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Health Share of Oregon – Meeting Members Where They Are with What They Need

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Diana Bianco
This next conversation, we will be hearing from Health Share here in the tri-county area. What they had been talking about. What they have been doing is thinking about how to implement best practices to manage and coordinate care. How to really serve and create a system of care for high-needs folks on the Oregon Health Plan. Central to this undertaking and what we're going to hear about today, is the use of health resilience specialists. (It goes a little bit to what Megan was talking about.) Who develop meaningful relationships with patients to really foster and enable wellness and more stability in their lives. Health resilience specialists go outside the confines of the clinic into their community to really try to make a difference for the folks that they serve. To tell us about this, we have David Labby who is Health Shares' Medical Director and who will provide context and background for the undertaking. Amy Vance is a health resilience specialist and she will talk about her role. Then Rebecca Ramsay, who is Care Oregon's Director of Community Care, will share what has really changed as a result of this work.

David Labby
Thanks Diana. We were fortunate to get a CMMI challenge grant in the first round in 2012. Our proposal was to build a regional system of care for adult high utilizers. It was really based on work that we had all been doing sort of collectively in the community over the previous years. We worked on medical homes. We worked on transitions of care. We had worked around complex care case management. We had, you know, the Portland area is a large area, the metro area is a very large area. Really the health care community is really a small community and we all sort of know each other. We really built on existing relationships which I think is a theme for all the CCOs. We received three years of funding. We engaged - this was a huge collaborative effort. Just counting it up, we have six hospitals, seventeen clinics, three behavioral health organizations, four community organizations. We have hired and created a work force of 104 new FTEs. Our interventions have touched over 10,000 people and that includes 3,200 people in intensive case management which is what we're going to talk about. Amy and Rebecca are going to talk about in more detail.

We had two basic strategies for the whole grant. The first was to improve transitions. There is a lot of work being done in many communities around transitions. What we focused on was making sure those people who had admissions for psychiatric or medical reasons who were at risk for failing the transition back to ambulatory care really had help. We created transition teams. We also changed the way in which handoffs were occurring between inpatient and outpatient. Changing the discharge summary to be more of a transition note with specifics about what happened and needed next. Also changing, working on the workflows in the ambulatory care settings so those things that needed to happen would be reliably done. We also placed teams in the emergency department so that they could help transitions out of the acute care setting back in to more stable primary care.

The second strategy was really to create more intensive interventions. Amy is going to talk about health resilience. What she does as a health resilience specialist. We also had teams in the 911 system for those people who seem to ride ambulances frequently. We have a team in a drop-in center in the community. We also have a team in the corrections system. We have learned a ton doing this. I think the thing that we really learned most of all is that high utilizers are not really high utilizers. That is not really what defines the population.

More and more we understand the vast majority of this population are really people who had a terrible time in life. They start out suffering all kinds of abuse. They don't do well in school. They don't build relationships. One thing leads to another. They get in problems with substance abuse with corrections et cetera, et cetera. Actually we were hearing this more and more anecdotally. And at one point we said to the folks who we are working with us from the Center for Outcomes Research and Education, it would be really good if we could study this. Can we actually sit down with a section of the people in our programs and really ask them what happened in their life. So we really understand what their lived experience is about. As everyone has said, you can't rebuild the system around lived experience unless you know what that lived experience looks like. That is really what rebuilding the system looks like.

Here is what we're finding. It is pretty startling. Two-thirds of the people we call high utilizers had some form of physical, emotional or sexual abuse in early life. Two-thirds. A third of those, the abuse started before the age of 6. Many spoke about poverty, about food insecurity, about not being able to have their own clothes, about moving frequently as their parents looked for work. A quarter lived with an adult who was a substance abuser. Thirty percent were separated from their birth parents. Half struggled in school. Forty-percent graduated from high school. Only one of the thirty had even started college but didn't finish. Sixty percent started using substances before they were 20 years old. A quarter experienced homelessness. Thirty percent said they had been in jail. Another twenty percent said they had been arrested and did not indicate whether they had been jailed. Fifty percent described their current situation was pretty isolated and they did not have much support. A little over sixty percent of them struggle with mental health conditions. Ninety-three percent described struggling to get the health care they need. These are people who we look at as high utilizers. None of them had current stable employment.

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This is how the social determinants of health work out in individual people's lives. This is about Medicaid as defined by poverty. A lot of the things that we're seeing are things that are driven by the social conditions in which people live. If we are going to build programs to meet their needs, it is going to have to look like something different than medical care. It is not going to be a case management program. These are people who need case management plus. They need more than care coordination. We kinda understand that what we really need to build is really a trauma recovery program. The world that they have grown up in and lived in is a world of trauma, a world of stress. We know what happens to people who have that kind of existence. They learn to be super vigilant, they are easily triggered because that's what allows them to survive. Long-term planning is really not in their portfolio because there is no long term for them in terms of stability. They are easily triggered. They are reactive. They are all the things that we think of as bad patients. It is not what is wrong with them, it is what has happened to them. If we are going to build a new program that will actually help them, that has to be our starting point. I will turn this over to Amy to talk about what she does to reengage these folks.

A**my Vance**
Hi. I am Amy Vance. I am a health resilience specialist working out of Northeast Multnomah County Clinic up here on MLK and Killingsworth. We are outreach workers who are embedded in primary care clinics. People are referred to us after one hospitalization within a year or six ER visits within the last year. We are meeting people where they are at. We are going to the hospital. We are in people's homes all the time. We are going to the streets if we need to and skilled nursing facilities. We are anywhere where people are really, where their needs need to be met. What we do takes a high level of care coordination. We are coordinating between medical systems, community organizations, natural support systems, families. We are doing a lot of skill building around the short amount of time that people have to talk to their doctors. We are doing a lot of skill building preparing for visits and things like that. What we know intimately from this work is that people aren't getting their needs met until they're getting very ill. What this means is that their costs are already very high. They haven't actually gotten the resources that will help them become healthier. In a minute, I will talk about a story that exemplifies that.

