Alternative Visits, Part 1

CCI CP3 Population Health Management
Low-Intensity Track Webinar
Thursday, November 17, 2016 from 1pm-2pm
Today’s Faculty

Megan O’Brien,
Value-Based Care Program Manager,
CCI

Ned Mossman,
Program Manager,
Payment Reform and Social Determinants of Health,
OCHIN

Please remember to fill out the post webinar brief survey!!
ALTERNATIVE VISITS, PART 1

• November 17, 2016 at 1-2pm
• Topics Covered:
  – Definitions and examples of "meaningful" alternative visits
  – Why they need to be measured, EHR considerations
  – How workflows could evolve with Value-Based Care

ALTERNATIVE VISITS, PART 2

• November 30, 2016 at 11am
• Topics Covered:
  – Nuts & Bolts of Implementing Alternative Visits:
    • Telephone Visits: San Mateo Medical Center
    • Patient Portals: Shasta Health Center
    • Shared Medical Appointments: Clinica Family Health Services
• Registration Link: https://cc.readytalk.com/r/ck77pzstchnz&eom
Office Hours

Virtual office hours via phone or a web-based service are opportunities to dive deeper and ask questions of presenters.

Email Megan (mobrien@careinnovations.org) and include the following:

1. which faculty you are interested in;
2. scope of your questions;
3. 30 or 60 minutes;
4. if you are interested in other organizations joining in, or want individualized time.

I will work with you on scheduling office hours.
Who’s Registered?

Comprehensive Track
1. CommuniCare Health Centers
2. LifeLong Medical Care
3. Monterey County Clinics
4. OLE Health
5. San Mateo Medical Center
6. Tiburcio Vasquez Health Center, Inc.
7. Venice Family Clinic
8. Vista Community Clinic
9. Ravenswood

Low-Intensity Track & Others
1. Altamed
2. Asian Health Services
3. Community Medical Centers, Inc.
4. Community Health Partnership
5. Frank Kiang Medical Center
6. Golden Valley Health Centers
7. Indian Health Services of Santa Clara Valley
8. La Clinica de La Raza
9. Neighborhood Healthcare
10. Northeast Valley Health Corp
11. San Joaquin General Hospital
12. Serve the People
13. Winters Healthcare Foundation
Alternative Encounters
Part 1

Ned A. Mossman, MPH
Program Manager
Alternative Payment Methodologies and Social Determinants of Health
Questions about Alternative Encounters

• What does “ideal” CHC transformation look like?

• What activities are being incentivized?

• How do we measure and provide accountability for them?
Future-Oriented Health Center Characteristics (1/2)

• Integrated care (Primary, Behavioral, Dental)

• Medical Home at the center of a medical neighborhood
  – Care coordination across different medical settings and systems
  – Centralized patient record
  – Referrals to community resources

• Changing staff roles and ratios
  – Position staff to work at the top of their license

• Engage new types of staff
  – Care Managers, Community Health Workers, Clinical Pharmacists, Social Workers
Future-Oriented Health Center Characteristics (2/2)

- Focus on population health management
  - Patient -> panel -> population
  - Panel management and outreach

- Patient-focused
  - Focus on increased patient access and experience
  - Patients and providers engaged in co-production of care
What types of data tell this “ideal CHC” story?

The old standbys:

• Clinical Quality Measures
  – UDS, CMS, MU, ACO, HEDIS, NQF

• Cost data
  – Utilization
  – Total cost of care

These will not be enough to support the real aims of Alternative Payment and Value-Based Care
“Touch” Basics: Patient-Centered Measures of Access
Alternative Encounters

• A.K.A., Alternative Touches, Enabling Services, etc.

• Examples:
  – Telephone encounter
  – Portal encounters
  – Home care encounters
  – Case management
  – Care coordination activities
  – Warm hand-offs
  – Panel management outreach

  – Group education or exercise classes
  – Support groups
  – Health education counseling
  – Transportation assistance
  – Assistance accessing community resources/services
  – Screening questionnaire administered
Alternative Encounters - Defined

- Traditionally non-billable (or non-reimbursed) activities that drive transformation of the delivery model, and improve patient health outcomes and quality of life.
Why is Alternative Encounter data important to collect?

• Demonstrate that as traditional office visits go down, other services are being offered in their place

• Track staff and resource use as care model shifts

• Measure the success of your innovation efforts

• *Document work that Community Health Centers have already been doing*
Which alternative encounters should we provide?

• Needs assessment
  – Start with 3 questions:
    • What are the needs in our patient population?
    • What alternative services are we already providing?
    • What are the highest-leverage activities?

