East Hawaii IPA

Sustaining Improvement Workshop Series

Workshop#1: Before Visit

National Kidney Foundation™ of Hawaii

East Hawaii IPA

PRACTICE SUPPORT

Best practice workshops

Individualized Coaching

Strengthen IT resources

Hired consultants

Facilitate CPC+ support

Hire manager & staff to deploy services

Engage Data Analyst & QI Expertise

RESOURCE CENTER

Establish Care Coordination hub of critical services:

Transitions of Care

Complex Care Management

Diabetes Management

Behavioral Health, ACP

Referrals fro Palliative Care/Hospice

OPERATIONS

Strategically align interests & serve as steward for financial & other resources

Oversee & deploy resources

Manage contracts, HR, IT

Engage membership & community

Set policies & procedures

Organize annual Symposium

ACRONYMS:

MIPS

TCM

C

QRS

MACRA

QPP

CPIA

P

PT

CPIQI

P4P

APM

AWV

PT

C

TCOC

eCQM

+

CMS

HEDIS

CCM

WEBSITES:

CPC+ HELPDESK

CPCPlus@cms.hhs.gov

CPC+ WEBINARS

https://engage.vevent.com/index.jsp?eid=7381&ecid=64

CPC+ eCQM

https://innovation.cms.gov/Files/x/cpcplus-qualrptpy2017.pdf

MIPS – QPP WEBSITE

https://qpp.cms.gov

HMSA Payment Transformation Toolkit

https://hmsa.com/portal/provider/zav_pel.aa.PAY.100.htm

HMSA P4Q

https://hmsa.com/portal/provider/1180-7076_P4Q_Guide_Commercial_QUEST_AA_Primary_Care_010117.pdf

MOVING FROM VOLUME BASED CARE TO VALUE-BASED CARE

WORKSHOP SERIES OVERVIEW

Workshop 1

- Empanelment
- Pre-visit planning
- Care Team
- Guidelines

Workshop 2

- Visit flow
- Care plan
- Patient self-management

Workshop 3

- Monitoring panel
- Closing referral loops
- ED and Hospital follow up

WORKSHOP TIMELINE AND CALENDAR

Workshop 1

FEBRUARY & MARCH

- Session 1 = What & Why
- Session 2 = break out sessions - How

Workshop 2

APRIL & MAY

- Session 1 = What & Why
- Session 2 = break out sessions - How

Workshop 3

JUNE & JULY

- Session 1 = What & Why
- Session 2 = break out sessions - How

VOLUME BASED CARE

VALUE-BASED CARE

BEFORE VISIT

EMPANELMENT

CARE TEAM

PRE-VISIT PLANNING

GUIDELINES

BEFORE VISIT

EMPANELMENT

Provider and team actively manage assigned patients so that continuity of care and access can be sustained

WHY?

Empanelment is a proven method to create continuity for both patients and providers.

In turn, patient continuity is associated with reductions in:

- **appointment demand,**
- **hospitalizations,**
- **referrals,**
- **labs and imaging,**
- **prescriptions, and**
- **no-show rates**

BEFORE VISIT

EMPANELMENT

Provider and team actively manage assigned patients so that continuity of care and access can be sustained

Attribution

Risk Stratification

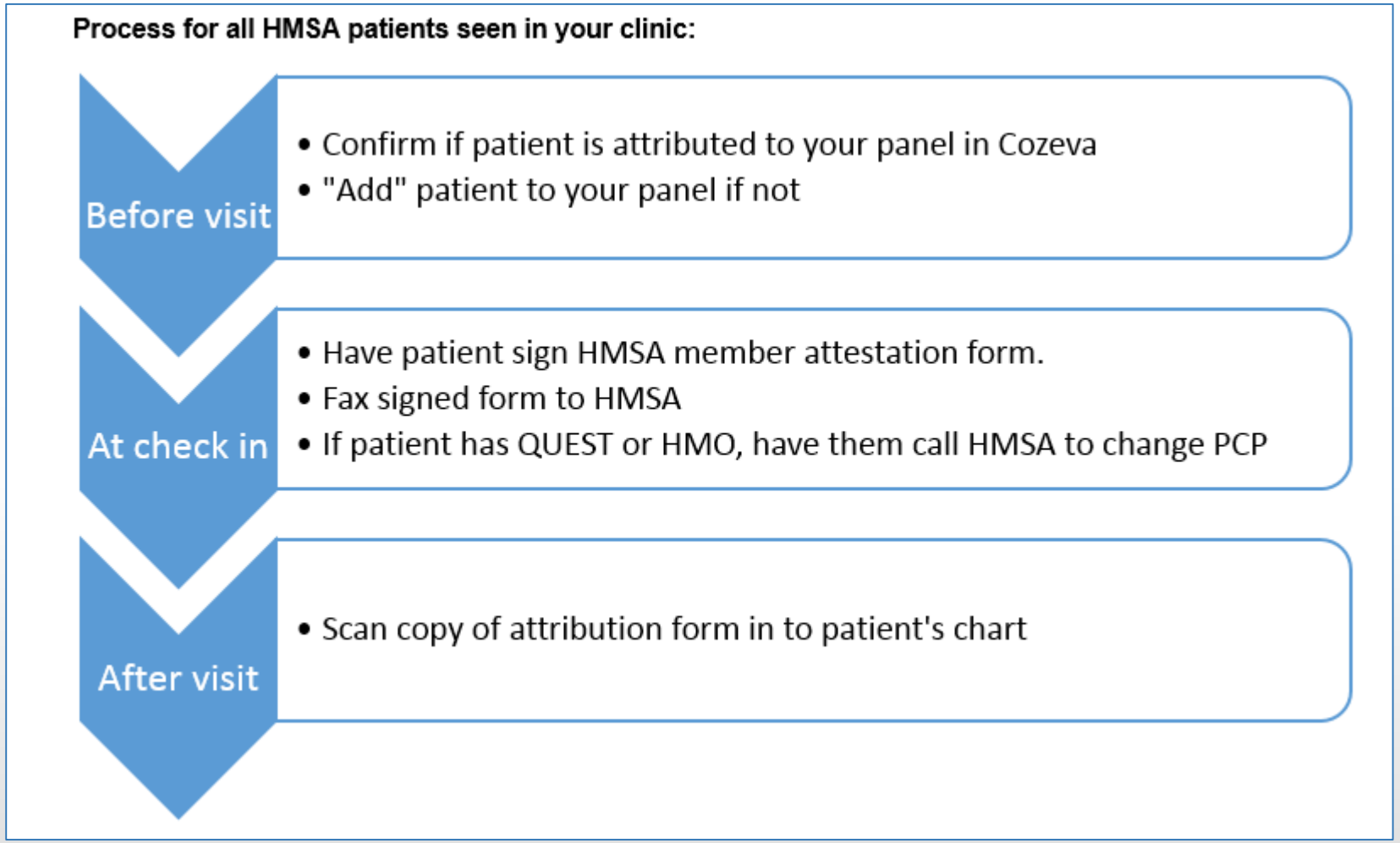
Touches

Annual Wellness Visits

Attribution

- Links each patient with an assigned provider or team
- Panel assigned by the insurance company
  - Member selection
  - # of visits
  - Recently seen
  - CMS (CPC+): Annual Wellness Visit

