ACO Technical Assistance: Building Teams for New Roles

October 20, 2017
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<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Facilitator</th>
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<tbody>
<tr>
<td>9:15 – 9:30</td>
<td>Welcome and Introductions</td>
<td>Ellen Hafer, Mass League</td>
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<tr>
<td>9:30 – 10:00</td>
<td>Overview of Enrollment Processes and Member Engagement for the ACO</td>
<td>Lisa Whittemore, Liz Sanchez</td>
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<tr>
<td>10:00 – 11:15</td>
<td>Social Determinants of Health, Best Practices to Assess and Respond</td>
<td>Liddy Garcia-Bunuel</td>
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<tr>
<td>11:15 – 12:00</td>
<td>Changing Team in the ACO – Use of Community Health Workers and Peer Navigators</td>
<td>Liddy Garcia-Bunuel</td>
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<tr>
<td>12:00 – 12:45</td>
<td>LUNCH</td>
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<tr>
<td>12:45 – 1:15</td>
<td>Adaptive Leadership Skills</td>
<td>Lisa Whittemore</td>
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<tr>
<td>1:30 – 2:30</td>
<td>Break-Out Session by Role - “What is my role to be successful in ACO environment”</td>
<td>Facilitators</td>
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<tr>
<td>2:30 – 3:00</td>
<td>Report Out</td>
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<tr>
<td>3:00 – 3:30</td>
<td>Summary of the Series</td>
<td>Lisa Whittemore, Myra Sessions</td>
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</table>
Agenda

Goals for Today

Enrollment Processes and Member Engagement

Social Determinants of Health

ACO Team to Address Unmet Social Needs

Adaptive Leadership Skills

Break-Out Session

Summary of the Series
Four-Part Series on Value Based Payment Readiness: Overview

Overview of Readiness Roadmap: How to Succeed in New Environment
• Setting the tone for change
• Review of roadmap
• Building the pyramid: risk stratification

Elements for Success – Finances and Infrastructure:
• Negotiation strategies
• Funds flow, infrastructure investments and levels of risk
• Division of Responsibilities: MCO and ACO
• Compensation systems to align incentives

Elements for Success – Population Management:
• Empanelment/engagement
• Population Management tasks and division of responsibilities
• Care Management Staffing & ROI
• Risk stratification: who to care manage
• BH Integration

Elements for Success: ACO Risk Stratification and Coding for Improvement
• Enrollment
• Role of social determinants: assessment and follow-up
• Leading Changes
• Communicating Change for an ACO
GOALS FOR TODAY

• Review recent guidance on enrollment from MassHealth
• How to assess for social determinants of health and how might a CHC design appropriate interventions.
• How do the CHCs staff correctly address patients’ nonclinical determinants of health
• Team based care in an ACO environment and role of each team member
• Setting the stage for your ACO: Communication and cultural change
• Review 4-part series: Value Based Payment Readiness
Agenda

Goals for Today

Enrollment Processes and Member Engagement

Social Determinants of Health

ACO Team to Address Unmet Social Needs

Adaptive Leadership Skills

Break-Out Session

Summary of the Series
Enrollment Processes and Member Engagement

• MassHealth poised to send notices to members beginning mid-November through December

11/13/2017
Members receive letters

12/22/2017

03/01/2018
Start of Plan Selection Period
Members who moved with PCP into a new ACO will be enrolled in a new health plan

06/01/2018
Start of Fixed Enrollment Period
Members enrolled in an ACO or MCO can only change their health plans for certain reasons

SOURCE: MassHealth ACO Notices pdf (10/17/17)
MASS HEALTH COMMUNICATION: TYPES AND NUMBERS OF PLANS

Accountable Care Partnership Plans

- PCPs
  You have to choose a PCP within the Accountable Care Partnership Plan's network.

- Medical Services and Behavioral Health Services
  You will receive medical AND behavioral health services from providers in the Accountable Care Partnership Plan's network.

There are 13 ACO Partnership Plans. See pages 7-23

Managed Care Organizations

- PCPs
  You have to choose a PCP within the MCO's network.

- Medical Services and Behavioral Health Services
  You will receive medical AND behavioral health services from providers in the MCO's network.

There are 2 MCO Plans. See pages 27-28

Primary Care ACOs

- PCPs
  You have to choose a PCP within the Primary Care ACO's network.

- Medical Services
  You will receive medical services from providers in the MassHealth network.

- Behavioral Health Services
  You will receive your behavioral health services from the Massachusetts Behavioral Health Partnership (MBHP) network.

There are 3 Primary Care ACO Plans. See pages 24-26

Primary Care Clinician Plan

- PCPs
  You have to choose a PCP within the PCC Plan network.

- Medical Services
  You will receive medical services from providers in the MassHealth network.

- Behavioral Health Services
  You will receive your behavioral health services from the Massachusetts Behavioral Health Partnership (MBHP) network.

