Improving the Health Status of Your Community

Friday, February 24, 2017 | 1:30 PM Eastern/12:30 PM Central

Sponsored by the ABA Center for Professional Development
ABA Health Law Section
Greater San Antonio Healthcare Foundation
South Texas Chapter, American College of Healthcare Executives
South Texas Chapter, Healthcare Finance Management Association
Faculty

• Moderator: Justice Rebeca C. Martinez, Fourth Court of Appeals, San Antonio, TX
• Panel Members:
  – Montrece McNeil Ransom, CDC, Atlanta, GA
  – Dr. Anil T. Mangla, University of the Incarnate Word, San Antonio, TX
  – Cary Fox, CHRISTUS Health, Irving, TX
  – Corinne Smith, Strasburger and Price, Austin, TX
Agenda

- Introductions
- Topics:
  - A Judge’s Perspective
  - A Public Health Lawyer’s Perspective
  - A Clinician’s Perspective
  - An Administrator’s Perspective
  - A Private Legal Practitioner’s Perspective
- Questions
Rebeca C. Martinez, Justice, Fourth Court of Appeals, San Antonio, TX
Our Panelists’ Topics

• What our panelists will address:
  – Justice Martinez: Thoughts from the bench
  – Montrece McNeil Ransom: Legal epidemiology
  – Dr. Anil T. Mangla: A clinician’s perspective
  – Cary Fox: An administrator’s perspective
  – Corinne Smith: A healthcare attorney’s perspective
Thoughts from the Bench

- Judiciary and its role in any health emergency
- Scope of government’s emergency and police powers and relation to public health
- Concerns about emergencies and how they impact on the community
- Collaboration between courts, legal professionals, and public health officials and experts
- Tools for effective management of future public health disasters
Montrece McNeil Ransom, JD, MPH, Team Lead, Training and Workforce Development, Public Health Law Program

Office for State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention, Atlanta, GA
The contents of this presentation have not been formally disseminated by the Centers for Disease Control and Prevention and should not be construed to represent any agency determination or policy.

These materials are for instructional use only and are not intended as a substitute for professional legal or other advice.

Always seek the advice of an attorney or other qualified professional with any questions you may have regarding a legal matter.
Social Determinants of Health

3 miles could equal up to 13-year life span difference

Kansas City, Missouri

Minneapolis and St. Paul, Minnesota

Life Span for Given Location


www.americanbar.org | www.abacle.org
Maintaining healthy housing
Creating transportation infrastructure
Promoting social and cognitive development through educational laws and policies
Legal epidemiology is the study of law as a factor in the cause, distribution, and prevention of disease and injury in a population.
Legal Epidemiology

We use legal epidemiology to
- Understand trends in law
- Study the impact and effectiveness of laws on health
- Inform and support best practices
- Develop an evidence base of what works

Legal Language Authorizing Involuntary Decontamination in Emergency Response to Radiological Incidents, by State and Select Cities

www.cdc.gov/phlp/docs/php-radioactive.pdf
Legal Assessments
What do laws say across jurisdictions on a topic?

Policy Surveillance
How do laws across jurisdictions change over time?

Association Studies
Do trends in law relate to trends in health?

Investigation Studies
What impact does the law have on health, cost, and the health system?
2012 Fungal Meningitis Outbreak Due to Contaminated Injectable Steroids

PROBLEM: Contaminated steroid given to many patients in hospitals and pain clinics across the United States

- **20 States**
- **751 Infections**
- **64 Deaths**
- **FDA Recall**
Evaluated Public Health Access to Electronic Health Records

- Interviews with health departments generated
  - List of barriers
  - Suggestions to overcome barriers
  - Highlight best practices and policies
  - Practical tools
Many perceived legal barriers to data use and release
- Not all are actual legal prohibitions

Overcoming perceived barriers
- Identify technologic solutions
- Identify legal solutions
Developed Toolkit on Accessing Electronic Health Records

- Worked with ASTHO to develop toolkit for health departments for perceived and actual barriers to EHR during outbreaks

<table>
<thead>
<tr>
<th>Best Practices for Access and Use of EHRs</th>
<th>Build and Sustain Good Relationships with Healthcare Facilities Before, During and After Outbreaks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evolving National Efforts and Resources to Improve Information Exchange</td>
<td>Address Patient Privacy, Authority and Security Concerns</td>
</tr>
</tbody>
</table>
How Do We Use Law To Affect Social Determinants of Health?

