

Arkansas Health Workforce Workgroup Meeting

July 13, 2011



ARKANSAS CENTER FOR HEALTH IMPROVEMENT

Agenda

- **Overview of Arkansas health system change process**
- **PCMH components and experience**
- **Strategy Development**
- **Next meeting preview**



Vision, Mission & Goal

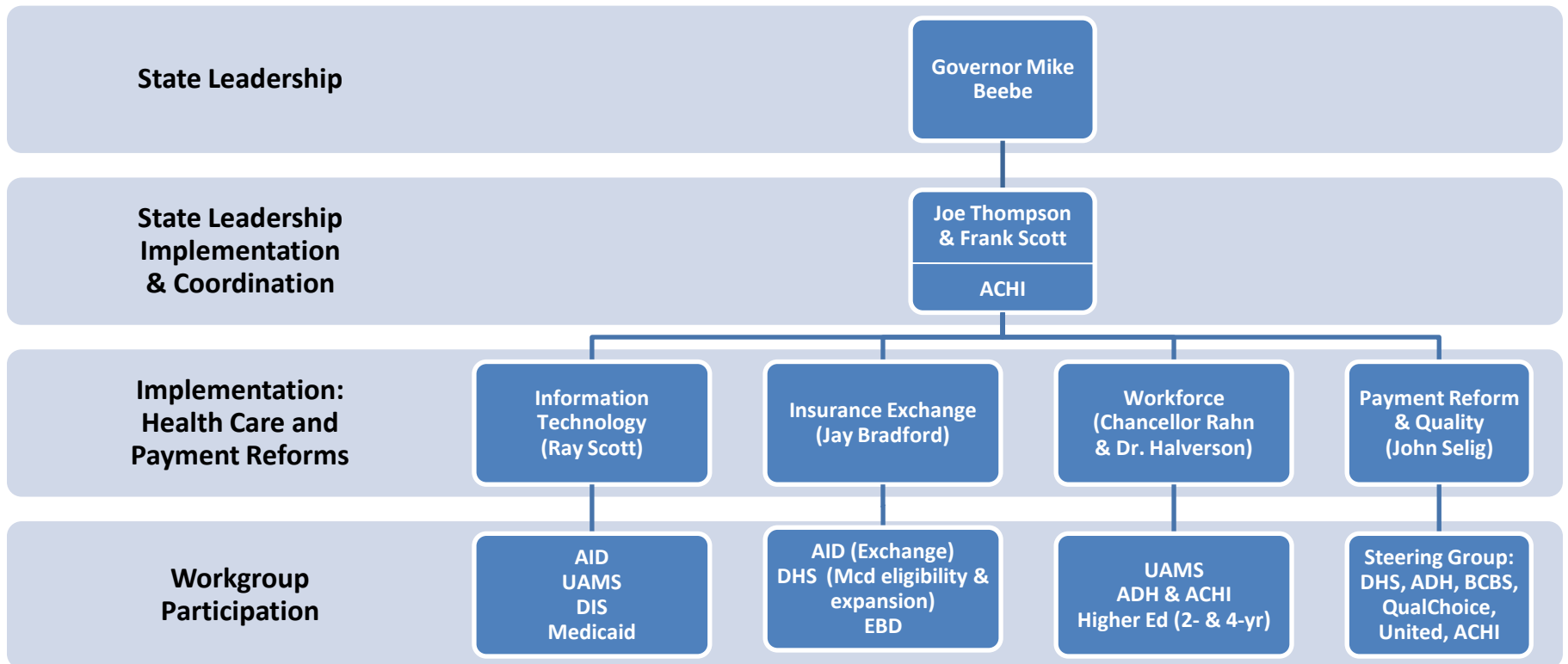
Vision: An Arkansas health system with an optimal health care workforce caring for the needs of Arkansans

Mission: Ensure that Arkansas has the appropriate workforce to meet its health needs, including accessible, efficient, and high quality care

Goal: Strategic plan to manage the current need, anticipated increased demand, and challenges & opportunities



