A SEAT AT THE TABLE:
Influencing State Health Care Delivery System Reforms & Aligning Internal HCH Operations
May 31, 2016
OBJECTIVES

• Identify how HCHs are participating in state-level system reforms and including social determinants of health in those plans

• Understand how HCHs are changing their internal operations to align with state-wide goals

• Understand state-level payers’ expectations for HCH grantees

• Explore how HCHs can strengthen their role in health systems change and embrace new opportunities to improve the health of vulnerable people.
SESSION 1: BIG PICTURE

- Overview of larger national and state goals for reform
- Explanation of structural mechanisms that states are using (DSRIP, ACO, SIM, etc.)
- The role of Medicaid and safety net providers within these systems
- How housing and other social determinants of health fit in
- Speaker: Kathy Moses, Senior Program Officer, Center for Health Care Strategies
A Seat at the Table: Medicaid Delivery System Reforms

May 31, 2016

Kathy Moses, Senior Program Officer
Center for Health Care Strategies
Agenda

• Delivery System and Payment Reform
  ► State Innovation Models (SIM)
  ► Accountable Care Organizations (ACO)
  ► Delivery System Reform Incentive Payment (DSRIP)

• Integrating Care and Services
  ► Physical Health/Behavioral Health Integration
  ► Health Homes
  ► Certified Community Behavioral Health Centers (CCBHC)
About the Center for Health Care Strategies

A non-profit health policy center dedicated to improving the health of low-income Americans
## Medicaid’s Purchasing Power

<table>
<thead>
<tr>
<th>Medicaid serves 70 million Americans</th>
<th>With Medicaid expansion, may serve more than 80 million</th>
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<tbody>
<tr>
<td></td>
<td>45% newborns</td>
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<tr>
<td></td>
<td>33% children</td>
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<td></td>
<td>Many people with chronic illnesses and disabilities</td>
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<td>Many frail elderly</td>
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<tr>
<td>Poor health care quality is an issue for all Americans; however, the gap is substantially greater for Medicaid beneficiaries</td>
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As the largest purchaser of health insurance, Medicaid can leverage its purchasing power to:

- Access performance data
- Identify and address gaps in quality
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  ► Certified Community Behavioral Health Centers (CCBHC)
State Innovation Models (SIM)

- State-led, multi-payer health care payment and service delivery models to address the Triple Aim:
  - Improve care outcomes;
  - Improve population health, and;
  - Decrease costs

- Center for Medicare and Medicaid Innovation supports include:
  - Financial support - $960 million across two rounds
  - Technical assistance teams
SIM Design and Test Awards

Key
- States with SIM design awards
- States with SIM test awards
- States without SIM awards

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American Samoa, Northern Mariana Islands, Puerto Rico
Agenda

• Delivery System and Payment Reform
  ► State Innovation Models (SIM)
  ► **Accountable Care Organizations (ACO)**
  ► Delivery System Reform Incentive Payment (DSRIP)

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Continuum of VBP Strategies
Accountable Care Organizations (ACO)

- Designed to improve care coordination and delivery by holding providers financially accountable for health of patient population through:
  - Implementing a value-based payment structure;
  - Measuring quality improvement; and
  - Collecting and analyzing data.
- Financial incentives include shared savings arrangement and global budget model
For more information visit the CHCS ACO Resource Center:
http://www.chcs.org/resource/aco-resource-center/
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Delivery System Reform Incentive Payment (DSRIP)

- Anchored in hospital system-based improvement efforts
- Authorized through Medicaid 1115 waivers and financed by redirecting disproportionate share hospital payments; must meet budget neutrality and generate reinvestment savings
- Programs address key domains
  - Infrastructure development;
  - System redesign;
  - Clinical outcomes improvements; and
  - Population-focused improvements.
Approved DSRIP Programs

- California
- Kansas
- Massachusetts
- New Hampshire
- New Jersey
- New Mexico
- New York
- Texas
- Others pursuing, not yet approved
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Hot Spots for Behavioral Health Delivery System Reform

Source: Internal CHCS analysis.
Considerations Regarding Behavioral Health Integration into Managed Care

- Geographic Rollout
  - Phase-in by region or implement statewide

- Plan Selection
  - Competitively bid or add new requirements

- Contracting
  - Encourage innovation or be prescriptive

- Oversight
  - Monitor and collaborate

- Stakeholder Engagement
  - “No such thing as too much”

Agenda

- Delivery System and Payment Reform
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  - Certified Community Behavioral Health Centers (CCBHC)
As of May 2016, 22 states and the District of Columbia have a total of 30 approved Medicaid health home models: Alabama, District of Columbia, Idaho, Iowa (2), Kansas, Maine (2), Maryland, Michigan (2), Minnesota, Missouri (2), New Jersey (2), New Mexico, New York, North Carolina, Ohio, Oklahoma (2), Rhode Island (3), South Dakota, Vermont, Washington, West Virginia, Wisconsin.
Approved Health Home Models

