



CENTRAL HEALTH



Workshop II: Health Care Outcomes

Community Health Champions

Tuesday, September 17, 2019



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Value Based Care

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Chief Medical Officer

CommUnityCare Health Centers



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History: Value Based Care

- **2008** - Centers for Medicare and Medicaid-Medicare Improvements for Patients and Providers Act (MIPPA) - rewarded eligible providers for electronic prescriptions
- **2009** - Health Information Technology for Economic and Clinical Health Act (HITECH)
 - Meaningful Use-of electronic health record

History: Value Based Care

- **2010** - Affordable Care Act (ACA) - an attempt to improve quality and efficiency of medical care - began transition to value rather than volume
- **2015** - Medicare Access and CHIP Reauthorization Act
 - Repeals sustainable growth rate formula
 - Changes the way that Medicare rewards clinicians for value over volume
 - Streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS)
 - Gives bonus payments for participation in eligible alternative payment models (APMs)



Why Care Model Redesign?



Why Care Model Redesign?



- Higher productivity of providers does not necessarily correlate with better outcomes
- Challenges in successfully caring for patients with increasingly complex needs
- Current approach to patient care has achieved some results but has plateaued in achieving quality goals
- Increased cost

Why Care Model Redesign?



- Decreased patient satisfaction
- Physician centric model to patient centric model
- Need for stronger community partnerships to address other determinants of health
- Increasing rates of burnout for providers and care teams as well as challenges in retention

