HEALTH MANAGEMENT ASSOCIATES

Massachusetts League of Community Health Centers

ACO Technical Assistance: Building Teams for New Roles

October 20, 2017

Neighborhood Health Plan™

PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

Agenda

Time	Topic	Facilitator
9:15 – 9:30	Welcome and Introductions	Ellen Hafer, Mass League
9:30 – 10:00	Overview of Enrollment Processes and Member Engagement for the ACO	Lisa Whittemore Liz Sanchez
10:00 – 11:15	Social Determinants of Health, Best Practices to Assess and Respond	Liddy Garcia-Bunuel
11:15 – 12:00	Changing Team in the ACO – Use of Community Health Workers and Peer Navigators	Liddy Garcia-Bunuel
12:00 – 12:45	LUNCH	
12:45 – 1:15	Adaptive Leadership Skills	Lisa Whittemore
1:30 – 2:30	Break-Out Session by Role - “What is my role to be successful in ACO environment”	Facilitators
2:30 – 3:00	Report Out	
3:00 – 3:30	Summary of the Series	Lisa Whittemore Myra Sessions

Agenda

- Goals for Today
- Enrollment Processes and Member Engagement
- Social Determinants of Health
- ACO Team to Address Unmet Social Needs
- Adaptive Leadership Skills
- Break-Out Session
- Summary of the Series

Four-Part Series on Value Based Payment Readiness: Overview

Overview of Readiness Roadmap: How to Succeed in New Environment
- Setting the tone for change
- Review of roadmap
- Building the pyramid: risk stratification

Elements for Success – Finances and Infrastructure:
- Negotiation strategies
- Funds flow, infrastructure investments and levels of risk
- Division of Responsibilities: MCO and ACO
- Compensation systems to align incentives

Elements for Success – Population Management:
- Empanelment/engagement
- Population Management tasks and division of responsibilities
- Care Management Staffing & ROI
- Risk stratification: who to care manage
- BH Integration

Elements for Success: ACO Risk Stratification and Coding for Improvement
- Enrollment
- Role of social determinants: assessment and follow-up
- Leading Changes
- Communicating Change for an ACO

GOALS FOR TODAY

- Review recent guidance on enrollment from MassHealth
- How to assess for social determinants of health and how might a CHC design appropriate interventions.
- How do the CHCs staff correctly address patients' nonclinical determinants of health
- Team based care in an ACO environment and role of each team member
- Setting the stage for your ACO: Communication and cultural change
- Review 4-part series: Value Based Payment Readiness

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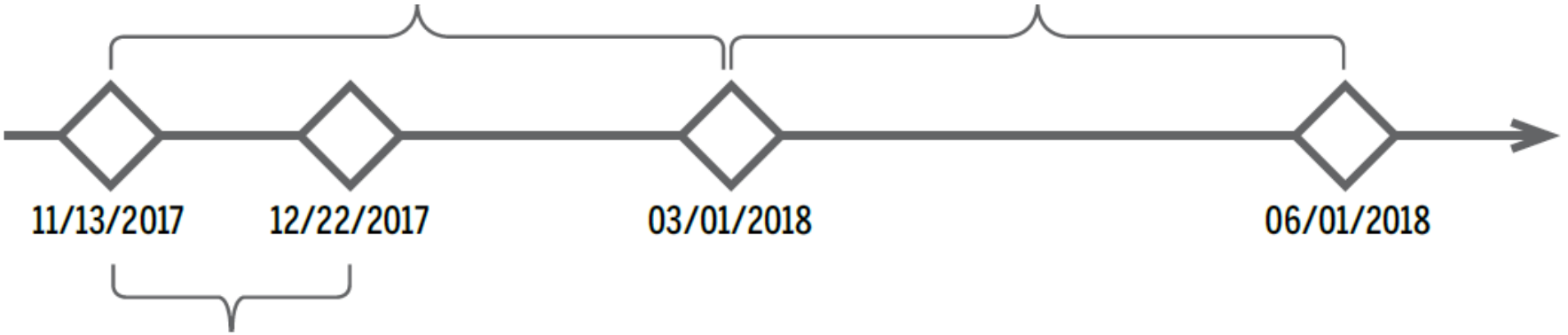
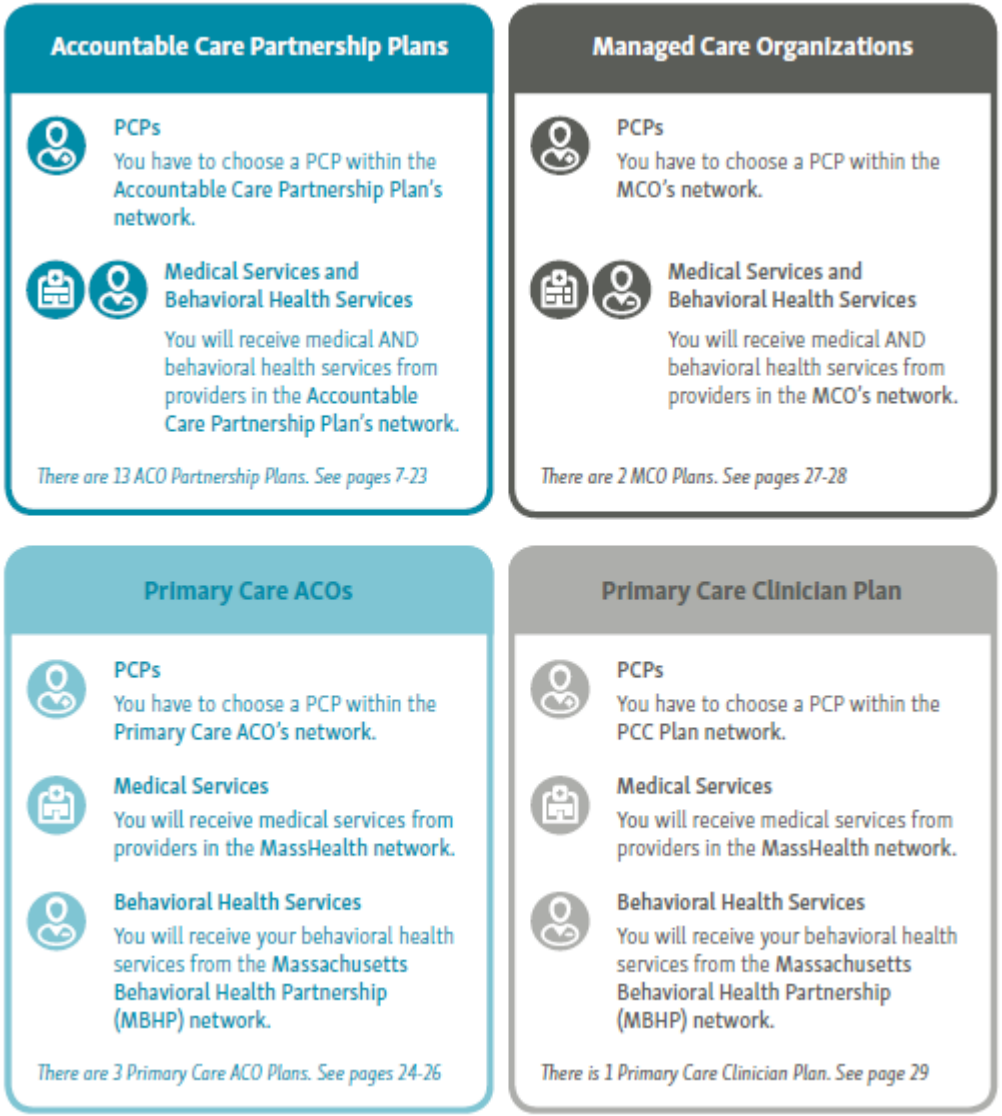
Enrollment Processes and Member Engagement

- MassHealth poised to send notices to members beginning mid-November through December



SOURCE: MassHealth ACO Notices pdf (10/17/17)

MASS HEALTH COMMUNICATION: TYPES AND NUMBERS OF PLANS



LETTERS FOR MASSHEALTH MEMBERS

LETTER #	LETTER ACTION	INDICATOR	REASON FOR MEMBER MOVEMENT	MEMBER MOVEMENT ON MARCH 1ST
1	Member moving to an Accountable Care Partnership Plan	Green stripe on envelope and letter and the phrase **"MassHealth A"** in the letter header	Member's PCP joins Partnership Plan ACO	Member is following their PCP into an Accountable Care Partnership Plan
2	Member moving to Primary Care ACO	Green stripe on envelope and letter and the phrase **"MassHealth B"** in the letter header	Member's PCP joins a Primary Care ACO	Member is following their PCP into a Primary Care ACO
3	Member moving to MCO-Administered ACO	Green stripe on envelope and letter and the phrase **"MassHealth C"** in the letter header	Member's PCP joins an MCO-Administered ACO	Member is following their PCP into the MCO
4	Member is being auto-assigned to a new health plan	Green stripe on envelope and letter and the phrase **"MassHealth AE"** in the letter header	Member's current health plan is no longer available for the member, and member's PCP did not join an ACO.	If a member does not select a new health plan by March 1st, they will be auto-assigned into a new health plan
5	Member is in their Plan Selection Period (PSP)	Green stripe on envelope and letter and the phrase **"MassHealth PSP"** in the letter header	No movement	None – member will remain in current plan, unless they select a new health plan

DISCUSSION

- How can you prepare for your patients' questions?

- How do you use your teams to address this challenge?

