COMMUNITY INVESTMENT PROSPECTUS

ADDRESSING HIGH-RISK POPULATIONS THROUGH THE ESTABLISHMENT OF REGIONAL INTEGRATED TRANSFORMATION ZONES

The Alliance for Integrated Medication Management

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Executive Summary: The Community Design Of Health Care Delivery

People are in crisis in our communities. Across the country, there are pockets of people for whom the healthcare delivery system does not work. Often, these people suffer from multiple chronic conditions many of which are not under control, take multiple medications from multiple prescribers and pharmacies and face social situations which prevent them from achieving their health care and life goals. Medications are the thread that ties everything together. If the medications are not right or working, then the healthcare problems will not be solved. If the medications are right and not working because of an issue facing the patient, the pharmacists and prescriber likely does not have a method or means for resolving it. This calls for the creation of a new delivery system that couples the active management of medications with resolution of social determinants of health to improve health outcomes and quality of life for this high-risk population.

The Alliance for Integrated Medication Management has developed a community-based approach that mobilizes and guides community partners in developing integrated delivery system solutions for high-risk populations. Communities organize themselves as Regional Integrated Transformation Zones (RITZ) to carry out the necessary design and implementation steps.

A coalition of conveners (organizations that can bring people together), funders (organizations that can finance start-up and development costs), patients (clients, caregivers and/or advocates to represent the voice of the patient), providers (health and social services) and payers (insurance companies and governmental organizations who purchase care) focus on certain underserved and under-resourced patient populations. Integrated delivery systems with coordinated care packages are built to serve them. The outcomes are generally lower cost of care, better health outcomes and a higher quality of life.

A core service in this approach is called Medication Care Coordination. It couples the expertise of an Advanced Medication Care Coordinator with the clinical expertise of Pharmacists and Physicians. Together, they develop a care plan that addresses the problems with medication and social determinants of health that need to be resolved for the patient to achieve their health and life goals.

AIMM is prepared to assist stakeholders in establishing a RITZ in their community. AIMM provides an array of services that can used to supplement resources and provide guidance in developing a successful solution.

For more information on establishing a RITZ in your community, contact:

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Overview: Medication Solutions Often Cause Problems

The management of medications has become a large part of people's desire to be healthy and improve their quality of life. These days it takes a lot of knowledge and coordination to safely manage a therapeutic drug regimen and ensure that the patient is getting the optimal results from the drugs. But not everyone is skilled enough, not everyone has access to the knowledge and information, not everyone has the mental acumen or caregivers to manage complex drug treatments. Most importantly, not everyone is in a social situation conducive to managing their medications and achieving the desired results.

Medications are Prevalent in Society.

- **One out of every 10** Americans (children and adults) take 5 or more prescription medications. [1]
- **Four out every 10** Americans over age 65 take 5 or more prescription medications.[2]
- **Seventy Four out of 100** Physician office visits result in a prescription given with 2.9 billion prescriptions written in 2016.[3]
- **Fifty Percent** of medications for chronic conditions are not taken as prescribed.

In fact, a study by the New England Health Care Institute suggest that 75 percent of Americans have trouble taking their medicine as directed.[4] Coupled with social determinants of health, this situation creates significant disparities in access and outcomes within a community. The societal objective of "healthcare equity" cannot be achieved if these disparities exist.

Imagine what it must be like to be someone in pain, with behavioral health issues, suffering from multiple chronic conditions, and several dozen medications to manage. The person might be homeless or with substance abuse disorders. Who do they turn to? Who is working with populations in crisis to resolve their issues and put them on a pathway to better health and improved quality of life? The answer is likely that no one in your community is positioned and prepared to do it.

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[1] CDC/NCHS, Health, United States, 2012, Figure 16 (table 91 excel file). Data from the National Health and Nutrition Examination Survey. http://www.cdc.gov/nchs/hus/contents2012.htm#fig16 and http://www.cdc.gov/nchs/data/hus/hus12.pdf#091

[2] Ibid

[3] National Ambulatory Medical Care Survey: 2016 Summary Tables, Tables 22,24,25 and http://www.cdc.gov/nchs/faststats/drugs.htm

[4] NEHI (New England Health Care Institute) 2009. Aug 12, [cited 2011 Nov 4]. Thinking outside the pillbox: a system-wide approach to improving patient medication adherence for chronic disease. Available from: URL: http://www.nehi.net/publications/44/-thinking_outside_the_pillbox_a_systemwide_approach_to_-improving_patient_medication_adherence_for_chronic_disease

RITZ, A Call for Community Action

The Alliance for Integrated Medication Management (AIMM) is working nationally to solve the problem of integrating comprehensive medication management into the social and medical delivery system where needed. AIMM has been working with communities for several years testing new and improved methods for bringing this service to people who can benefit.

