State Strategies to Expand Access to Care Through Safety Net Providers

August 15, 2013

For audio, please turn up your speakers.
Alternatively, call: (800) 747-9564

This webcast is made possible through the generous support of the Health Resources and Services Administration (HRSA)
Supporting Collaboration Between Medicaid and the Safety Net

This webinar is made possible through NASHP’s cooperative agreement with the Health Resources and Services Administration (HRSA) to support Medicaid Directors and other key officials in addressing the needs of vulnerable populations by facilitating collaboration with safety net providers.
Agenda

- **Welcome and Introductory Remarks**
  Kathleen Dunn, Associate Commissioner, New Hampshire Department of Health and Human Services; National Advisory Group member to NASHP’s cooperative agreement with HRSA

- **Highlights from NASHP’s Work on Access and the Safety Net**
  Andrew Snyder, Program Manager, National Academy for State Health Policy

- **Expanding Access to Care Through School-Based Wellness Centers in Los Angeles**
  MaryJane Puffer, Executive Director, Los Angeles Trust for Children’s Health

- **MaineCare: Value-Based Purchasing and Access to Care**
  Kitty Purington, Program Manager, Maine Department of Health and Human Services

- **Questions and Answers**
  *Use the chat feature on your screen to ask questions during the webinar*
Highlights from NASHP’s Work on Access and the Safety Net

Andrew Snyder
Program Manager, National Academy for State Health Policy

August 15, 2013
Context

- Millions will gain coverage under the Affordable Care Act (ACA) and seek primary care services
- Many of those who will become newly insured already interact with the safety net (SN)
- Safety net providers can be partners in expanding access to care for the newly insured because of:
  - Focus on traditionally uninsured populations
  - Enabling services to bring people into systems of care
  - Participation in delivery system reform efforts like development of patient-centered medical homes.
In managed care arrangements – both Medicaid and Marketplace – states can work with health plans to develop contract standards and supports that support enhanced access, including:

- Network adequacy standards that require or encourage contracting with SN providers
- Case management and care coordination supports for members

States can work with SN to develop ability to bill Medicaid, participate in Qualified Health Plans.

- See NASHP factsheets on Essential Community Providers and billing supports
State Roles: Purchasing Strategies

- In **new payment models** – PCMH, s. 2703 health homes, and accountable care activities – states can align goals to reward SN and other providers that expand their capacity
  - Adding evening and weekend hours; implementing open scheduling systems; using “virtual” access points
- States can develop access standards that go beyond NCQA
- States can organize supports for providers (including SN providers) to support transformation and spread successful models
- Upcoming NASHP conference session will explore SN-centered payment reform efforts
State Roles: Measuring Access and Capacity

- State and federal agencies have developed a variety of ways to measure access
  - MACPAC framework: enrollee characteristics, provider availability, and service utilization
  - States like California and New Hampshire produce quarterly access monitoring reports
  - New Hampshire also assesses capacity at health centers; found that a majority of respondents reported having the ability to add hundreds of patients each
  - NH reports available at http://www.dhhs.state.nh.us/ombp/publications.htm
Project Information

Find related reports, webinars and factsheets at http://nashp.org/access-and-safety-net

Contact: asnyder@nashp.org
L.A. Trust for Children’s Health

Bringing vital health resources and solutions to the students, families, and communities of Los Angeles since 1991

Mission: To increase student health and the readiness to learn through access advocacy and programs.
“Wellness takes into account the whole person and his/her environment, not just the emphasis on disease or lack of it.

The key to achieving wellness is prevention and early intervention at the appropriate stages of the life cycle.”

* Duplessis and Halfon, UCLA Center for Healthy Children, Families and Communities
WHY “WELLNESS”? 

The trend to moving upstream...
LAUSD Student Population

- Over 680,000 students
- 1081 schools
- Largest employer in LA

2nd Largest School District in U.S.A.

- 27% Uninsured
- 49% Medi-Cal
- 76% Free/Reduced lunch
- 90% Minority population
Focus on preventive services and linkage to community based sources of care

Resources are leveraged to support students and families

Shared understanding among stakeholders
WHO ARE WE TARGETING’?”

