Physician Organization Collaborative

September 28, 2017


Māhie 2020

ADVANCING THE HEALTH OF HAWAIʻI

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Agenda

1. **Integrated Health Management Services Support to Physician Organizations –** Rudy Marilla
2. **Newborn Attribution –** Dr. Jeff Tom
3. **PCP and PO Measures for 2018 –** Victoria Mizumoto
4. **Other Issues/Concerns –** POs

IHMS
Integrated Health Management Services

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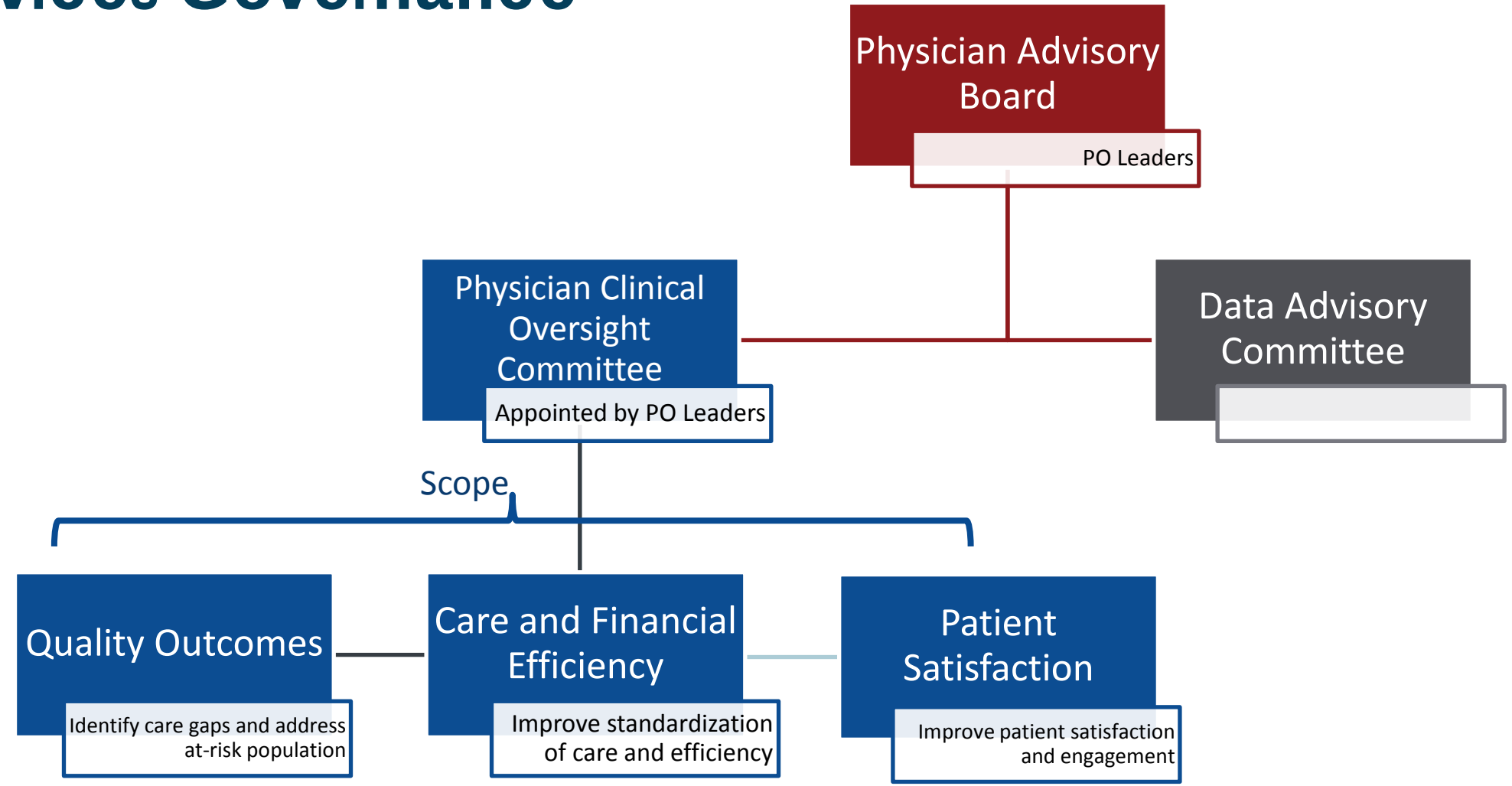
Agenda

