Massachusetts League of Community Health Centers: ACO Technical Assistance

May 19, 2017
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Facilitator</th>
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</table>
| 9:30 – 10:00 | Welcome and Introductions  
Review of the VBP TA Series and Goals for Today | Ellen Hafer, Mass League          |
| 10:00 – 11:30 | Review of Key Findings from VBP Readiness Survey:  
Challenges and Opportunities | Deborah Zahn; Peter Epp           |
| 11:30 – 12:15 | Creating Your Roadmap for VBP Readiness | Deborah Zahn; CHC teams           |
| 12:15 – 1:15 | LUNCH                                                                      |                                    |
| 1:15 – 2:15 | Adaptive and Technical Changes                                        | Lisa Whittemore                    |
| 2:15 – 2:30 | BREAK                                                                      |                                    |
| 2:30 – 3:15 | Building Your Pyramid                                                  | Lisa Whittemore                    |
| 3:15 – 3:30 | Wrap Up/Next Steps                                                     | Lisa Whittemore                    |
Agenda

Goals for Today

VBP Readiness Assessment Findings

Roadmap for VBP Readiness

Adaptive and Technical Change Management

Building Your Pyramid: Risk Stratification

Wrap Up/Next Steps
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
- Data systems and internal reporting
- Quality and incentive model, compensation systems

Elements for Success – Population Management:
- Empanelment/engagement
- Enrollment
- Best practices to achieve quality, outcomes improvements
- Health risk assessments and follow-up

Elements for Success: ACO Risk Stratification and Coding for Improvement
- Coding in new MassHealth environment
- Approaches to risk stratification for financial and quality improvements
- Role of social determinants
Goals for Today

• Review and understand the challenges and opportunities for CHCs based on the results of the Value-Based Payment Readiness Assessment Tool
• Develop a Roadmap to address opportunities with 30-, 60-, and 90-day timeframes
• Discuss approaches for managing change and creating strategies to sustain the change
• Begin developing integrated approaches for risk stratification
Agenda

Goals for Today

VBP Readiness Assessment Findings

Roadmap for VBP Readiness

Adaptive and Technical Changes

Build Your Pyramid: The New Risk Stratification

Wrap Up/Next Steps
VBP Readiness Assessment Results: Identification of Strategic Opportunities

Presented to MLCHCC
December 22, 2016
Revised April 28, 2017
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
Value-Based Payment (VBP) Readiness Assessment: Aggregated Results
Survey Analysis: Methods and Considerations

