COVID-19 Risk Mitigation and Value-Based Payment Strategies

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June 12, 2020

Agenda

- Welcome to our Learning Collaborative
- COVID-19 Survey Results
- COVID-19 and Moving Towards Value-Based Payment Models
- Review of Behavioral Health and other Co-Morbidities Report
- Partners' Best practices
- Unite Us-How it can aid in connecting patients to needed services
- Wrap Up

COVID-19 Report Utilization Survey Findings

- A small number of partners are using the reports to inform their COVID-19 Complication risk mitigation strategy
- Most respondents have not started utilizing data or do not intend to use data
- A small number are not using CNYCC COVID-19 Reports but are instead using other data sources for their risk mitigation strategy. Others are using the reports in conjunction with other available data.

COVID-19 Report Utilization Survey Findings

- Less than half of those using reports are using them to identify patients who would benefit from the outreach.
- Those doing outreach are primarily doing so via telephone to patients/clients using full spectrum of healthcare team with nursing staff being the most reported personnel used for outreach

- Reported Purpose/Goal of outreach:
  - Telehealth appointments,
  - COVID-19 protective measures,
  - Care coordination,
  - Address SDOH needs
  - Reassure patients,
  - Provide education and emotional support,
  - Determine candidacy of patient for services (CHHA, LHCSA, or care management)
  - Assess behavioral health needs,
  - Ensure medication supply,
  - Remote monitoring and managing chronic conditions

COVID-19 Report Utilization Survey Findings and VBP

- 90% of outreach was not exclusive to COVID-19 efforts. The efforts centered about Population health and Social Determinants of Health which IMPACT clinical outcomes and cost containment, the two factors which define Value in any value-based payment model

- COVID-19 provides healthcare providers an opportunity to begin using population health data to address

    - Clinical outcomes
    - Cost containment

- Addressing SDOH can impact cost containment and clinical outcomes

So what? I'm trying to recover from the business impact of COVID-19. I don't see how this will help us going forward

COVID-19 Reports and Value-Based Payment Models

- Healthcare experts forecast continued progression towards VBP models post COVID-19 where risk mitigation will need to be an integral part of a successful VBP strategy
- Experts are predicting a second COVID-19 wave this winter and a vaccine is not anticipated to be available for mass use during the next 12 months
- Morbidity and mortality for patients with COVID-19 who also have certain chronic conditions can be higher than for the rest of the population
- Cost of care for these patients can be significantly higher than patients with no complications
- Identification of patients at high risk for developing COVID-19 complication can inform a strategy to improve health outcomes for such patients while decreasing the cost of care for these patients

Healthcare experts forecast continued progression towards VBP models post COVID-19 where risk mitigation will need to be an integral part of a successful VBP strategy

BOSTON BUSINESS JOURNAL

7 predictions about how Covid-19 will change health care

#6: We anticipate that more businesses will be considering population health management programs as a long-term strategy for a healthier population that will, in turn, lower claims costs and lessen operational risk in the face of a similar catastrophe.

MEDPAGE TODAY's KevinMD.com
Social media's leading physician voice

The COVID-19 pandemic is a catalyst for reimagining future health care delivery

value-based systems encourage providers and payers to work together to scale innovations that lower costs and improve health outcomes. Such innovations have included developing and investing in population health data systems that can be used to track patients at high risk for contracting emerging diseases.

Healthcare experts forecast continued progression towards VBP models post COVID-19 where risk mitigation will need to be an integral part of a successful VBP strategy

Harvard Business Review

What Will U.S. Health Care Look Like After the Pandemic?

"it is critical to start considering how the lessons of this crisis can be captured not only to make the next crisis easier to manage but also to ensure that the ongoing operation of our health care system is improved in a fundamental manner."

Managed Healthcare EXECUTIVE

Trends Relevant in Healthcare Before COVID-19 Will Remain So After

"There's nothing like a contagion to shine a light on the importance of putting patient data into actionable profiles so care providers can improve clinical interventions and financial outcomes for different patient risk segments."

