Southern Prairie Community Care

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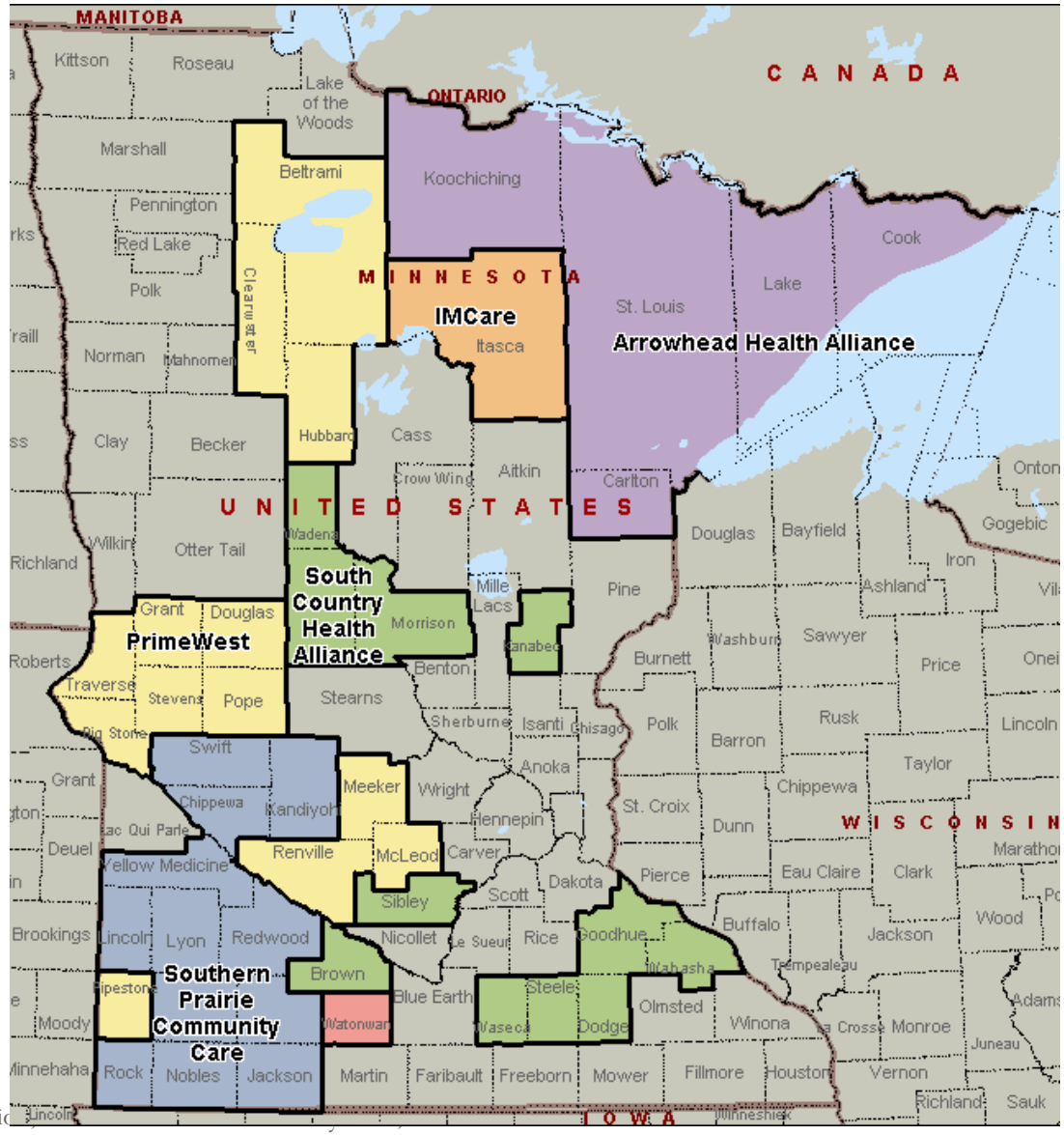
Southern Prairie Community Care

Mission:

To enhance the quality of life for our citizens by facilitating the integration of services and supports provided within our community.