• The tool was designed by HMA and CohnReznick in partnership with the DC Primary Care Association
• 25 Health Centers requested the survey; 22 CHCs returned the assessment (see Appendix for list of all Health Centers)
• All scored elements counted the same (high-priority elements were not weighted higher in the aggregate scores)
• Aggregate scores show the percentage of health centers that answered “Yes” or “Fully”
  – If a health center responded “Partial,” it was treated the same as a “No”
• Responses were self-administered and self-reported; not independently validated
• Aggregate scores do not speak to the variation in clinic responses
  – Question level responses are included in Appendix
<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>
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<tbody>
<tr>
<td><strong>Board, Leadership and Strategic Readiness</strong></td>
<td>Board engagement</td>
<td>91%</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Staff readiness</td>
<td>100%</td>
<td>Yes</td>
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<td></td>
<td>Performance management dashboard</td>
<td>73%</td>
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<tr>
<td><strong>Partnership Readiness</strong></td>
<td>Agreements/relationships with hospitals</td>
<td>5%</td>
<td>Yes</td>
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<td></td>
<td>Agreements/relationships with other medical providers and social service agencies</td>
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<td>Yes</td>
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<tr>
<td><strong>Population Health Management</strong></td>
<td>Technology to support retrieving, storing, calculating and reporting on clinical quality metrics</td>
<td>23%</td>
<td>Yes</td>
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<td></td>
<td>Real-time communication and alerts, including proactive alerts for ER and hospital use</td>
<td>91%</td>
<td>Yes</td>
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<td></td>
<td>Quality reports/data inform patient outreach</td>
<td>50%</td>
<td>Yes</td>
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<td></td>
<td>Have and use an actionable patient registry</td>
<td>86%</td>
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<tr>
<td><strong>Care Management</strong></td>
<td>Offer care management services; coordinated system of care</td>
<td>32%</td>
<td>Yes</td>
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<td></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>
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<td></td>
<td>Use care plans for care coordination</td>
<td>55%</td>
<td>Yes</td>
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<td></td>
<td>Strategy to outreach to and engage attributed managed care members</td>
<td>82%</td>
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<td><strong>Patient-Centeredness</strong></td>
<td>Same-day appointments for patients who need them</td>
<td>9%</td>
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<td></td>
<td>Offer enhanced access (e.g., evening/weekend hours, phone consultations)</td>
<td>18%</td>
<td>Yes</td>
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<td></td>
<td>Assess and address patients' linguistic and cultural needs</td>
<td>59%</td>
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<td><strong>BH/PC Integration</strong></td>
<td>Behavioral health staff on site and integrated into clinical care teams</td>
<td>27%</td>
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<td>Primary care and behavioral health staff document in a shared medical record</td>
<td>23%</td>
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<td><strong>Cost Efficiency of Current Operations</strong></td>
<td>Provider productivity (visits) measured/monitored on a regular basis</td>
<td>0%</td>
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<td></td>
<td>Analyze cost per visit as well as cost per patient on a regular basis to identify cost efficiencies</td>
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<td></td>
<td>Use a cost-based charge structure</td>
<td>36%</td>
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<td></td>
<td>Evaluate productivity based on Relative Value Units</td>
<td>77%</td>
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<td><strong>Financial Analysis of Patient-Centered Care</strong></td>
<td>Providers trained on appropriate coding practices an provider coding reviewed on a regular basis</td>
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<td></td>
<td>Employ professional coders to ensure the accuracy of provider coding practices and documentation</td>
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<td></td>
<td>Analyze patient utilization of specific services</td>
<td>64%</td>
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<td></td>
<td>Analyze total, annual cost per patient</td>
<td>27%</td>
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<td><strong>Financial Health</strong></td>
<td>Have working capital reserves in excess of 30 days an a positive net assets available for operations</td>
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<td></td>
<td>Have adequate financial management system</td>
<td>68%</td>
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<td>Have sustained operating surpluses in each year of the prior 3-year period</td>
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Overview

- Moving to a VBP model will likely be a significant shift
- Important that Board and all staff—leadership, frontline clinical and non-clinical staff, and other support staff—understand the reason for change and are willing and able to participate in the planning and execution of VBP strategies
- In particular, the role of the Board and leadership in supporting the changes is critical as is the need for a performance dashboard that enables you to track and respond to key metrics

This section includes:

- Board Engagement
- Executive Data
- Staff Readiness
Section I: Board, Leadership, and Strategic Readiness

**Strengths**

- **Patient Experience Survey Tracking:** 91% of health center/practice's management team regularly track the results of a patient experience survey (20 Yes; 2 Partial)

**Gaps**

- **Board Engagement (CORE):** 36% said health center/practice engaged in a comprehensive strategic planning process with Board and other key stakeholders that prepares for the transition to VBP while maintaining fidelity to organization’s mission, vision and values (8 Yes; 8 Partial)
- **Clinical Leadership Readiness:** 32% said clinical leadership is fully knowledgeable about and on board with movement toward payment reform. (7 Fully; 14 Partially)
- **Staff Readiness (CORE):** Although only 18% said providers and staff are Fully active in or willing to participate in practice transformation initiatives, 73% responded Partially. (4 Fully; 16 Partially)
- **Organizational Risk (CORE):** Only 14% said health center/practice determined the level of risk their organization is willing to take in relation to value-based payment through a process that included executive leadership and members of the governing Board. (10 No; 9 Partial)
- **Performance Management Dashboard (CORE):** 27% said health center/practice's leadership team have access to a performance management dashboard that enables it to monitor and respond to critical organizational indicators in real time (4 No; 12 Partial)
- **Staff Knowledgeable/On Board:** None said that providers and staff are Fully knowledgeable about and on board with participation in value-based payment models. (8 No; 14 Partially)
Considerations for Next Steps

• Need for enhanced engagement with Board, clinical leadership, and staff around VBP concepts and planning

• Need for improved data and processes to more specifically address levels of financial risk that the CHCs can take on.

• Need for fully-developed performance dashboard creation and use to measure organizational progress linked to key VBP metrics.

