

HEALTH MANAGEMENT ASSOCIATES

Building Population-Based Integrated Delivery Systems for Vulnerable Populations

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December 10, 2015

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Speaking:

▼ Panelists: 1

HMA Events (Host, me)

▼ Attendees: 0 (0 displayed)

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Select a participant in the Send to menu first, type chat message, and send... Send

▼ Q&A

All (0)

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Type your question here

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Q&A

All (0)

Select a question, and then type your answer here. There is a 256 character maximum.

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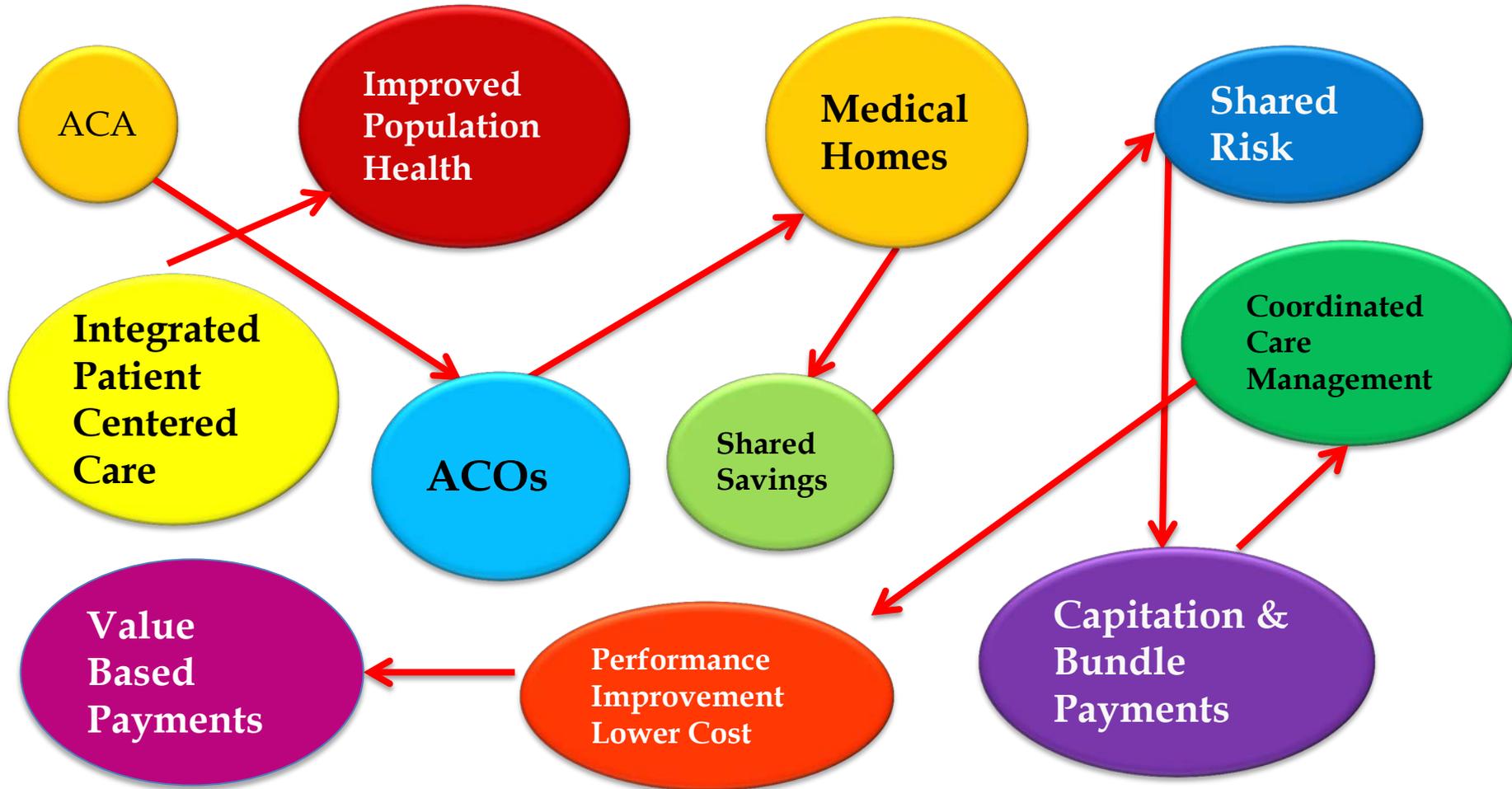
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Integrated Delivery of Care is the Future – Particularly for Publicly-Covered Populations

- For decades, uninsured populations or those covered by Medicaid, CHIP and other public programs, have had to navigate the various silos of health care available to them on their own.
- There was no financial incentive for providers to work together over the continuum of care (primary, specialty, emergent, acute, post-acute) or between disciplines (medical, mental health, substance abuse treatment) to assure both better use of resources and better health outcomes.
- That is changing.

CMS Strategic Direction

“Connecting the Dots of Healthcare System Transformation”



Integrated Delivery Initiatives

- States are moving toward requiring integration and, more and more, movement toward assumption of risk (i.e., Oregon, Colorado, Illinois, New Jersey, Iowa)
- CMS is supporting DSRIP initiatives in Waivers that will move delivery of care into integrated and risk-bearing networks (i.e., Texas, NY, California)
- Traditional Safety Net providers are seeing the value of creating provider partnerships and integrating their own previously siloed services (i.e., Cook County, San Francisco, LA, NY)

What Does All of This Mean to Providers on the Ground?

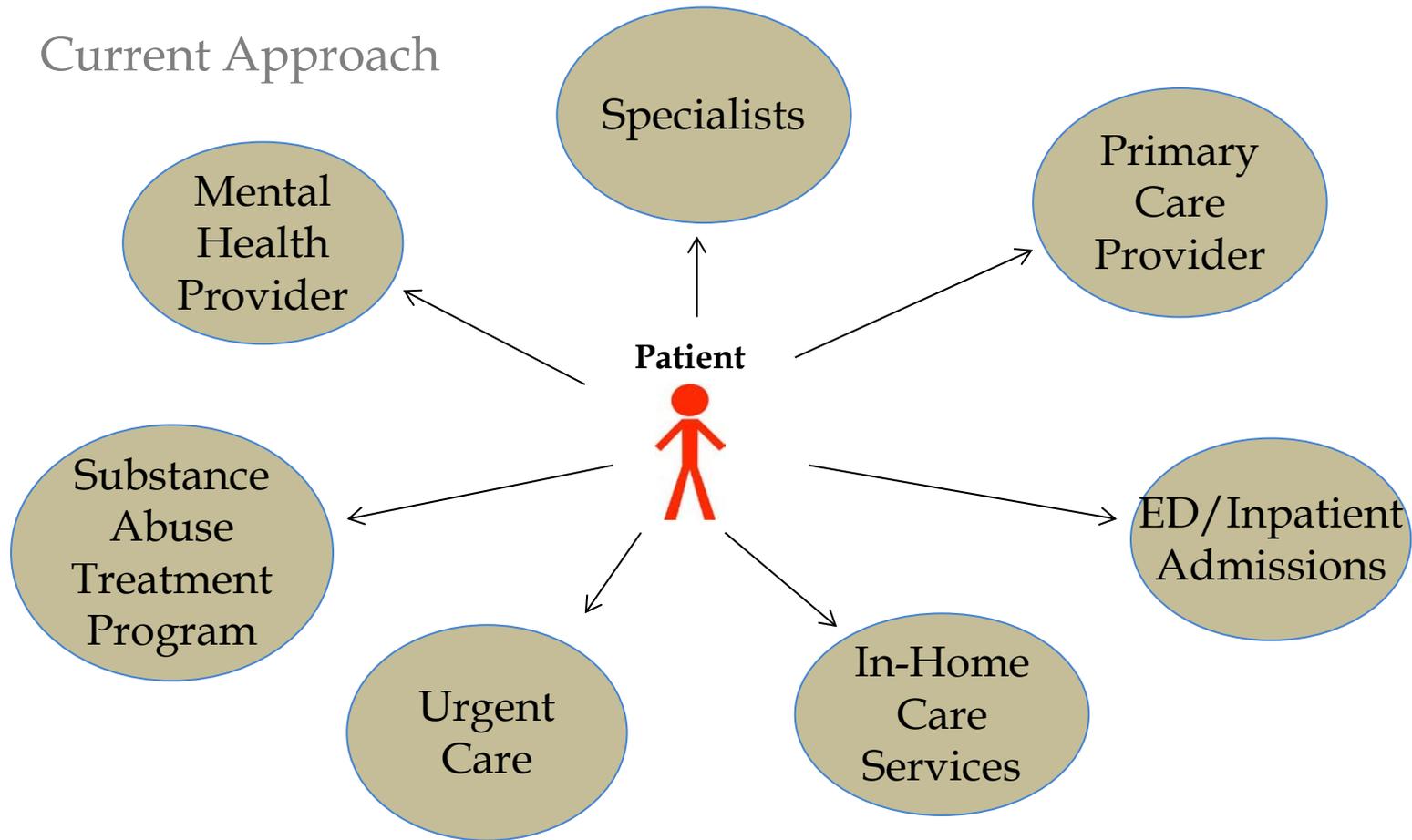
- HMA has been working with local governments, provider consortia, health plans and foundations for the past decade to develop implementable integrated delivery systems for vulnerable populations.
- The purpose of this webinar is to share lessons learned as well as to go into greater depth with two examples of integrated delivery systems with which HMA provided assistance in the formative stages.

What Elements Should an Integrated Care Network Include?

