A Perfect Storm: Health Share's Ecosystem data analysis

Cat Livingston, MD, MPH

May 29, 2024

Health Share of Oregon

Bio: Cat Livingston, MD, MPH

Cat Livingston, MD, MPH, is Medical Director of Health Share of Oregon, Oregon's largest Coordinated Care Organization. She is boarded in Family Medicine as well as Preventive Medicine and serves as a primary care physician and researcher at Oregon Health & Science University as an Adjunct Associate Professor.

Prior to joining Health Share, she worked for the Health Evidence Review Commission (HERC) for a decade on evidence-based policy making for Oregon Health Plan's unique Prioritized List. Her key areas of policy interest include evidence-based policy, substance use disorder, population health, metrics, and social determinants of health.

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- 54 yo man
- Living on streets, struggling with OUD
- Cellulitis, needing IV antibiotics
- Care is complicated by distrust, weekend admission and barrier to MOUD and behavioral concerns from nursing
- Discharge options unsatisfactory

Preventable morbidity, moral distress, systems failures

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Intersecting crises

The New York Times

Oregon Leaders Declare Drug Emergency in Portland

Oregon's governor, Tina Kotek, hopes to counter homelessness, crime and widespread public use of fentanyl that she says threatens the...

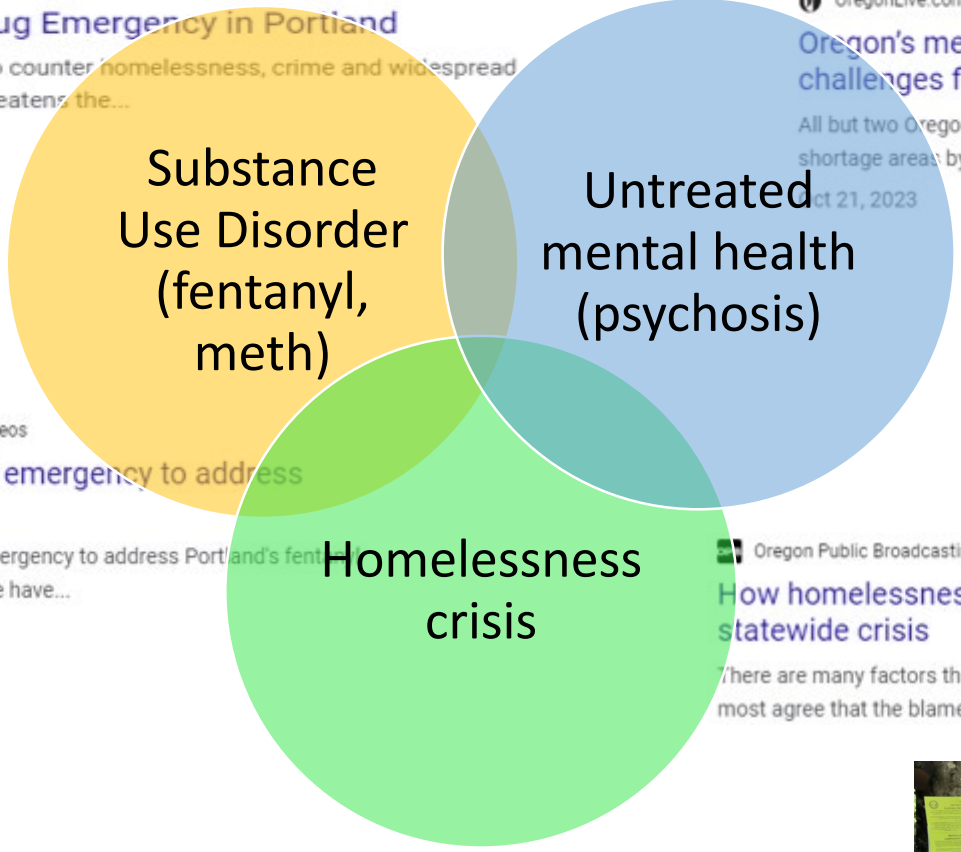
Jan 30, 2024

OregonLive.com

Oregon's mental health workforce 'crisis' exacer challenges finding care

All but two Oregon counties are designated as complete mental heal shortage areas by the federal government, according to the...

ct 21, 2023



ABC News - Breaking News, Latest News and Videos

Oregon officials declare state of emergency to address fentanyl crisis in Portland

Oregon officials declared a 90-day state of emergency to address Portland's fent crisis as fatal synthetic opioid overdoses there have...

Jan 31, 2024

Oregon Public Broadcasting - OPB

How homelessness in Oregon started, grew and beca statewide crisis

There are many factors that contributed to Oregon's current homelessness cr most agree that the blame largely falls on one problem: the...

Oregon Public Broadcasting - OPB

Multnomah County, Portland present plan to halve unsheltered homelessness by 2026

Multnomah County and the city of Portland unveiled details Monday of a long-promised plan to overhaul the region's response to homelessness.

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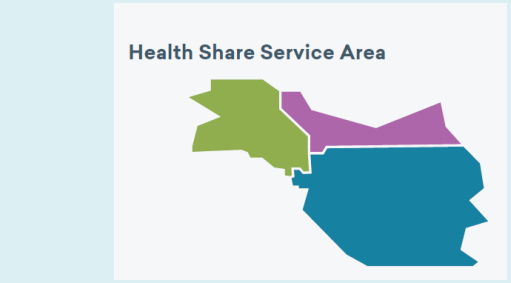
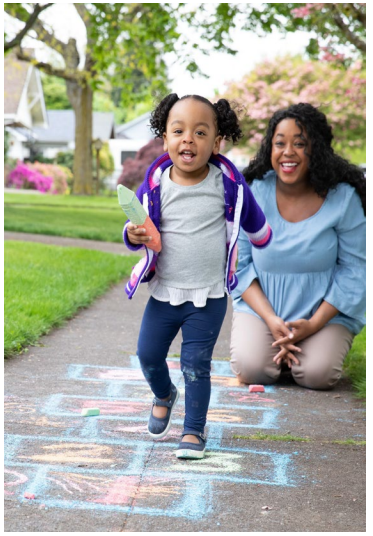
Health Share of Oregon

We bring together health plans, providers and community health resources so our members can get the care they need and achieve their best possible health.

We partner with communities to achieve ongoing transformation, health equity, and the best possible health for each individual.



Clackamas County	90,680
Multnomah County	234,876
Washington County	129,026
TOTAL MEMBERS	**454,582**



Oregon's largest Coordinated Care Organization, offering members a choice of five different health plans.

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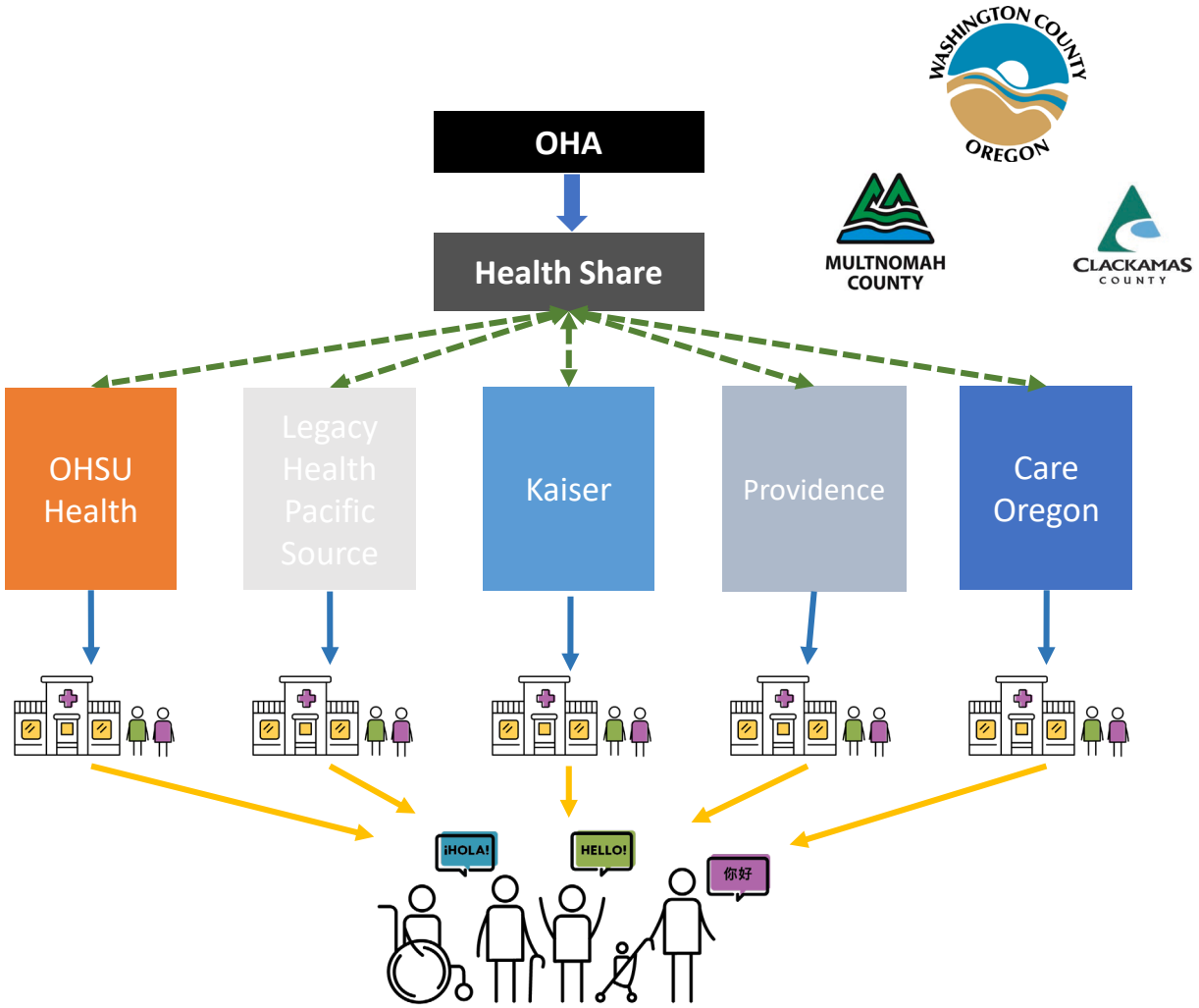
PacificSource | LEGACY HEALTH | KAISER PERMANENTE®

