Necessity as the Mother of Innovation
NYAPRS Fall Conference
Peter Ashenden, Sandy Forquer, PhD
OptumHealth™ Public Sector
September 15, 2011
Agenda

• About OptumHealth

• About Building Sustainable Health Communities

• Innovations Created Out of Necessity
  – Focus on Peer and Family Peer services
  – Crisis diversion and system redesign
  – Health care, housing and social services
  – Co-occurring disorders
  – Importance of engagement
  – Integration, integration, integration
About OptumHealth

• Industry leader in population health management, serving both the medical and behavioral health needs of consumers and communities nationwide
  – Over five million Medicaid and Medicare members
  – Every kind of organizational/program type (carve-out, carve-in, integrated, etc.)
  – Persons from all walks of life in employer- and government-sponsored programs

• Part of the Optum™ family of companies owned by UnitedHealth Group:
  – OptumHealth
  – OptumInsight (formerly Ingenix), one of the largest health information, technology, and consulting companies in the world
  – OptumRx (formerly Prescription Solutions), the pharmacy management leader in service, affordability, and clinical quality

• Intensely recovery-focused organization
• Initiator/facilitator of community innovations

Our MISSION is to help people live their lives to the fullest

The Optum Family
Information and technology enabled health services platform encompassing:
• Technology solutions
• Intelligence and decision support tools
• Health management and interventions
• Administrative and financial services
• Pharmacy solutions
OptumHealth and Sustainable Health Communities

• We believe that the health system is going to work better one community at a time
• We believe that no single payer can create meaningful and lasting change alone
• We need to begin to work together in new ways across the health system – consumers, providers, employers, support services, government, and individuals
• To be sustainable the Health Community must be: Connected, Intelligent and Aligned
• We can ultimately enable better care outcomes, more efficient use of resources and happier and healthier people
## OptumHealth’s Public Sector Commitments

<table>
<thead>
<tr>
<th>Significant capital and infrastructure investments over the last 4 years</th>
<th>2.9 million Medicaid and SCHIP members in 22 states</th>
<th>1.7 million Medicare members in 33 states</th>
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<tbody>
<tr>
<td>750 Public Sector staff</td>
<td>Strong New York presence</td>
<td>400 consumer and family organizations trained</td>
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<td>Manages 1 million Empire Plan lives</td>
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<td></td>
<td>270,000 Medicaid lives</td>
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<td>Operates one of the Chronic Illness Demonstration Project programs in Bronx and Queens</td>
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<td>Contracts with NYAPRS for peer bridger services</td>
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EXAMPLE 1: Necessity as the Mother of Innovation

Administrative Services Organization (ASO) Model Results from OptumHealth San Diego (OHSD)

<table>
<thead>
<tr>
<th>Special Help for At-Risk Individuals (SHARI)</th>
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<tbody>
<tr>
<td>OHSD coordinates with County staff</td>
</tr>
<tr>
<td>• Addresses needs of at-risk individuals</td>
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<tr>
<td>• Employs negotiated protocols that use evidence-based practices</td>
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<tr>
<td>• During first two years, SHARI reduced fee-for-service inpatient hospital days by 70%, saving the County $400,000</td>
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<tr>
<th>Community Resource Referral (integration with Social Services)</th>
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<tr>
<td>Toll-free, 24-hour access and crisis line linking callers with behavioral health services, food banks, domestic violence shelters, and support groups; Recovery Innovations, a local sponsor of support groups, reports significantly increased participation due to OHSD referrals</td>
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<tr>
<th>Designated Crisis Line</th>
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<tr>
<td>• National Suicide Prevention Lifeline Services partners with OHSD to direct County residents to OHSD access line for crisis services</td>
</tr>
<tr>
<td>• Expanded media coverage about this service in July after several suicides and murders — how to access and what happens</td>
</tr>
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EXAMPLE 1: Necessity as the Mother of Innovation

ASO Model Results from OptumHealth San Diego (OHSD) continued

Integration of Care

In close collaboration with San Diego County, OHSD works to further integrate care between the behavioral health provider network and Federally Qualified Health Centers (FQHC), where many consumers receive their medical care.