• While...addressing and minimizing “change fatigue” among staff and providers.
Section II: Partnership Readiness

Overview

- Partnerships with other health care providers along the entire continuum of care are critical to ensuring that your health center can effectively coordinate and manage health care and costs of patients for whom you will be responsible.
Section II: Partnership Readiness

CORE Strengths – Social Service/Medical Provider Contracts

• **Agreements with Hospitals:** 95% have agreements with hospitals (21 Yes)
• **BH Agreements:** 86% have agreements in place to serve the entire range of BH disorders (19 Yes)
• **Agreements with Schools:** 41% have agreements with schools/education organizations (9 Yes)

*Note: Some CHCs commented that they have relationships with many of the types of providers/organizations in the assessment even though they may not have formal agreements.*
Section II: Partnership Readiness

CORE Gaps – Social Service/Medical Provider Contracts

- **Agreements with Skilled Nursing/Long-Term Care:** Only 18% have agreements with skilled nursing/long-term care (4 Yes)
- **Agreements with Supported Employment Agencies:** Only 14% have agreements with supported employment agencies (3 Yes)
- **Agreements with Corrections:** Only 14% have agreements with Department of Corrections (3 Yes)
- **Agreements with Child Welfare:** Only 5% have agreements with child welfare (1 Yes)

Note: Some CHCs commented that they have relationships with many of the types of providers/organizations in the assessment even though they may not have formal agreements.
Behavioral Health Gaps

• Although most CHCs (86%) said they have agreements in place to serve the entire range of BH disorders, the following behavioral health service/provider gaps were noted in assessment:
  – Substance abuse
  – Severe mental illness
  – Pediatric BH
  – Pediatric inpatient psych
  – Developmental disability
  – Multilingual BH clinicians
  – Clinicians that accept patients’ insurance
Considerations for Next Steps

Creating a deliberate continuum of care to support patients in multiple care settings is key for VBP readiness:

• Identify CHCs best practices/most successful collaborations in order to advance a CHC-promulgated process for hospital communications:
  – Could be related to Care Management, event alerting, specific disease processes, etc.

• As ACOs mature, partnerships with Community-Based Organizations become more critical for success

• Identify best practices and collaboration agreements with SNFs that can be shared to support care transitions and linkages back to primary care prior to SNF/Rehab discharge

• Next step after access to behavioral health providers, is integration into the care team
Overview

• Effectively managing patient populations requires collecting and reporting accurate and comprehensive data about that population, in as real time as possible.
• Care team must have actionable data at the point of care to make appropriate clinical decisions and avoid duplication or unnecessary tests and services.
• Transitions of care can be costly
  – If managed appropriately with real-time data, they can be an opportunity to control costs and improve outcomes.

This section includes:

• Quality Improvement
• Data Monitoring
• Use of Alerts and Decision Support Tools
• Registries
• Quality Measures & Incentive Reporting
  • 77% have the technology to support retrieving, storing, calculating and reporting out on clinical quality metrics (CORE) (17 Yes; 5 Partial)
    • Of those 17 that said Yes, 53% have QI payment provisions with 3rd party payer contracts (9 Yes; 2 Partial)
  • 73% said quality/outcome measures are reviewed with clinical leadership and providers (16 Yes; 5 Partial)
  • 50% utilize quality/data reports to inform patient outreach when appropriate (CORE) (11 Yes; 10 Partial)
• Patient registry (CORE): 59% have an actionable patient registry (13 Yes; 7 Partial) and 55% use it (12 Yes; 8 Partial)
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)
Many CHCs have critical building blocks in place

- Nearly all CHCs reported QI work in major chronic disease initiatives, including diabetes, hypertension, coronary artery disease, CRCA
- All CHCs said they report on clinical quality metrics, including UDS, MU, CTC, HEDIS
- 95% of CHCs reported at least quarterly reviews of outcome measures with clinical leadership and providers
- 45% have a workflow in place to act on real time ED/inpatient alerts
Section III: Care Delivery/HIT and HIE
Part 1: Population Health Management

- At some CHCs, there are population health management tools available that are not fully utilized
  - Example: 45% have evidence-based clinical protocols and decision support tools in their EHR but only 30% of those said fully providers embrace their use

- Most do not have critical elements that enable managing care, outcomes, and costs under VBP contracts, including:
  - Proactive alerts
  - Actionable list of “Super utilizers” or other patients at-risk for hospital admission
Considerations for Next Steps

• While CHCs report they use data to monitor patient gaps, there is considerable variability across the health centers

• Using the quality framework developed for the MassHealth ACOs, work with participating CHCs to ensure they can retrieve data that will support excellence in the contract (partnership with DRVS)

• Develop a training to support working with the data to manage populations and performance
Considerations for Next Steps

• Pursue alerts for ED and inpatient utilization:
  – What are the considerations for acquisition/definition of tools the Mass HiWay or other venues?
  – Develop a CHC-defined set of standard practices that would be used with all hospital partners and support measurable improvements in reducing use of ED for ambulatory care sensitive conditions.

