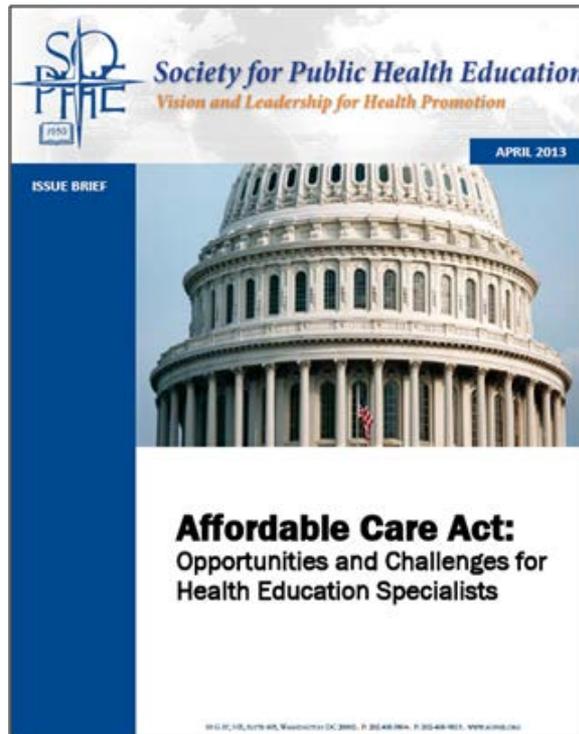


Opportunities and Challenges for Health Education Specialists

under the
Patient Protection & Affordable Care Act of 2010



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Presentation to Arkansas SOPHE: March 14, 2014

Objectives

- ▶ By the end of the session, the participant will be able to summarize the key challenges and opportunities for health educators presented by the Affordable Care Act (ACA).
- ▶ By the end of the session, the participant will be able to identify various pathways for health education specialists to find employment opportunities and market their skills to best fit into patient organizations.
- ▶ By the end of the session, the participant will be able to develop plans and ideas to advocate for the use of health education specialists in their local communities.

Topics:

- ▶ Examine Payer Reform and System/Delivery Reform and the intersection of the two.
- ▶ What is an ACO and PCMH? What is a value payment?
- ▶ The value a health educator can bring to these models of service
- ▶ The challenges of the initial roll out of these payment reform models - a view from the street.
- ▶ Identifying opportunities AND REAL SUCCESSES!
- ▶ Challenges we face.
- ▶ Importance of advocacy on the local level and taking the initiative to begin conversations.

ACA: Very Basic Overview

- ▶ U.S. is moving toward a system that is “health” rather than “sick” focused.
- ▶ Two broad areas of policy change:
 - ▶ 1. Insurance/payer reform
 - ▶ 2. System or delivery reform
- ▶ Additionally there is a focus on the challenges and needs of the public health and clinical workforces (to improve care, access and patient safety) and expanding community-based programming (supporting prevention and promotion).
 - ▶ E.g.: Prevention and Public Health Fund and Community Transformation Grants.
 - ▶ Corporate wellness programs

Payer Reforms - the Need

▶ Old School:

- ▶ Fee for Service: You get a service. They charge a fee.
- ▶ Intentionally or not, this creates financial incentive to provide MORE services without regard to better health outcomes.
- ▶ This is a significant reason why US Healthcare costs have continued to rise. In 2010 we spent 17.6% of our GDP on healthcare (public and private) or 2.5 times the average of Organization for Economic Co-operation and Development countries.
- ▶ WHO ranks the US as 37 in list of efficient countries
- ▶ Cuba, an impoverished nation with embargoes that block many drugs and equipment, matches the U.S. in many major health indicators such as adult mortality rate and healthy life expectancy and beats the US in others such as infant mortality rate, TB detection rate and percentage of newborns with low birth weight.