Crisis Beds

Working with the County and its contractor who operates six START (Short-Term Acute Residential Treatment) programs, OHSD has been designated four beds for consumers who might not meet the acute hospital level of care but require short-term intervention.

RICA Jail Outreach Program

The Recovery Innovations of California (RICA) Jail Outreach Program includes peer support to consumers in jail, as well as follow up services after their release.
Pay-for-performance Contracting Shows Encouraging Results to Date, including System of Care Improvement

### Pilot Background & Objectives

- In New Mexico, a performance-based contracting initiative aimed at improving affordability, quality outcomes and member health was launched July 2010
- Specific objectives were to increase community tenure for consumers with history of Out-Of-Home (OOH) placements within the New Mexico public sector population

### Measured Outcomes

<table>
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<tr>
<th>Metric</th>
<th>Target</th>
<th>Achievement</th>
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<tbody>
<tr>
<td>Reduction in OOH Units</td>
<td>20%</td>
<td>55%</td>
</tr>
<tr>
<td>Readmit Rate</td>
<td>Not to exceed baseline by more than 2%</td>
<td>Readmit Rate Declined</td>
</tr>
<tr>
<td>Critical Incidents</td>
<td>Not to exceed baseline by more than 2%</td>
<td>Critical Incident Rate Declined</td>
</tr>
</tbody>
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### Post-Pilot Expansion

- Identified 25 high volume facilities serving both commercial and public sector members as part of a phased implementation effort
- Aligning incentives to achieve reduction in ALOS, readmissions, and improvements in HEDIS 7-day ambulatory follow up
- Provider has opportunity to earn rate escalator based on achievement levels
EXAMPLE 3: Necessity as the Mother of Innovation

Promoting Integrated Mental Health, Substance Use Disorder, and Medical Care

Pierce County, Washington

- OptumHealth Pierce Regional Support Networks and MultiCare Health System have teamed up to provide a mobile medical clinic to help mental health agencies deliver primary care services.
- Designed to lower barriers to accessing primary care such as transportation challenges and stigma.
- The mobile clinic will travel to meet people where they receive their behavioral health treatment.
- Offers body mass indexing, blood pressure monitoring, blood glucose, and lipid profile screenings.
- Incorporates an electronic medical record system.
- Selected outcomes tracked quarterly.

The mobile integrated health clinic is a 38-foot mobile unit:

- Two fully functional treatment rooms.
- Staffed by an advanced registered nurse practitioner supervised by an offsite physician, nursing coordinator, and wellness peer-support coach.
OptumHealth works with states and counties to operationalize a comprehensive housing strategy aimed at providing access to safe, affordable and decent housing of their choice to persons served.

**Housing Projects in New Mexico include:**

- Linkages Supportive Housing voucher program for homeless/at-risk youth
- Move In Assistance and Eviction Prevention Program — provides one-time grant funds for rent or utilities for the precariously housed
- SAMHSA Healthy Homes: Peer Experts Supportive Housing Program — offers evidence-based, trauma-informed Permanent Supportive Housing to persons with SMI/Co-occurring Disorders who are homeless or at risk of homelessness
- Creation/management of statewide service delivery system for all consumers in supportive housing units through Core Service Agencies

**Partnership with New Mexico Mortgage Finance Authority**

- Partnership focused on ensuring the best and most impactful vehicle for infusing $15 M to $20 M in tax credits, bond financing and/or gap financing for brick-and-mortar supportive housing in New Mexico
- Short term: Through UnitedHealthcare, develop construction loan gap program with below-market loan interest rates of 1% to 3% during construction period
- Long term: Create national investment pool with other entities/states, providing sufficient funds for UnitedHealthcare® Treasury to act as investor, re: Low Income Tax Credit Projects
EXAMPLE 4: Necessity as the Mother of Innovation

