Positioning FQHCs for Value-Based Payment Arrangements

Kyle Vath, BSN, RN
513-828-8947
kwvath@healthspan.org
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PLEASE COMPLETE THE PRE-PRESENTATION SURVEY!
Scan QR Code with your smart phone to go to survey...
Pre-Presentation Survey

• Which answer best describes your familiarity/comfort-level with value-based payment (VBP) arrangements?
  – **Extremely High** - My Health Center already participates in one or more VBP contracts (Shared-savings, capitation, etc.).
  – **High** - I understand VBPs and feel like I know how to position our Health Center to enter into a VBP contract but have not participated in any value-based arrangements.
  – **Moderate** - I feel like I know what value-based care is but I do not have a strong grasp of how we can position ourselves as a Health Center that participates in value-based payment arrangements.
  – **Low** - I really do not understand value-based payment arrangements more than a high-level understanding and need to learn more.
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  - **Moderate** - I feel like I know what value-based care is but I do not have a strong grasp of how we can position ourselves as a Health Center that participates in value-based payment arrangements *(57.14%)*.
  - **Low** - I really do not understand value-based payment arrangements more than a high-level understanding and need to learn more *(42.86%)*.
Post-Presentation Survey

Which answer best describes your familiarity/comfort-level with value-based payment (VBP) arrangements?

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- **Low** - I really do not understand value-based payment arrangements more than a high-level understanding and need to learn more.
Outline

• **Understanding the “New World”**
  – An Introduction to Health Reform and Payment Arrangements
  – The World of Payers

• **A Framework for Building Value-Based Care**
  – Patient-Centered Access
  – Team-Based Care
  – Population Health Management
  – Care Management and Support
  – Care Coordination and Care Transitions
  – Performance Measurement/QI

• **Tying it all together for value-based care**
Objectives

• Attendees will be able to identify and define key terminology commonly utilized in value-based payment arrangements.

• Attendees will learn the details of common value-based payment arrangements and the challenges and opportunities associated with the payment design.

• Attendees will learn operational strategies for positioning facilities for value-based payment arrangements.
So What Is Value-Based Payment?

- It is a payment model that rewards providers for meeting certain performance measures for quality and efficiency. It often penalizes caregivers for poor outcomes or increased costs.
- Also known as “pay-for-performance” (P4P) or “value-based purchasing”.
- Contrasted with “fee-for-service” (FFS) or “volume-based payment”.
- ACA pushing towards VBP: ACOs and quality links to payment.
The Department of Health and Human Services (HHS) now intends to focus its energies on augmenting reform in three important and interdependent ways:

- **Payment Incentives**: Tying payment to value through alternative payment models;
- **Care Coordination**: Care delivery changes through greater teamwork, integration, coordination of providers across settings, and a focus on population health;
- **Data and Technology**: Harnessing the power of information to improve care for patients (*Burwell, 2015*).
**CMS Goals:** *(Announced 1/26/2015)*

- 85% of all Medicare fee-for-service payments tied to quality or value by 2016 (90% by 2018).
- 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016 (50% by the end of 2018).

**This is the first time in the history of the program that explicit goals for alternative payment models and value-based payments have been set for Medicare.**

Transitional Strategy

- Volume (FFS) Reimbursement
- Reimbursement Transition
- Value-Based Reimbursement
An Overview of the Journey

Volume-Based Care

Value-Based Care
An Overview of the Journey

Volume-Based Care

Transitional Bridge

Value-Based Care
An Overview of the Journey

Volume-Based Care

Transitional Bridge

Value-Based Care
An Overview of the Journey

Preparation Phase
- Invest in learning the insurance industry
- Pull claims data and analyze
- Know your quality data and compile it
- Know your payer mix and determine which to approach
- Explore partnerships
- Determine capitated rate/incentive payments needed
- Determine needs to complete plan (Attribution lists from payer, etc.)
- Become PQRS Proficient
- Target the Low-Hanging Fruit
- Develop an Organizational Revenue Transition Strategic Plan

