Objectives

- Identify key steps for practice or system leadership that support physician/provider/staff engagement in performance (value) payment opportunities
- Recognize quality improvement action steps that correlate to improved performance payment
- Distinguish how transitions of care decrease ED utilization and readmissions
- Implement key initiatives that move toward success in risk based contracts
Alternative Payment Model (APM) TRENDS

RESULTS
2015 Data: 23%
2016 Data: 29%
2017 Data: 34%
2018 Data: 50%

GOALS
Goal of U.S. health care payments linked to quality and value through APMs.
2016 at least 30%
2018 at least 50%

RESULTS
2015 Data: 23%
2016 Data: 29%
2017 Data: 34%
2018 Data: 50%
Characteristics of Success in APM

- Know your patients and your data
  - Attribution
  - Quality and cost reporting
- Build a dedicated team
  - Physician/leader engagement
  - Staff involvement
- Quality reporting to all
- Coding

OPTIMIZING
PERFORMANCE PAYMENT

Sandy Huckabee RN, BSN
Clinical Quality Coordinator
Willis Knighton Physician Services
JOURNEY TO PERFORMANCE PAYMENT SUCCESS

2014
- Administration review of quality reports & struggled with what to do
- Quality improvement efforts were fragmented and siloed
- Payers seemed to continually move the goals
- Initial efforts to create a quality team
- Performance was in the lower tier of mid payment group with major payors

2015
- Quality leads partnered to create a structured approach

2016
- Partnered with Quality Impact PTN
JOURNEY TO PERFORMANCE PAYMENT SUCCESS

2018
- Expanded the team for quality work
- Attribution cleanup
- Structured the work with the QI Clinical Action Program
- Expanded quality data sharing
- Achieved top tier for quality improvement payment with major payer

2019
- Continue to engage the team and achieve success on quality
- Expand focus on cost management
  - Created CIN
  - Joined MSSP
MANAGING ATTRIBUTION

GOAL: Accurate attribution, insures that we know the patients we are caring for

Engage leadership & team
Confirm accurate PCP on all patients
Inactivate deceased patients
Engaged IT developer to clean up scripts in MDI
MANAGING ATTRIBUTION: STAFF LEVEL WORK

- PCP field in demographics is mandatory
- Created a PCP pending option for patients who do not identify a PCP
- Provided resources for staff to provide patients who do not identify a PCP, emphasizing the importance of having a PCP.
- Educate all on the value of accurate PCP information, helps all understand the population they are caring for.
- Driving force is to ensure accurate data.

Jesse Langford said it best “I am just a big believer in data integrity”.
MULTI FACET QUALITY APPROACH

- ENGAGED physician leadership and clinical staff
  - Worked with our Quality director to develop and implement a Hypertension protocol
  - Physician to physician training on the HTN protocol
  - Held mandatory in-services for all clinical staff (RN, LPN, MA and office managers) surrounding the HTN protocol

- Participated in the SPRINT & CAP program thru Quality Impact

- Optimized payer & pharma resources to improve quality:
  - Humana provided a quality clinical advisor to support one of our larger clinics to help close HEDIS gaps.
  - Pfizer pneumovax postcard project

- Created an ER/IP hospital discharge report for clinics to utilize

- Screening initiatives:
  - Breast cancer screening initiative
  - RetinaVue Project (1 PCP and 1 endocrinology)
    - Improved access to retinal eye exam
QI Clinical Action Plan (CAP):

- Structured our approach to quality improvement at clinic level
- Created a competition for our primary care clinics, that included monetary awards:
  - Highest quality for HTN control
  - Most improved in HTN control
  - Highest quality for diabetes control
  - Most improved in diabetes control
- Set goals for improvement
- Reviewed baseline and trending data

Quality team goal was to improve patient care and outcomes while engaging the entire clinic in the process. We were trying to encourage everyone to feel like they had a part in the clinics successes.
Pierremont Family Physicians (5 physician clinic)

- Office Manager took the lead.
- Identified patients with HTN and diabetes gaps in care
- Prioritized:
  - Patients with controlled HTN or diabetes, overdue for visit
  - High risk: patients with HTN or diabetes, but poorly controlled-not at goal or in need of an appt
- Engaged the team:
  - Meet with all clinical staff to discuss goals of CAP
  - Educated the front staff on the importance of encouraging patients to keep and make follow up appointments
- Provided unblinded quality data weekly to all physicians
- In the end, only about 3 staff members and 3 physicians worked on it whole heartedly. However, they worked to improve the outcomes for the entire clinic.
- This clinic won HIGHEST HTN CONTROL
**Tristate Medical Clinic**

Physician led approach for this clinic

- Worked with quality team to obtain & share unblinded HTN data for all of the physician in this clinic monthly

- Dr Stuart met with the physicians monthly to discuss goals and progress

- Quality team provided them with lists of patients with poorly controlled HTN. The clinic staff worked to get patients in for needed appointments.

- Physicians, providers and staff encouraged patients to make and keep all follow up appts

- This clinic won most improved A1c control

**DIFFERING APPROACHES**
JOURNEY:
PERFORMANCE/VALUE PAYMENT
BCBS QBPC PROGRAM-HTN CONTROL — ALL PCP CLINICS

Baseline 2017  
Current

[Graph showing performance trends over time]
JOURNEY:

PERFORMANCE/VALUE PAYMENT
BCBS QBPC PROGRAM - DIABETES CONTROL HGBA1C < 8

Baseline 2017

Current

Reporting Period

July 2017

Nov. 2018

Score (m%)
As a network:

We improved our Hypertension control by 9%.

