

RE-FORMING HEALTH CARE DELIVERY
SYSTEMS:
A SUMMARY OF A FORUM FOR STATES
AND HEALTH CENTERS

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EXECUTIVE SUMMARY

The passage of the Patient Protection and Affordable Care Act (referred to as the Affordable Care Act or ACA) provides new tools and resources for transforming health care delivery systems. However, using these resources effectively to address health care access, cost and quality challenges—particularly for vulnerable populations—lies in the hands of state policymakers and key health system stakeholders.

In June 2010, the National Academy for State Health Policy (NASHP) convened *Re-Forming What We Have Into the Delivery System We Want: A Forum for State and Community Health Center Strategy Development*. Based on the presentations and discussions at the Forum, this paper presents a vision for a transformed delivery system; highlights key federal resources to help achieve this vision; explores the core elements of delivery system reform; and offers specific examples of health centers and states that are partnering to design and implement innovative models of health care.

Colorado’s vision. Colorado Medicaid provides an excellent example of a state working toward transforming its delivery system through the development of an accountable care organization (ACO) model. This ACO infrastructure is being built on a medical home platform. The Colorado Medical Home Initiative forms this platform providing Medicaid and Children’s Health Insurance Program (CHIP) children with access to a qualified medical home. Through this platform, Medicaid is poised to develop its ACO model, known as Regional Care Coordination Organizations (RCCOs). Seven RCCOs will be launched in 2011 to coordinate and integrate care among providers, between programs and through all phases of life. With this model, Colorado hopes to reduce costs and improve population health with an outcomes-driven system; allow regional entities to perform using their local strengths by building “pockets of excellence”; and pilot initial payment reform models which will greatly help the state move forward.

NEW ACA TOOLS AND RESOURCES TO ACHIEVE THE VISION

The Accountable Care Act contains a number of new tools and resources to help reform delivery systems above and beyond those that will increase coverage. Those highlighted during the Forum include:

- Support to states to increase Medicaid payments to 100 percent of Medicare levels for primary care services provided by primary care physicians for two years;
- A one percentage point federal medical assistance percentages (FMAP) increase for Medicaid preventive services recommended by the US Preventive Services Task Force and immunizations for adults (if offered with no cost sharing);
- Ninety percent Federal Medical Assistance Percentages (FMAP) support for a new state plan option to establish health homes for Medicaid beneficiaries with chronic conditions for two years; and
- Creation of new CMS Innovation Center to test innovative payment and service delivery models.

ACA also included substantial assistance for federally funded community health centers.

- \$11 billion in new funding for the Health Centers program over five years; \$9.5 billion for broad health center expansion and \$1.5 billion for capital needs;
- \$1.5 billion over five years for the National Health Service Corps;
- Health insurance plans offered through the Exchanges will be required to contract with health centers and pay the Medicaid Prospective Payment System (PPS) rate;

- Medicare will be required to pay the PPS rate for health center services; and
- \$230 million over five years is being provided for Teaching Health Centers for primary care residency programs.

ACA also provides funding to establish other programs that may help states redesign their delivery system, including a Prevention and Public Health Fund; a National Strategy for Quality Improvement in Health Care; and a core set of health care quality measures for adults eligible for benefits under Medicaid.

PROMISING MODELS AND APPROACHES TO ACHIEVING THE VISION

Models and approaches considered at the June Forum included those strengthening the primary care workforce, coordinating care across programs and providers, and aligning payment and reporting policies to support transformation.

Retooling the Primary Care Workforce. Solutions to transform our existing primary care workforce were discussed at the Forum:

- The Safety Net Medical Home Initiative is transforming 65 safety net practices in five different regions into high performing primary care practices.
- Cherokee Health Systems in Tennessee has developed a model that helps the primary care provider better manage time by adding a behavioral health specialist to the primary care team.
- Massachusetts has supported the development of the community health worker's role through formal training, supervision and integration into the health care setting.

Coordinating care across providers. Care coordination is the linchpin to gaining quality outcomes and cost efficiencies in the health care delivery system. Promising models include:

- Montana Medicaid discontinued its contract with its out-of-state third party vendor and selected 14 FQHCs geographically dispersed throughout the state to coordinate both preventive and chronic care services for *all* Medicaid beneficiaries.
- The Primary Care Information Project (PCIP) in New York City aims to improve care coordination by providing high volume Medicaid practices with a comprehensive Electronic Health Record (EHR) that supports prevention and population management goals.

Using measurement to align incentives across systems. States can use performance measurements as a tool to better achieve quality and meet cost goals across health systems. Models examined at the Forum included:

- California HealthCare Foundation (CHCF) has been working with 331 health care clinics to develop processes to collect, validate, and publicly report data on standardized clinical measures.
- Washington State Medicaid, managed care plans, and the Puget Sound Health Alliance have been collaborating to develop public reporting of performance measurements that will capture two-thirds of the state's population.
- The Rhode Island Health Insurance Commissioner is convening a medical home pilot that is using an all payer database to give feedback to providers to improve performance.

Using payment to align incentives across systems. Changing payment models to better meet delivery system goals is a powerful tool for driving system delivery change. Models discussed at the Forum included:

-
- The Pennsylvania Governor’s Office of Health Care Reform is convening a multi-payer initiative using the Chronic Care Model and payment incentives to transform practices.
 - The Oregon Department of Human Services, Addictions and Mental Health Division is implementing two demonstrations in which community partners voluntarily form a single management “entity” that is accountable for the delivery of integrated physical and behavioral health care.

COMMUNITY HEALTH CENTERS AND STATES NEED SUPPORT

Forum participants identified key areas where support was needed from the federal government, foundations, and other stakeholders to advance the vision for a re-formed delivery system.

- Support is needed for leading states to work together and assist other states in learning, developing, or adopting innovative strategies and models.
- Federal guidance, templates and platforms would be helpful in making clear the safe harbors and expectations for new federal funding opportunities.
- State and federal flexibility is needed to bring innovative models to scale.
- Financial support for development, testing and adoption of delivery reforms is needed particularly through mechanisms other than competitive grants.
- Partnerships and support in engaging important stakeholders are needed to bridge differences and unite around achieving common system goals.

CONCLUSION

The innovative models that states, health centers and other stakeholders have been developing and implementing to achieve better access, quality, and costs goals suggest that a transformed health care delivery system is within reach. However, the challenges of overcoming the current gaps in the system are significant. Leadership commitment and political will is needed to move delivery system reform to the top of a state’s health care agenda.

