The Webinar will begin promptly at 12pm

Due to the number of participants, you will be automatically placed on mute as you join to ensure good quality sound. If you would like to comment or ask a question, please use the "chat feature"

Send your questions to the host via the chat window in the Zoom meeting.

Q+A will open at the end of the presentation.

Follow-up questions?

Contact

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ACHIEVING BETTER OUTCOMES THROUGH VALUE-BASED CARE AND POPULATION HEALTH STRATEGIES

PRESENTED BY:
Caitlin Thomas-Henkel, MSW
Kelli Johnson, MBA

Tuesday,
December 6, 2022
12:00 pm – 1:00 pm EST

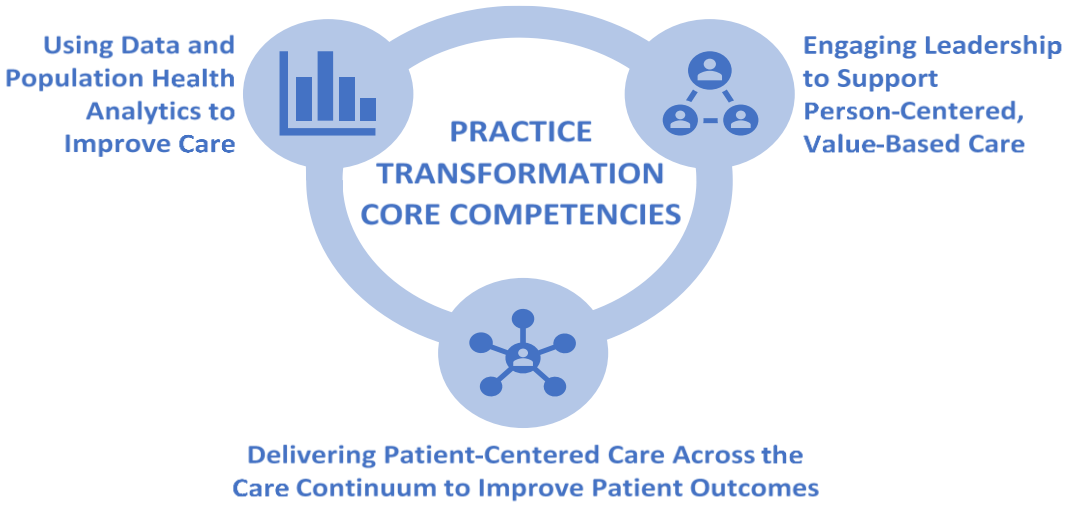
Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,616,075.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government.

WHAT IS INTEGRATED CARE DC?

- Integrated Care DC is a five-year program aimed to enhance Medicaid providers' capacity and core competencies to deliver whole person care for physical, behavioral health, SUD and social needs of beneficiaries.

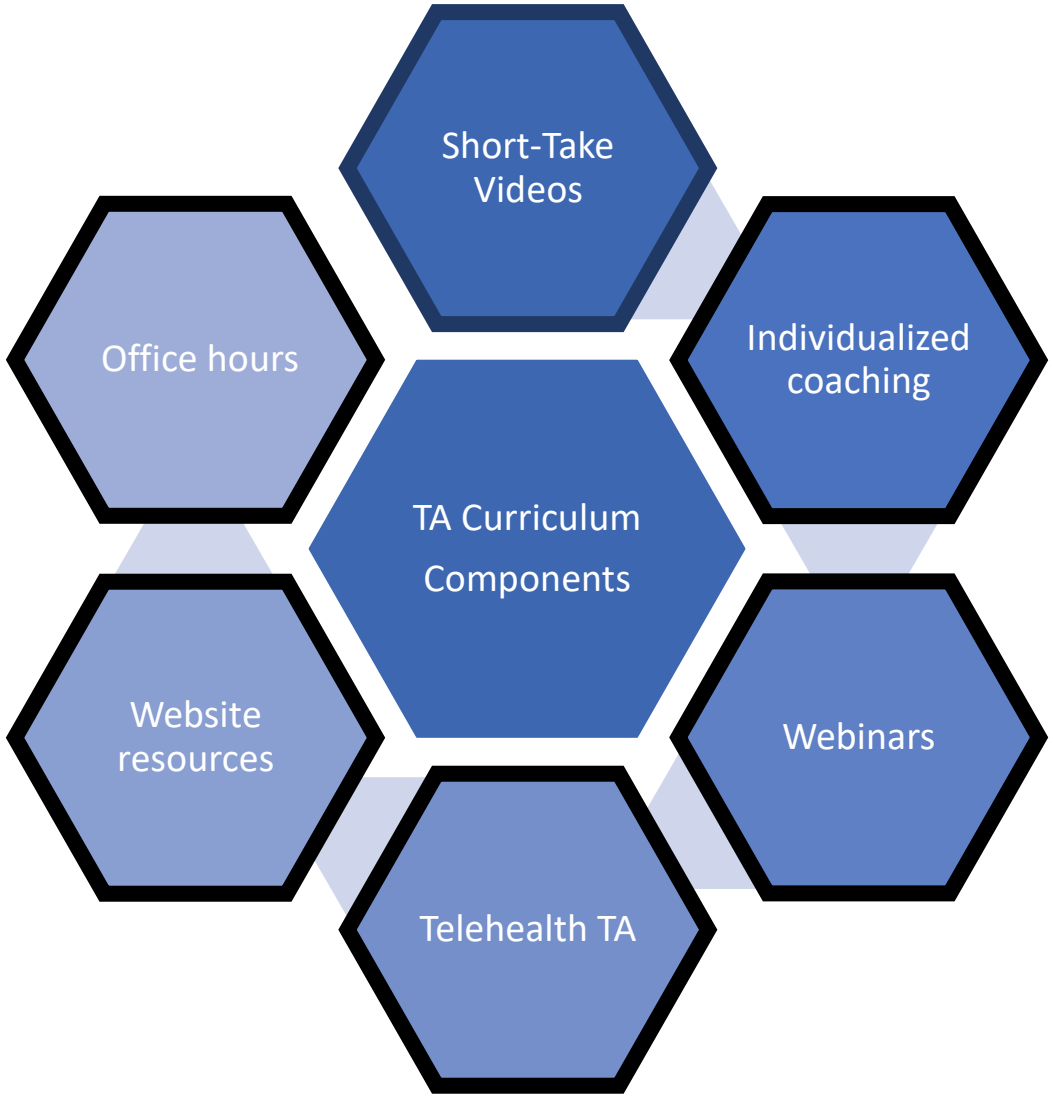
- Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). Health Management Associates will provide the training and technical assistance.

The goal is to improve care and Medicaid beneficiary outcomes within three practice transformation core competencies:



INTEGRATED CARE DC TECHNICAL ASSISTANCE

- The program offers several components of coaching and training. Material is presented in various formats. The content is created and delivered by HMA subject matter experts with provider spotlights.
- All material is available on the project website: Integratedcaredc.com
- Educational credit is offered at no cost to attendees for select elements.



INTEGRATED CARE DC UPDATES

Are you receiving our Integrated Care DC Newsletters?

Check your inbox at the beginning of the month for the Monthly Newsletter and around the 15th for the Mid-Month Update.

Got ideas?

Take this short survey to share suggestions and requests for trainings.
https://www.integratedcaredc.com/survey/

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Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A

HMA discloses all relevant financial relationships with companies whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients.

CONTINUING EDUCATION CREDITS

- Health Management Associates, #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. Health Management Associates maintains responsibility for this course. ACE provider approval period: 09/22/2022 – 09/22/2025. Social workers completing this course receive 1.0 continuing education credits.

To earn CE credit, social workers must log in at the scheduled time, attend the entire course and complete an online course evaluation. To verify your attendance, please be sure to log in from an individual account and link your participant ID to your audio.

- The AAFP has reviewed Integrated Care DC Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 02/08/2022 to 02/07/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session is approved for 1.0 Online Only, Live AAFP Prescribed credits.

