

WAVES OF THE FUTURE:

Drug Courts and Population Health



Drug Courts: Where Justice and Treatment Meet

September 25, 2015

Landscape of Drug Court



The New Landscape of Health Care







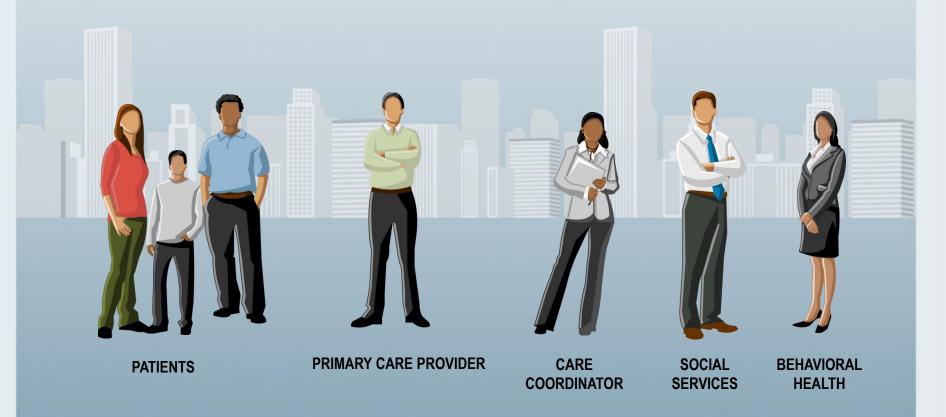
Drug Court "Cast of Characters"







"Cast of Characters" in New Healthcare Landscape







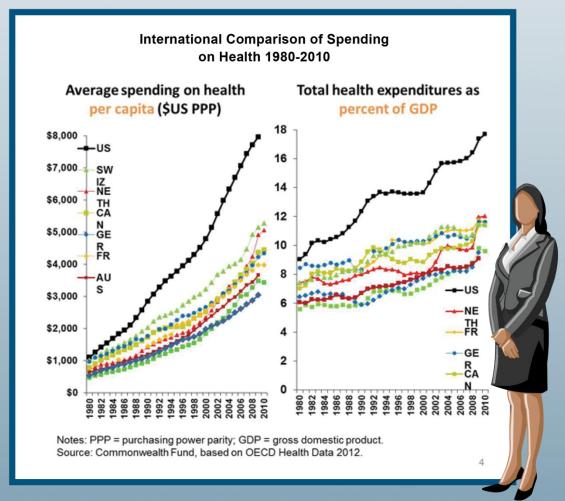
WHY POPULATION HEALTH



MANAGEMENT?



The Health Care System Faces Costly Challenges



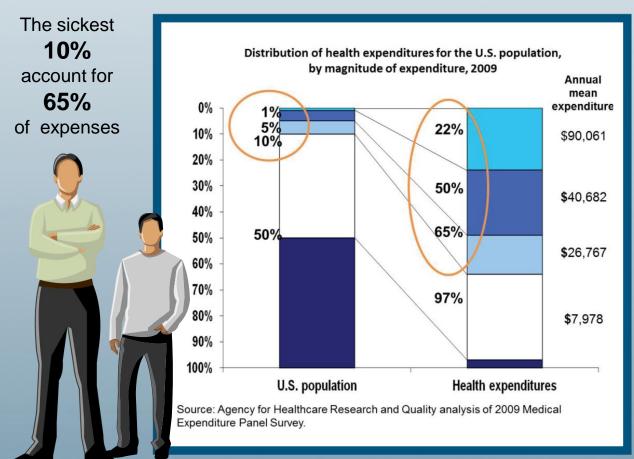
ANNA

As part of an ACO, her hospital must aim to deliver high-quality care while spending health care dollars wisely, with the potential to share in any savings it achieves for the Medicare program.





Health Care Costs Are Concentrated in a Sick Few



JULIUS

DIABETES & SUD

Before prison, he used the ER as his main health care point of access.

