Health, Healthcare and Human Services: What's Next?

CWDA Conference

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Why are we here today?

No one system has the mandate, resources, or reach to address both person-specific issues and the larger social conditions that exacerbate behavioral health problems, such as poverty, racism, inadequate housing, homelessness, poor schools, crime, and disparities.

Health is too important to leave solely for the health system.

Why are we here today?

"The pressures for fundamental change in health care have been building for decades...

Already unsustainable costs, an aging population, advances in medicine, and a growing proportion of patients in low reimbursement government programs have made the status quo unsustainable. Change is inevitable."

Michael Porter, Harvard Business Review Blog September 17, 2013

Proposed Shared Vision

A community where all are safe, well and healthy with a sense of purpose, belonging and opportunities to achieve their aspirations.

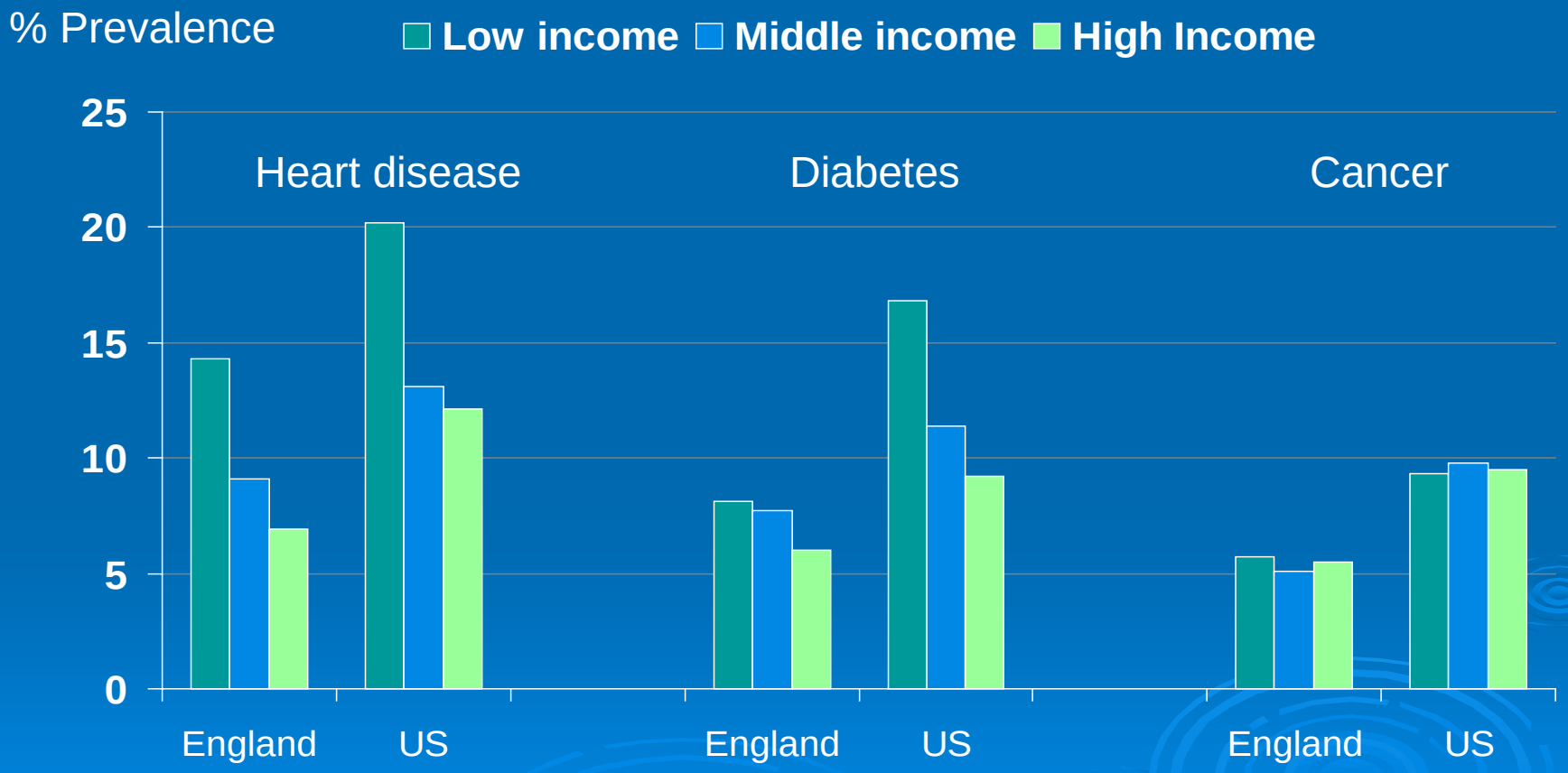
Key Demographic Trends

- Changing US population (over 20 years)
  - larger 282 up to 350 million
  - older 12% up to 18%
  - diverse 81% down to 78% white
- Virtually all persons with BH conditions will be insured
- Medicaid (80 million) and Medicare (75 million) will continue to grow

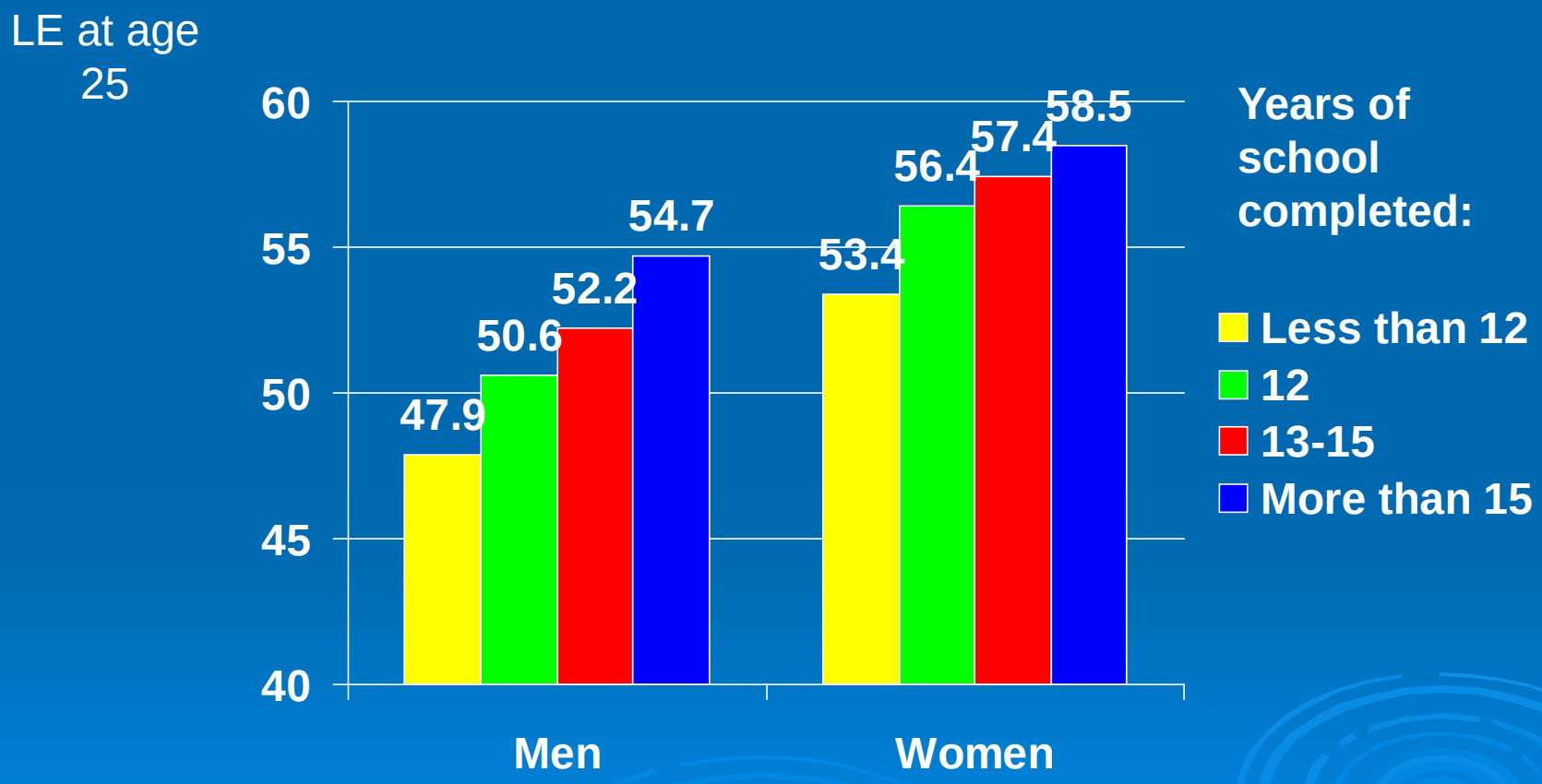
Why are we here today?