Contact:
Montrece McNeill Ransom, JD, MPH
mransom@cdc.gov

For more information, contact CDC
1-800-CDC-INFO (232-4636)

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Anil T. Mangla, PhD, MPH, FRSPH, Director of Public Health, Associate Professor, University of the Incarnate Word, San Antonio, TX
Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

-World Health Organization

Adapted from http://www.cdc.gov/socialdeterminants/FAQ.html
### Top 5 causes of preventable death
Bexar County, TX and US, 2013

**Preventable Deaths (rate per 100,000 people of all ages)**

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>Bexar County</th>
<th>Texas</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>175.6</td>
<td>170.7</td>
<td>169.8</td>
<td></td>
</tr>
<tr>
<td>Cancer, all</td>
<td>151.6</td>
<td>156.1</td>
<td>163.2</td>
<td></td>
</tr>
<tr>
<td>Chronic Obstructive</td>
<td>49.5</td>
<td>42.3</td>
<td>42.1</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>38.7</td>
<td>40.1</td>
<td>36.2</td>
<td></td>
</tr>
<tr>
<td>Diabetes (only)</td>
<td>23.5</td>
<td>21.6</td>
<td>21.2</td>
<td></td>
</tr>
</tbody>
</table>
Life expectancy at birth is the average number of years a newborn infant would be expected to live if healthy and living conditions at the time of birth remained the same throughout his/her life. Although life expectancy is a good starting point for discussing mortality patterns, it is important to note significant limitations of this measure.
All Diseases Rate
Bexar County, 2014

Census Tract
Rate by 100,000
(Quantiles)
- 33.3 - 352.7
- 352.8 - 548.8
- 548.9 - 719.2
- 719.3 - 977.4
- 977.5 - 2,108.3
- no cases
- suppressed data

(Chlamydia, Gonorrhea, Syphilis, HIV)

N = 11,218

15,508 cases in 2014
28% = 4,290 unable to geo-code
Diagnosed and undiagnosed diabetes among people 18 years or older, Bexar County, 2014

194,556
or 14.2% of adults have diabetes

54,087 adults may be undiagnosed diabetics

439,807 or 32.1% of adults in Bexar County are obese

479,540 or 35% of adults are pre-diabetic

Source: Texas BRFSS 2014, Summary Table, Bexar County - Weighted Data. Has a doctor, nurse, or other health professional ever told you that you have diabetes? Population 18 and older 2014 American Community Survey 1-Year Estimates
## Texas Hospital Inpatients Diagnosed with Diabetes or Diabetic Amputations by County, 2014

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Diagnosis of Diabetes</th>
<th>Rate of Diabetes per 1,000</th>
<th>Diabetics Amputations</th>
<th>Rate of Amputations per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris</td>
<td>4,447,577</td>
<td>98,573</td>
<td>22.2</td>
<td>2,804</td>
<td>28.4</td>
</tr>
<tr>
<td>Bexar</td>
<td>1,860,274</td>
<td>47,702</td>
<td>25.6</td>
<td>1,909</td>
<td>40.0</td>
</tr>
<tr>
<td>Dallas</td>
<td>2,519,625</td>
<td>56,801</td>
<td>22.5</td>
<td>1,854</td>
<td>32.6</td>
</tr>
<tr>
<td>Tarrant</td>
<td>1,946,346</td>
<td>41,516</td>
<td>21.3</td>
<td>1,277</td>
<td>30.8</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>831,561</td>
<td>23,464</td>
<td>28.2</td>
<td>712</td>
<td>30.3</td>
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<tr>
<td>El Paso</td>
<td>835,545</td>
<td>22,041</td>
<td>26.4</td>
<td>622</td>
<td>28.2</td>
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<tr>
<td>Travis</td>
<td>1,150,996</td>
<td>17,670</td>
<td>15.4</td>
<td>591</td>
<td>33.4</td>
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<td>Nueces</td>
<td>356,494</td>
<td>11,766</td>
<td>33.0</td>
<td>489</td>
<td>41.6</td>
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<tr>
<td>Cameron</td>
<td>420,400</td>
<td>12,993</td>
<td>30.9</td>
<td>375</td>
<td>28.9</td>
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<tr>
<td>Collin</td>
<td>886,052</td>
<td>12,978</td>
<td>14.6</td>
<td>343</td>
<td>26.4</td>
</tr>
<tr>
<td><strong>Texas</strong></td>
<td><strong>26,979,078</strong></td>
<td><strong>649,761</strong></td>
<td><strong>24.1</strong></td>
<td><strong>20,927</strong></td>
<td><strong>32.2</strong></td>
</tr>
</tbody>
</table>