There is 1 Primary Care Clinician Plan. See page 29
## LETTERS FOR MASSHEALTH MEMBERS

<table>
<thead>
<tr>
<th>LETTER #</th>
<th>LETTER ACTION</th>
<th>INDICATOR</th>
<th>REASON FOR MEMBER MOVEMENT</th>
<th>MEMBER MOVEMENT ON MARCH 1ST</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Member moving to an Accountable Care Partnership Plan</td>
<td>Green stripe on envelope and letter and the phrase “MassHealth A” in the letter header</td>
<td>Member’s PCP joins Partnership Plan ACO</td>
<td>Member is following their PCP into an Accountable Care Partnership Plan</td>
</tr>
<tr>
<td>2</td>
<td>Member moving to Primary Care ACO</td>
<td>Green stripe on envelope and letter and the phrase “MassHealth B” in the letter header</td>
<td>Member’s PCP joins a Primary Care ACO</td>
<td>Member is following their PCP into a Primary Care ACO</td>
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<tr>
<td>3</td>
<td>Member moving to MCO-Administered ACO</td>
<td>Green stripe on envelope and letter and the phrase “MassHealth C” in the letter header</td>
<td>Member’s PCP joins an MCO-Administered ACO</td>
<td>Member is following their PCP into the MCO</td>
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<tr>
<td>4</td>
<td>Member is being auto-assigned to a new health plan</td>
<td>Green stripe on envelope and letter and the phrase “MassHealth AE” in the letter header</td>
<td>Member’s current health plan is no longer available for the member, and member’s PCP did not join an ACO.</td>
<td>If a member does not select a new health plan by March 1st, they will be auto-assigned into a new health plan.</td>
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<tr>
<td>5</td>
<td>Member is in their Plan Selection Period (PSP)</td>
<td>Green stripe on envelope and letter and the phrase “MassHealth PSP” in the letter header</td>
<td>No movement</td>
<td>None — member will remain in current plan, unless they select a new health plan</td>
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Health Management Associates
• How can you prepare for your patients’ questions?

• How do you use your teams to address this challenge?
Agenda

Goals for Today

Update: Enrollment Processes and Member Engagement

Social Determinants of Health

ACO Team to Address Unmet Social Needs

Adaptive Leadership Skills

Break-Out Session

Summary of the Series
Re-balancing Medical and Social Spending to Promote Health

Exhibit 8. Health and Social Care Spending as a Percentage of GDP

Notes: GDP refers to gross domestic product.
MODIFIABLE FACTORS THAT INFLUENCE HEALTH

- **Social and Economic Factors**: 40%
- **Physical Environment**: 10%
- **Clinical Care**: 20%
- **Health Behaviors**: 30%

What are social determinants of health?

Who currently does a screening for social needs of patients?
Core Health-Related Social Needs

- Housing instability (e.g., homelessness, inability to pay mortgage/rent, housing quality);
- Utility needs (e.g., difficulty paying utility bills);
- Food insecurity;
- Interpersonal violence (e.g., intimate partner violence, elder abuse, child abuse, etc.); and
- Transportation needs (beyond medical transportation).
SOCIAL DETERMINANTS OF HEALTH: HOUSING
In recent years, evidence has emerged demonstrating that adequate, stable housing is linked to reduced health care costs and improved health.

With the emergence of this evidence, health care systems and providers have begun to:

- Understand lack of adequate, stable housing as a barrier to health and a contributor to high cost
- Increase their attention to housing needs
- Struggle with how to help
  - What works?
  - What can health plans and/or providers do?
HOUSING, NEIGHBORHOODS AND HEALTH

Access to healthy food
Walkability
Safety
Access to health care resources
Access to social services
Does where you live affect how long you live?

Find out:

Watch the film.

Enter your ZIP code.

46901

Your ZIP code is located in Howard County and the data indicate:

Average life expectancy (years)

74.2 Men

78.7 Women

Average life expectancy in America — Men: 75.6 Women: 80.7
Homeless individuals have, on average, five ED visits per year, with some using the ED weekly. 80% of these visits are for illnesses that could have been treated with preventive care.

In one study, homeless individuals had an average hospital length of stay that was four days longer than non-homeless.

In another study, the rate of psychiatric hospitalization was 100 times that of non-homeless.
CASE STUDY

Program to improve health and reduce utilization among “High Utilizers”

Massachusetts’ Home and Healthy for Good Program, which housed 766 chronically homeless individuals in supportive housing

FINDINGS

Prior to housing, total costs per person per year were $33,190

After housing, total costs per person per year were $8,603

Total estimated return on investment to the state was $9,118 per person, after program costs were accounted for
HOW ACOs CAN IMPACT HOUSING CHALLENGES

- Conduct Health Needs Assessments that include assessment of social determinants of health and social and other needs
- Include CBOs in networks of service providers
- Partner with housing providers and utility assistance providers (heat, electric)
- Implement CHC, multi-agency case consultation, formalized data sharing agreements, protocols for regular communication and information sharing, co-location of staff/services and coordinated funding strategies
- Use community health workers, care coordinators and patient navigators to serve at the intersection of health, housing and social services
- Utilize home visits to allow for safety checks (e.g., trip-hazard carpets and the elderly)
Social Determinants of Health: Food
We all know that eating healthy food, in the right quantities, is a key to health.

- Barriers to healthy eating can be complex, and are related to income, education, geography, transportation, available food sources, and mental health
- Solutions need to take into account these complexities
12.7% of American households (50 million people) were food insecure at least some time during 2015.

Over 30% of female-headed households are food insecure.

RISK FACTORS

- Low income
- High cost of food and non-food essentials
- Geographic isolation
- Health conditions requiring a special diet
- Lack of transportation
- Lack of food skills
Food insecure children are:

- at least twice as likely to report being in fair or poor health compared to food-secure children, and 1.4 times more likely to have asthma
- more likely to have behavioral problems, depression, suicidal ideation, poor oral health, and anemia
FOOD INSECURITY: IMPACTS ON HEALTH

Food insecure non-senior adults are:

- More likely to have mental health problems, including depression; more likely to have diabetes, hypertension, poor sleep and generally poorer health

Food insecure seniors:

- Are more than twice as likely as food secure seniors to have poor health
- Have limitations in activities of daily living comparable to seniors who are 14 years older than them
Decreased access to healthy food means people in low-income communities suffer more from diet-related diseases like obesity and diabetes than those in higher income neighborhoods with easy access to healthy food, particularly fresh fruits and vegetables.

