ALIGNING FOR SHARED ACCOUNTABILITY

LAN SUMMIT

Health Care Payment Learning & Action Network

Payer-Provider Collaboration to Improve Outcomes for High Need Populations

Welcome

Angelo Sinopoli

Chief Clinical Officer
Prisma Health

President, CEO & Founder
Care Coordination Institute

Panelists

Tim Gronniger

Chief Executive Officer & President
Caravan Health

James Schuster

Associate Chief Medical Officer and Senior Vice President of Medical and Behavioral Services
UPMC Insurance Services Division

Kate Abowd Johnson

Model Lead for the Accountable Health Communities Model
Center for Medicare & Medicaid Innovation

caravanhealth
bringing population health to life

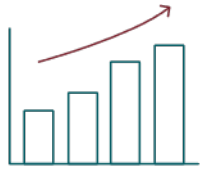
Presentation to the Health Care Payment Reform Learning and Action Network

Supporting Under-Resourced Providers in Care Transformation

October 24, 2019

Care Transformation in Rural and Safety Net Settings

More problems than you can count...



Staffing shortages ...

... Skills gap ...

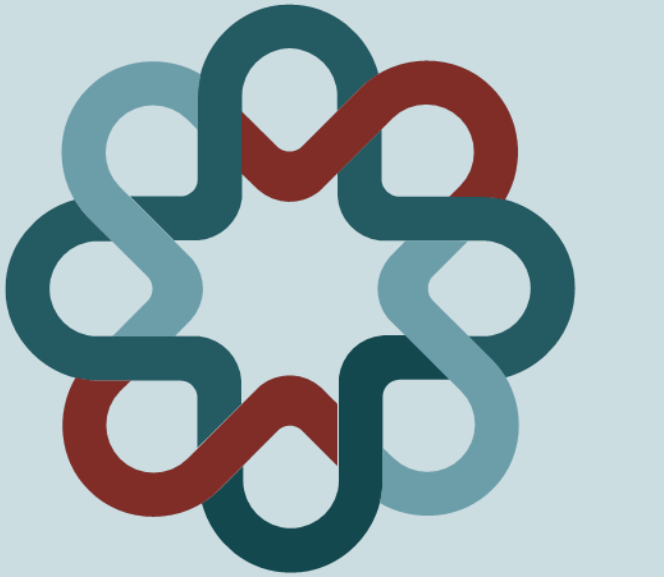
... Technology burnout...

... Patients with low income and massive unmet social needs ...

What can be done?

Build and teach from the **“Business Case for Quality”**

Use new CMS-created codes for wellness services, non face-to-face care, and coordination to fund staff to do that work, taking work off of the plate of the physician