INTRODUCTION

The passage of the Patient Protection and Affordable Care Act (referred to as the Affordable Care Act or ACA) provides new tools and resources for transforming health care delivery systems. However, using these resources effectively to address health care access, cost and quality challenges—particularly for vulnerable populations—lies in the hands of state policymakers and key health system stakeholders. Now more than ever, opportunities exist for state policymakers, federally qualified health centers (FQHCs), managed care plans, and other key partners to strengthen and better align capacities to create a delivery system to meet shared health care goals. In June 2010—less than three months after the passage of national health care reform legislation—the National Academy for State Health Policy (NASHP) convened *Re-Forming What We Have Into the Delivery System We Want: A Forum for State and Community Health Center Strategy Development*. The purpose of the Forum was to examine model approaches as well as surface new strategies that can be promoted with federal and state policymakers, foundations and the health center community to help progression toward re-formed health systems. This work builds on NASHP's efforts to inform state policymaking as it relates to federally-funded community health centers.

Through presentations, group discussions and facilitated breakout sessions, participants at the Forum discussed:

- A vision of what a reformed delivery system that meets access, cost and quality goals should look like;
- Resources and models available to assist states, FQHCs and key partners in achieving this vision; and
- Strategies to align incentives to move toward this vision.

This Forum was developed through and supported by NASHP's National Cooperative Agreement (NCA) with the federal Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC).¹ As part of the NCA, NASHP has convened state primary care and health policy teams, NASHP Academy advisors, partner organizations and key experts at Forums to discuss the role of community health centers (CHCs) in the context of state and federal health care reform efforts.

Based on the presentations and discussions at the Forum, this paper presents a vision for a transformed delivery system; highlights key federal resources to help achieve this vision; explores the core elements of delivery system reform; and offers specific examples of health centers and states that are partnering to design and implement innovative health care models. Further, based on conclusions drawn by Forum participants, the paper outlines a path forward towards a re-formed delivery system.

VISION AND GOALS FOR A RE-FORMED DELIVERY SYSTEM

The need for delivery system reform existed prior to the passage of ACA, but the law elevated the urgency and expectations for states to develop high performing health systems.² In 2014, there will be a substantial expansion of Medicaid to cover the uninsured. Medicare rolls will increase as well, as more baby-boomers become eligible for coverage. Other uninsured will be required to have health coverage purchased through health insurance Exchanges or a reformed private health insurance market. The newly insured will enter a stressed health care delivery system that not only lacks the capacity to serve our currently insured population, but also falls short of delivering high quality, cost-effective care.

A transformed delivery system that achieves access, quality, and costs goals requires the input of patients, families, providers, payers and communities.³ The meaningful input of these stakeholders will help states advance a shared vision across its health care system. The strategies to achieve this vision include:

- Establishing primary care medical homes, or health homes;
- Linking medical homes to other key providers including mental health, oral health, public health and tertiary care;
- Increasing the primary care workforce and improving its efficiency;
- Fostering high functioning, primary care teams that include behavioral health providers, care coordinators, and new provider types such as community health workers;
- Implementing health information technology and meaningful exchange to improve communication across providers and organizations;
- Establishing state and national measures to help achieve higher system performance and quality care;
- Developing payment structures that support improved performance and quality, encourage coordination, and decrease overuse;
- Promoting patient engagement, health literacy, and system navigation; and
- Keeping the needs of the underserved and vulnerable populations represented throughout all phases of the design and implementation process.

COLORADO: ONE STATE'S EFFORT TO MOVE TOWARD THE VISION

This vision of a transformed delivery system is already taking root in some states. Colorado Medicaid is restructuring its delivery system to better meet the needs of current and future users through the development of an accountable care organization (ACO) model. ACOs are generally defined as consisting of providers jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth.⁴ Colorado's ACO infrastructure framework has three components: local accountability for cost, quality, and capacity; shared savings; and performance measurement. Under this ACO umbrella, Colorado plans to make delivery system improvements by advancing medical homes, health information technology, and payment reform.⁵

Medicaid is driving much of the health system delivery reform in Colorado. Medicaid began this journey in 2007 with a legislative mandate to provide medical homes for children covered under Medicaid and

the Children's Health Insurance Program (CHIP). By laying the primary care infrastructure needed to advance medical homes, Medicaid was poised to develop its ACO model, known as Regional Care Coordination Organizations (RCCOs). The RCCO model puts medical homes at the center, working with hospitals, pharmacies, physical therapists and occupational therapists, among others, to deliver comprehensive, coordinated, integrated care to Medicaid beneficiaries. Using

a Request for Proposals process, seven RCCOs will be selected to coordinate and integrate care among providers, between programs and for all phases of life beginning in 2011. The RCCOs will collect and feed provider data to a statewide data analysis organization responsible for creating a web-based provider health information system. This system will extract and analyze statewide data to identify opportunities to improve care quality. With this delivery system model, the state hopes to reduce costs and improve population health with an outcomes driven system; allow regional entities to perform using their local strengths by building "pockets of excellence"; and pilot initial payment reform models which will greatly benefit the state in the future.⁶

The financing structures and benefits within this ACO model vary. The statewide data and analytics organization receives a fixed price contract. The RCCOs receive a per member per month dollar amount and are eligible for incentives and gain sharing. Providers' claims will be paid on a fee-for-service basis but providers also will be eligible for incentive and gain sharing payments. Additionally, RCCOs will support providers with practice redesign, assist with complex clients and make necessary changes in care processes using data feedback. Patients will benefit by having a focal point of care, with an emphasis on health and functioning (as opposed to service utilization), and assistance with coordination of all services, including social services.

Through the development of RCCOs, Colorado is taking steps to achieve the vision of improved access and quality while remaining budget-neutral or achieving cost savings. As other states travel the path towards transformed delivery systems, they may look to new federal support to help them get there.

Don't be lulled into thinking that practices that have achieved [medical home] recognition standards are functioning as patient centered medical homes. The proof should be in the outcomes.

Joan Henneberry
Colorado

NEW ACA TOOLS AND RESOURCES TO ACHIEVE THE VISION

The Accountable Care Act contains a number of new tools and resources to help reform delivery systems, above and beyond those that will increase coverage. Those highlighted at this Forum include:

- Support to states to increase Medicaid payments to 100 percent of Medicare levels for primary care services provided by primary care physicians for two years;
- A one percentage point federal medical assistance percentages (FMAP) increase for Medicaid preventive services recommended by the U.S. Preventive Services Task Force and immunizations for adults (if offered with no cost sharing); and
- Ninety percent FMAP support for a new state plan option to establish health homes for Medicaid beneficiaries with chronic conditions for two years.⁷

Under the new state plan option for Medicaid health homes, federal support will include comprehensive care management, care coordination and health promotion; comprehensive transitional care; referral to community and support services; and the use of health information technology (HIT) to link services.

