2020 CPHCC CONFERENCE

Innovations in Healthcare

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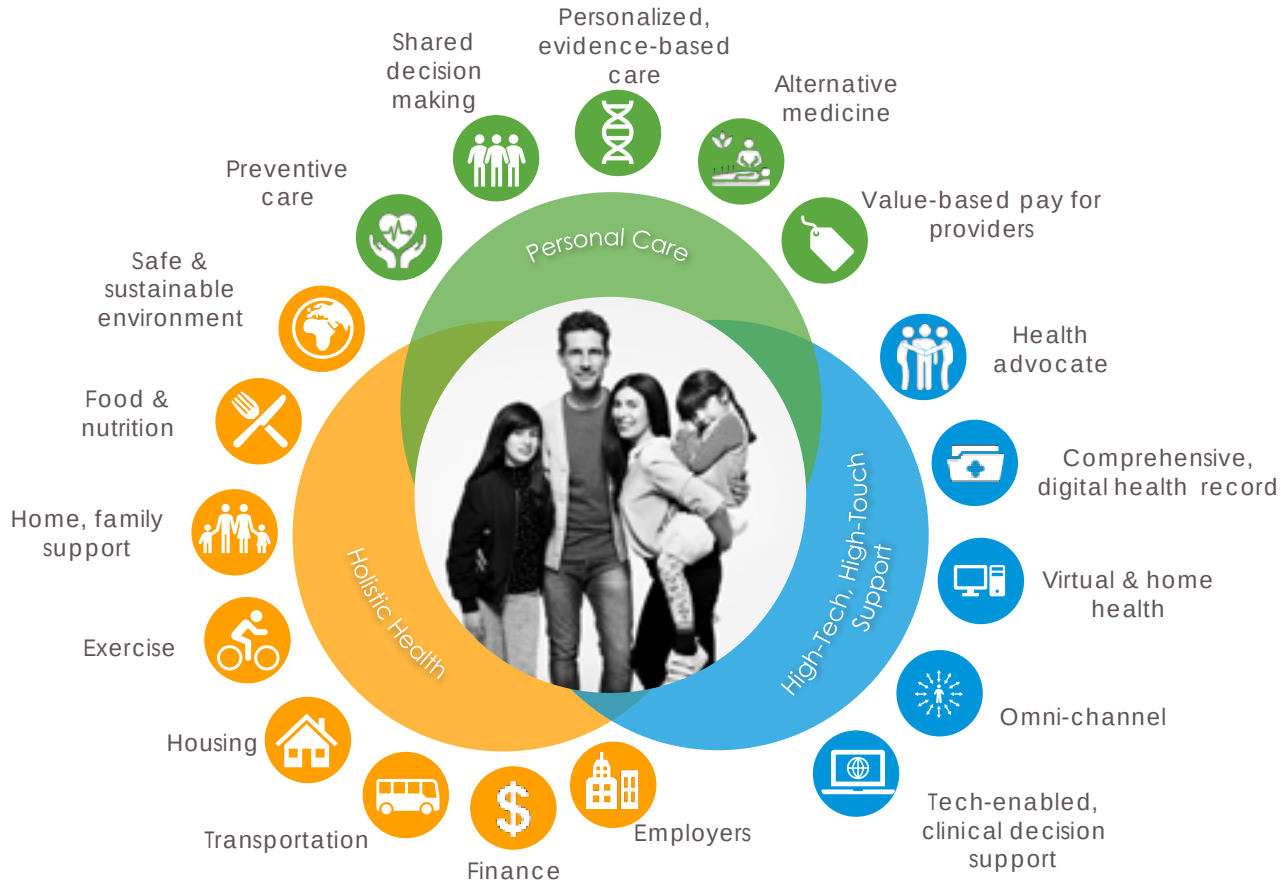