Source: Hospital Discharge  Texas Hospital Inpatient Discharge Public Use Data File.  
Texas Department of State Health Services, Center for Health Statistics, Hospital Discharge principal or other Diagnosis of diabetes or surgical or other procedure, ICD-9 code Diabetes mellitus 250, ICD-9-CM Amputations Procedure Code 84
Percent Diagnosed with Diabetes By Education, Bexar County

Source: U.S. Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS), Bexar County, 2014
HbA1c Control in patients within Bexar County by Age Group (n=13,856)
Projection of Complications from Diabetes Among Adults with Prediabetes or Diabetes in San Antonio in 20 Years

- End-Stage Renal Disease: Current 1.66%, Reduce A1c by 1% 0.92%
- Lower Extremity Amputation: Current 4.55%, Reduce A1c by 1% 2.91%
- Blindness: Current 15.09%, Reduce A1c by 1% 10.69%
- Myocardial Infarction: Current 23.82%, Reduce A1c by 1% 17.87%
- Stroke: Current 9.81%, Reduce A1c by 1% 7.15%

Legend: Red = Current, Blue = Reduce A1c by 1%
Projection of Chronic Health Conditions and their Consequences among Adults in San Antonio in Years

- Diabetes: 38.0% Current, 35.5% Improve Lifestyle
- Hypertension: 47.9% Current, 45.2% Improve Lifestyle
- High Cholesterol: 87.3% Current, 84.3% Improve Lifestyle
- Myocardial Infarction: 8.0% Current, 7.6% Improve Lifestyle
- Stroke: 5.1% Current, 4.9% Improve Lifestyle
Cost Saving Projection from Reducing A1c by 1% among Adults with Pre-diabetes or Diabetes in San Antonio in 20 Years

<table>
<thead>
<tr>
<th></th>
<th>End-Stage Renal Disease</th>
<th>Lower Extremity Amputation</th>
<th>Proliferative Retinopathy</th>
<th>Myocardial Infarction</th>
<th>Stroke</th>
<th>Total Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Averted Incidence</td>
<td>1,942</td>
<td>4,304</td>
<td>11,548</td>
<td>15,616</td>
<td>6,981</td>
<td></td>
</tr>
<tr>
<td>Annual Costs (per person)</td>
<td>$28,874</td>
<td>$16,010</td>
<td>$9,003</td>
<td>$7,569</td>
<td>$8,929</td>
<td></td>
</tr>
<tr>
<td>Annual Cost Savings</td>
<td>$56 Million</td>
<td>$68 Million</td>
<td>$103 Million</td>
<td>$118 Million</td>
<td>$62 Million</td>
<td>$409 Million</td>
</tr>
</tbody>
</table>
Cary Fox, MBA, FACHE, Executive Director, Population Health
CHRISTUS Health, Irving, TX
CHRISTUS Health

International Catholic, faith-based, not-for profit health system comprised of almost 350 services & facilities, more than 60 hospitals and long-term care facilities, 175 clinics & outpatient centers and dozens of other health ministries & ventures.
CHRISTUS Health

The mission of CHRISTUS Health is to extend the healing ministry of Jesus Christ

Vision
CHRISTUS Health, a Catholic health ministry, will be a leader, a partner and an advocate in the creation of innovative health & wellness solutions that improve the lives of individuals & communities so that all may experience God’s healing presence & love.
What’s Driving Health System Change?

- Health care costs continue to grow while health outcomes are not improving
- The biggest payer of health care services – CMS - is changing how care is paid for and delivered


- All payers are following this lead
- Health systems across the country are rapidly changing the way they organize and deliver care
- Enormous investments being made in infrastructure and resources to reshape care delivery
It’s Not Just Health Systems.....

- Physicians, other providers now face major changes in payment with MACRA
  - CMS Quality Payment Program (QPP) will base future payment on outcomes
- QPP will lead to greater alignment between health systems and providers
- CHRISTUS has implemented ACOs and clinically integrated networks to foster provider alignment, move toward a population-based care model
CMS Payment Model Framework

Category 1
Fee for Service – No Link to Quality
• 100% volume

Category 2
Fee for Service
Link to Quality
• Linkage to quality and/or efficiency

Category 3
Alternative Payment Models using FFS
Architecture
• Track 1 MSSP ACO

Category 4
Population-based Payment
• At risk Pioneer ACO and others
• “Advanced APMs”

Source: CMS

All Medicare FFS

Year 2016
30%
85%

Year 2018
50%
90%
Health Systems Living in 2 Worlds
While improving “Population Health” is a critical goal of society, **CHRISTUS Health’s** primary focus in our Congregations’ medical/health care ministries is providing **high quality, well-coordinated** medical services (and coordinating non-medical social support services as appropriate) that improve the **quality/value/outcome** of the care we provide in a coordinated manner so that they **improve health** of the **community one patient at a time**.
CHRISTUS’ Focus on Population Health

Population Health will play a more important role in the ever changing healthcare environment. What is the strategy?

