HAWAIʻI PRIMARY CARE ASSOCIATION

2011 ANNUAL CONFERENCE
JOURNEYS OF TRANSFORMATION

PLENARY SESSION

Journeys of Transformation

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HAWAIʻI PRIMARY CARE ASSOCIATION

JOURNEYS OF TRANSFORMATION

WAIʻANAE COAST COMPREHENSIVE HEALTH CENTER

`AHA Rural Oahu

Accountable Healthcare Alliance of Rural Oahu

From Volume to Value: Engaging Consumers in Healthcare Transformation

Richard P. Bettini, MPH, MS
President and Chief Executive Officer
Waianae Coast Comprehensive Health Center

2011 HPCA Annual Conference
September 29 & 30 ~ Hilton Hawaiian Beach Resort

Our first reaction is to fight back against cuts in our services and changes in our state's "caring" culture and values

Instead we formed AHA-RO
Our 3 Health Centers

Ko'olauloa Community Health & Wellness Center
Unduplicated Patients: **5,766**
Total Patient Visits: ***18,490***
Uninsured Patients: ***1,279***
Top two ethnic groups served:
Native Hawaiian = ***49.2% and***
Asian = ***13.2%***
Incorporation: ***October 10, 2003***
1st patient seen: ***May 2004***

Waimanalo Health Center:
Unduplicated Patients: ***4,195***
Total Patient Visits: ***20,760***
Uninsured Patients: ***1,321***
Medicaid Patients: ***2,033***
Top two ethnic groups served:
Native Hawaiian = ***46.4% and***
Other Pacific Islanders = ***15.7%***
Incorporation: January 25, 1989
1st patient seen: ***January 1992***

Waianae Coast Comprehensive Health Center:
Unduplicated Patients: **28, 912**
Total Patient Visits: **164,852**
Uninsured Patients: **13%**
Medicaid Patients: **55%**
Top two ethnic groups served:
Hawaiian/Part Hawaiian = **52% and**
Caucasian = **16%**
Incorporation: **1972**

Recognizing we must be constructive partners in containing healthcare costs and creating better value for our patients and payers.

AHA-RO Background Information
AHA-RO Mission

Promoting access, quality, and cost effectiveness in healthcare by empowering consumers to evaluate the performance of healthcare agencies that serve them.

- Consumers and taxpayers demanding accountability
- Using consensus and community problem solving
- Like a "Tea Party" only with no money and a belief in social justice and addressing health disparities

