

# Montana State Innovation Model Design

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**Governor's Council Meeting**

**July 12, 2016**

# Agenda

10:00 am – 10:05 am

**Welcome**

10:05 am – 10:45 am

**Updates**

- State Healthcare Innovation Plan
- Collaborative Care Pilot
- Billings HIE Pilot
- Patient Centered Medical Home Annual Report

10:45 am – 11:10 am

**Insurance Commissioner Report on Uninsured in Montana** (*media event*)

11:10 am – 12:10 pm

**Payment Reform Discussion**

- CPC+
- Payer Presentations and Discussion

12:10 pm – 12:40 pm

***Lunch Break***

12:40 pm – 1:15 pm

**National Rural Accountable Care Consortium Briefing**

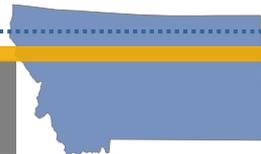
1:15 pm – 3:45 pm

**Health Care in Indian Country**

- Landscape
  - Overview, Delivery and Payment
  - Access for IHS Eligible with Insurance
- Models of Success
- Discussion

3:45 pm – 4:00 pm

**Other Stakeholder Updates and Public Comment**



# Updates



# State Healthcare Innovation Plan



# State Healthcare Innovation Plan



## Process for Transformation

Governor's Vision

Governor's Council

Stakeholder Engagement



## Montana Health Care Landscape

Providers and Shortages

Coverage and Payers

Challenges

Foundation for Reform



## Health Status and Equity

Health Status and Disparities

Access to Care

Target Populations for Delivery Reform



## Delivery System Transformation

ECHO-Enhanced Collaborative Care

Community Resource Teams

Medicaid Health Homes



## Operational Plan

Financial Analysis

Workforce

Metrics and Evaluation

Continued Planning Timeline



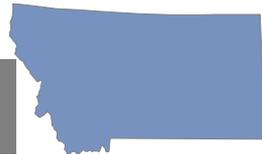
## Health IT

Landscape

Administrative Data Initiatives

Project ECHO

Billings HIE Pilot



## For More Details...

**The full State Healthcare Innovation Plan is available online and is under review with CMS.**

<http://dphhs.mt.gov/Portals/85/Documents/SIM/GovernorsCouncilonHealthcareInnovationPlan160630.pdf>



***Thank you for your contributions through the Governor's Council process!***



## **Collaborative Care Pilot**



# Collaborative Care Pilot Update

## Accomplishments

- ✓ Prototype pilot underway with two FQHCs: Southwest Montana Community Health Center (Butte) and Bullhook Community Health Center (Havre)
  - Six one hour sessions with participants (four completed to date, reviewed 6 cases)
  - FQHCs contributed funding to support pilot
- ✓ Obtained funding commitment from Blue Cross Blue Shield
- ✓ Joined multistate Mental Health ECHO Learning Collaborative with UW, UNM, OHSU, and Rochester
- ✓ Met with Center for Health Care Strategies to understand Medicaid funding mechanisms

## Next Steps

- ☐ Seek additional funding through payers and other stakeholders
  - 1:1 meetings with interested parties
  - Total fundraising goal:\$275k annually
- ☐ Determine pilot sites
- ☐ Establish Work Group comprised of pilot participants, funders, and critical stakeholders
- ☐ Monitor developments impacting Collaborative Care at the state and federal levels
  - Forthcoming CPT codes
  - Federal ECHO legislation



## Billings HIE Pilot



# Patient Centered Medical Home Annual Report



# Program Participation

- There were three new Montana clinics provisionally-qualified as PCMHs in 2015;
- Since then, one of those three became qualified when they received NCQA PCMH recognition in March 2016 and the other two expect to receive their NCQA recognition in October 2016.
- As of today there are 62 qualified PCMHs and 7 provisionally qualified PCMHs

# Montana PCMH Program Year 2

- Year 2 quality metric rates are comparable to last year's rates and is generally above national averages.
- Some of the change in rates can be attributed to improvement in data extraction by PCMHs.
- Improvement in data tracking is important progress, even if small, because data is a critical component to the complete practice transformation that occurs in PCMH implementation.

# PCMH Strengths & Progress

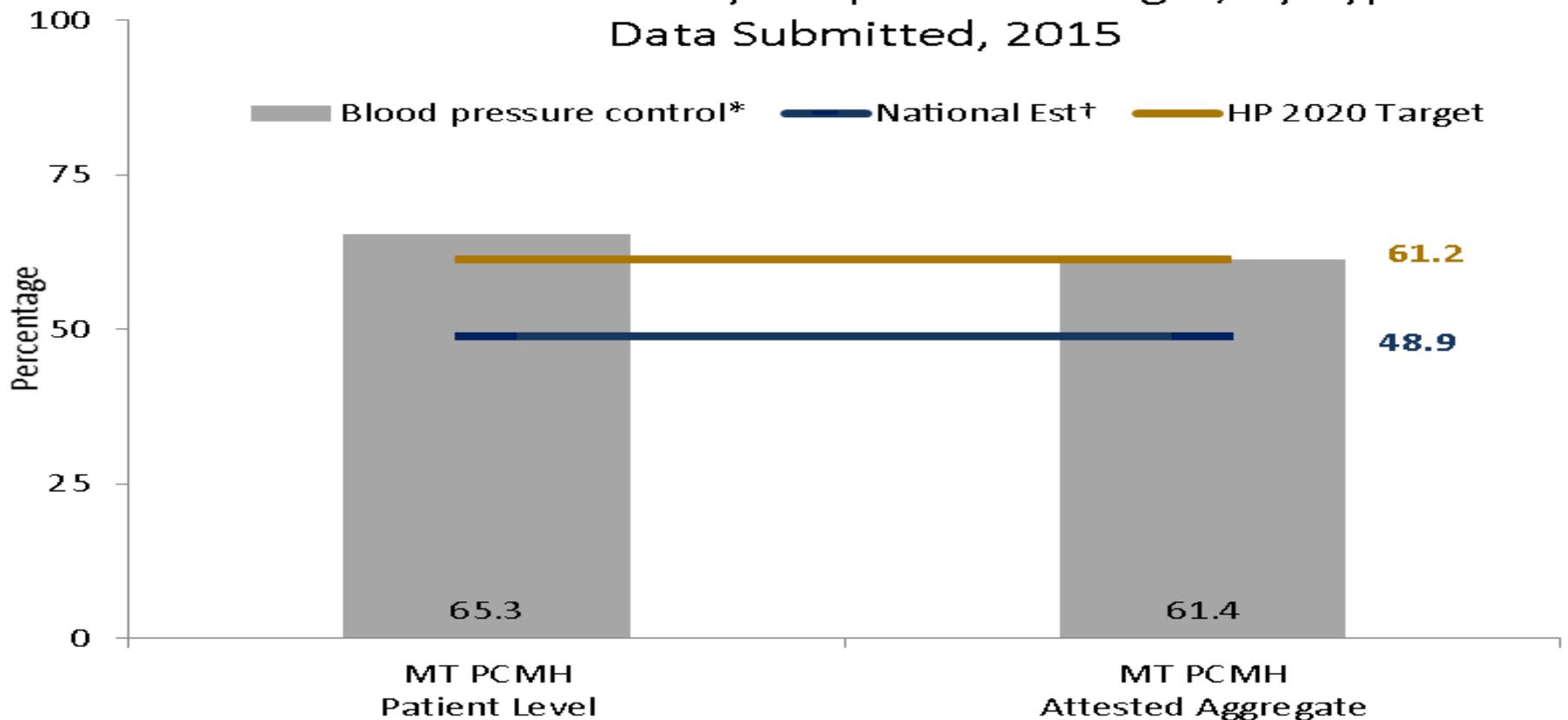
- Montana PCMHs have a better blood pressure control rate for hypertension patients. Better than Healthy People 2020 Target for two years in a row.
- PCMHs have a higher depression screening rate than the national estimate.

# PCMH Progress

- As of June 2016, HTS and DPHHS have recruited and worked with twenty-seven PCMH clinics on data technical assistance and clinical quality improvement.
- Clinics receiving this assistance are working on tracking 2016 data and improving their workflows, mainly with diabetes and hypertension patients.
- Patient-engagement, education and self-management tools are the key to improving the health of patients with these chronic diseases.
  - For instance, a common practice of PCMH clinics is loaning blood pressure cuffs to patients with hypertension, which increases patient awareness and promotes self-management.

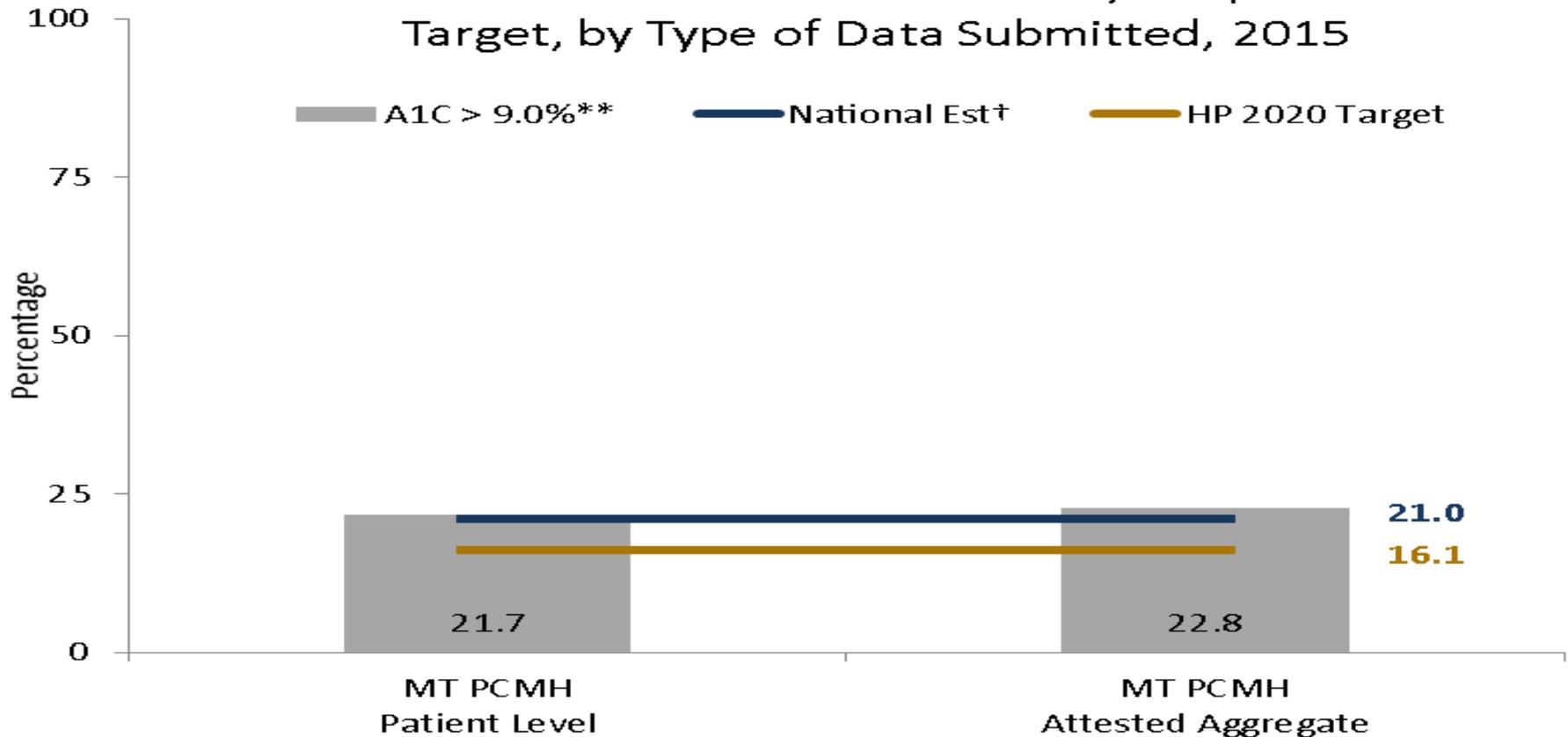
# PCMH Blood Pressure Control

Documented Blood Pressure Control Rate among Montana PCMH Clinics Compared to the National Estimate and Healthy People 2020 Target, by Type of Data Submitted, 2015



# PCMH Diabetes Control

Documented Rate of A1C >9.0% for Patients with Diabetes among Montana PCMH Clinics Compared to the National Estimate and Healthy People 2020 Target, by Type of Data Submitted, 2015



# PCMH Depression Screening

- PCMH clinics in Montana also have a higher depression screening rate than the national estimate.
- Clinics are working with HTS/DPHHS to
  - establish or improve workflows for depression screening; and
  - improve their data collection and tracking process.
- In some geographic service areas, there is still a lack of qualified mental health professionals, making follow up treatment difficult for some areas;
- Recommendations for filling this gap include the development of relationships with regional mental health professionals, mental health telemedicine services, and other remote consultation mental health services.

# Other Year 2 Highlights

- Increases in PCMHs offering same day appointments, a patient portal, and expanded office hours
- Increases in PCMHs that collaborate and assist patients in personal goals for their improved health (self-management and goal setting)
- 46% have primary care related integrated behavioral health services
- 81% have care coordinators/managers or patient navigators
- 43% have a certified diabetes educator
- 31% have a dietician
- 50% have a clinical pharmacist
- 78% are receiving enhanced PCMH reimbursement from a payor, up from 56% in Year 1
  - Unfortunately, the majority of those clinics reported that they only receive enhanced reimbursement for up to 10% of their patient population

# St. V's Absarokee Patient Story

53 years old male – smoker and type 2 diabetic

- Responded to “Readiness to Quit” tobacco letter that was sent to all tobacco users, met with PCP and developed plan to quit with quit line and kit
- Utilized integrated behavioral health services for coaching and monitoring progress
- Diabetic Educator monthly visits via telemedicine
- Patient responded to letter stating he was due for Hgb A1c repeat
  - Hgb A1c went from 11.6% to 6% in a 6 month period.
  - Estimated average glucose went from 295 to 126 mg/dL

# Patient Visit Summaries

Complex patient with multiple co-morbidities:

- Screened through the intake process and medications were reconciled;
- Patient reviewed the written visit summary provided to him and compared the medication list he received to his pill bottles.
- The patient realized his cardiologist had made a significant change to the dosage of one of his medications.
- He contacted the practice and advised nursing staff of the dosage change he had not reported to the staff at the time of his appointment. His medication list was updated.
- Staff and patient realized the role this simple process played in ensuring patient medication safety.

# A Comprehensive Approach to Primary Care

- At a routine check-up, a patient complained about sinus pressure; patient thought she had a sinus infection. Provider took time to ask a few more questions, including if the patient had fallen recently. Patient stated that she had fallen twice in the past couple of weeks. Doctor ordered a CT scan of her head and discovered that she had a large subdural hematoma, and scheduled surgery.
- **The patient's health outcome would have been very different had a provider not taken extra time to ask the right questions and look at the whole picture of the patient's health.**

# Team Based Care Example

A patient with severe behavioral health issues:

- Patient called the provider and his team up to of 5 times per day.
- The provider and his team embraced the "Patient Centered" model and began calling the patient daily.
- The provider scheduled the patient to see him weekly.
- **The team "wrapped their arms around" this patient.**
- The patient began seeing the behavioral health provider, after several introductions by the PCP.
- After 6 months, the patient is much more confident in managing her chronic conditions.
- She continues to see the behavioral health provider, but only sees her medical provider every 3 months and only calls the medical team with true medical issues/questions.

## **Insurance Commissioner Report on the Uninsured**



## Payment Reform Discussion



## CPC+ and Payment Reform



# Comprehensive Primary Care + (CPC+) Overview

Under CPC+, Medicare will partner with other health care payers (both public and private) to invest in enhancements to primary care practices.

## Application Timeline

Activity	Date
Payers apply first to participate in program	Applications submitted June 8 <sup>th</sup>
CMS will select up to 20 regions, based on payer applications, where the program will launch	By July 15 <sup>th</sup>
Providers in selected regions will apply to participate	July 15 <sup>th</sup> – September 1 <sup>st</sup>
Up to 5,000 practice sites will be selected to participate	October 2016
Program launches <i>Program will run for five years</i>	January 2017



# CPC+ Overview, Continued

Each payer proposed a payment model for primary care practices.

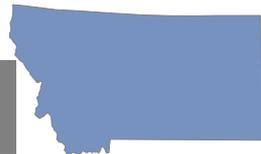
Medicare's payment model features two tracks:

## Track 1

- Focused on building capabilities for comprehensive primary care
- Practices provide care management, coordination, and similar services to all patients, agnostic of payer
- PMPM payment of \$15 on average, on top of usual FFS payment (excluding chronic care management code)
- Quality bonus of \$2.50 PMPM

## Track 2

- Focused on expanding care capabilities for more complex patients
- Capitated, comprehensive fee for care management and portion of expected FFS revenue based on historical claims (average \$235,000/year for site serving 700 Medicare beneficiaries)
- PMPM payment of \$100 for highest risk
- Quality bonus of \$4.00 PMPM
- Decreases in FFS payments



# Provider Engagement in CPC+

If Montana is selected as a CPC+ region, provider participation will be key.

- **Eligible applicants are primary care practices that:**

1. Pass CMS program integrity screening
2. Provide health services to a minimum of 150 attributed Medicare beneficiaries
3. Can meet the requirements of the CPC+ Participation Agreement

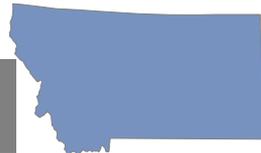
- **Practices will apply directly to the track for which they believe they are ready**

- CMS reserves the right to offer a practice entrance into Track 1 if they apply to but do not meet the eligibility requirements for Track 2

- CMS defines a **“Primary Care Practice”** site as the single “bricks and mortar” physical location where patients are seen; includes all NPIs billing under a TIN at a practice site address
- CMS defines **“Primary Care Practitioner”** as a physician (MD or DO), nurse practitioner (NP), physician assistant (PA), or Clinical Nurse Specialist (CNS) with a primary specialty designation of family medicine, internal medicine, or geriatric medicine
- **IHS, CHCs, and RHCs are not eligible to participate**



**Reminder:** Participation in CPC+ “counts” as a MACRA Alternative Payment Model. This pathway could help smaller providers avoid likely Medicare payment cuts under the Incentive Payment System pathway.