Agenda

- Goals for Today
- Update: Enrollment Processes and Member Engagement
- Social Determinants of Health
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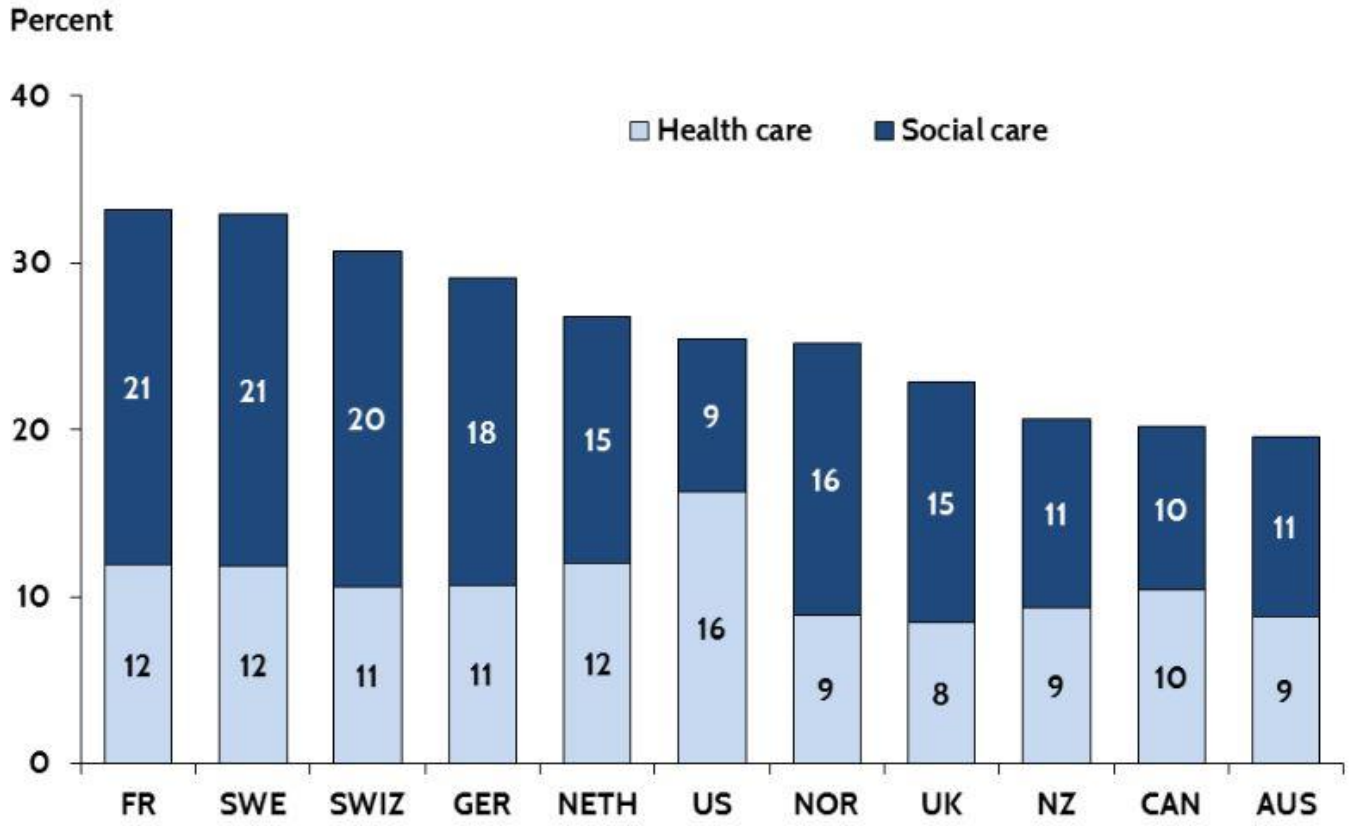
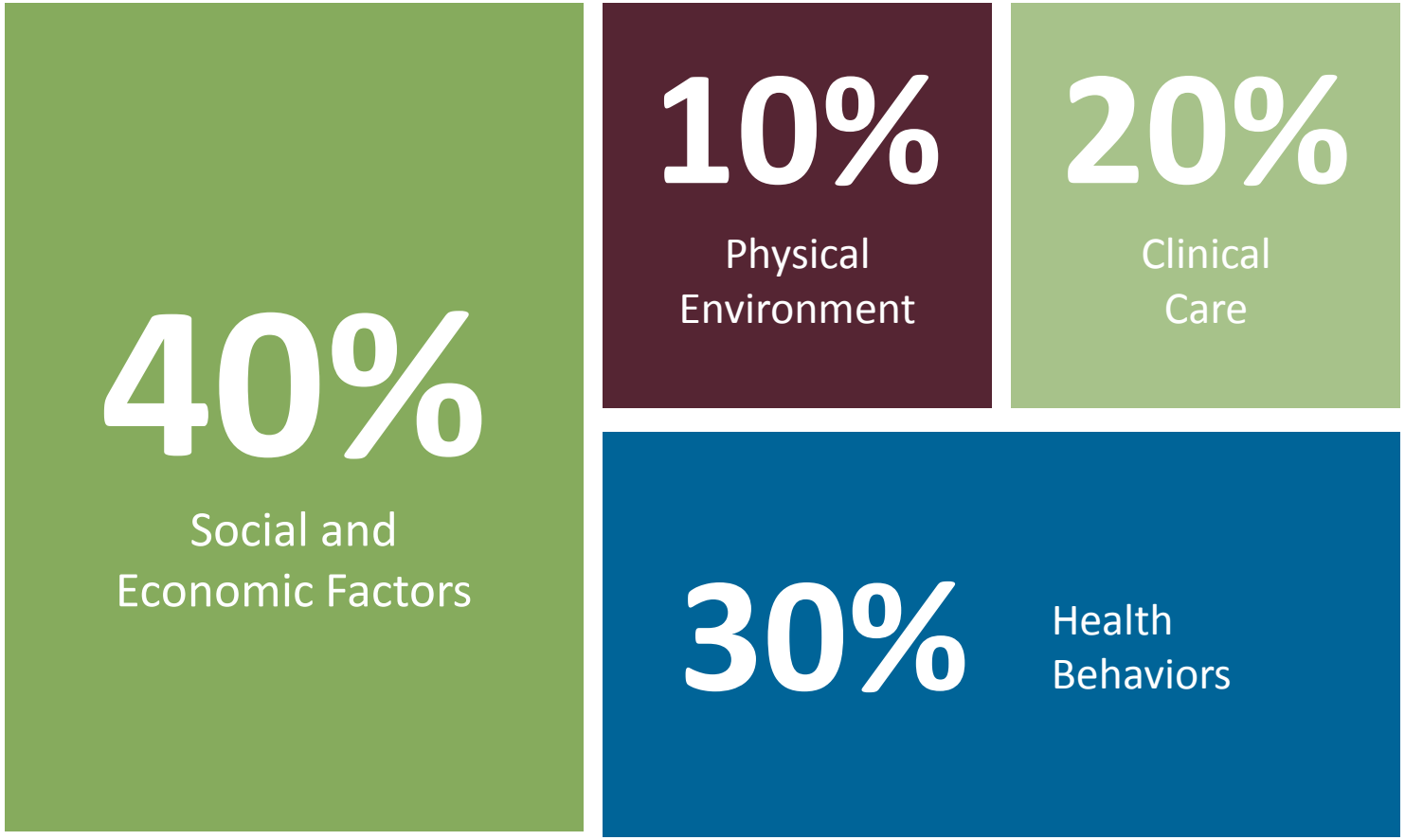
Re-balancing Medical and Social Spending to Promote Health

Exhibit 8. Health and Social Care Spending as a Percentage of GDP



Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

MODIFIABLE FACTORS THAT INFLUENCE HEALTH



* Source: Booske, B.C., Athens, J.K., Kindig, D.A., Park, H., & Remington, P.L. (2010). *County Health Rankings* http://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf.

DISCUSSION: SOCIAL DETERMINANTS OF HEALTH

What are social determinants of health?

Who currently does a screening for social needs of patients?

Core Health-Related Social Needs

- Housing instability (e.g., homelessness, inability to pay mortgage/rent, housing quality);
- Utility needs (e.g., difficulty paying utility bills);
- Food insecurity;
- Interpersonal violence (e.g., intimate partner violence, elder abuse, child abuse, etc.); and
- Transportation needs (beyond medical transportation).

HEALTH MANAGEMENT ASSOCIATES

SOCIAL DETERMINANTS OF HEALTH:

HOUSING

In recent years, evidence has emerged demonstrating that adequate, stable housing is linked to reduced health care costs and improved health.

With the emergence of this evidence, health care systems and providers have begun to:

- **Understand lack of adequate, stable housing as a barrier to health and a contributor to high cost**
- **Increase their attention to housing needs**
- **Struggle with how to help**
  + What works?
  + What can health plans and/or providers do?

HOUSING, NEIGHBORHOODS AND HEALTH

Access to healthy food

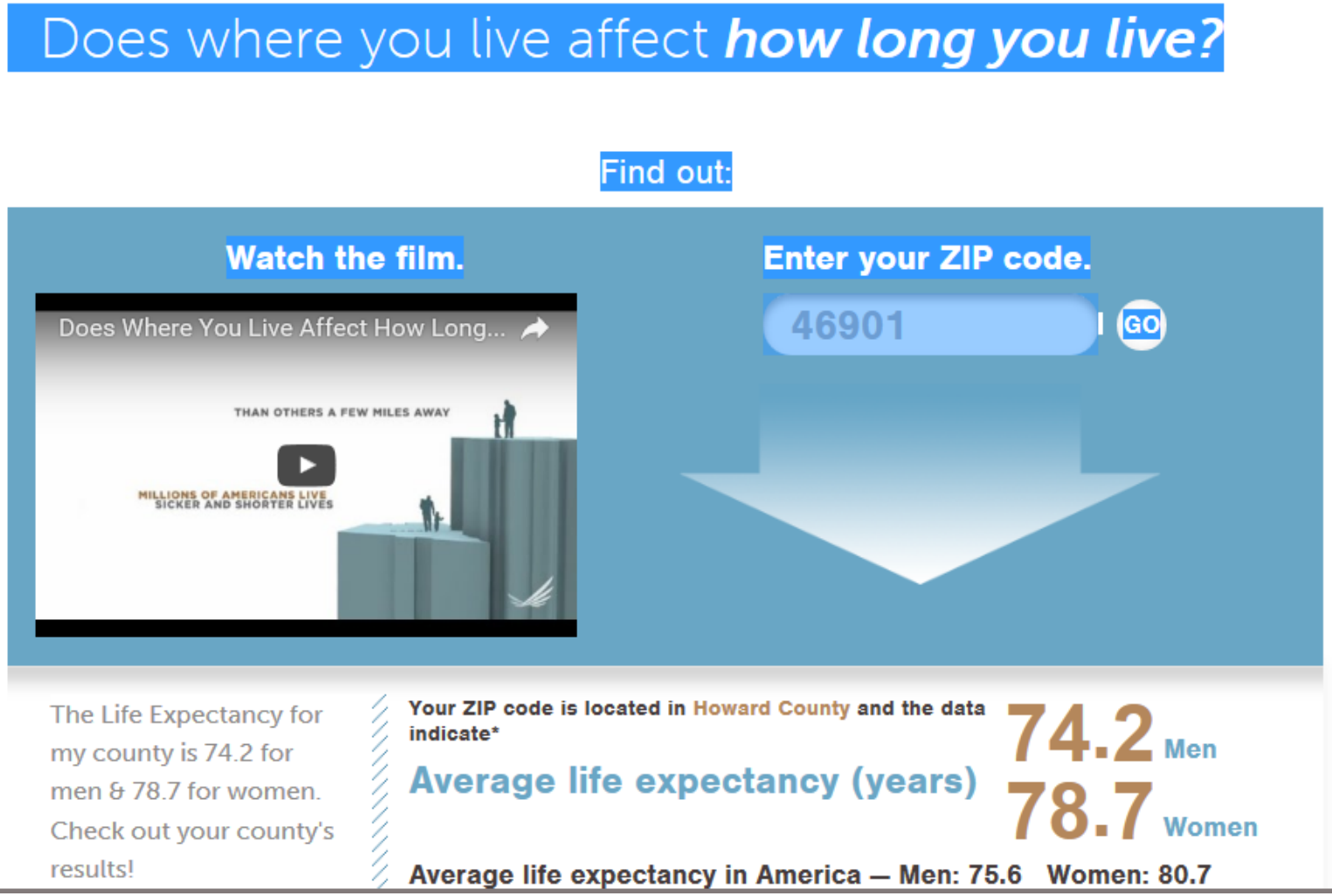
Walkability

Safety

access to health care resources

Access to social services

HOUSING, NEIGHBORHOODS AND HEALTH: ZIP CODES AS A PREDICTOR OF LIFE EXPECTANCY



LACK OF STABLE, HEALTHY HOUSING AS A BARRIER TO HEALTH AND A CONTRIBUTOR TO HEALTH SPENDING

In one study, homeless individuals had an average hospital length of stay that was four days longer than non-homeless

In another study, the rate of psychiatric hospitalization was 100 times that of non-homeless

Homeless individuals have, on average, five ED visits per year, with some using the ED weekly

80% of these visits are for illnesses that could have been treated with preventive care

CASE STUDY

Program to improve health and reduce utilization among "High Utilizers"

Massachusetts' Home and Healthy for Good Program, which housed 766 chronically homeless individuals in supportive housing

FINDINGS

Prior to housing, total costs per person per year were $33,190

After housing, total costs per person per year were $8,603

Total estimated return on investment to the state was $9,118 per person, after program costs were accounted for

HOW ACOs CAN IMPACT HOUSING CHALLENGES

- Conduct Health Needs Assessments that include assessment of social determinants of health and social and other needs
- Include CBOs in networks of service providers
- Partner with housing providers and utility assistance providers (heat, electric)
- Implement CHC, multi-agency case consultation, formalized data sharing agreements, protocols for regular communication and information sharing, co-location of staff/services and coordinated funding strategies
- Use community health workers, care coordinators and patient navigators to serve at the intersection of health, housing and social services
- Utilize home visits to allow for safety checks (e.g., trip-hazard carpets and the elderly)

HEALTH MANAGEMENT ASSOCIATES

SOCIAL DETERMINANTS OF HEALTH:

FOOD

FOOD AND HEALTH

We all know that eating healthy food, in the right quantities, is a key to health.

