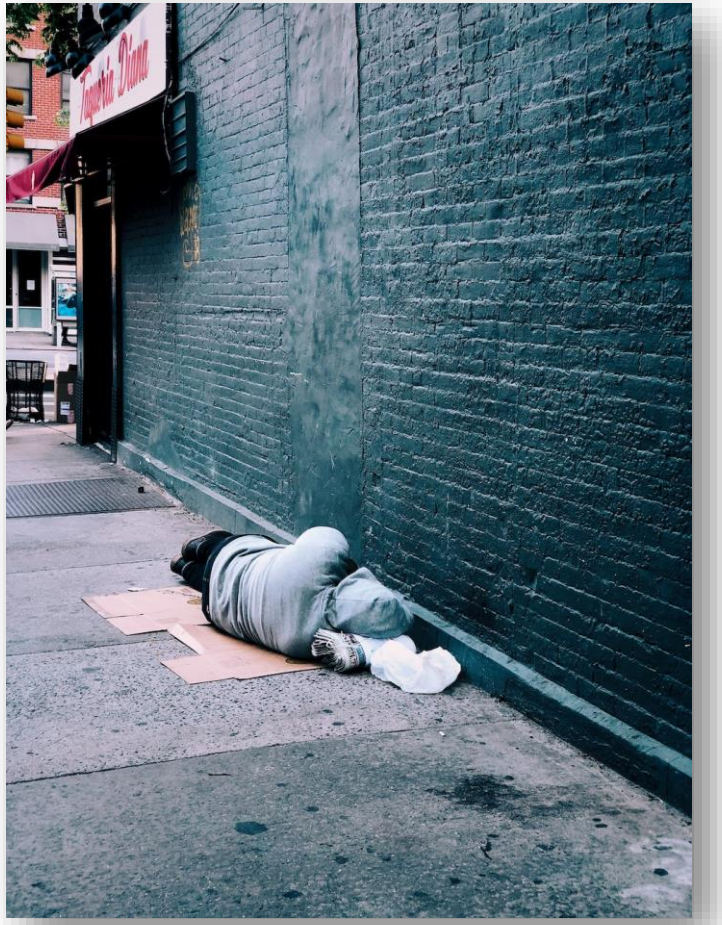
Learning To Bridge

Dr **Pritpal S Tamber** MD
Writer, Researcher & Consultant in Community Health
www.pstamber.com

The Medicaid Transformation Learning Symposium
Seattle, WA, October 9th, 2019



The Commonwealth Fund

NEWSROOM TO THE POINT LOG IN SEARCH

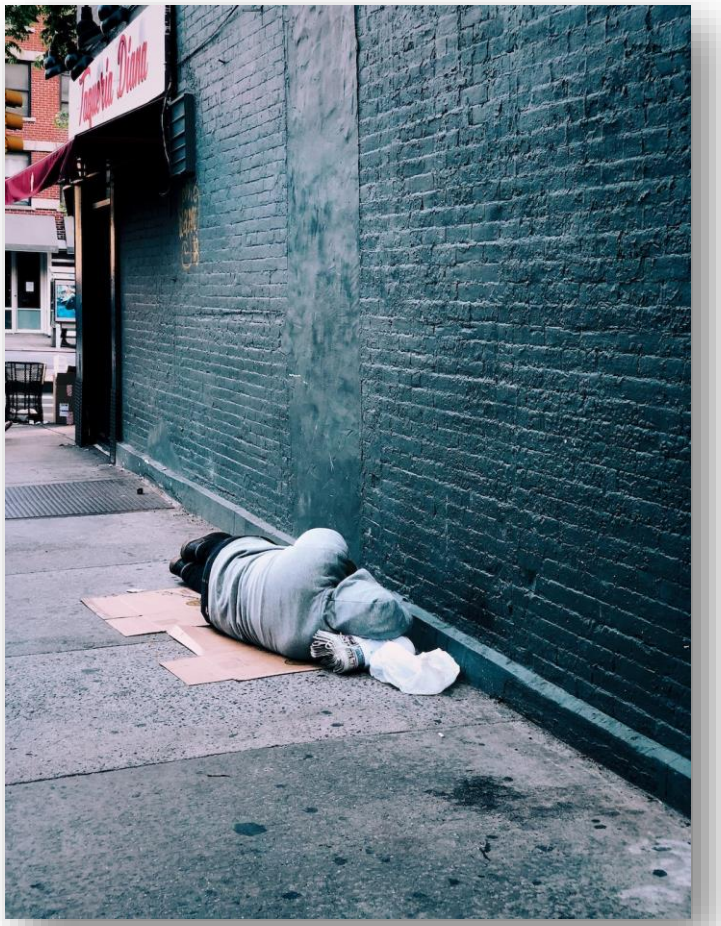
Affordable, quality health care. For everyone.