We improved our A1c control by 8%.

Different approaches worked.

Distribution of the “prize” money is very difficult.
Moved from low end of Tier 3 for payment to top of Tier 4

Attribution cleanup resulted in additional $125,000 at next payout
As a network and each clinic:

Set new goals based on payer revenue opportunities

Improve / Expand our data sharing work

Continue to work to engage team and share lessons learned

Improve revenue from performance to build infrastructure

QUALITY WORK CONTINUES
OPTIMIZING PERFORMANCE REVENUE

Gail Williams, BSN RN
Director of Quality/Post Acute Care Management
Ballad Health Physician Group Legacy Wellmont Medical Group
Key for Improvement

• **Understand your contracts**

• **Understand your population and data**

• **Know the language**

• **Identify what impacts the quality**

• **Select priority populations / measures**

• **Engage the team**
History of Quality Journey

• Initial Step - move the quality metrics
  o Definitive goals to optimize payment i.e. Hedis, STAR ratings
  o Identify the priority patient populations impacting lost revenue
    • Patients using ER & hospital
    • Patients with Diabetes
  o Implement programs with revenue opportunities that align with quality
    ▪ Transitions of Care (TCM) Program
    ▪ Annual Wellness Visit
    ▪ Medicare Advantage Patient Assessment

• Structure the work:
  ▪ Quality Impact Sprint & CAP programs
Transitions of Care

- Population: Patients with ER visit & Hospitalization
- Developed Transition Care Management (TCM) program to impact admissions/ readmissions.
- Optimize FFS revenue: TCM & increased post hospital E & M visit billing
- Identify high risk patients (frequent ER users and hospital use) for Chronic Care Management (CCM)
Chronic Care Management

• Managing chronic (high risk) patients included moving them from TCM program to Chronic Care Management (CCM) Program.
• Defined high risk patient
  – Frequent ER visit & hospitalizations
  – Complex/poorly controlled chronic disease
• Developed a Chronic Care Management (CCM) program
  – Provider education
  – Develop EMR ability to mark CCM status
  – Allow TCM nurses to refer for potential CCM
  – Built improved team thru TCM/CCM interactions (physicians/provider/TCM-CCM staff)
    • Physician/provider referral to CCM
• Financially viable approach to meeting needs of high risk patients
Next Step: Cost Savings

• Identify patient population
  – High cost
  – High Risk – ER/Hospital high utilizers; Poorly controlled

• Chronic Care Management
  – Provide ongoing care to decrease hospital admissions

• Coding – Coding – Coding
  – Accurate coding reflects the complexity of the patient
  – Coding impacts risk status which impacts reimbursement
CODING

• Enhance coding knowledge within your team:
  – Review upcoming appointments for HCC code gaps
  – Review previous documentation to ensure optimal coding

• Engage physicians/providers
  – Peer to peer education with physician coder
  – Individual and practice specific
  – Use payer offered help in coding education
<table>
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<tr>
<th>Time Frame thru Nov.</th>
<th>All Readmission</th>
<th>All Acute Admissions</th>
<th>All ED Rates</th>
<th>Chronic ED Rates</th>
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<tr>
<td>WMA 2017</td>
<td>14.09</td>
<td>269.5</td>
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<td>225.8</td>
<td>472.1</td>
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<td>% Reduction</td>
<td>20%</td>
<td>16%</td>
<td>10%</td>
<td>16%</td>
</tr>
</tbody>
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Impact on Commercial Payer

**Risk Score**

- 2013: 0.99
- 2015: 1.11
- 2016: 1.13
- 2017: 1.14
- 2018: 1.15

**COST: Medical Expense Ratio**

- 2013: 0.86
- 2014: 0.869
- 2015: 0.9
- 2016: 0.87
- 2017: 0.82
- 2018: 0.8
Value Based Payment: Taking Risk

CURRENT RISK is Upside Only: 25% Shared Savings
2018 - $302,820

Full Risk Option: 100% Shared Savings
2018 potential was $1.6 Million
## Current: Quality/Care Management Framework

### Quality
- Identify care gaps
- Identify needs/social determinants
- Confirm regular appointments
- Communicate to provider office via appointment notes

### TCM/CCM
- Follow up after hospitalization and when appropriate, refer to CCM
- Use Data base for reporting opportunities and tracking of work per nurse.

### CODER
- Review gaps in coding, emphasize those that impact risk score
- Ensure documentation that reflects complex work

### EMR
- EPIC allows for 1 patient, 1 record
- External results and records are also stored where they can be reviewed
- Health maintenance shows needs, risk score available after admission

### REPORTS
- Population Registries for priority patients – diabetes, MA
- Reporting Workbench
- Payer reports- all needed to keep track of the population
- Reports by provider allows us to track where additional teaching is needed

### CARE COORDINATION
- Handovers between sites of care (transitions), chronic care and complex care.
- The quality team works hand in hand with each other, the patient and with the practice
Success in Value Based Care

- Know/Understand your Contracts
- Build a Team Approach
- Technical Support
- Understand Barriers
- Consider New & Innovative Programs

• NEVER STOP LEARNING & RE-EVALUATING
The Road Ahead
It is a Continuous Process

Thank you
DISCUSSION & QUESTIONS