Minnesota County Collaborations



History of Movement

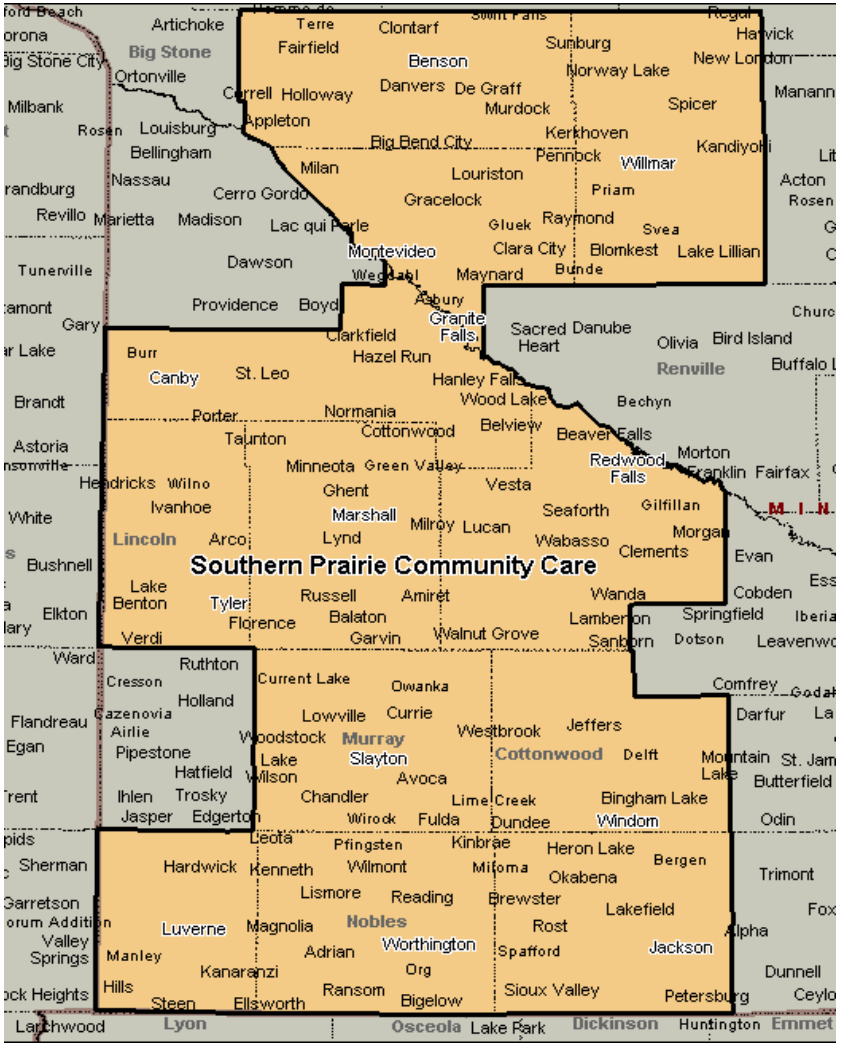
- What problem is SPCC working to solve?
- Long history of health care reform/cost containment in Minnesota
- County Based Purchasing movement/Health plan contracting (mid 1990s)
- Pawlenty administration limited expansion of CBP options (2006)
- Dayton administration shifted reform focus to ACO model approaches (2011)

Opportunities

- Discussions began in 2006 – with the following opportunities being identified:
  - To build upon local partnerships and increase local control around service decisions made for the vulnerable people living in our communities
  - Assure a focus on early intervention and prevention – allowing folks to remain in their own homes for as long as possible
  - Further integration of both the medical and county delivered services provided to our Medicaid populations
  - To build a rural system of care – specific to the strengths and challenges of delivering services in a remote (rural) location
  - Reinvestment potential – could any dollars saved be reinvested in the continuous improvement of our service delivery system?