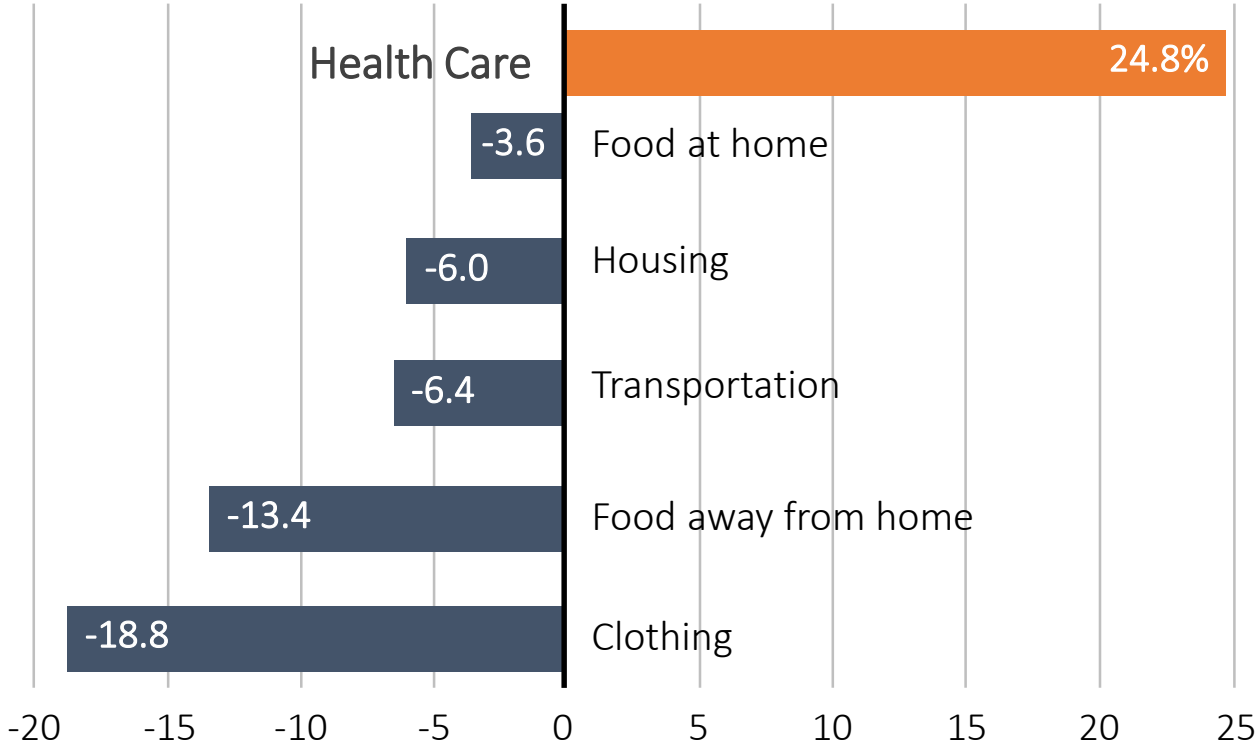
We are in the process of reimaging health and health improvement…