- **If you would like to receive CE/CME credit, the online evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar**.**

- Certificates of completion will be emailed within 10-12 business days of course completion.

AGENDA

Achieving Better Outcomes Through Value-Based Care and Population Health Strategies

- Welcome and Program
- Core Competencies of Value Based Payments
- Population health approaches
- Technology
- AmeriHealth's Care Coordination Dashboard

OBJECTIVES

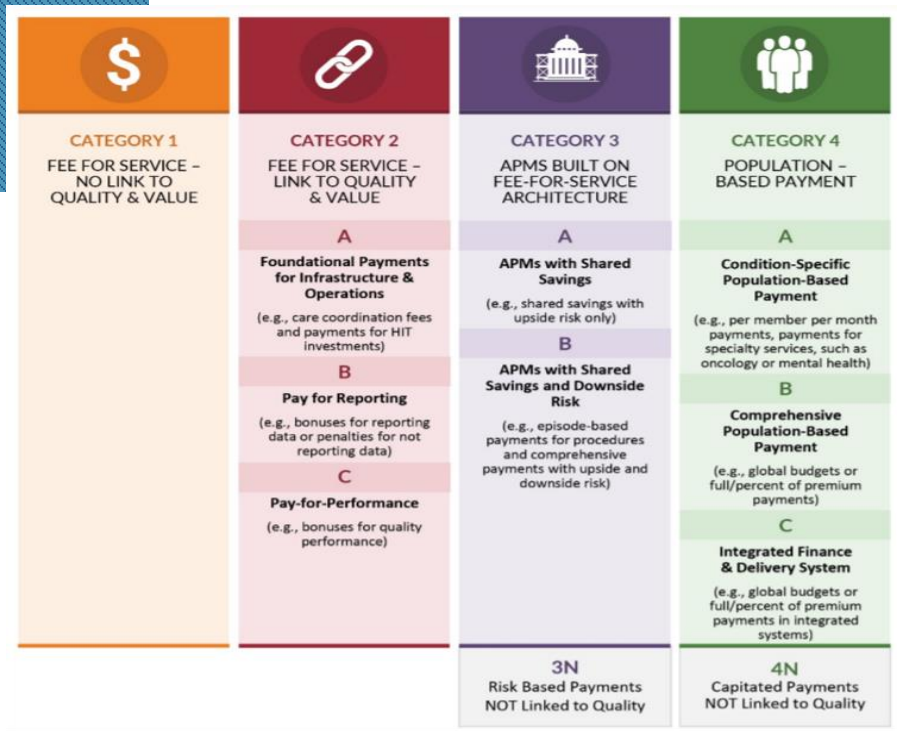
1. Describe the core competencies to support Value Based Payments
2. Identify key actions for developing population health approaches
3. Identify how technology can support VBP

Image permitted by DC Department of Health Care Finance

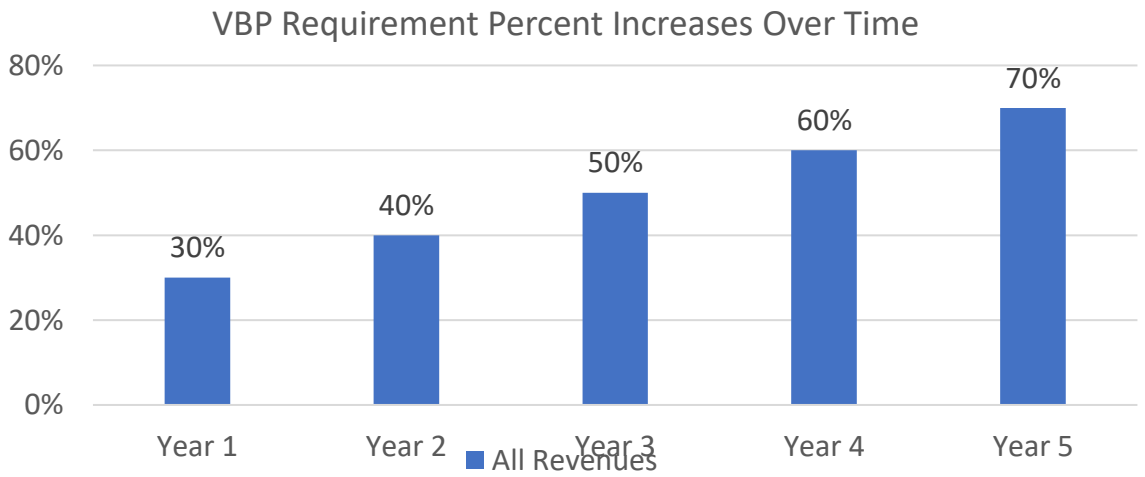
VALUE BASED PAYMENT (VBP) & CORE COMPETENCIES

MCO CONTRACTS PROVIDE GUIDANCE ON VBP TO MOVE THE NEEDLE

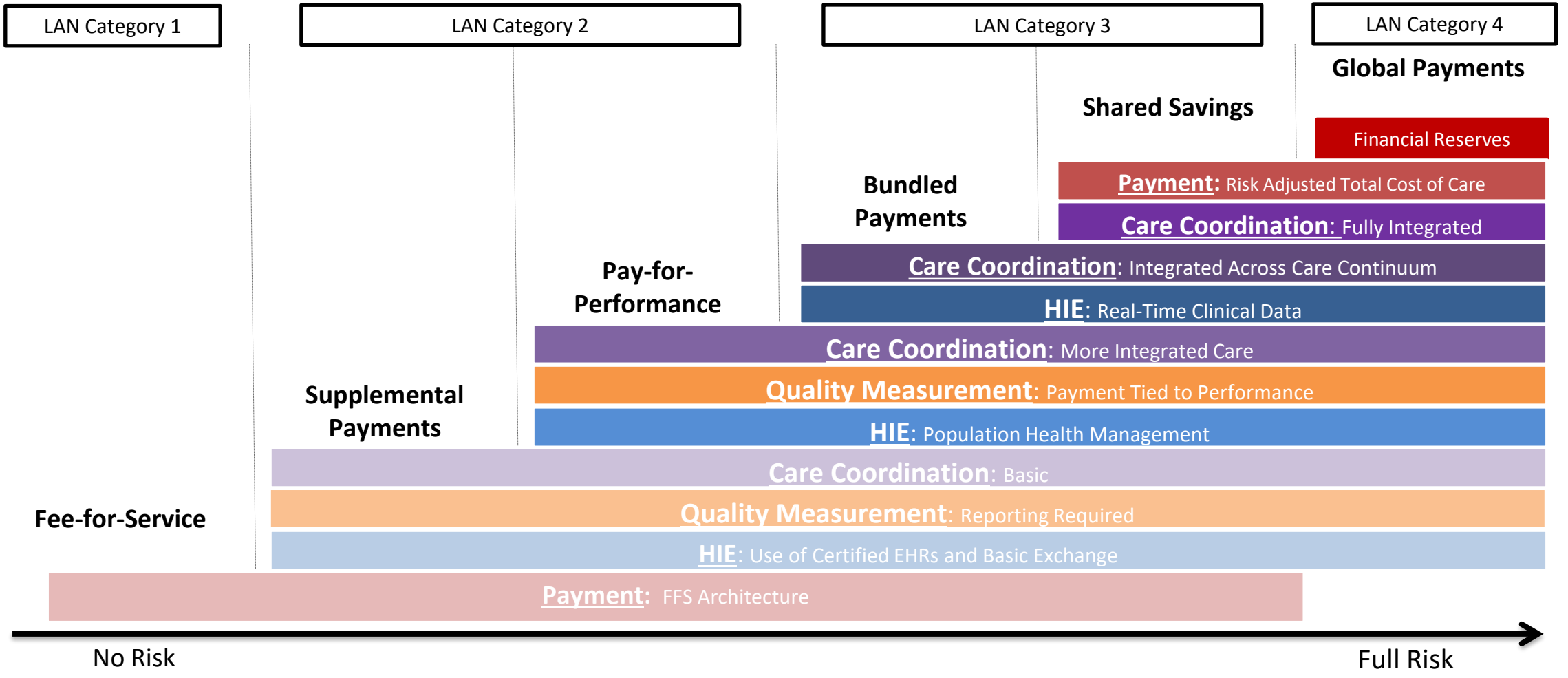
- Base Year One: **30% of total** medical expenditures through VBP arrangements
  - All qualifying expenditures can be through models in LAN categories 2-4
- Base Year Two: **40% of total** medical expenditures through VBP arrangements
  - All qualifying expenditures can be through models in LAN categories 2-4
- Base Year Three: **50% of total** medical expenditures through VBP arrangements
  - At least half of qualifying total medical expenditures must be through models in LAN categories 3-4
- Base Year Four: **60% of total** medical expenditures through VBP arrangements
  - At least half of qualifying total medical expenditures must be through models in LAN categories 3-4
- Base Year Five: **70% of total** medical expenditures through VBP arrangements
  - At least half of qualifying total medical expenditures must be through models in LAN categories 3-4