- **In 2005, federal, state, and local government spending as a result of substance abuse and addiction was at least $467.7 billion, or 10.7 % of their combined $4.4 trillion budgets.**
- **For each dollar of the $467.7 billion spent,**
  - **95.6 cents went to shoveling up the wreckage and only**
  - **1.9 cents on prevention and treatment,**
  - **0.4 cents on research,**
  - **1.4 cents on taxation or regulation and**
  - **0.7 cents on interdiction.**

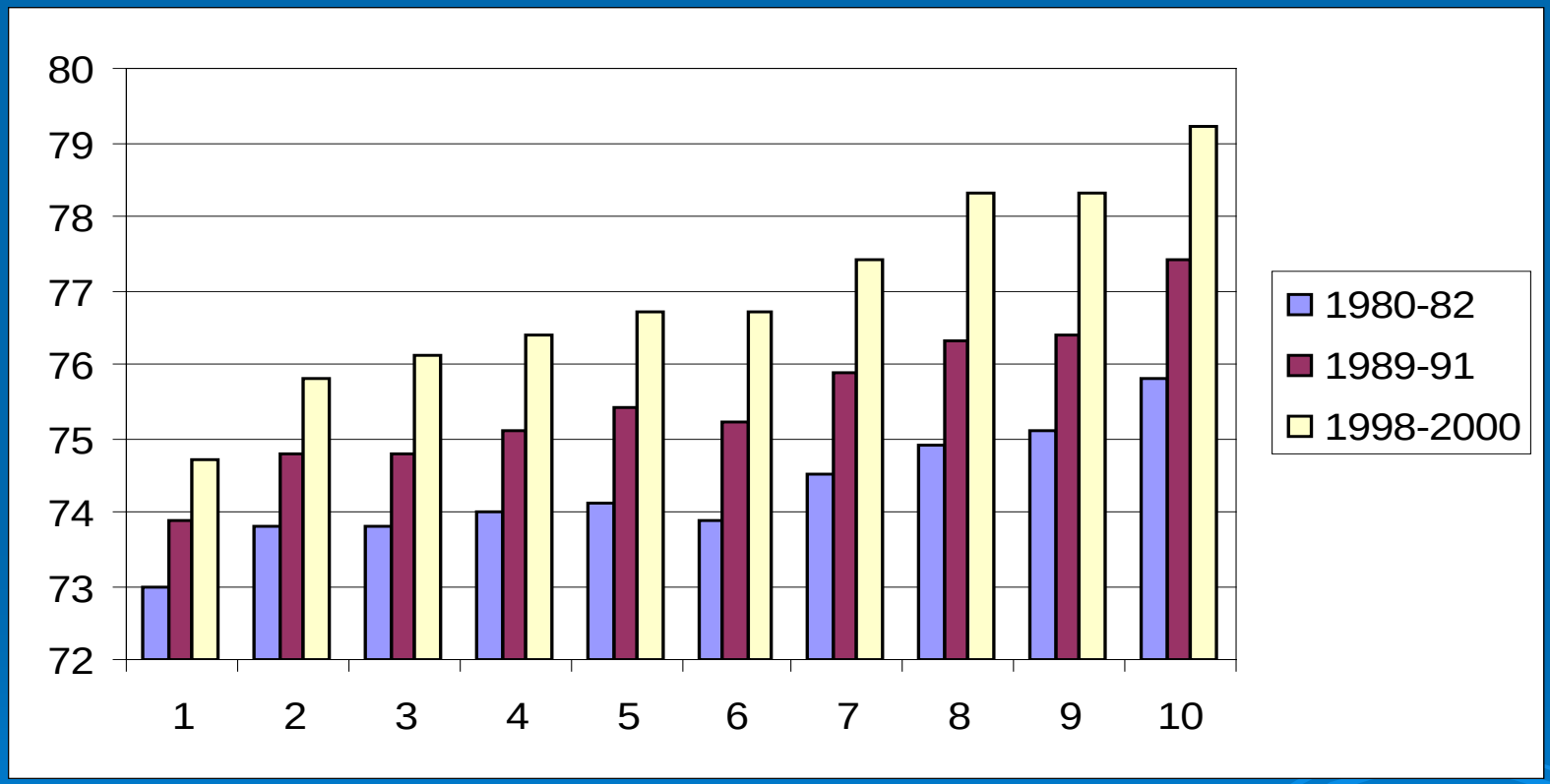
Health Differences Between England and the US for 55-64 Year Olds



Life expectancy at age 25 by education level in the US, 1988-98



Life expectancy at birth by socioeconomic level in the US



Low Income
High Income

WHY NOW

National Policy Level

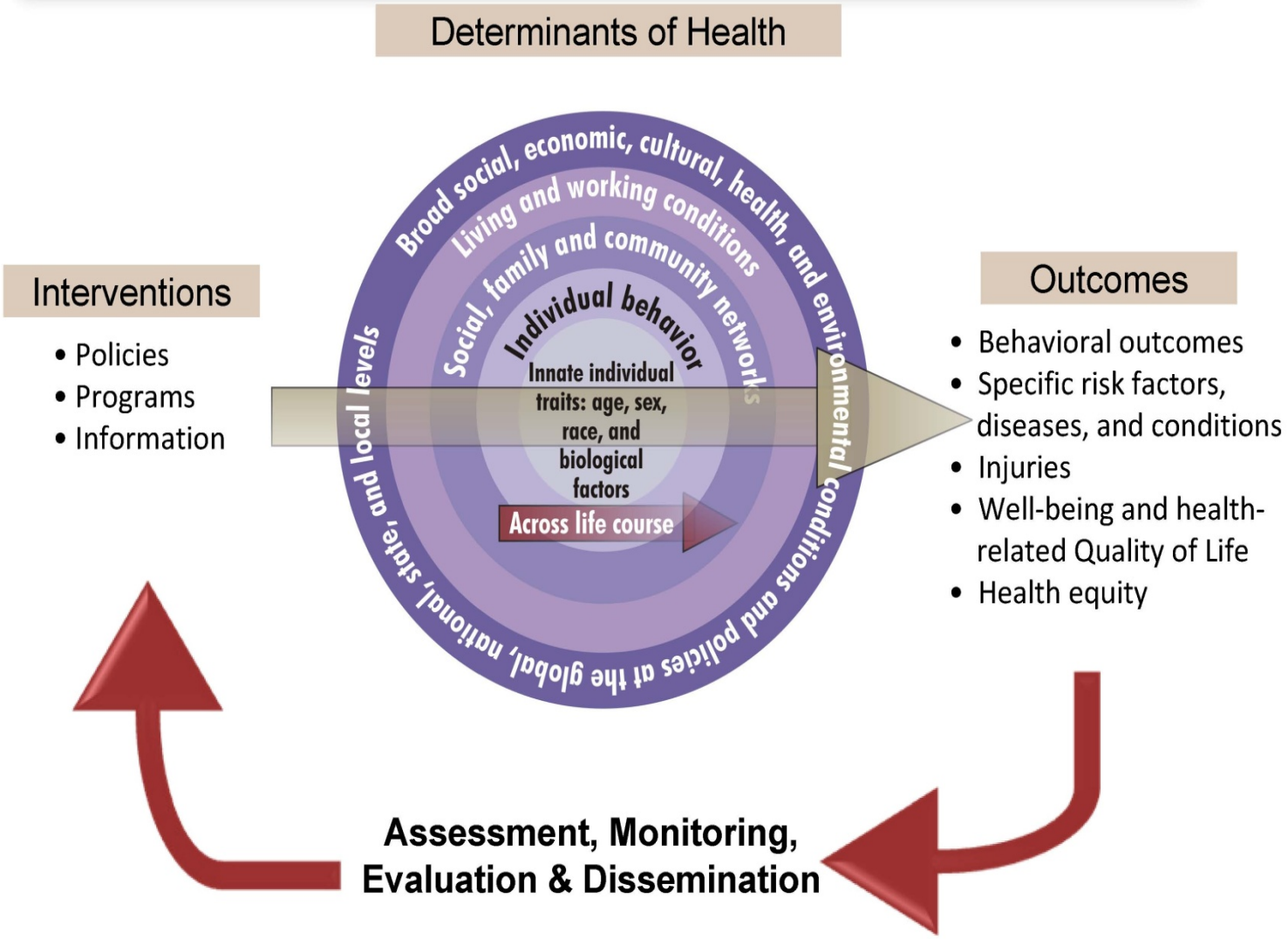
Healthy People 2020

National Prevention Strategy

National Quality Strategy

Centers for Medicare and Medicaid Services (CMS)

