

From Underserved to Better Served: Leveraging Payment Reform to Improve Care

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Session Objectives

- ✓ Learn how using data drives patient care
- ✓ Demonstrate how using risk stratification leads to increased engagement for patients at high risk
- ✓ Discuss how establishing a strong medical neighborhood meets patient's comprehensive needs

Community Health Center Association of Connecticut

- ✓ Primary Care Association of Connecticut
- ✓ Represents 94% of all Federally Qualified Health Centers (FQHCs) in Connecticut
- ✓ State-wide geographic coverage



94% of all FQHCs in CT belong to CT-PTN

Patients at Connecticut FQHCs



75.6% Racial/Ethnic Minorities



78% Medicaid or Uninsured



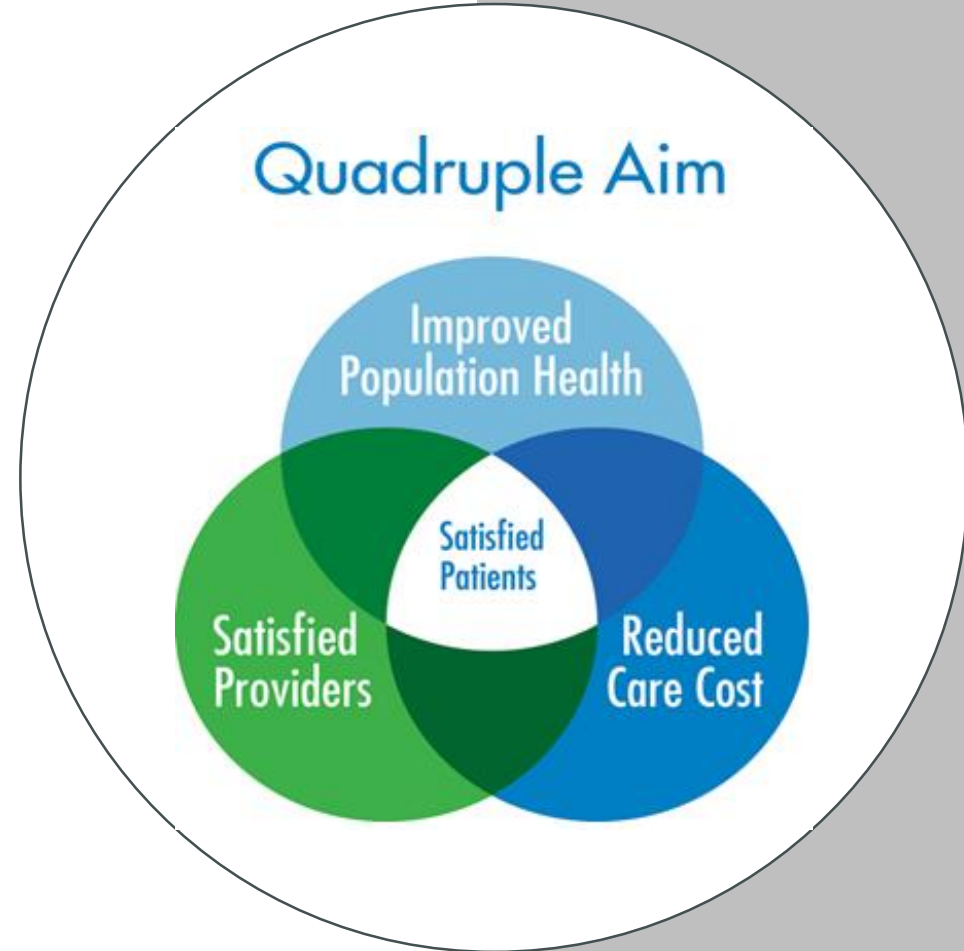
90% Below 200% FPL



26.5% are best served in a language other than English

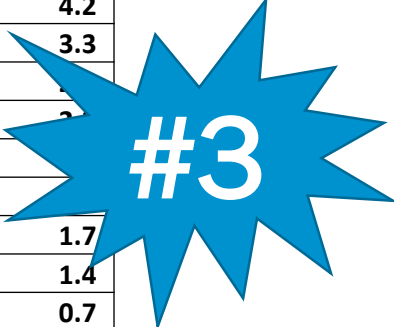
Transforming Clinical Practice Initiative

- ✓ \$700 million grant
- ✓ National Scope
- ✓ Prepare Primary and Specialty Care practices for value-based payments



PTN	Hospitalizations reduced/ clinician
UMass	20.9
AZHEC	14.2
CHCACT	12.6
PBGH	8.9
NYeC	8.0
Mayo	7.5
NYU	6.5
HQI	5.5
MQC	4.5
Vand	4.2
CCNC	3.3
RIQI	2.5
WDOH	2.0
Colorado	1.8
Vizient	1.7
CHOC	1.7
COSEHC	1.4
IHC	0.7
IU	0.5
PeaceHealth	0.4
HPD	0.3
CarePoint	0.3
BHSALA	0.1
UofWash	0.1
NJII	0.1
NatCouncil	0.1
VCSQI	0.1
NRACO	0.0
APA2	-
LA	-
VHS	-
TOTAL	2.9

CHCACT: 12.9 hospital utilizations per clinician



Leader in TCPi



CHCACT: \$43,962 saved per clinician

AIM 3
Reducing Unnecessary Hospital Admissions & Utilization

AIM 4
Generate savings to the federal government & commercial payers

PTN	Savings/ clinician
BHSALA	\$ 94,379
CHCACT	\$ 43,962
MQC	\$ 41,954
IHC	\$ 38,620
AZHEC	\$ 37,223
NatCouncil	\$ 34,644
Vand	\$ 34,205
WDOH	\$ 31,153
NYU	\$ 30,579
PBGH	\$ 29,969
NYeC	\$ 28,817
RIQI	\$ 23,294
IU	\$ 23,012
PeaceHealth	\$ 22,141
Colorado	\$ 21,843
UMass	\$ 18,657
NJII	\$ 14,983
NRACO	\$ 12,569
LA	\$ 12,523
HQI	\$ 11,788
UofWash	\$ 11,324
Vizient	\$ 11,065
COSEHC	\$ 11,009
Mayo	\$ 10,373
CHOC	\$ 10,290
HPD	\$ 4,999
CarePoint	\$ 4,952
VHS	\$ 3,967
VCSQI	\$ 3,713
CCNC	\$ 2,016
APA2	\$ -
TOTAL	20,755