CREATION OF NEW CMS INNOVATION LABORATORY

The Affordable Care Act also provides \$10 billion over 10 years for a new Center for Medicare and Medicaid Innovation (CMMI) within the Center for Medicare and Medicaid Services (CMS). CMMI is charged with testing innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing quality of care. The new models selected will not have to be budget-neutral during their initial testing period. Preference will be given to models that improve coordination, quality and efficiency of health care services. The goal of these new models is to achieve CMS' strategic outcomes for a transformed delivery system in a post health reform environment.⁸

FEDERAL COMMUNITY HEALTH CENTER SUPPORT

ACA also included substantial assistance for federally funded community health centers that includes:

- \$11 billion in new funding for the Health Centers program over five years; \$9.5 billion for broad health center expansion to serve approximately 20 million new patients; \$1.5 billion for capital needs;
- \$1.5 billion over five years for the National Health Service Corps;
- Health insurance plans offered through the Exchanges will be required to contract with "essential community providers," including health centers and pay the Medicaid Prospective Payment System (PPS) rate;
- Changes to Medicare payment policy that requires the Secretary of the U.S. Department of Health and Human Services (HHS) to develop a prospective payment system for services furnished by health centers; eliminates the Medicare payment cap for health centers; and ensures that certain preventive benefits are treated as part of the Medicare core FQHC service definition and paid by the new prospective payment system; and
- Authorization of a new Title VII grant program for the development of residency programs at health centers, as well as \$230 million over five years for a new Title III program providing payments to community-based entities that operate teaching programs.⁹

MORE DELIVERY SYSTEM TOOLS

In addition to the support mentioned above, ACA provides funding to establish other programs that may help states redesign their delivery system. The Affordable Care Act establishes:

- A Prevention and Public Health Fund and appropriates \$7 billion for fiscal years 2010 through 2015 and \$2 billion for each fiscal year after 2015 for prevention, wellness and public health activities.¹⁰
- A National Strategy for Quality Improvement in Health Care. Priorities for quality improvement include: (1) addressing gaps in quality, efficiency, comparative effectiveness information, health outcomes measures and data aggregation techniques; (2) improving federal payment policy to emphasize quality and efficiency; (3) enhancing the use of health care data to improve quality, transparency, and outcomes, and population health; (4) improving patient safety, preventable admissions and re-admissions, and health care-associated infections; (5) reducing health disparities.¹¹
- A core set of health care quality measures for adults eligible for benefits under Medicaid in the same manner as the Secretary of HHS identifies and publishes a core set of child health quality measures.¹²

The federal officials at the Forum noted that ACA has resulted in improvements to work within and across their agencies and with other departments to better coordinate federal efforts as well as better support state and regional efforts.

STATE AND COMMUNITY MODELS AND PROMISING APPROACHES TO ACHIEVING THE VISION

In addition to federal support, states can benefit from considering models for delivery system reform to potentially adapt and bring to scale in their states. Many states, regions, communities and providers—including health centers—have developed innovative models that may address key aspects of the vision for system transformation. Models and approaches considered at the June Forum included those addressing needed improvements in the primary care workforce; coordinating across programs and providers; and aligning payment and reporting policies to support transformation.

RETOOLING THE PRIMARY CARE WORKFORCE TO MEET NEW DEMANDS

The significant role primary care plays in a high performing health care delivery system has been well documented. The benefits of a strong primary care delivery system include:

- Greater access to needed services;
- Better quality of care;
- A greater focus on prevention;
- Early management of health problems; and
- A reduction in unnecessary and potentially harmful specialist care.¹³

Despite widespread agreement on the contributions of primary care to the overall health of a nation, physicians have described the U.S. primary care delivery system as being “on the verge of collapse.”¹⁴ Fewer U.S. medical students are choosing careers in primary care and many of those already in practice are leaving.¹⁵ Nurses, pharmacists, mental health specialists, dentists, and many other health care professionals also remain in short supply. Compounding this crisis is the fact that federal health care reform will introduce 32 million newly insured individuals to primary care, and that an aging baby boomer population will increase demand for chronic care services.

Community health centers provide a strong foundation to build a high performing primary care delivery system. U.S. populations served by community health centers are healthier than comparable populations served elsewhere, receive more preventive services and have greatly reduced disparities in care.¹⁶

Multi-faceted solutions are needed to address the challenges with the primary care workforce—attracting more primary care physicians to the pipeline through education and payment incentives is at the core. Another solution includes transforming the primary care workforce to ensure that existing resources are being spent wisely and managed well. Strategies here include retraining primary care practices to run more efficiently. Practice retraining includes improving the management of the primary care provider’s time by emphasizing the need for team-based care. Such solutions were topics of discussion at the June 2010 Forum.

Teaching new skills to primary care practices. During the June Forum, participants learned about the Safety Net Medical Home Initiative that supports transforming 65 safety net practices in five different regions into high performing primary care practices.¹⁷ Begun in 2009, the goal of this five-year pilot is to develop and demonstrate a replicable and sustainable implementation model that will help these safety net clinics meet benchmarks in quality, efficiency and patient and provider experience. Each of these five regions, supported by convening organizations known as regional coordinating centers, is expected to improve state policy connections by involving Medicaid and other stakeholders in developing a payment model to sustain these efforts after the pilot ends.

The Pittsburgh Regional Health Initiative (PRHI) was selected as one of the five regional coordinating centers and oversees the efforts of 10 federally qualified health centers.¹⁸ Basing its framework on the Toyota Production

System and its Pittsburgh spinoff, the Alcoa Business System, PRHI uses a “lean” health care approach known as “Perfecting Patient Care™.” Learning collaboratives, practice coaching, quality improvement meetings, and other technical assistance reinforce new skills, knowledge and tools. PRHI has focused on FQHCs acquiring enhanced skill sets to become patient centered medical homes. These skills are:

- Interpersonal Skills: communication, conflict resolution and teamwork;
- Quality Improvement Skills: real-time problem solving, use of data to drive change and work redesign; and
- Technology Competence: electronic health records and patient registries.

Training health center staff to gain competence in these skills is not limited to direct patient care staff. Any staff who have contact with the patient, including reception and billing staff, are educated to help them understand their relationship to the patient.

Integrating Behavioral Health Providers in Primary Care Teams. The high prevalence of behavioral health problems among those with chronic conditions and the interrelated nature of mental, addictive and physical treatment has led the Institutes of Medicine and the World Health Organization to call for the integration of behavioral and physical health care.^{19, 20} Cherokee Health Systems, based in Knoxville, Tennessee, has developed a model that helps primary care providers better manage time by adding a behavioral health specialist to the primary care team. This approach has been successful in improving patient outcomes and satisfaction while developing operational efficiencies that have resulted in this model being sustained and replicated.²¹

Cherokee’s success can be traced to its origins as a community mental health center (CMHC). Cherokee Health Systems succeeded in obtaining dual CMHC and FQHC status after merging the missions of both centers. Cherokee now operates 22 clinical sites in 15 eastern Tennessee counties. Twelve of these sites are fully integrated. These sites embed a licensed behavioral health consultant as a member of the primary care team and link providers through shared electronic medical records. This arrangement allows the primary care provider to conduct a physical assessment and then provide a “warm hand-off” to the behavioral health consultant for a behavioral health assessment. A psychiatrist is available—generally off-site by telephone or via telehealth—for consultation with either the primary care or behavioral health provider.

