Value-Based Care in Ambulatory Settings

Richard Ricciardi, PhD, CRNP, FAANP, FAAN
Professor, George Washington University

Panel 1: Identify Opportunities to promote and implement value based care strategies
October 2 from 9:45-11:15 am
Nurse-Led Care Conference 2019
Nashville, Tennessee

Agenda

- Overview of the Concept of Value
- Discuss Shared Value
- Perspectives on Value
- The Journey to Achieve Value in Primary Care

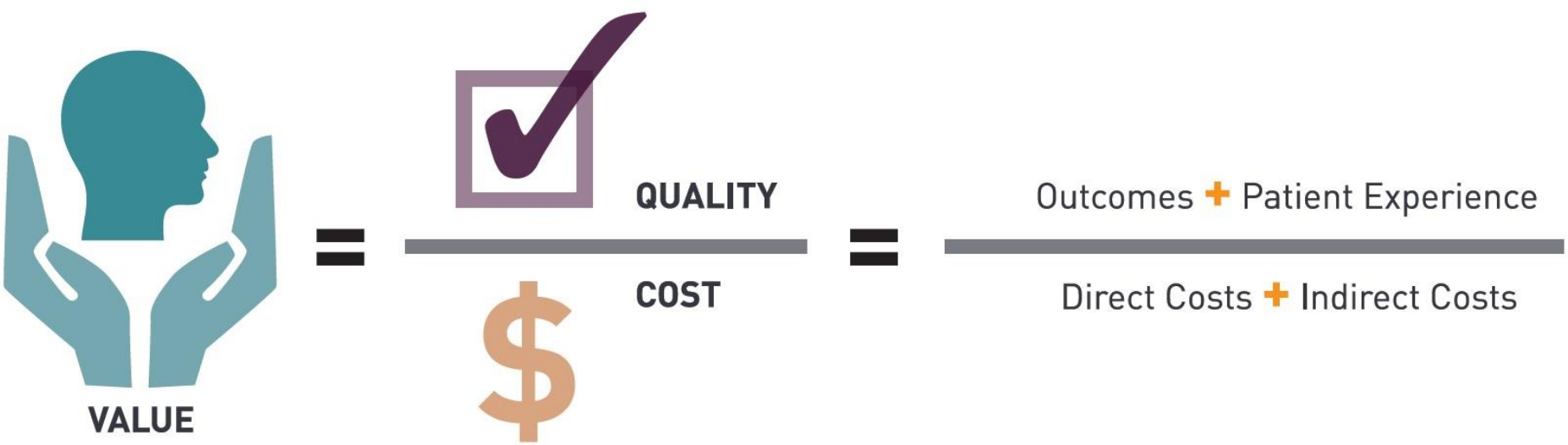
Why is Value in Healthcare a major policy issue in the US?

- Over three trillion dollars per year and approximately 18% of the GDP
- Growing deficits and debt at federal level and impact on state budgets
- Medicare and Medicaid costs
- Public opinion of healthcare
- Waist and administrative costs in healthcare
- Price Variations across US
- Relationship between cost and quality

Determining Value in Healthcare

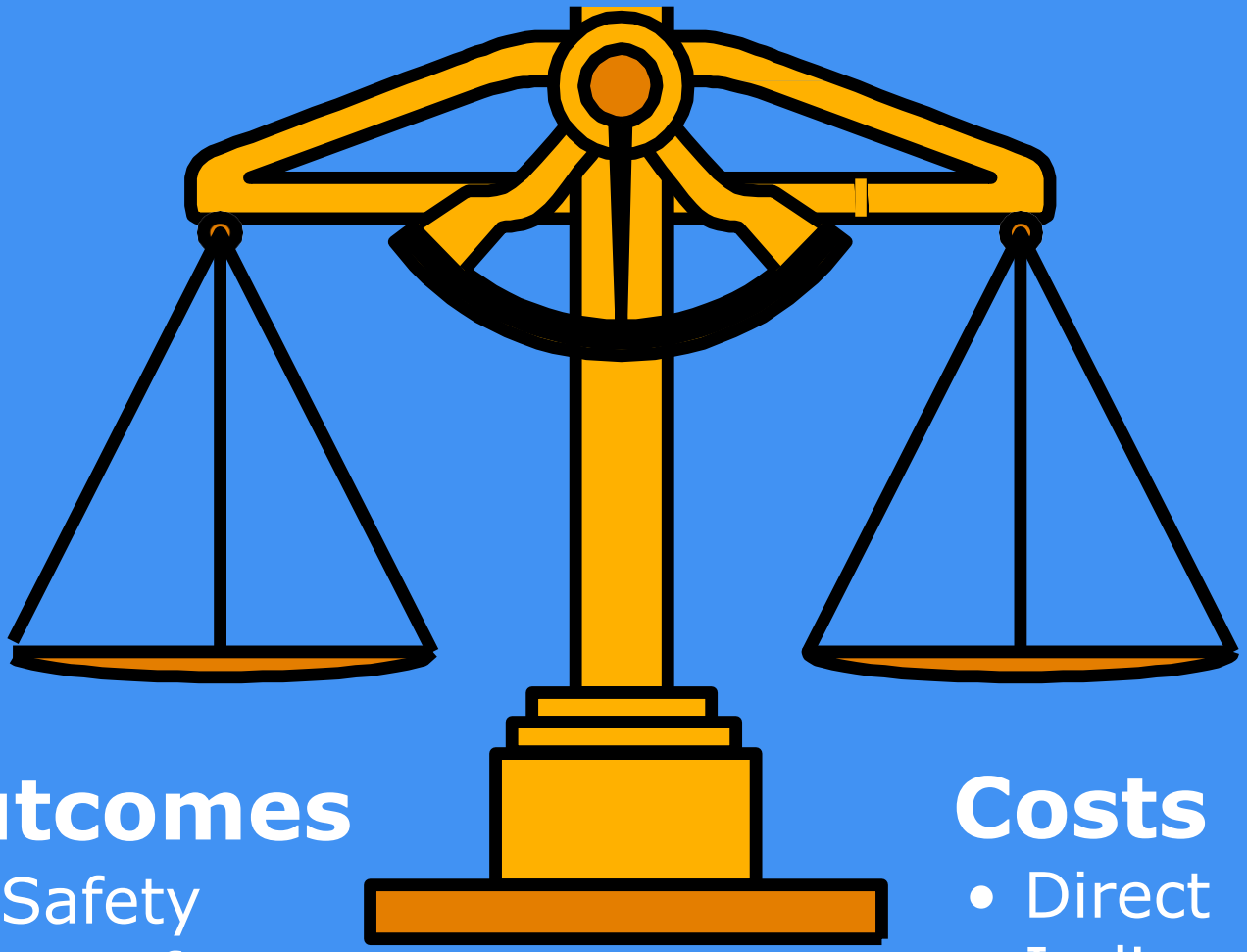
- Value defined as the health outcomes achieved per dollar spent

Porter, M. E. (2010). What is value in health care? *N Engl J Med, 363*(26), 2477-2481



https://www.pm360online.com/how-do-you-define-value-in-healthcare/

Value



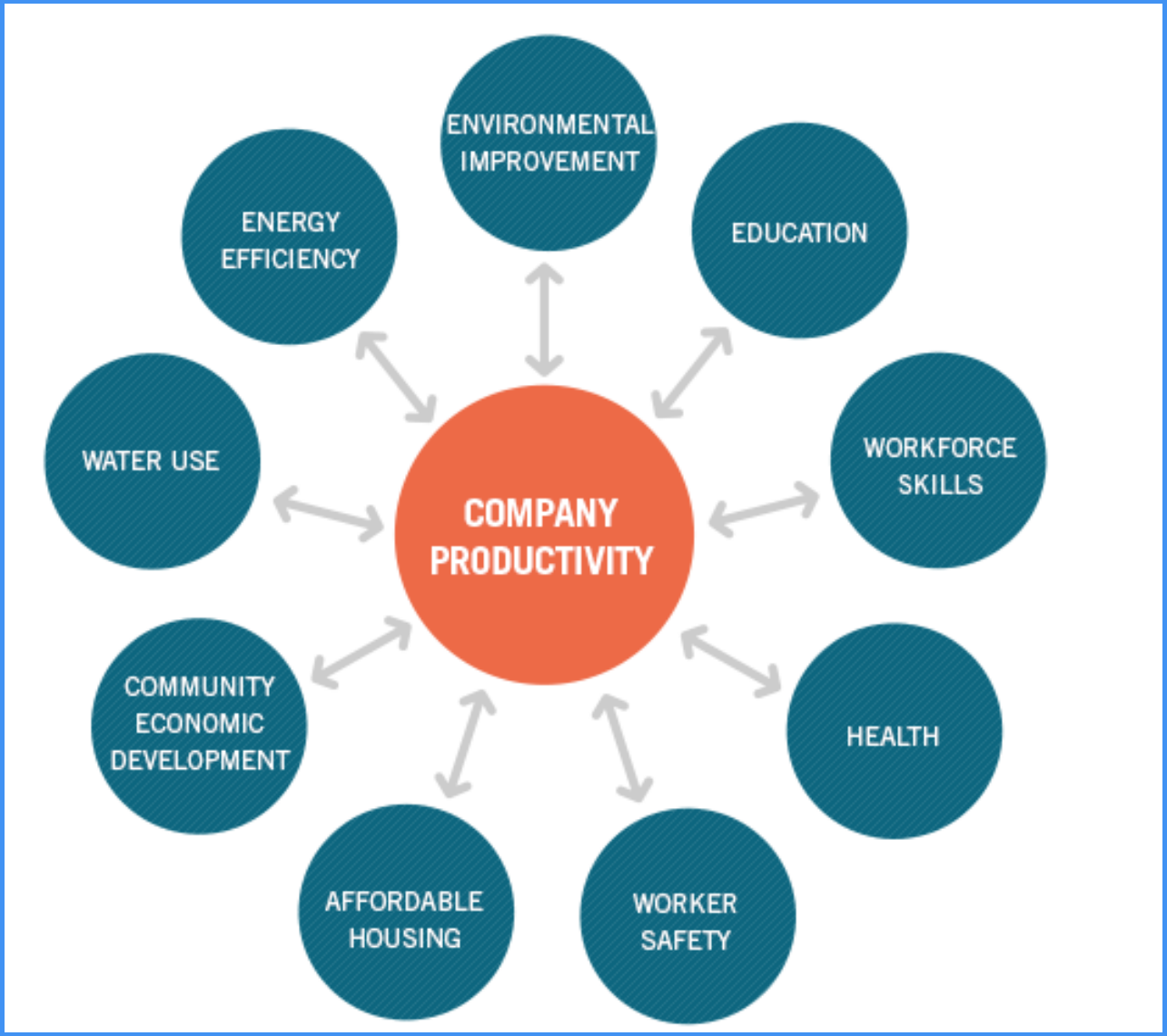
Outcomes

- Safety
- Benefits

Costs

- Direct
- Indirect

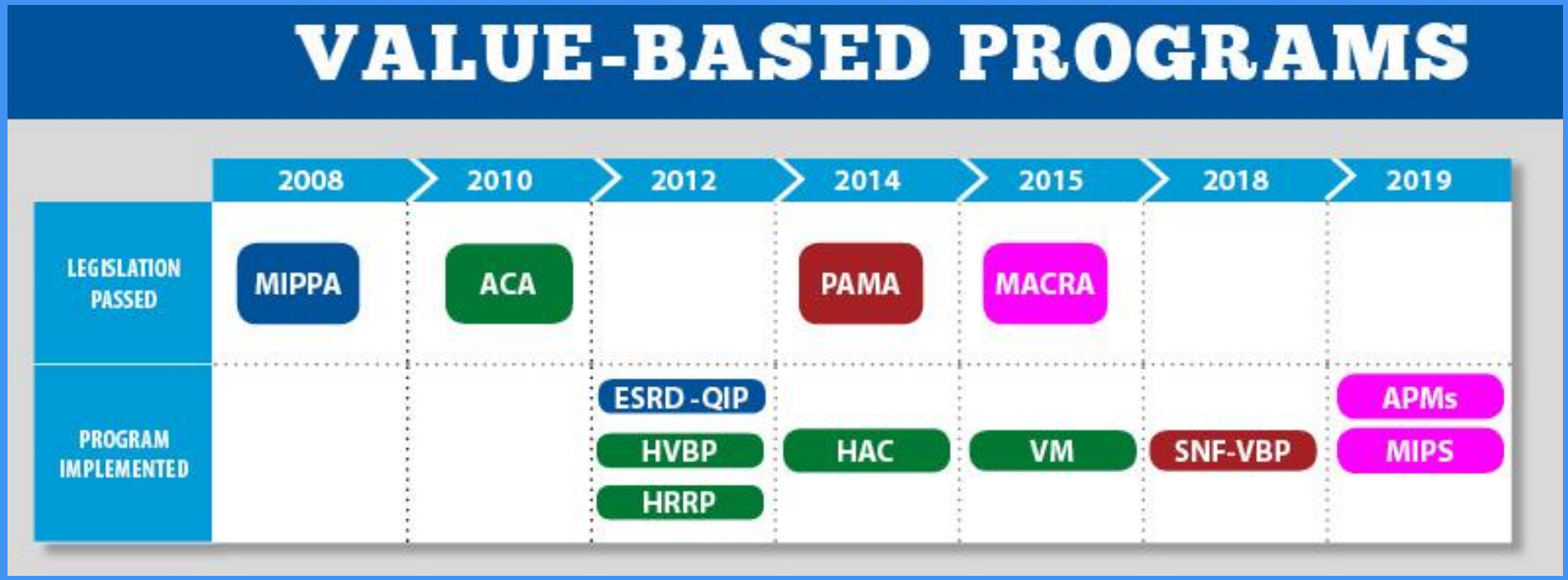
Shared Value



Porter, Michael E. "Creating Shared Value in Health Care." Building a Culture of Health: A New Imperative for Business, Harvard Business School and Robert Wood Johnson Foundation, Boston, MA, April 18–19, 2016.

CMS - Value-based Purchasing

- Defined as payment models in which clinicians and health care organizations are held accountable for the quality and cost of care instead of being paid based on the volume of services they deliver.



Patient Perspective on Value

- My out-of-pocket cost is affordable
- I’m able to schedule a timely appointment
- I’m confident in the provider’s expertise
- Office is conveniently located

Clinician Perspective on Value

- Knew and cared about their patient
- Ordered the right labs and exams
- Their patient's health improved
- Able to spend a sufficient amount of time with patient

The Journey to Value-Based Healthcare

Care to Me

Care with Me

Care by Me

Definition of Primary Care

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

National Research Council. Defining Primary Care: An Interim Report. Washington, DC: The National Academies Press, 1994.

The Importance of Working Together in Teams

- Care delivered by teams is **safer**, leads to **better outcomes**
- However, teams don't form naturally; they must be created, nurtured, and supported
- Commitment to core values and common goals

Operational Definition of a Team

"A team is a collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, who see themselves and who are seen by others as an intact social entity embedded in one or more larger social systems and who manage their relationships across organizational boundaries."