Our focus has become self-directed health goals. We are always looking for readiness for change. We very much have open-door policies with the people that we work with. When you are ready to, for instance go to detox or look for the resource that you think is going to help your health, we are there to walk alongside you. What we know from walking alongside people is that they don't want to be in the emergency room. They don't want to be hospitalized. They'd rather be spending their time getting the appropriate resources, like housing and detox. They'd rather get their needs met appropriately as well. We also know that people are making choices to change their lives.

This year, I had two women who had the confidence and bravery to become clean and sober. Both of them did the work so that they could get major life changing surgeries. I think that is what makes our work meaningful. I'm going to tell you a little bit about a client that I've worked with for a couple years. When I met her, she had been in and out of the hospital, in inpatient about once a month, in the ER a couple times a week. She is a dialysis patient, has diabetes. She was pretty hopeless at the time that I met her. Her cost, of course for medical care, was very high at that point. She was only going to dialysis about fifty percent of the time.

Our intervention, what it allows for, is the first three times that I met her. I met her at the hospital and I just listened. For an hour, the first three times that we met during her hospitalizations. What came from that is the acknowledgement that she was having a hard time with self-care because of childhood trauma. She was currently in a domestic violence relationship. Slowly over the course of a few months, she started to gain the strength to get a restraining order, to start to go to dialysis regularly. She went up to a hundred percent dialysis runs within like six months. She really thinks that is one of the biggest changes for her. She started to feel better because of dialysis runs.

Being able to be with people, listen, get the resources that people need, allows for something like what happened with this individual. Her costs, it was five hundred thousand. It was around half a million. I just looked today and it was about $200,000. That is a considerable cost difference. More importantly, her life is different. She has more time for community, more time to have relationships and do the self-care that she would like to do. She still struggles with bills. She still struggles with resources. I think that this program essentially, we say to people when they are in difficult situations, we say your life matters, your health matters and we will be with you during this time. Thank you.

Rebecca Ramsay
I think Amy has given you an amazing view into what can happen with this kind of intensive community-based approach. How it can change the trajectory of people's lives. How it heals people. How it recovers people. How it gives people new hope for being less sick and more well. The other change that is occurring that I want to share with you is a change in the culture in practice within primary care. We are introducing a new workforce to the primary care system. They have a different perspective, new skills and competencies. Their primary objective is to listen deeply and to really deeply understand the personal histories and the individual barriers that our most vulnerable patients face. When that information is brought back, when that knowledge is brought back to the primary care team, we see those teams adapt and modify the way they deliver care, to populations, to high-risk patients. They begin to pay more attention to the psychosocial and health literacy barriers of their patients. They bring more compassion to the interactions because they understand the root cause of so much of the behavior that may have seemed disruptive at times. They identify novel approaches to providing more support for these patients in meeting their needs in new ways.

So I want to give you a few examples of that. At OHSU Richmond Family Practice Clinic, within about a year of embedding two health resilience specialists as part of the primary care team there, the clinical champion recognized the prevalence of childhood and life trauma and realized they needed to add a social worker with specific skill around doing group trauma recovery interventions. A program called Seeking Safety. They did that, never had anything like that before in the clinic. They also then recognized they needed a better and more reliable process for paying attention and focusing on patients who are hospitalized. They built a Reach Team which has health resilience specialists on it, a panel manager, a social worker, the clinical champion and a nurse. That team huddles around a patient list, a hospitalized patient list several times a week with the sole goal of providing more support to those patients, to reduce their risk of rehospitalization and to improve their quality of life. Then after that,

as they started to develop that process they realized we have a lot of patients with advanced illness. That probably have a few more years to live. We need to connect more with our community-based palliative care partners. They built connections with palliative care and now they're making more and more referrals to that, you know, quality enhancing, cost reducing, fabulous service that we need to do more of.

Another example, at Multnomah County Northeast, where Amy works, there is a similar high-risk team called the Hope Team. Amy is on that team. Recently they added a community-oriented nurse. Amy helped the team recognize the benefit of adding a culturally specific peer support specialist, who incidentally is on a panel tomorrow. She is helping, among many other things, she's mentoring patients from her own lived experience to recover from their addiction issues. A year ago, six months ago, Multnomah County did not know what a peer support specialist was. Now they see that role as a critical part of their care team.

Finally at Virginia Garcia, just through the everyday interactions that our health resilience specialists are having with patients, they're modeling an approach called trauma informed care, which in a nutshell is providing more respectful care for people with a trauma history. Because of that modeling, the clinic has asked us to do two full-day workshops on trauma informed care. (Not myself, but a colleague that has more knowledge about that than me.) For their entire clinic, actually for clinic staff, to help understand and be more compassionate with patients with trauma history. That's amazing. These are amazing developments. Would these things have happened without the introduction of this new workforce and the Health Commons Grant? I guess we don't know the answer to that question but I have a hard time believing that if so, it probably wouldn't have happened as quickly and with as much commitment and enthusiasm from the provider community. The program has been a really big springboard for changes as I've discussed in that primary care delivery system and that has actual inspired a commitment by the Health Share's Board, by Care Oregon's Board and by the Providence Health plan to commit to funding, sustaining this program, this amazing program after the grant ends next year. I am so happy to end on that note. That is some the best news we have had since the program began, that it will continue. Thanks for having us.

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