Health Reimagined can be accomplished with a multifaceted effort



Why are we doing this?

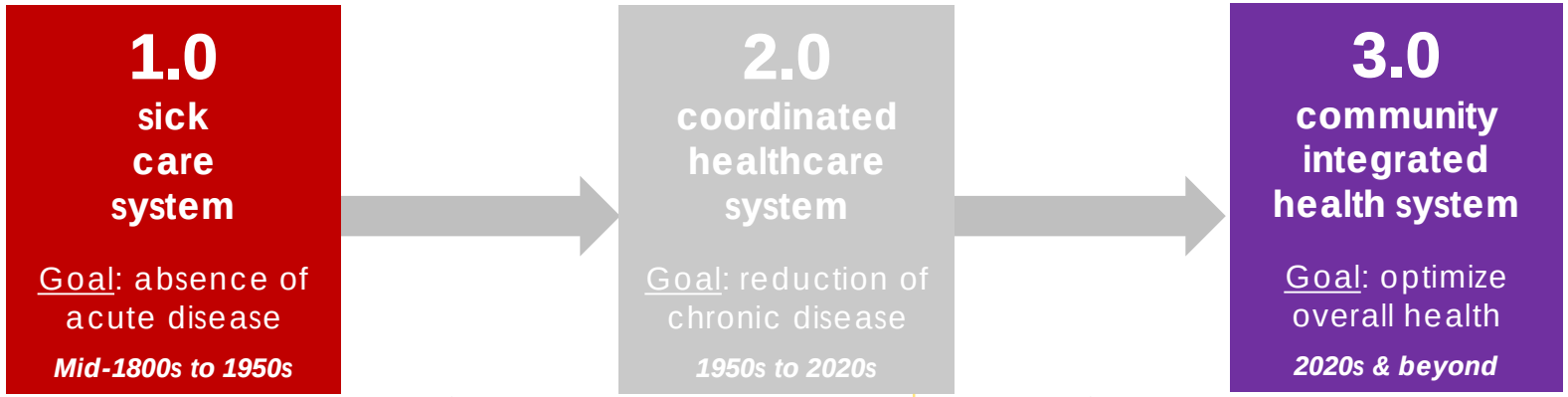
Patients are spending more but getting less.
Employers are spending 6% more on health care – *every year*.



Source: Brookings Institution, Wall Street Journal

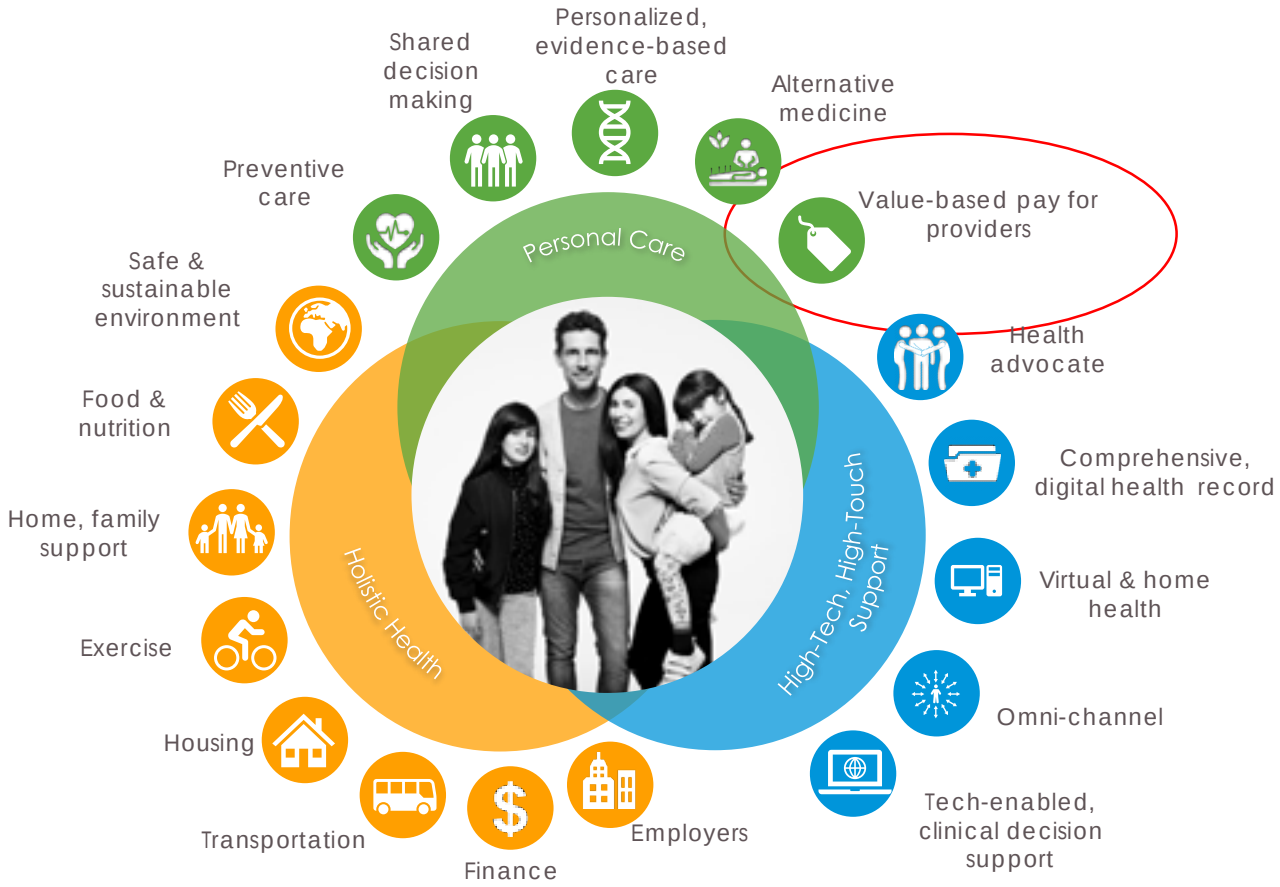
Percent change in middle income households' spending on basic needs (2007-2014).