JAKE

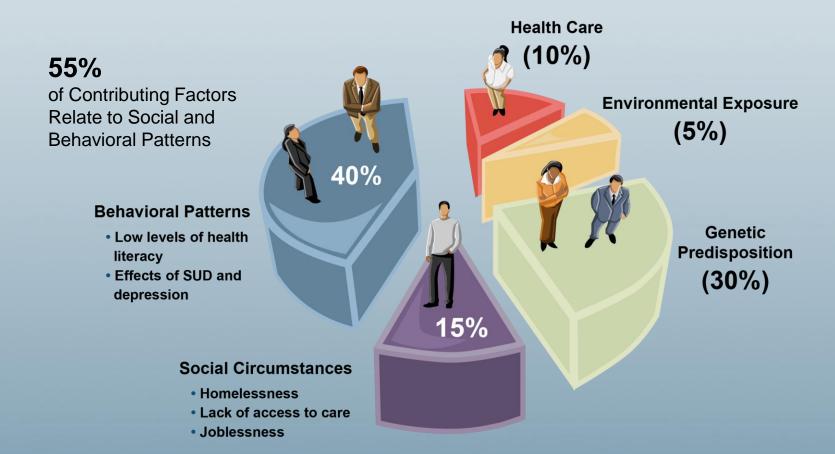
ADD & ASTHMA

His parents have had to access many points of care – hospital, clinics, and school therapists.





Behavioral Health and Social Conditions Significantly Impact Population Health



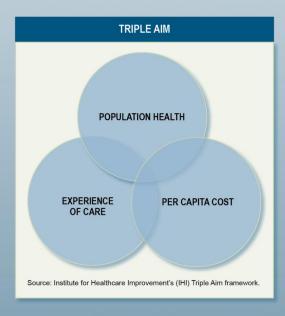
Source: New England Journal of Medicine

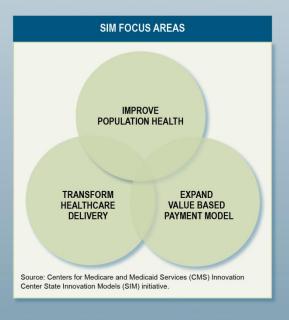




What is Population Health?

- The systematic effort to improve health outcomes in sub-populations that share multiple clinical and social attributes, a given geography and health insurance coverage.
- Population health reflects the interdependence of biology, behaviors, social, cultural, economic and environmental factors that impact wellbeing.
- Population health also compels health care and social service providers and the insurer to envision and develop organized and integrated delivery systems capable of achieving the Triple Aim.









What is Population Health Management?



Source: Care Continuum Alliance.





Goals of Population Health Management

1. Keep the patient population as healthy as possible.



- 2. Redefine healthcare as a set of interdependent activities that systematically address the preventive and chronic care needs of the population.
- 3. Modify the risk factors that make people sick or exacerbate their illnesses.







The Population Health Management Framework for Improving Health

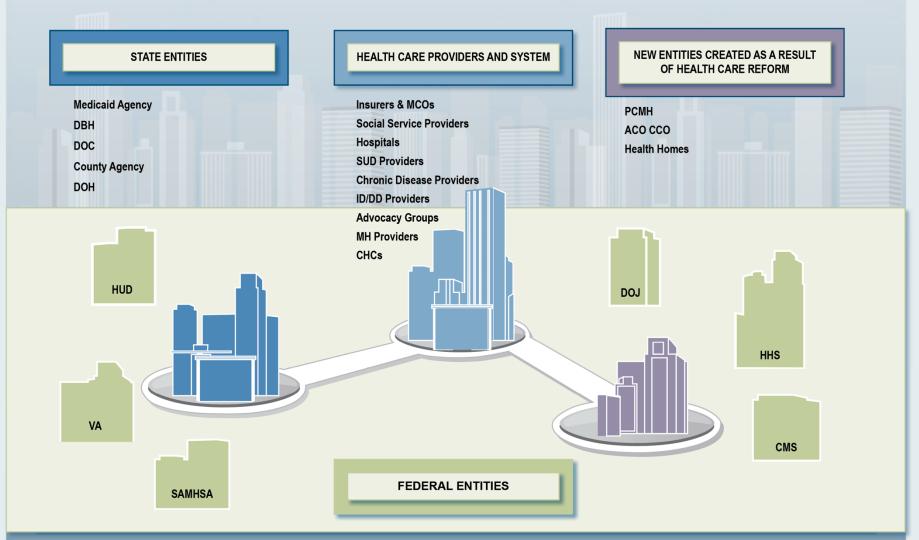


Source: Adapted from Frieden, Thomas R., "A framework for public health action: The Health Impact Pyramid." American Journal of Public Health 100, no. 4 (2010).





Complex State Health Care Environment







Complexity, Cost, and Fragmentation

VARIABLE FACTORS

Social Determinants & Quality of Life Indicators

Stable Housing

Emergency Shelter

Employment

Education

Family Cohesion

Legal (probation, parole, DUI, child placement, etc.)

