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

FOR AUDIO, PLEASE DIAL:

(866) 740-1260

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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.

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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

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Today's Speaker

Robert Trachtenberg, MS

Executive Director, Oregon Health and Science University
Family Medicine Richmond Clinic

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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)**

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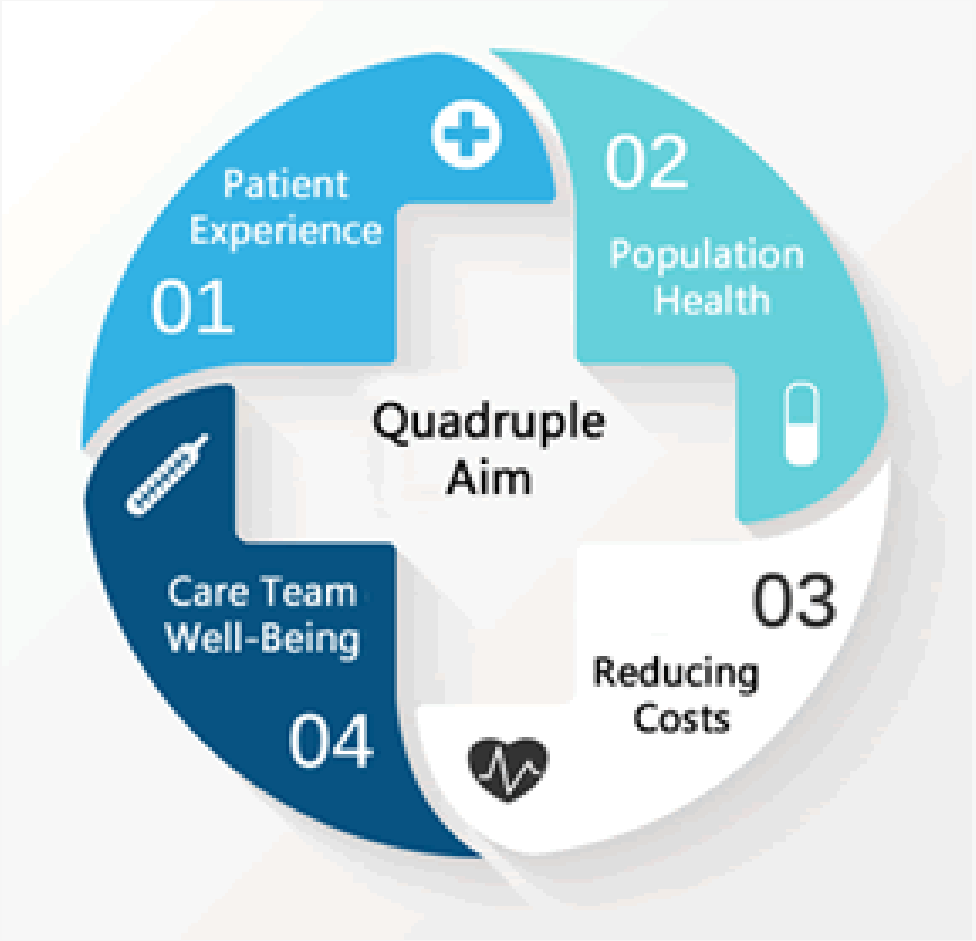
APCM develops and align payment with an efficient, effective, and emerging care model that achieves the Quadruple Aim in Oregon CHCs

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.

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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.

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APCM Goals

Tyranny of Typical Schedule

Time	Primary care physician	Medical Assistant	Nurse	Nurse Practitioner	Medical Assistant
8:00	Patient A	Assists with Patient A	TRIAGE		
8:15	Patient B	Assists with Patient B			
8:30	Patient C	Assists with Patient C			
8:45	Patient D	Assists with Patient D			
9:00	Patient E	Assists with Patient E			
9:15	Patient F	Assists with Patient F			
9:30	Patient G	Assists with Patient G			