• Increase number of CHCs with actionable patient registries:
  – Is this an opportunity for DRVS or another platform?
Section III: Care Delivery/HIT and HIE
Part 2: Care Management

PATIENT POPULATION

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<tr>
<th>Risk Management</th>
<th>Expense Management</th>
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<tr>
<td>Attributed Members/Not Yet Patients</td>
<td>BHCPs...</td>
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<tr>
<td>High Need, High Cost</td>
<td>Elevated Need, Elevated Cost</td>
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<td>High Risk</td>
<td>Complex Care Management</td>
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<td>Moderate Risk</td>
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<td>Care Coordination</td>
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<td>Wellness Initiatives</td>
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<td>Engagement and Outreach</td>
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INTERVENTION

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<td>Well Populations</td>
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Section III: Care Delivery/HIT and HIE
Part 2: Care Management

**Strengths**

- **Care management (CORE):**
  - 68% offer care management services (15 Yes; 7 Partial)
  - 68% have CM services integrated into the care team (15 Yes; 7 Partial)
- **Risk assessments (CORE):** 86% do risk assessments (13 Yes; 7 Partial) and 59% capture it as structured data
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)
Care Management Capacity

Number of CM FTEs and Individuals

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<th>#</th>
<th>CHC</th>
<th>FTE</th>
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<td>9</td>
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<td>3.25</td>
<td>20</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>10</td>
<td>2.75</td>
<td>3</td>
<td>21</td>
<td>13.5</td>
<td>14</td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>3</td>
<td>22</td>
<td>14</td>
<td>14</td>
</tr>
</tbody>
</table>

Average: 4.7 FTEs, 7.1 individuals

- CHCs had between 1-14 CM FTEs and 1-50 individuals spending at least some of their time in that role.
- CMs represented a variety of disciplines, both licensed (RNs, MSW, BSW, CDEs) and non-licensed (CHWs, PNs).
- Variation in training the CHCs provided to care managers in these roles.
Distribution of Care Management FTEs Across CHCs

Most of the CHCs that took the assessment have fewer than 6 CM FTEs.
Considerations for Next Steps

• Full commitment to Care Management staff across CHCs:
  – For CHCs using RNs or other professional staff for CM, are there opportunities to leverage best practices, education/training needs, assessment of deployment of CHWs?
  – Do you want/need TA to design effective and consistent CM programs with shared performance goals for quality and Total Medical Expense/Total Cost of Care?
  – Need to assess the use of CMs to work with a CHC-defined rising risk population
Considerations for Next Steps

• While majority of CHCs complete Health Risk Assessments, only 8 report use a risk stratification tool:
  – Need to develop systems to routinely use HRAs and do risk stratification
  – Is this a League purchasing option? To assess options to collectively acquire/purchase tool for use by all CHCs to improve understanding of member risk profiles?
Section III: Care Delivery/HIT and HIE
Part 3: Patient-Centeredness

Overview

- The care team must have a thorough understanding of their population, including the language, cultural, and social environments in order to provide meaningful care that will help implement improvements in health status.
- Patients should be the center of their care, including but not limited to being an active contributor to the care plan.
- Access to services should be available during and outside traditional business hours to effectively manage urgent concerns and avoid unnecessary ED visits.
- Experienced nursing staff can assess the urgency of medical complaints and can work with a provider when necessary in order to accommodate the appropriate level of care needed.

This section includes:

- PCMH
- Patient-Centered Care
- Enhanced Access
- Cultural/Linguistic Competency
Strengths