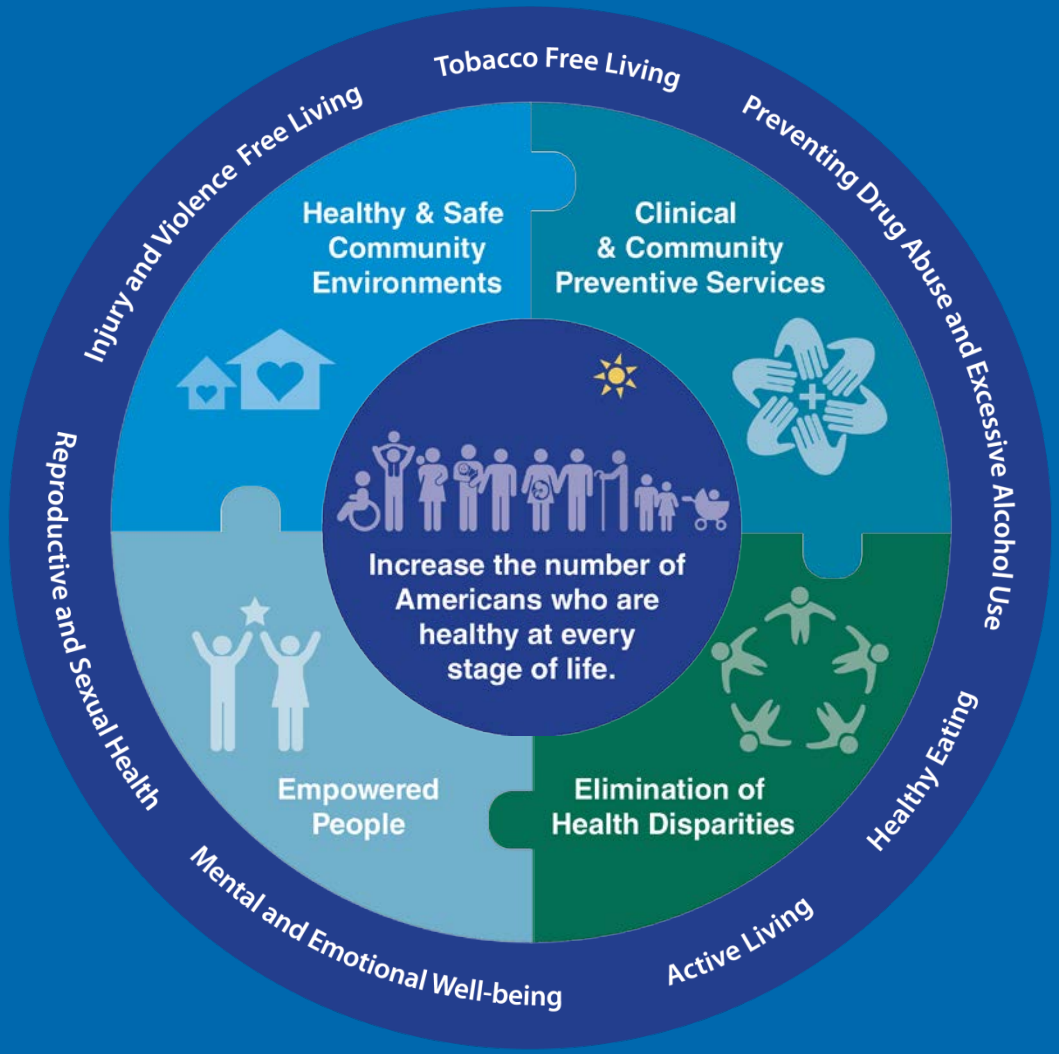
Action Model to Achieve Healthy People 2020 Overarching Goals



Social Determinants:

the cultural, social, economic, health, and environmental conditions at the national, regional, community, and family levels that influence one's life chances, including one's future physical and behavioral health.

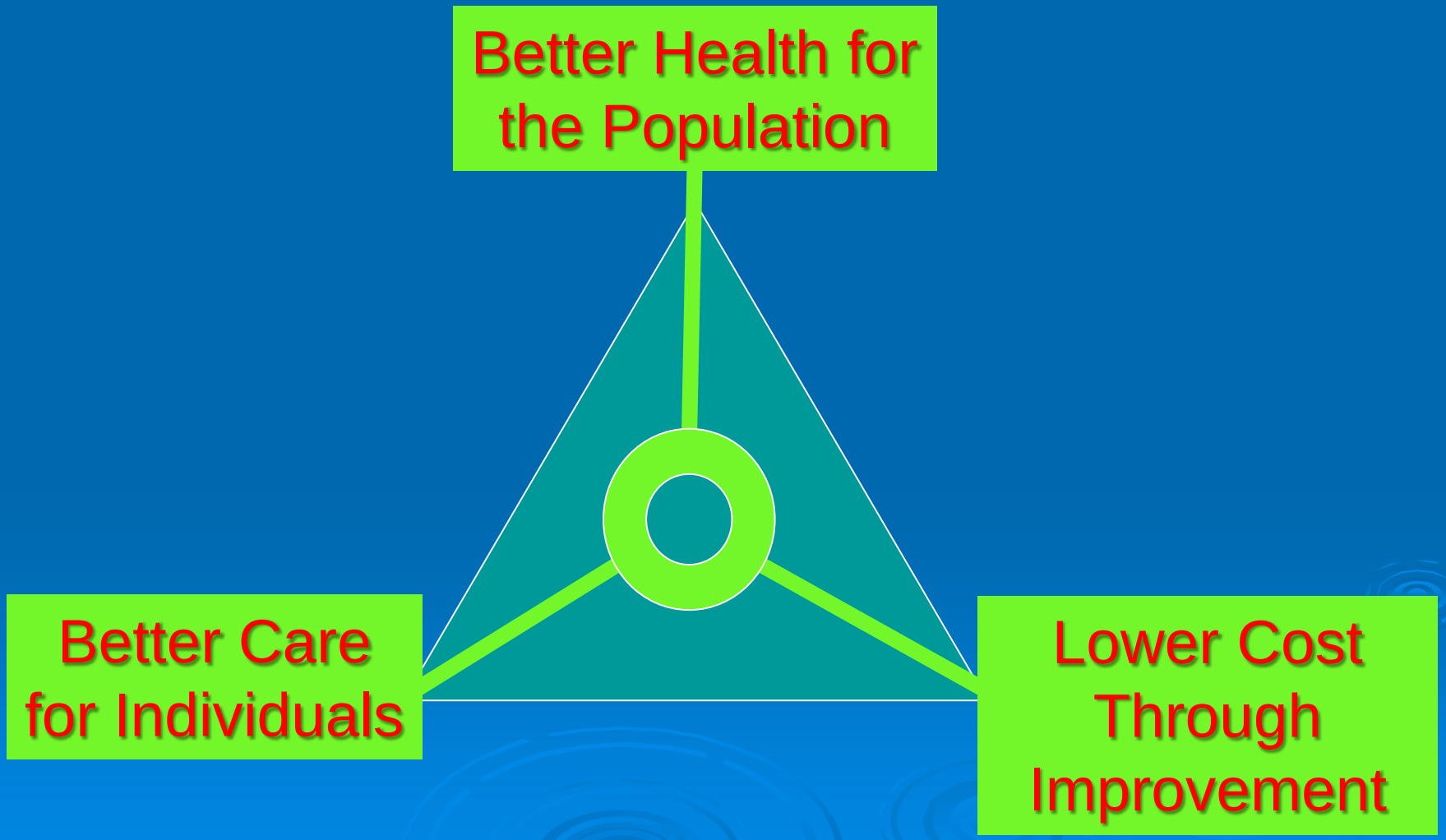
National Prevention Strategy



The Six Goals of the National Quality Strategy

1. Make care safer by reducing harm caused in the delivery of care
2. Strengthen person and family engagement as partners in their care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of chronic disease
5. Work with communities to promote healthy living
6. Make care affordable

