Willamette Valley Community Health Plan

Health Committee on Health Care Report

June 17, 2015

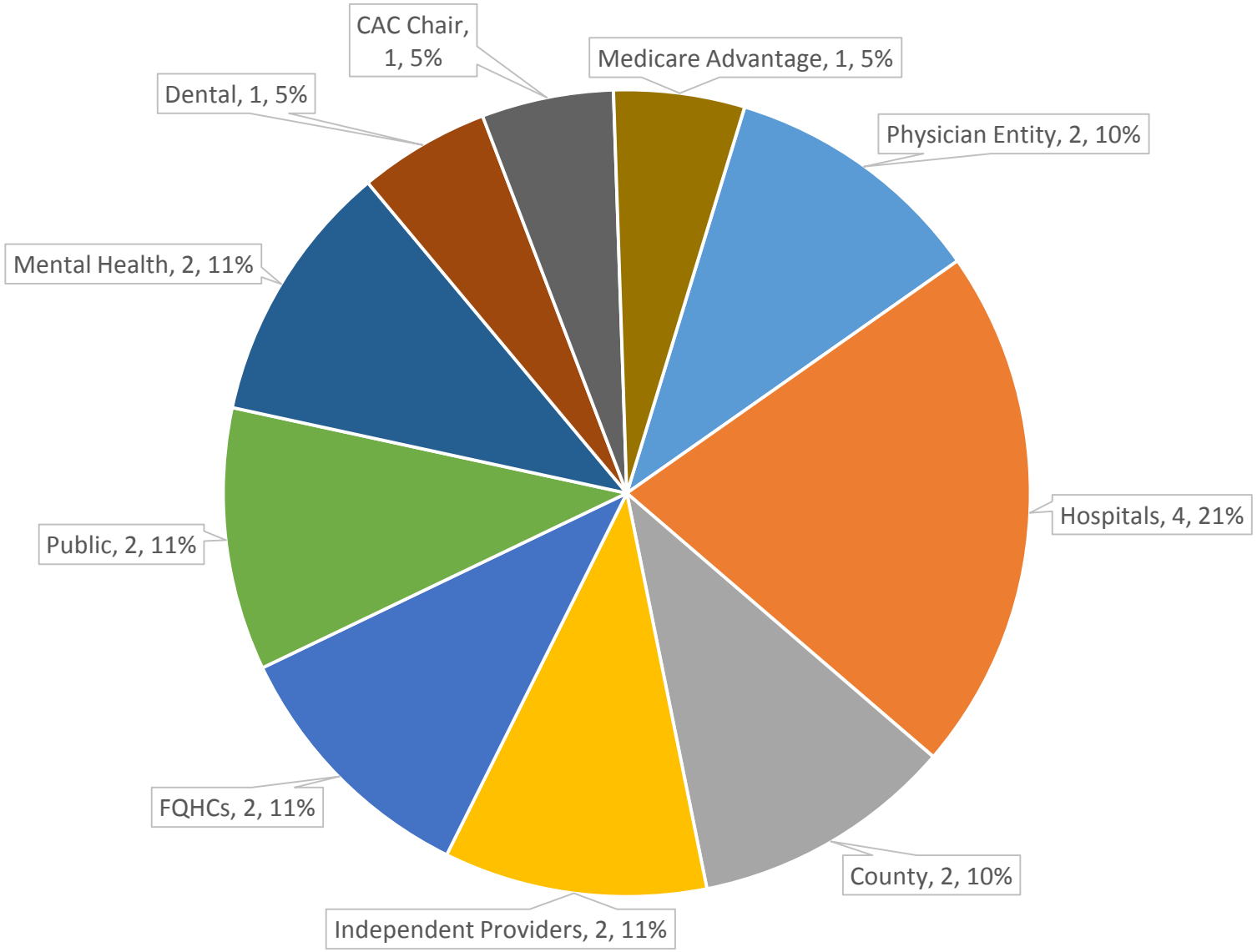
WVCH Mission Statement

"The purpose of WVCH is to improve the health status and outcomes for Marion and Polk residents through promoting prevention and wellness in a system that is cost-effective, integrated and equitable."

WVCH

Quality Coordinated Care

WVCH Board Governance Structure (19 members)