### Chronic Medical Focus
- Iowa
- Maine
- Michigan
- Missouri
- North Carolina
- Wisconsin

### SMI/SED/SUD Focus
- District of Columbia
- Iowa
- Kansas
- Maine
- Maryland
- Michigan
- Minnesota
- Missouri
- New Jersey
- New Mexico
- Ohio
- Oklahoma
- Rhode Island
- Vermont
- West Virginia

### Broad: Chronic Medical and SMI/SED
- Alabama
- Idaho
- New York
- South Dakota
- Washington
Agenda

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- Integrating Care and Services
  - Physical Health/Behavioral Health Integration
  - Health Homes
  - **Certified Community Behavioral Health Centers (CCBHC)**
CCBHC Integration Requirements

- Outpatient primary care screening and monitoring
- Care plans addressing medical, behavioral, and social needs
- Care coordination with physical health providers through:
  - health information technology systems
  - monitoring health behaviors and indicators
  - tracking of acute care utilization
- Medical Director who can prescribe medications
- Staff trainings on integration
Opportunities for Safety Net Providers

- Understand the state’s health care policy vision
- Connect to existing advisory committees/planning teams
- Share successful models from other states
- Frame the message
- Provide your subject matter expertise
Visit CHCS.org to...

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services

- **Subscribe** to CHCS e-mail, blog and social media updates to learn about new programs and resources

- **Learn** about cutting-edge efforts to improve care for Medicaid’s highest-need, highest-cost beneficiaries
SESSION 1: STATES & SYSTEMS

- Financial arrangements and quality measures states are setting to achieve health and cost goals;
- Relationships between states, insurers and providers that create new opportunities for care;
- Role of HCH providers in state discussions & decision-making;
- Speakers: Leslie Tallyn, Chief Clinical Operations Officer, Central City Concern, Portland; Will Kennedy, DO, Medical Director, Population Health Partnerships, CareOregon.
Payer-Provider Partnerships

Central City Concern
CareOregon
• Publically financed healthcare insurer for low-income citizens
• 234,000 Members; Medicaid and Medicare beneficiaries
  – 85% live in the Portland Metro region; rest are spread statewide
• Not for Profit
• Contracted network
  – Contracts with primary care providers, specialists, hospitals, medical equipment vendors, home health agencies, pharmacies
About 50% of our primary care providers practice in clinics that disproportionately care for the poor
• Nonprofit social services provider caring for more than 10,000 homeless and very low-income Portlanders.
  
  • CCC houses more than 2,000 people every year, in transitional and permanent housing, including both recovery-oriented and low-barrier housing.

  • CCC’s FQHC includes 11 sites providing primary care, mental health, and substance use disorder services to more than 8,000 patients every year.

• Central City Concern is a critically important delivery system partner for CareOregon. CCC’s Old Town Clinic provides trauma-informed primary care and integrated behavioral health care to 2,600 CareOregon members
  
  • 600 of these members (24%) are considered high risk, high cost members
• Old Town Clinic was one of the five original primary care practices that partnered with CareOregon on a safety-net medical home transformation model (2006)

• CCC outpatient behavioral health programs—safety-net community mental health and SUDS provider serving hundreds of CareOregon members
• Hooper Detox Center – medically supervised detox

• Recuperative Care Program – medical respite for homeless population

• Numerous housing and vocational programs that serve our members
Traditional Reform
Why Important?
“The barrier to change is not too little caring; it is too much complexity.”
FIG. 1 - Centralized, Decentralized and Distributed Networks
Overcoming Complexity
“Give me a lever long enough, and a fulcrum strong enough, and I shall move the world.”
CCC’s Ambulatory Intensive Care Unit - Summit

• The problem:
  • Even with a wealth of well-designed interventions, we lacked a medical home for medically fragile patients with major psychosocial issues

• The opportunity:
  • Create an ambulatory intensive care unit to meet the needs of the most medically & socially complex population

• The partnership:
  • CCC-designed program, refined through collaboration with CareOregon
  • Initial investment plus quality incentives program
CCC’s Recuperative Care Program

- Recuperative Care Program:
  - Post-hospitalization medical respite program for homeless patients
  - Combines supportive housing, case management, and access to high-quality, trauma-informed primary care
  - 75% of patients discharge with acute medical conditions resolved
  - 60% of patients discharge to stable housing

- History:
  - Pre-dated Affordable Care Act by many years
  - Originally funded primarily by hospitals, with a low percentage of insured patients

- Today:
  - Payer data is helping us understand the longer-term effects of the program
What we’ve learned along the way

• Finding the right partners, and investing the right way
• Designing programs that have broad benefit—and hypotheses we can deliver on
• Compromise comes with the territory—so trust is essential
What Health Plans Can Provide

- Data
- Technical Assistance
- Financial Support
- Convenor
Last 12 Months Before Leaving Palliative Care (Death or Hospice)
Recuperative Care Program

Methodological issues:

- Regression to the Mean
- Need a longer time horizon to “prove” effect
- Comparison groups are difficult
Lessons from Palliative Care
SESSION 2: STATES & SYSTEMS (CONT’D)

• Hannah Katch, Senior Health Policy Analyst, Center on Budget Policies and Priorities

• John Gilvar, Interim Manager, Health Care for the Homeless Network, Public Health - Seattle & King County

• Chase Napier, Community Transformation Manager, Washington State Health Care Authority

• Barry Bock, CEO, Boston HCH, Boston, Massachusetts

• Bobby Watts, Executive Director, Care for the Homeless, New York, New York

• Kevin Lindamood, President & CEO, Baltimore HCH, Baltimore, Maryland
Improving how we pay for services

Ensuring health care focuses on the whole person

Building healthier communities through a collaborative regional approach

Improving how we pay for services
We recognize that health is more than health care...