Inequitable access to healthy food is a major contributor to health disparities.
Adult Obesity Rate by State, 2016

Select years with the slicer to see historical data. Hover over states for more information. Click a state to lock the selection. Click again to unlock.

Percent of obese adults (Body Mass Index of 30+)

- 0 - 9.9%
- 10 - 14.9%
- 15 - 19.9%
- 20 - 24.9%
- 25 - 29.9%
- 30 - 34.9%
- 35%+

Adult obesity rates, 1990 to 2016

Massachusetts, 2016
- Adult Obesity Rate: 23.6%
- State Rank: 49
- 95% Confidence Interval: +/- 1.3%
NEGATIVE HEALTH OUTCOMES AND COSTS OF OBESITY

Annual Medical Costs of Obesity:

$190 BILLION (in 2005 dollars)

or 21% of all medical spending

Negative Health Outcomes of Obesity:

Diabetes, Heart disease, stroke, dyslipidemia (e.g., High blood cholesterol and triglycerides), high blood pressure, metabolic syndrome, liver disease, gallbladder disease, kidney disease, asthma, sleep apnea, arthritis, chronic back pain, mobility limitations, some types of cancer, reproductive complications, pregnancy-related complications, poor health-related quality of life, increased all-cause mortality, decreased life expectancy, increased risk of hospitalization, depression, anxiety, substance use disorders
ACCESS TO HEALTHY FOOD IS AN EQUITY ISSUE

In part because of lack of access to healthy food in lower income neighborhoods, communities of color, and in rural areas:

- Adult obesity rates are 51 percent higher for African Americans than whites, and 21 percent higher for Latinos, and Black and Latino children are more likely to become obese than white children (CDC).
- Multiple studies show correlations between high rates of obesity, and diabetes and other illnesses among communities without access to fresh food (grocery stores or farmer’s markets).
HOW ACOs CAN IMPACT FOOD CHALLENGES

- Conduct Health Needs Assessments that include assessment of social determinants of health and social and other needs: know the problems for your communities
- Help enroll members in SNAP
- Include CBOs in networks of service providers and partner with food providers
- Implement CHC, co-location of staff/services and coordinated funding strategies
- Use community health workers, care coordinators and patient navigators to serve at the intersection of health, food, economic security and social services
- Partner with, and encourage investment in, grocery stores, mobile produce services, farmer’s markets
- Develop and disseminate food pantry resources /contacts
Lack of Transportation: Who is Affected

About 3.6 million Americans miss or delay health care every year because of transportation challenges.

Low income populations are most affected, along with:

- Seniors
- Children
- Communities of color
- People with chronic conditions

People with reliable access to transportation see their doctors about twice as often as people without it.
Evidence suggests that lack of transportation to access primary care, preventive care, and care for chronic conditions is correlated with:

- Higher rates of ED visits
- Higher rates of hospital readmissions
- Lower rates of medication adherence
- Worse clinical outcomes

Reducing readmissions and ED visits results in significant cost savings, which outweigh the costs of investing in transportation for patients.
OPTIONS AND SERVICES

- Provide effective and reliable non-emergency medical transportation
- Provide mobile services
- Expand tele-health services
- Provide services where people are
Incorporate churches, social service providers, and beauty salons into prevention and referral efforts

Hair stylists conducting breast cancer education in hair salons, screen for and make depression referrals

Mobile Services
Mammograms, asthma testing and treatment

Clinics in accessible community settings
Schools, churches
Increase use of telehealth services

- Psychiatric services for individuals in rural areas
- Connecting specialists to primary care in hard to reach areas (i.e., Diabetes management)
- Crisis services
HOW ACOs CAN IMPACT TRANSPORTATION CHALLENGES

- Conduct Health Needs Assessments that include assessment of social determinants of health and social and other needs
- Help enroll members in transportation services
- Provide transportation and reimburse for public transportation costs
- Include CBOs in networks of service providers and partner with transportation providers
- Provide services in schools, community centers, and other community locations on public transportation lines
- Provide mobile services, in-home services
- Implement patient-centered medical homes, co-location of staff/services and coordinated funding strategies
- Use community health workers, care coordinators and patient navigators to serve at the intersection of health, transportation, food, economic security and social services
- Partner with, and encourage investment in, innovative transportation solutions
**ADVERSE CHILDHOOD EXPERIENCES (ACEs) ARE PREVALENT**

ACEs lead to a downward health spiral
ACEs CORRELATE WITH POOR MEDICAL OUTCOMES

As the number of ACEs increases, so does the risk of numerous poor medical outcomes, including:

- Chronic obstructive pulmonary disease
- Ischemic heart disease
- Liver disease
- Myocardial infarction
- Fetal death
- Disability
- Coronary heart disease
- Stroke
- Diabetes
- Asthma
- Obesity
ACEs CORRELATE WITH POOR BEHAVIORAL HEALTH OUTCOMES

Adverse Childhood Experiences (ACE) have been found to correlate with an increased risk of numerous poor behavioral health outcomes, including:

- Alcoholism and alcohol abuse
- Depression and depressive disorders
- Mental distress
- Anxiety
- Illicit drug use
- Suicide attempts
- Hallucinations
- Childhood autobiographical memory disorder
Interpersonal Violence: Health Outcomes