- Defined geographic area and population to be served (small enough to manage, large enough to have impact)
- A “model of care” that is determined by a critical mass of providers (traditional and non-traditional), integrating all levels of service
- Infrastructure support (IT, care management) to assure appropriate and effective utilization
- Documentable quality and cost goals
- Financial strategy to incentivize model of care
- Organizational structure to assure accountability

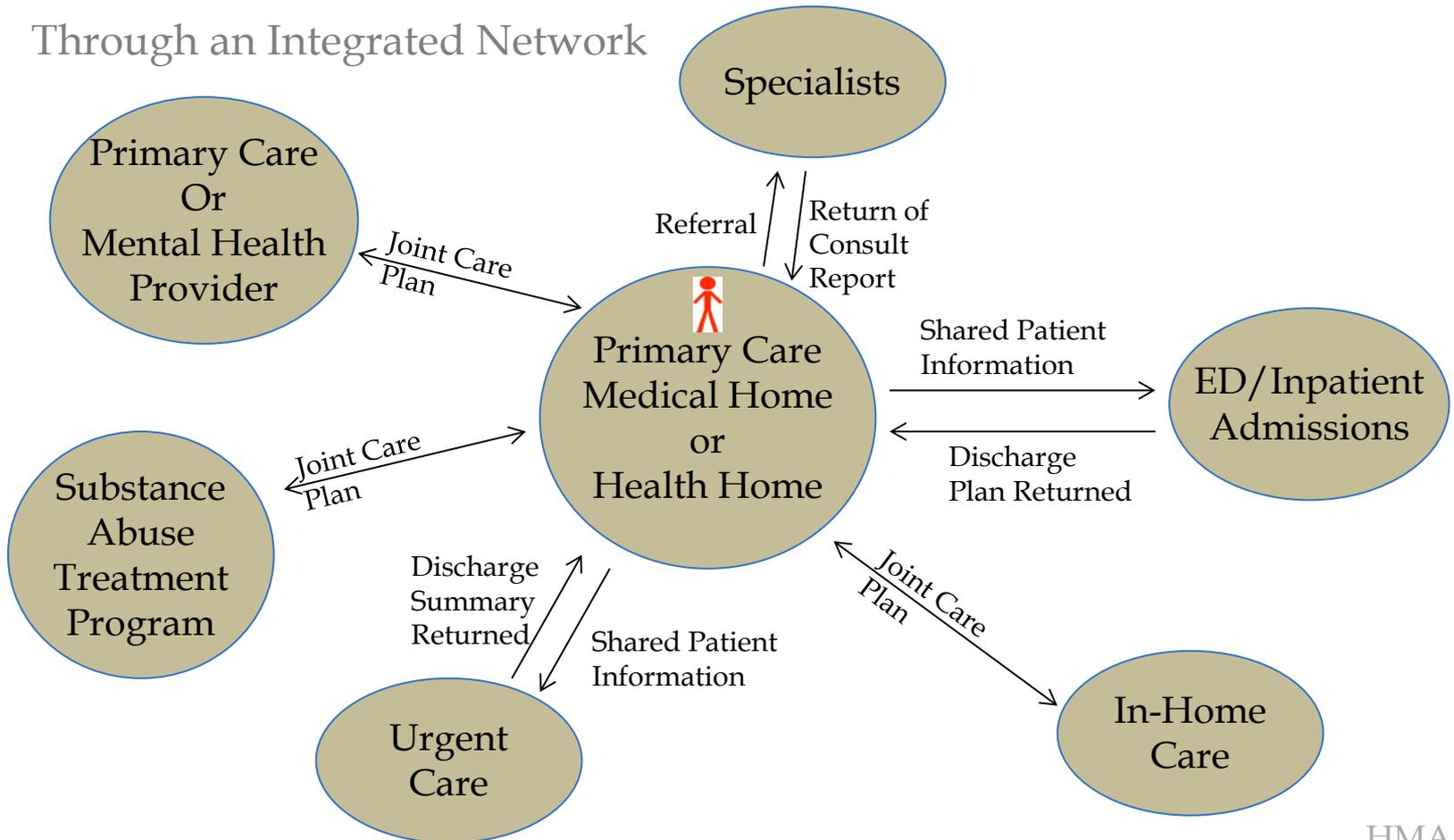
How Does Integrated Care Look Different for the Patient?

Current Approach



How Does Integrated Care Look Different for the Patient?

Through an Integrated Network



Other Critical Elements for Integrated Delivery to Support Organization of Providers

- Organization of care delivery that recognizes the need for different levels of medical homes
- Robust risk assessment and stratification (including social determinants of health)
- Assignment to most effective medical home (based on risk assessment)
- Provider-based and system-wide care management system
- IT with real-time alerts and emphasis on provider communication
- Integration of social services, dental, public health, housing
- Robust data analytics
- Financial incentives based on value, not volume of care
- Organizational structure that supports network effectiveness

What Spurs Initiation of Integrated Delivery for Vulnerable Populations?

- State mandates to move to managed care with provider risk.
- Providers realizing that they could do better cooperating than competing.
- Federal incentives for integrated care (i.e., DSRIP, CMMI).
- Foundations seeing integrated care as a public benefit.

What are the Common Themes in Integrated Care Initiatives?

- Someone needs to take the lead (foundation, hospital, county, consortium)
- Acceptance that old “protections” (IGTs, PPS rates, MH carve outs, etc.) will likely go away
- Belief that state and federal governments are looking for and will support new approaches – don’t wait to be directed
- Realization that providers all have assets and weaknesses and a willingness to give up something
- Universal commitment to act as a collaborative and accountable organization in every aspect of planning and implementation
- Resolution that the process will take significant effort – will need to be a forced march with setbacks along the way

What Does it Take to Get Going?

- Need an “honest broker” to resolve old animosities, competition
- All critical providers serving the population must participate
- The target population must be thoroughly understood (who are they, what are their health care needs, what are population health status priorities, where do they get care now, what are the current gaps and duplications, what are anticipated trends)
- The model of care must be defined and committed to by all participating providers

What Does it Take to Get Going?

- The strengths of participating providers must be determined and built upon and the gaps in the continuum of care identified and prioritized. Altruism is not enough.
- The infrastructure needs for assuring that the integrated system is being effectively utilized must be established (data, connective IT, care management)
- The current financing of health care delivery to the target population must be understood and new models developed that minimize duplication and incentivize the model of care.

What Does it Take to Get Going?

- Clear goals for improvement in the patient experience, enhancement of health status, and bending the cost curve must be established and a mechanism in place to document progress in meeting those goals.
- An organizational structure must be put in place to assure collective accountability and issues must be addressed that impede that accountability (i.e., sharing information, anti-trust, historic competition and distrust) must be resolved.

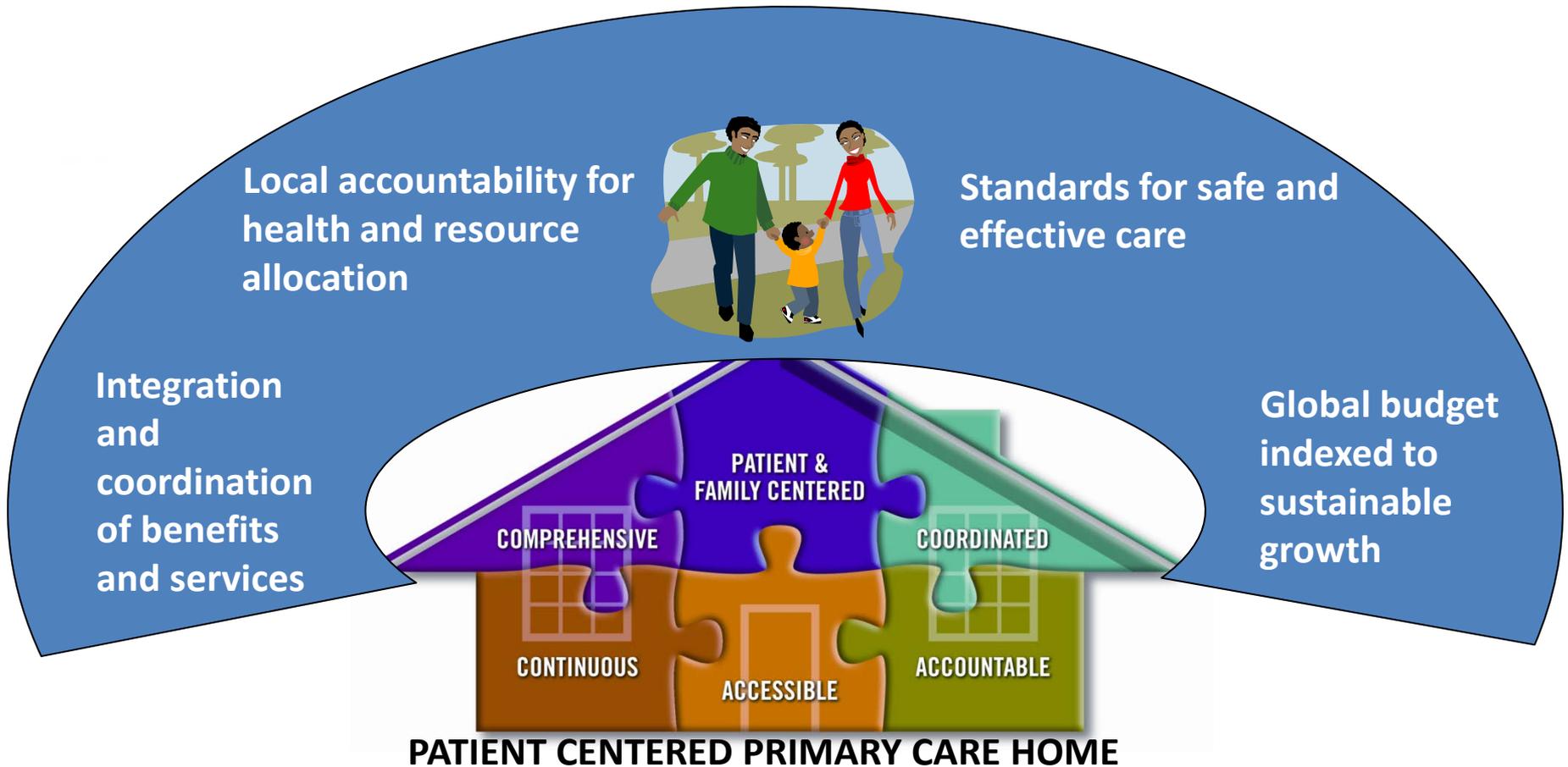
Conclusions

- Integrated care delivery is the model of the future for all publicly-financed programs.
- Moving from siloed care/payment to integrated care/payment is a very difficult transition.
- State/federal government are looking for models upon which to build.
- Do you want to wait for a model to be imposed or do you want to shape your own destiny?

