Greater Columbia Accountable Community of Health

Collaboration · Innovation · Engagement

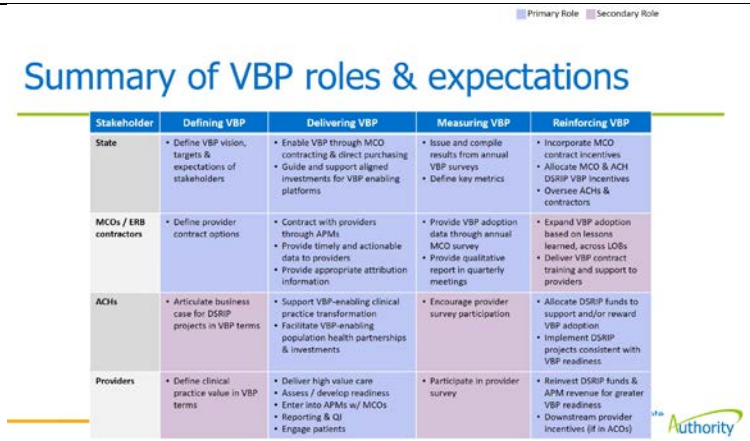
Leadership Council & Practice Transformation Learning Collaborative

Minutes

September 19, 2019 | 9:00 a.m. – 11:30 a.m.

ATTENDANCE	
Participants (*: called in, †: GCACH Board Member, Bold Lettering for presenters and panelists)	Amber Gonzalez, Charles Eaton, Susan Campbell, Theresa Ackisen, Robin Appling, Dr. Mike Maples, Yesenia Cruz, Juan Valdez, Jesse Flores, Donna Albaitero, Lisa Gonzalez, Morgan Linder, John Christensen, Sandra Quiroga, Debora Ramirez, Rick George, Ed Thornbrugh, Steve Ghiligone, Jodi Daly, Sean Domagalski, Ayesha Hague, Jennie Bryden, C. Devillenue, Shawna Banner, Penny Bell, Jaime Carson, Martha Lanman†, Barbara Mead, Bill Dunwoody, Jordyn Pedroza, Lisa Hefner, Hayley Middleton, Ashley Brighton, Morgan Linder, Michelle Sullivan, Cora Bourbon, Dana Oatis, Christina Woodbury, Kacie Dodsen, Judy Rios, Joel Chavez, Sara Clark, Kendra Palomarez, Sandra Suarez, Andy Nyberg, Christina Rodriguez, Sue Jetter, **JD Fischer, Courtney Ward, Kat Latet, Ruth Bush, Kahlie Dufresne, Megan Gillis, *Maria Paula Zapata,** Sarah Avant*, Mandee Olson*, Crystal Bagby*, Deborah Watson*, Diane Campos*, Jean Murrow*, Kelly Lanman*, Ken Dorais*, Dr. Kevin Martin*, Mary O'Brian*, Minnie Smith*, Patrick Flores*, Sue Skillman*, Joyce Newsom*, Corrie Blythe*
Staff (*: called in)	Carol Moser, Wes Luckey, Becky Kolln, Sam Werdel*, Rubén Peralta, Rachael Guess, Diane Halo, Jenna Shelton, Martin Sanchez, Lauren Johnson, Chelsea Chapman
MEETING PRESENTATIONS & REPORTS	
Welcome & Introductions (Sam Werdel, GCACH Staff)	• Sam Werdel facilitated the meeting. Carol Moser welcomed everyone and asked for introductions around the room.
Value Based Purchasing	• JD Fischer introduced his presentation titled, "Value-based purchasing and Washington provider's health plan' 2018 VBP experiences"