Interpersonal violence is associated with both medically explained and unexplained medical complaints

- ACEs associated with maladaptive family functioning (household challenges and neglect) are linked with the highest risk of mental and psychiatric disorders
- Interpersonal violence is the potentially traumatic event most closely associated with the development of PTSD
- Recurrent headaches are closely correlated to experiences of interpersonal violence

Experiences of interpersonal violence correlate with a high risk of illicit drug use beginning in adolescence

Experiences of interpersonal violence (especially when it leads to PTSD) are correlated with later perpetration of intimate partner violence
Physical and Sexual Abuse: Health Outcomes

Childhood abuse is associated with increases in complaints across a wide spectrum that lead them to become high utilizers of medical and emergency care services

☑ Gastrointestinal health
☑ Gynecologic and reproductive health
☑ Cardiopulmonary symptoms
☑ Obesity, including morbid obesity
☑ PTSD
☑ Alcohol and substance use disorders (Opioid overdose)
☑ Body dissatisfaction and eating disorders (Binge eating disorder/Night eating syndrome)
☑ Personality disorders
☑ Depression, including dysthymia

☑ Non-explained medical symptoms, including chronic pain
☑ Respiratory disease
☑ Early adolescent tobacco use
☑ Suicide attempts
☑ Risky sexual behavior and sexually transmitted diseases
☑ Low self-compassion and self-esteem
☑ Somatization disorder
☑ Anxiety
Medical providers, especially primary care practitioners, are in a position to identify families who are in need of support and ACE prevention activities, and refer those families to the necessary programs.

The American Academy of Pediatrics publishes the Bright Futures Guidelines:
- Up-to-date information on preventive screenings and services by visits
- Visit-by-visit anticipatory guidance for healthcare providers

Research is showing that patient-centered medical homes and family-centered medical homes are more effective at identifying, preventing and mitigating ACEs.
Addressing ACEs in a Medical Setting: Appropriate Referrals

When identifying families at risk of ACEs, primary care physicians and the care managers with whom they work can make referrals to appropriate services:

- Home visiting programs like the nurse-family partnership
- Parenting training programs
- Intimate partner violence prevention programs
- Social and financial support for parents
- Teen pregnancy prevention and teen parenting support programs
- High quality, affordable childcare
- Mental health and substance abuse treatment

The presence of a behavioral health disorder in the home is an ACE that puts a child at risk for future poor health outcomes. Parental behavioral health disorders are a risk factor in the occurrence of other ACEs (e.g. abuse and neglect).

High-quality, comprehensive, integrated behavioral healthcare is the single most effective intervention for reducing the impact of ACEs on health outcomes.
How to Screen for Social Determinants of Health

- Contact with Member
- Conduct Assessment
- Intervention
- Follow-up
## SAMPLE SCREENING TOOLS: Accountable Health Communities

### Health-Related Social Needs

<table>
<thead>
<tr>
<th>Core Needs</th>
<th>*Supplemental Needs</th>
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<tbody>
<tr>
<td>Housing Instability</td>
<td>Family &amp; Social Supports</td>
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<tr>
<td>Utility Needs</td>
<td>Education</td>
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<tr>
<td>Food Insecurity</td>
<td>Employment &amp; Income</td>
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<tr>
<td>Interpersonal Violence</td>
<td>Health Behaviors</td>
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<td>Transportation</td>
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Five Keys to a Great Screening Tool:

1. Make it short and simple
2. Choose clinically validated questions at the right level of precision
3. Integrate into clinical workflows
4. Ask patients to prioritize
5. Pilot before scaling

Recommended Screening Tool – can be tailored to your ACO (see packet)

Collecting Member Demographic Data

To address health equity, MDDC is critical. ACO should consider collecting information on:

- Race/Ethnicity (as disclosed by Patient)
- Preferred language
- Sexual Orientation and Gender Identity (SOGI)
- Disabilities
- Veteran Status
HOW TO USE MDDC DATA

- Helps identify disparities; i.e. participation rates in Hep B treatment; lung cancer treatment, diabetes management
- Targets intervention to improve outcomes
- Implement programs to support a variety of patient populations
- Allows providers to provide more competent care

Equity Enhancement Program Spotlight
Using REAL Data to Reduce Disparities and Improve Quality of Care

Harborview Medical Center addresses disparities-sensitive quality measures and improves data stratification with the additional collection of granular ethnicity.
Role of ACO in Addressing Social Determinants of Health

CMMI Accountable Health Communities Model Tracks for Intervention

Track 1

Awareness
Increase beneficiary awareness of available community services through information dissemination and referral

Track 2

Assistance
Provide community service navigation services to assist high-risk beneficiaries with accessing services