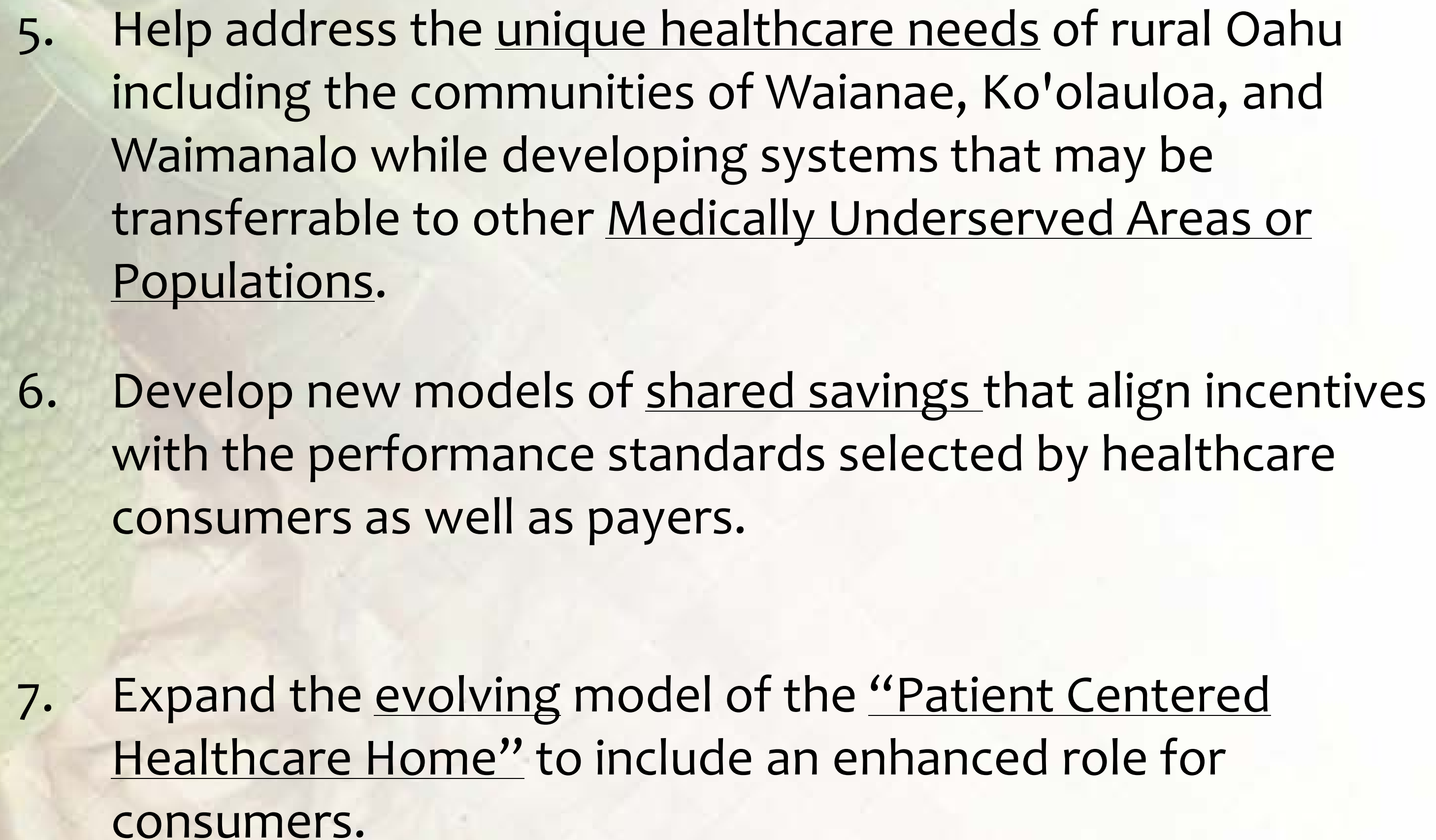
AHA-RO Goals

1. Form an interdisciplinary council, directed by consumers, to promote and utilize value based systems in healthcare.

2. Develop value based healthcare systems that include application of health information technology, performance metrics and research directed at improved access and quality while also promoting cost containment.

3. Help assure that medically underserved populations, including those with population characteristics of high poverty and cultural uniqueness, are not underrepresented in the development of performance metrics.

4. Engage government and other healthcare payers, medical and related service providers, and neighboring communities in a dialogue on the integration and reengineering of healthcare services with a particular emphasis on the consumer perspective.



5. Help address the unique healthcare needs of rural Oahu including the communities of Waianae, Ko'olauloa, and Waimanalo while developing systems that may be transferrable to other Medically Underserved Areas or Populations.

6. Develop new models of shared savings that align incentives with the performance standards selected by healthcare consumers as well as payers.

7. Expand the evolving model of the "Patient Centered Healthcare Home" to include an enhanced role for consumers.

WE HAVE AN OPPORTUNITY!

THE EMERGING HEALTHCARE ENVIRONMENT

New Healthcare Technology will lead to:
The measurement of the relative value healthcare providers offer payers and patients

(Reimbursement will then be associated with this measured value)

- Medical Home: Primarily Measures Capabilities (NCQA)
- Accountable Care: Share the Savings

Key Questions:

Will we be fairly valued? Who picks the measures? Who shares the savings?

AHA-RO Has Its "ROOTS" HERE:

Journey to an Island Health Care Home

A Leadership Conference for Community Health Center Board Members and Those That Support Them

December 1-2, 2008 ~ Pre-Conference
December 2-4, 2008 ~ Conference
Ihilani Resort & Spa ~ Ko Olina, Oahu, Hawaii

Hosted by: Waianae Coast Comprehensive Health Center

HEY NCQA!

A Healthcare Home in Waianae is NOT the same as a Medical Home in Kahala… Just like beachfront homes in the two places are NOT the same

"The most reliable predictor of population health is the zip code lived in"

Income – Schools – Crime – Unemployment – Stress – Access Barriers

July Crime Statistics for District 8 Sector 1

Makua – Makaha – Waianae

(Does not include Nanakuli)

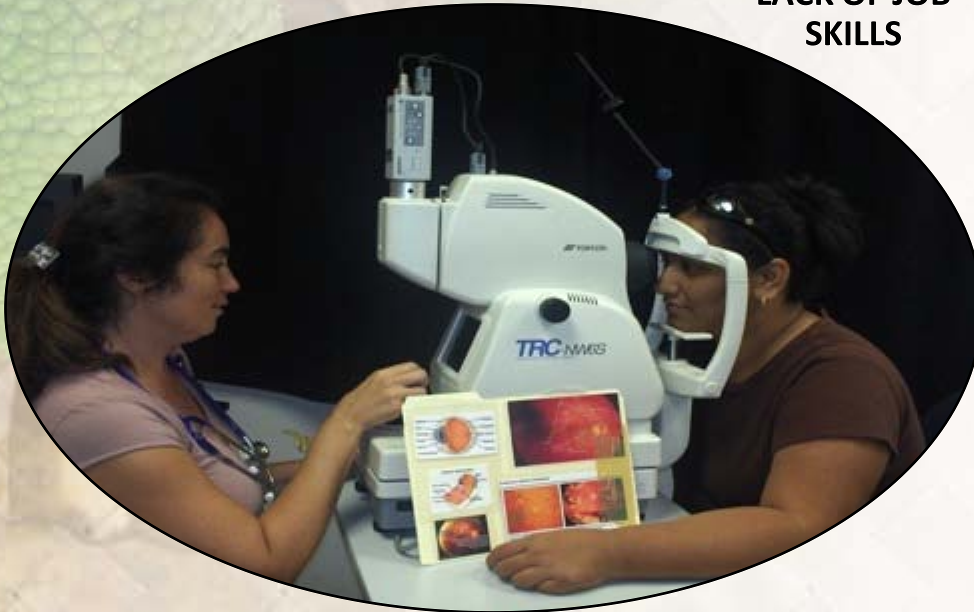
Arrests: 555 Adults
94 Juveniles
649 Total for the month

Population Size: 21,500

NOTE: Could be <u>one</u> person arrested 555 times in one month or social conditions could be different in the area

Why Supplemental NCQA Standards Are Needed for MUA Based Medical Homes
One Sample – Linking to Special Needs

The Link Between Employment & Health



The original concept of a Medical Home extends care into community networks that impact on well being

Founding Principles of Medical Home

1. Accessible – Community-based, Universal
2. Family-centered – Family as partners in care
3. Coordinated – Context of both family and community
4. Comprehensive – Treats the whole patient
5. Continuum – 24/7
6. Culturally Effective
7. Compassionate

The Journey Continues…Consumer Leadership in Health Care Transformation

August 25 – 26, 2011
San Diego, California

THE GAME

Outcome of 3 Game Series – (If patients could pick PCMH Scoring)

Supplemental Patient-Centered Medical Home Standards 32 Points

PCMH 7: For MUA/MUP Community Based Initiatives to help facilitate access to care in higher poverty level or culturally unique communities.

Element A: Care Enabling Services		**8 Points**		
The practice evaluates patients' abilities to receive services and has systems in place to overcome potential access barriers by:		**YES**	**NO**	**N/A**
1.	Assessing on an ongoing basis the self-reported and actual access barriers experienced by patients in the PCMH.			
2.	Having appropriate programs, staffing, and resources to provide these care enabling services.			
3.	Offering patients the eight basic enabling services identified by AAPCHO and NACHC (attached).			
4.	Coding and tracking these enabling services on charge tags or electronic records.			
5.	Measuring the impact of enabling services on performance metrics.			
6.	Developing and utilizing enabling protocols on electronic health record templates.			
7.	Having an established patient and family feedback system for appropriateness, effectiveness and improvement of care enabling services			

Scoring

100%	75%	50%	25%	0%
The practice meets all 7 factors	The practice meets 5 factors, including factor 3	The practice meets 3 factors including factor 3	The practice meets only factor 3	The practice meets no factors or does not meet factor 3

Element B: Cultural Proficiency — 8 Points

The practice addresses the cultural background of consumers in its policies, procedures and practices through the following:		YES	NO	N/A
1.	Assesses the diversity of consumers and trains staff, providers, and others about the diversity.			
2.	Has a panel of cultural advisors engaged in developing and evaluating cultural practices.			
3.	Has an established plan for cultural sensitivity training and professional development for staff.			
4.	Providers follow culturally specific protocols based on patient background and demographics.			
5.	Buildings and facilities that reflect the patient population's culture and background (e.g. male family planning clinic design to make men feel welcome).			
6.	Provides and/or promotes complementary and/or alternative healing practices in alignment with primary and preventive health services.			

Scoring

100%	75%	50%	25%	0%
The practice meets all 6 factors	The practice meets 4 factors, including factor 1	The practice meets 3 factors including factor 1	The practice meets factor 1	The practice meets no factors or does not meet factor 1

Element C: Community Involvement — 8 Points

	The practice is an integrated part of the community, encouraging participation and elevating the level of health education and organization through the following:	YES	NO	N/A
1.	Has a panel of patients or Consumer Board that reviews and approves an annual plan that identifies health care needs and disparities within the community; establishes an action plan to address these issues.			
2.	Reviews adequate data to measure performance to promote access, quality, cost effectiveness and makes recommendations for consideration.			
3.	Has a systematic process in place to measure patient satisfaction and performs any remedial actions deemed necessary.			
4.	Has a volunteer program that involves community members and various activities to promote a healthier community.			
5.	Conducts outreach with community participation through health fairs, etc.			
6.	Engages in Community Based Participatory Research with patients trained as the investigator (PI).			
7.	Has patients sitting on internal committees, (for example, Quality Improvement Committee or Cultural Competency Committee.)			

100%	75%	50%	25%	0%
The practice meets all 7 factors	The practice meets 5 factors, including factor 1	The practice meets 3 factors including factor 1	The practice meets only factor 1	The practice meets no factors or does not meet factor 1

Element D: Workforce and Economic Development — 8 Points

	The practice is a center of economic opportunity for the community by offering the following:	YES	NO	N/A
1.	A protocol in place to refer unemployed patients to job training activities within the service area.			
2.	An "on the job" training program for workers to improve job competencies that are aligned with healthcare transformation needs.			
3.	A plan in place to promote a continuum of job training activities for service area residents that ranges from entry level careers to professional education with preparatory or "pipeline" services identified.			
4.	Programs to support staff development activities, e.g. tuition reimbursement, flexible scheduling, job-sharing, telecommuting, and other training programs.			
5.	Programs to attract workers from other industries with transferable skills to work at a healthcare home.			
6.	Programs to share labor resources with other healthcare homes as needed.			
7.	Acting as a training site for at least 3 different health care disciplines, ex. medical assistants, nurses, nurse practitioners, physician's assistants, social workers, medical students, psychology interns, or medical or dental residents.			

	100%	75%	50%	25%	0%
Scoring	The practice meets all 7 factors	The practice meets 5 factors, including factor 1	The practice meets 3 factors including factor 1	The practice meets only factor 1	The practice meets no factors or does not meet factor 1

REQUIRED BY FEDERAL WAIVER – NOT BEING SUPPORTED TO ALL PLANS

What Are Care Enabling Services?

The Function of Reducing Access Barriers to Care

12 month visit count by procedure code at one AHA-RO Center

Description	Count
Case assessment	353
Case Finding	1058
Case Mgmt:Advocacy	867
Case Mgmt:Care Coordination	791
Case Mgmt:Chart Review	4562
Case Mgmt:Collaboration with other Prov	1201
Case Mgmt:Consultation with other prov	460
Case Mgmt:Counseling pt and/or family	332
Case Mgmt:Discharge/termination of svc	1124
Case Mgmt:Domestic Violence Screening	759
Case Mgmt:EDC third trimester contact	372
Case Mgmt:Information	4777
Case Mgmt:Initial assessment	462
Case Mgmt:Monitoring	5266
Case Mgmt:Outreach activities	897
Case Mgmt:Referral	278
Case Mgmt:Screening	203
Case Mgmt:Treatment Plan	589

What Are Care Enabling Services?
The Function of Reducing Access Barriers to Care

12 month visit count by procedure code at one AHA-RO Center

Entitlement Assistance:Eligibility	1372
Fitness Training	2567
Hlth Ed:Disease Management	577
Hlth Ed:Family Planning	742
Hlth Ed:Group-Nutrition	697
Hlth Ed:Indiv-Other	3532
Hlth Ed:Preventive Health	1125
Hlth Ed:Smoking Cessation	385
Medication Management	239
Perinatal:Adolescent	472
Perinatal:Medical/evolving risk	1901
Perinatal:Post-partum	1231
Perinatal:Substance Use-past	273
Perinatal:Substance Use-present	499
Perinatal:Well Baby	578

What Are Care Enabling Services?
The Function of Reducing Access Barriers to Care

12 month visit count by procedure code at one AHA-RO Center

Procedure	Count
Prev Hlth:Disease Self Management	3088
Prev Hlth:DM Eye Exam Referral Made	199
Prev Hlth:DM Foot Exam Done	194
Provision Assistance:Household items	515
Provision Assistance:Medical supplies	268
PT SVC:SFS APPLICATION	497
Referral/linkage:Case Management Program	2411
Referral/linkage:Medical Svc	229
Referral/linkage:Other Resource Info	261
Supportive Counseling:Individual	419
Supportive Counseling:Lifestyle	824
Transportation:WCCHC VAN	2028

In Addition to care Enabling Services there are other Value Added Services Some Plans Pay for and Some Don't and That Are Responsive to Special Population Needs

- Medical Nutrition Therapy
- Supervised Exercise by Certified Trainers
- CSAC Substance Abuse Counseling
- "Humbug Adjudication" (Ask us)
- Integrative & Traditional Practice – State Certified
- Pharmacy Counseling

So what has AHA-RO done so far?

STEP ONE:

We discussed where are the savings in healthcare:

- Met with plans
- Looked at data
- Discussed with health professionals

We have learned so far that savings can be found:

- In reducing hospital readmissions – especially for newly diagnosed chronic disease patients
- In coordinating care for complex patients
- By promoting integrated model of care at community level
- By preventing and managing the control of diabetes – for which there are very high rates in our 3 communities
- Better pharmacy management including pharmacy education

STEP TWO: Developed a Payment Model with a Health Plan (Pilot Program with the Plan)

1. We agreed to set aside a portion of our fee payment in a fund established by each health center.
2. The Plan agrees to match this amount with a prospective investment in care coordination and HIT system development.
3. The Plan agrees to support supplemental PCMH (non-PPS) services in centers that meet tiered supplemental standards (consumer developed) and become "Patient Centered Healthcare Homes".
4. Partners agree to exchange data and establish performance dashboards.
5. The Plan agrees to support non-blended rate covered services with capitation for additional care enabling services.
6. Risk pool savings are shared based on financial performance metrics negotiated.

Applying Shared Savings to Value Added Services

Healthcare Home Risk Pool Managed with Health Plan

A — The plan pays health centers for services required by the State under QUEST contract through blended FFS rate (PPS Scope).

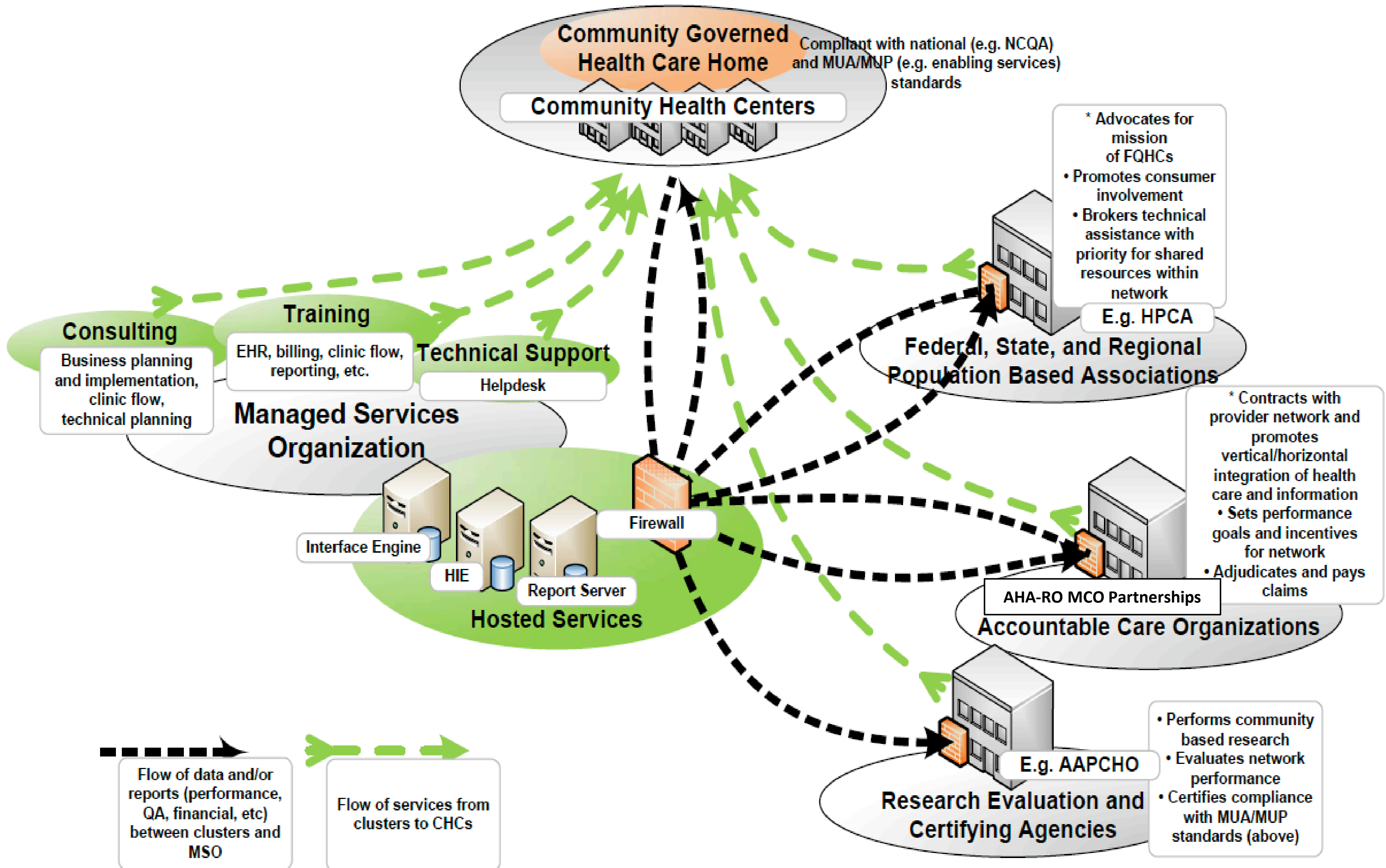
B — AHA-RO/Plan partners score participating centers on both State selected and (Supplemental MUA/MUP Healthcare Home Standards) and plan provides supplemental capitation based on tier.

C — Plan invests matching funds in HIT/Care coordination. Performance on mutually agreeable risk pool performance metrics. Performance can trigger future investments.

D — Plan capitates for non-fee blended services based on specific population needs. Clinical process measures apply.

E — Health Centers get up to "negotiated" percentage of savings in risk pools (limited by 25% of total payments being risk related). Financial performance metrics apply.

MUA/MUP Based Healthcare Home – Measuring Performance and Performing Value
Flow of Services and Data



AHA-Rural Oahu
Dashboards – Tools for Measuring Performance

Clinical Process & Outcome Measures

(Currently being used as PIC dashboard)

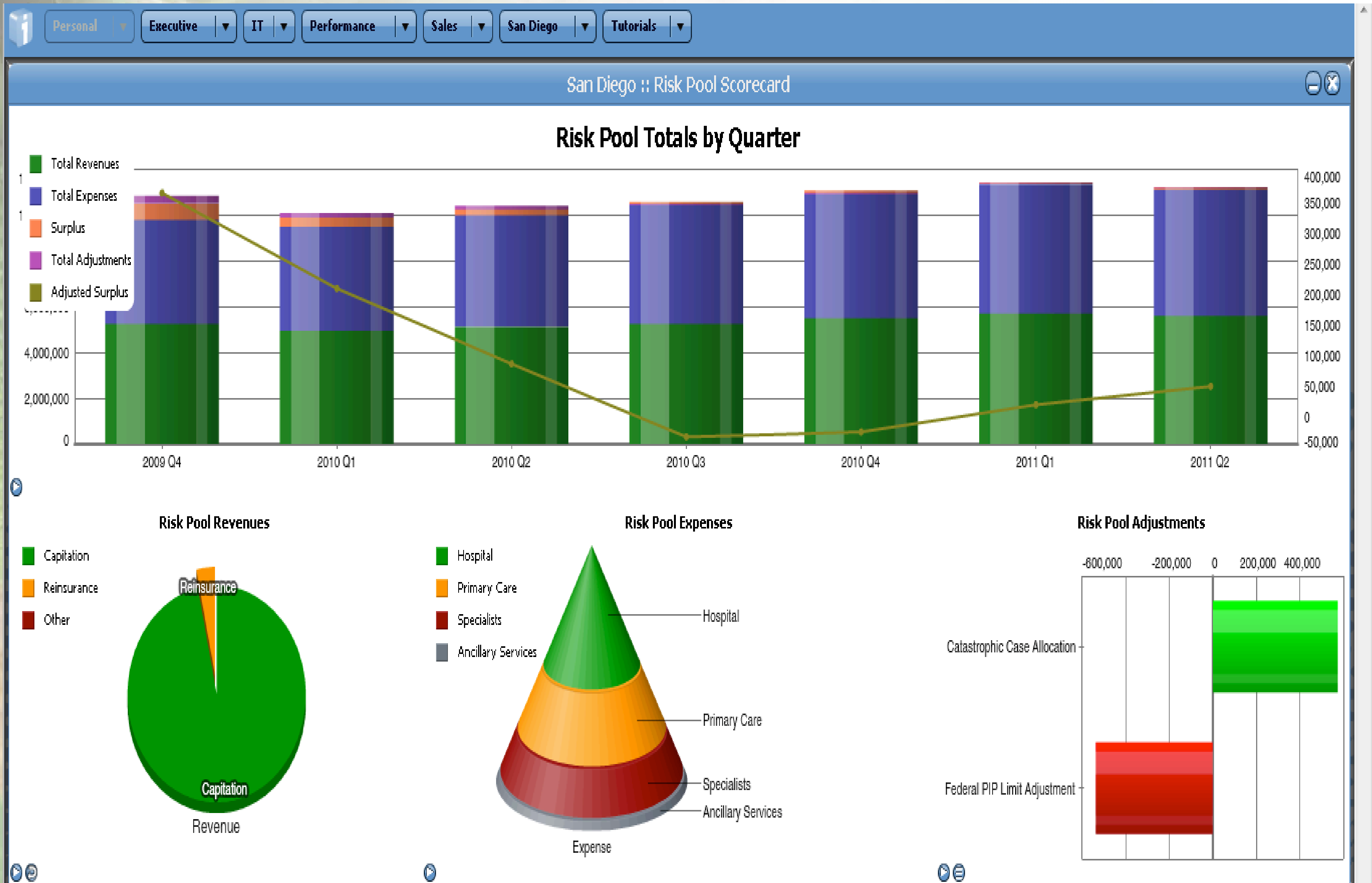
Community Selected & Utilized

- Being developed by Consumers
- Community Outcomes
- Community Transformation Project

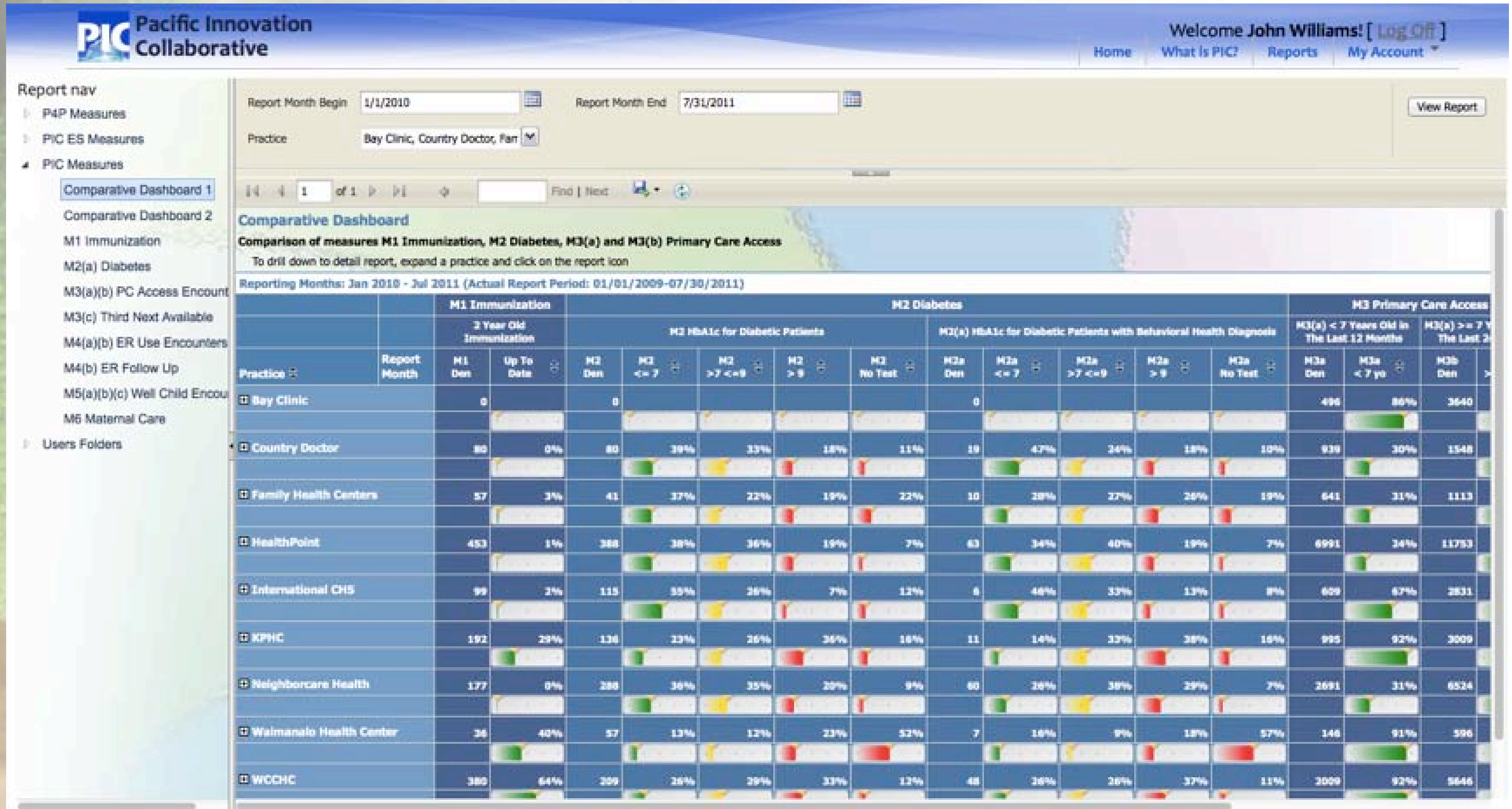
Direct Risk Pool Financial Data – To Repository

- Monthly update risk pool expenditures
- Targets and metrics on costs:
  - Pharmacy
  - Hospital
  - Primary Care
  - Specialty

Risk Pool Dashboard



Comparative Dashboard



Comparative Dashboard

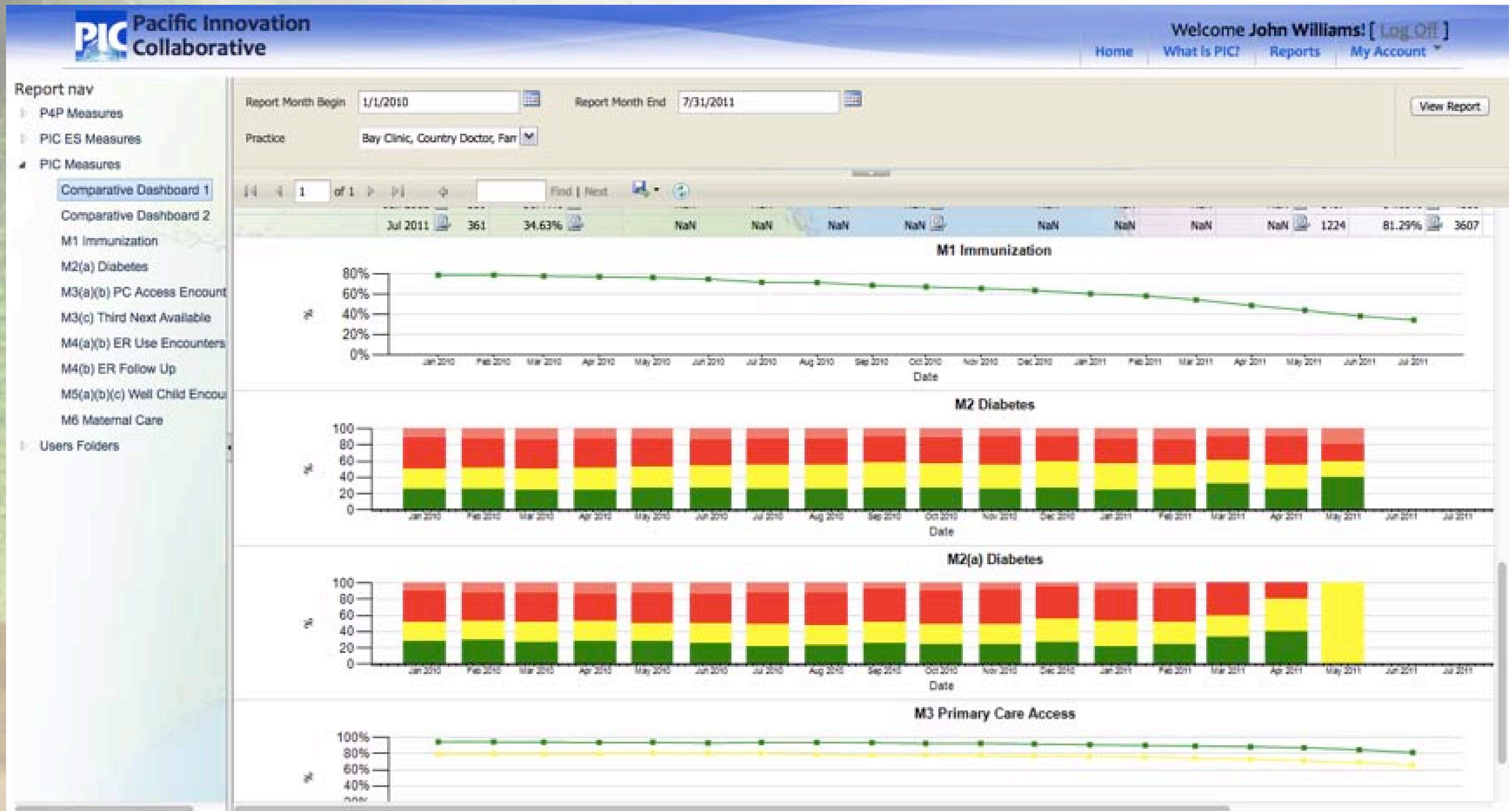
Comparison of measures M1 Immunization, M2 Diabetes, M3(a) and M3(b) Primary Care Access

