VALUE-BASED PAYMENT REFORM ACADEMY NASHP

Craig Hostetler
June 14, 2016
Why Are We Doing This?
Why Take the Risk?

- Our stakeholders wanted something better
  - Patients
  - Payers
  - Providers & support staff
- Recruitment getting harder
- Increased pressure
  - Transparency and accountability increasing
  - Payment moving from volume to value
OPCA’s goal for Alternative Payment Advanced Care Model (APCM)

Lead the development of and align payment with an efficient, effective, and emerging care model that achieves the Quadruple Aim in Oregon CHCs
Gaining CHC Buy-In

- Providers asked for payment change to support PCMH
- Started with a small group of advanced PCMH clinics
- Developed a rough model
- Approached state, gained interest/champions
- Presented to Oregon Primary Care Association (OPCA) board and then membership
- Important that all CHCs work together instead of cutting own deal
Starting the Conversation with Medicaid

- Our missions are aligned
- Payment reform should make primary care more effective
- Value-based pay makes sense
- Must account for behavioral and socio-economic barriers
- Let’s work together on a bridge to value-based pay
Adjusting/Stratifying for Patient Complexity

- **Not adjusting could increase disparities**
  - Chien et. al., “Do Physician Organizations Located in Lower Socioeconomic Status Areas Score Lower on P4P Measures?,” *Journal of General Internal Medicine*, 12/13/11

- **Paying for health homes in the safety net**

- **Not adjusting could penalize safety net**
Medicaid Relationship Critical

- Partnership between state, OPCA and CHCs is very strong
- Regular face-to-face and phone discussions
- Working together to remove barriers with a focus on better patient care
- The success of APM as measured by better cost, quality, access and patient experience is at the forefront
- Measuring social determinants of health (SDoH) to inform care interventions & payment
What’s in it for the State?

- Predictable cost per-member-per-month (PMPM)
- Promotes patient engagement/outreach to unengaged
- Gain a lot more information on cost, quality, access
- Develop relationship with PCA and CHCs to improve and be accountable to value
- Support the next phase of transformation after PCMH
- Allows FQHCs to better align with coordinated care organization (CCO) requirements
- Ultimately, it’s about better care for the patient
What’s in it for the MCO?

- Promotes robust, team-based care
- Clinics are testing SDoH interventions
- Predictable payment PMPM
- Can integrate with current payment reform efforts
- Promotes engagement of all assigned patients
- Alignment with value-based payments by taking away need to produce visit
Meeting facilitation/project management
Financial expertise to help develop rates
Data analysis and presentation
Learning community development and support
Onboarding new clinics
Additional cost to PCA - $500,000 annually
Oregon’s Alternative Payment Methodology (APM) and Safety Net Clinics

NASHP Value-Based Payment Reform Academy
June 14, 2016
Don Ross, Manager
Program Policy, Oregon Medicaid
Oregon Medicaid Health Systems Transformation and Coordinated Care Organizations

• Recognition that health care costs are unsustainable and that we do not get the health outcomes for the amount of money that we spend

• After 100s of hours of stakeholder meetings, tribal consultation and community meetings, a health transformation plan for Oregon’s Medicaid program is being implemented

• Triple Aim: Better Health, Better Care, Lower Costs!!
Other Current innovations under way

• Health Homes
  – Patient-Centered Primary Care Homes (PCPCHs)
  – More than 500 clinics have applied and been certified as PCPCHs in Oregon and many of them are FQHCs and RHCs

• All Oregon FQHCs in the APM pilot are certified PCPCHs and changed their model of care due to this certification and opportunities presented by
Health System Transformation & Alternative Payment Methodology

• Health Centers in Oregon are positioning themselves to benefit from CCO requirements by helping the state develop an APM that is aligned with Transformation objectives to move away from increased billing of office visits, and to integrate and coordinate services and management of patient needs in care teams:
  – Without suffering reduced revenue into the practice
  – With increased satisfaction of patients and physicians
  – While increasing access and quality of outcomes
Why change from PPS to PMPM?