Arkansas Health System Change—State Agency Organizational Structure



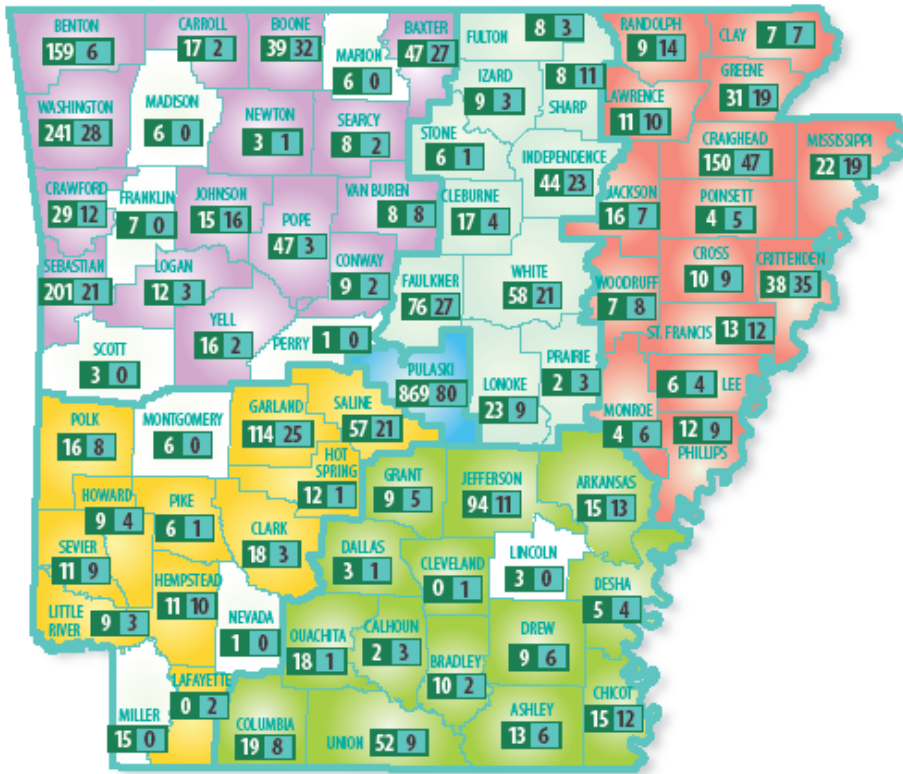
State Health Alliance for
Record Exchange
(ShARe)

REC Primary Care Provider EHRs

HITArkansas
 Health Information Technology Regional Extension Center
www.hitarkansas.com



Provider Participation Map



PCPs per county*

EPs** signed PSAs

HIT SPECIALISTS

- Kortni Dixon870-754-2170
- Marq Walker.....870-365-8031
- Lacey Howard.....870-577-0562
- Lori Brockinton...501-626-0596
- Troy Kall501-773-1779
- Valerie Moring ...870-917-8962
- Shared: Lacey, Lori & Valerie

STATE COUNT.....739
 (As of 7/8/2011)

*PCP count does not reflect all eligible professionals in each county (e.g. PAs, APNs)

** Eligible Professional as defined by ONC/CMS

Regional Extension
 Centers Program
 Division of the Office of the National Coordinator for
 Health Information Technology



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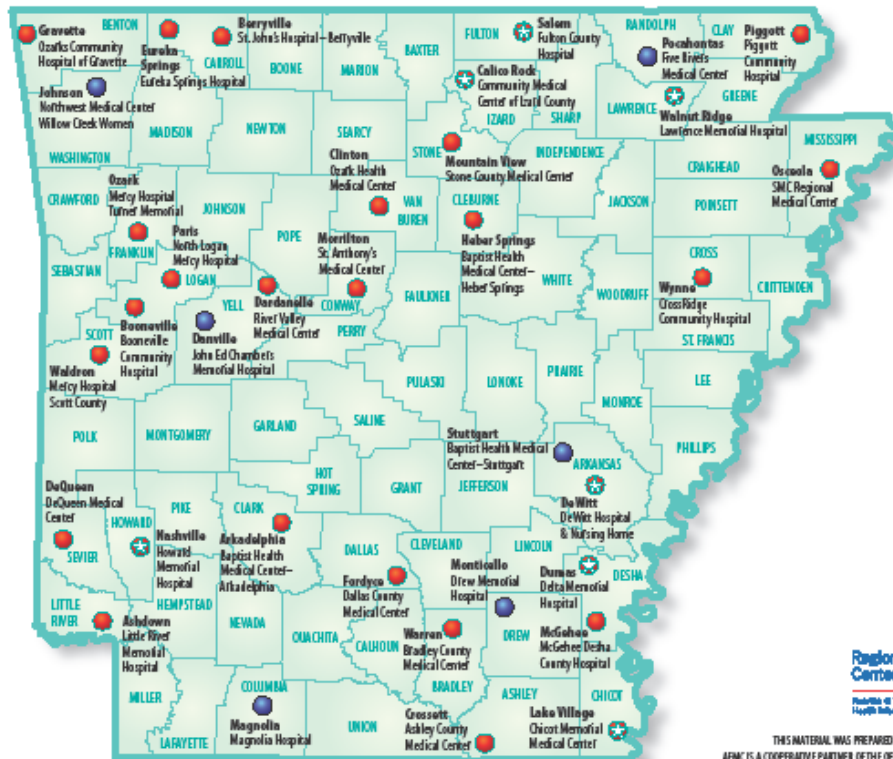