# Montana CPC+ and Payment Reform Updates

Four Montana payers applied:

CPC+ Payment Model and General Payment Reform Approach

Medicaid

BCBS

PacificSource

Allegiance



# Medicaid: Proposed CPC+ Payment Model

Medicaid has proposed a two-part payment model:

## PMPM Payments

### “Care Management Fee”

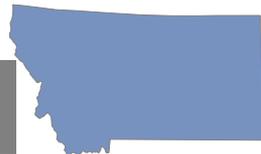
- Track 1: Four tiers of PMPM payments, depending on patient risk and level of care management required
- Track 2: Five tiers of PMPM payments; top tier is for most complex patients:
  - Top 5% of the CPC+ pool
  - Members with persistent and severe mental illness, dementia

**Specific payment amounts TBD, but will be adequate and will align with other payers**

## Performance-Based Incentives

- Annual bonus payment at end of year based on performance on specified measures relative to benchmarks/targets
- Utilization/Cost of Care measures: claims measures of inpatient admissions, ED visits for attributed members
- Quality/Outcomes measures: reported quality measures, CAHPS surveys, etc.

**Payments will align, as possible, with other payers in the State**



# Medicaid: Proposed CPC+ Payment Model

**Providers will be expected to deliver value to payers and beneficiaries in return for enhanced payments.**

CPC+ Driver	Provider Expectations
<b>Comprehensive primary care functions</b> , including: care management, access and continuity, planned care for population health, patient and family caregiver engagement	<ul style="list-style-type: none"><li>• Care management</li><li>• Increased access to care</li><li>• Increased continuity of care</li><li>• Better managed population health</li><li>• Better patient engagement</li><li>• Better family/support engagement</li><li>• Comprehensive coordinated care and services</li><li>• Reduced inpatient admissions</li><li>• Reduced ER visits</li><li>• Increased quality of care and patient experience based on CAHPS survey</li><li>• Quality measure reporting</li><li>• Enhanced and complex health IT systems*</li><li>• Further investment in health IT and EMRs*</li></ul>
<b>Use of enhanced, accountable payment</b>	*Enhanced expectations for Track 2 practices.
<b>Continuous improvement driven by data</b>	
<b>Optimal use of health IT</b>	



# Medicaid Payment Reform Pathway

These three Medicaid programs serve as the foundation for broader payment reforms

**Primary Care Case Management Program** for 70% of Medicaid enrollees (\$3 PMPM)

**Health Improvement Program** for higher need patients, centered in community and tribal health centers (\$3.75 PMPM)

**Team Care** is a restricted services program; patient care is managed by one PCP and one pharmacy (\$6 PMPM)

Limited scope program to date, could expand

## Patient Centered Medical Homes

- More comprehensive program targeted to those with specific chronic diseases
- \$9.33 PMPM for those with single chronic condition, \$15.33 PMPM for two conditions, \$3.33 for other patients
- Future plans: performance-based incentives
- Required quality reporting

Moving forward to develop new payment models

## Future Reform Models

- **CPC+**: Medicaid proposed PMPMs and performance-based incentives
- **Health Homes:** Considering health home program for high need enrollees (BH or multiple chronic conditions)
- Medicaid could provide enhanced PMPMs or other payment incentives under Health Home program



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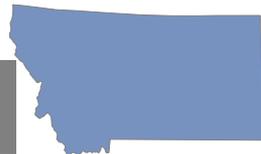
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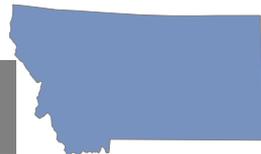
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## PacificSource Health Plans and CPC+

Todd Lovshin

Vice President and MT Regional Director



# Payment Reform



- PacificSource Health Plans goal in payment reform is to build lasting relationships with providers and our mutual members focused on quality outcomes. In doing so we will build healthier communities.
  - Agreed upon fee structure that bundles all services under one fee for knee replacement. Contract in place since 2014. This contracted payment methodology is focused on provider outcomes with financial incentives for the provider.
  - Patient Centered Medical Home agreements focused on payment for care coordination. Assuring that members are receiving adequate and follow up care. Including placement of a nurse care coordinator within the PCMH focused on our members. Payment is based on quality measures established by the PCMH council.

# Growing Value-Based Models

- Continue to build provider relationships that align with PacificSource values and approach.
  - Develop Risk Sharing agreements with key providers based on quality outcomes for our members.
  - Strategically align PCMH agreements that benefit our members overall health.
  - Continue to look for opportunities for bundled payment methodologies.
  - Build provider partnerships that enhance the member experience.
  - Align our CPC+ proposal with our SmartHealth provider contracts.

# Why CPC+

- As a newer carrier in Montana, entering in 2012, PacificSource is committed to working with CMS and other payers in the state to implement alternative payment models to support primary care transformation. We believe the CPC+ model provides the opportunity to bring together payers to advance transformation to achieve the Triple AIM.
- Our goal would be to use the CPC+ model to align with other payers, build our relationships with providers and expand our contracting to support and strengthen primary care reform.
- CPC+ provides Montana a unique opportunity for payers to coalesce and align with Five Comprehensive Primary Care functions outlined in CPC+ model and build a multi-payer collaboration to improve health and health care in Montana.

# CPC+ Payment Methodology

## Track #1 Savings

- 2% reduction IP admits, part offset by 0.5% increase OP surgery
- 2% reduction in ED visits
- 2% reduction in Advanced Imaging (OP & physician)
- 3% reduction to specialist, shift to PCP
- 3% reduction in brand non-specialty, increase in generic

Average PMPM CMF + UM/Quality  
Management Incentive = \$2 – \$3 PMPM

## Track #2 Savings

- 4% reduction IP admits, part offset by 1.0% increase OP surgery
- 4% reduction in ED visits
- 4% reduction in Advanced Imaging (OP & physician)
- 5% reduction to specialist, shift to PCP
- 3% reduction in brand non-specialty, increase in generic

Average PMPM CMF + UM/Quality  
Incentive = \$3 – 4.50 PMPM

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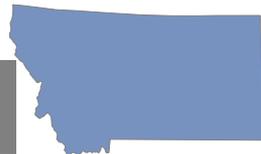
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# Allegiance Benefit Plan Management, Inc. and CPC+

- Support for enhanced, team based primary care
- If, if, if, etc.
- Educate self funded plans on CPC+
- Advocate for simplicity and consistency in payment reform

# Allegiance Strategies for Payment Reform

- Transparency through data sharing
- Comparability through reference based pricing
- Consistency to address unexplained variability
- Predictability in future costs

# Allegiance Tactics for Payment Reform

- Bundled Payments
  - Collaboration on included services
  - “routine” services
  - Bundle “busters”
- Complex Care Coordination
  - Supports embedded care coordinators and team care
  - Reimburses providers for services provided
  - Predictive modeling and disease registries
  - Gaps in care

# Allegiance Tactics for Payment Reform, cont.

- Partial Capitation
  - Direct primary care
  - Provider variability
  - Pricing services provided
- Telemedicine

# National Rural Accountable Care Consortium Briefing



**NATIONAL RURAL**  
ACCOUNTABLE CARE CONSORTIUM  
A 501(c)(3) ORGANIZATION





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# Population Health Management A Practical Way to Get Started

Lynn Barr, MPH

[www.CaravanHealth.com](http://www.CaravanHealth.com)

## 23 MSSP Rural ACO's

- 6,000 Clinicians
- 55 PPS Hospitals
- 92 Critical Access Hospitals
- 168 Rural Health Clinics
- 39 FQHC's
- 500,000 Medicare lives
- 32 states



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## Practice Transformation Network

- 11,000 Clinicians
- 600 Independent Practices



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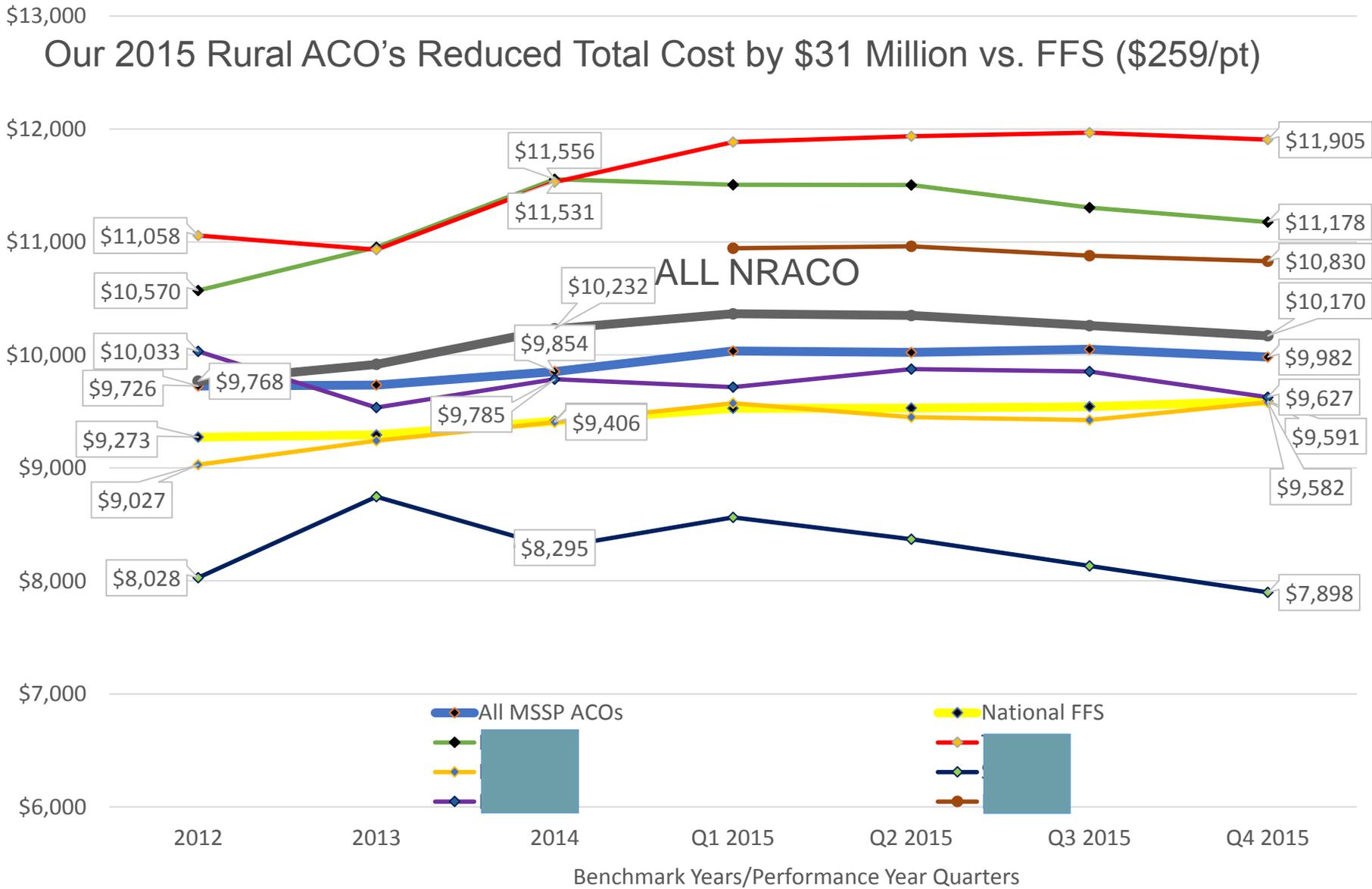
# Montana Participants

Account Name	Participant Type
Barrett Hospital and Health Care Organization	ACO
Broadwater Health Center	ACO
Central Montana Medical Center	ACO
Clark Fork Valley Hospital & Family Medicine Network	ACO
Community Hospital of Anaconda	ACO
Marcus Daly Memorial Hospital	ACO
North Valley Hospital	ACO
Sidney Health Center	ACO
St. Luke's Community Hospital	ACO
Beartooth Billings Clinic	TCPI
Big Sandy Medical Center	TCPI
Cabinet Peaks Medical Center	TCPI
Dahl Memorial Healthcare Assoc, Inc	TCPI
Daniels Memorial Healthcare Center	TCPI
Deer Lodge Medical Center	TCPI
Frances Mahon Deaconess Hospital-Glasgow Clinic	TCPI
Gabert Medical Services	TCPI
Glendive Medical Center	TCPI
Granite County Medical Center	TCPI
Livingston HealthCare	TCPI
Madison Valley Hospital Inc.	TCPI
McCone County Health Center	TCPI
Mineral Community Hospital	TCPI
Mountainview Medical Center, Inc.	TCPI
Phillips County Hospital	TCPI
Prairie Community Hospital	TCPI
Roosevelt Memorial Medical Center	TCPI
Roundup Memorial Healthcare	TCPI
Stillwater Billings Clinic	TCPI
Wheatland Memorial Healthcare	TCPI

# Our Triple Aim

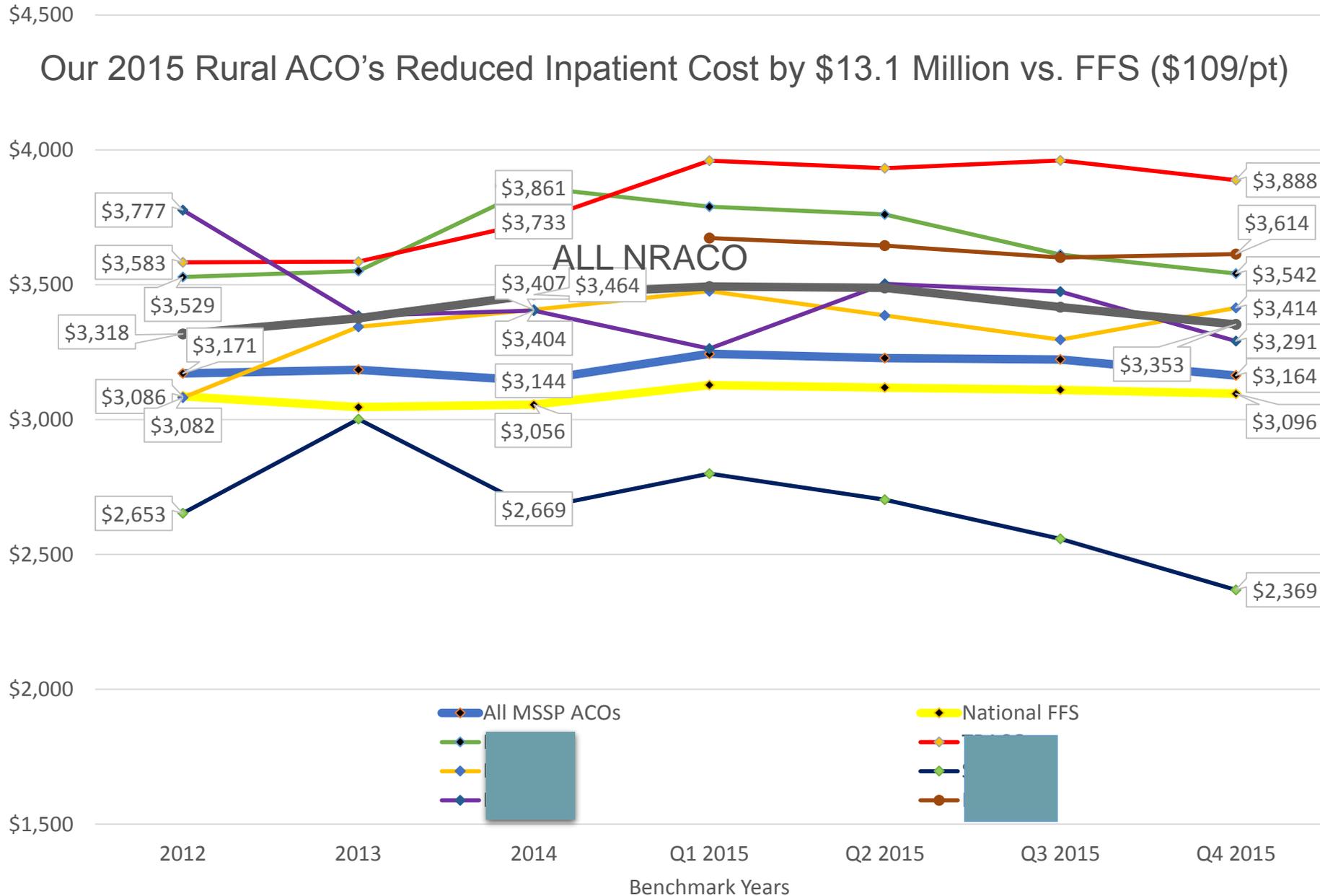


# Our 2015 Rural ACO's Reduced Total Cost by \$31 Million vs. FFS (\$259/pt)



Total Expenditures per Assigned Beneficiary

# Our 2015 Rural ACO's Reduced Inpatient Cost by \$13.1 Million vs. FFS (\$109/pt)



Total Inpatient Expenditures per Assigned Beneficiary

# NRACO: Improvement Over Prior Year

Metric Name	Percentage of Measures Met			Percentile Band		
	2014 Measure Rate	2015 Measure Rate	Measure Rate % Change	PY2014	PY2015	% Change
CARE-2 Fall Screening	14.68%	53.57%	264.95%	30	80	166.67%
CAD-7 ACE or ARB with Diabetes or LVSD	77.07%	68.21%	-11.50%	50	30	-40.00%
DM-2 HA1c Below 9%	81.76%	82.81%	1.28%	80	80	0.00%
HF-6 Beta-Blocker Therapy for LVSD	84.48%	88.60%	4.87%	80	80	0.00%
HTN-2 Controlling High Blood Pressure	65.88%	68.36%	3.76%	50	60	20.00%
IVD-2 Use of Antithrombotic	85.58%	85.26%	-0.38%	70	80	14.29%
PREV-05 Breast Screening	70.90%	88.49%	24.81%	60	80	33.33%
PREV-06 Colorectal Cancer Screening	57.14%	57.75%	1.06%	50	50	0.00%
PREV-07 Influenza Immunization	45.45%	48.75%	7.25%	40	40	0.00%
PREV-08 Pneumonia Vaccination	50.64%	60.90%	20.26%	40	60	50.00%
PREV-09 Body Mass Index Screening	53.78%	65.25%	21.34%	50	60	20.00%
PREV-10 Tobacco Use Screening	98.90%	90.08%	-8.92%	90	90	0.00%
PREV-11 High Blood Pressure Screening	76.32%	72.91%	-4.47%	70	70	0.00%
PREV-12 Clinical Depression Screening	16.25%	44.22%	172.12%	40	80	100.00%
<b>Total Average Rate/Percentile for PY:</b>	<b>62.77%</b>	<b>69.65%</b>	<b>10.96%</b>	<b>57.14</b>	<b>67.14</b>	<b>17.50%</b>

Below 30th = Failed the Measure  
 Between 30th and 60th  
 Above 70th

# 30 Rural Hospital CFO's In Charge

**Stop = 0**

**Slow Down = 0**

**Keep Going = 30**

**Best Year Ever = 6**



**WHAT, ME WORRY?**

**MAD**



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# Population Health 101

We know what needs to be done...