Survival [for CMHCs] requires rethinking and a paradigm shift. Can state policy play a role in that transition?

Dennis Freeman
Tennessee

With this model of care, Cherokee Health Systems has been able to offer patients needed behavioral health care services while more efficiently decreasing use of specialty mental health care. Its positive outcomes have enabled Cherokee to negotiate favorable rates with one of the Medicaid managed care plans to support its model, including payment for same-day primary care and behavioral health care visits as well as other visit codes. Cherokee is also a training ground for primary care physicians to gain experience in treating those with behavioral health problems and for psychologists to gain comfort in primary care settings. It provides training for other members of the primary care team as well, including certified peer specialists.

Developing a community health worker workforce. Community health workers serve as a bridge to connect patients and families to their primary care team and other health care and social services. Through

public and private partnerships, the Commonwealth of Massachusetts has been proactive, developing the community health worker's role through formal training, supervision and integration into the health care setting. In 2006, health care reform legislation required the Department of Health to further these efforts by developing a task force to investigate future roles of community health workers and make recommendations for a sustainable community health work program in Massachusetts.²² The task force noted that the addition of community health workers in the health care setting resulted in:

- Increased access to care;
- Improved health care quality;
- Reduced health disparities;
- Improved service delivery by reducing utilization of hospitals and emergency departments; and
- Improved self-management of health conditions.

Task force recommendations included:

- Adopting a statewide community health worker identity campaign;
- Agreeing on a common definition and role;
- Strengthening workforce development including establishing state certification;
- Expanding financing mechanisms through payers and foundations; and
- Establishing an infrastructure to ensure implementation of recommendations.

Community health workers also have been recognized nationally as valuable members of health care teams. ACA authorized grants to promote a community health workforce and recognize its potential role in expanded enrollment, chronic disease management and maternal and child health care.

COORDINATING CARE ACROSS PROVIDERS AND PROGRAMS

Care coordination is the linchpin to gaining efficiencies in the health care delivery system as well as driving better quality patient care. One of the seven Joint Principles of a Patient Centered Medical Home (developed by four major primary care physician associations and endorsed by hundreds of other organizations) emphasizes care coordination:

“Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.”²³

This acknowledgement of the central role care coordination plays in primary care is universally reflected in national and state medical home certification standards. These standards align enhanced payment to those practices that meet expectations around care coordination services, as well as provide other medical home services.²⁴

The June Forum offered opportunities to discuss a care coordination delivery model that uses FQHCs to address the needs of frontier and rural practices; the roles that health information technology can play in coordinating care and linking providers; and how integrated systems can deliver better coordinated care.

Designating FQHCs as the locus of care coordination. In 2009, Montana Medicaid discontinued its contract with its out-of-state third party vendor and selected 14 FQHCs across the state to coordinate both preventive and chronic care services for all Medicaid beneficiaries. Montana Medicaid pays \$3.75 per member per month to each of the selected FQHCs for *all* Medicaid recipients in each center's geographic area. This care coordination fee covers:

- Chronic care management for patients that are complex and high cost (not limited to previous four disease states; and
- Prevention efforts for patients at risk of developing chronic health conditions.²⁵

The Montana care managers are nurses and health coaches (social workers) employed and trained by FQHCs. Patients are identified by predictive modeling software using claims history and other demographic information to calculate a risk score. Primary care providers also may refer at-risk patients to the care managers. Medicaid secures provider agreements that require care managers to perform the following services:

- Health assessment (initial and periodic);
- Ongoing clinical assessment (in person and telephonic);
- Individualized treatment/action plan;
- Pre- and post-hospital planning visits;
- Self-management education;
- Group appointments;
- Tracking and documenting of visits; and
- Assistance with and referral to local resources.

In Montana, the state has capitalized on an important strength of FQHCs—their ability to provide a comprehensive range of supportive and enabling services based on the linkages they have developed in their local communities.

Using health information technology to connect providers. Health information technology (HIT) has the potential to empower providers to improve care delivery through better coordination and communication within a practice and between practices and facilities. Yet 83 percent of surveyed U.S. doctors do not use electronic health record (EHR) systems and only four percent have comprehensive EHRs that are capable of information exchange.²⁶ The transition from a paper-based system to an EHR is time consuming and expensive for many practices and often does not result in any information exchange between practices. The Primary Care Information Project (PCIP) in New York City provides an example of how a local government is working to overcome these obstacles by assisting high volume Medicaid practices adopt prevention-oriented EHRs capable of information exchange.²⁷ By providing practices with a comprehensive EHR that supports prevention and population management goals, technical assistance that supports workplace implementation, and financial incentives that reward participation, PCIP expects to reach more than half of all high volume Medicaid providers in New York City.

On a national scale, funds from the American Recovery and Reinvestment Act (ARRA) of 2009 are being used to connect at least 100,000 Medicaid providers with certified EHRs and participate in the meaningful exchange of health information by 2012. This work will be largely accomplished through the establishment of Regional Extension Centers (RECs) and the use of Medicare and Medicaid provider incentive

payments. RECs will first focus on serving public or not-for-profit hospitals, FQHCs, small group primary care practices, and settings that predominantly serve uninsured, underinsured, historically underserved and other special needs populations. REC goals are three fold:

1. Encourage adoption of electronic health records by clinicians and hospitals;
2. Assist clinicians and hospitals to become meaningful users of electronic health records; and
3. Increase the probability that adopters of electronic health record systems will become meaningful users of the technology.²⁸

Linking hospitals, specialists and primary care providers through shared incentives. The benefits of improving information and communication flow between hospitals, specialists and primary care providers are multifold; the challenges to realizing this goal are multifold as well. As mentioned in the previous section, health information technology provides a promising platform to facilitate information exchange. But there is a significant need to formalize relationships between providers either through partnerships, financial incentives, or contractual language.