- Cohen SG, Bailey DE. What makes teams work: Effectiveness research from the shop floor to the executive suite. J Manage 1997;23:239-290.

NAM Definition of Team-Based Care

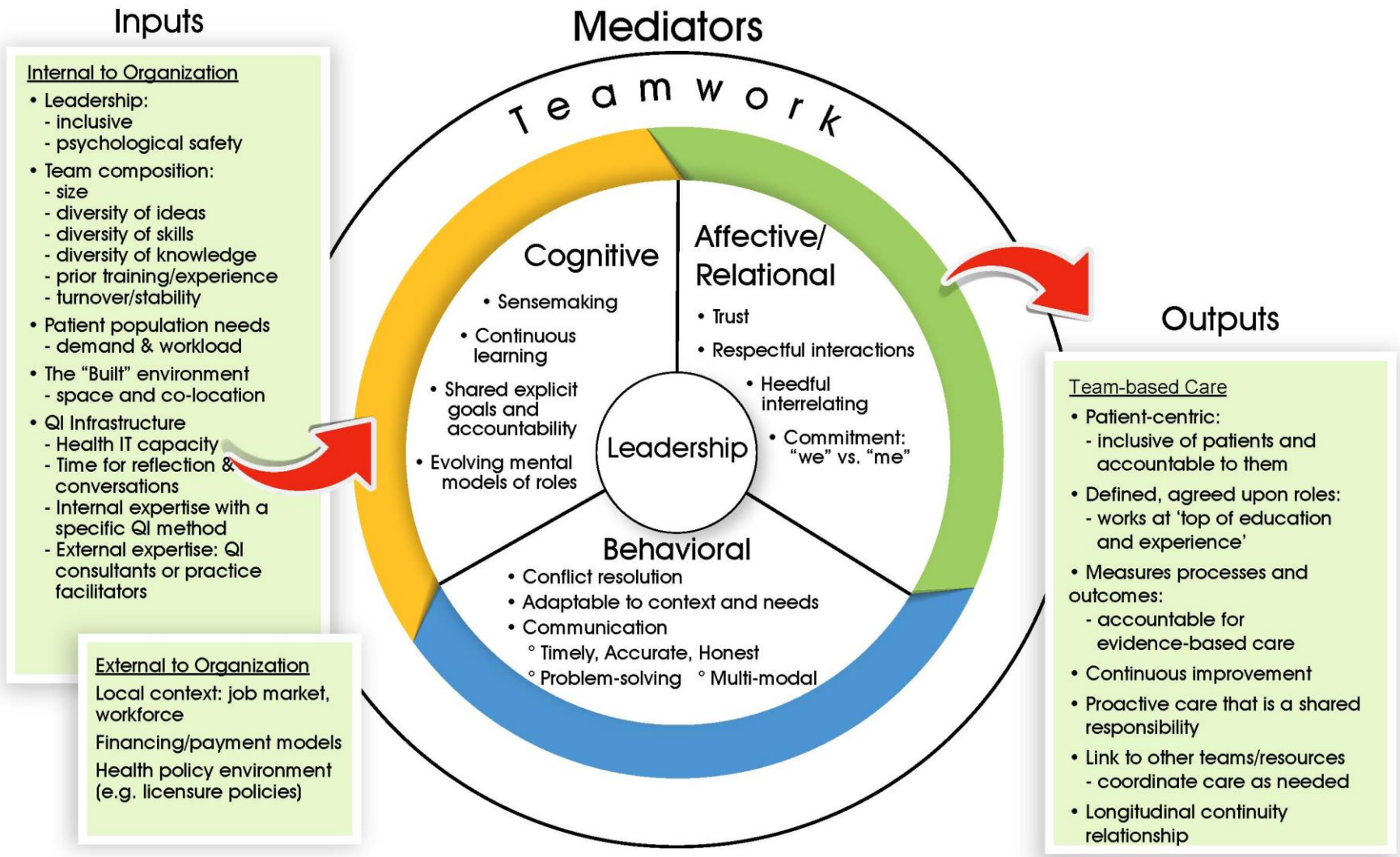
"…the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers-to the extent preferred by each patient-to accomplish shared goals within and across settings to achieve coordinated, high-quality care."

Mitchell, P., M. Wynia, R. Golden, B. et al. 2012. Core principles & values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC. .

Background

- Research on teams is available from other sectors
- Accumulating evidence that effective teams are associated with better patient outcomes
- Increasing recognition that successful primary care redesign efforts (e.g., medical home) will require a high-functioning primary care team that teams with other teams
- Tools and instruments to support these activities are critical
- Growing agreement on attributes of effective team-based care
- Education has similarly been evolving towards interprofessional models and curricula

Conceptual Framework - Team-based Care



Shoemaker, S. J., Parchman, M. L., Fuda, K. K., Schaefer, J., Levin, J., Hunt, M., & Ricciardi, R. (2016). A review of instruments to measure interprofessional team-based primary care. Journal of Interprofessional Care, 30(4), 423-432.

Teamwork

Refers to the actual behaviors, cognitions, and attitudes that make interdependence possible

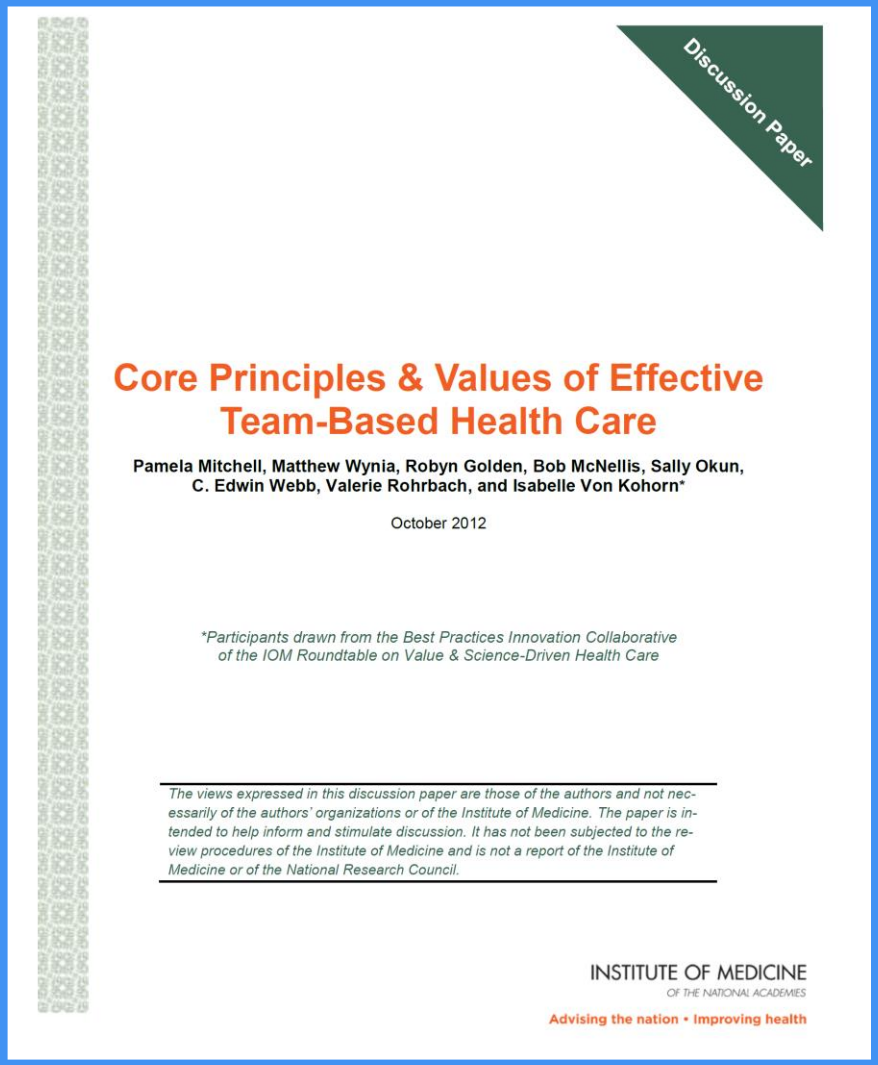
Salas, E. & Frush, K. Improving patient safety through teamwork and team training. (2013)

TeamSTEPPS®

- Evidence-based system to improve communication and teamwork among health care professionals
- Rooted in more than 20 years of research and lessons from application of teamwork principles within many industries
- Developed by Department of Defense's Patient Safety Program in collaboration with AHRQ

http://teamstepps.ahrq.gov

Team-based Care and Role of Patients and Family


Discussion Paper

Core Principles & Values of Effective Team-Based Health Care

Pamela Mitchell, Matthew Wynia, Robyn Golden, Bob McNellis, Sally Okun, C. Edwin Webb, Valerie Rohrbach, and Isabelle Von Kohorn*

October 2012

*Participants drawn from the Best Practices Innovation Collaborative of the IOM Roundtable on Value & Science-Driven Health Care

The views expressed in this discussion paper are those of the authors and not necessarily of the authors' organizations or of the Institute of Medicine. The paper is intended to help inform and stimulate discussion. It has not been subjected to the review procedures of the Institute of Medicine and is not a report of the Institute of Medicine or of the National Research Council.

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Discussion Paper

Patients and Health Care Teams Forging Effective Partnerships

Sally Okun, Stephen C. Schoenbaum, David Andrews, Preeta Chidambaran, Veronica Chollette, Jessie Gruman, Sandra Leal, Beth A. Lown, Pamela H. Mitchell, Carly Parry, Wendy Prins, Richard Ricciardi, Melissa A. Simon, Ron Stock, Dale C. Strasser, C. Edwin Webb, Matthew K. Wynia, and Diedtra Henderson*

December 2014

The authors are participants in the activities of the IOM Roundtable on Value & Science-Driven Health Care. The views expressed are those of the authors and not necessarily of the authors' organizations or of the Institute of Medicine. The paper is intended to help inform and stimulate discussion. It has not been through the review procedures of The National Academies and is not a report of the Institute of Medicine or of the National Research Council.

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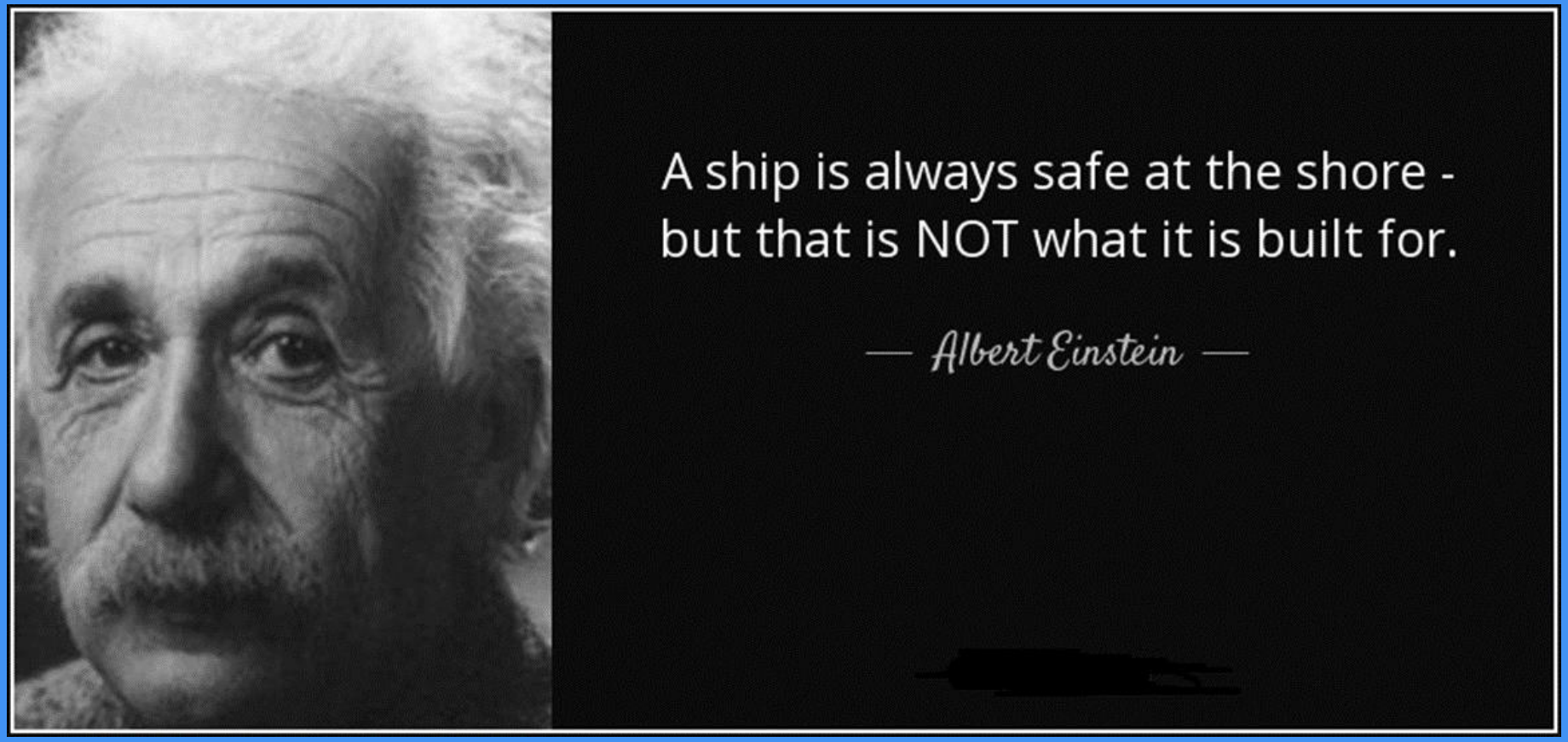
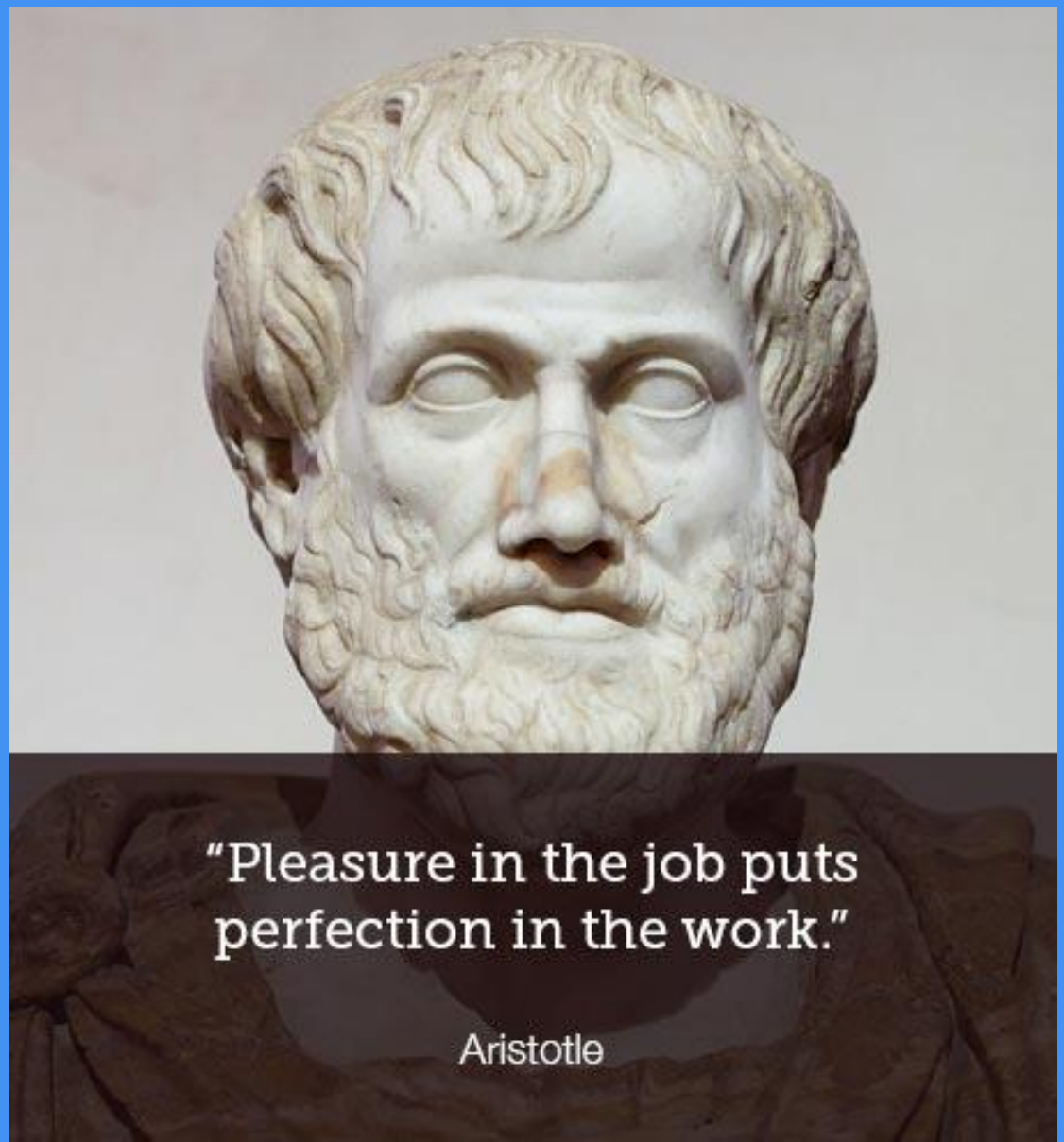

A ship is always safe at the shore -
but that is NOT what it is built for.
— Albert Einstein —

Dream Big - Follow Your Passion

Questions/Discussion



MOVING TO VALUE: CMS STRATEGY FOR IMPROVING THE QUALITY OF CARE

Jean Moody-Williams, RN, MPP

Acting Consortium Administrator, Consortium of Quality Improvement and Survey and Certification Operations

Deputy Center Director, Center for Clinical Standards and Quality

Center for Medicare & Medicaid Services

Disclaimer

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This presentation is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

No financial conflicts to disclose.

HHS Department-Level Strategy

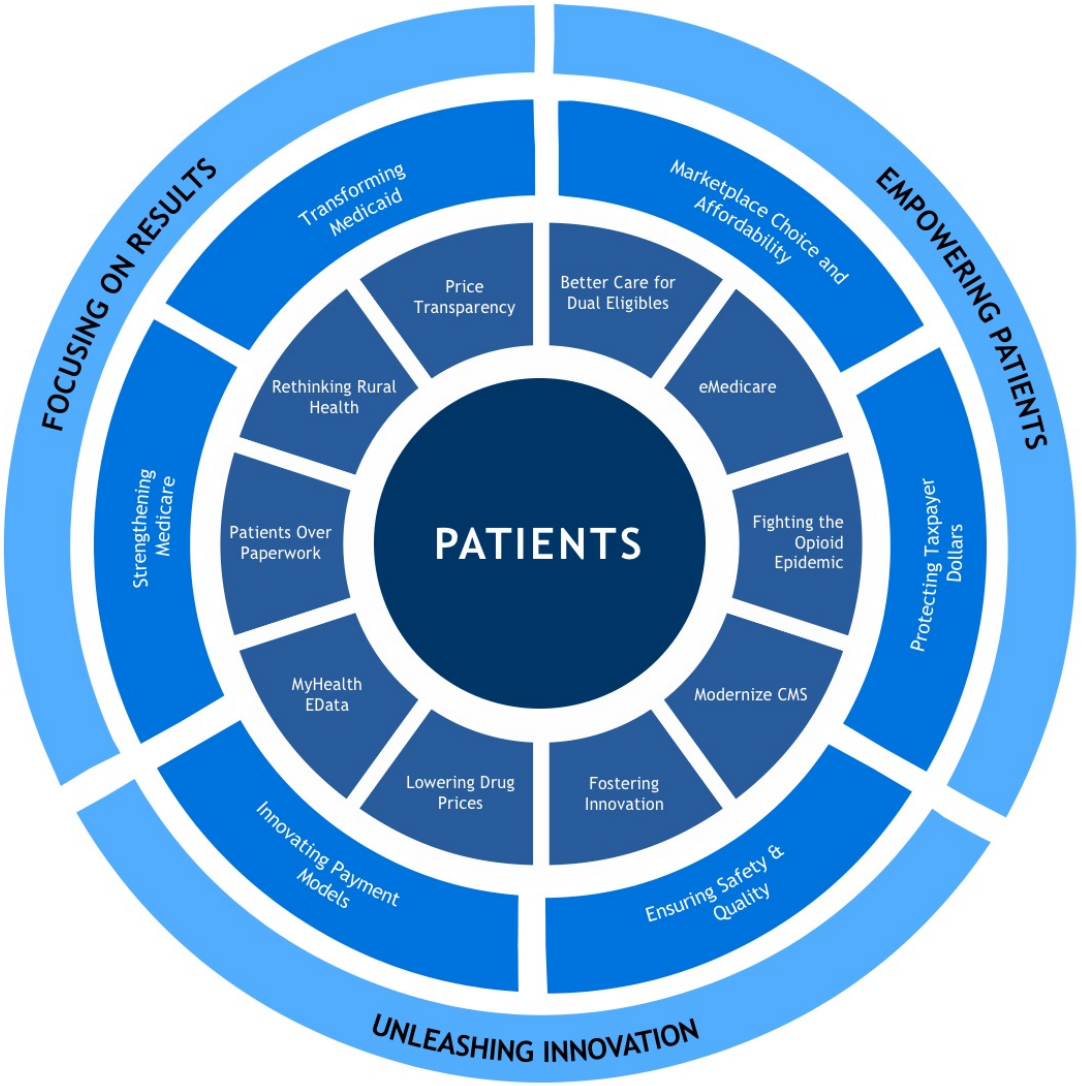
a health care system that results in better accessibility, quality, affordability, empowerment, and innovation

CMS has started a national conversation about **improving the health care delivery system**, how Medicare can contribute to making the delivery system less bureaucratic and complex, and how we can **reduce burden for clinicians, providers and beneficiaries** in a way that **increases quality of care** and decreases costs – **making the health care system more effective,** simple, and accessible, while maintaining program integrity and preventing fraud

Size and Scope of CMS Responsibilities

- CMS is the largest purchaser of health care in the world
- Combined, Medicare and Medicaid pay approximately one-third of national health expenditures (approx $800B)
- CMS covers 140 million people through Medicare, Medicaid, the Children's Health Insurance Program; or roughly 1 in every 3 Americans
- The Medicare program alone pays out over $1.5 billion in benefit payments per day
- Through various contractors, CMS processes over 1.2 billion fee-for-service claims and answers about 75 million inquiries annually

CMS Strategic Priorities for 2019



CMS Program Authorities

CMS Quality Payment Program
Hospital Value-Based Purchasing
ESRD Quality Improvement Program
Skilled Nursing Facility
Home Health Agencies,

Hospital Readmissions Reduction Program
Health Care Associated Conditions Program
Medicare Physician Fee Schedule
Physician Feedback Report Quality Resource Utilization Report

Care and Payment Model Tests
Accountable Care Organizations
Dual eligible demonstrations
Medicaid Section 1115 Waivers
Medicaid HCBS Programs
Medicaid State Plan Amendments

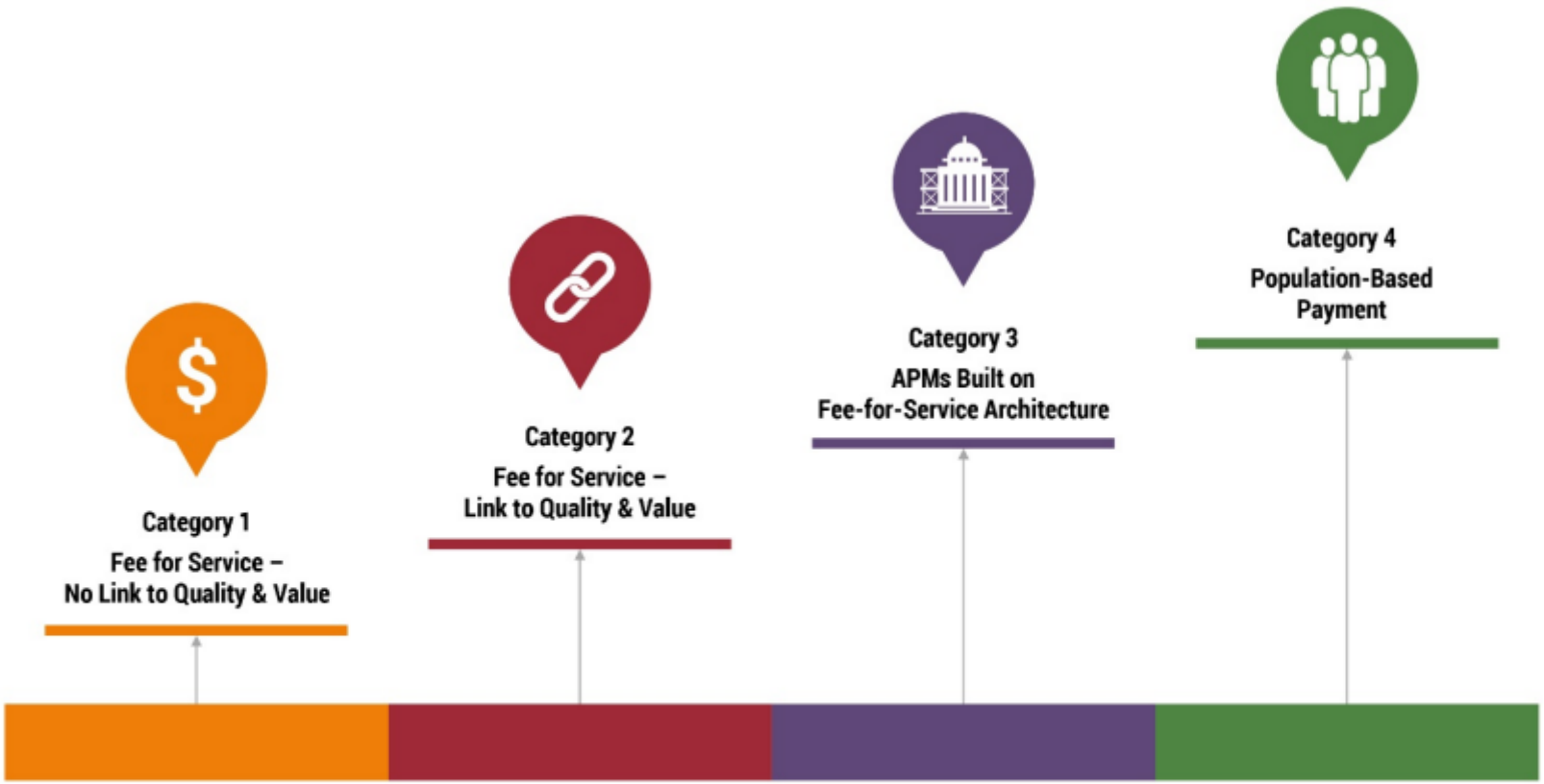
Targeted surveys
Quality Assurance Performance Improvement

Hospitals and PAC facilities, Home Health Agencies, ESRD Facilities, Hospices
Measure Development

QIOs
Hospital Innovation & Improvement Networks
ESRD Networks

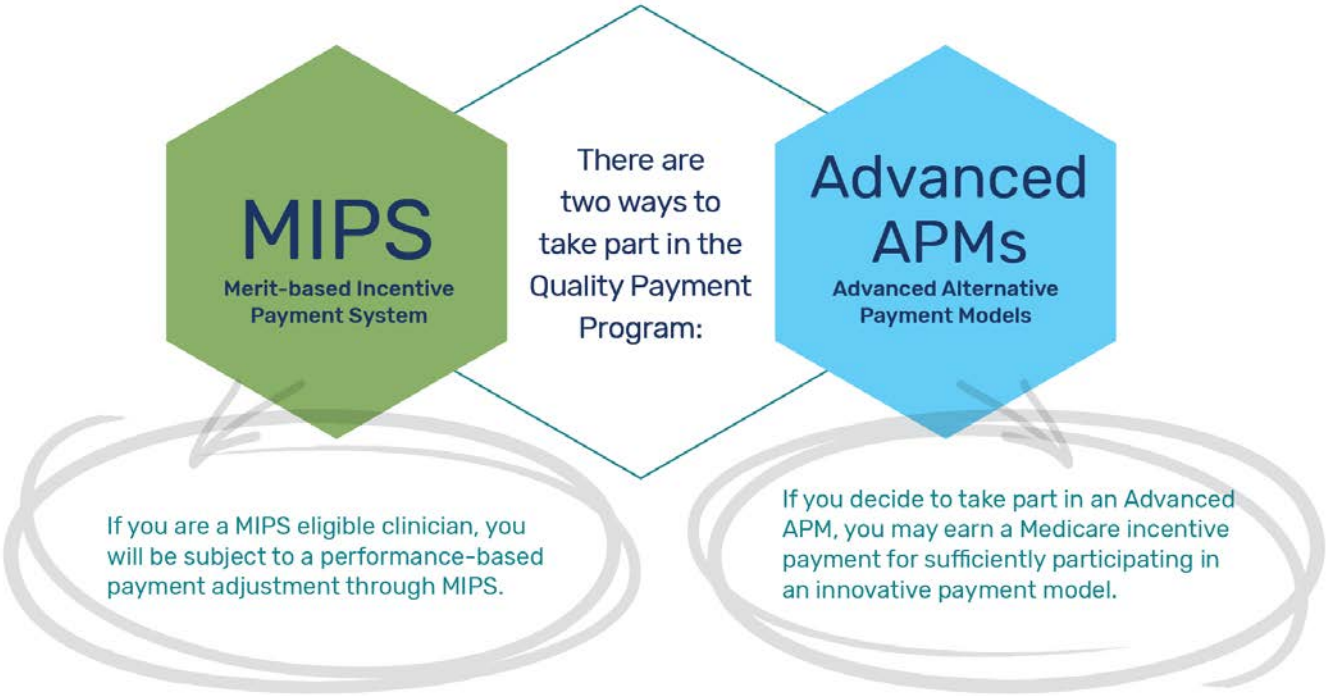
Hospital Inpatient Quality, Hospital Outpatient
In-Patient Psychiatric Hospitals
Cancer hospitals, Ambulatory Surgical Centers
Nursing homes
Home Health Agencies
Long-term Care Acute Hospitals
In-patient rehabilitation facilities
Hospices
ESRD Facilities

Payment Model Framework



Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides two participation tracks:



MIPS Value Pathways

While there have been incremental changes to the program each year, additional long-term improvements are needed to align with CMS' goal to develop a meaningful program for every clinician, regardless of practice size or specialty.