- **PCMH/PCHH Recognition**: 86% currently recognized as a PCMH or PCHH (19 Yes)
- **Care Teams**: 59% have care teams (13 Yes; 7 Partial) and 55% said their care team members meet once a day at least 3x per week in a brief huddle either at the start or end of the day (12 Yes; 7 Partial)
- **Patient Satisfaction Surveys**: 100% collect patient satisfaction data through a survey tool (22 Yes)
- **Nurse Triage (CORE)**: 68% said they have an individual engaged full time in clinical nursing for triage, care coordination and/or telephone consultation services (less than 20% administrative office work) (15 Yes; 4 Partial)
- **100%** of those that offer triage offer phone nurse triage during operating hours (15 Yes); **47%** after hours (7 Yes)
- **Same-Day Appointments (CORE)**: 91% offer same-day appointments for urgent and non-urgent care (20 Yes; 2 Partial)
- **Evening/Weekend Hours**: 86% have evening hours at least 3 days per week (19 CHCs); 77% have weekend hours every weekend (17 CHCs)
- **Language Services**: 77% said adequate language translation/interpretation services are available for patients (17 Yes; 5 Partial)
- **Patient Portal**: 82% provide use of an electronic patient portal (18 Yes; 2 Partial). One CHC said that more than 50% of patients use the electronic patient portal for any reason.
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)
Considerations for Next Steps

• Need a targeted effort to fully implement care teams
  – With systems that support their high functioning
  – Composition and scope defined by risk stratification and levels of care model

• Need to ensure the basic building blocks of access are in place
  – Need to implement or further implement/refine advanced access since many said that patients consistently have difficulty accessing appointments when needed/desired
  – Need to implement systems to track and act on patient visit cycle time

• Consider opportunities to jointly develop patient education materials and vehicles
  – CHC success under VBP depends on patient behavior change, self-care, and self-management

• Can increase communications via patient portal and/or design common patient portal capabilities for designated populations
Overview

- Nearly half of patients with one or more of the top five chronic medical conditions treated in primary care also suffer from a co-existing behavioral health issue.
- Providing primary and behavioral health care in one location by one integrated care team leads to improved outcomes (clinical and financial) for both medical and behavioral health issues as well as significantly lower long-term health care costs.
- The behavioral health staff should function as a core team member, not ancillary staff.
**Strengths**

- **BH Services Available**: 91% have BH services available to patients in the same physical facility as the medical care (20 Yes; 1 Partial)
- **BH Services Co-Located (CORE)**: 73% have a BH trained staff member part of the clinical care team, located on-site and available to confer with the team throughout the day (16 Yes; 4 Partial)
  - Of these 20 CHCs, 55% said the BH staff are available 100% of the time (11 CHCSs)
- **Shared Medical Records**: 77% said primary care and BH staff document in a shared medical record (17 Yes; 3 Partial)
- **BH services available**: 64% said patients could usually be seen the same day for a BH appointment (14 CHCs)
- **Care Review Meetings**: 55% said their clinical team has time set aside to discuss complicated or difficult cases, not including a brief huddle (12 Yes; 7 Partial)

**Gaps**

- **Care Review Meetings w/BH**: 47% of the health centers that have clinical team meetings to discuss complicated/difficult cases said they consistently include the BH provider as part of the meeting (9 Yes; 6 Partial)
Considerations for Next Steps

• CHCs reported a high degree of readiness, related to Behavioral Health-Primary Care Integration across a few dimensions

• Because not all CHCs report availability for same-day BH access, consider opportunity for shared telepsychiatry

• More than half need to implement systems to ensure that BH providers are included in clinical team meetings to discuss complicated/difficult cases
Overview

- VBP brings many unknowns to the financial well being of CHCs; ensuring that the core financial operations are in order is key.
- Success in VBP arrangements is grounded in improving health outcomes and realizing cost efficiencies thereby reducing the total healthcare spend.
- To realize these desired behaviors, VBP arrangements incorporate various payment models generally including:
  1. base compensation (to reimburse for services provided in-house),
  2. quality incentive payments,
  3. care coordination/management fees (PMPM) and
  4. managing the total cost of care of a patient.
- As a result, managing/monitoring financial performance will move away from per-visit analyses to quality metrics and patient-centered financial analyses (per patient).
Section IV: Financial Operational Readiness

Strengths

• **Provider Productivity (CORE):** 100% monitor provider productivity
  • But only 23% monitor RVUs (5 CHCs)

• **Demonstration of Organizational Financial Strength (CORE):**
  • 68% meet the HRSA standard for working capital (>30 days) (15 CHCs)
  • 95% have a positive unrestricted net asset position (21 CHCs)
  • 77% generated a positive operating margin for the past 3 fiscal years (10 CHCs)
  • 95% prepare monthly financial statements (21 CHCs)
  • 100% completed their independent audit (A-133 if applicable) within 6 months of year end for the past 3 fiscal years
  • 86% had no audit “findings” in the past 3 years (19 CHCs)

• **Cost per Visit (CORE):** 59% analyze cost per visit on a regular basis to identify cost efficiencies (13 CHCs)