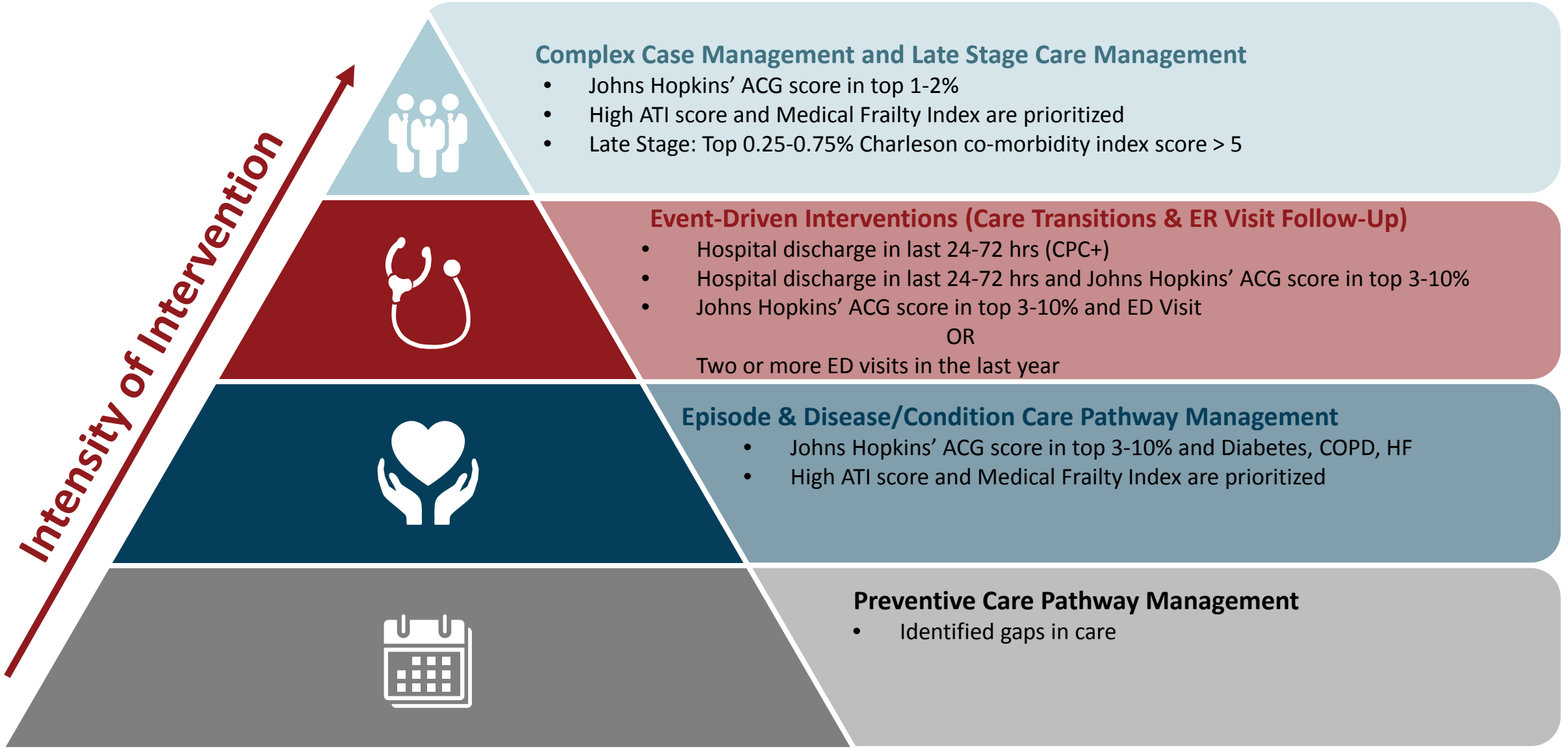
PO Collaborative

- IHMS Governance Structure
- IHMS Model of Care
- Joint Operating Committees

Integrated Health Management Services Governance



Transitioning to New Care Model



Model of Care Interventions Overview

Intensity of Intervention

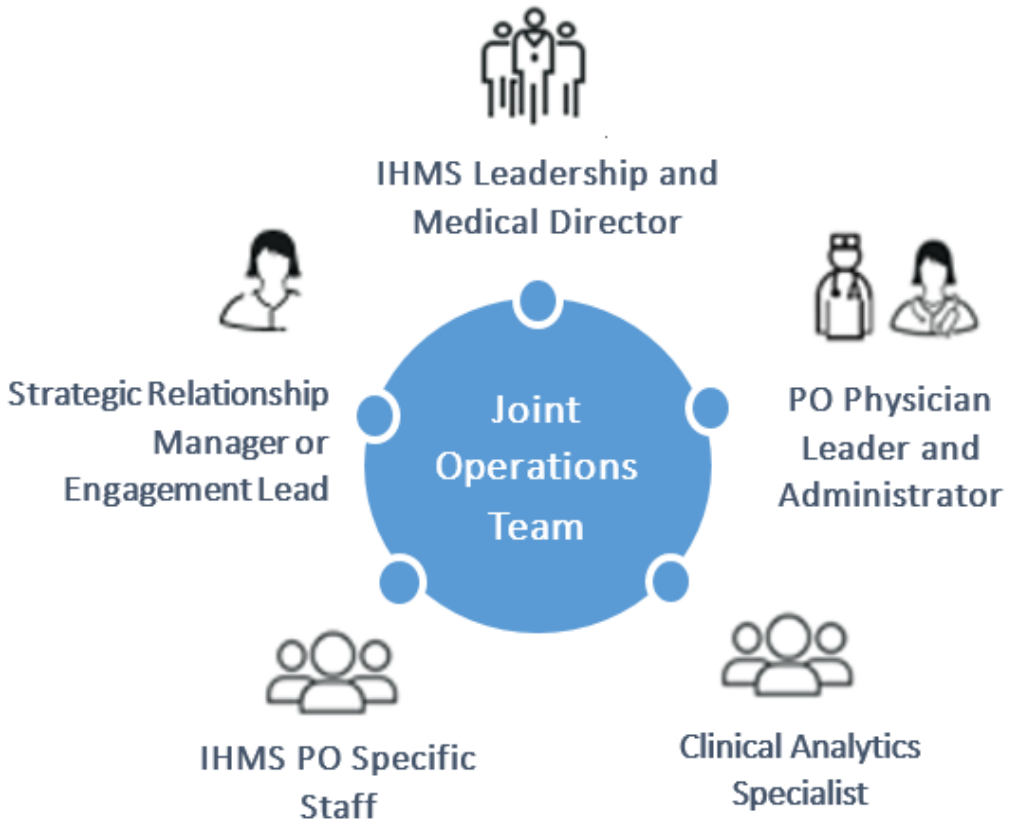
Intervention Name	Intervention Goals	Intervention Population	Population Volume	Primary Staff Complement	Primary Staff Location
Complex Case Management	• Complex Case Management • For late stage patients, facilitate end of life care planning	• Johns Hopkins' ACG score in top 1-2% • Late stage : top .25-.75%	~5015 patients	• Case Manager • Social Worker • Pharmacist by referral • Health educator by referral	• Home • Community • Hospital • OP Clinics
Event Driven Care	• Ensure safe transition to home/community • Reduce avoidable hospital readmisions and ED visits	• Johns Hopkins' ACG score in top 3-10% • Review inpatient stay • Review ED visit	• Monthly Acute Admissions ~4,000 • Monthly ER~ Visits ~17,000	• Care Transitions Specialist • Social Worker	• Home • Hospital • Emergency Department