## Prevention:

- Annual Assessments, Documentation and Prevention
- Chronic and Transitions Care Management
- Advanced Care Planning
- Behavioral Counseling
- Depression Screening
- Mental Health Support
- 24/7 Access

## Diagnosis Coding:

- Inpatient Specificity
- Hierarchical Condition Coding (HCC)

## Quality:

- Process Improvement
- Pre-visit Planning
- Empanelment
- Patient Satisfaction



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# PRIMARY CARE PRACTICE TRANSFORMATION PROGRAM

# Caravan Health Services



Set up providers to do billable care coordination services

- Train, certify and mentor care coordinators
- Implement the necessary IT infrastructure
- Provide a federally funded 24/7 nurse advice hotline



Redesign practices to manage population health

- Modify clinic workflows to address care gaps
- Report and improve ambulatory quality scores
- Promote evidence based medicine
- Measure patient satisfaction at the point of care

# Caravan Health Services



## Qualify providers for Patient Centered Medical Home

- Develop physician led care teams
- Facilitate coordinated, integrated care
- Promote culture of quality and safety
- Increase access to primary care



## Help providers increase revenue to promote sustainability

- Increase local utilization
- Maximize additional population health payments
- Prevent value-based payment penalties
- Identify the right advanced payment models for their community

# Analytics

- Lightbeam
- Reports
- Scorecards
- Comparisons

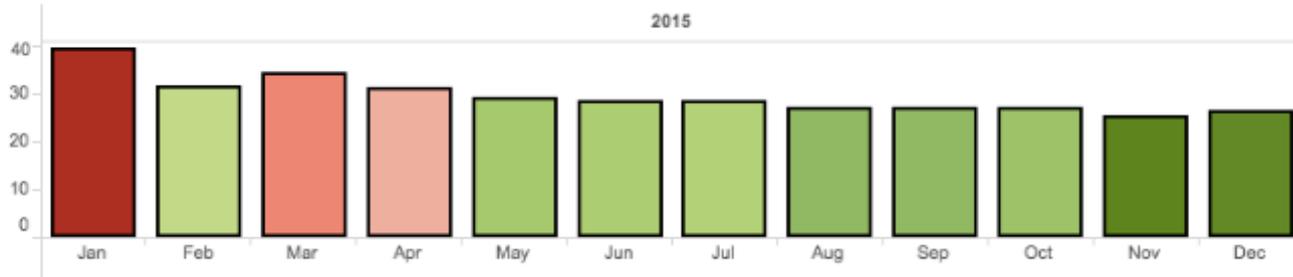


# Finance and Utilization

## By Location



## Metrics Over Time



## Financial Metrics

PPPM Actual (A)	\$910
PPPM Target (B)	\$825
% of Target (A/B)	110.32%
Avg. Risk Score (C)	1.00
Risk Adjusted Target (D)	\$825
% of Target (A/D)	110.31%
Patient Months	2,769,994
Total Paid	\$2,521,539,591
Part-A Paid	\$1,913,689,292
Facility Paid PPPM	\$691
Part-A Outpatient Paid	\$663,646,314
Facility Outpatient PPPM	\$240
Inpatient Acute Paid	\$810,725,231
IP Acute Paid PPPM	\$293

## Utilization Metrics

Pharmacy Count	8,307,319
Patient Months	2,769,994
ER Visits	171,300
ER Visits per K	62
Inpatient Acute Admits	80,680
IP Acute Admits per K	29
Inpatient Bed Days	397,243
IP Bed Days per K	143
Inpatient Re-Admits	12,596
IP Readmits per K	0
Inpatient Short Stays	22,121
IP Short Stays per K	8
Hospice Admits	15,943
Hospice Admits per K	6

## Professional Cost Categories



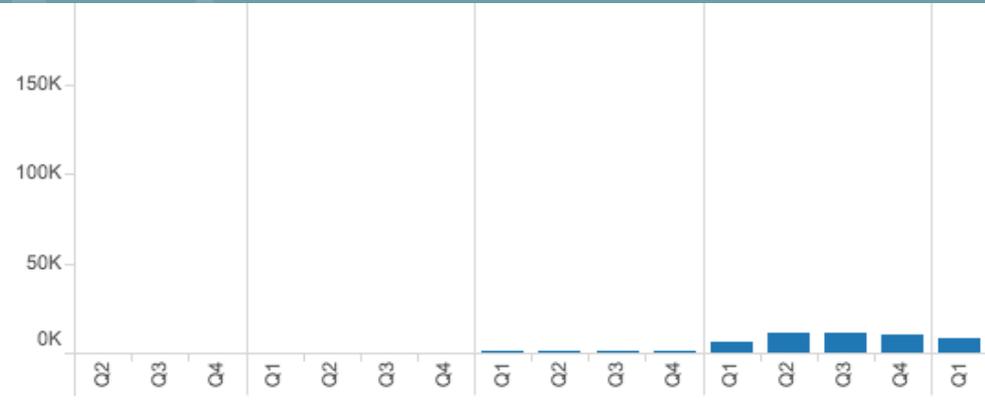
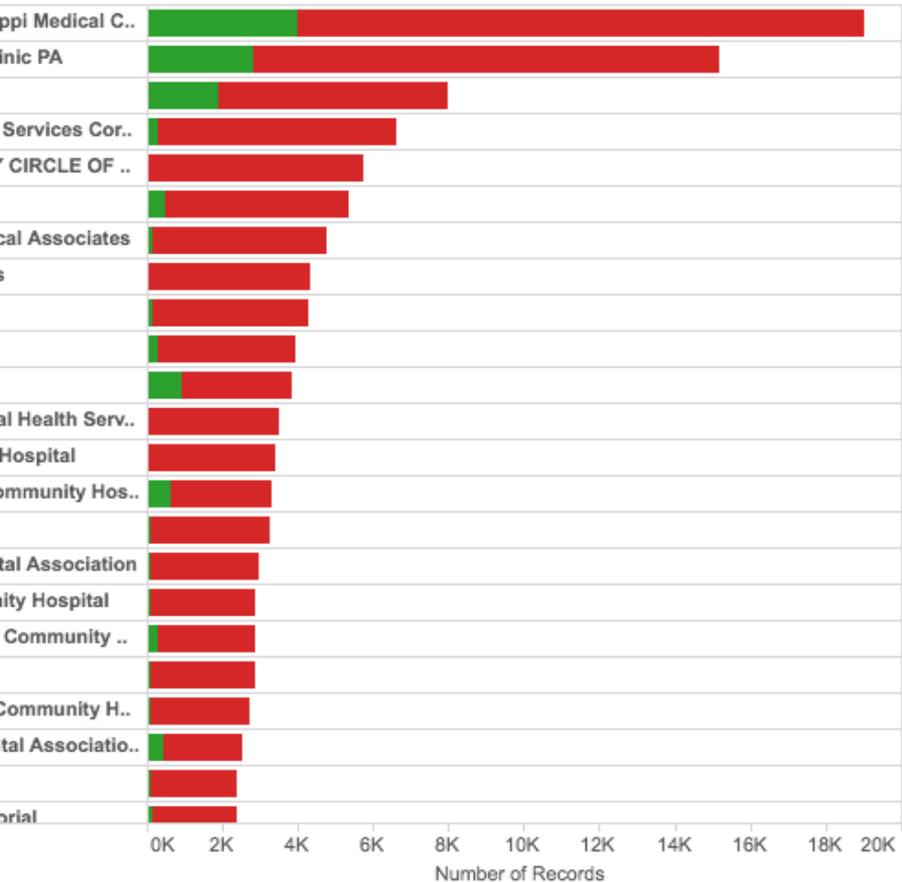
# Quality Reporting

ACO Measures Program-2016

At-Risk						Care Coordination/Patient Safety									BMI	BP2Y	CCS
CAD-ACE-LV	DM-EYE	DM-HbA1C>9	HF-BB-LVSD	HTN-BP	IVD-ASA	ASCA-CHF	ASCA-COPD	F	MEDS	RSAAR-CHF	RSAAR-DM	RSAAR-MCC	RSAAR-SNF	RSACR			
63%	7.7%	79%	96%	1.6%	57%	78%	63%	70%	38%	53%	23%	12%	0%	13%	36%	1.3%	63%

# Wellness Visits

## by Location

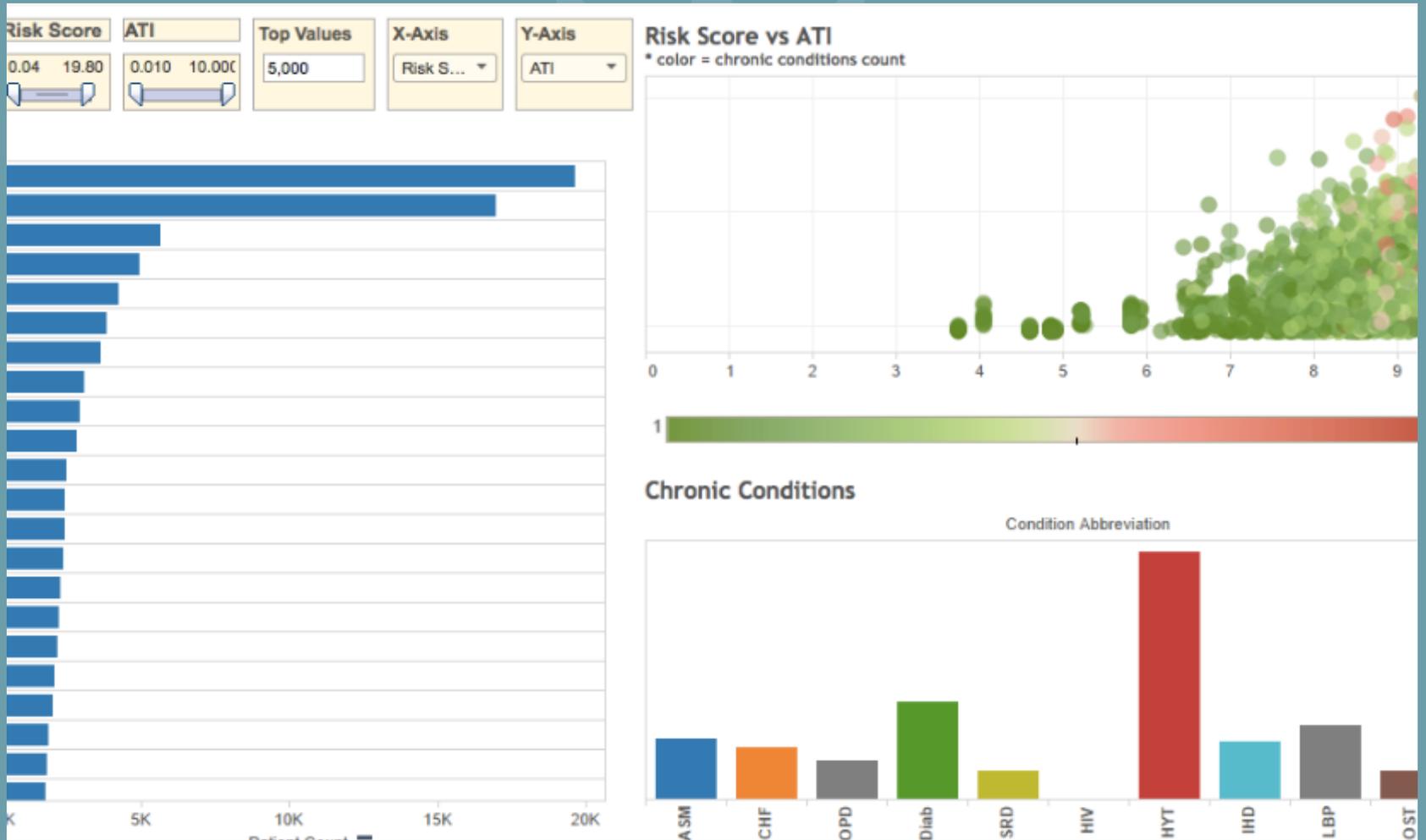


Show By ... ■ NO ■ YES

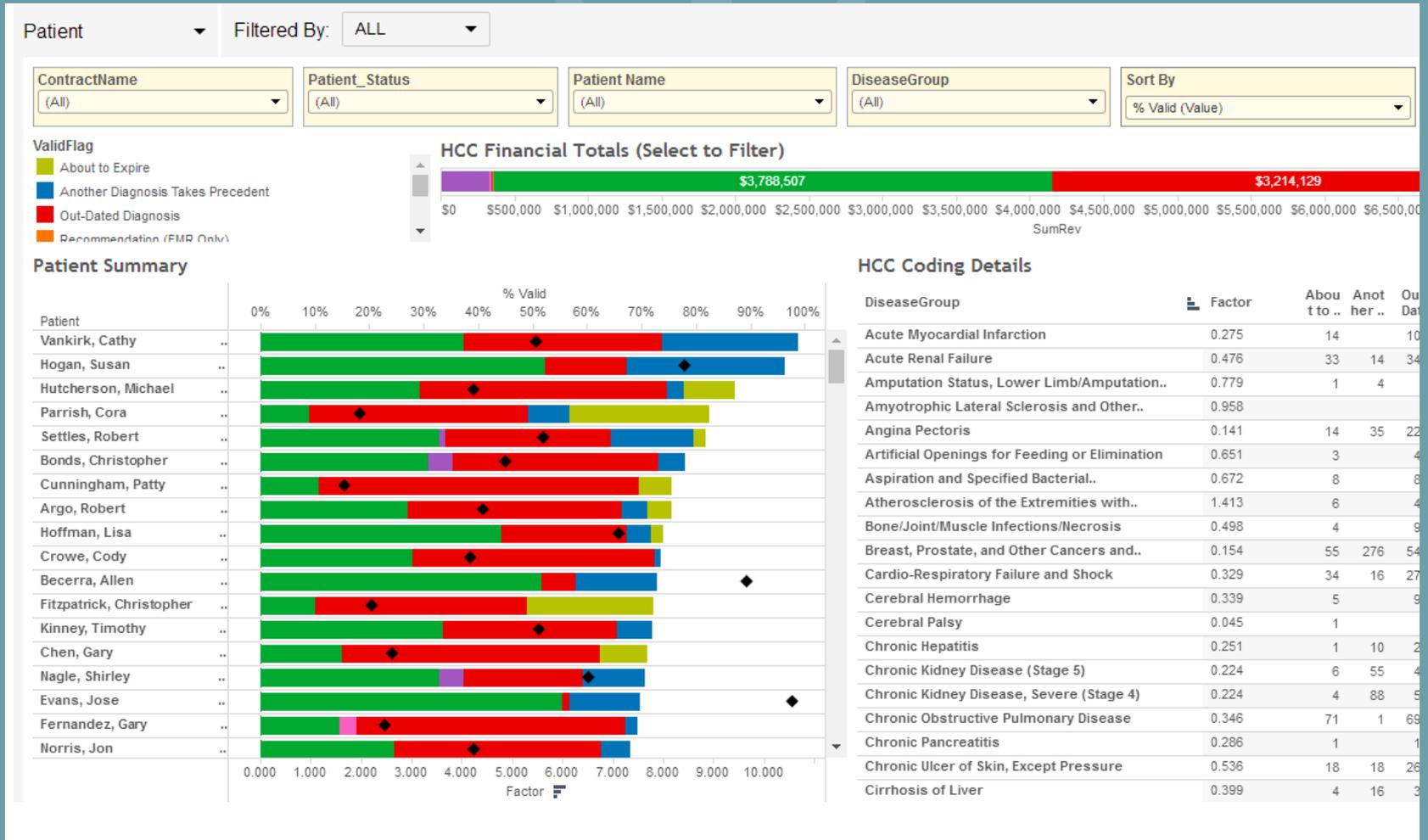
## Patients with Wellness Visits in Past 9 Months



# Risk Stratification



# Risk Stratification



# Accurate Risk Scoring



**TABITHA ASHER-SMITH (38 years )**  
Active (WithClaims)

DOB - 7/12/1977      Risk - 0.874      Race -  
Gender - Female      ATI - 4.180      Marital Status -  
Patient # - 308849725A      Care Gaps - 0      CCDs - 0