REC Critical Access & Rural Hospitals

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 Health Information Technology Regional Extension Center
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Participating Critical Access and Rural Hospitals



- Critical Access Hospitals
David Easley..... 501-626-5438
- Signed Critical Access Hospitals
- Rural Hospitals



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Improving the Health Care Payment System

Areas of focus

- **Handoffs in care between providers (transitions in care)**
- **Inefficient care provided by individual providers**
- **Care coordination**
- **Ineffective diagnostic decisions**
- **Ineffective clinical decision making**
- **Missed health promotion opportunities**
- **Better patient support and engagement**
- **Reducing health care acquired conditions**



Promising Conditions: Commercially Insured

- **Avoidable Expense –Condition Related**

 - Diabetes**

 - Hypertension**

 - COPD**

 - CHF**

- **Procedure Related**

 - Cesarean Section Rates**

- **Comparative Effectiveness**

 - Use of ACE inhibitor vs. ARB for Hypertension**



Promising Conditions:

Arkansas Medicaid


- **Pregnancy/Delivery: C-section, timing of delivery**
- **Neonatal Intensive Care Unit (NICU) care**
- **Outpatient Infections (ear infection, urinary tract infections)**
- **Activities of Daily Living (ADL's) - supportive care/appropriate location of care**
- **Preventive Care**
- **Mental Health/Behavioral Health**
- **Developmental/Intellectual Disabilities**
- **Ischemic Heart Disease**



Basic: Evaluation & Diagnosis (\$345)

- Interview with parent and patient to obtain information about patient's school functioning.
- Evaluate for co-morbid conditions.
- Review patient's medical, social and family history.


| | |
|--|------------------------|
| 1 or 2 MD visits for psychosocial assessment: 2 x 45-min MD visits = 6 x 15-min units x \$38.40/unit = | \$230.40 |
| Treatment plan: 4 units x \$28.80/unit = | <u>\$115.20</u> |
| TOTAL = | \$345.60 |

 Reason for next level: Clinical diagnosis ADHD
Actions required: Positive diagnosis of ADHD

Level 1: Uncomplicated ADHD (additional \$1,000/year-long episode of care)

- Pharmacological management visits every 2 months with FDA approved drug.
- Monitor for treatment emergent side effects.
- Review school and/or parent reports.


| | |
|---|------------------------|
| 6 MD visits for standard management: 6 x 30-min MD visits = 12 x 15-min units x \$38.40/unit = | \$460.80 |
| 10 paraprofessional units (15-min) for help obtaining school/parent ratings: 10 units x \$18.00/unit = | <u>\$180.00</u> |
| TOTAL = | \$640.80 |

 Reason to move from level 1 to 2: Less than optimum response
Actions required: Modified treatment plan; justification from MD; documenting evidence-based treatment; completed ATOM; TLC telephone consult

Level 2: ADHD + co-morbidities and/or less than optimal response to pharmacological mgmt (additional \$1,200/year-long episode of care)

- Continued Level I care
- Addition of behavior therapy
- Possible use of non-FDA approved medications

| | |
|---|------------------------|
| 2 x 30-min visits = 4 x 15-min units x \$38.40 = | \$153.60 |
| 10 therapy sessions (45 min): 10 sessions x 45 min = 30 x 15-min units x \$27.30/unit = | <u>\$819.00</u> |
| TOTAL = | \$972.60 |

 Reason to move from level 2 to 3: Less than optimum response except for non-compliance
Actions required: Modified treatment plan; justification from MD; documenting evidence-based treatment; ATOM; TLC in person or tele-video consult