Innovations in Housing continued

Pierce County, Washington

Creation of recovery-centered supportive housing units is a major goal of the OptumHealth Pierce County Regional Support Network

- Formed three-way partnership with Washington State Division of Behavioral Health and Recovery and Greater Lakes Mental Healthcare (in-network provider)

- Partnership applied for a SAMHSA Transformation Grant for Permanent Supported Housing
  - Awarded to the OptumHealth Pierce County Regional Support Network in September, 2010; went live January, 2011

- Referred to as PORCH: Permanent Options for Recovery-Centered Housing
  - At least 50% of PORCH staff will be consumers
  - Hiring two team co-leads with specialties in Housing and Employment
  - Services include extensive peer supports, housing and landlord liaison services, benefits support, WRAP planning, and trauma-informed care
  - Consumers and families involved in project review and evaluation process
  - Housing vouchers provided by Pierce County
EXAMPLE 4: Necessity as the Mother of Innovation

Innovations in Housing continued

Pierce County, Washington

Recovery Evolutionary Model of Intensive Mental Health Services to Support Individuals in Permanent Housing — new initiative for 2012

- RFQ released August 1, 2011
- OptumHealth currently funds mental health treatment in 147 RTF beds
- Individuals surveyed want to live in the community
- Long-term placement in a residential facility is not meeting the mental health needs of the individuals
- New model will reduce the number of RTF beds to 48, transitioning 99 individuals to permanent housing or other living arrangements (e.g. home with family)
  - Transition to occur over 12 months, resulting in 3 sixteen-bed facilities providing mental health treatment in a residential setting
- Intensive Mental Health Services to Support Individuals in Permanent Housing will provide:
  - A choice of safe, affordable and permanent housing
  - Housing that is integrated throughout the community available to all
  - Landlord liaison services
  - Intensive person-centered, team-based mental health services provided in the community with 24/7 support
  - Peers supporting one another on the journey of recovery;
  - Meaningful connections
  - Coordination of care with allied service systems (e.g. Division of Vocational Rehabilitation, substance abuse intervention, Department of Corrections, primary care providers, etc.)
Enhanced Supported Housing (ESH) level of care was created in January 2009 for members who have co-morbid physical health and/or co-occurring mental health/substance use conditions, and could not be managed in Supported Housing (SH) level of care.

Impetus for its creation was to help members in subacute hospital units with no discharge options due to their co-morbid and/or co-occurring conditions to have the ability to live in the community.

Members “stuck” in subacute hospital units often had physical health/ADL needs below what would qualify them for a nursing home, but beyond what could be addressed in other community settings.

Partners involved in ESH creation were TennCare, State Psychiatric Hospitals, and the ESH provider, Centerstone.

More medical oversight, treatment, and overall monitoring are provided and modest ADL assistance is given if needed.

The pilot home, Carver House, has regular on-site PCP/NP and psychiatrist visits as well as daily staffing by a licensed practical nurse or certified nurse technician.

Creation of the ESH level of care has resulted in dozens of members being able to live in the community who would otherwise have to live in a subacute unit in a psychiatric hospital.
Our solutions are customized based on the needs of our state, county and health plan customers, the consumers we serve and our comprehensive network of providers.