PROVIDENCE Health & Services | CareOregon | OHSU Health

Health Share Collaborative



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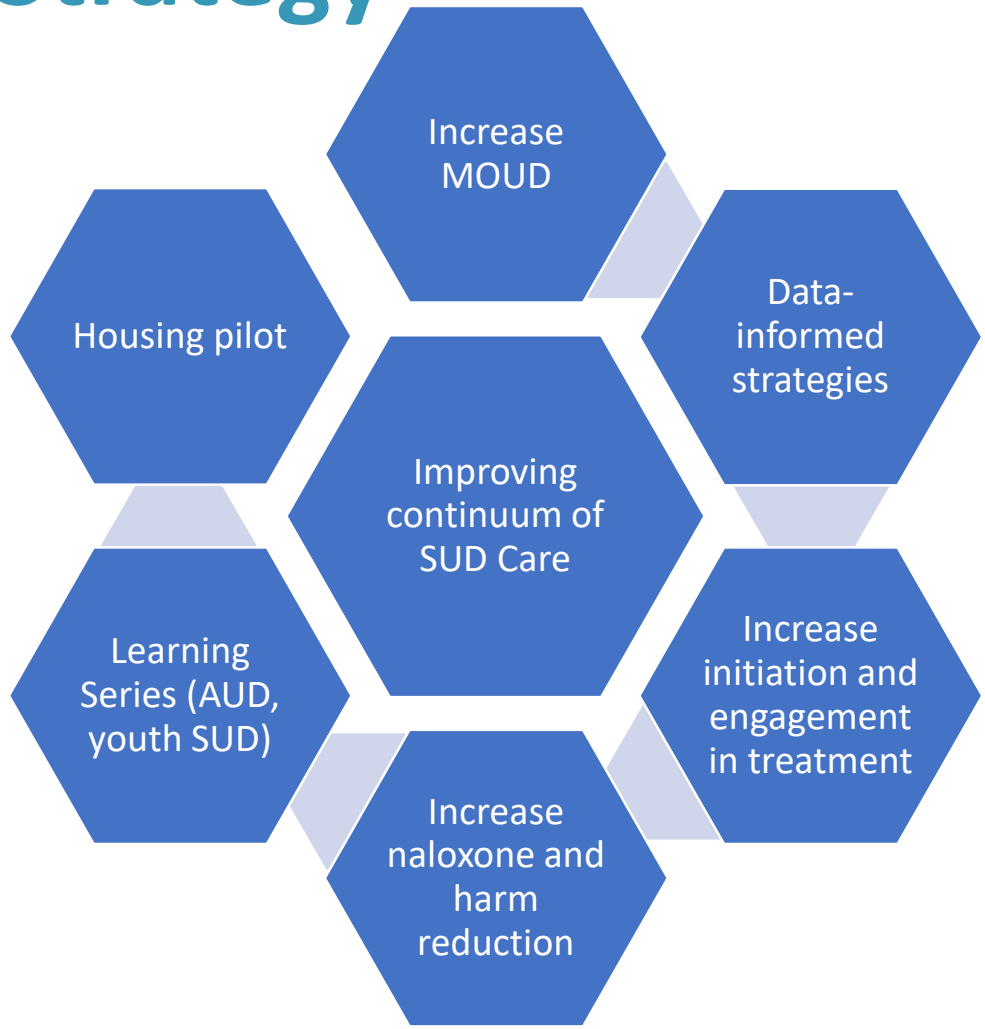
Health Share's Substance Use Disorder Strategy



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Ecosystem

All needed:

Physical health

Behavioral health

Housing organizations

Counties

Community based organizations

But there is FRAGMENTATION, and inequities

Ecosystem Analysis

- Data analysis looking at the nexus of substance use disorder, mental illness, and social determinants of health
- Known cause of high utilization and (potentially preventable) high morbidity and mortality
- Intersecting crises - New drugs, insufficient affordable housing, and the longstanding behavioral health capacity crisis are contributing to increased acuity
- Hospitals also facing capacity crisis
- Moral distress for care teams with discharging people with insufficient follow up care

➔**unmet needs and system out of balance**

Goals:

- Develop structured data and frameworks to support a region-wide response
- Understand the cohorts and acuity
- Inform potential strategies to **improve health outcomes**
- Will require breakdown of siloes

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Ecosystem Cohort Data Analysis

Health Share of Oregon

Ecosystem Cohort

Cohort	Current Health Share members (as of 12/31/23) with [listed below] between Jan – Dec 2023 (from claims data)
1. Opioid Use Disorder (OUD)	1+ OUD diagnosis
2. Stimulant Use Disorder	1+ stimulant use disorder diagnosis
3. Psychosis	1+ psychosis diagnosis
4. Substance associated overdose	1+ substance associated overdose (unintentional only)
Final cohort	**Any member in one or more of the cohorts 1-4**

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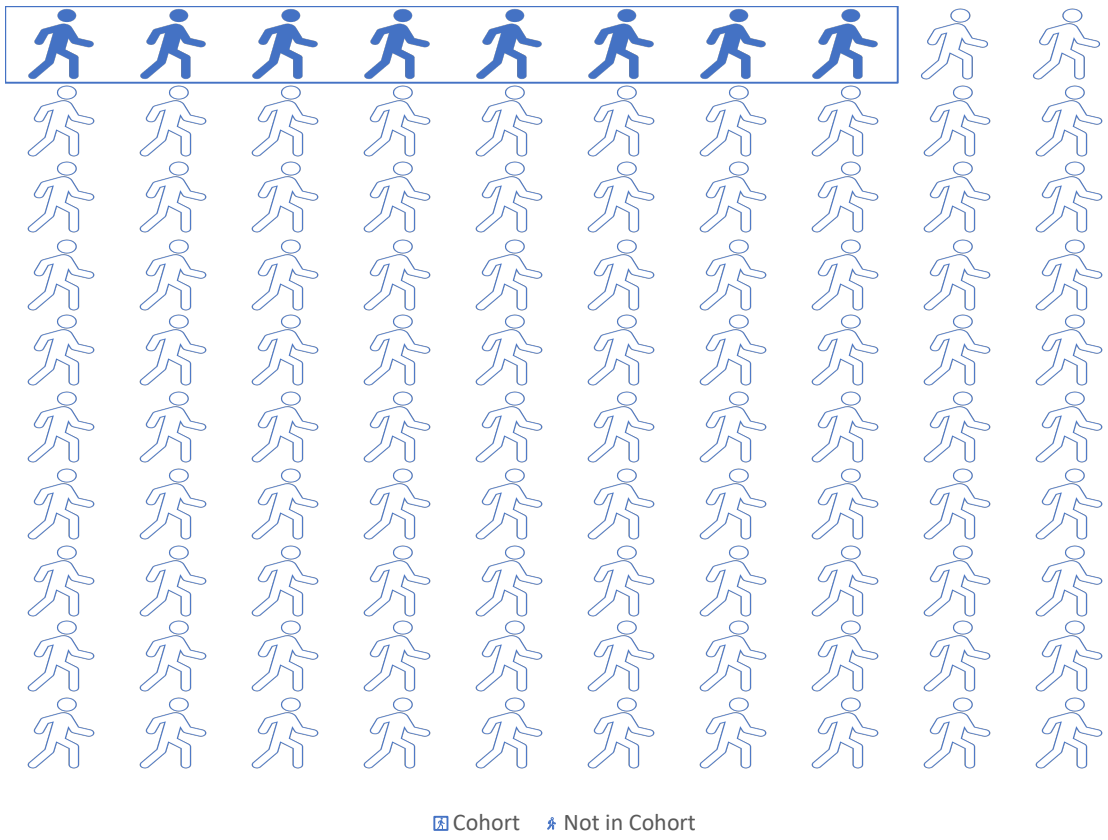
1 in 12 adult Health Share members (8%, n=26,068) are in the ecosystem cohort.



Data source: 2023 Health Share claims data, current as of April 2024

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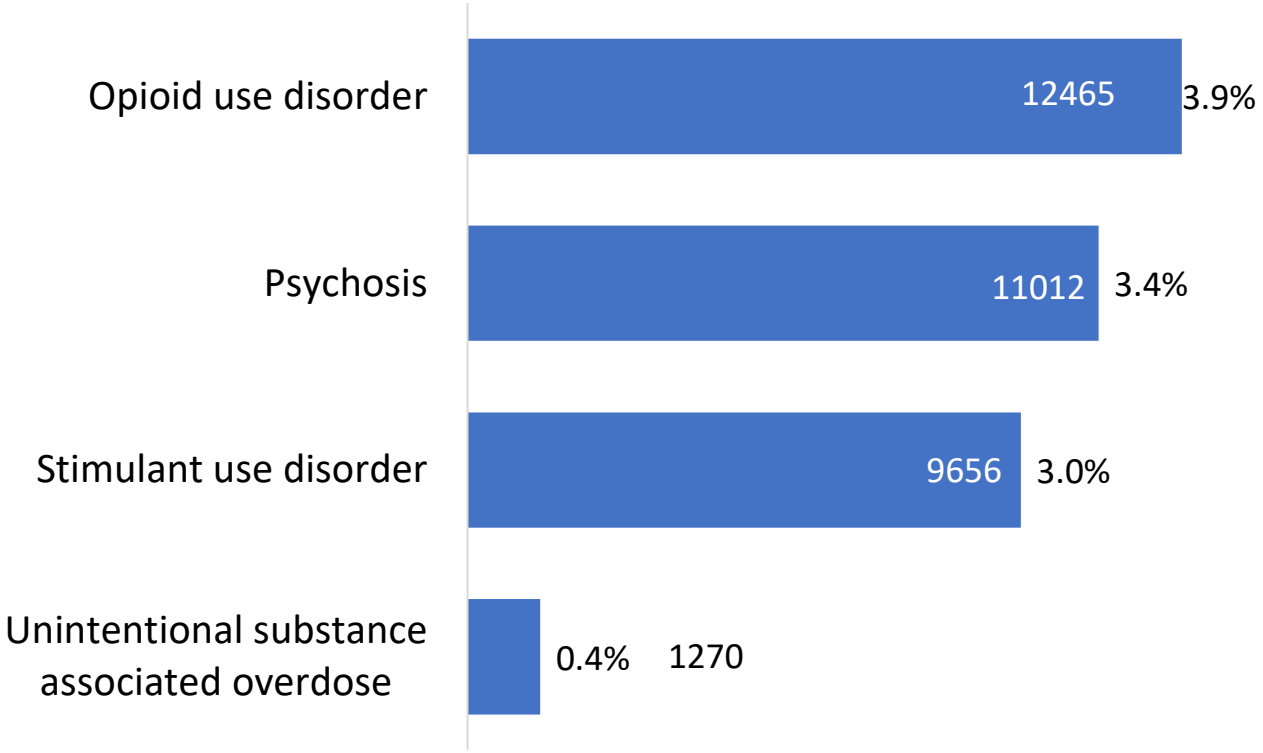
and % of adult members in the ecosystem cohort.



