mental Health
  - Engagement / Coping
  - Adherence to Treatment
  - Mental Health History
  - Mental Health Symptoms
  - Self Management & Mental Health Risk

The Team = Patient, Providers, RN Care Manager, patient’s support network
# The Patient Activation Measure (PAM)

1. When all is said and done, I am the person who is responsible for taking care of my health  
   - Disagree  
   - Disagree  
   - Agree  
   - Agree Strongly  
   - N/A

2. Taking an active role in my own health care is the most important thing that affects my health  
   - Disagree Strongly  
   - Disagree  
   - Agree  
   - Agree Strongly  
   - N/A

3. I know what each of my prescribed medications do  
   - Disagree Strongly  
   - Disagree  
   - Agree  
   - Agree Strongly  
   - N/A

4. I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.  
   - Disagree Strongly  
   - Disagree  
   - Agree  
   - Agree Strongly  
   - N/A

5. I am confident that I can tell a doctor concerns I have even when he or she does not ask.  
   - Disagree Strongly  
   - Disagree  
   - Agree  
   - Agree Strongly  
   - N/A

6. I am confident that I can follow through on medical treatments I may need to do at home  
   - Disagree Strongly  
   - Disagree  
   - Agree  
   - Agree Strongly  
   - N/A

7. I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising  
   - Disagree Strongly  
   - Disagree  
   - Agree  
   - Agree Strongly  
   - N/A

8. I know how to prevent problems with my health  
   - Disagree Strongly  
   - Disagree  
   - Agree  
   - Agree Strongly  
   - N/A

9. I am confident I can figure out solutions when new problems arise with my health.  
   - Disagree Strongly  
   - Disagree  
   - Agree  
   - Agree Strongly  
   - N/A

10. I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.  
    - Disagree Strongly  
    - Disagree  
    - Agree  
    - Agree Strongly  
    - N/A
What the Patient Brings: Activation Level

Level 1: Starting to take a role
- Individuals do not feel confident enough to play an active role in their own health. They are predisposed to be passive recipients of care.

Level 2: Building knowledge and confidence
- Individuals lack confidence and an understanding of their health or recommended health regimen.

Level 3: Taking action
- Individuals have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

Level 4: Maintaining behaviors
- Individuals have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

10-15% of the population*

20-25% of the population*

35-40% of the population*

25-30% of the population*

* Medicaid and Medicare populations skew lower in activation
The Often Hidden Driver: Adverse Childhood Events

ACE Score = 1 point each for positive responses to 10 questions inquiring about exposure to:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Physical neglect
- Emotional neglect
- Divorce/separation
- Domestic violence in the home
- Parent that used drugs or alcohol
- Parent that was incarcerated
- Parent that was mentally ill

From: www.acestudy.org

Embed behavioral health!
How does ACE play out later in life?

Increased smoking:
- The higher the ACE score, the greater the likelihood of current smoking

COPD:
- A person with an ACE score of 4 is 2.6 x more likely to have COPD than a person with an ACE score of 0

Depression:
- A person with an ACE score of 4 was 4.6 x more likely to be suffering from depression than a person with an ACE score of 0

Suicide:
- There was a 12.2 x increase in attempted suicide between ACE 4 vs. 0; at higher ACE scores, the prevalence of attempted suicide increases 30-51 fold!
- Between 66-80% of all attempted suicides could be attributed to ACE.
“Depression significantly increases the overall burden of illness in patients with chronic medical conditions...*depression is associated with a 50-100% increase in health services use and cost.*”

Depression is Often Not the Only Health Problem Our Patients Face

- Depression
- Neurologic Disorders 10-20%
- Geriatric Syndromes 20-40%
- Chronic Pain 40-60%
- Heart Disease 20-40%
- Diabetes 10-20%
- Cancer 10-20%
- Geriatric Syndromes 20-40%
- Chronic Pain 40-60%
- Heart Disease 20-40%
- Diabetes 10-20%
- Cancer 10-20%

2010 University of Washington – AIMS Center
General Rules for Team Care

Panel management: responsibilities for people, not tasks
Staff work to limits of their credential
Non-hierarchical meeting structure
Team Meetings

Mindfulness meditation – rotating leaders
Care Coordinator present new cases – 5 minutes each
  ➤ Background (support, family, work)
  ➤ What gives them joy?
  ➤ Problem List (clinician)
  ➤ Goals and action plans
  ➤ Team input

Difficult cases
Thanks jar
Book club
News

Burn out prevention!
Patient Health Portrait

HEALTH PORTRAIT - MQRRSVIODE, APTQHFFZ L

Patient: MQRRSVIODE, APTQHFFZ L
Provider: FZWVYIQ, HJJ U.