HMSA process detailed in PT Toolkit



Risk Stratification

PREDICT

risk

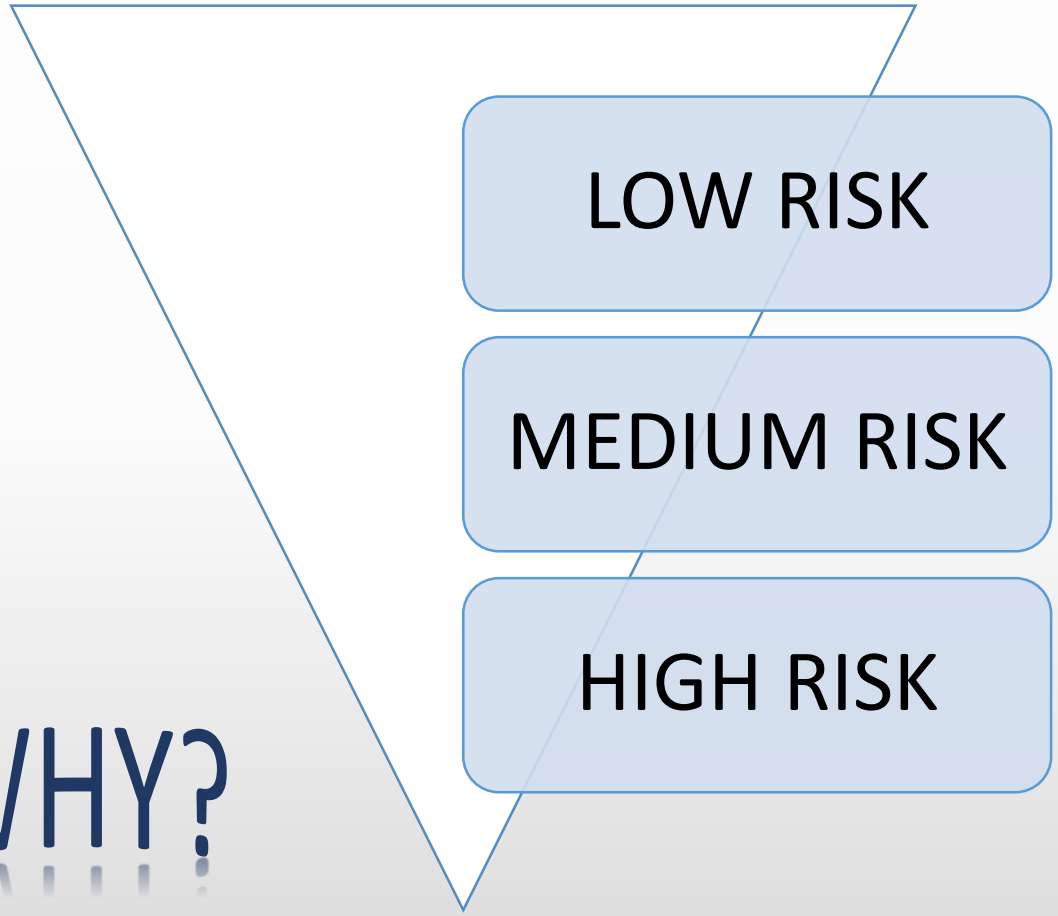
PRIORITIZE

interventions

PREVENT

Negative outcomes

Risk Stratification



IDENTIFYING PATIENT PANEL CHARACTERISTICS:

- **Healthy**
- **Chronic Disease**
- **High Risk/Complex**

WHY?

REDUCE COST, BETTER COORDINATE CARE

Risk Stratification

KEEP THEM HEALTHY!!
PREVENTATIVE SCREENINGS, WELLNESS & EDUCATION

LOW RISK

MEDIUM RISK

HIGH RISK

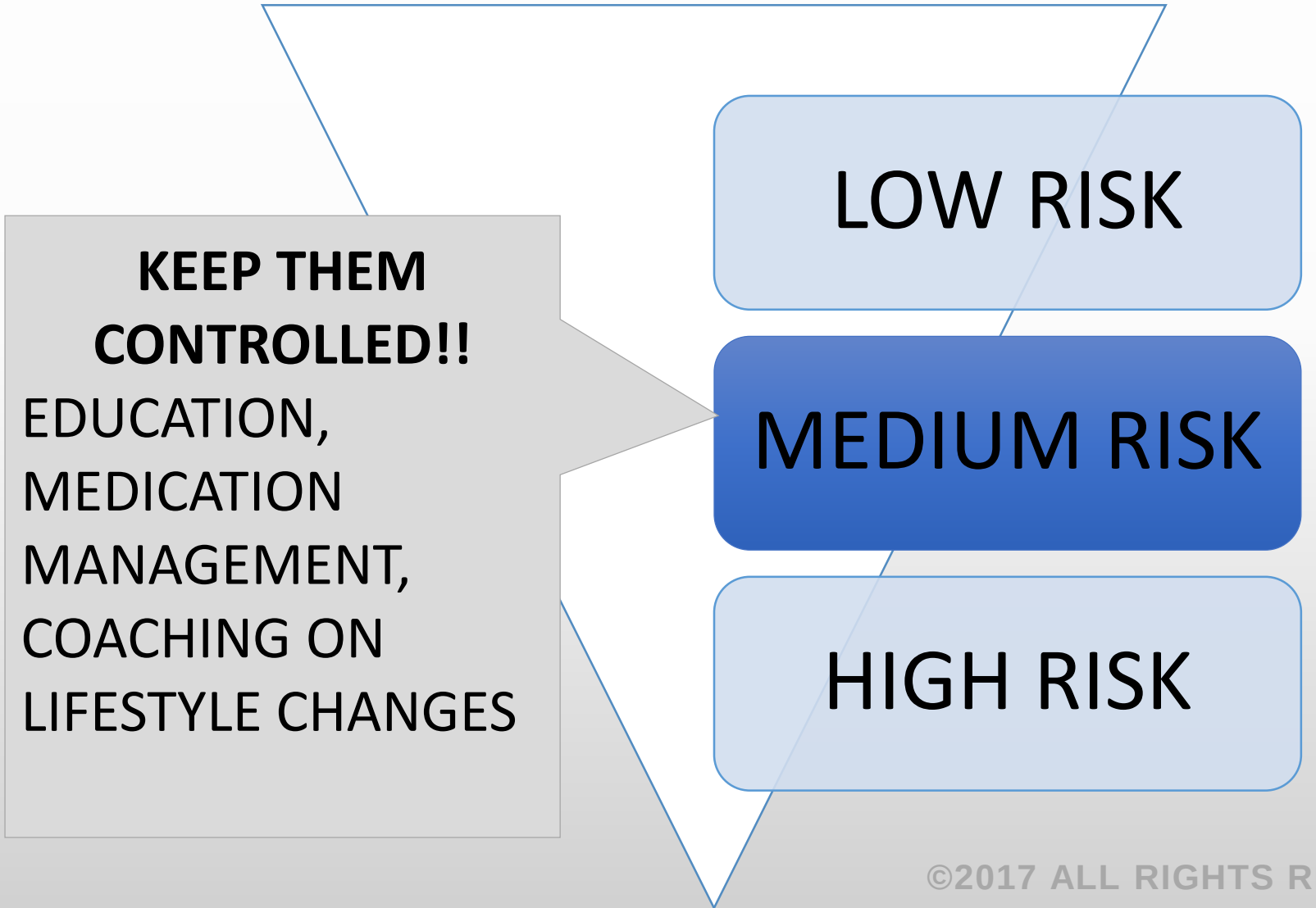
HMSA ENGAGEMENT MEASURES:

Sharecare Real Age Assessment, Engage Ecosystem

HMSA PERFORMANCE MEASURES:

Preventative Screenings, immunizations,

Risk Stratification



KEEP THEM CONTROLLED!!

EDUCATION, MEDICATION MANAGEMENT, COACHING ON LIFESTYLE CHANGES

HMSA ENGAGEMENT MEASURES:

Sharecare Real Age Assessment, Engage Ecosystem

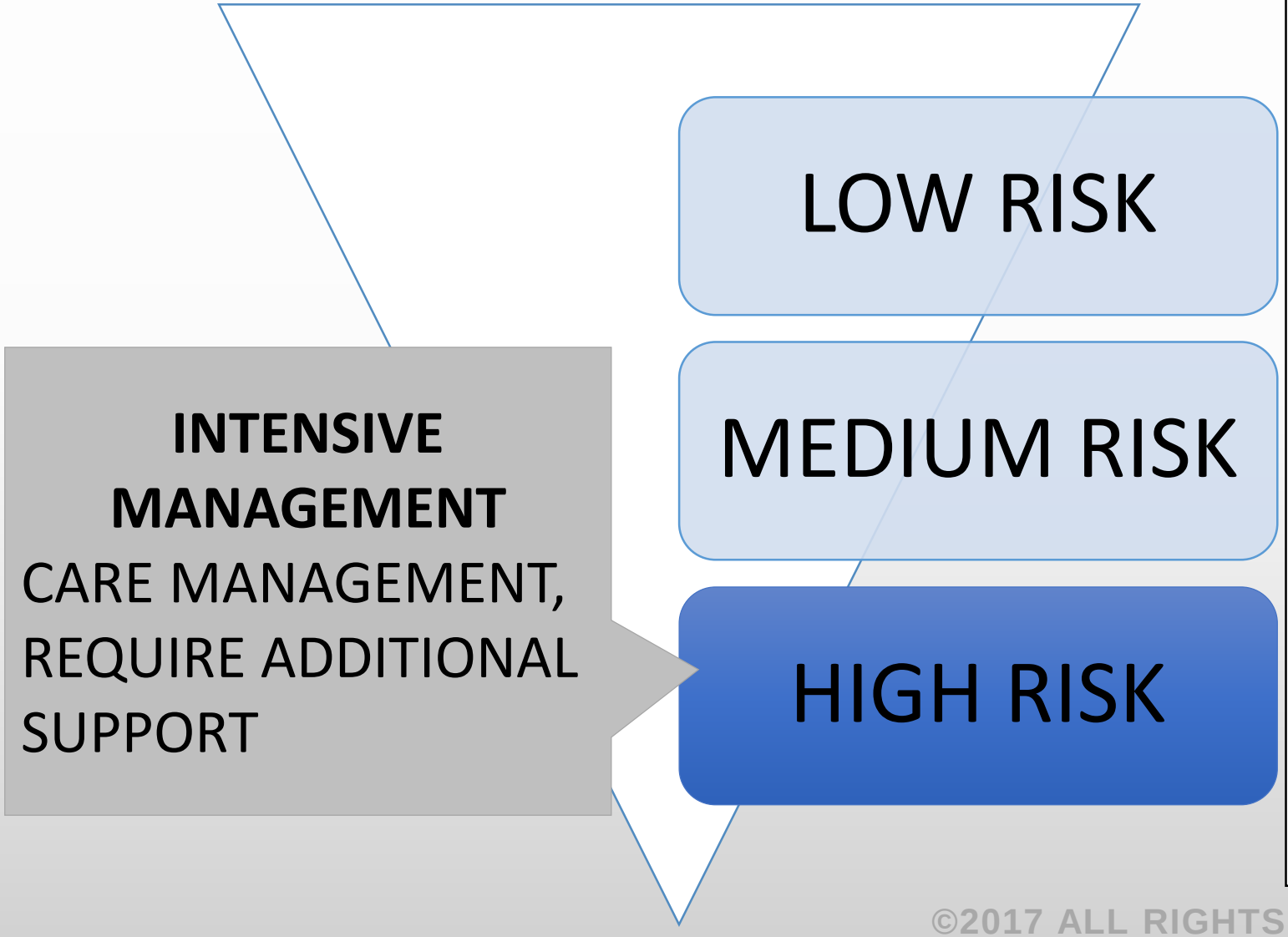
HMSA PERFORMANCE MEASURES:

Preventative Screenings, immunizations,

HMSA PERFORMANCE MEASURES:

Diabetes Care, RCC, Total Cost of Care,

Risk Stratification



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HMSA ENGAGEMENT MEASURES:

Sharecare Real Age Assessment, Engage Ecosystem

HMSA PERFORMANCE MEASURES:

Diabetes Care, RCC, Total Cost of Care,

HMSA RESOURCES:

POST, PMSO,

EHI RESOURCE CENTER

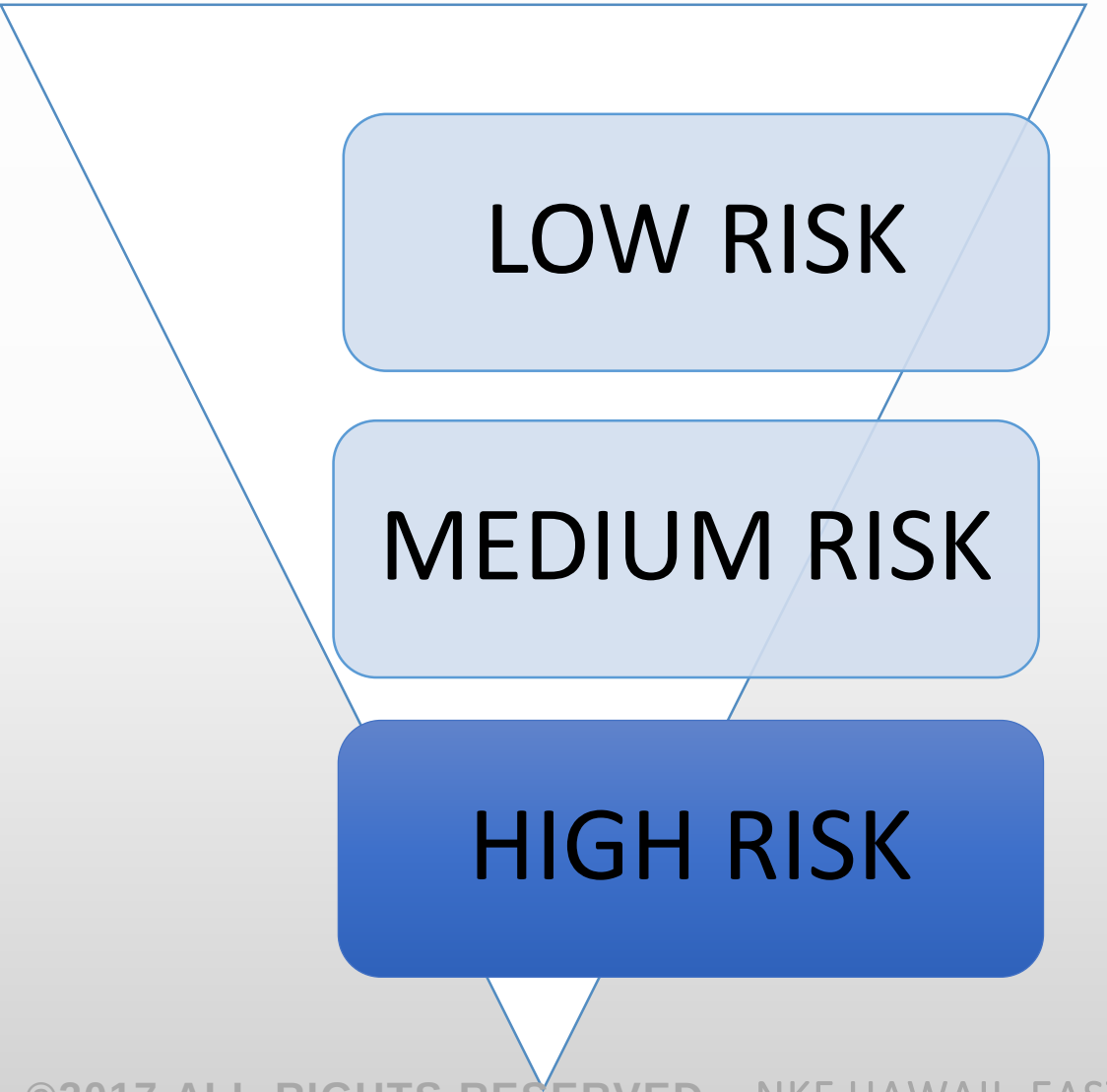
Risk Stratification

LOW RISK

MEDIUM RISK

HIGH RISK

Risk Stratification



CPC+ Functions	Program Milestones
Care Management	**1) Provide care management to all patients identified as at increased risk and use care plans.** **2) Ensure patients with ED visits receive a follow up interaction within 3 days of discharge.** **3) Contact at least 75% of patients who were hospitalized in target hospital(s), within 2 business days.**
Comprehensiveness and Coordination	1) Identify high volume, high cost specialists, 2) identify high volume ED, 3) Improve timeliness to notifications, 4) use collaborative care agreements with 2+ specialists, **5) integrate behavioral health into care** **6) assess patient's psycho social needs with evidence based tool,** **7) identify resources for psychosocial needs,** **8) identify target population and create plan to meet those needs.**

Care Delivery Requirements: Care Management

Requirements for Track 1

- **Risk stratify** all empanelled patients
- **Targeted, proactive, relationship-based care management** to all patients identified as at increased risk and who are likely to benefit from intensive care management
- **Short-term care management with medication reconciliation** to high and increasing percentage of empanelled patients who have a **hospital admission/discharge/transfer** and who are likely to benefit from care management
- **Patients with ED visits** receive a follow up interaction within **one week of discharge**
- Contact **at least 75%** of patients who are **hospitalized in target hospital(s)** within **2 business days**

Requirements for Track 2

- Use a **two-step risk stratification** process for all empanelled patients
- Use a **plan of care** centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management

TRACK	CMF: CARE MANAGEMENT FEE (PBPM)	PBIP: PERFORMANCE-BASED INCENTIVE PYMNT (PBPM)	FEE SCHEDULE PYMNT
1	AVG $15	$2.50 based on utilization, quality & patient experience	FFS
2	AVG $28	$4.00 based on utilization, quality & patient experience	Reduced FFS w/prospective CPCP

Longitudinal

- Systematically risk stratify empanelled population
- Proactively monitor
- Co-manage care with specialists
- Self-management support
- Long-term, personalized care management using care plan

Episodic

- Event triggers
- Follows-up with patients post discharge
- Accurate information shared across care settings (hospital to home, hospital to skilled nursing facility)
- Medication reconciliation
- Short-term care management support

ED VISITS, HOSPITAL ADMIT/DISCHARGE/TRANSFER

Touches

Proactively IDENTIFY, OUTREACH & TRACK all patients on your panel to:

- Check on their wellbeing
- Provide information, education
- Invite them in for a wellness exam
- Notify them that they are due for a follow up visit and/or tests, screenings

HMSA ENGAGEMENT MEASURES:

Panel Management

Panel Management

Description

PCPs will check on the well-being of all individual members in their panel at least once a measurement year. This requirement will be measured using an annual member survey administered to a sample of each provider's attributed members at the end of the measurement year.

- In the last 12 months, did this provider or someone else from their office contact you about your health and well-being? (Check all that apply.)