...and that clinical-community linkages are essential for better health outcomes.

**Community Factors**
- Nutritious Food
- Education
- Employment
- Crisis Intervention
- Housing
- Transportation
- Criminal Justice
- Family Support
- Public Health
- Built Environment

**Health and Recovery Care**
- Physical Health
- Long-Term Care
- Mental Health
- Substance use disorder
- Oral Health
- Built Environment

**Healthier Washington System Supports**
- Information Technology / Infrastructure
- Data and Measurement
- Workforce Development
- Practice Transformation
- Payment Redesign
Further information on ACHs is available at:
Waiver Initiatives

**Initiative 1**
Transformation through Accountable Communities of Health

**Delivery System Transformation**
- Each region, through its Accountable Community of Health, will be able to pursue projects that will transform the Medicaid delivery system to serve the whole person and use resources more wisely.
- Also known as Delivery System Reform Incentive Payments (DSRIP).

**Initiative 2**
Enable Older Adults to Stay at Home; Delay or Avoid the Need for More Intensive Care

**Benefit: Medicaid Alternative Care (MAC)**
- Community-based option for Medicaid clients and their families.
- Services to support unpaid family caregivers.

**Benefit: Tailored Supports for Older Adults (TSOA)**
- For individuals “at risk” of future Medicaid LTSS not currently meeting Medicaid financial eligibility criteria.
- Primarily services to support unpaid family caregivers.

**Benefit: Supportive Housing**
- Individualized, critical services and supports that will assist Medicaid clients to obtain and maintain housing. The housing-related services do **not** include Medicaid payment for room and board.

**Initiative 3**
Targeted Foundational Community Supports

**Benefit: Supportive Employment**
- Services such as individualized job coaching and training, employer relations, and assistance with job placement.
For more information, contact:

Website: www.hca.wa.gov/hw

Join the Healthier Washington Feedback Network: healthierwa@hca.wa.gov
Influencing state health care delivery system reforms & aligning internal HCH operations: Massachusetts Experience

Barry Bock, CEO
Boston Health Care for the Homeless Program
May 31, 2016
Chapter 58 of the Acts of 2006: “Near” universal health insurance coverage: #1 in USA
  o September 2014: 2.3% growth rate
  o September 2015: 4.8% growth rate
Medicaid almost 40% ($15B+) of the state’s budget
Current Medicaid Delivery System Reform Investment Program (DSRIP) waiver ends 6/2017. Opportunity to leverage $1.5B federal and reform delivery system
MassHealth ACO models: 3 types of ACO models

Model A: Integrated ACO/MCO model
- Fully integrated: an ACO joins with an MCO to provide full range of services
- Risk-adjusted, prospective capitation rate
- ACO/MCO entity takes on full insurance risk

Model B: Direct to ACO model
- ACO provider contracts directly with MassHealth for overall cost/quality
- Based on MassHealth/MBHP provider network
- ACO may have provider partnerships for referrals and care coordination
- Advanced model with two-sided performance (not insurance) risk

Model C: MCO-administered ACO model
- ACOs contract and work with MCOs
- MCOs play larger role to support population health management
- Various levels of risk; all include two-sided performance (not insurance) risk

Community Partner funding sources: overview

Summary of funding streams:

1. DSRIP directly to ACOs
   - For infrastructure, startup, ongoing costs
   - Contingent on formalizing relationships with Community Partners

2. DSRIP directly to CPs
   - PMPY for infrastructure and startup costs
   - PMPY based on population served (for ACOs and existing MCOs)
   - Years 3-5 for § 2703 BH Health Homes program
   - A portion (growing to 20% by Year 5) contingent on meeting process & quality metrics, and on ACO/MCO evaluation of CP performance

3. § 2703 Health Homes funding
   - Federal program (part of ACA), 90% federal match
   - 2 years of funding for care coordination/management (Years 3-5 transition to DSRIP)

4. DSRIP to ACOs: explicitly designated for flexible services
   - PMPY to ACOs based on attributed population
   - Can only be used for flexible services that address social determinants of health

