Readiness for Value Based Payment

Strategies and Activities for High Performance

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About Us:

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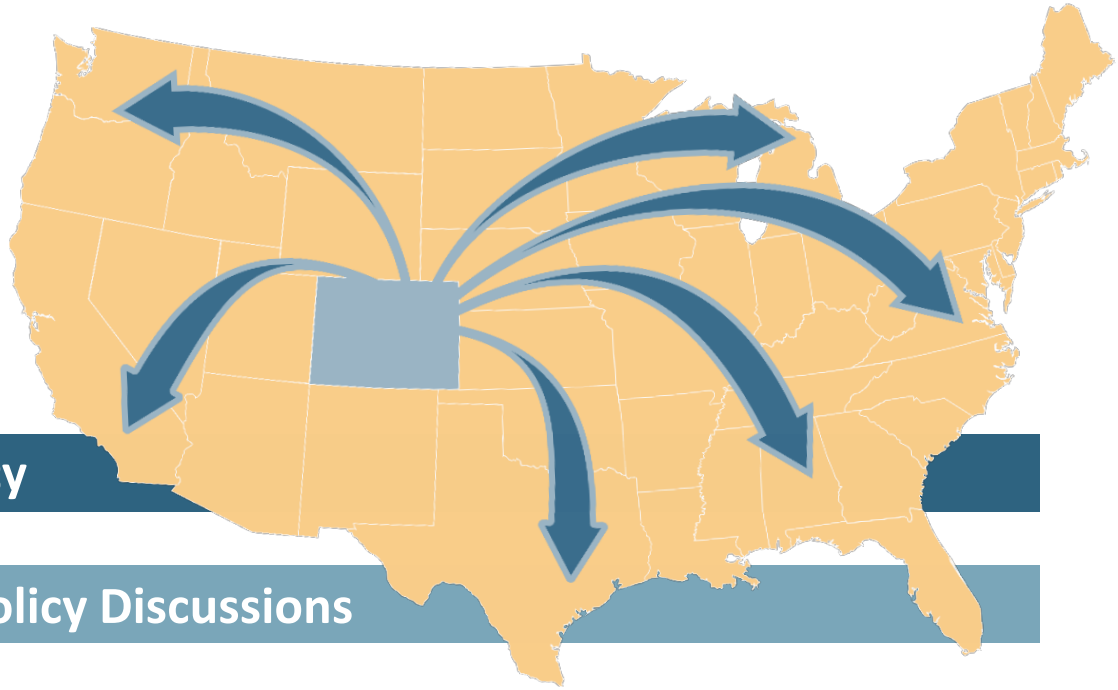


Inform State and National Policy

Contribute to Current Health Policy Discussions

Support Efforts to Improve Health

Three Takeaways

1. Value based payment is here.

2. Advanced care practices will use data for population health management, save costs throughout the system, and share in those savings.

3. Strengthening your infrastructure will serve you regardless of your policy environment and help you adapt.

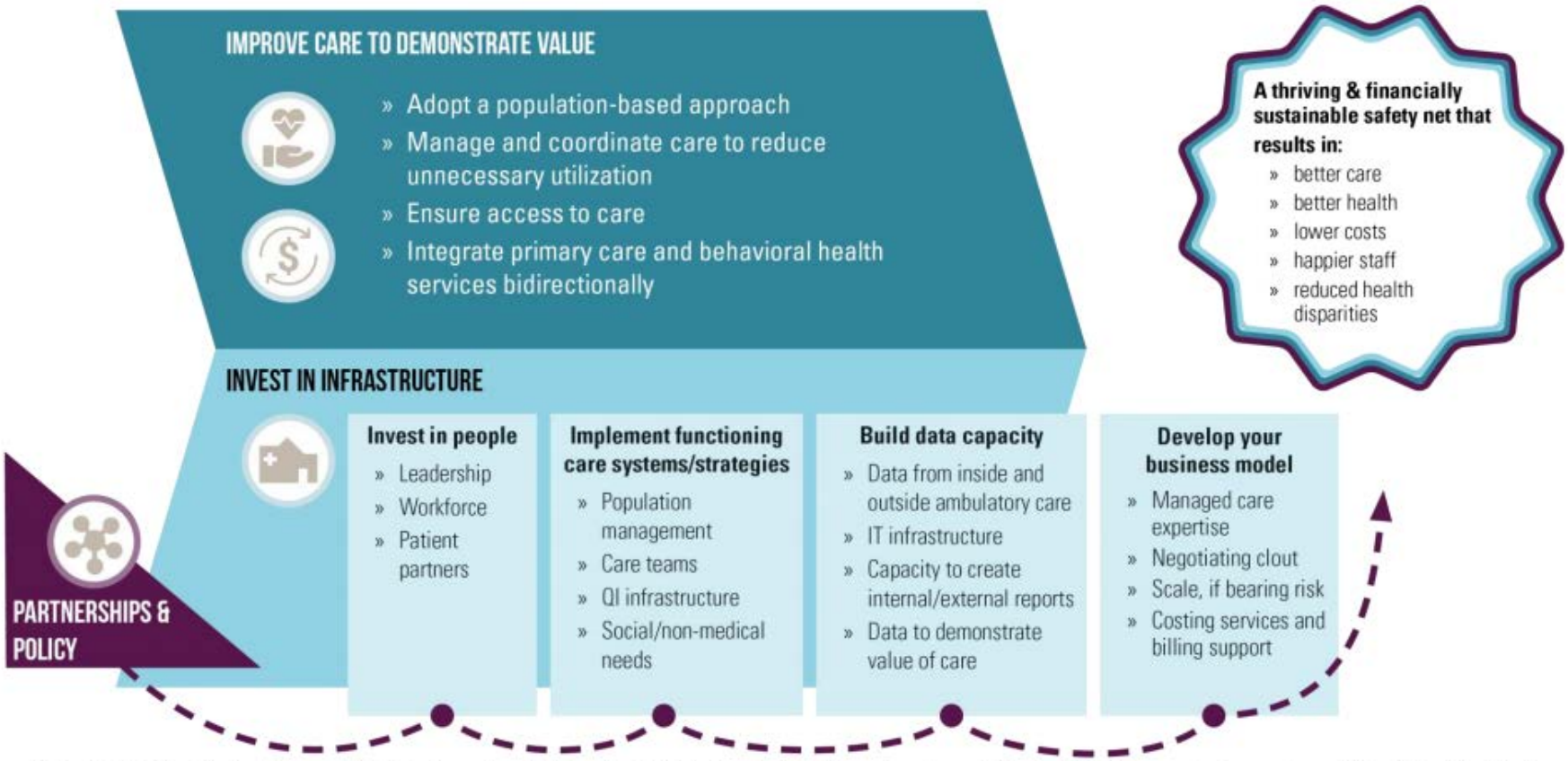
Value Based Payment for Ambulatory Safety Net Providers