• **Total, Annual Cost per Patient (CORE):** 73% calculate/monitor the total, annual cost per patient for in-house services (16 CHCs)

• **Cost-based charge structure:** 64% use a cost-based charge structure (14 CHCs)

• **Coding (CORE):**
  • 86% train providers on proper coding and documentation practices (19 CHCs)
  • 64% review the coding of providers on a regular basis (14 CHCs)
    • But only 45% have coders on staff (10 CHCs)
Section IV: Financial Operational Readiness

Gaps

- **Non-Provider Productivity:** Only 32% monitor the productivity (panel size) of non-provider staff (7 CHCs)
- **Margin:** 45% generated a positive margin for the past three fiscal years (10 CHCs)
- **Specific Services (CORE):** Only 36% monitor the utilization of specific services by patient for in-house services (8 CHCs)
- **Business Intelligence:** Only 18% use BI software to assimilate external claims data with internal data (4 CHCs) and only 14% to manipulate third party claims data (3 CHCs)
- **VBP Revenue Model & Reserves Needs (CORE):**
  - Only 14% has developed revenue model and evaluated investment and reserve requirements related to VBP readiness (3 CHCs)
  - 5% have evaluated the upfront costs of participating in a VBP arrangement (1 CHC)
  - 18% have evaluated reserve requirements and/or the opportunity to partner with other health centers (4 CHCs)
Current VBP Arrangements

• **82%** report agreements with payers that include quality incentive payments (18 CHCs)
  – Only two report being fully successful in receiving those incentives; the rest were partially successful

• **36%** report surplus sharing arrangements with payers (8 CHCs)
  – Only **27%** report active engagement in monitoring performance (3 Fully; 5 Partially)

• **23%** report risk-sharing arrangements (5 CHCs)
Considerations for Next Steps

• Overall, strong financial operations and results reported.
• Limited planning has been done to model financial performance under VBP and to prepare for Total Cost of Care management
  – This is about to change significantly with the implementation of the ACOs
• Limited analytics capability and data sources.
• Focus on defining data flow and analytic needs across all CHCs
  – Develop a focused training supporting the development of enhanced competencies in this area
## Closing Question: CHC Self-Ratings of Challenges to VBP Readiness

*Please rate these challenges to readiness for value based payment from your health center/practice's perspective:*

<table>
<thead>
<tr>
<th>Challenge</th>
<th># in Cohort Responded</th>
<th># in Cohort Responded</th>
<th># in Cohort Responded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Necessary time/staff resources to design and implement VBP readiness</td>
<td>10</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Adequate financial position/reserves</td>
<td>10</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Establishing partnerships with external providers</td>
<td>2</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Negotiation with plans</td>
<td>6</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>HIT infrastructure/support needed to implement changes</td>
<td>5</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Capability/willingness to exchange health information (HIE) with external partners</td>
<td>5</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Liability/audit risk</td>
<td>6</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Provider buy-in</td>
<td>3</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Board of Directors support</td>
<td>0</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Impact on clinical work flow</td>
<td>10</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Impact on fiscal work flow</td>
<td>9</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Impact on operational work flow</td>
<td>9</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Ability to meet clinical targets/ expectations set forth in VBP arrangements</td>
<td>9</td>
<td>13</td>
<td>0</td>
</tr>
</tbody>
</table>
Key Takeaways

• The survey results indicate that the CHCs have a number of the core building blocks of population health management, but there are some essential features missing from a majority of the CHCs:
  – Board engagement in risk tolerance and measurement tools of progress
  – Partnership Readiness with other than hospital providers
  – Delineation of key processes for care coordination and care transitions with hospital partners
  – Capturing care assessments as structured data
  – Real time communication alerts
Key Takeaways

• There are currently a number of VBP arrangements in place across the CHCs.
• The survey results indicate that there is significant opportunity to define CHC processes, standards and requirements with regard to data, communications with partners, and leveraging of common investment needs to build CHC Population Health approach.
Agenda

Goals for Today

VBP Readiness Assessment Findings

Roadmap for VBP Readiness

Adaptive and Technical Changes

Build Your Pyramid: Risk Stratification

Wrap Up/Next Steps
Now What?

30 Days

60 Days

90 Days

And Then...
Now What?

