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
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

Strategy + Business Insight

Data, Analytics, Clinical Knowledge, Best Practice

Customer Success
Practice Transformation

System
Clinics

Clinical Insight, Coaching, Accountability
## Illustration – Care Transformation

<table>
<thead>
<tr>
<th></th>
<th>MD-Furnished</th>
<th>Nurse / MA Furnished, MD concluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue Per Visit</td>
<td>$130</td>
<td>$130</td>
</tr>
<tr>
<td>MD Input Time Per Visit</td>
<td>20-40 min</td>
<td>5 min</td>
</tr>
<tr>
<td>Staff Time Per Visit</td>
<td>5 min</td>
<td>45 min</td>
</tr>
<tr>
<td>Cost Per Visit</td>
<td>$166</td>
<td>$40</td>
</tr>
<tr>
<td>Net Income Per Visit</td>
<td>$-36</td>
<td>$90</td>
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</table>
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:

- We’re mostly rural: 67.9% vs. 21.7%
- We’re small (mean # beneficiaries): 10,417 vs. 19,961
- Included safety net providers: 75.6% vs. 34.9%
- Included critical access hospitals: 53.3% vs. 14.3%
- Used management firms: 82.2% vs. 26.1%

Findings

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

<table>
<thead>
<tr>
<th></th>
<th>Per beneficiary per month (PBPM) spending</th>
<th>Aggregate spending (millions)</th>
<th>Net savings to Medicare (millions)</th>
<th>Percent net savings to Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PY 1</td>
<td>-$28.21</td>
<td>-$131.0</td>
<td>-$108.4</td>
</tr>
<tr>
<td></td>
<td>PY 2</td>
<td>-$36.94</td>
<td>-$187.7</td>
<td>-$153.4</td>
</tr>
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</table>

- Spending
  - Statistically significant reduction in total Medicare spending
  - PY 1: Inpatient hospitalization -2.4%, Hospital outpatient -4.3%, Skilled nursing facility -7.2%
  - PY 2: Inpatient hospitalization -3.4%, Hospital outpatient -4.4%, Skilled nursing facility -6.6%

- Utilization
  - Statistically significant reduction in total Medicare spending
  - Emergency department visits with no hospital admissions: PY 1 -1.5%, PY 2 -1.9%
  - Readmissions: PY 1 -4.0%, PY 2 -4.1%

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


Contact Information

James Schuster
schusterjm@upmc.edu
Thank You
Accountable Health Communities Model

Kate Abowd Johnson, PhD
October 24, 2019
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.
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
Standardized Screening for Health-Related Social Needs in Clinical Settings
The Accountable Health Communities Screening Tool

Alexander Billieux, MD, DPhil, Centers for Medicare & Medicaid Services;
Katherine Vertandier, MPH, Centers for Medicare & Medicaid Services;
Susan Anthony, DPhil, 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 (HRENS), 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 assessment tools to screen for clinical and behavioral drivers of poor health, such as alcohol dependency, decompensated heart failure, and depression; but screening for HRENS 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 interventions. 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...
AHC Model Structure

Bridge Organization
## Bridge Organizations

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

<table>
<thead>
<tr>
<th>Assistance Track</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexian Brothers Network</td>
<td>Illinois</td>
</tr>
<tr>
<td>Allina Health System</td>
<td>Minnesota</td>
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<tr>
<td>CHRISTUS Santa Rosa</td>
<td>Texas</td>
</tr>
<tr>
<td>Community Health Network Foundation</td>
<td>Indiana</td>
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<td>Hackensack University</td>
<td>New Jersey</td>
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<td>Mountain States Health Alliance</td>
<td>Virginia</td>
</tr>
<tr>
<td>Partners in Health, Inc.</td>
<td>West Virginia</td>
</tr>
<tr>
<td>Tift County Hosp. Authority</td>
<td>Georgia</td>
</tr>
<tr>
<td>UT Health Sciences Center</td>
<td>Texas</td>
</tr>
<tr>
<td>Yale-New Haven Hospital</td>
<td>Connecticut</td>
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## AHC Model Timeline