Funding tapers over time; must be built into total cost of care budget by Y6

SDH Consortium, Part I

- Boston Health Care for the Homeless Program
- Bay Cove Human Services
- Boston Public Health Commission
- Boston Rescue Mission
- Casa Esperanza
- Massachusetts Housing and Shelter Alliance
- New England Center and Home for Veterans
- Pine Street Inn
- St. Francis House
- Victory Programs
I. Our patients are complex:
• 68% mental illness
• 60% substance use disorders (SUD)
• 48% co-occurring mental illness & SUD
• High prevalence of medical illnesses, e.g. HCV (23%) & HIV (6%)
• High prevalence of chronic illnesses, e.g. 37% hypertension, 26% COPD or asthma, 18% diabetes mellitus
• Disease burden = DxCG score of 3.8

II. Our patients are costly:
• $2036 PMPM vs.$568 for all MassHealth members
• > 1/3 had 6 or more ED visits/yr; 1/5 had 3 or more hospitalizations
• 10% population accounted ~50% total expenditures

What we’ve accomplished:

1. Development of an integrated service delivery model
2. Formalized our partnership though joinder agreements
3. Plan for information technology sharing through Efforts to Outcomes (ETO®) & connecting to BHCHP EHR
4. Developed payment model: $ PMPM for case managers, stipend $ to consortium members for participation, $ for staff/infrastructure at BHCHP
5. Developed draft patient consent form
6. Developed evaluation plan: utilization, quality, SDH metrics

To do:

1. Secure claims/encounter data from MassHealth, MCOs;
2. Secure hospital daily admission, discharge, and transfer feeds
3. Secure funding (!)
Take Home Lessons

1. Know your data
2. Form partnerships with trusted organizations
3. Inventory strengths
4. Steal from others
5. Use your data, strengths & make your pitch
6. Start now (!)
Influencing NYS Health Reform Efforts

Bobby Watts
Care for the Homeless
New York City
Care for the Homeless

- Founded 1985

- Mission Statement: “Care for the Homeless fights homelessness by delivering high-quality and client-centered healthcare, human services and shelter to homeless men, women, and children and by advocating for policies to ameliorate, prevent, and end homelessness.

- For last five years our policy efforts to ameliorate homelessness have been around making the health system respondent to the needs of homeless people in two related main areas: 1) Medicaid Redesign and 2) Value-Based Payment
NYS Medicaid Redesign

• Governor Andrew Cuomo in his Inauguration Speech (January 1, 2011), stated "It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure”

• A rationale from Executive Order #5 (January 5, 2011): New York spends more than twice the national average on Medicaid on a per capita basis, and spending per enrollee is the second highest in the nation. At the same time, New York ranks 21st out of all states for overall health system quality and ranks last among all states for avoidable hospital use and costs.
Medicaid Redesign Team

• Medicaid Redesign Team comprised of health care administrators, practitioners, academics, government officials, health care unions, and advocates.

• In addition, there are eleven MRT Workgroups, including at least where HCH is represented:

  • Supportive Housing Work Group
  • Health Disparities Work Group
  • Social Determinants of Health Work Group
MRT Affordable Housing Workgroup

• “The thing we figured out,” according to then-U.S. HUD Secretary Shaun Donovan, “is that it’s actually cheaper, not just better for people, but cheaper to solve homelessness than it is to put a band-aid on it. Because at the end of the day it costs, between shelters and emergency rooms and jails, $40,000 a year for a homeless person to be on the streets.”

• The MRT supportive housing initiative funds innovative pilot projects, capital, rental subsidies and supportive services. State Agency partners include Homes and Community Renewal (HCR), Office of Temporary and Disability Assistance (OTDA), Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism and Substance Abuse Services, (OASAS), and the Department of Health's AIDS Institute.
MRT Affordable Housing Workgroup - Results

- $127 MM for Supportive Housing under this initiative for high-cost Medicaid recipients and subgroups
  - Capital $47 Million
  - Rental Subsidies $38 Million
  - New SH Pilot Programs $39 Million
  - Tracking and Evaluation $2.5 Million

- Commitment to plow savings back into more initiatives
Value-Based Payment

• Connected with NYS Delivery System Reform Incentive Payment (DSRIP) initiatives and NYS’ 1115 waiver
• To ensure the long term sustainability of the DSRIP investments in the waiver, the Terms and Conditions state that NYS must submit a multi-year roadmap for comprehensive payment reform. The Roadmap was submitted to CMS and received approval on July 22, 2015.
• An overarching goal is within five years 80-90% of all payments made under Medicaid will be value-based. A goal of DSRIP is to reduce avoidable hospitalizations by 25%.
• It is recognized that the value of the outcome is affected by social determinants of health, which is affected by those outside the health system. I sat on the VBP Social Determinants of Health and CBO Workgroup.
Results – Several Recommendations to NYS DOH that are in public comment period

1. Designing and improving SDH by creating guidelines and standards for Providers, Provider Networks, MCOs and the State.

2. Methods of addressing and developing an action plan for Medicaid Member housing determinants.

3. Determining methods which can be used to capture savings across public spending as related to SDH and CBOs.

4. Providing CBOs technical assistance and education for VBP
Recommendation #15:
Medicaid providers, MCOs, and the State should collect standardized housing stability data. The State should explore options and determine the best mechanism for capturing this data.