• High priorities in terms of timing

• Examples:
  – Getting the right people knowledgeable and engaged
  – Gaps that have to be filled before you can move forward
  – Where there are open doors
  – Things that make people feel better soon about something that matters to them
Exercise #1: Defining Your Priorities for Action

• Look at your CHC’s results from the Value-Based Payment Readiness Assessment (if no results available, review aggregated results)

• In the grid (folders), identify priorities for **ONLY THREE or FOUR** of the VBP themes where your organization has significant gaps

• What are your immediate priorities (30 Days) and medium-term priorities (60 Days and 90 Days) to address gaps?
Agenda

- Goals for Today
- VBP Readiness Assessment Findings
- Roadmap for VBP Readiness
- Adaptive and Technical Changes
- Build Your Pyramid: Risk Stratification
- Wrap Up/Next Steps
Organizational Change

• “Lasting success lies in changing individuals first; then the organization follows.”

• YOU are the leaders of those individuals.

“To improve is to change; to be perfect is to change often.”

-Winston Churchill
A Formula for Change

\[ C = (a b d) > x \]

Where:
- \( C \) = Change
- \( a \) = level of dissatisfaction with the status quo
- \( b \) = clear and understood desired state
- \( d \) = practical steps toward desired state
- \( x \) = "cost" of changing

— David Gleicher of Arthur D. Little
What is Technical and Adaptive Change?

• Technical change
  – Change in a system or processes
  – Training can help you make a technical change (e.g., how to use a new Electronic Medical Record [EMR])

• Adaptive change
  – Requires a change in belief, value, attitude, or habits of behavior (e.g., why should I start using this EMR?)

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.
Framing The Issues

• Adaptive
  – Challenge is complex
  – Need to change/address deeply held beliefs and values
  – Loss is inherent part of process
  – Cannot be done within present system

• Technical
  – Problem is well-defined
  – Answer can be found within present structure
  – Implementation is clear
Technical vs Adaptive Work

- **Energy for Change**
- **Disequilibrium**
- **Technical Problem**
- **Adaptive Challenge**
- **Limit of tolerance**
- **Threshold of learning**
- **PRODUCTIVE RANGE OF DISTRESS**

**Time**
The most common cause of leadership failure is treating an adaptive problem with a technical fix.
# CHALLENGES YOU FACE: TECHNICAL OR ADAPTIVE

<table>
<thead>
<tr>
<th>LEVEL 1: TECHNICAL</th>
<th>LEVEL 2: TECHNICAL AND ADAPTIVE</th>
<th>LEVEL 3: ADAPTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem definition is clear</td>
<td>Problem definition is clear</td>
<td>Problem definition, solution, and implementation require new learning</td>
</tr>
<tr>
<td>Leader or expert provides solution</td>
<td>Solution requires new learning</td>
<td>Responsibility for the solution resides within the followers</td>
</tr>
<tr>
<td>Easiest to resolve</td>
<td>Both leaders and followers are responsible for the solution</td>
<td>Most difficult to solve</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires second order change*</td>
</tr>
</tbody>
</table>

Second order change is creating a new way of seeing things completely. Second order change requires new learning and often begins through the informal system.
As you contemplate moving to the MassHealth ACO model, you will need to focus on adaptive and technical problems.

- At your tables, re-visit the list of 30-60-90 day priorities – which are adaptive changes, which are technical changes?
- Pick ONE change that will need to be made.
  - Is it an adaptive or a technical change?
  - How will you engage your team in solving the problem?
    - Are there different engagement strategies for adaptive problems or technical problems?
Using Authority with a New Focus

- Frame and provide tough questions rather than fulfilling the expectation for answers
- Let people feel the pinch of reality rather than protect people from an outside threat
- Disorient people so that new role relationships develop rather than orient people to their current roles
- Draw issues out rather than quell conflict
- Challenge the way to do business, distinguishing those values and norms that must endure from those that should go rather than maintain norms
Six Principles for Building Leadership Capacity for Adaptive Change

1. Get on the balcony: look at the problem while removed from it
2. Identify both technical and adaptive challenges, but focus on adaptive
3. Keep level of distress tolerable
4. Maintain disciplined attention
5. Give the work back to the people
6. Be supportive and challenging of the change
Zombie projects or activities are the living undead things that your organization does that no longer add or never *ever ever ever ever* added much or any value

...but you keep doing them anyway

and they are eating up your resources, energy, time, and brains.
Zombie Killer Exercise

- As an organization, identify **at least 3** projects or activities that you agree are zombies.
- Agree on **at least 1** that you will commit to killing, meaning you will take steps to stop doing it so you can free up time for things that add value!
Agenda

Goals for Today

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Adaptive and Technical Changes

Build Your Pyramid: Risk Stratification

Wrap Up/Next Steps
Risk Stratification for ACOs: Where to begin?

