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Moving Toward Value-Based Care:

Lessons Learned from CCI's CP3 Population Health Program

blue of california foundation

California Health Care Foundation

June 27, 2017

Webinar Reminders

1. Everyone is muted.
   - Press *7 to **unmute** and *6 to **mute** yourself.

2. Remember to chat in questions!

3. Webinar is being recorded and will be posted and sent out via email

Today's Focus

11:00am-11:05	**Welcome and Overview (5 mins)**
11:05-11:15	CP3 Pop Health Program: Where We've Been (10 mins) *Megan O'Brien, Value-Based Care Program Manager, CCI*
11:15 – 11:45	Lessons learned from 3 organizations that participated in the CP3 Pop Health Program (30 minutes) • San Mateo Medical Center • Tiburcio Vasquez Health Center • LifeLong Medical Care
11:45-12:00pm	Questions, Next Steps & Closing (15 mins)

CCI Program Team

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Today's Presenters

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Caleb Sandford, MBA
Chief Operations Officer
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Renata Fineberg
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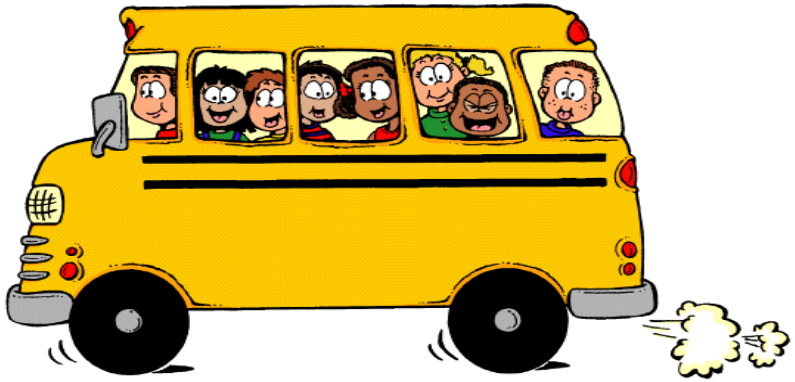
Low-Intensity Track: 4 Part Data for Pop. Health Series

Part 1: Building a Data-Driven Culture for Pop. Health Management	• **July 19, 2017 @12-1pm** • *Faculty:* SA Kushinka, CCI & Jerry Lassa, Data Matt3rs
Part 2: Design Thinking for Data Visualization	• **July 27, 2017 @ 12-1pm** • *Faculty:* Andrew Frueh, Health Catalyst
Part 3: Tableau in Action	• **August 10, 2017 @ 2-3pm** • *Faculty:* Dr. Jason Cunningham, West County Health Centers
Part 4: From Data to Action: Key Steps and Strategies for Using Data to Improve Care	• **August 17, 2017 @ 12-1pm** • *Faculty*: Boris Kalikstein, Pivotal Moment Consulting

Low-Intensity Track: Site Visits & In-Person Workshop



Site Visits

- West County Health Center: TDB
- Petaluma Health Center: Sept. 19

Stay tuned for information to apply!

In-Person Workshop

- Focused on Patient Communication
  - September 7, 2017
  - Held in Oakland or Berkeley
- Details to register will be sent out

Megan O'Brien,
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CP3 Pop. Health Program Activities & Impact


Care Delivery Transformation

Program Aim

By **April 2017**, all nine federally qualified health centers will test and measure care delivery changes in at least one of the following modules:

(1) team-based care,
(2) population health management, and/or
(3) planned care,

to support the delivery of high value care in a capitated payment environment.

Wins!

Stronger care teams & culture of pop. health; chart scrubbing tool, daily huddles, more robust empanelment
MONTERREY

Stronger improved data reports for planned care & outreach; redesigned MA scheduling; improved provider continuity
TIBURCIO VASQUEZ

Spread care team model & improved in-reach & outreach processes to improve preventative care services
SAN MATEO

Focus on shared understanding of transformation work; experimented with care team changes and alternative touches (telephone visit pilot)
VENICE

Clarified roles and responsibilities of the care team & supported team with panel data & dashboards
RAVENSWOOD

Stronger foundation, experimented with care team changes & expanded roles, RN flip visits
COMMUNICARE

Expansion of MAs' roles, testing staff ratios, created practice transformation "logo", created panel & new member access workgroups
LIFELONG