Despite the fact that the U.S. health care delivery system is overpopulated with specialists, the vast majority of health centers have difficulty obtaining specialty care, especially for their uninsured patients, and more than half of their Medicaid patients have difficulty getting specialty referrals.²⁹ Those health centers that reported less difficulty obtaining specialty care referrals had formalized hospital affiliations.³⁰ Not only do these affiliations improve specialty care referrals, they also improve care coordination. In addition, health centers with admitting privileges are more likely to receive notification and information about patient care.³¹

There is considerable attention being placed on primary care providers, specialists and providers forming accountable care organizations (ACOs) to formalize partnerships that create incentives for information sharing as well as financial risk. ACOs found in health systems such as Denver Health and Geisinger Health System have demonstrated that these formalized relationships result in high quality outcomes and lowered cost growth. Health centers have had limited experience in forming these partnerships, but ACA may provide new opportunities for those willing to partner with hospitals and specialists to integrate care both horizontally and vertically and to achieve improved outcomes.

USING MEASUREMENT TO ALIGN INCENTIVES ACROSS SYSTEMS

States can use performance measurements as a tool to gain alignment to better achieve quality and cost goals across health systems. In addition, by making these performance measurements transparent and easily available for other providers or the public to see, states may have another powerful tool to drive system change.

Using public reporting to improve quality in California health centers. The California HealthCare Foundation (CHCF), a private, non-profit foundation, has been developing strategies to publicly report health care information to help California's consumers make informed health care choices and to drive improved quality across the California health care system. Citing an *Annals of Internal Medicine* report,³² CHCF feels that providers are more apt to focus on quality when information is in the public domain. Emphasis must be placed on evidence-

Public reporting is more than transparency. It's about giving providers the skills to improve quality.

Melissa Schoen
California

based medicine, making the data easily understood. This is not an easy task; gaining provider and plan buy-in from the start is imperative.

California health centers represent a large number of providers in the state, more than 155 FQHCs operating 538 sites with 9.8 million annual visits. CHCF is working with 331 health care clinics to develop processes to collect, validate, and report data on standardized clinical measures. This process builds off the HRSA Health Disparities Collaborative work and has resulted in health centers reaching agreement on using standardized quality measures across clinics to allow comparison. There are also plans to add measures that will show operational efficiency and patient experience. Small incentives were given to encourage centralized reporting as well as technology to support data collection, including assistance for a number of health centers to purchase and implement registries. Experience to date has demonstrated that there is a range of experience among health centers with data and population management and there is a distinct need to focus on standardized measurements. By focusing on data collection, data review, result sharing with peers, and registry support, CHCF is developing a process to move health centers towards public reporting and transparency. This process is intended to drive quality improvements in the health centers, but will require financial incentives through aligned reimbursements to sustain and promote further improvements. Engaging California MediCal (Medicaid) and its numerous health plans could help further these efforts.

Building partnerships to promote measurement and transparency in Washington State. Over the past several years, Washington State Medicaid, managed care plans and Puget Sound Health Alliance have been building a foundation to inspire better quality in its health care delivery system through public reporting of performance measurements. Medicaid's role includes providing annual public reports of a subset of National Committee for Quality Assurance (NCQA) HEDIS measures for its managed care plans. In addition, since 2004, Medicaid provides \$2 million for performance payments for those that meet certain performance targets, including childhood immunizations and well-child care standards.³³

Medicaid and commercial payers have been supplying the Puget Sound Health Alliance, a regional partnership of employers, providers, patients, advocates and health plans, with data that covers two-thirds of the population of the state. The Puget Sound Health Alliance publicly reports this data through its website, www.wacommunitycheckup.org, that allows consumers to search and compare hospitals, clinics and medical groups for measures such as screening rates and use of evidence-based practices. This kind of reporting has helped Medicaid prioritize some of its quality initiatives such as targeting providers who are unnecessarily high cost-drivers.

In addition, Medicaid has developed its own predictive modeling software that integrates care across databases—mental health, criminal justice, pharmacy, etc.—to help assess the level of risk in their population and better target the kinds of resources providers need to manage patient care.

Aligning incentives with an all payer database in Rhode Island. The Rhode Island Health Insurance Commissioner is convening a medical home pilot that is using an all-payer database for provider feedback to improve performance. All providers participating in the multi-payer pilot are required to report on common measures agreed upon at the pilot's inception. Although there is some disagreement regarding the variability of the data being reported and the risks of comparing across practice sites (i.e. the biggest barrier is that the data is not risk adjusted), it is agreed that the data is beneficial for helping providers improve their own benchmarks and getting a system view of the pilot's progress. Technical support was offered to help providers develop their registries and compile measures. Resources are also provided through the state's Quality Improvement Organization to help practices review the data and use it to improve care.

The Rhode Island Health Insurance Commissioner cautioned against rushing to publicly report quality measures, saying that doing so creates a great deal of provider resistance and does little to inform a patient's selection of a provider. In the example provided by California HealthCare Foundation, the CHCF speaker noted that it is easier for a foundation to provide public reporting because they do not have the same political ramifications as a state. The CHCF speaker pointed out that although consumers are not using their website extensively, it is engaging those in health leadership positions to look at the data and make necessary changes.

Rhode Island pilot providers (including one health center) were surprised by the data results—mostly they thought they were doing better—but are now using the data to improve work internally. Although participation in HRSA's Health Disparities Collaborative has provided the participating health center with experience in data collection and measurement, participating in this pilot provides them (as well as the other practices) with the opportunity to learn from other practice types and become engaged in efforts to be accountable for overall population health and system improvement.

USING PAYMENT TO ALIGN INCENTIVES ACROSS SYSTEMS

Changing payment models to better meet delivery system goals is a powerful tool for driving system delivery change. Forum participants agreed that current payment models drive unnecessary volume, discourage non face-to-face care (i.e. care coordination), and perpetuate the siloing of health care funds (i.e. mental health, physical health). Many at the Forum agreed that fee-for-service payments are largely responsible for the current payment system dysfunction.

Reforming payments to health centers was a subject of the June Forum. Medicaid payments to health centers mostly use a prospective payment system (PPS) rate that is based on 2002 rates of care (with adjustments made annually for inflation and for increases or decreases in the scope of services). Other payers, such as commercial and Medicare, do not pay a PPS rate (although this will change with ACA) and many states choose to use an alternative payment methodology agreed to by the health centers and Medicaid. According to the National Association for Community Health Centers (NACHC), there is leeway in current CMS law and in future regulations under ACA for states to develop alternative payment methodologies for health centers that align value added services such as care coordination and patient education with payment, while receiving a federal match for these services. Getting health centers and other providers to agree on payment models that are aligned with new services has been a challenging task for many states.

Improving chronic care through regional payment models in Pennsylvania. Through the Governor's Office of Health Care Reform, Pennsylvania is rolling out a region-by-region initiative to improve the delivery of health care to the state's chronically ill. This multi-payer initiative is transforming primary care using the Chronic Care Model³⁴ and using payment incentives linked to achieving medical home recognition by NCQA. The Chronic Care Initiative has evolved since its inception in Southeast Pennsylvania in 2008 in which 32 practices (nine health centers) were enrolled and provided with substantial financial incentives to reach NCQA medical home recognition. The lesson learned from this first rollout was that practices rushed to reach recognition (and receive the payment bonus), spending little time on transforming practice processes. In addition, practices did not spend the payment bonus on practice enhancements.