Oregon's Experience with Multiple Provider Integrated Delivery Systems: The Coordinated Care Model

Oregon's Health System Transformation

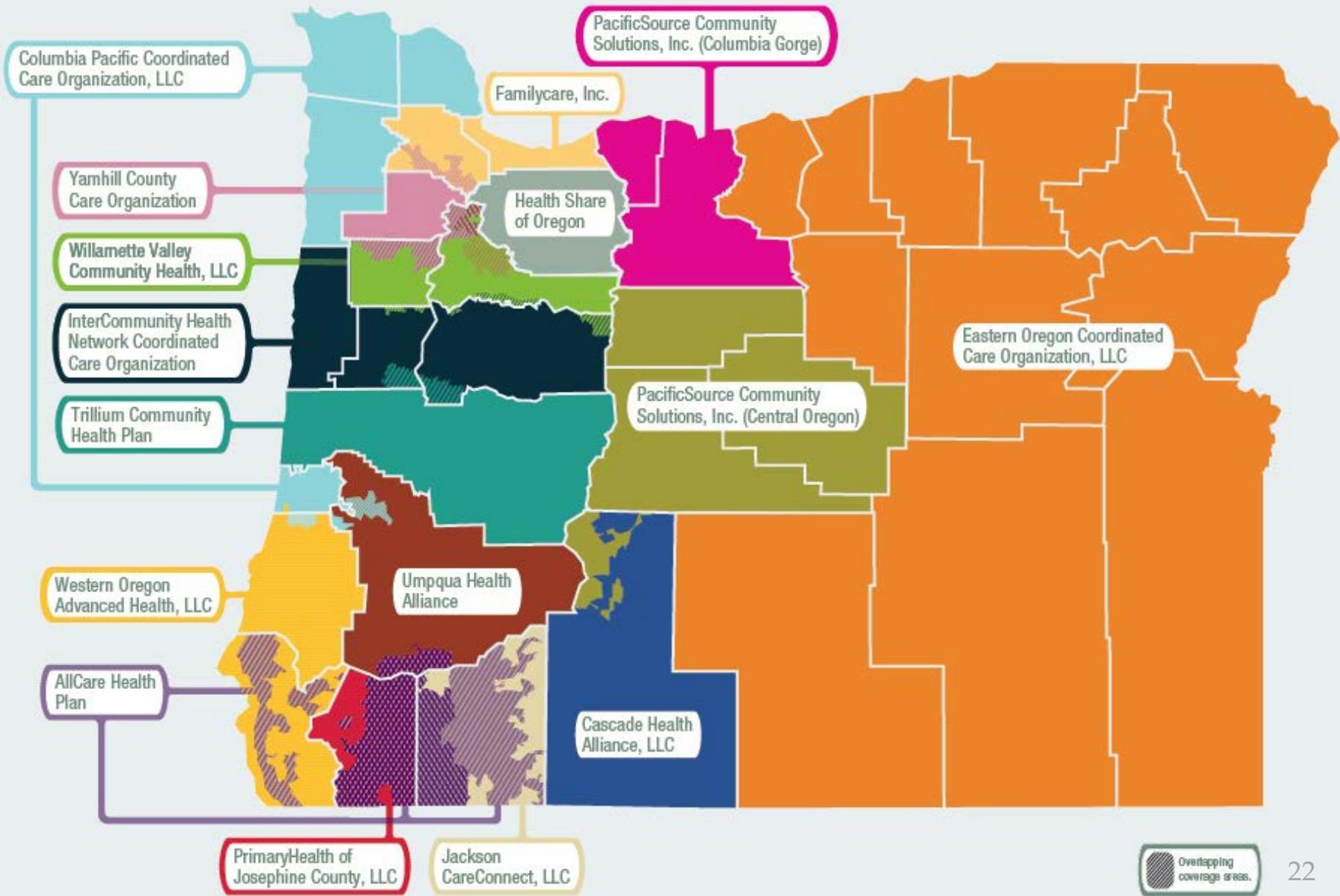
COORDINATED CARE ORGANIZATION



In Medicaid: Coordinated Care Organizations

- 16 regional organizations providing mental, physical, & dental care to 95% of Oregon enrollees as of 2013
- Risk-bearing entities with governance requirements to include providers, community advisory councils
- All services under a single budget with a capped rate of growth (2 percentage points below national trend); flexibility within that budget to use funds differently
- Incentives for quality performance
- Implemented in context of a pioneering Medicaid waiver

Coordinated Care Organization Service Areas



Local Accountability & Governance

- Governance Board must include:
 - All entities within the CCO taking financial risk
 - At least two community members
 - At least one member of the CCO's Community Advisory Council
 - At least two health care providers in active practice (representing primary care and mental health/chemical dependency)
- Clinical Advisory Panels – optional but most CCOs have
- Each CCO required to work with regional entities on a community-wide health assessment plan
- Each CCO also needs MOUs with local public health, tribes and area agency on aging
- Transformation Plan required and regularly updated with milestones and benchmarks

CCOs' Transformation Plans- Focus Areas

- Integration of physical, mental health/substance abuse and dental health services
- Emphasis on Primary Care; Patient Centered Primary Care Homes
- Population health assessment and planning across the community; with community partners
- Further EHR adoption, Health Information Exchange
- Eliminating disparities; improve cultural competency
- Implement Alternative Payment Methods

Integrating Behavioral Health

CCO in Eastern Oregon

- Media campaign to address negative stigma toward obtaining mental health services
- Provide a part-time peer mentor for older adults experiencing depression
- Embed behavioral health specialists within primary care clinics
- Provide “Mental Health First Aid” training to law enforcement, medical providers, DHS, school staff and crisis centers to increase early referrals and decreased crisis services

CCO in Southwest Oregon

- Established a Medication Therapy Management system to track and care for patients who have been diagnosed with mental illness and are taking those medications that are known to contribute to the development of diabetes.

CCO in Southern Oregon

- Women’s Health Center: Embedded primary care, specializing in addiction recovery among expectant mothers

Integrating Dental Health

CCO in the Portland Area

- Promote oral health through dental screening and fluoride varnish for children in Head Start
- The services are being provided a nonprofit created by the nine dental health organizations that serve the CCO to coordinate outreach and population-based care for the tri-county area.

CCO in Central Oregon

- Implement and evaluate a community-wide toothpaste distribution campaign enhanced by education and telephone support for low income children and families in Central Oregon.

Examples of Integrating Health and Healthcare

- CCO in Eastern Oregon:
- Increase physical activity
- Help fund a new wellness facility – Patients will be enrolled by their clinicians;
 - use is free to patients and the public;
 - includes first physical therapy space in the region
- Implement “Fit Fridays,” a physical education and nutrition program for children not engaged in activities outside the home on Fridays due to the four-day school week

Information Sharing is Crucial

Regional Health Information Exchange - Across 4 CCOs

- Referrals from PCP offices to regional Home Visiting Connection hub
 - Management and distribution of referrals
 - Close the loop with digital care plans to PCPs
- Assist the CCOs to identify high risk members
- Share enrollment paperwork
- Regional Jail –gather critical medical data for new arrivals
- Early HeadStart sending positive Developmental Screenings (ASQ's) to PCP
- Future: First responders update PCP on non-transported clients

Flexibility: Integrating Social Needs and Healthcare

CCO in Northeast Oregon

- Healthy Homes Demonstration Pilot:
- Partnered with the trained Community Action Team in the County to assess and diagnose health risks in the home, and help arrange for funding for home rehabilitation in order to improve health.

CCO in Northwest Oregon

- Approved purchase of an air conditioner for a frail elderly patient with severe congestive heart failure to reduce repeated ED and hospital stays.

Linking Health and Education

CCO working with Early Learning hub - Eugene Area

- Financial support to sustain and expand the offering of evidence-based parenting education and support programs in under-served areas in the county for approximately 200 families.
- Provided funding for additional training and curricula to help fill gaps in communities where there are limited qualified teachers of evidence-based parenting curricula.