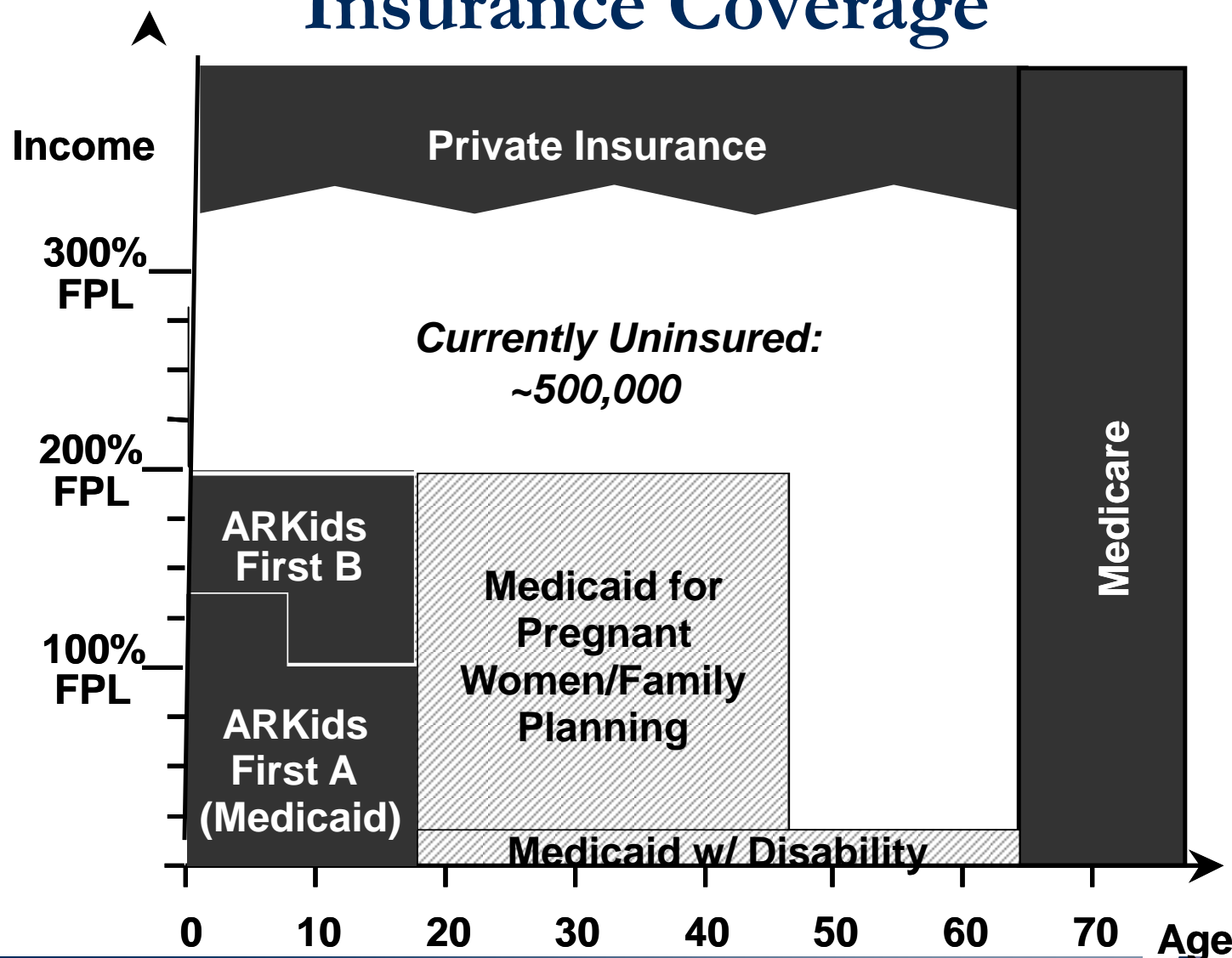
Level 3: Complex ADHD, only minimally responsive to pharmacologic treatment and behavior therapy (fee for service)

- Standard of care treatment.

