

# Medicaid Advisory Committee

March 27, 2012

General Services Building  
Salem, Oregon

<b>Time</b>	<b>Item</b>	<b>Presenter</b>
<b>9:00</b>	<b>Opening Remarks</b>	<b>Co-Chairs</b>
<b>9:10</b>	<b>Approval of Minutes – February 2013</b>	<b>MAC Members</b>
<b>9:15</b>	<b>Oregon Health Authority – Update</b> <ul style="list-style-type: none"> <li>• CCOs and HST</li> <li>• Transformation Center</li> <li>• Legislative Update</li> </ul>	<b>Rhonda Busek, Oliver Droppers</b>
<b>9:25</b>	<b>Person and Family Centered Approaches in Oregon (Part A)</b> <i>Oregon’s Patient Self-management Collaborative</i> <ul style="list-style-type: none"> <li>• Collaborative Overview</li> <li>• Lessons from Benton County</li> </ul>	<b>Danna Hastings, Cara Biddlecom, OHA; Kelly Volkman, Benton County</b>
<b>10:10</b>	<b>Break</b>	
<b>10:15</b>	<b>Person and Family Centered Approaches in Oregon (Part B)</b> <i>Child and Adolescent Mental Health and Wraparound</i> <ul style="list-style-type: none"> <li>• System of Care/Wraparound</li> <li>• Oregon’s Statewide Children’s Wraparound Initiative (SCWI)</li> </ul>	<b>Michael Morris, Administrator, Addictions and Mental Health Division, OHA; Bill Bouska, OHA Transformation Center</b>
<b>11:00</b>	<b>Person and Family Centered Approaches (PFCA) to Health</b> <ul style="list-style-type: none"> <li>• Discussion of key concepts</li> <li>• Review/feedback on draft report outline</li> </ul>	<b>Committee</b>
<b>11:50</b>	<b>Public Comment or Testimony</b>	
<b>11:55</b>	<b>Closing comments</b>	
<b>12:00</b>	<b>Adjourn</b>	<b>Co-Chairs</b>

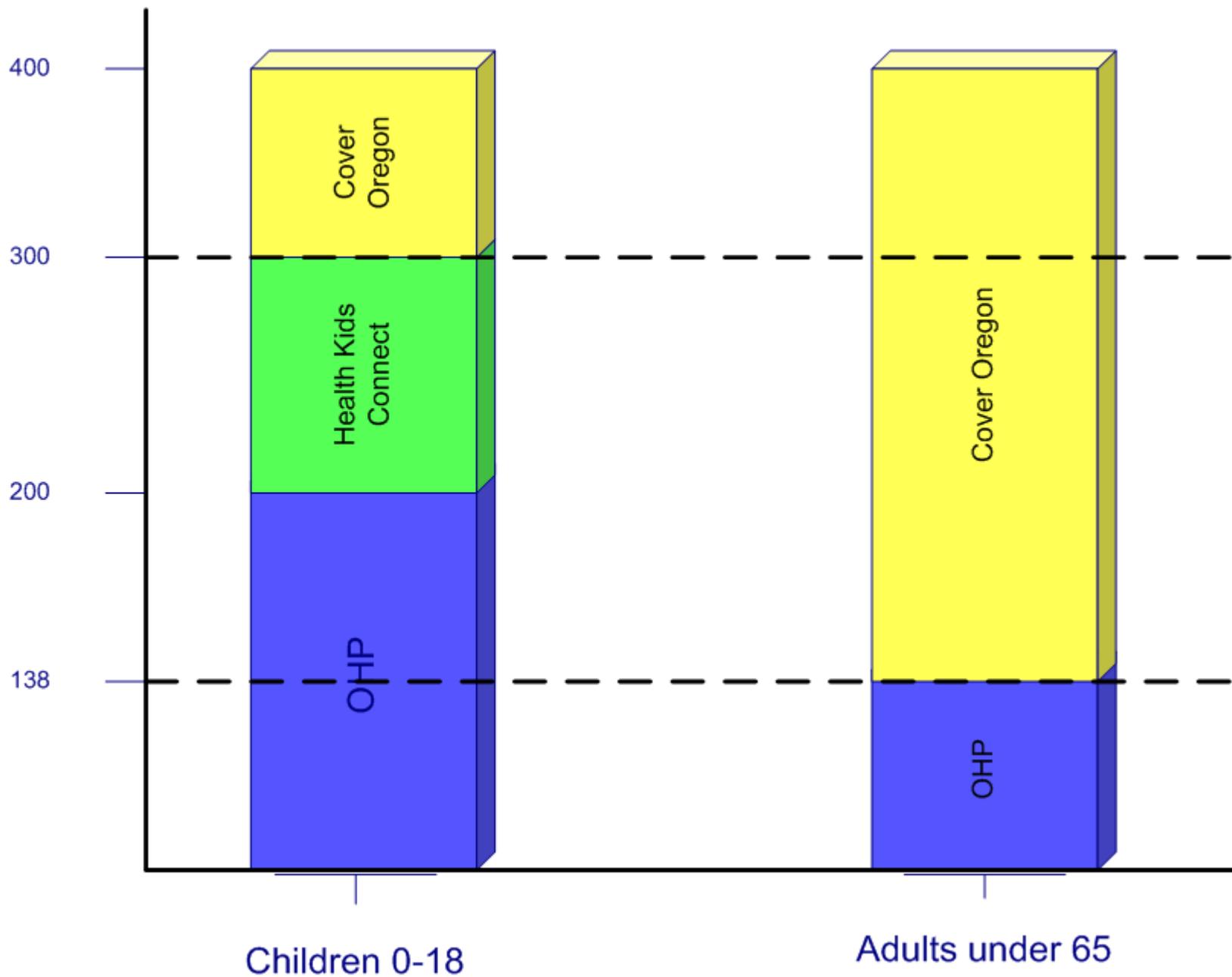
# Oregon Health Authority: Update

**Rhonda Busek**

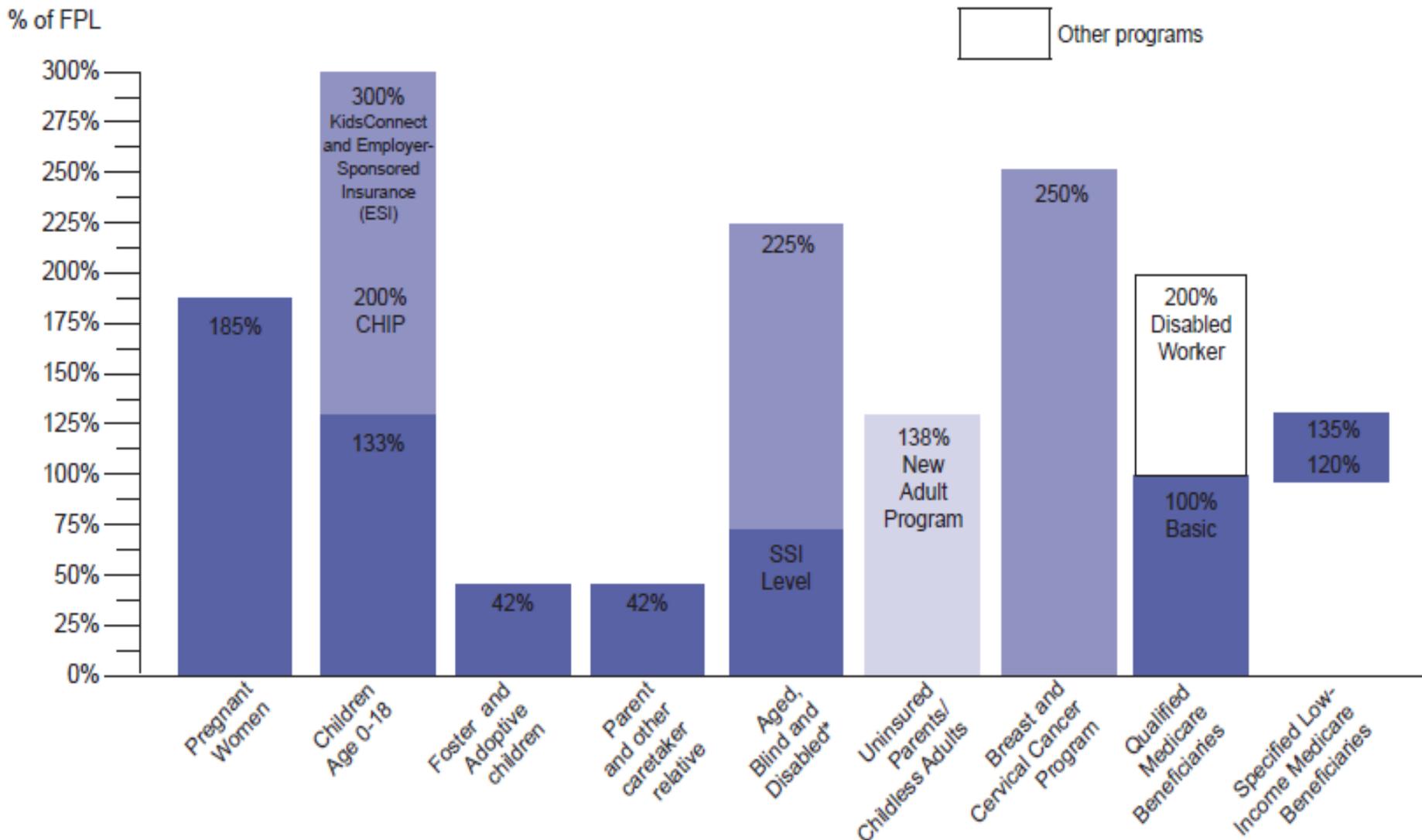
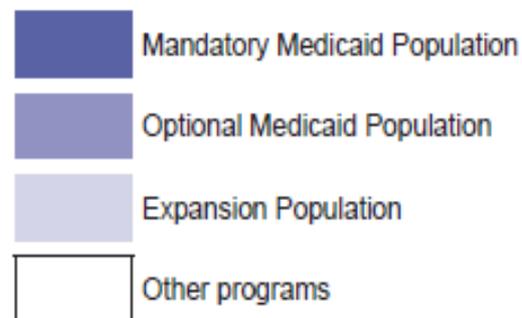
# Medicaid/Oregon Health Plan