CCO/Early Learning Hub – Northwest Oregon

- Engaged in support of several early literacy projects including Read and Feed in several soup kitchens
- Volunteers read to children who come for a meal and give them a copy of the book to take home with them

Council of Clinical Innovators

- State's Transformation Center developed selection process with delivery system leaders
- Fellows required connection with their local CCO
- Two cohorts of 15 so far; providers & others engaged in health care delivery
- Participation in a year-long learning experience with emphasis on health system transformation projects in their local communities
- Aim to develop and refine skills in leadership, quality improvement, implementation and dissemination science
- Creates a network of expertise supporting the Oregon coordinated care model



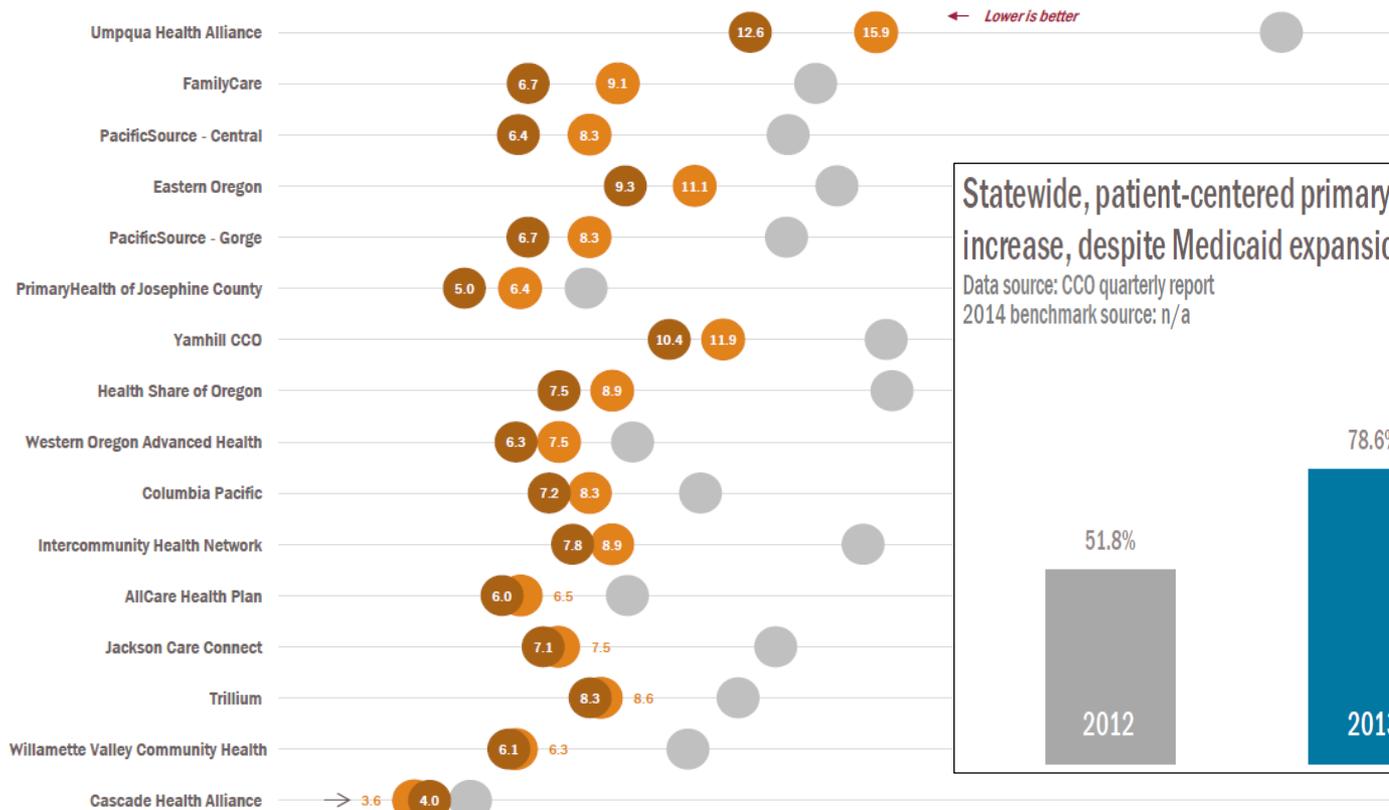
Central Oregon Pilot: Community workers make the difference

Addressing behavioral health: Reduced ED visits by 49% and reduced net costs more than \$600,000 in first six months.

Seeing improvements in avoidable ED use; avoidable hospitalizations; developmental screening; primary care homes

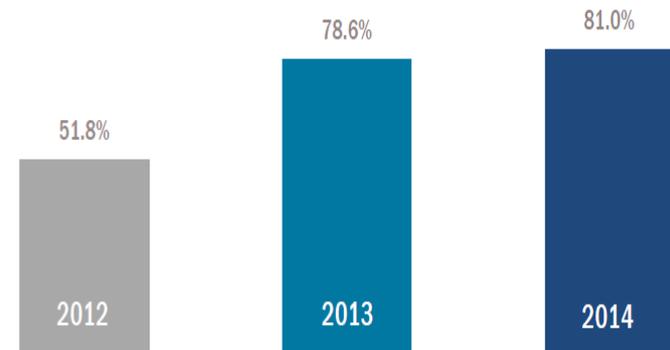
Avoidable emergency department utilization improved in 15 of 16 CCOs between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



Statewide, patient-centered primary care home enrollment continued to increase, despite Medicaid expansion.

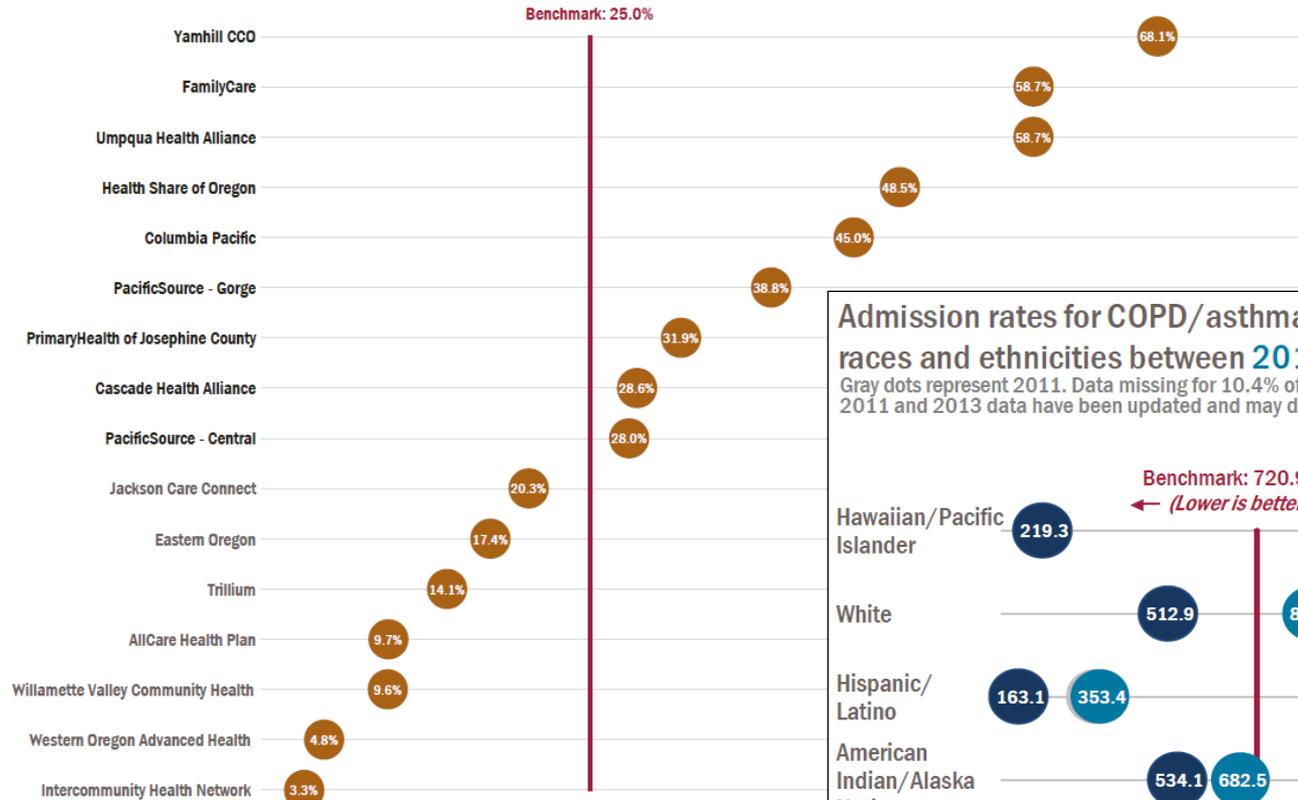
Data source: CCO quarterly report
2014 benchmark source: n/a



Lots of Variation Still

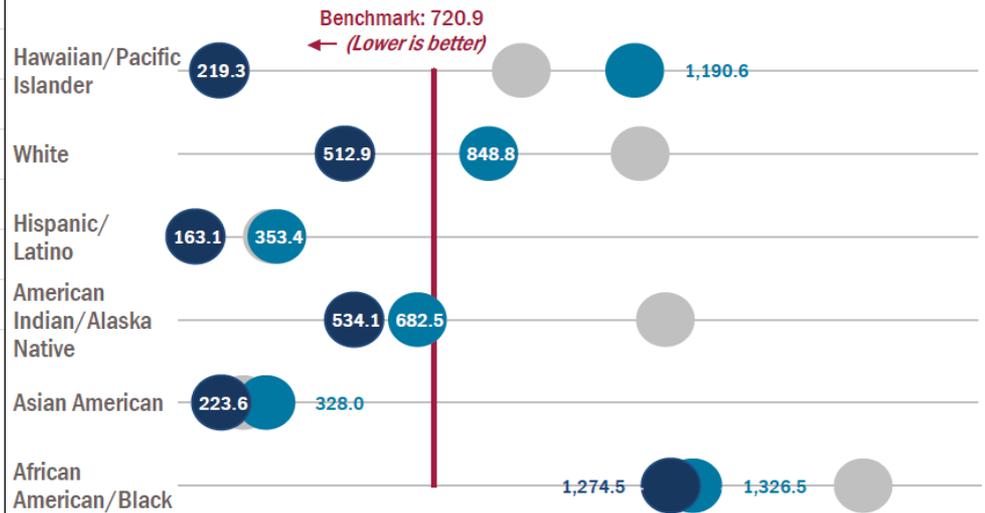
CCO performance on depression screening and follow-up was varied in 2014.