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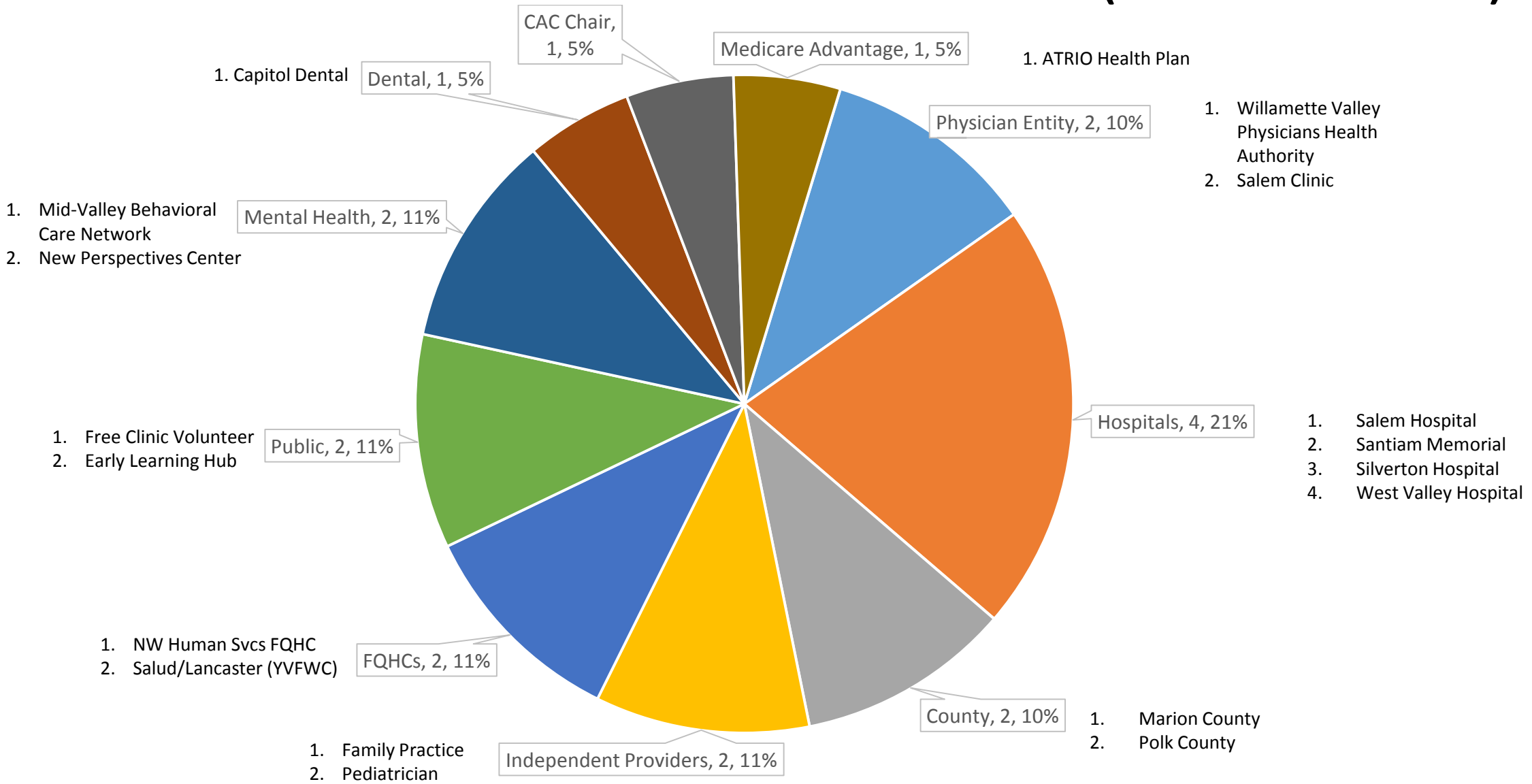
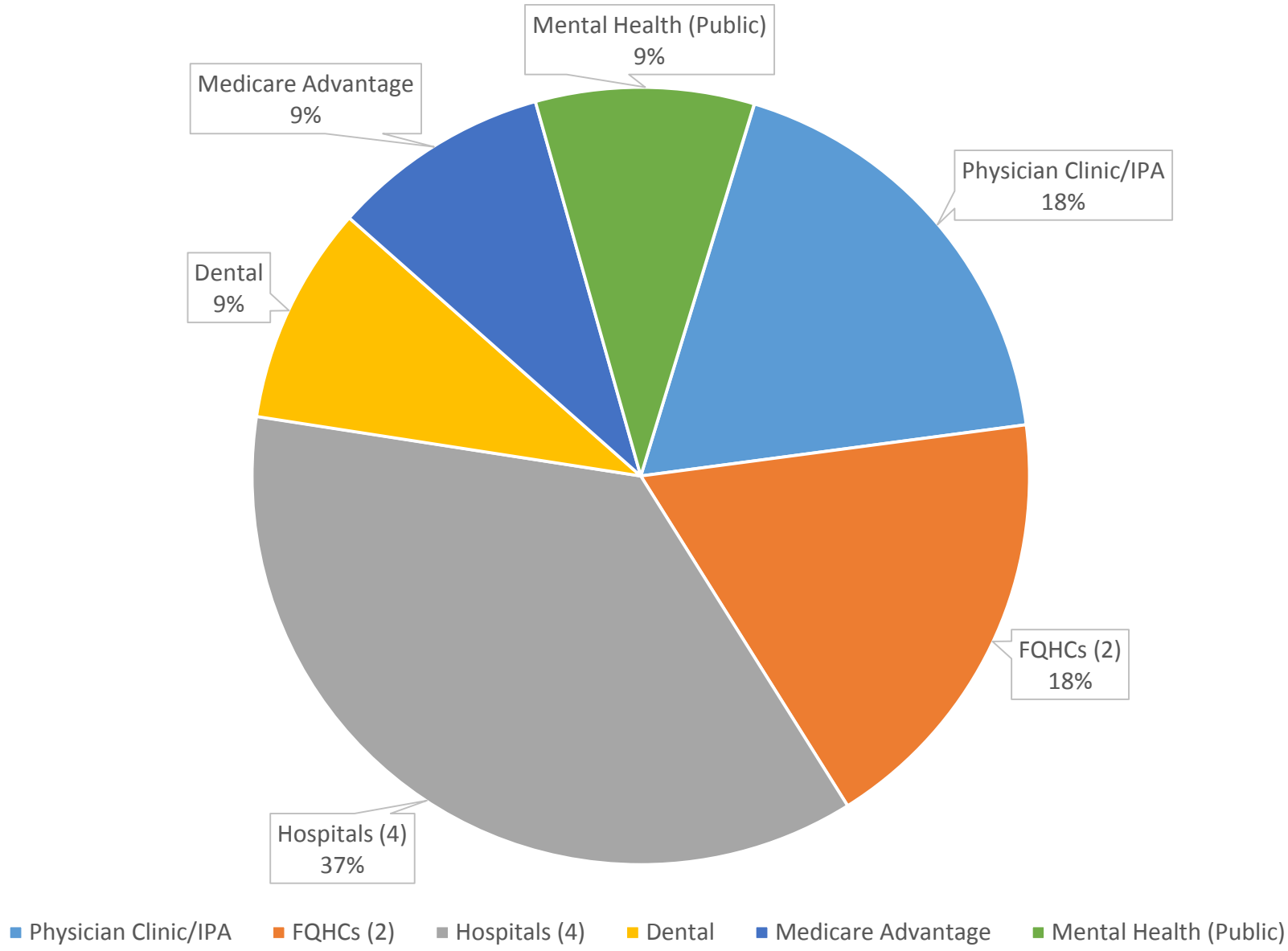


