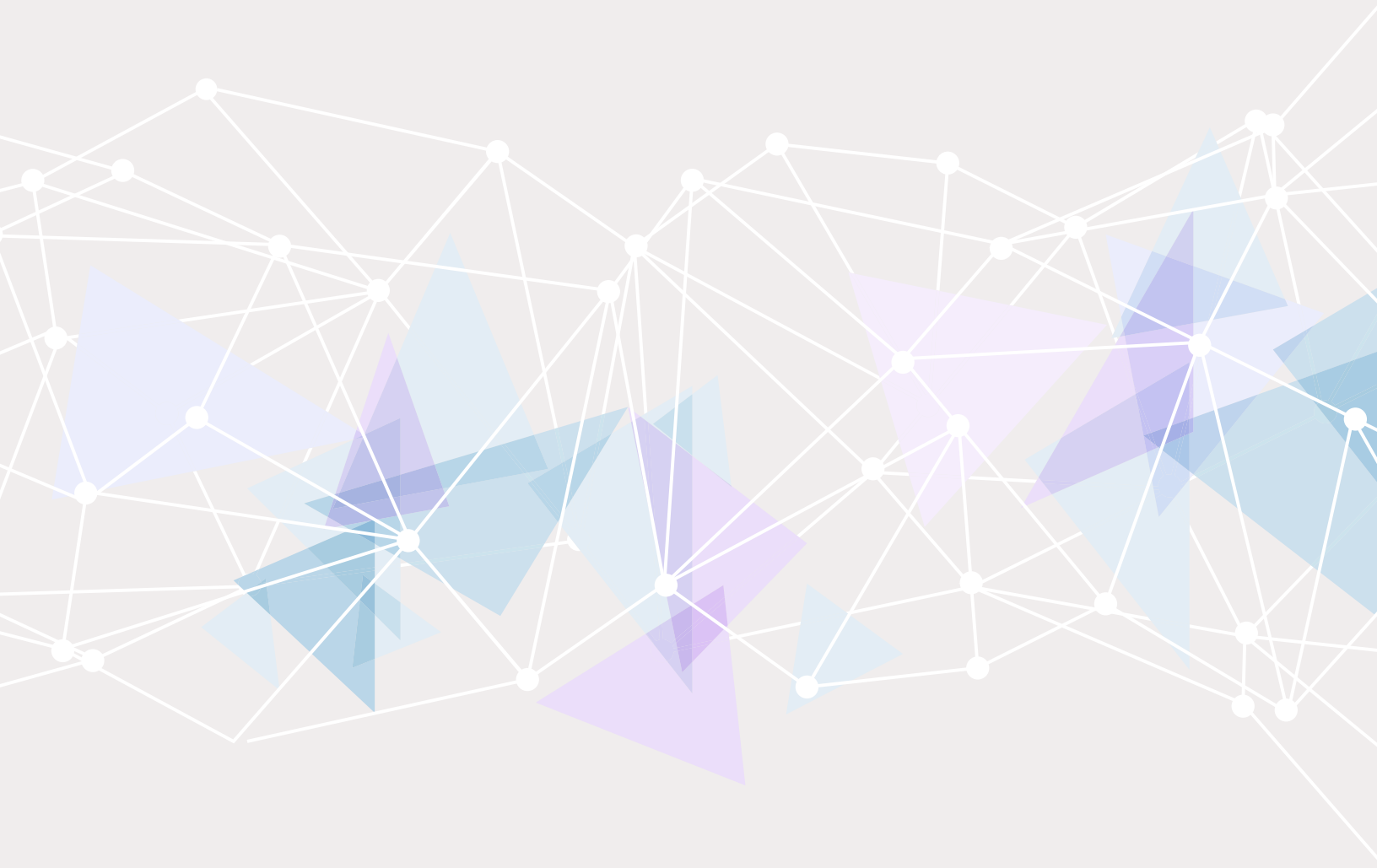
OUTREACH & VALUE-BASED CARE

Impacting Health Care Delivery and Cost through Integrated Community Health Outreach Programs



Health Outreach Partners

HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

Introduction

Health centers[1] are heralded for providing high quality, accessible, affordable, comprehensive health care to underserved populations. One method health centers use to reach populations with the greatest unmet need for comprehensive health care is community health outreach programs. Robust, community-driven outreach models are critical for ensuring access to and utilization of health care services by underserved populations.