Condition Care Programs	• Promote self-management of conditions to slow progression of disease and disease related complications	• Johns Hopkins' ACG score in top 3-10% • Diabetes, Heart Failure, Congestive Obstructive Pulmonary Disease	• Diabetes ~17,545 • HF ~3,785 • COPD ~2,849	• Registered Nurse, CCP • CDE • Registered Dietitian • Integrated Health Advisor	• Embedded in Provider Organizations
Preventive Care Programs	• Support population health management in outpatient setting • Identify and close preventative care gaps	• HMSA members that have providers in a Provider Organization	•All Commercial •All Medicare •All Medicaid	• Preventive Care Advocate II • Preventive Care Advocate I	• Embedded in Provider Organizations

Data above as of Sep 2017

Progress Update

- All Care Model interventions have been standardized and documented
- Training to frontline staff
  - **Complex Care:** 2 sets of three training sessions 9/22-10/13
  - **Event Driven:** 2 sets of four training sessions 9/27-10/18
  - **Condition Care Programs:** 2 sets of three training sessions 10/19-11/3
  - **Preventive Care Programs:** 2 sets of three training sessions 10/24 – 11/8
- Refined patient target list
- Operational dashboard in development
- HMSA Care Model Townhall meeting Friday (9/29) to discuss care delivery integration
- Finalizing assignments to POs for Condition Care Programs
  - Requesting support for integrating staff into POs
- Establish Joint Operations Committees (JOCs)

