Partnerships with Our Payors – An Evolution

October 16, 2018

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Coordinated Care Organizations (CCO)

A network of care providers who work together in local communities to serve people who receive Medicaid.

- Medicaid waiver from CMS 6 years ago
- Reduce trend to 3.4% (national avg. 5.6%)
- Community governed

Three CCO's in Jackson County

- Patient Centered Primary Care payment models - 17 health outcome measures
- Behavioral Health Enhanced payment models

Alternative Payment and Care Model (APCM)

Developed with the goal to align payment with the efficient, effective and emerging care models that achieve the quadruple aim in Oregon Health Centers.

Quality
Access
Cost
Population Management

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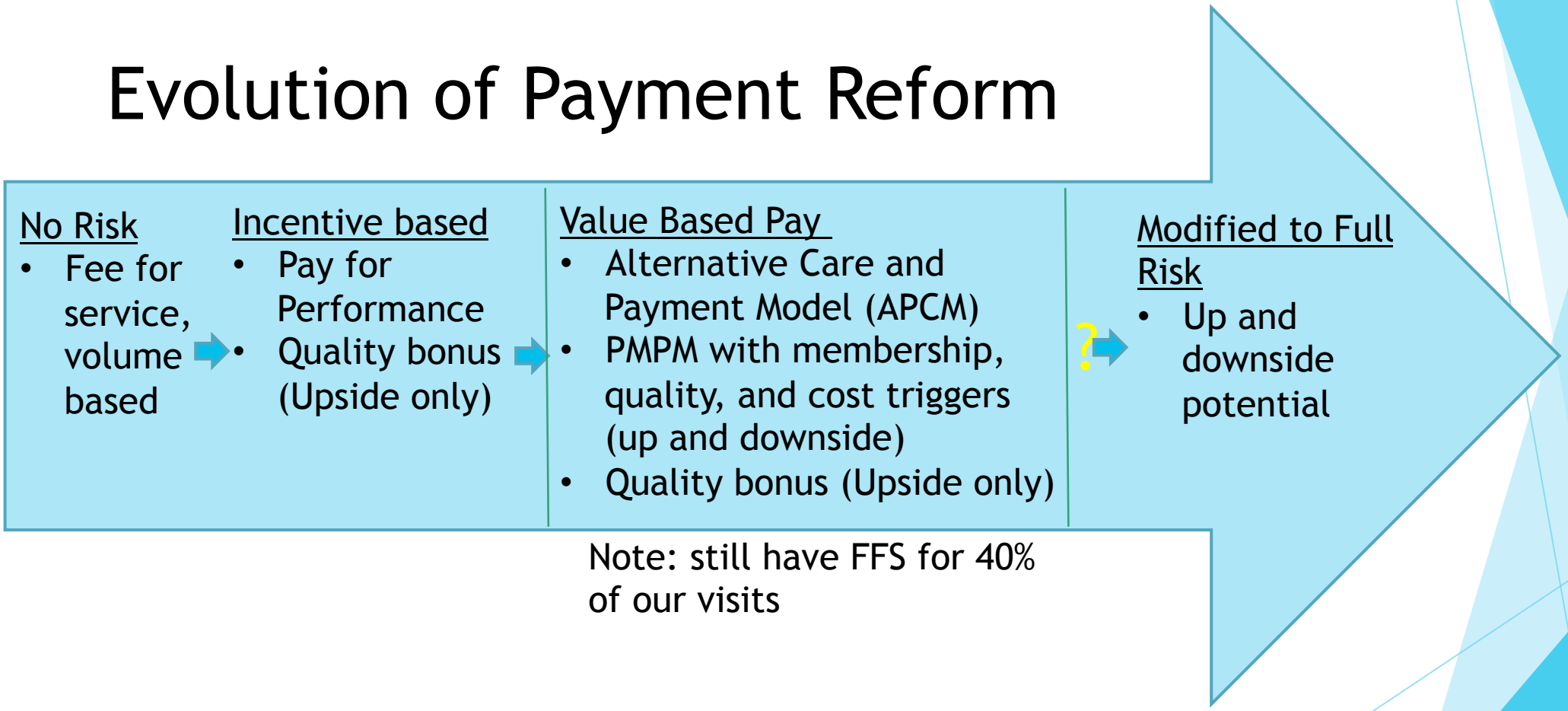
Evolution of Payment Reform



Note: still have FFS for 40% of our visits

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NAHC Payment Reform Readiness Assessment

- **Organizational Management**
- **Change management** and **service delivery** transformation with the ability to make **robust use of data and information**
- **Financial and operational analysis**

http://www.nachc.org/wp-content/uploads/2015/11/NACHC_PR_ReadinessAssessmentTool_Final_CORRECTED_8.5.2014-2.pdf

http://www.nachc.org/wp-content/uploads/2017/08/Oregon-FQHC-APM-December-2017.pdf

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Partnering with Coordinated Care Organizations: Population Management

Panel Coordinator Funded by CCO and stationed at Primary Care Clinic

Goals:

- 35-40 outreach calls daily
- 35-40 Charts scrubbed daily
- 75-member touches daily (calls, letters, scrubbing)
- 100-metric specific appointments per month

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Moving Forward

Successes:

- Increase in number of screening standing orders/clinical protocols
- Creation of in-reach and outreach standard work for quality metrics
- Increased patient awareness and engagement regarding preventive services

Challenges:

- Mitigating duplication of work between internal staff and CCO staff
- Closed loop corrections between payor audits and internal system
- Dual data entry for partnership staff

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Partnering with Coordinated Care Organizations: Cost Reduction Methods

Intention:

- To provide centers of excellence within primary care to serve the patients that need us the most and decrease cost of care.

Action:

- Assess and identify patient referral population and impact on cost of care through creating a model that can be replicated.

Deliverables:

- Focus on Rheumatology and Hepatitis C.
- Upskill providers, provide services within primary care, decrease referrals and/or wait times, decrease cost of care.

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Example: Hepatitis C Treatment in Primary Care

Hepatitis C May 2016- April 2017	Baseline	Outcome	Comments
Patients	0	17	Assessed and treated in primary care.
Adherence	0	100%	
Referral to Pre- Authorization	52 days	1-2 days	Enhanced partnerships and communication with payor and specialist,

Pre-Treatment Cost/Patient	Treatment Cost/Patient	Post Treatment Cost/ Paitient	Comments
$28,672	$61,157	$10,468	Claims based 97% treatment cost = meds
Adherence	0	100%	Success related to provision of nursing case management and behavioral health support in primary care
Referral to Pre-Authorization	52 days	1-2 days	

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What did we learn??

- Community Health Center teams meet the needs of complex patients.
- Challenges accessing objective outcome data specific to cost of care.
- Upskilling primary care providers decrease referrals and long waits.
- Partnerships (CCO) provided additional innovation funding and data support.
- Local specialist provided training and phone consultation.
- Chronic disease outcomes improved with the treatment of Hepatitis C.

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Questions?

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Ida Saito, Chief Operations Officer
isaito@laclinicahealth.org

Alexandra Salazar, Practice Manager
asalazar@laclinicahealth.org

Traci Fossen, Chief Quality Officer
tfossen@laclinicahealth.org

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