CHRISTUS Health will provide care to defined segments within our communities in the right place at the right time while improving quality, being good stewards of resources and improving outcomes.
CHRISTUS: Moving From Volume to Value

- Understanding the populations we serve – health and social determinants
- Fostering patient engagement and relationships with providers
- Changing culture and behavior – physician, patient, payer
- Harnessing robust clinical and financial performance data – complex and costly
- Implementing comprehensive care coordination infrastructure – changing the care delivery process
- Aligning physician, non-physician networks (evidence-based care, integrating data, standards of performance)
Aligning the Continuum of Care

Patient-Centered, Physician-Friendly Care

- Inpatient
- Outpatient
- Acute Care
- Long-Term Care
- Home Care
  - Remote Patient Monitoring
  - Home Visits
- Urgent Care
- Emergency Care
- PCP
Aligning Data to Manage our Populations

CHRISTUS is focused on the alignment of data and systems* which enables to:

- Make strategic decisions
- Risk stratify patients and populations
- Analyze potential opportunities for care improvement and cost reduction
- Assess gaps in care delivered

*Disparate systems make data integration difficult
Aligning the Delivery System

CHRISTUS Connected Care Network - San Antonio

www.americanbar.org | www.abacle.org
Population Health: CHRISTUS’ Targeted Approach

Categories Adapted from the Triple Aim

The IHI Triple Aim
Population Health

Programs targeted by:

- RACE
- SocioEconomics
- Ethnicity

<table>
<thead>
<tr>
<th>1. Population Health</th>
<th>1.1 Decrease 30-Day ED Revisit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 Improve utilization of primary care services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Care Experience</th>
<th>2.1 Identify culturally competent components integrated into program</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2 Patient Satisfaction by Program Survey</td>
<td></td>
</tr>
</tbody>
</table>

| 3. Cost Avoidance | 3.1 Utilization & Cost Comparison to Baseline (HEDI Department to Calculate) |
SRH Westover Hills Top Chronic Diagnostic Codes
Target Zip Codes – FY2016

HYPERTENSION: 1,271
TYPE 2 DIABETES: 656
HYPERLIPIDEMIA: 335
ATHEROSCLEROSIS & CORONARY ARTERY DISEASE: 261
GASTROESOPHAGEAL REFLUX DISEASE (GERD): 247
ANXIETY DISORDER: 234
HYPOTHYROIDISM: 181
END STAGE RENAL DISEASE: 162

All Other Top Diagnostic Codes, 20%
Hypertension + Type 2 Diabetes + Hyperlipidemia + Atherosclerosis & Coronary Artery Disease + End stage renal disease, 80%
Population Demographics For Target Diagnoses - FY 2016

Targeted Diagnostic Codes
- Hypertension
- Type 2 Diabetes
- Hyperlipidemia
- Atherosclerosis & Coronary Artery Disease
- End Stage Renal Disease

Bar chart showing percentages for:
- Race: Hispanics - 48%
- Insured - 93%
- Insured PCP - 78%
- Age: 55+ - 66%
- Gender: Female - 59%
A Population Health View: Analyzing Risk and Coordinating Care*

*FFS Medicare beneficiaries with one or more chronic conditions, and whose costs are predicted to move up at least 10%ile pts. and who are predicted to be in the top 40\textsuperscript{th} %ile in the next 12 months (Movers)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Race</th>
<th>Age</th>
<th>Population Category</th>
<th>Predicted Risk Index</th>
<th>Concurrent Risk Index</th>
<th>Predicted Cost</th>
<th>Frailty Risk</th>
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<tbody>
<tr>
<td>Female</td>
<td>Unknown</td>
<td>77</td>
<td>Movers</td>
<td>2.64</td>
<td>0.86</td>
<td>$23,605.15</td>
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<td>Male</td>
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<td>73</td>
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<td>2.61</td>
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<tr>
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<td>Movers</td>
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<td>2.10</td>
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<td>$21,645.52</td>
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<td>Movers</td>
<td>2.33</td>
<td>1.53</td>
<td>$20,871.18</td>
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<td>Movers</td>
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<td>0.86</td>
<td>$20,829.01</td>
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<td>Female</td>
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<td>59</td>
<td>Movers</td>
<td>2.32</td>
<td>0.65</td>
<td>$20,761.94</td>
<td>Yes</td>
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</tbody>
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A Population Health View: Focusing on Wellness and Prevention