CT-PTN Results



13,631 Avoided Hospital
Admissions & ED Visits



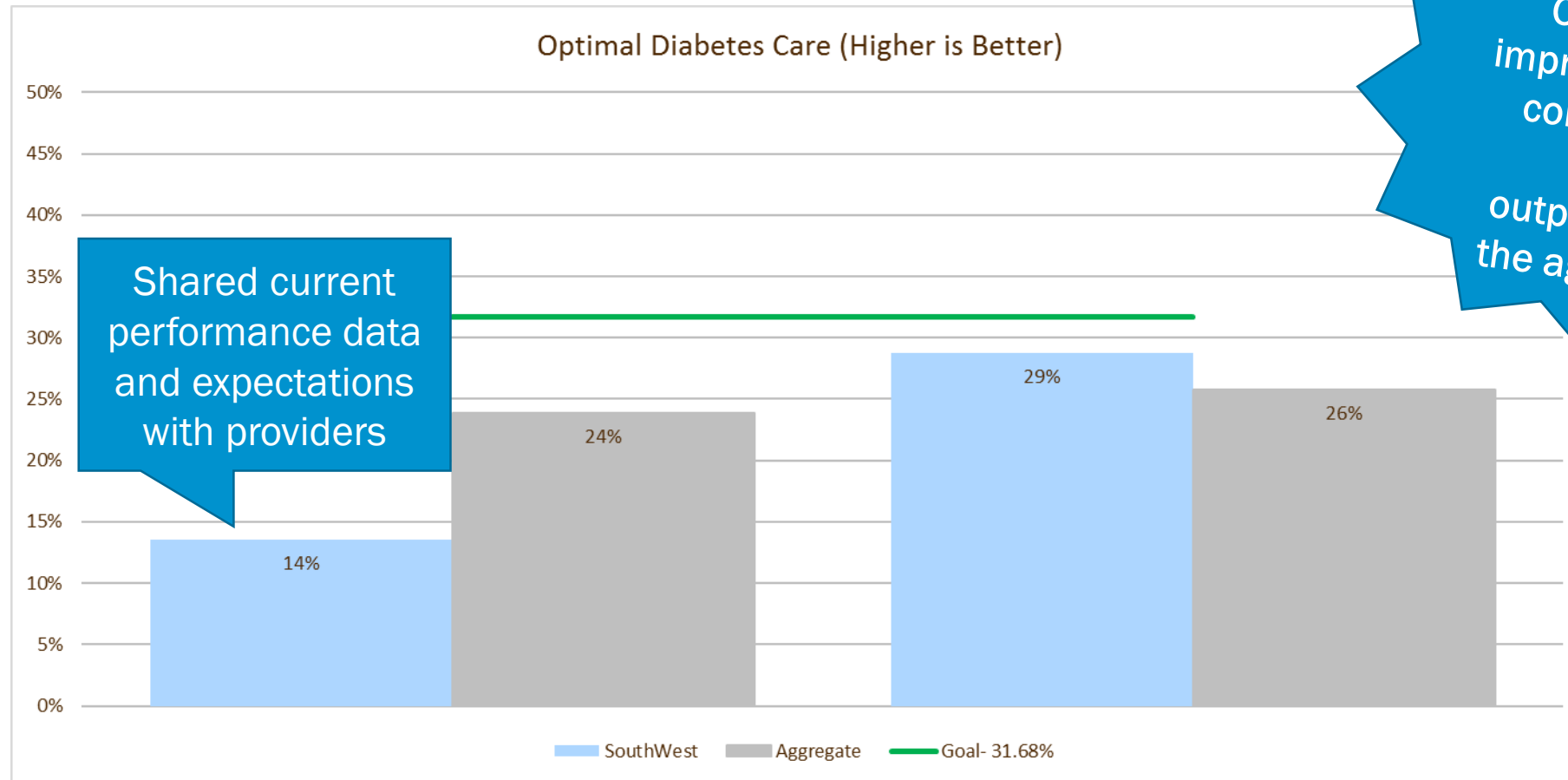
\$47.6 million in cost
savings

Using Data to Drive Patient Care

- ✓ Monthly data reports to providers
- ✓ Dashboards
- ✓ Huddles/Pre-visit planning



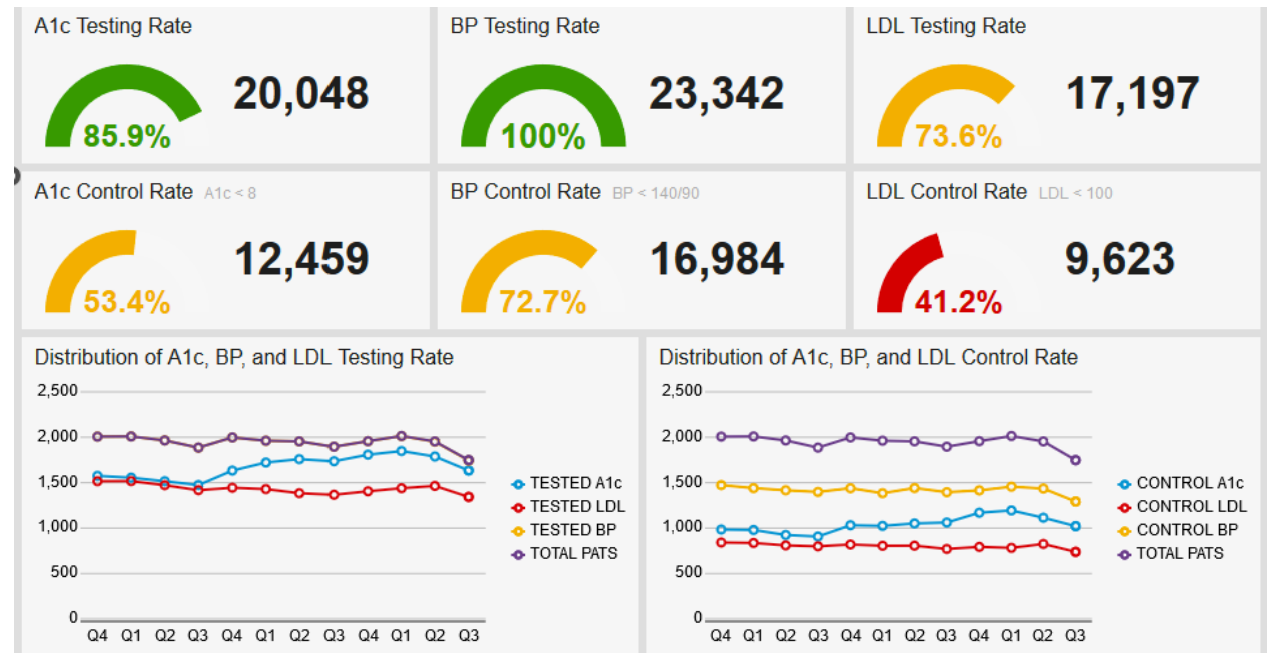
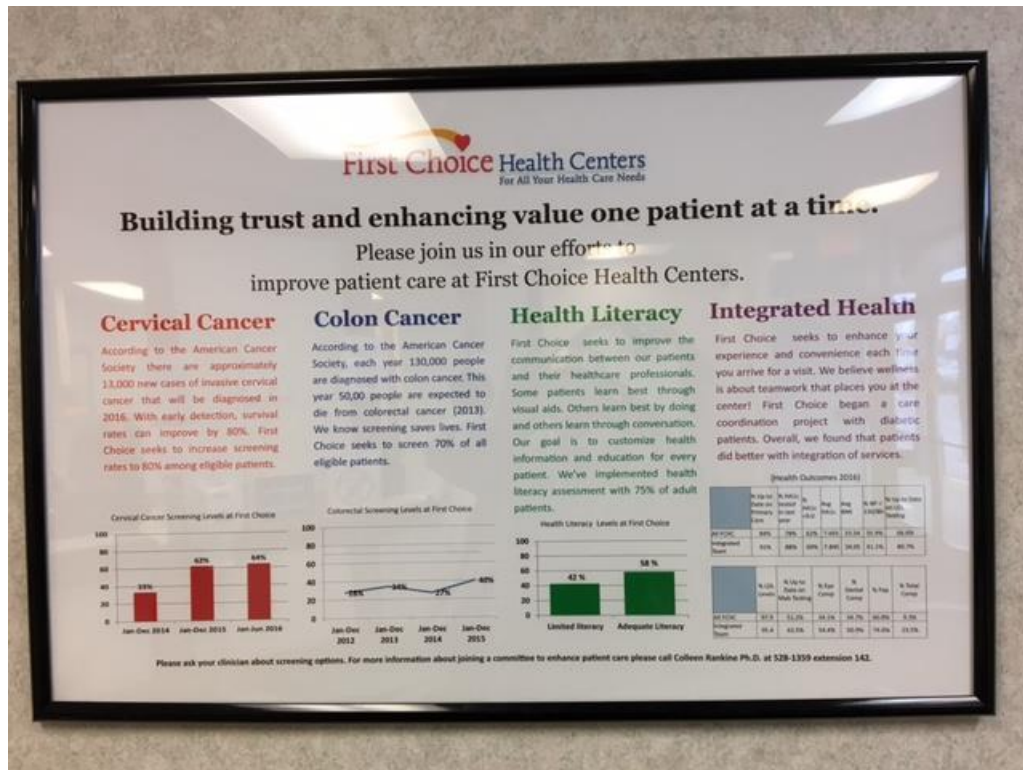
What Happens When You Share Data?