All CCOs received credit for submitting Year Two Technology Plans and required data. **Bolded names** received credit for achieving the benchmark for this measure. 2011 and 2013 data are not available for this measure.



Admission rates for COPD/asthma varied widely but improved for all races and ethnicities between 2013 and 2014.

Gray dots represent 2011. Data missing for 10.4% of respondents. Each race category excludes Hispanic/Latino. 2011 and 2013 data have been updated and may differ from earlier reports.



CCO plans for APMs

- Methods identified in CCO Transformation Plan Amendments range from sub-capitation to PCPCH incentives and bundled payments.
- The majority focus one on type of service (e.g., emergency department visits) or specialty (e.g., behavioral or oral health).
- Milestones to be achieved vary from piloting a payment method with one provider to targeting a percentage of total payments being made to providers using an alternate method.
- All CCOs have identified active or planned alternate payment method arrangements:
 - 13 include pay-for-performance
 - 9 include capitation or sub-capitation
 - 2 are considering episodic payments; 1 shared savings

“One of the problems we can solve is the tremendous fragmentation among the people who pay for the care and what they expect from us.”

Hood River family physician

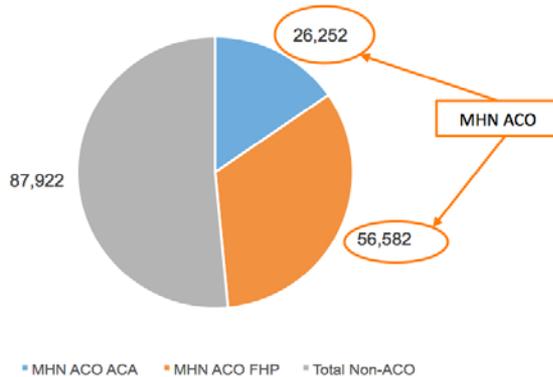
MHN ACO Partnerships Driving Delivery Transformation

MHN ACO Providers

9 FQHCs
3 Hospital Systems

86 Medical Homes
360 PCPs
120 Care Managers
1,200 Specialists
5 Hospitals

MHN ACO and CountyCare Membership



MHN ACO Geography

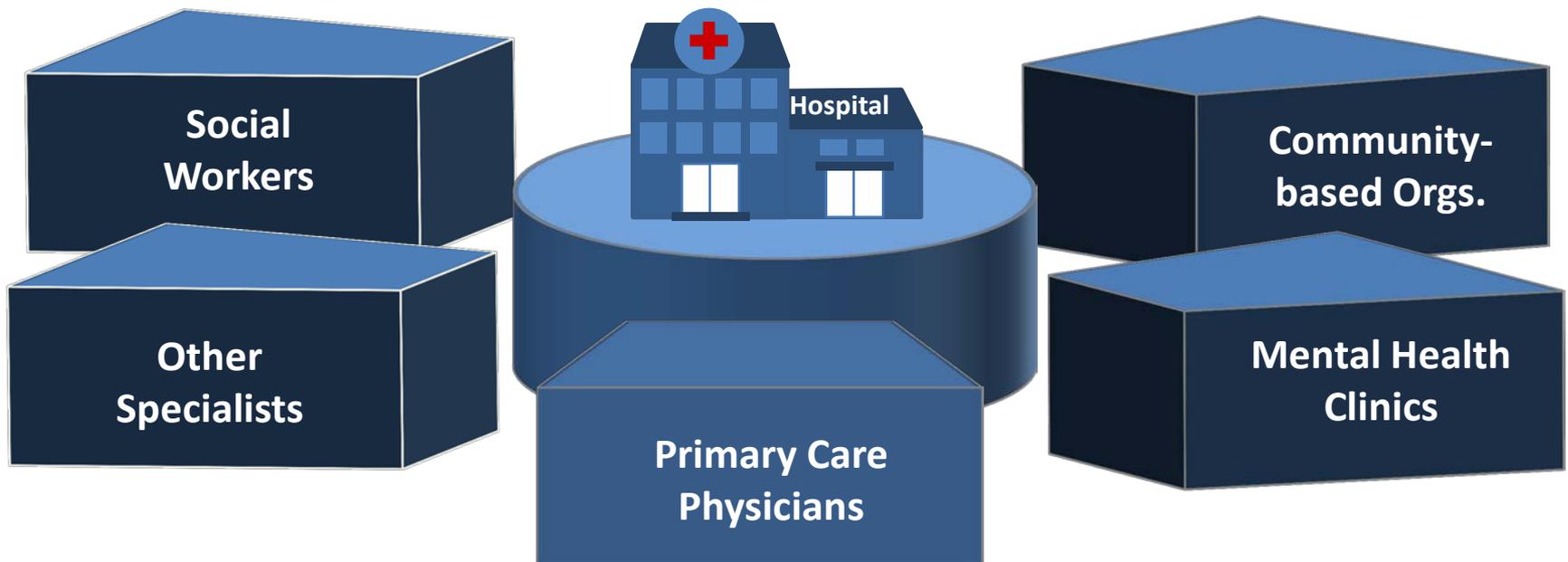


FQHC = Federally Qualified Health Center; PCP = primary care provider.

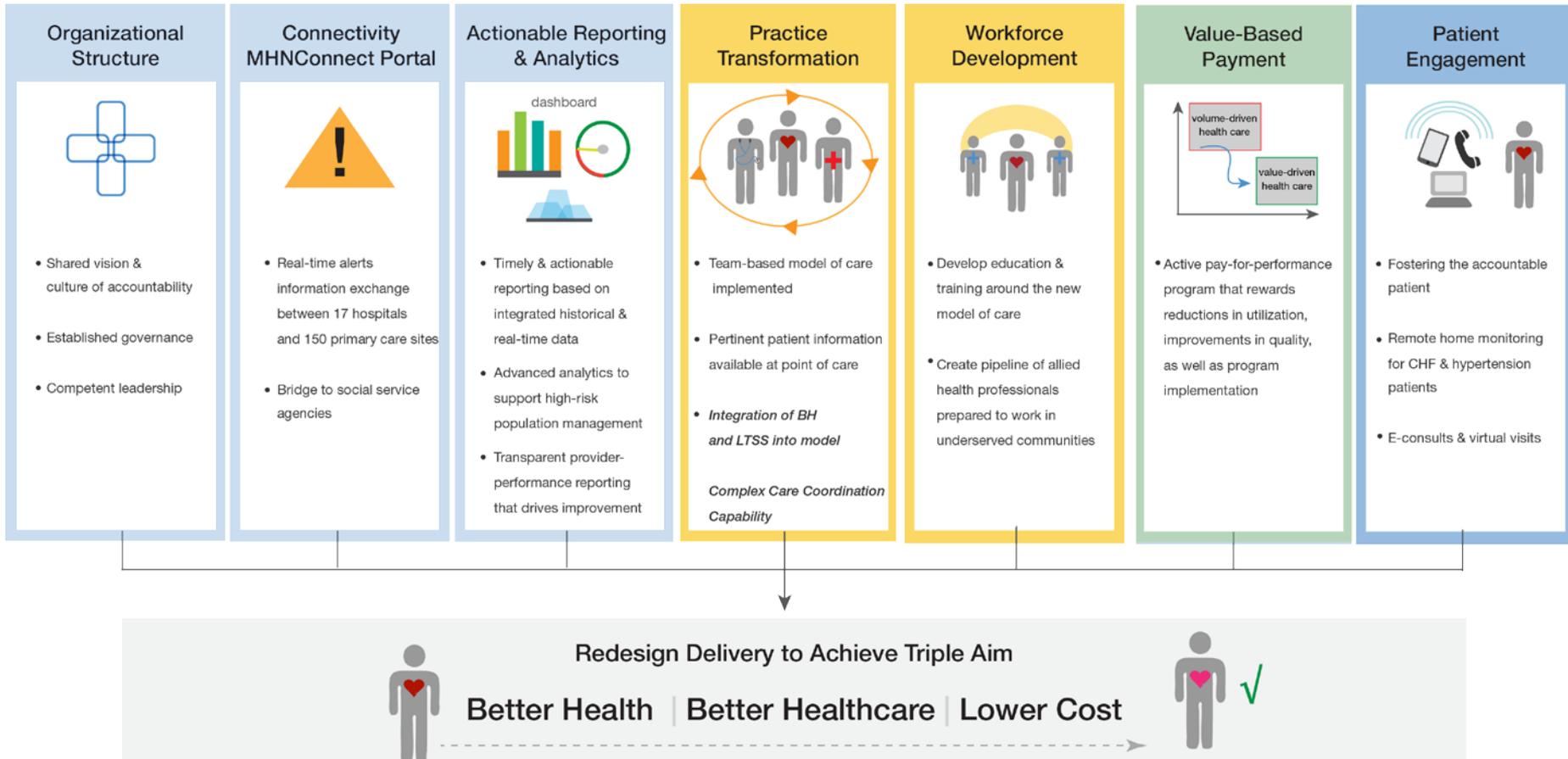
The content of this presentation is the sole responsibility of the author noted and does not reflect the work product of Sg2.