CMS: The “Triple Aim”



We need delivery system and payment transformation

Current State –

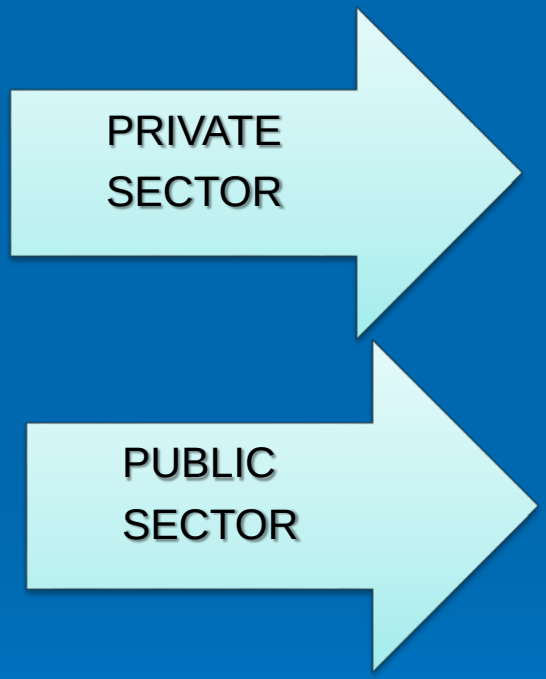
Producer-Centered

Volume Driven

Unsustainable

Fragmented Care Systems

FFS Payment Systems



Future State –

People-Centered

Outcomes Driven

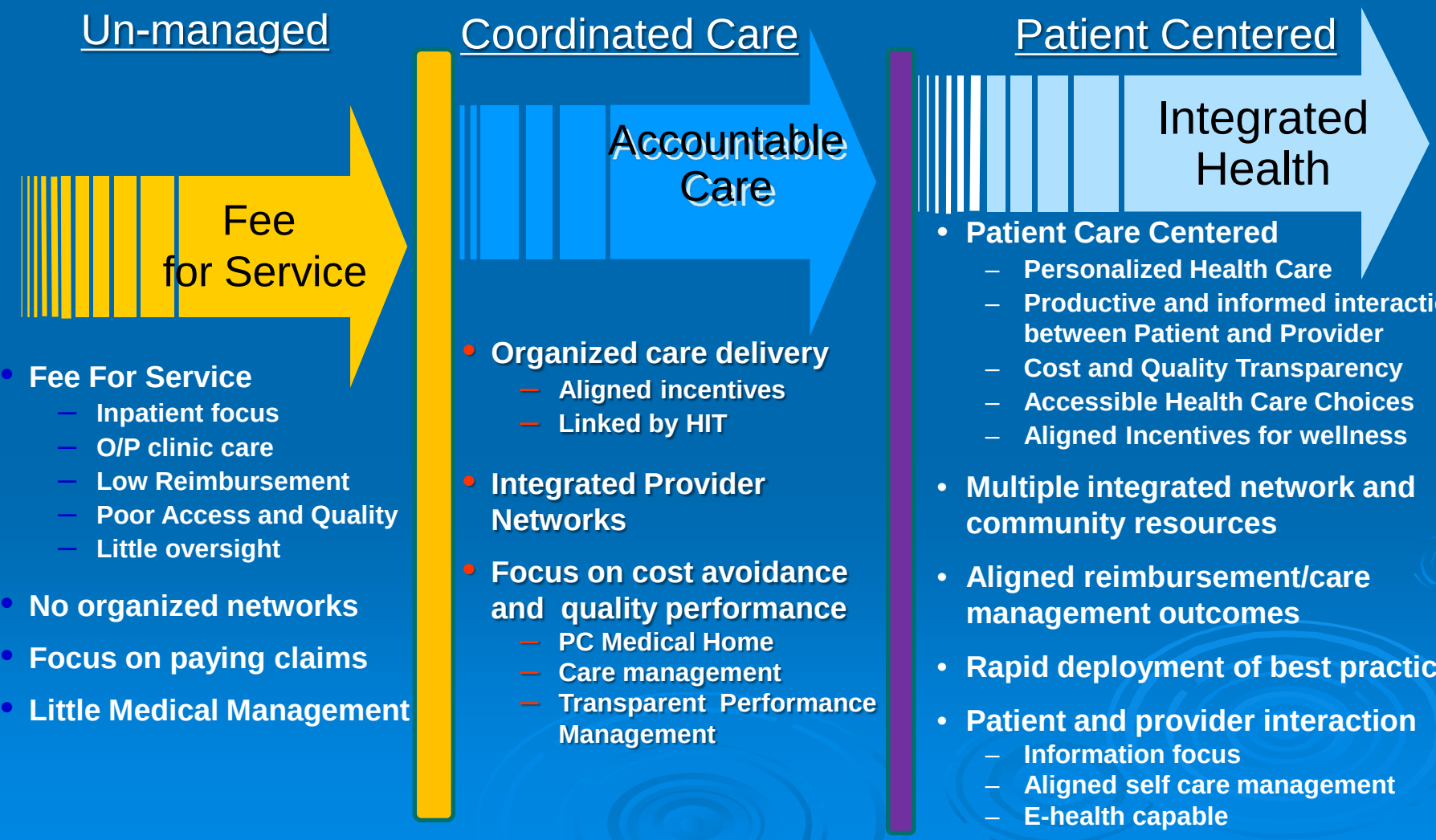
Sustainable

Coordinated Care Systems

New Payment Systems

- Value-based purchasing
- ACOs Shared Savings
- Episode-based payments
- Care Management Fees
- Data Transparency

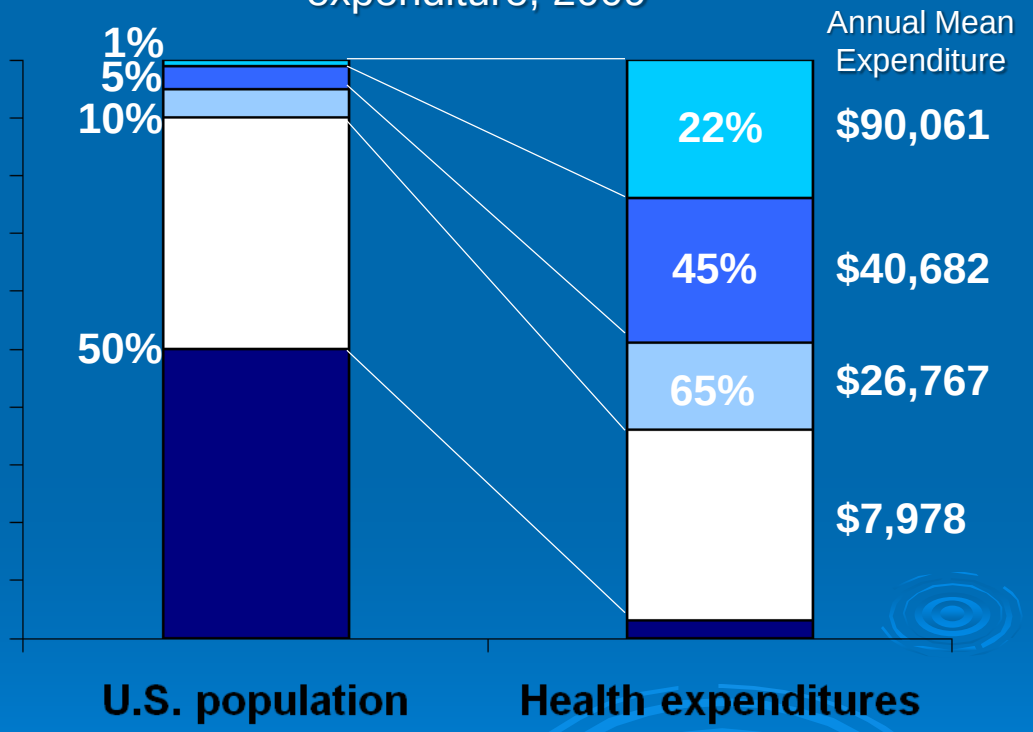
Driving Healthcare System Transformation



For Savings, Go Where the Money Is

- 10% of patients account for 65% of costs
- Focus efforts on patients with highest costs
- Three part strategy:
  - Primary care/delivery system reform
  - Payment reform
  - Health information technology
- Leadership can come from:
  - Federal government
  - State government
  - Employers
  - Providers
  - Insurers
  - Collaboration among all

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 2009



Source: D. Blumenthal, "Performance Improvement in Health Care—Seizing the Moment," New England Journal of Medicine, April 26, 2012 366(17)1203–427.