WVCH Board Ownership



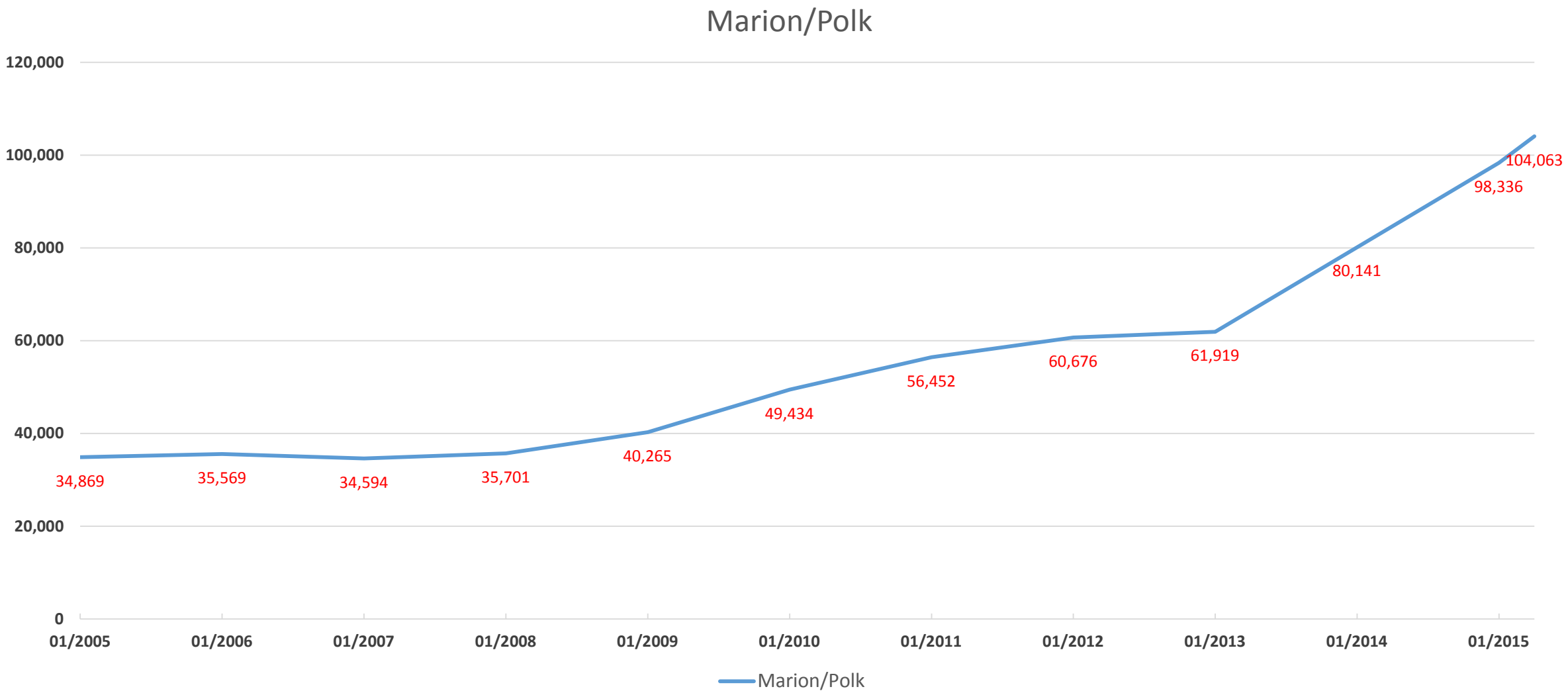
Key Partners (Providers)

Physicians	Hospitals	Mental Health	Substance Use Disorder	Dental	Other
WVP Health Authority	Salem Health/Salem Hospital	Mid Valley Behavioral Care Network	WVP (Local IPA) and Mid Valley Behavioral Care Network (Intergovernmental Agency)	Capitol Dental	ATRIO Health Plan (Medicare Advantage/ Dual Eligible Affiliation)
Salem Clinic Medical Foundation	West Valley Hospital (Polk)	Marion & Polk County Health Departments Linn County Health Department (border provider)	Marion & Polk County Health Departments	Advantage Dental	Marion and Polk County Health Departments
Northwest Human Services (FQHC)	Silverton Health	1 private health system (Silverton), 1 FQHC, + 10 additional community agencies	4 additional community providers	ODS Community Health	Salem-Keizer Transit District Triplink Call Center Transportation
Salud/Lancaster (YVFWC) (FQHC)	Santiam Memorial Hospital			Willamette Dental Group	PH Tech (Claims and Encounter processing)
					WVP Administrative Services
					Med Impact Pharmacy

Risk Sharing

- Alternative Payment Methodologies
  - Risk Sharing Groups
    - Independent Physician Association
      - Large Clinics
      - Grouping of Smaller Clinics and Independent and Solo practitioners
      - Hospital system (1 Large, 2 smaller A/B hospitals, employed physicians)
      - Small DRG Hospital system
  - Alternative Payment Methodology (APM) Tools
    - Pre-paid global risk budget model that mirrors the OHA's global budget methodology for medical (physical), mental, and dental health
    - Withholds
    - Risk pool sharing (specialists, hospital, pharmacy)
    - Patient Centered Primary Care Home Funding (93.3% in Tier 3 PCPCHs, 4.2% are in Tier 2)
    - Access for clinics remaining open to new adults and/or children
    - Adjustments for acuity
    - Quality Incentive Metrics Payment model which weights QIM payments and allocates payment to those performing encounter related work

Enrollment


Marion/Polk
120,000
100,000
80,000
60,000
40,000
20,000
0
34,869
35,569
34,594
35,701
40,265
49,434
56,452
60,676
61,919
80,141
98,336
104,063
01/2005
01/2006
01/2007
01/2008
01/2009
01/2010
01/2011
01/2012
01/2013
01/2014
01/2015
Marion/Polk

Nature of the Delivery System

- Physicians
  - 285 PCPs in 74 clinics
    - 3.3 Primary Care Visits Per Member Per Year
    - 97.5% in Primary Care Homes
  - 477 Specialists & Mid-levels
    - 1.2 Specialty Visits Per Member Per Year
    - Access Measures
- Hospitals or Hospital Systems: 8
    - ER Visits: .5 visits Per Member Per Year
    - ER Visits: .42 visits Per Member Per Year excluding mental health visits
- Mental Health
  - 1.7 Mental Health Visits Per Member Per Year
  - Embedded Behaviorists
  - County Providers
  - Private Sector Providers
- Dental Providers
  - 4 Dental Care Organizations
- Substance Use Disorder: 11 providers
  - County Health Providers
  - Public Sector Providers
  - Medication Assisted Treatment
- Home Health: 3 agencies
- Durable Medical Equipment: 28 vendors
- Non-Emergent Medical Transportation

School-Based Health Care

West Valley Hospital is the medical partner in the Central High School, School-Based Health Center, in Independence opening later this month and ready for the school year start. There is an Open House for that facility June 25,2015 from 4 - 6 pm. Our understanding is that perhaps it is one of the most integrated School-Based clinics in the state.

