Building Leadership Capacity to Prepare for Value-Based Care

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Disclosures

Existing contractual relationship with Kaiser Permanente

No relationship, neither intended nor explicit, with Blue Shield of California Foundation, UCSF, Center for Care Innovations, and/or Oregon Primary Care Association

Any reference to work by these organizations is based on now publicly available information, and are shared based on my experience as a thought-leader and contributor

Objectives

- Identify key characteristics of value-based care
- Describe leadership skills and capabilities needed to help organizations move toward value-based care
- Identify capacity building program factors and resources

Agenda

- About myself
- Describe principles of Value-Based Care
- Highlight two programs, based in California, seeking to build capacity in Safety Net
- Share tips on where to get started with type of work
- Questions

About Myself

- Over 15 years work experience in international, national, statewide and local health policy.
- Safety Net- Deputy Director of Health Policy & Planning for a County-based Health System
- Formerly a Program Officer for a statewide healthcare foundation
- Currently independent consultant: Kaiser Permanente National Community Benefit, Center for Care Innovations, OPCA

WHAT IS VBC & WHY DOES IT MATTER?

Current payment approach

Primary Care PPS: Payment based on face-to-face rate, no matter how long or short the visit:

- if seen by an eligible clinician
- for a medically-necessary visit
- at a PPS-eligible healthcare organization

Benefits/Challenges of the PPS System

Benefits:

- Ensures stable payment
- "Packages" enhanced services together with visits for eligible patients
- Pays health centers sustainable rate
- It is a familiar to system; staffing models and technology have been built around this payment methodology

Challenges:

- Prioritizes face-to-face visits
- Rate changes are time-consuming and often delayed
- Reinforces structural inequity
- Disincentives efficiency, such as two visits on same day

Value-Based Care

- Rewards safety net providers for the value of the care they provide, not the volume
- Creates the opportunity to provide care that is not face-to-face by a care team
- Strategies that support value-based care include:
  - Accountable care organization
  - Patient centered medical home
  - Payment reform

Vision for future

Value-based payments will fundamentally alter the model of care in Safety Net clinics.

Instead of being "delivered" from clinician to patient, care will be *co-created* by an *expanded care team* that includes the *patient* and community at large.

Patients will not only be collaborators, they will also be customers who are able to *access care in the locations*, times and channels that work best for them. All touchpoints—whether physical, digital or social—will be *designed from the customers' perspective*.

What Are The Capacities That Have To Be Built To Prepare The Safety Net?

Leadership today

Enduring needs

- Organizations that are **agile, strategic, data-driven, and collaborative**.
- Leaders who are **passionate** about **improving the quality and value of care**, forming and developing effective **teams,** and committed to improving the **health of communities**.
- Leaders at all levels with stronger **analytic skills**, more effective **interpersonal abilities,** and greater agility in **scanning the horizon**.
- **Leadership teams** with greater alignment and cohesion, and ability to take action in the setting of **ambiguity**.
- **Collaboration** among leaders to overcome isolation and to effectively **work across disciplines** and organizations to **transform systems** and improve care.

Leadership needs

Emerging needs as we move toward value-based care

- Unprecedented **pace of change** and resistance to **redesigning the delivery of care.**
- **Leadership commitment** to developing a culture of accountability.
- **Organizational structures** for managing change and ongoing learning
- Leaders who **embrace disruption, create traction, and display resilience.**

How do you build capacity to meet these needs?

Two examples of Capacity Building Programs

Individual development

Clinic Leadership Program
Emerging Leaders

Organizational development

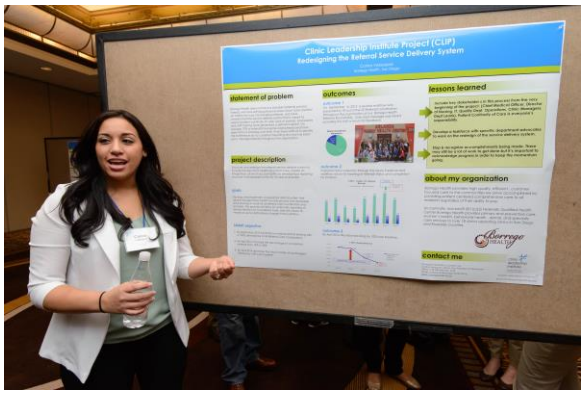
Capitated Payment Preparedness Program
CA Safety Net Organizations

