Whole Person Care Collaborative

"Individually, we are one drop. Together, we are an ocean." – Ryunosuke Satoro

August 3, 2020
Welcome, Introductions & Consent Agenda
DIGITAL TRANSFORMATION IS YEARS AWAY. I DON'T SEE OUR COMPANY HAVING TO CHANGE ANY TIME SOON.
Announcements

- WPCC - Virtual meetings only
  Zoom waiting rooms/passwords
As in the past, John Schapman, NCACH Deputy Director will be sending out the VBP survey. If you want more information, email John or I.
Group Sharing
Speed - engagement

Process: 1-2-4-All

Purpose: Engage everyone simultaneously in generating questions/ideas/suggestions

We will take a minute to individually think about this question:

*What did you do differently during the last 4 months, aside from implementing telehealth, that you would hope to carry forward?*
Speed - engagement

Break up into groups of 2 people - only 2 minutes to answer question

Combine groups of 2 to make groups of 4 – 4 minutes to share

Come back together and share as a big group
What did you do differently during the last 4 months, aside from implementing telehealth, that you would hope to carry forward?
WA HCA Multi-Payer Primary Care Transformation Model

ACH Meeting
June 29, 2020
Background

- HCA convened Wa payers and primary care providers in Spring 2019
- Payers and providers met individually to develop proposed components and lobbed to the opposite group.
- Joint meeting → Individual meetings & Repeat until May 2020
- Formed 2 workgroups that included payers, providers, purchasers, CMS and subject matter experts
  - Measures
  - Primary care financing model
## Measure Workgroup Recommendations
### Proposed Transformation Measures

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Transformation Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
<td>• Same day appointments. 24/7 e-health, telephonic access, and communication through IT innovations are offered for both physical AND behavioral health and integrated into care modalities.</td>
</tr>
<tr>
<td></td>
<td>• Practice regularly offers at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours in early mornings, evenings, and weekends.</td>
</tr>
<tr>
<td><strong>Care Coordination</strong></td>
<td>• Practice has and uses a documented strategy to identify care gaps and prioritize high-risk patients and families, AND proactively manages care gaps and documents outcomes, for example, using and documenting care plans.</td>
</tr>
<tr>
<td></td>
<td>• Practice consistently implements team-based care strategies (huddles, care mgmt. meetings, high risk patient panel review)</td>
</tr>
</tbody>
</table>
### Measure Workgroup Recommendations

#### Proposed Transformation Measures (Continued)

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Transformation Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Person Care</td>
<td>• Practice uses an evidence-based tool to screen for behavioral health issues, AND has a documented process for connecting patients/families with behavioral health resources following screening, including standing orders, and protocols for follow up</td>
</tr>
<tr>
<td></td>
<td>• Practice has and uses a documented risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs.</td>
</tr>
<tr>
<td></td>
<td>• Ensure patients’ goals, preferences, and needs are integrated into care through advance care planning.</td>
</tr>
<tr>
<td>Application of Actionable Analytics</td>
<td>• Capacity to query and use data to support clinical and business decisions.</td>
</tr>
<tr>
<td>Measure Workgroup Recommendations</td>
<td>Proposed Clinical Quality Measures (13)</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>1. Contraceptive Care – Most &amp; Moderately Effective Method (NQF 2903)</td>
<td>8. Adolescent Well Child Visits (AWC) (12-21 years of age)</td>
</tr>
<tr>
<td>2. Childhood Immunization Status (CIS) (Combo 10)</td>
<td>9. Medication Management for People with Asthma (MMA) Medication Compliance 75%</td>
</tr>
<tr>
<td>3. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) (CDCN)</td>
<td>10. Depression Remission and Response for adolescents and adults</td>
</tr>
<tr>
<td>4. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)</td>
<td>11. Screening for colorectal cancer</td>
</tr>
<tr>
<td>5. Percent of patients who receive annual BH screening in primary care (using NQF 0418)</td>
<td>12. Follow-up after ED visit for Alcohol and Other Drug Abuse of Dependence (FUA)</td>
</tr>
<tr>
<td>6. Reduction in Emergency Room utilization</td>
<td>13. Total Cost of Care (TBD)</td>
</tr>
</tbody>
</table>
Payment Workgroup Recommendations
Tweaked Proposed Payment Model

The payment model will be comprised of three components:

1) a **transformation of care fee (TCF)** paid to support the transformation to a coordinated delivery model that integrates behavioral and physical health care provided in a range of settings to ensure access;

2) a **comprehensive primary care payment (CPCP)** to cover costs of basic primary care services; and,

3) **performance incentive** available after three years with performance measured according to a combination of quality of clinical care and utilization measures.

To begin to receive TCFs, practices will be required to agree to make progress toward transformation as defined by specified transformation measures.

TCF will be provided up to three years before transitioning to PIPs

- The transition period within the three years may vary based on individual practices’ progress on transformation measures.
Multi-payer Primary Care Transformation Model

• You can find more details on the model and a link to the public comment survey on HCA's website at: https://tinyurl.com/WaMPM

• Public Comment Period: HCA is seeking public comment. It has been extended to August 7th. This will be an opportunity for payers (health care plans), providers, and many others to share their input. Feedback received will help HCA and our partners to further develop this model, and improve the health and health care delivery for Washington residents.
Insights from Virtual Site-Visits
Virtual Site-visit

- July 14 – July 29th we conducted 20 virtual site-visits
  - 16 organizations (met with Confluence Medical & Behavioral Health separately)
  - 3 Managed Care Organizations
  - Action Health Partners
- All lasted ~60 minutes
- Well attended by staff from each organization
- Included WPCC Staff, 2 consultants and Senator Parlette was able to attend 15/20 conducted visits
Looking ahead ...

After insights are shared, we will:

Small Group Discussion
- Pairs – 3 min
- Groups of 4 – 5 min
- All together – 10 min

This is an opportunity for gut reactions, don’t get caught up in the details
- 1-2 things that made you excited
- 1-2 things that made you think “oh boy”
WHAT WE LEARNED...

Shared services model pathways for BH scheduling
Common Themes

What would you like to work on in the next 18 months:
• Chronic care management – predominantly diabetes
• Behavioral Health Integration with focus on diabetes
• Telehealth
• Access
• Social Determinant of Health
Other issues

- Financial Concerns/Viability/Survivability
- Care gaps due to pandemic (stay home, stay safe)
  - Preventive care (e.g., immunizations, cancer screening, diabetes)
  - Treatment delays, ED use
- Rational care planning for the community, focus on centers of excellence of model by hospital
- Transitions/diversions focus (BH)
- Focus on what matters
- Sustainability of ACH support
- Stronger collaboration between the WPCC Learning community, MCOs and Community-based organizations
Opportunities

• Re-start the Population Health LAN – focus on diabetes and depression
• Telehealth (sharing, management, specific TA, change package, peer mentorship, funding, long-term planning and vision)
• Impact Monograph on telehealth and improved access advocating for sustained access
• Innovation exercise for first meeting
• Gaps in care monitoring
• Shared services model-pathways for BH scheduling
Opportunities cont.

• Planning for flu season and next round COVID
• Consultant report back as independent assessment
• Patient experience and preference with telehealth
• More frequent measurement on fewer measures aligned with MCOs
• Increased collaboration with MCOs around transformation efforts
• Future sustainability of current work
• Data Sharing
• Coordinating Care
Common Measures

- Diabetes Metrics
  - A1C screening
  - Uncontrolled
- Depression screening and follow-up
- Access to Care
Small Group Discussion
   Pairs – 3 min
   Groups of 4 – 5 min
   All together – 10 min

This is an opportunity for gut reactions, don’t get caught up in the details
   1-2 things that made you excited
   1-2 things that made you think “oh boy”
Moving Forward
• 2 Breakout session facilitated by Roger and Connie
  • Primary Care perspective - Connie
  • Behavioral Health perspective – Roger
• Each session will last 20 minutes
• Come back as one group to share
Next Steps
Next Meeting

September 14, 2020
Wenatchee, WA