Guiding Framework

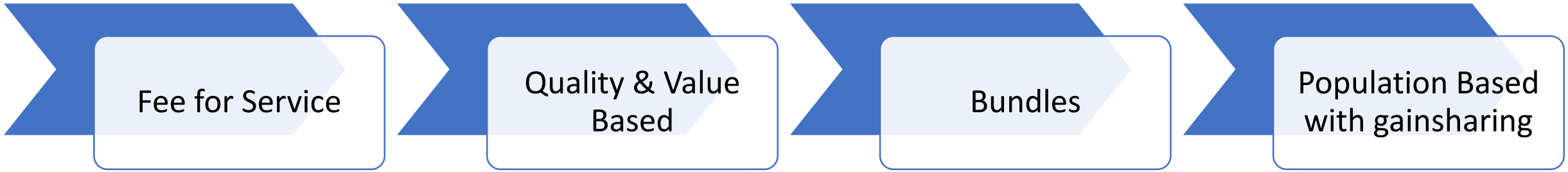


SYSTEM DESIGN	Health service providers, operating separately	Team-based care within health	Community integrated services, health care as one component
CARE MODEL	Little coordination between in/outpatient care, episodic treatment	Chronic condition management, patient-centered care coordination	Health, psychosocial, and wellness care integrated across the life course
DOMINANT PAYMENT APPROACH	Fee-for-service	Value-based health payments	Population-based global budgets, linked to multi-sector financial impact
APPROACH TO QUALITY	Variable, low transparency	Consistent, standardize processes and outcomes	Continuous learning and quality improvement
BENEFICIARY LENS	Individual	Patient and family	Subpopulation and communities, equity-oriented

Transforming how we pay for care is a critical component



Our goal is to pilot different payment models over time and transition toward full population based payment structures



Focus of our work today

Design and testing of innovative reimbursement strategies to ensure providers have:

- Flexibility to deliver services to patients
- Adequate resources to support provision of essential services
- Accountability for patient-centered outcomes that the provider can control
- No additional administrative burden
- Consistent and predictable payments

Target Objectives:

1. Improve provider satisfaction with reimbursement and processes
2. Improve patient quality and utilization outcomes
3. Ensure value and viability of enhanced reimbursement structures; ensure limited administrative burden

Model Currently in Testing

Primary Care Payment Model

Base Payments	Lower Acuity	Higher Acuity
Expanded Visit	Standard E&M + 99354	
Per Member Per Month Care Coordination Fee	PMPM	

Incentive opportunity:
25%* of annual total Evaluation and Management (E&M visit)