	• Health Care Authority is largest healthcare purchaser for over 2 million Washington residents. HCA is doing their best to leverage purchasing power to reward patient centered quality care, drive standardization where it makes sense, and reward partners for quality and value. The approach to purchasing involves transforming care on the ground in the clinic, making sure person's whole person needs are met, there is no wrong door approach to care, and better use data to make purchasing decisions and care practice transformation. By end of 2021, HCA aims to have 90% of state-financed healthcare in VBP arrangements, along with 50% of commercial market. Additionally, HCA is monitoring healthcare on a federal level and doing best to align with CMS reforms (e.g. the Quality Payment Program). The goal is to achieve the vision of a healthier Washington. By containing cost growth while improving outcomes and both consumer and provider experience. This is done through an aligned purchasing policy, whereas historically Medicaid and public employee benefits have operated in siloed environments, we are aggressively trying to align our strategic initiatives across those organizations to achieve the greatest common transformation. With regard to the roadmap, HCA is confident to meet the goal in 2018. Numbers are getting more aggressive going down the road. Confident we'll get there. Language has been aligned with a federal framework for category organization (e.g. CMS Alternative Payment Models (APM) framework). This is truly a system wide approach, it requires buy-in and participation from a variety of stakeholders. This invariably leads to needing specific role clarity. Four domains have been identified where roles are important to be clear- defining, delivering, measuring, and reinforcing VBP. • With regard to Apple Health, HCA has done a number of things to drive VBP. A withhold was implemented in 2017, where MCO's are able to earn back withhold in three different areas- general VBP adoption, hold providers accountable through incentives, and quality improvement. MCO VBP quality measures, including antidepressant medication management, prenatal and postpartum care, and substance use disorder treatment penetration. • HCA's Paying for Value Survey was provided to MCOs, commercial/Medicare Health Plan, and providers. The purpose was to track progress toward VBP goals. It was issued to all Washington State Health Plans (including five MCOs) and to provider organizations. MCO and provider surveys added regional context. Results show that VBP is accelerating. Summary findings include: o Providers' experience with VBP has been generally positive amongst those providers with some degree of VBP participation. o Most providers plan to increase VBP participation, or stay the same, and desire technical support o Lack of interoperable data systems remains the top-rated barrier • In order to facilitate acceleration, the goal would be to: o Improve timeliness and comprehensiveness of data shared to providers o Invest in inter-operability o Align quality measures and incentives o Foster collaborative and trusting relationships o Connect provider to technical support o Improve role clarity • Role clarity regarding stakeholders (ACH's, HCA, MCO's, providers).



- A question was inquired around ACH's role around was to support VBP enabling clinic transformation. Things would include helping them understand how to bill more effectively (if there are things that they are being incentivize through contracts), care coordination best practices. This stems from one on one practice coaching that is most valuable. ACH's are seen as a being a key role in connecting providers to that and potentially deploying resources through Medicaid transformation to that end.
- One of the roles of the MCO's is to provide timely and actionable data to providers. We hear a lot from provider offices that that's a gap. What is the HCA doing- or is that all coming from claims data? It's a mix. The MCO's have a big role to play there, especially when it comes to individual contracts with providers. We are trying to emphasize and build out the clinical data raspatory. For some providers there is an administrative burden with linking the EMR with the CDR. There is a lot of potential there. It's being backfilled with claims data, if its propagated in the way we that we hope. It would be filled with clinical date from EMRs. It is known that patient attribution is a big challenge. MCO's do assign apple health to providers, that doesn't dictate patient will see that provider. Curious to see how MCO's respond to primary care providers that see patients that aren't assigned to them. How often assignment roles are updated in response to that feedback, and how closely that assignment tracks with some sort of attraction model. The HCA is ring to develop a standard attribution model for the agency as another tool.

Managed Care Organizations (MCOs) Panel Discussion

- Panelists: Courtney Ward, Amerigroup; Kat Latet, Community Health Plan of Washington; Ruth Bush, Coordinated Care; Kahlie Dufresne, Megan Gillis, and Maria Paula Zapata, Molina Healthcare
- Jorge Rivera from Molina Healthcare provided information on the Molina Community Innovation Fund. This is three years' worth of $1 million worth of funding for programs that are delivered by organizations supporting integration of managed care in the state.
- Sam asked the audience to provide their own definition of Value Based Payments is. Comments included:
    - Pay for performance
    - Payment based on quality of service
    - Evidence based care connected to patients
    - Shared risk and shared reward

	• What does Practice Transformation mean to you?
	  o Technical assistance from Practice Transformation Navigators (i.e. Jenna from GCACH)
	  o Patient is really the center of care
	  o Transition from a sick care system to a healthcare system
	• Does culture play a significant role in PT? The group agreed.
	  o Trainings are done in siloes (nursing, social work).
	  o People always hear, this is how we always have done it
	• MCO's were asked what PT means to them. Key takeaways included
	  o Learning, conversations / collaboration, how to use data effectively, how to get information to places that it needs to go.
	  o There is no end point. The more we know the more we want to get better at taking care of individuals. It's about aligning our practices with evidence-based services, with what takes care of individuals.
	  o Culture shift to learning how this impacts the system
	  o Journey, not a destination. It's about being honest about where strengths and gaps are. It's about focusing on the individual and family is receiving the best care possible.
	• A surprising amount of people in the audience is not currently contracted with VBP arrangements. This speaks to the culture change that needs to happen, given these individuals may not know the organization is in a VBP arrangement.
	• How important is leadership to PT and VBP?
	  o Crucial. In terms of practice culture, culture is dependent on leadership. If leadership doesn't buy-in PT, it makes it difficult to make progress.
	• To those that have moved through this process, what have you found as helpful as leaders in moving this change forward?
	  o It's not just leadership, it's leadership with organizations that we are collaborating with. Having open communication to see how this looks like in real life (e.g. overload of information). Leadership is good at delegating information as needed.
	  o Leadership, data is an essential part of the process. It's critical that leaders know where the bulk or importance of their data lies and how to structure VBP or QI around that data. Trickle that down through staff as appropriate and make that the core focus of how you're moving quality through your organization. Data should be attributable to your specific organization.
	• MCO's acknowledged that they could improve with sharing data with BH providers. Attribution is one of the challenges. There's that natural barrier.
	• MCO's are trying to bring more actionable data, but the idea of how organizations can partner. There might be an idea of how data could be shared. How do we share data with individuals we are collectively serving?
	• Data would be in negotiating VBP contracts- it's understanding the capabilities of each entities, not just MCO's but also providers. What info can they provide- coding, supplemental data feeds- would be helpful in determining what