Transition Phase
- Maintain volume/frequency
- Work to make visits more effective, efficient
- Strengthen partnerships
- Monitor and improve Patient-Centered Access
- Build Team-Based Care Systems
- Focus on Population Health Management
- Train on Care Management and Support
- Develop systems for Care Coordination and Care Transitions
- Use data for Performance Measurement/QI
- Trial partial VBP models

Implementation Phase
- Decrease/maintain volume
- Improve effectiveness of each encounter
- Strengthen partnerships
- Monitor and improve Patient-Centered Access
- Build Team-Based Care Systems
- Focus on Population Health Management
- Train on Care Management and Support
- Perfect systems for Care Coordination and Care Transitions
- Use data for Performance Measurement/QI
- Fully-transition to VBP models

Volume-Based Care

Value-Based Care
What is Healthcare Value?

• “Health outcomes achieved per dollar spent.” (Porter, 2006)
• “Value should always be defined around the customer, and in a well-functioning health care system, the creation of value for patients should determine the rewards for all other actors in the system” (Porter, 2010).
• “Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge” (Porter, 2010).
• “Nor is value measured by the process of care used; process measurement and improvement are important tactics but are no substitutes for measuring outcomes and costs” (Porter, 2010).
What is Healthcare Value?

• The Customer’s View in Retail:
  – Marketing
  – Price
  – Ingredients
    • Individual dietary restrictions
      Experience (Taste)
      Scale (Quantity purchased)
What is Healthcare Value?

The Customer’s View

So who is the customer in healthcare?
What is Healthcare Value?

- The Patient’s View in Healthcare:
  - Marketing
  - Price
  - Ingredients/Processes
  - Socioeconomic factors
  - Social services
  - Experience/Outcomes
  - Scale

Nutrition Facts

<table>
<thead>
<tr>
<th>Serving Size 1 Cup as prepared (66g)</th>
<th>Servings Per Container 4</th>
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<td>Amount Per Serving</td>
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<td>Calories 260</td>
<td>Calories from Fat 15%</td>
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<td>Total Fat 4g</td>
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<td>Saturated Fat 1g</td>
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<td>Calcium 4%</td>
<td>Iron 10%</td>
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*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Calories 2,000 2,500
- Total Fat Less than 65g 75g
- Saturated Fat Less than 20g 25g
- Cholesterol Less than 300mg 300mg
- Sodium Less than 2,400mg 2,400mg
- Total Carbohydrate Less than 1,100g 1,100g
- Dietary Fiber 25g 28g

Calories per gram:
- Fat 9
- Carbohydrate 4
- Protein 4
What is Healthcare Value?

- The Patient’s View in Healthcare:
  - Marketing
  - Price
  - Ingredients/Processes
    - Socioeconomic factors
    - Social services
  - Experience/Outcomes
  - Scale
What is Healthcare Value?

The Customer’s View

So is the patient really the customer?
What is Healthcare Value?

• The Provider’s View in Healthcare:
  — Marketing
  — Price
  — Ingredients/Processes
    • Socioeconomic factors
    • Social services
  — Experience/Outcomes
  — Scale

The Provider’s View

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Carbohydrate
Protein

Calories per gram
Fat 9 = Carbohydrate 4 = Protein 4
What is Healthcare Value?

• The Payer’s View in Healthcare:
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  – Price
  – Ingredients/Processes
    • Socioeconomic factors
    • Social services
  – Experience/Outcomes
  – Scale
What is Healthcare Value?

Quality

Experience

Cost
The Value Equation

Value = Quality × Scale

Quality

• HEDIS Process Metrics
• HEDIS Outcomes Metrics
• Patient Satisfaction/QOL

Cost

• Payer Claims
• Shared Savings
• Insurance Premiums
• Tax Dollars
• Patient Out-of-Pocket Costs
• Duplication/Waste

Scale

• Number of lives served

Value

Payer

• Payer
• ACOs
• Patient/Caregiver
• Employer
• Government
The Value Equation

Customer = Payer

Consumer = Patient

How does this change the discussion? (Or, how doesn’t it?)
The Value Equation

• **Definition:**
  – Quality of care and scale in relation to cost.