Chronic Conditions
- A1C
- BMI
- BP (Systolic)
- LDL
- On AntiPlatelet: N
- Smoker: QUIT

Scores
- Domain Score: 8
- PAM Score: 2
- PMQO Score: -
- SF12 Score: -
- Pain Score: -

Care Gaps
- A/C Ratio Interval: -
- A1C Interval: -
- Last SIV Encounter: 12
- HS CIP Interval: -
- LDL Interval: -
- Eye Exam: -
- Foot Exam: -

Vitals and Labs

A1C
- Red
- Yellow

BP (Systolic)
- Red
- Yellow

LDL
- Red
- Yellow

BMI
- Red
- Yellow

Time
2000 2002 2006
2008 2007
2009 2011
2010 2012
1 2013
Q1 Q2 Q3 Q4
- 1-Jan 7-Jul
- 2-Feb 8-Aug
- 3-Mar 9-Sep
- 4-Apr 10-Oct
- 5-May 11-Nov
- 6-Jun 12-Dec

Print Page
Print FAQ
Monthly “Speed Dating”

- Each care coordinator conferences with relevant clinician on CC panel they share
- Each CC works with each clinician – allows for cross-coverage
- Focus on “red” areas – immediate risk for poor outcome
- CC panel ~100
- No one “falls through the cracks”
- Care gaps also addressed
Analytics Risk Dashboard
Case Study – “Depression and Behavioral Health Domain”

Morbid obesity
Type 2 Diabetes with complications
Smoker
Chronic depression

Baseline status:
- ACE score: 8
- PAM: Level 3
- PHQ-9: 17 (depressed)
- A1C: 9.5 (poor control)

Hadn’t checked her own glucose in 2 years
Case Study (2)

Current (June 2016)
PAM: Level 4 (from 3)
PHQ-9: 5 (from 17)
Weight: 237 (37 lb loss)
A1c: 7.5 (from 9.5)
No longer smoking
Humboldt Priority Care PAM Results

**Comparative Values by PAM Levels**

- **Level 1**
  - Initial: 15
  - Repeat: 10
- **Level 2**
  - Initial: 30
  - Repeat: 20
- **Level 3**
  - Initial: 45
  - Repeat: 35
- **Level 4**
  - Initial: 60
  - Repeat: 55

**How was this achieved?**
Preliminary Patient Activation Measures (PAM) Results through June 2014

Distribution of Baseline and Follow-up PAM Levels - All IOCP through 6/15/14

Based on 847 patients with repeated assessments

- 32% increased overall activation
- 14% decreased overall activation
- 54% same overall activation

*Additionally, preliminary independent group findings (Wave 1 sites) show lower admission and ED utilization from IOCP participants.
Comparative Values by PAM Levels

- Level 1
- Level 2
- Level 3
- Level 4

Initial
Repeat

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## Triple Aim Results

<table>
<thead>
<tr>
<th>Inpatient Admissions</th>
<th>ER Visits</th>
<th>Patient Experience</th>
<th>Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>-29%</td>
<td>-59%</td>
<td>99&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>-13% (~$1.8 million)</td>
</tr>
</tbody>
</table>

253 patients with at least 6 months enrollment
From “Cup Runneth Over”…

- Provider
- Medical Assistant/Care Coordinator
- Nurse
- Behavioral Health
- Clinical Pharmacist
- Physical Therapist
To “Share the Care”

Provider

Medical Assistant/Care Coordinator

Nurse

LCSW/Behavioral Health

Physical Therapist

Clinical Pharmacist
Dancing, Not Wrestling
Planning & Implementation Resources for HHP

- No-cost TA from PBGH and health plans
  - Guided HHP readiness support informed by CB-CME Organizational Assessment findings (PBGH)

- HHP Practice Transformation Learning Community – Register now
  - Next in-person session: Sept 14 Santa Rosa, Sept 21 Oakland
  - Monthly Practice Transformation webinars:
    - August 4: Kathy Moses, CHCS - Health Home Lessons Learned
    - September 29: Judy Thomas - Integrating Palliative Care into HHP and Primary Care
    - October – Supporting HHP Members Experiencing Homelessness

- HHP Concept Paper
  http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx