

Reflections and Looking Ahead

Value Based Payment and Population Health

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

Primary Behavioral Health
INTEGRATED CARE
Training Academy

Good Morning!

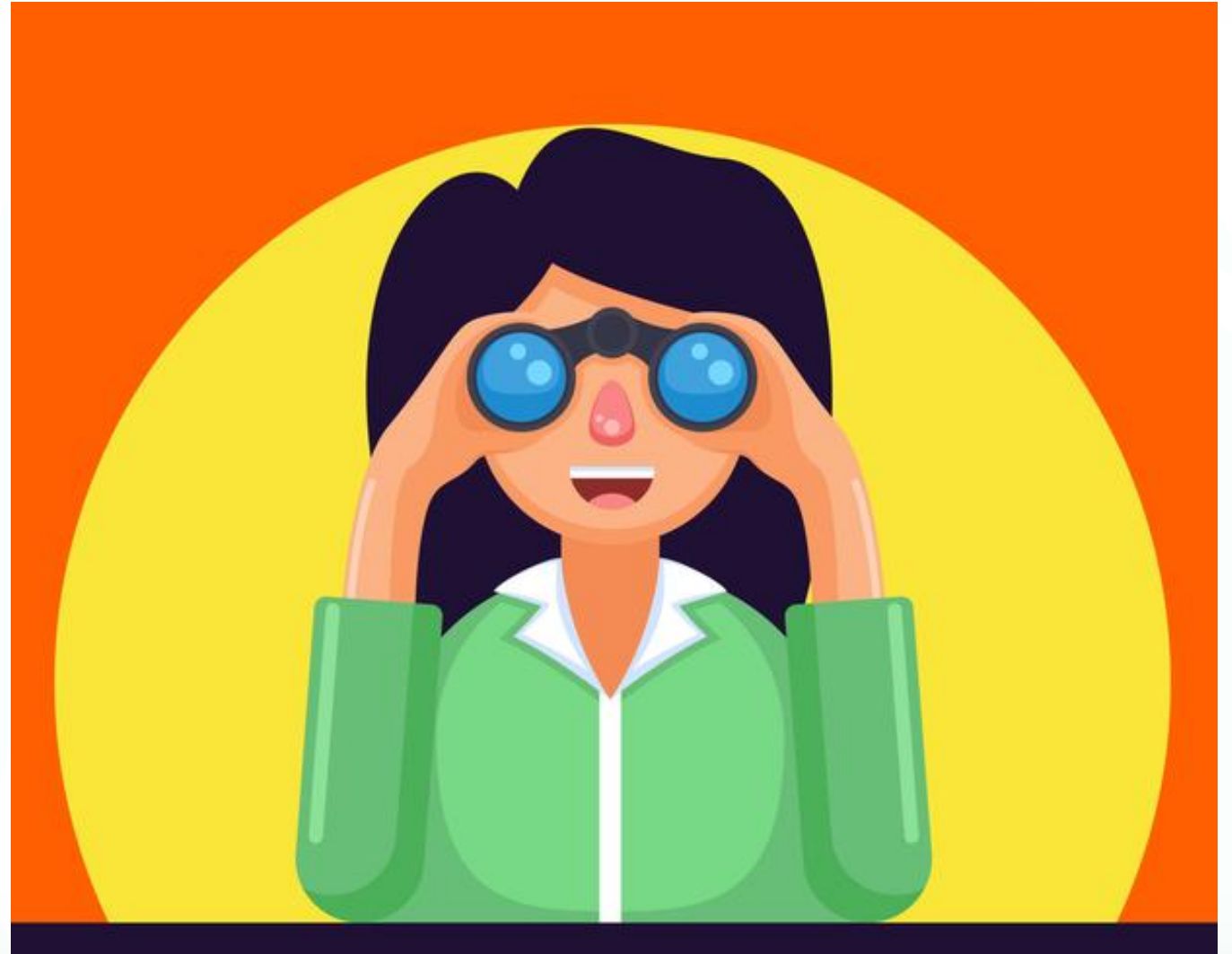
*Happy to
be back in
California!*



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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