- Currently covers children up to 300% Federal Poverty Level (FPL), categorical adults and about 60,000 non-categorical adults through OHP standard lottery.
- ACA allows expansion to all adults age 19-65 with incomes less than 138% FPL
  - Single person – \$15,856 year
  - Family of four - \$32,499
- ~180,000 uninsured adults could come on to the Oregon Health Plan next biennium
  - ~2/3 below poverty
  - ~1/3 living under 50% of poverty

# Federal Poverty



# Approximate Federal Poverty Levels (FPL) for Medical Eligibility Groups



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# Oregon Patient Self-Management Collaborative

Medicaid Advisory Committee Meeting

March 27, 2013



HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION  
Public Health Division

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# About the Public Health Division

- Focus on improving the health of all Oregonians
- Specific to Medicaid and Coordinated Care Organizations, public health supports the:
  - Provision of population health data
  - Development of coordinated local community health assessments and community health improvement plans
  - Implementation of evidence-based population health interventions (i.e., tobacco prevention, chronic disease self-management) that are proven to lower costs and improve health outcomes
  - Development of systems for improved care coordination and utilization of the nontraditional health workforce

# Healthy places, healthy people: A framework for Oregon

## Mission:

To advance policies, environments and systems that promote health and prevent and manage chronic diseases.

## Vision 2020:

All people in Oregon live, work, play, and learn in communities that support health and optimal quality of life.



Oregon  
**Health**  
Authority

PUBLIC HEALTH DIVISION

Health Promotion and Chronic Disease Prevention



## ***Prevalence of Selected Chronic Conditions Among Economically Disadvantaged Oregonians, Medicaid, and Oregonians, 2005***

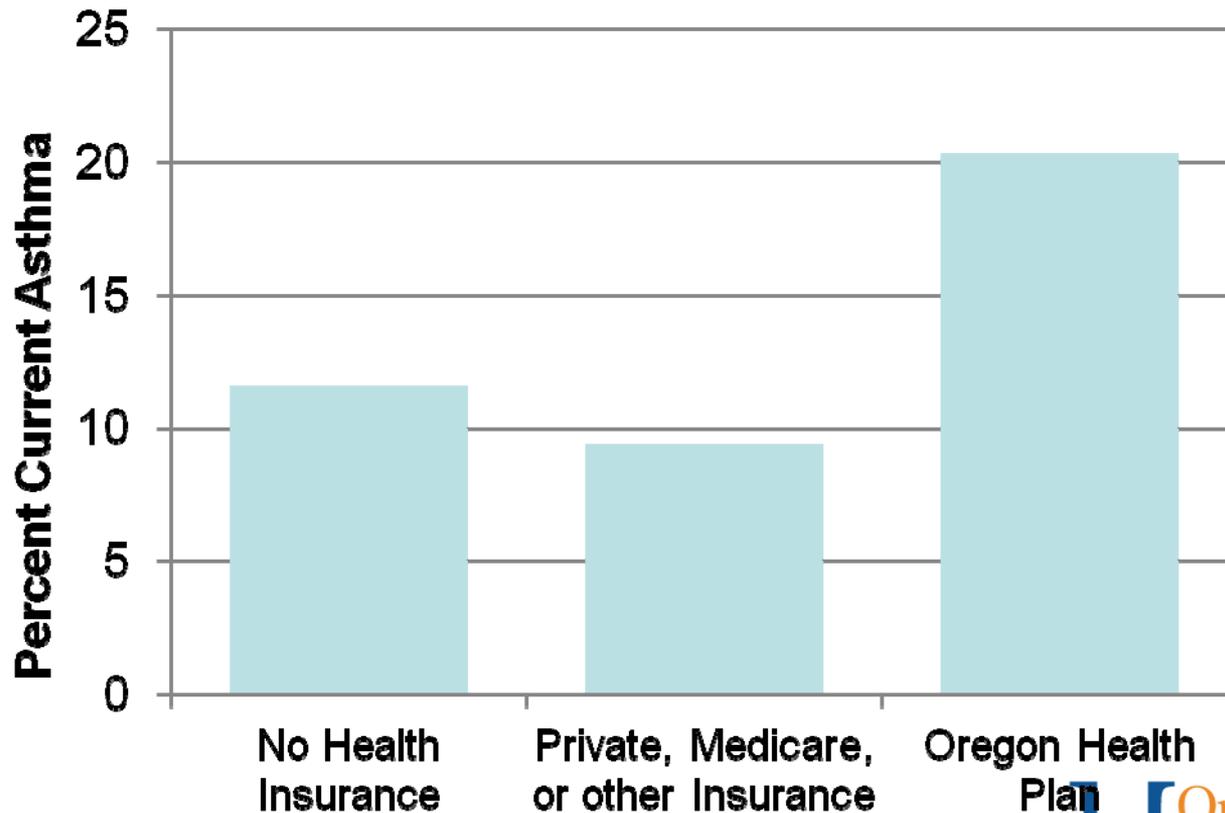
<b>Prevalence</b>	<b>% of General Population</b>	<b>% of Economically Disadvantaged Oregonians</b>	<b>% of Medicaid Recipients</b>
Arthritis	26%	30%**	39%**
Asthma	10%	14%**	19%**
Heart Attack	4%	7%**	7%**
Heart Disease	4%	5%**	8%**
Stroke	3%	6%**	8%**
Diabetes	6%	11%**	13%**
High Blood Pressure	23%	28%**	34%**
High Blood Cholesterol	32%	34%	37%**

\*\* Statistically significant difference, compared to Oregon General Population

Source: *Keeping Oregonians Healthy*, July 2007.

# Setting the Context: Asthma Disparities

***Oregon Adult Current Asthma by Type of Insurance***



Source: Behavioral Risk Factor Surveillance System (BRFSS).

# Program Background

- Five year grant from the Centers for Disease Control and Prevention Asthma program with funding directed to the Oregon Primary Care Association
- Intended outcomes
  - Improve clinic capacity to support patient-centeredness and self-management
  - Enhance progress towards clinic medical home recognition
  - Increase patient engagement in evidence-based self-management programs
  - Disseminate best practices

# Process

- Collaborative learning model
  - Each clinic chooses a multidisciplinary team that includes a community self-management partner
  - Practical, interactive approach
  - Emphasis on peer learning
- Clinic teams attend regular learning sessions
  - In-person conferences linked with other primary care quality improvement initiatives
  - Motivational Interviewing, Patient-Centered Observation, Facilitative Leadership, data and measurement training and webinars
  - Monthly collaborative team webinars

# Participating Clinics

- Community Health Centers of Benton and Linn Counties
- La Clinica del Valle
- Lincoln Community Health Center
- Multnomah County Health Department
- Northwest Human Services
- Yakima Valley Farm Workers Clinic

# Measurement

- Process outcomes
  - Documentation of self-management goals in patient health records
  - Tobacco use assessment and cessation counseling
  - “Closed loop” referrals to the Oregon Tobacco Quit Line and Living Well with Chronic Conditions/Tomando Control de su Salud programs
  - Improvement in at least one Meaningful Use measure related to the initiative’s population of focus
- Capacity outcomes
  - PCPCH or PCMH recognition and tier progression
  - Improvement of Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management
  - Implementation of tools to support patient-centered communications

# Preliminary Successes

- All participating clinics have built systems to systematically refer patients to the Oregon Tobacco Quit Line and Living Well with Chronic Conditions/Tomando Control de su Salud workshops.
- Many clinics began offering Living Well with Chronic Conditions/Tomando Control de su Salud workshops and/or tobacco cessation courses onsite for patients.
- All participating clinics have built infrastructure to support patient-centered communications (i.e., Motivational Interviewing training or implementation of the Patient-Centered Observation Form process).

# For More Information

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# Chronic Disease Self-Management and “Non-Traditional Health Workers”

Kelly Volkmann, RN, MPH  
Health Navigation Program Manager  
Benton County Health Services  
March 2013



# Patient Self-Management Collaborative: From the Clinic Perspective

- Community Health Centers of Benton and Linn Counties (Corvallis)
  - Four clinic sites: 3 in Benton County and 1 in Linn County
- Unique situation:
  - Co-located with Benton County Health Department
  - Health Navigation Program
  - Non-Traditional Health Workers:
    - Community Health Workers – “Health Navigators”
    - Peer Wellness Specialists



# Community Health Workers and Peer Specialists

- Trusted members of the community they serve
- Shared life experience
- Know the culture and language of their community – serve as “cultural brokers”
- Roles cross spectrum of services, from the clinic to the community:



# Community Health Workers and Peer Specialists

- Trained facilitators for *Living Well with Chronic Disease* and *Tomando Control de Su Salud*
- Provide linguistically-, culturally-, and health-literacy-appropriate chronic disease self-management
  - Increases patient understanding of their disease and how to take care of themselves
  - Leads to improved adherence to self management protocols and goals



# Why use a “Non-Traditional Health Worker”?

- Increased connection to patients
  - Improved communication between patient and provider
- Increased patient engagement and “activation”
  - Higher likelihood of adherence to self-management goals and protocol
- NTHW able to address barriers to care
  - Transportation, language, culture, finances
- Alternate payment structures with CCOs
  - May be able to cover costs under the “global payment” structure



# Case Study: AS

- 67 year old Latina, monolingual Spanish speaker
- Diagnosed with diabetes in Mexico, Winter 2012
- Relocated from Mexico to Oregon to live with adult children
- Established care at CHC March 2012