  - ☐ Had an in-person visit. (1)
  - ☐ Called me. (2)
  - ☐ Emailed me. (3)
  - ☐ Provider interact
  - ☐ Texted me. (5)
  - ☐ Sent me a letter,
  - ☐ No contact. (7)

Annual Wellness Visit

Designed to help prevent disease and disability based on your current health and risk factors

- Focus on overall well-being
- Personalized prevention plan to help you stay healthy

It includes:

- **Medical and family history**
- **Current providers and prescriptions**
- **Vitals**
- **Assess for cognitive impairment**
- **Personalized health advice**
- **Risk factors and treatment options**
- **A screening schedule for appropriate preventive services.**
- **Advance Care Planning**

Annual Wellness Visit

CPC+: Care Delivery Requirements

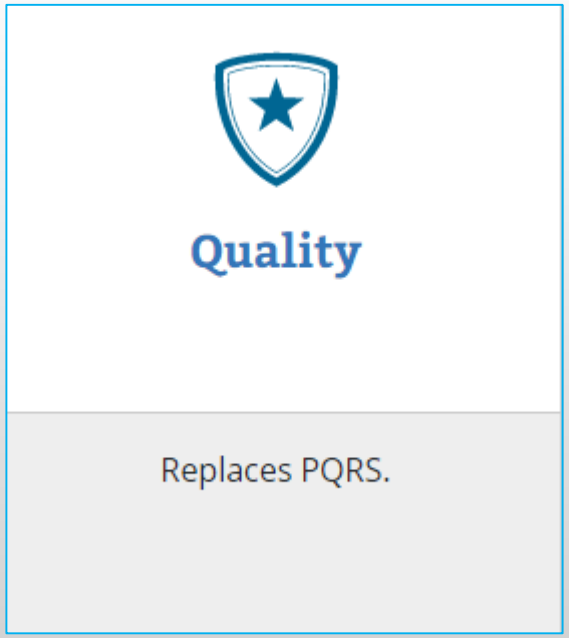
CPIA: Clinical Practice Improvement Activities (MIPS)

Improvement Activities

PROGRAM	CPIA	CPC+
Planned Care and Population Health	X	X
Behavioral Health Integration	X	X
Psycho-Social Assessments		X
Multi-Disciplinary Care Team		X
Dementia Care Management		X
Depression	X	X
Develop New Service For High Risk Pts.		X
Quality Improvement Program	X	X
Medication Reconciliation	X	X

Annual Wellness Visit

MIPS & CPC+:
QUALITY MEASURES



Measure	MIPS	CPC+
Fall Risk Screening	X	X
Blood Pressure Screening & Follow Up	X	X
Depression Screening & Remission	X	X
Breast Cancer Screening	X	X
Colorectal Cancer Screening	X	X
Influenza Vaccine	X	
Pneumococcal Vaccine	X	
BMI Screening and Follow Up	X	
Tobacco Use Screening and Follow Up	X	X
Use of High Risk Medications	X	X
Dementia Screening and Follow Up	X	X
Cervical Screening	X	X
Initiation of Alcohol/Drug Treatment	X	X

HOW DO WE DO THIS?

Key success factors:

LEADERSHIP
TEAMWORK
COMMUNICATION

BEFORE VISIT

CARE TEAM

TEAM MEMBERS: Identified & defined

Providers

Leadership

Clinical staff

Clerical staff

Tasks, roles & responsibilities are defined by skillset, protocols established.

BEFORE VISIT

CARE TEAM

Re-thinking & delegating

In a traditional practice model, failure to delegate often limits efficiency.

Each individual performs at the highest level of his or her qualifications.

BEFORE VISIT

Daily HUDDLES, Weekly Care Team meetings, alternative visits

CARE TEAM

reminder

CPC+ Functions	Program Milestones
Planned Care & Population Health	1) Conduct care team meetings at least weekly to review practice- and panel-level data, and use this data to guide testing of tactics to improve care & achieve practice goals in CPC+
Access & Continuity	1) Organize care by practice-identified teams responsible for a specific panel of patients to optimize continuity. 2) Offer at least one alternative to traditional office visits such as e-visits, phone visits, group visits, nurse visits, home visits

BEFORE VISIT

PRE-VISIT PLANNING

AMA's estimated cost savings by implementing an efficient pre-visit planning process in your office.

Your practice

$ 3.00 /min	$ 1.00 /min	220 days/year
Cost of physician's time	Cost of staff time	Clinic days per year

Estimate savings

				TIME		MONEY
30 min/day	+	30 min/day	=	1H 0M /DAY	=	$26,400
Physician time on results reporting		Staff time on results reporting		Time saved		Annual savings with Pre-visit Planning