The size of each cohort group ranges from **4%** (Opioid Use Disorder) to **less than 1%** (unintentional substance associated overdose) of all Health Share adult members.

Data source: 2023 Health Share claims data, current as of April 2024

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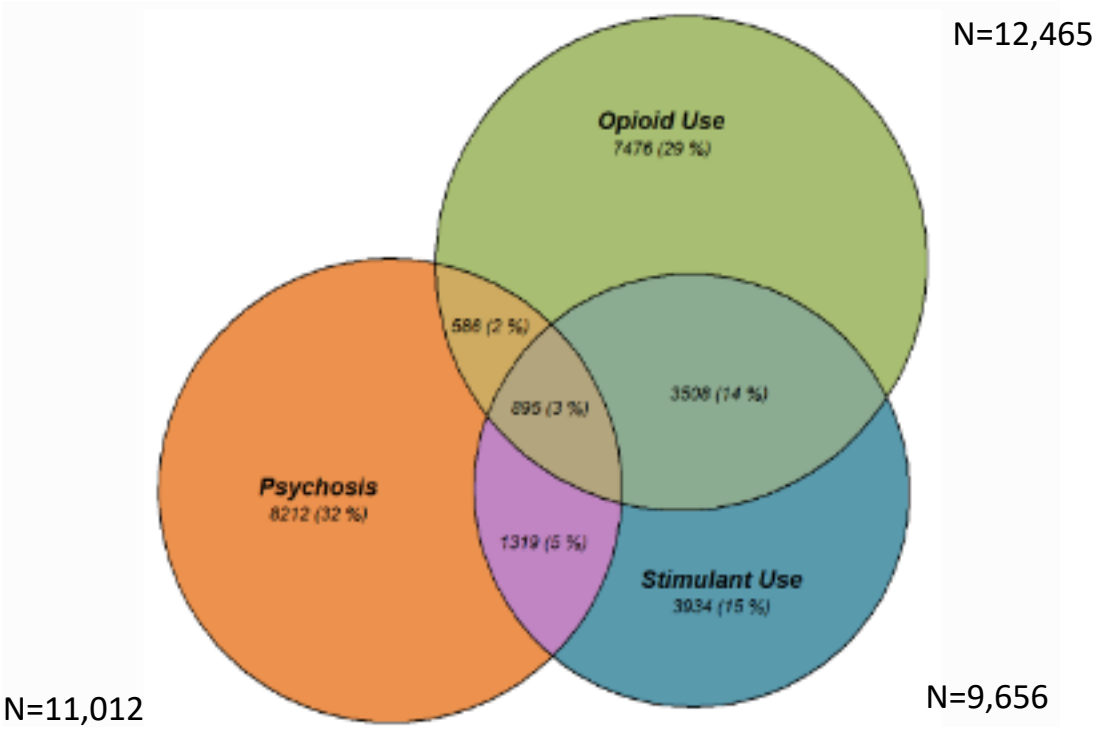
Overlap between the 3 most common cohort groups



There is significant overlap between the cohort groups – for example, 14% of all members in the ecosystem cohort had diagnoses of both Opioid Use Disorder and Stimulant Use Disorder in 2023.

Data source: 2023 Health Share claims data, current as of April 2024

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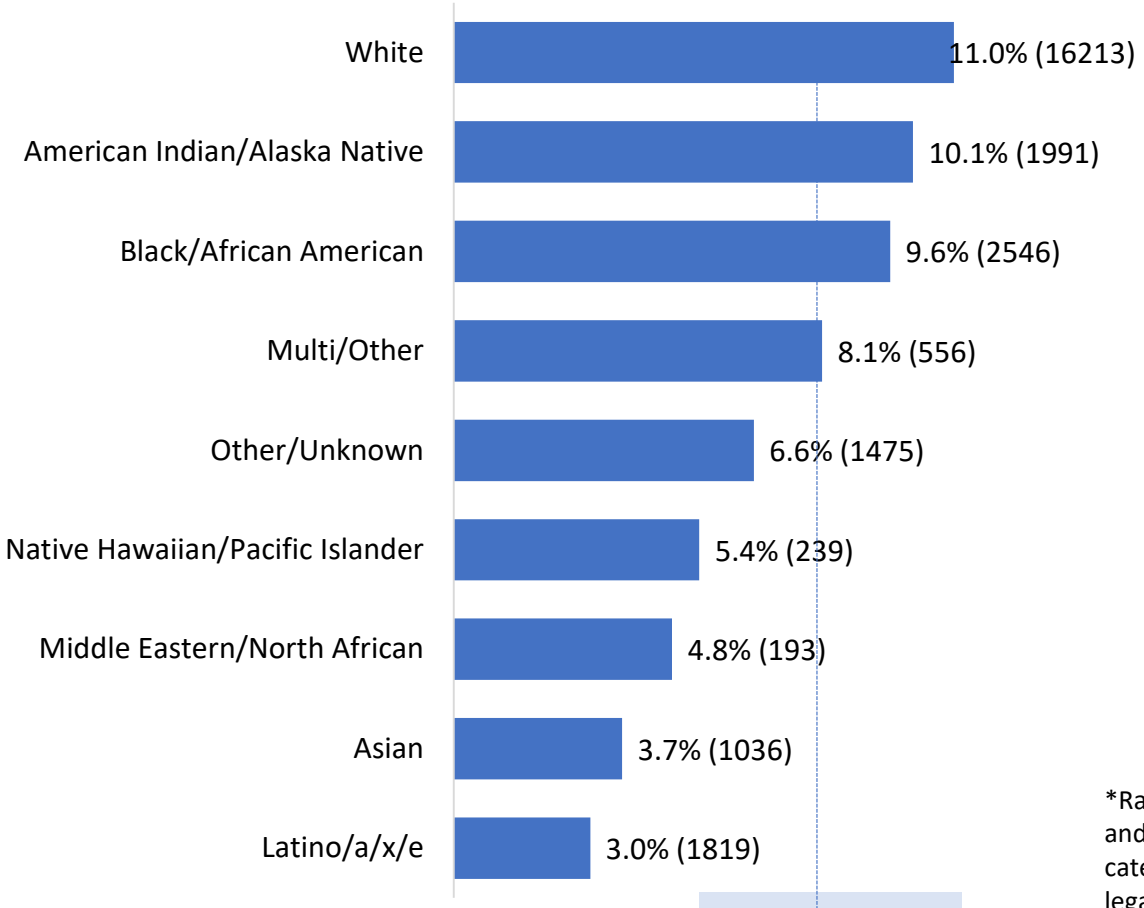
Race/ethnicity of Health Share members in the ecosystem cohort.



White, American Indian/Alaska Native, and Black/African/African American members are overrepresented in the ecosystem cohort.

*Race/ethnicity derived from a combination of REAL data and legacy data (when REAL is unavailable). The MENA category will be underrepresented because it was not a legacy field.

Data source: 2023 Health Share claims data, current as of April 2024

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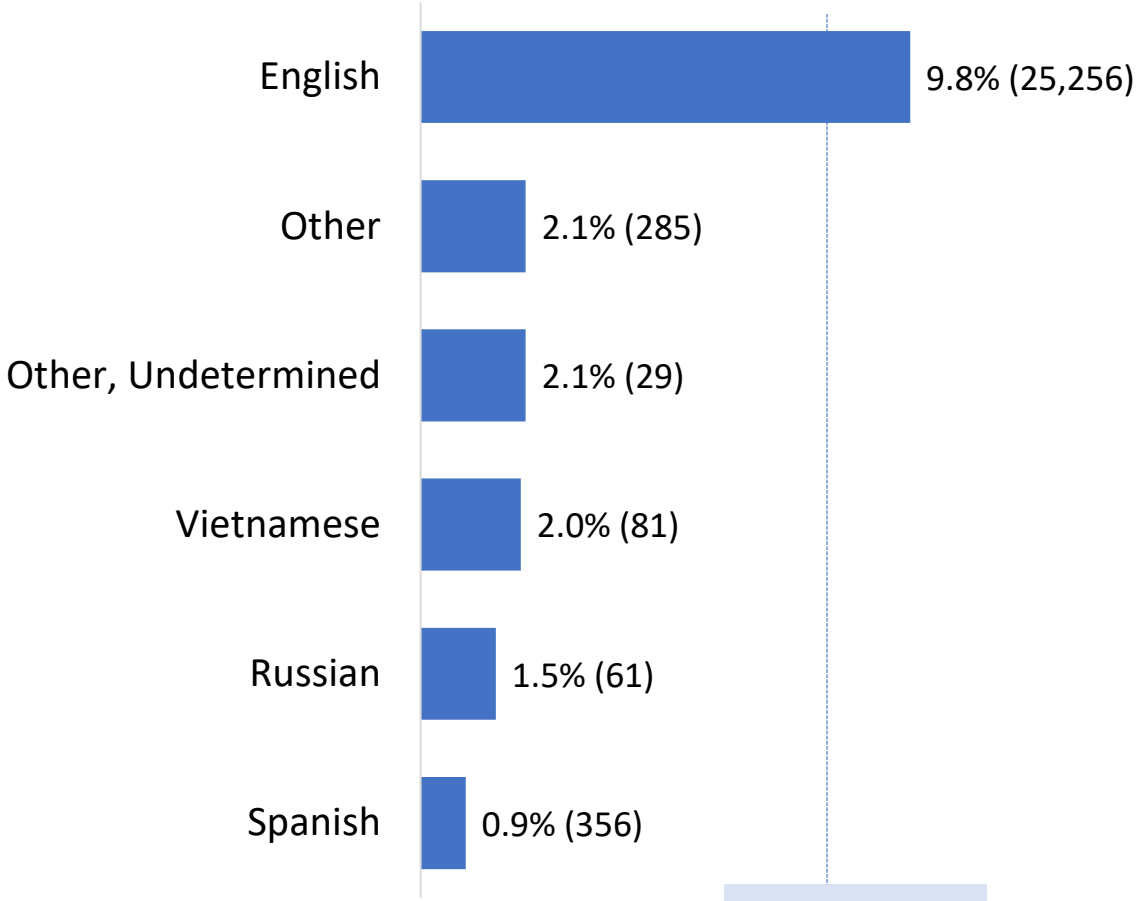
Language spoken for Health Share members in the ecosystem cohort.



English-speaking members are overrepresented in the ecosystem cohort.

