Safety Net Advisory Committee
Accountable Care Collaborative (ACC) Learning Lab #2
Thursday, June 28, 2012
Colorado Health Institute
Supplementary Meeting Notes

Agenda

- Welcome, introductions, agenda review
- Brief overview of the U.S. Supreme Court (SCOTUS) decision on the Affordable Care Act
- Review of SNAC objectives and ACC update
- Presentation and short CHI video: *What Tools are in the Toolbox? Care Coordination in Colorado's Accountable Care Collaborative*
- Facilitated discussion
    - Focus on how oral health can be integrated into the ACC
- Next steps
- Roundtable comments on the SCOTUS decision

SCOTUS Briefing

Michele Lueck (CHI): Looking forward, we will need to pay close attention to people's choices and behaviors in order to assess what is working and what is not. This will be an ongoing theme throughout ACA implementation.

SNAC Lab Objectives and ACC Update

Jeff Bontrager (CHI): The main objective of today's SNAC Lab is to leverage collective focus on vulnerable populations and share ideas about promising practices. Together, we can share early successes and challenges, and develop a shared body of evidence. Colorado is so far ahead of other states in terms of innovative pilots and it is best to strike while the iron is hot. This discussion includes policy makers, stakeholders and potentially other states. Thus far there are not a lot of quantitative data available, so we must rely on qualitative data such as key informant interviews, sub-committee meetings and other opportunities to inform the discussion.

ACC Update since the April SNAC Lab:

- ACC enrollment across seven Regional Care Collaborative Organizations (RCCOs) reached 125,000 enrollees as of April 2012. This is based on Medicaid enrollees receiving the ACC letter.
- Ten-thousand adults without dependent children with family income up to 10 percent of the federal poverty level (FPL) will be added to the ACC.
- HB12-1281 passed the Colorado legislature and establishes a process for ACC payment reform pilot programs.
- Are there are cost savings? The ACC is still based on a fee-for-service (FFS) system. A new incentive payment structure begins in July 2012: one dollar will be withheld from the provider and RCCO per member per month (PMPM) incentive payments, and RCCOs and providers can earn it back if they meet performance goals.

- There are other disciplines at the ACC's periphery that we need to think about, including oral health, which we will discuss today, and behavior and public health, which will be featured in future SNAC Labs.

Presentation: *What Tools are in the Tool Box? Care Coordination in Colorado's ACC*

Jeff: Care coordination is one of the most important tools in the ACC's tool box. RCCOs are trying out different models of care coordination. Sarah Rosenbaum, Health Policy and Law professor at George Washington University, suggested to CHI staff that it will be important to focus on the "organizational DNA" of the relationships between payers, RCCOs and providers. She urged CHI to explore the financial and legal arrangements—what goes into these arrangements, what works and what doesn't—in order to get a better sense of how and why models work or don't work.

When looking at Colorado's RCCOs we must ask the right questions about the mechanics in order to obtain the most applicable answers in terms of promising evidence-based practice.

The Take-Aways

- Evidence on cost effectiveness of care coordination is mixed, but may hold potential for Medicaid enrollees.
- RCCOs are using three organization models for the provision of care coordination resources.
- Integration is often the key to involving non-medical providers (e.g. oral health providers) in the ACC.

Defining Care Coordination and the Evidence

It is important to understand that care coordination is not a monolithic concept, but one that has several layers. The needs of the patient, acuity level and resources available are all factors that influence the type of care coordination performed. The evidence basis is still in the evolving stage. Community Care of North Carolina was able to decrease the percentage of hospital readmissions for the sickest cohort by 22 percent. How you measure success depends on how you ask the question. There is no right or wrong answer, but we need to always question how we define success. Is it cost savings? Improved quality of care? Ease of care? Currently care coordination may improve care quality, but not necessarily cost. The Care Transitions Model developed by Eric Coleman has demonstrated success in utilizing a "teach to fish" approach that empowers the patient to act as his or her own care coordinator.