• The PPS encounter rate payments reward FQHCs that bill the most services

• Difficulty recruiting and retaining professional level staff due to “hamster wheel” of churning out office visits (run harder for more revenue)

• PPS payment mechanism not centered around patient’s health and outcomes

• Time from service date to receiving payment sometimes greater than 1 year

• Providers more frequently working at the top of their licensure w/ care teams centered around the patient
Developing the APM

- Initiated by the Oregon Primary Care Association (OPCA) in partnership with member FQHCs, SPA approved summer 2012
- Proposed the OHA pay FQHCs a per-member per-month (PMPM) payment based on historical revenue and utilization
- Each FQHC’s encounters and revenue for the prior year were used to determine the PMPM rates
- First APM FQHCs joined in March 2013:
  - OHSU Family Medicine at Richmond
  - Mosaic Medical
  - Virginia Garcia Memorial Health Centers
Key Elements of APCM

The Financial Model
Participation Requirements

- 3 year commitment
- 30 day emergency exit
- All sites, all patients
- Some services carved out (mental health, dental, OB for now)
- Agree to Accountability Plan and Learning Community participation
Key Financial Elements

- Creating Day 1 lists, 18 month lookback
- New patient engagement, face-to-face with licensed provider
- Attribution – end date after 1st visit with FQHC/RHC/IHS
  - 2 visits with another provider
- Reconciliation – quarterly with annual settlement, if necessary; PPS is floor
Basic Rate Construct

PMPM payment

Wrap based on prior year

MCO payment *like anyone else’s*

Separate *bonus* payments
What’s Out?

- Prenatal
- Pharmacy
- Inpatient
- Mental, oral health (coming later)

What’s In?

PPS scope of primary care

Patients - Open card, Medi-Medi, SBHC
Key Elements – Care Model
Five Strategies

1. Use actionable and real time data
2. Increase access through new visit types
3. Build care teams that are a reflection of patient needs
4. Enhance appropriate care and work to reduce unnecessary emergency department utilization and ambulatory care sensitive admissions
5. Partner with patients to co-create and provide self-management services
Oregon APCM Metrics and Accountability Plan

Data
Track 9 CCO measures, 5 UDS measures, and 1 utilization measure. Focus on two of the clinical measures. Sustain or improve patient satisfaction.

Quality

Cost of care
Maintain or reduce adjusted per capita costs. Use risk adjustment methods based on TCOC. Match services and resources to complex care needs.

Access

Meaningful engagement
Document visits and engagement touches with 70% of established patients on an annual basis.

Population Management

Segmentation
Identify a population and use tool to learn more about bio-psychosocial needs. Improve quality through segmentation.
## APCM Metrics

**Focus Measures:** These are the measures clinics have chosen to work on improving as part of APCM. Clinics are encouraged to share the data for these measures to the state and OPCA via the reporting template.

<table>
<thead>
<tr>
<th>Measure</th>
<th>OHA collects this data to assess APCM outcomes</th>
<th>Clinics must report this data to the OHA quarterly</th>
<th>Virginia</th>
<th>OHSU</th>
<th>MCHD</th>
<th>OHSU Scappoose</th>
<th>Benton</th>
<th>Mosaic</th>
<th>Coastal</th>
<th>VYFWC</th>
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<td>Screening for clinical depression and follow-up plan</td>
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<td>Timeliness of prenatal care</td>
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<td>Weight control: Adults</td>
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<td>Childhood immunizations</td>
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<td>Adult asthma admission rate</td>
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<td>Alcohol and drug misuse: SBIRT - % that received brief intervention service</td>
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## Engagement Touches

<table>
<thead>
<tr>
<th>New Visit Types</th>
<th>Coordination and Integration</th>
<th>Education, Wellness and Community Support</th>
<th>Outreach and Engagement</th>
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<tbody>
<tr>
<td>• Home visit billable encounter <em>(auto)</em></td>
<td>• Information Management</td>
<td>• Health Education Supportive Counseling</td>
<td>• Flowsheet - screening tools <em>(auto)</em></td>
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<td>• E-visit <em>(MyChart - auto)</em></td>
<td>• Coordinating Care: Dental</td>
<td>• Education Provided in Group Setting</td>
<td>• Panel Management Outreach</td>
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<tr>
<td>• Telemedicine Encounter <em>(auto)</em></td>
<td>• Clinical Follow-up and Transitions</td>
<td>• Support Group Participant</td>
<td>• Case Management</td>
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<td>• Telephone Visit <em>(auto)</em></td>
<td>• Warm Hand-Off</td>
<td>• Exercise Class Participant</td>
<td>• Accessing Community Resource</td>
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<tr>
<td>• Home visit non-billable encounter</td>
<td>• Transportation Assistance</td>
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</table>
Segmentation Strategy

- Use data and analytics to figuring out people falling through the cracks in areas of quality metrics trying to improve.

