

CCHN 2021 Value Based Care Podcast Series

Transcript for Episode 1: Introduction to Value-Based Care and the Impact on CHC Workforce

Shannon Connell [00:00:00] Hello, and welcome to the Colorado Community Health Network Value Based Care Podcast, this short podcast series is hosted by the Colorado Community Health Network, or CCHN. CCHN is the collective voice for Colorado's 20 Community Health Centers, or CHCs, and the patients they serve. Colorado's CHCs provide a health care home to more than 847,000 of their community members, one in seven people in Colorado, from 63 of the state's 64 counties. This is a three-part podcast series meant to provide short, digestible introductions on how to work at Colorado's CHCs is changing in response to new models of care and payment in Medicaid. Each episode could be accessed at any time through CCHN's website. This series is not a comprehensive guide of what it means to operate under a value-based care framework. Instead, it provides an introduction to the topic of value-based care and investigates how the workforce at a Community Health Centers may be impacted by this model. I'm Shannon Connell, and in this episode, we're going to be exploring more about the value-based care framework with those who know it best. Before we jump in, here's some background on transformation in Colorado Medicaid payment. First, CCHN is working with the state Medicaid agency to create an optional payment methodology called APM Two or the Alternative Payment Methodology Two, that will reimburse providers for medical care on a per patient instead of a per visit basis. Three CHCs hope to go live with this payment model in 2021. Second, a portion of Medicaid reimbursement for all twenty CHCs is now tied to value. Under normal Medicaid payment, what is called APM One for CHCs, up to four percent of each CHC's medical Medicaid rate is at risk. CHCs earn points to retain four percent of their visit rate by being PCMH recognized and by meeting benchmarks or closing a performance gap on claims and ECQM measures that each CHC selects. CCHN and has a nickname for this payment model called the "Four Percent". I spoke with Polly Anderson, the Vice President of Strategy and Financing at CCHN, and Ross Brooks, CEO of Mountain Family Health Centers in May 2021. After talking through the basics of value-based care, we chatted about the current and anticipated impacts of these changes on CHC staff. How duties will change, how it will impact retention and how it will attract new staff to health care as the CHCs move into the value-based care future of health care.

Polly Anderson [00:02:54] My name is Polly Anderson, I'm the Vice President of Strategy and Financing at the Colorado Community Health Network, and I've been there for almost 16 years. And what drew me to work with health centers is a long passion for access to care, and for equity, and for ensuring that folks who have challenges accessing care, primary and preventive care, can get it. And health centers embody that as a mission and are excellent sources of quality and innovation. And it's a thrill to work on their behalf, particularly in the payment arena. I'm the staff lead at CCHN for our work in Medicaid payment reform.

Ross Brooks [00:03:39] Hi everyone. My name is Ross, I've been in the Community Health Center movement for close to two decades now. The first decade was at CCHN, and the last nine years I've served as the CEO of Mountain Family Health Centers.

Shannon Connell [00:03:54] Can you describe what value-based care is?

Polly Anderson [00:03:58] Historically, most reimbursement in health care has been tied to volume and not quality. Payers started to think about their purchasing power, including Medicaid and Medicare and private insurance companies, and think about how they could

use payment to incent best practices or promising practices in care delivery and to encourage providers to do more for quality improvement or to direct their payments and reimbursement towards providers that were already focused on that and leave providers that aren't focused on quality out of the equation.

Ross Brooks [00:04:34] When I think about value-based care and how to talk about it, it really goes back to the historical context that in the United States, health care is paid for on a volume basis. It has been historically and still much of health care delivery today is paid for on a volume basis, which incentivizes, excuse the ungraceful word, “widgets”, seeing patients quickly. We set our budgets at Mountain Family around medical productivity standards, how many human beings we serve every day, and how many visits we have with human beings. We do the same thing for behavioral health and the same thing for dental health. We set our budgets based on productivity to have a high volume of care. That is less humane and less human than incentivizing value-based care, which rewards health care teams and health care providers for caring for complex human beings and rewards them for helping improve the quality outcomes for those human beings. So, the real basis of value-based care, in my mind, is shifting away from a volume mentality and shifting into a value mentality that rewards caring for complex human beings, which we all happen to be pretty complex human beings. And it really incentivizes us as a health care provider to improve the health of the population. So really, the genesis of why we are participating in these pilots and the aspirations to shift the entire U.S. health care system towards value-based care is because I and we believe that it is a more humane way to deliver care to complex populations, which I would argue includes all of us.

Shannon Connell [00:06:25] Polly, were there any concerns that you heard from any of the participating health centers when you asked them to join value-based care?