Health Care Learning and Action (LAN) Framework: [2017 Update to the Health Care Payment Learning and Action Network Framework](#).



DHCF APPROACH TO VALUE BASED PAYMENT



* Alternative Payment Model (APM) categories are based on the 2017 Update to the Health Care Payment Learning and Action Network Framework. (LAN). In essence, category 1 is fee for service (FFS) with no link to quality; category 2 is FFS with a link to quality such as pay for reporting or a bonus payment for quality outcomes; category 3 is an an APM built on a fee for service architecture (e.g. shared savings, or shared savings with downside risk; and category 4 is population-based payment for populations or conditions.

Source: Edmunds, Hass, Holve (eds.),*Consumer Informatics and Digital Health*
https://www.springer.com/us/book/9783319969046

CORE ORGANIZATIONAL COMPETENCIES TO FULFILL WHAT IS GOING TO BE EXPECTED IN THE FUTURE

Today's Workshop Focus

Population Health Planning

Technology

Model of Care and Practices to Achieve Outcomes

Operational Supports

Incentive-based contracts

Organizational Engagement

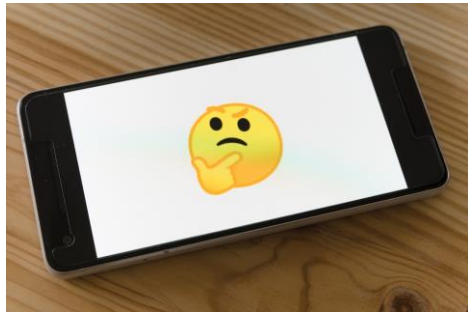
These ***Core Organizational Strategies*** are often known as population health strategies or value-based performance strategies.

POPULATION HEALTH

POPULATION HEALTH

1. Population health is the process of assessing and determining the current health and well-being of populations served by an organization, network or community. Includes understanding the desires and preferences of those served by the organization.
2. Determining what are the needed and desired outcomes for the populations(s) served by an organization and identifying metrics to measure, including but not limited those required by payors.
3. Population health data is used for many different purposes across the organization (e.g., model of care, staffing, training, budgeting, etc.)

Evolving from reacting to the ad hoc needs of individual patients to proactive management of a practice's patient panel.



Unsplash

POLL

- Poll: Are you currently using a population health approach to track clinical outcomes across a population of patients/consumers?
  - If yes, what outcomes are you tracking?

POPULATION HEALTH *STRATEGIES*

- Keeps track of all clients so no one “falls through the cracks”
  - Up-to-date client contact information
  - Referral for services completion
- Tells us who needs additional attention
  - High risk individuals in need of immediate attention
  - Clients who are not following up
  - Clients who are not improving
  - Reminders for clinicians & managers
  - Customized caseload reports
- Facilitates communication, specialty consultation, and care coordination
- Helps to select
  - chronic disease
  - cohort of consumers and interventions most likely to have the greatest effect on improving the management of chronic disease
- Choose the initiative most likely to have significant impact and use to focus educational efforts
- Allows for tracking on VBP- performance bonuses, incentive payments, etc

HMA

POPULATION HEALTH

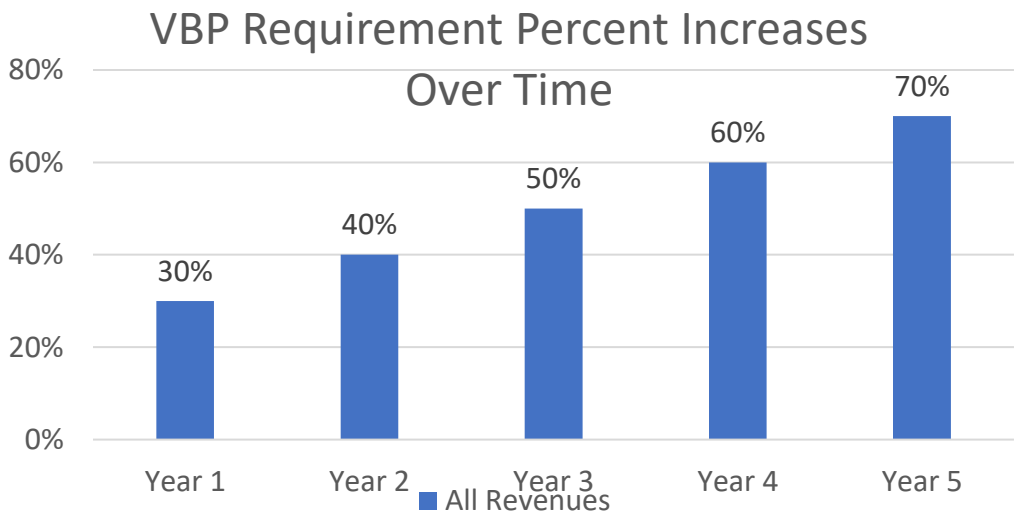
2. Determining what are the needed and desired outcomes for the populations(s) served by an organization and identifying metrics to measure, including but not limited those required by payors.

Based on the results of the ***Population Health Needs Assessment*** what impact is desired (for the overall population and for sub-populations) and establish metrics that can measure impact, such as:

- Health Plan required outcome/metrics:
  - HEDIS – Healthcare Effectiveness Data and Information Set, UDS (for non Medicaid members)
  - CMS Core Measure Set
- Adults
  - Individualizes treatment planning
  - Progress on treatment goals
- Overall
  - Reduce emergency department use, 7 day follow up for mental illness related visit
  - Follow-up after ED, crisis event, or inpatient stay

Can't do everything, prioritize what is measured based on population health assessment