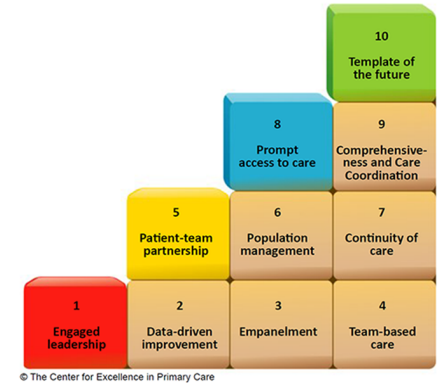
CommUnityCare's Health Care Evolution



Patient Centered
Medical Home



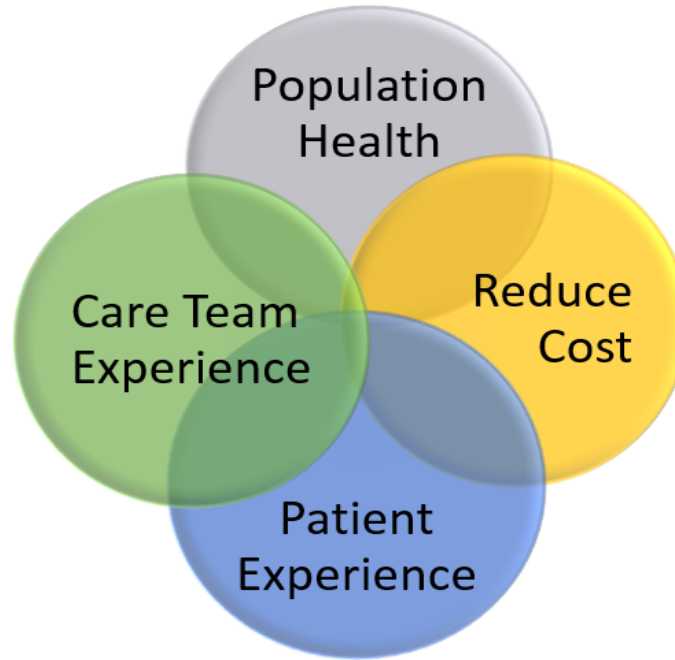
Value Based Care



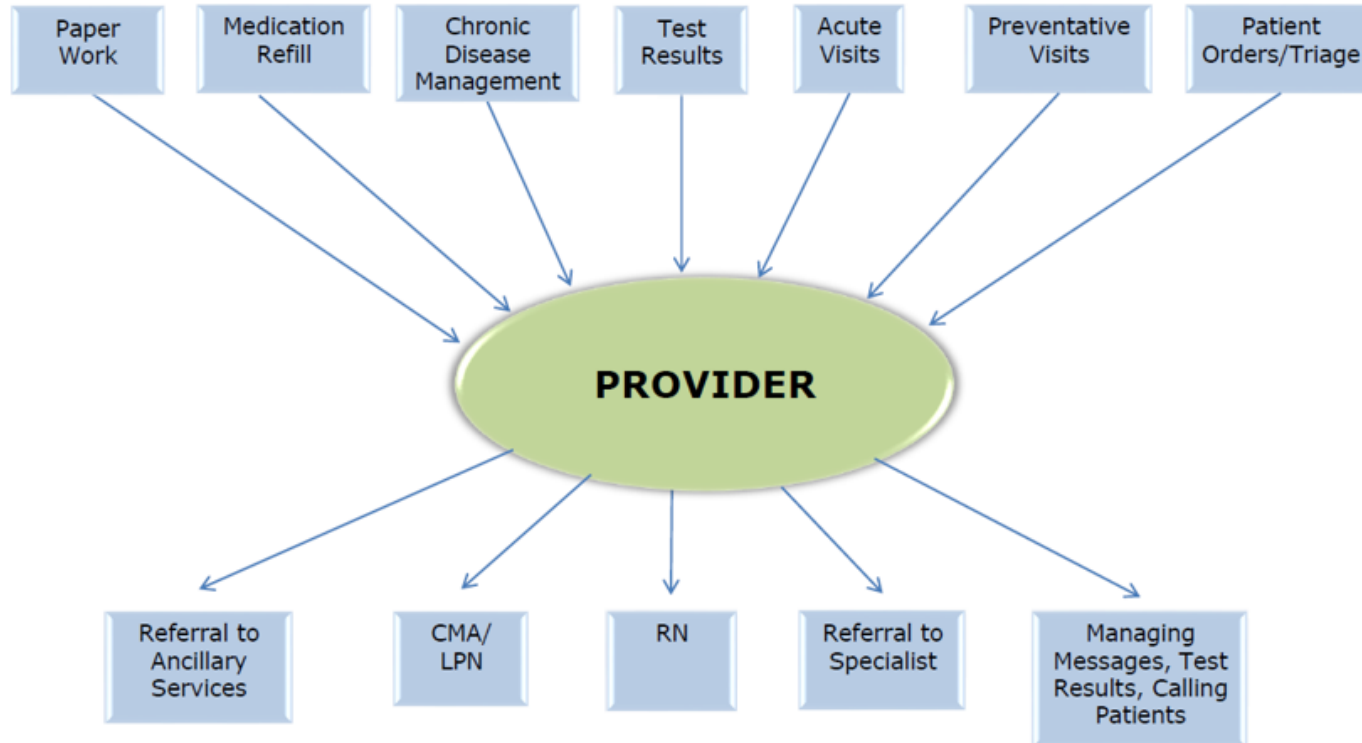
Building Blocks of
High Performing
Primary Care –
SHARE THE CARE
MODEL