What's Trending: Medicaid Work Requirements High-Need, High-Cost Patient Personas Non-ACA-Compliant Health Plans

Hennepin Health: A Care Delivery Paradigm for New Medicaid Beneficiaries

October 7, 2016 | Martha Hostetter, Sarah Klein, and Douglas McCarthy

- Jorge
- Food pantry manager
- Loses his job
- Wife dies suddenly
- Becomes homeless
- Son dies in combat in Afghanistan



HennepinHealthcare

- New health plan for new Medicaid beneficiaries (2011)
- A safety net Accountable Care Organization (ACO)
- Began in 2012 as a Medicaid demonstration project
- 4 partners: Public health, health center, a managed care plan, and a FQHC
- Goal: Reduce health care costs of the most ‘troubled’
- How: Coordinate and pool resources (not new programs)
- Jorge eligible

How They Work

- Proactive risk identification
  - Diagnoses
  - Hospital & ED visits
  - Shared EHR between partners
  - Also looking to corrections, foster care and housing
  - Multiple address changes
- Most likely to incur high costs
- High-risk members: 6-10% of members
- Tracked down
  - Community health workers look for them
  - Social worker teams up with local nonprofit

Hennepin Health: A Care Delivery Paradigm for New Medicaid Beneficiaries

Introduction

Jorge's life began spiraling out of control in 2010 when he lost his job managing a food pantry and his wife died suddenly. Soon after, he became homeless and often wandered the streets, crying uncontrollably. After another blow—his son's death in combat in Afghanistan—a priest took him to Hennepin County Medical Center where a social worker determined he was eligible to receive services from Hennepin Health, a safety-net accountable care organization (ACO). The ACO was launched in 2012 as a Medicaid demonstration project in Hennepin County, Minnesota, to create a new model of care for Medicaid beneficiaries like Jorge who may suffer from debilitating mental health problems, chemical dependencies, and other hallmarks of poverty, trauma, and social isolation.[1]

"These are patients who are systematically disenfranchised because of the chaos of their lives," says Paul Johnson, M.D., medical director of a clinic caring for the highest-risk Hennepin members. "They just do not fit into care systems." Instead, they turn up in emergency departments when their diabetes spirals out of control, an untreated wound becomes infected, or simply because they have no warm place to sleep. Hennepin Health's approach is to focus first on stabilizing members' lives, then encourage them to take medications, try counseling and addiction treatments, and seek care for their neglected medical problems. In Jorge's case, a community health worker gave him a coupon to get a haircut, toiletries, and groceries, and eventually found him a place in a group home.

- 12,000 Medicaid beneficiaries
- Close gaps, respond quickly
- Secured housing for up to 50% of members
- Dramatic drop in demand for ED and acute care
- Medical costs fallen 11% y-o-y
- Used the savings to do new things, such as an 'access clinic'
- Identify people of lower risk that may need help
- Bring in new types of non-Medicaid services (ie vocational counseling for prisoners)

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- "HH's leaders initially thought their members could be stabilized after 3-6 months of intensive oversight…"
- "In practice, however, most members have required this higher level of oversight for longer…"

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- Between 2012 and 2013, outpatient visits increased by 3.3%
- "It takes a lot of behavior change and work to build relationships – so the increase in [the use of] primary care services is very hopeful"
- "We're investing in people in ways that are going to take many years to pay off"

More Reality

Hospital Funds $250K in Housing Aid, Social Determinants of Health

UI Hospital has added $250,000 in funding for its Better Health Through Housing program, which addresses the social determinants of health.

January 09, 2018 - The University of Illinois Hospital has **reinvested** $250,000 into their Better Health Through Housing program, which helps address the social determinants of health such as housing security.

The social determinants of health are external factors that significantly impact patient health. Issues such as food security, public safety, and education are **common social determinants of health**.

University of Illinois at Chicago decided to reinvest in Better Health Through Housing, which initially launched in 2015, because of the considerable impact housing makes on the hospital's community.