Hired pop. health manager & redefined role of care coordinator, stronger staff buy-in
VISTA

Defined the role of the Care Coordinator; implemented tracking referrals system
OLE HEALTH

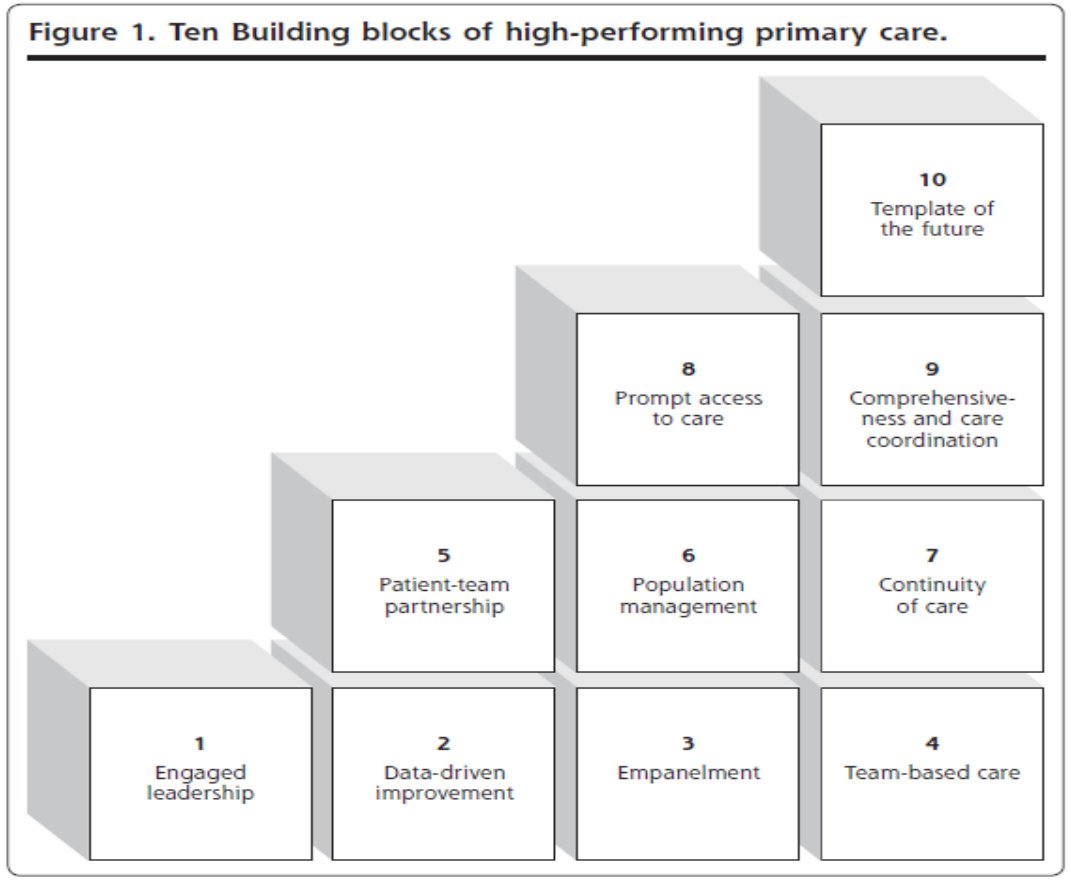
Key Learnings

1. **Communication and alignment** takes time; it was hard for teams to integrate CP3 into other care transformation initiatives and to get people on board quickly
2. 10 Building Blocks of Primary Care were foundational elements, but teams need **additional elements** to succeed in a value-based care environment
3. Teams spent time in the program making changes to their **team-based care models**, learning to use **data** for planned care, and testing out **alternative touches**
4. **In-person and site visits** were key to inspiring and sparking learning
5. Biggest gap was the **lack of a model to show the financial and productivity impacts** in an APM model, but great work still occurred without payment model in place