Payer Reforms

▶ ACA:

- ▶ Value Payment Systems. Incentivize better performance and positive health outcomes.
- ▶ New ground being broken as various value payment systems are being implemented and modified:
 - ▶ *Many of the payment systems are known as Bundled Payments:*
 - ▶ Episode of Care Payment
 - ▶ Capitated payment (fixed payment per person per timeframe)
 - ▶ Capitated payment with Value (adding in a layer for outcomes)
 - ▶ Global fee payment - one payment covering multiple provider services related to a single episode of care
 - ▶ Prospective payment: Predetermined rate per diem or case based.
 - ▶ Medicare Prospective Payment System - based on a fixed amount derived from the DRG (or other relevant classification system) for services.
 - ▶ Bundled Payments for Care Improvement Initiative from CMS. (Largest test yet for a bundled care program)

Payer Reforms

- ▶ Is it Really New Ground?
 - ▶ Many of these systems date back to the development of HMOs in the 1970s.
 - ▶ We will continue to see refinement and change.
 - ▶ Bottom Line:
 - ▶ PAYMENT REFORM = Payment that promotes or leverages greater value for patients, purchasers, payers and providers. “It” creates the parameters for the domains and metrics and scorecards used for rewards.
 - ▶ *****Value oriented payment: must reflect quality and safety of care; spur efficiency; reduce unnecessary spending. *****
 - ▶ If it only addresses efficiency, it is not value-oriented.

System/Delivery Reform

- ▶ Two Models du Jour:
 - ▶ Accountable Care Organizations (ACO)
 - ▶ Patient Centered Medical Homes (PCMH)
- ▶ Although focused on service delivery they are very closely tied to payment reform

ACO

- ▶ Currently associated with Medicare Providers and held to existing quality measures used by Medicare Shared Savings Program.
- ▶ Performance metrics (which result in financial bonuses):
 - ▶ 1. Patient Experience
 - ▶ 2. Care coordination and patient safety across a full array of providers
 - ▶ 3. Preventive Health
 - ▶ 4. Serving at-risk populations
- ▶ Shared Savings/Shared Loss across the associated practices

PCMH

- ▶ Heavily associated with Medicaid providers
 - ▶ Not new. Originated in 1967 by American Academy of Pediatrics and evolved into the Patient Centered Care Collaborative
 - ▶ Original emphasis: centrally locating a child's medical records
 - ▶ Overarching principle: care coordination for patient across all members of health care team ideally under one roof.
 - ▶ Many chronic diseases (e.g., HIV) have been moving towards or using this model for some time.

PCMH

- ▶ Today the principles of a PCMH include:
 - ▶ Whole person orientation through the life course and inclusive of familial environment
 - ▶ Coordinated/integrated care so a patient receives what they need where they need it in a culturally and linguistically appropriate manner.
 - ▶ Patient participate in decision making and feedback
 - ▶ Appropriate reimbursement recognizes the added value of non-physician staff who help coordinate care and improve communications as well as incentivize achievement of measurable and continuous quality improvements.

ACO and PCMH

Similarities

- ▶ Patient Oriented
- ▶ Improved outcomes
- ▶ Coordinate Care
- ▶ Lower costs through Payment Reform

ACO and PCMH - Differences

PCMH

- ▶ Physician directed medical practice.
- ▶ Physician responsible for patient coordination.
- ▶ A one-stop-shop for all outpatient services.

ACO

- ▶ Tend to be larger entities.
- ▶ May house many practices under one coordinating and billing entity.
- ▶ May or may not include a hospital.
- ▶ Patients free to seek care outside of ACO but care will be coordinated by the ACO.
- ▶ Shared Savings/Loss among all participating practices.