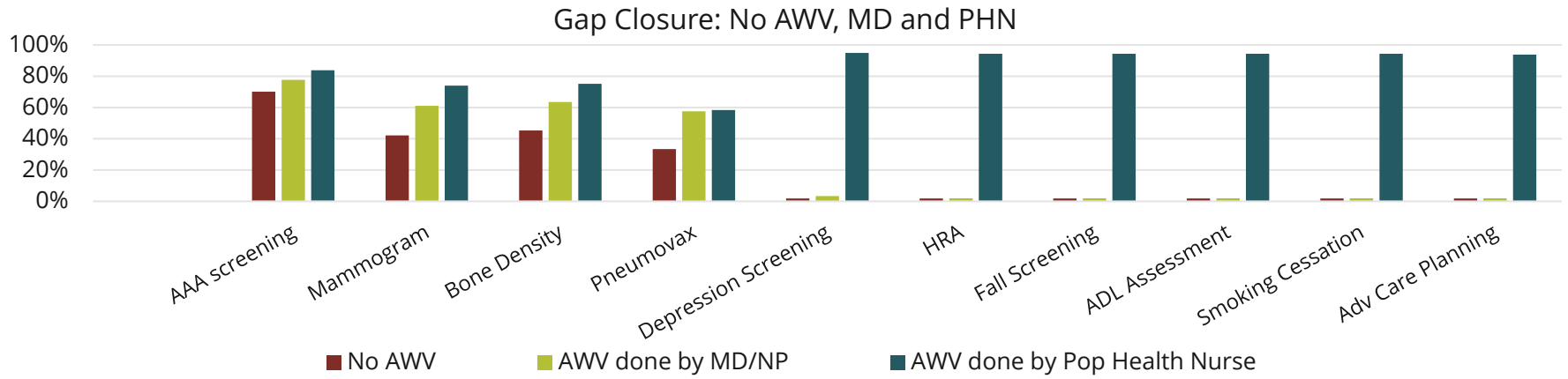


Practice Transformation Build Around Primary Care Business Needs

Illustration – Care Transformation

	MD-Furnished	Nurse / MA Furnished, MD conlcuded
Revenue Per Visit	$130	$130
MD Input Time Per Visit	20-40 min	5 min
Staf Time Per Visit	5 min	45 min
Cost Per Visit	$166	$40
Net Income Per visit	$-36	$90

Population Health Nurses & Annual Wellness Visits: Increased Prevention & Quality



Among 8917 Medicare beneficiaries, an AWV was associated with significantly reduced spending on hospital acute care and outpatient services.

Patients who received an AWV in the index month experienced a 5.7% reduction in adjusted total healthcare costs over the ensuing 11 months.

The greatest effect was seen for patients in the highest hierarchical condition category risk quartile.

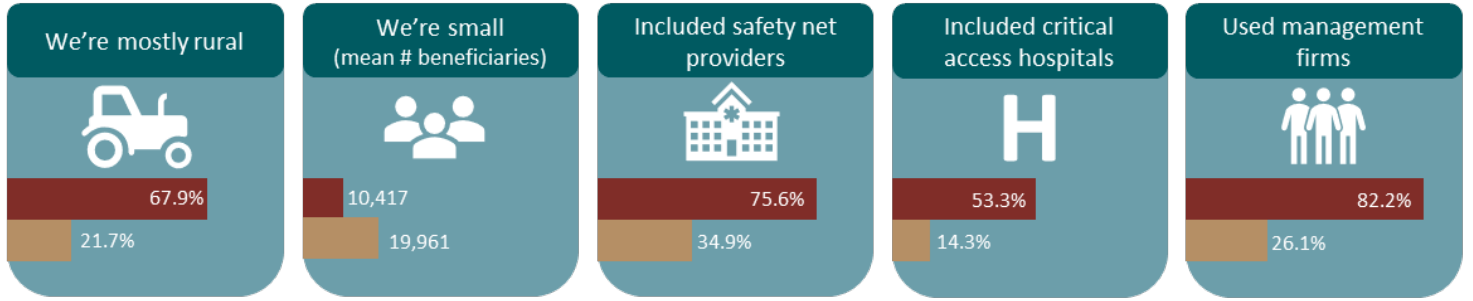
For those who received an AWV, this association was driven by reduced hospital spending

Beneficiaries who had an AWV were also more likely to receive recommended preventive clinical services.

Source: Caravan Health Client

ACO Investment Model

In 2017, compared to all other SSP ACOs, AIM ACOs:



Findings

AIM Test 1 ACOs Reduced Spending and Utilization Compared to Medicare FFS Beneficiaries

Statistically significant Reduction in Total Medicare Spending

	Per beneficiary per month (PBPM) spending	*Aggregate spending (millions)*	*Net savings to Medicare (millions)*	*Percent net savings to Medicare*
PY 1	-$28.21	-$131.0	-$108.4	2.3%
PY 2	-$36.94	-$187.7	-$153.4	3.0%

Statistically significant Reduction in Total Medicare Spending

	Spending			Utilization	
	Inpatient hospitalization	*Hospital Outpatient*	*Skilled nursing facility*	*Emergency department visits with no hospital admissions*	*readmissions*
PY 1	-2.4%	-4.3%	-7.2%	-1.5%	-4.0%
PY 2	-3.4%	-4.4%	-6.6%	-1.9%	-4.1%