- Community
- School staff
- Families
- Students
<table>
<thead>
<tr>
<th>School-based health center</th>
<th>Wellness center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary health care</td>
<td>Population health</td>
</tr>
<tr>
<td>Treatment of disease</td>
<td>Prevention and health promotion</td>
</tr>
<tr>
<td>Accessed by students</td>
<td>Open to families and communities</td>
</tr>
<tr>
<td>Clinic separate from school</td>
<td>Integrated/aligned with school mission</td>
</tr>
<tr>
<td>Grant and health agency funded</td>
<td>Multi-payer, sustainable collaboration</td>
</tr>
</tbody>
</table>
WHAT DO WELLNESS CENTERS LOOK LIKE?
**WHERE ARE THE WELLNESS CENTERS?**

<table>
<thead>
<tr>
<th>LD  1</th>
<th>Monroe High School (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD  3</td>
<td>Crenshaw High School (2)</td>
</tr>
<tr>
<td>LD  4</td>
<td>Hollywood High School (3)</td>
</tr>
<tr>
<td>LD  4</td>
<td>Belmont High School (4)</td>
</tr>
<tr>
<td>LD  5</td>
<td>Garfield High School (5)</td>
</tr>
<tr>
<td>LD  5</td>
<td>Jefferson High School (6)</td>
</tr>
<tr>
<td>LD  6</td>
<td>Gage MS/Elizabeth LC (7)</td>
</tr>
<tr>
<td>LD  7</td>
<td>Fremont High School (8)</td>
</tr>
<tr>
<td>LD  7</td>
<td>Jordan High School (9)</td>
</tr>
<tr>
<td>LD  7</td>
<td>Locke Early Ed Center (10)</td>
</tr>
<tr>
<td>LD  7</td>
<td>Manual Art High School (11)</td>
</tr>
<tr>
<td>LD  8</td>
<td>Washington Prep (12)</td>
</tr>
<tr>
<td>LD  8</td>
<td>Carson High School (13)</td>
</tr>
</tbody>
</table>

Los Angeles Unified School District
High School Attendance Area
Wellness Centers as Linkage Agent

**Community**
- Develop community asset map
- Insurance enrollment
- Parent/promotora education
- Advocacy
- Program partners
  - First 5
  - The Children’s Partnership
  - Root Down
  - Alliance for Better Community

**Wellness Networks**
- Consistent data
- Learning Collaborative
- Wellness Coordinating Councils
- Wellness policies

**School**
- Youth engagement/career pathways
- Student advisory boards
- Produce campus-wide campaigns
- Small learning academies
- Community service and after school programs
THE TRIPLE AIM

- Improving patient experience of care
- Improving health of populations
- Reducing per capita cost of health care
MODEL FOR IMPROVEMENT

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Act
Plan
Study
Do
**Strategies to Increase Access**

- Student engagement projects: blood pressure screening, STD prevention awareness campaigns, information and education on “Covered California”

- Community engagement projects: partnered with promotoras to get the word out and promote grassroots awareness campaigns

- School Health Policy Roundtable and School Health Coalition to promote best practice and develop universal policies
QUESTIONS?

- Contact information:
  
  Maryjane Puffer  
  Executive Director  
  Los Angeles Trust for Children’s Health  
  maryjane@thelatrust.org  
  www.thelatrust.org
MaineCare
Enhancing Access to Care
August 15, 2013

detty.purington@maine.gov
Overview: Maine’s Value-Based Purchasing Strategy

Accountable Communities

Health Homes for Individuals with Chronic Health Conditions
“Stage A”

Health Homes for Individuals with Behavioral Health Needs
“Stage B”
Mainecare Health Homes: Stage A

Grew out of Maine’s Patient Centered Medical Home Initiative:
- Leadership from Maine Quality Counts: [www.mainequalitycounts.org](http://www.mainequalitycounts.org)
- Stakeholder participation, including Maine’s physician community
- 75 practices

MaineCare now supports 159 practices via Health Homes “Stage A” - SPA approved in January 2012:
- NCQA Recognition
- Full EHR implementation
- Participation in PCMH/Health Homes Learning Collaborative lead by QC
- Achievement of ten Health Home “Core Expectations”
Health Home Core Expectations