A Person/Family Centered Approach

- Is Strengths Based –Assumes people have abilities, capacities
- Role focused, not problem focused (problems interfere with performing desired roles, diagnosis is not a role)
- Promotes direction of the process by the person/family
- Adopts an individualized approach to services (not a cookie cutter set of programs)
- Where changes made in individual circumstances may have system wide implications that benefit others (innovations)

CMS Definition

"…identify and access a PERSONALIZED mix of paid and non-paid services and supports that will assist him/her to achieve PERSONALLY-DEFINED OUTCOMES in the most inclusive community setting. The individual identifies planning goals to achieve these outcomes in COLLABORATION with those that the individual has identified , including medical and professional staff …."

Putting the Pieces Together in a Person-Centered Plan

GOAL
as Defined by Person

Strengths to Draw Upon

Barriers Which Interfere

Short-Term Objective
- Behavioral
- Achievable
- Measureable

Interventions/Action Steps
- Professional/"Billable" Services
- Clinical & Rehab
- Action Steps by Person in Recovery
- Roles/Actions by Natural Supporters

The plan is one slice in the pie…

The *practice* of PCP can only grow out of a *culture* that fully appreciates recovery, self-determination, and community inclusion.

Can change what people "do"… but also need to change way people feel and think.

Plan: (a written document)

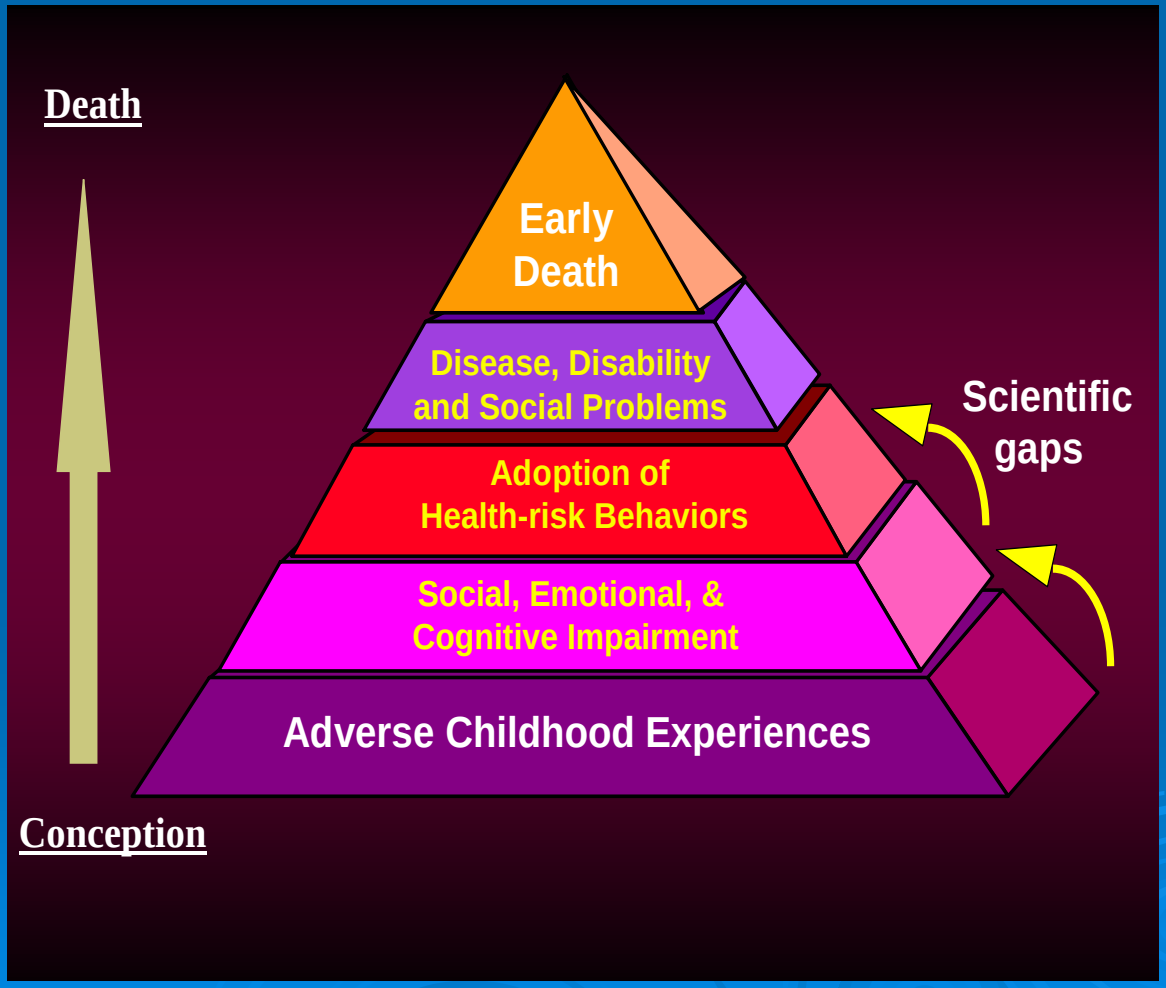
Process: (a way of doing)

Product: (multi-dimensional outcomes)

Philosophy: (a way of thinking & feeling)

WHY FAMILY

Adverse Child Experiences Study



Adverse Childhood Experiences Study

- Fairly common
- Generally clustered
- Have a cumulative effect on healthy development and health care status

What Do They Need?

Caregivers:

- Words to share experiences
- Understanding of family disease
- Time with their children for healing
- Making amends and forgiveness

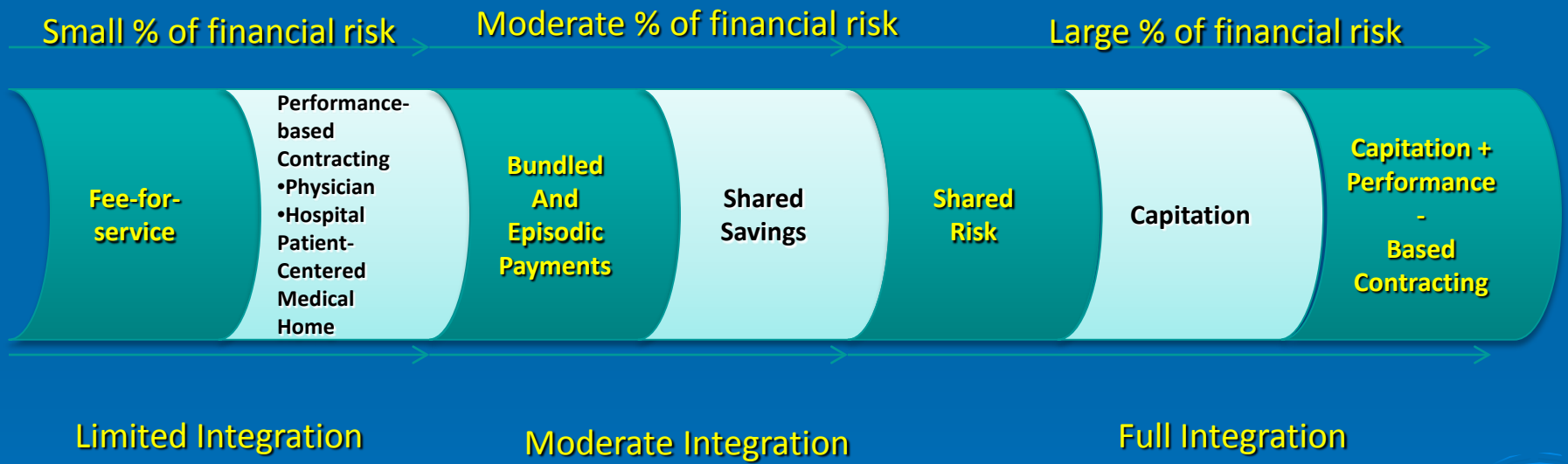
Children:

- Words to say what happened
- Understanding of family disease
- Time with their caregivers to heal
- Knowledge that it isn't their fault

WHY PROVIDERS

The shift toward increased collaboration, outcome-based payment, and new benefit design is driving innovation in both payment models and delivery system configuration.