What is SPCC?

- A collaboration of 12 counties in Southwest Minnesota
- A joint powers agreement was finalized in July of 2012 for the purpose of building a **service delivery network**-a care coordination model built upon the concepts of **an Accountable Care Organization (ACO)**



Health Delivery Reform and Changes

- Promoting Primary Care and Prevention
- Developing New Models for Coordinating and Delivering Care
- Use of Information Technology
- Reforming Provider Payments to Promote Outcomes

Health Care Reform - Minnesota

- **Minnesota State Health Care Reforms**
  - Bipartisan reform initiatives initiated in 2006
  - Triple Aim: cost containment, health improvement and consumer satisfaction
  - Strategies: health care homes, payment reform, public reporting of performance of health plans and providers
  - Moving forward since 2007, gaining speed in 2012

Key MN Reform Components

- Health Care Home (MDH standards/DHS payment)
- Payment Reform: flipping the incentives of health care payment methods to reward prevention and management of chronic conditions.
- "Health Care Delivery Systems"- provider networks who accept responsibility for managing costs, quality and consumer satisfaction for patients.
- ACO's or CCO's

DHS Health Care Delivery Demonstrations

- Authorizes DHS to approve alternative and innovative health care delivery systems organized by providers to provide services to groups of patients for an agreed upon total cost of care or risk/gain sharing arrangement.
- Phase I Demonstrations to launch early 2012; another waive in mid 2012.
- New RFP released in 2012 focused on dual eligible adults and seniors.

Goals of Demonstration Projects

- Primary Goal:
  - Encourage providers to innovate to deliver higher-value care to Minnesota Health Care Program (MHCP) enrollees
- Secondary Goals:
  - Support robust primary care and improve care coordination via Health Care Home or equivalent efforts
  - Test payment models that increase provider accountability for the three part aim – population health, patient experience, and cost effectiveness
  - Implement projects in different parts of the state
  - Allow participation of both larger and smaller provider groups;
  - Create alignment with similar initiatives across payers

Requirements of Participants

- Provide the full scope of primary care services and care coordination
- Engage and partner with patients and families
- Impact the quality and total cost of care through new models and strategies
- Develop formal (contractual?) community partnerships
- ***Not required*** to pay claims or administer benefits

Oregon

- Oregon's Health System Transformation Legislation: Legislation established the Oregon Integrated and Coordinated Health Care Delivery System. *
  - Coordinated Care Organizations (CCOs) intended to improve health, increase the quality, reliability, availability and continuity of care, and reduce the cost of care.
  - Will serve Medicaid recipients and dually eligible Medicaid/Medicare beneficiaries. Dually eligible individuals are permitted to remain enrolled in PACE or Medicare Advantage plans, until those plans are fully integrated into a CCO.
  - The CCOs will be supported through alternative payment methodologies that focus on prevention, use patient-centered primary care homes (PCPCHs), evidence-based practices and health information technology to improve health and reduce health disparities.

* This legislation, House Bill 3650, was signed by the Oregon Governor on July 1, 2011

Key Oregon Reform Components

- Health care services, other than Medicaid-funded long term care services, will be delivered through CCOs (emphasis on prevention and supporting individuals to live independently).
- The CCOs supported through alternative payment methodologies that focus on prevention, use patient-centered primary care homes (PCPCHs), evidence-based practices and health information technology.

Key Oregon Reform Components

- Organizational options for CCOs include local, community-based organizations; statewide organizations with community-based participation in governance; single corporate structures; or a network of providers organized through contractual relationships.
- The state must continue to contract with prepaid managed care organizations (MCOs) in areas of the state not covered by CCOs (contracts with MCOs must terminate no later than July 1, 2017).

Key Oregon Reform Components

- The qualification criteria and requirements for CCOs includes:
  - the CCOs demonstrated experience and capacity for: managing financial risk and establishing financial reserves; meeting minimum financial requirements;
  - operating within a fixed global budget;
  - developing and implementing alternative payment methodologies that target quality and improved outcomes;
  - coordinating the delivery of covered services;
  - and engaging community members and providers in improving community health.

