Leveraging Partnerships in High Value Care Initiatives

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the DELTA CENTER
for a thriving safety net

Today's Presenter

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SNAC
National Safety Net Advancement Center

- Currently serves as a consultant with Arizona State University's National Safety Net Advancement Center
  - https://safetynet.asu.edu/

CommUnityCare HEALTH CENTERS

- Currently Chief Executive Officer for Central Texas Community Health Centers dba CommUnityCare
  - https://communitycaretx.org/

West Side Community Health Services

- Former Chief Executive Officer for West Side Community Health Services (now Minnesota Community Care)
  - https://www.mncare.org/

FUHN
Leading your community-based health care in the Twin Cities

- Former Board Chairperson for the Federally Qualified Health Center Urban Health Network
  - https://www.fuhn.org/

Health Center Learnings

- Experience as a FQHC CEO spans 3 Midwestern states (IL, MI, and MN) and now Texas.
- Each transition has been to a progressively larger and more complex health care organizations yet challenges and their associated opportunities have been the same.
- In all settings, leveraging the “power of partnership” has been a key driver of success.

Need to be Opportunistic - Call to Innovate

vs.

Minnesota's Value Based Medicaid Opportunity

- Minnesota passed health care reform legislation in 2010 that directed it's Medicaid Program to pilot value-based care initiatives.

- Minnesota's Medicaid Program responded to this legislation by establishing its "Health Care Delivery System" demonstration program (now called Integrated Health Partnerships or IHPs.

- Minnesota's IHP Program allowed health systems to test Medicaid Accountable Care Organization (ACO) models with the goal of delivering higher quality and lower cost health care through innovative approaches to care and payment.

- Unique attribute of Minnesota's IHP "demo":
  - Direct provider contracting.

Minnesota's Experience and Key Attributes

- IHP Program incorporates a value-based payment model that takes into account the cost and quality of the health care services provided.
- Minnesota IHPs shared savings and/or losses under a risk/gain payment arrangement based on spending for a defined set of services (i.e. TCOC) for attributed Medicaid beneficiaries compared to spending for a prior period.
- From 2013 through 2017, Minnesota Medicaid saved an estimated **$276,716,761 with about $92 million returned to IHP providers as shared savings.**

Minnesota Integrated Health Partnership Demonstration: Results from 2013 through 2016 with Preliminary Results for 2017					
	2013	2014	2015	2016	2017*
Number IHPs Reported	6	9	16	19	21
Total number attributed enrollees	96,615	165,638	219,459	358,006	466,460
Number IHPs achieving savings/# meeting threshold	6 Achieved Savings / 5 Met Savings Threshold (i.e. Achieved Savings)	9 Achieved Savings / 9 Met Savings Threshold (i.e. Achieved Savings)	13 Achieved Savings / 10 Met Savings Threshold (i.e. Achieved Savings)	12 Achieved Savings / 6 Met Savings Threshold (i.e. Achieved Savings)	15 Achieved Savings / 9 Met Savings Threshold (i.e. Achieved Savings)
Estimated savings	$14,825,352	$65,339,161	$87,508,840	$48,361,582	$60,681,826
Number IHPs with losses/# meeting threshold	None	None	2/0	4/0	3/0
Estimated losses	None	None	$758,593	$4,307,703	995,683
Source: Minnesota Department of Human Services					

An Opportunity Almost Missed

- Minnesota Medicaid initially did not contemplate a "virtual" ACO model when the Health Care Delivery System demonstration was announced
  - Partly because there was a belief that an ACO had to be a large health system(s) or must at a minimal include a hospital.

Fortunately ….

- Federally Qualified Health Centers in MN were already partnered through our Primary Care Association, MNACHC.

Minnesota Association of COMMUNITY HEALTH CENTERS

- MNACHC apprised its membership that health care reform was coming to Minnesota and supported strategic contemplation about how MN FQHCs might collaborate as independent providers and potentially as a "system of care", with the latter including consideration of statewide IPA, MSO, etc.
- Clearly demonstrated through MNACHC's support was that only 1 MN FQHC had adequate patient volume to garner individual attention.

Reality …. Checked

- Through MNACHC, Minnesota's FQHCs used a request for information process with its Medicaid Program to push for a a "virtual" ACO pilot that did not require hospital participation.
- But why pursue a Medicaid ACO pilot and would it be worth the effort especially considering Minnesota was not going to provide any direct / upfront support …. So no guarantees other than a lot of work!
- So … the majority of the Twin Cities FQHCs (10 out of 12) decided that it was better **to drive the bus!** and created:

FUHN

Leading your community-based health care in the Twin Cities

What is FUHN?

- Federally Qualified Health Center Urban Health Network
- Collaborative partnership of 10 Minneapolis/St. Paul Federally Qualified Health Centers (FQHCs)
- Nation's first FQHC-only Safety Net Medicaid Accountable Care Organization.

axis MEDICAL CENTER

Indian HEALTH BOARD
COMMUNITY TRADITION WELLNESS

MINNESOTA COMMUNITY CARE

NATIVE AMERICAN COMMUNITY CLINIC
HONORING HEALTH AND TRADITION

NEIGHBORHOOD healthsource
Central Clinic · Fremont Clinic · Sheridan Clinic

Open Cities Health Center
COMMUNITY HEALTH WITH A HEART

People's Center
CLINICS & SERVICES

Southside
Community Health Services, Inc.

United Family Medicine
A COMMUNITY CLINIC

UNIVERSITY OF MINNESOTA
Community-University Health Care Center

What is FUHN? (continued)

- In 2017, FUHN member clinics served 110,000 patients in the Twin Cities area.
- Very Diverse - 91%; 41% best served in a language other than English.
- Very Poor - 95% under 200% FPL
- 50% Medicaid, 28% uninsured, 15% commercial, 7% Medicare
- 40 unique service sites
- Services include medical, dental, mental health, substance abuse, vision and enabling; also Variety of special programming – homeless, public housing, schools, HIV/AIDS, legal, case management, mobile, community education & outreach, enrollment in public programs, exercise, community gardens and farmers markets, domestic violence, etc.

Do You Know Which Game You are Playing?

- Challenge for all FQHCs and CBHOs as the health care landscape continues to change and push toward value over volume:

Play Checkers – Maintain mission to serving underserved

Play 3D Chess – Participate in "reform/evolving" marketplace

Peaceful Scene or is it?

Why an FQHC led ACO Developed in the Twin Cities?

- FUHN viewed Demonstration as:
  - Opportunity to (1) leverage resources;
  - Opportunity to (2) foster collaboration;
  - Opportunity to (3) learn together.