CMS has proposed **MIPS Value Pathways (MVPs)** to create a new participation framework beginning with the 2021 performance year. This new framework would:

- Unite and connect measures and activities across the **Quality**, **Cost**, **Promoting Interoperability**, and **Improvement Activities** performance categories of MIPS
- Incorporate a set of administrative claims-based quality measures that focus on population health/public health priorities
- Streamline MIPS reporting by limiting the number of required specialty or condition specific measures

MIPS Value Pathways

Current Structure of MIPS
(In 2020)

- Many Choices
- Not Meaningfully Aligned
- Higher Reporting Burden

New MIPS Value Pathways Framework
(In Next 1-2 Years)

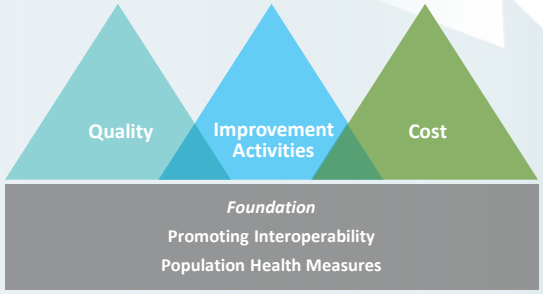
- Cohesive
- Lower Reporting Burden
- Focused Participation around Pathways that are Meaningful to Clinician's Practice/Specialty or Public Health Priority

Building Pathways Framework

MIPS Value Pathways

Clinicians report on fewer measures and activities base on specialty and/or outcome within a MIPS Value Pathway

Moving to Value



Future State of MIPS
(In Next 3-5 Years)

- Simplified
- Increased Voice of the Patient
- Increased CMS Provided Data
- Facilitates Movement to Alternative Payment Models (APMs)

Fully Implemented Pathways

Continue to increase CMS provided data and feedback to reduce reporting burden on clinicians

Population Health Measures: *a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.*

Clinician/Group Reported Data CMS Provided Data

Goal is for clinicians to report less burdensome data as MIPS evolves and for CMS to provide more data through administrative claims and enhanced performance feedback that is meaningful to clinicians and patients.

We Need Your Feedback on:

Pathways:
What should be the structure and focus of the Pathways? What criteria should we use to select measures and activities?

Participation:
What policies are needed for small practices and multi-specialty practices? Should there be a choice of measures and activities within Pathways?

Public Reporting:
How should information be reported to patients?
Should we move toward reporting at the individual clinician level?

Meaningful Measures

What is it?

Launched in 2017, the purpose of the Meaningful Measures initiative is to:

- Improve outcomes for patients
- Reduce data reporting burden and costs on clinicians and other health care providers
- Focus CMS's quality measurement and improvement efforts to better align with what is most meaningful to patients and clinicians

Meaningful Measures

Domains with Focus Areas

Promote Effective Communication & Coordination of Care

Meaningful Measure Areas

- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

Promote Effective Prevention & Treatment of Chronic Disease

Meaningful Measure Areas

- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

Work With Communities to Promote Best Practices of Healthy Living

Meaningful Measure Areas

- Equity of Care
- Community Engagement

Make Care Affordable

Meaningful Measure Areas

- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

Strengthen Person & Family Engagement as Partners in their Care

Meaningful Measure Areas

- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Functional Outcomes

Make Care Safer by Reducing Harm Caused in the Delivery of Care

Meaningful Measure Areas

- Healthcare-Associated Infections
- Preventable Healthcare Harm

Meaningful Measures

Filling the Gaps

- Appropriate use of opioids and avoidance of harm
- Nursing home safety measures
- Interoperability and care transitions
- Appropriate use of services
- Patient-reported outcome measures

Transparency

- Star Ratings
  - Nursing Home Compare
  - Hospital Compare
  - Physician Compare
- Price Transparency
- Quality Data Strategy
  - More rapid feedback to clinicians
  - API development for sharing quality data
  - Sharing data more broadly for research

Putting Data in the Hands of Patients

What this means for CMS

- Blue Button 2.0
  - Developer-friendly, standards-based API
  - Developer preview program – open now (over 1200 developers so far)
  - Data security is of the utmost importance
- Promoting Interoperability Program for Hospitals and Clinicians
  - Program alignment
  - Strong emphasis on interoperability and privacy/security
  - 2015 edition Certified EHR Technology
- Prevention of Information Blocking
- Star Ratings

Keeping the Patient at the Center of Care

BENEFICIARY CARE ACTIVITIES & TRANSITIONS

Between March-May of 2018, 46 people with Medicare and their caregivers shared stories of care transitions. This graphic illustrates the activities and types of transitions that are the most challenging in the eyes of people with Medicare.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
VERSION 1.2

BURDENSOME ACTIVITIES

Five activities were reported as being particularly challenging to people with Medicare and their caregivers, and occur during all types of care transitions.

CHOOSING CARE

To help choose providers or care settings, people look at quality, convenience, location, coverage, recommendations, and physician specialty and training, to name a few. To make the best decisions, people with Medicare need access to consolidated, usable information.

PAYING BILLS

Getting high cost medical care is even more stressful when people do not know how much a procedure will cost beforehand. People with Medicare want to know how much they will have to pay for a treatment or procedure before receiving the bill.

KEEPING HEALTH RECORDS

People use spreadsheets, notebooks, and memory to track their medical records completely and accurately in hopes of more thorough care. People want to be able to place more trust in providers to record, store, and read their medical history so as to provide the best care possible.

MANAGING MEDICATION

Prior authorizations, changing costs, and the danger of drug interactions add difficulty to people's lives. People want prescriptions to be managed more completely, a Medicare Part D that is easier to understand, fewer sudden changes in coverage, and more affordable prescription drug prices.

IMPLEMENTING CARE PLAN

The best care plan is worthless if someone does not have the ability to put it into action. Issues such as a lack of in-home support, no access to transportation, and low health literacy are obstacles to following a care plan. People need more help planning and preparing for daily life beyond the appointment.

BURDENSOME TRANSITIONS

The care transitions listed here were revealed as being exceptionally burdensome for people with Medicare.

1 Ambulance Transport

When faced with health emergencies, many people look to ambulances for access to care, not understanding that most ambulance trips are not covered. Consequently, many people end up paying large ambulance bills. To curb ambulance costs, some people now use ride-sharing services or taxis.

"I remember fighting with the insurance company. I used to take her to church but it got to be so hard to get her in and out of the car that I had to quit taking her to church. She went to the hospital after a fall and the insurance company didn't want to pay for the return ambulance trip." - Person with Medicare also acting as Caregiver

2 Hospital ↔ Home

Returning home is challenging when discharge plans do not account for details of life beyond the hospital. Transitions can be particularly difficult when a person misunderstands his or her care plan, does not have at-home support, or lacks proper medical equipment, all of which are crucial to implementing care plans.

"Be sure the social worker sees the patient to plan for release back home or to a facility. [Ask] what is needed? Is there support at home? If not, does the patient need inpatient nursing care or will home nursing care be sufficient? Does the patient need to be trained to care for things like a feeding tube? Who provides that training, support, and follow-up?"
- Person with Medicare

3 Hospital ↔ Nursing Home

Oftentimes moving between a hospital and a nursing home is cyclical and stressful in itself even without the added stresses of Medicare rules. People report confusion about the 3-day rule, feeling rushed to make decisions, and lacking usable, consolidated information to help them choose a nursing home.

"It's difficult to be hospitalized, we all know that. But then you're thinking about going to a nursing home, and then we add upon that the difficulty of understanding payment, dealing with a difficult situation mentally, and then there's paperwork and you might not understand all of that, so it kind of compounds that burden.
- Subject Matter Expert

4 Home Health

Although many people want to receive care in their own homes, finding reliable home health agencies, who are also covered by Medicare, is not an easy task. Caregivers are often either stuck with sub-par care, or are forced to pay out-of-pocket for better care.

"I pay privately for aides. We tried 3 different home health agencies covered through CMS and it was awful, actually it scared me, so I said, 'I'm paying.' I went down to see who was coming to his apartment and they were someone new every day …so that's a big part of burden is trying to set up home health care and then getting that right care.
- Caregiver of a Person with Medicare

5 Provider ↔ Provider

For many people, going to a new provider feels like a long game of telephone. Incomplete medical records, disconnected electronic health record (EHR) systems, privacy rules, and a lack of collaboration across providers make the continuous, comprehensive care that people with Medicare desire nearly impossible to achieve.

"I don't find that doctors transfer data anyways. I mean you even have a hard time getting information from your pulmonologist to your general practitioner and back. I mean with the general practitioner you're working with your blood pressure medicine, and then that's it. But the blood pressure medicine affects your breathing." - Person with Medicare

Thank You!

Jean Moody-Williams, RN, MPP

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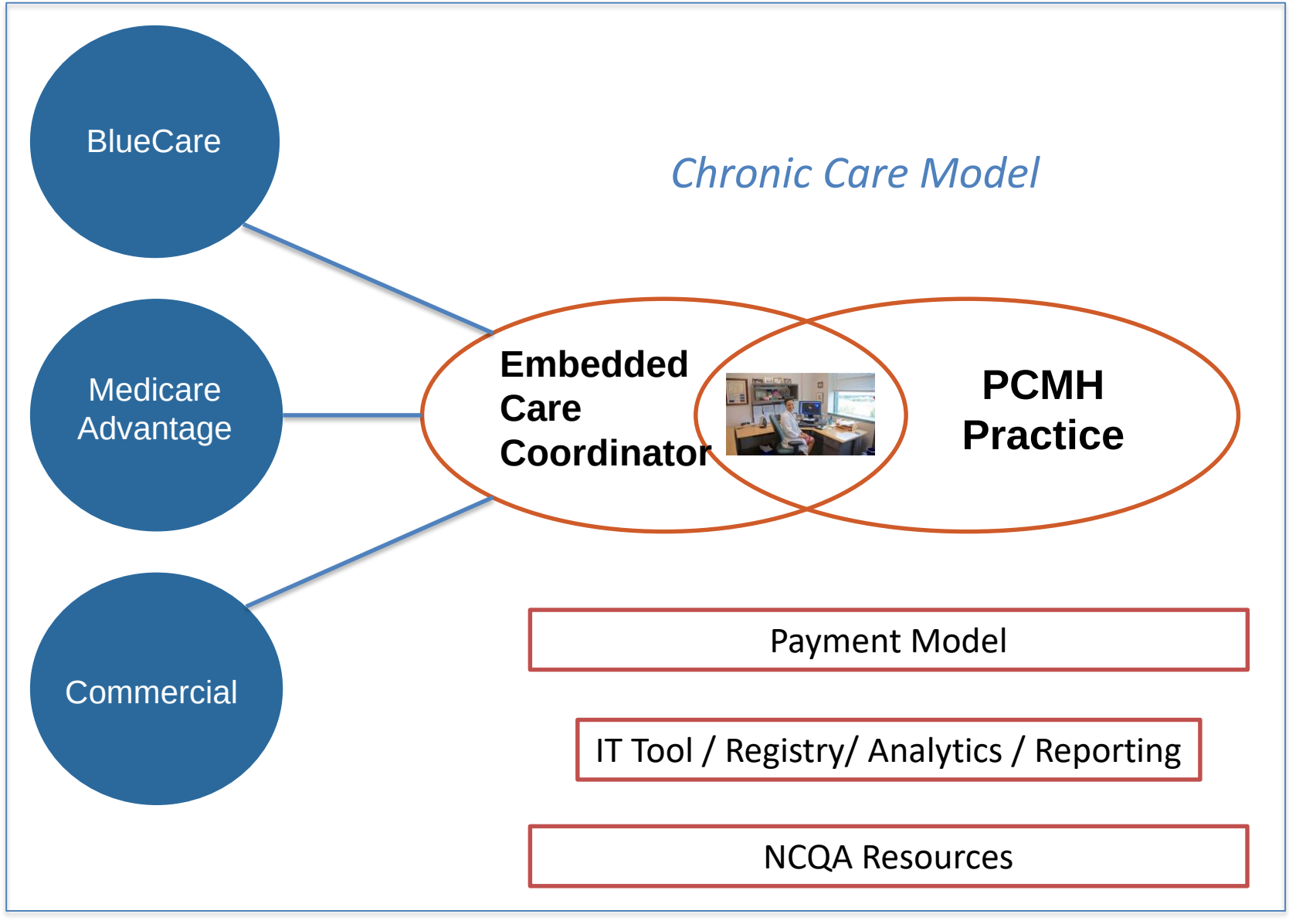
of Tennessee

BCBST
Value-Based Care Strategies

Nancy Jean Muldowney, BSN, RN, MLAS
Provider Network Management Program
Middle Region