• Assess in entire population

• Define subpopulations – Segmentation
  – Start small, test, iterate, and scale
Segmenting Patient Populations

Direct resources to targeted, high-leverage activities in patient subpopulations

Illustration Courtesy of Oregon Primary Care Association
Roadmap for Supporting Alternative Encounters (p2)

• Design delivery processes based on needs assessment
  – Identify appropriate staff to carry out alternative encounters
  – Identify any additional resources needed

• Design and re-design workflows to integrate alternative encounter activities
  – Model new activities on successes
  – Pull existing activities into process

• Emphasize data entry portion of workflow
  – Pay attention to which staff/roles do the data entry
    • Same as those performing services?
    • Test different approaches
  – Consider how the EHR can be leveraged
  – What do we need to capture and report?
Data Collection and Reporting
What activities will we need to collect for the pilot?

• This is still being decided

• For now, you can prioritize based on the following:
  – Focus first on services that are providing greatest value to your patients or addressing areas of greatest need
  – Decide how granular you need to be (vs. effort required to capture)
  – Determine if you want to include services that are considered part of your bundled PPS rate

• Bigger vs. smaller lists of AE types both have challenges
  – In our experience, less is more
Challenges for collecting and tracking AEs in the EHR

• EHR vendor support is mixed at best

• Difficult to assess EHR needs before final process/list is released

• Procedure codes (CPT/HCPCs) exist for many services, but are not standardized (see list later in presentation)
  – State/plans have indicated a strong preference for CPTs for all alternative encounters

• You can code as with other encounters/procedures, but be aware:
  – Existing codes may be too broad
  – May want to collect more information
EHR Considerations and Advice

• Start working with vendors now to ensure you give them enough time.

• Focus your ask, but be prepared to adapt based on cost and technical realities

• Focus on what you do know from needs assessment: what would workflows look like, who will be tracking, entering data, etc.

• Data entry burden: what has to be manually entered, and how much can be automated?
What should we ask from our EHR vendor?

• If possible, a separate tracking area in the EHR is recommended with the following information:
  – Alternative encounter type provided
  – Staff member (or role) who provided the service
  – Amount of time spent

• Customizable list of alternative encounter types

• Auto-population from certain activities
## Example EHR AE Data Entry Section

<table>
<thead>
<tr>
<th>Alt Encounter Type</th>
<th>Code(s)</th>
<th>Date/Time</th>
<th>Duration (m)</th>
<th>Staff</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education/ Supportive Counseling</td>
<td>G0437</td>
<td>10/2/2016 08:30</td>
<td>20</td>
<td>Alison Smith, LCSW</td>
<td>Discussed need to quit smoking</td>
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<tr>
<td>Patient Portal Encounter</td>
<td>98969</td>
<td>10/16/2016 17:46</td>
<td>13</td>
<td>John Doe</td>
<td>[Auto-entered 16OCT2016]</td>
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<tr>
<td>Care Management</td>
<td>T2022</td>
<td>10/30/2016 12:00</td>
<td>30</td>
<td>Lisa Johnson, CCHW</td>
<td>Case mgmt discussion</td>
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<tr>
<td>Home Services Encounter</td>
<td>S0274</td>
<td>10/31/2016 10:30</td>
<td>60</td>
<td>Mina Jones, NP</td>
<td></td>
</tr>
</tbody>
</table>
What else should we ask from our EHR vendor?

• Reporting: *flexible* reporting – configurable to final requirements, and also ongoing changes

• Find out if others using the same EHR are in the pilot, or are interested in AE
  – Split development/customization costs
  – Share testing responsibilities
  – Share and learn from others’ experiences
Other Advice

• Be flexible – things will change

• Keep in mind that this is a pilot program

• Use as an opportunity to innovate, and to capture previous innovation

• Take advantage of the feedback processes
  – Document your experience – good and bad
  – Make your Center’s voice heard
  – Focus on patient experience
  – Focus on staff experience
Potential Alternative Encounters Categories and Types for the Pilot Program
<table>
<thead>
<tr>
<th>Super-Category</th>
<th>Category</th>
<th>Alternative Encounter Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative Therapies</td>
<td>Acupuncture</td>
<td>Integrative Medical Therapies</td>
</tr>
<tr>
<td></td>
<td>Osteo/Chiro</td>
<td>Integrative Medical Therapies</td>
</tr>
<tr>
<td></td>
<td>PT/OT</td>
<td>Integrative Medical Therapies</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Behavioral Health</td>
<td>Marriage and Family Therapy</td>
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<tr>
<td></td>
<td>Substance Use</td>
<td>Substance Use Counselor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Education/Supportive Counseling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Care Mgt/Coordination</td>
<td>Care Coordination</td>
<td>Care Coordination</td>
</tr>
<tr>
<td></td>
<td>Care Management</td>
<td>Case Management</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>Case Management (Medical Team Conference)</td>
</tr>
<tr>
<td></td>
<td>Population Health Management</td>
<td>Population Health Management</td>
</tr>
</tbody>
</table>
## Alternative Encounter Details – From Latest Feedback Request (p2)