Shared current performance data and expectations with providers

Over 15% improvement in control rate AND outperformed the aggregate!

Other Examples



Why Risk Stratification?

- ✓ Is the foundation of population health
- ✓ Directs appropriate resources to patients most in need
- ✓ Holistic view of the patient to improve outcomes

Form: Care Level Assessment - 4.2017

Auto Neg Uncheck All

Care Level Assessment Outline Preview

**4 A # 3
Poor Control/
Complex Conditions**

**4 A # 2
Utilization**

Medical Assessment

- HgA1c >
- BP > 140/90
- High BMI/Obesity/ Family Hx Diabetes
- Smoking/Nicotine Dependence
- (+) Screenings (PHQ9/A/CAGE-A+/MCHAAT)
- Diagnosis of Asthma
- Diagnosis of COPD
- Diagnosis of Heart Disease
- Patient is HEP C positive.
- Patient is HIV positive.
- Diagnosis of Cancer
- Dx Dental/Oral Health/Ped Caries
- Pregnancy
- Chronic Debilitation/Disability/Ped Med Dx

Utilization

- Five MEDICAL visits in the past 12 months.
- Recent ER visit within the past 90 days.
- Frequent No Show (2 out of last 5 visits.)
- Inpatient Admissions w/in 90 days.

Social Risk Factors

- Unable to meet daily needs.
- Economic/Financial Issues/Unemployment
- Homeless/Migrant
- Uninsured.
- Language Barrier/Low Literacy
- Transportation/Social Issues.
- Legal issues (DCF, probation, etc.)

Mental Health

- Psychiatric Diagnosis
- Suicide attempt in the past 12 months.
- Substance abuse/Addiction.
- Psychiatric admission in the past 90 days
- TAY (Transition Aged Youth)

Age

- Age 0 to 18
- Age 65+

**4 A # 1
BH Conditions**

**4 A # 4
Social
Determinants**

Overall Score

Care Level Assessment - Additional Comments

Care Level Assessment - Overall Score

Overall score translates to Care Level Assignment Below and Pt is entered into corresponding Care Program.

