LAPTN and Strategic Initiatives

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Disclosure

We have no relevant financial relationships with commercial interests to disclose.

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Objectives

At the end of this presentation, participants are able to:

- Identify the structure and core outcomes for L.A. Care's Practice Transformation Network (LAPTN) Initiative.
- Explain the different components of Severe Mental Illness Network SMINET) Initiatives.
- Summarize the Association for Community Affiliated Plans (ACAP) System Re-Alignment Program and collaboratives.

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L.A. Care Health Plan

- The nation's largest publicly operated health plan
- The public plan of the Medi-Cal Two-Plan model developed in 1992
- An independent local public agency created by the State of California to serve low-income Los Angeles County residents
- Designed to provide health coverage to vulnerable populations and to support the safety net in Los Angeles County
- Active membership of over 2 million members in six product lines

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LAPTN™

LOS ANGELES PRACTICE TRANSFORMATION NETWORK

LAPTN Focused Agenda

- LAPTN Background and Program Design
- LAPTN Measures
- Practice Transformation
  - Phases of Practice Transformation
  - PAT Work to Date
  - CMS tools:
    - Practice Assessment Tool (PAT) & Change Package
    - Example PAT, Methodology, and Scoring
- Implementation Lessons Learned to Date
- Next Steps & Summary

Acronyms/Frequently Used Terms

Acronyms:

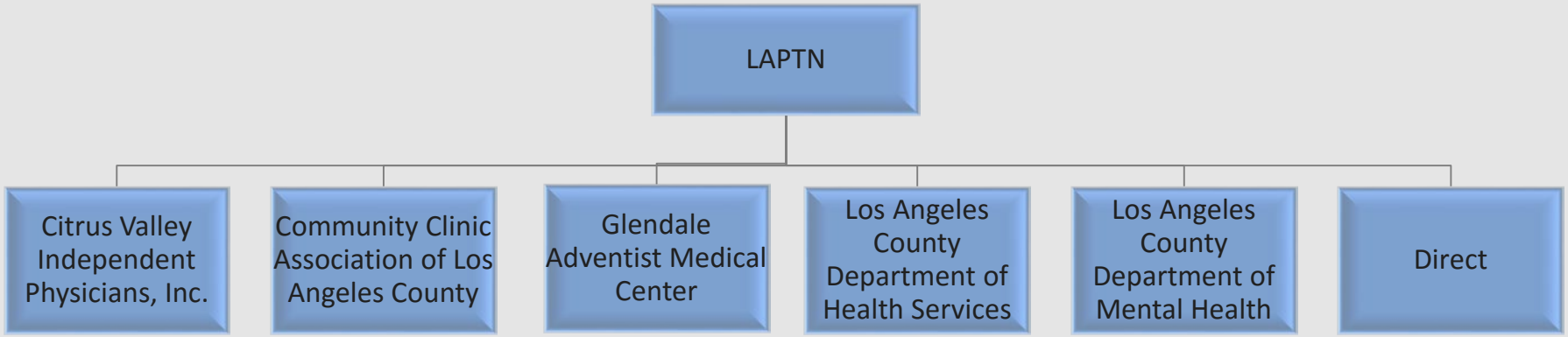
- TCPI: Transforming Clinical Practice Initiative
- LAPTN: Los Angeles Practice Transformation Network
- SAN: Support and Alignment Network
- QIN QIO: Quality Improvement Network Quality Improvement Organization
- PAT: Practice Assessment Tool
- eCQMs: Electronic Clinical Quality Measures

Definitions:

- Phases of Practice Transformation
- Primary Transformation Drivers
- Secondary Transformation Drivers
- Change Package and Change Concepts
- [PAT] Milestones

Background on LAPTN

- Transforming Clinical Practice Initiative (TCPI) Overview
  - Part of a CMMI program to transform 140,000 clinician practices
  - Includes 3,100 clinicians in the Los Angeles County area
- Focuses on practice transformation and clinical outcome measure improvement (diabetes and depression)
- Utilizes a network partner model



LAPTN Program Design

- Tailored to unique needs of practices
- Intervention based to improve clinical measures and/or advance transformation phases
- Uses continuous improvement approach to execute work
- On the ground coaches work directly with practices

LAPTN Measures

Practice Level eCQMs

- HBA1C Poor Control (>9%) (NQF# 0059)
- Medical Attention for Nephropathy Monitoring (NQF# 0062)
- BMI Screening and Follow-up (NQF# 0421)
- Screening for Clinical Depression and Follow-up (NQF# 0418)