Healthcare experts forecast continued progression towards VBP models post COVID-19 where risk mitigation will need to be an integral part of a successful VBP strategy

Yes there are reports that COVID-19 will slow down the transition from Fee for Service to Value Based Care models as healthcare providers drop out of MIPS and other Risk sharing programs however,

- the rising cost of care from COVID-19,
- the decrease revenue from postponed elective surgical procedures,
- adoption of telehealth and
- provider call for advanced payments will

Advance risk mitigation strategies as providers advance towards Value Based Care

Cost of care for patients with COVID-19 can be higher than for the rest of the population with the same COVID-19 complication while reimbursement can be less than half the cost

Average total cost of treatment for an inpatient admission for pneumonia

DRG 193 (“simple pneumonia & pleurisy w/ major complications")	$20,292
DRG 194 (cases with [not major] “complication and comorbidity”)	$13,767
DRG 195 (cases without complications)	$9,763

Average total cost of treatment for an inpatient COVID-19 admission for pneumonia

DRG 193	$74,310
DRG 195	$42,486

Avg total estimated allowed by commercial payor for COVID-19 adm for pneumonia

DRG 193	$38,755
DRG 195	$21,936

Morbidity and mortality for patients with COVID-19 who also have certain chronic conditions can be higher than for the rest of the population

Richardson, S, et al (2020) JAMA

- In this case series that included 5700 patients hospitalized with COVID-19 in the New York City area, the most common comorbidities were hypertension, obesity, and diabetes. Among patients who were discharged or died (n = 2634), 14.2% were treated in the intensive care unit, 12.2% received invasive mechanical ventilation, 3.2% were treated with kidney replacement therapy, and 21% died.

- Of the patients who died, those with diabetes were more likely to have received invasive mechanical ventilation or care in the ICU compared with those who did not have diabetes

- high mortality rates among ventilated patients

Docherty, A B et al (2020)

- Besides increasing age, and underlying heart, lung, liver and kidney disease -- factors already known to cause poor outcomes -- the researchers found that obesity and gender were key factors associated with the need for higher levels of care and higher risk of death in hospital.

Morbidity and mortality for patients with COVID-19 who also have certain chronic conditions can be higher than for the rest of the population

Center for Disease Control (2020)

- People 65 years and older
- People who live in a nursing home or long-term care facility
- People of all ages with underlying medical conditions, particularly if not well controlled, including:
    - People with chronic lung disease or moderate to severe asthma
    - People who have serious heart conditions
    - People who are immunocompromised
    - Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
    - People with severe obesity (body mass index [BMI] of 40 or higher)
    - People with diabetes

Summary

The transition from Fee for Service to Value Based Care will continue given the additional cost of care brought about by COVID-19

Value Based Care strategies offer an opportunity to improve the quality of care for patients including those at risk for COVID-19.

Value Based Care strategies offer an opportunity to reduce the cost of care by mitigating the risk of developing a COVID-19 complications.

Developing a risk mitigation strategy for patients at high risk for a COVID-19 complication because of a co-existing chronic medical condition saves lives, reduces the cost of care and prepares your organization for Value Based Care contracting by harnessing the power of population health data and addressing the social determinants of health impacting the patient's potential risk

COVID-19 Report Specs

- CNYCC sent over 50 Individual Reports to Partners identifying over 300,000 patients who were at-risk for COVID based on the following Comorbidity Categories:

    1. Bronchitis
    2. Coronary Artery Disease
    3. Chronic Obstructive Pulmonary Disease
    4. Diabetes
    5. Emphysema
    6. Heart Disease
    7. Heart Failure
    8. Hyperlipidemia
    9. Hypertension
    10. Lung Disease
    11. Obesity

- Additionally, CNYCC identified those patients who had the following Behavioral Health conditions:
    - Schizophrenia
    - Bipolar Disorder

- Patients included in the report are:
    - Patients attributed to your organization via CNYCC Attribution Models using Medicaid Claims Data through June 2019 and
    - Where applicable, those whose clinical data is integrated in IBM Watson Health indicating they are at high risk. Integrated clinical data is through 05/13/2020

- The use of this report can be used to develop COVID-19 strategies to meet the requirements of PA_411 use case which is due on 06/30/2020. Please visit cnycares.org for additional information.