• **Affected Positively By:**
  – Improvement in Processes
  – Improvement in Outcomes
  – Increase in Scale
  – Decrease in Cost

• **Affected Negatively By:**
  – Decline in Processes
  – Decline in Outcomes
  – Decrease in Scale
  – Increase in Cost
The Value Equation

- Challenges With Value (Blumenthal, 2013):
  - No clear value metric
  - Outcomes can be subtle and multidimensional
  - The ability of health care organizations to measure costs is primitive (and often retroactive)
  - Data system/IT lag
  - Varied industries and stakeholders

- Other Key Factors (Porter, 2010):
  - “The fact that value is not measured means that the most powerful tool for care improvement is lacking.”
  - “The fact that health care delivery is not organized around value works against excellent care and drives up cost.”
  - “The fact that reimbursement is not aligned with value cripples the process of innovation while rendering the profit motive a destructive force rather than a value driver.”
The Value Equation

• **Definition**
  - *Cost is the amount of money spent on healthcare by the payer.*

• **Strategies to Reduce Costs:**
  - *Reduce duplication/waste*
  - *Care coordination, others...*

• **Challenges:**
  - *Retroactive*
  - *Longitudinal*
The Value Equation

- **Definition**
  - *Scale refers to the number of lives served and paid for by the payer.*

- **Strategies to Increase Scale:**
  - *Collaborate with like providers to pool number of lives served.*
  - *Increase access*
The World of Payers

- Payment Models
- CMS 5-Star Rating
- HEDIS
- Risk-Stratification
- Claims
Intro to Health/Payment Reform

- **Types of Payment Models**
  - Fee-For-Service
  - Shared-Savings
  - Global Payments
  - Partial capitation
  - Full capitation
Risk vs. Reward

- Fee-For-Service
- Shared-Savings
- Global Payments
- Partial Capitation
- Full-Capitation
Intro to Health/Payment Reform

- **Types of Payment Models**
  - *Shared-Savings*

![Diagram showing cost over time for Shared Savings - Provider and Shared Savings - Payer.](image)
Intro to Health/Payment Reform

• **Types of Payment Models**
  – *Shared-Savings*
### Intro to Health/Payment Reform

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<th>Scale</th>
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*Note: These are lives covered by the payer.*

Your risk if you fail to increase your scale and move toward value...
## Intro to Health/Payment Reform

### Risk and Reward

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CMS 5-Star Rating

- Member Satisfaction: How do I see my Network
- HEDIS quality measures: How does the Network Perform?
CMS 5-Star Rating

• For plans covering health services, the overall score for quality of those services covers 36 different topics in five categories:
  – Staying healthy: prevention
  – Managing chronic (long-term) conditions: tests/treatments
  – Ratings of health plan responsiveness and care: member sat
  – Health plan member complaints and appeals: complaints
  – Health plan telephone customer service: calls
A number of HEDIS measures overlap with UDS (12 of 14):

- BMI (Adult) with follow-up plan (ABA)
- Hypertension (Controlled: <140/90) (CBP)
- Diabetes (Controlled A1C: <9%) (CDC)
- CAD with lipid-lowering therapy (CMC)
- Colorectal screening (COL)
- Tobacco Screening and cessation (MSC)
- Cervical Cancer Screenings (CCS, NCS)
- IVD with ASA therapy (ASP)
- Pre-Natal Care (PPC)
- Asthma (ASM, MMA)
- Childhood Immunizations (CIS, IMA)
- BMI (Child counseling) (WCC)
The Healthcare Risk Equation

Risk = Vulnerabilities\((\text{Probability} \times \text{Threats}) \times \text{Cost}\)

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<th>Risk</th>
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The Healthcare Risk Equation

Risk = Vulnerabilities(Probability x Threats) x Cost

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Possible resulting diagnoses, procedures, care utilization caused by the vulnerabilities
The Healthcare Risk Equation

Risk = Vulnerabilities (Probability x Threats) x Cost

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• Behavioral choices | Prevalence of threats, given vulnerabilities (national stats) | Possible resulting diagnoses, procedures, care utilization caused by the vulnerabilities | |
## The Healthcare Risk Equation