Compensation Continuum
(Level of Financial Risk)



Continuum of risks represents multiple value-based contracting options.

Leadership Skills

- Adaptive vs technical
- Collaborative
- Philadelphia transformation
  - Why, what, how
- Institute for Health Improvement
  - Will, ideas, execution

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Setting Aims

Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

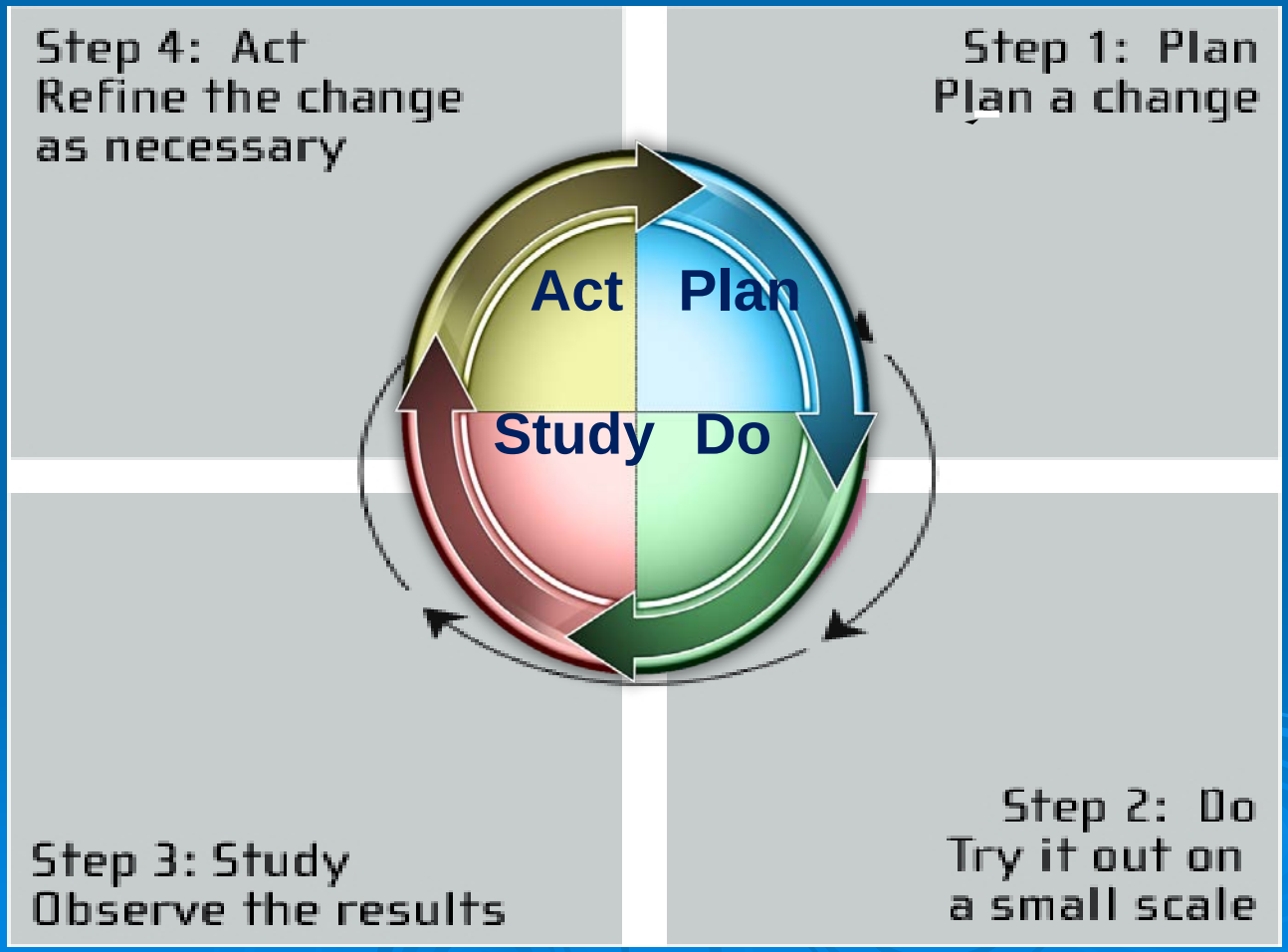
Establishing Measures

Use quantitative measures to determine if a specific change actually leads to an improvement.

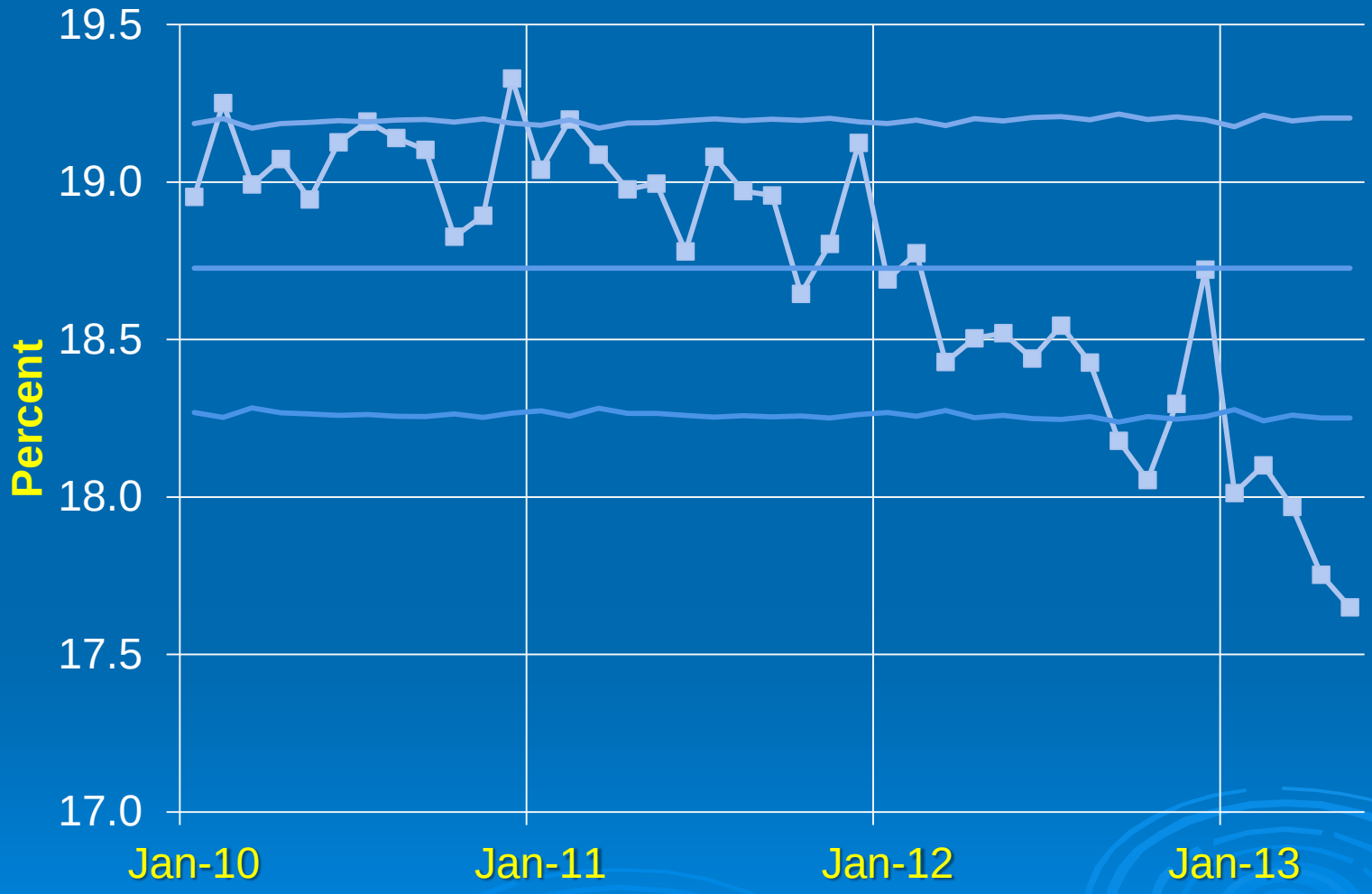
Selecting Changes

All improvement requires making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.