Reality Check

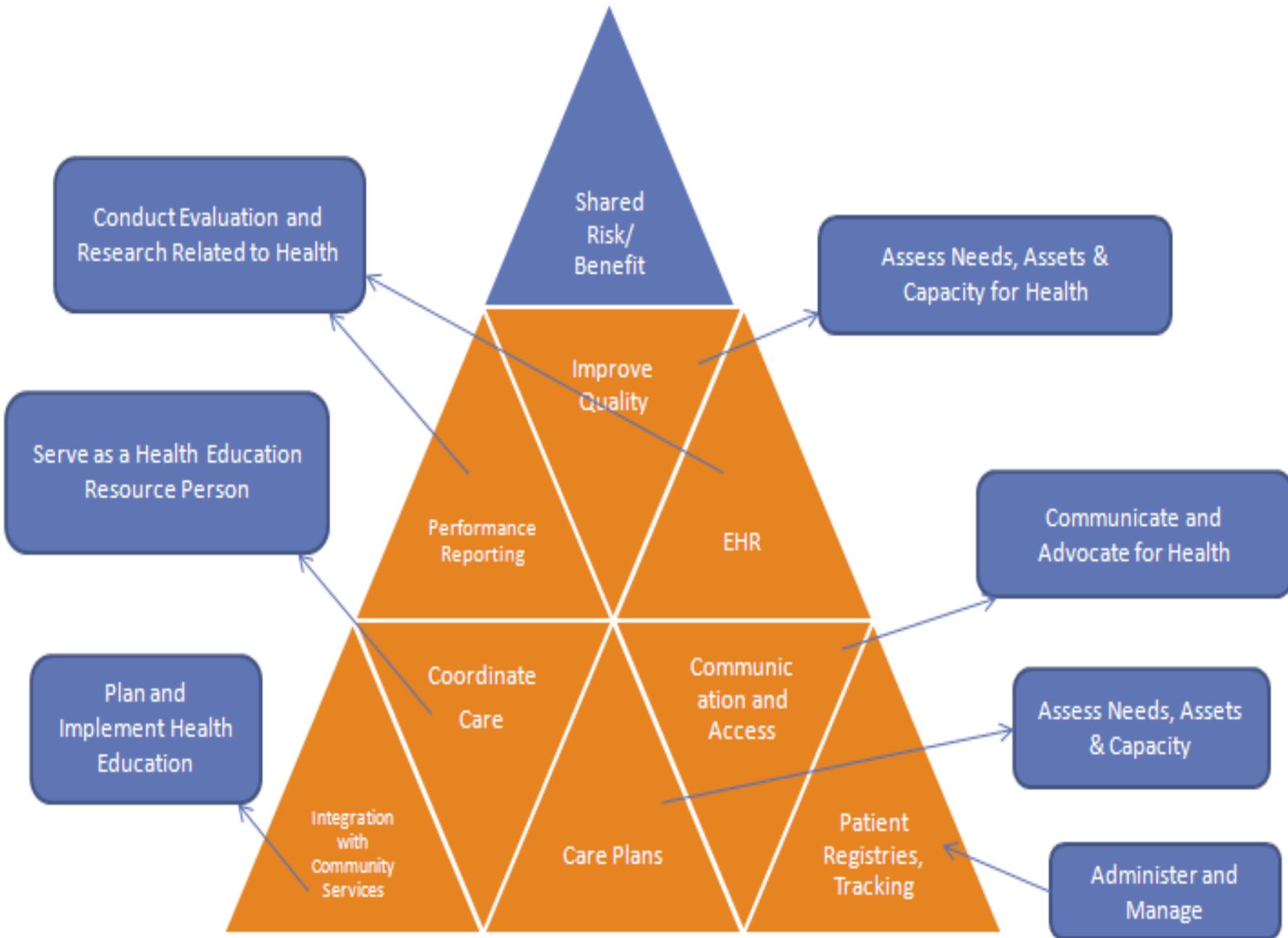
- ▶ If you have seen one ACO you have seen just one ACO.
- ▶ Insurance companies are contracting with ACOs to achieve goals related to cost containment.
- ▶ Market forces are driving the initial introduction/creation of ACOs.
 - ▶ There are PPO-ACOs and HMO-ACOs
- ▶ Private insurers are, in many cases, pushing back and introducing limited networks that will unilaterally exclude prominent providers.
 - ▶ California examples: CalPERS (the State's Retirement System) excluded Sutter Health (a major Northern California provider) from retiree plans. The City of Los Angeles excluded a major hospital (Cedars-Sinai) from its plans.

LATE BREAKER:

- ▶ Minnesota created the first ACO for MEDICAID.
- ▶ 10 FQHCs have joined together with a cumulative Medicaid patient load of 23,000.
- ▶ ACO called Federally Qualified Health Center Urban Health Network (FUHN)
- ▶ It created strategies and processes to work toward cost and quality benchmarks, and the challenges it faces in pursuing a care delivery model based on collaboration.
- ▶ Under their three-year ACO contract, the participating health centers will be collectively held accountable for meeting performance benchmarks
- ▶ They will collectively share in savings***

Health Education Specialists and ACOs ---

A natural fit!