Practice Level Behavioral Health focused eCQMs

- HBA1C Poor Control (>9%) (NQF# 0059)
- BMI Screening and Follow-up (NQF# 0421)
- Depression Utilization of the PHQ-9 Tool NQF# 0712)
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (NQF# 1365)
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (NQF# 0104)
- Follow-up after Hospitalization for Mental Illness (NQF# 0576)

LAPTN Level Reporting

- Utilization measures:
  - All-Cause Admissions for Patients with Diabetes
  - All-Cause Admissions for Patients with Depression
  - Reduction of Unnecessary Testing
  - Cost Savings

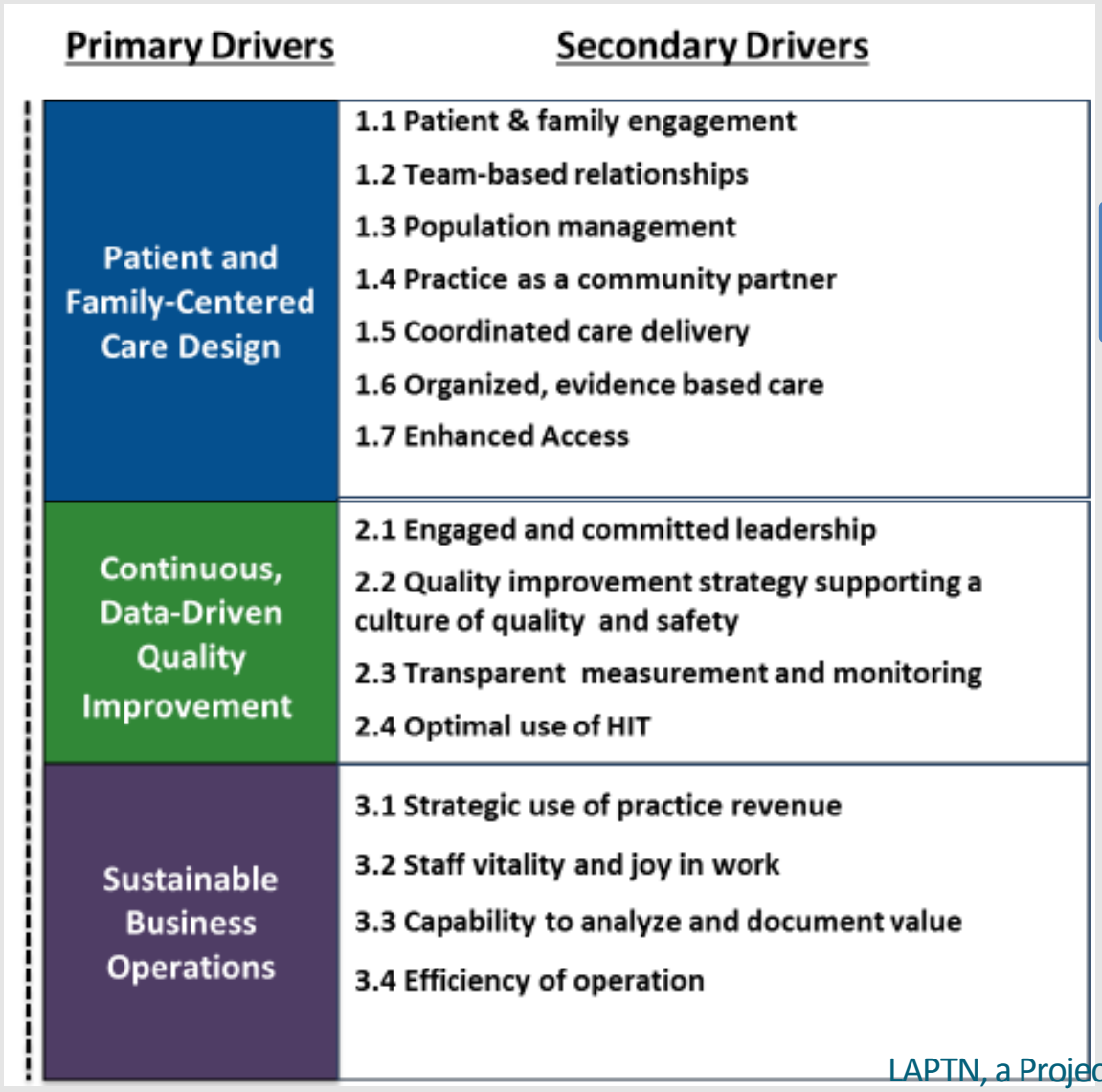
Phases of Practice Transformation

1. Set aims and develop basic capabilities
2. Report and use data to generate improvements
3. Achieve progress on aims of lower cost, better care, and better health
4. Achieve benchmark status
5. Thrive as a business via Pay-for-Value approaches