Access to Medical/Primary Care

Risky Behaviors

Resiliency

Recovery

Transportation

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Childcare

Nutrition

Safety (vis a vis domestic and neighborhood violence)

Exposure to drug use and alcohol abuse

Exposure to serious mental illness

Other

Chronic Conditions

Heart Disease

Hypertension

Asthma

COPD

Diabetes

SPMI like Schizophrenia and Bi-Polar

Disorder

Chronic Addiction

Multiple Sclerosis

Cerebral Palsy

Epilepsy

Parkinson's

Systemic Lupus

Payers and Funding Sources

Medicare

Medicaid

Commercial/Private Insurance

Companies

Community Health Plans

Managed Care Organizations

Federal Grants

State GR

County/City Funding

Other Federal Funding (VA, HUD, etc.)

Health & Behavioral Health Providers

Hospital

Inpatient Psych

Medical Detox

Residential MH and SUD

Outpatient Primary Care

Specialists

Community Health Centers and

FQHCs

Pharmacy

Lab

Imaging

Outpatient BH (MH and SUD)

Surgical Centers

Rehab Center

SNF

Durable Medical Goods

Medical Case Mgmt. and Care

Coordination

Disease Mamt.

Variety of Therapies (Occupational,

Speech, etc

Organized Systems of Care

Accountable Care Org (ACO)

Coordinated Care Org (CCO)

Health Home/PCMH

BH/PCP Integration

Disability Providers

Residential

Home and Community-Based

Providers

Assisted Living and other LTSS

Employment-related

Disability Case Mgmt. and Care

Coordination

Variety of Therapies

Caregiver Support and Respite

Social Service Providers

Peer Support Services

Home and Community-Based Health

Workers

Transitional Housing, Permanent Supportive Housing, Low-Income

Housing, and Emergency Shelters

Employment-related

Case Mgmt.

Education-related

Harm Reduction

Transportation

Childcare

Food Assistance

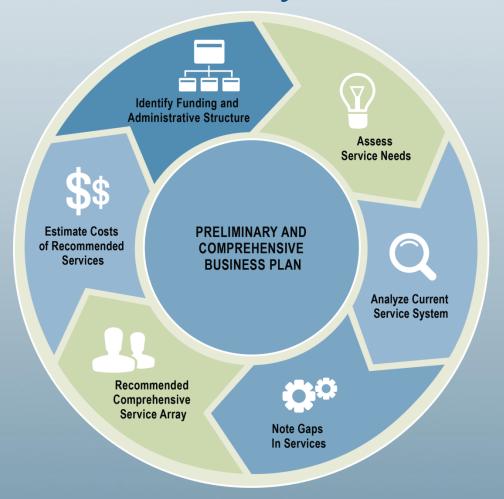
Financial Assistance

Benefit Enrollment





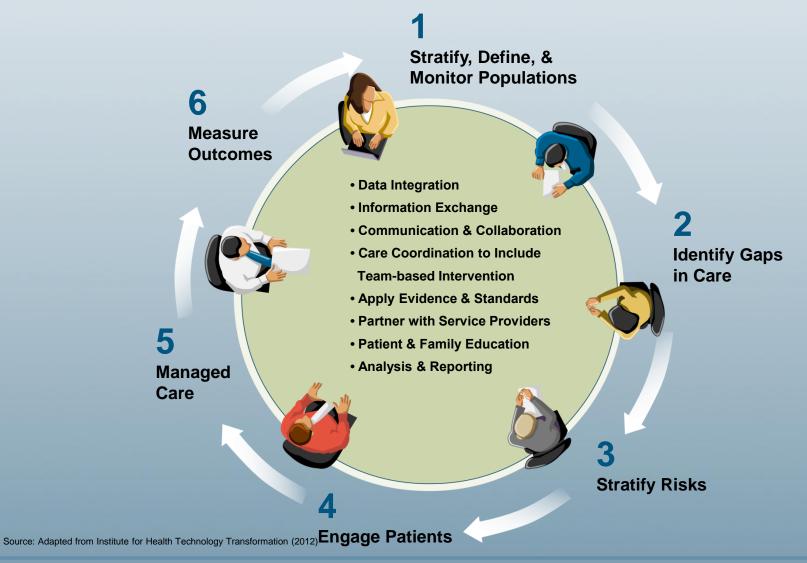
AHP's Approach to Population-linked Service Systems







Essentials of Population Health Management







Population Health: Tools and Approaches

CARE COORDINATION / PATIENT ENGAGEMENT

Inclusion of consumers and families in the design and concept of the approaches

Care Coordination platform and model design reflective of best practices and unique characteristics of the population and chronic conditions being served