District of Columbia MCO VBP Contracts



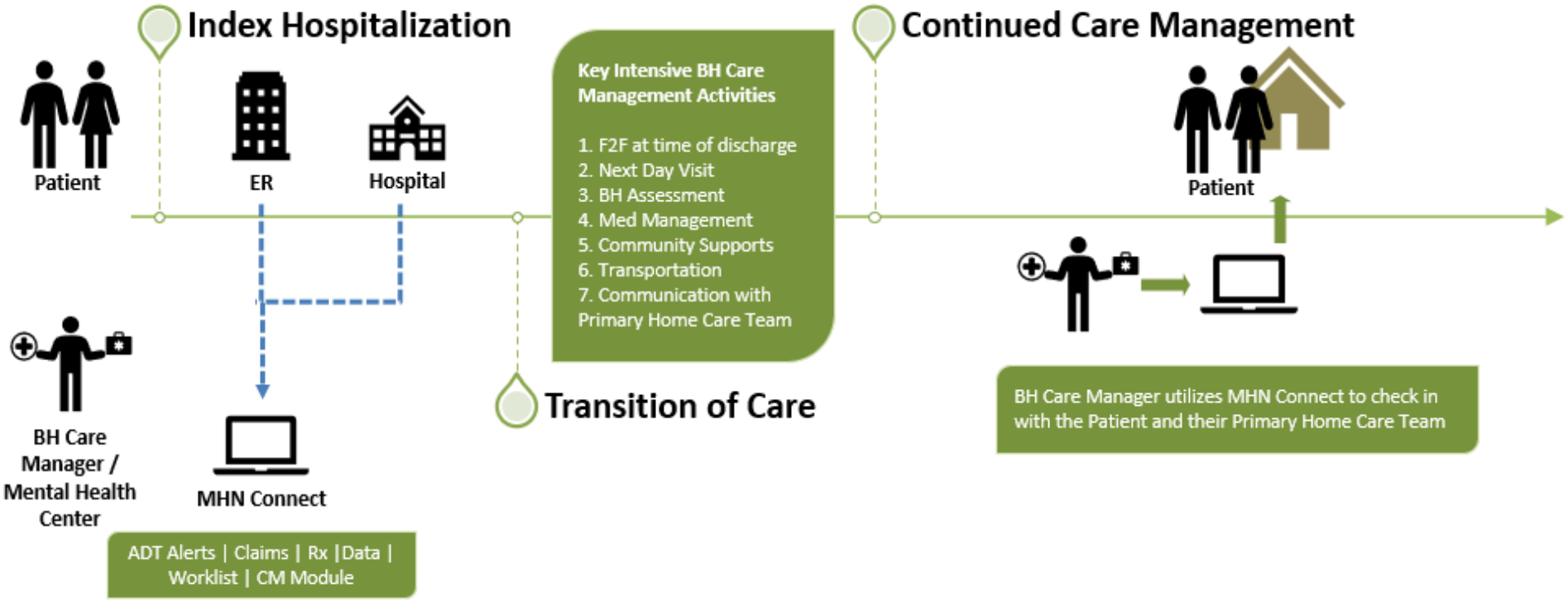
POPULATION HEALTH

3. Population health is used for many different purposes across the organization (e.g., model of care, staffing, training, budgeting, etc.)

Population Health is comprehensive enough to support the entire organization in planning efforts including

- Model of care
- Skills needed by staff
- Types of staff needed (e.g., professionals and paraprofessionals, support staff)
- Budget development
- Negotiate contracts with outcomes that are attainable
- Technology planning that reflects the needs of those served

4. Designing and implementing a whole health care delivery strategy that supports meeting the whole health needs of those served based on the population health assessment.



IDENTIFY CARE GAPS

Compare	Compare Registry Data to accepted Clinical Quality Indicators – HEDIS, UDS, etc
Identify	Identify Care Gaps – where are the outcomes not "meeting the mark?"
Sort	Sort patients with care gaps into specific To-Do lists by outcome (A1C, BP, etc)
Set up	Schedule visits (telehealth or in person) and share with care team and flag in EHR for providers

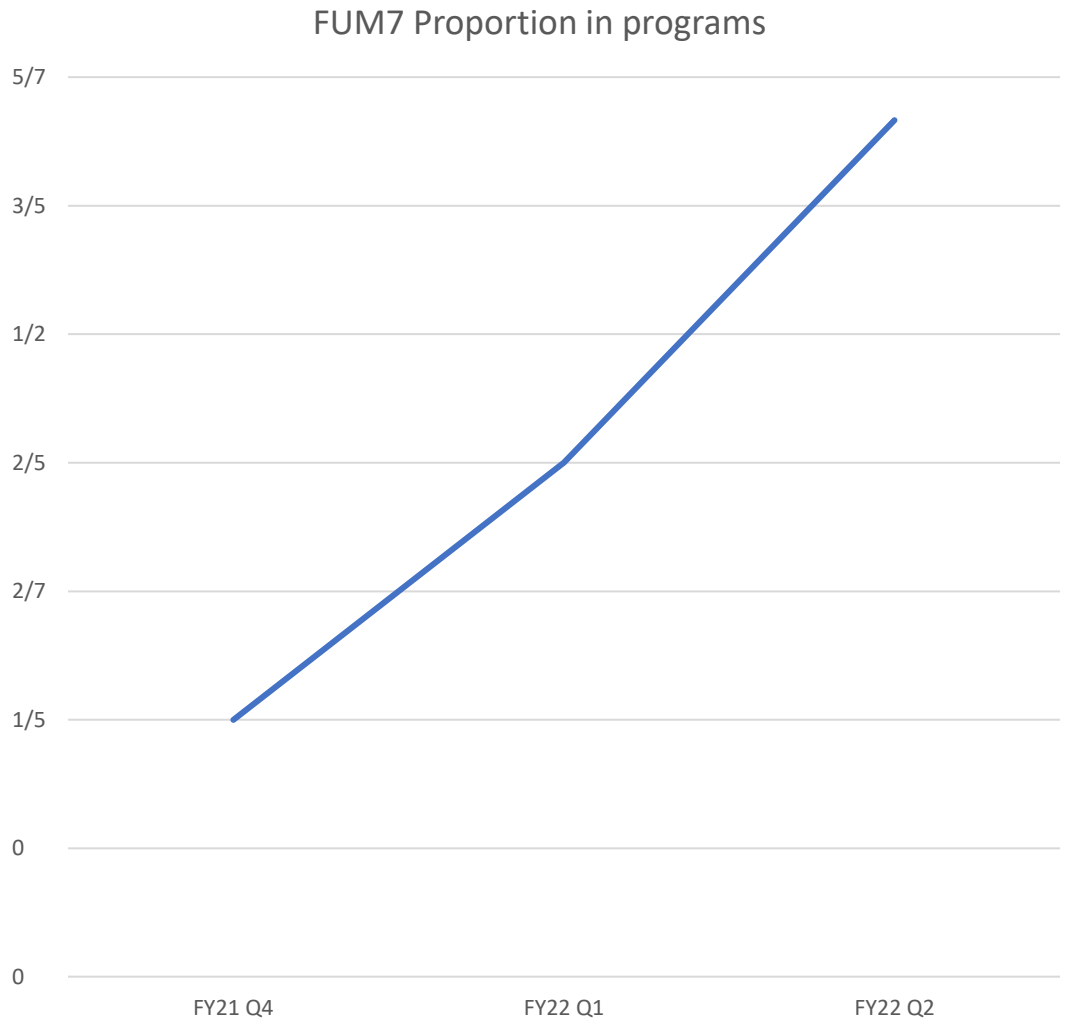
Amerihealth Value Based Payment Performance	FY21 Q4	FY22 Q1	FY22Q2
Behavioral Health			
Antidepressant Medication Management - Acute	NO	NO	NO
Antidepressant Medication Management - Continuation	YES	YES	YES
Follow-up After ED Visit (Mental Illness) - 7 Days	NO	NO	NO
Follow-up After ED Visit (Mental Illness) - 30 Days	NO	NO	NO
Follow-up After Hospitalization (Mental Illness) - 7 Days	NO	NO	NO
Follow-up After Hospitalization (Mental Illness) - 30 Days	NO	NO	NO
Physical Health			
Breast Cancer Screening	NO	NO	NO
Annual Monitoring Patients on Persistent Medications	NO	NO	NO
Comprehensive Diabetes Care - Eye Exams	NO	NO	NO
Comprehensive Diabetes Care - HbA1C Testing	NO	NO	NO
Hospital Utilization Measures			
All-Cause Patient Readmission Within 30 Days	YES	YES	NO
Avoidable Inpatient Admission Rate	YES	YES	YES
Low Acuity Non-Emergent ER Visits	YES	YES	YES

FOLLOW-UP AFTER ED VISIT FOR MENTAL ILLNESS WITHIN 7 AND 30 DAYS

- 7 Days
  - We missed 5 patients across all 3 quarters, plus 4 more in FY22 Q2
- 30 Days
  - We missed the same 3 patients across all 3 quarters
- Common Themes
  - Unable to establish contact and/or engagement with the parent
  - Some hospitals are slow to publish visits on CRISP

FOLLOW-UP AFTER ED VISIT FOR MENTAL ILLNESS WITHIN 7 DAYS (CONT.)