- FUHN participating health centers also had individual motivations, but universally was recognition that "change" was coming and there was a "survival threat" to individual organizational integrity, and historic populations served as a result of quickly reforming health environment

- Choice for each health center …. Join larger systems to gain access to resources OR take a leap of faith to transform our clinical practices as a collective **aligned** partnership?

- Partnership alignment:
  - FQHC mission … Community based, governed by patients, economic engine in urban core, tailored service delivery, social justice

What were West Side Community Health Centers', as a FUHN Health Center, Motivators?

Extrinsic

- Increased competition – default provider to provider of choice
- Increasingly irritated payers - Relatively weak unadjusted clinical outcomes compared to costs/spending = Unsustainable cost growth
  - Demographics
  - Disease burden

Intrinsic

- Desire to stay relevant in dynamically changing market plan
- Care Transformation
- Address health inequity while reducing health disparities
- Opportunity to leverage needed resources for populations served

Both: Extrinsic and Intrinsic

- Better access to clinical information and related insights
  - EMR adoption and Health Information Exchange
  - More information is better
- Financial Constraints/Pressures
- Service Delivery Constraints/Pressures

Partnership is Messy and Hard!

- As a large health center, why not just go it “alone”.
- Why bother? Why are we doing this? What is it in for me?
- Core belief that we are stronger together and that we can do great things better through collaboration.
  - But we are competitors or are we?
- FQHCs and Community Behavioral Health Organizations (CBHOs) are the model for this population:
  - Health reform trends (then and now!) place importance on primary care health care homes that focus on the health of patients and address social determinants.

Commit to the What

- Recognizing our need to respond to a new and emerging value-based market, the FUHN FQHCs decided they needed to undergo significant Clinical Practice Transformation that included deliberate initiatives around:
  - ✓People
  - ✓Process
  - ✓Technology

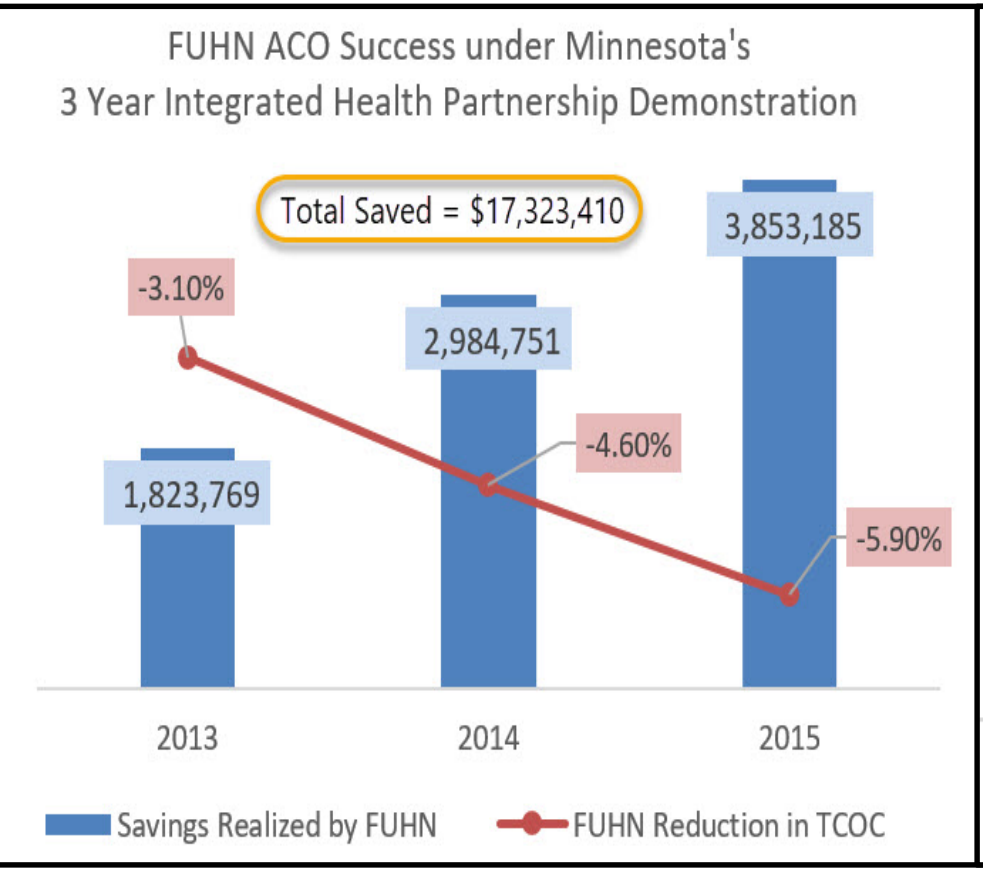
FUHN's How – Just an Example

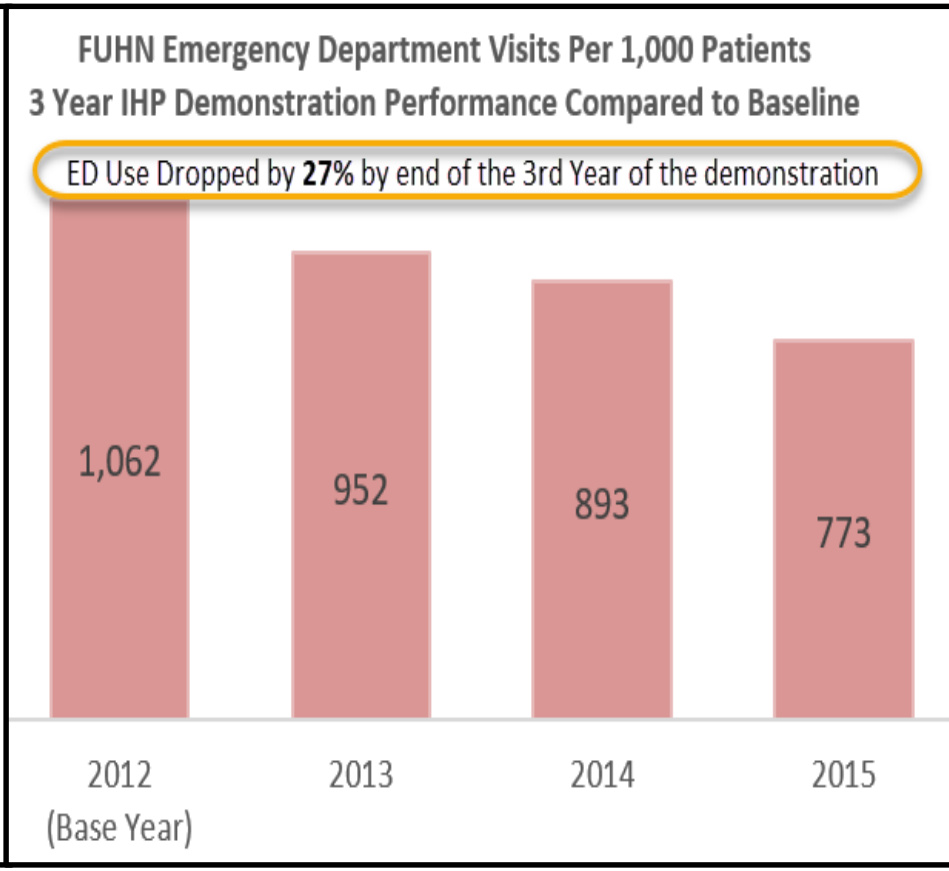
- Clinical Practice Transformation
  - Infuse Change Management Techniques – change culture
  - Achieve Health Care Home Certification as building block to establish policies/protocols/process
  - Use of e-health technologies and data analytics
    - Predictive modeling for higher cost patient costs
    - ID/Stratification for gaps in care leading to higher costs
    - eHealth Exchange for more comprehensive view of care
  - Design new and more effective clinical interventions with standardized medical protocols, workflow and processes and associated workforce training
  - Example: Avoidable ED utilization
- Re-invigorate care coordination
  - Motivational interviewing
  - LEAN process improvement
  - Utilization of population health analytics data
  - Team-based care, Pre-visit Planning, and Daily Team Huddles
  - Referral management
- Understand new payment models
  - Responsibility for total care received outside our 4 walls
  - Gain/risk-sharing around TCOC, quality and patient satisfaction

