# WACMHC
Washington Association of
Community & Migrant Health Centers

## APM: A Path to Innovative Care

*An Oregon FQHC's Experience*

*May 31, 2018*

# Welcome

## WEBINAR FACILITATOR

**Hannah Stanfield**
Practice Transformation Coordinator
WACMHC

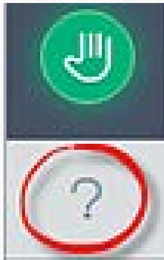
## FEATURED PRESENTERS

**Bob Marsalli, CEO**
WACMHC

**William North, CEO**
Rogue Community Health

# HOUSEKEEPING

- Your lines are currently muted
- We'll address questions at the end of the presentation
- You can ask a question in the following ways:



*RAISE YOUR HAND FUNCTION* - your line will be unmuted and you can ask the question verbally

*QUESTIONS FUNCTION* – type your question in the box and the facilitator will read it aloud

- This webinar is being recorded. A recording will be sent to you in a follow-up email
- Materials, including slides, are located in the Handouts section of your dashboard

# Learning Objectives

- Explain the intersection of team-based care, PCMH, and alternative payment methodologies
- Evaluate how identifying and addressing patient social risk is critical to optimize team-based care and improve patient outcomes
- Assess the value of leadership's role in value-based activities and initiatives

# What is Team-Based Care?

National Academy of Medicine (Previously named the Institute of Medicine):

"...the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient - to accomplish shared goals within and across settings to achieve coordinated, high-quality care."

American Medical Association:

"…a strategic redistribution of work among members of a practice team."

# What is Team-Based Care?

- Various combinations of physicians, nurses, PAs, pharmacists, social workers, case managers or other professionals on the care team
- Collaboration among team members, the patient, and family
- Shared goals within and across health care settings
- Physicians leading the team, maintaining authority for patient care to assure patient safety and quality of care

# Benefits of Team-Based Care

Agency for Healthcare Research and Quality:

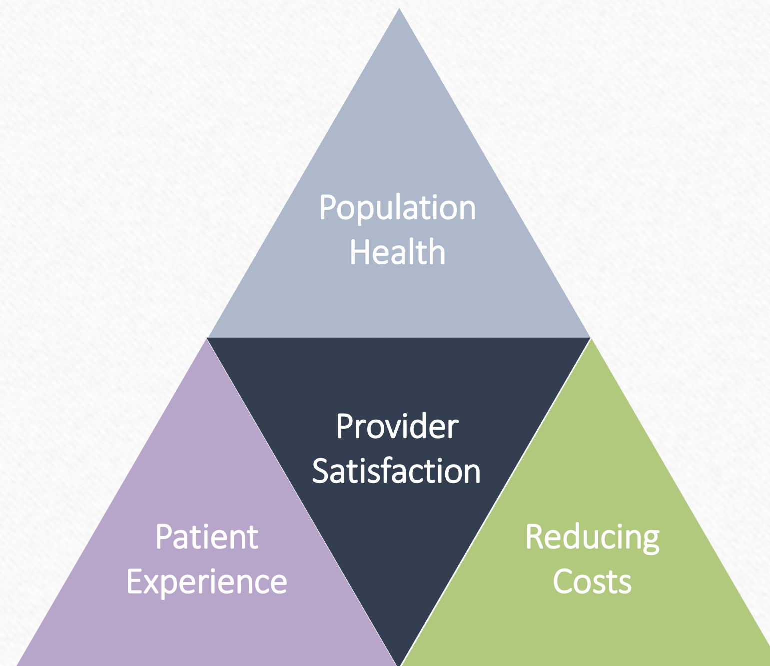
> "Well-implemented team-based care has the potential to improve the comprehensiveness, coordination, efficiency, effectiveness, and value of care, as well as the satisfaction of patients and providers."

National Association of Community Health Centers:

> "When the right mix of experts can work with the right tools to deliver "whole patient care" to defined groups of patients, health outcomes and patient satisfaction improves. It is also a critical tool for clinician recruitment and retention."

> "A successful care team can offer a full range of services based on the patient's needs, prevent wasteful services, and allow providers the time to see more patients. This system serves as a solution for physician shortages. Team members share the burden of care and keep each other informed."

# Benefits of Team-Based Care



# 5 Core Principles of Effective Team-Based Care

## Shared Goals

The team — including the patient and, where appropriate, family members or other support persons — works to establish shared goals that reflect patient and family priorities and that can be clearly articulated, understood and supported by all team members.

# 5 Core Principles of Effective Team-Based Care

## Clear Roles

There are clear expectations for each team member's functions, responsibilities and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.

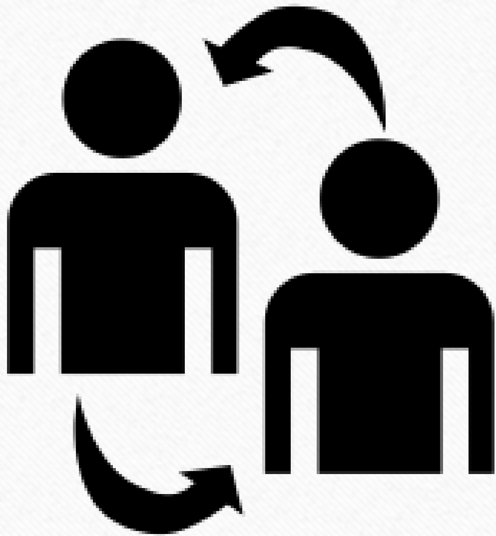
# 5 Core Principles of Effective Team-Based Care

## Mutual Trust

Team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

# 5 Core Principles of Effective Team-Based Care

## Effective Communication



The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.

# 5 Core Principles of Effective Team-Based Care

## Measurable Processes & Outcomes

The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time.

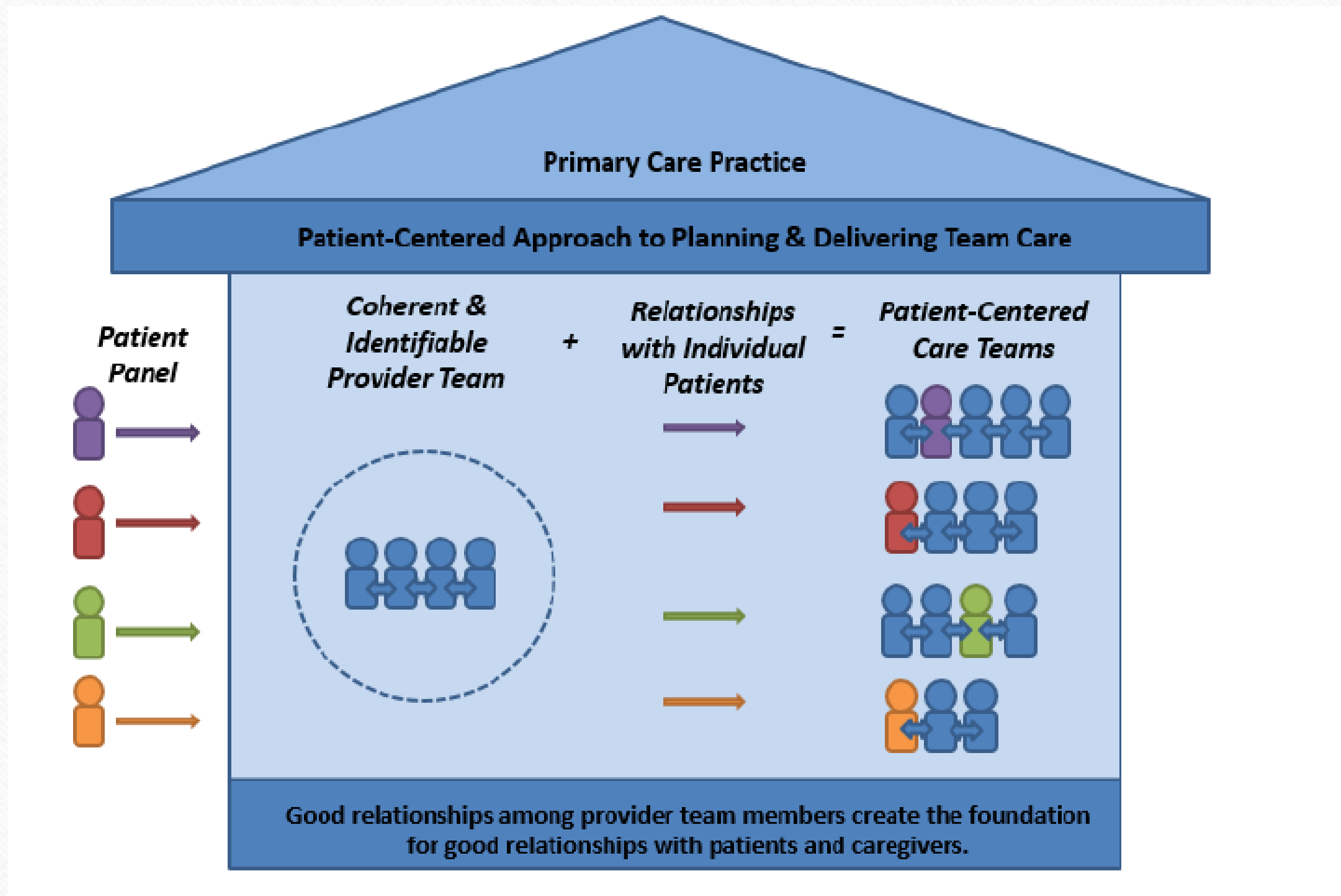
# Alignment with PCMH

Joint Principles of the Patient Centered Medical Home:

"The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. Care is coordinated and/or integrated across all elements of the complex health care system and the patient's community. Enhanced access to care is available through…new options for communication between patients, their personal physician, and practice staff."

Patient-Centered Primary Care Collaborative:

PCMH is "a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety."




https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care#fig1

# Alternative Payment Methodology (APM) & Team Based Care

Bob Marsalli, CEO

WACMHC

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# A bit about WACMHC

- WACMHC serves as the unified voice for Washington's 27 community health centers.
- Incorporated in 1985, our mission is to strengthen and advocate for Washington CHCs as they build healthcare access, innovation, and value.
- Washington health centers service more than 1,000,000 patients from over 300 service sites across 31 of 39 counties in the state.

# An Overview of APM4

- What?
  - APM4 is a prospective, population- and value-based payment methodology. It serves as an alternative to (not a substitute for) a health center’s conventional, encounter-based PPS reimbursement.
- Why?
  - CY 2013 – Washington Senate Bill 5034
  - CY 2014 – Medicaid Expansion
  - CY 2016 – CMS approves WA’s *Healthier Washington* 1115 Waiver Demonstration Project
- … and?

# How?: The Quality Wedge

| | 2015 Conversion Yr | Scenario #1 (2017) | Scenario #2 (2017) | Scenario #3 (2017) |
|---|---|---|---|---|
| Encounters | 21,120 | 20,000 | 20,000 | 21,120 |
| Rate (x1.02 MEI) | $195 | $198.90 | $198.90 | $198.90 |
| Member Months | 86,400 | 90,000 | 86,400 | 90,000 |
| APM 4 PMPM (x1.02 MEI) | $47.67 | $48.62 | $48.62 | 48.62 |
| Total APM 4 | $0 | $4,375,800 | $4,200,768 | $4,375,800 |
| Total APM 3 | $4,118,400 | $3,978,000 | $3,978,000 | $4,200,768 |
| APM 4 “Wedge” | $0 | **$397,800** | **$222,768** | **$175,032** |

# Putting it Into Practice

William North, CEO

Rogue Community Health

Medford, OR

# Rogue's AP/CM Model

Rogue Way to Health

# Oregon's APCM Model

- Health System Transformation - CCO
- Value Based Pay Modeling - CMS
- Oregon APCM FFS to capitation
- Quadruple Aim Dashboard:

  Quality, Access, Cost, Equity (Pop Hlth)

Rogue Way to Health

# Oregon Health Plan

- APCM Cohorts implemented annually
- Program began with 3 clinics in 2013
- Rogue was in Phase 3 - July 1, 2015
- Currently finishing Year 3 June 30, 2018