# Case Study: Challenges

- Diabetes poorly controlled
  - Sporadic glucose monitoring (range 58-500)
  - Limited understanding of relationship between glucose, eating, and physical activity
  - Reluctant to take insulin and other prescribed medication
- Diabetes Education classes at hospital not beneficial
  - Telephone interpretation service too complex and confusing
- Family member attends appointments with her but does not live with her
  - Information given at consult is relayed to adult daughter who cares for her mom



# Case Study: Solutions

- PCP began working with clinical health navigator (CHN)
- CHN attended office visits
  - Used teach-back methods to ensure that AS understands and agrees to plan of care
- Patient engagement and education
  - Engaged the daughter living with AS in treatment plan
  - Referred AS to *Tomando Control de Su Salud* - Chronic Disease Self-Management workshops
    - AS attends with daughter who lives with her



# Case Study: Solutions

- Culturally appropriate adaptations
  - Created health literacy appropriate monitoring instructions and glucose recording spreadsheet
  - Addressed dietary needs and requirements in culturally appropriate ways
- Phone follow up calls for additional outreach and engagement

## Results:

- AS reports improved health status and greater confidence
  - Evidenced by fewer highs/lows in glucose levels





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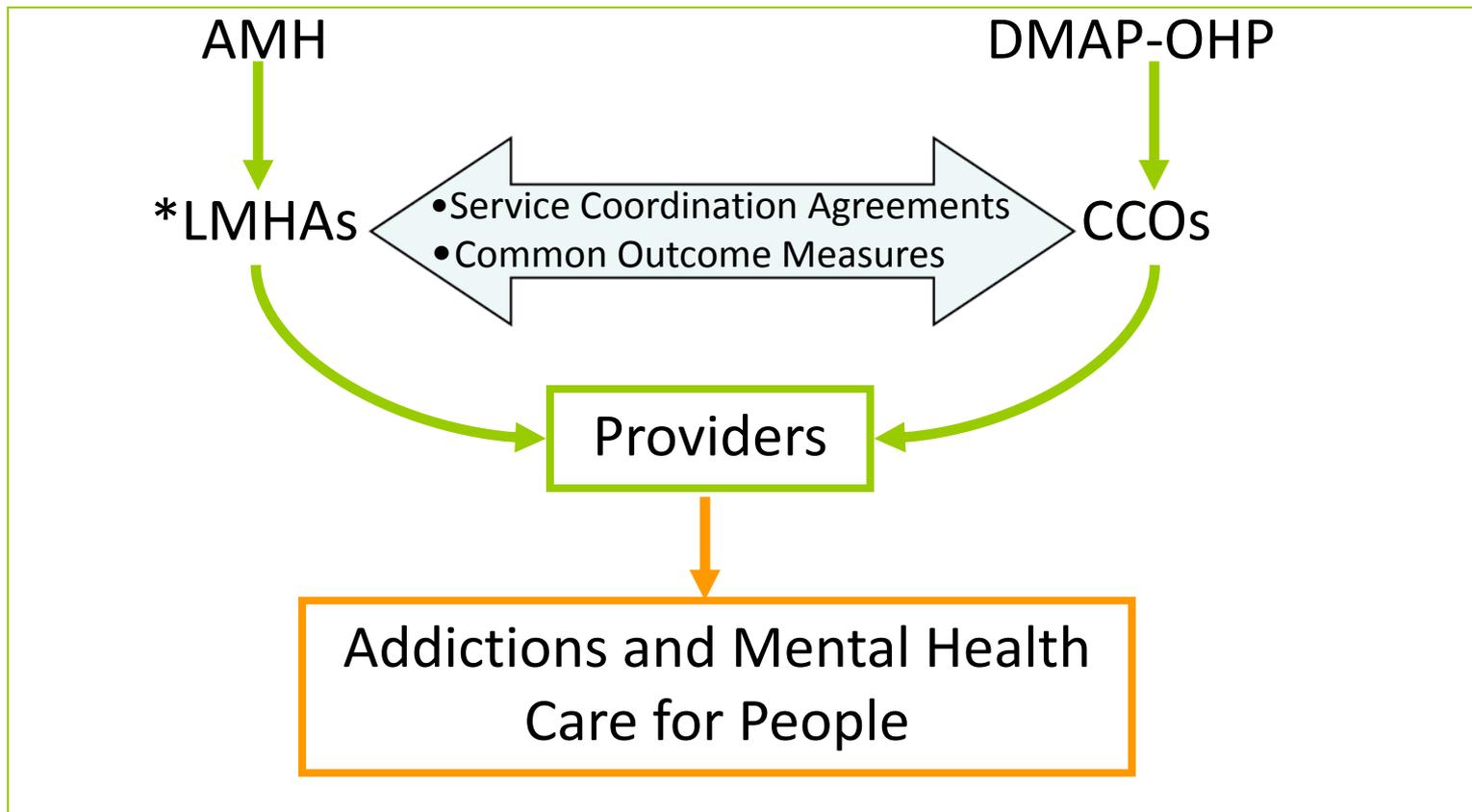
# Physical and Behavioral Health Integration

**Mike Morris, MS, Administrator**



# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE

## FUTURE ADDICTIONS & MENTAL HEALTH CARE SYSTEM



\*LMHA is Local Mental Health Authority  
Addictions and Mental Health Division

# Institute Of Medicine (IOM)

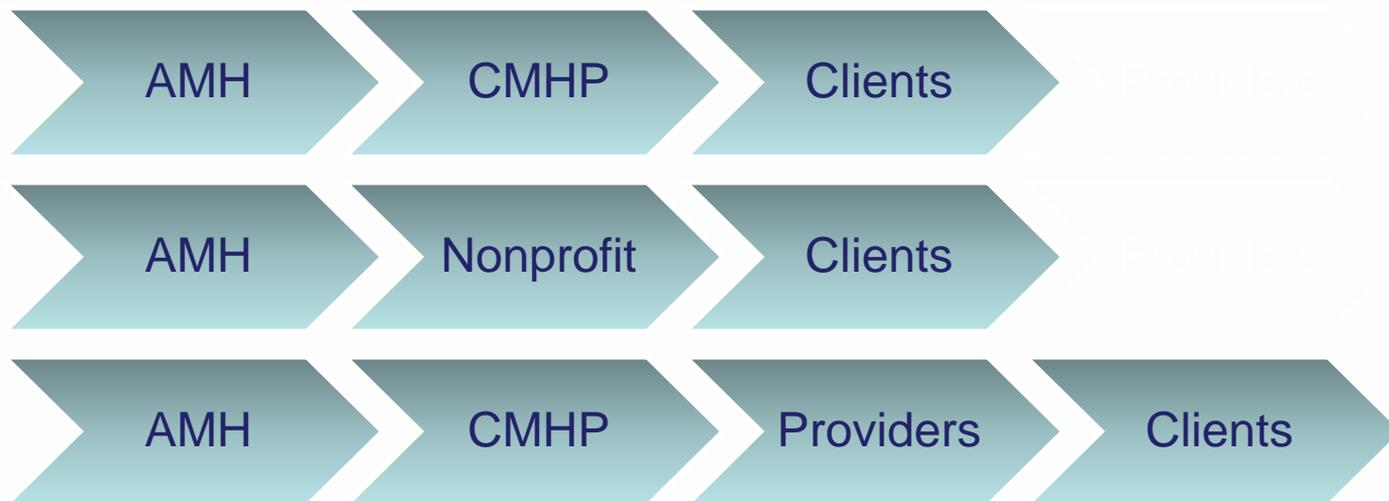
## Spectrum of Intervention



Source: Adapted from IOM, *Reducing Risks for Mental Disorders, Frontiers for Preventive Intervention Research*, 1994.

# Funding and oversight – three scenarios

- There are three primary scenarios for funding and oversight of mental health and addictions services that work in various areas of the state



CMHP = Community Mental Health Program

# CCO Transformation Plans

- Components Include:
  - Prevention, Promotion, Early Identification and Early Intervention
  - Shared Health Information
  - Training and Cross Training
  - Individuals with Serious and Persistent Mental Illness
  - System of Care
  - Transitions of Care
  - Recovery Management

# Prevention, Promotion, Early Identification and Early Intervention

- Examples:
  - Partnering with Local Public Health and Community Substance Abuse Prevention to integrate behavioral health profiles into Community Health Assessment.
  - SBIRT (Screening, Brief Intervention and Referral to Addiction Treatment)
  - Screening for clinical depression
  - EASA (Early Assessment Support Alliance)

# Shared Health Information

- Communication of physical health, mental health and addictions health information across a network of providers especially during care transitions.
- Resources:
  - OHA Tip Sheet
  - SAMHSA Fact Sheet on 42 CFR Part 2:  
[http://www.samhsa.gov/about/laws/SAMHSA\\_42CFRPART2FAQII\\_Revised.pdf](http://www.samhsa.gov/about/laws/SAMHSA_42CFRPART2FAQII_Revised.pdf)

# Training and Cross Training

- Cross training of behavioral health and physical health providers.
  - Physical health providers receive specific training on behavioral health
  - Behavioral health providers receive specific training on physical health
- Multidisciplinary meetings to identify barriers and develop solutions to further integration.

# Individuals with Serious and Persistent Mental Illness

- Provide physical health care for persons with SPMI and chronic health conditions (examples: cardiovascular disease, diabetes)
- Plans to incorporate physical health care outreach into the community for this population.
- Physical health care for individuals residing in licensed residential facilities (may be outside of CCO area).
- Person Centered Primary Care Homes.

# System of Care

- Incorporating models such as the Four Quadrant Clinical Integration Model of the National Council for Community Behavioral Healthcare and/or Wraparound for children with behavioral health disorders.
- Define mechanisms and capacity to meet access standards consistent with current standards of practice: emergency, urgent, regular, and post facility-based treatment.
- Adequacy of network accessible by members in various stages of behavioral health illness/recovery.