FUHN's Experience – "The Art of the Deal"

- 2013: Approximately 24,000 unique Medicaid beneficiaries
- 2015: Approximately 32,000 unique Medicaid beneficiaries with this growth are result of:
  - Medicaid expansion
  - Move from 12 months to 24 months attribution period
- Roughly 55% of the FUHN participating Medicaid patient population was attributed to the ACO.
- Annual spend (TCOC) for attributed patients was $175 million, but FUHN's TCOC was for $140 million or about 80% of the total as certain services were excluded (for example, in-patient mental health). FUHN TCOC included:
  - 100% of all pharmacy claims
  - 99% of all outpatient claims
  - 99% of all professional services
  - 97% of all inpatient services including emergency department services
  - 43% of mental health / chemical dependency services

FUHN's Results – Leveraging Resources and Partnership





How did FUHN achieve these results?

"Fierce competitors to extreme collaborators"

How did FUHN achieve its results?

- Implementation of a Care Coordination Program comprised of two essential components designed to put **ACTIONABLE** data in the hands of its Primary Care Providers:
  - Robust Data Analytics infrastructure using claims utilization and real-time clinical data.
  - Dedicated personnel in FUHN's clinic sites using this new data analytics to implement patient interventions designed to drive cost and quality improvements.
- This capability gave FUHN providers a sight line to patient utilization occurring OUTSIDE beyond the Health Centers' 4 walls.

But ….

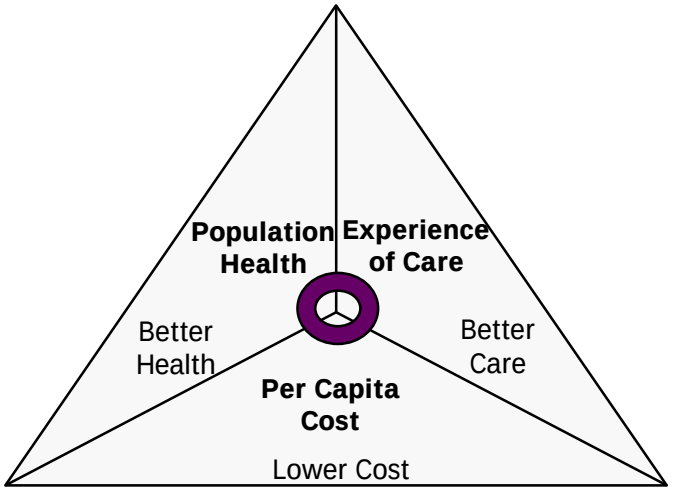
- Implementing a Care Coordination Program supported by robust analytics required a significant upfront investment … :
  - FUHN relied on an administrative partner (Optum) to provide the initial upfront funding necessary to acquire the data infrastructure and dedicated personnel required by our Care Coordination Program.

How did FUHN achieve its results (Continued)?

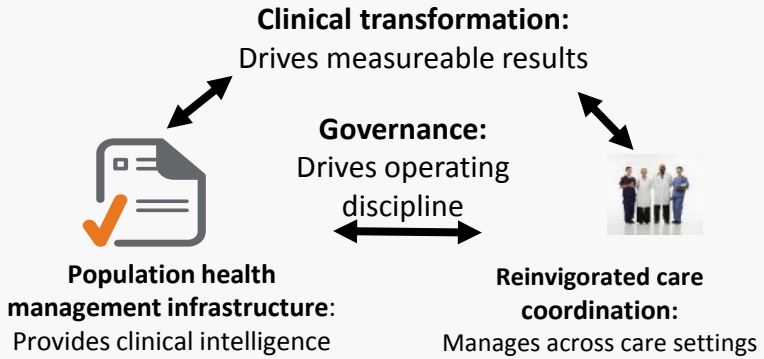
- Using ID/Stratification Tool
  - Emergency Department Reduction (minor conditions)
  - Asthma Management
  - Diabetes Management
  - Pain Management/Opioid RX
- Standardized clinical policy throughout the Network – Getting to the power of 10
- Work flow – Proliferation of LEAN

Triple Aim + 1:

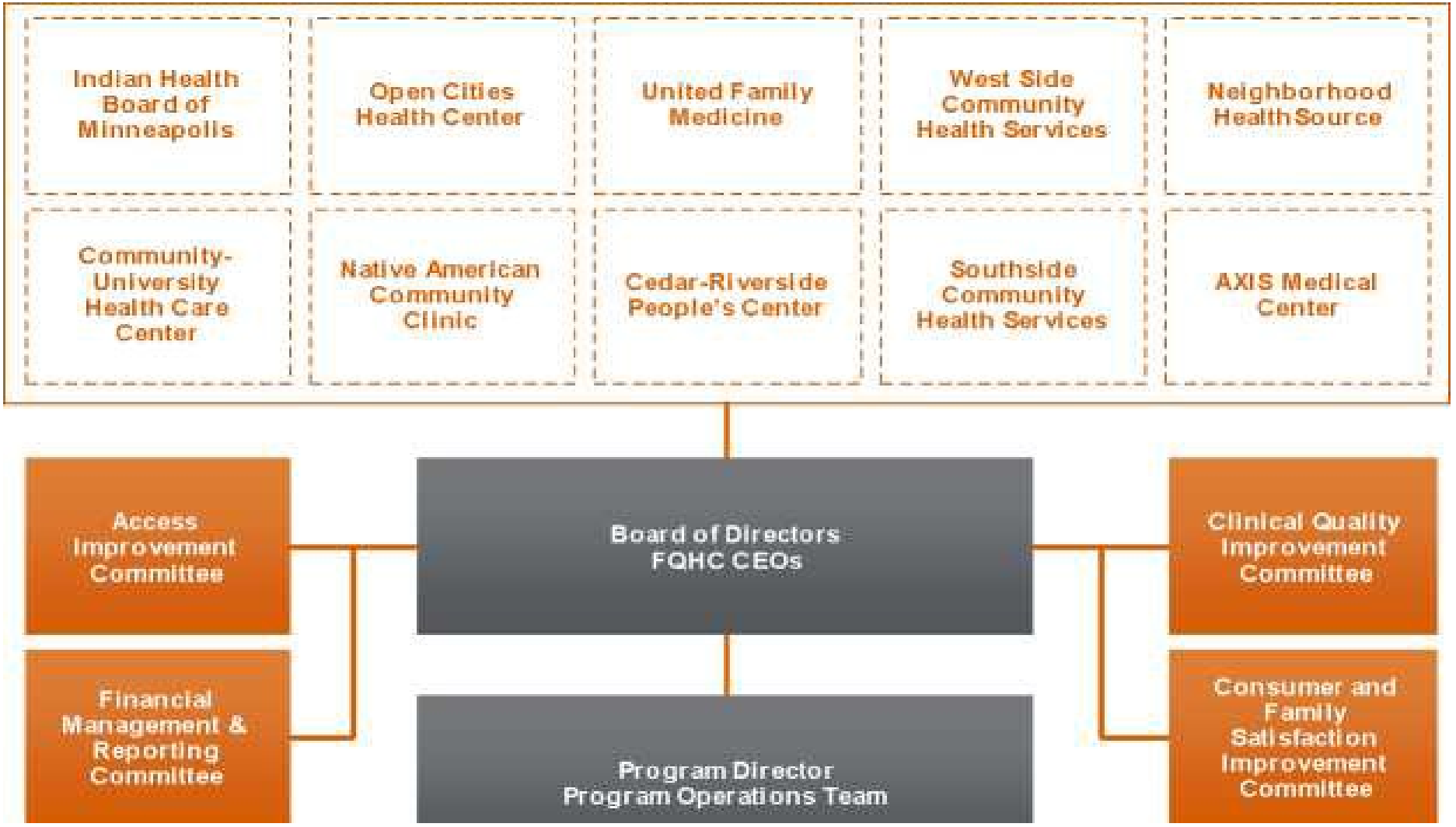
1. Reduced total cost of care
2. Improved clinical quality
3. Improved patient and family satisfaction
4. Emphasis on primary care services and relationship



- **Element #1: Population health management infrastructure**
- **Element #2: Program governance**
- **Element #3: Performance improvement & clinical transformation**
- **Element #4: Care coordination across care settings**



FUHN's Structure Fosters Collaboration and Consensus Decision Making



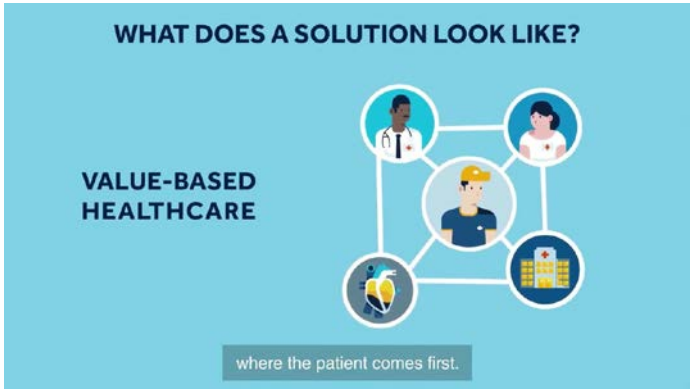
Lessons Learned

- Moving toward value-based initiatives necessitates transformation (people, technology, resources, systems, and intent).
- Upfront capital for technology is very expensive
- Investing in staff re-training is essential & takes lots of time
- Know what you know, recognize what you don't and get help.
- TCOC reduction and improved health outcomes are possible … just ask FUHN FQHCs.

Things to Think about

Best offense is a good defense …

Bring Value to the market …



Take a chance and step off …

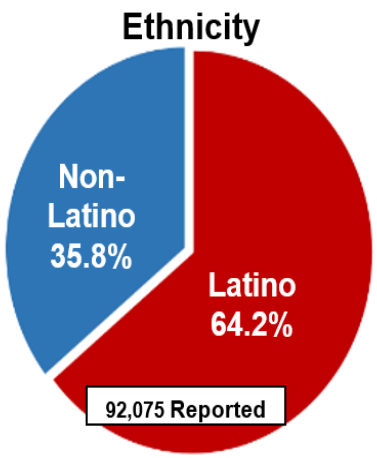
Preferably with friends.

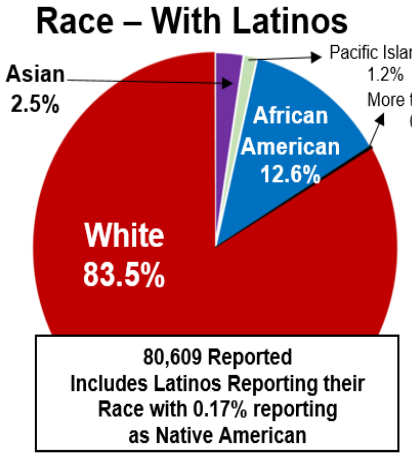
Meanwhile in Texas

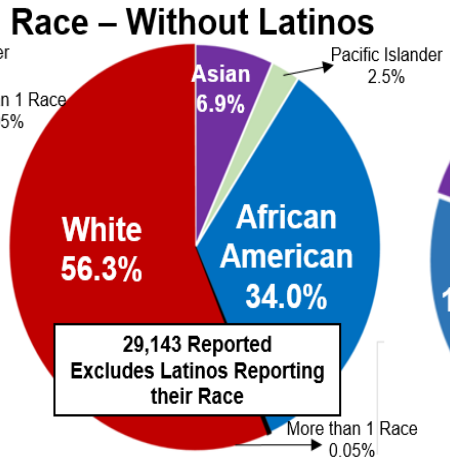
- Everything is bigger …. including unmet medical needs for under-resourced populations.