October 2, 2019

Care Coordinators: Connectors & Integrators



Patient-Centered Medical Home (PCMH) Program – Key Components

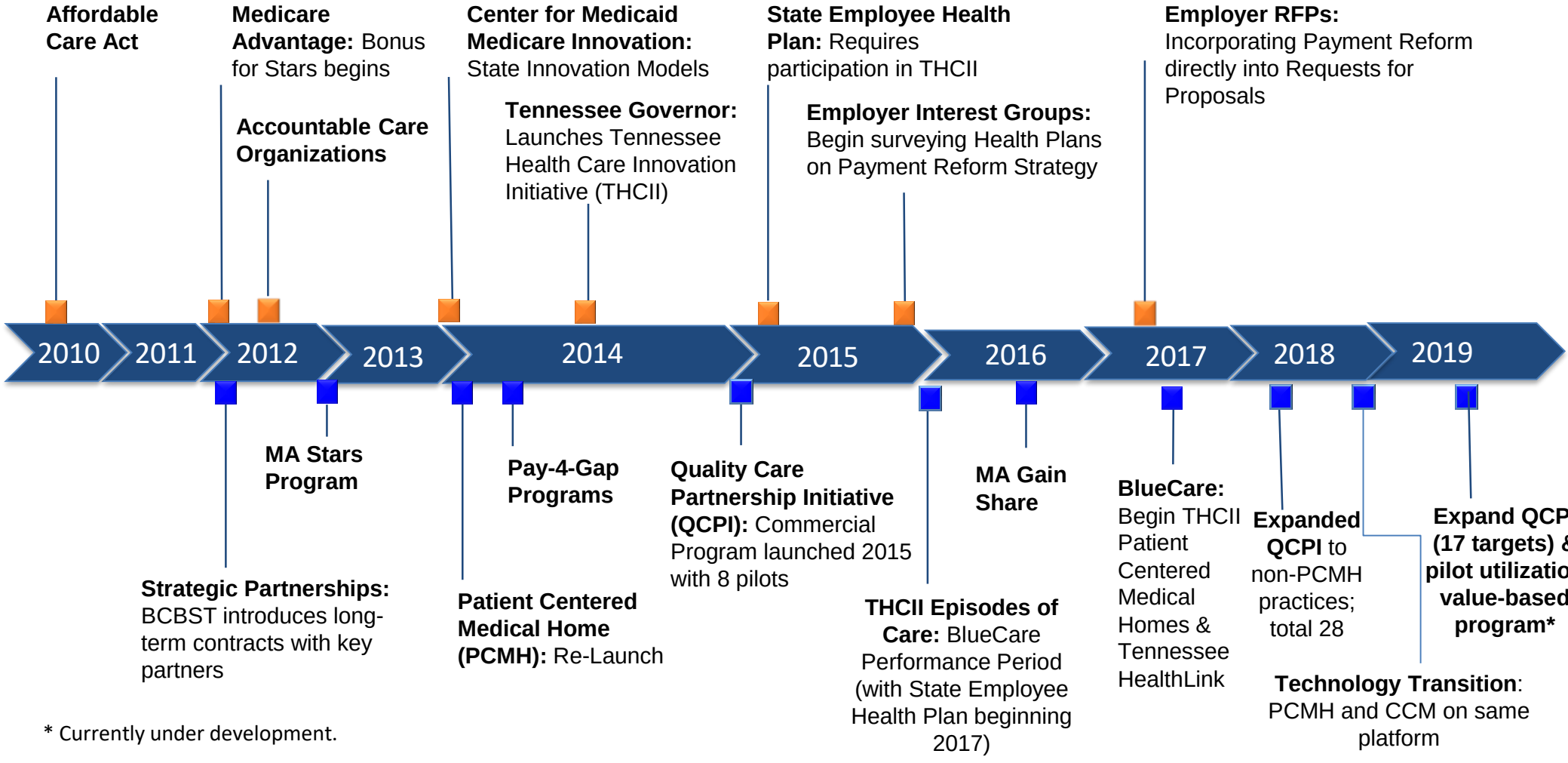
- ***Physician directed medical practice:***
  - The personal physician leads a practice team to take responsibility for the ongoing care of the patient
- ***Care is Coordinated and Integrated across all elements of the health care system***: (hospitals, health agencies, nursing homes, etc.)
- ***Quality and Safety: hallmarks of the PCMH.***
  - Evidence based medicine and clinical outcomes are measured and monitored to ensure continuous quality improvement in patient care
- ***Enhanced access to care***
  - Open scheduling, expanded hours, email/telephonic consultations

Patient-Centered Medical Home (PCMH) Program - Care Coordinator Roles & Responsibilities

- Nurses assisting with coordination of patient care needs and education on comorbid conditions: CHF, Diabetes, HTN, CAD, COPD and Asthma (telephonic and face-to-face)
  - Patients
  - Caregivers
- Focus on High ER utilizers and High Inpatient utilizers
  - Ensuring timely post D/C follow-up
  - Ensuring medications prescribed at D/C have been filled and patient is taking medications properly
  - Symptom management
- No PCP visit within the year – reaching out to schedule and complete visit
- Referrals to Chronic Case Management / Social Work
- Building relationships and trust with primary care providers and other specialists within their PCMH practice

Why Pay for Value

"The [Institute of Medicine] report found that higher prices, administrative expenses, and fraud accounted for almost half of [the $750 billion per year in] waste. Bigger than any of those, however, was the amount spent on unnecessary healthcare services." Dr. Atul Gawande, surgeon, researcher and CEO of Amazon-Berkshire-JPMorgan Chase health care partnership.



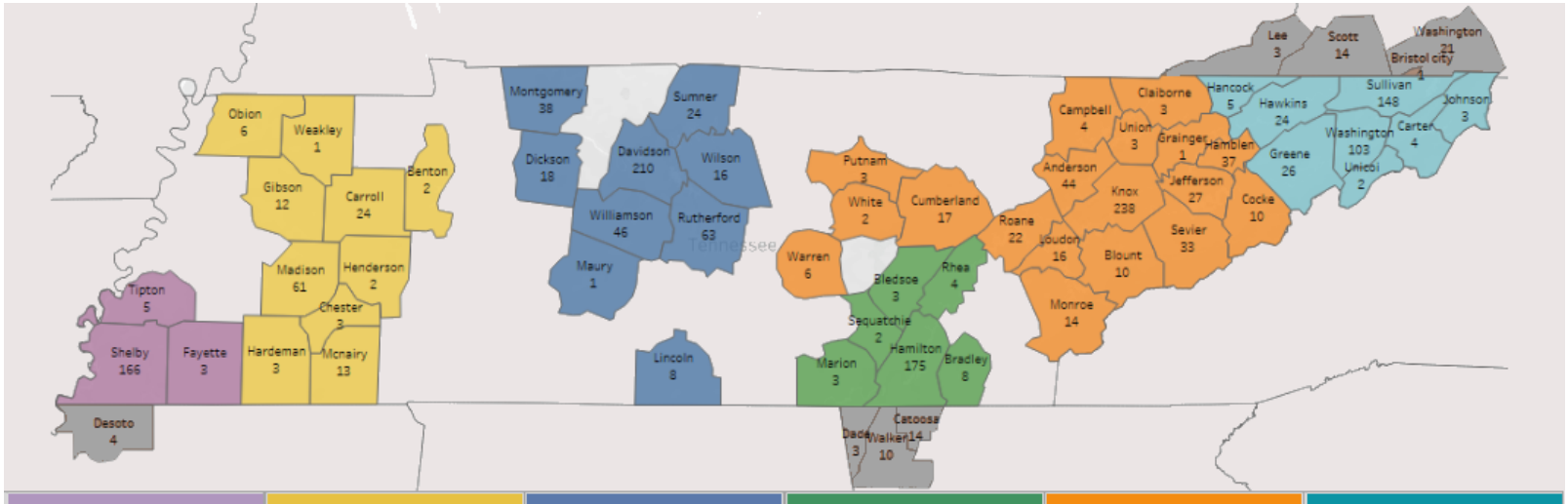
* Currently under development.

PRIMARY CARE STRATEGY

PATIENT CENTERED MEDICAL HOMES

~ 309K members attributed to the medical home; 27 practices

~ 337 locations with ~1,650 providers participating.



Memphis		Jackson		Nashville		Chattanooga		Knoxville		Johnson City	
Amisub SFH Inc	39	Jackson Clinic PA	59	Dickson Medical Associates	19	Erlanger Health Systems	71	Chota Community Health Services	12	Ballad Health Medical Assoc.	40
BMG of Tennessee	86	McKenzie Medical Center PC	21	Heritage Medical Associates PC	73	Galen Medical Group	28	Covenant Medical Management Group	126	Holston Medical Group	59
Consolidated Medical Practices of Memphis	46	West Tennessee Medical Group Inc	38	HH Physician Care Fayetteville Medical	8	Memorial Health Partners	109	Healthstar Physicians PC (UPA)	45	Mountain Region Family Medicine PC	20
The Family Physicians Group PC	16			Murfreesboro Medical Clinic PA	36			Summit Medical Group PLLC	304	Rural Health Services Consortiium Inc	38
				Premier Medical Group PC	37					State of Franklin Healthcare Assoc.	62
				St. Thomas Medical Partners	153					Universiy Physicians Practice Group	54
				Vanderbilt Medical Group	110						

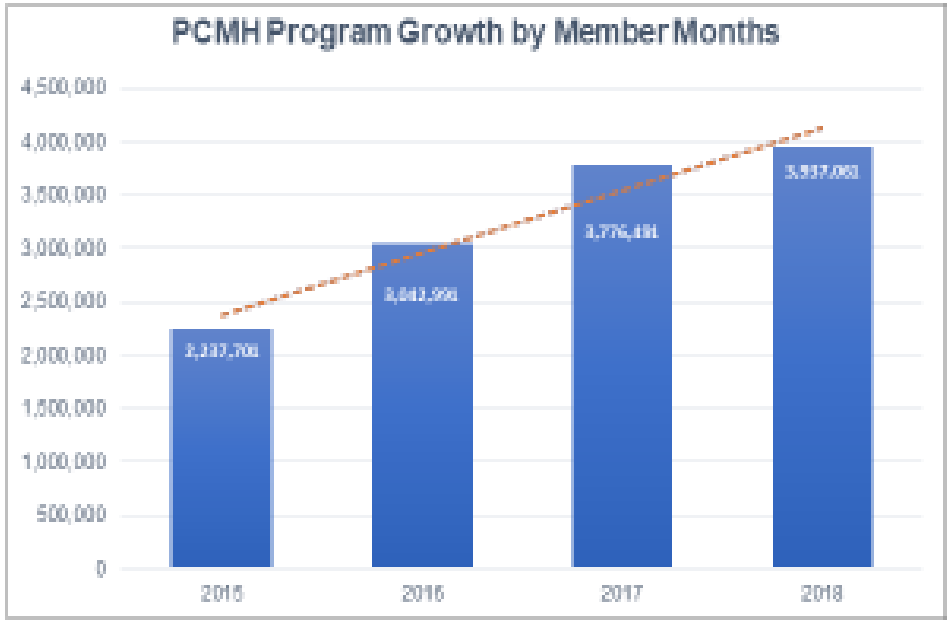
PCMH Program Growth – 2015 - 2018

Growth of PCMH Program: 2015 - 2018

Growth of PCMH Program by Member Months	2015	2016	2017	2018	% of Growth over 4 Years
PCMH Program	2,237,701	3,042,991	3,776,491	3,937,061	76%
West	308,503	324,317	454,313	562,167	82%
East	626,078	949,093	1,273,949	1,388,637	121%
Middle	794,760	1,090,174	1,170,137	1,169,458	47%
Tri-Cities	506,360	679,408	878,092	816,799	61%

Trend of PCMH Expansions	2015	2016	2017	2018
PCMH Expansion	8	7	6	3
West	2	1	4	2
East	1	4	0	0
Middle	3	1	2	0
Tri-Cities	1	1	0	+1 / -1

Note: In 2018, one group was termed within the Tri-Cities Region, and one group was added



PCMH Practices

In 2015, PCMH practices began participating in the Quality Care Partnership Initiative (QCPI), a Commercial value-based quality program. All PCMH practices must participate in QCPI by the end of 2019.

QUALITY CARE PARTNERSHIP INITIATIVE (QCPI)

- QCPI represents our expanded effort build incentive around the quality paradigm and advance pay for value reimbursement.
- Through fee schedules, participants have the incentive to earn an increase or decrease to their fee schedule depending on performance, which focus ~ 25 HEDIS measures.
- 2019 begins the 4th year of QCPI operations; the program continues to trend positively in comparison to other programs; reinforcing the HEDIS® objective and securing the rationale for continued investment.
- QCPI is now demonstrating “program effect” and illustrating actual performance change within engaged practices. Continued provider engagement strategy should yield year-over-year similar results

Where are we…and where are we going?

NATIONAL

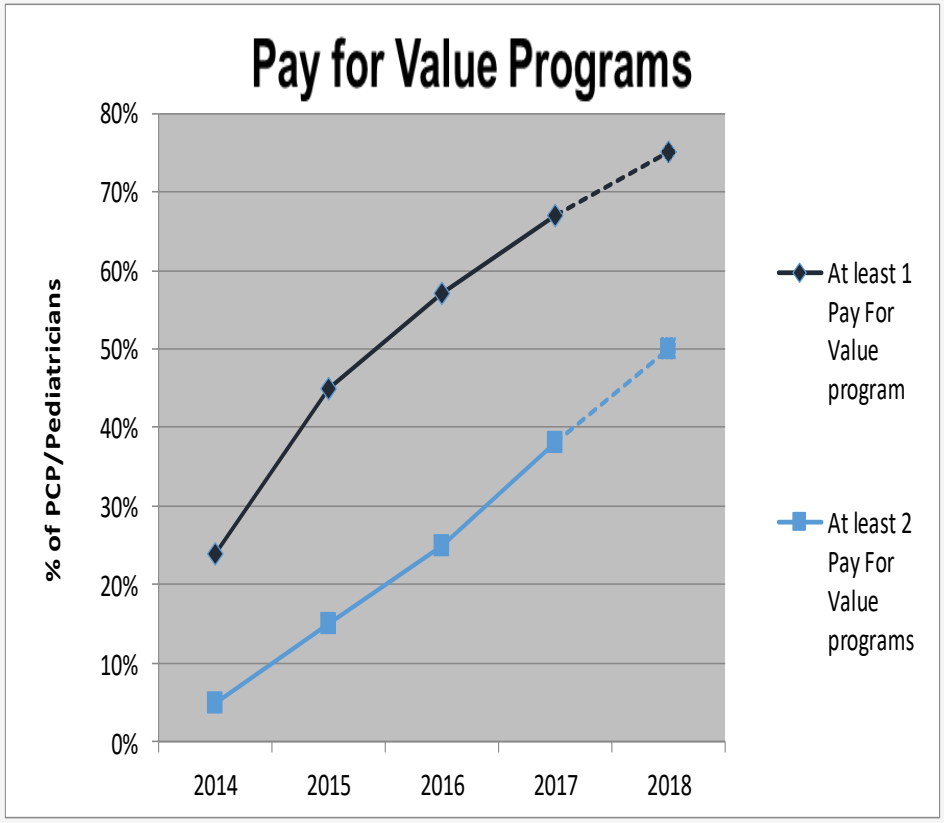
Market Comparison

Nationally, physician participation in value-based payment models is growing slowly:

- Approximately 30% participation in 2016
- Approximately 25% participation in 2014

Deloitte University Press; Practicing value-based care: What do doctors need?, 2016