All Level Providers: Guideline
MCOs: Guideline
The State: Standard

Implementation Mechanisms that Require Change: DOH Policy
Description:
Medicaid providers, MCOs, and the State should routinely collect and update standardized housing data. This information should be maintained in a shared database, such as the Regional Health Information Organization (RHIO), Salient, or other accessible system, for purposes of rate setting and appropriate intervention research and analysis. The State should determine a standardized mechanism for housing stability data collection and consider requiring providers and MCOs to capture this data in the future.
NYS Health Care Reform

• Medical Respite (MR) does not exist in NYC, though a “social respite” program does
• CFH has been a leader in trying to bring Medical Respite to NY, along with some other HCH providers
• The MRT Affordable Housing Workgroup recommended Medical Respite and created a MR subgroup to work out issues of licensure and models with NYSDOH and others.
• The VBP SDH and CBO workgroup made two recommendations that would advance Medical Respite
• The CFH and other HCH providers together are working with NYC government and City Council to establish Medical Respite.
SESSION 3: ROLE OF MCO PLANS

- MCO plan motivating factors, common goals, areas of flexibility for plans, how states hold MCOs accountable, contracting opportunities, recommendations for providers in maximizing MCO relationships
- Lessons learned from HCH providers
- Speakers: Jenny Ismert, Vice President of Policy, UnitedHealthcare; Paul Leon, CEO & President, Illumination Foundation, Irvine, California; Ed Stellon, Executive Director, Heartland Health Outreach, Chicago, Illinois; Frances Isbell, CEO, Health Care for the Homeless Houston, Houston, Texas
Managed Care and the Homeless Populations

A Seat at the Table – Health Care for the Homeless

Jenny Ismert, Vice President – Health Policy
CONTRIBUTORS TO PREMATURE DEATH

- Inadequate Health Care: 10%
- Environmental Exposure: 5%
- Social Circumstances: 15%
- Behavioral Patterns: 40%
- Genetic Predisposition: 30%

Source: McGinnis JM, et al. The case for more active policy attention to health promotion. Health Affairs. 2002
Navigating Federal Low-Income Assistance Programs

Benefits and Services for Low-Income Individuals: 80+ Programs Spending $1 Trillion per Year

Source: House Ways and Means Committee staff, using Congressional Research Service reports and other data.
National Context

- Medicaid Expansion
- Growing Footprint of Medicaid Managed Care
- Greater Recognition of Social Determinants of Health

Source: HMA Value of Medicaid Managed Care
Medicaid Managed Care

Federal Government
- Establishes basic rules and criteria States must follow in the design and operation of a Medicaid program
- Covers a significant portion of the costs of Medicaid (varies by state and population)
- Approves contracts and rates between states and managed care entities

State Governments
- Establish program rules, benefits, eligibility, contract provisions and the rates health plans will be paid to administer the Medicaid program
- Compensates the health plans using a per member per month capitated rate

Health Plans
- Administer the Medicaid program according to the terms of the contract with the state for their assigned Medicaid beneficiaries
- Measured on ability to support their members in receiving preventive treatment, achieving state goals, and meeting other quality metrics established by the state
- Established contracts with providers
## Care Models Evolve

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<th>Past</th>
<th>Present</th>
<th>Future</th>
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<tr>
<td>Fragmented benefit design and systems</td>
<td>Greater coordination of physical, behavioral and social services and supports</td>
<td>Full integration and whole person supports across Medicaid and non-Medicaid benefits</td>
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<td>Solely telephonic case management</td>
<td>Increasing use of Community Health Workers and Peer Supports</td>
<td>Combinations of telephonic/electronic engagement, CHWs, Peer Supports and Specialized Providers that improve engagement</td>
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<td>No connectivity and little recognition of the role of housing</td>
<td>Building relationships with housing providers, homeless services providers, incorporating questions of housing into care planning</td>
<td>Additional opportunities to link housing and health data, support housing of the most vulnerable and integrate broader array of human services</td>
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Meet & Identify Priorities

• Common goals exist and there are opportunities to collaborate to enhance the system’s performance to improve outcomes for homeless populations

• Focus on understanding – develop common language, discuss the model of care, what services are being offered, what managed care capabilities can be leveraged

• Identify strengths and opportunities to fill gaps in care or improve an MCO’s ability to locate and engage members

• While incentives may not be 100% aligned there are opportunities to develop partnerships that are complimentary
Share Data

• Data is powerful – matching patients to MCOs, understanding service utilization patterns of individuals served (services and locations)

• Special interest in patients that are high utilizers of EDs and hospitals

• Opportunity for MCOs to better understand patient barriers or additional supports needed

• Requires appropriate agreements (memorandum of understanding, contracts, or other agreements) to ensure compliant sharing of data
# Collaboration is Key

## Current State

- Current quality measures do not easily translate and address the full spectrum of needs of complex populations
- Responsible for health outcomes and health care utilization regardless of whether or not the beneficiary is located or engaged in care
- Poor engagement and/or health outcomes will negatively impact the plan’s measures
- MCOs are tasked with ensuring beneficiaries are receiving the right services, in the right settings at the right times
- Quality of life and individual experiences are difficult to consistently quantify