"We are an urban health system engaged in tackling complex social issues that affect health," said Robert Barish, MD, vice chancellor for health affairs at the University of Illinois at Chicago. "Lack of housing has been shown to have serious health effects. Without a home base, getting and staying healthy is extremely difficult, and this is why we have decided to reinvest in this program."

- Identify the homeless
- Super utilizers
- Provide housing support
- Costs per patient down 18%
- From $5879 to $4785
- Aim: Care for 48 homeless
- **Reality: ”hundreds” were homeless**

Basic Definitional Challenge

THE LANCET

EDITORIAL | VOLUME 394, ISSUE 10205, P1206, OCTOBER 05, 2019

Housing and homelessness as a health crisis

The Lancet

Published: October 05, 2019 • DOI: https://doi.org/10.1016/S0140-6736(19)32267-6 • Check for updates

PlumX Metrics

Ahead of World Homeless Day on Oct 10, the UK's National Housing Federation last week released new data based on the Understanding Society longitudinal study, drawing attention to the scale and breadth of the country's housing crisis—with 8·4 million people affected in one or more ways. Inhospitable conditions include overcrowding (affecting 3·6 million people), concealed households (2·5 million people), poor-quality housing (1·4 million people), and being homeless or at risk of homelessness (400 000 people). These data come with caveats—varied definitions and measures, and multiple bodies recording numbers, has led to non-comparable figures at national (and global) levels.

The health effects of homelessness have been extensively documented. A study by Robert Aldridge and colleagues shows how homelessness places people at heightened risk of morbidity and mortality, with almost one in three deaths among people who were homeless and had experienced hospitalisation being due to amenable causes. This is higher than in the comparison group (who were housed but living in deprived areas), as health-care interventions are made too late and can be inappropriate. The health care provided to homeless people in hospitals needs providers trained to be sensitive to patients' feelings of indignity and of silent stigma—how it would feel to be the only patient with no visitors and without clean clothing.

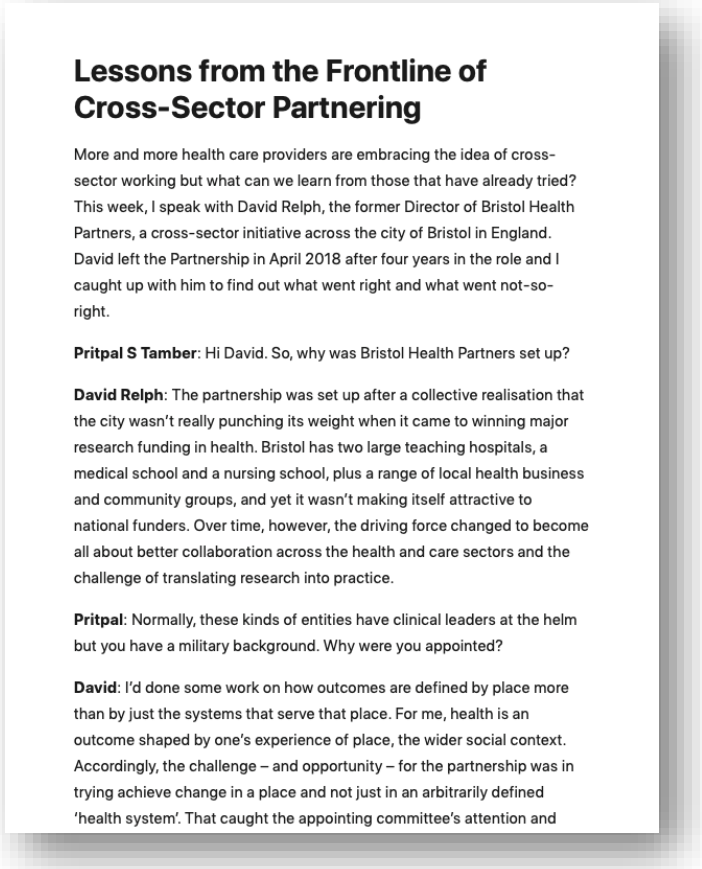
- Homelessness
- At risk of homelessness
- Poor quality housing
- Concealed households
- Over-crowding
- “The lack of accepted definitions of inadequate housing and homelessness hampers a full understanding of a life lived without a stable home and its impact on health”

Understanding the Realities

- City-wide collaboration
- Health and place
- TOC: Better relationships between institutions
- Benefit: To unlock skills and potential
- Goal: Collaboration, not cancer
- Relationships, skills and potential are problem-agnostic

But Then Things Changed…

- Budgetary pressure
- Board's focus shifted to financial returns
- David's team tried to respond
- But it's hard to make clear-cut ROI case
- Fragmented the city-wide perspective
- Removed 'place' from the frame
- Frayed inter-institutional relationships



Lessons from the Frontline of Cross-Sector Partnering

More and more health care providers are embracing the idea of cross-sector working but what can we learn from those that have already tried? This week, I speak with David Relph, the former Director of Bristol Health Partners, a cross-sector initiative across the city of Bristol in England. David left the Partnership in April 2018 after four years in the role and I caught up with him to find out what went right and what went not-so-right.