Incentive Opportunity (Values based on PMPM)	$0 (Low performance) — $25% E&M (High performance)
Resource Utilization (cost) 25% 1. Emergency room per 1000 members 2. Hospitalization (admits) per 1000 members 3. Generic medications prescribing rate (aligned with IHA measure for drug class)	**$0** Low performance — **$6.25%** High performance
Quality 50% 1. Percentage of patients with Hemoglobin A1C good control <8% 2. Percentage of Patients with Blood Pressure Control <140/90 mm Hg 3. Percentage of patients with Body Mass Index Screening and follow-up plan 4. Percentage of patients screened for depression and follow-up plan 5. Percentage of patients with breast cancer screening 6. Percentage of patients with an asthma medication ratio of >0.5	**$0** Low performance — **$12.5%** High performance
Member Experience 25% 1. Percentage score on the member experience survey	**$0.5** Low performance — **$6.25%** High performance

Making it real…

- Ava is 50 years old and has diabetes. Her doctor asks her to schedule a 90-minute appointment to discuss her health preferences. When they meet, her doctor and care team address her diabetes, preventive care screenings like her mammogram, and assess her behavioral health. Her doctor also asks her to take a shared decision-making survey to help Ava determine the best course of action/treatment for her diabetes.
- Ava and her doctor appreciate the longer appointment time to connect and work together on her health goals. Her doctor is compensated for the longer appointment because he is delivering high quality, affordable healthcare services. He makes sure Ava attends a follow-up visit and checks in on the progress of her diabetes management.
- Ava's health improves as a result of the support from her doctor and ongoing care to address her diabetes. Her doctor is rewarded for helping Ava improve her health and avoid unnecessary emergency room visits. Ava commits to diet and exercise changes that help her Ava commits to diet and exercise changes that help her enjoy optimum health.

Expanded Visit Services

The purpose of the expanded visit is to enable great care by encouraging providers to take the time required to examine their patients in a holistic way. The expanded visit is intended to be completed by an interdisciplinary team.

Clinical (20 min)

- ☐ Determination of optimal care management plan
- ☐ Detailed review of newly prescribed medications and/or medication reconciliation
- ☐ Use of appropriate medication price transparency tools
  - o Example: Blue Shield Gemini/EMR tool
- ☐ Time spent consulting with another physician by phone or email
- ☐ Pain management assessment, consultation and/or services

Shared Decision Making (20 min)

- ☐ Shared decision-making process

Behavioral (20 min)

- ☐ Depression screenings
  - o Example: Modified Mini Screen (MMS), PHQ-9
- ☐ Substance abuse screenings
  - o Example: CAGE-AID
- ☐ Other Behavioral health screenings

Social (20 min)

- ☐ Social needs and social determinants of health screening
  - o Example: PRAPARE tool
- ☐ Coordination with Health Advocate (nutritional programs, physical activity, transportation)
- ☐ Referrals to local and community resources relevant to the patient's needs

Education (20 min)

- ☐ Health/wellness discussions and review of available materials and resources
- ☐ Meeting with nutritionists, dieticians, behavioral health specialists, social workers or other care team staff, as needed
- ☐ Individualized, condition-specific education and goal setting

Screening and quality gaps (20-30 min)

- ☐ Comprehensive review of quality measures and care gaps

Care Coordination Services

The purpose behind reimbursing for care coordination is to incentivize providers to address patients' care needs outside the traditional office visit. Complex patients may need high-touch care or coordination with outside providers and specialists.

Services include:

- ☐ Continuity of Care with Designated Care Team Member
  - o Proactive outreach to other providers/PCP for coordination on diagnosis and treatment
  - o Home Health oversight, consultation and management
- ☐ Comprehensive Care Management and Care Planning
  - o Interdisciplinary teams connecting with health advocates / care coordinator / care navigator resources
- ☐ Transitional Care Management
- ☐ Coordination with Clinical, Home and Community-Based Clinical Service Providers
  - o Coordination with clinical pharmacists
- ☐ Proactive outreach to patients to encourage them to obtain tests, visit specialists to establish accurate diagnoses, or to make follow-up visits based on test results
- ☐ 24/7 Access to Address Urgent Needs
- ☐ Enhanced Communication (for example, email)

Other Models in Development and Testing

2019 Pilot Payment Models:

- Cardiology
- Endocrinology
- Maternity
- Oncology – breast & prostate
- Oncology – radiation therapy
- Orthopedics
- Pulmonology