Reflections and Looking Ahead
Value Based Payment and Population Health

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Chief Clinical Officer
Cherokee Health Systems

Population Health Learning Network Convening #3
Center for Care Innovations
Oakland, CA
Dec 5, 2019
Good Morning!

Happy to be back in California!
The View on VBP

Current State
Key Elements
Getting Ready
Current State:

**VBP Models**

- Pay for Performance
- Bundled Payments
- Primary Care Services Payment
- Shared Savings
- Shared Risk
- OTHER MISC
A 50-State Review of Value-Based Care and Payment Innovation

Commissioned by Change Healthcare

StateVBRstudy.com

- 40 states have implemented VBP for 2 years or longer
- 8 are in early stages
- 4 have little to no VBP
- 50% are multi-payor in scope
- 23 states have VBP targets
- 22 states have or planning ACOs
- 16 states have or planning EOCs
Current State: VBP

- F4S Linked to Quality and Value
- APM built on F4S Architecture
- Population Based Payment
Current State: The Need for Speed (?)  
*Hurry Up and Wait!*

1. Population Based Payment
2. APM built on F4S Architecture
3. F4S Linked to Quality and Value

VBP

Primary Behavioral Health Integrated Care Training Academy
Current State: VBP
WE'RE USED TO BEING THE UNDERDOG. I'M OK WITH THIS.

Nate Johnson

KEEP CALM AND EMBRACE THE MESS

Primary Behavioral Health INTEGRATED CARE Training Academy
## Innovative Practices: Key Elements

<table>
<thead>
<tr>
<th>Social and Community Factors</th>
<th>Collaboration &amp; Partnerships</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Transportation</td>
<td>• Team Based Care</td>
<td>• Transparency</td>
</tr>
<tr>
<td>• Food Security</td>
<td>• Expanded Workforce</td>
<td>• Interoperability</td>
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<tr>
<td>• Housing</td>
<td>• Payors</td>
<td>• Sharing</td>
</tr>
<tr>
<td>• Safety</td>
<td>• Patients</td>
<td>• Analytics</td>
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<tr>
<td>• Environmental Toxins</td>
<td>• Community Based Organizations</td>
<td></td>
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<tr>
<td>• Adverse Experiences</td>
<td>• Businesses</td>
<td></td>
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<td></td>
<td>• Schools</td>
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<td></td>
<td>• Law Enforcement</td>
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</tbody>
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**DATA**

- Transparency
- Interoperability
- Sharing
- Analytics
Food as Medicine

Why Food Could Be the Best Medicine of All

By Alice Park | Photographs by Zachary Zavislak for

February 21, 2019

Why doctors are writing prescriptions for food

Evidence suggests that healthy diets may be effective in helping chronic diseases such as type 2 diabetes, heart disease, and hyper

Food Is Medicine: Providing Medically Tailored Meals to Community Members with Disease-associated Nutritional Risk Supports Stable BMI and Decreased Hospitalization (PII-005-19)

Jule Anne Henstenburg, Claudia Parvanta, Laura Pontiggia, Sue Daugherty, Nicole Laverty
Collaboration & Partnerships

Ride to Health

We have partnered with Oceana County Council on Aging to assist households overcome transportation barriers to healthcare services. Eligible households can receive transportation vouchers for physical and mental health appointments.

Eligibility criteria:
- Oceana County resident
- Household has 1 or fewer vehicles
- Income below 50% of the Area Median Income
- Healthcare services must be located within Oceana County

Applications for Ride to Health can be requested in our office at 101 E. Washington St. in Rock or by calling toll-free 888-757-5429.

TRENDS IN PAYER-PROVIDER PARTNERSHIPS

- Overall number of product partnerships launched per year
- Partnered product launches by state
- Joint venture or co-branded products as % of total
- Communication of value-based compensation in product announcements
- Partnerships by exchange

Primary Behavioral Health
INTEGRATED CARE
Training Academy
Data Data Data Data
MOM!
WE'RE PLAYING HOSPITAL C.F.O. AND TIMMY SAYS HIS ANALYTICS ARE BETTER THAN MINE!
Getting Ready: Data

Descriptive
- Information
- Knowledge

Prediction
- Insight
- Action

High Need?
Vulnerable?
Medically Complex?

Tailored (e.g. precision medicine) strategy for complexity

# of patients with chronic health problems

Prescriptive
- Wisdom
- Optimization

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Getting Ready: Data Infrastructure

- Accurate
- Precise
- Accessible
- Actionable
## Getting Ready: Big Data to Actionable Data

**Amerigroup Quality Measures - Summary by Region**

### CHC Needs Assessment & Intervention Guidance

<table>
<thead>
<tr>
<th>CHC Needs</th>
<th>Intervention Guidance</th>
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<tbody>
<tr>
<td>Patient has Chronic Condition</td>
<td>• Does the patient see specialists outside CHS?</td>
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<tr>
<td></td>
<td>• If so, request ROI for each specialist, review upcoming apts, problem-solve and address barriers to attendance.</td>
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<tr>
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<td>• Ask the patient, “How often do you miss your medications?”</td>
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<td>• Problem-solve and address barriers to medication adherence (e.g., can the not afford medication, don’t understand how to take medication, don’t remember to take medication).</td>
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<td></td>
<td>• Encourage healthy diet, activity, and smoking cessation.</td>
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<td>Patient has had no PCP Visit in &gt; 6 months</td>
<td>• Who is patient’s assigned PCP?</td>
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<td>• If patient is assigned to an outside (non-CHS) PCP, does the patient want to become a CHS primary care patient?</td>
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<tr>
<td></td>
<td>• If so, add patient to a list of patients needing CHS PCP visits.</td>
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<tr>
<td></td>
<td>• If patient desires to keep an outside PCP, assist patient in scheduling a visit and problem-solving barriers to attendance.</td>
</tr>
</tbody>
</table>
Common Theme in Evidence
Healthcare is about RELATIONSHIPS
RELATIONSHIPS IN THE ORGANIZATION

Clinical

IT

Finance

Operations
RELATIONSHIPS WITH ‘NEIGHBORS’

- CBOs
- PAYORS
- SCHOOLS
- ACADEMIC
- GOVERNMENT
Building the Foundation: PHLN Domains

- Learning Organization
- Team Based Care
- Planned Care/In-Reach
- Proactive Outreach
- Behavioral Health Integration
- Care Management for Complex Patients
- Social Needs
- Data Governance and Analytics
You had the power all along, my dear.

? THANK YOU FOR YOUR ATTENTION ANY QUESTIONS?