Data source: 2023 Health Share claims data, current as of April 2024

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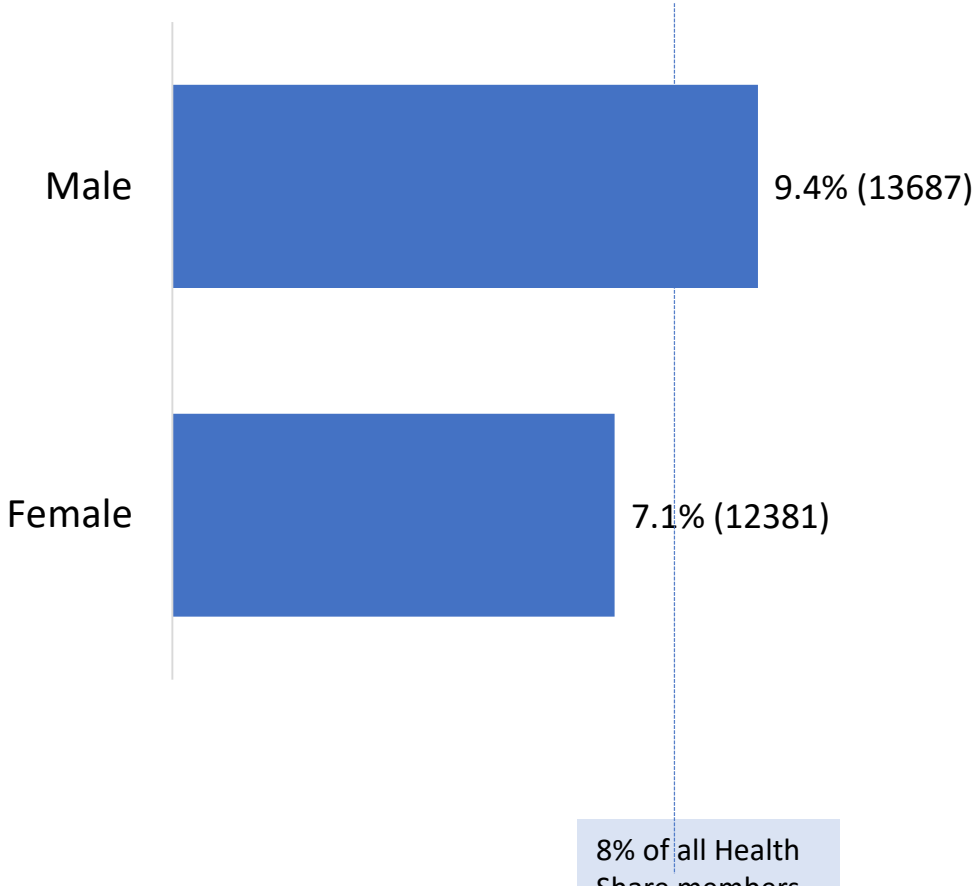
Sex assigned at birth for Health Share members in the ecosystem cohort.



Members assigned male at birth are overrepresented in the ecosystem cohort.

Data source: 2023 Health Share claims data, current as of April 2024

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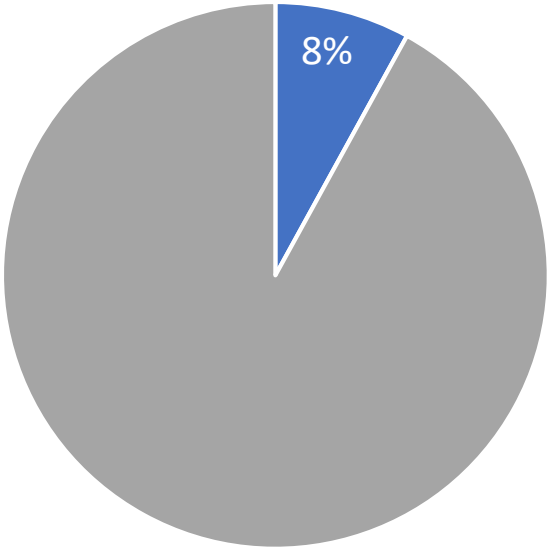
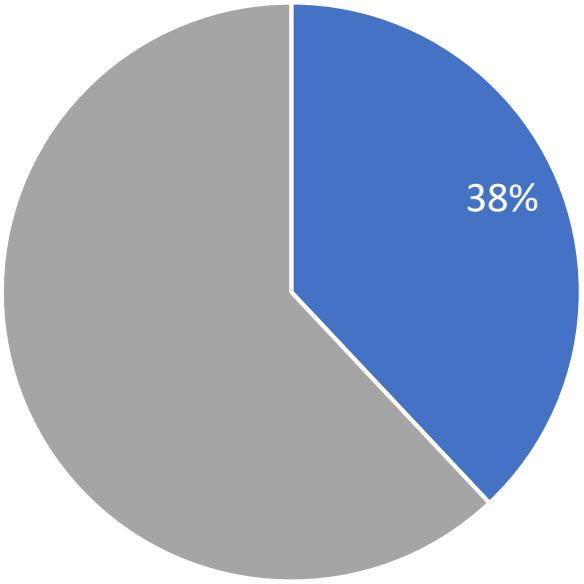
2023 Adult Inpatient Admissions.

8% of Health Share adult members are part of the **ecosystem cohort**



38% of adult medical inpatient admissions are among members of the **ecosystem cohort**



Data source: 2023 Health Share claims data, current as of April 2024

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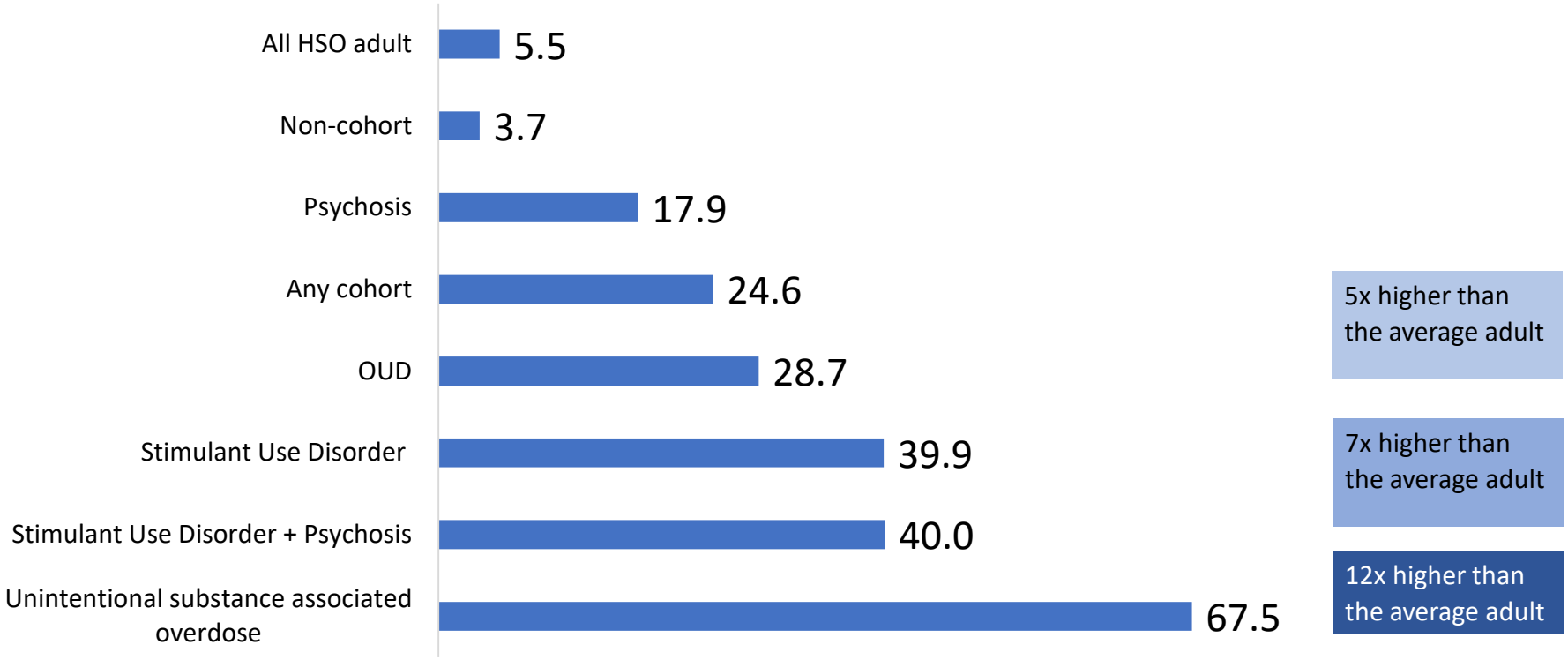
Utilization Comparisons: 2023 Medical Inpatient Admissions per 1000 member months



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Data source: 2023 Health Share claims data, current as of April 2024

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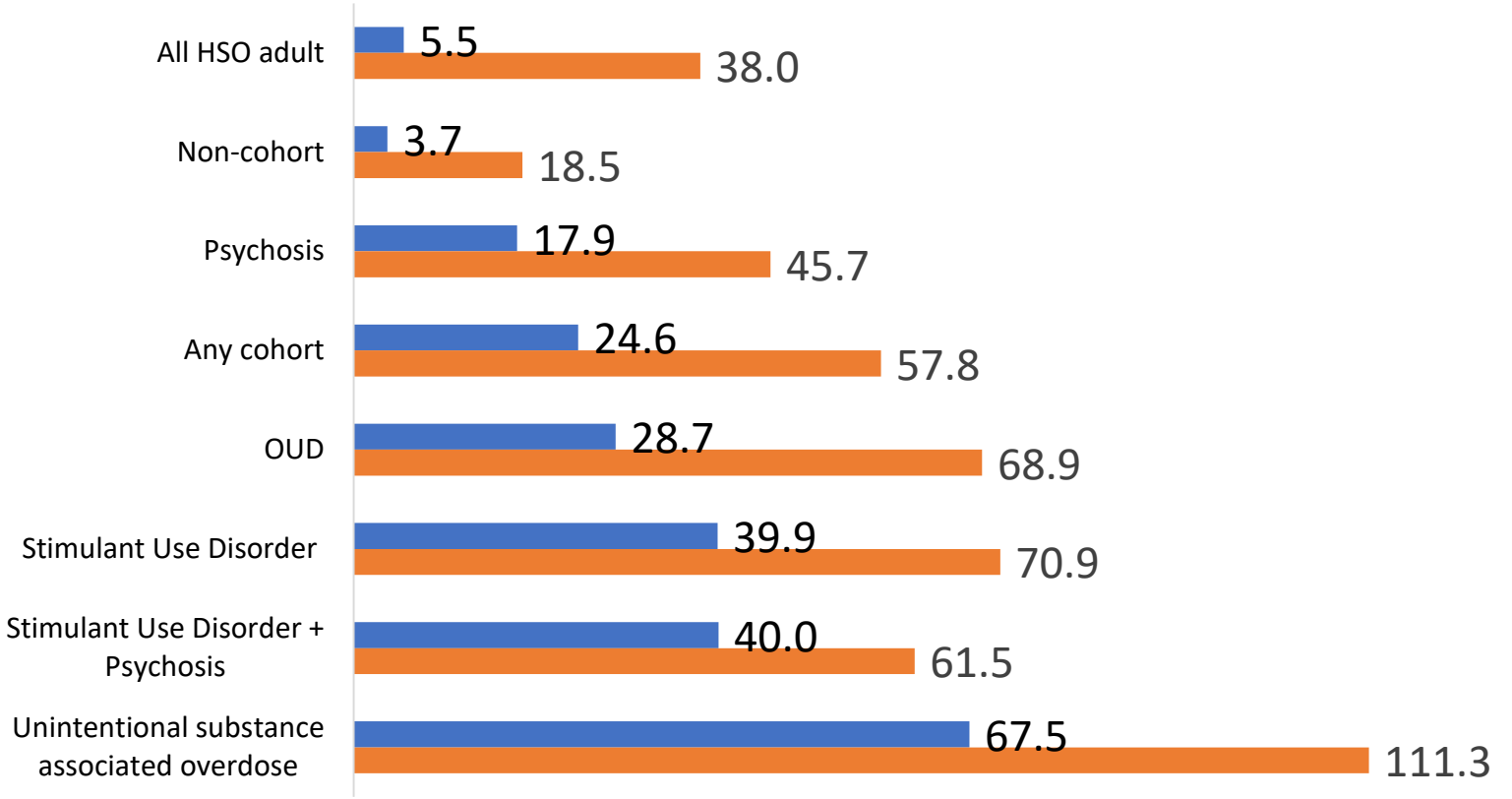
Utilization Comparisons: 2023 Medical Inpatient Admissions per 1000 member months – Housing Insecurity Overlay