Track 3

Alignment
Encourage partner alignment to ensure that community services are available and responsive to the needs of beneficiaries
“...ACOs can serve as effective bridge organizations”
<table>
<thead>
<tr>
<th>Intervention name</th>
<th>Description</th>
<th>Cost savings</th>
<th>Quality and care utilization measures</th>
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<tbody>
<tr>
<td>Adirondack Medical Home Demonstration</td>
<td>The Adirondack Medical Home Demonstration is a five-year pilot across payers and providers in the Adirondack region of New York State in which participating providers become NCQA-certified patient-centered medical homes (PCMHs). The payers distribute $7 per-member per-month to providers to support an extensive set of PCMH services, including employing care managers and community resource advocates who assist patients with social needs. The Hudson Headwaters Health Network, a participant in the Adirondack Medical Home Demonstration, has shown 15% to 20% savings for Medicaid beneficiaries.</td>
<td></td>
<td>After implementing a transition program for individuals discharged from the hospital, the Hudson Headwaters Health Network reduced its readmissions rate for targeted conditions from 19% to 7%. Within the Network, patients are assessed upon intake and referred to Community Resource Advocates to provide social supports, including assistance with housing/living conditions, food, and transportation.</td>
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<td>Camden Coalition of Healthcare Providers</td>
<td>The Camden Coalition of Healthcare Providers operates a care management program for high utilizers of health care services, where an outreach team assists participants with activities such as connecting to a medical home, obtaining housing and other public benefits, managing their legal needs, and meeting their personal goals. In the period post-intervention, average total hospital charges per month for 36 high utilizers fell by 56.4%, from $1,218,010 to $531,203.</td>
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<td>After participating in the intervention, the average total number of emergency department and hospital visits across 36 high utilizers fell by approximately 40%, decreasing from 61.6 to 37.2 visits per month.</td>
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<td>Community Asthma Initiative</td>
<td>The Community Asthma Initiative is an intervention operated out of Children’s Hospital Boston and a community health center, in which nurse case managers provide care coordination services for low-income children with asthma. The families receive home visits from nurses or community health workers supervised by nurses, who assess the families’ homes for asthma triggers, provide asthma remediation items, and connect families to community-based services. At two-year follow-up, the intervention saved $3,827 in decreased emergency department visits and hospitalizations per child when measured against a comparison group. The intervention cost $2,529 per child, resulting in a return on investment of 1.46.</td>
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<td>At 12 months into the intervention, participants experienced a 68% decrease in emergency department visits, an 85% decline in hospitalizations, and a 43% reduction in “days of limitation of physical activity.” In addition, children missed 41% fewer school days and their parents missed 50% fewer days of work.</td>
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<td>Frequent Users of Health Services Initiative</td>
<td>The Frequent Users of Health Services Initiative includes six hospital and community-based case management programs in California providing referrals to medical and social services for individuals who are frequent users of emergency departments.</td>
<td>After two years of program enrollment, average inpatient charges decreased by 69%, falling from $46,826 at one-year pre-enrollment to $14,684 at the two-year point.</td>
<td>Two years post-enrollment into the initiative, average inpatient days decreased by 62%.</td>
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<tr>
<td>Geriatric Resources for Assessment and Care of Elders (GRACE)</td>
<td>The GRACE intervention begins with a home visit by a nurse practitioner-led support team to assess low-income seniors' medical and psychosocial needs. The support team reports its findings to a larger group of health care professionals, which develops and implements a care plan to address the individual's needs, including those related to home safety and social support.</td>
<td>For individuals with a high-risk of hospitalization, a randomized controlled trial found similar costs between individuals participating in GRACE and a comparison group receiving usual care during the two years of the study. However, in the year following the intervention, individuals at high-risk of hospitalization participating in GRACE had significantly lower total mean costs than similar individuals in the comparison group: a difference of $5,088 v. $6,575, respectively.</td>
<td>Individuals receiving the intervention had a significantly lower rate of emergency department visits over a two-year period than individuals receiving usual care (1,445 per 1,000 v. 1,748 per 1,000). In addition, GRACE participants experienced statistically significant improvements on the SF-36 quality of life instrument in the areas of general health, vitality, social functioning, and mental health as compared with the usual care group.</td>
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<tr>
<td>Health Leads</td>
<td>In the clinics where Health Leads operates, physicians and other members of the clinical team can systematically screen their patients for unmet social needs and prescribe resources to meet those needs. Trained student Advocates connect the patients to community resources by leveraging a client management database and resource inventory. They then conduct follow-up to ensure the services were received, and loop back to the referring provider.</td>
<td>After the Dimock Center, a health and human services agency in Boston, instituted Health Leads, their pediatric social worker's average weekly billable therapy minutes increased by 57%.</td>
<td>In fiscal year 2013, 90% of patients with whom Health Leads worked successfully solved at least one need or reported that they are equipped to secure resources with the information provided by Health Leads and without further assistance.</td>
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## INTERVENTIONS – Cost Savings and Quality

<table>
<thead>
<tr>
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<th>Description</th>
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<tr>
<td>Medical-Legal Partnership</td>
<td>In the Medical-Legal Partnership (MLP), lawyers and paralegals work onsite in clinical settings or at locations affiliated with provider institutions and assist patients in addressing legal issues associated with health status.¹</td>
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<td>An MLP between a federally funded legal aid agency and a community health clinic in rural Illinois assisted individuals with appealing Medicaid coverage denials and obtained a 319% return on investment over a three-year period by obtaining reimbursement through health care recovery dollars.²</td>
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<td>In a small pilot study, adults with moderate to severe asthma who received services through an MLP in New York demonstrated a 91% decline in emergency department visits and hospital admissions. Approximately 92% of participants experienced a decrease of at least two asthma severity classes.³</td>
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<td>Seattle-King County Healthy Homes Project</td>
<td>The Seattle-King County Healthy Homes Project is an intervention in which community health workers conduct home visits for families of low-income children with uncontrolled asthma. Intervention participants received self-management support services including a home assessment for environmental triggers, help with reducing exposure to asthma triggers, and assistance in developing skills to better control asthma, such as correct use of medications.⁴</td>
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<td>Urgent care costs for participants in the high-intensity version of the intervention were estimated to be $201–$334 per child less than those in the low-intensity version of the intervention.⁵</td>
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<td>For participants in the high-intensity version of the intervention, from baseline to the period post-intervention, the percentage of participants using urgent health services over the past two months declined from 23.4% to 8.4%, a greater decline than observed in the low-intensity group. In addition, symptom-free days and asthma-related quality of life for the children’s caregivers improved more among families in the high-intensity group.⁶</td>
<td></td>
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</tr>
</tbody>
</table>
INTERVENTIONS
SCREENING AND INTERVENTION EXERCISE
HMA Community Strategies
## INTERVENTIONS – EXERCISE