**Risk** = **Vulnerabilities**\(\times (\text{Probability} \times \text{Threats}) \times \text{Cost}\)

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The Healthcare Risk Equation

Risk = Vulnerabilities(Probability x Threats) x Cost

What is our risk that a patient will cost our company $X based on the likelihood that he will have a heart attack, be in ICU for 3 weeks and have a CABG, due to the fact that the patient is over 60, diabetic, and has a BMI of 33 and because the cost of that care is $Z?
The Healthcare Risk Equation

Risk = Vulnerabilities(Probability x Threats) x Cost

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Risk = Vulnerabilities \times (Probability \times Threats) \times Cost

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<td>30% chance</td>
<td>AMI</td>
<td>$10,000</td>
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<td>20% chance</td>
<td>ICU x 3wks</td>
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Risk-Stratification

• Characteristics of the population
  – How old is the population you are enrolling?
  – How many in each age category?
  – What is the sex of the population (male-female ratio)
  – What diseases are carried by the population?

• Medications

• Evidence-Based Guidelines
Risk-Stratification

• Plan Services:
  – Case managers
  – Utilization management
  – Wellness programs
  – An HIV coordinator program
  – An end-stage renal program
  – A palliative care program
  – A mental health outreach program
Risk-Stratification

- Geo-Access
1% of patients account for 22.7% of costs (AHRQ, October, 2014)

5% of patients account for 50% of costs (AHRQ, October, 2014)
Longitudinal Care

Health Input
($, Resources)

Return
(Reduced $, Better Health)

Longitudinal Care
Risk-Stratification

• Medical Loss Ratio:
  – How much money to cover lives/how much to provide care.
  – ~85% or better is desired
Risk-Stratification

- **Risk-Stratification Uses:**
  - **Identify participants with a specific trigger**
    - Participants with more than 15 unique provider interactions in the prior 12 months
      (This is a High-Risk trigger)
  - **Determine if utilization patterns are an issue**
    - Participants may be seeing multiple providers appropriately because they have multiple medical issues, or inappropriately because they have not found a PCP
  - **Identify the percentage of High Risk participants in your population who are not actively involved in medical management**
    - High Risk participants not actively involved in medical management can be identified and assigned to a medical management staff member.
  - **Create a list of participants based on their Risk Stratification level or trigger for use in other applications**
    - A list of priority participants under a specific employer can be used to generate reports and registries.
Claims Data

- Potential Health Claims Data
  - Age
  - Sex
  - Employment status - employee, spouse, dependent, or retiree
  - Total health care costs
  - Diagnosis codes (use first or second code)
  - Procedure codes (for preventive services use)
  - Place of Service
• When reporting the results, it is important to clarify the time period for which the costs are reported (e.g., one or two-year period). It is also important to recognize patient retention and turnover rates when performing annual evaluations.

• Data collection and evaluation should focus on the patients that will eventually benefit from interventions and programmatic changes.

• It is important to recognize that health care claims information will come from the company’s health care plan providers which takes time to receive and may not come in a form that is ready to use or contain the necessary level of detail.
Claims Data

• Data Analysis:
  – Total health care costs (e.g., percent of total costs and average cost per enrollee)
    • Preventive care
    • Chronic care
    • Acute care
    • Ancillary care
    • Predictive modeling
Positioning the Medical Home For Value-Based Care

• 6 Main Domains
  – Patient-Centered Access
  – Team-Based Care
  – Population Health Management
  – Care Management and Support
  – Care Coordination and Care Transitions
  – Performance Measurement/QI

If framework followed, may be eligible for NCQA PCMH recognition
Positioning the Medical Home For Value-Based Care

• 6 Main Domains
  – Patient-Centered Access
Patient-Centered Access

- Same-day access/timely advice
- After-hours care
- Alternative types of clinical encounters
- Monitoring no-show rates
- Working to improve access
- Continuity of medical record
- Electronic/portal access
- Transmission of health record

If framework followed, may be eligible for NCQA PCMH recognition
Map represents readmission penalties (red) - See Interactive Map at:
Positioning the Medical Home For Value-Based Care