8-10x higher than the average adult

13x higher than the average adult

20x higher than the average adult

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Data source: 2023 Health Share claims data, current as of April 2024

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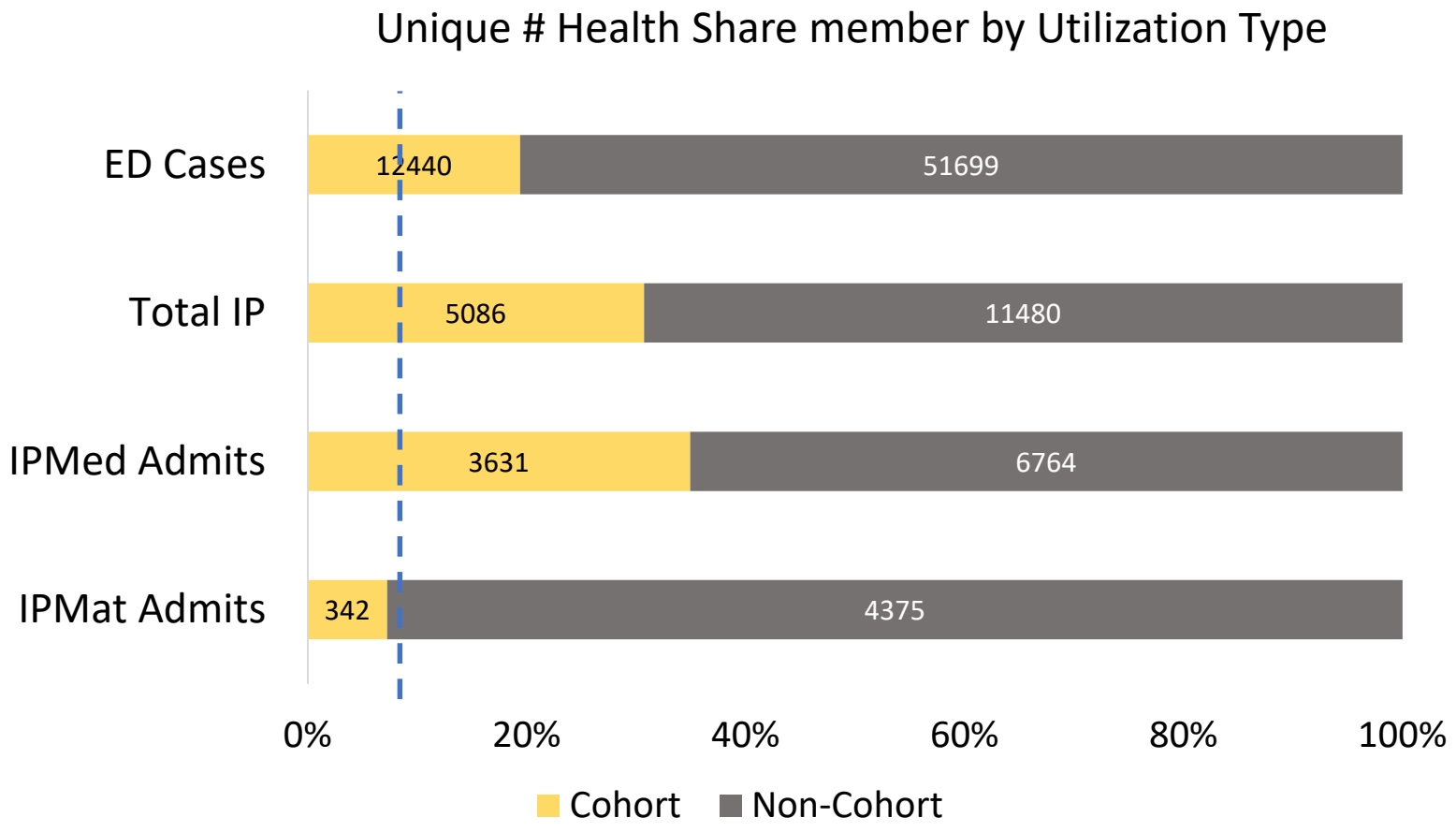
Cohort members with an ED or Inpatient admit are overrepresented for all care types except maternity inpatient.



8% of all Health Share adults are in a cohort

Data source: 2023 Health Share claims data, current as of April 2024

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ED Top 10 – Primary Diagnosis

DX_Group	Any Cohort	Non-Cohort	Opioid Use	Psychosis	Stimulant and Psychosis	Stimulant Use	Unintentional Overdose
Skin and subcutaneous tissue infections	1	4	1	4	2	1	2
Abdominal pain and other digestive/abdomen signs and symptoms	2	1	2	2	6	4	9
Schizophrenia spectrum and other psychotic disorders	3			1	1	3	7
Musculoskeletal pain, not low back pain	4	5	4	7	4	2	6
Nonspecific chest pain	5	2	3	6	7	6	4
Alcohol-related disorders	6		5	5	10	10	3
Superficial injury; contusion, initial encounter	7	7	7	9	9	7	10
Suicidal ideation/attempt/intentional self-harm	8			3	5	9	
Any dental condition including traumatic injury	9	8	6			8	
COVID-19	10	3					
Sprains and strains, initial encounter		6					
Urinary tract infections		9					
Nausea and vomiting		10	10				
External cause codes: poisoning by drug			8				1
Opioid-related disorders			9				
Anxiety and fear-related disorders				8	8		8
Stimulant-related disorders				10	3	5	5

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Data source: 2023 Health Share claims data, current as of April 2024

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Inpatient Top 10 – Primary Diagnosis

DX_Group	Any Cohort	Non-Cohort	Opioid Use	Psychosis	Stimulant and Psychosis	Stimulant Use	Unintentional Overdose
Septicemia	1	1	1	4	2	1	2
Schizophrenia spectrum and other psychotic disorders	2		6	1	1	3	7
Hypertension with complications and secondary hypertension	3	2	4	8	7	2	3
Depressive disorders	4	10	7	3	3	5	10
Bipolar and related disorders	5			2	4	8	
Skin and subcutaneous tissue infections	6		2	9	5	4	4
Diabetes mellitus with complication	7	3	3	7	10	6	9
External cause codes: poisoning by drug	8		5	6	6	7	1
Alcohol-related disorders	9	4	8	5	8	10	8
Respiratory failure; insufficiency; arrest	10		9			9	6
Cerebral infarction		5					
Pancreatic disorders (excluding diabetes)		6					
COVID-19		7					
Acute myocardial infarction		8					
Obesity		9					
Complication of other surgical or medical care, injury, initial encounter			10				
Trauma- and stressor-related disorders				10			
Heart failure					9	7	5

The reasons for inpatient admissions differ significantly between the ecosystem cohort and adult Health Share members not in the cohort – **5 of the most prevalent diagnoses for cohort members do not appear in the top 10 diagnoses for non-cohort members**.