Rogue Way to Health

# Care Team Restructure

- PCMH/PCPCH – Five Star Health Home
- Team-based IBH, RN, MA, PSR, Panels, **Rx**
- Member services – **CHWs** (13), EAs (4)
- Rogue Challenge Partners-Human Services
- Virtual Network and Services HUB

Rogue **Way to Health**

# Population Management Project

1. Quadrant Champions Assigned
2. A1c>9 no visits in last 12 months
3. 100 patients
4. PRAPARE tool
5. 47% success rate coming into clinic

Rogue COMMUNITY HEALTH

Rogue Way to Health

# Revise and Repeat

- Added revised RCH PRAPARE tool
- Utilized a single provider
- Completed 115 additional surveys
- Of 215 total completed surveys, 39 % indicate:
  - ***Food Insecurity* as a SDoH barrier**

# Collaboration is key

ACCESS, Inc. Mobile Food Pantry

- Community Action Agency
- Beginning May, 2016, $4^{th}$ Friday of each month
- On-site at Medford Clinic
- Staffed with Personal Shopper, CHW, Eligibility Asst.
- Healthy eating education, cooking demos

Rogue Way to Health

# Results

- Food Security Project Through June 2017
  - 720 individuals served
  - Avg. household = 2.45 members
  - Average amount of food distributed = 28.1 lbs
  - Average cost per person served = $1.69

Rogue Community Health

Rogue Way to Health

# The Work Continues

- Revised PRAPARE tool
- Patient Support Survey - Trauma Informed
- Ashland - rooming by M.A. for review, warm connection to Behavioral Health
- Referral to CHW - follow up 2 business days.

Rogue Way to Health

# Patient Support Survey

**Patient Initials** ____________________________

**Date of Service**____________________________

Your RCH Care Team can work with you to help achieve your goals.
Please circle items below that you would like support with.

Please list any additional goals you may like assistance with:

**May a Community Health Worker call you about this survey?**

❑ **Yes** ❑ **No**

For Staff Use Only:

MRN: ____________________

Notes:

Rogue **Way to Health**

# The Rogue Challenge

## Community partners:

- Addictions Recovery Center
- Family Nurturing Center
- ACCESS Inc.
- Head Start
- YMCA
- Goodwill

Rogue Way to Health

# The Rogue Challenge

**Shared Registration Process**

**Shared Case Management**

**Closed Feedback Loop**

**Referral Process/Warm Connection**

Rogue Way to Health

# Benefits of APCM

- Learning to manage in capitation drivers
- Capital infusion to develop new systems
- Transition glide path to Value-Based Care
- Engaging human services network partners
- Growing member services capabilities

Rogue Way to Health

# How to prepare for a value-based practice?

QUESTIONS

## *Upcoming WACMHC Trainings*

**Enhancing Workplace Dynamics through Managerial Skills Training**
Teambuilding Through Inspiring | June 13 & 25
Foundations of Emotional Intelligence | June 14 & 26

**Supporting Patients at Risk for Diabetes**
June 6 | 12:00 – 1:00pm
REGISTER

**Lean Boot Camp: Office Hours**
June 8 | 12:00 – 1:00pm
REGISTER

**Please complete the evaluation after the end of the session. Your feedback is appreciated!**

Questions? Contact the WACMHC Practice Transformation Team at
QualityImprove@wacmhc.org

# Resources


1. Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc
2. APM4 Overview and Data Processes. (2017, September 26). Retrieved from https://www.hca.wa.gov/assets/program/apm4-webinar092517.pdf
3. Creating Patient-centered Team-based Primary Care. Retrieved from https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care
4. Implementing Team-Based Care - STEPS Forward. Retrieved from https://www.stepsforward.org/modules/team-based-care
5. Joint Principles of the Patient-Centered Medical Home. (2007, March). Retrieved from https://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf
6. Paying for value. Retrieved from https://www.hca.wa.gov/about-hca/healthier-washington/paying-value
7. Population Health Management: Team-Based Care. (2016, August). Retrieved from http://www.nachc.org/wp-content/uploads/2015/12/NACHC_team_factsheet_FINAL.pdf
8. The IHI Triple Aim. Retrieved from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
9. The Practice Team. (2017, April 26). Retrieved from http://www.improvingprimarycare.org/team/practice-team