By the time the Chronic Care Initiative rolled out to Northeast Pennsylvania, the payers in this area had reaped the benefits of the lessons of three previous rollouts. The Northeast Pennsylvania payment model provides for a \$1.50 per member per month (PMPM) fee for ongoing practice costs. In month four of the pilot, practices can receive an additional \$1.50 PMPM care management payment contingent upon hiring a care manager with specific duties and responsibilities. In addition, practices are eligible to receive

“Value Reimbursement” payments at 12 months if they meet NCQA medical home recognition and certain performance criteria. These payments are only provided if there are savings to be shared between the plans and practices. Practices are also at risk for losing their PMPM payments if certain benchmarks are not being met.³⁵

Although there are no health centers participating in the Northeast Pennsylvania rollout, there was considerable discussion about whether this risk-sharing model would be allowed under current CMS policy and whether health centers could thrive. According to NACHC, CMS does permit alternative payment models that can include risk sharing for one or more health centers under a state plan amendment. This kind of risk-sharing agreement is considered a model of the future. And with accountable care organizations in development, it was agreed that widespread education is needed to bring health centers and Medicaid agencies to the table to discuss the possibilities.

Integrating funding streams to better manage care for people with behavioral and physical health problems in Oregon. In Oregon, an innovative approach to integrating primary care and behavioral health is being developed by the Department of Human Services (DHS), Addictions and Mental Health Division (AMH). DHS is implementing two demonstration projects in which community partners (such as local Mental Health Authorities, Mental Health Organizations, health centers, and health plans) voluntarily form a single management “entity,” or collaborative structure, that serves as the point of accountability for the delivery of integrated physical and behavioral health care. The demonstration project goals are to focus on:

- Service delivery (provide comprehensive, seamless care that promotes patient self-sufficiency);
- Cost efficiency (consolidate and streamline all available funds and align with performance); and
- Governance (single point of accountability that is locally managed).³⁶

This “entity” is responsible for addiction services and other DHS-covered services such as supportive housing and employment. While no new money is available for these projects, state funds that currently flow to multiple different entities within counties will be directed to the new management entity for distribution.

Two demonstration sites have been selected and are in various states of implementation. In Central Oregon, “Links 4 Health” formed a single management entity comprised of county governments, public payers, health center and volunteer programs and consumers and family members. The current focus is on emergency room diversion for the top emergency department visitors in a tri-county area using outcomes from the Institute of Health Improvement’s “Triple Aim.”³⁷ The other demonstration site in Northeastern Oregon is just getting underway.

The state’s primary objective is to produce changes system-wide that include:

- Streamlining the financing between state and local levels to single, accountable, decision-making structures; and
- Clinical level integration, with improvement in specific measurable outcomes for individuals receiving services, including measures such as increased use of appropriate routine medical care, increased access to addiction services, and reduced contacts with the criminal justice system.

Oregon hopes to identify the optimal model to braid funding streams and then make the case to federal partners for flexibility to implement statewide.

SURMOUNTING THE GAP BETWEEN VISION AND REALITY: CHALLENGES AND STRATEGIES FOR STATES AND HEALTH CENTERS IN RE-FORMING THE DELIVERY SYSTEM

Arrayed against the vision for a reformed delivery system laid out at the June Forum are the practical realities of the gap between the vision and where systems are today. National health care reform offers many opportunities to close that gap. Forum participants used structured breakout sessions to identify the key challenges within the current system to overcome and brainstormed strategies for addressing these challenges and moving towards a re-formed delivery system. First are overall challenges in surmounting the gap, followed by the specific challenges and strategies for the major elements of delivery reform discussed at the Forum: workforce; coordination and integration; and alignment of reporting and payment.

OVERALL CURRENT CHALLENGES

Participants at the June Forum identified several challenges to closing the gap between vision and reality.

Differing cultures and incentives. State officials in different agencies and branches of government, public and private payers, and health center and other providers all operate within different cultures that provide different incentives and disincentives for specific aspects of reform and for working together. Incentives and disincentives emanate from varying and sometimes conflicting federal and state policies, and structural characteristics and mandates, including mission and profit-driven motives.

Strained health care system capacities. Even before 32 million or more individuals gain insurance coverage in 2014, the system's current capacity is strained, with the degree of stress varying by state, community, and sector, extending from primary care to behavioral and oral health care and specialty services. This is true for the insured as well as the uninsured. Nearly 91 percent of uninsured and 71 percent of Medicaid insured individuals obtaining care in a health center find it somewhat or very difficult to obtain care with specialists.³⁸

Limited state agency funding and capacity. While not a focal point for discussion at the Forum, the reality of severely limited state funding and staffing capacity in the current fiscal climate were acknowledged as factors constraining states' abilities to provide leadership and support for delivery reform. The Affordable Care Act places many demands on state leadership and capacity. Most states are devoting their attention to the challenges of planning for insurance Exchanges and integrated enrollment systems, leaving limited capacity to focus on delivery reform. And while ACA offers a number of grant opportunities related to delivery systems reform, most are competitive, and states' constrained capacities make it difficult to devote resources to writing grants.

Insufficient leadership commitment and political will. The need for agency and legislative support from federal and state policymakers, as well as from the private sector, was underscored at the June Forum. Such leadership is essential when forging strategies across levels of government, provider types, and financing mechanisms. More recently, the change in state governors and legislatures serves to underscore the importance of securing political support.

Insufficient federal guidance and flexibility. Both more federal guidance and flexibility were identified as key needs in surmounting the gap between the reality and the vision for transforming health care delivery systems. Forum participants spoke of the value of having federal agencies lay out a road map, while providing states with flexibility on ways to reach the destination.

WORKFORCE - CHALLENGES AND STRATEGIES

Workforce challenges are a priority when addressing delivery system gaps. But in addition to pipeline issues, there is also a real need to rethink how to better train and employ all members of the health care field.

Inadequate provider capacity. Shortages, maldistribution and ineffective use of providers are among the most pressing barriers to achieving system transformation. Even while the system suffers the impact of inadequate numbers of providers where they are needed, participants noted that potential solutions involving changes in scope of practice were very challenging to advance politically. However, participants also noted a failure to ensure that all provider types are practicing to the limits of their scope of practice, or are functioning together efficiently as a team. Many providers currently lack the skills that will be required to operate in a transformed delivery system, including those essential to working in multidisciplinary teams.