## Opportunities

- Work jointly for state-level quality measures that address issues relevant to the health care of people who are homeless
- Collaborate to support positive sustained engagement to promote better outcomes for everyone
- Work with the state about housing support services and the covered package of benefits
- Partner to create and/or expand medical respite care and supportive housing programs
Policy Considerations

Medicaid benefit and program design matters!
• Expansion vs. non-expansion
• Populations under managed care contract
• Benefits under managed care contract – behavioral health, LTSS/HCBS, housing supports, etc.
• Medical Loss Ratio calculations
• Care coordination requirements
• State program priorities
• Delivery and payment reform requirements
• Quality definitions, calculations and accountability
Needed for Success

• Countless opportunities to collaborate exist, but resources and capacity on both sides are limited

• Evaluating opportunities:
  • Members impacted
  • Opportunity to improve quality
  • Opportunity to improve utilization
  • Data available to support the decision to invest, track and demonstrate impact
  • *Presence of trusted partners willing to innovate with unique skills and expertise*
Background on Initiative

- Recognized Interest
- 2015 Healthcare for the Homeless Annual Conference
- Began conversations
- Co-wrote the white paper and developed today’s webinar
- Beginning to an on-going conversation
SESSION 3: ROLE OF HOSPITALS

• Hospitals as central stakeholders to most state reform mechanisms
• Motivating factors and opportunities for hospitals to partner most effectively with community providers
• Speakers: Sean Kolmer, Senior Vice President of Policy and Strategy, Oregon Association of Hospitals & Health Systems (OAHHS); Tom Andrews, President, Mercy Care/CEO, Saint Joseph's Health System, Atlanta, Georgia
Hospitals as stakeholders.....effective partnerships with community providers.........
A local and national perspective

NHCHC Pre-Conference Institute
A Seat at the Table:
Influencing State Health Care Delivery System Reforms & Aligning Internal HCH Operations
Tom Andrews
Mercy Care, Atlanta
A local perspective.....

- The Atlanta safety-net – Grady & 4 FQHC’s (Historical relationships)
- Pre-ACA preparation
  - Philanthropic collaborative – Safety-net assessment – Need for primary care access
  - Grady – “White flag” – Ambulatory care strategies revealed
  - Grady Urgent care center & Patient navigator program - Kaiser
  - Primary care access planning sessions
  - Community Health Worker program – United Way
  - Grady opens up medical staff to FQHC’s – EMR Access
  - PCMH Recognition for FQHC’s – Care coordination focus
- The Georgia reality.....No Medicaid Expansion
Post Supreme Court Ruling Reality

• Accountable Care Organization
  • Medicare approved – No start-up funding
  • Morehouse based – Grady decides to participate
  • Infrastructure development – Data sharing, care coordination & first risk relationship

• National Collaborative Initiative
  • Kaiser Family Foundation – AEH, GWU & NACHC
  • Four cities – Denver, Cleveland, Richmond, Atlanta
  • Grady & 5 FQHC’s – Goal: Increased Access Opportunities & Support improving safety-net
  • Research: Best Practices: Local-level coverage solutions, 1115 Waivers – DSRIP and DSTI, State’s private option expansion opportunities
Post Supreme Court Ruling Reality

- Georgia Coverage Solution
  - Philanthropic collaborative funding – **Grady Lead**
  - Two Best Practices – Metro Health & Hennepin
  - 1115 Waiver – Care transformation focus
    - Model development with “political focus”
    - Total Cost of Care Analysis
    - Care coordination model
  - Georgia Coverage Solution - Proposal to Governor
  - Current Status – Georgia Chamber of Commerce Partnership
    - State-wide focus with rural emphasis
A national perspective

- Trinity Health – 2\textsuperscript{nd} Largest National Catholic Healthcare System
- Historical relationships with HCH programs
- People-Centered Health System Strategy
  - Episodic Health Care Management for Individuals
  - Population Health Management
  - Community Health & Well-Being (Emphasis on poor & underserved)
- Development of a Homeless Service Scorecard for each Regional Health Ministry – Focus on each strategy
  - Baseline year with scorecard for subsequent years to measure progress
Proposed Measurements

- Episodic Health Care Management for Individuals
  - Ministry screens patients for housing instability and records information in EHR
  - Ministry provides or supports outpatient services that are accessible to persons without homes
  - Ministry collaborates with internal and external parties to coordinate care for persons without homes

- Population Health Management
  - Ministry develops, shares and analyzes data on population health with safety-net providers
  - Ministry identifies and addresses insufficiencies and gaps in care for persons without homes
  - Ministry participates in provider networks that serve the homeless population
Additional Measurements

- Community Health & Well-Being
  - Ministry works to mitigate and remedy social determinants of health with focus on low income and those without homes
  - Ministry directs community benefit funds to those without homes or at risk of homelessness
SESSION 4: ALIGNING HCH INTERNAL OPERATIONS