# Transitions of Care

- People with behavioral health disorders are particularly vulnerable for relapse, losing supportive connections, and escalation in symptoms leading to poor clinical outcomes during times of transitions in care.
- Facilitate effective coordination of care for individuals transitioning levels of care such as:
  - Detoxification
  - Hospitalization for mental illness
  - Residential care (mental health and addictions)
  - Secure Children's Inpatient Program and Secure Adolescent Inpatient Program

# Recovery Management

- Help members connect with social supports such as housing, vocational, educational, cultural, basic needs and other services that support ongoing recovery for people with behavioral health conditions.
- Help members connect with peer-delivered services (family navigators, recovery mentors, and other non-traditional health workers) to promote motivation for recovery and sustain recovery connections in the community over time.

# Coordination with Community Mental Health Program

- CCOs are required to have a written agreement with the Local Mental Health Authority.
- Describe processes to operationalize the agreement
- Describe how the agreement will be monitored

# Links and Resources

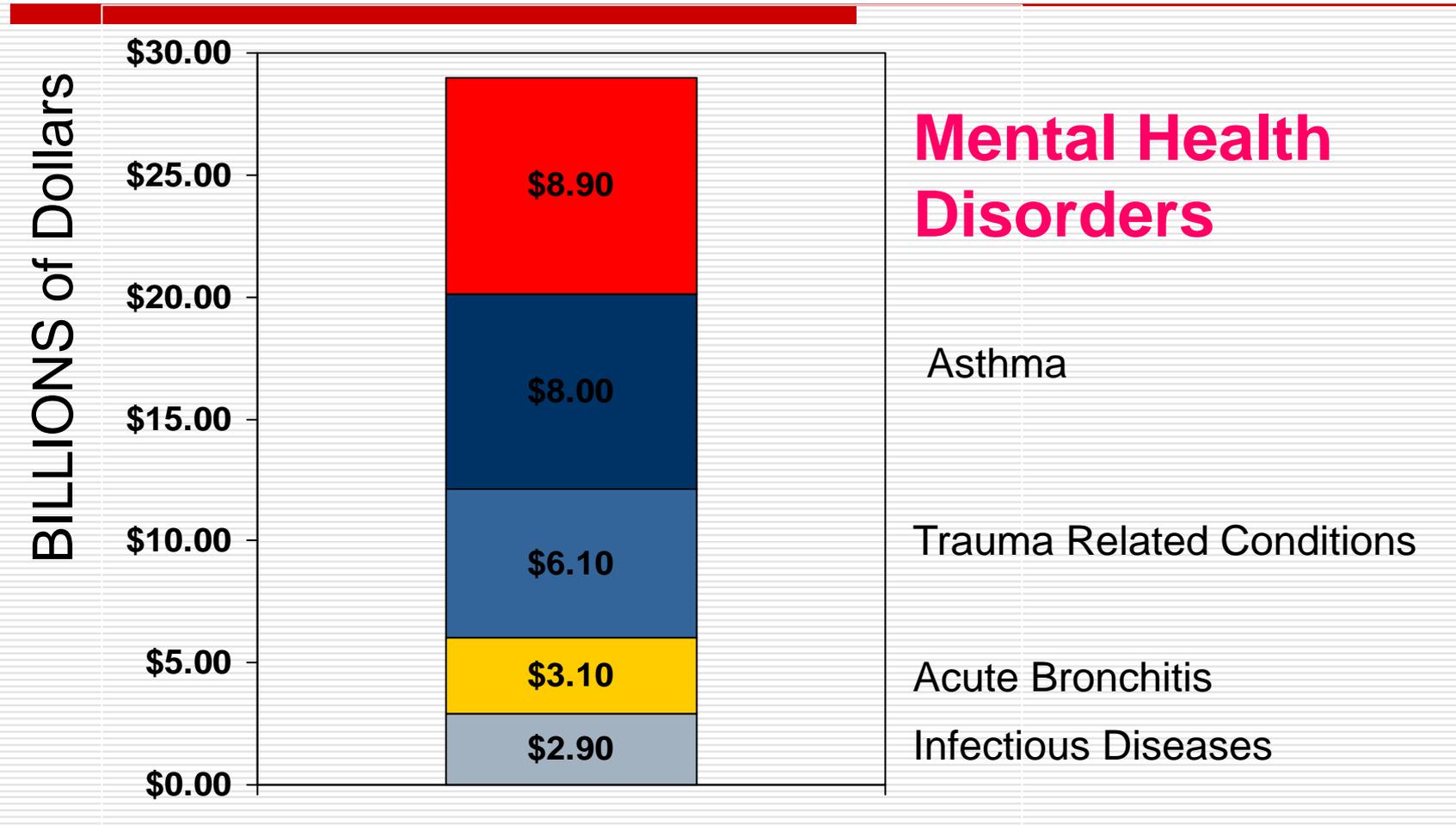
- EASA-
  - OHA State Contact: 503-947-5538
  - EASA Statewide Website: <http://www.easacommunity.org>
- SBIRT –
  - OHA State Contact: 503-569-7421
  - OHSU SBIRT Primary Care Residency Initiative [www.sbirtoregon.org](http://www.sbirtoregon.org)
- Wraparound
  - <http://www.oregon.gov/oha/amh/pages/wraparound/main.aspx>
- Recovery Oriented System of Care (addictions)
  - <http://partnersforrecovery.samhsa.gov/rosc.html>
- E-mail questions to: [ccotp.help@state.or.us](mailto:ccotp.help@state.or.us) or contact the assigned TA lead.

# Child and Adolescent Mental Health and Wraparound

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# Mental Health is the Costliest Health Condition of Childhood



## Children in Medicaid Who Use Behavioral Health Care Are an Expensive Population

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- *Estimate:* 9.6% of children in Medicaid who used behavioral health care in 2005 accounted for 38% of all spending for children in Medicaid
  - Based on: 1.2M children with FFS expenditure data

### *Caveats:*

- FFS expenditure data applied to children in capitated managed care arrangements
- Expenditures might be less in managed care

# Mean Health Expenditures for Children in Medicaid Using Behavioral Health Care\*, 2005

	All Children Using Behavioral Health Care	TANF	Foster Care	SSI/Disabled **	Top 10% Most Expensive Children Using Behavioral Health Care***
<b>Physical Health Services</b>	\$3,652	\$2,053	\$4,036	\$7,895	\$20,121
<b>Behavioral Health Services</b>	\$4,868	\$3,028	\$8,094	\$7,264	\$28,669
<b>Total Health Services</b>	\$8,520	\$5,081	\$12,130	\$15,123	\$48,790

\* Includes children using behavioral health services who are not enrolled in a comprehensive HMO, n = 1,213,201

\*\* Includes all children determined to be disabled by SSI or state criteria (all disabilities, including mental health disabilities)

\*\*\*Represents the top 10% of child behavioral health users with the highest mean expenditures, n = 121,323

# Children and Youth with Serious Behavioral Health Conditions Are a Distinct Population from Adults with Serious and Persistent Mental Illness

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- ✓ Children with SED do not have the same high rates of co-morbid physical health conditions as adults with SPMI
- ✓ Children, for the most part, have different mental health diagnoses from adults with SPMI (ADHD, Conduct Disorders, Anxiety; not so much Schizophrenia, Psychosis, Bipolar as in adults)
- ✓ Among children with serious behavioral health challenges, two-thirds are also involved with child welfare and/or juvenile justice systems and 60% may be in special education – governed by legal mandates
- ✓ Coordination with other children's systems – child welfare, juvenile justice, schools – and among behavioral health providers consumes most of care coordinator's time, not coordination with primary care
- ✓ To improve cost and quality of care, focus must be on child and family/caregiver(s)

# Why are Outcomes so Poor and Costs so High?

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- Child and family needs are complex
  - Youths with serious EBD typically have multiple and overlapping problem areas that need attention
  - Families often have unmet basic needs
  - Traditional services don't attend to health, mental health, substance abuse, and basic needs holistically
    - Or even know how to prioritize what to work on



# Behavioral Health Expenditures by Service Type

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## Top Three Highest Expenditure Services

- **Residential treatment and therapeutic group homes** account for largest percentage of total expenditures – 19.2% of all expenditures for 3.6% of children using behavioral health services
- Outpatient treatment second highest – 16.5% of all expenditures for 53.1% of children using behavioral health services
- **Psychotropic medications** third highest – 13.5% of all expenditures for 43.8% of children using behavioral health services
  - *Total Medicaid expense for child and adolescent psychotropic medication use in 2005 was **\$1.6b**, with **42% of expense represented by anti-psychotic use***

# Why are Outcomes so Poor and Costs so High?

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- Families are rarely fully engaged in services
  - They don't feel that the system is working for them
  - Leads to treatment dropouts and missed opportunities



# Outcomes are poor and costs high for youths with complex needs and multiple system involvement

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- ❑ Systems are in “silos”
- ❑ Systems don’t work together well for individual families unless there is a way to bring them together
  - Youth get passed from one system to another as problems get worse
  - Families relinquish custody to get help
  - Children are placed out of home



# The Wraparound Process

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- ❑ Wraparound is a defined, team-based service planning and coordination process
  - ❑ The Wraparound process ensures that there is one coordinated plan of care and one care coordinator
  - ❑ Wraparound is not a service per se, it is a structured approach to service planning and care coordination
  - ❑ The ultimate goal is both to improve outcomes and per capita costs of care
-

# What's Different in Wraparound?

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- High quality Teamwork
    - Collaborative activity
    - Brainstorming options
    - Goal setting and progress monitoring
  - The plan and the team process is driven by and "owned" by the family and youth
  - Taking a strengths based approach
  - The plan focuses on the priority needs as identified by the youth and family
  - A whole youth and family focus
  - A focus on developing optimism and self-efficacy
  - A focus on developing enduring social supports
-