The PDSA Cycle for Learning and Improvement

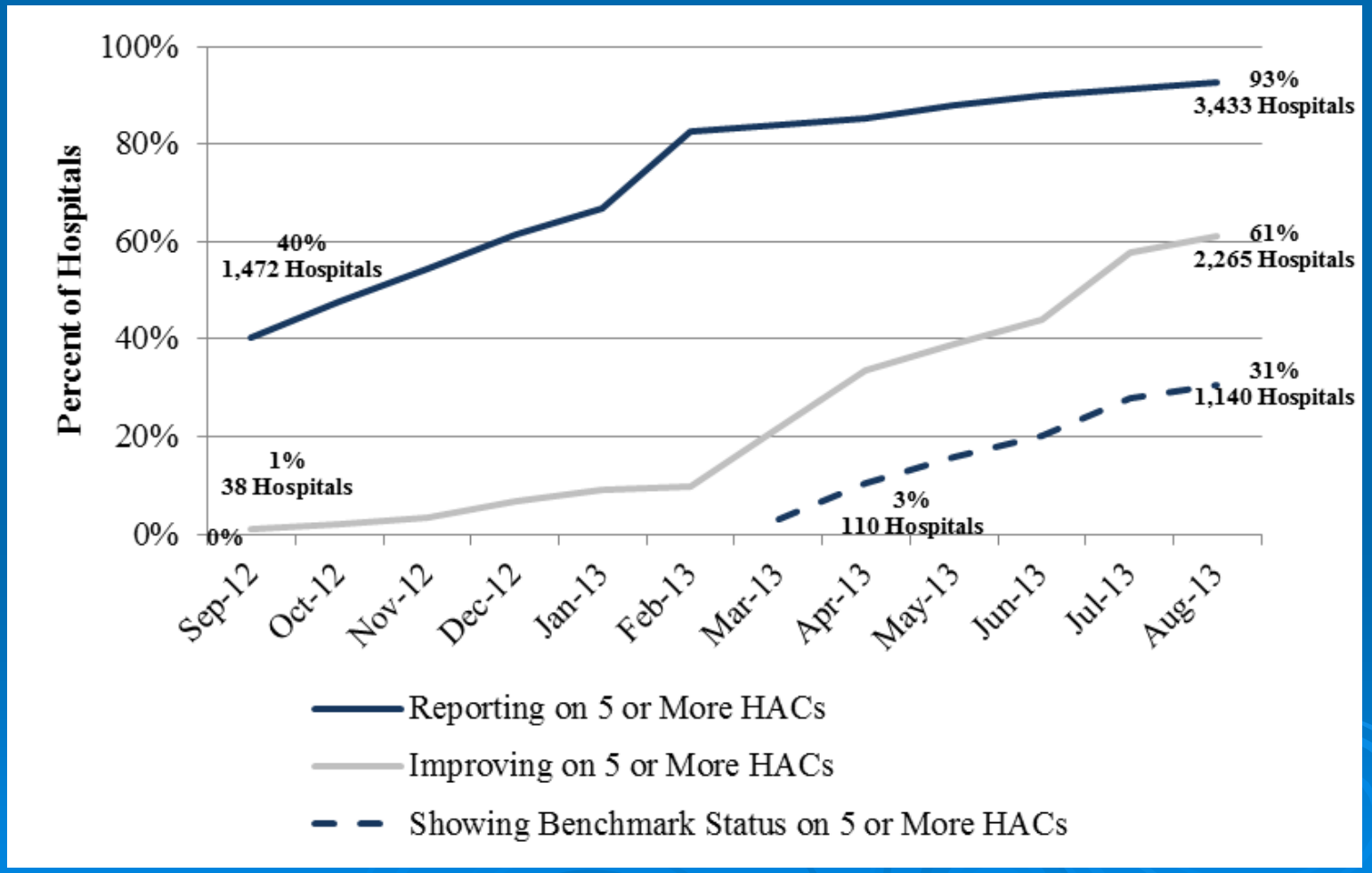


Medicare All Cause, 30 Day Hospital Readmission Rate



Source: Office of Information Products and Data Analytics, CMS

Partnership for Patients: Hospitals Continue to Generate Increases in Reporting, Improvement and Achievement on More Harm Areas



WHY COMMUNITY

EXTERNAL ASSETS

Support	1. Family support 2. Positive family communication 3. Other adult relationships 4. Caring neighborhood 5. Caring school climate 6. Parent involvement in schooling
Empowerment	7. Community values youth 8. Youth as resources 9. Service to others 10. Safety

EXTERNAL ASSETS (2)

Boundaries & Expectations	11. Family boundaries 12. School boundaries 13. Neighborhood boundaries 14. Adult role models 15. Positive peer influence 16. High expectations
Constructive Use of Time	17. Creative activities 18. Youth programs 19. Religious community 20. Time at home