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

Future State

Time	Primary care physician	Medical Assistant	Nurse	Nurse Practitioner	Medical Assistant
	TEAMLET 1			TEAMLET 2	
	Huddle and make plan for the day's work				
8:10	Telephone and e-mail visits – ***12 patients***	Panel management	RN diabetes visits	Drop-in Patients – 4 patients	Assist with drop-in patients, close phone loop, phone follow-up
9:00	PATIENT D			Patient J	Assists with Patient J
9:30	Coordinate w/ specialist and hospitalists. Consult w/ team	Health coach visit w/ patient J	Group visit for chronic care – ***12 patients***	PATIENT K	
10:00		BP clinic – 3 patients		Join group visit for chronic care	Panel management
10:15	Patient H and Patient B		Phone Outreach	Telephone and e-mail visits – 6 patients	

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

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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

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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)

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APCM Reporting Requirements

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

Measure	Benchmark	Source
Colorectal Cancer Screening	39.9%	UDS, CCO
Depression Screening and Follow Up	60.3%	UDC, COO
Diabetes Poor Control >9.0	32.1%	UDC, CCO
Hypertension in Control	62.4%	UDS, CCO
Childhood Immunization	42.8%	UDS
Entry in to Prenatal Care	74.1%	UDS, CCO
Developmental Screening	TBD	CCO

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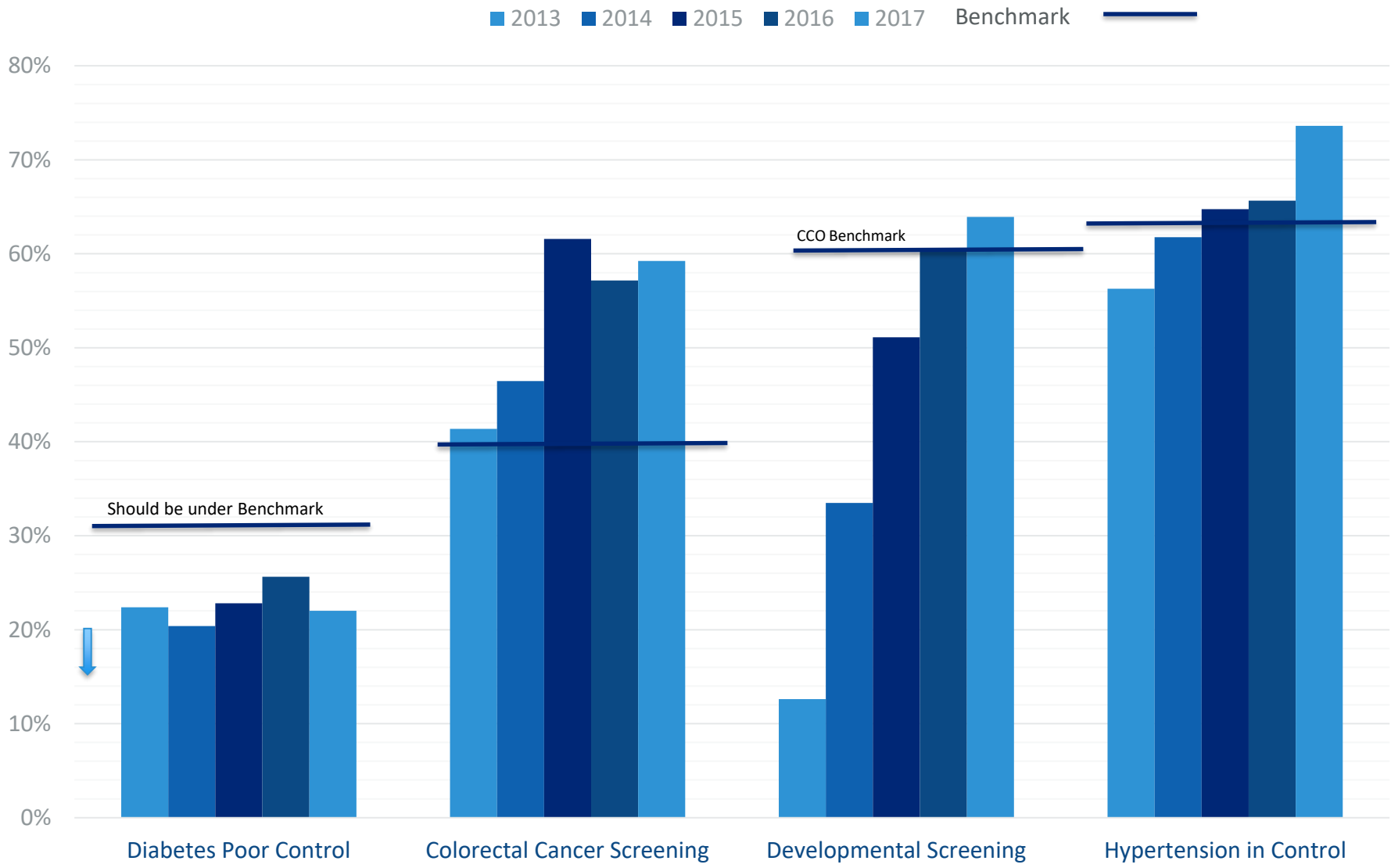
Quality Metrics Year Over Year- Total Population