Pritpal S Tamber: Hi David. So, why was Bristol Health Partners set up?

David Relph: The partnership was set up after a collective realisation that the city wasn't really punching its weight when it came to winning major research funding in health. Bristol has two large teaching hospitals, a medical school and a nursing school, plus a range of local health business and community groups, and yet it wasn't making itself attractive to national funders. Over time, however, the driving force changed to become all about better collaboration across the health and care sectors and the challenge of translating research into practice.

Pritpal: Normally, these kinds of entities have clinical leaders at the helm but you have a military background. Why were you appointed?

David: I'd done some work on how outcomes are defined by place more than by just the systems that serve that place. For me, health is an outcome shaped by one's experience of place, the wider social context. Accordingly, the challenge – and opportunity – for the partnership was in trying achieve change in a place and not just in an arbitrarily defined 'health system'. That caught the appointing committee's attention and

Lessons Learned

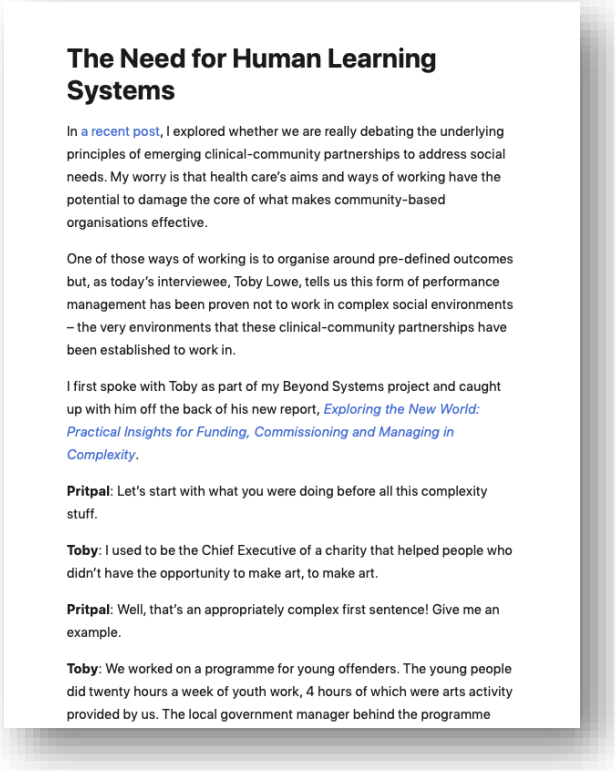
1. Frame health work on the basis of equality (equity)
   - Forces you to embrace social context
2. Do deeper work to understand participants' motivations
   - Makes it possible to withstand short-term pressures
3. Hold the operations of institutions to account on the basis of their stated values
   - Surface the incongruence of things like business cases based y-o-y returns when tackling inequity is longer-term work

Dealing with Complexity

- Outcomes-based performance management (OBPM)
- Aspirations get turned into measurable proxies (‘outcomes’)
- Leads to gaming – changing what’s measured or changing how it’s measured
- “What the hell else do we do?”
- Looked for alternatives
- Work based on: relationships and trust
- At the core of the work is learning

Responding to Emergence

- Human
  - Being human, building empathy, understanding people's strengths, creating trust
- Learning
  - A continuous process of learning to adapt to changing context and the people you work with
- Systems
  - Recognising that outcomes come from whole systems, not individuals or institutions



The Need for Human Learning Systems

In a recent post, I explored whether we are really debating the underlying principles of emerging clinical-community partnerships to address social needs. My worry is that health care's aims and ways of working have the potential to damage the core of what makes community-based organisations effective.

One of those ways of working is to organise around pre-defined outcomes but, as today's interviewee, Toby Lowe, tells us this form of performance management has been proven not to work in complex social environments – the very environments that these clinical-community partnerships have been established to work in.