UPMC HEALTH PLAN

Collaborative Care

Treating Depression in Primary Care Settings

James Schuster, MD, MBA
Sr. VP, Medical and Behavioral Services

Collaborative Care Overview

The History

Studied for the past 20 years

Initial IMPACT Model in 1999 (Improving Mood-Promoting Access to Collaborative Treatment)

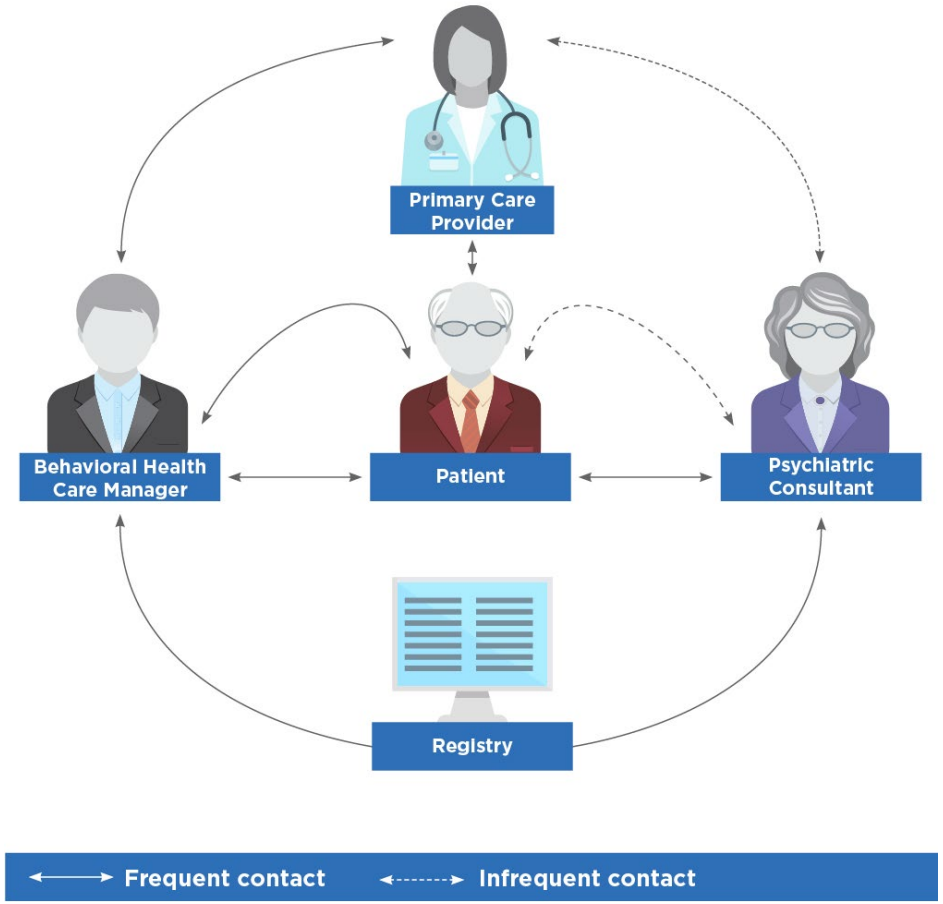
Initial Study: 1801 patients age 60+ with Depression, Dysthymic Disorder or both; in 18 PCP offices, from 8 health care organizations and 5 states. Significant clinical improvement

Since IMPACT, more than 80 randomized controlled trials evaluated and similar results reported

Collaborative Care Overview (cont. 1)

The Model

- Enhances “usual” primary care by adding two key services to the primary care team
- Care Management support for patients in behavioral health treatment
- Regular psychiatric inter-specialty consult



Collaborative Care Overview (cont. 2)

The Team Members

Treating (Billing Practitioner)

A physician and/or non-physician practitioner (physician assistant or RN practitioner); typically primary care, may be another specialty (ex. oncology, cardiology)

Behavioral Health Care Manager

A behavioral health practitioner (including social work, nursing or psychology), working under the oversight and direction of the billing practitioner.

Psychiatric Consult

A medical professional trained in psychiatry and qualified to prescribe the full range of medications.

Beneficiary

The beneficiary is a member of the care team.