• 6 Main Domains
  – Team-Based Care
Team-Based Care

- **Continuity of PCP (monitor and work to improve)**
- **Orient patients to practice**
- **Provide written care plans for transition from peds to adult**
- **Provide education on:**
  - Care coordination
  - How to request care during and after hours
  - Use of evidence-based care
  - Scope of services, including behavioral health services
  - Care regardless of payer type, helps enroll in insurance
  - How to transfer records

If framework followed, may be eligible for NCQA PCMH recognition
Team-Based Care

- **Provide culturally- and linguistically-appropriate services**
  - Use data to assess diversity and equity
  - Provide services in culturally-appropriate ways
- **Define roles of team members**
- **Hold regular care team/practice functioning meetings**
- **Use standing orders**
- **Assign a care team to Care Coordination**
- **Train staff in self-management, self-efficacy, behavior change, population management**
- **Involve patients and staff in QI/advisory councils**

If framework followed, may be eligible for NCQA PCMH recognition
Positioning the Medical Home For Value-Based Care

• 6 Main Domains
  – Care Management and Support
Care Management and Support

• **Identify patients for care management (and use data)**
  – Behavioral health conditions
  – High cost/high utilization
  – Poorly-controlled or complex conditions
  – Social determinants of health
  – Referrals by outside organizations

• **Support Self-Care**
  – Incorporate patient preference and goals
  – Identify treatment goals
  – Assess and address barriers
  – Develop a self-management plan/care plan

If framework followed, may be eligible for NCQA PCMH recognition
Care Management and Support

• **Medication Management**
  – Review and reconcile medications during care transitions
  – Educate on new prescriptions
  – Assess understanding of current medications
  – Assess response to medications and barriers to adherence
  – Document all OTC, herbal, and supplement meds

• **Use Electronic Prescribing**
  – Alert prescribers to generic alternatives

• **Use the EHR to identify patient-specific resources/materials**

• **Provide self-management tools**

• **Adopt shared decision-making aids**

• **Offer/refer patients to structured health education programs**

• **Know your community resources and assess usefulness**

If framework followed, may be eligible for NCQA PCMH recognition
Positioning the Medical Home For Value-Based Care

- 6 Main Domains
  - Population Health Management
Population Health Management

- Record patient information (DOB, gender, race, ethnicity, preferred language, telephone number, email address, occupation, legal guardian, primary caregiver, advance directives, health insurance, other providers)
- Maintain an accurate problem and diagnosis list
- Maintain an accurate allergy list
- Maintain an accurate medication list
- Maintain lists of trends of vitals
- Always ask about tobacco use
- Record a thorough and accurate family history list

If framework followed, may be eligible for NCQA PCMH recognition
Population Health Management

- Assess age-appropriate immunizations/screenings
- Assess family/social/cultural characteristics
- Assess communication needs
- Provide advance care planning
- Assess and record behaviors that may affect health
- Assess and record mental health/substance abuse history
- Provide developmental screenings for pediatric patients
- Screen for depression
- Assess health literacy

If framework followed, may be eligible for NCQA PCMH recognition
Population Health Management

• Use Data for Population Management
  – Assess and work to improve:
    • Preventative Care Services (>2)
    • Immunization rates (>2)
    • Chronic or acute care services (>3)
    • Patients not recently seen by the practice
    • Medication monitoring or alerts

• Implement Evidence-Based Decision Support
  – Mental health, chronic diseases, acute conditions, behavior-influenced condition, well-visit care, overuse/appropriateness issues

If framework followed, may be eligible for NCQA PCMH recognition
Population Health Management

Three Steps to Prioritize Population Health Interventions

1. Segment into Key Patient Groups
   - Utilize clinical and claims data to begin segmentation.
   - Every provider has clinical data, from electronic medical records to laboratory and preventive systems. Even clinical data from a simple disease registry can prove useful.

2. Fill in Gaps
   - Focus data collection to refine patient populations.
   - After you start segmenting your population, you might notice a few gaps. Even with an abundance of clinical and claims data, population health managers will still lack relevant important information about all risk/patients. Providers have used a range of approaches from mining demographic data to collecting new clinical data to close gaps and further segment the population.