High Risk for COVID19 Complications Patient Report

- Demonstration by Michele Jacobson

Risk Mitigation Strategies – Partner Experiences

- Catholic Charities of Oswego County
  - Outreach through their care management programs and data from their EMR
  - Expanded Food pantry and offered home delivery
  - Provided technology to needed county residents
  - Provided Entertainment bags
  - Expanded their Adult BH Drop Line to offer ongoing support

- HCR
  - Used other data sources for their outreach to patients
  - Provided telephonic patient outreach to all patients that had been discharged from the hospital in the past 90 days that were no longer on their panel in order to assess, support and educate.

Risk Mitigation Strategies – Partner Experiences

- Aurora of CNY
  - Provided two sign language interpreters to counties daily briefing- ASL and Nepalese as well as two hidden hearing interpreters assisting those on stage
  - Use of other data sources for outreach by CHWs and Social Workers to address safety concerns especially with their senior hearing and visually impaired. This included telephonic support, FaceTime and mail or drop off of assistive devices.
  - Created a virtual audio support group for the blind which was previously in person
  - Provided food to the door steps of the vulnerable Nepalese community
  - Provided downloaded audio books to the isolated that previously relied on library audiobooks.
  - Provided telephonic interpretation for patients with their healthcare provider.
  - Ordered clear masks for use by the deaf (still on back order).

  - Working with the community to overcome barriers created by the new rules such as plastic covering braille read options, separation barriers making connections more difficult.

COVID RISK MITIGATION

COMPASSIONATE FAMILY MEDICINE

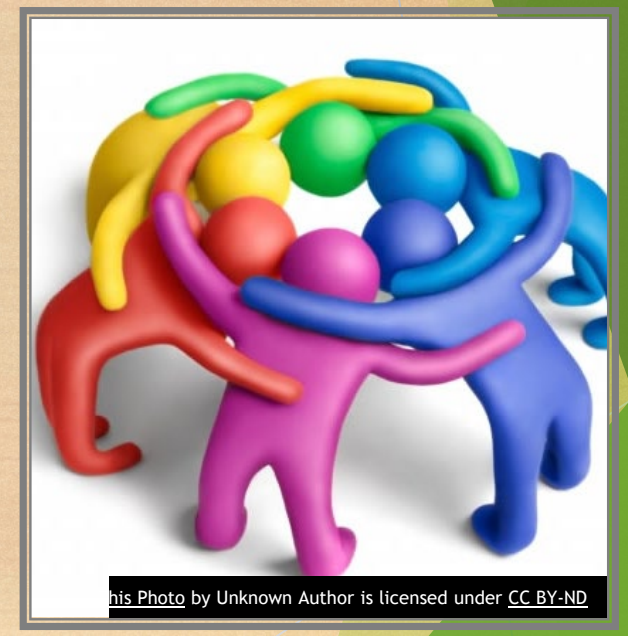
06/12/2020

OUTREACH TO AT RISK PATIENTS

- Identify patients with greatest risk that we must contact immediately based on social determinants of health.
- Schedule a TELEMEDICINE or a face to face visit as soon as possible.
- Assess, Educate and Reassure.

HOW WE DO IT?

- Our Health Care Coordinators dissect the list of high risk patients to further categorize them.
- They contact the patients to follow up closely and assist.
- They document on the patient's chart using an Assessment Tool implemented in our EMS.



ASSESSMENT TOOL

User	GARCIA,DULCE M	Status	Open	H:
Reason	HIGHRISK	Rating	2 Priority	W:

HIGH RISK PATIENTS

06/02/20 (Tue Jun 2) 03:06 PM Dulce M Garcia

Patient was reached since she/he is considered a High Risk Patient. She was called but she appeared not mentally stable to complete the assessment.
I contacted her family to make them aware of this situation. Immediately we started the process for Skilled Nursing Evaluation, Personal Care Form, and the provider was notified. The call helped to identify a serious situation at the patient's home that probably family member wasn't aware or didn't know what to do. Family was grateful with the prompt help. Patient will be referred through Unite Us for transportation and food service.