Distinct Provider Types

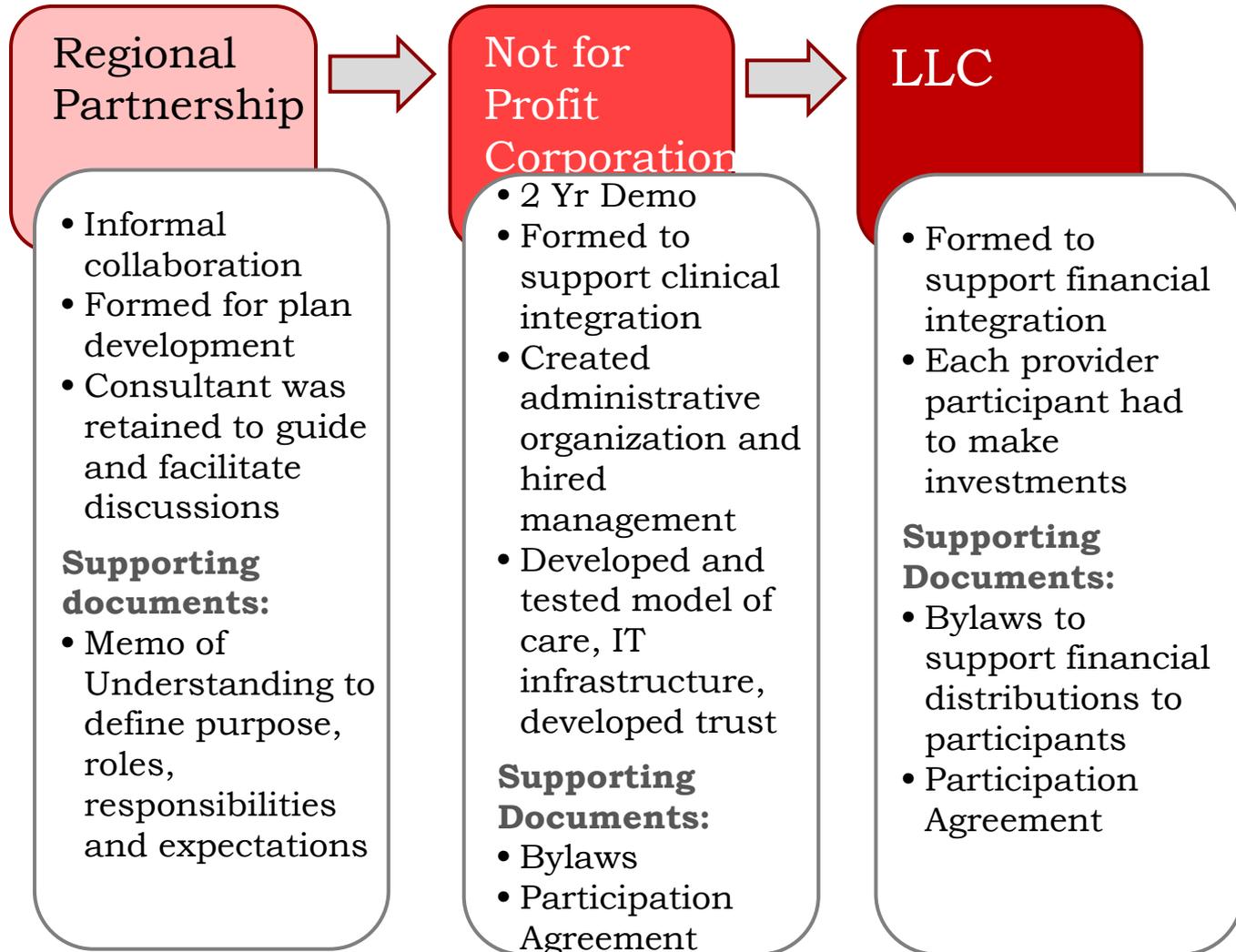
When health care is not integrated, continuous linkage to care from the hospital to outpatient providers represents a greater challenge



The Building Blocks for *Delivery System Transformation* & *Population Management*

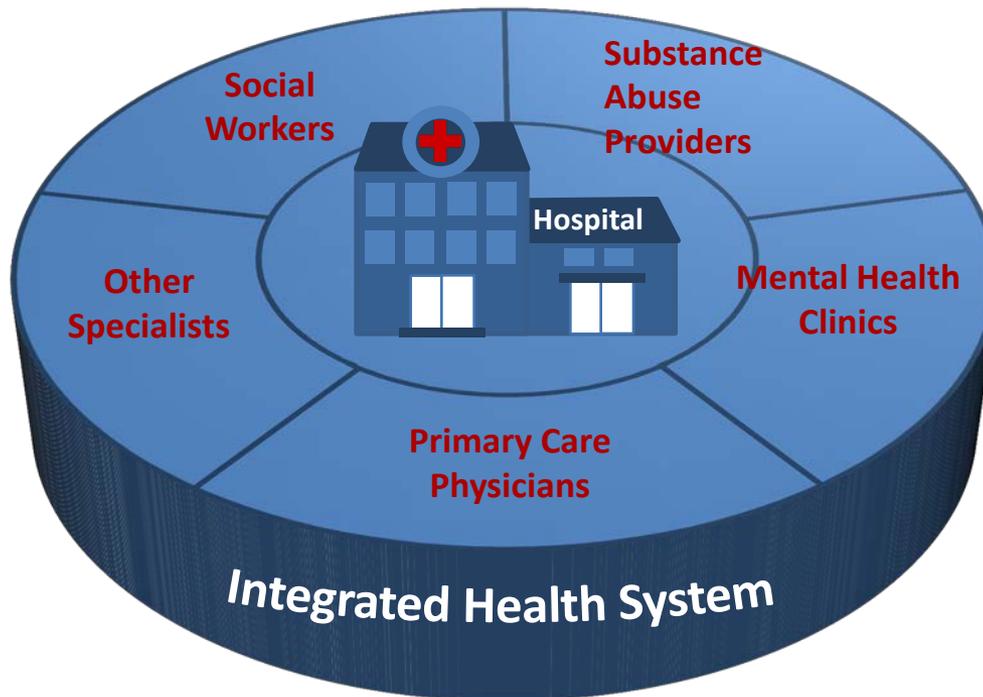


Evolution of MHN

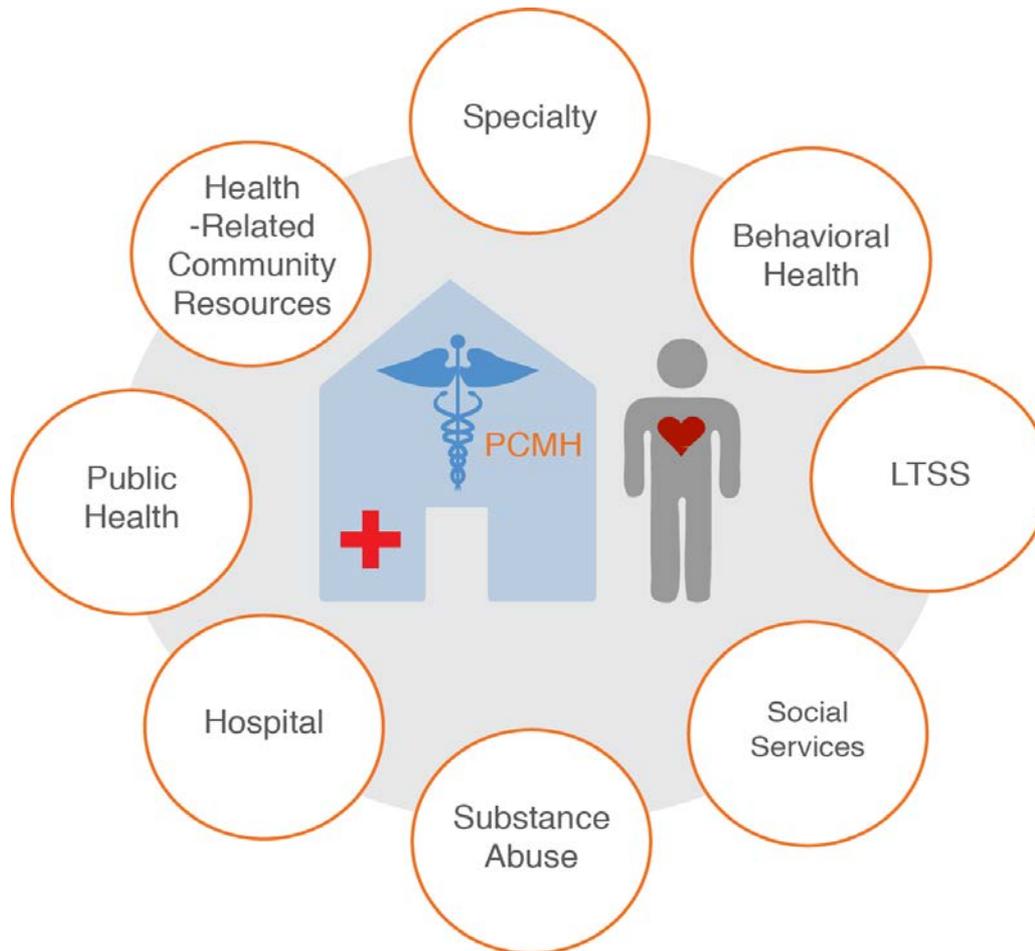


Integrated Health Systems The Hospital-Centric Model

Integrated health systems offer better linkages to care between the hospital and outpatient providers