- Central Health and Wellness Center at Central High School, Independence, OR
- A certified School-Based health center that serves the entire community, with Central School District students as its priority
- Community Benefits: access to primary care and preventative health, care for children regardless of ability to pay, reduce costs of Emergency Department and In-Patient, save parents time, keep students in class
- Services: Medical, Mental Health, Dental
- Funded by grants from: Kaiser Permanente Foundation, Meyer Memorial Trust, Ford Family Foundation, Spirit Mountain Community Fund, Marion and Polk Early Learning Hub
- www.centralhealthandwellnesscenter.org

Early Learning Hub

CCO connections with the Marion & Polk Early Learning Hub, Inc.

A strong relationship with the early learning hub characterized by:

- CCO serves on the Marion & Polk Early Learning Hub, Inc. (ELH) Board of Directors
- The Executive Director of ELH serves on the CCO Board of Directors as community member
- Provision of in-kind support through office space, HR, accounting and IT functions
- Aligned metrics around developmental screening and children with regular well-child visits

Mutual and emerging work:

- Developmental Screening Transformation Grant - input the Ages and Stages Questionnaires (ASQ) results conducted by early learning providers into the Case Management information system
- Co-communication to Plan Members regarding 2015 kindergarten registration in Marion and Polk Counties
- Parent education and child care provider education focusing on health, nutrition and healthy lifestyles
- Referral coordinator position in Health Promotion Services to assist with clinical referrals to community based in-home services
- Mutual exploration of the effect of poor health outcomes in areas such as the effects of poverty in the community, Trauma Informed Care, dealing with Adverse Childhood Experiences (ACES)

Flexible Services

WVCH has implemented policies and procedures that will allow the plan to fund items not historically provided by the medical system that have a high probability of reducing the overall cost of care for an individual patient. WVCH will make use of flexible goods or services to supplement traditional clinical services to prevent a more intensive level of care and to prevent or reduce hospital stays/claims expense in accordance with OAR 410-141-3120.

WVCH considers services such as:

- Training/Education for health improvement or management (e.g., classes on healthy meal preparation, diabetes self-management curriculum)
- Self-help or support group activities (e.g., post-partum depression programs, Weight Watchers groups)
- Care coordination, navigation or case management activities (not covered under State Plan benefit, e.g., high utilize prevention programs)
- Home/living environment items or improvements (non-DME items to improve mobility, access, hygiene or other improvements to address a particular health condition, e.g., air conditioner, athletic shoes or special clothing)
- Transportation not covered under State Plan benefits (such as transportation to medical appointment)
- Housing supports related to social determinants of health (e.g., shelter, utilities, and critical repairs)
- Assistance with food or social resources (e.g., supplemental food, referral to job training or social services)

Since the inception of this policy, 103 patients have requested a flexible service with 86 of the 103 meeting the criteria outlined in our policy.

Role of the Community Advisory Council

The Community Advisory Council envisions a CCO where needs of patients and families are central to the decisions of the Board of Directors and Clinical Advisory Panel and the goals of the Triple Aim are being met. The Council is made up of five Oregon Health Plan representatives, six Community Representatives and two County Public Health Representatives. The Community Advisory Council meets no less than quarterly, however, has met monthly for the past two years. The meetings are public and held in a variety of locations as well as having translation to accommodate the needs of the public and consumer members.

- The mission of the Willamette Valley Community Health Community Advisory Council is to ensure that the health care needs of the consumers and the community are being addressed by providing strategic direction to the WVCH Board of Directors. All CAC meetings are public and interpretation services are available.

Responsibilities of Community Advisory Council are to provide recommendations to the governing body and/or Clinical Advisory Panel on the following:

- Community Health Assessment
- Prevention programs and best practices for the Community Health Improvement Plan
    - Analysis and development of public and private resources
    - Health policy
    - System design
    - Outcome and quality improvement
    - Integration of service delivery
    - Workforce development
    - Annual CHIP progress report
- Policy guidelines on consumer related activities of WVCH

WVCH, like other CCO's, has vacancies on the CAC. To mitigate this challenge WVCH is using the Transformation Center's Technical Assistance (TA) Bank for consultation on this issue. The TA Bank consultant will be meeting with the CAC in the coming months to help devise a strategy for increasing consumer participation.

WVCH is actively recruiting consumers via our network providers and distributing recruitment materials throughout the community.

Role of the Community Advisory Council

- Creation of Community Health Assessment (CHA)
- Development of Community Health Improvement Plan (CHP)
- Oversight of the CCO's CHP implementation
- Provide WVCH Board with pertinent consumer feedback
- Serve as a conduit for Marion and Polk county residents to engage CCO
- Identify opportunities to improve population health in Marion and Polk counties

Revenue, Expenses, & Profitability

M: Million	2013	2014	2013 as % of Capitation	2014 as % of Capitation	2013 as % of Net Revenue	2014 as % of Net Revenue
Capitation and case rate revenue	$230 M	$408 M	100.0%	100.0%		
Quality Incentive/other grant revenue	$6.2 M	$7.3 M	2.7%	1.8%		
Hospital Reimbursement Adjustment	($34 M)	($49 M)	-14.9%	-11.9%		
MCO Taxes	($1.7 M)		-0.7%	0.0%		
Net Operating Revenue	$200 M	$365 M	87.1%	89.5%	100.0%	100.0%
Cost of Services (Purchased Healthcare, Claims, Pharmacy, Quality Incentive Expense)	$182 M	$327 M	79.1%	80.1%	90.9%	89.5%
General & Admin Expenses	$14.6 M	$24 M	6.4%	5.9%	7.3%	6.6%
Net Income	$3.5 M	$14 M	1.5%	3.4%	1.8%	3.8%