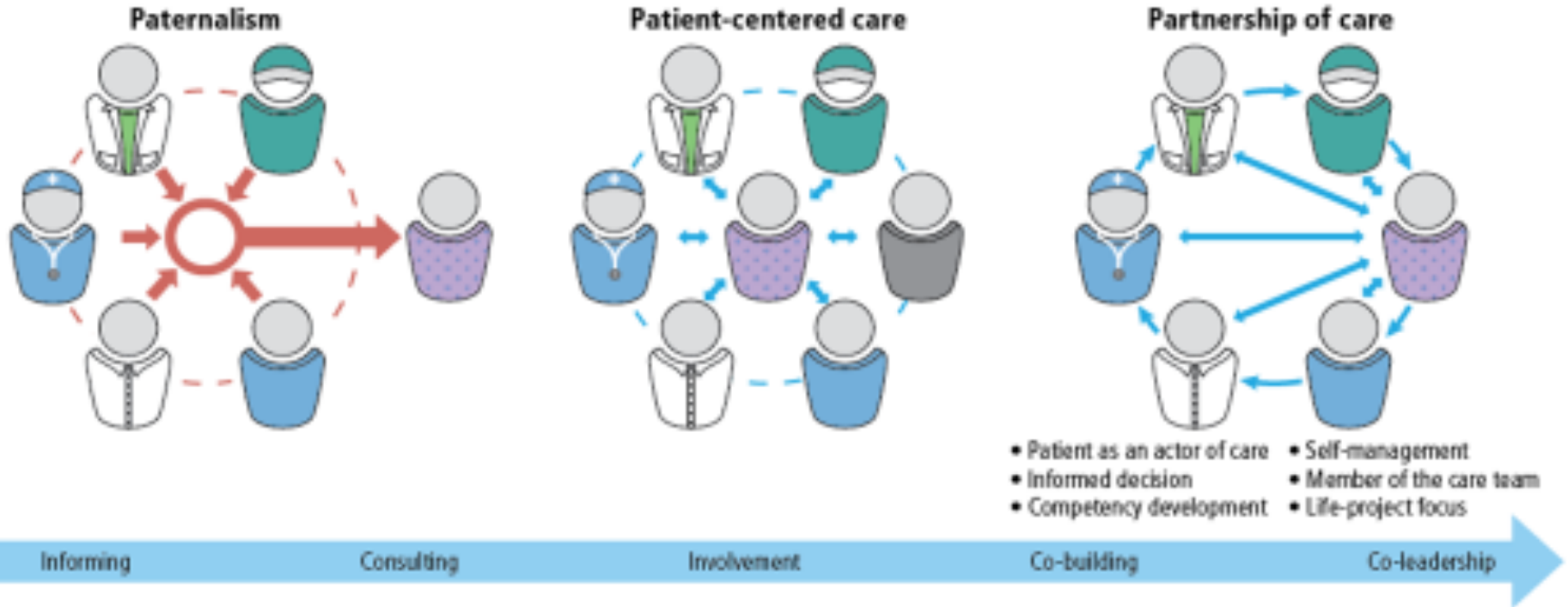
Quadruple Aim



Old Model of Patient Care

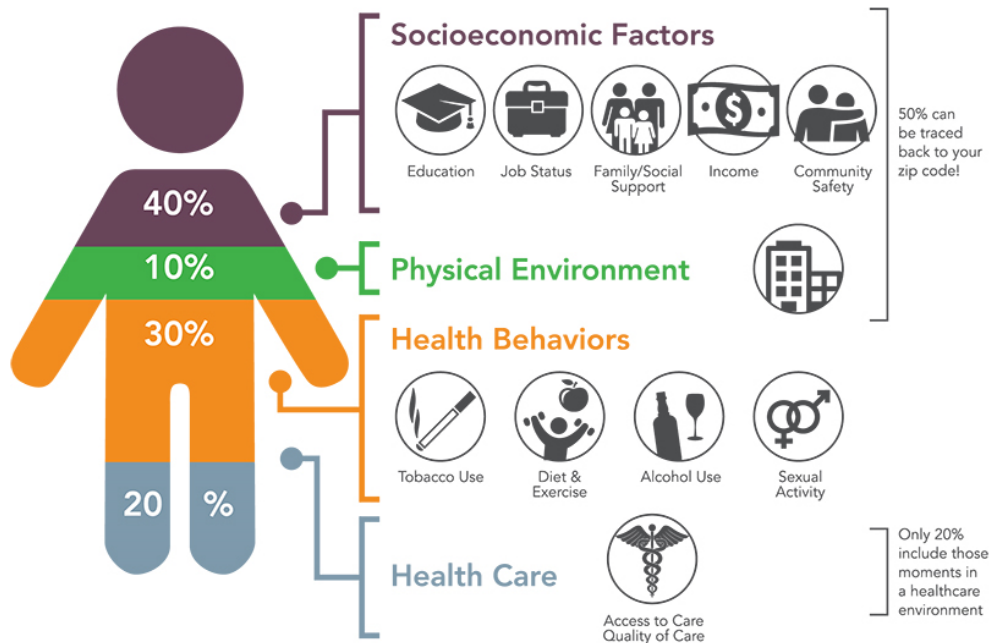


Patient Team Partnership



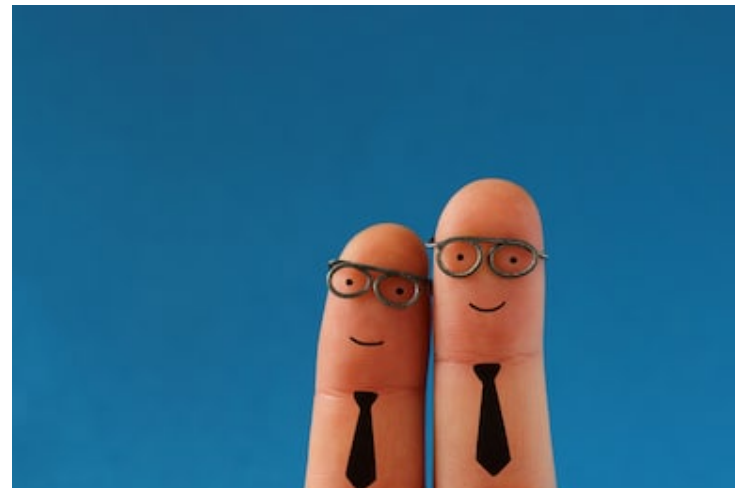
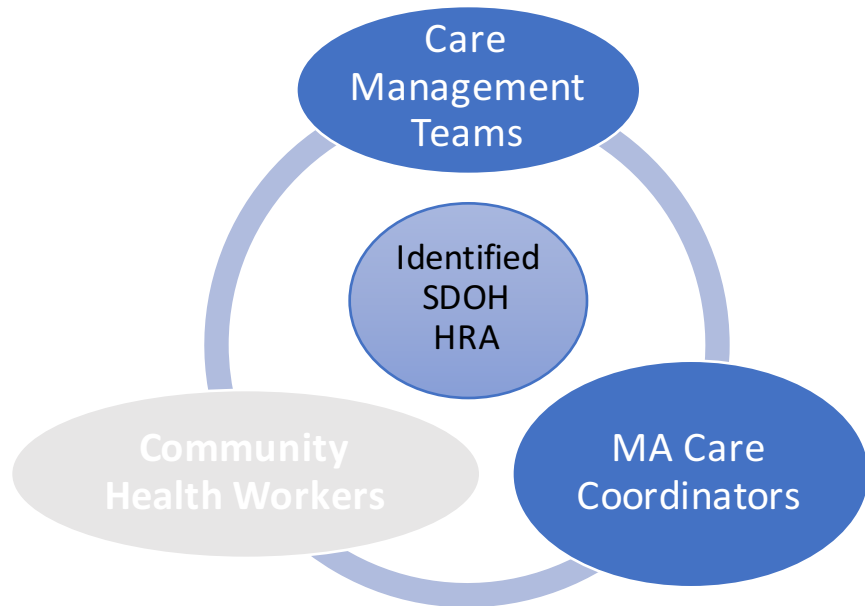
Social Determinants of Health