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>SDH Screening Question (validated)</th>
<th>Action in Health Center (Resources available)</th>
<th>Health Center Team for Follow-Up (who will follow-up and how?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td></td>
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<tr>
<td>Transportation</td>
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<tr>
<td>Utilities</td>
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<tr>
<td>Food</td>
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<tr>
<td>Safety or ACE</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Financial Security</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
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</tr>
</tbody>
</table>
Agenda

Goals for Today

Enrollment Processes and Member Engagement

Social Determinants of Health

ACO Team to Address Unmet Social Needs

Adaptive Leadership Skills

Break-Out Session

Summary of the Series
ACO STAFFING

WHO CURRENTLY USES COMMUNITY HEALTH WORKERS? HOW ARE THEY BEING USED?

HMA Community Strategies
Population Health Management

**PATIENT POPULATION**

- Attributed Members/Not Yet Patients
- Well Populations
- Chronic Conditions
- Elevated Need, Elevated Cost
- High Need, High Cost

**INTERVENTION**

- Wellness Initiatives
- Engagement and Outreach
- Care Coordination
- Care Management
- Complex Care Management
- Moderate Risk
- Low Risk
- Potential Rising Risk
- High Risk

**POPULATION HEALTH MANAGEMENT**
Section III: Care Delivery/HIT and HIE
Part 1: Population Health Management

Gaps

- **Proactive Alerts (CORE):** 9% said providers/care team members receive proactive alerts in their EHR for ER utilization and inpatient hospitalization (2 Yes; 3 Partial)
- **Super Utilizers (CORE):** 18% create an actionable list of “Super utilizers” (e.g. patients who have frequent ED use or hospital readmissions) (4 Yes; 11 Partial)
- **At-Risk Patients (CORE):** 23% create an actionable list of other patients at-risk for hospital admission (5 Yes; 9 Partial)

How can COMMUNITY HEALTH WORKERS fill these gaps?
Section III: Care Delivery/HIT and HIE
Part 2: Care Management

Gaps

- **Care plans (CORE):** 45% use a care plan as a source for the management of care (10 Yes; 10 Partial)
  - Only 36% have access to an electronic care management system for the care plan (8 Yes; 4 Partial)
- **Risk stratification (CORE):** 36% do risk stratification (8 Yes; 5 Partial) and 36% capture it as structured data
- **Outreach and engagement (CORE):** 18% have a strategy to outreach to and engage managed care members who are assigned to you but have never been seen in your health center (4 Yes; 8 Partial)
- **Hospital relationships:** 32% have good relationships and processes built with hospitals (e.g., hospital ED care navigators, discharge planners, coordinators) utilized by your patients for routine communications and handoffs (7 Yes; 10 Partial)

How can COMMUNITY HEALTH WORKERS fill these gaps?
Section III: Care Delivery/HIT and HIE
Part 3: Patient-Centeredness

Gaps

- **Patient visit cycle time**: 41% track patient visit cycle time (9 Yes; 4 Partial)
- **Patient feedback**: 64% said difficulty accessing appointments when needed/desired and wait times to see provider for appointment are consistently top issues mentioned in patient feedback (14 CHCs)
- **Patient education materials (CORE)**: 41% have developed patient education materials, information on tests and procedures in multiple languages and at appropriate health literacy levels (9 Yes; 11 Partial)

How can COMMUNITY HEALTH WORKERS fill these gaps?
To best manage your patient panel, these questions should be considered:

✚ Am I using the appropriate staff for the intervention? (clinical vs non-clinical, etc.)

✚ What is the appropriate panel size per staff?

✚ Should I hire an RN, social worker, MA, Care Manager, CHW, Peer Educator, Pharmacists?

✚ Should my care managers be located at the clinic or in the community?

✚ What time of relationship should care managers have with providers? Should they be required to document in HER?

✚ Are there models that already exist?

✚ How do we determine or measure success?
ACO STAFFING

Community Health Workers or Peer Educators.

- Transitional Care Coordination
- Patient Engagement
- Disease Specific Care Coordination
- Education and Referral
**Use Event Notification**
Real-time notification of acute events, i.e. hospitalization

**Bedside Engagement**
Warm handoff from hospital staff to Clinic Staff.

**Home Visit**
Home visit within 3 – days of post-discharge; Rx reconciliation

**90-day Care Plan**
CHW and RN creates 90-day care plan that addresses SDoH

**PCP Follow-Up**
Get patient back to PCP within 7-days of discharge. Share Care plan with PCP
Community Health Workers
From the same communities as your patients

- Outreach
  - Regular communication based on patient’s preferred method
- Follow-up to patient’s overdue for wellness visits
- Help engage patients around self management and adherence to care plans
- Health Literacy
Support the prevention and control of Chronic Diseases and Assist in Self-Management

Patient Education
About lifestyle changes and adherence to medication regimens and recommended treatments

Patient Navigation
Help patients and their families navigate the health care system, i.e. appointments, referrals, transportation

Self-Management
Support and assess patient’s ability to self-manage chronic disease.

Outreach and Engagement
Increase team’s cultural competence in reaching out and engaging member
Community Health Workers are considered trusted advocates and can easily engage patients’ regarding unmet social needs.