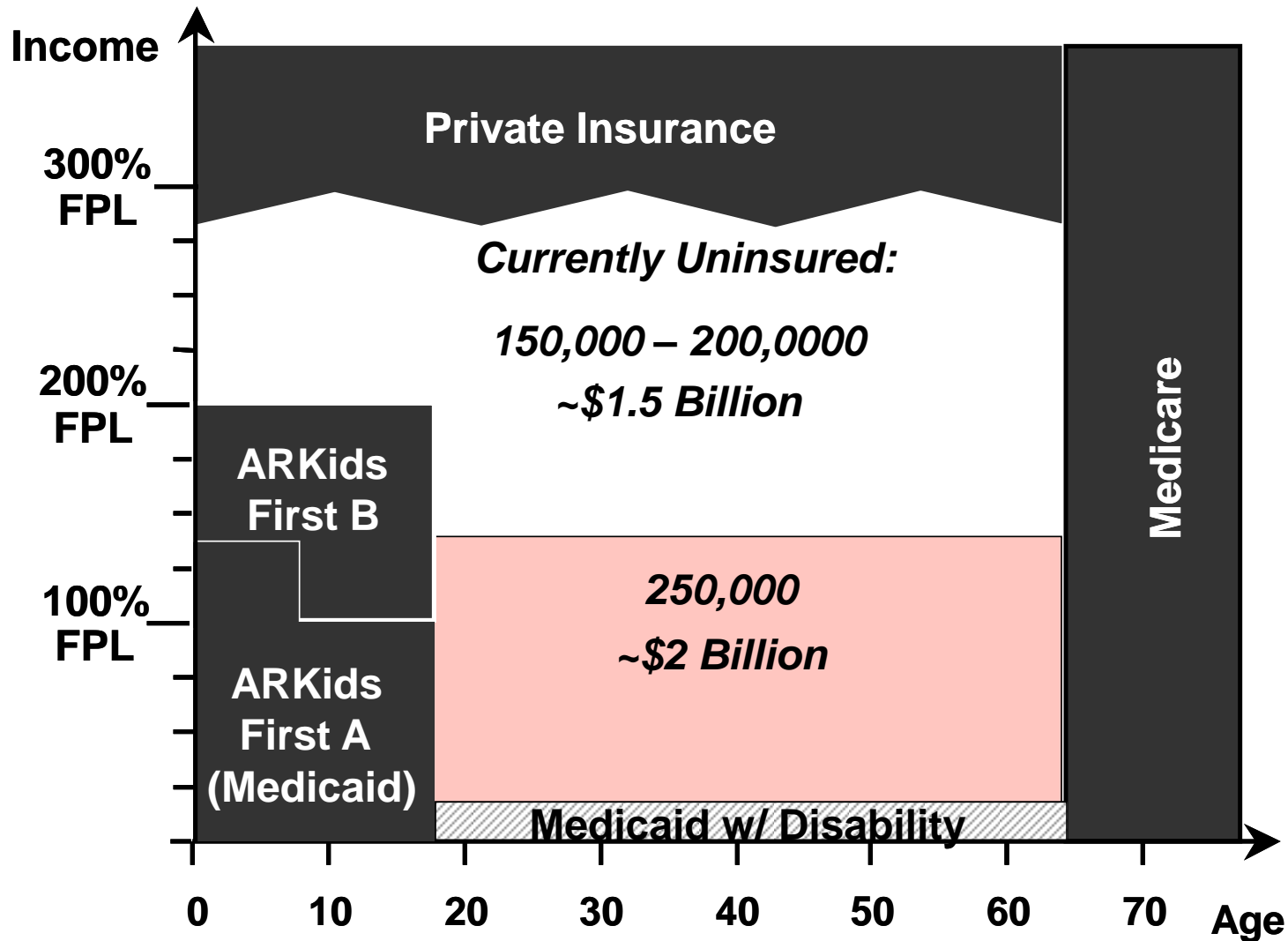
Fee for service reimbursement with managed care oversight

Health Insurance Expansion (2014)

Current Patchwork Quilt of Arkansas Health Insurance Coverage



Potential Arkansas Health Insurance Coverage



Arkansas Workforce Strategic Plan

2011 Reality / 2014 Future

- **Increasing health burdens**
- **Workforce pipeline is static, possibly decreasing (retirement)**
- **Misdistribution of workforce in the state**
- **Increasing demand for services**
- **Low health literacy**
- **Estimated 450,000 increase in insurance coverage (public and private)**
- **Increased funding for Medicaid expansion**



Future Care Delivery System

| Care Concept | What does this mean for the health workforce? |
|--|---|
| Utilize case managers, care coordinators, patient navigators, etc. | Key components to help improve patient outcomes and allow providers to focus on necessary care |
| Provide team-based care | Working in teams rather than as individuals; represents a shift from current thinking and practice |
| Facilitate use of non-physician providers (APNs and PAs) | Allows all clinicians to practice to top of license; APNs/PAs performing preventive and basic evidence-based care, allowing docs to do what they were trained to do |
| Utilize HIT | Utilize HIT as a tool to maximize ability of workforce to provide quality, efficient care for patients |