Helpful to understand the components of each to begin revamping professional development plans for your organization

Clinic Leadership Institute: Building The Capacity Of **Emerging Leaders** Within Safety Net Organizations

Program Elements

- Seminars
- Intersession work
- Executive coaching
- Capstone projects
- Peer groups
- Alumni network



Emerging Leader Eligibility

- Employed in community clinic, free clinic, tribal clinic, regional consortium, or statewide primary care association
- Currently in a management or supervisory role
- Demonstrated commitment & passion for community clinic field
- Open to learning about themselves and their organizations
- Recognized by others as a leader
- Agree to engage in the CLI Alumni Network
- At least 3 years in the clinic field
- Sponsored by current employer

Application & Selection

Application:

- One applicant per organization
- Must be nominated
- Essay questions
- Letters of reference

Selection:

- Interviews
- Cohort composition (geography & diversity)

Profile of a typical participant:

- Leads a team
- Has 5-7 years of experience in the clinic field
- Recognized as a strong manager
- Potential to lead outside their organization
- Will contribute to the clinic field for 10-15 more years

Program Specific Competencies

- Self-Awareness
- Creative Problem Solving & Decision Making
- Financial Management
- Project Management
- Effective Use of Time & Energy
- Leading Change
- Influence & Persuasion

- Building & Managing Teams
- Data Driven Decision Making
- Persuasive and Effective Communication
- Vision & Mission
- Monitor & Understand Health Care Trends

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- Vision & Mission
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Capstone Project

Clinic Leadership Institute Projects (CLIPs):

- Applied learning
- Participants contribution to their organization

Process:

- Define a problem to solve
- Get stakeholder buy-in
- Project management sessions
- Coaching from peers, pod advisors, "CLIP coaches"

Types:

- Organizational systems
- Care delivery
- Workforce
- Community

Clinic Leadership Institute Project (CLIP)
Payment Reform Readiness

Gralyn A. Jacques
Ravenswood Family Health Center, Inc., East Palo Alto

statement of problem

Reimbursement in Managed Medi-Cal is moving from volume based to capitation per life, which may or may not be a sustainable option for Ravenswood Family Health Center (RFHC). Our financial model and care delivery model are geared towards the pay per visit reimbursement model and they need to move towards a hybrid reimbursement model.

Panel Capitation Payment + FFS revenue + Control Costs = Sustainability

project description

To develop a new financial and care team model, given the likelihood of Medi-Cal Managed Care reimbursement changing from a volume-based plan to 100% capitation.

goal and objectives

goal

Given the change in reimbursement for Medi-Cal Managed Care (MMC), RFHC will determine how many MMC lives we need for sustainability under capitation. In the long term, develop a new care team mix to care for these lives along with FFS patients.

output-oriented objectives

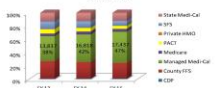
- By January 31, 2015 determine FY 2013, 2014, and 2015 (half year) payer mix.
- By April 30, 2015 determine utilization of MMC Population
- By April 30, 2015 determine best guess number of lives needed to capture estimated revenue needed from MMC population for alternative payment financial model.

outcome-oriented objectives

- By June 30, 2016, RFHC will know how many assigned lives will be required to sustain new facility
- By June 30, 2016, RFHC will know what provider mix it will take to accommodate patients in a transformed healthcare environment.

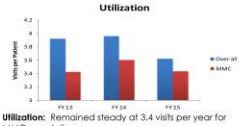
outputs & outcomes

Payer Mix



Payer Mix: The figure above shows that we have seen an increase in our MMC population post ACA implementation and a decrease in our County covered and SFS patients. We anticipate this trend to continue.