Health Outreach Partners (HOP) defines outreach as the process of improving people's quality of life by facilitating access to quality health care and social services; bringing linguistically and culturally responsive care directly to the community; providing health education; helping people to become equal partners in their care; and increasing community awareness of the presence of underserved populations. A strong health outreach program offers the best opportunity for the most vulnerable populations to establish care and become active partners in their own health maintenance.

Community health outreach programs that are fully integrated with the administrative and clinical aims of the organization can help health centers to meet their mission and their margin. However, under a traditional structure of payment for health services, many outreach activities and other enabling services[2] are non-reimbursable. As a result, many outreach programs are funded through small, limited-term, often disease-specific grants. Consequently, outreach programs can be fragmented and unstable. Over the past decade, however, there has been a national shift in the ways in which health care is delivered and reimbursed. New service delivery systems and alternative payment models afford health centers the opportunity to provide patient-centered care in a more flexible manner, including the use of health outreach programs.

The purpose of this resource is to:

- Present a framework for understanding how integrated community health outreach programs can support heath centers in achieving their missions while also remaining financially viable;
- Provide a broad overview of specific service delivery models and alternative payment arrangements that can leverage outreach to enhance value; and
- Share examples of activities that outreach programs can engage in to support health centers' ability to maximize revenue from these new models of care.

This is not intended to be a comprehensive overview of service delivery systems and alternative payment models. Rather, it is a supplement to HOP's Outreach Business Value (OBV) Toolkit, and may be used by health center leaders as they consider how to bring the talents of their whole team to bear on providing access to the best possible care for their most vulnerable community members.

[1] In this document, the term "health centers" refers to Health Center Program award recipients that receive federal funding under section 330 of the Public Health Service Act, as amended by the Health Centers Consolidated Act of 1996 (P.L. 104-299) and the Safety Net Amendments of 2002, as well as Health Center Program look-alikes.

[2] Enabling services are defined as "non-clinical services that aim to increase access to healthcare and improve health outcomes"

The Business Value of Outreach

In 2014, HOP developed the OBV Toolkit[3] to help health center leadership assess the financial return for investing in comprehensive community health outreach programs. A key feature of the OBV Toolkit is the Strategic Framework. Designed using a logic model approach, it includes the following elements:

- **Inputs/costs:** the potential resources needed to invest in an outreach program and their related costs, such as personnel, supplies, and overhead.
- **Outreach activities:** the activities associated with an outreach program, including, but not limited to, patient recruitment, eligibility and enrollment, transportation, interpretation, and care coordination.
- **Outputs:** the potential results of the outreach activities, such as new patients, newly insured patients, appropriate patient utilization of primary care, increased quality of care, and increased patient satisfaction.
- **Potential financial benefits:** the ways the resources invested in an integrated health outreach program may produce financial benefits to the health center, such as through increased patient revenue, clinical efficiency, payments for Triple Aim outcomes, and avoided costs.
- **Key internal/external factors:** questions for health center leadership to consider when determining the financial benefits of outreach activities for their health center.

The OBV Toolkit also includes four calculators that assess potential financial benefits in the following areas: outreach and enrollment, clinical efficiency, alternative payments, and avoided costs. This resource focuses on leveraging outreach programs to contribute to alternative payment revenues. Specifically, the focus is on using outreach to increase:

- Patient-Centered Medical Home/Health Home supplemental payments,
- Earnings for meeting quality benchmarks under pay-for-performance arrangements, and
- Cost savings under shared savings arrangements.

[3] Outreach Business Value Toolkit. Health Outreach Partners. https://outreach-partners.org/obv-toolkit/

Value-Based Care: Paying for Delivery System Trans-formation

The Triple Aim

In their 2008 Health Affairs article, "The Triple Aim: Care, Health, And Cost," authors Donald M. Berwick, Thomas W. Nolan, and John Whittington argued that improving the system of health care in the United States would require improvements in three key — and interconnected — areas: improving the experience of care, improving the health of populations, and reducing per capita cost of health care. They referred to this system of linked goals as the "Triple Aim" and stressed that it addresses improvements to the health care system as a whole, not just improvements at individual health provider sites.[4]

Service delivery models like Patient-Centered Medical Homes, Health Homes, and Accountable Care Organizations are examples of systems of care that focus on patient-centered care, population health, and health system accountability.[5] While many other service delivery models exist,[6] these three are especially amenable to contributions from an integrated community health outreach program.