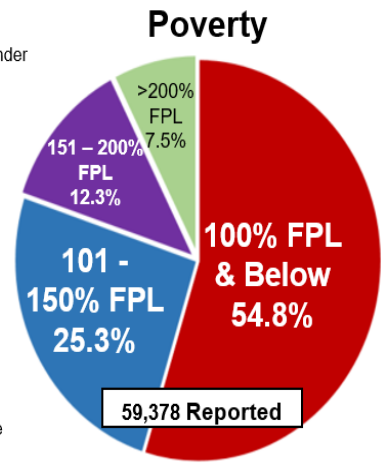
CommUnityCare HEALTH CENTERS

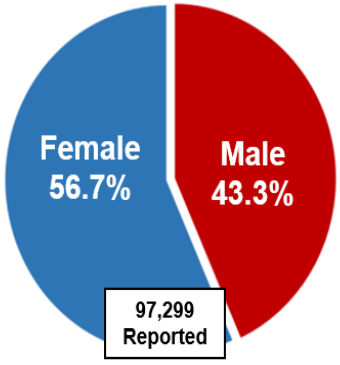
2018 Patient Population Characteristics



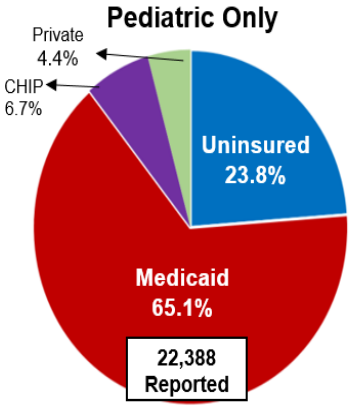


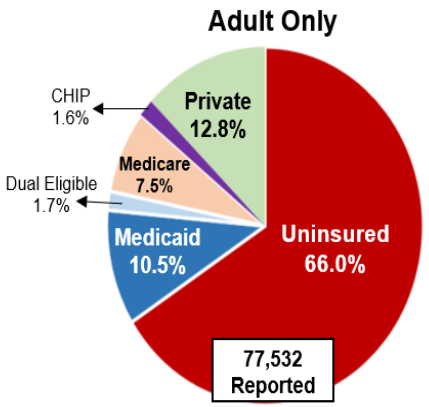


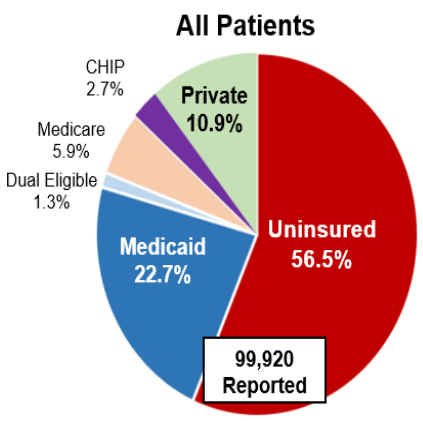




2018 Patients by Insurance







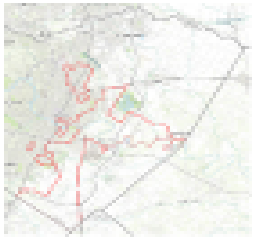
The View from Twenty Thousand Feet

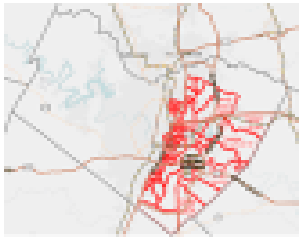
- In CommUnityCare's federally approved service area (which is essentially Travis County, Texas) there are:
  - Almost a ½ million individuals with household incomes below poverty
  - Almost 170,000 Medicaid / Public Insurance individuals

Report Area	Total Population (For Whom Insurance Status is Determined)	Total Uninsured Population	Percent Uninsured Population
Travis County, TX	1,169,148	171,556	**14.67%**
Arizona	6,701,990	814,408	12.15%
Colorado	5,344,703	503,311	9.42%
Iowa	3,074,216	172,418	5.61%
Maine	1,315,654	118,775	9.03%
Massachusetts	6,713,702	200,294	2.98%
Michigan	9,814,714	702,954	7.16%
Missouri	5,961,514	621,543	10.43%
New Mexico	2,050,101	256,162	12.5%
New York	19,556,260	1,481,650	7.58%
North Carolina	9,845,238	1,186,403	12.05%
Oregon	3,985,781	352,236	8.84%
Texas	26,943,687	4,916,911	**18.25%**
Washington	7,063,032	584,670	8.28%
United States	316,027,641	33,177,146	10.5%

The View from a Thousand Feet

- Significant and persistent health disparities adversely impact those CommUnityCare serves.