quality metrics could be included in future contracts. Just trying to determine member attributions and making sure MCO's have the most up do date info for provider rosters, and transparent this provider groups with which patients are assigned to them. Collaboration to identify the valuable metrics that will make it most useful.

- What would innovative contracts look like?
    - It's something proprietary, which makes it hard to share. We're always open to having one on one conversations about those. It's a fluid conversation with an open-door policy.
    - Trusted partnership and collaboration, and continuously moving to that space. There are a lot of great resources out there that have examples of contracts built nationally, which may be able to bring forward ideas.
    - Sometimes we have to take a step back to move toward innovation. This is a foundational data driven payment arrangement to get us to the point to purchase value. These are the critical steps to gather what we need.
    - Its critical for BH providers to focus on making sure we are getting encounters into the MCO's, which will be the foundation to having these conversations in the future. The PAM measure was mentioned.
- Data from different providers, in different formats, in separate portals are really challenging for staff to navigate and include in their care. One site with a database with nimble featuring tools would be ideal.
    - This is true population health; you have to have data that is manageable and centralized. The way to get there is unknown, but there is consensus that this is a critical value.
    - It's important to understand that the MCO wants this too. It's important to work with the HCA to make this happen. The HCA has the power of the purchaser, that's one of the key tenants of the PT work. With respect to managing Medicaid and employee benefits. We need the HCA to move that forward.
    - Giving MCO's feedback would encourage alignment. Some of that work is proprietary and is hard to share. What measures are other commands asking of providers in those arrangements? There might be different populations / focus, but the idea of how is data being collected and what measures are asked of you would be a beneficial discussion.
    - It's been helpful of HCA is the VBP strategy with a set of common measures that they were holding all MCO's accountable for. It created a common language that enabled alignment.
- Metrics currently being used was discussed. This included:
    - Number of intakes, transfer of care, funnels of care. For this specific organization, there are 600 plus data points tracked in EMS. There are some PT measures built in around risk stratification.
    - Penetration measures- managed care organizations have trouble getting the same rate as the HCA. It makes it more difficult to assess quality components within BH specific contracts. Feedback on the elements that are being tracked is helpful to MCO's.
- Examples of metrics for SUD clinics
    - Two large metrics are assigned by HCA- childhood assessments and QIRT (an in-depth view into a single individuals chart including how much was face to face, over the phone, scale of impact).

	○ For SUD folks who are pregnant and postpartum women. For Behavioral Health Providers and VBP, one of the key things is trust and relationships, conversations that happen frequently (bringing together different perspectives) is critical. • Remarks around using EDIE to measure frequent visits, and those who require finding a home, reuniting with family, overcoming legal issues are the list of challenges that a patient worries about before healthcare was discussed. ○ Coordinated Care did a CMS application with the HCA called integrated care for kids launch in January. It's going to measure pediatric population via access to food, truancy, etc. ○ Barriers to treatment include IV drug use and pregnancy. Looking at residential programs- diabetes, depression, and unhealthy relationships are big indicators if they will be successful in treatment.
ADJOURNMENT & MEETING SCHEDULE	
Adjournment	• Meeting adjourned by 1:30pm. • Minutes taken by Chelsea Chapman

Thank you for your time and engagement with Greater Columbia Accountable Community of Health!

The following 2019 Leadership Council Meetings will be held from 9 a.m. to 11:30 a.m.
at United Way of Benton & Franklin Counties (401 N Young St, Kennewick, WA 99336) on the following dates:

Thursday, October 17th
Thursday, November 21st