# Core Components of the Wraparound Theory of Change

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- Services and supports ***work better***:
    - Focusing on priority needs as identified by the youth and family
    - Creating an integrated plan
    - Greater engagement and motivation to participate on the part of the youth and family
  
  - The process ***builds family capacities***:
    - Increasing self-efficacy (i.e., confidence and optimism that they can make a difference in their own lives)
    - Increasing social support
-

# Coordination with Primary Care in a Wraparound Approach

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For children with complex behavioral health challenges enrolled in Health Home, Care Management Entity or Wraparound Team of Health Care Professionals --

- ✓ Ensures child has an identified primary care provider (PCP)
- ✓ Tracks whether child receives EPSDT screens on schedule
- ✓ Ensures child has an annual well-child visit (more frequent if on psychotropic medications or chronic health condition identified)
- ✓ Communicates with PCP opportunity to participate in child and family team and ensures PCP has child's plan of care and is informed of changes
- ✓ Ensures PCP has information about child's psychotropic medication and that PCP monitors for metabolic issues such as obesity and diabetes

# Does Wraparound Work?

Evidence from Nine Published Controlled Studies is Positive

Study	Target population	Control Group Design	N
1. Hyde et al. (1996)*	Mental health	Non-equivalent comparison	69
2. Clark et al. (1998)*	Child welfare	Randomized control	132
3. Evans et al. (1998)*	Mental health	Randomized control	42
4. Bickman et al. (2003)*	Mental health	Non-equivalent comparison	111
5. Carney et al. (2003)*	Juvenile justice	Randomized control	141
6. Pullman et al. (2006)*	Juvenile justice	Historical comparison	204
7. Rast et al. (2007)*	Child welfare	Matched comparison	67
8. Rauso et al. (2009)	Child welfare	Matched comparison	210
9. Mears et al. (2009)	MH/Child welfare	Matched comparison	121

\*Included in 2009 meta-analysis (Suter & Bruns, 2009)

# Outcomes of Wraparound

(9 controlled, published studies to date; Bruns & Suter, 2010)

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- ❑ Better functioning and mental health outcomes
- ❑ Reduced recidivism and better juvenile justice outcomes
- ❑ Increased rate of case closure for child welfare involved youths
- ❑ Reduction in costs associated with residential placements



# Costs and Residential Outcomes Are Robust

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- Wraparound Milwaukee reduced psychiatric hospitalization from 5000 to less than 200 days annually
    - Also reduced average daily residential treatment facility population from 375 to 50 (Kamradt & Jefferson, 2008).
  
  - Controlled study in Massachusetts found 32% lower emergency room expenses and 74% lower inpatient expenses than propensity score matched youths in "usual care".
    - Intervention youth spent 88% of days at home and showed improved clinical functioning on standard measures.
-

# Costs and Residential Outcomes Are Robust

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- New Jersey saved over \$30 million in inpatient psychiatric expenditures over the last three years (Hancock, 2012).
  - State of Maine reduced net Medicaid spending by 30%, even as use of home and community services increased
    - 43% reduction in inpatient and 29% in residential treatment expenses (Yoe, Bruns, & Ryan, 2011)
  - Los Angeles County DSS found 12 month placement costs were \$10,800 for Wraparound-discharged youths compared to \$27,400 for matched group of RTC youths
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# “Full fidelity” is critical

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- Research shows
    - Provider staff whose families experience better outcomes score higher on fidelity tools (Bruns, Rast et al., 2006)
    - Wraparound initiatives with positive fidelity assessments demonstrate more positive outcomes (Bruns, Leverentz-Brady, & Suter, 2008)
  - Much of wraparound implementation is in name only
    - Don't invest in workforce development such as training and coaching to accreditation
    - Don't follow the research-based practice model
    - Don't monitor fidelity and outcomes and use the data for CQI
    - Don't have the necessary support conditions to succeed (e.g., fiscal supports, comprehensive service array)
-

# Statewide Children's Wraparound Initiative

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## Phase 1

- ❑ children in the custody of DHS child welfare for more than one year
- ❑ and who have had at least 4 placements,
- ❑ or children who have behavioral, emotional and/or mental health conditions severe enough to warrant direct entry into the service system at a high level of care.

## Three Sites

- ❑ Washington County Wraparound
- ❑ Mid-Valley WRAP: Marion, Linn, Polk, Tillamook and Yamhill counties
- ❑ Rogue Valley Wraparound Collaborative: Jackson and Josephine counties

CY 2011-2012 served over 500 children

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# What Happens at the Community and Case Level

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- ❑ A single accountable entity in each community
  - ❑ Uniform referral and determination process
  - ❑ Care coordinator
  - ❑ Family navigator
  - ❑ Child and Family Team
  - ❑ Individualized Services and Supports Plan
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# Why Use System of Care and Wraparound?

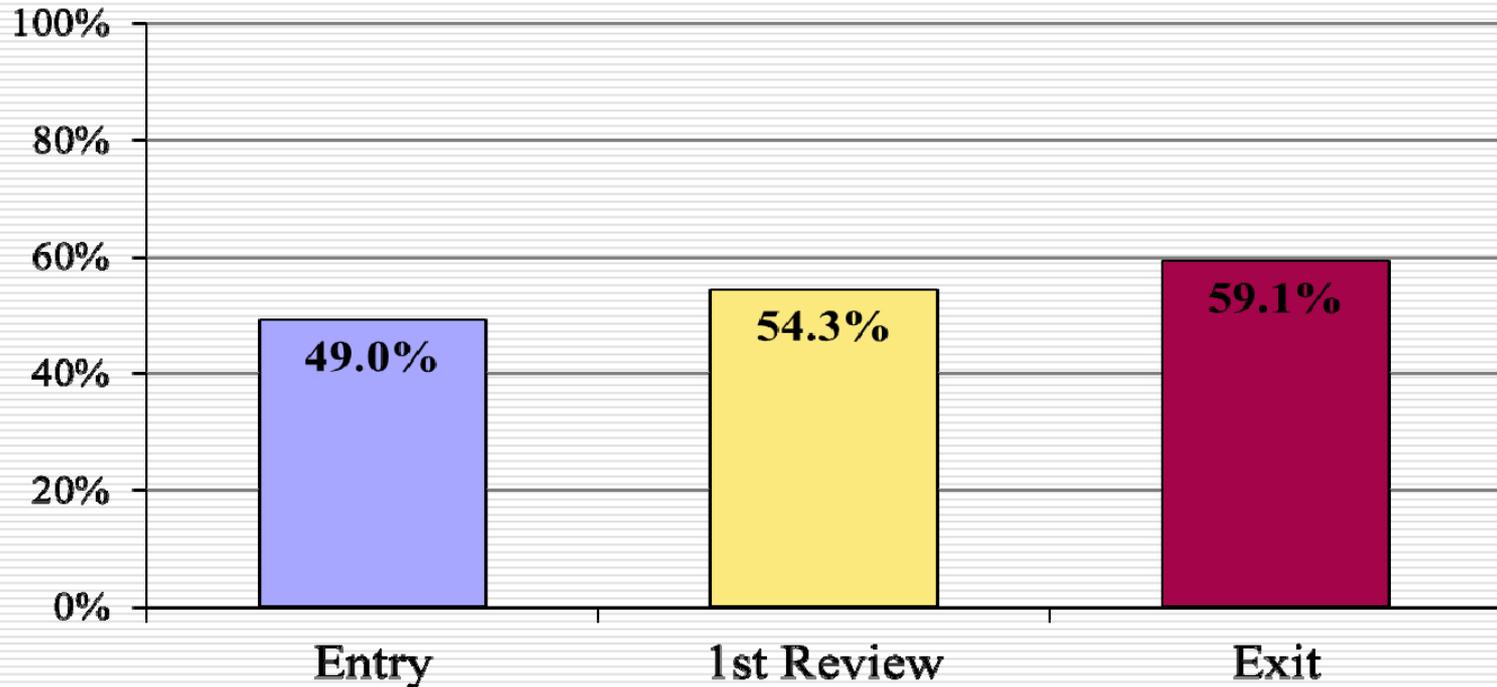
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- National and State experiences demonstrate
    - Better Health
    - Better Care
    - Lower Cost
-

# Better Health

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**Figure 3b: Children Who Are NOT Currently Prescribed Psychotropic Medications**