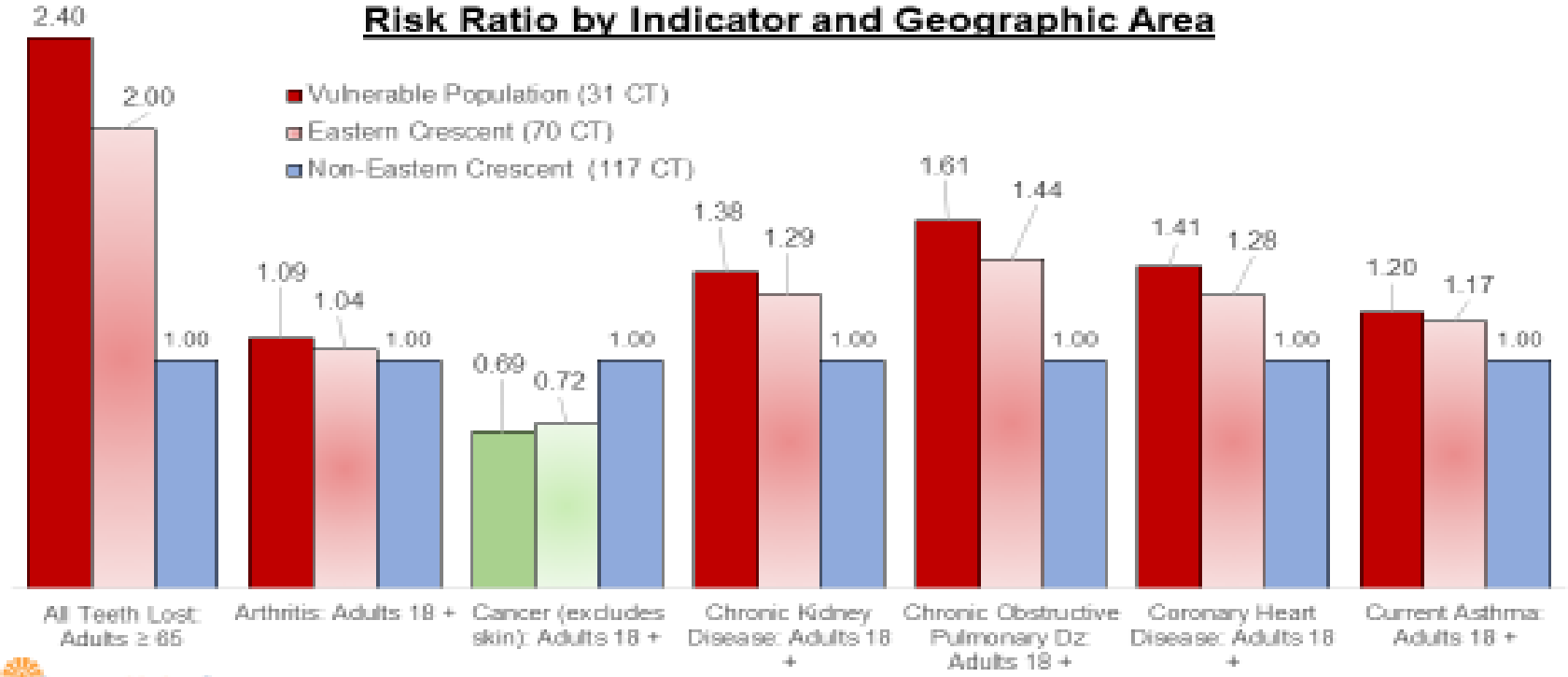




Health Outcome Disparities

West ≠ East

BRFSS Health Outcomes in Austin:
Risk Ratio by Indicator and Geographic Area



CommUnityCare HEALTH CENTERS

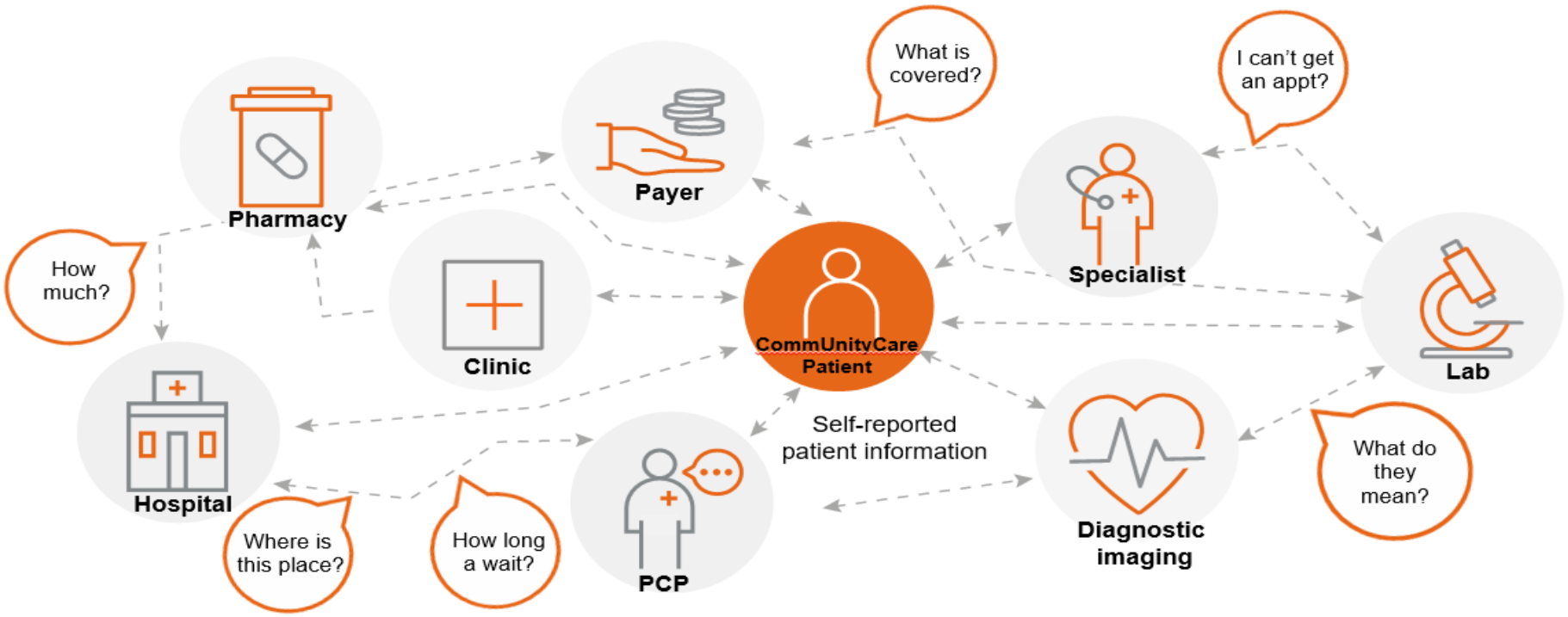
CommUnityCare's Journey Toward Value-Based, Accountable Care

What most of our patients confront:

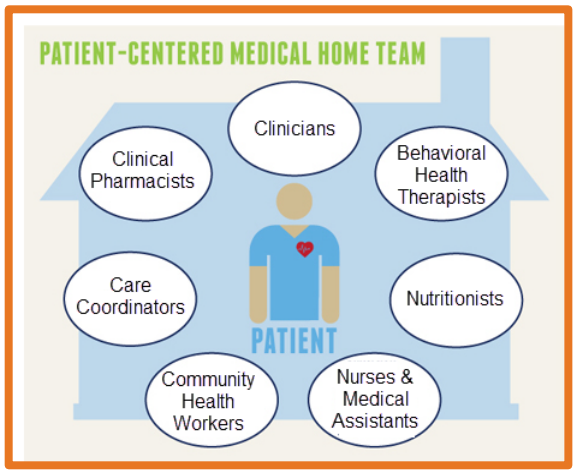
1. A complex, fragmented, and confusing system.
2. Providers and care systems that lack effective care coordination and care management.
3. Insurers (if they are insured) that are typically "hands off" with activation based on significant spend thresholds.

What CommUnityCare has emphasized on its journey to become a value driven, accountable health care provider:

1. Expanded care teams with enhanced responsibilities for all team members.
2. Assessment of current resources and needed resources to support a longitudinal patient management approach …. i.e. population health management approach.