![Bar Chart]

- **PQI14 - Influenza Immunization**
  - Compliant: 40
  - Non-Compliant: 101

- **PQI15 - Pneumococcal Immunization**
  - Compliant: 60
  - Non-Compliant: 123

- **PQI19 - Colorectal Cancer Screening**
  - Compliant: 49
  - Non-Compliant: 0

- **PQI20 - Mammography Screening**
  - Compliant: 33
  - Non-Compliant: 0
What’s Next?

• Without fundamental change, healthcare costs will continue to increase

• Health systems must remain agile in the ever-changing healthcare environment
  – This is definitely a journey

• Health systems are embracing value-based, population-focused health care
  – It is the right thing to do
  – New payment models will accelerate this change

• Our common goal must be:
Corinne Smith, JD, MHA, FACHE, Strasburger and Price, Austin, TX
Organized Health Care Arrangements: A HIPAA Construct for Population Health
OHCA as defined by HIPAA

An organized health care arrangement (“OHCA”) can involve clinical or operational integration among *legally separate* covered entities in which protected health information is shared for the joint management and operations of the arrangement.
OHCA Criteria

A clinically integrated care setting in which patients typically receive care from more than one healthcare provider:

• participating covered entities hold themselves out to the public as participating in a joint arrangement; and

• joint activities of the participating covered entities include at least one of the following:
  – Utilization review
  – Quality Improvement & Assessment
  – Payment Activities
Joint Activities Detailed

• **Utilization Review.**
  - Care decisions by participating entities are reviewed by other participating entities or by a 3rd party on their behalf.

• **Quality Assessment & Improvement Activities.**
  - Treatment provided by participating entities is assessed by other participating entities or by a 3rd party on their behalf.

• **Payment Activities.**
  - If the financial risk for delivering health care is shared by participating entities, the protected health information created or received by a covered entity is reviewed by other participating entities or by a 3rd party on their behalf for the purpose of administering the sharing of financial risk.
Community Care Collaborative (CCC)

- A non-profit corporation formed by Central Health, the hospital district in Travis County, and Seton Healthcare Family.
- Participants include:
  - Dell Medical School at the University of Texas,
  - Seton Healthcare Family,
  - Austin Travis County Integral Care,
  - local FQHCs, and
  - other providers.
OCHA: Example in Action

CCC provides care to an underserved population in Travis County. Its overarching goal is to improve local health outcomes by coordinating care across a spectrum of healthcare and social service providers.

- Improve quality of care
- Create a longitudinal patient record available at point of care
- Population health management
- State, national and regional reporting on 1115 waiver Delivery System Reform Improvement Projects
- Financial analysis
- Develop predictive analytics and clinical decision making tools
- Reduce duplicate services and unnecessary costs in the health care system
Health Care Operations

Compliance Activities
• QA/QI
• Peer review
• Healthcare professional training
• Accreditation
• Licensing
• Credentialing
• Medical reviews, legal and auditing services

General Administrative Activities
• Business Planning & Development (including formulary development)
• HIPAA Compliance
• Customer Service/Patient Satisfaction
• Grievance Resolution
• Marketing
• Eligibility & Claims
Designing an OHCA: Core Documents

• Participation Agreement
• Policies and Procedures
  – Who is in charge?
  – Contracting authority?
  – Communication of changes?
  – Removal of participants?
• Joint Notice of Privacy Practices
• Cyber Liability Coverage
All participants are required to use a Joint Notice of Privacy Practices (“Notice”).

The Notice should reflect the fact that it covers more than one provider and describe the OHCA and providers to which the Notice applies.

If applicable, the Notice should state that the covered entities participating in the OHCA will share PHI with each other, as necessary to carry out treatment, payment or healthcare operations relating to the OHCA.
Why Choose an OCHA Model?

• Improved quality of care
• Seamless care delivery system
• Population health management
• Cost savings (reduces redundant care)
• Reduces need to obtain and track individual patient consents
• Patient navigation