- **Barriers to healthy eating can be complex, and are related to income, education, geography, transportation, available food sources, and mental health**
- **Solutions need to take into account these complexities**

FOOD AND HEALTH

12.7%

of American households **(50 million people)** were food insecure at least some time during 2015.

Over 30% of female-headed households are food insecure.

RISK FACTORS

- Low income
- High cost of food and non-food essentials
- Geographic isolation
- Health conditions requiring a special diet
- Lack of transportation
- Lack of food skills

FOOD INSECURITY: IMPACTS ON HEALTH

Food insecure children are:

- at least twice as likely to report being in fair or poor health compared to food-secure children, and 1.4 times more likely to have asthma
- more likely to have behavioral problems, depression, suicidal ideation, poor oral health, and anemia

FOOD INSECURITY: IMPACTS ON HEALTH

Food insecure non-senior adults are:

More likely to have mental health problems, including depression; more likely to have diabetes, hypertension, poor sleep and generally poorer health

Food insecure seniors:

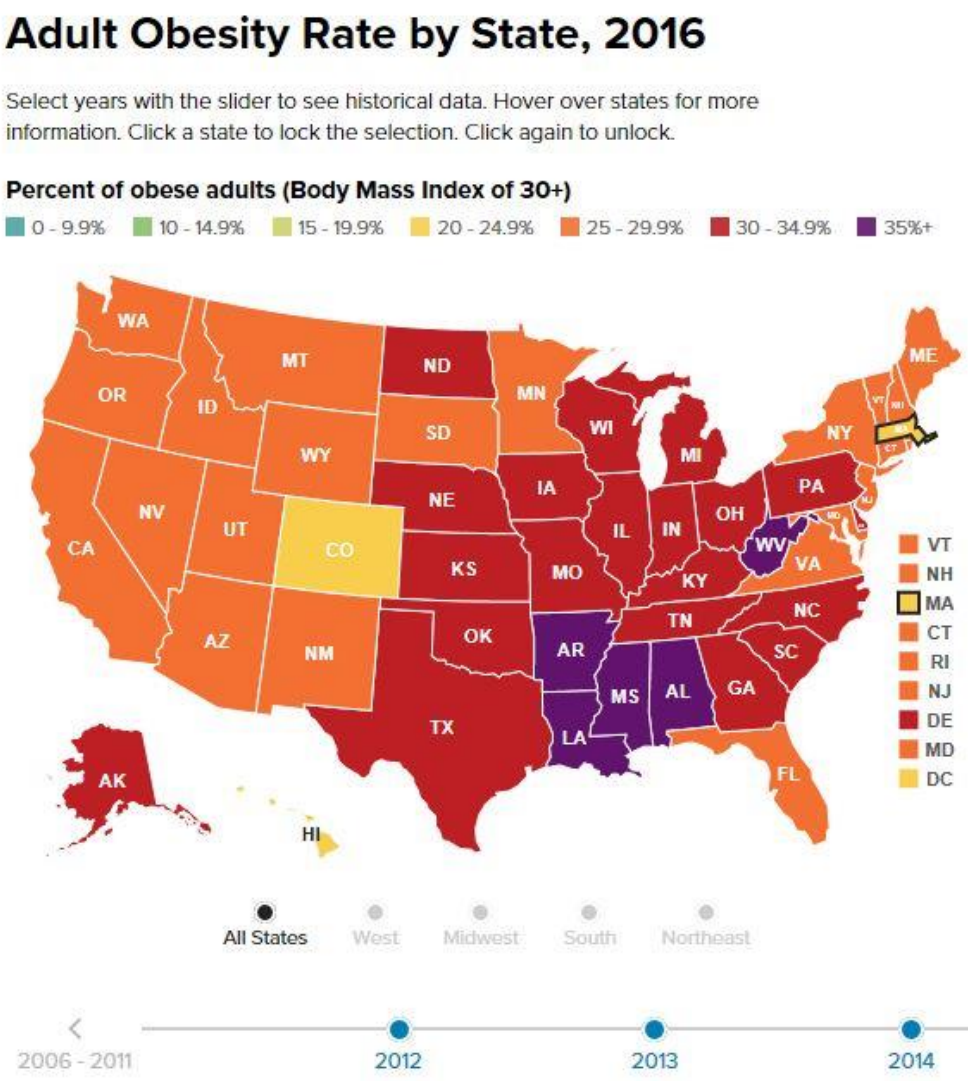
- Are more than twice as likely as food secure seniors to have poor health
- Have limitations in activities of daily living comparable to seniors who are 14 years older than them

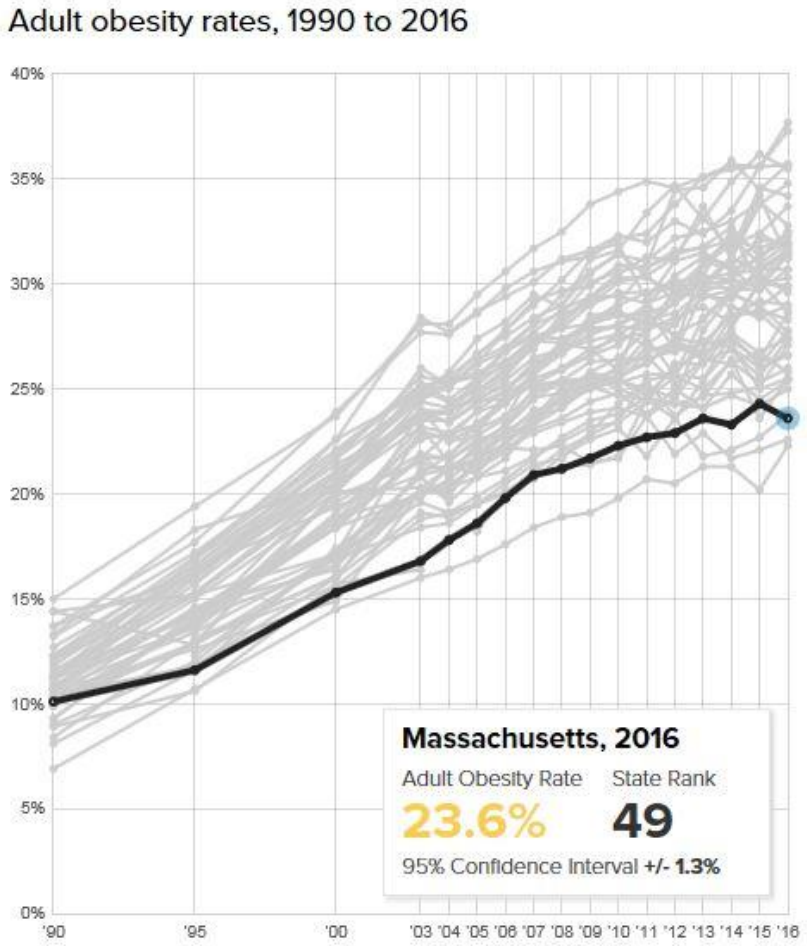
LACK OF ACCESS TO HEALTHY FOOD

Decreased access to healthy food means people in low-income communities suffer more from diet-related diseases like obesity and diabetes than those in higher income neighborhoods with easy access to healthy food, particularly fresh fruits and vegetables.

Inequitable access to healthy food
is a major contributor to health disparities.

INTERSECTION OF FOOD AND HEALTH: OBESITY IN MA





NEGATIVE HEALTH OUTCOMES AND COSTS OF OBESITY

Annual Medical Costs of Obesity:

$190
BILLION
(in 2005 dollars)

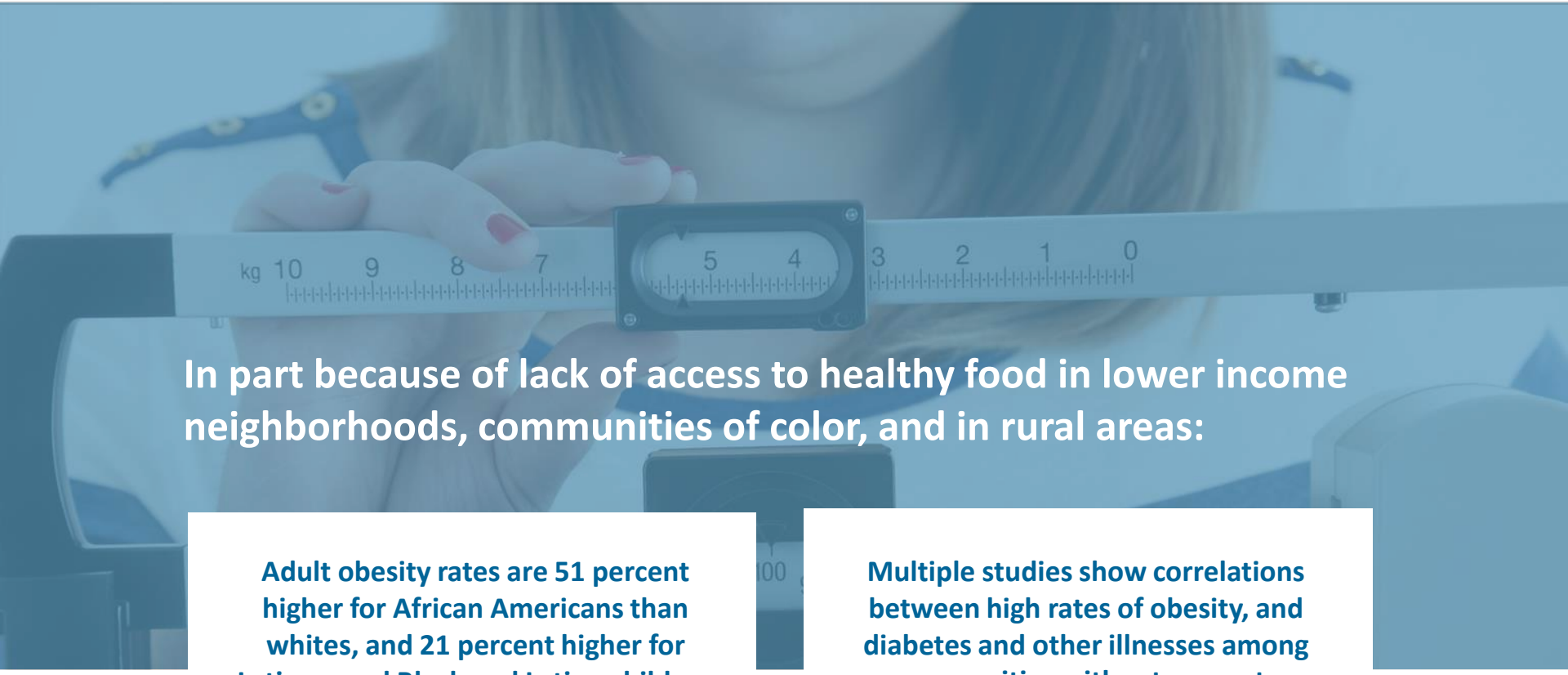
or

21%
of all medical spending

Negative Health Outcomes of Obesity:

Diabetes, Heart disease, stroke, dyslipidemia (e.g., High blood cholesterol and triglycerides), high blood pressure, metabolic syndrome, liver disease, gallbladder disease, kidney disease, asthma, sleep apnea, arthritis, chronic back pain, mobility limitations, some types of cancer, reproductive complications, pregnancy-related complications, poor health-related quality of life, increased all-cause mortality, decreased life expectancy, increased risk of hospitalization, depression, anxiety, substance use disorders

ACCESS TO HEALTHY FOOD IS AN EQUITY ISSUE



In part because of lack of access to healthy food in lower income neighborhoods, communities of color, and in rural areas:

Adult obesity rates are 51 percent higher for African Americans than whites, and 21 percent higher for Latinos, and Black and Latino children are more likely to become obese than white children (CDC).