Clinical Transformation Already Underway



- Expanded Care Team
- Alternative Care Models:
  - Alternative Visits
  - Mobile
  - Home Visits

Patient Centered.
Population Focused.

Building CommUnityCare's Capacity

- Measureable goals
- Cohesive clinical model
- Resource Stewardship

Care System Enhancements

- System of care design/management
- High needs — patient identification /stratification
- Coordination — cross care settings ED/IP encounter reduction
- Gaps in care reduction
- Service quality improvement — better patient reported outcomes

Change Management

- Transformational Change
- Continuous learning and continuous process improvement method(s) for disciplined reduction of variation
- Opportunity analysis and prioritization
- Workforce planning and development
- Practice improvement

Analytics infrastructure

- Multi-source data harmonization
- Population health improvement analytics — big data
- Patient care improvement information
- Data sharing across system of care — patient, practice/provider and population level information

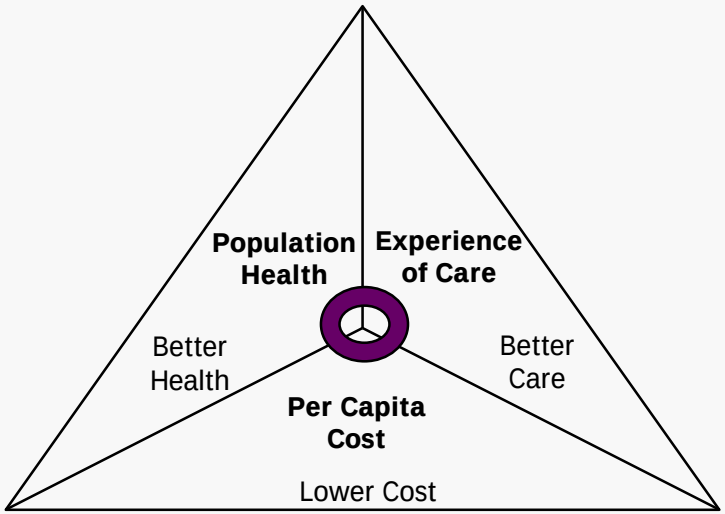
CommUnityCare – Shifting our Care Model
Critical Goals and Elements

Triple Aim + 2 :

1. Reduced total cost of care.
2. Improved clinical quality.
3. Improved patient and family satisfaction.
4. Emphasis on primary care services and relationship.
5. Enhanced Care Coordination and patient activation.

Key Program Components:

1. Population health management infrastructure and robust data analytics.
2. Performance improvement & clinical transformation that is provider and quality focused and led.
3. Care coordination across care settings including care transition and ED follow-up.
4. Risk stratification that accounts for utilization patterns, diagnostic criteria and social factors.
5. Effective population empanelment at the care team level.
6. Patient receptivity to change.
7. Hot spotting.
8. Executive commitment and program governance.



Clinical transformation through expanded care teams:
Drives measureable results

Leadership:
Drives operating discipline

Population health management infrastructure:
Provides clinical intelligence

Expanded care coordination:
Manages across care settings

So why do this if there are not Value Based Payment opportunities in Texas

Texas Value-Based Opportunities

- Essentially no value-based initiatives outside individual Medicaid MCOs currently available … but opportunities available
- Texas Healthcare Transformation and Quality Improvement Program (i.e. 1115 Medicaid Delivery System Reform Incentive Payment Initiatives)
- Local Indigent Care programs and healthcare / hospital districts

One thing regardless of location is things are changing and are going to continue to change.

The Power of a Partnerships

- Partnerships are critically important to CommUnityCare accomplishing its mission of strengthening the health and well-being of the communities we serve especially given the significant deficit of resource investment beyond our local community.