1. Communication/Integration

2. High Value Care– What's Needed?

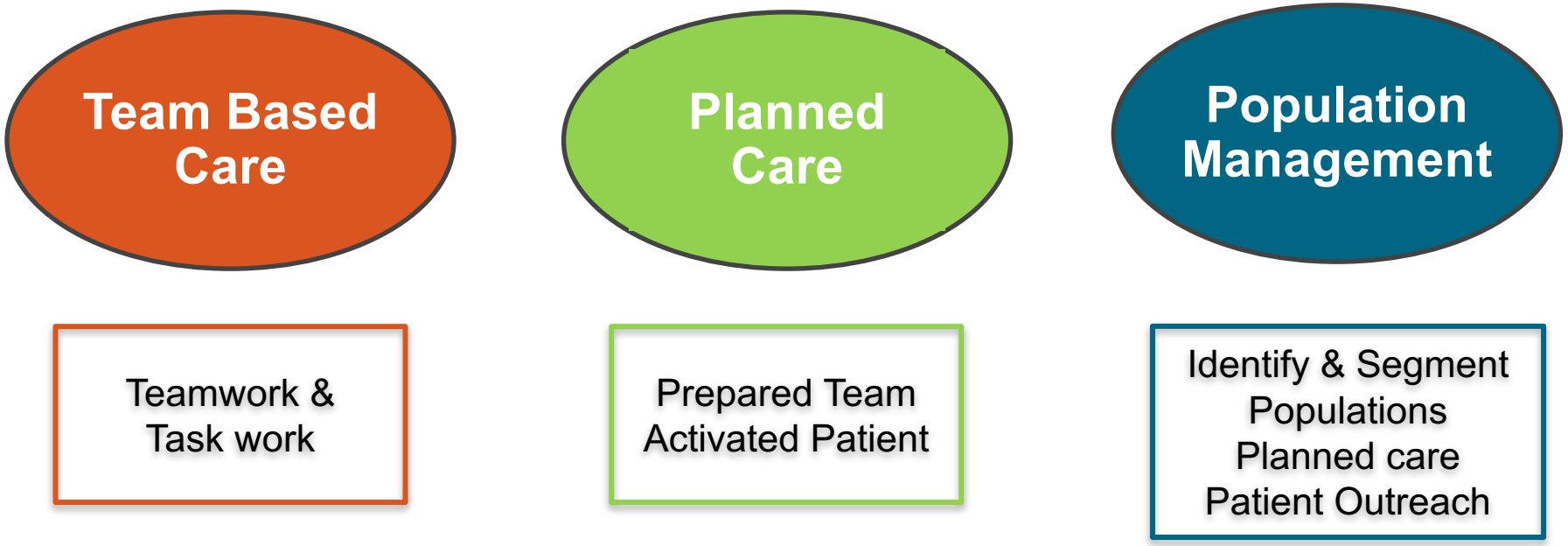
Practice level changes



Org-wide infrastructure changes to become a Learning Organization

- **Engaged leadership at all levels**
  - Clear vision, and goals
  - Adaptive leadership style
- **Robust data systems, measurement and reporting**
  - Financial/operational analytics
  - Clinical informatics
  - Performance monitoring
- **Training and knowledge management**
  - Institutes, programs
- **Continuous improvement**
  - Improvement methodology
  - Clear plan for spread and scale
  - Change Management

3. Comprehensive Track Areas of Focus



Adaptive leadership **Data systems** **Training & Knowledge Management** **Continuous improvement**

4. CCI Program TA Support: May 2016 – April 2017

Core Activities

- **Pre-work virtual meeting-** identify opportunities for improvement, set aims (May)
- **In-person learning sessions** focused on preparing orgs. for change, team-based care, planned care, population health management (July, Sept, Dec, March)
- **Coaching Calls** (monthly, 2hr min, max 6hrs/org)
- **Swap meets** virtual peer sharing/learning (when assigned presenter/reactor)

Optional

- **Faculty Office Hours**
- **Site visits**
- **Technical webinars** focused on timely content, spread and sustainability

5. What's Next?

- To move from prototyping and piloting to implementation and spread, **a new payment model is critical**
- APM sites were nervous to start implementing alternative visits, adding non-billable providers, and investing in IT systems, data reporting and analytics, without a way to financially "model" the changes absent a new payment model in place
- HOWEVER, still a lot of great work that can be done without a new payment model, including:
  - Strengthening team-based care model
  - Task work & teamwork
  - Building blocks of primary care
  - Changing mindset (thinking differently to do pop. health)

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Operations Strategist
San Mateo Medical Center