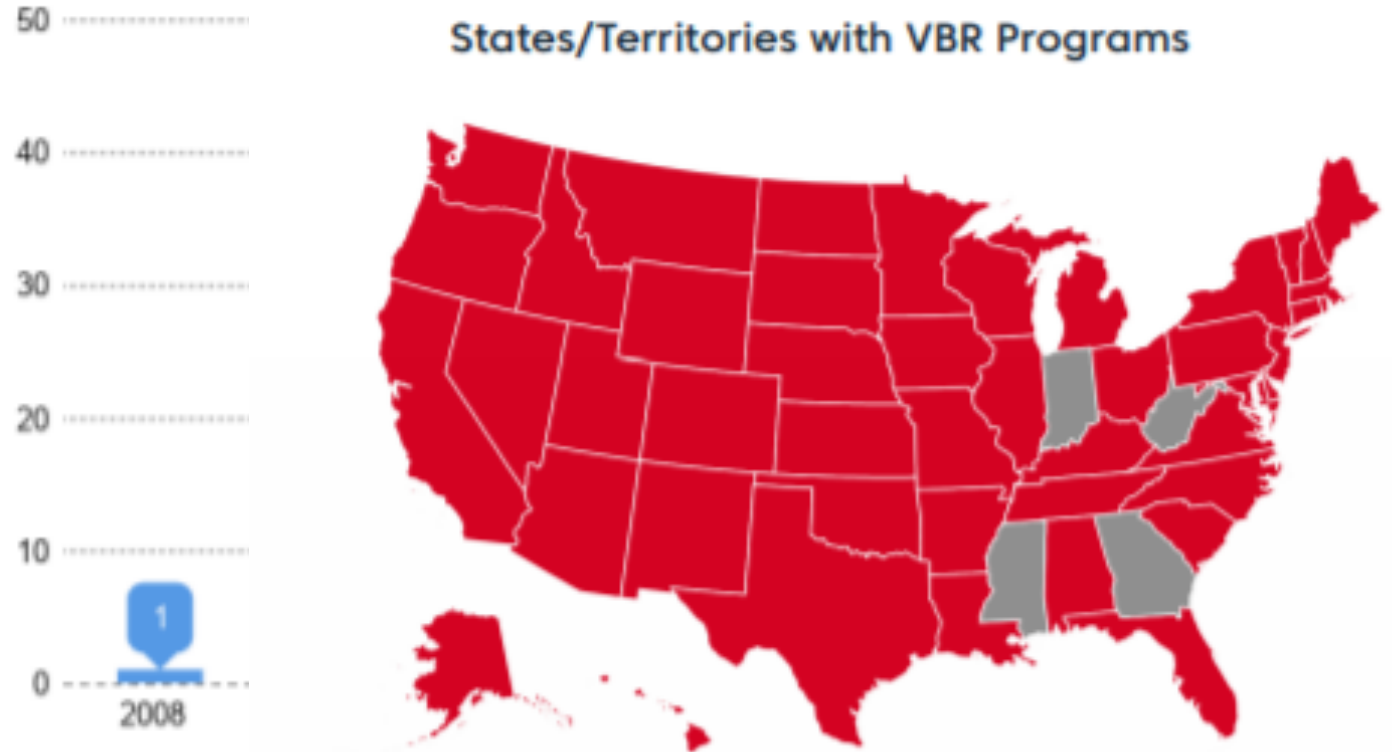
A 50-State Review of Value-Based Care and Payment Innovation