Joint Principles of the PCMH

Patient Centered Primary Care Collaborative: developed by AAFP, AAP, ACP and AOA – February 2007 (adopted by AMA)

- **Personal physician – ongoing relationship with a personal physician**
- **Physician directed medical practice – leads a team of individuals who collectively take responsibility for ongoing care**
- **Care is coordinated and/or integrated – across all elements of system and community, so that patients get care when and where they need and want it in a culturally appropriate manner**



Joint Principles of the PCMH (continued)

- **Whole person orientation – responsibility for providing or coordinating all care for all stages of life**
- **Quality and safety – evidence-based medicine, clinical decision support tools, voluntary performance measures, patient participation, IT utilized appropriately**
- **Enhanced access – open scheduling, expanded hours, new options for communication**
- **Payment – recognize added value of PCMH**

PCMH Accrediting Bodies: NCQA and The Joint Commission

Shared Accreditation Standards for PCMHs

Team-based care in which a patient-chosen primary care clinician is leading the individual patient care team (physician, APN or PA)

Access to care includes clinician availability (via expanded hours, telephone, email, web portal, etc.) as well as culturally and linguistically appropriate patient care and communication

Coordination of care internally through development and monitoring of individual care plans and treatment goals, and externally across facilities and transitions of care

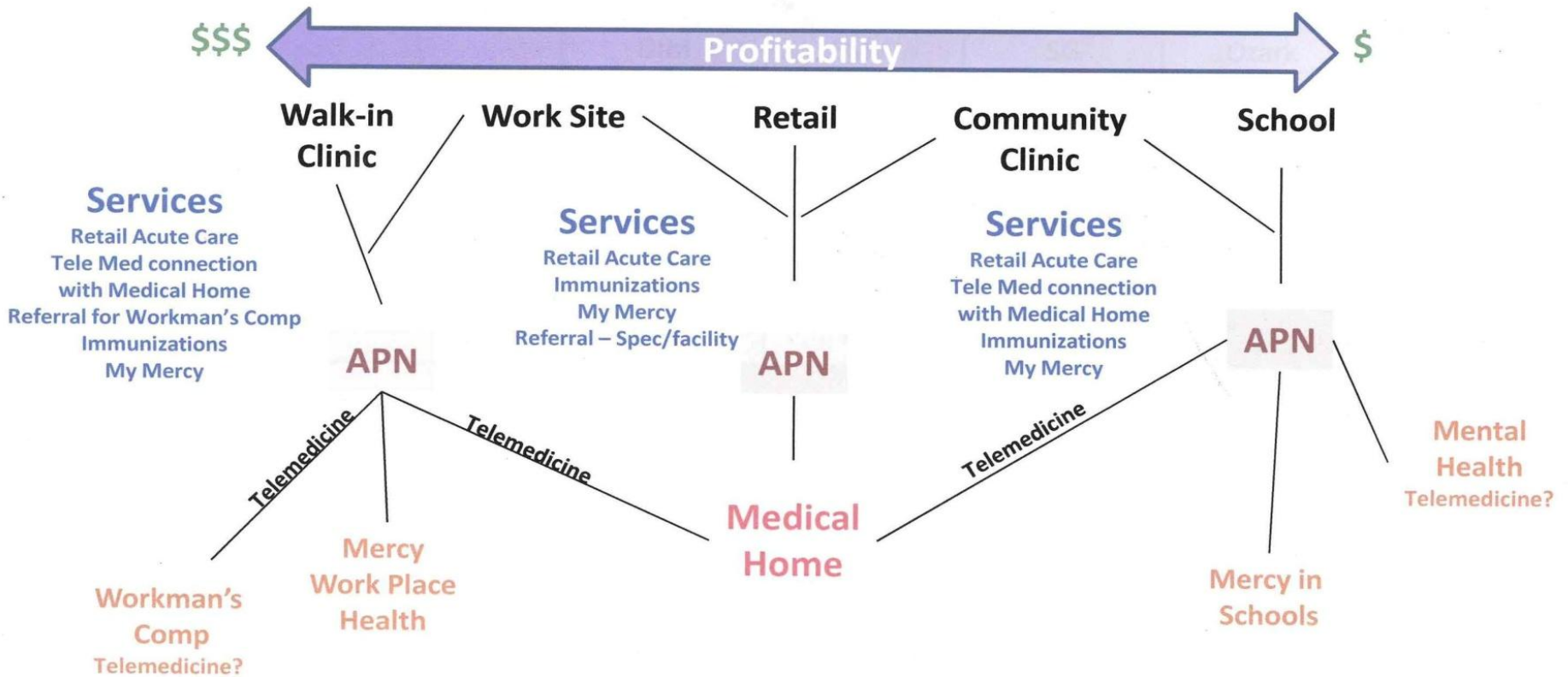
Patient involvement where patient is part of the care team and is given self-management tools, goals and resources to support his or her participation in the care plan