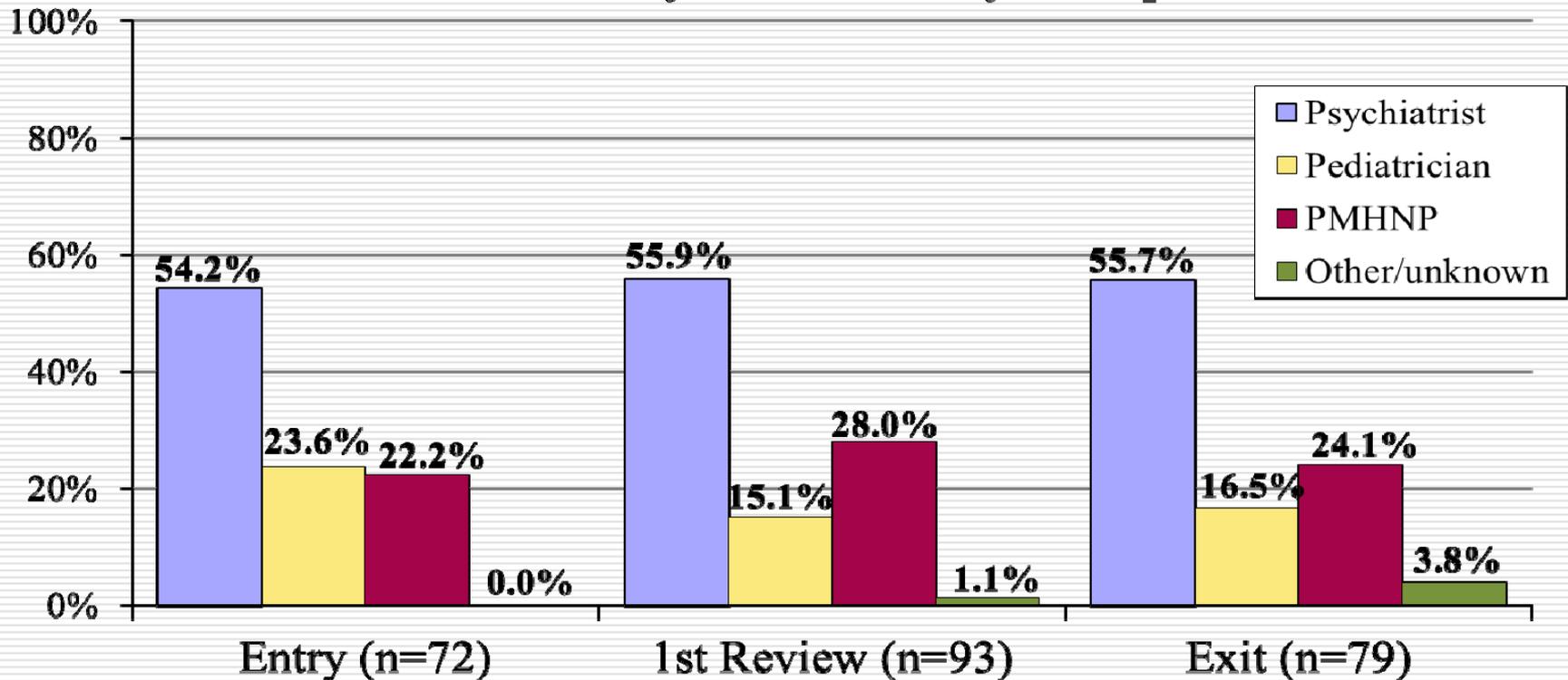


Results for 208 children with assessment at Entry, first Progress Review, and at Exit.

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# Better Health

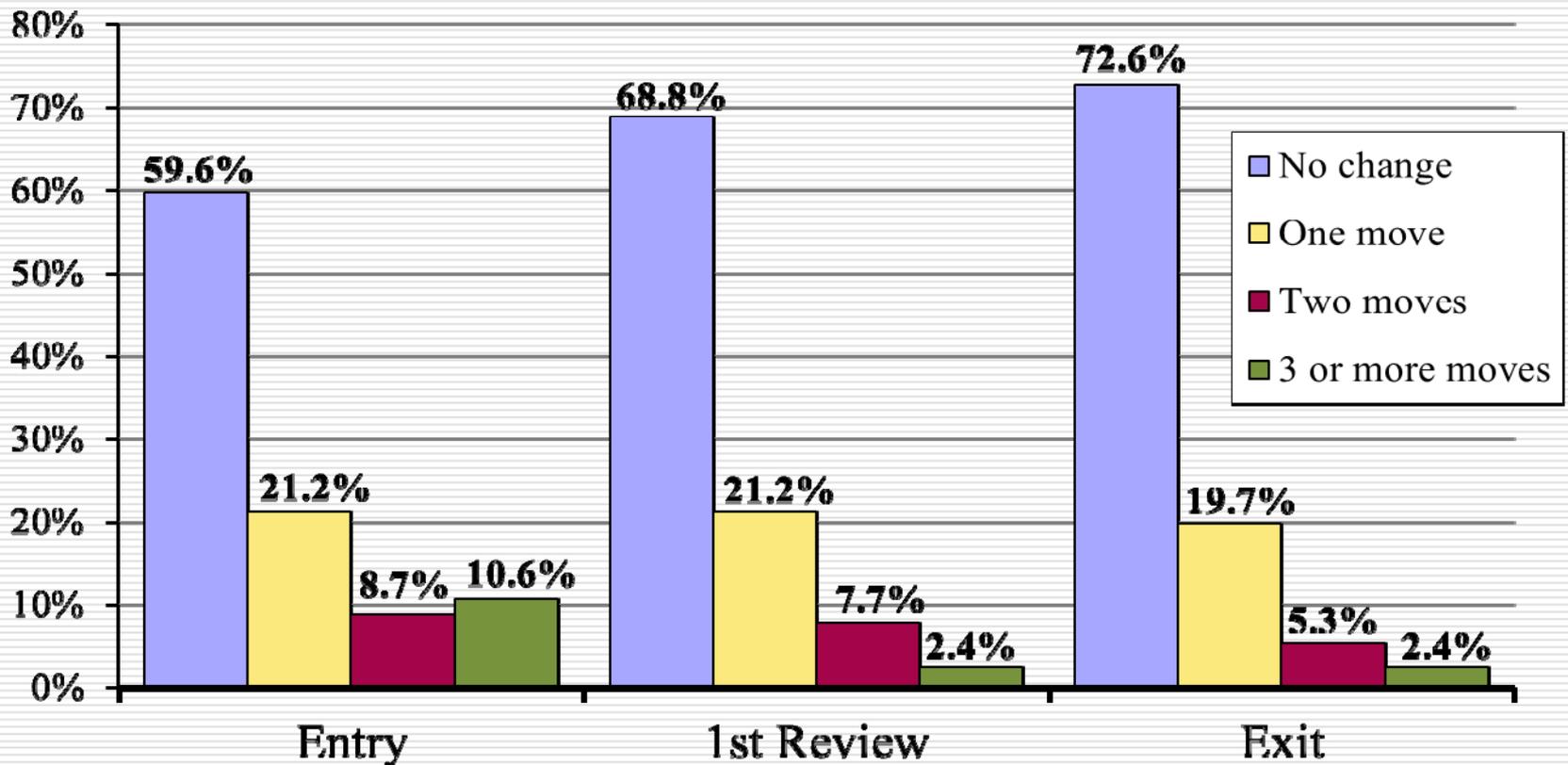
**Figure 3c: Type of Provider for Children Currently Prescribed Psychotropic Medications**



Results for 208 children with assessment at Entry, first Progress Review, and at Exit.

# Better Care

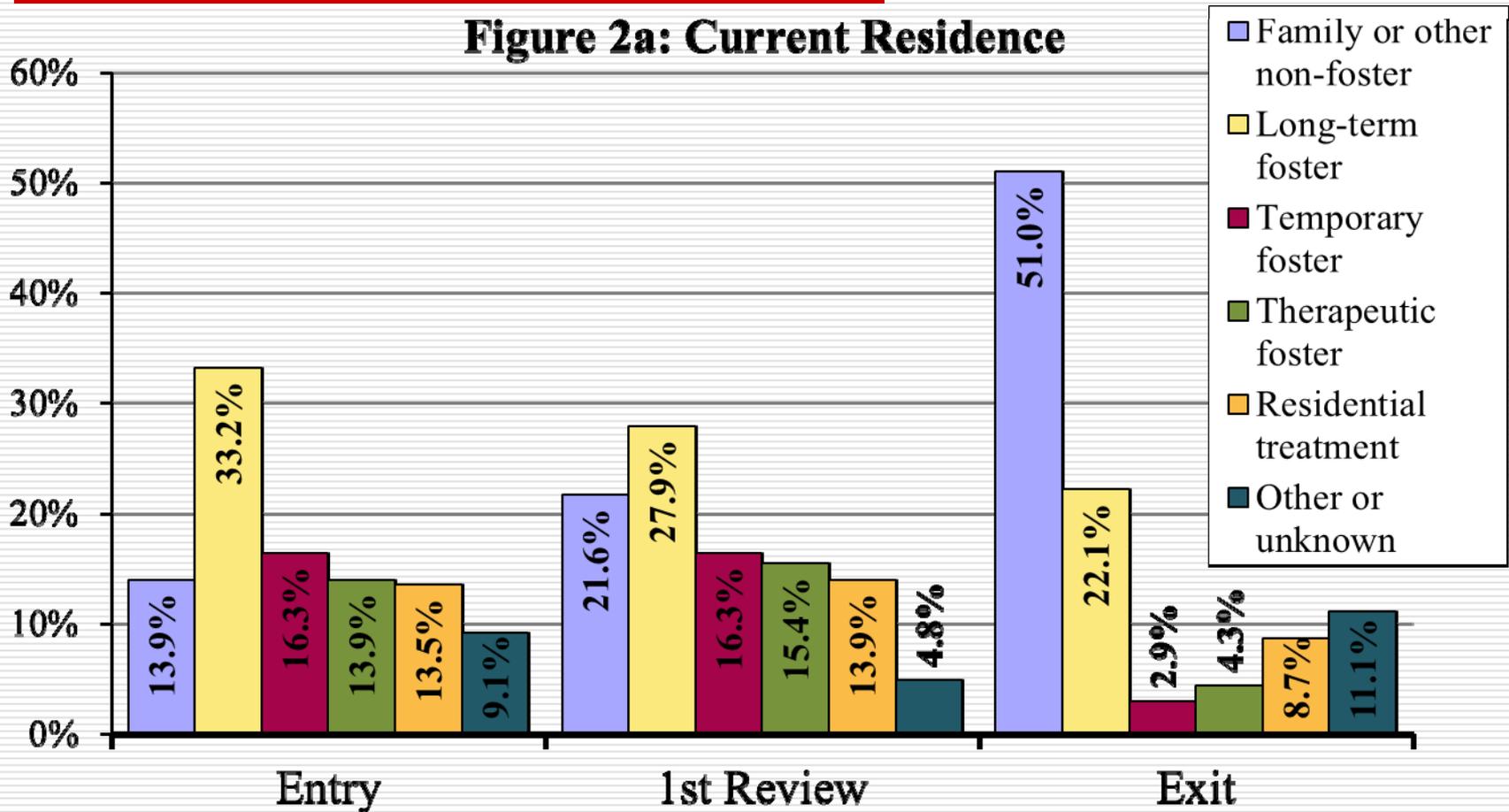
**Figure 2b: Residence Changes in Prior 90 Days**



Results for 208 children with assessment at Entry, first Progress Review, and at Exit.