CARE LEVEL ASSIGNMENT

Preventative (1 = Dark Green)	0 -> 3
Low Care Level (2 = Kelly Green)	4 -> 5
Moderate Care Level (3 = Lime Green)	6 -> 7
High Care Level (4 = Yellow)	8 -> 9
Highest Care Level (5 = Orange)	10 -> 11
Highest Care Level (6 = Red)	12+

FAMILY PRACTICE MENU V6.0

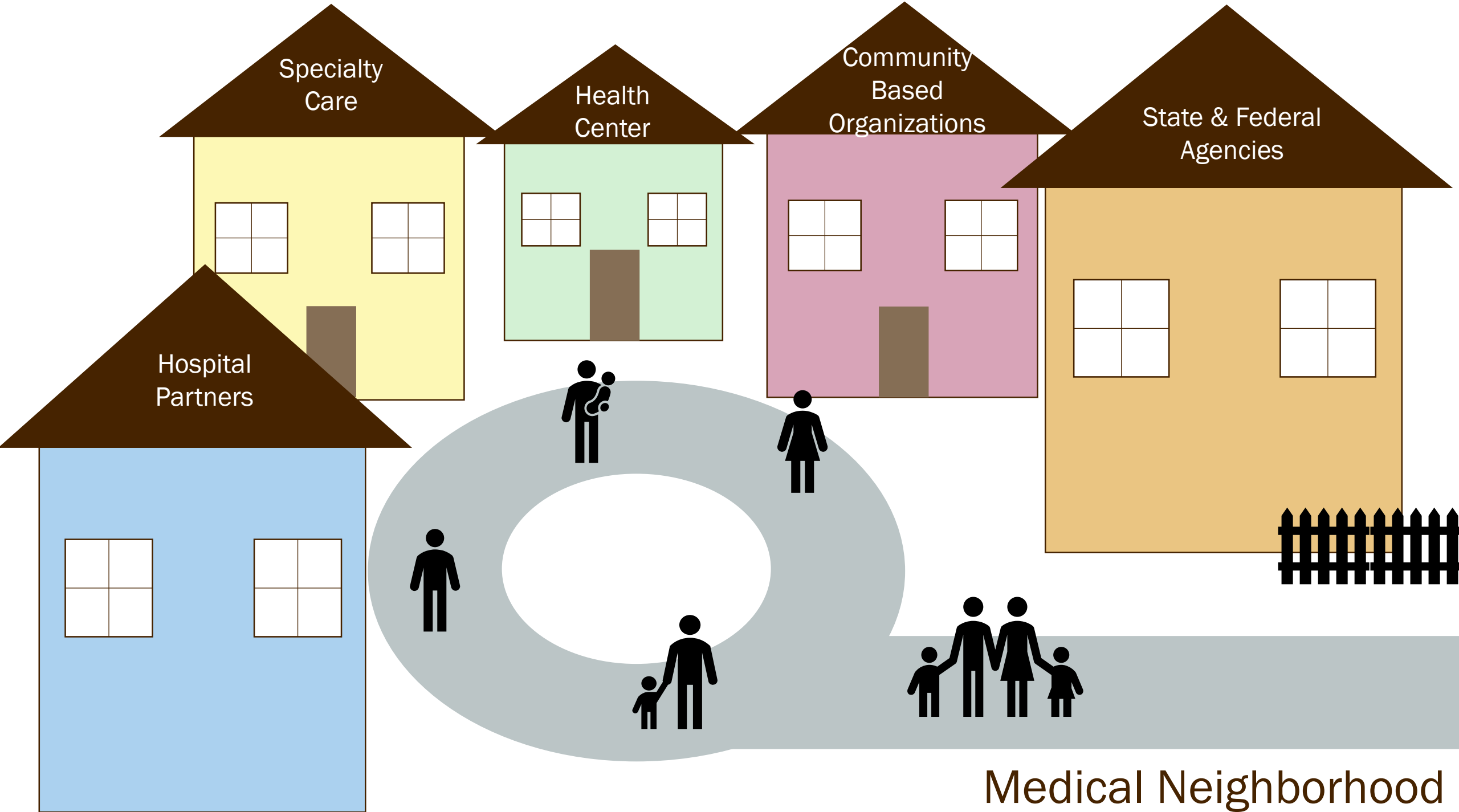
AK.Final 4/2017

How Does Risk Stratification Impact Care?



- ✓ Empanelment to a Care Team
- ✓ Appointment time length
- ✓ Pre-visit planning
- ✓ Care Coordination
- ✓ Integration of Care

Bradley, E. H., & Taylor, L. A. (2013). *The American health care paradox: Why spending more is getting us less.*



Questions?