Data source: 2023 Health Share claims data, current as of April 2024

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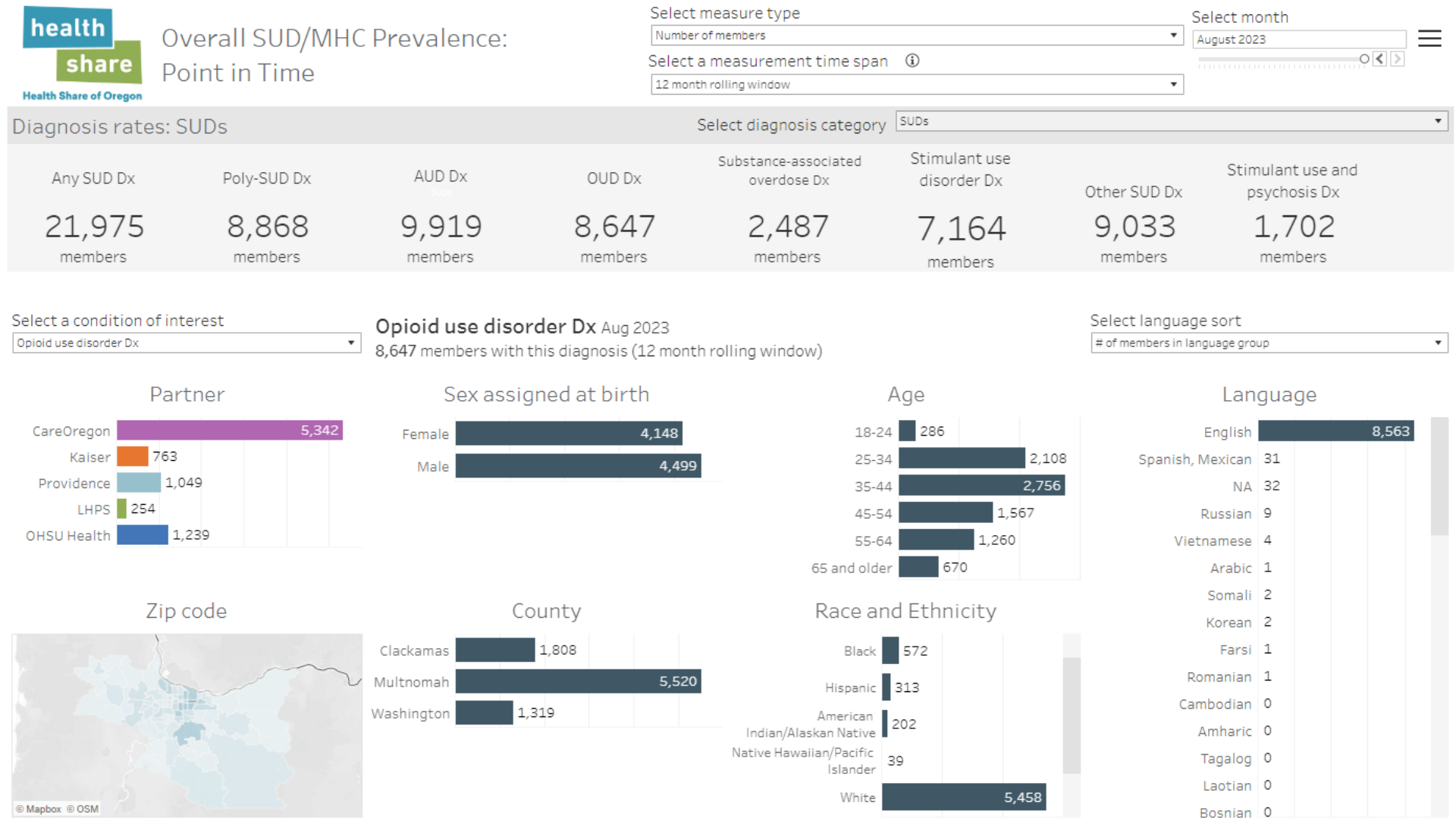
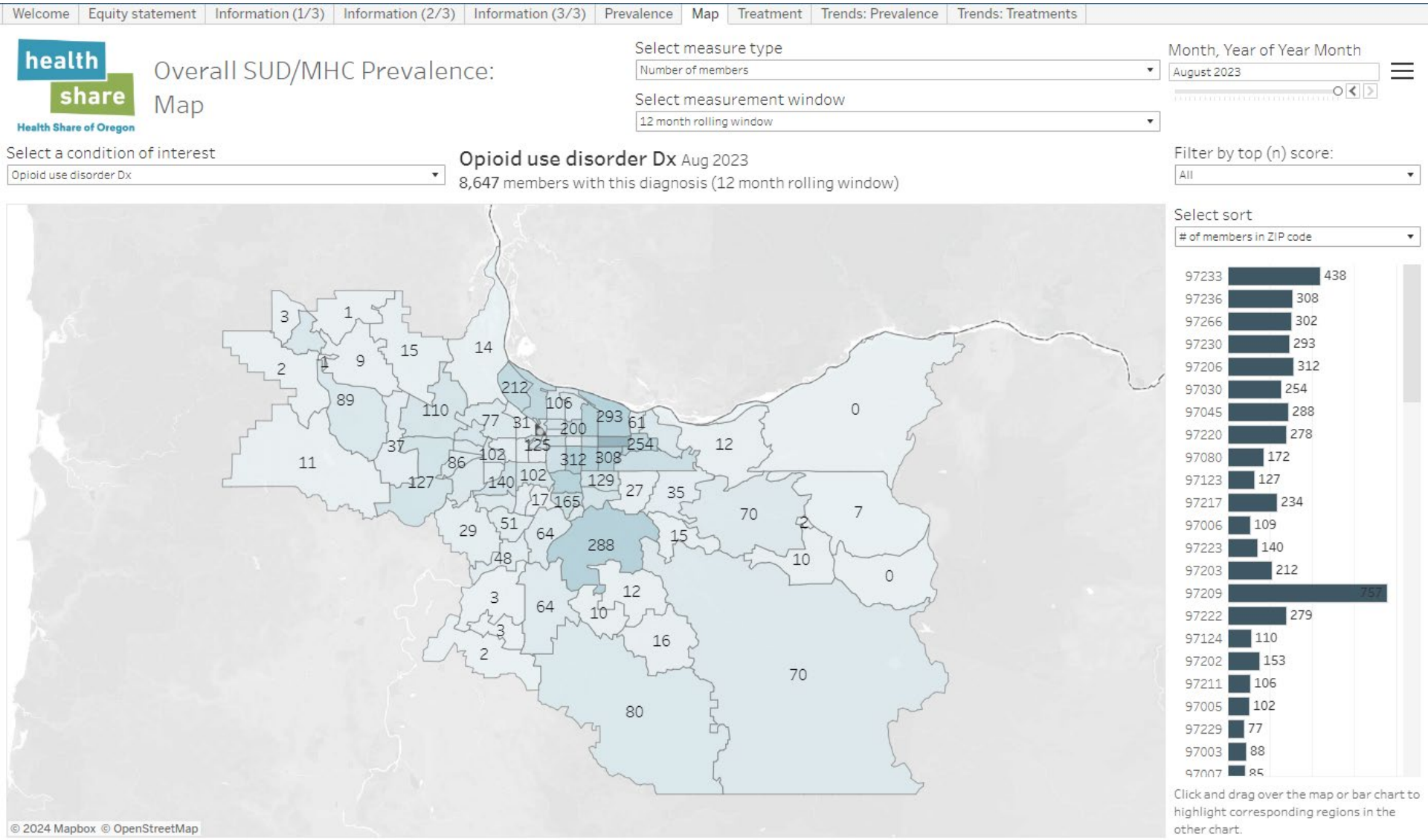
Dashboard Focus: Opioid Use Disorder



Dashboard Focus: Opioid Use Disorder



Synthesis

What does this analysis tell us?	Segmentation by these cohorts helps identify opportunities to improve care
	Many of the individuals struggling with these conditions have accessed the system multiple times only to have it fail them
	Many of these individuals do not access care in a single place, rely on a single provider, or engage in patterns that look like non-cohort members.
	The Medicaid funding model is not optimized to get the right resources to the right places--particularly when it comes to addressing SDOH and significant BH needs.
	The systems providing vital services and supports are not coordinated, including health, social services, and housing.

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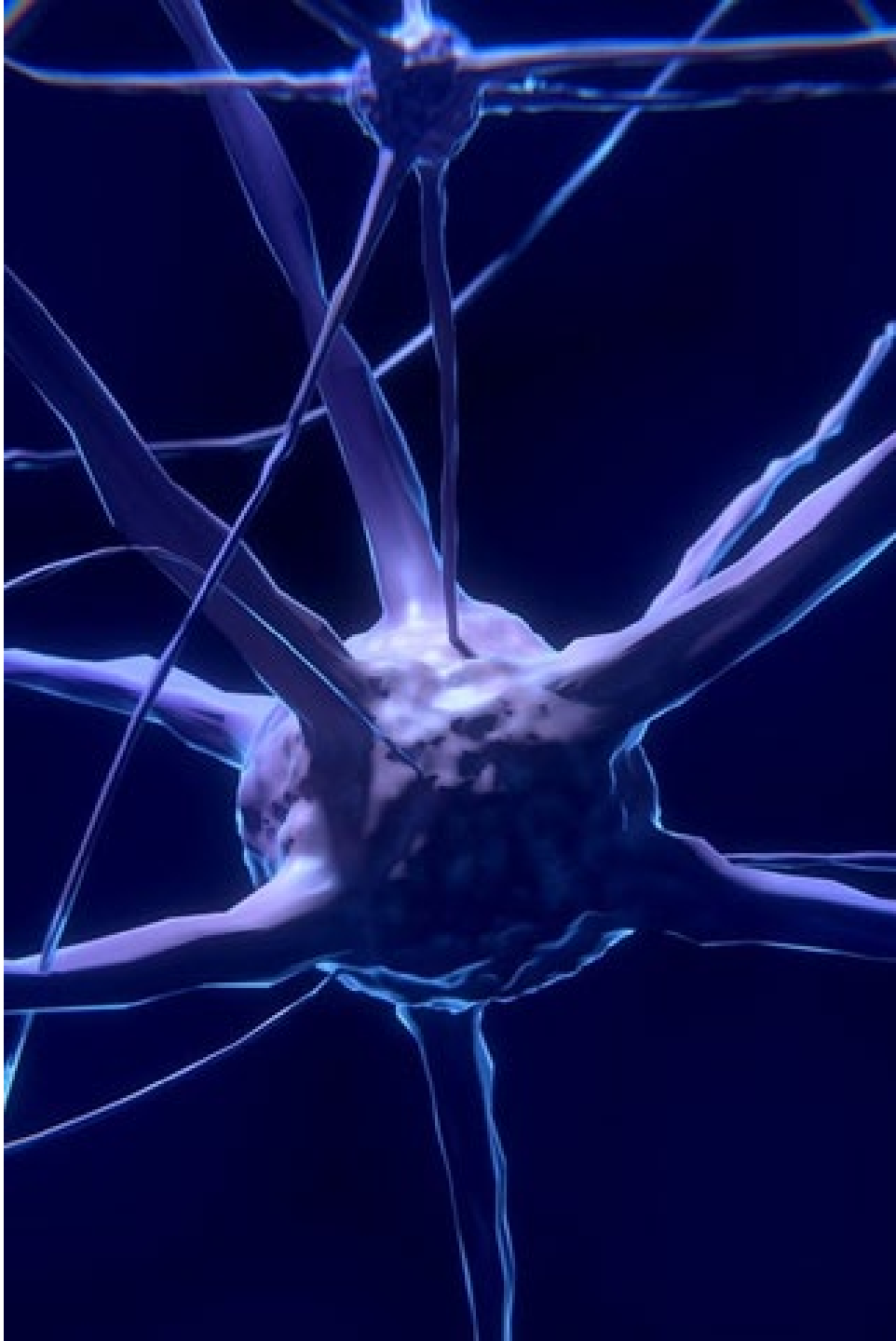
Health Share's Board

Question: How can we optimize Health Share's network to better meet the needs of these individuals and the systems designed to support them?