Multiple studies show correlations between high rates of obesity, and diabetes and other illnesses among communities without access to fresh food (grocery stores or farmer's markets)

HOW ACOs CAN IMPACT FOOD CHALLENGES

- Conduct Health Needs Assessments that include assessment of social determinants of health and social and other needs: know the problems for your communities
- Help enroll members in SNAP
- Include CBOs in networks of service providers and partner with food providers
- Implement CHC, co-location of staff/services and coordinated funding strategies
- Use community health workers, care coordinators and patient navigators to serve at the intersection of health, food, economic security and social services
- Partner with, and encourage investment in, grocery stores, mobile produce services, farmer's markets
- Develop and disseminate food pantry resources /contacts

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SOCIAL DETERMINANTS OF HEALTH:

TRANSPORTATION

Lack of Transportation: Who is Affected

About 3.6 million Americans miss or delay health care every year because of transportation challenges.

Low income populations are most affected, along with:

- **+ Seniors**
- **+ Children**
- **+ Communities of color**
- **+ People with chronic conditions**

People with reliable access to transportation see their doctors about twice as often as people without it.

LACK OF TRANSPORTATION: IMPACTS ON HEALTH

Evidence suggests that lack of transportation to access primary care, preventive care, and care for chronic conditions is correlated with:

- Higher rates of ED visits
- Higher rates of hospital readmissions
- Lower rates of medication adherence
- Worse clinical outcomes

Reducing readmissions and ED visits results in significant cost savings, which outweigh the costs of investing in transportation for patients

OPTIONS AND SERVICES

Provide effective and reliable non-emergency medical transportation

Provide mobile services

Expand tele-health services

Provide services where people are

Solutions: Mobile and Community-Based Services

Incorporate churches, social service providers, and beauty salons into prevention and referral efforts

Hair stylists conducting breast cancer education in hair salons, screen for and make depression referrals

Mobile Services

Mammograms, asthma testing and treatment

Clinics in accessible community settings

Schools, churches

Increase use of telehealth services

Psychiatric services for individuals in rural areas

Connecting specialists to primary care in hard to reach areas (i.e., Diabetes management)

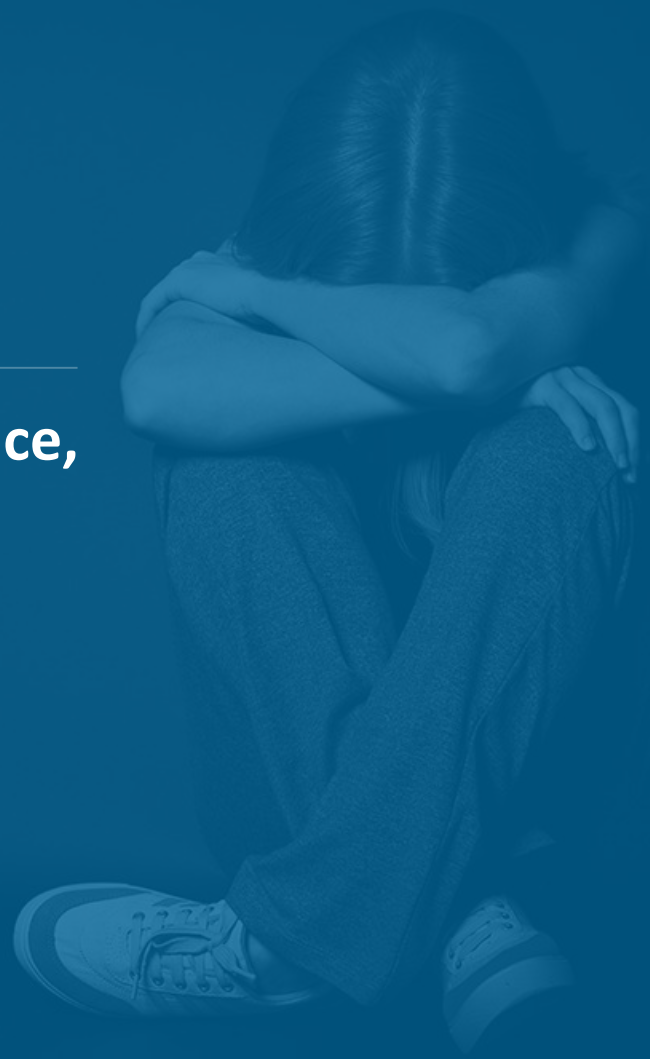
Crisis services

HOW ACOs CAN IMPACT TRANSPORATION CHALLENGES

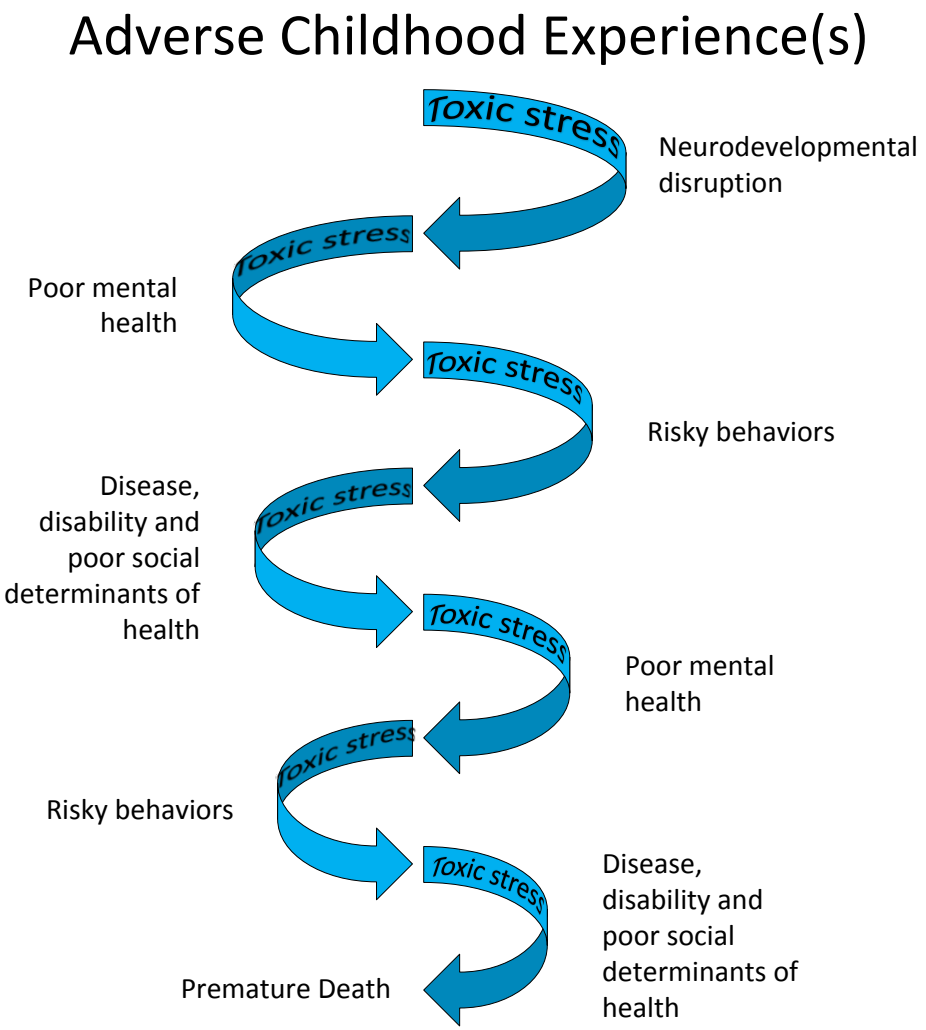
- Conduct Health Needs Assessments that include assessment of social determinants of health and social and other needs
- Help enroll members in transportation services
- Provide transportation and reimburse for public transportation costs
- Include CBOs in networks of service providers and partner with transportation providers
- Provide services in schools, community centers, and other community locations on public transportation lines
- Provide mobile services, in-home services
- Implement patient-centered medical homes, co-location of staff/services and coordinated funding strategies
- Use community health workers, care coordinators and patient navigators to serve at the intersection of health, transportation, food, economic security and social services
- Partner with, and encourage investment in, innovative transportation solutions

HEALTH MANAGEMENT ASSOCIATES

Impact of Interpersonal Violence, Abuse and Neglect on Health Outcomes



ACEs lead to a downward health spiral



ACEs CORRELATE WITH POOR MEDICAL OUTCOMES

As the number of ACEs increases, so does the risk of numerous poor medical outcomes, including:

- ☑ Chronic obstructive pulmonary disease
- ☑ Ischemic heart disease
- ☑ Liver disease
- ☑ Myocardial infarction
- ☑ Fetal death
- ☑ Disability
- ☑ Coronary heart disease
- ☑ Stroke
- ☑ Diabetes
- ☑ Asthma
- ☑ Obesity

ACEs CORRELATE WITH POOR BEHAVIORAL HEALTH OUTCOMES

Adverse Childhood Experiences (ACE) have been found to correlate with an increased risk of numerous poor behavioral health outcomes, including:

- Alcoholism and alcohol abuse
- Depression and depressive disorders
- Mental distress
- Anxiety
- Illicit drug use
- Suicide attempts
- Hallucinations
- Childhood autobiographical memory disorder

Interpersonal Violence: Health Outcomes

Interpersonal violence is associated with both medically explained and unexplained medical complaints

- ACEs associated with maladaptive family functioning (household challenges and neglect) are linked with the highest risk of mental and psychiatric disorders
- Interpersonal violence is the potentially traumatic event most closely associated with the development of PTSD
- Recurrent headaches are closely correlated to experiences of interpersonal violence

Experiences of interpersonal violence correlate with a high risk of illicit drug use beginning in adolescence

Experiences of interpersonal violence (especially when it leads to PTSD) are correlated with later perpetration of intimate partner violence

Physical and Sexual Abuse: Health Outcomes

Childhood abuse is associated with increases in complaints across a wide spectrum that lead them to become high utilizers of medical and emergency care services