BCBST



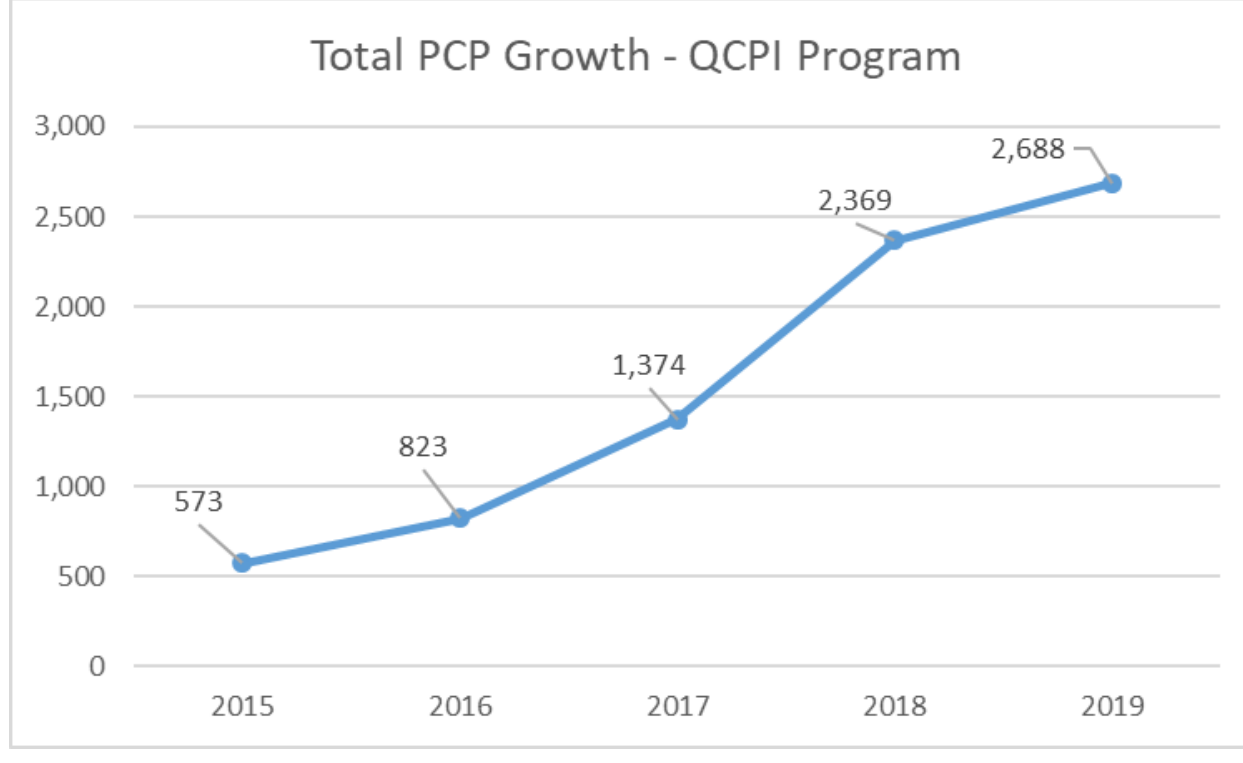
Goal: 86% of primary care doctors in 1 or more value-based program by end of 2018

QCPI 2018 Preliminary Scores

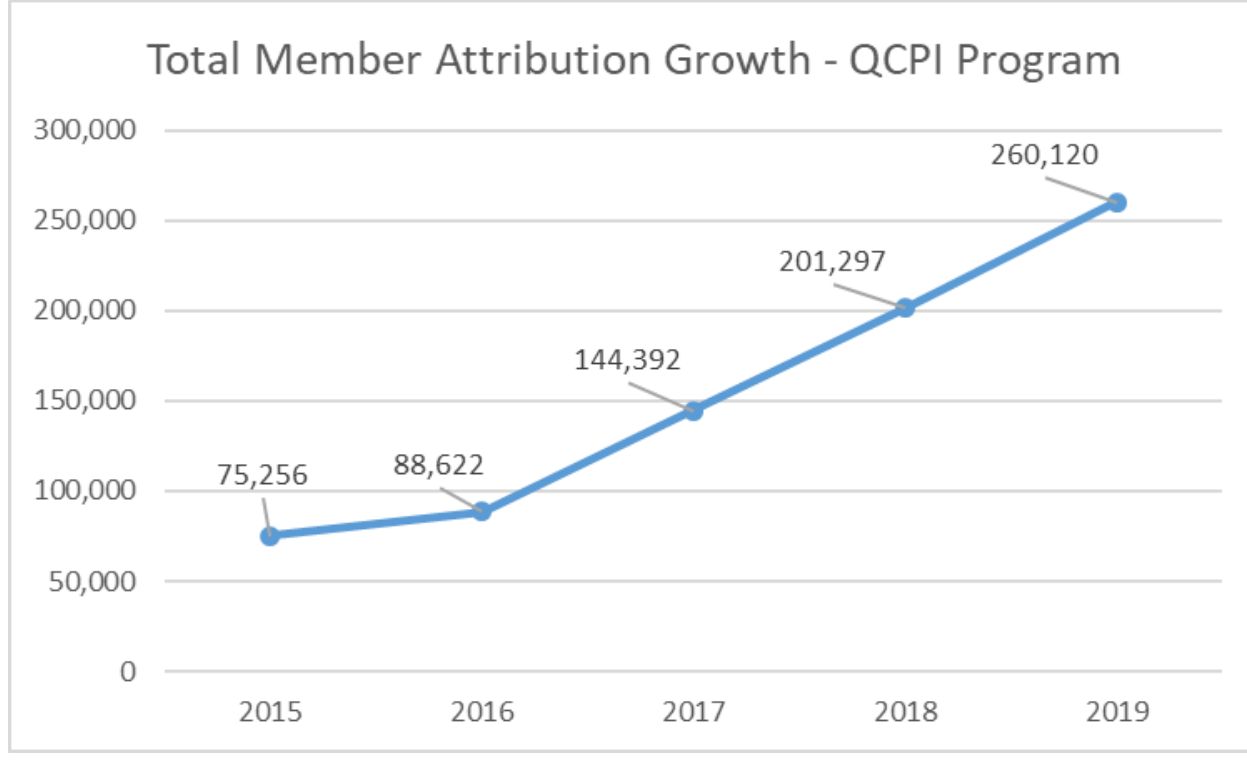
BENCHMARK POINTS NEEDED	1 STAR	2 STARS	3 STARS	4 STARS	5 STARS
POINTS NEEDED	<= 39	>= 40	>= 56	>= 73	>= 89
PRV_GRP_DSPLY_NME	REGION	PTS EARNED	STAR VALUE	POINTS TO NEXT LEVEL	CDE
State of Franklin Healthcare Associates PLLC	TriCities	99	5.0	0	Exchanging - Yellow
Columbia Pediatric Clinic Inc	Middle	95	5.0	0	No CDE
Murfreesboro Medical Clinic PA	Middle	94	5.0	0	Exchanging - Green
Premier Medical Group PC	Middle	94	5.0	0	Exchanging - Yellow
University Physicians Practice Group	TriCities	94	5.0	0	Exchanging - Yellow
Williamson Medical Group LLC	Middle	92	5.0	0	Testing
Cookeville Primary Care Associates	Middle	91	5.0	0	Exchanging - Green
Old Harding Pediatrics Associates	Middle	87	4.0	2	Exchanging - Green
Jackson Clinic PA	West	81	4.0	8	Exchanging - Yellow
Amisub SFH Inc	West	80	4.0	9	Exchanging - Yellow
Wellmont Medical Associates Inc	TriCities	80	4.0	9	Exchanging - Yellow
Holston Medical Group	TriCities	77	4.0	12	Exchanging - Green
Mountain Region Family Medicine PC	TriCities	77	4.0	12	Exchanging - Green
Blue Ridge Medical Management Corporation	TriCities	76	4.0	13	Exchanging - Yellow
McKenzie Medical Center PC	West	76	4.0	13	Exchanging - Yellow
HH Physician Care Fayetteville Medical Associates	Middle	75	4.0	14	Exchanging - Yellow
Vanderbilt Medical Group	Middle	74	4.0	15	Exchanging
Summit Medical Group PLLC	Knox	72	3.0	1	Exchanging - Yellow
Medical Care PLLC	TriCities	70	3.0	3	Exchanging - Yellow
Chota Community Health Services	Knox	69	3.0	4	Exchanging - Yellow
Cherokee Health Systems	Knox	66	3.0	7	Testing
Family Health Group	Middle	62	3.0	11	No CDE
Northcrest Physicians Services Inc	Middle	62	3.0	11	Exchanging - Yellow
Rural Health Services Consortium Inc	TriCities	62	3.0	11	Exchanging - Yellow
Maury Regional Hospital dba Lewis Health Center	Middle	58	3.0	15	Discussions
St Thomas Medical Partners	Middle	58	3.0	15	Exchanging - Red
West Tennessee Medical Group Inc	West	52	2.0	4	Discussions
UT Regional One Physicians Inc	West	44	2.0	12	Exchanging - Red

*Data thru Dec – Missing 3 Month Run Out

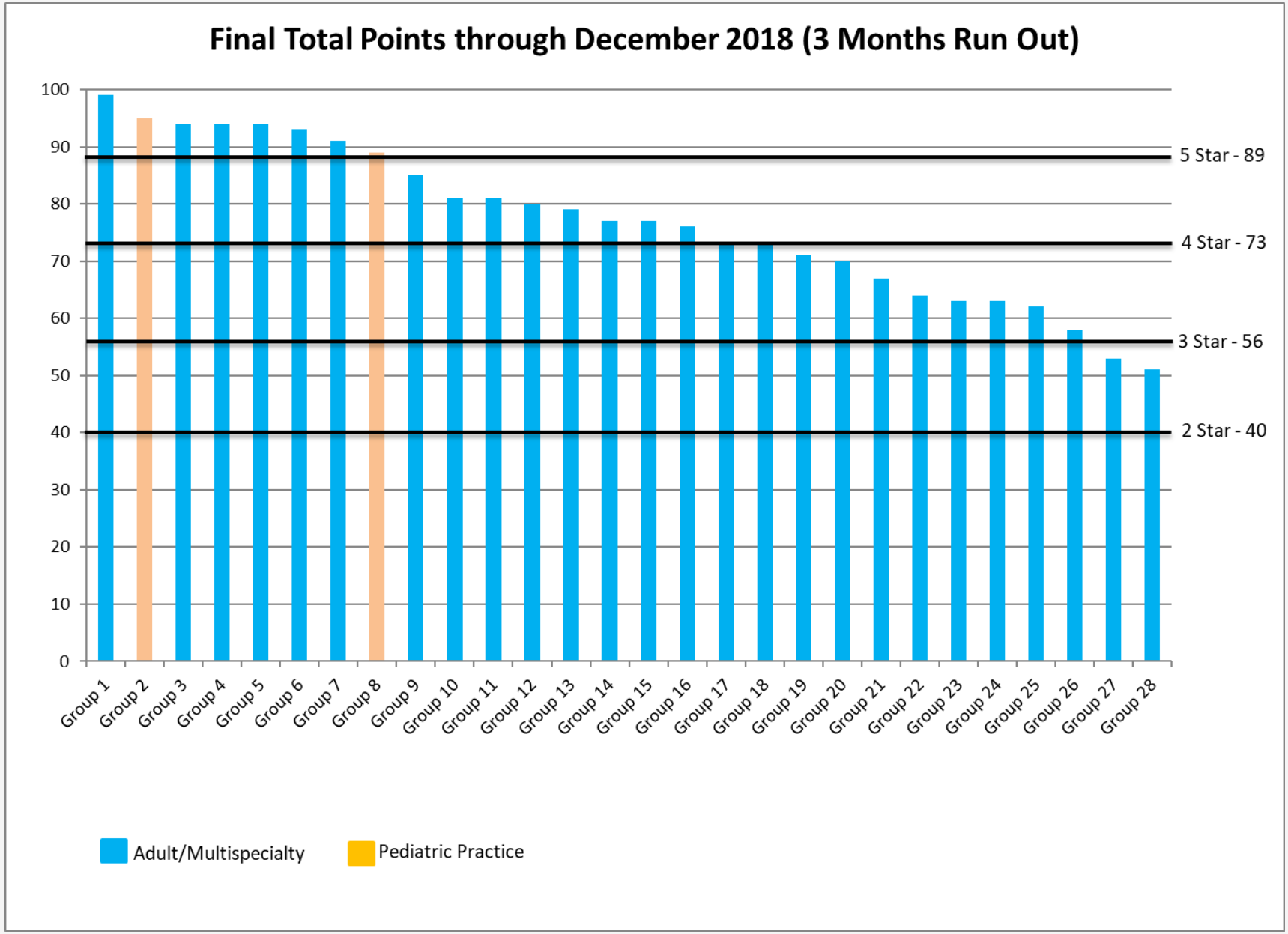
QCPI Primary Care Provider Growth



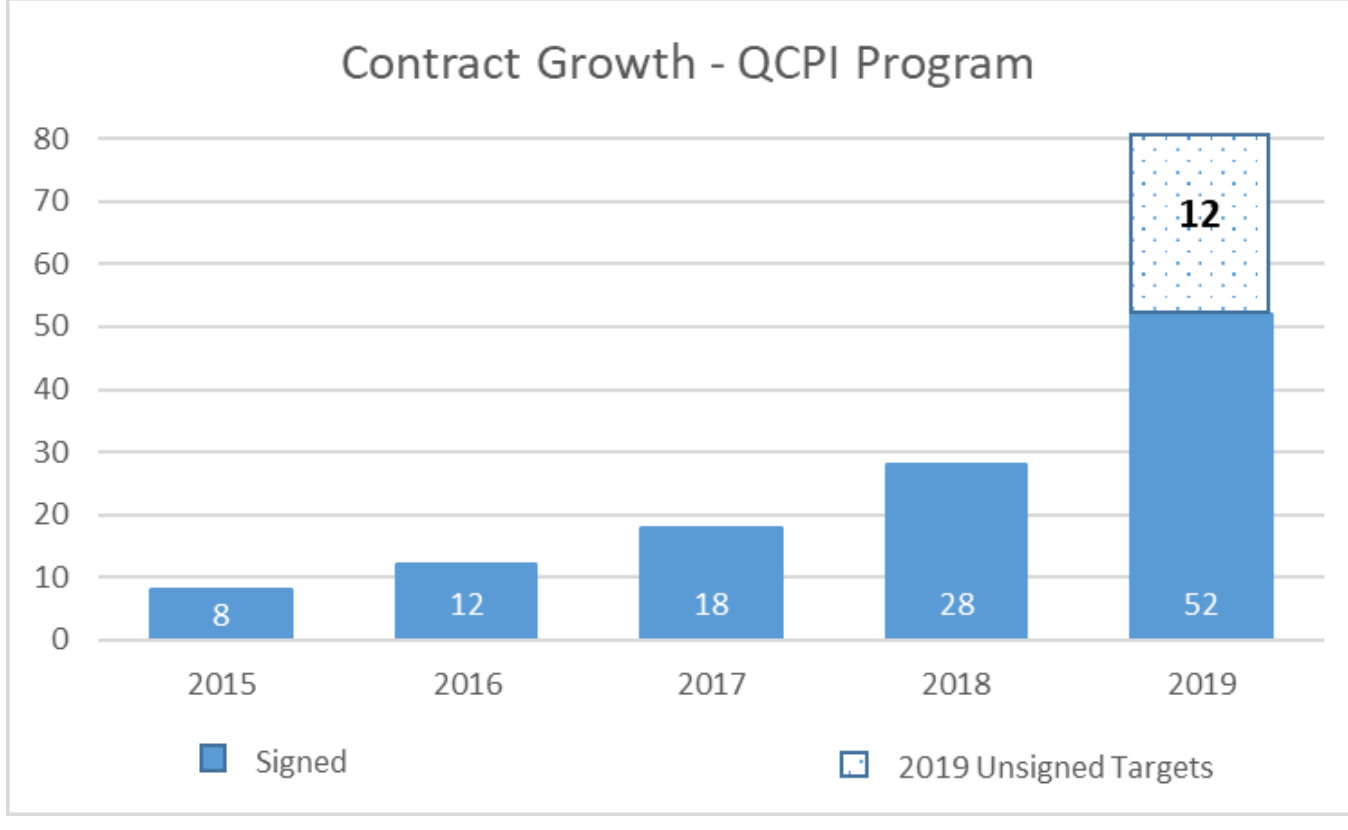
QCPI Member Attribution Growth



QCPI 2018 Final Scores



QCPI Contract Growth



Principles in our Pay for Value Approach

- Primary care providers are the best basis for value and have the least amount of counter-incentive to change
- Successfully measuring performance requires clear definition, supporting technology, meaningful reimbursement and thorough implementation
- Not all practices have the same capability; BCBST should design toward scalable solutions
- Physicians align best when variation is limited between our BCBST programs
- Clinical Data Exchange (CDE) between key partners helps improve scores and relationships
- Move toward reciprocal risk over time

Overview of Core Pay for Value Programs

***Objectives**: Align incentives with patient care and clinical outcomes, reward health care providers delivering higher-value care, and ultimately reduce medical costs*

1. **Quality Care Partnership Initiative**. Incorporates upside and downside risk sharing for performance against quality metrics; supported by Clinical Data Exchange
2. **BlueCare Quality Care Partnership Initiative**
3. **Medicare Advantage STARs**

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4. **Patient Centered Medical Homes**. Transforms primary care via standardized patient centered protocols and enhanced care coordination; supported by analytics on cost, quality and outcomes
5. **BlueCare Patient Centered Medical Homes**

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6. **Medicare Advantage Gain Share.** Permits upside gain for improved performance against benchmarked cost and outcomes; supported by Clinical Data Exchange

Common elements

- Pursue standardized metrics
- Share data timely
- Incentivize improved performance
- Support physician engagement

PCMH Provider Engagement & Partnership

https://youtu.be/alMMpNgZ9wU

Contact Information

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Thank you!
Questions?