Patient Notes 

Time Spent (Min)    **0'**    **ADD**

← PREV    → NEXT    ✕ CLOSE

**CONTACT INFORMATION**

Primary Language -  
Home Phone -  
Mobile Phone -  
Email -

CM Team - - +  
Care Manager -

Insurance - MSSP  
Primary Physician -  
Physician Phone -

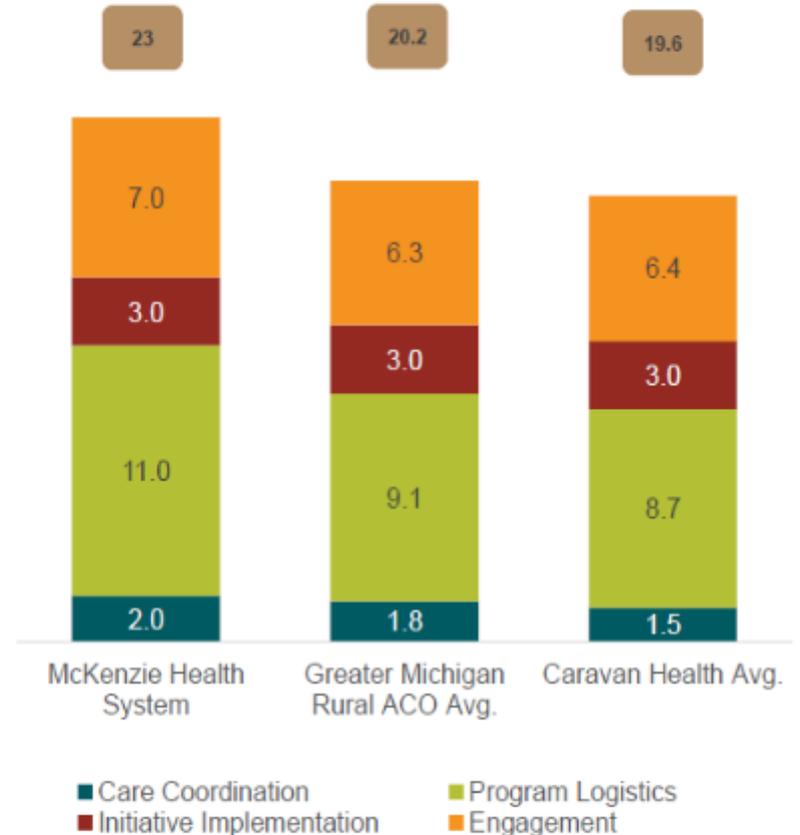
**AUTOMATED PREFERENCES**

Phone     SMS     Email

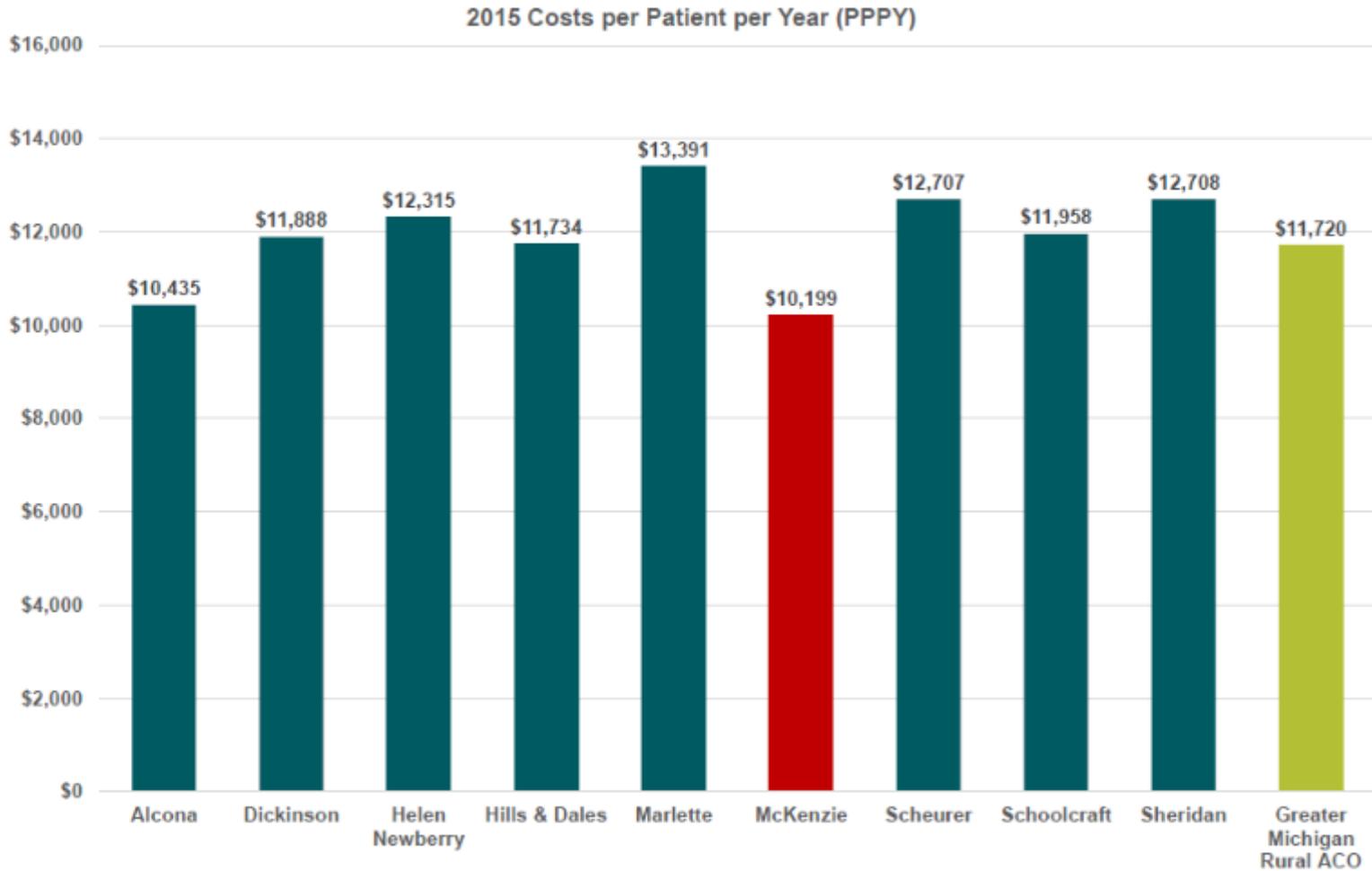
CASES	NOTES	FACE SHEET	CLINICAL	RISK PROFILE	ASSESSMENT	CARE GAPS	CCDs
Historical Summary (Past 12 Months) 							
<b>Historical Costs</b>				<b>Utilization</b>			
Facility Cost \$ <b>768.00</b> Professional Cost \$ <b>1290.00</b> Pharmacy Cost \$ <b>183.00</b> Past 12 Months (Excl Rx) \$ <b>2725.00</b>				ER Visits <b>1</b> Inpatient Admits <b>0</b> Inpatient Re-Admits <b>0</b>			
Characteristics 							
Hospital Dominant Morbidities <b>0</b> Diagnosis Used <b>14</b> Chronic Conditions <b>3</b>							
Conditions evidenced by ICD (Diagnosis), Rx(Pharmacy) or BTH(Both) in the past 12 months 							
Depression <b>BTH</b> Seizure Disorder <b>Rx</b>		Lipid Metabolism Disorder <b>Rx</b> Low Back Pain <b>ICD</b>		Hypertension <b>Rx</b>		Asthma <b>BTH</b>	

## Pre-Launch through May 6, 2016 Scorecard

Category	Metric	Current Status	Score
Care Coordination	Care Coordinator Hired by 4/1/16	Completed	1
	CC registered for ICCO Health Coaching Course by 4/15/16	Completed	1
	Course Status as of 4/30/16	Completed 2 of 5 Modules	NA
	Care Coordination Points		2
Total Points Possible		2	
Care Coordination Score		100%	
Program Logistics	MSSP Application Responsiveness	Completed	1
	Attended PreLaunch Webinar Series	Completed	1
	Financial Consultant Questionnaire Completed by 10/12/15	Completed	1
	Financial Consultant Selected by 11/15/15	Completed	1
	Nursewise Survey Completed by 1/1/16	Completed	1
	Demographics File submitted by 1/1/16	Completed	1
	Nursewise GoLive Date or have existing 24/7 coverage	03/01/2016	1
	Pt Satisfaction Questionnaire Completed by 1/1/16	Completed	1
	IT Systems Questionnaire Completed by 11/1/15	Completed	1
	Received Lightbeam User List	Completed	1
	Flat File Status as of 5/6/16	Complete	1
Program Logistics Points		11	
Total Points Possible		11	
Program Logistics Score		100%	
Initiative Implementation	Viewed Jan. TCM Billing Webinar	Completed	1
	Viewed Feb. CCM Billing Webinar	Completed	1
	Viewed March AWW/Prev Wellness Webinar	Completed	1
Initiative Implementation Points		3	
Total Points Possible		3	
Initiative Implementation Score		100%	
Engagement	Viewed Jan. Marketing Training Webinar	Completed	1
	Attended Annual Mtg in DC (Extra Credit)	Completed	1
	CEO or Proxy Attended Q1 ACO Board Meeting	Completed	1
	Hosted Launch Meeting	Completed	1
	Viewed EBM AWW Webinar for Physicians	Completed	1
	Viewed April Patient Satisfaction Webinar or have existing tool	Have Existing Tool	1
	Viewed May Lightbeam User Group Call (Extra Credit)	Incomplete	0
Attended April Quality Improvement Workshop	Completed	1	
Engagement Points		7	
Total Points Possible		6	
Total Extra Credit Points Possible		2	
Engagement Score		117%	
<b>Weighted Average</b>			<b>104.2%</b>

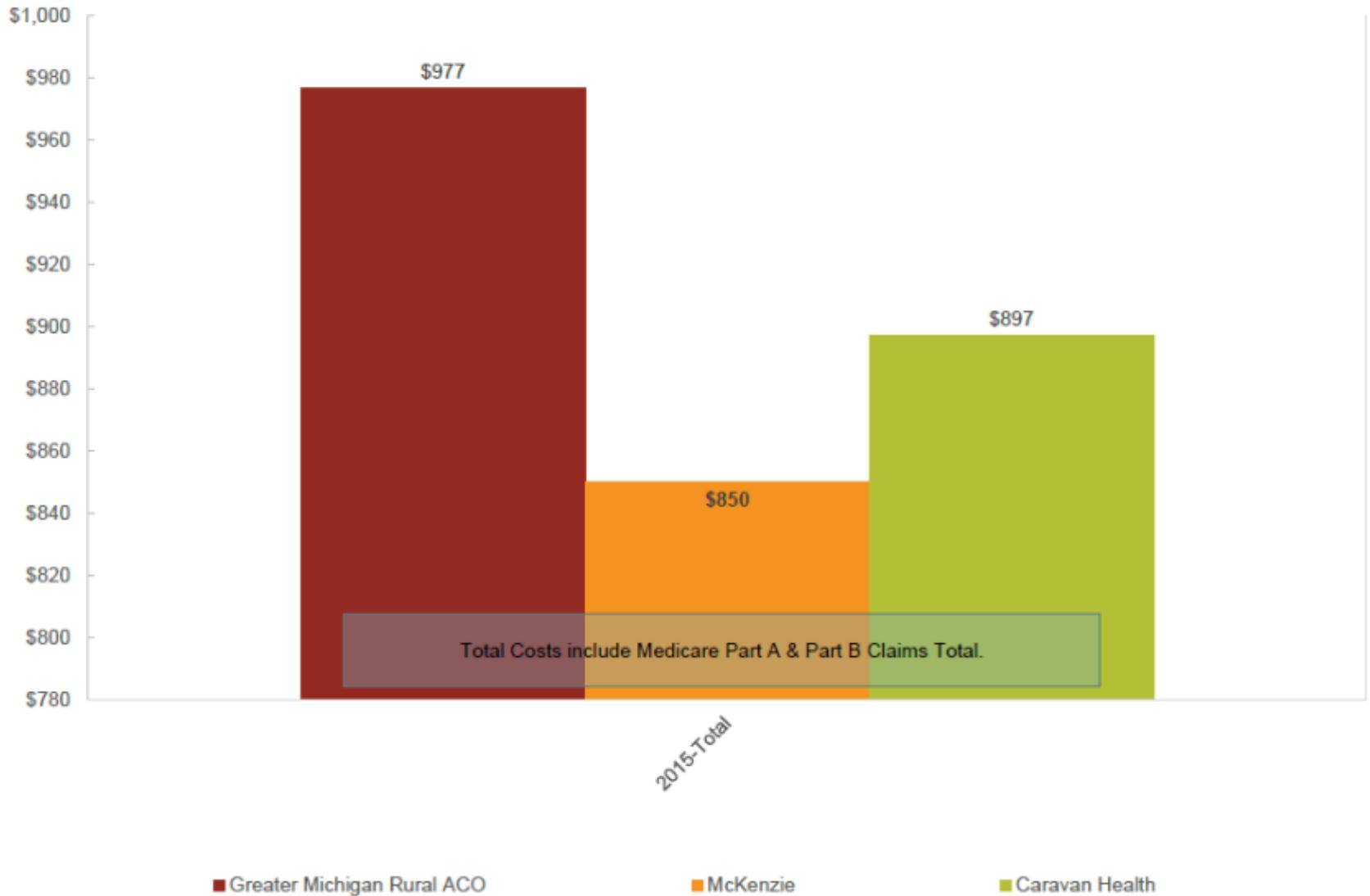


**\*\*All communities have a received a maximum score for viewing webinars in Q1 due to a late release of Swank, NRACO's Learning Management System used to track attendance.**  
**\*\*Scoring for the metric Nursewise GoLive Date or have existing 24/7 coverage is as follows: 1 = GoLive date on 3/1/2016 or have existing call line, .5 = GoLive date on 5/1/2016, .25 = GoLive date on 8/1/2016, 0 = No GoLive date or no existing call line if opted out**  
**\*\*Scoring for the metric Flat File Status as of 5/6/16 is as follows: 0 = Not Started, .25 = Development, File Validation, Demographics Production, .5 = All Production, Backload Sent, 1 = QA Process, Complete**

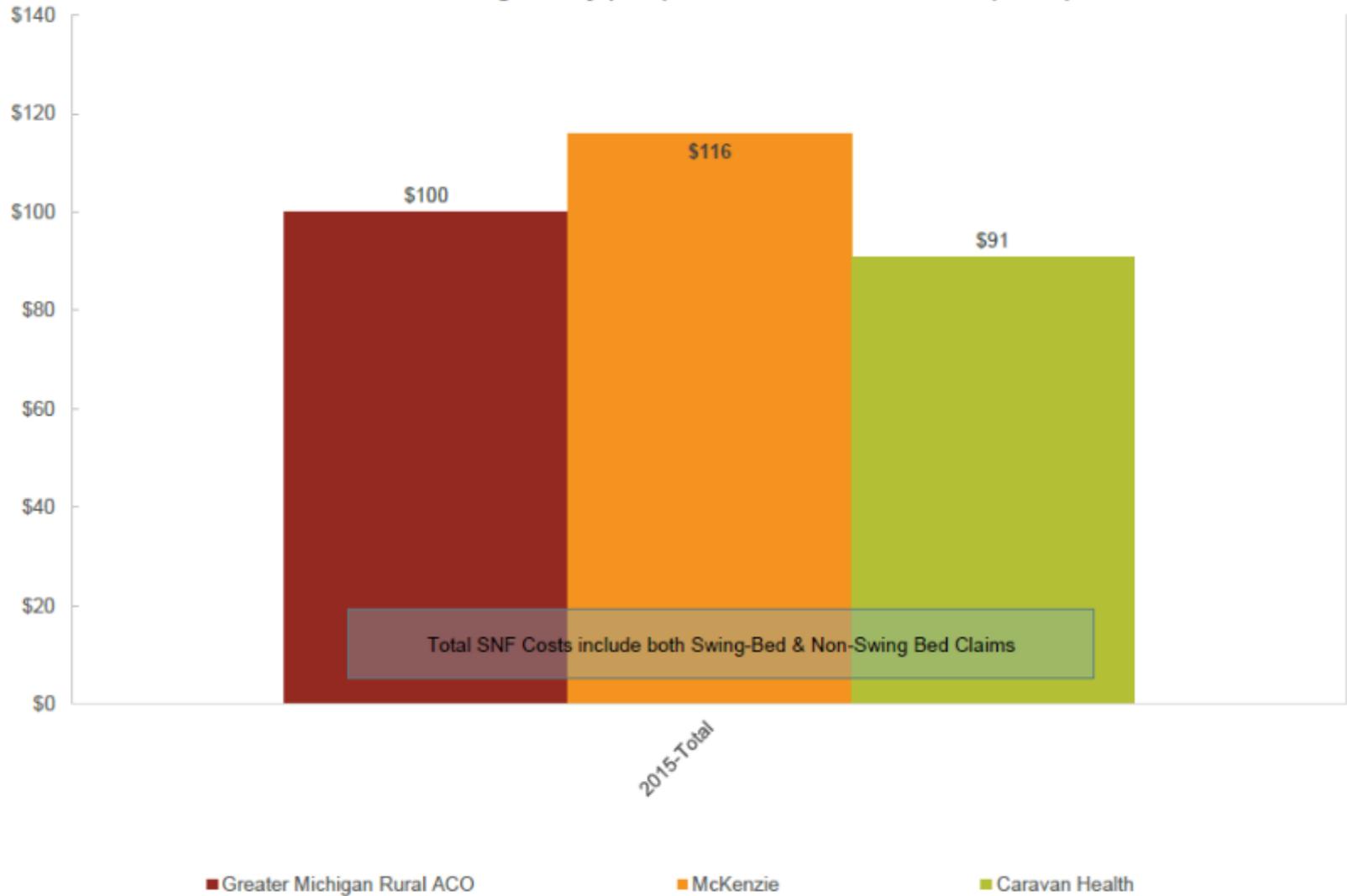


Total Costs include Medicare Part A & Part B Claims Total

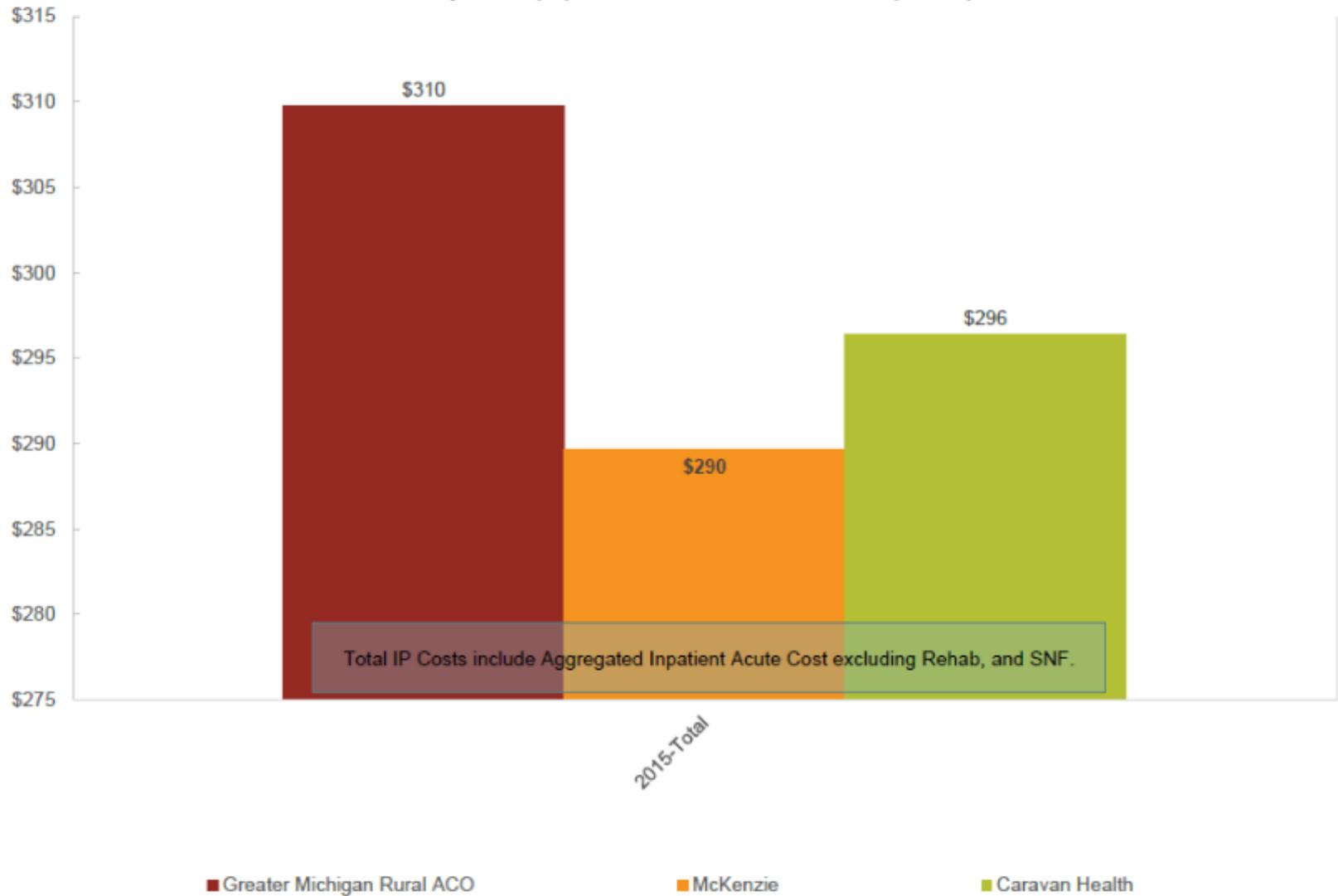
### Total Cost Per Patient Per Month (PPPM)