- The proportion of patients that failed to meet this measure rose from 1/5 to 2/3
- In FY22 Q2, 5/6 of the patients came from one specific hospital



CONCLUSIONS

- The patients that we miss consistently need more intervention to ensure they are getting the care they need

- For medication measures:
  - Improve communication with local pharmacy to alert us when meds are not filled
  - Develop semi-automated reminder messages via AppToTo, allowing receptionist to more closely follow up with no shows/cancellations

- For ED and hospital measures:
  - Collaborate with PCP practices on our shared patients

POLL: HOW DO YOU IDENTIFYING SUBPOPULATIONS

- What data do you currently have?
- Where do the prevalent conditions lead you?

KEY QUESTIONS

- How would you provide access to care differently if payment was not dependent on a fee-for-service methodology?
- How would you use care team staff differently?
- What impact would this have on staff recruitment and retention?
- How would this impact the number of patients that you served with your current number of PCPs and BH licensed clinicians?

TECHNOLOGY

BIG PICTURE: TECHNOLOGY

- ✓ Technology strategy and tools are designed to operate within the model of care and are outcome focused
- ✓ Technology systems require a governance structure for management and data integrity
- ✓ Systems that support data analysis and reporting at multiple levels of the organization
- ✓ Systems to support driving and monitoring of care (e.g., optimized through EHR action alerts, dashboards)
- ✓ Configuration of systems to allow for internal and external shared information and interoperability
- ✓ Technology features that allow for self-service tools by individuals and families serve

VBP CORE ORGANIZATIONAL COMPETENCIES: TECHNOLOGY

Minimum Capability Set

- Patient profiling including ability to identify SDOH and isolate “impactable” health factors/drivers
- Patient risk stratification that incorporates SDOH and reflects all medical conditions (physical and behavioral) and their “impactability”
- Facilitation of multi-disciplinary care planning, care plan execution and administration
- Ability to monitor contract-specific/payer-specific financial performance
- Facilitation of distribution of shared savings and incentive payments

Ideal Capability Set

In addition to minimum capability set

- Common data aggregation and analytics platform across all members that intakes, processes and enables analysis of data from multiple sources - EHR, eligibility files, claims, pharmacy fills, ADT feeds, health risk assessments, lab results, etc.
- Bidirectional payer integration
- Closed-loop referral management with as many providers as possible
- Ability to facilitate and track the effectiveness of transitions of care
- Ability to continuously track clinical quality, operational performance and financial performance
- Ability to monitor and model performance for all programs/contracts at all organizational levels –

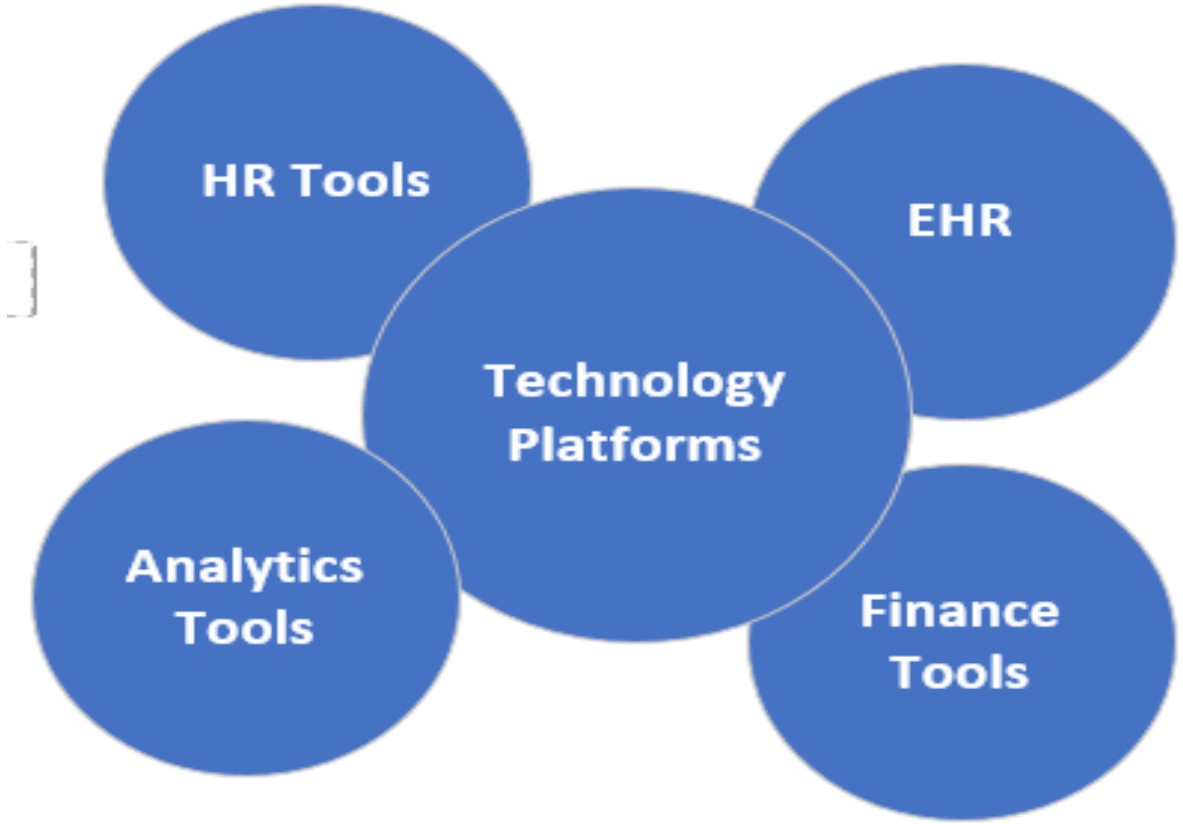
Critical Enablers

- Data aggregation and analytics capacity – including personnel that can conduct advanced analytics and modeling
- IT management infrastructure and operational discipline – IT change management, information security management, end user support, etc.
- Vendor management – ensure vendor performance, hold vendors accountable, leverage bargaining power
- Relationships with payers and other data suppliers/brokers such as HIEs – secure needed data, garner trust