Limited knowledge base. Forum participants noted that there is a limited amount of best practices and evidence showing the path forward towards an increased, more efficient, more effective workforce. Additionally, there is a lack of adequate tools to even assess the nature and magnitude of workforce shortages or to understand the impact that strategies, such as increasing provider rates, have on participation in the workforce.

New “outside the box” pipeline strategies and team models needed. While there is no silver bullet to addressing workforce issues, there was agreement on the need to be more creative with strategies, both to increase the pipeline and to define and develop provider and team roles. ACA includes some investments in workforce strategies that could provide resources and mechanisms for testing and moving to scale a variety of strategies. ACA also includes an expansion of the National Health Service Corps, which can help both with the pipeline and immediate needs in underserved communities. Parallel state health service corps programs were seen as a promising strategy for creating pipelines that would meet state-specific needs.

Other new approaches to meet current demands, such as shorter training programs for physician assistants, were offered at the Forum. Forum participants also recommended more effective use of graduate medical education funding and residency slots to match supply with demand. Other financing issues and strategies also surfaced, including the ideas that increased pay for nurse teaching faculty could help build that pipeline. Strategies that attract medical students to primary care from the beginning of their training also were suggested. It is important to build excitement and interest in the field, using such models and mechanisms as the patient-centered medical home and bringing the classroom into health centers. And, to build the type of workforce needed, it will be necessary to revise curricula and core competencies to teach future providers the skills needed to work in a multidisciplinary health care provider team.

Provider training and placement reforms are an important part of achieving needed system capacities, but they not only take time to bear fruit, they are also insufficient to meeting all system needs. Transforming the roles of a range of current and new provider types in the health care system will be essential to achieving system access, quality and cost goals and improved health outcomes. Integrating behavioral health practitioners into primary care teams, as Cherokee Health has done, is a promising strategy. Examination and greater recognition of the roles of community health workers, as in Massachusetts and other states, holds promise for extending primary care teams’ capacity as well as connections with communities. Reviewing the roles of providers against their allowed scope of practice and the respective roles of providers within teams can identify potential changes in practice to maximize the efficiency and appropriate use of each provider’s strengths.

COORDINATION AND INTEGRATION – CHALLENGES AND STRATEGIES

Improved communication between providers both horizontally and vertically offers some of the most promising rewards in not only bettering health outcomes, but also obtaining cost efficiencies.

Barriers to and limited spread of integration models. The need for coordination and beyond, to integration, in the health care delivery system is well recognized and much discussed, but achieving it is

highly challenging. As noted earlier, different cultures and incentives tend to divide rather than unite state policymakers and health care plans and providers, especially FQHCs, which operate under strong federal direction and incentives. Forum participants noted that the links between primary, specialty and hospital providers are increasingly problematic and dictated strongly by hospitals. Health centers report that they are only notified, on average, 23 percent of the time their patient has an emergency room visit, and that they receive discharge-summary reports from hospitals only 35 percent of the time.³⁹ While a number of models for various types of integration exist, such integration is not widespread.

Developing, testing and spreading models for coordination and integration. Forum participants underscored the need for further development and testing of models for coordination and integration of care, including:

- Behavioral health and primary care integration
- Care coordination
- Telehealth, including use for psychiatric, pharmacy, and school based health services
- Roles for FQHCs or others as “community utilities”, providing services to other providers
- Roles for FQHCs or others as teaching health centers
- Multi-payer approaches

As noted in overall challenges, while a number of integrated care delivery models exist, including those incorporating FQHCs, these models have not been extensively replicated or brought to scale at a state level. This holds true of systems such as Denver Health, which includes an FQHC, public hospital, school-based health clinic and public health department, and of Cherokee Health, the FQHC-CMHC that shared its model of primary and behavioral health care integration at the Forum. While some efforts are underway to disseminate the Cherokee model within the state and beyond, such efforts are not systematic.

In many ways the FQHC model, with its multi-disciplinary, comprehensive and community-based approach to services, lends itself to a coordinated and integrated approach to care delivery. FQHCs in many states and communities have been leaders in relevant service models such as primary and behavioral care integration, chronic disease management, and patient-centered medical homes. Yet more needs to be done to help more FQHCs adopt such approaches and work effectively as part of broader state and community systems that engage other providers and plans.

ALIGNING MEASUREMENT AND PAYMENT – CHALLENGES AND STRATEGIES

Paying for quality or value-based care has been one of the most difficult challenges in reaching the vision of a reformed delivery system. Yet, the research attention and demonstrations that focus on payment reform provide fresh ideas and new opportunities to address this challenge.

Difficulties of bringing the players together. Given the current differences in incentives and disincentives that drive the priorities and behavior of various players in health care systems, the difficulty of bringing them together was identified as a primary challenge in efforts to align those incentives. Without a compelling common interest or external driver for alignment, variation in resources and positions in the marketplace, as well as concerns for bottom lines, can work against alignment.

Inadequacies in current data systems. Other major challenges identified include weaknesses in the current systems for collection, analysis, sharing and reporting of data. Many states are operating with old “legacy” data systems that do not yield the data needed in today’s environment, and in many states, data

systems are siloed by programs and do not talk to each other. Some data systems, such as those for FQHCs, are driven by federal requirements, and do not talk effectively with state systems. Participants noted that the pressure to produce data quickly for policymakers only adds to the strains and tends to weaken the quality of the data. Federal policy guidance and funding support announced subsequent to the June Forum holds promise for helping states improve and integrate data systems.

Importance of setting common federal and state measurement priorities. Given the challenges as well as limited resources that can be devoted to collection and analysis of data for performance measurement and payment reform, Forum participants underscored the importance of establishing priorities to ensure consistency across states, payers, plans and providers. Participants called for the federal government to set priorities to promote consistency and avoid redundancy of efforts across states.

Need for tools for consumer engagement. Data alone will not drive system improvements, and Forum participants emphasized the importance of engaging consumers in their own health care, including assessments that can be drivers for aligning system incentives toward quality and population health. Measures aimed at assessing patient engagement and experience should be included in a standard measurement set to evaluate progress in moving towards a more engaged patient. Models for patient engagement, including care management and patient navigators, need to be further developed and supported.

Need for a range of innovative payment and financing strategies. Some very specific suggestions for payment and financing reform emerged through the Forum. It was suggested that federal agencies, including HRSA, CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) align their funding incentives toward delivery system reform. For example, HRSA could give preference to or reward health center grantees that are part of integrated systems. Some participants called for strategies that would affect allocation of resources within systems, possibly through considering a state health planning approach, or by promoting and learning from demonstration efforts such as Vermont's global waiver. Reimbursement reforms to support services and approaches that work to integrate care, such as care management, same day appointments with multiple providers, electronic visits and group appointments, also were recommended.