3. Assess Root Cause
   - Determine the root causes of risk to gain a better understanding of which interventions will actually make a difference.
   - Population health managers should consider a broader set of risks, including social risk, geographic risk, and behavioral risk. In addition, the degree of patient engagement can make a big difference in which interventions are most appropriate and most effective.

4. Take Action
   - A properly segmented population allows the population health manager to target finite resources where they’ll do the most good.
   - Each population segment has an intervention strategy appropriate for its level of risk.

Two key components of successful population health interventions are population health management (PHM) and healthspan. PHM focuses on the total population, without distinguishing whether members are covered by health insurance and customized interventions for self-funded populations. Healthspan focuses on a total cost of risk, combining the total risk of all members into a single cost to enable on-demand and immediate assessment of interventions.

Learn more about prioritizing population health interventions at: https://www.theadvocacygroup.com/healthspansion
SEGMENT INTO KEY PATIENT GROUPS
Utilize clinical and claims data to begin segmentation
Every provider has clinical data, from electronic medical records to laboratory and e-prescribing systems. Even clinical data from a simple disease registry can prove useful.

FILL IN GAPS
Focus data collection to refine patient populations
After you start segmenting your population, you might notice a few gaps. Even with an abundance of clinical and claims data, population health managers will still be missing important information about at-risk patients. Providers have used a range of approaches from mining demographic data to collecting new clinical data to close gaps and further segment the population.
Population Health Management

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Each population segment has an intervention strategy appropriate for its level of risk.
Positioning the Medical Home For Value-Based Care

• 6 Main Domains
  – Care Coordination and Care Transitions

If framework followed, may be eligible for NCQA PCMH recognition
Care Coordination and Care Transitions

• **Test Tracking and Follow-Up**
  - Track lab, imaging, diagnostics (flags abnormalities, notifies patients)
  - Follow-up with hospitals on newborn screenings
  - Labs, radiology, diagnostics should be ordered electronically and viewed electronically

• **Referrals**
  - Carefully evaluate referrals, consider quality/performance info
  - Maintain agreements with specialists and behavioral healthcare providers based on a set criteria
  - Integrate BH within practice site
  - Communicate clearly with consultants, electronically
  - Track referrals
  - Document co-management/other providers in EMR

If framework followed, may be eligible for NCQA PCMH recognition
Care Coordination and Care Transitions

- Coordinate Care Transitions
  - Proactively identify patients with unplanned hospital admissions and ED visits
  - Share clinical info with admitting hospitals and EDs
  - Develop and maintain a process for obtaining discharge summaries from hospitals/SNFs
  - Proactively contact patients following a hospital/ED visit
  - Establish appropriate consents for exchanging info across community partners

If framework followed, may be eligible for NCQA PCMH recognition
Care Coordination and Care Transitions

• 6 Evidence-Based Strategies to Reduce Readmissions (Bradley et al, 2013)
  – Partnering with local physicians and physician groups;
  – Collaborating with local facilities to develop consistent readmission reducing strategies;
  – Assigning nurses to manage medication plans;
  – Scheduling follow-up appointments for patients pre-discharge;
  – Following up with patients post-discharge with test results; and
  – Developing a post-discharge plan with the patient's primary physicians and sharing medical records with the physician.

If framework followed, may be eligible for NCQA PCMH recognition
Care Coordination and Care Transitions

• Interventions to Reduce Readmissions
  – Multifaceted, complex, and self-management-focused approaches are most-successful.
    • Telephone call — The discharging clinician, a clinical pharmacist, a clinician from the patient's primary care clinic
    • Home visits — Home visits made by a number of different types of providers have been shown to reduce need for readmission.
    • Telemonitoring — Use of telemonitoring devices have also been studied as a means for reducing readmissions.
    • High-risk patients — A randomized trial in 239 elderly patients with heart failure compared assigned advanced practice nurses with usual care
Care Coordination and Care Transitions