Collaborative Care Overview (cont. 3)

The Outcomes- A Literature Review

IMPACT at 12 months: 45% of the intervention patients had 50% or greater reduction in depression from baseline vs 19% of usual care participants

Collaborative Care positively impacts LDL cholesterol, glycated hemoglobin, and systolic blood pressure

Investment in collaborative care of $522 for older patients during year 1 results in net cost savings of $3363 over years 1-4. ROI of $3.50 per dollar

Net savings in every category of health care costs examined, including pharmacy, IP and OP Medical and MH specialty care

ROI most evident in years 3 and 4

BH Integration Reimbursement

Psychiatric Collaborative Care Models (CoCM) can be reimbursed using CPT codes 99492, 99493 and 99494

CPT code 99484 (General BHI) can be used to bill for services conducted using other BHI models of care

Medicare FFS Reimbursement Rates - 2018

Service/Time	Procedural Code	Rate
Initial psychiatric collaborative care management (first 70 min in a month)	99492	$162.18
Subsequent psychiatric collaborative care management (first 60 minutes in a subsequent month)	99493	$129.38
Initial or subsequent collaborative care management (Each additional 30 minutes in a month)	99494	$67.03
Care management services for BH conditions (at least 20 minutes of clinician time)	99484	$48.65

Collaborative Care Approach

UPMC's Approach

- Depression Screening in PCP offices involved in Shared Savings initiatives
- 2019 Results as of Claims paid through 8/31/2019
- Approximately 25% of all commercial and Medicare members screened, rate higher in SS practices)
- Proof of intervention pathways required for Shared Savings Practices 2020
- Implemented Collaborative Care Codes in fee schedules
- Supporting Collaborative Care implementation in clinics with pre-existing behavioral integration in place, with plans to scale
- Several FQHCs have already successfully implemented Collaborative Care

References

Collaborative Care Literature Review

AIMS Center, University of Washington, Psychiatry & Behavioral Sciences Division of Population Health. Retrieved from https://aims.uw.edu/collaborative-care/evidence-base

Katon, Wayne J MD. (2010) *Collaborative Care for Patients with Depression and Chronic Illnesses.* Retrieved from the New England Journal of Medicine: https://www.nejm.org/doi/full/10.1056/nejmoa1003955

Unutzer, Jurgen, MD. (2013) *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.* Retrieved from Center for Health Care Strategies, Inc https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

Contact Information

James Schuster
schusterjm@upmc.edu

Thank You

UPMC HEALTH PLAN

Accountable Health Communities Model

Kate Abowd Johnson, PhD

October 24, 2019

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Why the AHC Model?

- Many of the largest drivers of healthcare costs fall outside the clinical care environment
- Social and economic determinants, health behaviors, and the physical environment significantly drive utilization and costs
- There is emerging evidence that addressing HRSNs through enhanced clinical-community linkages can improve health outcomes and impact costs
- The AHC model seeks to address current gaps between healthcare delivery and community services

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Key Innovations

Systematic screening of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs

Tests the **effectiveness of referrals and community services navigation** on total cost of care using a rigorous mixed method evaluative approach

Partner alignment at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DISCUSSION PAPER

Standardized Screening for Health-Related Social Needs in Clinical Settings

The Accountable Health Communities Screening Tool

Alexander Billioux, MD, DPhil, Centers for Medicare & Medicaid Services;
Katherine Verlander, MPH, Centers for Medicare & Medicaid Services;
Susan Anthony, DrPH, Centers for Medicare & Medicaid Services;
Dawn Alley, PhD, Centers for Medicare & Medicaid Services

May 30, 2017

The impacts of unmet health-related social needs, such as homelessness, inconsistent access to food, and exposure to violence on health and health care utilization, are well-established. Growing evidence indicates that addressing these and other needs can help reverse their damaging health effects, but screening for social needs is not yet standard clinical practice. In many communities, the absence of established pathways and infrastructure and perceptions of inadequate time to make community referrals are barriers that seem to often keep clinicians and their staff from broaching the topic. The Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities Model, tested by the Center for Medicare and Medicaid Innovation, addresses this critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries impacts their total health care costs and improves health.