San Mateo Medical Center
A County System of Healthcare

CHANGES

1. **Continued definition and implementation of care team roles and responsibilities**
   - Expanded alternative touches: Telephone Visits, Health Coach Visits
   - Enhanced in-reach processes to increase Colorectal Cancer Screening
2. **Utilized change management techniques to spread culture change among clinic leaders**
3. **Organized a strategy around PCMH Transformation**

San Mateo Medical Center
Patient-Centered Medical Home

IMPACT

Patient Experience:

- ***Pt Feedback from Telephone Visits:*** *Saves time, Feeling that provider is paying more attention to their needs, Thankful that providers are available in this way, Appreciate not having to come into the clinic*

Patient Outcomes:

- **Colorectal Cancer Screening In-reach Pilot (Mar – Jun 2017):** 195/405 (~50%) CRC screening kits returned

Staff Experience:

- **How do you feel about Care Teams?**

"Care teams have impacted ICC in a positive way. We know who are team members are and who to turn to. Care teams have helped with our workload and we've noticed the number of TE's for nurses have been decreasing."

- **What do you like most about Care Teams?**

"The teams themselves! You sit next to your team members and become more familiar with your provider and everyone else you work closely with**".** ***--MSA, Innovative Care Clinic***

CHALLENGES

- *What is one big challenge you faced?*

It seemed like every other week, we would vent to Wendy (our coach) about the newest fire that we needed to put out – whether it be more issues with spread, an evaluation that we needed by yesterday, or our complete disbelief as to why people are still asking what "PCMH" stands for.

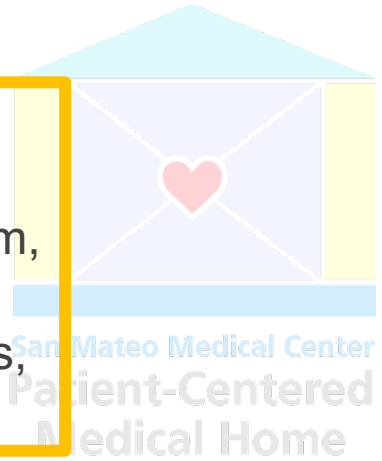
- *What steps have you taken or taking to manage that challenge?*

Divided work into focus areas:

1. NCQA Accreditation
2. Spread and Sustainability of Care Model
3. Communication
4. Evaluation
5. Connection with Other Strategic Initiatives

Each focus area has:

- A lead and support team
- A project charter outlining Aim, Scope, Expected Outcomes/Measurable Goals, and Anticipated Milestones



RECOMMENDATIONS

In order to facilitate organizational culture change, clear communication is essential. *(Don't forget the WIIFM!)*

San Mateo Medical Center
Patient-Centered Medical Home

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Caleb Sandford, MBA
Chief Operations Officer
Tiburcio Vasquez Health Center

Tiburcio Vasquez Health Center Inc.

CHANGES

What are three big changes you made in the CP3 program that you are most proud of?

1. Empanelment – The same provider every visit
    1. Assigned 25,000 patients to a PCP
    2. Currently have 85% of all scheduled visits being seen by the PCP
2. Care Teamlets – Every day, no matter what
    1. Assigned all MAs to Providers.
    2. Ensure that MA/Provider teamlets work together every day
    3. Pre-Visit Planning to check for needed services (Vaccines, Screenings, Etc)
3. Population Health – Integrating everyone under the same roof
    1. Added Integrated Behavioral Health to each of our main sites
    2. Added CPSP to each of our main sites
    3. Created electronic internal referral process to better enable transitions from Medical

IMPACT

What impact have the changes had on patient outcomes, patient experience, and staff experience?

- Patient Satisfaction
  - Patients now get to see the same Provider/MA care team every visit
  - Scored over 90% on Overall Satisfaction on most recent patient satisfaction survey
- Patient Outcomes
  - 2016 HEDIS Scores: 7 out of 8 key metrics higher than 2015
- Staff Experience
  - Providers love seeing their own patients. Less time having to review charts.
  - MAs appreciate being part of a team, and working with the same provider every day

CHALLENGES

- *What is one big challenge you faced? What steps have you taken or taking to manage that challenge?*

- Healthcare Politics – High degree of uncertainty regarding future of Medicaid
  - Focus on changes that make sense for the organization now and in an APM world (or an uninsured world)
  - Focus on changes that don't cost a lot of money

RECOMMENDATIONS

*What is **one thing** that you would recommend others do in preparation for the APM?*

- Focus on changes that bring meaningful value to YOUR patients
  - Don’t break the bank implementing something just because other organizations have done it
  - Think about a few things that would drive significant value for your patients (your patients are different than my patients), and then implement in a way that doesn’t negatively impact your profit margin.