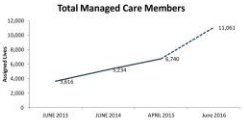
Utilization



Utilization: Remained steady at 3.4 visits per year for MMC population

75,216 X 50% (MMC Portion of Visits) = 37,608
37,608 visits / 3.4 (expected utilization) = 11,061 lives

Total Managed Care Members



Financial Model: Our current financial model projects 75,216 billable visits and we expect at least 50% to be from our MMC population. Converting these visits into lives based on current utilization of 3.4 visits a year per member we estimate needing 11,061 lives. Next steps in the next 15 months–develop strategies to achieve increasing our MMC population by 64%!!!

lessons learned

Think small but impactful. When embarking on this project and attending all the meetings with CPCA on Payment Reform and CPS, it was difficult to scale back to our specific issue of how moving to managing lives will affect us financially. Once I began to focus on what capitation means to us specifically, I was able to move forward.

I was disappointed that I was not able to do a project that went beyond finance. But with all of the evolution around us, it was not feasible.

This project, however, did allow me to build my interest and study in policy. One of my leadership weaknesses that I wanted to work on was learning the political landscape of our industry and how it affects how we operate today.

about my organization

Ravenswood Family Health Center, founded in 2001, is a federally qualified health center headquartered in the low-income East Palo Alto area of San Mateo County. We have grown from a start-up clinic with a budget of $1.1 million and 13 employees providing basic primary care to a full-service health center with a budget of over $21 million and 176 employees. The majority of our target population resides in the low-income communities of southeastern San Mateo County. Among our patients, 86% are from households with incomes 100% and below the federal poverty level ($23,850 for a family of four) and live in a place where unemployment is now 9% and has reached as high as 21% during the recent recession. Furthermore, 41% of our patients are uninsured and 59% are enrolled in public health coverage programs. The most commonly diagnosed chronic medical conditions among our patients include diabetes (1,223 patients), hypertension (1,337 patients), and asthma (735 patients). The majority of our patients are ethnic minorities (97%)—including 72% Latino, 7% African American, and 7% Native Hawaiian or Pacific Islander with 74% of the total patient population best served in a language other than English.

contact me

For more information, contact me:
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clinic leadership institute

To learn more about CLI go to:
www.clinicleadershipinstitute.org

Summary of Alumni Career Growth

- Advanced to a more senior role or position — 77%
- Received a salary increase of 10% or more — 60%
- Experienced significant growth in responsibilities — 46%
- Experienced much greater job satisfaction — 44%

* These data represent Cohorts 1–5 (n=119–123) alumni. Alumni who began the Program as CEOs/Executive Directors are not included as part of the "advanced to a more senior role or position" responses.

Preparation for other opportunities

- About half (55%) of alumni have pursued additional educational opportunities.
- Other programs, including the Safety Net Innovation Network, report that program alumni are more active and prepared than other participants.
- Alumni and CEOs believe that the Program has made a meaningful contribution to alumni's roles, credibility and influence.

Overall Lessons Learned

- Design a program that addresses the **unique needs of the field** and the particular environment in which participants are working.
- Offer an appropriate amount of **complementary and mutually reinforcing supports**.
- **Engage participants' superiors** to best position them for success during the program and as they work back at their organizations.
- Promote a **field view** when working on participant recruitment, development and retention.

Creating Systems Change/Building The Capacity Of Safety Net Organizations

Different approach

Clinic Leadership Institute

Individual-level change, with connect to organizational and field impacts

18-month, with intense focus on self-reflection & becoming increasing data-driven contributors

Foundation-driven, in partnership with field

Single foundation

One partner key partner: HealthForce

Capitated Payment Preparedness Program (CP3)

Systems-level change

Organizational impact- focused on teams

Long-term: Multi-year effort

Accountability/Stakes higher

Learning focus

Early engagement of key stakeholders

Multi-funder collaborative

Strong collaboration between PCA and funders

Multiple partners/TA providers

Program Development Approach

Group visioning process- Facilitated conversation to identify goals and elements

Assessment- various domains (including: analytics, financial management, population health, etc)

Regular convening of key stakeholders (clinics, consortia, funders and experts)

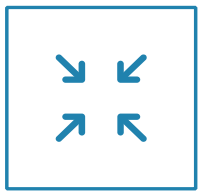
State engagement

Pilot site readiness needs

- Solid financial procedures/modeling/software tools
- Ability to track non-traditional care (e.g. alternative touches)
- Track/assess SDOH
- Data sharing with health plans/associations/hospitals
- Staff + time to implement new systems/models of care (e.g. core support)
- Billing systems; Better coding/charting
- Building New models of care
- Communication with sites, providers and patients

New Strategies for Change

Extreme Customer Orientation

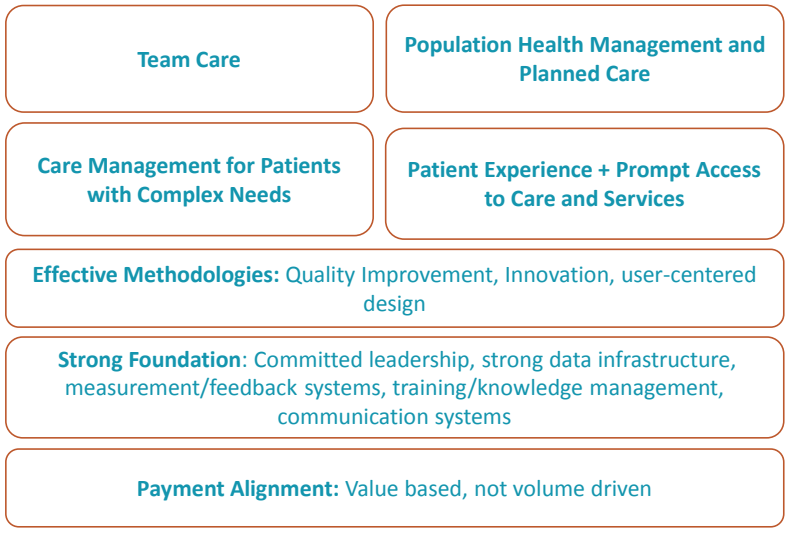


Disintermediation

Committed Community Partnerships

Source: Center for Care Innovations

CP3 Population Health Management Technical Assistance Program



Overview of readiness prep

	CCI	CPCA	CAPH (SNI)
Program name	TBD	CP^3R- capitation payment pilot readiness program	SNI assessment and whole-person pilots
Focus area	Alternative visits, appt access, models of care & pop mgt	Data aggregation, finance capacity, analytics, messaging	Data capacity assessment; cross-sector collaboration; messaging; planning tool
Structure	Optional modules, webinars, in-person	Scalable modules; open structure, but will ask pilot participants to inform modules	Reports, webinars and in-person convenings
Target audience	Up to 16 slots, re-granting, Phase I and II participants get preference	Executive teams, especially CFOs	PHS leadership; CSAC, County Welfare Directors Association

Outstanding issues

- Evaluation. what do we measure? (triple aim lens) how do we ensure consistency of data?
- Coordination of efforts around payment negotiations
- Defining "touches"
- Communication strategy
- Who are the pilot sites?
- Alignment on assessments
- Capitalizing on national platform
- Who are the advocates and how do we support their involvement?
- Health plan engagement
- Defining success
- Coordination of technology/system considerations
- How do we not overwhelm the potential pilot sites

Overall Lessons Learned

- Design a program that addresses the **unique needs of the field** and the particular environment in which participants are working.
- Offer an appropriate amount of **complementary and mutually reinforcing supports**.
- **Engage participants' superiors** to best position them for success during the program and as they work back at their organizations.
- Promote a **field view** when working on participant recruitment, development and retention.

Where do to start

Essential factors/resources necessary to replicate

Funding: Engage potential funders, including health plans, that may be able to create incentive-based payments.

Leadership and staff buy-in: Build a culture of quality improvement. Set plans and follow-through.

Become more data-driven: Start Small. Measure change.

Invest in impactful development: Focus your training efforts.

Account for turnover: Spread knowledge to ensure sustainable culture change and continuity of project.

Crispin's 6 takeaways– Things you can do today

1. **Define value** for your organization and create a plan to start working on it.
2. **Rethink your visits**. Try new things.
3. **Engage your patients**.
4. **Engage your staff**. Explore ideas from all levels of organization.
5. **Collaborate.** Find synergies across organizations.
6. **Document your journey.** Find creative ways to capture what you are learning, and share with broader staff and your community. This is another great way to engage funders.

Questions?

Thank you

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Clinic Leadership Institute at HealthForce (UCSF): http://healthforce.ucsf.edu/leadership-training/programs/clinic-leadership-institute-emerging-leaders

Center for Care Innovations: www.careinnovations.org