APCM Reporting Requirements

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

Domain	CAHPS Question
Access	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?
Access	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?
Care	In the last 6 months, how often did this provider listen carefully to you?
Care	In the last 6 months, how often did this provider show respect for what you had to say?
Front Office	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?
Front Office	In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

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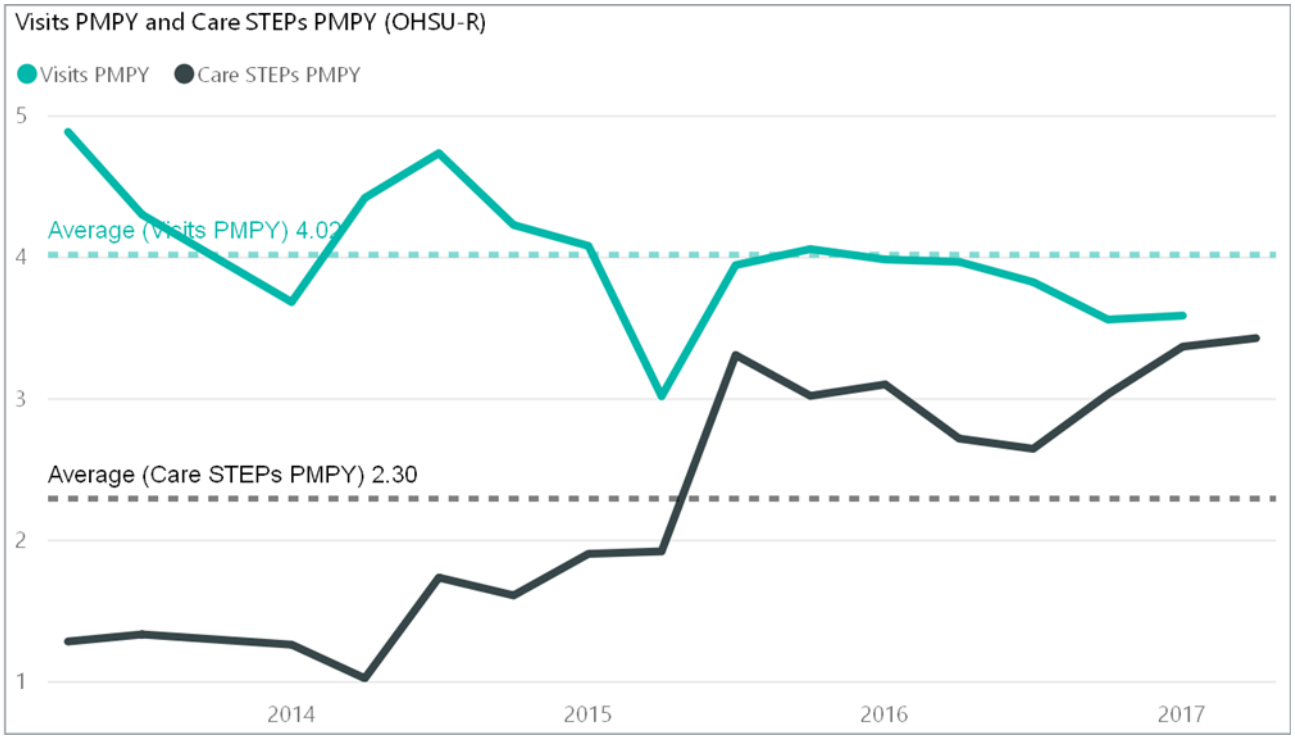
APCM Reporting Requirements