Joint Operations Committee



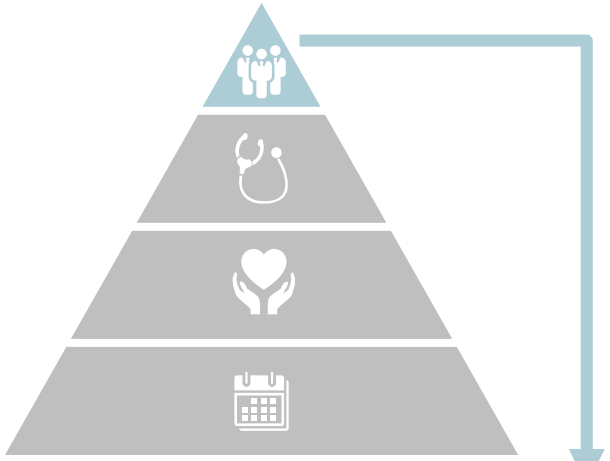
- Creates culture of collaboration
- Joint agenda creation
- Regular meeting cadence
- Review PO specific data and analytics
- Identify opportunities for improvement
- Recommend action plans
- High performing teams able to solve issues more efficiently and efficaciously

Appendix

PO Collaborative

- Care Model Interventions Detailed Breakouts

Complex Case Management and Late Stage Care Management



Patients with:

- Johns Hopkins' ACG score in top 1-2%
- ATI and Frailty Index scores in top 1-2%
- Charleston score of 6 or higher (late stage)
- Patients referred by physician will be evaluated

- Care for patients at highest risk of health care decline and hospitalization
- Patients identified for CCM will receive support from the IHMS team, in collaboration with their physicians, to avoid:
  - Unnecessary ED utilization, hospital admission or readmission
  - Disease-related complications
- Patients identified for late stage care management will receive support from the IHMS team, in collaboration with their physicians, to ensure:
  - Preparation for desired treatment
  - Hospice, palliative care, spiritual/memorial services are arranged
  - Legal documents are in place
- The goal of intervention is to provide proactive care to optimize their health status and stability and to determine patient's preferences for the final stages of life

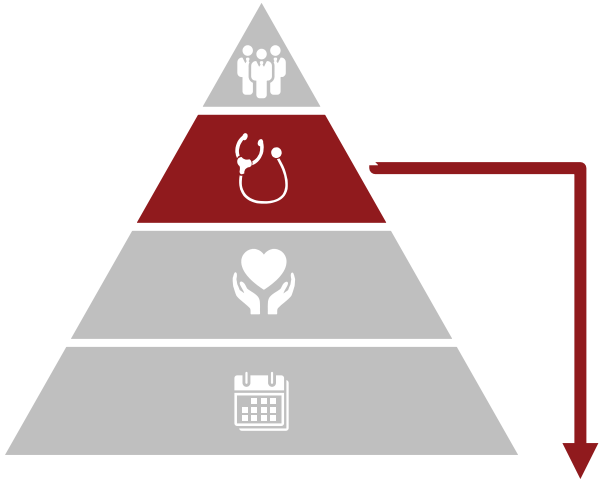
Complex Case Management Care Plan

- The 5 CCM Care Steps:
  1) Discuss current and past health history (physical, behavioral, cognitive)
  2) Reconcile and review medication
  3) Explain access of care (when to use PCP, urgent care, appropriate use of ED)
  4) Identify and address home health needs
  5) Ensure self-management and/or family support is present

Late Stage Care Management Care Plan

- Care Steps:
  1) Confirm patient has discussed ACD/POLST with PCP
  2) Facilitate ACD/POLST discussions and assist patient in completing forms
  3) Educate patient on benefits of having designated/documented medical power of attorney
  4) Discuss hospice/palliative care needs with PCP and patient

Event-Driven Interventions: Care Transitions



Patients with:

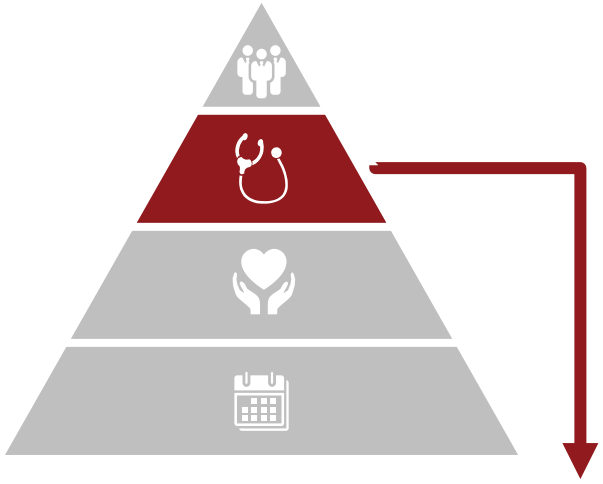
- Hospital discharge in last 24-72 hours
- Johns Hopkins' ACG score in top 3-10%
- Patients referred by physician will be evaluated

- Transitions from one level of care to another (e.g. from acute care facility to home)
- Patients will receive support from the IHMS team, in collaboration with their physicians, to ensure:
  - Timely post-hospital discharge contact within 1-3 days
  - Appropriate follow-up care is arranged, including medications, home health, DME and physician follow-up
- The goal of intervention is to avoid secondary complications or readmission

Event-Driven Interventions: Care Transitions Care Plan

- Care Steps:
  1) Discuss reason for hospital stay and current status
  2) Per patient's consent, contact and discuss care with family/care giver
  3) Reconcile and review medication; ensure prescribed medication is filled
  4) Educate patient on clinical signs and symptoms and when/how to access care
  5) Schedule all necessary follow-up appointments
  6) Ensure/arrange transportation to follow-up appointments
  7) Ensure self-management and/or family support is present
  8) Identify and address home health needs
  9) Confirm DME is received and patient is trained on use
  10) Establish home with family/care giver prior to discharge

Event-Driven Interventions: ED Visit Follow-Up



Patients with:

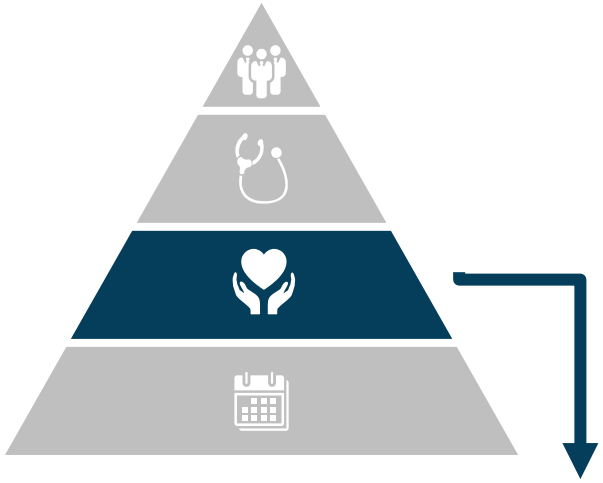
- 2 or more ED visits in past 12 months
- 1 ED visit in past 12 months with Johns Hopkins' ACG score in top 3-10%
- Patients referred by physician will be evaluated

- Patients with frequent and/or recent ED visits
- Patients will receive support from the IHMS team, in collaboration with their physicians, to ensure:
  - Education on appropriate venues of care
  - Appropriate use of ED
- The goal of intervention is to avoid unnecessary ED utilization

Event-Driven Interventions: ED Visit Follow-Up Care Plan

- Care Steps:
  1) Discuss reason for ED visit
  2) Educate patient on clinical signs and symptoms and when/how to access care
  3) Schedule PCP appointment following ED visit
  4) Explain access of care (when to use PCP, urgent care, appropriate use of ED)
  5) Reconcile and review medication; ensure prescribed medication is filled
  6) Discuss preventative and condition-specific care gaps

Condition Care Programs



Patients with:

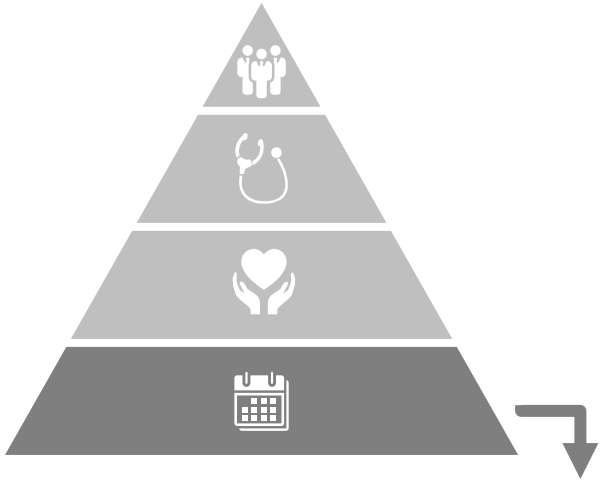
- Johns Hopkins' ACG score in top 3-10% and Diabetes, HF and/or COPD
- Highest ATI and Frailty Index
- Patients referred by physician will be evaluated

- Condition Specific care management programs to help avoid future complications and help patients remain healthy
- Patients will receive support from the PMSO team, in collaboration with their physicians, to ensure:
  - Education of self-management
  - Appropriate testing, treatment and clinical goals are met to optimize outcomes
- The goal of intervention to provide proactive care, avoid unnecessary disease-related complications and avoid costly/inconvenient care venues
- Future Care Pathways: HTN, Dyslipidemia, low back pain, obesity, depression, tobacco and substance use

Optional Care Plan Additions

- The following may be added to any patient care plan, as applicable:
  - Concerns with health benefits
  - Cultural sensitivity
  - Caregiver support
  - Communication capability
  - End-of-Life planning
  - Psychosocial concerns
  - Mobility/functionality
  - Self-management support

Preventive Care Pathway Management



Patients with:

- Care Gaps – Payment Transformation and CPC+

- Preventive care programs to help avoid future complications and help patients remain healthy
- Patients will receive support from the IHMS team, in collaboration with their physicians, to ensure:
  - Education of self-management
  - Appropriate testing, treatment and clinical goals are met to optimize outcomes
- The goal of intervention to provide proactive care, avoid unnecessary disease-related complications and avoid costly/inconvenient care venues

Newborn Attribution

Dr. Jeff Tom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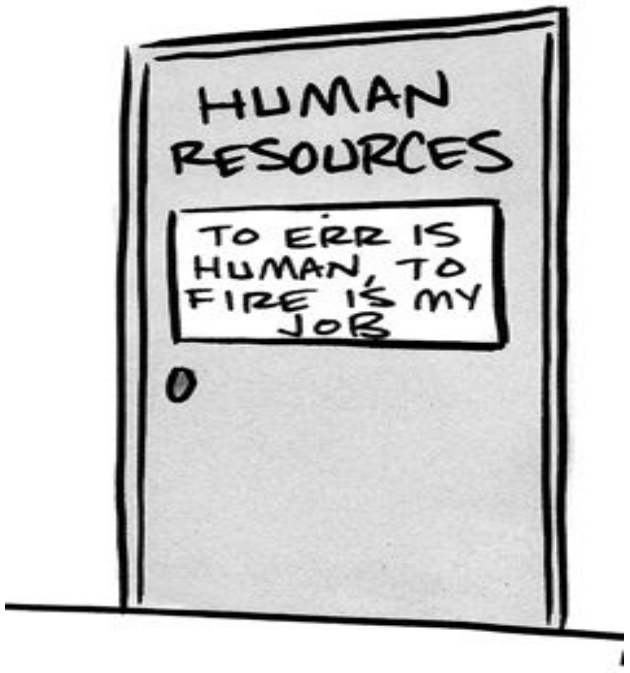
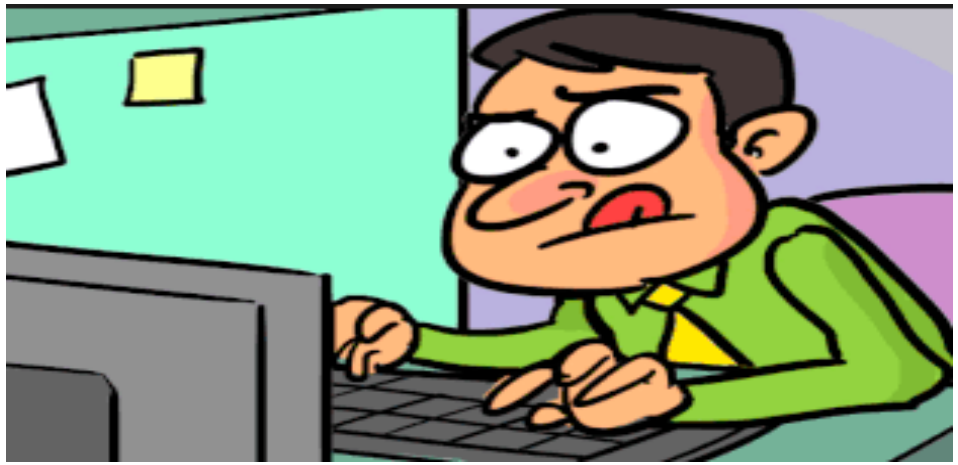
The Challenge