AIMM has found communities facing the follow common situations:

- **Populations are in crisis**. In every region there are patient populations effectively in health crisis. These are patients with high avoidable use of the ED, hospital in patient care. They are vulnerable to early entry into institutional care.
- **Delivery systems are not designed to address the needs of certain populations in crisis**. Regional delivery systems always have gaps. For certain population groups the current health care delivery system does not, and cannot, reach them with the right set of services.
- **No one is accountable or responsible**. The region's provider organizations (medical and social services) individually do not have the technical staff, experience, or resources to design and install the missing delivery systems. Most do not see putting a solution in place as their responsibility.
- **Regional players are stuck and locked in**. The health care and social services payment systems, even with value-based arrangements, do not trigger or support the development and maintenance of the missing delivery systems. The overall system is not set up to respond.

These situations collectively generate waste, increased costs, poor health, inequality, disparities, and a lower quality of life for the vulnerable populations.

AIMM has also found that communities have the resources and relationships needed to solve the problem. A community has points of contact with the patients in trouble; it has access to information about these patients; it has experience with collaboration; it has access to the resources these patients need. Communities need to organize themselves to collectively define and address the problem as it uniquely exists for their residents. Communities can undo the four situational barriers identified above. In every community there are organizations and people ready to lead and to convene. The call to action is for community organizations to come together and perform as a Regional Integrated Transformation Zone. Work together with system and method to fill the gaps in the local service delivery system. End health disparities.

The At Risk Populations are Known and Within Reach

From 10% to 30% of a region's population are generating exceptionally high avoidable costs while experiencing unnecessarily poor health outcomes and low quality of life. These relatively small by high cost patient groups are effectively in crisis. The at risk populations can be identified by several combinations of the following characteristics:

- Consistently not at goal on one or more chronic conditions.
- Have high avoidable utilization of ED and hospital inpatient services.
- Vulnerable to being moved into institutional care settings.
- Lack of care coordination across medical providers generates waste and errors.
- Major medication regimens that are beyond their ability to manage.
- Medication related problems are causing harms.
- Have social needs that create barriers to achieving health goals.
- Suffering from behavioral health disorders.
- Dealing with substance abuse disorders.
- Often socially isolated and unable to address activities of daily living

There are generally no delivery systems in place designed to manage the unique situations faced by this high-risk population. Left unaddressed, this population will consume significant health care resources without ever addressing the underlying problems.

Who these people are and where they are is knowable in two ways. First, most people currently at risk use the health care system. Health plans have data on their utilization of resources. Analysis of claims data and reported quality data can be used to identify patients with high risk of avoidable utilization. Health plans can carry out the analysis and assign patients to providers for assessment and treatment. Second, community business, social service and medication service organizations have access to and relationships with individuals. Staff can be trained to identify those that have signs of health problems or medication problems. Community organizations can build registries of people who show signs of needing attention. Moreover, the deep relationships enable community organizations to engage and enroll people who might not be reachable by health plans and traditional medical services. A community can organize the touch points in place to connect with individuals. A RITZ can organize to identify and reach all the individuals in these at risk population groups.

A Method To Transform the Regional Health Care Delivery System

The changes required to fill gaps in the regional health care delivery system are more like a transformation than an improvement project. It's a community wide undertaking.

Improvements are often changes in the operations of one organization or changes in one process involving several organizations. Using an action learning collaborative with a change package based on best practice, the improvements can be installed in 9 to 12 months. Improvement puts in place a better version of something familiar.

Transformation requires system change across many organizations and involves redesign of operations, financing, information flows, and working agreements. The transformation causes something new and different to be created. It happens in stages over a several year period.

To pursue this type of transformation, a community would form a Regional Integrated Transformation Zone (RITZ). The coalition of local organizations assumes accountability for designing, installing, and producing a delivery system designed to reach and service those populations in or near crisis.

The RITZ method is built on three primary pillars: Population Management, Design in Stages, and Concurrent Change at Three Organizational Levels.

Pillar #1: Population Management is risk assessment and segmentation to identify those in need. It begins with the identification of under-resourced and underserved populations (high-risk) in the region. The population in need is systematically segmented into well-defined "Populations of Focus" (PoFs), each with its own risk, scale, and requirements. The RITZ becomes the voice of these patients. Then, working with partners in the region, accountability is assigned, and the missing service delivery systems are put in place.

Pillar #2: Design in Stages refers to the unique developmental nature of the work. Delivery systems are tailored to the needs and situations of the local population groups. Development happens in three stages – pilot, prototype and full scale.

- *Pilot Stage*: Community based organizations are funded to work with the client groups that represent the population at risk. The objective is to understand their situation and needs in order to design an effective service package and delivery system. Community assets are identified, and best practices are reviewed. The scale and specific needs of the population are estimated. The pilot stage defines the population of focus and critical service design factors. The effort makes the gap in service strategically significant to all players in the region.
- *Prototype Stage:* Community based partners collaborate in the design, build out and operations of the needed service package and delivery systems. These prototype delivery systems are operated at a small but sufficient scale to feature operating

characteristics that need to be managed and to demonstrate high value performance with the population of focus. Partners engage purchasers and funders on value propositions to scale up and spread the prototype. Community wide agreement is reached on need, performance, and value.

- *Scale Up Stage*: Under value-based agreements, providers and payers in the community move to scale up operations to serve the whole population of focus. The effort adds partners and infrastructure to reach full scale within the region. The value added is documented and celebrated.