<table>
<thead>
<tr>
<th>Super-Category</th>
<th>Category</th>
<th>Alternative Encounter Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td>Education</td>
<td>Health Coach</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Education/Supportive Counseling</td>
</tr>
<tr>
<td></td>
<td>Education: CKD</td>
<td>Health Education/Supportive Counseling</td>
</tr>
<tr>
<td></td>
<td>Education: Prenatal/Postnatal</td>
<td>Health Education/Supportive Counseling</td>
</tr>
<tr>
<td></td>
<td>Group</td>
<td>Group Medical Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group Medical Visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Population Health Management</td>
</tr>
<tr>
<td><strong>Enabling/SDOH</strong></td>
<td>Enabling</td>
<td>Eligibility Assistance/Financial Counseling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interpretation</td>
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<tr>
<td></td>
<td>SDOH</td>
<td>Outreach</td>
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<tr>
<td></td>
<td>Transportation</td>
<td>Transportation</td>
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<tr>
<td><strong>Home</strong></td>
<td>Home Services</td>
<td>Home Nursing Visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home Services</td>
</tr>
<tr>
<td></td>
<td>Home Services: Pre/Postnatal</td>
<td>Home Services</td>
</tr>
<tr>
<td><strong>Medication</strong></td>
<td>Medication Management</td>
<td>Case Management (Medication Management</td>
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<tr>
<td></td>
<td></td>
<td>Health Education/Supportive Counseling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication Management</td>
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<tr>
<td></td>
<td></td>
<td>PharmD Visit</td>
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<td></td>
<td></td>
<td>PharmD/Clincial Pharmacist</td>
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## Alternative Encounter Details – From Latest Feedback Request (p3)

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<th>Super-Category</th>
<th>Category</th>
<th>Alternative Encounter Type</th>
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</thead>
<tbody>
<tr>
<td><strong>Pain</strong></td>
<td>Home Services: Pain</td>
<td>Pain Management</td>
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<tr>
<td></td>
<td>Pain Management</td>
<td>Pain Management</td>
</tr>
<tr>
<td><strong>Palliative/Hospice</strong></td>
<td>Palliative Care</td>
<td>Palliative Care</td>
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<tr>
<td><strong>PC - Prevention</strong></td>
<td>Preventive</td>
<td>Community Services, Wellness</td>
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<tr>
<td><strong>PC/BH</strong></td>
<td>PC/BH</td>
<td>Health Education/Supportive Counseling, Integrated Primary/BH Visits, Mobile Clinic, Office Visit</td>
</tr>
<tr>
<td><strong>Virtual</strong></td>
<td>Email</td>
<td>Email Encounter</td>
</tr>
<tr>
<td></td>
<td>Phone</td>
<td>Monitoring, Phone Encounter, Telephone Services</td>
</tr>
<tr>
<td></td>
<td>Telehealth</td>
<td>Telehealth (patient - provider) - real time, Telehealth eConsult/eRefferal, Telehealth Store and Forward</td>
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<td></td>
<td>Text</td>
<td>Texting</td>
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<tr>
<td></td>
<td>Virtual: Provider-to-Provider</td>
<td>Provider to Provider</td>
</tr>
<tr>
<td><strong>Wellness</strong></td>
<td>Exercise</td>
<td>Exercise</td>
</tr>
<tr>
<td></td>
<td>Nutrition</td>
<td>Integrative Medical Therapies, Nutrition, Nutrition Education</td>
</tr>
</tbody>
</table>
Resource for Enabling Services

AAPCHO Enabling Services Data Collection Implementation Companion

http://www.aapcho.org/projects/enabling-services-accountability-project/
Questions?

Remember, press *7 on your phone to unmute yourself. Press *6 to mute yourself.
CONTACT INFORMATION

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• OCHIN
  • Ned Mossman: mossman@ochin.org

THANK YOU!

Please remember to fill out the post swap-meet brief survey!!