Comprehensive, Community-based, Integrated The PCP-Centric Model



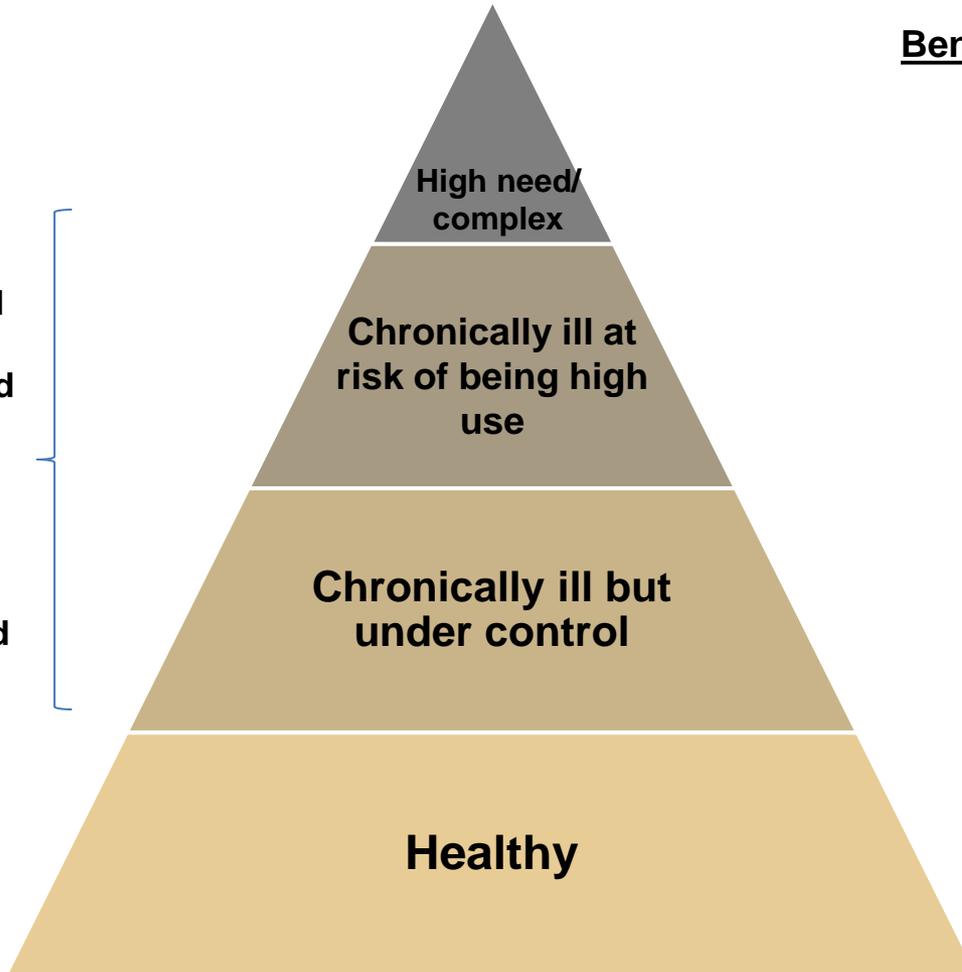
MHN Clinical Focus

- Improving transitions of care
- Care Management of high risk patients
- Behavioral and physical health integration
- Reducing low value medical practices
- Performance on Quality Parameters
- Becoming more member centric

Targeted Resources

B

Address modifiable risks and integrate and coordinate care, develop advanced patient-centered medical homes, primary care disease management, public health, and social service supports, and integrated specialty care



% of
Beneficiaries

A

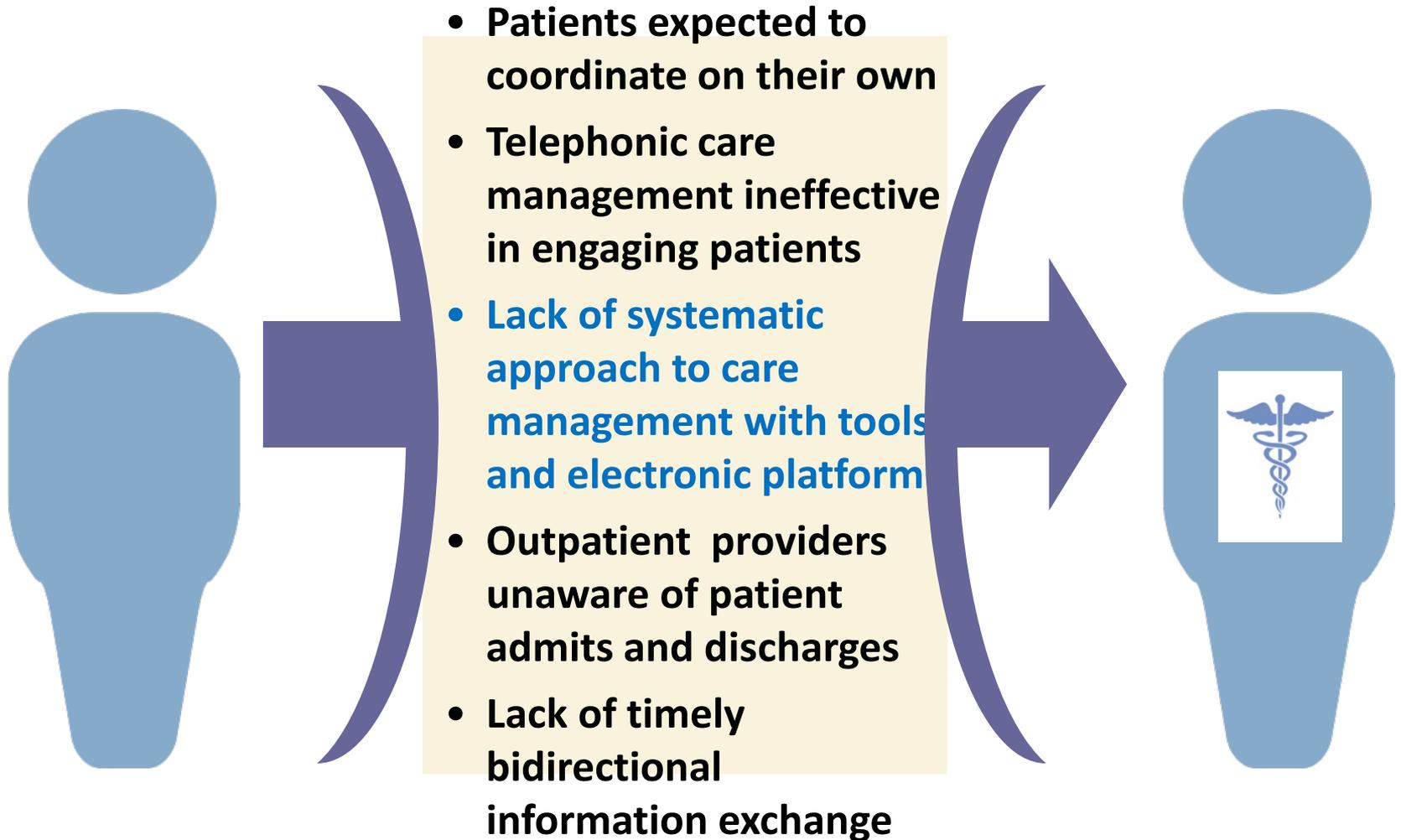
Care plans, support services, case management, new models, and other interventions for individuals with significant demands on health care resources

C

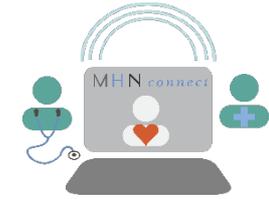
Promote and maintain health (e.g. via patient-centered medical homes)



Challenges to Care Coordination Services



Care Management Connect *Tracking Quality Assessments and Indicators*



MHNconnect
The MHNConnect System by Medical Home Network & Safety Net Connect

ADMINISTRATION Support Logout
Welcome > Laura Merrick (1766693)

Home Patient Search Census Dashboard Reports

Home > Clinic Connect > Care Management

Clinic Connect

Care Management

PATIENT INFORMATION 2644730 [Printable Version](#)

Name: [Redacted] RIN: [Redacted] Medical Home: [Redacted] Main Line: [Redacted]
Plan: [Redacted] Gender: [Redacted] Address: [Redacted] After Hrs Line: [Redacted]
Address: [Redacted] DOB: [Redacted] Portal Coord Line: [Redacted]
Phone: [Redacted] Risk: High Portal Coord: [Redacted]

Claims History (0) Rx History (0) MHN Hospital Activity (2) **Care Management**

- HRA** [Add New](#)
05/05/2015 Complete Risk Level: High
- CRA** [Add New](#)
05/07/2015 Complete Face to Face - All Other
- Care Plan** [Add New](#)
05/05/2015 Initial CP Complete Face to Face - All Other
- Med Rec** [Add New](#)
05/05/2015 Complete Phone Call
- Edu Material Given - Prevention & Wellness/PCMH** [Add New](#)
no records found
- Low-CHW Action Plan** [Add New](#)
no records found
- Risk Adjustment** [Add New](#)
no records found
- Opt Out** [Add New](#)
no records found

Notes
05/09/2015 01:25 PM Laura Merrick
Transportation Support Needed.