Polly Anderson [00:06:32] For sure. There's a number of concerns that I think we still have and are going to be watching closely when we finally launch APM 2 our PMPM. The first one is that it's difficult to innovate without new resources. And although the money will come in differently to the health centers in a monthly payment, rather than waiting for reimbursement to accrue based on face-to-face visits, it's still not additional dollars to bring new members of the care team in immediately to help address what the patient may need the most. So, that is a significant concern that it's a different way of getting paid, but it's not additional resources. And we know that health centers are already pretty lean, mean machines when it comes to revenue and don't have a lot of resources around to redesign care overnight. So, we think that will take some time. And the second concern that I think is pretty common is just that the revenue won't be sufficient, it won't be the same as what we would have gotten under traditional face to face visits. All we can do to address that concern is just work really closely with the state Medicaid agency on that rate setting and really do some testing on reimbursement and to track it really closely once we do finally launch.

Shannon Connell [00:07:49] Ross, can you describe some of the training that you will be doing or have already done with your staff to prepare them for a value-based care implementation?

Ross Brooks [00:07:58] I'll provide a little bit of context for our aspirations, but also concerns walking into the value-based future and trying to help create the value-based future. It still feels at Mountain Family today, May 2021, like we're flying this plane that has two different wings and two different engines on it. One wing is from the 1950s and is dependent on burning diesel fuel and it's very volume driven, and the other wing is made

of graphite and very light and is our aspirations for the value-based future. But in the real world, every day at Mountain Family feels like we're flying this plane with two different wings, one on volume, one dependent on the value that we've been talking with our team for the better part of the last decade about these aspirations towards value-based care. But what reality is, we haven't shifted very much of our revenue into value-based human centric revenue yet. In preparation to get there, and we're hopeful that we're going to launch with CCHN and Clinica and Salud this coming summer in 2021, we've started to prep our teams for the changes that are going to come. So from a training perspective, we have three work different groups at Mountain Family under our Value-Based Population Health Committee, which is made up of clinical leaders, financial leaders, operations leaders, boots on the ground, medical assistants, nurses, and other health care providers, really multidisciplinary teams whose job it is to work through a lot of the workflow changes that are likely to come at Mountain Family over this in the future and also to start to communicate with staff about what those changes might be and might look like, Those three different committees are called our Finance and Communication Work Group, that's one of our committees. The next one is really our Value-Based and Quality Improvement committee, and then the last one is our Risk Stratification Working Group committee. Those three groups help inform decisions. Now, all of that said, it's still pretty complicated.

Shannon Connell [00:10:06] Are you taking into account value-based care when recruiting new staff members?

Ross Brooks [00:10:10] Yes. Part of the conversation on our aspirations and our hiring process, and it is part of our current budget debate for our next fiscal year, which starts on June 1st, and value-based care and value-based reimbursement as part of our budget and staffing discussion the last two or three years now. Meaning that as we're walking into our new fiscal year, we're sitting down with the executive team saying "how might we shift the complex care nurses roles and responsibilities? Might we need more data analytics within our I.T. department? How might we shift our call center focus, given the value-based aspirations of the future?" So, it continues to be complicated, and that's a real-world problem we're working on still this week at Mountain Family as try to walk to our next fiscal year. That said, what I think is likely to happen is that we will hire more complex care nurses to help manage the complex care of our patients, and hire more data and analytics staff to help with risk stratification and really understanding the complexity of our patients across the board.

Shannon Connell [00:11:25] Ross, are you using the value-based care model to help recruit at all?

Ross Brooks [00:11:30] It's a conversation in most of our hires, especially for providers, and nurses, and executive level folks. And we use it as kind of an aspirational talking point, being realistic that we haven't implemented value-based care reimbursement for majority of our patients yet. So, we use it in conversations and I think some folks that relate to try to be on the leading edge of shifting into the value-based future. And for some folks, it's probably a detractor. Not everybody wants to be piloting and on an innovative edge of trying to change healthcare.

Shannon Connell [00:12:07] Polly, do you see value-based care as becoming a wider recruitment tool for Colorado Community Health Centers?