- ☑ Gastrointestinal health
- ☑ Gynecologic and reproductive health
- ☑ Cardiopulmonary symptoms
- ☑ Obesity, including morbid obesity
- ☑ PTSD
- ☑ Alcohol and substance use disorders (Opioid overdose)
- ☑ Body dissatisfaction and eating disorders (Binge eating disorder/Night eating syndrome)
- ☑ Personality disorders
- ☑ Depression, including dysthimia
- ☑ Non-explained medical symptoms, including chronic pain
- ☑ Respiratory disease
- ☑ Early adolescent tobacco use
- ☑ Suicide attempts
- ☑ Risky sexual behavior and sexually transmitted diseases
- ☑ Low self-compassion and self-esteem
- ☑ Somatization disorder
- ☑ Anxiety

Addressing ACEs in a Medical Setting: An Ounce of Prevention

Medical providers, especially primary care practitioners, are in a position to identify families who are in need of support and ACE prevention activities, and refer those families to the necessary programs

- **The American Academy of Pediatrics publishes the Bright Futures Guidelines**
  Up-to-date information on preventive screenings and services by visits

  Visit-by-visit anticipatory guidance for healthcare providers

Research is showing that patient-centered medical homes and family-centered medical homes are more effective at identifying, preventing and mitigating ACEs

Addressing ACEs in a Medical Setting: Appropriate Referrals

When identifying families at risk of ACEs, primary care physicians and the care managers with whom they work can make referrals to appropriate services

- **Home visiting programs like the nurse-family partnership**
- **Parenting training programs**
- **Intimate partner violence prevention programs**
- **Social and financial support for parents**
- **Teen pregnancy prevention and teen parenting support programs**
- **High quality, affordable childcare**
- **Mental health and substance abuse treatment**

The presence of a behavioral health disorder in the home is an ACE that puts a child at risk for future poor health outcomes
Parental behavioral health disorders are a risk factor in the occurrence of other ACEs (e.g. abuse and neglect)

High-quality, comprehensive, integrated behavioral healthcare is the single most effective intervention for reducing the impact of ACEs on health outcomes

How to Screen for Social Determinants of Health

Contact with Member

Conduct Assessment

Intervention

Follow-up

Health-Related Social Needs

Core Needs	*Supplemental Needs
Housing Instability	Family & Social Supports
Utility Needs	Education
Food Insecurity	Employment & Income
Interpersonal Violence	Health Behaviors
Transportation	

Five Keys to a Great Screening Tool:

1. Make it short and simple
2. Choose clinically validated questions at the right level of precision
3. Integrate into clinical workflows
4. Ask patients to prioritize
5. Pilot before scaling

Recommended Screening Tool – can be tailored to your ACO (see packet)

https://healthleadsusa.org/wp-content/uploads/2016/07/Health-Leads-Screening-Toolkit-July-2016.pdf

Collecting Member Demographic Data

To address health equity, MDDC is critical. ACO should consider collecting information on:

- ❑ **Race/Ethnicity (as disclosed by Patient)**
- ❑ **Preferred language**
- ❑ **Sexual Orientation and Gender Identity (SOGI)**
- ❑ **Disabilities**
- ❑ **Veteran Status**

HOW TO USE MDDC DATA

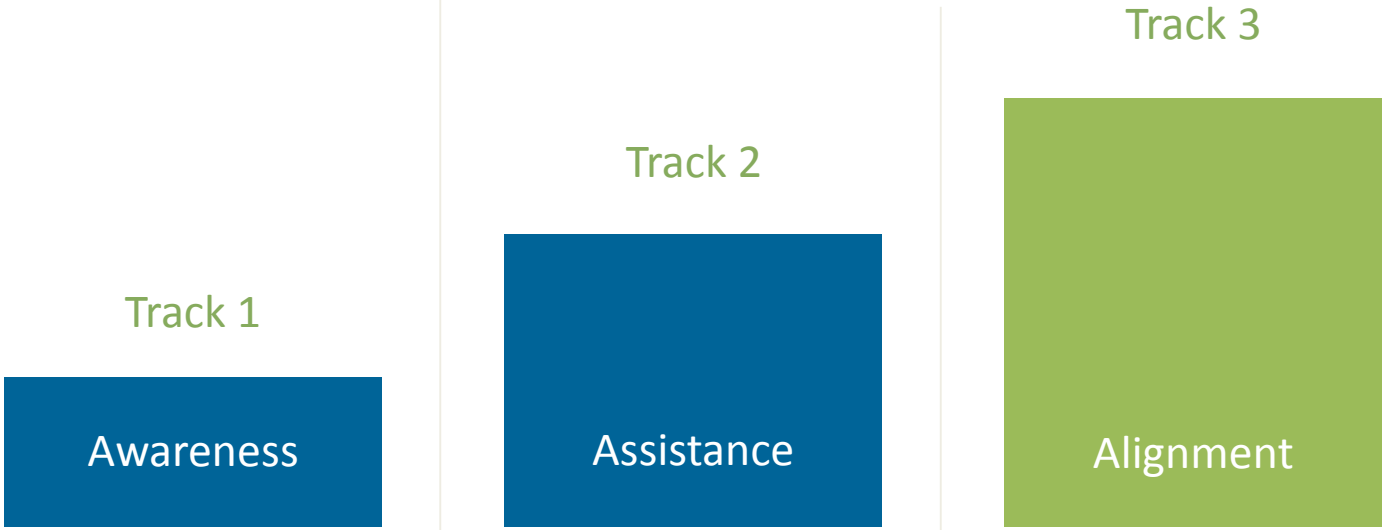
- Helps identify disparities; i.e. participation rates in Hep B treatment; lung cancer treatment, diabetes management
- Targets intervention to improve outcomes
- Implement programs to support a variety of patient populations
- Allows providers to provide more competent care

Equity Enhancement Program Spotlight

Using REAL Data to Reduce Disparities and Improve Quality of Care

Harborview Medical Center addresses disparities-sensitive quality measures and improves data stratification with the additional collection of granular ethnicity

CMMI Accountable Health Communities Model Tracks for Intervention



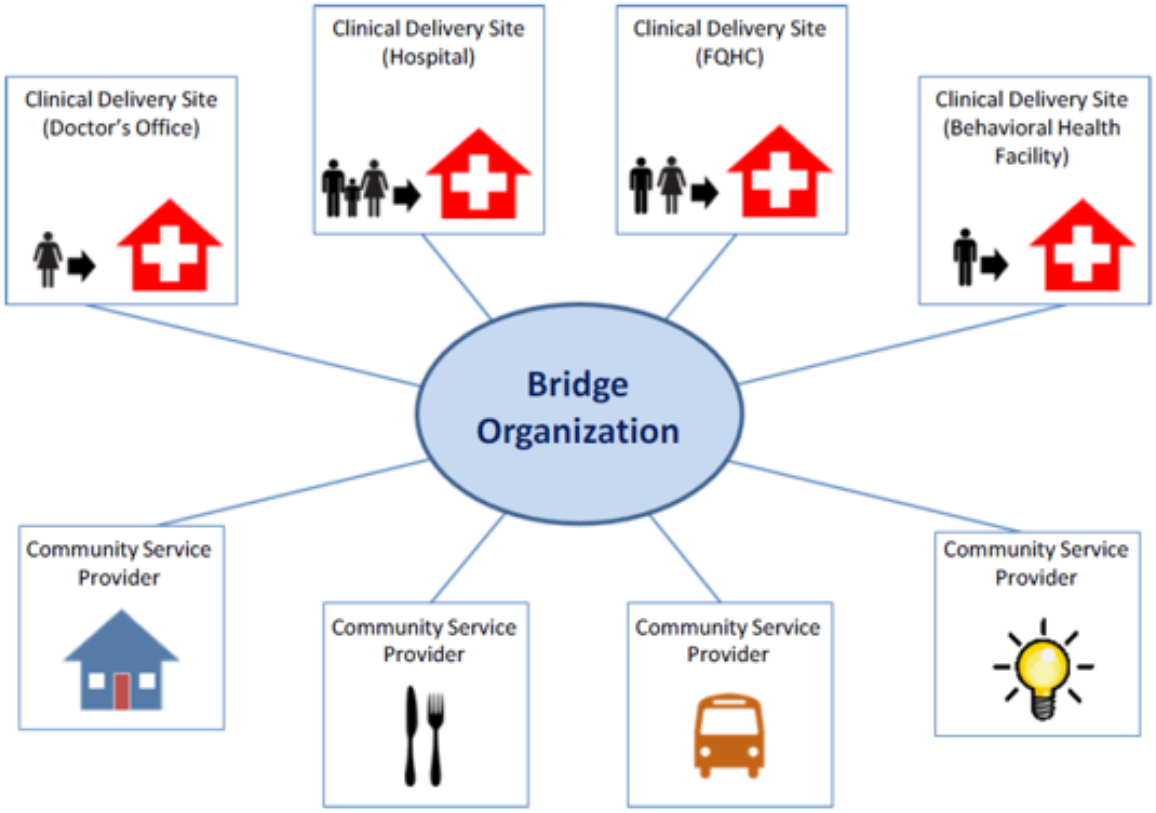
Increase beneficiary awareness of available community services through information dissemination and referral

Provide community service navigation services to assist high-risk beneficiaries with accessing services

Encourage partner alignment to ensure that community services are available and responsive to the needs of beneficiaries

ACO as a Bridge to Services

"…ACOs can serve as effective bridge organizations"



INTERVENTIONS – Cost Savings and Quality

Intervention name	Description	Cost savings	Quality and care utilization measures
Adirondack Medical Home Demonstration	The Adirondack Medical Home Demonstration is a five-year pilot across payers and providers in the Adirondack region of New York State in which participating providers become NCQA-certified patient-centered medical homes (PCMHs). The payers distribute $7 per-member per-month to providers to support an extensive set of PCMH services, including employing care managers and community resource advocates who assist patients with social needs.[a]	The Hudson Headwaters Health Network, a participant in the Adirondack Medical Home Demonstration, has shown 15% to 20% savings for Medicaid beneficiaries.[b]	After implementing a transition program for individuals discharged from the hospital, the Hudson Headwaters Health Network reduced its readmissions rate for targeted conditions from 19% to 7%. Within the Network, patients are assessed upon intake and referred to Community Resource Advocates to provide social supports, including assistance with housing/living conditions, food, and transportation.[c]
Camden Coalition of Healthcare Providers	The Camden Coalition of Healthcare Providers operates a care management program for high utilizers of health care services, where an outreach team assists participants with activities such as connecting to a medical home, obtaining housing and other public benefits, managing their legal needs, and meeting their personal goals.[d]	In the period post-intervention, average total hospital charges per month for 36 high utilizers fell by 56.4%, from $1,218,010 to $531,203.[e]	After participating in the intervention, the average total number of emergency department and hospital visits across 36 high utilizers fell by approximately 40%, decreasing from 61.6 to 37.2 visits per month.[f]
Community Asthma Initiative	The Community Asthma Initiative is an intervention operated out of Children's Hospital Boston and a community health center, in which nurse case managers provide care coordination services for low-income children with asthma. The families receive home visits from nurses or community health workers supervised by nurses, who assess the families' homes for asthma triggers, provide asthma remediation items, and connect families to community-based services.[g]	At two-year follow-up, the intervention saved $3,827 in decreased emergency department visits and hospitalizations per child when measured against a comparison group. The intervention cost $2,529 per child, resulting in a return on investment of 1.46.[h]	At 12 months into the intervention, participants experienced a 68% decrease in emergency department visits, an 85% decline in hospitalizations, and a 43% reduction in "days of limitation of physical activity." In addition, children missed 41% fewer school days and their parents missed 50% fewer days of work.[i]

