Value-Based Payment Reform Academy: Supporting FQHCs to Transition to Value-Based APMs

FOR AUDIO, PLEASE DIAL:
(866) 740-1260
ACCESS CODE: 2383339

JANUARY 8, 2018
3:00-4:00PM ET

This work is supported through NASHP’s Cooperative Agreement with the Health Resources and Services Administration (HRSA), grant #UD3OA22891
Logistics

- Your lines will only be unmuted during the Q&A period. During that time please mute your own lines except when speaking.
  - Please do not put us on hold at any time or we may hear hold music/announcements
- To ask a question or make a comment, please use the “raise your hand” feature or type it into chat box.
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience.
Agenda

- Introduction
- State role call
- Oregon’s APCM Program: Alternative Payment Methodology in a Time of Accountability
- Upcoming technical assistance opportunities
- Wrap up and evaluation reminder
Robert Trachtenberg, MS
Executive Director, Oregon Health and Science University
Family Medicine Richmond Clinic
Oregon’s APCM Program

Alternative Payment Methodology In A Time of Accountability

DATE: December 29, 2017    PRESENTED BY: Robert Trachtenberg, Executive Director at Family Medicine at Richmond OHSU
Agenda

• Richmond Overview
• APCM Overview
• APCM Goals & Learning Opportunities
• Metrics
• Future State
Who We Are

- Richmond is a Family Medicine Clinic of Oregon Health and Science University (OHSU)
- A Federally Qualified Health Center (FQHC)
- A Patient Centered Primary Care Medical Home (PCPCH)
- A School Based Health Center
- An Urgent Care Clinic
- A member of Coordinated Care Organizations
- A member of the National Association of Community Health Center (NACHC)
- A participant in Oregon’s Alternative Payment and Care Model (APCM)
APCM develops and aligns payment with an efficient, effective, and emerging care model that achieves the Quadruple Aim in Oregon CHCs.
Quadruple Aim
APCM Program Overview

• The Oregon Health Authority (OHA) and Oregon Primary Care Association (OPCA) co-sponsor the Medicaid APCM program.
• OHA receives data and provides payment.
• Moved us away from Fee for Service for this population.
• Must be an FQHC or a Rural Health Center to participate.
• Must be recognized as a Patient Centered Primary Care Home (PCPCH) by OHA.
APCM Goals

• **Quality**: Track 7 measures that are a combination of CCO and UDS. Sustain or improve patient experience.

• **Cost**: Maintain or reduce adjusted per capita costs.

• **Access**: Increase Care STEPs in lieu of billable visits.

• **Population Management**: Segment population to identify disparities, social determinant’s impact and track and intervene accordingly.

• **Role Revision**: Integration of clinical pharmacy and behavioral health, evolving RN role, MA working at the top of license.
### APCM Goals

#### Tyranny of Typical Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care physician</th>
<th>Medical Assistant</th>
<th>Nurse</th>
<th>Nurse Practitioner</th>
<th>Medical Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Patient A</td>
<td>Assists with Patient A</td>
<td>TRIAGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:15</td>
<td>Patient B</td>
<td>Assists with Patient B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td>Patient C</td>
<td>Assists with Patient C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:45</td>
<td>Patient D</td>
<td>Assists with Patient D</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>Patient E</td>
<td>Assists with Patient E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:15</td>
<td>Patient F</td>
<td>Assists with Patient F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>Patient G</td>
<td>Assists with Patient G</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patients still waiting, most staff is gone, limited support for provider, charting not complete, Exhaustion, frustration

#### Future State

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care physician</th>
<th>Medical Assistant</th>
<th>Nurse</th>
<th>Nurse Practitioner</th>
<th>Medical Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:10</td>
<td>Telephone and e-mail visits – 12 patients</td>
<td>Panel management</td>
<td>RN diabetes visits</td>
<td>Drop-in patients – 4 patients</td>
<td>Assist with drop-in patients, close phone loop, phone follow-up</td>
</tr>
<tr>
<td>9:00</td>
<td>PATIENT D</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>Coordinate w/ specialist and hospitals. Consult w/ team</td>
<td>Health coach visit w/ patient J</td>
<td>Group visit for chronic care – 12 patients</td>
<td>PATIENT K</td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td>BP clinic – 3 patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15</td>
<td>Patient H and Patient B</td>
<td>Phone Outreach</td>
<td>Telephone and e-mail visits – 6 patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5pm: Team signs out to overnight coverage and goes home. Days work is done.
APCM Goals

How we are getting there...