What Patients Benefit from Coordinated Care?

Care coordination targets individuals based on their health and social support needs. There seems to be a threshold at which care coordination works the best. Many RCCOs have employed a tiered needs assessment that allows the care coordinator to match the patient's needs with a particular type of coordination. One of the greatest areas of potential is using such tools to prevent a patient from moving to a more serious level of severity.

Care Manager Video

CHI showed a video of care managers from Colorado Access discussing their role in their patients' health, the tools they use and when they are most effective. The ability to assist patients as they navigate the system is the cornerstone of their role.

Tools that RCCOs are using

- Evidence basis: What has research to back it up?
- Targeted scheduling: Ensuring an appropriate care coordinator is present where and when the sickest patients seek care
- Multidisciplinary teams: Often a RN, social worker and the primary care provider (PCP)
- Combining data resources: Claims data may be augmented with real-time data to effectively identify who are those in need
- Community-driven approach: Local practitioners identify local needs and resources to produce local solutions
- Risk tiers: Assessing patient needs and matching them to an appropriate level of care coordination
- Contracts and relationships: Care coordination arrangements
- Integration of services: Across oral health, behavioral health and primary care

Organizational DNA: Care Coordination Arrangements

Jeff reviewed diagrams of financial arrangements, including the flow of PMPM payments, and who is actually responsible for the care coordination.

Model One (RCCO-Based Care Coordination): The PMPM goes to both the primary care medical provider (PCMP) and the RCCO to finance medical home services and care coordination, respectively. This model is often used with smaller practices without the economies of scale and/or extensive care coordinating experience.

Model Two (Delegated Care Coordination): This model is based on the RCCO delegating care coordination duties to the PCMP. It is a legal arrangement that is also based on trust. The RCCO shares the incentive payment with the medical provider to provide the care coordination. Federally qualified health centers often have had extensive experience in care coordination and may have delegation arrangements with RCCOs.

Model Three (Community-Based Care Coordination): This model is comprised of community-based care coordinators. The RCCO and/or PCMPs pool a portion of their PMPM payments and combines other community resources to utilize (or establish) a third party entity that provides care coordination services locally. An example is in Fort Collins (Region 1), where 3.5 FTEs, including a nurse, social worker, nurse practitioner and another medical professional, were hired to perform care coordination services in the community.

Focus on Integration of Oral Health
The key to involving oral health providers in the ACC is the integration of services. Jeff displayed a continuum of programs that employ varying levels of integration. Many safety net clinics have a combination of dental and primary care services housed in the same building, such as Clinica Family Health Services and Inner City Health Center. There are various impediments to integration, including a lack of universal diagnosis codes, expensive equipment and the fact that dentists often prefer to practice independently.

Facilitated Discussion

Jenny Nate (CIVHC): Is there a standard definition for care coordinators based on training or function?

Gretchen McGinnis (Colorado Access): There are some programs out there with available training, but these programs are not required nor are they always used. There is no standard training required for a care coordinator. Colorado Access bases the functions of their different care managers on their education level, training and licensure. Care coordinators and case managers are similar but not the same. Case managers tend to work more closely with patients who have behavioral health needs.

Abby Brookover (CCHA and PHP): Colorado Community Health Alliance uses a combination of professionals: social workers, RN staff and people with backgrounds in philanthropy. We call it a "health partners" program.

Amy Downs (CHI): How resource intensive is care coordination?

Gretchen M: In our three regions we use all three of the models Jeff described. Some patients, such as adults on Medicaid, the disabled and those with high behavioral health needs, tend to be more intensive. Children generally have low needs. The caseload per care manager is variable—it may be as many as 600—but the focus will always be on those who have the greatest and most urgent needs. Some patients will require an annual needs assessment and nothing more. Money tends to restrict what can be done and how many patients can be reached. Delegated community-based models help stretch the money but still within budget constraints. The number of care managers is strictly a financial limitation; more care managers result in more people being reached, more health problems being identified and more people being positively impacted. If we had more money, we would hire more.