PAT Work to Date

- PAT 1.0 migration to PAT 2.0 (released April 1)
- Working to complete all practice assessments
  - Have made iterative process improvements with each interaction
    - Activity is 1st impression
    - Not a mundane exercise
    - Goal to engage and gauge
- Summarizing and analyzing scores
- Compiling intervention priorities and opportunities
- Will have ongoing re-assessments every 6 months

CMS Tools: Change Package and PAT



Primary Drivers	Secondary Drivers
Patient and Family-Centered Care Design	1.1 Patient & family engagement 1.2 Team-based relationships 1.3 Population management 1.4 Practice as a community partner 1.5 Coordinated care delivery 1.6 Organized, evidence based care 1.7 Enhanced Access
Continuous, Data-Driven Quality Improvement	2.1 Engaged and committed leadership 2.2 Quality improvement strategy supporting a culture of quality and safety 2.3 Transparent measurement and monitoring 2.4 Optimal use of HIT
Sustainable Business Operations	3.1 Strategic use of practice revenue 3.2 Staff vitality and joy in work 3.3 Capability to analyze and document value 3.4 Efficiency of operation

3 **Primary Drivers**

17 Questions on the PAT

15 **Secondary Drivers**

5 Questions on the PAT

5 Questions on the PAT

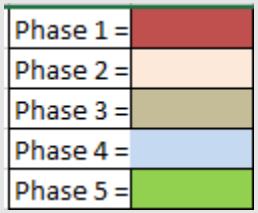
Measuring Transformation

- Walk through Change Package and PAT 2.0

- Goals:
  - Complete the secondary drivers, move through phases
  - Identify interventions to close gaps in change concepts/milestones
  - Inform educational content for the Learning Collaborative

PAT 2.0 – Scoring Methodology

- 3 ways to look at score:
  - Completing Secondary Drivers
    - If all milestones complete under a secondary driver, then that secondary driver has been successfully completed
    - 16 total (15 from change package, 1 on TCPI aims)
  - Counts of Concepts Complete
    - Counts the scores in each phase (color)
    - Shows progress as a count of completed milestone by phase (as a percentage of the total milestones for each phase)
    - 44 total
      - 1 for Phase 1, 12 for Phase 2, 13 for Phase 3, 16 for Phase 4, 2 for Phase 5



  - Adding up the Score
    - Points associated with completion are summed
    - Weighted score for each phase (close to same percentages in the first table)
    - 111 total
      - 3 for Phase 1, 22 for Phase 2, 32 for Phase 3, 48 for Phase 4, 6 for Phase 5