Patient is at age where they are high risk. 60 yrs or older: ☑ YES ☐ NO

Patient place of residence also places them at higher risk. ☑ YES ☐ NO

Patient has transportation difficulties: ☑ YES ☐ NO

Patient does have a history of mental health conditions such as Anxiety and Depression. ☑ Y ☐ N

☑ Due to the patient history of mental health their risk is higher.

Patient has a history of Alcohol and/ or Drug use. ☐ YES ☑ NO

Patient has language barrier: ☑ YES ☐ NO **Only speak Spanish**

Patient has Social Support. ☐ YES ☑ NO if YES Whom:

Have you traveled to an area with known local spread of COVID-19. Yes☐ No ☑

Have you been in contact (within 6 feet) with someone who has had a confirmed COVID- 19 diagnosis in the past 14 days? Yes☐ No ☑

Have you had a fever (greater than 100.4 F or 38.0 C)? Yes☐ No☑

Have you had a cough? Yes☐ No☑

Have you had shortness of breath or difficulty breathing? Yes ☐ No ☑

Appointment Scheduled:06/23/2020

Thank you
Dulce Garcia
Health Care Coordinator

MEDENT Sidebar MEDENT Sidebar

HEALTHeCONNECTIONS RESOURCE

- COVID-19 Results

Very useful data which allows us to identify COVID-19 positive patients in a timely manner to monitor them closely and keep a follow up on their health condition.

PATIENT'S STORY

- A 75 yrs. old patient
- Poor historian of Dementia, Asthma, DM, HTN, Malnutrition, Depression, Anxiety and Joint pain.
- Poor family support.
- Language barriers.
- Transportation issues.
- Eating deficit disorders

HOW WE COULD HELP THIS PATIENT?

- Skill Nursing involvement.
- Family Counselling.
- Local day Programs.
- Transportation Arrangements.
- Food Services.

Feel free to ask Questions or to give any Suggestions.

THANK YOU.

ST. JOSEPHS HEALTH

JASON DECKER
REGIONAL POPULATION HEALTH MANAGER

ST. JOSEPH'S HEALTH
A Member of Trinity Health

COVID Report Strategy

- Access to care with the identification of high risk population was primary use of report.
- Target population was individuals on the report who last had an appointment between the dates of January 2019 through March 2020.
- Combined chronic disease data from CNYCC report with an internal EMR report that shows last appointment and patient medical record number.
- Combined report sent to each individual practices.
- Practices have indicated an intention to use combined report to compare to upcoming appointments and direct access outreach efforts.

Telehealth

- Used 2 separate telehealth platforms
  - Zipnosis
    - Telehealth platform used for a screening to quickly assess for COVID related concerns and receive a telehealth visit
    - Used to assess low acuity acute conditions that could be completed via telehealth.
  - QliqSoft
    - Used for other visit types allowed via telehealth to ensure all patients are safe and reduce density in practice locations.

COVID Follow Up Program

- Trinity Health initiative for all RHMs to call COVID positive or suspected COVID positive patients and colleagues
- Assessment used to assess for worsening symptoms and social determinants to health. Multiple calls were made to patients to continue and assess through the process.

Call Date: _____ Call Time: _____

Caller name: _____ Relationship to patient: _____

Patient name: _____ Date of birth: _____

Contact number: _____ PCP: _____

Symptom Follow-up

1. Fever over 100.4 ☐Yes ☐No If yes, has your fever: ☐Increased ☐Same ☐Decreased Current Temp: _____	2. Cough ☐Yes ☐No If yes, has your cough: ☐Worsened ☐Same ☐Improved	3. Shortness of Breath ☐Yes ☐No If yes, have your breathing difficulties: ☐Worsened ☐Same ☐Improved

Social Needs Screening

4. Today or next week, will you need assistance with any of the following?
Check first box if patient would like assistance

a) Food	☐Yes	☐No	Urgent
b) Housing	☐Yes	☐No	Urgent
c) Finances	☐Yes	☐No	Urgent
d) Transportation	☐Yes	☐No	Urgent
e) Access to a Primary Care Doctor	☐Yes	☐No	Urgent
f) Dependent Care	☐Yes	☐No	Urgent

Please Circle Answers &
Check first box if patient would like assistance

5. Do you feel physically or emotionally safe where you currently live?	Yes	No	Urgent
6. Do you have people to support you in home/telephone/other methods?	Yes	No	Urgent
7. Would you like to receive assistance with any of these needs?	Yes	No	