The drivers of health
are complex and
interconnected

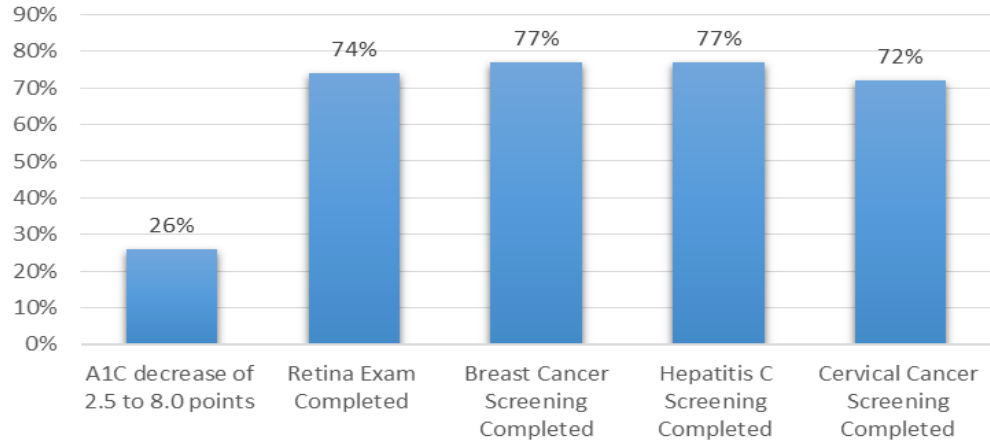


Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Addressing Social Determinants



Care Management Patient Outcomes



GET
READY
IT'S A
NEW
DAY



Team-Based Care

— REACHING FOR —
Health Equity



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Health Disparities Panel Discussion

Moderated by Veronica Buitron-Camacho
Director of Medical Management
Central Health



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Panel Discussion

- Diabetes: Aida Garza, Associate Pharmacy Director, CommUnityCare Health Centers
- Behavioral Health: Louise Lynch Network Authority Officer, Integral Care
- HIV: Brandon Wollerson, Director of Clinical Operations, Kind Clinic

Health Disparities: Behavioral Health

PREVALENCE OF SCHIZOPHRENIA DIAGNOSIS

Asian 14.6%

African-American 14.3%

White 6.1% (1.2% national)

PREVALENCE DATA FOR YOUTH DIAGNOSED with Oppositional Defiant Disorder

Hispanic 10.5%

African-American 6.2%

White 2.4% (2.3% national)



Source: Services Provided by Integral Care in 2018



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Health Disparities: Diabetes

PREVALENCE OF DIABETES

African-American

13%

Hispanic

12%

Non-Hispanic Whites

6%

65+
years old

21.3%

no
high school
diploma

17.4%

income less than

\$25k
a year

11.6%

Source: 2016 BRFSS Austin/Travis County



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Health Disparities: HIV

HIV PREVALENCE RATE RATIOS, BY RACE/ETHNICITY

2017



The rate of Black males living with an HIV diagnosis is 3.3 times that of White males.



The rate of Hispanic/Latino males living with an HIV diagnosis is 1.5 times that of White males.



The rate of Black females living with an HIV diagnosis is 17.4 times that of White females.



The rate of Hispanic/Latina females living with an HIV diagnosis is 2.5 times that of White females.



Source: 2017 AIDSvU



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Health care for **all**



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 Community
Care
Collaborative
A Central Health and Seton partnership

 CommUnityCare

 **SENDERO**
HEALTH PLANS



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