A Natural Fit

- ▶ Health Education Specialists (HES) are suited to play a role in every phase of care and prevention service delivery.
- ▶ We have a strong focus on standards and quality assurance
- ▶ Individual Level:
 - ▶ Strengthen the physician directed team improving patient outcomes
 - ▶ Coordinate and integrate care
 - ▶ Self Management, coaching, bridge to community resources
 - ▶ EBIs for health improvement and reduction of chronic disease complications
 - ▶ Theories and models of behavioral change
 - ▶ Advocacy to help evaluate and select proper coverage

A Natural Fit

▶ Community Level:

- ▶ HES have extensive knowledge of community assets and the ability to connect people to them.
- ▶ We have the skill to conduct community needs assessments.
- ▶ We are trained to build coalitions and mobilize communities to create a bridge between patients and health organizations requiring engagement and feedback.
- ▶ We focus on cultural competency.

A Natural Fit

▶ System Level:

- ▶ HES are trained to identify a health problem using an ecological model, develop an action plan or intervention and evaluate its success.
- ▶ We can serve as a resources for other health professionals, including the primary care team, to evaluate the clinical services being provided.
- ▶ Our multi-disciplinary education and training allows for truly culturally competent, patient-centered programs where structural barriers are identified along with the medical diagnosis.

A Natural Fit

- ▶ Summary:

- ▶ Outcomes on all levels will be improved with proper evaluation for measurement.

OPPORTUNITIES



Opportunities through Innovations and Possibilities

- ▶ 1. Working with the Primary Care Team
- ▶ 2. Additional Clinical Competencies
- ▶ 3. Community Centered Health Homes
- ▶ 4. Marketplace Navigation
- ▶ 5. New CMS Rule for Medicaid and CHIP beneficiaries
- ▶ 6. Corporate Wellness
- ▶ 7. Prevention Funding/Workforce Strengthening/
Infrastructure Investments.

1. Working with the Primary Care Team

- ▶ The value and utility of a HES working within a primary care team is well established.
- ▶ 40 years of literature supporting the concept.
- ▶ ARE WE FINALLY READY?
 - ▶ Participate in new models of service delivery
 - ▶ Broaden our impact

Working with the Primary Care Team - Example

- ▶ Sutter Health System - Northern California
 - ▶ St. Luke's is a safety net hospital in the Mission District of San Francisco. Nearly all patients are uninsured or on Medi-Cal (Medicaid)
 - ▶ Lost about \$25 million in 2007. Has never been profitable.
 - ▶ Is in process of implementing a new structure for personnel.
 - ▶ To preserve the valuable time of a doctor and best utilize a nurse (functionally and financially), a layer of Health Educators has been inserted to act as a "physician extender" and a patient will receive a "warm" hand-off to the health educator