Newborn's First Visit

Newborn's Attribution

Why This is Happening





Our Solution: Newborn Care Payment

Payment for all newborns equivalent to your PMPM multiplied by the months your patient was not attributed.

First visit: January
Attribution Date: March
Newborn Payment = 2 x PMPM

First visit: March
Attribution Date: July
Newborn Payment = 4 x PMPM

Implementation Plan

Beginning with babies born July 2018 onward, newborn care payments will be made four times a year.

- January, April, July, and October
- First Payment → Oct 2018

First visit: December
Attribution Date: March
Newborn Payment Date = April
(HMSA will pay you a PMPM for March plus December, January and February)

Key Takeaways

- PCPs will receive a Newborn Care Payment (quarterly) for babies born July 2018 onward

- Payment will be equivalent to your PMPM multiplied by the months your patient was not attributed (starting from the month of the first visit)

PCP and PO Measures for 2018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Reminder: Engagement Measures for all PCPs in 2017

Measure	Commercial	Akamai Advantage	QUEST Integration
PCP/staff log into Cozeva at least once a month [pass = 100%]	5%	5%	4%
Check on well-being of all patients in panel [patient survey; pass = 75% of pts surveyed have visit/report contact]	5%	5%	4%
Refer patients to health programs [Cozeva attestation; pass/fail]	5%	5%	4%
Sharecare Engagement	5%	5%	4%
Submit EPSDT forms			4%
TOTAL	20%	20%	20%

Engagement: Taking Action

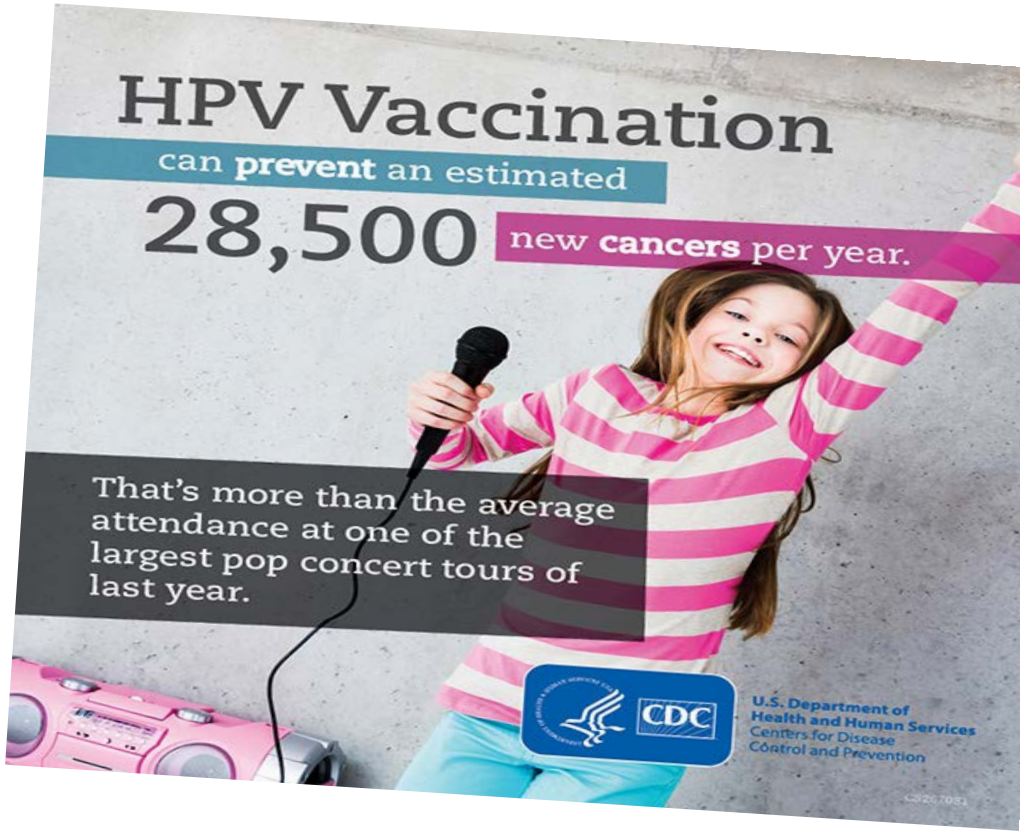
- Monthly log-in to **Cozeva**
- **Engagement with Ecosystem**: Attestation in Cozeva accepted after **October 1, 2017**. PCP attests to using varied programs, or any other community-based resources, that assist patients in managing their health and well-being.
- **Sharecare:** Submit photo and create Sharecare account to verify information by Dec. 31. POs given list of PCPs who have not completed Sharecare account.
- **Panel management**: Survey sent Dec-Jan to a sample of PCP's patients asking if the provider/office contacted them about their health and well-being (through visit, call, email, text, mail, Online Care)