INTERVENTIONS – Cost Savings and Quality

Intervention name	Description	Cost savings	Quality and care utilization measures
Frequent Users of Health Services Initiative	The Frequent Users of Health Services Initiative includes six hospital and community-based case management programs in California providing referrals to medical and social services for individuals who are frequent users of emergency departments.[j]	After two years of program enrollment, average inpatient charges decreased by 69%, falling from $46,826 at one-year pre-enrollment to $14,684 at the two-year point.[k]	Two years post-enrollment into the initiative, average inpatient days decreased by 62%.[l]
Geriatric Resources for Assessment and Care of Elders (GRACE)	The GRACE intervention begins with a home visit by a nurse practitioner-led support team to assess low-income seniors' medical and psychosocial needs. The support team reports its findings to a larger group of health care professionals, which develops and implements a care plan to address the individual's needs, including those related to home safety and social support.[m]	For individuals with a high-risk of hospitalization, a randomized controlled trial found similar costs between individuals participating in GRACE and a comparison group receiving usual care during the two years of the study. However, in the year following the intervention, individuals at high-risk of hospitalization participating in GRACE had significantly lower total mean costs than similar individuals in the comparison group; a difference of $5,088 v. $6,575, respectively.[n]	Individuals receiving the intervention had a significantly lower rate of emergency department visits over a two-year period than individuals receiving usual care (1,445 per 1,000 v. 1,748 per 1,000). In addition, GRACE participants experienced statistically significant improvements on the SF-36 quality of life instrument in the areas of general health, vitality, social functioning, and mental health as compared with the usual care group.[o]
Health Leads	In the clinics where Health Leads operates, physicians and other members of the clinical team can systematically screen their patients for unmet social needs and prescribe resources to meet those needs. Trained student Advocates connect the patients to community resources by leveraging a client management database and resource inventory. They then conduct follow-up to ensure the services were received, and loop back to the referring provider.[p]	After the Dimock Center, a health and human services agency in Boston, instituted Health Leads, their pediatric social worker's average weekly billable therapy minutes increased by 57%.[q]	In fiscal year 2013, 90% of patients with whom Health Leads worked successfully solved at least one need or reported that they are equipped to secure resources with the information provided by Health Leads and without further assistance.

INTERVENTIONS – Cost Savings and Quality

Intervention name	Description	Cost savings	Quality and care utilization measures
Medical-Legal Partnership	In the Medical-Legal Partnership (MLP), lawyers and paralegals work onsite in clinical settings or at locations affiliated with provider institutions and assist patients in addressing legal issues associated with health status.[r]	An MLP between a federally funded legal aid agency and a community health clinic in rural Illinois assisted individuals with appealing Medicaid coverage denials and obtained a 319% return on investment over a three-year period by obtaining reimbursement through health care recovery dollars.[s]	In a small pilot study, adults with moderate to severe asthma who received services through an MLP in New York demonstrated a 91% decline in emergency department visits and hospital admissions. Approximately 92% of participants experienced a decrease of at least two asthma severity classes.[t]
Seattle-King County Healthy Homes Project	The Seattle-King County Healthy Homes Project is an intervention in which community health workers conduct home visits for families of low-income children with uncontrolled asthma. Intervention participants received self-management support services including a home assessment for environmental triggers, help with reducing exposure to asthma triggers, and assistance in developing skills to better control asthma, such as correct use of medications.[u]	Urgent care costs for participants in the high-intensity version of the intervention were estimated to be $201–$334 per child less than those in the low-intensity version of the intervention.[v]	For participants in the high-intensity version of the intervention, from baseline to the period post-intervention, the percentage of participants using urgent health services over the past two months declined from 23.4% to 8.4%, a greater decline than observed in the low-intensity group. In addition, symptom-free days and asthma-related quality of life for the children's caregivers improved more among families in the high-intensity group.[w]

INTEREVENTIONS

SCREENING AND INTERVENTION EXERCISE

HMA Community Strategies

INTERVENTIONS – EXERCISE

TOPIC	SDH Screening Question (validated)	Action in Health Center (Resources available)	Health Center Team for Follow-Up (who will follow-up and how?)
Housing			
Transportation			
Utilities			
Food			
Safety or ACE			
Financial Security			
Other			

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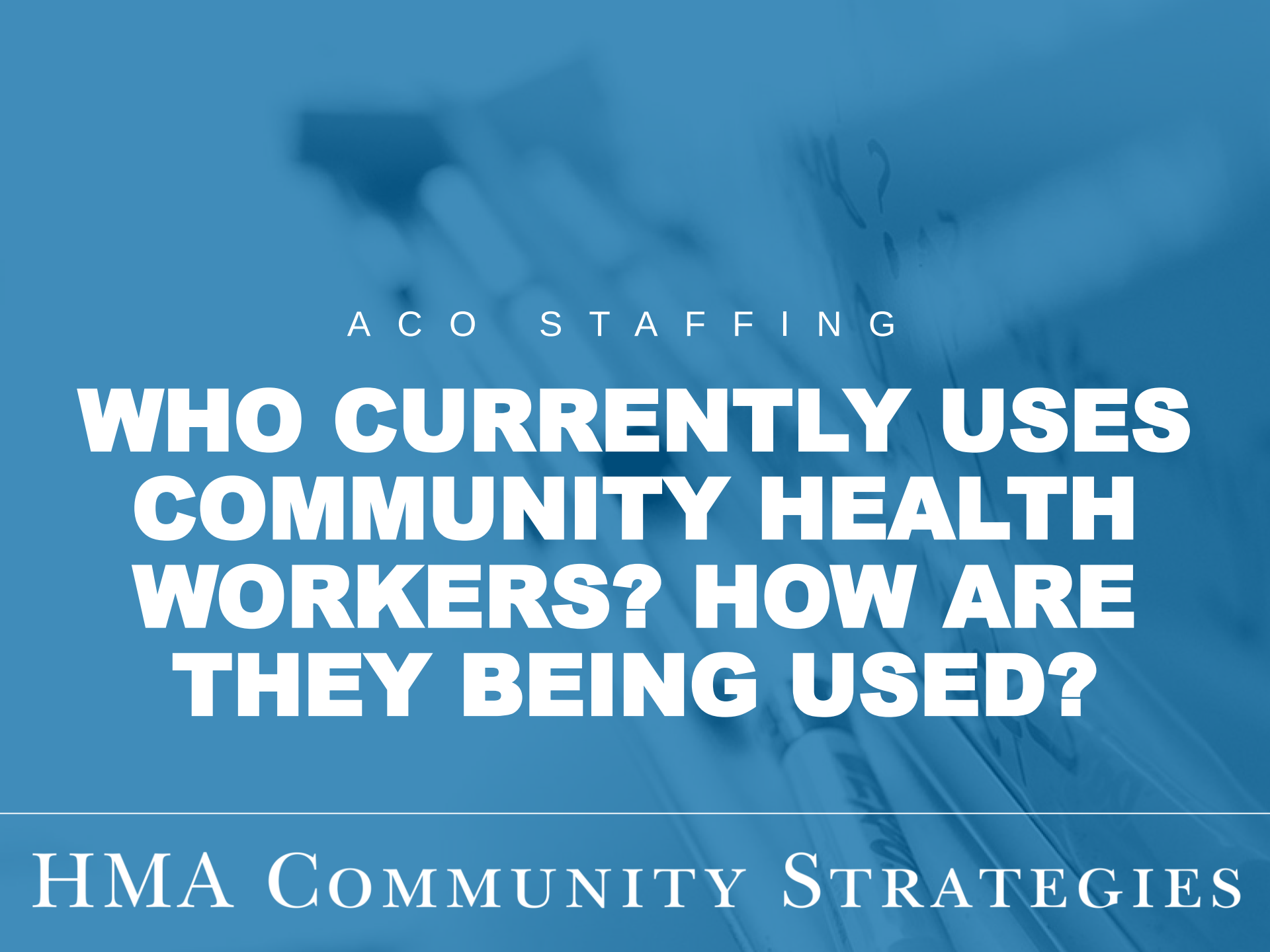
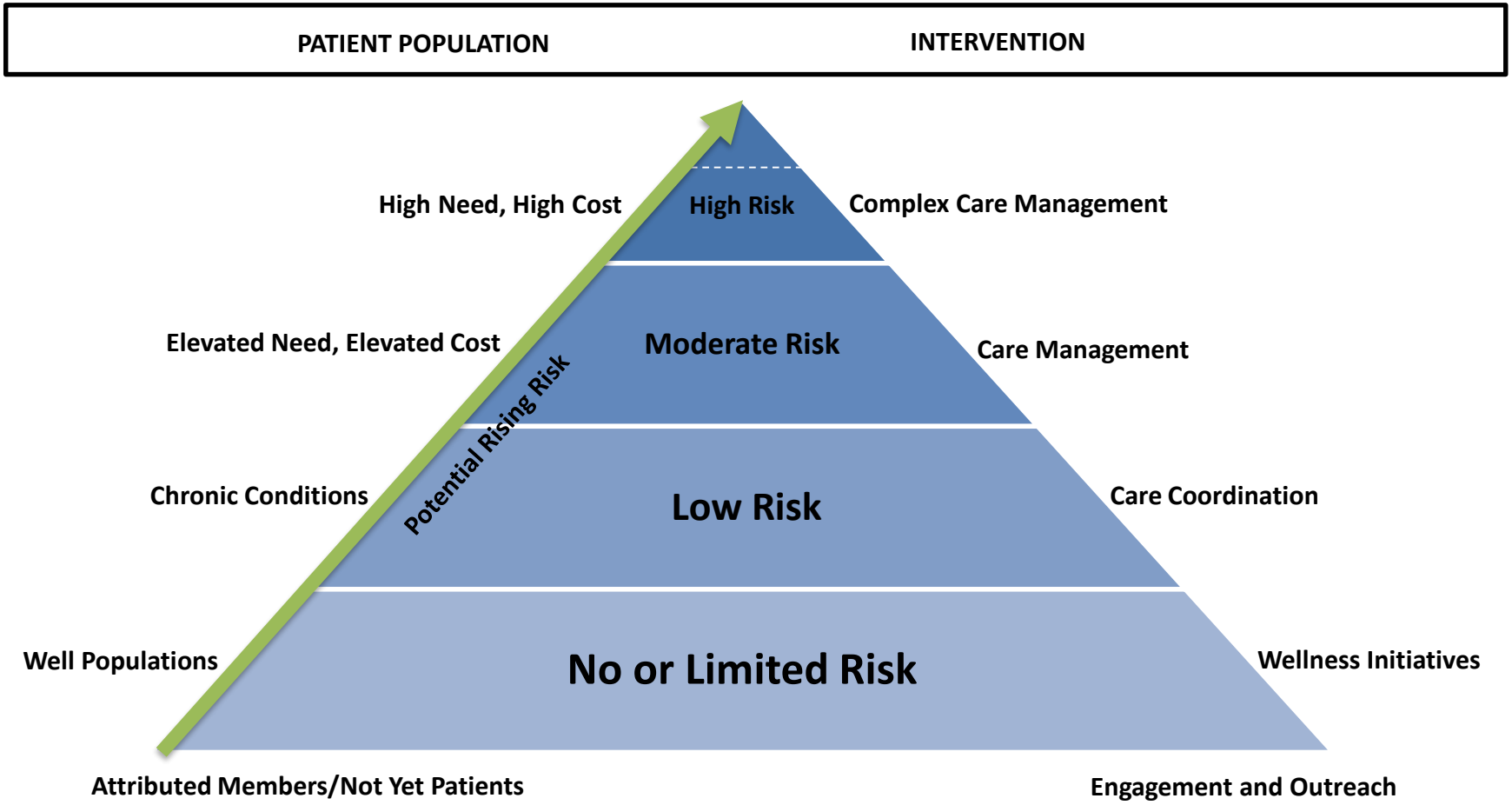


ACO STAFFING

WHO CURRENTLY USES COMMUNITY HEALTH WORKERS? HOW ARE THEY BEING USED?