BEFORE VISIT

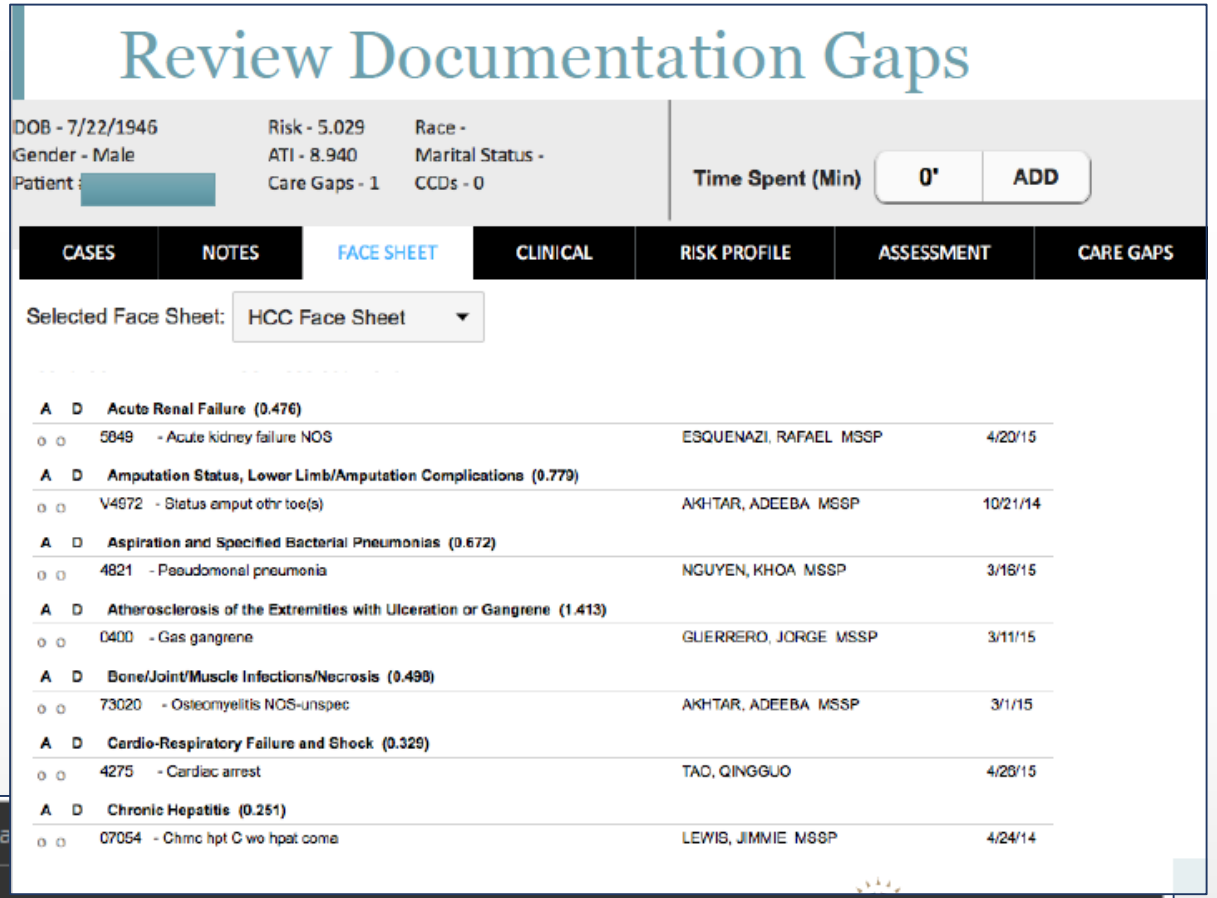
PRE-VISIT PLANNING

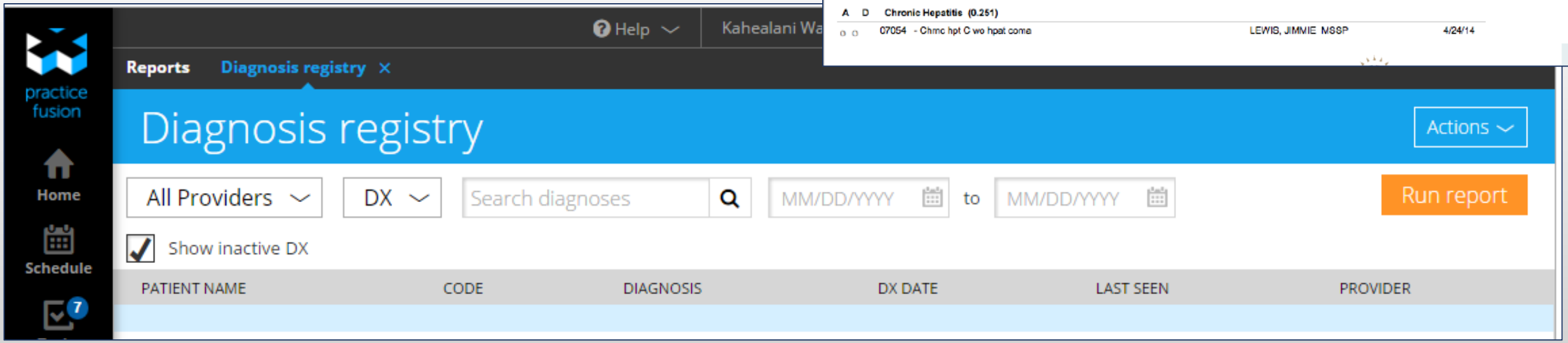
Identify

Review

Prepare

PRE-VISIT PLANNING REVIEW





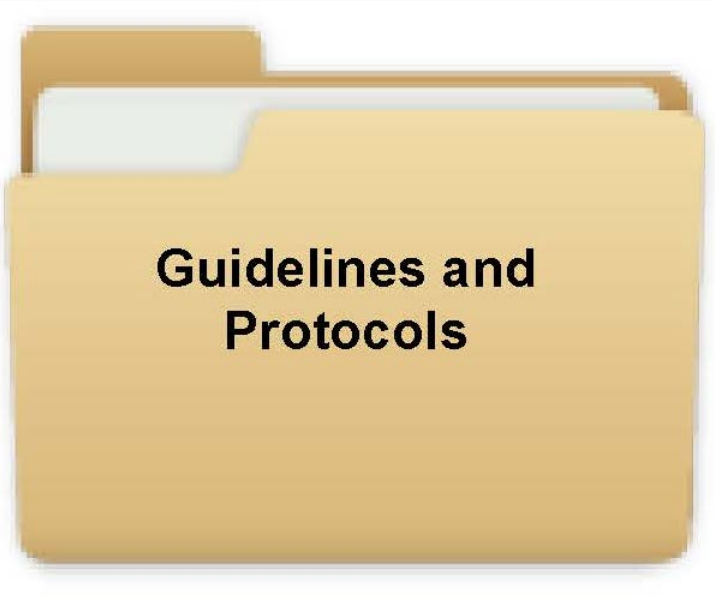
BEFORE VISIT

PRE-VISIT PLANNING

PREPARE

BEFORE VISIT

GUIDELINES



Written guidelines for:

Frequent tasks, evidence based guidelines, standing orders

Documentation

Scheduling

Messaging

Triage protocols

Prescription refills

Preventative care

Chronic disease management

BEFORE VISIT

GUIDELINES

Guidelines and Protocols

Trinity Clinic Whitehouse
Automatic Refill Policy
April, 2007

Overview

The following pages contain details on how to administer our automatic refill policy. Our intent is to streamline, standardize and reduce waiting times for refills of medications. The policy emphasizes standard times and rules for refills that should result in improved safety and quality of care.

The medications are listed by generic and trade names and have attached a time during which the patient must have had an office visit in order to obtain an automatic refill from nursing staff. If the patient has not been seen within this time frame, a one-month supply of medication may be sent by nursing staff to the pharmacy of the patient's choice, but the patient must schedule an office visit within that month before any additional refill is issued.

Under the following circumstances, an automatic, nurse-approved refill may **NOT** be given. The request should be forwarded to the treating physician in the form of a phone note:

1) There is a **NO SHOW** as the most recent "visit" in the chart.
2) A Trinity Clinic Whitehouse physician is not the original prescribing physician
3) The patient insists on doctor's review for a denial based upon protocol rules
4) The medication is in one of the following classes (these medications do not appear on the protocol):

- Narcotics
- Benzodiazepines
- Antibiotics
- ADD medication/triplicate
- Oral steroids
- Mood stabilizers (bipolar)
- Rheumatology drugs (lupus, RA)
- Sleeping pills