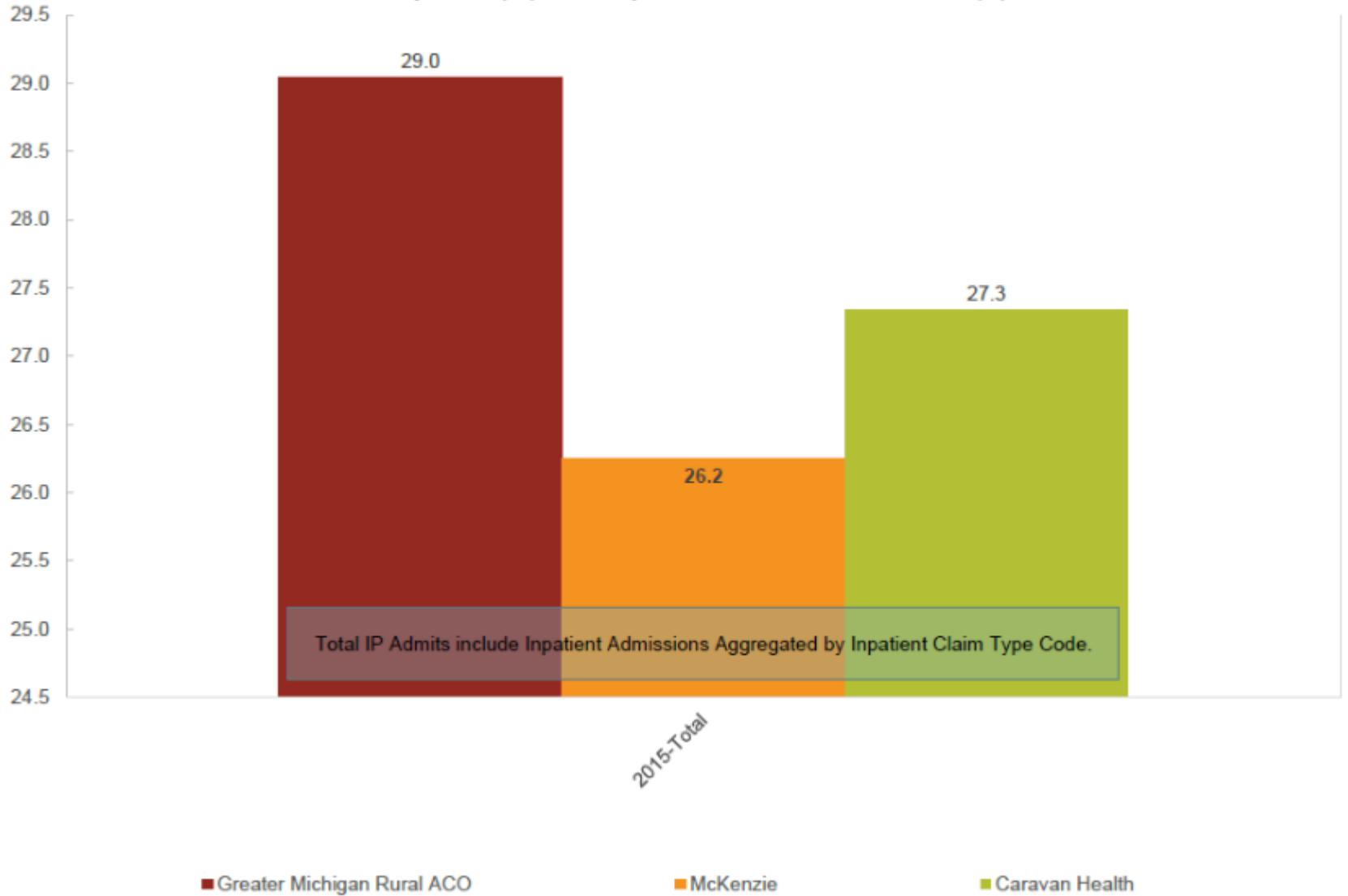
### Total Skilled Nursing Facility (SNF) Cost Per Patient Per Month (PPPM)



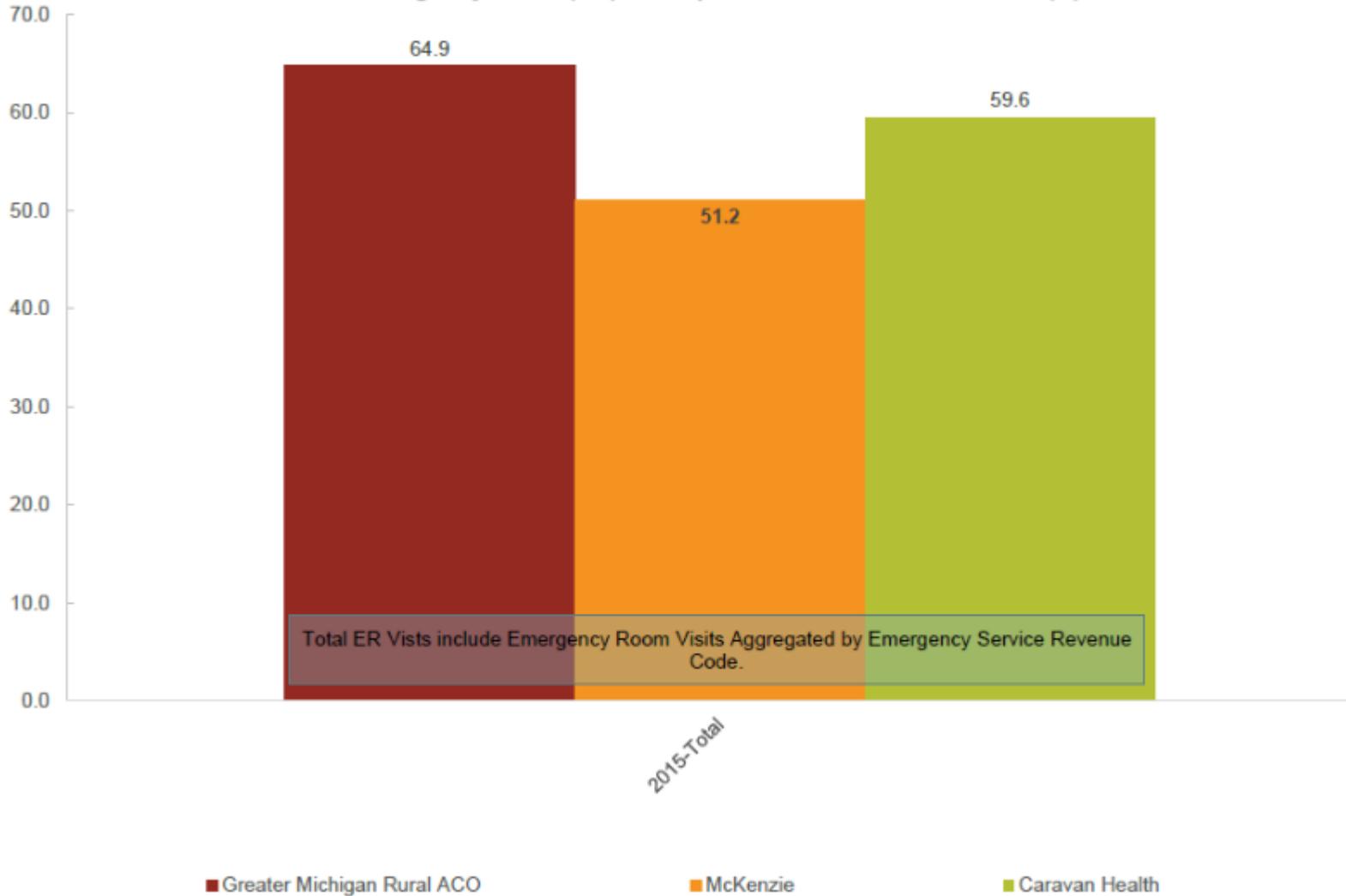
### Total Inpatient (IP) Cost Per Patient Per Month (PPPM)



Total Inpatient (IP) Admits per Thousand Patient Months (K)



Total Emergency Room (ER) Visits per Thousand Patient Months (K)



# McKenzie Health System

## 2015 Quality Measure Reporting Results

Metric ID	Metric Description	Total Eligible	Denominator Exceptions	Denominator	Measure Not Met	Measure Met	Measure Rate	McKenzie 2015 Benchmark	NRACO Measure Rate	NRACO Benchmark
CARE-2	Falls: Screening for Future Risk	27	0	27	14	13	48.15	70th	53.57	80th
CARE-3	Documentation of current Medications in the Medical Record	112	0	112	8	104	92.86	*	94.47	*
CAD-7	CAD: ACE Inhibitor or ARB Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	40	1	39	9	30	76.92	50th	68.21	30th
DM-2	Diabetes: Hemoglobin A1c Poor Control **	29	0	29	25	4	86.21	*	82.81	*
DM-7	Diabetes: Eye Exam	29	0	29	23	6	20.69	*	33.98	*
HF-6	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	24	0	24	5	19	79.17	70th	88.6	80th
HTN-2	Controlling High Blood Pressure	26	0	26	7	19	73.08	70th	68.36	60th
IVD-2	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	52	0	52	9	43	82.69	80th	85.26	80th
MH-1	Depression Remission at Twelve Months	1	0	1	1	0	0	*	2.63	*
PREV-5	Breast Cancer Screening	29	0	29	0	29	100	90th	88.49	80th
PREV-6	Colorectal Cancer Screening	24	0	24	13	11	45.83	40th	57.75	50th
PREV-7	Preventive Care and Screening: Influenza Immunization	25	2	23	11	12	52.17	50th	48.75	40th
PREV-8	Pneumonia Vaccination Status for Older Adults	24	0	24	15	9	37.5	30th	60.9	60th
PREV-9	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	23	0	23	11	12	52.17	50th	65.25	60th
PREV-10	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	23	0	23	0	23	100	90th	90.08	90th
PREV-11	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	17	0	17	3	14	82.35	80th	72.91	70th
PREV-12	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	17	0	17	11	6	35.29	70th	44.22	80th
<b>Total Average Rate/Percentile for PY:</b>							<b>62.65</b>	<b>64.62</b>	<b>65.07</b>	<b>66.15</b>

### Legend:

\* = Measure is Report Only for PY1, 2 & 3

\*\* Lower Measure Met indicates better quality

### Color Legend: Based on PY2015 Benchmark Percentile

Below 30th = Failed the Measure

Between 30th and 60th

Above 60th

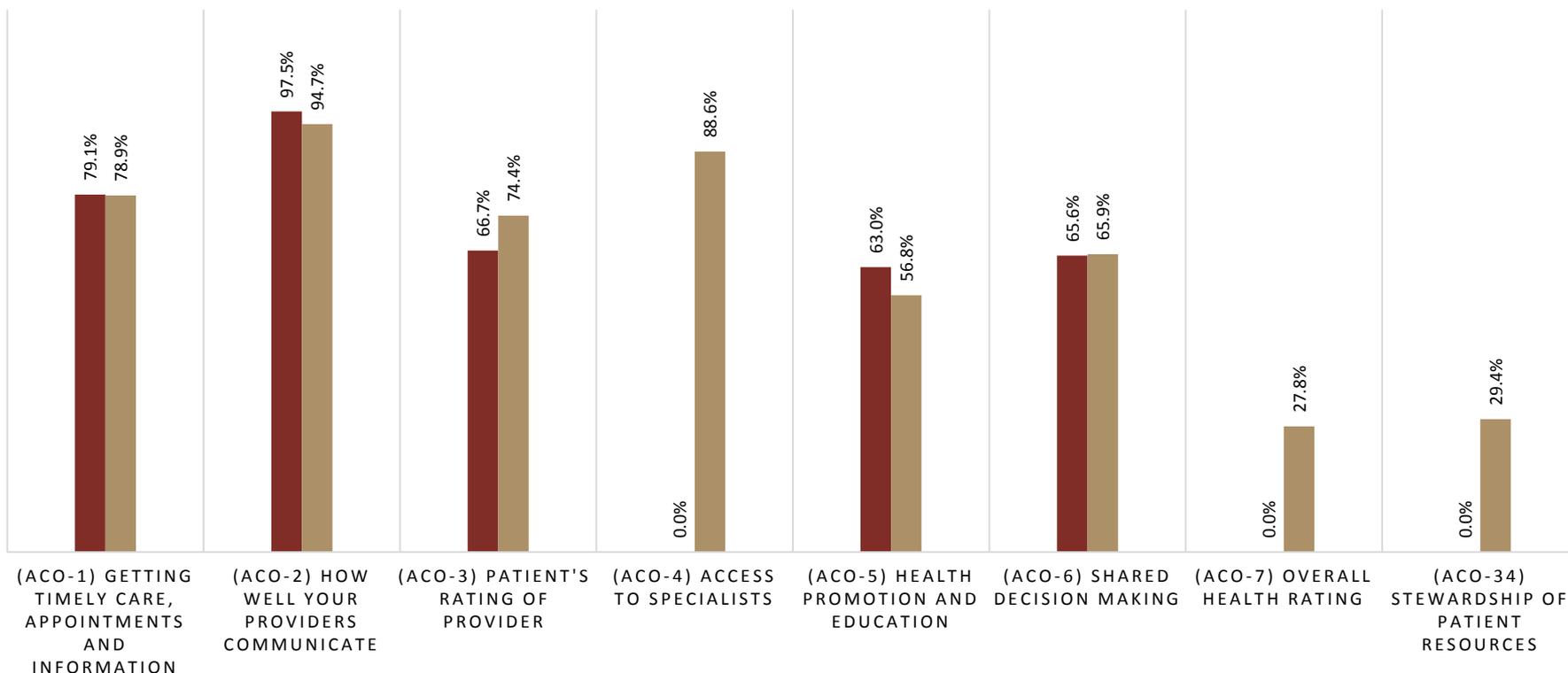


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# McKenzie 2015 ACO-CAHPS Patient Satisfaction Results

## PERCENT FAVORABLE RESPONSES

■ McKenzie ■ Caravan Health Avg



Response rate was not sufficiently large to report on ACO-4, ACO-7, & ACO-34

# McKenzie 2015 ACO-CAHPS Patient Satisfaction Results



<b>Strengths</b>	<b>Opportunities</b>
How Well Your Providers Communicate	Patient's Rating of Provider
Getting Timely Care, Appointments, and Information	
Health Promotion and Education	

# Our Version of the Wellness Visit

- Documentation of all drugs to support ongoing Med Rec
- Documentation of all co-morbidities to support accurate risk coding (HCC)
- Perform PHQ-9 Depression Screen, Mini-COG, Fall Risk
- Perform Advanced Care Planning
- Documentation of all interventions to support quality scores
- Maximize number of patients who get the service
- Realize revenue to support staff needed for population health activities

# Chronic Care Management Billing

- ~ \$42 PMPM
- Each community hires at least one coordinator
- CCM Support
  - Care Management Software
  - Care Plans
  - Training and Certification
  - Coaching
  - Peer Support
  - 24/hour Access to Care Plan

# CPC+: Primary Care is King and the Patient is the Queen



## For primary care providers:

- Freedom to care or patients the way they think is best.
- Receive substantial payments to support care transformation.



## For the patients:

- Support for complex patients to achieve their health goals.
- 24-hour access to care and health information.
- Effective delivery of preventive care.
- Engaged patients and their families.
- Collaboration with hospitals and other clinicians to provide better coordinated care.

# MACRA/CPC+ BOOT CAMP

- **Purpose:** Be successful no matter what path you choose.
- **Timeline:** Started June 30 – can join any time.
- **How:**
  - Join our Practice Transformation Network
  - Appoint a nurse in your practice that can **dedicate 72 hours** before September 1st. (Hint: Give us your best nurse! This is your future.)
  - If CPC+ is available/desired:
    - Caravan Health will complete your application.
    - Caravan Health will provide all letters of support.
  - If not, you will do very well under MACRA
- **Cost:** Free
- **DO:** Sign up now! Space is limited.