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LifeLong Medical Care
Health Services For All Ages
a california health center

CHANGES

- *What are three big changes you made in the CP3 program that you are most proud of?*

1. Developed a shared vision of the care team model and took active steps to advance it.
2. Developed project plan to identify, plan for, and build support and buy-in for projects that stemmed from that shared vision.
3. Creation of Manager of Nursing Development role for oversight and clinical management of MAs and RNs.
4. Culture shift towards becoming more inclusive in change processes.

IMPACT

- *What impact have the changes had on patient outcomes, patient experience, and staff experience?*

Staff experience

- Broad engagement in change process
- Providers gaining understanding of practice transformation outside of APM and are excited!
- MA turnover reduced from 40% in 2016 to 5% YTD 2017
- Increase in standard practices across the organization

Patient Outcomes/Experience

- Expect better patient-provider continuity through improvement empanelment processes
- Expect better access, including expanded access to non-provider care team members
- More preventive outreach with better tools
- Patients feel effect of pilot tests happening across clinics

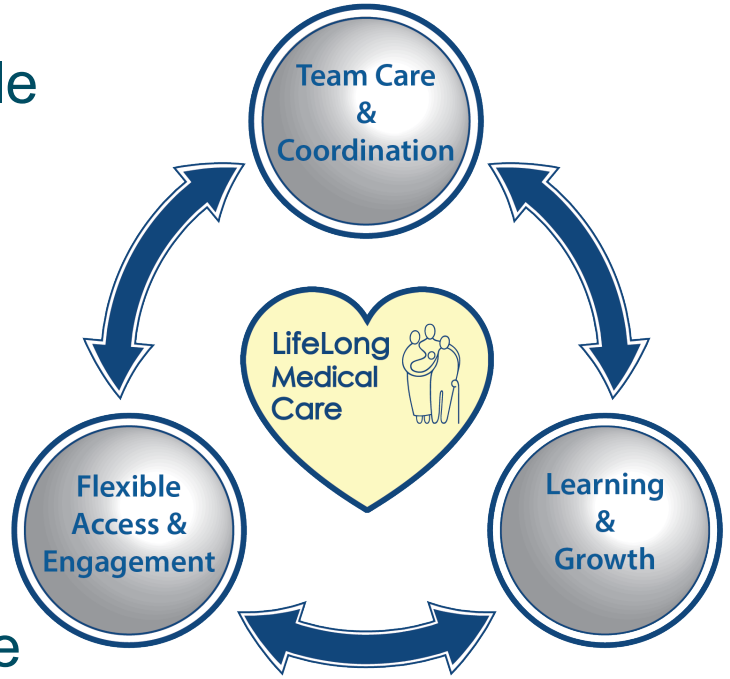
CHALLENGES

- *What is one big challenge you faced? What steps have you taken or taking to manage that challenge?*

Communication! Knowing how to communicate to the whole LifeLong community & de-linking from APM.

Steps to address:

- Created logo to help communicate aims and to help with branding
- Session at provider dinner to engage with providers
- Cross site leadership meetings
- CP3 steering committee changing to be more inclusive of non-APM sites and will continue to meet



RECOMMENDATIONS

- *What is **one thing** that you would recommend others do in preparation for the APM?*

Engage in Human Centered Design Thinking to drive your transformation work
…join the CCI Catalyst Program!

Q & A

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

Reminders: Upcoming Events

Event	Date
Data Webinar Series, Part 1: Building a Data-Driven Culture for Pop. Health Management	July 19, 2017
Data Webinar Series, Part 2: Design Thinking for Data Visualization	July 27, 2017
Data Webinar Series, Part 3: Tableau in Action	August 10, 2017
Data Webinar Series, Part 4: From Data to Action: Key Steps and Strategies for Using Data to Improve Care	August 17, 2017
Site Visits • Petaluma Health Center • West County Health Center	 Sept. 19, 2017 TBD
Patient Communication In-Person Workshop (East Bay, CA)	Sept. 7, 2017

CONTACT INFORMATION

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THANK YOU!