Key Oregon Reform Components

- CCO governance structure must include the diverse community and provider representation.
- CCOs must convene community advisory councils that meet regularly to ensure that community care needs are addressed, and the councils must meet community representation requirements.
- The councils must oversee a community health assessment process and adopt a community health improvement plan.
- The state will consider the community health assessment and the CCO's health care costs when determining the global CCO budget. The allocation of the payment, risk, and any cost-savings shall be determined by the CCO governing body.

Key Oregon Reform Components

- The CCO payment methodologies will reward value and good outcomes rather than volume.
- Providers may participate in the networks of multiple CCOs. CCOs may not discriminate among health care providers.
- Health care entities may not unreasonably refuse to contract with a CCO.
- Outcome and quality measures for the range of services provided by CCOs will be determined by the state, incorporated into contract, and published.

Medcaid ACO:
Beyond your Father's Managed Care

Provider Incentives

- Plan/Provider Partnerships
- Health Care Homes
- Common EMR and IT
- Local Governance and Integration of Social Services
- Public Reporting

Key Compliance Issues

- Billing and Enrollment
- Risk Adjustments
- Shared Savings Calculations
- Medical Home Payments and Services (Care coordination, transitional care, social service referral, IT)
- Financial Incentives (Disclosure, consent, impact on malpractice)
- Patient Engagement and Incentives
- Assumption of Financial Risk

Accountable Rural Community Health Networks: The Next Wave?

- ARCH Networks:
  - Accessing funding and services from multiple silos
  - Managing the Total Cost of all Services
  - Coordinate primary care, MH, dental, and social services through a single "health care home"
  - Payer alignment – a single set of payment methods and expectations for providers for all public program patients
  - Leveraging system improvements to improve care for the uninsured
  - Developing regional health information exchanges
  - Promoting population health to address community needs

Success Factors for Care Networks in the Future

- Know how to engage patients in managing their own health and chronic conditions
- Look beyond traditional medical services to provide other things patients need to be healthy or manage their conditions (transportation, social services, housing, etc.)
- Coordinate all services a person needs though a "Health Care Home."
- Use electronic medical records and other tools to provide the right services at the right time.

Success Factors, continued

- Use data on an entire group of patients to identify disease trends and utilization patterns and find opportunities to reduce costs and improve quality.
- Form new partnerships, because no small organization can independently acquire the expertise and IT technology that is needed to be successful in the future.
- Develop networks serving a critical mass of patients or members in order to spread the financial risk and justify the costs of infrastructure and administrative services.

Rural Health ACO
Southern Prairie Community Care

- Meaningful engagement at the Board level of local providers and community leaders.
- Emphasis on chronic disease management throughout the System.
- Engagement of all county provided services – housing, police, adult protection, child care, mental health, senior care, etc.
- Emphasis on person centered care through supportive technology – cloud-based electronic records of medical, public and social services.
- Implementation of a "health care home" for each enrollee.

Rural Health ACO

Cont.

- Actively engaging with the individual patients and families even when they are not or have not connected with a health care home.