I first spoke with Toby as part of my Beyond Systems project and caught up with him off the back of his new report, *Exploring the New World: Practical Insights for Funding, Commissioning and Managing in Complexity*.

Pritpal: Let's start with what you were doing before all this complexity stuff.

Toby: I used to be the Chief Executive of a charity that helped people who didn't have the opportunity to make art, to make art.

Pritpal: Well, that's an appropriately complex first sentence! Give me an example.

Toby: We worked on a programme for young offenders. The young people did twenty hours a week of youth work, 4 hours of which were arts activity provided by us. The local government manager behind the programme

No two projects are the same

But we can discern patterns across them

Include in a community's collective effort those who live there, those who work there, and those who deliver or support services there

Spend time understanding differences in context, goals and power

Appreciate the arc of local history as part of the story of a place

Elicit, value and respond to what matters to community residents

Facilitate and support the sharing of power, including building the capacity to use it and acknowledging existing imbalances

Operate at five levels at the same time: individual, family, community, institutional and policy

Accept that this is long-term, iterative work

Embrace uncertainty, tension and missteps as sources of success

Measure what matters, including the process and experience of the work

Build a vehicle buffered from the constraints of existing systems and able to respond to what happens, as it happens

Build a team capable of working in a collaborative, iterative way, including being able to navigate the tensions inherent in this work

Pursue sustainability creatively; it's as much about narrative, process and relationships as it is about resources

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Tensions, Tensions, Tensions…

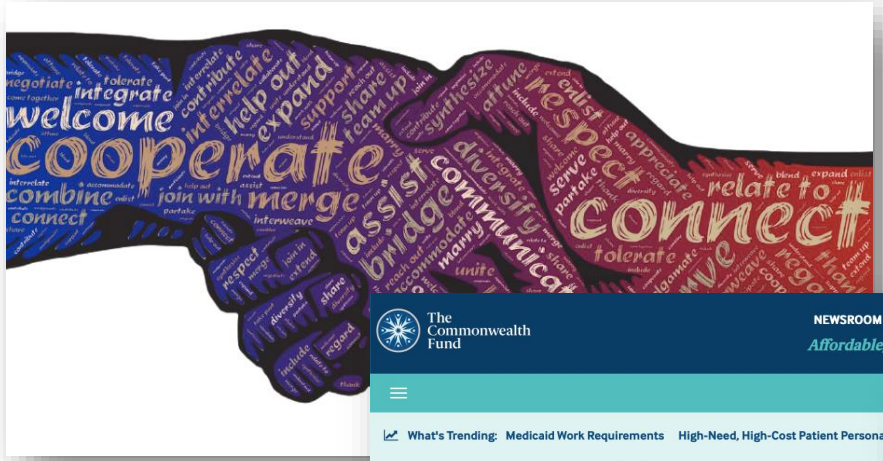
Payment reform **versus** SDoH-focussed work

Bottom-up creativity **versus** Top-down mandates

Demonstrate **versus** Sustain

Public health **versus** Clinical care

Urban **versus** Rural



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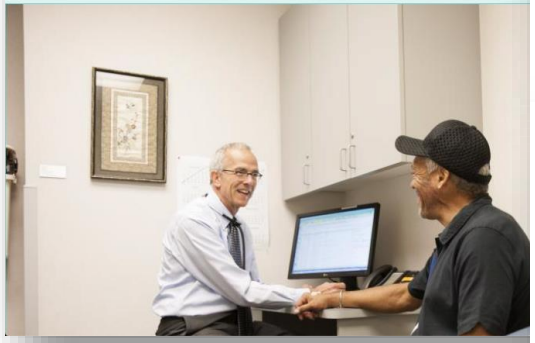