CENTRAL HEALTH

Community Care Collaborative

A Central Health and Seton partnership

Integral Care

Seton Healthcare Family

The University of Texas at Austin
Dell Medical School

THE UNIVERSITY OF TEXAS
SCHOOL OF NURSING

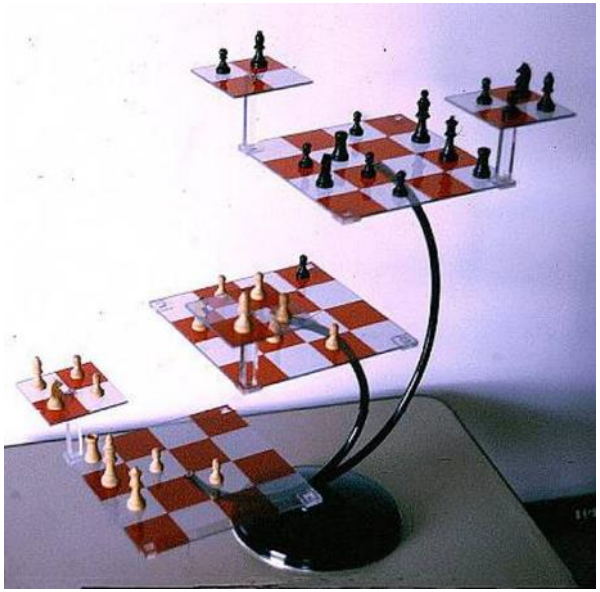
AUSTIN COMMUNITY COLLEGE DISTRICT

CENTRAL TEXAS FOOD BANK

Texas Value-Based Opportunities – We are In the Game

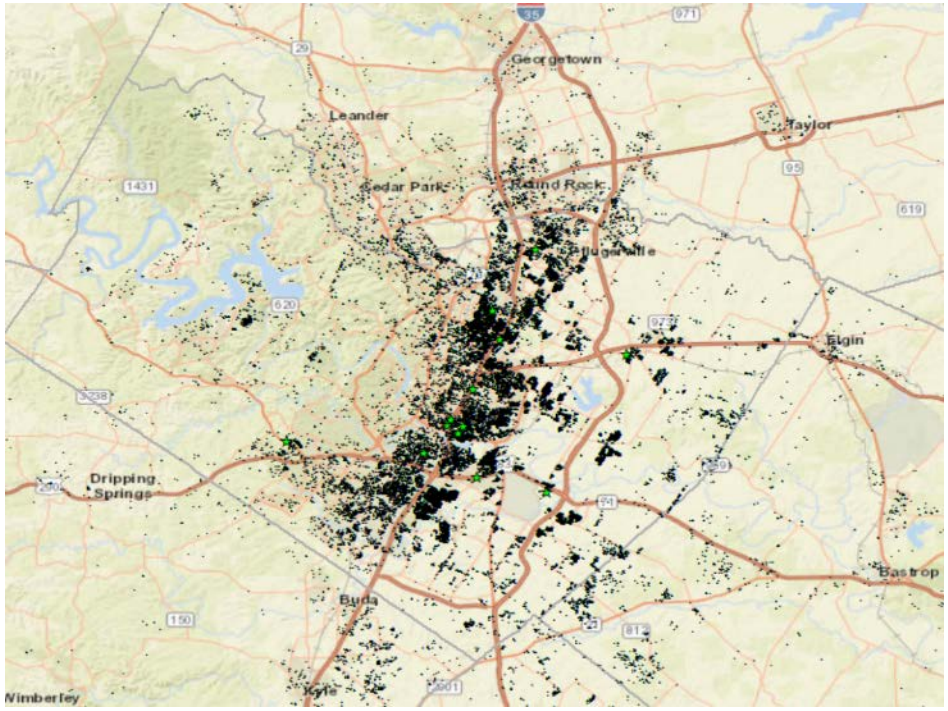
- Delivery System Reform Incentive Payment Participant – expect $10 million this year
- Population Health Management PMPM – Almost $4 million
- Pay for Performance Outcomes - $2 million
- Alternative Visits - $4.1 million

Essentially $20 million out of $110 million budget within some version of value based arrangement, with more to come.



Aligning Our Resources toward Longer Term Outcomes

- Overall objective of CommUnityCare's Population Health Management aim is to improve patient's health and outcomes while lowering costs
- Reduce waste
  - Unnecessary or low-value care, avoidable tests, procedures, readmissions, etc.)
  - Internal waste from inefficient workflows
- Improve quality and efficiency
- Understand the population and target the right care and resources efficiently to the right patients so that health and outcomes will improve.



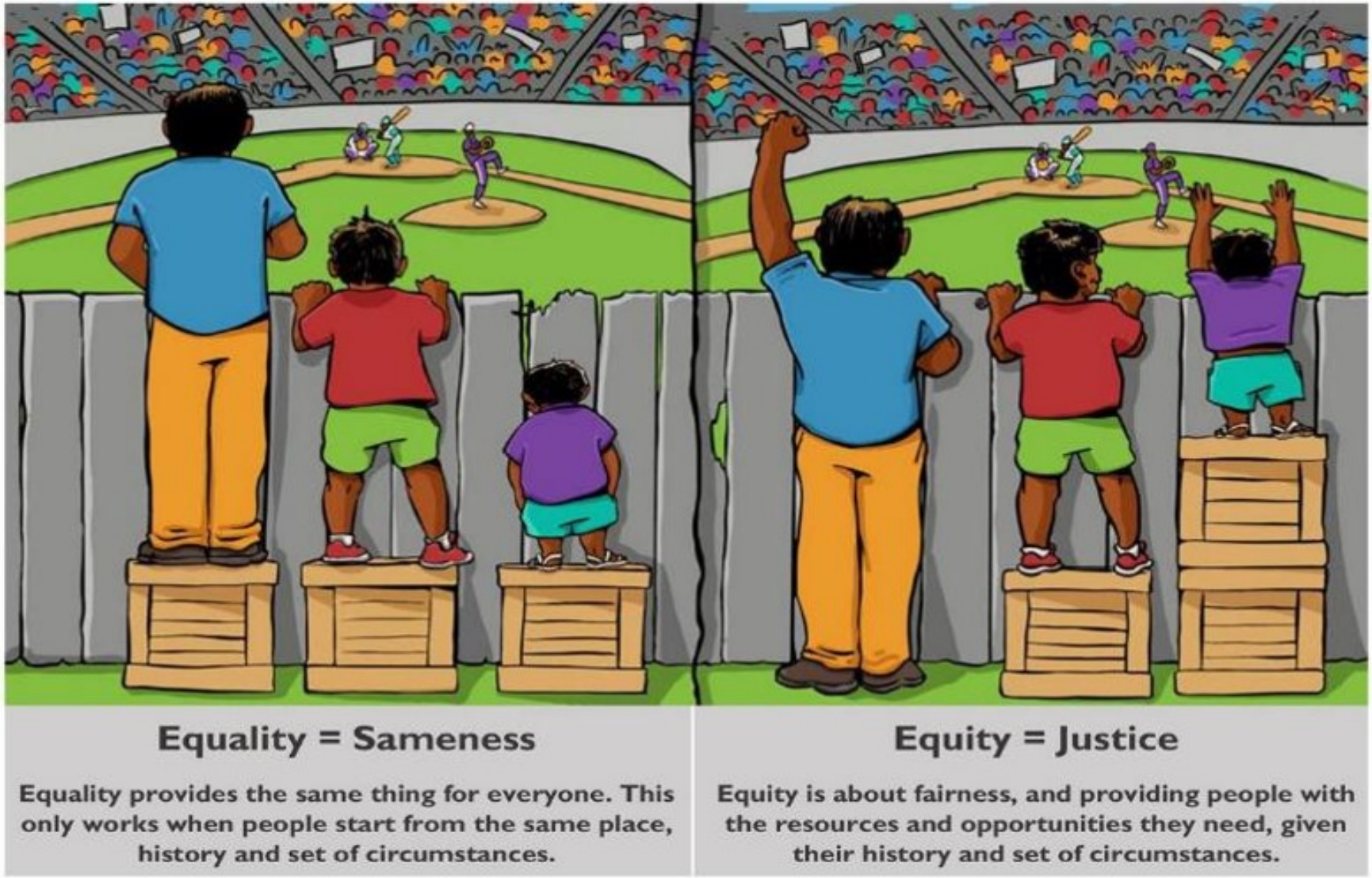
100,000 ≠ 160,000

Final Thoughts

- Is the primary driver about shifting risk to FQHCs / CBHOs and our clinical care teams from payers without needed resources?
- Is there conflict about where/how to allocate FQHCs / CBHOs' resources, such as care management?
- Is there alignment between payers about attribution, quality measurement, etc. – if not this will complicate things for FQHCs / CBHOs moving forward.
- Will value based initiatives "compensate" FQHCs / CBHOs innovation and modeling that generates long term savings.
- Lack of long term view and emphasis on population health …. Is cost containment the prime motivator driving "accountable care".
- Data informing clinical care initiatives must be actionable and timely. Must also prevent "tsunami" of data.
  - Dependent on analytic capabilities to identify at-risk/soon-to-be at-risk patients
  - Dependent on interoperability with external providers
- Can we activate our patients into their care?

Questions?

Please type any questions into the Chat box



Please email
deltacenter@jsi.com
with any questions that were not answered today