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

Number of States and Territories with VBR Programs



Current State: VBP

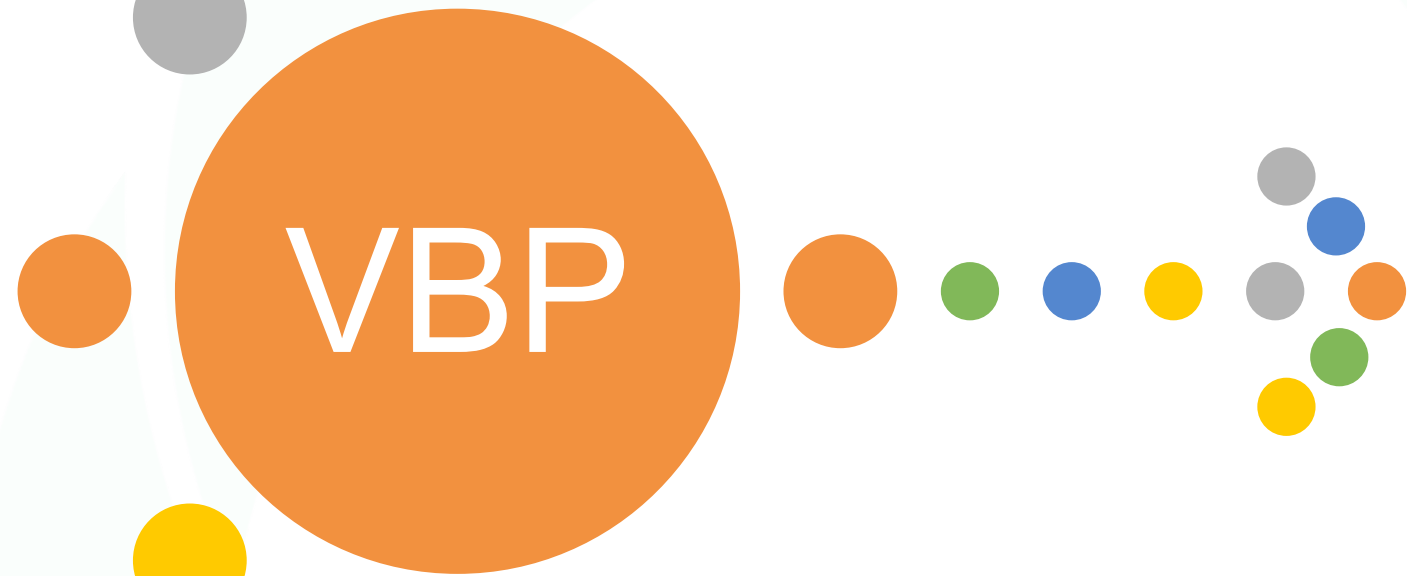
F4S Linked to Quality and Value



APM built on F4S Architecture

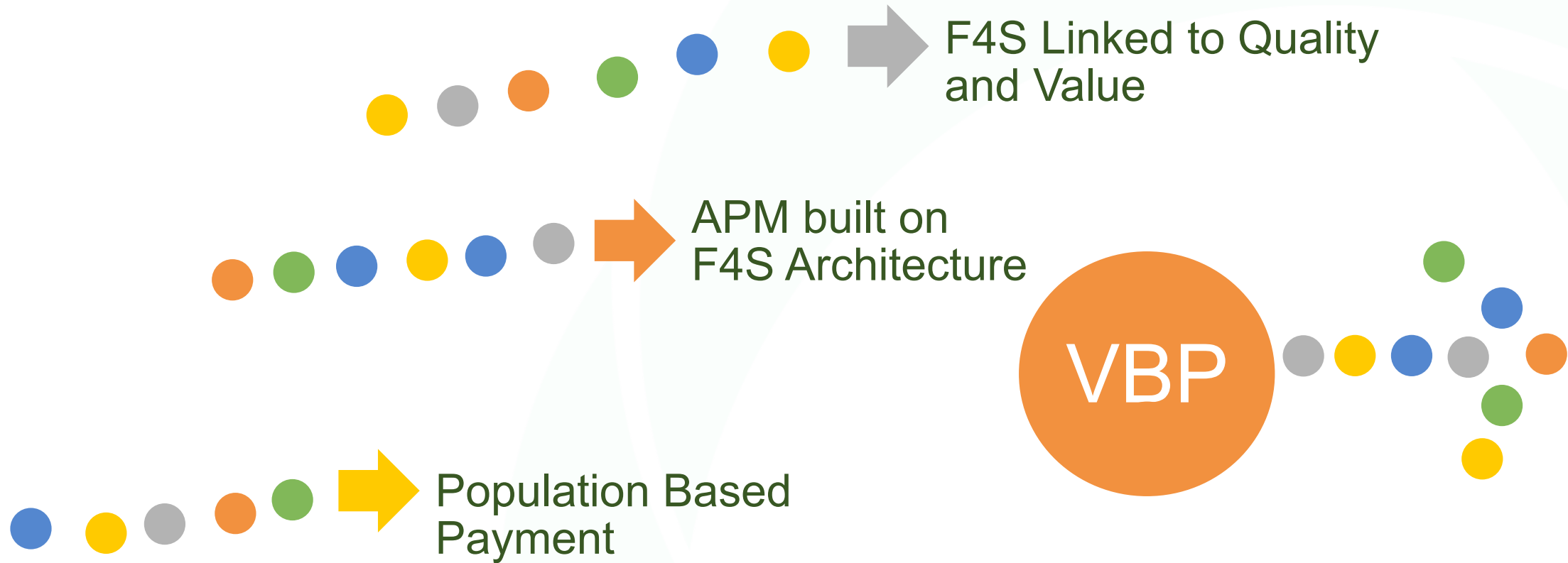


Population Based Payment



Current State: The Need for Speed (?)

Hurry Up and Wait!



Current State: VBP



**WE'RE USED TO
BEING THE
UNDERDOG. I'M OK
WITH THIS.**

Nate Johnson

QUOTEHD.COM



**KEEP
CALM
AND
EMBRACE
THE MESS**

KeepCalmAndPosters.com

Innovative Practices: *Key Elements*

Social and Community Factors

- Transportation
- Food Security
- Housing
- Safety
- Environmental Toxins
- Adverse Experiences

Collaboration & Partnerships

- Team Based Care
- Expanded Workforce
- Payors
- Patients
- Community Based Organizations
- Businesses
- Schools
- Law Enforcement

DATA

- Transparency
- Interoperability
- Sharing
- Analytics

Food as Medicine

HEALTH + LONGEVITY

Why Food Could Be the Best Medicine of All

By **Alice Park** | Photographs by **Zachary Zavislak** for

February 21, 2019

Food As Medicine: It's Not Just A Fringe Idea Anymore

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

Invited Commentary

April 22, 2019

Food Is Medicine—The Promise and Challenges of Integrating Food and Nutrition Into Health Care

Food Is Medicine: Providing Medically Tailored Meals to Community Members with Disease-associated Nutritional Risk Supports Stable BMI and Decreased Hospitalization (P12-005-19)



Jule Anne Henstenburg, Claudia Parvanta, Laura Pontiggia, Sue Daugherty, Nicole Lavery

Collaboration & Partnerships



OLIVER WYMAN

