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

CWDA Conference
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Sacramento, CA
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.”

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

% Prevalence

- **Low income**
- **Middle income**
- **High Income**

**Heart disease**
- England: Low income (14), Middle income (11), High Income (9)
- US: Low income (20), Middle income (15), High Income (10)

**Diabetes**
- England: Low income (5), Middle income (4), High Income (3)
- US: Low income (2), Middle income (1), High Income (0)

**Cancer**
- England: Low income (6), Middle income (5), High Income (4)
- US: Low income (3), Middle income (2), High Income (1)
Life expectancy at age 25 by education level in the US, 1988-98

<table>
<thead>
<tr>
<th>Years of school completed:</th>
<th>Men</th>
<th>Women</th>
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<tbody>
<tr>
<td>Less than 12</td>
<td>47.9</td>
<td>50.6</td>
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<tr>
<td>12</td>
<td>52.2</td>
<td>54.7</td>
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<tr>
<td>13-15</td>
<td>50.6</td>
<td>53.4</td>
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<tr>
<td>More than 15</td>
<td>54.7</td>
<td>56.4</td>
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<td></td>
<td>58.5</td>
<td>57.4</td>
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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

Determinants of Health

Interventions
- Policies
- Programs
- Information

Outcomes
- Behavioral outcomes
- Specific risk factors, diseases, and conditions
- Injuries
- Well-being and health-related Quality of Life
- Health equity

Assessment, Monitoring, Evaluation & Dissemination
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

Increase the number of Americans who are healthy at every stage of life.

- Tobacco Free Living
- Preventing Drug Abuse and Excessive Alcohol Use
- Healthy Eating
- Active Living
- Mental and Emotional Well-being
- Reproductive and Sexual Health
- Injury and Violence Free Living
- Clinical & Community Preventive Services
- Healthy & Safe Community Environments
- Empowered People
- Elimination of Health Disparities
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”

Better Health for the Population

Better Care for Individuals

Lower Cost Through Improvement
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

**Un-managed**
- Fee For Service
  - Inpatient focus
  - O/P clinic care
  - Low Reimbursement
  - Poor Access and Quality
  - Little oversight
- No organized networks
- Focus on paying claims
- Little Medical Management

**Fee for Service**

**Coordinated Care**
- Organized care delivery
  - Aligned incentives
  - Linked by HIT
- Integrated Provider Networks
- Focus on cost avoidance and quality performance
  - PC Medical Home
  - Care management
  - Transparent Performance Management

**Accountable Care**

**Patient Centered**
- Patient Care Centered
  - Personalized Health Care
  - Productive and informed interactions between Patient and Provider
  - Cost and Quality Transparency
  - Accessible Health Care Choices
  - Aligned Incentives for wellness
- Multiple integrated network and community resources
- Aligned reimbursement/care management outcomes
- Rapid deployment of best practices
- Patient and provider interaction
  - Information focus
  - Aligned self care management
  - E-health capable

**Integrated Health**
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

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 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.

The plan is one slice in the pie…

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
- Disease, Disability, and Social Problems
- Adoption of Health-risk Behaviors
- Social, Emotional, & Cognitive Impairment
- Early Death

Scientific gaps

Conception to Death
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)

- Small % of financial risk
  - Fee-for-service
    - Performance-based Contracting
      - Physician
      - Hospital
      - Patient-Centered Medical Home
  - Bundled And Episodic Payments
  - Shared Savings

- Moderate % of financial risk
  - Shared Risk

- Large % of financial risk
  - Capitation
  - Capitation + Performance-Based Contracting

**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
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

Step 1: Plan
Plan a change

Step 2: Do
Try it out on a small scale

Step 3: Study
Observe the results

Step 4: Act
Refine the change as necessary

Act
Plan
Study
Do
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

<table>
<thead>
<tr>
<th>Support</th>
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<tbody>
<tr>
<td>1. Family support</td>
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<td>2. Positive family communication</td>
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<td>3. Other adult relationships</td>
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<tr>
<td>4. Caring neighborhood</td>
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<tr>
<td>5. Caring school climate</td>
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<tr>
<td>6. Parent involvement in schooling</td>
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<table>
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<tr>
<th>Empowerment</th>
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<tr>
<td>7. Community values youth</td>
<td></td>
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<tr>
<td>8. Youth as resources</td>
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<td>9. Service to others</td>
<td></td>
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<tr>
<td>10. Safety</td>
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</tbody>
</table>
| 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  

**EXTERNAL ASSETS** (2)
## 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         |
<table>
<thead>
<tr>
<th>Social Competencies</th>
<th>32. Planning and decision making</th>
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<tbody>
<tr>
<td></td>
<td>33. Interpersonal competence</td>
</tr>
<tr>
<td></td>
<td>34. Cultural competence</td>
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<td></td>
<td>35. Resistance skills</td>
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<tr>
<td></td>
<td>36. Peaceful conflict resolution</td>
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<tr>
<td>Positive Identity</td>
<td>37. Personal power</td>
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<tr>
<td></td>
<td>38. Self-esteem</td>
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<tr>
<td></td>
<td>39. Sense of purpose</td>
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<td>40. Positive view of personal future</td>
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</table>
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**

**Community**
- Population-based denominator
- Multiple ways to define denominator, e.g., county, HRR
- Applicable to all providers

**Practice setting**
- Denominator based on practice setting, e.g., hospital, group practice

**Individual clinician and patient**
- Denominator bound by patients cared for
- Applies to all physicians
- Greatest component of a physician’s total performance

Increasing individual accountability
Increasing commonality among providers
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 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

- 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

- 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
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