Revenue, Expenses, & Profitability (pmpm)

	2013	2014	2013 as % of Capitation	2014 as % of Capitation	2013 as % of Net Revenue	2014 as % of Net Revenue
Capitation and case rate revenue	$298.23	$347.70	100.0%	100.0%		
Quality Incentive revenue/other revenues	$8.05	$6.20	2.7%	1.8%		
Hospital Reimbursement Adjustment	$44.39	$41.45	-14.9%	-11.9%		
MCO Taxes	$2.20	$0.00	-0.7%	0.0%		
Net Operating Revenue	$259.70	$311.15	87.1%	89.5%	100.0%	100.0%
Cost of Services (Purchased Healthcare, Claims, Pharmacy, Quality Incentive Expense)	$236.11	$278.51	79.1%	80.1%	90.9%	89.5%
General & Admin Expenses	$18.98	$20.62	6.4%	5.9%	7.3%	6.6%
Net Income	$4.59	$12.02	1.5%	3.4%	1.8%	3.8%

Changing the Way Health is Delivered and Financed

- Introduction of global capitation concepts
- Hospitals who employ primary care providers have adopted a financial model that changes emphasis on hospital utilization (a major change)
- Inclusion of hospitals in risk sharing is also a big difference from pre-CCO to post-CCO
- Case rates for some specialties (methadone and pain services)
- Leveraging quality metric funds to pay for performance and clinical results rather than visits/volume
- New in-panel Mental Health provider included to improve access. Marion and Polk County members now have access to the same Mental Health providers with the same authorization process
- Administrative barriers have been removed to expedite access to Mental Health and Substance Use Disorder (SUD) treatment. (Locus score requirement dropped, auto approval of detox, in-panel of Willamette Valley treatment to reduce administrative burden for the providers)

Changing the Way Health is Financed

	Before	Now under CCOs
Primary Care	Fee For Service, Capitation, Access Fees	Global Capitation + PCPCHs, Care Homes, Quality Incentives, Access Fees, Chronic condition fees, RX
Specialty Care	Fee For service with risk	FFS w/risk, case rates for chronic pain + chronic pain counseling
Hospital	Fee for service – no risk sharing	Global capitation; PCP risk sharing
Mental Health	Capitation via Counties/BCN: MHO for 5 counties	Capitation w/ BCN; Psych & medication management in PCP setting; BH home
Substance Use Disorder	Single Methadone provider with Case Rate; Evidence Based Guidelines used and services paid FFS	Addition of working with facilities across the state for residential services: Increased use of case rates Evidence Based Guidelines are used to determine the level of care
Pharmacy	Risk sharing	Risk Sharing between CCO and Primary Care risk groups based on funding vs. expenses.
Primary Care Homes	None	90%+ in Tier 3
Quality Incentive Metrics	Quality was not reimbursed	Methodologies to reward providers for quality
Dental	FFS and Staff Model	Same plus DCO contract from Surgical Center to Dental Office
Behaviorists	Grant funded pilots for behaviorists	75% of enrollees receive primary care from clinics with embedded behaviorists assisting primary care with mental health and substance abuse issues

WHEN will results be broadly evident?

Quality improvement results are evident in the reports released by OHA.

Key Results:

- Excellent results in 2013 quality metrics. (14.6 out of 17 measures met)
- Enrollment with Patients in a patient-centered primary care home is currently at 94.5% of all assigned patients. 91.5% are with clinics that are Tier 3
- Emergency Room utilization is below the State Benchmark (2013 metrics)
- Percentage of Medicaid members (adults and children) who self-report their overall health as excellent or very good increased. For adults, rate increased from 57% to 64%, children increased from 92% to 96%
- Transformation projects are on schedule
- Strong cross-governance with Early Learning Hub in Marion and Polk Countie
- Financial Model Supports OHA global budget methodology
- 2015 cost to State and taxpayers declined 0.4% per member per month compared to 2014 (Blended Per Member Per Month in 2015 is $332.50 compared to same services in 2014 of $333.76) – This difference when compared to the 3.4% increase benchmark saved the State of Oregon and its taxpayers an estimated $15.6 million dollars over one year (based on 102,857 members each month)

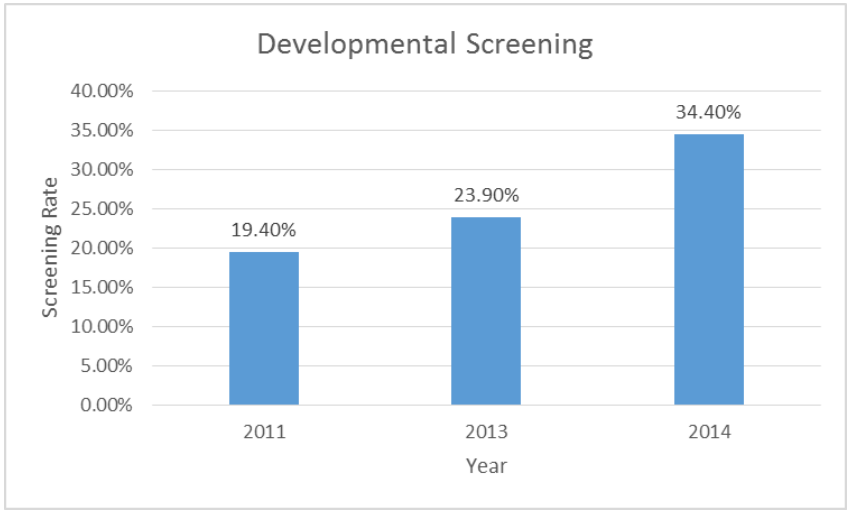
Key Results and the Triple Aim:

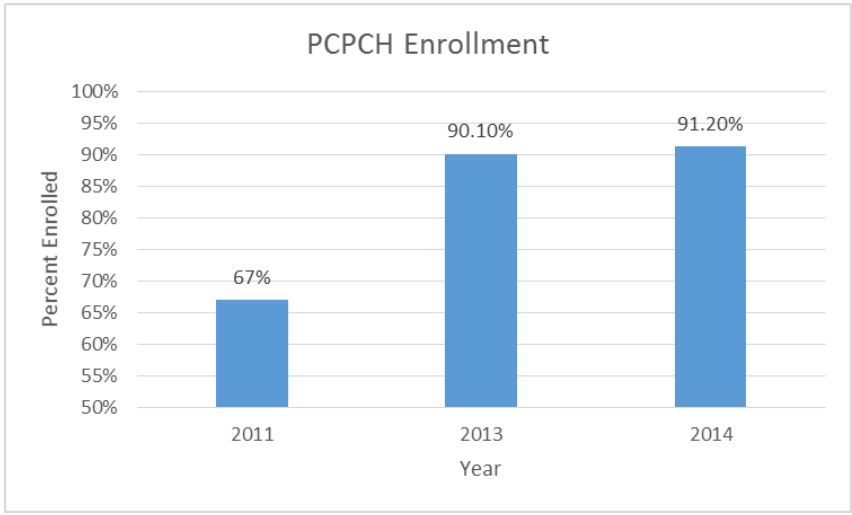
- Reduce the per capita cost of healthcare: Yes – Key Results 5, 7, 8
- Improve the Patient Experience (quality and satisfaction): Yes – Key Results 2, 3, 4, 5
- Improve the Health of the Population: Yes – Key Results 1, 2, 5, 6, 9

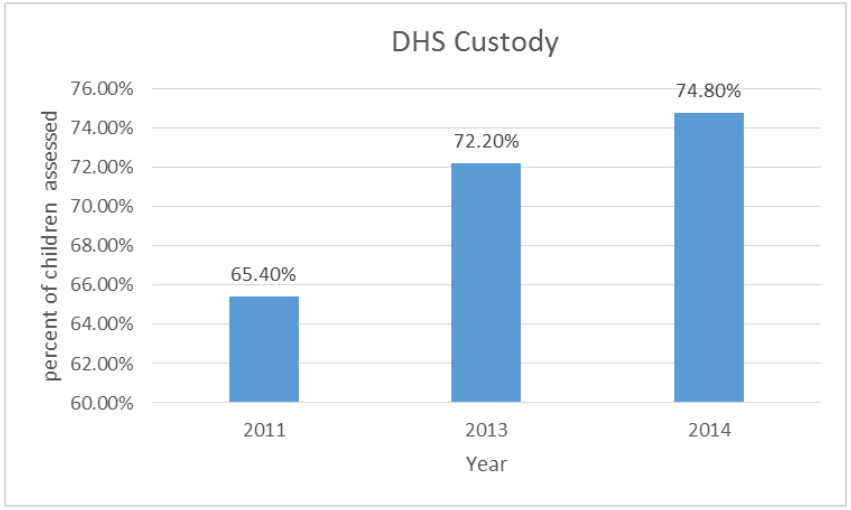
Specific efforts underway that integrate physical, mental and behavioral health

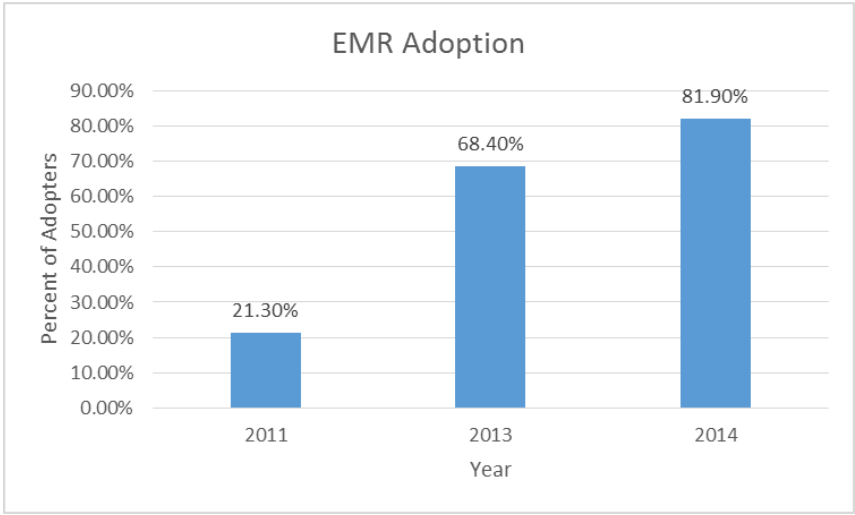
- Embedded behaviorists in primary care homes
- One mental health/Chemical Dependency provider with embedded primary care provider
- Early Learning (Represented on the CCO Board)
- Behavioral health staff co-located to be closer to CCO Administrative Service staff for increased collaboration and care coordination, planning, meetings, and operations
- Weekly care management meetings provide opportunities to discuss members with concurrent mental health and physical health issues
- Included mental health data into reporting database to integrate all physical, behavior and pharmacy data
- Dental van has been scheduled at a behavioral health consumer run organization with additional dates pending
- Data has been shared with FQHC to inform them which of their members are in treatment and who the mental health provider is
- Physical and Mental health data is part of the Emergency Department Information Exchange (EDIE)/PreManage “common core” development
- Collaboration with the physical plan management to develop and implement opioid Pharmacy guidelines
- Traditional health workers on emergency department diversion team have been partnering with mental health peer support specialist to decrease unnecessary Emergency Department visits
- Mental health consumer run programs provide support to encourage healthy lifestyle choices