- **The Patient-Centered Medical Home (PCMH)** is a model that promotes the use of care teams to deliver patient-centered, coordinated primary care. By incorporating a variety of staff with a range of skills and expertise, the care team is able to manage the full spectrum of a patient's needs.[7]
- **Health Homes (HH)** build on the PCMH model, but provide additional services and support to meet the needs of high-risk and high-cost patients, typically those with multiple chronic illnesses.
- **An Accountable Care Organization (ACO)** is a group of health care providers who voluntarily share responsibility for the care delivered and health outcomes of a defined patient population. ACOs typically include primary and specialty care providers and are held accountable for adhering to specific quality measures and total cost of care.[8]

Alternative Payment Models

Traditionally, health plans and Medicaid have paid health care providers using a "Fee for Service" (FFS) payment model. More than half of patient revenues received by FQHCs come from Medicaid. In a FFS model, payers reimburse provider organizations based on the number of health services delivered. Quality of care and patient outcomes are not taken into account. For this reason, traditional FFS payment models are often described as prioritizing volume – i.e., number of visits – over value. Moreover, these payments are generally tied to face-to-face visits by qualified providers. Outreach and other enabling services provided outside of a qualified visit are typically non-reimbursable.

[4] The Triple Aim: Care, Health, and Cost. Health Affairs, 27, no.3 (2008):759-769. Donald M. Berwick, Thomas W. Nolan and John Whittington

[5] Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts. The Kaiser Commission on Medicaid and the Uninsured, June 2015. http://files.kff.org/attachment/issue-brief-medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts

[6] ibid

[7] Leveraging Outreach to Support the Patient-Centered Medical Home Model. Health Outreach Partners. https://outreach-partners.org/wp-content/uploads/2015/09/PCMH_Resource.pdf

[8] http://files.kff.org/attachment/issue-brief-medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts

Increasingly, however, payers are rewarding the implementation of service delivery models that emphasize value over volume. In some states, health care providers receive **supplemental payments** for achieving and maintaining PCMH/HH recognition.[9] Other examples of payment models that emphasize the Triple Aim of improving patient experience, population health, and cost include **pay-for-performance** incentives, which are tied to meeting or exceeding certain targets; and **shared savings** arrangements, which reward health care organizations for meeting quality targets while containing costs.

The following section provides an overview of these three alternative payment arrangements[10] and discusses how, combined with newer service delivery models that can incorporate outreach, they are changing the way health care services are provided and reimbursed in the United States.

Alternative Payment Arrangements

Supplemental Payments / Care Management Fees

Medicaid and other payers may provide supplemental payments – often in the form of Per-Member-Per-Month (PMPM) care management or care coordination fees – to health centers that have achieved Patient-Centered Medical Home or Health Home (PCMH/HH) recognition. These payments are in addition to regular FFS payments for Medicaid patients. In some Accountable Care Organizations (ACOs), health center participation may also include a PMPM care management fee. ACO members collectively agree to the specific responsibilities required to qualify for this PMPM payment. In order to receive PMPM supplemental payments, health centers may need to have contact with the patient in some way. An outreach worker is often an optimal way to reach those patients who do not need a clinical intervention.

Example: Embedding Community Health Workers on Care Teams[11]

Mosaic Medical is a Federally Qualified Health Center in Oregon with five clinic sites, all with Tier 3 Patient-Centered Primary Care Home (PCPCH)[12] accreditation through the state. After many years of incorporating community health workers (CHWs) into general patient support roles, Mosaic worked to embed CHWs into clinical care teams. In order to fully integrate CHWs, Mosaic transitioned the supervision of the CHWs from the clinic managers to RN Care Coordinators. The CHWs not only focus on case management activities and outreach events, but also provide individual health education. Each CHW is trained as an instructor for Stanford's Living Well with Chronic Disease program and receives additional training on topics like tobacco cessation and obesity

[9] Mapping Medicaid Delivery System and Payment Reform. http://kff.org/interactive/delivery-system-and-payment-reform/

[10] Note: Many payment models are alternatives to fee-for-service. For an excellent overview, see http://files.kff.org/attachment/issue-brief-fp-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts

[11] Excerpted from Leveraging Outreach to Support the Patient-Centered Medical Home Model. Health Outreach Partners. https://outreach-partners.org/wp-content/uploads/2015/09/PCMH_Resource.pdf

[12] Note that different states may use different terminology for PCMH/HH service delivery models

prevention. Because CHWs have full access to the Electronic Health Record (EHR) system, all their activities are recorded in the patient record, which allows for ongoing conversations among the care team. In addition, all members of each care team regularly meet to discuss complex issues and work together to solve challenges.