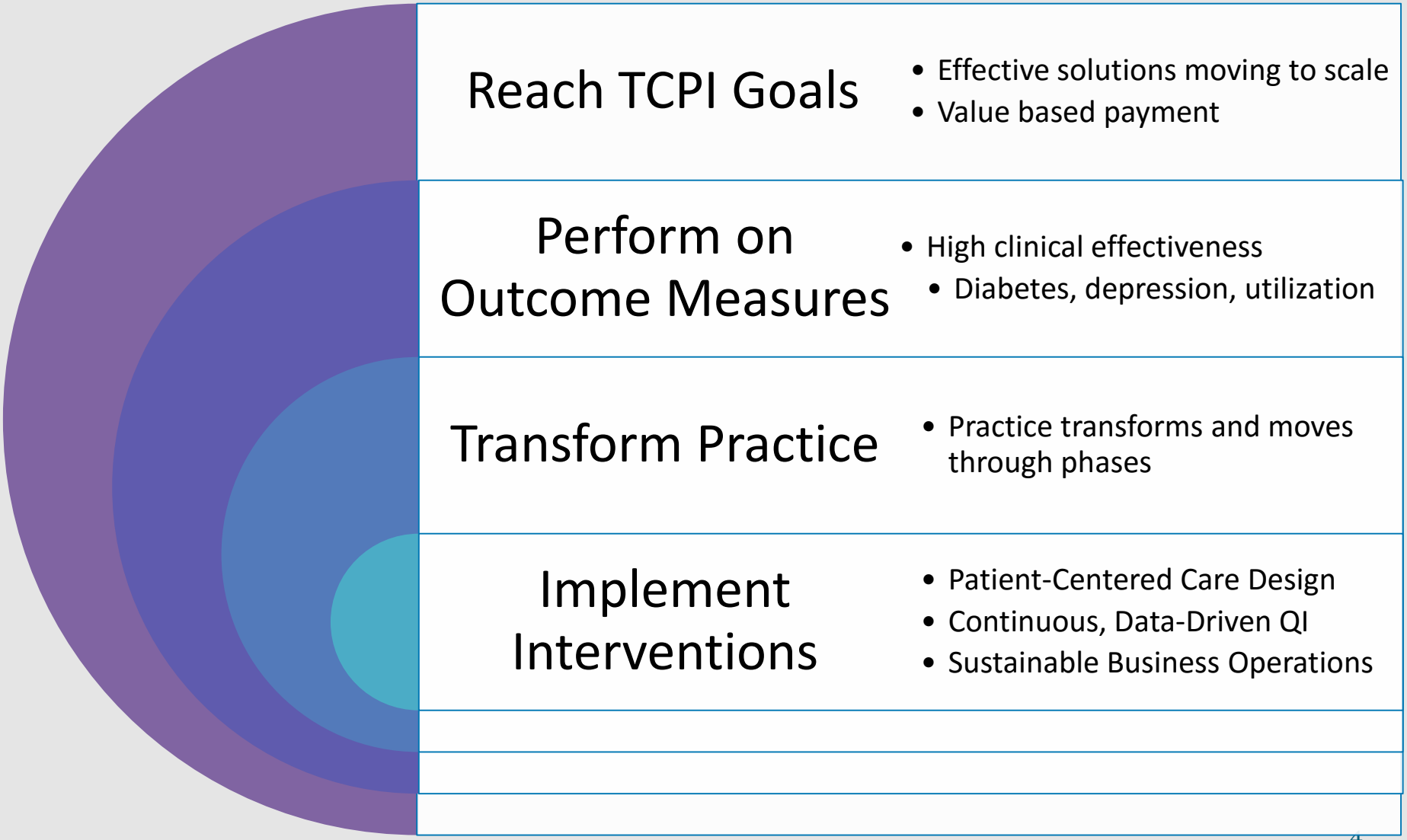
Implementation Lessons Learned to Date

- Find synergy with other programs/strategic goals of an organization or practice.
- The PAT is not a rote exercise, use it as an opportunity to engage and gauge the practice.
- Prioritize interventions that will address the lower performing milestones/secondary drivers and/or measure(s).
    - Consider ease of implementation (alignment with other programs, level of coaching support required), # of measures/drivers the intervention will impact, and organizational “enthusiasm” for the intervention.

Next Steps

- Continue to find synergy with other programs/ strategic goals of an organization or practice.
- Begin training and assignment of “practice coaches”
- Development and implementation of:
  - Learning Collaborative curriculum
  - Clinical Data Repository
  - Project Management interface/CRM
  - Intervention work plans for each Network Partner

Pulling it Together



Questions?

SMINET Learning Collaborative

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CATIE Trial

- CATIE – NIMH-funded Clinical Antipsychotic Trials of Intervention Effectiveness, a nationwide public health focused clinical trials
- At baseline:
  - 88.0% of subjects had dyslipidemia
  - 62.4% of subjects had hypertension
  - 30.2% of subjects had diabetes
  - NONE was receiving any treatment

RAND Study, 2003

- A quality of health care study
- Overall, adults receive 55% of recommended care, and they receive care that is not recommended and potentially harmful 11% of the time
- Gaps were seen even in patients with good health insurance and access
- People with diabetes received 45% of the care needed; <25% has blood sugar levels measured regularly
- People with coronary artery disease received 68% of recommended care; only 45% of MI patients received life-saving medications
- Patients with HTN received <65% of recommended care; greatly increasing the risks of heart disease, stroke and death

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Missouri Medicaid Review

- Done by Lewin Group in 2010
- 58,000 consumers reached $25,000 cost level in CY 2008
- This cohort represented 5.4% of the Medicaid population; but, they incurred 52.5% of all Medicaid costs
- Of those, 85% had at least one claim for a mental health diagnosis
  - Of those, 30% had a mental health prescription, but NO office visit
- 80% of the high volume med/surg users had evidence of at least one behavioral health condition

http://www.dss.mo.gov/mhd/oversight/reports.htm

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Reasons for Increased CVD Mortality in Major Mental Disorders

- Primary and secondary prevention limitations for people living with mental illness versus general population
  - Less likely to be screened or treated for dyslipidemia, hyperglycemia, hypertension
  - Less likely to receive angioplasty or CABG
  - Less likely to receive drug therapies of proven benefit (thrombolytics, aspirin, beta-blockers, ACE inhibitors) post-myocardial infarction
  - More likely to have premature mortality post- myocardial infarction

Newcomer J Hennekens CH. JAMA 2007; 298(15):1794-1796

Druss BG et al. Arch Gen Psychiatry. 2001;58:565-572.