Quality Improvement Metrics Trend

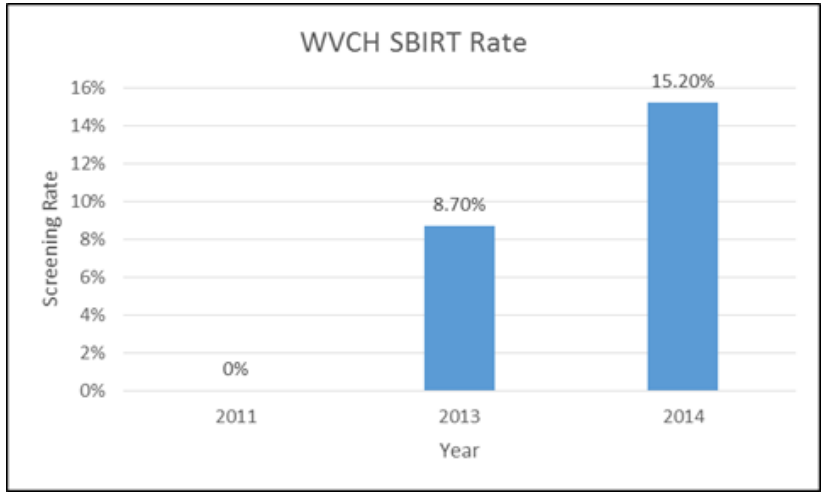


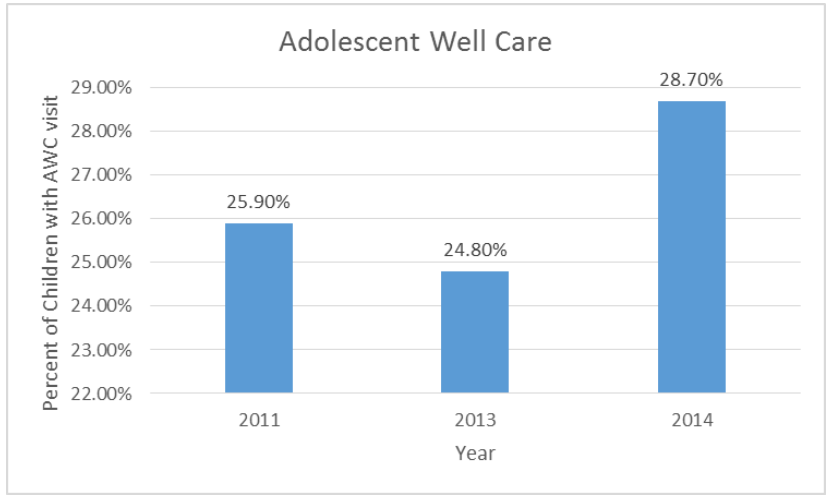


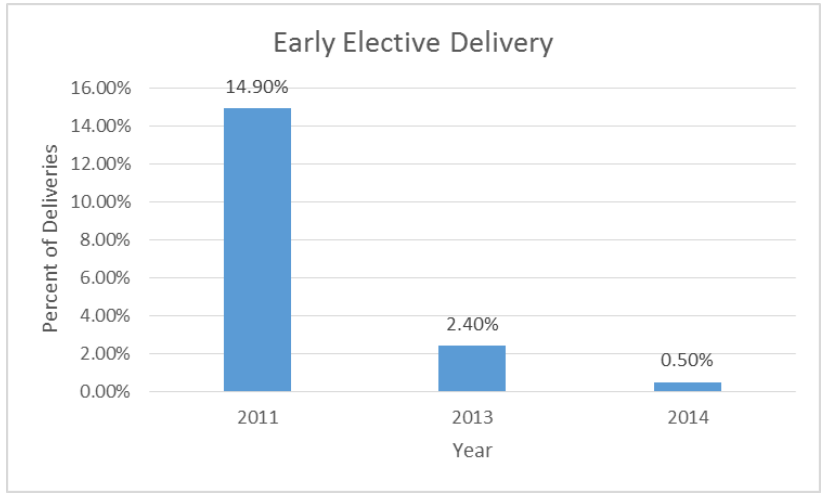


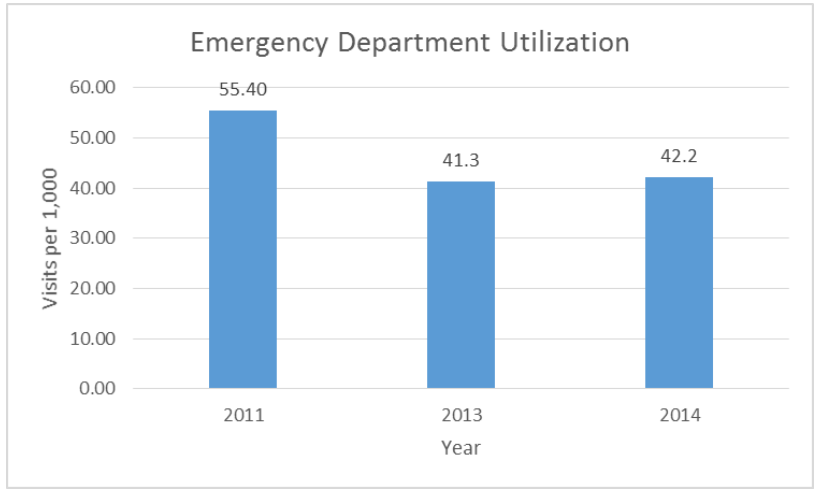


Quality Improvement Metrics Trend

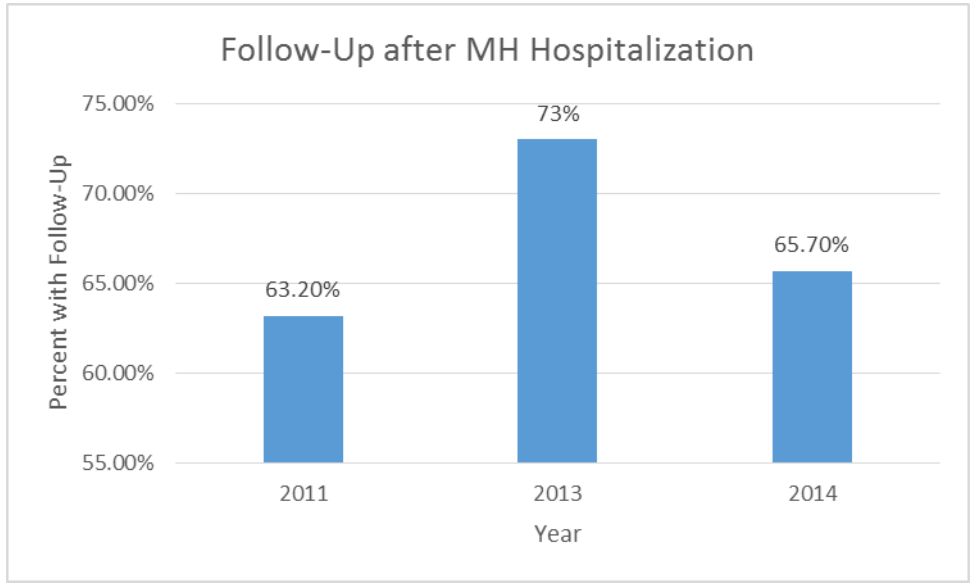


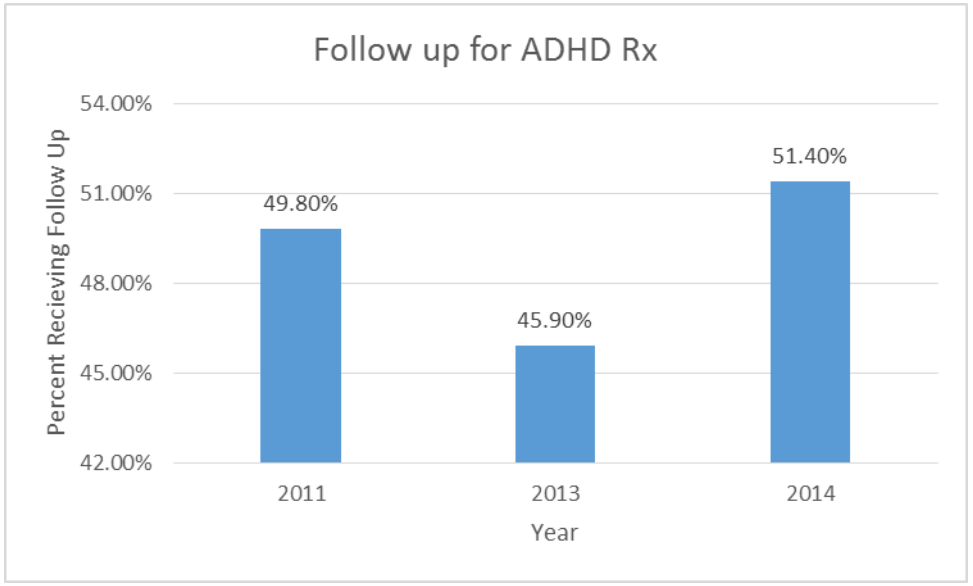






Quality Improvement Metrics Trend





WVCH 2014 QIM Preliminary Results

Measure	Target	Rate	Met?
Adolescent Well Care	28.1%	28.7%	YES
Assessment For Kids in DHS Custody	68.7%	74.8%	YES
Controlling Hypertension	N/A	N/A	YES
Developmental Screening	26.5%	34.4%	YES
Depression Screening and Follow-Up	N/A	N/A	YES
Diabetes: HbA1c Poor Control	N/A	N/A	YES
Early Elective Delivery	5%	0.5%	YES
Emergency Department Utilization	44.6/1,000	42.2/1,000	YES
EHR Adoption	71%	81.9%	YES
PCPCH Enrollment	60%	91.2%	YES
Follow-Up for Children Prescribed ADHD Rx	46.4%	51.4%	YES
MH Hospitalization Follow-Up	68.8%	65.7%	NO
SBIRT	11.7%	15.2%	YES

WVCH Incentive Measure Struggles

WVCH failed to meet two incentive measures in 2013:

- Adolescent Well Care Visits
- Follow-up care for children prescribed ADHD medication

The preliminary 2014 incentive measures show the lowest metric as:

- MH Hospitalization Follow Up

Adolescent Well Care Visits: Barriers

Inherent barriers to adolescent access

- Adolescents tend to enter the health care system from many points of entry
- Competing adolescent attitudes, beliefs and behaviors (lack of motivation)
- Issues with developmental appropriateness and confidentiality

Providers Question the Practicality and Efficacy of the Incentive Measure

- Policies and reimbursement vary across payers, necessitating unique workflows for Medicaid members
- Lack of understanding amongst providers regarding impact of adolescent well care visits; wide-spread sentiment that this is simply “counting widgets”
- Expansion of Medicaid population stretches capacity for clinics to conduct outreach

Adolescent Well Care Visits: CCO Actions

1. Provided assistance with targeted member outreach and appointment scheduling
2. Distributed member-level reports identifying children in need (gap analysis) of care
3. Developed quality pool payment methodology that incentivized providers to make incremental improvements
4. Modified WVCH benefit package to align with incentive measure