Messaging to patient

8. ☐Someone will follow up resource request to assist
9. ☐Advised to follow up with PCP/Nursing Triage line if symptoms worsen, but not emergent
10. ☐Call 911 if symptoms worsen, such as difficulty breathing
11. ☐Will follow up again within 2 days

Follow-up items:

☐Referred to primary care doctor due to worsening symptoms
☐Advised to call 911 due to emergency signs
☐Referred for social needs to RHM CHWB resource hub or established community partner
☐Follow up again within 48 hours
☐Discontinue Follow-up per protocol: At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**, At least 7 days have passed *since symptoms first appeared*

COVID Patient Story

- Patient who was a single mother afraid to return home for fear of exposing daughter. Patient stayed at a remote location for 2 weeks, but worried about food for her daughter. Health Home department has a food pantry onsite and we were able to use that food pantry to get food to the patient's daughter.

Circare

- Richard Hughes-Director of Quality Assurance and Compliance
- Molly Stuttler-James-CASAC Coordinator, Adult Care Management Services

Data Matching

- Used Power Query (MS Excel add-in) to match COVID-19 High-Risk Patients lists to current client rosters from two EHRs
- Identified 384 individuals on COVID-19 High-Risk Patients lists who were currently receiving services from one or more Circare programs
- Sorted list by program and direct care staff serving each high-risk individual; provided sorted list to programs
- Identified overlap between Health Home Care Management program and other Circare programs

Formulating Our Plan

- Driven by agency mission, values, and our experience working with individuals in the community
- MWF Leadership Check-in Calls
- Goal: protect high-risk individuals against COVID-19 exposure by providing structured education and COVID-19 safety kits
- Plan: gather resources, create structured education, assemble kits, prioritize distribution to high-risk individuals
- Two Distribution Phases

Community-Based Response

- Delivered structured education and kits to client's homes
- Staff followed CDC guidance: masks, social distancing, etc.
- COVID-19 structured education (client letter, CDC guidance)
- COVID-19 safety kits (mask, hand sanitizer)
- "Drive through" pickup for direct care staff
- Opportunity to check-in on client well-being, conduct COVID-19 and SDOH assessments, and educate about telehealth opportunities at Circare and other providers

Program-Based Response

- Review of Health Home charts to see how well co-morbidities were addressed in the Plan of Care
- COVID-19 education and support coordination between Health Home, Clinic, and HCBS programs

Welcome

UNITE US

CNY CARE COLLABORATIVE

What is the Central New York Care Collaborative Referral Network?

CNYCC Referral Network is coordinated care network that connects community partners (such as social service organizations, government agencies, and health care providers) to deliver integrated whole person care through a shared technology platform (Unite Us) to:

- Make electronic referrals
- Securely share client information
- Track outcomes together
- Inform community-wide discussion

Who's Involved

Network Leadership

- Central New York Care Collaborative leads network operations, monitors data and promotes network growth

Regional Networks

- The CNYCC Referral Network will share network access with two other regional networks: ADK Wellness Connections and Healthy Together
- Access between the three regions will allow for expanded service offerings with other community partners, collectively serving 19 counties across Central & Upstate New York
- Coordination Centers - Healthy Together and ADK Wellness Connections both house coordination center teams - the Coordination Centers ONLY serve the AHI and Alliance territories

Network Partners

- Send and receive referrals, share client updates with the network, and actively maintain and update their organization's profile
- Partners guide how best to implement the network within their region, based on realities on the ground