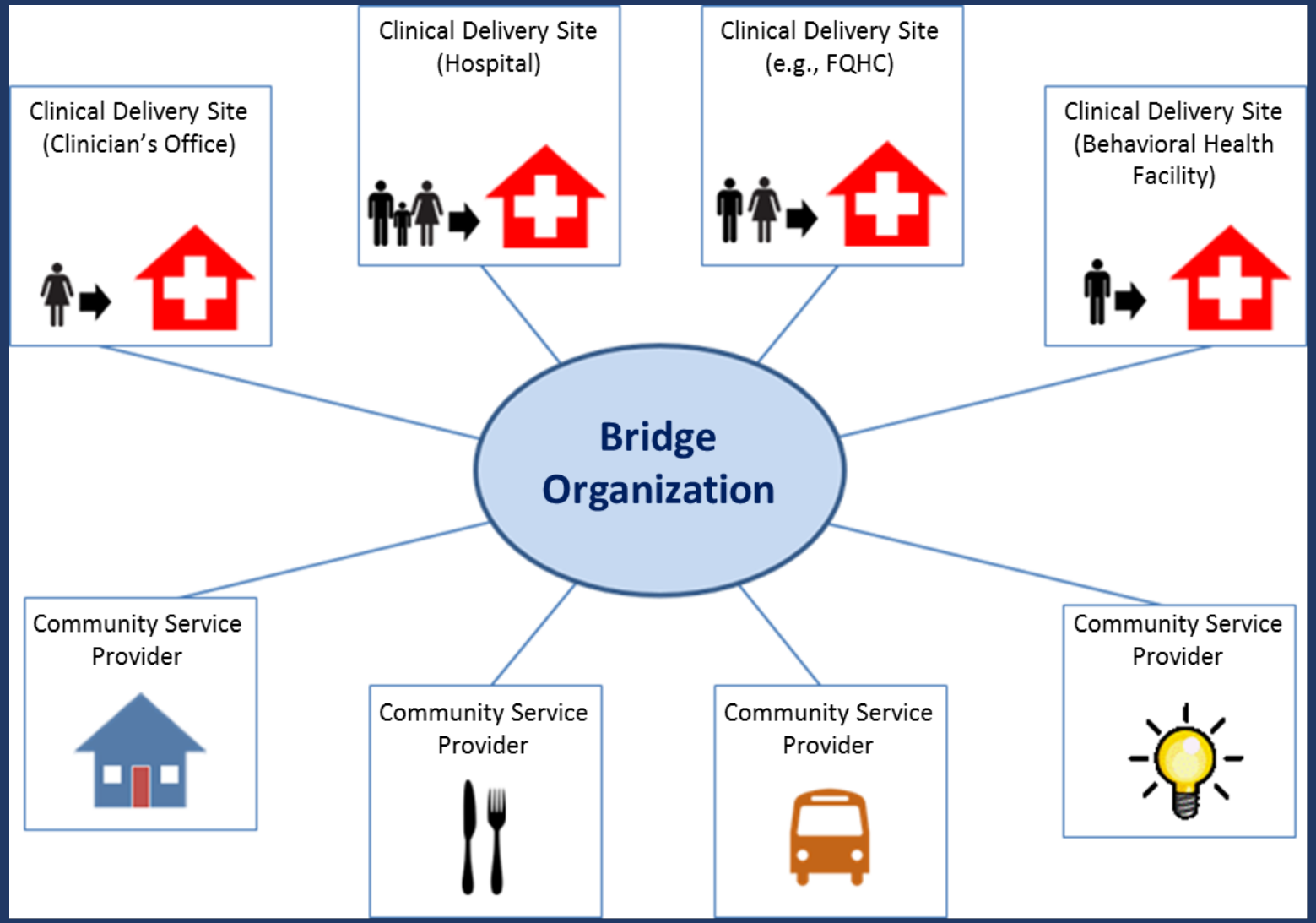
With input from a panel of national experts and after review of existing screening instruments, CMS developed a 10-item screening tool to identify patient needs in 5 different domains that can be addressed through community services (housing instability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety). Clinicians and their staff can use this short tool across a spectrum of ages, backgrounds, and settings, and it is streamlined enough to be incorporated into busy clinical workflows. Just like with clinical assessment tools, results from this screening tool can be used to inform a patient's treatment plan as well as make referrals to community services.