Care Plan

PATIENT INFORMATION

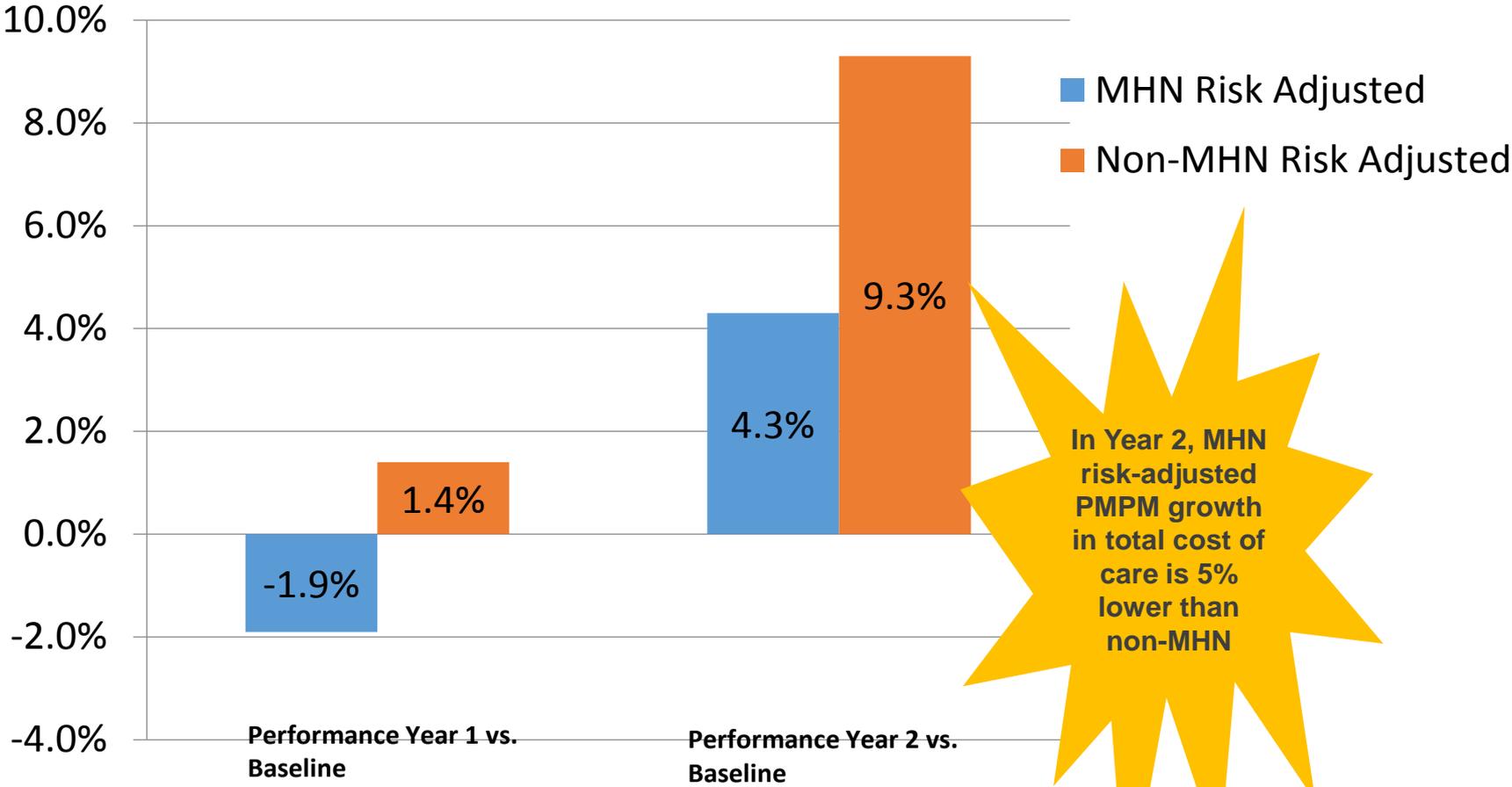
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Plan: [Redacted] Gender: [Redacted]
Address: [Redacted] DOB: [Redacted]
Phone: [Redacted]

Action Date: 05/05/2015
Status: Initial CP Complete
Contact Type: Face to Face - All Other
Note: [Redacted]
File Upload: [CarePlan1Test](#)

[Save](#) [Close](#)

Growth in Total Cost of Care: *MHN vs. non MHN Matched Cohort Trend*

Trend Over Baseline Period

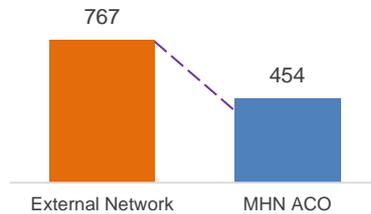


MHN ACO *Improvements in Outcomes & Engagement*

ANALYSIS MHNConnect™

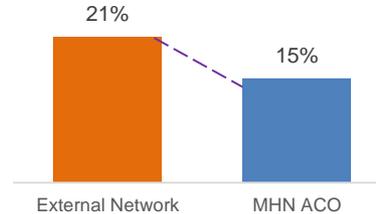
Improvements in Outcomes & Care*

40% BETTER OUTCOME



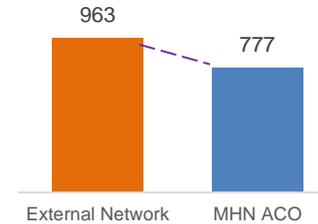
Inpatient Days/1000

30% BETTER OUTCOME



Readmission Rates

20% BETTER OUTCOME



ED Visits/1000

Improvements in Patient Engagement via Complete HRAs**



*Source Based on July CountyCare reported utilization stats 7/1/14-5/19/15

**Source: CountyCare State Filings

P4P/shared savings/capitation with uniform incentive criteria with aggregated basis for payment

Reimbursement Structure:

- All MCOs/Payers offer P4P with uniform parameters measured in a standardized fashion
- All MCOs/Payers offer shared savings/capitation based on standard set of services
- Contracts cover most if not all of a provider's panel

Integrated Delivery System/PPS

Behavioral Health

Specialists

Hospital

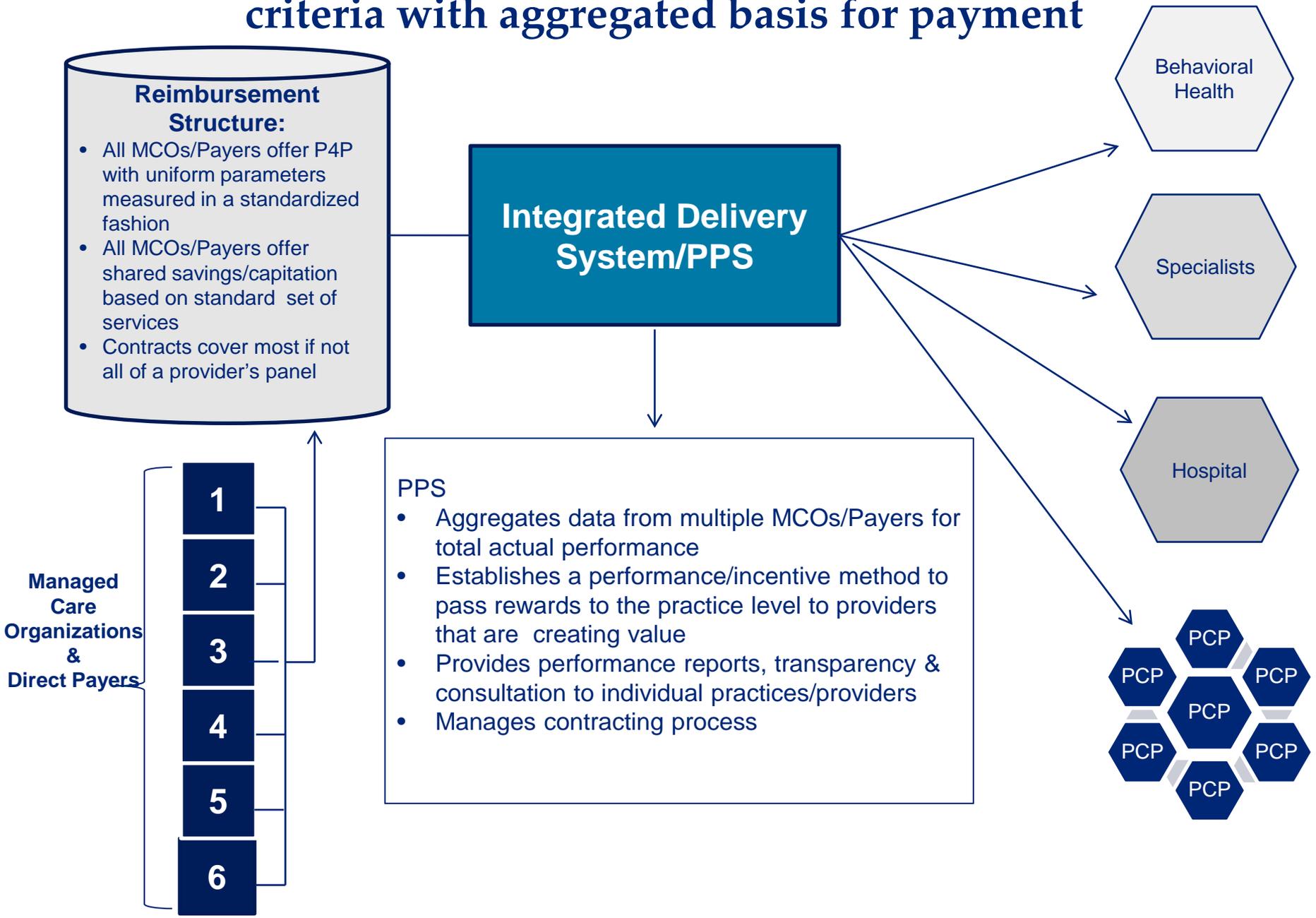
PCP

Managed Care Organizations & Direct Payers

- 1
- 2
- 3
- 4
- 5
- 6

PPS

- Aggregates data from multiple MCOs/Payers for total actual performance
- Establishes a performance/incentive method to pass rewards to the practice level to providers that are creating value
- Provides performance reports, transparency & consultation to individual practices/providers
- Manages contracting process



HEALTH MANAGEMENT ASSOCIATES

Q & A

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