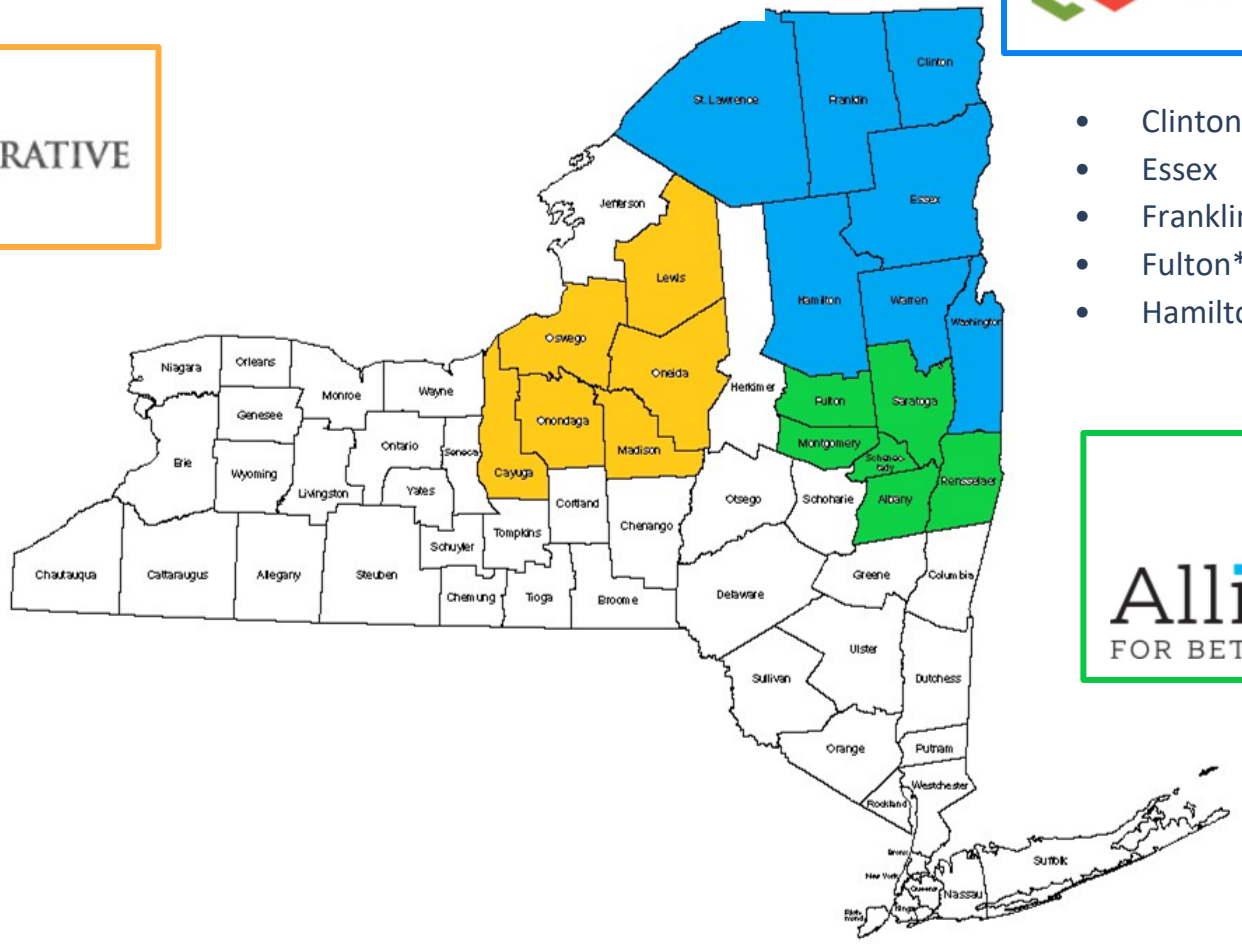
Unite Us

- Provides ongoing technology training and support to users, solicits feedback from the community, monitors aggregate engagement data to provide support to partners, and promotes Unite Us platform use and network growth

Who's Involved

CNY CARE COLLABORATIVE

- Cayuga
- Lewis
- Madison
- Oneida
- Onondaga
- Oswego



a·H·I

- Clinton
- Essex
- Franklin
- Fulton*
- Hamilton
- Saratoga*
- St. Lawrence
- Warren
- Washington

* denotes shared coverage

Alliance FOR BETTER HEALTH

- Albany
- Fulton*
- Montgomery
- Rensselaer
- Saratoga*
- Schenectady

* denotes shared coverage

How does it work?

REFERRAL WORKFLOW: PARTNER-TO-PARTNER

Wrap-Up

- CNYCC will continue to update COVID-19 Resources on our website
- Please share information from this webinar within your organization