PCP Performance Measures for 2018

- **Review of Chronic Conditions** (Akamai Advantage) – Completion from **Jan. 1 to Sept. 30, 2018**
- **Breast cancer** – recognize digital breast tomosynthesis (still subject to benefit limits)
- **Exclusion**s from all measures for patients in long-term institutional care. PCPs must submit Request for Reconsideration with evidence that patient has been institutionalized for at least 6 months of the measurement year. Requests accepted in Q3 2018.
- **Screening for depression/anxiety** – will allow other depression screening tools (such as PHQ-9) but PCP must also use anxiety screening tool

2018 PCP Performance Measure

- **Immunizations for Adolescents**
  - Will recognize Tdap beginning at age 7
  - Combo 1: meningococcal and Tdap by 13th birthday
  - Combo 2: meningococcal, Tdap and two-dose or three-dose HPV by 13th birthday
- **For 2018:**
  - Will score Combo 1 (no change)
  - Will display HPV rate



HEDIS 2017 (CY 2016 Services)

	Rate	Quality Compass Percentile
Commercial PPO		
HPV	24.82%	90th
Combo 1 (Men., Tdap)	73.24%	33th
Combo 2 (Men., Tdap, HPV)	23.84%	90th
Commercial HMO		
HPV	23.84%	90th
Combo 1	74.94%	33th
Combo 2	21.65%	90th
QUEST Integration		
HPV	20.19%	Not yet available
Combo 1	50.12%	Not yet available
Combo 2	18.25%	Not yet available

PO Performance Measures for 2018

1. Avoidable ED Utilization

- Year 1 (2018) will be scored as a process measure, with POs to analyze workflows and test/implement changes that can drive results
- Year 2 (2019) will be scored as a performance measure

- **Improvement Plans**
  - Q1 2018: Identify the problem, targeting conditions or members
  - Q2 2018 (Plan): Develop strategy and plan for reducing Avoidable ED visits for targeted conditions or members
  - Q3-4 2018 (Do, Study, Act): Implement interventions, assess results, describe effectiveness and lessons learned.
- In June 2018, PO workgroup proposes methodology for thresholds

2018 PO Performance Measure: Avoidable ED Utilization

ED discharge diagnoses classified in four categories:

1. **Non-emergent**: Immediate medical care was not required within 12 hours

2. **Emergent/Primary Care Treatable**: Treatment was required within 12 hours but could have been provided in a primary care setting.

3. **Emergent – ED Care Needed – Preventable/Avoidable**: ED care was required, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (i.e. flare-ups of asthma, diabetes, congestive heart failure)

4. **Emergent – ED Care Needed** – Not Preventable/Avoidable: ED care was required and ambulatory care treatment could not have prevented the condition (e.g. trauma, appendicitis, myocardial infarction)

PO Performance Measures for 2018

2. Hospitalization for Potentially Preventable Complications

- Use **chronic conditions** for current year
- POs gave feedback on proposal to add acute conditions
- Decision for 2018: Score on chronic conditions; *display-only* for acute conditions for data transparency and discussion

GET Payments

- GET payment checks expected to be mailed in mid-October
- Payment uses this methodology

1. Commercial PMPM minus PCMH PMPM = Adjusted PMPM
2. Take July 2017 eligible PPO members = Eligible Members
3. Adjusted PMPM X Eligible Members X PCP's Months in Payment Transformation for 2017 X GET Rate (Oahu vs. Neighbor Islands)

PO Issues and Concerns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