# BOOT CAMP

<b>Event title</b>	<b>Objective</b>	<b>Date/time</b>
<b>Introduction to MACRA Boot Camp</b>	Develop your individual work plan & sign up for free services.	June 30 <sup>th</sup>
<b>Nurse Response Hotline</b>	Set up 24/7 access for your patients to members of your virtual care team.	July 7 <sup>th</sup>
<b>Patient Assessments Using Annual Wellness Visits (AWV)</b>	Learn about how to maximize the health of your patients, capture the quality data you need and get well paid for your time.	July 14 <sup>th</sup>
<b>Annual Wellness Visit Implementation</b>	Identify personnel, space and workflow for wellness visits. Begin AWV program.	July 21 <sup>st</sup>
<b>Chronic Care Management Overview</b>	Identify nurse who will become the Care Coordinator and begin online training. Set up linkages with hospitals, EDs and discharge planning. Prepare to bill for CCM services.	July 28 <sup>th</sup>
<b>Care Management and Risk Stratification Software</b>	Learn to use Care Management Software to build care plans and track interventions for high-risk patients. Learn how to risk-stratify your patients.	Aug. 4 <sup>th</sup>
<b>CCM Implementation</b>	Create lists of community resources, begin building care plans for CCM patients and billing for services.	Aug. 11 <sup>th</sup>
<b>Empanelment</b>	Assign all patients in practice to a provider and care team. Ensure front desk uses empanelment for scheduling whenever possible.	Aug. 18 <sup>th</sup>
<b>Appropriate Diagnosis Coding</b>	Modify workflow to address significant co-morbidities at every visit and ensure that the full diagnosis is captured for every patient.	Aug. 25 <sup>th</sup>

# Proposal

- Enroll everyone in PTN that isn't already
- Support CPC+ applications
- Provide IT letters of support
  - No cost until accepted into APM, then \$5 PMPM for full support, \$1 PMPM for Lightbeam only.
- Form multiple Montana CINs for data aggregation and sharing.
- Form Super-CIN to share data among them with OHCA Declaration.
- Work with Payers for claims data and value-based payments.

# Caravan Health CIN Model

- Based on successful ACO governance model of independent entities
- Provider-owned and governed
- Board elected by providers representing hospitals, practices, RHCs, FQHCs and CAHs
- For value-based contracts only – not for negotiating rates
- Allows aggregation and transparency of data through OHCA declaration
- Does not bind participants to risk – opt-in model
- Draft legal agreements available under PTN.

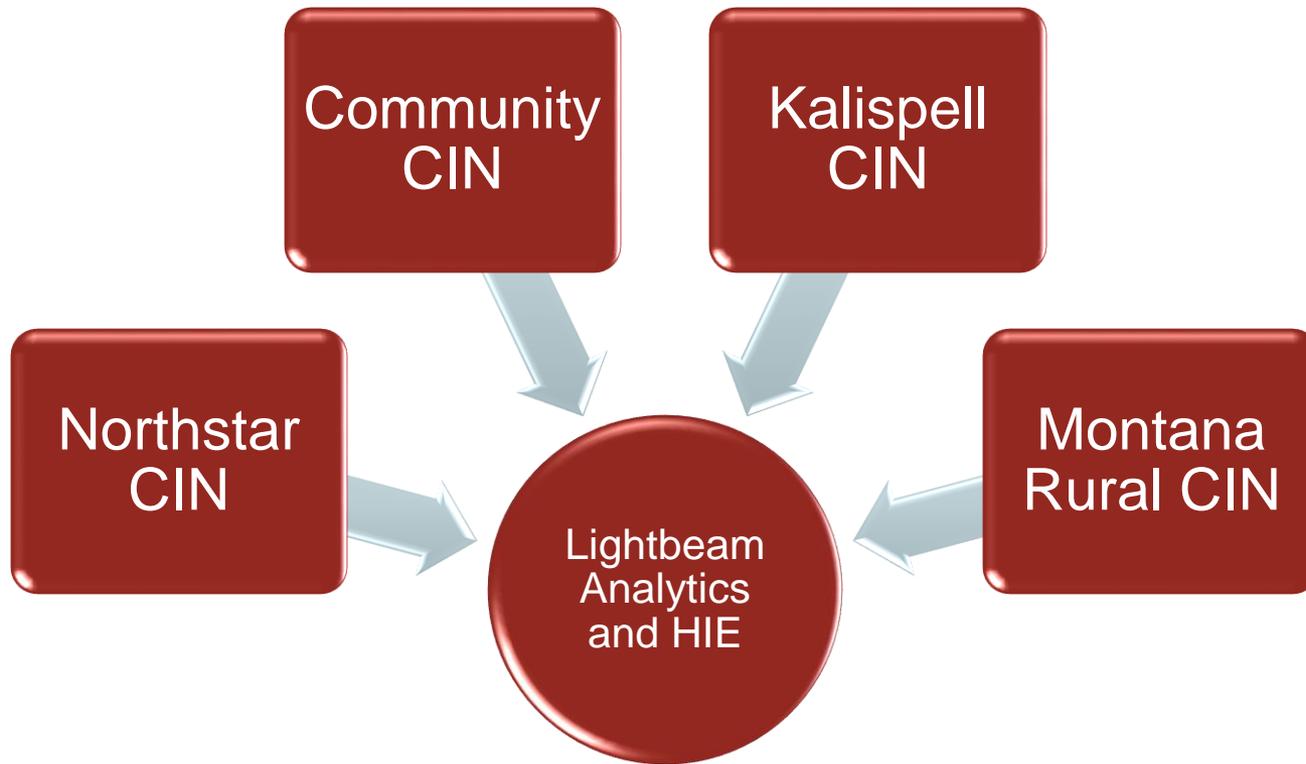
# What is an OHCA?

- An OHCA is an organized system of health care where the participating providers hold themselves out to the public as a joint arrangement and participate in one or more of the following joint activities:
  - Utilization review by participants of participant health care decisions;
  - Quality assessment and improvement activities, including participant review of care provided by other participants; or
  - Clinical integration
- If the Super CIN is structured so that it qualifies as an OHCA, it will allow the participating providers to share identifiable information

# What is an OHCA Declaration?

- An OHCA declaration is a short written statement that acknowledges that the providers are participating in the joint arrangement for the purpose of joint utilization review, joint quality assessment and improvement, and clinical integration
  - The OHCA declaration can be used by the providers to hold themselves out to the public as participating in the OHCA

# Montana Vision



...all engaged in the work of Population Health and Practice Transformation through the use of Caravan Health's tools and infrastructure

# Strategic Plan for Transformation:





caravanhealth

Thank You

[www.CaravanHealth.com](http://www.CaravanHealth.com)

[lbarr@CaravanHealth.com](mailto:lbarr@CaravanHealth.com)

925-876-5315

**Indian Health Service, Tribal and Urban (ITU)  
American Indian Health Care**



# Indian Country Health Care Landscape





# Tribes in Montana

---

## ▶ Blackfeet Reservation

Home of **Blackfeet Tribe**

Tribal Headquarters is in Browning

## ▶ Crow Reservation

Home of **Crow Tribe**

Tribal Headquarters is in Crow Agency

## ▶ Flathead Reservation

Home of **Confederated Salish & Kootenai Tribes**

Tribal Headquarters is in Pablo

## ▶ Fort Belknap Reservation

Home of **Assiniboine & Gros Ventre Tribes**

Tribal Headquarters is in Fort Belknap Agency

## ▶ Fort Peck Reservation

Home of **Assiniboine & Sioux Tribes**

Tribal Headquarters is in Poplar

## ▶ Northern Cheyenne Reservation

Home of **Northern Cheyenne Tribe**

Tribal Headquarters is in Lame Deer

## ▶ Rocky Boy's Reservation

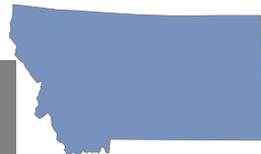
Home of **Chippewa & Cree Tribes**

Tribal Headquarters is in Rocky Boy Agency

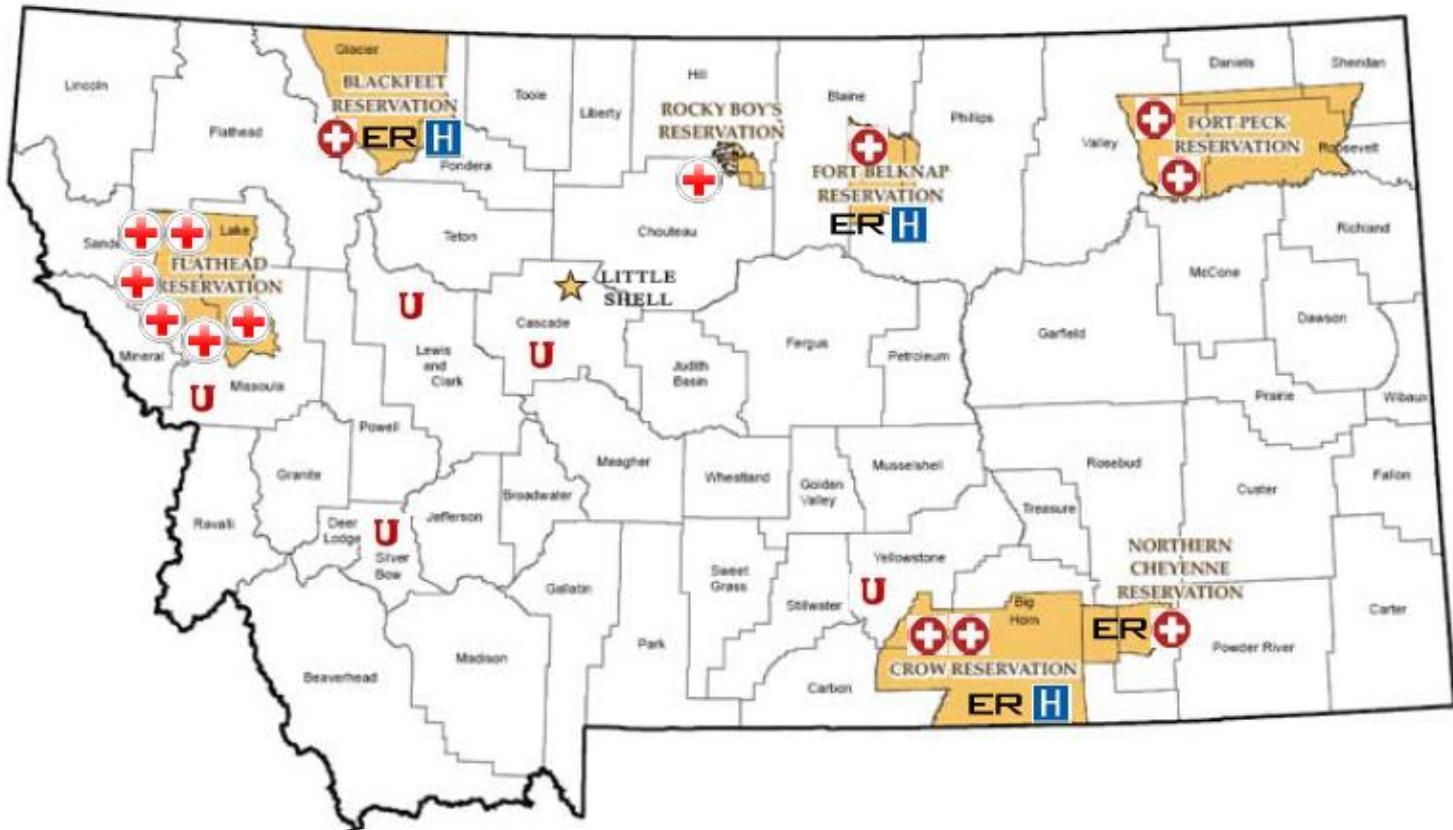
## ▶ \*Little Shell (only recognized by State of MT)

Referred to as the Little Shell Tribe of **Chippewa** Indians of Montana

Tribal Headquarters is in Great Falls, no large land base, seeking federal recognition



# Tribal, Urban and IHS Health Facilities in Montana



**IHS HOSPITALS** – Blackfeet (Browning), Crow/Northern Cheyenne (Crow Agency), Fort Belknap (Fort Belknap Agency)



**EMERGENCY ROOMS** – Blackfeet (Browning), Crow (Crow Agency), Fort Belknap (Fort Belknap Agency), Northern Cheyenne (Lame Deer)



**IHS CLINICS** – Blackfeet (Heart Butte); Crow (Lodge Grass, Pryor); Fort Belknap (Hays); Fort Peck (Poplar, Wolf Point); Lame Deer (Northern Cheyenne);



**TRIBALLY-OPERATED CLINICS** – Flathead (Arlee, Elmo, Polson, Ronan, St. Ignatius and Salish Kootenai College); Rocky Boy's (Rocky Boy Agency)



**URBAN INDIAN CLINICS** – Billings, Butte, Great Falls, Helena, Missoula

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## **Access and Payment for American Indian Health Care in Montana**



# American Indian Health in Montana

## Unique American Indian health delivery system and types of facilities

1

### Fully IHS Operated Facilities

- Blackfeet - Browning Hospital, Heart Butte Clinic
- Crow - Crow Agency Hospital, Lodge Grass and Pryor Clinics
- Northern Cheyenne - Lame Deer Hospital
- Fort Belknap - Fort Belknap Agency Hospital, Hays Clinic
- Fort Peck – Poplar and Wolf Point Clinics

2

### “Contracted” Facilities Operated by Both Tribes and IHS

- Ft. Peck Tribal Health and Ft. Peck IHS
- Ft. Belknap Tribal Health and Ft. Belknap IHS
- Blackfeet Tribal Health and Blackfeet IHS
- Crow Tribal Health and Crow IHS
- Northern Cheyenne Tribal Health and Northern Cheyenne Health Center IHS

3

### “Compacted” Facilities Operated Fully by Tribes

- Rocky Boy’s (Rocky Boy Health Board/Rocky Boy Clinic)
- Confederated Tribes of Salish Kootenai Tribal Health/CSKT (Arlee, Elmo, Polson, Ronan, St. Ignatius and Salish Kootenai College Clinics)

4

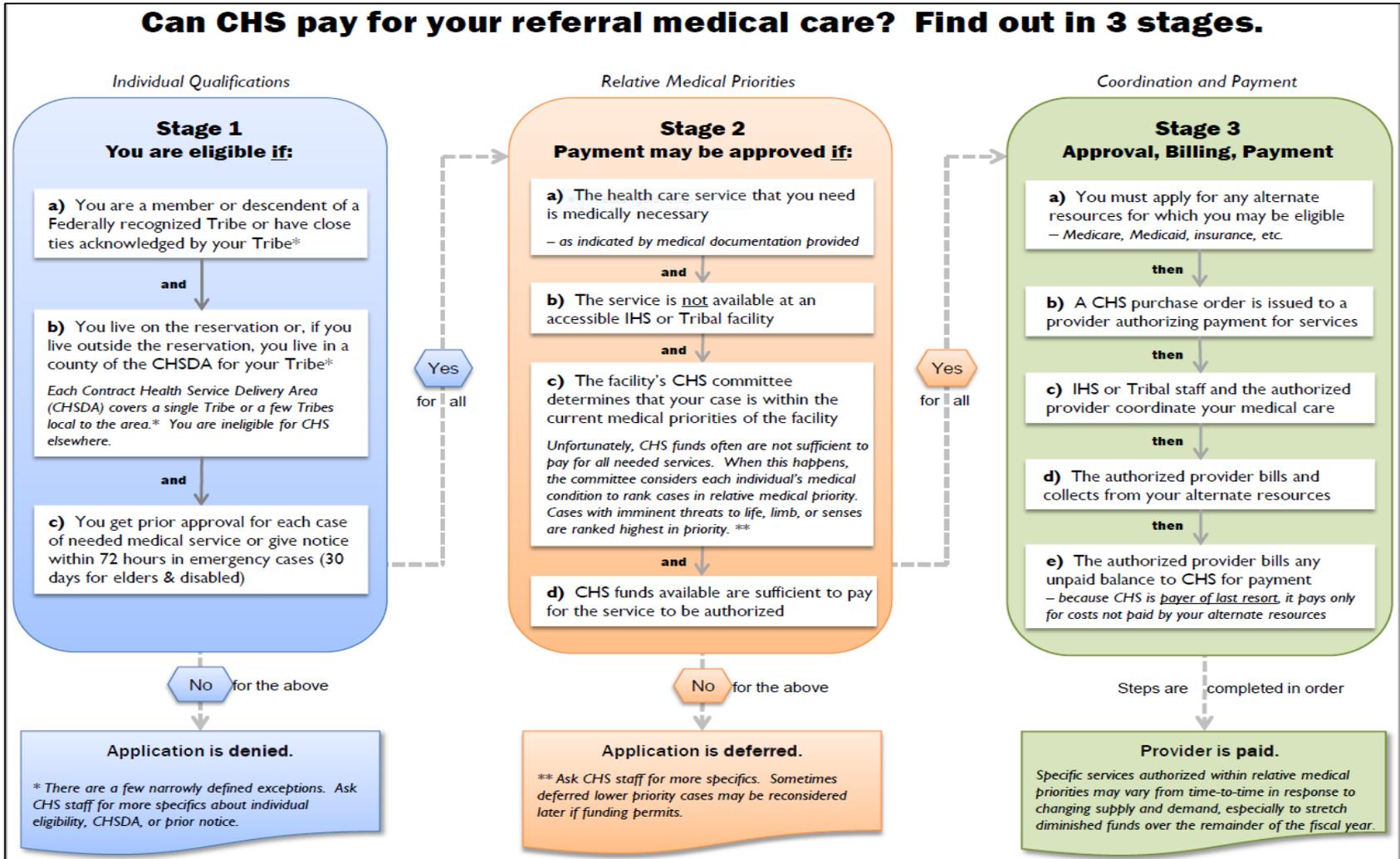
### Urban Indian Health Programs

IHS also contracts with, or makes grants to, 5 nonprofit Montana Urban Indian Health Programs: Billings, Helena, Butte, Missoula, Great Falls



# Purchased Referred Care (PRC) = CHS

## Can CHS pay for your referral medical care? Find out in 3 stages.



## The IHS Medical Priorities Levels are:

1. Emergent or Acutely Urgent Care Services
2. Preventive Care Services
3. Primary and Secondary Care Services
4. Chronic Tertiary Care Services
5. Excluded Services