Panel 1: Identify Opportunities to promote and implement value based care strategies:

RNs and Team Based Care

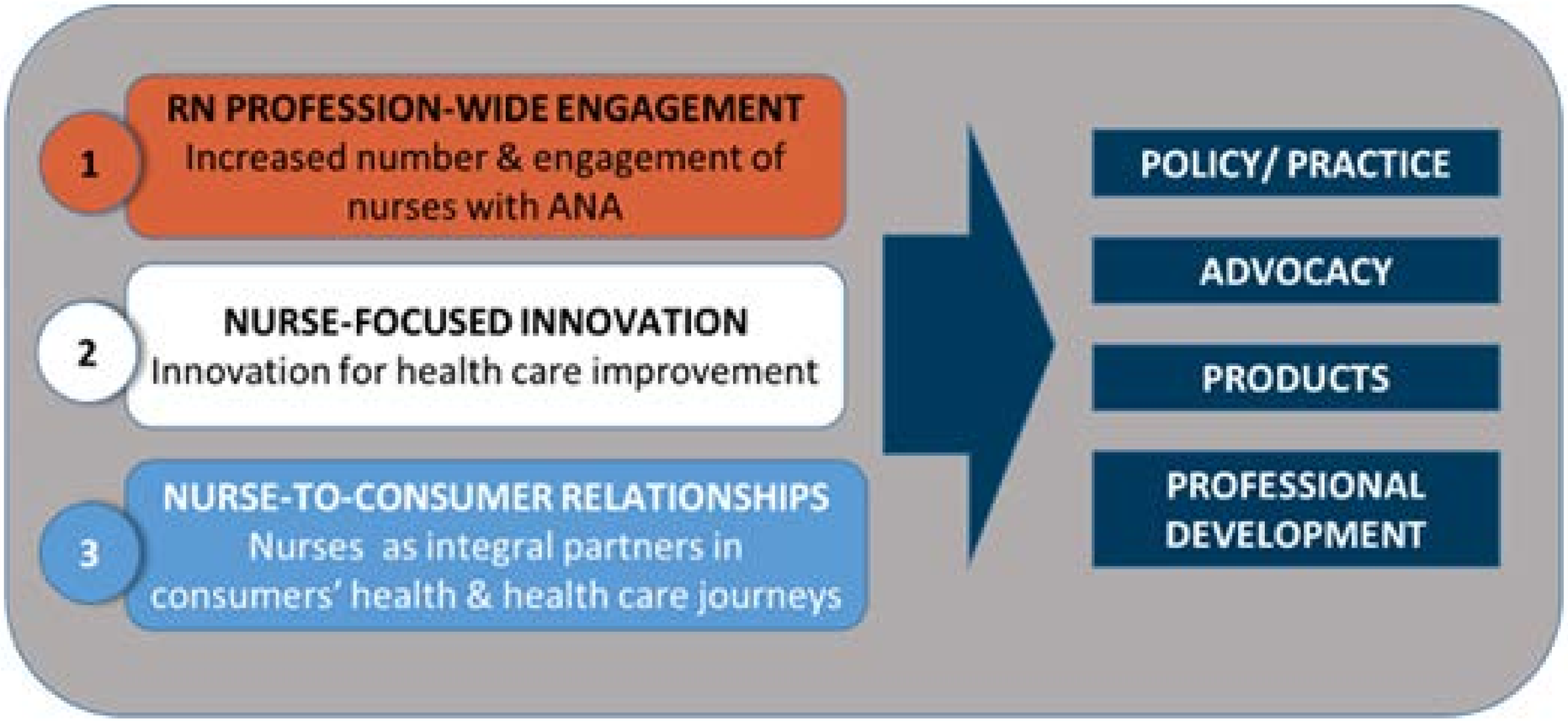
Faith Jones, MSN, RN, NEA-BC

ANA Board of Directors, Vice President

Director of Care Coordination, HealthTechS3

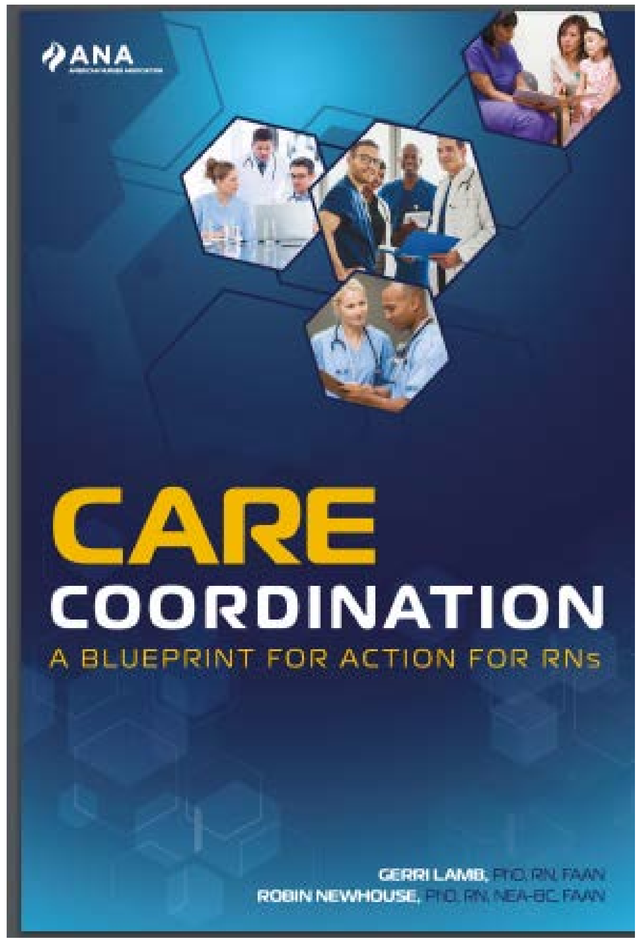
NATIONAL NURSE-LED CARE CONSORTIUM

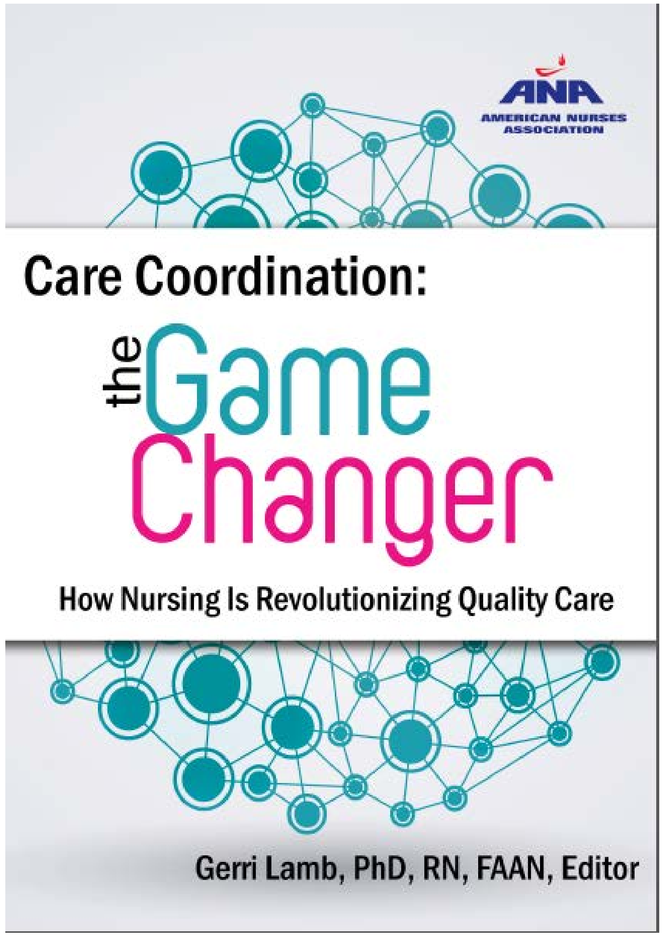
ANA Strategic Plan



https://www.nursingworld.org/ana/about-ana/strategic-plan/

Care Coordination Resources

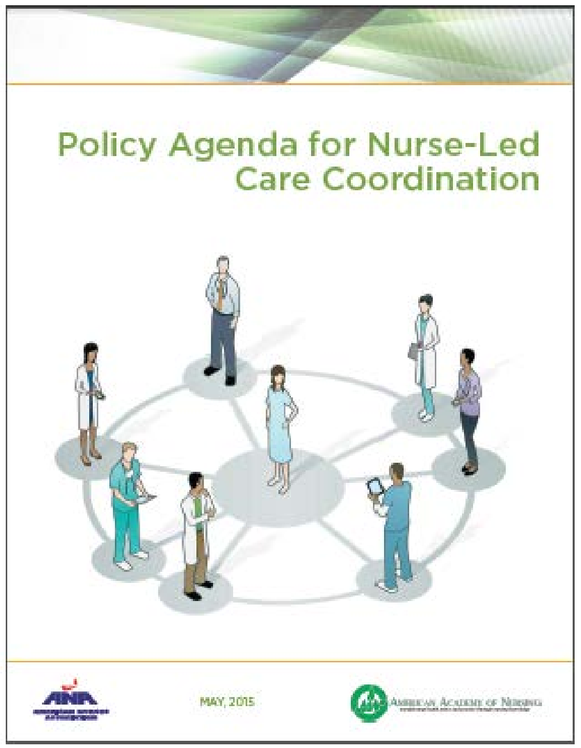




https://www.nursingworld.org/nurses-books/care-coordination-bundle/

HEALTHTECH S3

ANA and AAN – Policy and Advocacy



Policy

- Policy Brief: *Policy agenda for nurse-led care coordination*. Nursing Outlook 63 (July 2015) 521-530.
- Policy Brief: *The importance of health information technology in care coordination and transitional care*. Nursing Outlook 61 (November 2013) 475–489.
- Policy Brief: *The value of nursing care coordination: A white paper of the American Nurses Association*. Nursing Outlook 61 (November 2013) 490-501.
- Policy Brief: *The Imperative for Patient, Family, and Population Interprofessional Centered Approaches to Care Coordination and Transitional Care*. Nursing Outlook 60 (September 2012) 330-333.
- ANA's Care Coordination Statement (2012): ANA Urges Recognition and Funding for Nurses' Essential Role in Patient Care Coordination

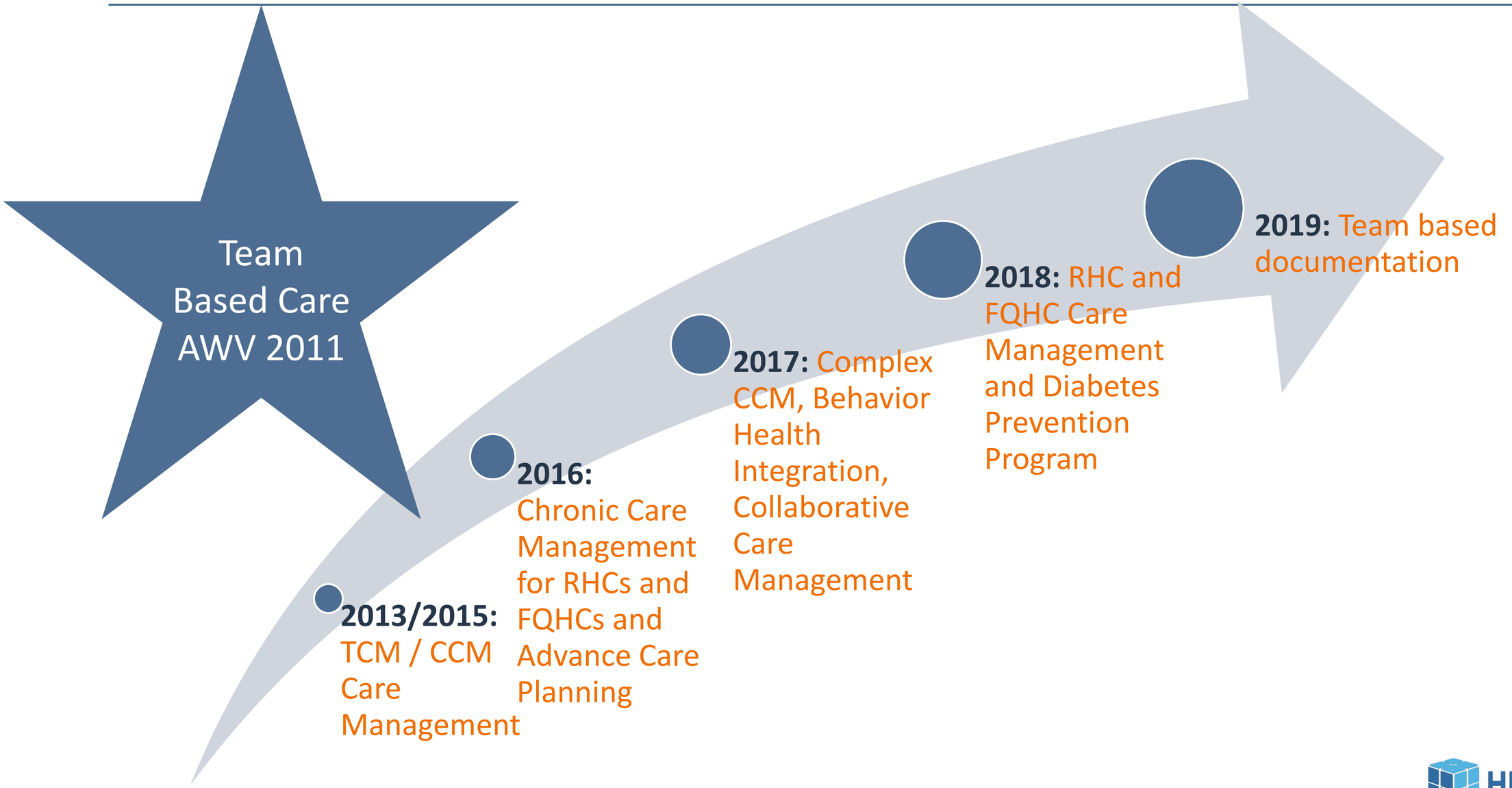
https://www.aannet.org/policy-advocacy/care-coordination

Care Delivery Models

"…new and evolving care delivery models, which feature an increased role for non-physician practitioners (often as care coordination facilitators or in team-based care) have been shown to improve patient outcomes while reducing costs, both of which are important Department goals as we move further toward quality- and value-based purchasing of health care services in the Medicare program and the health care system as a whole."