- Aligning state performance/outcome measures with internal measurements, collecting and reporting data, refining billing and other financial procedures

- Demonstrating improvements in health for vulnerable populations; leveraging population health data at the provider level

- Speakers: Rachel Solotaroff, MD, Chief Medical Director, Central City Concern, Portland, Oregon; Marty Sabol, Director of Health Services, Nasson Health Care, Springvale, Maine
Moving Beyond Metrics, Aligning Outcomes

Rachel Solotaroff, MD, MCR
NHCHC Pre-Conference Institute
May 31, 2016
Objectives

1. Review CCO Structure and Metrics in Oregon
2. Describe Central City Concern’s’s approach to CCO Metrics
3. Provide 2 case studies in reframing measures to support the mutual needs of our organization, our payers, our patients:
   • Summit (Ambulatory Intensive Care Unit)
   • Risk Modeling
The Early Years

CCO Metrics and Central City Concern
## Health Share of Oregon

<table>
<thead>
<tr>
<th>CCO Incentive Measure</th>
<th>2013 Baseline</th>
<th>2014 Final Nominator count</th>
<th>2014 Final Denominator count</th>
<th>2014 Final Rate</th>
<th>CCD meets Benchmark?</th>
<th>CCD meets Improvement Target?</th>
<th>CCD earned quality pool for this measure?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Well Care Visits</td>
<td>33.3%</td>
<td>12,971</td>
<td>34,094</td>
<td>37.8%</td>
<td>57.6%</td>
<td>No</td>
<td>35%</td>
</tr>
<tr>
<td>Screening, Brief Intervention and Referral to Treatment (SBIRT)</td>
<td>1.0%</td>
<td>3,686</td>
<td>100,284</td>
<td>3.6%</td>
<td>13.0%</td>
<td>No</td>
<td>4.0%</td>
</tr>
<tr>
<td>Ambulatory Care: Emergency Department Visits (per 1,000 member months)</td>
<td>52.8</td>
<td>126,322</td>
<td>2,503,137</td>
<td>4.9%</td>
<td>44.6%</td>
<td>No</td>
<td>52.0%</td>
</tr>
<tr>
<td>CAHPS: Access to Care</td>
<td>80.2%</td>
<td>n/a</td>
<td>n/a</td>
<td>83.6%</td>
<td>88.0%</td>
<td>No</td>
<td>82.2%</td>
</tr>
<tr>
<td>CAHPS: Satisfaction with Care</td>
<td>80.0%</td>
<td>n/a</td>
<td>n/a</td>
<td>83.6%</td>
<td>89.0%</td>
<td>No</td>
<td>82.2%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening¹</td>
<td>n/a</td>
<td>219</td>
<td>411</td>
<td>53.3%</td>
<td>47.0%</td>
<td>Yes</td>
<td>n/a</td>
</tr>
<tr>
<td>Developmental Screening 0-6 Months</td>
<td>83.9%</td>
<td>5,922</td>
<td>13,421</td>
<td>41.2%</td>
<td>50.0%</td>
<td>Yes</td>
<td>25.1%</td>
</tr>
<tr>
<td>Early Elective Delivery</td>
<td>3.5%</td>
<td>21.1</td>
<td>641</td>
<td>3.0%</td>
<td>5.0%</td>
<td>Yes</td>
<td>n/a</td>
</tr>
<tr>
<td>Electronic Health Record Adoption</td>
<td>51.3%</td>
<td>3,406</td>
<td>5,125</td>
<td>64.8%</td>
<td>72.0%</td>
<td>Yes</td>
<td>56.1%</td>
</tr>
<tr>
<td>Follow-up after Hospitalization for Mental Health (7 day)</td>
<td>69.1%</td>
<td>864</td>
<td>1,248</td>
<td>69.8%</td>
<td>68.8%</td>
<td>Yes</td>
<td>68.8%</td>
</tr>
<tr>
<td>Follow-up Care for Children Prescribed ADHD Medication (Initiation)</td>
<td>38.7%</td>
<td>310</td>
<td>515</td>
<td>60.2%</td>
<td>51.0%</td>
<td>Yes</td>
<td>51.0%</td>
</tr>
<tr>
<td>Mental and Physical Health Assessment within 60 Days of Children in DHS Custody</td>
<td>31.7%</td>
<td>174</td>
<td>270</td>
<td>64.0%</td>
<td>90.0%</td>
<td>No</td>
<td>77.5%</td>
</tr>
<tr>
<td>Patient-Centered Primary Care Home Enrolment</td>
<td>75.5%</td>
<td>373,179</td>
<td>673,254</td>
<td>84.9%</td>
<td>80.0%</td>
<td>No</td>
<td>70.7%</td>
</tr>
<tr>
<td>Timeliness of Prenatal Care¹</td>
<td>62.2%</td>
<td>297</td>
<td>374</td>
<td>63.9%</td>
<td>90.0%</td>
<td>No</td>
<td>70.7%</td>
</tr>
<tr>
<td>Year Two Technology Plan: submitted on time and approved by CNAL</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

¹The 2013 rates for Colorectal cancer screening were calculated as a rate per 1,000 member months using administrative data only. They are not comparable to 2014 rates.