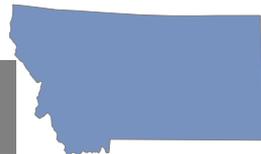
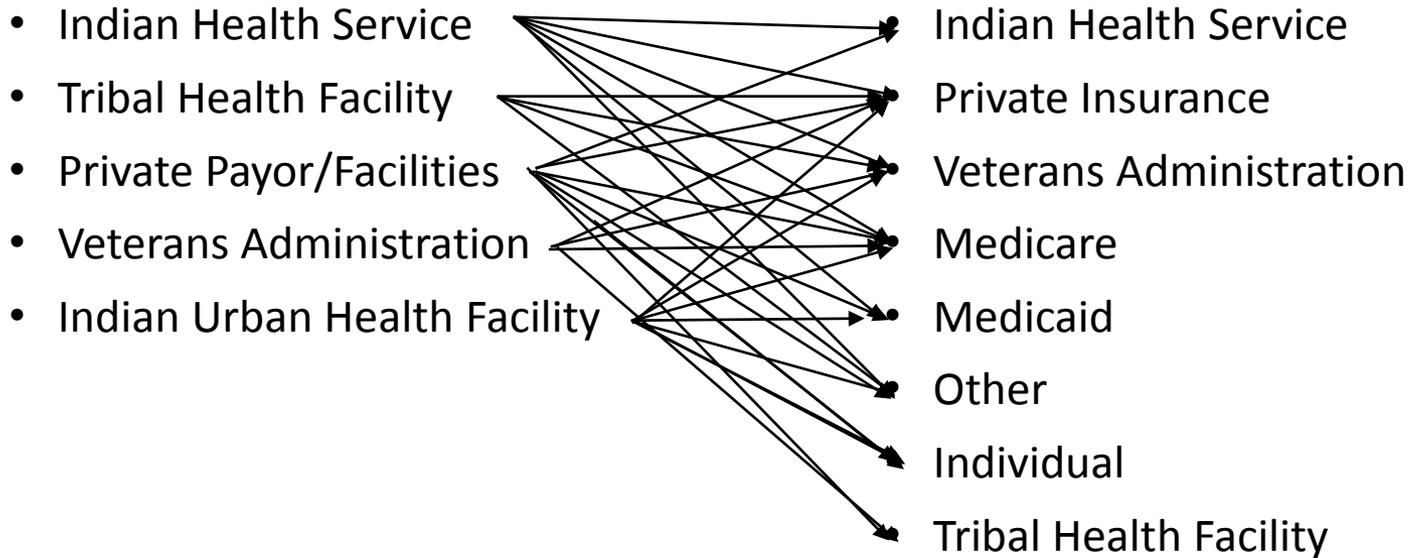
# Access and Reimbursement for AI/AN

- **Complex**
- **Multi-Tiered**
- **Limited Access**

- **Limited Funding**
- **Dependent upon restrictions (e.g., Contract Health Service Delivery Area -CHSDA)**

## Access

## Reimbursement



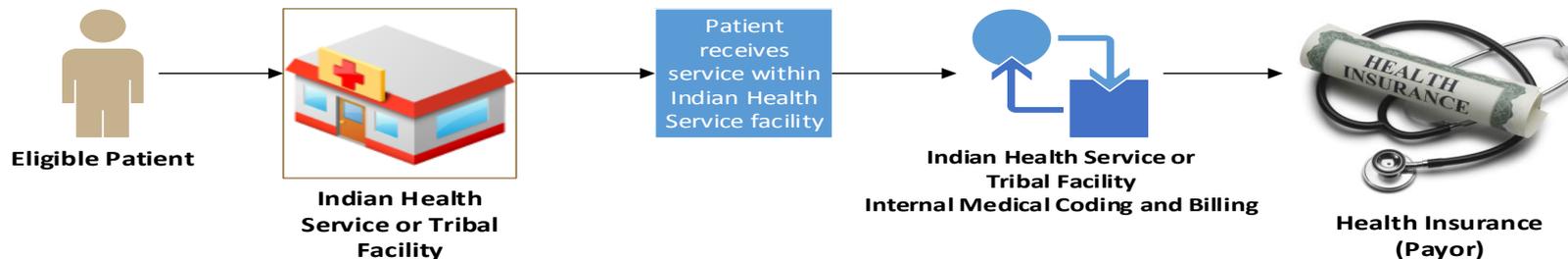
# Scenarios Impacting AI Healthcare Access and Payment

## AI Patient with Indian Health Service or Tribal Facility Only (no external services)

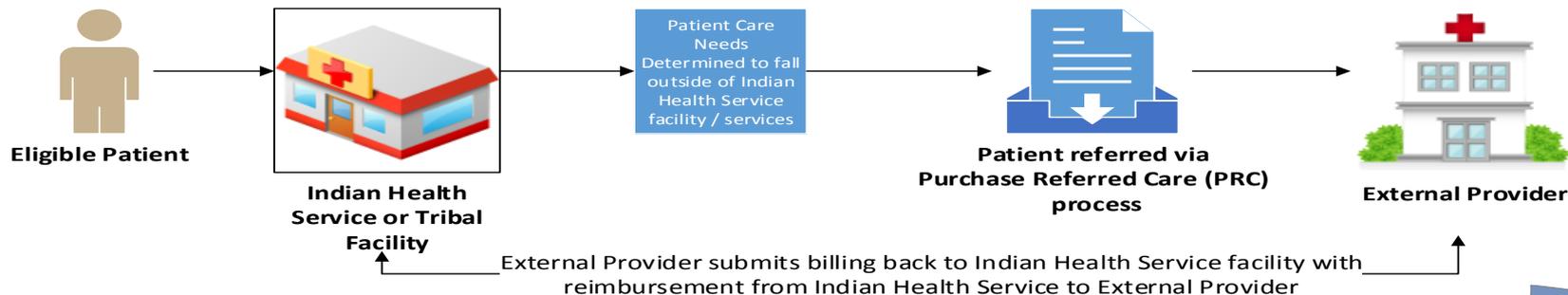


**IHS Funding**  
IHS provides limited funding for services to IHS-eligible patients, regardless of insurance status

## AI Patient with Insurance Seeking Service with Indian Health Service or Tribal Facility Only

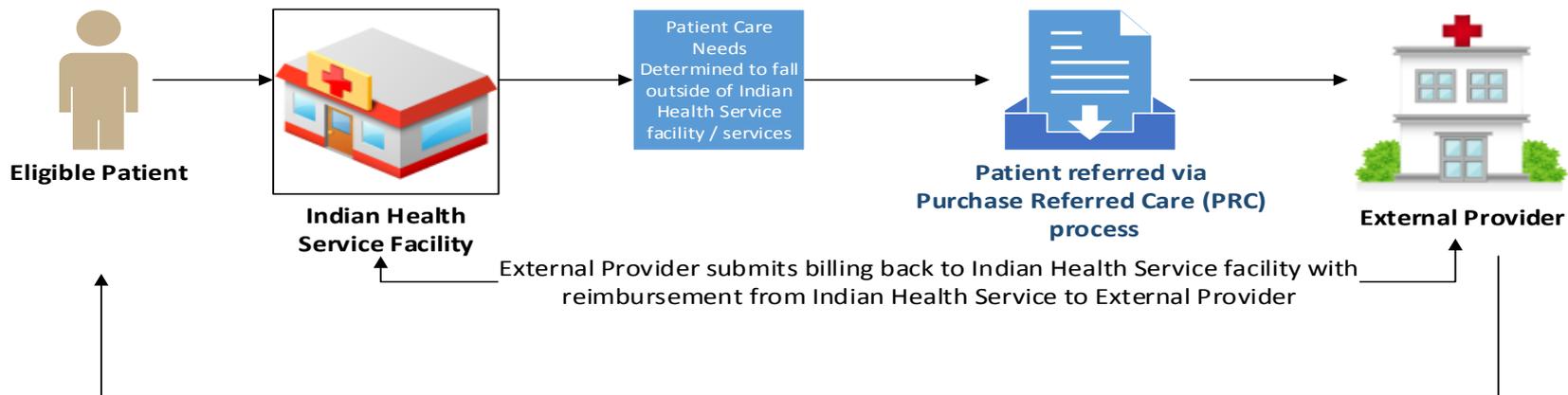


## AI Patient with Indian Health Service External Referral (no insurance)

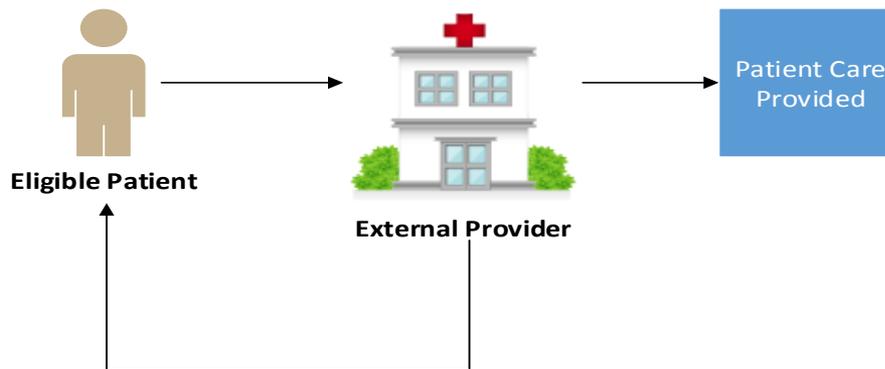


# Scenarios Impacting AI Healthcare Access and Payment

## AI Patient with Indian Health Service or Tribal Facility External Referral (no insurance) and no funding available and Patient Billed Directly

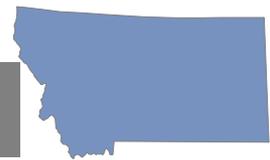
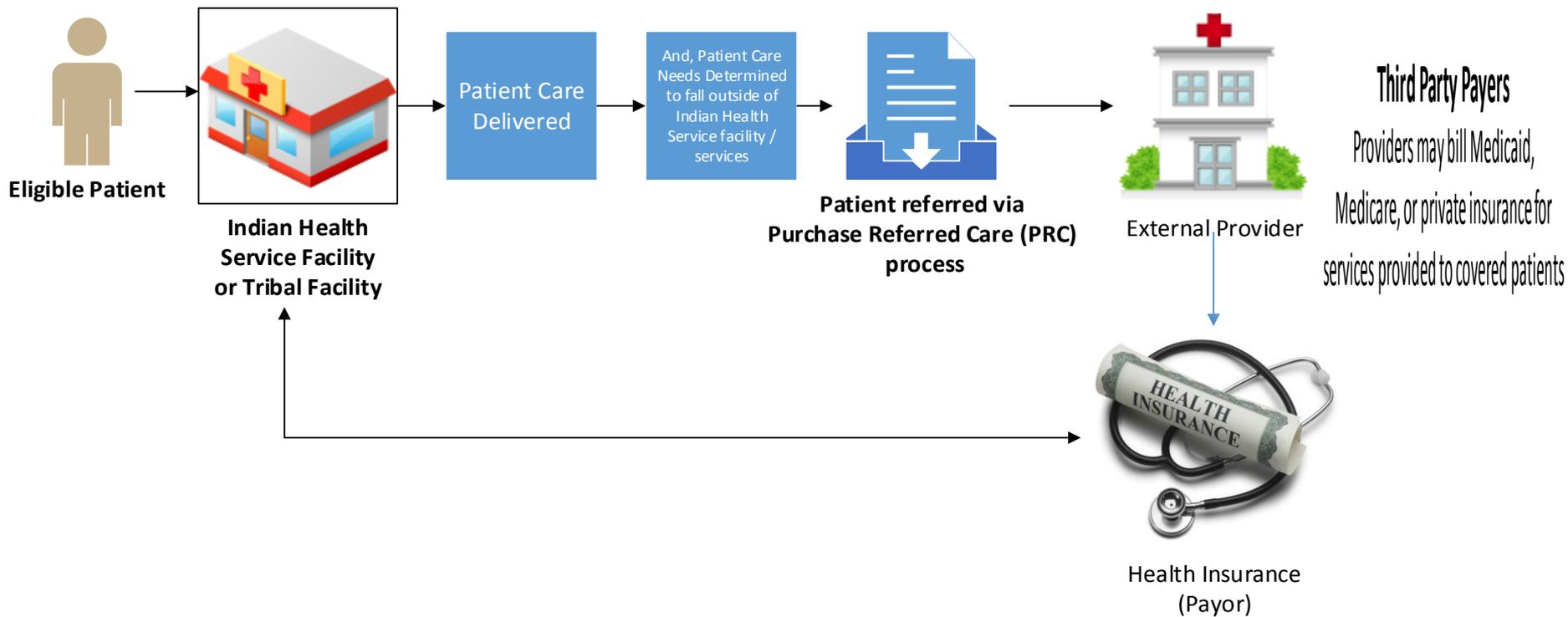


## AI Patient with Non-Indian Health Service / Tribal Clinic with No Referral or Insurance (Direct Pay)



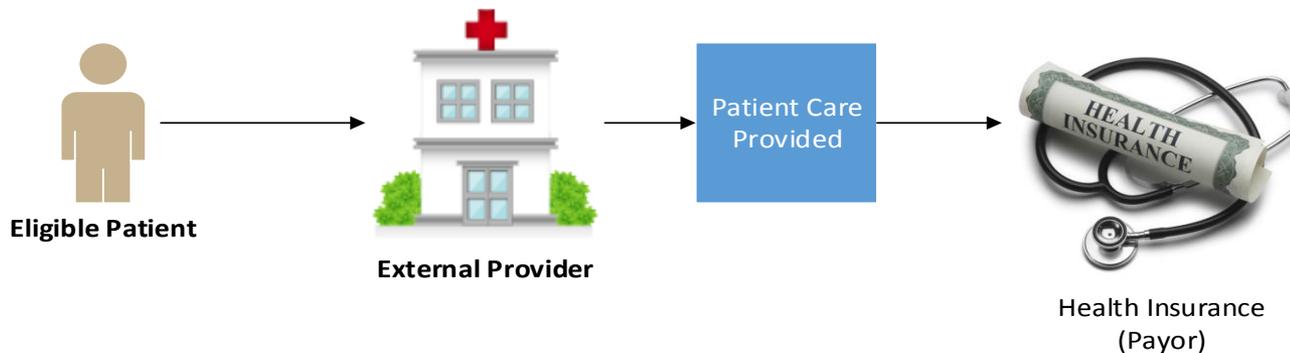
# Scenarios Impacting AI Healthcare Access and Payment

## AI Patients with Insurance Seeking Service with Indian Health Service or Tribal Facility External Referral

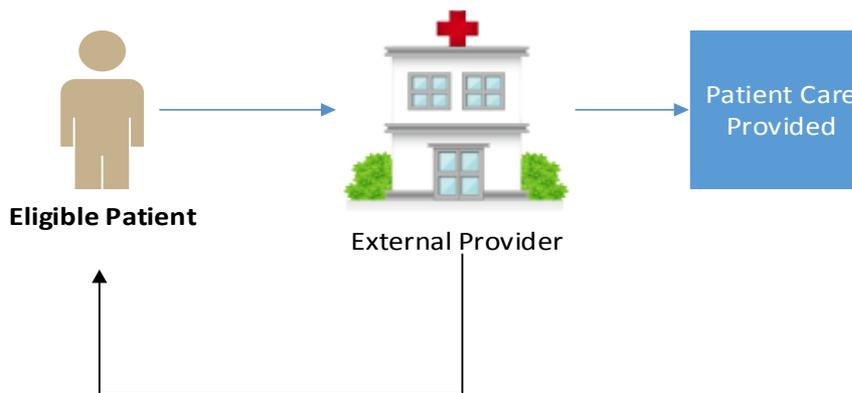


# Scenarios Impacting AI Healthcare Access and Payment

## AI Patient with insurance seeking care with non-Indian Health Service



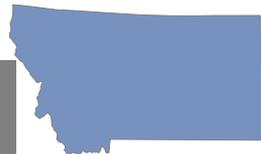
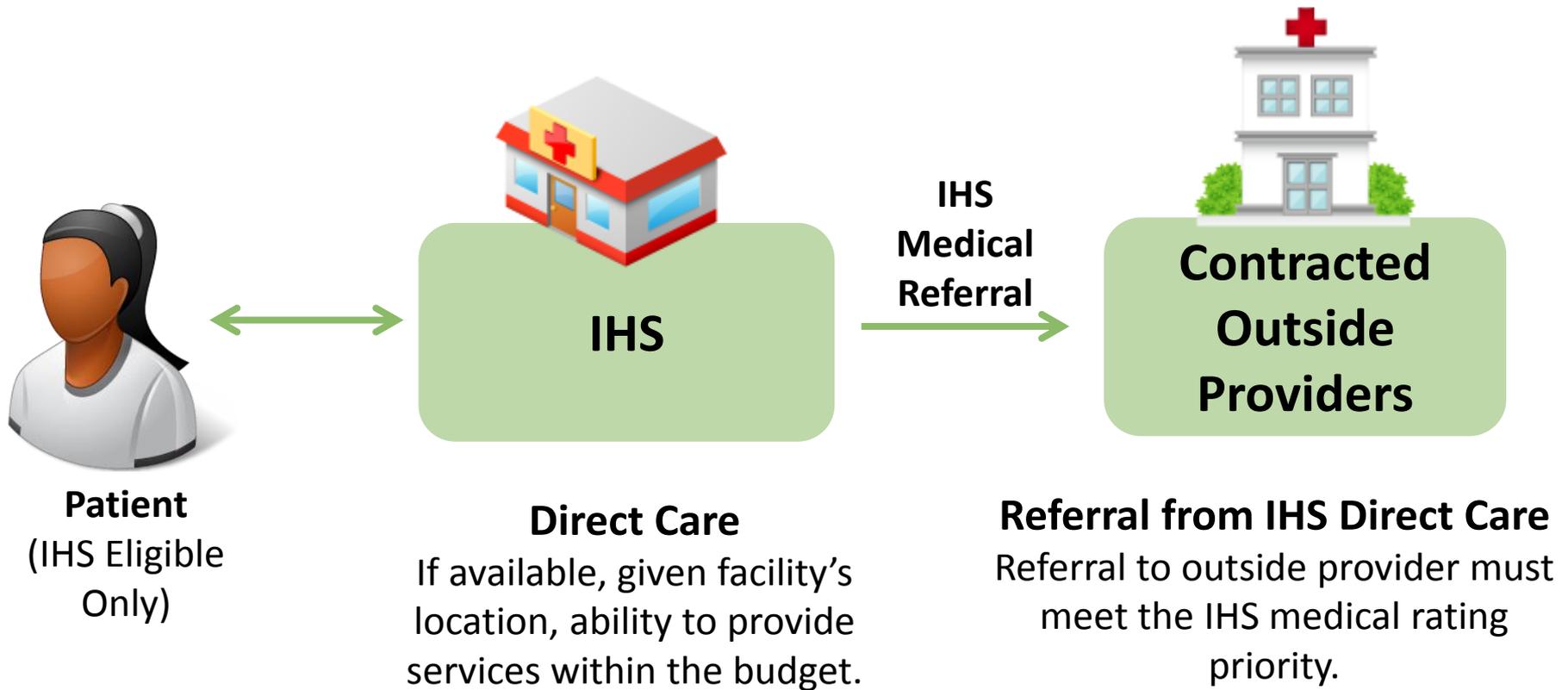
## AI Patient with non-Indian Health Service / Tribal Clinic with No Referral with no insurance (Direct Pay)