- Figure out health disparities, account for social and behavioral factors, and drilldown to a subset of 100 patients.

- Interview at least 10 people using a SDoH Screening Tool (PRAPARE+) to better understand their health challenges.

- Create a therapeutic alliance with the people you interview; learn to understand them more holistically.

- Apply learnings to your subpopulation.

- Improve health for group by experimenting with: Design new visit type, new role, new partnerships.
Outcomes

- Model appears budget neutral per patient, per year
- APM reconciliations have not triggered payment to date.
- State concerned about access
- MCO payments appear level
- Clinical quality indicators appear to be holding or improving in most cases, Optumas report
- Signs of improvement in total health care utilization
- Access under ACA posed a challenge to broader transformation
Lessons Learned
Payment Model Lessons

• Model should be hand in hand with payment
• Cash flow issue for state
• Data/Outcomes should be clear, thoughtful, aligned
• This is a Partnership requiring constant refinement and trouble shooting:
  • With Medicaid, MCOs, between clinics, IT/HCCNs
• Financial stability as a requirement to participate (NOT a consequence)
• Cascade of other financial implications:
  • Budgeting
  • Panel Size
  • Provider Reimbursement
Advanced Care Model: Lessons Learned

- Never separate from payment
- Consider immensity of change & competing demands
- Create less time pressure
- Plan for data collection
- Add ACM teams at all participating sites
- Co-create OPCA-ACM teams
- Keep learning (co-design is messy)
PMPM Rate Development

- Utilizing the FQHCs wraparound revenue, CCO payments, and member months, the “Wrap Cap PMPM Rate” was developed.
- Utilizing the FQHCs FFS revenue for open-card patients, the “Open-Card PMPM Rate” was developed.
- Each health center has both types of PMPM rates.
- Rate Calculation example: CY 2012
  $1,000,000/25,000 member months = $40 PMPM
Attribution: The Patient Lists

- From FQHC’s go-live date, we allow an 18 month look-back
- Patients receiving care at the health center in the prior 18 months are attributed, and PMPM payments issue to the health center each month
- Patient lists are uploaded by the health center using MMIS Provider Web Portal
• **NEW** patients may be enrolled with the health center after an encounter is registered
  – PMPM payments begin on the day patient is established at health center
• Patients are moved by the state when they establish care with a different primary care provider, so they retain choice of providers- PMPM payments stop and/or are recouped
• The health centers now have a tangible list of patients for whom they are responsible for improving health and outcomes
• With revenue delivered on time each month, health centers may focus on delivering the **right care** at the **right time** for the patient and their family
What if Health Centers Stop Seeing Patients?!

After detaching their revenue from the billable office visit, how do we know they are taking care of their patients?

- Monitor quarterly reports on “Touches”
- Monitor quarterly Quality Metric Reports
- Monitor their encounter data by analyzing their PPS equivalency, quarterly
Touches Reports

- Touches are also known:
  - Enabling Services
  - Flexible Services (CCOs)
  - Core Services (PCPCHs)
  - Alternative Services
  - Non billable, non-reimbursable services

- The OHA has encouraged FQHCs to focus on the non-billable services (touches) that drive transformation of the delivery model, and improve patient health, outcomes and quality of life
Some of the touches currently being reported include:

- Referrals to community resources, coordinating clinical follow-ups, coordinating transitions in care settings, exercise classes, education provided in group settings, support groups, non-billable warm hand-offs, non-billable home visits, among many others!
What Health Centers are Saying

• “Since beginning (APM), Virginia Garcia has seen high-impact changes that have allowed our organization to better pursue our core mission in Washington and Yamhill Counties. By utilizing APM, we now have the time to do the work of being a Patient Centered Primary Care Home and optimize the core practices of our patient teams.”  
  – Virginia Garcia Memorial Health Center