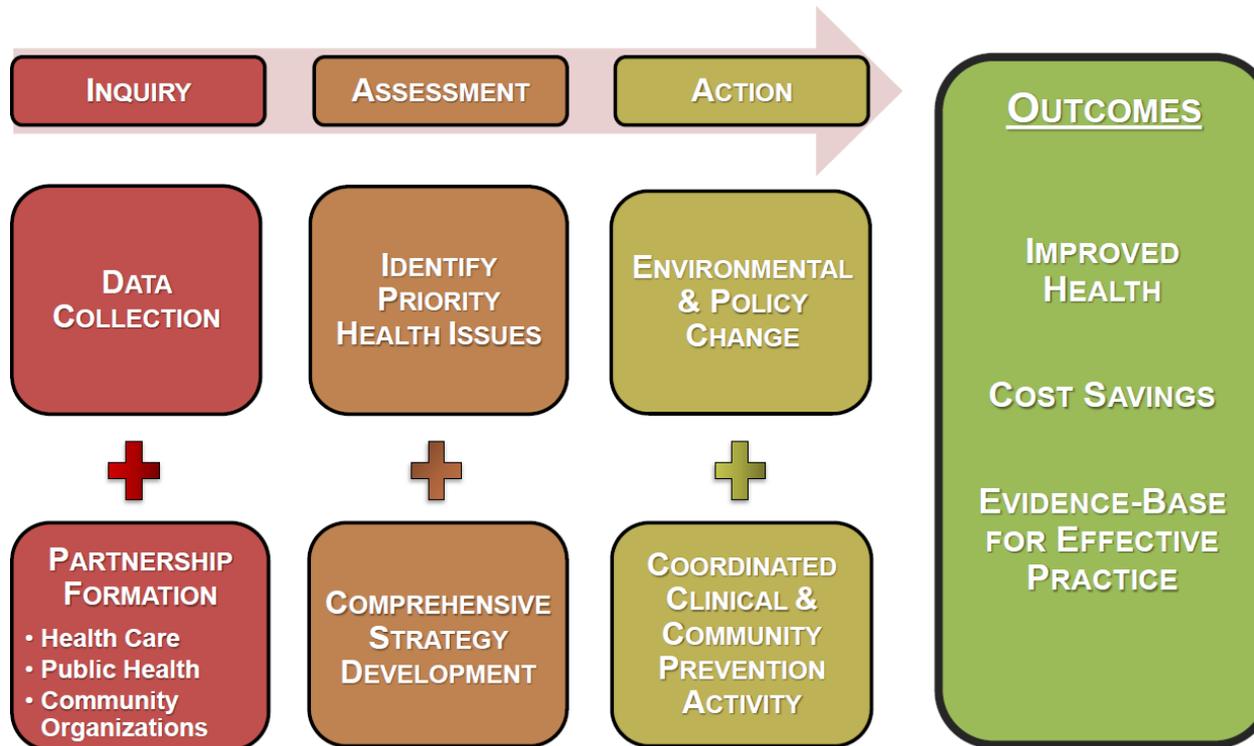
2. Additional Clinical Competencies

- ▶ Should we be having a discussion - locally on up to nationally - on adding appropriate competencies to improve a HES's clinical value?
- ▶ Could be part of standard curriculum or could be through additional credit hours for specialization.
- ▶ Example: An HES with MCHES may now sit for the Certified Diabetes Educator exam with 15 continuing education credit hours applicable to diabetes. (And required practice experience that is recognized by the National Standards for Diabetes Self Management Education.
- ▶ Asthma? Cardiac care?
- ▶ WHY?
 - ▶ Becomes easy to have hours reimbursed by appropriate payer
 - ▶ We become even more valuable and versatile. YES WE CAN do it all

3. Community Centered Health Homes

► Idea put forth by The Prevention Institute.

CLINICAL/COMMUNITY POPULATION HEALTH INTERVENTION MODEL



4. Marketplace Navigation

- ▶ The roll-out of grant funding for navigators has essentially been used for community health workers versus health educators.
- ▶ Opportunities exist :
 - ▶ Learn the marketplace
 - ▶ Train to receive enrollment certification or gain the knowledge to supervise.
 - ▶ Seek jobs that will allow you to design the outreach programs and supervise the navigators.
 - ▶ Remember - the hard to reach populations or those with the most barriers to understanding enrollment will be the focus of efforts once the initial rush to enroll (by those who can) is over.
 - ▶ Lots to truly understand - lots to educate.
 - ▶ As of March 1, 4.2 million have enrolled out of 13 million eligible. Original goal: 7 million. Revised goal 5.5-6 million.

4. Marketplace Navigation

- ▶ As of March 1, 2014, Arkansas has:
 - ▶ 58,173 individuals eligible to enroll in a marketplace plan. 38,500 of those are eligible for financial assistance.
 - ▶ 57,455 individuals determined to be eligible for Medicaid/CHIP by the Marketplace.
 - ▶ 27,395 (total) have selected a plan.
- ▶ Yet, a recent amendment was made to the Arkansas Medicaid - Private Option that prohibits the use of any funds to promote either the ACA or the availability of coverage.
- ▶ This will impact health educators! Places like University of Arkansas Medical Services may not have a formal promotion program but certainly want people insured if possible.

5. CMS RULE

- ▶ Effective 1/1/14: the Centers for Medicaid and Medicare Services (CMS) has changed an important regulation:
 - ▶ Relates to the provision of prevention services to Medicaid and CHIP recipients.
- ▶ It allows a state Medicaid program to reimburse for any preventive service provided by a professional outside of a state's clinical licensure system *if* the service has been recommended by a physician or other licensed practitioner.
- ▶ **ADVOCACY:** Make sure this is implemented in your state! Work with other groups with shared interest.