Systematic data collection used for performance monitoring and to inform improvement activities

PCMH Example: Mercy

APN Clinics

Extensions of Primary Care
Patient Access



PCMH Example: Mercy

- **10-site pilot study, 2005-2010**
- **Shared savings model with 80/20 split**
- **It took two years to see the first savings, since then ½ of sites have seen savings, total savings to date for Mercy is >\$78mm**
- **Moving toward APN/PA to physician ratio of 3:1 (currently about 1.7:1)**
- **Care managers have 200-250 patients, care coordinators 1,000-1,500 patients**



PCMH Example:

Blue Cross Blue Shield of Arkansas

- **Just finished first year of 2-year program**
- **7 sites operating (out of 40 applicants)**
- **Must have EHR to participate**
- **Goals: move from provider- to patient-centered, improve patient satisfaction, decrease ER visits**
- **incentives: E&M codes increased by 15%, autoapproval for some tests (ie radiology)**
- **Expect to move to shared savings or per patient fee in the future**
- **Provider “roundtable” is required**



PCMH Example: CHCs

- **All CHCs have functional EHR's**
- **All CHCs, including 12 primary and 73 satellite sites, will be submitting a notice of intent to apply to NCQA for Level III PCMH designation by August 1, 2011**
- **Leadership anticipates a one year cycle for completion of the designation process**
- **As required by HRSA, all primary sites have a physician as Medical Director**



PCMHs: Lessons Learned

Physicians in leadership must be committed; best to have one who is practicing

Requires long-term commitment because it takes several years to change a practice, improve patient care and see savings

Patient visits increase when resources/team members are used efficiently

PCMHs work within an entire system to save money, but not necessarily alone

Mercy is moving its APN/PA to physician ratio towards 3:1

If not already working in team environment, it's very difficult to switch the institutional setup as well as personal thinking and habits

Doesn't matter if practices started with EHR or not, were equally successful

Change is hard no matter what

Implementing a strict cost accounting system is important

You can "check all the boxes" and not achieve a patient-centered approach

Telemedicine can alleviate access to providers and bring relief to providers who have limited or no backup

Using PCMH concepts to inform the AR Health Workforce Strategic Plan

- **PCMH concepts are generalizable to multiple models, not just PCMH**
- **Focus should be on these concepts and skills rather than any one model or payment system**
- **So, without counting on PCMHs, how do we get as far as possible by Jan 1, 2014?**
 - **Using the four concepts**
 - **Using the EXISTING workforce**
 - **Given the realities and restrictions we are facing for this 2-3 year strategic plan**