HMA COMMUNITY STRATEGIES

Population Health Management



Section III: Care Delivery/HIT and HIE
Part 1: Population Health Management

Gaps

- **Proactive Alerts (CORE): 9**% said providers/care team members receive proactive alerts in their EHR for ER utilization and inpatient hospitalization (2 Yes; 3 Partial)
- **Super Utilizers (CORE): 18%** create an actionable list of "Super utilizers" (e.g. patients who have frequent ED use or hospital readmissions) (4 Yes; 11 Partial)
- **At-Risk Patients (CORE): 23%** create an actionable list of other patients at-risk for hospital admission (5 Yes; 9 Partial)

How can COMMUNITY HEALTH WORKERS fill these gaps?

Section III: Care Delivery/HIT and HIE
Part 2: Care Management

Gaps

- **Care plans (CORE): 45%** use a care plan as a source for the management of care (10 Yes; 10 Partial)
  - Only **36%** have access to an electronic care management system for the care plan (8 Yes; 4 Partial)
- **Risk stratification (CORE): 36%** do risk stratification (8 Yes; 5 Partial) and **36%** capture it as structured data
- **Outreach and engagement (CORE): 18%** have a strategy to outreach to and engage managed care members who are assigned to you but have never been seen in your health center (4 Yes; 8 Partial)
- **Hospital relationships: 32%** have good relationships and processes built with hospitals (e.g., hospital ED care navigators, discharge planners, coordinators) utilized by your patients for routine communications and handoffs (7 Yes; 10 Partial)

How can COMMUNITY HEALTH WORKERS fill these gaps?

Section III: Care Delivery/HIT and HIE
Part 3: Patient-Centeredness

Gaps

- **Patient visit cycle time: 41%** track patient visit cycle time (9 Yes; 4 Partial)
- **Patient feedback: 64%** said difficulty accessing appointments when needed/desired and wait times to see provider for appointment are consistently top issues mentioned in patient feedback (14 CHCs)
- **Patient education materials (CORE): 41%** have developed patient education materials, information on tests and procedures in multiple languages and at appropriate health literacy levels (9 Yes; 11 Partial)

How can COMMUNITY HEALTH WORKERS fill these gaps?

QUESTIONS TO CONSIDER

To best manage your patient panel, these questions should be considered:

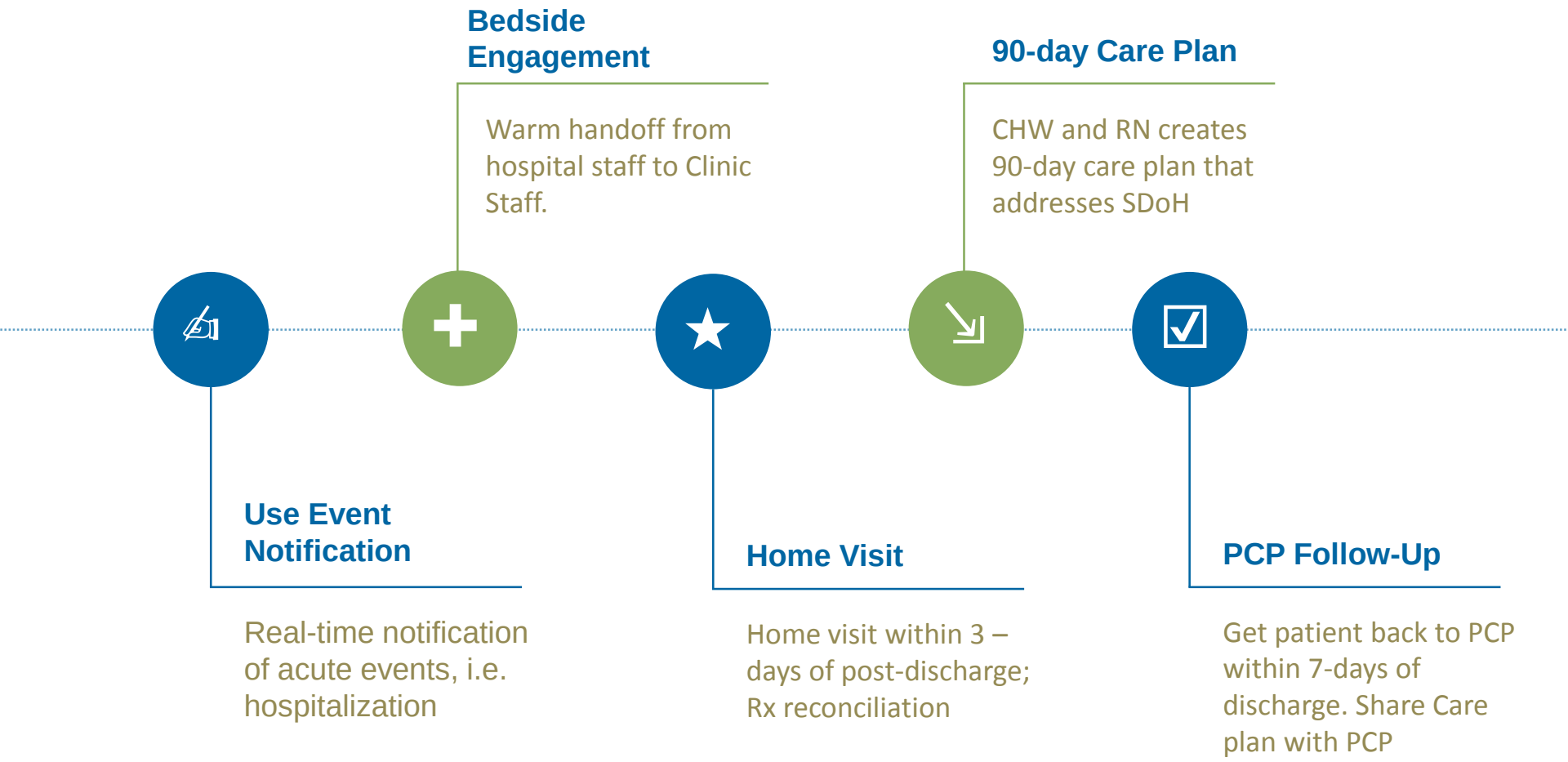
- Am I using the appropriate staff for the intervention? (clinical vs non-clinical, etc.)
- What is the appropriate panel size per staff?
- Should I hire an RN, social worker, MA, Care Manager, CHW, Peer Educator, Pharmacists?
- Should my care managers be located at the clinic or in the community?
- What time of relationship should care managers have with providers? Should they be required to document in HER?
- Are there models that already exist?
- How do we determine or measure success?

ACO STAFFING

Community Health Workers or Peer Educators.

- Transitional Care Coordination
- Patient Engagement
- Disease Specific Care Coordination
- Education and Referral

TRANSITIONAL CARE COORDINATION - CCT



Community Health Workers

From the same communities as your patients

- Outreach
- Regular communication based on patient's preferred method
- Follow-up to patient's overdue for wellness visits
- Help engage patients around self management and adherence to care plans
- Health Literacy

CHWs

Support the prevention and control of Chronic Diseases and Assist in Self-Management

Patient Education
About lifestyle changes and adherence to medication regimens and recommended treatments

Patient Navigation
Help patients and their families navigate the health care system, i.e. appointments, referrals, transportation

Self-Management
Support and assess patient's ability to self-manage chronic disease.

Outreach and Engagement
Increase team's cultural competence in reaching out and engaging member

EDUCATION AND REFERRAL

CHWs as part of the SOLUTION to address patients' social determinants of health.

Trusted Advocate

Community Health Workers are considered trusted advocates and can easily engage patients' regarding unmet social needs.

Community Resources

Once screening has occurred and needs have been identified, CHWs can play a critical role in linking the patients to critical community resources.

CHWs REDUCE COSTS

"Evidence demonstrates that CHW interventions with high resource utilization results in savings to the medical system."

EXAMPLE 1: Molina Healthcare
CHW outreach, education, advocacy and referral services for high-risk patients.

Net cost savings: $1,522,722

EXAMPLE 2: Boston Children's Hospital Pediatric Asthma Community-Based Case Management Program

ROI: 1.33

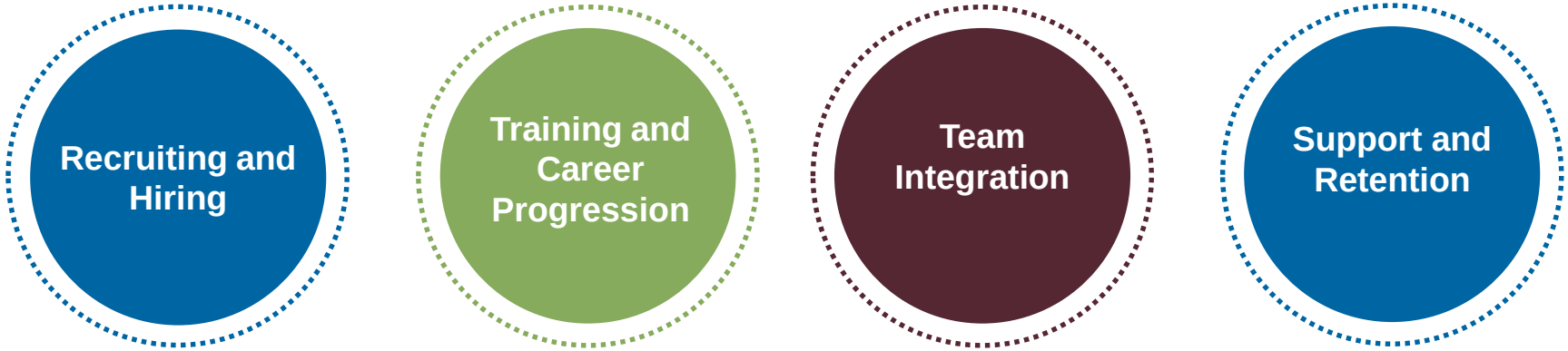
Integrating CHWs into Community Health Centers

"Most of what drives health care utilization happens outside of the traditional health care delivery system" Hennepin Health, ACO

- Community Health Workers are the bridge to the community. They can engage patients in meaning relationships that improve adherence to care plans and care coordination efforts between the continuum of care.
- CHWs know the community and have a unique perspective and ability to build trusting relationships with a diverse population who have not traditionally been served well by traditional delivery systems.

Key Considerations for CHW Integration

Maximize value of Community Health Workers – they are the bridge to the community in which your patients live. They can help both patients and providers.



CHWs should reflect the patient population both in culture and language.

Ensure CHWs have been certified and are well trained. Support career development.

Educate staff about CHW contribution and specific role. Ensure proper communication among team.