ASSISTANCE COMMUNITY HEALTH CENTERS AND STATES NEED TO ADVANCE THE VISION FOR A RE-FORMED HEALTH SYSTEM

The state teams and Academy advisors and other NCA partners identified key areas where support was needed from the federal government, foundations, and other stakeholders to advance the vision for a re-formed delivery system. The immediate answer to the question of what areas of technical assistance were needed was a resounding “all”. In many instances, as noted below, the federal government has released guidance and grant support since the Forum was held in June 2010, which is responsive to needs identified at the Forum.

Support for state roles and leadership in delivery reform. Many states have provided leadership in one or more key areas necessary to service delivery reform, including workforce strategies, new models of care delivery, or aligning system incentives. Other states have been less active. Given the primary role of states in implementing national health care reform and the need for service delivery reform to be tailored to state and local circumstances, state leadership is an important ingredient for successful reform, and warrants greater support, especially in the current challenging fiscal climate. Support for leading, innovative states to work together and assist other states in learning and developing or adopting strategies and models that work for them is needed.

Federal guidance, templates and platforms. Throughout the Forum, including in breakout groups, there was a call for federal leadership and assistance in providing tools for states and communities to use in reforming delivery systems. Proactive federal guidance would be helpful in making clear the safe harbors and rules of the road as states, FQHCs and others work to develop models and bring effective approaches to scale. Templates and guidance in areas such as establishing rates that can promote adequate access and quality of care would be helpful. While not a primary focus of this Forum, participants discussed the value of establishing a federal platform for eligibility determinations and enrollment that states could plug into, allowing them to direct more of their scarce time and other resources to delivery system reform, which is necessary to sustain the expansive coverage reforms in ACA. Guidance and assistance on establishing Exchanges that can play a role not only in enrollment, but in shaping the market in ways consistent with system reform goals also were identified needs. Federal action since the Forum, including both guidance and grants available to all states has helped to address much of this need.

State and federal flexibility. Innovation and bringing it to scale requires the ability to try new ways of doing things. These new approaches often are difficult to implement in government agencies that operate under rules that have been built up for many good reasons, such as fraud and abuse prevention, but which can hamstring reform. Forum participants called for greater flexibility in key areas necessary to promoting delivery reform, at both state and federal levels. Greater state flexibility on hiring and procurement could make a big difference to the efficiency and effectiveness of state agency implementation of system reforms. Federal flexibility that would enable integration across programs and providers, including in aligning financial incentives, was emphasized as important to achieving desired system results. Here again, federal action subsequent to the Forum has moved in this direction with guidance on the role of Medicare in medical homes.

Financial support for development, testing and adoption of delivery reforms. Acknowledging that ACA authorizes and funds some support for the work that states, plans, providers and other stakeholders need to accomplish in developing and advancing system reforms, there was a strong call for financial support through mechanisms other than competitive grants, for several reasons. State staffing capacity is strained and little relief is expected in the near term, leaving state agencies often unable to devote resources to grant writing or having to be highly selective in prioritizing which grants they can afford to apply for. Further, participants noted that competitive grants were not the best mechanisms for fostering cooperation and integration. Alterna-

tives to grant funding, such as increases in federal match rates, non-competitive grants, and simplification of application requirements all were suggested for both federal and foundation grant makers. Participants noted a need for funding for basic but critical functions in development and spread of delivery reform, including support for convening the various agencies and stakeholders, and analysis of data that is essential to planning, developing rate reforms, and evaluation.

Partnerships and support in engaging important stakeholders. In moving toward more efficient consumer-centered systems that focus on the health of populations, including the underserved and vulnerable, policymakers, managed care plans, payers, health centers and other providers need to establish ways to bridge differences and unite around achieving common goals. Stronger federal partnerships, including among CMS, HRSA and SAMHSA, are important to modeling, facilitating and supporting partnerships at state and community levels. Stronger partnerships among payers are also key. Multi-payer partnerships hold a great deal of promise in reaching decisions on shared payment, support and measurement policies that an integrated delivery system requires. The state teams and Academy advisors and other NCA partners also cited the need to engage and support key providers across delivery system sectors, including health plans, non-federal health centers, public hospitals and public health agencies.

CONCLUSION AND FOLLOW-UP STEPS

While the assistance described above could be instrumental in moving towards the vision for a transformed delivery system outlined at this Forum, vision and assistance are critical but insufficient ingredients for results on their own. The innovative models that states, health centers and other key system stakeholders have been developing and implementing to achieve better access and higher quality care at a reduced cost suggest the attainability of the vision for a transformed health care delivery system; however, the challenges of overcoming the current gaps in the system are significant. Leadership commitment and political will to put delivery reform on the agenda and provide the supports necessary is essential.

NASHP has and will be following up on the results of the Forum in a number of ways.

- NASHP organized a session at its 2010 conference titled *New Roles for FQHCs in State Delivery System Reform*. The session identified model approaches and new strategies to strengthen, build upon and align community health centers with the existing state delivery system infrastructure in order to create a health system better able to meet state and national health care goals. The session highlighted the challenges in achieving delivery system reform as well as the strategies identified at the June Forum for moving towards the vision of a reformed delivery system. State presenters focused primarily on how FQHCs can engage and work with state health systems and their own provider networks in an effort to improve patient access to care and patient outcomes. A presentation from this conference session is among the most reviewed conference presentations at nashpconference.org.
- Through the National Cooperative Agreement, NASHP will work with Academy advisors and state health policy and primary care teams to explore the issues more in depth and develop more specific potential policy and operational solutions for transforming delivery systems using strategies such as payment reform and health information technology and exchange. Another Forum is being planned for 2011, and NASHP hopes to continue working with selected state teams on systems transformation in the coming years and to spread lessons learned more broadly to other states and to national policymakers.
- Actively communicating the results of the 2010 Forum to federal policymakers and program administrators and seeking their feedback and potential action on suggestions made, through existing and potentially new mechanisms for dialogue and collaboration between states, federal agencies and other key stakeholders.
- Collaborating with National Cooperative Agreement partner organizations including National Association of Community Health Centers (NACHC), Association of State and Territorial Health Officials (ASTHO), and National Conference of State Legislatures (NCSL) to determine ways to foster continued attention to and collaboration on the issues through separate and cooperative efforts.

We urge states, federal agencies, national partner organizations and the community health center community to review the strategies identified through the Forum and consider how they can take steps to address the issues and advance these strategies.

APPENDIX

APPENDIX: FORUM PARTICIPANTS

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ENDNOTES

- 1 NASHP was awarded a two-year NCA with HRSA BPHC in September 2006, and received a second three-year NCA in September 2008. The state teams working with NASHP on the NCA include state Primary Care Associations (PCAs), Primary Care Offices (PCOs) and other state officials such as Medicaid directors.
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