# Better Care

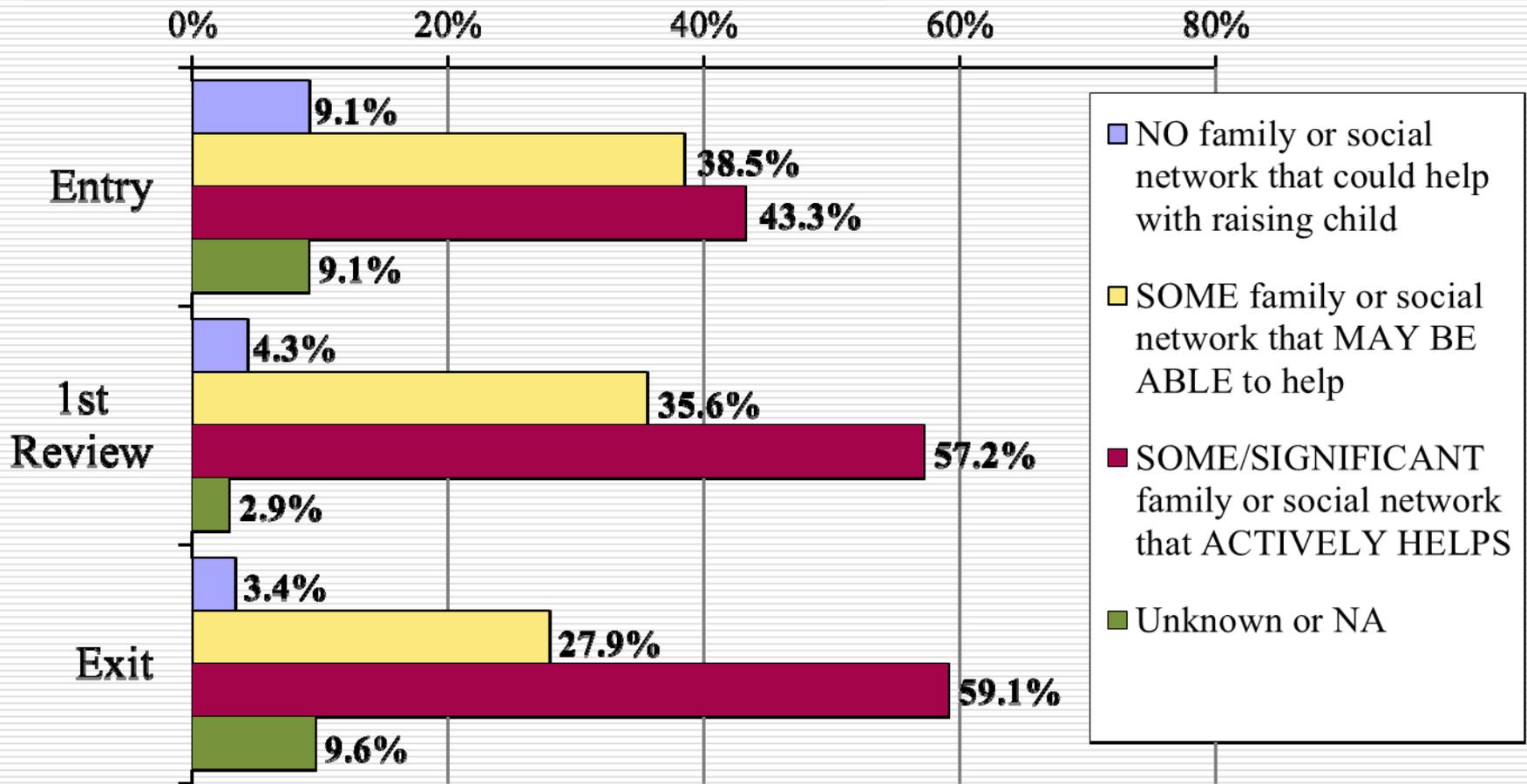
**Figure 2a: Current Residence**



Results for 208 children with assessment at Entry, first Progress Review, and at Exit.

# Better Care

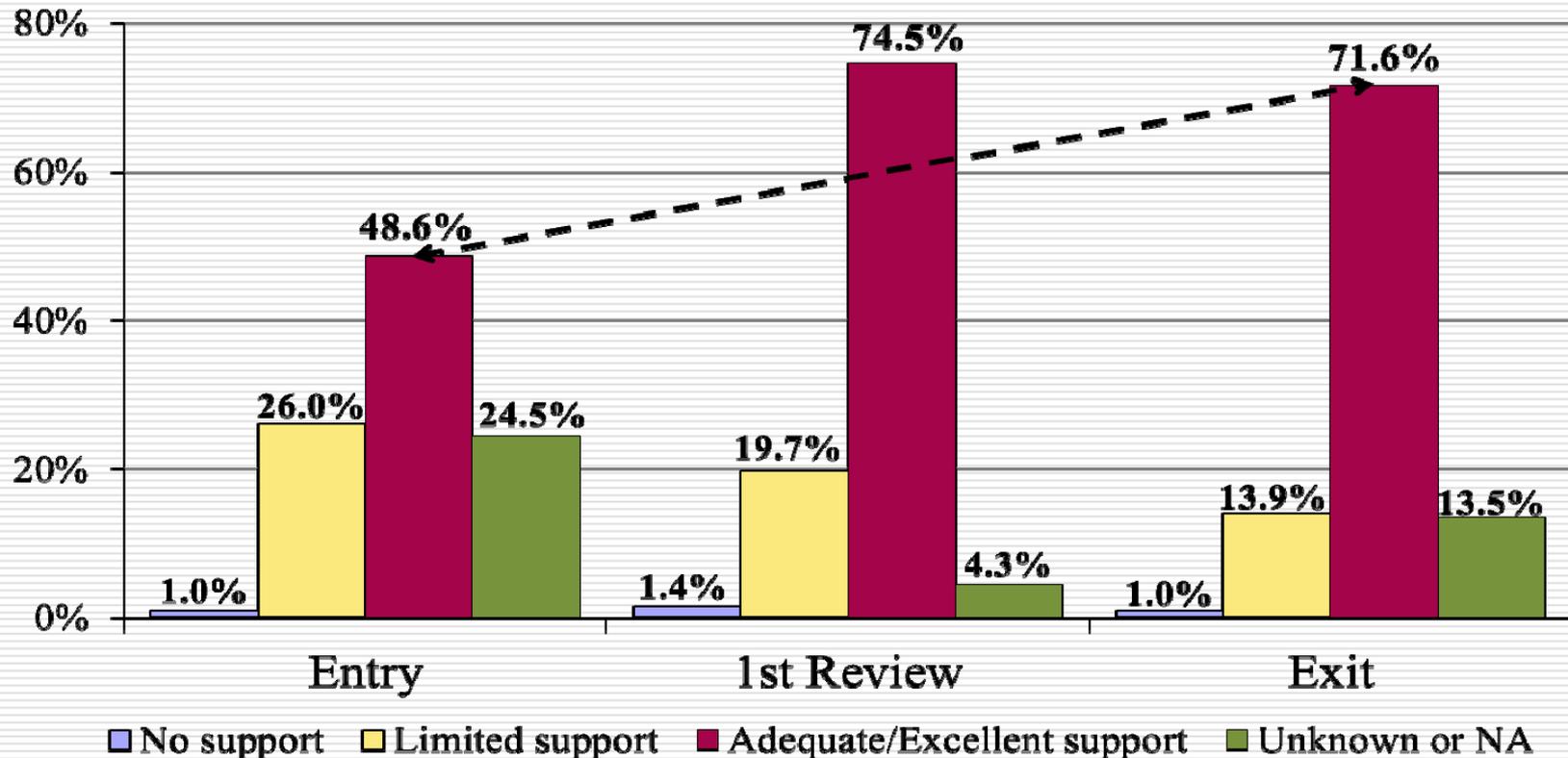
**Figure 6a: Caregiver Family/Social Network Support Past 30 Days**



Results for parents/caregivers of 208 children with assessment at Entry, first Progress Review, and at Exit

# Better Care

**Figure 6b: Caregiver Support to Address Problematic Behaviors**

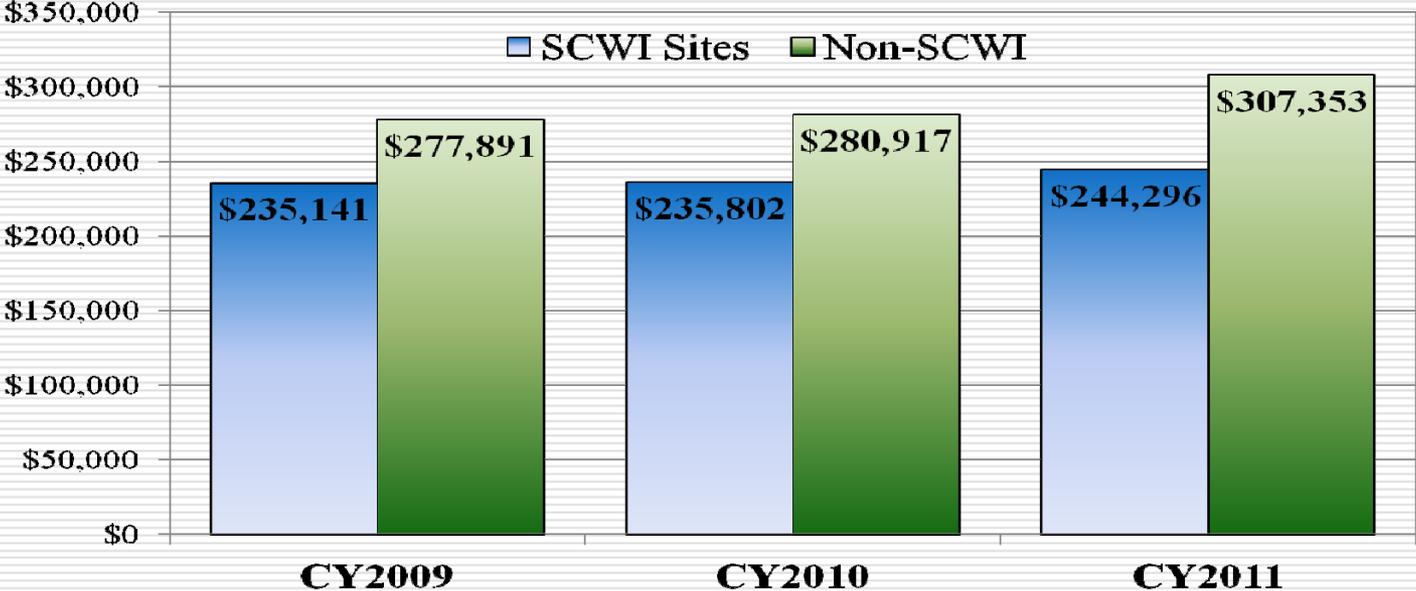


Results for parents/caregivers of 208 children with assessment at Entry, first Progress Review, and at Exit