TECHNOLOGY

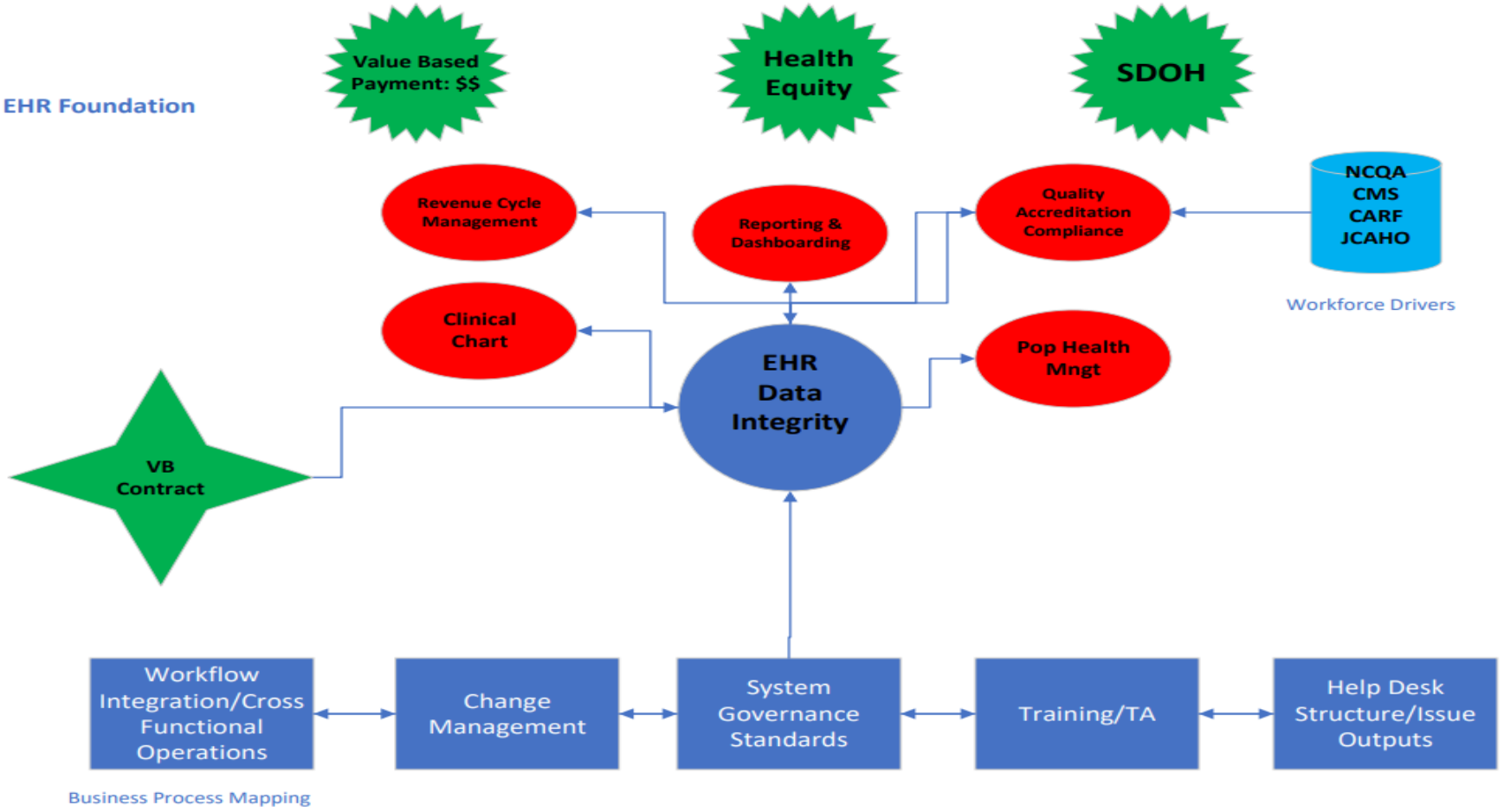
1. Technology strategy and tools are designed to operate within the model of care and are outcome focused

Consider the full array of the technology enterprise, and related parts



TECHNOLOGY

1. Continued - Technology strategy and tools are designed to operate within the model of care and are outcome focused



2. Technology systems require a governance structure for management and data integrity

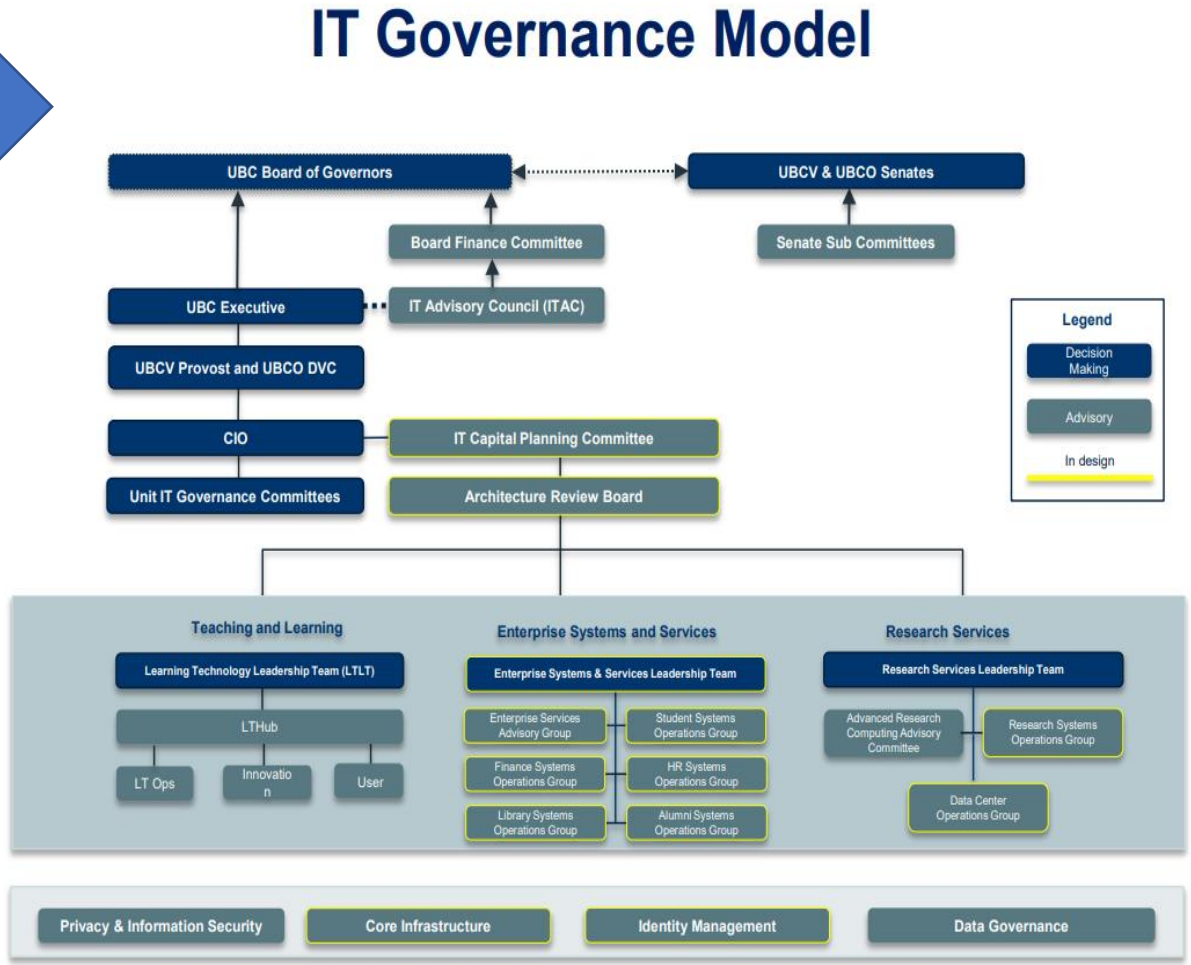
Technology governance can be super complicated

or

Just enough structure to support strong technology planning and implementation and support a strong data strategy.

A simplified version could be a cross functional group that is charged with:

- Research and receive input to make a technology and data plan
- Design technology to support workflows that are consistency amongst cross departmental staff
- Review all payor contracts and standards (new or amendments) to load properly
- Use reporting outputs and requests by staff to prioritize and drive technology changes or use
- As clinical practices evolve or programs are changed, group oversees tech changes