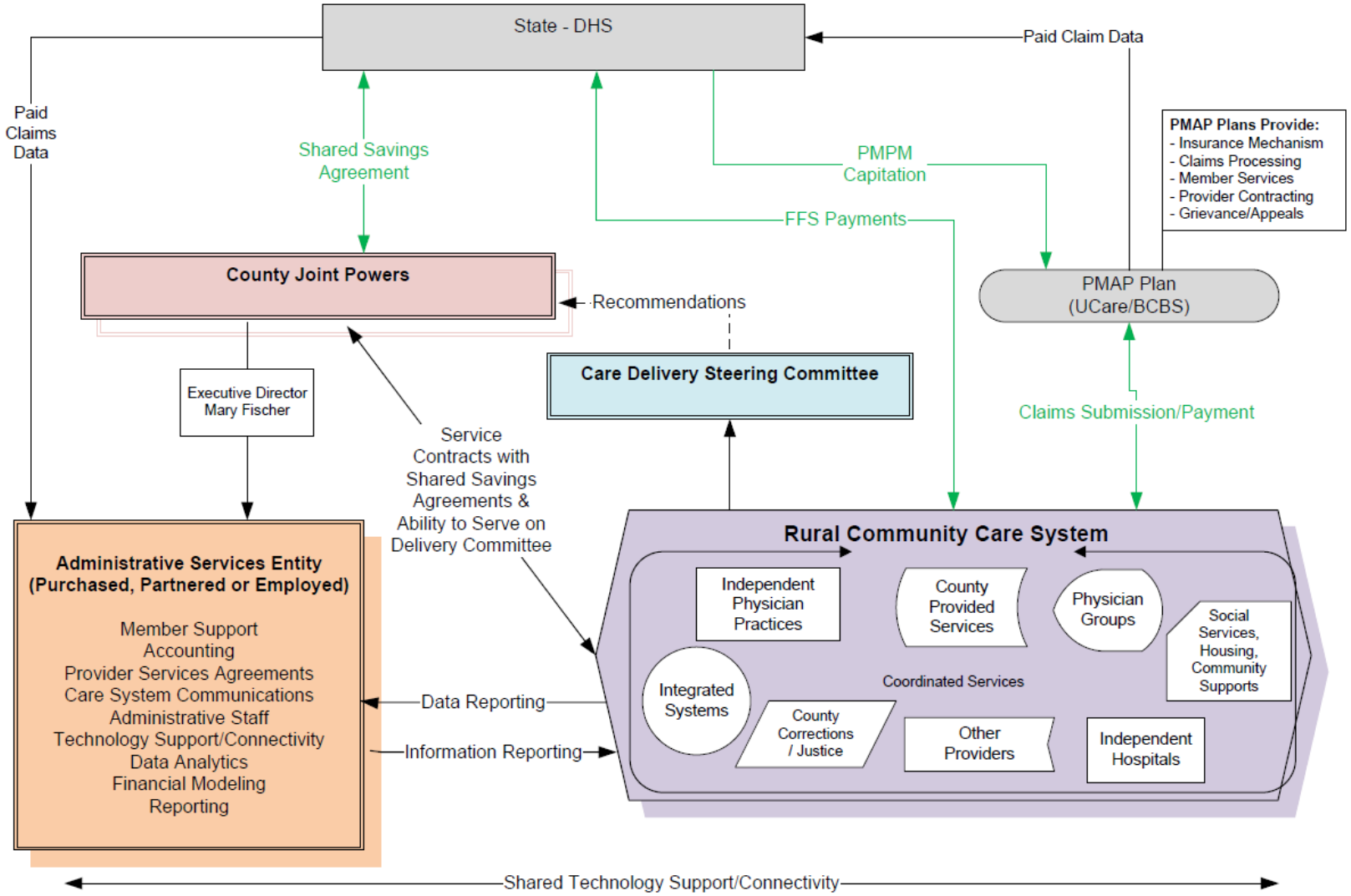
- Engage the population in a integrated approach which is designed to improve their daily lives – not only focused on medical 'health' but meaningful day-to-day issues that impact their lives – social and medical.

Rural Health ACO

Cont.

- Actively engaging in partnerships within the community, both within the counties themselves as well as with other county organizations, in order to provide the most appropriate and cost effective ways to coordinate services.

- Identifying and developing strategies to help support residents of the counties who live at the fringe of society, that are homeless or at risk of being so, those that engage with law enforcement frequently, and including those that have mental or chemical health issues, etc.