Sharon Adams (ClinicNET): There is a lot of dialogue about care coordination, patient navigators, etc. Are there any differences in scope of practice between these professionals?

Terri Hurst Greene (CBHC): Behavioral health, public health and primary care are finally sharing a dialogue.

Michelle Mills (CRHC): What is important in a community to move it forward? We need to reflect on the importance of a community health needs assessment.

Gretchen M: The problem is that the ACC only covers a subset of the population. As RCCOs expand,

the goal will be to be efficient and encompass all aspects of health into care coordination (i.e. behavioral health, oral health, etc.).

Abby: They are working with BHOs to develop a plan to jointly use some of the money.

Jeff: How do the RCCO models resonate with everyone?

Jenny: Can RCCOs use any model combination? Yes.

Sharon: Fort Collins Family Residency Program care coordinators have helped track patients usage and made sure they were going to their assigned clinic.

Michele Lueck (CHI): At the end of the year, we will be able to review some of the data and get a sense of the variation in outcomes across counties, models, etc. In the process, we should go through the steps of understanding why variation may occur. Let's look at the flow of money and the relationships that providers have with each other and the RCCOs. We will have to match the organizational structure with the data results to further guide best practices.

Patrick Gordon (RMHP): The distillation of the three RCCOs models is accurate, but we can't think of it in such a divided manner. The models are a good descriptive approach. It is a practical response in each community based on the resources available. It is sometimes more effective to pool resources. We need to think of this in a "multi-modal and continuous way." There are still other components that play a significant role, such as case management from Grand Junction, etc.

Dr. Gary VanderArk (CCMU/Doctors Care): Think about Doctors Care, which has trained volunteer coordinators who work with paid coordinators.

Jeff: How do we define success? What can we add to HCPF's three indicators (emergency room visits, hospital readmissions and high cost imaging)? When we start seeing differences in the RCCOS what are factors that may account for this?

Abby: We need to deploy care management to the highest risk group. It would be helpful to have real-time data to supplement the claims data, which has a three-month lag.

Jeff: The data piece is essential. Right now many RCCOs and providers are still supplementing retrospective claims data with other real-time data.

Neysa Bermingham (Kaiser Permanente): Is this a more cost-efficient method of health care delivery?

Amy: What is the right output of care coordination? It is important to have enough resources that it is paying for itself, but we don't want to spend too much.

Maureen O'Brien (CFMC): The Patient Activation Measure (PAM) Assessment tool is useful.

Patrick: PAM is promising. The patient-reported segment is the most important, but it is also the data that is least accessible and least aggregated.

Gretchen M: Yes, while there are some people who know who their care manager is, many only know them by name. There are sometimes miscommunications when patients are asked about their "care manager" rather than "Sarah, the person that helped them get my medicine." We need to make sure we keep this in mind when obtaining data.

Jeff: How do we integrate oral health?

Jenny: How do they incentivize dentists who don't work in the Medicaid system?

Karen Cody Carlson (OHAC): There are some changes within the dental education and professional world that might help. Historically they have been taught the business model. Dentists need to be seen as part of the medical team. Hospital data makes it hard to extract oral health-related diagnoses to see what oral health procedures are being performed in the ED.

Michelle M: Rural dental care is a major challenge. There are no dental providers available. There are reimbursement challenges.

Karen: Without diagnostic codes we can't look at hospital data to see how many admissions were for oral health cases. This presents a problem especially because we are trying to reduce hospital ED admissions and readmissions.

Patrick: We may be able to look at new models of payment reform as a flexible way to add dental benefits even though they are not traditionally covered.

Next Steps

The next SNAC Lab, which will focus on the patient experience of care, will be held at CHI on Thursday, September 27, 2012 from noon to 2 p.m.

SCOTUS Decision

Each SNAC member shared their thoughts, questions and reflections on the SCOTUS decision.