# Lower Cost

## All levels of service

Total Billed per 1,000 Members age 0-17  
Calendar Years 2009-2011



Source: Medicaid Management Information System (MMIS); data pulled on 10/18/2012

# Lower Costs

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## Outpatient Services

Total Billed per 1,000 Members age 0-17

Calendar Years 2009-2011



Source: Medicaid Management Information System (MMIS); data pulled on 10/18/2012

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# CCO Contract Examples

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- ❑ Physical Health and Behavioral Health Integration
  - ❑ Children's Mental Health Section: Integrated Service Array is based on Wraparound principles and processes
  - ❑ Children's Wraparound Demonstration Projects
  - ❑ Medication Management
-

# CCO Contract Examples

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- Intensive Case Management
  - Member and Member Representative Engagement and Activation
  - Integration and Coordination:
    - Implementation of a system of care approach, incorporating models such as...Wraparound for children with behavioral health disorders
-

# CCO Contract Examples

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- Access to Care
  - Patient Centered Primary Care
  - Care Coordination
  - Care Integration
-

# CCO Contract Examples

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- ❑ Intensive Care Coordination for Special Health Members
  - ❑ State and Local Government Agencies and Community Social and Support Services Organizations
  - ❑ Health Equity
-

# CCO Contract Examples

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- Performance Improvement Projects
  - Transformation Plan
  - Learning Collaborative
  - Members with Special Health Care Needs
-

# The Goal: Children are at home, in school, out of trouble and with friends

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- Fully developed local and statewide Systems of Care in Oregon are necessary to maximize the efforts of child serving agencies and support their activities on behalf of children and families.
  - It is essential to integrate and coordinate efforts through evidence-based practices like Wraparound to ensure positive clinical outcomes for Oregon's children and their families.
  - Family and Youth voice must inform all levels of the system. Families with shared experience can support each other in being active participants in the planning for their children.
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# Washington County's Experience

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- Implemented the Children's System Change Initiative in 2005
    - Reduced utilization of residential services and increased community based services
    - Cost per client: \$34,000/year
    - We thought we were doing it!
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# Wraparound Demonstration

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- In 2010 we became a demonstration site and learned – you don't know what you don't know!
    - Workforce development from PSU
      - A critical upfront investment
    - Reduced caseloads
      - 15 or fewer
    - Philosophical shift in practice
      - Focus on needs, not services
-

# Washington County Results

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## Since Wraparound implementation:

- ❑ Total cost per client served decreased by 33% (this *includes* the cost of care coordination)
  - ❑ Cost of Psychiatric Residential Treatment decreased by 43% per client served
  - ❑ Cost of Psychiatric Day Treatment decreased by 71%
  - ❑ Overall use of acute and subacute care by children and adolescents has declined by 58%
  - ❑ 38% of Child Welfare involved Wraparound participants had left Child Welfare custody upon discharge
  - ❑ 6% were living with family at intake, 51% living with family at discharge
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# Washington County's Next Steps

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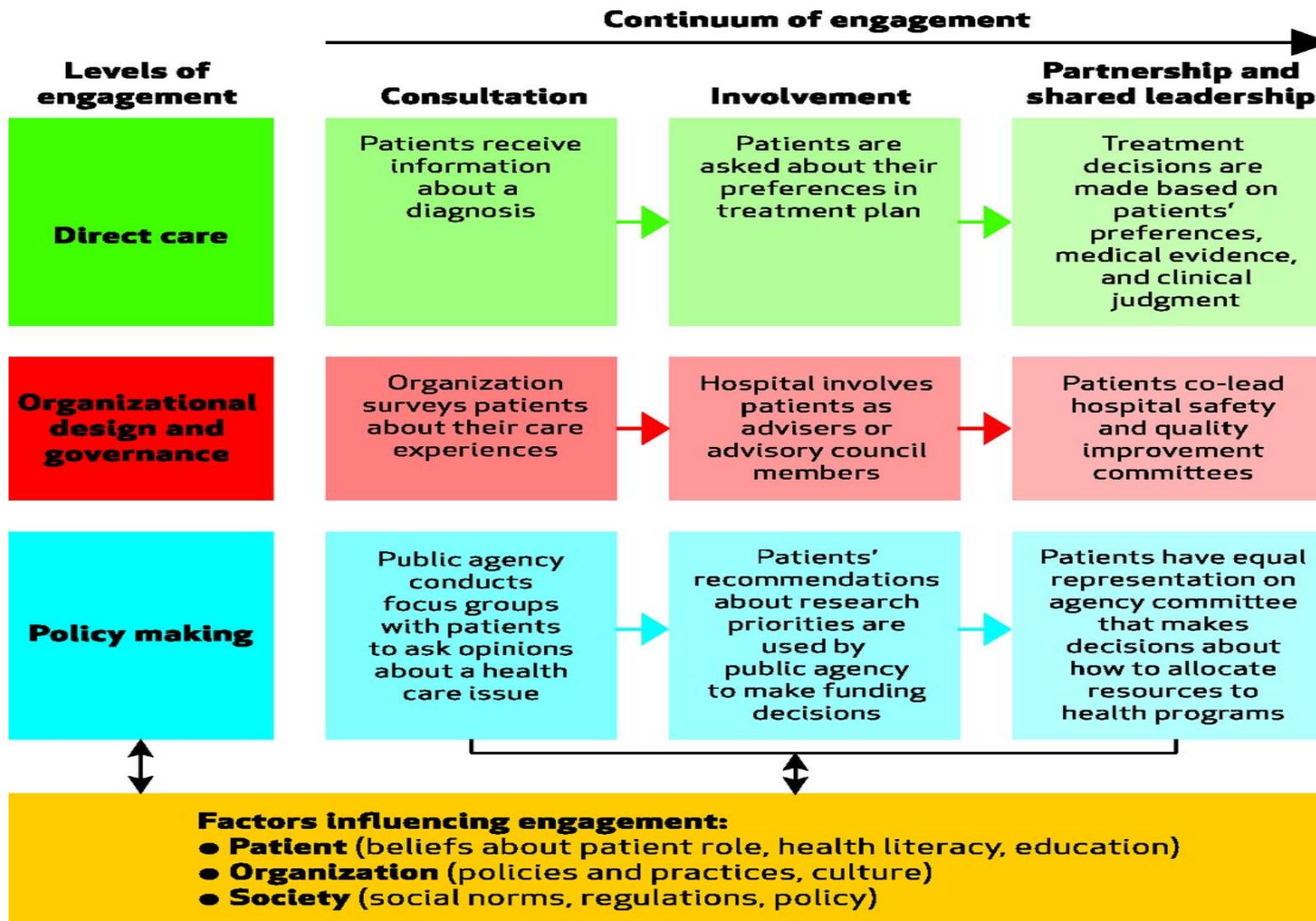
- Integrate our existing program with the Wraparound demonstration so it is “the way we do business.”
    - Caseloads of 15 or fewer
    - Sustainable workforce development plan
-

# Person and Family Centered Approaches (PFCA) to Health

# Committee Discussion

- Key concepts/terminology
- Review proposed draft report outline
- Propose next steps for the committee

# A Multidimensional Framework For Patient And Family Engagement In Health And Health Care.



# GOAL: Triple Aim

A new vision for a healthy Oregon

- 1 Better health.
- 2 Better care.
- 3 Lower costs.

# GOAL: Triple Aim

A new vision for a healthy Oregon

*“The most direct route to the Triple Aim is through implementation of patient and family-centered care in its fullest form.”*

Don Berwick, former administrator for CMS (2012)

# Key Concepts

- Patient and family advisors
- Patient activation
- Patient and family engagement
- Patient- and family-centered care
- Patient engagement
- Shared decision-making

# Potential Discussion Questions

- What does the health care community need to focus on to achieve more individual centered?
- What is the patient or individual's role in Oregon's Health System Transformation?
- What are effective and evidence-based approaches to foster active engagement across the community?
- What activities and approaches is the committee most interested about?
- What else would be helpful to know or better understand to make informed recommendations?

# Next Steps

- Continue to highlight patient engagement, activation, and shared-decision examples in Oregon
- Assess gaps and opportunities in our state that may help to inform and enhance patient and family centered care from a statewide policy perspective
- Next steps:
  - April: staff to develop an Oregon environmental assessment
  - May: committee to formulate draft recommendations
  - June: revise and finalize committee's report

# Public Comment

# Closing remarks