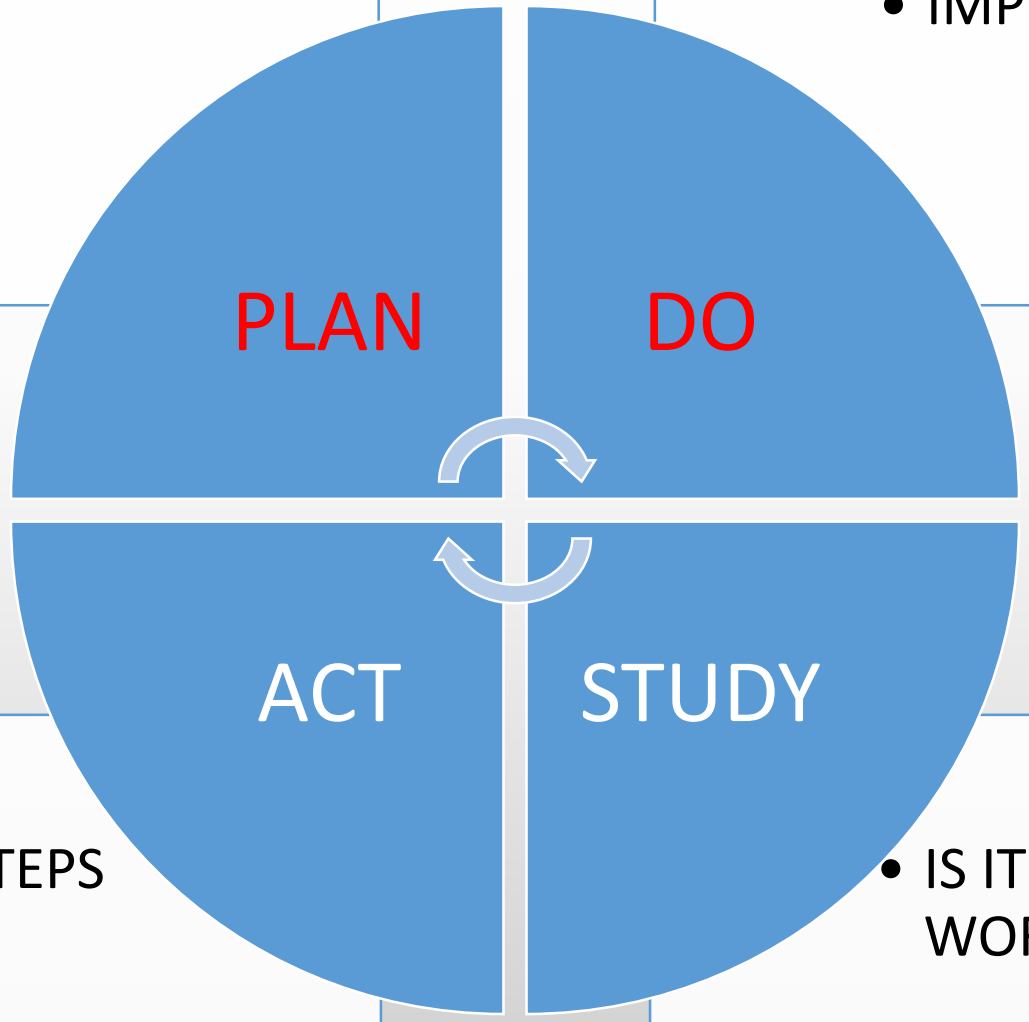
Please note: for antihypertensive medications, the patient must have had an in-person or virtual office visit within the past 6 months **AND** their last blood pressure reading in the flowsheet within that past 6 months must be less than 140 systolic **AND** less than 90 diastolic. This will ensure that patients are not missing their short-term follow-up visits for blood pressure medication titration.

If at any time there is a question about how to apply the policy, the default is to send the matter/question to the treating physician in the form of a phone note.

QI ACTIVITY: ED VISITS & HOSPITAL ADMIT/DISCHARGE/TRANSFER

- WHO
- PLAN

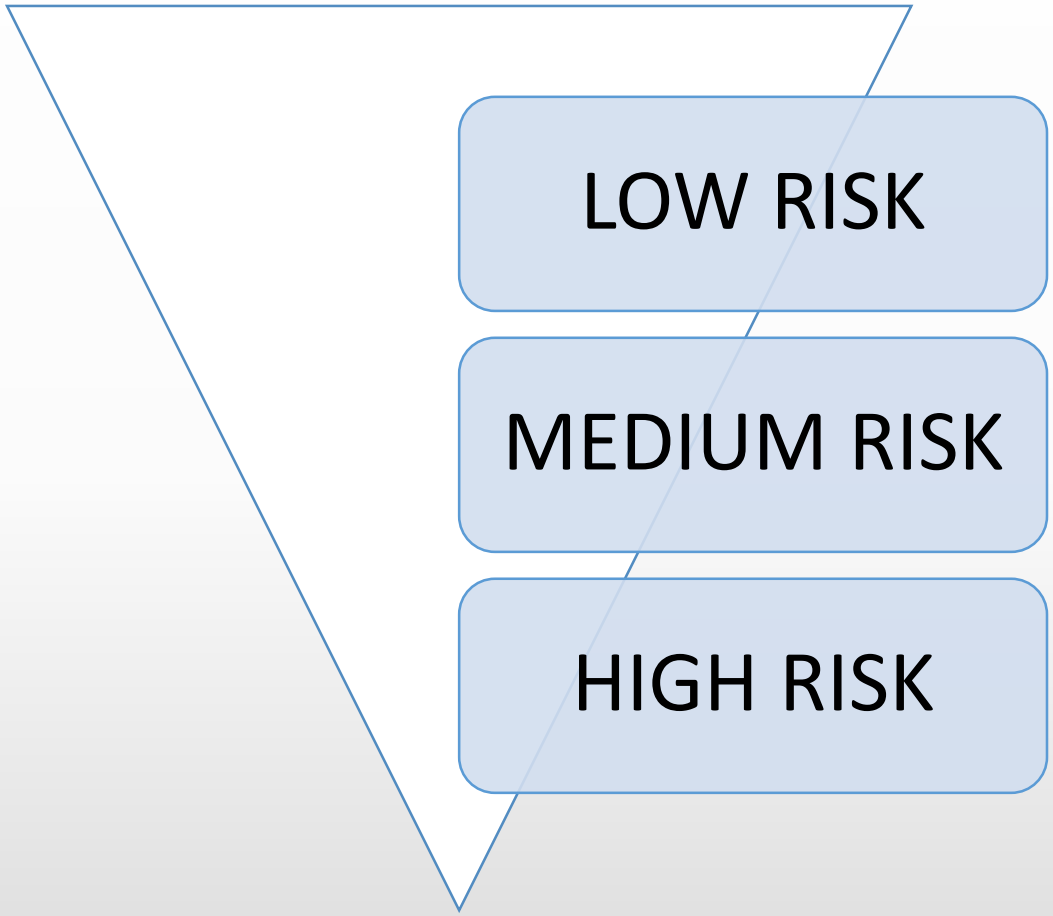
- IMPLEMENT



- NEXT STEPS

- IS IT WORKING?