- **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

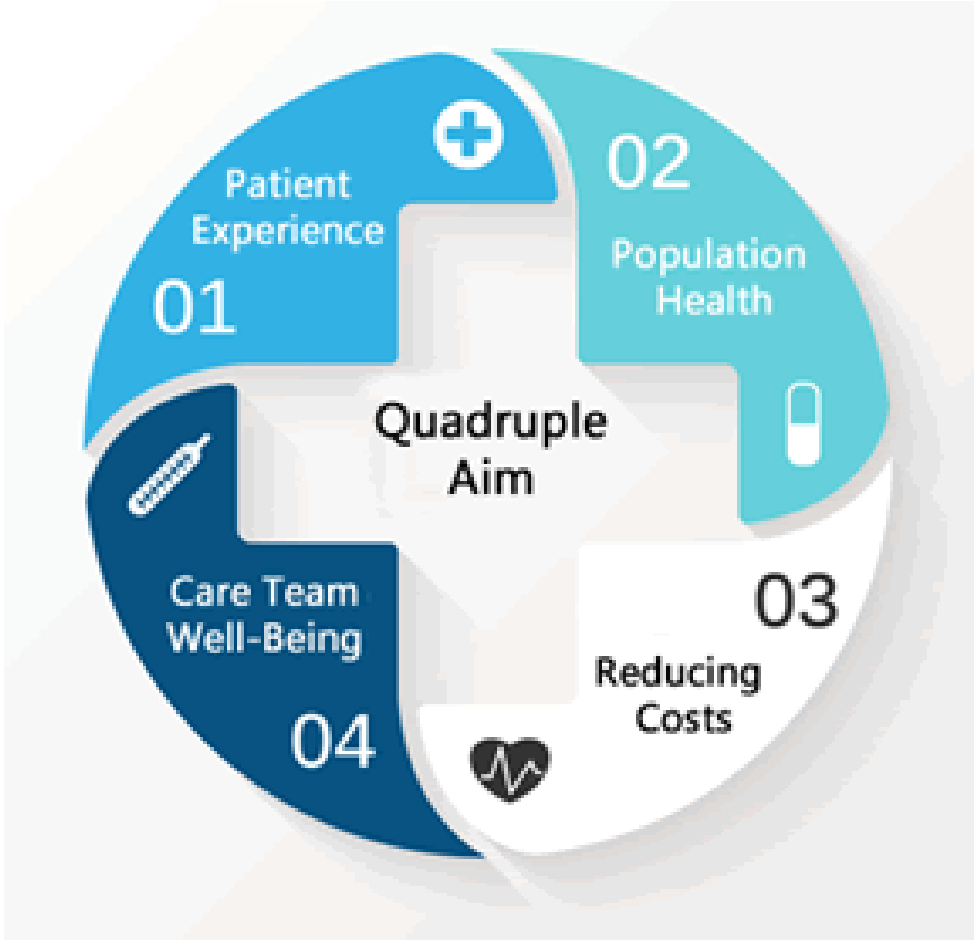
PMPM payment from the state

MCO payment **like anyone else's**

Medical services included

Separate **bonus** payments

Future Desired State



Thank You

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Question & Answer

To ask a question, please use the '**raise your hand**' feature or type it into the '**chat' box**.

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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

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Thank You!

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

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