Introduction

Evidence demonstrates that non-medical health-related social needs (HRSNs), such as housing instability, food insecurity, and exposure to interpersonal violence, drive health care utilization and impact health outcomes [1, 2, 3]. Clinicians routinely employ standardized questions and validated assessment tools to screen for clinical and behavioral drivers of poor health, such as alcohol dependency, decompensated heart failure, and depression, but screening for HRSNs is not yet standard clinical practice [4, 5, 6]. Standardized application of screening tools as a part of clinical routines allows provider teams to quickly and consistently identify possible health needs for further investigation and intervention. A variety of assessment tools have been developed to help health providers identify the presence of deleterious social circumstances, and a few recent studies have demonstrated the efficacy

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

AHC Model Structure



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Bridge Organizations

Alignment Track	State
Baltimore City Health Department	Maryland
Camden Coalition of Healthcare Providers	New Jersey
Danbury Hospital	Connecticut
Denver Regional Council of Governments	Colorado
Dignity Health dba St. Joseph's Hospital & Medical	Arizona
Health Net of West Michigan	Michigan
MyHealth Access Network, Inc.	Oklahoma
Oregon Health & Science University	Oregon
Parkland Center for Clinical Innovation	Texas
Presbyterian Healthcare Services	New Mexico
Reading Hospital	Pennsylvania
Rocky Mountain HMO	Colorado
The Health Collaborative	Ohio
The New York and Presbyterian Hospital	New York
United Healthcare Service Inc.	Hawaii
United Way of Greater Cleveland	Ohio
University of Kentucky Research Foundation	Kentucky
VHQC dba Health Quality Innovators	Virginia

Assistance Track	State
Alexian Brothers Network	Illinois
Allina Health System	Minnesota
CHRISTUS Santa Rosa	Texas
Community Health Network Foundation	Indiana
Hackensack University	New Jersey
Mountain States Health Alliance	Virginia
Partners in Health, Inc.	West Virginia
St. Josephs Hosp. Health Ctr.	New York
Tift County Hosp. Authority	Georgia
UT Health Sciences Center	Texas
Yale-New Haven Hospital	Connecticut

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

AHC Model Timeline

Assistance Track	Alignment Track
Start-Up Period • Finalizing relationships with clinical delivery sites • Developing SOPs for screening, referral, randomization, and navigation • Hiring and training staff	**Start-Up Period** • Finalizing relationships with clinical delivery sites • Developing SOPs for screening, referral, and navigation • Hiring and training staff • Establishing Advisory Board
Implementation Period • Offering universal screening to beneficiaries at participating sites • Providing community referrals and navigation services to those eligible	**Implementation Period** • Offering universal screening to beneficiaries at participating sites • Providing community referrals and navigation services to those eligible • Performing community-level quality improvement and gap analyses

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS

Accountable Health Communities

CASE STUDY

Promising Strategies For Community Service Navigation: Lessons From Health Quality Innovators

ACCOUNTABLE HEALTH COMMUNITIES MODEL OVERVIEW

The Accountable Health Communities (AHC) Model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.

The model provides support to community bridge organizations to test promising service delivery approaches aimed at linking beneficiaries with community services that may address their health-related social needs (i.e., housing instability, food insecurity, utility needs, interpersonal violence, and transportation needs). Bridge organizations in the Assistance and Alignment Tracks of the AHC Model are implementing and testing separate service delivery approaches:

- Assistance Track: Provides community service navigation services to assist high-risk beneficiaries with accessing services to address identified health-related social needs
- Alignment Track: Encourages partner alignment to ensure that community services are available and responsive to the needs of beneficiaries

To implement each approach, bridge organizations serve as 'hubs' in their communities coordinating consortia to:

- Identify and partner with clinical delivery sites (i.e., physician practices, behavioral health providers, clinics, hospitals) to conduct systematic health-related social needs screenings of all community-dwelling beneficiaries and make referrals to community services that may be able to address the identified health-related social needs;
- Coordinate and connect high-risk community-dwelling beneficiaries to community service providers through community service navigation; and
- Align model partners to optimize community capacity to address health-related social needs (Alignment Track only).