TRENDS IN PAYER-PROVIDER PARTNERSHIPS



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Data Data Data Data





Getting Ready: *Data*

of patients with
chronic health problems

Descriptive

- Information
- Knowledge

High Need?
Vulnerable?
Medically Complex?

Prediction

- Insight
- Action

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

Prescriptive

- Wisdom
- Optimization

Getting Ready: Data Infrastructure



Accurate
Precise



Accessible



Actionable

Getting Ready: Big Data to Actionable Data

Amerigroup Quality Measures - Summary by Region

Measure	Target	Total	Not Seen*	R1	R2	R3	R4	R5
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CHC Needs Assessment & Intervention Guidance

CHC Needs	Intervention Guidance
Patient has Chronic Condition	<ul style="list-style-type: none">• Does the patient see specialists outside CHS?<ul style="list-style-type: none">• If so, request ROI for each specialist, review upcoming appts, problem-solve and address barriers to attendance.• Ask the patient, "How often do you miss your medications?"<ul style="list-style-type: none">• 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).• Encourage healthy diet, activity, and smoking cessation.
Patient has had no PCP Visit in > 6 months	<ul style="list-style-type: none">• Who is patient's assigned PCP?<ul style="list-style-type: none">• If patient is assigned to an outside (non-CHS) PCP, does the patient want to become a CHS primary care patient?• If so, add patient to a list of patients needing CHS PCP visits.• If patient desires to keep an outside PCP, assist patient in scheduling a visit and problem-solving barriers to attendance.