### Pierce County, WA

**Crisis System Redesign**
- Recovery Response Center staffed 24/7: 50% peer support, 50% clinical staff
- Features a “living room” model providing a secure welcoming environment
- 19.5% reduction in hospitalizations
- 32% reduction in Involuntary Treatment Act (ITA) admissions
- 32% reduction in readmission rate
- Inpatient Bed Days/1,000 decreased; 38% below state average

### New York

**Peer Wellness Program**
As part of Chronic Illness Demonstration Project (CIDP), contracted with NYAPRS to provide certified peer specialists with additional certification in health and wellness coaching to members; evaluation in process

**Peer Bridger Program**
- Our UnitedHealthcare Community and State New York Program; NYAPRS provides 210 peer bridger slots
- Increased 7-day follow-up rate by 12 percentage points; 30-day follow-up by 9 points

### Texas

**Late Life Peer Whole Health Coaching**
- Certified peer specialists are used as health coaches with late-life populations
- Average age of consumer served: 71
- 100% of consumers had been hospitalized prior to peer coaching; only 3.4% were hospitalized after getting a coach
- Average length of stay prior to having a coach was 6 days; average length of stay after getting a coach was just 2.3 days
EXAMPLE 5: Necessity as the Mother of Innovation

Innovation In Crisis Diversion, Peer Wellness and Peer Bridger Programs

Salt Lake County

Crisis Response Innovation Planning Process (Contract initiation: 7/01/2011)

✓ Mapped current Salt Lake crisis response system and processes
✓ Gathered data on crisis response activity in Salt Lake
✓ Established shared goals to reduce ER use, inpatient utilization and impact of offenders with mental illness on jail populations (jail diversion)
✓ Discussed elements of model crisis response system based on Pierce County system
✓ Provided data on crisis system activities in Pierce County
✓ Visit to Pierce County to review their crisis system now scheduled; visitors will include a Planning Committee member as well as a representative from the State Mental Health Division
✓ Finalize recommendations and report to County Criminal Justice Committee and County Council by 11/20/2011
✓ Formulate funding and implementation plan for revised crisis system by 12/2011
✓ Develop RFP to solicit providers for key Crisis System Elements by 1/20/2012
✓ New Crisis Elements expected to be operational prior to 5/2012
Short-term Changes that BHOs Could Serve as a Catalyst to Drive Over the Next Two Years

• Increased valuing of recovery and resiliency as a means to improved outcomes and bending the cost trend
• Enhanced role of peer and family peer specialists in engagement and outreach efforts
• Greater adoption of peer and family peer services as a means to divert hospitalizations, reduce inpatient stays and unnecessary ER visits
• Enhanced discharge planning with increased use of peer bridgers and peers as health and wellness coaches
• Successful implementation of BHOs as health homes (HH) for persons with serious mental illness and peer-led teams to support HH members
• Redesign of crisis systems
• Increased focus on service integration efforts among mental health, substance abuse and physical health
  – These efforts recognize the need of the whole person by integrating service planning and delivery
How to Prepare: New Directions for Provider and Consumer Leaders

Major message:
“Health care reform is a journey to top performance”

• Shift from acute-care focus to a population-management focus; shift from “sick care” to “health care”

• IT systems will need new “robust” functionality for bundled payments, sub-capitation and data reporting in order to manage risk effectively in new financial arrangements

• New relationship between quality and finance
  – Recent article in *Hospital and Health Networks* (November 2010) discusses finance-quality integration
  – “Quality will explicitly determine how you are paid”
  – Finance needs to understand quality measures attached to payment; quality needs to understand financial impact of each quality/performance measure and its cost, if not met
  – Value-based purchasing
What You Can Do Now to Prepare:

• New focus on top performance both inside your walls and in the community at large
  – Taking health care to the community vs. bringing the community to you
  – Building new community relationships, strategic partnerships with allied systems of care
  – Care coordination and clinical integration
• **Use data:** invest in data capture and management
• **Track your outcomes:** talk about your accomplishments
• **Be creative:** conduct pilots and share what you learn
• **Stick to your budgets:** operating discipline could be the difference between remaining viable and closing your doors
• Consider reading *The Innovator’s Prescription: A Disruptive Solution for Health Care* by Clayton M. Christensen
  – Notice emphasis on creating value networks
  – Think about how peer- and family-run programs can become part of your future value network
Thank you.

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