Ensure CHWs have reasonable case load and empower CHWs.

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Organizations do not change until the people within them change and decide to change the organization.

- John Kotter

But…..

- Change is:
  - Stressful
  - Draining
  - Strains relationships

Beliefs behind Dr. Ron Heifetz' work:

- Problems are embedded within complicated and interactive systems
- Much of human behavior reflects an adaption to circumstances.
- People adapt more successfully to their environments by facing painful circumstances and developing new attitudes and behaviors.

TYPES OF SITUATIONS REQUIRING LEADERSHIP

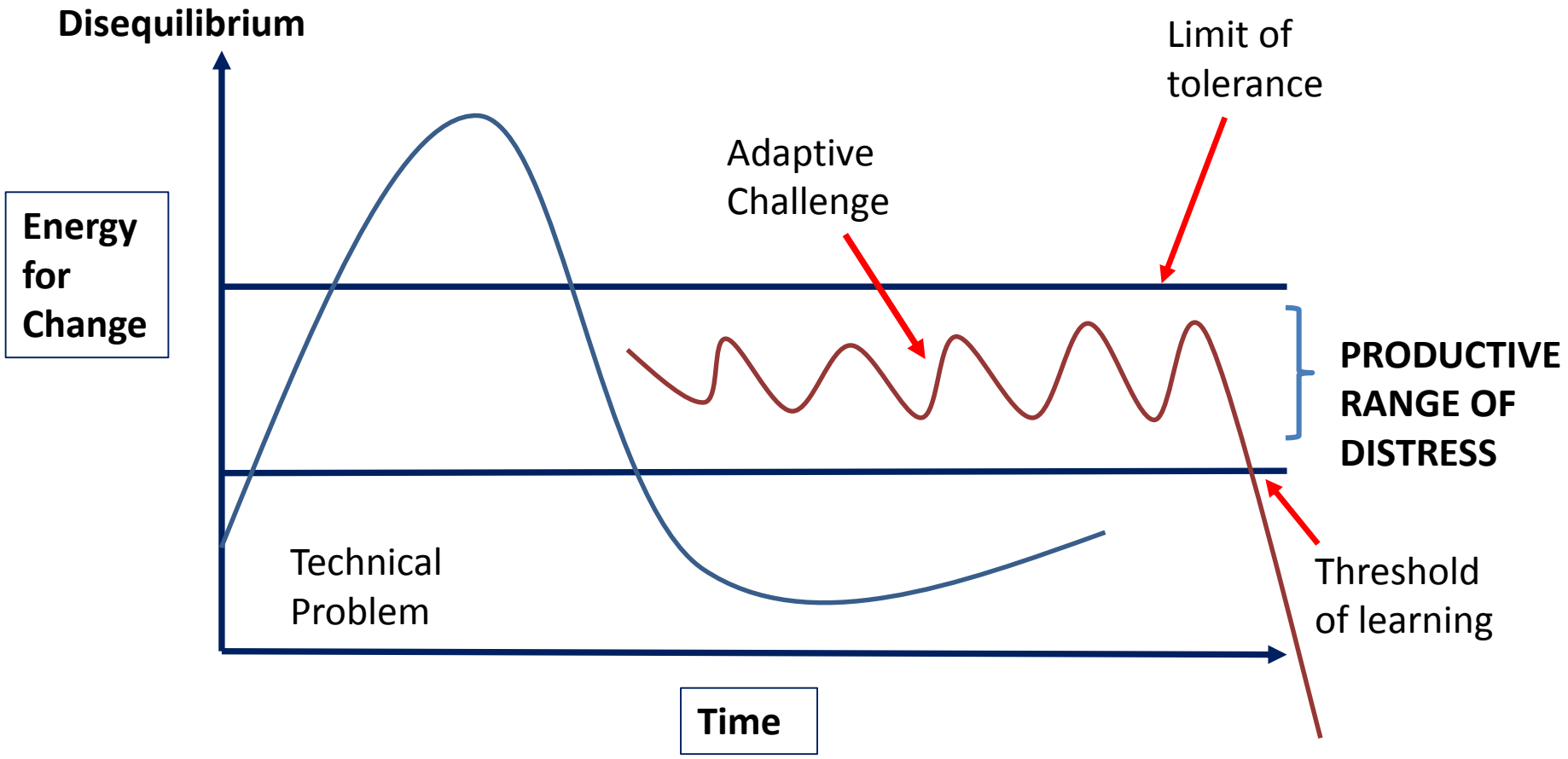
- Technical
  - Apply abilities that already exist in the system's capabilities
    - Current metrics
    - Increasing or decreasing FTEs
- Adaptive
  - People deeply and broadly within the organization need to learn new capabilities
    - New metrics to support vision

- **ADAPTIVE WORK DIMINISHES THE GAP BETWEEN THE WAY THINGS ARE AND THE WAY THINGS NEED TO BE TO CREATE A BETTER FUTURE**
- **ADAPTIVE LEADERSHIP IS THE ACTIVITY THAT MOBILIZES PEOPLE TO PERFORM ADAPTIVE WORK**

PROPERTIES OF AN ADAPTIVE CHALLENGE

- Gap between aspirations and reality (vision versus regulatory requirements)
- Tension between values
- Requires difficult learning
- Involves loss
- Loyalties need to be refashioned
- New competencies must be developed
- Shareholders have problem solving responsibility
- Takes longer than technical work
- Requires experimentation
- Generates disequilibrium, distress and work avoidance

Technical vs Adaptive Work



Exercising leadership to do adaptive work means disappointing people's expectations at a rate they can tolerate.

ADAPTIVE WORK MEANS GRAPPING WITH:

- Competing values
- Changing attitudes
- Encouraging new learning
- Developing new behaviors
- Holding the tension of polarities
  - “Both AND” rather than “Either OR”

LEADING CULTURE CHANGE REQUIRES CREATING PRODUCTIVE TENSION

- Make it safe to disagree and debate but not OK to opt out and disengage
- Talk honestly to one another about the challenge
- Listen with genuine interest to the various points of view
- Build trust
- Have difficult conversations

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Developing your ACO “Stump Speech”

- Objective: To develop an ACO "Stump Speech" that communicates the imperative for change and engages teams and individuals in the work ahead to realize the goals of the ACO.

What are the key terms your group used in your stump speeches?

How did you create the productive tension needed to inspire change?

How are messages for patients similar and different?

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Readiness for Value-Based Payment

- Requires new skills, capacity, and systems for managing clinical, financial, and operational performance and risk, including:
  - Engaging *attributed* patients
  - Being able to *reliably* achieve performance for care, outcomes, and costs across multiple dimensions
  - Employing advanced methods for population health management, care coordination, clinical care management, and care transitions inside and outside of your walls
  - Integrating services and care
  - Managing operational efficiency
  - Managing patient utilization of services and costs per patient
  - Reducing the total cost of care per patient

Results Summary: Core Gaps

Category from Assessment	Core Element	% of CHCs (out of 22) w/Core Element Gap*	Timing priority
Cost Efficiency of Current Operations	Provider productivity (visits) measured/monitored on a regular basis	0%	
Partnership Readiness	Agreements/relationships with hospitals	5%	Yes
Patient-Centeredness	Same-day appointments for patients who need them	9%	Yes
Patient-Centeredness	Offer enhanced access (e.g., evening/weekend hours, phone consultations)	18%	Yes
Population Health Management	Technology to support retrieving, storing, calculating and reporting on clinical quality metrics	23%	Yes
BH/PC Integration	Primary care and behavioral health staff document in a shared medical record	23%	Yes
Financial Health	Have sustained operating surpluses in each year of the prior 3-year period	23%	Yes
BH/PC Integration	Behavioral health staff on site and integrated into clinical care teams	27%	Yes
Financial Analysis of Patient-Centered Care	Analyze total, annual cost per patient	27%	
Care Management	Offer care management services; coordinated system of care	32%	Yes
Cost Efficiency of Current Operations	Use a cost-based charge structure	36%	Yes
Cost Efficiency of Current Operations	Analyze cost per visit as well as cost per patient on a regular basis to identify cost efficiencies	41%	Yes
Financial Health	Have working capital reserves in excess of 30 days an a positive net assets available for operations	41%	Yes
Population Health Management	Quality reports/data inform patient outreach	50%	Yes
Care Management	Use care plans for care coordination	55%	Yes
Financial Analysis of Patient-Centered Care	Employ professional coders to ensure the accuracy of provider coding practices and documentation	55%	
Patient-Centeredness	Assess and address patients' linguistic and cultural needs	59%	Yes
Financial Analysis of Patient-Centered Care	Providers trained on appropriate coding practices an provider coding reviewed on a regular basis	59%	
Financial Analysis of Patient-Centered Care	Analyze patient utilization of specific services	64%	Yes
Financial Health	Have adequate financial management system	68%	Yes
Board, Leadership and Strategic Readiness	Performance management dashboard	73%	Yes
Care Management	Conduct patient assessments and capture results as structured data in EHR, care plan or other database (including risk assessment and risk stratification)	73%	Yes
Cost Efficiency of Current Operations	Evaluate productivity based on Relative Value Units	77%	
Care Management	Strategy to outreach to and engage attributed managed care members	82%	
Population Health Management	Have and use an actionable patient registry	86%	
Board, Leadership and Strategic Readiness	Board engagement	91%	
Population Health Management	Real-time communication and alerts, including proactive alerts for ER and hospital use	91%	Yes
Board, Leadership and Strategic Readiness	Staff readiness	100%	Yes
Partnership Readiness	Agreements/relationships with other medical providers and social service agencies	100%	

** **Green** indicates a strength. **Red** indicates an area for improvement. **White** indicates a % in the middle.*

VALUE BASED PAYMENT READINESS: WHERE HAVE WE BEEN?

Overview of Value Based Payment Readiness: There are a limited number of high-value structures, investments and priorities that can streamline transition to value-based payment environments and can help ensure success in that environment.

- Board, Leadership and Staff Engagement and Readiness
- Building Partnerships
- Population Management and Risk Stratification
- Care Management
- Financial Management

What we discussed:

1. Building adaptive leadership capacity to lead changes
2. Strategies for broad-based engagement and participation to improve quality
3. Alignment of incentives and compensation
4. Prioritization of tasks and finding some time: killing some zombies

What we discussed:

- Defining the tasks for the health center, for the ACO and for the MCO (as applicable)
- Using technology for connectivity, communication and collaboration across the continuum of care
- Engaging with community based organizations to achieve alignment and meet SDH needs of communities and patients

What We Discussed:

- Registry exercises: Define data elements in risk stratification methodologies, test assumptions
- High risk and rising risk, with link to the total cost of care
- Gathering and using data on risk, including social risk factors
- Incorporating social determinants of health in a meaningful way
- Attribution and members not currently engaged in care

What We Discussed:

- Defining Care Coordination/ Care Management tasks and roles, matching the appropriate staff with diverse skill sets
- Estimate volume of staff needed for Care Coordination/ Management; cost implications of the model
- Primary Care and Behavioral Health Integration

What We Discussed:

- Review of the “three-legged stool” of VBP arrangements: base compensation, global payments, quality incentives
- Revenue enhancements and cost efficiencies required to manage peaks and valleys of VBP cash flow
- Funds flow and negotiation strategies within ACO
- Three year financial modeling including cash positions

- Evaluation of this four-part series coming your way – stay tuned.

- Please complete the evaluation of this session on your tables.

THANK YOU