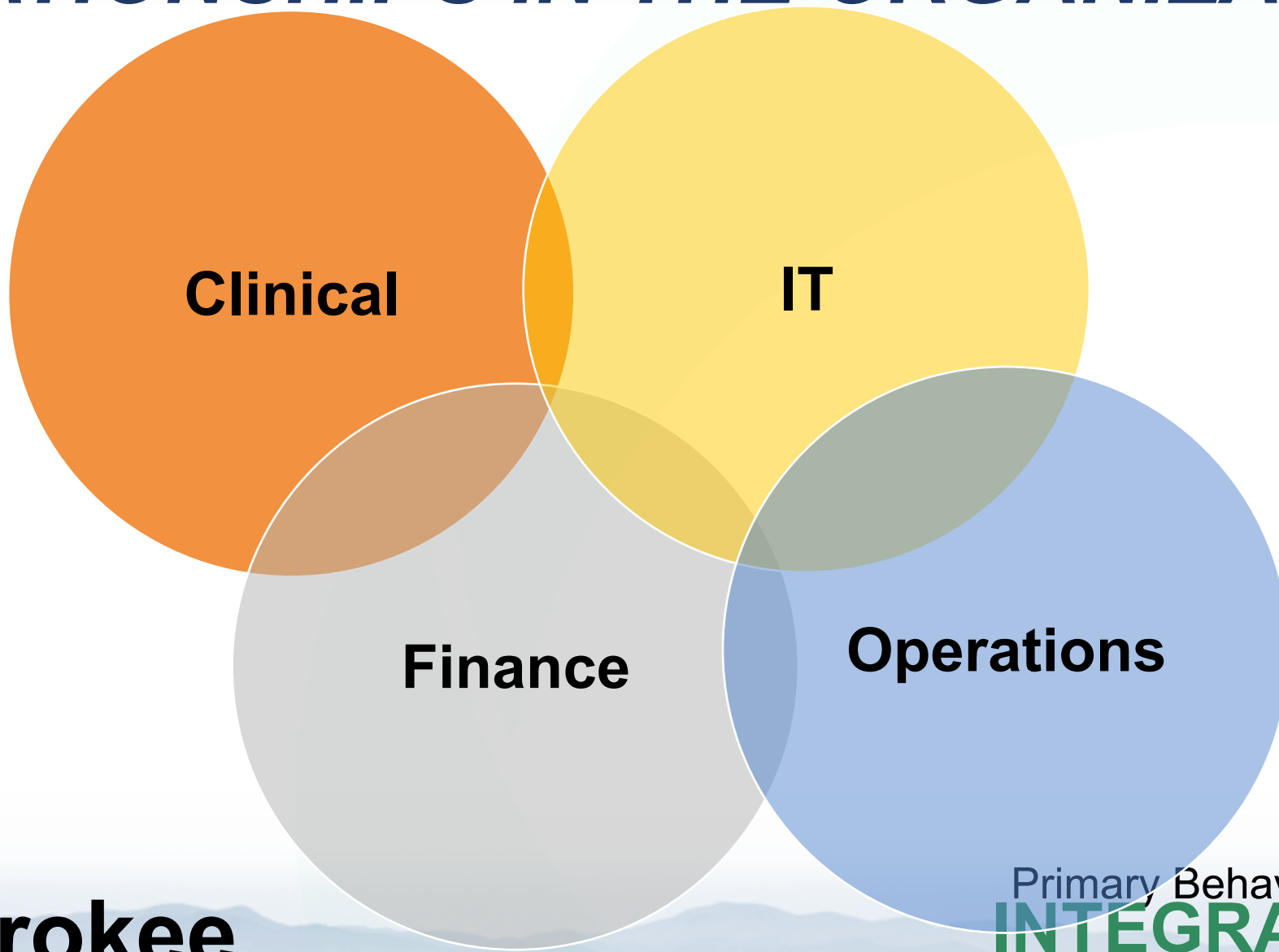
Common Theme in Evidence



Healthcare is about *RELATIONSHIPS*



RELATIONSHIPS IN THE ORGANIZATION



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



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THANK YOU
FOR
YOUR
ATTENTION
ANY QUESTIONS?