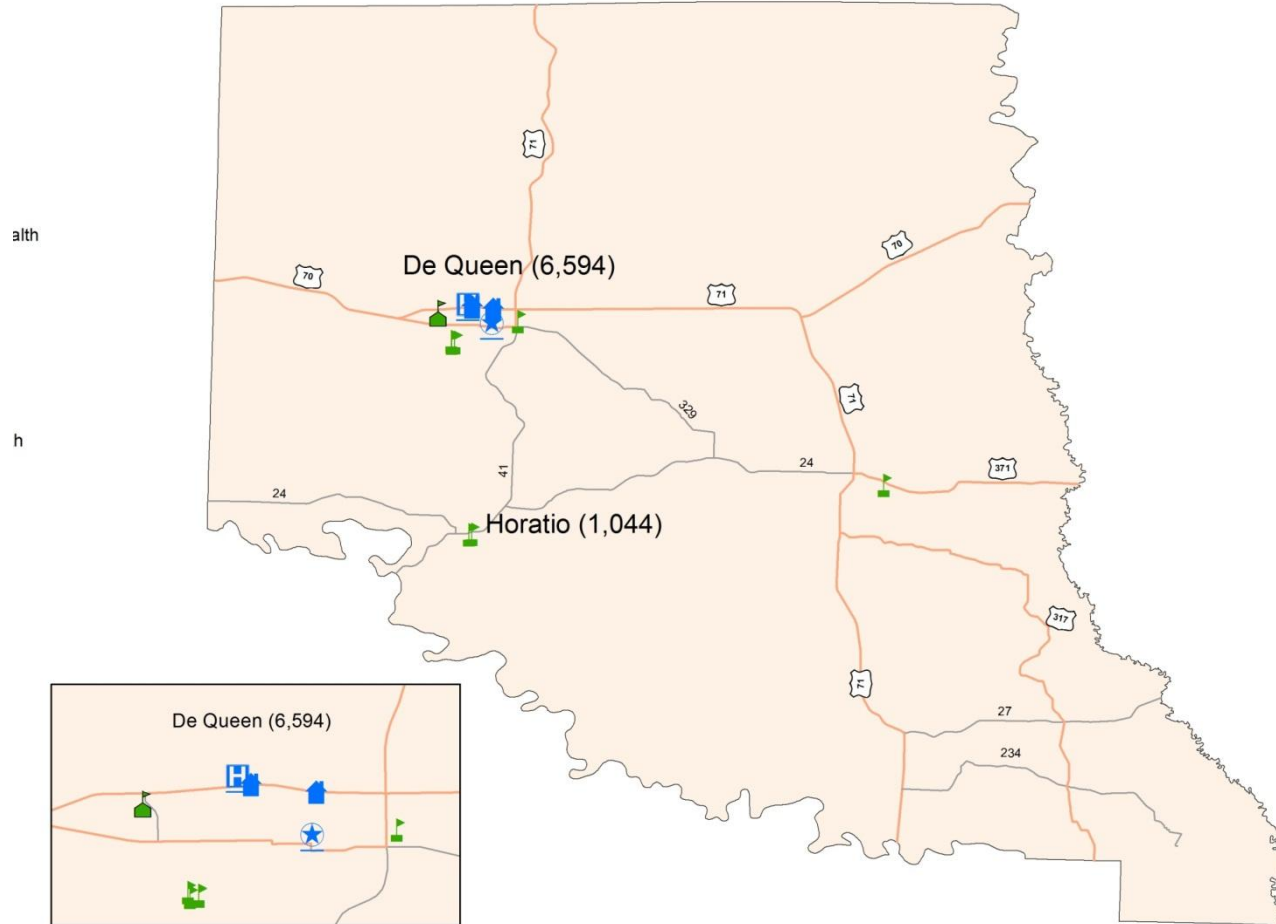
Strategy Development Session: County Scenarios

- **Newton**
- **Prairie**
- **Sebastian**
- **Sevier**






Sevier County, AR

Population: 17,058





Source: Arkansas Department of Health, AR Geosstor – Retrieved July 1, 2011

Health Related Facilities

-  Local Health Unit - AR Dept of Health
-  Hospital
-  Nursing Home

Education Related Facilities

-  K-12 School
-  Cossatot Community College

Strategy Development Session

Charge: Identify short-term health workforce strategies that are achievable in 2-3 years (by Jan 1, 2014) that will also support Arkansas' long-term workforce growth and changes.



Assumptions

- **Workforce will have no real change in number, type, training or quality – and may shrink (ie retirement, lifestyle choices, etc.)**
- **HIT will have limited capacity (SHARE with secure email, supporting information transfer)**
- **Workforce will have spotty HIT capability**
- **Low health literacy (patients)**
- **Low cultural competency (providers)**
- **Funding will be extremely limited**



Strategy Questions: How do we...

- **meet the need for more access in 2014 and beyond?**
- **resolve geographic distribution challenges?**
- **more effectively utilize APNs/PAs?**
- **recruit new WF and retain existing WF?**
- **create team based culture with care coordination?**
- **optimize HIT/telemedicine utilization?**
- **identify and support new roles (care coordinator) for workforce?**



What's next?

- **Reporting out from groups: what were your most important or exciting suggestions?**
- **Next meeting: August 17th**
- **Meeting topics:**
 - **Summary of results from today's strategy development session**
 - **Workplan update**
 - **Accessibility analyses**
 - **Draft outline of strategic plan**
 - **Strategy development session: integrating behavioral health into primary care**