• Accountable Care means:
  – Knowing who your patients are
    • Attribution methodologies
  – Defining strategies to understand patient needs AND effective interventions to improve outcomes
    • Claims and non-claims based data approaches
    • Where do you start?
Factors in Attribution

PCPs Attributed to Site, ACO or TIN

Patients with identified PCP attributed to PCP

Patients with no identified PCP attributed based on claims, geography, other factors?

ACO Risk Pool Defined
Population Health Management

**PATIENT POPULATION**

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

**INTERVENTION**

- Engagement and Outreach
- Wellness Initiatives
- Care Coordination
- Revenue Management
- Expense Management
- Care Management
- Complex Care Management

**Risk Management**

- Potential Rising Risk
- Moderate Risk
- Low Risk
- No or Limited Risk

**Risk Mitigation**
Identifying the High-Cost, High-Risk Population

- Best methods employ quantitative and qualitative methods simultaneously
- High-cost, high-risk population changes continually
  - “Persisters” account for only 45% of the high-cost population in any given year
  - Fewer than half of these individuals are over 65

- High-cost patients that benefit from care management
  - Patients with advanced illness including those receiving LTSS
    - Focus on end-of-life discussions, informed choice, other supports
  - Patients with persistent high spending patterns
    - Multiple chronic conditions, psycho-social barriers to care
      - Often seen in the Medicaid population
      - Behavioral health conditions often contributes to these patterns

- High-cost patients that benefit less from care management
  - Patients with episodic high spending (“reverters”)

CLINICAL CHARACTERISTICS OF PATIENTS WITH PERSISTENT HIGH SPENDING: MENTAL HEALTH AND SUBSTANCE USE DIAGNOSES ARE AMONG THE MOST SIGNIFICANT DRIVERS OF COST

FIGURE 7. COMMON CONDITIONS AMONG NON-ELDERLY HIGH SPENDERS, 2006

## Annual Cost of Care: Common Chronic Mental Illnesses with Comorbid Mental Condition

<table>
<thead>
<tr>
<th>Patient Groups</th>
<th>Annual Cost of Care</th>
<th>Illness Prevalence</th>
<th>% with Comorbid Mental Condition*</th>
<th>Annual Cost with Mental Condition</th>
<th>% Increase with Mental Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Insured</td>
<td>$2,920</td>
<td></td>
<td>10-15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>$5,220</td>
<td>6.6%</td>
<td>36%</td>
<td>$10,710</td>
<td>94%</td>
</tr>
<tr>
<td>Asthma</td>
<td>$3,730</td>
<td>5.9%</td>
<td>35%</td>
<td>$10,030</td>
<td>169%</td>
</tr>
<tr>
<td>Cancer</td>
<td>$11,650</td>
<td>4.3%</td>
<td>37%</td>
<td>$18,870</td>
<td>62%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$5,480</td>
<td>8.9%</td>
<td>30%</td>
<td>$12,280</td>
<td>124%</td>
</tr>
<tr>
<td>CHF</td>
<td>$9,770</td>
<td>1.3%</td>
<td>40%</td>
<td>$17,200</td>
<td>76%</td>
</tr>
<tr>
<td>Migraine</td>
<td>$4,340</td>
<td>8.2%</td>
<td>43%</td>
<td>$10,810</td>
<td>149%</td>
</tr>
<tr>
<td>COPD</td>
<td>$3,840</td>
<td>8.2%</td>
<td>38%</td>
<td>$10,980</td>
<td>186%</td>
</tr>
</tbody>
</table>

*Courtesy: Cartesian Solutions, Inc.™--consolidated health plan claims data, Roger Kathol, MD
*Melek S et al APA 2013 www.psych.org
Exercise #3: Registry

• Look at the patient examples in the registry.
• Which patients do you focus on?
• What is the proposed intervention?
• Within your staffing model, what role would be responsible for the proposed intervention?
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Success in Value Based Payment is Dependent on:

• Identifying and knowing your challenges and opportunities
• Having a clear plan with defined milestones for execution
• Understanding the stress change places on your health center and developing tools to address the change and engage all key partners
• Knowing your patients and where to focus your energy to improve outcomes and contain costs
Next Session

- June 2, 2017: Elements for Success, Finances and Infrastructure
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