• “REaCH Team (Richmond Engagement and Community Health) is a multi-disciplinary team focused on high-utilizer patients. Activities include linking patients to Outreach Workers who help connect to community resources, navigate healthcare system, support self-management, etc. A Care Coordinator tracks Richmond patients when admitted and using Emergency Room to ensure coordinated follow-up care or touch is made.”  
  – OHSU Richmond Family Medicine
• “APM model of care helps support a “hotspotting team” we’ve assembled, referred to as the Community Care Coordination Team (comprised of a Family Nurse Practitioner, Mental Health Specialist, and Community Health Worker), to target complex patients with high emergency department and in-patient utilization. This work has resulted in a 76% reduction in ED visits and an 82% reduction in hospital admissions. These drops in utilization have resulted in 74% reductions in hospital charges for over 190 patients.”
  – Virginia Garcia Memorial Health Center (self reported data)
What Health Centers are Saying, continued…

- “APM is allowing VG the flexibility with addressing preventive care and behavior change through an innovative program such as our Teaching Kitchen, where a cohort of 8 to 12 patients are engaged in an 8 week class on cooking nutritious meals.”
  – Virginia Garcia Memorial Health Center

- “VG is integrating other wellness activities such as low-impact exercise, physical therapy, acupuncture, Zumba, and tai chi as part of the care plan for patients.”
  – Virginia Garcia Memorial Health Center

- “Social Workers began Dialectical Behavioral Therapy group visits focusing on REaCH patients and others with depression, anxiety, anger issues and usually history of some sort of trauma which interferes with treatment of chronic or other conditions. The groups meet for 6 week courses and are well attended.”
  – OHSU Richmond
Quality Metric Reports

• Each APM HC currently submits quarterly reports on the following metrics:
  – Tobacco Screenings
  – Depression Screenings
  – Diabetes Control
  – Cervical Cancer Screenings
  – Weight Control: Adults and Kids
  – HTN Controlled (most recent BP less than 140/90)
  – Childhood Immunizations
  – % of patients that would recommend their care team
  – % of patient visits with assigned care team
  – % of patients assigned by CCO that have been established
1st Year Metrics: How are they Doing?

- For January 1st 2013 through December 31st 2013:
  - Tobacco Screenings hit and remained at **100%**
  - Weight control for kids **increased by 145%**!
  - Childhood immunizations **increased 115%**!
  - Patients with a favorable survey response regarding their care team **averaged 96%** among the health centers (**a 50% increase**)!
Cost Performance

• Analytics ongoing
• ED and hospital inpatient are clearly reduced
• Total cost of care (TCC)?
  – Cost and utilization of referred services
  – Sub-capitation arrangements of CCOs
  – Pharmacy costs
  – Where do savings accrue short and long term?
Payment Reconciliation Reports

- Health Centers submit Payment Reconciliation reports each quarter detailing all of their encounters and payments.

- Federal statutory requirements guarantee that health centers will be reimbursed at least equal to what PPS payments would have been, the “PPS Equivalent”:
  - Actual Encounters $ \times $ PPS Rate = PPS Equivalent
  - If actual payments are below the PPS equivalency, the OHA will issue an annual settlement check.
Looking forward

• The OPCA hosts quarterly Advanced Payment and Care Model summits where the health centers, national health care experts, and the Oregon Health Authority share insights and engage in planning the future of the APM program.

• Quality Metric reports expected to evolve and align with CCO Incentive Measures so that health centers can better assist CCOs in accomplishing Triple Aim goals.
Looking forward, continued…

• Currently, APM PMPM payments are issued for Medical services only
  – Mental health, dental health, prenatal/OB services are carved-out and pay at the PPS encounter rate
  – Medical encounters are billed, but $0 pay in the MMIS

• Ongoing work to carve mental health and OB services into the PMPM rates
Lessons Learned

• **System Functionality** – Do you have a way to process the methodology you’ve chosen?