• Population health data analysis

• Advancing new competencies among care team members
  ▪ Health Coaching
  ▪ Clinical Pharmacy
  ▪ Behavioral Health/Social Work/CHW
  ▪ Care Management
  ▪ Social Determinants of Health Coordinator

• Collaboration and negotiations with our payers
  ▪ Health Resiliency Specialists
  ▪ PMPM payments

• Workflow improvement and training
  ▪ Monthly optimization meetings for staff (MAs, Providers etc.)

• Robust Patient Advisory Council engaged in program development and oversight
APCM Challenges

- Need and Use MORE Information
  - Medical/social history
  - Integrated clinical, utilization, demographic and claims data
  - Social determinants of health and condition specific questionnaires
  - Data integrity
- Need to design service and treatment “pathways” to design interventions using the best evidence-based knowledge available.
- Need to develop and/or strengthen partnerships with multiple community resources to work collaboratively in promoting each patient’s well being and our communities.
- ‘Clicking for Credit’ is seen as an additional burden for providers.
- Need to continue to listen and engage our patients as key stakeholders and decision-makers
APCM Reporting Requirements

• **Clinical Quality:** Chronic conditions, prevention for adults and children

• **Patient Experience:** Shared measures of access, care provider and customer service

• **STEPS (Services That Engage Patients):** Formally “touches”; non-billable services provided face-to-face, by phone, MyChart, or in alternative settings (hospital, home)
**APCM Reporting Requirements**

- **Clinical Quality** – Chronic conditions, prevention for adults and children.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Benchmark</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening</td>
<td>39.9%</td>
<td>UDS, CCO</td>
</tr>
<tr>
<td>Depression Screening and Follow Up</td>
<td>60.3%</td>
<td>UDC, COO</td>
</tr>
<tr>
<td>Diabetes Poor Control &gt;9.0</td>
<td>32.1%</td>
<td>UDC, CCO</td>
</tr>
<tr>
<td>Hypertension in Control</td>
<td>62.4%</td>
<td>UDS, CCO</td>
</tr>
<tr>
<td>Childhood Immunization</td>
<td>42.8%</td>
<td>UDS</td>
</tr>
<tr>
<td>Entry in to Prenatal Care</td>
<td>74.1%</td>
<td>UDS, CCO</td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>TBD</td>
<td>CCO</td>
</tr>
</tbody>
</table>
Quality Metrics Year Over Year - Total Population

- Diabetes Poor Control
- Colorectal Cancer Screening
- Developmental Screening
- Hypertension in Control

Benchmark
CCO Benchmark

Should be under Benchmark
APCM Reporting Requirements

- **Patient Experience:** Shared measures of access, care provider and customer service.

<table>
<thead>
<tr>
<th>Domain</th>
<th>CAHPS Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</td>
</tr>
<tr>
<td>Access</td>
<td>In the last 6 months, when you contacted this provider’s office during regular office hours, how often did you get an answer to your medical question that same day?</td>
</tr>
<tr>
<td>Care</td>
<td>In the last 6 months, how often did this provider listen carefully to you?</td>
</tr>
<tr>
<td>Care</td>
<td>In the last 6 months, how often did this provider show respect for what you had to say?</td>
</tr>
<tr>
<td>Front Office</td>
<td>In the last 6 months, how often were the clerks and receptionists at this provider's office as helpful as you thought they should be?</td>
</tr>
<tr>
<td>Front Office</td>
<td>In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?</td>
</tr>
</tbody>
</table>
APCM Reporting Requirements

• **STEPS (Services That Engage Patients)**: Non-billable services provided face-to-face, by phone, MyChart, or in alternative settings (hospital, home)
APCM Basic Rate Construct

- **PMPM payment**: from the state
- **Medical services included**
- **MCO payment** like anyone else’s
- **Separate bonus payments**
Future Desired State

01 Patient Experience

02 Population Health

03 Reducing Costs

04 Care Team Well-Being

Quadruple Aim
Thank You
To ask a question, please use the ‘raise your hand’ feature or type it into the ‘chat’ box.
Upcoming Technical Assistance Opportunities

- **All-State Quarterly Call**: January 16, 3:30-4:30pm ET

- **Individual state quarterly conference calls**: throughout January

- **Next group webinar**: Mid-to-Late February
  - Topic: FQHC Participation in Massachusetts’ ACO Model
Thank You!

Thank you for joining this Value-Based Payment Reform Academy Group Technical Assistance Webinar!

Please complete the evaluation form following this presentation.