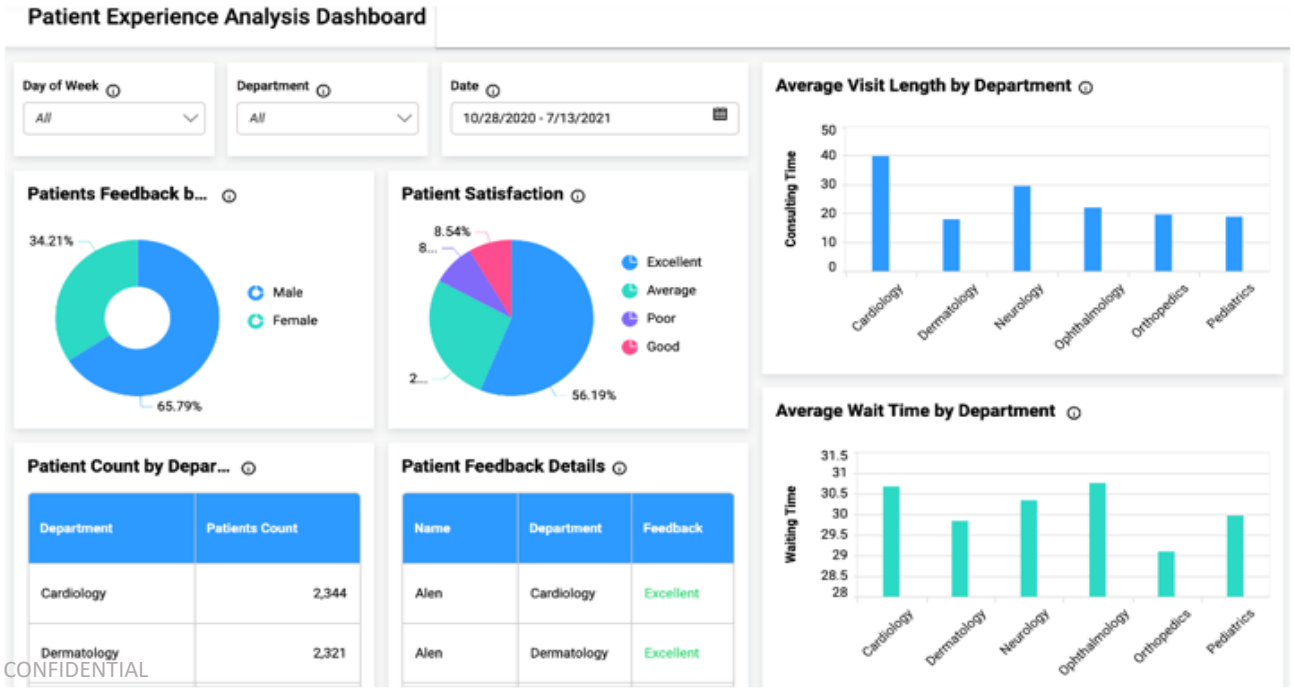


3. Systems that support data analysis and reporting at multiple levels of the organization

- Data metric inventory: Current State v. Future State
- Standardizing reports across the organization to drive harmonious management
- Reports that have needed data for
  - Board
  - Executive Management
  - Middle Management
  - End Users

4. Systems that support driving and monitoring of care (e.g., optimized through EHR action alerts, dashboards)

- Determine what Tools Avatar/Netsmart can offer today
- Establish the "business rules" to when features are used and by whom
- Determine the process for sharing data, with whom and monitoring for CQI
- Dashboards/KPI Dashboard data points driven from EHR content



TECHNOLOGY

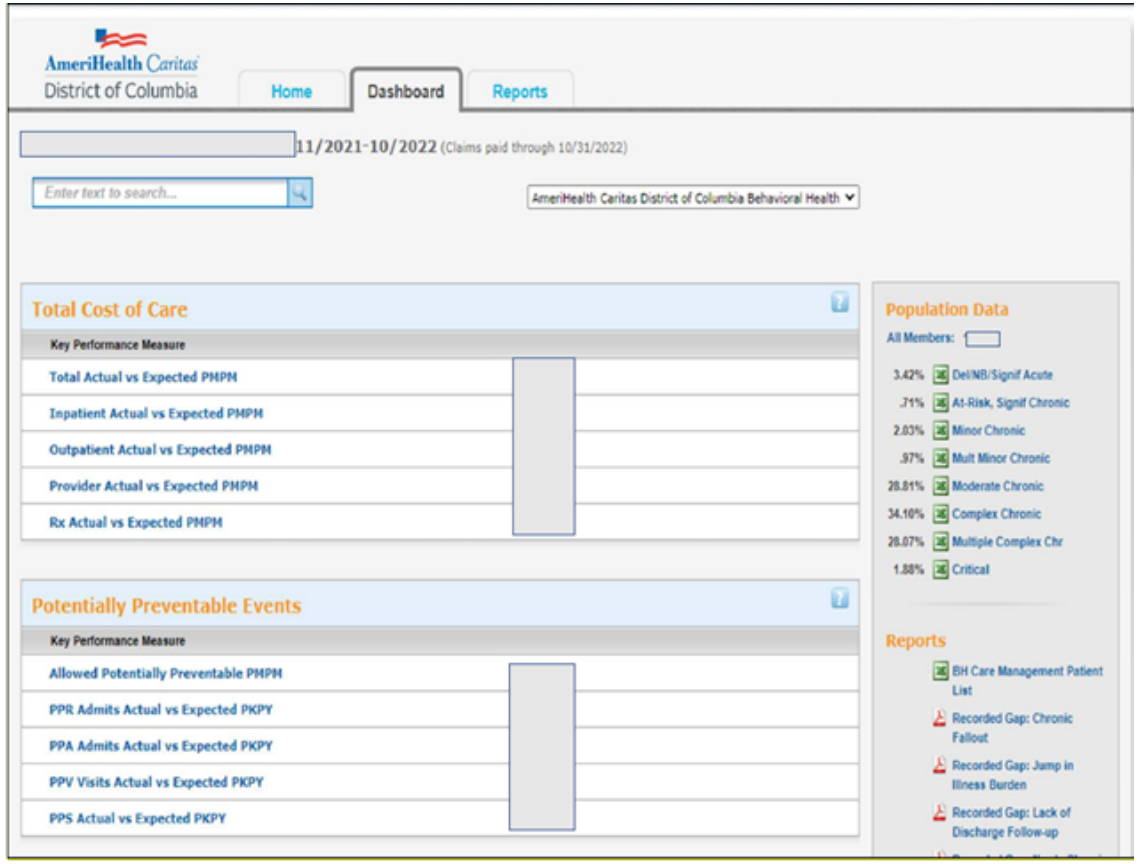
5. Configuration of systems to allow for internal and external shared information and interoperability

- Internal workflow driving security set up and system configuration
- Data integrity mapped to national standards for interoperability requirements
- Adjusting workflows related to take in data or exporting associated with care coordination

6. Tools that facilitate active treatment engagement with individuals and families

- Planned texting focused on closing gaps, immunizations, etc.
- Care coordination enhanced by didactic communication outside of scheduled appointments
- Real time communication potential
- Efficiencies created by documentation directly for standard forms

AmeriHealth Caritas Behavioral Health Dashboard



Key Performance Indicators:

- Potentially Preventable Admissions (PPA)
- Potentially Preventable ER Visits (PPV)
- Potentially Preventable Readmissions (PPR)