• **Attribution details** - Leakage, look back, adds and deletes, no duplicate payment and no free care

• **What to carve out and for how long?** – OB, Oral (primary and specialty), Mental Health and SUD
Alternative Payment: Perspective from Point of Care

NASHP FQHC Payment Reform Meeting
June 2016

Sherlyn Dahl
Integrated Public Health, Mental Health, Primary Care, Dental Services

Public entity FQHC with Benton County sites;
  ◦ Corvallis (includes admin, Mental Health & Public Health)
  ◦ South Corvallis (also a School-Based Health Center)
  ◦ Monroe (also a School-Based Health Center)
  ◦ Alsea

Additional sites in Linn County
  ◦ Lebanon
  ◦ Sweet Home

Served 9,200 patients in 2015
Services

- **Medical: Patient Centered Primary Care Home**
  - Primary Care
  - Family Planning
  - School Based Health Center (Lincoln & Monroe)

- **Mental Health: Integrated & Specialty**
  - Behavioral Health
  - Adult Mental Health
  - Children’s Mental Health
  - Addiction Services

- **Dental**
  - Services to Children
  - Varnish & sealant program
  - Adult Hygiene
  - Van & Voucher program
Transforming Payment
Alternative Payment Methodology Pilots
OHA/OPCA APM Pilot

- Started July 1, 2014
- Paid a monthly PMPM (per member per month) for all engaged patients
- PMPM is for ‘wrap’ portion of Medicaid payment
- Required reporting on touches
- Quarterly reconciliation
CCO Alternative Payment Pilot

- Started January 2015
- Methodology for payment
  - Paid a monthly PMPM (per member per month) for enrolled Oregon Health Plan (OHP) patients
    - Rate of PMPM based on the rate group the member is assigned
- 6,000 IHN members assigned
  - 2,500 – 3,000 not yet seen by clinic
- Monthly member reconciliation
- Quarterly reporting
  - Access, Outcome, & Utilization Metrics
Transforming Care Delivery
Patient Centered Primary Care Home (PCPCH)
Prep for APM: ‘Right Size’ Care Team

- Core Team
  - Providers (2)
  - Medical Assistants (2)
  - Scheduler
- Additional Members
  - Panel Manager
  - RN Care Coordinator
  - Behaviorist
  - Clinical Navigator
  - Clinical Pharmacist
- Hired additional staff (5 FTE across all sites)
Additional Preparation

- Assess assignment process, accessing member data from the CCO, & matching clinic patients to CCO lists
- Defined ‘touches’ & reporting process
- Assessed EHR capability to generate needed reports
- Assessed space; team pod & consult rooms
- Determined panel size & complexity
Initial Focus of Care Team

- Shared office space & communication
- Refine roles & work flow
  - Role of Panel Manager & all team members
  - Supported working at ‘top of license’
  - Identified ‘care coordination’ work
- Managing panels
  - Scheduling processes
  - Team communication (scrubbing & huddles)
  - Patient engagement in care & self management
- Proactive Care
  - Prevention & Screening
  - Recall system for follow-up of chronic conditions
Care Team Infrastructure

Dental
- Vans / Vouchers
- Varnish & Sealants in Schools
- B & G Club Treatment

Hygienist

Primary Care
- Provider
  - MA
  - RN
  - PharmD
- Behaviorist
  - Psych RN
  - Psychiatrist

Mental Health

Public Health
- MCH Nurses

Community
- Outreach & Enrollment
- Neighborhood Navigators
Next Layer of Focus

- Patient engagement
  - Initial contact for newly assigned
  - Access for assigned but not yet seen by provider
- Appropriate utilization
  - Use of ED & Urgent Care
  - Leakage to other primary care providers
- Expanding Access
  - Matching team resources & expertise to panel characteristics
- Quality Improvement
  - Improving clinical outcome priorities
- Assessing Social Determinants of Health
  - Interface with community, Public Health
Impact & Takeaways
Clinical Impact of APM

- Detached payment from a provider visit/schedule
- Increased reliance on team
  - Added FTE to fully staff teams
- Exploring alternative methods for access
  - Team member visits
  - Navigators
  - Group visits
- Enhanced focus on quality & outcomes
- Resources for innovation & integration
Benefits

- Financial ‘predictability’
- Resources for innovation
- Better care
- Improved access
Be Prepared

- Staff time in preparation for APM & on-going work with reconciliation
- Increase team staffing
- Increase staffing to create, generate, & distribute reports
- Lots of change
  - Work flow adjustments
  - Roles & responsibilities
  - Areas of focus