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SMINET

- The SMINET project builds strongly on the established multi-state consortium developed under Rutgers' ARRA award R18 HS019937 (MEDNET) to increase uptake of evidence-based practices in Medicaid-funded mental health care
- It draws strongly on the multistate network; data exchange arrangements and core data resources; collaborative relationships with staff of state agencies, health plans, provider networks, and other state stakeholders; expertise with state programs and data; dataset management and collaboration infrastructure via secure remote access; and other resources

QI Implementation

- Target population: Cal MediConnect (Dual Medi-Caid & Medicare) with SMI
- Location of intervention: Los Angeles County
- Important community partners and stakeholders: LAC DMH, LAC DPH, L.A. Care Stakeholders Meeting/Collaborative Meetings, and Regional Consumer Advocacy Committee
- Improvement goals
- Improve care coordination across continuum of care and service delivery systems
- Expected timeline
- Currently in its initial process, working out details of interventions and strategies
- Waiting for DHCS to approve data exchange protocol

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Logic Model of SMINET QI Process

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Aims

- Measure/monitor hospitalization and rehospitalization patterns, and improve management of transitions
- Improve management of comorbid conditions and reduce early mortality
- Measure, monitor, and feed back quality measures on adherence in SMI
- Improve use of evidence based treatment for people with treatment resistance

ACAP System Re-Alignment Program

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Our Project

- *Project Description*: Integration of Behavioral Health and Physical Health services for people living with Severe Persistent Illness (SMI) at two pilot sites
- *Project Rationale*: L.A. Care Health Plan proposed a care model focusing on creating an integrated care network between the different carved out systems of care
- *Project Goals*:
  - Re-align different funding systems around a specific vulnerable population
  - Use of data matching to identify mutual members across systems
  - Re-assign members to a single integrated network/clinic team

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L.A. Care's Approach

A multi-pronged approach which included:

- Funding systems collaboration
- Identification of mutual members using data
- Re-assigning members to a single integrated network/clinic by encouraging members to the model via education to honor members' choice

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Initial Target Population

- Inclusion Criteria:
  - L.A. Care members receiving specialty mental health services at pilot sites
  - Link specialty mental health site with in-network primary care provider(s) (PCP)
  - Identified members agree to re-assignment of PCP
- Data Sources:
  - L.A. Care and LA County Department of Mental Health (DMH) data exchange file, L.A. Care member/PCP assignment data

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Interventions

- System Re-alignment: Create Memorandum of Understanding (MOU) between LA County DMH and L.A. Care Primary Care network
- Identify L.A. Care members receiving care at DMH pilot sites
- Develop an approved letter of PCP re-assignment approved by the State
- Educate identified members on Health Integration
- Member re-assignment
- Improvement in clinical outcomes
- Engage all health care providers with social services providers and community based organizations in a Health Neighborhood

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Clinical Core Measures

- Medication reconciliation
- Decrease inappropriate Emergency Room visits
- Decrease inappropriate hospitalization
- Increase access to care → increase in PCP visits
- Improvement in metabolic measures such as lipid panel, Hgb A1c, BMI, etc

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Progress Made

- At San Fernando Valley Mental Health Clinic (SFVMHC)
  - A county directly operated specialty clinic
  - MOU developed between county DMH and Tarzana Treatment Center (TTC)
  - Tarzana Treatment Center provides primary care and Substance Use Disorder services
  - Developing integration letter to distribute to member for re-assignment
- At Antelope Valley Children & Family Guidance Center
  - A county contracted specialty clinic
  - Already identified a potential primary care partner

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Progress Made

- Identified 80 unique patients receiving specialty mental health services at SFVMHC
- 75 members are currently assigned to 39 different PCPs
- 5 members are currently assigned to TTC as PCP
- TTC has begun providing primary care services on site at SFVMHC

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Q & A

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