Health Care Reform in Rural Context

- Accountability and Transparency
  - Local, Rural Health Plans are Accountable and Transparent
- Health Care Homes
  - Rural Health Care is Grounded in Primary Care and Personal Relationships with a Local Provider
- Coordinated Care
  - Most Needed when Patients Seek Care Directly from Multiple Specialists and Often Don't Have a Primary Care Provider to Coordinate Care for Them

SPCC – Guiding Principles

1. The concepts inherent in the State's Patient-Centered Health Care Homes program will best position us to achieve our mission:
   - that primary care providers, families, and patients need to work together to improve health outcomes and quality of life;
   - that engaging patients with a care team focused on linking services and supports will improve the likelihood of attaining our goals; and
   - all providers participating in SPCC will adopt this approach in their practice.

SPCC - Guiding Principles

2. We use Care Guides to assist participants
3. Our model is flexible enough to allow for variations based on the needs of individuals living in our rural community, yet consistent in its' fundamental functions.
4. Our model is designed to impact outcomes for our population as a whole by taking care of individuals
5. Our model easy to understand by the individuals we serve, by our providers, our county partners and our community partners.

SPCC – Guiding Principles

6. We recognize that resources are limited so our efforts must be focused on areas and individuals where we can most likely impact the total cost of care and services, member satisfaction and quality (IHI's Triple Aim).

SPCC – Guiding Principles

7. We recognize our ability to influence health outcomes beyond good medical care and the ability to share information between services and supports providers. County lead policy changes are within the purview of SPCC activities.

8. Community partners include 'non-traditional' health care partners including schools, faith based communities, employers, social clubs, etc.

SPCC – Guiding Principles

9. We will use data and best practices to support and provide focus to our work and confirmation of our outcomes.

10. SPCC is a rural model focused on our local needs and desires; return on our investments needs to be dedicated toward local health and social services capacity building and economic development.

Financial Model Principles

- The best interests of SPCC prevail over special interests of individual organizations
- A critical mass of providers is essential to our success
- A critical mass of participants is essential in order to reduce variability and to justify system development expenses
- Administrative complexity is balanced against expense
- Those who are able to affect the overall quality and total cost should receive a portion of shared savings accrued
- Systems are present to monitor cost, utilization and outcomes of SPCC activities

The Focus of SPCC

To build a rural community care system – an integrated care coordination network including BOTH the medical community AND county provided services, such as:

- Medical Services
- Behavioral Health
- Public Health
- Human Services
- Corrections
- Treatment (*i.e.*, MH/CD)
- Housing
- Transportation
- Inpatient facilities
- Outpatient facilities
- Emergency Departments
- Other community services and support

Focus of SPCC (continued)

- We want to build a strong primary care system, emphasizing:
  - Health Care Home concepts (MDH certification process)
  - Strong physician engagement
  - Patient/family engagement to the fullest extent possible

- Incorporation of the Behavioral Health Home concepts to ensure both mental health as well as medical needs are being met