Follow-Up After ADHD Prescription: Barriers

The prevalence of Attention Deficit with Hyperactivity Disorder (ADHD) amongst WVCH members has historically exceeded the statewide Oregon Health Plan population

- Driven by community prescribing practices that favor medication
- Exacerbated by loose CCO and Pharmacy Benefit Manager (PBM) oversight of ADHD medication

Limitations to incentive measure structure and intent

- Many physicians view the required office visit as an inappropriate use of resources and believe a phone call would be sufficient for follow-up
- Claims lag makes it difficult for CCO to provide case management support within the 30 day window

Follow-Up After ADHD: Actions

1. Implemented strict prior authorization process for new prescriptions
2. Engaged provider community in discussion surrounding Attention Deficit with Hyperactivity Disorder prescribing practices
3. Collaboration between Mid-Valley Behavioral Health Care Network (MVBCN) and primary care practices to educate providers regarding impact of ADHD medication on children

MH Hospitalization Follow Up: Barriers

- Patients who are hospitalized on fee-for-service but discharged as WVCH members. CCO is not notified and does not have the opportunity to manage care
- Limited number of billing codes count towards the metric, some completed contacts are not included
- Some individuals refuse follow-up appointments
- Some individuals no-show for scheduled visits
- Some hospitalizations are out of area or out of state and CCO is not notified until the claim arrives months later

MH Hospitalization Follow Up: Actions

1. New staff has increased their involvement with discharge planning and follow-up with outpatient providers to ensure contact and appropriate billing
2. Exploring whether we can find a way that clinical support from BCN staff could count
3. Setting up real-time tracking system so that we aren't reliant on six month delay in OHA data
4. Bringing outpatient MH providers into the hospital to initiate care and improve engagement in follow-up care

Impact of Incentive Measure Activities

2014 preliminary results indicate WVCH surpassed improvement target for both “Follow-Up After Attention Deficit with Hyperactivity Disorder Prescriptions” and “Adolescent Well Care Visits” as well as continuing to improve on the other metrics.