Health Share Ecosystem Workgroups

Workstream	Scope	Q1 and Q2 Deliverables 2024
Clinical Model (ie. Programs)	Develop population stratification model to identify and respond to segmented clinical needs and meet specific needs of racial/ethnic groups overrepresented in segments.	• Refine clinical data priorities • Assess existing models and where to scale • Develop intervention(s) draft • Identify model and support needed for implementation launch • Engagement with model development with services outside health (prioritizing housing, corrections)
Care Management Strategy (ie. Systems)	Determine how population health management should be organized across delivery system discharge, PH and BH health plan care management, and housing providers.	• Assess existing care management structure; define new options • Develop mechanisms for engagement of County housing teams • Prototype proactive integrated case review/conferencing to learn needs/gaps • Identify appropriate Care Management Platform (and/or improvements needed to existing platform?) • Develop integrated care coordination strategy (including housing, mobile crisis, etc.)
Risk Model and Outcomes Workgroup (ie Financial Model)	Finalize outcome metrics, incorporating use of an equity lens and develop staged financial model to support clinical model of care.	• Kick off group! • Explore national models for this type of arrangement • Finalize operating definition of population (in consultation with clinical group) • Develop simple model requirements to begin • Develop draft of outcomes metrics • Assess risk model options • Complete recommendation on risk sharing models • Develop ongoing monitoring reporting requirements

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Ecosystem Care Model Settings

Maternity

Emergency Department

Inpatient Medicine

Outpatient/Interstitial

- Street Medicine
- Post discharge transition

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Housing Overlay

Approach

Mini work groups

- Representation across health plans
- Review research
- Identify current existing services
- Develop consensus on core components of effective models
- Develop recommendations for implementing/scaling/spreading

Questions for each model:

- What are key outcomes?
- How could we better impact equity and support culturally responsive care?
- What is the role of care coordination?

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PROJECTNURTURE

OVERVIEW:

Project Nurture is a "Center of Excellence" model that provides integrated maternity care and substance use treatment during pregnancy and for the first year postpartum. "Center of Excellence" refers to a unique location in the community that provides high quality care to a very specific population. Project Nurture concentrates providers with expertise in treatment of substance use disorders during pregnancy in one location. Pregnant people with a substance use disorder (SUD) experience significantly improved care coordination at Project Nurture sites whereas traditionally SUD and maternity care are distinct and often fragmented from each other.

CORE MODEL COMPONENTS:

PROJECT NURTURE SITES:

OHSU & CODA	Legacy & Lifeworks NW	Providence	Kaiser & MHAAO
*CODA *Richmond Clinic	*Legacy Midwifery Clinic	*Milwaukie *North Portland	*Interstate *Rockwood

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PROJECTNURTURE

KEY OUTCOMES:

McConnell et al., April 2020

Improved parenting outcomes

- Decreased foster care placements
- Less child maltreatment
- 92% parenting one year after delivery

Improved Medical outcomes

- Increased prenatal care visits
- Decreased newborn hospital length of stay

Improved substance use recovery

- 92% sustained recovery one year after delivery

PROJECTED COST SAVINGS:

Project Nurture evaluation findings, August 2018

HIGH NEEDS CARE

- 0.9 cases of high needs care prevented for every 100 births.
- $16,200 saved per high needs care averted (removed duplication for pre-term deliveries)

C-SECTIONS

- *8.4 C-sections prevented for every 100 births*
- *$2,900 saved per C-section prevented.*

PRETERM DELIVERIES

- *7.6 preterm births prevented for every 100 births.*
- *$13,646 saved per preterm birth prevented.*

TOTAL SAVINGS:

- $161,339 per 100 births
- $1,613 per participant

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Project Nurture Expansion

Identified Needs	Potential Solutions
Funding barriers for peers, population management	• Project Nurture enhanced Alternative Payment Methodology (APM) • Potential statewide APM rates supporting model
Community of practice gaps	• Support network enhancement • Continue hosting community of practice • Develop linkages to cross-sector providers
Greater demand; inpatient growth	• Add Project Nurture site(s) in Washington County • Expand inpatient support • Contingency management for stimulant use disorder
Housing needs	• Short term: Navigation to housing supports • Long term: Specific housing for Project Nurture families

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SUD Inpatient Consult Core Components Workgroup

Members	Current Work	Next Steps
Alison Noice, MA. MS, CADC-III Executive Director at CODA, Inc.	Defining core components of Addiction Consult Model program at OHSU	Identify and discuss desired program outcomes
Bradley Buchheit, MD, MS Addiction & Family Medicine Doctor and Interim Medical Director for Addiction Consult Service at OHSU	Synthesizing a document comprised of core components + desired outcomes	Determine care coordination needs and workflows
Brian Liebreich, MD Regional Medical Director at Providence	Clarifying roles, services, and systems needs for successful implementation	Identify ways to scale model based on hospital size
Nick Kashey, MD, MPH Clinical Vice President of Population Health at Legacy	Convening weekly to determine ways to implement the program and maintain understanding of evolving best practices	Bring document and findings to High Risk BH workgroup and steering committee
Cat Livingston, MD, MPH Medical Director at Health Share of Oregon		Send core components document to subgroups on funding/sustainability and care coordination.
Stacie Andoniadis SUD Program Manager at CareOregon		

Addiction Consult Service Model		
Tier I: Essential Clinical Components		
Component	Possible Roles	Function
SUD medical consultant	Board Certified Addiction Medicine Provider or Addiction Psychiatrist	In consultation or as attending of record, prescribes and inducts medications for substance use disorders, provides medical care for co-occurring/comorbid diagnoses, and withdrawal management. Leads ACS team. Provides Addiction Consultation to other physicians and clinicians.
Peer that is fully integrated into the ACS team. Offering advocacy/support to all patients engaged with ACS team	Peer Support Specialist or Certified Recovery Mentor	Establishes rapport and builds trust with patients. Assists patients in navigating SUD recovery and treatment. This role sometimes acts as a support between patient and medical provider. Peers offer continuity after leaving hospital. (60 days)
Integrated substance use disorder care coordination to SUD-specific services	Behavioral health practitioner who is fully integrated into the ACS team with functional awareness of SUD treatment continuum	Identifies and provides linkage to most appropriate services/provider at discharge. Identifies and links to most appropriate level of care. Functional awareness with ASAM and levels of care. Familiarity with local SUD continuum of care

Addiction Consult Service Model		
Tier I: Essential Systems Components		
Component	**Possible Roles**	**Function**
Informatics support – capacity to capture, synthesize, and report metrics and outcomes	Informatics and subject matter expert (SME)	Ensures that order sets are developed, updated, and utilized. Ensures EMR supports best practices within substance use disorder treatment.
Medication dispensing and prescribing	Pharmacy and providers	Ensures all medications for SUD are on formulary and can be dispensed, including long acting injectables and naloxone/overdose prevention medications. 72-hour methadone available.
Dedicated workflows with other teams in the hospital	Infectious disease team, cardiology/cardiothoracic surgery team, Labor and Delivery and psychiatric consultation. Defining workflows between teams and/or having collaborative meetings.	Coordination between this program and others in the hospital for concurrent, wraparound care. Include Labor and Delivery and psychiatric consultation. Defining workflows between teams and/or having collaborative meetings.
Collaboration as an ACS team	ACS team members	Regular and frequent communication and rounding.

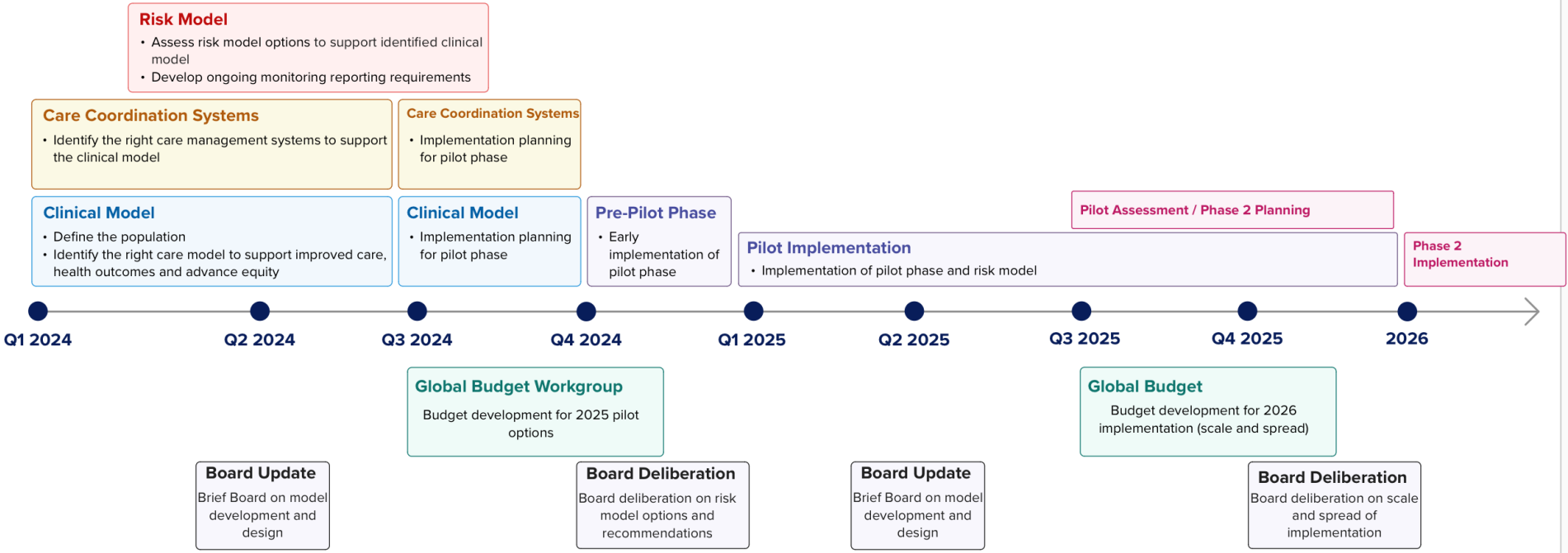
Addiction Consult Service Model

Tier I: Essential Systems Components

Component	Possible Roles	Function
ACS serves as consultants to entire hospital system; ability to triage	Medical Provider	ACS can consult across entire hospital, including L&D, ICU
Systems change champion with decision making capability	At least one medical provider	Generates motivation around program rationale and implementation. Moves the program forward and is accountable to ensuring that workflows are established and maintained. Leads internal program advocacy.
Bi-directional relationship between the hospital and its community-based partners	To be determined by ACS staff	Provides navigation to SUD services and other resources, facilitates warm hand off. Must have expertise and knowledge of the hospital and SUD treatment system.
Cross-training and upskilling	To be determined by ACS staff	Assesses staff knowledge and education needs, implements trainings and upskilling as needed, ensures that evidence-based practices are known and implemented by all staff in the program.