Per Maine’s approved State Plan Amendment for Stage A, Health Home practices commit to implementation of the following Core Expectations:

- Demonstrated leadership
- Team-based approach to care
- Population risk stratification and management
- Practice-integrated care management
- **Enhanced access to care**
- Behavioral-physical health integration
- Inclusion of patients & families in implementation of PCMH model
- Connection to community
- Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services
- Integration of health information technology (HIT)
### Quarterly Report: Enhanced Access

<table>
<thead>
<tr>
<th>0 - No Progress</th>
<th>1 - Early progress</th>
<th>2 - Moderate progress</th>
<th>3 - Regular part of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>We do not yet have panel population reports by provider.</td>
<td>We have begun generating panel reports and are working to ensure accuracy.</td>
<td>Leadership's vision for preserving access to their patient populations is seen by most in the organization. (e.g., we can generate accurate panel reports and are planning a system to regularly monitor these reports)</td>
<td>We demonstrate our commitment to preserving access to our population of patients. (Examples: our providers receive and review accurate panel reports, and we monitor them to ensure sufficient access to care)</td>
</tr>
<tr>
<td>We do not offer same day access scheduling</td>
<td>We provide same day access appointments for some, but not all, patients</td>
<td>We have daily openings in our schedule for same day appointments and we are exploring other systems to meet patients access to care that meets their needs (see examples under Regular Part of Care)</td>
<td>We have systems in place to ensure our patients have same-day access to their provider, and use some form of care that meets their needs (Examples: telephonic support, and/or secure messaging, group visits, RN visits.)</td>
</tr>
<tr>
<td>TTT is not tracked at this practice</td>
<td>We consistently track TTT across all providers for both short and longer office visit. Averages: short = 2+ days; longer = 7+ days</td>
<td>We have set a goal of zero for time to 3rd (TTT) next available appointment for short office visit (15/20 minutes); we consistently track TTT and have reached an average TTT of 3-6 days or less when measured across all providers over past 30 days.</td>
<td>We have set a goal of zero for time to 3rd (TTT) next available appointment for short office visit (15/20 minutes); we consistently track TTT and have reached an average TTT of &lt;3 days when measured across all providers over past 30 days.</td>
</tr>
</tbody>
</table>
Maine’s Behavioral Health Home = Behavioral Health Home Organization (BHHO) + Health Home Practice(s)

- Will align with Stage A Health Homes criteria and Core Expectations for Primary Care

- Will use existing mechanisms to track access to behavioral health (assignment to a case manager within three working days); these standards will be folded into the Behavioral Health Home expectations and used to monitor/improve access to services
In Development: MaineCare Accountable Communities

• Providers will engage in an alternative contract with the Department for shared savings
• Shared savings will depend on the attainment of quality benchmarks
• Open to any willing and qualified providers statewide
  – Qualified providers will be determined through an application process
  – Accountable Communities will not be limited by geographical area
• All fully eligible Medicaid members eligible, including duals
• Members retain choice of providers
Accountable Communities must commit to:

– Integration of behavioral and physical health

– Demonstrated leadership for practice and system transformation

– Inclusion of patients & families as partners in care, and in organizational quality improvement activities and leadership roles

– Developing formal and informal partnerships with community organizations, social service agencies, local government, etc. under the care delivery model

– Participation in Accountable Community and/or ACO learning collaborative opportunities
Accountable Communities: Enhanced Access

• MaineCare model envisions a low population barrier (minimum 1,000 members) to encourage participation of providers in rural areas, specialty/nontraditional providers, etc.

• Assignment criteria to Accountable Community will include behavioral health to ensure full participation of these community providers

• Accountable Communities do not have to partner with Health Homes, but AC model will incorporate Core Expectations, including enhanced access
Question & Answer

Please use the chat feature on your screen to send in your questions during the call.
REGISTER NOW!

NASHP's 26th Health Policy Conference

October 9-11, 2013

Seattle, WA

For more information visit

www.nashpconference.org
Conclusion

• Thank you for attending!
• Please complete the webcast evaluation. Your feedback counts!
• Continue the conversation at:

  www.nashp.org
  www.statereforum.org

Follow us on Twitter: @nashphealth