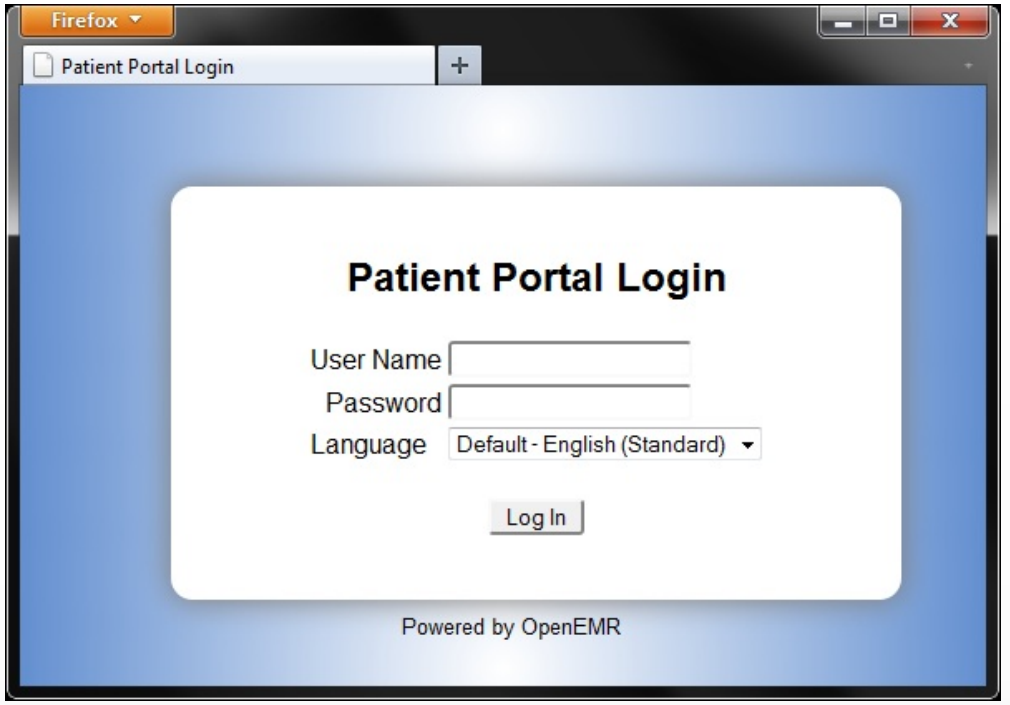
TO DO:
RISK STRATISFY



reminder

TO DO:

TOUCH ALL OF YOUR PATIENTS



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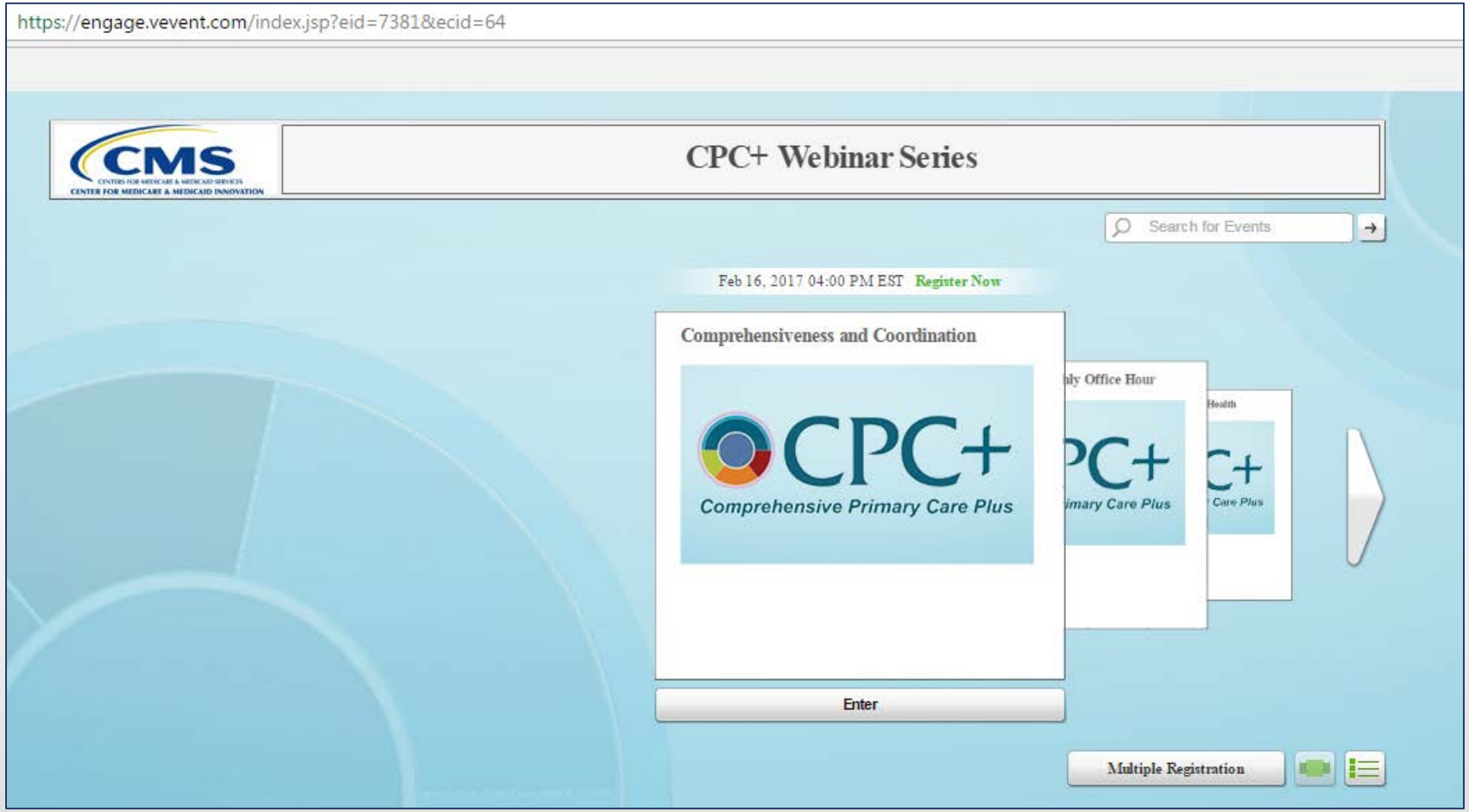
TO DO: IMPLEMENT DAILY HUDDLE, WEEKLY CARE TEAM MTG

reminder

TO DO:

ADDRESS YOUR ED & HOSPITAL NOTIFICATIONS

TO DO:
CPC+ WEBINARS & OFFICE HOURS



THANK YOU FOR YOUR PARTICIPATION!

PLEASE COMPLETE WORKSHOP EVALUATION

SIGN UP FOR BREAK OUT SESSIONS WILL BE SENT OUT