²The 2013 rates for Timeliness of prenatal care were calculated using administrative data only. They are not directly comparable to 2014 rates.

**Measure Specifications:** [http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx](http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx)

**Reference Instructions:** [http://www.oregon.gov/oha/analytics/CCCOdata/2014%20Reference%20Instructions.txt](http://www.oregon.gov/oha/analytics/CCCOdata/2014%20Reference%20Instructions.txt)
What We Did

Focus on areas of need in our population:
- SBIRT:
  - Only clinic to meet this metric in first year
  - Provided TA to other sites
- Decreased ED utilization

Less focus on:
- CRC screening (subsequently added)
- Maternal/child health
New Models, New Measures
Case Study 1: Summit (AICU)

Key Activities:
• Foster relationships
• Ensure access to primary, specialty, and behavioral health care
• Facilitate utilization of outpatient care
• Manage care transitions
• Provide psychosocial and material supports

To produce:
• Improved quality
• Improved access
• Reduced cost
• Improved staff well-being
Theories behind activities:

- Relationship building
- Team self-reflection
- Process improvement

Decrease treatment burden

Increase Pt self-efficacy

Team Wellness

Specific activities of SUMMIT:

- Access/Utilization
- Patient capacity
- Team Wellness

Intermediate outcomes:

- Improved access/utilization
- Streamlined Care
- Increased Patient Capacity
- Patient-centered, comprehensive Care

Long-term outcomes: Reduced

- morbidity and mortality, hospitalization/utilization/costs
- Improved patient experience
- Improved Provider experience

Activities:

- Patient capacity
- Team Wellness
- Access/Utilization

Long-term outcomes:

- Streamlined Care
- Improved patient experience
- Improved Provider experience
Activities
(incl BH)
- Transitions of care
- Pharmacy medication management
- Home-visits, inpatient consultation
- Case management on team
- 24/7 provider availability
- Pt determines appointment length

Increase patient capacity:
- Trust building/increased touches by fewer providers
- Intensive & integrated assessment
- Patient-centered care plans
- Integration of palliative care
- Flexible support funds, expedited benefits

Team Wellness:
- Mindfulness, reflection
- Trauma Stewardship
- Built in continuous process improvement (CQI)

Intermediate Outcomes
Improved access/ utilization
- Decreased ED visits
- Increased clinical “touches”
- Reduced referrals to outside providers
- Improved transitions from hospital to community
- Increased patient engagement Summit
- Improved capacity at Old Town Clinic

Increase patient capacity:
- Increased PAM score
- Reduced CHAOS score
- Improved ENRICHED score
- Patient/provider care plan development
- Increased percentage of housed patients
- Increased percentage of patients with maximized benefits
- Improved clinical outcomes (HbA1c, hypertension, etc.)

Global Outcomes
Improved quality:
- Improved Global Health measure (ESAS)
- Reduced 30-day readmissions
- Improved functional status (DLA-20, SF-12)

Reduced costs:
- Reduced ambulatory care sensitive condition hospitalizations
- Reduced inpatient Length of Stay

Improved patient experience:
- Improved CAHPS

Improved team wellness:
- Decreased Maslach Burnout Inventory

Improved provider experience:
- Improved Maslach Burnout Index
Sample Intermediate Measures

• Patient Activation Measure:
  • Taking an active role in my own health care is the most important thing that affects my health
  • I am confident that I can follow through on medical treatments I may need to do at home

• CHAOS scale:
  • My life is organized
  • My daily activities from week to week are unpredictable

• ENRICHED social support inventory:
  • Is there someone available to you whom you can count on to listen to you when you need to talk?
  • Is there someone available to you who shows you love and affection?
Summit Patient Engagement

- **Completed Appointments**
- **Avg roll 12 mo completed appts**
Case Study 2: Risk Modeling

Data Sources:

• Clinical data from EMR
• Clinic Appointments from Practice Management System
• Hospitalizations/ED visits from CCO
• Specialist visits from CCO
• Rx from CCO
• Cost of Care from CCO
• Acrual LOS and GM LOS from CCO
Challenges

• Very time and resource intensive

• Finding the right people to do the work (and teach you as they go)

• Convince yourself that “fail harder” is more than just a catchy slogan

• Convince your payer that “fail harder” is more than just a catchy slogan

• Finding the right payment model to truly match the work
Thank you!

Rachel Solotaroff, MD, MCR
rachel.solotaroff@ccconcern.org
971-271-6084
SESSION 5: MOVING FORWARD

- Synthesize themes from the presentations and discussions, identify opportunities and challenges/common approaches/goals
- Importance of internal & external data, focus on quality & outcomes, need to establish value of HCH model of care (and methodology for that)
- Increasing attention on social determinants of health (especially housing,
- HCH role in advancing state health care delivery system reforms, and support needed for HCH projects to maximize macro-level change