<table>
<thead>
<tr>
<th>Assistance Track</th>
<th>Alignment Track</th>
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<tbody>
<tr>
<td><strong>Start-Up Period</strong></td>
<td><strong>Start-Up Period</strong></td>
</tr>
<tr>
<td>• Finalizing relationships with clinical delivery sites</td>
<td>• Finalizing relationships with clinical delivery sites</td>
</tr>
<tr>
<td>• Developing SOPs for screening, referral, randomization, and navigation</td>
<td>• Developing SOPs for screening, referral, and navigation</td>
</tr>
<tr>
<td>• Hiring and training staff</td>
<td>• Hiring and training staff</td>
</tr>
<tr>
<td>• Establishing Advisory Board</td>
<td></td>
</tr>
<tr>
<td><strong>Implementation Period</strong></td>
<td><strong>Implementation Period</strong></td>
</tr>
<tr>
<td>• Offering universal screening to beneficiaries at participating sites</td>
<td>• Offering universal screening to beneficiaries at participating sites</td>
</tr>
<tr>
<td>• Providing community referrals and navigation services to those eligible</td>
<td>• Providing community referrals and navigation services to those eligible</td>
</tr>
<tr>
<td></td>
<td>• Performing community-level quality improvement and gap analyses</td>
</tr>
</tbody>
</table>
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 using systematicity and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services that impact health care costs and reduce utilization.

The model provides support to community-bridge organizations to test promoting service delivery approaches aimed at linking beneficiaries with community services that may address their health-related social needs, such as housing instability, food insecurity, utility needs, interpersonal violence, and transportation needs. Bridge organizations in the Access 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 services to:

- Identify and partner with clinical delivery sites (i.e., physicians, 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 services provided through community service navigation and alignment (Track only).

- **Alignment** and **Track**: 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 practices 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 described 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.
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 single-site organization participating in the Accountable Health Community 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 patient management team shares the reports with staff to set performance targets, 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 lessons for others who are looking to use data-driven quality improvement. The case study concludes with a discussion of future considerations for St. Joseph’s as it seeks to use similar data-based approaches to monitor and improve patient outcomes.

BACKGROUND ON THE ACCOUNTABLE HEALTH COMMUNITIES MODEL

The Accountable Health Communities (AHC) Model addresses a critical gap between clinical care and community services to 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 disparities. With support from the AHC Model, bridge organizations are implementing approaches to link beneficiaries with community services to address health-related social needs, including health insurance, housing, food insecurity, utility problems, transportation needs, and more. For more information about the model, visit the website at https://www.cms.gov/AHC.

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 Livonia, Michigan. St. Joseph’s began implementing the AHC Model in 2016. St. Joseph’s serves as the “hub” for 12 clinical network 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 clinic 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 site and working with local leaders at the state to implement quality improvement efforts. The staff who offer screening for the AHC Model at St. Joseph’s include entering registration staff (that is, front desk staff), new staff fast-tracked and hired specifically for the implementation of the AHC Model, or a combination of the two.
Want to know more?

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

AccountableHealthCommunities@cms.hhs.gov
Visit the LAN Website for our Resources

https://hcp-lan.org/

What is the Health Care Payment Learning & Action Network?

The Health Care Payment Learning & Action Network (HCPLAN, or LAN) is an active group of public and private health care leaders dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate our care system's adoption of alternative payment models (APMs). The LAN mobilizes payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, reduce the barriers to APM participation, and promote shared accountability.

Since 2015, health care stakeholders have relied on the LAN to align them around core APM design components, host forums and summits to share information and inspire action, build consensus among leaders, and measure the progress of APM adoption. The LAN will continue to be a trusted partner that connects the public and private sectors, identifies and shares best practices, and guides the field in rapidly moving to value-based payment.

OUR GOAL STATEMENT

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of shared accountability (i.e., two-sided risk) APMs that include nominal risk to:

<table>
<thead>
<tr>
<th></th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Medicare Advantage</th>
<th>Traditional Medicare</th>
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<tbody>
<tr>
<td>2020</td>
<td>15%</td>
<td>15%</td>
<td>30%</td>
<td>30%</td>
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<tr>
<td>2022</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
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</table>
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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.

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LAN Summit Overall Survey
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