Vol. 80 Wednesday, No. 135 July 15, 2015, P 226

Care Coordination Growth and Development



Team Based Care

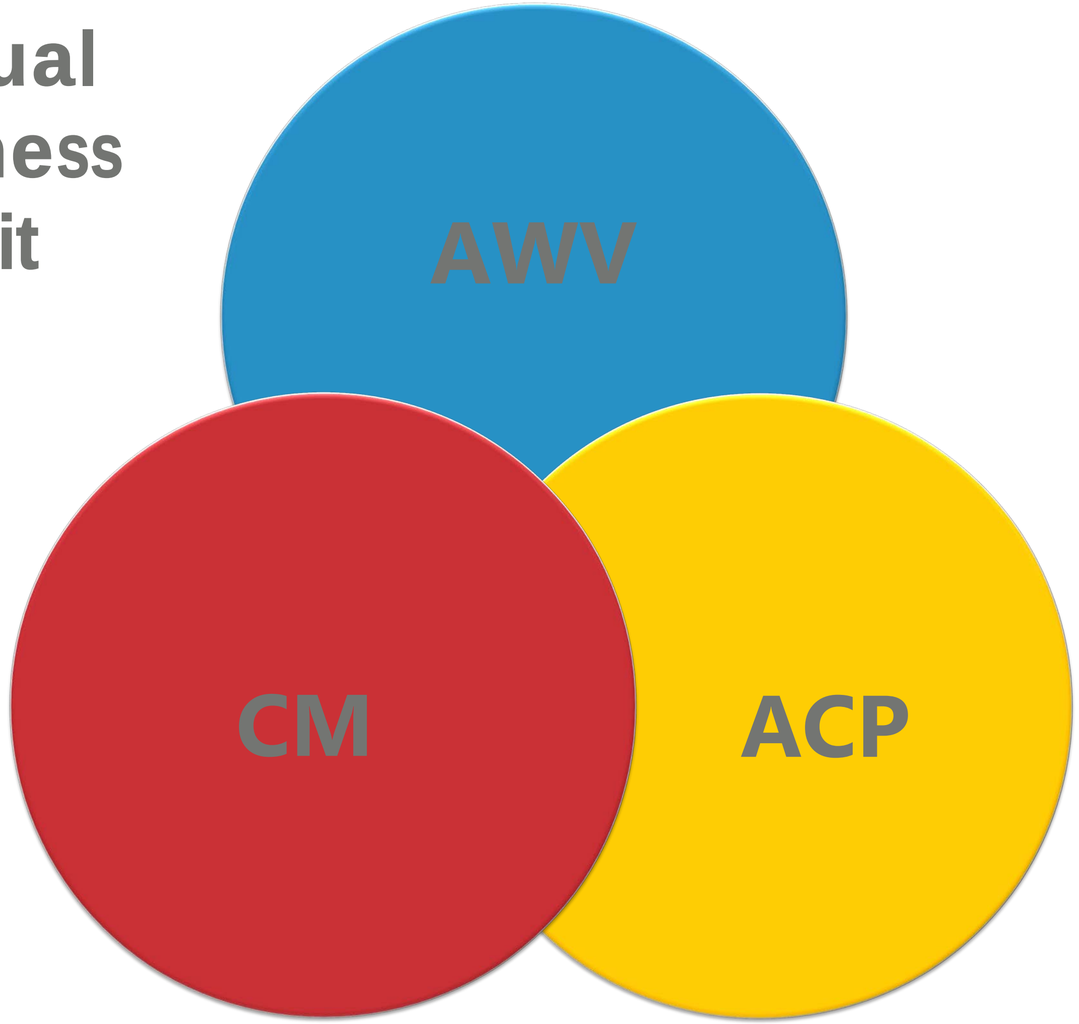
Care Coordination uses a Team Based Care Approach

Shared goals: The team—including the patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.
Clear roles: There are clear expectations for each team member's functions, responsibilities, and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.
Mutual trust: Team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement.
Effective communication: The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.
Measurable processes and outcomes: The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time.

Source: Mitchell et al., 2012

Care Coordination Trifecta

Annual Wellness Visit



Care Management
TCM, CCM, BHI

Advance Care Planning

Transitional Care Management (TCM)

- Patient does not need to be enrolled or agree to service
- Elements include:
  - An interactive contact
  - Non face to face reviews by clinical staff
  - Medication Reconciliation
  - Non face to face review by provider
  - Community Resource Identification
  - Referral Management
- RHC does not receive additional pay for TCM visit type paid at AIR payment
- Start CCM on day of Discharge and use office visit E&M and not TCM for the hospital follow up visit

Chronic Care Management

“We acknowledged that the care coordination included in services such as office visits does not always describe adequately the non-face-to-face care management work involved in primary care and may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries”

CMS CFR 7-15-2015

Elements of Chronic Care Management

Practice Eligibility

- Qualified EMR
- Availability of electronic communication with patient and care giver
- Collaboration and communication with community resources & referrals
- After hours coverage
- Care Plan Access
- Primary Care Provider general supervision of clinical staff

Patient Eligibility

- Medicare Patient
- Two or more chronic conditions expected to last at least 12 months or until the death of the patient
- At significant risk of death, acute exacerbation, decompensation, or functional decline without management
- Patient Consent
- CCM initiated by the primary care provider
- Time tracking of at least 20 min per calendar month

Elements of BHI and CoCM

Behavior Health Integration

- BHI is a team-based, collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions
- Same requirements as CCM except:
  - One mental or behavior health condition
  - Care Coordinator facilitates and coordinates treatments such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation
- Must use a validated rating scale assessment
- Provide at least 20 min of coordination per calendar month

Collaborative Care Management

- CoCM is a specific model of psychiatric care provided by the primary care team consisting of PCP and behavioral care manager who work in collaboration with a psychiatric consultant
- Behavioral care manager must be a qualified health care professional with formal education or training in behavioral; health such as social work, nursing, or psychology.
- Psychiatric consultant must be a medical professional trained in psychiatry and qualified to prescribe a full range of meds
- Conduct care conferences on patients weekly
- Must use a validated rating scale assessment
- Provide at least 60 min of coordination per calendar month

Why Wellness Visits?

"The AWV will include the establishment of, or update to, the individual's medical and family history, measurement of his or her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the ***goal of health promotion*** and ***disease detection*** and ***fostering the coordination of the screening and preventive services*** that may already be covered and paid for under Medicare Part B."

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7079.pdf

Who is Eligible to Provide the AWV?

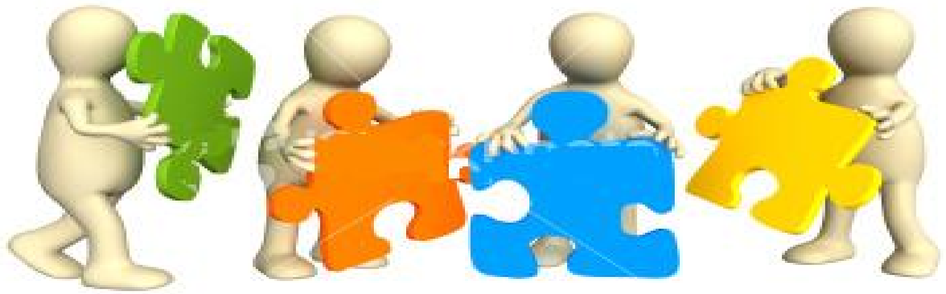
- A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act); **or**,
- A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); **or**,
- A ***medical professional*** (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii)) ….

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7079.pdf

The purpose of the Annual Wellness Visit is…

To provide:

- **Personalized Prevention Plan of Care**



Medicare's Definition of ACP

Voluntary Advance Care Planning

- "Voluntary ACP means the face-to-face service between a physician (***or other qualified health care professional***) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. "

MLN Matters® Number: MM9271 Related Change Request Number: 9271

Who Can Perform ACP?

"the services described by CPT codes 99497 and 99498 are appropriately provided by physicians

or using a team-based approach"

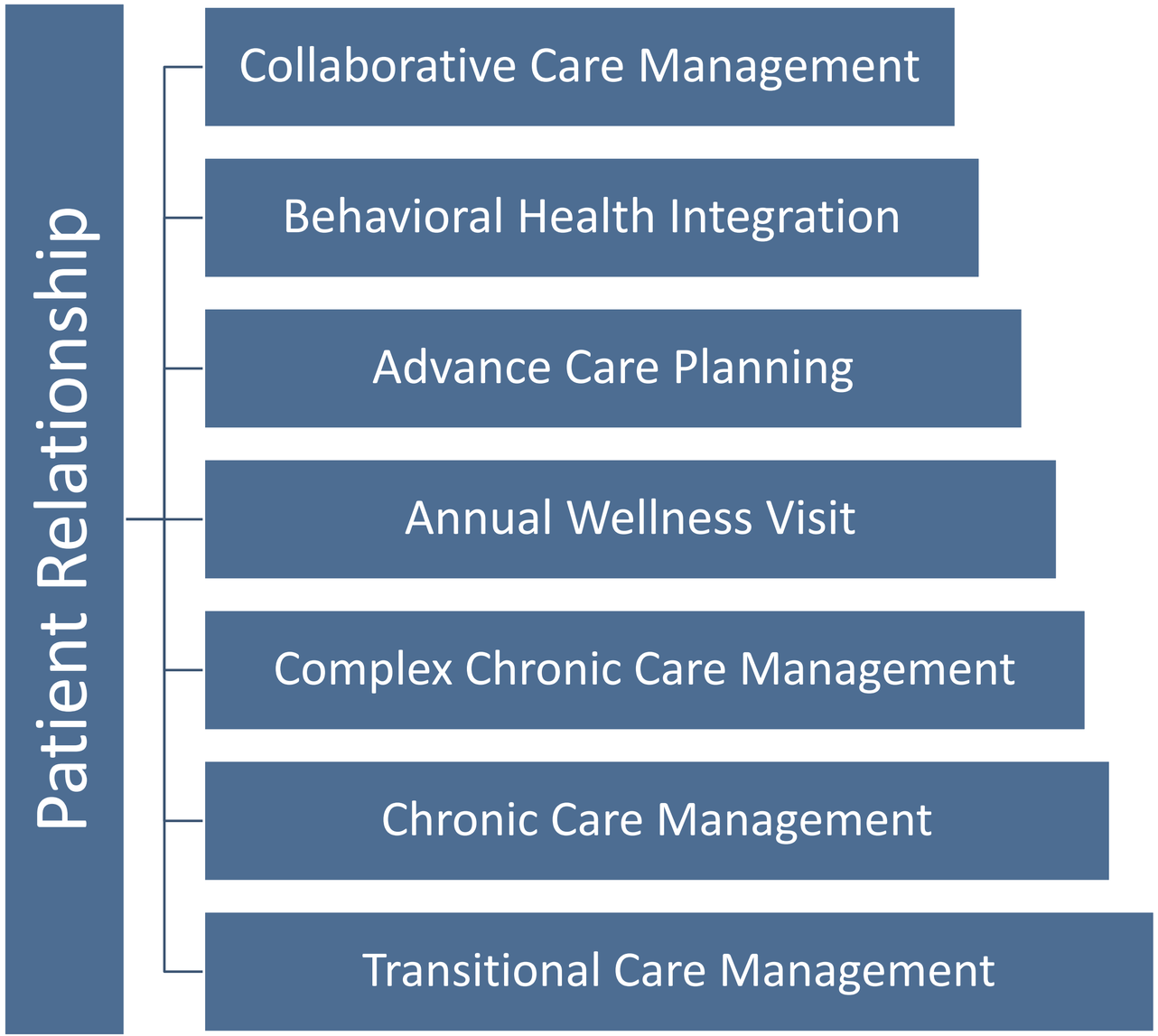
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

Advance Care Planning & Advance Directives

Advance Care Planning = Procedure

Advance Directive = Product

Building your Care Management Program



RNs in Primary Care is Affordable and Sustainable

Transitional Care Management (TCM) ~$238.98 within 7 day visit

Transitional Care Management (TCM) ~$166.50 within 14 day visit

Chronic Care Management (CCM) ~$42.17 per patient per month

Complex Chronic Care Management (CCM) ~$92.98 per patient per month

- Add'l Complex Chronic Care Management (CCM) ~$46.49 add'l 30 min

Behavior Health Integration (BHI) ~$48.65 per patient per month

Collaborative Care Management (CoCM) ~$129.38 per patient per month

- Add'l Collaborate Care Management (CoCM) ~$67.03 add'l 30 min

Annual Wellness Visit (AWC) ~$118.71

Advance Care Planning (ACP)~$86.49 first 30 minutes

Fee for Service

RNs in Primary Care is Affordable and Sustainable

Chronic Care Management (CCM) ~$67.03 per patient per month

Behavior Health Integration (BHI) ~$67.03 per patient per month

Collaborative Care Management (CoCM) ~$145.95 per patient per month

Annual Wellness Visit (AWC) ~$AIR Payment annually

Advance Care Planning (ACP)~$86.49 first 30 minutes

RHCs and FQHCs

Contact Information

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Director of Care Coordination and Lean Consulting

Faith Jones began her healthcare career in the US Navy over 35 years ago. She has worked in a variety of roles in clinical practice, education, management, administration, consulting, and healthcare compliance. Her knowledge and experience spans various settings including ambulance, clinics, hospitals, home care, and long term care. In her leadership roles she has been responsible for operational leadership for all clinical functions including multiple nursing specialties, pharmacy, laboratory, imaging, nutrition, therapies, as well as administrative functions related to quality management, case management, medical staff credentialing, staff education, and corporate compliance. She currently implements care coordination programs focusing on the Medicare population and teaches care coordination concepts nationally. She also holds a Green Belt in Healthcare and is a Certified Lean Instructor.

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