INFORMATION TECHNOLOGY

Certified EMR with clinical alert capabilities

Patient/Disease Registries

Data warehousing of demographics, claims, HRAs, outcomes, etc., enabling Predictive Modeling

Risk stratification based on social risk factors, claims experience, diagnoses and other indicators of complexity/intensity and needs

Clinical Decision Support System

Integration of data into the Care Coordination workflow

Health Info. Exchange & clinical messaging service

Variety of targeted QA, outcomes, and cost measures

INTERVENTION / RELATIONSHIP WITH CLINICIANS

Workforce Development, training, in-service

Multi-disciplinary approach to: (i) screening,

(ii) treatment planning,(iii) transition planning and(iv) care coordination

Facilitate and monitor referrals to Service Partnership

Enable communications

NEW CLINICAL ACTIVITY

Patient and family engagement in plan, goals and identifying barriers

Monitor medication and treatment plan adherence

Face-to-face Care Coordination enabled by Community Health Workers and Peer Support Specialists in addition to RNs, NPs, MSWs and other specialists on the team

Patient and family education – print, group, and web-based







Population-linked Service Systems (PLSS)

Our mission is to **ensure and facilitate the linkages** between providers of health, behavioral health and related community services in organized and integrated delivery systems while ensuring that the **Triple Aim** can be met in the process.

We help **preserve** the very best of the special of systems of care that have evolved and **prepare** them for a rapidly changing financial, operational, technological and clinical environments resulting from **health care reforms**.



HEALTH & BEHAVIORAL HEALTH PROVIDERS

Hospital

Inpatient Psych

Medical Detox

Residential MH and SUD

Outpatient Primary Care

Specialists

Community Health Centers and FQHCs

Pharmacy

Lab

Imaging

Outpatient BH (MH and SUD)

Surgical Centers

Rehab Center

SNF

Durable Medical Goods

Medical Case Mgmt. and Care Coordination

Disease Mgmt.

Variety of Therapies (Occupational, Speech, etc.)

DISABILITY PROVIDERS

Residential

Home and Community-Based Providers

Assisted Living and other LTSS

Employment-related

Disability Case Mgmt. and Care Coordination

Variety of Therapies

Caregiver Support and Respite

SOCIAL SERVICE PROVIDERS

Peer Support Services

Home and Community-Based Health Workers

Transitional Housing, Permanent Supportive Housing,

Low-Income Housing, and Emergency Shelters

Employment-related

Case Mgmt.

Education-related

Harm Reduction

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Food Assistance

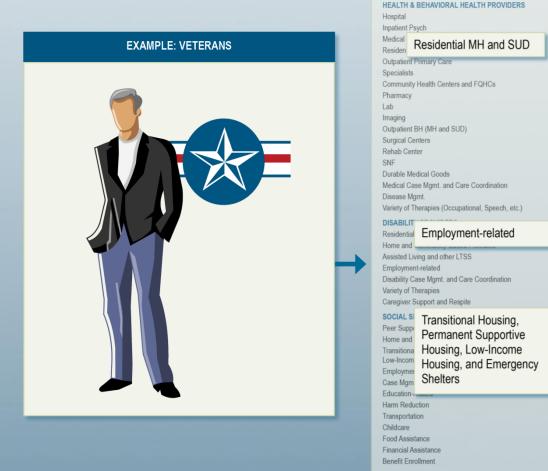
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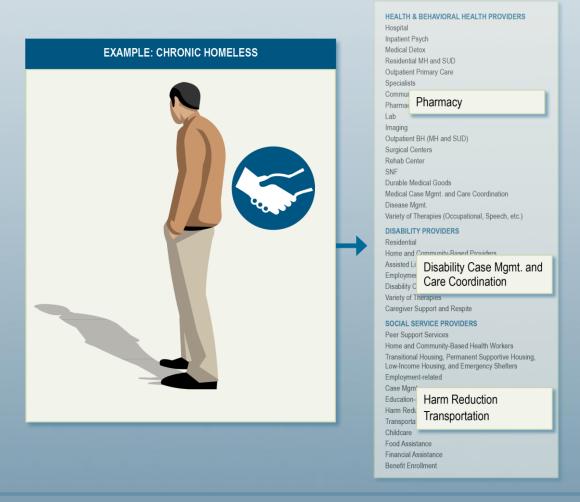
PLSS Example: Veterans







PLSS Example: Chronic Homeless







Thank You

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