## **Delivery of IHS, Tribal and Urban Indian Health Care**

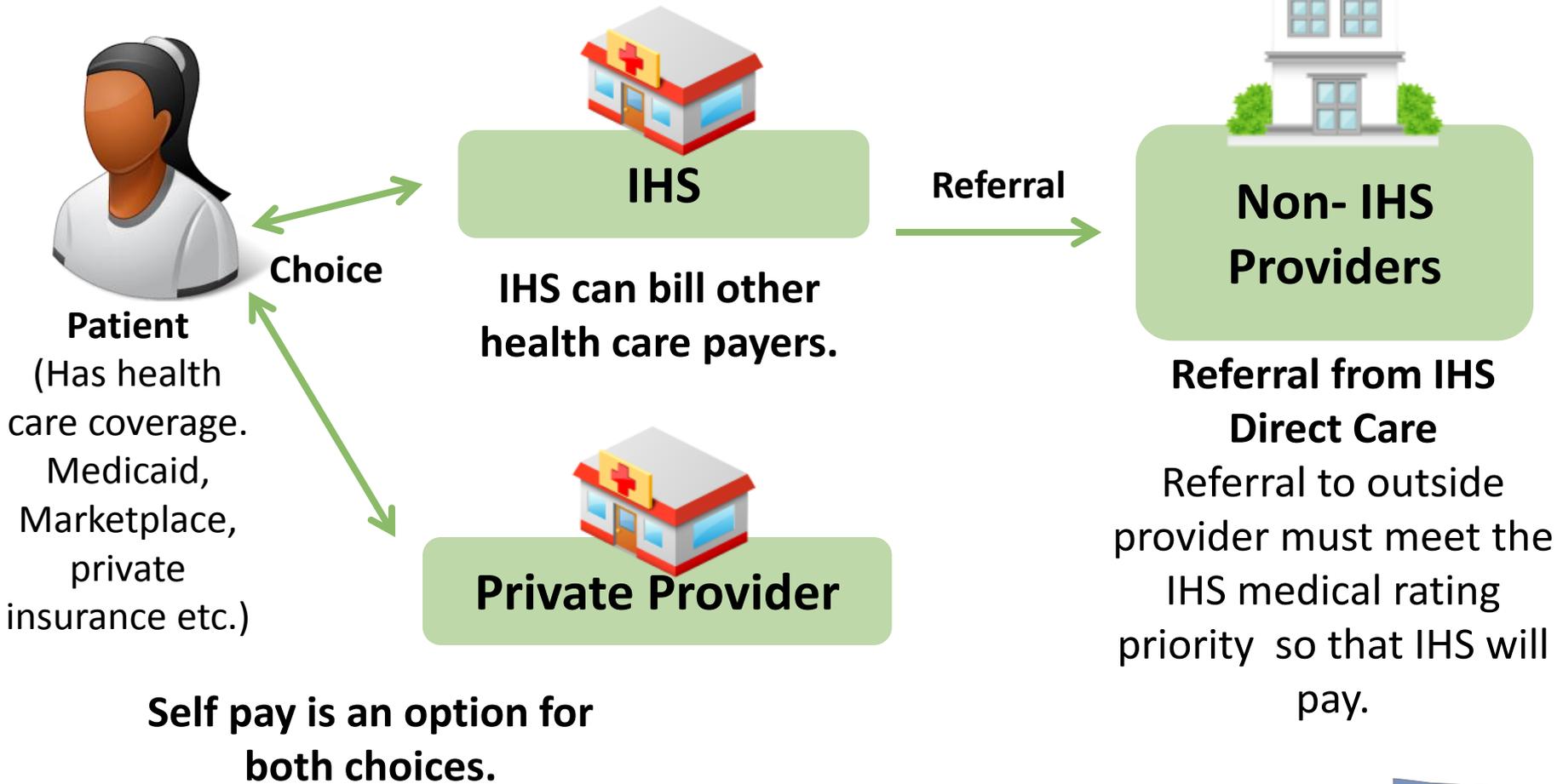


# Access for AI/AN Patients – IHS Eligible Only



# Access for AI/AN Patients – IHS + Health Care Coverage

If you have coverage you don't need to go to IHS for care if you are willing to pay your health plan's cost sharing requirements.



## Montana Models of Success





# Native American Outreach

# Native American Programs Overview

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## **Mission**

- Reduce health disparities among Native Americans in Montana with the purpose of improving quality of life and saving lives in a culturally and spiritually sensitive manner.

## **Vision**

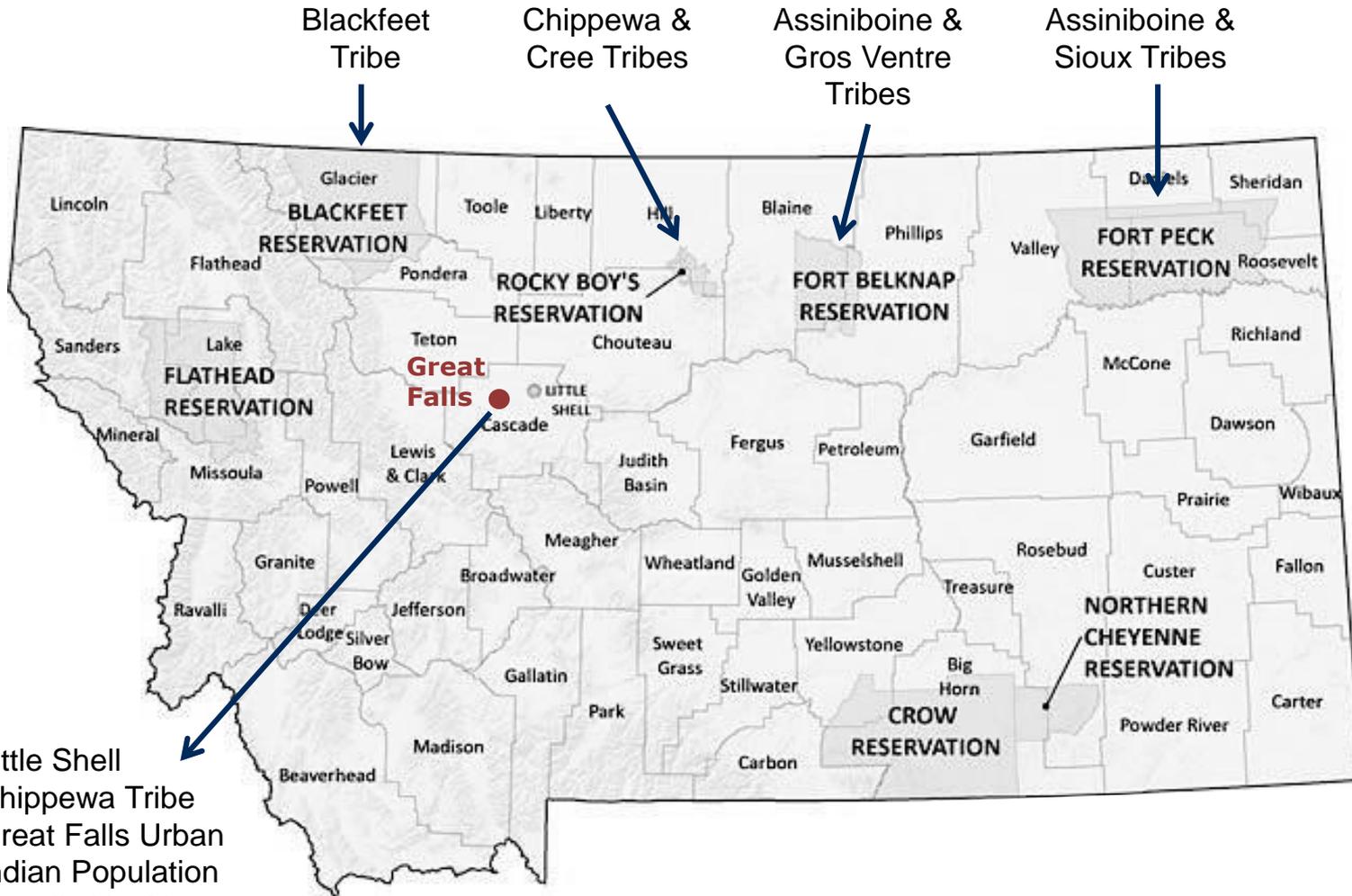
- Identify barriers to healthcare, starting with cancer and then expanding to other chronic diseases.
- In partnership with Native Americans, determine solutions to healthcare barriers.
- Determine which areas are most appropriate for our joint involvement
- Identify resources available at Benefis.
- Seek external funding from governmental agencies and private foundations to support these efforts.
- Implement plans to address issues.

# Native American Programs Background

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- Native Americans have long experienced lower health status when compared to other Americans, including lower life expectancy and disproportionate disease burden.
- This health disparity is caused by factors such as:
  - Poverty
  - Poor delivery of healthcare
  - Cultural differences
- The primary service area at Benefis includes four Native American Reservations and the Great Falls urban Indian community, resulting in more than 40,000 Native Americans in the 229,000-person service area.
- In an effort to improve service for Native American patients at Benefis, we partnered with area tribes to better understand the needs of Native American patients and their families.

# Partnerships



- Little Shell Chippewa Tribe
- Great Falls Urban Indian Population
- Benefis Health System Native American Programs

# Native American Board

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- Board Consists Of:
  - Tribal Leaders (Tribal Council Representatives)
  - Tribal College Presidents
  - IHS Representatives
  - Health Directors
  - Urban Representatives
  - Department of Public Health and Human Services Representative
- Board Members Come From Area Tribes/Reservations in the Benefis Service Area, Including:
  - Blackfeet
  - Fort Belknap
  - Rocky Boy
  - Fort Peck
  - Great Falls Indian Family Clinic
  - Little Shell Chippewa

# Projects and Initiatives

- Native American Relations and Communications
- Blackfeet Community College Issksiniip Job Shadow Project
- Native American Nurse Internship Program
- Health Disparity Reduction Efforts
- Affordable Care Act Certified Application Counselors
- Native American Patient/Family Advocate



# Papoose Rattler Memorial Native American Welcoming Center

- Serves as a point of contact for reservation hospitals/clinics and community health representatives.
- Provides soup and a sandwich for our daily visitors. We have had 2289 visitors YTD 2016.
- Assists family members with items such as meal cards or bus passes.
- Offers a kids' area, kitchenette/lunch, waiting/TV area, and prayer room on both campuses.
- Celebrating our 10 year anniversary in September.



# Religious Ceremonies

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- Benefis employees are encouraged to make every effort to accommodate Native American religious ceremonies and to understand Native American culture and spirituality.
- Benefis employs staff who facilitate Native American religious ceremonies such as smudging.
- Benefis provides Native American cultural education in our orientation for new employees.

# Medicaid Enrollment Events

\*Jan 4<sup>th</sup>, 12<sup>th</sup> & 26<sup>th</sup> . 9am to 4pm -Native American Welcoming Center  
Enrollment Events at Benefis

Jan 19<sup>th</sup> 9 am to 5 pm – Great Falls IHS Center

\*Jan 20<sup>th</sup> Browning Medicaid Enrollment Event – Glacier Peaks Casino

\*Feb 4<sup>th</sup> – 9am to 4 pm Medicaid Enrollment – Glacier Peaks Casino

Feb 8<sup>th</sup>- Benefis Teton Medical Center, 10a to 5pm

\*Feb 10th – 9 to 3pm – Medicaid Enrollment – Glacier Peaks Casino

Feb. 17<sup>th</sup> – Ft Benton Missouri River Healthcare, 10a to 5 pm

Every Thursday @ US Bank 10a-3p; Tuesday at St. Vincent's 11a-3p; Every Tuesday at the Great Falls Public Library 10a-6p; Every Monday at the Senior Center 9a-6p-  
Tax assistance with RDI until April 18th, 11 am to 5 pm;

\*Feb 3rd – Browning Blackfeet Community College, 9a to 4pm

\*Feb 23<sup>rd</sup> - Benefis Health System Native American Welcoming Center, 9a to 4:30pm

\*Feb 25 – Browning IHS, 8:30 am to 4:30pm

March 2<sup>nd</sup> – Ft Benton Missouri River Healthcare, 10a to 5 pm

March 4<sup>th</sup>- Senior Citizen Center, 10a to 5pm

March 8<sup>th</sup> & 22<sup>nd</sup> 9am to 4pm -Native American Welcoming Center  
Enrollment Events at Benefis

\*March 10<sup>th</sup> 9 – 3 Medicaid Enrollment – Glacier Peaks

March 8<sup>th</sup> - Benefis Health System Native American Welcoming Center, 9a to 4:30 p

\*March 10th – Browning – Glacier Peaks Casino- 9a to 3pm (Tentative)

March 16<sup>th</sup> - Benefis Health System Guy Tabaco Room, 11a to 5pm

March 18th- Senior Citizen Center, 10a to 5pm

April 12<sup>th</sup> and 26<sup>th</sup> 9am to 4pm -Native American Welcoming Center  
Enrollment Events at Benefis

May 19<sup>th</sup> and 31<sup>st</sup> 9am to 4pm -Native American Welcoming Center  
Enrollment Events at Benefis

May 20<sup>th</sup> Native American Men's Health Day- Paris Gibson Alternative High School 1130 to 230

# Questions?

Terry Preite, MS, CCHP, CHCE

President, Benefis Spectrum Medical and Regional Relationships

406-455-5013

[terrypreite@benefis.org](mailto:terrypreite@benefis.org)

# **Montana Healthcare Foundation: *Partnering with American Indian communities to improve health and health systems***

*Governor's Council on Healthcare Innovation*

*July 12, 2016*

*Aaron Wernham, MD, MS*

*CEO, Montana Healthcare Foundation*

[www.mthcf.org](http://www.mthcf.org)

[info@mthcf.org](mailto:info@mthcf.org)

# Montana Healthcare Foundation

[www.mthcf.org](http://www.mthcf.org)

- First call for grant proposals in 2015
- ~50 grants issued to date
- Three focus areas:
  - *American Indian Health*
  - *Partnerships for Better Health* (focused on value-based care/triple aim)
  - *Behavioral Health* (mental illness and drug & alcohol use)
    - Integrated Behavioral Health Initiative

# Why does MHCF focus on AI health?

- Burden of illness (i.e. “health disparities”)
- Resource disparities (workforce; funding; capacity)
- Relative isolation from other parts of Montana’s healthcare system

# Challenges we heard from external stakeholders during strategic planning

- “We aren’t sure where to start”—health disparities in Native American communities are a complex, long-standing problem.
- The “IHS” can be hard to work with
- Building relationships is difficult—“no one returns our calls or emails.”
- Tribal governments and priorities change frequently

# What we heard from talking with tribes, urban Indian health centers

## Challenges:

- Administrative capacity: coding, billing, IT, lack of support staff
- Health workforce shortages: both health professionals and admin staff
- System complexity: complex rules for eligibility, reimbursement, tribal management and compliance, fragmented funding
- Inadequate communication and collaboration with the non-tribal health system (CHCs, CAHs, large hospitals, county health departments, DPHHS).
- Trauma and the social determinants

# What we heard from talking with tribes, urban Indian health centers

## Strengths:

- Tribal Health and urban Indian Health Center leadership: talented, committed, and creative current leaders
- Tremendous potential for revenue generation to build a strong, self-sustaining health system
- Many innovative, successful tribal health programs
- Strong health-focused Native-led non-profits in some communities
- “Social capital” – cultural identity; strong inter-generational and community ties

# MHCF's approach

**General:** *“We work directly with Tribes, tribally-controlled non-profits, and other American Indian stakeholders to identify priorities and implement and sustain effective solutions.”*

# MHCF's approach

## Specific:

- Invest time in building relationships and trust
- Identify and work within time, technology, and staffing barriers. For Eg:
  - Communication preferences: phone, email, in person?
  - Assist with online application system if technology isn't working well
  - Set up time away from office to work on grant ideas
  - Reschedule meetings when needed
  - Hire a grant-writer to help write proposals to MHCF

# Status of MHCf work with AI communities:

## *2015-2016 grants*

- 15 grants to date (out of 50 issued in 2015-16)
- Grants and other assistance in 7 reservations, 2 UIHCs

### **Examples:**

- Focus on Enrollment & Revenue cycle: strengthening the health system through strengthening the bottom line. For example:
  - *Audit and improve coding, billing, revenue capture*
  - *Insurance enrollment and utilization*
  - *Establish tribally-run school-based clinic*
  - *Establish partnerships on telemedicine, specialty services*
- Injury prevention
- Joint tribal/county community health assessment
- Assistance writing other grants: e.g. IHS Tribal Management Grant

## Status of MHCF work with AI communities:

### *Beyond grantmaking: facilitating collaboration*

- Office of American Indian Health: Worked with tribes, DPHHS, and Governor's Office to help develop the framework
- Data needs: Facilitating conversations between DPHHS, RMTEC, and tribes on data needs, sharing data and analytic expertise
- Perinatal drug use: Developing collaborations between tribes and private hospitals on perinatal drug use



# American Indian Health Leaders Group

*First meeting: May 20, 2016*

- At their request, facilitating gatherings of Tribal Health Directors & Urban Indian Health Center Directors
- Overall goal: develop shared objectives, work together to achieve them
- Forum for focused discussions with state, IHS, non-tribal health system



# Take home points

- Strong relationships are a prerequisite: there is no substitute for investing time and being flexible.
- Resource disparities are a contributor to health disparities: working within limits in staff time, technology, and capacity is a key to making progress
- There are great opportunities for new partnerships, with potential benefits on both sides of the equation

# Opportunities

There is a strong, proactive group of AI health leaders serving in the tribal health departments & urban Indian health centers:

- Better coordination of care: developing systems to track and coordinate care between I/T/U and “outside” providers
- Partnerships on specific health issues (eg. perinatal drug use)
- Consulting/staff sharing agreements
- ACA/Medicaid enrollment
- Management services/training agreements? Billing, coding, administration

# *Thank you*

*More information on American Indian health in Montana: <http://www.mthcf.org/our-work-in-american-indian-health/>*

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## Discussion





**How are you working to health equity or the challenges and opportunities discussed today? (including those planned but not yet started)**



**What does this landscape mean for the delivery models we have discussed? (e.g., PCMH, Collaborative Care, Project ECHO, Community Resource Teams)**



**How can the Governor's Council work together to address health equity or the challenges and opportunities discussed today?**



**What additional information is needed?**



## **Other Stakeholder Updates and Public Comment**