- **Base:** Alternative Payment Methodology (for FQHCs) for in-scope services
- **Doing more:** Payment for services beyond the scope (e.g. care management)
- **Doing well:** Payment (or losses) for outcomes

Value Based Payment Success Factors

- Population-based strategies as well as patient-centered ones
- Managing and coordinating care to reduce hospitalizations and other costly/preventable issues
- Using data to demonstrate value to patients, payers, partners, and policy makers.

Advancing High Performance in Primary Care and Behavioral Health



*Adapted 8/20/2018 from The MacColl Center for Health Care Innovation and JSI Research & Training Institute, Inc. (2018). ***Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment,*** California Health Care Foundation. Available at: https://www.chcf.org/publication/partnering-succeed-small-health-centers/

Source: Delta Center for a Thriving Safety Net

Invest in People

- **Leadership:** continuously learning, adaptive, visionary…while managing day-to-day demands
- **Workforce:** Recruit, develop, retain
- **Patients:** engage in design, improvement, and governance of the model

Implement Functioning Care Systems/Strategies

- **Dynamic empanelment:** data-driven, proactive partnerships with members
- **Quality improvement:** standardized model for improvement/change; communicate the WHY

Implement Functioning Care Systems/Strategies

The Care Team:

- Matches patients to provider teams
- Plans and manages care
- Manages medications
- Supports patient self-management
- Integrates other services
- Enhances access
- Manages referrals
- Maintains community linkages
- Manages population health through a QI strategy
- Builds on what's good!

Build Data Capacity

Electronic health record linked to:

- Population health management systems
- Health information exchanges (with hospitals, community agencies, law enforcement, etc.)

Analytic capacity for internal and external reports: Support “clean data”

- Democratize the data
- Work the data (stratify, analyze/predict, intervene, assess)
- Ensure data security and confidentiality

Develop Business Model

Clarify your "niche:" Who do we serve? Who are we the best at serving?

- Who are "our" patients according to the payer?
- What are the major health care needs and health disparities of each population by payer – i.e. what will the demand be for which services?

Community perceptions: Are we a provider of choice or provider of last resort?

Develop Business Model

- Understand the goals and regulatory constraints/supports of the payer
- Know your costs
- Strengthen coding
- Identify and obtain the legal and financial support necessary to successfully negotiate contracts

Where to Begin?

- Engage leadership (Board, executive team, site managers, etc.)
- Identify and apply a systematic approach to change (phases everyone understands)

Partnerships

Partnerships & Policy

- Be “at the table, not on the menu”
- Strengthen existing and establish new collaborative relationships that create
- New and attractive care services and systems
- “Insider” player status
- Better together: Stay engaged actively with your Primary Care Association and Health Center Controlled Network

Getting Ready

- Assess yourself:
  - People
  - Systems and Strategies
  - Data
  - Business model
- Assess your community context
- Weigh options
- Connect

Source: Delta Center for a Thriving Safety Net

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Creating a Culture of Data

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- Make data part of every meeting
- Set value targets
- Recognize performance
- Prioritize the “impactable”
- Evaluate/plan for programs

Moving to a Culture of Data Requires Adaptive Leadership

- Elephants in the room are named
- Responsibility for the organization's future is shared
- Independent judgement is expected
- Reflection and continuous learning are institutionalized
- Leadership capacity is developed

Heifetz, R. et al. (2009). *The Practice of Adaptive Leadership.*

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