At-A-Glance Year 4 Summary

August 14, 2023 – August 13, 2024

In Year 4, **Integrated Care DC**, a learning community for DC Medicaid providers, delivered practice coaching, live and on-demand webinars, and collaborative learning. The initiative enhanced provider and organizational capacity to deliver person-centered care across the care continuum; use data and population health analytics to address complex medical, behavioral health, and social needs; and engage leadership to support value-based care.

Integrated Care DC has made significant strides, empowering DC Medicaid providers to deliver integrated, whole-person care and prepare for value-based payment (VBP) models. In Year 4, our combined efforts resulted in measurable improvements in care integration, directly benefiting patients and positioning our healthcare system for a more efficient, patient-centered future.

Key Achievements:

Practice-Level Coaching

We provided tailored support to **39** practice teams from **35** organizations. Of 24 practice sites with at least six months of coaching, **82%** scored at or above an intermediate level of integration with gains in such areas as care planning, digital tool utilization, and screening.

Community-Level Training

Our learning collaboratives and webinars reached **113** individuals from **62** organizations, including FQHCs, hospitals, and primary care and behavioral health providers. About **75%** of training participants were newly engaged with Integrated Care DC.

Online Resources

We maintained a comprehensive learning library of tools and training materials at the award-winning **IntegratedCareDC.com** website, ensuring that providers have **24/7** access to valuable resources.

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Preparing for Value-Based Care

Integrated Care DC supports an informal community of practices by engaging the broad DC provider community in group learning centered on core competencies for integrated, whole-person care, and by allowing providers to share best practices and learn from each other's experiences. During Year 4, sessions focused on preparing providers for value-based care through three learning series.

Leadership Through Change Learning Collaborative

Convened December 2023 through August 2024, the Leadership Through Change Learning Collaborative introduced and reinforced practical leadership skills for individuals in management and decision-making roles to support their teams in moving toward successful value-based contracting. The collaborative series comprised core sessions and cohorted small-group and peer learning, with an associated Integrated Care DC lead to guide participants through the series and provide individualized support.

- **50** leadership representatives from 27 FQHCs, hospitals, and behavioral health organizations participated.
- **97%** of participants plan to apply something they learned to their practice, as they reported greater confidence in leading organizational change, understanding alternative payment models, and implementing collaborative care.

Photo: Leadership Through Change Learning Collaborative, February 21, 2024

Value-Based Care Learning Collaborative

The year-long Value-Based Care Learning Collaborative launched in July 2024 is focused on improving care and outcomes tied to payment through Medicaid value-based payment arrangements in the District of Columbia, and on how VBP programs can help improve financial sustainability. Participants will receive tailored assistance over four learning cycles, leveraging virtual and in-person group sessions, peer-to-peer learning, and 1:1 coaching.

Cost of Care Learning Series

The four-part Cost of Care Learning Series, convened November 2023 through May 2024, emphasized the importance of understanding and managing healthcare costs for better business decisions. Topics included cost calculation and its impact on financial strategies, and the relationship between healthcare costs and quality outcomes. A tool for determining the cost of care accompanied the sessions, which engaged 32 representatives from 23 provider organizations.

Insights shared by participants:

I will immediately incorporate the lens of incentives when evaluating internal and external policies.

I plan to work with my team to begin analysis of potentially preventable hospitalizations within our clinic.

I plan to apply what I learned today about using CRISP, [and] the importance of follow-up hospital and ER encounters to maximize revenue incentives.

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Coaching Practices for Success

Integrated Care DC enrolled providers in individual practice coaching on a rolling basis to allow for flexibility in engagement and to facilitate higher levels of ongoing participation. Integrated Care DC coaches responded to practice needs discovered during the onboarding and assessment process. This personalized approach allowed us to address specific challenges and opportunities within each practice, leading to more targeted improvements.

In Year 4, we saw improvements in key integration metrics.[1]

82%
of practices scored at or above an intermediate level of integration.

29%
of practices improved their processes for screening, assessment, and follow-up.

33%
of practices enhanced person-centered care planning.

33%
of practices advanced in the use of digital tools such as the CRISP DC HIE.

These improvements translate to more comprehensive, coordinated patient care. Better screening and assessment mean health issues are caught earlier. Enhanced care planning ensures that treatment is tailored to individual needs. Using digital tools via electronic health record (EHR) systems or the CRISP DC Health Information Exchange (HIE) to get care alerts, create patient registries, and conduct population health analytics means smoother information sharing and fewer gaps in care. These advancements lay the groundwork for a successful transition to value-based care. As practices become more integrated and efficient, they're better positioned to improve outcomes while managing costs – the core goal of value-based payment models.

Practice Spotlight:
Improved referral processes at **HIPS**

With the practice-level coaching provided by Integrated Care DC in Year 4, HIPS, a DC-based harm-reduction organization, successfully established formal partnerships to improve referrals for integrated care, built communication mechanisms with key referral partners, and implemented a referral tracking system to ensure follow-through.

> Integrated Care DC has helped HIPS to be able to form partnerships in a way that is not only sustainable but standardized. [The coaches] have provided a wealth of resources that they made accessible and impactful for our specific needs. We have felt consistently supported, understood, and valued during our time working with them.

[1] Based on year-over-year assessment of 24 practice sites that completed at least six months of coaching in Year 4.

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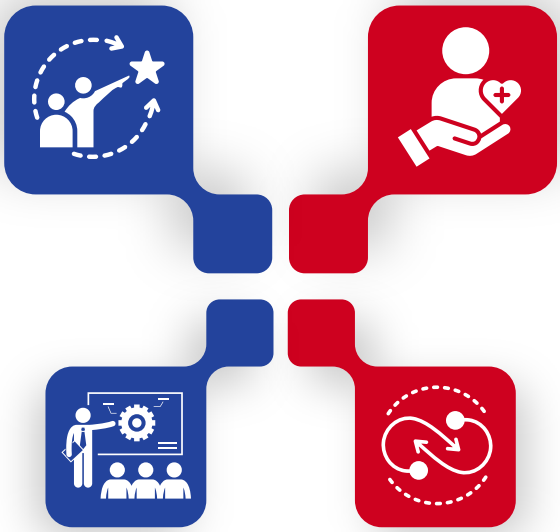
Vision for Year 5: What's Next

Our vision is a future where every Medicaid beneficiary in DC receives high-quality, integrated care that addresses their whole-person needs, delivered by providers thriving in a value-based care environment. Integrated Care DC aims to catalyze a transformation in DC's healthcare landscape by focusing on the following two strategic priorities:

Priority 1

Deliver quality improvement and value-based care readiness support that pairs group learning with individual practice coaching and peer-to-peer sharing opportunities.



Priority 2

Foster linkages among health and social service organizations and Medicaid managed care plans to address health-related social needs.

Aims:

Increase provider understanding of quality metrics, how to use digital health tools to improve care, and how quality metrics relate to payment.

Aims:

Prepare social service organizations to participate in the District's Medicaid program and enhance referral networks to improve person-centered care.

DHCF
Department of Health Care Finance

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