BH Care Management Patient List

Preventable Events

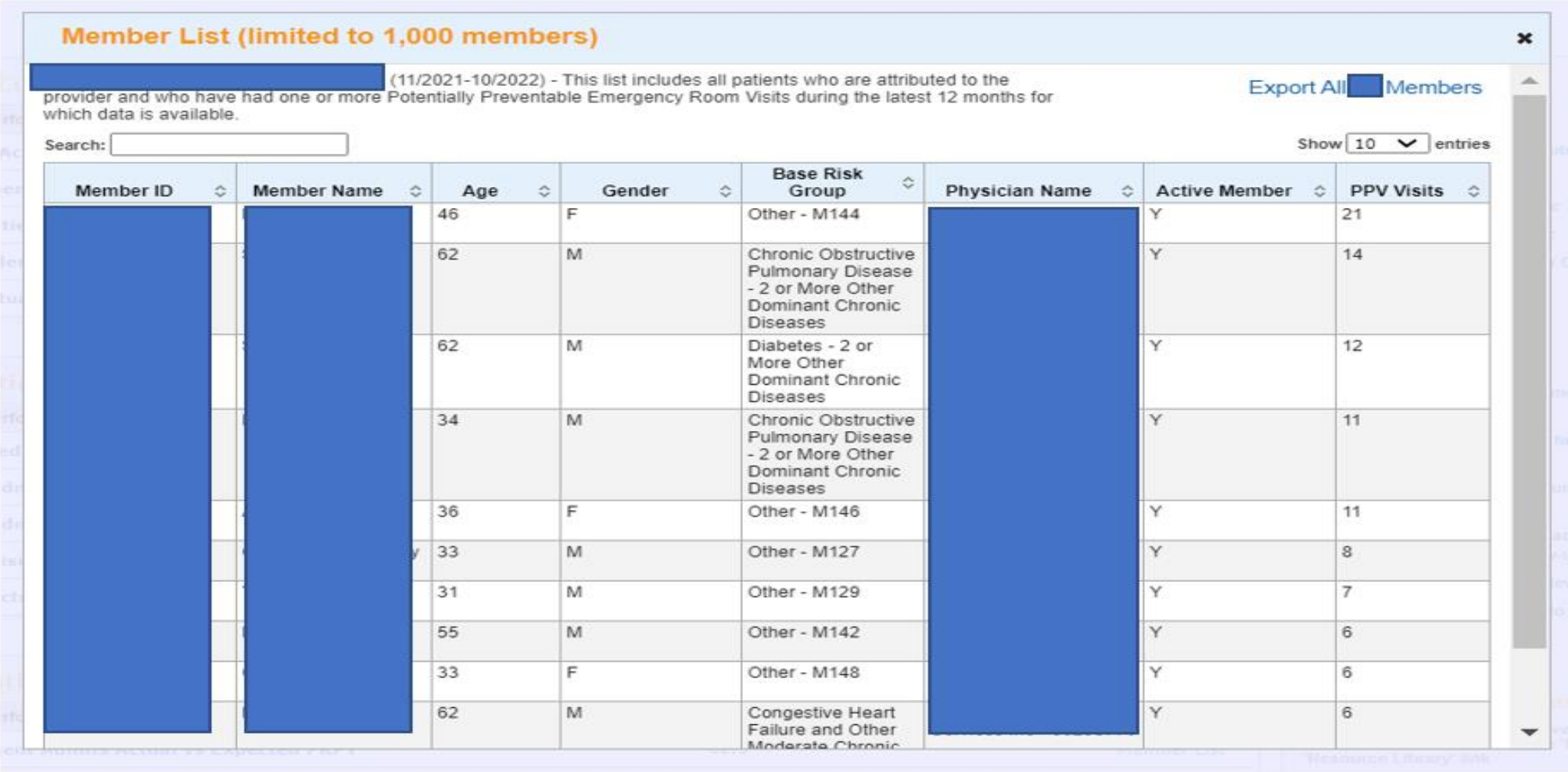
Potentially Preventable Admissions (PPA) - Hospital admissions that could potentially have been dealt with in the outpatient setting and avoided with adequate monitoring and follow-up. May result from hospital and or ambulatory care inefficiency, lack of adequate access to outpatient care, or inadequate coordination of ambulatory care services.

Potentially Preventable ER Visits (PPV) – Visits that could have been treated by a care provider in a non-emergency setting and could have been prevented by adequate patient monitoring and treatment.

Potentially Preventable Readmissions (PPR) – Return hospitalizations within a 30-day readmission time interval that is clinically-related to a previous hospital admission and may result from incomplete treatment of the underlying problem, or the development of complications that become evident after discharge.

Behavioral Health Population Data Dashboard: Preventable ED Visits

AmeriHealth Caritas District of Columbia



Member List (limited to 1,000 members)

[redacted] (11/2021-10/2022) - This list includes all patients who are attributed to the provider and who have had one or more Potentially Preventable Emergency Room Visits during the latest 12 months for which data is available.

Export All [redacted] Members

Search:

Show 10 entries

Member ID	Member Name	Age	Gender	Base Risk Group	Physician Name	Active Member	PPV Visits
[redacted]	[redacted]	46	F	Other - M144	[redacted]	Y	21
		62	M	Chronic Obstructive Pulmonary Disease - 2 or More Other Dominant Chronic Diseases		Y	14
		62	M	Diabetes - 2 or More Other Dominant Chronic Diseases		Y	12
		34	M	Chronic Obstructive Pulmonary Disease - 2 or More Other Dominant Chronic Diseases		Y	11
		36	F	Other - M146		Y	11
		33	M	Other - M127		Y	8
		31	M	Other - M129		Y	7
		55	M	Other - M142		Y	6
		33	F	Other - M148		Y	6
		62	M	Congestive Heart Failure and Other Moderate Chronic		Y	6

Clinical Risk Groupers: the relative illness burden of a population, risk-adjusted to a standard population

- Provide a population classification system that uses inpatient and ambulatory diagnosis and procedure codes, pharmaceutical data and health status to assign each individual to a single, severity-adjusted group
- Patient-centric data, focusing on the total burden of illness rather than one disease or service, and use a categorical approach to patient classification that provides clinicians with actionable data
- Demonstrate the health status and burden of illness of individuals and can help identify medically complex individuals
- Account for co-morbidities and measure the health status of an individual over time

Care Management Patient List:

An excel spreadsheet that provides a list of patients who have at least one of the identified gaps noted below and is useful for identifying at-risk patients. This report provides an additional way to sort, manage, and organize all of the information in the report.

Report fields include:

- Chronic Fallout
- Jump in Illness Burden
- Lack of Discharge Follow-up – 7 Day and 30 Day
- Missing Office Visit
- Newly Chronic

Chronic Fallout: This report identifies patients who were identified as having a chronic, catastrophic, or malignant condition in a prior 12-month period and are no longer flagged as such in the current data set. This may indicate incomplete medical documentation or a gap in care for that individual.

Jump in Illness Burden: This report identifies those patients whose CRG score has jumped significantly in status. A significant jump in status could entail moving from having one chronic condition to having multiple conditions, or showing an increase in the severity of an existing condition.

Lack of Discharge Follow-up – 7 Day and 30 Day: This report presents all patients who had an admission to the hospital for any cause during the reporting period but who did not have seven day and/or thirty day follow-up visits to any provider.

Missing Office Visit: This report identifies chronically ill patients who have not had a provider visit in the last 6 months.

Newly Chronic: This report identifies patients that are now considered chronic but were previously not chronic. These could be previously healthy patients or newly attributed/enrolled patients.

3M™ Core Health Status Groups

AmeriHealth Caritas District of Columbia

3M CRG Core health status groups (1-9)	Description and Example	Severity Levels
9 – Catastrophic Conditions	Catastrophic conditions include long term dependency on a medical technology (e.g., dialysis, respirator, total parenteral nutrition) and life-defining chronic diseases or conditions that dominate the medical care required (e.g., acquired quadriplegia, severe cerebral palsy, cystic fibrosis, history of heart transplant).	4
8 – Malignancy, Under	A malignancy under active treatment.	4
7 – Dominant Chronic Disease in three or more organ systems	Three or more (usually) dominant Primary Chronic Condition (PCDs). In selected instances, criteria for one of the three PCDs may be met by selected moderate chronic PCDs. Example: Diabetes mellitus, congestive heart failure and chronic obstructive pulmonary disease.	6
6 – Significant Chronic Disease in Multiple Organ Systems	Two or more dominant or moderate chronic PCDs. Example: Diabetes mellitus and CHF.	6
5 – Single Dominant or Moderate Chronic Disease	A single dominant or moderate chronic PCD. Example: Diabetes mellitus.	4
4 – Minor Chronic Disease in Multiple Organ Systems	Two or more minor chronic PCD. Example: Migraine and benign prostatic hyperplasia.	4
3 – Single Minor Chronic Disease	A single minor chronic PCD. Example: Migraine	2
2 – History of Significant Acute Disease	Example: Chest pains.	None
1 - Healthy	The absence of any significant acute Episode Diagnostic Category (EDCs) or Episode Procedure Categories (EPCs) occurring within the last twelve months of the analysis period along with the absence of any validated PCDs reported at any time during the analysis period.	None

REFERENCE LIST

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WRAP UP AND NEXT STEPS

- Please complete the online evaluation! **If you would like to receive CE or CME credit, the evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar.

- The webinar recording will be available within a few days at: https://www.integratedcaredc.com/learning/

- **Upcoming Webinar:**
  - *Allowing Data to Tell a Story: Relevant Metrics to Help Reflect the Infinite Values of Integrated Healthcare*, December 13, 12:00pm-1:00 pm EST

- For more information about Integrated Care DC, please visit: https://www.integratedcaredc.com/

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