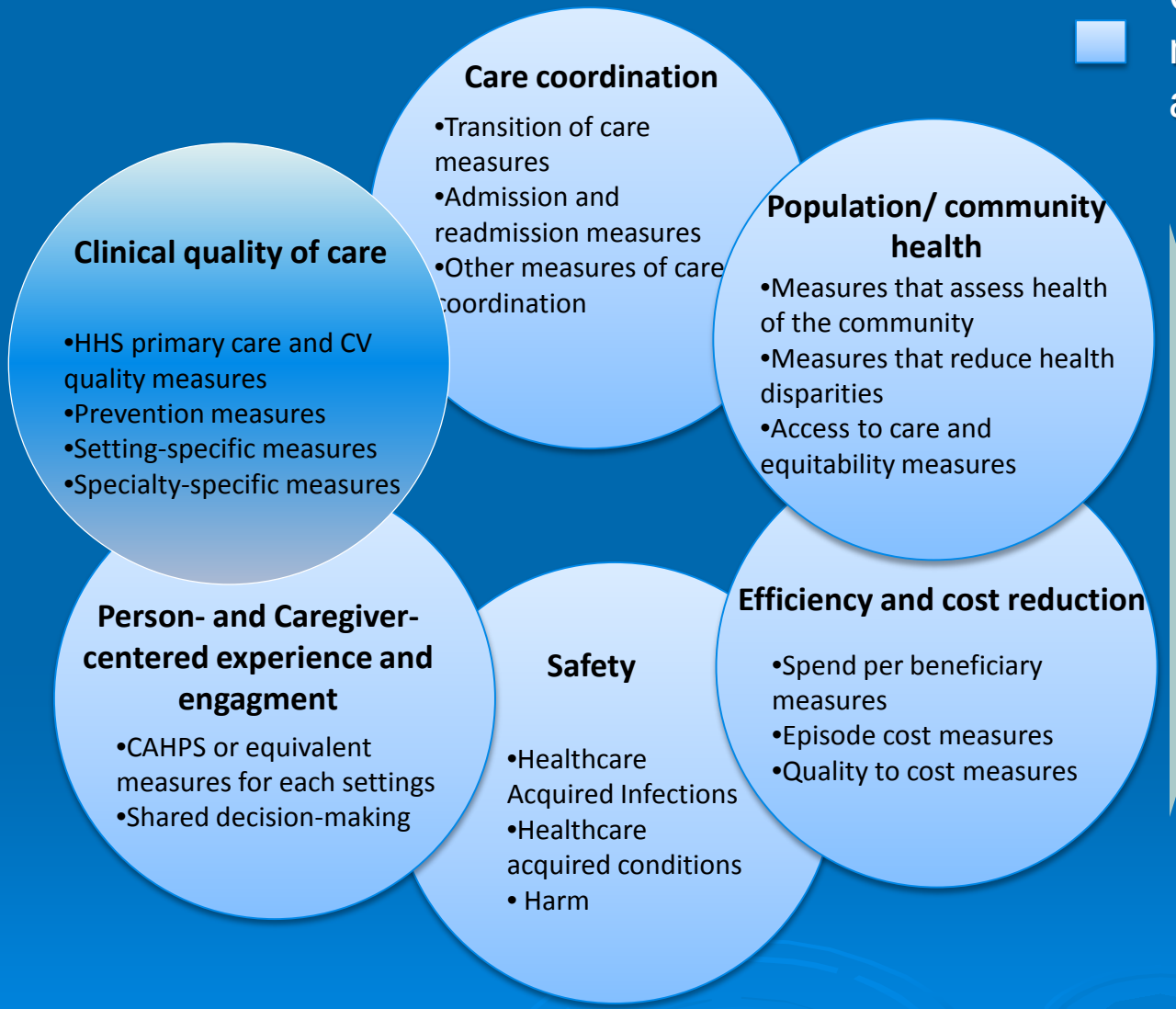
INTERNAL ASSETS

Commitment to Learning	21. Achievement motivation 22. School engagement 23. Homework 24. Bonding to school 25. Reading for pleasure
Positive Values	26. Caring 27. Equality and social justice 28. Integrity 29. Honesty 30. Responsibility 31. Restraint

INTERNAL ASSETS (2)

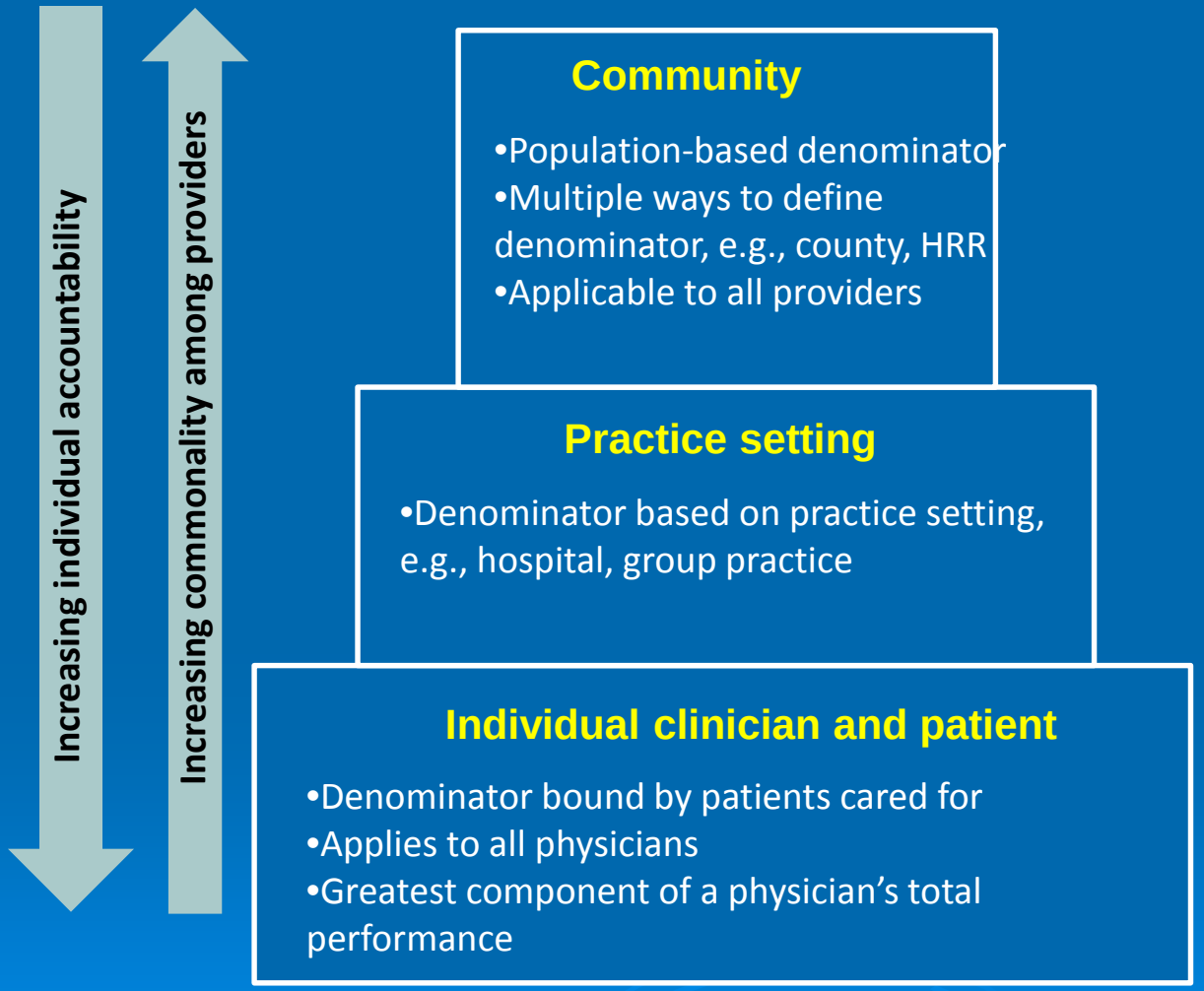
Social Competencies	32. Planning and decision making 33. Interpersonal competence 34. Cultural competence 35. Resistance skills 36. Peaceful conflict resolution
Positive Identity	37. Personal power 38. Self-esteem 39. Sense of purpose 40. Positive view of personal future

CMS framework for measurement maps to the six national priorities



- Greatest commonality of measure concepts across domains
  - Measures should be patient-centered and outcome-oriented whenever possible
  - Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures

Quality can be measured and improved at multiple levels



- **Measure concepts should "roll up" to align quality improvement objectives at all levels**
- **Patient-centric, outcomes oriented measures preferred at all three levels**
- **The six NQS domains can be measured at each of the three levels**

PROPOSED INNOVATION:
Family Health & Wellness Center

FAMILY HEALTH & WELLNESS CENTER

- ADRC
  - No wrong door approach
  - Information and referral
  - Person-centered screening, assessment and services
  - Coordination of care
  - Determine eligibility for public LTSS

- Recovery Centers
  - Peer to peer services/supports
  - Recovery coaching
  - Increases recovery capital

FAMILY HEALTH & WELLNESS CENTER 2

- Family Resource Centers
  - Family education, supports and activities e.g., cultural, recreation, social
  - Healthy family living skills

- The Center would provide:
  - Bridge formal and informal systems of care
  - Raise awareness and encourage social action
  - Increase human, recovery and social capital
  - Improve community health and wellness

FAMILY HEALTH & WELLNESS CENTER 3

- Builds upon already successful approaches
- A family and community-centered “place”
- Emphasis on increasing human, recovery and social capital
- Bridging formal and informal “systems of care”
- Addressing person/family and social issues
- Engage, convene and activate family, system and community stakeholders

Key Takeaways

- Multiple and overlapping system "transformations" underway
  - Triple Aim , FFS to value based care
- Design and delivery changes
  - Inadequate capacity, workforce issues, continuum of care, recovery oriented system of care
- Use of IT
  - Data-driven decisions, clinical and administrative, Outputs to Outcomes to Quality of Life

Key Takeaways 2

- Changing role of person/family from patient/client to collaborative partner
- Focus on social determinants of health at individual, family, and community level
  - Need for a community level, multi-sector governance and leadership structure
  - Reduce/eliminate stigma, discrimination, and disparities

Need for a New Vision

Opportunities and Challenges of a Lifelong Health System

- Goal of system to optimize health outcomes and lower costs over much longer time horizons
- Payers, including Medicare and Medicaid, increasingly responsible for care for longer periods of time
- Health trajectories modifiable and compounded over time
- Importance of early years of life

Source: Halfon N, Conway PH. The Opportunities and Challenges of a Lifelong Health System. NEJM 2013 Apr 25; 368, 17: 1569-1571

CONTACT INFORMATION

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