6. Corporate Wellness

- ▶ Programs have been increasing over several years even before the Reform
- ▶ Large businesses have begun to realize the value of a healthy workforce.
- ▶ ACA offers strong economic incentives to both employer and employee.
 - Employee: A savings of up to 30% of their health care costs upon achievement of specific biometric milestones
 - Employer: Lower insurance costs and proven increases in productivity (less sick time)

7. Prevention/Promotion Funding

- ▶ Prevention and Public Health Fund:
 - ▶ \$14.5 BILLION investment over 10 years.
 - ▶ First mandatory funding stream dedicated to improving health and prevention of chronic disease through evidence based community programs.
 - ▶ One component: Community Transformation Grants which address chronic disease through policy, environmental and infrastructure changes. Sadly, Arkansas did not receive any of this money and all CTG funding has been terminated in the upcoming budget.
 - ▶ Still, recent Omnibus Spending Bill doubles funding for state-level diabetes, heart disease and stroke prevention.
 - ▶ \$1Billion - We are grateful. But the Fund is not where it should be.
 - ▶ \$369 million increase to CDC and HRSA had 60% of sequestration cuts restored.

CHALLENGES



Challenges are what
make life interesting.

Overcoming them is
what makes it
meaningful.

Challenges

- ▶ Ambiguity of Job Titles: patient navigator, patient activator, health coach, patient advocate, community health worker, care coordinator, patient navigator, marketplace navigator....\ul> - ▶ Navigator was initially used around 1990 to reduce disparities in breast cancer.
 - ▶ AMA defines “navigator” as a role “filled formally or informally by individuals with clinical, legal, financial or administrative experience or ... has personal experience facing health care-related challenges.”
- ▶ High degree of overlap that leads to inconsistencies of job titles
- ▶ Arkansas Board of Health Education: is it possible for that board to work on standards of care or best practices?

Scope of Practice for Selected Public Health Educators/Workers

Role/Competency	Title of Profession							
	Health Educator (CHES)	Registered Dietician (RD)	Asthma Educator (AE-C)	Community Health Worker	Patient Navigator	Patient Advocate	Care Coordinator	Health Coach
Assess Needs, Assets and Capacity	X			X				
Comprehensive Planning of Health Education Program	X							
Implement or provide culturally appropriate Health Promotion and Education programming	X	Specific to healthy eating	Specific to asthma	HIV, cancer screening, diabetes, CV, other	Primarily cancer		PCMH	PCMH
<ul style="list-style-type: none"> Provide self-management support 	X	X	X	X	Emerging		Emerging	X
<ul style="list-style-type: none"> Bridge the gap between clinician and patient 	X	X	X	X	X		X	X
<ul style="list-style-type: none"> Help patients navigate the health care system (includes access to care) 	X	X	X	X	X	X	X	X
<ul style="list-style-type: none"> Offer emotional support 	X	X	X	X	X	X	X	X
<ul style="list-style-type: none"> Serve as a continuity figure 	X	X	X	X	X		X	X
<ul style="list-style-type: none"> Bridge the gap between communities and the health and social service systems 	X			X	Emerging		Emerging	
Evaluate and Research	X							
Administer and Manage	X							
Serve as a Resource Person	X	X	X	X		X	X	X
Communicate and Advocate	X			X		X	X	
Reimbursement	Primarily grants	Yes	Yes	Some states or grants	Primarily grants	Own business	Yes, Usually RN or LSW	Yes, if RN or own business

Challenges

- ▶ Reimbursements; Payment Models and Value
 - ▶ We have moved from a system that rewards lots of service (fee for service) to a system that will reward achievement of health through large incentives.
 - ▶ But are the payment models (and metrics used to measure success) going to allow sufficient margin for health education specialists and prevention activities that are meaningful?
 - ▶ Community Preventive Services Task Force (CDC) - synthesizing data for policy recommendations. Be involved - make comments - look for ways to participate.

Challenges: Prevention and Public Health Fund

- ▶ Fund is in constant jeopardy despite being a cornerstone of the ACA.
- ▶ Risk is not partisan - it is coming from both sides of the aisle.
 - ▶ President Obama has proposed significant "raids" on the fund in his past budgets. The fund was used for the Medicare "doc fix".
- ▶ We must protect this investment. Remember prevention has a 5 to 1 return on investment.

HOW CAN WE HELP YOU?

- ▶ There is plenty to be done on all levels.
- ▶ Can or should SOPHE be doing something or providing you something to help?
- ▶ LET US KNOW!

Acknowledgments

- ▶ SOPHE (www.sophe.org)
- ▶ The Prevention Institute (<http://www.preventioninstitute.org/component/jlibrary/article/id-298/127.html>)
- ▶ Trust for America's Health (http://healthyamericans.org/health-issues/story_category/community-transformation-grant?type=prevention_story)
- ▶ Full references/citations are available upon request.

Questions? Thank you!

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