EXECUTIVE SUMMARY

This case study describes key strategies that Health Quality Innovators, an Alignment Track bridge organization, developed to conduct community service navigation as part of the Accountable Health Communities Model. The purpose of this case study is to highlight a successful navigation approach from one bridge organization that could help inform practice at other Accountable Health Communities Model sites or in the healthcare community. Accountable Health Communities bridge organizations are using multiple strategies to deliver community service navigation, each with different strengths, challenges, and promising practices. The navigation approach discussed in this case study works in the Health Quality Innovators community and outcomes may vary at other sites. This case study is not part of the formal Accountable Health Communities Model evaluation.

JULY 2019

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS

Accountable Health Communities

CASE STUDY

Using Data for Quality Improvement: A Case Study from St. Joseph's Hospital Health System

EXECUTIVE SUMMARY

This case study describes how St. Joseph's Hospital Health System (St. Joseph's), a bridge organization participating in the Accountable Health Communities Model, uses screening data to monitor performance and drive quality improvement efforts. The study (1) lays out St. Joseph's process for developing data monitoring reports; (2) explains how the project management team shares the reports with staff to review performance, identify areas for improvement, and foster shared accountability; (3) showcases examples of how St. Joseph's uses the reports to guide quality improvement efforts; and (4) offers several tips for those who are looking to pursue data-driven quality improvement. The case study concludes with a discussion of future considerations for St. Joseph's as it seeks to use a similar data-based approach to monitor and improve navigation activities.

BACKGROUND ON THE ACCOUNTABLE HEALTH COMMUNITIES MODEL

The Accountable Health Communities (AHC) Model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce utilization. With support from the AHC Model, bridge organizations are implementing approaches to link beneficiaries with community services to address health-related social needs stemming from housing instability, food insecurity, utility needs, interpersonal violence, and transportation needs. For more information about the design of the AHC Model, visit the website at https://innovation.cms.gov/initiatives/ahcm.

BACKGROUND ON ST. JOSEPH'S

St. Joseph's is a nonprofit health care system in Syracuse, New York, and a member of Trinity Health, a Catholic national health care system with headquarters in Michigan. St. Joseph's began implementing the AHC Model in 2018. St. Joseph's serves as the "hub" for 19 clinical delivery sites that participate in the AHC Model, which are sites where screening for health-related social needs takes place and include primary care practices, urgent care centers, a labor and delivery unit, an inpatient psychiatry ward, and an emergency department.

A project manager and clinical liaison manage St. Joseph's implementation of the AHC Model. The project manager leads the implementation of the AHC Model and is responsible for monitoring screening and navigation data. The clinical liaison supports the project manager by supervising the day-to-day activities that take place at the sites and working with local leaders at the sites to implement quality improvement efforts. The staff who offer screening for the AHC Model at St. Joseph's include existing registration staff (that is, front desk staff), new staff funded by and hired specifically for the implementation of the AHC Model, or a combination of the two.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Want to know more?

AHC Website:

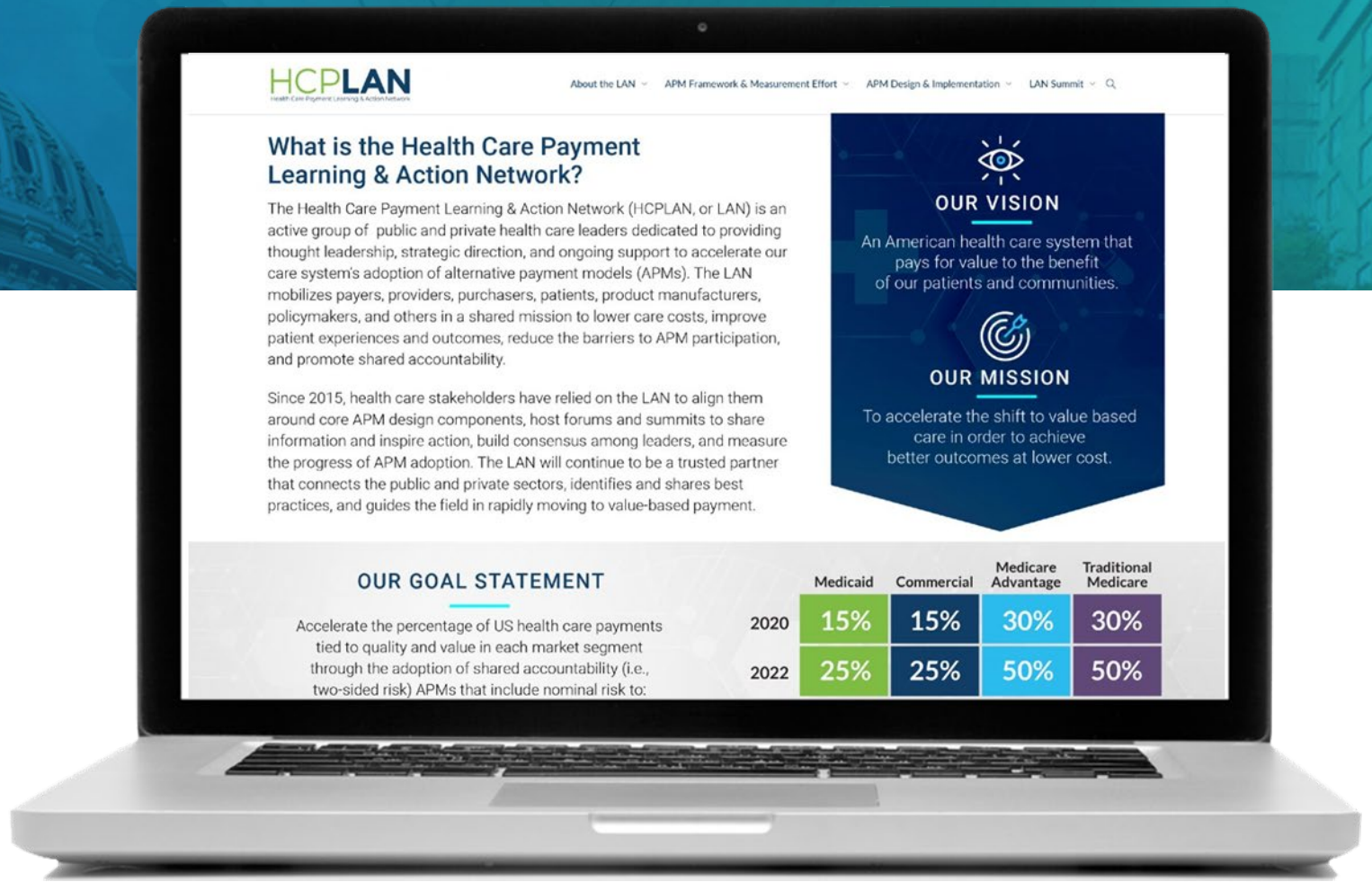
https://innovation.cms.gov/initiatives/ahcm

AccountableHealthCommunities@cms.hhs.gov

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Visit the LAN Website for our Resources

https://hcp-lan.org/



Exit Survey

We want to know what you think!

Let us know your thoughts at the end of each session! The Guidebook app provides quick, simple evaluations for your feedback.

Session Evaluation Survey (or scan QR code)

LAN Summit Overall Survey

Contact Us

We want to hear from you!

www.hcp-lan.org

@Payment_Network

PaymentNetwork@mitre.org

/in/Payment-Network

Search: Health Care Payment Learning and Action Network

ALIGNING FOR SHARED ACCOUNTABILITY

LAN SUMMIT

Health Care Payment Learning & Action Network

Thank You!