Because Mosaic Medical receives Per-Member-Per-Month (PMPM) payments as part of an alternative payment methodology, non-clinic visits can receive more emphasis. One of the ways Mosaic maximizes PMPM payments is by using CHWs to conduct home visits. For example, one health center in particular has a sizeable aging Medicare population. CHWs at this location conduct home safety visits with these patients to help assess mobility and safety. In addition, CHWs can assist patients in learning how to navigate the public transportation system in order to decrease no-show rates and support access to health services.

Example: Using Community Health Workers to Support High Utilizers:[13]

In 2012, Missouri was the first state in the country to gain approval from the Center for Medicare and Medicaid Services (CMS) to add Primary Care Health Home (PCHH) services to the state Medicaid plan. The principal goal of Missouri's PCHH initiative is to improve patient care and reduce costs to the Medicaid system by addressing unnecessary emergency room admissions. The Missouri Primary Care Association (MPCA) was heavily involved in the planning of this initiative and worked closely with its members to meet PCHH requirements. Provider sites receive supplemental PMPM payments for providing PCHH services.[14]

In 2015, the Missouri Medicaid Agency began the Community Health Worker Pilot for the PCHH initiative. MPCA supported implementation of this pilot project at three health centers where CHWs offer support to high utilizers of the hospital inpatient and ER services. In this pilot, patients were provided in-home and community-based support services by CHWs in partnership with the care team at the PCHH. Those services include advancing patient health literacy, assisting with coordination of medication management, facilitating appointments, and assistance in obtaining social services. This pilot program demonstrated positive results: participating health centers reported stronger ties to the community and credit the CHWs for fostering this connection.

[13] Excerpted from Outreach Reference Manual, 3rd Edition, Care Coordination Chapter. Health Outreach Partners, 2016. https://outreach-partners.org/2015/06/30/outreach-reference-manual/

[14] MO HealthNet Primary Care Health Home Initiative. Missouri Department of Social Services. http://dss.mo.gov/mhd/cs/health-homes/

Shared Savings

Under shared savings arrangements, Accountable Care Organizations (ACOs) or individual Patient-Centered Medical Homes/Health Homes can financially benefit from managing care in such a way that it results in savings to the payer. In order to share in this savings, providers/ACOs have to reduce costs and meet certain performance and quality measures.[15] For health centers participating in ACOs, a strong outreach program can be viewed as a strategy for achieving success, especially if outreach activities are targeted at assisting patients to avert costly emergency department visits, hospital admissions, and readmissions.

Example: Care Coordination for High-Risk Medicare Patients[16]

As a member of the GulfCoast Accountable Care Network,[17] a Medicare Shared Savings Program ACO, Gulf Coast Health Center in southeast Texas participates in a care coordination program to reduce emergency room admissions of high-risk/high-need Medicare patients. Working closely with other ACO members, Gulf Coast Health Center identifies a list of Medicare patients to enroll in the care coordination program. Once a patient is enrolled, a Registered Nurse Case Manager (RN) and community health worker (CHW) work closely with the provider to support patient adherence to their treatment plan. Together, the RN and CHW assist patients with:

- Scheduling primary care appointments,
- Referral follow-up,
- Updating patient chart with medical history,
- Medication management, and
- If needed, connecting patients to social services (i.e. housing, food).

CHWs facilitate the communication between the provider and the patient by assessing for patient barriers to care and providing language translation. In addition, CHWs connect patients with social service needs. Together, the efforts of the CHWs increase patient access to care, facilitate patient engagement in their care, and improve health outcomes.