DRAFT Roadmap for BH High Impact Optimization

Feb. 20, 2024



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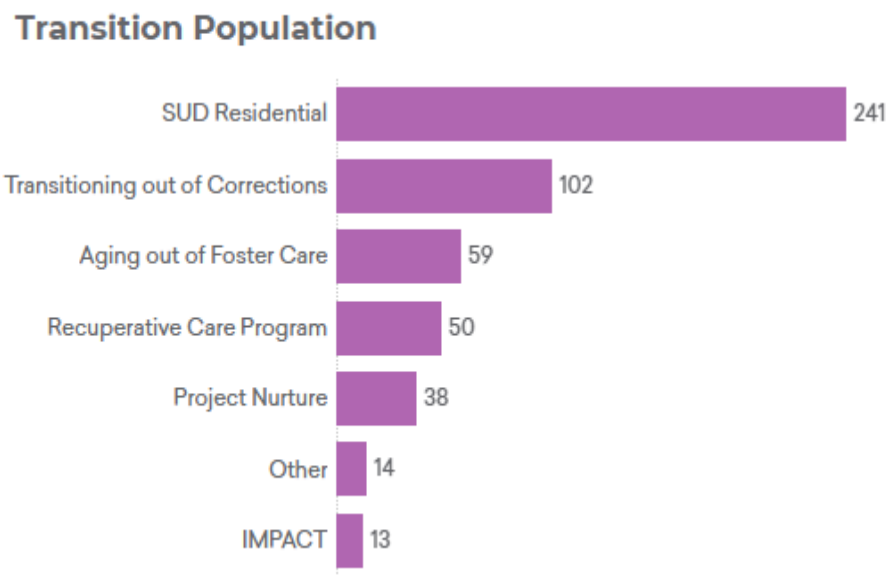
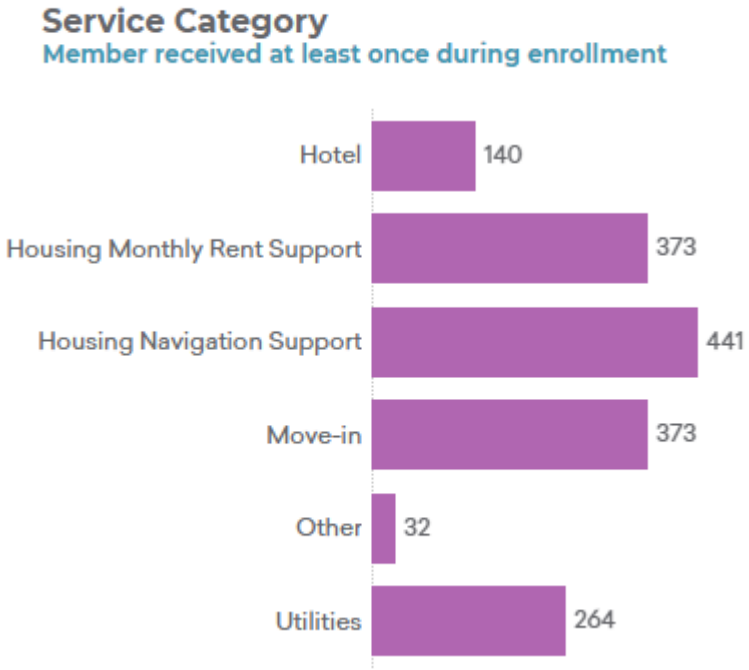
Housing & Health Share Housing Pilot

Health Share Housing Pilot 2022-2024

- 505 Total Members served
- 186 Currently active in pilot
- Average length of service 9.8 months





Housing & Health Share

Health-related Social Needs HRSN Benefit (1115 Waiver)

- Launching November 2024
- Those at-risk of homelessness
- Benefit includes
  - Rental assistance or temporary housing (e.g., rental payments, deposits, utility assistance) for up to 6 months
  - Home modifications (e.g., ramps, handrails, environmental remediation)
  - Pre-tenancy and tenancy support services (e.g., housing application, moving support, eviction prevention)
  - Housing-focused navigation and/or case manager

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54 yo man with OUD and cellulitis

System changes could have improved his outcomes:

- Initiation of MOUD in hospital
- Peer support during hospitalization and transition
- **Temporary housing support with Medicaid funds while healing**
- Connection to outpatient behavioral health and physical health, wound care
- **Connection to long-term permanent supportive housing**
- Care coordination across all these settings

~~Preventable morbidity, moral distress, systems failures~~

Conclusion

System(s) not meeting needs of the ecosystem cohort

Re-envisioning care

- Clinical and non-clinical partnerships
- Understanding who leads coordination and navigation
- Call to action

Re-envisioning financing

- Need investment up-front: will require multiple years
- Different payment models needed to offer flexibility

Housing and Medicaid – extraordinary opportunity and work ahead

health share

HEALING THE WAY HOME

Aligning at the Crossroads Of Health & Housing

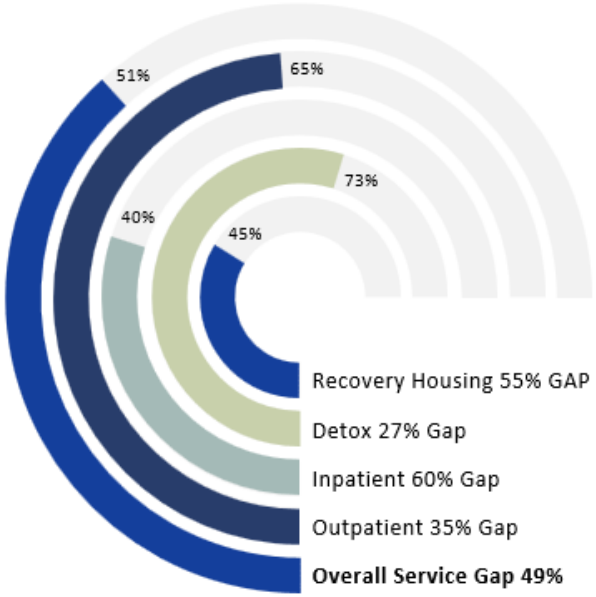
Sean Hubert
Central City Concern

KEY FACTORS IN HOMELESSNESS

**Most of these are system issues*

- Involvement with systems, particularly criminal justice and foster care
- Substance Abuse
- Untreated Mental Illness
- Chronic untreated disease
- Lack of right time, right care
- Race
- Job loss
- Housing Cost
- Age
- Domestic Abuse

UNMET BEHAVIORAL HEALTH NEEDS ARE DRIVING CHRONIC HOMELESSNESS



UNDERSTAND & IMPACT KEY "INFLOWS"; BUILD FOR STRONGER "OUTFLOWS"; FOCUS ON CHRONICITY FACTORS

Inflows

- Health & Behavioral Health Discharges to the Street
- Criminal Justice Discharges and Diversion
- Youth and Foster Care Transitions
- Housing Returns to the Street by People with Histories of Chronic \ Recurrent Homelessness

Outflows

- Continuum built on Flow, Stability & Connection
- ***Employment and Income Attainment***
- ***Social Connectivity***
- ***Health & Wellness***
- Purpose & Population-Built Communities (Recovery, Aging, Multi-Generational)
- Flexible Assistance
- Flexible Rental Assistance

BUILD A TRUE SUPPORTIVE SHELTER & HOUSING CONTINUUM

Shelter & Transitional Housing Continuum

- Oregon has one of highest rates of unsheltered homeless per capita & lowest rates of shelter beds per capita
- ***While Permanent Housing is the goal, Shelter is more flexible & has fewer regulations than housing; better at providing immediate, zero-barrier, same-day access***
- Critical for system transitions and outreach team engagement
- Shelter can have lower construction & operating costs *and take on different risks*
- Person-centered design
- ***On-site shelter services need to be targeted at housing stability; health and behavioral health stability; employment access; and permanent housing placement***
- *Key opportunity to continue to connect clinical services to housing*

INVEST IN COMMUNITY "CONNECTIVE TISSUE" BUILT AROUND KEY INVESTED PARTNERS

Set a new table by establishing system-wide scaled navigation, care coordination & crisis intervention capability that drives enhanced partnership between City, County, Health and Criminal Justice partners.

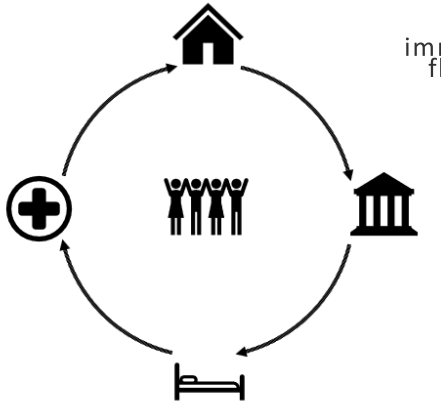
Solve for:

1) **End Discharges to the Street** (Systems & Housing)
2) **Provide same-day supportive shelter access for outreach and crisis teams**

Health Partnerships that support stabilization and wellness and coordinate across key transitions

Crisis Response Network that supports quick connection to health and behavioral health stabilization with the goal of housing retention and stability

- Align Project Respond, Portland Street Response, and Health System Care Navigation
- Focused on rapid Behavioral Health & Shelter Access; Housing retention & stability



Housing Navigation designed for immediate access to Shelter; positive flow from Shelter to Housing; and long-term Housing Stability

System Navigation includes " pre-release or discharge" care and navigation planning

Shared data and system platform includes critical real-time bed access availability as well as ongoing system performance analysis leading to rapid improvement capability

FOUNDATIONAL STRATEGIES

- Supply

  Increase availability of shelter (built around hardest to house), supportive housing units, and overall housing supply

- Navigation

  Establish system-wide, scaled navigation, care coordination & crisis intervention; ***End discharges to the street.***

- Behavioral Health Access

  Increase behavioral health services & access

- Governance & Partnership

  Enlarge the table to include key systems (Health) with overlapping populations & investments; clarify roles and responsibilities; Jointly develop intentional supported pathways to housing for multiple key populations

- Targeted Prevention

  Focus on Chronicity Drivers; Prevent people exiting key systems including criminal justice and health from becoming homeless

- Fund Comprehensive Services across Navigation, Shelter and Housing

  That drive stability, wellness, and flow out of homelessness. (Employment -7x housing stability outcomes)

- Leverage Investments

  Use the right dollar for the right services

- Real Time Data

  Real time data to coordinate care and housing transitions and drive ongoing system performance improvements

VISION

A Community that takes care of one another, fosters opportunity, and works together to tackle tough challenges.

Street Homelessness should be rare and, when it does occur, brief.

Services should be coordinated, key systems aligned, and interventions balanced across short- and long-term outcomes.

By working together, we can build a community that cares for all people and is better at supporting the building blocks of stability and wellness.

Questions/comments

1) Having heard the health data, and the system perspective, are there care or service gaps right now that you think we should be leaning more into?

2) Who do you see as key partners in collaborating between safety net, housing, and health?

3) Are there additional pilot concepts you would propose that address that intersection of health and housing?

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All Together, All for You.

Thank you

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Health Share of Oregon