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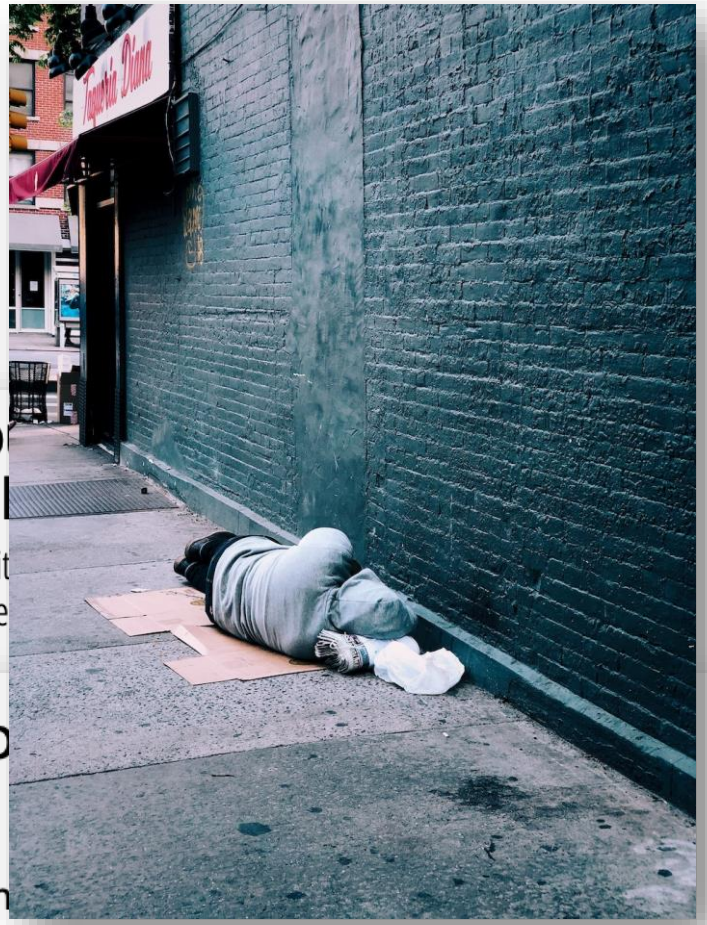

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Bottom-up creativity **versus** Top-down mandates

Demonstrate **versus** Sustain

Public health **versus** Clinical care

Urban **versus** Rural

(or West **versus** East)

Thanks for listening

A Deeper Dive

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What We’re Going To Do

- Reflect on the keynote
  - What came to mind?
- Talk about your work
  - What’s working, what’s not, and what might be done regionally?
- Spend time with the 12 Principles
  - What resonated, what’s missing and should we spend time on the four highlighted in the keynote?
- Get to know each other along the way
- Try to take a 15-minute break after an hour

Reflecting on the Keynote

What came to mind?

Include in a community's collective effort those who live there, those who work there, and those who deliver or support services there

Spend time understanding differences in context, goals and power

Appreciate the arc of local history as part of the story of a place

Elicit, value and respond to what matters to community residents

Facilitate and support the sharing of power, including building the capacity to use it and acknowledging existing imbalances

Operate at five levels at the same time: individual, family, community, institutional and policy

Accept that this is long-term, iterative work

Embrace uncertainty, tension and missteps as sources of success

Measure what matters, including the process and experience of the work

Build a vehicle buffered from the constraints of existing systems and able to respond to what happens, as it happens

Build a team capable of working in a collaborative, iterative way, including being able to navigate the tensions inherent in this work

Pursue sustainability creatively; it's as much about narrative, process and relationships as it is about resources

Let’s talk about your work

What’s working, what’s not, and what might be done regionally?

The 12 Principles

What resonated, what’s missing and should we spend time on the four highlighted in the keynote?

Accept that this is long-term iterative work

- Do you acknowledge this basic fact?
- Does your vision acknowledge this basic fact?
- Is there at least one area of your work configured to allow strategy and solutions to evolve in response to the world outside?
- Is your work entirely configured on the basis of ‘emergent learning’?

Embrace uncertainty, tension and missteps as sources of success

- Do you operate on the basis that the work is implicitly uncertain?
- Do you reflect on these uncertainties and look for issues that need discussing, even if they’re uncomfortable?
- Is assessing and reflecting on uncertainties a normal part of your work routine?
- Do you embrace as crucial and informative the instances when parts of the work do not go as planned?

Build a vehicle buffered from the constraints of existing systems and able to respond to what happens, as it happens

- Do you acknowledge the constraints in the mindsets, processes, incentives and demands of the existing?
- Do you actively explore a different frame, business model and set of values in your work?
- Do you prototype a microcosm of work within or alongside your wider work that uses a new frame, model or set of value?
- Do you explore how to take learnings from that microcosm and apply it to other work?

Pursue sustainability creatively; it’s as much about narrative, process and relationships as it is about resources

- Do you have a broad understanding of sustainability?
- Do you dedicate time to understand and develop the narrative of how your work is creating value?
- Are you developing strategies informed by these narratives to sustain the processes and relationships of your work?
- Are you able to sustain your work through these narratives, while also exploring how the narrative might evolve?