Once screening has occurred and needs have been identified, CHWs can play a critical role in linking the patients to critical community resources.

Trusted Advocate
Community Health Workers are considered trusted advocates and can easily engage patients’ regarding unmet social needs.

Community Resources
Once screening has occurred and needs have been identified, CHWs can play a critical role in linking the patients to critical community resources.
“Evidence demonstrates that CHW interventions with high resource utilization results in savings to the medical system.”

EXAMPLE 1: Molina Healthcare CHW outreach, education, advocacy and referral services for high-risk patients.

Net cost savings: $1,522,722

EXAMPLE 2: Boston Children’s Hospital Pediatric Asthma Community-Based Case Management Program

ROI: 1.33
“Most of what drives health care utilization happens outside of the traditional health care delivery system” Hennepin Health, ACO

Community Health Workers are the bridge to the community. They can engage patients in meaningful relationships that improve adherence to care plans and care coordination efforts between the continuum of care.

CHWs know the community and have a unique perspective and ability to build trusting relationships with a diverse population who have not traditionally been served well by traditional delivery systems.
Maximize value of Community Health Workers – they are the bridge to the community in which your patients live. They can help both patients and providers.

- CHWs should reflect the patient population both in culture and language.

- Ensure CHWs have been certified and are well trained. Support career development.

- Educate staff about CHW contribution and specific role. Ensure proper communication among team.

- Ensure CHWs have reasonable case load and empower CHWs.
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Break-Out Session

Summary of the Series
Organizations do not change until the people within them change and decide to change the organization.

- John Kotter
THE REASON TO CHANGE IS A BETTER FUTURE...

But.....

• Change is:
  • Stressful
  • Draining
  • Strains relationships
Beliefs behind Dr. Ron Heifetz’ work:

• Problems are embedded within complicated and interactive systems

• Much of human behavior reflects an adaption to circumstances.

• People adapt more successfully to their environments by facing painful circumstances and developing new attitudes and behaviors.
TYPES OF SITUATIONS REQUIRING LEADERSHIP

- **Technical**
  - Apply abilities that already exist in the system’s capabilities
    - Current metrics
    - Increasing or decreasing FTEs

- **Adaptive**
  - People deeply and broadly within the organization need to learn new capabilities
    - New metrics to support vision

- **ADAPTIVE WORK DIMINISHES THE GAP BETWEEN THE WAY THINGS ARE AND THE WAY THINGS NEED TO BE TO CREATE A BETTER FUTURE**

- **ADAPTIVE LEADERSHIP IS THE ACTIVITY THAT MOBILIZES PEOPLE TO PERFORM ADAPTIVE WORK**
PROPERTIES OF AN ADAPTIVE CHALLENGE

- Gap between aspirations and reality (vision versus regulatory requirements)
- Tension between values
- Requires difficult learning
- Involves loss
- Loyalties need to be refashioned
- New competencies must be developed
- Shareholders have problem solving responsibility
- Takes longer than technical work
- Requires experimentation
- Generates disequilibrium, distress and work avoidance
Technical vs Adaptive Work

Disequilibrium

Energy for Change

Technical Problem

Adaptive Challenge

Time

Limit of tolerance

PRODUCTIVE RANGE OF DISTRESS

Threshold of learning

H E A L T H  M A N A G E M E N T  A S S O C I A T E S
Exercising leadership to do adaptive work means disappointing people’s expectations at a rate they can tolerate.
ADAPTIVE WORK MEANS GRAPPPING WITH:

- Competing values
- Changing attitudes
- Encouraging new learning
- Developing new behaviors
- Holding the tension of polarities
  - “Both AND” rather than “Either OR”
• Make it safe to disagree and debate but not OK to opt out and disengage
• Talk honestly to one another about the challenge
• Listen with genuine interest to the various points of view
• Build trust
• Have difficult conversations
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<td>Adaptive Leadership Skills</td>
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<td>Break-Out Session and Report-Out</td>
</tr>
<tr>
<td>Summary of the Series</td>
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</tbody>
</table>
Developing your ACO “Stump Speech”

• **Objective:** To develop an ACO "Stump Speech" that communicates the imperative for change and engages teams and individuals in the work ahead to realize the goals of the ACO.
What are the key terms your group used in your stump speeches?

How did you create the productive tension needed to inspire change?

How are messages for patients similar and different?
Agenda

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Break-Out Session

Summary of the Series
Readiness for Value-Based Payment

- Requires new skills, capacity, and systems for managing clinical, financial, and operational performance and risk, including:
  - Engaging *attributed* patients
  - Being able to *reliably* achieve performance for care, outcomes, and costs across multiple dimensions
  - Employing advanced methods for population health management, care coordination, clinical care management, and care transitions inside and outside of your walls
  - Integrating services and care
  - Managing operational efficiency
  - Managing patient utilization of services and costs per patient
  - Reducing the total cost of care per patient
# Results Summary: Core Gaps