Polly Anderson [00:12:13] I was thinking that I really do think once launched and when we begin to rack up some successes under the PMPM that it really will become a

recruitment tool. I think a challenge of working with health centers is the complexity of patients, and the fact that there's never enough time to chase down referrals or to spend maybe the time that patients need in the exam room for complex, for their complex health conditions that are brought on by poverty and racial injustice, systemic racism, etc. The promise is that with everyone working at the top of their license, you know, whether you're an MA, care coordinating nurse, or a typically billable provider, if everyone is being triaged to meet with the member of the care team that they need the most, it should free up the traditional providers time to spend in the exam room, or on the phone, or on telemedicine with patients who have more complex need without that push to get to 16 or 20 visits a day, they could actually spend a good 45 minutes with more complex patients. Meanwhile, your nurse is doing a simple throat swab for a kid who's got strep, freeing up that provider's time because the visit with the provider isn't needed to generate revenue. You know, two kinds of extreme examples, but I do think that reorienting the system around what the patient needs will take the pressure off the volume system that is health care and I think should be very attractive for providers and for all staff. The health center is reoriented towards what the providers want to do and what patients need are some real opportunity for us to transition our uninsured patients to that model of care, since they don't have a payer per say that they can move into that population based approach and de-medicalize issues where it's needed and provide additional time with providers where that's needed too. On the short term, there's a lot of experiments going on and they don't impact all patients.

Ross Brooks [00:14:22] Yeah, that's a great point, Polly. And if I could just add on there as well, the upside is this opens up opportunities with payers and other partners to shift to value-based care. Polly's right in that different payers are going to have a different pace by which they adopt, shifting the primary care capitation focus with hopeful gain share for total cost of care. But on the flip side, we've started working with our local hospital partners and county partners, pitching them on an uninsured per member per month model for our uninsured patients that don't have regular payer source. So that opportunity exists in part because of the CCHN/HCPF pilot and the work of Medicaid prime to try to shift reimbursement for uninsured into a more value-based structure. That's an exciting upside of all of this. The other, I think, realistic complication is that even if we move the vast majority of our medical patients, let's call it 80% plus, to value-based reimbursement and care, our dental care and behavioral health care, for the most part, is still going to be pretty volume dependent in the short run. So, one of our long term goals is to figure out how do we shift behavioral health care and reimbursement and dental health care and reimbursement into a more value-based system over the coming three to five years.

Shannon Connell [00:15:42] Great, thank you. Is there anything else that either of you would add from the leadership or operations perspective to someone who might be considering adding the value-based care model to their CHCs?

Polly Anderson [00:15:56] Yeah, we haven't talked too much about the Four Percent program, and that's where health centers have up to four percent of their rate that's paid for medical visits at risk if they don't meet certain quality improvement benchmarks or if they're not patient centered, medical home recognized or working towards it. That is a pretty low risk area of value-based care experimentation that we encourage health centers to take an active role in. There is real opportunity if all providers in Medicaid, especially health centers who see such a large portion of patients, to go after a certain health condition like depression or blood pressure screening and follow up and really move quality of care forward on that. It's not a perfect program because ideally in value-based care where there's risk, there should also be opportunity for high performance and for

health centers right now is not an opportunity for any upside or additional reimbursement or to get rewarded for the ultimate outcome of our quality improvement efforts, which is reducing the total cost of care and improving the quality of life and care for patients. But this is an opportunity and I think as health centers, as we can demonstrate year after year that we're able to meet quality improvement benchmarks or exceed them. That will give us more leverage to negotiate better value-based care programs in Medicaid and to work, as said, to spread those to other payers where we can say, "hey, look what we're doing over here. If you pay us this way, we can do the same thing for your patients." I do think there's some real opportunities. It's not just the provider who is part of the team that's going to be influencing that depression screening or that blood pressure outcome. It's everyone from the staff who are doing triage and scheduling, who do outreach to patients based on their chronic conditions, to the follow up that happens to the referral to specialists, etc. There's hardly a person that works at a health center that doesn't have an opportunity to be part of shared goals of quality improvement. And value-based care is a chance to really focus in a few areas rather than on the whole entire world of measure sets and put resources towards improving care outcomes. And that gives me leverage here at the Primary Care Association to push for better and more programs that recognize and reward the health center's role in quality care, especially for people who are more burdened with illness and poverty.

Ross Brooks [00:18:36] I think the question that I ask myself and that I would encourage my peers to ask is what kind of care do I want to receive? What kind of care do I want my family to receive and what kind of care do I want our patients and our community to receive? In the answer to that is, humanistic care that meets me as a patient, where I'm at and where my family is at and provides the resources and the support for my entire human being, body promise and value-based care moves us in that direction. That's the question I think we should be asking ourselves. It requires significant intestinal fortitude, thick skin and a soft heart to continue to move in that direction. And I think for Community Health Centers, it is very attached to the DNA of who we are.

Shannon Connell [00:19:31] Thank you all for listening and thank you to our speaker for sharing. Don't forget to listen to all the CCHN Value-Based Care podcast episodes. Take a moment to check out further resources on this topic found on the CCHN's website and leave us a review by filling up the evaluation form on this series in our email communications. Questions about this podcast can be said to Shannon Connell at sconnell@cchn.org. Have a great day and thank you for your time.