Over time this process produces integrated delivery systems for all population groups in the underserved and under resourced population. It is estimated that each three-stage cycle can take several years to go from pilot to full scale.

Pillar #3: Concurrent Change at Three Levels calls for the RITZ to be in action at three levels: Service Delivery Operations, Financial Agreements, Executive Leadership. In order to fill the gaps in the regional health care system, partners come together and work collaboratively at each of the three organizational levels.

- *Level 1: Service Delivery Operations:* The RITZ can do the design and installation of service delivery systems that individual organizations are not staffed or resourced to do. Work at this level puts in place operations and practice agreements that produce intended results. Care is effectively and efficiently coordinated across organizations. Management systems assure performance on budget and objectives.
- *Level 2: Financial Agreements*: This level develops the understanding of costs and value associated with a well-defined population of focus. Multiple providers develop value-based financial agreements with regional purchasers/payers to deliver coordinated care.
- *Level 3: Executive Leadership:* The RITZ as a regional "coalition" creates a new executive voice with influence. Through participation in the regional coalition, partner organizations contribute to the development of regional consensus on service delivery and finance. This design is captured in a regional "Guide" for providers in the region. It is used to share the learnings and insights with other communities across the state and nation. The financing approach is captured in a regional "Compact". The coalition crafts a consensus on how the regional health care system should be financed for each specific population of focus.

Partner organizations in the RITZ are organized to engage at these three levels. A convener will provide platforms to facilitate this work. Funding is be secured to execute on the three pillars.

Medication Care Coordination, a Core Service and Catalyst

Coordinated care means that the patient receives all the different types of care needed at the right time and in the right place. Coordinated care enables the patient to navigate through systems providing medical care, behavioral health service, services to address the social determinants of health. In the region all the at risk patient groups will have a common problem. Their medications will not be under control making it unlikely that their health conditions will be at clinical goal. The various coordinated care delivery systems, tailored for at risk populations, will all have a common requirement, medication management services.

Medication Care Coordination (MCC) is a defining part of a coordinated care delivery system. It couples a professional medication care coordinator with a pharmacist and actively engages the enrolled participant and caregivers, in the home and through telemedicine. With the prescriber team, it ensures that the individualized medication care plan achieves the intended goals of therapy.

The foundation of the MCC service is the development of a trusting relationship. It brings together the participant, their caregivers and their prescribers on one side, and the medication care coordinator and clinical pharmacist on the other. This relationship extends the eyes and ears of the clinical staff into the home and enables the medication care plan to be aligned with other services that may be impacting the enrolled patient.

The MCC service ensures the proper medications are being used, the patient is adhering to the proper regime in a safe and effective manner. Studies have shown that effective medication management can reduce the use of Emergency Departments, lower the rate of inpatient admissions, and reduce the percent of people re-admitted within 30 days of hospitalization. This helps reduce or retard the growth in total cost of care.

MCC is a catalyst for integrating services and introducing coordinated care. The pharmacist assumes a new clinical role beyond dispensing. The pharmacist and AMCC are in a new working relationship with the physician. The AMCC is a new skilled professional role. These profound changes can be transformative for the whole system. They create a new service, new disciplines and new product.

MCC service should be an essential part of a community's social and healthcare system. The clinical pharmacist and care coordinator workforces will have to be developed. Currently there is a limited ability to fund the medication management service. They will have to be covered under value based purchasing agreement. Communities across each state will need to work with legislatures and payers to establish a sustainable payment system that enables this service to be provided to those most in need.

AIMM As A Champion For and Partner In RITZ

AIMM's vision is that every community will have a RITZ able to tailor and install delivery systems that provide the right care to all population groups. AIMM sees medication care coordination as a catalyst in making that happen.

At the national level AIMM will organize RITZ as a campaign. AIMM will facilitate a "RITZ National Leadership Council" comprised of RITZ leaders from across the country operating as an action learning collaborative. AIMM maintains a body of knowledge on best practices and captures the emerging theory of action and makes it available to the RITZ. AIMM will produce and update the guide on how to organize and run a RITZ and pace the community of RITZ leaders through its implementation.

At the local level AIMM will partner with conveners and coalitions who want to pursue the RITZ model. AIMM provides an action learning platform to help communities build a powerful RITZ. AIMM has developed models to guide the operation of a RITZ, the development of coordinated care delivery systems, and the delivery of comprehensive medication management.

AIMM provides design and technical support to individual RITZs in eight areas:

- bring the right players together in a working coalition.
- Develop the right kind of coordinated care packages for the region.
- bring the patient voice into the design process and to
- make the populations of focus health crises a local priority for transformation.
- establish a "population management" discipline
- assist in securing financing (start-up funding, value-based payments)
- develop infrastructure and agreements for care coordination
- establish the new professional roles that will emerge

AIMM will assist a local RITZ in establishing the three pillars of the coalition, develop the missing delivery systems in three stages, and work at three organizational levels to cause transformation.

For more information on establishing a RITZ in your community, contact:

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