<table>
<thead>
<tr>
<th>Category from Assessment</th>
<th>Core Element</th>
<th>% of CHCs (out of 22) w/Core Element Gap*</th>
<th>Timing priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Efficiency of Current Operations</td>
<td>Provider productivity (visits) measured/monitored on a regular basis</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Partnership Readiness</td>
<td>Agreements/relationships with hospitals</td>
<td>5%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient-Centeredness</td>
<td>Same-day appointments for patients who need them</td>
<td>9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient-Centeredness</td>
<td>Offer enhanced access (e.g., evening/weekend hours, phone consultations)</td>
<td>18%</td>
<td>Yes</td>
</tr>
<tr>
<td>Population Health Management</td>
<td>Technology to support retrieving, storing, calculating and reporting on clinical quality metrics</td>
<td>23%</td>
<td>Yes</td>
</tr>
<tr>
<td>BH/PC Integration</td>
<td>Primary care and behavioral health staff document in a shared medical record</td>
<td>23%</td>
<td>Yes</td>
</tr>
<tr>
<td>Financial Health</td>
<td>Have sustained operating surpluses in each year of the prior 3-year period</td>
<td>23%</td>
<td>Yes</td>
</tr>
<tr>
<td>BH/PC Integration</td>
<td>Behavioral health staff on site and integrated into clinical care teams</td>
<td>27%</td>
<td>Yes</td>
</tr>
<tr>
<td>Financial Analysis of Patient-Centered Care</td>
<td>Analyze total, annual cost per patient</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Care Management</td>
<td>Offer care management services; coordinated system of care</td>
<td>32%</td>
<td>Yes</td>
</tr>
<tr>
<td>Cost Efficiency of Current Operations</td>
<td>Use a cost-based charge structure</td>
<td>36%</td>
<td>Yes</td>
</tr>
<tr>
<td>Cost Efficiency of Current Operations</td>
<td>Analyze cost per visit as well as cost per patient on a regular basis to identify cost efficiencies</td>
<td>41%</td>
<td>Yes</td>
</tr>
<tr>
<td>Financial Health</td>
<td>Have working capital reserves in excess of 30 days and a positive net assets available for operations</td>
<td>41%</td>
<td>Yes</td>
</tr>
<tr>
<td>Population Health Management</td>
<td>Quality reports/data inform patient outreach</td>
<td>50%</td>
<td>Yes</td>
</tr>
<tr>
<td>Care Management</td>
<td>Use care plans for care coordination</td>
<td>55%</td>
<td>Yes</td>
</tr>
<tr>
<td>Financial Analysis of Patient-Centered Care</td>
<td>Employ professional coders to ensure the accuracy of provider coding practices and documentation</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Patient-Centeredness</td>
<td>Assess and address patients' linguistic and cultural needs</td>
<td>59%</td>
<td>Yes</td>
</tr>
<tr>
<td>Financial Analysis of Patient-Centered Care</td>
<td>Providers trained on appropriate coding practices and provider coding reviewed on a regular basis</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td>Financial Analysis of Patient-Centered Care</td>
<td>Analyze patient utilization of specific services</td>
<td>64%</td>
<td>Yes</td>
</tr>
<tr>
<td>Financial Health</td>
<td>Have adequate financial management system</td>
<td>68%</td>
<td>Yes</td>
</tr>
<tr>
<td>Board, Leadership and Strategic Readiness</td>
<td>Performance management dashboard</td>
<td>73%</td>
<td>Yes</td>
</tr>
<tr>
<td>Care Management</td>
<td>Conduct patient assessments and capture results as structured data in EHR, care plan or other database (including risk assessment and risk stratification)</td>
<td>73%</td>
<td>Yes</td>
</tr>
<tr>
<td>Cost Efficiency of Current Operations</td>
<td>Evaluate productivity based on Relative Value Units</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>Care Management</td>
<td>Strategy to outreach to and engage attributed managed care members</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Population Health Management</td>
<td>Have and use an actionable patient registry</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td>Board, Leadership and Strategic Readiness</td>
<td>Board engagement</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>Population Health Management</td>
<td>Real-time communication and alerts, including proactive alerts for ER and hospital use</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Board, Leadership and Strategic Readiness</td>
<td>Staff readiness</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Partnership Readiness</td>
<td>Agreements/relationships with other medical providers and social service agencies</td>
<td>100%</td>
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</tbody>
</table>

*Green indicates a strength. Red indicates an area for improvement. White indicates a % in the middle.*
Overview of Value Based Payment Readiness: There are a limited number of high-value structures, investments and priorities that can streamline transition to value-based payment environments and can help ensure success in that environment.

- Board, Leadership and Staff Engagement and Readiness
- Building Partnerships
- Population Management and Risk Stratification
- Care Management
- Financial Management
What we discussed:

1. Building adaptive leadership capacity to lead changes
2. Strategies for broad-based engagement and participation to improve quality
3. Alignment of incentives and compensation
4. Prioritization of tasks and finding some time: killing some zombies
What we discussed:

• Defining the tasks for the health center, for the ACO and for the MCO (as applicable)
• Using technology for connectivity, communication and collaboration across the continuum of care
• Engaging with community based organizations to achieve alignment and meet SDH needs of communities and patients
What We Discussed:

• Registry exercises: Define data elements in risk stratification methodologies, test assumptions
• High risk and rising risk, with link to the total cost of care
• Gathering and using data on risk, including social risk factors
• Incorporating social determinants of health in a meaningful way
• Attribution and members not currently engaged in care
What We Discussed:

• Defining Care Coordination/ Care Management tasks and roles, matching the appropriate staff with diverse skill sets

• Estimate volume of staff needed for Care Coordination/ Management; cost implications of the model

• Primary Care and Behavioral Health Integration
What We Discussed:

• Review of the “three-legged stool” of VBP arrangements: base compensation, global payments, quality incentives

• Revenue enhancements and cost efficiencies required to manage peaks and valleys of VBP cash flow

• Funds flow and negotiation strategies within ACO

• Three year financial modeling including cash positions
• Evaluation of this four-part series coming your way – stay tuned.

• Please complete the evaluation of this session on your tables.

THANK YOU