The SPCC Care Model

The Community

Creating a Supportive Environment

Health Policy MDH and DHS

Correctional systems

Public Health WIC, Maternal/Child health

Meals on Wheels

Adult Day Care

Employers

Assisted Living

End of Life

Nursing Homes

Schools

Dental

Family Services

Housing Services

Mental Health

Aging Services

Community Pharmacies

Transportation

Faith Communities

Home Care

Interpretive services

Health Care Organizations

PCP/HCH

Hospital

BHH

PCP/HCH

PCP/HCH

Hospital

BHH

PCP/HCH

PCP/HCH

Hospital

BHH

PCP/HCH

Information Flow

The Patient/Family, the Quarterback and the Care Team

Informed, engaged community partners

Informed, engaged consumer

Prepared, proactive practice team

Prepared, proactive community partners

Productive Interactions

Improved Outcomes

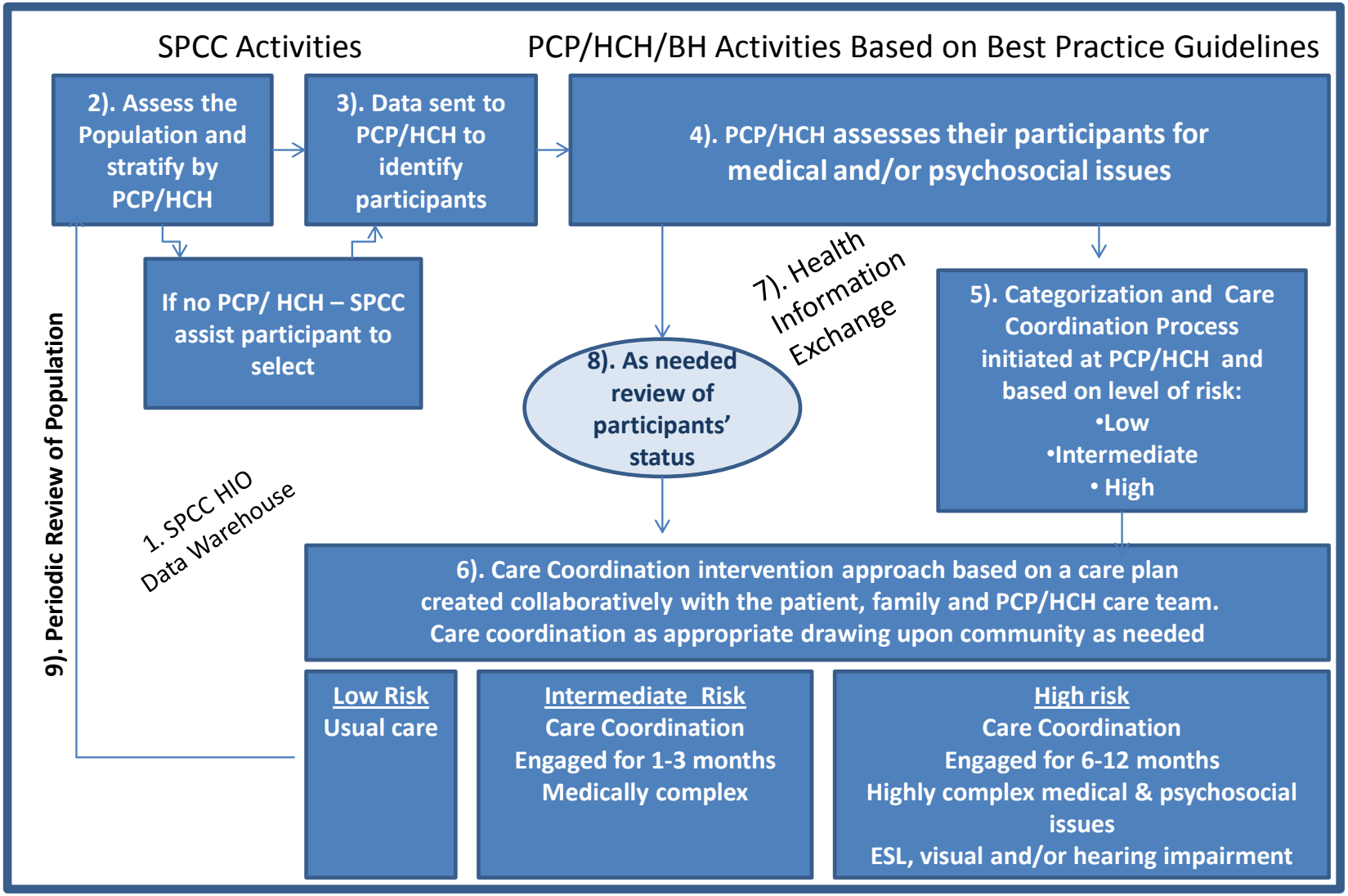
Our Initial Areas of Focus

1. Participants with dual diagnoses – mental health and chemical dependency diagnoses and/or those who are mentally ill with co-occurring significant medical conditions
2. Diabetes management
3. Pre-diabetes intervention/management
4. Frequent hospitalizations/ER Visits

Other:

- Medication Management
- Acute Dental
- Obesity Prevention
- High cost elderly

The SPCC Care Coordination Model

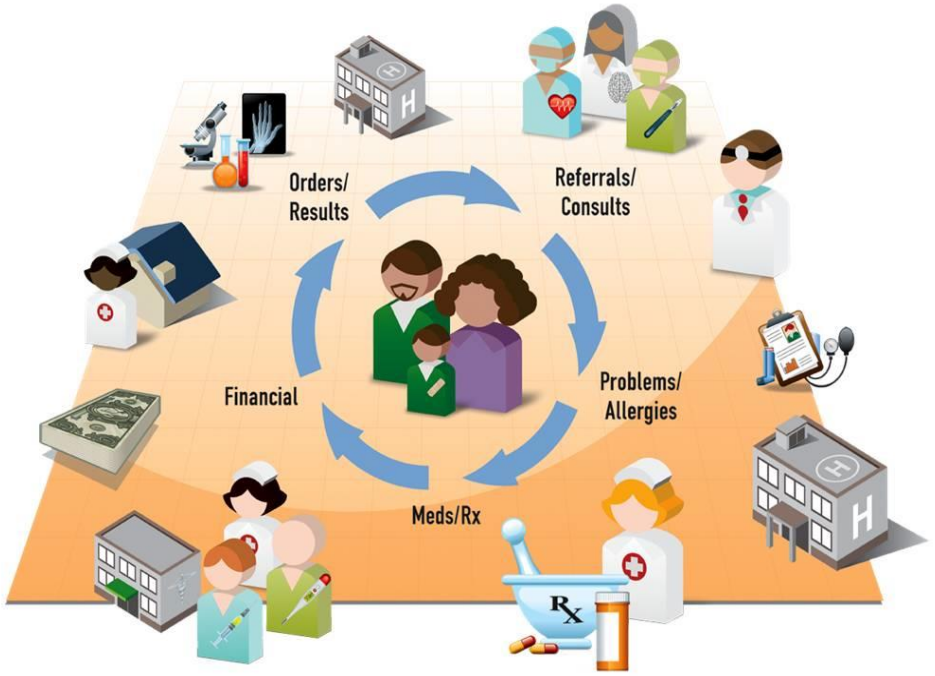


The SPCC Model: Built on Best Practices

- SPCC plans to use existing **data** (and **best practices**) to support and **focus the work** of our initiative to confirm our outcomes

The SPCC Model: an Integrated Record

- Efforts will focus on the development of **an integrated electronic record** –providers of both medical and community based services will have access to "real-time" information at the point of service using existing EMR's and processes, thus improving communication across our entire care delivery network.



The SPCC Model: Patient-centered

- **Engaging patients/consumers** to the fullest extent possible

Provider Measures

- The Core Measures:
  - Optimal diabetes care composite (2011 specifications)
  - Optimal vascular care composite (2011 specifications)
  - Depression remission at six months
  - Optimal asthma care (Child/adolescent and Adults)
  - Patient experience (CG=CAHPS)

- Additional Measure
  - Major depression in adults in primary care: percentage of patients whose symptoms are reassessed by the use of a quantitative symptom assessment tool (such as PHQ-9) within six months of initiating treatment (ICSI).

Hospital Measures

- Heart failure
- Pneumonia – Appropriate Care Composite
- Home management plan for care for asthma
- Patient experience (HCAHPS)

Our Timeline

- Projects Awarded: June 26, 2013
- Begin Serving Medicaid and MN Care Recipients: January 1, 2014

In Summary – The Impact of SPCC

SPCC plans to put our collective energies into efforts which will impact:

- **Quality** of services provided-through closely coordinated care
- **Member satisfaction** by closely aligning the consumer with his/her primary care doctor and the entire service delivery team (We believe increased patient engagement will translate into a higher level of satisfaction)
- **Total cost of care** will be impacted through a focus on early intervention/prevention strategies

Questions?

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