To drill down to detail report, expand a practice and click on the report icon

Reporting Months: Jan 2010 - Jul 2011 (Actual Report Period: 01/01/2009-07/30/2011)

		M1 Immunization		M2 Diabetes										M3 Primary Care Access		
		2 Year Old Immunization		M2 HbA1c for Diabetic Patients					M2(a) HbA1c for Diabetic Patients with Behavioral Health Diagnosis					M3(a) < 7 Years Old in The Last 12 Months		M3(a) >= 7 Y The Last 2
Practice	Report Month	M1 Den	Up To Date	M2 Den	M2 <= 7	M2 >7 <=9	M2 > 9	M2 No Test	M2a Den	M2a <= 7	M2a >7 <=9	M2a > 9	M2a No Test	M3a Den	M3a < 7 yo	M3b Den
Bay Clinic		0		0					0					496	86%	3640
Country Doctor		80	0%	80	39%	33%	18%	11%	19	47%	24%	18%	10%	939	30%	1548
Family Health Centers		57	3%	41	37%	22%	19%	22%	10	28%	27%	26%	19%	641	31%	1113
HealthPoint		453	1%	388	38%	36%	19%	7%	63	34%	40%	19%	7%	6991	34%	11753
International CHS		99	2%	115	55%	26%	7%	12%	6	46%	33%	13%	8%	609	67%	2831
KPHC		192	29%	136	23%	26%	36%	16%	11	14%	33%	38%	16%	995	92%	3009
Neighborcare Health		177	0%	288	36%	35%	20%	9%	60	26%	38%	29%	7%	2691	31%	6524
Waimanalo Health Center		36	40%	57	13%	12%	23%	52%	7	16%	9%	18%	57%	146	91%	596
WCCHC		380	64%	209	26%	29%	33%	12%	48	26%	26%	37%	11%	2009	92%	5646

Dashboard Drill-Down



Community Dashboard

“How Does Your Garden Grow?”

WCCHC Hemoglobin A1c Diabetic Patient Care
2nd Quarter 2009

San Ysidro Hemoglobin A1c Diabetic Patient Care
4th Quarter 2010

Consumer Satisfaction Survey

Average Jan-07 - Jan-11

Ease of getting care:
Hours Center is open

4.54

Consumer Satisfaction Summary View

Other AHA-RO Activities

- Evaluating Medicaid Health Plans
- Evaluating State Agencies including Medicaid RFPs
- Evaluating effectiveness of other groups that receive grant funds to address health problems within our service area

3 Ways to Evaluate Medicaid Health Plans

(Evaluation survey available on request)

- ❑ Claims & HIT Capability
- ❑ Value Added Services
- ❑ Shared Savings Model

These values are more important to our community than how plans score on HEDIS Measures?

AHA-RO Correspondence to DHS and Town Meetings Linked by Teleconference

- We can live with cutting costs if you can build values through QUEST RFP.

- We can work with restricted drug formulary, however, why not apply it to QUEST Expanded as well?

- To improve QUEST RFP

  - ✓ Require standards for provider networks (Thanks)
  - ✓ Reward plans that provide value added services (Problem)
  - ✓ Measure plan impact on total state economy (Not done)

- Do not ration primary care services: It's the key to creating savings that can be used to help sustain supplemental services.
  (Huge problem – And not constructive)

Projected Impact of Rationing Primary Care Visits on Health Care Home – at one Health Center

Medicaid Cut Revenue Impact
Visits in excess of 20 or 26 with BH (assuming 4 outside visits)
Based on CY2010 Data

Clinics	Excess Visit Count	Percentage	Possible Revenue Loss
Behavioral Health	1455	55%	$284,484.70
Primary Care	656	25%	$128,146.26
Specialty Care	274	10%	$53,501.06
Urgent Care	276	10%	$54,013.65
Grand Total	2661		$520,145.67

The Challenge We Face Today

Hawaii's New Medicaid RFP

- ✓ Requires plans to use NCQA type Medical Home Standards to develop 2 tiers of payments.

PLATINUM & GOLD

- ✓ Requires development of Pay for Performance component based on HEDIS Measures (no population adjustment in scoring).
- ✓ The QUEST RFP is much better than the last QUEST RFP – still does not capture value added comparisons we seek.

QUESTIONS

What if incentives were given to health plans that actually invest in community based solutions?

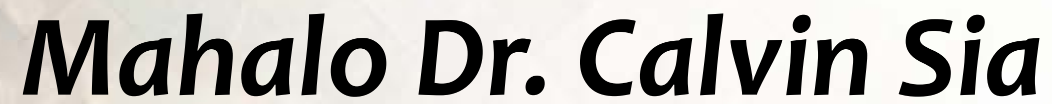
What if we added a patient selected Healthcare Home Standards? (Copper level)

Why is there no economic diffusion analysis (yet) as to where the $$$ flow and how much leaves the State. This is a billion dollar program!

And Beware of the two faces

We support Healthcare Homes!

We ration primary care for complex patients with co-morbidities!


Mahalo Dr. Calvin Sia

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Questions?

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