• Risk factors for readmission
  – Clinical factors include the following:
    • Use of high risk medication (antibiotics, glucocorticoids, anticoagulants, narcotics, antiepileptic medications, antipsychotics, antidepressants, and hypoglycemic agents)
    • Polypharmacy (five or more medications)
    • More than six chronic conditions
    • Specific clinical conditions (eg, advanced COPD, diabetes, heart failure, stroke, cancer, weight loss, depression)

Care Coordination and Care Transitions

• Risk factors for readmission
  – Demographic and logistical factors include:
    • Prior hospitalization, typically including unplanned hospitalizations within the last 6 to 12 months
    • Black race
    • Low health literacy
    • Reduced social network indicators like being alone most of the day with limited or no family or friend contact by phone or in person
    • Lower socioeconomic status

Care Coordination and Care Transitions Map represents readmission penalties (red) - See Interactive Map at:
Positioning the Medical Home For Value-Based Care

• 6 Main Domains
  – Performance Measurement/QI
Performance Measurement/QI

• **Assess and work to improve:**
  – Preventative Care Services (>2)
  – Immunization rates (>2)
  – Chronic or acute care services (>3)
  – Patients not recently seen by the practice
  – Medication monitoring or alerts
  – Vulnerable populations/stratify disparities
  – Care coordination measures (>2)
  – Utilization measures affecting cost (>2)

If framework followed, may be eligible for NCQA PCMH recognition
Performance Measurement/QI

- **Measure Patient/Family Experience**
  - Survey patients about access, communication, coordination and whole-person care (CAHPS)
  - Survey experiences of vulnerable patient groups
  - Form a Patient Advisory Committee

If framework followed, may be eligible for NCQA PCMH recognition
Partnering with ACOs/Payers

- FQHCs play a critical role in caring for low-income populations.
- Medicaid accountable care organizations (ACOs) could surely benefit from the participation of safety net providers.
- FQHC providers have been relatively slow to engage in Medicaid ACO arrangements.

Partnering with ACOs/Payers

• With these factors in mind, several state Medicaid ACO initiatives have taken steps to encourage safety net provider participation. States may wish to consider the following strategies to support the integration of safety net providers in Medicaid ACO programs.

  – Allow a Flexible Governance Structure
  – Set Flexible Population Size Parameters
  – Phase in Financial Risk
  – Support Infrastructure Development and Facilitate Data Exchange
  – Establish Provider Supports

Partnering with ACOs/Payers

• Value-Based Contract Design Fundamentals:
  
  – Data:
    • Identify the most vulnerable populations using data.
  
  – Design:
    • Creating the design that aligns the players with the goal, identifying metrics over time; Group contracting.
  
  – Delivery:
    • Contracting for the delivery of services (providers, HIT, communications, coordination) that will support the patients’ journey to goal in the most efficient manner.
  
  – Dividends:
    • Identifying and sharing the dividends for each of the players in the contract.

http://thehealthcareblog.com/blog/2014/08/06/writing-the-value-based-contract/
An Overview of the Journey

Preparation Phase
- Invest in learning the insurance industry
- Pull claims data and analyze
- Know your quality data and compile it
- Know your payer mix and determine which to approach
- Explore partnerships
- Determine capitated rate/incentive payments needed
- Determine needs to complete plan (Attribution lists from payer, etc.)
- Become PQRS Proficient
- Target the Low-Hanging Fruit
- Develop an Organizational Revenue Transition Strategic Plan

Transition Phase
- Maintain volume/frequency
- Work to make visits more effective, efficient
- Strengthen partnerships
- Monitor and improve Patient-Centered Access
- Build Team-Based Care Systems
- Focus on Population Health Management
- Train on Care Management and Support
- Develop systems for Care Coordination and Care Transitions
- Use data for Performance Measurement/QI
- Trial partial VBP models

Implementation Phase
- Decrease/maintain volume
- Improve effectiveness of each encounter
- Strengthen partnerships
- Monitor and improve Patient-Centered Access
- Build Team-Based Care Systems
- Focus on Population Health Management
- Train on Care Management and Support
- Perfect systems for Care Coordination and Care Transitions
- Use data for Performance Measurement/QI
- Fully-transition to VBP models
An Overview of the Journey

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Volume-Based Care

Value-Based Care
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