[15] Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts. The Kaiser Commission on Medicaid and the Uninsured, June 2015. http://files.kff.org/attachment/issue-brief-medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts

[16] Excerpted from Outreach Reference Manual, 3rd Edition, Care Coordination Chapter. Health Outreach Partners, 2016. https://outreach-partners.org/2015/06/30/outreach-reference-manual/

[17] http://www.gulfcoastacn.com/

Pay-For-Performance:

In a Pay-for-Performance (P4P) model, a portion of payments to provider organizations is based on meeting quality benchmarks or other pre-determined goals. Payments may be based on clinical process measures, patient satisfaction, patient health outcomes, or other measures.[18] Outreach can play a role in achieving specific quality measures that may be included in a P4P arrangement. For example, if outreach workers are able to convince female patients to be screened for cervical cancer and address patient barriers to care, a health center may receive a financial benefit tied to achieving higher screening rates.[19]

Example: Outreach Team Supports Clinical Performance Measures[20]

Benton County Health Services (BCHS) consists of four clinic sites in the Willamette Valley area of Oregon, which all have Tier 3 Patient-Centered Primary Care Home (PCPCH) accreditation through the state. BCHS's outreach program includes a team of full-time community health workers (CHWs), several of whom serve in the role of clinical navigators. The clinical navigators receive extensive training in topics including health literacy, Medicaid, diabetes management, motivational interviewing, popular education, and tobacco cessation. With proper training, close supervision, and consistent access to clinical staff, the clinical navigators have become integral members of primary care teams at BCHS. They see patients, participate in morning huddles, talk with providers and pharmacists, and work closely with nurses. They regularly provide self-management support and health education based on individual patient needs. In addition to the work done inside the health center, all navigators participate in outreach events and spend time in the community doing activities like home visits. BCHS's navigators are trained to chart interactions as interim notes in the Electronic Health Records (EHR) system.

Much of the work navigators complete with patients is coded as "PCPCH" in the EHR under care coordination, comprehensive care management, or community and social support. Recording how many and what type of client interactions navigators provide supports BCHS's understanding of the navigators' role in both contributing to the provision of PCPCH services and addressing the social determinants of health. This information is shared with BCHS administrators and board members to reinforce the value of the navigators and highlight how navigators support organizational initiatives such as BCHS's alternative payment methodology pilot project and the work conducted with a Coordinated Care Organization.[21]

[18] http://files.kff.org/attachment/issue-brief-medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts

[19] Outreach Business Value Toolkit. Health Outreach Partners. https://outreach-partners.org/obv-toolkit/

[20] Excerpted from Leveraging Outreach to Support the Patient-Centered Medical Home Model. Health Outreach Partners. https://outreach-partners.org/wp-content/uploads/2015/09/PCMH_Resource.pdf

[21] Note that different states may use different terminology for the Accountable Care Organization service delivery model

Conclusion

Sustained investment in community health outreach programs that are well integrated with the administrative and clinical goals of the health center offers the best opportunity to reach the most vulnerable community members and connect them to care. While many outreach services are non-reimbursable under a traditional fee-for-service payment model, there is nevertheless potential for outreach programs to contribute financial benefits through increased patient revenue, increased clinical efficiency, and avoided costs. Additionally, under alternative payment models, outreach programs can help health centers maximize revenues from supplemental payments, pay-for-performance incentives, and shared savings opportunities.

To Learn More

- **Outreach Business Value Toolkit.** Health Outreach Partners. https://outreach-partners.org/obv-toolkit/
- **Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts.** The Kaiser Commission on Medicaid and the Uninsured, June 2015. http://files.kff.org/attachment/issue-brief-medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts
- **The Triple Aim: Care, Health, and Cost.** Health Affairs, 2008. Donald M. Berwick, Thomas W. Nolan and John Whittington. http://content.healthaffairs.org/content/27/3/759.full
- **Alternative Payment Model Framework, Final White Paper.** Health Care Payment Learning & Action Network, Alternative Payment Model Framework and Progress Tracking Workgroup, 2016. https://hcp-lan.org/workproducts/apm-whitepaper-total.pdf
- **Leveraging Outreach to Support the Patient-Centered Medical Home Model.** Health Outreach Partners, 2015. https://outreach-partners.org/wp-content/uploads/2015/09/PCMH_Resource.pdf
- **The Role of Outreach in Care Coordination.** Outreach Reference Manual, 3rd Edition. Health Outreach Partners, 2016. https://outreach-partners.org/2015/06/30/outreach-reference-manual/

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